This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM AP payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO.

OMB NO. 0938-0050 EXPIRES 03-31-2022

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION Provider CCN: 15-0090 Period: Worksheet S From 01/01/2020 To 12/31/2020 Date/Time Prepared: 7/20/2021 1: 27 pm				EMITHE OF OF EGEL
		Provider CCN: 15-0090	From 01/01/2020	Parts I-III

		10 12/31/2020 Bate/11lile 11 cpareu.
		7/29/2021 1:27 pm
PART I - COST	REPORT STATUS	
Provi der	1. [X] Electronically prepared cost report	Date: 7/29/2021 Time: 1:27 pm
use only	2. [] Manually prepared cost report	
	3. [0] If this is an amended report enter the number of times	
	4. [F] Medicare Utilization. Enter "F" for full or "L" for lo	DW.
Contractor	5. [1]Cost Report Status 6. Date Received:	10. NPR Date:
use only	(1) As Submitted 7. Contractor No.	11. Contractor's Vendor Code: 4
, , , , , , , , , , , , , , , , , , ,	(2) Settled without Audit 8. [N] Initial Report for this I	
	(3) Settled with Audit 9. [N] Final Report for this Pro	number of times reopened = 0-9.
	(4) Reopened	

PART II - CERTIFICATION

(5) Amended

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by FRANCISCAN HEALTH- DYER (15-0090) for the cost reporting period beginning 01/01/2020 and ending 12/31/2020 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

]I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my original signature.

(Si gned)_______Officer or Administrator of Provider(s)

CHIEF FINANCIAL OFFICER

Title

Date

			Title XVIII				
	Cost Center Description		Part A	Part B	HI T	Title XIX	
		1.00	2.00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	26, 206	-100, 301	0	0	1.00
2.00	Subprovi der - IPF	0	0	0		0	2. 00
3.00	Subprovider - IRF	0	19, 158	75		0	3. 00
4.00	SUBPROVI DER I						4. 00
5.00	Swing Bed - SNF	0	0	0		0	5. 00
6.00	Swi ng Bed - NF	0				0	6. 00
200.00	Total	0	45, 364	-100, 226	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.

Health Financial Systems FRANCISCAN HEALTH- DYER In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0090 Peri od: Worksheet S-2 From 01/01/2020 Part I Date/Time Prepared: 12/31/2020 7/29/2021 1:27 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 24 JOLIET STREET 1.00 PO Box: 1.00 State: IN Zip Code: 46311-1799 County: LAKE 2.00 City: DYER 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, 0, or N) Certi fi ed Number Number Type XVIII XIX 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 Hospi tal FRANCISCAN HEALTH- DYER 150090 23844 07/01/1966 Ν Р 0 3.00 1 Subprovider - IPF 4.00 4.00 5.00 Subprovider - IRF FRANCISCAN HEALTH -15T090 23844 5 01/01/2002 N Ρ Т 5.00 DYER -REHAB 6.00 Subprovider - (Other) 6.00 Swing Beds - SNF 7.00 7 00 8.00 Swing Beds - NF 8.00 9.00 Hospi tal -Based SNF 9.00 Hospi tal -Based NF 10.00 10.00 11.00 Hospi tal -Based OLTC 11.00 12.00 Hospi tal -Based HHA 12.00 Separately Certified ASC 13.00 13.00 Hospi tal -Based Hospi ce 14.00 14.00 Hospital-Based Health Clinic - RHC 15.00 15 00 16.00 Hospital-Based Health Clinic - FQHC 16.00 17.00 Hospital-Based (CMHC) I 17.00 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: 1. 00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2020 12/31/2020 20.00 21.00 Type of Control (see instructions) 21.00 1. 00 2. 00 3.00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for Υ N 22.00 disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim uncompensated care payments for this 22.01 Υ Υ 22.01 cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1.

Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)

Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) 22.02 22.02 N Ν Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to 22.03 N Ν N rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. Which method is used to determine Medicaid days on lines 24 and/or 25 Ν 23.00 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost

reporting period different from the method used in the piror cost								
	reporting period? In column 2, enter "Y" for yes or	"N" for no.						
		In-State	In-State	Out-of	Out-of	Medi cai	d Other	
		Medi cai d	Medi cai d	State	State	HMO day	s Medicaid	
		paid days	eligible	Medi cai d	Medi cai d		days	
		, ,	unpai d	paid days	eligible			
			days		unpai d			
		1.00	2. 00	3. 00	4. 00	5. 00	6.00	1
24. 00	If this provider is an IPPS hospital, enter the	51	0	1, 395	272	1, 6	32 0	24.00
	in-state Medicaid paid days in column 1, in-state							
	Medicaid eligible unpaid days in column 2,							
	out-of-state Medicaid paid days in column 3,							
	out-of-state Medicaid eligible unpaid days in column							
	4, Medicaid HMO paid and eligible but unpaid days in							
	column 5, and other Medicaid days in column 6.							

	program specialty, if any, and the number of FTE					
	residents for each expanded program. (see instructions) Enter in column 1, the program name.					
	Enter in column 2, the program code. Enter in column					
	3, the IME FTE unweighted count. Enter in column 4,					
	the direct GME FTE unweighted count.					
	Terror arrost one file armor greed obarrer					
					1.00	
	ACA Provisions Affecting the Health Resources and Sei	rvices Administration	(HRSA)			
62.00	Enter the number of FTE residents that your hospital	trained in this cost	reporting peri	od for which	0.00	62.00
	your hospital received HRSA PCRE funding (see instruc					
	Enter the number of FTE residents that rotated from a			your hospital	0.00	62. 01
	during in this cost reporting period of HRSA THC prog		าร)			
	Teaching Hospitals that Claim Residents in Nonprovide					
63. 00	Has your facility trained residents in nonprovider se				N	63.00
	"Y" for yes or "N" for no in column 1. If yes, comple	<u>ete lines 64 through 6</u>				
			Unweighted	Unwei ghted	Ratio (col. 1/	
			FTES	FTEs in	(col. 1 + col.	
			Nonprovi der	Hospi tal	2))	
			Si te	0.00	2.00	
	D 11 5504 C 11 404 B 17 575 B 11 1 1 1 1		1.00	2.00	3.00	
	Section 5504 of the ACA Base Year FTE Residents in No		This base year	is your cost i	reporting	
44.00	period that begins on or after July 1, 2009 and before Enter in column 1, if line 63 is yes, or your facilit		0.00	0. 00	0. 000000	44 00
64.00	in the base year period, the number of unweighted nor		0.00	0.00	0.000000	64.00
	resident FTEs attributable to rotations occurring in					
	settings. Enter in column 2 the number of unweighted					
	resident FTEs that trained in your hospital. Enter in					
	of (column 1 divided by (column 1 + column 2)). (see					
	of (cordinit rativided by (cordinit r + cordinit 2)). (see	Thisti de trons)				l

From 01/01/2020 Part I Date/Time Prepared: 12/31/2020 7/29/2021 1:27 pm Program Code Unwei ghted Unwei ghted Program Name Ratio (col. (col. 3 + col FTEs FTEs in Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3.00 4.00 5.00 65.00 Enter in column 1, if line 63 is yes, or your facility 0.000000 65.00 0. 00 0. 00 trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Unwei ghted Unwei ghted Ratio (col. 1/ FTEs FTEs in (col. 1 + col Nonprovi der Hospi tal 2)) Si te 1.00 2.00 3.00 Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 Enter in column 1 the number of unweighted non-primary care resident 0.00 6. 00 0.000000 66.00 FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Program Name Unwei ghted Ratio (col. 3/ Program Code Unwei ahted FTES FTEs in (col. 3 + col Nonprovi der Hospi tal 4)) Si te 2.00 3. 00 1.00 4.00 5.00 67.00 Enter in column 1, the program 0.000000 67.00 INTERN MEDICINE 3900 0.00 0.37 name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)) (see instructions) 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? 70.00 Enter "Y" for yes or "N" for no. 71.00 If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most O 71.00 recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF 75.00 subprovider? Enter "Y" for yes and "N" for no. If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most Ν Ν 0 76.00 recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Pr	ovider C	CN: 15-0090	Peri od: From 01/01/2020 To 12/31/2020	Worksheet S- Part I Date/Time Pr 7/29/2021 1:	epared:
				1.00	
Long Term Care Hospital PPS 80.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes and Is this a LTCH co-located within another hospital for part or all "Y" for yes and "N" for no.			ng period? Enter	N N	80. 00 81. 00
TEFRA Providers 15.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFR 16.00 Did this facility establish a new Other subprovider (excluded units) 16.12 40(f)(1)(i)(2) Enter "V" for year and "N" for no				N	85. 00 86. 00
\$413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. 1s this hospital an extended neoplastic disease care hospital cla 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	ssi fi ed	under sectio	١	N	87. 00
Todo(d)(1)(b)(v1): Enter 1 Tol yes of N Tol Ho.			V 1. 00	XI X 2. 00	
Title V and XIX Services	. 0.5	1 11/ 6	N.		
10.00 Does this facility have title V and/or XIX inpatient hospital ser yes or "N" for no in the applicable column.	VICES? E	nter "Y" Tor	N	Y	90.00
11.00 is this hospital reimbursed for title V and/or XIX through the co- full or in part? Enter "Y" for yes or "N" for no in the applicabl			N	Y	91.00
22.00 Are title XIX NF patients occupying title XVIII SNF beds (dual ce	erti fi cat			N	92. 00
instructions) Enter "Y" for yes or "N" for no in the applicable of 3.00 Does this facility operate an ICF/IID facility for purposes of ti		d XIX? Enter	N	N	93. 00
"Y" for yes or "N" for no in the applicable column. 14.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "	N" for n	o in the	N	N	94.00
applicable column.					
15.00 If line 94 is "Y", enter the reduction percentage in the applicate 16.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "			0. 00 N	0. 00 N	95. 0 96. 0
applicable column. 7.00 If line 96 is "Y", enter the reduction percentage in the applicable.	ole colum	n.	0. 00	0.00	97. 0
8.00 Does title V or XIX follow Medicare (title XVIII) for the interns stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for year			N	Y	98. 0
column 1 for title V, and in column 2 for title XIX. 188.01 Does title V or XIX follow Medicare (title XVIII) for the reportic, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V title XIX.		Y	98. 0		
.02 Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.					98. 0
28.03 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. 0
Does title V, and TH column 2 for the XIX. 8.04 Does title V or XIX follow Medicare (title XVIII) for a CAH reimboutpatient services cost? Enter "Y" for yes or "N" for no in column 2 for title XIX.			N N	N	98. 0
18.05 Does title V or XIX follow Medicare (title XVIII) and add back the Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column				Υ	98. 0
Does title VIX. Does title V or XIX follow Medicare (title XVIII) when cost reimbor. Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for column 2 for title XIX.			N	Y	98. 0
Rural Providers 05.00 Does this hospital qualify as a CAH?			N		105. 0
06.00 If this facility qualifies as a CAH, has it elected the all-inclu	usive met	hod of payme	nt N		106. 0
for outpatient services? (see instructions) 07.00 Column 1: If line 105 is Y, is this facility eligible for cost retraining programs? Enter "Y" for yes or "N" for no in column 1.	(see ins	tructions)	N		107. 0
Column 2: If column 1 is Y and line 70 or line 75 is Y, do you tapproved medical education program in the CAH's excluded IPF and Enter "Y" for yes or "N" for no in column 2. (see instructions)					
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.	fee sche	dul e? See 42	2 N		108. 0
Ph	ysi cal	Occupation		Respiratory	
09.00 f this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	1. 00 N	2.00 N	3. 00 N	4. 00 N	109. 0
, , , , , , , , , , , , , , , , , , , ,				4.00	
10.00Did this hospital participate in the Rural Community Hospital Den	onetrati	on project (S410A	1. 00 N	110. 00

		N: 15-0090		Worksheet S-	
TOOL THE MOST THE HEALTH ONCE COME EEX TRENTH ON TON BAIN	11001461 001	10 0070	From 01/01/2020	Part I	
11.001f this field lifty gallifles as a CAL did it participate in the Frentier Community 1.00 1.073/200 1.	7/29/2021 1:				
			1. 00	2.00	
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	ost reporting p Dlumn 1 is Y, e ticipating in	eriod? Enter nter the column 2.			111. 00
		1. 00	2. 00	3.00	
demonstration for any portion of the current cost reporting Enter "Y" for yes or "N" for no in column 1. If column 1 is in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceaparticipation in the demonstration, if applicable.	peri od? 5 "Y", enter ne	N			112.00
15.00 Is this an all-inclusive rate provider? Enter "Y" for yes or in column 1. If column 1 is yes, enter the method used (A, B in column 2. If column 2 is "E", enter in column 3 either "9 for short term hospital or "98" percent for long term care (psychiatric, rehabilitation and long term hospitals provider	3, or E only) 3" percent includes	N			0 115. 00
116.00 Is this facility classified as a referral center? Enter "Y"	for yes or	N			116. 00
117.00 s this facility legally-required to carry malpractice insur	ance? Enter	Υ			117. 00
118.00 s the malpractice insurance a claims-made or occurrence pol			2		118. 00
	rence.	Premi ums	Losses	Insurance	
40.04					0110.0
18.01 List amounts of maipractice premiums and paid losses:		708, 2	63)	0 118. 0
10.00 Are mal practice promitume and paid Lacces reported in a cost	contor other t	han the		2. 00	118. 0
Administrative and General? If yes, submit supporting sched and amounts contained therein. 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 "N" for no. Is this a rural hospital with < 100 beds that qualifies the contact of the c	lule listing co I Harmless prov n column 1, "Y" nalifies for th	st centers ision in ACA for yes or e Outpatient	N N	N	119. 0 120. 0
21.00 Did this facility incur and report costs for high cost impla	ıntable devices	charged to	Υ		121. 0
	ined in §1903 <i>(</i>)	w)(3) of the	. Y	5. 04	122. 0
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.					
25.00 Does this facility operate a transplant center? Enter "Y" fo	or yes and "N"	for no. If	N		125.0
26.00 <mark>lf this is a Medicare certified kidney transplant center, en</mark>		cation date	:		126. 0
27.00 If this is a Medicare certified heart transplant center, ent	er the certifi	cation date			127. (
		cation date			128. 0
in column 1 and termination date, if applicable, in column 2	2.		n		129. 0
column 1 and termination date, if applicable, in column 2.					130. 0
date in column 1 and termination date, if applicable, in col	umn 2.				131. 0
date in column 1 and termination date, if applicable, in col	umn 2.				132. 0
		Sati on date			133. 0
34.00 If this is an organ procurement organization (OPO), enter the and termination date, if applicable, in column 2.	ne OPO number i	n column 1			134. 0
40.00 Are there any related organization or home office costs as d chapter 10? Enter "Y" for yes or "N" for no in column 1. If			Y	158014	140. (

Health Financial Systems FRANCISCAN HEALTH- DYER In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0090 Peri od: Worksheet S-2 From 01/01/2020 Part I То 12/31/2020 Date/Time Prepared: 7/29/2021 1:27 pm 3.00 If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number 141.00 Name: FRANCISCAN ALLIANCE, INC Contractor's Name: WISCONSIN PHYSICIAN Contractor's Number: 08101 141 00 SERVI CES 142.00 Street: 1515 DRAGOON TRAIL PO Box: 142.00 143.00 City: MISHAWAKA State: ΙN Zip Code: 46546 143.00 1.00 144.00 Are provider based physicians' costs included in Worksheet A? 144. 00 2.00 1.00 145.00|| f costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is 145.00 no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.

146.00 Has the cost allocation methodology changed from the previously filed cost report? Ν 146, 00 Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2. 1.00 147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. 147. 00 N 148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. N 148.00 149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no Ν 149.00 Part A Part B Title V Title XIX 1 00 3.00 2 00 4 00 Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13) 155.00 Hospi tal N Ν Ν N 155. 00 156.00 Subprovi der - IPF Ν 156. 00 Ν Ν Ν 157.00 Subprovi der - IRF 157 00 Ν Ν Ν N 158. 00 SUBPROVI DER 158.00 159.00 SNF N Ν Ν Ν 159. 00 160.00 HOME HEALTH AGENCY 160.00 Ν Ν Ν Ν 161.00 CMHC Ν Ν Ν 161.00 1.00 Mul ti campus 165.00 Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no. Ν 165.00 FTE/Campus Zip Code Name County **CBSA** State | 3.00 5.00 0 1.00 2.00 4.00 166.00 If line 165 is yes, for each 0. 00 166. 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 (HIT) incentive in the American Recovery and Reinvestment Act

hearth findination reciniology (iii) incentive in the American Recovery and Reinvestment	ACI						
167.00 s this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.		Υ	167. 00				
168.00 If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"),	enter the		168. 00				
reasonable cost incurred for the HIT assets (see instructions)							
168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship							
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 user (line 167 is "Y") and is not a CAH (line 105 is "!	N"), enter the	0.0	00169.00				
transition factor. (see instructions)							
	Begi nni ng	Endi ng					
	1. 00	2.00					
170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting			170. 00				
period respectively (mm/dd/yyyy)							
	1.00	0.00					
	1. 00	2. 00					
171.00 If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter	N		0 171. 00				
"Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section							
1876 Medicare days in column 2. (see instructions)							
11070 medicale days in condimi 2. (See Instituctions)	I	I	1				

	Financial Systems FRANCISCAN HI AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CN: 15-0090	Peri od:	u of Form CMS- Worksheet S-2	
				From 01/01/2020 To 12/31/2020	Part II Date/Time Pre	epared:
				V (8)	7/29/2021 1:2	27 pm
				Y/N	Date	-
	Conoral Instruction, Enter V for all VES recogness. Enter N	l for all NO ro	cnoncoc Ento	1.00	2. 00	
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	i for all no re	sponses. Ente	ari dates in t	.ne	
	Provider Organization and Operation					
00	Has the provider changed ownership immediately prior to the reporting period? If yes, enter the date of the change in a	e beginning of	the cost	N		1. (
	preporting perrou? If yes, enter the date of the change in t	corumir z. (see	Y/N	Date	V/I	
			1.00	2. 00	3. 00	
00	Has the provider terminated participation in the Medicare F yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.		N			2. (
. 00	Is the provider involved in business transactions, includir contracts, with individuals or entities (e.g., chain home cor medical supply companies) that are related to the provide officers, medical staff, management personnel, or members of directors through ownership, control, or family and other relationships? (see instructions)	offices, drug der or its of the board	N			3. 0
	Trefationships. (See Thistractions)		Y/N	Type	Date	
			1. 00	2. 00	3. 00	
00	Financial Data and Reports Column 1: Were the financial statements proposed by a Continuous	ified Dublic	Υ	۸	04/20/2021	4 ,
. 00	Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" for "R" for Reviewed. Submit complete copy or enter date avacolumn 3. (see instructions) If no, see instructions.	for Compiled,	Y	A	04/20/2021	4.0
. 00	Are the cost report total expenses and total revenues diffe		N			5. 0
	those on the filed financial statements? If yes, submit rec	conciliation.		V//NI	Lagal Ones	
				Y/N 1. 00	Legal Oper. 2.00	
	Approved Educational Activities				2.00	
. 00	Column 1: Are costs claimed for nursing school? Column 2: the legal operator of the program?	If yes, is th	e provider is	N		6. 0
00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.		during the	N N		7. C 8. C
00	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction		al education	N		9. (
O. 00	Was an approved Intern and Resident GME program initiated of		he current	N		10.0
1. 00	cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	roved	N		11. (
	reaching frogram on worksheet A: IT yes, see first detrons.				Y/N	
	Bad Debts				1. 00	
2. 00	Is the provider seeking reimbursement for bad debts? If yes	s, see instruct	i ons.		Υ	12. (
3. 00	If line 12 is yes, did the provider's bad debt collection pperiod? If yes, submit copy.	oolicy change d	luring this co	st reporting	N	13. (
. 00	If line 12 is yes, were patient deductibles and/or co-payme Bed Complement	ents waived? If	yes, see ins	tructi ons.	N	14.
5. 00	Did total beds available change from the prior cost reporti	, , , , , , , , , , , , , , , , , , , ,	yes, see inst t A		t B	15.
		Y/N	Date	Y/N	Date	
	PS&R Data	1.00	2. 00	3. 00	4. 00	
b. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see	N		N		16. (
. 00	instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	Y	04/07/2021	Y	04/07/2021	17. (
3. 00	in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	N		N		18. (
9. 00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19. (

ROSPITAL AND HOSPITAL HEALTH CARE REIMBURSEWRT QUESTIONNAIRE	Heal th	Financial Systems FRANCISCAN H	EALTH- DYER		In Lie	u of Form CMS-	2552-10
Description Y/N Y/N			Provi der C	CN: 15-0090	Peri od: From 01/01/2020	Worksheet S-2 Part II Date/Time Pre	epared:
Page			Descr	ipti on	Y/N		, p
Report data for Other? Describe the other adjustments: Y/B Date Y/N Date		1011 11 12 13 13 13 13 13 13 13 13 13 13 13 13 13	()			
21.00 Bast the cost report prepared only using the provider's N 0.00 2.00 3.00 4.00	20. 00				N	N	20.00
21.00 Was the cost report prepared only using the provider's N N 21.00		report data for other: beserred the other adjustments.	Y/N	Date	Y/N	Date	
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instructions. 2.00 Now reassets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see		If yes, see instructions	· ·				
26.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see N 26.00	25. 00		the cost repor	ting period?	'If yes, see	N	25. 00
27.00 copy. Interest Expense	26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during the	he cost reporti	ng period? I	f yes, see	N	26. 00
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30.00 Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see	29. 00	11	bond funds (De	bt Service R	eserve Fund)	N	29. 00
31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see	30. 00	1		debt? If yes	, see	N	30. 00
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40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 instructions. 1.00 2.00 Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. 42.00 Enter the employer/company name of the cost report preparer. 43.00 Enter the telephone number and email address of the cost 541-290-2515 GLENN. JOHNSON@FRANCISCANALLI 43.00	39. 00	If line 36 is yes, did the provider render services to other			, N		39. 00
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43.00 Enter the telephone number and email address of the cost 541-290-2515 GLENN. JOHNSON@FRANCISCANALLI 33.00	42. 00	Enter the employer/company name of the cost report	FRANCISCAN ALL	IANCE INC			42. 00
	43. 00	Enter the telephone number and email address of the cost	541-290-2515			FRANCI SCANALLI	43.00

Heal th	Financial Systems FRANCISCA	N H	EALTH- DYER	In Lieu of Form CMS-2552-10			
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE			Provider CCN: 15-0090	eriod: com 01/01/2020 o 12/31/2020		pared:	
			3. 00				
	Cost Report Preparer Contact Information						
41.00	Enter the first name, last name and the title/position		MANAGER REIMBURSEMENT			41.00	
	held by the cost report preparer in columns 1, 2, and 3	,					
	respecti vel y.						
42.00	Enter the employer/company name of the cost report					42.00	
	preparer.						
43.00	Enter the telephone number and email address of the cos	t				43.00	
	report preparer in columns 1 and 2, respectively.						

Provider CCN: 15-0090

						3 12/31/2020	7/29/2021 1: 2	
							I/P Days / O/P	
							Visits / Trips	
	Component	Worksheet A	No.	of Beds	Bed Days	CAH Hours	Title V	
	'	Line Number			Avai I abl e			
		1.00		2.00	3.00	4. 00	5. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		90	32, 879	0.00	0	1. 00
	8 exclude Swing Bed, Observation Bed and							
	Hospice days) (see instructions for col. 2							
	for the portion of LDP room available beds)							
2.00	HMO and other (see instructions)							2. 00
3.00	HMO IPF Subprovider							3. 00
4.00	HMO IRF Subprovider							4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF						0	5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						0	6. 00
7.00	Total Adults and Peds. (exclude observation			90	32, 879	0.00	0	7. 00
	beds) (see instructions)							
8.00	INTENSIVE CARE UNIT	31. 00		14	5, 124			8. 00
9.00	CORONARY CARE UNIT	32. 00		0	0	0.00	0	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	43. 00					0	13. 00
14.00	Total (see instructions)			104	38, 003	0.00	0	14. 00
15.00	CAH visits						0	15. 00
16.00	SUBPROVI DER - I PF							16. 00
17.00	SUBPROVI DER - I RF	41. 00		30	10, 980		0	17. 00
18.00	SUBPROVI DER	42. 00		0	0		0	18. 00
19.00	SKILLED NURSING FACILITY							19. 00
20.00	NURSING FACILITY							20. 00
21.00	OTHER LONG TERM CARE							21. 00
22. 00	HOME HEALTH AGENCY							22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)							23. 00
24.00	HOSPI CE							24. 00
24. 10	HOSPICE (non-distinct part)	30. 00						24. 10
25. 00	CMHC - CMHC							25. 00
26.00	RURAL HEALTH CLINIC							26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00					0	26. 25
27.00	Total (sum of lines 14-26)			134				27. 00
28. 00	Observation Bed Days						0	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)			0	0			32. 00
32. 01	Total ancillary labor & delivery room							32. 01
	outpatient days (see instructions)							
33.00	LTCH non-covered days							33. 00
33. 01	LTCH site neutral days and discharges							33. 01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-0090

Peri od: Worksheet S-3 From 01/01/2020 Part I To 12/31/2020 Date/Time Prepared:

33.00

33.01

7/29/2021 1:27 pm I/P Days / O/P Visits / Trips Full Time Equivalents Title XVIII Component Title XIX Total All Total Interns Employees On Pati ents & Residents Payrol I 10.00 6.00 7.00 8.00 9.00 1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8, 303 1, 575 18, 640 1.00 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 2 00 HMO and other (see instructions) 1, 632 2 00 4.482 3.00 HMO IPF Subprovider 3.00 HMO IRF Subprovider 4.00 1, 157 4.00 5.00 Hospital Adults & Peds. Swing Bed SNF 0 5.00 0 Hospital Adults & Peds. Swing Bed NF 6.00 0 6.00 1, 575 7.00 Total Adults and Peds. (exclude observation 8, 303 18,640 7.00 beds) (see instructions) INTENSIVE CARE UNIT 8.00 1,026 143 2,847 8.00 CORONARY CARE UNIT 9.00 9.00 10.00 BURN INTENSIVE CARE UNIT 10.00 11.00 SURGICAL INTENSIVE CARE UNIT 11.00 12.00 OTHER SPECIAL CARE (SPECIFY) 12.00 13.00 NURSERY 13.00 14.00 Total (see instructions) 9, 329 1,718 21, 487 7.01 794.76 14.00 CAH visits 15.00 15.00 SUBPROVIDER - IPF 16.00 16.00 SUBPROVIDER - IRF 17.00 4,705 683 7,652 0.00 74.49 17.00 18.00 SUBPROVI DER 0.00 0.00 18.00 19.00 SKILLED NURSING FACILITY 19.00 20 00 NURSING FACILITY 20 00 21.00 OTHER LONG TERM CARE 21.00 22.00 HOME HEALTH AGENCY 22.00 23.00 AMBULATORY SURGICAL CENTER (D. P.) 23.00 HOSPI CE 24 00 24 00 24. 10 HOSPICE (non-distinct part) 0 24.10 CMHC - CMHC 25.00 25.00 26, 00 RURAL HEALTH CLINIC 26, 00 FEDERALLY QUALIFIED HEALTH CENTER 0.00 0.00 26.25 0 C 0 26.25 27.00 Total (sum of lines 14-26) 7.01 869.25 27.00 28.00 Observation Bed Days 597 3,525 28.00 29.00 29.00 Ambul ance Trips 30.00 Employee discount days (see instruction) 0 30.00 31.00 Employee discount days - IRF 0 31.00 Labor & delivery days (see instructions) Total ancillary labor & delivery room 0 32.00 32.00 0 C 0 32.01 32.01 outpatient days (see instructions)

33.00

LTCH non-covered days

33.01 LTCH site neutral days and discharges

Provider CCN: 15-0090

					12/31/2020	7/29/2021 1: 2	
		Full Time		Di sch	arges		
		Equi val ents					
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
		11. 00	12. 00	13. 00	14. 00	15. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		0	1, 805	364	4, 194	1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
2 00	for the portion of LDP room available beds)			450	257		2 00
2.00	HMO and other (see instructions)			650	257		2.00
3.00	HMO I PF Subprovi der				42		3.00
4. 00 5. 00	HMO IRF Subprovider				43		4. 00 5. 00
6. 00	Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF						6.00
7. 00	Total Adults and Peds. (exclude observation						7.00
7.00	beds) (see instructions)						7.00
8. 00	INTENSIVE CARE UNIT						8. 00
9. 00	CORONARY CARE UNIT						9. 00
10. 00	BURN INTENSIVE CARE UNIT						10. 00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12. 00
13. 00	NURSERY						13. 00
14. 00	Total (see instructions)	0.00	0	1, 805	364	4, 194	
15. 00	CAH visits		_	.,		.,	15. 00
16. 00	SUBPROVIDER - IPF						16. 00
17. 00	SUBPROVI DER - I RF	0. 00	0	364	43	601	17. 00
18.00	SUBPROVI DER	0. 00	0		o	0	18. 00
19.00	SKILLED NURSING FACILITY						19. 00
20.00	NURSING FACILITY						20. 00
21.00	OTHER LONG TERM CARE						21. 00
22.00	HOME HEALTH AGENCY						22. 00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24.00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)						24. 10
25.00	CMHC - CMHC						25. 00
26.00	RURAL HEALTH CLINIC						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 Tri ps						29. 00
30. 00	Employee discount days (see instruction)						30. 00
31. 00	Employee discount days - IRF						31. 00
32.00	Labor & delivery days (see instructions)						32. 00
32. 01	Total ancillary labor & delivery room						32. 01
00.05	outpatient days (see instructions)			_			00.00
33. 00	LTCH non-covered days			0			33.00
33. U1	LTCH site neutral days and discharges			0			33. 01

| Peri od: | Worksheet S-3 | From 01/01/2020 | Part | I | To 12/31/2020 | Date/Time Prepared: Provider CCN: 15-0090

				_	T		Date/Time Pre 7/29/2021 1:2	7 pm
		Wkst. A Line Number	Amount Reported	Reclassificati on 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	69, 190, 683	0	69, 190, 683	1, 863, 072. 11	37. 14	1.00
2.00	instructions) Non-physician anesthetist Part A		0	0	0	0.00	0. 00	2. 00
3.00	Non-physician anesthetist Part		0	0	0	0.00	0. 00	3.00
4. 00	Physician-Part A - Administrative		0	0	0	0.00	0. 00	4. 00
4. 01 5. 00	Physicians - Part A - Teaching Physician and Non		0	0	0	0. 00 0. 00	l .	
6. 00	Physician-Part B Non-physician-Part B for hospital-based RHC and FQHC		0	О	0	0.00	0.00	6.00
7. 00	services Interns & residents (in an approved program)	21. 00	0	О	0	0.00	0. 00	7. 00
7. 01	Contracted interns and residents (in an approved programs)		1, 010, 717	О	1, 010, 717	20, 716. 00	48. 79	7.0
8.00	Home office and/or related organization personnel		9, 562, 120	0	9, 562, 120	249, 338. 00	38. 35	8. 00
9. 00 10. 00	SNF Excluded area salaries (see instructions)	44. 00	0 10, 962, 959	521	· ·	0. 00 332, 049. 00		
11. 00	OTHER WAGES & RELATED COSTS Contract labor: Direct Patient		1, 732, 734	0	1, 732, 734	29, 670. 00	58. 40	11. 00
12. 00	Care Contract labor: Top level management and other management and administrative		0	0	0	0.00	0. 00	12. 00
13. 00	services Contract Labor: Physician-Part A - Administrative		257, 110	0	257, 110	1, 987. 00	129. 40	13. 00
14. 00	Home office and/or related organization salaries and		0	0	0	0.00	0. 00	14.00
14. 01 14. 02 15. 00	wage-related costs Home office salaries Related organization salaries Home office: Physician Part A - Administrative		8, 271, 313 0 0	0	0	215, 666. 00 0. 00 0. 00	0. 00	
16. 00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0. 00	16. 00
16. 01	Home office Physicians Part A - Teaching		0	0	0	0.00	0. 00	16. 0°
16. 02	Home office contract Physicians Part A - Teaching WAGE-RELATED COSTS		0	0	0	0.00	0.00	16. 0
17. 00	Wage-related costs (core) (see instructions)		14, 663, 435	0	14, 663, 435			17.00
18. 00	Wage-related costs (other) (see instructions)							18. 0
19. 00 20. 00	Excluded areas Non-physician anesthetist Part		2, 927, 936 0	0	2, 927, 936 0			19. 00 20. 00
21. 00	Non-physician anesthetist Part B		0	o	О			21. 00
22. 00	Physician Part A - Administrative		0	0	0			22. 00
22. 01 23. 00 24. 00 25. 00	Physician Part A - Teaching Physician Part B Wage-related costs (RHC/FQHC) Interns & residents (in an		0 0 0 0	0 0	0 0 0 0			22. 0° 23. 0° 24. 0° 25. 0°
25. 50	approved program) Home office wage-related		3, 077, 167	0	3, 077, 167			25. 50
25. 51	(core) Related organization wage-related (core)		0	0	0			25. 5°
25. 52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25. 52

| Peri od: | Worksheet S-3 | From 01/01/2020 | Part | I | To 12/31/2020 | Date/Time Prepared:

					10	3 12/31/2020	7/29/2021 1: 2	
		Wkst. A Line	Amount	Reclassi fi cati	Adjusted	Pai d Hours	Average Hourly	
		Number	Reported	on of Salaries	Sal ari es		Wage (col. 4 ÷	
			·	(from Wkst.	(col.2 ± col.	Salaries in	col . 5)	
				A-6)	3)	col. 4		
		1.00	2.00	3. 00	4. 00	5. 00	6. 00	
25. 53	Home office: Physicians Part A		0	0	0			25. 53
	- Teaching - wage-related							
	(core)							
	OVERHEAD COSTS - DIRECT SALARIE							
26. 00	Employee Benefits Department	4. 00	1, 109, 786	l .	.,,	·		
27. 00	Administrative & General	5. 00	16, 043, 196			·		
28. 00	Administrative & General under		472, 282	0	472, 282	3, 921. 00	120. 45	28. 00
	contract (see inst.)							
29. 00	Maintenance & Repairs	6. 00	637, 390	ŀ	637, 390	·		29. 00
30. 00	Operation of Plant	7. 00	1, 123, 183	0	1, 123, 183			
31. 00	Laundry & Linen Service	8. 00	0	0	0	0. 00		
32.00	Housekeepi ng	9. 00	1, 409, 917	0	1, 409, 917	82, 576. 00		
33. 00	Housekeeping under contract		0	0	0	0. 00	0.00	33. 00
	(see instructions)							
34.00	Di etary	10. 00	995, 264	-508, 178	487, 086	·		34.00
35. 00	Di etary under contract (see		0	0	0	0.00	0. 00	35. 00
	instructions)							
36. 00	Cafeteri a	11. 00	0	508, 178	508, 178	·		
37. 00	Maintenance of Personnel	12. 00	0	0	0	0. 00		
38. 00	Nursing Administration	13. 00	1, 640, 926	0	1, 640, 926	36, 195. 00	45. 34	38. 00
39. 00	Central Services and Supply	14. 00	219, 117	0	219, 117	9, 591. 00	22. 85	39. 00
40.00	Pharmacy	15. 00	1, 905, 293	0	1, 905, 293	37, 659. 00	50. 59	40.00
41.00	Medical Records & Medical	16. 00	210, 559	0	210, 559	5, 872. 00	35. 86	41.00
	Records Library							
42.00	Soci al Servi ce	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
HOSPITAL WAGE INDEX INFORMATION FRANCISCAN HEALTH- DYER Provider CCN: 15-0090

| Peri od: | Worksheet S-3 | From 01/01/2020 | Part III | To 12/31/2020 | Date/Time Prepared:

					'	0 12/31/2020	7/29/2021 1: 2	
		Worksheet A	Amount	Reclassi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from	(col.2 ± col.	Salaries in	col . 5)	
				Worksheet A-6)	3)	col. 4		
		1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		59, 090, 128	0	59, 090, 128	1, 596, 939. 11	37. 00	1.00
	instructions)							
2.00	Excluded area salaries (see		10, 962, 959	521	10, 963, 480	332, 049. 00	33. 02	2.00
	instructions)							
3.00	Subtotal salaries (line 1		48, 127, 169	-521	48, 126, 648	1, 264, 890. 11	38. 05	3.00
	minus line 2)							
4.00	Subtotal other wages & related		10, 261, 157	0	10, 261, 157	247, 323. 00	41. 49	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		17, 740, 602	0	17, 740, 602	0.00	36. 86	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		76, 128, 928	-521	76, 128, 407	1, 512, 213. 11	50. 34	6.00
7.00	Total overhead cost (see		25, 766, 913	-47, 176	25, 719, 737	491, 345. 75	52. 35	7.00
	instructions)							

Health Financial Systems	FRANCISCAN HEALTH- DYER	In Lieu of Form CMS-25	52-10
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 15-0090	Period: Worksheet S-3 From 01/01/2020 Part IV	
		To 12/21/2020 Data/Time Drope	rod.

	To 12/31/2020	Date/Time Prep 7/29/2021 1:2	
		Amount	, <u>D</u>
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	1, 336, 060	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3. 00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	5, 085, 656	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5. 00
6.00	Legal /Accounting/Management Fees-Pension Plan	0	6. 00
7.00	Employee Managed Care Program Administration Fees	0	7. 00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8. 00
8. 01	Health Insurance (Self Funded without a Third Party Administrator)	0	8. 01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	6, 101, 609	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	0	10.00
	Life Insurance (If employee is owner or beneficiary)	31, 297	
12.00		0	12.00
13. 00	Disability Insurance (If employee is owner or beneficiary)	141, 785	
14. 00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	
15. 00		713, 415	
16. 00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16. 00
	Non cumulative portion)		
	TAXES		
	FICA-Employers Portion Only	4, 058, 946	
18. 00	Medicare Taxes - Employers Portion Only	0	18. 00
	Unemployment Insurance	76, 132	
20. 00	State or Federal Unemployment Taxes	0	20. 00
	OTHER THE PLANT OF		
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see	0	21. 00
22. 00	instructions))	0	22. 00
	Day Care Cost and Allowances Tuition Reimbursement	ŭ	23. 00
		46, 673	
24. UU	Total Wage Related cost (Sum of lines 1 -23) Part B - Other than Core Related Cost	17, 591, 573	24.00
25 00	OTHER WAGE RELATED COSTS (SPECIFY)		25. 00
25.00	OTHER WAGE RELATED GOOTS (SPECITI)	ļ	25.00

Health Financial Systems	FRANCISCAN HEALTH- DYER	In Lieu of Form CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provi der CCN: 15-0090	Peri od: Worksheet S-3 From 01/01/2020 Part V To 12/31/2020 Date/Time Prepared:

		0 12/31/2020	7/29/2021 1: 2	
	Cost Center Description	Contract 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	0	0	1.00
2.00	Hospi tal	0	0	2.00
3.00	Subprovi der - I PF			3. 00
4.00	Subprovi der - I RF	0	0	4. 00
5.00	Subprovi der - (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	Hospi tal -Based SNF			8. 00
9.00	Hospi tal -Based NF			9. 00
10.00	Hospi tal -Based OLTC			10.00
11. 00	Hospi tal -Based HHA			11. 00
12.00	Separately Certified ASC			12.00
13.00	Hospi tal -Based Hospi ce			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15. 00	Hospital-Based Health Clinic FQHC			15. 00
16. 00	Hospi tal -Based-CMHC			16.00
17. 00	Renal Di al ysi s			17. 00
18. 00	Other	0	0	18. 00

SPI TAL	_ UNCOMPENSATED AND INDIGENT CARE DATA Pr	rovider CCI	N: 15-0090	Peri od:	Worksheet S-	-10	
				From 01/01/2020 To 12/31/2020	Date/Time Pr	epare	
				12, 01, 2020	7/29/2021 1:		
					1.00		
	ncompensated and indigent care cost computation			0)	0.01501		
	cost to charge ratio (Worksheet C, Part I line 202 column 3 divi- edicaid (see instructions for each line)	ded by lin	ie 202 columi	ո 8)	0. 26596	3 1	
	let revenue from Medicaid				8, 410, 26	8 2	
	Did you receive DSH or supplemental payments from Medicaid?				N	3	
	fline 3 is yes, does line 2 include all DSH and/or supplementa	al payments	from Medica	ai d?	Υ	4	
- 1	fline 4 is no, then enter DSH and/or supplemental payments from	om Medicaid	l		80, 286, 49	0 5	
- 1	ledicaid cost (line 1 times line 6) Difference between net revenue and costs for Medicaid program (l	ine 7 minu	e sum of liv	nes 2 and 5: if	21, 353, 23 12, 942, 97		
	zero then enter zero)	111e 7 III111c	13 3uii 01 111	ies 2 and 5, 11	12, 942, 97	٦	
	hildren's Health Insurance Program (CHIP) (see instructions for	each line)				
4	let revenue from stand-alone CHIP					0 9	
1	Stand-allone CHIP charges					0 10	
	Stand-alone CHIP cost (line 1 times line 10) Difference between net revenue and costs for stand-alone CHIP (I	ino 11 min	us lino Ori	f < zoro thon		0 11	
	enter zero)	THE IT IIII	ius IIIIe 9, I	1 < Zei o tileli		0 12	
	ther state or local government indigent care program (see instru	uctions fo	r each line))			
	let revenue from state or local indigent care program (Not inclu					0 13	
	Charges for patients covered under state or local indigent care	program (N	lot included	in lines 6 or		0 14	
- 1	0) State or local indigent care program cost (line 1 times line 14)					0 15	
- 1	Difference between net revenue and costs for state or local indi		program (li	ne 15 minus line		0 16	
1	3; if < zero then enter zero)						
	rants, donations and total unreimbursed cost for Medicaid, CHIP	and state	/local indi	gent care program	ns (see		
i i	nstructions for each line)			gent care program		0 17	
00 P 00 G	nstructions for each line) Private grants, donations, or endowment income restricted to fun- Government grants, appropriations or transfers for support of ho	nding chari ospital ope	ty care erations			-	
00 P 00 G 00 T	nstructions for each line) Private grants, donations, or endowment income restricted to fun- Government grants, appropriations or transfers for support of how Total unreimbursed cost for Medicaid , CHIP and state and local	nding chari ospital ope	ty care erations			0 18	
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65. 00		1	0					1
66. 00 06600 PHYSI CAL THERAPY 3, 089, 274 7, 001, 110 10, 090, 384 -19, 406 10, 070, 978 66. 67. 00 06700 0CCUPATI ONAL THERAPY 541, 851 194, 126 735, 977 -7, 225 728, 752 67. 68. 00 06800 SPECH PATHOLOGY 313, 746 202, 940 516, 686 -93, 755 422, 931 68. 69. 00 06900 ELECTROCARDI OLOGY 714, 455 340, 168 1, 054, 623 -8, 884 1, 045, 739 69. 00 07000 ELECTROENCEPHALOGRAPHY 123, 477 94, 184 217, 661 -6, 757 210, 904 70. 00 70100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 6, 477, 934 6, 477, 934 71. 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 4, 759, 714 4, 759, 714 73. 76. 00 03630 ULTRA SOUND 399, 818 244, 141 643, 959 -14, 422 629, 537 76. 01 03951 PAI N CLI NI C 533, 347 310, 980 844, 327 -64, 154 780, 173 76. 02 03952 CATH LAB 1, 107, 858 5, 219, 984 6, 327, 842 -4, 616, 221 1, 711, 621 76. 03 03953 ACTI VI TY THERAPEUTI C 2, 229, 031 801, 137 3, 030, 168 -858 3, 029, 310 76. 04 03954 WOUND CARE CENTER 310, 155 283, 367 593, 522 -157, 045 436, 477 76. 76. 05 03340 BARI ATRI C CLI NI C 451, 743 336, 336 788, 079 -5, 773 782, 306 76. 06 03030 HEALTHY LI VI NI G CENTER 0 0 0 0 0 0 0 0 0			001 (01					1
67. 00 06700 OCCUPATI ONAL THERAPY 541, 851 194, 126 735, 977 -7, 225 728, 752 67. 68. 00 06800 SPEECH PATHOLOGY 313, 746 202, 940 516, 686 -93, 755 422, 931 68. 69. 00 06900 ELECTROCARDI OLOGY 714, 455 340, 168 1, 054, 623 -8, 884 1, 045, 739 69. 00 07000 ELECTROENCEPHALOGRAPHY 123, 477 94, 184 217, 661 -6, 757 210, 904 70. 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 0 0 6, 477, 934 71. 72. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 0 0 0 8, 013, 060 72. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 4, 759, 714 4, 759, 714 73. 76. 01 03951 PAIN CLINI C 533, 347 310, 980 844, 327 -64, 154 780, 173 76. 02 03952 CATH LAB 1, 107, 858 5, 219, 984 6, 327, 842 -4, 616, 221 1, 711, 621 76. 03 03953 ACTI VITY THERAPEUTI C 2, 229, 031 801, 137 3, 030, 168 -858 3, 029, 310 76. 05 03340 BARI ATRI C CLINI C 451, 743 336, 336 788, 079 -5, 773 782, 306 76. 06 03030 HEALTHY LIVING CENTER 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0						· ·		1
69. 00 06900 ELECTROCARDI OLOGY 714, 455 340, 168 1, 054, 623 -8, 884 1, 045, 739 69. 70. 00 07000 ELECTROENCEPHALOGRAPHY 123, 477 94, 184 217, 661 -6, 757 210, 904 70. 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 0, 4, 759, 714 4, 759, 714 71. 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0, 4, 759, 714 4, 759, 714 76. 00 03630 ULTRA SOUND 399, 818 244, 141 643, 959 -14, 422 629, 537 76. 01 03951 PAI N CLI NI C 533, 347 310, 980 844, 327 -64, 154 780, 173 76. 02 03952 CATH LAB 1, 107, 858 5, 219, 984 6, 327, 842 -4, 616, 221 1, 711, 621 76. 03 03953 ACTI VI TY THERAPEUTI C 2, 229, 031 801, 137 3, 030, 168 -858 3, 029, 310 76. 04 03954 WOUND CARE CENTER 310, 155 283, 367 593, 522 -157, 045 436, 477 76. 05 03340 BARI ATRI C CLI NI C 451, 743 336, 336 788, 079 -5, 773 782, 306 76. 06 03030 HEALTHY LI VI NG CENTER 0 0 0 0 0 0 76. 07 03950 CV RESOURCE CENTER 106, 102 28, 402 134, 504 0 134, 504 76.								1
70. 00 07000 ELECTROENCEPHALOGRAPHY 123, 477 94, 184 217, 661 -6, 757 210, 904 70. 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0 0 0 6, 477, 934 6, 477, 934 71. 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 8, 013, 060 8, 013, 060 72. 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 4, 759, 714 4, 759, 714 73. 76. 76. 01 0 4, 759, 714 4, 759, 714 73. 76. 76. 01 0 0 4, 759, 714 4, 759, 714 73. 76. 76. 01 03951 PAI N CLI NI C 533, 347 310, 980 844, 327 -64, 154 780, 173 76. 76. 76. 02 03952 CATH LAB 1, 107, 858 5, 219, 984 6, 327, 842 -4, 616, 221 1, 711, 621 76. 76. 04 76. 04 03954 WOUND CARE CENTER 310, 155 283, 367 593, 522 -157, 045 436, 477								
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0 0 0 6, 477, 934 6, 477, 934 71. 72. 00 07200 MPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 8, 013, 060 72. 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 4, 759, 714 4, 759, 714 73. 76. 00 03630 ULTRA SOUND 399, 818 244, 141 643, 959 -14, 422 629, 537 76. 01 03951 PAI N CLINIC 533, 347 310, 980 844, 327 -64, 154 780, 173 76. 02 03952 CATH LAB 1, 107, 858 5, 219, 984 6, 327, 842 -4, 616, 221 1, 711, 621 76. 03 03953 ACTIVITY THERAPEUTIC 2, 229, 031 801, 137 3, 030, 168 -858 3, 029, 310 76. 04 03954 WOUND CARE CENTER 310, 155 283, 367 593, 522 -157, 045 436, 477 76. 05 03340 BARIATRIC CLINIC 451, 743 336, 336 788, 079 -5, 773 782, 306 76. 06 03030 HEALTHY LIVING CENTER 0 0 0 0 76. 07 03950 CV RESOURCE CENTER 106, 102 28, 402 134, 504 0 134, 504 76.								
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 8,013,060 8,013,060 72. 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 4,759,714 4,759,714 73. 76. 00 03630 ULTRA SOUND 399,818 244,141 643,959 -14,422 629,537 76. 76. 01 03951 PAIN CLINIC 533,347 310,980 844,327 -64,154 780,173 76. 76. 02 03952 CATH LAB 1,107,858 5,219,984 6,327,842 -4,616,221 1,711,621 76. 76. 03 03953 ACTIVITY THERAPEUTIC 2,229,031 801,137 3,030,168 -858 3,029,310 76. 76. 04 03954 WOUND CARE CENTER 310,155 283,367 593,522 -157,045 436,477 76. 76. 06 03030 HEALTHY LIVING CENTER 0 0 0 0 0 0 76. 76. 07 03950 CV RESOURCE CENTE			1		· ·			
76. 00 03630 ULTRA SOUND 399, 818 244, 141 643, 959 -14, 422 629, 537 76. 01 03951 PAIN CLINIC 533, 347 310, 980 844, 327 -64, 154 780, 173 76. 02 03952 CATH LAB 1, 107, 858 5, 219, 984 6, 327, 842 -4, 616, 221 1, 711, 621 76. 03 03953 ACTIVITY THERAPEUTIC 2, 229, 031 801, 137 3, 030, 168 -858 3, 029, 310 76. 04 03954 WOUND CARE CENTER 310, 155 283, 367 593, 522 -157, 045 436, 477 76. 05 03340 BARIATRIC CLINIC 451, 743 336, 336 788, 079 -5, 773 782, 306 76. 06 03030 HEALTHY LIVING CENTER 0 0 0 0 0 76. 076. 076. 076. 076. 076.			Ö	O				
76. 01 03951 PAIN CLINIC 533, 347 310, 980 844, 327 -64, 154 780, 173 76. 02 03952 CATH LAB 1, 107, 858 5, 219, 984 6, 327, 842 -4, 616, 221 1, 711, 621 76. 03 03953 ACTIVITY THERAPEUTIC 2, 229, 031 801, 137 3, 030, 168 -858 3, 029, 310 76. 04 03954 WOUND CARE CENTER 310, 155 283, 367 593, 522 -157, 045 436, 477 76. 05 03340 BARIATRIC CLINIC 451, 743 336, 336 788, 079 -5, 773 782, 306 76. 06 03030 HEALTHY LIVING CENTER 0 0 0 0 0 0 76. 076. 07 03950 CV RESOURCE CENTER 106, 102 28, 402 134, 504 0 134, 504 76.			0	0	(
76. 02 03952 CATH LAB 1, 107, 858 5, 219, 984 6, 327, 842 -4, 616, 221 1, 711, 621 76. 76. 76. 76. 76. 76. 76. 76. 76. 76.								•
76. 03 03953 ACTIVITY THERAPEUTIC 2, 229, 031 801, 137 3, 030, 168 -858 3, 029, 310 76.								
76. 04 03954 WOUND CARE CENTER 310, 155 283, 367 593, 522 -157, 045 436, 477 76. 05 03340 BARI ATRI C CLI NI C 451, 743 336, 336 788, 079 -5, 773 782, 306 76. 06 03030 HEALTHY LI VI NG CENTER 0 0 0 0 0 76. 07 03950 CV RESOURCE CENTER 106, 102 28, 402 134, 504 0 134, 504 76.								
76. 06 03030 HEALTHY LIVING CENTER 0 0 0 0 0 76. 076. 07 03950 CV RESOURCE CENTER 106, 102 28, 402 134, 504 0 134, 504 76.							436, 477	76. 04
76. 07 03950 CV RESOURCE CENTER 106, 102 28, 402 134, 504 0 134, 504 76.			451, 743	336, 336	788, 07	-5, 773		1
100, 102		1	106 102	28 402	134 50	4 0		
76. 08 03955 OTHER ANCILLARY SERVICE COST CENTERS 0 0 0 0 0 0 76	76. 08	03955 OTHER ANCILLARY SERVICE COST CENTERS	0	0	101,00	0	0	76. 08
76. 09 03956 LACTATION CLINIC 0 0 0 0 76.		03956 LACTATION CLINIC	0	0		0	0	
			0	0	(0	0	76. 10
			409 925	201 261	611 18	5 -31 262	579 924	76. 11 76. 12
OUTPATIENT SERVICE COST CENTERS	70. 12		107, 720	201, 201	011, 10	5	0//, /21	70. 12
			4, 386, 655	1, 866, 909	6, 253, 56	-679, 992	5, 573, 572	
	92. 00							92.00
SPECIAL PURPOSE COST CENTERS 99, 184 99, 184 3, 206, 514 3, 305, 698 113. 00 11300 I NTEREST EXPENSE 99, 184 99, 184 3, 206, 514 3, 305, 698 113.	113 00			99 184	99 18	3 206 514	3 305 698	113 00
118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 61, 088, 781 90, 408, 199 151, 496, 980 -521 151, 496, 459 118.			61, 088, 781					1
NONREI MBURSABLE COST CENTERS		NONREI MBURSABLE COST CENTERS						
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 22, 186 57, 293 79, 479 0 79, 479 190.								•
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 5, 772, 927 1, 655, 713 7, 428, 640 521 7, 429, 161 192. 01 19201 WORKI NG WELL 0 110 110 0 110 192.			3, 112, 921 N					•
194. 00 07950 RESI DENTI AL 2, 306, 789 1, 212, 750 3, 519, 539 0 3, 519, 539 194.			2, 306, 789					
194. 01 07951 0MN			0	0	(0		194. 01
194. 02 07952 PSYCHI ATRI C 0 0 0 0 0 0 194. 194. 03 07953 CENTER OF HOPE 0 5, 584 5, 584 0 5, 584 194.			0	0 5 504	E E0			194. 02
174. 00 07700 0ENTER OF HOLE U 5, 304 5, 304 U 5, 384 194.	174. U	NOT TOPE	<u>ı</u>	ა, აგ4	J 5, 58	- 0	J, 364	1174. 03

Heal th Financi	al Systems	FRANCISCAN HEA	ALTH- DYER		In Lie	u of Form CMS-2	2552-10
RECLASSI FI CAT	ION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider CO		eri od:	Worksheet A	
				l _	rom 01/01/2020	Date/Time Pre	aarad.
				'	o 12/31/2020	7/29/2021 1: 2	
C	ost Center Description	Sal ari es	0ther	Total (col. 1	Recl assi fi cati	Recl assi fi ed	
				+ col. 2)	ons (See A-6)	Trial Balance	
						(col. 3 +-	
						col . 4)	
		1.00	2. 00	3. 00	4. 00	5. 00	
200. 00 T	OTAL (SUM OF LINES 118 through 199)	69, 190, 683	93, 339, 649	162, 530, 332	. 0	162, 530, 332	200. 00

Heal th	Financial Systems	FRANCISCAN HE	ALTH- DYER		In Lieu	of Form CMS-2552-
	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O		Provider CCN:	15-0090	Peri od:	Worksheet A
					From 01/01/2020 To 12/31/2020	Date/Time Prepared
						7/29/2021 1:27 pm
	Cost Center Description	Adjustments	Net Expenses			
			For Allocation			
	GENERAL SERVICE COST CENTERS	6. 00	7. 00			
1.00	00100 CAP REL COSTS-BLDG & FIXT	-1, 418, 687	4, 198, 980			1. (
2. 00	00200 CAP REL COSTS-MVBLE EQUIP	0	4, 192, 930			2.0
3.00	00300 OTHER CAP REL COSTS	0	0			3. (
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	1, 431, 454	2, 717, 930			4. (
5.04	00593 OTHER ADMINISTRATIVE AND GENERAL	1, 457, 707	29, 647, 512			5. (
6.00	00600 MAI NTENANCE & REPAI RS	0	2, 658, 847			6. (
7.00	00700 OPERATION OF PLANT	0	6, 867, 245			7.0
8. 00	00800 LAUNDRY & LINEN SERVICE	0	263, 077			8.0
9.00	00900 HOUSEKEEPI NG	0	2, 237, 953			9. (
10.00	01000 DI ETARY	-17, 366	874, 977			10. (
11. 00 13. 00	01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON	-311, 430 -53, 265	619, 554 2, 597, 272			11. (
14. 00	01400 CENTRAL SERVICES & SUPPLY	-216, 796	2, 597, 272			14. (
15. 00	01500 PHARMACY	-741, 471	3, 149, 414			15. (
16. 00	01600 MEDICAL RECORDS & LIBRARY	685, 739	1, 005, 907			16.0
17. 00	01700 SOCIAL SERVICE	0	0			17. (
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	-306, 472	560, 766			22. (
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS	-208, 289	14, 548, 453			30. 0
31. 00	03100 INTENSIVE CARE UNIT	-25, 908	3, 371, 586			31. 0
32. 00	03200 CORONARY CARE UNIT	0	0			32.0
41. 00	04100 SUBPROVI DER – I RF	1, 208, 001	5, 025, 024			41. (
42.00	04200 SUBPROVI DER	0	0			42.0
43. 00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	0			43. (
50. 00	05000 OPERATING ROOM	-637, 891	1, 945, 461			50.0
50. 00	05001 OUTPATIENT SURGERY	-5, 560	1, 235, 263			50.0
51. 00	05100 RECOVERY ROOM	-4, 368	434, 531			51. (
53.00	05300 ANESTHESI OLOGY	-5, 848	2, 838, 747			53.0
54.00	05400 RADI OLOGY-DI AGNOSTI C	-186, 039	2, 279, 776			54.0
54.01	05401 RADI OLOGY-SPECI AL PROCEDURES	-32, 133	522, 484			54.0
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0			55.0
56. 00	05600 RADI 0I SOTOPE	-7, 178	484, 695			56.0
60.00	06000 LABORATORY	-883, 818	5, 426, 034			60. (
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	-31, 125	3, 598			63. (
65.00	06500 RESPIRATORY THERAPY	-412, 949	2, 154, 113			65. (
66.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	-1, 295, 614	8, 775, 364			66.0
67. 00 68. 00	06800 SPEECH PATHOLOGY	-4, 137 -2, 996	724, 615 419, 935			67. (
69. 00	06900 ELECTROCARDI OLOGY	-24, 803	1, 020, 936			69. (
70. 00	07000 ELECTROENCEPHALOGRAPHY	-5, 199	205, 705			70.0
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	6, 477, 934			71. (
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	o	8, 013, 060			72. (
73.00	07300 DRUGS CHARGED TO PATIENTS	o	4, 759, 714			73. (
76. 00	03630 ULTRA SOUND	-43, 203	586, 334			76. 0
76. 01	03951 PAIN CLINIC	0	780, 173			76. (
76. 02	03952 CATH LAB	-49, 289	1, 662, 332			76. (
76. 03	03953 ACTIVITY THERAPEUTIC	0	3, 029, 310			76. (
76. 04 76. 05	03954 WOUND CARE CENTER 03340 BARI ATRI C CLI NI C	-926	435, 551			76. (76. (
76. 05	03030 HEALTHY LIVING CENTER	-45, 263	737, 043			76.0
76. 07	03950 CV RESOURCE CENTER		134, 504			76.0
76. 08	03955 OTHER ANCILLARY SERVICE COST CENTERS		134, 304			76.0
76. 09	03956 LACTATION CLINIC	l ol	o			76. (
76. 10	03957 OTHER ANCILLARY SERVICE COST CENTERS	0	O			76.
76. 11	03958 OTHER ANCILLARY SERVICE COST CENTERS	o	О			76.
76. 12	03959 ANTI COAGULATION CLINIC	-2, 082	577, 842			76. 1
	OUTPATIENT SERVICE COST CENTERS	,				
	09100 EMERGENCY	-56, 724	5, 516, 848			91. (
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART					92. (
112 0	SPECIAL PURPOSE COST CENTERS	2 205 (00				112
	11300 INTEREST EXPENSE	-3, 305, 698	145 024 022			113. (
118. 00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	-5, 559, 626	145, 936, 833			118. (
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	O	79, 479			190. (
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		7, 429, 161			190. (
	19201 WORKI NG WELL	l ő	110			192. (
	07950 RESI DENTI AL		3, 519, 539			194. (
	07951 OMNI		0			194. (
	07952 PSYCHI ATRI C	O	o			194. (
	07953 CENTER OF HOPE	0	5, 584			194. (
200.00	TOTAL (SUM OF LINES 118 through 199)	-5, 559, 626	156, 970, 706			200. (

| Period: | Worksheet A-6 | From 01/01/2020 | To 12/31/2020 | Date/Time Prepared: 7/29/2021 1:27 pm Provider CCN: 15-0090

