This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 03-31-2022 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 15-0165 Worksheet S Peri od: From 01/01/2020 Parts I-III AND SETTLEMENT SUMMARY 12/31/2020 Date/Time Prepared: 7/29/2021 4:40 pm PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 7/29/2021 4:40 pm Manually prepared cost report use only] If this is an amended report enter the number of times the provider resubmitted this cost report] Medicare Utilization. Enter "F" for full or "L" for low. [1] Cost Report Status
[1] As Submitted
[2] Settled without Audit
[3] Settled with Audit
[4] Date Received:
[5] To. NPR Date:
[6] 10. NPR Date:
[7] 11. Contractor's Vendor Code:
[7] 12. [8] Final Report for this Provider CCN
[9] [8] Final Report for this Provider CCN
[10] NPR Date:
[11] 12. Contractor's Vendor Code:
[11] 12. [8] 13. Contractor's Vendor Code:
[12] 13. NPR Date:
[13] 14. Contractor's Vendor Code:
[14] 15. Contractor's Vendor Code:
[15] 16. NPR Date:
[16] 17. Contractor's Vendor Code:
[17] 18. Contractor's Vendor Code:
[18] 19. Contractor's Vendor Code:
[19] 19. Contractor's Vendor Code:
[1 Contractor use only number of times reopened = 0-9.

PART II - CERTIFICATION

(3) Settled with Audit

(4) Reopened (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 MUNSTER (15-0165) 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 aned) Officer or Administrator of Provider(s)

DIVISIONAL CFO

Title

Date

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
		1. 00	2.00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	121, 622	150, 466	0	0	1. 00
2.00	Subprovider - IPF	0	0	0		0	2. 00
3.00	Subprovider - IRF	0	0	0		0	3. 00
5.00	Swing Bed - SNF	0	0	0		0	5. 00
6.00	Swing Bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7. 00
8.00	NURSING FACILITY	0				0	8. 00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9. 00
10.00	RURAL HEALTH CLINIC I	0		0		0	10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11. 00
12.00	CMHC I	0		0		0	12.00
200.00	Total	0	121, 622	150, 466	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. 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. 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.

	reporting period? In column 2, enter "Y" for yes or	N FOR NO.						
		In-State	In-State	Out-of	Out-of	Medi cai d	0ther	
		Medi cai d	Medi cai d	State	State	HMO days	Medi cai d	
		paid days	eligible	Medi cai d	Medi cai d		days	
			unpai d	pai d days	eligible			
			days		unpai d			
		1.00	2. 00	3. 00	4. 00	5. 00	6. 00	
24.00	If this provider is an IPPS hospital, enter the	0	0	0	562	744	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.							

		Y/N	IME	Direct GME	IME	Direct GME	o piii		
		1. 00	2. 00	3. 00	4. 00	5. 00			
61. 00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61. 00		
61. 01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61. 01		
61. 02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61. 02		
61. 03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61. 03		
61. 04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period (see instructions).						61. 04		
61. 05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61. 05		
61. 06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61. 06		
		Pr	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count			
			1. 00	2. 00	3.00	4. 00			
	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name.				0. 00		61. 20		
	Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.								
	ACA Provisions Affecting the Health Resources and Ser	vi ces	Administration	(HRSA)		1.00			
62. 00	Enter the number of FTE residents that your hospital	trai ned			od for which	0.00	62. 00		
62. 01	your hospital received HRSA PCRE funding (see instructions and in this cost reporting period of HRSA THC programming in this cost reporting period of HRSA THC programming in the cost reporting period of HRSA THC programming in the cost reporting period of HRSA THC programming in the cost reporting period of HRSA THC programming in the cost reporting period of HRSA THC programming in the cost reporting period of HRSA THC programming in the cost reporting period of HRSA THC programming in the cost reporting period of HRSA THC programming in the cost reporting period of HRSA THC programming in the cost reporting period of HRSA THC programming in the cost reporting period of HRSA THC programming in the cost reporting period of HRSA THC programming in the cost reporting period of HRSA THC programming period pe	ı Teachi ıram. (s	see instruction		your hospital	0.00	62. 01		
63. 00	Teaching Hospitals that Claim Residents in Nonprovide Has your facility trained residents in nonprovider se	er Sett ettings	ings during this co	ost reporting p	eriod? Enter	N	63. 00		
	"Y" for yes or "N" for no in column 1. If yes, comple				ctions)	Ratio (col. 1/			
				FTEs Nonprovi der Si te		(col. 1 + col. 2))			
	Spotian SEOA of the ACA Page Veer STE Decidents in Me	nnrov!	dor Sottings	1. 00	2.00	3.00			
			9	mis base year	is your cost r	eporting			
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider SettingsThis base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)								

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0165 Peri od: Worksheet S-2 From 01/01/2020 Part I Date/Time Prepared: 12/31/2020 7/29/2021 4:40 pm Program Code Unwei ghted Unwei ghted Program Name Ratio (col. 3/ (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. 00 0. 00 0.000000 65.00 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 0. 00 0.000000 66.00 FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Program Name Unwei ghted Ratio (col. 3/ Program Code Unwei ahted FTES FTEs in (col. 3 + col Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3. 00 4.00 5.00 67.00 Enter in column 1, the program 0.000000 67.00 0.00 0.00 name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)) (see instructions) 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS 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 N 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 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)

	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der CC	CN: 15-0165	Peri od: From 01/01/2020 To 12/31/2020		repared:	
					1.00		
	Long Term Care Hospital PPS Is this a long term care hospital (LTCH)? Enter "Y" for yes Is this a LTCH co-located within another hospital for part o "Y" for yes and "N" for no.			ng period? Enter	N N	80.00	
	TEFRA Providers Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) Did this facility establish a new Other subprovider (exclude §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				N	85. 00 86. 00	
37. 00	7.00 Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.						
	1000(0)(1)(b)(vi): Enter 1 101 yes 01 N 101 110.			V 1. 00	XI X 2. 00		
00 00	Title V and XIX Services Does this facility have title V and/or XIX inpatient hospita	L convicos? E	otor "V" for	N	Y	90.00	
	yes or "N" for no in the applicable column.						
1. 00	Is this hospital reimbursed for title V and/or XIX through t full or in part? Enter "Y" for yes or "N" for no in the appl	N	N	91.00			
2. 00	Are title XIX NF patients occupying title XVIII SNF beds (duinstructions) Enter "Y" for yes or "N" for no in the applica	al certificati			N	92.00	
3. 00	Does this facility operate an ICF/IID facility for purposes		d XIX? Enter	N	N	93. 00	
4. 00	"Y" for yes or "N" for no in the applicable column. OD Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the					94. 0	
5. 00	applicable column. 00 If line 94 is "Y", enter the reduction percentage in the applicable column. 0.					95. 0	
6. 00	00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the					96. 0	
	applicable column. Olf line 96 is "Y", enter the reduction percentage in the applicable column. 0.00						
8. 00	Does title V or XIX follow Medicare (title XVIII) for the in stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" f	Y	Y	98. 0			
10 N1	column 1 for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. Y					98. 0	
0.01	C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for ti				Y	70.0	
8. 02	title XIX. Does title V or XIX follow Medicare (title XVIII) for the ca	lculation of o	observati on	Y	Υ	98. 0	
	bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes o for title V, and in column 2 for title XIX.	r "N" for no i	n column 1				
8. 03	Does title V or XIX follow Medicare (title XVIII) for a crit				N	98. 0	
	reimbursed 101% of inpatient services cost? Enter "Y" for ye for title V, and in column 2 for title XIX.						
8. 04	Does title V or XIX follow Medicare (title XVIII) for a CAH outpatient services cost? Enter "Y" for yes or "N" for no in			N N	N	98. 0	
10 NE	in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) and add ba				Y	98. 0	
0. 03	Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in c				'	70.0	
8. 06	column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) when cost	reimbursed fo	· Wkst. D,	Y	Υ	98. 0	
	Pts. I through IV? Enter "Y" for yes or "N" for no in column column 2 for title XIX.	1 for title \	/, and in				
	Rural Providers						
	Does this hospital qualify as a CAH? If this facility qualifies as a CAH, has it elected the all-	inclusive meth	nod of payme	nt N		105. 0 106. 0	
	for outpatient services? (see instructions) Column 1: If line 105 is Y, is this facility eligible for co		. 3			107. 0	
07.00	training programs? Enter "Y" for yes or "N" for no in column	1. (see ins	tructions)			107.0	
	Column 2: If column 1 is Y and line 70 or line 75 is Y, do approved medical education program in the CAH's excluded IP						
08 OC	Enter "Y" for yes or "N" for no in column 2. (see instructi Is this a rural hospital qualifying for an exception to the	ons)	. ,	2 N		108. 0	
JJ. UL	CFR Section §412.113(c). Enter "Y" for yes or "N" for no.				D		
		Physi cal 1.00	Occupation 2.00	Speech 3.00	Respiratory 4.00	/_	
	If this hospital qualifies as a CAH or a cost provider, are					109.00	

	Physi cal	Occupati onal	Speech	Respi ratory	
	1.00	2.00	3. 00	4. 00	
109.00 If this hospital qualifies as a CAH or a cost provider, are					109. 00
therapy services provided by outside supplier? Enter "Y"					
for yes or "N" for no for each therapy.					
				1.00	
110.00 Did this hospital participate in the Rural Community Hospital Demonstration) for the current cost reporting period? Enter 'complete Worksheet E, Part A, lines 200 through 218, and Worapplicable.	N	110. 00			

are claimed, enter in column 2 the home office chain number. (see instructions)

Health Financial Systems FRANCISCAN HEALTH MUNSTER In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0165 Peri od: Worksheet S-2 From 01/01/2020 Part I 12/31/2020 Date/Time Prepared: To 7/29/2021 4:40 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 OO Name: FRANCISCAN ALLIANCE Contractor's Name: WISCONSIN PHYSICIAN Contractor's Number: 8001 141 00 SERVI CE 142.00 Street: 1515 DRAGOON TRAIL PO Box: 142.00 143.00 City: MISHAWAKA State: Zip Code: 46546 143.00 1.00 144.00 Are provider based physicians' costs included in Worksheet A? 144. 00 1.00 2.00 145.00|| 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 2 00 3.00 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 Ν 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 N 159. 00 160.00 HOME HEALTH AGENCY 160.00 Ν Ν Ν Ν 161.00 CMHC Ν Ν N 161.00 161. 10 CORF N Ν 161. 10 1.00 Multicampus 165.00 s this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? N 165.00 Enter "Y" for yes or "N" for no. County CBSA FTE/Campus State Zip Code Name 0 1.00 2.00 3.00 4.00 5.00 166.00 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 167.00 Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no. 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 of this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship 168 01

exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)	nai usin p		100.01
169.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N transition factor. (see instructions)	"), enter the	9.	99169.00
	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 period respectively (mm/dd/yyyy)			170. 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 "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)	N		0 171. 00

	Financial Systems FRANCISCAN HEA AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CN: 15-0165	Peri od: From 01/01/2020 To 12/31/2020	u of Form CMS Worksheet S- Part II Date/Time Pr 7/29/2021 4:	2 epared:
				Y/N	Date	
	C	NO		1.00	2. 00	
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format.	i for all NO re	esponses. Ente	er all dates in t	ne	
	COMPLETED BY ALL HOSPITALS					
	Provider Organization and Operation					
. 00	Has the provider changed ownership immediately prior to the	beginning of	the cost	N		1.0
	reporting period? If yes, enter the date of the change in c	column 2. (see				
			Y/N	Date	V/I	
. 00	Has the provider terminated participation in the Medicare F	Program2 If	1.00 N	2. 00	3. 00	2.0
	yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.	nn 3, "V" for				
. 00	Is the provider involved in business transactions, includir contracts, with individuals or entities (e.g., chain home or 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
			Y/N	Type	Date	
			1.00	2. 00	3. 00	
0.0	Financial Data and Reports	. 6 1 5			04/00/2003	٠
. 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 ava column 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues difference.	for Compiled, ailable in	Y	A	04/20/2021	4.0
. 00	those on the filed financial statements? If yes, submit rec		14] 3.0
	The tribution of the tribution of the territory of the tribution of the tr	2011011111111111111	1	Y/N	Legal Oper.	
				1. 00	2. 00	
	Approved Educational Activities					
. 00	Column 1: Are costs claimed for nursing school? Column 2:	If yes, is th	ne provider is	s N		6.0
. 00	the legal operator of the program? Are costs claimed for Allied Health Programs? If "Y" see in	netructione		N		7.0
. 00	Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.		d during the	N N		8. 0
. 00	Are costs claimed for Interns and Residents in an approved		cal education	N		9.0
0. 00	program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated cost reporting period? If yes, see instructions.		the current	N		10.0
1. 00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	proved	N	V (N	11. 0
					Y/N 1. 00	
	Bad Debts				1.00	
	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection p			ost reporting	Y N	12. C
4. 00	period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or co-payme Bed Complement	ents waived? I1	fyes, see ins	structions.	N	14. (
5. 00	Did total beds available change from the prior cost reporti				Y	15.0
			rt A	Par Y/N		
		1. 00	2.00	3.00	Date 4.00	
	PS&R Data	1.00	2.00	3.00	7.00	
6. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N		16.0
7. 00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	Y	05/05/2021	Y	05/05/2021	17. 0
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. 0
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. (

Heal th	Financial Systems FRANCISCAN HE.	ALTH MUNSTER		In Lie	u of Form CMS-	-2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CN: 15-0165	Peri od: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part II Date/Time Pre 7/29/2021 4:4	epared:
		Descri	ipti on	Y/N	Y/N	, o p
		()	1. 00	3. 00	
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20. 00
	report data for other; bescribe the other adjustments.	Y/N	Date	Y/N	Date	
		1.00	2.00	3. 00	4. 00	
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21. 00
					1 00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	EPT CHILDRENS H	USDI TAI S)		1. 00	
	Capital Related Cost	ETT OTTEBREIG	001117120)			
22.00	Have assets been relifed for Medicare purposes? If yes, see	e instructions			N	22. 00
23. 00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.	ing the cost	N	23. 00		
24. 00	Were new leases and/or amendments to existing leases entered of the second second leases and/or amendments to existing leases entered in the second s	ed into during	this cost re	eporting period?	N	24. 00
25. 00	Have there been new capitalized leases entered into during instructions.	the cost repor	ting period?	Plf yes, see	N	25. 00
26. 00	Instructions. Were assets subject to Sec. 2314 of DEFRA acquired during the instructions.	N	26. 00			
27. 00	Has the provider's capitalization policy changed during the copy.	N	27. 00			
28. 00	Interest Expense Were new Loans, mortgage agreements or Letters of credit er	N	28. 00			
29. 00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or	N	29. 00			
30. 00	treated as a funded depreciation account? If yes, see insti- Has existing debt been replaced prior to its scheduled matu	N	30. 00			
31. 00	<pre>instructions. Has debt been recalled before scheduled maturity without is instructions.</pre>	N	31. 00			
	Purchased Services					
32. 00	Have changes or new agreements occurred in patient care ser arrangements with suppliers of services? If yes, see instru		d through co	ontractual	N	32. 00
33. 00	If line 32 is yes, were the requirements of Sec. 2135.2 applies, see instructions.		g to competi	tive bidding? If	N	33. 00
	Provi der-Based Physi ci ans					
34. 00	Are services furnished at the provider facility under an ar	rrangement with	provi der-ba	sed physicians?	Υ	34. 00
35. 00	If yes, see instructions. If line 34 is yes, were there new agreements or amended exi		its with the	provi der-based	N	35. 00
	physicians during the cost reporting period? If yes, see in	nstructions.		Y/N	Date	
				1. 00	2. 00	
	Home Office Costs					
36. 00	Were home office costs claimed on the cost report?			Y		36.00
37. 00	If line 36 is yes, has a home office cost statement been pullf yes, see instructions.					37. 00
	If line 36 is yes, was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end	d of the home o	ffi ce.			38. 00
39. 00	If line 36 is yes, did the provider render services to othe see instructions.	·	,			39. 00
40. 00	If line 36 is yes, did the provider render services to the instructions.	home office?	If yes, see	N		40. 00
		1	00	2.	00	
	Cost Report Preparer Contact Information	1.		Ζ.		
41. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	GLENN		JOHNSON		41. 00
42. 00	respectively. Enter the employer/company name of the cost report	FRANCISCAN HEA	LTH			42. 00
43. 00	preparer. Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	219-940-6386		GLENN. JOHNSON@I ANC	FRANCI SCANALLI	43. 00
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42.00
43.00
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 HOSPITAL
 AND
 HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA
 Provider CCN: 15-0165

						То	12/31/2020	Date/Time Pre 7/29/2021 4:4	
								I/P Days / 0/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		54	19, 76	54	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			54	19, 7 <i>6</i>	54	0.00	0	7. 00
	beds) (see instructions)								
8.00	INTENSIVE CARE UNIT	31. 00		9	3, 29	94	0. 00	0	8. 00
9.00	CORONARY CARE UNIT	32. 00		0	1	0	0.00	0	9. 00
10.00	BURN INTENSIVE CARE UNIT	33. 00		0)	0	0.00	0	10.00
11. 00	SURGICAL INTENSIVE CARE UNIT	34. 00		0)	0	0.00	0	11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)								12.00
13.00	NURSERY	43. 00						0	13. 00
14.00	Total (see instructions)			63	23, 05	8	0.00	0	14. 00
15.00	CAH visits							0	15. 00
16.00	SUBPROVI DER - I PF	40. 00		0	1	0		0	16. 00
17. 00	SUBPROVI DER - I RF	41. 00		0	1	0		0	17. 00
18.00	SUBPROVI DER								18. 00
19.00	SKILLED NURSING FACILITY	44. 00		0	1	0		0	19. 00
20.00	NURSING FACILITY	45. 00		0	1	0		0	20. 00
21. 00	OTHER LONG TERM CARE	46. 00		0	1	0			21. 00
22. 00	HOME HEALTH AGENCY	101. 00						0	22. 00
23.00	AMBULATORY SURGICAL CENTER (D. P.)	115. 00							23. 00
24.00	HOSPI CE	116. 00		0	1	0			24. 00
24. 10	HOSPICE (non-distinct part)	30. 00							24. 10
25. 00	CMHC - CMHC	99. 00						0	
25. 10	CMHC - CORF	99. 10						0	
26. 00	RURAL HEALTH CLINIC	88. 00						0	
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00						0	26. 25
27. 00	Total (sum of lines 14-26)			63					27. 00
28. 00	Observation Bed Days							0	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)			0	1	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				1				33. 01

Health Financial Systems FRANCIS
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

In Lieu of Form CMS-2552-10

Period:	Worksheet S-3	
From 01/01/2020	Part	
To 12/31/2020	Date/Time Prepared:	7/29/2021 4:40 pm

						7/29/2021 4: 4	0 pm
		I/P Days	o / O/P Visits	/ Trips	Full Time	Equi val ents	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
				Pati ents	& Residents	Payrol I	
		6. 00	7. 00	8. 00	9. 00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	3, 737	531	10, 615			1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
0.00	for the portion of LDP room available beds)	2.40/	F.(0				0.00
2.00	HMO and other (see instructions)	3, 106	562	•			2.00
3.00	HMO IPF Subprovider	0	0				3. 00
4.00	HMO IRF Subprovider	U	0	1			4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF	U	0				5.00
6. 00 7. 00	Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation	3, 737	531				6. 00 7. 00
7.00	beds) (see instructions)	3, 131	331	10, 613			7.00
8.00	INTENSIVE CARE UNIT	1, 107	213	1, 679			8. 00
9. 00	CORONARY CARE UNIT	1, 107	0	·			9. 00
10.00	BURN INTENSIVE CARE UNIT	0	0				10.00
11. 00	SURGICAL INTENSIVE CARE UNIT	0	0				11.00
12. 00	OTHER SPECIAL CARE (SPECIFY)	Ğ	O	Ĭ			12. 00
13. 00	NURSERY		0	0			13. 00
14. 00	Total (see instructions)	4, 844	744			467. 05	
15. 00	CAH visits	0	0				15. 00
16. 00	SUBPROVI DER - I PF	o	0		0.00	0.00	
17. 00	SUBPROVIDER - IRF	o	0	0			
18.00	SUBPROVI DER						18. 00
19.00	SKILLED NURSING FACILITY	o	0	0	0.00	0.00	19. 00
20.00	NURSING FACILITY		0	0	0.00	0.00	20. 00
21.00	OTHER LONG TERM CARE			0	0.00	0.00	21. 00
22.00	HOME HEALTH AGENCY	0	0	0	0.00	0.00	22. 00
23.00	AMBULATORY SURGICAL CENTER (D. P.)				0.00	0.00	23. 00
24. 00	HOSPI CE	0	0	0	0.00	0.00	24. 00
24. 10	HOSPICE (non-distinct part)			0			24. 10
25. 00	CMHC - CMHC	0	0	0			
25. 10	CMHC - CORF	0	0				
26. 00	RURAL HEALTH CLINIC	0	0				
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			
27. 00	Total (sum of lines 14-26)				0.00	467. 05	27. 00
28. 00	Observation Bed Days	_	172	1, 527			28. 00
29. 00	Ambul ance Tri ps	0					29. 00
30. 00	Employee discount days (see instruction)			0			30. 00
31. 00	Employee discount days - IRF			0			31. 00
32.00	Labor & delivery days (see instructions)	0	0	0			32. 00
32. 01	Total ancillary labor & delivery room						32. 01
33. 00	outpatient days (see instructions)						33. 00
	LTCH non-covered days LTCH site neutral days and discharges	0					33. 00
33.01	LIGHT SITE HEALT AT LAYS AND UI SCHALLYES	۱		I	I	I	J J J J J J J J J J J J J J J J J J J

| Period: | Worksheet S-3 | From 01/01/2020 | Part | To 12/31/2020 | Date/Time Prepared:
 Heal th Financial
 Systems
 FRANCIS

 HOSPITAL
 AND
 HOSPITAL
 HEALTH CARE COMPLEX
 STATISTICAL
 DATA
 Provider CCN: 15-0165

				To	12/31/2020	Date/Time Prep 7/29/2021 4:40	
		Full Time		Di scha	arges	772772021 1. 1	O PIII
		Equi val ents			_		
	Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11. 00	12. 00	13. 00	14. 00	15. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and		0	1, 072	173	2, 658	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)			538	92		2. 00
3. 00	HMO IPF Subprovider			000	0		3. 00
4. 00	HMO IRF Subprovider				0		4. 00
5. 00	Hospital Adults & Peds. Swing Bed SNF]		5. 00
6. 00	Hospital Adults & Peds. Swing Bed NF						6. 00
7. 00	Total Adults and Peds. (exclude observation						7. 00
	beds) (see instructions)						
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, 072	173	2, 658	14.00
15.00	CAH visits						15. 00
16. 00	SUBPROVI DER - I PF	0. 00	0	0	0	0	16. 00
17. 00	SUBPROVI DER - I RF	0. 00	0	0	0	0	17. 00
18. 00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY	0. 00					19. 00
20.00	NURSING FACILITY	0. 00					20. 00
21. 00	OTHER LONG TERM CARE	0. 00				0	21. 00
22. 00	HOME HEALTH AGENCY	0. 00					22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)	0. 00					23. 00
24. 00	HOSPI CE	0. 00					24. 00
24. 10	HOSPICE (non-distinct part)						24. 10
25. 00	CMHC - CMHC	0. 00					25. 00
25. 10	CMHC - CORF	0.00					25. 10
26. 00	RURAL HEALTH CLINIC	0.00					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	Ambulance Trips						29. 00
30. 00 31. 00	Employee discount days (see instruction) Employee discount days - IRF						30. 00 31. 00
	, , ,						
32. 00 32. 01	Labor & delivery days (see instructions) Total ancillary labor & delivery room						32. 00 32. 01
3∠. UI	outpatient days (see instructions)						J∠. UI
33. 00	LTCH non-covered days			0			33. 00
	LTCH site neutral days and discharges			0			33. 01
55. 51	12.5 5. to hout at days and at sonat gos	ı		٩	ı	l	30.01

In Lieu of Form CMS-2552-10

Period: Worksheet S-3
From 01/01/2020 Part II
To 12/31/2020 Date/Time Prepared: 7/29/2021 4:40 pm

							7/29/2021 4:4	
		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries	Adj usted Sal ari es		Average Hourly Wage (col. 4 ÷	
		Namber	Ropor tou	(from Wkst.	(col.2 ± col.	Salaries in	col . 5)	
		1. 00	2. 00	A-6) 3.00	3) 4. 00	col . 4 5. 00	6. 00	
	PART II - WAGE DATA							
1.00	SALARIES Total salaries (see	200. 00	38, 053, 687	0	38, 053, 687	971, 466. 52	39. 17	1.00
2. 00	instructions) Non-physician anesthetist Part		0	0	0	0. 00	0. 00	2.00
3. 00	A Non-physician anesthetist Part		0	0	0	0. 00	0. 00	3.00
4. 00	B Physician-Part A -		0	0	0	0. 00	0. 00	4.00
4. 01	Administrative Physicians - Part A - Teaching		0	0	0	0. 00	0. 00	4. 01
5.00	Physician and Non Physician-Part B		0	0	0			
6. 00	Non-physician-Part B for hospital-based RHC and FQHC services		0	О	0	0.00	0.00	6. 00
7. 00	Interns & residents (in an	21. 00	0	0	0	0.00	0. 00	7. 00
7. 01	approved program) Contracted interns and residents (in an approved		0	0	0	0.00	0.00	7. 01
8. 00	programs) Home office and/or related		0	0	0	0.00	0. 00	8.00
9.00	organization personnel SNF	44. 00	1 700 004	0	_	0.00		
10. 00	Excluded area salaries (see instructions)		1, 722, 384	0	1, 722, 384	28, 892. 43	59. 61	10. 00
11. 00	OTHER WAGES & RELATED COSTS Contract Labor: Direct Patient		0	0	0	0.00	0. 00	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		84, 376	0	84, 376	729. 00	115. 74	13. 00
14. 00	A - Administrative Home office and/or related organization salaries and		0	0	0	0. 00	0.00	14. 00
14. 01	wage-related costs Home office salaries		6, 991, 269	0	6, 991, 269	198, 270. 00	35, 26	14. 01
14. 02	Related organization salaries		0	0	0	0.00	0.00	14. 02
15. 00	Home office: Physician Part A - Administrative		0	0	0	0. 00	0.00	15. 00
16. 00	Home office and Contract Physicians Part A - Teaching		0	0	0	0. 00	0.00	16. 00
16. 01	Home office Physicians Part A		0	0	0	0. 00	0. 00	16. 01
16. 02	- Teaching Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16. 02
17. 00	WAGE-RELATED COSTS Wage-related costs (core) (see		9, 612, 313	0	9, 612, 313			17. 00
18. 00	instructions) Wage-related costs (other)							18. 00
19. 00	(see instructions) Excluded areas		0	0	0			19. 00
20. 00	Non-physician anesthetist Part A		0	0	0			20.00
21. 00	Non-physician anesthetist Part B		0	0	0			21. 00
22. 00	Physician Part A - Administrative		0	0	0			22. 00
	Physician Part A - Teaching Physician Part B		0	0	0			22. 01 23. 00
24.00	Wage-related costs (RHC/FQHC) Interns & residents (in an		0					24. 00 25. 00
25. 50	approved program) Home office wage-related		2, 063, 419	0	2, 063, 419			25. 50
25. 51	(core) Related organization		0	0	0			25. 51
25. 52	wage-related (core) Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25. 52

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

					10	5 12/31/2020	7/29/2021 4:40	
		Wkst. A Line	Amount	Reclassi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Number	Reported	on of Salaries	Sal ari es	Related to	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	376, 927		376, 927	1, 621. 00		
27. 00	Administrative & General	5. 00	9, 321, 389	0	9, 321, 389	117, 785. 85		
28. 00	Administrative & General under		357, 492	0	357, 492	3, 388. 00	105. 52	28. 00
	contract (see inst.)							
29. 00	Maintenance & Repairs	6. 00	579, 370	0	579, 370	·		29. 00
30.00	Operation of Plant	7. 00	0	0	0	0.00		
31. 00	Laundry & Linen Service	8. 00	0	0	0	0.00		
32.00	Housekeepi ng	9. 00	680, 282	0	680, 282	44, 242. 00		
33.00	Housekeeping under contract		0	0	0	0.00	0. 00	33. 00
	(see instructions)							
34.00	Di etary	10. 00	565, 116	-346, 424	218, 692	16, 118. 00	l .	
35. 00	Di etary under contract (see		0	0	0	0.00	0. 00	35. 00
	instructions)							
36. 00	Cafeteri a	11. 00	0	346, 424	346, 424	17, 000. 00		36. 00
37. 00	Maintenance of Personnel	12. 00	0	0	0	0.00		
38. 00	Nursing Administration	13. 00	1, 547, 685		1, 547, 685	34, 882. 33		
39. 00	Central Services and Supply	14. 00	161, 299	0	161, 299	8, 007. 98	20. 14	39. 00
40.00	Pharmacy	15. 00	1, 024, 061	0	1, 024, 061	22, 643. 22	45. 23	40.00
41.00	Medical Records & Medical	16. 00	239, 854	0	239, 854	6, 662. 46	36. 00	41.00
	Records Library							
42.00	Social Service	17. 00	0	0	0	0.00		42.00
43.00	Other General Service	18. 00	0	0	0	0.00	0.00	43.00

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

Worksheet A Line Number Reported Sal arie s (col. 2 ± col. 3) Related to Sal arie s (col. 4 ÷ col. 5) Related to Sal arie s in col. 4 Col. 4 ÷ col. 5) Related to Sal arie s in col. 4 Col. 4 ÷ col. 5) Related to Sal arie s in col. 4 Col. 2 ± col. 30 Col. 4 ÷ col. 5) Related to Sal arie s in col. 4 Col. 4 ÷ col. 5 Col. 4 † Col. 5 Col. 4 † Col. 4 † Col. 5 Col. 4 † Col. 4 † Col. 5 Col. 5 Col. 4 † Col. 5 Col. 5						'	0 12/31/2020	7/29/2021 4:4	
Col. 2 ± col. 3 Salaries in col. 5			Worksheet A	Amount	Recl assi fi cati	Adj usted	Pai d Hours	Average Hourly	
Net salaries (see instructions) 1,722,384 0 1,722,384 28,892.43 59.61 2.00 2.00 36,688,795 945,962.09 38.78 3.00 3.0			Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
1.00 2.00 3.00 4.00 5.00 6.00					(from	(col.2 ± col.	Salaries in	col. 5)	
PART III - HOSPITAL WAGE INDEX SUMMARY 1.00 Net salaries (see 38,411,179 0 38,411,179 974,854.52 39.40 1.00 instructions) 2.00 Excluded area salaries (see 1,722,384 0 1,722,384 28,892.43 59.61 2.00 instructions) 3.00 Subtotal salaries (line 1 36,688,795 0 36,688,795 945,962.09 38.78 3.00 minus line 2) 4.00 Subtotal other wages & related 7,075,645 0 7,075,645 198,999.00 35.56 4.00 costs (see inst.) 5.00 Subtotal wage-related costs 11,675,732 0 11,675,732 0.00 31.82 5.00 (see inst.) 6.00 Total (sum of lines 3 thru 5) 55,440,172 0 55,440,172 1,144,961.09 48.42 6.00 7.00 Total overhead cost (see 14,853,475 0 14,853,475 331,663.84 44.78 7.00					Worksheet A-6)	3)	col. 4		
1.00 Net salaries (see instructions) 2.00 Excluded area salaries (see instructions) 3.00 Subtotal salaries (line 1 36,688,795 0 36,688,795 945,962.09 38.78 3.00 subtotal other wages & related costs (see inst.) 5.00 Subtotal wage-related costs (see inst.) 6.00 Total (sum of lines 3 thru 5) 7.00 Total overhead cost (see 14,853,475 0 14,853,475 331,663.84 44.78 7.00			1. 00	2. 00	3.00	4. 00	5. 00	6. 00	
instructions) 2.00 Excluded area salaries (see instructions) 3.00 Subtotal salaries (line 1 minus line 2) 4.00 Subtotal other wages & related costs (see inst.) 5.00 Subtotal wage-related costs (see inst.) 6.00 Total (sum of lines 3 thru 5) 7.00 Total overhead cost (see		PART III - HOSPITAL WAGE INDEX	SUMMARY						
2.00 Excluded area salaries (see instructions) 3.00 Subtotal salaries (line 1 36,688,795 0 36,688,795 945,962.09 38.78 3.00 4.00 Subtotal other wages & related costs (see inst.) 5.00 Subtotal wage-related costs (see inst.) 6.00 Total (sum of lines 3 thru 5) 7.00 Total overhead cost (see	1.00	Net salaries (see		38, 411, 179	0	38, 411, 179	974, 854. 52	39. 40	1. 00
instructions) 3.00 Subtotal salaries (line 1		instructions)							
3.00 Subtotal salaries (line 1 minus line 2) 4.00 Subtotal other wages & related costs (see inst.) 5.00 Subtotal wage-related costs (see inst.) 6.00 Total (sum of lines 3 thru 5) 7.00 Total overhead cost (see	2.00	`		1, 722, 384	. 0	1, 722, 384	28, 892. 43	59. 61	2. 00
minus line 2) 4.00 Subtotal other wages & related costs (see inst.) 5.00 Subtotal wage-related costs (see inst.) 6.00 Total (sum of lines 3 thru 5) 7,075,645 0 7,075,645 198,999.00 35.56 4.00 11,675,732 0.00 31.82 5.00 55,440,172 0 55,440,172 1,144,961.09 48.42 6.00 7.00 Total overhead cost (see 14,853,475 0 14,853,475 331,663.84 44.78 7.00		instructions)							
4.00 Subtotal other wages & related costs (see inst.) 5.00 Subtotal wage-related costs (see inst.) 6.00 Total (sum of lines 3 thru 5) 7,075,645 0 7,075,645 198,999.00 31.82 5.00 11,675,732 0 11,675,732 0 55,440,172 0 55,440,172 1,144,961.09 48.42 6.00 7,000 Total overhead cost (see 14,853,475) 14,853,475 0 14,853,475 198,999.00 31.82 5.00 31.82 5.00 31.82 5.00 31.82 5.00	3.00	Subtotal salaries (line 1		36, 688, 795	0	36, 688, 795	945, 962. 09	38. 78	3. 00
costs (see inst.) 5.00 Subtotal wage-related costs (see inst.) 6.00 Total (sum of lines 3 thru 5) 7.00 Total overhead cost (see 11,675,732 0 11,675,732 0 11,675,732 0 55,440,172 0 55,440,172 1,144,961.09 48.42 6.00 14,853,475 0 14,853,475 331,663.84 44.78 7.00		,							
5.00 Subtotal wage-related costs (see inst.) 11,675,732 0 11,675,732 0.00 31.82 5.00 6.00 Total (sum of lines 3 thru 5) 55,440,172 0 55,440,172 1,144,961.09 48.42 6.00 7.00 Total overhead cost (see 14,853,475 0 14,853,475 331,663.84 44.78 7.00	4.00	3		7, 075, 645	0	7, 075, 645	198, 999. 00	35. 56	4. 00
(see inst.) 6.00 Total (sum of lines 3 thru 5) 7.00 Total overhead cost (see 14, 853, 475 0 14, 853, 475 331, 663. 84 44. 78 7. 00		costs (see inst.)							
6.00 Total (sum of lines 3 thru 5) 55,440,172 0 55,440,172 1,144,961.09 48.42 6.00 7.00 Total overhead cost (see 14,853,475 0 14,853,475 331,663.84 44.78 7.00	5.00	Subtotal wage-related costs		11, 675, 732	. 0	11, 675, 732	0.00	31. 82	5. 00
7.00 Total overhead cost (see 14, 853, 475 0 14, 853, 475 331, 663. 84 44. 78 7.00		(see inst.)							
	6.00	Total (sum of lines 3 thru 5)		55, 440, 172	. 0	55, 440, 172	1, 144, 961. 09	48. 42	6. 00
instructions)	7.00	Total overhead cost (see		14, 853, 475	0	14, 853, 475	331, 663. 84	44. 78	7. 00
		instructions)							

Health Financial Systems	FRANCISCAN HEALTH MUNSTER	In Lieu of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 15-0165	Peri od: Worksheet S-3
		From 01/01/2020 Part IV

	To 12/31/2020	Date/Time Prep 7/29/2021 4:40	
		Amount	
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		1
1.00	401K Employer Contributions	929, 115	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)	893, 000	4. 00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		1
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal /Accounting/Management Fees-Pension Plan	981, 083	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)	3, 274, 345	8. 02
8. 03	Health Insurance (Purchased)	0	8. 03
9.00	Prescription Drug Plan	0	9. 00
10.00	Dental, Hearing and Vision Plan	295, 941	10.00
11. 00	Life Insurance (If employee is owner or beneficiary)	13, 074	11. 00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	382, 383	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	681, 156	15. 00
16. 00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16. 00
	Non cumulative portion)		
	TAXES		
17.00	FICA-Employers Portion Only	2, 074, 087	17. 00
18.00	Medicare Taxes - Employers Portion Only	0	18. 00
19.00	Unempl oyment Insurance	88, 129	19. 00
20.00	State or Federal Unemployment Taxes	0	20. 00
	OTHER		
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see	0	21. 00
	instructions))		1
22. 00	Day Care Cost and Allowances	0	22. 00
	Tuition Reimbursement	0	23. 00
24. 00	Total Wage Related cost (Sum of lines 1 -23)	9, 612, 313	24. 00
	Part B - Other than Core Related Cost		
25. 00	OTHER WAGE RELATED COSTS (SPECIFY)]	25. 00

Health Financial Systems	FRANCISCAN HEALTH MUNSTER	In Lieu of Form CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provi der CCN: 15-0165	
		From 01/01/2020 Part V
		To 12/21/2020 Dota/Time December d.

