In Lieu of Form CMS-2552-10

	s required by law (42 USC 1395g; 42 CF since the beginning of the cost repor					N FORM APPROVED OMB NO. 0938- EXPIRES 05-31	-0050
AND SETTLEMEN		ORT CERTIFICATIO	N Provider C	CN: 15-0162	Period: From 01/01/2018 To 12/31/2018	Worksheet S Parts I-III Date/Time Pre 5/31/2019 7:4	
	REPORT STATUS						
Provi der use onl y	<ol> <li>[X] Electronically filed cost rep</li> <li>[] Manually submitted cost repor</li> <li>[0] If this is an amended report</li> <li>[F] Medicare Utilization. Enter</li> </ol>	rt enter the numbe 'F" for full or	r of times th "L" for low.				7:47 am
Contractor use only	(1) Ås Submitted 7. Contr (2) Settled without Audit 8. [N]	Received: actor No. Initial Report Final Report fo	for this Prov r this Provid	11.C ider CCN12.[	PR Date: ontractor's Vend O ]If line 5, co number of tin	or Code: olumn 1 is 4: { nes reopened =	4 Enter 0-9.
PART II - CER	TI FI CATI ON						
PROVI DED OR P ADMI NI STRATI V CERTI I HER el ect Expen 01/01 corre i nstr provi compl [ ]	E ACTION, FINE AND/OR IMPRISONMENT UNE ROCURED THROUGH THE PAYMENT DIRECTLY OF E ACTION, FINES AND/OR IMPRISONMENT MA FICATION BY CHIEF FINANCIAL OFFICER OF EBY CERTIFY that I have read the above ronically filed or manually submitted ses prepared by ST. FRANCIS HOSPITAL & /2018 and ending 12/31/2018 and to the ct, complete and prepared from the boo uctions, except as noted. I further of sion of health care services, and that i ance with such laws and regulations. I have read and agree with the above of signature on this certification stater	OR INDIRECTLY OF AY RESULT. R ADMINISTRATOR e certification cost report and & HEALTH CENTER e best of my kno obs and records certify that I a t the services i certification st	A KICKBACK O OF PROVIDER(S statement and the Balance (15-0162) f wledge and be of the provid m familiar wi dentified in atement. I ce	R WERE OTHER that I have Sheet and St or the cost elief, this r ler in accord th the laws this cost re ertify that I	WISE ILLEGAL, CRI examined the acc atement of Revenu- reporting period eport and stateme ance with applica and regulations in port were provide intend my elect	MINAL, CIVIL A companying ue and beginning ent are true, able regarding the ed in conic	
	signature on this certification state			ig equivarent	or my originar .	si gila cai e.	
		(Si gne		er or Adminis	strator of Provic	ler(s)	
			Title				
			Date				
			Title	XVIII			
С	ost Center Description	Title V	Part A	Part B	НІТ	Title XIX	
		1.00	2.00	3.00	4.00	5.00	

		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	-635, 230	189, 574	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	46, 085	-364		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
200.0	0 Total	0	-589, 145	189, 210	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.

	Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX		ATA	Provi c	ler CC		-0162	Period: From 01/01/ To 12/31/	/2018 /2018	of For Workshe Part I Date/Ti 5/31/20	et S-2 me Pre	2 epare
	<u>1.00</u> Hospital and Hospital Health Care Cc		00		3.00				4.00			
	Street: 8111 S. EMERSON AVENUE	PO Box:										1.
	City: INDIANAPOLIS	State: I	N	Zip Cod	e: 462	37	Coun	ty: MARION				2.
		Component Na	ame	CCN	CBS		Provi der			nt Syst		
				Number	Numb	ber	Туре	Certi fi ed		0, or		-
		1.00		2.00	3.0	0	4.00	5.00	V 6.00	XVIII 7.00		+
	Hospital and Hospital-Based Componer		I	2.00	] 3.0		4.00	3.00	0.00	17.00	0.00	-
		ST. FRANCIS HOSP		150162	2690	00	1	05/01/2006	N	Р	Р	3.
		HEALTH CENTER										
	Subprovider - IPF Subprovider - IRF	REHAB UNI T		15T162	2690	00	5	01/01/2005	N	P	Р	4.
	Subprovider - (Other)	KERAD UNI I		101102	2090		5	01/01/2005				6.
	Swing Beds - SNF											7.
	Swing Beds - NF											8.
	Hospital-Based SNF											9.
	Hospital-Based NF											10.
	Hospital-Based OLTC Hospital-Based HHA				-							11.
	Separately Certified ASC											13.
		HOSPI CE		151523	2690	00		01/01/2014				14.
	Hospital-Based Health Clinic - RHC											15.
	Hospital-Based Health Clinic - FQHC Hospital-Based (CMHC) I											16.
	Renal Dialysis											17.
	Other											19
								From:		То		
0	Cost Reporting Period (mm/dd/yyyy)							1.00		2.0		20.
	Type of Control (see instructions)							1		12/ 51/	2010	21.
					ļ		1 00					4
	Inpatient PPS Information						1.00	2.00		3. (	00	
01	Does this facility qualify and is it disproportionate share hospital adju §412.106? In column 1, enter "Y" fo facility subject to 42 CFR Section § hospital?) In column 2, enter "Y" fo Did this hospital receive interim un cost reporting period? Enter in colu	stment, in accord r yes or "N" for 412.106(c)(2)(Pid r yes or "N" for compensated care mn 1, "Y" for yes	dance wi no. Is ckle ame no. payment s or "N"	th 42 CF this endment s for th for no	R is for		Y Y	N Y				22.
02	the portion of the cost reporting pe Enter in column 2, "Y" for yes or "N reporting period occurring on or aft Is this a newly merged hospital that payments to be determined at cost re Enter in column 1, "Y" for yes or "N cost reporting period prior to Octob or "N" for no, for the portion of th October 1.	" for no for the er October 1. (se requires final u port settlement? " for no, for the er 1. Enter in co	portion ee instr uncomper (see in e portic olumn 2,	of the ructions) Isated ca Istructio In of the "Y" for	cost re ns) yes		Y	N				22.
03	Did this hospital receive a geograph rural as a result of the OMB standar adopted by CMS in FY2015? Enter in c for the portion of the cost reportin in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no.	ds for delineatin olumn 1, "Y" for g period prior to no for the portio er October 1. (so 100 but not more	ng stati yes or o Octobe on of th ee instr than 49	stical a "N" for er 1. Ent ecost cuctions) 9 beds (	reas no er as		Ν	Ν		Ν		22.
00	Which method is used to determine Me below? In column 1, enter 1 if date if date of discharge. Is the method reporting period different from the reporting period? In column 2, ente	of admission, 2 i of identifying th method used in th	f censu ne days ne prior	is days, in this cost no.	or 3 cost	0.1	t-of	3 N Out-of M	ledi cai	d 0	ther	23.
			Medicai paid da	id Medi ys elig unp da	caid ible aid ys	St Med pai c	tate i cai d d days	State H Medicaid eligible unpaid	IMO day	ys Med c	li cai d lays	
00	If this provider is an IPPS hospital	, enter the	<u>1.00</u> 1,	<u>2.</u> 617	355		. 00 9	4.00	<u>5.00</u> 16,3		<u>. 00</u> 309	24.
	In-state Medicaid paid days in colum Medicaid eligible unpaid days in col out-of-state Medicaid paid days in co out-of-state Medicaid eligible unpai 4, Medicaid HMO paid and eligible bu column 5, and other Medicaid days in	n 1, in-state umn 2, olumn 3, d days in column t unpaid days in							-, .		,	

PITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION D	ATA	Provider CC	CN: 15-0162	Period:		Workshe	et S-2	<u>2552-</u> 2
				From 01/0 To 12/3	01/2018 31/2018	Part I Date/Ti 5/31/20		
	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medica HMO da	iys   Med	ther li cai d lays	
	1.00	2.00	3.00	4.00	5.00	) 6	. 00	1
D0 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, 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.	23	21	0	0		360		25.
					Rural S 00	Date of 2.(	U	-
20 Enter your standard geographic classification (not w cost reporting period. Enter "1" for urban or "2" for		s at the be	ginning of		1	2.0		26.
D0 Enter your standard geographic classification (not w reporting period. Enter in column 1, "1" for urban of enter the effective date of the geographic reclassif	wage) status or "2" for i fication in	rural. If a column 2.	ppl i cabl e,		1			27.
00 If this is a sole community hospital (SCH), enter th effect in the cost reporting period.	ne number of	f periods S	CH status i		0	<b>E</b> 1		35.
					ni ng: 00	Endi 2. (	5	
00 Enter applicable beginning and ending dates of SCH s of periods in excess of one and enter subsequent dat	tes.	·						36.
00  f this is a Medicare dependent hospital (MDH), enter is in effect in the cost reporting period. 01  s this hospital a former MDH that is eligible for t				s	0			37.
accordance with FY 2016 OPPS final rule? Enter "Y" f instructions) 00 If line 37 is 1, enter the beginning and ending date	for yes or '	'N" for no.	(see					38.
greater than 1, subscript this line for the number of enter subsequent dates.								50.
				Y/	′N 00	Y/ 2. (		-
Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i 1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (i or "N" for no. (see instructions)	), (ii), on the mileage	<sup>-</sup> (iii)? En e requireme	ter in colu nts in	ume M nn	1	N		39.
<ul> <li>N" for no in column 1, for discharges prior to Octo</li> <li>"N" for no in column 1, for discharges prior to Octo</li> <li>no in column 2, for discharges on or after October 1</li> </ul>	ober 1. Ente	er "Y" for			/ V	XVIII	XIX	40.
Description Developt Conten (DDC) Conital					1.00	) 2.00	3.00	1
Prospective Payment System (PPS)-Capital D0 Does this facility qualify and receive Capital payme	ent for disp	proportiona	te share in	accordance	e N	Y	N	45.
with 42 CFR Section §412.320? (see instructions) 10 Is this facility eligible for additional payment exc pursuant to 42 CFR §412.348(f)? If yes, complete Wks Pt. III.	•		2		N	N	N	46.
00 Is this a new hospital under 42 CFR §412.300(b) PPS 00 Is the facility electing full federal capital paymer					N N	N N	N N	47. 48.
Teaching Hospitals 00 Is this a hospital involved in training residents in or "N" for no.	n approved (	GME program	s? Enter "	Y" for yes	Y			56.
D0 If line 56 is yes, is this the first cost reporting GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mor for yes or "N" for no in column 2. If column 2 is " "N", complete Wkst. D, Parts III & IV and D-2, Pt. I	or yes or "M nth of this 'Y", complet	N" for no i cost repor te Workshee	n column 1. ting period	lf column ? Enter "`	("			57.
D If line 56 is yes, did this facility elect cost rein defined in CMS Pub. 15-1, chapter 21, §2148? If yes,	mbursement 1	for physici	ans' servi c	es as	N			58.
00 Are costs claimed on line 100 of Worksheet A? If ye	es, complete	e Wkst. D-2	, Pt. I. NAHE 413.8 Y/N		N neet A e #	Pass-Th Qualifi Crite Coo	cation rion	59
			1.00	2.	00	3. (		
00 Are you claiming nursing and allied health education any programs that meet the criteria under §413.85? 01 If line 60 is yes, complete columns 2 and 3 for each	(see instru	uctions)	Y		23. 00	1		60. 60.
instructions) 22 If line 60 is yes, complete columns 2 and 3 for each					23.00	1		60.
instructions)								60.
03 If line 60 is yes, complete columns 2 and 3 for each					23.02	1		

Health Financial Systems HOSPITAL AND HOSPITAL HEALTH	CARE COMPLEX IDENTIFICATION DA		L & HEALTH CEN Provider C	CN: 15-0162 Pe	eriod:	u of Form CMS-2 Worksheet S-2	
				T	rom 01/01/2018 p 12/31/2018		
				NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qual i fi cati on Cri teri on Code	
	alata columna 2 and 2 for each		m (222	1.00	2.00	3.00	(0.0)
instructions)	plete columns 2 and 3 for each	progra	im. (see		23.03	1	60.04
		Y/N	I ME	Direct GME	I ME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
51.00 Did your hospital rece section 5503? Enter "Y column 1. (see instruc	' for yes or "N" for no in	Y			0. 81	0.00	61.00
51.01 Enter the average number FTEs from the hospital ending and submitted be	er of unweighted primary care s 3 most recent cost reports efore March 23, 2010. (see						61.01
FTE count (excluding O	total unweighted primary care 3/GYN, general surgery FTEs, added under section 5503 of						61.02
ACA). (see instructions 51.03 Enter the base line FTI and/or general surgery	5)						61.03
instructions) 61.04 Enter the number of un surgery allopathic and,	weighted primary care/or /or osteopathic FTEs in the						61.04
51.05 Enter the difference be and/or general surgery primary care and/or gen	FTEs and the current year's neral surgery FTE counts (line						61.05
	A §5503 award that is being d/or FTEs that are nonprimary						61.06
		Pr	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
			1.00	2.00	3.00	4.00	
specialty, if any, and for each new program. column 1, the program i program code. Enter in unweighted count. Enter FTE unweighted count. 51.20 Of the FTEs in line 61.	r in column 4, the direct GME				0.00		61.10
Enter in column 2, the	column 1, the program name. program code. Enter in column ted count. Enter in column 4,						
						1.00	
	ng the Health Resources and Sen E residents that your hospital				ind for which	0.00	62.00
your hospital received 52.01 Enter the number of FTI	HRSA PCRE funding (see instruct cresidents that rotated from a porting period of HRSA THC prog	ctions) a Teach	ing Health Cer	nter (THC) into			62.0 <sup>°</sup>
Teaching Hospitals tha 53.00 Has your facility train	t Claim Residents in Nonprovide ned residents in nonprovider se no in column 1. If yes, comple	er Sett ettings	tings during this c	cost reporting		Y	63.00
	no ni cordini i. Ti yes, compre			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
	A Base Year FTE Residents in No			1.00 This base year	2.00 is your cost	3.00 reporting	
54.00 Enter in column 1, if in the base year period resident FTEs attributa settings. Enter in col resident FTEs that trai	or after July 1, 2009 and before ine 63 is yes, or your facilit d, the number of unweighted nor able to rotations occurring in umn 2 the number of unweighted ned in your hospital. Enter in y (column 1 + column 2)). (see	ty trai n-prima all no d non-p n colum	ned residents ny care onprovider orimary care on 3 the ratio	0.00	0.00	0. 000000	64.00

	PLEX IDENTIFICATION I	DATA Provider (		eriod: com 01/01/2018	Worksheet S-2 Part I	
			Tc			parec
	Program Name	Program Code	Unweighted	Unweighted	Ratio (col.	
			FTEs Nonprovider	FTEs in Hospital	3/ (col. 3 + col. 4))	
			Site	nospi tai		
	1.00	2.00	3.00	4.00	5.00	
is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3	FAMI LY MEDI CI NE GENERAL	1350	9.00	13. 91	0. 392842	. 65.
divided by (column 3 + column 4)). (see instructions)			Unweighted FTEs Nonprovider	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			Si te	2.00	2.00	-
Section 5504 of the ACA Current	Year FTE Residents	in Nonprovider Settir	1.00 ngsEffective f	2.00 or cost report	3.00	
beginning on or after July 1, 2	010					
		ary caro rocidont	0.00	0.00		66 1
FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospi	occurring in all non unweighted non-prim tal. Enter in column	provider settings. ary care resident 3 the ratio of	0.00	0.00	0. 000000	66.0
FTEs attributable to rotations of Enter in column 2 the number of	occurring in all non unweighted non-prim tal. Enter in column	provider settings. ary care resident 3 the ratio of	Unwei ghted	Unwei ghted	Ratio (col.	66.0
FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospi	occurring in all non unweighted non-prim tal. Enter in column + column 2)). (see i	provider settings. ary care resident 3 the ratio of nstructions)	Unweighted FTEs	Unweighted FTEs in	Ratio (col. 3/ (col. 3 +	66.0
FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospi	occurring in all non unweighted non-prim tal. Enter in column + column 2)). (see i	provider settings. ary care resident 3 the ratio of nstructions)	Unwei ghted	Unwei ghted	Ratio (col.	66.0
FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospi (column 1 divided by (column 1 -	occurring in all non unweighted non-prim tal. Enter in column + column 2)). (see i Program Name 1.00 FAMILY MEDICINE	provider settings. ary care resident 3 the ratio of nstructions)	Unweighted FTEs Nonprovider	Unweighted FTEs in	Ratio (col. 3/ (col. 3 + col. 4)) 5.00	-
FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospi (column 1 divided by (column 1 -	occurring in all non unweighted non-prim tal. Enter in column + column 2)). (see i Program Name <u>1.00</u> FAMILY MEDICINE GENERAL	provider settings. ary care resident 3 the ratio of nstructions) Program Code 2.00	Unweighted FTEs Nonprovider Site 3.00	Unweighted FTEs in Hospital 4.00	Ratio (col. 3/ (col. 3 + col. 4)) 5.00	-
<ul> <li>FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospir (column 1 divided by (column 2 divided by column 1 divided by (column 1 divided by (column 2 divided by column 2 divided by (column 3 divided by (column 4 divided by (column</li></ul>	occurring in all non unweighted non-prim tal. Enter in column + column 2)). (see i Program Name <u>1.00</u> FAMILY MEDICINE GENERAL	provider settings. ary care resident 3 the ratio of nstructions) Program Code 2.00	Unweighted FTEs Nonprovider Site 3.00	Unweighted FTEs in Hospital 4.00	Rati o (col . 3/ (col . 3 + col . 4)) 5.00 0.475388	-
<ul> <li>FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospir (column 1 divided by (column 2, the program code. 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)</li> </ul>	occurring in all non unweighted non-prim tal. Enter in column + column 2)). (see i Program Name <u>1.00</u> FAMILY MEDICINE GENERAL	provider settings. ary care resident 3 the ratio of nstructions) Program Code 2.00 1350	Unwei ghted FTEs Nonprovi der Si te 3.00 10.72	Unwei ghted FTEs in Hospi tal 4.00 11.83	Ratio (col. 3/ (col. 3 + col. 4)) 5.00 0.475388	-
<ul> <li>FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospir (column 1 divided by (column 2, the program code. 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)</li> <li>Inpatient Psychiatric Facility 1</li> <li>Is this facility an Inpatient PS Enter "Y" for yes or "N" for no 1f line 70 is yes: Column 1: Divise face to cost report filed on or 1 d2 CFR 412. 424(d)(1)(iii)(c)) C program in accordance with 42 Cl column 3: If column 2 is Y, indi</li> </ul>	PPS sychiatric Facility have before November 15, olumn 2: Did this fa FR 412. 424 (d)(1)(ii	provider settings. ary care resident 3 the ratio of nstructions) Program Code 2.00 1350 (IPF), or does it con an approved GME teach 2004? Enter "Y" for cility train resident i)(D)? Enter "Y" for	Unweighted FTEs Nonprovider Site 3.00 10.72 10.72	Unwei ghted FTEs in Hospi tal 4.00 11.83 11.83 11.00 provi der? N the most no. (see ni ng no.	Ratio (col. 3/ (col. 3 + col. 4)) 5.00 0.475388	67.1
Enter in column 2 the number of FTEs that trained in your hospir (column 1 divided by (column 1 ) (column 1 divided by (column 1 ) (column 1 divided by (column 1 ) ) (column 1 divided by (column 1 ) ) ) (column 1 divided by (column 1 ) ) ) ) (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) ) (D) Inpatient Psychiatric Facility 1 ) (D) Is this facility an Inpatient Psychiatric Facility 1 ) (C) (C) (C) (C) (C) (C) (C)	<pre>occurring in all non unweighted non-prim tal. Enter in column tal. Enter in column column 2)). (see i Program Name 1.00 FAMILY MEDICINE GENERAL PPS sychiatric Facility o. d the facility have before November 15, olumn 2: Did this fa FR 412.424 (d)(1)(ii i cate which program ty PPS</pre>	provider settings. ary care resident 3 the ratio of nstructions) Program Code 2.00 1350 (IPF), or does it con an approved GME teach 2004? Enter "Y" for cility train resident i)(D)? Enter "Y" for year began during thi	Unweighted FTEs Nonprovider Site 3.00 10.72 tain an IPF subp ing program in types or "N" for m s in a new teach yes or "N" for m s cost reporting	Unwei ghted FTEs in Hospi tal 4.00 11.83 11.83 11.00 provi der? N the most no. (see ni ng no.	Ratio (col. 3/ (col. 3 + col. 4)) 5.00 0.475388 0.475388 0.2.00 3.00	- 67.1

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	rovider CCN: 15-0162	Period: From 01/01/2018 To 12/31/2018		epared:
		1.0	0 2.00 3.00	)
6.00 If line 75 is yes: Column 1: Did the facility have an approved 6 recent cost reporting period ending on or before November 15, 20 no. Column 2: Did this facility train residents in a new teachir CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Col indicate which program year began during this cost reporting period.	004? Enter "Y" for yes ng program in accordan umn 3: If column 2 is	or "N" for ce with 42 Y,	0	76.00
Long Term Care Hospital PPS			1.00	_
0.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes and 1.00 Is this a LTCH co-located within another hospital for part or al "Y" for yes and "N" for no. TEFRA Providers		ng period? Enter	N N	80.00 81.00
<ul> <li>6.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEF</li> <li>6.00 Did this facility establish a new Other subprovider (excluded ur §413.40(f)(1)(i)? Enter "Y" for yes and "N" for no.</li> </ul>			N	85.00 86.00
7.00 Is this hospital an extended neoplastic disease care hospital cl 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	assified under sectio	n	Ν	87.00
		V 1.00	XI X 2.00	_
Title V and XIX Services 0.00 Does this facility have title V and/or XIX inpatient hospital se yes or "N" for no in the applicable column.	ervices? Enter "Y" for	N	Y	90.00
1.00 Is this hospital reimbursed for title V and/or XIX through the c full or in part? Enter "Y" for yes or "N" for no in the applicab		N	Y	91.00
2.00 Are title XIX NF patients occupying title XVIII SNF beds (dual c instructions) Enter "Y" for yes or "N" for no in the applicable	certification)? (see column.		N	92.00
<ol> <li>Does this facility operate an ICF/IID facility for purposes of t "Y" for yes or "N" for no in the applicable column.</li> <li>Does title V or XIX reduce capital cost? Enter "Y" for yes, and</li> </ol>		N N	N	93.00
applicable column. 5.00   f line 94 is "Y", enter the reduction percentage in the applica		0.00	0.00	95.00
6.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or applicable column.		N	N	96.00
7.00 If line 96 is "Y", enter the reduction percentage in the applica 8.00 Does title V or XIX follow Medicare (title XVIII) for the interr stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for y column 1 for title V, and in column 2 for title XIX.	ns and residents post	0. 00 N	0. 00 Y	97.00 98.00
8. 01 Does title V or XIX follow Medicare (title XVIII) for the report C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title title XIX.			Y	98.01
8.02 Does title V or XIX follow Medicare (title XVIII) for the calcul bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N for title V, and in column 2 for title XIX.		Ν	Y	98.02
8. 03 Does title V or XIX follow Medicare (title XVIII) for a critical reimbursed 101% of inpatient services cost? Enter "Y" for yes or for title V, and in column 2 for title XIX.			N	98.03
8. 04 Does title V or XIX follow Medicare (title XVIII) for a CAH reim outpatient services cost? Enter "Y" for yes or "N" for no in col in column 2 for title XIX.		N	N	98.04
8.05 Does title V or XIX follow Medicare (title XVIII) and add back t Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in colum column 2 for title XIX.			Y	98.0
8.06 Does title V or XIX follow Medicare (title XVIII) when cost reim Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 f column 2 for title XIX. Rural Providers		N	Y	98.00
05.00 Does this hospital qualify as a CAH? 06.00 If this facility qualifies as a CAH, has it elected the all-incl	usive method of payme	nt N	-	105.00 106.00
for outpatient services? (see instructions) 07.00 If this facility qualifies as a CAH, is it eligible for cost rei training programs? Enter "Y" for yes or "N" for no in column 1. yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 reimburged lf wes complete Wkst. D. 2.	(see instructions) If			107.00
reimbursed. If yes complete Wkst. D-2, Pt. II. 08.00 s this a rural hospital qualifying for an exception to the CRNA CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	A fee schedule? See 4	2 N		108.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider C		eriod: rom 01/01/2			et S-2	
		Т	o 12/31/2				epared: 47 am
	Physi cal	Occupati onal	Speech			atory	
109.00 If this hospital qualifies as a CAH or a cost provider, are	1.00 N	2.00 N	3.00 N		4.0 N		109.00
therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.							
					1.0		
110.00 Did this hospital participate in the Rural Community Hospital Demonstration) for the current cost reporting period? Enter " complete Worksheet E, Part A, lines 200 through 218, and Wor applicable.	Y" for yes or	"N" for no. I	f yes,		N		110.00
			1.00		2.0	0	-
111.00 If this facility qualifies as a CAH, did it participate in t Health Integration Project (FCHIP) demonstration for this co "Y" for yes or "N" for no in column 1. If the response to co integration prong of the FCHIP demo in which this CAH is par Enter all that apply: "A" for Ambulance services; "B" for ad for tele-health services.	ost reporting Diumn 1 is Y, rticipating ir	period? Enter enter the column 2.	N				111.00
Miscellaneous Cost Reporting Information				1.00 2	2.00	3.00	
115.00 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, chapter 22, §2208.1.	If column 2 nt for long te rs) based on 1	is "E", enter erm care (inclu the definition	in column des	N		0	115.00
116.00 s this facility classified as a referral center? Enter "Y" 117.00 s this facility legally-required to carry malpractice insur no.			"N" for	N N			116.00 117.00
118.00 Is the malpractice insurance a claims-made or occurrence pol claim-made. Enter 2 if the policy is occurrence.	icy? Enter 1	if the policy	is	2			118.00
		Premi ums	Losses		nsura	ance	
		1.00	2.00		3.0	0	-
118.01 List amounts of malpractice premiums and paid losses:		899, 509		063			9118. O
			1.00		2.0	0	-
118.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sched and amounts contained therein.			N		2.0	0	118.0
19.00 DO NOT USE THIS LINE 20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in	ר" א column 1,	(" for yes or	N		N		119.0 120.0
"N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA §3121 and applicable amendmen							
Hold Harmless provision in ACA §3121 and applicable amendmen Enter in column 2, "Y" for yes or "N" for no. 121.00Did this facility incur and report costs for high cost impla	nts? (see inst	tructions)	Y				121.00
<ul> <li>Hold Harmless provision in ACA \$3121 and applicable amendment</li> <li>Enter in column 2, "Y" for yes or "N" for no.</li> <li>21.00 Did this facility incur and report costs for high cost implation patients? Enter "Y" for yes or "N" for no.</li> <li>22.00 Does the cost report contain heal thcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included.</li> </ul>	nts? (see inst antable device fined in §1903	tructions) es charged to B(w)(3) of the	Y Y		5.0	3	
<ul> <li>Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no.</li> <li>21.00 Did this facility incur and report costs for high cost implation patients? Enter "Y" for yes or "N" for no.</li> <li>22.00 Does the cost report contain heal thcare related taxes as defact? Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information</li> <li>25.00 Does this facility operate a transplant center? Enter "Y" for</li> </ul>	nts? (see ins1 antable device fined in §1903 Lis "Y", ente	tructions) es charged to 8(w)(3) of the er in column 2			5.0	3	122. 0
<ul> <li>Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no.</li> <li>21.00 Did this facility incur and report costs for high cost implation patients? Enter "Y" for yes or "N" for no.</li> <li>22.00 Does the cost report contain heal thcare related taxes as defact?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information</li> <li>25.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below.</li> <li>26.00 If this is a Medicare certified kidney transplant center, enter</li> </ul>	nts? (see inst antable device fined in §1903 I is "Y", ente or yes and "N" nter the certi	tructions) es charged to B(w)(3) of the er in column 2	Y		5.0	3	122.0
<ul> <li>Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no.</li> <li>21.00 Did this facility incur and report costs for high cost implation patients? Enter "Y" for yes or "N" for no.</li> <li>22.00 Does the cost report contain heal thcare related taxes as defined to the worksheet A line number where these taxes are included. Transplant Center Information</li> <li>25.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below.</li> <li>26.00 If this is a Medicare certified kidney transplant center, entire this is a Medicare certified heart transplant center, entire the section of the section</li></ul>	nts? (see inst intable device ined in §1903 is "Y", ente or yes and "N" nter the certi 2. cer the certif	tructions) es charged to 3(w)(3) of the er in column 2 f for no. If fication date	Y		5.0	3	122. 0 125. 0 126. 0
<ul> <li>Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no.</li> <li>21.00 Did this facility incur and report costs for high cost implation patients? Enter "Y" for yes or "N" for no.</li> <li>22.00 Does the cost report contain heal thcare related taxes as defined to the Worksheet A line number where these taxes are included. Transplant Center Information</li> <li>25.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below.</li> <li>26.00 If this is a Medicare certified heart transplant center, entin column 1 and termination date, if applicable, in column 2</li> <li>27.00 If this is a Medicare certified heart transplant center, entin column 1 and termination date, if applicable, in column 2</li> </ul>	nts? (see inst antable device fined in §1903 is "Y", ente or yes and "N' nter the certi cer the certif cer the certif	tructions) es charged to 3(w)(3) of the er in column 2 for no. If fication date fication date	Y		5.0	3	122. 0 125. 0 126. 0 127. 0
<ul> <li>Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no.</li> <li>21.00 Did this facility incur and report costs for high cost implation patients? Enter "Y" for yes or "N" for no.</li> <li>22.00 Does the cost report contain healthcare related taxes as deformed and the worksheet A line number where these taxes are included. Transplant Center Information</li> <li>25.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyy) below.</li> <li>26.00 If this is a Medicare certified kidney transplant center, entin column 1 and termination date, if applicable, in column 2</li> <li>27.00 If this is a Medicare certified heart transplant center, entin column 1 and termination date, if applicable, in column 2</li> <li>28.00 If this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 2</li> <li>29.00 If this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 2</li> </ul>	nts? (see inst antable device fined in §1903 is "Y", ente or yes and "N" nter the certi 2. cer the certif 2. cer the certif 2.	tructions) es charged to 8(w)(3) of the er in column 2 for no. If fication date fication date	Y N		5. 0	3	122. 0 125. 0 126. 0 127. 0 128. 0
<ul> <li>Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no.</li> <li>21.00 Did this facility incur and report costs for high cost implation patients? Enter "Y" for yes or "N" for no.</li> <li>22.00 Does the cost report contain heal thcare related taxes as defined act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information</li> <li>25.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyy) below.</li> <li>26.00 If this is a Medicare certified kidney transplant center, entin column 1 and termination date, if applicable, in column 2</li> <li>27.00 If this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 2</li> <li>28.00 If this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 2</li> <li>29.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2</li> <li>29.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2</li> <li>29.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2</li> <li>29.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2</li> <li>20.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2</li> <li>29.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2</li> </ul>	nts? (see inst antable device fined in §1903 is "Y", ente or yes and "N" nter the certi for the certif er the certif er the certifi enter the certifi	tructions) es charged to 3(w)(3) of the er in column 2 for no. If fication date fication date fication date cation date in	Y N		5. 0	3	122. 0 125. 0 126. 0 127. 0 128. 0 129. 0
<ul> <li>Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no.</li> <li>21.00 Did this facility incur and report costs for high cost implation patients? Enter "Y" for yes or "N" for no.</li> <li>22.00 Does the cost report contain heal thcare related taxes as defined Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information</li> <li>25.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below.</li> <li>26.00 If this is a Medicare certified heart transplant center, entin column 1 and termination date, if applicable, in column 2</li> <li>27.00 If this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 2</li> <li>28.00 If this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 2</li> <li>29.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2</li> <li>29.00 If this is a Medicare certified lung transplant center, enter column 1 and termination date, if applicable, in column 2</li> <li>20.00 If this is a Medicare certified lung transplant center, enter column 1 and termination date, if applicable, in column 2</li> <li>20.00 If this is a Medicare certified lung transplant center, enter column 1 and termination date, if applicable, in column 2</li> <li>20.00 If this is a Medicare certified lung transplant center, enter column 1 and termination date, if applicable, in column 2</li> <li>20.00 If this is a Medicare certified pancreas transplant center, enter column 1 and termination date, if applicable, in column 2</li> <li>20.00 If this is a Medicare certified pancreas transplant center, enter column 1 and termination date, if applicable, in column 2</li> </ul>	nts? (see inst antable device fined in §1903 is "Y", ente or yes and "N" neer the certif cer the certif cer the certifi enter the certifi enter the certifi enter the certifi	tructions) es charged to 3(w)(3) of the er in column 2 f for no. If fication date fication date fication date cation date in tification	Y N		5.0	3	122. 0 125. 0 126. 0 127. 0 128. 0 129. 0 130. 0
<ul> <li>Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no.</li> <li>21.00 Did this facility incur and report costs for high cost implation patients? Enter "Y" for yes or "N" for no.</li> <li>22.00 Does the cost report contain heal thcare related taxes as deformed a cost report contain heal thcare related taxes as deformed a transplant center Information</li> <li>25.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below.</li> <li>26.00 If this is a Medicare certified kidney transplant center, entin column 1 and termination date, if applicable, in column 2</li> <li>27.00 If this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 2</li> <li>28.00 If this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 2</li> <li>29.00 If this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 2</li> <li>29.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2</li> <li>20.00 If this is a Medicare certified lung transplant center, enter column 1 and termination date, if applicable, in column 2</li> <li>20.00 If this is a Medicare certified lung transplant center, enter column 1 and termination date, if applicable, in column 2</li> <li>20.00 If this is a Medicare certified pancreas transplant center, date in column 1 and termination date, if applicable, in column 2</li> <li>20.00 If this is a Medicare certified pancreas transplant center, date in column 1 and termination date, if applicable, in column 2</li> <li>20.00 If this is a Medicare certified intestinal transplant center, date in column 1 and termination date, if applicable, in column 2</li> </ul>	nts? (see instantable device fined in §1900 lis "Y", ente or yes and "N" nter the certif cer the certif cer the certif enter the certifi enter the certifi enter the certifi c, enter the certifi c, enter the certifi c, enter the certifi	tructions) es charged to 3(w)(3) of the er in column 2 for no. If fication date fication date cation date in tification certification	Y N		5. 0	3	122. 0 125. 0 126. 0 127. 0 128. 0 129. 0 130. 0 131. 0
<ul> <li>Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no.</li> <li>121.00 Did this facility incur and report costs for high cost implation patients? Enter "Y" for yes or "N" for no.</li> <li>122.00 Does the cost report contain heal thcare related taxes as defined Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information</li> <li>125.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below.</li> <li>126.00 If this is a Medicare certified heart transplant center, entin column 1 and termination date, if applicable, in column 2</li> <li>127.00 If this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 2</li> <li>128.00 If this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 2</li> <li>128.00 If this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 2</li> <li>129.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2</li> <li>130.00 If this is a Medicare certified lung transplant center, enter column 1 and termination date, if applicable, in column 2</li> <li>131.00 If this is a Medicare certified pancreas transplant center, enter date in column 1 and termination date, if applicable, in column 2</li> </ul>	nts? (see instantable device Fined in §1903 is "Y", enter or yes and "N" nter the certif cer the certif cer the certif enter the certifi enter the certifi enter the certifi cer the certifi cer the certifi cer the certifi cer the certifi	tructions) es charged to 3(w)(3) of the er in column 2 for no. If fication date fication date fication date cation date in rtification certification fication date	Y N		5. 0	3	121. 00 122. 00 125. 00 126. 00 127. 00 128. 00 129. 00 130. 00 131. 00 132. 00 133. 00

Health Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE COMPLE		PITAL & HEALTH CEN Provider C	CN: 15-0162	In Lie Period: From 01/01/2018 To 12/31/2018	u of Form CMS- Worksheet S-2 Part I Date/Time Pre 5/31/2019 7:4	2 epared:
						_
				1.00	2.00	
140.00 Are there any related organization chapter 10? Enter "Y" for yes or are claimed, enter in column 2 the	"N" for no in column 1	. If yes, and home umber. (see instruc	e office costs		158014	140.00
1.00 If this facility is part of a cha office and enter the home office			ough 143 the r	3.00 name and address	s of the home	
141.00 Name: SI STERS OF ST. FRANCI S HEA SERVI C	LTH Contractor's Nam	e: WI SCONSI N PHYSI ( SERVI CES	CIANSContracto	r's Number: 0810	)1	141.00
142.00 Street: 1515 W DRAGOON TRL	PO Box:	1290				142.00
143.00City: MISHAWAKA	State:	IN	Zip Code:	4654	14	143.00
					1.00	_
	ata inaludad in Washala	+ A2			1.00	144.00
144.00 Are provider based physicians' com	sts included in worksn	leet A?			Y	144.00
				1.00	2.00	-
145.00 If costs for renal services are c	laimed on Wkst A lin	e 74 are the cost	ts for	Y	2.00	145.00
inpatient services only? Enter "Y no, does the dialysis facility in period? Enter "Y" for yes or "N"	" for yes or "N" for n clude Medicare utiliza	no in column 1. If	column 1 is			
146.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no i yes, enter the approval date (mm/	n column 1. (See CMS P			N		146.00
						_
					1.00	
147.00 Was there a change in the statist	ical basis? Enter "Y"	for yes or "N" for	no.		N	147.00
148.00 Was there a change in the order of	f allocation? Enter "Y	" for yes or "N" f	for no.		N	148.00
149.00 Was there a change to the simplif	led cost finding metho				N	149.00
		Part A 1.00	Part B 2.00	Title V 3.00	Title XIX 4.00	-
Does this facility contain a prov	idor that qualifies fo					
or charges? Enter "Y" for yes or						
155.00 Hospi tal		N	N	N	N	155.00
156.00 Subprovi der – IPF		N	N	N	N	156.00
157. 00 Subprovi der – IRF		N	N	N	N	157.00
158. 00 SUBPROVI DER						158.00
159. 00 SNF		Ν	N	N	N	159.00
160.00 HOME HEALTH AGENCY		N	N	N	N	160.00
161. 00 CMHC			N	N	N	161.00
					1.00	-
Mul ti campus						
165.00 Is this hospital part of a Multic	ampus hospital that ha	is one or more camp	ouses in diffe	rent CBSAs?	N	165.00
Enter "Y" for yes or "N" for no.						
	Name	County		Code CBSA	FTE/Campus	-
	0	1.00	2.00 3	4.00	5.00	
166.00 If line 165 is yes, for each					0.00	0166.00
campus enter the name in column O, county in column 1, state in						
column 2, zip code in column 3,						
CBSA in column 4, FTE/Campus in						
column 5 (see instructions)						
					1.00	-
Health Information Technology (HI	T) incentive in the Am	nerican Recovery a	nd Reinvestmer	nt Act		
167.00 Is this provider a meaningful use					Y	167.00
168.00 If this provider is a CAH (line 1				, enter the	(	0168.00
reasonable cost incurred for the	HIT assets (see instru	ictions)				
168.01 If this provider is a CAH and is						168.01
exception under §413.70(a)(6)(ii)	? Enter "Y" for yes or	"N" for no. (see	instructions)			
169.00 If this provider is a meaningful		and is not a CAH	(line 105 is	"N"), enter the	9.9	9169.00
transition factor. (see instruction	ons)					
				Begi nni ng	Endi ng	-
170 00 Enton in columns 1 and 2 the FUD	poginning data and and	ling data far the	conorting	1.00	2.00	170.00
170.00 Enter in columns 1 and 2 the EHR period respectively (mm/dd/yyyy)	beginning date and end	ning date for the r	eporiting	01/01/2018	12/31/2018	170.00

Health Financial Systems						
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX I	DENTIFICATION DATA	Period: From 01/01/2018	Worksheet S-2	2		
			To 12/31/2018			
			1.00	2.00		
171.00 If line 167 is "Y", does this provide section 1876 Medicare cost plans repo	N		0171.00			
"Y" for yes and "N" for no in column 1876 Medicare days in column 2. (see	1. If column 1 is yes,	enter the number of secti	on			

OSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C		eriod:	Worksheet S-2	2
				rom 01/01/2018 o 12/31/2018		epare
					5/31/2019 7:4	
				Y/N	Date	
	Constal Instruction: Enter V for all VES responses. Enter N	for all NO r		1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format.	N TOF ALL NO TO	esponses. Enter	an dates in	the	
	COMPLETED BY ALL HOSPITALS					
	Provider Organization and Operation					
. 00	Has the provider changed ownership immediately prior to the			N		1.
	reporting period? If yes, enter the date of the change in o	column 2. (see	1			_
			Y/N 1.00	Date 2.00	V/I 3.00	-
. 00	Has the provider terminated participation in the Medicare F	Program? If	N 1.00	2.00	3.00	2.
. 00	yes, enter in column 2 the date of termination and in colum					
	voluntary or "I" for involuntary.				ĺ	
. 00	Is the provider involved in business transactions, includir		Y			3.
	contracts, with individuals or entities (e.g., chain home of					
	or medical supply companies) that are related to the provid officers, medical staff, management personnel, or members of					
	of directors through ownership, control, or family and othe					
	relationships? (see instructions)					
			Y/N	Туре	Date	
			1.00	2.00	3.00	
	Financial Data and Reports					- · ·
. 00	Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" f		Y	A		4.
	or "R" for Reviewed. Submit complete copy or enter date ava					
	column 3. (see instructions) If no, see instructions.					
. 00	Are the cost report total expenses and total revenues diffe	erent from	N		ĺ	5.
	those on the filed financial statements? If yes, submit red	conciliation.				
				Y/N	Legal Oper.	_
				1.00	2.00	
. 00	Approved Educational Activities Column 1: Are costs claimed for nursing school? Column 2:	lf vos ist	he provider is	N		6.
. 00	the legal operator of the program?	TT yes, TS t	ne provider is	IN		0.
. 00	Are costs claimed for Allied Health Programs? If "Y" see in	nstructions.		Ν	İ	7.
. 00	Were nursing school and/or allied health programs approved	and/or renewe	d during the	Y	ĺ	8.
	cost reporting period? If yes, see instructions.					
. 00	Are costs claimed for Interns and Residents in an approved		cal education	Y		9.
D. 00	program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated of		the current	N		10.
0.00	cost reporting period? If yes, see instructions.			IN		10.
1.00	Are GME cost directly assigned to cost centers other than I	I & R in an Ap	proved	Ν	ĺ	11.
	Teaching Program on Worksheet A? If yes, see instructions.					
					Y/N	
					1.00	
2 00	Bad Debts Is the provider seeking reimbursement for bad debts? If yes		tiono		Y	1 1 2
	If line 12 is yes, did the provider's bad debt collection p			st reporting	N N	12.
5.00	period? If yes, submit copy.	porrey change	during this co.	st reporting		13.
4.00	If line 12 is yes, were patient deductibles and/or co-payme	ents waived? I	fyes, see ins <sup>.</sup>	tructions.	N	14.
	Bed Complement					
5.00	Did total beds available change from the prior cost report				Y	15.
			t A		<u>t B</u>	
		Y/N 1.00	Date 2.00	Y/N 3.00	Date 4.00	
	PS&R Data	1.00	2.00	3.00	4.00	
6.00	Was the cost report prepared using the PS&R Report only?	N		N		16.
	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)					
7.00	Was the cost report prepared using the PS&R Report for	Y	04/04/2019	Y	04/04/2019	17.
	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)				1	
		N		Ν	1	18.
8. 00	If line 16 or 17 is yes, were adjustments made to PS&R	-		-	1	
8. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed					1
8. 00	Report data for additional claims that have been billed but are not included on the PS&R Report used to file this					
	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.					
8. 00 9. 00	Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	N		N		19.

Health Financial Systems

ST.	FRANCI S	HOSPI TAL	&	HEALTH	CENTER	
			_			-

HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C		Peri od:	Worksheet S-2	2
				rom 01/01/2018		
			'	o 12/31/2018	Date/Time Pre 5/31/2019 7:4	
		Descri	ntion	Y/N	Y/N	
			)	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R			N	N	20.00
	Report data for Other? Describe the other adjustments:					
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's	N		N		21.00
	records? If yes, see instructions.					
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC				1.00	
	Completed by cost Related Cost	LFT CHILDRENS I	IUSFITALS)			-
22 00	Have assets been relifed for Medicare purposes? If yes, se	e instructions			N	22.00
	Have changes occurred in the Medicare depreciation expense		sals made duri	ng the cost	N	23.00
20100	reporting period? If yes, see instructions.			ing the obset		20100
24.00	Were new leases and/or amendments to existing leases enter	ed into during	this cost rep	orting period?	N	24.00
	If yes, see instructions	-		•		
25.00	Have there been new capitalized leases entered into during	the cost repo	rting period?	lfyes, see	Ν	25.00
	instructions.					
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during t	he cost report	ing period? If	yes, see	N	26.00
27 00	instructions.	a aget reporti	an noniod? If	voo oubmit	N	27.00
27.00	Has the provider's capitalization policy changed during th	le cost reportin	ng period? IT	yes, subili t	N	27.00
	copy. Interest Expense					
28 00	Were new Loans, mortgage agreements or Letters of credit e	ntered into du	ring the cost	reporting	N	28.00
20.00	period? If yes, see instructions.		ing the cost	ropor tring		20.00
29.00	Did the provider have a funded depreciation account and/or	bond funds (D	ebt Service Re	serve Fund)	N	29.00
	treated as a funded depreciation account? If yes, see inst	ructions				
30.00	Has existing debt been replaced prior to its scheduled mat	urity with new	debt? If yes,	see	Ν	30.00
	instructions.					
31.00	Has debt been recalled before scheduled maturity without i	ssuance of new	debt? If yes,	see	N	31.00
	i nstructi ons. Purchased Servi ces					-
32 00	Have changes or new agreements occurred in patient care se	rvices furnish	ed through con	tractual	N	32.00
52.00	arrangements with suppliers of services? If yes, see instr		eu through con	ti ac tuai	IN IN	52.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 ap		na to competit	ive biddina? If		33.00
	no, see instructions.	F F	5	<b>J</b>		
	Provi der-Based Physi ci ans					
34.00	Are services furnished at the provider facility under an a	rrangement witl	h provider-bas	ed physicians?	Y	34.00
	lf yes, see instructions.					
35.00	If line 34 is yes, were there new agreements or amended ex		nts with the p	rovi der-based	N	35.00
	physicians during the cost reporting period? If yes, see i	nstructions.			D. L.	
				Y/N 1.00	Date 2.00	
	Home Office Costs			1.00	2.00	
36.00	Were home office costs claimed on the cost report?			Y		36.00
	If line 36 is yes, has a home office cost statement been p	repared by the	home office?	N		37.00
57.00	If yes, see instructions.					
38.00	If line 36 is yes, was the fiscal year end of the home of	fice different	from that of	Ν		38.00
	the provider? If yes, enter in column 2 the fiscal year en					
39.00	If line 36 is yes, did the provider render services to oth	er chain compo	nents? If yes,	Y		39.00
	see instructions.					
40.00	If line 36 is yes, did the provider render services to the	home office?	lf yes, see	Y		40.00
	instructions.					
		1	00	2	00	-
	Cost Report Preparer Contact Information	I. I.	00	2.	00	
41 00	Enter the first name, last name and the title/position	KERRY		BEJARANO		41.00
11.00	held by the cost report preparer in columns 1, 2, and 3,			220/10/10		
	respectively.					
42.00	Enter the employer/company name of the cost report	BKD, LLP				42.00
	preparer.					
43.00	Enter the telephone number and email address of the cost	317-383-4000		KBEJARANO@BKD.	COM	43.00
	report preparer in columns 1 and 2, respectively.					

Heal th	Financial Systems	ST. FRANCIS HOSPITA	L & HEALTH CENTER		In Lieu	of Form CMS-2	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEM	ENT QUESTI ONNAI RE	Provider CCN: 15-016		eriod: rom 01/01/2018	Worksheet S-2	
				T		Date/Time Pre 5/31/2019 7:4	
			3.00				
	Cost Report Preparer Contact Informati	on					
41.00	Enter the first name, last name and th	ne title/position	SENIOR MANAGER				41.00
	held by the cost report preparer in co	olumns 1, 2, and 3,					
	respecti vel y.						
42.00	Enter the employer/company name of the	e cost report					42.00
	preparer.						
43.00	Enter the telephone number and email a	address of the cost					43.00
	report preparer in columns 1 and 2, re	especti vel y.					

8	Component spital Adults & Peds. (columns 5, 6, 7 and exclude Swing Bed, Observation Bed and spice days)(see instructions for col. 2 r the portion of LDP room available beds) D and other (see instructions) D IPF Subprovider D IRF Subprovider Spital Adults & Peds. Swing Bed SNF spital Adults & Peds. Swing Bed SNF spital Adults and Peds. (exclude observation ds) (see instructions) TENSIVE CARE UNIT SONARY CARE UNIT RONARY CARE UNIT ROI INTENSIVE CARE UNIT ROI INTENSIVE CARE UNIT	Worksheet A Li ne Number 1.00 30.00 31.00 31.01 32.00	No. of Beds 2.00 257 257 257 60 27 60	Bed Days Avai I abl e 3. 00 93, 805 93, 805 21, 900 9, 855	0. 00 0. 00	0 0 0	2. ( 3. ( 4. ( 5. ( 6. (
8         ex           Hosp         for           for         for           00         HM0           00         HM0           00         HM0           00         HM0           00         Hosp           00         Hosp           00         Hosp           00         Hosp           00         Hosp           00         Intre           00         INTE           00         CORC           00         NURS           1.00         SUBF           0.00         NURS           1.00         OTHE           2.00         HOME           3.00         AMBL           4.00         HOSF           5.00         CMHC           6.00         RURA           6.25         FEDE	spital Adults & Peds. (columns 5, 6, 7 and exclude Swing Bed, Observation Bed and spice days)(see instructions for col. 2 r the portion of LDP room available beds) O and other (see instructions) O IPF Subprovider Spital Adults & Peds. Swing Bed SNF spital Adults & Peds. Swing Bed NF tal Adults and Peds. (exclude observation ds) (see instructions) TENSIVE CARE UNIT RN INTENSIVE CARE UNIT	Li ne Number 1.00 30.00 31.00 31.00 31.01	2.00 257 257 257 60 27	<u>Avai I abi e</u> <u>3. 00</u> 93, 805 93, 805 21, 900	4.00 0.00 0.00 0.00	5.00 0 0 0 0 0	2. ( 3. ( 4. ( 5. ( 6. (
8         ex           Hosp         for           for         for           00         HM0           00         HM0           00         HM0           00         HM0           00         Hosp           00         Hosp           00         Hosp           00         Hosp           00         Hosp           00         Intre           00         INTE           00         CORC           00         NURS           1.00         SUBF           0.00         NURS           1.00         OTHE           2.00         HOME           3.00         AMBL           4.00         HOSF           5.00         CMHC           6.00         RURA           6.25         FEDE	exclude Swing Bed, Observation Bed and spice days)(see instructions for col. 2 r the portion of LDP room available beds) O and other (see instructions) O IPF Subprovider O IRF Subprovider spital Adults & Peds. Swing Bed SNF spital Adults & Peds. Swing Bed NF tal Adults and Peds. (exclude observation ds) (see instructions) TENSIVE CARE UNIT RONARY CARE UNIT RN INTENSIVE CARE UNIT	1.00 30.00 31.00 31.00 31.01	257 257 60 27	3.00 93,805 93,805 93,805 21,900	0.00 0.00 0.00	0 0 0 0	2. ( 3. ( 4. ( 5. ( 6. (
8         ex           Hosp         for           for         for           00         HM0           00         HM0           00         HM0           00         HM0           00         Hosp           00         Hosp           00         Hosp           00         Hosp           00         Hosp           00         Intre           00         INTE           00         CORC           00         NURS           1.00         SUBF           0.00         NURS           1.00         OTHE           2.00         HOME           3.00         AMBL           4.00         HOSF           5.00         CMHC           6.00         RURA           6.25         FEDE	exclude Swing Bed, Observation Bed and spice days)(see instructions for col. 2 r the portion of LDP room available beds) O and other (see instructions) O IPF Subprovider O IRF Subprovider spital Adults & Peds. Swing Bed SNF spital Adults & Peds. Swing Bed NF tal Adults and Peds. (exclude observation ds) (see instructions) TENSIVE CARE UNIT RONARY CARE UNIT RN INTENSIVE CARE UNIT	30. 00 31. 00 31. 01	257 257 60 27	93, 805 93, 805 21, 900	0.00 0.00 0.00	0 0 0 0	2. ( 3. ( 4. ( 5. ( 6. (
.00         HM0           .00         HM0           .00         Hosp           .00         Hosp           .00         Hosp           .00         Hosp           .00         Hosp           .00         Tota           beds         beds           .00         INTE           .01         NEON           .00         CORC           .00         BURN           1.00         SURG           2.00         OTHE           3.00         NURS           5.00         CAH           6.00         SUBF           9.00         SKIL           1.00         OTHE           3.00         AUBS           4.00         HOSF           4.00         HOSF           5.00         CMHC           6.00         RURA           6.00         RURA           6.00         RURA	D and other (see instructions) D IPF Subprovider D IRF Subprovider Spital Adults & Peds. Swing Bed SNF spital Adults & Peds. Swing Bed NF tal Adults and Peds. (exclude observation ds) (see instructions) TENSIVE CARE UNIT DNATAL INTENSIVE CARE UNIT RONARY CARE UNIT RN INTENSIVE CARE UNIT	31.01	60 27	21, 900	0.00	0	3. ( 4. ( 5. ( 6. (
.00         Hosp Hosp Tota beds           .00         INTE Control           .00         INTE Control           .00         INTE Control           .00         INTE Control           .00         INTE Control           .00         INTE Control           .00         BURN           1.00         SURC           2.00         OTHE           3.00         NURS           4.00         Tota           5.00         CAH           6.00         SUBF           9.00         SKI L           0.00         NURS           1.00         OTHE           2.00         HOME           3.00         AMBL           4.00         HOSF           3.00         AUBL           4.00         HOSF           6.00         RURA           6.25         FEDE	spital Adults & Peds. Swing Bed SNF spital Adults & Peds. Swing Bed NF tal Adults and Peds. (exclude observation ds) (see instructions) TENSIVE CARE UNIT ONATAL INTENSIVE CARE UNIT RONARY CARE UNIT RN INTENSIVE CARE UNIT	31.01	60 27	21, 900	0.00	0	5. ( 6. (
.00         Total beds           .00         I NTE           .01         NE0N           .00         COR           .00         BURN           .00         SURC           .00         SURC           .00         NURS           .00         SURC           .00         NURS           .00         Totz           .00         Totz           .00         SUBF           .00         MURSF           .00         MBL           .00         MBL           .00         CMHC           .00         CMHC           .00         FEDE	tal Adults and Peds. (exclude observation ds) (see instructions) TENSIVE CARE UNIT DNATAL INTENSIVE CARE UNIT RONARY CARE UNIT RN INTENSIVE CARE UNIT	31.01	60 27	21, 900	0.00	0	
.01         NEON           .00         CORC           .00         BURN           .00         SURO           .00         OTHE           .00         NURS           .00         NURS           .00         NURS           .00         NURS           .00         NURS           .00         SUBF           .00         SUBF           .00         SUBF           .00         SUBF           .00         NURS           1.00         OTHE           2.00         HOME           3.00         AMBL           4.00         HOSF           3.00         AMBL           4.00         HOSF           5.00         CMHC           6.00         RURA           6.00         FEDE	DNATAL INTENSIVE CARE UNIT RONARY CARE UNIT RN INTENSIVE CARE UNIT	31.01	27			0	
.00         CORC           0.00         BURN           1.00         SURC           2.00         OTHE           3.00         NURS           4.00         Tota           5.00         CAH           6.00         SUBF           8.00         SUBF           8.00         SUBF           9.00         SKI L           0.00         NURS           1.00         OTHE           2.00         HOME           3.00         AMBL           4.00         HOSF           5.00         CMHC           6.00         RURA           6.00         RURA           6.00         RURA	RONARY CARE UNIT RN INTENSIVE CARE UNIT			0 955			8.
0.00         BURN           1.00         SURC           2.00         OTHE           3.00         NURS           5.00         CAH           6.00         SUBF           7.00         SUBF           9.00         SKI           9.00         SKI           0.00         NURS           1.00         OTHE           3.00         AMBL           4.00         HOSF           4.10         HOSF           4.10         HOSF           6.00         RURA           6.00         RURA           6.25         FEDE	RN INTENSIVE CARE UNIT	32.00	44				
1.00         SURG           2.00         OTHE           3.00         NURS           4.00         Tota           5.00         CAH           6.00         SUBF           7.00         SUBF           9.00         SKI L           0.00         NURS           1.00         OTHE           2.00         KI L           0.00         NURS           1.00         OTHE           2.00         HOME           4.00         HOSF           5.00         CMHC           5.00         RURA           5.25         FEDE			00	24,090	0.00	0	
2.00         OTHE           3.00         NURS           4.00         Tota           5.00         CAH           6.00         SUBF           7.00         SUBF           8.00         SUBF           9.00         SKI L           0.00         NURS           1.00         OTHE           2.00         HOME           3.00         AMBL           4.00         HOSF           5.00         CMHC           5.00         RURA           6.25         FEDE	RGICAL INTENSIVE CARE UNIT						10.
B. 00         NURS           4. 00         Tota           5. 00         CAH           5. 00         SUBF           7. 00         SUBF           8. 00         SUBF           9. 00         SKI L           0. 00         NURS           1. 00         OTHE           2. 00         HOME           3. 00         AMBL           4. 00         HOSF           5. 00         CMHC           5. 00         RURA           5. 25         FEDE		34.00	31	11, 315	0.00	0	11.
4.00         Tota           5.00         CAH           6.00         SUBF           7.00         SUBF           8.00         SUBF           9.00         SKIL           0.00         NURS           1.00         OTHE           2.00         HOME           3.00         AMBL           4.00         HOSF           5.00         CMHC           6.00         RURA           6.25         FEDE	HER SPECIAL CARE (SPECIFY)	10.00					12.
5.00 CAH 6.00 SUBF 7.00 SUBF 8.00 SUBF 8.00 SKI L 0.00 NURS 1.00 OTHE 2.00 HOME 3.00 AMBL 4.00 HOSF 4.10 HOSF 4.10 HOSF 6.00 RURA 6.25 FEDE		43.00		1/0 0/5	0.00	0	
6.00         SUBF           7.00         SUBF           8.00         SUBF           9.00         SKI           9.00         SKI           1.00         OTHE           2.00         HOME           3.00         AMBL           4.00         HOSF           5.00         CMHC           6.00         RURA           6.25         FEDE	tal (see instructions)		441	160, 965	0.00	0	14.
7.00         SUBF           8.00         SUBF           9.00         SK1 L           0.00         NURS           1.00         OTHE           2.00         HOME           4.00         HOSF           5.00         CMHC           5.00         RURA           6.25         FEDE	3PROVIDER – IPF					0	15.
B. 00         SUBF           9. 00         SK1 L           0. 00         NURS           1. 00         OTHE           2. 00         HOME           3. 00         AMBL           4. 00         HOSF           5. 00         CMHC           6. 25         FEDE		41.00	21	7, 938		0	
P. 00         SKI L           0.00         NURS           1.00         OTHE           2.00         HOME           3.00         AMBL           4.00         HOSF           4.10         HOSF           5.00         CMHC           5.00         RURA           5.25         FEDE		41.00	21	7, 930		U	18.
D. 00         NURS           1. 00         OTHE           2. 00         HOME           3. 00         AMBL           4. 00         HOSF           5. 00         CMHC           5. 00         RURA           5. 00         RURA           5. 25         FEDE	I LLED NURSING FACILITY						19
1.00         OTHE           2.00         HOME           3.00         AMBL           4.00         HOSF           5.00         CMHC           5.00         CMHC           5.00         RURA           5.25         FEDE	RSING FACILITY						20
2. 00         HOME           3. 00         AMBU           4. 00         HOSF           4. 10         HOSF           5. 00         CMHC           5. 00         RURA           5. 25         FEDE	HER LONG TERM CARE						21
4.00 HOSF 4.10 HOSF 5.00 CMHC 5.00 RURA 5.25 FEDE	ME HEALTH AGENCY	101.00				0	22.
4. 10 HOSF 5. 00 CMHC 5. 00 RURA 5. 25 FEDE	BULATORY SURGICAL CENTER (D. P.)						23.
5. 00 CMHC 5. 00 RURA 5. 25 FEDE	SPICE	116.00	0	C			24
5.00 RURA 5.25 FEDE	SPICE (non-distinct part)	30.00					24
5. 25 FEDE	HC – CMHC						25.
	RAL HEALTH CLINIC						26.
	DERALLY QUALIFIED HEALTH CENTER	89.00				0	26.
	tal (sum of lines 14-26)		462				27
	servation Bed Days					0	
	oulance Trips						29.
	oloyee discount days (see instruction)						30.
				~			31
	oloyee discount days - IRF	1	0	C			32.
outp	oloyee discount days - IRF por & delivery days (see instructions)						32.
3.00 LTCH 3.01 LTCH	oloyee discount days - IRF por & delivery days (see instructions) tal ancillary labor & delivery room tpatient days (see instructions)				1		33

IOSPI TAL	AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC	F	eriod: rom 01/01/2018 o 12/31/2018		eparec
		I/P Days	/ O/P Visits	/ Trips	Full Time E	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
8 H	ospital Adults & Peds. (columns 5, 6, 7 and exclude Swing Bed, Observation Bed and ospice days)(see instructions for col. 2	23, 348	1, 194	52, 777			1. (
	or the portion of LDP room available beds) MO and other (see instructions)	18, 361	16, 305				2.
	MO I PF Subprovi der	10, 301	10, 303				3.
	MO IRF Subprovider	816	330				4.
. 00 H	ospital Adults & Peds. Swing Bed SNF	0	0	0			5.
	ospital Adults & Peds. Swing Bed NF		0	0			6.
	otal Adults and Peds. (exclude observation eds) (see instructions)	23, 348	1, 194	52, 777			7.
	NTENSI VE CARE UNI T	4, 485	520	17, 827			8.
	EONATAL INTENSIVE CARE UNIT	0	0	5, 445			8.
	ORONARY CARE UNIT	5, 808	127	11, 735			9
	URN INTENSIVE CARE UNIT URGICAL INTENSIVE CARE UNIT	4, 415	41	8, 434			10
	THER SPECIAL CARE (SPECIFY)	4, 415	41	0, 434			12
	URSERY		124	3, 803			13
	otal (see instructions)	38, 056	2,006	100, 021	22.46	2, 464. 99	
	AH visits	0	0	0			15.
6. 00 S	UBPROVIDER – IPF						16.
	UBPROVIDER – IRF	2, 685	7	5, 071	0.00	41.63	
	UBPROVI DER						18
	KILLED NURSING FACILITY						19
	URSING FACILITY THER LONG TERM CARE						20
	OME HEALTH AGENCY	0	0	0	0.00	0, 00	
	MBULATORY SURGICAL CENTER (D. P. )	0	0	0	0.00	0.00	23
	OSPICE	454	21	551	0.00	72.94	
	OSPICE (non-distinct part)			0			24
	MHC - CMHC						25
	URAL HEALTH CLINIC						26
	EDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	
	otal (sum of lines 14-26)			40.00	22.46	2, 579. 56	
	bservation Bed Days	0	2, 329	10, 884			28
	mbulance Trips mployee discount days (see instruction)	0		0			29
	mployee discount days (see fistilaction)			0			31
	abor & delivery days (see instructions)	0	309	744			32
	otal ancillary labor & delivery room	0	507	0			32.
	utpatient days (see instructions)						
	TCH non-covered days	0					33.
3.01 L	TCH site neutral days and discharges	0					33

HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider C	CN: 15-0162	Period: From 01/01/2018 To 12/31/2018	Worksheet S-3 Part I Date/Time Pre 5/31/2019 7:4	pared:
		Full Time Equivalents		Di s	charges		
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions)		0	7, 6		19, 234	1.00 2.00
3.00	HMO I PF Subprovi der			0,2	0		3.00
4.00	HMO I RF Subprovi der				24		4.00
5.00 6.00 7.00	Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation						5.00 6.00 7.00
8.00	beds) (see instructions) INTENSIVE CARE UNIT						8.00
8. 01	NEONATAL INTENSIVE CARE UNIT						8. 0 <sup>-</sup>
9.00	CORONARY CARE UNIT						9.00
10. 00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		_				13.00
14.00	Total (see instructions)	0.00	0	7,6	76 242	19, 234	14.00
15.00	CAH visits						15.00
16.00 17.00	SUBPROVI DER – I PF SUBPROVI DER – I RF	0, 00	0	20	07 3	378	16.00
17.00	SUBPROVIDER - TRF	0.00	0	20	3	378	17.00 18.00
19.00	SUBPROVIDER SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
20.00	OTHER LONG TERM CARE						20.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D. P. )	0.00					23.00
24.00	HOSPI CE	0.00					24.00
24.10	HOSPICE (non-distinct part)	0.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambul ance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32. 01	Total ancillary labor & delivery room outpatient days (see instructions)						32. 01
33.00	LTCH non-covered days				0		33.00
33.01	LTCH site neutral days and discharges				0		33.0

Heal th	Financial Systems	ST. FI	RANCIS HOSPITA	L & HEALTH CEN	TER	In Lie	u of Form CMS-2	2552-10
	AL WAGE INDEX INFORMATION			Provider C	F	eriod: rom 01/01/2018 o 12/31/2018	Worksheet S-3 Part II	pared:
		Wkst. A Line Number	Amount Reported	Reclassificat ion of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA SALARIES							-
1.00	Total salaries (see	200.00	166, 545, 029	0	166, 545, 029	5, 333, 075. 20	31. 23	1.00
2.00	instructions) Non-physician anesthetist Part		0	0	0	0.00	0.00	2.00
	A		0					
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		196, 602	0	196, 602	1, 868. 14	105.24	4.00
4.01	Physicians - Part A - Teaching		1, 656, 875		1, 656, 875			
5.00	Physician and Non Physician-Part B		1, 486, 521	0	1, 486, 521	11, 798. 24	126.00	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC		0	0	0	0.00	0.00	6.00
7.00	services Interns & residents (in an approved program)	21.00	4, 907, 229	-2, 992, 299	1, 914, 930	53, 600. 05	35.73	7.00
7.01	Contracted interns and residents (in an approved programs)		C	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	
10.00	Excluded area salaries (see instructions)		19, 204, 879	108, 179	19, 313, 058	571, 766. 71	33. 78	10.00
	OTHER WAGES & RELATED COSTS Contract Labor: Direct Patient		3, 748, 278	0	3, 748, 278	60, 293. 00	62. 17	11.00
12.00	Care Contract Labor: Top Level		0	0	0	0.00	0.00	12.00
12.00	management and other management and administrative		Ū			0.00	0.00	12.00
13.00	services Contract Labor: Physician-Part A - Administrative		312, 341	0	312, 341	2, 522. 17	123. 84	13.00
14.00	Home office and/or related organization salaries and		0	0	0	0.00	0.00	14.00
14.01	wage-related costs Home office salaries		38, 815, 394	0	38, 815, 394	1, 104, 449. 00	35. 14	14.01
14.02	Related organization salaries		28, 190, 771	0	28, 190, 771	788, 751. 62	35.74	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
17.00	WAGE-RELATED COSTS Wage-related costs (core) (see		58, 464, 206	0	58, 464, 206			17.00
18.00	instructions) Wage-related costs (other)		0	0	0			18.00
19.00	(see instructions) Excluded areas		7, 571, 794	0	7, 571, 794			19.00
20.00	Non-physician anesthetist Part ₄		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		58, 197	0	58, 197			22.00
	Physician Part A - Teaching		451, 325		451, 325			22.01 23.00
	Physician Part B Wage-related costs (RHC/FQHC)		409, 547 0	0	409, 547 0			23.00
	Interns & residents (in an approved program)		738, 160		738, 160			25.00
25.50	Home office wage-related (core)		14, 219, 354	0	14, 219, 354			25.50
25. 51	Related organization wage-related (core)		11, 394, 560	0	11, 394, 560			25. 51
25. 52	Home office: Physician Part A - Administrative -		0	0	0			25. 52
25. 53	wage-related (core) Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0			25. 53

Hearth	FINANCIAI SYSTEMS	SI. FI	RANCIS HUSPITA	L & HEALTH CEN	IER	In Lie	U OT FORM CMS-2	2552-10
HOSPI T	AL WAGE INDEX INFORMATION			Provider CO	CN: 15-0162	Period: From 01/01/2018 To 12/31/2018		
							5/31/2019 7:4	
		Wkst. A Line	Amount	Recl assi fi cat	Adj usted	Paid Hours	Average	
		Number	Reported	ion of	Sal ari es	Related to	Hourly Wage	
				Sal ari es	(col.2 ± col	. Salaries in	(col. 4 ÷	
				(from Wkst.	3)	col. 4	col. 5)	
				A-6)				
		1.00	2.00	3.00	4.00	5.00	6.00	
	OVERHEAD COSTS - DIRECT SALARI	ES						
26.00	Employee Benefits Department	4.00	0	0		0 0.00		26.00
27.00	Administrative & General	5.00	1, 448, 347	0	1, 448, 34	40, 450. 96	35.81	27.00
28.00	Administrative & General under contract (see inst.)		3, 261, 763	0	3, 261, 76	55, 781. 48	58.47	28.00
29.00	Maintenance & Repairs	6.00	0	0		0 0.00	0.00	29.00
30.00	Operation of Plant	7.00	3, 892, 732	0	3, 892, 73			
31.00	Laundry & Linen Service	8.00	217,068		217, 06			31.00
32.00	Housekeeping	9.00	3, 824, 395		3, 824, 39			
33.00	Housekeeping under contract		77, 200		77, 20			33.00
	(see instructions)		,					
34.00	Dietary	10.00	2, 110, 662	-1, 362, 867	747, 79	41, 771. 54	17.90	34.00
35.00	Dietary under contract (see instructions)		0	0		0 0.00	0.00	35.00
36.00	Cafeteria	11.00	812, 392	1, 362, 867	2, 175, 25	59 127, 389. 48	17 08	36.00
37.00	Maintenance of Personnel	12.00	012, 372	1, 302, 007	2, 175, 20	0 0.00		37.00
38.00	Nursing Administration	13.00	4, 430, 199		4, 430, 19		40. 52	
39.00	Central Services and Supply	14.00	765, 407		765, 40			39.00
40.00	Pharmacy	15.00	6, 166, 881					40.00
41.00	Medical Records & Medical	16.00	0, 100, 001	0	0,002,0	0 0.00		
	Records Library		0					
42.00	Social Service	17.00	0	0		0 0.00		42.00
43.00	Other General Service	18.00	0	0		0 0.00	0.00	43.00

## Health Financial Systems ST. FRANCIS HOSPITAL & HEALTH CENTER In Lieu of Form CMS-2552-10

HOSPI T	AL WAGE INDEX INFORMATION			Provider C		Period: From 01/01/2018 To 12/31/2018		pared:
		Worksheet A	Amount	Recl assi fi cat		Paid Hours	Average	
		Line Number	Reported	ion of	Sal ari es	Related to	Hourly Wage	
				Sal ari es	(col.2 ± col.	Salaries in	(col. 4 ÷	
				(from	3)	col. 4	col. 5)	
				Worksheet				
				A-6)				
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		161, 833, 367	2, 992, 299	164, 825, 66	6 5, 315, 008. 30	31.01	1.00
	instructions)							
2.00	Excluded area salaries (see		19, 204, 879	108, 179	19, 313, 05	8 571, 766. 71	33. 78	2.00
	instructions)							
3.00	Subtotal salaries (line 1		142, 628, 488	2, 884, 120	145, 512, 60	8 4, 743, 241. 59	30. 68	3.00
	minus line 2)							
4.00	Subtotal other wages & related		71, 066, 784	0	71, 066, 78	4 1, 956, 015. 79	36. 33	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		84, 136, 317	0	84, 136, 31	7 0.00	57.82	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		297, 831, 589	2, 884, 120	300, 715, 70	9 6, 699, 257. 38	44.89	6.00
7.00	Total overhead cost (see		27,007,046	-114, 865	26, 892, 18	1 970, 351. 14	27.71	7.00
	instructions)							

ST.	FRANCIS	HOSPI TAL	-				
				Drovi do	r CCNI 10	0140	Doni

In Lieu of Form CMS-2552-10 Worksheet S-3

0 25.00

HUSPI I	AL WAGE RELATED COSTS	Provider CCN: 15-0162	From 01/01/2018 To 12/31/2018		pared:
				Amount	
				Reported	
				1.00	
	PART IV - WAGE RELATED COSTS				
	Part A - Core List				1
	RETIREMENT COST				1
1.00	401K Employer Contributions			2, 749, 631	1 1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution			0	2.00
3.00	Nongualified Defined Benefit Plan Cost (see instructions)			0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)			22, 250, 249	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				1
5.00	401K/TSA Plan Administration fees			0	5.00
6.00	Legal /Accounting/Management Fees-Pension Plan			0	6.00
7.00	Employee Managed Care Program Administration Fees			0	7.00
	HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)			0	1 8.00
8.01	Health Insurance (Self Funded without a Third Party Administr	ator)		0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrato			27, 483, 337	8.02
8.03	Heal th Insurance (Purchased)	- /		0	8.03
9.00	Prescription Drug Plan			0	9.00
10.00	Dental, Hearing and Vision Plan			1, 311, 105	
	Life Insurance (If employee is owner or beneficiary)			133, 022	11.00
	Accident Insurance (If employee is owner or beneficiary)			0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)			453, 068	
	Long-Term Care Insurance (If employee is owner or beneficiary	)		0	
15.00	'Workers' Compensation Insurance	,		772,607	
16.00	Retirement Health Care Cost (Only current year, not the extra	ordinary accrual requi	red by FASB 106	0	•
101.00	Non cumulative portion)		100 09 1100 1001	Ū	10100
	TAXES				
17 00	FICA-Employers Portion Only			12, 499, 167	1 17.00
	Medicare Taxes - Employers Portion Only			0	18.00
	Unemployment Insurance			41,043	
				0	20.00
20.00	OTHER			0	20.00
21.00		enorted on lines 1 thr	rough 4 above (see	0	21.00
21.00	instructions))	opor tou on trines i thi	Jugii - 10000. (366		21.00
22.00	Day Care Cost and Allowances			0	22.00
	Tuition Reimbursement			0	
	Total Wage Related cost (Sum of Lines 1 -23)			67, 693, 229	
24.00	Total mage nerated cost (Juli of Thes 1 -23)			07,075,227	_ 24.00

Part B - Other than Core Related Cost 25.00 OTHER WAGE RELATED COSTS (SPECIFY)

неагтп	FINANCIAL SYSTEMS ST. FRANCIS HUSPITAL	& HEALTH CENTER	In Lie	U OF FORM CMS-∠	2552-10
HOSPI T	AL CONTRACT LABOR AND BENEFIT COST	Provider CCN: 15-0162	Period: From 01/01/2018		
			To 12/31/2018	Date/Time Pre 5/31/2019 7:4	
	Cost Center Description		Contract	Benefit Cost	
			Labor		
			1.00	2.00	
	PART V - Contract Labor and Benefit Cost				
	Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost		3, 748, 278	67, 693, 229	1.00
2.00	Hospi tal		3, 748, 278	59, 383, 275	2.00
3.00	Subprovider - IPF				3.00
4.00	Subprovider - IRF		0	1, 091, 100	4.00
5.00	Subprovider - (Other)		0	0	5.00
6.00	Swing Beds - SNF		0	0	6.00
7.00	Swing Beds - NF		0	0	7.00
8.00	Hospital-Based SNF				8.00
9.00	Hospital-Based NF				9.00
10.00	Hospital-Based OLTC				10.00
11.00	Hospital-Based HHA		0	0	11.00
12.00	Separately Certified ASC				12.00
13.00	Hospi tal -Based Hospi ce		0	2,074,372	13.00
14.00	Hospital-Based Health Clinic RHC				14.00
15.00	Hospital-Based Health Clinic FQHC				15.00
16.00	Hospital-Based-CMHC				16.00
17.00	Renal Dialysis		0	0	17.00
18.00	Other		0	5, 144, 482	18.00

near th trhaner ar by stems	01. 1			TER			2002 10
HOSPITAL-BASED HOSPICE IDENTIFICATI	ON DATA		Provider C		Period: From 01/01/2018 To 12/31/2018	Worksheet S-9 PARTS I THROU Date/Time Pre	GHIV
			nospi ce co	N. 15-1525	10 12/31/2010	5/31/2019 7:4	7 am
					Hospi ce I		
	Undupl i cated						
	Days						
	Title XVIII	Title XIX	Title XVIII	Title XIX	All Other	Total (sum of	
			Skilled	Nursi ng		cols. 1, 2 &	
			Nursi ng	Facility		5)	
			Facility				
	1.00	2.00	3.00	4.00	5.00	6.00	
PART I - ENROLLMENT DAYS FOR		PERIODS BEGINNI	NG BEFORE OCT	DBER 1, 2015			
1.00 Hospice Continuous Home Care							1.00
2.00 Hospice Routine Home Care							2.00
3.00 Hospice Inpatient Respite Ca	ire						3.00
4.00 Hospice General Inpatient Ca	ire						4.00
5.00 Total Hospice Days							5.00
Part II - CENSUS DATA FOR CO	ST_REPORTING PER	ODS BEGINNING	BEFORE OCTOBE	R 1, 2015			
6.00 Number of patients receiving							6.00
hospi ce care							
7.00 Total number of unduplicated							7.00
Continuous Care hours billab	le						
to Medicare							
8.00 Average Length of Stay (line	9 5						8.00
/line 6)							
9.00 Unduplicated census count							9.00
NOTE: Parts I and II, columns 1 and	1 2 also include	the days repor	ted in columns	3 and 4.			
			Title XVIII	Title XIX	Other	Total (sum of	
						cols. 1	
						through 3)	
			1.00	2.00	3.00	4.00	
PART III - ENROLLMENT DAYS F		G PERIODS BEGI	NNING ON OR AF	TER OCTOBER 1	, 2015		
				1	0 0	0	
10.00 Hospice Continuous Home Care	2		0		0		
11.00 Hospice Routine Home Care			25, 139				
<ul><li>11.00 Hospice Routine Home Care</li><li>12.00 Hospice Inpatient Respite Ca</li></ul>	ire		373	1	16 52	441	12.00
<ul><li>11.00 Hospice Routine Home Care</li><li>12.00 Hospice Inpatient Respite Ca</li><li>13.00 Hospice General Inpatient Ca</li></ul>	ire		373 81	1	16 52 5 24	441 110	12.00 13.00
<ul> <li>11.00 Hospice Routine Home Care</li> <li>12.00 Hospice Inpatient Respite Ca</li> <li>13.00 Hospice General Inpatient Ca</li> <li>14.00 Total Hospice Days</li> </ul>	ire re		373 81 25, 593	1, 31	16 52 5 24 12 3, 187	441 110 30, 092	12.00 13.00
11.00Hospice Routine Home Care12.00Hospice Inpatient Respite Ca13.00Hospice General Inpatient Ca14.00Total Hospice DaysPART IV - CONTRACTED STATIST	ire ire I CAL DATA FOR CO	ST REPORTING PI	373 81 25, 593	1, 31	16 52 5 24 12 3, 187	441 110 30, 092	12.00 13.00 14.00
<ul> <li>11.00 Hospice Routine Home Care</li> <li>12.00 Hospice Inpatient Respite Ca</li> <li>13.00 Hospice General Inpatient Ca</li> <li>14.00 Total Hospice Days</li> </ul>	ire ire I CAL DATA FOR CO ire	ST REPORTING PI	373 81 25, 593	1, 31 NG ON OR AFTE	16 52 5 24 12 3, 187	441 110 30, 092 5 0	12.00 13.00 14.00 15.00

Heal th Fi	nanci al	Systems			
HOSPI TAL	UNCOMPE	NSATED AND	) INDIGENT	CARE	DATA

In Lieu of Form CMS-2552-10 Worksheet S-10

HUSPI I	AL UNCOMPENSATED AND INDIGENT CARE DATA	Tovider CC	N: 15-0162	Periou: Erom 01/01/2019	worksneet S-I	0			
				From 01/01/2018 To 12/31/2018					
					1.00				
	Uncomponented and indigent core cost computation				1.00				
1.00	Uncompensated and indigent care cost computation Cost to charge ratio (Worksheet C, Part I line 202 column 3 div	idad by Li	no 202 colum	vp (9)	0. 197100	1.00			
1.00	Medicaid (see instructions for each line)	Tueu by TI	The 202 COTUN	III 0 <i>)</i>	0. 197100	1.00			
2.00	Net revenue from Medicaid				58, 657, 480	2.00			
3.00	Did you receive DSH or supplemental payments from Medicaid?				N 50,057,400	3.00			
4.00	If line 3 is yes, does line 2 include all DSH and/or supplement	al payment	s from Medic	ai d?	N	4.00			
5.00	If line 4 is no, then enter DSH and/or supplemental payments fr	1 2			0	•			
6.00	Medicaid charges		-		355, 964, 217	•			
7.00	Medicaid cost (line 1 times line 6)				70, 160, 547	•			
8.00	Difference between net revenue and costs for Medicaid program (	line 7 mir	nus sum of li	nes 2 and 5; if	11, 503, 067	8.00			
	< zero then enter zero)								
	Children's Health Insurance Program (CHIP) (see instructions fo	r each lin	ie)		•				
9.00	Net revenue from stand-alone CHIP				0	9.00			
10.00	Stand-alone CHIP charges				0				
11.00	Stand-alone CHIP cost (line 1 times line 10)				0	1			
12.00	Difference between net revenue and costs for stand-alone CHIP (	line 11 mi	nus line 9;	if < zero then	0	12.00			
	nter zero)								
	Other state or local government indigent care program (see inst				-				
13.00	Net revenue from state or local indigent care program (Not incl				0				
14.00	Charges for patients covered under state or local indigent care 10)	e program (	Not included	lin lines 6 or	0	14.00			
15.00	State or local indigent care program cost (line 1 times line 14				0				
16.00	Difference between net revenue and costs for state or local ind	ligent care	e program (li	ne 15 minus line	<b>}</b> 0	16.00			
	13; if < zero then enter zero)				,				
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see								
17.00	instructions for each line) Private grants, donations, or endowment income restricted to fu	nding obor	1 + 4 00 - 20		0	17.00			
18.00	Government grants, appropriations or transfers for support of h				0				
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local			s (sum of lines	11, 503, 067				
17.00	8, 12 and 16)	indigent		13 (30m 01 11163	11, 303, 007	17.00			
			Uni nsured pati ents	I nsured pati ents	Total (col. 1 + col. 2)				
		-	1.00	2.00	3.00				
	Uncompensated Care (see instructions for each line)	I							
20.00	Charity care charges and uninsured discounts for the entire fac	ility	35, 007, 2	10 26, 480, 051	61, 487, 261	20.00			
21.00	(see instructions) Cost of patients approved for charity care and uninsured discou	nts (see	6, 899, 9	21 26, 480, 051	33, 379, 972	21.00			
	instructions)	-	0,077,7						
22.00	Payments received from patients for amounts previously written charity care	on as		1 50	51	22.00			
23.00	Cost of charity care (line 21 minus line 22)		6, 899, 9	20 26, 480, 001	33, 379, 921	23.00			
					1.00				
24 00	Does the amount on line 20 column 2, include charges for patien	t days bey	ond a length	of stay limit	N 1.00	24.00			
21.00	imposed on patients covered by Medicaid or other indigent care		iona a rengti	i or stuy rimit		21.00			
25.00	If line 24 is yes, enter the charges for patient days beyond th stay limit		care progra	m's length of	0	25.00			
26.00		tructions)			52, 470, 038	26.00			
	Medicare reimbursable bad debts for the entire hospital complex				1, 246, 904	•			
	Medicare allowable bad debts for the entire hospital complex (s				1, 918, 314				
28.00	Non-Medicare bad debt expense (see instructions)				50, 551, 724	•			
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt exp	ense (see	instructions	;)	10, 635, 155				
	Cost of uncompensated care (line 23 column 3 plus line 29)			1	44, 015, 076				
	Total unreimbursed and uncompensated care cost (line 19 plus li	ne 30)			55, 518, 143				