					7/29/2021 1: 2	
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
	2. 00	3. 00	4. 00	5. 00		
	A - CAPITAL					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0_	<u>4, 192, 930</u>		1. 00
	TOTALS		0	4, 192, 930		
4 00	B - INTEREST EXPENSE	4 00		074 077		4 00
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	371, 976		1.00
2. 00	I NTEREST EXPENSE	113.00	0	3, 578, 670		2. 00
	TOTALS C - CAFETERIA		U	3, 950, 646		1
1. 00	CAFETERIA	11. 00	508, 178	422, 806		1.00
1.00	TOTALS		508, 178	422, 806		1.00
	D - INSURANCE EXPENSE		300, 170	422, 000		
1. 00	OTHER ADMINISTRATIVE AND	5. 04	ol	1, 065, 410		1.00
1.00	GENERAL	3.04	٩	1, 003, 410		1.00
	TOTALS	+		1, 065, 410		
	E - PATIENT TRANSPORT		-1	.,,		
1.00	ADULTS & PEDIATRICS	30.00	17, 949	0		1.00
2.00	RADI OLOGY-DI AGNOSTI C	54.00	100, 145	0		2. 00
3.00	RADI OI SOTOPE	56.00	30, 435	0		3. 00
4.00	ELECTROCARDI OLOGY	69. 00	7, 021	0		4. 00
5.00	ULTRA SOUND	76.00	12, 486	0		5. 00
6.00	CATH LAB	76. 02	6, 630	0		6. 00
7.00	EMERGENCY	91.00	11, 144	0		7. 00
8.00	PHYSICIANS' PRIVATE OFFICES	192.00	521	0		8. 00
	TOTALS		186, 331	0		
	F - CHARGEABLE SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	14, 490, 994		1. 00
	PATI ENT					
2.00		0.00	0	0		2. 00
3. 00		0.00	0	0		3. 00
4.00		0.00	0	0		4. 00
5.00		0.00	0	0		5. 00
6.00		0.00	0	0		6. 00
7.00		0.00	0	0		7. 00
8.00		0.00	0	0		8. 00
9. 00 10. 00		0. 00 0. 00	0	0		9.00
11. 00		0.00	0	0		10.00
12. 00		0.00	0	0		11. 00 12. 00
13. 00		0.00	0	0		13. 00
14. 00		0.00	o	0		14. 00
15. 00		0.00	0	0		15. 00
16. 00		0.00	o	0		16. 00
17. 00		0.00	ő	Ö		17. 00
18. 00		0.00	ő	Ö		18. 00
19. 00		0.00	ő	Ö		19. 00
20. 00		0.00	o	Ö		20. 00
21. 00		0.00	o	0		21. 00
22. 00		0.00	O	0		22. 00
23. 00		0.00	O	0		23. 00
24.00		0.00	o	0		24. 00
25. 00		0.00	Ö	Ö		25. 00
26. 00		0.00	Ö	0	İ	26. 00
27. 00		0.00	0	0		27. 00
28. 00		0.00	О	0		28. 00
29. 00		0.00	O	0		29. 00
30.00		0.00	O	0		30.00
31.00		0.00	0	0		31. 00
	TOTALS		0	14, 490, 994]
	G - DRUGS CHARGED TO PATIENTS					
1.00	DRUGS CHARGED TO PATIENTS	73. 00	0	4, 759, 714		1. 00
2.00		0. 00	0	0		2. 00
3. 00		0.00	0	0		3. 00
4.00		0.00	0	0		4. 00
5.00		0.00	0	0		5. 00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7. 00
8. 00		0.00	0	0		8. 00
9.00		0.00	0	0		9. 00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11. 00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14. 00 15. 00
15. 00	1	0. 00	0	0		15.00

Heal th Financial SystemsFRANCISCAN HEALTH- DYERIn Lieu of Form CMS-2552-10RECLASSIFICATIONSProvider CCN: 15-0090Period: From 01/01/2020Worksheet A-6

					To 12/31/2020 Date/Ti	ime Prepared: 021 1:27 pm
		Increases				
	Cost Center	Li ne #	Sal ary	Other		
	2. 00	3. 00	4.00	5. 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		0.00	0	0		19. 00
20.00		0.00	0	0		20. 00
21.00		0.00	0	0		21. 00
	TOTALS		0	4, 759, 714		
	H - INTERNS AND RESIDENTS					
1.00	I&R SERVICES-OTHER PRGM	22. 00	47, 176	820, 062		1. 00
	COSTS APPRV					

820, 062

8, 013, 060

8, 013, 060 37, 715, 622

47, 176

741, 685

0

ō

2.00

1.00

500.00

0.00

72.00

2.00

1.00

TOTALS

J - IMPLANTABLE DEVICES
IMPL. DEV. CHARGED TO
PATIENTS
TOTALS

500.00 Grand Total: Increases

Health Financial Systems RECLASSIFICATIONS Provider CCN: 15-0090

Cost Center	1. 00 2. 00 1. 00 1. 00
1.00	1. 00 2. 00
A - CAPITAL 1. 00	1. 00 2. 00
TOTALS B - INTEREST EXPENSE 1. 00 INTEREST EXPENSE 1. 00 OTHER ADMINISTRATI VE AND CENERAL TOTALS O 3, 950, 646 C - CAFETERI A 1. 00 DI ETARY TOTALS D - I NSURANCE EXPENSE 1. 00 CAP REL COSTS-BLDG & FIXT TOTALS C - PATIENT TRANSPORT EMERGENCY 91. 00 186, 331 O 0 O 0 O 0 O 0 O 0 O 0 O 0 O	1. 00 2. 00
B - INTEREST EXPENSE 1. 00 INTEREST EXPENSE	2.00
1. 00 INTEREST EXPENSE 113. 00 0 371, 976 11 2. 00 OTHER ADMINISTRATIVE AND 5. 04 0 3, 578, 670 0 GENERAL TOTALS 0 3, 950, 646 C - CAFETERIA 1. 00 DI ETARY 10. 00 508, 178 422, 806 0 TOTALS 508, 178 422, 806 0 D - INSURANCE EXPENSE 1. 00 CAP REL COSTS-BLDG & FIXT 1.00 0 1, 065, 410 9 TOTALS 0 1, 065, 410 9 TOTALS 0 1, 065, 410 9 TOTALS 0 1, 065, 410 9 E - PATIENT TRANSPORT 1. 00 EMERGENCY 91. 00 186, 331 0 0 0 2. 00 0 0 0 0	2.00
2. 00 OTHER ADMINISTRATIVE AND S. 04 O 3, 578, 670 O GENERAL O 3, 950, 646 O 3, 950, 646 O 3, 950, 646 O 3, 950, 646 O 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2.00
GENERAL	1.00
C - CAFETERI A 1. 00 DI ETARY	
1. 00 DI ETARY 10. 00 508, 178 422, 806 0 TOTALS 508, 178 422, 806 0 D - I NSURANCE EXPENSE 1. 00 CAP REL COSTS-BLDG & FIXT 1.00 0 1, 065, 410 9 TOTALS 0 1, 065, 410 9 E - PATIENT TRANSPORT 1. 00 EMERGENCY 91. 00 186, 331 0 0 2. 00 0 0 0 0	
TOTALS D - INSURANCE EXPENSE 1.00 CAP REL COSTS-BLDG & FIXT TOTALS D - INSURANCE EXPENSE 1.00 CAP REL COSTS-BLDG & FIXT TOTALS D - INSURANCE EXPENSE 1.00 D - INSURANCE EXPENSE 1.	
D - INSURANCE EXPENSE CAP REL COSTS-BLDG & FIXT	1.00
TOTALS 0 1,065,410 E - PATIENT TRANSPORT 1. 00 EMERGENCY 91. 00 186, 331 0 0 2. 00 0 0 0 0	1.00
E - PATIENT TRANSPORT 1. 00	
1. 00 EMERGENCY 91. 00 186, 331 0 0 0 0 0 0 0 0	
2.00 0.00 0 0	1.00
3 00	2. 00
	3. 00
4.00 0.00 0 0 0	4. 00
5. 00	5. 00
7.00	6. 00
8.00	8. 00
TOTALS 186, 331 0	
F - CHARGEABLE SUPPLIES	1.00
1.00 NURSING ADMINISTRATION 13.00 0 96,495 0 2.00 CENTRAL SERVICES & SUPPLY 14.00 0 88,335 0	1.00
3. 00 PHARMACY 15. 00 0 17, 953 0	3. 00
4.00 1 &R SERVICES-OTHER PRGM 22.00 0 4 0	4. 00
COSTS APPRV	
5. 00 ADULTS & PEDIATRICS 30. 00 0 775, 012 0 6. 00 INTENSIVE CARE UNIT 31. 00 0 304, 698 0	5. 00 6. 00
7. 00 SUBPROVI DER - I RF 41. 00 0 161, 839 0	7. 00
8. 00 OPERATING ROOM 50. 00 6, 014, 221 0	8. 00
9. 00 OUTPATIENT SURGERY 50. 01 0 428, 548 0	9. 00
10. 00 RECOVERY ROOM 51. 00 0 7, 740 0 14. F. 07. 00 14. F. 07.	10.00
11. 00 ANESTHESI OLOGY 53. 00 0 165, 968 0 12. 00 RADI OLOGY-DI AGNOSTI C 54. 00 0 169, 056 0	11. 00 12. 00
13. 00 RADI OLOGY-SPECI AL PROCEDURES 54. 01 0 265, 344 0	13. 00
14. 00 RADI 0I SOTOPE 56. 00 0 3, 699 0	14. 00
15. 00 LABORATORY 60. 00 0 739 0	15. 00
16. 00 BLOOD STORING, PROCESSING & 63. 00 0 313, 082 0 TRANS.	16. 00
17. 00 RESPIRATORY THERAPY 65. 00 0 174, 947 0	17. 00
18.00 PHYSICAL THERAPY 66.00 0 19,384 0	18. 00
19. 00 OCCUPATI ONAL THERAPY 67. 00 0 7, 225 0	19. 00
20. 00 SPEECH PATHOLOGY 68. 00 0 93, 687 0 0 21. 00 ELECTROCARDI OLOGY 69. 00 0 14, 016 0	20.00
22. 00 ELECTROENCEPHALOGRAPHY 70. 00 0 6, 757 0	22. 00
23. 00 ULTRA SOUND 76. 00 0 26, 908 0	23. 00
24.00 PAIN CLINIC 76.01 0 64,146 0	24. 00
25. 00 CATH LAB 76. 02 0 4, 622, 833 0 24. 02 0 0 0 0 0 0 0 0 0	25. 00
26. 00 ACTIVITY THERAPEUTIC 76. 03 0 858 0 27. 00 WOUND CARE CENTER 76. 04 0 143, 452 0	26. 00 27. 00
28. 00 BARI ATRI C CLINI C 76. 05 0 3, 969 0	28. 00
29.00 ANTICOAGULATION CLINIC 76.12 0 31,262 0	29. 00
30. 00 EMERGENCY 91. 00 468, 637 0	30.00
31. 00 INTEREST EXPENSE	31.00
G - DRUGS CHARGED TO PATIENTS	
1.00 CENTRAL SERVI CES & SUPPLY 14.00 0 676 0	1.00
2. 00 PHARMACY 15. 00 0 4, 459, 565 0	2. 00
3.00 ADULTS & PEDIATRICS 30.00 0 6,159 0 4.00 INTENSIVE CARE UNIT 31.00 0 25,235 0	3.00
4. 00 INTENSIVE CARE UNIT 31. 00 0 25, 235 0 5. 00 SUBPROVI DER - I RF 41. 00 0 2, 597 0	4. 00 5. 00
6. 00 OPERATING ROOM 50. 00 3 0	6. 00
7. 00 OUTPATI ENT SURGERY 50. 01 0 5, 035 0	7. 00
8. 00 RECOVERY ROOM 51. 00 0 19 0	8.00
9. 00 ANESTHESI OLOGY 53. 00 0 41, 632 0 10. 00 RADI OLOGY-DI AGNOSTI C 54. 00 0 4, 003 0	9. 00 10. 00
11. 00 RADI OLOGY-DI AGNOSTI C	11.00
12. 00 RADI OI SOTOPE 56. 00 0 189, 233 0	12. 00
13. 00 RESPIRATORY THERAPY 65. 00 0 1, 474 0	13.00
14. 00 PHYSI CAL THERAPY 66. 00 0 22 0	14. 00

Health Financial Systems RECLASSIFICATIONS FRANCISCAN HEALTH- DYER In Lieu of Form CMS-2552-10 Provider CCN: 15-0090

Peri od: From 01/01/2020 To 12/31/2020 Date/Time Prepared: 7/29/2021 1: 27 pm

					1/29/2021 1: 2	/ pili
	Decreases					
Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref.		
6. 00	7. 00	8. 00	9. 00	10. 00		
SPEECH PATHOLOGY	68.00	0	68	(0	15.00
ELECTROCARDI OLOGY	69.00	0	1, 889	(0	16.00
PAIN CLINIC	76. 01	0	8	(0	17.00
CATH LAB	76. 02	0	18	(0	18.00
WOUND CARE CENTER	76. 04	0	13, 593	(0	19.00
BARIATRIC CLINIC	76. 05	0	1, 804	(0	20.00
EMERGENCY	91.00	0	6, 504	(0	21.00
TOTALS		Ō	4, 759, 714			
H - INTERNS AND RESIDENTS						
OTHER ADMINISTRATIVE AND	5. 04	47, 176	790, 398	(1.00
GENERAL						
EMERGENCY	<u>91.</u> 00		2 <u>9, 6</u> 64	(<u> </u>	2.00
TOTALS		47, 176	820, 062			
J - IMPLANTABLE DEVICES						
MEDICAL SUPPLIES CHARGED TO	71. 00	0	8, 013, 060	(0	1.00
PATI ENT						
TOTALS		0				
Grand Total: Decreases		741, 685	37, 715, 622			500.00
	6.00 SPEECH PATHOLOGY ELECTROCARDI OLOGY PAIN CLINIC CATH LAB WOUND CARE CENTER BARIATRIC CLINIC EMERGENCY TOTALS H - INTERNS AND RESIDENTS OTHER ADMINISTRATIVE AND GENERAL EMERGENCY TOTALS J - IMPLANTABLE DEVICES MEDICAL SUPPLIES CHARGED TO PATIENT TOTALS	Cost Center	Cost Center	Cost Center	Cost Center	Decreases

| Peri od: | Worksheet A-7 |
| From 01/01/2020 | Part |
| To 12/31/2020 | Date/Time Prepared:

				10	12/31/2020	7/29/2021 1:2	
				Acqui si ti ons		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	, p
		Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances				Retirements	
		1. 00	2. 00	3.00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
1.00	Land	346, 472	0	0	0	0	1. 00
2.00	Land Improvements	9, 701, 677	0	0	0	0	2. 00
3.00	Buildings and Fixtures	68, 407, 983	0	0	0	55, 460	3. 00
4.00	Building Improvements	178, 989	0	0	0	0	4. 00
5.00	Fi xed Equi pment	164, 422, 783	4, 314, 794	0	4, 314, 794	0	5. 00
6.00	Movable Equipment	0	0	0	0	0	6. 00
7.00	HIT designated Assets	0	0	0	0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	243, 057, 904	4, 314, 794	0	4, 314, 794	55, 460	8. 00
9. 00	Reconciling Items	0	0	0	0	0	9. 00
10.00	Total (line 8 minus line 9)	243, 057, 904	4, 314, 794	0	4, 314, 794	55, 460	10. 00
		Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
		6.00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET		al				
1.00	Land	346, 472					1. 00
2.00	Land Improvements	9, 701, 677	4, 256, 005				2. 00
3.00	Buildings and Fixtures	68, 352, 523	32, 948, 852				3. 00
4.00	Building Improvements	178, 989	2, 893				4. 00
5.00	Fi xed Equi pment	168, 737, 577	32, 681, 715				5. 00
6.00	Movable Equipment	0	0				6. 00
7.00	HIT designated Assets	0	0				7. 00
8.00	Subtotal (sum of lines 1-7)	247, 317, 238	69, 889, 465				8. 00
9.00	Reconciling Items	0	0				9. 00
10. 00	Total (line 8 minus line 9)	247, 317, 238	69, 889, 465			ļ	10. 00

Heal th	Financial Systems	FRANCISCAN HEALTH- DYER			In Lieu of Form CMS-2552-10		
	CILIATION OF CAPITAL COSTS CENTERS		Provider CO	CN: 15-0090	Peri od:	Worksheet A-7	
					From 01/01/2020		
					To 12/31/2020		
						7/29/2021 1: 2	7 pm
SUMMARY OF CAPITAL							
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see	Taxes (see	
					instructions)		
		9. 00	10.00	11. 00	12.00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	10, 504, 031	0		0 0	0	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		0 0	0	2. 00
3.00	Total (sum of lines 1-2)	10, 504, 031	0		0 0	0	3. 00
		SUMMARY O	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum				
	·	Capi tal -Relate	of cols. 9				
		d Costs (see	through 14)				
		instructions)	,				
		14. 00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	10, 504, 031				1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2. 00
	1	1	40 504 004				

0 0 0

10, 504, 031

1. 00 2. 00 3. 00

3.00 Total (sum of lines 1-2)

Health Financial Systems	FRANCISCAN H	EALTH- DYER		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der Co		Period: From 01/01/2020 To 12/31/2020		
	COM	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col.	Ratio (see instructions)	Insurance	
			2)			
DART 111 DECONOLITATION OF CARLEY COOKS OF	1.00	2.00	3. 00	4. 00	5. 00	
PART III - RECONCILIATION OF CAPITAL COSTS CE		1		0.540007		
1. 00 CAP REL COSTS-BLDG & FLXT	4, 931, 099	l .	4, 931, 099		0	1.00
2. 00 CAP REL COSTS-MVBLE EQUIP	4, 185, 420	l .	4, 185, 420		0	2.00
3.00 Total (sum of lines 1-2)	9, 116, 519	TION OF OTHER (9, 116, 51 ⁹		F CAPITAL	3. 00
	ALLUCA	IION OF OTHER (CAPITAL	SUMMARY	F CAPITAL	
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
		Capi tal -Relate				
		d Costs	through 7)			
	6. 00	7. 00	8. 00	9. 00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE	NTERS					
1.00 CAP REL COSTS-BLDG & FLXT	0	0	(3, 827, 004	0	1. 00
2.00 CAP REL COSTS-MVBLE EQUIP	0	0		4, 192, 930	0	2.00
3.00 Total (sum of lines 1-2)	0	0	(8, 019, 934	0	3. 00
		Sl	JMMARY OF CAPI	TAL		
Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
		instructions)	instructions)	Capi tal -Rel ate	of cols. 9	
				d Costs (see	through 14)	
				instructions)		
	11. 00	12.00	13.00	14. 00	15. 00	
PART III - RECONCILIATION OF CAPITAL COSTS CE	NTERS					
1.00 CAP REL COSTS-BLDG & FLXT	371, 976	0		0	4, 198, 980	1.00
2.00 CAP REL COSTS-MVBLE EQUIP	0		(0	4, 192, 930	2.00
3.00 Total (sum of lines 1-2)	371, 976	0	(0	8, 391, 910	3. 00

				To	12/31/2020	Date/Time Prep 7/29/2021 1:2	pared: 7 pm
				Expense Classification on		772772021 1.2	, p
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basi s/Code (2) 1.00	Amount 2.00	Cost Center 3.00	Li ne # 4. 00	Wkst. A-7 Ref. 5.00	
1.00	Investment income - CAP REL	1.00		CAP REL COSTS-BLDG & FIXT	1.00	5.00	1. 00
2. 00	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	2. 00
	COSTS-MVBLE EQUIP (chapter 2)	_	0	CAL REE GOSTS MVBEE EQUIT			
3. 00	Investment income - other (chapter 2)	В	0		0. 00	0	3. 00
4.00	Trade, quantity, and time	В	-97, 716	CENTRAL SERVICES & SUPPLY	14. 00	0	4. 00
5.00	discounts (chapter 8) Refunds and rebates of		0		0. 00	0	5. 00
6. 00	expenses (chapter 8) Rental of provider space by		0		0. 00	0	6. 00
	suppliers (chapter 8)		0				
7. 00	Telephone services (pay stations excluded) (chapter		0		0. 00	0	7. 00
0.00	21)		0		0.00		0.00
8. 00	Television and radio service (chapter 21)		U		0. 00	0	8. 00
9. 00 10. 00	Parking Lot (chapter 21) Provider-based physician	A-8-2	-591, 972		0.00	0	9. 00 10. 00
	adjustment	A-0-2					
11. 00	Sale of scrap, waste, etc. (chapter 23)		0		0. 00	0	11. 00
12. 00	Related organization	A-8-1	127, 735			0	12. 00
13. 00	transactions (chapter 10) Laundry and linen service		0		0. 00	0	13. 00
14. 00 15. 00	Cafeteria-employees and guests Rental of quarters to employee		-311, 430	CAFETERI A	11. 00 0. 00	0	
	and others		0				
16. 00	Sale of medical and surgical supplies to other than		0		0. 00	0	16. 00
17. 00	patients Sale of drugs to other than		0		0. 00	0	17. 00
17.00	patients		0		0.00	O .	17.00
18. 00	Sale of medical records and abstracts	В	0	MEDICAL RECORDS & LIBRARY	16. 00	0	18. 00
19. 00	Nursing and allied health		0		0. 00	0	19. 00
	education (tuition, fees, books, etc.)						
20. 00 21. 00	Vending machines Income from imposition of	В	-13, 012 0	DI ETARY	10. 00 0. 00	0	
21.00	interest, finance or penalty		0		0.00	J	21.00
22. 00	charges (chapter 21) Interest expense on Medicare		0		0. 00	0	22. 00
	overpayments and borrowings to				2.23		
23. 00	repay Medicare overpayments Adjustment for respiratory	A-8-3	0	RESPIRATORY THERAPY	65. 00		23. 00
	therapy costs in excess of limitation (chapter 14)						
24. 00	Adjustment for physical	A-8-3	0	PHYSI CAL THERAPY	66. 00		24. 00
	therapy costs in excess of limitation (chapter 14)						
25. 00	Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	114. 00		25. 00
	(chapter 21)						
26. 00	Depreciation - CAP REL COSTS-BLDG & FLXT		0	CAP REL COSTS-BLDG & FIXT	1. 00	0	26. 00
27. 00	Depreciation - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	27. 00
28. 00	COSTS-MVBLE EQUIP Non-physician Anesthetist		0	*** Cost Center Deleted ***	19. 00		28. 00
29. 00 30. 00	Physicians' assistant Adjustment for occupational	A-8-3	0	OCCUPATI ONAL THERAPY	0. 00 67. 00	0	29. 00 30. 00
50.00	therapy costs in excess of	N-0-3	Ü	OCCUPATIONAL HIERAPT	67.00		30.00
30. 99	Hospice (non-distinct) (see	1	Ω	ADULTS & PEDIATRICS	30. 00	-	30. 99
	instructions)						
31. 00	Adjustment for speech pathology costs in excess of	A-8-3	0	SPEECH PATHOLOGY	68. 00		31. 00
32 00	limitation (chapter 14) CAH HIT Adjustment for		0		0. 00	0	32. 00
52.00	Depreciation and Interest		U		0.00		52.00

Provider CCN: 15-0090

				To	om 01/01/2020 12/31/2020		
				Expense Classification on To/From Which the Amount is		7/29/2021 1: 2	7 pm
					, , , ,		
	Cost Center Description	Pasis/Codo (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
		1.00	2. 00	3.00	4. 00	5. 00	
33. 00	RENTAL INCOME	В	-7, 810	OTHER ADMINISTRATIVE AND GENERAL	5. 04	0	33. 00
34. 00	MI SC I NCOME	В	-9, 491	OTHER ADMINISTRATIVE AND GENERAL	5. 04	0	34. 00
35. 00 36. 00	DIETETIC INSTRUCTION OTHER ADJUSTMENTS (SPECIFY) (3)	В	-1, 120 0	DI ETARY	10. 00 0. 00	0 0	35. 00 36. 00
37. 00	ADVERTISING EXPENSE	A	-333	OTHER ADMINISTRATIVE AND GENERAL	5. 04	0	37. 00
38. 00	MI SCELLANEOUS - OTHER OPERATING	В	-501	RADI OLOGY-DI AGNOSTI C	54.00	0	38. 00
40. 00	MI SCELLANEOUS - OTHER OPERATING	В	-11, 089	OTHER ADMINISTRATIVE AND GENERAL	5. 04	0	40. 00
41. 00	OTHER ADJUSTMENTS (SPECIFY)		0	l .	0.00	0	41. 00
42. 00	PROGRAM FEES	В	-6, 918	OTHER ADMINISTRATIVE AND GENERAL	5. 04	0	42. 00
43. 00 44. 00	UNECESSARY BORROWING LOBBYING EXPENSE	A A		I NTEREST EXPENSE OTHER ADMINI STRATI VE AND GENERAL	113. 00 5. 04	0	43. 00 44. 00
45. 00	DI SCOUNTS EARNED/REBATES	В		DI ETARY	10.00	О	45. 00
46. 00 47. 00	PENSION ADJUSTMENT DI SCOUNTS EARNED/REBATES	A B		EMPLOYEE BENEFITS DEPARTMENT OTHER ADMINISTRATIVE AND	4. 00 5. 04	0	46. 00 47. 00
48. 00	DI SCOUNTS EARNED/REBATES	В		GENERAL CENTRAL SERVICES & SUPPLY	14. 00	0	48. 00
49. 00 49. 01	DI SCOUNTS EARNED/REBATES DI SCOUNTS EARNED/REBATES	B B		PHARMACY OPERATING ROOM	15. 00 50. 00	0 0	49. 00 49. 01
49. 02	DI SCOUNTS EARNED/REBATES	В		RADI OLOGY-DI AGNOSTI C	54. 00	O	49. 02
49. 03 49. 04	DI SCOUNTS EARNED/REBATES DI SCOUNTS EARNED/REBATES	B B		LABORATORY RESPIRATORY THERAPY	60. 00 65. 00	0	49. 03 49. 04
49. 04	DI SCOUNTS EARNED/REBATES	В		PHYSICAL THERAPY	66.00	0	49. 04
49. 06	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0. 00	0	49. 06
49. 07 49. 08	DIETETIC INSTRUCTION PODIATRIC RESIDENT COORDINATOR	B A		BARIATRIC CLINIC I&R SERVICES-OTHER PRGM	76. 05 22. 00	0 0	49. 07 49. 08
49. 09	HAF FEES	А	-4, 209, 161	COSTS APPRV OTHER ADMINISTRATIVE AND	5. 04	0	49. 09
49. 10	PROPERTY TAX	А	-101, 165	GENERAL OTHER ADMINISTRATIVE AND	5. 04	0	49. 10
49. 11	OTHER ADJUSTMENTS (SPECIFY)		0	GENERAL	0.00	0	49. 11
49. 12	(3) OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	49. 12
49. 13	(3) OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	49. 13
49. 14 49. 15	(3) PROGRAM FEES OTHER ADJUSTMENTS (SPECIFY)	В	-4, 665 0	PHYSI CAL THERAPY	66. 00 0. 00	0 0	49. 14 49. 15
49. 16	(3) CONTRACT REVENUE	В	-23, 951	OTHER ADMINISTRATIVE AND GENERAL	5. 04	0	49. 16
49. 17	PROGRAM FEES	В	-17, 356	OTHER ADMINISTRATIVE AND GENERAL	5. 04	0	49. 17
49. 18	DI SCOUNTS EARNED REBATES	В	-35, 641	OTHER ADMINISTRATIVE AND GENERAL	5. 04	0	49. 18
49. 19	OTHER ADJUSTMENTS (SPECIFY) (3)		0	i T	0.00	0	49. 19
49. 20	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	49. 20
49. 21	(3) OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	49. 21
49. 22	(3) MISC - OTHER OPERATING	А	-2, 928	OTHER ADMINISTRATIVE AND GENERAL	5. 04	0	49. 22
49. 23	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	49. 23
49. 24	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	49. 24
50. 00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-5, 559, 626				50. 00

Health Financial Systems	FRANCI SCAN HI	EALTH- DYER	In Lieu of Form CMS-2552-10			
ADJUSTMENTS TO EXPENSES			Provider CCN: 15-0090	Peri od:	Worksheet A-8	
				From 01/01/2020 To 12/31/2020	Date/Time Pre 7/29/2021 1:2	
			Expense Classification o			
			To/From Which the Amount is	to be Adjusted		
Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
	1. 00	2.00	3. 00	4. 00	5. 00	

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

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

 B. Amount Received if cost cannot be determined.

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provi der CCN: 15-0090

Peri od: Worksheet A-8-1 From 01/01/2020

12/31/2020 Date/Time Prepared: 7/29/2021 1:27 pm Li ne No. Cost Center Expense I tems Amount of Amount Allowable Cost Included in Wks. A, column 1.00 3.00 4.00 5.00 2.00 COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS 1.00 113.00 I NTEREST EXPENSE INTEREST 936, 186 3, 578, 670 1.00 1. 00 CAP REL COSTS-BLDG & FIXT ALLOWABLE NEW CAPITAL COSTS 1, 153, 589 2, 572, 276 2.00 2.00 5. 04 OTHER ADMINISTRATIVE AND GEN A&G 3.00 13, 857, 737 16, 575, 346 3.00 4.00 15. 00 PHARMACY COVP / PHARMACY 308, 719 4.00 4.01 16.00 MEDICAL RECORDS & LIBRARY нім 685, 739 4.01 5. 04 OTHER ADMINISTRATIVE AND GEN ELIMINATIONS -8, 707, 447 4 02 4 02 C 14.00 CENTRAL SERVICES & SUPPLY 4.03 SPD 4.03 4.04 15. 00 PHARMACY PHARMACY 147, 518 1, 042, 414 4.04 203, 448 4.05 30. 00 ADULTS & PEDIATRICS NEPHROLOGY 4.05 41. 00 SUBPROVI DER - I RF REHABI LI TATI ON 4.06 4.06 4.07 50. 00 OPERATING ROOM OPERATING ROOM 5,735 34, 297 4.07 50. 00 OPERATING ROOM 4.08 ORTHOPEDI CS 94 563 4.08 50. 01 OUTPATIENT SURGERY ENDOSCOPY 10, 697 4 09 11,880 4 09 4.10 51.00 RECOVERY ROOM RECOVERY 1,091 5, 459 4.10 53. 00 ANESTHESI OLOGY ANESTHESI OLOGY 5, 017 10,865 4.11 4.12 54. 00 RADI OLOGY-DI AGNOSTI C RADIOLOGY DIAGNOSTIC 29, 816 86, 508 4.12 54. 00 RADI OLOGY-DI AGNOSTI C 37, 308 COMPUTED TOMOGRAPHY 108, 245 4.13 4 13 4.14 54. 00 RADI OLOGY-DI AGNOSTI C MRI 17,022 49, 388 4.14 54. 01 RADI OLOGY-SPECI AL PROCEDURES RADI OLOGY-SPECI AL PROCEDURES 5, 911 4.15 38, 044 4.15 55. 00 RADI OLOGY-THERAPEUTI C RADIATION ONCOLOGY 4.16 4.16 60. 00 LABORATORY CHEMI STRY 1,020,556 4.17 153, 220 4 17 4.18 63.00 BLOOD STORING, PROCESSING & BLOOD BANK 1,084 32, 209 4. 18 65. 00 RESPIRATORY THERAPY RESPIRATORY THERAPY 4.19 233, 506 636, 660 4.19 66. 00 PHYSI CAL THERAPY PHYSICAL THERAPY 4.20 4.20 66.00 PHYSI CAL THERAPY REHAR UNIT THERAPY 4, 036, 634 5, 319, 992 4.21 4 21 4.22 67. 00 OCCUPATIONAL THERAPY OCCUPATIONAL THERAPY 1, 453 5,590 68. 00 SPEECH PATHOLOGY SPEECH THERAPY 4.23 1, 310 4, 306 4. 23 4.24 69. 00 ELECTROCARDI OLOGY NON INVASIVE VASCULAR 27, 303 2,500 4.24 69. 00 ELECTROCARDI OLOGY 4. 25 CARDIAC REHAB 4.25 6, 440 4.26 70. 00 ELECTROENCEPHALOGRAPHY NEURO DIAGNOSTICS 4. 26 11.639 4.27 76. 00 ULTRA SOUND ULTRASOUND 5, 433 48, 636 4.27 56. 00 RADI 0I SOTOPE NUCLEAR MEDICINE 9.445 4. 28 4.28 2, 267 4.29 91. 00 EMERGENCY 4.29 41. 00 SUBPROVI DER - I RF REHAB UNIT OVERHEAD 4.30 1, 208, 001 0 4.30 0.00 0 4.31 4.31 22, 854, 033 TOTALS (sum of lines 1-4). 5.00 22, 726, 298 5.00 Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.

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

				Related Organization(s) and/	or Home Office		
	Symbol (1)	Name	Percentage of	Name	Percentage of		
			Ownershi p		Ownershi p		
	1. 00	2.00	3. 00	4. 00	5. 00		
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:							

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

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

6.00	В	FRANCISCAN ALLI	100.00 FRANCI SCAN ALLI	100. 00	6. 00
7.00			0. 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:				

STATEME OFFICE	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND H	OME Provider (CCN: 15-0090	Peri od: From 01/01/2020	Worksheet A-8	8-1
OTTTOL	00013				To 12/31/2020	Date/Time Pre 7/29/2021 1:2	
				Related Organ	nization(s) and/	or Home Office	
	Symbol (1)	Name	Percentage of Ownership	1	lame	Percentage of Ownership	

3. 00

4. 00

FRANCISCAN HEALTH- DYER

In Lieu of Form CMS-2552-10

5. 00

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

Health Financial Systems

1. 00

- 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.

2.00

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.

			To 12/31/2020	Date/Time Prepared: 7/29/2021 1:27 pm
	Net	Wkst. A-7 Ref.		7,27,2021 1127 5111
	Adjustments			
	(col. 4 minus			
	col. 5)*			
	6. 00	7.00		
			ENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR C	LAIMED
	HOME OFFICE CO			
1.00	-2, 642, 484			1. 00
2.00	-1, 418, 687			2. 00
3.00	-2, 717, 609			3.00
4.00	308, 719			4. 00
4. 01	685, 739			4. 01
4. 02	8, 707, 447			4. 02
4. 03	0	· · · · · · · · · · · · · · · · · · ·		4. 03
4.04	-894, 896			4. 04
4.05	-203, 448			4. 05
4.06	0			4. 06
4. 07	-28, 562			4. 07
4. 08	-469			4. 08
4. 09	-1, 183			4. 09
4. 10	-4, 368			4. 10
4. 11	-5, 848			4. 11
4. 12	-56, 692			4. 12
4. 13	-70, 937			4. 13
4. 14	-32, 366			4. 14
4. 15	-32, 133			4. 15
4. 16	0 0 7 22 0	T		4. 16
4. 17	-867, 336			4. 17
4. 18	-31, 125			4. 18 4. 19
4. 19 4. 20	-403, 154 0			4. 19
4. 20	-1, 283, 358			4. 20
4. 21	-1, 203, 336			4. 21
4. 22	-2, 996			4. 23
4. 23	-24, 803			4. 24
4. 25	-24,003			4. 25
4. 26	-5, 199			4. 26
4. 27	-43, 203			4. 27
4. 28	-7, 178			4. 28
4. 29	-7,170			4. 29
4. 30	1, 208, 001			4. 30
4. 31	1, 200, 001			4. 31
5. 00	127, 735			5. 00
3.00	127,733		and in detail to Wantahart A and an	/ 1:

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

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

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

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

6.00	HEALTHCARE SERV	6.00
7.00		7. 00 8. 00
8.00		8.00
9.00		9.00
10.00		10.00
100.00		100.00

Health Financial Systems	FRANCISCAN HEAL	FRANCISCAN HEALTH- DYER		
STATEMENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HOME	Provider CCN: 15-0090	Peri od:	Worksheet A-8-1
OFFICE COSTS			From 01/01/2020 To 12/31/2020	Date/Time Prepared: 7/29/2021 1:27 pm
Related Organization(s) and/or Home Office				
Type of Business				
6. 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.

Peri od: Worksheet A-8-2 From 01/01/2020 To 12/31/2020 Date/Time Prepared: 7/29/2021 1:27 pm

					'	12/31/2020	7/29/2021 1:2	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component	
				'	'		Hours	
	1. 00	2.00	3.00	4.00	5. 00	6. 00	7. 00	
1.00	5. 04	OTHER ADMINISTRATIVE AND	104, 132	102, 500	1, 632	197, 500	13	1. 00
		GENERAL		·		•		
2.00	13. 00	NURSING ADMINISTRATION	60, 861	49, 696	11, 165	197, 500	80	2. 00
3.00		ADULTS & PEDIATRICS	20, 318	0	20, 318	197, 500	163	3. 00
4. 00		INTENSIVE CARE UNIT	73, 669	4, 206		197, 500		4. 00
5. 00		OPERATING ROOM	269, 280	269, 280	0	0	0	5. 00
6. 00		OUTPATIENT SURGERY	18, 000	3, 600	_	-		6. 00
7. 00		LABORATORY	38, 733	0,000		197, 500	310	7. 00
8. 00		RESPI RATORY THERAPY	8, 592	1, 442		197, 500	57	8. 00
9. 00		CATH LAB	66, 000	44, 000		197, 500	176	9. 00
10. 00		BARIATRIC CLINIC	17, 500	7, 500		197, 500	80	10. 00
11. 00		WOUND CARE CENTER	3, 490	80		197, 500	27	11. 00
12. 00		ANTICOAGULATION CLINIC	5, 500	1, 000		197, 500		12. 00
13. 00	91.00	EMERGENCY	103, 630			197, 500		13. 00
200.00	14/1 1 A 1 ' "	0 1 0 1 (8)	789, 705	525, 188		Б	2,054	200. 00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	
		ldenti fi er	Limit	Unadjusted RCE		Component	of Malpractice	
				Limit	Continuing	Share of col.	Insurance	
	4.00	0.00	0.00	0.00	Educati on	12	11.00	
1 00	1.00	2.00	8.00	9. 00	12. 00	13. 00	14. 00	1 00
1. 00	5. 04	OTHER ADMINISTRATIVE AND	1, 234	62	0	0	0	1. 00
2 00	12.00	GENERAL	7.50/	200		_		2 00
2.00		NURSI NG ADMI NI STRATI ON	7, 596	380				
3.00		ADULTS & PEDIATRICS	15, 477	774	0	0	0	3. 00
4.00		INTENSIVE CARE UNIT	47, 761	2, 388		0		
5.00		OPERATING ROOM	0	0		0	0	5. 00
6. 00		OUTPATIENT SURGERY	13, 623	681	0	0	0	6. 00
7. 00		LABORATORY	29, 435	1, 472		0	0	7. 00
8. 00		RESPI RATORY THERAPY	5, 412	271	0	0	0	8. 00
9. 00		CATH LAB	16, 711	836	0	0	0	9. 00
10. 00		BARIATRIC CLINIC	7, 596	380		0	0	10.00
11. 00		WOUND CARE CENTER	2, 564	128		0	0	11. 00
12. 00		ANTICOAGULATION CLINIC	3, 418	171	0	0	0	12. 00
13. 00	91. 00	EMERGENCY	46, 906	2, 345		0	0	
200.00			197, 733	9, 888		0	0	200.00
	Wkst. A Line #		Provi der	Adjusted RCE	RCE	Adjustment		
		l denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
			14					
	1. 00	2. 00	15. 00	16. 00	17. 00	18. 00		
1. 00		OTHER ADMINISTRATIVE AND	0	1, 234	398	102, 898		1. 00
		GENERAL						
2.00		NURSING ADMINISTRATION	0	,		53, 265		2. 00
3.00		ADULTS & PEDIATRICS	0		4, 841	4, 841		3. 00
4.00		INTENSIVE CARE UNIT	0	,	21, 702	25, 908		4. 00
5.00		OPERATING ROOM	0	· ·	0	269, 280		5. 00
6.00		OUTPATI ENT SURGERY	0			4, 377		6. 00
7.00		LABORATORY	0	29, 435	9, 298	9, 298		7. 00
8.00	65. 00	RESPI RATORY THERAPY	0	5, 412	1, 738	3, 180		8. 00
9. 00	76. 02	CATH LAB	0	16, 711	5, 289	49, 289		9. 00
10.00	76. 05	BARIATRIC CLINIC	0	7, 596	2, 404	9, 904		10.00
11. 00		WOUND CARE CENTER	0	1	846	926		11. 00
12. 00		ANTICOAGULATION CLINIC	0			2, 082		12.00
13. 00		EMERGENCY	Ō					13. 00
200.00			Ö					200. 00
- !		!				•		

| Period: | Worksheet B | From 01/01/2020 | Part | To 12/31/2020 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS FRANCISCAN HEALTH- DYER Provider CCN: 15-0090

						o 12/31/2020	Date/Time Pre	
				CAPI TAL REI	LATED COSTS		7/29/2021 1: 2	/ pm
				DI DO A FLVT	10/01 5 50/11 0	545, 0755		
		Cost Center Description	Net Expenses for Cost	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS	Subtotal	
			Allocation			DEPARTMENT		
			(from Wkst A					
			col. 7) 0	1. 00	2.00	4. 00	4A	
		AL SERVICE COST CENTERS	-					
1.00	1	CAP REL COSTS-BLDG & FIXT	4, 198, 980	4, 198, 980				1.00
2. 00 4. 00		CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT	4, 192, 930 2, 717, 930	17, 334	4, 192, 930 18, 714	I .		2. 00 4. 00
5. 04		OTHER ADMINISTRATIVE AND GENERAL	29, 647, 512	313, 231			30, 752, 730	5. 04
6.00		MAINTENANCE & REPAIRS	2, 658, 847	633, 796			3, 408, 465	1
7. 00 8. 00	1	OPERATION OF PLANT LAUNDRY & LINEN SERVICE	6, 867, 245 263, 077	179, 735 0		l ' '	7, 101, 917 263, 077	7. 00 8. 00
9.00		HOUSEKEEPING	2, 237, 953	48, 076	1	- I	2, 347, 471	9.00
10.00	01000	DI ETARY	874, 977	42, 411			954, 133	
11.00		CAFETERI A	619, 554	61, 226		,	701, 337	1
13. 00 14. 00		NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY	2, 597, 272 217, 504	6, 477 54, 606			2, 758, 965 342, 955	1
15. 00	01500	PHARMACY	3, 149, 414	30, 484			3, 261, 239	
16. 00		MEDICAL RECORDS & LIBRARY	1, 005, 907	43, 589			1, 058, 358	1
17. 00 22. 00	1	SOCIAL SERVICE I&R SERVICES-OTHER PRGM COSTS APPRV	0 560, 766	0		1	0 562, 674	17. 00 22. 00
22.00		IENT ROUTINE SERVICE COST CENTERS	300, 700	0		1, 700	302, 074	22.00
30. 00	03000	ADULTS & PEDIATRICS	14, 548, 453	707, 611			16, 029, 992	1
31. 00 32. 00		INTENSIVE CARE UNIT CORONARY CARE UNIT	3, 371, 586	88, 596		I	3, 747, 202	31.00
41. 00		SUBPROVI DER - I RF	5, 025, 024	4, 755 52, 974		- 1	4, 755 5, 210, 925	1
42. 00	04200	SUBPROVI DER	0	0		I	0	42. 00
43. 00		NURSERY	0	0	(0	0	43. 00
50. 00		LARY SERVICE COST CENTERS OPERATING ROOM	1, 945, 461	147, 092	595, 417	54, 121	2, 742, 091	50. 00
50. 01		OUTPATI ENT SURGERY	1, 235, 263	125, 637			1, 486, 962	1
51.00	1	RECOVERY ROOM	434, 531	49, 521			538, 678	1
53. 00 54. 00	1	ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C	2, 838, 747 2, 279, 776	200 229	,		2, 959, 098	1
54. 00		RADI OLOGY-BI AGNOSTI C	2, 279, 776 522, 484	209, 228 13, 756			3, 477, 737 773, 367	54. 00
55. 00	05500	RADI OLOGY-THERAPEUTI C	0	892			20, 708	1
56.00	1	RADI OI SOTOPE	484, 695	43, 990			647, 522	
60. 00 63. 00		LABORATORY BLOOD STORING, PROCESSING & TRANS.	5, 426, 034 3, 598	61, 627 25, 256		I I	5, 492, 498 28, 854	1
65. 00		RESPIRATORY THERAPY	2, 154, 113	19, 091		1	2, 276, 959	1
66. 00	1	PHYSI CAL THERAPY	8, 775, 364	12, 954			8, 939, 835	
67. 00 68. 00		OCCUPATIONAL THERAPY SPEECH PATHOLOGY	724, 615 419, 935	4, 960 0			751, 494 437, 470	67. 00 68. 00
69. 00		ELECTROCARDI OLOGY	1, 020, 936	33, 972			1, 114, 072	
70. 00	07000	ELECTROENCEPHALOGRAPHY	205, 705	46, 943			278, 348	70. 00
71.00		MEDICAL SUPPLIES CHARGED TO PATIENT	6, 477, 934	0		- 1	6, 477, 934	1
72. 00 73. 00		IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS	8, 013, 060 4, 759, 714	0	•	I I	8, 013, 060 4, 759, 714	1
76. 00	1	ULTRA SOUND	586, 334	20, 421	1	-	747, 567	
76. 01		PAIN CLINIC	780, 173	109, 936			918, 713	1
76. 02 76. 03		CATH LAB ACTIVITY THERAPEUTIC	1, 662, 332 3, 029, 310	80, 630 50, 904		I	2, 328, 802 3, 170, 383	1
76. 04		WOUND CARE CENTER	435, 551	56, 774			509, 877	
76. 05		BARIATRIC CLINIC	737, 043	17, 191	5, 400	18, 274	777, 908	1
76. 06	1	HEALTHY LIVING CENTER	124 504	0			120 704	76.06
76. 07 76. 08		CV RESOURCE CENTER OTHER ANCILLARY SERVICE COST CENTERS	134, 504 0	0		4, 292	138, 796 0	76. 07 76. 08
76. 09		LACTATION CLINIC	0	Ö	Č	Ö	0	76. 09
76. 10		OTHER ANCILLARY SERVICE COST CENTERS	0	0	(-	0	76. 10
76. 11 76. 12	1	OTHER ANCILLARY SERVICE COST CENTERS ANTICOAGULATION CLINIC	0 577, 842	0 3, 925	290		0 598, 639	76. 11 76. 12
70. 12		TIENT SERVICE COST CENTERS	377,042	3, 723	270	10, 302	370,037	70.12
		EMERGENCY	5, 516, 848	143, 470	177, 270	170, 362	6, 007, 950	1
92. 00		OBSERVATION BEDS (NON-DISTINCT PART AL PURPOSE COST CENTERS					0	92.00
113.00		INTEREST EXPENSE						113. 00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	145, 936, 833	3, 563, 071	4, 140, 996	2, 426, 219	144, 921, 231	
100.00		IMBURSABLE COST CENTERS	70 470	7 401	4.55	007	07 500	100.00
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN PHYSICIANS' PRIVATE OFFICES	79, 479 7, 429, 161	7, 101 122, 193		I I	87, 580 7, 799, 607	
		WORKING WELL	110	122, 173		I I		192. 01
		RESI DENTI AL	3, 519, 539	270, 374		I	3, 898, 692	
194. 01	07951	OMNI	0	0	(이	0	194. 01

Health Financial Systems	FRANCISCAN HE	EALTH- DYER		In Lieu of Form CMS-2552-10			
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der CO	Provi der CCN: 15-0090 Peri od:				
				From 01/01/2020 To 12/31/2020		nared·	
					7/29/2021 1: 2		
		CAPI TAL REL	LATED COSTS				
Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP		Subtotal		
	for Cost			BENEFI TS			
	Allocation			DEPARTMENT			
	(from Wkst A						
	0	1. 00	2.00	4. 00	4A		
194. 02 07952 PSYCHI ATRI C	0	236, 241			257, 902	194. 02	
194.03 07953 CENTER OF HOPE	5, 584	0		0 0	5, 584	194. 03	
200.00 Cross Foot Adjustments					0	200. 00	
201.00 Negative Cost Centers		0		0 0	0	201. 00	
202.00 TOTAL (sum lines 118 through 201)	156, 970, 706	4, 198, 980	4, 192, 93	2, 753, 978	156, 970, 706	202. 00	

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2020 Part I
To 12/31/2020 Date/Time Prepared: 7/29/2021 1:27 pm

				'	0 12/01/2020	7/29/2021 1: 2	
	Cost Center Description	OTHER	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
		ADMI NI STRATI VE AND GENERAL	REPAI RS	PLANT	LINEN SERVICE		
		5. 04	6. 00	7. 00	8. 00	9. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUI P						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	20 752 720					4. 00
5. 04 6. 00	00593 OTHER ADMINISTRATIVE AND GENERAL 00600 MAINTENANCE & REPAIRS	30, 752, 730					5. 04 6. 00
7. 00	00700 OPERATION OF PLANT	830, 466 1, 730, 368		1			7.00
8. 00	00800 LAUNDRY & LINEN SERVICE	64, 098		0 9,007,029	327, 175		8.00
9. 00	00900 HOUSEKEEPI NG	571, 957		1			1
10.00	01000 DI ETARY	232, 473					1
11. 00	01100 CAFETERI A	170, 879	80, 236	181, 737	0	63, 635	11. 00
13.00	01300 NURSI NG ADMI NI STRATI ON	672, 216				6, 732	1
14. 00	01400 CENTRAL SERVICES & SUPPLY	83, 560				56, 755	1
15.00	01500 PHARMACY	794, 594				31, 683	1
16.00	01600 MEDICAL RECORDS & LIBRARY	257, 867 0	57, 123	1	0	45, 304	1
17. 00 22. 00	01700 SOCIAL SERVICE 02200 L&R SERVICES-OTHER PRGM COSTS APPRV	137, 094	1		0	0	
22.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	137,074		η <u></u> Ο	0	0	22.00
30. 00	03000 ADULTS & PEDIATRICS	3, 905, 648	927, 315	2, 100, 398	161, 522	735, 455	30.00
31.00	03100 INTENSIVE CARE UNIT	912, 998					1
32.00	03200 CORONARY CARE UNIT	1, 159	6, 231	14, 114	0	4, 942	32. 00
41. 00	04100 SUBPROVI DER - I RF	1, 269, 631	69, 422	157, 243	66, 306	55, 059	41. 00
42.00	04200 SUBPROVI DER	0	-	1	0	0	1
43. 00	04300 NURSERY	0	0) 0	0	0	43. 00
FO 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	//0.105	100 7/0	427 /14		152.001	FO 00
50. 00 50. 01	05000 OPERATING ROOM 05001 OUTPATIENT SURGERY	668, 105 362, 295					
51. 00	05100 RECOVERY ROOM	131, 248					
53. 00	05300 ANESTHESI OLOGY	720, 978		1	0	0	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	847, 344		1	0	217, 462	
54. 01	05401 RADI OLOGY-SPECI AL PROCEDURES	188, 429				14, 298	
55.00	05500 RADI OLOGY-THERAPEUTI C	5, 045	1, 169	2, 648	0	927	
56.00	05600 RADI OI SOTOPE	157, 767	57, 649	130, 577	0	45, 721	56. 00
60.00	06000 LABORATORY	1, 338, 236			0	64, 053	1
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	7, 030			0	,	1
65.00	06500 RESPI RATORY THERAPY	554, 777		1		19, 843	1
66.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	2, 178, 173				10, 100	
67. 00 68. 00	06800 SPEECH PATHOLOGY	183, 100 106, 589		14, 723	0	5, 155 0	1
69. 00	06900 ELECTROCARDI OLOGY	271, 441		1	0	35, 309	
70. 00	07000 ELECTROENCEPHALOGRAPHY	67, 819		1	0	48, 791	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 578, 336		0	0	0	1
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1, 952, 366		0	0	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	1, 159, 695	0	0	0	0	73. 00
76. 00	03630 ULTRA SOUND	182, 143				21, 224	1
76. 01	03951 PAIN CLINIC	223, 843				114, 262	
	03952 CATH LAB	567, 408					76. 02
76. 03	03953 ACTIVITY THERAPEUTIC	772, 457		· ·		52, 907	
76. 04 76. 05	03954 WOUND CARE CENTER 03340 BARI ATRI C CLI NI C	124, 231 189, 536				59, 009 17, 868	
76. 06	03030 HEALTHY LIVING CENTER	104, 550	22, 327	0 0 0 0	0	0	1
76. 07	03950 CV RESOURCE CENTER	33, 817			0	0	
76. 08	03955 OTHER ANCILLARY SERVICE COST CENTERS	0	Ö	ō	0	Ō	1
76. 09	03956 LACTATION CLINIC	0	0	0	0	0	76. 09
76. 10	03957 OTHER ANCILLARY SERVICE COST CENTERS	0	C	0	0	0	76. 10
76. 11	03958 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76. 11
76. 12	03959 ANTI COAGULATI ON CLINIC	145, 857	5, 144	11, 652	0	4, 080	76. 12
04.00	OUTPATIENT SERVICE COST CENTERS	4 4/0 005	100.01/	105.070		440.444	04.00
91.00	09100 EMERGENCY	1, 463, 825	188, 016	425, 863	0	149, 116	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART SPECIAL PURPOSE COST CENTERS						92.00
113 00	11300 I NTEREST EXPENSE			1			113. 00
118.00	1	27, 816, 898	3, 405, 578	7, 180, 251	252, 498	2, 464, 201	
110.00	NONREI MBURSABLE COST CENTERS	27,010,070	0, 100, 070	7, 100, 201	202, 170	2, 101, 201	1110.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	21, 339	9, 306	21, 079	0	7, 381	190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	1, 900, 359				127, 002	
192. 01	1 19201 WORKING WELL	27	O	0	0	0	192. 01
	07950 RESI DENTI AL	949, 909	354, 322	802, 552	0	281, 014	
	07951 OMNI	0	0	0	0		194. 01
	2 07952 PSYCHI ATRI C	62, 837		701, 236	74, 677	245, 538	
	3 O7953 CENTER OF HOPE	1, 361	0	0 ار	0	0	194. 03
200. 00 201. 00		0	0	0	_		200. 00 201. 00
201.00	INEGALI VE COST CEITEIS	1 0	1 0	, ₁ 0	1 0	1 0	1201.00

Health Financial Systems	FRANCISCAN HEALTH- DYER			In Lieu of Form CMS-2552-10		
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der CO	CN: 15-0090 I	Peri od:	Worksheet B	
				From 01/01/2020		
			-	Γo 12/31/2020	Date/Time Pre	
					7/29/2021 1: 2	7 pm
Cost Center Description	OTHER	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
	ADMI NI STRATI VE	REPAI RS	PLANT	LINEN SERVICE		
	AND GENERAL					
	5. 04	6. 00	7. 00	8. 00	9. 00	
202.00 TOTAL (sum lines 118 through 201)	30, 752, 730	4, 238, 931	9, 067, 82	327, 175	3, 125, 136	202. 00