		To	12/31/2020	Date/Time Pre	
				7/29/2021 4: 40	O pm
	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 - IPF		0	0	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		o	0	8. 00
9.00	Hospi tal -Based NF		o	0	9. 00
10.00	Hospi tal -Based OLTC				10.00
11. 00	Hospi tal -Based HHA		o	0	11. 00
12.00	Separately Certified ASC		o	0	12.00
13.00	Hospi tal -Based Hospi ce		o	0	13. 00
14.00	Hospital-Based Health Clinic RHC		o	0	14. 00
15. 00	Hospital-Based Health Clinic FQHC		o	0	15. 00
16.00	Hospi tal -Based-CMHC		ol	0	16. 00
	Hospi tal -Based-CMHC 10		o	0	16. 10
	Renal Dialysis		o	0	17. 00
	Other		o	0	18. 00

Heal th	Financial Systems FRANCISCAN HEALTH	MUNSTER	In Lie	u of Form CMS-2	2552-10	
	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-0165	Peri od:	Worksheet S-1		
			From 01/01/2020 To 12/31/2020	Date/Time Pre	nared:	
			10 12/31/2020	7/29/2021 4: 4		
				1. 00		
	Uncompensated and indigent care cost computation					
1. 00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 di Medicaid (see instructions for each line)	vided by line 202 colu	mn 8)	0. 239443	1. 00	
2.00	Net revenue from Medicaid			9, 106, 210	2. 00	
3.00	Did you receive DSH or supplemental payments from Medicaid?				3. 00	
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemen		cai d?		4. 00	
5. 00 6. 00	If line 4 is no, then enter DSH and/or supplemental payments f Medicaid charges	rom Medicaid		0 49, 410, 964		
7. 00	Medicald charges Medicald cost (line 1 times line 6)			11, 831, 109		
8. 00	Difference between net revenue and costs for Medicaid program	(line 7 minus sum of L	ines 2 and 5: if	2, 724, 899	1	
	< zero then enter zero)	•				
	Children's Health Insurance Program (CHIP) (see instructions for	or each line)				
9.00	Net revenue from stand-alone CHIP			0		
10.00	Stand-alone CHIP charges				10.00	
11. 00 12. 00	Stand-alone CHIP cost (line 1 times line 10) Difference between net revenue and costs for stand-alone CHIP	(line 11 minus line 0	if / zero then		11. 00 12. 00	
12.00	enter zero)	(Title II millus IIIle 7,	TT < Zero then		12.00	
	Other state or local government indigent care program (see ins	tructions for each lin	e)			
13. 00	Net revenue from state or local indigent care program (Not inc			0	13. 00	
14. 00	Charges for patients covered under state or local indigent car	e program (Not include	d in lines 6 or	0	14. 00	
15. 00	10) State or local indigent care program cost (line 1 times line 1	1)		0	15. 00	
16. 00	Difference between net revenue and costs for state or local in		ine 15 minus line		16.00	
	13; if < zero then enter zero)	a. gont oar o program (.			10.00	
	Grants, donations and total unreimbursed cost for Medicaid, CH	P and state/local ind	igent care program	ns (see		
17. 00	<pre>instructions for each line) Private grants, donations, or endowment income restricted to f</pre>	inding charity care		0	17. 00	
18. 00	Government grants, appropriations or transfers for support of	9		0	1	
19. 00	Total unreimbursed cost for Medicaid , CHIP and state and Loca 8, 12 and 16)		ms (sum of lines	2, 724, 899		
	12 and 10)	Uni nsure	d Insured	Total (col. 1		
		pati ents	pati ents	+ col . 2)		
		1.00	2. 00	3. 00		
20.00	Uncompensated Care (see instructions for each line)	211111	0/1 / 022 01/	10 07/ 077	20.00	
20. 00	Charity care charges and uninsured discounts for the entire fa (see instructions)	cility 4,944,	061 6, 032, 016	10, 976, 077	20.00	
21. 00	Cost of patients approved for charity care and uninsured disco	unts (see 1,183,	821 6, 032, 016	7, 215, 837	21. 00	
	instructions)					
22. 00	Payments received from patients for amounts previously written	off as	0 0	0	22. 00	
23. 00	charity care Cost of charity care (line 21 minus line 22)	1, 183,	821 6, 032, 016	7, 215, 837	23 00	
23.00	1003t of charty care (fine 21 millus fine 22)	1, 103,	0,032,010	7, 213, 037	23.00	
				1. 00		
24. 00	Does the amount on line 20 column 2, include charges for patie		h of stay limit	N	24. 00	
25. 00	imposed on patients covered by Medicaid or other indigent care If line 24 is yes, enter the charges for patient days beyond t		am's length of	0	25. 00	
0/ 00	stay limit					
26. 00						
27. 00 27. 01	Medicare reimbursable bad debts for the entire hospital comple Medicare allowable bad debts for the entire hospital complex (•		271, 704 418, 007	1	
28. 00	Non-Medicare bad debt expense (see instructions)	see Thati ueti Ullaj		218, 682	1	
29. 00	Cost of non-Medicare and non-reimbursable Medicare bad debt ex	oense (see instruction	s)	198, 665	1	
	Cost of uncompensated care (line 23 column 3 plus line 29)	•		7, 414, 502	1	
31. 00	Total unreimbursed and uncompensated care cost (line 19 plus l	ne 30)		10, 139, 401	31.00	

	Financial Systems	FRANCI SCAN HEAL		1-		u of Form CMS-2	2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (OF EXPENSES	Provi der CC		Period: From 01/01/2020	Worksheet A	
					o 12/31/2020	Date/Time Pre	
	Cook Cooks Doors at the	C-1	0+1	T-+-1 (1 1	D1: 6:+:	7/29/2021 4:4	O pm
	Cost Center Description	Sal ari es	0ther	+ col . 2)	Reclassifications (See A-6)	Reclassified Trial Balance	
				+ COI. 2)	0113 (See A-0)	(col . 3 +-	
						col . 4)	
		1.00	2. 00	3.00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT		11, 407, 956	11, 407, 956	-72, 132	11, 335, 824	1.00
2. 00 3. 00	00200 CAP REL COSTS-MVBLE EQUIP 00300 OTHER CAP REL COSTS		0			0	2. 00 3. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	376, 927	576, 263	953, 190	-41, 853	911. 337	4.00
5. 00	00500 ADMINISTRATIVE & GENERAL	9, 321, 389	12, 509, 158			21, 499, 846	5. 00
6.00	00600 MAINTENANCE & REPAIRS	579, 370	5, 370, 720	5, 950, 090	-16, 930	5, 933, 160	6. 00
7.00	00700 OPERATION OF PLANT	0	0	C	0	0	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	195, 118			195, 118	8. 00
9.00	00900 HOUSEKEEPI NG 01000 DI ETARY	680, 282	387, 952			1, 064, 477	9.00
10. 00 11. 00	01100 CAFETERI A	565, 116	403, 571	968, 687		335, 279 593, 819	10. 00 11. 00
12. 00	01200 MAINTENANCE OF PERSONNEL		0		0	0	12.00
13. 00	01300 NURSI NG ADMI NI STRATI ON	1, 547, 685	797, 690	2, 345, 375	-71, 034	2, 274, 341	1
14.00	01400 CENTRAL SERVICES & SUPPLY	161, 299	179, 648		-44, 259	296, 688	14. 00
15. 00	01500 PHARMACY	1, 024, 061	3, 038, 603	4, 062, 664	-2, 479, 108	1, 583, 556	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	239, 854	106, 867	346, 721	0	346, 721	
17. 00	01700 SOCIAL SERVICE	0	0	C	0	0	17. 00
18. 00 19. 00	01850 OTHER GEN SERV 01900 NONPHYSICIAN ANESTHETISTS	0	0			0	18. 00 19. 00
20.00	02000 NURSI NG SCHOOL		0			0	20.00
21. 00	02100 &R SERVI CES-SALARY & FRINGES APPRVD	o	0		ol ol	0	21.00
22. 00	02200 &R SERVICES-OTHER PRGM COSTS APPRVD	0	0	c	o	0	22. 00
23. 00	02301 PARAMED ED PRGM	0	0	C	0	0	23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	7, 125, 249	2, 587, 998			9, 379, 190	30.00
31.00	03100 I NTENSI VE CARE UNI T	1, 575, 940	608, 252	2, 184, 192	-136, 716	2, 047, 476	31.00
32. 00 33. 00	03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT	0	0			0	32. 00 33. 00
34. 00	03400 SURGICAL INTENSIVE CARE UNIT		0			0	34.00
40. 00	04000 SUBPROVI DER - I PF	o	0		ol ol	0	40.00
41.00	04100 SUBPROVI DER - I RF	0	0	C	o	0	41.00
43.00	04300 NURSERY	0	0	C	0	0	43. 00
44. 00	04400 SKILLED NURSING FACILITY	0	0	C	0	0	44. 00
45. 00	04500 NURSING FACILITY	0	0	C	0	0	45. 00
46. 00	04600 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS	J U	U)l Ol	0	46. 00
50. 00	05000 OPERATI NG ROOM	3, 224, 127	10, 272, 554	13, 496, 681	-7, 196, 460	6, 300, 221	50.00
51.00	05100 RECOVERY ROOM	696, 789	276, 563				51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	C	O	0	52.00
53.00	05300 ANESTHESI OLOGY	27, 601	1, 304, 431			1, 238, 576	
54. 00	05400 RADI OLOGY - DI AGNOSTI C	1, 527, 370	1, 078, 223	2, 605, 593		2, 299, 419	
	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE	0	0		0	0	55. 00 56. 00
56. 00 57. 00	05700 CT SCAN	414, 179	464, 109	878, 288	-102, 677	775, 611	57.00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	786, 201	827, 065			1, 393, 028	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	862, 746	2, 328, 796			1, 320, 701	59. 00
60.00	06000 LABORATORY	0	5, 845, 708			5, 618, 490	60.00
60. 01	06001 BLOOD LABORATORY	0	0	C	0	0	60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0	C	0	0	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	C	0	0	62.00
63. 00 64. 00	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY	0	0			0	63. 00 64. 00
65. 00	06500 RESPIRATORY THERAPY	747, 428	375, 339	1, 122, 767	-89, 318	1, 033, 449	65.00
66. 00	06600 PHYSI CAL THERAPY	200, 348	98, 949			298, 796	
67. 00	06700 OCCUPATI ONAL THERAPY	115, 217	43, 869		1	158, 460	67. 00
68. 00	06800 SPEECH PATHOLOGY	23, 390	21, 223	44, 613	-20	44, 593	68. 00
69. 00	06900 ELECTROCARDI OLOGY	313, 180	140, 091	453, 271		423, 387	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	363, 852	976, 611	1, 340, 463		1, 315, 198	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		1, 881, 871	1, 881, 871	71.00
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS		0		9, 171, 997 2, 857, 963	9, 171, 997 2, 857, 963	72. 00 73. 00
74. 00	07400 RENAL DIALYSIS		0		2,037,703	2,037,703	74.00
75. 00	07500 ASC (NON-DISTINCT PART)		0		ol ől	0	75. 00
76. 00	03950 OTHER ANCILL SRVC	Ö	18, 975	18, 975	s o	18, 975	76. 00
76. 01	03951 CARDI AC AND PULMONARY REHAB	135, 359	65, 291	200, 650		200, 086	76. 01
76. 02	03952 WOUND CARE	32, 332	25, 319	57, 651	-7, 210	50, 441	76. 02
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0		0	0	77. 00
go 🗥	OUTPATIENT SERVICE COST CENTERS					0	80 00
88. 00 89. 00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	l C		0	88. 00 89. 00
90.00	09000 CLINIC		0			0	90.00
	1	<u>, *1</u>			. 71		

Health Financial Systems	FRANCI SCAN HEAL	_TH MUNSTER		In Lie	u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider CO		Peri od:	Worksheet A	
				rom 01/01/2020		
				Γο 12/31/2020	Date/Time Pre 7/29/2021 4:4	
Cost Center Description	Sal ari es	Other	Total (col 1	Recl assi fi cati	Reclassified	O DIII
oust contain bescription	Sur ur res	Other	+ col . 2)	ons (See A-6)	Trial Balance	
			,	, ,	(col. 3 +-	
					col . 4)	
	1.00	2.00	3. 00	4. 00	5. 00	
90. 01 09001 CLI NI C	1, 757, 220	684, 675	2, 441, 89	-72, 460	2, 369, 435	90. 01
90. 02 09002 CLI NI C	251, 614	370, 330	· ·			
91. 00 09100 EMERGENCY	1, 655, 178	1, 808, 871	3, 464, 04	-257, 849	3, 206, 200	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
OTHER REIMBURSABLE COST CENTERS						
94. 00 09400 HOME PROGRAM DI ALYSI S	0	0	(0	0	94. 00
95. 00 09500 AMBULANCE SERVICES	0	0	(0	0	95. 00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0	0		0	0	96.00
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 98. 00 09850 OTHER REI MBURSE		0		0	0	97. 00 98. 00
99. 00 09900 CMHC		0		0	0	
99. 10 09910 CORF		0			0	
100.00 10000 1&R SERVICES-NOT APPRVD PRGM		0			Ĭ	100.00
101. 00 10100 HOME HEALTH AGENCY		0				101. 00
SPECIAL PURPOSE COST CENTERS	J 3	<u> </u>	·	51 0		101.00
105. 00 10500 KI DNEY ACQUI SI TI ON	0	0		0	0	105. 00
106. 00 10600 HEART ACQUISITION	0	0		0	0	106. 00
107.00 10700 LIVER ACQUISITION	O	0		0	0	107. 00
108.00 10800 LUNG ACQUISITION	O	0		0	0	108. 00
109.00 10900 PANCREAS ACQUISITION	0	0	(0	0	109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0	(0	0	110. 00
111.00 11100 ISLET ACQUISITION	0	0	(0	0	111. 00
113. 00 11300 I NTEREST EXPENSE		-269, 791	-269, 79 ⁻	269, 791		113. 00
114.00 11400 UTI LI ZATI ON REVI EW-SNF	0	0	(0		114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	(0		115. 00
116. 00 11600 HOSPI CE	0	0	(0		116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	36, 331, 303	64, 926, 997	101, 258, 30	0	101, 258, 300	118.00

41, 708

1, 680, 676

38, 053, 687

41, 517

710, 874

65, 684, 414

5, 026

83, 225

5, 026

2, 391, 550

103, 738, 101

83, 225 190. 00 0 191. 00 2, 391, 550 192. 00

5, 026 192. 01 0 193. 00 103, 738, 101 200. 00

NONREI MBURSABLE COST CENTERS

190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN
191.00 19100 RESEARCH

TOTAL (SUM OF LINES 118 through 199)

192. 00 19200 PHYSI CLANS' PRI VATE OFFICES 192. 01 19201 CENTER OF HOPE

193. 00 19300 NONPALD WORKERS

200.00

Peri od: Worksheet A From 01/01/2020 To 12/31/2020 Date/Ti me Prepared:

				7/29/2021	
	Cost Center Description	Adjustments	Net Expenses		
			For Allocation 7.00		
	GENERAL SERVICE COST CENTERS	6.00	7.00		
1.00	00100 CAP REL COSTS-BLDG & FLXT	-1, 219, 416	10, 116, 408		1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	0	o		2. 00
3.00	00300 OTHER CAP REL COSTS	0	0		3. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	88, 083	999, 420		4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	331, 904	21, 831, 750		5. 00
6. 00	00600 MAI NTENANCE & REPAI RS	-170	5, 932, 990		6. 00
7.00	00700 OPERATION OF PLANT	0	0		7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	195, 118		8. 00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	0 -64	1, 064, 477		9. 00 10. 00
11. 00	01100 CAFETERI A	-222, 522	335, 215 371, 297		11.00
12. 00	01200 MAINTENANCE OF PERSONNEL	-222, 522	371, 247		12.00
13. 00	01300 NURSI NG ADMI NI STRATI ON	o o	2, 274, 341		13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	296, 688		14. 00
15.00	01500 PHARMACY	168, 162	1, 751, 718		15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	822, 074	1, 168, 795		16. 00
17. 00	01700 SOCIAL SERVICE	0	0		17. 00
18. 00		0	0		18. 00
19. 00	01900 NONPHYSI CLAN ANESTHETI STS	0	0		19.00
20. 00 21. 00	02000 NURSI NG SCHOOL 02100 L&R SERVI CES-SALARY & FRI NGES APPRVD	0			20. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	0			22. 00
23. 00	02301 PARAMED ED PRGM	0			23. 00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>	<u> </u>		
30.00	03000 ADULTS & PEDI ATRI CS	-119, 553	9, 259, 637		30.00
31. 00	03100 INTENSIVE CARE UNIT	-6, 933	2, 040, 543		31.00
32.00	03200 CORONARY CARE UNIT	0	0		32. 00
33. 00	03300 BURN INTENSIVE CARE UNIT	0	0		33. 00
34.00	03400 SURGI CAL INTENSI VE CARE UNI T	0	0		34.00
40.00	04000 SUBPROVI DER - I PF	0	0		40.00
41. 00 43. 00	04100 SUBPROVI DER - I RF 04300 NURSERY	0			41. 00 43. 00
44. 00	04400 SKILLED NURSING FACILITY	0			44. 00
45. 00	04500 NURSING FACILITY	0	0		45. 00
46. 00	04600 OTHER LONG TERM CARE	o o	Ö		46. 00
	ANCILLARY SERVICE COST CENTERS		-		
50.00	05000 OPERATING ROOM	-1, 320, 375	4, 979, 846		50. 00
51.00	05100 RECOVERY ROOM	0	902, 882		51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0		52. 00
53.00	05300 ANESTHESI OLOGY	0	1, 238, 576		53.00
54.00	05400 RADI OLOGY - DI AGNOSTI C	-773	2, 298, 646		54.00
55. 00 56. 00	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE	0	0		55. 00 56. 00
57. 00	05700 CT SCAN	-2, 803	772, 808		57.00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	-13, 992	1, 379, 036		58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	-58, 686	· · · · · · · · · · · · · · · · · · ·		59.00
60.00	06000 LABORATORY	-5, 814			60.00
60. 01	06001 BLOOD LABORATORY	0	0		60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0		61. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		62. 00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
64. 00 65. 00	06400 I NTRAVENOUS THERAPY	0	1 022 440		64. 00
66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0	1, 033, 449 298, 796		65. 00 66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	158, 460		67. 00
68. 00	06800 SPEECH PATHOLOGY		44, 593		68. 00
69. 00		0	423, 387		69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	-5, 013	1, 310, 185		70. 00
71. 00		0	1, 881, 871		71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	9, 171, 997		72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	2, 857, 963		73. 00
74.00	07400 RENAL DIALYSIS	0	0		74.00
75. 00	07500 ASC (NON-DISTINCT PART)	0	0		75. 00
76. 00	03950 OTHER ANCILL SRVC	-18, 975	101 741		76. 00 76. 01
76. 01 76. 02	03951 CARDI AC AND PULMONARY REHAB 03952 WOUND CARE	-18, 345 0	181, 741 50, 441		76. 01
77.00	1 1	0	0		77. 00
, , . 00	OUTPATIENT SERVICE COST CENTERS		9		- 7.00
88. 00	08800 RURAL HEALTH CLINIC	0	0		88. 00
89. 00	1 1	0	O		89. 00
90.00	09000 CLI NI C	0	0		90. 00
90. 01	09001 CLI NI C	0	2, 369, 435		90. 01
90. 02	09002 CLI NI C	-7, 163	574, 526		90. 02

 Heal th Financial
 Systems
 FRANCISCAN

 RECLASSIFICATION
 AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES
 In Lieu of Form CMS-2552-10 FRANCISCAN HEALTH MUNSTER

Peri od: From 01/01/2020 Provider CCN: 15-0165 Worksheet A

			To 12/31/2020	Date/Ti me Prepared: 7/29/2021 4:40 pm
Cost Center Description	Adjustments	Net Expenses		
	(See A-8)	For Allocation		
	6. 00	7. 00		
91. 00 09100 EMERGENCY	0	3, 206, 200		91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)				92. 00
OTHER REIMBURSABLE COST CENTERS				
94.00 09400 HOME PROGRAM DIALYSIS	0	0		94. 00
95. 00 09500 AMBULANCE SERVICES	0	0		95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		96. 00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0		97. 00
98. 00 09850 OTHER REI MBURSE	0	0		98. 00
99. 00 09900 CMHC	0	0		99. 00
99. 10 09910 CORF	0	0		99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0		100. 00
101.00 10100 HOME HEALTH AGENCY	0	0		101. 00
SPECIAL PURPOSE COST CENTERS				
105.00 10500 KIDNEY ACQUISITION	0	0		105. 00
106. 00 10600 HEART ACQUI SI TI ON	0	0		106. 00
107.00 10700 LIVER ACQUISITION	0	0		107. 00
108.00 10800 LUNG ACQUISITION	0	0		108. 00
109.00 10900 PANCREAS ACQUISITION	0	0		109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0		110. 00
111.00 11100 I SLET ACQUI SI TI ON	0	0		111. 00
113.00 11300 INTEREST EXPENSE	0	0		113. 00
114.00 11400 UTI LI ZATI ON REVI EW-SNF	0	0		114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0		115. 00
116. 00 11600 HOSPI CE	0	0		116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	-1, 610, 374	99, 647, 926		118. 00
NONREI MBURSABLE COST CENTERS				
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	83, 225		190. 00
191. 00 19100 RESEARCH	0	0		191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	2, 391, 550		192. 00
192.01 19201 CENTER OF HOPE	0	5, 026		192. 01
193.00 19300 NONPALD WORKERS	0	0		193. 00
200.00 TOTAL (SUM OF LINES 118 through 199)	-1, 610, 374	102, 127, 727		200. 00

Period: Worksheet A-6
From 01/01/2020
To 12/31/2020 Date/Time Prepared: 7/29/2021 4:40 pm Provider CCN: 15-0165

					10	12/31/2020	7/29/2021 4: 40 pm
		Increases			<u> </u>		
	Cost Center	Li ne #	Sal ary	Other			
	2. 00	3.00	4.00	5. 00			
	A - INSURANCE						
1.00	CAP REL COSTS-BLDG & FLXT	1.00	0	197, 659			1.00
	0 = = = = =			197, 659			
	B - INTEREST EXPENSE		'				
1.00	INTEREST EXPENSE	113.00	0	269, 791			1.00
	0			269, 791			
	C - DRUG EXPENSE						
1.00	DRUGS CHARGED TO PATIENTS	73. 00	0	2, 857, 963			1. 00
2. 00	INTENSIVE CARE UNIT	31.00	o	15			2. 00
3.00	THE STATE OF THE	0.00	o	0			3. 00
4. 00		0. 00	Ö	Ö			4. 00
5. 00		0.00	o	Ö			5. 00
6.00		0.00	o	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			•
			0	0			10.00
11.00		0.00					11.00
12. 00			9	0			12. 00
	U MED CURRILLEG EVRENCE		0	2, 857, 978			
4 00	D - MED SUPPLIES EXPENSE	74 00		44 050 070			1.00
1. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	11, 053, 868			1.00
0.00	PATI ENTS	0.00					0.00
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		0.00	0	0			15. 00
16.00		0.00	0	0			16. 00
17.00		0.00	0	0			17. 00
18.00		0.00	0	0			18. 00
19.00		0.00	0	0			19.00
20.00		0.00	0	0			20.00
21.00		0.00	0	0			21.00
22.00		0.00	0	0			22. 00
23.00		0.00	0	0			23. 00
24. 00		0.00	o	0			24.00
25. 00		0. 00	o	Ö			25. 00
26. 00		0.00	o	Ö			26. 00
27. 00		0.00	o	o			27. 00
28. 00		0.00	o	0			28. 00
29. 00		0.00	0	0			29. 00
27.00			0	11, 053, 868			27.00
	E - IMPLANTABLE DEVICES		<u> </u>	11, 000, 000			
1.00	IMPL. DEV. CHARGED TO	72.00	n n	9, 171, 997			1.00
1.00	PATIENTS	12.00	٩	7, 1/1, 79/			1.00
	0	+	₀	9, 171, 997			1
	F - CAFE		<u> </u>	7, 171, 797			
1 00	CAFETERI A	11. 00	346, 424	247, 395			1.00
1. 00	TOTALS		34 <u>6, 424</u> 346, 424	24 <u>7, 3</u> 95 247, 395			1.00
500.00	Grand Total: Increases		346, 424	23, 798, 688			500.00
500. UU	pi anu Tutai. THCLEases	l	340, 424	ZS, 190, 088			500.00

Health Financial Systems RECLASSIFICATIONS Provider CCN: 15-0165

Period: Worksheet A-6
From 01/01/2020
To 12/31/2020 Date/Time Prepared: 7/29/2021 4:40 pm

						21 4:40 pm
		Decreases				
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref.	
	6. 00	7. 00	8. 00	9. 00	10. 00	
1 00	A - I NSURANCE	F 00	ما	107 (50	11	1 00
1. 00	ADMI NI STRATI VE & GENERAL		0	19 <u>7, 6</u> 59		1.00
	D INTEDEST EXPENSE		U	197, 659	7	
1. 00	B - INTEREST EXPENSE CAP REL COSTS-BLDG & FIXT	1. 00	0	269, 791	11	1.00
1.00	O REL COSTS-BLDG & FIXT			26 <u>9, 7</u> 91		1.00
	C - DRUG EXPENSE		<u> </u>	207, 771		
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	40, 885	5 0	1.00
2. 00	NURSI NG ADMI NI STRATI ON	13. 00	ő	719		2.00
3.00	PHARMACY	15. 00	ol	2, 466, 121		3. 00
4.00	ADULTS & PEDIATRICS	30.00	o	3, 384		4. 00
5.00	OPERATING ROOM	50.00	O	26, 296		5. 00
6.00	ANESTHESI OLOGY	53.00	О	1, 874		6. 00
7.00	RADI OLOGY-DI AGNOSTI C	54.00	О	269, 354	1 0	7. 00
8.00	EMERGENCY	91.00	O	949	0	8. 00
9.00	RECOVERY ROOM	51.00	0	4	1 0	9. 00
10.00	WOUND CARE	76. 02	0	1, 810	0	10.00
11.00	CLINIC	90. 01	0	43, 969		11. 00
12.00	CLINIC	<u>90.</u> 02	•_	<u>2, 6</u> 13		12. 00
	0		0	2, 857, 978	3	
	D - MED SUPPLIES EXPENSE					
1. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	968		1.00
2.00	ADMINISTRATIVE & GENERAL	5. 00	0	133, 042		2. 00
3.00	MAINTENANCE & REPAIRS	6.00	0	16, 930		3. 00
4.00	HOUSEKEEPI NG	9.00	0	3, 757		4.00
5.00	DI ETARY	10.00	0	39, 589		5. 00
6.00	NURSING ADMINISTRATION	13.00	0	70, 315		6.00
7. 00 8. 00	CENTRAL SERVICES & SUPPLY PHARMACY	14. 00 15. 00	0	44, 259 12, 987		7. 00 8. 00
9. 00	ADULTS & PEDIATRICS	30.00	0	330, 673		9. 00
10.00	INTENSIVE CARE UNIT	31.00	0	136, 731		10.00
11. 00	OPERATING ROOM	50.00	0	7, 170, 164	_	11.00
12. 00	RECOVERY ROOM	51.00	0	7, 170, 16-		12.00
13. 00	ANESTHESI OLOGY	53.00	Ö	91, 582		13. 00
14. 00	RADI OLOGY-DI AGNOSTI C	54.00	ol	36, 820	_	14. 00
15. 00	CT SCAN	57.00	O	102, 677		15. 00
16.00	MAGNETIC RESONANCE IMAGING	58.00	o	220, 238		16. 00
	(MRI)					
17.00	CARDIAC CATHETERIZATION	59. 00	0	1, 870, 841	0	17. 00
18.00	LABORATORY	60.00	0	227, 218	0	18. 00
19.00	RESPI RATORY THERAPY	65. 00	0	89, 318		19. 00
20.00	PHYSI CAL THERAPY	66. 00	0	501		20. 00
21. 00	OCCUPATI ONAL THERAPY	67. 00	0	626		21. 00
22. 00	SPEECH PATHOLOGY	68. 00	0	20		22. 00
23. 00	ELECTROCARDI OLOGY	69.00	0	29, 884		23. 00
24. 00	ELECTROENCEPHALOGRAPHY	70.00	0	25, 265		24. 00
25. 00	CARDIAC AND PULMONARY REHAB	76. 01	0	564		25. 00
26. 00	WOUND CARE	76. 02	0	5, 400		26.00
27. 00	CLINIC	90. 01	0	28, 491		27. 00
28. 00 29. 00	CLINIC EMEDIENCY	90. 02	0	37, 642		28. 00
∠7. UU	EMERGENCY	<u>91.</u> 00		25 <u>6, 9</u> 00 11, 053, 868		29. 00
	E - IMPLANTABLE DEVICES		U	11,000,000	/	
1. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	ما	9, 171, 997	7 0	1.00
1.00	PATI ENTS	71.00	٩	7, 171, 777		1.00
	0 — —	+		9, 171, 997	, 	
	F - CAFE		<u> </u>	., ., ., ,,		
1.00	DI ETARY	10.00	346, 424	247, 395	5 0	1.00
	TOTALS		346, 424	247, 395		
500.00	Grand Total: Decreases		346, 424	23, 798, 688		500.00
	·					•