Heal th	Fi nanci al	Syst	ems
DECLAS			

		RANCIS HOSPITAL				u of Form CMS-2	2552-10
RECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C	F EXPENSES	Provider C		Period:	Worksheet A	
					From 01/01/2018 To 12/31/2018		nared
					10 12/31/2010	5/31/2019 7:4	
	Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cat		
	·			+ col. 2)	ions (See	Trial Balance	
				· · ·	A-6)	(col. 3 +-	
					,	col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
	00100 CAP REL COSTS-BLDG & FIXT		0	(	21, 371, 192	21, 371, 192	1.00
	00200 CAP REL COSTS-MVBLE EQUIP		34, 438, 158	34, 438, 15			2.00
	00400 EMPLOYEE BENEFITS DEPARTMENT	0	0		52, 924, 198		
	00570 ADMI TTI NG	0	1,050				5.01
	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	0	0		o o		5.02
	00590 OTHER ADMIN & GENERAL	1, 448, 347	32, 107, 662				5.03
	00700 OPERATI ON OF PLANT	3, 892, 732	9, 722, 008				7.00
	00800 LAUNDRY & LINEN SERVICE	217,068	1, 516, 953				8.00
	00900 HOUSEKEEPI NG	3, 824, 395	2, 761, 830				9.00
	01000 DI ETARY	2, 110, 662	2, 289, 714				10.00
	01100 CAFETERI A	812, 392	1, 178, 794				
	01300 NURSI NG ADMI NI STRATI ON	4, 430, 199	1, 306, 602				
	01400 CENTRAL SERVICES & SUPPLY	765, 407	2, 486, 499				
	01500 PHARMACY	6, 166, 881	25, 190, 013				14.00
	01600 MEDICAL RECORDS & LIBRARY	0, 100, 001	23, 170, 013		0 0		16.00
	02100 I &R SERVICES-SALARY & FRINGES APPRV	-	2, 610, 971		-	1, 902, 598	
	02200 I&R SERVICES-SALARY & FRINGES APPRV 02200 I&R SERVICES-OTHER PRGM COSTS APPRV	4, 907, 229	2,010,971				21.00
			0				
	02300 MEDICAL LABORATORY SCIENTIST PRGM 02302 PHARMACY PRGM	82, 837	33, 279 137, 338				
		372, 923					
	02301 EMERGENCY MEDICAL SERVICES	1, 103, 458	480, 268				
	02303 PARAMEDI C PRGM	0	0		0 726, 747	726, 747	23.03
	INPATIENT ROUTINE SERVICE COST CENTERS	07 4/4 0/4	40.0/5./7/	00 001 00		00 5// 0//	
	03000 ADULTS & PEDIATRICS	27, 466, 261	10, 865, 676				30.00
	03100 I NTENSI VE CARE UNI T	6, 551, 065	3, 118, 060			6, 905, 704	31.00
	02060 NEONATAL INTENSIVE CARE UNIT	3,043,224	2, 236, 762				
	03200 CORONARY CARE UNIT	8, 384, 353	3, 400, 328				32.00
	03400 SURGI CAL I NTENSI VE CARE UNI T	4, 469, 756	1, 927, 151				
	04100 SUBPROVI DER – I RF	2, 767, 434	1, 059, 611				41.00
	04300 NURSERY	573, 302	281, 100	854, 402	2 –236, 786	617, 616	43.00
	ANCILLARY SERVICE COST CENTERS			1			
	05000 OPERATING ROOM	11, 994, 882	44, 518, 217				50.00
	05200 DELIVERY ROOM & LABOR ROOM	2, 608, 481	1, 382, 486				52.00
	05400 RADI OLOGY-DI AGNOSTI C	8, 226, 815	8, 493, 397				
	05500 RADI OLOGY-THERAPEUTI C	1, 553, 941	10, 799, 643	12, 353, 58	4 -501, 310	11, 852, 274	55.00
	05600 RADI OI SOTOPE	241, 717	928, 017				
	05900 CARDI AC CATHETERI ZATI ON	2, 276, 870	15, 015, 684				59.00
	06000 LABORATORY	928, 620	22, 666, 459				
	06400 I NTRAVENOUS THERAPY	2, 568, 315	34, 853, 136	37, 421, 45		3, 163, 390	64.00
	06500 RESPI RATORY THERAPY	7, 402, 289	4, 269, 012	11, 671, 30	1 -3, 988, 924	7, 682, 377	65.00
	06600 PHYSI CAL THERAPY	4, 579, 100	2, 479, 405	7, 058, 50		5, 534, 294	66.00
	06700 OCCUPATI ONAL THERAPY	1, 692, 061	658, 141	2, 350, 202	2 -569, 479	1, 780, 723	67.00
68.00	06800 SPEECH PATHOLOGY	842, 315	487, 525	1, 329, 840			68. OC
69.00	06900 ELECTROCARDI OLOGY	1, 359, 910	936, 513	2, 296, 42	3 – 755, 383	1, 541, 040	69. OC
70.00	07000 ELECTROENCEPHALOGRAPHY	1, 428, 391	1, 366, 460	2, 794, 85	1 -533, 447	2, 261, 404	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 05 004 405	05 004 405	
72.00		0	0	(	35, 221, 485	35, 221, 485	
	07200 IMPL. DEV. CHARGED TO PATIENTS	õ	0				71.00
	07200 I MPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS	-			27, 956, 914	27, 956, 914	71.00 72.00
73.00		0	0	( 95	0 27, 956, 914 7 54, 641, 002	27, 956, 914 54, 641, 959	71.00 72.00 73.00
73.00 74.00	07300 DRUGS CHARGED TO PATIENTS	0 0 591, 619	0 957 315, 126	95 906, 74	0 27, 956, 914 7 54, 641, 002 5 -296, 167	27, 956, 914 54, 641, 959 610, 578	71.00 72.00 73.00 74.00
73.00 74.00 76.97	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DI ALYSI S	0	0 957	95 906, 74	0 27, 956, 914 7 54, 641, 002 5 -296, 167	27, 956, 914 54, 641, 959 610, 578	71.00 72.00 73.00 74.00
73.00 74.00 76.97	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS 07697 CARDIAC REHABILITATION	0 0 591, 619	0 957 315, 126	95 906, 74 690, 36	D 27, 956, 914 7 54, 641, 002 5 -296, 167 1 -154, 198	27, 956, 914 54, 641, 959 610, 578 536, 163	71.00 72.00 73.00 74.00
73.00 74.00 76.97 90.00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS 07697 CARDIAC REHABILITATION OUTPATIENT SERVICE COST CENTERS	0 0 591, 619 463, 806	0 957 315, 126 226, 555	95 906, 74 690, 36 6, 972, 54	27, 956, 914 7 54, 641, 002 5 -296, 167 1 -154, 198 5 -84, 515	27, 956, 914 54, 641, 959 610, 578 536, 163 6, 888, 030	71.00 72.00 73.00 74.00 76.97
73.00 74.00 76.97 90.00 90.01	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS 07697 CARDIAC REHABILITATION OUTPATIENT SERVICE COST CENTERS 09000 CLINIC 09001 IBMT JOINT VENTURE	0 0 591, 619 463, 806 4, 677, 436 1, 182, 711	0 957 315, 126 226, 555 2, 295, 109 3, 980, 083	95 906, 74 690, 36 6, 972, 54 5, 162, 79	27, 956, 914 7 54, 641, 002 -296, 167 -154, 198 5 -84, 515 4 -423, 611	27, 956, 914 54, 641, 959 610, 578 536, 163 6, 888, 030 4, 739, 183	71.00 72.00 73.00 74.00 76.97 90.00 90.01
73.00 74.00 76.97 90.00 90.01 90.05	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS 07697 CARDIAC REHABILITATION OUTPATIENT SERVICE COST CENTERS 09000 CLINIC 09001 IBMT JOINT VENTURE 09005 CV DIAGNOSTIC SERVICES	0 591, 619 463, 806 4, 677, 436 1, 182, 711 6, 602, 954	0 957 315, 126 226, 555 2, 295, 109 3, 980, 083 5, 633, 498	95 906, 74 690, 36 6, 972, 54 5, 162, 79 12, 236, 45	27, 956, 914 7 54, 641, 002 -296, 167 -154, 198 5 -84, 515 4 -423, 611 2 -2, 680, 995	27, 956, 914 54, 641, 959 610, 578 536, 163 6, 888, 030 4, 739, 183 9, 555, 457	71.00 72.00 73.00 74.00 76.97 90.00 90.01 90.05
73.00 74.00 76.97 90.00 90.01 90.05 91.00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS 07697 CARDIAC REHABILITATION OUTPATIENT SERVICE COST CENTERS 09000 CLINIC 09001 IBMT JOINT VENTURE 09005 CV DIAGNOSTIC SERVICES 09100 EMERGENCY	0 0 591, 619 463, 806 4, 677, 436 1, 182, 711	0 957 315, 126 226, 555 2, 295, 109 3, 980, 083	95 906, 74 690, 36 6, 972, 54 5, 162, 79 12, 236, 45	27, 956, 914 7 54, 641, 002 -296, 167 -154, 198 5 -84, 515 4 -423, 611 2 -2, 680, 995	27, 956, 914 54, 641, 959 610, 578 536, 163 6, 888, 030 4, 739, 183 9, 555, 457	71.00 72.00 73.00 74.00 76.97 90.00 90.01 90.05 91.00
73.00 74.00 76.97 90.00 90.01 90.05 91.00 92.00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS 07697 CARDIAC REHABILITATION OUTPATIENT SERVICE COST CENTERS 09000 CLINIC 09001 IBMT JOINT VENTURE 09005 CV DIAGNOSTIC SERVICES	0 591, 619 463, 806 4, 677, 436 1, 182, 711 6, 602, 954	0 957 315, 126 226, 555 2, 295, 109 3, 980, 083 5, 633, 498	95 906, 74 690, 36 6, 972, 54 5, 162, 79 12, 236, 45	27, 956, 914 7 54, 641, 002 -296, 167 -154, 198 5 -84, 515 4 -423, 611 2 -2, 680, 995	27, 956, 914 54, 641, 959 610, 578 536, 163 6, 888, 030 4, 739, 183 9, 555, 457	71.00 72.00 73.00 74.00 76.97 90.00 90.01 90.05
73.00 74.00 76.97 90.00 90.01 90.05 91.00 92.00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS 07697 CARDIAC REHABILITATION OUTPATIENT SERVICE COST CENTERS 09000 CLINIC 09001 IBMT JOINT VENTURE 09005 CV DIAGNOSTIC SERVICES 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS	0 591, 619 463, 806 4, 677, 436 1, 182, 711 6, 602, 954 7, 054, 644	0 957 315, 126 226, 555 2, 295, 109 3, 980, 083 5, 633, 498 3, 860, 272	95 906, 74 690, 36 6, 972, 54 5, 162, 79 12, 236, 45 10, 914, 916	27, 956, 914         54, 641, 002         -296, 167         -154, 198         5         -84, 515         4         -22, 680, 995         -3, 052, 712	27, 956, 914 54, 641, 959 610, 578 536, 163 6, 888, 030 4, 739, 183 9, 555, 457 7, 862, 204	71.00 72.00 73.00 74.00 76.97 90.00 90.01 90.05 91.00 92.00
73.00 74.00 76.97 90.00 90.01 90.05 91.00 92.00 101.00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS 07697 CARDIAC REHABILITATION 0UTPATIENT SERVICE COST CENTERS 09000 CLINIC 09001 IBMT JOINT VENTURE 09005 CV DIAGNOSTIC SERVICES 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART 0THER REIMBURSABLE COST CENTERS 10100 HOME HEALTH AGENCY	0 591, 619 463, 806 4, 677, 436 1, 182, 711 6, 602, 954	0 957 315, 126 226, 555 2, 295, 109 3, 980, 083 5, 633, 498	95 906, 74 690, 36 6, 972, 54 5, 162, 79 12, 236, 45 10, 914, 916	27, 956, 914         54, 641, 002         -296, 167         -154, 198         5         -84, 515         4         -22, 680, 995         -3, 052, 712	27, 956, 914 54, 641, 959 610, 578 536, 163 6, 888, 030 4, 739, 183 9, 555, 457 7, 862, 204	71.00 72.00 73.00 74.00 76.97 90.00 90.01 90.05 91.00
73.00 74.00 76.97 90.00 90.01 90.05 91.00 92.00 101.00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS 07697 CARDIAC REHABILITATION 0UTPATIENT SERVICE COST CENTERS 09000 CLINIC 09001 IBMT JOINT VENTURE 09005 CV DIAGNOSTIC SERVICES 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART 0THER REIMBURSABLE COST CENTERS 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0 591, 619 463, 806 4, 677, 436 1, 182, 711 6, 602, 954 7, 054, 644	0 957 315, 126 226, 555 2, 295, 109 3, 980, 083 5, 633, 498 3, 860, 272	95 906, 74 690, 36 6, 972, 54 5, 162, 79 12, 236, 45 10, 914, 91 304, 67	27, 956, 914         54, 641, 002         -296, 167         -154, 198         5         -84, 515         4         -22, 680, 995         -3, 052, 712	27, 956, 914 54, 641, 959 610, 578 536, 163 6, 888, 030 4, 739, 183 9, 555, 457 7, 862, 204 0	71.00 72.00 73.00 74.00 76.97 90.00 90.01 90.05 91.00 92.00
73.00 74.00 76.97 90.00 90.01 90.05 91.00 92.00 101.00 113.00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS 07697 CARDIAC REHABILITATION 0UTPATIENT SERVICE COST CENTERS 09000 CLINIC 09001 IBMT JOINT VENTURE 09005 CV DIAGNOSTIC SERVICES 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART 0THER REIMBURSABLE COST CENTERS 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE	0 591, 619 463, 806 4, 677, 436 1, 182, 711 6, 602, 954 7, 054, 644 0	0 957 315, 126 226, 555 2, 295, 109 3, 980, 083 5, 633, 498 3, 860, 272 304, 672	95 906, 74 690, 36 6, 972, 54 5, 162, 79 12, 236, 45 10, 914, 916 304, 67	27, 956, 914         54, 641, 002         -296, 167         -154, 198         5         -84, 515         -2, 680, 995         -3, 052, 712         2         -304, 672         0       0	27, 956, 914 54, 641, 959 610, 578 536, 163 6, 888, 030 4, 739, 183 9, 555, 457 7, 862, 204 0	71.00 72.00 73.00 74.00 76.97 90.00 90.01 90.05 91.00 92.00 101.00
73.00 74.00 76.97 90.00 90.01 90.05 91.00 92.00 101.00 113.00 116.00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS 07697 CARDIAC REHABILITATION 0UTPATIENT SERVICE COST CENTERS 09000 CLINIC 09001 IBMT JOINT VENTURE 09005 CV DIAGNOSTIC SERVICES 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART 0THER REIMBURSABLE COST CENTERS 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE 11600 HOSPICE	0 591, 619 463, 806 4, 677, 436 1, 182, 711 6, 602, 954 7, 054, 644 0 5, 261, 377	0 957 315, 126 226, 555 2, 295, 109 3, 980, 083 5, 633, 498 3, 860, 272 304, 672 0 3, 313, 513	95 906, 74 690, 36 6, 972, 54 5, 162, 79 12, 236, 45 10, 914, 91 304, 67	27, 956, 914         54, 641, 002         -296, 167         -154, 198         5         -84, 515         -2, 680, 995         -3, 052, 712         2         -304, 672         0       0         -1, 612, 526	27, 956, 914 54, 641, 959 610, 578 536, 163 6, 888, 030 4, 739, 183 9, 555, 457 7, 862, 204 0 0 6, 962, 364	71.00 72.00 73.00 74.00 76.97 90.00 90.01 90.05 91.00 92.00 101.00 113.00 116.00
73.00 74.00 76.97 90.00 90.01 90.05 91.00 92.00 101.00 113.00 116.00 118.00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS 07697 CARDIAC REHABILITATION 0UTPATIENT SERVICE COST CENTERS 09000 CLINIC 09001 IBMT JOINT VENTURE 09005 CV DIAGNOSTIC SERVICES 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART 0THER REIMBURSABLE COST CENTERS 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE 11600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117)	0 591, 619 463, 806 4, 677, 436 1, 182, 711 6, 602, 954 7, 054, 644 0	0 957 315, 126 226, 555 2, 295, 109 3, 980, 083 5, 633, 498 3, 860, 272 304, 672	95 906, 74 690, 36 6, 972, 54 5, 162, 79 12, 236, 45 10, 914, 91 304, 67	27, 956, 914         54, 641, 002         -296, 167         -154, 198         5         -84, 515         -2, 680, 995         -3, 052, 712         2         -304, 672         0       0         -1, 612, 526	27, 956, 914 54, 641, 959 610, 578 536, 163 6, 888, 030 4, 739, 183 9, 555, 457 7, 862, 204 0 0 6, 962, 364	71.00 72.00 73.00 74.00 76.97 90.00 90.01 90.05 91.00 92.00 101.00 113.00 116.00
73.00 74.00 76.97 90.00 90.01 90.05 91.00 92.00 101.00 113.00 118.00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS 07697 CARDIAC REHABILITATION OUTPATIENT SERVICE COST CENTERS 09000 CLINIC 09001 IBMT JOINT VENTURE 09005 CV DIAGNOSTIC SERVICES 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS 11300 INTERST EXPENSE 11600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117) NORREIMBURSABLE COST CENTERS	0 591, 619 463, 806 4, 677, 436 1, 182, 711 6, 602, 954 7, 054, 644 0 5, 261, 377 156, 928, 179	0 957 315, 126 226, 555 2, 295, 109 3, 980, 083 5, 633, 498 3, 860, 272 304, 672 0 3, 313, 513 307, 933, 707	95 906, 74 690, 36 6, 972, 54 5, 162, 79 12, 236, 45 10, 914, 91 304, 67 8, 574, 89 464, 861, 88	27, 956, 914         54, 641, 002         -296, 167         -154, 198	27, 956, 914 54, 641, 959 610, 578 536, 163 6, 888, 030 4, 739, 183 9, 555, 457 7, 862, 204 0 0 6, 962, 364 467, 055, 932	71.00 72.00 73.00 74.00 76.97 90.00 90.01 90.05 91.00 92.00 101.00 113.00 116.00 118.00
73.00 74.00 76.97 90.00 90.01 90.05 91.00 92.00 101.00 113.00 118.00 118.00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS 07697 CARDIAC REHABILITATION OUTPATIENT SERVICE COST CENTERS 09000 CLINIC 09001 IBMT JOINT VENTURE 09005 CV DIAGNOSTIC SERVICES 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE 11600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0 0 591, 619 463, 806 4, 677, 436 1, 182, 711 6, 602, 954 7, 054, 644 0 0 5, 261, 377 156, 928, 179 245, 216	0 957 315, 126 226, 555 2, 295, 109 3, 980, 083 5, 633, 498 3, 860, 272 304, 672 0 3, 313, 513 307, 933, 707 355, 529	95 906, 74 690, 36 6, 972, 54 5, 162, 79 12, 236, 45 10, 914, 91 304, 67 8, 574, 89 464, 861, 88	27, 956, 914         54, 641, 002         -296, 167         -154, 198         5         -84, 515         -423, 611         2         -3, 052, 712         2         -304, 672         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         -1, 612, 526         2, 194, 046	27, 956, 914 54, 641, 959 610, 578 536, 163 6, 888, 030 4, 739, 183 9, 555, 457 7, 862, 204 0 6, 962, 364 467, 055, 932	71.00 72.00 73.00 74.00 76.97 90.00 90.01 90.05 91.00 92.00 101.00 113.00 116.00 118.00
73.00 74.00 76.97 90.00 90.01 90.05 91.00 92.00 101.00 113.00 116.00 118.00 190.00 192.00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS 07697 CARDIAC REHABILITATION OUTPATIENT SERVICE COST CENTERS 09000 CLINIC 09001 IBMT JOINT VENTURE 09005 CV DIAGNOSTIC SERVICES 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE 11600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117) NORREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	0 591, 619 463, 806 4, 677, 436 1, 182, 711 6, 602, 954 7, 054, 644 0 5, 261, 377 156, 928, 179 245, 216 5, 884, 346	0 957 315, 126 226, 555 2, 295, 109 3, 980, 083 5, 633, 498 3, 860, 272 304, 672 0 3, 313, 513 307, 933, 707 355, 529 3, 908, 768	95 906, 74 690, 36 6, 972, 54 5, 162, 79 12, 236, 45 10, 914, 91 304, 67 8, 574, 89 464, 861, 88 600, 74 9, 793, 11	27, 956, 914         54, 641, 002         -296, 167         -154, 198         5         -84, 515         -22, 680, 995         -3, 052, 712         2         -304, 672         0         -1, 612, 526         2, 194, 046         5         -77, 480         4         -1, 305, 554	27, 956, 914 54, 641, 959 610, 578 536, 163 6, 888, 030 4, 739, 183 9, 555, 457 7, 862, 204 0 6, 962, 364 467, 055, 932 523, 265 8, 487, 560	71.00 72.00 73.00 74.00 76.97 90.00 90.01 90.05 91.00 92.00 101.00 113.00 118.00 118.00 190.00
73.00 74.00 76.97 90.00 90.01 90.05 91.00 92.00 101.00 113.00 116.00 118.00 190.00 192.00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS 07697 CARDIAC REHABILITATION 0UTPATIENT SERVICE COST CENTERS 09000 CLINIC 09001 IBMT JOINT VENTURE 09005 CV DIAGNOSTIC SERVICES 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART 0THER REIMBURSABLE COST CENTERS 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE 11600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES 07955 MARKETING & COMMUNITY RELATIONS	0 591, 619 463, 806 4, 677, 436 1, 182, 711 6, 602, 954 7, 054, 644 0 5, 261, 377 156, 928, 179 245, 216 5, 884, 346 64, 750	0 957 315, 126 226, 555 2, 295, 109 3, 980, 083 5, 633, 498 3, 860, 272 304, 672 0 3, 313, 513 307, 933, 707 355, 529 3, 908, 768 34, 791	95 906, 74 690, 36 6, 972, 54 5, 162, 79 12, 236, 45 10, 914, 91 304, 67 8, 574, 89 464, 861, 88 600, 74 9, 793, 11 99, 54	27, 956, 914         54, 641, 002         -296, 167         -154, 198         5         -84, 515         -22, 680, 995         -3, 052, 712         2         -304, 672         0         1         -77, 480         1         -20, 857	27, 956, 914 54, 641, 959 610, 578 536, 163 6, 888, 030 4, 739, 183 9, 555, 457 7, 862, 204 0 6, 962, 364 467, 055, 932 523, 265 8, 487, 560 78, 684	71.00 72.00 73.00 74.00 76.97 90.00 90.01 90.05 91.00 92.00 101.00 113.00 116.00 118.00 192.00 192.00
73.00 74.00 76.97 90.00 90.01 90.05 91.00 92.00 101.00 113.00 116.00 118.00 190.00 192.00 194.00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS 07697 CARDIAC REHABILITATION 0UTPATIENT SERVICE COST CENTERS 09000 CLINIC 09001 IBMT JOINT VENTURE 09005 CV DIAGNOSTIC SERVICES 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART 0THER REIMBURSABLE COST CENTERS 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE 11600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117) NORREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES 07955 MARKETING & COMMUNITY RELATIONS 07952 WOMEN'S CENTER	0 591, 619 463, 806 4, 677, 436 1, 182, 711 6, 602, 954 7, 054, 644 0 5, 261, 377 156, 928, 179 245, 216 5, 884, 346 64, 750 111, 533	0 957 315, 126 226, 555 2, 295, 109 3, 980, 083 5, 633, 498 3, 860, 272 304, 672 304, 672 0 3, 313, 513 307, 933, 707 355, 529 3, 908, 768 34, 791 237, 652	95 906, 74 690, 36 6, 972, 54 5, 162, 79 12, 236, 45 10, 914, 91 304, 67 8, 574, 89 464, 861, 88 600, 74 9, 793, 11 99, 54 349, 18	$\begin{array}{c} 27, 956, 914\\ 54, 641, 002\\ -296, 167\\ -154, 198\\ \hline \\ 5\\ -84, 515\\ 4\\ -423, 611\\ 2\\ -2, 680, 995\\ -3, 052, 712\\ \hline \\ 2\\ -304, 672\\ \hline \\ 0\\ -1, 612, 526\\ 5\\ 2, 194, 046\\ \hline \\ 5\\ -77, 480\\ 4\\ -1, 305, 554\\ 1\\ -20, 857\\ -34, 903\\ \hline \end{array}$	27, 956, 914 54, 641, 959 610, 578 536, 163 6, 888, 030 4, 739, 183 9, 555, 457 7, 862, 204 0 6, 962, 364 467, 055, 932 523, 265 8, 487, 560 78, 684 314, 282	71.00 72.00 73.00 74.00 76.97 90.00 90.01 90.05 91.00 92.00 101.00 113.00 116.00 118.00 190.00 192.00 194.00
73.00 74.00 76.97 90.00 90.01 90.05 91.00 92.00 101.00 113.00 116.00 118.00 190.00 192.00 194.00 194.01	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS 07697 CARDIAC REHABILITATION 0UTPATIENT SERVICE COST CENTERS 09000 CLINIC 09001 IBMT JOINT VENTURE 09005 CV DIAGNOSTIC SERVICES 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART 0THER REIMBURSABLE COST CENTERS 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE 11300 INTEREST EXPENSE 11600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES 07955 WOMEN'S CENTER 07952 WOMEN'S CENTER	0 591, 619 463, 806 4, 677, 436 1, 182, 711 6, 602, 954 7, 054, 644 0 5, 261, 377 156, 928, 179 245, 216 5, 884, 346 64, 750 111, 533 3, 311, 005	0 957 315, 126 226, 555 2, 295, 109 3, 980, 083 5, 633, 498 3, 860, 272 304, 672 304, 672 0 3, 313, 513 307, 933, 707 355, 529 3, 908, 768 34, 791 237, 652 47, 842, 565	95 906, 74 690, 36 6, 972, 54 5, 162, 79 12, 236, 45 10, 914, 91 304, 67 8, 574, 89 464, 861, 88 600, 74 9, 793, 11 9, 793, 11 9, 793, 11 51, 153, 57	27, 956, 914         7       54, 641, 002         -296, 167         -154, 198         5       -84, 515         4       -423, 611         2       -304, 672         2       -304, 672         2       -304, 672         0       0         -1, 612, 526       2, 194, 046         5       -77, 480         4       -1, 305, 554         1       -20, 857         5       -34, 903         0       -755, 252	27, 956, 914 54, 641, 959 610, 578 536, 163 6, 888, 030 4, 739, 183 9, 555, 457 7, 862, 204 0 6, 962, 364 467, 055, 932 523, 265 8, 487, 560 78, 684 314, 282 50, 398, 318	71.00 72.00 73.00 74.00 76.97 90.00 90.01 90.05 91.00 92.00 101.00 113.00 114.00 192.00 194.00 194.01
73.00 74.00 76.97 90.00 90.01 90.05 91.00 92.00 101.00 113.00 116.00 118.00 190.00 194.00 194.01 194.04	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS 07697 CARDIAC REHABILITATION OUTPATIENT SERVICE COST CENTERS 09000 CLINIC 09001 IBMT JOINT VENTURE 09005 CV DIAGNOSTIC SERVICES 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE 11600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES 07955 MARKETING & COMMUNITY RELATIONS 07952 WOMEN'S CENTER 07956 FOUNDATION	0 591, 619 463, 806 4, 677, 436 1, 182, 711 6, 602, 954 7, 054, 644 0 5, 261, 377 156, 928, 179 245, 216 5, 884, 346 64, 750 111, 533	0 957 315, 126 226, 555 2, 295, 109 3, 980, 083 5, 633, 498 3, 860, 272 304, 672 304, 672 0 3, 313, 513 307, 933, 707 355, 529 3, 908, 768 34, 791 237, 652	95 906, 74 690, 36 6, 972, 54 5, 162, 79 12, 236, 45 10, 914, 91 304, 67 304, 67 8, 574, 89 464, 861, 88 600, 74 9, 793, 11 9, 793, 11 9, 54 349, 18 51, 153, 570	27, 956, 914         54, 641, 002         -296, 167         -154, 198         5         -84, 515         -423, 611         -2, 680, 995         -3, 052, 712         2         -304, 672         0       0         0       0         1, 612, 526         2, 194, 046         5       -77, 480         4       -1, 305, 554         -20, 857         -34, 903         0       -755, 252         0       0	27, 956, 914 54, 641, 959 610, 578 536, 163 6, 888, 030 4, 739, 183 9, 555, 457 7, 862, 204 0 6, 962, 364 467, 055, 932 523, 265 8, 487, 560 78, 684 314, 282 50, 398, 318 0	71.00 72.00 73.00 74.00 76.97 90.00 90.01 90.05 91.00 92.00 101.00 113.00 113.00 118.00 192.00 194.01 194.04 194.05

ULASSI	FICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EAPENSES	Provider CCN	. 15-0162	Period: From 01/01/2018	Worksheet	н
					To 12/31/2018	Date/Time	Prepar
	Cost Center Description	Adjustments	Net Expenses		,	5/31/2019	<u>/:4/a</u>
		(See A-8)	For				
			Allocation				
		6. 00	7.00				
	ENERAL SERVICE COST CENTERS 0100 CAP REL COSTS-BLDG & FIXT	13, 860, 306	35, 231, 498				1
	0200 CAP REL COSTS-MVBLE EQUIP	0					
	0400 EMPLOYEE BENEFITS DEPARTMENT	5, 490, 451	58, 414, 649				4
	0570 ADMI TTI NG	0	1, 050				5
	0580 CASHI ERI NG/ACCOUNTS RECEI VABLE	0	Ű				5
	0590 OTHER ADMIN & GENERAL	89, 378, 028					5
		6, 360, 946					7
	0800 LAUNDRY & LI NEN SERVI CE 0900 HOUSEKEEPI NG	0					6
	1000 DI ETARY	-364, 260					10
	1100 CAFETERI A	-2, 588, 057					11
00 01	1300 NURSING ADMINISTRATION	3, 295, 088					13
	1400 CENTRAL SERVICES & SUPPLY	-475, 321	1, 432, 424				14
	1500 PHARMACY	292, 749					15
	1600 MEDI CAL RECORDS & LI BRARY	270, 126					16
	2100 I & R SERVICES-SALARY & FRINGES APPRV	-154, 443					21
	2200 I&R SERVICES-OTHER PRGM COSTS APPRV 2300 MEDICAL LABORATORY SCIENTIST PRGM	-852, 603 -67, 670					22
	2302 PHARMACY PRGM	-07,070					23
	2301 EMERGENCY MEDICAL SERVICES	-259, 167					23
	2303 PARAMEDI C PRGM	-691, 200					23
	NPATIENT ROUTINE SERVICE COST CENTERS						
	3000 ADULTS & PEDIATRICS	-11, 968					30
	3100 INTENSIVE CARE UNIT	0	6, 905, 704				31
	2060 NEONATAL INTENSIVE CARE UNIT	-299, 215					31
	3200 CORONARY CARE UNIT 3400 SURGICAL INTENSIVE CARE UNIT	0	8, 552, 431 4, 673, 768				32
	4100 SUBPROVIDER - IRF	-48, 050					41
	4300 NURSERY	0					43
AN	NCILLARY SERVICE COST CENTERS						
	5000 OPERATING ROOM	-4, 186, 185					50
	5200 DELIVERY ROOM & LABOR ROOM	0	_/ = = / • • • •				52
	5400 RADI OLOGY-DI AGNOSTI C	671, 393					54
	5500  RADI OLOGY-THERAPEUTI C 5600  RADI OI SOTOPE	-3, 226, 915	8, 625, 359 1, 082, 930				55 56
	5900 CARDI AC CATHETERI ZATI ON	-592, 566					59
	6000 LABORATORY	-802, 179					60
00 06	6400 I NTRAVENOUS THERAPY	-553, 773	2, 609, 617				64
	6500 RESPI RATORY THERAPY	-39, 252					65
	6600 PHYSI CAL THERAPY	24, 733					66
	6700 OCCUPATIONAL THERAPY	0	.,				67
	6800 SPEECH PATHOLOGY 6900 ELECTROCARDI OLOGY	-18, 376 -151, 200					68
	7000 ELECTROENCEPHALOGRAPHY	-262,037					70
	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	202,037					71
	7200 IMPL. DEV. CHARGED TO PATIENTS	0					72
00 07	7300 DRUGS CHARGED TO PATIENTS	0	54, 641, 959				73
	7400 RENAL DI ALYSI S	-3, 752					74
	7697 CARDI AC REHABI LI TATI ON	-20, 800	515, 363				76
	JTPATI ENT SERVICE COST CENTERS 9000 CLINIC	076 446	6 012 245				90
	9000 CLINIC 9001 IBMT JOINT VENTURE	-875, 665 -800					90
	9005 CV DIAGNOSTIC SERVICES	-1, 049, 891	8, 505, 566				90
	9100 EMERGENCY	-61, 129					91
	9200 OBSERVATION BEDS (NON-DISTINCT PART						92
	THER REIMBURSABLE COST CENTERS						
	0100 HOME HEALTH AGENCY	0	0				101
	PECIAL PURPOSE COST CENTERS	0	0				111
	1300 I NTEREST EXPENSE 1600 HOSPI CE	0	-				113
. 00 1	SUBTOTALS (SUM OF LINES 1 through 117)	101, 987, 346					118
	ONREIMBURSABLE COST CENTERS	101, 707, 340	307, 043, 270				$\dashv$
	9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	523, 265				190
	9200 PHYSICIANS' PRIVATE OFFICES	0	8, 487, 560				192
. 00 07	7955 MARKETING & COMMUNITY RELATIONS	23, 557	102, 241				194
	7952 WOMEN'S CENTER	0	314, 282				194
. 04/07	7954 OTHER NRCC 7956 FOUNDATI ON	26, 028, 637 64, 256					194
			64, 256				194

# Health Financial Systems RECLASSIFICATIONS

### ST. FRANCIS HOSPITAL & HEALTH CENTER

Provider CCN: 15-0162

In Lieu of Form CMS-2552-10

Peri od: Worksheet A-6 From 01/01/2018 To 12/31/2018 Date/Time Prepared:

					To 12/31/2018 Date/Time Pr 5/31/2019 7:	
		Increases				
	Cost Center	Line #	Sal ary	Other		
		3.00	4.00	5.00		
1.00	A - MEDICAL SUPPLIES MEDICAL SUPPLIES CHARGED TO	71.00	0	35, 221, 485		1.00
	PATI ENT		0			
2.00	I MPL. DEV. CHARGED TO PATI ENTS	72.00		27, 956, 914		2.00
3.00	NURSING ADMINISTRATION	13.00	0	11, 739		3.00
4.00 5.00		0.00 0.00	0	0 0		4.00 5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00 0.00	0	0 0		9.00
10. 00 11. 00		0.00	0	0		10.00
12.00		0.00	Ō	0		12.00
13.00		0.00	0	0		13.00
14.00 15.00		0.00 0.00	0	0 0		14.00 15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00 20.00		0.00 0.00	0	0 0		19.00 20.00
21.00		0.00	0	0		21.00
22.00		0.00	О	0		22.00
23.00 24.00		0.00 0.00	0	0 0		23.00 24.00
24.00		0.00	0	0		24.00
26.00		0.00	0	0		26.00
27.00		0.00	0	0		27.00
28.00 29.00		0.00 0.00	0	0 0		28.00 29.00
30.00		0.00	0	0		30.00
31.00		0.00	0	0		31.00
32.00 33.00		0.00 0.00	0	0 0		32.00 33.00
34.00		0.00	0	0		34.00
35.00		0.00	О	0		35.00
36.00			0	00 63, 190, 138		36.00
	B – DRUG		U	03, 190, 138		-
1.00	DI ETARY	10. 00	0	117		1.00
2.00	NURSING ADMINISTRATION	13.00	0	22		2.00
3.00 4.00	DRUGS CHARGED TO PATIENTS	73.00 0.00	0	54, 641, 024 0		3.00 4.00
5.00		0.00	0	0		5.00
6.00		0.00	О	0		6.00
7.00		0.00	0	0		7.00
8.00 9.00		0. 00 0. 00	0	0 0		8.00 9.00
10.00		0.00	0 0	0		10.00
11.00		0.00	0	0 0 0 0		11.00
12.00 13.00		0.00 0.00	0	0		12.00 13.00
14.00		0.00	0	0		14.00
15.00		0.00	О	0 0		15.00
16.00		0.00	0	0		16.00
17.00 18.00		0.00 0.00	0	0 0		17.00 18.00
19.00		0.00	Ő	0		19.00
20.00		0.00	0	0		20.00
21.00 22.00		0.00 0.00	0	0 0		21.00 22.00
22.00		0.00	0	0		22.00
24.00		0.00	О	0		24.00
25.00		0.00	0	0		25.00
26.00 27.00		0.00 0.00	0	0 0		26.00 27.00
28.00		0.00	0			27.00
29.00		0.00	О	0 0		29.00
30.00		0.00	0	0		30.00
31.00	0		0	000000		31.00
	1.	i I	9	2., 5, 100		1

# Heal th RECLASS

1.00 2.00 3.00 4.00

4.00 5.00 6.00 7.00 8.00

9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00

1.00 2.00

1.00

1.00

1.00 2.00

1.00 2.00 3.00 4.00 5.00

6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00 20.00 21.00 22.00 23.00

23.00 24.00 25.00 26.00 27.00

28.00 29.00 30.00

31.00 32.00

33.00 34.00

35.00

36.00

FI CATI ONS			Provider CCN: 15-0162	Period: From 01/01/2018	Worksheet A-6
				To 12/31/2018	Date/Time Prepared: 5/31/2019 7:47 am
Cost Costor	Increases	Calarry	Other		
Cost Center 2.00	Li ne # 3.00	Salary 4.00	0ther 5.00		
- EQUI PMENT LEASE					
AP REL COSTS-MVBLE EQUIP	2.00	0	1, 120, 018		1.00
	0.00 0.00	0	0		2.00
	0.00	0	0		4.00
	0.00	0	0		5.00
	0.00	0	0		6.00
	0.00 0.00	0	0 0		7.00
	0.00	0	Ö		9.00
	0.00	0	0		10.00
	0.00 0.00	0	0 0		11.00
	0.00	0	o		13.00
	0.00	0	0		14.00
	0.00 0.00	0	0		15.00 16.00
	0.00	0	0		17.00
	0.00	0	0		18.00
	0.00	0			19.00
- DEPRECIATION		0	1, 120, 018		
AP REL COSTS-BLDG & FIXT	1.00	0	21, 371, 192		1.00
AP REL COSTS-MVBLE EQUIP		<u>0</u>	_ <u>344, 460</u> 21, 715, 652		2.00
- CAFETERIA		U	21, 710, 002		
FETERI A	<u>11.00</u>	1, 362, 867	<u>1, 712, 923</u>		1.00
- PARAMEDI CAL ED		1, 362, 867	1, 712, 923		
DI CAL LABORATORY SCIENTI ST	23.00	129, 081	40, 934		1.00
<u>G</u> M	+				
- INTERNS AND RESIDENT		129, 081	40, 934		
R SERVICES-OTHER PRGM	22.00	1, 777, 249	372, 831		1.00
DSTS APPRV	90.00	1, 215, 050	434, 681		2.00
		2, 992, 299	434, 681 807, 512		2.00
- EMPLOYEE BENEFITS	4.00		F2 024 100		
PLOYEE BENEFITS DEPARTMENT ME HEALTH AGENCY	4.00 101.00	0	52, 924, 198 222		1.00
	0.00	0	0		3.00
	0.00	0	0		4.00
	0.00 0.00	0 0	0		5.00
	0.00	0	0 0		7.00
	0.00	0	0		8.00
	0.00 0.00	0	0 0		9.00 10.00
	0.00	0	0		11.00
	0.00	0	0		12.00
	0.00 0.00	0 0	0 0		13.00 14.00
	0.00	0	0		14.00
	0.00	0	0		16.00
	0.00	0	0		17.00
	0.00 0.00	0 0	0 0		18.00 19.00
	0.00	0	0		20.00
	0.00	0	0		21.00
	0.00 0.00	0 0	0 0		22.00 23.00
	0.00	0	0		23.00
	0.00	0	0		25.00
	0.00	0	0		26.00
	0.00 0.00	0 0	0 0		27.00 28.00
	0.00	0	0		29.00
	0.00	0	0		30.00
	0.00 0.00	0	0 0		31.00
	0.00	0 0	0		32.00 33.00
	0.00	0	0		34.00
	0.00	0	0 0		35.00

Hearth	FINANCIAI Systems	51.	FRANCIS HUSPITA	AL & HEALTH CE	NIER	In Lieu	J OT FORM CMS	-2552-10
RECLASS	SI FI CATI ONS			Provi der	CCN: 15-0162	Peri od:	Worksheet A-	-6
						From 01/01/2018		
						To 12/31/2018	Date/Time Pr	repared:
							5/31/2019 7:	<u>47 am</u>
		Increases						
	Cost Center	Line #	Sal ary	Other				
	2.00	3.00	4.00	5.00				
37.00		0.00	0	C				37.00
38.00		0.00	0	C				38.00
39.00		0.00	0	C	)			39.00
40.00		0.00	0	C	)			40.00
41.00		0.00	0	C	)			41.00
42.00		0.00	o	C				42.00
43.00		0.00	o	C				43.00
44.00		0.00	0	C				44.00
45.00		0,00	0	C				45.00
46.00		0.00	0	C				46.00
	<u> </u>			52,924,420				
	I - PHARMACY RESIDENCY			· · ·				1
1.00	PHARMACY PRGM	23.01	114, 865	C	)			1.00
	<u> </u>		114, 865					
	J - EMS & PARAMEDIC RECLASS		· · · ·					1
1.00	PARAMEDI C PRGM	23.03	706, 072	20, 675				1.00
2.00	EMERGENCY	91.00	135, 767	84, 082				2.00
	TOTALS		841,839	104, 757				
	K - HOME HEALTH RECLASS	· · ·						1
	OTHER NRCC	194.04	0	304, 894				1.00
	TOTALS		— — — of	304, 894				
	Grand Total: Increases		5, 440, 951	196, 562, 411				500.00
000.00		· · ·	5,, , 0 1	., 0, 002, 111	1			1 300.00

In Lieu of Form CMS-2552-10

Period: From 01/01/2018 To 12/31/2018 Date/Time Prepared: 5/31/2019 7:47 am

						5/31/2018 bate/fime Pr	
		Decreases		÷	_		
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00 A - MEDI CAL SUPPLI ES	7.00	8.00	9.00	10.00		
1.00	OTHER ADMIN & GENERAL	5.03	0	12, 399	0		1.00
2.00	OPERATION OF PLANT	7.00	0	5, 948			2.00
3.00	LAUNDRY & LINEN SERVICE	8.00	0	301			3.00
4.00	HOUSEKEEPING	9.00	0	13, 794			4.00
5.00	DIETARY	10.00	0	60, 533			5.00
6.00 7.00	CENTRAL SERVICES & SUPPLY PHARMACY	14.00	0	1,007,628			6.00
8.00	I&R SERVICES-SALARY &	15. 00 21. 00	0	957, 021 22, 098			7.00 8.00
0.00	FRI NGES APPRV	21.00	0	22,070	, o		0.00
9.00	EMERGENCY MEDICAL SERVICES	23. 02	0	2, 742	0		9.00
10.00	ADULTS & PEDIATRICS	30.00	0	944, 091			10.00
11.00	INTENSIVE CARE UNIT	31.00	0	615, 375			11.00
12.00	NEONATAL INTENSIVE CARE UNIT	31.01	0	190, 782			12.00
13.00 14.00	CORONARY CARE UNIT SURGICAL INTENSIVE CARE UNIT	32.00 34.00	0	483, 427 282, 642			13.00 14.00
14.00	SUBPROVIDER - IRF	41.00	0	40, 687			15.00
16.00	NURSERY	43.00	0	51, 962			16.00
17.00	OPERATING ROOM	50.00	0	36, 101, 279			17.00
18.00	DELIVERY ROOM & LABOR ROOM	52.00	0	492, 321			18.00
19.00	RADI OLOGY-DI AGNOSTI C	54.00	0	2, 629, 652			19.00
20.00	RADI OI SOTOPE	56.00	0	8, 519			20.00
21.00 22.00	CARDI AC CATHETERI ZATI ON LABORATORY	59.00 60.00	0 0	14, 026, 912			21.00 22.00
22.00	INTRAVENOUS THERAPY	64.00	0	1, 202, 089 666, 877			22.00
24.00	RESPI RATORY THERAPY	65.00	0	1, 329, 465	-		24.00
25.00	PHYSI CAL THERAPY	66.00	0	46, 574			25.00
26.00	OCCUPATIONAL THERAPY	67.00	0	23, 658			26.00
27.00	SPEECH PATHOLOGY	68.00	0	13, 464			27.00
28.00	ELECTROCARDI OLOGY	69.00	0	315, 091			28.00
29.00	ELECTROENCEPHALOGRAPHY	70.00	0	75, 911			29.00
30.00	DRUGS CHARGED TO PATIENTS	73.00	0	22			30.00
31.00 32.00	RENAL DIALYSIS CARDIAC REHABILITATION	74.00 76.97	0	65, 055 5, 359			31.00 32.00
33.00	CLINIC	90.00	0	223, 628			33.00
34.00	IBMT JOINT VENTURE	90.01	0	42, 675			34.00
35.00	CV DIAGNOSTIC SERVICES	90. 05	0	304, 986	0		35.00
36.00	EMERGENCY	<u>91.</u> 00	<u>0</u>	925, 171			36.00
			0	63, 190, 138	8		-
1.00	B - DRUG OTHER ADMIN & GENERAL	5.03	0	26	0		1.00
2.00	OPERATION OF PLANT	7.00	0	26			2.00
3.00	CENTRAL SERVICES & SUPPLY	14.00	0	1, 098			3.00
4.00	PHARMACY	15.00	0	21,064,660			4.00
5.00	I&R SERVICES-SALARY &	21.00	0	185, 507	0		5.00
( 00	FRI NGES APPRV	22.02		47			( 00
6.00 7.00	EMERGENCY MEDICAL SERVICES ADULTS & PEDIATRICS	23. 02 30. 00	0	47 27, 159			6.00 7.00
8.00	INTENSIVE CARE UNIT	31.00	0	5, 233	-		8.00
9.00	NEONATAL INTENSIVE CARE UNIT	31.01	0	2, 190			9.00
10.00	CORONARY CARE UNIT	32.00	0	4, 711			10.00
11.00	SURGICAL INTENSIVE CARE UNIT	34.00	0	2, 681			11.00
12.00	SUBPROVIDER - IRF	41.00	0	170			12.00
13.00	NURSERY	43.00	0	2	0		13.00
14.00 15.00	OPERATING ROOM DELIVERY ROOM & LABOR ROOM	50. 00 52. 00	0 0	139, 249 3, 303			14.00 15.00
16.00	RADI OLOGY-DI AGNOSTI C	54.00	0	9, 232			16.00
17.00	RADI OI SOTOPE	56.00	0	439			17.00
18.00	CARDI AC CATHETERI ZATI ON	59.00	0	24, 471			18.00
19.00	LABORATORY	60.00	0	141, 268			19.00
20.00	INTRAVENOUS THERAPY	64.00	0	32, 745, 318			20.00
21.00		65.00	0	161, 740			21.00
22.00 23.00	PHYSI CAL THERAPY OCCUPATI ONAL THERAPY	66. 00 67. 00	0 0	570 602			22.00 23.00
23.00	SPEECH PATHOLOGY	68.00	0	654	-		23.00
25.00	ELECTROCARDI OLOGY	69.00	0	186			25.00
26.00	ELECTROENCEPHALOGRAPHY	70.00	0	15	0		26.00
27.00	RENAL DI ALYSI S	74.00	0	34, 111			27.00
28.00		90.00	0	1, 702			28.00
29.00	I BMT JOI NT VENTURE	90.01	0	196			29.00 30.00
30.00 31.00	CV DI AGNOSTI C SERVI CES EMERGENCY	90. 05 91. 00	0 0	11, 044 73, 553			30.00
51.00		<u> </u>	0				31.00
	· ·	I	0	.,	1		•

Heal th	Financial Systems	ST. F	RANCIS HOSPITA	L & HEALTH CE	NTER	In Lie	u of Form CMS	5-2552-10
RECLAS	SIFICATIONS			Provi der (	CCN: 15-0162	Peri od:	Worksheet A	-6
						From 01/01/2018 To 12/31/2018	Date/Time Pr	roparod
						10 12/31/2010	5/31/2019 7:	
		Decreases						
	Cost Center	Line #	Sal ary	Other	Wkst. A-7 Ref	·.		
	6. 00	7.00	8.00	9.00	10.00			
	C – EQUI PMENT LEASE							_
1.00	OTHER ADMIN & GENERAL	5.03	0	900		10		1.00
2.00	OPERATION OF PLANT	7.00	0	2, 023		0		2.00
3.00		10.00	0	12, 335		0		3.00
4.00 5.00	CENTRAL SERVICES & SUPPLY PHARMACY	14.00	0	89, 232 622, 021		0		4.00
5.00 6.00	I&R SERVICES-SALARY &	15. 00 21. 00	0	622, 021 5, 980		0		5.00 6.00
0.00	FRINGES APPRV	21.00	0	5, 960	,	0		0.00
7.00	ADULTS & PEDIATRICS	30.00	0	21, 056	5	0		7.00
8.00	I NTENSI VE CARE UNI T	31.00	0	28, 271		0		8.00
9.00	CORONARY CARE UNIT	32.00	0	43, 920		0		9.00
10.00	SUBPROVI DER – I RF	41.00	0	8, 636		0		10.00
11.00	OPERATI NG ROOM	50.00	0	147, 321		0		11.00
12.00	RADI OLOGY-DI AGNOSTI C	54.00	0	295		0		12.00
13.00	CARDI AC CATHETERI ZATI ON	59.00	0	12	2	0		13.00
14.00	LABORATORY	60.00	0	2,673	3	0		14.00
15.00	INTRAVENOUS THERAPY	64.00	0	9, 679	2	0		15.00
16.00	RESPI RATORY THERAPY	65.00	0	109, 390	)	0		16.00
17.00	RENAL DI ALYSI S	74.00	0	6, 165		0		17.00
18.00	CLINIC	90.00	0	9, 737		0		18.00
19.00	CV_DI_AGNOSTI_C_SERVI_CES	90.05	0			Q		19.00
			0	1, 120, 018	3			_
1 00	D - DEPRECIATION	0.00		01 071 100		0		1
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	21, 371, 192		9		1.00
2.00	LABORATORY	<u>60.00</u>	0	344,460		9		2.00
	E – CAFETERIA		0	21, 715, 652	<u>-</u>			-
1.00	DI ETARY	10.00	1, 362, 867	1, 712, 923		0		1.00
1.00		10.00	1, 362, 867	1, 712, 923				1.00
	F - PARAMEDICAL ED		1, 302, 007	1,712,723	<u>'</u>			-
1.00	LABORATORY	60.00	129, 081	40, 934	1	0		1.00
1.00		00.00	129,081	40, 934	<u> </u>			1.00
	G - INTERNS AND RESIDENT		,					-
1.00	I &R SERVI CES-SALARY &	21.00	2, 992, 299	807, 512	2	0		1.00
	FRI NGES APPRV							
2.00		0.00	0	<u>C</u>	)	Q		2.00
	0		2, 992, 299	807, 512	2			
	H - EMPLOYEE BENEFITS				1			_
1.00	OTHER ADMIN & GENERAL	5.03	0	435, 830		0		1.00
2.00	OPERATION OF PLANT	7.00	0	1, 249, 476		0		2.00
3.00	LAUNDRY & LINEN SERVICE	8.00	0	69, 963		0		3.00
4.00	HOUSEKEEPING	9.00	0	1, 215, 098		0		4.00
5.00		10. 00 11. 00	0	683, 509		0		5.00
6.00	CAFETERIA NURSING ADMINISTRATION	13.00	0	260, 593 1, 429, 594	-			6.00
7.00 8.00	CENTRAL SERVICES & SUPPLY	14.00	0	246, 203		0		7.00 8.00
9.00	PHARMACY	15.00	0	1, 955, 646		0		9.00
10.00	I &R SERVICES-SALARY &	21.00	0	1, 602, 206		0		10.00
10.00	FRINGES APPRV	21.00	0	1,002,200				10.00
11.00	MEDICAL LABORATORY SCIENTIST	23.00	0	26, 791	I I	0		11.00
	PRGM							
12.00	PHARMACY PRGM	23. 01	0	119, 858		0		12.00
13.00	EMERGENCY MEDICAL SERVICES	23. 02	0	352, 288		0		13.00
14.00	ADULTS & PEDIATRICS	30.00	0	8, 773, 290		0		14.00
15.00	INTENSIVE CARE UNIT	31.00	0	2, 114, 542	2	0		15.00
16.00	NEONATAL INTENSIVE CARE UNIT	31.01	0	985, 868		0		16.00
17.00	CORONARY CARE UNIT	32.00	0	2, 700, 192		0		17.00
18.00	SURGICAL INTENSIVE CARE UNIT	34.00	0	1, 437, 816		0		18.00
19.00	SUBPROVIDER - IRF	41.00	0	874, 276		0		19.00
20.00	NURSERY	43.00	0	184, 822		0		20.00
21.00	OPERATING ROOM	50.00	0	3, 865, 745		0		21.00
22.00	DELIVERY ROOM & LABOR ROOM	52.00	0	842, 426		0		22.00
23.00	RADI OLOGY-DI AGNOSTI C	54.00	0	2, 514, 833		0		23.00
24.00	RADI OLOGY-THERAPEUTI C	55.00	0	501, 310		0		24.00
25.00		56.00	0	77,846		0		25.00
26.00	CARDI AC CATHETERI ZATI ON	59.00	0	735, 280		0		26.00
27.00		60.00	0	283, 624		0		27.00
28.00	INTRAVENOUS THERAPY	64.00 65.00	0	836, 187		0		28.00
29.00		65.00	0	2, 388, 329		0		29.00
30. 00 31. 00	PHYSICAL THERAPY	66.00 67.00	0	1, 477, 067 545, 219				30.00
51 111	OCCUPATIONAL THERAPY SPEECH PATHOLOGY	67.00 68.00	0	545, 219 271, 576		0		31.00 32.00
		08.00	U					
32.00		60 00		110 104	5	0		22 00
	ELECTROCARDI OLOGY ELECTROENCEPHALOGRAPHY	69.00 70.00	0	440, 106 457, 521		0		33.00 34.00

# Health Financial Systems ST. FRANCIS HOSPITAL & HEALTH CENTER In Lieu of Form CMS-2552-10 RECLASSIFICATIONS Provider CCN: 15-0162 Period: Form 01 (01 (2010) Worksheet A-6

Perroc	1.	worksneet	A-0
From (	01/01/2018		
To 1	2/31/2018	Date/Time	Prepared:
		5/31/2019	7:47 am

		_			ļ	5/31/2019 7:4	
		Decreases					
	Cost Center	Line #	Sal ary		Wkst. A-7 Ref.		
	6. 00	7.00	8.00	9.00	10.00		
35.00	RENAL DI ALYSI S	74.00	0	190, 836	0		35.00
36.00	CARDIAC REHABILITATION	76.97	0	148, 839	0		36.00
37.00	CLINIC	90.00	0	1, 499, 179	0		37.00
38.00	IBMT JOINT VENTURE	90.01	0	380, 740	0		38.00
39.00	CV DI AGNOSTI C SERVI CES	90.05	0	2, 364, 593	0		39.00
40.00	EMERGENCY	91.00	0	2, 273, 837			40.00
41.00	HOSPI CE	116.00	0	1, 612, 526			41.00
42.00	GIFT, FLOWER, COFFEE SHOP &	190.00	0	77, 480			42.00
	CANTEEN			,	_		
43.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	1, 305, 554	0		43.00
44.00	MARKETING & COMMUNITY	194.00	0	20, 857	0		44.00
	RELATIONS			,	_		
45.00	WOMEN'S CENTER	194.01	0	34, 903	0		45.00
46.00	OTHER NRCC	194.04	0	1,060,146	0		46.00
				52, 924, 420			
	I - PHARMACY RESIDENCY	I	-1		I		
1.00	PHARMACY	15.00	114, 865	0	0		1.00
1.00			114,865	<u> </u>	•		1.00
	J - EMS & PARAMEDIC RECLASS		111,000	0	I		
1.00	EMERGENCY MEDICAL SERVICES	23.02	841, 839	104, 757	0		1.00
2.00	EMERGENCI MEDICAL SERVICES	0,00	041,037	104, 737	0		2.00
2.00	TOTALS		841,839	104, 757	— — <sup>4</sup>		2.00
	K - HOME HEALTH RECLASS		041,037	104, 737			
1 00		101 00	0	204 004	0		1 00
1.00	HOME_HEALTH_AGENCY	101.00	¥				1.00
500.00	TOTALS		5 440 054	304, 894			500 00
500.00	Grand Total: Decreases		5, 440, 951	196, 562, 411		·	500.00

Provi der CCN: 15-0162

In Lieu of Form CMS-2552-10 Period: Worksheet A-7 From 01/01/2018 Part I

					o 12/31/2018		
				Acqui si ti ons			
		Begi nni ng	Purchases	Donati on	Total	Disposals and	
		Bal ances				Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE						
1.00	Land	9, 582, 383	0	(	0 0	0	1.00
2.00	Land Improvements	30, 999, 613	3, 733, 694	(	3, 733, 694	0	2.00
3.00	Buildings and Fixtures	223, 434, 236	19, 229, 651	(	19, 229, 651	0	3.00
4.00	Building Improvements	8, 496, 237	48, 065	(	48, 065	0	4.00
5.00	Fixed Equipment	260, 902, 549	15,034,408	(	15, 034, 408	0	5.00
6.00	Movable Equipment	158, 095, 952	5, 259, 957	(	5, 259, 957	0	6.00
7.00	HIT designated Assets	0	0	(	0 0	0	7.00
8.00	Subtotal (sum of lines 1-7)	691, 510, 970	43, 305, 775	(	43, 305, 775	0	8.00
9.00	Reconciling Items	0	0	(	0 0	0	9.00
10.00	Total (line 8 minus line 9)	691, 510, 970	43, 305, 775	(	43, 305, 775	0	10.00
		Endi ng	Fully				
		Bal ance	Depreciated				
			Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	T BALANCES					
1.00	Land	9, 582, 383	0				1.00
2.00	Land Improvements	34, 733, 307	5, 552, 760				2.00
3.00	Buildings and Fixtures	242, 663, 887	18, 342, 149				3.00
4.00	Building Improvements	8, 544, 302	2, 218, 403				4.00
5.00	Fixed Equipment	275, 936, 957	15, 629, 296				5.00
6.00	Movable Equipment	163, 355, 909	72, 248, 687				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	734, 816, 745	113, 991, 295				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	734, 816, 745	113, 991, 295				10.00

RECONC	STEFATION OF CAPITAL COSTS CENTERS		Provi der Co	CN: 15-0162	From 01/01/2018 To 12/31/2018		pared:
		SUMMARY OF CAPITAL					
	Cost Center Description	Depreciation	Lease	Interest	I nsurance (see i nstructi ons)	Taxes (see instructions)	
	1	9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUN	NN 2, LINES 1 a	and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	0		0 0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	34, 438, 158	0		0 0	0	2.00
3.00	Total (sum of lines 1-2)	34, 438, 158	0		0 0	0	3.00
		SUMMARY O	F CAPI TAL				
	Cost Center Description	Other	Total (1)				
		Capi tal -Rel at	(sum of cols.				
		ed Costs (see	9 through 14)				
		instructions)					
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUN	IN 2, LINES 1 a	and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	0				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	34, 438, 158				2.00
3.00	Total (sum of lines 1-2)	0	34, 438, 158				3.00

Health Financial Systems ST. F	RANCIS HOSPITA	L & HEALTH CEN	TER	In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS	_	Provider C	F	Period: rom 01/01/2018 o 12/31/2018		pared:
	COMF	PUTATION OF RAT	FI OS	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
	1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS C			574 440 007	0.777/00		1
1. 00 CAP REL COSTS-BLDG & FLXT 2. 00 CAP REL COSTS-MVBLE FOULP	571, 460, 837		571, 460, 837			1.00
2.00 CAP REL COSTS-MVBLE EQUIP 3.00 Total (sum of lines 1-2)	163, 355, 909 734, 816, 746		100/000//00			2.00 3.00
		TION OF OTHER (	/01/010///0		F CAPI TAL	3.00
	ALLUCA	ITON OF OTHER (	JAPITAL	SUMMART	F CAPITAL	
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
		Capital -Relat	cols. 5	•		
		ed Costs	through 7)			
	6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS	1		1		
1.00 CAP REL COSTS-BLDG & FIXT	0	0	0	= ., , =		1.00
2.00 CAP REL COSTS-MVBLE EQUIP	0	0	0	13, 411, 426		2.00
3.00 Total (sum of lines 1-2)	0	0	0	34, 782, 618	1, 120, 018	3.00
		SL	IMMARY OF CAPIT	AL		
Cost Center Description	Interest	Insurance	Taxes (see	Other	Total (2)	
		(see	instructions)	Capi tal -Rel at	(sum of cols.	
		instructions)		ed Costs (see	9 through 14)	
				instructions)		
	11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CI					05 004 400	
1.00 CAP REL COSTS-BLDG & FIXT	13, 860, 306	0	-	-		1.00
2.00 CAP REL COSTS-MVBLE EQUIP 3.00 Total (sum of lines 1-2)			0	-	11/001/111	2.00
3.00  Total (sum of lines 1-2)	13, 860, 306	1 0	0	0	49, 762, 942	3.00

ealth Financial Systems DJUSTMENTS TO EXPENSES	51. F	NAINCES HUSPELA		Period:	u of Form CMS-2 Worksheet A-8	
				From 01/01/2018 To 12/31/2018		pared
			Expense Classification or To/From Which the Amount is		5/31/2019 7:4	7 am
			TO/FION WHICH THE AMOUNT IS	to be Adjusted		
Cost Center Description	Basi s/Code	Amount	Cost Center	Line #	Wkst. A-7	
cost center bescription	(2)			-	Ref.	
00 Investment income - CAP REL	1.00 B	2.00 -162,404	3.00 CAP REL COSTS-BLDG & FIXT	4.00	5. 00 11	1. (
COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.(
COSTS-MVBLE EQUIP (chapter 2) Investment income - other		0		0.00	0	3. (
(chapter 2)						
00 Trade, quantity, and time discounts (chapter 8)		0		0.00	0	
00 Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.0
00 Rental of provider space by suppliers (chapter 8)		0		0.00	0	6. (
00 Telephone services (pay stations excluded) (chapter		0		0.00	0	7.(
21)				0.00		
00 Television and radio service (chapter 21)		0		0.00	0	
00 Parking lot (chapter 21) .00 Provider-based physician	A-8-2	0 -7, 141, 524		0.00	0	
adjustment 00 Sale of scrap, waste, etc.		0		0.00	0	11.(
(chapter 23) 00 Related organization	A-8-1	174, 711, 010				12. (
transactions (chapter 10)	N O T	1,4,711,010		0.00		
<ul><li>00 Laundry and linen service</li><li>00 Cafeteria-employees and guests</li></ul>	В	-2, 516, 189	CAFETERI A	0. 00 11. 00	0	
00 Rental of quarters to employee and others		0		0.00	0	15. (
00 Sale of medical and surgical supplies to other than		0		0.00	0	16. (
patients .00 Sale of drugs to other than		0		0.00	0	17.(
patients						
00 Sale of medical records and abstracts		0		0.00		18. (
00 Nursing and allied health education (tuition, fees,		0		0.00	0	19. (
books, etc.) 00 Vending machines	В	-71 868	CAFETERI A	11.00	0	20. (
00 Income from imposition of	U	0		0.00	0	
interest, finance or penalty charges (chapter 21)		-				
.00 Interest expense on Medicare overpayments and borrowings to		0		0.00	0	22. (
repay Medicare overpayments .00 Adjustment for respiratory	A-8-3	0	RESPI RATORY THERAPY	65.00		23. (
therapy costs in excess of limitation (chapter 14)						
. 00 Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSI CAL THERAPY	66.00		24.0
limitation (chapter 14)						
.00 Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	114.00		25.0
(chapter 21) 00 Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.0
COSTS-BLDG & FIXT OO Depreciation - CAP REL			CAP REL COSTS-MVBLE EQUIP	2.00		27.0
COSTS-MVBLE EQUI P					0	
00 Non-physician Anesthetist 00 Physicians' assistant		0	*** Cost Center Deleted ***	19.00 0.00	0	
00 Adjustment for occupational therapy costs in excess of	A-8-3	0	OCCUPATI ONAL THERAPY	67.00		30. (
limitation (chapter 14) .99 Hospice (non-distinct) (see			ADULTS & PEDIATRICS	30.00		30. 9
i nstructi ons)		0	AUDICIO & LULATINI CO	30.00		00.9

04/0

In Lieu of Form CMS-2552-10

ADJUST	MENTS TO EXPENSES				Period:	Worksheet A-8	
					From 01/01/2018 To 12/31/2018	Date/Time Pre 5/31/2019 7:4	
				Expense Classification or	n Worksheet A		
				To/From Which the Amount is	to be Adjusted		
					- 1		
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
31.00	Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
	pathology costs in excess of						
	limitation (chapter 14)		_			-	
32.00	CAH HIT Adjustment for		0		0.00	0	32.00
22.00	Depreciation and Interest	В	27 704		5.03	0	33.00
33.00 33.01	MI SCELLANEOUS I NCOME MI SCELLANEOUS I NCOME	В	-27, 794 -418, 685	OTHER ADMIN & GENERAL	10.00	0	33.00
33.01	MI SCELLANEOUS I NCOME	B		OPERATION OF PLANT	7.00		33.02
33.02	MI SCELLANEOUS I NCOME	B		CENTRAL SERVICES & SUPPLY	14.00	0	33.02
33.04	MI SCELLANEOUS I NCOME	В		PHARMACY	15.00	0	33.04
33.05	MI SCELLANEOUS I NCOME	В		I &R SERVICES-SALARY &	21.00	0	33.05
				FRINGES APPRV			
33.06	MI SCELLANEOUS I NCOME	В		MEDICAL LABORATORY SCIENTIS PRGM		0	
33.07	MI SCELLANEOUS I NCOME	В		EMERGENCY MEDICAL SERVICES	23. 02	0	33.07
33.08	MI SCELLANEOUS I NCOME	В		OPERATING ROOM	50.00	0	33.08
33.09	MI SCELLANEOUS I NCOME	В		RADI OLOGY-DI AGNOSTI C	54.00	0	33.09
33.10	MI SCELLANEOUS I NCOME	В	-3, 226, 915	RADI OLOGY-THERAPEUTI C	55.00	0	33.10
33.11	MI SCELLANEOUS I NCOME	В		CARDI AC CATHETERI ZATI ON	59.00	0	33.11
33.12		В		LABORATORY	60.00	0	33.12
33.13	MI SCELLANEOUS I NCOME	В		INTRAVENOUS THERAPY	64.00	0	33.13
33.14	MISCELLANEOUS INCOME	В		RESPIRATORY THERAPY	65.00	0	33.14
33. 15 33. 16	MI SCELLANEOUS I NCOME MI SCELLANEOUS I NCOME	B		ELECTROENCEPHALOGRAPHY CARDI AC REHABI LI TATI ON	70.00 76.97	0	33. 15 33. 16
33.17	MI SCELLANEOUS I NCOME	В	-70, 800		90.00	-	33.10
33.17	MI SCELLANEOUS I NCOME	B		IBMT JOINT VENTURE	90.00		33.17
33.19	MI SCELLANEOUS I NCOME	В		CV DI AGNOSTI C SERVI CES	90.05	0	33.19
33.20	MI SCELLANEOUS I NCOME	В		SPEECH PATHOLOGY	68.00	0	33.20
33. 21	MI SCELLANEOUS I NCOME	В		PARAMEDIC PRGM	23.03	0	33.21
33. 22	MI SCELLANEOUS I NCOME	В		EMERGENCY	91.00	0	33.22
33. 23	ADVERTI SI NG	A	-14, 707	CV DIAGNOSTIC SERVICES	90.05	0	33.23
33.24	ADVERTI SI NG	А	-1, 121	OPERATING ROOM	50.00	0	33.24
33.25	ADVERTI SI NG	A		RESPI RATORY THERAPY	65.00	0	33.25
33.26	ADVERTI SI NG	А	-1,037	I &R SERVI CES-SALARY & FRI NGES APPRV	21.00	0	33. 26
33. 27	NONALLOWABLE INTEREST	А	-1, 304, 067	CAP REL COSTS-BLDG & FIXT	1.00	11	33.27
33.28	NEUROLOGY TESTING EXPENSE	A		ELECTROENCEPHALOGRAPHY	70.00	0	33.28
33.29	NEUROLOGY TESTING EXPENSE	В		ELECTROENCEPHALOGRAPHY	70.00	0	33.29
33.30	HAF OFFSET	А		OTHER ADMIN & GENERAL	5.03	0	33.30
33. 31	ON CALL COVERAGE	A		HOSPI CE	116.00	0	33. 31
33. 32	PHYSI CI AN RECRUI TMENT	A	-101, 594	I &R SERVI CES-SALARY & FRI NGES APPRV	21.00	0	33. 32
33.33	PENSION ADJ PER REGS 2142.5	А	5, 348, 005	EMPLOYEE BENEFITS DEPARTMEN	T 4.00	0	33.33
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A,		128, 103, 796				50.00
· · · > - =	column 6, line 200.)	L					L

(1) Description - all chapter references in this column pertain to CMS  $\overline{\text{Pub. 15-1.}}$ 

(2) Basis for adjustment (see instructions).
 A. Costs - if cost, including applicable overhead, can be determined.
 B. Amount Received - if cost cannot be determined.

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

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

Heal th	Financial Systems	ST. FRANCIS HOSPIT	AL & HEALTH CENTER	In Lie	u of Form CMS-2	2552-10
	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HO	ME Provider CCN: 15-0162	Period: From 01/01/2018	Worksheet A-8-	-1
OFFICE	COSTS			To 12/31/2018		
	Line No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost		
					Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUST					
	OFFICE COSTS:	NEW 10 RECORDED NO 77 RECOEL OF			OEM MED HOME	
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	SHARED SERVICE ALLOCATION	142, 446	0	1.00
2.00	5.03	OTHER ADMIN & GENERAL	SHARED SERVICE ALLOCATION	33, 893, 240	0	2.00
3.00	7.00	OPERATION OF PLANT	SHARED SERVICE ALLOCATION	6, 623, 781	0	3.00
4.00	10.00	DI ETARY	SHARED SERVICE ALLOCATION	54, 425	0	4.00
4.01	13.00	NURSING ADMINISTRATION	SHARED SERVICE ALLOCATION	3, 295, 088	0	4.01
4.02	16.00	MEDICAL RECORDS & LIBRARY	SHARED SERVICE ALLOCATION	270, 126	0	4.02
4.03	54.00	RADI OLOGY-DI AGNOSTI C	SHARED SERVICE ALLOCATION	1, 701, 101	0	4.03
4.04	1.00	CAP REL COSTS-BLDG & FIXT	SHARED SERVICE ALLOCATION	-551, 715	0	4.04
4.05	194.00	MARKETING & COMMUNITY RELATI	SHARED SERVICE ALLOCATION	23, 557	0	4.05
4.06	194.04	OTHER NRCC	SHARED SERVICE ALLOCATION	26, 028, 637	0	4.06
4.07	194.05	FOUNDATI ON	FRANCISCAN HOME OFFICE	64, 256	0	4.07
4.08	5.03	OTHER ADMIN & GENERAL	FRANCISCAN HOME OFFICE	11, 189, 111	0	4.08
4.09	1.00	CAP REL COSTS-BLDG & FIXT	FRANCISCAN HOME OFFICE	15, 878, 492	0	4.09
4.10	5.03	OTHER ADMIN & GENERAL	FRANCISCAN HOME OFFICE	70, 805, 775	0	4.10
4.11	5.03	OTHER ADMIN & GENERAL	FRANCISCAN HOME OFFICE	4, 654, 084	0	4.11
4.12	15.00	PHARMACY	SHARED SERVICE ALLOCATION	1, 272, 092	0	4.12
4.13	60.00	LABORATORY	SHARED SERVICE ALLOCATION	17, 451, 481	18, 084, 967	4.13
	TOTALS (sum of lines 1-4).			192, 795, 977	18, 084, 967	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) ar	nd∕or Home Office	
Symbol (1)	Name	Percentage of	Name	Percentage of	1
		Ownershi p		Ownershi p	
1.00	2.00	3.00	4.00	5.00	
B. INTERRELATIONSHIP TO RELAT	FED 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	SI STERS	100.00	0.00	6.00
7.00	В	APHL	100.00	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 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.

#### Health Financial Systems In Lieu of Form CMS-2552-10 ST. FRANCIS HOSPITAL & HEALTH CENTER STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME Provider CCN: 15-0162 Peri od: Worksheet A-8-1 From 01/01/2018 Date/Time Prepared OFFICE COSTS

			Io 12/31/2018 Date/lime Prep 5/31/2019 7:47	
	Net	Wkst. A-7 Ref.		
	Adjustments			
	(col. 4 minus			
	col. 5)*			
	6.00	7.00		
	A. COSTS INCUR	RED AND ADJUSTN	MENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME	
	OFFICE COSTS:			
1.00	142, 446			1.00
2.00	33, 893, 240	0		2.00
3.00	6, 623, 781	0		3.00
4.00	54, 425			4.00
4.01	3, 295, 088	0		4.01
4.02	270, 126	0		4.02
4.03	1, 701, 101	0		4.03
4.04	-551, 715	11		4.04
4.05	23, 557	0		4.05
4.06	26, 028, 637	0		4.06
4.07	64, 256	0		4.07
4.08	11, 189, 111	0		4.08
4.09	15, 878, 492	11		4.09
4.10	70, 805, 775	0		4.10
4.11	4, 654, 084	0		4.11
4.12	1, 272, 092	0		4.12
4.13	-633, 486	0		4.13
5.00	174, 711, 010			5.00
* The	and the second s	1 4 (	according to appropriate) and transformed in detail to Worksheet A column ( lines of	

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	A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.	
Rel ated Organi zati on(s)		
and/or Home Office		
Type of Business		
51		
6.00		
B. INTERRELATIONSHIP TO REL	LATED 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	SHARED LAB	7.00
8.00		8.00
9.00		9.00
10.00		10.00
10. 00 100. 00		100.00

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

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
 B. Corporation, partnership, or other organization has financial interest in provider.