Control Control Research Final Price CASEFFREN ANNISH OF STROKE Price CASEFFREN CASEFFRE				10) 12/31/2020	Date/lime Pre 7/29/2021 1:2	
	Cost Center Description	DI ETARY				•	
Debts Debt		10.00	11 00	13 00		15 00	
2.00 000000 DOUGNO PREL DOSTS -MYRELE EDUIT	GENERAL SERVICE COST CENTERS	10.00		10.00	111.00	10100	
4.00 00000 PARIFLOYER ERPERT TS FEMALEMENT							1
5.04 DOUSSY DIFFER AMEN SINKELLY & AND GENERAL DOUSSY DIFFER AMEN SINKELLY & AND GENERAL DOUSSY DIFFER AMEN SINKELLY & AND GENERAL DOUSSY DIFFER AMEN SINKELLY & SERVICE DOUSSY DIFFER AMEN SINKEL & SERVICE DOUSSY DIFFER AMEN SINKELLY & SERVICE DOUSSY DIFFER AME							1
0.00 000000 LAMINTENANCE & REPAIRS							1
7.00 00000 (DODO OPERATION OF PLANT							1
9.00 00000 HUSEKEEPIN INC							1
10.00 01000 DIETARY 1.412,154 1.197,192 1.100 1.	8.00 00800 LAUNDRY & LINEN SERVICE						8. 00
11.00 01100 CAFETERIA 0 1.197.824 11.00 13.00		4 440 454					1
13.00 01300 MURSING ADMINISTRATION 0 36,0500 3.501,070 126,471 14.00 14.00 01400 CHIRRAL SERVICE SES SURPLY 0 0 37,122 0 912 4,256,382 15,000 15.00 16		· · · · · · · · · · · · · · · · · · ·	1 107 024				1
14.00 01400 CENTRAL SERVICES & SURPLY 0 9,551 0 726,471 4,256,382 15.00 10100 MIDICAL RELORDIS & LIBRARY 0 5,643 0 0 0 10.00 MIDICAL RELORDIS & LIBRARY 0 5,643 0 0 0 10.00 MIDICAL RELORDIS & LIBRARY 0 5,643 0 0 0 10.00 MIDICAL RELORDIS & LIBRARY 0 5,643 0 0 0 10.00 MIDICAL RELORDIS & LIBRARY 0 5,643 0 0 0 10.00 MIDICAL RELORDIS & LIBRARY 0 5,643 0 0 0 10.00 MIDICAL RELORDIS & LIBRARY 0 0 0 0 0 12.00 MIDICAL RELORDIS & RELOR	1	١					1
16.00 14.00 16.00 16.00 16.00 16.00 16.00 16.00 17.00	I I	o		0	726, 471		1
17.00 0.00 1700 SCOLAL SERVICE COST CENTERS 0 0 0 0 0 0 0 0 0		0		0	912	4, 256, 382	15. 00
		0		0			
NAPATI ENI ROUTINE SERVICE COST CENTERS 1,007,019 242,465 1,451,162 39,356 5,508 30,00 31.00 30100 INTENSIVE CARE UNIT 153,800 52,925 450,005 15,473 22,570 31.00 32.00 320.00	1	-1	-	0	0	0	1
0.000 0.00		ı o	0	<u> </u>	ΟĮ	<u> </u>	22.00
32.00 3200 CORDMARY CARE LINIT 0 0 0 0 0 32.00		1, 007, 019	242, 465	1, 451, 162	39, 356	5, 508	30.00
41.00 04.00 SURPROVIDER - I IFF 0 87,037 262,258 8,218 2,323 41.00 42.00 42.00 04.00 0 0 0 0 0 0 0 0 0	l i	i i	52, 935	450, 005	15, 473		1
A2 00 04200 NURSENT 0 0 0 0 0 0 0 0 0		-1	07 027	0	0 210		1
0 0 0 0 0 0 0 0 0 0		· ·			·		
50.00	l i	· ·		ı	-1		1
50.00 05001 OSTOPAT IENT SURGERY 0 20,407 154,081 21,762 4,503 50.01							
51.00 05100 RECVERY ROOM 0 4,807 42,205 393 17 51.00 54.00 05300 ARSTHESI OLOGY 0 1,782 0 8,428 37,225 53.00 54.00 05400 RADIOLOGY-DIAGNOSTIC 0 44,917 338 8,585 3,580 54.00 55.00 05500 RADIOLOGY-TREAPEUTIC 0 0 0 0 0 0 55.00 05500 RADIOLOGY-TREAPEUTIC 0 0 0 0 0 0 55.00 05500 RADIOLOGY-TREAPEUTIC 0 0 0 0 0 0 60.00 05500 RADIOLOGY-TREAPEUTIC 0 0 0 0 0 0 60.00 05500 RADIOLOGY-TREAPEUTIC 0 0 0 0 0 0 60.00 05500 RADIOLOGY-TREAPEUTIC 0 0 0 0 0 0 60.00 05600 RADIOLOGY-TREAPEUTIC 0 0 0 0 0 0 60.00 06600 RADIOLOGY-TREAPEUTIC 0 0 0 0 0 38 0 60 60.00 06600 RADIOLOGY-TREAPEUTIC 0 0 0 0 0 38 0 60 60.00 06600 RADIOLOGY-TREAPEUTIC 0 0 0 0 0 38 0 60 60.00 06600 RADIOLOGY-TREAPEUTIC 0 0 0 0 0 0 0 60.00 06600 PHYSICAL TREAPEY 0 29,689 0 8,884 1,318 65 00 60.00 06600 PHYSICAL TREAPEY 0 62,7255 0 994 20 66 0 60.00 06600 PHYSICAL TREAPEY 0 67,000 0 307 0 67 00 60.00 06600 SPECCIP ARTIOLOGY 0 5,718 0 4,758 61 66 00 60.00 06600 SPECCIP ARTIOLOGY 0 11,354 0 367 0 67 00 60.00 06600 ELECTROCARDIOLOGY 0 10,740 38,544 712 1,689 69 00 71.00 07000 DELIC SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 0 71.00 07000 DELIC SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 72.00 07200 DELIC SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 0 73.00 07300 DELIC SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 0 74.00 07300 DELIC SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 0 75.00 07300 DELIC SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 0 76.01 03955 PAIN CLINIC HARGED TO PATIENTS 0 0 0 0 0 0 0 0 76.01 03955 PAIN CLINIC HARGED TO PATIENTS 0 0 0 0 0 0 0 0 76.01 03955		- I				3	1
53.00 085000 ANESTHESI OLOGY 0 1, 782 0 8, 428 37, 235 53.00 54.00 05400 RADI OLOGY-SPECIAL PROCEDURES 0 8, 971 37, 240 13, 474 158 54.01 05401 RADI OLOGY-SPECIAL PROCEDURES 0 8, 971 37, 240 13, 474 158 54.01 05600 RADI OLOGY-SPECIAL PROCEDURES 0 6, 568 0 188 169, 246 56.00 05600 RADI OLOGY-PHERAPEUTI C 0 0 0 0 0 0 0 0 0		- 1					1
54. 00 05400 RADIOLOGY-DIAGNOSTIC 0 44. 917 338 8. 885 3. 880 54. 00							1
55.00 0.5500 RADIOLOGY-THERAPEUTIC 0 0 0 0 38 169, 246 56.00		O					1
56.00 OSOOD RADIO ISOTOPE 0 6,568 0 188 169,246 56.00 63.00 0.00	l	- I	8, 971	37, 240	13, 474		1
60.00 0.6000 LABORATORY 0		0	O	0	-1		1
63.00 06300 06000 STORING, PROCESSING & TRANS. 0 0 0 15,899 0 63.00		0		0			1
65.00		o	0	ő		0	1
67.00 0670		O	29, 689	0		1, 318	1
68.00 06800 SPECH PATHOLOGY 0 5,718 0 4,788 6.1 68.00	I I	0					1
69 00 0900 CELECTROCARDI OLOCY 0 16, 740 38, 544 712 1, 689 69, 00 700	I I	0				_	1
70. 00 07000 CALCANDERPHALOGRAPHY 0 2,942 0 343 0 70,00							1
17.2 00 07.200 IMPL DEV. CHARGED TO PATIENTS 0 0 0 0 3, 988, 541 73. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 3, 988, 541 73. 00 76. 01 03951 PAIN CLINIC 0 11, 229 97. 930 3, 257 7 76. 01 76. 02 03952 CATH LAB 0 0 24, 841 165, 757 234, 752 16 76. 02 76. 03 03953 CATIVITY THERAPEUTIC 0 60, 994 5, 292 44 0 76. 03 76. 04 03954 WOUND CARE CENTER 0 8, 163 46, 483 7, 285 12, 157 76. 05 76. 05 76. 05 76. 05 76. 05 76. 05 76. 05 76. 06 76. 05 76. 06 76. 05 76. 06 76. 05 76. 06 76.		o		0		· ·	1
73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 3, 988,541 73.00		o	0	0	0	0	71. 00
76. 00 03430 ULTRA SOUND 0 7, 417 357 1, 366 0 76. 00 76. 01 03951 PAIN CLINIC 0 11, 229 97, 930 3, 257 7 76. 01 76. 02 03952 CATH LAB 0 24, 841 155, 757 234, 752 16 76. 02 76. 03 03953 ACTIVITY THERAPEUTIC 0 60, 994 5, 292 44 0 76. 03 76. 04 76. 03 03954 WOUND CARE CENTER 0 8, 163 46, 483 7, 285 12, 157 76. 04 76. 05 76. 06 03340 BARI ATRI C CLINIC 0 11, 188 0 202 1, 613 76. 05 76. 06 03030 HEALTHY LIVING CENTER 0 0 0 0 0 0 0 0 76. 07 76. 07 76. 08 76. 09 76. 09 76. 09 76. 09 76. 00 0 0 0 0 0 0 0 0 0		0	0	0	0		1
76. 01 03951 PAIN CLINIC 0 11, 229 97, 930 3, 257 7 76. 01 76. 02 03952 CATH LAB 0 24, 841 165, 757 234, 752 16 76. 02 76. 03 03953 ACTIVITY THERAPEUTIC 0 60, 994 5, 292 44 0 76. 03 76. 04 03954 WOUND CARE CENTER 0 8, 163 46, 483 7, 285 12, 157 76. 04 76. 05 76. 05 76. 06 76. 07 76. 08 76. 09 76. 08 76. 09 76. 08 76. 09 76. 08 76. 09 7		0	0 7 /17	257	1 266		1
76. 02 03952 CATH LAB 0 24,841 165,757 234,752 16 76. 02 76. 03 03953 ACTIVITY THERAPEUTIC 0 60,094 5,292 44 0 76. 03 76. 04 03954 WOUND CARE CENTER 0 8,163 46,483 7,285 12,157 76. 04 76. 05 03340 BARI ATRIC CLINIC 0 11,188 0 202 1,613 76. 05 76. 06 03030 HEALTHY LIVING CENTER 0 1,740 0 202 1,613 76. 05 76. 07 03950 CV RESOURCE CENTER 0 1,740 0 0 0 0 76. 07 76. 08 03955 OTHER ANCILLARY SERVICE COST CENTERS 0 0 0 0 0 0 0 0 76. 07 76. 08 03955 OTHER ANCILLARY SERVICE COST CENTERS 0 0 0 0 0 0 0 76. 07 76. 08 03955 OTHER ANCILLARY SERVICE COST CENTERS 0 0 0 0 0 0 0 0 76. 10 03957 OTHER ANCILLARY SERVICE COST CENTERS 0 0 0 0 0 0 0 0 76. 10 76. 11 03958 OTHER ANCILLARY SERVICE COST CENTERS 0 0 0 0 0 0 0 0 76. 10 76. 11 03958 OTHER ANCILLARY SERVICE COST CENTERS 0 0 0 0 0 0 0 0 76. 11 76. 12 03959 ANTICOAGULATION CLINIC 0 0 8,3449 0 1,588 0 76. 11 76. 12 03959 ANTICOAGULATION CLINIC 0 0 8,3449 0 1,588 0 76. 11 76. 12 03959 ANTICOAGULATION CLINIC 0 0 8,3449 0 1,588 0 76. 12 03959 ANTICOAGULATION CLINIC 0 0 8,349 0 1,588 0 76. 12 03959 ANTICOAGULATION CLINIC 0 0 8,349 0 1,588 0 76. 12 03959 ANTICOAGULATION BEDS (NON-DISTINCT PART SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113. 00 11300 INTEREST EXPENSE 113. 00 11300 INTEREST EXPENSE 113. 00 1900.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 77,134 636,178 0 0 190. 00						-	1
76. 04 03954 WOUND CARE CENTER 0 8, 163 46, 483 7, 285 12, 157 76. 04 76. 05 03340 BARI ATRIC CLINI C 0 11, 188 0 202 1, 613 76. 05 76. 06 03030 HEALTHY LIVING CENTER 0 0 0 0 0 0 0 0 76. 06 76. 07 03950 CV RESOURCE CENTER 0 1,740 0 0 0 0 0 0 76. 07 76. 08 03955 THER ANCI LLARY SERVICE COST CENTERS 0 0 0 0 0 0 0 0 0		-1				-	1
76. 05		O					
76. 06 03030 HEALTHY LIVING CENTER 0 0 0 0 0 0 76. 06 76. 07 03950 CV RESOURCE CENTER 0 1,740 0 0 0 0 76. 07 76. 08 03955 OTHER ANCILLARY SERVICE COST CENTERS 0 0 0 0 0 0 0 76. 09 03956 LACTATION CLINIC 0 0 0 0 0 0 0 76. 10 03957 OTHER ANCILLARY SERVICE COST CENTERS 0 0 0 0 0 0 76. 11 03957 OTHER ANCILLARY SERVICE COST CENTERS 0 0 0 0 0 0 76. 12 03959 ANTICOAGULATION CLINIC 0 8, 349 0 1,588 0 76. 12 76. 12 03959 ANTICOAGULATION CLINIC 0 8, 349 0 1,588 0 76. 12 76. 12 04 04 04 05 76. 13 04 05 05 05 76. 14 03959 ANTICOAGULATION CLINIC 0 8, 349 0 1,588 0 76. 12 76. 15 04 05 05 05 76. 16 03959 ANTICOAGULATION BEDS (NON-DISTINCT PART 5 0 76. 17 04 05 05 76. 18 04 05 05 05 76. 19 05 05 05 76. 19 05 05 05 76. 10 05 05 05 76. 10 05 05 05 76. 10 05 05 05 76. 10 05 05 05 76. 10 05 05 05 76. 10 05 05 05 76. 10 05 05 05 76. 10 05		0					
76. 07 03950 CV RESOURCE CENTER 0 1,740 0 0 0 76. 07 76. 08 03955 OTHER ANCI LLARY SERVI CE COST CENTERS 0 0 0 0 0 0 0 0 76. 09 76. 10 03957 OTHER ANCI LLARY SERVI CE COST CENTERS 0 0 0 0 0 0 0 0 76. 09 76. 11 03958 OTHER ANCI LLARY SERVI CE COST CENTERS 0 0 0 0 0 0 0 0 0 76. 10 76. 11 03958 OTHER ANCI LLARY SERVI CE COST CENTERS 0 0 0 0 0 0 0 0 0 76. 11 76. 12 03959 ANTI COAGULATI ON CLI INI C 0 0 8, 349 0 1, 588 0 76. 12 0017PATI ENT SERVI CE COST CENTERS 91. 00 09100 EMERGENCY 92. 00 09200 (BSERVATI ON BEDS (NON-DISTI NCT PART SPECIAL PURPOSE COST CENTERS) 113. 00 11300 I NTEREST EXPENSE 114. 00 1900 (GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 192. 00 19200 (PHYSI CI ANS' PRI VATE OFFI CES 0 0 77, 134 636, 178 0 0 192. 00 192. 01 19201 (WORKI NG WELL 0 0 96, 526 0 0 0 0 192. 00 194. 00 194. 01 194. 01 07951 (MNI) 194. 01 07951 (MNI) 0 0 0 0 0 0 0 0 194. 01 194. 01 194. 01 07951 (MNI) CENTER OF HOPE 0 0 0 0 0 0 194. 02 194. 03 07953 (ENTER OF HOPE 0 0 0 0 0 0 194. 03 200. 00 0 0 0 0 194. 03 200. 00 0 0 0 0 0 0 194. 03 200. 00 0 0 0 0 0 0 194. 03 200. 00 0 0 0 0 0 0 0 0 0 0 194. 03 200. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0	11, 188	0	202		
76. 08 03955 OTHER ANCILLARY SERVICE COST CENTERS 0 0 0 0 0 0 76. 08 76. 09 03956 LACTATI ON CLI NI C 0 0 0 0 0 0 0 76. 10 03957 OTHER ANCILLARY SERVICE COST CENTERS 0 0 0 0 0 0 76. 11 03958 OTHER ANCILLARY SERVICE COST CENTERS 0 0 0 0 0 76. 11 03958 OTHER ANCILLARY SERVICE COST CENTERS 0 0 0 0 0 76. 12 03959 ANTICOAGULATI ON CLI NI C 0 8, 349 0 1, 588 0 76. 12 04 04 04 76. 12 04 04 05 05 76. 12 04 04 05 76. 12 04 05 05 76. 12 04 05 05 76. 12 04 05 05 76. 12 04 05 76. 12 04 05 76. 12 04 05 76. 12 04 05 76. 12 04 05 76. 12 04 05 76. 12 04 05 76. 12 04 05 76. 12 05 05 76. 12 05 05 76. 12 05 05 76. 10 05 05 77. 134 056, 178 78. 10 05 05 79. 10 05 05 79. 10		o	1, 740	o	o		
76. 10 03957 OTHER ANCILLARY SERVICE COST CENTERS 0 0 0 0 0 0 0 0 76. 10 76. 11 03958 OTHER ANCILLARY SERVICE COST CENTERS 0 0 0 0 0 0 0 0 76. 11 76. 12 03959 OTHER ANCILLARY SERVICE COST CENTERS 0 0 0 0 0 0 0 76. 11 76. 12 03959 OTHER ANCILLARY SERVICE COST CENTERS 0 0 0 0 0 0 0 76. 11 76. 12 03959 OTHER ANCILLARY SERVICE COST CENTERS 0 0 0 1,588 0 76. 12 P1. 00 OUTPATIENT SERVICE COST CENTERS 91. 00 O9200 OBSERVATION BEDS (NON-DISTINCT PART SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117) 1,160,828 942,865 2,765,627 726,471 4,256,382 118. 00 100 NONREI MBURSABLE COST CENTERS 112. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 1,057 0 0 0 190.00 190.00 190.00 190.00 PHYSICIANS' PRIVATE OFFICES 0 77,134 636,178 0 0 192.00 192.00 192.00 PHYSICIANS' PRIVATE OFFICES 0 0 77,134 636,178 0 0 192.00 194.00 194.00 07950 RESIDENTIAL 0 0 96,526 0 0 0 0 194.00 194.01 194.02 07952 DMNI 0 0 0 0 0 0 0 194.01 194.02 07952 PSYCHIATRIC 251,326 80,242 99,871 0 0 0 194.02 194.02 07952 PSYCHIATRIC 251,326 80,242 99,871 0 0 0 194.02 194.02 07953 CENTER OF HOPE 0 0 0 0 0 0 0 0 0 0 194.02 200.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0	0	0	0	0	1
76. 11 03958 OTHER ANCI LLARY SERVI CE COST CENTERS 0 0 0 0 0 0 76. 11 76. 12 03959 ANTI COAGULATI ON CLI NI C 0 8, 349 0 1, 588 0 76. 12 00 00 00 0 1, 588 0 0 76. 12 00 00 00 00 00 0 0 0 0 0 0 0 0 0 0 0		0	0	0	0	0	1
76. 12		0	0	0	0		1
91. 00		0	8 340	0	1 500		
91. 00		<u> </u>	0, 347	<u> </u>	1, 300		70. 12
SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 11300 INTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117) 1,160,828 942,865 2,765,627 726,471 4,256,382 118.00 190.00		0	87, 162	3, 805	23, 798	5, 817	91. 00
113. 00 118. 00 119. 0							92. 00
18. 00 SUBTOTALS (SUM OF LINES 1 through 117) 1, 160, 828 942, 865 2, 765, 627 726, 471 4, 256, 382 18. 00 NONREI MBURSABLE COST CENTERS 1,057 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0							112 00
NONREL MBURSABLE COST CENTERS 190.00 19000 GFT, FLOWER, COFFEE SHOP & CANTEEN 0 1,057 0 0 190.00 190.00 192.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 77, 134 636, 178 0 0 192.00 192.01 192.01 WORKI NG WELL 0 0 0 0 0 0 192.01 194.00 07950 RESI DENTI AL 0 96,526 0 0 0 194.00 194.00 194.01 07951 OMNI 0 0 0 0 0 0 194.00 194.00 194.01 194.02 07952 PSYCHI ATRI C 251,326 80,242 99,871 0 0 194.02 194.03 1	I I	1 160 828	942 865	2 765 627	726 471	4 256 382	1
190. 00 19000 GFT, FLOWER, COFFEE SHOP & CANTEEN 0 1, 057 0 0 190. 00 192. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 77, 134 636, 178 0 0 192. 00 192. 01 19201 WORKI NG WELL 0 0 0 0 0 0 192. 01 194. 00 07950 RESI DENTI AL 0 0 96, 526 0 0 0 194. 00 194. 00 194. 01 194. 02 07952 PSYCHI ATRI C 251, 326 80, 242 99, 871 0 0 194. 02 194. 03 07953 CENTER OF HOPE 0 0 0 0 0 194. 03 200. 00 Cross Foot Adjustments	1 11 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	1, 100, 020	742, 003	2, 703, 027	720, 471	4, 250, 502	1110.00
192. 01 19201 WORKI NG WELL 0 0 0 0 0 0 192. 01 194. 00 194. 00 194. 00 194. 01 194. 00 194. 01 194. 01 194. 02 194. 02 194. 03 194. 0		0	1, 057	0	0	0	190. 00
194. 00 07950 RESI DENTI AL 0 96, 526 0 0 0 194. 00 194. 01 194. 02 194. 02 07952 PSYCHI ATRI C 251, 326 80, 242 99, 871 0 0 194. 03 07953 CENTER OF HOPE 0 0 0 0 0 194. 03 200. 00 0 0 0 0 0 0 194. 03 200. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0	77, 134	636, 178	o		
194. 01 07951 0MNI 0 0 0 0 0 194. 01 194. 02 194. 02 07952 PSYCHI ATRI C 251, 326 80, 242 99, 871 0 0 194. 02 194. 03 07953 CENTER 0F HOPE 0 0 0 0 194. 03 200. 00 Cross Foot Adjustments 200. 00		0	0/ 50/	0	O		
194. 02 07952 PSYCHIATRIC 251, 326 80, 242 99, 871 0 0 194. 02 194. 03 07953 CENTER 0F HOPE 0 0 0 0 194. 03 200. 00 Cross Foot Adjustments 251, 326 80, 242 99, 871 0 0 194. 03 200. 00			96, 526 N	0	0		
194. 03 07953 CENTER OF HOPE 0 0 0 194. 03 200. 00 Cross Foot Adjustments 200. 00 0 0 194. 03		251, 326	80, 242	99, 871	ol		
	194. 03 07953 CENTER OF HOPE	o	0	0	O		194. 03
201. 00 Negative Cost Centers 0 0 0 0 0 201. 00			-			_	
	ZUI. UU Negative Cost Centers	<u> </u> 0	0	<u> </u> 0	O	0	1201.00

Health Financial Systems	FRANCISCAN HE	In Lie	u of Form CMS-:	2552-10		
COST ALLOCATION - GENERAL SERVICE COSTS		Provider Co	F	Period: From 01/01/2020 To 12/31/2020		
Cost Center Description	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	
	10.00	11. 00	13. 00	14.00	15. 00	
202.00 TOTAL (sum lines 118 through 201)	1, 412, 154	1, 197, 824	3, 501, 676	726, 471	4, 256, 382	202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0090

				Ic	12/31/2020	Date/lime Pre 7/29/2021 1:2	
	Cost Center Description	MEDI CAL RECORDS & LI BRARY		I NTERNS & RESI DENTS SERVI CES-OTHER PRGM COSTS APPRV	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	, p
	OSUSSAL OSSULOS COOT OSUTEDO	16. 00	17. 00	22. 00	24. 00	25. 00	
1. 00	GENERAL SERVICE COST CENTERS OO100 CAP REL COSTS-BLDG & FIXT		I			I	1. 00
2. 00	00200 CAP REL COSTS-BLDG & TTXT						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 04	00593 OTHER ADMINISTRATIVE AND GENERAL						5. 04
6.00	00600 MAINTENANCE & REPAIRS						6. 00
7.00	00700 OPERATION OF PLANT						7. 00
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
9.00	00900 HOUSEKEEPI NG						9. 00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A			•			10. 00 11. 00
13.00	01300 NURSI NG ADMI NI STRATI ON			•			13.00
14. 00	01400 CENTRAL SERVI CES & SUPPLY						14. 00
15.00	01500 PHARMACY						15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	1, 553, 880					16. 00
17. 00	01700 SOCIAL SERVICE	0	0				17. 00
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRV	0	0	699, 768			22. 00
30. 00	O3000 ADULTS & PEDIATRICS	146, 997	0	418, 630	27, 171, 467	-418, 630	30. 00
31. 00	03100 INTENSIVE CARE UNIT	35, 268			5, 886, 097		31.00
32. 00	03200 CORONARY CARE UNIT	0	Ö	ő	31, 201	Ö	32. 00
41.00	04100 SUBPROVI DER - I RF	36, 892	0	0	7, 225, 314	0	41. 00
42.00	04200 SUBPROVI DER	0	0	_	0		42. 00
43. 00	04300 NURSERY	0	0	0	0	0	43. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	145, 156	0	26, 677	4, 713, 615	-26, 677	50. 00
50. 00	05001 OUTPATI ENT SURGERY	22, 752			2, 740, 917		50. 00
51. 00	05100 RECOVERY ROOM	14, 685		o	995, 395		51. 00
53.00	05300 ANESTHESI OLOGY	44, 709		0	3, 772, 230		53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	150, 332	0	8, 208	5, 653, 747	-8, 208	54.00
54. 01	05401 RADI OLOGY-SPECI AL PROCEDURES	13, 108	0	_	1, 107, 906		54. 01
55. 00	O5500 RADI OLOGY-THERAPEUTI C	0	0	0	30, 497		55. 00
56. 00 60. 00	05600 RADI OI SOTOPE 06000 LABORATORY	30, 390 157, 140			1, 245, 628 7, 315, 656		56. 00 60. 00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	6, 145		_	192, 242		63. 00
65. 00	06500 RESPI RATORY THERAPY	37, 421	Ō		3, 010, 579		65. 00
66. 00	06600 PHYSI CAL THERAPY	50, 695	0	0	11, 301, 330		66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	13, 103	0	_	985, 796		67. 00
68. 00	06800 SPEECH PATHOLOGY	7, 335	0	0	561, 931	0	68. 00
69. 00 70. 00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	44, 502 7, 447	0	0	1, 668, 368 606, 550		69. 00 70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	91, 076			8, 147, 346		70.00
	07200 I MPL. DEV. CHARGED TO PATIENTS	35, 693			10, 001, 119		72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	99, 762	0	0	10, 007, 712	0	73. 00
76. 00	03630 ULTRA SOUND	21, 964		0	1, 069, 413		76. 00
76. 01	03951 PAIN CLINIC	27, 425		0	1, 867, 057		76. 01
76. 02 76. 03	03952 CATH_LAB 03953 ACTIVITY_THERAPEUTIC	124, 900 16, 098		0	3, 875, 276 4, 295, 983		76. 02 76. 03
76. 03	03954 WOUND CARE CENTER	6, 024		0	1, 016, 154		76. 03
76. 05	03340 BARI ATRI C CLI NI C	1, 594		ő	1, 073, 466		76. 05
76. 06	03030 HEALTHY LIVING CENTER	0	0	0	0	0	76. 06
76. 07	03950 CV RESOURCE CENTER	0	0	0	174, 353	0	76. 07
76. 08	03955 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76. 08
76. 09	03956 LACTATION CLINIC	0	0	0	0	0	76. 09
76. 10 76. 11	03957 OTHER ANCILLARY SERVICE COST CENTERS 03958 OTHER ANCILLARY SERVICE COST CENTERS	0		0	0	0	76. 10 76. 11
76. 11	03959 ANTI COAGULATI ON CLINIC	2, 998	-	0	778, 307	0	76. 11
	OUTPATIENT SERVICE COST CENTERS	_,			,		
	09100 EMERGENCY	162, 269	0	246, 253	8, 763, 874	-246, 253	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART					0	92. 00
112 00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE		I	1		Ι	113. 00
118.00	1	1, 553, 880	0	699, 768	137, 286, 526		
	NONREI MBURSABLE COST CENTERS	., 230, 030					
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		147, 742		190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	-	11, 063, 120		192. 00
	19201 WORKI NG WELL 07950 RESI DENTI AL	0		0	137 6, 383, 015		192. 01 194. 00
	07951 OMNI	0	0		0, 303, 013		194. 00
	· · · ·			. 1			·

Health Financial Systems FRANCISCAN HEALTH- DYER				In Lieu of Form CMS-2552-10		
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der C	CN: 15-0090	Peri od:	Worksheet B	
				From 01/01/2020 To 12/31/2020		narod:
				10 12/31/2020	7/29/2021 1: 2	
			INTERNS &			
			RESI DENTS			
Cost Center Description	MEDI CAL	SOCIAL SERVICE	SERVI CES-OTHE	R Subtotal	Intern &	
	RECORDS &		PRGM COSTS		Residents Cost	
	LI BRARY		APPRV		& Post	
					Stepdown	
					Adjustments	
	16.00	17. 00	22.00	24.00	25. 00	
194. 02 07952 PSYCHI ATRI C	0	C		0 2, 083, 221	0	194. 02
194. 03 07953 CENTER OF HOPE	0	C		0 6, 945	0	194. 03
200.00 Cross Foot Adjustments				0	0	200. 00
201.00 Negative Cost Centers	0	C		0	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	1, 553, 880	l c	699, 76	156, 970, 706	-699, 768	202. 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2020 | Part I | To 12/31/2020 | Date/Time Prepared: 7/29/2021 1:27 pm Provider CCN: 15-0090

			7/29/2021 1: 2	27 pm
	Cost Center Description	Total		
		26. 00		
	GENERAL SERVICE COST CENTERS			
1.00	00100 CAP REL COSTS-BLDG & FLXT			1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP			2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT			4.00
5.04	00593 OTHER ADMINISTRATIVE AND GENERAL			5. 04
6.00	00600 MAINTENANCE & REPAIRS			6.00
7.00	00700 OPERATION OF PLANT			7. 00
8.00	00800 LAUNDRY & LINEN SERVICE			8. 00
9. 00	00900 HOUSEKEEPI NG			9. 00
10. 00	01000 DI ETARY			10.00
11. 00	01100 CAFETERI A			11.00
	1 1			
13.00	01300 NURSI NG ADMI NI STRATI ON			13.00
	01400 CENTRAL SERVICES & SUPPLY			14. 00
	01500 PHARMACY			15. 00
	01600 MEDICAL RECORDS & LIBRARY			16. 00
17. 00	01700 SOCI AL SERVI CE			17. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV			22. 00
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000 ADULTS & PEDI ATRI CS	26, 752, 837		30.00
31.00	03100 INTENSIVE CARE UNIT	5, 886, 097		31.00
32.00	03200 CORONARY CARE UNIT	31, 201		32.00
	04100 SUBPROVI DER - I RF	7, 225, 314		41. 00
42. 00	04200 SUBPROVI DER	0		42. 00
43. 00		0		43. 00
43.00	04300 NURSERY	U		43.00
	ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	4, 686, 938		50.00
50. 01	05001 OUTPATI ENT SURGERY	2, 740, 917		50. 01
51. 00	05100 RECOVERY ROOM	995, 395		51.00
53.00	05300 ANESTHESI OLOGY	3, 772, 230		53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	5, 645, 539		54.00
54. 01	05401 RADI OLOGY-SPECI AL PROCEDURES	1, 107, 906		54. 01
55.00	05500 RADI OLOGY-THERAPEUTI C	30, 497		55. 00
56. 00	05600 RADI OI SOTOPE	1, 245, 628		56. 00
60.00	06000 LABORATORY	7, 315, 656		60.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.			63. 00
	1	192, 242		
65. 00	06500 RESPI RATORY THERAPY	3, 010, 579		65. 00
66. 00	06600 PHYSI CAL THERAPY	11, 301, 330		66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	985, 796		67. 00
68. 00	06800 SPEECH PATHOLOGY	561, 931		68. 00
69. 00	06900 ELECTROCARDI OLOGY	1, 668, 368		69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	606, 550		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	8, 147, 346		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	10, 001, 119		72.00
	07300 DRUGS CHARGED TO PATIENTS	10, 007, 712		73. 00
	03630 ULTRA SOUND	1, 069, 413		76. 00
	03951 PAIN CLINIC	1, 867, 057		76. 01
	03952 CATH LAB	3, 875, 276		76. 02
76. 02	03953 ACTIVITY THERAPEUTIC	4, 295, 983		76. 02
	1 1			
76. 04	03954 WOUND CARE CENTER	1, 016, 154		76. 04
76. 05	03340 BARI ATRI C CLI NI C	1, 073, 466		76. 05
	03030 HEALTHY LIVING CENTER	0		76. 06
76. 07	03950 CV RESOURCE CENTER	174, 353		76. 07
	03955 OTHER ANCILLARY SERVICE COST CENTERS	0		76. 08
76.09	03956 LACTATION CLINIC	0		76. 09
	03957 OTHER ANCILLARY SERVICE COST CENTERS	0		76. 10
76. 11	03958 OTHER ANCILLARY SERVICE COST CENTERS	o		76. 11
	03959 ANTI COAGULATI ON CLI NI C	778, 307		76. 12
	OUTPATIENT SERVICE COST CENTERS	, , 0, 001		1
91. 00	09100 EMERGENCY	8 517 621		91. 00
		8, 517, 621		
72. UU	09200 OBSERVATION BEDS (NON-DISTINCT PART			92. 00
	SPECIAL PURPOSE COST CENTERS			4
	11300 I NTEREST EXPENSE			113. 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	136, 586, 758		118. 00
	NONREI MBURSABLE COST CENTERS			
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	147, 742		190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	11, 063, 120		192. 00
	19201 WORKI NG WELL	137		192. 01
	07950 RESI DENTI AL	6, 383, 015		194. 00
	07951 OMNI	0, 303, 013		194. 00
	07952 PSYCHI ATRI C	2, 083, 221		194. 01
	07953 CENTER OF HOPE	6, 945		194. 03
200.00	, ,	0		200. 00
201.00		0		201. 00
202.00	TOTAL (sum lines 118 through 201)	156, 270, 938		202. 00

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2020 | Part II | To 12/31/2020 | Date/Time Prepared: | 12/31/2020 | Part II | Part II | Part II | Prepared: | 12/31/2020 | Part II | Part Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0090

				lo	12/31/2020	Date/lime Pre 7/29/2021 1:2	
			CAPI TAL REI	LATED COSTS		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	, p
	Coot Conton Decemintion	Di manti v	DIDC 0 FLVT	M/DLE FOLLID	Cubtatal	EMDL OVEE	
	Cost Center Description	Directly Assigned New	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS	
		Capi tal				DEPARTMENT	
		Related Costs					
	CENEDAL CEDIULCE COCT CENTEDO	0	1. 00	2. 00	2A	4. 00	
1. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	17, 334		36, 048	36, 048	4. 00
5. 04	00593 OTHER ADMINISTRATIVE AND GENERAL	0	313, 231		458, 179	8, 494	5. 04
6. 00 7. 00	00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT	0	633, 796 179, 735		723, 834 189, 237	337 594	6. 00 7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	l o	0		0	0	8. 00
9.00	00900 HOUSEKEEPI NG	0	48, 076	4, 408	52, 484	746	9. 00
10.00	01000 DI ETARY	0	42, 411		59, 452	258	10.00
11. 00 13. 00	01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON	0	61, 226 6, 477		61, 226 95, 314	269 868	11. 00 13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	l ő	54, 606		116, 587	116	14. 00
15. 00	01500 PHARMACY	0	30, 484		34, 752	1, 008	15. 00
16.00	01600 MEDI CAL RECORDS & LI BRARY	0	43, 589		43, 933	111	16.00
17. 00 22. 00	01700 SOCIAL SERVICE 02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	-	0	0 25	17. 00 22. 00
22.00	INPATIENT ROUTINE SERVICE COST CENTERS			0	<u> </u>	23	22.00
30.00	03000 ADULTS & PEDI ATRI CS	0	707, 611	346, 418	1, 054, 029	5, 591	30. 00
31.00	03100 NTENSI VE CARE UNI T	0	88, 596		289, 941	1, 120	31.00
32. 00 41. 00	03200 CORONARY CARE UNIT 04100 SUBPROVI DER - I RF	0	4, 755 52, 974		4, 755 70, 166	0 1, 513	32. 00 41. 00
42. 00	04200 SUBPROVI DER		32, 4/4		70, 100	1, 513	42.00
43.00	04300 NURSERY	0	0		0	0	43. 00
	ANCILLARY SERVICE COST CENTERS	1	4.47.000	T 505 445	7.0 500	700	
50. 00 50. 01	O5000 OPERATING ROOM O5001 OUTPATIENT SURGERY	0	147, 092 125, 637		742, 509 215, 166	708 478	50. 00 50. 01
51. 00	05100 RECOVERY ROOM		49, 521		92, 205	156	51.00
53.00	05300 ANESTHESI OLOGY	0	0		118, 862	19	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	209, 228		1, 137, 969	785	54.00
54. 01 55. 00	05401 RADI OLOGY-SPECI AL PROCEDURES 05500 RADI OLOGY-THERAPEUTI C	0	13, 756 892		235, 161 20, 708	206 0	54. 01 55. 00
56. 00	05600 RADI OLOGI - ITIERAF LUTT C		43, 990		149, 012	181	56.00
60.00	06000 LABORATORY	O	61, 627		66, 464	0	60.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	25, 256		25, 256	0	63. 00
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0	19, 091 12, 954		86, 776 39, 504	472 1, 634	65. 00 66. 00
67. 00	06700 OCCUPATI ONAL THERAPY		4, 960		4, 960	287	67.00
68. 00	06800 SPEECH PATHOLOGY	O	0	4, 843	4, 843	166	68. 00
69. 00	06900 ELECTROCARDI OLOGY	o	33, 972		63, 951	382	69. 00
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	46, 943 0	1	67, 648 0	65 0	70. 00 71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	- 1	0	0	71.00
	07300 DRUGS CHARGED TO PATIENTS	l o	0		Ö	0	73. 00
76. 00	03630 ULTRA SOUND	0	20, 421		144, 554	218	1
76. 01 76. 02	03951 PAIN CLINIC	0	109, 936		116, 965 621, 387	282	76. 01
76. 02	03952 CATH LAB 03953 ACTIVITY THERAPEUTIC		80, 630 50, 904		50, 904	590 1, 179	ł
76. 04	03954 WOUND CARE CENTER	O	56, 774		61, 780	164	ı
76. 05	03340 BARI ATRI C CLI NI C	o	17, 191	5, 400	22, 591	239	ł
76.06	03030 HEALTHY LIVING CENTER	0	0	_	0	0	76.06
76. 07 76. 08	03950 CV RESOURCE CENTER 03955 OTHER ANCILLARY SERVICE COST CENTERS		0	0	0	56 0	76. 07 76. 08
76. 09	03956 LACTATION CLINIC	O	0	Ö	Ö	0	76. 09
76. 10	03957 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76. 10
76. 11	03958 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76. 11
76. 12	03959 ANTI COAGULATI ON CLINI C OUTPATI ENT SERVI CE COST CENTERS] 0	3, 925	290	4, 215	217	76. 12
91. 00	09100 EMERGENCY	l ol	143, 470	177, 270	320, 740	2, 228	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART			,	0		92. 00
110 00	SPECIAL PURPOSE COST CENTERS						1112 00
113.00	11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117)	0	3, 563, 071	4, 140, 996	7, 704, 067	31, 762	113.00
1 10.00	NONREI MBURSABLE COST CENTERS	<u> </u>	3, 303, 071	7, 140, 770	7, 704, 007	31,702	1. 10. 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	7, 101		7, 204		190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	122, 193		136, 898		192.00
	19201 WORKI NG WELL 07950 RESI DENTI AL	0	0 270, 374	-	0 285, 839		192. 01 194. 00
	07950 RESIDENTIAL	0	270, 374	15, 405	200, 009		194. 00
	07952 PSYCHI ATRI C		236, 241	21, 661	257, 9 02		194. 02
		<u> </u>		<u> </u>			

Heal th Fina	ncial Systems	FRANCISCAN HE	FRANCISCAN HEALTH- DYER			In Lieu of Form CMS-2552-10			
ALLOCATI ON	OF CAPITAL RELATED COSTS				Peri od: Worksheet B				
					From 01/01/2020 To 12/31/2020		narad:		
					10 12/31/2020	7/29/2021 1: 2			
			CAPI TAL REI	_ATED COSTS					
	Cost Center Description	Di rectly	BLDG & FLXT	MVBLE EQUIP	Subtotal	EMPLOYEE			
		Assigned New				BENEFITS			
		Capi tal				DEPARTMENT			
		Rel ated Costs							
		0	1. 00	2.00	2A	4. 00			
194. 03 0795	3 CENTER OF HOPE	0	0		0	0	194. 03		
200. 00	Cross Foot Adjustments				0		200. 00		
201.00	Negative Cost Centers		0		0	0	201.00		
202. 00	TOTAL (sum lines 118 through 201)	0	4, 198, 980	4, 192, 93	0 8, 391, 910	36, 048	202. 00		

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2020 Part II
To 12/31/2020 Date/Time Prepared: 7/29/2021 1:27 pm

						7/29/2021 1: 2	
	Cost Center Description	OTHER	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
		ADMI NI STRATI VE AND GENERAL	REPAI RS	PLANT	LINEN SERVICE		
		5. 04	6. 00	7. 00	8. 00	9. 00	
	GENERAL SERVICE COST CENTERS			,	ı		
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2. 00 4. 00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2. 00 4. 00
5. 04	00593 OTHER ADMINISTRATIVE AND GENERAL	466, 673					5. 04
6. 00	00600 MAI NTENANCE & REPAI RS	12, 601	736, 772				6.00
7.00	00700 OPERATION OF PLANT	26, 256					7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	973		0	973		8. 00
9.00	00900 HOUSEKEEPI NG	8, 679				76, 905	
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	3, 527 2, 593			0	1, 085 1, 566	1
13. 00	01300 NURSING ADMINISTRATION	10, 200			0	1, 300	
14. 00	01400 CENTRAL SERVICES & SUPPLY	1, 268		1		1, 397	1
15. 00	01500 PHARMACY	12, 057	6, 943	2, 565	0	780	15. 00
16.00	01600 MEDI CAL RECORDS & LI BRARY	3, 913			0	1, 115	1
17. 00	01700 SOCIAL SERVICE	0	-	1	0	0	1
22. 00	02200 1 &R SERVICES-OTHER PRGM COSTS APPRV INPATIENT ROUTINE SERVICE COST CENTERS	2, 080		ıl U	0		22. 00
30. 00	03000 ADULTS & PEDIATRICS	59, 307	161, 177	59, 537	481	18, 098	30.00
31.00	03100 INTENSIVE CARE UNIT	13, 853					1
32.00	03200 CORONARY CARE UNIT	18	1, 083			122	32. 00
41. 00	04100 SUBPROVI DER – I RF	19, 265			197	1, 355	1
42. 00	04200 SUBPROVI DER	0	0	٦ ~	0		1
43. 00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	0) 0	0	0	43.00
50. 00	05000 OPERATING ROOM	10, 138	33, 504	12, 376	0	3, 762	50.00
50. 01	05001 OUTPATI ENT SURGERY	5, 497	28, 617		0		1
51.00	05100 RECOVERY ROOM	1, 991	11, 280	4, 167	0	1, 267	51.00
53. 00	05300 ANESTHESI OLOGY	10, 940		· -	0	0	
54.00	05400 RADI OLOGY - DI AGNOSTI C	12, 857			0	5, 351	1
54. 01 55. 00	05401 RADI OLOGY-SPECI AL PROCEDURES 05500 RADI OLOGY-THERAPEUTI C	2, 859 77	3, 133 203		0	352 23	1
56. 00	05600 RADI OI SOTOPE	2, 394			0		1
60.00	06000 LABORATORY	20, 306			0	1, 576	1
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	107					1
65. 00	06500 RESPI RATORY THERAPY	8, 418					1
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	33, 051			0	331 127	1
68. 00	06800 SPEECH PATHOLOGY	2, 778 1, 617		417	0	0	1
69. 00	06900 ELECTROCARDI OLOGY	4, 119		1	0	869	
70.00	07000 ELECTROENCEPHALOGRAPHY	1, 029	10, 693	3, 950	0	1, 201	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	23, 949		0	0	0	1
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	29, 624	0	0	0	0	
73. 00 76. 00	07300 DRUGS CHARGED TO PATIENTS 03630 ULTRA SOUND	17, 597 2, 764	4, 651	1, 718	0	0 522	
76. 00	03951 PAIN CLINIC	3, 396				2, 812	1
	03952 CATH LAB	8, 610					76. 02
76. 03	03953 ACTIVITY THERAPEUTIC	11, 721	11, 595	4, 283		1, 302	
76. 04	03954 WOUND CARE CENTER	1, 885			0	1, 452	
76. 05	03340 BARI ATRIC CLINIC	2, 876		1, 446	0	440	1
76. 06 76. 07	03030 HEALTHY LIVING CENTER 03950 CV RESOURCE CENTER	0 513	1		0	0	1
76. 07	03955 OTHER ANCILLARY SERVICE COST CENTERS	0			0	0	1
76. 09	03956 LACTATION CLINIC	0		o o	0	0	1
76. 10	03957 OTHER ANCILLARY SERVICE COST CENTERS	0	o	0	0	0	1
76. 11	03958 OTHER ANCILLARY SERVICE COST CENTERS	0	O	0	0	0	76. 11
76. 12	03959 ANTI COAGULATI ON CLI NI C	2, 213	894	330	0	100	76. 12
01 00	OUTPATIENT SERVICE COST CENTERS	22 211	22.470	12 071	0	3, 670	01 00
91. 00 92. 00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	22, 211	32, 679	12, 071	0	3,670	91. 00 92. 00
72.00	SPECIAL PURPOSE COST CENTERS			<u> </u>			72.00
113.00	11300 INTEREST EXPENSE						113. 00
118.00		422, 127	591, 926	203, 524	751	60, 641	118. 00
	NONREI MBURSABLE COST CENTERS		1		T	1	
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	324		1	0		190.00
	0 19200 PHYSICIANS' PRIVATE OFFICES 19201 WORKING WELL	28, 835	27, 833	10, 281	0		192. 00 192. 01
	07950 RESIDENTIAL	14, 413	61, 585	22, 748	0		194. 00
	07951 OMNI] 0] 0) 22,7.10	Ö		194. 01
194. 02	07952 PSYCHI ATRI C	953		19, 876	222		194. 02
	07953 CENTER OF HOPE	21	0	0	0	0	194. 03
200. 00 201. 00		0		0	_	_	200. 00 201. 00
201.00	Negative Cost Centers	1 0	<u> </u>	<u>′1</u>	1 0	1 0	1201.00

Health Financial Systems	FRANCISCAN HE	EALTH- DYER		In Lieu of Form CMS-2552-10			
ALLOCATION OF CAPITAL RELATED COSTS		Provider CO		Period: From 01/01/2020 Fo 12/31/2020	Worksheet B Part II Date/Time Pre 7/29/2021 1:2		
Cost Center Description	OTHER	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG		
	ADMI NI STRATI VE	REPAI RS	PLANT	LINEN SERVICE			
	AND GENERAL						
	5. 04	6. 00	7. 00	8. 00	9. 00		
202.00 TOTAL (sum lines 118 through 201)	466, 673	736, 772	257, 02	973	76, 905	202. 00	

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2020 | Part II | To 12/31/2020 | Date/Time Prepared: | 12/31/2020 | Part II | Part II | Part II | Prepared: | 12/31/2020 | Part II | Part

			10) 12/31/2020	Date/lime Pre 7/29/2021 1:2	
Cost Center Description	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES &	PHARMACY	
	10.00	11. 00	13. 00	SUPPLY 14. 00	15. 00	
GENERAL SERVICE COST CENTERS	10.00	11.00	13.00	14.00	15.00	
1.00 O0100 CAP REL COSTS-BLDG & FLXT						1. 00
2. 00 00200 CAP REL COSTS-MVBLE EQUI P						2. 00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 04 00593 OTHER ADMINISTRATIVE AND GENERAL 6. 00 00600 MAINTENANCE & REPAIRS						5. 04 6. 00
7.00 00700 OPERATION OF PLANT						7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00 00900 HOUSEKEEPI NG						9. 00
10. 00 01000 DI ETARY	77, 550					10.00
11. 00 01100 CAFETERI A 13. 00 01300 NURSI NG ADMINI STRATI ON	0	84, 751	111, 119			11.00
14. 00 01400 CENTRAL SERVICES & SUPPLY		2, 551 676		137, 076		13. 00 14. 00
15. 00 01500 PHARMACY	o	2, 655	Ö	172	60, 932	15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	o	413	0	0	0	16. 00
17. 00 01700 SOCIAL SERVICE	0	0	0	0	0	17. 00
22. 00 02200 I &R SERVI CES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	55, 301	17, 152	46, 050	7, 426	79	30. 00
31. 00 03100 I NTENSI VE CARE UNI T	8, 447	3, 745		2, 920	323	31. 00
32. 00 03200 CORONARY CARE UNIT	0	0	0	0	0	32. 00
41. 00 04100 SUBPROVI DER - I RF	0	6, 158	8, 322	1, 551	33	41.00
42. 00 04200 SUBPROVI DER	0	0	0	0	0	42.00
43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	0	<u> </u>	U	0	43. 00
50. 00 05000 OPERATING ROOM	0	2, 388	323	57, 624	0	50. 00
50. 01 05001 OUTPATI ENT SURGERY	0	1, 444		4, 106	64	50. 01
51.00 05100 RECOVERY ROOM	0	340		74	0	51.00
53. 00 05300 ANESTHESI OLOGY	0	126		1, 590	533	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 54. 01 05401 RADI OLOGY-SPECI AL PROCEDURES	0	3, 178 635	11 1, 182	1, 620 2, 543	51 2	54. 00 54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C		033	1, 182	2, 543	0	55. 00
56. 00 05600 RADI 0I SOTOPE	o	465	Ö	35	2, 423	56. 00
60. 00 06000 LABORATORY	0	0	0	7	0	60.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	3, 000	0	63. 00
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	0	2, 101 4, 439	0	1, 676	19 0	65. 00 66. 00
67. 00 06700 OCCUPATI ONAL THERAPY		803	0	186 69	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	o	405	Ö	898	1	68. 00
69. 00 06900 ELECTROCARDI OLOGY	o	1, 184	1, 223	134	24	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	208	0	65	0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 72.00 07200 MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	71. 00 72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS		0	0	0	57, 100	72.00
76. 00 03630 ULTRA SOUND	o	525	11	258	07, 100	76. 00
76. 01 03951 PAIN CLINIC	o	795		615	0	76. 01
76. 02 03952 CATH LAB	0	1, 758		44, 296	0	76. 02
76. 03 03953 ACTI VI TY THERAPEUTI C	0	4, 316		1 275	0 174	76. 03
76. 04 03954 WOUND CARE CENTER 76. 05 03340 BARIATRIC CLINIC		578 792		1, 375 38	23	76. 04 76. 05
76. 06 03030 HEALTHY LIVING CENTER	o	0	o o	0	0	76. 06
76. 07 03950 CV RESOURCE CENTER	O	123	0	0	0	76. 07
76.08 03955 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76. 08
76. 09 03956 LACTATION CLINIC	0	0	0	0	0	76. 09
76. 10 03957 OTHER ANCILLARY SERVICE COST CENTERS 76. 11 03958 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76. 10 76. 11
76. 12 03959 ANTI COAGULATION CLINIC		591		300	0	76. 11
OUTPATIENT SERVICE COST CENTERS	-					
91. 00 09100 EMERGENCY	0	6, 167	121	4, 490	83	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE				T		113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	63, 748	66, 711	87, 762	137, 076	60, 932	
NONREI MBURSABLE COST CENTERS	00,710	00,711	07,702	107, 070	00, 702	110.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	75	0	0		190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	5, 458	20, 188	0	0	192. 00
192. 01 19201 WORKI NG WELL		0	0	0		192. 01 194. 00
194. 00 07950 RESI DENTI AL 194. 01 07951 OMNI		6, 830 0		0		194. 00
194. 02 07952 PSYCHI ATRI C	13, 802	5, 677	3, 169	ol		194. 01
194. 03 07953 CENTER OF HOPE	O	0	0	ō		194. 03
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	0	0	0	0	201. 00

Health Financial Systems	FRANCISCAN HEALTH- DYER			In Lieu of Form CMS-2552-10			
ALLOCATION OF CAPITAL RELATED COSTS		Provider Co		Period: From 01/01/2020 To 12/31/2020	Worksheet B Part II Date/Time Pre 7/29/2021 1:2		
Cost Center Description	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI OI		PHARMACY		
	10.00	11. 00	13.00	SUPPLY 14, 00	15. 00		
202.00 TOTAL (sum lines 118 through 201)	77, 550					202. 00	

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2020 | Part II | To 12/31/2020 | Date/Time Prepared: | 12/31/2020 | Part II | Part II | Part II | Prepared: | 12/31/2020 | Part II | Part Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0090

				10	12/31/2020	Date/lime Pre 7/29/2021 1:2	
	Cost Center Description	MEDI CAL RECORDS & LI BRARY		INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	, p
	OSUSSAL OSSULOS COOT OSUTEDO	16. 00	17. 00	22. 00	24. 00	25. 00	
1 00	GENERAL SERVICE COST CENTERS						1 00
1. 00 2. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1. 00 2. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 04	00593 OTHER ADMINISTRATIVE AND GENERAL						5. 04
6. 00	00600 MAI NTENANCE & REPAI RS						6. 00
7. 00	00700 OPERATION OF PLANT						7. 00
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
9.00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY						10.00
11. 00	01100 CAFETERI A						11. 00
13. 00	01300 NURSING ADMINISTRATION						13. 00
14.00	01400 CENTRAL SERVI CES & SUPPLY						14. 00
15. 00	01500 PHARMACY	(2.001					15.00
16. 00 17. 00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	63, 081 0	o				16. 00 17. 00
	02200 I &R SERVI CES-OTHER PRGM COSTS APPRV	0		1			22. 00
22.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0		2, 103		1	22.00
30. 00	03000 ADULTS & PEDIATRICS	5, 975	0		1, 490, 203	0	30. 00
31.00	03100 INTENSIVE CARE UNIT	1, 434	l c		366, 036	1	31.00
32.00	03200 CORONARY CARE UNIT	0	0		6, 378	0	32. 00
41.00	04100 SUBPROVI DER - I RF	1, 500	O		126, 583	0	41. 00
42.00	04200 SUBPROVI DER	0	0		0		42.00
43. 00	04300 NURSERY	0	0		0	0	43. 00
F0 00	ANCILLARY SERVICE COST CENTERS	F 000			0/0 000		F0 00
50. 00 50. 01	05000 OPERATI NG ROOM 05001 OUTPATI ENT SURGERY	5, 900 925			869, 232 274, 970	1	50. 00 50. 01
51. 00	05100 RECOVERY ROOM	597		1	113, 416	1	51. 00
53. 00	05300 ANESTHESI OLOGY	1, 817			133, 887		53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	6, 111			1, 233, 194	1	54. 00
54. 01	05401 RADI OLOGY-SPECI AL PROCEDURES	533	C		247, 763	1	54. 01
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0		21, 086	0	55. 00
56.00	05600 RADI OI SOTOPE	1, 235	0		170, 591	1	56. 00
60.00	06000 LABORATORY	6, 387	0		113, 962	1	60. 00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	250	0		37, 137	1	63. 00
65. 00	06500 RESPI RATORY THERAPY	1, 521	0		107, 426	1	65. 00
66. 00 67. 00	O6600 PHYSI CAL THERAPY O6700 OCCUPATI ONAL THERAPY	2, 061 533			85, 247 11, 104	1	66. 00 67. 00
68. 00	06800 SPEECH PATHOLOGY	298			8, 228	1	68. 00
69. 00	06900 ELECTROCARDI OLOGY	1, 809	ł .		84, 291	1	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	303	Ö		85, 162	l e	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	3, 702	0		27, 651	0	71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	1, 451	0		31, 075	0	72. 00
	07300 DRUGS CHARGED TO PATIENTS	4, 055			78, 752		73. 00
76. 00	03630 ULTRA SOUND	893			156, 114		76. 00
76. 01	03951 PAIN CLINIC	1, 115	0)	163, 379	1	76. 01
76. 02 76. 03	03952 CATH LAB	5, 077			714, 190		76. 02 76. 03
76. 03 76. 04	03953 ACTIVITY THERAPEUTIC 03954 WOUND CARE CENTER	654 245			86, 130 86, 837		76. 03 76. 04
76. 05	03340 BARI ATRI C CLI NI C	65			32, 426		76. 05
76. 06	03030 HEALTHY LIVING CENTER	0			02, 120	1	76.06
76. 07	03950 CV RESOURCE CENTER	0	C		692	0	76. 07
76. 08	03955 OTHER ANCILLARY SERVICE COST CENTERS	0	O		0	0	76. 08
76. 09	03956 LACTATION CLINIC	0	0		0	0	76. 09
	03957 OTHER ANCILLARY SERVICE COST CENTERS	0	0		0	0	76. 10
76. 11	03958 OTHER ANCILLARY SERVICE COST CENTERS	0	0	1	0	0	76. 11
76. 12	03959 ANTI COAGULATI ON CLINI C	122	0)[8, 982	! 0	76. 12
01 00	OUTPATIENT SERVICE COST CENTERS	4 512	0	1	410 072	0	01 00
	O9100 EMERGENCY O9200 OBSERVATION BEDS (NON-DISTINCT PART	6, 513		'	410, 973	0	91. 00 92. 00
72.00	SPECIAL PURPOSE COST CENTERS						72.00
113.00	11300 I NTEREST EXPENSE						113. 00
118.00	1	63, 081	O	O	7, 383, 097		118. 00
	NONREI MBURSABLE COST CENTERS				·		
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	1	10, 012		190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0		235, 672		192. 00
	19201 WORKI NG WELL	0	0]	200 550		192. 01
	07950 RESI DENTI AL 07951 OMNI	0			399, 550		194. 00 194. 01
174. U I	O7701 OWNVI	1 0	1	1	0	'I U	1174. 01

Health Financial Systems	FRANCISCAN HEALTH- DYER			In Lieu of Form CMS-2552-10		
ALLOCATION OF CAPITAL RELATED COSTS		Provi der C		Peri od:	Worksheet B	
				From 01/01/2020 To 12/31/2020		narad.
				10 12/31/2020	7/29/2021 1: 2	
			INTERNS &			
			RESI DENTS			
Cost Center Description	MEDI CAL	SOCIAL SERVICE	SERVI CES-OTHE	R Subtotal	Intern &	
	RECORDS &		PRGM COSTS		Residents Cost	
	LI BRARY		APPRV		& Post	
					Stepdown	
					Adjustments	
	16. 00	17. 00	22. 00	24. 00	25. 00	
194. 02 07952 PSYCHI ATRI C	C	0)	361, 453	0	194. 02
194.03 07953 CENTER OF HOPE	C) c		21	0	194. 03
200.00 Cross Foot Adjustments			2, 10	5 2, 105	0	200. 00
201.00 Negative Cost Centers	C) c		0	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	63, 081	c	2, 10	5 8, 391, 910	0	202. 00