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

					To 12/31/2		0ate/Time Prep 7/29/2021 4:40	
				Acqui si ti ons	5		72972021 4.40) piii
		Begi nni ng	Purchases	Donati on	Total	Di	isposals and	
		Bal ances					Retirements	
		1.00	2. 00	3. 00	4. 00		5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	Γ BALANCES						
1.00	Land	9, 641, 227	0		0	0	0	1.00
2.00	Land Improvements	2, 703, 106	0		0	0	0	2.00
3.00	Buildings and Fixtures	79, 480, 471	0		0	0	0	3.00
4.00	Building Improvements	0	0		0	0	0	4. 00
5.00	Fixed Equipment	0	0		0	0	0	5. 00
6.00	Movable Equipment	116, 385, 476	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)	208, 210, 280	0		0	0	0	8. 00
9.00	Reconciling Items	-5, 889, 330	0		0	0	0	9. 00
10.00	Total (line 8 minus line 9)	214, 099, 610	0		0	0	0	10. 00
		Endi ng Bal ance	Fully					
			Depreci ated					
		(00	Assets					
	DADT I ANALYCIC OF CHANCEC IN CADITAL ACCE	6.00	7. 00					
1. 00	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	F BALANCES 9, 641, 227	0					1. 00
		1 1	U					
2. 00 3. 00	Land Improvements	2, 703, 106	0					2. 00 3. 00
4. 00	Buildings and Fixtures	79, 480, 471	0					4. 00
4. 00 5. 00	Building Improvements Fixed Equipment		0					4. 00 5. 00
6. 00	Movable Equipment	116, 385, 476	0					6. 00
7. 00	HIT designated Assets	110, 363, 470	0					7. 00
8. 00	Subtotal (sum of lines 1-7)	208, 210, 280	0					8. 00
9. 00	Reconciling I tems	-5, 889, 330	0					9. 00
10.00		214, 099, 610	0					10.00
10.00	Tiotal (Title o milius Title 7)	214,099,010	٠Į				Į	10.00

Heal th	Financial Systems	FRANCISCAN HEA	ALTH MUNSTER		Inlie	u of Form CMS-2	2552_10
	CILIATION OF CAPITAL COSTS CENTERS	TRANCI SCAN TIE	Provi der CC	CN: 15-0165	Peri od: From 01/01/2020 To 12/31/2020	Worksheet A-7 Part II	pared:
			SU	JMMARY OF CAP	PLTAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	,	
		9. 00	10.00	11. 00	12.00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	11, 407, 956	0		0 0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		0 0	ol	2.00
3.00	Total (sum of lines 1-2)	11, 407, 956	0		0 0	0	3. 00
		SUMMARY 0	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	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FLXT	0	11, 407, 956				1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2. 00
2 00	T-+-! (£ !! 1 2)		11 107 05/	1			1 2 22

0 0 0

11, 407, 956

1. 00 2. 00 3. 00

1.00 CAP REL COSTS-BLDG & FLX1
2.00 CAP REL COSTS-MVBLE EQUIP
3.00 Total (sum of lines 1-2)

Heal th	n Financial Systems	FRANCI SCAN HEA	ALTH MUNSTER		In Lie	eu of Form CMS-2	2552-10
RECONG	CILIATION OF CAPITAL COSTS CENTERS	F		Period: From 01/01/2020 To 12/31/2020			
		COMI	PUTATION OF RA	TIOS	ALLOCATION OF		
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets		Insurance	
			Leases	for Ratio	instructions)		
				(col . 1 - col 2)			
		1.00	2.00	3.00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C						
1.00	CAP REL COSTS-BLDG & FLXT	8, 622, 383	C	8, 622, 38		l .	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0)	0. 000000		2.00
3.00	Total (sum of lines 1-2)	8, 622, 383		8, 622, 38			3. 00
		ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL					
	Cost Center Description	Taxes	0ther	Total (sum of	f Depreciation	Lease	
			Capi tal -Rel ate				
			d Costs	through 7)	0.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CI	6.00	7. 00	8. 00	9. 00	10.00	
1. 00	CAP REL COSTS-BLDG & FIXT	INTERS 0	0	ı	0 11, 398, 794	0	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1		0 11, 370, 774	0	2. 00
3.00	Total (sum of lines 1-2)	0			0 11, 398, 794	- 1	3. 00
		-	SI	JMMARY OF CAPI			
	Cost Center Description	Interest	Insurance (see		0ther	Total (2) (sum	
			instructions)	instructions)) Capi tal -Rel ate		
					d Costs (see instructions)	through 14)	
		11.00	12. 00	13.00	14. 00	15. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CI		12.00	10.00	1 1.00	10.00	
1.00	CAP REL COSTS-BLDG & FLXT	-1, 282, 386	О		0 0	10, 116, 408	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		0 0		2. 00
3.00	Total (sum of lines 1-2)	-1, 282, 386	o)	0	10, 116, 408	3.00

| Period: | Worksheet A-8 | From 01/01/2020 | To 12/31/2020 | Date/Time Prepared: Provider CCN: 15-0165

					o 12/31/2020		
				Expense Classification on	Worksheet A	7/29/2021 4: 40	J pm
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description		Amount	Cost Center		Wkst. A-7 Ref.	
1.00	Investment income - CAP REL	1.00 A	2. 00	3.00 CAP REL COSTS-BLDG & FIXT	4. 00	5. 00 11	1. 00
	COSTS-BLDG & FIXT (chapter 2)						
2. 00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	2. 00
3.00	Investment income - other	В	0	CAP REL COSTS-BLDG & FIXT	1. 00	9	3. 00
4.00	(chapter 2) Trade, quantity, and time		0		0.00	0	4. 00
	di scounts (chapter 8)		· ·]	
5. 00	Refunds and rebates of expenses (chapter 8)	В	-465, 739	ADMINISTRATIVE & GENERAL	5. 00	0	5. 00
6.00	Rental of provider space by		0		0.00	О	6. 00
7. 00	suppliers (chapter 8) Telephone services (pay		0		0.00	0	7. 00
	stations excluded) (chapter						
8. 00	21) Television and radio service		0		0.00	0	8. 00
0.00	(chapter 21)				0.00		0.00
9. 00 10. 00	Parking Lot (chapter 21) Provider-based physician	A-8-2	-1, 497, 838		0.00	0	9. 00 10. 00
11 00	adj ustment		0		0.00		11 00
11. 00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11. 00
12. 00	Related organization	A-8-1	3, 736, 487			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		-175, 859	CAFETERI A	11. 00 0. 00	0	14. 00 15. 00
15.00	and others		O		0.00		15.00
16. 00	Sale of medical and surgical supplies to other than		0		0.00	0	16. 00
	pati ents		_			_	
17. 00	Sale of drugs to other than patients		0		0.00	0	17. 00
18. 00	Sale of medical records and abstracts	В	-751	ADMINISTRATIVE & GENERAL	5. 00	0	18. 00
19. 00	Nursing and allied health		0		0.00	0	19. 00
	education (tuition, fees, books, etc.)						
20. 00	Vending machines	В	-16, 872	CAFETERI A	11.00	0	20. 00
21. 00	Income from imposition of interest, finance or penalty		0		0.00	0	21. 00
	charges (chapter 21)						
22. 00	Interest expense on Medicare overpayments and borrowings to		0		0.00	0	22. 00
22.00	repay Medicare overpayments			DECDI DATODY THEDADY	/ F 00		22.00
23. 00	Adjustment for respiratory therapy costs in excess of	A-8-3	0	RESPI RATORY THERAPY	65. 00		23. 00
24. 00	limitation (chapter 14) Adjustment for physical	A-8-3	0	PHYSI CAL THERAPY	66. 00		24. 00
21.00	therapy costs in excess of	7. 5 5	· ·	i marake melwir	00.00		21.00
25. 00	limitation (chapter 14) Utilization review -		0	UTILIZATION REVIEW-SNF	114. 00		25. 00
	physicians' compensation						
26. 00	(chapter 21) Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26. 00
27.00	COSTS-BLDG & FIXT Depreciation - CAP REL		0	CAD DEL COSTS MADLE FOLLID	2 00	0	27.00
27. 00	COSTS-MVBLE EQUIP			CAP REL COSTS-MVBLE EQUIP	2.00		
28. 00 29. 00	Non-physician Anesthetist Physicians' assistant		0	NONPHYSICIAN ANESTHETISTS	19. 00 0. 00	0	28. 00 29. 00
30. 00	Adjustment for occupational	A-8-3	Ö	OCCUPATI ONAL THERAPY	67. 00	-	30.00
	therapy costs in excess of limitation (chapter 14)						
30. 99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30. 99
31. 00	instructions) Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68. 00		31. 00
	pathology costs in excess of limitation (chapter 14)						
32. 00	CAH HIT Adjustment for		0		0.00	0	32. 00
33 00	Depreciation and Interest PROPERTY TAXES (51009800)	А	-176 590	ADMINISTRATIVE & GENERAL	5. 00	١	33. 00
	1 2	1 23 1	175,570	r Orion 12 d Ochervic	3.00	ı	

From 01/01/2020 | Nate/Time Prepared:

					o 12/31/2020	Date/Time Pre	
				Expense Classification on	Worksheet A	1/29/2021 4.4	O pili
				To/From Which the Amount is			
				Toy I Tom Will cit the 7 thouse I s	to be haj astea		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
		1.00	2. 00	3. 00	4. 00	5. 00	
33. 01	ADVERTISING (41860XXX)	A		MAINTENANCE & REPAIRS	6.00	0	33. 01
33. 02	RENTAL INCOME	В	-295, 408	ADMINISTRATIVE & GENERAL	5.00	0	33. 02
33. 03	MI SCELLANEOUS - OTHER	В	-2, 619	ADMINISTRATIVE & GENERAL	5. 00	0	33. 03
	OPERATI NG						
33. 04	DI SCOUNTS/REBATES	В	-3, 019	CARDIAC CATHETERIZATION	59.00	0	33. 04
33. 05	HAF ASSESSMENT FEES	В	-2, 960, 277	ADMINISTRATIVE & GENERAL	5. 00	0	33. 05
33. 06	PENSI ON	A	88, 083	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33. 06
33. 07	MEDICAL STAFF FEES	В	-64	DI ETARY	10.00	0	33. 07
33. 08	INTEREST INCOME - OTHER	В	0	ADMINISTRATIVE & GENERAL	5. 00	0	33. 08
33. 09	MI SCELLANEOUS REVENUE	В	-773	RADI OLOGY-DI AGNOSTI C	54.00	0	33. 09
33. 10	LOBBYI NG	A	-2, 090	ADMINISTRATIVE & GENERAL	5.00	0	33. 10
33. 11	PROPERTY TAXES (51009800)	A	0	RADI OLOGY-DI AGNOSTI C	54.00	0	33. 11
33. 12	PROPERTY TAXES (51009800)	A	-2, 803	CT SCAN	57.00	0	33. 12
33. 13	PROPERTY TAXES (51009800)	A	-13, 992	MAGNETIC RESONANCE IMAGING	58.00	0	33. 13
				(MRI)			
33. 14	MISC OTHER OPERATING	В	-80	ADMINISTRATIVE & GENERAL	5. 00	0	33. 14
33. 15	REFUNDS & REBATES	В	-29, 791	CAFETERI A	11.00	0	33. 15
33. 16	RENTAL INCOME	В	-60, 000	OPERATING ROOM	50.00	0	33. 16
50.00	TOTAL (sum of lines 1 thru 49)		-1, 610, 374				50.00
	(Transfer to Worksheet A,						
	column 6, line 200.)						

⁽¹⁾ Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

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

OFFICE COSTS

From 01/01/2020 To 12/31/2020 1/2020 Dato/Time Propared

				10 12/31/2020	7/29/2021 4:4	
	Li ne No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost	Included in	
					Wks. A, column	
					5	
	1. 00	2. 00	3. 00	4. 00	5. 00	
	A. COSTS INCURRED AND ADJUSTM	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OR	GANIZATIONS OR	CLAI MED	
	HOME OFFICE COSTS:					
1.00			I NTEREST	1, 796, 055	3, 276, 100	1. 00
2.00	1.00	CAP REL COSTS-BLDG & FIXT	ALLOWABLE NEW CAPITAL COSTS	1, 247, 574	1, 256, 736	2.00
3.00	5. 00	ADMINISTRATIVE & GENERAL	A&G	12, 706, 254	8, 470, 796	3.00
4.00	15. 00	PHARMACY	COVP / PHARMACY	168, 162	0	4.00
4.01	16. 00	MEDICAL RECORDS & LIBRARY	HI M	822, 074	0	4. 01
5.00	TOTALS (sum of lines 1-4).			16, 740, 119	13, 003, 632	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

1103 110	t been posted to worksheet A,	cordinas rand/or 2, the amoun	it allowable 311	oura be marcated in cordini 4	or this part.	
				Related Organization(s) and/	or Home Office	
	Symbol (1)	Name	Percentage of	Name	Percentage of	
			Ownershi p		Ownershi p	
	1. 00	2.00	3. 00	4. 00	5. 00	
	B. INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HO	ME OFFICE:			

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

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

	Comorre unuo: tr tr c /tr				
6.00	В	FRANCISCAN ALLI	100.00	0. 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:				

- (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

Heal th	Financial Syste	ems		FRANC	ISCAN HEALT	H MUNSTER			In Lie	u of Form C	MS-2552-10
STATEME	NT OF COSTS OF	SERVICES FROM	RELATED	ORGANI ZATI ONS	AND HOME	Provi der	CCN:	15-0165	Peri od:	Worksheet	A-8-1
OFFICE	COSTS								From 01/01/2020		
									To 12/31/2020		
			_						<u> </u>	7/29/2021	4: 40 pm
	Net	Wkst. A-7 Ref									
	Adjustments										
	(col. 4 minus										
	col. 5)*										
	6. 00	7. 00									
	A. COSTS INCUR	RED AND ADJUS	MENTS REC	QUIRED AS A RE	SULT OF TRA	NSACTI ONS	WI TH	RELATED (ORGANI ZATI ONS OR	CLAI MED	
	HOME OFFICE CO	STS:									
1.00	-1, 480, 045	1	1								1. 00
2.00	-9, 162		9								2. 00
3.00	4, 235, 458		ol								3. 00
4.00	168, 162		ol								4. 00
4.01	822, 074		ol								4. 01

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

5 00

1103 1101	been posted to worksheet A,	cordinate and or 2, the amount arrowable should be mareated in cordinate of this part.	
	Related Organization(s)		
	and/or Home Office		
	Type of Business		
	3.		
	6. 00		
	B. INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

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

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

5.00

3, 736, 487

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Provider CCN: 15-0165

						0 12/31/2020	7/29/2021 4:4	eparea: 40 pm
	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	30.00	ADULTS & PEDIATRICS	119, 553	119, 553	0	0	0	1. 00
2.00	31.00	INTENSIVE CARE UNIT	6, 933	6, 933	0	0	0	2. 00
3.00	50.00	OPERATING ROOM	1, 290, 227	1, 257, 027	33, 200	200, 300	310	3. 00
4.00	59. 00	CARDIAC CATHETERIZATION	55, 667			0	0	4. 00
5.00	60.00	LABORATORY	23, 051	1 0	23, 051	200, 300	179	5. 00
6.00	70.00	ELECTROENCEPHALOGRAPHY	28, 125			200, 300		6. 00
7. 00		OTHER ANCILL SRVC	18, 975		· ·	0	0	1
8.00		CARDIAC AND PULMONARY REHAB	18, 345	•		0	0	8. 00
9. 00	•	90. 02 CLI NI C				0	0	9. 00
10. 00	0.00		7, 163	1,		0	0	
200.00			1, 568, 039	1, 483, 663	84, 376		729	1
200.00	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	
		I denti fi er		Unadjusted RCE		Component	of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1. 00	2.00	8.00	9.00	12. 00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1. 00
2.00		INTENSIVE CARE UNIT	0	0	0	0	0	2. 00
3.00	50.00	OPERATING ROOM	29, 852	1, 493	0	0	0	3. 00
4.00	59. 00	CARDIAC CATHETERIZATION	0	0	0	0	0	4. 00
5.00	60.00	LABORATORY	17, 237	862	0	0	0	5. 00
6.00	70.00	ELECTROENCEPHALOGRAPHY	23, 112	1, 156	0	0	0	6.00
7.00	76. 00	OTHER ANCILL SRVC	0	0	0	0	0	7. 00
8.00	76. 01	CARDIAC AND PULMONARY REHAB	0	0	0	0	0	8. 00
9.00	90. 02	CLINIC	0	0	0	0	0	9. 00
10.00	0.00		0	0	0	0	0	10.00
200.00			70, 201	3, 511		0	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		I denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
			14					
	1. 00	2. 00	15. 00	16. 00	17. 00	18. 00		
1.00		ADULTS & PEDIATRICS	0	0	0	119, 553		1. 00
2.00	31.00 I NTENSI VE CARE UNI T		0	0	0	6, 933		2. 00
3.00	50.00 OPERATING ROOM		0	29, 852	3, 348	1, 260, 375		3. 00
4.00	59. 00 CARDI AC CATHETERI ZATI ON		0	0	J	55, 667		4. 00
5.00	60. 00 LABORATORY		0	17,207		5, 814		5. 00
6.00	70. 00 ELECTROENCEPHALOGRAPHY		0	23, 112	5, 013			6. 00
7.00	76.00 OTHER ANCILL SRVC		0	0	0	18, 975		7. 00
8.00	76.01 CARDIAC AND PULMONARY REHAB		0	0	0	18, 345		8. 00
9.00	90. 02 CLI NI C		0	0	0	7, 163		9. 00
10.00	0. 00		0	0	0	0		10.00
200.00			0	70, 201	14, 175	1, 497, 838		200. 00

Health Financial Systems FRANCISCAN HEALTH MUNSTER In Lieu of Form CMS-2552-10 COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0165 Peri od: Worksheet B From 01/01/2020 Part I Date/Time Prepared: 12/31/2020 7/29/2021 4:40 pm CAPITAL RELATED COSTS Net Expenses BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Subtotal Cost Center Description for Cost **BENEFITS** DEPARTMENT All ocation (from Wkst A col. 7) 1.00 2.00 4. 00 4A GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 10, 116, 408 1 00 10, 116, 408 2.00 00200 CAP REL COSTS-MVBLE EQUIP 0 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 999, 420 129, 196 0 1, 128, 616 4.00 00500 ADMINISTRATIVE & GENERAL 21, 831, 750 0 5 00 1, 241, 718 279, 229 23 352 697 5 00 6.00 00600 MAINTENANCE & REPAIRS 5, 932, 990 0 17, 355 5, 950, 345 6.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 195, 118 0 195, 118 8.00 8.00 00900 HOUSEKEEPI NG 0 20, 378 9 00 1,064,477 1, 084, 855 9 00 10.00 01000 DI ETARY 335, 215 446, 210 6,551 787, 976 10.00 01100 CAFETERI A 0 11.00 371, 297 10, 377 381, 674 11.00 01200 MAINTENANCE OF PERSONNEL 0 12.00 12.00 n 01300 NURSING ADMINISTRATION 0 2, 320, 702 13.00 2, 274, 341 Ω 46.361 13 00 14.00 01400 CENTRAL SERVICES & SUPPLY 296, 688 0 4,832 301, 520 14.00 01500 PHARMACY 15.00 1, 751, 718 173, 318 30, 676 1, 955, 712 15.00 01600 MEDICAL RECORDS & LIBRARY 7, 185 1, 168, 795 0 1, 184, 136 16,00 8, 156 16,00 17 00 01700 SOCIAL SERVICE 0 17 00 01850 OTHER GEN SERV 18.00 18.00 0 19 00 01900 NONPHYSICIAN ANESTHETISTS 0 C 0 0 O 19.00 02000 NURSING SCHOOL 0 20.00 0 0 20.00 C 0 02100 I&R SERVICES-SALARY & FRINGES APPRVD 0 21.00 0 0 0 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 0 0 22.00 0 22.00 02301 PARAMED ED PRGM 23.00 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 9, 259, 637 2, 174, 237 0 213, 437 11, 647, 311 30.00 03100 INTENSIVE CARE UNIT 31.00 2,040,543 523, 920 47, 207 2, 611, 670 31.00 32.00 03200 CORONARY CARE UNIT C 0 32.00 0 03300 BURN INTENSIVE CARE UNIT 33.00 0 C 0 0 0 33.00 03400 SURGICAL INTENSIVE CARE UNIT 0 0 34.00 34.00 04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF 0 0 40.00 0 0 Ω 40.00 0 0 41 00 C Λ 41 00 04300 NURSERY 0 0 43.00 0 0 43.00 04400 SKILLED NURSING FACILITY 0 0 0 44.00 0 44.00 04500 NURSING FACILITY 0 45.00 45.00 0 04600 OTHER LONG TERM CARE 0 46.00 0 46.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 4, 979, 846 986, 782 96, 579 6, 063, 207 50.00 05100 RECOVERY ROOM 0 51 00 902 882 432 899 20 872 1, 356, 653 51 00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 n 52.00 53.00 05300 ANESTHESI OLOGY 1, 238, 576 0 827 1, 239, 403 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 2, 298, 646 458, 784 0 45, 752 2, 803, 182 54.00 05500 RADI OLOGY-THERAPEUTI C 0 55 00 55 00 0 56.00 05600 RADI OI SOTOPE 0 56.00 05700 CT SCAN 772, 808 0 12, 407 785, 215 57.00 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 58.00 1, 379, 036 0 23, 551 1, 402, 587 58.00 05900 CARDIAC CATHETERIZATION 932, 011 0 2, 219, 870 59 00 1, 262, 015 25.844 59 00 60.00 06000 LABORATORY 5, 612, 676 160, 178 0 5, 772, 854 60.00 06001 BLOOD LABORATORY 60.01 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 61.00 0 0 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 62.00 0 C 0 0 62 00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 63.00 0 06400 I NTRAVENOUS THERAPY 64.00 0 64.00 06500 RESPIRATORY THERAPY 1,033,449 79, 806 0 22.389 1, 135, 644 65.00 65 00 66.00 06600 PHYSI CAL THERAPY 298, 796 6,001 304, 797 66.00 06700 OCCUPATIONAL THERAPY 67.00 158, 460 3, 451 161, 911 67.00 06800 SPEECH PATHOLOGY 45, 294 68.00 44.593 0 701 68.00 06900 ELECTROCARDI OLOGY 0 9 381 69.00 423.387 432, 768 69 00 07000 ELECTROENCEPHALOGRAPHY 1, 310, 185 407, 298 10,899 1, 728, 382 70.00 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71 00 1,881,871 1, 881, 871 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 9.171.997 0 9, 171, 997 72.00 72.00 0 07300 DRUGS CHARGED TO PATIENTS 0 73.00 2, 857, 963 C 0 2, 857, 963 73.00 07400 RENAL DIALYSIS 74.00 74.00 07500 ASC (NON-DISTINCT PART) o 75.00 0 0 75.00 03950 OTHER ANCILL SRVC 76.00 0 C 0 0 0 76.00 0 4, 055 76.01 03951 CARDIAC AND PULMONARY REHAB 181, 741 185, 796 76.01 76.02 03952 WOUND CARE 50.441 0 969 51, 410 76.02 07700 ALLOGENEIC STEM CELL ACQUISITION 77.00 77.00 0 OUTPATIENT SERVICE COST CENTERS

0

0

0

0

0 88.00

88.00 08800 RURAL HEALTH CLINIC

			To	o 12/31/2020	Date/Time Pre 7/29/2021 4:4	
CAPI			CAPITAL RELATED COSTS		772772021 1. 1	DIII
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
	0	1.00	2.00	4. 00	4A	
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 90. 00 09000 CLI NI C 90. 01 09001 CLI NI C 90. 02 09002 CLI NI C 91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	0 0 2, 369, 435 574, 526 3, 206, 200	0 0 0 68, 364 560, 736	0 0 0 0	0 0 52, 638 7, 537 49, 581	0 0 2, 422, 073 650, 427 3, 816, 517 0	90. 00 90. 01 90. 02 91. 00
OTHER REIMBURSABLE COST CENTERS 94. 00 09400 HOME PROGRAM DI ALYSI S		0	0	O	0	94. 00
95. 00 09500 AMBULANCE SERVI CES 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD	0 0	0	0	0	0	95. 00 96. 00 97. 00
98. 00 09850 OTHER REI MBURSE	o	0	Ō	Ō	0	98. 00
99. 00 09900 CMHC	0	0	0	0	0	99. 00
99. 10 09910 CORF	0	0	0	0	0	
100.00 10000 I&R SERVICES-NOT APPRVD PRGM 101.00 10100 HOME HEALTH AGENCY	0	0		0		100. 00 101. 00
SPECIAL PURPOSE COST CENTERS	ı o	U	U	<u> </u>	0	1101.00
105. 00 10500 KIDNEY ACQUISITION	0	0	0	0	0	105. 00
106. 00 10600 HEART ACQUI SI TI ON	0	0	0	0		106. 00
107. 00 10700 LI VER ACQUI SI TI ON	0	0	0	0		107. 00
108.00 10800 LUNG ACQUISITION 109.00 10900 PANCREAS ACQUISITION	0	0	0	0		108. 00 109. 00
110. 00 11000 NTESTI NAL ACQUI SI TI ON		0	0	0		1109.00
111. 00 11100 SLET ACQUISITION		0	0	0		111.00
113. 00 11300 NTEREST EXPENSE		J	Ĭ	Ö	Ŭ	113. 00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115. 00
116. 00 11600 H0SPI CE	0	0	0	0		116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	99, 647, 926	8, 783, 613	0	1, 077, 022	98, 263, 537	118. 00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	02.225	0	0	1 240	04 474	100 00
190. 00 19000 GTFT, FLOWER, COFFEE SHOP & CANTEEN	83, 225	0	0	1, 249		190. 00 191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	2, 391, 550	1, 332, 795	0	50, 345	3, 774, 690	
192. 01 19201 CENTER OF HOPE	5, 026	0	ő	0		192. 01
193. 00 19300 NONPALD WORKERS	0	0	o	o		193. 00
200.00 Cross Foot Adjustments					0	200. 00
201.00 Negative Cost Centers		0	0	O		201. 00
202.00 TOTAL (sum lines 118 through 201)	102, 127, 727	10, 116, 408	0	1, 128, 616	102, 127, 727	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 4:40 pm

				. ''		7/29/2021 4:4	
	Cost Center Description	ADMI NI STRATI VE		OPERATION OF PLANT	LAUNDRY &	HOUSEKEEPI NG	
		& GENERAL 5.00	REPAI RS 6. 00	7. 00	LINEN SERVICE 8.00	9. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUI P						2.00
4. 00 5. 00	OO4OO	23, 352, 697					4. 00 5. 00
6. 00	00600 MAINTENANCE & REPAIRS	1, 772, 554	7, 722, 899				6. 00
7. 00	00700 OPERATION OF PLANT	0	0	0			7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	58, 124	0	0	253, 242		8. 00
9.00	00900 HOUSEKEEPI NG	323, 169	0	0	0	1, 408, 024	9. 00
10.00	01000 DI ETARY	234, 731	394, 035	0	0	71, 840	
11. 00 12. 00	O1100 CAFETERI A O1200 MAI NTENANCE OF PERSONNEL	0	0	0	0	0	
13. 00	01300 NURSING ADMINISTRATION	691, 316	0	0	0	0	
14. 00	01400 CENTRAL SERVICES & SUPPLY	89, 820	0	ő	0	0	14. 00
15.00	01500 PHARMACY	582, 589	153, 052	0	0	27, 904	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	352, 743	7, 202	0	0	1, 313	1
17. 00	01700 SOCIAL SERVICE	0	0	0	0	0	17. 00
18.00	01850 OTHER GEN SERV	0	0	0	0	0	18. 00 19. 00
20. 00	01900 NONPHYSI CI AN ANESTHETI STS 02000 NURSI NG SCHOOL	0	0	0	0	0	1
21. 00	02100 I &R SERVI CES-SALARY & FRINGES APPRVD		0	0	0	0	21. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	o	0	0	0	0	ı
23. 00	02301 PARAMED ED PRGM	0	0	0	0	0	23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDI ATRI CS	3, 469, 653	1, 920, 009		218, 656	350, 051	30. 00
31.00	03100 INTENSIVE CARE UNIT	777, 993	462, 659	0	34, 586	84, 351	1
32.00	03200 CORONARY CARE UNIT	0	0	0	0	0	32. 00 33. 00
33. 00 34. 00	03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	
40. 00	04000 SUBPROVI DER - I PF		0	0	0	0	40. 00
41. 00	04100 SUBPROVI DER – I RF	l o	0	Ö	0	Ö	41. 00
43.00	04300 NURSERY	0	0	0	0	0	43.00
44.00	04400 SKILLED NURSING FACILITY	0	0	0	0	0	44. 00
45.00	04500 NURSING FACILITY	0	0	0	0	0	45. 00
46. 00	04600 OTHER LONG TERM CARE	0	0	0	0	0	46. 00
FO 00	ANCI LLARY SERVI CE COST CENTERS	1 00/ 175	071 200		0	150.070	F0 00
50. 00 51. 00	O5000 OPERATI NG ROOM O5100 RECOVERY ROOM	1, 806, 175 404, 135	871, 399 382, 281	0 0	0	158, 872 69, 697	50. 00 51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	404, 133	0 0	0	0	07, 077	52.00
53. 00	05300 ANESTHESI OLOGY	369, 207	0	o o	0	Ö	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	835, 043	405, 139	0	0	73, 864	1
55.00	05500 RADI OLOGY-THERAPEUTI C	O	0	0	0	0	55. 00
56. 00	05600 RADI OI SOTOPE	0	0	0	0	0	56. 00
57. 00	05700 CT SCAN	233, 908	0	0	0	0	57. 00
58. 00 59. 00	05800 MAGNETI C RESONANCE I MAGING (MRI) 05900 CARDIAC CATHETERIZATION	417, 818 661, 279	823, 032	0	0	0 150, 054	58. 00 59. 00
60.00	06000 LABORATORY	1, 719, 681	623, 032 141, 449	•	0	25, 789	1
60. 01	06001 BLOOD LABORATORY	1, 717, 001	0		0	23, 707	ı
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61. 00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	o	0	0	0	0	62. 00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63. 00
64. 00	06400 I NTRAVENOUS THERAPY	0	0	0	0	0	64. 00
65. 00	06500 RESPIRATORY THERAPY	338, 298	70, 474	0	0	12, 849	1
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	90, 796 48, 232	0	0	0	0	66. 00 67. 00
68. 00	06800 SPEECH PATHOLOGY	13, 493	0	0	0	0	68.00
69. 00	06900 ELECTROCARDI OLOGY	128, 918	0	0	0	0	69.00
70. 00	07000 ELECTROENCEPHALOGRAPHY	514, 869	359, 673	0	0	65, 575	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	560, 592	0	0	0	0	71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS	2, 732, 255	0	0	0	0	
73. 00	07300 DRUGS CHARGED TO PATIENTS	851, 361	0	0	0	0	
74. 00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
75. 00	07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75. 00
76. 00 76. 01	03950 OTHER ANCILL SRVC 03951 CARDIAC AND PULMONARY REHAB	55, 347	0	0	0	0	76. 00 76. 01
76. 01	03952 WOUND CARE	15, 315	0	0	0	0	76. 01
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION	15, 315	0	0	0	0	1
	OUTPATIENT SERVICE COST CENTERS	<u>. </u>					1
88. 00		0	0	0	0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	
	09000 CLI NI C	0	0	0	0	0	
90. 01	09001 CLI NI C	721, 514	0	0	0	0	90. 01
90. 02 91. 00	09002 CLI NI C 09100 EMERGENCY	193, 756	60, 371		0	11, 007	90. 02 91. 00
71.00	0.3 1.00 LWLNGLING I	1, 136, 906	495, 170	1 0	1 0	90, 2/8	71.00