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

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

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

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

In Lieu of Form CMS-2552-10 Worksheet A-8-2

PROVI DE	R BASED PHYSI	CLAN ADJUSTMENT		Provider (		Period:	Worksheet A-8	3-2
						From 01/01/2018 To 12/31/2018	3 Date/Time Pre	epared:
	Wkst. A Line :	Cost Center/Physician	Totol	Professi onal	Provi der	DCE Amount	5/31/2019 7: 4	17 am
	WKSL A LINE	Identi fi er	Total Remuneration	Component	Component	RCE Amount	Physician/Prov ider Component	
				oomponone	componente		Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00		3 OTHER ADMIN & GENERAL	138, 483	128, 583	9, 900			1.00
2.00		DPHARMACY	21, 150	0				2.00
3.00	22.00	DI&R SERVICES-OTHER PRGM COSTS APPRV	2, 107, 876	0	2, 107, 876	211, 500	12, 345	3.00
4.00	23 0	2 EMERGENCY MEDICAL SERVICES	22, 000	0	22,000	211, 500	265	4.00
5.00		DADULTS & PEDIATRICS	23, 763	3, 086				5.00
6.00		NEONATAL INTENSIVE CARE UNIT		299, 215				6.00
7.00		SUBPROVIDER - IRF	48, 050	48, 050	0	246, 400	0	7.00
8.00		OPERATING ROOM	2, 864, 330	2, 855, 687	8, 643			8.00
9.00		DRADI OLOGY-DI AGNOSTI C	814, 339	814, 339				9.00
10. 00 11. 00		DCARDIAC CATHETERIZATION	151, 200	151, 200		260, 300		10.00
12.00		DINTRAVENOUS THERAPY	162, 776 -4, 936	102, 326 -4, 936		211, 500 211, 500		11.00 12.00
13.00		DRESPIRATORY THERAPY	18, 250	4, 750				
14.00		DPHYSICAL THERAPY	-24, 733	-24, 733	0			14.00
15.00	69.00	ELECTROCARDI OLOGY	151, 200	151, 200	0	211, 500	0	15.00
16.00		DELECTROENCEPHALOGRAPHY	29, 005	4, 780			128	16.00
17.00		DRENAL DIALYSIS	7, 413	1, 988				17.00
18.00			804, 865	804, 865		,		
19.00		I I BMT JOI NT VENTURE	108, 471	0 861, 086	100/111			
20. 00 21. 00		5 CV DIAGNOSTIC SERVICES DEMERGENCY	861, 086 65, 922	29, 922		,		20.00 21.00
200.00	91.00		8, 669, 725	6, 227, 508			17,002	
200100	Wkst. A Line :	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	200100
		I denti fi er			Memberships &	Component	of Mal practi ce	
				Limit	Conti nui ng	Share of col.	Insurance	
	1.00	2.00	8.00	9.00	Education 12.00	12 13.00	14.00	
1.00		3 OTHER ADMIN & GENERAL	6, 711	336				1.00
2.00		DPHARMACY	14, 337	717			0	2.00
3.00	22.00	DI&R SERVICES-OTHER PRGM	1, 255, 273	62, 764	0	0	0	3.00
		COSTS APPRV						
4.00		2 EMERGENCY MEDICAL SERVICES	26, 946	1, 347			0	4.00
5.00 6.00		ADULTS & PEDIATRICS	11, 795 0	590 0		-	0	5.00
8.00 7.00		1 NEONATAL INTENSIVE CARE UNIT DSUBPROVIDER – IRF	0	0		-	0	6.00 7.00
8.00		DOPERATING ROOM	11, 765	588	-	-	0	8.00
9.00		DRADI OLOGY-DI AGNOSTI C	0	0		0	0	9.00
10.00	59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	10.00
11.00		DLABORATORY	42, 707	2, 135	0	0	0	11.00
12.00		DINTRAVENOUS THERAPY	0	0	0	0	0	12.00
13.00			11, 795	590		0	0	13.00
14.00 15.00		DPHYSI CAL THERAPY DELECTROCARDI OLOGY	0	0 0		0	0	14.00 15.00
16.00		DELECTROENCEPHALOGRAPHY	13,015	651	0		0	
17.00		DRENAL DIALYSIS	3, 661	183	0	0	0	17.00
18.00	90.00		189, 943	9, 497		0	0	18.00
19.00		IBMT JOINT VENTURE	113, 681	5, 684	0	0	0	19.00
20.00		5 CV DIAGNOSTIC SERVICES	0	0	0	0	0	20.00
21.00	91.00	DEMERGENCY	29, 793	1,490		0	0	
200.00	Wkst. A Line :	Cost Center/Physician	1, 731, 422 Provi der	86,572 Adjusted RCE	RCE	Adjustment	0	200.00
		I denti fi er	Component	Limit	Di sal I owance	naj as tiliont		
			Share of col.					
			14					
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00		3 OTHER ADMIN & GENERAL	0	6, 711	3, 189			1.00
2.00 3.00		DPHARMACY DI&R SERVICES-OTHER PRGM	0	14, 337 1, 255, 273	6,813			2.00
3.00	22.00	COSTS APPRV		1,200,273	852, 603	852, 603		3.00
4.00	23. 0	2 EMERGENCY MEDICAL SERVICES	0	26, 946	0	0		4.00
5.00		ADULTS & PEDIATRICS	0	11, 795		11, 968		5.00
6.00		NEONATAL INTENSIVE CARE UNIT	0	0	0	299, 215		6.00
7.00		SUBPROVIDER - IRF	0	0	0	48, 050		7.00
8.00		OPERATING ROOM	0	11, 765		2, 855, 687		8.00
9.00		DRADI OLOGY-DI AGNOSTI C	0	0	0	814, 339		9.00
10. 00 11. 00		DCARDIAC CATHETERIZATION DLABORATORY	0	0 42, 707	17, 743	151, 200 120, 069		10.00 11.00
12.00		DINTRAVENOUS THERAPY		42, 707 A	17,743	-4, 936		12.00
13.00		DRESPIRATORY THERAPY	0	11, 795	5, 605			12.00
14.00		DPHYSI CAL THERAPY	0	0	0	-24, 733		14.00
15.00	69.00	ELECTROCARDI OLOGY	0	0	0	151, 200		15.00
16.00	70.00	DELECTROENCEPHALOGRAPHY	0	13, 015	11, 210	15, 990		16.00

Heal th Financial	Systems	
DDOVIDED BASED D		AD ILISTMENT

## ST. FRANCIS HOSPITAL & HEALTH CENTER In Lieu of Form CMS-2552-10

Wkst. A Line #     Cost Center/Physician     Provider     Adjusted RCE     RCE     Adjustment       Limit     Disal I owance     14	
Wkst. A Line #       Cost Center/Physician       Provider       Adjusted RCE       RCE       Adjustment         Identifier       Component       Limit       Disallowance       Disallowance	alli
I dentifier Component Limit Disallowance Share of col.	
14	
14	
<u>1.00</u> <u>2.00</u> <u>15.00</u> <u>16.00</u> <u>17.00</u> <u>18.00</u>	
17. 00 74. 00 RENAL DI ALYSI S 0 3, 661 1, 764 3, 752	7.00
18.00 90.00 CLINIC 0 189,943 0 804,865	8.00
19.00 90.01 BMT JOI NT VENTURE 0 113,681 0 0	9.00
20. 00 90. 05 CV DI AGNOSTI C SERVI CES 0 0 0 861, 086	20.00
21.00 91.00 EMERGENCY 0 29,793 6,207 36,129	21.00
200.00 0 1, 731, 422 914, 016 7, 141, 524 2	0.00

 ST.
 FRANCIS HOSPITAL & HEALTH CENTER
 In Lieu of Form CMS-2552-10

 Provider CCN: 15-0162
 Period: From 01/01/2018
 Worksheet B

Cost Center Description         Net Expenses for Cost Al location (from Wsst A col. 7)         CAPITAL RELATED COSTS         EMPLOYEE BENEFITS DEPARTMENT         ADMITTING           1.00         00100 [CAP REL COSTS-BLDG & FIXT 00         0         1.00         2.00         4.00         5.01           2.00         00200 [CAP REL COSTS-BLDG & FIXT 00         35,231,498 14,531,444         35,231,498 14,531,444         14,531,444 0         14,531,444 14,531,444         14,531,444 0         14,531,444 0         14,531,444 0         14,531,444 0         14,531,444 0         14,531,444 0         14,531,444 0         135,73           5.01         00570 ADMITTING 5.02         00580 [CASHI ERI NG/ACCOUNTS RECEI VABLE 0         1,050         95,387         39,343 0         0         135,73           5.02         00580 [CASHI ERI NG/ACCOUNTS RECEI VABLE 0         0         136,280         56,209 0         0         136,352           8.00         00590 [OTHER ADMIN & GENERAL 122,484,882         122,484,882         50,614         20,876         507,999           9.00         00700 [OPERATION OF PLANT         18,718,213         3,685,517         1,50,114         1,365,352           8.00         00800 LAUNDRY & LINEN SERVICE         1,663,757         331,272,730         112,489         1,31,384           10.00         01000 [D ETARY	1.00           2.00           4.00           30           5.01           0           5.02           0           0           0           0           0           0           0           0           0           0           0           0           0           11.00           0           11.00           0           11.00           0           11.00           0           11.00           0           11.00           0           12.00           0           14.00           0           22.00           0           23.01           0           23.02           0           23.03
General Service COST CENTERS         General Service COST CENTERS         Benefits Department           1.00         00100 CAP REL COSTS - BLDG & FIXT         35, 231, 498         35, 231, 498         14, 531, 444         14, 531, 444           2.00         00200 CAP REL COSTS - BLDG & FIXT         35, 231, 498         35, 231, 498         14, 531, 444         14, 531, 444           4.00         00400 EMPLOYEE BENEFITS DEPARTMENT         58, 414, 649         0         0         58, 414, 649           5.01         00570 ADMI TTI NG         1, 050         95, 387         39, 343         0         135, 75           5.02         00570 ADMI TTI NG         122, 484, 882         50, 614         20, 876         507, 999           7.00         00700 OPERATI ON OF PLANT         18, 718, 213         3, 685, 517         1, 365, 352           8.00         00800 LAUNDRY & LINEN SERVICE         1, 663, 757         371, 912         153, 397         76, 135           9.00         00900 HOUSEKEEPI NG         5, 357, 333         272, 730         112, 489         1, 341, 384           10.00         01300 NURSI NG ADMI NI STRATI ON         7, 614, 056         59, 100         24, 376         1, 553, 866           11.00         01300 QURSI NG ADMI NI STRATI ON         7, 614, 056         59, 100         24	$\begin{array}{c} 2.00\\ 4.00\\ 5.01\\ 0\\ 5.02\\ 0\\ 5.03\\ 0\\ 0\\ 5.03\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 10.00\\ 0\\ 11.00\\ 0\\ 11.00\\ 0\\ 11.00\\ 0\\ 11.00\\ 0\\ 11.00\\ 0\\ 11.00\\ 0\\ 11.00\\ 0\\ 11.00\\ 0\\ 11.00\\ 0\\ 12.00\\ 0\\ 21.00\\ 0\\ 22.00\\ 0\\ 23.01\\ 0\\ 23.01\\ 0\\ 23.02\\ 0 \end{array}$
O         1.00         2.00         4.00         5.01           GENERAL SERVICE COST CENTERS           1.00         00100         CAP REL COSTS-BLDG & FIXT         35, 231, 498         35, 231, 498         14, 531, 444         14, 531, 444         14, 531, 444         14, 531, 444         14, 531, 444         14, 531, 444         14, 531, 444         14, 531, 444         14, 531, 444         14, 531, 444         14, 531, 444         14, 531, 444         14, 531, 444         15, 75         50         00500         CAP REL COSTS-MUBLE EQUIP         14, 531, 444         14, 531, 444         14, 531, 444         14, 531, 444         15, 75         50         00500         CASHI ERI NG/ACCOUNTS RECEI VABLE         0         136, 280         56, 209         0         5.03         00590         OTHER ADMIN N & GENERAL         122, 484, 882         50, 614         20, 876         507, 999         7         76, 135         5         5         5         5         5         5         7         7         6, 135         5	$\begin{array}{c} 2.00\\ 4.00\\ 5.01\\ 0\\ 5.02\\ 0\\ 5.03\\ 0\\ 0\\ 5.03\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 10.00\\ 0\\ 11.00\\ 0\\ 11.00\\ 0\\ 11.00\\ 0\\ 11.00\\ 0\\ 11.00\\ 0\\ 11.00\\ 0\\ 11.00\\ 0\\ 11.00\\ 0\\ 11.00\\ 0\\ 12.00\\ 0\\ 21.00\\ 0\\ 22.00\\ 0\\ 23.01\\ 0\\ 23.01\\ 0\\ 23.02\\ 0 \end{array}$
1.00       00100       CAP       REL       COSTS-BLDG & FIXT       35, 231, 498       35, 231, 498         2.00       00200       CAP       REL       COSTS-MVBLE       EQUIP       14, 531, 444       14, 531, 444         4.00       00400       EMPLOYEE       BENEFITS       DEPARTMENT       58, 414, 649       0       0       58, 414, 649         5.01       00570       ADMITTING       1, 050       95, 387       39, 343       0       135, 75         5.02       00580       CASHI ERING/ACCOUNTS       RECEIVABLE       0       136, 280       56, 209       0         5.03       00590       OTHER ADMIN & GENERAL       122, 484, 882       50, 614       20, 876       507, 999         7.00       00700       OPERATION OF PLANT       18, 718, 213       3, 685, 517       1, 520, 114       1, 365, 352         8.00       00800       LAUNDRY & LINEN SERVICE       1, 663, 757       371, 912       153, 397       76, 135         9.00       00900       HOUSEKEEPING       5, 357, 333       272, 730       112, 489       1, 341, 384         10.00       01000       DETARY       204, 066       365, 814       150, 882       262, 285         11.00       01000 <td< th=""><th><math display="block">\begin{array}{c} 2.00\\ 4.00\\ 5.01\\ 0\\ 5.02\\ 0\\ 5.03\\ 0\\ 0\\ 5.03\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 10.00\\ 0\\ 11.00\\ 0\\ 11.00\\ 0\\ 11.00\\ 0\\ 11.00\\ 0\\ 11.00\\ 0\\ 11.00\\ 0\\ 11.00\\ 0\\ 11.00\\ 0\\ 11.00\\ 0\\ 12.00\\ 0\\ 21.00\\ 0\\ 22.00\\ 0\\ 23.01\\ 0\\ 23.01\\ 0\\ 23.02\\ 0 \end{array}</math></th></td<>	$\begin{array}{c} 2.00\\ 4.00\\ 5.01\\ 0\\ 5.02\\ 0\\ 5.03\\ 0\\ 0\\ 5.03\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 10.00\\ 0\\ 11.00\\ 0\\ 11.00\\ 0\\ 11.00\\ 0\\ 11.00\\ 0\\ 11.00\\ 0\\ 11.00\\ 0\\ 11.00\\ 0\\ 11.00\\ 0\\ 11.00\\ 0\\ 12.00\\ 0\\ 21.00\\ 0\\ 22.00\\ 0\\ 23.01\\ 0\\ 23.01\\ 0\\ 23.02\\ 0 \end{array}$
2.00       00200       CAP_REL_COSTS-MVBLE_EQUIP       14, 531, 444       14, 531, 444         4.00       00400       EMPLOYEE_BENEFITS_DEPARTMENT       58, 414, 649       0       0       58, 414, 649         5.01       00570       ADMITTING       1,050       95,387       39,343       0       135,72         5.02       00580       CASHI ERI NG/ACCOUNTS RECEI VABLE       0       136,280       56,209       0         5.03       00590       OTHER ADMIN & GENERAL       122,484,882       50,614       20,876       507,999         7.00       00700       OPERATI ON OF_PLANT       18,718,213       3,685,517       1,520,114       1,365,352         8.00       00800       LAUNDRY & LI NEN SERVICE       1,663,757       371,912       153,397       76,135         9.00       00900       HOUSEKEEPING       5,357,333       272,730       112,489       1,341,384         10.00       01000       DI ETARY       204,066       365,814       150,882       262,285         11.00       01100       CAFEREI A       2,218,326       555,181       228,988       762,959         13.00       01300       NURSI NG ADMINI STRATI ON       7,614,056       59,100       24,376       1,553,866	$\begin{array}{c} 2.00\\ 4.00\\ 5.01\\ 0\\ 5.02\\ 0\\ 5.03\\ 0\\ 0\\ 5.03\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 10.00\\ 0\\ 11.00\\ 0\\ 11.00\\ 0\\ 11.00\\ 0\\ 11.00\\ 0\\ 11.00\\ 0\\ 11.00\\ 0\\ 11.00\\ 0\\ 11.00\\ 0\\ 11.00\\ 0\\ 12.00\\ 0\\ 21.00\\ 0\\ 22.00\\ 0\\ 23.01\\ 0\\ 23.01\\ 0\\ 23.02\\ 0 \end{array}$
5. 03       00590       OTHER ADMI N & GENERAL       122, 484, 882       50, 614       20, 876       507, 999         7. 00       00700       OPERATI ON OF PLANT       18, 718, 213       3, 685, 517       1, 520, 114       1, 365, 352         8. 00       00800       LAUNDRY & LI NEN SERVI CE       1, 663, 757       371, 912       153, 397       76, 135         9. 00       00900       HOUSEKEEPI NG       5, 357, 333       272, 730       112, 489       1, 341, 384         10. 00       01000       DI ETARY       204, 066       365, 814       150, 882       262, 285         11. 00       01100       CAFETERI A       2, 218, 326       555, 181       228, 988       762, 959         13. 00       01300       NURSI NG ADMI NI STRATI ON       7, 614, 056       59, 100       24, 376       1, 553, 866         14. 00       01400       CENTRAL SERVI CES & SUPPLY       1, 432, 424       1, 589, 260       655, 500       268, 462         15. 00       01500       PHARMACY       6, 935, 430       401, 035       165, 409       2, 122, 708         16. 00       01600       MEDI CAL RECORDS & LI BRARY       270, 126       0       0       0         21. 00       02100       I & SERVI CES-SALARY & FRI NGE	$\begin{array}{cccc} 0 & 5.03 \\ 0 & 7.00 \\ 0 & 8.00 \\ 0 & 9.00 \\ 0 & 10.00 \\ 0 & 11.00 \\ 0 & 13.00 \\ 0 & 14.00 \\ 0 & 15.00 \\ 0 & 16.00 \\ 0 & 21.00 \\ 0 & 23.00 \\ 0 & 23.01 \\ 0 & 23.02 \end{array}$
9.00         00900         HOUSEKEEPING         5, 357, 333         272, 730         112, 489         1, 341, 384           10.00         01000         DI ETARY         204, 066         365, 814         150, 882         262, 285           11.00         01100         CAFETERIA         2, 218, 326         555, 181         228, 988         762, 959           13.00         01300         NURSI NG ADMINI STRATI ON         7, 614, 056         59, 100         24, 376         1, 553, 866           14.00         01400         CENTRAL SERVICES & SUPPLY         1, 432, 424         1, 589, 260         655, 500         268, 462           15.00         01500         PHARMACY         6, 935, 430         401, 035         165, 409         2, 122, 708           16.00         01600         MEDI CAL RECORDS & LI BRARY         270, 126         0         0         0         0           21.00         02100         I & R SERVICES-SALARY & FRINGES APPRV         1, 748, 155         72, 361         29, 846         671, 650	$\begin{array}{cccc} 0 & 9,00\\ 0 & 10,00\\ 0 & 11,00\\ 0 & 13,00\\ 0 & 14,00\\ 0 & 15,00\\ 0 & 16,00\\ 0 & 21,00\\ 0 & 22,00\\ 0 & 23,00\\ 0 & 23,01\\ 0 & 23,02 \end{array}$
13. 0001300NURSI NG ADMI NI STRATI ON7, 614, 05659, 10024, 3761, 553, 86614. 0001400CENTRAL SERVI CES & SUPPLY1, 432, 4241, 589, 260655, 500268, 46215. 0001500PHARMACY6, 935, 430401, 035165, 4092, 122, 70816. 0001600MEDI CAL RECORDS & LI BRARY270, 12600021. 0002100I & R SERVI CES-SALARY & FRI NGES APPRV1, 748, 15572, 36129, 846671, 650	$\begin{array}{cccc} 0 & 13.\ 00 \\ 0 & 14.\ 00 \\ 0 & 15.\ 00 \\ 0 & 16.\ 00 \\ 0 & 21.\ 00 \\ 0 & 22.\ 00 \\ 0 & 23.\ 01 \\ 0 & 23.\ 02 \\ \end{array}$
16. 00         01600         MEDI CAL         RECORDS         & LI BRARY         270, 126         0         0         0           21. 00         02100         I & R         SERVI CES-SALARY         & FRI NGES         APPRV         1, 748, 155         72, 361         29, 846         671, 650	0 16.00 0 21.00 0 22.00 0 23.00 0 23.01 0 23.02
22. 00 02200 1 &R SERVICES-OTHER PRGM COSTS APPRV 1, 297, 477 0 0 623, 359	0 23.00 0 23.01 0 23.02
23. 00         02300         MEDI CAL         LABORATORY         SCI ENTI ST         PRGM         191, 670         0         0         74, 329           23. 01         02302         PHARMACY         PRGM         505, 268         0         0         171, 089           23. 02         02301         EMERGENCY         MEDI CAL         SERVICES         22, 886         0         0         91, 761	
23. 03 02303 PARAMEDI C PRGM 35, 547 0 0 247, 651	20.00
INPATI ENT ROUTI NE SERVI CE COST CENTERS           30. 00         03000         ADULTS & PEDI ATRI CS         28, 554, 373         6, 258, 794         2, 581, 480         9, 633, 605         14, 7'           31. 00         03100         INTENSI VE CARE UNI T         6, 905, 704         766, 253         316, 045         2, 297, 747         3, 1'	
31. 01         02060         NEONATAL         INTENSI VE         CARE         UNI T         3, 801, 931         544, 351         224, 521         1, 067, 393         2, 55           32. 00         03200         CORONARY         CARE         UNI T         8, 552, 431         1, 780, 460         734, 362         2, 940, 762         3, 00           34. 00         03400         SURGI CAL         INTENSI VE         CARE         UNI T         4, 673, 768         906, 839         374, 031         1, 567, 740         2, 56	05 32.00
41. 00       04100       SUBPROVI DER - I RF       2, 855, 226       601, 148       247, 947       970, 661       1, 33         43. 00       04300       NURSERY       617, 616       136, 109       56, 139       201, 082       661         ANCI LLARY SERVICE COST CENTERS       617, 616       136, 109       56, 139       201, 082       661	84 41.00 63 43.00
50. 00         05000         OPERATI NG ROOM         12, 073, 320         3, 664, 069         1, 511, 267         4, 207, 133         12, 07           52. 00         05200         DELI VERY ROOM & LABOR ROOM         2, 652, 917         901, 040         371, 639         914, 909         3, 5	
54. 00         05400         RADI OLOGY-DI AGNOSTI C         12, 237, 593         2, 850, 485         1, 175, 700         2, 885, 506         9, 55	59 54.00
	93 55.00 97 56.00
59. 00 05900 CARDI AC CATHETERI ZATI ON 1, 913, 313 924, 620 381, 365 798, 598 4, 6	35 59.00
60. 00         06000         LABORATORY         20, 648, 771         1, 509, 223         622, 488         280, 434         12, 33	
64. 00         06400         I NTRAVENOUS         THERAPY         2, 609, 617         392, 166         161, 751         900, 821         24           65. 00         06500         RESPI RATORY         THERAPY         7, 643, 125         210, 901         86, 987         2, 596, 308         6, 22	62 64.00 34 65.00
	14 66.00
67. 00         06700         0CCUPATI ONAL THERAPY         1, 780, 723         0         0         593, 480         1, 29	
	77 68.00
69. 00         06900         ELECTROCARDI OLOGY         1, 389, 840         500, 772         206, 546         476, 980         2, 2'           70. 00         07000         ELECTROENCEPHALOGRAPHY         1, 999, 367         0         0         501, 000         3'	76 69.00 65 70.00
	01 71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 27, 956, 914 0 0 10, 0	
73. 00         07300         DRUGS         CHARGED         TO         PATI ENTS         54, 641, 959         0         0         18, 7           74. 00         07400         RENAL         DI ALYSI S         606, 826         162, 930         67, 201         207, 507         8/	15 73.00 64 74.00
76. 97 07697 CARDI AC REHABI LI TATI ON 515, 363 0 0 162, 677	0 76.97
OUTPATIENT SERVICE COST CENTERS	
	55 90.00 28 90.01
	48 90.01
91. 00 09100 EMERGENCY 7, 801, 075 1, 876, 572 774, 004 2, 521, 994 7, 1	77 91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART OTHER REI MBURSABLE COST CENTERS	92.00
101.00         10100         HOME         HEALTH         AGENCY         0	0 101.00
	113.00 0 116.00 30 118.00
NONREI MBURSABLE         COST         CENTERS           190. 00         I 9000         GI FT,         FLOWER,         COFFEE         SHOP         & CANTEEN         523, 265         228, 213         94, 128         86, 008	0 190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFICES 8, 487, 560 211, 455 87, 216 2, 063, 899	0 192.00
194. 00 07955         MARKETING & COMMUNITY RELATIONS         102, 241         0         0         22, 711           194. 01 07952         WOMEN'S CENTER         314, 282         97, 732         40, 310         39, 120	0 194.00
194. 01/07952 WOMEN S CENTER 314, 282 97, 732 40, 310 39, 120 194. 04/07954 OTHER NRCC 76, 426, 955 1, 454, 473 599, 906 1, 161, 315	0 194.01
194. 05 07956 FOUNDATI ON 64, 256 0 0 0	0 194.05

<u>Health Fina</u>	ncial Systems	ST. F	RANCIS HOSPITA	L & HEALTH CEN	TER	In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS				Provider CCN: 15-0162		Period: From 01/01/2018 To 12/31/2018		
				CAPI TAL REL	LATED COSTS			
	Cost Center Description		Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFI TS DEPARTMENT	ADMI TTI NG	
			0	1.00	2.00	4.00	5. 01	
200.00 201.00 202.00	Cross Foot Adjustments Negative Cost Centers TOTAL (sum lines 118 through 201)		654, 961, 837	0 35, 231, 498	14, 531, 44	0 0 14 58, 414, 649	-	200. 00 201. 00 202. 00

Heal th	Fi nanci al	Systems	
OOCT A			CEE

#### ST. FRANCIS HOSPITAL & HEALTH CENTER

JST A	LLOCATION - GENERAL SERVICE COSTS		Provi der CC	F	veriod: rom 01/01/2018 o 12/31/2018	Worksheet B Part I Date/Time Pre 5/31/2019 7:4	epare 17 an
	Cost Center Description	Subtotal	CASHI ERI NG/AC COUNTS RECEI VABLE	Subtotal	OTHER ADMIN & GENERAL	OPERATION OF PLANT	
		5A. 01	5. 02	5A. 02	5.03	7.00	
	GENERAL SERVICE COST CENTERS						
00	00100 CAP REL COSTS-BLDG & FIXT						1.
00	00200 CAP REL COSTS-MVBLE EQUIP						2.
00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.
01	00570 ADMI TTI NG						5.
02	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	192, 489	192, 489				5.
03	00590 OTHER ADMIN & GENERAL	123, 064, 371	36, 170	123, 100, 541	123, 100, 541		5
00	00700 OPERATION OF PLANT	25, 289, 196	7, 435	25, 296, 631	5, 854, 956	31, 151, 587	7
00	00800 LAUNDRY & LINEN SERVICE	2, 265, 201	666	2, 265, 867	524, 439	370, 578	8
00	00900 HOUSEKEEPI NG	7, 083, 936	2, 083	7, 086, 019	1, 640, 073	271, 752	9
. 00	01000 DI ETARY	983, 047	289	983, 336	227, 595	364, 502	10
. 00	01100 CAFETERI A	3, 765, 454	1, 107	3, 766, 561	871, 778	553, 190	11
. 00	01300 NURSING ADMINISTRATION	9, 251, 398	2, 720	9, 254, 118	2, 141, 884	58, 888	13
. 00	01400 CENTRAL SERVICES & SUPPLY	3, 945, 646	1, 160	3, 946, 806	913, 496	1, 583, 561	14
. 00	01500 PHARMACY	9,624,582		9, 627, 412			
. 00	01600 MEDI CAL RECORDS & LI BRARY	270, 126		270, 205		0	
. 00	02100 I &R SERVICES-SALARY & FRINGES APPRV	2, 522, 012		2, 522, 753			
. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	1, 920, 836	565	1, 921, 401		0	
. 00	02300 MEDICAL LABORATORY SCIENTIST PRGM	265, 999		266, 077		0	
. 00	02302 PHARMACY PRGM	676, 357	199	676, 556		0	
	02302 PHARMACT PROM 02301 EMERGENCY MEDICAL SERVICES					0	
. 02	02303 PARAMEDIC PRGM	114,647	34	114, 681		0	
. 03		283, 198	83	283, 281	00, 000	0	23
~~	INPATIENT ROUTINE SERVICE COST CENTERS	47 042 020	10.001	47.054.040	10 001 404	( 22( 250	1
. 00	03000 ADULTS & PEDIATRICS	47,043,029		47,056,860			
. 00	03100 I NTENSI VE CARE UNI T	10, 288, 924		10, 291, 949		763, 505	
. 01	02060 NEONATAL INTENSIVE CARE UNIT	5, 640, 726		5, 642, 384		542, 399	
. 00	03200 CORONARY CARE UNI T	14, 011, 020		14, 015, 139		1, 774, 076	
. 00	03400 SURGI CAL I NTENSI VE CARE UNI T	7, 524, 939		7, 527, 151		903, 587	
00	04100 SUBPROVI DER – I RF	4, 676, 366		4, 677, 741			
. 00	04300 NURSERY	1, 011, 609	297	1, 011, 906	234, 208	135, 621	43
	ANCILLARY SERVICE COST CENTERS						
. 00	05000 OPERATING ROOM	21, 467, 866	6, 312	21, 474, 178	4, 970, 241	3, 650, 929	50
. 00	05200 DELIVERY ROOM & LABOR ROOM	4, 844, 016	1, 424	4,845,440	1, 121, 487	897, 808	52
. 00	05400 RADI OLOGY-DI AGNOSTI C	19, 158, 843	5, 633	19, 164, 476	4, 435, 656	2, 840, 263	54
. 00	05500 RADI OLOGY-THERAPEUTI C	9, 178, 055	2, 698	9, 180, 753	2, 124, 904	5, 268	55
. 00	05600 RADI OI SOTOPE	1, 218, 981	358	1, 219, 339		36, 030	56
. 00	05900 CARDI AC CATHETERI ZATI ON	4, 022, 581	1, 183	4, 023, 764		921, 304	
00	06000 LABORATORY	23, 073, 249		23, 080, 033		1, 503, 811	
00	06400 INTRAVENOUS THERAPY	4,064,617	1, 195	4, 065, 812		390, 760	
. 00	06500 RESPI RATORY THERAPY	10, 543, 555		10, 546, 655			
. 00	06600 PHYSI CAL THERAPY	7, 673, 009		7, 675, 265			
00	06700 OCCUPATI ONAL THERAPY	2, 375, 487	698	2, 376, 185		0	
00	06800 SPEECH PATHOLOGY			1, 381, 114		41, 638	
		1, 380, 708					
		2, 576, 414		2, 577, 171		498, 976	
	07000 ELECTROENCEPHALOGRAPHY	2, 500, 732	735	2, 501, 467		0	
00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	35, 236, 886	10, 360	35, 247, 246		0	
00	07200 I MPL. DEV. CHARGED TO PATIENTS	27, 966, 944	8, 222	27, 975, 166		0	
00	07300 DRUGS CHARGED TO PATIENTS	54, 660, 674	16, 070	54, 676, 744		0	
00	07400 RENAL DI ALYSI S	1,045,328		1,045,635			
97	07697 CARDI AC REHABI LI TATI ON	678, 040	199	678, 239	156, 980	0	76
<i></i>	OUTPATIENT SERVICE COST CENTERS						
00	09000 CLINIC	9, 561, 747	2, 811	9, 564, 558		1, 045, 878	
01	09001 I BMT JOI NT VENTURE	5, 303, 810	1, 559	5, 305, 369		106, 219	
05	09005 CV DIAGNOSTIC SERVICES	10, 821, 560	3, 182	10, 824, 742		0	
. 00	09100 EMERGENCY	12, 980, 822	3, 816	12, 984, 638	3, 005, 320	1, 869, 843	
00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0		0			92
	OTHER REIMBURSABLE COST CENTERS						
1.00	10100 HOME HEALTH AGENCY	0	0	C	0	0	101
	SPECIAL PURPOSE COST CENTERS						
3.00	11300 INTEREST EXPENSE						113
5.00	11600 HOSPI CE	8, 807, 760	2, 589	8, 810, 349	2, 039, 173		116
3. 00		562, 856, 792	165, 410	562, 829, 713		29, 166, 857	
	NONREI MBURSABLE COST CENTERS	, ,		, ,		,,,	1
), nr	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	931, 614	274	931, 888	215, 687	227, 394	1190
	19200 PHYSI CLANS' PRI VATE OFFICES	10, 850, 130		10, 853, 320		210, 697	
	07955 MARKETING & COMMUNITY RELATIONS						
		124, 952	37	124, 989			194
	07952 WOMEN' S CENTER	491, 444	144	491, 588		97, 382	
	07954 OTHER NRCC	79, 642, 649	23, 415	79, 666, 064		1, 449, 257	
	07956 FOUNDATI ON	64, 256	19	64, 275	14, 877	0	194
0. 00		0		C			200
1.00		0	0	C	0		201
2.00	TOTAL (sum lines 118 through 201)	654, 961, 837	192, 489	654, 961, 837	123, 100, 541	31, 151, 587	1

Heal th	Fi nanci al	Systems	
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	inancial Systems ST. F LOCATION - GENERAL SERVICE COSTS	RANCIS HOSPITAL	Provider CC		in Lie eriod:	u of Form CMS-2 Worksheet B	2552-10
CUST ALL	LUCATION - GENERAL SERVICE COSTS			Fr Tc	om 01/01/2018	Part I	pared: 7 am
	Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI O N	
		8.00	9.00	10.00	11.00	13.00	
	ENERAL SERVICE COST CENTERS	1 1	T	Ι			
	0100 CAP REL COSTS-BLDG & FIXT						1.00
	0200 CAP REL COSTS-MVBLE EQUIP 0400 EMPLOYEE BENEFITS DEPARTMENT						4.00
	10400 EMPLOTEE BENEFITS BEPARTMENT						5.01
	0580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5.02
	0590 OTHER ADMIN & GENERAL						5.03
7.00 0	0700 OPERATION OF PLANT						7.00
	10800 LAUNDRY & LINEN SERVICE	3, 160, 884					8.00
	0900 HOUSEKEEPI NG	0	8, 997, 844	4 (00 000			9.00
	1000 DI ETARY	0	107, 500	1, 682, 933	E 2E4 477		10.00
	1100 CAFETERI A 1300 NURSI NG ADMI NI STRATI ON	0	163, 148 17, 367	0 0	5, 354, 677 122, 984		11.00 13.00
	1400 CENTRAL SERVICES & SUPPLY	13, 847	467, 027	0	49, 565		14.00
	1500 PHARMACY	0	117, 850	0	177, 171	0	15.00
16.00 0	1600 MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
21.00 0	2100 I&R SERVICES-SALARY & FRINGES APPRV	0	21, 264	0	60, 298	0	21.00
	2200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	17, 066		22.00
	2300 MEDICAL LABORATORY SCIENTIST PRGM	0	0	0	7, 316	0	23.00
	2302 PHARMACY PRGM	0	0	0	10, 282		23.01
	2301 EMERGENCY MEDICAL SERVICES 2303 PARAMEDIC PRGM	0	0	0	13, 573 35, 316		23.02 23.03
	NPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>	U	0	30, 310	0	23.03
	3000 ADULTS & PEDIATRICS	1, 243, 708	1, 839, 236	845, 166	1,034,795	5, 823, 106	30.00
	3100 INTENSIVE CARE UNIT	205, 277	225, 174	285, 480	232, 420		
31.01 0	2060 NEONATAL INTENSIVE CARE UNIT	20, 534	159, 965	87, 196	96, 228	600, 770	31.01
	3200 CORONARY CARE UNI T	232, 134	523, 214	187, 923	303, 240		
	3400 SURGI CAL I NTENSI VE CARE UNI T	154, 212	266, 487	135, 061	170, 546		34.00
	4100 SUBPROVIDER - IRF	63, 888	176, 656	81, 206	97, 422		41.00
	14300 NURSERY NCI LLARY SERVI CE COST CENTERS	8, 695	39, 998	60, 901	18, 768	419, 601	43.00
	15000 OPERATI NG ROOM	283, 497	1, 076, 738	0	398, 955	0	50.00
	5200 DELIVERY ROOM & LABOR ROOM	145, 928	264, 783	0	86, 475		52.00
	5400 RADI OLOGY-DI AGNOSTI C	178, 181	837, 655	0	278, 183		54.00
	5500 RADI OLOGY-THERAPEUTI C	0	1, 554	0	42, 578	0	55.00
	5600 RADI OI SOTOPE	7,609	10, 626	0	6, 407	0	56.00
	5900 CARDI AC CATHETERI ZATI ON	79, 387	271, 713	0	65, 413		59.00
		358	443, 507	0 0	22,878		60.00 64.00
	6400 I NTRAVENOUS THERAPY 6500 RESPI RATORY THERAPY	0	115, 244 61, 976	0	90, 580 263, 003		65.00
	6600 PHYSI CAL THERAPY	48, 176	105, 269	0	147, 013		66.00
	6700 OCCUPATI ONAL THERAPY	0	0	0	57, 976		67.00
68.00 0	6800 SPEECH PATHOLOGY	0	12, 280	0	29, 427		68.00
	6900 ELECTROCARDI OLOGY	8, 723	147, 159	0	49, 527	0	69.00
	7000 ELECTROENCEPHALOGRAPHY	7, 200	0	0	48, 952	0	70.00
	7100 MEDI CAL SUPPLIES CHARGED TO PATI ENT	0	0	0	0	0	71.00
	7200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 0 74.00 0	17300 DRUGS CHARGED TO PATIENTS 17400 RENAL DIALYSIS	10, 174	47, 879	0	0 16, 160	0	73.00
	7697 CARDI AC REHABILI TATI ON	0	47,079	0	18, 707	0	76.97
	UTPATIENT SERVICE COST CENTERS				10,101		/0///
	9000 CLI NI C	14, 091	308, 452	0	220, 333	0	90.00
	9001 I BMT JOI NT VENTURE	5, 339	31, 326	0	38, 674	0	90.01
	9005 CV DI AGNOSTI C SERVI CES	0	0	0	303, 020		90.05
	9100 EMERGENCY	386, 377	551, 457	0	265, 236	0	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
	THER REIMBURSABLE COST CENTERS 0100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
	PECIAL PURPOSE COST CENTERS	<u> </u>	U	0	0	0	101.00
	1300 I NTEREST EXPENSE						113.00
116.001	1600 HOSPI CE	0	0	0	170, 671	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	3, 117, 335	8, 412, 504	1, 682, 933	5, 067, 158	11, 595, 241	118.00
	ONREI MBURSABLE COST CENTERS						
	9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	12,005	67,064	0	17,620		190.00
	9200 PHYSI CLANS' PRI VATE OFFI CES	13, 085	62, 139	0	136, 688		192.00
	7955 MARKETING & COMMUNITY RELATIONS 7952 WOMEN'S CENTER	0 30, 464	0 28, 720	0	2, 724 5, 310		194.00 194.01
	17952 WOMEN S CENTER 17954 OTHER NRCC	30, 464	28, 720 427, 417	0	5, 310 125, 177		194.01
	17954 OTHER NRCC		4∠7,417 ∩	0	120, 177 N		194.04
200.00	Cross Foot Adjustments		0	0	0		200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	3, 160, 884	8, 997, 844	1, 682, 933	5, 354, 677	11, 595, 241	202.00

IST ALLOCATION - GENERAL SERVICE COSTS		Provider CC			Date/Time Pre 5/31/2019 7:4	epare 17 am
Cost Center Description	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	SERVI CES-SALA RY & FRI NGES APPRV	RESI DENTS SERVI CES-OTHE R PRGM COSTS APPRV	
	14.00	15.00	16.00	21.00	22.00	
GENERAL SERVICE COST CENTERS		[]		r	Γ	÷
00         00100         CAP         REL         COSTS-BLDG         & FIXT           00         00200         CAP         REL         COSTS-MVBLE         EQUIP           00         00400         EMPLOYEE         BENEFITS         DEPARTMENT           01         00570         ADMITTING         DEPARTMENT           02         00580         CASHI         ERING/ACCOUNTS         RECEI         VABLE           03         00590         OTHER         ADMIN         & GENERAL         00         000700         OPERATION OF         PLANT         00         00800         LAUNDRY         & LI NEN         SERVICE         00         00900         HOUSEKEEPING         00         00900         HOUSEKEEPING         00         01000         DI ETARY         00         01100         CAFETERIA         8.00         01300         NURSI NG         ADMINISTRATION         00         01400         CENTRAL         SERVICES         SUPPLY         00         01600         MEDICAL         RECORDS         & LI BRARY         00         01400         CENTRAL         SERVICES-SALARY         & FRINGES         APF           0.00         01400         CENTRAL         SERVICES-SALARY         & FRI NGES         APF	PRV 0 1 61 15 1, 194	12, 562, 749 0 0 0 0 0 0 0 0 0 0 0	332, 744 0 0 0 0 0 0 0	3, 261, 385	2, 383, 179	23. 23. 23.
8. 03 02303 PARAMEDIC PRGM	541	0	0			23.
INPATIENT ROUTINE SERVICE COST CENTERS           0.00         03000         ADULTS & PEDIATRICS           .00         03100         INTENSIVE CARE UNIT           .01         02060         NEONATAL INTENSIVE CARE UNIT           .00         03200         CORONARY CARE UNIT           .00         03400         SURGICAL INTENSIVE CARE UNIT           .00         04100         SUBPROVIDER - IRF           .00         04300         NURSERY	15, 317 2, 091 838 3, 670 2, 748 768 281	0 0 0 0 0 0	20, 408 3, 551 2, 829 3, 360 2, 864 1, 547 741	87, 455 30, 945 0 0 0	63, 905 22, 613 0 0 0	31. 31. 32. 34. 41.
ANCI LLARY SERVICE COST CENTERS				T	I I	
0.00         05000         OPERATING         ROOM           2.00         05200         DELIVERY         ROOM & LABOR         ROOM           .00         05400         RADIOLOGY-DIAGNOSTIC	40, 637 1, 205 34, 144 330	0 0 0 0	23, 427 3, 937 38, 081 7, 010	000000000000000000000000000000000000000	0 0 0	52. 54. 55.
.00         05600         RADI OI SOTOPE           .00         05900         CARDI AC         CATHETERI ZATI ON           .00         06000         LABORATORY           .00         06400         I NTRAVENOUS         THERAPY	85, 071 2, 052 1, 323 7, 767	0 0 0	1, 032 14, 142 33, 054 2, 824	0 10, 764	0	59 60
.00         06500         RESPI RATORY         THERAPY           .00         06600         PHYSI CAL         THERAPY           .00         06700         OCCUPATI ONAL         THERAPY	2, 134 1, 946 391	0 0 0	7, 990 4, 748 2, 273	30, 945 269, 091 0	196, 632 0	65 66 67
<ul> <li>00 06800 SPEECH PATHOLOGY</li> <li>00 06900 ELECTROCARDI OLOGY</li> <li>00 07000 ELECTROENCEPHALOGRAPHY</li> <li>00 07100 MEDI CAL SUPPLIES CHARGED TO PATIE</li> </ul>	243 491 845 SNT 3, 678, 554	0 0 0	1, 240 4, 142 2, 327 21, 920	87, 455 0	63, 905 0	69 70
.00 07200 IMPL. DEV. CHARGED TO PATIENTS .00 07300 DRUGS CHARGED TO PATIENTS .00 07400 RENAL DIALYSIS .97 07697 CARDIAC REHABILITATION	2, 919, 848 0 158 637	0 12, 562, 749 0 0	20, 393 62, 953 1, 016 312	0 0 82, 073	0 0 59, 973	72 73 74
OUTPATIENT SERVICE COST CENTERS			512			1 '
00 09000 CLINIC 01 09001 IBMT JOINT VENTURE 05 09005 CV DIAGNOSTIC SERVICES 00 09100 EMERGENCY	2, 925 749 29, 908 5, 743	0 0 0	1, 372 670 7, 899 31, 972	0	0	90 90
00 09200 OBSERVATION BEDS (NON-DISTINCT PA OTHER REIMBURSABLE COST CENTERS		0	51,772	127, 104	74, 363	91
1. 00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	101
3. 00 11300 I NTEREST EXPENSE 6. 00 11600 HOSPI CE 8. 00 SUBTOTALS (SUM OF LINES 1 through NONREI MBURSABLE COST CENTERS	12, 222 117) 6, 870, 354	0 12, 562, 749	2, 710 332, 744		2, 223, 907	113 116 118
0. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTE 2. 00 19200 PHYSICIANS' PRIVATE OFFICES 4. 00 07955 MARKETING & COMMUNITY RELATIONS	EN 25, 430 11, 419 0	0 0 0	0 0 0	-	159, 272	190 192 194
4. 01 07952 WOMEN' S CENTER 4. 04 07954 OTHER NRCC 4. 05 07956 FOUNDATI ON 0 000 Foot Adjustments	652 66, 447 0	0 0 0	0 0 0	0	0	194 194 194
00.00 Cross Foot Adjustments 01.00 Negative Cost Centers	0	О	0	0		200 201

Health Financial Systems	ST. FRANCIS HOSPITA	L & HEALTH CEN	TER	In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC		eriod:	Worksheet B	
				rom 01/01/2018		
				o 12/31/2018	Date/Time Pre	pared:
					5/31/2019 7:4	<u>/ am</u>
				INTERNS &	RESI DENTS	
Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	SERVI CES-SALA	SERVI CES-OTHE	
	SERVICES &		RECORDS &	RY & FRINGES	R PRGM COSTS	
	SUPPLY		LI BRARY	APPRV	APPRV	
	14.00	15.00	16.00	21.00	22.00	
202.00 TOTAL (sum lines 118 through 201)	) 6, 974, 302	12, 562, 749	332, 744	3, 261, 385	2, 383, 179	202.00

	Financial Systems ST. F ALLOCATION - GENERAL SERVICE COSTS	RANCIS HOSPITA	L & HEALTH CEN Provider CO	CN: 15-0162 P	eriod: rom 01/01/2018	u of Form CMS- Worksheet B Part I Date/Time Pre 5/31/2019 7:4	epared:
	Cost Center Description	LABORATORY SCIENTIST PRGM	PHARMACY PRGM	EMERGENCY MEDI CAL SERVI CES	PARAMEDI C PRGM	Subtotal	
	GENERAL SERVICE COST CENTERS	23.00	23.01	23.02	23.03	24.00	
	OO100       CAP       REL       COSTS-BLDG & FIXT         O0200       CAP       REL       COSTS-MVBLE       EQUI P         O0400       EMPLOYEE       BENEFITS       DEPARTMENT         O0570       ADMI TTI NG       OS80       CASHI ERI NG/ACCOUNTS       RECEI VABLE         O0590       OTHER       ADMI N & GENERAL       O0700       OPERATI ON OF PLANT         O0800       LAUNDRY & LI NEN SERVI CE       O0900       HOUSEKEEPI NG         O1000       DI ETARY       O1100       CAFETERI A         O1300       NURSI NG ADMI NI STRATI ON       O1400       CENTRAL       SERVI CES & SUPPLY         O1500       PHARMACY       SERVI CES & SUPPLY       SUPLY       SUPLY						$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 4.\ 00\\ 5.\ 01\\ 5.\ 02\\ 5.\ 03\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00 \end{array}$
16.00 21.00 22.00	01600 MEDI CAL RECORDS & LI BRARY 02100 I &R SERVI CES-SALARY & FRI NGES APPRV 02200 I &R SERVI CES-OTHER PRGM COSTS APPRV 02300 MEDI CAL LABORATORY SCI ENTI ST PRGM 02302 PHARMACY PRGM 02301 EMERGENCY MEDI CAL SERVI CES 02303 PARAMEDI C PRGM I NPATI ENT ROUTI NE SERVI CE COST CENTERS	335, 038	843, 443	155, 991	384, 704		16.00 21.00 22.00 23.00 23.01 23.02 23.03
30.00	03000 ADULTS & PEDIATRICS	0	0	0	0	78, 746, 107	30.00
31.00 31.01 32.00	03100 INTENSIVE CARE UNIT 02060 NEONATAL INTENSIVE CARE UNIT 03200 CORONARY CARE UNIT	0 0 0	0 0 0	0	0 0 0	16, 509, 827 8, 512, 642 21, 581, 360	31.01 32.00
34.00 41.00	03400 SURGI CAL I NTENSI VE CARE UNI T 04100 SUBPROVI DER – I RF	0	0 0	0	0	11, 835, 389 7, 340, 398	
41.00	04300 NURSERY	0	0		0	1, 930, 720	1
	ANCILLARY SERVICE COST CENTERS						
50.00 52.00	05000 OPERATING ROOM	0	0 0		0	32, 186, 392	
52.00 54.00	05200 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC	0	0		0	7, 367, 063 27, 806, 639	1
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	11, 362, 397	
56.00	05600 RADI OI SOTOPE	0	0	0	0	1, 648, 332	
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	6, 309, 083	
60.00 64.00	06000 LABORATORY 06400 I NTRAVENOUS THERAPY	335, 038 0	0	0	0	30, 780, 551 5, 614, 027	
65.00	06500 RESPI RATORY THERAPY	0	0	0	0	13, 586, 504	
66.00	06600 PHYSI CAL THERAPY	0	0	0	0	10, 581, 535	
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0	2, 986, 798	1
	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0	0	0	0	1, 785, 604 4, 034, 040	
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	3, 139, 761	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	47, 105, 766	
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	37, 390, 315	
	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0	843, 443 0		384, 704 0	81, 185, 635 1, 667, 428	
	07697 CARDI AC REHABI LI TATI ON	0	0		0	854, 875	
	OUTPATIENT SERVICE COST CENTERS						
90. 00 90. 01	09000 CLINIC 09001 IBMT JOINT VENTURE	0	0	0	0	13, 371, 345	
90.01 90.05	09005 CV DI AGNOSTI C SERVI CES	0	0	0	0	6, 716, 284 13, 670, 977	1
	09100 EMERGENCY	0	0	155, 991	0	19, 480, 124	1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
101.00	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	101.00
112 00	SPECIAL PURPOSE COST CENTERS						113.00
	11600 HOSPI CE	o	0	0	0	11, 035, 125	
118.00		335, 038	843, 443	155, 991	384, 704	538, 123, 043	
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	-	0	1, 485, 083	
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0	14, 176, 607	
	07955 MARKETING & COMMUNITY RELATIONS 07952 WOMEN'S CENTER	0	0	0	0	156, 642 767, 895	
	07954 OTHER NRCC	0	0	0	0	100, 173, 415	
	07956 FOUNDATI ON	О	0	0	0	79, 152	194.05
200.00		0	0	0	0		200.00
201.00 202.00		0 335, 038	0 843, 443	0 155, 991	0 384, 704	0 654, 961, 837	201.00
		555, 550	515, 115	1	557,704		1-02.00

leal th Financial Systems ST. F COST ALLOCATION - GENERAL SERVICE COSTS	RANCIS HUSPITAL	<u>A HEALTH CENTER</u> Provider CCN: 15-0	In Lieu of Form CMS- D162 Period: Worksheet B	2002-
Soft ALLOCATION SERVICE SERVICE COSTS			From 01/01/2018 Part I To 12/31/2018 Date/Time Pre	
Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments 25.00	Total	5/31/2019 7:4	<u>47 am</u>
GENERAL SERVICE COST CENTERS	23.00	20.00		
1.00       00100       CAP       REL       COSTS-BLDG & FIXT         2.00       00200       CAP       REL       COSTS-MVBLE       EQUIP         4.00       00400       EMPLOYEE       BENEFITS       DEPARTMENT         5.01       00570       ADMITTING         5.02       00580       CASHI ERING/ACCOUNTS       RECEIVABLE         5.03       00590       OTHER       ADMIN       & GENERAL         7.00       00700       OPERATION       OF PLANT         8.00       00800       LAUNDRY       & LINEN       SERVICE         9.00       00900       HOUSEKEEPING         10.00       01000       DI ETARY         11.00       01100       CAFETERIA				1. ( 2. ( 4. ( 5. ( 5. ( 7. ( 8. ( 9. ( 10. ( 11. (
3. 00       01300       NURSI NG       ADMI NI STRATI ON         4. 00       01400       CENTRAL       SERVI CES       & SUPPLY         5. 00       01500       PHARMACY         6. 00       01600       MEDI CAL       RECORDS       & LI BRARY         11. 00       02100       I & R SERVI CES-SALARY       & FRI NGES       APPRV         22. 00       02200       I & R SERVI CES-OTHER       PRGM       COSTS       APPRV         33. 01       02300       MEDI CAL       LABORATORY       SCI ENTI ST       PRGM         33. 01       02302       PHARMACY       PRGM				13. 14. 15. 16. 21. 23. 23. 23. 23. 23.
30. 00 03000 ADULTS & PEDIATRICS	-3, 739, 757	75,006,350		30.0
31.00       03100       INTENSIVE       CARE       UNIT         31.01       02060       NEONATAL       INTENSIVE       CARE       UNIT         32.00       03200       CORONARY       CARE       UNIT         34.00       03400       SURGI CAL       INTENSIVE       CARE       UNIT         34.00       03400       SURGI CAL       INTENSIVE       CARE       UNIT         11.00       04100       SUBPROVI DER       -       IRF         13.00       04300       NURSERY       -       IRF	-151, 360 -53, 558 0 0 0 0	16, 358, 467 8, 459, 084 21, 581, 360 11, 835, 389 7, 340, 398 1, 930, 720		31. 31. 32. 34. 41. 43.
ANCI LLARY SERVI CE COST CENTERS				
0.00 05000 OPERATING ROOM 2.00 05200 DELIVERY ROOM & LABOR ROOM 4.00 05400 RADIOLOGY-DIAGNOSTIC 5.00 05500 RADIOLOGY-THERAPEUTIC 6.00 05600 RADIOLOGY-THERAPEUTIC 6.00 05900 CARDIAC CATHETERIZATION 0.00 06000 LABORATORY 4.00 06400 INTRAVENOUS THERAPY 5.00 06500 RESPIRATORY THERAPY 5.00 06600 PHYSICAL THERAPY 6.00 06600 PHYSICAL THERAPY 7.00 06700 OCUPATIONAL THERAPY 8.00 06800 SPEECH PATHOLOGY 9.00 06900 ELECTROCARDIOLOGY 0.00 07000 ELECTROCARDIOLOGY 0.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 2.00 07300 DRUGS CHARGED TO PATIENTS 3.00 07300 DRUGS CHARGED TO PATIENTS 4.00 07400 RENAL DIALYSIS 6.97 07697 CARDIAC REHABILITATION 0000 OUTPATIENT SERVICE COST CENTERS 0.00 09000 CLINIC	-267, 790 0 0 0 -18, 629 0 -53, 558 -465, 723 0 0 -151, 360 0 0 -151, 360 0 0 0 -142, 046 0	31, 918, 602 7, 367, 063 27, 806, 639 11, 362, 397 1, 648, 332 6, 309, 083 30, 761, 922 5, 614, 027 13, 532, 946 10, 115, 812 2, 986, 798 1, 785, 604 3, 882, 680 3, 139, 761 47, 105, 766 37, 390, 315 81, 185, 635 1, 525, 382 854, 875 13, 371, 345		50. 52. 54. 55. 56. 59. 60. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 76. 90.
0.00 09000 CLINIC 0.01 09001 IBMT JOINT VENTURE	0	13, 371, 345 6, 716, 284		90. 90.
0. 05 09001 IBMT JOINT VENTORE 0. 05 09005 CV DI AGNOSTI C SERVICES 1. 00 09100 EMERGENCY 2. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 07HER REIMBURSABLE COST CENTERS	0 0 -223, 547 0	6, 716, 284 13, 670, 977 19, 256, 577		90. 90. 91. 92.
D1. 00 10100 HOME HEALTH AGENCY	0	0		101.
SPECIAL PURPOSE COST CENTERS	 	· · ·		
3. 00 11300 I NTEREST EXPENSE 6. 00 11600 HOSPI CE 8. 00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	0 -5, 267, 328	11, 035, 125 532, 855, 715		113. 116. 118.
NUMBER         MODERSABLE         COST         CENTERS           20.00         19000         GIFT,         FLOWER,         COFFEE         SHOP & CANTEEN           22.00         19200         PHYSI CLANS'         PRI VATE         OFFICES           44.00         07955         MARKETI NG & COMMUNI TY         RELATIONS           44.01         07952         WOMEN' S         CENTER           44.04         07954         OTHER         NRCC           44.05         07956         FOUNDATION	0 -377, 236 0 0 0 0 0	1, 485, 083 13, 799, 371 156, 642 767, 895 100, 173, 415 79, 152		190. 192. 194. 194. 194. 194.
00.00 Cross Foot Adjustments 01.00 Negative Cost Centers	0 0	0		200. 201.

Health Financial Systems	ST.	ST. FRANCIS HOSPITAL & HEALTH CENTER			In Lieu of Form CMS-2552-10			
COST ALLOCATION - GENERAL SERVICE COSTS			Provider CC	CN: 15-0162	Period: From 01/01/2018 To 12/31/2018	Worksheet B Part I Date/Time Pr 5/31/2019 7:		
Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total					
		25.00	26.00					
202.00 TOTAL (sum lines 118 through 20	)	-5, 644, 564	649, 317, 273				202.00	

LOCA	TION OF CAPITAL RELATED COSTS		Provider CC	Fi	eriod: rom 01/01/2018 p 12/31/2018	Worksheet B Part II Date/Time Pre 5/31/2019 7:4	pared 7 am
	Cost Center Description	Directly Assigned New Capital Related Costs	CAPI TAL REL	ATED COSTS	Subtotal	EMPLOYEE BENEFI TS DEPARTMENT	
		0	1.00	2.00	2A	4.00	
	GENERAL SERVICE COST CENTERS						
00 00 01 02 03 00 00 00 00 00 00 00 00 00 00 00 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00570 ADMITTING 00580 CASHI ERING/ACCOUNTS RECEIVABLE 00590 OTHER ADMIN & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 02100 I & SERVICES-SALARY & FRINGES APPRV 02200 I & SERVICES-OTHER PRGM COSTS APPRV	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 95, 387 136, 280 50, 614 3, 685, 517 371, 912 272, 730 365, 814 555, 181 59, 100 1, 589, 260 401, 035 0 72, 361 0	0 39, 343 56, 209 20, 876 1, 520, 114 153, 397 112, 489 150, 882 228, 988 24, 376 655, 500 165, 409 0 29, 846 0	0 134, 730 192, 489 71, 490 5, 205, 631 525, 309 385, 219 516, 696 784, 169 83, 476 2, 244, 760 566, 444 0 102, 207 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	5.0 5.0 7.0 8.0 9.0 10.0 11.0 13.0 14.0 15.0 16.0 21.0 22.0
	02300 MEDICAL LABORATORY SCIENTIST PRGM	0	0	0	0	0	
	02302 PHARMACY PRGM	0	0	0	0	0	
	02301 EMERGENCY MEDICAL SERVICES 02303 PARAMEDIC PRGM	0	0	0	0	0	
	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>	0	0	V	0	23.0
	03000 ADULTS & PEDI ATRI CS	0	6, 258, 794	2, 581, 480	8, 840, 274	0	30.0
	03100 I NTENSI VE CARE UNI T	0	766, 253	316, 045	1, 082, 298	0	31.0
	02060 NEONATAL INTENSIVE CARE UNIT	0	544, 351	224, 521	768, 872	0	
	03200 CORONARY CARE UNIT	0	1, 780, 460	734, 362	2, 514, 822	0	
	03400 SURGI CAL I NTENSI VE CARE UNI T	0	906, 839	374, 031	1, 280, 870	0	
	04100 SUBPROVI DER – I RF	0	601, 148	247, 947	849, 095	0	
	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	136, 109	56, 139	192, 248	0	43.0
	05000 OPERATI NG ROOM	0	3, 664, 069	1, 511, 267	5, 175, 336	0	50. C
2.00	05200 DELIVERY ROOM & LABOR ROOM	0	901, 040	371, 639	1, 272, 679	0	
	05400 RADI OLOGY-DI AGNOSTI C	0	2, 850, 485	1, 175, 700	4, 026, 185	0	
	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE	0	5, 287	2, 181	7,468	0	
	05900 CARDI AC CATHETERI ZATI ON	0	36, 159 924, 620	14, 914 381, 365	51, 073 1, 305, 985	0	
	06000 LABORATORY	0	1, 509, 223	622, 488	2, 131, 711	0	
	06400 I NTRAVENOUS THERAPY	0	392, 166	161, 751	553, 917	0	64.0
	06500 RESPI RATORY THERAPY	0	210, 901	86, 987	297, 888		65.0
	06600 PHYSI CAL THERAPY	0	358, 224	147, 752	505, 976		
	06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	
	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0	41, 788 500, 772	17, 236 206, 546	59, 024 707, 318	0	
	07000 ELECTROENCEPHALOGRAPHY	0	500,772	200, 540	107, 318	0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	
	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	
	07400 RENAL DI ALYSI S	0	162, 930	67, 201	230, 131	0	
	07697 CARDIAC REHABILITATION OUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	76.
	09000 CLINIC	0	1, 049, 642	432, 931	1, 482, 573	0	90.
	09001 I BMT JOI NT VENTURE	0	106, 602	43, 968	150, 570	0	
	09005 CV DI AGNOSTI C SERVI CES	0	0	0	0	0	
. 00	09100 EMERGENCY	0	1, 876, 572	774, 004	2, 650, 576	0	91.
	09200 OBSERVATION BEDS (NON-DISTINCT PART				0		92.
	OTHER REIMBURSABLE COST CENTERS		0	0	0	0	101
	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	101.
	11300 I NTEREST EXPENSE						113.
	11600 HOSPI CE	0	0	0	0	0	116.
8. 00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	0		13, 709, 884	46, 949, 509	0	118.
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	228, 213	94, 128	322, 341		190.
0.00			211, 455	87, 216	298, 671	0	192.
0.00 2.00	19200 PHYSI CLANS' PRI VATE OFFI CES	0		~	~ ~		104
0.00 2.00 4.00	07955 MARKETING & COMMUNITY RELATIONS	0	0	0	120 042		
90.00 92.00 94.00 94.01	07955 MARKETING & COMMUNITY RELATIONS 07952 WOMEN'S CENTER	0	0 97, 732	0 40, 310 599, 906	0 138, 042 2 054 379	0	194.0
0.00 2.00 4.00 4.01 4.01	07955 MARKETING & COMMUNITY RELATIONS		0	0 40, 310 599, 906 0	0 138, 042 2, 054, 379 0	0 0	194.0 194.0 194.0 194.0

Health Fina	ancial Systems ST	. FRANCIS HOSPITA	L & HEALTH CEN	TER	In Lie	u of Form CMS-	2552-10
ALLOCATI ON	OF CAPITAL RELATED COSTS		Provider C		Period:	Worksheet B	
					From 01/01/2018	Part II   Date/Time Pre	enared
						5/31/2019 7:4	17 am
			CAPI TAL REI	LATED COSTS			
	Cost Center Description	Di rectl y	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
		Assigned New				BENEFI TS	
		Capi tal				DEPARTMENT	
		Related Costs					
		0	1.00	2.00	2A	4.00	
201.00	Negative Cost Centers		0	(	0 0	C	201.00
202.00	TOTAL (sum lines 118 through 201)	0	35, 231, 498	14, 531, 44	4 49, 762, 942	C	202.00

	Financial Systems ST. F TION OF CAPITAL RELATED COSTS	RANCIS HOSPITA	Provider C	CN: 15-0162 P	eriod: rom 01/01/2018 o 12/31/2018	Worksheet B Part II Date/Time Pre 5/31/2019 7:4	
	Cost Center Description	ADMI TTI NG	COUNTS RECEI VABLE	OTHER ADMIN & GENERAL	PLANT	LAUNDRY & LINEN SERVICE	
		5. 01	5.02	5.03	7.00	8.00	
1.00 2.00 4.00 5.01 5.02	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00570 ADMITTING 00580 CASHIERING/ACCOUNTS RECEIVABLE	134, 730 0	102 490				1.00 2.00 4.00 5.01 5.02
5. 02 5. 03 7. 00 8. 00 9. 00	00590 CASH ERING ACCOUNTS RECEIVABLE 00590 OTHER ADMIN & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING	0 0 0 0 0	192, 489 36, 170 7, 435 666 2, 083	107, 660 5, 110 458	5, 218, 176 62, 075	588, 508 0	5.03 7.00 8.00
10.00 11.00 13.00	01000 DI ETARY 01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON	0 0 0	289 1, 107 2, 720	761	92, 664	0 0 0	11.00
14.00 15.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	0	1, 160 2, 830	797 1, 945	265, 261 66, 936	2, 578 0	14.00 15.00
16.00 21.00 22.00 23.00 23.01	01600 MEDICAL RECORDS & LIBRARY 02100 I&R SERVICES-SALARY & FRINGES APPRV 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 02300 MEDICAL LABORATORY SCIENTIST PRGM 02302 PHARMACY PRGM	0 0 0 0	79 741 565 78 199	510 388 54	12, 078 0	0 0 0 0 0	21.00 22.00 23.00
23.01 23.02 23.03	02301 EMERGENCY MEDICAL SERVICES 02303 PARAMEDIC PRGM	0 0 0	34 83	23	-	0 0 0	23.02
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	44.770	10.001	0.505	1 044 /	004 550	1 20 00
30.00 31.00 31.01	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 02060 NEONATAL INTENSIVE CARE UNIT	14, 643 3, 147 2, 507	13, 831 3, 025 1, 658	2, 079	127, 894	231, 559 38, 219 3, 823	31.00
32.00 34.00 41.00	03200 CORONARY CARE UNIT 03400 SURGI CAL I NTENSI VE CARE UNIT 04100 SUBPROVI DER – I RF	2, 977 2, 538 1, 271	4, 119 2, 212 1, 275	1, 520	151, 359	43, 220 28, 712 11, 895	34.00
43.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	1, 371 657	1, 375 	204	22, 718	1, 619	43.00
50.00 52.00	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM	11, 967 3, 479	6, 312 1, 424			52, 783 27, 170	
52.00 54.00 55.00	05200 DELIVERY ROOM & LABOR ROOM 05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	3, 479 9, 472 192	1, 424 5, 633 2, 698	3, 871	475, 770	27, 170 33, 175 0	54.00
56.00 59.00 60.00	05600 RADI OI SOTOPE 05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	195 4, 642 12, 220	358 1, 183 6, 784	813	154, 327	1, 417 14, 781 67	59.00
64.00 65.00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	259 6, 178	1, 195 3, 100	821 2, 130	65, 456 35, 201	0 0	64.00 65.00
66.00 67.00 68.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	1, 897 1, 272 472	2, 256 698 406	480	0	8, 970 0 0	67.00
70.00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	2, 256 362 15, 261	757 735 10, 360	505	83, 583 0	1, 624 1, 340 0	1
72.00 73.00	07200 I MPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS	9, 939 18, 731	8, 222 16, 070 307	5, 651 11, 045	0 0	0 0	72.00 73.00
76. 97	07400 RENAL DI ALYSI S 07697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVI CE COST CENTERS	856 0	199	137	0	1, 894 0	76.97
90.00 90.01 90.05	09000 CLINIC 09001 IBMT JOINT VENTURE 09005 CV DIAGNOSTIC SERVICES	54 28 47	2, 811 1, 559 3, 182	1, 072	17, 793	2, 623 994 0	90.01
91.00 92.00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	7, 111	3, 816			71, 937	
	OTHER REIMBURSABLE COST CENTERS 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	101.00
	11300 INTEREST EXPENSE						113.00
116.00 118.00	11600 HOSPI CE SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	0 134, 730	2, 589 165, 410			0 580, 400	116.00 118.00
192.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSI CLANS' PRI VATE OFFI CES 07955 MARKETI NG & COMMUNI TY RELATI ONS	0 0 0	274 3, 190 37	2, 192	35, 294	2, 436	190.00 192.00 194.00
194. 01 194. 04 194. 05	07952 WOMEN' S CENTER 07954 OTHER NRCC 07956 FOUNDATI ON	0 0 0 0	37 144 23, 415 19	99 16, 317	16, 312 242, 764	5, 672 0	194. 01 194. 04 194. 05
200.00 201.00 202.00	Negative Cost Centers	0 134, 730	0 192, 489		-		200.00 201.00 202.00

Heal th	Financial Systems ST. F	RANCIS HOSPITAL	& HEALTH CEN	TER	In Lie	u of Form CMS-:	2552-10
	ATION OF CAPITAL RELATED COSTS		Provider CC	CN: 15-0162 P	eri od:	Worksheet B	
					rom 01/01/2018 o 12/31/2018	Part II Date/Time Pre	pared:
						5/31/2019 7:4	
	Cost Center Description	HOUSEKEEPING	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI O	CENTRAL SERVICES &	
					N	SUPPLY	
		9.00	10.00	11.00	13.00	14.00	
1 00	GENERAL SERVICE COST CENTERS	1			1		1 4 00
1.00 2.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570 ADMI TTI NG						5.01
5.02	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5.02
5.03	00590 OTHER ADMIN & GENERAL						5.03
7.00	00700 OPERATION OF PLANT						7.00
8.00 9.00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	434, 254					8.00 9.00
10.00	01000 DI ETARY	5, 188	583, 429				10.00
11.00	01100 CAFETERI A	7, 874	0	886, 575			11.00
13.00	01300 NURSING ADMINISTRATION	838	0	20, 363			13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	22, 540	0	8, 206		2, 545, 302	
15.00	01500 PHARMACY	5, 688	0	29, 334		4, 538	1
16.00 21.00	01600 MEDICAL RECORDS & LIBRARY 02100 I&R SERVICES-SALARY & FRINGES APPRV	0 1, 026	0 0	0 9, 984	-	0 391	16.00 21.00
21.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	1, 020	0	2, 826		0	
23.00	02300 MEDICAL LABORATORY SCIENTIST PRGM	0	0	1, 211		22	23.00
23.01	02302 PHARMACY PRGM	0	0	1, 702	0	6	23.01
23.02	02301 EMERGENCY MEDICAL SERVICES	0	0	2, 247		436	•
23.03	02303 PARAMEDIC PRGM	0	0	5, 847	0	198	23.03
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	88, 764	292, 998	171, 335	59, 827	5, 590	30.00
30.00	03100 I NTENSI VE CARE UNI T	10, 867	98, 968	38, 482		763	
31.01	02060 NEONATAL INTENSIVE CARE UNIT	7, 720	30, 228	15, 932		306	
32.00	03200 CORONARY CARE UNIT	25, 251	65, 148	50, 207		1, 339	32.00
34.00	03400 SURGI CAL I NTENSI VE CARE UNI T	12, 861	46, 822	28, 237		1, 003	•
41.00	04100 SUBPROVIDER - IRF	8, 526	28, 152	16, 130		280	•
43.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	1, 930	21, 113	3, 107	4, 311	102	43.00
50.00	05000 OPERATING ROOM	51, 966	0	66, 055	0	14, 830	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	12, 779	0	14, 318		440	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	40, 427	0	46, 059		12, 461	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	75	0	7,050		120	•
56.00 59.00	05600 RADI OI SOTOPE 05900 CARDI AC CATHETERI ZATI ON	513 13, 113	0 0	1, 061		31, 047	•
60.00	06000 LABORATORY	21, 405	0	10, 830 3, 788		749 483	•
64.00	06400 I NTRAVENOUS THERAPY	5, 562	0	14, 997		2, 835	•
65.00	06500 RESPI RATORY THERAPY	2, 991	0	43, 545		779	
66.00	06600 PHYSI CAL THERAPY	5, 081	0	24, 341		710	•
67.00	06700 OCCUPATI ONAL THERAPY	0	0	9, 599		143	•
68.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	593 7, 102	0 0	4, 872 8, 200		89 179	
70.00		7,102	0	8, 200		308	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	1, 342, 509	•
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	1,065,606	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	
74.00		2, 311	0	2,676		58	•
/0.9/	07697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVI CE COST CENTERS		0	3, 097	0	233	76.97
90.00	09000 CLINIC	14, 887	0	36, 481	0	1, 068	90.00
90.01	09001 I BMT JOINT VENTURE	1, 512	0	6, 403		273	90.01
90.05	09005 CV DI AGNOSTI C SERVI CES	0	0	50, 171		10, 915	90.05
91.00	09100 EMERGENCY	26, 614	0	43, 915	0	2, 096	
92.00							92.00
101 00	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	101.00
101.00	SPECIAL PURPOSE COST CENTERS	<u> </u>	0	0	<u> </u>	0	101.00
113.00	11300 INTEREST EXPENSE						113.00
	11600 HOSPI CE	0	0	28, 258			116.00
118.00		406, 004	583, 429	838, 971	119, 130	2, 507, 366	118.00
100 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	3, 237	0	2, 917	o	0 201	190.00
	19000 GFFT, FLOWER, COFFEE SHOP & CANTEEN	2, 999	0	2, 917 22, 631			190.00
	07955 MARKETING & COMMUNITY RELATIONS	2, 999	0	451			194.00
	07952 WOMEN' S CENTER	1, 386	0	879			194.01
194.04	O7954 OTHER NRCC	20, 628	0	20, 726		24, 250	194.04
	07956 FOUNDATI ON	0	0	0	0	0	194.05
200.00				~		~	200.00
201.00 202.00	5	0 434, 254	0 583, 429	0 886, 575	0 119, 130	0 2, 545, 302	201.00
202.00		1 +34, 234	505, 427	000, 375	1 17, 130	2, 545, 502	1202.00

In Lieu of Form CMS-2552-10 Worksheet B

ALLOCATION OF CAPITAL RELATED COSTS		Provider C	CN: 15-0162	Period: From 01/01/2018 To 12/31/2018		epared:
			I NTERNS	& RESI DENTS	10/01/2017 11	
Cost Center Description	PHARMACY	MEDI CAL RECORDS & LI BRARY	SERVI CES-SAL RY & FRI NGES APPRV	A SERVI CES-OTHE R PRGM COSTS APPRV	MEDI CAL LABORATORY SCI ENTI ST PRGM	
	15.00	16.00	21.00	22.00	23.00	_
GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00       00200       CAP REL COSTS-MVBLE EQUIP         4.00       00400       EMPLOYEE BENEFITS DEPARTMENT         5.01       00570       ADMI TTI NG         5.02       00580       CASHI ERI NG/ACCOUNTS RECEI VABLE         5.03       00590       OTHER ADMI N & GENERAL         7.00       00700       OPERATI ON OF PLANT         8.00       00800       LAUNDRY & LI NEN SERVI CE         9.00       00900       HOUSEKEEPI NG         10.00       01000       DI ETARY         11.00       011000       CAFETERI A         13.00       01300       NURSI NG ADMI NI STRATI ON         14.00       014000       CENTRAL SERVI CES & SUPPLY         15.00       01500       PHARMACY         16.00       01600       MEDI CAL RECORDS & LI BRARY         21.00       02100       I & SERVI CES-SALARY & FRI NGES APPRV         22.00       02200       I & SERVI CES-OTHER PRGM COSTS APPRV         23.00       02300       MEDI CAL LABORATORY SCI ENTI ST PRGM         23.01       C2322       PHARMACY PRGM         23.02       02301       EMERGENCY MEDI CAL SERVI CES         23.03       02303       PARMEDI C PRGM	677, 715 0 0 0 0 0 0 0 0	134 0 0 0 0 0 0 0 0 0 0 0 0	126, 93	37 3, 779	1, 365	$\left \begin{array}{c} 2.\ 00\\ 4.\ 00\\ 5.\ 01\\ 5.\ 02\\ 5.\ 03\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 21.\ 00\\ 22.\ 00\\ \end{array}\right.$
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00  03000  ADULTS & PEDI ATRI CS 31. 00  03100  I NTENSI VE CARE UNI T	0	0				30.00
31. 01 02060 NEONATAL INTENSIVE CARE UNIT	0	0				31.00
32.00 03200 CORONARY CARE UNIT	0	0				32.00
34. 00   03400  SURGI CAL I NTENSI VE CARE UNI T 41. 00   04100  SUBPROVI DER – I RF	0	0				34.00
43. 00 04300 NURSERY	0	0				43.00
ANCILLARY SERVICE COST CENTERS			1			
50.00 05000 OPERATING ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0				50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM 54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0				52.00
55.00 05500 RADI OLOGY-THERAPEUTI C	0	0				55.00
56. 00 05600 RADI OI SOTOPE	0	0				56.00
59. 00  05900  CARDI AC CATHETERI ZATI ON 60. 00  06000  LABORATORY	0	0				59.00
60. 00  06000  LABORATORY 64. 00  06400  I NTRAVENOUS THERAPY	0	0				60.00 64.00
65. 00 06500 RESPIRATORY THERAPY	0	0				65.00
66. 00 06600 PHYSI CAL THERAPY	0	0				66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0				67.00
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	0	0				68.00 69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0				70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	(77,715	0				72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 74. 00 07400 RENAL DIALYSIS	677, 715 0	134 0				73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0				76.97
OUTPATIENT SERVICE COST CENTERS			1	_		
90. 00  09000  CLINIC 90. 01  09001  I BMT JOINT VENTURE	0	0				90.00
90. 05 09005 CV DI AGNOSTI C SERVI CES	0	0				90.01
91. 00 09100 EMERGENCY	0	0				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS	0	0	1			101 00
101. 00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	U	0				101.00
113.00 11300 INTEREST EXPENSE						113.00
116.00 11600 HOSPI CE	0	0				116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	677, 715	134		0 0	0	118.00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN	0	0	1			190.00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0				192.00
194.00 07955 MARKETING & COMMUNITY RELATIONS	0	0				194.00
194. 01 07952 WOMEN' S CENTER	0	0				194.01
194. 04 07954 OTHER NRCC 194. 05 07956 FOUNDATI ON	0	0				194.04 194.05
200.00 Cross Foot Adjustments		0	126, 93	3, 779	1, 365	200.00
· · · ·			• · · · · · · · · · · · · · · · · · · ·		-	

Health Fin	ancial Systems ST.	FRANCIS HOSPITA	L & HEALTH CEN	TER	In Lie	u of Form CMS-2	2552-10
ALLOCATI ON	I OF CAPITAL RELATED COSTS		Provider C		Period: From 01/01/2018	Worksheet B Part II	
					Fo 12/31/2018		pared: 7 am
				INTERNS &	RESIDENTS		
	Cost Center Description	PHARMACY	MEDI CAL RECORDS &	RY & FRINGES		MEDI CAL LABORATORY	
			LI BRARY	APPRV	APPRV	SCI ENTI ST PRGM	
		15.00	16.00	21.00	22.00	23.00	
201.00	Negative Cost Centers	0	0	(	0 0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	677, 715	134	126, 937	3, 779	1, 365	202.00

ALLOCATION OF CAPITAL RELATED COSTS	FRANCIS HOSPITAL	Provider CO	CN: 15-0162 P	eriod: rom 01/01/2018		
			T		5/31/2019 7:4	pared: 7 am
Cost Center Description	PHARMACY PRGM	EMERGENCY MEDI CAL SERVI CES	PARAMEDI C PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
	23.01	23.02	23.03	24.00	25.00	
GENERAL SERVICE COST CENTERS						1.0
2.00 00200 CAP REL COSTS-MVBLE EQUIP						2.0
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.0
						5.0
5. 02 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5. 03 00590 OTHER ADMIN & GENERAL						5.0
7. 00 00700 OPERATION OF PLANT						7.0
3. 00 00800 LAUNDRY & LINEN SERVICE						8.0
9.00 00900 HOUSEKEEPI NG						9.0
IO. 00   O1000   DI ETARY I1. 00   O1100   CAFETERI A						10.0
13. 00 01300 NURSING ADMINISTRATION						13.0
14.00 01400 CENTRAL SERVICES & SUPPLY						14.0
15. 00 01500 PHARMACY						15.0
16.00 01600 MEDICAL RECORDS & LIBRARY						16.0
21.00 02100 I &R SERVICES-SALARY & FRINGES APPRV 22.00 02200 I &R SERVICES-OTHER PRGM COSTS APPRV						21.0
23. 00 02300 MEDICAL LABORATORY SCIENTIST PRGM						22.0
23.01 02302 PHARMACY PRGM	2, 044					23.0
23. 02 02301 EMERGENCY MEDICAL SERVICES		2, 740				23.0
23. 03 02303 PARAMEDI C PRGM I NPATI ENT ROUTI NE SERVI CE COST CENTERS			6, 185			23.0
30. 00 03000 ADULTS & PEDIATRICS				10, 772, 971	0	30.0
31. 00 03100 I NTENSI VE CARE UNI T				1, 425, 950	0	
31.01 02060 NEONATAL INTENSIVE CARE UNIT				929, 215	0	31.0
32. 00 03200 CORONARY CARE UNIT				3, 020, 391	0	
34. 00 03400 SURGICAL INTENSIVE CARE UNIT 11. 00 04100 SUBPROVIDER - IRF				1, 565, 695 1, 023, 854	0	1
13. 00 04300 NURSERY				248, 306	0	
ANCILLARY SERVICE COST CENTERS	I					
50. 00 05000 OPERATING ROOM				5, 995, 151	0	
52.00 05200 DELIVERY ROOM & LABOR ROOM 54.00 05400 RADIOLOGY-DIAGNOSTIC				1, 483, 659	0	52.0 54.0
55. 00 05500 RADI OLOGY-DI AGNOSTI C				4, 653, 053 20, 341	0	
56. 00 05600 RADI OI SOTOPE				91, 945	0	
59. 00 05900 CARDI AC CATHETERI ZATI ON				1, 506, 423	0	
50. 00 06000 LABORATORY				2, 433, 022	0	
54. 00 06400 I NTRAVENOUS THERAPY 55. 00 06500 RESPI RATORY THERAPY				645, 042 391, 812	0	
56.00 06600 PHYSI CAL THERAPY				610, 572	0	
57.00 06700 OCCUPATI ONAL THERAPY				12, 192	0	
58.00 06800 SPEECH PATHOLOGY				72, 710	0	
59. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY				811, 540 11, 355	0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT				1, 375, 250	0	
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS				1, 089, 418	0	
73.00 07300 DRUGS CHARGED TO PATIENTS				723, 695	0	
74.00 07400 RENAL DIALYSIS				265, 638	0	
76. 97 07697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVI CE COST CENTERS	<u> </u>			3, 666	0	76.9
20. 00 09000 CLINIC				1, 717, 623	0	90.0
20. 01 09001 I BMT JOINT VENTURE				180, 204	0	
20. 05 09005 CV DI AGNOSTI C SERVI CES				66, 502	0	
01.00 09100 EMERGENCY 02.00 09200 OBSERVATION BEDS (NON-DISTINCT PART				3, 121, 904	0	
OTHER REIMBURSABLE COST CENTERS	1				0	92.0
101.00 10100 HOME HEALTH AGENCY				0	0	]101.0
SPECIAL PURPOSE COST CENTERS	T T		1			
113. 00 11300   NTEREST EXPENSE 116. 00 11600 HOSPI CE				37, 088	0	113.0 116.0
I18.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	46, 306, 187		118.0
NONREI MBURSABLE COST CENTERS		0		10,000,107		
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN				376, 329		190. 0
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES				371, 580		192.0
194.0007955 MARKETING & COMMUNITY RELATIONS 194.0107952 WOMEN'S CENTER				513 162 772		194.0 194.0
194. 01 07952  WOMEN'S CENTER 194. 04 07954  OTHER NRCC				162, 772 2, 402, 479		194.0
194. 05 07956 FOUNDATI ON				2, 402, 473		194.0
200.00 Cross Foot Adjustments	2, 044	2, 740	6, 185	143, 050	0	200.0
201.00 Negative Cost Centers		0	0	0	0	201.0

Heal th Fin	ancial Systems ST.	FRANCIS HOSPITA	L & HEALTH CEN	TER	In Lie	u of Form CMS-:	2552-10
ALLOCATI ON	OF CAPITAL RELATED COSTS		Provider C		Period:	Worksheet B	
					From 01/01/2018 To 12/31/2018	Date/Time Pre	narod
					10 12/31/2010	5/31/2019 7:4	7 am
	Cost Center Description	PHARMACY PRGM	EMERGENCY	PARAMEDI C	Subtotal	Intern &	
			MEDI CAL	PRGM		Residents	
			SERVI CES			Cost & Post	
						Stepdown	
						Adjustments	
		23.01	23.02	23.03	24.00	25.00	
202.00	TOTAL (sum lines 118 through 201)	2, 044	2, 740	6, 18	35 49, 762, 942	0	202.00

Provider CCN: 15-0162

In Lieu of Form CMS-2552-10 Period: Worksheet B From 01/01/2018 Part II

	Cost Center Description	Total	5/31/2019 7	
	· · · · · · · · · · · · · · · · · · ·	26.00		
00	GENERAL SERVICE COST CENTERS			1
. 00	00100 CAP REL COSTS-BLDG & FIXT			1.
. 00	00200 CAP REL COSTS-MVBLE EQUIP			2.
	00400 EMPLOYEE BENEFITS DEPARTMENT			4.
. 01				5.
. 02	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE			5.
. 03	00590 OTHER ADMIN & GENERAL			5.
. 00	00700 OPERATION OF PLANT			7.
. 00	00800 LAUNDRY & LINEN SERVICE			8.
. 00	00900 HOUSEKEEPI NG			9
0.00	01000 DI ETARY			10
				11
	01300 NURSI NG ADMI NI STRATI ON			13.
	01400 CENTRAL SERVICES & SUPPLY			14.
	01500 PHARMACY			15.
	01600 MEDI CAL RECORDS & LI BRARY			16.
	02100 I & R SERVICES-SALARY & FRINGES APPRV			21.
	02200 I &R SERVICES-OTHER PRGM COSTS APPRV			22.
				23
	02302 PHARMACY PRGM			23
	02301 EMERGENCY MEDICAL SERVICES			23
3.03	02303 PARAMEDI C PRGM			23
	INPATIENT ROUTINE SERVICE COST CENTERS			
0.00	03000 ADULTS & PEDIATRICS	10, 772, 971		30
1.00	03100 I NTENSI VE CARE UNI T	1, 425, 950		31
1. 01	02060 NEONATAL INTENSIVE CARE UNIT	929, 215		31
	03200 CORONARY CARE UNI T	3, 020, 391		32
	03400 SURGI CAL I NTENSI VE CARE UNI T	1, 565, 695		34.
1.00	04100 SUBPROVI DER – I RF	1, 023, 854		41.
3.00	04300 NURSERY	248, 306		43.
	ANCILLARY SERVICE COST CENTERS			
0.00	05000 OPERATING ROOM	5, 995, 151		50
2.00	05200 DELIVERY ROOM & LABOR ROOM	1, 483, 659		52
4.00	05400 RADI OLOGY-DI AGNOSTI C	4, 653, 053		54
5.00	05500 RADI OLOGY-THERAPEUTI C	20, 341		55
6.00	05600 RADI OI SOTOPE	91, 945		56
9.00	05900 CARDI AC CATHETERI ZATI ON	1, 506, 423		59
0.00	06000 LABORATORY	2, 433, 022		60
4.00	06400 I NTRAVENOUS THERAPY	645, 042		64
5.00	06500 RESPI RATORY THERAPY	391, 812		65
6.00	06600 PHYSI CAL THERAPY	610, 572		66.
7.00	06700 OCCUPATI ONAL THERAPY	12, 192		67
8.00	06800 SPEECH PATHOLOGY	72, 710		68
9.00	06900 ELECTROCARDI OLOGY	811, 540		69
0.00	07000 ELECTROENCEPHALOGRAPHY	11, 355		70
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 375, 250		71
2.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1,089,418		72
3.00	07300 DRUGS CHARGED TO PATIENTS	723, 695		73
	07400 RENAL DI ALYSI S	265, 638		74
	07697 CARDI AC REHABI LI TATI ON	3, 666		76
	OUTPATIENT SERVICE COST CENTERS	.,		
0.00	09000 CLINIC	1, 717, 623		90
	09001 I BMT JOI NT VENTURE	180, 204		90
	09005 CV DI AGNOSTI C SERVI CES	66, 502		90
	09100 EMERGENCY	3, 121, 904		91
	09200 OBSERVATION BEDS (NON-DISTINCT PART	5, 121, 704		92.
50	OTHER REIMBURSABLE COST CENTERS			- '2
01 00	D10100 HOME HEALTH AGENCY	0		101
51.00	SPECIAL PURPOSE COST CENTERS	0		
13 00	D11300 INTEREST EXPENSE			113
	11600 HOSPI CE	37, 088		116
18.00 18.00				118
10. UL		46, 306, 187		-118
00 00	NONREI MBURSABLE COST CENTERS	07/ 000		100
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	376, 329		190
	19200 PHYSI CI ANS' PRI VATE OFFI CES	371, 580		192
	07955 MARKETING & COMMUNITY RELATIONS	513		194
	07952 WOMEN'S CENTER	162, 772		194
	07954 OTHER NRCC	2, 402, 479		194
	07956 FOUNDATI ON	32		194
00.00		143,050		200
		0		201.
01.00				