In Lieu of Form CMS-2552-10

| Period: | Worksheet B | From 01/01/2020 | Part II |
| To | 12/31/2020 | Date/Time Prepared: | 7/29/2021 | 1:27 pm | Provider CCN: 15-0090

			7/29/2021 1:27	
	Cost Center Description	Total		•
	DENIEDAL OFFICIAL OFFICE OFFICE OF OFFICE OF	26. 00		
	GENERAL SERVICE COST CENTERS			1 00
1	DO100 CAP REL COSTS-BLDG & FLXT DO200 CAP REL COSTS-MVBLE EQUIP			1. 00 2. 00
1	00400 EMPLOYEE BENEFITS DEPARTMENT			4. 00
1	00593 OTHER ADMINISTRATIVE AND GENERAL			5. 04
1	00600 MAINTENANCE & REPAIRS			6. 00
7.00	00700 OPERATION OF PLANT			7.00
8.00	DO800 LAUNDRY & LINEN SERVICE			8.00
1	00900 HOUSEKEEPI NG			9. 00
1	D1000 DI ETARY			10.00
1	01100 CAFETERI A			11.00
	D1300 NURSING ADMINISTRATION D1400 CENTRAL SERVICES & SUPPLY			13. 00 14. 00
1	D1500 PHARMACY			15. 00
1	01600 MEDICAL RECORDS & LIBRARY			16. 00
1	01700 SOCI AL SERVI CE			17. 00
22. 00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV			22.00
I	NPATIENT ROUTINE SERVICE COST CENTERS			
1	03000 ADULTS & PEDIATRICS	1, 490, 203		30.00
	D3100 NTENSI VE CARE UNI T	366, 036		31.00
	03200 CORONARY CARE UNIT	6, 378		32. 00
	D4100 SUBPROVI DER - I RF D4200 SUBPROVI DER	126, 583 0		41. 00 42. 00
	04300 NURSERY	0		43. 00
H-	ANCI LLARY SERVI CE COST CENTERS	<u> </u>		43.00
	D5000 OPERATI NG ROOM	869, 232		50.00
	05001 OUTPATIENT SURGERY	274, 970		50. 01
51.00	D5100 RECOVERY ROOM	113, 416		51.00
	D5300 ANESTHESI OLOGY	133, 887		53.00
1	D5400 RADI OLOGY-DI AGNOSTI C	1, 233, 194		54.00
1	05401 RADI OLOGY-SPECI AL PROCEDURES	247, 763		54. 01
1	D5500 RADI OLOGY-THERAPEUTI C	21, 086		55.00
	D5600 RADI OI SOTOPE D6000 LABORATORY	170, 591 113, 962		56. 00 60. 00
1	D6300 BLOOD STORING, PROCESSING & TRANS.	37, 137		63.00
1	06500 RESPIRATORY THERAPY	107, 426		65. 00
1	06600 PHYSI CAL THERAPY	85, 247		66. 00
67. 00	06700 OCCUPATIONAL THERAPY	11, 104		67.00
68.00	D6800 SPEECH PATHOLOGY	8, 228		68. 00
1	D6900 ELECTROCARDI OLOGY	84, 291		69. 00
1	07000 ELECTROENCEPHALOGRAPHY	85, 162		70.00
	D7100 MEDICAL SUPPLIES CHARGED TO PATIENT D7200 IMPL. DEV. CHARGED TO PATIENTS	27, 651		71. 00 72. 00
	D7300 DRUGS CHARGED TO PATIENTS	31, 075 78, 752		73.00
1	D3630 ULTRA SOUND	156, 114		76.00
	D3951 PAIN CLINIC	163, 379		76. 01
	03952 CATH LAB	714, 190		76. 02
	D3953 ACTIVITY THERAPEUTIC	86, 130		76. 03
76. 04	03954 WOUND CARE CENTER	86, 837		76. 04
	D3340 BARI ATRI C CLI NI C	32, 426		76. 05
	03030 HEALTHY LIVING CENTER	0		76.06
	03950 CV RESOURCE CENTER	692 0		76. 07 76. 08
	D3955 OTHER ANCILLARY SERVICE COST CENTERS D3956 LACTATION CLINIC	0		76. 08 76. 09
	03957 OTHER ANCILLARY SERVICE COST CENTERS	0		76. 10
	03958 OTHER ANCILLARY SERVICE COST CENTERS	o		76. 11
	D3959 ANTICOAGULATION CLINIC	8, 982		76. 12
C	OUTPATIENT SERVICE COST CENTERS			
	09100 EMERGENCY	410, 973		91. 00
<u> </u>	09200 OBSERVATION BEDS (NON-DISTINCT PART			92. 00
	SPECIAL PURPOSE COST CENTERS			110 00
1	11300 INTEREST EXPENSE	7 202 007		113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	7, 383, 097		118. 00
-	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	10, 012		190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	235, 672		190.00
	19201 WORKI NG WELL	0		192. 01
	07950 RESI DENTI AL	399, 550		194. 00
194. 01 (07951 OMNI	0		194. 01
	D7952 PSYCHI ATRI C	361, 453		194. 02
	07953 CENTER OF HOPE	21		194. 03
200.00	Cross Foot Adjustments	2, 105		200.00
201.00	Negative Cost Centers	0 201 010		201. 00
202. 00	TOTAL (sum lines 118 through 201)	8, 391, 910		202. 00

Health Financial Systems In Lieu of Form CMS-2552-10 COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0090 Peri od: Worksheet B-1 From 01/01/2020 12/31/2020 Date/Time Prepared: 7/29/2021 1:27 pm CAPITAL RELATED COSTS Cost Center Description BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Reconciliation OTHER (SQUARE FEET) (DOLLAR VALUE) ADMI NI STRATI VE BENEFITS DEPARTMENT AND GENERAL (GROSS (ACCUM. COST) SALARI ES) 1.00 2.00 5A. 04 5. 04 4.00 GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 470 676 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 3, 691, 967 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 1,943 16, 478 68, 080, 897 4.00 00593 OTHER ADMINISTRATIVE AND GENERAL 15, 996, 020 5 04 127, 630 -30, 752, 730 126 217 976 5 04 35.111 6.00 00600 MAINTENANCE & REPAIRS 71,044 79, 280 637, 390 3, 408, 465 6.00 7.00 00700 OPERATION OF PLANT 20, 147 8, 367 1, 123, 183 7, 101, 917 7.00 00800 LAUNDRY & LINEN SERVICE 0 263, 077 8.00 8.00 0 00900 HOUSEKEEPI NG 1, 409, 917 9 00 5.389 3.881 2.347.471 9 00 10.00 01000 DI ETARY 4,754 15,005 487, 086 0 954, 133 10.00 01100 CAFETERI A 701, 337 11.00 6,863 508, 178 0 0 0 0 11.00 01300 NURSING ADMINISTRATION 78, 223 1, 640, 926 2, 758, 965 13.00 726 13.00 01400 CENTRAL SERVICES & SUPPLY 219, 117 14.00 6, 121 54, 576 342, 955 14 00 15.00 01500 PHARMACY 3, 417 3, 758 1, 905, 293 3, 261, 239 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 4,886 303 210, 559 1, 058, 358 16.00 0 01700 SOCIAL SERVICE 17.00 17.00 0 C 0 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 22.00 Ω 47, 176 0 562, 674 22.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 79, 318 305, 029 10, 568, 318 0 16, 029, 992 30.00 03100 INTENSIVE CARE UNIT 3, 747, 202 31.00 9,931 177, 289 0 31.00 2, 117, 932 0 32.00 03200 CORONARY CARE UNIT 533 C 4, 755 32.00 04100 SUBPROVIDER - IRF 5, 938 0 5, 210, 925 41.00 41.00 15, 138 2, 861, 057 0 42.00 04200 SUBPROVI DER 42.00 0 04300 NURSERY 0 0 43.00 43.00 0 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 16. 488 524, 278 1, 337, 906 2, 742, 091 50.00 o 50.01 05001 OUTPATIENT SURGERY 14,083 78.832 903.128 1, 486, 962 50.01 37, 584 0 51.00 05100 RECOVERY ROOM 5, 551 295, 210 538, 678 51.00 05300 ANESTHESI OLOGY 104, 661 2, 959, 098 53.00 36, 817 0 0 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 23, 453 817, 778 1, 483, 035 3, 477, 737 54.00 05401 RADI OLOGY-SPECI AL PROCEDURES 194 952 54 01 1,542 388, 650 773, 367 54 01 55.00 05500 RADI OLOGY-THERAPEUTI C 100 17, 448 20, 708 55.00 05600 RADI OI SOTOPE 56, 00 4.931 92, 474 341, 508 647, 522 56.00 06000 LABORATORY 6, 908 5, 492, 498 60.00 4, 259 60.00 0 06300 BLOOD STORING, PROCESSING & TRANS. 2, 831 28, 854 63.00 Ω 63.00 65.00 06500 RESPIRATORY THERAPY 2, 140 59, 598 891, 681 2, 276, 959 65.00 66.00 06600 PHYSI CAL THERAPY 1, 452 23, 378 3, 089, 274 8, 939, 835 66.00 541, 851 67 00 06700 OCCUPATIONAL THERAPY 556 751, 494 67 00 06800 SPEECH PATHOLOGY 68.00 4, 264 313, 746 437, 470 68.00 69.00 06900 ELECTROCARDI OLOGY 3,808 26, 397 721, 476 1, 114, 072 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 5, 262 18, 231 123, 477 278, 348 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 6, 477, 934 71 00 71 00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 8,013,060 72.00 07300 DRUGS CHARGED TO PATIENTS 0 4, 759, 714 73.00 76.00 03630 ULTRA SOUND 2, 289 109, 302 412, 304 747, 567 76, 00 76.01 03951 PAIN CLINIC 12, 323 6, 189 533, 347 918, 713 76 01 76.02 03952 CATH LAB 9,038 476, 148 1, 114, 488 2, 328, 802 76.02 03953 ACTIVITY THERAPEUTIC 2, 229, 031 76.03 5,706 3, 170, 383 76.03 03954 WOUND CARE CENTER 6, 364 4, 408 310, 155 76.04 509.877 76.04 03340 BARLATRIC CLINIC 76.05 1.927 4, 755 451, 743 777, 908 76.05 03030 HEALTHY LIVING CENTER 76.06 76.06 03950 CV RESOURCE CENTER 0 76.07 0 Ω 106, 102 138, 796 76.07 0 03955 OTHER ANCILLARY SERVICE COST CENTERS 0 76 08 C 0 0 76.08 76.09 03956 LACTATION CLINIC 0 0 0 0 76.09 03957 OTHER ANCILLARY SERVICE COST CENTERS 0 76.10 0 0 76.10 03958 OTHER ANCILLARY SERVICE COST CENTERS 76.11 0 76. 11 0 0 03959 ANTI COAGULATION CLINIC 440 255 409, 925 598, 639 76.12 76.12 OUTPATIENT SERVICE COST CENTERS 91 00 09100 EMERGENCY 16,082 156,090 4, 211, 468 6,007,950 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | INTEREST EXPENSE 113.00 -30, 752, 730 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 399, 395 3, 646, 238 59, 978, 474 114, 168, 501 118. 00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 796 Q1 22, 186 87, 580 190. 00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 13,697 12, 948 5, 773, 448 0 7, 799, 607 192. 00 192. 01 19201 WORKING WELL 0 110 192. 01

30, 307

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2, 306, 789

13, 617

3, 898, 692 194. 00

0 194. 01

194. 01 07951 OMNI

194. 00 07950 RESI DENTI AL

Health Financial Systems	FRANCISCAN HEALTH- DYER	In Lieu of Form CMS-2552-10		
COST ALLOCATION - STATISTICAL BASIS	Provi der CCN: 15-0090	Peri od: From 01/01/2020 To 12/31/2020 Date/Time Prepared: 7/29/2021 1:27 pm		

				''	0 12/31/2020	7/29/2021 1: 2	
		CAPITAL REI	LATED COSTS				
	Cost Center Description	BLDG & FLXT	MVBLE EQUIP	 EMPLOYEE	Reconciliation	OTHER	
	oost conten beschiptron		(DOLLAR VALUE)	BENEFITS		ADMI NI STRATI VE	
		,	,	DEPARTMENT		AND GENERAL	
				(GROSS		(ACCUM. COST)	
		1.00		SALARI ES)	54.04		
101 00 0705	DOVOU ATRAO	1.00	2.00	4. 00	5A. 04	5. 04	101.00
	PSYCHI ATRI C	26, 481	19, 073	0	0	257, 902	
	CENTER OF HOPE	0	0	0	0		194. 03
200. 00	Cross Foot Adjustments					l	200. 00
201. 00	Negative Cost Centers					1	201. 00
202. 00	Cost to be allocated (per Wkst. B, Part I)	4, 198, 980	4, 192, 930	2, 753, 978		30, 752, 730	202. 00
203. 00	Unit cost multiplier (Wkst. B, Part I)	8. 921169	1. 135690	0. 040452		0. 243648	203. 00
204. 00	Cost to be allocated (per Wkst. B, Part II)			36, 048		466, 673	204. 00
205. 00	Unit cost multiplier (Wkst. B, Part			0. 000529		0. 003697	205. 00
206. 00	NAHE adjustment amount to be allocated						206. 00
207. 00	(per Wkst. B-2) NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0090

Peri od: Worksheet B-1 From 01/01/2020 To 12/31/2020 Date/Ti me Prepared:

7/29/2021 1:27 pm Cost Center Description MAINTENANCE & OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY LINEN SERVICE (PATIENT ME REPAI RS PLANT (SQUARE FEET) (SQUARE FEET) (SQUARE FEET) (POUNDS OF ALS) LAUNDRY) 10.00 6.00 7.00 9.00 8.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4 00 5.04 00593 OTHER ADMINISTRATIVE AND GENERAL 5.04 00600 MAINTENANCE & REPAIRS 6.00 362, 578 6.00 00700 OPERATION OF PLANT 342, 431 7.00 7.00 20, 147 00800 LAUNDRY & LINEN SERVICE 8.00 462, 150 8.00 5, 389 5, 389 9.00 00900 HOUSEKEEPI NG C 337.042 9.00 01000 DI ETARY 4,754 4, 754 4, 754 195, 046 10.00 10.00 0 6, 863 6, 863 01100 CAFETERI A 0 11.00 6, 863 Λ 11.00 01300 NURSING ADMINISTRATION 13.00 726 726 0 726 0 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 6, 121 6, 121 6, 121 0 14.00 01500 PHARMACY 0 15.00 3.417 3, 417 3.417 15.00 0 01600 MEDICAL RECORDS & LIBRARY 0 16.00 4,886 4, 886 4,886 0 16.00 17.00 01700 SOCIAL SERVICE 0 0 17.00 02200 | &R SERVICES-OTHER PRGM COSTS APPRV 22.00 0 22.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 79, 318 79, 318 228, 156 79, 318 139, 089 30.00 03100 INTENSIVE CARE UNIT 9, 931 9, 931 34, 848 9, 931 21, 244 31.00 31.00 32.00 03200 CORONARY CARE UNIT 533 533 533 32.00 0 04100 SUBPROVI DER - I RF 41.00 5 938 5, 938 93, 661 5 938 41 00 0 42.00 04200 SUBPROVI DER 0 C C 0 0 42.00 04300 NURSERY 43.00 0 0 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 16, 488 16, 488 16, 488 0 50.00 05001 OUTPATIENT SURGERY 14,083 14, 083 0 14, 083 0 50.01 50.01 05100 RECOVERY ROOM 0 51.00 5, 551 5, 551 5, 551 0 51.00 0 05300 ANESTHESI OLOGY 53 00 53 00 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 23.453 23, 453 23, 453 0 54.00 05401 RADI OLOGY-SPECI AL PROCEDURES 0 54.01 54.01 1,542 1, 542 1,542 0 05500 RADI OLOGY-THERAPEUTI C 55.00 100 100 0 100 0 55.00 0 05600 RADI OI SOTOPE 4.931 4, 931 4.931 56.00 0 56.00 0 60.00 06000 LABORATORY 6,908 6, 908 6,908 0 60.00 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 2,831 2,831 2,831 63.00 65.00 06500 RESPIRATORY THERAPY 2, 140 2, 140 0 2.140 0 65.00 0 06600 PHYSI CAL THERAPY 66.00 1.452 1, 452 1.452 0 66.00 67.00 06700 OCCUPATIONAL THERAPY 556 556 0 67.00 556 68.00 06800 SPEECH PATHOLOGY 0 0 68.00 06900 ELECTROCARDI OLOGY 0 3.808 3.808 69.00 69.00 3.808 0 07000 ELECTROENCEPHALOGRAPHY 70.00 5.262 5, 262 5, 262 0 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 0 0 0 73.00 76.00 03630 ULTRA SOUND 2, 289 2, 289 2, 289 0 76.00 76.01 03951 PAIN CLINIC 12, 323 12, 323 12, 323 0 76.01 0 03952 CATH LAB 9,038 9, 038 9, 038 76.02 76.02 0 03953 ACTIVITY THERAPEUTIC 0 76.03 5,706 5, 706 5, 706 0 76.03 03954 WOUND CARE CENTER 6, 364 6, 364 6, 364 76.04 76.04 0 0 76.05 03340 BARLATRIC CLINIC 1, 927 1, 927 1, 927 0 76.05 0 03030 HEALTHY LIVING CENTER 76.06 0 0 0 76.06 76.07 03950 CV RESOURCE CENTER 0 C 0 0 76.07 76.08 03955 OTHER ANCILLARY SERVICE COST CENTERS 0 0 0 0 0 76.08 0 0 0 76.09 03956 LACTATION CLINIC 76.09 C 0 03957 OTHER ANCILLARY SERVICE COST CENTERS 0 76.10 0 C 0 0 76.10 03958 OTHER ANCILLARY SERVICE COST CENTERS 76. 11 0 0 0 0 76.11 03959 ANTICOAGULATION CLINIC 76.12 440 440 0 440 0 76.12 OUTPATIENT SERVICE COST CENTERS 91.00 91.00 09100 EMERGENCY 16,082 16, 082 0 16,082 0 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | NTEREST EXPENSE 113 00 SUBTOTALS (SUM OF LINES 1 through 117) 118.00 291, 297 271, 150 356, 665 265, 761 160, 333 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 796 796 796 0 190. 00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 192.00 13, 697 13, 697 13, 697 192. 01 19201 WORKING WELL 0 0 192. 01 194. 00 07950 RESI DENTI AL 30, 307 0 194.00 30, 307 0 30, 307 194. 01 07951 OMNI 0 0 194. 01 194. 02 07952 PSYCHI ATRI C 34, 713 194. 02 105, 485 26, 481 26, 481 26, 481 194.03 07953 CENTER OF HOPE 0 194. 03 200.00 Cross Foot Adjustments 200.00

Health Financial Systems	FRANCISCAN HEALTH- DYER In Lie				u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der C		Period: From 01/01/2020	Worksheet B-1	
			-	Го 12/31/2020	Date/Time Prep 7/29/2021 1:2	
Cost Center Description	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	REPAI RS	PLANT	LINEN SERVICE	(SQUARE FEET)	(PATIENT ME	

				'	0 12/31/2020	7/29/2021 1:2	
	Cost Center Description	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		REPAI RS	PLANT	LINEN SERVICE	(SQUARE FEET)	(PATIENT ME	
		(SQUARE FEET)	(SQUARE FEET)	(POUNDS OF		ALS)	
				LAUNDRY)			
		6.00	7. 00	8. 00	9. 00	10.00	
201.00	Negative Cost Centers						201. 00
202.00	Cost to be allocated (per Wkst. B,	4, 238, 931	9, 067, 825	327, 175	3, 125, 136	1, 412, 154	202. 00
	Part I)						
203.00	Unit cost multiplier (Wkst. B, Part I)	11. 691087	26. 480736	0. 707941	9. 272245	7. 240107	203. 00
204.00	Cost to be allocated (per Wkst. B,	736, 772	257, 026	973	76, 905	77, 550	204. 00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part	2. 032037	0. 750592	0. 002105	0. 228176	0. 397599	205. 00
	[11]						
206.00	NAHE adjustment amount to be allocated						206. 00
	(per Wkst. B-2)						
207. 00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)						

In Lieu of Form CMS-2552-10 Health Financial Systems FRANCISCAN HEALTH- DYER COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0090 Peri od: Worksheet B-1 From 01/01/2020 12/31/2020 Date/Time Prepared: 7/29/2021 1:27 pm Cost Center Description CAFETERI A NURSI NG CENTRAL PHARMACY MEDI CAL SERVICES & (HOURS WORK ADMI NI STRATI ON (COSTED REQ RECORDS & ED) **SUPPLY** UISI) LI BRARY (DIRECT NRS (COSTED (GROSS CHAR ING) REQUIS.) GES) 11.00 13.00 14.00 15.00 16.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00593 OTHER ADMINISTRATIVE AND GENERAL 5.04 5. 04 00600 MAINTENANCE & REPAIRS 6.00 6.00 00700 OPERATION OF PLANT 7.00 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10 00 10 00 11.00 01100 CAFETERI A 57,815 11.00 1, 740 13.00 01300 NURSING ADMINISTRATION 362, 575 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 461 14, 305, 984 14.00 17, 953 01500 PHARMACY 4, 759, 038 15 00 15 00 1 811 Ω 16.00 01600 MEDICAL RECORDS & LIBRARY 282 C C 513, 555, 260 16.00 0 01700 SOCIAL SERVICE 17.00 0 0 0 0 17.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 22 00 22 00 0 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 11, 703 150, 258 775, 012 6, 159 48, 578, 093 30.00 03100 INTENSIVE CARE UNIT 46, 595 31.00 25, 235 11, 655, 087 31.00 2,555 304, 698 03200 CORONARY CARE UNIT 32 00 C 0 32 00 41.00 04100 SUBPROVI DER - I RF 4, 201 27, 155 161,839 2,597 12, 191, 671 41.00 04200 SUBPROVI DER 42.00 42.00 43.00 04300 NURSERY 0 0 0 0 43.00 0 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 1,629 1, 053 6, 014, 221 47, 969, 538 50.00 05001 OUTPATIENT SURGERY 7, 518, 975 50.01 985 15, 954 428, 548 5.035 50.01 05100 RECOVERY ROOM 4, 370 4, 853, 072 51.00 232 7.740 19 51.00 165, 968 05300 ANESTHESI OLOGY 14, 774, 998 53.00 86 41, 632 53.00 05400 RADI OLOGY-DI AGNOSTI C 2, 168 35 169, 056 4,003 49, 679, 988 54.00 54.00 05401 RADI OLOGY-SPECI AL PROCEDURES 54.01 433 3,856 265, 344 177 4, 331, 908 54.01 05500 RADI OLOGY-THERAPEUTI C 55.00 C 55.00 C 0 10, 042, 834 56.00 05600 RADI OI SOTOPE 317 C 3.699 189, 233 56 00 06000 LABORATORY 51, 929, 817 60.00 739 60.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. C 313, 082 2, 030, 689 63.00 06500 RESPIRATORY THERAPY 1, 474 65.00 1.433 174.947 12, 366, 641 C 65, 00 66.00 06600 PHYSI CAL THERAPY 3.028 C 19, 384 22 16, 753, 017 66.00 67.00 06700 OCCUPATIONAL THERAPY 548 0 7, 225 4, 329, 991 67.00 06800 SPEECH PATHOLOGY 93, 687 2, 424, 017 68.00 276 68.00 68 3, 991 06900 FLECTROCARDI OLOGY 14, 016 1,889 14, 706, 570 69.00 808 69 00 70.00 07000 ELECTROENCEPHALOGRAPHY 142 6, 757 2, 460, 953 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 30, 097, 934 71.00 11, 795, 315 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 0 C 0 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 0 r 0 4, 459, 565 32, 968, 282 73.00 76.00 03630 ULTRA SOUND 358 37 26, 908 7, 258, 564 76, 00 03951 PAIN CLINIC 542 10, 140 9, 063, 003 76.01 76.01 64.146 03952 CATH LAB 1 199 41, 275, 703 76.02 17, 163 4, 622, 833 18 76.02 76.03 03953 ACTIVITY THERAPEUTIC 2.944 548 858 5, 320, 025 76.03 03954 WOUND CARE CENTER 1, 990, 591 76.04 394 4,813 143, 452 13, 593 76.04 03340 BARLATRIC CLINIC 76.05 1.804 526, 686 76.05 540 3.969 76.06 03030 HEALTHY LIVING CENTER 0 C Ω 76.06 76.07 03950 CV RESOURCE CENTER 84 C 0 0 0 76.07 76. 08 03955 OTHER ANCILLARY SERVICE COST CENTERS 0 0 76.08 0 0 0 76 09 03956 LACTATION CLINIC 0 Ω 0 76 09 0 C 76.10 03957 OTHER ANCILLARY SERVICE COST CENTERS 0 0 0 0 76.10 03958 OTHER ANCILLARY SERVICE COST CENTERS 0 0 76. 11 03959 ANTI COAGULATION CLINIC 403 0 31, 262 990, 621 76.12 76.12 OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 4, 207 394 468, 637 6,504 53, 670, 677 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE 113 00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 45, 509 286, 362 14, 305, 984 4, 759, 038 513, 555, 260 118. 00 NONREIMBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190. 00 51 192.00 19200 PHYSICIANS' PRIVATE OFFICES 3,723 65, 872 0 0 0 192.00 192. 01 19201 WORKI NG WELL 0 0 0 192. 01 0 194. 00 07950 RESI DENTI AL 4.659 0 0 194.00

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0 194. 02

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194. 02 07952 PSYCHI ATRI C

194.03 07953 CENTER OF HOPE

194. 01 07951 OMNI

FRANCISCAN HEALTH- DYER	In Lie	u of Form CMS-2552-10
Provi der CCN: 15-0090	Peri od:	Worksheet B-1
	From 01/01/2020	
_		Provi der CCN: 15-0090 Peri od:

				Т	o 12/31/2020	Date/Time Pre 7/29/2021 1:2	
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		(HOURS WORK	ADMI NI STRATI ON	SERVICES &	(COSTED REQ	RECORDS &	
		ED)		SUPPLY	UISI)	LI BRARY	
			(DI RECT NRS	(COSTED		(GROSS CHAR	
			I NG)	REQUIS.)		GES)	
		11. 00	13. 00	14. 00	15. 00	16. 00	
200.00	Cross Foot Adjustments						200. 00
201. 00	Negative Cost Centers						201. 00
202.00	Cost to be allocated (per Wkst. B,	1, 197, 824	3, 501, 676	726, 471	4, 256, 382	1, 553, 880	202. 00
	Part I)						
203. 00	Unit cost multiplier (Wkst. B, Part I)	20. 718222	9. 657798	0. 050781	0. 894379	0. 003026	203. 00
204.00	Cost to be allocated (per Wkst. B,	84, 751	111, 119	137, 076	60, 932	63, 081	204. 00
	Part II)						
205. 00	Unit cost multiplier (Wkst. B, Part	1. 465900	0. 306472	0. 009582	0. 012803	0. 000123	205. 00
	[11]						
206. 00	NAHE adjustment amount to be allocated						206. 00
	(per Wkst. B-2)						
207. 00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)						[

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS FRANCISCAN HEALTH- DYER In Lieu of Form CMS-2552-10

Provider CCN: 15-0090

					To 12/31/2020 Date/lime Pre	
				INTERNS &		-
		0 1 0 1 0 1 1	COOLAL CERVICOE	RESI DENTS		
		Cost Center Description	SOCI AL SERVI CE	PRGM COSTS		
			(GROSS CHAR	APPRV		
			GES)	(ASSI GNED		
			17.00	TIME)		
	CENED	AL SERVICE COST CENTERS	17. 00	22. 00		
1.00		CAP REL COSTS-BLDG & FIXT				1.00
2.00	1	CAP REL COSTS-MVBLE EQUIP				2. 00
4.00		EMPLOYEE BENEFITS DEPARTMENT				4. 00
5. 04	1	OTHER ADMINISTRATIVE AND GENERAL				5. 04
6. 00 7. 00		MAINTENANCE & REPAIRS OPERATION OF PLANT				6. 00 7. 00
8. 00	1	LAUNDRY & LINEN SERVICE				8. 00
9.00	1	HOUSEKEEPI NG				9. 00
10. 00		DI ETARY				10. 00
11.00	1	CAFETERI A				11.00
13. 00 14. 00	1	NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY				13. 00 14. 00
15. 00	1	PHARMACY				15. 00
16.00		MEDICAL RECORDS & LIBRARY				16. 00
17. 00		SOCIAL SERVICE	513, 555, 260			17. 00
22. 00	_	I &R SERVICES-OTHER PRGM COSTS APPRV	0	682		22. 00
30. 00		I ENT ROUTINE SERVICE COST CENTERS ADULTS & PEDIATRICS	48, 578, 093	408		30.00
31. 00		INTENSIVE CARE UNIT	11, 655, 087	0	•	31. 00
32. 00		CORONARY CARE UNIT	0	0		32. 00
41. 00	1	SUBPROVI DER - I RF	12, 191, 671	0	1	41. 00
42.00	1	SUBPROVI DER	0	0	1	42.00
43. 00		NURSERY LARY SERVICE COST CENTERS	0	0	y	43. 00
50. 00		OPERATING ROOM	47, 969, 538	26		50.00
50. 01	05001	OUTPATI ENT SURGERY	7, 518, 975	0		50. 01
51.00	1	RECOVERY ROOM	4, 853, 072	0	1	51.00
53.00	1	ANESTHESI OLOGY	14, 774, 998	0	1	53.00
54. 00 54. 01		RADI OLOGY-DI AGNOSTI C RADI OLOGY-SPECI AL PROCEDURES	49, 679, 988 4, 331, 908	8	1	54. 00 54. 01
55. 00		RADI OLOGY-THERAPEUTI C	0	0	1	55. 00
56.00	05600	RADI OI SOTOPE	10, 042, 834	0		56. 00
60.00	1	LABORATORY	51, 929, 817	0	1	60.00
63. 00 65. 00	1	BLOOD STORING, PROCESSING & TRANS. RESPIRATORY THERAPY	2, 030, 689 12, 366, 641	0		63. 00 65. 00
66. 00	1	PHYSI CAL THERAPY	16, 753, 017	0	1	66. 00
67. 00	1	OCCUPATI ONAL THERAPY	4, 329, 991	0	1	67. 00
68. 00		SPEECH PATHOLOGY	2, 424, 017	0		68. 00
69. 00	1	ELECTROCARDI OLOGY	14, 706, 570	0	1	69.00
70. 00 71. 00	1	ELECTROENCEPHALOGRAPHY MEDICAL SUPPLIES CHARGED TO PATIENT	2, 460, 953 30, 097, 934	0		70. 00 71. 00
		IMPL. DEV. CHARGED TO PATIENTS	11, 795, 315			72.00
73. 00	07300	DRUGS CHARGED TO PATIENTS	32, 968, 282	0		73. 00
76. 00		ULTRA SOUND	7, 258, 564	0	1	76. 00
76. 01	1	PAIN CLINIC	9, 063, 003	0	1	76. 01
76. 02 76. 03		CATH LAB ACTIVITY THERAPEUTIC	41, 275, 703 5, 320, 025	0	1	76. 02 76. 03
76. 04		WOUND CARE CENTER	1, 990, 591	0		76. 04
76. 05	03340	BARIATRIC CLINIC	526, 686	0		76. 05
76.06	1	HEALTHY LIVING CENTER	0	0	1	76. 06
76. 07 76. 08	1	CV RESOURCE CENTER OTHER ANCILLARY SERVICE COST CENTERS	0	0		76. 07 76. 08
76. 09		LACTATION CLINIC	0	0		76. 08
		OTHER ANCILLARY SERVICE COST CENTERS	l ő	0		76. 10
76. 11	1	OTHER ANCILLARY SERVICE COST CENTERS	0	0	1	76. 11
76. 12		ANTI COAGULATI ON CLINI C	990, 621	0)	76. 12
Q1 ∩∩		TIENT SERVICE COST CENTERS EMERGENCY	53, 670, 677	240		91. 00
91.00		OBSERVATION BEDS (NON-DISTINCT PART	33, 070, 077	240	<u></u>	91.00
55		AL PURPOSE COST CENTERS				1
	11300	INTEREST EXPENSE			•	113. 00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	513, 555, 260	682		118. 00
190 00		IMBURSABLE COST CENTERS GIFT, FLOWER, COFFEE SHOP & CANTEEN		0		190. 00
		PHYSICIANS' PRIVATE OFFICES		0		190.00
		WORKI NG WELL		Ö		192. 01
		RESI DENTI AL	0	0		194. 00
194. 01	07951	OMNI	0	0)	194. 01

Health Financial Systems	FRANCISCAN HEALTH- DYER	In Lieu of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS	Provi der CCN: 15-0090	Peri od: From 01/01/2020 To 12/31/2020 Date/Ti me Prepared: 7/29/2021 1:27 pm

				 10 12/01/2020	7/29/2021 1	
			INTERNS &			
			RESI DENTS			
	Cost Center Description	SOCIAL SERVICE				
			PRGM COSTS			
		(GROSS CHAR	APPRV			
		GES)	(ASSI GNED			
			TIME)			
		17. 00	22. 00			
194. 02 07952	PSYCHI ATRI C	0	0			194. 02
194. 03 07953	CENTER OF HOPE	0	0			194. 03
200.00	Cross Foot Adjustments					200. 00
201. 00	Negative Cost Centers					201. 00
202. 00	Cost to be allocated (per Wkst. B,	0	699, 768			202. 00
	Part I)					
203. 00	Unit cost multiplier (Wkst. B, Part I)	0. 000000	1, 026. 052786			203. 00
204. 00	Cost to be allocated (per Wkst. B,	0	2, 105			204. 00
	Part II)					
205. 00	Unit cost multiplier (Wkst. B, Part	0. 000000	3. 086510			205. 00
	11)					
206. 00	NAHE adjustment amount to be allocated					206. 00
	(per Wkst. B-2)					
207. 00	NAHE unit cost multiplier (Wkst. D,					207. 00
	Parts III and IV)					

Total Cost Title Number Total Cost						From 01/01/2020 Fo 12/31/2020	Date/Time Pre	pared:
NPAT ENT ROUTINE SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00				T: +1 -		11: +-1	7/29/2021 1: 2	7 pm
NOTATION COST COS				litie	XVIII		PPS	
INPATIENT ROUTINE SERVICE COST CENTERS Add		Coot Conton Decemintion	Total Cost	Thomany Limit	Total Coots		Tatal Casts	
NPATLENT ROUTINE SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00		Cost Center Description			Total Costs		Total Costs	
INPATIENT ROUTINE SERVICE COST CENTERS 1.00				Auj .		DI Sai i Owalice		
INPATI ENT ROUTINE SERVICE COST CENTERS 26, 752, 837 26, 752, 837 26, 752, 837 30, 00 4, 00 5, 00 30, 00								
INPATIENT ROUTI ME SERVICE COST CENTERS				2 00	3 00	4 00	5.00	
30.00 030000 ADULTS & PEDIATRICS 26, 752, 837 2, 6752, 837 4, 841 26, 757, 678 30.00 33.00 33.00 032000 ORFORNARY CARE UNIT 5, 886, 097 21, 702 5, 97, 678 30.00 32.00 03200 ORFORNARY CARE UNIT 5, 886, 097 21, 702 5, 97, 678 30.00 32.00 03200 ORFORNARY CARE UNIT 5, 886, 097 21, 702 5, 97, 799 31.00 32.00 04.00		INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	0.00	1. 00	0.00	
31.00 03100 INTERSIVE CARE UNIT 5,886,097 21,702 5,907,799 31,00 32.00 3200 02000 COROMARY CARE UNIT 31,201 31,201 0,31,201 32.00 32.00 0200 0 0 0 0 0 0 0	30. 00		26, 752, 837		26, 752, 837	4. 841	26, 757, 678	30.00
32.00 03200 03200 0300ANFY CARE UNIT 31.201 31.201 0 31.201 32.00								
141.00 04100 SUBPROVI DER 1.0F	32. 00	l l						
42.00 04200 04200 042.00 0 0 0 0 42.00 0 0 0 0 0 0 0 0 0	41. 00							
AS DO OSDO OSDO OSDO OSDO OSDO OSDO OSDO					1			
50.00 0500	43.00		0			0	0	43.00
50.01		ANCILLARY SERVICE COST CENTERS						
55.00 0500 RESPORTED LOGY 3,772, 230 3,772, 230 0, 3772, 230 3,772, 2	50.00	05000 OPERATING ROOM	4, 686, 938		4, 686, 938	0	4, 686, 938	50.00
53.00 05300 ANESTHESI OLOGY 3,772,230 3,772,230 53.00 54.00 05400 RADIOLOGY-DIACNOSTIC 5,645,539 5,645,539 0,5645,539 54.00 54.01 05401 RADIOLOGY-SPECI AL PROCEDURES 1,107,906 1,107,906 0 1,107,906 54.01 55.00 05500 RADIOLOGY-SPECI AL PROCEDURES 1,245,628 0 1,245,628 0 1,245,628 60.00 60.00 065000 RADIOLOGY-THERAPEUTIC 30,497 30,497 0 30,497 55.00 60.00 065000 RADIOLOGY-THERAPEUTIC 30,497 30,497 55.00 60.00 065000 RADIOLOGY-THERAPEUTIC 7,315,656 7,315,656 9,298 7,324,954 60.00 60.00 065000 BLODD STORIN G, PROCESSI NG & TRANS. 192,242 192,242 0 192,242 63.00 65.00 065000 RADIOLOGY-THERAPEY 3,101,579 0 3,010,579 1,738 3,012,317 65.00 66.00 06600 PHYSI CAL THERAPY 3,101,579 0 3,010,579 1,738 3,012,317 65.00 67.00 06700 OCCUPATI ONAL THERAPY 985,796 0 985,796 0 985,796 0 985,796 0 985,796 67.00 69.00 06800 SPECH PATHOLOGY 561,931 0 561,931 0 561,931 0 561,931 0 0 69.00 06800 SPECH PATHOLOGY 1,668,368 1,668,368 0 1,668,368 0 0,606,550 0 606,550 0 71.00 07000 LELECTROENCEPHALOGRAPHY 606,550 606,550 0 606,550 0 606,550 0 0 71.00 07000 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 10,007,712 10,007,712 0 10,007,712 73.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 10,007,112 10,007,712 0 10,007,712 73.00 74.00 07300 DRUGS CHARGED TO PATI ENTS 10,007,712 10,007,712 0 10,007,712 73.00 74.00 07300 DRUGS CHARGED TO PATI ENTS 10,007,712 10,007,712 0 10,007,712 73.00 74.00 07300 DRUGS CHARGED TO PATI ENTS 10,007,712 10,007,712 0 10,007,712 73.00 74.00 07300 DRUGS CHARGED TO PATI ENTS 10,007,712 10,007,712 0 10,007,712 73.00 74.00 07300 DRUGS CHARGED TO PATI ENTS 10,007,712 10,007,712 0 10,007,712 0 75.00 07300 DRUGS CHARGED TO PATI ENTS 10,007,712 10,007,712 0 10,007,	50. 01	05001 OUTPATI ENT SURGERY	2, 740, 917		2, 740, 917	7 777	2, 741, 694	50. 01
54. 01 05400 RADIOLOGY-DIAGNOSTIC 5, 645, 539 5, 645, 539 6, 40 0540 RADIOLOGY-SPECIAL PROCEDURES 1, 107, 906 1, 107, 906 30, 497 30, 497 0 30, 497 55. 00 05500 RADIOLOGY-THERAPEUTIC 30, 497 30, 497 0 30, 497 55. 00 05500 RADIOLOGY-THERAPEUTIC 30, 497 30, 497 0 30, 497 55. 00 05600 RADIOLOGY-THERAPEUTIC 7, 315, 656 7, 315, 796 7,	51.00	05100 RECOVERY ROOM	995, 395		995, 395	5 0	995, 395	51. 00
54.01 05401 RADI 0.05CV_SPECI AL PROCEDURES 1, 107, 906 1, 107, 906 54.01 15.00 05500 RADI 0.05CV_THERAPEUTI C 30, 497 30, 497 0 30, 497 55.00 0.05CV_THERAPEUTI C 30, 497 30, 497 0 30, 497 55.00 0.05CV_THERAPEUTI C 30, 497 30, 497 30, 497 0 30, 497 55.00 0.05CV_THERAPEUTI C 30, 497	53.00	05300 ANESTHESI OLOGY	3, 772, 230		3, 772, 230	0	3, 772, 230	53. 00
55.00 05500 ADDI OLOGY-THERAPEUTIC 30, 497 55.00 05600 ADDI OSTOPPE 1, 245, 628 1, 245, 628 0 1, 245, 628 6.00 06000 LABORATORY READED 1, 245, 628 1, 245, 628 0 1, 245, 628 6.00 06000 LABORATORY READED 1, 245, 242 0 192, 242 192, 242 192, 242 192, 242 192, 242 192, 242 192, 242 192, 242 192, 242 192, 242 192, 242 192, 242 192, 242 192, 242 192, 242 192, 242 192, 242 192, 242 192,	54.00	05400 RADI OLOGY-DI AGNOSTI C	5, 645, 539		5, 645, 539	9 0	5, 645, 539	54.00
56. 00 05600 RADIOI SOTOPE 1, 245, 628 1, 245, 628 0, 1, 245, 628 66. 00 06000 06000 LABORATORY 7, 315, 656								
60. 00 06000 LABORATORY 7, 315, 656 7, 315, 656 9, 298 7, 324, 954 60. 00 63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 192, 242 192, 242 0 192, 242 63. 00 66. 00 06500 RESPIRATORY THERAPY 3, 010, 579 0 3, 010, 579 1, 738 3, 012, 317 65. 00 66. 00 06600 PHYSI CAL THERAPY 11, 301, 330 0 11, 301, 330 0 11, 301, 330 60. 00 66. 00 06600 PHYSI CAL THERAPY 11, 301, 330 0 11, 301, 330 0 11, 301, 330 60. 00 68. 00 06800 SPEECH PATHOLOGY 98, 5, 796 0 988, 796 6 0 988, 796 6 7. 00 06700 ICCUPATIONAL THERAPY 561, 931 0 5							· ·	
63.00 06300 BLOOD STORING, PROCESSING & TRANS. 192, 242 192, 242 0 192, 242 63.00 65.00 06500 RESPI RATORY THERAPY 3,010,579 0 3,010,579 1,738 3,012,317 65.00 06600 PHYSI CAL THERAPY 11,301,330 0 11,301,330 0 11,301,330 0 67.00 06700 0CCUPATI ONAL THERAPY 985,796 0 985,796 0 985,796 0 06,000 68.00 06600 SPECH PATHOLOGY 561,931 0 561,931 0 561,931 0 561,931 0 69.00 06900 ELECTROCARDI OLOGY 1,668,368 1,668,368 0 1,668,368 69.00 70.00 07000 ELECTROCARDI OLOGY 1,668,368 1,668,368 0 1,668,368 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 8,147,346 8,147,346 0			1, 245, 628		1, 245, 628		1, 245, 628	56. 00
65.00 06500 RESPIRATORY THERAPY 3,010,579 0 3,010,579 1,738 3,012,317 65.00 66.00 06600 PHYSI CAL THERAPY 11,301,330 0 11,301,330 0 11,301,330 0 11,301,330 67.00 06700 OCCUPATI ONAL THERAPY 985,796 0 985,796 0 985,796 0 985,796 67.00 68.00 06800 SPECCH PATHOLOGY 561,931 0 561,931 0 561,931 0 561,931 0 561,931 0 561,931 0 561,931 0 60,000 69.00 06900 ELECTROCARDI OLOGY 1,668,368 1,668,368 0 1,668,368 0 0 1,668,368 69.00 69.00 07000 ELECTROENCEPHALOGRAPHY 606,550 606,550 0 606,550 70.00 69.00 07000 ELECTROENCEPHALOGRAPHY 606,6550 606,550 606,550 0 606,550 70.00 69.00 07000 ELECTROENCEPHALOGRAPHY 606,6550 606,550 606,550 0 606,550 70.00 69.00 07000 ELECTROENCEPHALOGRAPHY 606,6550 606,550 606,550 606,550 0 606,550 70.00 69.00 07000 ELECTROENCEPHALOGRAPHY 606,6550 606,550 606								
66.00 06600 PHYSI CAL THERAPY 11, 301, 330 0 11, 301, 330 0 0 067. 00 06700 06700 06700 06700 06700 06800 06800 SPEECH PATHOLOGY 561, 931 0 561, 931								
67. 00 06700 OCCUPATI ONAL THERAPY 985, 796 0 985, 796 0 985, 796 67. 00 68. 00 06800 SPEECH PATHOLOGY 1, 668, 368 1, 668, 368 0, 168, 368 69. 00 69. 00 06900 ELECTROCARDI OLOGY 1, 668, 368 1, 668, 368 0, 1, 668, 368 69. 00 70. 00 07000 ELECTROENCEPHALOGRAPHY 606, 550 606, 550 0 606, 550 70. 00 71. 00 07000 ELECTROENCEPHALOGRAPHY 606, 550 606, 550 0 606, 550 70. 00 72. 00 07000 ELECTROENCEPHALOGRAPHY 70. 00 71. 00 7100 MPDIC ALSUPPLIES CHARGED TO PATI ENT 8, 147, 346 8, 147, 346 0 8, 147, 346 0 8, 147, 346 0 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 10. 001, 119 10. 001, 119 0 10. 001, 119 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 10. 007, 712 10. 007, 712 0 10. 007, 712 73. 00 76. 01 03951 PAIN CLINIC 1, 867, 057 1, 867, 057 0 1, 867, 057 76. 01 76. 02 03952 CATH LAB 3, 875, 276 3, 875, 276 5, 289 3, 880, 565 76. 02 76. 04 03954 MOUND CARE CENTER 1, 016, 154 1, 016, 154 846 1, 017, 000 76. 04 76. 05 03304 BARI ATRIC CLINIC 1, 073, 466 2, 404 1, 075, 870 76. 05 76. 06 03030 HEALTHY LIVING CENTER 174, 353 174, 353 0 174, 353 76. 07 76. 07 03955 OTHER ANCILLARY SERVICE COST CENTERS 0 0 0 0 0 0 76. 10 76. 10 03955 OTHER ANCILLARY SERVICE COST CENTERS 0 0 0 0 0 0 76. 10 76. 10 03959 OTHER ANCILLARY SERVICE COST CENTERS 0 0 0 0 0 76. 10 76. 10 03959 OTHER ANCILLARY SERVICE COST CENTERS 0 0 0 0 0 0 0 0 76. 10 03959 OTHER ANCILLARY SERVICE COST CENTERS 0 0 0 0 0 0 0 76. 10 03959 OTHER ANCILLARY SERVICE COST CENTERS 0 0 0 0 0 0 0 76. 10 03959 OTHER ANCILLARY SERVICE COST CENTERS 0 0 0 0 0 0 0 76. 10 03959 OTHER ANCILLARY SERVICE COST CENTERS 0 0 0 0 0 0 0 76. 10 03959 OTHER ANCILLARY SERVICE COST CENTERS 0 0 0 0 0 0 0 76.								
68.00 06800 SPEECH PATHOLOGY 561, 931 0 561, 931 0 561, 931 0 69.00 6900 ELECTROCARDIOLOGY 1, 668, 368 0 1, 668, 368 0 0.000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.00000 0.00000 0.00000 0.000000 0.000000 0.00000000								
69. 00 06900 ELECTROCARDIOLOGY 1, 668, 368 0, 00 1, 668, 368 69. 00 70. 00 07000 ELECTROENCEPHALOGRAPHY 606, 550 606, 550 0 606, 550 70. 00 70. 00 07000 ELECTROENCEPHALOGRAPHY 606, 550 70. 00 70. 00 ELECTROENCEPHALOGRAPHY 70. 00 70. 00 70. 00 606, 550 70. 0				_				
70. 00 07000 ELECTROENCEPHALOGRAPHY 606, 550 70. 00 71. 00 710 00 710 00 0710 00 0				0				
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 8, 147, 346 10, 007 10, 001 119 10, 001 119 10, 001 119 10, 001 119 12 20 10, 007 12 12 12 12, 007 12 12 12, 007 12 12 12, 007 12 12 12, 007 12 12, 007 12 12, 007 12 12, 007 12 12, 007 12 12, 007 12 12, 007 12 12, 007 12 12, 007 12 12, 007 12 12, 007 12 12, 007 12 12, 007 12 12, 007 12 12, 007 12 12, 007 12 12, 007 12 12, 007								
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 10, 001, 119 10, 001, 119 0 10, 001, 119 72. 00 73300 DRUGS CHARGED TO PATIENTS 10, 007, 712 10, 007, 712 0 10, 007, 712 73. 00 76. 00 03630 ULTRA SOUND 1, 069, 413 1, 069, 413 0 1, 069, 414 0 1, 079, 810 0 1, 079, 810 0 1, 079, 810 0 1, 079, 810 0 1, 079, 810 0 1, 079, 810 0 1, 079, 810 0 1, 079, 810 0 1, 079, 414 0 1, 079, 810 0 1, 079, 810 0 1, 079, 414 0 1, 079, 810 0 1,							· ·	
73. 00								
76. 00								
76. 01								1
76. 02 03952 CATH LAB 3, 875, 276 3, 880, 565 76. 02 76. 03 03953 ACTI VI TY THERAPEUTI C 4, 295, 983 4, 295, 983 0 4, 295, 983 76. 03 76. 04 03954 WOUND CARE CENTER 1, 016, 154 1, 016, 154 846 1, 017, 000 76. 04 76. 05 03340 BARI ATRI C CLI NI C 1, 073, 466 1, 073, 466 2, 404 1, 075, 870 76. 05 76. 06 03030 HEALTHY LI VI NG CENTER 0 0 0 0 76. 06 76. 07 03950 CV RESOURCE CENTER 174, 353 174, 353 0 174, 353 76. 07 76. 08 03955 OTHER ANCI LLARY SERVI CE COST CENTERS 0 0 0 0 76. 09 76. 10 03957 OTHER ANCI LLARY SERVI CE COST CENTERS 0 0 0 0 76. 09 76. 11 03958 OTHER ANCI LLARY SERVI CE COST CENTERS 0 0 0 0 0 76. 10 76. 11 03958 OTHER ANCI LLARY SERVI CE COST CENTERS 0 0 0 0 0 76. 11 76. 12 03959 ANTI COAGULATI ON CLI NI C 778, 307 778		l l						
76. 03		l l						
76. 04 03954 WOUND CARE CENTER								
76. 05								
76. 06 03030 HEALTHY LIVING CENTER		l l						1
76. 07 03950 CV RESOURCE CENTER 174, 353 174, 353 0 174, 353 76. 07 76. 08 03955 OTHER ANCI LLARY SERVI CE COST CENTERS 0 0 0 0 0 76. 08 76. 09 03956 LACTATI ON CLI NI C 0 0 0 0 0 76. 09 76. 10 03957 OTHER ANCI LLARY SERVI CE COST CENTERS 0 0 0 0 0 0 76. 10 76. 11 03958 OTHER ANCI LLARY SERVI CE COST CENTERS 0 0 0 0 0 0 76. 11 76. 12 03959 ANTI COAGULATI ON CLI NI C 778, 307 778, 307 1, 082 779, 389 76. 12 0UTPATI ENT SERVI CE COST CENTERS 91. 00 09100 EMERGENCY 8, 517, 621 8, 517, 621 14, 840 8, 532, 461 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 4, 255, 380 4, 255, 380 4, 255, 380 92. 00 SPECI AL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 200. 00 Subtotal (see instructions) 140, 842, 138 0 140, 842, 138 62, 817 140, 904, 955 200. 00 201. 00 Less Observation Beds 4, 255, 380 4, 255, 380 201. 00			1,073,400		1,073,400			1
76. 08			17/ 353		17/ 35	ار ا	-	
76. 09					174, 33			
76. 10 03957 OTHER ANCI LLARY SERVI CE COST CENTERS 0 0 0 0 0 76. 10 76. 11 03958 OTHER ANCI LLARY SERVI CE COST CENTERS 0 0 0 0 0 76. 11 76. 12 03959 ANTI COAGULATI ON CLI NI C 778, 307 778, 307 778, 307 1, 082 779, 389 76. 12 00 09100 EMERGENCY 8, 517, 621 8, 517, 621 14, 840 8, 532, 461 91. 00 99200 OBSERVATI ON BEDS (NON-DI STI NCT PART 4, 255, 380 4, 255, 380 4, 255, 380 92. 00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE 113. 00 201. 00 Less Observati on Beds 4, 255, 380 4, 255, 380 4, 255, 380 201. 00			1					1
76. 11 03958 OTHER ANCILLARY SERVICE COST CENTERS 0 0 0 0 0 0 76. 11 03958 ANTI COAGULATION CLINIC 778, 307 778, 307 778, 307 1, 082 779, 389 76. 12 00 09100 EMERGENCY 8, 517, 621 8, 517, 621 14, 840 8, 532, 461 91. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 4, 255, 380 4, 255, 380 4, 255, 380 92. 00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113. 00 100 EMERGENCY Subtotal (see instructions) 140, 842, 138 0 140, 842, 138 62, 817 140, 904, 955 200. 00 201. 00 Less Observation Beds 4, 255, 380 4, 255, 380 201. 00			1					
76. 12 03959 ANTI COAGULATI ON CLI NI C 778, 307 778, 307 7, 389 76. 12 0UTPATI ENT SERVI CE COST CENTERS 91. 00 09100 EMERGENCY 8, 517, 621 8, 517, 621 14, 840 8, 532, 461 91. 00 9200 OBSERVATI ON BEDS (NON-DI STI NCT PART 4, 255, 380 4, 255, 380 4, 255, 380 133. 00 11300 INTEREST EXPENSE 113. 00 100 Subtotal (see instructions) 140, 842, 138 0 140, 842, 138 62, 817 140, 904, 955 200. 00 201. 00 Less Observation Beds 4, 255, 380 4, 255, 380 201. 00			_			ا ا	-	
OUTPATIENT SERVICE COST CENTERS 91. 00 09100 EMERGENCY 8, 517, 621 8, 517, 621 14, 840 8, 532, 461 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART 4, 255, 380) 4, 255, 380 4, 255, 380 92. 00 SPECI AL PURPOSE COST CENTERS 113. 00 INTEREST EXPENSE 113. 00 11300 INTEREST EXPENSE 113. 00 200. 00 Subtotal (see instructions) 140, 842, 138 0 140, 842, 138 62, 817 140, 904, 955 200. 00 201. 00 Less Observation Beds 4, 255, 380 4, 255, 380 4, 255, 380 201. 00			_		778 30	ار ا		
91. 00	70.12		770,007		170,00	1,002	777,007	70.12
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART 4, 255, 380 4, 255, 380 92. 00	91. 00		8, 517, 621		8, 517, 621	14.840	8, 532, 461	91, 00
SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 1200.00 Subtotal (see instructions) 140,842,138 0 140,842,138 62,817 140,904,955 200.00 201.00 Less Observation Beds 4,255,380 4,255,380 201.00								
113. 00			,,		, 255, 000		,,	1
200. 00 Subtotal (see instructions) 140, 842, 138 0 140, 842, 138 62, 817 140, 904, 955 200. 00 201. 00 4, 255, 380 4, 255, 380 201. 00	113.00							113. 00
201. 00 Less Observation Beds 4, 255, 380 4, 255, 380 201. 00			140, 842, 138	0	140, 842, 138	62, 817	140, 904, 955	
	201.00	Less Observation Beds	4, 255, 380		4, 255, 380		4, 255, 380	201. 00
	202.00	Total (see instructions)	136, 586, 758	0			136, 649, 575	202. 00

				Τ	o 12/31/2020	Date/Time Pre 7/29/2021 1:2	pared:
			Title	xVIII	Hospi tal	PPS	7 рііі
			Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
	, , , , , , , , , , , , , , , , , , ,			+ col. 7)	Ratio	Inpati ent	
				_		Rati o	
		6. 00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDI ATRI CS	40, 289, 026		40, 289, 026			30. 00
31. 00	03100 INTENSIVE CARE UNIT	11, 655, 087		11, 655, 087	'		31. 00
32. 00	03200 CORONARY CARE UNIT	0		(32. 00
41. 00	04100 SUBPROVI DER - I RF	12, 191, 671		12, 191, 671			41. 00
42.00	04200 SUBPROVI DER	0		(42. 00
43.00	04300 NURSERY	0		(43. 00
	ANCILLARY SERVICE COST CENTERS	1					
50.00	05000 OPERATING ROOM	22, 220, 819	25, 748, 719			0. 000000	
50. 01	05001 OUTPATI ENT SURGERY	2, 108, 981	5, 409, 994			0. 000000	
51.00	05100 RECOVERY ROOM	2, 105, 943	2, 747, 129			0. 000000	
53.00	05300 ANESTHESI OLOGY	5, 684, 697	9, 090, 301	14, 774, 998		0. 000000	
54.00	05400 RADI OLOGY-DI AGNOSTI C	17, 407, 218	32, 272, 770			0. 000000	
54. 01	05401 RADI OLOGY-SPECI AL PROCEDURES	2, 702, 375	1, 629, 533	4, 331, 908		0. 000000	
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0		0.000000	0. 000000	1
56. 00	05600 RADI 0I SOTOPE	1, 264, 969	8, 777, 865			0. 000000	1
60.00	06000 LABORATORY	26, 667, 315	25, 262, 502	51, 929, 817		0. 000000	1
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	1, 625, 487	405, 202	2, 030, 689		0. 000000	1
65. 00	06500 RESPI RATORY THERAPY	8, 749, 154	3, 617, 487	12, 366, 641		0. 000000	
66.00	06600 PHYSI CAL THERAPY	4, 587, 010	12, 166, 007	16, 753, 017		0. 000000	
67. 00	06700 OCCUPATI ONAL THERAPY	4, 175, 082	154, 909			0. 000000	
68. 00	06800 SPEECH PATHOLOGY	1, 697, 108	726, 909	2, 424, 017		0. 000000	1
69. 00	06900 ELECTROCARDI OLOGY	6, 326, 035	8, 380, 535			0. 000000	1
70.00	07000 ELECTROENCEPHALOGRAPHY	436, 511	2, 024, 442	2, 460, 953		0. 000000	1
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	17, 444, 683	12, 653, 251	30, 097, 934		0.000000	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	5, 829, 241	5, 966, 074	11, 795, 315		0. 000000	1
73.00	07300 DRUGS CHARGED TO PATIENTS	25, 308, 991	7, 659, 291	32, 968, 282		0. 000000	
76.00	03630 ULTRA SOUND	2, 669, 079	4, 589, 485	7, 258, 564		0. 000000	
76. 01	03951 PAIN CLINIC	21, 877	9, 041, 126	9, 063, 003		0. 000000	1
76. 02	03952 CATH LAB	15, 360, 244	25, 915, 459			0.000000	1
76. 03	03953 ACTIVITY THERAPEUTIC	3, 070, 935	2, 249, 090			0.000000	1
76. 04	03954 WOUND CARE CENTER	11, 114	1, 979, 477	1, 990, 591		0.000000	1
76. 05	03340 BARI ATRI C CLI NI C	1, 170	525, 516			0. 000000	
76.06	03030 HEALTHY LIVING CENTER	0	0			0. 000000	
76. 07	03950 CV RESOURCE CENTER	0	0	C		0. 000000	
76. 08	03955 OTHER ANCILLARY SERVICE COST CENTERS	0	0			0.000000	
76. 09	03956 LACTATION CLINIC	0	0		0.00000	0.000000	
76. 10	03957 OTHER ANCILLARY SERVICE COST CENTERS	0	0	C		0. 000000	1
76. 11	03958 OTHER ANCILLARY SERVICE COST CENTERS	14 (15	070.054	000 (00		0.000000	1
76. 12	03959 ANTI COAGULATI ON CLI NI C	11, 665	978, 956	990, 621	0. 785676	0. 000000	76. 12
01 00	OUTPATIENT SERVICE COST CENTERS	10 2/2 5//	25 400 111	F2 (70 (7	0 150700	0.000000	01 00
91.00	09100 EMERGENCY	18, 262, 566	35, 408, 111			0.000000	1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	8, 289, 067	8, 289, 067	0. 513373	0. 000000	92. 00
112 0	SPECIAL PURPOSE COST CENTERS 11300 NTEREST EXPENSE	1		I			112 00
		250 004 052	252 440 207	E12 EEE 240	,		113. 00 200. 00
200.00	,	259, 886, 053	253, 669, 207	513, 555, 260	<u>'</u>		200.00
201. 00 202. 00		259, 886, 053	253, 669, 207	513, 555, 260	,		201.00
202. U	p Total (See Histinctions)	237, 000, 053	200, 009, 207	1 313, 333, 200	′I I		1202.00