			'	0 12/01/2020	7/29/2021 4:4	
Cost Center Description	ADMI NI STRATI VE	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
· ·	& GENERAL	REPAI RS	PLANT	LINEN SERVICE		
	5. 00	6. 00	7. 00	8. 00	9. 00	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
94. 00 09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94. 00
95. 00 09500 AMBULANCE SERVICES	o	0	0	0	0	95. 00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	o	0	0	0	0	96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	o	0	0	0	0	97. 00
98. 00 09850 OTHER REI MBURSE	0	0	0	0	0	98. 00
99. 00 09900 CMHC	0	0	0	0	0	99. 00
99. 10 09910 CORF	0	0	0	0	0	99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	o	0	0	0	0	100.00
101.00 10100 HOME HEALTH AGENCY	o	0	0	0		101. 00
SPECIAL PURPOSE COST CENTERS	' ' '					
105. 00 10500 KIDNEY ACQUISITION	0	0	0	0	0	105. 00
106. 00 10600 HEART ACQUISITION	o	0	0	0		106. 00
107. 00 10700 LIVER ACQUISITION	o	0	0	0		107. 00
108. 00 10800 LUNG ACQUISITION	0	0	0	0		108. 00
109. 00 10900 PANCREAS ACQUISITION	0	0	0	0		109. 00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON	0	0	0	0		110.00
111. 00 11100 I SLET ACQUI SI TI ON	0	0	0	0		111. 00
113. 00 11300 I NTEREST EXPENSE	1	_	_		_	113. 00
114. OO 11400 UTI LI ZATI ON REVI EW-SNF	1					114. 00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	0	0	115. 00
116. 00 11600 HOSPI CE	0	0	0	0		116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	22, 201, 590	6, 545, 945	0	253, 242	1, 193, 444	
NONREI MBURSABLE COST CENTERS		2, 2 . 2, 1 2	-		.,,	
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	25, 164	0	0	0	0	190. 00
191. 00 19100 RESEARCH	0	0	0	0		191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	1, 124, 446	1, 176, 954	0	0	214, 580	
192. 01 19201 CENTER OF HOPE	1, 497	0, 1, 2, 7, 3, 1	0	0		192. 01
193. 00 19300 NONPALD WORKERS	.,.,	0	0	0		193. 00
200.00 Cross Foot Adjustments		o o		J	Ü	200. 00
201.00 Negative Cost Centers	n	n	0	n	n	201. 00
202.00 TOTAL (sum lines 118 through 201)	23, 352, 697	7, 722, 899	١	253, 242		
202. 00 10 me (30m 11103 110 th ough 201)	20,002,077	,,,22,077	١	200, 242	1, 100, 024	1232.00

CONTINUE					10 12/31/2020	Date/lime Pre 7/29/2021 4:4	
SUMMAN SERVICE COST COMPLISON	Cost Center Description	DI ETARY	CAFETERI A			CENTRAL	
DEFECT STATE COLUMN TOTAL TO				PERSONNEL	ADMINISTRATION		
1.00		10.00	11. 00	12.00	13.00		
2.00 00000CAR PET LOSTS-MARIE FOUR 2.00 00000CAR PET LOSTS-MARIE FOUR 2.00 00000CAR PET LOSTS-MARIE & CRIESAL 4.00 0000CAR PET LOSTS-MARIE & CRIESAL 4.00 0000CAR PET LOSTS MARIE & CRIESAL 4.0							
4.00 Occool Park OVER EMPIRIT SECRETARY 5.00 COCOO MAINTENANCE & CREMAN 5.00 COCOO MAINTENANCE & CREMAN 5.00 COCOO MAINTENANCE & REPAIR IS 5.00 COCOO MAINTE	1 1						
5.00 00-0000 00-000 00-000 00-000 00-000 00-000 00-000 00-0000 00-000 00-0000 00-0000 00-0000 00-0000 00-0000 00-0000 00-0000 00-0000 00-0000 00-0000 00-0000 00-0000 00-0000 00-0000 00-0000 00-0000 00-0000 00-00000 00-0000 00-0000 00-0000 00-0000 00-0000 00-0000 00-0000 00-00000 00-00000 00-00000 00-00000 00-00000 00-00000 00-00000 00-00000 00-00000 00-00000 00-0000000 00-000000 00-00000000	1 1						1
0.00 0.0000 MAINTENANCE & REPAIR IS 0.00 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000000	1 1						1
7.00 00000 00000 00 00 00 00	1 1						1
8.00 00 00000 LUMINORY AS LINEN SERVICE	1 1						1
9.00 OSCOOL MUSICKETP IN INC. 1,488, 582 381,674 10 00 00 11 1,00 10 10 10 10 11 1,00 10 10 11 1,00 11 1	1 1						1
11.00 01100 CAFETER A 0 381,674 11.00 12.0	1 1						9. 00
12.00 01/200 MIN HTENANCE OF PERSONNEL 0 0 0 0 3,012,018 313.00 130 01/300 MINSTER ADMINISTRATION 0 0 0 0 3,012,018 319.301 14.00 01/300 PAPRARACY 0 0 0 0 0 0 0 0 391,340 14.00 15.00 1000 PAPRARACY 0 0 0 0 0 0 0 0 0 0 15.00 15.00 17.0	10. 00 01000 DI ETARY	1, 488, 582					10.00
13.00 1300 NURSING ADMINISTRATION 0 0 3.012,018 13.00 14.00 14.00 14.00 14.00 14.00 14.00 15.00	11. 00 01100 CAFETERI A	0	381, 674				11. 00
14.00 01400 CRITATA SERVICES & SURPLY 0 0 0 0 0 0 15.00 15.00 15.00 10.00 10.00 15.00 15.00 15.00 10.00 10.00 10.00 15.00 15.00 10.00	1 1	0	0		9		
15.00 01500 PHABMACY 0 0 0 0 0 15.00 17.00 01070 SUCIAL SERVICE 0 0 0 0 0 0 17.00 17.00 01070 SUCIAL SERVICE 0 0 0 0 0 0 0 17.00 17.00 01080 0101 010 01080 0101 010 010 010 010 20.00 02000 0101 010 010 010 0 0 0	1 1	0	0)	3, 012, 018	201 240	1
16.00 01-000 MEDICAL RECORDS & LIBRARY 0 0 0 0 0 16.00 18.00 01-000 01-000 01-00 0 0 0 0 0 18.00 01-000 01-000 01-00 0 0 0 0 0 18.00 01-000 01-000 01-00 0 0 0 0 0 20.00 02-000 01-000 01-000 0 0 0 0 0 0 20.00 02-000 01-000 01-000 0 0 0 0 0 0 20.00 02-000 01-000 01-000 0 0 0 0 0 0 20.00 02-000 01-000 01-000 0 0 0 0 0 0 20.00 02-000 01-000 01-000 0 0 0 0 0 0 20.00 02-000 02-000 02-000 0 0 0 0 0 0 20.00 02-000 02-000 02-000 0 0 0 0 0 0 20.00 02-000 02-000 02-000 0 0 0 0 0 0 20.00 02-000 02-000 02-000 0 0 0 0 0 0 20.00 02-000 02-000 02-000 02-000 0 0 0 0 0	1 1	0	0		0		1
17.00 01700 SOCIAL SERVICE 0 0 0 0 0 17.00 19.00 01900 NOMPHYSICIAN AMESTHETISTS 0 0 0 0 0 0 18.00 19.00 01900 NOMPHYSICIAN AMESTHETISTS 0 0 0 0 0 0 0 19.00 10.00 10200 NURSIN MS. SCHOOL 0 0 0 0 0 0 0 0 0 10.00 10200 NURSIN MS. SCHOOL 0 0 0 0 0 0 0 0 10.00 10200 NURSIN MS. SCHOOL 0 0 0 0 0 0 0 0 0 10.00 10200 NURSIN MS. SCHOOL 0 0 0 0 0 0 0 0 0 10.00 10200 NURSIN MS. SCHOOL 0 0 0 0 0 0 0 0 0 10.00 10200 NURSIN MS. SCHOOL 0 0 0 0 0 0 0 0 0 10.00 10200 NURSIN MS. SCHOOL 0 0 0 0 0 0 0 0 0 10.00 10200 NURSIN MS. SCHOOL 0 0 0 0 0 0 0 0 10.00 10200 NURSIN MS. SCHOOL 0 0 0 0 0 0 0 0 10.00 10200 NURSIN MS. SCHOOL 0 0 0 0 0 0 0 0 0	1 1	0	0				1
18.00 0.1850 0.1HER CERL SERV 0 0 0 0 0 19.00 19.00 0.00 0.00 0.19.00 0.20.00 0.00 0.20.00 0.00 0.20	1 1	0	0				1
19.00 0 1900 (MORPHYSICIAN AMESTHEITISTS 0 0 0 0 0 0 0 20.00 21.00 0 20.00 0 20.00 0 20.00 0 0 0 0 0 0	1 1	Ö	Ö		0 0		
21.00 02100 188 SERVICES-SALARY & FRINCES APPRVD 0 0 0 0 0 0 0 22.0 0220 02200 188 SERVICES-SCHEP PROBLE OSTS APPRVD 0 0 0 0 0 0 0 0 22.0 02301 PARAMED ED PROM 0 0 0 0 0 0 0 0 22.0 10301 PARAMED ED PROM 0 0 0 0 0 0 0 0 22.0 10301 PARAMED ED PROM 0 0 0 0 0 0 0 0 22.0 10300 030000 03000 03000 030000 03000	1 1	O	O		0 0	0	
22.00 02200 IAR SERVICES-OTHER PROW O	20. 00 02000 NURSI NG SCHOOL	O	0		0	0	20.00
33.00 03201 PARAMED ED PRICAL 0 0 0 0 0 0 23.00	1 1	0	0)	0		21. 00
INPATI ENT ROUTI NE SERVICE COST CENTERS 329.549	1 1	0	0		0		
30.00 3000 ADULTS & PEDIATRICS 1, 285, 291 329, 549 0 1, 351, 276 0 30.00		0	0)	0 0	0	23. 00
31.00 03700 NTENSIVE CARE UNIT 203, 291 52, 125 0 428,006 0 31.00 32.00 33.00 33.00 03800 BURN INTENSIVE CARE UNIT 0 0 0 0 0 32.00 33.00 34.00 3		1 205 201	220 540		0 1 251 277	0	20.00
32.00				•			1
33.00 03300 BURN INTENSIVE CARE UNIT 0 0 0 0 0 0 0 0 0	1 1	203, 291	52, 125		0 428,003		1
34. 00 03400 SURGICAL INTENSIVE CARE UNIT 0 0 0 0 0 0 0 0 0	1 1	0	0				
0.00 0.4000 SUBPROVIDER - IPF	1 1	o	0		0 0		1
41.00 04100 SUBPROVIDER - LIFE	1 1	O	0		0 0	0	1
44. 00 0.4400 SKILLED NURSING FACILITY		О	0		0 0	0	41. 00
45. 00 04500 JURSING FACILITY	43. 00 04300 NURSERY	0	0		0	0	43.00
A6. 00 OdeOo OTHER LONG TERM CARE		0	0		0	-	44. 00
ANCILLARY SERVICE COST CENTERS		-	0		0		1
50.00 05000 05000 05000 0 0 0		0	0)	0 0	0	46. 00
51.00 OS100 RECOVERY ROOM OS OS OS OS OS OS OS		٥		\	O E01 102	0	E0 00
52.00 05200 DELI VERY ROOM & LABOR ROOM 0 0 0 0 0 0 53.00	1 1		0		0 371, 163		1
53.00 05300 ANESTHESI OLOGY 0 0 0 0 0 53.00	1 1	-	0				1
54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 1, 206 0 54. 00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 0 0 0 0 0 0	1 1	o	0		0 0		
56.00 05600 RADIOI SOTOPE 0 0 0 0 0 0 0 0 56.00 0.57.00 0.5700 0.5700 0.5700 0.5700 0.5700 0.5700 0.5700 0.5700 0.5700 0.5700 0.5700 0.5700 0.5700 0.5700 0.5800	54. 00 05400 RADI OLOGY-DI AGNOSTI C	О	0		0 1, 206	0	54.00
57.00 05700 05700 05700 050000 050000 05000 050000 050000 050000 050000 050000 050000 050000 050000 050000 0500000 0500000 0500000 05000000 0500000000		O	0		0	0	55.00
58. 00 05900 CARDIAC CATHETERI ZATION 0 0 0 0 131, 206 0 59. 00 59. 00 05900 CARDIA C CATHETERI ZATION 0 0 0 0 131, 206 0 59. 00 60. 00 06000 LABORATORY 0 <		0	0)	0	0	56. 00
59. 00 05900 CARDI AC CATHETERI ZATION 0 0 0 131, 206 0 59, 00 60. 00 0		0	0		0 302		1
60.00 06000 LABORATORY 0 0 0 0 0 0 0 0 0		0	0)	0 0		1
60.01 06.001 06.001 06.0000 06.0000 06.0000 06.0000 06.0000		0	0)	0 131, 206		1
61.00 06100 BPD CLINICAL LAB SERVICES-PRCM ONLY		U O	0		0	-	
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 0 0 0 0 62. 00 63. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 0 0 0 0 0 0 0 0 64. 00 06400 INTRAVENOUS THERAPY 0 0 0 0 0 0 0 65. 00 06500 RESPI RATORY THERAPY 0 0 0 0 0 0 0 66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 0 0 0 67. 00 06700 OCCUPATI ONAL THERAPY 0 0 0 0 0 0 68. 00 06600 OCCUPATI ONAL THERAPY 0 0 0 0 0 0 68. 00 06800 SPEECH PATHOLOGY 0 0 0 0 0 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 71. 00 07000 ELECTROEARDI OLOGY 0 0 0 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 0 0 72. 00 07200 IMPL DEV. CHARGED TO PATI ENTS 0 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 74. 00 07400 RENAL DI ALYSI S 0 0 0 0 0 75. 00 07500 ASC (NON-DISTI NCT PART) 0 0 0 0 0 76. 01 03951 CARDI AC AND PULMONARY REHAB 0 0 0 0 0 76. 02 03952 WOUND CARE 0 0 0 0 0 77. 00 0000 CUPATI ENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC 0 0 0 0 0 99. 00 09000 CLINIC O 0 0 0 99. 01 09001 CLINIC O 0 0 99. 01 09001 CLINIC 0 0 0 99. 01 09001 CLINIC 0 0 90. 01 09001 CLINIC 0 0 0 90. 01 09001 CLINIC 0 0 90. 01 09001 CLINIC 0 0 0 90. 01 09001 CLINIC 0 0 90. 01 09001 CLINIC 0 0	1 1	U	U	1		0	1
63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 0 0 0 63. 00 64. 00 06400 INTRAVENOUS THERAPY 0 0 0 0 0 0 64. 00 65. 00 06500 RESPIRATORY THERAPY 0 0 0 0 0 0 66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 0 0 67. 00 06600 PHYSI CAL THERAPY 0 0 0 0 0 0 68. 00 06600 OCCUPATI ONAL THERAPY 0 0 0 0 0 0 68. 00 06600 SPEECH PATHOLOGY 0 0 0 0 0 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 70. 00 07000 ELECTROCARDI OLOGY 0 0 0 0 70. 00 07000 ELECTROCARDI OLOGY 0 0 0 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 0 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 74. 00 07400 RENAL DI ALYSI S 0 0 0 0 75. 00 07500 ASC (NON-DI STINCT PART) 0 0 0 0 76. 01 03951 CARDI AC AND PULMONARY REHAB 0 0 0 0 76. 01 03952 CARDI AC AND PULMONARY REHAB 0 0 0 0 77. 00 00700 ALLOGENEIC STEM CELL ACQUI SI TI ON 0 0 0 77. 00 007000 CLINIC COST CENTERS 88. 00 08900 RURAL HEALTH CLINIC 0 0 0 0 90. 01 09000 CLINIC 0 0 0 90. 01 09000 CLINIC 0 0 0 90. 01 09000 CLINIC 0 0 90. 01 09000 CLINIC 0 0 90. 01 09000 CLINIC 0 90. 01 09000 CLINIC 0 0 90. 01 09000 CLINIC 0 90. 01 09000 CLINIC 0 0 90. 01 09000 CLINIC 0 90. 01 09000 CLINIC 0 0 90. 01 09000 CLINIC 0 90. 01 09000 CLINIC 0 0 90. 01 09000 CLINIC 0 90. 01 09000 CLINIC 0 0 90. 01 09000 CLINIC 0 90. 01 09000 CLINIC 0 0 90. 01 09000 CLINIC 0 90. 01 09000 CLINIC 0 0 90. 01 09000 CLINIC 0 90. 01 09000 CLINIC 0 0 90. 01 09000 CLINIC 0 90. 01 09000 CLINIC 0 0 90. 01 09000 CLINIC 0 90. 01 09000 CLINIC 0 90. 01 09000 CLINIC 0 90.	· · · · · · · · · · · · · · · · · · ·	0	0		0	0	1
64. 00 06400 INTRAVENOUS THERAPY 0 0 0 0 0 0 0 64. 00 65. 00 06500 RESPI RATORY THERAPY 0 0 0 0 0 0 0 0 66. 00 06600 PHSVI CAL THERAPY 0 0 0 0 0 0 0 67. 00 06700 OCCUPATI ONAL THERAPY 0 0 0 0 0 0 0 68. 00 06700 OCCUPATI ONAL THERAPY 0 0 0 0 0 0 69. 00 06900 SPEECH PATHOLOGY 0 0 0 0 0 0 69. 00 07000 ELECTROCARDI OLOGY 0 0 0 0 0 70. 00 07000 ELECTROCARDI OLOGY 0 0 0 0 71. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 0 0 72. 00 07200 IMPL DEV. CHARGED TO PATI ENTS 0 0 0 0 0 73. 00 07300 RENAL DI ALYSI S 0 0 0 0 0 74. 00 07400 RENAL DI ALYSI S 0 0 0 0 0 75. 00 07500 ASC (NON-DI STI NCT PART) 0 0 0 0 0 76. 01 03951 CARDI AC AND PULMONARY REHAB 0 0 0 0 0 76. 02 03952 WOUND CARE 0 0 0 0 0 77. 00 07700 ALLOGENEIC STEM CELL ACQUI SI TI ON 0 0 0 0 89. 00 08900 RURAL HEALTH CLINIC 0 0 0 0 0 90. 01 09000 CLI NI C 0 0 0 90. 01 09000 CLI NI C 0 0 90. 01 09000 CLI NI C		o	Ö				
66. 00 06600 PHYSICAL THERAPY 0 0 0 0 0 0 0 0 66. 00 67. 00 67. 00 06700 OCCUPATI ONAL THERAPY 0 0 0 0 0 0 0 0 67. 00 68. 00 6800 SPEECH PATHOLOGY 0 0 0 0 0 0 0 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		Ö	0		0 0		
67. 00 06700 OCCUPATIONAL THERAPY 0 0 0 0 0 0 0 0 67. 00 68. 00 6800 SPEECH PATHOLOGY 0 0 0 0 0 0 0 68. 00 6900 ELECTROCARDIOLOGY 0 0 0 0 0 0 0 0 68. 00 6900 ELECTROCARDIOLOGY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1 1	О	0		0 0	0	65. 00
68. 00	66. 00 06600 PHYSI CAL THERAPY	О	0		0	0	66. 00
69. 00		0	0)	0	0	
70. 00 07000 CLECTROENCEPHALOGRAPHY 0 0 0 0 0 70. 00 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 391, 340 71. 00 72. 00 07200 MPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 73. 00 74. 00 07400 RENAL DI ALYSIS 0		0	0		0		
71. 00	1 1	0	0)	0 302		1
72. 00	1 1	0	0)	0		
73. 00		0	0		0		
74. 00		0	0		0		
75. 00		0	0			-	
76. 00	, , , , , , , , , , , , , , , , , , ,	0	0		o o		
76. 01		ol	0		0 0		
76. 02 03952 WOUND CARE 0 0 0 0 0 0 0 76. 02 77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION 0 0 0 0 0 0 77. 00 OUTPATIENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC 0 0 0 0 0 88.00 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 0 89. 00 90. 00 09000 CLINIC 0 0 0 0 0 0 90. 00 90. 01 09001 CLINIC 0 0 0 0 0 118,840 0 90. 01	1 1	ol	0		0 0		
SERVICE COST CENTERS	76. 02 03952 WOUND CARE	o	0		0 0	0	
SERVICE COST CENTERS		0	0)	0 0	0	77. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 0 0 89. 00 90. 00 09000 CLI NI C 0 0 0 0 0 0 90. 01 09001 CLI NI C 0 0 0 0 0 118, 840 0 90. 01		1			_		
90. 00 09000 CLI NI C 0 0 0 0 90. 00 90. 01 09001 CLI NI C 0 0 0 0 90. 01 0 0 0 0 0 0 0 0 0	, , , , , , , , , , , , , , , , , , ,	0	0)	0		
90. 01 09001 CLI NI C 0 0 118, 840 0 90. 01	· · · · · · · · · · · · · · · · · · ·	0	0		0		
		0	0		0		
70. 02 07002 0E1 M 0 0 00, 030 0 90. 02	· · · · · · · · · · · · · · · · · · ·	0	0				1
	70. 02 07002 0E1 N1 0	ا ا		n	00, 033	<u> </u>	1 /0.02

In Lieu of Form CMS-2552-10
Period: Worksheet B
From 01/01/2020 Part I
To 1/21/21/2020 Part I

			Τ̈́	o 12/31/2020	Date/Time Pre 7/29/2021 4:4	
Cost Center Description	DI ETARY	CAFETERI A	MAINTENANCE OF	NURSI NG	CENTRAL	, p
			PERSONNEL	ADMI NI STRATI ON	SERVICES &	
					SUPPLY	
	10.00	11. 00	12.00	13.00	14. 00	
91. 00 09100 EMERGENCY	0	0	C	308, 863	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DIALYSIS	0	0	C	0	0	94. 00
95. 00 09500 AMBULANCE SERVICES	0	0	C	0	0	95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	C	0	0	96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	C	0	0	97. 00
98. 00 09850 OTHER REI MBURSE	0	0	C	0	0	98. 00
99. 00 09900 CMHC	0	0	C	0	0	99. 00
99. 10 09910 CORF	0	0	C	0	0	99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	C	0	0	100.00
101.00 10100 HOME HEALTH AGENCY	0	0	C	0	0	101. 00
SPECIAL PURPOSE COST CENTERS						
105.00 10500 KIDNEY ACQUISITION	0	0	C	0	0	105. 00
106. 00 10600 HEART ACQUI SI TI ON	0	0	C	0	0	106. 00
107.00 10700 LIVER ACQUISITION	0	0	C	0	0	107. 00
108.00 10800 LUNG ACQUISITION	0	0	C	0	0	108. 00
109.00 10900 PANCREAS ACQUISITION	0	0	C	0	0	109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0	C	0		110. 00
111. 00 11100 I SLET ACQUI SI TI ON	0	0	C	0	0	111. 00
113. 00 11300 I NTEREST EXPENSE						113. 00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	C	0		115. 00
116. 00 11600 HOSPI CE	0	0	C	0	0	116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	1, 488, 582	381, 674	C	3, 012, 018	391, 340	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	C	0		190. 00
191. 00 19100 RESEARCH	0	0	C	0		191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	C	0		192. 00
192. 01 19201 CENTER OF HOPE	0	0	C	0		192. 01
193. 00 19300 NONPALD WORKERS	0	0	C	0	0	193. 00
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	0	C	0		201. 00
202.00 TOTAL (sum lines 118 through 201)	1, 488, 582	381, 674	(3, 012, 018	391, 340	202. 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2020 | Part | | To 12/31/2020 | Date/Time Prepared: | 7/29/2021 4:40 pm | OTUER CENTER.

						7/29/2021 4:4	O pm
					OTHER GENERAL		
	Coot Conton Decemintion	PHARMACY	MEDICAL	COCLAL CEDVICE	SERVI CE	NONDHIVELCLAN	
	Cost Center Description	PHARMACY	MEDI CAL RECORDS &	SOCIAL SERVICE	UTHER GEN SERV	NONPHYSI CI AN ANESTHETI STS	
			LI BRARY			ANESTHETISTS	
		15.00	16. 00	17. 00	18. 00	19. 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
5.00	00500 ADMINISTRATIVE & GENERAL						5. 00
6.00	00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT						6.00
7. 00 8. 00	00800 LAUNDRY & LINEN SERVICE						7. 00 8. 00
9. 00	00900 HOUSEKEEPING						9.00
10.00	01000 DI ETARY						10.00
11. 00	01100 CAFETERI A						11.00
12.00	01200 MAINTENANCE OF PERSONNEL						12.00
13.00	01300 NURSING ADMINISTRATION						13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY						14. 00
15. 00	01500 PHARMACY	2, 719, 257					15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	1, 545, 394	1			16.00
17. 00	01700 SOCIAL SERVICE	0	0	0			17.00
18. 00 19. 00	01850 OTHER GEN SERV 01900 NONPHYSI CI AN ANESTHETI STS	0	0		0	0	18. 00 19. 00
20. 00	02000 NURSI NG SCHOOL	0	0		0	U	20.00
21. 00	02100 I &R SERVI CES-SALARY & FRI NGES APPRVD	0	0		0		21.00
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRVD	o	0	o o	ő		22.00
23. 00	02301 PARAMED ED PRGM	o	0	o	0		23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	1		'			
30.00	03000 ADULTS & PEDI ATRI CS	0	112, 097	0	0	0	30. 00
31. 00	03100 INTENSIVE CARE UNIT	0	23, 520	0	0	0	31. 00
32. 00	03200 CORONARY CARE UNIT	0	0	0	0	0	32. 00
33.00	03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	33. 00
34. 00	03400 SURGI CAL INTENSI VE CARE UNI T	0	0	0	0	0	34.00
40.00	04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF	0	0		0	0	40.00
41. 00 43. 00	04300 NURSERY		0		0	0	41. 00 43. 00
44. 00	04400 SKILLED NURSING FACILITY	0	0		0	0	44. 00
45. 00	04500 NURSING FACILITY	o	0	o o	0	0	45. 00
46. 00	04600 OTHER LONG TERM CARE	o	0		1	0	46. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	200, 112		0	0	50. 00
51. 00	05100 RECOVERY ROOM	0	21, 677		1	0	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53. 00	05300 ANESTHESI OLOGY	0	50, 252		0	0	53.00
54. 00 55. 00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	0	91, 879	0	0	0	54. 00 55. 00
56. 00	05600 RADI OLOGT - THERAPEUTT C	0	0		0	0	56.00
57. 00	05700 CT SCAN		127, 628		0	0	57.00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	o	77, 166		o	0	58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	75, 983	1	O	0	1
60.00	06000 LABORATORY	0	181, 370		0	0	60.00
60. 01	06001 BLOOD LABORATORY	0	0	0	0	0	60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400 I NTRAVENOUS THERAPY	0	15 200	0	0	0	64.00
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0	15, 208 6, 155		0	0	65. 00 66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	4, 257		0	0	67.00
68. 00	06800 SPEECH PATHOLOGY	0	1, 222		0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	o	47, 624		ő	0	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	o	14, 918		0	0	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	O	66, 579		0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	88, 530	0	0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	2, 719, 257	78, 781	0	0	0	73. 00
74. 00	07400 RENAL DIALYSIS	0	0	0	0	0	74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75. 00
76. 00	03950 OTHER ANCILL SRVC	0	0	9	0	0	76.00
76. 01	03951 CARDI AC AND PULMONARY REHAB	0	1, 463		0	0	76. 01
76. 02 77. 00	03952 WOUND CARE 07700 ALLOGENEIC STEM CELL ACQUISITION	0 0	519	0	· ·	0	76. 02 77. 00
77.00	OUTPATIENT SERVICE COST CENTERS	<u> </u>	U	, U	L U	U	, , ,
88. 00	08800 RURAL HEALTH CLINIC	o	0	0	O	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	1	· ·	0	89. 00
90. 00	09000 CLINIC	Ö	0	1		0	90.00
				'			

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

			1	o 12/31/2020	Date/Time Prep 7/29/2021 4:40	
				OTHER GENERAL	772772021 1. 1	O PIII
				SERVI CE		
Cost Center Description	PHARMACY	MEDI CAL	SOCIAL SERVICE	OTHER GEN SERV	NONPHYSI CI AN	
		RECORDS &			ANESTHETI STS	
	45.00	LI BRARY	47.00	40.00	10.00	
00.04 00004 01.111.0	15. 00	16.00	17. 00	18. 00	19. 00	00.01
90. 01 09001 CLI NI C	0	89, 183		0	0	90. 01
90. 02 09002 CLI NI C 91. 00 09100 EMERGENCY		23, 566 145, 705		U	0	90. 02 91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		145, 705	U	٩	ا	91.00
OTHER REIMBURSABLE COST CENTERS						92.00
94. 00 09400 HOME PROGRAM DIALYSIS	0	0	0	٥	0	94. 00
95. 00 09500 AMBULANCE SERVICES		0	0		0	95.00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED		0	0	٥	0	96.00
97. 00 09700 DURABLE MEDICAL EQUI P-SOLD	0	0	0	Ö	0	97. 00
98. 00 09850 OTHER REIMBURSE	0	0	0	Ö	0	98. 00
99. 00 09900 CMHC	o	0	0	ol	0	99. 00
99. 10 09910 CORF	0	0	0	o	0	99. 10
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	0	0	0	o	0	100.00
101.00 10100 HOME HEALTH AGENCY	0	0	0	o	0	101. 00
SPECIAL PURPOSE COST CENTERS						
105.00 10500 KIDNEY ACQUISITION	0	0	0	0	0	105. 00
106.00 10600 HEART ACQUISITION	0	0	0	0		106. 00
107.00 10700 LIVER ACQUISITION	0	0	0	0		107. 00
108.00 10800 LUNG ACQUISITION	0	0	0	0		108. 00
109.00 10900 PANCREAS ACQUISITION	0	0	0	0		109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0		110. 00
111. 00 11100 I SLET ACQUI SI TI ON	0	0	0	0		111. 00
113. 00 11300 I NTEREST EXPENSE						113. 00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF						114. 00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	0		115. 00
116. 00 11600 HOSPI CE	2 710 257	1 545 204	0	0		116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	2, 719, 257	1, 545, 394	0	l U	0	118. 00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		0	0	O	0	190. 00
190.00/1900/GIFT, FLOWER, COFFEE SHOP & CANTEEN		0	0	0		190.00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES		0	0	0		191.00
192. 01 19201 CENTER OF HOPE		0	0			192. 00
193. 00 19300 NONPALD WORKERS		0	1 0	ام		193. 00
200.00 Cross Foot Adjustments		0	Ĭ	l		200.00
201.00 Negative Cost Centers	0	0	0	o		201. 00
202.00 TOTAL (sum lines 118 through 201)	2, 719, 257	1, 545, 394	l o	o		202. 00
			'	'		'