### ST. FRANCIS HOSPITAL & HEALTH CENTER Provider CCN: 15-0162 Period:

In Lieu of Form CMS-2552-10 Worksheet B-1

COST A	ALLOCATION - STATISTICAL BASIS		Provider C		Period: From 01/01/2018 To 12/31/2018		
		CAPI TAL REL	ATED COSTS			5/31/2019 7:4	
	Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUI P (SQUARE FEET)	EMPLOYEE BENEFI TS DEPARTMENT (GROSS	ADMI TTI NG (I NPATI ENT CHARGES)	Reconciliatio n	
		1.00	2.00	SALARIES) 4.00	5. 01	5A. 02	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT	826, 242					1.00
2.00 4.00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT	0	826, 242 0		0		2.00 4.00
4.00 5.01	00570 ADMITTING	2,237	2, 237		0 1, 237, 427, 378		5.01
5.02	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	3, 196	3, 196		0 0		
5.03	00590 OTHER ADMIN & GENERAL	1, 187	1, 187				
7.00	00700 OPERATION OF PLANT	86, 432	86, 432				
8.00 9.00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	8, 722 6, 396	8, 722 6, 396		-		
10.00	01000 DI ETARY	8, 579	8, 579				
11.00	01100 CAFETERI A	13, 020	13, 020				
13.00	01300 NURSI NG ADMI NI STRATI ON	1, 386	1, 386				
14.00 15.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	37, 271 9, 405	37, 271 9, 405				
16.00	01600 MEDI CAL RECORDS & LI BRARY	0	0		0 0		
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRV	1, 697	1, 697	1, 914, 93			•
22.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0				
23. 00 23. 01	02300 MEDICAL LABORATORY SCIENTIST PRGM 02302 PHARMACY PRGM	0	0			-	
23.01	02301 EMERGENCY MEDICAL SERVICES	0	0		-		
23.03	02303 PARAMEDI C PRGM	0	0				
~~ ~~	INPATIENT ROUTINE SERVICE COST CENTERS	444 700			1 101 000 717		
30.00 31.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	146, 780 17, 970	146, 780 17, 970				
31.00	02060 NEONATAL INTENSIVE CARE UNIT	12, 766	12, 766				
32.00	03200 CORONARY CARE UNI T	41, 755	41, 755				
34.00	03400 SURGI CAL I NTENSI VE CARE UNI T	21, 267	21, 267				
41.00 43.00	04100 SUBPROVI DER – I RF 04300 NURSERY	14, 098 3, 192	14, 098 3, 192				
43.00	ANCI LLARY SERVICE COST CENTERS	5, 172	5, 172	575,50	2 0,024,031	0	43.00
50.00	05000 OPERATING ROOM	85, 929	85, 929				•
52.00	05200 DELIVERY ROOM & LABOR ROOM	21, 131	21, 131				
54.00 55.00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	66, 849 124	66, 849 124				
56.00	05600 RADI OI SOTOPE	848	848			-	
59.00	05900 CARDI AC CATHETERI ZATI ON	21, 684	21, 684				
60.00 64.00	06000 LABORATORY 06400 I NTRAVENOUS THERAPY	35, 394 9, 197	35, 394 9, 197				
65.00	06500 RESPIRATORY THERAPY	4, 946	4, 946				
66.00	06600 PHYSI CAL THERAPY	8, 401	8, 401				•
67.00	06700 OCCUPATI ONAL THERAPY	0	0				
68.00 69.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	980 11, 744	980 11, 744				
70.00	07000 ELECTROCARDI OLOGI	0	0				1
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 140, 008, 311		1
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 91, 181, 804		
73.00 74.00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0 3, 821	0 3, 821		0 173, 196, 207 9 7, 854, 660		
	07697 CARDI AC REHABI LI TATI ON	3, 821	3, 021				
	OUTPATIENT SERVICE COST CENTERS					-	
90.00	09000 CLINIC	24, 616	24, 616				
90. 01 90. 05	09001 I BMT JOI NT VENTURE 09005 CV DI AGNOSTI C SERVI CES	2, 500	2, 500 0				
91.00	09100 EMERGENCY	44,009	44,009				•
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
101 00			0				101 00
101.00	DIO100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	0		0 0	0	101.00
113.00	11300 I NTEREST EXPENSE						113.00
		0	0				116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	779, 529	779, 529	156, 928, 17	9 1, 237, 427, 378	-192, 489	118.00
190. ೧೧	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	5, 352	5, 352	245, 21	6 0	0	190.00
192.00	19200 PHYSI CLANS' PRI VATE OFFI CES	4, 959	4, 959			0	192.00
	07955 MARKETING & COMMUNITY RELATIONS	0	0				194.00
	07952 WOMEN' S CENTER 07954 OTHER NRCC	2, 292 34, 110	2, 292 34, 110				194. 01 194. 04
	07954 OTHER INCC	34, 110			0 0		194.04 194.05
	· · · ·				*	-	<u> </u>

#### ST. FRANCI'S HOSPITAL & HEALTH CENTER Provi der CCN: 15-0162

In Lieu of Form CMS-2552-10 Period: Worksheet B-1 From 01/01/2018 To 12/31/2018 Date/Time Prepared: 5/31/2019 7:47 am

				1	o 12/31/2018	Date/Time Pre 5/31/2019 7:4	
		CAPI TAL REI	LATED COSTS				
	Cost Center Description	BLDG & FI XT (SQUARE FEET)	MVBLE EQUI P (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	ADMI TTI NG (INPATI ENT CHARGES)	Reconciliatio n	
		1.00	2.00	4.00	5.01	5A. 02	
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	35, 231, 498	14, 531, 444	58, 414, 649	135, 780		202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	42. 640652	17. 587394	0. 350744	0. 000110		203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			(	134, 730		204.00
205.00	Unit cost multiplier (Wkst. B, Part			0.00000	0. 000109		205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

#### ST. FRANCIS HOSPITAL & HEALTH CENTER

	ncial Systems ST. F FION - STATISTICAL BASIS	FRANCIS HOSPITAL	Provider CO	CN: 15-0162 P	eriod: rom 01/01/2018		
				T	o 12/31/2018	Date/Time Pre 5/31/2019 7:4	
	Cost Center Description	CASHI ERI NG/AC COUNTS RECEI VABLE	Reconciliatio n	OTHER ADMIN & GENERAL (ACCUM. COST)	PLANT	LAUNDRY & LINEN SERVICE (POUNDS OF	
		(ACCUM. COST) 5.02	5A. 03	5.03	7.00	LAUNDRY) 8.00	
GENER	AL SERVICE COST CENTERS	5.02	JA. 03	5.05	7.00	0.00	
. 00 00200 . 00 00400	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT ADMITTING						1 2 4 5
03 00590 00 00700	CASHI ERI NG/ACCOUNTS RECEI VABLE OTHER ADMIN & GENERAL OPERATI ON OF PLANT	654, 769, 348 123, 064, 371 25, 289, 196	-123, 100, 541 0	531, 861, 296 25, 296, 631	733, 190		5 5 7
00 00900	LAUNDRY & LI NEN SERVI CE HOUSEKEEPI NG DI ETARY	2, 265, 201 7, 083, 936 983, 047	0 0 0	2, 265, 867 7, 086, 019 983, 336	6, 396	0	9
	CAFETERIA NURSI NG ADMI NI STRATI ON	3, 765, 454 9, 251, 398	0 0	3, 766, 561 9, 254, 118			11   13
	CENTRAL SERVICES & SUPPLY PHARMACY	3, 945, 646 9, 624, 582	0 0	3, 946, 806 9, 627, 412		10, 990 0	14 15
-	MEDICAL RECORDS & LIBRARY I&R SERVICES-SALARY & FRINGES APPRV	270, 126 2, 522, 012	0	270, 205 2, 522, 753		0	16 21
. 00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV MEDICAL LABORATORY SCIENTIST PRGM	1, 920, 836 265, 999	0	1, 921, 401 266, 077	0	0	22
. 01 02302	PHARMACY PRGM EMERGENCY MEDICAL SERVICES	676, 357	0	676, 556	0	0	23
. 03 02303	PARAMEDIC PRGM	114, 647 283, 198	0	114, 681 283, 281		0	23
	I ENT ROUTI NE SERVI CE COST CENTERS ADULTS & PEDI ATRI CS	47,043,029	0	47, 056, 860	146, 780	987, 072	30
. 00 03100	INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE UNIT	10, 288, 924 5, 640, 726	0	10, 291, 949 5, 642, 384	17, 970	162, 919	31
. 00 03200	CORONARY CARE UNIT SURGICAL INTENSIVE CARE UNIT	14, 011, 020	0	14, 015, 139	41, 755	184, 234	32
. 00 04100	SUBPROVI DER – I RF	7, 524, 939 4, 676, 366	0		14, 098	50, 705	41
	NURSERY LARY SERVICE COST CENTERS	1,011,609	0	1, 011, 906	3, 192	6, 901	43
. 00 05000	OPERATING ROOM DELIVERY ROOM & LABOR ROOM	21, 467, 866 4, 844, 016	0	21, 474, 178 4, 845, 440		224, 998 115, 816	
00 05400	RADI OLOGY-DI AGNOSTI C	19, 158, 843	0	19, 164, 476	66, 849	141, 414	54
. 00 05600	RADI OLOGY-THERAPEUTI C RADI OI SOTOPE	9, 178, 055 1, 218, 981	0	9, 180, 753 1, 219, 339	848	6, 039	
. 00 06000	CARDI AC CATHETERI ZATI ON LABORATORY	4, 022, 581 23, 073, 249	0 0	4, 023, 764 23, 080, 033	35, 394	284	60
	I NTRAVENOUS THERAPY RESPI RATORY THERAPY	4, 064, 617 10, 543, 555	0 0	4, 065, 812 10, 546, 655		0	64
. 00 06600	PHYSI CAL THERAPY OCCUPATI ONAL THERAPY	7, 673, 009	0	7, 675, 265 2, 376, 185	8, 401	38, 235	66
. 00 06800	SPEECH PATHOLOGY	1, 380, 708	0	1, 381, 114	980	0	68
. 00 07000	ELECTROCARDI OLOGY ELECTROENCEPHALOGRAPHY	2, 576, 414 2, 500, 732	0 0	2, 577, 171 2, 501, 467	0	6, 923 5, 714	70
	MEDICAL SUPPLIES CHARGED TO PATIENT IMPL. DEV. CHARGED TO PATIENTS	35, 236, 886 27, 966, 944	0 0	35, 247, 246 27, 975, 166		0	71
. 00 07300	DRUGS CHARGED TO PATIENTS RENAL DIALYSIS	54, 660, 674 1, 045, 328	0	54, 676, 744 1, 045, 635	0	0 8, 075	73
. 97 07697	CARDIAC REHABILITATION TIENT SERVICE COST CENTERS	678, 040	0	678, 239		0	76
. 00 09000	CLINIC	9, 561, 747	0	9, 564, 558			
	I BMT JOINT VENTURE CV DIAGNOSTIC SERVICES	5, 303, 810 10, 821, 560	0 0	5, 305, 369 10, 824, 742		4, 237 0	90 90
	EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART	12, 980, 822	0	12, 984, 638	44, 009	306, 649	91 92
OTHER	REIMBURSABLE COST CENTERS HOME HEALTH AGENCY	0	0	0	0	0	101
SPECI	AL PURPOSE COST CENTERS		0				1113
6. 00 11600 8. 00		8, 807, 760 562, 664, 303	0 -123, 100, 541	8, 810, 349 439, 729, 172		0 2, 474, 082	116
0. 00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN PHYSICIANS' PRIVATE OFFICES	931, 614 10, 850, 130	0	931, 888			190
4.0007955	MARKETING & COMMUNITY RELATIONS	124, 952	0	10, 853, 320 124, 989	0	0	194
	WOMEN' S CENTER OTHER NRCC	491, 444 79, 642, 649	0 0	491, 588 79, 666, 064			194 194
	FOUNDATION Cross Foot Adjustments	64, 256	0	64, 275			194 200
	Negative Cost Centers						201

	nancial Systems ST. F CATION - STATISTICAL BASIS	RANCIS HOSPITA	Provi der C		Peri od:	u of Form CMS-: Worksheet B-1	
CUST ALLU	CATION - STATISTICAL DASIS		FIOVIDELC		From 01/01/2018		
			_		To 12/31/2018		
	Cost Center Description		Reconciliatio		OPERATION OF	LAUNDRY &	
		COUNTS	n	GENERAL	PLANT	LINEN SERVICE	
		RECEI VABLE		(ACCUM. COST)	(SQUARE FEET)	(POUNDS OF	
		(ACCUM. COST)				LAUNDRY)	
		5. 02	5A. 03	5.03	7.00	8.00	
202.00	Cost to be allocated (per Wkst. B, Part I)	192, 489		123, 100, 54	1 31, 151, 587	3, 160, 884	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0. 000294		0. 23145	2 42. 487741	1. 259997	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	192, 489		107, 660	5, 218, 176	588, 508	204.00
205.00	Unit cost multiplier (Wkst. B, Part	0. 000294		0. 000202	2 7. 117086	0. 234592	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

Health Financial	Systems
MOLTADO LIA T200	

	nancial Systems ST. I CATION - STATISTICAL BASIS	FRANCIS HOSPITA	L & HEALTH CEN Provider CO		In Lie eriod:	u of Form CMS- Worksheet B-1	
0001 71220				F	rom 01/01/2018 o 12/31/2018		epared:
	Cost Center Description	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	
		(SQUARE FEET)	(TOTAL PATI ENT DAYS)	(FTES)	ADMI NI STRATI O N	SERVICES & SUPPLY	
			Entr britis)		(TOTAL PATI	(COSTED	
		9.00	10.00	11.00	ENT DAYS) 13.00	REQUIS.) 14.00	
	NERAL SERVICE COST CENTERS	7.00	10.00	11.00	13.00	14.00	
	100 CAP REL COSTS-BLDG & FIXT 200 CAP REL COSTS-MVBLE EQUIP						1.00
	400 EMPLOYEE BENEFITS DEPARTMENT						4.00
	570 ADMI TTI NG						5.01
	580 CASHI ERI NG/ACCOUNTS RECEI VABLE 590 OTHER ADMI N & GENERAL						5.02 5.03
	700 OPERATION OF PLANT						7.00
	800 LAUNDRY & LINEN SERVICE	710 070					8.00
	900 HOUSEKEEPI NG 000 DI ETARY	718, 072 8, 579	105, 092				9.00
11.00 01	100 CAFETERI A	13, 020	0	4, 759, 867			11.00
	300 NURSI NG ADMI NI STRATI ON 400 CENTRAL SERVI CES & SUPPLY	1, 386 37, 271	0	109, 323 44, 059		66, 777, 535	13.00
	500 PHARMACY	9, 405	0	44, 059 157, 490		119, 059	
	600 MEDI CAL RECORDS & LI BRARY	0	0	0	0	0	16.00
	100 I &R SERVICES-SALARY & FRINGES APPRV 200 I &R SERVICES-OTHER PRGM COSTS APPRV	1, 697 0	0	53, 600 15, 170		10, 265 0	1
	300 MEDICAL LABORATORY SCIENTIST PRGM	0	0	6, 503		584	
23.01 023	302 PHARMACY PRGM	0	0	9, 140	0	147	
	301 EMERGENCY MEDICAL SERVICES 303 PARAMEDIC PRGM	0	0	12, 065 31, 393		11, 430 5, 183	
	PATIENT ROUTINE SERVICE COST CENTERS		0	51, 575	0	5, 105	23.03
	DOO ADULTS & PEDIATRICS	146, 780	52, 777	919, 852		146, 658	
	100 INTENSIVE CARE UNIT 060 NEONATAL INTENSIVE CARE UNIT	17, 970 12, 766	17, 827 5, 445	206, 602 85, 539		20, 019 8, 019	
	200 CORONARY CARE UNI T	41, 755	11, 735				
	400 SURGI CAL I NTENSI VE CARE UNI T	21, 267	8, 434	151, 601		26, 308	
	100 SUBPROVI DER – I RF 300 NURSERY	14, 098 3, 192	5, 071 3, 803	86, 600 16, 683		7, 355 2, 687	
ANG	CILLARY SERVICE COST CENTERS		0,000			2,00,	
	000 OPERATING ROOM 200 DELIVERY ROOM & LABOR ROOM	85, 929	0	354, 638		389, 088	
	400 RADI OLOGY-DI AGNOSTI C	21, 131 66, 849	0	76, 869 247, 282		11, 538 326, 917	
55.00 055	500 RADI OLOGY-THERAPEUTI C	124	0	37, 848	0	3, 161	55.00
	600 RADI OI SOTOPE 900 CARDI AC CATHETERI ZATI ON	848 21, 684	0	5, 695 58, 147		814, 539 19, 652	
	DOO LABORATORY	35, 394	0	20, 337		12, 667	
	400 I NTRAVENOUS THERAPY	9, 197	0	80, 518		74, 370	
	500 RESPI RATORY THERAPY 600 PHYSI CAL THERAPY	4, 946 8, 401	0	233, 788 130, 682		20, 430 18, 634	
	700 OCCUPATIONAL THERAPY	0,401	0				67.00
68.00 068	800 SPEECH PATHOLOGY	980	0	26, 158		2, 325	68.00
	900 ELECTROCARDI OLOGY 000 ELECTROENCEPHALOGRAPHY	11, 744 0	0	44, 025 43, 514		4, 700 8, 087	
	100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		35, 221, 482	
	200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	-	27, 956, 917	
	300 DRUGS CHARGED TO PATIENTS 400 RENAL DIALYSIS	03,821	0	14, 365	0	0 1, 509	
76.97 076	697 CARDI AC REHABI LI TATI ON	0	0	16, 629		6, 100	
	TPATIENT SERVICE COST CENTERS	24 (1(	0	105 050	0	20.010	90.00
	DOO CLINIC DOT IBMT JOINT VENTURE	24, 616 2, 500	0	195, 858 34, 378		28, 010 7, 168	
90.05 090	DO5 CV DI AGNOSTI C SERVI CES	0	0	269, 360	0	286, 361	90.05
	100 EMERGENCY 200 OBSERVATION BEDS (NON-DISTINCT PART	44, 009	0	235, 773	0	54, 984	91.00 92.00
92.00 092 OTH	HER REIMBURSABLE COST CENTERS						92.00
	100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
	ECIAL PURPOSE COST CENTERS 300 INTEREST EXPENSE						113.00
	600 HOSPI CE	0	0	151, 712	0	117, 025	
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	671, 359	105, 092	4, 504, 287		65, 782, 262	
	NREIMBURSABLE COST CENTERS	5, 352	0	15, 663	0	243, 484	190 00
	200 PHYSICIANS' PRIVATE OFFICES	4, 959	0	121, 504	-	109, 332	
194.00079	955 MARKETING & COMMUNITY RELATIONS	0	0	2, 421	0	0	194.00
	952 WOMEN'S CENTER 954 OTHER NRCC	2, 292 34, 110	0	4, 720 111, 272		6, 240 636, 217	194.01
	956 FOUNDATI ON	0	0	0			194.04
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00

Health Fina	ncial Systems ST. F	RANCIS HOSPITA	L & HEALTH CEN	TER	In Lie	u of Form CMS-2	2552-10
COST ALLOCA	ATION - STATISTICAL BASIS		Provider C		Peri od:	Worksheet B-1	
					From 01/01/2018 Fo 12/31/2018		pared: 7 am
	Cost Center Description	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	
		(SQUARE FEET)	(TOTAL PATI	(FTES)	ADMI NI STRATI O		
			ENT DAYS)		N	SUPPLY	
					(TOTAL PATI	(COSTED	
					ENT DAYS)	REQUIS.)	
		9.00	10.00	11.00	13.00	14.00	
202.00	Cost to be allocated (per Wkst. B, Part I)	8, 997, 844	1, 682, 933	5, 354, 67	7 11, 595, 241	6, 974, 302	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	12. 530560	16. 013902	1. 12496	110. 334193	0. 104441	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	434, 254	583, 429	886, 57	5 119, 130	2, 545, 302	204.00
205.00	Unit cost multiplier (Wkst. B, Part	0. 604750	5. 551602	0. 18626	1. 133578	0. 038116	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

R	In Lieu	」 of Form CMS-2552-10
15-0162	Period: From 01/01/2018 To 12/31/2018	Worksheet B-1 Date/Time Prepared: 5/31/2019 7:47 am

			T	o 12/31/2018	Date/Time Pre 5/31/2019 7:4	
		L.	I NTERNS &	RESI DENTS		
Cost Center Description	PHARMACY	MEDI CAL		SERVI CES-OTHE	MEDI CAL	
	(COSTED REQUIS.)	RECORDS & LI BRARY	RY & FRINGES APPRV	R PRGM COSTS APPRV	LABORATORY SCI ENTI ST	
	(Least of )	(GROSS	(ASSI GNED	(ASSI GNED	PRGM	
		CHARGES)	TIME)	TIME)	(ASSI GNED TI ME)	
	15.00	16.00	21.00	22.00	23.00	
GENERAL         SERVICE         COST         CENTERS           1.00         00100         CAP         REL         COSTS-BLDG & FIXT						1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP						2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 01 00570 ADMITTING						4.00 5.01
5. 02 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5.02
5. 03 00590 OTHER ADMIN & GENERAL 7. 00 00700 OPERATI ON OF PLANT						5.03 7.00
8.00 00800 LAUNDRY & LI NEN SERVI CE						8.00
9. 00 00900 HOUSEKEEPI NG						9.00
10. 00  01000  DI ETARY 11. 00  01100  CAFETERI A						10.00 11.00
13. 00 01300 NURSING ADMINISTRATION						13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY 15. 00 01500 PHARMACY	100					14.00 15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	0	2, 703, 478, 274				16.00
21.00 02100 I &R SERVICES-SALARY & FRINGES APPRV 22.00 02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0	2, 424	2, 424		21.00 22.00
23. 00 02200 MEDICAL LABORATORY SCIENTIST PRGM	0	0		2,424	100	22.00
23. 01 02302 PHARMACY PRGM	0	0				23.01
23. 02 02301 EMERGENCY MEDI CAL SERVI CES 23. 03 02303 PARAMEDI C PRGM	0	0				23.02 23.03
INPATIENT ROUTINE SERVICE COST CENTERS		1/5 000 500				
30. 00 03000 ADULTS & PEDI ATRI CS 31. 00 03100 I NTENSI VE CARE UNI T	0	165, 922, 528 28, 867, 111	1, 606		0	30.00 31.00
31. 01 02060 NEONATAL INTENSIVE CARE UNIT	0	23, 001, 709	23	23	0	31.01
32.00 03200 CORONARY CARE UNIT 34.00 03400 SURGI CAL I NTENSI VE CARE UNIT	0	27, 314, 375 23, 285, 917		-	0	32.00 34.00
41. 00 04100 SUBPROVIDER - IRF	0	12, 579, 222	0	0	0	41.00
43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	6, 024, 031	0	0	0	43.00
50. 00 05000 OPERATI NG ROOM	0	190, 463, 713			0	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM 54. 00 05400 RADI 0LOGY-DI AGNOSTI C	0	32, 011, 796 309, 604, 329		-	0	52.00 54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	56, 991, 265		0	0	55.00
56. 00 05600 RADI 0I SOTOPE 59. 00 05900 CARDI AC CATHETERI ZATI ON	0	8, 391, 684 114, 975, 983		-	0	56.00 59.00
60. 00 06000 LABORATORY	0	268, 731, 994	-	-	100	60.00
	0	22, 955, 492			0	64.00
65. 00  06500  RESPI RATORY THERAPY 66. 00  06600  PHYSI CAL THERAPY	0	64, 958, 011 38, 603, 501	23 200		0 0	65.00 66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	18, 478, 183			0	67.00
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	0	10, 078, 304 33, 676, 057			0	68.00 69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	18, 916, 695	0	0	0	70.00
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 72.00 07200 I MPL. DEV. CHARGED TO PATI ENTS	0	178, 212, 721 165, 795, 753	0	-	0	71.00 72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	100	510, 051, 485	0	-	0	73.00
74. 00 07400 RENAL DI ALYSI S 76. 97 07697 CARDI AC REHABI LI TATI ON	0	8, 258, 979 2, 538, 513			0	74.00 76.97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC 90. 01 09001 IBMT JOINT VENTURE	0	11, 153, 367 5, 449, 796			0	90. 00 90. 01
90. 05 09005 CV DI AGNOSTI C SERVI CES	0	64, 216, 703		-	0	90.01 90.05
91.00 09100 EMERGENCY	0	259, 938, 189	96	96	0	91.00
92.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART OTHER REI MBURSABLE COST CENTERS						92.00
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE						113.00
116.00 11600 HOSPI CE	0	22, 030, 868				116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	100	2, 703, 478, 274	2, 262	2, 262	100	118.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	-		190.00
192.00 19200 PHYSICLANS' PRIVATE OFFICES 194.00 07955 MARKETING & COMMUNITY RELATIONS	0	0	162 0			192.00 194.00
194.0107952WOMEN'S CENTER	o o	0	0	0	0	194.01
194.04 07954 0THER NRCC	0	0	0	0	0	194.04

# Health Financial Systems COST ALLOCATION - STATISTICAL BASIS

ST. FRANCIS HOSPITAL & HEALTH CENTER In Lieu of Form CMS-2552-10 Provider CCN: 15-0162 Period: Worksheet B-1

COST A	LLOCATION - STATISTICAL BASIS		Provider C		Period:	Worksheet B-1	
					From 01/01/2018 To 12/31/2018		
						5/31/2019 7:4	
				INTERNS 6	RESIDENTS		
	Cost Center Description	PHARMACY	MEDI CAL	SERVI CES-SALA	SERVI CES-OTHE	MEDI CAL	
	bost benter bescription	(COSTED	RECORDS &	RY & FRINGES		LABORATORY	
		REQUIS.)	LI BRARY	APPRV	APPRV	SCI ENTI ST	
		inizacitor ()	(GROSS	(ASSI GNED	(ASSI GNED	PRGM	
			CHARGES)	TIME)	TIME)	(ASSI GNED	
				,	,	TIME)	
		15.00	16.00	21.00	22.00	23.00	
194.05	07956 FOUNDATI ON	0	0	(	0 0	0	194.05
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00		12, 562, 749	332, 744	3, 261, 38	2, 383, 179	335, 038	202.00
	Part I)						
203.00	Unit cost multiplier (Wkst. B, Part I)	125, 627. 49000	0. 000123	1, 345. 45585	983. 159653	3, 350. 380000	203.00
		0					
204.00		677, 715	134	126, 93	3, 779	1, 365	204.00
205 00	Part II)	( 777 150000	0,000000	F2 2//74	1 550000	10 (50000	205 00
205.00		6, 777. 150000	0. 000000	52. 36674	1. 558993	13.650000	205.00
206.00	II) NAME adjustment amount to be all ecoted					0	206.00
200. UL	NAHE adjustment amount to be allocated (per Wkst. B-2)					0	200.00
207.00						0. 000000	207 00
207.00	Parts III and IV)					0.000000	207.00
		I I		1	1	1	1

Heal th Financial	Systems	
COST ALLOCATION		RΔ

ST. FRANCIS HOSPITAL & HEALTH CENTER In Lieu of Form CMS-2552-10 Provider CCN: 15-0162 Period: Worksheet B-1

Heal th	Financial Systems ST. I	FRANCIS HOSPITA	L & HEALTH CEN	TER	In Lie	eu of Form C	MS-2552-10
COST A	LLOCATION - STATISTICAL BASIS		Provider C	CN: 15-0162	Peri od:	Worksheet	B-1
					From 01/01/2018		Droparad
					To 12/31/2018	B Date/Time 5/31/2019	
	Cost Center Description	PHARMACY PRGM (ASSI GNED TIME)	EMERGENCY MEDI CAL SERVI CES (ASSI GNED TI ME)	PARAMEDI C PRGM (ASSI GNED TI ME)			
		23.01	23. 02	23.03			
	GENERAL SERVICE COST CENTERS	1		1			
11. 00 13. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00570 ADMITTING 00580 CASHIERING/ACCOUNTS RECEIVABLE 00590 OTHER ADMIN & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION						$\begin{array}{c} 1.00\\ 2.00\\ 4.00\\ 5.01\\ 5.02\\ 5.03\\ 7.00\\ 8.00\\ 9.00\\ 10.00\\ 11.00\\ 13.00\\ \end{array}$
15.00 16.00 21.00 22.00 23.00 23.01 23.02	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 02100 I&R SERVICES-SALARY & FRINGES APPRV 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 02300 MEDICAL LABORATORY SCIENTIST PRGM 02302 PHARMACY PRGM 02301 EMERGENCY MEDICAL SERVICES 02303 PARAMEDIC PRGM INPATIENT ROUTINE SERVICE COST CENTERS	100	100		00		14.00 15.00 16.00 21.00 22.00 23.00 23.01 23.02 23.03
30.00	03000 ADULTS & PEDIATRICS	0	0		0		30.00
	03100 INTENSIVE CARE UNIT	0	0		0		31.00
	02060 NEONATAL INTENSIVE CARE UNIT	0	0		0		31.01
	03200 CORONARY CARE UNI T	0	0		0		32.00
	03400 SURGI CAL I NTENSI VE CARE UNI T	0	0		0		34.00
	04100 SUBPROVIDER - IRF	0	0		0		41.00
43.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	0	I	0		43.00
50.00	05000 OPERATING ROOM	0	0		0		50.00
	05200 DELIVERY ROOM & LABOR ROOM	0	0		0		52.00
	05400 RADI OLOGY-DI AGNOSTI C	0	0		0		54.00
	05500 RADI OLOGY-THERAPEUTI C	0	0		0		55.00
	05600 RADI OI SOTOPE	0	0		0		56.00
	05900 CARDI AC CATHETERI ZATI ON	0	0		0		59.00
	06000 LABORATORY	0	0		0		60.00
64.00	06400 I NTRAVENOUS THERAPY	0	0		0		64.00
65.00	06500 RESPI RATORY THERAPY	0	0		0		65.00
	06600 PHYSI CAL THERAPY	0	0		0		66.00
	06700 OCCUPATI ONAL THERAPY	0	0		0		67.00
	06800 SPEECH PATHOLOGY	0	0		0		68.00
	06900 ELECTROCARDI OLOGY	0	0		0		69.00
	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0		70.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0		72.00
	07300 DRUGS CHARGED TO PATIENTS	100	0	1 1	00		73.00
	07400 RENAL DI ALYSI S	0	0		0		74.00
	07697 CARDI AC REHABI LI TATI ON	0	0		0		76.97
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLINIC	0	0		0		90.00
	09001 I BMT JOI NT VENTURE	0	0		0		90.01
	09005 CV DI AGNOSTI C SERVI CES	0	0		U		90.05
	09100 EMERGENCY	0	100		U		91.00
92. UU	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS			L			92.00
101 00	10100 HOME HEALTH AGENCY	0	0		0		101.00
101.00	SPECIAL PURPOSE COST CENTERS		0	1	<u> </u>		
113.00	11300 I NTEREST EXPENSE						113.00
116. 00 118. 00	11600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	0 100	0 100		0 00		116. 00 118. 00
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0		190.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	0	0		Ő		190.00
	07955 MARKETING & COMMUNITY RELATIONS		0		õ		192.00
	07952 WOMEN' S CENTER	0	0	1	0		194.00
	07954 OTHER NRCC	0	0	1	0		194.04
	07956 FOUNDATI ON	0	0	1	0		194.05
171.00		1		1	1		
200.00							200. 00 201. 00

#### Health Financial Systems COST ALLOCATION - STATISTICAL BASIS

### ST. FRANCIS HOSPITAL & HEALTH CENTER Provider CCN: 15-0162 Period:

In Lieu of Form CMS-2552-10 Worksheet B-1

					From 01/01/201 To 12/31/201	8 Date/Time Pr 5/31/2019 7:	
	Cost Center Description	PHARMACY PRGM	EMERGENCY	PARAMEDI C			
		(ASSI GNED	MEDI CAL	PRGM			
		TIME)	SERVI CES	(ASSI GNED			
			(ASSI GNED	TIME)			
			TIME)				
		23.01	23. 02	23.03			
202.00	Cost to be allocated (per Wkst. B, Part I)	843, 443	155, 991	384, 70	04		202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	8, 434. 430000	1, 559. 910000	3, 847. 04000	00		203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	2, 044	2, 740	6, 18	35		204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	20. 440000	27. 400000	61.85000	00		205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)	0	0		0		206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)	0. 000000	0. 000000	0. 00000	00		207.00

	TRANCIS HOSTITA					2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-0162	Period: From 01/01/2018 To 12/31/2018	Worksheet C Part I Date/Time Pre	nared
				10 12/31/2010	Date/Time Pre 5/31/2019 7:4	7 am
		Title	XVIII	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs		Total Costs	
	(from Wkst.	Adj.		Di sal I owance	10101 00313	
	B, Part I,	, naj .		bi sui i ondrice		
	col. 26)					
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
30. 00 03000 ADULTS & PEDI ATRI CS	75,006,350		75, 006, 3	50 8, 882	75, 015, 232	30.00
31. 00 03100 I NTENSI VE CARE UNI T	16, 358, 467		16, 358, 40		16, 358, 467	
31.01 02060 NEONATAL INTENSIVE CARE UNIT	8, 459, 084		8, 459, 08		8, 459, 084	
32.00 03200 CORONARY CARE UNIT	21, 581, 360		21, 581, 30		21, 581, 360	
34. 00 03400 SURGI CAL I NTENSI VE CARE UNI T	11, 835, 389		11, 835, 38		11, 835, 389	
41.00 04100 SUBPROVI DER - I RF	7, 340, 398		7, 340, 39		7, 340, 398	
43. 00 04300 NURSERY	1, 930, 720		1, 930, 72	20 0	1, 930, 720	43.00
ANCILLARY SERVICE COST CENTERS	1	1				
50. 00 05000 OPERATI NG ROOM	31, 918, 602		31, 918, 60		31, 918, 602	
52.00 05200 DELIVERY ROOM & LABOR ROOM	7, 367, 063		7, 367, 00		7, 367, 063	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	27, 806, 639		27, 806, 63		27, 806, 639	
55. 00 05500 RADI OLOGY-THERAPEUTI C	11, 362, 397		11, 362, 39	97 0	11, 362, 397	55.00
56. 00 05600 RADI OI SOTOPE	1, 648, 332		1, 648, 33	32 0	1, 648, 332	56.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	6, 309, 083		6, 309, 08	33 0	6, 309, 083	59.00
60. 00 06000 LABORATORY	30, 761, 922		30, 761, 92	17, 743	30, 779, 665	60.00
64.00 06400 INTRAVENOUS THERAPY	5, 614, 027		5, 614, 02	27 0	5, 614, 027	64.00
65. 00 06500 RESPI RATORY THERAPY	13, 532, 946				13, 538, 551	
66. 00 06600 PHYSI CAL THERAPY	10, 115, 812				10, 115, 812	66.00
67.00 06700 OCCUPATI ONAL THERAPY	2, 986, 798				2, 986, 798	
68.00 06800 SPEECH PATHOLOGY	1, 785, 604				1, 785, 604	
69. 00 06900 ELECTROCARDI OLOGY	3, 882, 680		3, 882, 68		3, 882, 680	
70. 00 07000 ELECTROENCEPHALOGRAPHY	3, 139, 761		3, 139, 70		3, 150, 971	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	47, 105, 766		47, 105, 76		47, 105, 766	
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	37, 390, 315		37, 390, 3		37, 390, 315	
73.00 07300 DRUGS CHARGED TO PATIENTS	81, 185, 635		81, 185, 63		81, 185, 635	
74.00 07400 RENAL DIALYSIS	1, 525, 382		1, 525, 38		1, 527, 146	
76. 97 07697 CARDI AC REHABI LI TATI ON	854, 875		854, 8	75 0	854, 875	76.97
	10 071 045		10 071 0		10 071 045	00.00
90. 00 09000 CLINIC	13, 371, 345		13, 371, 34		13, 371, 345	
90. 01 09001 I BMT JOI NT VENTURE	6, 716, 284		6, 716, 28		6, 716, 284	
90. 05 09005 CV DI AGNOSTI C SERVI CES	13, 670, 977		13, 670, 9		13, 670, 977	
91.00 09100 EMERGENCY	19, 256, 577		19, 256, 5		19, 262, 784	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	12, 825, 161		12, 825, 10	51	12, 825, 161	92.00
OTHER REIMBURSABLE COST CENTERS	-					
101.0010100 HOME HEALTH AGENCY	0			0	0	101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE						113.00
116.00 11600 HOSPI CE	11,035,125		11, 035, 12	25	11, 035, 125	
200.00 Subtotal (see instructions)	545, 680, 876	0	545, 680, 8	76 51, 411	545, 732, 287	200.00
201.00 Less Observation Beds	12, 825, 161		12, 825, 10	51	12, 825, 161	
202.00 Total (see instructions)	532, 855, 715					
					==	

Health Financial Systems ST.	FRANCIS HOSPITA	L & HEALTH CEN	ITER	In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-0162	Peri od:	Worksheet C	
				From 01/01/2018 To 12/31/2018	Part I	
				To 12/31/2018	Date/Time Pre	epared:
					5/31/2019 7:4	i am
			e XVIII	Hospi tal	PPS	
	1	Charges			TEEDA	
Cost Center Description	I npati ent	Outpati ent		6 Cost or Other	TEFRA	
			+ col. 7)	Ratio	Inpati ent	
	(	7 00	0.00		Ratio	
UNDATIONT DOUTING CEDVICE COST CENTEDS	6.00	7.00	8.00	9.00	10.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS           30. 00         03000         ADULTS & PEDI ATRI CS	100 115 500		100 115 50			200.00
	128, 115, 589		128, 115, 58			30.00
31.00 03100 INTENSIVE CARE UNIT	28, 867, 111		28, 867, 1			31.00
31.01 02060 NEONATAL INTENSIVE CARE UNIT	23, 001, 709		23, 001, 70			31.01
32.00 03200 CORONARY CARE UNIT	27, 314, 375		27, 314, 37			32.00
34.00 03400 SURGI CAL I NTENSI VE CARE UNI T	23, 285, 917		23, 285, 91			34.00
41.00 04100 SUBPROVIDER - IRF	12, 579, 222		12, 579, 22			41.00
43. 00 04300 NURSERY	6, 024, 031		6, 024, 03	31		43.00
ANCI LLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	109, 788, 512				0.00000	
52.00 05200 DELIVERY ROOM & LABOR ROOM	31, 918, 158				0.00000	
54.00 05400 RADI OLOGY-DI AGNOSTI C	86, 900, 559				0. 000000	
55. 00 05500 RADI OLOGY-THERAPEUTI C	1, 757, 753		56, 991, 26	0. 199371	0. 000000	
56. 00 05600 RADI OI SOTOPE	1, 791, 073				0. 000000	
59. 00 05900 CARDI AC CATHETERI ZATI ON	42, 589, 328	72, 386, 655	114, 975, 98	0. 054873	0. 000000	59.00
60. 00 06000 LABORATORY	112, 114, 668	156, 617, 326	268, 731, 99	0. 114471	0.00000	60.00
64.00 06400 INTRAVENOUS THERAPY	2, 380, 535	20, 574, 957	22, 955, 49	0. 244561	0. 000000	64.00
65. 00 06500 RESPI RATORY THERAPY	56, 676, 086	8, 281, 925	64, 958, 01	0. 208334	0.00000	65.00
66. 00 06600 PHYSI CAL THERAPY	17, 403, 430	21, 200, 071	38, 603, 50	0. 262044	0.00000	66.00
67.00 06700 OCCUPATI ONAL THERAPY	11, 672, 583	6, 805, 600	18, 478, 18	0. 161639	0. 000000	67.00
68.00 06800 SPEECH PATHOLOGY	4, 334, 714	5, 743, 590	10, 078, 30	0. 177173	0. 000000	68.00
69. 00 06900 ELECTROCARDI OLOGY	20, 692, 713	12, 983, 344	33, 676, 05	0. 115295	0.00000	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	3, 320, 992	15, 595, 703	18, 916, 69	0. 165978	0. 000000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	140,008,311	38, 204, 410			0. 000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	91, 181, 804	74, 613, 949	165, 795, 75	0. 225520	0. 000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	173, 196, 207	336, 855, 278			0.000000	
74.00 07400 RENAL DI ALYSI S	7, 854, 660				0.000000	
76. 97 07697 CARDI AC REHABI LI TATI ON	4, 021	2, 534, 492			0.000000	
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	496, 898	10, 656, 469	11, 153, 36	1. 198862	0. 000000	90.00
90. 01 09001 I BMT JOINT VENTURE	257, 161	5, 192, 635			0.000000	
90. 05 09005 CV DI AGNOSTI C SERVI CES	434, 299				0.000000	
91. 00 09100 EMERGENCY	65, 241, 831	194, 696, 358			0. 000000	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	6, 223, 128				0. 000000	
OTHER REIMBURSABLE COST CENTERS		.,				
101.00 10100 HOME HEALTH AGENCY	0	0	)	0		101.00
SPECIAL PURPOSE COST CENTERS						1
113.00 11300 INTEREST EXPENSE						1113.00
116. 00 11600 HOSPI CE	0	22, 030, 868	22, 030, 86	58		116.00
200.00 Subtotal (see instructions)	1, 237, 427, 378	1, 466, 050, 896	2.703.478.2			200.00
201.00 Less Observation Beds	., 20., .2., 0.0	.,,,,,,				201.00
202.00 Total (see instructions)	1, 237, 427, 378	1, 466, 050, 896	2, 703, 478, 27	74		202.00
	1 ., 20., 12,, 070	.,	1 = 1,000, 1,0,2	-1	1	

Health Financial Systems S	ST. FRANCIS HOSPITAL	& HEALTH CENTER	In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0162	Peri od:	Worksheet C	
			From 01/01/2018	Part I	
			To 12/31/2018	Date/Time Pre	epared:
		The Martin	11	5/31/2019 7:4	7 am
		Title XVIII	Hospi tal	PPS	
Cost Center Description	PPS Inpatient				
	Ratio				
	11.00		· · · · · · · · · · · · · · · · · · ·		
INPATIENT ROUTINE SERVICE COST CENTERS					1 00 00
30. 00 03000 ADULTS & PEDI ATRI CS					30.00
31.00 03100 INTENSIVE CARE UNIT					31.00
31.01 02060 NEONATAL INTENSIVE CARE UNIT					31.01
32.00 03200 CORONARY CARE UNIT					32.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT					34.00
41.00 04100 SUBPROVIDER - IRF					41.00
43. 00 04300 NURSERY					43.00
ANCI LLARY SERVI CE COST CENTERS					
50.00 05000 OPERATING ROOM	0. 167584				50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 230136				52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 089813				54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 199371				55.00
56. 00 05600 RADI OI SOTOPE	0. 196424				56.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 054873				59.00
60. 00 06000 LABORATORY	0. 114537				60.00
64.00 06400 INTRAVENOUS THERAPY	0. 244561				64.00
65. 00 06500 RESPI RATORY THERAPY	0. 208420				65.00
66.00 06600 PHYSI CAL THERAPY	0. 262044				66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 161639				67.00
68.00 06800 SPEECH PATHOLOGY	0. 177173				68.00
69.00 06900 ELECTROCARDI OLOGY	0. 115295				69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0. 166571				70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIEN	Г 0. 264323				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 225520				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 159171				73.00
74.00 07400 RENAL DIALYSIS	0. 184907				74.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 336762				76.97
OUTPATIENT SERVICE COST CENTERS	01000702				10177
90. 00 09000 CLINIC	1. 198862				90.00
90. 01 09001 I BMT JOI NT VENTURE	1. 232392				90.01
90. 05 09005 CV DI AGNOSTI C SERVI CES	0. 212888				90.05
91. 00 09100 EMERGENCY	0. 074105				91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PAR					92.00
OTHER REIMBURSABLE COST CENTERS	0. 337220				72.00
101.00 10100 HOME HEALTH AGENCY					101.00
SPECIAL PURPOSE COST CENTERS					101.00
113. 00 11300 I NTEREST EXPENSE					113.00
116. 00 11600 HOSPI CE					116.00
200.00 Subtotal (see instructions)					200.00
200.00 Subtotal (see instructions) 201.00 Less Observation Beds					200.00
201.00 Total (see instructions)					201.00
					202.00

	FRANCIS HUSPITA					2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2018 To 12/31/2018	Date/Time Pre	pared:
		T: +1		llaani tal	5/31/2019 7:4	7 am
			e XIX	Hospi tal	PPS	
Cont. Conton Deceniation	Tatal Cast	The second second second	Tatal Casta	Costs RCE	Tatal Casta	
Cost Center Description	Total Cost (from Wkst.	Therapy Limit Adj.	Total Costs	Di sal I owance	Total Costs	
	B, Part I,	Auj .		DISALLOWALICE		
	col. 26)					
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
30. 00 03000 ADULTS & PEDIATRICS	75,006,350		75,006,35	0 8, 882	75, 015, 232	30.00
31. 00 03100 I NTENSI VE CARE UNI T	16, 358, 467		16, 358, 46		16, 358, 467	
31.01 02060 NEONATAL INTENSIVE CARE UNIT	8, 459, 084		8, 459, 08		8, 459, 084	31.00
32.00 03200 CORONARY CARE UNIT	21, 581, 360		21, 581, 36		21, 581, 360	
34.00 03400 SURGICAL INTENSIVE CARE UNIT	11, 835, 389		11, 835, 38		11, 835, 389	
41. 00 04100 SUBPROVI DER – I RF	7, 340, 398		7, 340, 39		7, 340, 398	
43. 00 04300 NURSERY	1, 930, 720		1, 930, 72		1, 930, 720	
ANCI LLARY SERVICE COST CENTERS	1, 730, 720		1, 930, 72	0	1, 730, 720	45.00
50. 00 05000 OPERATI NG ROOM	31, 918, 602		31, 918, 60	2 0	31, 918, 602	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	7, 367, 063		7, 367, 06		7, 367, 063	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	27, 806, 639		27, 806, 63		27, 806, 639	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	11, 362, 397		11, 362, 39		11, 362, 397	
56. 00 05600 RADI OL SOTOPE	1, 648, 332		1, 648, 33		1, 648, 332	56.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	6, 309, 083		6, 309, 08		6, 309, 083	
60. 00 06000 LABORATORY	30, 761, 922		30, 761, 92		30, 779, 665	60.00
64.00 06400 INTRAVENOUS THERAPY	5, 614, 027		5, 614, 02		5, 614, 027	64.00
65. 00 06500 RESPIRATORY THERAPY	13, 532, 946				13, 538, 551	65.00
66. 00 06600 PHYSI CAL THERAPY	10, 115, 812				10, 115, 812	
67. 00 06700 OCCUPATI ONAL THERAPY	2, 986, 798				2, 986, 798	
68.00 06800 SPEECH PATHOLOGY	1, 785, 604		_,,		1, 785, 604	68.00
69. 00 06900 ELECTROCARDI OLOGY	3, 882, 680		3, 882, 68		3, 882, 680	
70. 00 07000 ELECTROENCEPHALOGRAPHY	3, 139, 761		3, 139, 76		3, 150, 971	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	47, 105, 766		47, 105, 76		47, 105, 766	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	37, 390, 315		37, 390, 31		37, 390, 315	
73. 00 07300 DRUGS CHARGED TO PATIENTS	81, 185, 635		81, 185, 63		81, 185, 635	
74. 00 07400 RENAL DIALYSIS	1, 525, 382		1, 525, 38		1, 527, 146	
76. 97   07697   CARDI AC REHABI LI TATI ON	854, 875		854, 87		854,875	
OUTPATIENT SERVICE COST CENTERS	054,075		054,07	5 0	034, 075	/0. 7/
90. 00 09000 CLINIC	13, 371, 345		13, 371, 34	5 0	13, 371, 345	90.00
90. 01 09000 CET M C 90. 01 09001 I BMT JOI NT VENTURE	6, 716, 284		6, 716, 28		6, 716, 284	90.00
90. 05 09005 CV DI AGNOSTI C SERVI CES	13, 670, 977		13, 670, 97		13, 670, 977	90.01
91. 00 09100 EMERGENCY	19, 256, 577		19, 256, 57		19, 262, 784	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	12, 825, 161		12, 825, 16		19, 202, 784	91.00
OTHER REIMBURSABLE COST CENTERS	12, 625, 101		12, 023, 10	1	12, 020, 101	92.00
101.00 10100 HOME HEALTH AGENCY	0			0	0	101.00
SPECIAL PURPOSE COST CENTERS	0			U	0	101.00
113. 00 11300 I NTEREST EXPENSE						113.00
116. 00 11600 HOSPI CE	11, 035, 125		11, 035, 12	5	11, 035, 125	•
200.00 Subtotal (see instructions)	545, 680, 876				545, 732, 287	
201.00 Less Observation Beds	12, 825, 161		12, 825, 16		12, 825, 161	
202.00 Total (see instructions)	532, 855, 715					
	552,055,715	1 0	552,055,71	51,411	552, 707, 120	202.00

COMPUTATION OF BATIO OF COSTS TO CHARGES         Provider CON: 15-0162         Period: From 01/01/2018 From 01/01/2018         Worksheet C To 12/31/2018         Worksheet C Dato/1 in proparod.           Image: Construction of the cost of the cos	Health Financial Systems ST.	FRANCIS HOSPITA	L & HEALTH CEN	ITER	In Lie	u of Form CMS-	2552-10
To         12/31/2018         Date Frequence           Cost Center Description         Inpatient         Outpatient         Total (col. n)         Cost or Other Ratio         TERA No.	COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-0162	Period:	Worksheet C	
Line         Title XIX         Hospital         PPS           Cost Center Description         Inpatient         Outpatient         Total (col. of each of the Ratio         Cost or Other Ratio         Inpatient           0.0         030.00         AUDIAL         6.00         7.00         8.00         9.00         10.00           30.0         03000 (AULTS & PEDIATRICS         128, 115, 589         128, 115, 589         30.00         30.00           31.0         03000 (AULTS & PEDIATRICS         128, 115, 589         128, 115, 589         30.00         31.01           30.0         030200 (CokOMAPC ARE UNIT         23, 001, 709         23, 201, 709         33.00         30.00           30.000 (SUBICAL INTENSIVE CARE UNIT         23, 205, 707         23, 285, 977         34, 00         44.00           04100 (SUBICAL INTERSIVE CARE UNIT         23, 285, 971         32.00         6.024, 031         43.00           05000 (PENDIATRIC ROOM         13, 978, 512         80, 475, 201         120, 41, 706         0.15784         0.000000 (S0.00           00         03000 (PENDIATRIC ROOM         13, 978, 512         80, 475, 201         120, 44, 370         0.000000 (S0.00         52.00           00         04000 (PENDIATRIC ROOM         13, 978, 512         80, 475, 201					From 01/01/2018	Part I	
Line         Title XIX         Hospital         PPS           Cost Center Description         Inpatient         Outpatient         Total (col. of each of the Ratio         Cost or Other Ratio         Inpatient           0.0         030.00         AUDIAL         6.00         7.00         8.00         9.00         10.00           30.0         03000 (AULTS & PEDIATRICS         128, 115, 589         128, 115, 589         30.00         30.00           31.0         03000 (AULTS & PEDIATRICS         128, 115, 589         128, 115, 589         30.00         31.01           30.0         030200 (CokOMAPC ARE UNIT         23, 001, 709         23, 201, 709         33.00         30.00           30.000 (SUBICAL INTENSIVE CARE UNIT         23, 205, 707         23, 285, 977         34, 00         44.00           04100 (SUBICAL INTERSIVE CARE UNIT         23, 285, 971         32.00         6.024, 031         43.00           05000 (PENDIATRIC ROOM         13, 978, 512         80, 475, 201         120, 41, 706         0.15784         0.000000 (S0.00           00         03000 (PENDIATRIC ROOM         13, 978, 512         80, 475, 201         120, 44, 370         0.000000 (S0.00         52.00           00         04000 (PENDIATRIC ROOM         13, 978, 512         80, 475, 201					To 12/31/2018	Date/Time Pre	epared:
Cost Center Description         Cost Center Description         Cost Center Description         Total (col. 6 (col. 7)         Cost or Other Ratio         TEFRA Inpatient Ratio         TEFRA Inpatient Ratio           0.00         03000 ADULTS & PEDIATRICS         128, 115, 589         128, 115, 589         30. 00         30. 00           30. 00         03000 ORNAWC CARE UNIT         28, 867, 111         28, 867, 111         28, 867, 111         31. 01           30. 00         03400 OSNBROW DERASH LINTENSI VE CARE UNIT         23, 301, 709         23, 201, 709         31. 01           31. 01         03400 OSMBROW DERASH LINTENSI VE CARE UNIT         23, 285, 917         23, 201, 709         34. 00           41. 00         04100 OSMBROW DERASH CE CAST CENTERS         6, 024, 031         40. 00         40300 MURSERY         6, 024, 031         90, 463, 71         0. 167584         0. 000000         50. 00           50. 00         05500 OPELIVERY ROMM & LABOR ROM         13, 158         93, 638         32, 011, 796         23.016         0. 000000         54. 00           50. 00         05500 OPELIVERY ROMM & LABOR ROM         13, 158         93, 643, 329         0. 08473         0. 000000         54. 00         0. 56400 RADIOCY-HIRAPEUTIC         1, 777, 753         55, 333, 512         56. 991, 704         0. 1144771         0. 000000 55. 00 </td <td></td> <td></td> <td></td> <td></td> <td>11</td> <td>5/31/2019 /: 4</td> <td>/ am</td>					11	5/31/2019 /: 4	/ am
Cost Center Description         Inpatient         Outpatient         Total (col 0)         Cost or Other Ratio         TEFRA Inpatient Ratio           INPATIENT ROUTINE SERVICE COST CENTERS         6.00         7.00         8.00         9.00         10.00         30.00           0.01000 DAULTS & PEDIATRICS         228.115.589         128.115.589         228.017.79         30.00 <td></td> <td></td> <td></td> <td>e XIX</td> <td>Hospital</td> <td>PPS</td> <td></td>				e XIX	Hospital	PPS	
INPATIENT ROUTINE SERVICE COST CENTERS         128.115.589         128.115.589         128.115.589         30.00         30.00           30.00         030001 ADULTS & PEDIATRICS         128.115.589         128.115.589         30.00         31.01           31.01         02000 ORNARY CARE UNIT         28.867.111         28.867.111         28.867.111         30.00           31.01         02000 ORNARY CARE UNIT         23.001.709         23.201.709         31.01           34.00         03400 SURGICAL INTENSIVE CARE UNIT         23.285.917         23.285.917         34.00           41.00         04100 ONUNSERY         6.024.031         6.024.031         41.00           43.00         04300 DELIVERY ROMM & LABOR ROOM         31.918         32.017.709         32.301.709           50.00         05500 OELIVERY ROMM & LABOR ROOM         31.918         58.03         32.017.708         32.014         0.000000 55.00           50.00         05600 CARDI ACCHITERS TURPERTIC         1.757.55         55.33.51         55.991.70         0.3216         0.000000 55.00           50.00         05600 CARDI ACCHITERPERTIC         1.777.753         55.33.51         55.991.0648.73         0.000000 55.00           50.00         05600 CARDI ACCHITERPERTIC         1.771.773         55.00         0.783.00 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
IMPATI ENT ROUTI NE SERVICE COST CENTERS         6.00         7.00         8.00         9.00         10.00           0.01         0.02000 AULTS & FEDIATRI CS         128, 115, 589         128, 115, 589         30.00         30.00           31.00         0.05000 CORONATAL INTENSIVE CARE UNIT         28, 867, 111         28, 867, 111         31.00           32.00         0.02000 CORONARY CARE UNIT         23, 301, 709         23, 001, 709         31.01           32.00         0.0100 NURSERY         ARE UNIT         23, 285, 917         23, 285, 917         34.00           41.00         0.0100 SUBFROVI DER         - EFE         12, 579, 222         41.00         43.00           0.00         052000 DEPERATING ROM         31.978, 158         93, 638         32, 011, 796         0.230316         0.000000         52.00           0.00         052000 DEPERATING ROM         31.978, 158         93, 638         32, 011, 796         0.230316         0.000000         55.00           0.00         05200 DELUSERY PROM & LABOR ROM         31.978, 158         93, 638         32, 011, 796         0.1967431         0.000000         55.00           0.00         05500 RADI OLOCY-THERAFUTIC         1.757, 753         52, 233, 512         56, 971, 295         0.199371         0.000000	Cost Center Description	Inpati ent	Outpati ent				
IMPACT ENT ROUTINE SERVICE COST CENTERS         6.00         7.00         8.00         9.00         10.00           30.00         03000 ADULTS & PEDIATRICS         128.115.589         30.00				+ col. 7)	Ratio		
INPART ENT ROUTI NE SERVICE COST CENTERS         128.115.589         128.115.589         28.667.111         30.00							
30:00       03000 ADULTS & PEDI ATRICS       128, 115, 589       128, 115, 589       30:00       31:00       31:01       110       031:01       01101       0260 NEONATAL INTENSIVE CARE UNIT       23, 867, 111       28, 867, 111       28, 867, 111       28, 867, 111       28, 867, 111       28, 867, 111       23, 200       31:00       30:00       30:00       30:00		6.00	7.00	8.00	9.00	10.00	
31:0.0       310.0       INTENSIVE CARE. UNIT       28, 667, 111       28, 667, 111       31.00         32:0.0       05000 KONATAL INTENSIVE CARE. UNIT       23, 300, 709       23, 300, 709       23, 300, 709       31.01         32:0.0       05000 CORONARY CARE UNIT       23, 285, 917       23, 285, 917       32, 300, 709       34.00         41:0.0       04100 SUBGROLL INTENSIVE CARE UNIT       23, 285, 917       23, 285, 917       34.00         43:0.0       05000 OPERATING ROOM       109, 788, 512       80, 675, 201       190, 463, 713       0.167584       0.000000       52.00         50:00       05000 OPERATING ROOM       319, 918, 158       93, 638       32, 011, 796       0.230136       0.000000       52.00         50:00       05400 RADI LOGY-THERAPEUTI C       1, 757, 753       55, 233, 512       56, 911, 26, 60, 911, 26, 50       0.999913       0.000000       55.00         05000 CRDI LOGY-THERAPEUTI C       1, 757, 753       55, 655       114, 975, 983       0.643, 29       0.999913       0.000000       55.00         05000 CRDI LOGY-THERAPEUTI C       1, 757, 753       55, 623, 512       56, 611, 475, 967       0.22, 903, 700       0.000000       65.00       0.00000       65.00       0.00000       65.00       0.000000       65.00       0.000				1		[	
31. 01       0260 MEONATAL INTENSIVE CARE UNIT       23. 001, 709       23. 001, 709       31. 01         32.00       03200 CORONARY CARE UNIT       23. 285, 917       23. 285, 917       32. 00         41. 00       04100 SUBPROVIDER - 1 RF       12, 579, 222       12, 579, 222       41. 00         41. 00       04100 OPERATING ROOM       109, 788, 512       80, 675, 201       90, 604, 32       0. 04000         50. 00       05000 OPERATING ROOM       109, 788, 512       80, 675, 201       190, 643, 713       0. 167584       0. 000000       52. 00         52. 00       05200 DELI VERY ROOM & LABOR ROOM       31, 918, 158       99, 644, 329       0. 08931       0. 000000       52. 00         55. 00       05500 RADI OLGOY-THERAPEUTIC       1, 757, 753       55, 233, 512       56, 991, 265       0. 199371       0. 000000       59, 00         50. 00       05500 CADI AC CATHETERI ZATI ON       42, 589, 328       72, 366, 655       114, 975, 983       0. 054873       0. 000000       64. 00         60. 00       6400 INTRAVENOUS THERAPY       2, 380, 535       20, 574, 957       22, 955, 492       0. 244561       0. 000000       64. 00         60. 00       6400 INTRAVENOUS THERAPY       12, 146, 68       156, 677, 326       266, 731, 944       0. 1147170 <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td></td<>							
32: 00       032:00       CROWARY CARE UNIT       27, 314, 375       27, 314, 375       32, 00         40: 00 300 SURGICAL INTENSIVE CARE UNIT       23, 285, 917       32, 205       32, 205       34, 00         41: 00       SURGICAL INTENSIVE CARE UNIT       23, 285, 917       12, 579, 222       12, 579, 222       41, 00         43: 00       04300       UINSERY       6, 024, 031       6, 024, 031       0, 463, 713       0, 167584       0, 000000         50: 00       05000       DELIVERY ROMM & LABOR ROM       31, 918, 158       93, 658       22, 703, 770       39, 604, 329       0, 089813       0, 000000       54. 00         50: 00       05000 RADI DLOGY-THERAPEUTIC       1, 757, 753       55, 523, 512       56, 912, 665       0, 199371       0, 000000       56. 00         50: 00       05000 RADI DLOGY-THERAPEUTIC       1, 791, 073       6, 600, 611       83, 911, 684       0, 199473       0, 000000       56. 00         60: 00       06000 LABORATORY       12, 114, 668       156, 617, 322       25, 55, 233, 11, 994       0, 114471       0, 000000       65. 00         60: 00       06000 LABORATORY       12, 314, 324       36, 600       18, 478, 813       0, 166398       0, 000000       65. 00         60: 00       06000 LABORATORY <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>31.00</td>							31.00
34.00       03400       SURCI CAL. INTENSIVE CARE. UNIT       23, 285, 917       23, 285, 917       34, 00       43, 00         41.00       04300       NURSPERV       6, 024, 031       6, 024, 031       43, 00         43.00       JANCILLARY SERVICE COST CENTERS       6, 024, 031       6, 024, 031       43, 00         50.00       OSC00       DELVERY ROOM & LABOR ROOM       119, 788, 512       80, 675, 201       190, 463, 713       0. 167584       0. 000000       52. 00         51.00       05000       DELVERY ROOM & LABOR ROOM       119, 788, 512       80, 675, 201       190, 463, 713       0. 167584       0. 000000       52. 00         52.00       05200       DELVERY ROOM & LABOR ROOM       119, 777, 753       55, 233, 512       56, 991, 265       0. 199371       0. 000000       56. 00         50.00       05600       RADI LOCY-THERAPEUTI C       1, 757, 753       55, 233, 512       56, 991, 265       0. 199371       0. 000000       56. 00         50.00       DEGOD LABORATORY       112, 114, 668       156, 617, 326       26, 873, 1994       0. 144741       0. 000000       66. 00         60.00       G6500       RESPI RATORY THERAPY       17, 672, 893       6, 805, 600       18, 478, 183       0. 161639       0. 000000       67. 00 </td <td>31.01 02060 NEONATAL INTENSIVE CARE UNIT</td> <td>23, 001, 709</td> <td></td> <td>23, 001, 70</td> <td>)9</td> <td></td> <td>31.01</td>	31.01 02060 NEONATAL INTENSIVE CARE UNIT	23, 001, 709		23, 001, 70	)9		31.01
41.00       04100       SUBPROVIDER - IRF       12, 579, 222       12, 579, 222       41.00         43.00       04300       05000       OPERATING ROM       109, 788, 512       80, 675, 201       190, 463, 713       0.167584       0.000000       50.00         50.00       05000       DELIVERY NOM & LABOR ROOM       31, 918, 158       93, 633       32, 011, 796       0.230136       0.000000       52.00         50.00       05400       RADI LOGY-DI AGNOSTIC       86, 900, 559       222, 703, 770       309, 604, 329       0.089813       0.000000       55.00         50.00       05600       RADI LOGY-THERAPEUTIC       1, 757, 753       52, 233, 512       56, 991, 266       0.99371       0.000000       55.00         50.00       05600       RADI LOGY-THERAPEUTIC       1, 791, 733       6, 600, 611       8, 91, 684       0.196424       0.000000       59.00         50.00       05600       RADI LOGY-THERAPEUTIC       1, 791, 733       6, 676, 086       8, 281, 925       64, 958, 011       0.02834       0.000000       65.00         60.00       6600       RESPI RATORY THERAPY       17, 403, 430       21, 92, 44, 95       0.14471       0.00000       66.00         60.00       0600       RESPI RATORY THERAPY       17, 40	32.00 03200 CORONARY CARE UNIT	27, 314, 375		27, 314, 37	75		32.00
43.00         04300         NURSERY         6,024,031         6,024,031         43.00           ANCILLARY SERVICE COST CENTERS	34.00 03400 SURGICAL INTENSIVE CARE UNIT	23, 285, 917		23, 285, 91	17		34.00
43.00         04300         NURSERY         6,024,031         6,024,031         43.00           ANCILLARY SERVICE COST CENTERS	41.00 04100 SUBPROVIDER - IRF	12, 579, 222		12, 579, 22	22		41.00
ANCILLARY SERVICE COST CENTERS         1 <th1< th="">         1         1         <th1< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td>43.00</td></th1<></th1<>							43.00
50. 00         05000 (DEERATING ROOM         109, 788, 512         80, 675, 201         190, 463, 713         0. 167564         0. 000000         52.00           52. 00         05200         DELI VERY ROOM & LABOR ROOM         31, 918, 158         93, 638         32, 011, 796         0. 230136         0. 000000         52.00           54. 00         05400         RADI OLGGY-THERAPEUTIC         1, 757, 753         55, 233, 512         56, 991, 265         0. 199371         0. 000000         55.00           55. 00         OS500         RADI OLGGY-THERAPEUTIC         1, 757, 753         55, 233, 512         56, 991, 265         0. 199371         0. 000000         55.00           50. 00         OS600         CADI AC CATHETERI ZATI ON         42, 589, 328         72, 386, 655         114, 975, 983         0. 054873         0. 000000         64.00           64. 00         06400         INTRAVENOUS THERAPY         56, 670, 086         8, 281, 925         64, 958, 011         0. 280344         0. 000000         65.00           65. 00         06500         PERCIP ATHORY THERAPY         11, 672, 583         64, 958, 011         0. 280344         0. 000000         67.00           67. 00         06700         OCUPATI ONAL, THERAPY         11, 672, 583         50, 100, 773.00         0.000000						1	
52.00         OS200         DELIVERY ROM & LABOR ROM         31,918,158         93,638         32,011,796         0.230136         0.000000         52.00           54.00         05400         RADI OLOGY-THERAPEUTIC         1,757,753         55,233,512         56,991,265         0.199371         0.000000         55.00           55.00         OS500         RADI OLOGY-THERAPEUTIC         1,757,753         55,233,512         56,991,265         0.199371         0.000000         56.00           50.00         OS500         CARDI AC CATHETERIZATI ON         42,589,328         72.386,655         114,975,893         0.05403         0.004000         56.00           60.00         GEOD RESPIRATORY         THERAPY         2,380,535         20,574,957         22,958,911         0.208324         0.000000         66.00           66.00         RESPIRATORY         THERAPY         74,03,430         21,200,711         38,603,501         0.262044         0.000000         66.00           66.00         66.00         RESPIRATORY         THERAPY         14,672,893         33,676,057         0.17529         0.000000         66.00           66.00         06600         RESPIRATORY         THERAPY         3.32,0921         15,557,03         18,616,695         0.15978 <td< td=""><td></td><td>109, 788, 512</td><td>80, 675, 201</td><td>190, 463, 7</td><td>0, 167584</td><td>0.00000</td><td>1 50.00</td></td<>		109, 788, 512	80, 675, 201	190, 463, 7	0, 167584	0.00000	1 50.00
54. 00       05400       RADI OLGCY-DIAGNOSTI C       86, 900, 559       322, 703, 770       309, 604, 329       0. 08913       0. 000000       55. 00         55. 00       05500       RADI OLGY-THERAPEUTI C       1, 757, 753       55, 233, 512       56, 991, 265       0. 199371       0. 000000       55. 00         56. 00       05600       RADI OLGY-THERAPEUTI C       1, 791, 073       6, 600, 611       8, 391, 684       0. 196424       0. 000000       55. 00         50. 00       05000       LABORTORY       112, 114, 668       156, 617, 326       268, 731, 994       0. 114471       0. 000000       66. 00         64. 00       06400       INTRAVENOUS THERAPY       2, 380, 535       20, 574, 957       22, 955, 492       0. 244561       0. 000000       66. 00         65. 00       06500       RESPI RATORY THERAPY       11, 612, 583       6, 805, 600       18, 478, 183       0. 161639       0. 000000       66. 00         67. 00       06700       0CUPATI ONAL THERAPY       11, 612, 583       6, 805, 600       18, 478, 183       0. 161639       0. 000000       67. 00         69. 00       690000       ELECTROCARDI OLGY       20, 692, 713       12, 983, 344       33, 676, 057       0. 115295       0. 000000       71. 00	52.00 05200 DELIVERY ROOM & LABOR ROOM						52.00
55.00       05500       RADI OLOCY-THERAPEUTI C       1, 757, 753       55, 233, 512       56, 991, 265       0. 199371       0. 000000       55.00         59.00       05000       CARDI AC CATHETER ZATI ON       42, 589, 328       72, 386, 655       114, 797, 983       0. 014424       0. 000000       56.00         60.00       LABDRATORY       112, 114, 668       156, 617, 326       268, 731, 994       0. 114471       0. 000000       60.00         64.00       OKOOU       INTRAVENUS       THERAPY       2, 380, 535       20, 574, 957       22, 955, 492       0. 244561       0. 000000       64.00         65.00       06500       RESPI RATORY THERAPY       17, 403, 430       21, 200, 071       38, 603, 501       0. 262044       0. 000000       65.00         66.00       06600       PHYSI CAL THERAPY       11, 672, 583       6, 805, 600       18, 478, 183       0. 161539       0. 000000       67.00         67.00       06000       CLECTROCARDI OLOGY       20, 692, 713       12, 983, 344       33, 676, 057       0. 115295       0.000000       69.00         68.00       06800       SPECH PATHOLOGY       4, 334, 714       5, 743, 590       10, 078, 304       0. 177173       0. 000000       70.00         71.00							
56.00       NADIOL SOTOPE       1,791,073       6,600,611       8,391,684       0.196424       0.00000       59.00         59.00       05900       CARDIA C CATHETERI ZATI ON       42,589,328       72,386,655       114,975,983       0.054873       0.000000       59.00         64.00       06400       LABORATORY       2,380,535       20,574,957       22,955,492       0.244561       0.000000       65.00         65.00       06500       RESPI RATORY THERAPY       56,676,086       8,281,925       64,958,011       0.208334       0.000000       65.00         66.00       06600       PHYSI CAL THERAPY       17,403,430       21,200,071       38,603,501       0.262044       0.000000       65.00         68.00       06900       SEECTROCARDI OLOGY       4,334,714       5,743,590       0.177173       0.000000       68.00         69.00       06900       ELECTROCARDI OLOGY       20,692,713       12,983,344       33,676,057       0.115295       0.000000       69.00         70.00       07000       ELECTROCARDI ALGRAPHY       3,320,992       15,595,703       18,916,695       0.165978       0.000000       71.00         71.00       07100       MEIGS CHARGED TO PATI ENTS       173,196,207       336,855,278       <							
59.00         CARDI AC CATHETERI ZATI ON         42, 589, 328         72, 386, 655         114, 975, 983         0.054873         0.000000         60.00           60.00         06000         LABORATORY         112, 114, 668         156, 617, 326         268, 731, 994         0.114471         0.000000         64.00           64.00         06400         INTRAVENOUS THERAPY         2, 380, 535         20, 574, 957         22, 955, 492         0.244561         0.000000         66.00           65.00         06500         PRST LAT THERAPY         56, 676, 086         8, 281, 925         64, 958, 011         0.262044         0.000000         66.00           66.00         06000         PHST CAL THERAPY         11, 672, 583         6, 805, 600         18, 478, 183         0.161639         0.000000         67.00           68.00         06900         ELECTROEACENDILOGY         4, 334, 714         5, 743, 597         10, 078, 304         0.177173         0.000000         69.00           71.00         07000         ELECTROEACENDILOGY         20, 692, 713         12, 983, 344         178, 212, 721         0.264323         0.000000         71.00           72.00         07200         IMPL         DEV <charged ents<="" pati="" td="" to="">         91, 1864         74, 613, 949         155, 795, 753</charged>							
60.00       06000       LABORATORY       112, 114, 668       156, 617, 326       268, 731, 994       0.114471       0.000000       64.00         64.00       06400       INTRAVENOUS THERAPY       2, 380, 535       20, 574, 957       22, 955, 492       0.244561       0.000000       64.00         65.00       06500       RESPI RATORY THERAPY       17, 403, 430       21, 200, 071       38, 603, 501       0.262044       0.000000       66.00         67.00       06700       OCUPATI ONAL THERAPY       11, 672, 583       6, 805, 600       18, 478, 183       0.161639       0.000000       67.00         69.00       06600       SPEECH PATHOLOGY       4, 334, 714       5, 743, 590       10, 078, 304       0.177173       0.000000       69.00         70.00       07000       ELECTROCARDI OLOGY       20, 692, 713       12, 983, 344       33, 676, 057       0.155978       0.000000       70.00         71.00       07100       MEDL CAL SUPPLIES CHARGED TO PATIENTS       171, 181, 804       74, 613, 949       165, 795, 753       0.225520       0.000000       72.00         73.00       07300       RUBA CRARGED TO PATIENTS       173, 196, 207       336, 855, 278       510, 051, 485       0.159717       0.000000       74.00         74.00 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
64.00       06400       INTRAVENOUS THERAPY       2, 380, 535       20, 574, 957       22, 955, 492       0.244561       0.000000       64.00         65.00       06500       RESPI RATORY THERAPY       56, 676, 086       8, 281, 925       64, 958, 011       0.2020334       0.000000       65.00         67.00       06700       OCCUPATI ONAL THERAPY       17, 403, 430       21, 200, 071       38, 603, 501       0.262044       0.000000       67.00         68.00       06800       SPEECH PATHOLOGY       4, 334, 714       57, 435, 500       10, 078, 304       0.177173       0.000000       68.00         69.00       6900       ELECTROENCERHALOGRAPHY       3, 320, 992       15, 595, 703       18, 916, 695       0.165978       0.000000       70.00         71.00       07100       MEDI CAL SUPPLIES CHARGED T0 PATI ENT       140, 008, 311       38, 204, 410       178, 212, 721       0.264323       0.000000       71.00         72.00       0700       INPL. DEV. CHARGED T0 PATI ENTS       173, 196, 207       336, 855, 278       510, 051, 485       0.159171       0.000000       73.00         74.00       07400       RENAL DI ALYSI S       7, 854, 660       404, 319       8, 258, 979       0.184694       0.000000       74.00 <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td></td<>							
65.00         06500         RESPI RATORY THERAPY         56, 676, 086         8, 281, 925         64, 958, 011         0.208334         0.000000         65.00           66.00         06600         PHYSI CAL THERAPY         17, 403, 430         21, 200, 071         38, 603, 501         0.262044         0.000000         66.00           67.00         06700         OCCUPATI ONAL THERAPY         11, 672, 583         6, 805, 600         18, 478, 183         0.161639         0.000000         67.00           68.00         SPECCH PATHOLOGY         4, 334, 714         5, 743, 590         10, 078, 304         0.177173         0.000000         68.00           69.00         ELECTROCARDIOLOGY         20, 692, 713         12, 983, 344         33, 676, 057         0.115295         0.000000         70.00           71.00         DEV. CHARGED TO PATI ENT         140, 008, 311         38, 204, 410         178, 212, 721         0.264323         0.000000         72.00           73.00         07300         DRUS CHARGED TO PATI ENTS         173, 196, 207         336, 855, 278         510, 051, 485         0.159171         0.000000         73.00           74.00         DAVO         RENAL DI ALYSI S         7, 854, 660         404, 319         8, 258, 979         0.184694         0.000000							
66.00       06600       PHYSI CAL THERAPY       17, 403, 430       21, 200, 071       38, 603, 501       0. 262044       0. 000000       66.00         67.00       0CCUPATI ONAL THERAPY       11, 672, 583       6, 805, 600       18, 478, 183       0. 161639       0. 000000       67.00         68.00       06900       ELECTROCARDI OLOGY       4, 334, 714       5, 743, 590       10, 078, 304       0. 177173       0. 000000       69.00         69.00       07000       ELECTROCARDI OLOGY       20, 692, 713       12, 983, 344       33, 676, 057       0. 115295       0. 000000       69.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENT       140, 008, 311       38, 204, 410       178, 212, 721       0. 245220       0. 000000       71.00         71.00       07200       IMUC. DEV. CHARGED TO PATI ENTS       91, 181, 804       74, 613, 949       165, 795, 753       0. 225520       0. 000000       72.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       91, 181, 804       74, 613, 949       165, 795, 753       0. 225520       0. 000000       74.00         74.00       07400       RNAL DI ALYSI S       7, 854, 660       404, 319       8, 258, 979       0. 184694       0. 000000       74.00         70							
67.00       06700       0CCUPATI ONAL THERAPY       11, 672, 583       6, 805, 600       18, 478, 183       0. 161639       0.000000       67.00         68.00       06800       SPECH PATHOLOGY       4, 334, 714       5, 743, 590       10, 078, 304       0. 177173       0.000000       68.00         69.00       06900       ELECTROCARDI OLOGY       20, 692, 713       12, 983, 344       33, 676, 057       0. 115295       0.000000       70.00         71.00       07000       ELECTROENCEPHALDGRAPHY       3, 320, 992       15, 595, 703       18, 916, 695       0. 165978       0.000000       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENT       140, 008, 311       38, 204, 410       178, 212, 721       0.264323       0.000000       72.00         73.00       07300       RUGS CHARGED TO PATI ENTS       91, 181, 804       74, 613, 949       165, 795, 753       0.225520       0.000000       74.00         74.00       07400       RENAL DI ALYSI S       7, 854, 660       404, 319       8, 258, 979       0. 184694       0.000000       74.00         76.97       CARDI AC REHABI LITATI ON       4, 021       2, 534, 492       2, 538, 513       0. 336762       0.000000       90.00         90.01       99000							
68.00       06800       SPEECH PATHOLOGY       4, 334, 714       5, 743, 590       10, 078, 304       0. 177173       0. 000000       68.00         69.00       06900       ELECTROCARDI OLOGY       20, 692, 713       12, 983, 344       33, 676, 057       0. 115295       0. 000000       69.00         71.00       07100       MEDICAL SUPPLIES CHARGED TO PATIENT       140, 008, 311       38, 204, 410       178, 212, 721       0. 264323       0.000000       71.00         72.00       07200 I IMPL. DEV. CHARGED TO PATIENTS       91, 181, 804       74, 613, 949       165, 795, 753       0. 225520       0.000000       72.00         73.00       07400       RENAL DI ALYSIS       173, 196, 207       336, 855, 278       510, 051, 485       0. 159171       0.000000       74.00         76.97       07407       CARDI AC REHABILI TATI 0N       4, 021       2, 534, 492       2, 538, 513       0. 336762       0.000000       74.00         90.00       09000       CLI NI C       496, 898       10, 656, 469       11, 153, 367       1.19862       0.000000       90.00         90.01       09001       IBMT JOI NT VENTURE       257, 161       5, 192, 635       5, 449, 796       1.232392       0.000000       90.01         90.01       09000 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
69.00       06900       ELECTROCARDIOLOGY       20,692,713       12,983,344       33,676,057       0.115295       0.000000       69.00         70.00       07000       ELECTROCARDIOLOGY       3,320,992       15,595,703       18,916,695       0.165978       0.000000       70.00         71.00       07100       MEDICAL SUPPLIES CHARGED TO PATIENT       140,008,311       38,204,410       178,212,721       0.264323       0.000000       72.00         73.00       07200       IMPL       D.V. CHARGED TO PATIENTS       91,181,804       74,613,949       165,795,753       0.225520       0.000000       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       173,196,207       336,855,278       510,051,485       0.159171       0.000000       74.00         76.97       CARDIA C REHABILITATION       4,021       2,534,492       2,538,513       0.336762       0.000000       90.00         90.00       09000       CLINIC       496,898       10,656,469       11,153,367       1.198862       0.000000       90.00         90.01       D9001       IBMT JOINT VENTURE       257,161       5,192,635       5,449,796       1.232392       0.000000       90.05         91.00       09100       EMERGENCY       65							
70.00         07000         ELECTROENCEPHALOGRAPHY         3, 320, 992         15, 595, 703         18, 916, 695         0. 165978         0. 000000         70.00           71.00         07100         MEDI CAL SUPPLIES CHARGED TO PATIENT         140, 008, 311         38, 204, 410         178, 212, 721         0. 264323         0. 000000         71.00           72.00         07200         IMPL. DEV. CHARGED TO PATIENTS         91, 181, 804         74, 613, 949         165, 795, 753         0. 225520         0. 000000         72.00           73.00         07400         RENAL DI ALYSIS         173, 196, 207         336, 855, 278         510, 051, 485         0. 15971         0. 000000         74.00           76.97         07697         CARDI AC REHABILI TATI ON         4, 021         2, 534, 492         2, 538, 513         0. 336762         0. 00000         76.97           0.01         09000         CLI NI C         496, 898         10, 656, 469         11, 153, 367         1. 198862         0.000000         90.00         90.00           90.01         09000         CLI NI C         496, 898         10, 656, 469         11, 153, 367         1. 198862         0.000000         90.00           90.05         09005         CV DI AGNOSTI C SERVI CES         434, 299         63, 782							
71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENT       140,008,311       38,204,410       178,212,721       0.264323       0.000000       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       91,181,804       74,613,949       165,795,753       0.225520       0.000000       72.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       173,196,207       336,855,278       510,051,485       0.159171       0.000000       74.00         74.00       07400       RENAL DI ALYSI S       7,854,660       404,319       8,258,979       0.184694       0.000000       74.00         70.00       O7400       RENAL DI ALYSI S       7,854,660       404,319       8,258,979       0.336762       0.000000       74.00         70.01       OT000       CLINI C       496,898       10,656,469       11,153,367       1.198862       0.000000       90.01         90.00       090001       LBMT JOINT VENTURE       257,161       5,192,635       5,449,796       1.232392       0.000000       90.01         91.00       09100       EMERGENCY       65,241,831       194,696,358       259,938,189       0.074081       0.000000       91.00         92.00       OSECI AL PURPOSE COST CENTERS       0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       91, 181, 804       74, 613, 949       165, 795, 753       0. 225520       0. 000000       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       173, 196, 207       336, 855, 278       510, 051, 485       0. 159171       0. 000000       73.00         74.00       07400       RENAL DI ALYSIS       7, 854, 660       404, 319       8, 258, 979       0. 184694       0. 000000       74.00         76.97       CARDI AC REHABILITATION       4, 021       2, 534, 492       2, 538, 513       0. 336762       0. 000000       74.00         90.00       OPODO CLINIC       496, 898       10, 656, 469       11, 153, 367       1. 198862       0. 000000       90.00         90.01       PODO CLINIC       496, 898       10, 656, 469       11, 153, 367       1. 198862       0. 000000       90.00         90.05       OPODO CLINIC       496, 898       10, 656, 469       11, 153, 367       1. 232392       0. 000000       90.00         91.00       09000       CLINIC       65, 241, 831       194, 696, 358       259, 938, 189       0. 074081       0.000000       91.00         92.00       DSERVATION BEDS (NON-DI STINCT PART       6, 223, 128       31, 583, 811       37,							
73.00       07300       DRUGS CHARGED TO PATIENTS       173, 196, 207       336, 855, 278       510, 051, 485       0. 159171       0. 000000       73.00         74.00       07400       RENAL DI ALYSI S       7, 854, 660       404, 319       8, 258, 979       0. 184694       0. 000000       74.00         76.97       CARDI AC REHABILITATION       4, 021       2, 534, 492       2, 538, 513       0. 336762       0. 000000       76.97         0UTPATIENT SERVICE COST CENTERS       496, 898       10, 656, 469       11, 153, 367       1. 198862       0. 000000       90.01         90.00       09000       CLINIC       496, 898       10, 656, 469       11, 153, 367       1. 232392       0. 000000       90.01         90.01       IBMT JOINT VENTURE       257, 161       5, 192, 635       5, 449, 796       1. 232392       0. 000000       90.01         90.05       CV DI AGNOSTI C SERVI CES       434, 299       63, 782, 404       64, 216, 703       0. 212888       0. 000000       91.00         91.00       09100       EMERGENCY       65, 241, 831       194, 696, 358       259, 938, 189       0. 074081       0. 000000       92.00         92.00       OBSERVATION BEDS (NON-DI STINCT PART       6, 223, 128       31, 583, 811       37, 806, 9		140, 008, 311					
74.00       07400       RENAL DI ALYSI S       7,854,660       404,319       8,258,979       0.184694       0.000000       74.00         76.97       07697       CARDI AC REHABI LI TATI ON       4,021       2,534,492       2,538,513       0.336762       0.000000       76.97         0UTPATI ENT SERVICE COST CENTERS       496,898       10,656,469       11,153,367       1.198862       0.000000       90.00         90.00       09001       IBMT JOI NT VENTURE       257,161       5,192,635       5,449,796       1.232392       0.000000       90.01         90.01       09005       CV DI AGNOSTI C SERVICES       434,299       63,782,404       64,216,703       0.212888       0.000000       90.05         91.00       O9005       CV DI AGNOSTI C SERVICES       65,241,831       194,696,358       259,938,189       0.074081       0.000000       91.00         92.00       0BSERVATION BEDS (NON-DI STINCT PART       6,223,128       31,583,811       37,806,939       0.339228       0.000000       92.00         92.00       DBSERVATION BEDS (NON-DI STINCT PART       6,223,128       31,583,811       37,806,939       0.339228       0.000000       92.00         91.00       10100       HOME HEALTH AGENCY       0       0       0		91, 181, 804	74, 613, 949	165, 795, 75			
76. 97         07697         CARDIAC REHABILITATION         4,021         2,534,492         2,538,513         0.336762         0.000000         76. 97           0UTPATIENT SERVICE COST CENTERS         00100         COOD         CLINIC         496,898         10,656,469         11,153,367         1.198862         0.000000         90.00         90.00         90001         IBMT JOINT VENTURE         257,161         5,192,635         5,449,796         1.232392         0.000000         90.01         90.01         9005         CV DI AGNOSTI C SERVICES         434,299         63,782,404         64,216,703         0.21288         0.000000         90.01         90.01         90.01         0         0.000000         91.00         90.01         0.000000         90.01         90.01         0.000000         91.00         0.000000         90.01         90.01         90.01         90.01         0.000000         90.01         90.01         90.01         90.01         90.01         90.000         90.01         90.01         90.01         90.01         90.01         90.01         90.01         90.01         90.01         90.01         90.00000         90.01         90.01         90.01         90.01         90.01         90.01         90.01         90         0.00000         90.010 <td>73.00 07300 DRUGS CHARGED TO PATIENTS</td> <td></td> <td></td> <td>510, 051, 48</td> <td>35 0. 159171</td> <td>0.000000</td> <td>73.00</td>	73.00 07300 DRUGS CHARGED TO PATIENTS			510, 051, 48	35 0. 159171	0.000000	73.00
76. 97         07697         CARDIAC REHABILITATION         4,021         2,534,492         2,538,513         0.336762         0.000000         76. 97           0UTPATIENT SERVICE COST CENTERS         00100         COOD         CLINIC         496,898         10,656,469         11,153,367         1.198862         0.000000         90.00         90.00         90001         IBMT JOINT VENTURE         257,161         5,192,635         5,449,796         1.232392         0.000000         90.01         90.01         9005         CV DI AGNOSTI C SERVICES         434,299         63,782,404         64,216,703         0.21288         0.000000         90.01         90.01         90.01         0         0.000000         91.00         90.01         0.000000         90.01         90.01         0.000000         91.00         0.000000         90.01         90.01         90.01         90.01         0.000000         90.01         90.01         90.01         90.01         90.01         90.000         90.01         90.01         90.01         90.01         90.01         90.01         90.01         90.01         90.01         90.01         90.00000         90.01         90.01         90.01         90.01         90.01         90.01         90.01         90         0.00000         90.010 <td>74.00 07400 RENAL DIALYSIS</td> <td>7,854,660</td> <td>404, 319</td> <td>8, 258, 97</td> <td>0. 184694</td> <td>0.000000</td> <td>74.00</td>	74.00 07400 RENAL DIALYSIS	7,854,660	404, 319	8, 258, 97	0. 184694	0.000000	74.00
90.00       09000       CLINIC       496,898       10,656,469       11,153,367       1.198862       0.000000       90.00         90.01       09001       IBMT JOINT VENTURE       257,161       5,192,635       5,449,796       1.232392       0.000000       90.01         90.05       09005       CV DIAGNOSTIC SERVICES       434,299       63,782,404       64,216,703       0.212888       0.000000       90.05         91.00       09100       EMERGENCY       65,241,831       194,696,358       259,938,189       0.074081       0.000000       91.00         92.00       092000       OBSERVATION BEDS (NON-DISTINCT PART       6,223,128       31,583,811       37,806,939       0.339228       0.000000       92.00         0THER REIMBURSABLE COST CENTERS       0       0       0       0       0       101.00         SPECIAL PURPOSE COST CENTERS       0       0       0       101.00       101.00       101.00         113.00       11300       INTEREST EXPENSE       0       22,030,868       22,030,868       22,030,868       21.00,00       116.00         200.00       Subtotal (see instructions)       1,237,427,378       1,466,050,896       2,703,478,274       200.00       201.00	76. 97 07697 CARDI AC REHABI LI TATI ON			2, 538, 51	0. 336762	0. 000000	76.97
90.01       09001       I BMT JOI NT VENTURE       257, 161       5, 192, 635       5, 449, 796       1. 232392       0. 000000       90. 01         90.05       09005       CV DI AGNOSTI C SERVI CES       434, 299       63, 782, 404       64, 216, 703       0. 212888       0. 000000       90. 05         91.00       09100       EMERGENCY       65, 241, 831       194, 696, 358       259, 938, 189       0. 074081       0. 000000       91. 00         92.00       0BSERVATI ON BEDS (NON-DI STINCT PART       6, 223, 128       31, 583, 811       37, 806, 939       0. 339228       0. 000000       92. 00         0THER REIMBURSABLE COST CENTERS       0       0       0       0       101.00       10100       HOME HEALTH AGENCY       0       0       0       101. 00         131.00       INTEREST EXPENSE       0       0       0       0       113. 00       116. 00         146.00       11600       HOSPI CE       0       22, 030, 868       22, 030, 868       22, 030, 868       200. 00       200. 00         200.00       Less Observati on Beds       1, 237, 427, 378       1, 466, 050, 896       2, 703, 478, 274       200. 00       201. 00	OUTPATIENT SERVICE COST CENTERS			·			
90.05       09005       CV DIAGNOSTIC SERVICES       434,299       63,782,404       64,216,703       0.212888       0.000000       90.05         91.00       09100       EMERGENCY       65,241,831       194,696,358       259,938,189       0.074081       0.000000       91.00         92.00       0BSERVATION BEDS (NON-DISTINCT PART       6,223,128       31,583,811       37,806,939       0.339228       0.000000       92.00         0THER       REIMBURSABLE COST CENTERS       0       0       0       0       101.00         10100       HOME       HEALTH       AGENCY       0       0       0       101.00         SPECIAL       PURPOSE COST CENTERS       113.00       INTEREST EXPENSE       113.00       113.00       113.00       113.00       116.00         113.00       11300       INTEREST EXPENSE       0       22,030,868       22,030,868       216.00       116.00         200.00       Subtotal (see instructions)       1,237,427,378       1,466,050,896       2,703,478,274       200.00       201.00	90. 00 09000 CLINIC	496, 898	10, 656, 469	11, 153, 36	57 1. 198862	0.000000	90.00
90.05       09005       CV DIAGNOSTIC SERVICES       434,299       63,782,404       64,216,703       0.212888       0.000000       90.05         91.00       09100       EMERGENCY       65,241,831       194,696,358       259,938,189       0.074081       0.000000       91.00         92.00       0BSERVATION BEDS (NON-DISTINCT PART       6,223,128       31,583,811       37,806,939       0.339228       0.000000       92.00         0THER       REIMBURSABLE COST CENTERS       0       0       0       0       101.00         10100       HOME       HEALTH       AGENCY       0       0       0       101.00         SPECIAL       PURPOSE COST CENTERS       113.00       INTEREST EXPENSE       113.00       113.00       113.00       113.00       116.00         113.00       11300       INTEREST EXPENSE       0       22,030,868       22,030,868       216.00       116.00         200.00       Subtotal (see instructions)       1,237,427,378       1,466,050,896       2,703,478,274       200.00       201.00	90.01 09001 IBMT JOINT VENTURE	257, 161	5, 192, 635	5, 449, 79	1, 232392	0. 000000	90.01
91.00       09100       EMERGENCY       65, 241, 831       194, 696, 358       259, 938, 189       0.074081       0.000000       91.00         92.00       0BSERVATION BEDS (NON-DISTINCT PART       6, 223, 128       31, 583, 811       37, 806, 939       0.339228       0.000000       92.00         0THER REIMBURSABLE COST CENTERS       0       0       0       0       0       0       101.00         10100       HOME HEALTH AGENCY       0       0       0       0       101.00       0       101.00         SPECI AL PURPOSE COST CENTERS       0       0       0       0       101.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       116.00       22, 030, 868       22, 030, 868       21.00       116.00         200.00       Subtotal (see instructions)       1, 237, 427, 378       1, 466, 050, 896       2, 703, 478, 274       200.00       201.00         201.00       Less Observation Beds       201.00       201.00       201.00       201.00       201.00							
92.00         09200         0BSERVATION BEDS (NON-DISTINCT PART         6,223,128         31,583,811         37,806,939         0.339228         0.000000         92.00           0THER REIMBURSABLE COST CENTERS         0							
OTHER         REI MBURSABLE         COST         CENTERS           101.00         10100         HOME         HEALTH         AGENCY         0         0         0         101.00           SPECIAL         PURPOSE         COST         CENTERS         113.00         11300         INTEREST         EXPENSE         113.00         11300         114600         HOSPICE         0         22,030,868         22,030,868         116.00         116.00           200.00         Subtotal         (see instructions)         1,237,427,378         1,466,050,896         2,703,478,274         200.00         201.00							
101.00         10100 HOME HEALTH AGENCY         0         0         0         101.00           SPECIAL PURPOSE COST CENTERS         113.00         11300 INTEREST EXPENSE         113.00         11300 HOSPICE         113.00         113.00         11300 HOSPICE         113.00         116.00         22,030,868         22,030,868         116.00         116.00         116.00         200.00         Subtotal (see instructions)         1,237,427,378         1,466,050,896         2,703,478,274         200.00         201.00		0,220,120	01,000,011	07,000,70	0.007220	0.00000	12.00
SPECIAL PURPOSE COST CENTERS           113.00         INTEREST EXPENSE           116.00         11600           10600         HOSPICE           00         22,030,868           200.00         Subtotal (see instructions)           11,237,427,378         1,466,050,896           201.00         Less Observation Beds		0	0		0		101 00
113.00       11300       INTEREST EXPENSE       113.00         116.00       11600       HOSPICE       0       22,030,868       22,030,868       116.00         200.00       Subtotal (see instructions)       1,237,427,378       1,466,050,896       2,703,478,274       200.00         201.00       Less Observation Beds       201.00       201.00       201.00		0		1			101.00
116.00         116.00         HOSPICE         0         22,030,868         22,030,868         116.00           200.00         Subtotal (see instructions)         1,237,427,378         1,466,050,896         2,703,478,274         200.00         201.00							112 00
200.00         Subtotal (see instructions)         1, 237, 427, 378         1, 466, 050, 896         2, 703, 478, 274         200.00           201.00         Less Observation Beds         1, 237, 427, 378         1, 466, 050, 896         2, 703, 478, 274         200.00				22.020.07			
201.00 Less Observation Beds 201.00				22, 030, 86			
		1, 237, 427, 378	1, 466, 050, 896	2, 703, 478, 2	/4		
202.00   10Tail (see instructions)   1,237,427,378  1,466,050,896  2,703,478,274    [202.00]		4 007 407 070		0 700 470 0			
	202.00   IOTAI (See Instructions)	1,237,427,378	1, 466, 050, 896	2, 703, 478, 2	/4		J202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CCN: 15-0162	Period: From 01/01/2018	Worksheet C Part I Date/Time Pre 5/31/2019 7:4	epared.
		Title XIX	Hospi tal	PPS	
Cost Center Description	PPS Inpatient				
	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS					30.00
31. 00 03100 I NTENSI VE CARE UNI T					31.00
31. 01 02060 NEONATAL INTENSIVE CARE UNIT					31.01
32. 00 03200 CORONARY CARE UNI T					32.00
34.00 03400 SURGI CAL I NTENSI VE CARE UNI T					34.00
41.00 04100 SUBPROVIDER - IRF					41.00
43.00 04300 NURSERY					43.00
ANCILLARY SERVICE COST CENTERS					
50. 00 05000 OPERATI NG ROOM	0. 167584				50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 230136				52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 089813				54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 199371				55.00
56. 00 05600 RADI OI SOTOPE	0. 196424				56.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 054873				59.00
60. 00 06000 LABORATORY	0. 114537				60.00
64. 00 06400 I NTRAVENOUS THERAPY	0. 244561				64.00
65. 00 06500 RESPIRATORY THERAPY	0. 208420				65.00
66. 00 06600 PHYSI CAL THERAPY	0. 262044				66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 161639				67.00
68. 00 06800 SPEECH PATHOLOGY	0. 177173				68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 115295				69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 166571				70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 264323				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 225520				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 159171				73.00
74. 00 07400 RENAL DI ALYSI S	0. 184907				74.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 336762				76.97
OUTPATIENT SERVICE COST CENTERS	0. 330702				10. 77
90. 00 09000 CLINIC	1. 198862				90.00
90. 01 09000 ELTING 90. 01 09001 I BMT JOI NT VENTURE	1. 232392				90.00
90. 05 09005 CV DI AGNOSTI C SERVI CES	0. 212888				90.01
91. 00 09100 EMERGENCY	0. 074105				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 339228				92.00
OTHER REIMBURSABLE COST CENTERS	0. 339220				92.00
101.00 10100 HOME HEALTH AGENCY					101.00
SPECIAL PURPOSE COST CENTERS					
113. 00 11300 INTEREST EXPENSE					113.00
116. 00/11600 H0SPI CE					116.00
200.00 Subtotal (see instructions)					200.00
201.00 Less Observation Beds					200.00
201.00 Total (see instructions)					201.00
	I				1202.00