Health Financial Systems	FRANCISCAN HEALTH- DYER	In Lieu of Form CMS-2552-1	10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0090	Peri od:	:

					7/29/2021 1:27 pm
			Title XVIII	Hospi tal	PPS
	Cost Center Description	PPS Inpatient			
		Ratio			
		11. 00			
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDI ATRI CS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
32.00	03200 CORONARY CARE UNIT				32.00
41.00	04100 SUBPROVI DER - I RF				41.00
42.00	04200 SUBPROVI DER				42. 00
43.00	04300 NURSERY				43.00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0. 097707			50.00
50. 01	05001 OUTPATIENT SURGERY	0. 364637			50. 01
51.00	05100 RECOVERY ROOM	0. 205106			51.00
53.00	05300 ANESTHESI OLOGY	0. 255312			53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0. 113638			54. 00
54. 01	05401 RADI OLOGY-SPECI AL PROCEDURES	0. 255755			54. 01
55. 00	05500 RADI OLOGY-THERAPEUTI C	0. 000000			55. 00
56. 00	05600 RADI OI SOTOPE	0. 124032			56. 00
60.00	06000 LABORATORY	0. 141055			60.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 141033			63. 00
65. 00					
	06500 RESPI RATORY THERAPY	0. 243584			65. 00
66.00	06600 PHYSI CAL THERAPY	0. 674585			66.00
67.00	06700 OCCUPATI ONAL THERAPY	0. 227667			67. 00
68. 00	06800 SPEECH PATHOLOGY	0. 231818			68. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 113444			69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0. 246470			70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 270695			71.00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 847889			72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 303556			73. 00
76.00	03630 ULTRA SOUND	0. 147331			76. 00
76. 01	03951 PAIN CLINIC	0. 206009			76. 01
76. 02	03952 CATH LAB	0. 094016			76. 02
76. 03	03953 ACTIVITY THERAPEUTIC	0. 807512			76. 03
76. 04	03954 WOUND CARE CENTER	0. 510904			76. 04
76.05	03340 BARI ATRI C CLI NI C	2. 042716			76. 05
76.06	03030 HEALTHY LIVING CENTER	0. 000000			76.06
76. 07	03950 CV RESOURCE CENTER	0. 000000			76. 07
76. 08	03955 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000			76. 08
76. 09	03956 LACTATION CLINIC	0. 000000			76. 09
76. 10	1 1	0. 000000			76. 10
76. 10	03958 OTHER ANCI LLARY SERVICE COST CENTERS	0. 000000			76. 10
76. 12	03959 ANTI COAGULATION CLINIC	0. 786768			76. 11
70.12	OUTPATIENT SERVICE COST CENTERS	0.700700			70. 12
91. 00	09100 EMERGENCY	0. 158978			91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 138478			92.00
12.00	SPECIAL PURPOSE COST CENTERS	0.313373			72.00
113 00	11300 INTEREST EXPENSE				113. 00
200.00	i i				
					200. 00
201.00	1 1				201. 00
202.00	Total (see instructions)				202. 00

					o 12/31/2020	Date/Time Pre 7/29/2021 1:2	
			Ti tl	e XIX	Hospi tal	Cost	7 рііі
					Costs		
	Cost Center Description	Total Cost (from Wkst. B, Part I, col.	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
		26)					
		1. 00	2. 00	3.00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	26, 752, 837		26, 752, 837	4, 841	26, 757, 678	30. 00
31.00	03100 INTENSIVE CARE UNIT	5, 886, 097		5, 886, 097	21, 702	5, 907, 799	31. 00
32.00	03200 CORONARY CARE UNIT	31, 201		31, 201	0	31, 201	32. 00
41.00	04100 SUBPROVI DER - I RF	7, 225, 314		7, 225, 314	0	7, 225, 314	41. 00
42.00	04200 SUBPROVI DER	0		l c	0	0	42. 00
43.00	04300 NURSERY	0		l c	0	0	43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	4, 686, 938		4, 686, 938	0	4, 686, 938	50.00
50. 01	05001 OUTPATI ENT SURGERY	2, 740, 917		2, 740, 917	777	2, 741, 694	50. 01
51.00	05100 RECOVERY ROOM	995, 395		995, 395	0	995, 395	51.00
53.00	05300 ANESTHESI OLOGY	3, 772, 230		3, 772, 230	0	3, 772, 230	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	5, 645, 539		5, 645, 539	0	5, 645, 539	54.00
54. 01	05401 RADI OLOGY-SPECI AL PROCEDURES	1, 107, 906		1, 107, 906	0	1, 107, 906	54. 01
55.00	05500 RADI OLOGY-THERAPEUTI C	30, 497		30, 497	0	30, 497	55. 00
56.00	05600 RADI 0I SOTOPE	1, 245, 628		1, 245, 628	0	1, 245, 628	56. 00
60.00	06000 LABORATORY	7, 315, 656		7, 315, 656	9, 298	7, 324, 954	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	192, 242		192, 242	0	192, 242	63. 00
65.00	06500 RESPI RATORY THERAPY	3, 010, 579	0	3, 010, 579	1, 738	3, 012, 317	65. 00
66.00	06600 PHYSI CAL THERAPY	11, 301, 330	0	11, 301, 330	0	11, 301, 330	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	985, 796	0	985, 796	0	985, 796	67.00
68. 00	06800 SPEECH PATHOLOGY	561, 931	0	561, 931	0	561, 931	68. 00
69. 00	06900 ELECTROCARDI OLOGY	1, 668, 368		1, 668, 368	0	1, 668, 368	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	606, 550		606, 550	0	606, 550	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	8, 147, 346		8, 147, 346	0	8, 147, 346	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	10, 001, 119		10, 001, 119	0	10, 001, 119	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	10, 007, 712		10, 007, 712	0	10, 007, 712	73. 00
76. 00	03630 ULTRA SOUND	1, 069, 413		1, 069, 413	0	1, 069, 413	76. 00
76. 01	03951 PAIN CLINIC	1, 867, 057		1, 867, 057	0	1, 867, 057	76. 01
76. 02	03952 CATH LAB	3, 875, 276		3, 875, 276	5, 289	3, 880, 565	76. 02
76. 03	03953 ACTIVITY THERAPEUTIC	4, 295, 983		4, 295, 983		4, 295, 983	76. 03
76. 04	03954 WOUND CARE CENTER	1, 016, 154		1, 016, 154		1, 017, 000	
76. 05	03340 BARI ATRI C CLI NI C	1, 073, 466		1, 073, 466	2, 404	1, 075, 870	76. 05
76. 06	03030 HEALTHY LIVING CENTER	0		0	0	0	76. 06
76. 07	03950 CV RESOURCE CENTER	174, 353		174, 353	0	174, 353	
76. 08	03955 OTHER ANCILLARY SERVICE COST CENTERS	0		0	0	0	76. 08
76. 09	03956 LACTATION CLINIC	0		0	0	0	76. 09
76. 10	03957 OTHER ANCILLARY SERVICE COST CENTERS	0		0	0	0	76. 10
76. 11	03958 OTHER ANCILLARY SERVICE COST CENTERS	0		C	0	0	76. 11
76. 12	03959 ANTI COAGULATI ON CLINI C	778, 307		778, 307	1, 082	779, 389	76. 12
04.05	OUTPATIENT SERVICE COST CENTERS	0 = 1 = 1 = 1		0 = 1 = 1 = 1	a. e.=	0.500.4::	04 00
91. 00	09100 EMERGENCY	8, 517, 621		8, 517, 621		8, 532, 461	91.00
92. 00	09200 OBSERVATI ON BEDS (NON-DISTINCT PART	4, 255, 380		4, 255, 380	1	4, 255, 380	92.00
110.00	SPECIAL PURPOSE COST CENTERS						112 00
	11300 I NTEREST EXPENSE	140 040 400	_	140 040 400	(2.247	140 004 055	113. 00
200.00		140, 842, 138	0			140, 904, 955	
201. 00 202. 00		4, 255, 380 136, 586, 758	0	4, 255, 380 136, 586, 758		4, 255, 380 136, 649, 575	
202.00	Tiotal (See Histiactions)	130, 300, 738	0	130, 300, 738	02,017	130, 049, 3/5	1202.00

				1	To 12/31/2020	Date/Time Pre 7/29/2021 1:2	
-			Ti +l	e XIX	Hospi tal	Cost	/ pili
			Charges	CAIA	nospi tai	0031	
	Cost Center Description	Inpatient	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
				+ col . 7)	Ratio	Inpatient	
				<u> </u>		Rati o	
		6.00	7. 00	8. 00	9. 00	10.00	
	TIENT ROUTINE SERVICE COST CENTERS						
	O ADULTS & PEDIATRICS	40, 289, 026		40, 289, 026			30.00
	O INTENSIVE CARE UNIT	11, 655, 087		11, 655, 087	7		31. 00
	O CORONARY CARE UNIT	0		(32. 00
	O SUBPROVI DER - I RF	12, 191, 671		12, 191, 67			41. 00
	O SUBPROVI DER	0		()		42. 00
	O NURSERY	0		()		43. 00
	LLARY SERVICE COST CENTERS	22 220 010	25 740 710	47.0(0.52)	0.007707	0.007707	F0 00
	O OPERATI NG ROOM	22, 220, 819	25, 748, 719			0. 097707	50.00
	1 OUTPATI ENT SURGERY	2, 108, 981	5, 409, 994			0. 364533	
	O RECOVERY ROOM	2, 105, 943	2, 747, 129			0. 205106	1
	O ANESTHESI OLOGY	5, 684, 697	9, 090, 301			0. 255312	
	0 RADI OLOGY-DI AGNOSTI C 1 RADI OLOGY-SPECI AL PROCEDURES	17, 407, 218 2, 702, 375	32, 272, 770 1, 629, 533			0. 113638 0. 255755	
	O RADI OLOGY-SPECTAL PROCEDURES	2, 702, 375	1, 029, 533	4, 331, 908	0. 255755	0. 255755	
	O RADI OLOGI - THEKAPEUTI C	1, 264, 969	0 777 045	10, 042, 834		0. 124032	56. 00
	O LABORATORY	26, 667, 315	8, 777, 865 25, 262, 502			0. 124032	
	O BLOOD STORING, PROCESSING & TRANS.	1, 625, 487	405, 202			0. 140678	63.00
	O RESPIRATORY THERAPY	8, 749, 154	3, 617, 487			0. 094000	65. 00
	O PHYSI CAL THERAPY	4, 587, 010	12, 166, 007			0. 674585	
	O OCCUPATIONAL THERAPY	4, 175, 082	154, 909			0. 227667	67. 00
	O SPEECH PATHOLOGY	1, 697, 108	726, 909			0. 231818	
	O ELECTROCARDI OLOGY	6, 326, 035	8, 380, 535			0. 113444	
	O ELECTROENCEPHALOGRAPHY	436, 511	2, 024, 442			0. 246470	70.00
	O MEDICAL SUPPLIES CHARGED TO PATIENT	17, 444, 683	12, 653, 251			0. 270695	
	O IMPL. DEV. CHARGED TO PATIENTS	5, 829, 241	5, 966, 074			0. 847889	
	O DRUGS CHARGED TO PATIENTS	25, 308, 991	7, 659, 291			0. 303556	73.00
	O ULTRA SOUND	2, 669, 079	4, 589, 485			0. 147331	76. 00
	1 PAIN CLINIC	21, 877	9, 041, 126			0. 206009	
	2 CATH LAB	15, 360, 244	25, 915, 459			0. 093888	76. 02
	3 ACTIVITY THERAPEUTIC	3, 070, 935	2, 249, 090			0. 807512	76, 03
	4 WOUND CARE CENTER	11, 114	1, 979, 477			0. 510479	76. 04
76. 05 03340	O BARIATRIC CLINIC	1, 170	525, 516	526, 686	2. 038152	2. 038152	76. 05
76. 06 03030	O HEALTHY LIVING CENTER	0	0	. (0. 000000	0.000000	76. 06
76. 07 03950	O CV RESOURCE CENTER	o	0		0. 000000	0.000000	76. 07
76. 08 0395!	OTHER ANCILLARY SERVICE COST CENTERS	0	0		0. 000000	0.000000	76. 08
76. 09 03956	6 LACTATION CLINIC	o	0	(0. 000000	0.000000	76. 09
76. 10 0395	7 OTHER ANCILLARY SERVICE COST CENTERS	0	0	(0. 000000	0.000000	76. 10
76. 11 03958	8 OTHER ANCILLARY SERVICE COST CENTERS	0	0	(0. 000000	0.000000	76. 11
76. 12 03959	9 ANTICOAGULATION CLINIC	11, 665	978, 956	990, 62°	0. 785676	0. 785676	76. 12
OUTPA	ATIENT SERVICE COST CENTERS						
	O EMERGENCY	18, 262, 566	35, 408, 111		0. 158702	0. 158702	91.00
	O OBSERVATION BEDS (NON-DISTINCT PART	0	8, 289, 067	8, 289, 067	0. 513373	0. 513373	92. 00
	IAL PURPOSE COST CENTERS						
	O INTEREST EXPENSE						113. 00
200. 00	Subtotal (see instructions)	259, 886, 053	253, 669, 207	513, 555, 260	9		200. 00
201. 00	Less Observation Beds	050	050				201. 00
202. 00	Total (see instructions)	259, 886, 053	253, 669, 207	513, 555, 260	기		202. 00

Health Financial Systems	FRANCISCAN HEALTH- DYER	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0090	Peri od: Worksheet C From 01/01/2020 Part I To 12/31/2020 Date/Time Prepared:

				10 12/01/2020	7/29/2021 1:27 pm
			Title XIX	Hospi tal	Cost
	Cost Center Description	PPS Inpatient			
		Ratio			
		11. 00			
	INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00	03000 ADULTS & PEDI ATRI CS				30.00
31. 00	03100 I NTENSI VE CARE UNI T				31. 00
32.00	03200 CORONARY CARE UNIT				32.00
41.00	04100 SUBPROVI DER – I RF				41. 00
42.00	04200 SUBPROVI DER				42. 00
43. 00	04300 NURSERY				43. 00
50. 00	ANCI LLARY SERVI CE COST CENTERS 05000 OPERATI NG ROOM	0. 000000			50.00
50. 00	05001 OUTPATIENT SURGERY	0.000000			50.00
51. 00	05100 RECOVERY ROOM	0.000000			51. 00
53.00	05300 ANESTHESI OLOGY	0.000000			53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0.000000			54. 00
54. 00	1	1			54. 00
55. 00	05401 RADI OLOGY-SPECI AL PROCEDURES 05500 RADI OLOGY-THERAPEUTI C	0. 000000 0. 000000			55. 00
56. 00	05600 RADI OI SOTOPE	0. 000000			56. 00
60.00	06000 LABORATORY	0. 000000			60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000			63. 00
65. 00	06500 RESPIRATORY THERAPY	0.000000			65. 00
66.00	06600 PHYSI CAL THERAPY	0.000000			66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0.000000			67. 00
68. 00	06800 SPEECH PATHOLOGY	0. 000000			68. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 000000			69. 00
	07000 ELECTROENCEPHALOGRAPHY	0. 000000			70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000			71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			72.00
	07300 DRUGS CHARGED TO PATIENTS	0. 000000			73. 00
76. 00	03630 ULTRA SOUND	0. 000000			76. 00
76. 01	03951 PAIN CLINIC	0. 000000			76. 01
76. 02	03952 CATH LAB	0. 000000			76. 02
76. 03	03953 ACTIVITY THERAPEUTIC	0. 000000			76. 03
76. 04	03954 WOUND CARE CENTER	0. 000000			76. 04
76. 05	03340 BARI ATRI C CLINI C	0. 000000			76. 05
76.06	03030 HEALTHY LIVING CENTER	0. 000000			76. 06
76. 07	03950 CV RESOURCE CENTER	0. 000000			76. 07
76. 08	03955 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000			76. 08
76. 09	03956 LACTATION CLINIC	0. 000000			76. 09
	03957 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000			76. 10
76. 11	03958 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000			76. 11
76. 12	03959 ANTI COAGULATION CLINIC	0. 000000			76. 12
	OUTPATIENT SERVICE COST CENTERS				
91.00	09100 EMERGENCY	0. 000000			91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000			92. 00
	SPECIAL PURPOSE COST CENTERS				
113.00	11300 INTEREST EXPENSE				113. 00
200.00	Subtotal (see instructions)				200. 00
201.00	Less Observation Beds				201. 00
202.00	Total (see instructions)				202. 00

Health Financial Systems	FRANCISCAN HI	EALTH- DYER		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider Co	Provider CCN: 15-0090		Worksheet D Part I Date/Time Pre 7/29/2021 1:2	pared: 7 pm
		Title	Title XVIII		PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient		
	Related Cost	Adjustment	Capi tal	Days	3 / col . 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col . 1 - col			
	26)		2)			
	1.00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDI ATRI CS	1, 490, 203		1, 490, 20	22, 165	67. 23	30.00
31.00 INTENSIVE CARE UNIT	366, 036		366, 03			
32. 00 CORONARY CARE UNIT	6, 378		6, 37	'8 0	0.00	32. 00
41. 00 SUBPROVI DER - I RF	126, 583	0	126, 58	7, 652	16. 54	41. 00
42. 00 SUBPROVI DER	0	0		0 0	0.00	42.00
43. 00 NURSERY	0			0 0	0.00	43.00
200.00 Total (lines 30 through 199)	1, 989, 200		1, 989, 20	32, 664		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	8, 303				l	30. 00
31.00 INTENSIVE CARE UNIT	1, 026	131, 913			l	31. 00
32. 00 CORONARY CARE UNIT	0	0			ļ	32. 00
41. 00 SUBPROVI DER - I RF	4, 705	77, 821			ļ	41. 00
42. 00 SUBPROVI DER	0	0			ļ	42. 00
43. 00 NURSERY	0	0			ļ	43.00
200.00 Total (lines 30 through 199)	14, 034	767, 945				200. 00

Health Financial Systems	inancial Systems FRANCISCAN HEALTH- DYER In Lieu					
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der C		Peri od:	Worksheet D	
				From 01/01/2020	Part II	
				To 12/31/2020	Date/Time Pre	pared:
			\au_1.1		7/29/2021 1: 2	7 pm
	1		XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
	Related Cost	(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,		(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	_	,				
50.00 05000 OPERATING ROOM	869, 232		0. 01812	0 5, 610, 163	101, 656	50.00
50. 01 05001 0UTPATI ENT SURGERY	274, 970	7, 518, 975	0. 03657	0 1, 627, 922	59, 533	50. 01
51.00 05100 RECOVERY ROOM	113, 416	4, 853, 072	0. 02337	0 621, 931	14, 535	51.00
53. 00 05300 ANESTHESI OLOGY	133, 887	14, 774, 998	0. 00906	2 1, 926, 129	17, 455	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 233, 194	49, 679, 988	0. 02482	3 7, 787, 023	193, 297	54.00
54. 01 05401 RADI OLOGY-SPECI AL PROCEDURES	247, 763			5 731, 949	41, 864	54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C	21, 086		1	ol o	0	55. 00
56. 00 05600 RADI OI SOTOPE	170, 591	10, 042, 834	1		10, 289	56. 00
60. 00 06000 LABORATORY	113, 962		1		22, 719	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	37, 137		l .		15, 364	63. 00
65. 00 06500 RESPIRATORY THERAPY	107, 426				32, 101	65. 00
66. 00 06600 PHYSI CAL THERAPY	85, 247				5, 451	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	11, 104				2, 292	67. 00
68. 00 06800 SPEECH PATHOLOGY	8, 228		1		1, 560	68. 00
1			1		· ·	1
69. 00 06900 ELECTROCARDI OLOGY	84, 291	14, 706, 570			16, 585	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	85, 162				6, 982	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	27, 651	30, 097, 934			5, 070	71. 00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	31, 075				6, 967	72. 00
73.00 O7300 DRUGS CHARGED TO PATIENTS	78, 752				23, 259	73. 00
76.00 03630 ULTRA SOUND	156, 114				25, 097	76. 00
76. 01 03951 PAIN CLINIC	163, 379	9, 063, 003	0. 01802	7 8, 877	160	76. 01
76. 02 03952 CATH_LAB	714, 190	41, 275, 703			119, 048	76. 02
76.03 03953 ACTIVITY THERAPEUTIC	86, 130	5, 320, 025	0. 01619	0 10, 461	169	76. 03
76. 04 03954 WOUND CARE CENTER	86, 837	1, 990, 591	0. 04362	4 9, 217	402	76. 04
76. 05 03340 BARI ATRI C CLI NI C	32, 426	526, 686	0. 06156	6 141	9	76. 05
76.06 03030 HEALTHY LIVING CENTER	0	0	0. 00000	ol ol	0	76. 06
76. 07 03950 CV RESOURCE CENTER	692	1	0.00000		0	76. 07
76. 08 03955 OTHER ANCILLARY SERVICE COST CENTERS	0		0. 00000		0	76. 08
76. 09 03956 LACTATION CLINIC	0		0. 00000		0	76. 09
76. 10 03957 OTHER ANCILLARY SERVICE COST CENTERS	0		0. 00000		0	76. 10
76. 11 03958 OTHER ANCI LLARY SERVICE COST CENTERS		Ĭ	0. 00000		0	76. 10
76. 12 03959 ANTI COAGULATI ON CLINI C	8, 982				10	76. 11
OUTPATIENT SERVICE COST CENTERS	0, 982	1 990, 021	0.00900	1,000	10	70.12
91. 00 09100 EMERGENCY	410, 973	53, 670, 677	0. 00765	7, 665, 177	58, 692	91. 00
					58, 692 0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	236, 995					
200.00 Total (lines 50 through 199)	5, 630, 892	449, 419, 476	1	72, 956, 131	780, 566	J∠UU. UU

Health Financial Systems APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER F	FRANCISCAN HI PASS THROUGH COS			Period: From 01/01/2020	worksheet D Part III	
				To 12/31/2020	Date/Time Pre 7/29/2021 1:2	epared: 27 pm
		Title	: XVIII	Hospi tal	PPS	. т рііі
Cost Center Description		Nursing School		h Allied Health	All Other	
	Post-Stepdown		Post-Stepdow		Medi cal	
	Adj ustments		Adjustments		Education Cost	
INDATI ENT DOUTING CEDVI CE COCT CENTEDO	1A	1.00	2A	2. 00	3. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	0	0		0 0	0	30.00
31. 00 03100 NTENSI VE CARE UNI T				0 0	0	
32. 00 03200 CORONARY CARE UNIT		0		0 0	0	
41. 00 04100 SUBPROVI DER - I RF	0	0			0	
42. 00 04200 SUBPROVI DER	0	0		0 0	Ö	
43. 00 04300 NURSERY	0	Ö		0 0	ő	
200.00 Total (lines 30 through 199)	0	O		0 0	0	200.00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patien	t Per Diem (col.	Inpati ent	
	Adjustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,				
		minus col. 4)				
INDATIONS DOUBLING CODY OF COCT CONTEDC	4. 00	5. 00	6. 00	7. 00	8. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	0	0	22, 16	5 0.00	8, 303	30.00
31. 00 03100 NTENSI VE CARE UNI T		0	1		1, 026	
32. 00 03200 CORONARY CARE UNIT		0	1	0.00	1,020	1
41. 00 04100 SUBPROVI DER - RF	0	0	7, 65		4, 705	
42. 00 04200 SUBPROVI DER	0	Ö		0.00	0	1
43. 00 04300 NURSERY		0		0.00		
200.00 Total (lines 30 through 199)		0	32, 66	54	14, 034	200.00
Cost Center Description	I npati ent					
	Program					
	Pass-Through					
	Cost (col. 7 x col. 8)					
	9.00					
INPATIENT ROUTINE SERVICE COST CENTERS	7.00					
30. 00 03000 ADULTS & PEDIATRICS	0					30.00
31. 00 03100 I NTENSI VE CARE UNI T	0					31.00
32. 00 03200 CORONARY CARE UNIT	0					32. 00
41. 00 04100 SUBPROVI DER - I RF	0					41.00
42. 00 04200 SUBPROVI DER	0					42.00
43. 00 04300 NURSERY	0					43. 00
200.00 Total (lines 30 through 199)	0					200.00

Health Financial Systems	FRANCISCAN HEAL	TH- DYER	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0090	Peri od: From 01/01/2020 To 12/31/2020	Worksheet D Part IV Date/Time Prepared:

					10 12/31/2020	7/29/2021 1:2	parea: 7 nm
			Ti tl e	e XVIII	Hospi tal	PPS	7 p
	Cost Center Description	Non Physician	Nursing School	Nursing School	Allied Health	Allied Health	
	'	Anestheti st	Post-Stepdown		Post-Stepdown		
		Cost	Adjustments		Adjustments		
		1.00	2A	2. 00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATI NG ROOM	0	C)	0	0	
50. 01	05001 OUTPATI ENT SURGERY	0	C)	0	0	50. 01
51.00	05100 RECOVERY ROOM	0	C) (0	0	51.00
53.00	05300 ANESTHESI OLOGY	0	C) (0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	C) (0	0	54.00
54. 01	05401 RADI OLOGY-SPECI AL PROCEDURES	0	C) (0	0	54. 01
55.00	05500 RADI OLOGY-THERAPEUTI C	0	C) (0	0	55. 00
56.00	05600 RADI 0I SOTOPE	0	C) (0	0	56. 00
60.00	06000 LABORATORY	0	C)	0	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	C)	0	0	63.00
65.00	06500 RESPI RATORY THERAPY	0	C)	0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0	C)	0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	C)	0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	C) (0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	C)	0	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	C)	0	0	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	C)	0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	C)	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	C)	0	0	73. 00
76.00	03630 ULTRA SOUND	0	C)	0	0	76. 00
76. 01	03951 PAIN CLINIC	0	C)	0	0	76. 01
76. 02	03952 CATH LAB	0	C)	0	0	76. 02
76. 03	03953 ACTIVITY THERAPEUTIC	0	C)	0	0	76. 03
76. 04	03954 WOUND CARE CENTER	0	C)	0	0	76. 04
76. 05	03340 BARI ATRI C CLI NI C	0	C)	0	0	76. 05
76.06	03030 HEALTHY LIVING CENTER	0	C)	0	0	76. 06
76. 07	03950 CV RESOURCE CENTER	0	C)	0	0	76. 07
76. 08	03955 OTHER ANCILLARY SERVICE COST CENTERS	0	C) (0	0	76. 08
76. 09	03956 LACTATION CLINIC	0	C) (0	0	76. 09
76. 10	03957 OTHER ANCILLARY SERVICE COST CENTERS	0	C) (0	0	76. 10
76. 11	03958 OTHER ANCILLARY SERVICE COST CENTERS	0	C) (0	0	76. 11
76. 12	03959 ANTI COAGULATI ON CLINIC	0	C) (0	0	76. 12
	OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	0	C		0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0				0	92.00
200.00	Total (lines 50 through 199)	0	C) (0	0	200. 00

Health Financial Systems	FRANCISCAN HEAL	TH- DYER	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0090	Peri od:	Worksheet D
THROUGH COSTS			From 01/01/2020	

THROUGH COSTS				From 01/01/2020 To 12/31/2020		
		Title	XVIII	Hospi tal	PPS	, biii
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
	Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	
		,	and 4)		(see	
					instructions)	
	4, 00	5. 00	6. 00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	0	0		0 47, 969, 538	0.000000	50.00
50, 01 05001 OUTPATIENT SURGERY	0	0		7, 518, 975	0.000000	50. 01
51. 00 05100 RECOVERY ROOM	0	0		4, 853, 072		51.00
53. 00 05300 ANESTHESI OLOGY	0	0		14, 774, 998		•
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		49, 679, 988		•
54. 01 05401 RADI OLOGY-SPECI AL PROCEDURES	0	0		4, 331, 908		•
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		1, 551, 755	0. 000000	•
56. 00 05600 RADI 0I SOTOPE	0	0		10, 042, 834		1
60. 00 06000 LABORATORY		0		51, 929, 817	0.000000	1
	0	0				
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	· ·		2, 030, 689		•
65. 00 06500 RESPIRATORY THERAPY	0	0		12, 366, 641		ı
66. 00 06600 PHYSI CAL THERAPY	0	0		16, 753, 017		66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		0 4, 329, 991		1
68. 00 06800 SPEECH PATHOLOGY	0	0		2, 424, 017		68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0		14, 706, 570		1
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		2, 460, 953		1
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		30, 097, 934		1
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		11, 795, 315	0.000000	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		32, 968, 282	0.000000	73. 00
76.00 03630 ULTRA SOUND	0	0		7, 258, 564	0.000000	76. 00
76. 01 03951 PALN CLINIC	0	0		9, 063, 003	0.000000	76. 01
76. 02 03952 CATH_LAB	0	0		0 41, 275, 703	0.000000	76. 02
76. 03 03953 ACTIVITY THERAPEUTIC	0	0		5, 320, 025	0.000000	76. 03
76. 04 03954 WOUND CARE CENTER	0	0		1, 990, 591	0.000000	76. 04
76. 05 03340 BARI ATRI C CLI NI C	0	0		526, 686	0.000000	76. 05
76.06 03030 HEALTHY LIVING CENTER	0	0		0 0	0.000000	76.06
76. 07 03950 CV RESOURCE CENTER	0	0		0	0.000000	•
76. 08 03955 OTHER ANCILLARY SERVICE COST CENTERS	0	0		0	0. 000000	76. 08
76. 09 03956 LACTATION CLINIC	0	0		0	0. 000000	1
76. 10 03957 OTHER ANCILLARY SERVICE COST CENTERS	0	0		0 0	0. 000000	76. 10
76. 11 03958 OTHER ANCILLARY SERVICE COST CENTERS	0	0		0 0		l
76. 12 03959 ANTI COAGULATI ON CLINI C	0	0		990, 621		l
OUTPATIENT SERVICE COST CENTERS	U			3 770, 021	0.00000	70.12
91. 00 09100 EMERGENCY	0	0		53, 670, 677	0.000000	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		8, 289, 067		1
200.00 Total (lines 50 through 199)	0	0		0 449, 419, 476		200. 00
200.00 Total (Titles 50 till ough 199)	ı o	U	'	J 447, 417, 470	I I	₁ 200.00

He	al th Financial	Systems		FRA	ANCI SCA	N HEAL	TH- DYER			In Lie	u of Form CMS-2552-10
	PPORTIONMENT OF ROUGH COSTS	I NPATI ENT/OUTPATI ENT	ANCI LLARY	SERVI CE	OTHER	PASS	Provi der	CCN:	15-0090	From 01/01/2020	Worksheet D Part IV

THROUGH COSTS			Fi To	rom 01/01/2020 o 12/31/2020	Part IV Date/Time Pre	pared:
					7/29/2021 1:2	
			XVIII	Hospi tal	PPS	
Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	Charges	Pass-Through	
	(col. 6 ÷ col.		Costs (col. 8		Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10. 00	11. 00	12. 00	13. 00	
ANCILLARY SERVICE COST CENTERS			_		_	
50. 00 05000 OPERATI NG ROOM	0. 000000	5, 610, 163		4, 969, 531	0	50. 00
50. 01 05001 OUTPATI ENT SURGERY	0. 000000	1, 627, 922	1	1, 436, 383	0	50. 01
51. 00 05100 RECOVERY ROOM	0. 000000	621, 931	0	562, 742	0	51. 00
53. 00 05300 ANESTHESI OLOGY	0. 000000	1, 926, 129		1, 981, 814	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	7, 787, 023		8, 748, 657	0	54. 00
54. 01 05401 RADI OLOGY-SPECI AL PROCEDURES	0. 000000	731, 949	0	215, 395	0	54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	0	0	0	0	55. 00
56. 00 05600 RADI OI SOTOPE	0. 000000	605, 724	0	3, 664, 628	0	56. 00
60. 00 06000 LABORATORY	0. 000000	10, 350, 426	0	718, 552	0	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	840, 117	0	35, 201	0	63. 00
65. 00 06500 RESPIRATORY THERAPY	0. 000000	3, 695, 331	0	1, 742, 198	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	1, 071, 330	0	41, 058	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	893, 825	0	910	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	459, 639	0	77, 255	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	2, 893, 381	0	3, 597, 392	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	201, 762	0	412, 290	0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	5, 517, 313	0	3, 050, 099	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	2, 644, 207	0	2, 577, 589	0	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	9, 735, 950	0	2, 550, 621	0	73. 00
76.00 03630 ULTRA SOUND	0. 000000	1, 166, 879		1, 108, 693	0	76. 00
76. 01 03951 PALN CLINIC	0. 000000	8, 877	0	2, 287, 978	0	76. 01
76. 02 03952 CATH LAB	0. 000000	6, 880, 192	0	11, 577, 229	0	76. 02
76. 03 03953 ACTIVITY THERAPEUTIC	0. 000000	10, 461	0	31, 787	0	76. 03
76. 04 03954 WOUND CARE CENTER	0. 000000	9, 217	0	1, 002, 508	0	76. 04
76. 05 03340 BARI ATRI C CLI NI C	0. 000000	141		44, 623	0	76. 05
76.06 03030 HEALTHY LIVING CENTER	0. 000000	0		0	0	76. 06
76. 07 03950 CV RESOURCE CENTER	0. 000000	0	0	0	0	76. 07
76.08 03955 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000	0	0	0	0	76. 08
76. 09 03956 LACTATION CLINIC	0. 000000	0	_	0	0	76. 09
76. 10 03957 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000	0	0	0	0	76. 10
76. 11 03958 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000	0	o o	0	0	76. 11
76. 12 03959 ANTI COAGULATI ON CLINI C	0. 000000	1, 065		577, 335	0	76. 12
OUTPATIENT SERVICE COST CENTERS	0.000000	1,000		077,000		70.12
91. 00 09100 EMERGENCY	0. 000000	7, 665, 177	0	6, 135, 385	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0,000,177		1, 001, 402	0	
200.00 Total (lines 50 through 199)		72, 956, 131			_	200.00
	1	, 2, , 55, 101	١	00, , 200		1-30.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0090 Peri od: Worksheet D From 01/01/2020 Part V Date/Time Prepared: 12/31/2020 7/29/2021 1:27 pm Title XVIII Hospi tal PPS Charges Costs Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Ratio From Services (see Rei mbursed Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Part I, col. 9 Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 1.00 2.00 5. 00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 097707 4, 969, 531 485, 558 50.00 50.01 05001 OUTPATIENT SURGERY 0.364533 1, 436, 383 0 0 523, 609 50.01 05100 RECOVERY ROOM 0 51 00 0.205106 562, 742 51 00 115, 422 0 0 53.00 05300 ANESTHESI OLOGY 0.255312 1, 981, 814 505, 981 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.113638 8, 748, 657 0 994, 180 54.00 55, 088 54.01 05401 RADI OLOGY-SPECI AL PROCEDURES 0. 255755 0 0 54.01 215, 395 05500 RADI OLOGY-THERAPEUTI C 0 55.00 0.000000 Λ 55.00 56.00 05600 RADI OI SOTOPE 0.124032 3, 664, 628 454, 531 56.00 60.00 06000 LABORATORY 0.140876 718, 552 24, 976 0 101, 227 60.00 06300 BLOOD STORING, PROCESSING & TRANS. 0.094668 35, 201 63 00 0 3, 332 63 00 65.00 06500 RESPIRATORY THERAPY 0. 243444 1, 742, 198 0 424, 128 65.00 06600 PHYSI CAL THERAPY 0.674585 0 0 27, 697 66.00 41,058 66.00 0 06700 OCCUPATIONAL THERAPY 910 0. 227667 67.00 0 207 67.00 77, 255 06800 SPEECH PATHOLOGY 17, 909 68.00 0. 231818 0 68 00 69.00 06900 ELECTROCARDI OLOGY 0.113444 3, 597, 392 37, 195 0 408, 103 69.00 07000 ELECTROENCEPHALOGRAPHY 0 70.00 0. 246470 412, 290 0 101, 617 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0. 270695 3, 050, 099 0 0 825, 647 71.00 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 72 00 0.847889 2, 577, 589 2, 185, 509 72 00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.303556 2, 550, 621 19, 966 774, 256 73.00 03630 ULTRA SOUND 0 76.00 0.147331 1, 108, 693 0 163, 345 76.00 0 03951 PAIN CLINIC 76.01 0.206009 2, 287, 978 0 471.344 76.01 03952 CATH LAB 0 0 76.02 0.093888 11, 577, 229 1,086,963 76 02 76.03 03953 ACTIVITY THERAPEUTIC 0.807512 0 31, 787 25,668 76.03 03954 WOUND CARE CENTER 76. 04 0.510479 1,002,508 0 511, 759 76.04 03340 BARIATRIC CLINIC 44, 623 0 90, 948 76.05 2.038152 76.05 0 76.06 03030 HEALTHY LIVING CENTER 0.000000 Ω 76.06 C 03950 CV RESOURCE CENTER 0.000000 0 0 0 76.07 0 76.07 76.08 03955 OTHER ANCILLARY SERVICE COST CENTERS 0.000000 0 0 0 76.08 76 09 03956 LACTATION CLINIC 0 0.000000 C Ω 76.09 0 76. 10 03957 OTHER ANCILLARY SERVICE COST CENTERS 0.000000 0 76. 10 03958 OTHER ANCILLARY SERVICE COST CENTERS o 76. 11 0.000000 0 0 76. 11 03959 ANTI COAGULATION CLINIC 0.785676 577, 335 453, 598 76. 12 0 76. 12 OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 0. 158702 6, 135, 385 0 0 973, 698 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.513373 514, 093 92.00 1,001,402 0 200.00 Subtotal (see instructions) 19.966 200.00 60, 149, 255 62, 171 12, 295, 417 201.00 Less PBP Clinic Lab. Services-Program 201.00 Only Charges

60, 149, 255

62, 171

19, 966

12, 295, 417 202. 00

202.00

Net Charges (line 200 - line 201)

12/31/2020 Date/Time Prepared: 7/29/2021 1:27 pm Title XVIII Hospi tal PPS Costs Cost Center Description Cost Cost Rei mbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 6.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 50.00 50.01 05001 OUTPATIENT SURGERY 0 0 0 0 50.01 51. 00 05100 RECOVERY ROOM 0 51 00 05300 ANESTHESI OLOGY 53.00 0 53.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 54.00 0 54. 01 05401 RADI OLOGY-SPECI AL PROCEDURES 0 54.01 05500 RADI OLOGY-THERAPEUTI C 0 55.00 55.00 56.00 05600 RADI OI SOTOPE 0 0 56.00 06000 LABORATORY 0 60.00 3, 519 60.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 63 00 63.00 0 65.00 06500 RESPIRATORY THERAPY 0 0 65.00 66.00 06600 PHYSI CAL THERAPY 0 0 66.00 06700 OCCUPATIONAL THERAPY 67.00 0 0 67.00 0 0 68.00 06800 SPEECH PATHOLOGY 68.00 69.00 06900 ELECTROCARDI OLOGY 4, 220 0 69.00 07000 ELECTROENCEPHALOGRAPHY 0 0 70.00 70.00 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71.00 000000000000000 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 72.00 Ω 73.00 07300 DRUGS CHARGED TO PATIENTS 6,061 73.00 03630 ULTRA SOUND 76.00 76.00 0 03951 PAIN CLINIC 76. 01 0 76.01 03952 CATH LAB 76.02 0 76.02 76. 03 03953 ACTIVITY THERAPEUTIC 0 76.03 03954 WOUND CARE CENTER 76. 04 76.04 76. 05 03340 BARIATRIC CLINIC 0 76.05 03030 HEALTHY LIVING CENTER 76.06 76.06 76. 07 03950 CV RESOURCE CENTER 76.07 03955 OTHER ANCILLARY SERVICE COST CENTERS 0 76. 08 76.08 76.09 03956 LACTATION CLINIC 0 76.09 03957 OTHER ANCILLARY SERVICE COST CENTERS 76. 10 0 76. 10 03958 OTHER ANCILLARY SERVICE COST CENTERS 0 76. 11 0 76. 11 03959 ANTI COAGULATION CLINIC 76.12 0 76. 12 OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 0 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 200.00 Subtotal (see instructions) 6,061 200.00 7,739

7,739

6,061

201. 00

202.00

201.00

202.00

Less PBP Clinic Lab. Services-Program

Net Charges (line 200 - line 201)

Only Charges

Health Financial Systems	FRANCI SCAN HE		ON 45 0000		eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L C0515	Provi der Co	CN: 15-0090	Peri od: From 01/01/2020	Worksheet D Part II	
		Component	CCN: 15-T090	To 12/31/2020	Date/Time Pre 7/29/2021 1:2	pared: 7 pm
		Title	× XVIII	Subprovi der – I RF	PPS	· ·
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,	9	Program	(column 3 x	
	(from Wkst. B,	· ·	(col . 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26) 1. 00	2.00	3.00	4. 00	5. 00	
ANCI LLARY SERVI CE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
50. 00 05000 OPERATING ROOM	869, 232	47, 969, 538	0. 0181:	20 114, 139	2, 068	50. 00
50. 01 05001 01PATI ENT SURGERY	274, 970		1			1
51. 00 05100 RECOVERY ROOM	113, 416					1
53. 00 05300 ANESTHESI OLOGY	133, 887					
54. 00 05400 RADI OLOGY - DI AGNOSTI C	1, 233, 194				8, 505	
54. 01 05401 RADI OLOGY-SPECI AL PROCEDURES	247, 763		1		0, 303	1
55. 00 05500 RADI OLOGY-THERAPEUTI C	21, 086		1		Ö	
56. 00 05600 RADI OI SOTOPE	170, 591		1			
60. 00 06000 LABORATORY	113, 962					1
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	37, 137					
65. 00 06500 RESPIRATORY THERAPY	107, 426		1			1
66. 00 06600 PHYSI CAL THERAPY	85, 247	16, 753, 017				66.00
67. 00 06700 OCCUPATI ONAL THERAPY	11, 104					67. 00
68. 00 06800 SPEECH PATHOLOGY	8, 228			1, 021, 787	3, 468	68. 00
69. 00 06900 ELECTROCARDI OLOGY	84, 291	14, 706, 570	0.0057	32 61, 193	351	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	85, 162	2, 460, 953	0. 03460	05 13, 187	456	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	27, 651	30, 097, 934	0.0009	19 636, 187	585	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	31, 075	11, 795, 315	0. 0026	35 39, 951	105	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	78, 752	32, 968, 282	0.0023	39 1, 219, 044	2, 912	73. 00
76.00 03630 ULTRA SOUND	156, 114	7, 258, 564	0. 02150	08 52, 714	1, 134	76. 00
76. 01 03951 PAIN CLINIC	163, 379				0	76. 01
76. 02 03952 CATH LAB	714, 190					1
76. 03 03953 ACTIVITY THERAPEUTIC	86, 130					76. 03
76. 04 03954 WOUND CARE CENTER	86, 837		1			
76. 05 03340 BARI ATRI C CLI NI C	32, 426	l	1			
76.06 03030 HEALTHY LIVING CENTER	0				1	
76. 07 03950 CV RESOURCE CENTER	692	0				
76. 08 03955 OTHER ANCILLARY SERVICE COST CENTERS	0	1	1 0.0000		1	
76. 09 03956 LACTATION CLINIC	0	0	1 0.0000		0	
76. 10 03957 OTHER ANCILLARY SERVICE COST CENTERS	0	0			0	
76. 11 03958 OTHER ANCILLARY SERVICE COST CENTERS	0	0			1	76. 11
76. 12 03959 ANTI COAGULATI ON CLI NI C	8, 982	990, 621	0.0090	57 10, 600	96	76. 12
OUTPATIENT SERVICE COST CENTERS	410.070	E2 /70 /77	0.007/1	7 212 205	1 (22	01 00
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	410, 973 0	1			1, 633	
200.00 Total (lines 50 through 199)	5, 393, 897		1	10, 961, 839		200.00
200.00 Total (Titles 50 till ough 199)	0, 373, 077	1 447,417,4/0	11	10, 701, 039	1 52, 209	1200.00

Health Financial Systems	FRANCISCAN HEAL	u of Form CMS-2552-10		
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0090	Peri od: From 01/01/2020	Worksheet D Part IV
Tilkoboli Costs		Component CCN: 15-T090		
		Title XVIII	Subprovi der -	PPS

		Title	xVIII	Subprovi der - I RF	PPS	
Cost Center Description	Non Dhycician	Nursing School	Nurcing School	Allied Health	Allied Health	
cost center bescription	Anesthetist	Post-Stepdown	INUISITIS SCHOOL	Post-Stepdown	Allieu nealth	
	Cost	Adjustments		Adjustments		
	1.00	2A	2.00	3A	3. 00	
ANCILLARY SERVICE COST CENTERS	1.00	ZA	2.00	JA.	3.00	
50. 00 05000 OPERATI NG ROOM	0	0		0	0	50.00
50. 01 05001 0UTPATI ENT SURGERY	0	0		0	o o	50. 01
51. 00 05100 RECOVERY ROOM	0	0	1	0	0	51.00
53. 00 05300 ANESTHESI OLOGY	0	0	l č	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	l č	0	0	54.00
54. 01 05401 RADI OLOGY-SPECI AL PROCEDURES	0	0	d	0	0	54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	d	0	0	55. 00
56. 00 05600 RADI OI SOTOPE	0	0	d	0	0	56.00
60. 00 06000 LABORATORY	0	0	d	0	0	60.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	d	0	0	63. 00
65. 00 06500 RESPIRATORY THERAPY	0	0	d	0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0	d	0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	d	0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	l o	d	Ö	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	,	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	,	0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	73. 00
76. 00 03630 ULTRA SOUND	0	0		0	0	76. 00
76. 01 03951 PALN CLINIC	0	0		0	0	76. 01
76. 02 03952 CATH_LAB	0	0	ol c	0	0	76. 02
76. 03 03953 ACTIVITY THERAPEUTIC	0	0	ol c	0	0	76. 03
76. 04 03954 WOUND CARE CENTER	0	0	ol c	0	0	76. 04
76. 05 03340 BARI ATRI C CLI NI C	0	0	ol c	0	0	76. 05
76.06 03030 HEALTHY LIVING CENTER	0	0) c	0	0	76. 06
76. 07 03950 CV RESOURCE CENTER	0	0) c	0	0	76. 07
76.08 03955 OTHER ANCILLARY SERVICE COST CENTERS	0	0) c	0	0	76. 08
76.09 03956 LACTATION CLINIC	0	0) c	0	0	76. 09
76. 10 03957 OTHER ANCILLARY SERVICE COST CENTERS	0	0) c	0	0	76. 10
76.11 03958 OTHER ANCILLARY SERVICE COST CENTERS	0	0	C	0	0	76. 11
76. 12 03959 ANTI COAGULATI ON CLINIC	0	0	C	0	0	76. 12
OUTPATIENT SERVICE COST CENTERS						
91. 00 09100 EMERGENCY	0	0	C	0	0	, , , , , , ,
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0		(c)	0	92. 00
200.00 Total (lines 50 through 199)	0	0) c	0	0	200. 00

	<u>Financial Systems</u> TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI	FRANCISCAN H		CN. 15 0000		eu of Form CMS-2	2552-10
	TONMENT OF INPATTENT/OUTPATTENT ANCILLARY SEI SH COSTS	RVICE UTHER PAS	S Provider C	CN: 15-0090	Peri od: From 01/01/2020	Worksheet D Part IV	
THROUG	n C0313		Component	CCN: 15-T090	To 12/31/2020	Date/Time Pre	pared:
						7/29/2021 1:2	7 pm
			Titl€	× XVIII	Subprovi der - I RF	PPS	
	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
		Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
		Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
			4)	col s. 2, 3,		7)	
				and 4)		(see	
						instructions)	
		4. 00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS						
50. 00	05000 OPERATI NG ROOM	0		1	0 47, 969, 538		
50. 01	05001 OUTPATI ENT SURGERY	0	-	1	0 7, 518, 975	0.000000	1
51. 00	05100 RECOVERY ROOM	0	0		0 4, 853, 072	0.000000	
53.00	05300 ANESTHESI OLOGY	0	0		0 14, 774, 998	l e	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 49, 679, 988	0.000000	1
54. 01	05401 RADI OLOGY-SPECI AL PROCEDURES	0	0		0 4, 331, 908	0.000000	
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0		0	0.000000	1
56.00	05600 RADI 0I SOTOPE	0	0		0 10, 042, 834	0. 000000	1
60.00	06000 LABORATORY	0	0	1	0 51, 929, 817	0. 000000	1
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	1	0 2, 030, 689	0. 000000	1
65. 00	06500 RESPI RATORY THERAPY	0	0	1	0 12, 366, 641	0. 000000	1
66. 00	06600 PHYSI CAL THERAPY	0	0		0 16, 753, 017	0.000000	
67. 00	06700 OCCUPATI ONAL THERAPY	0	0		0 4, 329, 991	0.000000	1
68. 00	06800 SPEECH PATHOLOGY	0	0		0 2, 424, 017	0. 000000	1
69. 00	06900 ELECTROCARDI OLOGY	0	0	1	0 14, 706, 570	0.000000	1
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0 2, 460, 953	0. 000000	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 30, 097, 934	0.000000	1
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 11, 795, 315	0.000000	1
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 32, 968, 282	0.000000	1
76. 00	03630 ULTRA SOUND	0	0		0 7, 258, 564		1
76. 01	03951 PAIN CLINIC	0	0		0 9, 063, 003	0.000000	1
76. 02	03952 CATH LAB	0	0		0 41, 275, 703	0.000000	
76. 03	03953 ACTIVITY THERAPEUTIC	0	0		0 5, 320, 025	0.000000	1
76. 04	03954 WOUND CARE CENTER	0	0		0 1, 990, 591	0.000000	1
76. 05	03340 BARI ATRI C CLI NI C	0	0		0 526, 686	0.000000	1
76.06	03030 HEALTHY LIVING CENTER	0	0		0 0	0.000000	1
76. 07	03950 CV RESOURCE CENTER	0	0		0 0	0.000000	1
76. 08	03955 OTHER ANCILLARY SERVICE COST CENTERS	0				0.000000	
76. 09 76. 10	03957 OTHER ANCILLARY SERVICE COST CENTERS	0				0. 000000 0. 000000	1
	03958 OTHER ANCILLARY SERVICE COST CENTERS		1		0 0	0.00000	1
	1 1			1	٥	l	1
70. 12	03959 ANTI COAGULATI ON CLINI C OUTPATI ENT SERVI CE COST CENTERS		1 0	1	0 990, 621	0. 000000	76. 12
91. 00	09100 EMERGENCY	0	0		0 53, 670, 677	0. 000000	91.00
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART				0 8, 289, 067	0.00000	1
200.00					0 449, 419, 476	l	200.00
200.00	1.000 00 till odgil 177)	1	1	1	-1, 11,, 470	ı	,_00.00

	Outpati ent	Component (CN: 15-T090	From 01/01/2020 To 12/31/2020	Part IV	
	Outpatient	Title		10 12/01/2020	Date/Time Pre 7/29/2021 1:2	
	Outnatient		XVIII	Subprovider - IRF	PPS	
Ra		I npati ent	I npati ent	Outpati ent	Outpati ent	
	atio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
(C	col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
_	7) 9. 00	10.00	x col. 10) 11.00	12.00	x col . 12) 13.00	
ANCILLARY SERVICE COST CENTERS	9.00	10. 00	11.00	12.00	13.00	
0. 00 05000 OPERATING ROOM	0. 000000	114, 139		0 0	0	50.00
0. 01 05000 OPERATING ROOM 0. 01 05001 OUTPATIENT SURGERY	0. 000000			0 0	0	50.00
1	0. 000000	20, 670 14, 716		0 0	0	
I. 00 05100 RECOVERY ROOM B. 00 05300 ANESTHESI OLOGY	0. 000000	26, 500		0 0	0	51. 00 53. 00
1. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	342, 617		0 0	0	
1. 01 05400 RADI OLOGY-DI AGNOSTI C 1. 01 05401 RADI OLOGY-SPECI AL PROCEDURES	0. 000000	342, 617		0 0	0	
5. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	0		0 0	0	
5. 00 05600 RADI 0I SOTOPE	0. 000000	8, 586		0 0	0	56.00
0. 00 06000 LABORATORY	0. 000000	825, 875		0 0	0	60.00
3. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	21, 762		0 0	0	63.00
5. 00 06500 RESPIRATORY THERAPY	0. 000000	524, 340		0 0	0	65.00
5. 00 06600 PHYSI CAL THERAPY	0. 000000	2, 943, 685		0 0	0	66.00
7. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	2, 826, 900		0 0	0	67.00
3. 00 06800 SPEECH PATHOLOGY	0. 000000	1, 021, 787		0 0	0	
P. 00 06900 ELECTROCARDI OLOGY	0. 000000	61, 193		o o	0	
0. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	13, 187		0 0	0	70.00
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	636, 187		0 0	0	71.00
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	39, 951		0 0	0	72.00
3.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	1, 219, 044		0 0	0	73.00
5. 00 03630 ULTRA SOUND	0. 000000	52, 714		0 0	0	76.00
5. 01 03951 PALN CLINIC	0. 000000	0		0	0	76. 01
5. 02 03952 CATH LAB	0. 000000	23, 956		0	0	76. 02
5. 03 03953 ACTI VI TY THERAPEUTI C	0. 000000	225		0	0	76. 03
5. 04 03954 WOUND CARE CENTER	0. 000000	0		0 0	0	76. 04
5. 05 03340 BARIATRIC CLINIC	0. 000000	0		0 0	0	76. 05
5. 06 03030 HEALTHY LIVING CENTER	0. 000000	0		0	0	76. 06
5. 07 03950 CV RESOURCE CENTER	0. 000000	0		0 0	0	76. 07
5. 08 03955 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000	0		0 0	0	76. 08
5. 09 03956 LACTATION CLINIC	0. 000000	0		0	0	
5. 10 03957 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000	0		0	0	
5. 11 03958 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000	0		0	0	
5. 12 03959 ANTI COAGULATI ON CLINI C	0. 000000	10, 600		0 0	0	76. 12
OUTPATIENT SERVICE COST CENTERS	0.00001	040		-		
I. 00 09100 EMERGENCY	0. 000000	213, 205		0	0	
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 00.00 Total (lines 50 through 199)	0. 000000	0 10, 961, 839		0 0	0	92. 00 200. 00

Health Financial Systems FRANCISCAN HEALTH- DYER				In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES	AND VACCINE COST	Provider CO		Peri od: From 01/01/2020	Worksheet D Part V	
		Component (To 12/31/2020		
		Title	XVIII	Subprovider - IRF	PPS	
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
	Ratio From S	Services (see	Reimbursed	Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Services	Services Not		

				Charges		Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed		Cost	PPS Services	
		Ratio From	Services (see	Rei mbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not	(222 111231)	
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins.	Ded. & Coins.		
				(see inst.)	(see inst.)		
		1.00	2.00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0. 097707	0	0	0	0	50.00
50. 01	05001 OUTPATI ENT SURGERY	0. 364533	0	0	0	0	50. 01
51.00	05100 RECOVERY ROOM	0. 205106	0	0	0	0	51.00
53.00	05300 ANESTHESI OLOGY	0. 255312	0	0	0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 113638	0	0	0	0	54.00
54. 01	05401 RADI OLOGY-SPECI AL PROCEDURES	0. 255755	l .	0	0	0	54. 01
55. 00	05500 RADI OLOGY-THERAPEUTI C	0. 000000		0	0	0	55. 00
56. 00	05600 RADI OI SOTOPE	0. 124032	l .	0	0	0	56. 00
60.00	06000 LABORATORY	0. 140876		0	0	0	60.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 094668	l .	0	0	0	63. 00
65. 00	06500 RESPIRATORY THERAPY	0. 243444	0	0	0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0. 674585	0	0	0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 227667	0	0	0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0. 231818	0	l o	_	Ö	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 113444	0	0		0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 246470	0	0	_	0	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 270695	l .		0	0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 847889			0	Ö	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 303556	l .		800	0	73. 00
76. 00	03630 ULTRA SOUND	0. 147331				_	76. 00
76. 01	03951 PAIN CLINIC	0. 206009	0	٥		Ö	76. 01
76. 02	03952 CATH LAB	0. 093888		0		0	76. 02
76. 03	03953 ACTIVITY THERAPEUTIC	0. 807512		٥	_	Ö	76. 03
76. 04	03954 WOUND CARE CENTER	0. 510479				0	76. 04
76. 05	03340 BARI ATRI C CLI NI C	2. 038152	0		_	0	76. 05
76. 06	03030 HEALTHY LIVING CENTER	0. 000000			0	0	76. 06
76. 07	03950 CV RESOURCE CENTER	0. 000000		0	0	Ö	76. 07
76. 08	03955 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000			0	0	76. 08
76. 09	03956 LACTATION CLINIC	0. 000000			0	0	76. 09
76. 10	03957 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000		ĺ	0	Ö	76. 10
76. 13	03958 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000				0	76. 11
	03959 ANTI COAGULATI ON CLI NI C	0. 785676				_	76. 12
70. 12	OUTPATIENT SERVICE COST CENTERS	0.703070	· · · · · ·			0	70.12
91. 00	09100 EMERGENCY	0. 158702	0	290	0	0	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 138702		i e		_	1
200.00	1	0.010070		290		_	200.00
201.00	,			270	000		201.00
201.00	Only Charges			١			201.00
202.00			0	290	800	n	202. 00
	1 201)	1		1 270	000		1-32.00