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0165

				11	0 12/31/2020	Date/lime Pre 7/29/2021 4:4	
			INTERNS &	RESI DENTS			
	Cost Center Description	NURSING SCHOOL	SERVICES_SALAR	SERVI CES-OTHER	PARAMED ED	Subtotal	
	cost center bescription	NORST NO SCHOOL	Y & FRINGES	PRGM COSTS	PRGM	Subtotal	
		20.00	21. 00	22. 00	23. 00	24. 00	
1 00	GENERAL SERVI CE COST CENTERS					ı	1 00
1. 00 2. 00	OO100 CAP REL COSTS-BLDG & FLXT OO200 CAP REL COSTS-MVBLE EQUIP						1. 00 2. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						5. 00
6.00	00600 MAI NTENANCE & REPAI RS						6. 00
7.00	00700 OPERATION OF PLANT						7.00
8. 00 9. 00	O0800 LAUNDRY & LINEN SERVICE O0900 HOUSEKEEPING						8. 00 9. 00
10.00	01000 DI ETARY						10.00
11. 00	01100 CAFETERI A						11. 00
12. 00	01200 MAINTENANCE OF PERSONNEL						12. 00
13.00	01300 NURSI NG ADMI NI STRATI ON						13.00
14. 00 15. 00	O1400 CENTRAL SERVICES & SUPPLY O1500 PHARMACY						14. 00 15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY						16. 00
17. 00	01700 SOCI AL SERVI CE						17. 00
18. 00	01850 OTHER GEN SERV						18. 00
19.00	01900 NONPHYSI CI AN ANESTHETI STS						19.00
20. 00 21. 00	02000 NURSI NG SCHOOL 02100 I &R SERVI CES-SALARY & FRI NGES APPRVD	0	0				20.00
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRVD			0			22. 00
23. 00	02301 PARAMED ED PRGM				0		23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	0	0		0		
31.00	03100 I NTENSI VE CARE UNI T	0	0		0	4, 678, 200	1
32. 00 33. 00	03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	32. 00 33. 00
34. 00	03400 SURGICAL INTENSIVE CARE UNIT	0	Ö	Ö	0	Ö	34. 00
40.00	04000 SUBPROVI DER - I PF	0	0	0	0	0	40. 00
41. 00	04100 SUBPROVI DER - I RF	0	0	0	0	0	41. 00
43.00	04300 NURSERY	0	0	0	0	0	43.00
44. 00 45. 00	04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY	0		0	0	0	44. 00 45. 00
46. 00	04600 OTHER LONG TERM CARE	0	0		0	1	46. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0		0		
51.00	05100 RECOVERY ROOM	0	0		0	2, 234, 443	1
52. 00 53. 00	05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	0) 	0	0	0 1, 658, 862	52. 00 53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	Ö	0	0	4, 210, 313	
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55. 00
56. 00	05600 RADI OI SOTOPE	0	0	0	0	0	56. 00
57. 00	05700 CT SCAN	0	0	0	0	1, 147, 053	1
58. 00 59. 00	05800 MAGNETI C RESONANCE I MAGING (MRI) 05900 CARDIAC CATHETERIZATION	0	0	0	0	1, 897, 571 4, 061, 424	
60. 00	06000 LABORATORY	0	Ö	0	0	7, 841, 143	
60. 01	06001 BLOOD LABORATORY	0	0	0	0	0	60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY					0	61. 00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63. 00 64. 00	06300 BLOOD STORING, PROCESSING & TRANS. 06400 NTRAVENOUS THERAPY	0	0	0	0	0	63. 00 64. 00
65. 00	06500 RESPIRATORY THERAPY	0	0	0	0	1, 572, 473	1
66. 00	06600 PHYSI CAL THERAPY	0	0	0	0	401, 748	
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	0	0	214, 400	
68. 00	06800 SPEECH PATHOLOGY	0	0	0	0	60, 009	
69. 00 70. 00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	609, 612 2, 683, 417	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	2, 900, 382	
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	Ö	Ö	Ö	11, 992, 782	
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	6, 507, 362	73. 00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	
75. 00 76. 00	O7500 ASC (NON-DISTINCT PART) O3950 OTHER ANCILL SRVC	0	0	0	0	0	75. 00 76. 00
76. 00 76. 01	03951 CARDI AC AND PULMONARY REHAB	0			0	242, 606	
76. 01	03952 WOUND CARE	0		0	O	67, 244	1
	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	
89. 00 90. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC	0	0	0	0	0	89. 00 90. 00
90. 01	09001 CLI NI C	0	Ö	ő	Ö	3, 351, 610	
		*	-		•		·

NURSING SCHOOL SERVICES-SALAR SERVICES-OTHER PARAMED ED Subtotal PROME P
NURSING SCHOOL SERVICES-SALAR SERVICES-OTHER PARAMED ED PRGM PRGM COSTS
Y & FRI NGES PRGM COSTS PRGM
Y & FRINGES PRGM COSTS PRGM
90. 02 09002 CLINIC 0 0 0 0 0 0 0 1,019,962 90. 02 91. 00 09100 EMERGENCY 0 0 0 0 0 5,993,439 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 0 5,993,439 91. 00 94. 00 09400 HOME PROGRAM DIALYSIS 0 0 0 0 0 0 95. 00 09500 AMBULANCE SERVICES 0 0 0 0 0 0 95. 00 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED 0 0 0 0 0 96. 00 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 0 0 0 97. 00 98. 00 09850 OTHER REI MBURSE 0 0 0 0 0 0 98. 00 99. 00 09900 CMHC 0 0 0 0 0 0 99. 00 99. 10 09910 CORF 0 0 0 0 0 0 0 101. 00 10000 L&R SERVICES-NOT APPRVD PRGM 0 0 0 0 0 0 101. 00 10100 HOME HEALTH AGENCY 0 0 0 0 0 105. 00 105. 00 10500 KI DNEY ACQUISITION 0 0 0 0 105. 00 90. 00 0000 10000 KI DNEY ACQUISITION 0 0 0 0 105. 00 90. 00 0000 1000
90. 02 09002 CLINI C 0 0 0 0 0 1, 019, 962 90. 02 91. 00 09100 EMERGENCY 0 0 0 0 0 5, 993, 439 91. 00 92. 00 09200 DESERVATI ON BEDS (NON-DI STI NCT PART) 92. 00 09200 DESERVATI ON BEDS (NON-DI STI NCT PART) 92. 00 00 00 00 00 00 00 00
91. 00
92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 92. 00 OTHER REI MBURSABLE COST CENTERS 94. 00 09400 HOME PROGRAM DI ALYSI S 0 0 0 0 0 0 94. 00 95. 00 09500 AMBULANCE SERVI CES 0 0 0 0 0 0 0 95. 00 95. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 0 0 96. 00 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 0 0 0 0 97. 00 98. 00 09850 OTHER REI MBURSE 0 0 0 0 0 0 0 98. 00 99. 00 09900 CMHC 0 0 0 0 0 0 0 99. 00 99. 10 09910 CORF 0 0 0 0 0 0 0 0 99. 10 100. 00 100. 00 100. 00 18R SERVI CES-NOT APPRVD PRGM 0 0 0 0 0 0 101. 00 101. 00 10100 HOME HEALTH AGENCY 0 0 0 0 0 105. 00
94. 00
94. 00
95. 00
96. 00
97. 00
98. 00
99. 00
99. 10 09910 CORF 0 0 0 0 0 99. 10 100. 00 18R SERVI CES-NOT APPRVD PRGM 0 0 0 0 0 0 100. 00 101. 00
100. 00 10000 &R SERVI CES-NOT APPRVD PRGM
101.00 10100 HOME HEALTH AGENCY 0 0 0 0 101.00
SPECIAL PURPOSE COST CENTERS 105.00 10500 KI DNEY ACQUI SI TI ON O O O 0 105.00
105.00 10500 KI DNEY ACQUISITION 0 0 0 0 105.00
107. 00 10700 LI VER ACQUI SI TI ON 0 0 0 0 10107. 00
108. 00 10800 LUNG ACQUI SI TI ON 0 0 0 0 10108. 00
109. 00 10900 PANCREAS ACQUISITION 0 0 0 10109. 00
110. 00 11000 NTESTI NAL ACQUI SI TI ON 0 0 0 0 1110. 00
111.00 11100 ISLET ACQUISITION
113.00 11300 INTEREST EXPENSE
114. 00 11400 UTI LI ZATI ON REVI EW-SNF
115. 00 11500 AMBULATORY SURGI CAL CENTER (D. P.) 0 0 0 0 0 0 0 115. 00
116. 00 11600 HOSPI CE 0 0 0 0 1116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) 0 0 0 95,720,896[118.00
NONREI MBURSABLE COST CENTERS
190. 00 19000 G FT, FLOWER, COFFEE SHOP & CANTEEN O O O 109. 638 190. 00
191.0019100 RESEARCH 0 0 0 0 0 0 191.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 0 0 6, 290, 670 192.00
192. 01 19201 CENTER OF HOPE 0 0 0 6, 523 192. 01
193. 00 19300 NONPAI D WORKERS 0 0 0 0 0 193. 00
200. 00 Cross Foot Adjustments 0 0 0 0 0 200. 00
201.00 Negative Cost Centers 0 0 0 0 0 201.00
202.00 TOTAL (sum lines 118 through 201) 0 0 0 102,127,727 202.00

In Lieu of Form CMS-2552-10 Health Financial Systems FRANCISCAN HEALTH MUNSTER

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0165 Peri od: Worksheet B From 01/01/2020 Part I Date/Time Prepared: 12/31/2020 7/29/2021 4:40 pm Cost Center Description Intern & Total Residents Cost & Post Stepdown Adjustments 25.00 26.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 00600 MAINTENANCE & REPAIRS 6.00 6.00 00700 OPERATION OF PLANT 7.00 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10 00 10 00 01100 CAFETERI A 11.00 11.00 12. 00 01200 MAINTENANCE OF PERSONNEL 12.00 13.00 01300 NURSING ADMINISTRATION 13.00 01400 CENTRAL SERVICES & SUPPLY 14 00 14 00 15. 00 01500 PHARMACY 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16.00 17. 00 01700 SOCIAL SERVICE 17 00 01850 OTHER GEN SERV 18.00 18.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 19.00 20.00 02000 NURSING SCHOOL 20.00 02100 I &R SERVICES-SALARY & FRINGES APPRVD 21 00 21 00 22.00 02200 I &R SERVICES-OTHER PRGM COSTS APPRVD 22.00 02301 PARAMED ED PRGM 23.00 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 20, 683, 893 30.00 31.00 03100 INTENSIVE CARE UNIT 4, 678, 200 31.00 0000000 03200 CORONARY CARE UNIT 32.00 32.00 03300 BURN INTENSIVE CARE UNIT 33.00 0 33.00 03400 SURGICAL INTENSIVE CARE UNIT 34.00 0 34 00 40.00 04000 SUBPROVIDER - IPF 0 40.00 04100 SUBPROVI DER - I RF 41.00 0 41.00 43.00 04300 NURSERY 0 43.00 04400 SKILLED NURSING FACILITY 44.00 Ω 44 00 0 04500 NURSING FACILITY 45.00 45.00 04600 OTHER LONG TERM CARE 0 46.00 46.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 9, 690, 948 50.00 51.00 05100 RECOVERY ROOM 0 2, 234, 443 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 53.00 05300 ANESTHESI OLOGY 53.00 1, 658, 862 54.00 05400 RADI OLOGY-DI AGNOSTI C 00000000 4, 210, 313 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 55.00 56.00 05600 RADI OI SOTOPE 56.00 57.00 05700 CT SCAN 1, 147, 053 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 1, 897, 571 58.00 05900 CARDI AC CATHETERI ZATI ON 59.00 4, 061, 424 59.00 06000 LABORATORY 60.00 7, 841, 143 60 00 60.01 06001 BLOOD LABORATORY Ω 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 0 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 62.00 00000000000000000 62.00 0 63.00 06300 BLOOD STORING, PROCESSING & TRANS. Λ 63.00 64.00 06400 I NTRAVENOUS THERAPY 64.00 06500 RESPIRATORY THERAPY 65.00 1, 572, 473 65.00 66 00 06600 PHYSI CAL THERAPY 401 748 66 00 06700 OCCUPATIONAL THERAPY 67.00 214, 400 67.00 06800 SPEECH PATHOLOGY 60,009 68.00 69.00 06900 ELECTROCARDI OLOGY 609, 612 69.00 70 00 07000 ELECTROENCEPHALOGRAPHY 2, 683, 417 70 00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 2, 900, 382 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 11, 992, 782 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 6, 507, 362 73.00 74.00 07400 RENAL DIALYSIS Ω 74.00 75.00 07500 ASC (NON-DISTINCT PART) 0 75.00 03950 OTHER ANCILL SRVC 76.00 76.00 76.01 03951 CARDIAC AND PULMONARY REHAB 242, 606 76.01 76.02 03952 WOUND CARE 0 67, 244 76.02 07700 ALLOGENEIC STEM CELL ACQUISITION 77.00 77.00 OUTPATIENT SERVICE COST CENTERS 88 00 0 88.00

Ω

0

89.00

90.00

0

90. 00 09000 CLINIC

108800 RURAL HEALTH CLINIC

89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER

			To 12/31/2020 Pate/Time Pr 7/29/2021 4:	epared:
Cost Center Description	Intern &	Total	7/29/2021 4.	40 pili
oust contain bescription	Residents Cost	rotar		
	& Post			
	Stepdown			
	Adjustments			
	25. 00	26.00		
90. 01 09001 CLI NI C	0	3, 351, 610	•	90. 01
90. 02 09002 CLI NI C	0	1, 019, 962	•	90. 02
91. 00 09100 EMERGENCY	0	5, 993, 439		91. 00
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART)	0			92. 00
OTHER REIMBURSABLE COST CENTERS	1		I	٠
94. 00 09400 HOME PROGRAM DIALYSIS	0	0	l .	94.00
95. 00 09500 AMBULANCE SERVICES	0	0		95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0		97. 00
98. 00 09850 OTHER REI MBURSE 99. 00 09900 CMHC	0	0		98. 00 99. 00
99. 10 09900 CMHC 99. 10 09910 CORF	0	0		99. 00
100.00 10000 &R SERVI CES-NOT APPRVD PRGM	0	0		100.00
101. 00 10100 HOME HEALTH AGENCY	0	0		100.00
SPECIAL PURPOSE COST CENTERS	U	U		101.00
105. 00 10500 KI DNEY ACQUI SI TI ON	O	0		105. 00
106. 00 10600 HEART ACQUI SI TI ON		0	•	106. 00
107. 00 10700 LI VER ACQUI SI TI ON	0	0		107. 00
108. 00 10800 LUNG ACQUISITION	o	0		108. 00
109. 00 10900 PANCREAS ACQUISITION	o	0		109. 00
110.00 11000 INTESTINAL ACQUISITION	O	0		110.00
111.00 11100 I SLET ACQUI SITION	o	0		111. 00
113.00 11300 INTEREST EXPENSE				113. 00
114.00 11400 UTILIZATION REVIEW-SNF				114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0		115. 00
116. 00 11600 HOSPI CE	0	0		116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	95, 720, 896		118. 00
NONREI MBURSABLE COST CENTERS				
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	109, 638	1	190.00
191. 00 19100 RESEARCH	0	0		191. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0	6, 290, 670	•	192.00
192. 01 19201 CENTER OF HOPE	0	6, 523		192. 01
193. 00 19300 NONPAI D WORKERS	0	0		193. 00 200. 00
200.00 Cross Foot Adjustments 201.00 Negative Cost Centers		0		200.00
201.00 Negative Cost Centers 202.00 TOTAL (sum lines 118 through 201)		102, 127, 727		201.00
202.00 TOTAL (Suill Titles 110 through 201)	١	102, 121, 121	I	J202. 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: | To 12/31/2020 | Prepared: | Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0165

Cost Center Description					lo	12/31/2020	Date/lime Pre 7/29/2021 4:4	
Assigned Nove County Cou				CAPI TAL REI	LATED COSTS			
THE PRICE STRENG COST CHAPTES 1.00 2.0		Cost Center Description	Assigned New Capital	BLDG & FIXT	MVBLE EQUIP	Subtotal	BENEFI TS	
1.00 001000 CAP MEL COSIS-SELIS & FITX				1. 00	2.00	2A	4. 00	
2.00								
B.O.D. 0.0800 LANDRY & LINEN SERVICE 0	2. 00 4. 00 5. 00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	1				31, 964	2. 00 4. 00 5. 00
12 00 0 10200 MAINTENNANCE OF PERSONNÉE. 0 0 0 0 0 0 0 12 00 14 00 14 00 14 00 0 0 0 0 0 0 0 0 0	8. 00 9. 00 10. 00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY	0 0 0	0 0 0 446, 210	0 0 0 0	0 0 0 446, 210	0 2, 333 750	8. 00 9. 00 10. 00
16.00 0 10400 MEDICAL RECORDS & LIBRARY 0 0 8, 156 0 0 0 0 0 0 0 0 0 17.00 0 1700 0 1700 SOCIAL SERVICE 0 0 0 0 0 0 0 0 0 18.00 18.00 18.00 0 18.00 0 18.00 0 18.00 0 18.00 0 18.00 0 18.00 0 18.00 0 18.00 0 18.00 0 18.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	12. 00 13. 00 14. 00	01200 MAI NTENANCE OF PERSONNEL 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	0 0	0 0 0 0 173, 318	0 0	0 0 0 0 173, 318	0 5, 307 553	12. 00 13. 00 14. 00
11 00 02100 RR SERVI CES-SALRAY & FRINCES APPRUD 0 0 0 0 0 22.00 0220 RR SERVI CES-SOHER PREMO COSTS APPRUD 0 0 0 0 0 0 22.00 0220 PARAMED ED PROM 0 0 0 0 0 0 0 0 0	16. 00 17. 00 18. 00 19. 00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 01850 OTHER GEN SERV 01900 NONPHYSICIAN ANESTHETISTS	0 0		1		822 0 0 0	16. 00 17. 00 18. 00 19. 00
30 00 030000 ADULTS & PEDIATRICS 0 2,174,237 0 2,174,237 24,432 30,00 32,00 03200 03200 03700 03700 0320	21. 00 22. 00	02100 &R SERVICES-SALARY & FRINGES APPRVD 02200 &R SERVICES-OTHER PRGM COSTS APPRVD 02301 PARAMED ED PRGM	1	0 0 0	0 0 0	0 0 0 0	0	21. 00 22. 00
32. 00 03200 CORONARY CARE UNIT 0 0 0 0 0 0 32. 00 33. 00 03300 DURN INTERSIVE CARE UNIT 0 0 0 0 0 0 0 33. 00 34. 00 03400 SURRI CAL INTERSIVE CARE UNIT 0 0 0 0 0 0 0 0 34. 00 44. 00 04400 SUSPROVIDER - IPF 0 0 0 0 0 0 0 0 0 41. 00 44. 00 04400 SUSPROVIDER - IPF 0 0 0 0 0 0 0 0 0 41. 00 44. 00 04400 SURIS LED NUSSING FACILITY 0 0 0 0 0 0 0 0 44. 00 45. 00 04400 NURSING FACILITY 0 0 0 0 0 0 0 0 44. 00 46. 00 04400 NURSING FACILITY 0 0 0 0 0 0 0 0 44. 00 46. 00 04400 NURSING FACILITY 0 0 0 0 0 0 0 0 45. 00 46. 00 04400 NURSING FACILITY 0 0 0 0 0 0 0 0 45. 00 46. 00 04400 NURSING FACILITY 0 0 0 0 0 0 0 0 0 45. 00 46. 00 04400 NURSING FACILITY 0 0 0 0 0 0 0 0 45. 00 46. 00 04400 NURSING FACILITY 0 0 0 0 0 0 0 0 45. 00 46. 00 04400 OTHER LONG TERN CARE 0 0 0 0 0 0 0 45. 00 46. 00 04400 OTHER LONG TERN CARE 0 0 0 0 0 0 0 0 0 45. 00 46. 00 04400 OTHER LONG TERN CARE 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		03000 ADULTS & PEDIATRICS	1					1
33.00 03300 038000 038000 03800 038000 03800 038000 03800 03800 03800			1	523, 920		523, 920		•
33.0 0 03400 SURRICAL INTENSIVE CARE UNIT 0 0 0 0 0 0 0 34.00 41.00 04100 SUBPROVIDER - 1 FF 0 0 0 0 0 0 0 0 40.00 41.00 04100 SUBPROVIDER - 1 FF 0 0 0 0 0 0 0 0 43.00 43.00 04300 NURSERY 0 0 0 0 0 0 0 0 43.00 44.00 04400 SKI LED NURSI NG FACI LITY 0 0 0 0 0 0 0 0 44.00 46.00 04400 SKI LED NURSI NG FACI LITY 0 0 0 0 0 0 0 0 45.00 46.00 04500 NURSI NG FACI LITY 0 0 0 0 0 0 0 0 0 45.00 46.00 04500 NURSI NG FACI LITY 0 0 0 0 0 0 0 0 0 45.00 46.00 04500 NURSI NG FACI LITY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	0	0	0		
40.00 0.0000 0.0000 0.0000 0			0	0	0	0		
11.00 04100 SUBPROVIDER - I RF			0	0	Ö	Ö		•
43. 00 04300 NURSERY 40. 00 440.00 SAILLED NURSING FACILITY 50 0 0 0 0 0 0 0 0 0 0 44. 00 45. 00 04500 OR OSTORING TERRI CARE 51. 00 0500 OR TERRI CARE 52. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	0	ō	0		•
45.00 04500 NURSI NG FACILITY			0	0	0	0	0	•
46. 00 04600 O16PR CARRE O O O O O O O O O	44.00	04400 SKILLED NURSING FACILITY	0	0	0	0	0	44. 00
ANCILLARY SERVICE COST CENTERS	45.00	04500 NURSING FACILITY	0	0	0	0	0	45. 00
50.00 0500	46. 00		0	0	0	0	0	46. 00
51.00 05100 RECOVERY ROOM LABOR ROOM O C C C C C C C C C			ام	004 700		004 700	44.05/	
S2.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 0 0 52.00			0					
53.00 05300 AMESTHESI OLOGY 0 0 0 0 95 53.00			0	432, 899	0	432, 899		
54.00 05400 RADI OLOGY-THERAPEUTI C 0 458, 784 0 458, 784 0 5.237 54. 00 55. 00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 0 0 0 0 0 0			0	0	0	0		•
55. 00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 0 0 0 55. 00			0	458 784		458 784		
56. 00 05600 RADI OI SOTOPE 0 0 0 0 0 56. 00			0	430, 704		430, 704		1
57. 00 05700 CT SCAN 0 0 0 0 0 0 1, 420 57. 00		· ·	O	0	Ö	Ö		•
59,00 05900 CARDI AC CATHETERI ZATI ON 0 932, 011 0 932, 011 2, 958 59, 00			0	0	o	O	1, 420	
60. 00 06000 LABORATORY 0 160, 178 0 160, 178 0 60. 00	58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	o	0	2, 696	58. 00
60. 01 06001 BLOOD LABORATORY 0 0 0 0 0 0 60. 01 61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 0 0 0 0 61. 00 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 0 0 0 63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 0 0 0 64. 00 06400 INTRAVENOUS THERAPY 0 0 0 0 0 0 65. 00 06500 RESPIRATORY THERAPY 0 79, 806 0 79, 806 2, 563 66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 0 67. 00 06600 PHYSI CAL THERAPY 0 0 0 0 0 68. 00 06600 SPEECH PATHOLOGY 0 0 0 0 69. 00 06800 SPEECH PATHOLOGY 0 0 0 0 69. 00 06900 ELECTROCARDIOLOGY 0 0 0 0 69. 00 07000 ELECTROCARDIOLOGY 0 407, 298 1, 248 70. 00 67. 00 07000 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 67. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 67. 00 07400 RENAL DI ALYSI S 0 0 0 0 0 67. 00 07500 ASC (NON-DI STINCT PART) 0 0 0 0 0 67. 00 03950 OTHER ANCILL SRVC 0 0 0 0 0 67. 00 03950 OTHER ANCILL SRVC 0 0 0 0 0 67. 00 03950 OTHER ANCILL SRVC 0 0 0 0 0 67. 00 0000 LIPLL DEV CHARGED TO PATIENTS 0 0 0 0 67. 00 0000 LIPLL DEV CHARGED TO PATIENTS 0 0 0 0 67. 00 07500 ASC (NON-DI STINCT PART) 0 0 0 0 0 67. 00 07500 ASC (NON-DI STINCT PART) 0 0 0 0 0 67. 00 07500 ALLOGENEI C STEM CELL ACQUI SI TI ON 0 0 0 0 67. 00 07500 ALLOGENEI C STEM CELL ACQUI SI TI ON 0 0 0 0 68. 00 00 0 0 0 0 0 69. 00 00 0 0 0 0 0 60. 00 00 0 0 0 0 60. 00 00 0 0 0 0 0 60. 00 00 00 0 0 0 0 60. 00 00 0 0 0 0 0 60. 00 00 00 0 0 0 0 60. 00 00 00 0 0 0 0 60. 00 00 00 0 0 0 0 60. 00 00 0 0 0 0 0 0 60. 00 00 0 0 0 0 0 60. 00 00 0 0 0 0 0 0 60. 00 0	59. 00	05900 CARDI AC CATHETERI ZATI ON	0	932, 011	0	932, 011	2, 958	59. 00
61. 00		1	0	160, 178	0	160, 178		1
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 0 0 0 62. 00 63. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 0 0 0 0 0 0 0 64. 00 06400 INTRAVENOUS THERAPY 0 0 0 0 0 0 65. 00 06500 RESPI RATORY THERAPY 0 79, 806 0 79, 806 2, 563 65. 00 66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 0 0 67. 00 06700 OCCUPATI ONAL THERAPY 0 0 0 0 0 395 67. 00 68. 00 06800 SPEECH PATHOLOGY 0 0 0 0 395 67. 00 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 1, 074 69. 00 70. 00 07000 ELECTROENCEPHALOGRAPHY 0 407, 298 0 407, 298 1, 248 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 0 74. 00 07400 RENAL DI ALYSI S 0 0 0 0 0 0 75. 00 07500 ASC (NON-DISTI NCT PART) 0 0 0 0 0 0 76. 00 03950 OTHER ANCI LL SRVC 0 0 0 0 0 76. 01 03951 CARDI AC AND PULMONARY REHAB 0 0 0 0 0 76. 02 03952 WOUND CARE 0 0 0 0 0 77. 00 000 TURAL HEALTH CLINIC 0 0 0 0 0 88. 00			0	0	0	0	0	1
63. 00		i i				0		1
64. 00 06400 INTRAVENOUS THERAPY 0 0 0 0 0 0 64. 00 65. 00 06500 RESPI RATORY THERAPY 0 79, 806 0 79, 806 2, 563 65. 00 66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 0 0 67. 00 06700 OCCUPATI ONAL THERAPY 0 0 0 0 0 395 67. 00 06800 SPEECH PATHOLOGY 0 0 0 0 395 68. 00 06800 SPEECH PATHOLOGY 0 0 0 0 0 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 70. 00 07000 ELECTROCARDI OLOGY 0 407, 298 0 407, 298 1, 248 70. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 0 0 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 74. 00 07400 RENAL DI ALYSI S 0 0 0 0 0 75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 76. 00 03950 OTHER ANCI LL SRVC 0 0 0 0 0 76. 01 03951 CARDI AC AND PULMONARY REHAB 0 0 0 0 0 76. 02 03952 WOUND CARE 0 0 0 0 0 77. 00 0000 RURAL HEALTH CLINIC 0 0 0 0 80. 64. 00 0 0 0 0 80. 64. 00 0 0 0 0 80. 65. 00 0 0 0 0 80. 65. 00 0 0 0 80. 64. 00 0 0 0 80. 65. 00 0 0 0 80. 65. 00 0 0 0 80. 65. 00 0 0 0 80. 65. 00 0 0 80. 65. 00 0 0 0 80. 65. 00 0 0 80. 65. 00 0 0 0 80. 65. 00 0 0 80. 65. 00 0 0 80. 65. 00 0 0 80. 65. 00 0 0 80. 65. 00 0 0 80. 65. 00 0 0 80. 65. 00 0 0 80. 67. 00 0 0 0 80. 65. 00 0 0 80. 67. 00 0 0 80. 67. 00 0 0 0 80. 68. 00 0 0 80. 68. 00 0 0 0 80. 68. 00 0 0 0 80. 69. 00 0 0 0 80. 69. 00 0 0 0 80. 69. 00 0 0 0 80. 69. 00 0 0 0 80. 69. 00 0 0 0 80. 69. 00 0 0 0 80. 69. 00 0 0 0 80. 69. 00 0 0 0 80. 69. 00 0 0 0 80. 69. 00 0 0 0 80. 69. 00 0 0 0 80. 69. 00 0 0 0 80. 69. 00 0 0 0			0	0	0	0		1
65. 00 06500 RESPI RATORY THERAPY 0 79, 806 0 79, 806 2, 563 65. 00 660. 00 06600 PHYSI CAL THERAPY 0 0 0 0 0 0 687 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 0 0 0 0 0 0 395 67. 00 68. 00 06800 SPEECH PATHOLOGY 0 0 0 0 0 0 0 80 68. 00 69. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	0	0	0		•
66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 0 687 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 0 395 67. 00 68. 00 06800 SPEECH PATHOLOGY 0 0 0 0 0 80 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 1,074 69. 00 70. 00 07000 ELECTROENCEPHALOGRAPHY 0 407, 298 0 407, 298 1, 248 70. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 0 0 0 72. 00 07200 IMPL DEV. CHARGED TO PATI ENTS 0 0 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 0 74. 00 07400 RENAL DI ALYSI S 0 0 0 0 0 75. 00 07500 ASC (NON-DI STI NCT PART) 0 0 0 0 0 76. 00 03950 OTHER ANCI LL SRVC 0 0 0 0 0 76. 01 03951 CARDI AC AND PULMONARY REHAB 0 0 0 0 0 76. 02 03952 WOUND CARE 0 0 0 0 0 77. 00 000TATH IENT SERVI CE COST CENTERS 88. 00 08800 RURAL HEALTH CLI NI C 0 0 0 0 0 880 RURAL HEALTH CLI NI C			0	79 806		79 806		
67. 00 06700 OCCUPATI ONAL THERAPY 0 0 0 0 0 395 67. 00 68. 00 06800 SPEECH PATHOLOGY 0 0 0 0 0 80 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 1, 074 69. 00 07000 ELECTROCARDI OLOGY 0 0 0 0 0 0 1, 074 69. 00 07000 ELECTROENCEPHALOGRAPHY 0 407, 298 0 407, 298 1, 248 70. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 0 0 0 0 72. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 0 0 0 73. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 0 0 73. 00 74. 00 07400 RENAL DI ALYSI S 0 0 0 0 0 0 0 0 74. 00 75. 00 07500 ASC (NON-DI STI NCT PART) 0 0 0 0 0 0 0 0 0 75. 00 76. 00 03950 OTHER ANCI LL SRVC 0 0 0 0 0 0 0 0 0 76. 00 76. 00 76. 01 03951 CARDI AC AND PULMONARY REHAB 0 0 0 0 0 0 0 0 111 76. 02 03952 WOUND CARE 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	77,000	Ö	77,000		
69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0 1,074 69. 00 70. 00			0	0	Ō	0		
70. 00 07000 ELECTROENCEPHALOGRAPHY 0 407, 298 0 407, 298 1, 248 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 73. 00 74. 00 07400 RENAL DI ALYSIS 0 0 0 0 0 0 74. 00 75. 00 07500 ASC (NON-DI STINCT PART) 0 0 0 0 0 0 75. 00 76. 00 03950 OTHER ANCILL SRVC 0 0 0 0 0 0 76. 00 76. 01 03951 CARDI AC AND PULMONARY REHAB 0 0 0 0 0 0 111 76. 01 77. 02 0770			0	0	0	0	80	
71. 00	69. 00	06900 ELECTROCARDI OLOGY	0	0	0	0	1, 074	69. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 73. 00 74. 00 07400 RENAL DIALYSIS 0 0 0 0 0 0 74. 00 75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 0 75. 00 76. 00 03950 OTHER ANCILL SRVC 0 0 0 0 0 0 76. 00 76. 01 03951 CARDI AC AND PULMONARY REHAB 0 0 0 0 464 76. 01 76. 02 03952 WOUND CARE 0 0 0 0 0 111 76. 02 77. 00 07700 ALLOGENEI C STEM CELL ACQUISITION 0 0 0 0 0 0 0 88. 00 08800 RURAL HEALTH CLINIC 0 0 0 0 0 0 0			0	407, 298	0	407, 298		
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 73. 00 74. 00 07400 RENAL DI ALYSIS 0 0 0 0 0 74. 00 75. 00 07500 ASC (NON-DI STINCT PART) 0 0 0 0 0 0 75. 00 76. 00 03950 OTHER ANCI LL SRVC 0 0 0 0 0 0 76. 01 03951 CARDI AC AND PULMONARY REHAB 0 0 0 0 0 76. 02 03952 WOUND CARE 0 0 0 0 0 111 76. 02 77. 00 07700 ALLOGENEI C STEM CELL ACQUI SITION 0 0 0 0 0 0UTPATI ENT SERVI CE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC 0 0 0 0 0 88. 00			0	0	0	0		1
74. 00 07400 RENAL DI ALYSI S 0 0 0 0 0 0 74. 00 75. 00 07500 ASC (NON-DI STI NCT PART) 0 0 0 0 0 0 75. 00 76. 00 03950 OTHER ANCI LL SRVC 0 0 0 0 0 0 76. 00 76. 01 03951 CARDI AC AND PULMONARY REHAB 0 0 0 0 0 0 464 76. 01 76. 02 03952 WOUND CARE 0 0 0 0 0 111 76. 02 77. 00 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON 0 0 0 0 0 0 0 77. 00 0UTPATI ENT SERVI CE COST CENTERS 88. 00 08800 RURAL HEALTH CLI NI C 0 0 0 0 0 0 88. 00			0	0	0	0		1
75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 75. 00 76. 00 03950 OTHER ANCILL SRVC 0 0 0 0 0 76. 00 76. 01 03951 CARDI AC AND PULMONARY REHAB 0 0 0 0 0 76. 02 03952 WOUND CARE 0 0 0 0 0 77. 00 07700 ALLOGENEI C STEM CELL ACQUI SITION 0 0 0 0 0 0UTPATI ENT SERVI CE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC 0 0 0 0 0 88. 00			0	0	0	0		•
76. 00			0	0	0	0		•
76. 01 03951 CARDI AC AND PULMONARY REHAB 0 0 0 0 0 464 76. 01 76. 02 03952 WOUND CARE 0 0 0 0 0 111 76. 02 77. 00 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON 0 0 0 0 0 0 77. 00 0UTPATI ENT SERVI CE COST CENTERS 88. 00 08800 RURAL HEALTH CLINI C 0 0 0 0 0 0 88. 00			0	0	Ö	0		•
76. 02 03952 WOUND CARE 0 0 0 0 111 76. 02 77. 00 07700 ALLOGENEI C STEM CELL ACQUISITION 0 0 0 0 0 77. 00 OUTPATIENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC 0 0 0 0 0 0 88. 00				Ö	o	o		•
OUTPATI ENT SERVI CE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC 0 0 0 0 0 88.00		03952 WOUND CARE	0	0	0	o		•
88. 00 08800 RURAL HEALTH CLINIC 0 0 0 88. 00	77. 00		0	0	0	0	0	77. 00
89. 00 UNYUU FEDEKALLY QUALIFIED HEALIH CENIEK 0 0 0 0 89. 00			1					
	89.00	U89UU FEDERALLY QUALIFIED HEALIH CENIER	l O	0	η Ο <u>Ι</u>	이	0	89.00