ALCULATION OF OUTPATIENT SERVICE COST TO CHARGE R EDUCTIONS FOR MEDICAID ONLY	ATIOS NET OF	Provider C	CN: 15-0162	Period: From 01/01/2018	Worksheet C Part II	
				To 12/31/2018	Date/Time Pre 5/31/2019 7:4	epared:
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Total Cost	Capital Cost	Operating	Capi tal	Operating	
	(Wkst. B,	(Wkst. B,	Cost Net of	Reduction	Cost	
	Part I, col.	Part II col.	Capital Cos	t	Reducti on	
	26)	26)	(col. 1 -		Amount	
			col. 2)			
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVICE COST CENTERS	01.010.000	E 005 454	05 000 4	- 4		-
D. 00 05000 OPERATING ROOM	31, 918, 602				0	
2.00 05200 DELIVERY ROOM & LABOR ROOM	7, 367, 063				0	
4. 00 05400 RADI OLOGY-DI AGNOSTI C	27, 806, 639				0	
5. 00 05500 RADI OLOGY-THERAPEUTI C	11, 362, 397				0	
6. 00  05600  RADI OI SOTOPE 9. 00  05900  CARDI AC_CATHETERI ZATI ON	1, 648, 332				0	
0. 00 06000 LABORATORY	6, 309, 083				0	
4. 00 06400 I NTRAVENOUS THERAPY	30, 761, 922 5, 614, 027				0	
5. 00 06500 RESPIRATORY THERAPY	13, 532, 946				0	
5. 00 06600 PHYSI CAL THERAPY	10, 115, 812				0	
7. 00 06700 OCCUPATI ONAL THERAPY	2, 986, 798				0	
3. 00 06800 SPEECH PATHOLOGY	1, 785, 604				0	
2. 00 06900 ELECTROCARDI OLOGY	3, 882, 680				0	
0. 00 07000 ELECTROENCEPHALOGRAPHY	3, 139, 761	11, 355			0	
1. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	47, 105, 766				0	1
2. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	37, 390, 315				0	
3. 00 07300 DRUGS CHARGED TO PATIENTS	81, 185, 635				0	
4. 00 07400 RENAL DI ALYSI S	1, 525, 382				0	
5. 97 07697 CARDI AC REHABI LI TATI ON	854, 875				0	
OUTPATIENT SERVICE COST CENTERS						
D. 00 09000 CLINIC	13, 371, 345	1, 717, 623	11, 653, 7	22 0	0	90.0
D. 01 09001 I BMT JOI NT VENTURE	6, 716, 284			30 0	0	90.0
D. 05 09005 CV DI AGNOSTI C SERVI CES	13, 670, 977			75 0	0	90.0
1.00 09100 EMERGENCY	19, 256, 577	3, 121, 904	16, 134, 6	73 0	0	91.0
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	12, 825, 161		10, 983, 34	40 0	0	92.0
OTHER REIMBURSABLE COST CENTERS						
D1.00 10100 HOME HEALTH AGENCY	0	0		0 0	0	101.0
SPECIAL PURPOSE COST CENTERS						
13.00 11300 INTEREST EXPENSE						113.
16. 00 11600 HOSPI CE	11, 035, 125					116.
00.00 Subtotal (sum of lines 50 thru 199)	403, 169, 108					200. (
01.00 Less Observation Beds	12, 825, 161					201.0
D2.00 Total (line 200 minus line 201)	390, 343, 947	27, 319, 805	363, 024, 14	42 0	0	202.0

ALCULATION OF OUTPATIENT SERVICE COST TO CHARGE R	ATIOS NET OF	Provider C	CN: 15-0162		iod: m 01/01/2018	Worksheet C Part II	
EDUCTIONS FOR MEDICAID ONLY				To	12/31/2018	Date/Time Pr 5/31/2019 7:	epared 47 am
		Titl	e XIX		Hospi tal	PPS	
Cost Center Description	Cost Net of	Total Charges	Outpati ent				
	Capital and	(Worksheet C,	Cost to				
	Operati ng	Part I,	Charge Rati	0			
	Cost	column 8)	(col. 6 /				
	Reduction 6.00	7.00	col. 7) 8.00	_			
ANCI LLARY SERVICE COST CENTERS	6.00	7.00	8.00				
0. 00 05000 OPERATING ROOM	31, 918, 602	190, 463, 713	0. 1675	84			50.0
2. 00 05200 DELIVERY ROOM & LABOR ROOM	7, 367, 063						52.0
1. 00 05400 RADI OLOGY-DI AGNOSTI C	27, 806, 639						54.0
5. 00 05500 RADI OLOGY-THERAPEUTI C	11, 362, 397						55.0
5. 00 05600 RADI OI SOTOPE	1, 648, 332			24			56.0
9. 00 05900 CARDI AC CATHETERI ZATI ON	6, 309, 083						59.
0. 00 06000 LABORATORY	30, 761, 922						60.
1. 00 06400 I NTRAVENOUS THERAPY	5, 614, 027						64.
5. 00 06500 RESPI RATORY THERAPY	13, 532, 946						65.
5. 00 06600 PHYSI CAL THERAPY	10, 115, 812	38, 603, 501	0. 2620	44			66.
7.00 06700 OCCUPATI ONAL THERAPY	2, 986, 798			39			67.
3. 00 06800 SPEECH PATHOLOGY	1, 785, 604	10, 078, 304	0. 1771	73			68.
2. 00 06900 ELECTROCARDI OLOGY	3, 882, 680		0. 1152	95			69.
0. 00 07000 ELECTROENCEPHALOGRAPHY	3, 139, 761	18, 916, 695	0. 1659	78			70.
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	47, 105, 766	178, 212, 721	0. 2643	23			71.
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	37, 390, 315	165, 795, 753	0. 2255	20			72.
3. 00 07300 DRUGS CHARGED TO PATIENTS	81, 185, 635		0. 1591	71			73.
1.00 07400 RENAL DIALYSIS	1, 525, 382	8, 258, 979	0. 1846	94			74.
5. 97 07697 CARDIAC REHABILITATION	854, 875	2, 538, 513	0. 3367	62			76.
OUTPATIENT SERVICE COST CENTERS	-						
D. 00 09000 CLINIC	13, 371, 345						90.
D. 01 09001 I BMT JOI NT VENTURE	6, 716, 284						90.
0. 05 09005 CV DI AGNOSTI C SERVI CES	13, 670, 977						90.
I. 00 09100 EMERGENCY	19, 256, 577						91.
2. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	12, 825, 161	37, 806, 939	0. 3392	28			92.
OTHER REIMBURSABLE COST CENTERS	0	0	0,0000	00			101
01. 00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	0	0.0000	00			101.0
13. 00 11300 I NTEREST EXPENSE							113.
16. 00 11600 HOSPI CE	11, 035, 125	22, 030, 868	0. 5008	94			116.
00.00 Subtotal (sum of lines 50 thru 199)		2, 454, 290, 320					200.
01.00 Less Observation Beds	12, 825, 161						201.
D2.00 Total (line 200 minus line 201)		2, 454, 290, 320					202.

Health Financial Systems	ST. FRANCIS HOSPITA	L & HEALTH CEN	TER	In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CA	APITAL COSTS	Provider C		Period:	Worksheet D	
				From 01/01/2018 To 12/31/2018		narod
				10 12/31/2016	5/31/2019 7:4	7 am
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem	
	Related Cost	Adjustment	Capi tal	Days	(col. 3 /	
	(from Wkst.	-	Related Cost	-	col. 4)	
	B, Part II,		(col. 1 -			
	col . 26)		col. 2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS			1	-		
30. 00 ADULTS & PEDIATRICS	10, 772, 971		10, 772, 97		169. 22	
31.00 INTENSIVE CARE UNIT	1, 425, 950		1, 425, 950		79.99	
31.01 NEONATAL INTENSIVE CARE UNIT	929, 215		929, 21		170.65	
32.00 CORONARY CARE UNIT	3, 020, 391		3, 020, 39		257.38	
34.00 SURGICAL INTENSIVE CARE UNIT	1, 565, 695		1, 565, 69		185.64	
41.00 SUBPROVIDER - IRF	1, 023, 854		1, 023, 854		201.90	
43.00 NURSERY	248, 306		248, 30		65.29	
200.00 Total (lines 30 through 199)	18, 986, 382		18, 986, 38	2 115, 976		200.00
Cost Center Description	I npati ent	Inpati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x				
	( 00	col. 6)	-			
	6.00	7.00				
30.00 ADULTS & PEDIATRICS		2 050 040	1			30,00
	23, 348					
31.00 INTENSIVE CARE UNIT 31.01 NEONATAL INTENSIVE CARE UNIT	4, 485					31.00 31.01
31. OT INCONATAL INTENSIVE CARE UNIT 32. 00 CORONARY CARE UNIT	5, 808	-				31.01
34. 00 SURGICAL INTENSIVE CARE UNIT	4, 415		•			32.00
41. 00 SUBPROVIDER – IRF	2, 685		•			41.00
41.00 SUBPROVIDER - TRF 43.00 NURSERY	2,000	542, 102 0				41.00
200.00 Total (lines 30 through 199)	40, 741	0				200.00
200. OUTOTAL (TITLES SU THEOUGH 199)	40,741	1, 100, 270	1			1200.00

Health Financial Systems ST. I	FRANCIS HOSPITA	L & HEALTH CEN	ITER	In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT.	AL COSTS	Provider C		Period: From 01/01/2018 To 12/31/2018		
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col. 2)			
	col. 26)					
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS	1	1				
50.00 05000 OPERATING ROOM	5, 995, 151			7 42, 973, 247	1, 352, 669	
52.00 05200 DELIVERY ROOM & LABOR ROOM	1, 483, 659	32, 011, 796	0. 04634	7 151, 251	7,010	52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	4, 653, 053			9 39, 548, 945	594, 381	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	20, 341	56, 991, 265	0. 00035	57 0	0	55.00
56. 00 05600 RADI OI SOTOPE	91, 945	8, 391, 684	0. 01095	959, 539	10, 514	56.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	1, 506, 423	114, 975, 983	0. 01310		238, 514	59.00
60. 00 06000 LABORATORY	2, 433, 022	268, 731, 994	0. 00905	46, 879, 363	424, 446	60.00
64.00 06400 INTRAVENOUS THERAPY	645, 042	22, 955, 492	0. 02810	933, 614	26, 235	64.00
65. 00 06500 RESPI RATORY THERAPY	391, 812	64, 958, 011	0. 00603	23, 237, 460	140, 168	65.00
66. 00 06600 PHYSI CAL THERAPY	610, 572	38, 603, 501	0. 01581	6 6, 752, 897	106, 804	66.00
67.00 06700 OCCUPATI ONAL THERAPY	12, 192	18, 478, 183	0. 00066	4, 189, 176	2, 765	67.00
68.00 06800 SPEECH PATHOLOGY	72, 710	10, 078, 304	0. 00721	5 1, 506, 780	10, 871	68.00
69. 00 06900 ELECTROCARDI OLOGY	811, 540	33, 676, 057	0. 02409	9, 773, 768	235, 528	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	11, 355	18, 916, 695	0. 00060	1, 390, 697	834	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 375, 250	178, 212, 721	0. 00771	7 56, 531, 165	436, 251	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	1, 089, 418	165, 795, 753	0. 00657	41, 196, 111	270, 700	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	723, 695	510, 051, 485	0. 00141	9 64, 649, 629	91, 738	73.00
74.00 07400 RENAL DIALYSIS	265, 638	8, 258, 979	0. 03216	4, 106, 496	132, 081	74.00
76. 97 07697 CARDI AC REHABI LI TATI ON	3, 666	2, 538, 513	0. 00144	4 400	1	76.97
OUTPATIENT SERVICE COST CENTERS						1
90.00 09000 CLINIC	1, 717, 623	11, 153, 367	0. 15400	0 82, 897	12, 766	90.00
90. 01 09001 I BMT JOINT VENTURE	180, 204			6 16, 503		
90. 05 09005 CV DI AGNOSTI C SERVI CES	66, 502	64, 216, 703	0.00103	116, 964	121	90.05
91.00 09100 EMERGENCY	3, 121, 904			0 30, 853, 719	370, 553	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 841, 821			6 3, 139, 068	152, 923	92.00
200.00   Total (lines 50 through 199)		2, 432, 259, 452		397, 194, 073		

Health Financial Systems ST.	FRANCIS HOSPITA	AL & HEALTH CEN	ITER	In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER	PASS THROUGH COS	STS Provider C	CN: 15-0162	Peri od:	Worksheet D	
				From 01/01/2018	Part III	
				To 12/31/2018		epared:
					5/31/2019 7:4	17 am
·		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng	Nursi ng		h Allied Health	All Other	
	School	School	Post-Stepdow	n Cost	Medi cal	
	Post-Stepdown		Adjustments		Educati on	
	Adjustments				Cost	
	1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1				
30. 00 03000 ADULTS & PEDI ATRI CS	0	) 0		0 0	0	30.00
31. 00 03100 I NTENSI VE CARE UNI T	0	-		0 0	0	31.00
31. 01 02060 NEONATAL INTENSIVE CARE UNIT	0				0	
	0			0 0		
32.00 03200 CORONARY CARE UNIT	0			0 0	0	
34.00 03400 SURGI CAL I NTENSI VE CARE UNI T	0	0		0 0	0	
41.00 04100 SUBPROVIDER - IRF	0	0 0		0 0	0	
43. 00 04300 NURSERY	0	0		0 0	0	43.00
200.00 Total (lines 30 through 199)	0	0		0 0		200.00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patien	t Per Diem	I npati ent	
	Adjustment	(sum of cols.	Days	(col. 5 ÷	Program Days	
	Amount (see	1 through 3,		col. 6)		
		minus col. 4)				
	4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	0 0	63, 66	0. 00	23, 348	30.00
31. 00 03100 I NTENSI VE CARE UNI T			17,82			
31. 01 02060 NEONATAL INTENSIVE CARE UNIT			5, 44			
32. 00 03200 CORONARY CARE UNIT						
		0	11, 73			
34.00 03400 SURGI CAL I NTENSI VE CARE UNI T		0	8, 43			
41.00 04100 SUBPROVIDER - IRF	0	-	5, 07			•
43. 00 04300 NURSERY		0				
200.00 Total (lines 30 through 199)		0	115, 97	6	40, 741	200.00
Cost Center Description	I npati ent					
	Program					
	Pass-Through					
	Cost (col. 7					
	x col. 8)					
	9.00	1				
INPATIENT ROUTINE SERVICE COST CENTERS					-	
30. 00 03000 ADULTS & PEDI ATRI CS	0					30.00
31. 00 03100 I NTENSI VE CARE UNI T	0					31.00
31. 01 02060 NEONATAL INTENSIVE CARE UNIT						31.00
	0					
32.00 03200 CORONARY CARE UNIT	0					32.00
34.00 03400 SURGI CAL I NTENSI VE CARE UNI T	0					34.00
41. 00 04100 SUBPROVI DER – I RF	0					41.00
43. 00 04300 NURSERY	0					43.00
200.00 Total (lines 30 through 199)	0					200.00
-						

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS	VICE OTHER PAS		CN: 15-0162	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part IV	
	Non Physician	Titlo		10 12/31/2018	Date/Time Pre 5/31/2019 7:4	
	Non Physician		XVIII	Hospi tal	PPS	
Cost Center Description			Nursing	Allied Health		
	Anesthetist	School	School	Post-Stepdown		
	Cost	Post-Stepdown		Adjustments		
		Adjustments				
	1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0		0 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0 0	0	55.00
56. 00 05600 RADI OI SOTOPE	0	0		0 0	0	56.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0	59.00
60. 00 06000 LABORATORY	0	0		0 0	335, 038	60.00
64.00 06400 INTRAVENOUS THERAPY	0	0		0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
66.00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	1, 228, 147	73.00
74.00 07400 RENAL DI ALYSI S	0	0		0 0	0	74.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0 0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	0		0 0	0	90.00
90. 01 09001 I BMT JOI NT VENTURE	0	0		0 0	0	90.01
90. 05 09005 CV DI AGNOSTI C SERVI CES	0	0		0 0	0	90.05
91. 00 09100 EMERGENCY	0	0		0 0	155, 991	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0	0	92.00
200.00 Total (lines 50 through 199)	0	0		0 0	1, 719, 176	200.00

Health Financial Systems ST. F	RANCIS HOSPITA	L & HEALTH CEN	TER	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SET THROUGH COSTS	RVICE OTHER PAS	S Provider C		Period: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Pre 5/31/2019 7:4	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
	Educati on	1, 2, 3, and	Cost (sum of	C, Part I,	(col. 5 ÷	
	Cost	4)	col s. 2, 3,	col. 8)	col. 7)	
			and 4)			
	4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0		0 190, 463, 713	0.00000	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 32, 011, 796	0.00000	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 309, 604, 329	0.00000	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0 56, 991, 265	0.00000	55.00
56. 00 05600 RADI OI SOTOPE	0	0		0 8, 391, 684	0.00000	56.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 114, 975, 983	0.000000	59.00
60. 00 06000 LABORATORY	0	335, 038	335, 03	8 268, 731, 994	0.001247	60.00
64.00 06400 INTRAVENOUS THERAPY	0	0		0 22, 955, 492	0.000000	64.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 64, 958, 011	0.000000	65.00
66.00 06600 PHYSI CAL THERAPY	0	0		0 38, 603, 501	0.000000	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 18, 478, 183	0.000000	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 10, 078, 304	0.000000	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 33, 676, 057	0.000000	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 18, 916, 695	0.000000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 178, 212, 721	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 165, 795, 753	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	1, 228, 147	1, 228, 14	7 510, 051, 485	0.002408	73.00
74.00 07400 RENAL DIALYSIS	0	0		0 8, 258, 979	0.000000	74.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0 2, 538, 513	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS				- <b>-</b>		1
90. 00 09000 CLINIC	0	0		0 11, 153, 367	0.000000	90.00
90. 01 09001 I BMT JOI NT VENTURE	0	0		0 5, 449, 796	0.000000	90.01
90. 05 09005 CV DI AGNOSTI C SERVI CES	0	0		0 64, 216, 703	0.000000	90.05
91.00 09100 EMERGENCY	0	155, 991	155, 99		0.000600	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0 37, 806, 939	0.000000	92.00
200.00 Total (lines 50 through 199)	0	1, 719, 176	1, 719, 17	6 2, 432, 259, 452		200.00
						-

Health Financial Systems ST.	FRANCIS HOSPITAL	& HEALTH CEN	TER	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	Provider C		Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2018		
				To 12/31/2018	Date/Time Pre 5/31/2019 7:4	pared: 7 am
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Outpati ent	I npati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	Charges	Pass-Through	
	(col. 6 ÷		Costs (col.	8	Costs (col. 9	
	col. 7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS			1			
50.00 05000 OPERATING ROOM	0. 000000	42, 973, 247		0 19, 625, 413		
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	151, 251		0 0	-	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	39, 548, 945		0 61, 392, 005		54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	0		0 21, 858, 515	0	55.00
56. 00 05600 RADI OI SOTOPE	0. 000000	959, 539		0 1, 796, 940	0	56.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	18, 204, 384		0 26, 333, 630	0	59.00
60. 00 06000 LABORATORY	0. 001247	46, 879, 363	58, 45	9 19, 798, 615	24, 689	60.00
64.00 06400 INTRAVENOUS THERAPY	0. 000000	933, 614		0 6, 385, 566	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	23, 237, 460		0 2, 081, 868	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	6, 752, 897		0 190, 332	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	4, 189, 176		0 94, 436	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	1, 506, 780		0 57, 892	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	9, 773, 768		0 3, 845, 913	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	1, 390, 697		0 2, 695, 606	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	56, 531, 165		0 22, 214, 347	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	41, 196, 111		0 12, 648, 865	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.002408	64, 649, 629	155, 67	6 132, 106, 187	318, 112	73.00
74.00 07400 RENAL DI ALYSI S	0. 000000	4, 106, 496		0 180, 314	0	74.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000	400		0 968, 040	0	76.97
OUTPATIENT SERVICE COST CENTERS	· ·					1
90. 00 09000 CLI NI C	0.000000	82, 897		0 3, 470, 608	0	90.00
90. 01 09001 I BMT JOINT VENTURE	0. 000000	16, 503		0 470, 642	0	90.01
90. 05 09005 CV DI AGNOSTI C SERVI CES	0. 000000	116, 964		0 23, 580, 725	0	90.05
91. 00 09100 EMERGENCY	0. 000600	30, 853, 719	18, 51	2 33, 165, 849	19, 900	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	3, 139, 068		0 5, 146, 123	0	92.00
200.00 Total (lines 50 through 199)		397, 194, 073	232, 64	7 400, 108, 431	362, 701	200.00

Heal th Financia			L & HEALTH CEN		In Lie	u of Form CMS-2	2552-10
APPORTI ONMENT	OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C		Period:	Worksheet D	
					From 01/01/2018 To 12/31/2018	Part V Date/Time Pre	nared
					10 12/31/2010	5/31/2019 7:4	17 am
			Title	XVIII	Hospi tal	PPS	
				Charges		Costs	
Со	ost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
		Charge Ratio	Rei mbursed	Reimbursed	Reimbursed	(see inst.)	
		From	Services (see	Servi ces	Services Not		
		Worksheet C,	inst.)	Subject To	Subject To		
		Part I, col.		Ded. & Coins.	Ded. & Coins.		
		9	0.00	(see inst.)	(see inst.)	F 00	
		1.00	2.00	3.00	4.00	5.00	
	RY SERVICE COST CENTERS	0. 167584	19, 625, 413	1	0 0	3, 288, 905	50.00
	ELIVERY ROOM & LABOR ROOM				-		
	ADI OLOGY-DI AGNOSTI C	0. 230136 0. 089813			0 0 0 0	0 E E12 000	
	ADI OLOGY-DI AGNOSTI C	0. 199371			0 0	5, 513, 800	
	ADI OLOGY - THERAPEOTIC	0. 199371			0 0	4, 357, 954 352, 962	
	ARDI AC CATHETERI ZATI ON	0. 198424			0 0	1, 445, 005	
	ABORATORY	0. 114471			0 0	2, 266, 367	
	TRAVENOUS THERAPY	0. 244561			0 0	1, 561, 660	
	ESPIRATORY THERAPY	0. 208334			0 0	433, 724	
	IYSI CAL THERAPY	0. 262044			0 0	49,875	
	CCUPATIONAL THERAPY	0. 161639			0 0	15, 265	
	PEECH PATHOLOGY	0. 177173			0 0	10, 257	
	LECTROCARDI OLOGY	0. 115295			0 0	443, 415	
	LECTROENCEPHALOGRAPHY	0. 165978			0 0	447, 411	
	EDICAL SUPPLIES CHARGED TO PATIENT	0. 264323				5, 871, 763	
	MPL. DEV. CHARGED TO PATIENTS	0. 225520			0 0	2, 852, 572	
	RUGS CHARGED TO PATIENTS	0. 159171			0 166, 138	21, 027, 474	
	ENAL DI ALYSI S	0. 184694			0 0	33, 303	
76.97 07697 CA	ARDI AC REHABI LI TATI ON	0. 336762			0 0	325, 999	76.97
OUTPATI E	ENT SERVICE COST CENTERS						1
90.00 09000 CL	LINIC	1. 198862	3, 470, 608		0 0	4, 160, 780	90.00
90.01 09001 I B	BMT JOINT VENTURE	1. 232392	470, 642		0 0	580, 015	90.01
90.05 09005 CV	/ DIAGNOSTIC SERVICES	0. 212888	23, 580, 725		0 0	5, 020, 053	90.05
91.00 09100 EM		0. 074081	33, 165, 849		0 13, 950	2, 456, 959	91.00
92.00 09200 OB	SSERVATION BEDS (NON-DISTINCT PART	0. 339228	5, 146, 123		0 0	1, 745, 709	92.00
200. 00 Su	ubtotal (see instructions)		400, 108, 431	1, 10	4 180, 088	64, 261, 227	200.00
201.00 Le	ess PBP Clinic Lab. Services-Program				0 0		201.00
	nly Charges						
202.00 Ne	et Charges (line 200 - line 201)		400, 108, 431	1, 10	4 180, 088	64, 261, 227	202.00

Health Financial Systems ST.	FRANCIS HOSPITA	L & HEALTH CEN	TER	In Lieu	」of Form CMS-25	552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	D VACCINE COST	Provider C	CN: 15-0162	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part V Date/Time Prepa 5/31/2019 7:47	ared: am
		Title	XVIII	Hospi tal	PPS	
	Cos					
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.					
	(see inst.) 6.00	(see inst.) 7.00	-			
ANCILLARY SERVICE COST CENTERS	0.00	7.00				
50. 00 05000 OPERATI NG ROOM	0	0			F	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0				52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0				55.00
56. 00 05600 RADI 0I SOTOPE	0	0				56.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0				59.00
60. 00 06000 LABORATORY	0	0				60.00
64.00 06400 INTRAVENOUS THERAPY	0	0				64.00
65. 00 06500 RESPI RATORY THERAPY	0	0			6	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0				66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0			6	67.00
68.00 06800 SPEECH PATHOLOGY	0	0			6	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0				69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0				70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	292	0				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	26, 444	1			73.00
74.00 07400 RENAL DI ALYSI S	0	0				74.00
76. 97 O7697 CARDI AC REHABI LI TATI ON	0	0				76.97
	0	0	1			00.00
90. 00 09000 CLINIC 90. 01 09001 IBMT JOINT VENTURE	0	0	1			90.00
90. 01 09001 I BMT JOINT VENTURE 90. 05 09005 CV DI AGNOSTI C SERVI CES	0	0	•			90. 01 90. 05
90. 05 09005 CV DIAGNOSTIC SERVICES 91. 00 09100 EMERGENCY		1, 033				90.05 91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	1,033				91.00
200.00 Subtotal (see instructions)	292	27, 477				92.00
201.00 Less PBP Clinic Lab. Services-Program	272	27,477				01.00
Only Charges					20	01.00
202.00 Net Charges (line 200 - line 201)	292	27, 477			20	02.00
	1				1	

Health Financial Systems ST. I	RANCIS HOSPITA	L & HEALTH CEN	TER	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider C	CN: 15-0162	Peri od:	Worksheet D	
				From 01/01/2018		
		Component	CCN: 15-T162	To 12/31/2018	Date/Time Pre 5/31/2019 7:4	pared: 7 am
		Title	XVIII	Subprovider -	PPS	
				I RF		
Cost Center Description	Capi tal	Total Charges			Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col. 2)			
	col. 26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	5, 995, 151	190, 463, 713			1, 309	
52.00 05200 DELIVERY ROOM & LABOR ROOM	1, 483, 659	32, 011, 796			0	52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	4, 653, 053	309, 604, 329				•
55. 00 05500 RADI OLOGY-THERAPEUTI C	20, 341	56, 991, 265			0	55.00
56. 00 05600 RADI OI SOTOPE	91, 945	8, 391, 684			64	56.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	1, 506, 423	114, 975, 983			0	59.00
60. 00 06000 LABORATORY	2, 433, 022	268, 731, 994			6, 408	
64.00 06400 INTRAVENOUS THERAPY	645, 042	22, 955, 492			0	
65. 00 06500 RESPI RATORY THERAPY	391, 812	64, 958, 011	0. 00603			
66. 00 06600 PHYSI CAL THERAPY	610, 572	38, 603, 501	0. 01581	6 1, 766, 222	27, 935	66.00
67.00 06700 OCCUPATI ONAL THERAPY	12, 192	18, 478, 183	0. 00066	0 1, 565, 025	1, 033	67.00
68.00 06800 SPEECH PATHOLOGY	72, 710	10, 078, 304	0.00721	5 792, 676	5, 719	68.00
69. 00 06900 ELECTROCARDI OLOGY	811, 540	33, 676, 057	0. 02409	60, 917	1, 468	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	11, 355	18, 916, 695	0. 00060	9, 348	6	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 375, 250	178, 212, 721	0.00771	7 872, 682	6, 734	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	1, 089, 418	165, 795, 753	0.00657	/1 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	723, 695	510, 051, 485	0.00141	9 1, 024, 435	1, 454	73.00
74.00 07400 RENAL DI ALYSI S	265, 638	8, 258, 979	0. 03216	229, 825	7, 392	74.00
76. 97 07697 CARDI AC REHABI LI TATI ON	3, 666	2, 538, 513	0.00144	4 0	0	76.97
OUTPATIENT SERVICE COST CENTERS			•			
90. 00 09000 CLI NI C	1, 717, 623	11, 153, 367	0. 15400	0 0	0	90.00
90. 01 09001 I BMT JOI NT VENTURE	180, 204	5, 449, 796	0. 03306	0 0	0	90.01
90. 05 09005 CV DI AGNOSTI C SERVI CES	66, 502	64, 216, 703	0.00103	36 0	0	90.05
91.00 09100 EMERGENCY	3, 121, 904	259, 938, 189		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	37, 806, 939	0.00000	0 0	0	92.00
200.00 Total (lines 50 through 199)	27, 282, 717	2, 432, 259, 452		8, 025, 421	69, 358	•
					-	

Health Financial Systems ST.	FRANCIS HOSPITA	AL & HEALTH CEN	TER		In Lieu	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY S	ERVICE OTHER PAS	SS Provider C	CN: 15-0162	Peri		Worksheet D	
THROUGH COSTS		Component	CCN: 15-T162	Fror	m 01/01/2018 12/31/2018		narod
		component	CCN: 15-1162	10	12/31/2018	5/31/2019 7:4	7 am
		Title	× XVIII	Sul	bprovider -	PPS	
					I RF		
Cost Center Description	Non Physician		Nursi ng			Allied Health	
	Anestheti st	School	School		ost-Stepdown		
	Cost	Post-Stepdown		P	Adjustments		
	1.00	Adjustments 2A	2.00		3A	3.00	
ANCI LLARY SERVI CE COST CENTERS	1.00	ZA	2.00		3A	3.00	
50. 00 05000 OPERATING ROOM	0	0		0	0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C				0	0	0	
55. 00 05500 RADI OLOGY-THERAPEUTI C				0	0	0	1
56. 00 05600 RADI OLOGI - THERA LUTIC				0	0	0	
59. 00 05900 CARDI AC CATHETERI ZATI ON				0	0	0	
60. 00 06000 LABORATORY		0		0	0	335, 038	
64.00 06400 INTRAVENOUS THERAPY	0	0		0	0	000,000	1
65. 00 06500 RESPIRATORY THERAPY	0	0		0	0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		õ	0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		0	0	0	
68.00 06800 SPEECH PATHOLOGY	0	0		0	0	0	
69. 00 06900 ELECTROCARDI OLOGY	0	0		0	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		0	0	0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	1, 228, 147	73.00
74.00 07400 RENAL DIALYSIS	0	0		0	0	0	74.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90. 00 09000 CLI NI C	0	0		0	0	0	90.00
90.01 09001 IBMT JOINT VENTURE	0	0		0	0	0	90.01
90. 05 09005 CV DI AGNOSTI C SERVI CES	0	0		0	0	0	
91. 00 09100 EMERGENCY	0	0		0	0	155, 991	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0		0	1 2.00
200.00   Total (lines 50 through 199)	0	0		0	0	1, 719, 176	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS       Provider CCN: 15-0162 From 01/01/2018 To 12/31/2018       Period: Part IV Date/Time Prepar 5/31/2019 7: 47 a         Title XVIII       Subprovider - IRF       PPS         Cost Center Description       All Other       Total Cost       Total Charges       Ratio of Cost	ed: m
Component CCN: 15-T162     To     12/31/2018     Date/Time Prepar       5/31/2019     7: 47 a       Title XVIII     Subprovider - IRF     PPS       Cost Center Description     All Other     Total Cost     Total	ed: m
Subprovider -     5/31/2019 7: 47 a       Title XVIII     Subprovider -     PPS       IRF     IRF     IRF	<u>m</u>
Title XVIII     Subprovider -     PPS       Cost Center Description     All Other     Total Cost     Total     Total Charges     Ratio of Cost	
Cost Center Description All Other Total Cost Total Total Charges Ratio of Cost	
Medical (sum of cols. Outpatient (from Wkst. to Charges	
Education 1, 2, 3, and Cost (sum of C, Part I, (col. 5 +	
Cost         4)         col s. 2, 3,         col . 8)         col . 7)	
and 4)         3           4.00         5.00         6.00         7.00         8.00	
4. 00 5. 00 6. 00 7. 00 8. 00 ANCI LLARY SERVICE COST CENTERS	
	). 00
	2.00
	1.00
	5.00
	5.00
	9.00
	), 00
	1.00
	5.00
	5.00
	7.00
68. 00 06800 SPEECH PATHOLOGY 0 0 10, 078, 304 0. 000000 68	3. 00
69. 00 06900 ELECTROCARDI OLOGY 0 0 0 33, 676, 057 0. 000000 69	9.00
70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 18, 916, 695 0. 00000 70	0. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 178, 212, 721 0. 00000 71	. 00
	2.00
	3.00
	1.00
	5. 97
OUTPATIENT SERVICE COST CENTERS	
	0. 00
	0. 01
	0. 05
	1.00
	2.00
200.00    Total (lines 50 through 199)   0 1,719,176 1,719,176 2,432,259,452  200	0. 00

Health Financial Systems ST. I	FRANCIS HOSPITAL	& HEALTH CEN	TER	In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	Provider C	CN: 15-0162	Period:	Worksheet D	
THROUGH COSTS		Company	CON 15 T1/0	From 01/01/2018		
		component	CCN: 15-T162	To 12/31/2018	Date/Time Pre 5/31/2019 7:4	
		Title	XVIII	Subprovider -	PPS	
				I RF		
Cost Center Description	Outpati ent	Inpati ent	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷		Costs (col.	8	Costs (col. 9	
	col. 7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVI CE COST CENTERS	0.00000	44 500				
50.00 05000 OPERATING ROOM	0. 000000	41, 582		0 0	-	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 0		52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	456, 996		0 0	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	0		0 0	0	55.00
56. 00 05600 RADI OI SOTOPE	0. 000000	5, 849		0 0	0	56.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	0		0 0	0	59.00
60. 00 06000 LABORATORY	0. 001247	707, 778	88		0	60.00
64.00 06400 INTRAVENOUS THERAPY	0. 000000	0		0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	492, 086		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	1, 766, 222		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	1, 565, 025		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	792, 676		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	60, 917		0 0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	9, 348		0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	872, 682		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 002408	1, 024, 435	2,40	57 0	0	73.00
74.00 07400 RENAL DI ALYSI S	0. 000000	229, 825		0 0	0	74.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000	0		0 0	0	76.97
OUTPATIENT SERVICE COST CENTERS			•		•	
90. 00 09000 CLI NI C	0.000000	0		0 0	0	90.00
90. 01 09001 I BMT JOI NT VENTURE	0. 000000	0		0 0	0	90.01
90. 05 09005 CV DI AGNOSTI C SERVI CES	0. 000000	0		0 0	0	90.05
91.00 09100 EMERGENCY	0. 000600	0		0 960	1	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0		0 0	0	92.00
200.00 Total (lines 50 through 199)		8, 025, 421	3, 35	50 960	1	200.00
					•	

ealth Financial Systems ST.	FRANCIS HOSPITA	AL & HEALTH CEN			u of Form CMS-	2552-10
PPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES A	ND VACCINE COST	Provider C	CN: 15-0162	Peri od:	Worksheet D	
		Component	CCN: 15-T162	From 01/01/2018 To 12/31/2018	Part V Date/Time Pre	anarod
		component	CCN. 15-1102	10 12/31/2010	5/31/2019 7:4	
		Title	e XVIII	Subprovider -	PPS	
				' I RF		
			Charges		Costs	
Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
	Charge Ratio	Reimbursed	Reimbursed	Reimbursed	(see inst.)	
	From	Services (see		Services Not		
	Worksheet C,	inst.)	Subject To	Subject To		
	Part I, col.		Ded. & Coins			
	9		(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVICE COST CENTERS	0.4/750/	1	1			
0.00 05000 OPERATING ROOM	0. 167584			0 0	0	
2.00 05200 DELIVERY ROOM & LABOR ROOM	0. 230136			0 0	0	
4.00 05400 RADI OLOGY-DI AGNOSTI C	0. 089813	0		0 0	0	
5.00 05500 RADI OLOGY-THERAPEUTI C	0. 199371	0		0 0	0	
66. 00 05600 RADI OI SOTOPE	0. 196424	0		0 0	0	
9.00 05900 CARDI AC CATHETERI ZATI ON	0. 054873	0		0 0	0	
0.00 06000 LABORATORY	0. 114471	0		0 0	0	
4.00 06400 I NTRAVENOUS THERAPY	0. 244561	0		0 0	0	
5.00 06500 RESPIRATORY THERAPY	0. 208334			0 0	0	
6.00 06600 PHYSI CAL THERAPY	0. 262044			0 0	0	
57.00 06700 OCCUPATI ONAL THERAPY	0. 161639			0 0	0	
8.00 06800 SPEECH PATHOLOGY	0. 177173			0 0	0	
9.00 06900 ELECTROCARDI OLOGY	0. 115295			0 0	0	
0.00 07000 ELECTROENCEPHALOGRAPHY	0. 165978			0 0	0	
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 264323			0 0	0	
2.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 225520	0		0 0	0	1 12:00
3.00 07300 DRUGS CHARGED TO PATIENTS	0. 159171	0		0 928	0	
4.00 07400 RENAL DIALYSIS	0. 184694			0 0	0	
6. 97 07697 CARDI AC REHABI LI TATI ON	0. 336762	0		0 0	0	76.97
OUTPATIENT SERVICE COST CENTERS		-	1	-	-	
0.00 09000 CLINIC	1. 198862			0 0	0	
0. 01 09001 I BMT JOINT VENTURE	1. 232392			0 0	0	
00. 05 09005 CV DI AGNOSTI C SERVI CES	0. 212888			0 0	0	
1.00 09100 EMERGENCY	0. 074081	960		0	71	
22.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 339228			0	0	1 12:00
200.00 Subtotal (see instructions)		960		0 928	71	200.00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges				0 000	74	
02.00   Net Charges (line 200 - line 201)		960	1	0 928	/ 1	202.00

	FRANCIS HOSPITA	L & HEALTH CEN	TER	In Lieu	u of Form CMS-25	552-1
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	D VACCINE COST	Provider C	CN: 15-0162	Peri od:	Worksheet D	
				From 01/01/2018	Part V	
		Component	CCN: 15-T162	To 12/31/2018	Date/Time Prep 5/31/2019 7:47	ared:
		Title	XVIII	Subprovi der -	PPS	
		in the		IRF	115	
	Cos	sts				
Cost Center Description	Cost	Cost				
·	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00				
ANCI LLARY SERVI CE COST CENTERS	-					
50. 00 05000 OPERATI NG ROOM	0	0				50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0				52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0				55.00
56. 00 05600 RADI OI SOTOPE	0	0				56.0
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0				59.0
60. 00 06000 LABORATORY	0	0				60.00
64. 00 06400 I NTRAVENOUS THERAPY	0	0				64.0
65. 00 06500 RESPIRATORY THERAPY	0	0				65.0
66. 00 06600 PHYSI CAL THERAPY	0	0				66.0
67. 00 06700 OCCUPATI ONAL THERAPY	0	0				67.0
	0	0				
	0	0				68.0
59. 00 06900 ELECTROCARDI OLOGY	0	0				69.0
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0				70.0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0				71.0
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0				72.0
73.00 07300 DRUGS CHARGED TO PATIENTS	0	148	1			73.0
74.00 07400 RENAL DIALYSIS	0	0				74.0
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0				76.9
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	0				90.0
90. 01 09001 I BMT JOI NT VENTURE	0	0				90.0
90. 05 09005 CV DIAGNOSTIC SERVICES	0	0				90.0
91. 00 09100 EMERGENCY	0	0				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0				92.0
200.00 Subtotal (see instructions)	0	148				200.0
201.00 Less PBP Clinic Lab. Services-Program	0				2	201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)	0	148			2	202.00

Health Financial Systems ST.	FRANCIS HOSPITA	L & HEALTH CEN	ITER	In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider C		Period: From 01/01/2018 To 12/31/2018	Date/Time Pre	
					5/31/2019 7:4	7 am
			e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem	
	Related Cost	Adjustment	Capi tal	Days	(col. 3 /	
	(from Wkst.		Related Cost		col. 4)	
	B, Part II,		(col. 1 -			
	col. 26)		col. 2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS		Γ	I	I		
30.00 ADULTS & PEDIATRICS	10, 772, 971		10, 772, 97		169. 22	
31.00 INTENSIVE CARE UNIT	1, 425, 950		1, 425, 95		79.99	
31.01 NEONATAL INTENSIVE CARE UNIT	929, 215		929, 21			
32.00 CORONARY CARE UNIT	3, 020, 391		3, 020, 39			•
34.00 SURGICAL INTENSIVE CARE UNIT	1, 565, 695		1, 565, 69			
41.00 SUBPROVIDER – IRF	1, 023, 854	0	1, 023, 85	4 5, 071	201.90	41.00
43.00 NURSERY	248, 306		248, 30	6 3, 803	65.29	43.00
200.00 Total (lines 30 through 199)	18, 986, 382		18, 986, 38	2 115, 976		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, 194					30.00
31.00 INTENSIVE CARE UNIT	520	41, 595				31.00
31.01 NEONATAL INTENSIVE CARE UNIT	0	0				31.01
32.00 CORONARY CARE UNIT	127	32, 687				32.00
34.00 SURGICAL INTENSIVE CARE UNIT	41	7, 611				34.00
41.00 SUBPROVIDER – IRF	7	1, 413				41.00
43.00 NURSERY	124	8, 096				43.00
200.00 Total (lines 30 through 199)	2, 013	293, 451				200.00

Health Financial Systems ST. I	RANCIS HOSPITA	L & HEALTH CEN	ITER	In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT.	AL COSTS	Provider C		Period: From 01/01/2018 To 12/31/2018		
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col. 2)			
	col. 26)					
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS	r	-	-			
50.00 05000 OPERATI NG ROOM	5, 995, 151					•
52.00 05200 DELIVERY ROOM & LABOR ROOM	1, 483, 659					•
54.00 05400 RADI OLOGY-DI AGNOSTI C	4, 653, 053				148, 315	•
55. 00 05500 RADI OLOGY-THERAPEUTI C	20, 341				0	
56. 00 05600 RADI OI SOTOPE	91, 945	8, 391, 684	0. 01095	57 114, 444	1, 254	56.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	1, 506, 423		0. 01310		41, 357	59.00
60. 00 06000 LABORATORY	2, 433, 022					
64.00 06400 INTRAVENOUS THERAPY	645, 042	22, 955, 492	0. 02810	0 296, 529	8, 332	64.00
65. 00 06500 RESPI RATORY THERAPY	391, 812	64, 958, 011	0. 00603	8, 202, 866	49, 480	65.00
66. 00 06600 PHYSI CAL THERAPY	610, 572	38, 603, 501	0. 01581	6 435, 562	6, 889	66.00
67.00 06700 OCCUPATI ONAL THERAPY	12, 192			958, 402	633	67.00
68.00 06800 SPEECH PATHOLOGY	72, 710	10, 078, 304	0. 00721	5 243, 955	1, 760	68.00
69. 00 06900 ELECTROCARDI OLOGY	811, 540	33, 676, 057	0. 02409	1, 966, 107	47, 379	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	11, 355	18, 916, 695	0. 00060	418, 680	251	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 375, 250	178, 212, 721	0.00771	7 15, 320, 705	118, 230	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	1, 089, 418	165, 795, 753	0.00657	5, 909, 014	38, 828	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	723, 695	510, 051, 485	0. 00141	9 28, 185, 306	39, 995	73.00
74.00 07400 RENAL DIALYSIS	265, 638	8, 258, 979	0. 03216	4 777, 208	24, 998	74.00
76. 97 07697 CARDIAC REHABILITATION	3, 666	2, 538, 513	0.00144	4 328	0	76.97
OUTPATIENT SERVICE COST CENTERS			·			1
90. 00 09000 CLINIC	1, 717, 623	11, 153, 367	0. 15400	0 113, 675	17, 506	90.00
90. 01 09001 I BMT JOINT VENTURE	180, 204	5, 449, 796	0. 03306	6 4, 959	164	90.01
90. 05 09005 CV DI AGNOSTI C SERVI CES	66, 502	64, 216, 703	0. 00103	6 9, 708	10	90.05
91.00 09100 EMERGENCY	3, 121, 904	259, 938, 189	0. 01201	0 6, 969, 609	83, 705	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 841, 821	37, 806, 939	0. 04871	6 438, 690	21, 371	92.00
200.00 Total (lines 50 through 199)	29, 124, 538	2, 432, 259, 452		118, 529, 610	1, 553, 844	200.00

## ST. FRANCIS HOSPITAL & HEALTH CENTER

	TRANCIS HUSFIT					2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER	PASS THROUGH COS		-	Period: From 01/01/2018 Fo 12/31/2018	Date/Time Pre 5/31/2019 7:4	epared: 17 am
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Nursi ng	Nursi ng	Allied Health	Allied Health	All Other	
	School	School	Post-Stepdowr		Medi cal	
				0031		
	Post-Stepdown		Adjustments		Educati on	
	Adjustments				Cost	
	1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					•	
30. 00 03000 ADULTS & PEDIATRICS	C	0		0 0	0	30.00
				-	-	
31. 00 03100 I NTENSI VE CARE UNI T	C	-	1	0 0	-	
31. 01 02060 NEONATAL INTENSIVE CARE UNIT	C	0		0 0	0	31.01
32.00 03200 CORONARY CARE UNIT	0	0		0	0	32.00
34. 00 03400 SURGI CAL I NTENSI VE CARE UNI T					0	
		0	1	0	-	
41. 00 04100 SUBPROVI DER – I RF		0	1	0	0	
43. 00 04300 NURSERY	C	0		0 0	0	43.00
200.00   Total (lines 30 through 199)	0	0		0	0	200.00
Cost Center Description	Swing-Bed	Total Costs	Total Patient	Per Diem	I npati ent	200.00
cost center bescription						
	Adjustment	(sum of cols.	Days	(col. 5 ÷	Program Days	
	Amount (see	1 through 3,		col. 6)		
	instructions)	minus col. 4)				
	4,00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	0.00	0.00	7.00	0.00	
			(0.44	1 0.00	4 404	1 00 00
30. 00 03000 ADULTS & PEDI ATRI CS	C	0	63, 66			
31.00 03100 INTENSIVE CARE UNIT		0	17, 82	7 0.00	520	31.00
31.01 02060 NEONATAL INTENSIVE CARE UNIT		0	5, 44	5 0.00	0	31.01
32.00 03200 CORONARY CARE UNI T		0	11, 73			
		0				
34.00 03400 SURGI CAL I NTENSI VE CARE UNI T		0	8, 43			
41. 00 04100 SUBPROVIDER – IRF	C	0	5,07	1 0.00	7	41.00
43. 00 04300 NURSERY		0	3, 80	3 0.00	124	43.00
200.00 Total (lines 30 through 199)		0				200.00
Cost Center Description	I npati ent	0	113, 77	J	2,013	200.00
cost center bescription						
	Program					
	Pass-Through					
	Cost (col. 7					
	x col. 8)					
	9,00	4				
	9.00					
INPATIENT ROUTINE SERVICE COST CENTERS						_
30. 00 03000 ADULTS & PEDIATRICS	C					30.00
31. 00 03100 INTENSIVE CARE UNIT	0					31.00
31. 01 02060 NEONATAL INTENSIVE CARE UNIT						31.01
32.00 03200 CORONARY CARE UNI T	( C					32.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	C					34.00
41.00 04100 SUBPROVI DER - I RF	C					41.00
	-					
43.00 04300 NURSERY	C					43.00
200.00   Total (lines 30 through 199)	C					200.00

Health Financial Systems ST. I	FRANCIS HOSPITA	L & HEALTH CEN	TER		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PAS	S Provider C	CN: 15-0162		ri od:	Worksheet D	
THROUGH COSTS				Fro	om 01/01/2018 12/31/2018		norod.
				10	12/31/2018	5/31/2019 7:4	
		Ti tl	e XIX		Hospi tal	PPS	
Cost Center Description	Non Physician		Nursi ng			Allied Health	
	Anesthetist	School	School		Post-Stepdown		
	Cost	Post-Stepdown			Adjustments		
		Adjustments					
	1.00	2A	2.00		3A	3.00	
ANCI LLARY SERVI CE COST CENTERS			1				
50.00 05000 OPERATING ROOM	0	0		0	0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	0	52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0	0	0	55.00
56. 00 05600 RADI 0I SOTOPE	0	0		0	0	0	56.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0	0	0	59.00
60. 00 06000 LABORATORY	0	0		0	0	335, 038	60.00
64.00 06400 INTRAVENOUS THERAPY	0	0		0	0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0	0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0	0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0	0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0	0	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0	0	0	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	1, 228, 147	73.00
74.00 07400 RENAL DI ALYSI S	0	0		0	0	0	74.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0	0	0	76.97
OUTPATIENT SERVICE COST CENTERS				0		0	00.00
90. 00 09000 CLINIC	0	0		0	0	0	90.00
90. 01 09001 I BMT JOI NT VENTURE	0	0		0	0	0	90.01
90. 05 09005 CV DI AGNOSTI C SERVI CES	0			0	0	0 155 001	90.05
91.00 09100 EMERGENCY	0	0		0	0	155, 991	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0		0	92.00
200.00  Total (lines 50 through 199)	0	0	1	0	0	1, 719, 176	∠UU. UU

Health Financial Systems ST. F	RANCIS HOSPITA	L & HEALTH CEN	TER	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SET THROUGH COSTS	RVICE OTHER PAS	S Provider C		Period: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Pre 5/31/2019 7:4	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
	Educati on	1, 2, 3, and	Cost (sum of	C, Part I,	(col. 5 ÷	
	Cost	4)	cols. 2, 3,	col. 8)	col. 7)	
			and 4)			
	4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0		0 190, 463, 713	0.00000	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 32, 011, 796	0.000000	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 309, 604, 329	0.000000	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0 56, 991, 265	0.000000	55.00
56. 00 05600 RADI OI SOTOPE	0	0		0 8, 391, 684	0.000000	56.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 114, 975, 983	0.000000	59.00
60. 00 06000 LABORATORY	0	335, 038	335, 03	8 268, 731, 994	0.001247	60.00
64.00 06400 INTRAVENOUS THERAPY	0	0		0 22, 955, 492	0.000000	64.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 64, 958, 011	0.000000	65.00
66.00 06600 PHYSI CAL THERAPY	0	0		0 38, 603, 501	0.000000	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 18, 478, 183	0.000000	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 10, 078, 304	0.000000	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 33, 676, 057	0.000000	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 18, 916, 695	0.000000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 178, 212, 721	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 165, 795, 753	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	1, 228, 147	1, 228, 14	7 510, 051, 485	0.002408	73.00
74.00 07400 RENAL DIALYSIS	0	0		0 8, 258, 979	0.000000	74.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0 2, 538, 513	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS						1
90. 00 09000 CLI NI C	0	0		0 11, 153, 367	0.00000	90.00
90. 01 09001 I BMT JOINT VENTURE	0	0		0 5, 449, 796	0.000000	
90. 05 09005 CV DI AGNOSTI C SERVI CES	0	0		64, 216, 703	0.000000	
91. 00 09100 EMERGENCY	0	155, 991	155, 99		0.000600	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		37, 806, 939	0.000000	
200.00 Total (lines 50 through 199)	0	1, 719, 176	1, 719, 17	6 2, 432, 259, 452		200.00

Health Financial Systems ST.	FRANCIS HOSPITAL	& HEALTH CEN	TER	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	S Provider C		Period:	Worksheet D	
THROUGH COSTS				From 01/01/2018 To 12/31/2018		narod
				10 12/31/2010	5/31/2019 7:4	7 am
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Outpati ent	Inpatient	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷		Costs (col.	8	Costs (col. 9	
	col. 7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVI CE COST CENTERS	0.000000	10.005.0/4	1	0		50.00
50.00 05000 OPERATING ROOM	0.000000	10, 205, 064		0 0	u u	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0.000000	9, 557, 095		0 0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0.000000	9, 868, 599		0 0	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0.000000	0		0 0	0	55.00
56. 00 05600 RADI OI SOTOPE	0.000000	114, 444		0 0	0	56.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0.000000	3, 156, 573		0 0	0	59.00
	0.001247	15, 376, 532			0	60.00
64. 00 06400 I NTRAVENOUS THERAPY 65. 00 06500 RESPI RATORY THERAPY	0. 000000	296, 529		0 0	0	64.00 65.00
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY		8, 202, 866		0 0	0	65.00
	0.000000	435, 562		0 0	0	67.00
67.00 06700 OCCUPATI ONAL THERAPY 68.00 06800 SPEECH PATHOLOGY	0. 000000 0. 000000	958, 402		0 0	0	67.00
69. 00 06900 ELECTROCARDI OLOGY		243, 955		0 0	0	
	0. 000000	1, 966, 107		0 0	-	69.00
	0.000000	418, 680		0 0	0	70.00 71.00
		15, 320, 705		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000 0. 002408	5, 909, 014				72.00
73.00 07300 DRUGS CHARGED TO PATTENTS 74.00 07400 RENAL DIALYSIS	0.002408	28, 185, 306 777, 208			0	73.00
74. 00 107400 RENAL DIALYSIS 76. 97 107697 CARDIAC REHABILITATION	0.000000	328		0 0		74.00
OUTPATIENT SERVICE COST CENTERS	0.000000	320		0 0	0	10.91
90. 00 09000 CLINIC	0.000000	113, 675	1	0 0	0	90.00
90. 01 09001 I BMT JOI NT VENTURE	0.000000	4, 959		0 0	0	90.00
90. 05 09005 CV DI AGNOSTI C SERVI CES	0.000000	9, 708		0 0		90.01
90. 05 109005 CV DIAGNOSTIC SERVICES 91. 00 109100 EMERGENCY	0.000000	6, 969, 609			0	90.03
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	438, 690		0 0	-	92.00
200.00 Total (lines 50 through 199)	0.000000	118, 529, 610		-	, v	200.00
	1 I	110, 527, 010	1 71, 22	0	0	200.00

Health Financial Systems ST. F	RANCIS HOSPITA	AL & HEALTH CEN	TER	In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C		Period:	Worksheet D	
				From 01/01/2018 To 12/31/2018	Part V Date/Time Pre	marod
				10 12/31/2010	5/31/2019 7:4	
		Ti tl	e XIX	Hospi tal	PPS	
			Charges		Costs	
Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
	Charge Ratio	Reimbursed	Reimbursed	Reimbursed	(see inst.)	
	From	Services (see		Services Not		
	Worksheet C,	inst.)	Subject To	Subject To		
	Part I, col.		Ded. & Coins.			
	9		(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVICE COST CENTERS		-		-	-	
50.00 O5000 OPERATING ROOM	0. 167584				0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 230136				0	
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 089813				0	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 199371		-,,		0	
56. 00 05600 RADI OI SOTOPE	0. 196424				0	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 054873				0	
60. 00 06000 LABORATORY	0. 114471				0	
64.00 06400 I NTRAVENOUS THERAPY	0. 244561		1, 659, 75		0	
65. 00 06500 RESPI RATORY THERAPY	0. 208334		1, 526, 64		0	
66. 00 06600 PHYSI CAL THERAPY	0. 262044		3, 937, 59		0	
67.00 06700 OCCUPATI ONAL THERAPY	0. 161639		2, 576, 72		0	67.00
68. 00 06800 SPEECH PATHOLOGY	0. 177173		_,,		0	
69. 00 06900 ELECTROCARDI OLOGY	0. 115295		1, 864, 33		0	
70.00 07000 ELECTROENCEPHALOGRAPHY 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 165978		3, 244, 43		0	
	0. 264323		9, 464, 65		0	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS	0. 225520 0. 159171		2, 772, 18 30, 080, 13		0	
73.00 07300 DR0GS CHARGED TO PATTENTS 74.00 07400 RENAL DIALYSIS	0. 184694				-	
76. 97   07697 CARDI AC REHABI LI TATI ON	0. 184694					
OUTPATIENT SERVICE COST CENTERS	0. 330/02	0	00,98	0 0	0	/0.9/
90. 00 09000 CLINIC	1. 198862	0	1, 963, 56	2 0	0	90.00
90.00 09000 CETNIC 90.01 09001 IBMT JOINT VENTURE	1. 232392					
90. 05 09005 CV DI AGNOSTI C SERVI CES	0. 212888				0	
90. 05 09005 CV DIAGNOSTIC SERVICES 91. 00 09100 EMERGENCY	0. 212000				0	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 339228		4, 714, 22		0	1
200.00 Subtotal (see instructions)	0. 337220		220, 221, 15		-	200.00
201.00 Less PBP Clinic Lab. Services-Program			220, 221, 10	0 0	0	200.00
Only Charges				0		201.00
202.00 Net Charges (line 200 - line 201)		0	220, 221, 15	0 0	0	202.00
	I					

PPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	D VACCINE COST	Provider C	CN: 15-0162	Peri od: From 01/01/2018 To 12/31/2018	Worksheet D Part V Date/Time Pr 5/31/2019 7:	epared: 47 am
		Ti tl	e XIX	Hospi tal	PPS	
	Cos	ts				
Cost Center Description	Cost	Cost	1			
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
		Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00				
ANCILLARY SERVICE COST CENTERS						
0.00 05000 OPERATING ROOM	1, 935, 378	0				50.0
2.00 05200 DELIVERY ROOM & LABOR ROOM	7, 177	0				52.0
4. 00 05400 RADI OLOGY-DI AGNOSTI C	3, 295, 189	0	1			54.C
5. 00 05500 RADI OLOGY-THERAPEUTI C	1, 176, 476	0	1			55. C
6. 00 05600 RADI 0I SOTOPE	136, 820	0				56.0
9. 00 05900 CARDI AC CATHETERI ZATI ON	299, 454	0	1			59.0
D. 00 06000 LABORATORY	3, 216, 411	0				60.0
4.00 06400 INTRAVENOUS THERAPY	405, 911	0				64.0
5. 00 06500 RESPI RATORY THERAPY	318, 053	0				65.0
6. 00 06600 PHYSI CAL THERAPY	1, 031, 824	0				66.0
7.00 06700 OCCUPATI ONAL THERAPY	416, 498	0				67.0
8.00 06800 SPEECH PATHOLOGY	470, 705	0				68.0
9. 00 06900 ELECTROCARDI OLOGY	214, 948	0				69.0
0.00 07000 ELECTROENCEPHALOGRAPHY	538, 505	0				70.0
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2, 501, 725	0				71.0
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	625, 184	0				72.0
3.00 07300 DRUGS CHARGED TO PATIENTS	4, 787, 885	0				73.0
4. 00 07400 RENAL DIALYSIS	10, 641	0				74.0
5. 97 07697 CARDI AC REHABI LI TATI ON	20, 536	0				76.9
OUTPATIENT SERVICE COST CENTERS						_
D. 00 09000 CLINIC	2, 354, 040	0				90.0
D. 01 09001 I BMT JOI NT VENTURE	208, 616	0				90.0
0. 05 09005 CV DI AGNOSTI C SERVI CES	853, 643	0				90.0
1.00 09100 EMERGENCY	4, 521, 932	0				91.0
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 599, 196	0				92.0
00.00 Subtotal (see instructions)	30, 946, 747	0				200.0
01.00 Less PBP Clinic Lab. Services-Program	0					201.0
Only Charges	20.044 747	~				
02.00 Net Charges (line 200 - line 201)	30, 946, 747	0	1			202. (

Health Financial Systems ST. I	FRANCIS HOSPITA	L & HEALTH CEN	TER	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider C	CN: 15-0162	Peri od:	Worksheet D	
				From 01/01/2018		
		Component	CCN: 15-T162	To 12/31/2018	Date/Time Pre 5/31/2019 7:4	pared: 7 am
		Ti tl	e XIX	Subprovider -	PPS	
				I RF		
Cost Center Description	Capi tal	Total Charges			Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col. 2)			
	col. 26)					
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	5, 995, 151	190, 463, 713			5, 812	
52.00 05200 DELIVERY ROOM & LABOR ROOM	1, 483, 659	32, 011, 796			0	52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	4, 653, 053	309, 604, 329			1, 771	•
55. 00 05500 RADI OLOGY-THERAPEUTI C	20, 341	56, 991, 265			0	
56. 00 05600 RADI OI SOTOPE	91, 945	8, 391, 684			162	
59. 00 05900 CARDI AC CATHETERI ZATI ON	1, 506, 423	114, 975, 983			0	59.00
60. 00 06000 LABORATORY	2, 433, 022	268, 731, 994			2, 373	
64.00 06400 INTRAVENOUS THERAPY	645, 042	22, 955, 492				
65. 00 06500 RESPI RATORY THERAPY	391, 812	64, 958, 011	0. 00603			
66. 00 06600 PHYSI CAL THERAPY	610, 572	38, 603, 501	0. 01581	6 898, 971	14, 218	66.00
67.00 06700 OCCUPATI ONAL THERAPY	12, 192	18, 478, 183			7	67.00
68.00 06800 SPEECH PATHOLOGY	72, 710	10, 078, 304	0. 00721	5 11, 492	83	68.00
69. 00 06900 ELECTROCARDI OLOGY	811, 540	33, 676, 057	0. 02409	8 18, 592	448	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	11, 355	18, 916, 695	0. 00060	40, 041	24	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 375, 250	178, 212, 721	0. 00771	7 63, 757	492	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	1, 089, 418	165, 795, 753	0. 00657	232, 800	1, 530	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	723, 695	510, 051, 485	0. 00141	9 380, 709	540	73.00
74.00 07400 RENAL DI ALYSI S	265, 638	8, 258, 979	0. 03216	04 0	0	74.00
76. 97 07697 CARDI AC REHABI LI TATI ON	3, 666	2, 538, 513	0. 00144	4 0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	1, 717, 623	11, 153, 367	0. 15400	0 17, 284	2,662	90.00
90. 01 09001 I BMT JOI NT VENTURE	180, 204	5, 449, 796	0. 03306	6 0	0	90.01
90. 05 09005 CV DI AGNOSTI C SERVI CES	66, 502	64, 216, 703	0.00103	6 0	0	90.05
91.00 09100 EMERGENCY	3, 121, 904	259, 938, 189		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	37, 806, 939	0.00000	0 0	0	92.00
200.00 Total (lines 50 through 199)	27, 282, 717	2, 432, 259, 452		2, 341, 027	31, 053	200.00
					-	

Health Financial Systems ST. I	FRANCIS HOSPITA	L & HEALTH CEN	TER		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PAS	S Provider C	CN: 15-0162	Perio		Worksheet D	
THROUGH COSTS		Common and	CON 15 T1/0		01/01/2018	Part IV	
		component	CCN: 15-T162	То	12/31/2018	Date/Time Pre 5/31/2019 7:4	pared: 7 am
		Ti tl	e XIX	Sub	provider -	PPS	
					I RF		
Cost Center Description	Non Physician		Nursi ng			Allied Health	
	Anestheti st	School	School		st-Stepdown		
	Cost	Post-Stepdown		AC	ljustments		
	1.00	Adjustments	2.00		24	2.00	
ANCI LLARY SERVI CE COST CENTERS	1.00	2A	2.00		3A	3.00	
50. 00 05000 OPERATING ROOM	0	0	1	0	0	0	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	0	52.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0	0	-	55.00
	0	0		0	0	0	
	0	0		0	0	0	56.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0	0	0	59.00
	0	0		0	0	335, 038	
64. 00 06400 I NTRAVENOUS THERAPY	0	0		0	0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0	0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0	0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0	0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0	0		0	0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0	0	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0	0	0	70.00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	0	0		0	0	0	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	1, 228, 147	73.00
74.00 07400 RENAL DI ALYSI S	0	0		0	0	0	74.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0	0	0	76.97
		0	1		0	0	00.00
90. 00 09000 CLINIC	0	0		0	0	0	90.00
90. 01 09001 I BMT JOINT VENTURE	0	0		0	0	0	90.01
90. 05 09005 CV DI AGNOSTI C SERVI CES	0	0		0	0	0	90.05
91.00 09100 EMERGENCY	0	0		0	0	155, 991	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 200.00 Total (lines 50 through 199)	0	_		0	~	0	92.00
200.00   10.01 (THES SO THEOUGH 199)	0	0	1	Ч	0	1, 719, 176	200.00