Heal th	Financial Systems	FRANCI SCAN H	EALTH- DYER		In Lie	u of Form CMS-	2552-10
	TONMENT OF MEDICAL, OTHER HEALTH SERVICES AN		Provi der C	CN: 15-0090 CCN: 15-T090	Peri od: From 01/01/2020 To 12/31/2020	Worksheet D Part V	epared:
			Title	e XVIII	Subprovi der -	PPS	
		Co	sts		1.00	L	
	Cost Center Description	Cost	Cost	1			
	•	Rei mbursed	Rei mbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
		Ded. & Coins.	Ded. & Coins.				
		(see inst.)	(see inst.)				
		6.00	7.00				
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	C	1	1			50.00
50. 01	05001 OUTPATI ENT SURGERY	C		1			50. 01
51.00	05100 RECOVERY ROOM	C	0)			51.00
53.00	05300 ANESTHESI OLOGY	C	0)			53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	C	0)			54. 00
54. 01	05401 RADI OLOGY-SPECI AL PROCEDURES	C) 0)			54. 01
55. 00	05500 RADI OLOGY-THERAPEUTI C	C) 0)			55. 00
56.00	05600 RADI OI SOTOPE	C) 0)			56. 00
60.00	06000 LABORATORY	C) 0	1			60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	C) 0)			63. 00
65.00	06500 RESPI RATORY THERAPY	C) 0)			65. 00
66. 00	06600 PHYSI CAL THERAPY	C) 0)			66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	C) 0)			67. 00
68. 00	06800 SPEECH PATHOLOGY	C	0				68. 00
	06900 ELECTROCARDI OLOGY	C	0				69. 00
	07000 ELECTROENCEPHALOGRAPHY	C	0	1			70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	C) 0	1			71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS	C) 0)			72. 00
	07300 DRUGS CHARGED TO PATIENTS	C	243				73. 00
76. 00	03630 ULTRA SOUND	C	0	1			76. 00
	03951 PAIN CLINIC	C	0	1			76. 01
	03952 CATH LAB	C	0	1			76. 02
	03953 ACTIVITY THERAPEUTIC	C	0)			76. 03
	03954 WOUND CARE CENTER	C	0	1			76. 04
76. 05	03340 BARI ATRI C CLI NI C	C	0	1			76. 05
76. 06	03030 HEALTHY LIVING CENTER	C	0				76. 06

76.06	03030 HEALTHY LIVING CENTER	O	0		76.06
76. 07	03950 CV RESOURCE CENTER	0	0		76.07
76. 08	03955 OTHER ANCILLARY SERVICE COST CENTERS	0	0		76.08
76. 09	03956 LACTATION CLINIC	0	0		76.09
76. 10	03957 OTHER ANCILLARY SERVICE COST CENTERS	0	0		76. 10
76. 11	03958 OTHER ANCILLARY SERVICE COST CENTERS	0	0		76. 11
76. 12	03959 ANTI COAGULATI ON CLINIC	0	0		76. 12
	OUTPATIENT SERVICE COST CENTERS				
91.00	09100 EMERGENCY	46	0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00	Subtotal (see instructions)	46	243		200. 00
201.00	Less PBP Clinic Lab. Services-Program	0			201. 00
	Only Charges				
202.00	Net Charges (line 200 - line 201)	46	243		202. 00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0090 Peri od: Worksheet D From 01/01/2020 Part V Date/Time Prepared: 12/31/2020 7/29/2021 1:27 pm Title XIX Hospi tal Cost Charges Costs Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Ratio From Services (see Rei mbursed Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Part I, col. 9 Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 1.00 2.00 5. 00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 097707 6, 160, 455 601, 920 50.00 50.01 05001 OUTPATIENT SURGERY 0.364533 727, 615 0 0 265, 240 50.01 05100 RECOVERY ROOM 0 51 00 0.205106 108, 127 51 00 527, 176 0 0 53.00 05300 ANESTHESI OLOGY 0.255312 1, 237, 213 315, 875 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.113638 2, 641, 291 0 300, 151 54.00 87, 772 54.01 05401 RADI OLOGY-SPECI AL PROCEDURES 0. 255755 0 0 54.01 22 448 05500 RADI OLOGY-THERAPEUTI C 0 55.00 0.000000 Λ 55.00 56.00 05600 RADI OI SOTOPE 0.124032 644, 841 79, 981 56.00 0 60.00 06000 LABORATORY 0.140876 2, 561, 607 0 0 0 0 0 0 0 0 0 0 0 0 360, 869 60.00 0 06300 BLOOD STORING, PROCESSING & TRANS. 0.094668 63 00 40, 553 3, 839 63 00 06500 RESPIRATORY THERAPY 65.00 0. 243444 269, 596 65, 632 65.00 06600 PHYSI CAL THERAPY 0.674585 4, 337, 887 0 2, 926, 274 66.00 66.00 06700 OCCUPATIONAL THERAPY 6, 040 0. 227667 0 1, 375 67.00 67.00 0 06800 SPEECH PATHOLOGY 171, 128 68.00 0. 231818 39, 671 68 00 69.00 06900 ELECTROCARDI OLOGY 0.113444 557, 794 0 63, 278 69.00 235, 476 07000 ELECTROENCEPHALOGRAPHY 0. 246470 70.00 58, 038 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0. 270695 0 71.00 4, 916 1, 331 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0.847889 72 00 0 72 00 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0.303556 736, 920 223, 696 73.00 03630 ULTRA SOUND 0 76.00 0.147331 413, 628 60, 940 76.00 03951 PAIN CLINIC 1, 178, 873 0 76.01 0.206009 242, 858 76.01 0 03952 CATH LAB 76.02 0.093888 1, 269, 114 119, 155 76.02 66, 550 76.03 03953 ACTIVITY THERAPEUTIC 0.807512 0 0 0 0 0 0 0 53, 740 76.03 03954 WOUND CARE CENTER 0 76. 04 0.510479 92, 210 47,071 76.04 03340 BARIATRIC CLINIC 0 76.05 2.038152 155, 590 317, 116 76.05 03030 HEALTHY LIVING CENTER 0 76.06 0.000000 C 0 76.06 03950 CV RESOURCE CENTER 0.000000 76.07 0 76.07 0 76.08 03955 OTHER ANCILLARY SERVICE COST CENTERS 0.000000 0 0 76.08 76 09 03956 LACTATION CLINIC 0 0.000000 C Ω 76.09 0 76. 10 03957 OTHER ANCILLARY SERVICE COST CENTERS 0.000000 0 76.10 03958 OTHER ANCILLARY SERVICE COST CENTERS 0 o 76. 11 0.000000 O 76. 11 03959 ANTI COAGULATION CLINIC 11, 911 0.785676 0 76.12 15, 160 76. 12 OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 0. 158702 3, 879, 656 0 0 615, 709 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.513373 0 0 92.00 0 28, 019, 061 0 200.00 Subtotal (see instructions) 6, 906, 245 200. 00

0

0

o

28, 019, 061

201.00

6, 906, 245 202. 00

201.00

202.00

Less PBP Clinic Lab. Services-Program

Net Charges (line 200 - line 201)

Only Charges

				To 12/31/2020	Date/Time Pro 7/29/2021 1::	
		Ti tl	e XIX	Hospi tal	Cost	27 piii
	Cos	sts	I NIX	nospi tui	0031	
Cost Center Description	Cost	Cost				
oost conton boscii pti cii	Rei mbursed	Rei mbursed				
	Servi ces	Servi ces Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7. 00	1			
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	0	0)			50. 00
50. 01 05001 OUTPATI ENT SURGERY	0	0				50. 01
51.00 05100 RECOVERY ROOM	0	0				51.00
53. 00 05300 ANESTHESI OLOGY	0	0)			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0)			54.00
54. 01 05401 RADI OLOGY-SPECI AL PROCEDURES	0	0				54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0)			55. 00
56. 00 05600 RADI 0I SOTOPE	0	0)			56. 00
60. 00 06000 LABORATORY	0	0	,			60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	,			63. 00
65. 00 06500 RESPIRATORY THERAPY	0	0				65. 00
66. 00 06600 PHYSI CAL THERAPY	0	Ö	1			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0				67. 00
68. 00 06800 SPEECH PATHOLOGY	0	Ö	1			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	0	0				71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	Ô				72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	Ö				73. 00
76. 00 03630 ULTRA SOUND	0	Ö				76. 00
76. 01 03951 PAIN CLINIC	0	Ö				76. 01
76. 02 03952 CATH LAB	0	0				76. 02
76. 03 03953 ACTIVITY THERAPEUTIC	0	0	1			76. 03
76. 04 03954 WOUND CARE CENTER	0	Ö	1			76. 04
76. 05 03340 BARI ATRI C CLI NI C	0	Ö	1			76. 05
76. 06 03030 HEALTHY LIVING CENTER	0	0				76. 06
76. 07 03950 CV RESOURCE CENTER	0	0				76. 07
76. 08 03955 OTHER ANCILLARY SERVICE COST CENTERS	0	0				76. 08
76. 09 03956 LACTATION CLINIC	0	0				76. 09
76. 10 03957 OTHER ANCILLARY SERVICE COST CENTERS	0	0				76. 10
76. 11 03958 OTHER ANCILLARY SERVICE COST CENTERS	0	0				76. 10
76. 12 03959 ANTI COAGULATION CLINIC	0	0				76. 11
OUTPATIENT SERVICE COST CENTERS	0		1			70.12
91. 00 09100 EMERGENCY	0	0				91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	1			92.00
200.00 Subtotal (see instructions)		0	1			200.00
201. 00 Less PBP Clinic Lab. Services-Program			1			200.00
Only Charges						201.00
202.00 Net Charges (line 200 - line 201)	0	0	,			202. 00
202. 00	1	١	T			1-02. 00

	EDANOL COAN LI	-ALTU DVED			6.5	2550 40
Health Financial Systems APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	FRANCI SCAN HI		CN. 1F 0000	Period:	u of Form CMS-2 Worksheet D	2552-10
APPORTIONMENT OF INPATTENT ANCILLARY SERVICE CAPITA	L CUS13	Provi der C	UN: 15-0090	From 01/01/2020	Part II	
		Component	CCN: 15-T090	To 12/31/2020	Date/Time Pre 7/29/2021 1:2	pared: 7 pm
		Ti tl	e XIX	Subprovi der – I RF	TEFRA	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos		Capital Costs	
	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 + col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS					_	
50. 00 05000 OPERATING ROOM	869, 232		l .		0	50. 00
50. 01 05001 OUTPATI ENT SURGERY	274, 970				0	50. 01
51.00 05100 RECOVERY ROOM	113, 416				0	51. 00
53. 00 05300 ANESTHESI OLOGY	133, 887		1		0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 233, 194		1		0	54. 00
54. 01 05401 RADI OLOGY-SPECI AL PROCEDURES	247, 763		1		0	54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C	21, 086				0	55. 00
56. 00 05600 RADI 01 SOTOPE	170, 591				0	56. 00
60. 00 06000 LABORATORY	113, 962				0	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	37, 137				0	63. 00
65. 00 06500 RESPI RATORY THERAPY	107, 426				0	65. 00
66. 00 06600 PHYSI CAL THERAPY	85, 247				0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	11, 104				0	67. 00
68. 00 06800 SPEECH PATHOLOGY	8, 228		1		0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	84, 291		1		0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	85, 162				0	70. 00
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	27, 651		1		0	71. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	31, 075				0	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	78, 752				0	73.00
76. 00 03630 ULTRA SOUND	156, 114				0	76.00
76. 01 03951 PAIN CLINIC	163, 379		1		0	76. 01
76. 02 03952 CATH LAB	714, 190		1		0	76. 02
76. 03 03953 ACTI VI TY THERAPEUTI C	86, 130				0	76. 03
76. 04 03954 WOUND CARE CENTER	86, 837		l .		0	76. 04
76. 05 03340 BARI ATRI C CLINI C 76. 06 03030 HEALTHY LIVING CENTER	32, 426				0 0	76. 05
	_	_				76.06
76. 07 03950 CV RESOURCE CENTER	692	0			0	76. 07
76. 08 03955 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.0000		0	76. 08
76. 09 03956 LACTATION CLINIC	0	0	0.0000		0	76. 09
76. 10 03957 OTHER ANCILLARY SERVICE COST CENTERS	0	0			0	76. 10
76. 11 03958 OTHER ANCILLARY SERVICE COST CENTERS 76. 12 03959 ANTICOAGULATION CLINIC	0 000	000 (21			0	76. 11
76. 12 03959 ANTI COAGULATION CLINIC OUTPATIENT SERVICE COST CENTERS	8, 982	990, 621	0.0090	0	0	76. 12
91. 00 O9100 EMERGENCY	410, 973	53, 670, 677	0. 0076	57 600	5	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	410, 973	1			0	91.00
200.00 Total (lines 50 through 199)	5, 393, 897		1	600		200. 00
	5,070,077	1,, +/0	1	, 300	3	1=00.00

Health Financial Systems	FRANCISCAN HEAL	In Lieu of Form CMS-2552-10		
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0090	Peri od: From 01/01/2020	Worksheet D
THROUGH COSTS		Component CCN: 15-T090		Date/Time Prepared: 7/29/2021 1:27 pm
-		Title XIX	Subprovi der -	TEFRA

		Ti tl	e XIX	Subprovider -	TEFRA	
	I. 5	h	h	IRF		
Cost Center Description			Nursing School	Allied Health	Allied Health	
	Anesthetist	Post-Stepdown		Post-Stepdown		
	Cost	Adjustments	2.00	Adjustments	2.00	
ANCILLADY CEDVICE COCT CENTERS	1.00	2A	2. 00	3A	3. 00	
ANCI LLARY SERVI CE COST CENTERS 50.00 05000 0PERATI NG ROOM			1	1	0	50.00
		0				
50. 01 05001 0UTPATI ENT SURGERY	0	0	C		0	50. 01
51. 00 05100 RECOVERY ROOM		0			0	51.00
53. 00 05300 ANESTHESI OLOGY	0	0			0	53.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	0	0		0	0	54.00
54. 01 05401 RADI OLOGY-SPECI AL PROCEDURES	0	0		0	0	54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0	0	55. 00
56. 00 05600 RADI 0I SOTOPE	0	0		0	0	56. 00
60. 00 06000 LABORATORY	0	0	0	0	0	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	C	0	0	63. 00
65. 00 06500 RESPI RATORY THERAPY	0	0	(0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0	(0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	C	0	0	67. 00
68.00 06800 SPEECH PATHOLOGY	0	0	C	0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	C	0	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	C	0	0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	C	0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	C	0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	C	0	0	73. 00
76.00 03630 ULTRA SOUND	0	0	C	0	0	76.00
76. 01 03951 PALN CLINIC	0	0	C	0	0	76. 01
76. 02 03952 CATH LAB	0	0	C	0	0	76. 02
76. 03 03953 ACTIVITY THERAPEUTIC	0	0	C	0	0	76. 03
76. 04 03954 WOUND CARE CENTER	0	0	l c	0	0	76. 04
76. 05 03340 BARI ATRI C CLI NI C	0	0	l c	0	0	76. 05
76.06 03030 HEALTHY LIVING CENTER	0	0	l c	0	0	76. 06
76. 07 03950 CV RESOURCE CENTER	0	0	l c	0	0	76. 07
76.08 03955 OTHER ANCILLARY SERVICE COST CENTERS	0	0		0	0	76. 08
76. 09 03956 LACTATION CLINIC	0	0	l c	0	0	76. 09
76. 10 03957 OTHER ANCILLARY SERVICE COST CENTERS	0	0		0	0	76. 10
76. 11 03958 OTHER ANCILLARY SERVICE COST CENTERS	0	0		0	0	76. 11
76. 12 03959 ANTI COAGULATI ON CLINIC	0	0		0	0	76. 12
OUTPATIENT SERVICE COST CENTERS	-	-	<u> </u>			
91. 00 09100 EMERGENCY	0	0	C	0	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART			ĺ		0	•
200.00 Total (lines 50 through 199)						200.00
	1	'	1	1	1	

Health Financial S		FRANCI SCAN H		ON 45 0000		eu of Form CMS-2	2552-10
	NPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PAS	S Provider C	CN: 15-0090	Peri od: From 01/01/2020	Worksheet D Part IV	
THROUGH COSTS			Component	CCN: 15-T090	To 12/31/2020	Date/Time Pre	nared·
			ooporrorre			7/29/2021 1: 2	7 pm
			Ti tl	e XIX	Subprovi der -	TEFRA	
		1			IRF		
Cost (Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
		Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
		Education Cost		Cost (sum of		(col. 5 ÷ col.	
			4)	col s. 2, 3, and 4)	8)	7) (see	
				allu 4)		instructions)	
		4.00	5.00	6. 00	7. 00	8. 00	
ANCILLARY S	ERVICE COST CENTERS	1.00	0.00	0.00	7.00	0.00	
50. 00 05000 OPERA		0	С		0 47, 969, 538	0.000000	50. 00
	TI ENT SURGERY	0		1	0 7, 518, 975	0.000000	
51. 00 05100 RECOVE		0	l o)	0 4, 853, 072	0. 000000	51.00
53. 00 05300 ANESTH	HESI OLOGY	0	l o)	0 14, 774, 998	0. 000000	53. 00
54. 00 05400 RADI 01	LOGY-DI AGNOSTI C	0	l o)	0 49, 679, 988	0. 000000	
54. 01 05401 RADI 0L	LOGY-SPECIAL PROCEDURES	0	l c	,	0 4, 331, 908	0.000000	54. 01
	LOGY-THERAPEUTI C	0	0	1	0 0	0.000000	55. 00
56. 00 05600 RADI 01	SOTOPE	0	0	1	0 10, 042, 834	0.000000	56. 00
60. 00 06000 LABORA	ATORY	0	0	1	0 51, 929, 817	0.000000	60.00
63. 00 06300 BL00D	STORING, PROCESSING & TRANS.	0	0	1	0 2, 030, 689	0.000000	63.00
65. 00 06500 RESPI F	RATORY THERAPY	0	0	1	0 12, 366, 641	0.000000	65. 00
66. 00 06600 PHYSI (CAL THERAPY	0	0)	0 16, 753, 017	0.000000	66. 00
67. 00 06700 OCCUPA	ATIONAL THERAPY	0	0)	0 4, 329, 991	0.000000	67. 00
68. 00 06800 SPEECH	H PATHOLOGY	0	0)	0 2, 424, 017	0.000000	68. 00
69. 00 06900 ELECTF	ROCARDI OLOGY	0	0)	0 14, 706, 570	0.000000	69. 00
70. 00 07000 ELECT	ROENCEPHALOGRAPHY	0	O)	0 2, 460, 953	0.000000	70. 00
	AL SUPPLIES CHARGED TO PATIENT	0	0	1	0 30, 097, 934	0.000000	71. 00
	DEV. CHARGED TO PATIENTS	0	0)	0 11, 795, 315	0.000000	
	CHARGED TO PATIENTS	0	0)	0 32, 968, 282	0.000000	
76. 00 03630 ULTRA		0	0		0 7, 258, 564		
76. 01 03951 PAIN (0	0		0 9, 063, 003	0.000000	1
76. 02 03952 CATH L		0	0		0 41, 275, 703	0.000000	
	TY THERAPEUTIC	0	0		0 5, 320, 025	0. 000000	
	CARE CENTER	0	0		0 1, 990, 591	0. 000000	
76. 05 03340 BARI A		0	0		0 526, 686	0. 000000	
	HY LIVING CENTER	0	0		0 0	0.000000	
	SOURCE CENTER	0	0		0 0	0.000000	1
	ANCILLARY SERVICE COST CENTERS	0	0		0 0	0.000000	
76. 09 03956 LACTA		0	0		0 0	0.000000	
	ANCILLARY SERVICE COST CENTERS	0	0		0 0	0.000000	
	ANCILLARY SERVICE COST CENTERS	0		1	0 0	0.000000	
76. 12 03959 ANTI CO		0	0	1	0 990, 621	0.000000	76. 12
91. 00 09100 EMERGE	SERVICE COST CENTERS	0	0	1	0 53, 670, 677	0. 000000	91.00
	ENCY VATION BEDS (NON-DISTINCT PART	0			0 53, 670, 677 0 8, 289, 067	0.000000	
	(lines 50 through 199)	0			0 449, 419, 476	l	200.00
200.00 10tal	(Tries so through 177)	1	1	T	5 777, 717, 470	I	1200.00

	TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF H COSTS	RVICE OTHER PASS		CN: 15-0090 CCN: 15-T090	Peri od: From 01/01/2020 To 12/31/2020	Worksheet D Part IV Date/Time Pre 7/29/2021 1:2	pared:
			Ti tl	e XIX	Subprovi der - I RF	TEFRA	<u>л рііі — </u>
	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-Throug		Pass-Through	
		(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
		7)	10.00	x col . 10)	10.00	x col . 12)	
	ANOLIL ARY OFRIVER ASSET OFFITTERS	9. 00	10. 00	11.00	12. 00	13. 00	
	ANCILLARY SERVICE COST CENTERS			,			
50.00	05000 OPERATI NG ROOM	0. 000000	(1	0 0	0	
50. 01	05001 OUTPATI ENT SURGERY	0. 000000	(0 0	0	50. 01
51.00	05100 RECOVERY ROOM	0. 000000	(1	0 0	0	51.00
53.00	05300 ANESTHESI OLOGY	0. 000000	(1	0 0	0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	(1	0 0	0	
54. 01	05401 RADI OLOGY-SPECI AL PROCEDURES	0. 000000	(1	0	0	
55. 00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	(1	0 0	0	
56.00	05600 RADI OI SOTOPE	0. 000000	(1	0 0	0	56. 00
60.00	06000 LABORATORY	0. 000000	(1	0 0	0	60.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	(1	0 0	0	63. 00
65.00	06500 RESPI RATORY THERAPY	0. 000000	(1	0 0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0. 000000	(1	0 802, 199	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 000000	(1	0 270	0	
68. 00	06800 SPEECH PATHOLOGY	0. 000000	(1	0	0	
69. 00	06900 ELECTROCARDI OLOGY	0. 000000	(1	0 8, 010	0	
70. 00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	(1	0 0	0	
71.00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0. 000000	(1	0 0	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000	(0 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	(0 0	0	73.00
76. 00	03630 ULTRA SOUND	0. 000000	(1	0 0	0	76. 00
76. 01	03951 PAIN CLINIC	0. 000000	(1	0 0	0	76. 01
76. 02	03952 CATH LAB	0.000000	(1	0 0	0	
76. 03	03953 ACTIVITY THERAPEUTIC	0.000000	(1	0 0	0	
76. 04	03954 WOUND CARE CENTER	0.000000	•	1	٥	-	
76.05	03340 BARI ATRI C CLI NI C	0.000000	(1	0 0	0	
76.06	03030 HEALTHY LIVING CENTER	0.000000	-		٥	0	76.06
76. 07	03950 CV RESOURCE CENTER	0.000000	(0 0	0	
76. 08	03955 OTHER ANCILLARY SERVICE COST CENTERS	0.000000	(1	0 0	0	76. 08
76. 09 76. 10	03956 LACTATION CLINIC 03957 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000 0. 000000	(1	0 0	0	76. 09 76. 10
76. 10	03958 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000	(1	0 0	0	76. 10
76. 11 76. 12		0. 000000	(0 0	0	
10. 12	03959 ANTI COAGULATI ON CLI NI C	0.000000		Ί	<u>U</u> 0	0	76. 12
91. 00	OUTPATIENT SERVICE COST CENTERS 09100 EMERGENCY	0.000000	600	1	0 0	0	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000 0. 000000	000	1	0 0	0	1
92.00							

Cost Center Description Cost to Charge Ratio From Worksheet C, Part I, col. 9 PS Reimbursed Services (see Inst.) Reimbursed Services (see Inst.) Subject To Ded. & Coins. (see Inst.) Cost			Ti tl	e XIX	Subprovider - IRF	TEFRA	
Cost Center Description Cost to Charge Ratio From Worksheet C, Part I, col. 9 PS Reimbursed Services (see inst.) Services Subject To Ded. & Coins. (see inst.) Ded. & Coins. (see inst.) Ded. & Coins. (see inst.)				Charges		Costs	
Ratio From Worksheet C, Part I, col. 9 Services (see inst.) Subject To Ded. & Coins. (see inst.) Subject To Ded. & Coins. (see inst.) Subject To Ded. & Coins. (see inst.) Services (see inst.) Subject To Ded. & Coins. (s	Cost Center Description	Cost to Charge	PPS Reimbursed		Cost		
Part I, col. 9 Subject To Ded. & Coins. (see inst.) Ded. & Coins. (see inst.)	·				Rei mbursed	(see inst.)	
Part I, col. 9 Subject To Ded. & Coins. (see inst.) Ded. & Coins. (see inst.)		Worksheet C,	inst.)	Servi ces	Services Not		
NACILLARY SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00			ŕ	Subject To	Subject To		
1.00 2.00 3.00 4.00 5.00				Ded. & Coins	Ded. & Coins.		
ANCI LLARY SERVI CE COST CENTERS				(see inst.)	(see inst.)		
50. 00 05000 OPERATI NG ROOM 0. 097707 0 0 0 0 0 0 50. 00 50. 01 05001 OUTPATI ENT SURGERY 0. 364533 0 0 0 0 0 50. 01 50. 01 51. 00 0 0 0 0 0 0 0 0 0 51. 00 0		1.00	2.00	3.00	4. 00	5. 00	
50. 01 05001 0UTPATI ENT SURGERY 0. 364533 0 0 0 0 50. 01 51. 00 05100 RECOVERY ROOM 0. 205106 0 0 0 0 0 51. 00 53. 00 05300 ANESTHESI OLOGY 0. 255312 0 0 0 0 0 53. 00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0. 113638 0 0 0 0 54. 00 54. 01 05401 RADI OLOGY-SPECI AL PROCEDURES 0. 255755 0 0 0 0 0 55. 00 55. 00 05500 RADI OLOGY-THERAPEUTI C 0. 000000 0 0 0 0 0 55. 00 56. 00 05600 RADI OL SOTOPE 0. 124032 0 0 0 0 0 0 60. 00					_		
51. 00 05100 RECOVERY ROOM 0. 205106 0 0 0 0 51. 00 53. 00 05300 ANESTHESI OLOGY 0. 255312 0 0 0 0 53. 00 54. 00 O5400 RADI OLOGY-DI AGNOSTI C 0. 113638 0 0 0 0 0 54. 00 54. 01 O5401 RADI OLOGY-SPECI AL PROCEDURES 0. 255755 0 0 0 0 0 54. 01 55. 00 O5500 RADI OLOGY-THERAPEUTI C 0. 000000 0 0 0 0 55. 00 56. 00 05600 RADI OLOGY-THERAPEUTI C 0. 124032 0 0 0 0 0 56. 00 60. 00 06000 LABORATORY 0. 140876 0		1	-		-1		
53. 00 05300 ANESTHESI OLOGY 0. 255312 0 0 0 0 53. 00 54. 00 05400 RADI OLOGY - DI AGNOSTI C 0. 113638 0 0 0 0 54. 00 54. 01 05401 RADI OLOGY - SPECI AL PROCEDURES 0. 255755 0 0 0 0 0 54. 01 55. 00 05500 RADI OLOGY - THERAPEUTI C 0. 000000 0 0 0 0 55. 00 56. 00 05600 RADI OI SOTOPE 0. 124032 0 0 0 0 0 56. 00 60. 00 06000 LABORATORY 0. 140876 0 0 0 0 0 0 60. 00			0				ł
54. 00 05400 RADI OLOGY-DI AGNOSTI C 0. 113638 0 0 0 0 54. 00 54. 01 05401 RADI OLOGY-SPECI AL PROCEDURES 0. 255755 0 0 0 0 54. 01 55. 00 05500 RADI OLOGY-THERAPEUTI C 0. 000000 0 0 0 0 0 55. 00 56. 00 05600 RADI OI SOTOPE 0. 124032 0 0 0 0 0 60. 00 60. 00 06000 LABORATORY 0. 140876 0 0 0 0 0 60. 00	l I	1	0		0		
54. 01 05401 RADI OLOGY-SPECI AL PROCEDURES 0. 255755 0 0 0 0 54. 01 55. 00 05500 RADI OLOGY-THERAPEUTI C 0. 000000 0 0 0 0 55. 00 56. 00 05600 RADI OI SOTOPE 0. 124032 0 0 0 0 0 56. 00 60. 00 06000 LABORATORY 0. 140876 0 0 0 0 0 60. 00	l I		0		0		
55. 00 05500 RADI OLOGY-THERAPEUTI C 0. 000000 0 0 0 55. 00 56. 00 05600 RADI OI SOTOPE 0. 124032 0 0 0 0 0 56. 00 60. 00 06000 LABORATORY 0. 140876 0 0 0 0 0 60. 00			0		٦		
56. 00 05600 RADI OI SOTOPE 0. 124032 0 0 0 0 56. 00 60. 00 06000 LABORATORY 0. 140876 0 0 0 0 60. 00	l l		0		0	0	1
60. 00 06000 LABORATORY 0. 140876 0 0 0 60. 00	55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	0		0	0	55. 00
	l I	1	0		0	0	56. 00
63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0.094668 0 0 0 0 63.00	60. 00 06000 LABORATORY	0. 140876	0		0	0	60.00
	63.00 06300 BLOOD STORING, PROCESSING & TRANS.		0		0	0	63.00
65. 00 06500 RESPI RATORY THERAPY 0. 243444 0 0 0 65. 00	65. 00 06500 RESPI RATORY THERAPY		0		0	0	65.00
66. 00 06600 PHYSI CAL THERAPY 0. 674585 802, 199 0 0 541, 151 66. 00	66. 00 06600 PHYSI CAL THERAPY	0. 674585	802, 199		0	541, 151	66. 00
67. 00 06700 0CCUPATI ONAL THERAPY 0. 227667 270 0 0 61 67. 00	67. 00 06700 OCCUPATI ONAL THERAPY	0. 227667	270		0	61	67. 00
68. 00 06800 SPEECH PATHOLOGY 0. 231818 0 0 0 68. 00		0. 231818	-	l .	-1	_	68. 00
69. 00 06900 ELECTROCARDI OLOGY 0. 113444 8, 010 0 0 909 69. 00			8, 010			909	1
70. 00 07000 ELECTROENCEPHALOGRAPHY			0		0	0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.270695 0 0 0 71.00	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIEN	T 0. 270695	0		0	0	71. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS 0. 847889 0 0 0 72. 00	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 847889	0		0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS 0.303556 0 0 0 73.00	73.00 07300 DRUGS CHARGED TO PATIENTS	0. 303556	0		0 0	0	73. 00
76. 00 03630 ULTRA SOUND 0. 147331 0 0 0 76. 00	76.00 03630 ULTRA SOUND	0. 147331	0		0 0	0	76. 00
76. 01 03951 PAIN CLINIC 0. 206009 0 0 76. 01	76. 01 03951 PAIN CLINIC	0. 206009	0		0 0	0	76. 01
76. 02 03952 CATH LAB 0. 093888 0 0 0 76. 02	76. 02 03952 CATH LAB	0. 093888	0		0 0	0	76. 02
76. 03 03953 ACTI VI TY THERAPEUTI C 0. 807512 0 0 0 76. 03	76. 03 03953 ACTIVITY THERAPEUTIC	0. 807512	0		0 0	0	76. 03
76. 04 03954 WOUND CARE CENTER 0. 510479 0 0 0 76. 04	76.04 03954 WOUND CARE CENTER	0. 510479	0		0 0	0	76. 04
76. 05 03340 BARI ATRI C CLI NI C 2. 038152 0 0 0 76. 05	76.05 03340 BARIATRIC CLINIC	2. 038152	0		0 0	0	76. 05
76. 06 03030 HEALTHY LIVING CENTER 0. 000000 0 0 0 76. 06	76.06 03030 HEALTHY LIVING CENTER	0. 000000	0		0	0	76. 06
76. 07 03950 CV RESOURCE CENTER 0. 000000 0 0 76. 07	76. 07 03950 CV RESOURCE CENTER	0. 000000	0		0 0	0	76. 07
76.08 03955 OTHER ANCILLARY SERVICE COST CENTERS 0.000000 0 0 0 76.08	76.08 03955 OTHER ANCILLARY SERVICE COST CENTE	RS 0. 000000	0		0 0	0	76. 08
76. 09 03956 LACTATION CLINIC 0. 000000 0 0 76. 09	76.09 03956 LACTATION CLINIC	0. 000000	0		0 0	0	76. 09
76. 10 03957 OTHER ANCILLARY SERVICE COST CENTERS 0.000000 0 0 0 76. 10	76. 10 03957 OTHER ANCILLARY SERVICE COST CENTE	RS 0. 000000	0		0 0	0	76. 10
76. 11 03958 OTHER ANCILLARY SERVICE COST CENTERS 0.000000 0 0 0 76. 11	76. 11 03958 OTHER ANCILLARY SERVICE COST CENTE	RS 0. 000000	0		0 0	0	76. 11
76. 12 03959 ANTI COAGULATI ON CLINI C 0. 785676 0 0 0 0 76. 12	76. 12 03959 ANTI COAGULATI ON CLINIC	0. 785676	0		0 0	0	76. 12
OUTPATIENT SERVICE COST CENTERS	OUTPATIENT SERVICE COST CENTERS						
91. 00 09100 EMERGENCY 0. 158702 0 0 0 91. 00			0		0 0	0	91.00
92.00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART 0.513373 0 0 0 92.00	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PAR	T 0. 513373	0		0	_	
200. 00 Subtotal (see instructions) 810, 479 0 0 542, 121 200. 00			810, 479		0	542, 121	200. 00
201.00 Less PBP Clinic Lab. Services-Program 0 0 201.00		ram			0		201. 00
Only Charges							
202.00 Net Charges (line 200 - line 201) 810,479 0 542,121 202.00	202.00 Net Charges (line 200 - line 201)		810, 479	1	0 0	542, 121	202. 00

Health Financial Systems	FRANCISCAN H	EALTH- DYER		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	O VACCINE COST	Provi der Co	CN: 15-0090	Peri od:	Worksheet D	
		Component	CCN: 15-T090	From 01/01/2020 To 12/31/2020	Part V Date/Time Pre 7/29/2021 1:2	
		Ti tl	e XIX	Subprovi der - I RF	TEFRA	
	Со	sts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.) 6.00	(see inst.) 7.00				
ANCILLARY SERVICE COST CENTERS	0.00	7.00				
50. 00 05000 OPERATI NG ROOM	C	0				50.00
50. 01 05001 OUTPATIENT SURGERY						50. 01
51. 00 05100 RECOVERY ROOM		l control of the cont				51.00
53. 00 05300 ANESTHESI OLOGY		0				53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	C	0				54.00
54. 01 05401 RADI OLOGY-SPECI AL PROCEDURES		0				54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C		0				55. 00
56. 00 05600 RADI 0I SOTOPE	C	0				56. 00
60. 00 06000 LABORATORY	C	1				60.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	C	1				63. 00
65. 00 06500 RESPI RATORY THERAPY	C	1				65. 00
66. 00 06600 PHYSI CAL THERAPY	C	1				66.00
67. 00 06700 OCCUPATI ONAL THERAPY		1				67.00
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY						68. 00
69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY		1				69. 00 70. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT						71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		1				72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS		1				73. 00
76. 00 03630 ULTRA SOUND						76. 00
76. 01 03951 PAIN CLINIC		1				76. 01
76. 02 03952 CATH LAB						76. 02
76. 03 03953 ACTIVITY THERAPEUTIC		0				76. 03
76. 04 03954 WOUND CARE CENTER	C	0				76. 04
76. 05 03340 BARI ATRI C CLI NI C	C	0				76. 05
76.06 03030 HEALTHY LIVING CENTER	()	0				76. 06
76. 07 03950 CV RESOURCE CENTER		0				76. 07
76.08 03955 OTHER ANCILLARY SERVICE COST CENTERS		0				76. 08
76. 09 03956 LACTATI ON CLINI C	0	0				76. 09
76. 10 03957 OTHER ANCILLARY SERVICE COST CENTERS	<u> </u>	0				76. 10
76. 11 03958 OTHER ANCILLARY SERVICE COST CENTERS	C	1	ı			76. 11
76. 12 03959 ANTI COAGULATI ON CLINIC		ol o	I			76. 12

0 0 0

0

76. 12

91.00

92. 00 200. 00

201. 00

202. 00

76. 12 03959 ANTI COAGULATION CLINIC

91. 00 09100 EMERGENCY

200.00

201.00

202.00

OUTPATIENT SERVICE COST CENTERS

92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART

Subtotal (see instructions)

Less PBP Clinic Lab. Services-Program

Only Charges Net Charges (line 200 - line 201)

Health Financial Systems	FRANCI SCAN HEALTH	H- DYER	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OP	PERATING COST	Provi der CCN: 15-0090	Peri od: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Pre 7/29/2021 1:2	pared:
		Title XVIII	Hospi tal	PPS	

			12, 01, 2020	7/29/2021 1: 2	7 pm
	Cost Contor Description	Title XVIII	Hospi tal	PPS	
	Cost Center Description			1. 00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days			22, 165	1. 00
2. 00	Inpatient days (including private room days, excluding swing-			22, 165	2. 00
3. 00	Private room days (excluding swing-bed and observation bed day	ys). If you have only pr	ivate room days,	0	3. 00
4.00	do not complete this line. Semi-private room days (excluding swing-bed and observation be	ad days)		18, 640	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private roo		r 31 of the cost	18, 640	5. 00
3.00	reporting period	on days) through becembe	i 31 of the cost	0	3.00
6. 00	Total swing-bed SNF type inpatient days (including private roo	om davs) after December	31 of the cost	0	6. 00
	reporting period (if calendar year, enter 0 on this line)			- I	
7.00	Total swing-bed NF type inpatient days (including private roor	m days) through December	31 of the cost	0	7. 00
	reporting period			 	
8. 00	Total swing-bed NF type inpatient days (including private roor	m days) after December 3	1 of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)			0.000	0.00
9. 00	Total inpatient days including private room days applicable to newborn days) (see instructions)	the Program (excluding	swing-bed and	8, 303	9. 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or	nly (including private r	nom days)	0	10.00
	through December 31 of the cost reporting period (see instructions)		John days)	١	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days) after	0	11. 00
	December 31 of the cost reporting period (if calendar year, en				
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX	Konly (including privat	e room days)	0	12. 00
40.00	through December 31 of the cost reporting period				40.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX after December 31 of the cost reporting period (if calendar ye			0	13. 00
14. 00	Medically necessary private room days applicable to the Progra			0	14. 00
15. 00	Total nursery days (title V or XIX only)	dir (exer darrig swrrig bed	uuys)	0	15. 00
16. 00	Nursery days (title V or XIX only)			0	16.00
	SWING BED ADJUSTMENT				
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	f the cost	0.00	17. 00
	reporting period			 	
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0. 00	18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	through Docombon 21 of	the cost	0.00	19. 00
19.00	reporting period	s through becember 31 or	the cost	0.00	19.00
20. 00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of t	he cost	0.00	20. 00
	reporting period			 -	
21. 00	Total general inpatient routine service cost (see instructions			26, 757, 678	
22. 00	Swing-bed cost applicable to SNF type services through December	er 31 of the cost report	ing period (line	0	22. 00
22.00	5 x line 17)	21 -6			22 00
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reportin	g period (iine 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reporti	na period (line	0	24. 00
2 00	7 x line 19)	or or the east report.	ing point du (initial	١	2 11 00
25. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25. 00
	x line 20)			 -	
26. 00	Total swing-bed cost (see instructions)	(1)		0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost	(IINE 21 MINUS IINE 26)		26, 757, 678	27. 00
28. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed	d and observation had ch	arnes)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)	a and observation bed en	ai gcs)	0	29. 00
30. 00	Semi -pri vate room charges (excluding swing-bed charges)			0	30.00
31. 00	General inpatient routine service cost/charge ratio (line 27	: line 28)		0. 000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	•		0.00	32. 00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33. 00
34.00	Average per diem private room charge differential (line 32 min	nus line 33)(see instruc	tions)	0.00	34. 00
35. 00	Average per diem private room cost differential (line 34 x line 31)				35. 00
36. 00	OO Private room cost differential adjustment (line 3 x line 35)			0	36.00
37. 00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	26, 757, 678	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	ISTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see			1, 207. 20	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line	•		10, 023, 382	39. 00
40. 00	Medically necessary private room cost applicable to the Progra	•		0	40.00
41.00	Total Program general inpatient routine service cost (line 39			10, 023, 382	41.00
			·		

<u>Heal th</u>	Financial Systems	FRANCISCAN HEA	ALTH- DYER		In <u>Li</u> e	eu of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der Co	CN: 15-0090	Peri od: From 01/01/2020	Worksheet D-1	
					To 12/31/2020	Date/Time Pre	
			Title	: XVIII	Hospi tal	7/29/2021 1: 2 PPS	7 pm
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
	'	Inpatient Cost	npatient Days	Diem (col. 1		(col. 3 x col.	
		1.00	2. 00	col . 2) 3.00	4.00	4) 5. 00	
42. 00	NURSERY (title V & XIX only)	1.00	2.00				42. 00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	5, 907, 799	2, 847				•
44. 00 45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT	31, 201	0	0.0	00	0	44. 00 45. 00
46. 00	SURGICAL INTENSIVE CARE UNIT						46. 00
	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description					1.00	
48. 00	Program inpatient ancillary service cost (Wk:	st. D-3. col. 3.	Line 200)			1. 00 15, 503, 040	48. 00
	Total Program inpatient costs (sum of lines		,	ns)		27, 655, 475	•
	PASS THROUGH COST ADJUSTMENTS						
50. 00	Pass through costs applicable to Program inpa	atient routine s	ervices (from	Wkst. D, sum	of Parts I and	690, 124	50. 00
51. 00	Pass through costs applicable to Program inp	atient ancillary	services (fr	om Wkst. D, s	um of Parts II	780, 566	51.00
	and IV)	,	•				
52. 00 53. 00	Total Program excludable cost (sum of lines! Total Program inpatient operating cost exclu		atod non nice	elelan anaa+	otist and	1, 470, 690	1
53.00	medical education costs (line 49 minus line !		ated, non-pny	sician anestr	etist, and	26, 184, 785	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION	,					
	Program di scharges					0	
55. 00 56. 00	Target amount per discharge Target amount (line 54 x line 55)					0.00	1
57. 00	,	ing cost and tar	get amount (I	ine 56 minus	line 53)		•
58. 00	Bonus payment (see instructions)	•			•	0	
59. 00	Lesser of lines 53/54 or 55 from the cost re	porting period e	nding 1996, u	pdated and co	mpounded by the	0.00	59. 00
60. 00	market basket Lesser of lines 53/54 or 55 from prior year	cost report, upd	lated by the m	arket basket		0.00	60.00
61. 00	If line 53/54 is less than the lower of line				the amount by	0	ı
	which operating costs (line 53) are less that		(lines 54 x	60), or 1% of	the target		
62. 00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	instructions)				0	62. 00
	Allowable Inpatient cost plus incentive payme	ent (see instruc	tions)			0	63. 00
	PROGRAM INPATIENT ROUTINE SWING BED COST				1 1 (0	1	
64. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	ts through Decem	iber 31 of the	cost reporti	ng period (See	0	64. 00
65. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decembe	er 31 of the c	ost reporting	period (See	0	65. 00
// 00	instructions)(title XVIII only)			E) (11 11 10 11 1			,, ,,
66. 00	Total Medicare swing-bed SNF inpatient routing CAH (see instructions)	ne costs (line 6	4 plus line 6	5)(title XVII	I only). For	0	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routing	e costs through	December 31 o	f the cost re	porting period	0	67. 00
	(line 12 x line 19)						
68. 00	Title V or XIX swing-bed NF inpatient routing (line 13 x line 20)	e costs after De	cember 31 of	the cost repo	rting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient	routine costs (I	ine 67 + line	68)		0	69. 00
	PART III - SKILLED NURSING FACILITY, OTHER NU	<u>'</u>				1	
70. 00 71. 00	Skilled nursing facility/other nursing facili Adjusted general inpatient routine service of	-					70. 00 71. 00
71.00	Program routine service cost (line 9 x line		ne 70 ÷ Title	2)			72.00
73. 00	Medically necessary private room cost application	able to Program					73. 00
74.00	Total Program general inpatient routine servi	•					74.00
75. 00	Capital-related cost allocated to inpatient 26. line 45)	routine service	costs (Trom W	orksneet B, F	art II, column		75. 00
76. 00	Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 00
77. 00	Program capital-related costs (line 9 x line						77. 00
78. 00 79. 00	Inpatient routine service cost (line 74 minu: Aggregate charges to beneficiaries for exces:		ovi der rocord	e)			78. 00 79. 00
	Total Program routine service costs for compa				us line 79)		80.00
81. 00	Inpatient routine service cost per diem limi	tati on			,		81.00
82.00	Inpatient routine service cost limitation (I						82.00
83. 00 84. 00	Reasonable inpatient routine service costs (Program inpatient ancillary services (see in:		•)				83. 00 84. 00
85. 00	Utilization review - physician compensation		ıs)				85. 00
86. 00	Total Program inpatient operating costs (sum	of lines 83 thr					86. 00
07 00	PART IV - COMPUTATION OF OBSERVATION BED PASS					2 525	07.00
87. 00 88. 00	Total observation bed days (see instructions Adjusted general inpatient routine cost per	•	line 2)			3, 525 1, 207. 20	
	Observation bed cost (line 87 x line 88) (see	•	,			4, 255, 380	

Health Financial Systems	FRANCISCAN HE	EALTH- DYER		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2020 To 12/31/2020		
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital -related cost	1, 490, 203	26, 757, 678	0. 05569	3 4, 255, 380	236, 995	90.00
91.00 Nursing School cost	0	26, 757, 678	0.00000	0 4, 255, 380	0	91.00
92.00 Allied health cost	0	26, 757, 678	0.00000	0 4, 255, 380	0	92.00
93.00 All other Medical Education	0	26, 757, 678	0. 00000	0 4, 255, 380	0	93. 00

Health Financial Systems	FRANCISCAN HEALTH- DYER	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0090		Worksheet D-1
	Component CCN: 15-T090	From 01/01/2020 To 12/31/2020	
	Title XVIII	Subprovi der -	PPS

		litle XVIII	I RF	PPS	
	Cost Center Description		TIM		
	T			1. 00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days	s excluding newborn)		7, 652	1. 00
2. 00	Inpatient days (including private room days, excluding swing-			7, 652	
3.00	Private room days (excluding swing-bed and observation bed day		ivate room days,	0	3. 00
	do not complete this line.				
4.00	Semi-private room days (excluding swing-bed and observation by		. 21 -6 -1	7, 652	4. 00
5.00	Total swing-bed SNF type inpatient days (including private round reporting period	om days) through becembe	er 31 of the cost	0	5. 00
6.00	Total swing-bed SNF type inpatient days (including private ro	om days) after December	31 of the cost	0	6. 00
	reporting period (if calendar year, enter 0 on this line)				
7.00	Total swing-bed NF type inpatient days (including private room	m days) through December	31 of the cost	0	7. 00
8. 00	reporting period Total swing-bed NF type inpatient days (including private room	m days) after December 3	1 of the cost	0	8. 00
8.00	reporting period (if calendar year, enter 0 on this line)	ii days) ai tei beceiibei s	ii oi tile cost	U	8.00
9.00	Total inpatient days including private room days applicable to	o the Program (excluding	swing-bed and	4, 705	9. 00
	newborn days) (see instructions)				
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII of through December 31 of the cost reporting period (see instructions)	nly (including private r	oom days)	0	10. 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII o	nlv (including private r	noom days) after	0	11. 00
00	December 31 of the cost reporting period (if calendar year, en		dayo, a. to.	Ü	
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including privat	e room days)	0	12. 00
12.00	through December 31 of the cost reporting period	· · · · · · · · · · · · · · · · · · ·		0	12.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI after December 31 of the cost reporting period (if calendar year)			0	13. 00
14. 00	Medically necessary private room days applicable to the Progra			0	14. 00
15.00	Total nursery days (title V or XIX only)	, 3	,	0	15. 00
16. 00	Nursery days (title V or XIX only)			0	16. 00
17 00	SWING BED ADJUSTMENT	no through December 21 a	f the cost	0.00	17. 00
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through becember 31 c	ii the cost	0.00	17.00
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0.00	18. 00
	reporting period				
19. 00	Medical drate for swing-bed NF services applicable to services	s through December 31 of	the cost	0. 00	19. 00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	s after December 31 of t	he cost	0.00	20. 00
20.00	reporting period		ne cost	0.00	20.00
21. 00	Total general inpatient routine service cost (see instructions			7, 225, 314	
22. 00	Swing-bed cost applicable to SNF type services through December	er 31 of the cost report	ing period (line	0	22. 00
23. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	na neriod (line 6	0	23. 00
20.00	x line 18)	or or the cost reporter	ig period (iiiie e	G	20.00
24. 00	Swing-bed cost applicable to NF type services through December	r 31 of the cost reporti	ng period (line	0	24. 00
05.00	7 x line 19)	24 6 11			05.00
25. 00	Swing-bed cost applicable to NF type services after December 3 x line 20)	31 of the cost reporting	period (line 8	0	25. 00
26. 00	Total swing-bed cost (see instructions)			0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		7, 225, 314	27. 00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		,		
28.00	General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges)	d and observation bed cr	arges)	0	28. 00 29. 00
30.00	Semi - pri vate room charges (excluding swing-bed charges)			0	30.00
31. 00	General inpatient routine service cost/charge ratio (line 27	+ line 28)		0. 000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32. 00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
34. 00 35. 00	Average per diem private room charge differential (line 32 mil Average per diem private room cost differential (line 34 x li		ctions)	0. 00 0. 00	
36. 00	Private room cost differential adjustment (line 3 x line 35)	le 31)		0.00	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	7, 225, 314	
	27 minus line 36)		`		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	ICTMENTS			
38. 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU Adjusted general inpatient routine service cost per diem (see			944. 24	38. 00
39.00	Program general inpatient routine service cost per diem (see			4, 442, 649	
40. 00	Medically necessary private room cost applicable to the Progra			0	40.00
41. 00	Total Program general inpatient routine service cost (line 39	+ line 40)		4, 442, 649	41. 00

	Financial Systems	FRANCISCAN HEA		ON 45 0000		eu of Form CMS-	
COMPUT	ATION OF INPATIENT OPERATING COST		Provider Component		Period: From 01/01/2020 To 12/31/2020	Date/Time Pre	pared:
			Title	XVIII	Subprovi der -	7/29/2021 1: 2 PPS	7 pm
	Cost Center Description	Total Inpatient Costlr	Total patient Days	Average Per Diem (col. 1	Program Days	Program Cost (col. 3 x col.	
		1.00	2.00	col . 2) 3.00	4. 00	4) 5. 00	
42. 00	NURSERY (title V & XIX only)	0	2.00				42. 00
43. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	O	0	0.0	0 0	0	43. 00
44.00	CORONARY CARE UNIT	Ö	0			•	44. 00
45. 00 46. 00	BURN INTENSIVE CARE UNIT						45. 00 46. 00
	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description					1.00	
48. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3,	line 200)			3, 819, 736	48. 00
49. 00	Total Program inpatient costs (sum of lines - PASS THROUGH COST ADJUSTMENTS	11 through 48)(se	ee instructio	ns)		8, 262, 385	49. 00
50. 00	Pass through costs applicable to Program inpulli)	atient routine se	ervices (from	Wkst. D, sum	of Parts I and	77, 821	50. 00
51. 00	Pass through costs applicable to Program inpland IV)	atient ancillary	services (fr	om Wkst. D, s	um of Parts II	52, 209	51.00
52. 00	Total Program excludable cost (sum of lines					130, 030	1
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line ! TARGET AMOUNT AND LIMIT COMPUTATION		ated, non-phy	sician anesth	etist, and	8, 132, 355	53. 00
54.00	Program di scharges					0	
55. 00 56. 00	Target amount per discharge Target amount (line 54 x line 55)					0.00	55. 00 56. 00
57. 00	Difference between adjusted inpatient operat	ng cost and targ	get amount (I	ine 56 minus	line 53)	0	57. 00
58. 00 59. 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost re	oorting period er	nding 1996, u	pdated and co	mpounded by the	0.00	58. 00 59. 00
60. 00	market basket Lesser of lines 53/54 or 55 from prior year	cost report upda	ated by the m	arket basket		0.00	60.00
61. 00	If line 53/54 is less than the lower of line which operating costs (line 53) are less than	s 55, 59 or 60 er n expected costs	nter the Less	er of 50% of		0	61. 00
62. 00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	nstructions)				0	62. 00
63. 00	Allowable Inpatient cost plus incentive payments	ent (see instruct	tions)			0	63. 00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cost instructions) (title XVIII only)	ts through Decemb	per 31 of the	cost reporti	ng period (See	0	64. 00
65. 00	Medicare swing-bed SNF inpatient routine cos	ts after December	31 of the c	ost reporting	period (See	0	65. 00
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routing	ne costs (line 64	1 plus line 6	5)(title XVII	l only). For	0	66. 00
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routing (line 12 x line 19)	e costs through [December 31 o	f the cost re	porting period	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routing (line 13 x line 20)	e costs after Dec	cember 31 of	the cost repo	rting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient	•				0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facil						70.00
71.00	Adjusted general inpatient routine service co	ost per diem (lir					71.00
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost applications)	•	(line 14 x li	ne 35)			72. 00 73. 00
74. 00	Total Program general inpatient routine servi		•	(0)			74. 00
75. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service o	costs (from W	orksheet B, P	art II, column		75. 00
76. 00	Per diem capital-related costs (line 75 ÷ line Program capital-related costs (line 9 x line						76. 00 77. 00
78. 00	Inpatient routine service cost (line 74 minus						78. 00
79.00	Aggregate charges to beneficiaries for excess	s costs (from pro					79. 00
80. 00 81. 00	Total Program routine service costs for companient routine service cost per diem limi		st limitation	(line 78 min	us line 79)		80. 00 81. 00
82. 00	Inpatient routine service cost per drem Time						82. 00
83.00	Reasonable inpatient routine service costs ()				83. 00
84. 00 85. 00	Program inpatient ancillary services (see in: Utilization review - physician compensation		5)				84. 00 85. 00
86. 00	Total Program inpatient operating costs (sum	of lines 83 thro					86.00
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions					0	87. 00
88. 00	Adjusted general inpatient routine cost per		ine 2)			1	88. 00
89. 00	Observation bed cost (line 87 x line 88) (see	e instructions)				0	89. 00

Health Financial Systems	FRANCISCAN HE	EALTH- DYER		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
		Component (From 01/01/2020 To 12/31/2020	Doto/Time Dro	aanad.
		Component	CCN: 15-T090	To 12/31/2020	Date/Time Pre 7/29/2021 1:2	
		Title	XVIII	Subprovi der -	PPS	
				IRF		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	126, 583	7, 225, 314	0. 01751	9 0	0	90.00
91.00 Nursing School cost	0	7, 225, 314	0. 00000	0 0	0	91.00
92.00 Allied health cost	0	7, 225, 314	0.00000	0 0	0	92.00
93.00 All other Medical Education	0	7, 225, 314	0. 00000	0 0	0	93.00

Health Financial Systems	FRANCISCAN HEALTH- DYER	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0090		Worksheet D-1
	Component CCN: 15-T090	From 01/01/2020 To 12/31/2020	
	Title XIX	Subprovi der -	TEFRA

		II the XIX	I RF	ILIKA	
	Cost Center Description	<u> </u>			
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days	s, excluding newborn)		7, 652	1. 00
2.00	Inpatient days (including private room days, excluding swing-b			7, 652	
3. 00	Private room days (excluding swing-bed and observation bed day do not complete this line.	(s). If you have only pri	vate room days,	0	3. 00
4. 00	Semi-private room days (excluding swing-bed and observation be	ed days)		7, 652	4. 00
5.00	Total swing-bed SNF type inpatient days (including private roo		31 of the cost	0	5. 00
	reporting period		4 6 11		, 00
6. 00	Total swing-bed SNF type inpatient days (including private roof reporting period (if calendar year, enter 0 on this line)	om days) after December 3	or the cost	0	6. 00
7. 00	Total swing-bed NF type inpatient days (including private room	days) through December	31 of the cost	0	7. 00
	reporting period				
8. 00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	n days) after December 31	of the cost	0	8. 00
9. 00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	683	9. 00
	newborn days) (see instructions)				
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		om days)	0	10. 00
11. 00	through December 31 of the cost reporting period (see instruct Swing-bed SNF type inpatient days applicable to title XVIII or		om days) after	0	11. 00
11.00	December 31 of the cost reporting period (if calendar year, er	nter 0 on this line)	om days) arter	G	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XI>		room days)	0	12. 00
13. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XI)	only (including private	room days)	0	13. 00
13.00	after December 31 of the cost reporting period (if calendar ve			U	13.00
14.00	Medically necessary private room days applicable to the Progra	-	′	0	14. 00
15. 00	Total nursery days (title V or XIX only)			0	15. 00
16. 00	Nursery days (title V or XLX only) SWING BED ADJUSTMENT			0	16. 00
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 of	the cost	0.00	17. 00
	reporting period	G			
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of t	he cost	0. 00	18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	through December 31 of	the cost	0.00	19. 00
	reporting period			2.22	
20. 00	Medicaid rate for swing-bed NF services applicable to services	after December 31 of th	e cost	0. 00	20. 00
21. 00	reporting period Total general inpatient routine service cost (see instructions	:)		7, 225, 314	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December		ng period (line	0	22. 00
	5 x line 17)			_	
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reporting	period (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reportin	g period (line	0	24. 00
	7 x line 19)	·			
25. 00	Swing-bed cost applicable to NF type services after December 3 x line 20)	31 of the cost reporting	period (line 8	0	25. 00
26. 00	Total swing-bed cost (see instructions)			0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost ((line 21 minus line 26)		7, 225, 314	27. 00
00.00	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT		` `		00.00
28. 00 29. 00	General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges)	and observation bed cha	rges)	0	28. 00 29. 00
30.00	Semi -pri vate room charges (excluding swing bed charges)			0	30.00
31. 00	General inpatient routine service cost/charge ratio (line 27 =	· line 28)		0.000000	
32. 00	Average private room per diem charge (line 29 ÷ line 3)			0.00	
33. 00 34. 00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 mir	nus line 33)(see instruct	ions)	0. 00 0. 00	
35. 00	Average per diem private room cost differential (line 34 x lin		1013)	0.00	
36. 00	Private room cost differential adjustment (line 3 x line 35)	•		0	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost dif	ferential (line	7, 225, 314	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJL	STMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see	instructions)		944. 24	
39.00	Program general inpatient routine service cost (line 9 x line			644, 916	
40. 00 41. 00	Medically necessary private room cost applicable to the Progra Total Program general inpatient routine service cost (line 39	,		0 644, 916	40. 00 41. 00
00	1.2.2		l	311, 710	