In Lieu of Form CMS-2552-10
Period: Worksheet B
From 01/01/2020 Part II Provider CCN: 15-0165

			Ť	0 12/31/2020	Date/Time Pre 7/29/2021 4:4	
		CAPI TAL REI	ATED COSTS		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	, p
Cost Center Description	Directly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
· ·	Assigned New				BENEFI TS	
	Capi tal				DEPARTMENT	
	Related Costs	1. 00	2.00	2A	4. 00	
90. 00 09000 CLI NI C	0	1.00			4.00	90.00
90. 01 09001 CLI NI C	l o	0	l o		6, 026	
90. 02 09002 CLI NI C	O	68, 364	0	68, 364	863	90. 02
91. 00 09100 EMERGENCY	0	560, 736	0	560, 736	5, 676	91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)				0		92. 00
OTHER REIMBURSABLE COST CENTERS						04.00
94. 00 09400 HOME PROGRAM DI ALYSI S 95. 00 09500 AMBULANCE SERVI CES	0	0	0		0	94. 00 95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0		0	0	97.00
98. 00 09850 OTHER REIMBURSE	0	0	0	Ö	0	98. 00
99. 00 09900 CMHC	0	0	Ö	o	0	99. 00
99. 10 09910 CORF	0	0	0	o	0	99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0		100. 00
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00
SPECIAL PURPOSE COST CENTERS	0				0	105 00
105. 00 10500 KIDNEY ACQUISITION 106. 00 10600 HEART ACQUISITION	0	0	0			105. 00 106. 00
107. 00 10700 LIVER ACQUISITION		0	0	0		107. 00
108. 00 10800 LUNG ACQUISITION	0	0	0	0		107.00
109. 00 10900 PANCREAS ACQUISITION	l o	0	Ö	o o		109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	O		110.00
111.00 11100 ISLET ACQUISITION	0	0	0	o	0	111. 00
113.00 11300 INTEREST EXPENSE						113. 00
114.00 11400 UTILIZATION REVIEW-SNF						114. 00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0			115.00
116.00 11600 HOSPICE 118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	0 8, 783, 613	0			116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	l ol	8, 783, 013		8, 783, 013	123, 290	1118.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	O	143	190. 00
191. 00 19100 RESEARCH	0	0	Ö	_		191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	o	1, 332, 795	0	1, 332, 795	5, 763	192. 00
192. 01 19201 CENTER OF HOPE	0	0	0	0		192. 01
193. 00 19300 NONPALD WORKERS	0	0	0	0	0	193. 00
200.00 Cross Foot Adjustments				0		200. 00
201.00 Negative Cost Centers		0	0	-		201. 00
202.00 TOTAL (sum lines 118 through 201)	0	10, 116, 408	0	10, 116, 408	129, 196	J202. 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 4:40 pm

		1				7/29/2021 4: 4	
	Cost Center Description	ADMI NI STRATI VE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	
		5. 00	6. 00	7. 00	8. 00	9. 00	
1. 00	GENERAL SERVICE COST CENTERS O0100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	1, 273, 682					5. 00
6.00	00600 MAI NTENANCE & REPAI RS	96, 675	98, 662				6.00
7. 00 8. 00	OO7OO OPERATION OF PLANT OO8OO LAUNDRY & LINEN SERVICE	3, 170	0	0	3, 170		7. 00 8. 00
9. 00	00900 HOUSEKEEPI NG	17, 626	0	0	0, 170	19, 959	9. 00
10.00	01000 DI ETARY	12, 802	5, 034	0	0	1, 018	
11. 00	01100 CAFETERI A	0	0	0	0	0	11. 00
12.00	01200 MAI NTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13. 00 14. 00	O1300 NURSI NG ADMI NI STRATI ON O1400 CENTRAL SERVI CES & SUPPLY	37, 704 4, 899	0	0	0	0	13. 00 14. 00
15. 00	01500 PHARMACY	31, 774	1, 955	0	0	396	15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	19, 239	92	0	0	19	16. 00
17. 00	01700 SOCIAL SERVICE	0	0	0	0	0	17. 00
18.00	01850 OTHER GEN SERV	0	0	0	0	0	18. 00
20. 00	01900 NONPHYSI CI AN ANESTHETI STS 02000 NURSI NG SCHOOL	0	0	0	0	0	19. 00 20. 00
21. 00	02100 I &R SERVI CES-SALARY & FRI NGES APPRVD		0	0	0	0	21. 00
22. 00	02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22. 00
23. 00	02301 PARAMED ED PRGM	0	0	0	0	0	23. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	189, 260	24 520	0	2 727	4.040	20.00
30. 00 31. 00	03000 ADULTS & PEDI ATRI CS 03100 I NTENSI VE CARE UNI T	42, 432	24, 529 5, 911) 0	2, 737 433	4, 960 1, 196	30. 00 31. 00
32. 00	03200 CORONARY CARE UNIT	0	0, , 11	Ö	0	0	32. 00
33. 00	03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	33. 00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34. 00
40. 00 41. 00	04000 SUBPROVI DER - I PF	0	0	0	0	0	40.00
41.00	04100 SUBPROVI DER - RF 04300 NURSERY	0	0] 0	0	0	41. 00 43. 00
44. 00	04400 SKILLED NURSING FACILITY	0	0	Ö	Ö	Ö	44. 00
45.00	04500 NURSING FACILITY	0	0	0	0	0	45. 00
46. 00	04600 OTHER LONG TERM CARE	0	0	0	0	0	46. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	98, 509	11, 132	0	0	2, 252	50. 00
51. 00	05100 RECOVERY ROOM	22, 042	4, 884	0	0	988	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52. 00
53. 00	05300 ANESTHESI OLOGY	20, 137	0	0	0	0	53. 00
54. 00 55. 00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	45, 543	5, 176	0	0	1, 047 0	54. 00 55. 00
56. 00	05600 RADI OLOGI - ITIERAF LUTT C	0	0	0	0	0	56.00
57. 00	05700 CT SCAN	12, 757	0	0	0	0	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	22, 788	0	0	0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	36, 066	10, 514	0	0	2, 127	59. 00
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	93, 792	1, 807 0))	0	366 0	•
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0		J		61. 00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62. 00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64. 00 65. 00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	18, 451	900	0	0	0 182	64. 00 65. 00
66. 00	06600 PHYSI CAL THERAPY	4, 952	900		0	0	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	2, 631	0	Ö	0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	736	0	0	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	7, 031	0	0	0	0	69. 00
	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	28, 081 30, 575	4, 595	0	0	930 0	70. 00 71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS	149, 017	0	0	0	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	46, 433	0	0	0	0	73. 00
	07400 RENAL DIALYSIS	0	0	0	0	0	74. 00
	07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75. 00
76. 00 76. 01	03950 OTHER ANCILL SRVC 03951 CARDIAC AND PULMONARY REHAB	3, 019	0	0	0	0	76. 00 76. 01
	03952 WOUND CARE	835	0		0	0	76. 01
	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77. 00
00	OUTPATIENT SERVICE COST CENTERS						00.5-
	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	88.00
	09000 CLINIC			n o	0	0	89. 00 90. 00
90. 01	09001 CLI NI C	39, 351	Ö	Ö	0	0	90. 01
90. 02	09002 CLI NI C	10, 567	771	0	0	156	90. 02
91. 00	09100 EMERGENCY	62, 007	6, 326	1 0	0	1, 280	91. 00

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

			1	0 12/31/2020	7/29/2021 4:4	
Cost Center Description	ADMI NI STRATI VE	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
	& GENERAL	REPAI RS	PLANT	LINEN SERVICE		
	5. 00	6. 00	7. 00	8. 00	9. 00	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						1
94.00 09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
95. 00 09500 AMBULANCE SERVICES	0	0	0	0	0	95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97. 00
98. 00 09850 OTHER REI MBURSE	0	0	0	0	0	98. 00
99. 00 09900 CMHC	0	0	0	0	0	99. 00
99. 10 09910 CORF	0	0	0	0	0	99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00
SPECIAL PURPOSE COST CENTERS						
105.00 10500 KIDNEY ACQUISITION	0	0	0	0	0	105. 00
106. 00 10600 HEART ACQUI SI TI ON	0	0	0	0	0	106. 00
107.00 10700 LIVER ACQUISITION	0	0	0	0	0	107. 00
108.00 10800 LUNG ACQUISITION	0	0	0	0	0	108. 00
109.00 10900 PANCREAS ACQUISITION	0	0	0	0	0	109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0	0	110. 00
111.00 11100 I SLET ACQUI SI TI ON	0	0	0	0	0	111. 00
113.00 11300 INTEREST EXPENSE						113. 00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	0	0	115. 00
116. 00 11600 HOSPI CE	0	0	0	0	0	116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	1, 210, 901	83, 626	0	3, 170	16, 917	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1, 372	0	0	0	0	190. 00
191. 00 19100 RESEARCH	0	0	0	0		191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	61, 327	15, 036	0	0	3, 042	192. 00
192.01 19201 CENTER OF HOPE	82	0	0	0	0	192. 01
193. 00 19300 NONPALD WORKERS	0	0	0	0	0	193. 00
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	0	0	0		201. 00
202.00 TOTAL (sum lines 118 through 201)	1, 273, 682	98, 662	0	3, 170	19, 959	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 4:40 pm

					0 12/31/2020	7/29/2021 4:4	
	Cost Center Description	DI ETARY	CAFETERI A	MAINTENANCE OF PERSONNEL	NURSI NG ADMI NI STRATI ON	CENTRAL SERVICES &	
				PERSONNEL	ADMINISTRATION	SUPPLY	
		10.00	11. 00	12.00	13. 00	14. 00	
1. 00	GENERAL SERVICE COST CENTERS OO100 CAP REL COSTS-BLDG & FIXT						1.00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						5. 00
6.00	00600 MAINTENANCE & REPAIRS						6. 00
7.00	00700 OPERATION OF PLANT						7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE						8. 00
9.00	00900 HOUSEKEEPI NG	4/5 044					9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	465, 814	1 100				10.00
12. 00	01200 MAI NTENANCE OF PERSONNEL	0	1, 188	1			11. 00 12. 00
13. 00	01300 NURSING ADMINISTRATION				43, 011		13. 00
	01400 CENTRAL SERVI CES & SUPPLY	0	(ol o	0	5, 452	1
15.00	01500 PHARMACY	0	Ć	o	0	0	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	(0	0	0	16. 00
17. 00	01700 SOCIAL SERVICE	0	(0	0	0	17. 00
	01850 OTHER GEN SERV	0	(0	0	0	
	01900 NONPHYSI CI AN ANESTHETI STS	0	(0	0	0	
	02000 NURSI NG SCHOOL	0	(0	0	0	20.00
21. 00 22. 00	02100 I &R SERVICES-SALARY & FRINGES APPRVD 02200 I &R SERVICES-OTHER PRGM COSTS APPRVD		(0	0	21. 00 22. 00
23. 00	02301 PARAMED ED PRGM		(0	0	1
23.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	J		γ <u> </u>	<u> </u>	<u> </u>	25.00
30.00	03000 ADULTS & PEDIATRICS	402, 199	1, 026	0	19, 296	0	30. 00
31.00	03100 I NTENSI VE CARE UNI T	63, 615	162	1		0	31. 00
32.00	03200 CORONARY CARE UNIT	0	(0	0	0	32. 00
33.00	03300 BURN INTENSIVE CARE UNIT	0	(0	0	0	33. 00
34. 00	03400 SURGICAL INTENSIVE CARE UNIT	0	(0	0	0	34. 00
40.00	04000 SUBPROVI DER - I PF	0	(0	0	0	40.00
41. 00	04100 SUBPROVI DER - I RF	0	(0	0	0	41.00
43. 00 44. 00	04300 NURSERY 04400 SKILLED NURSING FACILITY		(0	0	
	04500 NURSING FACILITY		(0	0	1
46. 00	04600 OTHER LONG TERM CARE		(1	0	0	
	ANCILLARY SERVICE COST CENTERS			-			1
50.00	05000 OPERATI NG ROOM	0	(0	8, 442	0	50. 00
51.00	05100 RECOVERY ROOM	0	(0	0	0	51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	(0	0	0	52. 00
53. 00	05300 ANESTHESI OLOGY	0	(0	0	0	53.00
54. 00 55. 00	05400 RADI OLOGY THERAPEUT C	0	(17	0	
56. 00	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE		(0	0	
57. 00	05700 CT SCAN		(4	0	1
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	(ol o	0	0	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	Ć	o	1, 874	0	59. 00
60.00	06000 LABORATORY	0	(o	0	0	60. 00
60. 01	06001 BLOOD LABORATORY	0	(0	0	0	60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	(0	0	0	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	(0	0	0	
64. 00 65. 00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY		(0	0	
66. 00	06600 PHYSI CAL THERAPY		(0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY		(0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	(ol o	0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	Ć	o	4	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	() o	0	0	70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	(0	0	5, 452	1
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	(0	0	0	
	07300 DRUGS CHARGED TO PATIENTS	0	(0	0	0	
	07400 RENAL DIALYSIS		(0	0	0	
	07500 ASC (NON-DISTINCT PART) 03950 OTHER ANCILL SRVC		(0	0	75. 00 76. 00
	03951 CARDI AC AND PULMONARY REHAB		(0	76.00
	03952 WOUND CARE		(0	0	1
	07700 ALLOGENEIC STEM CELL ACQUISITION		(0	n	77. 00
	OUTPATIENT SERVICE COST CENTERS						1
88. 00	08800 RURAL HEALTH CLINIC	0	(0	0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	(0	0	0	89. 00
90. 00	09000 CLI NI C	0	(0	0	0	
90. 01	09001 CLI NI C	0	() 0	1, 697	0	90. 01
90. 01	09002 CLI NI C	^	,	\ \ ^	1, 154	0	90. 02

In Lieu of Form CMS-2552-10
Period: Worksheet B
From 01/01/2020 Part II

			Ť	o 12/31/2020	Date/Time Pre 7/29/2021 4:4	
Cost Center Description	DI ETARY	CAFETERI A	MAINTENANCE OF	NURSI NG	CENTRAL	, p
μ				ADMI NI STRATI ON	SERVICES &	
					SUPPLY	
	10.00	11. 00	12.00	13.00	14. 00	
91. 00 09100 EMERGENCY	0	0	0	4, 411	0	91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
94. 00 09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94. 00
95. 00 09500 AMBULANCE SERVICES	0	0	0	0	0	95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
98. 00 09850 OTHER REI MBURSE	0	0	0	0	0	98. 00
99. 00 09900 CMHC	0	0	0	0	0	99. 00
99. 10 09910 CORF	0	0	0	0	0	99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	o	0	0	o	0	100.00
101.00 10100 HOME HEALTH AGENCY	o	0	0	0	0	101. 00
SPECIAL PURPOSE COST CENTERS						
105.00 10500 KIDNEY ACQUISITION	0	0	0	0	0	105. 00
106. 00 10600 HEART ACQUI SI TI ON	0	0	0	0	0	106. 00
107.00 10700 LIVER ACQUISITION	0	0	0	0	0	107.00
108.00 10800 LUNG ACQUISITION	0	0	0	0	0	108. 00
109.00 10900 PANCREAS ACQUISITION	0	0	0	0	0	109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0	0	110. 00
111.00 11100 I SLET ACQUI SI TI ON	0	0	0	0	0	111. 00
113. 00 11300 I NTEREST EXPENSE						113. 00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	0	0	115. 00
116. 00 11600 HOSPI CE	0	0	0	0	0	116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	465, 814	1, 188	0	43, 011	5, 452	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190. 00
191. 00 19100 RESEARCH	0	0	0	0		191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0	0	192. 00
192. 01 19201 CENTER OF HOPE	0	0	0	0	0	192. 01
193. 00 19300 NONPALD WORKERS	O	0	0	0	0	193. 00
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	O	0	0	0		201. 00
202.00 TOTAL (sum lines 118 through 201)	465, 814	1, 188	0	43, 011	5, 452	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 4:40 pm Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0165

					0 12/31/2020	7/29/2021 4:4	
					OTHER GENERAL		
	Cost Center Description	PHARMACY	MEDI CAL	SUCTAL SERVICE	SERVI CE OTHER GEN SERV	NONPHYSI CI AN	
	cost center bescription	FTIARWACT	RECORDS &	SOCIAL SERVICE	OTTICK GEN SERV	ANESTHETISTS	
			LI BRARY				
	T	15. 00	16. 00	17. 00	18. 00	19. 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
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						5. 00
6.00	00600 MAINTENANCE & REPAIRS						6. 00
7.00	00700 OPERATION OF PLANT						7.00
8. 00 9. 00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING						8. 00 9. 00
10.00	01000 DI ETARY						10.00
11. 00	01100 CAFETERI A						11. 00
12. 00	01200 MAINTENANCE OF PERSONNEL						12. 00
13.00	01300 NURSI NG ADMI NI STRATI ON						13. 00
14. 00 15. 00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	210, 955					14. 00 15. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	210, 933	28, 328				16.00
17. 00	01700 SOCIAL SERVICE	O	0	О			17. 00
18. 00	01850 OTHER GEN SERV	0	0	0	0		18. 00
19. 00	01900 NONPHYSI CI AN ANESTHETI STS	0	0	0		0	1
20.00	02000 NURSI NG SCHOOL	0	0	0	_		20.00
21. 00 22. 00	02100 &R SERVICES-SALARY & FRINGES APPRVD 02200 &R SERVICES-OTHER PRGM COSTS APPRVD		0	0			21. 00 22. 00
23. 00	02301 PARAMED ED PRGM		0				23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDIATRICS	0	2, 059				30. 00
31.00	03100 I NTENSI VE CARE UNI T	0	432				31.00
32. 00 33. 00	03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT		0	0	0		32. 00 33. 00
34. 00	03400 SURGICAL INTENSIVE CARE UNIT		0	Ö	0		34. 00
40.00	04000 SUBPROVI DER - I PF	o	0	0	0		40. 00
41. 00	04100 SUBPROVI DER - I RF	0	0	0			41. 00
43.00	04300 NURSERY	0	0	0	_		43.00
44. 00 45. 00	04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY		0	0			44. 00 45. 00
46. 00	04600 OTHER LONG TERM CARE		0				46. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0	3, 621	0			50.00
51. 00 52. 00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	0	398 0				51. 00 52. 00
53. 00	05300 ANESTHESI OLOGY		923		_		53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	o	1, 687	0			54. 00
55.00	05500 RADI OLOGY-THERAPEUTI C	O	0	0	0		55. 00
56.00	05600 RADI OI SOTOPE	0	0	0	_		56. 00
57. 00 58. 00	05700 CT SCAN	0	2, 344				57.00
59. 00	05800 MAGNETIC RESONANCE I MAGING (MRI) 05900 CARDIAC CATHETERIZATION		1, 417 1, 395				58. 00 59. 00
60.00	06000 LABORATORY	l o	3, 331	Ö			60.00
60. 01	06001 BLOOD LABORATORY	O	0	0	0		60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61. 00
62. 00 63. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06300 BLOOD STORING, PROCESSING & TRANS.	0	0) 0 0			62. 00 63. 00
64. 00	06400 I NTRAVENOUS THERAPY		0	_	0		64.00
65. 00	06500 RESPI RATORY THERAPY	o	279		0		65. 00
66. 00	06600 PHYSI CAL THERAPY	0	113		0		66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	78		_		67. 00
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0	22 875				68. 00 69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY		274		_		70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	Ö	1, 223				71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	1, 626	0	0		72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	210, 955	1, 447	0	0		73. 00
74.00	07400 RENAL DI ALYSI S	0	0		0		74.00
75. 00 76. 00	07500 ASC (NON-DISTINCT PART) 03950 OTHER ANCILL SRVC		0		0		75. 00 76. 00
76. 01	03951 CARDI AC AND PULMONARY REHAB	Ö	27	Ö	0		76. 01
76. 02	03952 WOUND CARE	0	10	0	0		76. 02
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0		77. 00
88 AA	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC		0	0	0		88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0				89.00
	09000 CLI NI C		Ö				90.00
	· · · · · · · · · · · · · · · · · · ·	<u>'</u>					

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

			1	0 12/31/2020	7/29/2021 4:4	
				OTHER GENERAL	172772021 1. 1	J pin
				SERVI CE		
Cost Center Description	PHARMACY	MEDI CAL	SOCIAL SERVICE	OTHER GEN SERV	NONPHYSI CI AN	
·		RECORDS &			ANESTHETI STS	
		LI BRARY				
	15. 00	16. 00	17. 00	18. 00	19. 00	
90. 01 09001 CLI NI C	0	1, 638		0		90. 01
90. 02 09002 CLI NI C	0	433	0	0		90. 02
91. 00 09100 EMERGENCY	0	2, 676	0	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DIALYSIS	0	0	0	0		94. 00
95. 00 09500 AMBULANCE SERVICES	0	0	0	0		95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0		96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0		97. 00
98. 00 09850 OTHER REI MBURSE	0	0	0	0		98. 00
99. 00 09900 CMHC	0	0	0	0		99. 00
99. 10 09910 CORF	0	0	0	0		99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0		100. 00
101.00 10100 HOME HEALTH AGENCY	0	0	0	0		101. 00
SPECIAL PURPOSE COST CENTERS						
105.00 10500 KIDNEY ACQUISITION	0	0		· ·		105. 00
106. 00 10600 HEART ACQUI SI TI ON	0	0	0	0		106. 00
107.00 10700 LIVER ACQUISITION	0	0	0	0		107. 00
108.00 10800 LUNG ACQUISITION	0	0	0	0		108. 00
109.00 10900 PANCREAS ACQUISITION	0	0	0	0		109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0		110. 00
111.00 11100 I SLET ACQUI SI TI ON	0	0	0	0		111. 00
113.00 11300 INTEREST EXPENSE						113. 00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	0		115. 00
116. 00 11600 HOSPI CE	0	0	0	0		116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	210, 955	28, 328	0	0	0	118. 00
NONREI MBURSABLE COST CENTERS	,			1		1
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0			190. 00
191. 00 19100 RESEARCH	0	0	0	0		191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192. 00
192.01 19201 CENTER OF HOPE	0	0	0	0		192. 01
193. 00 19300 NONPALD WORKERS	0	0	0	0		193. 00
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	0	0	0		201. 00
202.00 TOTAL (sum lines 118 through 201)	210, 955	28, 328	0	0	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 4:40 pm Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0165

				10	3 12/31/2020	7/29/2021 4: 4	
			INTERNS &	RESI DENTS			
	Cost Center Description	MITEST NC SCHOOL	SEDVICES SALAD	SERVI CES-OTHER	PARAMED ED	Subtotal	
	cost center bescription	NURSTING SCHOOL	Y & FRINGES	PRGM COSTS	PRGM	Subtotal	
		20.00	21. 00	22.00	23. 00	24.00	
	GENERAL SERVICE COST CENTERS						
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. 00	00500 ADMINISTRATIVE & GENERAL						5. 00
6.00	00600 MAINTENANCE & REPAIRS						6. 00
7.00	00700 OPERATION OF PLANT						7. 00
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY						9. 00 10. 00
11. 00	01100 CAFETERI A						11.00
12. 00	01200 MAINTENANCE OF PERSONNEL						12. 00
13.00	01300 NURSING ADMINISTRATION						13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY						14.00
15. 00 16. 00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY						15. 00 16. 00
17. 00	01700 SOCIAL SERVICE						17. 00
18. 00	01850 OTHER GEN SERV						18. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS						19. 00
20.00	02000 NURSI NG SCHOOL	0					20. 00
21. 00	02100 I &R SERVI CES-SALARY & FRINGES APPRVD		0				21. 00
22. 00 23. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD 02301 PARAMED ED PRGM			0	0		22. 00 23. 00
23.00	INPATIENT ROUTINE SERVICE COST CENTERS				0		23.00
30.00	03000 ADULTS & PEDI ATRI CS					2, 844, 735	30. 00
31. 00	03100 INTENSIVE CARE UNIT					649, 617	31. 00
32.00	03200 CORONARY CARE UNIT					0	1
33. 00 34. 00	03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT					0	33. 00 34. 00
40. 00	04000 SUBPROVI DER – I PF						1
41. 00	04100 SUBPROVI DER - I RF					Ö	
43.00	04300 NURSERY					0	43. 00
44. 00	04400 SKILLED NURSING FACILITY					0	
45. 00	04500 NURSING FACILITY					0	
46. 00	04600 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS					0	46. 00
50.00	05000 OPERATING ROOM					1, 121, 794	50. 00
51.00	05100 RECOVERY ROOM					463, 600	
52.00	05200 DELIVERY ROOM & LABOR ROOM					0	
53. 00 54. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C					21, 155 517, 491	1
55. 00	05500 RADI OLOGY-THERAPEUTI C					0	1
56. 00	05600 RADI OI SOTOPE					Ō	
57. 00	05700 CT SCAN					16, 525	1
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)					26, 901	
59. 00 60. 00	O5900 CARDI AC CATHETERI ZATI ON O6000 LABORATORY					986, 945 259, 474	
60. 01	06001 BLOOD LABORATORY					259, 474	1
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS					0	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.					0	
64. 00 65. 00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY					0 102, 181	64. 00 65. 00
66. 00	06600 PHYSI CAL THERAPY	1				5, 752	1
67. 00	06700 OCCUPATI ONAL THERAPY	1				3, 104	1
68.00	06800 SPEECH PATHOLOGY					838	68. 00
69.00	06900 ELECTROCARDI OLOGY					8, 984	1
70.00	07000 ELECTROENCEPHALOGRAPHY					442, 426	1
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 MPL. DEV. CHARGED TO PATIENTS					37, 250 150, 643	1
73. 00	07300 DRUGS CHARGED TO PATIENTS					258, 835	
74.00	07400 RENAL DIALYSIS					0	74. 00
75. 00	07500 ASC (NON-DISTINCT PART)					0	1
76. 00	03950 OTHER ANCILL SRVC					0	
76. 01 76. 02	03951 CARDI AC AND PULMONARY REHAB 03952 WOUND CARE	-				3, 510 956	1
76. 02	07700 ALLOGENEIC STEM CELL ACQUISITION					956	1
	OUTPATIENT SERVICE COST CENTERS]
88. 00	08800 RURAL HEALTH CLINIC					0	
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER					0	
90. 00 90. 01	09000 CLI NI C 09001 CLI NI C					0 48, 712	1
70.01	10,000.10E1.111.0	I	<u>I</u>	I		1 70,712	1 /3.01

In Lieu of Form CMS-2552-10
Period: Worksheet B
From 01/01/2020 Part II Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0165

				o 12/31/2020	Date/Time Pre	
		INTERNS &	RESI DENTS		172972021 4.4	o piii
Cost Center Description	NURSING SCHOOL	SERVI CES-SALAR	SERVI CES-OTHER	PARAMED ED	Subtotal	
		Y & FRINGES	PRGM COSTS	PRGM		
	20. 00	21. 00	22. 00	23. 00	24. 00	
90. 02 09002 CLI NI C					82, 308	
91. 00 09100 EMERGENCY					643, 112	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
OTHER REIMBURSABLE COST CENTERS						04.00
94. 00 09400 HOME PROGRAM DI ALYSI S					0	94. 00
95. 00 09500 AMBULANCE SERVI CES 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED					0	95. 00 96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-RENTED					0	96.00
98. 00 09850 OTHER REIMBURSE					0	98.00
99. 00 09900 CMHC					0	99.00
99. 10 09910 CORF					0	99. 10
100.00 10000 I &R SERVI CES-NOT APPRVD PRGM					-	100.00
101. 00 10100 HOME HEALTH AGENCY						101.00
SPECIAL PURPOSE COST CENTERS					0	101.00
105. 00 10500 KIDNEY ACQUISITION					0	105. 00
106. 00 10600 HEART ACQUISITION					0	106. 00
107. 00 10700 LIVER ACQUISITION					0	107. 00
108.00 10800 LUNG ACQUISITION					0	108. 00
109.00 10900 PANCREAS ACQUISITION					0	109. 00
110.00 11000 INTESTINAL ACQUISITION					0	110. 00
111.00 11100 ISLET ACQUISITION					0	111. 00
113.00 11300 INTEREST EXPENSE						113. 00
114.00 11400 UTILIZATION REVIEW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)					0	115. 00
116. 00 11600 HOSPI CE					0	116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	0	8, 696, 848	118. 00
NONRE MBURSABLE COST CENTERS	,					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN						190. 00
191. 00 19100 RESEARCH						191. 00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES					1, 417, 963	
192. 01 19201 CENTER OF HOPE						192. 01
193. 00 19300 NONPALD WORKERS						193. 00
200.00 Cross Foot Adjustments	0	0	0	0		200. 00
201.00 Negative Cost Centers	0	0	0	0		201. 00
202.00 TOTAL (sum lines 118 through 201)	0	0	0	0	10, 116, 408	202. 00

Heal th FinancialSystemsFRANCISCAN HEALTH MUNSTERIn Lieu of Form CMS-2552-10ALLOCATION OF CAPITALRELATED COSTSProvider CCN: 15-0165Period:Worksheet B

From 01/01/2020 Part II Date/Time Prepared: 12/31/2020 7/29/2021 4:40 pm Cost Center Description Intern & Total Residents Cost & Post Stepdown Adjustments 25.00 26.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 00600 MAINTENANCE & REPAIRS 6.00 6.00 00700 OPERATION OF PLANT 7.00 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10 00 10 00 01100 CAFETERI A 11.00 11.00 12. 00 01200 MAINTENANCE OF PERSONNEL 12.00 13.00 01300 NURSING ADMINISTRATION 13.00 01400 CENTRAL SERVICES & SUPPLY 14 00 14 00 15.00 01500 PHARMACY 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16.00 01700 SOCIAL SERVICE 17 00 17 00 01850 OTHER GEN SERV 18.00 18.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 19.00 20.00 02000 NURSING SCHOOL 20.00 02100 I &R SERVICES-SALARY & FRINGES APPRVD 21 00 21 00 22.00 02200 I &R SERVICES-OTHER PRGM COSTS APPRVD 22.00 02301 PARAMED ED PRGM 23.00 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 2.844.735 30.00 31.00 03100 INTENSIVE CARE UNIT 649, 617 31.00 0000000 03200 CORONARY CARE UNIT 32.00 32.00 03300 BURN INTENSIVE CARE UNIT 33.00 0 33.00 03400 SURGICAL INTENSIVE CARE UNIT 34.00 0 34 00 40.00 04000 SUBPROVI DER - I PF 0 40.00 04100 SUBPROVI DER - I RF 41.00 0 41.00 43.00 04300 NURSERY 0 43.00 04400 SKILLED NURSING FACILITY 44.00 Ω 44 00 0 04500 NURSING FACILITY 45.00 45.00 04600 OTHER LONG TERM CARE 0 46.00 46.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 1, 121, 794 50.00 51.00 05100 RECOVERY ROOM 0 463, 600 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 53.00 05300 ANESTHESI OLOGY 53.00 21, 155 54.00 05400 RADI OLOGY-DI AGNOSTI C 00000000 517, 491 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 55.00 56.00 05600 RADI OI SOTOPE 56.00 57.00 05700 CT SCAN 16, 525 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 26, 901 58.00 05900 CARDI AC CATHETERI ZATI ON 59.00 986, 945 59.00 06000 LABORATORY 60.00 259, 474 60.00 60.01 06001 BLOOD LABORATORY Ω 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 62.00 00000000000000000 0 62.00 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 0 63.00 64.00 06400 I NTRAVENOUS THERAPY C 64.00 06500 RESPIRATORY THERAPY 65.00 102, 181 65.00 66 00 06600 PHYSI CAL THERAPY 5 752 66 00 06700 OCCUPATIONAL THERAPY 67.00 3, 104 67.00 06800 SPEECH PATHOLOGY 838 68.00 68.00 69.00 06900 ELECTROCARDI OLOGY 8, 984 69.00 70 00 07000 ELECTROENCEPHALOGRAPHY 442 426 70 00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 37, 250 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 150, 643 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 258, 835 73.00 74.00 07400 RENAL DIALYSIS Ω 74.00 75.00 07500 ASC (NON-DISTINCT PART) 0 75.00 03950 OTHER ANCILL SRVC 76.00 76.00 76.01 03951 CARDIAC AND PULMONARY REHAB 3.510 76.01 76.02 03952 WOUND CARE 0 956 76.02 07700 ALLOGENEIC STEM CELL ACQUISITION 77.00 0 77.00 OUTPATIENT SERVICE COST CENTERS 88 00 0 88.00 08800 RURAL HEALTH CLINIC Ω 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 89.00 90. 00 09000 CLINIC 90.00