Health Financial Systems ST. 1	FRANCIS HOSPITA	L & HEALTH CEN	TER	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PAS	S Provider C		Period:	Worksheet D	
THROUGH COSTS		Component (		From 01/01/2018 To 12/31/2018		nared
		•			5/31/2019 7:4	7 am
		Ti tl	e XIX	Subprovider -	PPS	
				I RF		
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	Medi cal	(sum of cols.	Outpatient	(from Wkst.	to Charges	
	Educati on	1, 2, 3, and	Cost (sum of		(col. 5 ÷	
	Cost	4)	cols. 2, 3, and 4)	col. 8)	col. 7)	
	4,00	5.00	6.00	7.00	8,00	
ANCI LLARY SERVI CE COST CENTERS	4.00	5.00	0.00	7.00	0.00	
50. 00 05000 OPERATING ROOM	0	0		0 190, 463, 713	0.00000	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 32, 011, 796		
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 309, 604, 329		•
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0 56, 991, 265		•
56. 00 05600 RADI OI SOTOPE	0	0		0 8, 391, 684		
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 114, 975, 983		•
60. 00 06000 LABORATORY	0	335, 038	335, 03	8 268, 731, 994	0.001247	60.00
64.00 06400 INTRAVENOUS THERAPY	0	0		0 22, 955, 492	0.000000	64.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 64, 958, 011	0.000000	65.00
66.00 06600 PHYSI CAL THERAPY	0	0		0 38, 603, 501	0. 000000	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 18, 478, 183	0. 000000	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 10, 078, 304	0.000000	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 33, 676, 057	0.00000	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 18, 916, 695	0.00000	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 178, 212, 721	0.00000	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 165, 795, 753		
73.00 07300 DRUGS CHARGED TO PATIENTS	0	1, 228, 147	1, 228, 14			
74.00 07400 RENAL DI ALYSI S	0	0		0 8, 258, 979		
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0 2, 538, 513	0. 000000	76.97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	0		0 11, 153, 367		
90. 01 09001 I BMT JOI NT VENTURE	0	0		0 5, 449, 796		
90. 05 09005 CV DI AGNOSTI C SERVI CES	0	0		0 64, 216, 703		
91.00 09100 EMERGENCY	0	155, 991				
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0 37, 806, 939		•
200.00   Total (lines 50 through 199)	0	1, 719, 176	1, 719, 17	6 2, 432, 259, 452		200.00

Health Financial Systems ST. I	RANCIS HOSPITAL	& HEALTH CEN	TER	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI		Provider C		Period:	Worksheet D	
THROUGH COSTS				From 01/01/2018	Part IV	
		Component (	CCN: 15-T162	To 12/31/2018	Date/Time Pre 5/31/2019 7:4	pared: 7 am
		Ti tl	e XIX	Subprovider -	PPS	
				I RF		
Cost Center Description	Outpati ent	I npati ent	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷		Costs (col.	8	Costs (col. 9	
	col. 7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS			1			
50.00 05000 OPERATING ROOM	0. 000000	184, 657		0 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	117, 862		0 0	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	0		0 0	0	55.00
56. 00 05600 RADI OI SOTOPE	0. 000000	14, 797		0 0	0	56.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	0		0 0	0	59.00
60. 00 06000 LABORATORY	0.001247	262, 123	32	27 0	0	60.00
64.00 06400 I NTRAVENOUS THERAPY	0. 000000	18, 456		0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	68, 266		0 0	0	65.00
66.00 06600 PHYSI CAL THERAPY	0. 000000	898, 971		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	11, 220		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	11, 492		0 0	0	68.00
69.00 06900 ELECTROCARDI OLOGY	0. 000000	18, 592		0 0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0.000000	40, 041		0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	63, 757		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	232, 800		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.002408	380, 709	9.	17 0	0	73.00
74.00 07400 RENAL DIALYSIS	0. 000000	0		0 0	0	74.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000	0		0 0	0	76.97
OUTPATIENT SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·					
90. 00 09000 CLINIC	0. 000000	17, 284		0 0	0	90.00
90. 01 09001 I BMT JOI NT VENTURE	0.000000	0		0 0	0	90.01
90. 05 09005 CV DI AGNOSTI C SERVI CES	0. 000000	0		0 0	0	90.05
91.00 09100 EMERGENCY	0. 000600	0		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0		0 0	0	92.00
200.00 Total (lines 50 through 199)		2, 341, 027	1, 24	14 0	0	200.00
		· ·				•

ST	•.	FRANCI S	HOSPI TAL	&	HEALTH	CENTER	

eai th	Financial Systems ST. FRANCIS HOSPITAL &	& HEALTH CENTER	In Lieu	u of Form CMS-2	2552-
OMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0162	Period: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Pre	pare
		Title XVIII	Hocpi tal	5/31/2019 7:4 PPS	/ am
	Cost Center Description		Hospi tal	PPS	
	cost center bescription		-	1.00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	INPATIENT DAYS				1
00	Inpatient days (including private room days and swing-bed day	/s, excluding newborn)		63, 661	1.
00	Inpatient days (including private room days, excluding swing-			63, 661	2.
00	Private room days (excluding swing-bed and observation bed da	ays). If you have only p	orivate room days,	0	3.
~~	do not complete this line.				
00 00	Semi-private room days (excluding swing-bed and observation b Total swing-bed SNF type inpatient days (including private ro		or 21 of the cost	52, 777 0	4. 5.
00	reporting period	Join days) through becenic		0	5.
00	Total swing-bed SNF type inpatient days (including private ro	oom davs) after December	31 of the cost	0	6.
	reporting period (if calendar year, enter 0 on this line)				
00	Total swing-bed NF type inpatient days (including private roc	om days) through Decembe	er 31 of the cost	0	7.
	reporting period				
00	Total swing-bed NF type inpatient days (including private roc	om days) after December	31 of the cost	0	8.
~~	reporting period (if calendar year, enter 0 on this line)			00.040	
00	Total inpatient days including private room days applicable t newborn days)	to the Program (excludin	ng swing-bed and	23, 348	9.
. 00	Swing-bed SNF type inpatient days applicable to title XVIII o	only (including private	room days)	0	10
	through December 31 of the cost reporting period (see instruc		l com dayoy	0	
. 00	Swing-bed SNF type inpatient days applicable to title XVIII c		room days) after	0	11
	December 31 of the cost reporting period (if calendar year, e		-		
. 00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including priva	ate room days)	0	12
00	through December 31 of the cost reporting period			0	1.2
. 00	Swing-bed NF type inpatient days applicable to titles V or XI after December 31 of the cost reporting period (if calendar y			0	13
. 00	Medically necessary private room days applicable to the Progr			0	14
	Total nursery days (title V or XIX only)	all (excluding swing-bec	(uays)	0	
	Nursery days (title V or XIX only)			-	16
	SWING BED ADJUSTMENT				1
. 00	Medicare rate for swing-bed SNF services applicable to service	ces through December 31	of the cost	0.00	17
	reporting period				
3. 00	Medicare rate for swing-bed SNF services applicable to service	ces after December 31 of	the cost	0.00	18.
. 00	reporting period Medicaid rate for swing-bed NF services applicable to service	s through December 21	of the cost	0.00	10
. 00	reporting period	is through becember 51 c	I the cost	0.00	17
. 00	Medicaid rate for swing-bed NF services applicable to service	es after December 31 of	the cost	0.00	20
	reporting period				
	Total general inpatient routine service cost (see instruction			75, 015, 232	
. 00	Swing-bed cost applicable to SNF type services through Decemb	per 31 of the cost repor	rting period (line	0	22
~~	5 x line 17)				
. 00	Swing-bed cost applicable to SNF type services after December x line 18)	- 31 of the cost reporti	ng period (line 6	0	23
. 00	Swing-bed cost applicable to NF type services through December	or 31 of the cost report	ting period (line	0	24
. 00	7 x line 19)		ing period (inic	0	2
. 00	Swing-bed cost applicable to NF type services after December	31 of the cost reportir	ng period (line 8	0	25
	x line 20)				
. 00	Total swing-bed cost (see instructions)			0	
. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		75, 015, 232	27
. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-be	and observation had a	charges)	0	28
. 00	Private room charges (excluding swing-bed charges)		silar yes)	0	
. 00	Semi-private room charges (excluding swing-bed charges)			0	
. 00	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0. 000000	
. 00	Average private room per diem charge (line 29 ÷ line 3)	·		0.00	
00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
00	Average per diem private room charge differential (line 32 mi		uctions)	0.00	
. 00	Average per diem private room cost differential (line 34 x li	ne 31)		0.00	
. 00	Private room cost differential adjustment (line 3 x line 35)	and private men and	lifforontial (1)	75 015 222	
. 00	General inpatient routine service cost net of swing-bed cost	and private room cost d	urrerential (line	75, 015, 232	37
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				1
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	IUSTMENTS			1
. 00	Adjusted general inpatient routine service cost per diem (see			1, 178. 35	38
				27, 512, 116	
	Program general inpatient routine service cost (line 9 x line				
. 00	Medically necessary private room cost applicable to the Progr			0	

In Lieu of Form CMS-2552-10 Worksheet D-1

carti	Financial Systems ST. F	FRANCIS HOSPITA	L & HEALTH CEN	TER	In Lie	u of Form CMS-	2552
OMPUT	ATION OF INPATIENT OPERATING COST		Provider C	CN: 15-0162	Period:	Worksheet D-1	1
					From 01/01/2018		
					To 12/31/2018	Date/Time Pre 5/31/2019 7:4	
			Title	XVIII	Hospi tal	PPS	<del>1</del> 7 an
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
		Inpatient	I npati ent	Diem (col. 1		(col. 3 x	
		Cost	Days	÷ col. 2)		col. 4)	
		1.00	2.00	3.00	4.00	5.00	
2.00	NURSERY (title V & XIX only)	0	0	0.00	0 0	0	) 42.
	Intensive Care Type Inpatient Hospital Units	;					
. 00	INTENSIVE CARE UNIT	16, 358, 467	17, 827	917.6	2 4, 485	4, 115, 526	5 43
3. 01	NEONATAL INTENSIVE CARE UNIT	8, 459, 084	5, 445	1, 553. 5	5 0	0	) 43
1.00	CORONARY CARE UNIT	21, 581, 360	11, 735	1, 839. 0	6 5, 808	10, 681, 260	) 44
5.00	BURN INTENSIVE CARE UNIT						45
6.00	SURGICAL INTENSIVE CARE UNIT	11, 835, 389	8, 434	1, 403. 2	9 4, 415	6, 195, 525	5 46
7.00	OTHER SPECIAL CARE (SPECIFY)						47
	Cost Center Description						
						1.00	
. 00	Program inpatient ancillary service cost (Wk					65, 267, 648	
. 00	Total Program inpatient costs (sum of lines	41 through 48)(	(see instructi	ons)		113, 772, 075	5 49
	PASS THROUGH COST ADJUSTMENTS						
. 00	Pass through costs applicable to Program inp	patient routine	services (fro	n Wkst. D, sun	n of Parts I and	6, 624, 168	3 50
~~						1 051 0//	-
. 00	Pass through costs applicable to Program inp	batient and itar	ry services (r	COM WKST. D, S	sum or Parts II	4, 851, 066	5 51
2.00	and IV) Total Program excludable cost (sum of lines	50 and 51)				11, 475, 234	1 52
2.00 3.00	Total Program inpatient operating cost exclu		lated non ph	veician anosti	notist and	102, 296, 841	
. 00	medical education costs (line 49 minus line		nateu, non-pri	ysi ci an anesti	ictist, anu	102, 270, 041	55
	TARGET AMOUNT AND LIMIT COMPUTATION	<i>∞∠</i> )					1
1.00	Program di scharges					C	54
5.00	Target amount per discharge					0.00	
. 00	Target amount (line 54 x line 55)					0.00	
. 00	Difference between adjusted inpatient operat	ting cost and ta	arget amount (	line 56 minus	line 53)		
. 00	Bonus payment (see instructions)	and to	anger amount (				
. 00	Lesser of lines 53/54 or 55 from the cost re	eporting period	ending 1996	updated and co	ompounded by the		
. 00	market basket	sporting porrou	chung 1770,	apuatea ana ee	inpounded by the	0.00	
). 00	Lesser of lines 53/54 or 55 from prior year	cost report, up	dated by the	market basket		0.00	0 60
1.00	If line 53/54 is less than the lower of line				the amount by	0	61
	which operating costs (line 53) are less that						
	amount (line 56), otherwise enter zero (see	instructions)			0		
2.00	Relief payment (see instructions)					0	) 62
3.00	Allowable Inpatient cost plus incentive paym	nent (see instru	uctions)			0	) 63
	PROGRAM INPATIENT ROUTINE SWING BED COST						
1.00	Medicare swing-bed SNF inpatient routine cos	sts through Dece	ember 31 of th	e cost reporti	ng period (See	0	) 64
	instructions)(title XVIII only)						
5.00	Medicare swing-bed SNF inpatient routine cos	sts after Decemb	per 31 of the	cost reportinç	, period (See	0	) 65
	instructions)(title XVIII only)						
5.00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line	55)(title XVII	l only). For	0	) 66
	CAH (see instructions)					_	
7.00	Title V or XIX swing-bed NF inpatient routin	ne costs through	n December 31	of the cost re	porting period	0	) 67
	(line 12 x line 19)						
3.00	Title V or XIX swing-bed NF inpatient routin	ne costs after L	December 31 of	the cost repo	orting period	0	68   0
0 00	(line 13 x line 20)	routing goota (	(line (7 . lin	- (D)			
9.00	Total title V or XIX swing-bed NF inpatient		•	· · · · · · · · · · · · · · · · · · ·		0	0 69
0. 00	PART III - SKILLED NURSING FACILITY, OTHER N Skilled nursing facility/other nursing facil						70
. 00	Adjusted general inpatient routine service of	5				1	71
. 00	Program routine service cost (line 9 x line			<i>~)</i>		1	72
3. 00	Medically necessary private room cost applic		n (line 14 v l	ine 35)		1	73
. 00	Total Program general inpatient routine serv					1	74
5.00	Capital -related cost allocated to inpatient	•		·	Part II. column	1	75
	26, line 45)				, cor unit	1	' '
. 00	Per diem capital-related costs (line 75 ÷ li	ne 2)				1	76
. 00	Program capital -related costs (line 9 x line				ļ	1	77
. 00	Inpatient routine service cost (line 74 minu					1	78
. 00	Aggregate charges to beneficiaries for exces		provider recor	ds)		1	79
. 00	Total Program routine service costs for comp	• •			us line 79)	1	80
. 00	Inpatient routine service cost per diem limi			•	,	1	81
. 00	Inpatient routine service cost limitation (I		1)			1	82
3.00	Reasonable inpatient routine service costs (		· .		ļ	1	83
1.00	Program inpatient ancillary services (see in	•				1	84
5.00	Utilization review - physician compensation		ons)			1	85
5.00	Total Program inpatient operating costs (sum					1	86
-	PART IV - COMPUTATION OF OBSERVATION BED PAS		5 - /				
	Total observation bed days (see instructions					10, 884	1 87
7.00							
7.00 3.00	Adjusted general inpatient routine cost per	diem (line 27 ÷	+ line 2)		1	1, 178. 35	5 88

Health Financial Systems ST.	FRANCIS HOSPITA	L & HEALTH CEN	TER	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period: From 01/01/2018	Worksheet D-1	
		Т			Date/Time Pre 5/31/2019 7:4	pared: 7 am
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	10, 772, 971	75, 015, 232	0. 14361	0 12, 825, 161	1, 841, 821	90.00
91.00 Nursing School cost	0	75, 015, 232	0.00000	12, 825, 161	0	91.00
92.00 Allied health cost	0	75, 015, 232	0.00000	12, 825, 161	0	92.00
93.00 All other Medical Education	0	75, 015, 232	0.00000	12, 825, 161	0	93.00

	Financial Systems ST. FRANCIS HOSPITAL &		Period:	u of Form CMS-2	
OMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0162		Worksheet D-1	
		Component CCN: 15-T162	From 01/01/2018 To 12/31/2018		
		Title XVIII	Subprovider -	5/31/2019 7:4 PPS	/ an
	Cost Center Description		I RF	1.00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	INPATIENT DAYS			F 071	
00 00	Inpatient days (including private room days and swing-bed day Inpatient days (including private room days, excluding swing-			5, 071 5, 071	1
00	Private room days (excluding swing-bed and observation bed da		rivate room days,	0	
	do not complete this line.		-		
00 00	Semi-private room days (excluding swing-bed and observation b Total swing-bed SNF type inpatient days (including private ro		or 21 of the cost	5, 071 0	4
	reporting period	Join days) thi dugh beceind	er si or the cost	0	
00	Total swing-bed SNF type inpatient days (including private ro	oom days) after December	31 of the cost	0	6
	reporting period (if calendar year, enter 0 on this line)	m dava) through Decembe	r 21 of the east	0	
00	Total swing-bed NF type inpatient days (including private roo reporting period	Sin days) through beceinde	r 31 OF the cost	0	7
00	Total swing-bed NF type inpatient days (including private roo	om days) after December	31 of the cost	0	8
	reporting period (if calendar year, enter 0 on this line)			0 (05	
00	Total inpatient days including private room days applicable t newborn days)	to the Program (excluding	g swing-bed and	2, 685	Ģ
00	Swing-bed SNF type inpatient days applicable to title XVIII o	only (including private	room days)	0	10
	through December 31 of the cost reporting period (see instruct			0	
00	Swing-bed SNF type inpatient days applicable to title XVIII of December 31 of the cost reporting period (if calendar year, e		room days) after	0	11
00	Swing-bed NF type inpatient days applicable to titles V or XI		te room days)	0	12
	through December 31 of the cost reporting period			_	
	Swing-bed NF type inpatient days applicable to titles V or XI after December 31 of the cost reporting period (if calendar y			0	13
	Medically necessary private room days applicable to the Progr			0	14
00	Total nursery days (title V or XIX only)	. 3 3	5 /	0	
	Nursery days (title V or XIX only)			0	16
	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to servic	res through December 31	of the cost	0.00	1 17
	reporting period	thi bugit becember 31		0.00	' '
00	Medicare rate for swing-bed SNF services applicable to servic	ces after December 31 of	the cost	0.00	18
00	reporting period Medicaid rate for swing-bed NF services applicable to service	es through December 31 o	f the cost	0.00	19
00	reporting period		***	0.00	
00	Medicaid rate for swing-bed NF services applicable to service reporting period	alter December 31 01	the cost	0.00	20
. 00	Total general inpatient routine service cost (see instruction	ns)		7, 340, 398	21
00	Swing-bed cost applicable to SNF type services through Decemb	per 31 of the cost repor	ting period (line	0	22
. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December	- 31 of the cost reporti	ng period (line 6	0	23
	x line 18)				
. 00	Swing-bed cost applicable to NF type services through December $7 \times 1$ (ine 19)	er 31 of the cost report	ing period (line	0	24
. 00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	g period (line 8	0	25
. 00	x line 20) Total swing-bed cost (see instructions)			0	26
	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		7, 340, 398	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
	General inpatient routine service charges (excluding swing-be Private room charges (excluding swing-bed charges)	ed and observation bed c	narges)	0	
	Semi -pri vate room charges (excluding swing-bed charges)			0	
00	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0.000000	31
	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 mi	nus line 33)(see instru	ctions)	0.00 0.00	
00	Average per diem private room cost differential (line 34 x li		/	0.00	35
	Private room cost differential adjustment (line 3 x line 35)			0	
. 00	General inpatient routine service cost net of swing-bed cost 27 minus line 36)	and private room cost d	itterential (line	7, 340, 398	37
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				1
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ				
	Adjusted general inpatient routine service cost per diem (see			1,447.52	
. 00	Descrop concerned in notions noutling and in and it is a straight of the				
. 00 . 00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Progr	-		3, 886, 591 0	

	FRANCIS HOSPITAL				u of Form CMS-2	
OMPUTATION OF INPATIENT OPERATING COST		Provider C	CN: 15-0162	Period: From 01/01/2018	Worksheet D-1	
		Component		To 12/31/2018		
		Ti +Lo	e XVIII	Subprovider -	5/31/2019 7:4 PPS	17 am
				I RF	FFJ	
Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
	Inpati ent	Inpati ent	Diem (col. 1		(col. 3 x	
	Cost 1.00	Days 2.00	÷ col. 2) 3.00	4.00	<u>col. 4)</u> 5.00	
2.00 NURSERY (title V & XIX only)	1.00	2.00C				42.0
Intensive Care Type Inpatient Hospital Unit			0.0	0		1 12.1
3. 00 INTENSIVE CARE UNIT	0	C	0.0	0 0	0	43.0
3. 01 NEONATAL INTENSIVE CARE UNIT	0	C	1		0	
4. 00 CORONARY CARE UNI T	0	C	0.0	0 0	0	
5. 00 BURN I NTENSI VE CARE UNI T						45.
5. 00 SURGICAL INTENSIVE CARE UNIT 7. 00 OTHER SPECIAL CARE (SPECIFY)	0	C	0.0	0 0	0	46. 47.
Cost Center Description			1			47.
					1.00	
3.00 Program inpatient ancillary service cost (N					1, 533, 833	
9.00 Total Program inpatient costs (sum of lines	s 41 through 48)(	(see instructi	ons)		5, 420, 424	49.
PASS THROUGH COST ADJUSTMENTS 0.00 Pass through costs applicable to Program in	postient routine	services (fro	m Wkst D su	m of Parts L and	542, 102	50.
		Services (110	ii wkst. D, Su		542, 102	50.
1.00 Pass through costs applicable to Program in	npatient ancillar	ry services (f	rom Wkst. D, s	sum of Parts II	72, 708	51.
and IV)						
2.00 Total Program excludable cost (sum of lines					614, 810	
3.00 Total Program inpatient operating cost excl medical education costs (line 49 minus line		erated, non-ph	ysician anesti	hetist, and	4, 805, 614	53.
TARGET AMOUNT AND LIMIT COMPUTATION	5 52)					
4.00 Program di scharges					0	54.
5.00 Target amount per discharge					0.00	55.
5.00 Target amount (line 54 x line 55)					0	
7.00 Difference between adjusted inpatient opera	ating cost and ta	arget amount (	line 56 minus	line 53)	0	
3.00 Bonus payment (see instructions) 9.00 Lesser of lines 53/54 or 55 from the cost (	concrting ported	onding 1004	undated and a	ampounded by the	0.00	
market basket	eporting period	enuring 1990,		Jiipourided by the	0.00	37.
0.00 Lesser of lines 53/54 or 55 from prior year	r cost report, up	dated by the	market basket		0.00	60.
1.00 If line 53/54 is less than the lower of lin				the amount by	0	61.
which operating costs (line 53) are less the		ts (lines 54 x	60), or 1% of	f the target		
amount (line 56), otherwise enter zero (see	e instructions)					10
2.00 Relief payment (see instructions) 3.00 Allowable Inpatient cost plus incentive pay	ument (see instru	uctions)			0	
PROGRAM INPATIENT ROUTINE SWING BED COST						00.
4.00 Medicare swing-bed SNF inpatient routine co	osts through Dece	ember 31 of th	e cost reporti	ng period (See	0	64.
instructions)(title XVIII only)						
<ol> <li>Medicare swing-bed SNF inpatient routine control instructions) (title XVIII only)</li> </ol>	osts after Decemb	per 31 of the	cost reporting	j period (See	0	65.
5.00 Total Medicare swing-bed SNF inpatient rou	tine costs (line	64 plus line	65)(title XVI)	l only). For	0	66.
CAH (see instructions)		- p		· · · · · · · · · · · · · · · · · · ·	-	
7.00 Title V or XIX swing-bed NF inpatient routi	ne costs through	n December 31	of the cost re	eporting period	0	67.
(line 12 x line 19)						
3.00 Title V or XIX swing-bed NF inpatient routi (line 13 x line 20)	ne costs atter L	December 31 or	the cost repo	orting period	0	68.
9.00 Total title V or XIX swing-bed NF inpatien	t routine costs (	(line 67 + lin	e 68)		0	69.
PART III - SKILLED NURSING FACILITY, OTHER						1
0.00 Skilled nursing facility/other nursing faci				)		70.
1.00 Adjusted general inpatient routine service		ine 70 ÷ line	2)		1	71.
2.00 Program routine service cost (line 9 x line		(lipo 14 v l	ino 25)			72.
3.00  Medically necessary private room cost appli 4.00  Total Program general inpatient routine se						73.
5.00 Capital -related cost allocated to inpatient	•		,	Part II, column		75.
26, line 45)						
5.00 Per diem capital-related costs (line 75 ÷ 1	,					76.
7.00 Program capital-related costs (line 9 x line 0 v line 0 x line 0 x line 0 v line 74 mix						77.
3.00 Inpatient routine service cost (line 74 min 0.00 Aggregate charges to beneficiaries for excerning)		provi der recor	ds)			78.
00 Total Program routine service costs for cor				nus line 79)		80
.00 Inpatient routine service cost per diem lin					l	81
2.00 Inpatient routine service cost limitation	(line 9 x line 81	1)			l	82
8.00 Reasonable inpatient routine service costs	•	ıs)			1	83
4.00 Program inpatient ancillary services (see i		>			1	84.
5.00 Utilization review - physician compensation						85.
5.00 Total Program inpatient operating costs (su PART IV - COMPUTATION OF OBSERVATION BED PA		irougn 85)				86.
FART IV - COMPUTATION OF UDSERVATION BED PA					0	87.
7.00 Total observation bed days (see instruction	าร)					
7.00 Total observation bed days (see instruction 3.00 Adjusted general inpatient routine cost per		⊦line 2)			0.00	88.

Health Financial Systems	ST. FRANCIS HOSPITA	L & HEALTH CEN	TER	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period: From 01/01/2018	Worksheet D-1	
		Component (		To 12/31/2018	Date/Time Pre 5/31/2019 7:4	
		Title	XVIII	Subprovider -	PPS	
				I RF		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
		ŕ		(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS TH	HROUGH COST					
90.00 Capital-related cost	1, 023, 854	7, 340, 398	0. 13948	2 0	0	90.00
91.00 Nursing School cost	0	7, 340, 398	0.00000	0 0	0	91.00
92.00 Allied health cost	0	7, 340, 398	0. 00000	0 0	0	92.00
93.00 All other Medical Education	0	7, 340, 398	0. 00000	0 0	0	93.00

ST.	FRANCIS HOSPITAL 8	HEALTH	CENTER	

alth Financial S				u of Form CMS-2	
DMPUTATION OF INF	PATIENT OPERATING COST	Provi der CCN: 15-0162	Peri od: From 01/01/2018 To 12/31/2018	Date/Time Pre 5/31/2019 7:4	pare
Cost (	Center Description	Title XIX	Hospi tal	PPS	
				1.00	
	L PROVIDER COMPONENTS				-
00 Inpatient d	ays ays (including private room days and swing-bed day	vs excluding newborn)		63, 661	1 1.
	ays (including private room days and swing bed da			63, 661	2.
	m days (excluding swing-bed and observation bed da		rivate room days,	0	
	lete this line.	5, 5, 5,			
	e room days (excluding swing-bed and observation b	5,		52, 777	
00 Total swing reporting p	-bed SNF type inpatient days (including private re	oom days) through Decemb	er 31 of the cost	0	5.
	-bed SNF type inpatient days (including private ro	oom davs) after December	31 of the cost	0	6.
reporting p	eriod (if calendar year, enter 0 on this line)				
	-bed NF type inpatient days (including private roo	om days) through Decembe	r 31 of the cost	0	7.
reporting p			01 - <del>C</del> + b +	0	
	-bed NF type inpatient days (including private roo eriod (if calendar year, enter 0 on this line)	om days) after December	31 of the cost	0	8.
	ient days including private room days applicable	to the Program (excludin	g swing-bed and	1, 194	9.
newborn day	s)	5	0 0		
	NF type inpatient days applicable to title XVIII of		room days)	0	10.
	ember 31 of the cost reporting period (see instruction NF type inpatient days applicable to title XVIII of		room dave) after	0	11.
	of the cost reporting period (if calendar year, e		room days) arter	0	11.
	F type inpatient days applicable to titles V or XI		te room days)	0	12.
	ember 31 of the cost reporting period				
	F type inpatient days applicable to titles V or X			0	13.
arter Decem 1.00 Medically n	ber 31 of the cost reporting period (if calendar y ecessary private room days applicable to the Progr	year, enter U on this II ram (excluding swing-bed	ne) davs)	0	14.
	ry days (title V or XIX only)	Tam (excluding swing-bed	uays)	3, 803	
	rs (title V or XIX only)			124	
SWING BED A					
	te for swing-bed SNF services applicable to service	ces through December 31	of the cost	0.00	17.
reporting p 3.00 Medicare ra	eriod te for swing-bed SNF services applicable to servio	ces after December 31 of	the cost	0.00	1.9
reporting p	0			0.00	10.
	te for swing-bed NF services applicable to service	es through December 31 o	f the cost	0.00	19.
reporting p					
0.00 Medicaid ra reporting p	te for swing-bed NF services applicable to service	es after December 31 of	the cost	0.00	20.
	al inpatient routine service cost (see instruction	ns)		75, 015, 232	21.
5	ost applicable to SNF type services through Decemb		ting period (line		
5 x line 17	·				
	ost applicable to SNF type services after December	r 31 of the cost reporti	ng period (line 6	0	23.
x line 18) 4.00 Swing-bed c	ost applicable to NF type services through Decembe	er 31 of the cost report	ing period (line	0	24.
7 x line 19	11 51 5	er of the cost report	ring period (inne	0	27.
5.00 Swing-bed c	ost applicable to NF type services after December	31 of the cost reportin	g period (line 8	0	25.
x line 20)					
	-bed cost (see instructions) atient routine service cost net of swing-bed cost	(line 21 minus line 26)		0 75, 015, 232	
	M DI FFERENTI AL ADJUSTMENT	(THE 21 Millus THE 20)		75,015,252	27.
	atient routine service charges (excluding swing-be	ed and observation bed c	harges)	0	28.
	m charges (excluding swing-bed charges)		_	0	
	e room charges (excluding swing-bed charges)			0	
	atient routine service cost/charge ratio (line 27 vate room per diem charge (line 29 ÷ line 3)	÷ TThe 28)		0.000000	
	i-private room per diem charge (line 30 ÷ line 4)			0.00	
U U	diem private room charge differential (line 32 mi	inus line 33)(see instru	ctions)	0.00	
5.00 Average per	diem private room cost differential (line 34 x li			0.00	
	m cost differential adjustment (line 3 x line 35)		166-mart 1 (1)	0	
	atient routine service cost net of swing-bed cost	and private room cost d	ifferential (line	75, 015, 232	37.
27 minus li PART II - H	DSPITAL AND SUBPROVIDERS ONLY				
	ATIENT OPERATING COST BEFORE PASS THROUGH COST AD.	JUSTMENTS			1
3.00 Adjusted ge	neral inpatient routine service cost per diem (see			1, 178. 35	38.
0 0	eral inpatient routine service cost (line 9 x line	-		1, 406, 950	
	ecessary private room cost applicable to the Program appared inpatient routing carvice cost (line 2)			1 404 050	
	am general inpatient routine service cost (line 39	7 + IIIIE 40)		1, 406, 950	41.

In Lieu of Form CMS-2552-10 Worksheet D-1

lear th	Financial Systems ST.	FRANCIS HOSPITAL	L & HEALTH CEN	TER	In Lie	eu of Form CMS-	2552-1
COMPUT	ATION OF INPATIENT OPERATING COST		Provider C	CN: 15-0162	Period:	Worksheet D-1	1
					From 01/01/2018 To 12/31/2018		aparad
					10 12/31/2010	5/31/2019 7:4	
			Titl	e XIX	Hospi tal	PPS	
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
		I npati ent	I npati ent	Diem (col. 1		(col. 3 x	
		Cost	Days	÷ col. 2)		col. 4)	
		1.00	2.00	3.00	4.00	5.00	
2.00	NURSERY (title V & XIX only)	1, 930, 720	3, 803	507.6	8 124	62, 952	2 42. C
	Intensive Care Type Inpatient Hospital Units					1	
3.00	INTENSIVE CARE UNIT	16, 358, 467	17, 827				
3.01	NEONATAL INTENSIVE CARE UNIT	8, 459, 084	5,445				
4.00	CORONARY CARE UNIT	21, 581, 360	11, 735	1, 839. 0	6 127	233, 561	
15.00	BURN INTENSIVE CARE UNIT	11 005 000	0 404	1 400 0		57 505	45.0
	SURGICAL INTENSIVE CARE UNIT	11, 835, 389	8, 434	1, 403. 2	9 41	57, 535	5 46.0 47.0
17.00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description			<u> </u>			47.0
	cost center bescription					1.00	-
8.00	Program inpatient ancillary service cost (W	kst D-3 col 3	line 200)			19, 965, 771	48.0
9.00	Total Program inpatient costs (sum of lines			ons)		22, 203, 931	
7.00	PASS THROUGH COST ADJUSTMENTS	41 through 40) (		5113)		22,203,731	47.0
0.00	Pass through costs applicable to Program in	patient routine	services (fro	n Wkst D sur	n of Parts I and	d 292, 038	3 50. C
0.00			001 11 000 (11 0			1 2,2,000	
51.00	Pass through costs applicable to Program in	patient ancillar	ry services (fi	rom Wkst. D, s	sum of Parts II	1, 645, 071	51.0
	and IV)						
2.00	Total Program excludable cost (sum of lines	50 and 51)				1, 937, 109	52.0
53.00	Total Program inpatient operating cost excl		elated, non-phy	ysician anesth	netist, and	20, 266, 822	2 53.0
	medical education costs (line 49 minus line	52)					
	TARGET AMOUNT AND LIMIT COMPUTATION						
4.00	Program di scharges					0	
5.00	Target amount per discharge					0.00	
6.00	Target amount (line 54 x line 55)					0	
7.00	Difference between adjusted inpatient opera	ting cost and ta	arget amount (	ine 56 minus	line 53)	0	
8.00	Bonus payment (see instructions)					0	
9.00	Lesser of lines 53/54 or 55 from the cost r	eporting period	ending 1996, i	updated and co	ompounded by the	e 0.00	) 59.0
0 00	market basket					0.00	
0.00	Lesser of lines 53/54 or 55 from prior year				the amount by	0.00	
51.00	If line 53/54 is less than the lower of lin which operating costs (line 53) are less th					0	61.0
	amount (line 56), otherwise enter zero (see		.5 (1111eS 54 X	00), 01 1% 01	the target		
2 00	Relief payment (see instructions)	riisti ucti olisj				0	62.0
	Allowable Inpatient cost plus incentive pay	ment (see instru	uctions)			0	
	PROGRAM INPATIENT ROUTINE SWING BED COST					<u> </u>	00.0
64.00	Medicare swing-bed SNF inpatient routine co	sts through Dece	ember 31 of the	e cost reporti	na period (See	0	64.0
	instructions)(title XVIII only)				5 1 2 2 2		
5.00	Medicare swing-bed SNF inpatient routine co	sts after Decemb	per 31 of the o	cost reporting	period (See	0	65.0
	instructions)(title XVIII only)			1 5			
6.00	Total Medicare swing-bed SNF inpatient rout	ine costs (line	64 plus line	65)(title XVII	l only). For	0	66.0
	CAH (see instructions)						
57.00	Title V or XIX swing-bed NF inpatient routi	ne costs through	n December 31 (	of the cost re	eporting period	0	) 67.0
	(line 12 x line 19)						
8.00	Title V or XIX swing-bed NF inpatient routi	ne costs after D	December 31 of	the cost repo	orting period	0	68.0
	(line 13 x line 20)			( )			
9.00	Total title V or XIX swing-bed NF inpatient		•			0	) 69. C
0 00	PART III - SKILLED NURSING FACILITY, OTHER I Skilled nursing facility/other nursing faci				)	1	70 0
0.00	Adjusted general inpatient routine service	5		• • •	)		70.0
2.00	Program routine service cost (line 9 x line		ine /u - line	<i>∠)</i>			72.0
3.00	Medically necessary private room cost appli		ı (line 14 x li	ine 35)			73.0
4.00	Total Program general inpatient routine ser	0	•				74.0
5.00	Capital -related cost allocated to inpatient				Part II, column		75.0
	26, line 45)				,		
6.00	Per diem capital-related costs (line 75 ÷ 1	ine 2)					76.0
7.00	Program capital-related costs (line 9 x lin	e 76)					77.0
8.00	Inpatient routine service cost (line 74 min	us line 77)					78.0
9.00	Aggregate charges to beneficiaries for exce	ss costs (from p	provider record	(at			79. (
0.00	Total Program routine service costs for com	parison to the c	cost limitation	n (line 78 mir	nus line 79)		80.0
1.00	Inpatient routine service cost per diem lim						81.0
2.00	Inpatient routine service cost limitation (						82.0
3.00	Reasonable inpatient routine service costs	•	ıs)				83. (
4.00	Program inpatient ancillary services (see i						84.0
5.00	Utilization review - physician compensation	•					85.0
0.00	Total Program inpatient operating costs (su		nrough 85)				86.0
	DADT IV COMPUTATION OF ORCEDVATION DED DAG	SS THROUGH COST					
36.00	PART IV - COMPUTATION OF OBSERVATION BED PAS						
36.00 37.00	Total observation bed days (see instruction	s)				10, 884	
36.00 37.00 38.00		s) diem (line 27 ÷				10, 884 1, 178. 35 12, 825, 161	5 88. C

Health Financial Systems ST.	FRANCIS HOSPITA	L & HEALTH CEN	TER	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period:	Worksheet D-1	
				From 01/01/2018 To 12/31/2018		pared: 7 am
	_	Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	10, 772, 971	75, 015, 232	0. 14361	0 12, 825, 161	1, 841, 821	90.00
91.00 Nursing School cost	0	75, 015, 232	0.00000	0 12, 825, 161	0	91.00
92.00 Allied health cost	0	75, 015, 232	0.00000	0 12, 825, 161	0	92.00
93.00 All other Medical Education	0	75, 015, 232	0.00000	12, 825, 161	0	93.00

	Financial Systems ST. FRANCIS HOSPITAL &	& HEALTH CENTER	In Lie	u of Form CMS-2	2552
OMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0162	Period: From 01/01/2018	Worksheet D-1	
		Component CCN: 15-T162	To 12/31/2018		
		Title XIX	Subprovider -	5/31/2019 7:4 PPS	/ ar
	Cost Center Description		I RF	1.00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	INPATIENT DAYS				
00 00	Inpatient days (including private room days and swing-bed day Inpatient days (including private room days, excluding swing-			5, 071 5, 071	1
00	Private room days (excluding swing-bed and observation bed da		rivate room davs	5,071	
	do not complete this line.		i vato i com adjo,		
00	Semi-private room days (excluding swing-bed and observation b			5, 071	4
00	Total swing-bed SNF type inpatient days (including private ro reporting period	oom days) through Decemb	er 31 of the cost	0	5
00	Total swing-bed SNF type inpatient days (including private ro	oom davs) after December	31 of the cost	0	6
	reporting period (if calendar year, enter 0 on this line)			-	
00	Total swing-bed NF type inpatient days (including private roc	om days) through Decembe	r 31 of the cost	0	7
00	reporting period Total swing-bed NF type inpatient days (including private roc	om davs) after December	31 of the cost	0	8
,0	reporting period (if calendar year, enter 0 on this line)	and a solution become		0	
00	Total inpatient days including private room days applicable t	to the Program (excludin	g swing-bed and	7	9
00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII c	anly (including private	room dave)	0	10
00	through December 31 of the cost reporting period (see instruc		room days)	0	
00	Swing-bed SNF type inpatient days applicable to title XVIII c	only (including private	room days) after	0	11
00	December 31 of the cost reporting period (if calendar year, e Swing-bed NF type inpatient days applicable to titles V or XI		to room days)	0	12
. 00	through December 31 of the cost reporting period	TX ONLY (THEFUUTING PITVA	te room uays)	0	'2
00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including priva	te room days)	0	13
00	after December 31 of the cost reporting period (if calendar y				
00	Medically necessary private room days applicable to the Progr Total nursery days (title V or XIX only)	ram (excluding swing-bed	days)	0 3, 803	
00	Nursery days (title V or XIX only)			124	
	SWING BED ADJUSTMENT				
. 00	Medicare rate for swing-bed SNF services applicable to service	ces through December 31	of the cost	0.00	17
. 00	reporting period Medicare rate for swing-bed SNF services applicable to servic	ces after December 31 of	the cost	0.00	18
	reporting period				
. 00	Medicaid rate for swing-bed NF services applicable to service reporting period	es through December 31 o	f the cost	0.00	19
00	Medicaid rate for swing-bed NF services applicable to service reporting period	es after December 31 of	the cost	0.00	20
. 00	Total general inpatient routine service cost (see instruction	ns)		7, 340, 398	21
. 00	Swing-bed cost applicable to SNF type services through Decemb	per 31 of the cost repor	ting period (line	0	22
. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December	- 31 of the cost reporti	ng period (line 6	0	23
	x line 18)	· · · · · · · ·			
. 00	Swing-bed cost applicable to NF type services through December 7 x line 19)	er 31 of the cost report	ing period (line	0	24
00	Swing-bed cost applicable to NF type services after December	31 of the cost reportin	g period (line 8	0	25
. 00	x line 20) Total swing-bed cost (see instructions)			0	26
. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		7, 340, 398	27
00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	and abcomunition to the	harges)		
00	General inpatient routine service charges (excluding swing-be Private room charges (excluding swing-bed charges)	eu anu observation ded C	nai yes)	0	
00	Semi-private room charges (excluding swing-bed charges)			0	
00	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0.00000	
00 00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0.00 0.00	
00	Average per diem private room charge differential (line 32 mi	nus line 33)(see instru	ctions)	0.00	
00	Average per diem private room cost differential (line 34 x li		-	0.00	35
00	Private room cost differential adjustment (line 3 x line 35)	and private many and l	fforontial (1)	0	
. 00	General inpatient routine service cost net of swing-bed cost 27 minus line 36)	and private room cost d	irrerential (line	7, 340, 398	37
. 00	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
. 00		JUSTMENTS			
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ			4 447 50	38
. 00	Adjusted general inpatient routine service cost per diem (see	e instructions)		1, 447. 52	
. 00 . 00 . 00		e instructions) e 38)		1, 447. 52 10, 133 0	39

	SIS HOSPITAL				u of Form CMS-2	
OMPUTATION OF INPATIENT OPERATING COST		Provider C	CN: 15-0162	Period: From 01/01/2018	Worksheet D-1	
		Component	CCN: 15-T162	To 12/31/2018		
		Ti †I	e XIX	Subprovider -	5/31/2019 7:4 PPS	7 am
				IRF	110	_
Cost Center Description	Total	Total	Average Per	0 5	Program Cost	
	npatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)		(col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
2.00 NURSERY (title V & XIX only)	0	0				42.0
Intensive Care Type Inpatient Hospital Units						
3. 00   I NTENSI VE CARE UNI T 3. 01 NEONATAL I NTENSI VE CARE UNI T	0	0			0	
4. 00 CORONARY CARE UNIT	0	0			0	
5. 00 BURN I NTENSI VE CARE UNI T		0			Ū	45.0
6.00 SURGI CAL I NTENSI VE CARE UNI T	0	0	0.0	0 0	0	
7. 00 OTHER SPECIAL CARE (SPECIFY)						47.0
Cost Center Description					1.00	
8.00 Program inpatient ancillary service cost (Wkst.	D-3, col. 3,	line 200)			492, 109	48.
9.00 Total Program inpatient costs (sum of lines 41 t			ons)		502, 242	49. (
PASS THROUGH COST ADJUSTMENTS				C Durley I	1 110	1 50 1
0.00 Pass through costs applicable to Program inpatie (111)	nt routine se	ervices (Troi	m WKST. D, SU	m of Parts I and	1, 413	50.0
1.00 Pass through costs applicable to Program inpatie	nt ancillary	services (fi	rom Wkst. D,	sum of Parts II	32, 297	51.0
and IV)	5					
2.00 Total Program excludable cost (sum of lines 50 a					33, 710	
3.00 Total Program inpatient operating cost excluding medical education costs (line 49 minus line 52)	capital rela	ated, non-pr	ysician anest	netist, and	468, 532	53.0
TARGET AMOUNT AND LIMIT COMPUTATION						
4.00 Program discharges					0	
5.00 Target amount per discharge					0.00	
<ul><li>6.00 Target amount (line 54 x line 55)</li><li>7.00 Difference between adjusted inpatient operating</li></ul>	cost and tar	not amount (	lino 56 minus	lino 52)	0	
3.00 Bonus payment (see instructions)		get amount (	TTHE 50 III TIUS	TTHE 55)	0	
9.00 Lesser of lines 53/54 or 55 from the cost report	ing period er	nding 1996, i	updated and c	ompounded by the		
market basket						
0.00 Lesser of lines 53/54 or 55 from prior year cost 1.00 If line 53/54 is less than the lower of lines 55					0.00	
which operating costs (line 53) are less than ex					0	01.
amount (line 56), otherwise enter zero (see inst		(	,,	<u>.</u>		
2.00 Relief payment (see instructions)					0	
3.00 Allowable Inpatient cost plus incentive payment PROGRAM INPATIENT ROUTINE SWING BED COST	(see instruct	tions)			0	63.
4.00 Medicare swing-bed SNF inpatient routine costs t	hrough Decemb	ber 31 of the	e cost report	ing period (See	0	64.
instructions)(title XVIII only)						
5.00 Medicare swing-bed SNF inpatient routine costs a	fter December	r 31 of the o	cost reportin	g period (See	0	65.
instructions)(title XVIII only) 6.00 Total Medicare swing-bed SNF inpatient routine c	osts (line 64	4 nlus line /	65)(title XVI	II only) For	0	66.
CAH (see instructions)			00)((1110 X))	TT Only). TO	0	00.
7.00 Title V or XIX swing-bed NF inpatient routine co	sts through [	December 31 (	of the cost r	eporting period	0	67.
(line 12 x line 19)			+h+		0	10
B. 00 Title V or XIX swing-bed NF inpatient routine co (line 13 x line 20)	sts after Dec	cember 31 of	the cost rep	orting period	0	68.
9.00 Total title V or XIX swing-bed NF inpatient rout	ine costs (li	ine 67 + lin	e 68)		0	69.
PART III - SKILLED NURSING FACILITY, OTHER NURSI						
0.00 Skilled nursing facility/other nursing facility/				)		70.
1.00 Adjusted general inpatient routine service cost 2.00 Program routine service cost (line 9 x line 71)	per diem (lir	ne /0 ÷ line	2)			71.
3.00 Medically necessary private room cost applicable	to Program (	(line 14 x li	ine 35)			73.
4.00 Total Program general inpatient routine service						74.
5.00 Capital-related cost allocated to inpatient rout	ine service o	costs (from )	Worksheet B,	Part II, column		75.
26, line 45) 6.00 Per diem capital-related costs (line 75 ÷ line 2	)					76.
7.00 Program capital-related costs (line 9 x line 76)						77.
3.00 Inpatient routine service cost (line 74 minus li	ne 77)					78.
2.00 Aggregate charges to beneficiaries for excess co	• •					79.
<ul> <li>00 Total Program routine service costs for comparis</li> <li>00 Inpatient routine service cost per diem limitati</li> </ul>		st limitatio	n (line 78 mi	nus line 79)		80. 81.
.00  Inpatient routine service cost per diem limitati .00  Inpatient routine service cost limitation (line						82.
Reasonable inpatient routine service costs (see	· · · · · · · · · · · · · · · · · · ·	)				83.
00 Program inpatient ancillary services (see instru	ctions)					84.
0.00 Utilization review - physician compensation (see						85.
5.00 Total Program inpatient operating costs (sum of		bugn 85)				86.
PART IV - COMPLITATION OF ORSERVATION RED DASS TH					0	87.
PART IV - COMPUTATION OF OBSERVATION BED PASS TH 7.00 Total observation bed days (see instructions)					0	
	(line 27 ÷ l	line 2)			0.00	

Health Financial Systems	ST. FRANCIS HOSPITA	L & HEALTH CEN	TER	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider C		Period: From 01/01/2018	Worksheet D-1	
		Component (		To 12/31/2018		
		Ti tl	e XIX	Subprovider -	PPS	
				I RF		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
		ŕ		(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS T	HROUGH COST					
90.00 Capital-related cost	1, 023, 854	7, 340, 398	0. 13948	2 0	0	90.00
91.00 Nursing School cost	0	7, 340, 398	0.00000	0 0	0	91.00
92.00 Allied health cost	0	7, 340, 398	0.00000	0 0	0	92.00
93.00 All other Medical Education	0	7, 340, 398	0.00000	0 0	0	93.00

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Hear the Financial Systems ST. FRANCIS HUSPITAL &				TH LIEU OF FOLID CM3-		2002-10
INPATIENT AN	NCILLARY SERVICE COST APPORTIONMENT	Provider C		Peri od:	Worksheet D-3	3
				From 01/01/2018		
				To 12/31/2018	Date/Time Pre	epared:
				11	5/31/2019 7:4	i/am
		litle	XVIII	Hospi tal	PPS	
	Cost Center Description		Ratio of Cos	· · · · · · ·	I npati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x	
					col. 2)	
			1.00	2.00	3.00	
I NPAT	IENT ROUTINE SERVICE COST CENTERS					
30.00 03000	ADULTS & PEDIATRICS			50, 858, 597		30.00
31.00 03100	INTENSIVE CARE UNIT			13, 021, 972		31.00
	NEONATAL INTENSIVE CARE UNIT			0		31.01
	CORONARY CARE UNIT			13, 774, 452		32.00
	SURGI CAL I NTENSI VE CARE UNI T			10, 060, 031		34.00
	SUBPROVIDER - IRF			0		41.00
	NURSERY					43.00
	LARY SERVICE COST CENTERS		1			-
	OPERATING ROOM		0. 16758		7, 201, 629	•
	DELIVERY ROOM & LABOR ROOM		0. 23013	6 151, 251	34, 808	52.00
54.00 05400	RADI OLOGY-DI AGNOSTI C		0. 08981	3 39, 548, 945	3, 552, 009	54.00
55.00 05500	RADI OLOGY-THERAPEUTI C		0. 19937	1 0	0	55.00
56.00 05600	RADI OI SOTOPE		0. 19642	4 959, 539	188, 476	56.00
	CARDI AC CATHETERI ZATI ON		0. 05487		998, 929	
	LABORATORY		0. 11453			
	INTRAVENOUS THERAPY		0. 24456		228, 326	
	RESPI RATORY THERAPY					
			0. 20842			
	PHYSI CAL THERAPY		0. 26204		1, 769, 556	
	OCCUPATIONAL THERAPY		0. 16163			
	SPEECH PATHOLOGY		0. 17717			
	ELECTROCARDI OLOGY		0. 11529			
70.00 07000	ELECTROENCEPHALOGRAPHY		0. 16657	1, 390, 697	231, 650	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0. 26432	3 56, 531, 165	14, 942, 487	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS		0. 22552	41, 196, 111	9, 290, 547	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS		0. 15917	1 64, 649, 629	10, 290, 346	73.00
	RENAL DIALYSIS		0. 18490			
	CARDI AC REHABI LI TATI ON		0. 33676			
	TI ENT SERVICE COST CENTERS		0. 33070	400	100	/0. //
	CLINIC		1. 19886	2 82, 897	99, 382	90.00
			1. 23239			
	CV DI AGNOSTI C SERVI CES		0. 21288		24, 900	
	EMERGENCY		0.07410			
	OBSERVATION BEDS (NON-DISTINCT PART		0. 33922			
200.00	Total (sum of lines 50 through 94 and 96 through 98)			397, 194, 073	65, 267, 648	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charge	s (line 61)		0		201.00
202.00	Net charges (line 200 minus line 201)			397, 194, 073		202.00
- 1			•		•	

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	Trancial Systems SI. FRANCIS HUSPITAL 6	A HEALIH CEN	TEN		U OT FORM CMS-2	2552-
I NPATI ENT	F ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0162	Peri od:	Worksheet D-3	
				From 01/01/2018		
		Component	CCN: 15-T162	To 12/31/2018		
		Title	XVIII	Subprovider -	5/31/2019 7:4 PPS	alli
		intre		I RF	FFJ	
	Cost Center Description		Ratio of Cos		I npati ent	
	oust denter beschiption		To Charges	Program	Program Costs	
				Charges	(col. 1 x	
				ondi ges	col. 2)	
			1.00	2.00	3.00	
LNE	PATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	5.00	
	000 ADULTS & PEDI ATRI CS			0		30.0
	100 I NTENSI VE CARE UNI T			0		31.
	060 NEONATAL INTENSIVE CARE UNIT			0		31.
	200 CORONARY CARE UNIT			0		32.
	400 SURGI CAL I NTENSI VE CARE UNI T			0		34.
	100 SUBPROVIDER - IRF			6, 604, 840		41.
	300 NURSERY			0, 004, 640		41.
	CILLARY SERVICE COST CENTERS					43.
	000 OPERATI NG ROOM		0. 1675	84 41, 582	6, 968	50.
	200 DELIVERY ROOM & LABOR ROOM		0. 2301		0,900	
	400 RADI OLOGY-DI AGNOSTI C		0. 2301.		41,044	
	500 RADI OLOGY-THERAPEUTI C					
	600 RADI OLOGY - THERAPEOTIC		0. 1993		0	
			0. 1964		1, 149	
	900 CARDI AC CATHETERI ZATI ON		0.0548		0	
			0. 1145			
	400 I NTRAVENOUS THERAPY		0. 2445		0	
	500 RESPIRATORY THERAPY		0. 2084		102, 561	
	600 PHYSI CAL THERAPY		0. 2620		462, 828	
	700 OCCUPATI ONAL THERAPY		0. 1616		252, 969	
	800 SPEECH PATHOLOGY		0. 1771		140, 441	
	900 ELECTROCARDI OLOGY		0. 1152		7, 023	
	000 ELECTROENCEPHALOGRAPHY		0. 1665		1, 557	
	100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 2643		230, 670	
	200 IMPL. DEV. CHARGED TO PATIENTS		0. 2255		0	72.
	300 DRUGS CHARGED TO PATIENTS		0. 1591		163, 060	
	400 RENAL DIALYSIS		0. 18490		42, 496	
	697 CARDI AC REHABI LI TATI ON		0. 3367	62 0	0	76.
	TPATIENT SERVICE COST CENTERS					
	000 CLINIC		1. 1988		0	90.
	001 I BMT JOINT VENTURE		1. 2323		0	90.
	005 CV DI AGNOSTI C SERVI CES		0. 2128		0	90.
	100 EMERGENCY		0. 07410		0	91.
	200 OBSERVATION BEDS (NON-DISTINCT PART		0. 3392		0	92.
200.00	Total (sum of lines 50 through 94 and 96 through 98)			8, 025, 421	1, 533, 833	200.
001 00	Less PBP Clinic Laboratory Services-Program only charge	s (line 61)		0		201.
201.00				0		201.

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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		CN: 15-0162	Period:	Worksheet D-3	
			From 01/01/2018 To 12/31/2018	Date/Time Pre 5/31/2019 7:4	pared: 7 am
	Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description		Ratio of Cos		I npati ent	
		To Charges	5	Program Costs	
			Charges	(col. 1 x	
		1.00	2.00	col. 2)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDI ATRI CS		1	18, 086, 463		30.00
31. 00 03100 I NTENSI VE CARE UNI T			4, 843, 207		31.00
31. 01 02060 NEONATAL INTENSIVE CARE UNIT			10, 847, 650		31.00
32. 00 03200 CORONARY CARE UNIT			2, 114, 439		32.00
34. 00 03400 SURGI CAL I NTENSI VE CARE UNI T			2, 265, 016		34.00
41. 00 04100 SUBPROVI DER - I RF			0		41.00
43. 00 04300 NURSERY			2, 827, 566		43.00
ANCILLARY SERVICE COST CENTERS					
50. 00 05000 OPERATI NG ROOM		0. 1675			50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 2301			52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 0898			54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C		0. 1993			55.00
56. 00 05600 RADI 0I SOTOPE		0. 1964			56.00
59. 00 05900 CARDI AC CATHETERI ZATI ON		0.0548			
		0. 1145			60.00
64. 00 06400 I NTRAVENOUS THERAPY		0.2445			
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY		0.2084			65.00
66. 00  06600  PHYSI CAL_THERAPY 67. 00  06700  0CCUPATI ONAL_THERAPY		0. 2620 0. 1616			
68. 00 06800 SPEECH PATHOLOGY		0. 1818			68.00
69. 00 06900 ELECTROCARDI OLOGY		0. 1771			
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 1665			
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 2643			
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS		0. 2255			
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 1591			
74.00 07400 RENAL DIALYSIS		0. 1849			
76. 97 07697 CARDIAC REHABILITATION		0. 3367			
OUTPATI ENT SERVI CE COST CENTERS					
90. 00 09000 CLI NI C		1. 1988	62 113, 675	136, 281	90.00
90. 01 09001 IBMT JOINT VENTURE		1. 2323			90.01
90. 05 09005 CV DI AGNOSTI C SERVI CES		0. 2128			90.05
91.00 09100 EMERGENCY		0.0741			
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 3392			
200.00 Total (sum of lines 50 through 94 and 96 through 98)			118, 529, 610		
201.00 Less PBP Clinic Laboratory Services-Program only charg	es (line 61)		0		201.00
202.00 Net charges (line 200 minus line 201)		1	118, 529, 610	I	202.00

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	ENT	ANCLL	ΛDV	SERVICE	CO

ST. FRANCIS HOSPITAL & HEALTH CENTER In Lieu of Form CMS-2552-10

				111 21 0		
INPATII	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0162	Period: From 01/01/2018	Worksheet D-3	3
		Component	CCN: 15-T162	To 12/31/2018		
		Ti tl	e XIX	Subprovider - IRF	PPS	
	Cost Center Description		Ratio of Cos		I npati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x	
				-	col. 2)	
			1.00	2.00	3.00	
	INPATIENT ROUTINE SERVICE COST CENTERS					
	03000 ADULTS & PEDIATRICS			0		30.0
	03100 INTENSIVE CARE UNIT			0		31.0
31.01	02060 NEONATAL INTENSIVE CARE UNIT			0		31.0
32.00	03200 CORONARY CARE UNIT			0		32.0
	03400 SURGICAL INTENSIVE CARE UNIT			0		34.0
41.00	04100 SUBPROVI DER – I RF			1, 329, 533		41.0
43.00	04300 NURSERY			0		43.0
	ANCILLARY SERVICE COST CENTERS					
	05000 OPERATING ROOM		0. 1675	84 184, 657	30, 946	50.0
	05200 DELIVERY ROOM & LABOR ROOM		0. 2301		0	52.0
	05400 RADI OLOGY-DI AGNOSTI C		0. 0898	13 117, 862	10, 586	54.0
55.00	05500 RADI OLOGY-THERAPEUTI C		0. 1993	71 0	0	55.0
56.00	05600 RADI OI SOTOPE		0. 1964	24 14, 797	2, 906	56.0
59.00	05900 CARDI AC CATHETERI ZATI ON		0. 0548	73 0	0	59.0
60.00	06000 LABORATORY		0. 1145	37 262, 123	30, 023	60.0
64.00	06400 I NTRAVENOUS THERAPY		0. 2445	61 18, 456	4, 514	64.0
65.00	06500 RESPI RATORY THERAPY		0. 2084	20 68, 266	14, 228	65.0
66.00	06600 PHYSI CAL THERAPY		0. 2620	44 898, 971	235, 570	66.0
67.00	06700 OCCUPATI ONAL THERAPY		0. 1616	39 11, 220	1, 814	67.0
68.00	06800 SPEECH PATHOLOGY		0. 1771	73 11, 492	2, 036	68.0
	06900 ELECTROCARDI OLOGY		0. 1152	95 18, 592	2, 144	69.0
	07000 ELECTROENCEPHALOGRAPHY		0. 1665		6, 670	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 2643			
	07200 IMPL. DEV. CHARGED TO PATIENTS		0. 2255	20 232, 800	52, 501	72.0
	07300 DRUGS CHARGED TO PATIENTS		0. 1591	71 380, 709	60, 598	73.0
	07400 RENAL DI ALYSI S		0. 1849		0	
	07697 CARDIAC REHABILITATION		0. 3367	62 0	0	76.9
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC		1. 1988	62 17, 284	20, 721	90.0
	09001 I BMT JOI NT VENTURE		1. 2323	92 0	0	90.0
	09005 CV DIAGNOSTIC SERVICES		0. 2128		0	90.0
91.00	09100 EMERGENCY		0. 0741	05 0	0	91.0
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 3392		0	92.0
200.00	Total (sum of lines 50 through 94 and 96 through 98)			2, 341, 027	492, 109	200.0
201.00	Less PBP Clinic Laboratory Services-Program only charge	es (line 61)		0		201.0
202.00	Net charges (line 200 minus line 201)			2, 341, 027		202.0

Health Fin	anci al	Systems	
CALCULATIC	N OF R	FIMBURSEMENT	SETTI EMENT

ST.	FRANCI S	HOSPI TAL	&	HEALTH	C	ENTEF	2
				Drovi do	r	CONH	1

ALTH CENTER In Lieu of Form CMS-2552-10 ovider CCN: 15-0162 Period: Worksheet F

CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0162	Period: From 01/01/2018 To 12/31/2018		pared: 7 am
		Title XVIII	Hospi tal	PPS	
				1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS			1.00	
1. 00 1. 01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurr instructions)	ring prior to October 1	(see	0 60, 755, 331	1.00 1.01
1.02	DRG amounts other than outlier payments for discharges occurs instructions)	ring on or after October	1 (see	20, 739, 809	1. 02
1.03	DRG for federal specific operating payment for Model 4 BPCI 1 1 (see instructions)	for di scharges occurri ng	prior to October	0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI 1 October 1 (see instructions)	for di scharges occurri ng	on or after	0	1.04
2. 00 2. 01	Outlier payments for discharges. (see instructions) Outlier reconciliation amount			5, 252, 763 0	2.00 2.01
2.02 3.00	Outlier payment for discharges for Model 4 BPCI (see instruct Managed Care Simulated Payments			0 36, 557, 699	2.02 3.00
4.00	Bed days available divided by number of days in the cost repo Indirect Medical Education Adjustment			411. 18	4.00
5.00	FTE count for allopathic and osteopathic programs for the most or before 12/31/1996. (see instructions)				5.00
6.00	FTE count for allopathic and osteopathic programs that meet new programs in accordance with 42 CFR 413.79(e)				6.00
7.00 7.01	MMA Section 422 reduction amount to the IME cap as specified ACA § 5503 reduction amount to the IME cap as specified under cost report straddles July 1, 2011 then see instructions.			0. 32 0. 00	7.00 7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopa affiliated programs in accordance with 42 CFR 413.75(b), 413. 1998), and 67 FR 50069 (August 1, 2002).	athic and osteopathic pr .79(c)(2)(iv), 64 FR 263	ograms for 40 (May 12,	-0. 10	8.00
8. 01	The amount of increase if the hospital was awarded FTE cap sl report straddles July 1, 2011, see instructions.	lots under § 5503 of the	ACA. If the cost	0. 81	8. 01
8. 02	The amount of increase if the hospital was awarded FTE cap sl under § 5506 of ACA. (see instructions)	lots from a closed teach	ing hospital	0.00	8. 02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lin instructions)	nes (8, 8,01 and 8,02)	(see	17.14	9.00
10.00	FTE count for allopathic and osteopathic programs in the curr	rent year from your reco	rds	22.46	
11.00 12.00	FTE count for residents in dental and podiatric programs. Current year allowable FTE (see instructions)				11.00 12.00
13.00	Total allowable FTE count for the prior year.				13.00
14.00	Total allowable FTE count for the penultimate year if that ye otherwise enter zero.	ear ended on or after Se	ptember 30, 1997,		14.00
15.00	Sum of lines 12 through 14 divided by 3.			17.07	15.00
16.00	Adjustment for residents in initial years of the program			0.00	16.00
	Adjustment for residents displaced by program or hospital clo	osure			17.00
18.00	Adjusted rolling average FTE count				18.00
	Current year resident to bed ratio (line 18 divided by line 4	4).		0.041515	
20.00	Prior year resident to bed ratio (see instructions) Enter the lesser of lines 19 or 20 (see instructions)			0. 041423 0. 041423	
22.00	IME payment adjustment (see instructions) IME payment adjustment – Managed Care (see instructions)			1, 823, 454 817, 979	
23. 00	Indirect Medical Education Adjustment for the Add-on for § 42 Number of additional allopathic and osteopathic IME FTE resid (f)(1)(iv)(C).		CFR 412.105	0.00	23.00
24. 00 25. 00	IME FTE Resident Count Over Cap (see instructions) If the amount on line 24 is greater than -O-, then enter the	lower of line 23 or lin	e 24 (see		24. 00 25. 00
26.00	instructions) Resident to bed ratio (divide line 25 by line 4)			0. 000000	26.00
27.00	IME payments adjustment factor. (see instructions)			0. 000000	27.00
28.00	IME add-on adjustment amount (see instructions)			0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions	s)		0	
29. 00 29. 01	Total IME payment ( sum of lines 22 and 28) Total IME payment - Managed Care (sum of lines 22.01 and 28.0	01)		1, 823, 454 817, 979	
00.00	Disproportionate Share Adjustment			0.51	
	Percentage of SSI recipient patient days to Medicare Part A	patient days (see instru	CTIONS)		30.00
31.00	Percentage of Medicaid patient days (see instructions)			18.48	
32.00	Sum of lines 30 and 31	2)			32.00
	Allowable disproportionate share percentage (see instructions	5)			33.00
34.00	Disproportionate share adjustment (see instructions)			1, 456, 726	1 34.00

Heal th	Financial Systems SI. FRANCIS HOSPITAL &	HEALIH CENIER	In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT		eriod:	Worksheet E	
			rom 01/01/2018 0 12/31/2018		narodi
		1	o 12/31/2018	Date/Time Pre 5/31/2019 7:4	
		Title XVIII	Hospi tal	PPS	<u>, cin</u>
			Prior to 10/1	,	
			1.00	2.00	
	Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)		6, 766, 695, 164	8, 272, 872, 447	35.00
35.01	Factor 3 (see instructions)		0.000597737	0.000819816	
35.02	Hospital uncompensated care payment (If line 34 is zero, enter	zero on this line) (see		6, 782, 233	
	instructions)	, (	., ,		
35.03	Pro rata share of the hospital uncompensated care payment amour	nt (see instructions)	3, 025, 216	1, 709, 496	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		4, 734, 712		36.00
	Additional payment for high percentage of ESRD beneficiary disc	/			
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding di		0		40.00
	652, 682, 683, 684 and 685 (see instructions)	3			
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683	3, 684 an 685. (see	0		41.00
	instructions)				
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DF	RGs 652, 682, 683, 684	0		41.01
	an 685. (see instructions)				
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify	y for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682,	, 683, 684 an 685. (see	0		43.00
	instructions)				
44.00	Ratio of average length of stay to one week (line 43 divided by	y line 41 divided by 7	0. 000000		44.00
	days)				
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.0	01)	0		46.00
47.00	Subtotal (see instructions)		94, 762, 795		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, sma	all rural hospitals	0		48.00
	only. (see instructions)				
				Amount	
				1.00	
49.00	Total payment for inpatient operating costs (see instructions)			95, 580, 774	
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and			8, 336, 208	
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. I			0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line	e 49 see instructions).		775, 438	
53.00	Nursing and Allied Health Managed Care payment			192, 038	
54.00	Special add-on payments for new technologies			46, 095	54.00
54.01	Islet isolation add-on payment	<b>N</b>		0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)	e		0	55.00
56.00 57.00	Cost of physicians' services in a teaching hospital (see intrue Routine service other pass through costs (from Wkst. D, Pt. III		nough 2E)	0	56.00 57.00
58.00			ough 55).	232, 647	58.00
58.00 59.00	Ancillary service other pass through costs from Wkst. D, Pt. IN Total (sum of amounts on lines 49 through 58)	v, cor. If fine 200)		105, 163, 200	•
60.00	Primary payer payments			8, 643	
61.00	Total amount payable for program beneficiaries (line 59 minus l	Lino (0)		105, 154, 557	61.00
62.00	Deductibles billed to program beneficiaries			7, 236, 664	•
63.00	Coinsurance billed to program beneficiaries			294, 613	
64.00	Allowable bad debts (see instructions)			637,065	
65.00	Adjusted reimbursable bad debts (see instructions)			414, 092	
66. 00	Allowable bad debts for dual eligible beneficiaries (see instru	uctions)		112, 842	
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			98, 037, 372	
68.00	Credits received from manufacturers for replaced devices for ag	nnlicable to MS_DPCs (so	- instructions)		
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (F			0	
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		,	0	70.00
70.00	Rural Community Hospital Demonstration Project (§410A Demonstra	ation) adjustment (see in	nstructions)	0	70.00
70. 30	Demonstration payment adjustment amount before sequestration	ation, agastherit (see I		0	70.87
70.87	SCH or MDH volume decrease adjustment (contractor use only)			0	70.87
70.88	Pioneer ACO demonstration payment adjustment amount (see instru	uctions)			70.88
70.89	HSP bonus payment HVBP adjustment amount (see instructions)			0	70.89
70.90	HSP bonus payment HRR adjustment amount (see instructions)			0	70.90
70.92	Bundled Model 1 discount amount (see instructions)			0	70.92
	. , ,			-340, 560	
				-111, 761	70.93
					70.95
70. 93 70. 94 70. 95	HVBP payment adjustment amount (see instructions) HRR adjustment amount (see instructions) Recovery of accelerated depreciation				761

	A HEALTH CEN	IER		u of Form CMS-2	2002-
ALCULATION OF REIMBURSEMENT SETTLEMENT	Provider C		Period: From 01/01/2018 To 12/31/2018	Date/Time Pre	pare
				5/31/2019 7:4	7 am
	litie	XVIII	Hospi tal	PPS	
		FFY	(уууу)	Amount	
) 0/ Low volume adjustment for federal ficeral very (very) (Enter i			0	1.00	70
0.96 Low volume adjustment for federal fiscal year (yyyy) (Enter i the corresponding federal year for the period prior to 10/1)			0	0	70.
D. 97 Low volume adjustment for federal fiscal year (yyyy) (Enter i the corresponding federal year for the period ending on or af			0	0	70.
).98 Low Volume Payment-3				0	70.
). 99 HAC adjustment amount (see instructions)				1, 035, 108	70.
1.00 Amount due provider (line 67 minus lines 68 plus/minus lines	69 & 70)			96, 549, 943	71.
01 Sequestration adjustment (see instructions)				1, 930, 999	
0.02 Demonstration payment adjustment amount after sequestration				0	
2.00 Interim payments				95, 254, 174	72.
3.00 Tentative settlement (for contractor use only)				0	73.
I.OO Balance due provider/program (line 71 minus lines 71.01, 71.0 73)	2, 72, and			-635, 230	74.
5.00 Protested amounts (nonallowable cost report items) in accorda CMS Pub. 15-2, chapter 1, §115.2	nce with			2, 090, 350	75.
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
0.00 Operating outlier amount from Wkst. E, Pt. A, line 2, or sum plus 2.04 (see instructions)	of 2.03			0	90.
.00 Capital outlier from Wkst. L, Pt. I, line 2				0	91.
. 00 Operating outlier reconciliation adjustment amount (see instr				0	92
.00 Capital outlier reconciliation adjustment amount (see instruc	tions)			0	93
.00 The rate used to calculate the time value of money (see instr				0.00	94
.00 Time value of money for operating expenses (see instructions)	,			0	95
.00 Time value of money for capital related expenses (see instruc				0	96
			Prior to 10/1	On/After 10/1	
			Prior to 10/1 1.00	0n/After 10/1 2.00	
HSP Bonus Payment Amount			1.00	2.00	100
0.00 HSP bonus amount (see instructions)				2.00	100
0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment			1.00	2.00	
0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 1.00 HVBP adjustment factor (see instructions)			0.000000000	2.00 0 0.000000000	101
0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment 1.00 HVBP adjustment factor (see instructions) 2.00 HVBP adjustment amount for HSP bonus payment (see instruction	s)		1.00	2.00 0 0.000000000	101
<ul> <li>0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment</li> <li>1.00 HVBP adjustment factor (see instructions)</li> <li>2.00 HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment</li> </ul>	s)		1.00 0 0.0000000000 0	2.00 0 0.000000000 0	101 102
<ul> <li>0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment</li> <li>1.00 HVBP adjustment factor (see instructions)</li> <li>2.00 HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment</li> <li>3.00 HRR adjustment factor (see instructions)</li> </ul>			1.00 0.000000000 0 0.0000	2.00 0 0.000000000 0 0.0000	101 102 103
<ul> <li>0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment</li> <li>1.00 HVBP adjustment factor (see instructions)</li> <li>2.00 HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment</li> <li>3.00 HRR adjustment factor (see instructions)</li> <li>4.00 HRR adjustment amount for HSP bonus payment (see instructions)</li> </ul>	;)		1.00 0 0.0000000000 0	2.00 0 0.000000000 0 0.0000	101 102 103
<ul> <li>0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment</li> <li>1.00 HVBP adjustment factor (see instructions)</li> <li>2.00 HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment</li> <li>3.00 HRR adjustment factor (see instructions)</li> <li>4.00 HRR adjustment amount for HSP bonus payment (see instructions)</li> <li>Rural Community Hospital Demonstration Project (§410A Demonst</li> </ul>	) ration) Adju		1.00 0.000000000 0 0.0000	2.00 0.000000000 0 0.0000 0.0000 0	101 102 103 104
<ul> <li>0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment</li> <li>1.00 HVBP adjustment factor (see instructions)</li> <li>2.00 HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment</li> <li>3.00 HRR adjustment factor (see instructions)</li> <li>4.00 HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst</li> <li>0.00 Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no.</li> </ul>	) ration) Adju		1.00 0.000000000 0 0.0000	2.00 0.000000000 0 0.0000 0.0000 0	101 102 103 104
<ul> <li>0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment</li> <li>1.00 HVBP adjustment factor (see instructions)</li> <li>2.00 HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment</li> <li>3.00 HRR adjustment factor (see instructions)</li> <li>4.00 HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst</li> <li>0.00 Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement</li> </ul>	) ration) Adju riod under		1.00 0.000000000 0 0.0000	2.00 0 0.000000000 0 0.0000 0	101 102 103 104 200
<ul> <li>0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment</li> <li>1.00 HVBP adjustment factor (see instructions)</li> <li>2.00 HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment</li> <li>3.00 HRR adjustment factor (see instructions)</li> <li>4.00 HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst</li> <li>0.00 Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement</li> <li>1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin</li> </ul>	) ration) Adju riod under		1.00 0.000000000 0 0.0000	2.00 0.0000000000 0.0000 0.0000 0	101 102 103 104 200
<ol> <li>0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment</li> <li>1.00 HVBP adjustment factor (see instructions)</li> <li>2.00 HVBP adjustment for HSP Bonus Payment (see instruction HRR Adjustment for HSP Bonus Payment</li> <li>3.00 HRR adjustment factor (see instructions)</li> <li>4.00 HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst</li> <li>0.00 Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement</li> <li>1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. 11, lin</li> <li>2.00 Medicare discharges (see instructions)</li> </ol>	) ration) Adju riod under		1.00 0.000000000 0 0.0000	2.00 0.000000000 0 0.0000 0	101 102 103 104 200 201 202
<ul> <li>0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment</li> <li>1.00 HVBP adjustment factor (see instructions)</li> <li>2.00 HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment</li> <li>3.00 HRR adjustment factor (see instructions)</li> <li>4.00 HRR adjustment amount for HSP bonus payment (see instructions)</li> <li>4.00 HRR adjustment amount for HSP bonus payment (see instructions)</li> <li>4.00 HRR adjustment amount for HSP bonus payment (see instructions)</li> <li>6.00 Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement</li> <li>1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin</li> <li>2.00 Medicare discharges (see instructions)</li> <li>3.00 Case-mix adjustment factor (see instructions)</li> </ul>	) ration) Adju riod under e 49)	the 21st	1.00 0.000000000 0.0000 0.0000 0.0000	2.00 0.000000000 0 0.0000 0	101 102 103 104 200 201 202
<ul> <li>0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment</li> <li>1.00 HVBP adjustment factor (see instructions)</li> <li>2.00 HVBP adjustment for HSP Bonus Payment</li> <li>3.00 HRR adjustment factor (see instructions)</li> <li>4.00 HRR adjustment factor (see instructions)</li> <li>4.00 HRR adjustment amount for HSP bonus payment (see instructions)</li> <li>4.00 HRR adjustment amount for HSP bonus payment (see instructions)</li> <li>4.00 HRR adjustment amount for HSP bonus payment (see instructions)</li> <li>4.00 HRR adjustment amount for HSP bonus payment (see instructions)</li> <li>6.00 HRR adjustment amount for HSP bonus payment (see instructions)</li> <li>7.00 HSP bonus payment (see instructions)</li> <li>7.00 HSP bonus payment (see instructions)</li> <li>8.00 Case-mix adjustment factor (see instructions)</li> <li>8.00 Case-mix adjustment factor (see instructions)</li> <li>7.00 Medicare of Demonstration Target Amount Limitation (N/A in Computation of Demonstration Target Amount Limitation</li> </ul>	) ration) Adju riod under e 49)	the 21st	1.00 0.000000000 0.0000 0.0000 0.0000	2.00 0.000000000 0 0.0000 0	101 102 103 104 200 201 202
<ul> <li>0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment</li> <li>1.00 HVBP adjustment factor (see instructions)</li> <li>2.00 HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment</li> <li>3.00 HRR adjustment factor (see instructions)</li> <li>4.00 HRR adjustment for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst</li> <li>0.00 Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement</li> <li>1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin</li> <li>2.00 Medicare discharges (see instructions)</li> <li>3.00 Case-mix adjustment factor (see instructions)</li> <li>Computation of Demonstration Target Amount Limitation (N/A in period)</li> </ul>	) ration) Adju riod under e 49)	the 21st	1.00 0.000000000 0.0000 0.0000 0.0000	2.00 0.000000000 0.0000 0 0.0000 0	101 102 103 104 200 201 202 203
<ul> <li>0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment</li> <li>1.00 HVBP adjustment factor (see instructions)</li> <li>2.00 HVBP adjustment for HSP Bonus Payment (see instruction HRR Adjustment for HSP Bonus Payment</li> <li>3.00 HRR adjustment factor (see instructions)</li> <li>4.00 HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst 0.00 Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement</li> <li>1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin</li> <li>2.00 Medicare discharges (see instructions)</li> <li>3.00 Case-mix adjustment factor (see instructions)</li> <li>4.00 Medicare target amount</li> </ul>	) ration) Adju riod under e 49)	the 21st	1.00 0.000000000 0.0000 0.0000 0	2.00 0.000000000 0.0000 0.0000 0	101 102 103 104 200 201 202 203
<ul> <li>0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment</li> <li>1.00 HVBP adjustment factor (see instructions)</li> <li>2.00 HVBP adjustment for HSP Bonus Payment (see instruction HRR Adjustment for HSP Bonus Payment</li> <li>3.00 HRR adjustment factor (see instructions)</li> <li>4.00 HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst 0.00 Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement</li> <li>1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin</li> <li>2.00 Medicare discharges (see instructions)</li> <li>3.00 Case-mix adjustment factor (see instructions)</li> <li>4.00 Medicare target amount</li> <li>4.00 Medicare inpatient service costs (line 203 times line 204)</li> </ul>	.) rition) Adju ritiod under e 49) first year	the 21st	1.00 0.000000000 0.0000 0.0000 0	2.00 0.000000000 0.0000 0.0000 0	101 102 103 104 200 201 202 203 203 204 204
<ul> <li>0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment</li> <li>1.00 HVBP adjustment factor (see instructions)</li> <li>2.00 HVBP adjustment for HSP Bonus Payment (see instruction HRR adjustment for HSP Bonus Payment</li> <li>3.00 HRR adjustment factor (see instructions)</li> <li>4.00 HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst 0.00 Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement</li> <li>1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin 2.00 Medicare discharges (see instructions)</li> <li>3.00 Case-mix adjustment factor (see instructions)</li> <li>4.00 Medicare target amount</li> <li>5.00 Case-mix adjusted target amount (line 203 times line 204)</li> <li>6.00 Medicare inpatient routine cost cap (line 202 times line 205)</li> </ul>	.) rition) Adju ritiod under e 49) first year	the 21st	1.00 0.000000000 0.0000 0.0000 0	2.00 0.000000000 0.0000 0.0000 0	101 102 103 104 200 201 202 203
<ul> <li>0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment</li> <li>1.00 HVBP adjustment factor (see instructions)</li> <li>2.00 HVBP adjustment for HSP Bonus Payment (see instruction HRR adjustment for HSP Bonus Payment</li> <li>3.00 HRR adjustment factor (see instructions)</li> <li>4.00 HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst 0.00 Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement</li> <li>1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin</li> <li>2.00 Medicare discharges (see instructions)</li> <li>3.00 Case-mix adjustment factor (see instructions)</li> <li>3.00 Case-mix adjustment factor (see instructions)</li> <li>4.00 Medicare target amount</li> <li>5.00 Kase-mix adjusted target amount (line 203 times line 204)</li> <li>5.00 Medicare to Medicare Part A Inpatient Reimbursement</li> </ul>	) ration) Adju riod under e 49) first year	the 21st	1.00 0.000000000 0.0000 0.0000 0	2.00 0.0000000000 0 0.0000 0	101 102 103 104 200 201 202 203 204 205 206
<ul> <li>0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment</li> <li>1.00 HVBP adjustment factor (see instructions)</li> <li>2.00 HVBP adjustment for HSP Bonus Payment (see instruction HRR adjustment for HSP Bonus Payment</li> <li>3.00 HRR adjustment factor (see instructions)</li> <li>4.00 HRR adjustment factor (see instructions)</li> <li>4.00 HRR adjustment amount for HSP bonus payment (see instructions)</li> <li>4.00 HRR adjustment amount for HSP bonus payment (see instructions)</li> <li>4.00 HRR adjustment amount for HSP bonus payment (see instructions)</li> <li>6.00 HRR adjustment amount for HSP bonus payment (see instructions)</li> <li>7.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin period)</li> <li>4.00 Medicare target amount</li> <li>6.00 Medicare inpatient factor (see instructions)</li> <li>6.00 Medicare target amount</li> <li>6.00 Medicare target amount</li> <li>7.00 Program reimbursement under the §410A Demonstration (see instruction)</li> </ul>	) ration) Adju riod under e 49) first year ructions)	the 21st	1.00 0.000000000 0.0000 0.0000 0	2.00 0.00000000000000000000000000000000	101 102 103 104 200 201 202 203 204 205 206 207
<ul> <li>0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment</li> <li>1.00 HVBP adjustment factor (see instructions)</li> <li>2.00 HVBP adjustment for HSP Bonus Payment</li> <li>3.00 HRR adjustment for HSP Bonus Payment</li> <li>3.00 HRR adjustment factor (see instructions)</li> <li>4.00 HRR adjustment factor (see instructions)</li> <li>4.00 HRR adjustment amount for HSP bonus payment (see instructions)</li> <li>4.00 HRR adjustment factor (see instructions)</li> <li>4.00 HRR adjustment amount for HSP bonus payment (see instructions)</li> <li>6.00 HRR adjustment amount for HSP bonus payment (see instructions)</li> <li>7.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin 200 Medicare discharges (see instructions)</li> <li>8.00 Case-mix adjustment factor (see instructions)</li> <li>8.00 Medicare target amount</li> <li>6.00 Medicare inpatient routine cost cap (line 203 times line 204)</li> <li>6.00 Medicare Part A Inpatient Reimbursement</li> <li>7.00 Program reimbursement under the \$410A Demonstration (see instruction (see instructions)</li> </ul>	) ration) Adju riod under e 49) first year ructions)	the 21st	1.00 0.000000000 0.0000 0.0000 0	2.00 0.000000000 0.0000 0 0.0000 0	101 102 103 104 200 201 202 203 204 205 206 207 208
<ul> <li>0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment</li> <li>1.00 HVBP adjustment factor (see instructions)</li> <li>2.00 HVBP adjustment for HSP Bonus Payment (see instruction HRR Adjustment for HSP Bonus Payment</li> <li>3.00 HRR adjustment factor (see instructions)</li> <li>4.00 HRR adjustment factor (see instructions)</li> <li>4.00 HRR adjustment amount for HSP bonus payment (see instructions)</li> <li>7.00 HRR adjustment factor (see instructions)</li> <li>7.00 HRR adjustment amount for HSP bonus payment (see instructions)</li> <li>8.00 HRR adjustment amount for HSP bonus payment (see instructions)</li> <li>7.00 HRR adjustment amount for HSP bonus payment (see instruction per Century Cures Act? Enter "Y" for yes or "N" for no.</li> <li>7.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin 2.00 Medicare discharges (see instructions)</li> <li>8.00 Case-mix adjustment factor (see instructions)</li> <li>8.00 Case-mix adjusted target amount (line 203 times line 204)</li> <li>6.00 Medicare inpatient routine cost cap (line 202 times line 205)</li> <li>7.00 Program reimbursement under the §410A Demonstration (see instructions)</li> <li>8.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, 9.00 Adjustment to Medicare IPPS payments (see instructions)</li> </ul>	) ration) Adju riod under e 49) first year ructions)	the 21st	1.00 0.000000000 0.0000 0.0000 0	2.00 0.000000000 0.0000 0.0000 0	101 102 103 104 200 201 202 203 204 205 206 207 208 207 208 209
<ul> <li>0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment</li> <li>1.00 HVBP adjustment factor (see instructions)</li> <li>2.00 HVBP adjustment for HSP Bonus Payment (see instruction HRR adjustment for HSP Bonus Payment</li> <li>3.00 HRR adjustment factor (see instructions)</li> <li>4.00 HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement</li> <li>1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin</li> <li>2.00 Medicare discharges (see instructions)</li> <li>3.00 Case-mix adjustment factor (see instructions)</li> <li>4.00 Medicare target amount</li> <li>5.00 Case-mix adjusted target amount (line 203 times line 204)</li> <li>6.00 Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement</li> <li>7.00 Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, 9.00 Adjustment to Medicare IPPS payments (see instructions)</li> </ul>	) ration) Adju riod under e 49) first year first year ructions) line 59)	the 21st	1.00 0.000000000 0.0000 0.0000 0	2.00 0.000000000 0.0000 0.0000 0	101 102 103 104 200 201 202 203 204 205 206 207 208 207 208 209 210
<ul> <li>0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment</li> <li>1.00 HVBP adjustment factor (see instructions)</li> <li>2.00 HVBP adjustment for HSP Bonus Payment (see instruction HRR Adjustment for HSP Bonus Payment</li> <li>3.00 HRR adjustment factor (see instructions)</li> <li>4.00 HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst 0.00 Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement</li> <li>1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin 2.00 Medicare discharges (see instructions)</li> <li>3.00 Case-mix adjustment factor (see instructions)</li> <li>3.00 Case-mix adjusted target amount (line 203 times line 204)</li> <li>4.00 Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement</li> <li>7.00 Program reimbursement under the §410A Demonstration (see inst Adjustment to Medicare IPPS payments (see instructions)</li> <li>0.00 Reserved for future use</li> <li>1.00 Total adjustment to Medicare IPPS payments (see instructions)</li> </ul>	) ration) Adju riod under e 49) first year first year ructions) line 59)	the 21st	1.00 0.000000000 0.0000 0.0000 0	2.00 0.000000000 0.0000 0.0000 0	101 102 103 104 200 201 202 203 204 205 206 207 208 207 208 209 210
<ul> <li>0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment</li> <li>0.00 HVBP adjustment factor (see instructions)</li> <li>00 HVBP adjustment for HSP Bonus Payment (see instruction HRR Adjustment for HSP Bonus Payment (see instructions)</li> <li>00 HRR adjustment factor (see instructions)</li> <li>00 HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst 0.00 Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no.</li> <li>Cost Reimbursement</li> <li>00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin 0.00 Case-mix adjustment factor (see instructions)</li> <li>00 Case-mix adjustment factor (see instructions)</li> <li>00 Case-mix adjustment factor (see instructions)</li> <li>00 Medicare target amount</li> <li>01 OM Medicare target amount</li> <li>02 Case-mix adjusted target amount (line 203 times line 204)</li> <li>03 Medicare inpatient routine cost cap (line 202 times line 205)</li> <li>04 Adjustment to Medicare Part A Inpatient Reimbursement</li> <li>05 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, 19:00 Adjustment to Medicare IPPS payments (see instructions)</li> <li>00 Reserved for future use</li> <li>01 Otal adjustment to Medicare IPPS payments (see instructions)</li> <li>02 Comparision of PPS versus Cost Reimbursement</li> </ul>	) ration) Adju riod under e 49) first year ructions) line 59)	the 21st	1.00 0.000000000 0.0000 0.0000 0	2.00 0.0000000000 0.0000 0.0000 0 	101 102 103 104 200 201 202 203 204 205 206 207 208 209 210 211
<ul> <li>0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment</li> <li>0.00 HVBP adjustment factor (see instructions)</li> <li>0.00 HVBP adjustment for HSP Bonus Payment (see instruction HRR Adjustment for HSP Bonus Payment (see instructions)</li> <li>0.00 HRR adjustment amount for HSP bonus payment (see instructions)</li> <li>0.00 HRR adjustment factor (see instructions)</li> <li>0.00 HRR adjustment amount for HSP bonus payment (see instructions)</li> <li>0.00 HRR adjustment amount for HSP bonus payment (see instructions)</li> <li>0.00 Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no.</li> <li>Cost Reimbursement</li> <li>0.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin</li> <li>0.00 Case-mix adjustment factor (see instructions)</li> <li>1.00 Medicare target amount</li> <li>1.00 Program reimbursement under the §410A Demonstration (see inst</li> <li>1.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A,</li> <li>1.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A,</li> <li>1.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A,</li> <li>1.00 Medicare Part to Medicare IPPS payments (see instructions)</li> <li>1.00 Total adjustment to Medicare Part A IPPS payments (from line</li> </ul>	) ration) Adju riod under e 49) first year ructions) line 59)	the 21st	1.00 0.000000000 0.0000 0.0000 0	2.00 0.000000000 0.0000 0.0000 0 0.0000 0 0 0 0 0 0 0 0 0 0 0 0	101 102 103 104 200 201 202 203 204 205 206 207 208 209 210 211 212
<ul> <li>00.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment</li> <li>01.00 HVBP adjustment factor (see instructions)</li> <li>02.00 HVBP adjustment for HSP Bonus Payment (see instruction HRR Adjustment for HSP Bonus Payment (see instructions)</li> <li>03.00 HRR adjustment factor (see instructions)</li> <li>04.00 HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst 00.00 Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement</li> <li>01.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin 02.00 Medicare discharges (see instructions)</li> <li>03.00 Case-mix adjustment factor (see instructions)</li> <li>04.00 Medicare target amount</li> <li>05.00 Case-mix adjusted target amount (line 203 times line 204)</li> <li>04.00 Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement</li> <li>04.00 Program reimbursement under the §410A Demonstration (see inst 07.00 Program reimbursement under the \$410A Demonstration (see inst 08.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, 09.00 Adjustment to Medicare IPPS payments (see instructions)</li> <li>03.00 Reserved for future use</li> <li>1.00 Total adjustment to Medicare IPPS payments (see instructions)</li> </ul>	) riod under e 49) first year ructions) line 59) 211)	of the curre	1.00 0.000000000 0.0000 0.0000 0	2.00 0.000000000 0.0000 0.0000 0 0.0000 0 0 0 0 0 0 0 0 0 0 0 0	101 102 103 104 200 201 202 203 204 205 206 207 208 207 208 209 210