	Financial Systems	FRANCISCAN HEAI				u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provider CCN:	F	eriod: rom 01/01/2020	Worksheet D-1	norod.
			Component CCN		0 12/31/2020	7/29/2021 1: 2	
					Subprovider - IRF	TEFRA	
	Cost Center Description	Total Inpatient Cost In		verage Per em (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
42.00	NUDCEDY (4) 41 a V 0 VIV and 1)	1.00	2.00	3. 00	4. 00	5. 00	42.00
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	0	0.00	0	0	42. 00
43.00	INTENSIVE CARE UNIT	0	0	0.00	l .	0	
44. 00 45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT	0	0	0. 00	O	0	44. 00 45. 00
46. 00	SURGICAL INTENSIVE CARE UNIT						46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47. 00
10.00	·					1.00	10.00
48. 00 49. 00	Program inpatient ancillary service cost (Wk Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS			•		95 645, 011	
50.00	Pass through costs applicable to Program inp	atient routine se	ervices (from Wk	st. D, sum o	of Parts I and	0	50. 00
51. 00	<pre> </pre>	atient ancillary	services (from	Wkst. D, sur	m of Parts II	5	51. 00
52. 00	and IV) Total Program excludable cost (sum of lines	,	`			5	52. 00
53. 00	Total Program inpatient operating cost exclu		nted, non-physic	cian anesthe	tist, and	645, 006	
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					
54. 00	Program di scharges					43	54. 00
55. 00 56. 00	Target amount per discharge Target amount (line 54 x line 55)					0. 00 0	55. 00 56. 00
57. 00	Difference between adjusted inpatient operat	ing cost and targ	get amount (line	e 56 minus li	ine 53)	-645, 006	
58.00	Bonus payment (see instructions)					0	58.00
59. 00	Lesser of lines 53/54 or 55 from the cost re market basket	porting period er	iai ng 1996, upaa	ated and com	pounded by the	0. 00	59. 00
60.00							60. 00 61. 00
01.00	61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target						01.00
62. 00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	instructions)				0	62. 00
63. 00	Allowable Inpatient cost plus incentive paym	ent (see instruct	i ons)			5	
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Decemb	per 31 of the co	ost reporting	g period (See	0	64. 00
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos</pre>	ts after December	31 of the cost	reporting	period (See	0	65. 00
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	ne costs (line 64	l plus line 65)(title XVIII	only). For	0	66. 00
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routin	e costs through D	December 31 of t	the cost rep	orting period	0	67. 00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	e costs after Dec	cember 31 of the	e cost repor	ting period	0	68. 00
60 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient				3 1 3 3	0	
07.00	PART III - SKILLED NURSING FACILITY, OTHER N	URSING FACILITY,	AND ICF/IID ONL	Υ		<u> </u>	07.00
70. 00 71. 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service c			(line 37)			70. 00 71. 00
72. 00	Program routine service cost (line 9 x line	71)	,				72. 00
73. 00 74. 00	Medically necessary private room cost applic Total Program general inpatient routine serv			35)			73. 00 74. 00
75. 00	Capital -related cost allocated to inpatient 26, line 45)	•	,	sheet B, Pa	rt II, column		75. 00
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line						76. 00 77. 00
78. 00	Inpatient routine service cost (line 74 minu	•					78. 00
79.00	Aggregate charges to beneficiaries for exces			. 70 .	11 70)		79. 00
80. 00 81. 00	Total Program routine service costs for comp Inpatient routine service cost per diem limi		st limitation (I	ine /8 minus	s iinė 79)		80. 00 81. 00
82. 00	Inpatient routine service cost limitation (I	ine 9 x line 81)					82. 00
83. 00 84. 00	Reasonable inpatient routine service costs (Program inpatient ancillary services (see in						83. 00 84. 00
85. 00	Utilization review - physician compensation	(see instructions					85. 00
86. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PAS:		ough 85)				86. 00
87. 00	Total observation bed days (see instructions)	,			0	87. 00
88. 00 89. 00	Adjusted general inpatient routine cost per Observation bed cost (line 87 x line 88) (se		ine 2)				88. 00 89. 00
00	(30)				ļ		

Health Financial Systems	FRANCI SCAN H	EALTH- DYER		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der Co		Peri od:	Worksheet D-1	
		Component		From 01/01/2020 To 12/31/2020		
		Ti tl	e XIX	Subprovi der -	TEFRA	
	I			I RF		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
				,	4) (see	
					instructions)	
	1.00	2. 00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital -related cost	0	7, 225, 314	0.00000	0 0	0	90. 00
91.00 Nursing School cost	0	7, 225, 314	0.00000	0 0	0	91. 00
92.00 Allied health cost	0	7, 225, 314	0. 00000	0 0	0	92.00
93.00 All other Medical Education	0	7, 225, 314	0. 00000	0 0	0	93. 00

Health Financial Systems	FRANCISCAN HEALTH- DYER			u of Form CMS-	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0090	Peri od:	Worksheet D-3	
			From 01/01/2020 To 12/31/2020	Date/Time Pre	nared:
			10 12/31/2020	7/29/2021 1: 2	
	Ti tl e	XVIII	Hospi tal	PPS	<u> </u>
Cost Center Description		Ratio of Cos	t Inpatient	Inpati ent	
· ·		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					ļ
30. 00 03000 ADULTS & PEDI ATRI CS			17, 549, 087		30. 00
31. 00 03100 I NTENSI VE CARE UNIT			4, 721, 528		31. 00
32. 00 03200 CORONARY CARE UNIT			0		32.00
41. 00 04100 SUBPROVI DER - I RF			0		41.00
42. 00 04200 SUBPROVI DER			0		42. 00
43. 00 04300 NURSERY					43. 00
ANCILLARY SERVICE COST CENTERS		0.00776	T (10.1(2)	F40 1F2	F0 00
50. 00 05000 OPERATING ROOM		0.09770		548, 152	
50. 01 05001 OUTPATIENT SURGERY		0. 36463		593, 601	50. 01
51. 00 05100 RECOVERY ROOM 53. 00 05300 ANESTHESI OLOGY		0. 20510 0. 25531		127, 562 491, 764	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 2553		884, 902	
54. 01 05400 RADI OLOGY-DI AGNOSTI C		0. 11363		187, 200	
55. 00 05500 RADI OLOGY-THERAPEUTI C		0. 00000		187, 200	
56. 00 05600 RADI 0I SOTOPE		0. 12403		75, 129	
60. 00 06000 LABORATORY		0. 14105		1, 459, 979	
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 09466		79, 532	
65. 00 06500 RESPI RATORY THERAPY		0. 24358		900, 124	1
66. 00 06600 PHYSI CAL THERAPY		0. 67458		722, 703	1
67. 00 06700 OCCUPATI ONAL THERAPY		0. 22766		203, 494	
68. 00 06800 SPEECH PATHOLOGY		0. 23181	· ·	106, 553	1
69. 00 06900 ELECTROCARDI OLOGY		0. 11344		328, 237	
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 24647		49, 728	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 27069			
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS		0. 84788		2, 241, 994	1
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 30355			
76. 00 03630 ULTRA SOUND		0. 14733		171, 917	
76. 01 03951 PALN CLINIC		0. 20600		1, 829	
76. 02 03952 CATH LAB		0. 09401	6, 880, 192	646, 848	76. 02
76. 03 03953 ACTIVITY THERAPEUTIC		0. 80751	10, 461	8, 447	76. 03
76. 04 03954 WOUND CARE CENTER		0. 51090	9, 217	4, 709	76. 04
76. 05 03340 BARI ATRI C CLI NI C		2. 04271	16 141	288	76. 05
76.06 03030 HEALTHY LIVING CENTER		0.00000	00	0	76. 06
76. 07 03950 CV RESOURCE CENTER		0.00000		0	, 0, 0,
76.08 03955 OTHER ANCILLARY SERVICE COST CENTERS		0.00000		0	
76 09 03956 LACTATION CLINIC		0 00000	0 0	0	76 09

0 76.09

0

0

838

15, 503, 040 200. 00

1, 218, 595

76. 10

76. 11

76. 12

91.00

92.00 0

201.00

202. 00

0.000000

0.000000

0.000000

0. 786768

0. 158978

0. 513373

1, 065

7, 665, 177

72, 956, 131

72, 956, 131

76. 09 03956 LACTATION CLINIC

91. 00 09100 EMERGENCY

76. 10

76. 11

76. 12

200.00 201.00

202.00

03957 OTHER ANCILLARY SERVICE COST CENTERS
03958 OTHER ANCILLARY SERVICE COST CENTERS
03959 ANTICOAGULATION CLINIC

Net charges (line 200 minus line 201)

Total (sum of lines 50 through 94 and 96 through 98)

Less PBP Clinic Laboratory Services-Program only charges (line 61)

OUTPATIENT SERVICE COST CENTERS

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART

PATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0090	Peri	od: n 01/01/2020	Worksheet D-3	
	Component	CCN: 15-T090	To	12/31/2020	Date/Time Pre 7/29/2021 1:2	
	Title	e XVIII	Suk	oprovider - IRF	PPS	. / pi
Cost Center Description		Ratio of Cos	st	Inpatient	Inpati ent	
		To Charges		Program	Program Costs	
				Charges	(col. 1 x col.	
		1.00		2. 00	2) 3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	_	2.00	3.00	
. 00 03000 ADULTS & PEDI ATRI CS				0		30
.00 03100 INTENSIVE CARE UNIT				0		31
.00 03200 CORONARY CARE UNIT				0		32
00 04100 SUBPROVIDER - IRF				7, 489, 199		4
. 00 04200 SUBPROVI DER				0		42
. 00 04300 NURSERY		L				43
ANCI LLARY SERVI CE COST CENTERS			0.7		44.450	<u>ا</u> ۔
00 05000 OPERATI NG ROOM		0.0977		114, 139	11, 152	
.01 05001 0UTPATIENT SURGERY .00 05100 RECOVERY ROOM		0. 3646 0. 2051		20, 670 14, 716	7, 537 3, 018	
. 00 05100 RECOVERY ROOM . 00 05300 ANESTHESI OLOGY		•		·		
. 00 05300 ANESTHESTOLOGY . 00 05400 RADI OLOGY-DI AGNOSTI C		0. 2553 0. 1136		26, 500 342, 617	6, 766 38, 934	
. 01 05401 RADI OLOGY - SPECI AL PROCEDURES		0. 1130		342, 017	0	
. 00 05500 RADI OLOGY-THERAPEUTI C		0. 0000		0	0	
. 00 05600 RADI OI SOTOPE		0. 1240		8, 586	1, 065	
00 06000 LABORATORY		0. 1410		825, 875	116, 494	
.00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 0946		21, 762	2, 060	
. 00 06500 RESPI RATORY THERAPY		0. 2435	84	524, 340	127, 721	6
00 06600 PHYSI CAL THERAPY		0. 6745	85	2, 943, 685	1, 985, 766	6
00 06700 OCCUPATI ONAL THERAPY		0. 2276		2, 826, 900	643, 592	
00 06800 SPEECH PATHOLOGY		0. 2318		1, 021, 787	236, 869	
00 06900 ELECTROCARDI OLOGY		0. 1134		61, 193	6, 942	
00 07000 ELECTROENCEPHALOGRAPHY		0. 2464		13, 187	3, 250	
. OO O7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 2706		636, 187	172, 213	
.00 07200 IMPL. DEV. CHARGED TO PATIENTS .00 07300 DRUGS CHARGED TO PATIENTS		0. 8478		39, 951	33, 874 370, 048	
.00 03630 ULTRA SOUND		0. 3035 0. 1473		1, 219, 044 52, 714	7, 766	
01 03951 PALN CLINIC		0. 1473		32, 714 0	0	
02 03952 CATH LAB		0. 0940		23, 956	2, 252	1
. 03 03953 ACTIVITY THERAPEUTIC		0. 8075		225	182	
. 04 03954 WOUND CARE CENTER		0. 5109		0	0	
. 05 03340 BARI ATRI C CLI NI C		2. 0427	16	0	0	7
.06 03030 HEALTHY LIVING CENTER		0.0000	00	0	0	7
07 03950 CV RESOURCE CENTER		0.0000	00	0	0	7
.08 03955 OTHER ANCILLARY SERVICE COST CENTERS		0.0000	00	0	0	
09 03956 LACTATION CLINIC		0.0000		0	0	
. 10 03957 OTHER ANCILLARY SERVICE COST CENTERS		0.0000		0	0	
. 11 03958 OTHER ANCILLARY SERVICE COST CENTERS		0.0000		0	0	
. 12 O3959 ANTI COAGULATI ON CLINI C		0. 7867	08	10, 600	8, 340	7
OUTPATIENT SERVICE COST CENTERS OO 09100 EMERGENCY		0. 1589	7.2	213, 205	33, 895	9
.00 09100 EMERGENCY .00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 1589		∠13, ∠U5 ∩	33, 895	
0.00 Total (sum of lines 50 through 94 and 96 through 98)		0.3133	, 3	10, 961, 839	3, 819, 736	
1.00 Less PBP Clinic Laboratory Services-Program only charge	s (line 61)			10, 701, 039 N	3,017,730	20
2.00 Net charges (line 200 minus line 201)	(10, 961, 839		20

Health Financial Systems FRANCISCAN HEALTH- DYER In Lieu of Form CMS-2552-10 INPATIENT ANCILLARY SERVICE COST APPORTIONMENT Provider CCN: 15-0090 Period: From 01/01/2020 To 12/31/2020 Date/Time Prepared: 7/29/2021 1:27 pm Title XIX Hospital Cost Cost Center Description Ratio of Cost Inpatient Program Costs Charges Charges (col. 1 x col. 2)							
From 01/01/2020 To 12/31/2020 Date/Time Prepared: 7/29/2021 1: 27 pm Title XIX Hospital Cost Cost Center Description Ratio of Cost Inpatient To Charges Program Charges (col. 1 x col.)	Health Financial Systems	FRANCI SCAN HEAL	TH- DYER		In Lie	u of Form CMS-2	2552-10
Title XIX Hospital Cost Cost Center Description Ratio of Cost Inpatient Program Costs Charges Charges (col. 1 x col.)	INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provi der C			Worksheet D-3	
Cost Center Description Ratio of Cost Inpatient To Charges Program Program Costs Charges (col. 1 x col.					To 12/31/2020		pared: 7 pm
To Charges Program Program Costs Charges (col. 1 x col.			Ti tl	e XIX	Hospi tal	Cost	
Charges (col. 1 x col.	Cost Center Description			Ratio of Cos	t Inpatient	Inpati ent	
				To Charges	Program	Program Costs	
2)					Charges	(col. 1 x col.	
						2)	
1.00 2.00 3.00				1.00	2. 00	3. 00	

	Cost Center Description	Ratio of Cost To Charges	Inpati ent Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2. 00	3. 00	
11	NPATIENT ROUTINE SERVICE COST CENTERS				
30.00 0	3000 ADULTS & PEDI ATRI CS		2, 670, 198	8	30. 00
31.00 0	3100 INTENSIVE CARE UNIT		1, 133, 458		31.00
32.00 0	3200 CORONARY CARE UNIT		C)	32. 00
41.00 0	4100 SUBPROVI DER - I RF		C)	41.00
42.00 0	4200 SUBPROVI DER		C		42. 00
43.00 0	4300 NURSERY		C		43. 00
Al	NCILLARY SERVICE COST CENTERS	•			
	5000 OPERATING ROOM	0. 097707	5, 105, 070	498, 801	50.00
50. 01 0	5001 OUTPATI ENT SURGERY	0. 364533	231, 796	•	50. 01
1	5100 RECOVERY ROOM	0. 205106	294, 362	•	51.00
	5300 ANESTHESI OLOGY	0. 255312	660, 075	•	53.00
	5400 RADI OLOGY-DI AGNOSTI C	0. 113638	1, 086, 829	1	54.00
	5401 RADI OLOGY-SPECI AL PROCEDURES	0. 255755	168, 939	•	54. 01
	5500 RADI OLOGY-THERAPEUTI C	0. 000000	(1	55. 00
	5600 RADI OI SOTOPE	0. 124032	73, 690	9, 140	56. 00
	6000 LABORATORY	0. 140876	2, 422, 012	1	60.00
	6300 BLOOD STORING, PROCESSING & TRANS.	0. 094668	124, 913		63. 00
1	6500 RESPIRATORY THERAPY	0. 243444	848, 227	•	65. 00
	6600 PHYSI CAL THERAPY	0. 674585	165, 984	1	
	6700 OCCUPATI ONAL THERAPY	0. 227667	172, 480	1	
	6800 SPEECH PATHOLOGY	0. 231818	58, 070		
1	6900 ELECTROCARDI OLOGY	0. 113444	491, 370	1	1
	7000 ELECTROENCEPHALOGRAPHY	0. 113444	45, 240		
	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 270695	6, 082		
	7200 IMPL. DEV. CHARGED TO PATIENTS	0. 270043	0, 002	1	72.00
1	7300 DRUGS CHARGED TO PATTENTS		_	1	73.00
	3630 ULTRA SOUND	0. 303556	2, 525, 557	•	76.00
		0. 147331	181, 093 (1	76. 00
	3951 PAIN CLINIC	0. 206009	-	-	
1	3952 CATH LAB	0. 093888	842, 011	•	76. 02
	3953 ACTIVITY THERAPEUTIC	0.807512	1, 316, 772		76. 03
1	3954 WOUND CARE CENTER	0. 510479	400	1	76. 04
1	3340 BARI ATRI C CLI NI C	2. 038152	C	_	76. 05
1	3030 HEALTHY LIVING CENTER	0.000000	(0	76. 06
	3950 CV RESOURCE CENTER	0.000000	(0	76. 07
	3955 OTHER ANCILLARY SERVICE COST CENTERS	0.000000	C	-	76. 08
	3956 LACTATION CLINIC	0.000000	C	-	76. 09
	3957 OTHER ANCILLARY SERVICE COST CENTERS	0.000000	C		76. 10
	3958 OTHER ANCILLARY SERVICE COST CENTERS	0.000000	C	1	76. 11
	3959 ANTI COAGULATI ON CLINI C	0. 785676	C	0	76. 12
	UTPATIENT SERVICE COST CENTERS		4 700 040	075 005	
	9100 EMERGENCY	0. 158702	1, 733, 340	1	91. 00
	9200 OBSERVATION BEDS (NON-DISTINCT PART	0. 513373	40 == 1 = 1	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		18, 554, 312	3, 991, 795	
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		40 554 313	<u>'</u>	201. 00
202. 00	Net charges (line 200 minus line 201)		18, 554, 312	4	202. 00

PATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C		Peri od:	Worksheet D-3	}
	Component		From 01/01/2020 To 12/31/2020	Date/Time Pre 7/29/2021 1:2	
	Ti tl	e XIX	Subprovi der - I RF	TEFRA	, p
Cost Center Description		Ratio of Cos		I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		1.00	2. 00	2) 3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	0.00	
. 00 03000 ADULTS & PEDIATRICS			0		30.
. 00 03100 INTENSIVE CARE UNIT			0		31.
. 00 03200 CORONARY CARE UNIT			0		32.
. 00 04100 SUBPROVI DER - I RF			280, 500		41.
. 00 04200 SUBPROVI DER			0		42.
. 00 O4300 NURSERY			0		43.
ANCILLARY SERVICE COST CENTERS		0.00770	احر	0	-
. 00 05000 OPERATING ROOM . 01 05001 OUTPATIENT SURGERY		0. 09770 0. 36453		0	
. 00 05100 RECOVERY ROOM		0. 20510		0	
. 00 05300 ANESTHESI OLOGY		0. 25531		0	1
. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 11363	_	0	
. 01 05401 RADI OLOGY-SPECI AL PROCEDURES		0. 25575		0	54
. 00 05500 RADI OLOGY-THERAPEUTI C		0.00000	0 0	0	55
. 00 05600 RADI OI SOTOPE		0. 12403	0	0	56
00 06000 LABORATORY		0. 14087		0	
. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 09466		0	
. 00 06500 RESPI RATORY THERAPY		0. 24344		0	
. 00 06600 PHYSI CAL THERAPY		0. 67458		0	1
. 00 06700 OCCUPATI ONAL THERAPY . 00 06800 SPEECH PATHOLOGY		0. 22766 0. 23181	_	0	
. 00 06900 ELECTROCARDI OLOGY		0. 23161		0	
00 07000 ELECTROENCEPHALOGRAPHY		0. 24647		0	
. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 27069		0	
.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0.84788		0	72
. 00 07300 DRUGS CHARGED TO PATIENTS		0. 30355	66 0	0	73
. 00 03630 ULTRA SOUND		0. 14733	0	0	76
. 01 03951 PALN CLINIC		0. 20600		0	
. 02 03952 CATH LAB		0. 09388		0	
. 03 03953 ACTIVITY THERAPEUTIC		0. 80751		0	
. 04 03954 WOUND CARE CENTER		0. 51047		0	
. 05 03340 BARIATRIC CLINIC . 06 03030 HEALTHY LIVING CENTER		2. 03815		0	
. 07 03950 CV RESOURCE CENTER		0.00000		0	
. 08 03955 OTHER ANCILLARY SERVICE COST CENTERS		0. 00000		0	1
. 09 03956 LACTATI ON CLI NI C		0. 00000		0	1
. 10 03957 OTHER ANCILLARY SERVICE COST CENTERS		0.00000		0	
. 11 03958 OTHER ANCILLARY SERVICE COST CENTERS		0.00000	0 0	0	76
. 12 03959 ANTICOAGULATION CLINIC		0. 78567		0	
OUTPATIENT SERVICE COST CENTERS					
. 00 09100 EMERGENCY		0. 15870			91
. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 51337			92
0.00 Total (sum of lines 50 through 94 and 96 through 98)			600	95	200
1.00 Less PBP Clinic Laboratory Services-Program only cha	rges (line 61)	1	0		201

Health Financial Systems	FRANCISCAN HEALTH- DYER	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0090	Peri od: From 01/01/2020 To 12/31/2020	Worksheet E Part A Date/Time Prepared: 7/29/2021 1:27 pm

			10 12/31/2020	7/29/2021 1: 2	
		Title XVIII	Hospi tal	PPS	
				1. 00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1. 00	DRG Amounts Other than Outlier Payments			0	1. 00
1. 01	DRG amounts other than outlier payments for discharges occurring pri	or to October 1 (s	see	12, 930, 744	1. 01
1 00	instructions)		1 /	4 077 201	1 00
1. 02	DRG amounts other than outlier payments for discharges occurring on	or after october	i (see	4, 877, 381	1. 02
1. 03	instructions) DRG for federal specific operating payment for Model 4 BPCI for disc	charges occurring i	orior to October	0	1. 03
1.03	1 (see instructions)	marges occurring p	or to october	O	1.03
1. 04	DRG for federal specific operating payment for Model 4 BPCI for disc	0	1. 04		
	October 1 (see instructions)	g		_	
2.00	Outlier payments for discharges. (see instructions)				2. 00
2.01	Outlier reconciliation amount			0	2. 01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)			0	2. 02
2.03	Outlier payments for discharges occurring prior to October 1 (see in	nstructi ons)		429, 795	2. 03
2.04	Outlier payments for discharges occurring on or after October 1 (see	e instructions)		178, 400	2. 04
3.00	Managed Care Simulated Payments			7, 355, 224	3. 00
4.00	Bed days available divided by number of days in the cost reporting p	period (see instru	ctions)	94. 20	4. 00
	Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recer	nt cost reporting p	period ending on	7. 80	5. 00
	or before 12/31/1996. (see instructions)				
6.00	FTE count for allopathic and osteopathic programs that meet the crit	eria for an add-o	n to the cap for	0. 00	6. 00
	new programs in accordance with 42 CFR 413.79(e)				
7. 00	MMA Section 422 reduction amount to the IME cap as specified under 4			0. 89	7. 00
7. 01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFF	₹ §412. 105(f)(1)(i	v)(B)(2) If the	0. 00	7. 01
	cost report straddles July 1, 2011 then see instructions.		_		
8. 00	Adjustment (increase or decrease) to the FTE count for allopathic ar			0. 00	8. 00
	affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2	?)(IV), 64 FR 26340) (May 12,		
0.01	1998), and 67 FR 50069 (August 1, 2002).	C EEOO -E +L-	16 th	0.00	0.01
8. 01	The amount of increase if the hospital was awarded FTE cap slots unc	ier 8 2203 of the 1	ACA. IT the cost	0. 00	8. 01
8. 02	report straddles July 1, 2011, see instructions. The amount of increase if the hospital was awarded FTE cap slots fro	om a closed teachi	na hosni tal	0. 00	8. 02
0.02	under § 5506 of ACA. (see instructions)	mi a crosed teachir	ig nospi tai	0.00	0.02
9. 00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8,	8 01 and 8 02) (202	6. 91	9. 00
7. 00	instructions)	0,01 and 0,02) (.	300	0. 71	7. 00
10.00	FTE count for allopathic and osteopathic programs in the current year	ar from vour recor	ds	4. 17	10.00
11. 00	FTE count for residents in dental and podiatric programs.	you		2. 84	
12. 00	Current year allowable FTE (see instructions)			7. 01	
13. 00	Total allowable FTE count for the prior year.			7. 07	
14. 00	Total allowable FTE count for the penultimate year if that year ende	ed on or after Sen	tember 30 1997	8. 67	
00	otherwise enter zero.	ла от от аттот обр		0.07	00
15. 00	Sum of lines 12 through 14 divided by 3.			7. 58	15. 00
16. 00	Adjustment for residents in initial years of the program			0.00	
	Adjustment for residents displaced by program or hospital closure				17. 00
	Adjusted rolling average FTE count			7. 58	
	Current year resident to bed ratio (line 18 divided by line 4).			0. 080467	
	Prior year resident to bed ratio (see instructions)			0. 075704	
	Enter the lesser of lines 19 or 20 (see instructions)			0. 075704	
	IME payment adjustment (see instructions)			721, 140	
	IME payment adjustment - Managed Care (see instructions)			297, 850	
	Indirect Medical Education Adjustment for the Add-on for § 422 of th	ne MMA			
23. 00	Number of additional allopathic and osteopathic IME FTE resident cap		FR 412. 105	0.00	23. 00
	(f)(1)(iv)(C).				
24.00	IME FTE Resident Count Over Cap (see instructions)			-2.74	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of	of line 23 or line	24 (see	0. 00	25. 00
	instructions)				
26.00	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	· · · · · · · · · · · · · · · · · · ·		0	28. 00	
28. 01					28. 01
29.00	Total IME payment (sum of lines 22 and 28)				29. 00
29. 01					29. 01
	Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient	days (see instruction	tions)	3. 12	30. 00
31. 00	Percentage of Medicaid patient days (see instructions)			15. 59	31.00
32.00	Sum of lines 30 and 31			18. 71	
	Allowable disproportionate share percentage (see instructions)				33. 00
34.00	Disproportionate share adjustment (see instructions)			218, 595	34.00

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0090	Peri od: From 01/01/2020 To 12/31/2020	Worksheet E Part A Date/Time Prep 7/29/2021 1:2	
		Title XVIII	Hospi tal	PPS 12 (1	
			Prior to 10/1 1.00	2.00	
	Uncompensated Care Adjustment				
5.00	Total uncompensated care amount (see instructions)		8, 350, 599, 096		
5. 01 5. 02	Factor 3 (see instructions) Hospital uncompensated care payment (If line 34 is zero, ente	er zero on this line) (se	0. 000154997 e 1, 294, 322	0. 000315558 2, 615, 979	1
J. UZ	instructions)	er zero on this rine) (se	1, 274, 322	2,013,717	33.0
5. 03	Pro rata share of the hospital uncompensated care payment amount	,	968, 973	659, 371	35.0
6. 00	Total uncompensated care (sum of columns 1 and 2 on line 35.0 Additional payment for high percentage of ESRD beneficiary di		1, 628, 344		36.0
0. 00	Total Medicare discharges, excluding MS-DRGs 652, 682, 683, 6		0		40.0
	instructions)				
1. 00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 6 instructions)	683, 684 an 685. (see	0		41.0
1. 01	Total ESRD Medicare covered and paid discharges excluding MS-	-DRGs 652. 682. 683. 684	0		41.0
	an 685. (see instructions)				
2.00	Divide line 41 by line 40 (if less than 10%, you do not quali Total Medicare ESRD inpatient days excluding MS-DRGs 652, 68		0.00		42. C
3. 00	וסומו Medicare ESRD impatient days excluding MS-DRGS סאל, אל instructions)	32, 683, 684 an 685. (See	0		43.0
4. 00	Ratio of average length of stay to one week (line 43 divided	by line 41 divided by 7	0. 000000		44. 0
5. 00	days) Average weekly cost for dialysis treatments (see instructions	-)	0.00		45. C
6. 00	Total additional payment (line 45 times line 44 times line 47	•	0.00		46. (
7. 00	Subtotal (see instructions)		20, 984, 399		47. (
8. 00	Hospital specific payments (to be completed by SCH and MDH, s	small rural hospitals	0		48. (
	only. (see instructions)			Amount	
				1. 00	
9. 00	Total payment for inpatient operating costs (see instructions			21, 282, 249	49. (
0.00	Payment for inpatient program capital (from Wkst. L, Pt. I ar			1, 452, 654	1
1. 00 2. 00	Exception payment for inpatient program capital (Wkst. L, Pt. Direct graduate medical education payment (from Wkst. E-4, Ii			0 289, 384	
3. 00	Nursing and Allied Health Managed Care payment	The 49 See Thistructions).		207, 304	53.
4. 00	Special add-on payments for new technologies			32, 478	54. (
4. 01	Islet isolation add-on payment	(0)		0	54.
5. 00 6. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line & Cost of physicians' services in a teaching hospital (see intr			0	55. 56.
7. 00	Routine service other pass through costs (from Wkst. D, Pt. I	•	hrough 35).	0	57.
8. 00	Ancillary service other pass through costs from Wkst. D, Pt.		J ,	0	58.
9.00	Total (sum of amounts on lines 49 through 58)			23, 056, 765	
0. 00	Primary payer payments Total amount payable for program beneficiaries (line 59 minus	s line 60)		0 23, 056, 765	60. 61.
2. 00	Deductibles billed to program beneficiaries	3 11116 00)		1, 716, 660	
3. 00	Coinsurance billed to program beneficiaries			80, 190	63.
	Allowable bad debts (see instructions)			378, 097	
5. 00 6. 00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see inst	tructions)		245, 763 185, 742	1
7. 00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	tructrons)		21, 505, 678	1
3. 00	Credits received from manufacturers for replaced devices for	applicable to MS-DRGs (s	ee instructions)	0	
9. 00	Outlier payments reconciliation (sum of lines 93, 95 and 96).	(For SCH see instruction	s)	0	
0.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	tration) adjustment (ass	i notrusti ono)	0	70.
0. 50 0. 87	Rural Community Hospital Demonstration Project (§410A Demonst Demonstration payment adjustment amount before sequestration	tration) adjustment (see	instructions)	0	70. 70.
0. 88	SCH or MDH volume decrease adjustment (contractor use only)			Ö	1
0. 89	Pioneer ACO demonstration payment adjustment amount (see inst	tructions)			70.
0. 90	HSP bonus payment HVBP adjustment amount (see instructions)			0	1
0. 91 0. 92	HSP bonus payment HRR adjustment amount (see instructions) Bundled Model 1 discount amount (see instructions)			0	
0. 92	HVBP payment adjustment amount (see instructions)			-141, 729	
0. 94	HRR adjustment amount (see instructions)			-148, 338	70.
	Recovery of accelerated depreciation			0	70.

Health Financial Systems FRANCISCAN HE	EALTH- DYER		In Lie	u of Form CMS-	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der Co	CN: 15-0090	Peri od: From 01/01/2020 To 12/31/2020		
	Title	XVIII	Hospi tal	PPS	
		FFY	(yyyy)	Amount	
			0	1. 00	
70.96 Low volume adjustment for federal fiscal year (yyyy) (Enter the corresponding federal year for the period prior to 10/1			0	0	70. 96
70.97 Low volume adjustment for federal fiscal year (yyyy) (Enter the corresponding federal year for the period ending on or			0	0	70. 97

	Title	XVIII	Hospi tal	PPS	7 PIII
			уууу)	Amount	
			0	1. 00	
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0	(0	0	70. 96
	the corresponding federal year for the period prior to 10/1)				
70. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0	(0	0	70. 97
	the corresponding federal year for the period ending on or after 10/1)			_	
70. 98	Low Volume Payment-3			0	
70. 99	HAC adjustment amount (see instructions)			0	70. 99
71. 00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)			21, 215, 611	
71. 01	Sequestration adjustment (see instructions)			140, 023	1
	Demonstration payment adjustment amount after sequestration			0	
71. 03	Sequestration adjustment-PARHM pass-throughs			21 040 202	71. 03
	Interim payments			21, 049, 382	1
	Interim payments-PARHM Tentative settlement (for contractor use only)			0	72. 01
73. 00	Tentative settlement (for contractor use only)			U	73. 00 73. 01
74. 00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and			26, 206	
74.00	[73]			20, 200	74.00
74. 01	Balance due provider/program-PARHM (see instructions)				74. 01
75. 00	Protested amounts (nonallowable cost report items) in accordance with			514, 740	1
70.00	CMS Pub. 15-2, chapter 1, §115.2			011,710	70.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03			0	90.00
	plus 2.04 (see instructions)				
91.00	Capital outlier from Wkst. L, Pt. I, line 2			0	91. 00
92.00	Operating outlier reconciliation adjustment amount (see instructions)			0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)			0	93. 00
94.00	The rate used to calculate the time value of money (see instructions)			0.00	94. 00
95.00	Time value of money for operating expenses (see instructions)			0	95. 00
96. 00	Time value of money for capital related expenses (see instructions)			0	96. 00
			Prior to 10/1	On/After 10/1	
			1. 00	2. 00	
	HSP Bonus Payment Amount				
100.00	HSP bonus amount (see instructions)		0	0	100. 00
404 00	HVBP Adjustment for HSP Bonus Payment				
	HVBP adjustment factor (see instructions)		0.0000000000	0.0000000000	1
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	0	102. 00
100.00	HRR Adjustment for HSP Bonus Payment		0.0000	0.0000	100 00
	HRR adjustment factor (see instructions)		0.0000	0.0000	
104.00	HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjus	+mon+	0	U	104. 00
200.00					200 00
200.00	Is this the first year of the current 5-year demonstration period under th Century Cures Act? Enter "Y" for yes or "N" for no.	ie zist			200. 00
	Cost Reimbursement				
201 00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)				201. 00
	Medicare discharges (see instructions)				202. 00
	Case-mix adjustment factor (see instructions)				203. 00
	Computation of Demonstration Target Amount Limitation (N/A in first year o	of the current	5-vear demonst	ration	
	peri od)		- ,		
204.00	Medicare target amount				204. 00
	Case-mix adjusted target amount (line 203 times line 204)				205. 00
	Medicare inpatient routine cost cap (line 202 times line 205)				206. 00
	Adjustment to Medicare Part A Inpatient Reimbursement				
207.00	Program reimbursement under the §410A Demonstration (see instructions)				207. 00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)				208. 00
209.00	Adjustment to Medicare IPPS payments (see instructions)				209. 00
	Reserved for future use				210. 00
211. 00	Total adjustment to Medicare IPPS payments (see instructions)				211. 00
	Comparision of PPS versus Cost Reimbursement				
	Total adjustment to Medicare Part A IPPS payments (from line 211)				212. 00
	Low-volume adjustment (see instructions)				213. 00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimb	oursement)			218. 00
	(line 212 minus line 213) (see instructions)				1

Provider CCN: 15-0090

				-	101111		7/29/2021 1: 2	/ pill
		W/C E Dort A	Amounts (from	Title Pre/Post	Period Prior	Hospi tal Peri od	PPS Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	On/After 10/01		
		0	1.00	2.00	3.00	4. 00	5. 00	
1.00	DRG amounts other than outlier	1. 00	0	0	(0	0	1. 00
1. 01	payments DRG amounts other than outlier payments for discharges	1. 01	12, 930, 744	0	12, 930, 744	1	12, 930, 744	1. 01
1. 02	occurring prior to October 1 DRG amounts other than outlier payments for discharges occurring on or after October	1. 02	4, 877, 381	0		4, 877, 381	4, 877, 381	1. 02
1. 03	1 DRG for Federal specific operating payment for Model 4	1. 03	0	0	C)	0	1. 03
1. 04	BPCI occurring prior to October 1 DRG for Federal specific operating payment for Model 4 BPCI occurring on or after	1. 04	0	0		0	0	1. 04
2. 00	October 1 Outlier payments for discharges (see instructions)	2. 00						2. 00
2. 01	Outlier payments for discharges for Model 4 BPCI	2. 02	0	0	(0	0	2. 01
2. 02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2. 03	429, 795	O	429, 795	5	429, 795	2. 02
2. 03	Outlier payments for discharges occurring on or after October 1 (see	2. 04	178, 400	0		178, 400	178, 400	2. 03
3. 00	instructions) Operating outlier reconciliation	2. 01	0	0	(0	0	3. 00
4. 00	Managed care simulated payments	3. 00	7, 355, 224	0	5, 579, 011	1, 776, 213	7, 355, 224	4. 00
	Indirect Medical Education Adju	ustment						
5.00	Amount from Worksheet E, Part	21. 00	0. 075704	0. 075704	0. 075704	0. 075704		5. 00
6.00	A, line 21 (see instructions) IME payment adjustment (see	22. 00	721, 140	0	523, 630	197, 510	721, 140	6. 00
6. 01	instructions) IME payment adjustment for managed care (see	22. 01	297, 850	О	225, 922	71, 928	297, 850	6. 01
	instructions)		A	1: 400 6.1	1 1414			
7. 00	Indirect Medical Education Adju IME payment adjustment factor	27.00	0. 000000			0.000000		7. 00
8. 00	(see instructions) IME adjustment (see	28. 00	0	0	(0	0	8. 00
8. 01	instructions) IME payment adjustment add on for managed care (see	28. 01	0	0	C	0	0	8. 01
9. 00	<pre>instructions) Total IME payment (sum of lines 6 and 8)</pre>	29. 00	721, 140	0	523, 630	197, 510	721, 140	9. 00
9. 01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29. 01	297, 850	0	225, 922	71, 928	297, 850	9. 01
	Di sproporti onate Share Adjustme	ent		l				1
10. 00	Allowable disproportionate share percentage (see instructions)	33.00	0. 0491	0. 0491	0. 0491	0. 0491		10. 00
11. 00	Disproportionate share adjustment (see instructions)	34. 00	218, 595	0	158, 725	59, 870	218, 595	11. 00
11. 01	Uncompensated care payments Additional payment for high per	36.00 centage of ESF	1, 628, 344 RD beneficiary		1, 138, 045	216, 350	1, 354, 395	11. 01
12. 00	Total ESRD additional payment	46.00	0	0	(0	0	12. 00
13. 00 14. 00	(see instructions) Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.)	47. 00 48. 00	20, 984, 399 0	0	15, 454, 888 (5, 529, 511 0 0	20, 984, 399 0	ı
15. 00	(see instructions) Total payment for inpatient operating costs (see instructions)	49. 00	21, 282, 249	0	15, 680, 810	5, 601, 439	21, 282, 249	15. 00
16. 00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50. 00	1, 452, 654	0	1, 065, 247	387, 407	1, 452, 654	16. 00

						o 12/31/2020	Date/Time Pre 7/29/2021 1:2	pared:
				Title	: XVIII	Hospi tal	PPS	
		W/S E, Part A		Pre/Post	Period Prior	Peri od	Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	On/After 10/01	through 4)	
		0	1.00	2.00	3. 00	4. 00	5. 00	
17. 00	Special add-on payments for new technologies	54.00	32, 478	0	(32, 478	32, 478	17. 00
17. 01	Net organ aquisition cost							17. 01
17. 02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68. 00	0	0	(0	0	17. 02
18. 00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	O	0	(0	0	18. 00
19.00	SUBTOTAL			0	16, 746, 057	6, 021, 324	22, 767, 381	19. 00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3. 00	4. 00	5. 00	
20.00	Capital DRG other than outlier	1. 00	1, 380, 110	0	1, 014, 285	365, 825	1, 380, 110	20.00
20. 01	Model 4 BPCI Capital DRG other than outlier		0	0	(0	0	20. 01
21. 00	Capital DRG outlier payments	2. 00	21, 342	0	13, 332	8, 010	21, 342	21. 00
21. 01	Model 4 BPCI Capital DRG outlier payments	2. 01	0	0	(0	0	21. 01
22. 00	Indirect medical education percentage (see instructions)	5. 00	0. 0371	0. 0371	0. 037	0. 0371		22. 00
23. 00	Indirect medical education adjustment (see instructions)	6. 00	51, 202	0	37, 630	13, 572	51, 202	23. 00
24. 00	Allowable disproportionate share percentage (see instructions)	10.00	0. 0000	0.0000	0.0000	0.0000		24. 00
25. 00	Disproportionate share adjustment (see instructions)	11.00	0	0	(0	0	25. 00
26. 00	Total prospective capital payments (see instructions)	12. 00	1, 452, 654	0	1, 065, 247	387, 407	1, 452, 654	26. 00
		W/S E, Part A						
		line	Part A)					
		0	1.00	2.00	3. 00	4. 00	5. 00	
27. 00 28. 00	Low volume adjustment factor Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 96			0.00000	0. 000000	0	27. 00 28. 00
29. 00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 97				0	0	29. 00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		N					100. 00

Heal th Financial SystemsFRANCISCAN HEADHOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 Provider CCN: 15-0090

				10) 12/31/2020	7/29/2021 1:2	
			Title	XVIII	Hospi tal	PPS	, p
		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	
1. 00 1. 01	DRG amounts other than outlier payments DRG amounts other than outlier payments for	1. 00 1. 01	12, 930, 744	12, 930, 744		12, 930, 744	1. 00 1. 01
1. 02	discharges occurring prior to October 1 DRG amounts other than outlier payments for discharges occurring on or after October 1	1. 02	4, 877, 381		4, 877, 381	4, 877, 381	1. 02
1. 03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October	1. 03	0	0		0	1. 03
1. 04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1. 04	0		0	0	1. 04
2. 00	Outlier payments for discharges (see instructions)	2.00					2. 00
2. 01	Outlier payments for discharges for Model 4 BPCI	2. 02	0	0	0	0	2. 01
2. 02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2. 03	429, 795	429, 795		429, 795	2. 02
2. 03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2. 04	178, 400		178, 400	178, 400	2. 03
3. 00 4. 00	Operating outlier reconciliation Managed care simulated payments	2. 01 3. 00	0 7, 355, 224	0 5, 579, 011	0 1, 776, 213	0 7, 355, 224	3. 00 4. 00
5. 00	Indirect Medical Education Adjustment Amount from Worksheet E, Part A, line 21	21. 00	0. 075704	0. 075704	0. 075704		5. 00
	(see instructions)						
6. 00 6. 01	IME payment adjustment (see instructions) IME payment adjustment for managed care (see	22. 00 22. 01	721, 140 297, 850		197, 510 71, 928	721, 140 297, 850	6. 00 6. 01
	instructions) Indirect Medical Education Adjustment for the	Add on for So	otion 122 of t	ho MMA			
7. 00	IME payment adjustment factor (see	27. 00	0. 000000		0. 000000		7. 00
	instructions)	27.00	0.00000	0.00000	0.00000		7.00
8. 00 8. 01	IME adjustment (see instructions) IME payment adjustment add on for managed care (see instructions)	28. 00 28. 01	0	- 1	0	0	8. 00 8. 01
9. 00 9. 01	Total IME payment (sum of lines 6 and 8) Total IME payment for managed care (sum of lines 6.01 and 8.01)	29. 00 29. 01	721, 140 297, 850		197, 510 71, 928	721, 140 297, 850	9. 00 9. 01
	Di sproporti onate Share Adjustment						
10.00	Allowable disproportionate share percentage	33.00	0. 0491	0. 0491	0. 0491		10. 00
11. 00	(see instructions) Disproportionate share adjustment (see instructions)	34.00	218, 595	158, 725	59, 870	218, 595	11. 00
11. 01	Uncompensated care payments	36. 00	1, 628, 344	641, 993	604, 623	1, 246, 616	11. 01
	Additional payment for high percentage of ESF	D beneficiary					
12. 00	Total ESRD additional payment (see	46. 00	0	0	0	0	12. 00
13. 00 14. 00	<pre>instructions) Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see</pre>	47. 00 48. 00	20, 984, 399 0		5, 917, 784 0	20, 984, 399 0	
15. 00	instructions) Total payment for inpatient operating costs (see instructions)	49. 00	21, 282, 249	15, 292, 537	5, 989, 712	21, 282, 249	15. 00
16. 00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50. 00	1, 452, 654	1, 065, 247	387, 407	1, 452, 654	16. 00
17. 00 17. 01	Special add-on payments for new technologies Net organ acquisition cost	54. 00	32, 478	0	32, 478	32, 478	17. 00 17. 01
17. 02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68. 00	0	0	0	0	
18. 00	Capital outlier reconciliation adjustment amount (see instructions)	93. 00	0	0	0	0	18. 00
19. 00	SUBTOTAL			16, 357, 784	6, 409, 597	22, 767, 381	19. 00

Heal th	Financial Systems	FRANCISCAN HE	EALTH- DYER		In Lie	u of Form CMS-	2552-10
HOSPI TA	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5	Provi der CO		eri od:	Worksheet E	
				F	rom 01/01/2020		
				1	o 12/31/2020	Date/Time Pre	pared:
						7/29/2021 1:2	7 pm
			Title	XVIII	Hospi tal	PPS	
		Wkst. L, line	(Amt. from				
			Wkst. L)				
		0	1.00	2.00	3. 00	4. 00	
20. 00	Capital DRG other than outlier	1.00	1, 380, 110	1, 014, 285	365, 825	1, 380, 110	20. 00
20. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	0	۱ ،		Λ.	20. 01

			Title	XVIII	Hospi tal	PPS	
		Wkst. L, line	(Amt. from				
			Wkst. L)				
		0	1. 00	2. 00	3. 00	4. 00	
20. 00	Capital DRG other than outlier	1. 00	1, 380, 110	1, 014, 285	365, 825		
20. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	0	0	0	0	
21. 00	Capital DRG outlier payments	2. 00	21, 342	13, 332	8, 010		
21. 01	Model 4 BPCI Capital DRG outlier payments	2. 01	0	0	0	0	1 21.01
22. 00	Indirect medical education percentage (see instructions)	5. 00	0. 0371	0. 0371	0. 0371		22. 00
23. 00	Indirect medical education adjustment (see instructions)	6. 00	51, 202	37, 630	13, 572	51, 202	23. 00
24. 00		10.00	0. 0000	0. 0000	0. 0000		24. 00
25. 00	,	11. 00	0	0	0	0	25. 00
26. 00	Total prospective capital payments (see instructions)	12. 00	1, 452, 654	1, 065, 247	387, 407	1, 452, 654	26. 00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1. 00	2. 00	3. 00	4. 00	
27.00							27. 00
28.00	Low volume adjustment prior to October 1	70. 96	0	0		0	
29.00	Low volume adjustment on or after October 1	70. 97	0		0	0	29. 00
30.00	HVBP payment adjustment (see instructions)	70. 93	-141, 729	-79, 755	-61, 974	-141, 729	30.00
30. 01	HVBP payment adjustment for HSP bonus payment (see instructions)	70. 90	0	0	0	0	30. 01
31.00	HRR adjustment (see instructions)	70. 94	-148, 338	-68, 533	-79, 805	-148, 338	31.00
31. 01	HRR adjustment for HSP bonus payment (see instructions)	70. 91	0	0	0	0	31. 01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3. 00	4. 00	
32. 00	HAC Reduction Program adjustment (see instructions)	70. 99		0	0	0	32. 00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100. 00

Health Financial Systems	FRANCISCAN HEALTH- DYER	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0090	Peri od: From 01/01/2020 To 12/31/2020 Date/Ti me Prepared: 7/29/2021 1:27 pm

		Title XVIII	Hospi tal	7/29/2021 1: 2 PPS	7 pm
No. No. Color and other services (see instructions) 1.2, 200,			nospi tui	113	
Medical and other services (see Instructions) 13,800 1.00		DART D. MEDICAL AND STUED HEALTH SERVICES		1. 00	
Medical and other services reinbursed under OPPS (see Instructions) 12,295,477 2.00 2	1 00			12 900	1 00
Books Bayes 1.50 1.00		· · · · · · · · · · · · · · · · · · ·			
Dutil er recond Listion anount (see instructions)					
Enter the hospital specific payment to cost ratio (see instructions) 0.000 5.00 1.000	4.00	Outlier payment (see instructions)		60, 214	4. 00
United States United State		· · · · · · · · · · · · · · · · · · ·		l e	1
2.00 Sum of Tines 3					1
1.00 Content					1
				l e	1
11.00 Total cost (sum of lines 1 and 10) (see instructions) 11.00		, , , , , , , , , , , , , , , , , , , ,	00		
COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges Reason	10.00	Organ acqui si ti ons		0	10.00
Reasonable charges	11. 00			13, 800	11. 00
12.00 Ancil lary service charges 12.131 12.00 10.10 10.10 10.11 12.00 10.11 12.00 10.11 12.00 10.11 12.00 10.11 12.00 10.11 12.00 10.11 12.00 10.11 12.00 10.11 12.00 10.11 12.00 10.11 12.00 10.11 12.00 10.11 12.00 10.11 12.00 10.11 12.00 10.11 12.00 10.11 12.00 12.10 12.00 12.10 12.00 12.10 12.00 12.10 12.00					-
13.00 Organ acquisition charges (from Wist. D-4, Pt. III. col. 4, line 69) 0 13.00	12 00			82 137	12 00
14.00					1
15.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis 0 15.00					
16.00 Amounts that would have been realized from patients I able for payment for services on a chargebasis 0 16.00				,	
had such payment been made in accordance with 42 CFR §413.13(e) 0.000000 17.00					
17.00 Ratio of line 15 to line 16 (not to exceed 1.000000) 0.000000 17.00 17.00 17.00 18.00 Total customery charges (see instructions) 82.137 18.00 18.00 Total customery charges (see instructions) 18.00	16.00		ces on a chargebasis	0	16.00
18.00 Total customary charges (see instructions) 82, 137 18.00	17 00			0 000000	17 00
19.00 Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see 68, 337 19.00				l .	1
20.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see 0 20.00	19. 00		ds line 11) (see		
Instructions 13,800 21.00					
13,800 21.00 22.00 22.00 Cost or charges (see instructions) 0.22.00 22.00 Cost of physicians' services in a teaching hospital (see instructions) 0.22.00 23.00 Cost of physicians' services in a teaching hospital (see instructions) 0.22.00 23.00 Cost of physicians' services in a teaching hospital (see instructions) 0.22.00 Cost of physicians' services in a teaching hospital (see instructions) 1.50.6,81.583,81.20.00 Communation of the communities of t	20. 00		ds line 18) (see	0	20.00
22.00 Interns and residents (see instructions) 0 22.00 23.00 23.00 Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) 8,658,583 24.00 23.00 24.00 25	21 00			13 800	21 00
24. 00 Total prospective payment (sum of lines 3, 4, 4, 01, 8 and 9) COMPUTATION OF BETIBBURSEWIN SETTLEBENT		· · · · · · · · · · · · · · · · · · ·			1
COMPUTATION OF REIMBURSEMENT SETTLEMENT 12,000 25.00 Deductible sand coinsurance amounts (for CAH, see instructions) 12,392 25.00 26.00 Deductible sand coinsurance amounts relating to amount on line 24 (for CAH, see instructions) 1,506,840 26.00 27.00 28.00 Deductible sand coinsurance amounts relating to amount on line 24 (for CAH, see instructions) 1,506,840 26.00 29.00 29.00 25.00 Direct graduate medical education payments (from Wkst. E-4, line 50) 99,149 28.00 29.00 25.00 ESRD direct medical education costs (from Wkst. E-4, line 36) 0.99.00 29.00 25.00 29.00 25.00 29.00 29.00 25.00 29.0					
25.00 Deductible and coin surance amounts (For CAH, see instructions) 12,392 25.00	24. 00			8, 658, 583	24. 00
20.00 Deductible sand Coinsurance amounts relating to amount on line 24 (for CAH, see instructions) 1,506,840 26.00	25.00			12 202	25 00
27.00 Subtotal [(I ines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see 1, 153, 15 27.00			instructions)		1
Instructions		, , ,			
29. 00 ESRD direct medical education costs (from Wkst. E-4, line 36) 0 29. 00 30. 00 Subtotal (sum of lines 27 through 29) 7, 252, 300 30. 00 30. 00 30. 00 Subtotal (sum of lines 27 through 29) 7, 252, 300 30. 00 30. 00 Subtotal (line 30 minus line 31) 7, 248, 784 32. 00 ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		-,	- \		
30. 00 Subtotal (sum of lines 27 through 29) 7, 252, 300 30, 00 7, 30, 00 7, 30, 30, 30 7, 30, 30					
3. 10					1
32.00 Subtotal (ilne 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) 33.00 Composite rate ESRD (from Wkst. I-5, line 11) 0 33.00 34.00 Allowable bad debts (see instructions) 260,547 34.00 35.00 Adjusted reimbursable bad debts (see instructions) 169,356 35.00 36.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 129,565 36.00 37.00 Subtotal (see instructions) 7,418,140 37.00 Subtotal (see instructions) 7,418,140 37.00 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) 9.50 Pioneer ACO demonstration payment adjustment (see instructions) 39.50 9.50 Pioneer ACO demonstration payment adjustment (see instructions) 0 39.97 39.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39.99 9.90 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39.99 40.00 Subtotal (see instructions) 7,418,070 40.00 40.00 Sequestration adjustment amount after sequestration 48,959 40.01 40.00 Demonstration payment adjustment amount after sequestration 48,959 40.01 40.02 40.02 40.02 40.02 40.02 40.03 40.02 40.03		, ,			
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) 0 33.00					
34. 00 Allowable bad debts (see instructions) 260, 547 34. 00 35. 00 Adjusted reimbursable bad debts (see instructions) 169, 356 35. 00 37. 00 30. 00 Allowable bad debts for dual eligible beneficiaries (see instructions) 129, 565 36. 00 37. 00 38. 00 MSP-LCC reconciliation amount from PS&R 7, 418, 140 37. 00 38. 00 MSP-LCC reconciliation amount from PS&R 70 38. 00 MSP-LCC reconciliation amount from PS&R 70 39. 00 39. 50 39. 00 39. 50 39. 00 39. 50 39. 00 39. 50 39. 90 39					
35.00					
36. 00		· · · · · · · · · · · · · · · · · · ·			
37.00 Subtotal (see instructions) 7,418,140 37.00 38.00 MSP-LCC reconciliation amount from PS&R 70 38.00 39.00 Ther ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.00 39.50 39.50 97 Demonstration payment adjustment (see instructions) 39.97 39.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39.97 39.99 RECOVERY OF ACCELERATED DEPRECIATION 0 39.99 40.00 Sequestration adjustment amount after sequestration 48,959 40.01 40.00		, ,			
39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.00 39.50 91 91 91 92 92 93.50 93.50 93.50 94 94 94 94 94 94 94 9		· · · · · · · · · · · · · · · · · · ·			
39.50 Pi oneer ACO demonstration payment adjustment (see instructions) 39.50 39.97 39.98 39.97 39.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39.97 39.98 RECOVERY OF ACCELERATED DEPRECIATION 0 39.99 40.00 Subtotal (see instructions) 7,418,070 40.00 40.01 Sequestration adjustment (see instructions) 48,959 40.01 40.02 Demonstration payment adjustment amount after sequestration 0 40.02 40.03 Sequestration adjustment-PARHM pass-throughs 7,469,412 41.00 Interim payments 7,469,412 41.00 41.01 Interim payments-PARHM 42.00 Tentative settlement (for contractors use only) 42.01 Tentative settlement-PARHM (for contractor use only) 42.01 Tentative settlement-PARHM (for contractor use only) 43.00 Balance due provider/program (see instructions) 43.01 43.00 43.01 Balance due provider/program-PARHM (see instructions) 43.01 43.01 43.00 43.01 43	38. 00	MSP-LCC reconciliation amount from PS&R		70	38. 00
39.97 39.98 39.97 39.98 39.99 Partial or full credits received from manufacturers for replaced devices (see instructions) 39.98 39.99 RECOVERY OF ACCELERATED DEPRECIATION 0 Subtotal (see instructions) 40.00 Subtotal (see instructions) 40.01 Sequestration adjustment (see instructions) 40.02 Demonstration payment adjustment amount after sequestration 40.03 Sequestration adjustment amount after sequestration 40.04 Linter im payments 40.05 Sequestration adjustment encount after sequestration 40.06 Inter im payments 40.07 41.00 Inter im payments 41.01 Inter im payments 41.01 Tentative settlement (for contractors use only) 42.01 Tentative settlement (for contractor use only) 43.01 Balance due provider/program-PARHM (see instructions) 43.01 Balance due provider/program-PARHM (see instructions) 43.01 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 44.00 Si15.2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 0 90.00 91.00 Outlier reconciliation adjustment amount (see instructions) 0 91.00 92.00 The rate used to calculate the Time Value of Money 0 0.00 Og 2.00				0	
39.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 39.98 RECOVERY OF ACCELERATED DEPRECIATION 0 39.99 40.00 Subtotal (see instructions) 7, 418,070 40.00 Demonstration adjustment (see instructions) 80.01 Sequestration adjustment amount after sequestration 91.02 Demonstration payment adjustment amount after sequestration 92.03 Sequestration adjustment-PARHM pass-throughs 93.99 7, 418,070 7, 418,070 40.00					
39.99 RECOVERY OF ACCELERATED DEPRECIATION 0 39.99 40.00 Subtotal (see instructions) 7,418,070 40.00 40.01 Sequestration adjustment (see instructions) 48,959 40.01 48,959 40.01 40.02 40.02 40.03 40.02 40.03			structions)		1
40.00 Subtotal (see instructions) 40.01 Sequestration adjustment (see instructions) 40.02 Demonstration payment adjustment amount after sequestration 40.03 Sequestration adjustment-PARHM pass-throughs 41.00 Interim payments 41.01 Interim payments 41.01 Interim payments-PARHM 42.00 Tentative settlement (for contractors use only) 42.01 Tentative settlement-PARHM (for contractor use only) 43.00 Bal ance due provider/program (see instructions) 43.01 Bal ance due provider/program-PARHM (see instructions) 43.01 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 90.00 Original outlier amount (see instructions) 90.00 The rate used to calculate the Time Value of Money 90.00 The rate used to calculate the Time Value of Money 90.00 The rate used to calculate the Time Value of Money 90.00 The rate used to calculate the Time Value of Money 90.00 The rate used to calculate the Time Value of Money 90.00 The rate used to calculate the Time Value of Money 90.00 The rate used to calculate the Time Value of Money 90.00 The rate used to calculate the Time Value of Money 90.00 The rate used to calculate the Time Value of Money 90.00 The rate used to calculate the Time Value of Money 90.00 The rate used to calculate the Time Value of Money 90.00 The rate used to calculate the Time Value of Money 90.00 The rate used to calculate the Time Value of Money 90.00 The rate used to calculate the Time Value of Money		,	Structions)		
40.01 Sequestration adjustment (see instructions) 40.02 Demonstration payment adjustment amount after sequestration 40.03 Sequestration adjustment-PARHM pass-throughs 41.00 Interim payments 41.01 Interim payments-PARHM 42.00 Tentative settlement (for contractors use only) 42.01 Tentative settlement-PARHM (for contractor use only) 43.00 Balance due provider/program (see instructions) 43.01 Balance due provider/program-PARHM (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2 70 BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 92.00 The rate used to calculate the Time Value of Money 93.01 A0.02 94.02 94.03 94.03 94.00 94.00 94.00 94.00 94.00 95.00 96.00 97.00					1
40. 03 Sequestration adjustment-PARHM pass-throughs 40. 03 41. 00 Interim payments 7, 469, 412 41. 00 41. 01 Interim payments-PARHM 42. 00 Tentative settlement (for contractor use only) 42. 01 Tentative settlement-PARHM (for contractor use only) 42. 01 43. 00 Balance due provider/program (see instructions) -100, 301 43. 00 43. 01 Balance due provider/program-PARHM (see instructions) 43. 01 44. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44. 00 §115. 2 10 10 10 10 10 10 10	40. 01	Sequestration adjustment (see instructions)		48, 959	40. 01
41.00 Interim payments 41.01 Interim payments-PARHM 42.00 Tentative settlement (for contractors use only) 42.01 Tentative settlement-PARHM (for contractor use only) 43.00 Balance due provider/program (see instructions) 43.01 Balance due provider/program-PARHM (see instructions) 43.01 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.01 At 1.00 A				0	
41.01 Interim payments-PARHM 42.00 Tentative settlement (for contractors use only) 42.01 Tentative settlement-PARHM (for contractor use only) 43.00 Balance due provider/program (see instructions) 43.01 Balance due provider/program-PARHM (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, solution of the complete of the com				7 4/0 410	
42.00 Tentative settlement (for contractors use only) 42.01 Tentative settlement-PARHM (for contractor use only) 43.00 Balance due provider/program (see instructions) 43.01 Balance due provider/program-PARHM (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 0 42.00 42.01 43.00 42.01 43.00 43.01 43.00 0-100,301 43.00 0-100,301 0-100,				7, 469, 412	1
42.01 Tentative settlement-PARHM (for contractor use only) 43.00 Balance due provider/program (see instructions) 43.01 Balance due provider/program-PARHM (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 42.01 43.00 43.00 43.01 40.00 41.00 42.01 43.00 43.01 43.00 44.00				0	
43.01 Balance due provider/program-PARHM (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 43.01 44.00 44.00 90.00 90.00 91.00 91.00 92.00 92.00 93.00 94.00 94.00 94.00 94.00 94.00 95.00 96.00 97.00		•			1
44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 \$\frac{\sqrt{115.2}}{\text{TO BE COMPLETED BY CONTRACTOR}}\$ 90.00 Original outlier amount (see instructions) 0 90.00 0utlier reconciliation adjustment amount (see instructions) 0 91.00 92.00 The rate used to calculate the Time Value of Money 0.00 92.00	43.00	Balance due provider/program (see instructions)		-100, 301	
\$115.2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Outlier reconciliation adjustment amount (see instructions) 94.00 Outlier reconciliation adjustment amount (see instructions) 95.00 Outlier reconciliation adjustment amount (see instructions) 96.00 Outlier reconciliation adjustment amount (see instructions) 97.00 Outlier reconciliation adjustment amount (see instructions)		,		_	
TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 10 90.00 91.00 92.00 Octobr/> 92.00 The rate used to calculate the Time Value of Money 11 0 90.00 92.00 Octobr/> 92.00 Octobr/> 93.00 Octobr/> 94.00 Octobr/> 95.00 Octobr/> 96.00 Octobr/> 97.00 Octobr/> 97.00 Octobr/> 98.00 Octobr/> 98.00 Octobr/> 99.00 Octobr/> 99.	44. 00	, , ,	5-2, chapter 1,	0	44.00
90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 0.00 99.00					1
91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 0 91.00 92.00	90. 00			0	90.00
		, , , , , , , , , , , , , , , , , , ,		0	91. 00
U3 (N) Illime Value of Money (see instructions)					
93.00 Third value of world (See Thistructions) 94.00 Total (sum of lines 91 and 93) 0 94.00	93.00			0	
77. 00 10 tai (Suin of 11 lies 71 and 73)	74.00	proteir (Swiii of Fiffics 21 driu 20)		1	74.00