			To 12/31/2020 Part Ti	
0 1 0 1 0 1		-	7/29/2021 4:	40 pm
Cost Center Description	Intern &	Total		
	Residents Cost & Post			
	Stepdown			
	Adjustments			
	25. 00	26. 00		
90. 01 09001 CLI NI C	0	48, 712		90. 01
90. 02 09002 CLINIC		82, 308		90. 02
91. 00 09100 EMERGENCY		643, 112		91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	2.2,		92.00
OTHER REIMBURSABLE COST CENTERS	· · · · · · · · · · · · · · · · · · ·			
94.00 09400 HOME PROGRAM DIALYSIS	0	0		94. 00
95. 00 09500 AMBULANCE SERVICES	o	0		95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	o	0		96. 00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0		97. 00
98. 00 09850 OTHER REI MBURSE	0	0		98. 00
99. 00 09900 CMHC	0	0		99. 00
99. 10 09910 CORF	0	0		99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0		100.00
101.00 10100 HOME HEALTH AGENCY	0	0		101. 00
SPECIAL PURPOSE COST CENTERS				
105.00 10500 KIDNEY ACQUISITION	0	0		105. 00
106. 00 10600 HEART ACQUISITION	0	0		106. 00
107.00 10700 LIVER ACQUISITION	0	0		107. 00
108.00 10800 LUNG ACQUISITION	0	0		108. 00
109.00 10900 PANCREAS ACQUISITION	0	0		109. 00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON	0	0		110.00
111. 00 11100 SLET ACQUI SITI ON	0	0		111. 00
113. 00 11300 INTEREST EXPENSE				113.00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF				114.00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0		115.00
116. 00 11600 HOSPI CE	0	0 (0(040		116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	l d	8, 696, 848		118. 00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		1, 515		190. 00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		1, 515		190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES		1, 417, 963		191.00
192. 01 19201 CENTER OF HOPE		1, 417, 403		192. 00
193. 00 19300 NONPALD WORKERS		0		193. 00
200.00 Cross Foot Adjustments		0		200. 00
201.00 Negative Cost Centers		0		201. 00
202.00 TOTAL (sum lines 118 through 201)		10, 116, 408		202. 00
	١	.5,5, 100	I	1-02. 00

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0165 Peri od: Worksheet B-1 From 01/01/2020 12/31/2020 Date/Time Prepared: 7/29/2021 4:40 pm CAPITAL RELATED COSTS BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Reconciliation ADMINISTRATIVE Cost Center Description (SQUARE FEET) (SQUARE FEET) BENEFITS & GENERAL (ACCUM. COST) DEPARTMENT (GROSS SALARI ES) 1.00 2.00 5. 00 4.00 5A GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 178 609 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 178, 609 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 2, 281 2, 281 37, 676, 760 4.00 00500 ADMINISTRATIVE & GENERAL 21, 923 5 00 21, 923 9, 321, 389 -23, 352, 697 78 393 356 5 00 6.00 6.00 00600 MAINTENANCE & REPAIRS 0 579, 370 5, 950, 345 7.00 00700 OPERATION OF PLANT 0 7.00 00800 LAUNDRY & LINEN SERVICE 0 195, 118 8.00 8.00 C C 0 00900 HOUSEKEEPI NG 9 00 680, 282 1, 084, 855 0 0 9 00 10.00 01000 DI ETARY 7,878 7,878 218, 692 787, 976 10.00 01100 CAFETERI A -381, 674 11.00 0 346, 424 11.00 01200 MAINTENANCE OF PERSONNEL 12.00 12.00 0 0 01300 NURSING ADMINISTRATION 1, 547, 685 2, 320, 702 13.00 0 C 0 13 00 14.00 01400 CENTRAL SERVICES & SUPPLY 161, 299 0 301, 520 14.00 0 01500 PHARMACY 0 15.00 3,060 3,060 1,024,061 1, 955, 712 15.00 0 01600 MEDICAL RECORDS & LIBRARY 239, 854 1, 184, 136 16,00 144 144 16,00 17 00 01700 SOCIAL SERVICE 0 C C 17 00 01850 OTHER GEN SERV 0 0 0 18.00 18.00 0 0 19 00 01900 NONPHYSICIAN ANESTHETISTS 0 C 0 O 19.00 0 20.00 02000 NURSING SCHOOL 0 20.00 C 0 0 0 0 21.00 02100 I &R SERVICES-SALARY & FRINGES APPRVD 0 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 0 22.00 0 0 22.00 02301 PARAMED ED PRGM 23.00 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 38, 387 38, 387 7, 125, 249 0 11, 647, 311 30.00 03100 INTENSIVE CARE UNIT 0 31.00 9, 250 9, 250 1, 575, 940 2, 611, 670 31.00 0 32.00 03200 CORONARY CARE UNIT 0 0 32.00 0 03300 BURN INTENSIVE CARE UNIT 0 33.00 0 C 0 0 33.00 03400 SURGICAL INTENSIVE CARE UNIT 0 0 34.00 34.00 04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF 0 40.00 0 0 0 Ω 40.00 0 0 41 00 C Λ 41 00 04300 NURSERY 0 43.00 0 0 43.00 04400 SKILLED NURSING FACILITY 0 0 0 44.00 0 44.00 04500 NURSING FACILITY 45.00 0 45.00 0 04600 OTHER LONG TERM CARE 46.00 0 46.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 17, 422 17, 422 3, 224, 127 6, 063, 207 50.00 o 05100 RECOVERY ROOM 51 00 7 643 7 643 696, 789 1, 356, 653 51 00 05200 DELIVERY ROOM & LABOR ROOM 52.00 \cap 0 52.00 53.00 05300 ANESTHESI OLOGY 27, 601 0 1, 239, 403 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 8, 100 8, 100 1, 527, 370 0 2, 803, 182 54.00 05500 RADI OLOGY-THERAPEUTI C 55 00 55 00 Ω 0 56.00 05600 RADI OI SOTOPE 0 56.00 05700 CT SCAN 0 414, 179 785, 215 57.00 0 0 0 57.00 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 786, 201 1, 402, 587 58.00 0 05900 CARDIAC CATHETERIZATION 2, 219, 870 16, 455 16, 455 59 00 862, 746 59 00 60.00 06000 LABORATORY 2,828 2,828 0 5, 772, 854 60.00 06001 BLOOD LABORATORY 60.01 0 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 0 61.00 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 62 00 0 C 0 0 62.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 63.00 0 06400 I NTRAVENOUS THERAPY 0 64.00 0 64.00 0 06500 RESPIRATORY THERAPY 747, 428 1, 135, 644 65.00 1, 409 1, 409 65 00 0 66.00 06600 PHYSI CAL THERAPY 200, 348 304, 797 66.00 06700 OCCUPATIONAL THERAPY 0 67.00 0 115, 217 161, 911 67.00 0 06800 SPEECH PATHOLOGY 45, 294 68.00 0 0 23, 390 68.00 06900 ELECTROCARDI OLOGY 313, 180 69.00 0 432, 768 69 00 07000 ELECTROENCEPHALOGRAPHY 7, 191 363, 852 0 0 0 1, 728, 382 70.00 70.00 7, 191 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71 00 1, 881, 871 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 9, 171, 997 72.00 0 72.00 0 07300 DRUGS CHARGED TO PATIENTS 0 73.00 C 0 2, 857, 963 73.00 07400 RENAL DIALYSIS 0 74.00 74.00 07500 ASC (NON-DISTINCT PART) 0 75.00 0 0 0 75.00 Ol 03950 OTHER ANCILL SRVC 76.00 C 0 0 76.00 76.01 03951 CARDIAC AND PULMONARY REHAB 0 135, 359 0 185, 796 76.01 76.02 03952 WOUND CARE 0 32, 332 0 51, 410 76.02 07700 ALLOGENEIC STEM CELL ACQUISITION 77.00 77.00 OUTPATIENT SERVICE COST CENTERS 0 88.00 08800 RURAL HEALTH CLINIC 0 0 0 0 88.00

| Period: | Worksheet B-1 | From 01/01/2020 | To 12/31/2020 | Date/Time Prepared: Provider CCN: 15-0165

				Ť	o 12/31/2020		
		CAPITAL REL	L _ATED_COSTS			7/29/2021 4:4	O pm
		CALLIAE KEE	LATED COSTS				
	Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Reconciliation	ADMI NI STRATI VE	
	•	(SQUARE FEET)	(SQUARE FEET)	BENEFITS		& GENERAL	
				DEPARTMENT		(ACCUM. COST)	
				(GROSS			
				SALARI ES)			
	T	1.00	2. 00	4.00	5A	5. 00	
	FEDERALLY QUALIFIED HEALTH CENTER	0	0		_	-	
	CLI NI C	0	0	1	_		90.00
	CLI NI C	0	0	.,,===		_,,	
	CLINIC EMERGENCY	1, 207 9, 900	1, 207			650, 427	90. 02
	OBSERVATION BEDS (NON-DISTINCT PART)	9, 900	9, 900	1, 655, 178	0	3, 816, 517	91. 00 92. 00
	REIMBURSABLE COST CENTERS						92.00
	HOME PROGRAM DIALYSIS	0	0	C	0	0	94. 00
	AMBULANCE SERVICES	0	0				95.00
	DURABLE MEDICAL EQUIP-RENTED	0	0	•			96.00
	DURABLE MEDICAL EQUIP-SOLD	0	0			_	97. 00
	OTHER REIMBURSE	0	0	1	_	_	98. 00
99.00 09900		0	0	l c	0	0	99. 00
99. 10 09910	CORF	0	0	C	0	0	
100.00 10000	I&R SERVICES-NOT APPRVD PRGM	0	0	l c	0	0	100.00
101.00 10100	HOME HEALTH AGENCY	0	0	C	0	0	101. 00
SPECI	AL PURPOSE COST CENTERS						
105.00 10500	KIDNEY ACQUISITION	0	0	C	0	0	105. 00
	HEART ACQUISITION	0	0	C	0		106. 00
	LIVER ACQUISITION	0	0	C	0		107. 00
	LUNG ACQUISITION	0	0	1	_		108. 00
	PANCREAS ACQUISITION	0	0	1			109. 00
	INTESTINAL ACQUISITION	0	0	C	0		110.00
	I SLET ACQUI SI TI ON	0	0	0	0	0	111.00
	I NTEREST EXPENSE						113.00
	UTILIZATION REVIEW-SNF				0		114. 00
	AMBULATORY SURGICAL CENTER (D. P.)	0	0		· ·		115. 00 116. 00
116. 00 11600 118. 00	l control of the cont	155.078	155.070	1	1		
	SUBTOTALS (SUM OF LINES 1 through 117) IMBURSABLE COST CENTERS	155,078	155, 078	35, 954, 376	-23, 734, 371	74, 529, 166	1118.00
	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	41, 708	0	84, 474	100 00
191. 00 19100	RESEARCH	0	0	,			191. 00
	PHYSICIANS' PRIVATE OFFICES	23, 531	23, 531	1			
	CENTER OF HOPE	0	0	1,000,070			192. 01
	NONPALD WORKERS	0	Ö				193. 00
200.00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers						201. 00
202.00	Cost to be allocated (per Wkst. B,	10, 116, 408	0	1, 128, 616	,	23, 352, 697	202. 00
	Part I)						
203.00	Unit cost multiplier (Wkst. B, Part I)	56. 639968	0. 000000	0. 029955		0. 297891	
204.00	Cost to be allocated (per Wkst. B,			129, 196	1	1, 273, 682	204. 00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part			0. 003429		0. 016247	205. 00
201 00							00/ 00
206. 00	NAHE adjustment amount to be allocated						206. 00
207. 00	(per Wkst. B-2) NAHE unit cost multiplier (Wkst. D,						207. 00
207.00	Parts III and IV)						207.00
I	1:	1	ı	ı	1	ı	ı

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0165

				1	0 12/31/2020	Date/lime Pre 7/29/2021 4:4	
	Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LI NEN SERVI CE (POUNDS OF	HOUSEKEEPING (SQUARE FEET)	DI ETARY (MEALS SERVED)	
		6. 00	7. 00	LAUNDRY) 8. 00	9. 00	10.00	
	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 5. 00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL						4. 00 5. 00
6. 00	00600 MAINTENANCE & REPAIRS	154, 405					6.00
7. 00	00700 OPERATION OF PLANT	0	154, 405				7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	0	382, 570			8. 00
9. 00	00900 HOUSEKEEPI NG	0	0	0	154, 405		9. 00
10.00	01000 DI ETARY	7, 878	7, 878	0	7, 878		10.00
11. 00 12. 00	01100 CAFETERIA 01200 MAINTENANCE OF PERSONNEL	0	0	0	0	0	11. 00 12. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON	0	٥	Ö	Ö	Ö	13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	Ö	ō	0	0	14. 00
15.00	01500 PHARMACY	3, 060	3, 060	0	3, 060	0	15. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	144	144	0	144	0	16. 00
17. 00	01700 SOCIAL SERVICE	0	0	0	0	0	17. 00
18. 00 19. 00	01850 OTHER GEN SERV 01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	18. 00 19. 00
20. 00	02000 NURSI NG SCHOOL	0		0	0		20.00
21. 00	02100 I &R SERVI CES-SALARY & FRI NGES APPRVD	0	Ö	Ö	Ö	0	21.00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22. 00
23. 00	02301 PARAMED ED PRGM	0	0	0	0	0	23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	38, 387	1	1		64, 925	30.00
31. 00 32. 00	03100 NTENSI VE CARE UNI T 03200 CORONARY CARE UNI T	9, 250	9, 250	52, 248	9, 250	10, 269 0	31. 00 32. 00
33. 00	03300 BURN INTENSIVE CARE UNIT	0			0	0	33.00
34. 00	03400 SURGICAL INTENSIVE CARE UNIT	0		0	0	Ö	34.00
40. 00	04000 SUBPROVI DER - I PF	0	0	Ō	Ō	0	40. 00
41.00	04100 SUBPROVI DER - I RF	0	0	0	0	0	41. 00
43.00	04300 NURSERY	0	0	0	0	0	43. 00
44.00	04400 SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45. 00 46. 00	04500 NURSING FACILITY 04600 OTHER LONG TERM CARE	0	0	0	0	0	45. 00 46. 00
40.00	ANCI LLARY SERVI CE COST CENTERS	0	0	<u> </u>	0	0	40.00
50.00	05000 OPERATI NG ROOM	17, 422	17, 422	0	17, 422	0	50.00
51.00	05100 RECOVERY ROOM	7, 643	7, 643	0	7, 643	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52. 00
53. 00	05300 ANESTHESI OLOGY	0 100	0 100	0	0	0	53.00
54. 00 55. 00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	8, 100	8, 100	0	8, 100	0	54. 00 55. 00
56. 00	05600 RADI OLOGI - ITIERAF LUTT C	0			0	0	56.00
57. 00	05700 CT SCAN	0	ĺ	Ö	0	Ö	57.00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0	0	0	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	16, 455	16, 455	0	16, 455	0	59. 00
60. 00	06000 LABORATORY	2, 828	2, 828	0	2, 828	0	60.00
60. 01	06001 BLOOD LABORATORY	0	0	0	0	0	60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS				0		61. 00 62. 00
62. 00 63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0		0	0	0	63.00
64. 00	06400 NTRAVENOUS THERAPY	0		0	0	Ö	64.00
65. 00	06500 RESPIRATORY THERAPY	1, 409	1, 409	Ō	1, 409		65. 00
66.00	06600 PHYSI CAL THERAPY	0	0	0	0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	7 101	7 101	0	7 101	0	69.00
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	7, 191	7, 191	0	7, 191	0	70. 00 71. 00
71.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0			0	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	ĺ	Ö	0	Ö	73.00
74. 00	07400 RENAL DIALYSIS] 0	0	Ö	Ö	Ö	74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75. 00
76. 00	03950 OTHER ANCILL SRVC	0	0	0	0	0	76. 00
76. 01	03951 CARDI AC AND PULMONARY REHAB	0	0	0	0	0	76. 01
76. 02 77. 00	03952 WOUND CARE 07700 ALLOGENEIC STEM CELL ACQUISITION	0			0	0	76. 02 77. 00
11.00	OUTPATIENT SERVICE COST CENTERS	. 0		<u>'</u>			177.00
88. 00		0	0	0	0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89. 00
90.00	09000 CLI NI C	0	1	0	0	0	90.00
90. 01	09001 CLI NI C	0	0	0	0	0	90. 01

				Ť	0 12/31/2020	Date/Time Pre 7/29/2021 4:4	
	Cost Center Description	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	J Dill
	5551 5511tol 25551 pt 511	REPAI RS	PLANT	LINEN SERVICE		(MEALS SERVED)	
		(SQUARE FEET)	(SQUARE FEET)	(POUNDS OF	(()	
		,	,	LAUNDRY)			
		6. 00	7. 00	8.00	9. 00	10.00	
90. 02	09002 CLI NI C	1, 207	1, 207	0	1, 207	0	90. 02
91. 00	09100 EMERGENCY	9, 900	9, 900	0	9, 900	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS						
94.00	09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94. 00
95.00	09500 AMBULANCE SERVICES	0	0	0	0	0	95. 00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96. 00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97. 00
98. 00	09850 OTHER REI MBURSE	0	0	0	0	0	98. 00
99. 00	09900 CMHC	0	0	0	0	0	99. 00
99. 10	09910 CORF	0	0	0	0	0	99. 10
100.00	10000 I &R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00	10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00
	SPECIAL PURPOSE COST CENTERS						
	10500 KIDNEY ACQUISITION	0	1		_		105. 00
	10600 HEART ACQUISITION	0	0	1	0		106. 00
	10700 LIVER ACQUISITION	0	0	0	0		107. 00
108.00	10800 LUNG ACQUISITION	0	0	0	0	0	108. 00
109. 00	10900 PANCREAS ACQUISITION	0	0	0	0	0	109. 00
110. 00	11000 INTESTINAL ACQUISITION	0	0	0	0	0	110. 00
111. 00	11100 I SLET ACQUISITION	0	0	0	0	0	111. 00
113. 00	11300 I NTEREST EXPENSE						113. 00
114. 00	11400 UTILIZATION REVIEW-SNF						114. 00
115. 00	11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	0	0	115. 00
	11600 H0SPI CE	0	0	0	0	l	116. 00
118. 00		130, 874	130, 874	382, 570	130, 874	75, 194	118. 00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	· -	1	_		190. 00
	19100 RESEARCH	0	0	0		l	191. 00
	19200 PHYSICIANS' PRIVATE OFFICES	23, 531	23, 531	0	23, 531		192. 00
	19201 CENTER OF HOPE	0	0	0	0	l	192. 01
	19300 NONPALD WORKERS	0	0	0	0	0	193. 00
200.00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers						201. 00
202.00	Cost to be allocated (per Wkst. B,	7, 722, 899	0	253, 242	1, 408, 024	1, 488, 582	202. 00
	Part I)						
203.00	Unit cost multiplier (Wkst. B, Part I)	50. 017156	l			19. 796553	
204.00	Cost to be allocated (per Wkst. B,	98, 662	0	3, 170	19, 959	465, 814	204. 00
005 00	Part II)	0 (00000		0.00000/	0.4000/4	, ,,,,,,,,	005 00
205.00	Unit cost multiplier (Wkst. B, Part	0. 638982	0. 000000	0. 008286	0. 129264	6. 194829	205.00
20/ 00	NAUE adjustment amount to be allegated						204 20
206. 00	NAHE adjustment amount to be allocated						206. 00
207. 00	(per Wkst. B-2) NAHE unit cost multiplier (Wkst. D,						207. 00
207.00							207.00
	Parts III and IV)	1	l	l	ļ	l	I

Heal th Financial Systems

FRANCISCAN HEALTH MUNSTER

In Lieu of Form CMS-2552-10

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0165

Period:
From 01/01/2020
To 12/31/2020
Date/Time Prepared:
7/29/2021 4: 40 pm

CAFETERIA
(MEALS SERVED)

PERSONNEL
(NUMBER
HOUSED)

(DI RECT NURS. (COSTED)

CAST Centrer Description							7/29/2021 4: 4	O pm
CHARGE CONTINUES CONTINU		Cost Center Description						
ARREAD SHAYLOR DUST CENTERS 11.00 12.00 15.00			(MEALS SERVED)		ADMINISTRATION			
PROPERTY 11.00 12.00 13.00 14.00 15.00				•	(DI RECT NURS		REQUIS.)	
CHRINAL SERVICE CREST CHATEBY 11.00 12.00 13.00 14.00 15.00				1100022)	7	,		
1.00 00000 CAP REC COSTS-BUELD & FIXX 2.00 00000 CAP REC COSTS-BUELD & FIXX 2.00 00000 CAP REC COSTS-BUELD & CAP			11.00	12.00			15. 00	
2.00		GENERAL SERVICE COST CENTERS						
0.000 DOMO DAMIN STATAT VE SECREDAL		1 I						1
0.0000 0.0000 AMIN HEMANICA & GENERAL		1						1
0.000 0.0000 M. IMENIANCE & REPAIR IS		1						ı
7. 00 00700 DOPENTH TO NO F PLANT 7. 00 9. 00 100		1 I						1
B. DO OBBOOL AMADISKY & LINEN SERVICE								1
0.000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.00000000								1
10.00 01000 DETARY		1 I						1
11.00 01100 CAPETERIA 12.294								1
12.00 1200 MAINTENINGE OF PRESONNEL 0 0 9,986 13.00 1300			12 294					1
13.00 13.00 9URSI NA ADMINISTRATION 0 0 9.96 13.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 15.00 0 0 0 0 0 0 15.00 1		l	12, 274	(1
14 00 0 1400 [CENTRAL SERVICES & SUPPLY 0 0 0 0 0 0 0 0 15.0 0 15.0 0 15.0 0 15.0 0 15.0 0 1600 [MEDI CAL, RECORDS & LI BRARY 0 0 0 0 0 0 0 0 0 0 1 16.0 0 17.0 0 1700 0 1		l	0	(1			1
15.00 01500 PHANBACY 0 0 0 0 10.01 0.01 0.01 10.00		l	0	(100		1
16.00 1000 MEDICAL, RECORDS & LIBRARY 0 0 0 0 0 10 00 17.00 1700		l	O	Ć	o	o	100	1
17.00 0 1700 SOCI AL SERVICE			o	(o	o	0	16. 00
19.00 0.900 NOMINYSICI AN ARESTHETISTS	17. 00		0	(o	o	0	17. 00
20.00 0.0000 MURS INS SCHOOL 0 0 0 0 0 0 0 22 0.00	18.00	01850 OTHER GEN SERV	O	(o	o	0	18. 00
21.00	19.00	01900 NONPHYSICIAN ANESTHETISTS	0	(o	o	0	19. 00
22.00 02200 RAR SERVI CES-OTHER PREMI COSTS APPRVD 0 0 0 0 22.00 1 1 1 1 1 1 1 1 1	20.00	02000 NURSI NG SCHOOL	0	(0	0	0	20. 00
23.0	21. 00		0	(0	0	0	21. 00
INPATIENT ROUTINE SERVICE COST CENTERS	22. 00	l I	0	-	1	0	0	22. 00
30.00	23. 00		0	(0	0	0	23. 00
31.00 03100 INTENSI VE CARE UNIT								
22.00 03200 03200 03200 0300 03 0 0 0 0 0 0		1 I	1		1		0	1
33. 00 03200 BURN INTENSIVE CARE UNIT 0 0 0 0 0 0 33. 00 43. 00 03400 SURGICAL INTENSIVE CARE UNIT 0 0 0 0 0 0 0 0 34. 00 43. 00 03400 SURGICAL INTENSIVE CARE UNIT 0 0 0 0 0 0 0 0 0 41. 00 43. 00 03400 SURGICAL INTENSIVE CARE UNIT 0 0 0 0 0 0 0 0 41. 00 43. 00 04300 SURGICAL INTENSIVE CARE UNIT 0 0 0 0 0 0 0 0 41. 00 43. 00 04300 SURGICAL INTENSIVE CARE UNIT 0 0 0 0 0 0 0 0 44. 00 44. 00 04400 SURGICAL INTENSIVE CARE 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1 I	1, 679	(1, 419	0	0	
34. 00 03400 SURGICAL INTENSIVE CARE UNIT 0 0 0 0 0 34. 00		1 I	0	(0	0	1
40.00 0.000 0.00		1	0	(U		1
141.00 04100 SUBPROVIDER - 1 RF		1 I	0	(U	_	ı
43. 00 04300 NURSERY 44. 00 0400 SSELLED NURSING FACILITY 50. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1 I	0	(0	-	1
44. 00 04400 SKILLED NURSING FACILITY 0 0 0 0 0 0 0 0 45. 00 45. 00 04500 NURSING FACILITY 0 0 0 0 0 0 0 0 45. 00 46. 00 04600 OHER LONG TERM CARE 0 0 0 0 0 0 0 0 0 0 46. 00 ANCILLARY SERVICE COST CENTERS 50. 00 05000 DEFERTING ROOM 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1		(0	-	1
45. 00 04500 NURSI NG FACILITY		1 I		(0		1
46. 00 04600 OTHER LONG TERM CARE 0 0 0 0 0 0 0 0 0		1	0	(Ö	_	1
ANCILLARY SERVICE COST CENTERS		1 I	0	-	1	_		1
50.00 05000 05000 05000 0 0 0			-1		-1	-1		
52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 0 0 52.00	50.00	05000 OPERATING ROOM	0	(1, 960	0	0	50. 00
53.00 05300 ABSTHESI OLOCY 0 0 0 0 0 53.00	51.00	05100 RECOVERY ROOM	0	(0	o	0	51.00
54.00 05400 RADI OLOGY-DI ACNOSTIC 0 0 0 0 0 0 0 0 55.00	52.00	05200 DELIVERY ROOM & LABOR ROOM	0	(0	0	0	52. 00
55. 00 05500 RADI OLOGY-THERAPEUTI C		l	0	(0	0	0	1
56. 00 05600 RADI OI SOTOPE 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		l	0	(4	0	0	1
57. 00 05700 CT SCAN 0 0 0 1 0 0 57. 00		l	0	(0	0	_	1
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)			0	(0	0	0	1
59, 00 05900 CARDI AC CATHETERIZATION 0 0 0 435 0 0 59, 00		1 I	0	(] 1	0	0	1
60. 00 06000 LABORATORY			0	(0	0		1
60. 01 06001 BLOOD LABORATORY 0 0 0 0 0 0 0 0 0		1 I	0	(U		1
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY			0	(U O		
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 0 0 0 0 0 62. 00 63. 00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 0 0 0 0 0 0 63. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1 I	٧	(٩	U	
63. 00		1 I	0	(٥	0	1
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66. 00		1 I	o	(ol ol	ol	0	1
67. 00 06700 OCCUPATIONAL THERAPY 0 0 0 0 0 0 0 67. 00 68. 00 6800 SPEECH PATHOLOGY 0 0 0 0 0 0 68. 00 69. 00 6900 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 68. 00 69. 00 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1	o	Ć	o	o	0	
69. 00 06900 ELECTROCARDI OLOGY 0 0 1 0 0 69. 00 70. 00	67.00		o	(o	o	0	67. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 100 0 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 0 100 73. 00 74. 00 07400 RENAL DI ALYSI S 0 0 0 0 0 0 0 73. 00 75. 00 07500 ASC (NON-DI STI NCT PART) 0 0 0 0 0 75. 00 76. 00 03950 OTHER ANCI LL SRVC 0 0 0 0 0 0 76. 00 76. 01 03951 CARDI AC AND PULMONARY REHAB 0 0 0 0 0 0 0 76. 02 76. 02 03952	68.00	06800 SPEECH PATHOLOGY	O	(o	o	0	68. 00
71. 00	69.00	06900 ELECTROCARDI OLOGY	0	(1	0	0	69. 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 0 100 73. 00 74. 00 07400 RENAL DI ALYSIS 0 0 0 0 0 0 74. 00 75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 0 0 0 0 0 75. 00 76. 00 03950 OTHER ANCILL SRVC 0 0 0 0 0 0 0 76. 00 76. 01 03951 CARDI AC AND PULMONARY REHAB 0 0 0 0 0 0 0 0 76. 01 76. 02 03952 WOUND CARE 0 0 0 0 0 0 0 0 0 0 0 76. 02 77. 00 07700 ALLOGENEIC STEM CELL ACOUISITION 0 0 0 0 0 0 0 0 0 0 0 0 </td <td>70.00</td> <td>07000 ELECTROENCEPHALOGRAPHY</td> <td>0</td> <td>(</td> <td>0</td> <td>0</td> <td>0</td> <td>70. 00</td>	70.00	07000 ELECTROENCEPHALOGRAPHY	0	(0	0	0	70. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 100 73. 00 74. 00 74. 00 75. 00 07400 RENAL DI ALYSIS 0 0 0 0 0 0 0 74. 00 75. 00 07500 ASC (NON-DI STINCT PART) 0 0 0 0 0 0 0 75. 00 07500 07500 07500 07500 07500 07500 07500 07500 07500 07500 0 0 0 0 0 0 0 0 0	71. 00		0	(0	100	0	71. 00
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75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 0 75. 00 76. 00 03950 OTHER ANCILL SRVC 0 0 0 0 0 76. 00 76. 01 03951 CARDI AC AND PULMONARY REHAB 0 0 0 0 0 76. 01 76. 02 03952 WOUND CARE 0 0 0 0 0 0 77. 00 07700 ALLOGENEI C STEM CELL ACQUI SITION 0 0 0 0 0 0UTPATI ENT SERVI CE COST CENTERS 0 0 0 0 0 88. 00 08900 RURAL HEALTH CLINI C 0 0 0 0 0 89. 00 08900 FEDERALLY QUALI FIED HEALTH CENTER 0 0 0 0 0 89. 00 08900 FEDERALLY QUALI FIED HEALTH CENTER 0 0 0 0 0 90 0 0 0 0 0 0 90 0 0 0 0 0 90 0 0 0 0 90 0 0 0 90 0 0 0 90 0 0 0 90 0 0 0 90 0 0 90 0 0 90 0 0 90 0 0 90 0 0 90 0 0 90 0 0 90 0 0 90 0 0 90 0 0 90 0 0 90 0 0 90 0 0 90 0 0 90 0 0 90 0 90 0		l	0	(0	0		1
76. 00 03950 OTHER ANCILL SRVC 0 0 0 0 0 0 76. 00 76. 00 76. 01 03951 CARDI AC AND PULMONARY REHAB 0 0 0 0 0 0 76. 01 76. 01 76. 02 03952 WOUND CARE 0 0 0 0 0 0 0 76. 02 77. 00 01 01 01 01 01 01 01 01 01 01 01 01		l	0	(0		
76. 01 03951 CARDI AC AND PULMONARY REHAB 0 0 0 0 0 0 76. 01 76. 02 03952 WOUND CARE 0 0 0 0 0 0 76. 02 77. 00 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON 0 0 0 0 0 0 77. 00 OUTPATI ENT SERVI CE COST CENTERS 88. 00 08800 RURAL HEALTH CLINI C 0 0 0 0 0 0 88. 00 89. 00 08900 FEDERALLY QUALI FI ED HEALTH CENTER 0 0 0 0 0 89. 00		1 1 '	0	(0		
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88. 00 08800 RURAL HEALTH CLINIC 0 0 0 0 0 88. 00 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 89. 00	11.00		0	(<u> </u>	U _I	0	1 / / . 00
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COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0165 Peri od: Worksheet B-1 From 01/01/2020 12/31/2020 Date/Time Prepared: 7/29/2021 4:40 pm Cost Center Description CAFETERI A MAINTENANCE OF NURSI NG CENTRAL **PHARMACY** (MEALS SERVED) PERSONNEL ADMI NI STRATI ON SERVICES & (COSTED (NUMBER **SUPPLY** REQUIS.) (DIRECT NURS (COSTED HOUSED) REQUIS.) HRS.) 11.00 12.00 15.00 13.00 14.00 90. 01 09001 CLINIC 394 90.01 0 0 09002 CLI NI C 0 0 90. 02 268 90.02 0 0 91.00 09100 EMERGENCY 1,024 91.00 0 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0 0 94.00 0 09500 AMBULANCE SERVICES 0 0 00000 95.00 95.00 0 0 0 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 0 0 96.00 97.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 0 0 97.00 98.00 09850 OTHER REIMBURSE 0 0 98.00 0 09900 CMHC 0 99.00 99.00 0 0 99. 10 09910 CORF 0 0 99. 10 100.00 10000 I &R SERVICES-NOT APPRVD PRGM 0 0 100.00 0 0 0 101.00 10100 HOME HEALTH AGENCY 0 Ω 0 0 0 101 00 SPECIAL PURPOSE COST CENTERS 105.00 10500 KIDNEY ACQUISITION 0 0 105. 00 000000 0 0 106. 00 10600 HEART ACQUISITION 0 0 106, 00 Ω 0 107.00 10700 LIVER ACQUISITION 0 0 107, 00 108.00 10800 LUNG ACQUISITION 0 0 0 108. 00 0 109.00 10900 PANCREAS ACQUISITION 0 0 109. 00 110.00 11000 INTESTINAL ACQUISITION 0 0 110.00 Ω 111.00 11100 | SLET ACQUISITION 0 0 0 0 111.00 113.00 11300 INTEREST EXPENSE 113. 00 114.00 11400 UTILIZATION REVIEW-SNF 114. 00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 Ω 0 0 0 115.00 116. 00 11600 HOSPI CE 0 0 0 116.00 SUBTOTALS (SUM OF LINES 1 through 117) 12, 294 9, 986 100 100 118.00 118.00 NONREI MBURSABLE COST CENTERS 0 190, 00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 191. 00 19100 RESEARCH 0 0 0 0 0 191. 00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 0 192. 00 192. 01 19201 CENTER OF HOPE 0 0 0 0 0 192. 01 193. 00 19300 NONPALD WORKERS 0 193. 00 0 r 0 0 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00 2, 719, 257 202. 00 202.00 Cost to be allocated (per Wkst. B, 381, 674 3, 012, 018 391, 340 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 31.045551 0.000000 301.624074 3, 913. 400000 27, 192. 570000 203. 00 204.00 Cost to be allocated (per Wkst. B, 1, 188 43, 011 5, 452 210, 955 204. 00 Part II) 2, 109. 550000 205. 00 205.00 Unit cost multiplier (Wkst. B, Part 0.096633 0.000000 4.307130 54. 520000 11) 206.00 NAHE adjustment amount to be allocated 206. 00 (per Wkst. B-2) NAHE unit cost multiplier (Wkst. D, 207.00 207.00 Parts III and IV)