OSPI 1	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5	5 Provider C	CN: 15-0162	Period:	Worksheet E	
					From 01/01/2018 To 12/31/2018	Part A Exhibi Date/Time Pre 5/31/2019 7:4	pared:
			Title	XVIII	Hospi tal	PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
. 00	DRG amounts other than outlier payments	1.00					1.00
. 01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1. 01	60, 755, 331	60, 755, 33	31	60, 755, 331	1.01
. 02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1. 02	20, 739, 809		20, 739, 809	20, 739, 809	1.0
. 03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1. 03	0		0	0	1.03
. 04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.0
. 00	Outlier payments for discharges (see instructions)	2.00	5, 252, 763	4, 215, 14	41 1, 037, 622	5, 252, 763	2.0
. 01	Outlier payments for discharges for Model 4 BPCI	2. 02	0		0 0	0	2.0
. 00	Operating outlier reconciliation	2. 01	0		0 0	0	3.0
. 00	Managed care simulated payments Indirect Medical Education Adjustment	3.00	36, 557, 699	27,037,80	9, 519, 897	36, 557, 699	4.0
. 00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0. 041423	0. 04142	0. 041423		5.0
. 00	IME payment adjustment (see instructions)	22.00	1, 823, 454	1, 359, 40	464, 053	1, 823, 454	6.0
. 01	IME payment adjustment for managed care (see instructions)		817, 979		213, 008	817, 979	6.0
~~	Indirect Medical Education Adjustment for the						
. 00	IME payment adjustment factor (see instructions)	27.00	0. 000000	0.0000			7.0
. 00 . 01	IME adjustment (see instructions) IME payment adjustment add on for managed care (see instructions)	28. 00 28. 01	0		0 0 0 0	0	8. C 8. C
. 00 . 01	Total IME payment (sum of lines 6 and 8) Total IME payment for managed care (sum of	29. 00 29. 01	1, 823, 454 817, 979			1, 823, 454 817, 979	9.0 9.0
	lines 6.01 and 8.01)						
	Disproportionate Share Adjustment						
0. 00	Allowable disproportionate share percentage (see instructions)	33.00	0. 0715	0. 071	0. 0715		10. C
1. 00	Disproportionate share adjustment (see instructions)	34.00	1, 456, 726	1, 086, 00	370, 724	1, 456, 726	11. C
1. 01	Uncompensated care payments	36.00	4, 734, 712	3, 025, 21	16 1, 709, 496	4, 734, 712	11.0
	Additional payment for high percentage of ESI						
2.00	Total ESRD additional payment (see instructions)	46.00	0		0 0	0	
3.00 4.00	Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	47.00 48.00	94, 762, 795 0	70, 441, 09	91 24, 321, 704 0 0	94, 762, 795 0	
5.00	Total payment for inpatient operating costs (see instructions)	49.00	95, 580, 774	71, 046, 06	52 24, 534, 712	95, 580, 774	15.0
5. 00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50. 00	8, 336, 208	6, 235, 02	25 2, 101, 183	8, 336, 208	16.0
7.00 7.01	Special add-on payments for new technologies Net organ acquisition cost	54.00	46, 095	34, 47	77 11, 618	46, 095	17.0 17.0
7. 02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0		0 0	0	
8.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0		0 0	0	18.0
0 00	SUBTOTAL			77, 315, 56	64 26, 647, 513	103, 963, 077	10 0

IOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCUL	ATION EXHIBIT 5			Period: From 01/01/2018 To 12/31/2018	Date/Time Pre 5/31/2019 7:4	pared:
	Wkst. L, line	(Amt. from Wkst. L)	XVIII	Hospi tal	PPS	
	0	1.00	2.00	3.00	4,00	
20.00 Capital DRG other than outlier	1.00	6, 636, 580	4, 963, 79			20.00
20.01 Model 4 BPCI Capital DRG other than outlier	1.01	0	.,	0 0		
21.00 Capital DRG outlier payments	2.00	1, 279, 533	957, 02	322, 513	1, 279, 533	
21.01 Model 4 BPCI Capital DRG outlier payments	2.01	0		0 0	0	
22.00 Indirect medical education percentage (see instructions)	5.00	0. 0183	0. 018	0. 0183		22.0
23.00 Indirect medical education adjustment (see instructions)	6.00	121, 449	90, 83	30, 612	121, 449	23.0
24.00 Allowable disproportionate share percentage (see instructions)	10. 00	0. 0450	0. 045	0. 0450		24.0
25.00 Disproportionate share adjustment (see instructions)	11.00	298, 646	223, 37	71 75, 275	298, 646	25.0
26.00 Total prospective capital payments (see instructions)	12.00	8, 336, 208	6, 235, 02	2, 101, 183	8, 336, 208	26.0
	Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
	0	1.00	2.00	3.00	4.00	
27.00						27.0
8.00 Low volume adjustment prior to October 1	70. 96	0		0	0	
9.00 Low volume adjustment on or after October 1	70. 97	0		0	0	1 - / . 0
30.00 HVBP payment adjustment (see instructions)	70. 93	-340, 560	-254, 72	-85, 840	-340, 560	
80.01 HVBP payment adjustment for HSP bonus payment (see instructions)	70. 90	0		0 0	0	
31.00 HRR adjustment (see instructions)	70. 94	-111, 761	-83, 59	-28, 170		
81.01 HRR adjustment for HSP bonus payment (see instructions)	70. 91	0		0 0	0	31.0
					(Amt. to Wkst. E, Pt. A)	
	0	1.00	2.00	3.00	4.00	
32.00 HAC Reduction Program adjustment (see instructions)	70. 99		769, 77	265, 335	1, 035, 108	32.0
00.00 Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100. 0

Health Financial Systems S CALCULATION OF RELMBURSEMENT SETTLEMENT

ST.	FRANCI S	HOSPI TAL	&	HEALTH	CENTER	

		Provi der CCN: 15-0162	Peri od: From 01/01/2018 To 12/31/2018		epare
		Title XVIII	Hospi tal	PPS	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
00	Medical and other services (see instructions)			27, 769	1 1.
00	Medical and other services reimbursed under OPPS (see instruct	ions)		63, 898, 526	
00	OPPS payments			52, 873, 795	
00	Outlier payment (see instructions)			270, 389	
01	Outlier reconciliation amount (see instructions)			0	1
00	Enter the hospital specific payment to cost ratio (see instruc	tions)		0.000	
00	Line 2 times line 5			0.000	
00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	
00	Transitional corridor payment (see instructions)			0.00	
00	Ancillary service other pass through costs from Wkst. D, Pt. 1	V col 13 line 200		362, 701	
	Organ acquisitions	v, col. 13, time 200		0	
	5 I			-	
. 00	Total cost (sum of lines 1 and 10) (see instructions)			27, 769	11.
	COMPUTATION OF LESSER OF COST OR CHARGES				-
~~	Reasonable charges			101 100	1 1 2
	Ancillary service charges			181, 192	
	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, li	ne 69)		0	
. 00	Total reasonable charges (sum of lines 12 and 13)			181, 192	14
	Customary charges				
	Aggregate amount actually collected from patients liable for p	3	U	0	
. 00	Amounts that would have been realized from patients liable for		on a chargebasis	0	16
	had such payment been made in accordance with 42 CFR §413.13(e				
	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.00000	
. 00	Total customary charges (see instructions)			181, 192	18
. 00	Excess of customary charges over reasonable cost (complete onl	y if line 18 exceeds l	ine 11) (see	153, 423	19
	instructions)				
. 00	Excess of reasonable cost over customary charges (complete onl	y if line 11 exceeds li	ine 18) (see	0	20
	instructions)				
. 00	Lesser of cost or charges (see instructions)			27, 769	21
. 00	Interns and residents (see instructions)			0	22
. 00	Cost of physicians' services in a teaching hospital (see instr	uctions)		0	23
. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			53, 506, 885	24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
. 00	Deductibles and coinsurance amounts (for CAH, see instructions	)		221	25
	Deductibles and Coinsurance amounts relating to amount on line	-	ructions)	9, 495, 882	
	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) p	•	,	44, 038, 551	
	instructions)		(		
00	Direct graduate medical education payments (from Wkst. E-4, li	ne 50)		418, 223	28
	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	
	Subtotal (sum of lines 27 through 29)			44, 456, 774	
	Primary payer payments			8, 834	
	Subtotal (line 30 minus line 31)			44, 447, 940	
. 00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVIC	ES)		44, 447, 740	32
		E3)		0	1 22
00					
	Composite rate ESRD (from Wkst. 1-5, line 11)			-	
00	Allowable bad debts (see instructions)			1, 278, 645	34
00 00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			1, 278, 645 831, 119	34 35
00 00 00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instr	uctions)		1, 278, 645 831, 119 740, 694	34 35 36
00 00 00 00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instr Subtotal (see instructions)	uctions)		1, 278, 645 831, 119 740, 694 45, 279, 059	34 35 36 37
00 00 00 00 00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instr Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R	uctions)		1, 278, 645 831, 119 740, 694 45, 279, 059 -214	34 35 36 37 38
00 00 00 00 00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instr Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			1, 278, 645 831, 119 740, 694 45, 279, 059	34 35 36 37 38 39
00 00 00 00 00 00 50	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instr Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions			1, 278, 645 831, 119 740, 694 45, 279, 059 -214	34 35 36 37 38 39
00 00 00 00 00 00 50	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instr Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			1, 278, 645 831, 119 740, 694 45, 279, 059 -214	34 35 36 37 38 39 39
00 00 00 00 00 50 97	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instr Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions	)	ctions)	1, 278, 645 831, 119 740, 694 45, 279, 059 -214 0	34 35 36 37 38 39 39 39
00 00 00 00 00 50 97 98	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instr Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions Demonstration payment adjustment amount before sequestration	)	ctions)	1, 278, 645 831, 119 740, 694 45, 279, 059 -214 0	34 35 36 37 38 39 39 39 39
00 00 00 00 00 50 97 98 99	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instr Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions Demonstration payment adjustment amount before sequestration Partial or full credits received from manufacturers for replac	)	ctions)	1, 278, 645 831, 119 740, 694 45, 279, 059 -214 0 0 0	34 35 36 37 38 39 39 39 39 39
00 00 00 00 00 50 97 98 99 00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instr Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions Demonstration payment adjustment amount before sequestration Partial or full credits received from manufacturers for replac RECOVERY OF ACCELERATED DEPRECIATION	)	ctions)	1, 278, 645 831, 119 740, 694 45, 279, 059 -214 0 0 0 0 0 0	34 35 36 37 38 39 39 39 39 39 39
00 00 00 00 00 50 97 98 99 00 01	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instr Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions Demonstration payment adjustment amount before sequestration Partial or full credits received from manufacturers for replac RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions)	)	ctions)	1, 278, 645 831, 119 740, 694 45, 279, 059 -214 0 0 0 0 45, 279, 273	34 35 36 37 38 39 39 39 39 39 40 40
00 00 00 00 00 50 97 98 99 00 01 02	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instr Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions Demonstration payment adjustment amount before sequestration Partial or full credits received from manufacturers for replac RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions) Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration	)	ctions)	1, 278, 645 831, 119 740, 694 45, 279, 059 -214 0 0 45, 279, 273 905, 585 0	34 35 36 37 38 39 39 39 39 39 40 40
. 00 . 00 . 00 . 00 . 00 . 00 . 50 . 97 . 98 . 99 . 00 . 01 . 02 . 00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instr Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions Demonstration payment adjustment amount before sequestration Partial or full credits received from manufacturers for replac RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions) Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration Interim payments	)	ctions)	1, 278, 645 831, 119 740, 694 45, 279, 059 -214 0 0 45, 279, 273 905, 585 0 44, 184, 114	34 35 36 37 38 39 39 39 39 39 40 40 40 40
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 50 . 97 . 98 . 99 . 00 . 01 . 02 . 00 . 00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instr Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions Demonstration payment adjustment amount before sequestration Partial or full credits received from manufacturers for replac RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions) Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration Interim payments Tentative settlement (for contractors use only)	)	ctions)	1, 278, 645 831, 119 740, 694 45, 279, 059 -214 0 0 45, 279, 273 905, 585 0 44, 184, 114 0	34 35 36 37 38 39 39 39 39 39 40 40 40 41 42
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 97 . 98 . 99 . 00 . 01 . 02 . 00 . 00 . 00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instr Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions Demonstration payment adjustment amount before sequestration Partial or full credits received from manufacturers for replac RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions) Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration Interim payments Tentative settlement (for contractors use only) Balance due provider/program (see instructions)	) ed devices (see instru		1, 278, 645 831, 119 740, 694 45, 279, 059 -214 0 0 45, 279, 273 905, 585 0 44, 184, 114 0 189, 574	34 35 36 37 38 39 39 39 39 39 39 40 40 40 40 41 42 43
. 00 . 00 . 00 . 00 . 00 . 00 . 50 . 97 . 98 . 99 . 00 . 01 . 02 . 00 . 00 . 00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instr Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions Demonstration payment adjustment amount before sequestration Partial or full credits received from manufacturers for replac RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions) Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration Interim payments Tentative settlement (for contractors use only) Balance due provider/program (see instructions) Protested amounts (nonallowable cost report items) in accordan	) ed devices (see instru		1, 278, 645 831, 119 740, 694 45, 279, 059 -214 0 0 45, 279, 273 905, 585 0 44, 184, 114 0	34 35 36 37 38 39 39 39 39 39 39 40 40 40 40 41 42 43
. 00 . 00 . 00 . 00 . 00 . 00 . 50 . 97 . 98 . 99 . 00 . 01 . 02 . 00 . 00 . 00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instr Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions Demonstration payment adjustment amount before sequestration Partial or full credits received from manufacturers for replac RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions) Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration Interim payments Tentative settlement (for contractors use only) Balance due provider/program (see instructions) Protested amounts (nonallowable cost report items) in accordan §115. 2	) ed devices (see instru		1, 278, 645 831, 119 740, 694 45, 279, 059 -214 0 0 45, 279, 273 905, 585 0 44, 184, 114 0 189, 574	34 35 36 37 38 39 39 39 39 39 39 40 40 40 40 41 42 43
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instr Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions Demonstration payment adjustment amount before sequestration Partial or full credits received from manufacturers for replac RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions) Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration Interim payments Tentative settlement (for contractors use only) Balance due provider/program (see instructions) Protested amounts (nonallowable cost report items) in accordan §115.2 TO BE COMPLETED BY CONTRACTOR	) ed devices (see instru		1, 278, 645 831, 119 740, 694 45, 279, 059 -214 0 45, 279, 273 0 45, 279, 273 905, 585 0 44, 184, 114 0 189, 574 0	34 35 36 37 38 39 39 39 39 39 40 40 40 41 42 43 44
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instr Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions Demonstration payment adjustment amount before sequestration Partial or full credits received from manufacturers for replac RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions) Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration Interim payments Tentative settlement (for contractors use only) Balance due provider/program (see instructions) Protested amounts (nonallowable cost report items) in accordan §115.2 TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions)	) ed devices (see instru		1, 278, 645 831, 119 740, 694 45, 279, 059 -214 0 45, 279, 273 905, 585 0 44, 184, 114 0 189, 574 0	34 35 36 37 38 39 39 39 39 39 40 40 40 40 41 42 43 44
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instr Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions Demonstration payment adjustment amount before sequestration Partial or full credits received from manufacturers for replac RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions) Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration Interim payments Tentative settlement (for contractors use only) Balance due provider/program (see instructions) Protested amounts (nonallowable cost report items) in accordan §115.2 TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions)	) ed devices (see instru		1, 278, 645 831, 119 740, 694 45, 279, 059 -214 0 45, 279, 273 905, 585 0 44, 184, 114 0 189, 574 0 0	34 35 36 37 38 39 39 39 39 39 40 40 40 40 41 42 43 44 90 91
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instr Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions Demonstration payment adjustment amount before sequestration Partial or full credits received from manufacturers for replac RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions) Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration Interim payments Tentative settlement (for contractors use only) Balance due provider/program (see instructions) Protested amounts (nonallowable cost report items) in accordan §115.2 TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions)	) ed devices (see instru		1, 278, 645 831, 119 740, 694 45, 279, 059 -214 0 45, 279, 273 905, 585 0 44, 184, 114 0 189, 574 0	34 35 36 37 38 39 39 39 39 39 40 40 40 40 41 42 43 44 90 91 92

LCUL	ATION OF REIMBURSEMENT SETTLEMENT	& HEALTH CENTER Provider CCN: 15-0162	Peri od:	Worksheet E	2552-
		Component CCN: 15-T162	From 01/01/2018 To 12/31/2018	Part B Date/Time Pre 5/31/2019 7:4	
		Title XVIII	Subprovider - IRF	PPS	
			-	1.00	
00	PART B - MEDICAL AND OTHER HEALTH SERVICES			140	1
00 00	Medical and other services (see instructions) Medical and other services reimbursed under OPPS (see instru-	ctions)		148 70	
00	OPPS payments			0	
00	Outlier payment (see instructions)			0	
01 00	Outlier reconciliation amount (see instructions)	uctions)		0 0. 000	
00	Enter the hospital specific payment to cost ratio (see instru- Line 2 times line 5			0.000	6
00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	
00	Transitional corridor payment (see instructions)			0	
00 . 00	Ancillary service other pass through costs from Wkst. D, Pt. Organ acquisitions	IV, col. 13, line 200		1 0	
. 00	Total cost (sum of lines 1 and 10) (see instructions)			148	
	COMPUTATION OF LESSER OF COST OR CHARGES			110	
	Reasonable charges				
2.00 3.00	Ancillary service charges Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4,	Line (0)		928 0	
. 00	Total reasonable charges (sum of lines 12 and 13)	TTTE 69)		928	
	Customary charges		I		
5.00	Aggregate amount actually collected from patients liable for			0	
o. 00	Amounts that would have been realized from patients liable for had such payment been made in accordance with 42 CFR §413.13		on a chargebasi's	0	16
. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)	(e)		0.000000	17
3. 00	Total customary charges (see instructions)			928	
. 00	Excess of customary charges over reasonable cost (complete or	nly if line 18 exceeds l	ine 11) (see	780	19
0. 00	instructions) Excess of reasonable cost over customary charges (complete o	nly if line 11 exceeds l	ino 19) (soo	0	20
. 00	instructions)	In y IT The IT exceeds I		0	20
. 00	Lesser of cost or charges (see instructions)			148	21
2.00	Interns and residents (see instructions)			0	
3. 00 . 00	Cost of physicians' services in a teaching hospital (see ins Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	tructions)		0	
. 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			<u> </u>	24
. 00	Deductibles and coinsurance amounts (for CAH, see instruction			0	25
. 00	Deductibles and Coinsurance amounts relating to amount on lin			0	
. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) instructions)	plus the sum of lines 2	2 and 23] (see	149	27
3. 00	Direct graduate medical education payments (from Wkst. E-4,	line 50)		0	28
. 00	ESRD direct medical education costs (from Wkst. E-4, line 36	)		0	29
0.00	Subtotal (sum of lines 27 through 29)			149	
. 00	Primary payer payments Subtotal (line 30 minus line 31)			0 149	
. 00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVI	I CES)		147	32
8.00	Composite rate ESRD (from Wkst. I-5, line 11)			0	33
. 00	Allowable bad debts (see instructions)			0	
5.00 5.00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see ins	tructions)		0	
	Subtotal (see instructions)			149	
. 00	MSP-LCC reconciliation amount from PS&R			0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
	Pioneer ACO demonstration payment adjustment (see instruction			0	39
97 9. 97 9. 98	Demonstration payment adjustment amount before sequestration Partial or full credits received from manufacturers for repla		ctions)	0	
. 99	RECOVERY OF ACCELERATED DEPRECIATION		/	0	
	Subtotal (see instructions)			149	
0.01	Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration			3	
. 02	Interim payments			510	
2.00	Tentative settlement (for contractors use only)			0	42
8.00	Balance due provider/program (see instructions)			-364	
. 00	Protested amounts (nonallowable cost report items) in accorda §115.2	ance with CMS Pub. 15-2,	chapter 1,	0	44
	TO BE COMPLETED BY CONTRACTOR				1
0. 00	Original outlier amount (see instructions)			0	
	Outlier reconciliation adjustment amount (see instructions)			0	
	The rate used to calculate the Time Value of Money			0.00	
3.00	Time Value of Money (see instructions) Total (sum of lines 91 and 93)			0	

VALY:	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CO	-	Period: From 01/01/2018 To 12/31/2018		pare
		Title	XVIII	Hospi tal	PPS	
		I npati en	t Part A	Par	tВ	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
00 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero List separately each retroactive lump sum adjustment		95, 171, 974 (	4	44, 184, 114 0	1. 2. 3.
	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					
01	ADJUSTMENTS TO PROVIDER	07/30/2018	52,600		0	3.
02		07/30/2018	29, 600		0	3.
03				2	0	3
04 05					0	3
00	Provider to Program			5	0	
50	ADJUSTMENTS TO PROGRAM		(	D	0	3
51				C	0	3
52				C	0	3
53 54					0	3
54 99	Subtotal (sum of lines 3.01–3.49 minus sum of lines		82, 200	-	0	3
<i>, ,</i>	3. 50-3. 98)		02,200		0	
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		95, 254, 174	4	44, 184, 114	4
	TO BE COMPLETED BY CONTRACTOR					
00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5
	Program to Provider					
01	TENTATI VE TO PROVIDER			2 2	0	5
)2 )3					0	5
,5	Provider to Program				0	
50	TENTATI VE TO PROGRAM			D	0	5
51				C	0	5
52 99	Subtatal (our of lines E 01 E 40 minus our of lines				0	5
17	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		(		0	5
00	Determined net settlement amount (balance due) based on the cost report. (1)					6
01	SETTLEMENT TO PROVIDER			C	189, 574	6
)2	SETTLEMENT TO PROGRAM		635, 230		0	6
00	Total Medicare program liability (see instructions)		94, 618, 94	4 Contractor	44, 373, 688 NPR Date	7
				Number	(Mo/Day/Yr)	

NALYS	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider Concernent (	CN: 15-0162 CCN: 15-T162	Period:         Worksheet E-           From 01/01/2018         Part I           To         12/31/2018           Date/Time Pris/2019         7:		parec
		Title	XVIII	Subprovider - IRF	PPS	
		I npati en	t Part A		t B	
	-	mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
. 00 . 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		4, 481, 5	0	510 0	1. ( 2. (
. 00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3. (
01	ADJUSTMENTS TO PROVIDER			0	0	3. (
02 03 04				0 0 0	0 0 0	3. 3. 3.
05				0	0	3.
- 0	Provider to Program				0	~
50 51 52 53 54 99	ADJUSTMENTS TO PROGRAM Subtotal (sum of lines 3.01-3.49 minus sum of lines			0 0 0 0 0	0 0 0 0 0 0	3. 3. 3. 3. 3. 3.
00	3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as <u>appropriate</u> ) TO BE COMPLETED BY CONTRACTOR		4, 481, 5	83	510	4.
00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					5.
01	TENTATI VE TO PROVI DER			0	0	5.
02 03				0	0	5. 5.
-	Provider to Program			- n		
50 51	TENTATI VE TO PROGRAM			0 0	0 0	5 5
52 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0 0	0 0	5
00	5.50-5.98) Determined net settlement amount (balance due) based on the cost report. (1)					6.
)1 )2	SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM		46, 0	0	0 364	6. 6.
00	Total Medicare program liability (see instructions)		4, 527, 6	68 Contractor Number	146 NPR Date (Mo/Day/Yr)	7.
		(		1. 00	(MO/Day/YF) 2.00	

Heal th	Financial Systems ST. FRANCIS HOSPITAL	& HEALTH CENTER	In Lieu	u of Form CMS-	2552-10	
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0162	Period: From 01/01/2018 To 12/31/2018	Worksheet E-1 Part II Date/Time Pre 5/31/2019 7:4	epared:	
		Title XVIII	Hospi tal	PPS		
				1.00		
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS					
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				1.00	
1.00	.00 Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14					
2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12					2.00	
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3.00	
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8	3-12			4.00	
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5.00	
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 I	ine 20			6.00	
7.00	CAH only - The reasonable cost incurred for the purchase of c	certified HIT technology	Wkst. S-2, Pt. I		7.00	
	line 168					
8.00	Calculation of the HIT incentive payment (see instructions)				8.00	
9.00	Sequestration adjustment amount (see instructions)				9.00	
10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)			10.00	
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH					
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00	
31.00	Other Adjustment (specify)				31.00	
32.00	Balance due provider (line 8 (or line 10) minus line 30 and l	ine 31) (see instructio	ns)		32.00	

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0162	Period: From 01/01/2018		
		Component CCN: 15-T162	To 12/31/2018	Date/Time Pre 5/31/2019 7:4	pare 7 am
		Title XVIII	Subprovider -	PPS	
				1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS				
. 00 . 00	Net Federal PPS Payment (see instructions) Medicare SSI ratio (IRF PPS only) (see instructions)			4, 042, 344 0. 0345	1. 2.
. 00	Inpatient Rehabilitation LIP Payments (see instructions)	s)		141, 078	3.
. 00	Outlier Payments	5)		456, 468	4
00	Unweighted intern and resident FTE count in the most re	ecent cost reporting period e	nding on or prior	0.00	
01	to November 15, 2004 (see instructions) Cap increases for the unweighted intern and resident Fi	TE count for residents that we	re displaced by	0.00	5
01	program or hospital closure, that would not be counted CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions	without a temporary cap adjus		0.00	
00	New Teaching program adjustment. (see instructions)	-,		0.00	6
00	Current year's unweighted FTE count of I&R excluding FT	TEs in the new program growth	period of a "new	0.00	7
	teaching program" (see instructions)				
00	Current year's unweighted I&R FTE count for residents v teaching program" (see instructions)	within the new program growth	period of a "new	0.00	8
00	Intern and resident count for IRF PPS medical education	n adjustment (see instructions	)	0.00	9
. 00	Average Daily Census (see instructions)			13. 893151	10
	Teaching Adjustment Factor (see instructions)			0. 000000	
	Teaching Adjustment (see instructions)			0	12
	Total PPS Payment (see instructions)			4, 639, 890	
	Nursing and Allied Health Managed Care payments (see in	nstruction)		0	
	Organ acquisition (DO NOT USE THIS LINE) Cost of physicians' services in a teaching hospital (se	oo instructions)		0	15
	Subtotal (see instructions)			4, 639, 890	
	Primary payer payments			4,037,070	18
	Subtotal (line 17 less line 18).			4, 639, 890	
	Deducti bl es			18, 760	
. 00	Subtotal (line 19 minus line 20)			4, 621, 130	21
. 00	Coinsurance			23, 725	22
	Subtotal (line 21 minus line 22)			4, 597, 405	
	Allowable bad debts (exclude bad debts for professional	l services) (see instructions)		2, 604	
	Adjusted reimbursable bad debts (see instructions)			1, 693	
	Allowable bad debts for dual eligible beneficiaries (se	ee instructions)		2,604	26
	Subtotal (sum of lines 23 and 25)	$ \begin{bmatrix} 4 \\ 1 \end{bmatrix} $ (inc. 40)		4, 599, 098	
	Direct graduate medical education payments (from Wkst. Other pass through costs (see instructions)	E-4, ITTIE 49)		0 3, 350	28
	Outlier payments reconciliation			3, 330	30
	OTHER ADJUSTMENTS			17, 621	31
	Pioneer ACO demonstration payment adjustment (see instr	ructions)		0	31
	Demonstration payment adjustment amount before sequestr			0	3
. 00	Total amount payable to the provider (see instructions)	)		4, 620, 069	32
. 01	Sequestration adjustment (see instructions)			92, 401	32
. 02	Demonstration payment adjustment amount after sequestra	ation		0	32
	Interim payments			4, 481, 583	
	Tentative settlement (for contractor use only)			0	34
	Balance due provider/program (line 32 minus lines 32.07 Protested amounts (nonallowable cost report items) in a \$115.2		chapter 1,	46, 085 0	35 36
	TO BE COMPLETED BY CONTRACTOR				
	Original outlier amount from Wkst. E-3, Pt. III, line			456, 468	
	Outlier reconciliation adjustment amount (see instructi	ions)		0	51
	The rate used to calculate the Time Value of Money			0.00	L 52

	FINANCIAI SYSTEMIS SI. FRANCIS HUSPITAL & HE	ALTH GENTER			2002-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	ovider CCN: 15-0162	Period: From 01/01/2018 To 12/31/2018	Worksheet E-3 Part VII Date/Time Pre 5/31/2019 7:4	pared:
		Title XIX	Hospi tal	PPS	
			I npati ent	Outpati ent	
			1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVIO	CES FOR TITLES V OR		2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		0		1.00
2.00	Medical and other services		Ŭ	30, 946, 747	2.00
3.00	Organ acquisition (certified transplant centers only)		0	00, 710, 717	3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		0	30, 946, 747	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	30, 946, 747	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e Charges				
8.00	Routi ne servi ce charges		0		8.00
9.00	Ancillary service charges		118, 529, 610	220, 221, 150	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)		118, 529, 610	220, 221, 150	12.00
	CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for s	ervices on a charge	0	0	13.00
	basi s				
14.00	Amounts that would have been realized from patients liable for p		on 0	0	14.00
45 00	a charge basis had such payment been made in accordance with 42	CFR §413.13(e)			15 00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	
	Total customary charges (see instructions)		118, 529, 610	220, 221, 150	
17.00	Excess of customary charges over reasonable cost (complete only	IT LINE 16 exceeds	118, 529, 610	189, 274, 403	17.00
10 00	line 4) (see instructions)	flips 1 sysseds li	ne O	0	10 00
18.00	Excess of reasonable cost over customary charges (complete only 16) (see instructions)	IT TTHE 4 exceeds ITT	ie 0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
	Cost of physicians' services in a teaching hospital (see instruc	tions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		0	30, 946, 747	
21.00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be con	nnleted for PPS provi		00, 710, 717	21.00
22.00	Other than outlier payments		0	0	22.00
	Outlier payments		0	0	23.00
	Program capital payments		0	-	24.00
	Capital exception payments (see instructions)		0		25.00
	Routine and Ancillary service other pass through costs		91, 227	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		91, 227	0	27.00
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)		91, 227	30, 946, 747	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		91, 227	30, 946, 747	31.00
32.00	Deducti bl es		0	0	32.00
33.00	Coinsurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 3	3)	91, 227	30, 946, 747	36.00
37.00	TO ZERO OUT MEDICAID		-91, 227	-30, 946, 747	37.00
38.00	Subtotal (line 36 ± line 37)		0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	40.00
	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	with CMS Pub 15-2,	0	0	43.00
	chapter 1, §115.2				

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0162	Period: From 01/01/2018	Worksheet E-3 Part VII	
		Component CCN: 15-T162	To 12/31/2018	Date/Time Pre 5/31/2019 7:4	epare 17 an
		Title XIX	Subprovider - IRF	PPS	
			I npati ent	Outpati ent	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SE	FRVICES FOR TITLES V OR 2	1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES				1
00	Inpatient hospital/SNF/NF services		0		1
00	Medical and other services			0	2
00	Organ acquisition (certified transplant centers only)		0		3
00	Subtotal (sum of lines 1, 2 and 3)		0	0	
00	Inpatient primary payer payments		0	0	5
00 00	Outpatient primary payer payments		0	0	
00	Subtotal (line 4 less sum of lines 5 and 6) COMPUTATION OF LESSER OF COST OR CHARGES		U	0	
	Reasonable Charges				1
00	Routine service charges		0		18
00	Ancillary service charges		2, 341, 027	0	9
0. 00	Organ acquisition charges, net of revenue		0		10
. 00	Incentive from target amount computation		0		11
. 00	Total reasonable charges (sum of lines 8 through 11)		2, 341, 027	0	12
	CUSTOMARY CHARGES				
3.00	Amount actually collected from patients liable for payment for	or services on a charge	0	0	13
00	basis			0	114
. 00	Amounts that would have been realized from patients liable for		on 0	0	14
5.00	a charge basis had such payment been made in accordance with Ratio of line 13 to line 14 (not to exceed 1.000000)	42 CFR 9413. 13(e)	0.000000	0.000000	15
5.00	Total customary charges (see instructions)		2, 341, 027	0.000000	
. 00	Excess of customary charges over reasonable cost (complete or	nlvifline 16 exceeds	2, 341, 027	0	
	line 4) (see instructions)		2,011,02,	Ū	
3. 00	Excess of reasonable cost over customary charges (complete or	nly if line 4 exceeds lin	ne 0	0	18
	16) (see instructions)	-			
0. 00	Interns and Residents (see instructions)		0	0	19
	Cost of physicians' services in a teaching hospital (see inst	-	0	0	
. 00	Cost of covered services (enter the lesser of line 4 or line		0	0	21
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be	e completed for PPS provi			
	Other than outlier payments		0	0	
8.00	Outlier payments		0	0	
1.00 5.00	Program capital payments Capital exception payments (see instructions)		0		24
	Routine and Ancillary service other pass through costs		1, 244	0	
7.00	Subtotal (sum of lines 22 through 26)		1, 244	0	
	Customary charges (title V or XIX PPS covered services only)		0	0	
	Titles V or XIX (sum of lines 21 and 27)		1, 244	0	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
0. 00	Excess of reasonable cost (from line 18)		0	0	30
. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6	6)	1, 244	0	
2. 00	Deducti bl es		0	0	
. 00	Coinsurance		0	0	
. 00	Allowable bad debts (see instructions)		0	0	
. 00	Utilization review	24 22)	0 1, 244	0	35
		Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)			
2.00	Subtotal (line 36 ± line 37)	TO ZERO OUT MEDICALD			37
	Direct graduate medical education payments (from Wkst. E-4)		0	0	38
). 00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	
	Interim payments	,	0	0	
2.00	Balance due provider/program (line 40 minus line 41)		0	0	
3.00	Protested amounts (nonallowable cost report items) in accorda	ance with CMS Pub 15-2	0	0	
	chapter 1, §115.2				1

DIRECT (	inancial Systems ST. FRANCIS HOSPITAL GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provider CO		Peri od:	Worksheet E-4	
MEDI CAL	EDUCATION COSTS			From 01/01/2018 To 12/31/2018	Date/Time Pre	pared
		T; +1 o	XV/LLL	llooni tol	5/31/2019 7:4 PPS	
		Intre	XVIII	Hospi tal	PP5	
0	OMPUTATION OF TOTAL DIRECT GME AMOUNT				1.00	
	Inweighted resident FTE count for allopathic and osteopathic	programs for	r cost report	ing periods	19.50	1.0
e	ending on or before December 31, 1996.			0 1		
	Inweighted FTE resident cap add-on for new programs per 42 CF mount of reduction to Direct GME cap under section 422 of M		(1) (see inst	ructions)	0.00 0.94	
	Direct GME cap reduction amount under ACA §5503 in accordance		R §413.79 (m)	. (see	0.00	
i	nstructions for cost reporting periods straddling 7/1/2011)					
	djustment (plus or minus) to the FTE cap for allopathic and ME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f)		programs due	to a Medicare	-0. 10	4.
	ICA Section 5503 increase to the Direct GME FTE Cap (see inst		r cost report	ing periods	0.00	4.
	traddling 7/1/2011)				0.00	
	.CA Section 5506 number of additional direct GME FTE cap slot periods straddling 7/1/2011)	ts (see inst	tructions for	cost reporting	0.00	4.
	TE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 pl	us or minus	line 4 plus	lines 4.01 and	18.46	5.
	02 plus applicable subscripts	programa for	a tha aurrant	VOOR FROM VOUR	22.44	
	Inweighted resident FTE count for allopathic and osteopathic records (see instructions)	programs for	the current	year from your	22.46	6.
	inter the lesser of line 5 or line 6				18.46	7.
			Primary Care		Total	
. 00 W	leighted FTE count for physicians in an allopathic and osteop	oathi c	1.00 22.4	2.00 6 0.00	3.00	8.
р	program for the current year.					
	f line 6 is less than 5 enter the amount from line 8, otherwoultiply line 8 times the result of line 5 divided by the amo		18.4	.6 0.00	18.46	9.
6						
	leighted dental and podiatric resident FTE count for the curr			0.00		10.
	Inweighted dental and podiatric resident FTE count for the cu	urrent year	18. 4	.6 0. 00		10.
	otal weighted FTE count otal weighted resident FTE count for the prior cost reportin	na vear (see				11.
i	nstructions)					
	otal weighted resident FTE count for the penultimate cost revear (see instructions)	eporti ng	18.2	.6 0.00		13.
	colling average FTE count (sum of lines 11 through 13 divided	d by 3).	18.3	0.00		14.
	djustment for residents in initial years of new programs	5	0. C			15.
	Inweighted adjustment for residents in initial years of new p		0.0			15.
	djustment for residents displaced by program or hospital clo		0.0			16.
	Inweighted adjustment for residents displaced by program or H :losure	iospi tai	0.0	0 0.00		16.
	djusted rolling average FTE count		18. 3			17.
	er resident amount pproved amount for resident costs		115, 766. 1		2, 128, 939	18.
9.00 A			2, 128, 93	9 0	2, 120, 939	19.
· · · · · · · · · · · · · · · · · · ·					1.00	
	dditional unweighted allopathic and osteopathic direct GME F sec. 413.79(c)(4)	-IE resident	cap slots re	ceived under 42	0.00	20.
	Direct GME FTE unweighted resident count over cap (see instru	uctions)			4.00	21.
. 00 A	llowable additional direct GME FTE Resident Count (see instr	ructions)			0.00	22.
	inter the locality adjustment national average per resident a	amount (see i	nstructions)		0.00	
	Nultiply line 22 time line 23				0	
. 00   T	otal direct GME amount (sum of lines 19 and 24)		Inpati ent	Managed care	2, 128, 939	25.
			Part A	Ű		
			1.00	2.00	3.00	
	OMPUTATION OF PROGRAM PATIENT LOAD npatient Days (see instructions)		40, 74	1 19, 177		26.
	otal Inpatient Days (see instructions)		102, 03			20.
	Ratio of inpatient days to total inpatient days		0. 39929			28.
	Program direct GME amount		850, 06			29.
	Reduction for direct GME payments for Medicare Advantage			56, 539		30.
	let Program direct GME amount		1		1, 193, 661	1 21

Health Financial Systems ST. FRANCIS HOSPITAL & HEALTH CENTER In Lieu	u of Form CMS-2	2552-10
DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT Provider CCN: 15-0162 Period:	Worksheet E-4	
MEDICAL EDUCATION COSTS From 01/01/2018	Date/Time Pre	narod
10 12/31/2016	5/31/2019 7:4	
Title XVIII Hospital	PPS	
	1.00	
DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMED	I CAL	
EDUCATI ON COSTS)		
32.00 Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)	0	32.00
33.00 Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)	8, 258, 979	33.00
34.00 Ratio of direct medical education costs to total charges (line 32 ÷ line 33)	0.00000	34.00
35.00 Medicare outpatient ESRD charges (see instructions)	0	35.00
36.00 Medicare outpatient ESRD direct medical education costs (line 34 x line 35)	0	36.00
APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY		
Part A Reasonable Cost		
37.00 Reasonable cost (see instructions)	119, 192, 499	
38.00 Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, Line 69)	0	38.00
39.00 Cost of physicians' services in a teaching hospital (see instructions)	0	39.00
40.00 Primary payer payments (see instructions)	8,643	
41.00 Total Part A reasonable cost (sum of lines 37 through 39 minus line 40) Part B Reasonable Cost	119, 183, 856	41.00
42. 00 Reasonable cost (see instructions)	64, 289, 215	12 00
43.00 Primary payer payments (see instructions)	8, 834	
44.00 Total Part B reasonable cost (line 42 minus line 43)	64, 280, 381	44.00
45.00 Total reasonable cost (sum of lines 41 and 44)	183, 464, 237	
46.00 Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)	0. 649630	
47.00 Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)	0.350370	47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B		
48.00 Total program GME payment (line 31)	1, 193, 661	
49.00 Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)	775, 438	
50.00  Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)	418, 223	50.00

	E SHEET (If you are nonproprietary and do not maintain ype accounting records, complete the General Fund column	Provider C	F	eriod: rom 01/01/2018		
nly)				o 12/31/2018		
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	CURRENT ASSETS	1.00	2.00	3.00	4.00	
00	Cash on hand in banks	13, 440, 708	0	0	0	1 1
00	Temporary investments	0	0	-		
00	Notes receivable	0	0		0	
00	Accounts receivable	411, 055, 224	0	0	0	4
00	Other receivable	7, 696, 737	0	0	0	5
00	Allowances for uncollectible notes and accounts receivable	-294, 049, 886	0	0	0	
00	Inventory	13, 182, 272		-		
	Prepaid expenses	3, 025, 171		0	0	-
	Other current assets	0	0	-	0	
	Due from other funds	13, 866, 007				
	Total current assets (sum of lines 1-10)	168, 216, 233	0	0	0	11
	FIXED ASSETS	0		0	0	1 1 2
	Land		-	-		
	Land improvements Accumulated depreciation	51, 055, 105 -21, 201, 144		-		
	Buildings	518, 600, 845		-	0	
	Accumul ated depreciation	-189, 769, 614			0	
	Leasehold improvements	6, 046, 519	-	-	0	
	Accumulated depreciation	-4, 967, 937		-	0	
	Fixed equipment	0	0	-	0	
	Accumulated depreciation	o o	Ö		0	
	Automobiles and trucks	0	0	0	0	
	Accumulated depreciation	0	0	0	0	22
	Major movable equipment	165, 853, 691	0	0	0	23
	Accumulated depreciation	-121, 950, 088	0	0	0	24
. 00	Minor equipment depreciable	0	0	0	0	25
. 00	Accumulated depreciation	0	0	0	0	26
. 00	HIT designated Assets	0	0	0	0	27
. 00	Accumulated depreciation	0	0	0	0	28
. 00	Minor equipment-nondepreciable	0	0			
	Total fixed assets (sum of lines 12-29)	403, 667, 377	0	0	0	30
	OTHER ASSETS			1		
-	Investments	21, 243, 066		-		
-	Deposits on Leases	0	0	-	0	
	Due from owners/officers	10 000 400	0	-	0	
	Other assets	19, 892, 432 41, 135, 498			0	
	Total other assets (sum of lines 31-34)	613, 019, 108				
	Total assets (sum of lines 11, 30, and 35) CURRENT LIABILITIES	013,019,100	<u> </u>	0	0	30
	Accounts payable	42, 482, 980	0	0	0	37
	Salaries, wages, and fees payable	1 42,402,700				
	Payroll taxes payable	17, 439, 627				
	Notes and Loans payable (short term)	81, 261			0	
	Deferred income	0	0	0	0	
	Accelerated payments	0				42
. 00	Due to other funds	0	0	0	0	43
. 00	Other current liabilities	9, 530, 337	0	0	0	44
. 00	Total current liabilities (sum of lines 37 thru 44)	69, 534, 205	0	0	0	45
	LONG TERM LIABILITIES					
	Mortgage payable	0	0			
	Notes payable	0	0	-	-	
	Unsecured Loans	0	0	-	0	
	Other long term liabilities	-40, 015, 677			0	
	Total long term liabilities (sum of lines 46 thru 49)	-40, 015, 677				
	Total liabilities (sum of lines 45 and 50)	29, 518, 528	0	0	0	51
	CAPITAL ACCOUNTS	500 500 500		1		1
-	General fund balance	583, 500, 580				52
	Specific purpose fund		0			53
	Donor created - endowment fund balance - restricted			0		54
	Donor created - endowment fund balance - unrestricted			0		55
	Governing body created - endowment fund balance			0	_	56
	Plant fund balance - invested in plant				0	
. 00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	
. 00	Total fund balances (sum of lines 52 thru 58)	583, 500, 580	0	0	0	59
	Total liabilities and fund balances (sum of lines 51 and	613, 019, 108		-		
			. 0			1 00

Healt	th	Fin	anc	i al	Syst	ems			
STAT	EM	ENT	OF	СНА	NGES	LN	FUND	RΛI	

	Financial Systems ST. F NT OF CHANGES IN FUND BALANCES	RANCI S HOSPI TAI	Provi der CC		Peri od: From 01/01/2018 To 12/31/2018	u of Form CMS-2 Worksheet G-1 Date/Time Pre 5/31/2019 7:4	pared:
		General	Fund	Speci al	Purpose Fund	Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
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) FUND EQUITY CHANGES PBC ADJUSTMENTS Total additions (sum of line 4-9)	24, 992, 911 12, 859, 475 0 0 0 0	552, 371, 094 272, 461, 402 824, 832, 496 37, 852, 386		0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0	
12.00 13.00 14.00 15.00 16.00 17.00 18.00	Subtotal (line 3 plus line 10) SHARED SERVICES Total deductions (sum of lines 12-17) Fund balance at end of period per balance	279, 184, 302 0 0 0 0 0 0	862, 684, 882 279, 184, 302 583, 500, 580		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0	11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00
!	sheet (line 11 minus line 18)						
		Endowment Fund	PI ant	Fund	_		
		6.00	7.00	8.00			
2.00 3.00 4.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) FUND EQUITY CHANGES PBC ADJUSTMENTS	0	0 0 0 0 0		0		1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
10.00         11.00         12.00         13.00         14.00         15.00         16.00         17.00         18.00         19.00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) SHARED SERVICES Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0 0 0	0 0 0 0 0 0		0 0 0 0		10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00

 Health Financial Systems
 ST. FRANCIS HOSPITAL & HEALTH CENTER
 In Lieu of Form CMS-2552-10

	IENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provi der CC	CN: 15-0162 P F	eriod: rom 01/01/2018	Worksheet G-2 Parts I & II Date/Time Pre 5/31/2019 7:4	
	Cost Center Description		Inpati ent	Outpati ent	Total	
			1.00	2.00	3.00	
	PART I - PATIENT REVENUES					-
	General Inpatient Routine Services		4/0 5/7 7/4		1/0 5/7 7/4	1
1.00	Hospi tal		160, 547, 761		160, 547, 761	1.00
2.00	SUBPROVIDER - IPF		00 004 007		00 004 007	2.00
3.00	SUBPROVIDER - IRF		20, 224, 987		20, 224, 987	
4.00	SUBPROVI DER		0			4.00
5.00	Swing bed - SNF Swing bed - NF		0		0	
6.00 7.00	SKILLED NURSING FACILITY		U		0	6.00 7.00
7.00 8.00	NURSING FACILITY					8.00
8.00 9.00	OTHER LONG TERM CARE					9.00
9.00 10.00	Total general inpatient care services (sum of lines 1-9)		180, 772, 748		180, 772, 748	
10.00	Intensive Care Type Inpatient Hospital Services		100, 772, 740		100, 772, 740	10.00
11.00	INTENSIVE CARE UNIT		54, 209, 157		54, 209, 157	111 00
11.00	NEONATAL INTENSIVE CARE UNIT		34, 209, 137		0, 207, 137	11.00
12.00	CORONARY CARE UNIT		35, 171, 104		35, 171, 104	
	BURN INTENSIVE CARE UNIT		55, 171, 104		33, 171, 104	13.00
14.00	SURGI CAL I NTENSI VE CARE UNI T		26, 157, 991		26, 157, 991	
15.00	OTHER SPECIAL CARE (SPECIFY)		20, 107, 771		20, 137, 771	15.00
16.00	Total intensive care type inpatient hospital services (sum of )	lines	115, 538, 252		115, 538, 252	
10.00	11-15)	111103	110,000,202		110,000,202	10.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)		296, 311, 000		296, 311, 000	17.00
	Ancillary services				2, 028, 370, 056	
19.00			66, 115, 330			
20.00	RURAL HEALTH CLINIC		C	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER		C	0	0	21.00
	HOME HEALTH AGENCY			0	0	22.00
	AMBULANCE SERVICES					23.00
24.00	СМНС					24.00
25.00	AMBULATORY SURGICAL CENTER (D. P. )					25.00
26.00	HOSPI CE		C	22, 030, 868	22, 030, 868	26.00
27.00	OTHER REVENUE		13, 267, 992	136, 873, 847	150, 141, 839	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3	to Wkst.	1, 271, 900, 189	1, 570, 791, 780	2, 842, 691, 969	28.00
	G-3, line 1)					
	PART II - OPERATING EXPENSES			1		
29.00	Operating expenses (per Wkst. A, column 3, line 200)			526, 858, 041		29.00
30.00	ADD (SPECIFY)		C			30.00
31.00			C			31.00
32.00			C			32.00
33.00			0			33.00
34.00			0			34.00
35.00			0			35.00
36.00	Total additions (sum of lines 30-35)		_	0		36.00
37.00	DEDUCT (SPECI FY)		0			37.00
38.00			0			38.00
39.00			C			39.00
40.00						40.00
41.00	Total deductions (sum of lines 27 41)		0	_		41.00
42.00 43.00	Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42	)(transfor		526, 858, 041		42.00 43.00
43.00	to Wkst. G-3, line 4)			520, 656, 041		43.00
	10 mkst. 0-0, 1116 4)		I	I	I	I

Health Financial Systems

## ST. FRANCIS HOSPITAL & HEALTH CENTER

near th		A HEALTH CENTER	111 LIE		2552-10
STATEN	IENT OF REVENUES AND EXPENSES	Provider CCN: 15-0162	Period: From 01/01/2018	Worksheet G-3	
				Date/Time Pre	pared:
				5/31/2019 7:4	
				1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, lir			2, 842, 691, 969	
2.00	Less contractual allowances and discounts on patients' accour	nts		2,077,942,147	
3.00	Net patient revenues (line 1 minus line 2)			764, 749, 822	
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)		526, 858, 041 237, 891, 781		
5.00	Net income from service to patients (line 3 minus line 4)				5.00
	OTHER INCOME				
6.00	Contributions, donations, bequests, etc			18, 000	
7.00	Income from investments			162, 404	
8.00	Revenues from telephone and other miscellaneous communication	n servi ces		0	8.00
9.00	Revenue from television and radio service			0	9.00
	Purchase di scounts			4, 432, 346	
	Rebates and refunds of expenses			0	
	Parking lot receipts			370	12.00
	Revenue from Laundry and Linen service			0	
	Revenue from meals sold to employees and guests			2, 810, 321	
	Revenue from rental of living quarters			0	
	Revenue from sale of medical and surgical supplies to other t	than patients		0	16.00
17.00	Revenue from sale of drugs to other than patients			0	17.00
	Revenue from sale of medical records and abstracts			0	
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	
20.00	Revenue from gifts, flowers, coffee shops, and canteen			389, 692	20.00
21.00	Rental of vending machines			71, 868	21.00
22.00	Rental of hospital space			2, 933, 578	22.00
23.00	Governmental appropriations			0	23.00
24.00	OTHER INCOME			23, 751, 042	24.00
25.00	Total other income (sum of lines 6-24)			34, 569, 621	25.00
26.00	Total (line 5 plus line 25)			272, 461, 402	26.00
27.00	OTHER EXPENSES (SPECIFY)			0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)			0	28.00
29 00	Net income (or loss) for the period (line 26 minus line 28)			272, 461, 402	29.00

- 28.00Total other expenses (sum of line 27 and subscripts)29.00Net income (or loss) for the period (line 26 minus line 28)

In Lieu of Form CMS-2552-10

Hospice COX         15-1523         To         12/31/2019         Date:/Time Prepared           Image: Cox         SALARIES         OTHER         SUBTOTAL         Cox         SUBTOTAL         SUBTOTAL           Cox         1.00         2.00         3.00         4.00         5.00           1.00         2.00         3.00         4.00         5.00           1.00         2.00         3.00         0	ANALYS	SIS OF HOSPITAL-BASED HOSPICE COSTS		Provider C		Peri od:	Worksheet 0	
L         SIN DIFF         OTHER         SUBJIC 101 (Col 1 plus products)         SUBJIC 101 (Col 1 plus products)         SUBJIC 101 (Col 1 plus products)         SUBJIC 101 products         SUBJIC 101 products				Hospi ce CCI		From 01/01/2018 To 12/31/2018	Date/Time Pre	pared:
SALARIES         OTHER         SUBTOTAL col. 2)         SUBTOTAL col. 2)         SUBTOTAL col. 2)           CAP REL COSTS-BLOG & FIAT*         0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>5/31/2019 7:4</td> <td>7 am</td>							5/31/2019 7:4	7 am
Col.         1         Col.         2         Col.         2         CATIONS           0         COP RELOGITS BUDG CONT CENTERS         1         0         3         0         1         0 </td <td></td> <td></td> <td>SALADIES</td> <td></td> <td>SURTOTAL</td> <td></td> <td>SUPTOTAL</td> <td></td>			SALADIES		SURTOTAL		SUPTOTAL	
Col         Col         Col         Col         Col         Col         Col         Col           1.00         CARPALL COST CENTRES         0			SALARIES	UTHER			SUBTUTAL	
CHARRAL SERVICE COST CENTERS         0         3.00         4.00         5.00           1.00         CAP RLL COSTS-MULE & FLX1*         0<						CATTONS		
CENERAL SERVICE COST CENTERS         0			1.00	2.00		4,00	5.00	
2.00         CAP         REL         COST         O <th< td=""><td></td><td>GENERAL SERVICE COST CENTERS</td><td>I I</td><td></td><td></td><td></td><td></td><td></td></th<>		GENERAL SERVICE COST CENTERS	I I					
3.00         EMPLOYEE BENEFITS DEPARTMENT*         0         1, 12, 220         -1, 120         -1, 12, 220         -1, 12, 220         -1, 12, 220         -1, 12, 220         -1, 12, 220         -1, 12, 220         -1, 12, 220         -1, 12, 220         -1, 12, 220         -1, 12, 12, 12, 12, 12, 12, 12, 12, 12, 1	1.00	CAP REL COSTS-BLDG & FIXT*		0		0 C	0	1.00
4.00         ADMI NI STRATIVE & GENERAL*         3.095, 182         109, 033         3.204, 815         -2, 503, 849         760, 966         4.00           6.00         LAUNDRY & LINEN SERVICE*         0         15, 812         0         <	2.00	CAP REL COSTS-MVBLE EQUIP*		0		0 C	0	2.00
5.00         PLANT OPERATION & MAINTERNACE*         0	3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	1, 612, 526	1, 612, 52	6 -1, 612, 526	0	3.00
6.00         LAUNDRY & LINEM SERVICE*         0         15, 812         0         15, 812         0			3, 095, 182	169, 633	3, 264, 81	5 -2, 503, 849	760, 966	4.00
0.00         HOUSERCEPT NO**         0			0	0		-	-	5.00
8.00         DETARY*         0         20, 937         20, 937         106         21, 043         8, 00           0.00         RUDTINE< MEDICAL SUPPLIES*			0	15, 812	15, 81	2 0		6.00
9.00         NURSI NO. ADMINISTRATION*         0         10         0         0         11         00         0         0         0         0         11         0         0         0         0         0         11         0         0         0         0         11         00         0         0         0         13         0         0         0         0         0         13         0         0         0         0         0         13         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0			0	0		0 0		
10. 00         ROUTINE_MEDICAL_SUPPLIES*         0         10. 00         0         0         0         0         0         0         0         10. 00         0         0         0         0         10. 00         0         0         0         0         11. 00         0         0         0         11. 00         0			0	20, 937				
11.00       MEDICAL RECORDS*       0			0	0				
12.00       STAFF TRANSPORTATION*       0       83,197       0       83,197       0       83,197       12.00         13.00       VOLUNTEER SERVIC COORDINATION*       0       345,692       345,692       345,692       14.00       345,692       14.1,251       133,151       15.00         15.00       PHARMACY*       0       -8,100       -8,100       141,251       133,151       15.00       16.00       16.00       16.00       16.00       16.00       16.00       16.00       16.00       16.00       16.00       16.00       16.00       17.00       071       17.00       17.00       17.00       17.00       17.00       17.00       16.00       0       0       0       26.00       17.00       0.00       0       0       27.00       0.00       0       0       0       27.00       0.00       0			0	0			-	
13. 00         VOLUNTEER SERVICE COORDINATION*         0         0         0         0         15. 00         PATE SERVICE         0         345. 692         345. 692         0         345. 692         0         345. 692         0         345. 692         0         13. 00         141. 251         133. 151         15. 00           10         COTE CONTRACTORS         0         <			0	0 83 107	83 10	7 0		
14. 00       PHARMACY*       0       345. 692       1.00       345. 692       1.00         15. 00       PHYSIC IAN ADMINISTRATIVE SERVICES*       0       -8, 100       -8, 100       141. 251       133. 151       15. 00         16. 00       OTHER GENERAL SERVICE       0       -0       0       0       16. 00       -0       141. 251         10. 0PATIENT CARE-SERVICES *       0       0       0       0       0       0       25. 00         26. 00       PHYSIC IAN SERVICES**       0       0       0       0       0       27. 00       0       0       0       0       0       0       27. 00       0       0       0       0       0       0       0       0       0       0       0       27. 00       0			0	03, 177				
15:00         PHYSICIAN JAMIN IN STRATU & SERVICES*         0         -8,100         -8,100         141,251         133,151         15.00           0:00         PATIENT/RESIDENTIAL CARE SERVICES         0 </td <td></td> <td></td> <td>0</td> <td>345 602</td> <td></td> <td></td> <td></td> <td></td>			0	345 602				
16.00       OTHER GENERAL SERVICES*       O			0					
17. 00         PATL ENT/ARESIDENTIAL CARE SERVICES         17. 00         0         0         0         0         0         25. 00         17. 00         17. 00         0         0         0         0         25. 00         17. 00         0         0         0         0         27. 00         00         0         0         0         27. 00         0         0         0         0         0         27. 00         0 <th< td=""><td></td><td></td><td>0</td><td>0, 100</td><td></td><td></td><td></td><td></td></th<>			0	0, 100				
DIRECT PATIENT CARE SERVICE COST CENTERS           00         INPATIENT CARE. CONTRACTED**         0         0         0         0         26.00           26.00         PHYSI CIAN SERVICES**         0         0         0         0         26.00           27.00         NURSE**         0         0         0         0         27.00           27.00         NURSE**         0         0         0         0         27.00           29.00         LPN/LW**         0         0         0         0         27.00           30.00         PHYSI CLAI THERAPY**         0         0         0         0         27.00           31.00         OCCUPATI ONAL THERAPY**         0         0         0         0         31.00           32.00         SPECH/LANGUAGE PATHOLOCY**         0         0         0         31.00           33.00         MEDI CAL SOCIAL SERVI CES**         0         0         0         35.00           35.00         DIETARY COUNSELING - NTER**         0         0         0         36.00           39.00         PATIENT TRANSPORTATION**         0         0         0         0         36.00           39.00         DATERY *			Ŭ	0		0	Ū	17.00
25:00       INPATIENT CARE-CONTRACTED**       0	17.00							17.00
26.00       PHYSICIANSERVICES**       0       0       0       0       26.00         27.00       NURSE PRACTI TONER**       0       0       0       0       27.00         28.00       REGISTERED NURSE**       0       0       0       0       0       29.00         29.00       LPN/LWN**       0       0       0       0       29.00         31.00       OCCUPATI ONAL THERAPY**       0       0       0       0       31.00         31.00       OCCUPATI ONAL THERAPY**       0       0       0       0       31.00         32.00       SECULAXISCACE PATHOLOGY**       0       0       0       0       31.00         33.00       MEDICAL SOCIAL SERVICES**       0       0       0       0       35.00         35.00       DIETARY COUNSELING**       0       0       0       0       36.00         36.00       DURBALE MEDICAL EOUI PIER**       0       0       0       0       0       37.00         39.00       PATI ENT TRANSPORTATION**       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0 <td>25.00</td> <td></td> <td></td> <td>0</td> <td></td> <td>0 0</td> <td>0</td> <td>25.00</td>	25.00			0		0 0	0	25.00
28.00       REGISTERED NURSE**       0       86,729       1,509,808       1,596,537       28.00         90.00       PNYSICAL THERAPY**       0       0       0       0       0       29.00         93.00       OPLYAUN**       0       0       0       0       1412       412       30.00         93.00       OPLYSICAL THERAPY**       0       0       0       0       31.00       0       0       0       0       31.00       0       0       0       0       0       31.00       0       0       0       0       0       31.00       0			0	0		0 0	0	26.00
99.00         LPN/LVN**         0         <	27.00	NURSE PRACTI TI ONER**	0	0		0 0	0	27.00
90.00         PHYSICAL THERAPY**         0         0         412         412         30.00           31.00         OCCUPATIONAL THERAPY**         0	28.00	REGI STERED NURSE**	0	86, 729	86, 72	9 1, 509, 808	1, 596, 537	28.00
11.00         CCUPATIONAL THERAPY**         0         0         0         0         0         31.00           32.00         SPEECH/LANGUAGE PATHOLOGY**         0         0         0         0         32.00           33.00         MEDICAL SOCIAL SERVICES**         0         0         0         138.714         138.714         33.01           34.00         SPIRITUAL COUNSELING**         0         0         0         0         35.00         158.714         138.714         33.714         33.714         33.714         33.714         33.714         33.714         33.714         33.717         37.00         35.00         0         0         0         0         35.00         0         0         0         0         35.00         0         35.00         0         36.00         39.179         37.00         39.00         0         39.01         0	29.00	LPN/LVN**	0	0		0 0	0	29.00
12         00         00         0         00 </td <td>30.00</td> <td>PHYSICAL THERAPY**</td> <td>0</td> <td>0</td> <td></td> <td>D 412</td> <td>412</td> <td>30.00</td>	30.00	PHYSICAL THERAPY**	0	0		D 412	412	30.00
33.00       MEDICAL SOCIAL SERVICES**       0       0       217,427       217,427       33.00         34.00       SPIRITUAL COUNSELING**       0       0       0       138,714       138,714       138,714       34.00         35.00       DIETARY COUNSELING**       0       0       0       0       0       35.00         36.00       COUNSELING - OTHER**       0       0       0       0       36.00       0       39.01       37.01       MOSPICE AI DE HOMEMAKER SERVICES**       0       0       0       39.01       39.41,79       37.47,73       37.07         38.00       DURABLE MEDICAL EQUIPMENT/OXYGEN**       0       236,824       236,824       0       236,824       38.00       39.00       0       0       0       0       39.00       0 <t< td=""><td>31.00</td><td>OCCUPATIONAL THERAPY**</td><td>0</td><td>0</td><td></td><td>0 0</td><td>0</td><td>31.00</td></t<>	31.00	OCCUPATIONAL THERAPY**	0	0		0 0	0	31.00
34.00       SPIRITUAL COUNSELING**       0       0       138,714       138,714       34.00         35.00       DIETARY COUNSELING**       0       0       0       35.00         36.00       COUNSELING - OTHER**       0       0       0       0       36.00         37.00       HOSPICE AI DE & HOMEMAKER SERVICES**       0       0       0       394,179       394,179       374,179       374,00       37.00         38.00       DURABLE MEDI CAL EQUIPMENT/OXYGEN**       0       236,824       236,824       0		SPEECH/LANGUAGE PATHOLOGY**	0	0		0 0	0	32.00
35.00         DIETARY COUNSELING**         0         0         0         0         35.00           36.00         COUNSELING - OTHER**         0         0         0         0         36.00           37.00         HOSPICE AIDE & HOMEMAKER SERVICES**         0         0         39.01         39.01           38.00         DURABLE MEDICAL EQUIPMENT/OXYGEN**         0         236,824         236,824         0         236,824         38.01           39.00         PATIENT TRANSPORTATION**         0         0         0         0         0         0         39.01           41.00         LABS & DIAGNOSTICS**         0         0         0         0         0         0         0         41.00           42.00         MEDICAL SUPPLIES-NON-ROUTINE**         0         136,242         136,242         0         136,242         0         42.00           44.00         PALLIATIVE RABIATION THERAPY*         0         0         0         0         0         44.00           0         OUTPATIENT SERVICES (SPECIFY)**         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0			0	0				
36.00       COUNSELING - OTHER**       0       0       0       0       36.00         37.00       HOSPIC AIDE & HOMEMAKER SERVICES**       0       0       394,179       37.03         38.00       DURABLE MEDICAL EQUIPMENT/OXYGEN**       0       236,824       20       236,824       38.00         39.00       PATI ENT TRANSPORTATI ON**       0       0       0       39.00         40.00       IMAGING SERVICES**       0       0       0       40.00         41.00       LABS & DI AGNOSTICS**       0       0       0       41.00         42.00       MEDICAL SUPPLIES-NON-ROUTINE**       0       136,242       42.00       42.50         DRUGS CHARGED TO PATI ENTS**       0       0       0       0       42.00         43.00       OUTPATI ENT SERVICES**       0       578,598       578,598       0       578,598         44.00       PALLIATIVE RADIATION THERAPY**       0       0       0       0       44.00         45.00       OTHER PATI ENT CARE SERVICES (SPECI FY)**       0       0       0       64.00         61.00       VOLUNTEER PATI ENT CARE SERVICES (SPECI FY)**       0       0       0       64.00         62.00       FE			0	0				
37.00       HOSPICE AI DE & HOMEMAKER SERVICES**       0       0       394, 179       394, 179       37.00         38.00       DURABLE MEDICAL EQUIPMENT/OXYGEN**       0       236, 824       236, 824       0       236, 824       38.00         90.00       PATIENT TRANSPORTATION**       0       0       0       0       0       39.01         40.00       IMAGING SERVICES**       0       0       0       0       0       40.00         41.00       LABS & DI AGNOSTICS**       0       0       0       0       41.00         42.00       MEDI CAL SUPPLIES-NON-ROUTINE**       0       136, 242       136, 242       42.00         42.00       DRUGS CHARGED TO PATIENTS**       0       578, 598       578, 598       0       578, 598       43.00         43.00       OUTPATIENT SERVICES (SPECIFY)**       0       0       0       0       44.00         45.00       PALLIATIVE CHEMOTHERAPY**       0       0       0       0       0       0       45.00         60.00       BEREAVEMENT PROGRAM *       0       0       0       0       0       60.00       63.00         61.00       VOLUNTEER PROGRAM *       0       0       0       <			0	0				
38.00       DURABLE MEDI CAL EQUI PMENT/OXYGEN**       0       236,824       236,824       0       236,824       38.00         39.00       PATI ENT TRANSPORTATI ON**       0       0       0       0       39.00         40.00       IMAGING SERVICES**       0       0       0       0       0       40.00         41.00       LABS & DI AGNOSTI CS**       0       0       0       0       0       41.00         42.00       MEDI CAL SUPPLI ES-NON-ROUTI NE**       0       136,242       136,242       0       136,242       42.50         33.00       PALLA TIVE SENVICES**       0       578,598       0       578,598       0       578,598       43.00         44.00       PALLI ATI VE RADI ATI ON THERAPY**       0       0       0       0       44.00         45.00       PALLI ATI VE RADI ATI ON THERAPY**       0 <td></td> <td></td> <td>0</td> <td>0</td> <td></td> <td>-</td> <td>-</td> <td>•</td>			0	0		-	-	•
39.00       PATIENT TRANSPORTATION**       0       0       0       39.00         40.00       IMAGING SERVICES**       0			0	0	224 02			
40.00       IMAGI NG SERVI CES**       0 </td <td></td> <td></td> <td>0</td> <td>236, 824</td> <td></td> <td></td> <td></td> <td></td>			0	236, 824				
41.00       LABS & DI AGNOSTI CS**       0			0	0				
42.00       MEDI CAL SUPPLI ES-NON-ROUTI NE**       0       136, 242       136, 242       0       136, 242       42.00         42.50       DRUGS CHARGED TO PATI ENTS**       0       0       0       0       0       42.50         43.00       OUTPATI ENT SERVI CES**       0       578, 598       578, 598       0       578, 598       0       42.60         44.00       PALLI ATI VE RADI ATI ON THERAPY**       0       0       0       0       0       44.00         45.00       PALLI ATI VE CHEMOTHERAPY**       0       0       0       0       0       44.00         46.00       OTHER PATI ENT CARE SERVICES (SPECI FY)**       0       0       0       0       0       45.00         60.00       BEREAVEMENT PROGRAM *       0       0       0       0       0       0       0       60.00         61.00       VOLUNTEER PROGRAM *       0       0       0       0       0       0       0       63.00         63.00       HOSPI CE/PALLI ATI VE MEDI CI NE FELLOWS*       0       0       0       0       0       0       65.00         64.00       CHURAR SING*       0       0       0       0       0       0			0	0				
42.50       DRUGS CHARGED TO PATIENTS**       0       0       0       0       42.50         43.00       OUTPATIENT SERVICES**       0       578,598       578,598       0       578,598       43.00         44.00       PALLIATIVE RADIATION THERAPY**       0			0	136 242	136 24		-	
43.00       OUTPATIENT SERVICES**       0       578,598       578,598       0       578,598       43.00         44.00       PALLIATIVE RADIATION THERAPY**       0       0       0       0       44.00         45.00       PALLIATIVE CHEMOTHERAPY**       0       0       0       0       44.00         45.00       PALLIATIVE CHEMOTHERAPY**       0       0       0       0       44.00         46.00       OTHER PATIENT CARE SERVICES (SPECIFY)**       0       0       0       0       45.00         0       OTHER PATIENT CARE SERVICES (SPECIFY)**       0       0       0       0       45.00         0       OUTHORAISING*       0       0       0       0       0       61.00         60.00       BEREAVEMENT PROGRAM *       0       0       0       0       61.00         62.00       FUNDRAISING*       0       0       0       0       0       62.00         64.00       PALLIATIVE CARE PROGRAM*       2, 166, 195       35, 423       2, 201, 618       64.00         64.00       PALLIATIVE CARE PROGRAM*       2, 166, 195       35, 423       2, 201, 618       64.00         65.00       OTHER PHYSICIAN SERVICES*       0			0	130, 242	130, 24			
44.00       PALLI ATI VE RADI ATI ON THERAPY**       0       0       0       0       44.00         45.00       PALLI ATI VE CHEMOTHERAPY**       0       0       0       0       45.00         46.00       OTHER PATI ENT CARE SERVICES (SPECI FY)**       0       0       0       0       0       0       46.00         NONREI MBURSABLE COST CENTERS       0       0       0       0       0       0       0       0       0       61.00         61.00       VOLUNTEER PROGRAM *       0       0       0       0       0       61.00       0       62.00       61.00       62.00       63.00       62.00       63.00       62.00       63.00       62.00       63.00       62.00       63.00       62.00       63.00       62.00       63.00       62.00       63.00       62.00       63.00       62.00       63.00       64.00       64.00       64.00       64.00       64.00       64.00       64.00       64.00       64.00       64.00       64.00       64.00       64.00       66.00       65.00       65.00       65.00       65.00       66.00       65.00       66.00       65.00       66.00       66.00       66.00       66.00       66.00 <t< td=""><td></td><td></td><td>0</td><td>578 598</td><td>578 59</td><td>3 O</td><td></td><td></td></t<>			0	578 598	578 59	3 O		
45.00       PALLI ATI VE CHEMOTHERAPY**       0       0       0       0       45.00         46.00       OTHER PATI ENT CARE SERVICES (SPECIFY)**       0       0       0       0       46.00         NONREI MBURSABLE COST CENTERS         60.00       BEREAVEMENT PROGRAM *       0       0       0       0       60.00         61.00       VOLUNTEER PROGRAM *       0       0       0       0       61.00         62.00       FUNDRAI SI NG*       0       0       0       0       62.00         63.00       HOSPI CE/PALLI ATI VE MEDI CI NE FELLOWS*       0       0       0       63.00         64.00       PALLI ATI VE CARE PROGRAM*       2, 166, 195       35, 423       2, 201, 618       0       2, 201, 618       64.00         65.00       OTHER PHYSI CI AN SERVI CES*       0       0       0       0       66.00         66.00       RESI DENTI AL CARE*       0       0       0       0       66.00         68.00       TELEHALTH/TELEMONI TORI NG*       0       0       0       0       66.00         69.00       THRI FT STORE*       0       0       0       0       0       67.00         70.			0	0,0,0,0				
46.00         OTHER PATIENT CARE SERVICES (SPECIFY)**         0         0         0         0         0         0         46.00           NORREI MBURSABLE COST CENTERS			0	0				
NONRE I MBURSABLE COST CENTERS           60.00         BEREAVEMENT PROGRAM *         0         0         0         56, 361         56, 361         60.00           61.00         VOLUNTEER PROGRAM *         0         0         0         0         0         61.00           62.00         FUNDRAI SI NG*         0         0         0         0         62.00           63.00         HOSPI CE/PALLI ATI VE MEDI CI NE FELLOWS*         0         0         0         0         63.00           64.00         PALLI ATI VE CARE PROGRAM*         2, 166, 195         35, 423         2, 201, 618         0         2, 201, 618         64.00           65.00         OTHER PHYSI CI AN SERVICES*         0         0         0         0         65.00           66.00         RESI DENTI AL CARE*         0         0         0         0         65.00           67.00         ADVERTI SI NG*         0         0         0         0         0         67.00           68.00         TELEHEALTH/TELEMONI TORI NG*         0         0         0         0         68.00           69.00         THRI FT STORE*         0         0         0         0         0         0         0         0 <td></td> <td></td> <td>0</td> <td>0</td> <td></td> <td>0 0</td> <td></td> <td></td>			0	0		0 0		
60.00       BEREAVEMENT PROGRAM *       0       0       0       56, 361       56, 361       60.00         61.00       VOLUNTEER PROGRAM *       0       0       0       0       0       61.00         62.00       FUNDRAI SI NG*       0       0       0       0       0       62.00         63.00       HOSPI CE/PALLI ATI VE MEDI CI NE FELLOWS*       0       0       0       0       63.00         64.00       PALLI ATI VE CARE PROGRAM*       2, 166, 195       35, 423       2, 201, 618       0       2, 201, 618       64.00         65.00       OTHER PHYSI CI AN SERVI CES*       0       0       0       0       0       65.00         66.00       RESI DENTI AL CARE*       0       0       0       0       0       65.00         67.00       ADVERTI SI NG*       0       0       0       0       0       66.00         68.00       TELEHEALTH/TELEMONI TORI NG*       0       0       0       0       68.00         69.00       THRI FT STORE*       0       0       0       0       0       0       0       0         70.00       NURSI NG FACI LI TY ROOM & BOARD*       0       0       0       0								
61.00       VOLUNTEER PROGRAM *       0       0       0       0       61.00         62.00       FUNDRAI SI NG*       0       0       0       0       62.00         63.00       HOSPI CE/PALLI ATI VE MEDI CI NE FELLOWS*       0       0       0       0       63.00         64.00       PALLI ATI VE CARE PROGRAM*       2, 166, 195       35, 423       2, 201, 618       0       2, 201, 618       64.00         65.00       OTHER PHYSI CI AN SERVICES*       0       0       0       0       65.00         66.00       RESI DENTI AL CARE*       0       0       0       0       66.00         67.00       ADVERTI SI NG*       0       0       0       0       66.00         67.00       ADVERTI SI NG*       0       0       0       0       66.00         68.00       TELEHEALTH/TELEMONI TORI NG*       0       0       0       0       68.00         69.00       THRI FT STORE*       0       0       0       0       0       69.00         70.00       NURSI NG FACI LI TY ROOM & BOARD*       0       0       0       0       70.00       71.00       0       0       0       0       71.00	60.00		0	0		56, 361	56, 361	60.00
63.00       HOSPICE/PALLIATIVE MEDICINE FELLOWS*       0       0       0       0       63.00         64.00       PALLIATIVE CARE PROGRAM*       2,166,195       35,423       2,201,618       0       2,201,618       64.00         65.00       OTHER PHYSICIAN SERVICES*       0       0       0       0       0       65.00         66.00       RESIDENTIAL CARE*       0       0       0       0       66.00         67.00       ADVERTISING*       0       0       0       0       66.00         68.00       TELEHEALTH/TELEMONITORING*       0       0       0       0       68.00         69.00       THRIFT STORE*       0       0       0       0       0       69.00         70.00       NURSING FACILITY ROOM & BOARD*       0 </td <td></td> <td></td> <td>0</td> <td>0</td> <td></td> <td></td> <td></td> <td></td>			0	0				
64.00       PALLIATIVE CARE PROGRAM*       2, 166, 195       35, 423       2, 201, 618       0       2, 201, 618       64.00         65.00       OTHER PHYSICIAN SERVICES*       0       0       0       0       0       65.00         66.00       RESIDENTIAL CARE*       0       0       0       0       0       66.00         67.00       ADVERTISING*       0       0       0       0       67.00         68.00       TELEHEALTH/TELEMONITORING*       0       0       0       67.00         69.00       THRIFT STORE*       0       0       0       0       69.00         70.00       NURSING FACILITY ROOM & BOARD*       0       0       0       0       0       69.00         71.00       OTHER NONREI MBURSABLE (SPECI FY)*       0       0       0       0       0       71.00         100.00       TOTAL       5, 261, 377       3, 313, 513       8, 574, 890       -1, 612, 526       6, 962, 364       100.00		FUNDRAI SI NG*	0	0		0 0	0	
65.00       OTHER PHYSICIAN SERVICES*       0       0       0       0       65.00         66.00       RESIDENTIAL CARE*       0       0       0       0       66.00         67.00       ADVERTISING*       0       0       0       0       66.00         68.00       TELEHEALTH/TELEMONITORING*       0       0       0       67.00       68.00         69.00       THRIFT STORE*       0       0       0       0       69.00         70.00       NURSING FACILITY ROOM & BOARD*       0       0       0       0       70.00         71.00       OTHER NONREI MBURSABLE (SPECI FY)*       0       0       0       0       71.00         100.00       TOTAL       5, 261, 377       3, 313, 513       8, 574, 890       -1, 612, 526       6, 962, 364       100.00	63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0		0 0	0	63.00
65.00       OTHER PHYSICIAN SERVICES*       0       0       0       0       65.00         66.00       RESIDENTIAL CARE*       0       0       0       0       66.00         67.00       ADVERTISING*       0       0       0       0       66.00         68.00       TELEHEALTH/TELEMONITORING*       0       0       0       67.00       68.00         69.00       THRIFT STORE*       0       0       0       0       69.00         70.00       NURSING FACILITY ROOM & BOARD*       0       0       0       0       70.00         71.00       OTHER NONREI MBURSABLE (SPECI FY)*       0       0       0       0       71.00         100.00       TOTAL       5, 261, 377       3, 313, 513       8, 574, 890       -1, 612, 526       6, 962, 364       100.00	64.00	PALLIATIVE CARE PROGRAM*	2, 166, 195	35, 423	2, 201, 61	в О	2, 201, 618	64.00
67.00       ADVERTISING*       0       0       0       0       67.00         68.00       TELEHEALTH/TELEMONITORING*       0       0       0       0       68.00         69.00       THRIFT STORE*       0       0       0       0       69.00         70.00       NURSING FACILITY ROOM & BOARD*       0       0       0       0       70.00         71.00       OTHER NONREI MBURSABLE (SPECIFY)*       0       0       0       0       71.00         100.00       TOTAL       5, 261, 377       3, 313, 513       8, 574, 890       -1, 612, 526       6, 962, 364       100.00			0	0			0	
68.00         TELEHEALTH/TELEMONI TORI NG*         0         0         0         0         68.00           69.00         THRI FT STORE*         0         0         0         0         69.00           70.00         NURSI NG FACILI TY ROOM & BOARD*         0         0         0         0         70.00           71.00         OTHER NONREI MBURSABLE (SPECI FY)*         0         0         0         0         71.00           100.00         TOTAL         5, 261, 377         3, 313, 513         8, 574, 890         -1, 612, 526         6, 962, 364         100.00			0	0		0 0		
69.00       THRI FT STORE*       0       0       0       69.00         70.00       NURSI NG FACI LI TY ROOM & BOARD*       0       0       0       0       70.00         71.00       OTHER NONREI MBURSABLE (SPECI FY)*       0       0       0       0       71.00         100.00       TOTAL       5, 261, 377       3, 313, 513       8, 574, 890       -1, 612, 526       6, 962, 364       100.00			0	0		0 0		
70.00         NURSI NG FACI LI TY ROOM & BOARD*         0         0         0         0         70.00           71.00         OTHER NONREI MBURSABLE (SPECI FY)*         0         0         0         0         71.00         71.00         0         0         0         71.00         71.00         71.00         0         0         0         71.00         71			0	0		0 0	-	
71.00         OTHER         NONREI MBURSABLE         (SPECI FY)*         0         0         0         0         71.00           100.00         TOTAL         5, 261, 377         3, 313, 513         8, 574, 890         -1, 612, 526         6, 962, 364         100.00			0	0		0 0		
100. 00 TOTAL 5, 261, 377 3, 313, 513 8, 574, 890 -1, 612, 526 6, 962, 364 100. 00			0	0		0 0		
		· · ·	0	0	0 574 00			
* Transfer the amounts in column 7 to Wkst. 0–5, column 1, line as appropriate.					8,574,89	J -1, 612, 526	6, 962, 364	100.00

\* Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate. \*\* See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

In Lieu of Form CMS-2552-10

Heal th	Financial Systems ST.	FRANCIS HOSPITA	L & HEALTH CENT	ER	In Lieu	u of Form CMS	-2552-10
ANALYSI	S OF HOSPITAL-BASED HOSPICE COSTS		Provider CCN	N: 15-0162	Peri od:	Worksheet O	
			Hospi ce CCN:	15-1523	From 01/01/2018 To 12/31/2018	Date/Time Pr	enared
			nospi ce cen.	10 1020	10 12/31/2010	5/31/2019 7:	
					Hospi ce I		
		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)				
		6.00	7.00				
C	GENERAL SERVICE COST CENTERS	0.00	7.00		<u> </u>		-
	CAP REL COSTS-BLDG & FIXT*	0	0				1.00
	CAP REL COSTS-MVBLE EQUIP*	0	o				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0				3.00
4.00	ADMI NI STRATI VE & GENERAL*	0	760, 966				4.00
	PLANT OPERATION & MAINTENANCE*	0	0				5.00
	LAUNDRY & LINEN SERVICE*	0	15, 812				6.00
	HOUSEKEEPI NG*	0	0				7.00
	DI ETARY*	0	21, 043				8.00
	NURSING ADMINISTRATION*	0	0				9.00
1	ROUTINE MEDICAL SUPPLIES*	0	0				10.00
	MEDI CAL RECORDS*	0	02 107				11.00
	STAFF TRANSPORTATI ON* VOLUNTEER SERVI CE COORDI NATI ON*	0	83, 197 45, 591				12.00
	PHARMACY*	0	345, 692				14.00
	PHYSI CI AN ADMI NI STRATI VE SERVI CES*	0	133, 151				15.00
	OTHER GENERAL SERVICE*	0	0				16.00
	PATIENT/RESIDENTIAL CARE SERVICES	, i i i i i i i i i i i i i i i i i i i					17.00
-	DIRECT PATIENT CARE SERVICE COST CENTERS						
	INPATIENT CARE-CONTRACTED**	0	0				25.00
26.00	PHYSICIAN SERVICES**	0	0				26.00
27.00	NURSE PRACTI TI ONER**	0	0				27.00
	REGI STERED NURSE**	0	1, 596, 537				28.00
	LPN/LVN**	0	0				29.00
	PHYSI CAL THERAPY**	0	412				30.00
1	OCCUPATIONAL THERAPY**	0	0				31.00
	SPEECH/LANGUAGE PATHOLOGY**	0	0				32.00
	MEDICAL SOCIAL SERVICES**	0	217, 427				33.00
1	SPI RI TUAL COUNSELI NG**	0	138, 714				34.00
		0	0				35.00
1	COUNSELING - OTHER** HOSPICE AIDE & HOMEMAKER SERVICES**	0	394, 179				36.00
	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	236, 824				38.00
1	PATIENT TRANSPORTATION**	0	230, 824				39.00
	I MAGI NG SERVI CES**	0	0				40.00
	LABS & DI AGNOSTI CS**	0	0				41.00
	MEDICAL SUPPLIES-NON-ROUTINE**	0	136, 242				42.00
42.50	DRUGS CHARGED TO PATIENTS**	0	0				42.50
43.00	OUTPATI ENT SERVI CES**	0	578, 598				43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0				44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0				45.00
	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0				46.00
	VONREIMBURSABLE COST CENTERS						
	BEREAVEMENT PROGRAM *	0	56, 361				60.00
	VOLUNTEER PROGRAM *	0	0				61.00
	FUNDRALSING*	0	0				62.00
	HOSPICE/PALLIATIVE MEDICINE FELLOWS* PALLIATIVE CARE PROGRAM*	0					63.00
		0	2, 201, 618				64.00
	OTHER PHYSICIAN SERVICES* RESIDENTIAL CARE*		0				65.00 66.00
	ADVERTI SI NG*		0				67.00
	ADVERTI SI NG^ TELEHEALTH/TELEMONI TORI NG*		0				67.00
	THRIFT STORE*						69.00
	NURSING FACILITY ROOM & BOARD*						70.00
1	OTHER NONREIMBURSABLE (SPECIFY)*	0	0				71.00
100.00		0	6, 962, 364				100.00
	ifer the amounts in column 7 to Wkst. 0-5, c	-					

\*\* See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

	· · · · <b>J</b> · · · ·	RANCIS HOSPITA				u of Form CMS-2	
	IS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPIC	CE ROUTINE HOME	Provider C	CN: 15-0162	Period: From 01/01/2018	Worksheet 0-2	
CARE			Hospi ce CCI	N: 15-1523	To 12/31/2018	Date/Time Pre 5/31/2019 7:4	
					Hospi ce I		
		SALARI ES	OTHER	SUBTOTAL	RECLASSI FI -	SUBTOTAL	
				(col. 1 +	CATIONS		
				col. 2)			
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS	г					
25.00	INPATIENT CARE-CONTRACTED						25.00
26.00	PHYSI CLAN SERVI CES	0	0		0 0	0	26.00
27.00	NURSE PRACTI TI ONER	0	0		0 0	0	27.00
28.00	REGI STERED NURSE	0	85, 141	85, 14	47, 096	132, 237	28.00
29.00	LPN/LVN	0	0		0 0	0	29.00
30.00	PHYSI CAL THERAPY	0	0		0 412	412	30.00
31.00	OCCUPATIONAL THERAPY	0	0		0 0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		0 0	0	32.00
33.00	MEDI CAL SOCI AL SERVI CES	0	0		0 217, 427	217, 427	33.00
34.00	SPI RI TUAL COUNSELI NG	0	0		0 138, 714	138, 714	34.00
35.00	DI ETARY COUNSELI NG	0	0		0 0	0	35.00
36.00	COUNSELING - OTHER	0	0		0 0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	0		0 386, 199	386, 199	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	236, 824	236, 82	24 0	236, 824	38.00
39.00	PATI ENT TRANSPORTATI ON	0	0		0 0	0	39.00
40.00	I MAGI NG SERVI CES	0	0		0 0	0	40.00

39.00	PATTENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	I MAGI NG SERVI CES	0	0	0	0	0	40.00
41.00	LABS & DI AGNOSTI CS	0	0	0	0	0	41.00
42.00	MEDI CAL SUPPLI ES-NON-ROUTI NE	0	133, 747	133, 747	0	133, 747	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50
43.00	OUTPATI ENT SERVI CES	0	563, 667	563, 667	0	563, 667	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	0	1, 019, 379	1, 019, 379	789, 848	1, 809, 227	100.00
* Tran	sfer the amount in column 7 to Wkst. 0-5, col	umn 1, line 51					

		ADJUSTMENTS	TOTAL (col. 5	
			± col. 6)	
		6.00	7.00	
	RECT PATIENT CARE SERVICE COST CENTERS			
25.00 INF	PATIENT CARE-CONTRACTED			25.0
26. 00 PHY	YSI CI AN SERVI CES	0	0	26.0
27.00 NUF	RSE PRACTI TI ONER	0	0	27.0
28.00 REC	GI STERED NURSE	0	132, 237	28.0
29.00 LPN	N/LVN	0	0	29.0
30. 00 PHY	YSI CAL THERAPY	0	412	30.00
31.00 OCC	CUPATI ONAL THERAPY	0	0	31.0
32.00 SPE	EECH/LANGUAGE PATHOLOGY	0	0	32.0
33. OO MEE	DI CAL SOCIAL SERVICES	0	217, 427	33.0
34.00 SPI	I RI TUAL COUNSELI NG	0	138, 714	34.0
35.00 DIE	ETARY COUNSELING	0	0	35.0
36.00 COL	UNSELING - OTHER	0	0	36.0
37.00 HOS	SPICE AIDE & HOMEMAKER SERVICES	0	386, 199	37.0
38. 00 DUF	RABLE MEDICAL EQUIPMENT/OXYGEN	0	236, 824	38.0
39. 00 PA1	TI ENT TRANSPORTATI ON	0	0	39.0
10.00 IMA	AGI NG SERVI CES	0	0	40.0
41.00 LAE	BS & DIAGNOSTICS	0	0	41.0
12.00 MED	DI CAL SUPPLI ES-NON-ROUTI NE	0	133, 747	42.0
12.50 DRL	UGS CHARGED TO PATIENTS	0	0	42.5
13. OO 0UT	TPATI ENT SERVI CES	0	563, 667	43.0
14.00 PAL	LLIATIVE RADIATION THERAPY	0	0	44. C
15.00 PAL	LLIATIVE CHEMOTHERAPY	0	0	45. C
16. 00 OTH	HER PATIENT CARE SERVICES (SPECIFY)	0	0	46.0
100. OO TOT	TAL *	0	1, 809, 227	100.0

DIRECT PATIENT CARE SERVICE COSTS FOR HOSPICE INPATIENT         Provider CCN: 15-0162 Hospice CCN: 15-1523         Provider CCN: 15-0162 From 01/01/2018 To 12/21/2019         Worksheet 0-3 Date/Time Prepared: 521/2019           Image: Construct Const			RANCIS HOSPITAL				u of Form CMS-	
Inclusion         Hospice CCN:         15-1523         To         12/31/2018         Date/Time Prepared: 5/31/2019         5/31/2019         7:47 am           Image: Solution of the spice of t			CE INPATIENT	Provider CC			Worksheet 0-3	3
DIRECT PATIENT CARE SERVICE COST CENTERS         OTHER         SUBTOTAL (col. 1)         RECLASSIFI- CATIONS         SUBTOTAL CATIONS           25.00         INPATIENT CARE-CONTRACTED         0 </td <td>RESPI T</td> <td>E CARE</td> <td></td> <td>Hospi co. CCN</td> <td></td> <td></td> <td>Dato/Timo Pro</td> <td>narod</td>	RESPI T	E CARE		Hospi co. CCN			Dato/Timo Pro	narod
SALARI ES         OTHER         SUBTOTAL (col. 1 + col. 2)         RECLASSI FI - CATIONS         SUBTOTAL (Cal. 2)           DI RECT PATI ENT CARE SERVICE COST CENTERS         1.00         2.00         3.00         4.00         5.00           DI RECT PATI ENT CARE CONTRACTED         0         0         0         0         25.00           1.00         1.00         2.00         3.00         4.00         5.00           25.00         INPATI ENT CARE-CONTRACTED         0         0         0         0         25.00           28.00         REGISTERED         0         0         0         0         27.00         0         0         0         27.00           29.00         LPN/LVN         0         0         0         0         0         29.00           29.00         LPN/LVN         0         0         0         0         29.00         30.00         29.00         30.00         29.00         30.00         29.00         30.00         29.00         30.00         29.00         30.00         29.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00         30.00				nospi ce con	1. 15-1525	10 12/31/2010	5/31/2019 7:4	7 am
DIRECT PATIENT CARE SERVICE COST CENTERS         I.00         2.00         3.00         4.00         5.00           DIRECT PATIENT CARE SERVICE COST CENTERS         0         0         0         0         25.00           INPATIENT CARE-CONTRACTED         0         0         0         0         26.00           26.00         INPATIENT CARE-CONTRACTED         0         0         0         26.00           27.00         NURSE PRACTITIONER         0         0         0         26.00           28.00         REGISTERED NURSE         0         1.271         1.271         1.168,580         1.669,851         28.00           29.00         LPM/LVN         0         0         0         0         29.00           30.00         PHYSICAL THERAPY         0         0         0         0         31.00           31.00         OCCUPATIONAL THERAPY         0         0         0         0         33.00           32.00         SPICAL/ANGUAGE PATHOLOGY         0         0         0         33.00           33.00         DICAL SOCIAL SERVICES         0         0         0         33.00           33.00         DICAL SOCIAL SERVICES         0         0         0						Hospi ce I		
DIRECT PATIENT CARE SERVICE COST CENTERS         1.00         2.00         3.00         4.00         5.00           25.00         INPATIENT CARE SERVICE COST CENTERS         0         0         0         0         25.00           26.00         PHYSI CIAN SERVICES         0         0         0         0         25.00           26.00         PHYSI CIAN SERVICES         0         0         0         0         25.00           27.00         NURSE PRACTITIONER         0         0         0         0         27.00           28.00         REGISTERED NURSE         0         1,271         1,271         1,168,580         1,169,851         28.00           29.00         LPN/LVN         0         0         0         0         29.00           29.00         CCUPATIONAL THERAPY         0         0         0         31.00           31.00         OCCUPATIONAL THERAPY         0         0         0         32.00           32.00         SPECH/LANGUAGE PATHOLOGY         0         0         0         33.00           32.00         SPERTITAL COUNSELING         0         0         0         33.00           34.00         SPIRI TUAL COUNSELING         0         0			SALARI ES	OTHER	SUBTOTAL	RECLASSI FI -	SUBTOTAL	
DI RECT PATIENT CARE SERVICE COST CENTERS           25.00         INPATIENT CARE-CONTRACTED         0         0         0         25.00           26.00         PHYSICIAN SERVICES         0         0         0         0         25.00           26.00         PHYSICIAN SERVICES         0         0         0         0         26.00           27.00         NURSE PRACTITIONER         0         0         0         0         27.00           28.00         REGISTERED NURSE         0         1.271         1.271         1.68,580         1.169,851         28.00           29.00         LPN/LVN         0         0         0         0         29.00           30.00         PHYSICAL THERAPY         0         0         0         0         29.00           31.00         OCCUPATIONAL THERAPY         0         0         0         0         31.00           32.00         SPEECH/LANGUAGE PATHOLOGY         0         0         0         33.00         33.00           33.00         MEDI CAL SOCI AL SERVICES         0         0         0         33.00           35.00         DI ETARY COUNSELING         0         0         0         35.00					(col. 1 +	CATI ONS		
DI RECT PATI ENT CARE SERVICE COST CENTERS           25.00         INPATI ENT CARE-CONTRACTED         0         0         0         25.00           26.00         PHYSI CLAN SERVICES         0         0         0         0         25.00           27.00         NURSE PRACTI TI ONER         0         0         0         0         27.00           28.00         REGI STERED NURSE         0         1,271         1,271         1,168,580         1,169,851         28.00           29.00         LPV/LVN         0         0         0         0         0         29.00           30.00         PHYSI CAL THERAPY         0         0         0         0         0         30.00           31.00         OCCUPATI ONAL THERAPY         0         0         0         0         0         32.00           32.00         SPECH/LANGUAGE PATHOLOGY         0         0         0         0         33.00           34.00         SPI RITUAL COUNSELING         0         0         0         0         33.00           35.00         DI FTARY COUNSELING         0         0         0         0         36.00           37.00         HABRABLING         0         0								
25.00       INPATI ENT CARE-CONTRACTED       0       0       0       25.00         26.00       PHYSI CI AN SERVI CES       0       0       0       0       26.00         27.00       NURSE PRACTI TI ONER       0       0       0       0       0       27.00         28.00       REGI STERED NURSE       0       1, 271       1, 271       1, 168, 580       1, 169, 851       28.00         29.00       LPN/LVN       0       0       0       0       0       29.00         30.00       PHYSI CAL THERAPY       0       0       0       0       30.00         31.00       OCCUPATI ONAL THERAPY       0       0       0       0       31.00         32.00       SPEECH/LANGUAGE PATHOLOGY       0       0       0       0       32.00         33.00       MEDI CAL SOCI AL SERVI CES       0       0       0       0       33.00         34.00       SPIRI TUAL COUNSELI NG       0       0       0       0       34.00         35.00       DETARY COUNSELI NG       0       0       0       0       35.00         36.00       OUNSELI NG       0       0       0       0       0       35.0			1.00	2.00	3.00	4.00	5.00	
26.00       PHYSICIAN SERVICES       0       0       0       26.00         27.00       NURSE PRACTITIONER       0       0       0       27.00         28.00       REGISTERED NURSE       0       1,271       1,168,580       1,169,851       28.00         29.00       LPN/LVN       0       0       0       0       28.00         30.00       PHYSICAL THERAPY       0       0       0       0       30.00         31.00       OCUPATIONAL THERAPY       0       0       0       0       30.00         32.00       SPECH/LANGUAGE PATHOLOGY       0       0       0       32.00         33.00       MEDI CAL SOCIAL SERVICES       0       0       0       33.00         34.00       SPIRI TUAL COUNSELING       0       0       0       34.00         35.00       DI ETARY COUNSELING       0       0       0       0       35.00         37.00       HOSPICE AI DE & HOMEMAKER SERVICES       0       0       0       0       35.00         37.00       HOSPICE AI DE & HOMEMAKER SERVICES       0       0       0       0       38.00         39.00       PATI ENT TRANSPORTATION       0       0			TT			- 1		
27.00       NURSE PRACTITIONER       0       0       0       27.00         28.00       REGISTERED NURSE       0       1,271       1,271       1,168,580       1,169,851       28.00         29.00       LPM/LVN       0       0       0       0       0       29.00         29.00       LPM/LVN       0       0       0       0       0       29.00         30.00       PHYSI CAL THERAPY       0       0       0       0       0       30.00         31.00       OCUPATI ONAL THERAPY       0       0       0       0       31.00         32.00       SPEECH/LANGUAGE PATHOLOGY       0       0       0       0       32.00         34.00       SPI RI TUAL COUNSELI NG       0       0       0       0       33.00         35.00       DI ETARY COUNSELI NG       0       0       0       0       35.00       36.00         37.00       HOSPI CE AI DE & HOMEMAKER SERVI CES       0       0       0       0       36.00         38.00       DURABLE MEDI CAL EQUI PMENT/OXYGEN       0       0       0       0       38.00         39.00       PATI ENT TRANSPORTATI ON       0       0       0				0		0 0	-	
28.00       REGI STERED NURSE       0       1, 271       1, 271       1, 168, 580       1, 169, 851       28.00         29.00       LPN/LVM       0       0       0       0       29.00         30.00       PHYSI CAL THERAPY       0       0       0       0       30.00         31.00       OCCUPATI ONAL THERAPY       0       0       0       0       31.00         32.00       SPEECH/LANGUAGE PATHOLOGY       0       0       0       0       32.00         33.00       MEDI CAL SOCI AL SERVI CES       0       0       0       33.00         34.00       SPIRI TUAL COUNSELI NG       0       0       0       34.00         35.00       DI ETARY COUNSELI NG       0       0       0       35.00         36.00       COUNSELI NG - OTHER       0       0       0       36.00         37.00       HOSPI CE AI DE & HOMEMAKER SERVI CES       0       0       0       37.00         38.00       DIRABLE MEDI CAL EQUI PMENT/OXYGEN       0       0       0       39.00         99.00       PATI ENT TRANSPORTATI ON       0       0       0       39.00         40.00       IMAGI NG SERVI CES       0       0			0	0		0 0	-	
29.00       LPN/LVN       0       0       0       0       0       29.00         30.00       PHYSI CAL THERAPY       0       0       0       0       30.00         31.00       OCCUPATI ONAL THERAPY       0       0       0       0       30.00         32.00       SPEECH/LANGUAGE PATHOLOGY       0       0       0       31.00         32.00       SPEECH/LANGUAGE PATHOLOGY       0       0       0       32.00         33.00       MEDI CAL SOCIAL SERVICES       0       0       0       0       33.00         34.00       SPI RI TUAL COUNSELI NG       0       0       0       0       34.00         35.00       DI ETARY COUNSELI NG       0       0       0       0       35.00         36.00       COUNSELI NG - OTHER       0       0       0       0       36.00         37.00       HOSPI CE AL DE & HOMEMAKER SERVI CES       0       0       0       38.00       39.00         39.00       PATI ENT TRANSPORTATI ON       0       0       0       0       39.00         40.00       IMAGI NG SERVI CES       0       0       0       0       0       41.00         42.00			0	0		0 0		
30.00       PHYSICAL THERAPY       0       0       0       0       30.00         31.00       OCCUPATIONAL THERAPY       0       0       0       0       31.00         32.00       SPEECH/LANGUAGE PATHOLOGY       0       0       0       0       32.00         32.00       SPEECH/LANGUAGE PATHOLOGY       0       0       0       0       32.00         33.00       MEDI CAL SOCIAL SERVICES       0       0       0       0       33.00         34.00       SPIRI TUAL COUNSELING       0       0       0       0       34.00         35.00       DI ETARY COUNSELING       0       0       0       0       35.00         36.00       COUNSELING - OTHER       0       0       0       0       36.00         37.00       HOSPICE AI DE & HOMEMAKER SERVICES       0       0       0       0       38.00         38.00       DURABLE MEDI CAL EQUI PMENT/0XYGEN       0       0       0       0       39.00         39.00       PATI ENT TRANSPORTATI ON       0       0       0       0       0       40.00         41.00       LABS & DI AGNOSTI CS       0       0       0       0       0       4			0	1, 271	1, 27	1 1, 168, 580		
31.00       0CCUPATI ONAL THERAPY       0       0       0       0       31.00         32.00       SPEECH/LANGUAGE PATHOLOGY       0       0       0       32.00         33.00       MEDI CAL SOCI AL SERVICES       0       0       0       0       33.00         34.00       SPI RI TUAL COUNSELI NG       0       0       0       0       34.00         35.00       DI ETARY COUNSELI NG       0       0       0       0       35.00         10 E TARY COUNSELI NG       0       0       0       0       35.00       0       36.00         36.00       COUNSELI NG - OTHER       0       0       0       0       36.00         37.00       HOSPI CE AI DE & HOMEMAKER SERVICES       0       0       0       38.00         90       PATI ENT TRANSPORTATI ON       0       0       0       39.00         40.00       IMAGI NG SERVI CES       0       0       0       0       40.00         41.00       LABS & DI AGNOSTI CS       0       0       0       0       41.00         42.00       MEDI CAL SUPPLI ES-NON-ROUTI NE       0       1, 997       1, 997       0       1, 997         42.00 <t< td=""><td></td><td></td><td>0</td><td>0</td><td></td><td>0 0</td><td>-</td><td></td></t<>			0	0		0 0	-	
32.00       SPEECH/LANGUAGE PATHOLOGY       0       0       0       32.00         33.00       MEDI CAL SOCI AL SERVI CES       0       0       0       33.00         34.00       SPI RI TUAL COUNSELI NG       0       0       0       34.00         35.00       DI ETARY COUNSELI NG       0       0       0       34.00         35.00       DI ETARY COUNSELI NG       0       0       0       35.00         36.00       COUNSELI NG - OTHER       0       0       0       0       36.00         37.00       HOSPI CE AI DE & HOMEMAKER SERVI CES       0       0       0       6,375       6,375       37.00         38.00       DURABLE MEDI CAL EQUI PMENT/OXYGEN       0       0       0       0       39.00         40.00       IMAGI NG SERVI CES       0       0       0       0       39.00         41.00       LABS & DI AGNOSTI CS       0       0       0       0       40.00         42.00       MEDI CAL SUPPLI ES-NON-ROUTI NE       0       0       0       0       42.00         42.00       MEDI CAL SUPPLI ES-NON-ROUTI NE       0       0       0       0       42.50         MEDI CAL SUPPLI ES-NON-ROUTI NE<			0	0		0 0	0	
33.00       MEDICAL SOCIAL SERVICES       0       0       0       33.00         34.00       SPIRITUAL COUNSELING       0       0       0       34.00         35.00       DIETARY COUNSELING       0       0       0       34.00         35.00       DIETARY COUNSELING       0       0       0       35.00         36.00       COUNSELING - OTHER       0       0       0       0       35.00         37.00       HOSPICE AIDE & HOMEMAKER SERVICES       0       0       0       6,375       6,375       37.00         38.00       DURABLE MEDICAL EQUIPMENT/OXYGEN       0       0       0       0       38.00         9.00       PATI ENT TRANSPORTATION       0       0       0       0       39.00         40.00       IMAGING SERVICES       0       0       0       0       39.00         41.00       LABS & DIAGNOSTICS       0       0       0       0       40.00         42.00       MEDICAL SUPPLIES-NON-ROUTINE       0       1,997       1,997       0       1,997       42.00         43.00       OUTPATI ENT SERVICES       0       0       0       0       0       44.00         44.00<			0	0		0 0	0	
34.00       SPIRITUAL COUNSELING       0       0       0       34.00         35.00       DI ETARY COUNSELING       0       0       0       0       35.00         36.00       COUNSELING - OTHER       0       0       0       0       36.00         37.00       HOSPICE AIDE & HOMEMAKER SERVICES       0       0       0       6,375       6,375       37.00         38.00       DURABLE MEDICAL EQUIPMENT/OXYGEN       0       0       0       0       38.00         39.00       PATIENT TRANSPORTATION       0       0       0       39.00       30.00       30.00       39.00       39.00       30.00       30.00       39.00       39.00       39.00       30.00       30.00       30.00       30.00       39.00       30.00       30.00       30.00       30.00       30.00       30.00       30.00       30.00       30.00       30.00       30.00			0	0		0 0	0	
35.00       DI ETARY COUNSELING       0       0       0       35.00         36.00       COUNSELING - OTHER       0       0       0       36.00         37.00       HOSPICE AIDE & HOMEMAKER SERVICES       0       0       0       6,375       6,375       37.00         38.00       DURABLE MEDICAL EQUIPMENT/OXYGEN       0       0       0       0       38.00         39.00       PATIENT TRANSPORTATION       0       0       0       39.00       39.00       39.00       0       0       0       39.00       39.00       39.00       39.00       0       0       0       0       39.00       39.00       39.00       39.00       0       0       0       39.00       39.00       39.00       39.00       39.00       39.00       39.00       39.00       39.00       39.00       39.00       39.00       39.00       39.00       39.00       39.00       40.00       40.00       40.00       40.00       40.00       40.00       40.00       40.00       41.00       42.00       42.00       41.00       42.00       42.50       42.50       50       50.00       50.00       42.50       43.00       42.50       43.00       42.50       43.00			0	0		0 0	u u	
36.00       COUNSELING - OTHER       0       0       0       36.00         37.00       HOSPICE AIDE & HOMEMAKER SERVICES       0       0       0       6,375       6,375       37.00         38.00       DURABLE MEDICAL EQUIPMENT/OXYGEN       0       0       0       0       38.00         39.00       PATIENT TRANSPORTATION       0       0       0       0       39.00         40.00       IMAGING SERVICES       0       0       0       0       39.00         41.00       LABS & DI AGNOSTICS       0       0       0       0       40.00         42.00       MEDICAL SUPPLIES-NON-ROUTINE       0       1,997       1,997       0       1,997         42.50       DRUGS CHARGED TO PATIENTS       0       0       0       0       42.00         43.00       OUTPATIENT SERVICES       0       11,950       11,950       33.00       43.00         44.00       PALLIATIVE RADIATION THERAPY       0       0       0       0       42.00         45.00       PALLIATIVE CHEMOTHERAPY       0       0       0       0       44.00         45.00       OLTHER PATIENT CARE SERVICES (SPECIFY)       0       0       0       0			0	0		0 0	U U	
37.00       HOSPICE AIDE & HOMEMAKER SERVICES       0       0       6,375       6,375       37.00         38.00       DURABLE MEDICAL EQUIPMENT/OXYGEN       0       0       0       38.00         39.00       PATIENT TRANSPORTATION       0       0       0       39.00         40.00       IMAGING SERVICES       0       0       0       0       39.00         41.00       LABS & DI AGNOSTICS       0       0       0       0       40.00         42.00       MEDICAL SUPPLIES-NON-ROUTINE       0       1,997       1,997       0       1,997       42.00         43.00       OUTPATIENT SERVICES       0       0       0       0       43.00         44.00       PALLIATIVE RADIATION THERAPY       0       11,950       11,950       43.00         45.00       PALLIATIVE CHEMOTHERAPY       0       0       0       0       44.00         45.00       OTHER PATIENT CARE SERVICES (SPECIFY)       0       0       0       0       45.00			0	0		0 0	u u	
38.00       DURABLE MEDI CAL EQUI PMENT/OXYGEN       0       0       0       38.00         39.00       PATI ENT TRANSPORTATI ON       0       0       0       39.00         40.00       IMAGI NG SERVI CES       0       0       0       0       39.00         41.00       LABS & DI AGNOSTI CS       0       0       0       0       40.00         42.00       MEDI CAL SUPPLI ES-NON-ROUTI NE       0       1,997       1,997       0       1,997       42.00         43.00       OUTPATI ENT SERVI CES       0       0       0       0       43.00         44.00       PALLI ATI VE RADI ATI ON THERAPY       0       11,950       11,950       43.00         45.00       PALLI ATI VE CHEMOTHERAPY       0       0       0       0       44.00         45.00       OTHER PATI ENT CARE SERVICES (SPECI FY)       0       0       0       0       45.00			0	0		0 0	-	
39.00       PATIENT TRANSPORTATION       0       0       0       39.00         40.00       IMAGING SERVICES       0       0       0       0       40.00         41.00       LABS & DIAGNOSTICS       0       0       0       0       41.00         42.00       MEDICAL SUPPLIES-NON-ROUTINE       0       1,997       1,997       0       1,997       42.00         42.50       DRUGS CHARGED TO PATIENTS       0       0       0       0       42.50         43.00       OUTPATIENT SERVICES       0       11,950       11,950       43.00       44.00       44.00       44.00       44.00       44.00       44.00       44.00       44.00       0       0       0       0       44.00         45.00       PALLIATIVE CHEMOTHERAPY       0       0       0       0       0       44.00         46.00       OTHER PATIENT CARE SERVICES (SPECIFY)       0       0       0       0       45.00			0	0		0 6,375		
40.00       IMAGING SERVICES       0       0       0       0       40.00         41.00       LABS & DIAGNOSTICS       0       0       0       0       41.00         42.00       MEDICAL SUPPLIES-NON-ROUTINE       0       1,997       1,997       0       1,997       42.00         42.50       DRUGS CHARGED TO PATIENTS       0       0       0       0       42.50         43.00       OUTPATIENT SERVICES       0       11,950       11,950       43.00         44.00       PALLIATIVE RADIATION THERAPY       0       0       0       44.00         45.00       PALLIATIVE CHEMOTHERAPY       0       0       0       0       45.00         46.00       OTHER PATIENT CARE SERVICES (SPECIFY)       0       0       0       0       46.00			0	0				
41.00       LABS & DIAGNOSTICS       0       0       0       0       41.00         42.00       MEDICAL SUPPLIES-NON-ROUTINE       0       1,997       1,997       0       1,997       42.00         42.50       DRUGS CHARGED TO PATIENTS       0       0       0       0       42.50         43.00       OUTPATIENT SERVICES       0       11,950       11,950       43.00         44.00       PALLIATIVE RADIATION THERAPY       0       0       0       44.00         45.00       PALLIATIVE CHEMOTHERAPY       0       0       0       44.00         45.00       OTHER PATIENT CARE SERVICES (SPECIFY)       0       0       0       0       45.00			0	0			-	
42.00       MEDI CAL SUPPLI ES-NON-ROUTI NE       0       1,997       1,997       0       1,997       42.00         42.50       DRUGS CHARGED TO PATI ENTS       0       0       0       0       42.50         43.00       OUTPATI ENT SERVICES       0       11,950       11,950       11,950       43.00         44.00       PALLI ATI VE RADI ATI ON THERAPY       0       0       0       0       44.00         45.00       OTHER PATI ENT CARE SERVICES (SPECI FY)       0       0       0       0       46.00			0	0			-	
42.50       DRUGS CHARGED TO PATIENTS       0       0       0       42.50         43.00       OUTPATIENT SERVICES       0       11,950       11,950       0       11,950         44.00       PALLIATIVE RADIATION THERAPY       0       0       0       0       44.00         45.00       PALLIATIVE CHEMOTHERAPY       0       0       0       0       45.00         46.00       OTHER PATIENT CARE SERVICES (SPECIFY)       0       0       0       0       46.00			0	1 007	1 00	7 0	-	
43.00       0UTPATI ENT SERVICES       0       11,950       11,950       0       11,950       43.00         44.00       PALLIATI VE RADIATION THERAPY       0       0       0       0       44.00         45.00       PALLIATI VE CHEMOTHERAPY       0       0       0       0       45.00         46.00       OTHER PATIENT CARE SERVICES (SPECIFY)       0       0       0       0       46.00			0	1, 777	1, 22			
44.00       PALLIATIVE RADIATION THERAPY       0       0       0       0       44.00         45.00       PALLIATIVE CHEMOTHERAPY       0       0       0       0       0       45.00         46.00       OTHER PATIENT CARE SERVICES (SPECIFY)       0       0       0       0       0       46.00			0	11 950	11 95		-	
45.00         PALLIATIVE CHEMOTHERAPY         0         0         0         0         45.00           46.00         OTHER PATIENT CARE SERVICES (SPECIFY)         0         0         0         0         0         46.00			0	0	11, 70	0 0		
46.00 OTHER PATIENT CARE SERVICES (SPECIFY) 0 0 0 0 46.00			0	0		0 0	-	
			0	0		0 0	Ű	
			0	15, 218	15, 21	8 1, 174, 955	-	

 45.00
 PALLIATIVE CHEMOTHERAPY
 0

 46.00
 OTHER PATIENT CARE SERVICES (SPECIFY)
 0

 100.00
 TOTAL \*
 0

 \* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 52.

	ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
	6,00	7.00	
DI RECT PATI ENT CARE SERVI CE COST CENTERS			
25.00 INPATIENT CARE-CONTRACTED	0	0	25.00
26.00 PHYSICIAN SERVICES	0	0	26.00
27.00 NURSE PRACTITIONER	0	0	27.00
28.00 REGI STERED NURSE	0	1, 169, 851	28.00
29.00 LPN/LVN	0	0	29.00
30. 00 PHYSI CAL THERAPY	0	0	30.00
31. 00 OCCUPATI ONAL THERAPY	0	0	31.00
32.00 SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33. 00 MEDI CAL SOCI AL SERVI CES	0	0	33.00
34.00 SPIRITUAL COUNSELING	0	0	34.00
35. 00 DI ETARY COUNSELI NG	0	0	35.00
36.00 COUNSELING - OTHER	0	0	36.00
37.00 HOSPICE AIDE & HOMEMAKER SERVICES	0	6, 375	
38.00 DURABLE MEDI CAL EQUI PMENT/OXYGEN	0	0	38.00
39.00 PATIENT TRANSPORTATION	0	0	39.00
40.00 I MAGI NG SERVI CES	0	0	40.00
41.00 LABS & DI AGNOSTI CS	0	0	41.00
42.00 MEDI CAL SUPPLI ES-NON-ROUTI NE	0	1, 997	
42.50 DRUGS CHARGED TO PATIENTS	0	0	42.50
43.00 OUTPATI ENT SERVI CES	0	11, 950	
44.00 PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00 PALLIATIVE CHEMOTHERAPY	0	0	45.00
46.00 OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46.00
100.00 TOTAL *	0	1, 190, 173	100.00
* Transfer the amount in column 7 to Wkst. 0-5, col	umn 1, line 52		

	Financial Systems ST. IS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPI	FRANCIS HOSPITAL	Provider CCN: 15-0162		Peri od:	u of Form CMS-2 Worksheet 0-4	
	ENT CARE	CE GENERAL	Provider CC		From 01/01/2018		
INFAIL			Hospi ce CCN		To 12/31/2018	Date/Time Pre 5/31/2019 7:4	
					Hospi ce I		
		SALARI ES	OTHER	SUBTOTAL	RECLASSI FI -	SUBTOTAL	
				(col. 1 +	CATIONS		
				col. 2)			
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS	1 1			1		
	INPATIENT CARE-CONTRACTED		0		0 0	0	20.00
	PHYSI CI AN SERVI CES	0	0		0 0	0	
27.00	NURSE PRACTITIONER	0	0		0 0	0	
	REGI STERED NURSE	0	317	31	7 294, 132	294, 449	•
	LPN/LVN	0	0		0 0	0	27.00
	PHYSI CAL THERAPY	0	0		0 0	0	30.00
	OCCUPATI ONAL THERAPY	0	0		0 0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		0 0	0	02.00
	MEDICAL SOCIAL SERVICES	0	0		0 0	0	00.00
34.00	SPI RI TUAL COUNSELI NG	0	0		0 0	0	000
	DI ETARY COUNSELI NG	0	0		0 0	0	00.00
	COUNSELING - OTHER	0	0		0 0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	0		0 1,605	1, 605	37.00

0

0

0

0

0 0

498

2, 981

299, 533

0

0

0

0

498

0

0 0 0

498

38.00

40.00

40.00

41.00

42.00

42.50

43.00

44.00

45.00

46.00

100.00

0

0 39.00

0

0 41.00

498 42.00

		-			-	
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 42.50
43.00	OUTPATI ENT SERVI CES	0	2, 981	2, 981	0	2, 981 43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0 44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0 45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0 46.00
100.00	TOTAL *	0	3, 796	3, 796	295, 737	299, 533 100. 00
* Tran	sfer the amount in column 7 to Wkst. 0-5, col	umn 1, line 53				
		ADJUSTMENTS	TOTAL (col. 5			
			± col. 6)			
		6.00	7.00			
	DIRECT PATIENT CARE SERVICE COST CENTERS					
25.00	INPATIENT CARE-CONTRACTED	0	0			25.00
26.00	PHYSI CI AN SERVI CES	0	0			26.00
27.00	NURSE PRACTITIONER	0	0			27.00
28.00	REGI STERED NURSE	0	294, 449			28.00
29.00	LPN/LVN	0	0			29.00
30.00	PHYSI CAL THERAPY	0	0			30.00
31.00	OCCUPATIONAL THERAPY	0	0			31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0			32.00
33.00	MEDICAL SOCIAL SERVICES	0	0			33.00
34.00	SPI RI TUAL COUNSELI NG	0	0			34.00
35.00	DI ETARY COUNSELI NG	0	0			35.00
36.00	COUNSELING - OTHER	0	0			36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	1, 605			37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0			38.00
39.00	PATI ENT TRANSPORTATI ON	0	0			39.00
		-	-	1		

0

40.00

41.00

42.00

42.50

43.00

44.00

100.00 TOTAL \*

I MAGING SERVICES

LABS & DIAGNOSTICS

OUTPATIENT SERVICES

45.00 PALLIATIVE CHEMOTHERAPY

MEDICAL SUPPLIES-NON-ROUTINE

PALLIATIVE RADIATION THERAPY

46.00 OTHER PATIENT CARE SERVICES (SPECIFY)

\* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 53.

DRUGS CHARGED TO PATIENTS

38.00 DURABLE MEDICAL EQUI PMENT/OXYGEN

42.00 MEDI CAL SUPPLI ES-NON-ROUTI NE

39.00 PATIENT TRANSPORTATION

40.00 I MAGI NG SERVICES

41.00 LABS & DIAGNOSTICS

Heal th I	Financial Systems ST. FRANCIS HOSPITAL	& HEALTH CEN	ITER	In Lie	u of Form CMS-2	2552-10
COST AL	LOCATION - DETERMINATION OF HOSPITAL-BASED HOSPICE NET	Provider C	CN: 15-0162	Peri od:	Worksheet 0-5	
EXPENSE	S FOR ALLOCATION			From 01/01/2018		
		Hospi ce CC	N: 15-1523	To 12/31/2018		
				Hospi ce I	5/31/2019 7:4	
	Descriptions		HOSPI CE	GENERAL	TOTAL	
	beschiptions		DI RECT	SERVI CE	EXPENSES (sum	
				EXPENSES FROM		
				WKST B PART I	2)	
				(see	-/	
				instructions)		
			1.00	2.00	3.00	
C	GENERAL SERVICE COST CENTERS					
1.00	CAP REL COSTS-BLDG & FIXT			0 0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP			0 0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT			0 1, 845, 396	1, 845, 396	3.00
4.00	ADMI NI STRATI VE & GENERAL		760, 96	6 2, 212, 433	2, 973, 399	4.00
5.00 I	PLANT OPERATION & MAINTENANCE			0 0	0	5.00
6.00	LAUNDRY & LINEN SERVICE		15, 81	2 0	15, 812	6.00
7.00	HOUSEKEEPING			0 0	0	7.00
8.00 I	DI ETARY		21, 04	3 0	21, 043	8.00
9.00	NURSING ADMINISTRATION			0 0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES			0 12, 222	12, 222	10.00
11.00	MEDI CAL RECORDS			0 2, 710	2, 710	11.00
12.00	STAFF TRANSPORTATION		83, 19	7	83, 197	12.00
13.00	VOLUNTEER SERVICE COORDINATION		45, 59	1	45, 591	13.00
14.00 I	PHARMACY		345, 69	2 0	345, 692	14.00
15.00 I	PHYSI CI AN ADMI NI STRATI VE SERVI CES		133, 15	1	133, 151	15.00
16.00	OTHER GENERAL SERVICE			0 0	0	16.00
17.00 I	PATI ENT/RESI DENTI AL CARE SERVI CES			0	0	17.00
	LEVEL OF CARE					
	HOSPICE CONTINUOUS HOME CARE			0	0	50.00
	HOSPICE ROUTINE HOME CARE		1, 809, 22		1, 809, 227	51.00
	HOSPICE INPATIENT RESPITE CARE		1, 190, 17		1, 190, 173	
	HOSPICE GENERAL INPATIENT CARE		299, 53	3	299, 533	53.00
-	NONREI MBURSABLE COST CENTERS					
	BEREAVEMENT PROGRAM		56, 36		56, 361	60.00
	VOLUNTEER PROGRAM			0	0	61.00
	FUNDRAI SI NG			0	0	62.00
	HOSPICE/PALLIATIVE MEDICINE FELLOWS			0	0	63.00
	PALLIATIVE CARE PROGRAM		2, 201, 61		2, 201, 618	64.00
	OTHER PHYSICIAN SERVICES			0	0	65.00
	RESI DENTI AL CARE			0	0	66.00
	ADVERTI SI NG			0	0	67.00
	TELEHEALTH/TELEMONI TORI NG			0	0	68.00
	THRIFT STORE			0	0	69.00
	NURSING FACILITY ROOM & BOARD			U	0	70.00
	OTHER NONREI MBURSABLE (SPECI FY)			0	0	71.00
	NEGATI VE COST CENTER			4 070 7/4	0	99.00
100.00	IUTAL		6, 962, 36	4 4, 072, 761	11, 035, 125	100.00

COST A	ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL	SERVICE COSTS	Provider C Hospice CC			iod: m 01/01/2018 12/31/2018	Worksheet 0-6 Part I Date/Time Pre 5/31/2019 7:4	pared:
						Hospi ce I		
	Descriptions	TOTAL	CAP REL BLDG	CAP REL MVB	LE	EMPLOYEE	SUBTOTAL	
		EXPENSES	& FIX	EQUI P		BENEFI TS DEPARTMENT		
		0	1.00	2.00		3.00	3A	
	GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0					1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0			0			2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	1, 845, 396	0		0	1, 845, 396		3.00
4.00	ADMI NI STRATI VE & GENERAL	2, 973, 399	0		0	209, 652	3, 183, 051	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0		0	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE	15, 812	0		0	0	15, 812	6.00
7.00	HOUSEKEEPING	0	0		0	0	0	7.00
8.00	DI ETARY	21, 043	0		0	38	21, 081	8.00
9.00	NURSI NG ADMI NI STRATI ON	0	0		0	0	0	9.00
10.00	ROUTI NE MEDI CAL SUPPLI ES	12, 222	0		0	0	12, 222	10.00
11.00	MEDI CAL RECORDS	2, 710	0		0	0	2,710	11.00
12.00	STAFF TRANSPORTATION	83, 197	0		0	0	83, 197	12.00
13.00	VOLUNTEER SERVICE COORDINATION	45, 591	0		0	16, 164	61, 755	13.00
14.00	PHARMACY	345, 692	0		0	0	345, 692	14.00
15.00	PHYSI CLAN ADMI NI STRATI VE SERVI CES	133, 151	0		0	50, 079	183, 230	15.00
16.00	OTHER GENERAL SERVICE	0	0		0	0	0	1
17.00	PATI ENT/RESI DENTI AL CARE SERVI CES		0		0		0	17.00
	LEVEL OF CARE							1
50.00	HOSPICE CONTINUOUS HOME CARE	0				0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	1, 809, 227				280, 034	2, 089, 261	51.00
52.00	HOSPI CE I NPATI ENT RESPI TE CARE	1, 190, 173	0	)	0	416, 571	1,606,744	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	299, 533	0		0	104, 851	404, 384	
	NONREI MBURSABLE COST CENTERS			•				
60.00	BEREAVEMENT PROGRAM	56, 361	0	)	0	0	56, 361	60.00
61.00	VOLUNTEER PROGRAM	0	0	)	0	0	0	61.00
62.00	FUNDRAI SI NG	0	0	)	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	)	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	2, 201, 618	0		0	768, 007	2, 969, 625	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0		0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0		0	o	0	66.00
67.00	ADVERTI SI NG	0	0		0	0	0	67.00
68.00	TELEHEALTH/TELEMONI TORI NG	0	0		0	ō	0	68.00
69.00	THRI FT STORE	0	0		0	ō	0	
70.00	NURSING FACILITY ROOM & BOARD	0				-	0	
71.00	OTHER NONREI MBURSABLE (SPECIFY)	0	0		0	o	0	
99.00	NEGATI VE COST CENTER	0	0		0	ō		99.00
	TOTAL	-		1	0	-		100.00

COST /	ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL	SERVICE COSTS		CN: 15-0162 N: 15-1523		/2018		pared:
			DIANT		Hospi ce			
	Descriptions	ADMI NI STRATI V E & GENERAL	PLANT OPERATI ON & MAI NTENANCE	LAUNDRY &		PING	DI ETARY	
		4.00	5.00	6.00	7.00	)	8.00	
	GENERAL SERVICE COST CENTERS			-				
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00 \end{array}$	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MUBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT ADMINI STRATIVE & GENERAL PLANT OPERATION & MAINTENANCE LAUNDRY & LINEN SERVICE HOUSEKEEPING DIETARY NURSING ADMINISTRATION ROUTINE MEDICAL SUPPLIES MEDICAL RECORDS STAFF TRANSPORTATION VOLUNTEER SERVICE COORDINATION PHARMACY PHYSICIAN ADMINISTRATIVE SERVICES	3, 183, 051 0 6, 410 0 8, 546 0 4, 955 1, 099 33, 726 25, 034 140, 136 74, 277		22, 2	222	0 0 0 0 0 0 0 0 0 0	29, 627	9.00 10.00 11.00 12.00 13.00 14.00 15.00
16.00 17.00	OTHER GENERAL SERVICE PATI ENT/RESIDENTI AL CARE SERVICES	0	0			0		16.00 17.00
17.00	LEVEL OF CARE	0	0	/		0		17.00
50.00 51.00 52.00 53.00	HOSPICE CONTINUOUS HOME CARE HOSPICE ROUTINE HOME CARE HOSPICE INPATIENT RESPITE CARE HOSPICE GENERAL INPATIENT CARE	0 846, 938 651, 337 163, 928	C			0 0	23, 712 5, 915	•
60.00 61.00 62.00 63.00 65.00 65.00 66.00 67.00 68.00 69.00 70.00 71.00 99.00 100.00	NONREI MBURSABLE COST CENTERS BEREAVEMENT PROGRAM VOLUNTEER PROGRAM FUNDRAI SI NG HOSPI CE/PALLI ATI VE MEDI CI NE FELLOWS PALLI ATI VE CARE PROGRAM OTHER PHYSI CI AN SERVI CES RESI DENTI AL CARE ADVERTI SI NG TELEHEALTH/TELEMONI TORI NG THRI FT STORE NURSI NG FACI LI TY ROOM & BOARD OTHER NONREI MBURSABLE (SPECI FY) NEGATI VE COST CENTER TOTAL	22, 847 0 0 1, 203, 818 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0 0 0 222	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 29, 627	67.00 68.00 69.00 70.00 71.00

COST A	LLOCATION - HOSPITAL-BASED HOSPICE GENERAL S	SERVICE COSTS	Provider CC	CN: 15-0162	Period: From 01/01/2018	Worksheet 0-6 Part I	
			Hospi ce CCN	N: 15-1523	To 12/31/2018	Date/Time Pre 5/31/2019 7:4	pared: 7 am
					Hospi ce I	0,01,201, 111	<u>/ um</u>
	Descriptions	NURSI NG	ROUTI NE	MEDI CAL	STAFF	VOLUNTEER	
		ADMI NI STRATI O	MEDI CAL	RECORDS	TRANSPORTATI 0	SERVI CE	
		N	SUPPLI ES		N	COORDI NATI ON	
		9.00	10.00	11.00	12.00	13.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMI NI STRATI VE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DI ETARY						8.00
9.00	NURSI NG ADMI NI STRATI ON	0					9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	17, 177				10.00
11.00	MEDI CAL RECORDS	0		3, 8			11.00
12.00	STAFF TRANSPORTATION	0			116, 923		12.00
13.00	VOLUNTEER SERVICE COORDINATION	0			0	86, 789	13.00
14.00	PHARMACY	0			0	0	14.00
15.00	PHYSI CI AN ADMI NI STRATI VE SERVI CES	0			0	0	15.00
16.00	OTHER GENERAL SERVICE	0			0	0	16.00
17.00	PATI ENT/RESI DENTI AL CARE SERVI CES						17.00
50.00	HOSPICE CONTINUOUS HOME CARE	0	0		0 0	0	50.00
51.00	HOSPICE CONTINUOUS HOME CARE	0	16, 862	3,7	-	85, 200	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	252		56 0	1, 272	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	63		14 0	317	53.00
00.00	NONREI MBURSABLE COST CENTERS	0	00			017	00.00
60.00	BEREAVEMENT PROGRAM	0			0	0	60.00
61.00	VOLUNTEER PROGRAM	0			0	0	61.00
62.00	FUNDRAL SI NG	o			0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0			0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0			0	0	65.00
66.00	RESIDENTIAL CARE	0			0	0	66.00
67.00	ADVERTI SI NG	0			0	0	67.00
68.00	TELEHEALTH/TELEMONI TORI NG	0			0	0	68.00
69.00	THRI FT STORE	0			0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
	OTHER NONREI MBURSABLE (SPECI FY)	0			0	0	71.00
99.00	NEGATIVE COST CENTER	0	0		0 0	0	99.00
	TOTAL	0	17, 177	3, 8	09 116, 923	86, 789	1100 00

Health Financial Systems ST. FRANCIS HOSPITAL & HEALTH CENTER

Health	i Financial Systems SI. F	RANCIS HOSPIIA	L & HEALIH CEN	ITER	In Lie	eu of Form CMS	5-2552-10
COST /	ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SE	RVICE COSTS	Provider C	CN: 15-0162	Peri od:	Worksheet 0-	-6
					From 01/01/2018	Part I	
			Hospi ce CC	N: 15-1523	To 12/31/2018	Date/Time Pr	repared:
						5/31/2019 7:	:47 am
					Hospi ce I		
	Descriptions	PHARMACY	PHYSI CI AN	OTHER GENERA	L PATIENT/	TOTAL	
			ADMI NI STRATI V	SERVI CE	RESI DENTI AL		
			E SERVICES	DERVIOE	CARE SERVICES		
		14.00	15.00	16.00	17.00	18.00	_
	CENEDAL CEDULCE COST CENTERS	14.00	15.00	10.00	17.00	18.00	
	GENERAL SERVICE COST CENTERS	r		1		T	
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMI NI STRATI VE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPI NG						7.00
8.00	DI ETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTI NE MEDI CAL SUPPLI ES						10.00
11.00	MEDI CAL RECORDS						11.00
12.00	STAFF TRANSPORTATION						12.00
13.00	VOLUNTEER SERVICE COORDINATION						13.00
14.00	PHARMACY	485, 828					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	00,020					15.00
16.00	OTHER GENERAL SERVICE	0			0		16.00
17.00	PATI ENT/RESI DENTI AL CARE SERVI CES	0			0		17.00
17.00					0	<u> </u>	17.00
	LEVEL OF CARE	-	-	-	-1	1	
50.00	HOSPICE CONTINUOUS HOME CARE	0	-		0		0 50.00
51.00	HOSPICE ROUTINE HOME CARE	476, 932			0	3, 888, 64	
52.00	HOSPI CE I NPATI ENT RESPI TE CARE	7, 120	3, 774		0 0	2, 312, 05	53 52.00
53.00	HOSPICE GENERAL INPATIENT CARE	1, 776	941		0 0	581, 77	74 53.00
	NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0			0	79, 20	08 60.00
61.00	VOLUNTEER PROGRAM	0			0		0 61.00
62.00	FUNDRALSING	0			0		0 62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0		0 63.00
64.00		0			0		
	PALLIATIVE CARE PROGRAM	0			0	4, 173, 44	
65.00	OTHER PHYSI CI AN SERVI CES	0			0		0 65.00
66.00	RESI DENTI AL CARE	0	0		0 0		0 66.00
67.00	ADVERTI SI NG	0			0		0 67.00
68.00	TELEHEALTH/TELEMONI TORI NG	0			0		0 68.00
69.00	THRIFT STORE	0			0		0 69.00
70.00	NURSING FACILITY ROOM & BOARD						0 70.00
71.00		0	l o		0 0	,	0 71.00
99.00	NEGATI VE COST CENTER		0		0 0		0 99.00
	TOTAL	485, 828	-		0 0		
100.00		405,020	257,507	I	9	11,033,12	-51100.00

Heal th	Financial Systems	ST. FRANCIS HOSPITA	L & HEALTH CEN	ITER	In Lie	u of Form CMS-2	2552-10
	LLOCATION - HOSPITAL-BASED HOSPICE GENE				Peri od:	Worksheet 0-6	
STATI S	TI CAL BASI S				From 01/01/2018	Part II	
			Hospi ce CC	N: 15-1523	To 12/31/2018		
						5/31/2019 7:4	7 am
					Hospi ce I		
	Cost Center Descriptions		CAP REL MVBLE	EMPLOYEE		ADMI NI STRATI V	
		& FLX	EQUI P	BENEFI TS	N	E & GENERAL	
		(SQUARE FEET)	(DOLLAR	DEPARTMENT		(ACCUMULATED	
			VALUE)	(GROSS		COSTS)	
				SALARI ES)			
	F	1.00	2.00	3.00	4A	4.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0					1.00
2.00	CAP REL COSTS-MVBLE EQUIP		0				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	5, 205, 01	6		3.00
4.00	ADMI NI STRATI VE & GENERAL	0	0			7, 852, 074	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	l o		0 0	0	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0		0 0	15, 812	6.00
7.00	HOUSEKEEPING	0		1	0 0	0	7.00
8.00	DI ETARY	0		10		21,081	8.00
9.00	NURSI NG ADMI NI STRATI ON	0		1	0 0	21,001	9.00
9.00 10.00	ROUTINE MEDICAL SUPPLIES	0		1		-	•
		0				12, 222	•
11.00	MEDI CAL RECORDS	0	0		0 0	2,710	•
12.00	STAFF TRANSPORTATION	0	0		0 0	83, 197	•
13.00	VOLUNTEER SERVICE COORDINATION	0	0	10,0,		61, 755	•
14.00	PHARMACY	0	0		0 0	345, 692	
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	141, 25	1 0	183, 230	15.00
16.00	OTHER GENERAL SERVICE	0	0		0 0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		0	0	17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE				0 0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE			789, 84	8 0	2, 089, 261	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	l o	1, 174, 95	5 0	1, 606, 744	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0					53.00
	NONREIMBURSABLE COST CENTERS		-		· <b>·</b> ·		
60.00	BEREAVEMENT PROGRAM	0	0		0 0	56, 361	60.00
61.00	VOLUNTEER PROGRAM	0			0 0		61.00
62.00	FUNDRALSING	0			0 0	-	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	-		0 0		
64.00	PALLIATIVE CARE PROGRAM	0	0				64.00
65.00		0		_,		_/ /	65.00
	OTHER PHYSICIAN SERVICES	0	0		0 0	0	
66.00	RESIDENTIAL CARE	0	0		0 0	0	66.00
67.00	ADVERTI SI NG	0	0		0	0	
68.00	TELEHEALTH/TELEMONI TORI NG	0	0		0 0	0	68.00
69.00	THRI FT STORE	0	0		0 0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD				0		70.00
71.00	OTHER NONREI MBURSABLE (SPECIFY)	0	0		0 0	0	71.00
99.00	NEGATI VE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Pa	art I) 0	0	1, 845, 39	6	3, 183, 051	100.00
101.00	UNIT COST MULTIPLIER	0. 000000	0. 000000	0. 35454	2	0. 405377	101.00
				•			•

Heal th	Financial Systems ST.	FRANCIS HOSPITA	L & HEALTH CEN	ITER	In Lie	u of Form CMS-2	2552-10
	LLOCATION - HOSPITAL-BASED HOSPICE GENERAL S		Provider C		Peri od:	Worksheet 0-6	
STATI S	TI CAL BASI S				From 01/01/2018		
			Hospi ce CC	N: 15-1523	To 12/31/2018		
					lleen! ee l	5/31/2019 7:4	/ am
	Cost Costos Descriptions	DLANT			Hospi ce I		
	Cost Center Descriptions	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	NURSI NG	
		OPERATION &	LINEN SERVICE	(SQUARE FEET)		ADMI NI STRATI O	
			(IN-FACILITY		DAYS)		
		(SQUARE FEET)	DAYS)			(DI RECT NURS.	
		5.00	6.00	7.00	0.00	HRS.) 9.00	
	CENERAL SERVICE COST CENTERS	5.00	0.00	7.00	8.00	9.00	
1 00	GENERAL SERVICE COST CENTERS						1 00
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMI NI STRATI VE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE	0					5.00
6.00	LAUNDRY & LINEN SERVICE	0	551				6.00
7.00	HOUSEKEEPING	0			0		7.00
8.00	DI ETARY	0			0 551		8.00
9.00	NURSING ADMINISTRATION	0			0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0			0	0	10.00
11.00	MEDI CAL RECORDS	0			0	0	11.00
12.00	STAFF TRANSPORTATION	0			0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0			0	0	13.00
14.00	PHARMACY	0			0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0			0	0	15.00
16.00	OTHER GENERAL SERVICE	0			0	0	16.00
17.00	PATI ENT/RESI DENTI AL CARE SERVI CES	0			0	Ŭ	17.00
17.00	LEVEL OF CARE	0			0		17.00
50.00	HOSPICE CONTINUOUS HOME CARE			1		0	50.00
51.00	HOSPICE ROUTINE HOME CARE					0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	441		0 441	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0			0 110		53.00
55.00	NONREIMBURSABLE COST CENTERS	0				0	55.00
60,00	BEREAVEMENT PROGRAM	0	[	I	0	0	60.00
61.00	VOLUNTEER PROGRAM	0			0	0	61.00
62.00	FUNDRAI SI NG	0				0	62.00
63.00		0				0	63.00
	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			•		
64.00	PALLIATIVE CARE PROGRAM	0			0	0	64.00
65.00	OTHER PHYSI CI AN SERVI CES	0			0	0	65.00
66.00	RESI DENTI AL CARE	0	0		0 0		66.00
67.00	ADVERTI SI NG	0			0	0	67.00
68.00	TELEHEALTH/TELEMONI TORI NG	0			0	0	68.00
69.00	THRI FT STORE	0			0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREI MBURSABLE (SPECIFY)	0	0		0 0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	0 0	22, 222		0 29, 627	0	100.00
101.00	UNIT COST MULTIPLIER	0. 000000	40. 330309	0.00000	0 53. 769510	0. 000000	101.00
	,						

Heal th	Financial Systems ST. F	RANCIS HOSPITAL	& HEALTH CEN	ITER	In Lie	u of Form CMS-2	2552-10
	LLOCATION - HOSPITAL-BASED HOSPICE GENERAL SE		Provider C		Period:	Worksheet 0-6	
STATI S	TI CAL BASI S		Hospi ce CC		rom 01/01/2018 o 12/31/2018		pared:
						5/31/2019 7:4	
					Hospi ce I		
	Cost Center Descriptions	ROUTI NE	MEDI CAL	STAFF	VOLUNTEER	PHARMACY	
		MEDI CAL	RECORDS	TRANSPORTATI 0		(CHARGES)	
		SUPPLI ES	(PATI ENT	N (MULEACE)	COORDI NATI ON		
		(PATI ENT	DAYS)	(MI LEAGE)	(HOURS OF		
		DAYS) 10.00	11.00	12.00	SERVICE) 13.00	14.00	
	GENERAL SERVICE COST CENTERS	10.00	11.00	12.00	13.00	14.00	
1.00	CAP REL COSTS-BLDG & FIXT			1			1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMI NI STRATI VE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DI ETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTI NE MEDI CAL SUPPLI ES	30, 092					10.00
11.00	MEDI CAL RECORDS		30, 092				11.00
12.00	STAFF TRANSPORTATION			100	)		12.00
13.00	VOLUNTEER SERVICE COORDINATION			c	30, 092		13.00
14.00	PHARMACY			0	0 0	30, 092	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES			0	0	0	15.00
16.00	OTHER GENERAL SERVICE			0	0 0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	LEVEL OF CARE			1			
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	-		0	
51.00	HOSPICE ROUTINE HOME CARE	29, 541	29, 541			29, 541	
52.00	HOSPICE INPATIENT RESPITE CARE	441	441			441	
53.00	HOSPICE GENERAL INPATIENT CARE	110	110	0	110	110	53.00
(0.00	NONREI MBURSABLE COST CENTERS					0	1 (0.00
60.00	BEREAVEMENT PROGRAM			0			
61.00	VOLUNTEER PROGRAM			0			
62.00					-	0	
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS					0	
64.00 65.00	PALLIATIVE CARE PROGRAM OTHER PHYSICIAN SERVICES				0	0	
66.00	RESIDENTIAL CARE				0	0	
67.00	ADVERTI SI NG				0	0	
68.00	TELEHEALTH/TELEMONI TORI NG					0	•
69.00	THRIFT STORE				-	0	
70.00	NURSING FACILITY ROOM & BOARD				0	0	70.00
70.00	OTHER NONREIMBURSABLE (SPECIFY)			0	0	0	•
	NEGATI VE COST CENTER					0	99.00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	17, 177	3, 809	116, 923	86, 789	485, 828	
	UNIT COST MULTIPLIER	0. 570816		1, 169. 230000			
			2 5070	,			1

Heal th	Financial Systems ST. I	RANCIS HOSPITA	AL & HEALTH CEN	ITER	In Lie	u of Form CMS	-2552-10
	ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SI	ERVICE COSTS	Provider C	CN: 15-0162	Period: From 01/01/2018	Worksheet O- Part II	-6
STATES	ITI CAL BASI S		Hospi ce CC	N: 15-1523	To 12/31/2018		
					Hospi ce I	5/51/2017 /.	47 011
	Cost Center Descriptions	PHYSI CI AN	OTHER GENERAL				
		ADMI NI STRATI V	SERVI CE	RESI DENTI AL			
		E SERVICES	(SPECI FY	CARE SERVICE			
		(PATI ENT	BASI S)	(IN-FACILIT	Y		
		DAYS)	1( 00	DAYS)			
	GENERAL SERVICE COST CENTERS	15.00	16.00	17.00			
1.00	CAP REL COSTS-BLDG & FIXT	1	1	1			1.00
2.00	CAP REL COSTS-BEDG & TTXT						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMI NI STRATI VE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPI NG						7.00
8.00	DI ETARY						8.00
9.00	NURSI NG ADMI NI STRATI ON						9.00
10.00	ROUTI NE MEDI CAL SUPPLI ES						10.00
11.00	MEDI CAL RECORDS						11.00
12.00	STAFF TRANSPORTATION						12.00
13.00	VOLUNTEER SERVICE COORDINATION						13.00
14.00	PHARMACY						14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	30, 092					15.00
16.00	OTHER GENERAL SERVICE		0				16.00
17.00	PATI ENT/RESI DENTI AL CARE SERVI CES				0		17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	C	0	)			50.00
51.00	HOSPICE ROUTINE HOME CARE	29, 541	C				51.00
52.00	HOSPICE INPATIENT RESPITE CARE	441	0		0		52.00
53.00	HOSPICE GENERAL INPATIENT CARE	110	0	)	0		53.00
	NONREI MBURSABLE COST CENTERS		-				
60.00	BEREAVEMENT PROGRAM		C				60.00
61.00	VOLUNTEER PROGRAM		C				61.00
62.00	FUNDRAI SI NG		C				62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS		C				63.00
64.00	PALLIATIVE CARE PROGRAM		C				64.00
65.00	OTHER PHYSI CI AN SERVI CES	_	0				65.00
66.00	RESIDENTIAL CARE	C			0		66.00
67.00	ADVERTI SI NG		0				67.00
68.00	TELEHEALTH/TELEMONI TORI NG						68.00
69.00	THRIFT STORE						69.00
70.00	NURSING FACILITY ROOM & BOARD				0		70.00
71.00	OTHER NONREI MBURSABLE (SPECI FY)	C	C		0		71.00
99.00	NEGATIVE COST CENTER	257 507			0		99.00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)			0.0000	0		100.00
101.00	UNIT COST MULTIPLIER	8. 557324	0.00000	η <u>0.0000</u>			101.00

	Financial Systems ST.	FRANCIS HOSPITA	Provider C		Peri od:	u of Form CMS-2	
	OF CARE	LEVICE CUSIS DI	Provider C	JN. 15-0102	From 01/01/2018		
			Hospi ce CC	N: 15-1523		Date/Time Pre	pared 7 am
					Hospi ce I		
				Charges by	LOC (from Provi	der Records)	
	Cost Center Descriptions	From Wkst. C, Part I, Col.	Cost to Charge Ratio	НСНС	HRHC	HI RC	
		9 line					
		0	1.00	2.00	3.00	4.00	
	ANCI LLARY SERVICE COST CENTERS	44.00	0.0/0011			2	
	PHYSI CAL THERAPY	66.00	0. 262044		0 0	-	1.0
	OCCUPATIONAL THERAPY SPEECH PATHOLOGY	67.00			0 0		2.0
00		68.00	0. 177173			-	3.
00 00	DRUGS CHARGED TO PATIENTS	73.00 96.00	0. 159171		0 0	0	4. 5.
00	DURABLE MEDICAL EQUIP-RENTED LABORATORY	98.00 60.00	0. 114471		0 0	0	5. 6.
	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0. 114471		0 0		7.
	OTHER OUTPATIENT SERVICE COST CENTER	93.00	0. 204323		0 0	0	8.
00	RADI OLOGY-THERAPEUTI C	93.00 55.00	0. 199371		0 0	0	0. 9.
	CARDI AC REHABILI TATI ON	76.97	0. 1993/1		0 0		
	Totals (sum of lines 1-11)	70. 77	0. 330702		0 0	0	11.
. 00		Charges by		Shared Servi	ce Costs by LOC		11.
		LOC (from		Sharea Servi	00 00010 09 200		
		Provi der					
		Records)					
	Cost Center Descriptions	HGI P	HCHC (col. 1	HRHC (col.	1 HIRC (col. 1		
			x col. 2)	x col. 3)	x col. 4)		
		5.00	6.00	7.00	8.00	9.00	
	ANCILLARY SERVICE COST CENTERS						
	PHYSI CAL THERAPY	0	0		0 0		1.
00	OCCUPATIONAL THERAPY	0	0		0 0		2.
00	SPEECH PATHOLOGY	0	0		0 0		3.
00	DRUGS CHARGED TO PATIENTS	0	0		0 0	0	4.
00	DURABLE MEDICAL EQUIP-RENTED		-			-	5.
00		0	0		0 0		6.
	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 0	0	7.
	OTHER OUTPATIENT SERVICE COST CENTER		~			~	8.
00 . 97	RADI OLOGY-THERAPEUTI C CARDI AC REHABI LI TATI ON	0	0		0 0	-	9. 10.
		0	0		0 0 0 0		
. 00	IULAIS (SUIL UL TITIES I-IT)	- I	0		0	0	1.1.1

CALCULATION OF HOSPITAL-BASED HOSPICE PER DIEM COST		Provider CC	CN: 15-0162	Peri od:	Worksheet 0-8	
		Hospi ce CCN	l: 15-1523	From 01/01/2018 To 12/31/2018	Date/Time Pre 5/31/2019 7:4	
				Hospi ce I		_
			TITLE XVII	TITLE XIX	TOTAL	
			MEDI CARE	MEDI CAI D		
			1.00	2.00	3.00	
	HOSPICE CONTINUOUS HOME CARE					
. 00	Total cost (Wkst. 0-6, Part I, col. 18, line 50 plus Wkst. 0-	-7, col. 6,			0	1.0
	line 11)					
. 00	Total unduplicated days (Wkst. S-9, col. 4, line 10)				0	1
. 00	Total average cost per diem (line 1 divided by line 2)				0.00	
. 00	Unduplicated program days (Wkst. S-9 col. as appropriate, lir	ne 10)		0 0		4.
. 00	Program cost (line 3 times line 4)			0 0		5.
	HOSPICE ROUTINE HOME CARE	I				
00	Total cost (Wkst. 0-6, Part I, col. 18, line 51 plus Wkst. 0-	-7, col. 7,			3, 888, 647	6.
	line 11)					_
00	Total unduplicated days (Wkst. S-9, col. 4, line 11)				29, 541	7.
00	Total average cost per diem (line 6 divided by line 7)				131.64	
00	Unduplicated program days (Wkst. S-9, col. as appropriate, li	ne 11)	25, 1			9.
0. 00	Program cost (line 8 times line 9)		3, 309, 2	98 169, 947		10.
	HOSPICE INPATIENT RESPITE CARE					
I. 00	Total cost (Wkst. 0-6, Part I, col. 18, line 52 plus Wkst. 0-	-7, col. 8,			2, 312, 053	11.
	line 11)					10
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 12)					12.
. 00	Total average cost per diem (line 11 divided by line 12)	10)		70 1/	5, 242. 75	
. 00	Unduplicated program days (Wkst. S-9, col. as appropriate, li	ne I2)		73 16		14.
5.00	Program cost (line 13 times line 14)		1, 955, 5	46 83, 884		15.
~~	HOSPICE GENERAL INPATIENT CARE	7		1	F01 774	11/
. 00	Total cost (Wkst. 0-6, Part I, col. 18, line 53 plus Wkst. 0- line 11)	-7, COL. 9,			581, 774	10.
. 00	Total unduplicated days (Wkst. S-9, col. 4, line 13)				110	17.
. 00	Total average cost per diem (line 16 divided by line 17)				5, 288. 85	
. 00	Unduplicated program days (Wkst. S-9, col. as appropriate, li	no 12)		81 5	5, 200. 05	10.
. 00		ne is)	428.3	· · · · ·		20.
. 00	TOTAL HOSPICE CARE		428, 3	20, 444		_ ∠∪.
~~	Total cost (sum of line 1 + line 6 + line 11 + line 16)				6, 782, 474	21
()()				1	0, 102, 414	1 4 1 .
1.00	Total unduplicated days (Wkst. S-9, col. 4, line 14)				30, 092	22

Health Financial Systems ST. FRANCIS HOSPITAL & HEALTH CENTER In Lieu of Form CMS-2552-10 CALCULATION OF CAPITAL PAYMENT Provider CCN: 15-0162 Peri od: Worksheet L From 01/01/2018 Parts I-III Date/Time Prepared: 5/31/2019 7:47 am То 12/31/2018 Title XVIII Hospi tal PPS 1.00 PART I - FULLY PROSPECTIVE METHOD CAPITAL FEDERAL AMOUNT Capital DRG other than outlier 1.00 6, 636, 580 1.00 Model 4 BPCI Capital DRG other than outlier 1.01 1 01 0 2.00 Capital DRG outlier payments 1, 279, 533 2.00 Model 4 BPCI Capital DRG outlier payments 2.01 0 2.01 3.00 Total inpatient days divided by number of days in the cost reporting period (see instructions) 265.65 3.00 4.00 Number of interns & residents (see instructions) 17.07 4.00 5.00 Indirect medical education percentage (see instructions) 1.83 5.00 6.00 Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 121, 449 6.00 1.01) (see instructions) 7 00 Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 7 00 3.26 30) (see instructions) 8.00 Percentage of Medicaid patient days to total days (see instructions) 18.48 8.00 9 00 Sum of lines 7 and 8 21.74 9.00 Allowable disproportionate share percentage (see instructions) 10.00 4.50 10.00 11.00 Disproportionate share adjustment (see instructions) 298, 646 11.00 12.00 Total prospective capital payments (see instructions) 12.00 8, 336, 208 1.00 PART II - PAYMENT UNDER REASONABLE COST Program inpatient routine capital cost (see instructions) 1.00 0 1.00 Program inpatient ancillary capital cost (see instructions) 2.00 0 2.00 3.00 Total inpatient program capital cost (line 1 plus line 2) 0 3.00 4.00 Capital cost payment factor (see instructions) 0 4.00 Total inpatient program capital cost (line 3 x line 4) 5.00 0 5.00 1.00 PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) 1.00 0 1.00 Program inpatient capital costs for extraordinary circumstances (see instructions) 2.00 0 2.003.00 Net program inpatient capital costs (line 1 minus line 2) 0 3.00 4.00 Applicable exception percentage (see instructions) 0.00 4.00 5 00 Capital cost for comparison to payments (line 3 x line 4) 5 00 0 0.00 6.00 Percentage adjustment for extraordinary circumstances (see instructions) 6.00 7.00 Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6) 0 7.00 8.00 Capital minimum payment level (line 5 plus line 7) 0 8.00 Current year capital payments (from Part I, line 12, as applicable) 9 00 9 00 0 Current year comparison of capital minimum payment level to capital payments (line 8 less line 9) 10.00 0 10.00 Carryover of accumulated capital minimum payment level over capital payment (from prior year 11.00 0 11.00 Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital payments (line 10 plus line 11) 12.00 0 12.00 13.00 Current year exception payment (if line 12 is positive, enter the amount on this line) 0 13.00 14.00 Carryover of accumulated capital minimum payment level over capital payment for the following period 0 14.00 (if line 12 is negative, enter the amount on this line) 15.00 Current year allowable operating and capital payment (see instructions) 0 15.00 Current year operating and capital costs (see instructions) 16.00 0 16.00

0 17.00

17.00 Current year exception offset amount (see instructions)