Health Financial Systems	FRANCISCAN HEALTH- DYER	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0090	Peri od:	Worksheet E
		From 01/01/2020	
	Component CCN: 15-T090	To 12/31/2020	Date/Time Prepared:
			7/29/2021 1:27 pm
	Title XVIII	Subprovi der -	PPS

		litle XVIII	Subprovi der - I RF	PPS	
				1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1. 00	
1.00	Medical and other services (see instructions)			289	1. 00
2.00	Medical and other services reimbursed under OPPS (see instructions)	1)		0	2.00
3. 00 4. 00	OPPS payments Outlier payment (see instructions)			371 0	3. 00 4. 00
4. 00	Outlier reconciliation amount (see instructions)			0	4. 00
5. 00	Enter the hospital specific payment to cost ratio (see instructions	s)		0. 000	5. 00
6.00	Line 2 times line 5			0	6. 00
7. 00 8. 00	Sum of lines 3, 4, and 4.01, divided by line 6 Transitional corridor payment (see instructions)			0. 00 0	7. 00 8. 00
9. 00	Ancillary service other pass through costs from Wkst. D, Pt. IV, co	ol 13 line 200		0	9. 00
10. 00	Organ acquisitions	01. 10, 11110 200		0	10. 00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			289	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
12. 00	Reasonable charges Ancillary service charges			1, 090	12. 00
13. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 6	9)		0	13. 00
14.00	Total reasonable charges (sum of lines 12 and 13)	·		1, 090	14. 00
15 00	Customary charges	nt for complete on s	oborgo bosi s	0	15 00
15. 00 16. 00	Aggregate amount actually collected from patients liable for payment Amounts that would have been realized from patients liable for payments.		•	0	15. 00 16. 00
10.00	had such payment been made in accordance with 42 CFR §413.13(e)	morre for Services on	a chargebasis		10.00
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	17. 00
18. 00 19. 00	Total customary charges (see instructions)	Elino 10 ovecede lir	o 11) (coo	1, 090 801	18. 00 19. 00
19.00	Excess of customary charges over reasonable cost (complete only if instructions)	Title to exceeds titl	le II) (See	801	19.00
20. 00	Excess of reasonable cost over customary charges (complete only if	line 11 exceeds lin	ie 18) (see	0	20. 00
21 00	instructions)			200	21 00
21. 00 22. 00	Lesser of cost or charges (see instructions) Interns and residents (see instructions)			289 0	21. 00 22. 00
23. 00	Cost of physicians' services in a teaching hospital (see instruction	ons)		Ö	23. 00
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			371	24. 00
25 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			0	25. 00
25. 00 26. 00	Deductibles and coinsurance amounts (for CAH, see instructions) Deductibles and Coinsurance amounts relating to amount on line 24	(for CAH, see instru	ictions)	0	26. 00
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus	•	,	660	27. 00
00.00	instructions)	0)			00.00
28. 00 29. 00	Direct graduate medical education payments (from Wkst. E-4, line 50 ESRD direct medical education costs (from Wkst. E-4, line 36)	0)		0	28. 00 29. 00
30. 00	Subtotal (sum of lines 27 through 29)			660	30.00
31.00	Primary payer payments			0	31. 00
32. 00	Subtotal (line 30 minus line 31)			660	32. 00
33. 00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) Composite rate ESRD (from Wkst. I-5, line 11)			0	33. 00
34. 00	Allowable bad debts (see instructions)			0	34. 00
35. 00	Adjusted reimbursable bad debts (see instructions)			0	35. 00
	Allowable bad debts for dual eligible beneficiaries (see instructions)	ons)		0	36.00
37. 00 38. 00				660 0	37. 00 38. 00
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			Ö	39. 00
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)				39. 50
39. 97	Demonstration payment adjustment amount before sequestration	loud and Cook i materiat	i ana)	0	39. 97 39. 98
39. 98 39. 99	Partial or full credits received from manufacturers for replaced de RECOVERY OF ACCELERATED DEPRECIATION	evices (see instruct	10115)	0	39. 98 39. 99
40. 00	Subtotal (see instructions)			660	40. 00
40. 01	Sequestration adjustment (see instructions)			4	40. 01
40. 02	Demonstration payment adjustment amount after sequestration			0	40. 02
40. 03 41. 00	Sequestration adjustment-PARHM pass-throughs Interim payments			581	40. 03 41. 00
41. 01	Interim payments-PARHM			1	41. 01
42.00	Tentative settlement (for contractors use only)			0	42. 00
42. 01	Tentative settlement-PARHM (for contractor use only)				42. 01
43. 00 43. 01	Balance due provider/program (see instructions) Balance due provider/program-PARHM (see instructions)			75	43. 00 43. 01
44. 00	Protested amounts (nonallowable cost report items) in accordance wi	ith CMS Pub. 15-2, c	hapter 1,	0	44. 00
	§115. 2		· · ·		
00.00	TO BE COMPLETED BY CONTRACTOR			0	00 00
90.00	Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions)			0	90. 00 91. 00
92. 00				0. 00	
93.00	Time Value of Money (see instructions)			0	93.00
94.00	Total (sum of lines 91 and 93)			0	94. 00

Health Financial Systems FRA ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Peri od: | Worksheet E-1 | From 01/01/2020 | Part | To 12/31/2020 | Date/Time Prepared: Provider CCN: 15-0090

				10 12/31/2020	7/29/2021 1: 2	
		Ti tl	e XVIII	Hospi tal	PPS	•
		Inpatie	nt Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4. 00	
1.00	Total interim payments paid to provider		21, 049, 38	32	7, 469, 412	1. 00
2.00	Interim payments payable on individual bills, either			0	0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER			0	0	3. 01
3. 02				0	0	3. 02
3.03				0	0	3. 03
3.04				0	0	3. 04
3.05				0	0	3. 05
	Provi der to Program	ı	_			
3.50	ADJUSTMENTS TO PROGRAM			0	0	3. 50
3. 51				0	0	3. 51
3. 52				0	0	3. 52
3. 53				0	0	3. 53
3. 54 3. 99	Subtatal (sum of lines 2 01 2 40 minus sum of lines			0	0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			U	٥	3. 99
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		21, 049, 38	22	7, 469, 412	4.00
4.00	(transfer to Wkst. E or Wkst. E-3, line and column as		21,047,30	, , , , , , , , , , , , , , , , , , ,	7, 407, 412	7.00
	appropriate)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5.01	TENTATI VE TO PROVI DER			0	0	5. 01
5.02				0	0	5. 02
5.03				0	0	5. 03
	Provider to Program					
5. 50	TENTATI VE TO PROGRAM			0	0	5. 50
5. 51				0	0	5. 51
5. 52				0	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5. 99
	5. 50-5. 98)					
6. 00	Determined net settlement amount (balance due) based on					6. 00
. 01	the cost report. (1)		1 2/ 2/			, 01
6. 01	SETTLEMENT TO PROVIDER		26, 20		0	6. 01
6. 02	SETTLEMENT TO PROGRAM		21 075 5	0	100, 301	6. 02
7.00	Total Medicare program liability (see instructions)		21, 075, 58		7, 369, 111	7. 00
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1. 00	2. 00	
8. 00	Name of Contractor		<u> </u>	1.00	2.00	8. 00
5. 50	Tham of Soft dotor	I		1	1 1	. 5.50

Component CCN: 15-T090

Subprovi der -Title XVIII

		litle	XVIII	Subprovider -	PPS	
		I npati en	t Dort A	I RF	t B	
		<u>'</u>				
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2. 00	3. 00	4. 00	
1.00	Total interim payments paid to provider		8, 193, 293		581	1. 00
2.00	Interim payments payable on individual bills, either		0		0	2. 00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
3. 00	write "NONE" or enter a zero					3. 00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate					3.00
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER		0		0	3. 01
3. 02	The second secon		0		ol	3. 02
3. 03			0		o	3. 03
3.04			0		0	3. 04
3.05			0		o	3. 05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3. 50
3. 51			0		0	3. 51
3.52			0		0	3. 52
3.53			0		0	3. 53
3.54			0		0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		0		0	3. 99
4 00	3. 50-3. 98)		0 100 000		F01	4 00
4. 00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as		8, 193, 293		581	4. 00
	appropriate)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		0		0	5. 01
5.02			0		0	5. 02
5.03			0		0	5. 03
	Provi der to Program			1		
5.50	TENTATI VE TO PROGRAM		0		0	5. 50
5. 51			0		0	5. 51
5. 52 5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		0		0	5. 52 5. 99
5. 99	5. 50-5. 98)		U		ا	5. 99
6. 00	Determined net settlement amount (balance due) based on					6. 00
0.00	the cost report. (1)					0.00
6. 01	SETTLEMENT TO PROVIDER		19, 158		75	6. 01
6.02	SETTLEMENT TO PROGRAM		0		o	6. 02
7.00	Total Medicare program liability (see instructions)		8, 212, 451		656	7. 00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
0.00		()	1. 00	2. 00	0.00
8. 00	Name of Contractor			l	l l	8. 00

Heal th	Financial Systems FRANCISCAN F	EALTH- DYER	In Lie	u of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0090	Peri od:	Worksheet E-1	
			From 01/01/2020 To 12/31/2020		epared:
				7/29/2021 1:2	2 7 pm
		Title XVIII	Hospi tal	PPS	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULAT				1.00
	1.00 Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14				
2.00	Medicare days 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				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.				6. 00
7. 00	CAH only - The reasonable cost incurred for the purchase o	f 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 sequestrati	on (see instructions)			10.00
	I NPATIENT HOSPITAL SERVICES UNDER THE I PPS & CAH				
	Initial/interim HIT payment adjustment (see instructions)				30.00
	Other Adjustment (specify)				31.00
32. 00	Balance due provider (line 8 (or line 10) minus line 30 an	d line 31) (see instruction	ns)		32. 00

1	Health Financial Systems	FRANCISCAN HEALTH- DYER	In Lie	u of Form CMS-2552-10
	CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0090		Worksheet E-3
			From 01/01/2020	
		Component CCN: 15-T090	To 12/31/2020	Date/Time Prepared:
_		·		7/29/2021 1: 27 pm
		Title XVIII	Subprovi der -	PPS
			LDE	

	IRF	110	
		1. 00	
	PART III - MEDICARE PART A SERVICES - IRF PPS	1.00	
1.00	Net Federal PPS Payment (see instructions)	7, 880, 737	1. 00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0. 0347	2. 00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	297, 892	3. 00
4.00	Outlier Payments	154, 873	4. 00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior	0.00	5.00
	to November 15, 2004 (see instructions)		
5. 01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by	0.00	5. 01
	program or hospital closure, that would not be counted without a temporary cap adjustment under 42		
	CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)		
6.00	New Teaching program adjustment. (see instructions)	0.00	6. 00
7. 00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new	0. 00	7. 00
8. 00	teaching program" (see instructions) Current year's unweighted I&R FTE count for residents within the new program growth period of a "new	0. 00	8. 00
8.00	teaching program" (see instructions)	0.00	8.00
9. 00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0.00	9. 00
10. 00	Average Daily Census (see instructions)	20. 907104	
11. 00	Teaching Adjustment Factor (see instructions)	0.000000	
12. 00	Teaching Adjustment (see instructions)	0	12. 00
13. 00	Total PPS Payment (see instructions)	8, 333, 502	13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)	0	14.00
15.00	Organ acqui si ti on (DO NOT USE THIS LINE)	ı	15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)	0	16.00
17. 00	Subtotal (see instructions)	8, 333, 502	17.00
18. 00	Primary payer payments	797	18.00
19. 00	Subtotal (line 17 less line 18).	8, 332, 705	
20. 00	Deducti bl es	29, 524	20. 00
21. 00	Subtotal (line 19 minus line 20)	8, 303, 181	21. 00
22. 00	Coinsurance	36, 168	
23. 00	Subtotal (line 21 minus line 22)	8, 267, 013 0	23. 00 24. 00
24. 00 25. 00	Allowable bad debts (exclude bad debts for professional services) (see instructions) Adjusted reimbursable bad debts (see instructions)	0	24. 00 25. 00
26. 00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	26. 00
27. 00	Subtotal (sum of lines 23 and 25)	8, 267, 013	
28. 00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0, 207, 013	28. 00
29. 00	Other pass through costs (see instructions)	ő	29. 00
30. 00	Outlier payments reconciliation	ol	30. 00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	31.00
31. 50	Pioneer ACO demonstration payment adjustment (see instructions)	o	31. 50
31. 99	Demonstration payment adjustment amount before sequestration	0	31. 99
32.00	Total amount payable to the provider (see instructions)	8, 267, 013	32.00
32. 01	Sequestration adjustment (see instructions)	54, 562	32. 01
32. 02	Demonstration payment adjustment amount after sequestration	0	32. 02
33. 00	Interim payments	8, 193, 293	33.00
34.00	Tentative settlement (for contractor use only)	0	34. 00
35.00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)	19, 158	35. 00
36. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	0	36. 00
	§115. 2 TO BE COMPLETED BY CONTRACTOR		
50. 00		154, 873	50. 00
	Outlier reconciliation adjustment amount (see instructions)	154, 673	51. 00
52. 00	The rate used to calculate the Time Value of Money	- 1	52. 00
	Time Value of Money (see instructions)	0	53. 00
	· · · · · · · · · · · · · · · · · · ·	- 1	

Health Financial Systems	FRANCISCAN HEALTH- DYER	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0090	Peri od: Worksheet E-3 From 01/01/2020 Part VII To 12/31/2020 Date/Time Prepared: 7/29/2021 1:27 pm

			lo 12/31/2020	Date/lime Pre 7/29/2021 1:2	
		Title XIX	Hospi tal	Cost	, biii
			Inpatient	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SEF	RVICES FOR TITLES V OR XI)	SERVI CES		
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		0		1.00
2.00	Medical and other services			0	2. 00
3.00	Organ acquisition (certified transplant centers only)		0		3. 00
4.00	Subtotal (sum of lines 1, 2 and 3)		0	0	4. 00
5.00	Inpatient primary payer payments		0		5. 00
6.00	Outpatient primary payer payments			0	6. 00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		0	0	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable Charges		_		
8.00	Routine service charges		0		8. 00
9.00	Ancillary service charges		18, 554, 312	28, 019, 061	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)		18, 554, 312	28, 019, 061	12. 00
40.00	CUSTOMARY CHARGES	 	1		
13. 00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13. 00
14.00	basis		0	0	14 00
14. 00	Amounts that would have been realized from patients liable for a charge basis had such payment been made in accordance with		0	0	14. 00
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)	+2 CFR 9413. 13(e)	0. 000000	0.000000	15. 00
16. 00	Total customary charges (see instructions)		18, 554, 312	28, 019, 061	16.00
17. 00	Excess of customary charges over reasonable cost (complete onl	v if line 16 exceeds	18, 554, 312	28, 019, 061	
17.00	line 4) (see instructions)	y II IIIIc To exceeds	10, 334, 312	20, 017, 001	17.00
18. 00	Excess of reasonable cost over customary charges (complete onl	vifline 4 exceeds line	0	0	18. 00
10.00	16) (see instructions)	ye . executee		ŭ	10.00
19. 00	Interns and Residents (see instructions)		0	0	19. 00
20.00	Cost of physicians' services in a teaching hospital (see instr	ructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line	16)	0	0	21. 00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be	completed for PPS provide	ers.		
22.00	Other than outlier payments		0	0	22. 00
	Outlier payments		0	0	23. 00
24.00	Program capital payments		0		24. 00
	Capital exception payments (see instructions)		0		25. 00
26. 00	Routine and Ancillary service other pass through costs		0	0	
27. 00	Subtotal (sum of lines 22 through 26)		0	0	
28. 00	Customary charges (title V or XIX PPS covered services only)		0	0	
29. 00	Titles V or XIX (sum of lines 21 and 27)		0	0	29. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		_		
30. 00	Excess of reasonable cost (from line 18)		0	0	
31. 00)	0	0	
32. 00	Deducti bl es		0	0	
33. 00	Coinsurance		0	0	
34. 00	Allowable bad debts (see instructions)		0	0	34.00
36. 00	Utilization review Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	4 33)	0	0	35. 00 36. 00
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	1 33)	0	0	
	Subtotal (line 36 ± line 37)		0	0	38.00
	Direct graduate medical education payments (from Wkst. E-4)		0	U	39. 00
	Total amount payable to the provider (sum of lines 38 and 39)		0	0	1
41. 00	Interim payments		0	0	
42. 00	Balance due provider/program (line 40 minus line 41)		0	0	
43. 00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub 15-2	0	0	1
	chapter 1, §115.2			Ŭ	
	· · · · · · · · · · · · · · · · · · ·		'		

Health Financial Systems	FRANCISCAN HEALTH- DYER	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0090	Peri od:	Worksheet E-3
	C	From 01/01/2020	
	Component CCN: 15-T090		Date/Time Prepared:
			7/29/2021 1:27 pm
	Title XIX	Subprovi der -	TEFRA
		IDE	

		II tile xix	I RF	TEFKA	
			Inpatient	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SER	VICES FOR TITLES V OR XI)		2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES	VI 020 1 011 11 1220 1 011 711 7	. 02.111 020		
1.00	Inpatient hospital/SNF/NF services		5		1. 00
2.00	Medical and other services			o	2. 00
3.00	Organ acquisition (certified transplant centers only)		o		3. 00
4. 00	Subtotal (sum of lines 1, 2 and 3)		5	ol	4. 00
5. 00	Inpatient primary payer payments		o		5. 00
6.00	Outpatient primary payer payments			0	6. 00
7. 00	Subtotal (line 4 less sum of lines 5 and 6)		5	ő	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES		-1	_	
	Reasonable Charges				
8.00	Routine service charges		0		8. 00
9. 00	Ancillary service charges		600	810, 479	9. 00
10. 00	Organ acquisition charges, net of revenue		0	0.0, .,,	10.00
11. 00	Incentive from target amount computation		o		11. 00
12. 00	Total reasonable charges (sum of lines 8 through 11)		600	810, 479	12. 00
	CUSTOMARY CHARGES			2.27	
13.00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13. 00
	basis	g-		_	
14.00	Amounts that would have been realized from patients liable for	payment for services on	o	o	14.00
	a charge basis had such payment been made in accordance with 4				
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0. 000000	15. 00
16.00	Total customary charges (see instructions)		600	810, 479	16. 00
17. 00	Excess of customary charges over reasonable cost (complete onl	y if line 16 exceeds	595	810, 479	17. 00
	line 4) (see instructions)	,			
18.00	Excess of reasonable cost over customary charges (complete onl	y if line 4 exceeds line	o	o	18. 00
	16) (see instructions)				
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instr	uctions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 1	6)	5	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be	completed for PPS provide	ers.		
22. 00	Other than outlier payments		0	0	22. 00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26. 00	Routine and Ancillary service other pass through costs		0	0	26.00
27. 00	Subtotal (sum of lines 22 through 26)		0	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)		5	0	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)		5	0	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	33)	5	0	36. 00
37. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37. 00
38. 00	Subtotal (line 36 ± line 37)		5	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)		5	0	40. 00
41. 00	Interim payments		5	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 accordan	ce with CMS Pub 15-2,	0	0	43.00
	chapter 1, §115.2			l	

	RADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT EDUCATION COSTS	Provi der Co	CN: 15-0090	Peri od: From 01/01/2020 To 12/31/2020	Worksheet E-4 Date/Time Prep 7/29/2021 1:2	
		Title	XVIII	Hospi tal	PPS	
					1. 00	
COI	MPUTATION OF TOTAL DIRECT GME AMOUNT					
	nweighted resident FTE count for allopathic and osteopathic and on or before December 31, 1996.	programs for	cost reporti	ng peri ods	7. 76	1. 00
	nweighted FTE resident cap add-on for new programs per 42 CF	R 413.79(e)(1) (see instr	ructions)	0. 00	2. 00
- 1	mount of reduction to Direct GME cap under section 422 of MM.				0. 86	3. 00
	rect GME cap reduction amount under ACA §5503 in accordance astructions for cost reporting periods straddling 7/1/2011)	with 42 CFR	§413.79 (m).	(see	0. 00	3. 0
	djustment (plus or minus) to the FTE cap for allopathic and	osteopathi c	programs due	to a Medicare	0. 00	4. 0
	ME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f)				0.00	4.0
	CA Section 5503 increase to the Direct GME FTE Cap (see instandeling 7/1/2011)	ructions for	cost reporti	ng perioas	0. 00	4. 0
. 02 AC	CA Section 5506 number of additional direct GME FTE cap slot	s (see inst	ructions for	cost reporting	0. 00	4. 0
	eriods straddling 7/1/2011) FE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 pl	ue or minue	lino 4 plue l	inos 4 01 and	6. 90	5. 00
	02 plus applicable subscripts	us or illi rius	Title 4 prus i	THES 4.01 and	0. 90	5.00
. 00 Un	nweighted resident FTE count for allopathic and osteopathic	programs for	the current	year from your	3. 53	6. 0
1	ecords (see instructions) hter the lesser of line 5 or line 6				3. 53	7. 00
. 00 [11]	ittel the resser of time 5 of time 0		Primary Care	e Other	Total	7.00
1			1.00	2. 00	3. 00	
	eighted FTE count for physicians in an allopathic and osteop rogram for the current year.	athi c	0. 2	27 2. 91	3. 18	8. 0
.00 if	fline 6 is less than 5 enter the amount from line 8, otherw		0. 2	27 2. 91	3. 18	9. 0
	ultiply line 8 times the result of line 5 divided by the amo	unt on line				
0.00 We	eighted dental and podiatric resident FTE count for the curr	ent year		2. 84		10. 0
0. 01 Un	nweighted dental and podiatric resident FTE count for the cu	,		0.00		10. 0
	otal weighted FTE count	(0. 2	1		11. 0
	otal weighted resident FTE count for the prior cost reporting distructions)	g year (see	0.4	6. 33		12. 00
3. 00 To	otal weighted resident FTE count for the penultimate cost re	porti ng	0. 5	7. 31		13. 0
-	ear (see instructions) olling average FTE count (sum of lines 11 through 13 divided	by 2)	0. 4	42 6. 46		14. 00
	ljustment for residents in initial years of new programs	by 3).	0.0	1		15. 0
	nweighted adjustment for residents in initial years of new p		0. 0	1		15. 0
	djustment for residents displaced by program or hospital clo		0.0	I I		16.0
	nweighted adjustment for residents displaced by program or hoosure	ospi tai	0.0	0.00		16. 0°
	djusted rolling average FTE count		0. 4			17. 0
4	er resident amount		90, 010. 5			18. 0
9.00 Ap	proved amount for resident costs		37, 80	04 561, 970	599, 774	19.00
					1. 00	
	dditional unweighted allopathic and osteopathic direct GME F	TE resident	cap slots red	ceived under 42	0. 00	20. 00
1	ec. 413.79(c)(4) rect GME FTE unweighted resident count over cap (see instru	ctions)			0.00	21. 0
1	lowable additional direct GME FTE Resident Count (see instru				0.00	
	nter the locality adjustment national average per resident a	mount (see i	nstructions)		0.00	
1	ultiply line 22 time line 23				0 500 774	24. 0
5. 00 To	otal direct GME amount (sum of lines 19 and 24)		Inpatient Par	rt Managed Care	599, 774 Total	25. 00
			А	ŭ	0.00	
COL	MPUTATION OF PROGRAM PATIENT LOAD		1. 00	2.00	3. 00	
5. 00 In	nopatient Days (see instructions) (Title XIX - see S-2 Part I 02, column 2)	X, line	14, 03	5, 639		26. 0
	otal Inpatient Days (see instructions)		29, 13	39 29, 139		27. 0
1	atio of inpatient days to total inpatient days		0. 48162	1		28. 00
4	rogram direct GME amount		288, 86	116, 069	404, 934	29. 0 29. 0
1	ercent reduction for MA DGME eduction for direct GME payments for Medicare Advantage			16, 401	16, 401	29. 0 30. 0
0.00 Re						

Hoal th	Financial Systems FRANCISCAN HEAL	TU DVED	In Lin	u of Form CMS 1	2552 10	
	Health Financial Systems FRANCISCAN HEALTH- DYER In Lieu of Form CMS-2 DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT Provider CCN: 15-0090 Period: Worksheet E-4					
	From 01/01/2020			Date/Time Pre	pared:	
		Title XVIII	Hospi tal	PPS		
				1. 00		
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLI EDUCATION COSTS)	E XVIII ONLY (NURSING SC	HOOL AND PARAMEDI	CAL		
32. 00	1	Pt. I, sum of col. 20 an	d 23, lines 74	0	32. 00	
	and 94)					
33. 00	Renal dialysis and home dialysis total charges (Wkst. C, Pt.		74 and 94)	0		
34. 00	Ratio of direct medical education costs to total charges (lin	e 32 ÷ line 33)		0. 000000		
	Medicare outpatient ESRD charges (see instructions)	0.4		0		
36.00	Medicare outpatient ESRD direct medical education costs (line			0	36. 00	
	APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII	UNLY			1	
37. 00	Part A Reasonable Cost Reasonable cost (see instructions)			35, 917, 860	27.00	
37.00	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)			35, 917, 860	ı	
	Cost of physicians' services in a teaching hospital (see inst	rusti ons)		0		
40.00	, , ,	ructions)		797		
	Total Part A reasonable cost (sum of lines 37 through 39 minu	s lino 40)		35, 917, 063		
41.00	Part B Reasonable Cost	3 11116 40)	l	33, 717, 003	41.00	
42 00	Reasonable cost (see instructions)			12, 309, 506	42 00	
	Primary payer payments (see instructions)			3, 516	1	
44. 00	31313 \			12, 305, 990		
45. 00	Total reasonable cost (sum of lines 41 and 44)			48, 223, 053		
46.00	,	e 41 ÷ line 45)		0. 744811		
47.00	Ratio of Part B reasonable cost to total reasonable cost (line	e 44 ÷ line 45)		0. 255189	47. 00	
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PAI		<u>'</u>		1	
48.00	Total program GME payment (line 31)			388, 533	48. 00	
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only)	(see instructions)		289, 384	49. 00	
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only)	(see instructions)		99, 149	50.00	

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

Provider CCN: 15-0090

Peri od: Worksheet G From 01/01/2020 To 12/31/2020 Date/Time Prepared:

7/29/2021 1:27 pm Speci fi c Endowment Fund General Fund Plant Fund Purpose Fund 1.00 3.00 4.00 2.00 CURRENT ASSETS 1.00 1.00 Cash on hand in banks 18,878 0 0 0 Temporary investments 0 0 2.00 0 2.00 0 3.00 Notes receivable 0 0 3.00 0 4 00 24, 858, 947 4 00 Accounts receivable 0 0 5.00 Other receivable 4, 373, 492 0 0 5.00 -4, 592, 262 6.00 Allowances for uncollectible notes and accounts receivable 6.00 0 2, 189, 216 7.00 Inventory 0 0 7.00 0 8.00 Prepaid expenses 0 8.00 0 9.00 Other current assets 0 9.00 10 00 Due from other funds 0 0 0 10 00 Total current assets (sum of lines 1-10) 26, 848, 271 0 0 11.00 0 11 00 FIXED ASSETS 12.00 Land 346, 472 0 0 0 12.00 Land improvements 0 13.00 9, 701, 677 0 0 0 0 0 0 0 0 0 0 0 0 0 13.00 οĺ Accumulated depreciation 14.00 0 14.00 15.00 Bui I di ngs 68, 352, 523 0 0 15.00 16.00 Accumulated depreciation 0 16.00 0 17.00 Leasehold improvements 17.00 178, 989 0 0 18 00 Accumulated depreciation Λ 18 00 Fi xed equipment 19.00 19.00 0 20.00 Accumulated depreciation 0 20.00 0 21.00 Automobiles and trucks C 0 21.00 22.00 Accumulated depreciation 0 22.00 23.00 Major movable equipment 168, 737, 576 0 23.00 Accumulated depreciation -154, 516, 650 24.00 24.00 0 25.00 Mi nor equi pment depreci able Λ 25, 00 26.00 Accumulated depreciation 0 0 26.00 C 27.00 HIT designated Assets 0 0 0 0 27.00 0 28.00 Accumulated depreciation 0 0 28.00 0 29.00 Mi nor equi pment-nondepreci abl e 0 29.00 30.00 Total fixed assets (sum of lines 12-29) 92, 800, 587 0 30.00 OTHER ASSETS 31 00 Investments O 0 0 31 00 0 0 32.00 Deposits on Leases C 0 32.00 Due from owners/officers 0 0 0 33.00 33.00 0 34.00 Other assets 383, 221 0 0 34.00 0 Total other assets (sum of lines 31-34) 35.00 383, 221 0 35, 00 36.00 Total assets (sum of lines 11, 30, and 35) 120, 032, 079 0 0 0 36.00 CURRENT LIABILITIES 37 00 6 720 001 O 0 n 37 00 Accounts payable 0 0 38.00 Salaries, wages, and fees payable 5, 272, 554 0 38.00 0 Payroll taxes payable 0 39.00 39.00 0 Notes and Loans payable (short term) 0 40.00 40.00 0 0 0 Deferred income 41 00 41 00 C 0 42.00 Accelerated payments 42.00 568, 012 43.00 Due to other funds 0 0 0 43.00 Other current liabilities 0 0 44.00 1.434.574 0 44.00 Total current liabilities (sum of lines 37 thru 44) 0 13, 995, 141 0 45.00 0 45.00 ONG TERM LIABILITIES 46.00 Mortgage payable 0 46.00 0 0 Notes payable 0 0 47.00 47.00 48 00 Unsecured Loans 0 0 0 48 00 Other long term liabilities 60, 451, 087 0 0 49.00 49.00 0 50 00 Total long term liabilities (sum of lines 46 thru 49) 60, 451, 087 0 0 0 50.00 Total liabilities (sum of lines 45 and 50) 51.00 74, 446, 228 0 0 0 51.00 CAPITAL ACCOUNTS General fund balance 52.00 45, 585, 851 52.00 53.00 Specific purpose fund 0 53.00 Donor created - endowment fund balance - restricted Donor created - endowment fund balance - unrestricted 54.00 0 54.00 55.00 0 55.00 56.00 Governing body created - endowment fund balance 0 56.00 Plant fund balance - invested in plant Plant fund balance - reserve for plant improvement, 57.00 57.00 0 58.00 0 58.00 replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 45, 585, 851 0 59.00 60.00 Total liabilities and fund balances (sum of lines 51 and 120, 032, 079 0 0 0 60.00

Provider CCN: 15-0090

					То	12/31/2020	Date/Time Pre 7/29/2021 1:2	
		General	Fund	Speci al	Pur	pose Fund	Endowment Fund	, Dill
4.00		1.00	2. 00	3.00		4. 00	5. 00	4 00
1.00	Fund balances at beginning of period		230, 078, 207			0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2)		-52, 141, 969			0		2.00
3. 00 4. 00	CONTRIBUTIONS OF PPE	52, 336	177, 936, 238		0	U	0	3. 00 4. 00
5.00	CONTRIBUTIONS OF PPE	52, 550			0		0	5. 00
6.00					0		0	6. 00
7. 00					0		0	7. 00
8. 00					0		0	8. 00
9. 00					0		Ö	9. 00
10. 00	Total additions (sum of line 4-9)		52, 336			0	Ü	10. 00
11. 00	Subtotal (line 3 plus line 10)		177, 988, 574			0		11. 00
12. 00	EQUITY TRANSFERS	132, 402, 722	,,		0		0	12. 00
13.00	ROUNDI NG	1			0		0	13. 00
14.00		o			0		0	14. 00
15.00		o			0		0	15. 00
16.00		o			0		0	16. 00
17. 00		0			0		0	17. 00
18.00	Total deductions (sum of lines 12-17)		132, 402, 723			0		18. 00
19. 00	Fund balance at end of period per balance		45, 585, 851			0		19. 00
	sheet (line 11 minus line 18)	E 1 . E 1	DI I					
		Endowment Fund	PI ant	Fund				
		6. 00	7. 00	8. 00				
1. 00	Fund balances at beginning of period	0.00	7.00	0.00	0			1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)							2. 00
3.00	Total (sum of line 1 and line 2)	o			0			3. 00
4.00	CONTRIBUTIONS OF PPE		0					4.00
5.00			0					5. 00
6.00			0					6. 00
7.00			0					7. 00
8.00			0					8. 00
9.00			0					9. 00
10.00	Total additions (sum of line 4-9)	0			0			10. 00
11. 00	Subtotal (line 3 plus line 10)	0			0			11.00
12.00	EQUITY TRANSFERS		0					12.00
13.00	ROUNDI NG		0					13.00
14.00			0					14. 00
15. 00 16. 00			0					15. 00 16. 00
17. 00			0					16.00
18.00	Total deductions (sum of lines 12-17)	0	U		0			18.00
19. 00	Fund balance at end of period per balance				0			19. 00
17.00	sheet (line 11 minus line 18)				Ĭ			. 7. 00
	1	' '	'	•	,			

Health Financial Systems
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-0090

Cost Center Description Inpatient Outpatient Outp			Т	o 12/31/2020	Date/Time Pre 7/29/2021 1: 2	
PART I - PATIENT REVENUES 1.00 2.00 3.00		Cost Center Description	Inpatient	Outpati ent		, piii
Seneral Inpatient Routine Services		'				
1.00 Hospital		PART I - PATIENT REVENUES				
2. 00 SUBPROVIDER - IPF 12, 191, 671 12, 191, 671 3. 00 0 4. 00 0 4. 00 0 4. 00 0 4. 00 0 5. 00 0 6. 00 0 5. 00 0 6. 00 0 0 0 0 0 0 0 0 0		General Inpatient Routine Services				
3.00 SUBPROVIDER - IRF	1.00	Hospi tal	40, 289, 026		40, 289, 026	1. 00
3.00 SUBPROVIDER		SUBPROVI DER - I PF				2. 00
5.00			12, 191, 671		12, 191, 671	3. 00
Sung bod - NF Sung bod - Sung bod - Sung bod - Sung bod - NF Sung bod - Sung bo			0		-	
7. 00 SKILLED NURSING FACILITY 8. 00 9. 00 0. 00 0. 01 0			0		-	
8. 00 NURSING FACILITY			0		0	ł
9, 00 OTHER LONG TERM CARE 10, 00 Total operarial inpatient care services (sum of lines 1-9) 52, 480, 697 10, 00 11, 00 11, 00 11, 00 11, 00 11, 00 11, 00 11, 00 11, 00 11, 00 11, 00 11, 00 12, 00 12, 00 12, 00 13, 00 14, 00 14, 00 14, 00 14, 00 14, 00 14, 00 14, 00 14, 00 14, 00 16						1
10.0 Total general inpatient care services (sum of lines 1-9) 52,480,697 52,480,697 10.0						1
Intensive Care Type Inpatient Hospital Services						•
11.00 INTENSIVE CARE UNIT 11.655,087 11.055,087 12.00 12.00 13.00 14.0	10. 00		52, 480, 697		52, 480, 697	10. 00
12.00 CORONARY CARE UNIT 0 12.00 13.00			1			
13. 00 BURN INTENSIVE CARE UNIT						
14. 00 SURGICAL INTENSIVE CARE UNIT 14. 00 15. 00 OTHER SPECIAL CARE (SPECIFY) 15. 00 10 10 10 11. 655, 087 11. 655, 087 16. 00 11. 10 10 11. 655, 087 11. 655, 087 16. 00 16. 00 11. 10 10 11. 655, 087 11. 655, 087 11. 655, 087 16. 00 16. 00 11. 10 10 11. 655, 087 11. 655, 087 16. 00 16. 00 16. 00 17. 00 10 10 10 10 10 10 10			0		0	1
15. 00 OTHER SPECIAL CARE (SPECIFY) 16. 00 Total intensive care type inpatient hospital services (sum of lines 11,655,087 11,655,087 11,655,087 11.655,087 11.655,087 11.11.655,087 11.655,087 11.1.15) 17. 00 Total inpatient routine care services (sum of lines 10 and 16) 64,135,784 64,135,784 17. 00 18. 00 17. 188,551 18. 00 17. 188,551 18. 00 17. 188,551 18. 00 17. 188,551 18. 00						l .
16.00 Total intensive care type inpatient hospital services (sum of lines 11, 655, 087 11-15) 17.00 Total inpatient routine care services (sum of lines 10 and 16) 18.00 Ancillary services 18.00 Ancillary services 19.00 Outpatient services 18.26, 566 43, 697, 178 64, 135, 784 177, 188, 551 210, 271, 181 387, 459, 732 18. 00 20.00 RURAL HEALTH CLINIC 20.00 HOME HEALTH ACENCY 23.00 AMBULATORY SURGICAL CENTER (D.P.) 25.00 HOME CHAILTH ACENCY 26.00 HOSPICE 27.00 NON REI MBURSEABLE COST CENTERS 28.00 Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst. 268, 273, 645 273, 256, 332 541, 529, 977 279, 777, 777 270, 070, 770, 770, 770, 770,						1
11-15) 17. 00 Total inpatient routine care services (sum of lines 10 and 16) 18. 00 Ancillary services 19. 00 Outpatient services 19. 00 Outpatient services 18. 26, 566 17. 188, 551 210, 271, 181 387, 459, 732 18. 00 21. 00 FEDERALLY QUALIFIED HEALTH CENTER 22. 00 HOME HEALTH AGENCY 23. 00 AMBULANCE SERVICES 24. 00 CMHC 25. 00 AMBULATORY SURGICAL CENTER (D.P.) 26. 00 HOSPICE 27. 00 NON REIMBURSEABLE COST CENTERS 28. 00 HOSPICE 29. 00 Operating expenses (per Wkst. A, column 3, line 200) 30. 00 31. 00 32. 00 33. 00 34. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 40. 00 41. 00 42. 00 Total additions (sum of lines 37-41) 43. 00 Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer		· · · ·	44 (55 007		44 /55 007	
17. 00 Total inpatient routine care services (sum of lines 10 and 16) 64, 135, 784 17. 00 18. 00 Ancillary services 387, 459, 732 18. 00 387, 459, 732 18. 00 387, 459, 732 18. 00 387, 459, 732 18. 00 387, 459, 732 18. 00 00 00 00 00 00 00 00	16.00		11, 655, 087		11, 655, 087	16.00
18.00 Ancillary services 177, 188, 551 210, 271, 181 387, 459, 732 18. 00 19. 00 Outpatient services 18, 262, 566 43, 697, 178 61, 959, 744 19. 00 Outpatient services 0 0 0 0 0 0 0 0 0	17.00		/ / 105 704		(4 105 704	17.00
19,00				210 271 101		ł
20. 00 RURÂL HEALTH CLINIC 0 0 0 0 0 20. 00 21. 00 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 22. 00 NOME HEALTH AGENCY 22. 00 23. 00 AMBULANCE SERVICES 24. 00 24. 00 CMHC 24. 00 25. 00 AMBULATORY SURGICAL CENTER (D. P.) 25. 00 26. 00 HOSPICE 8, 686, 744 19, 287, 973 27, 974, 717 27. 00 NON REI MBURSEABLE COST CENTERS 8, 686, 744 19, 287, 973 27, 974, 717 28. 00 G-3, line 1) PART II - OPERATING EXPENSES 0 0 31. 00 30. 00 ADD (SPECIFY) 0 162, 530, 332 31. 00 33. 00 33. 00 33. 00 33. 00 34. 00 0 0 33. 00 34. 00 35. 00 36. 00 35. 00 36. 00 Total additions (sum of lines 30-35) 0 0 38. 00 39. 00 40. 00 0 0 41. 00 40. 00 41. 00 41. 00 42. 00 Total operating expenses (sum of lines 37-41) 42. 00 Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer 162, 530, 310 43. 00 Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer 162, 530, 310 43. 00 Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer 162, 530, 310 43. 00 Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer 162, 530, 310 43. 00 Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer 162, 530, 310 43. 00 Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer 162, 530, 310 43. 00 Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer 162, 530, 310 43. 00 Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer 162, 530, 310 43. 00 Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer 162, 530, 310 43. 00 Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer 162, 530, 310 43. 00 Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer 162, 530, 310 43. 00 Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer 162, 530, 310				I I		
21. 00 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 21. 00 22. 00 HOME HEALTH AGENCY 22. 00 23. 00 AMBULANCE SERVICES 23. 00 24. 00 25. 00 AMBULATORY SURGICAL CENTER (D. P.) 26. 00 HOSPICE 8, 686, 744 19, 287, 973 27, 974, 717 27. 00 NON REIMBURSEABLE COST CENTERS 268, 273, 645 273, 256, 332 541, 529, 977 28. 00 Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst. 268, 273, 645 273, 256, 332 541, 529, 977 29. 00 Operating expenses (per Wkst. A, column 3, line 200) 0 31. 00 31. 00 32. 00 33. 00 0 32. 00 33. 00 34. 00 35. 00 34. 00 35. 00 36. 00 37. 00 Total additions (sum of lines 30-35) 0 36. 00 37. 00 ROUNDING 22 37. 00 38. 00 39. 00 0 38. 00 39. 00 0 0 38. 00 39. 00 0 0 39. 00 41. 00 Total deductions (sum of lines 37-41) 41. 00 42. 00 Total deductions (sum of lines 29 and 36 minus line 42) (transfer to lines 42) (transfer to long lines 19. 21. 00 21. 00 22. 00 22. 00 22. 00 23. 00 24. 00 24. 00 25. 00 26. 00 25. 00 26. 00 27. 00 26. 00 27. 00 28. 00 27. 00 28. 00 29. 00 29. 00 30. 00 31. 00 32. 00 32. 00 33. 00 33. 00 34. 00 34. 00 35. 00 35. 00 36. 00 37. 00 38. 00 38. 00 39. 00		·				1
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23. 00 24. 00 24. 00 24. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 29. 00 30. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 37. 00 38. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 39. 00 30			0	٩	U	
24. 00 25. 00 26. 00 27. 00 26. 00 27. 00 27. 00 28. 00 27. 00 28. 00 29. 00 29. 00 29. 00 20						1
25. 00						
26. 00 27. 00 27. 00 27. 00 28. 00 27. 00 28. 00 29. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 37. 00 38. 00 39. 00 39. 00 39. 00 39. 00 39. 00 30						1
27. 00						
28. 00 Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst. G-3, line 1) PART II - OPERATING EXPENSES 29. 00 Operating expenses (per Wkst. A, column 3, line 200) ADD (SPECIFY) Description of lines 30-35) ROUNDING Total additions (sum of lines 30-35) ROUNDING Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer column 3 to Wkst. 268, 273, 645 273, 256, 332 273, 256, 332 541, 529, 977 28. 00 30. 00 31. 00 32. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00 42. 00 Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer lines 20, 530, 310) Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer lines 20, 530, 310)			8 686 744	10 287 073	27 974 717	
G-3, line 1) PART II - OPERATING EXPENSES 29. 00 30. 00 31. 00 31. 00 32. 00 33. 00 33. 00 34. 00 35. 00 36. 00 37. 00 37. 00 38. 00 37. 00 38. 00 39. 00 40. 00 41. 00 42. 00 Total deductions (sum of lines 37-41) 43. 00 Total operating expenses (per Wkst. A, column 3, line 200)						1
PART II - OPERATING EXPENSES 29. 00 30. 00 31. 00 31. 00 32. 00 33. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 38. 00 39. 00 40. 00 41. 00 42. 00 Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer) 29. 00 162, 530, 332 29. 00 30. 00 31. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00 42. 00 Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer) 29. 00 162, 530, 332 29. 00 30. 00 31. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 40. 00 41. 00 42. 00 Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer) 42. 00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer)	20.00		200, 270, 010	270, 200, 002	011,027,777	20.00
29. 00 Operating expenses (per Wkst. A, column 3, line 200) 162,530,332 29.00 30.00 31.00 31.00 32.00 33.00						
30.00 ADD (SPECIFY) 0 30.00 31.00 32.00 33.00 32.00 33	29. 00			162, 530, 332		29. 00
31.00 32.00 33.00 33.00 34.00 35.00 36.00 Total additions (sum of lines 30-35) ROUNDING 0 31.00 32.00 33.00 34.00 35.00 36.00 37.00 38.00 39.00 40.00 41.00 42.00 Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer) 10 31.00 32.00 33.00 33.00 33.00 34.00 35.00 36.00 37.00 38.00 39.00 40.00 41.00 42.00 Total deductions (sum of lines 37-41) 22 42.00 43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer) 162,530,310	30. 00		0			30.00
33.00 34.00 35.00 36.00 Total additions (sum of lines 30-35) 37.00 ROUNDING 22 37.00 38.00 39.00 40.00 41.00 42.00 Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 162, 530, 310) 33.00 34.00 35.00 36.00 37.00 37.00 38.00 39.00 40.00 41.00 42.00 Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 162, 530, 310) 33.00 34.00 34.00 35.00 36.00 37.00 37.00 38.00 39.00 40.00 41.00 42.00 Total deductions (sum of lines 37-41) 43.00	31.00		0			31.00
34.00 35.00 36.00 Total additions (sum of lines 30-35) 37.00 ROUNDING 22 37.00 38.00 39.00 40.00 41.00 42.00 Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 34.00 35.00 36.00 37.00 36.00 37.00 36.00 37.00 38.00 0 0 40.00 41.00 42.00 Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 162,530,310 43.00	32.00		0			32. 00
35.00 36.00 Total additions (sum of lines 30-35) 37.00 ROUNDING 22 37.00 38.00 39.00 40.00 41.00 42.00 Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 162, 530, 310 35.00 0 36.00 37.00 0 38.00 0 39.00 0 41.00 0 42.00 162,530,310	33.00		0			33. 00
36. 00 Total additions (sum of lines 30-35) 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00 42. 00 Total deductions (sum of lines 37-41) 22 43. 00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 162, 530, 310 36. 00 37. 00 38. 00 0 38. 00 0 39. 00 40. 00 41. 00 41. 00 42. 00 42. 00 43. 00 43. 00 43. 00 43. 00 43. 00 44. 00	34.00		0			34.00
37. 00	35.00		0			35. 00
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39.00 40.00 41.00 42.00 Total deductions (sum of lines 37-41) 43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 162, 530, 310 43.00	37.00	ROUNDI NG	22			37. 00
40.00 41.00 42.00 Total deductions (sum of lines 37-41) 43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer	38. 00		0			38. 00
41.00 42.00 Total deductions (sum of lines 37-41) 43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 162, 530, 310 43.00	39.00		0			39. 00
42.00 Total deductions (sum of lines 37-41) 22 42.00 43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer) 162,530,310 43.00			0			
43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 162,530,310 43.00			0			
[+- Wi-+ C 2 1: 4)	43.00		er	162, 530, 310		43. 00
to wkst. G-3, line 4)		to Wkst. G-3, line 4)	I			l

	FRANCISCA MENT OF REVENUES AND EXPENSES FRANCISCA	N HEALTH- DYER Provider CCN: 15-0090	Peri od:	u of Form CMS-2 Worksheet G-3	
IAIL	MENT OF REVENUES AND EXTENSES	110V1del CGN. 13-0070	From 01/01/2020	WOI KSHEET U-5	
			To 12/31/2020		
				7/29/2021 1: 2	7 pm
				1. 00	
. 00	Total patient revenues (from Wkst. G-2, Part I, column	3. line 28)		541, 529, 977	1.0
. 00	Less contractual allowances and discounts on patients'			444, 611, 543	
. 00	Net patient revenues (line 1 minus line 2)			96, 918, 434	
. 00	Less total operating expenses (from Wkst. G-2, Part II,	line 43)		162, 530, 310	4. (
. 00	Net income from service to patients (line 3 minus line	4)		-65, 611, 876	5.0
	OTHER I NCOME				
. 00	Contributions, donations, bequests, etc			155, 043	6.
. 00	Income from investments			0	
. 00	Revenues from telephone and other miscellaneous communi	cation services		0	
00	Revenue from television and radio service			0	
0. 00	Purchase di scounts			797, 491	
1. 00	Rebates and refunds of expenses			0	1
2. 00				0	
3. 00	1 · · · · · · · · · · · · · · · · · · ·			0	
4. 00				347, 909	
5. 00	3 1			0	
	Revenue from sale of medical and surgical supplies to o	ther than patients		0	
	Revenue from sale of drugs to other than patients			0	1
	Revenue from sale of medical records and abstracts			0	
	Tuition (fees, sale of textbooks, uniforms, etc.)			0	1
0.00	3			59, 779	
1.00	3			13, 012	
2. 00	Rental of hospital space			42, 183	
3. 00	Governmental appropriations			0	1
4. 00	OT, PREM - REV			12, 054, 490	
	COVI D-19 PHE Funding			0	
	Total other income (sum of lines 6-24)			13, 469, 907	
	Total (line 5 plus line 25)			-52, 141, 969	
	OTHER EXPENSES (SPECIFY)			0	
	Total other expenses (sum of line 27 and subscripts)	20)		0	
7. UU	Net income (or loss) for the period (line 26 minus line	28)	I	-52, 141, 969	29.

Heal th	Financial Systems FRANCISCAN	HEALTH- DYER	Inlie	u of Form CMS-2	2552_10	
	ATION OF CAPITAL PAYMENT	Provi der CCN: 15-0090	Peri od: From 01/01/2020 To 12/31/2020	Worksheet L Parts I-III Date/Time Prep 7/29/2021 1:2	pared:	
		Title XVIII	Hospi tal	PPS		
	DART I FULLY PROPERTING METURE			1. 00		
	PART I - FULLY PROSPECTIVE METHOD					
1 00	CAPITAL FEDERAL AMOUNT			1 200 110	1 00	
1.00	Capital DRG other than outlier			1, 380, 110 0		
1. 01 2. 00	Model 4 BPCI Capital DRG other than outlier Capital DRG outlier payments			21, 342	1. 01 2. 00	
2. 00	Model 4 BPCI Capital DRG outlier payments			21, 342		
3. 00	Total inpatient days divided by number of days in the cos	t reporting period (see inst	ructions)	58. 71	3.00	
4. 00	Number of interns & residents (see instructions)	t reporting perrou (see riist	i uctions)	7. 58	4.00	
5.00	Indirect medical education percentage (see instructions)			7. 38 3. 71	5.00	
6. 00	Indirect medical education percentage (see instructions)	the sum of lines 1 and 1 01	columns 1 and	51, 202	6.00	
0.00	1.01) (see instructions)	the sum of filles I and I.O.	, corumns i and	31, 202	0.00	
7. 00	Percentage of SSI recipient patient days to Medicare Part 30) (see instructions)	A patient days (Worksheet E	, part A line	0. 00	7. 00	
8. 00	Percentage of Medicaid patient days to total days (see in	etructions)		0.00	8. 00	
9. 00	Sum of lines 7 and 8	structions)		0.00		
10. 00	Allowable disproportionate share percentage (see instruct	i ons)			10.00	
11. 00	Disproportionate share adjustment (see instructions)	1 0113)		0.00		
	Total prospective capital payments (see instructions)			1, 452, 654		
12.00	Total prospective capital payments (see mistractions)			1, 432, 034	12.00	
				1. 00		
	PART II - PAYMENT UNDER REASONABLE COST					
1.00	Program inpatient routine capital cost (see instructions)			0	1.00	
2.00	Program inpatient ancillary capital cost (see instruction	s)		0	2. 00	
3.00	Total inpatient program capital cost (line 1 plus line 2)	,		0	3. 00	
4.00	Capital cost payment factor (see instructions)			0	4. 00	
5.00	Total inpatient program capital cost (line 3 x line 4)			0	5. 00	
				1. 00		
	PART III - COMPUTATION OF EXCEPTION PAYMENTS					
1.00	Program inpatient capital costs (see instructions)			0		
2.00	Program inpatient capital costs for extraordinary circums	tances (see instructions)		0		
3.00	Net program inpatient capital costs (line 1 minus line 2)			0	0.00	
4.00	Applicable exception percentage (see instructions)			0. 00		
5.00	Capital cost for comparison to payments (line 3 x line 4)			0		
6.00	Percentage adjustment for extraordinary circumstances (se			0. 00		
7. 00	Adjustment to capital minimum payment level for extraordi	nary circumstances (line 2 x	:line 6)	0		
8.00	Capital minimum payment level (line 5 plus line 7)			0		
9.00	Current year capital payments (from Part I, line 12, as a			0		
10.00	Current year comparison of capital minimum payment level			0		
11. 00	Carryover of accumulated capital minimum payment level ov Worksheet L, Part III, line 14)	er capital payment (from pri	or year	0	11. 00	
12.00	Net comparison of capital minimum payment level to capita	l payments (line 10 plus lin	ie 11)	0	12.00	
13.00	Current year exception payment (if line 12 is positive, e			0	13.00	
14.00	Carryover of accumulated capital minimum payment level ov			0	14. 00	
	(if line 12 is negative, enter the amount on this line)		- '			
15.00	Current year allowable operating and capital payment (see	i nstructi ons)		0	15. 00	
16. 00	3	s)		0		
17. 00	Current year exception offset amount (see instructions)			o l	17. 00	