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0165

				Τ̈́	o 12/31/2020	Date/Time Pre 7/29/2021 4:4	
				OTHER GENERAL		7,27,202	J
	Cost Center Description	MEDI CAL	SOCIAL SERVICE	SERVICE OTHER GEN SERV	NONPHYSICIAN	NURSING SCHOOL	
		RECORDS &			ANESTHETI STS		
		LI BRARY (GROSS	(TIME SPENT)	(TIME SPENT)	(ASSI GNED TI ME)	(ASSIGNED TIME)	
		CHARGES)			IIWE)	I I WE	
	T	16. 00	17. 00	18. 00	19. 00	20.00	
1. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT			I			1.00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMI NI STRATI VE & GENERAL						5. 00
6. 00 7. 00	00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT						6. 00 7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00	00900 HOUSEKEEPI NG						9. 00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A			•			10.00
12. 00	01200 MAI NTENANCE OF PERSONNEL						12.00
13. 00	01300 NURSING ADMINISTRATION						13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY						14.00
15. 00 16. 00	O1500 PHARMACY O1600 MEDI CAL RECORDS & LI BRARY	399, 765, 113					15. 00 16. 00
17. 00	01700 SOCI AL SERVI CE	0	О				17. 00
18. 00	01850 OTHER GEN SERV	0	0	C)		18. 00
19. 00 20. 00	01900 NONPHYSI CI AN ANESTHETI STS 02000 NURSI NG SCHOOL	0	0			0	19. 00 20. 00
21. 00	02100 I &R SERVI CES-SALARY & FRINGES APPRVD	0					21.00
22. 00	02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	c	1		22. 00
23. 00	O2301 PARAMED ED PRGM INPATIENT ROUTINE SERVICE COST CENTERS	0	0	<u> </u> C)		23. 00
30. 00	03000 ADULTS & PEDIATRICS	28, 995, 550	0	C		0	30.00
31. 00	03100 INTENSIVE CARE UNIT	6, 083, 713	0			0	31. 00
32.00	03200 CORONARY CARE UNIT	0	0	C	0	0	1
33. 00 34. 00	03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT	0	0			0	
40. 00	04000 SUBPROVI DER - I PF	0	Ö	i c		ő	
41. 00	04100 SUBPROVI DER - I RF	0	0	C	0	0	1
43. 00 44. 00	04300 NURSERY 04400 SKILLED NURSING FACILITY	0	0		0	0	
45. 00	04500 NURSING FACILITY	0				0	
46. 00	04600 OTHER LONG TERM CARE	0	0	c	0	0	46. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	51, 787, 900	o	1 0		0	50.00
51. 00	05100 RECOVERY ROOM	5, 607, 032			-	1	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	c	0	0	52. 00
53.00	05300 ANESTHESI OLOGY	12, 998, 374	0	C	0	0	
54. 00 55. 00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	23, 766, 020 0	0			0	
	05600 RADI OI SOTOPE	Ö	Ö	Č		ő	
57. 00	05700 CT SCAN	33, 012, 900	l e	C	0	0	
58. 00 59. 00	05800 MAGNETI C RESONANCE MAGING (MRI) 05900 CARDIAC CATHETERIZATION	19, 960, 100 19, 654, 170				0	
60. 00	06000 LABORATORY	46, 914, 064				0	1
60. 01	06001 BLOOD LABORATORY	0	0	C	0	0	
61. 00 62. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0				o	61. 00 62. 00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0				0	1
64. 00	06400 I NTRAVENOUS THERAPY	0	0	C	0	o	1
65. 00	06500 RESPIRATORY THERAPY	3, 933, 732	0	C	0	0	
66. 00 67. 00	O6600 PHYSI CAL THERAPY O6700 OCCUPATI ONAL THERAPY	1, 592, 014 1, 101, 195	0			0	
68. 00	06800 SPEECH PATHOLOGY	316, 141	Ö	i c		ő	
69. 00	06900 ELECTROCARDI OLOGY	12, 318, 762		c	0	0	1
70.00	07000 ELECTROENCEPHALOGRAPHY	3, 858, 670	0	C	0	0	
71. 00 72. 00	O7100 MEDICAL SUPPLIES CHARGED TO PATIENTS O7200 MPL. DEV. CHARGED TO PATIENTS	17, 221, 561 22, 899, 645	0) 0	0	1
73. 00	07300 DRUGS CHARGED TO PATIENTS	20, 377, 871	Ö	ď		ő	73. 00
74. 00	07400 RENAL DI ALYSI S	0	0	<u> </u>	0	0	
75. 00 76. 00	O7500 ASC (NON-DISTINCT PART) O3950 OTHER ANCILL SRVC	0	0) 0	0	
76. 00 76. 01	03951 CARDI AC AND PULMONARY REHAB	378, 458				0	1
76. 02	03952 WOUND CARE	134, 151	0	· c	-	0	76. 02
77. 00	O7700 ALLOGENEI C STEM CELL ACQUI SI TI ON OUTPATI ENT SERVI CE COST CENTERS	0	0	C) 0	0	77. 00
88. 00	08800 RURAL HEALTH CLINIC	0	0	C	0	0	88. 00
	1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2		1		1		

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0165

				10	5 12/31/2020	7/29/2021 4:40	
				OTHER GENERAL		772772021 4.4	J pili
				SERVI CE			
	Cost Center Description	MEDI CAL	SOCIAL SERVICE	OTHER GEN SERV	NONPHYSI CI AN	NURSING SCHOOL	
	•	RECORDS &			ANESTHETI STS		
		LI BRARY	(TIME SPENT)	(TIME SPENT)	(ASSI GNED	(ASSI GNED	
		(GROSS			TIME)	TIME)	
		CHARGES)					
		16. 00	17. 00	18. 00	19. 00	20. 00	
	FEDERALLY QUALIFIED HEALTH CENTER	0		1	0		89. 00
	CLI NI C	0	0	_	0		90. 00
	CLI NI C	23, 068, 448	0	_	0	_	90. 01
	CLINIC	6, 095, 779	0	0	0	0	90. 02
	EMERGENCY	37, 688, 863	0	0	0	0	91.00
	OBSERVATION BEDS (NON-DISTINCT PART) REIMBURSABLE COST CENTERS						92. 00
	HOME PROGRAM DIALYSIS	0	0	0	0	0	94. 00
	AMBULANCE SERVICES	0			0		95. 00
	DURABLE MEDICAL EQUIP-RENTED	0		1	0		96. 00
	DURABLE MEDICAL EQUIP-SOLD	0		_	0	-	97. 00
	OTHER REIMBURSE	0	Ö		0		98. 00
99. 00 09900		0	Ö		0	0	99. 00
99. 10 09910		0	Ö	Ō	0	Ö	99. 10
	I&R SERVICES-NOT APPRVD PRGM	0	O	o	0	0	100.00
	HOME HEALTH AGENCY	0	o	o	0	0	101. 00
SPECI	AL PURPOSE COST CENTERS						
105. 00 10500	KIDNEY ACQUISITION	0	0	0	0	0	105.00
	HEART ACQUISITION	0	0	0	0		106. 00
	LIVER ACQUISITION	0	0	_	0		107. 00
	LUNG ACQUISITION	0	0	_	0	_	108. 00
	PANCREAS ACQUISITION	0	0	_	0		109. 00
	INTESTINAL ACQUISITION	0	0	0	0		110. 00
	I SLET ACQUI SI TI ON	0	0	0	0		111. 00
	I NTEREST EXPENSE						113. 00
	UTILIZATION REVIEW-SNF				0		114. 00
	AMBULATORY SURGICAL CENTER (D. P.)	0	0		0		115. 00
116. 00 11600 118. 00	l e e e e e e e e e e e e e e e e e e e	399, 765, 113	0	_	0		116. 00 118. 00
	SUBTOTALS (SUM OF LINES 1 through 117) IMBURSABLE COST CENTERS	399, 705, 113		ul U	0	0	118.00
	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
191. 00 19100		0			0		191. 00
	PHYSICIANS' PRIVATE OFFICES	0	Ö		0		192. 00
	CENTER OF HOPE	0	Ö	o o	0		192. 01
	NONPALD WORKERS	0	Ö	o o	0		193. 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, 545, 394	0	0	0	0	202. 00
	Part I)						
203. 00	Unit cost multiplier (Wkst. B, Part I)	0. 003866	0. 000000	0.000000	0.000000	0.000000	203. 00
204. 00	Cost to be allocated (per Wkst. B,	28, 328	0	0	0	0	204. 00
	Part II)						
205. 00	Unit cost multiplier (Wkst. B, Part	0. 000071	0. 000000	0. 000000	0. 000000	0. 000000	205. 00
20/ 00	NAME of the state						20/ 22
206. 00	NAHE adjustment amount to be allocated					0	206. 00
207. 00	(per Wkst. B-2) NAHE unit cost multiplier (Wkst. D,					0. 000000	207 00
207.00	Parts III and IV)					0.000000	201.00
ı	1	I	ı	1		1	

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Peri od: Worksheet B-1 From 01/01/2020 To 12/31/2020 Date/Time Prepared: Provider CCN: 15-0165

						Date/Time Prep 7/29/2021 4:40	
		INTERNS &	RESI DENTS			7/29/2021 4.40	Э рііі
	Cost Center Description	SERVI CES-SALAR Y & FRI NGES (ASSI GNED TI ME) 21.00	SERVI CES-OTHER PRGM COSTS (ASSI GNED TI ME) 22.00	PARAMED ED PRGM (ASSI GNED TI ME) 23. 00			
	GENERAL SERVICE COST CENTERS						
1. 00 2. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 14. 00 15. 00 16. 00 17. 00 18. 00 20. 00 21. 00 22. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01200 MAINTENANCE OF PERSONNEL 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 01850 OTHER GEN SERV 01900 NONPHYSICIAN ANESTHETISTS 02000 NURSING SCHOOL 02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	0				1. 00 2. 00 4. 00 5. 00 6. 00 7. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 20. 00 21. 00 22. 00
23. 00	02301 PARAMED ED PRGM				0		23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	0	0	1	0		30.00
31. 00 32. 00	03100 INTENSIVE CARE UNIT	0	0		0		31. 00 32. 00
33. 00	03300 BURN INTENSIVE CARE UNIT	0	0		0		33. 00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0	0		0		34.00
40.00	04000 SUBPROVI DER - I PF	0	0)	0		40.00
41. 00	04100 SUBPROVI DER – I RF	0	0	1	0		41. 00
43. 00	04300 NURSERY	0	0	1	0		43. 00
44. 00	04400 SKILLED NURSING FACILITY	0	0		0		44. 00
45. 00 46. 00	04500 NURSING FACILITY 04600 OTHER LONG TERM CARE	0	0	1	0		45. 00 46. 00
46.00	ANCI LLARY SERVI CE COST CENTERS	U	U		U _I		46.00
50. 00	05000 OPERATING ROOM	0	0		0		50. 00
51. 00	05100 RECOVERY ROOM	o	0	1	0		51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0	,	0		52. 00
53.00	05300 ANESTHESI OLOGY	0	0)	0		53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0		54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0		0		55. 00
56. 00	05600 RADI OI SOTOPE	0	0		0		56.00
57. 00 58. 00	1 1	0	0		0		57. 00 58. 00
59. 00	05900 CARDIAC CATHETERIZATION	0	0		0		59. 00
60.00	1 1	ő	0		0		60. 00
60. 01	06001 BLOOD LABORATORY	0	0		0		60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0)	0		62.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	1	0		63. 00
64. 00	06400 I NTRAVENOUS THERAPY	0	0		0		64. 00
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0	0		0		65. 00 66. 00
67. 00	06700 OCCUPATIONAL THERAPY	0	0		0		67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0		0		68. 00
69. 00	06900 ELECTROCARDI OLOGY	o	0	,	0		69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0)	0		70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0		71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0		72. 00
73.00	1	0	0	1	0		73.00
74.00	07400 RENAL DIALYSIS	0	0		U		74.00
75. 00 76. 00	O7500 ASC (NON-DISTINCT PART) O3950 OTHER ANCILL SRVC		0		0		75. 00 76. 00
76. 00	03951 CARDI AC AND PULMONARY REHAB		0		Ö		76. 00 76. 01
76. 02	1 1	Ö	0		0		76. 02
77. 00	1 1	0	0		0		77. 00
	OUTPATIENT SERVICE COST CENTERS				_		
88. 00	1 1	0	0	1	0		88. 00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	1	0		89. 00

			10	5 12/31/2020 Date/lime P 7/29/2021 4	
	INTERNS &	RESI DENTS		172772021 4	. 40 piii
Cost Center Description	SERVI CES-SALAR		PARAMED ED		
	Y & FRINGES	PRGM COSTS	PRGM		
	(ASSI GNED	(ASSI GNED	(ASSI GNED		
	TI ME) 21.00	TI ME) 22. 00	TI ME) 23. 00		
90. 00 09000 CLI NI C	21.00	22.00	23.00		90.00
90. 01 09001 CLI NI C		0	0		90. 01
90. 02 09002 CLINI C		o	0		90. 02
91. 00 09100 EMERGENCY	l ol	o	0		91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT	PART)				92. 00
OTHER REIMBURSABLE COST CENTERS			<u>'</u>		
94.00 09400 HOME PROGRAM DIALYSIS	0	0	0		94. 00
95. 00 09500 AMBULANCE SERVICES	0	0	0		95. 00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0		96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0		97. 00
98. 00 09850 OTHER REI MBURSE	0	0	0		98. 00
99. 00 09900 CMHC	0	0	0		99. 00
99. 10 09910 CORF	0	0	0		99. 10
100. 00 10000 I &R SERVICES-NOT APPRVD PRGM	0	0	0		100.00
101. 00 10100 HOME HEALTH AGENCY	0	0	0		101. 00
SPECIAL PURPOSE COST CENTERS 105. 00 10500 KIDNEY ACQUISITION	0	ol	0		105. 00
106. 00 10600 HEART ACQUISITION	0	0	0		106. 00
107. 00 10700 LI VER ACQUI SI TI ON	J O	0	0		107. 00
108. 00 10800 LUNG ACQUISITION	l ő	0	0		107.00
109. 00 10900 PANCREAS ACQUISITION	Ö	0	0		109.00
110. 00 11000 NTESTI NAL ACQUI SI TI ON		0	0		110.00
111. 00 11100 SLET ACQUISITION	o	o	0		111. 00
113.00 11300 INTEREST EXPENSE					113. 00
114.00 11400 UTILIZATION REVIEW-SNF					114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. F	P.) 0	0	0		115. 00
116. 00 11600 HOSPI CE			0		116. 00
118.00 SUBTOTALS (SUM OF LINES 1 throu	ıgh 117) 0	0	0		118. 00
NONREI MBURSABLE COST CENTERS					
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CAN		0	0		190. 00
191. 00 19100 RESEARCH	0	0	0		191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES 192.01 19201 CENTER OF HOPE	0	0	0		192. 00 192. 01
193. 00 19300 NONPALD WORKERS	0	0	0		192.01
200.00 Cross Foot Adjustments		U	U		200. 00
201.00 Negative Cost Centers					201. 00
202.00 Cost to be allocated (per Wkst.	В	0	0		202.00
Part I)	5,	ď	J		202.00
203.00 Unit cost multiplier (Wkst. B,	Part I) 0.000000	0. 000000	0.000000		203. 00
204.00 Cost to be allocated (per Wkst.	B, O	0	0		204. 00
Part II)					
205.00 Unit cost multiplier (Wkst. B,	Part 0.000000	0. 000000	0. 000000		205. 00
11)					
206.00 NAHE adjustment amount to be al	I ocated		0		206. 00
(per Wkst. B-2)			0.000000		207.00
207.00 NAHE unit cost multiplier (Wkst Parts III and IV)	. υ,		0. 000000		207. 00
raits iii allu iv)	l l	I			I

	i Financiai Systems	FRANCI SCAN HEA				u of Form CMS-2	2552-10
COMPUT	TATION OF RATIO OF COSTS TO CHARGES		Provi der C		Peri od:	Worksheet C	
					From 01/01/2020 To 12/31/2020		narod:
					10 12/31/2020	7/29/2021 4:4	nm nm
			Ti tl e	e XVIII	Hospi tal	PPS	о р
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	5551 551151 55551 Pt. 511	(from Wkst. B,	Adj .	10141 00010	Di sal I owance		
		Part I, col.	,, .		Di oui i oliulioo		
		26)					
		1.00	2. 00	3.00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	0.00	1.00	0.00	
30. 00		20, 683, 893		20, 683, 89	3 0	20, 683, 893	30.00
		4, 678, 200		4, 678, 20		4, 678, 200	•
		0			ol ol	0	32.00
	l l					0	
34. 00				•	0 0	0	
						0	40.00
40.00		0			0	0	
41.00		0			0	_	41.00
43. 00		0				0	43.00
44. 00		0				0	44.00
45. 00	l l	0			0	0	45. 00
46. 00		0			0 0	0	46. 00
	ANCILLARY SERVICE COST CENTERS	0 (00 040			0 0.01	0 (04 00)	
50.00		9, 690, 948		9, 690, 94			1
51. 00		2, 234, 443		2, 234, 44		2, 234, 443	
52.00		0		1	0	0	52. 00
53. 00		1, 658, 862		1, 658, 86		1, 658, 862	53. 00
54. 00		4, 210, 313		4, 210, 31		4, 210, 313	
55. 00		0			0 0	0	55. 00
56.00		0			0 0	0	56. 00
57.00	05700 CT SCAN	1, 147, 053		1, 147, 05	3 0	1, 147, 053	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	1, 897, 571		1, 897, 57	1 0	1, 897, 571	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	4, 061, 424		4, 061, 42	4 0	4, 061, 424	59.00
60.00	06000 LABORATORY	7, 841, 143		7, 841, 14	3 5, 814	7, 846, 957	60.00
60. 01	06001 BLOOD LABORATORY	o			o o	0	60. 01
61.00		0			o o	0	61.00
62.00					0	0	62.00
63. 00		0				0	63. 00
64. 00		0				0	64.00
65. 00		1, 572, 473	(1, 572, 47	3 0	1, 572, 473	•
66. 00	l l	401, 748		401, 74		401, 748	
67. 00	l l	214, 400		214, 40		214, 400	
							•
68. 00		60, 009	C	60, 00		60, 009	
69. 00		609, 612		609, 61		609, 612	
70.00		2, 683, 417		2, 683, 41	· ·		•
				2, 900, 38		2, 900, 382	•
		11, 992, 782		11, 992, 78		11, 992, 782	
		6, 507, 362		6, 507, 36		6, 507, 362	
	07400 RENAL DI ALYSI S	0			0 0	0	
		0			이	0	
	03950 OTHER ANCILL SRVC	0			0 0		
	03951 CARDI AC AND PULMONARY REHAB	242, 606		242, 60			
	03952 WOUND CARE	67, 244		67, 24		67, 244	76. 02
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0			0 0	0	77. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00		0			0 0	0	
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0			0 0	0	89. 00
90.00	09000 CLI NI C	O			0 0	0	90.00
90.01	09001 CLI NI C	3, 351, 610		3, 351, 61	0 0	3, 351, 610	90. 01
90.02	09002 CLI NI C	1, 019, 962		1, 019, 96	2 0	1, 019, 962	90. 02
91.00	09100 EMERGENCY	5, 993, 439		5, 993, 43	9 0	5, 993, 439	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1		2, 601, 24	5	2, 601, 245	
	OTHER REIMBURSABLE COST CENTERS				-1		
94.00		0			0 0	0	94.00
		0			o o	0	
		0			ol ol	0	96.00
	09700 DURABLE MEDICAL EQUIP-SOLD				ol ol	0	97.00
						0	98.00
	09900 CMHC	0				0	99.00
	09910 CORF	0			o I	0	ı
	l l	1		•	0		100.00
	0 10000 1&R SERVICES-NOT APPRVD PRGM	0		l l			
101.00	0 10100 HOME HEALTH AGENCY	0			0	0	101. 00
105 00	SPECIAL PURPOSE COST CENTERS						105 00
	0 10500 KI DNEY ACQUI SI TI ON	0			0	0	105.00
	0 10600 HEART ACQUISITION	0			0		106.00
	0 10700 LIVER ACQUISITION	0			0		107. 00
	0 10800 LUNG ACQUISITION	0			0		108. 00
	0 10900 PANCREAS ACQUISITION	0			0		109.00
	0 11000 I NTESTI NAL ACQUI SI TI ON	0			0		110.00
111.00	0 11100 ISLET ACQUISITION	0		<u> </u>	0	0	111. 00

Health Financial Systems	FRANCI SCAN HE	ALTH MUNSTER		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der C	CN: 15-0165	Peri od: From 01/01/2020 To 12/31/2020	Worksheet C Part I Date/Time Pre 7/29/2021 4:4	
		Title	e XVIII	Hospi tal	PPS	
				Costs		
Cook Cooker Dooreitstien	Total Coot	The amount of the state of	T-+-1 C+	- DCF	T-+-1 C+-	

		Title	XVIII	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst. B,	Adj .		Di sal I owance		
	Part I, col.	•				
	26)					
	1.00	2.00	3. 00	4. 00	5. 00	
113. 00 11300 INTEREST EXPENSE						113. 00
114.00 11400 UTILIZATION REVIEW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0		0		0	115. 00
116. 00 11600 HOSPI CE	0		0		0	116. 00
200.00 Subtotal (see instructions)	98, 322, 141	0	98, 322, 141	14, 175	98, 336, 316	200. 00
201.00 Less Observation Beds	2, 601, 245		2, 601, 245		2, 601, 245	201.00
202.00 Total (see instructions)	95, 720, 896	0	95, 720, 896	14, 175	95, 735, 071	202. 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet C | From 01/01/2020 | Part | | To 12/31/2020 | Date/Time Prepared: | 7/29/2021 4:40 pm Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0165

					7/29/2021 4:4	O pm
			XVIII	Hospi tal	PPS	_
Cook Cooker Doorsinking	1	Charges	T-+-1 (1 (0+ 0+	TEEDA	
Cost Center Description	Inpatient	Outpati ent		Cost or Other	TEFRA	
			+ col. 7)	Ratio	I npati ent Rati o	
	6. 00	7. 00	8.00	9. 00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00	0.00	7. 00	10.00	
30. 00 03000 ADULTS & PEDI ATRI CS	19, 951, 514		19, 951, 514			30. 00
31. 00 03100 INTENSIVE CARE UNIT	6, 083, 713		6, 083, 713			31. 00
32. 00 03200 CORONARY CARE UNIT	0,000,7.10		0,000,710			32. 00
33. 00 03300 BURN INTENSIVE CARE UNIT	0		1 0			33. 00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	0		0			34.00
40. 00 04000 SUBPROVI DER - 1 PF	0		0			40.00
41. 00 04100 SUBPROVI DER - I RF	0		0			41. 00
43. 00 04300 NURSERY	0		0			43.00
44.00 04400 SKILLED NURSING FACILITY	0		0			44. 00
45.00 04500 NURSING FACILITY	0		0			45. 00
46.00 O4600 OTHER LONG TERM CARE	0		0			46. 00
ANCI LLARY SERVI CE COST CENTERS			T			
50. 00 05000 OPERATI NG ROOM	9, 986, 757	41, 801, 143			0.000000	1
51. 00 05100 RECOVERY ROOM	935, 794		1		0.000000	1
52. 00 05200 DELI VERY ROOM & LABOR ROOM	2 704 040	10 204 226	· -		0.000000	
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 704, 048		1		0. 000000 0. 000000	
55. 00 05500 RADI OLOGY - DI AGNOSTI C	4, 319, 521 0	19, 446, 499 0	1		0. 000000	
56. 00 05600 RADI 0I SOTOPE	0				0. 000000	
57. 00 05700 CT SCAN	7, 313, 543	25, 699, 357	_		0. 000000	
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	1, 702, 075				0. 000000	
59. 00 05900 CARDI AC CATHETERI ZATI ON	11, 017, 293				0. 000000	1
60. 00 06000 LABORATORY	14, 428, 954	32, 485, 110			0. 000000	
60. 01 06001 BLOOD LABORATORY	0	O	0		0. 000000	
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	O	0		0. 000000	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0.000000	0. 000000	62. 00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	O	0	0.000000	0. 000000	63. 00
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0. 000000	0. 000000	64. 00
65. 00 06500 RESPIRATORY THERAPY	2, 649, 702	1, 284, 030	3, 933, 732	0. 399741	0. 000000	65. 00
66. 00 06600 PHYSI CAL THERAPY	1, 083, 657	508, 357	1, 592, 014	0. 252352	0.000000	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	823, 875	277, 320	1, 101, 195		0. 000000	
68. 00 06800 SPEECH PATHOLOGY	296, 436		1	0. 189817	0. 000000	
69. 00 06900 ELECTROCARDI OLOGY	3, 663, 987	8, 654, 775	1		0. 000000	
70. 00 07000 ELECTROENCEPHALOGRAPHY	61, 906				0. 000000	
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	7, 487, 887	9, 733, 674			0. 000000	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	7, 683, 678		1		0.000000	
73. 00 07300 DRUGS CHARGED TO PATIENTS	11, 526, 699		1		0.000000	1
74. 00 07400 RENAL DIALYSIS 75. 00 07500 ASC (NON-DISTINCT PART)	0	0	•		0. 000000 0. 000000	
76. 00 07500 ASC (NON-DISTINCT PART) 76. 00 03950 OTHER ANCILL SRVC	0				0. 000000	
76. 01 03951 CARDI AC AND PULMONARY REHAB	64	378, 394	_		0. 000000	
76. 02 03952 WOUND CARE	2, 418		1		0. 000000	
77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION	2,110	0	1		0. 000000	1
OUTPATIENT SERVICE COST CENTERS			-	2. 22222		
88. 00 08800 RURAL HEALTH CLINIC	0	C	0			88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			89. 00
90. 00 09000 CLI NI C	0	0	0	0. 000000	0. 000000	90.00
90. 01 09001 CLI NI C	627, 631	22, 440, 817	23, 068, 448	0. 145290	0.000000	90. 01
90. 02 09002 CLI NI C	0	6, 095, 779			0. 000000	1
91. 00 09100 EMERGENCY	10, 141, 468				0. 000000	1
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART)	1, 000, 000	8, 044, 036	9, 044, 036	0. 287620	0. 000000	92. 00
OTHER REIMBURSABLE COST CENTERS		-		0.0000==	0.0005	
94. 00 09400 HOME PROGRAM DI ALYSI S		0			0.000000	1
95. 00 09500 AMBULANCE SERVI CES	0	0			0.000000	
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD			0		0.000000	1
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 98. 00 09850 OTHER REI MBURSE			0		0. 000000 0. 000000	
99. 00 09900 CMHC	0	0			0.00000	99. 00
99. 10 09910 CORF	0		Ö			99. 10
100.00 10000 I &R SERVI CES-NOT APPRVD PRGM	0	Ö	•			100.00
101. 00 10100 HOME HEALTH AGENCY	0	Ö	1			101.00
SPECIAL PURPOSE COST CENTERS						1
105. 00 10500 KI DNEY ACQUI SI TI ON	0	O	0			105. 00
106. 00 10600 HEART ACQUI SI TI ON	0	0	l .			106. 00
107.00 10700 LIVER ACQUISITION	0	0	0			107. 00
108.00 10800 LUNG ACQUISITION	0	0	0			108. 00
109.00 10900 PANCREAS ACQUISITION	0	0	0			109. 00
110. 00 11000 NTESTI NAL ACQUI SI TI ON	0	0	0			110. 00
111. 00 11100 SLET ACQUI SI TI ON	0	0	0			111.00
113.00 11300 INTEREST EXPENSE	1					113. 00

Health Financial Systems	FRANCISCAN HEA	ALTH MUNSTER		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider Co		Peri od: From 01/01/2020 To 12/31/2020	Worksheet C Part I Date/Time Pre 7/29/2021 4:40	
		Title	: XVIII	Hospi tal	PPS	
		Charges		·		
Cost Center Description	I npati ent	Outpati ent	Total (col.	6 Cost or Other	TEFRA	

			litle	XVIII	ноѕрі таі	PPS	
			Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
				+ col . 7)	Ratio	I npati ent	
						Ratio	
		6.00	7. 00	8. 00	9. 00	10.00	
114. 00 11400	UTILIZATION REVIEW-SNF						114. 00
115. 00 11500	AMBULATORY SURGICAL CENTER (D. P.)	0	0	C			115. 00
116. 00 11600	HOSPI CE	0	0	C			116. 00
200.00	Subtotal (see instructions)	125, 492, 620	274, 272, 493	399, 765, 113			200.00
201. 00	Less Observation Beds						201.00
202. 00	Total (see instructions)	125, 492, 620	274, 272, 493	399, 765, 113			202. 00

Title XVIII

		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 NTENSI VE CARE UNI T					31.00
32. 00 03200 CORONARY CARE UNIT					32. 00
					33.00
33. 00 03300 BURN INTENSIVE CARE UNIT					
34. 00 03400 SURGI CAL INTENSI VE CARE UNI T					34. 00
40. 00 04000 SUBPROVI DER - I PF					40. 00
41. 00 04100 SUBPROVI DER - I RF					41. 00
43. 00 04300 NURSERY					43.00
44.00 04400 SKILLED NURSING FACILITY					44.00
45.00 04500 NURSING FACILITY					45. 00
46.00 04600 OTHER LONG TERM CARE					46. 00
ANCILLARY SERVICE COST CENTERS					1 .0.00
50. 00 05000 OPERATI NG ROOM	0. 187192				50.00
	1				1
51. 00 05100 RECOVERY ROOM	0. 398507				51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000				52. 00
53. 00 05300 ANESTHESI OLOGY	0. 127621				53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 177157				54. 00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000				55. 00
56. 00 05600 RADI OI SOTOPE	0. 000000				56. 00
57. 00 05700 CT SCAN	0. 034746				57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 095068				58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 206644				59.00
60. 00 06000 LABORATORY	0. 167262				60.00
	1				1
60. 01 06001 BLOOD LABORATORY	0. 000000				60. 01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000				61. 00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000				62. 00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000				63.00
64.00 06400 INTRAVENOUS THERAPY	0. 000000				64. 00
65. 00 06500 RESPIRATORY THERAPY	0. 399741				65.00
66. 00 06600 PHYSI CAL THERAPY	0. 252352				66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 194698				67.00
	1				1
68. 00 06800 SPEECH PATHOLOGY	0. 189817				68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 049486				69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 696725				70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 168416				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 523710				72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 319335				73. 00
74. 00 07400 RENAL DIALYSIS	0. 000000				74. 00
75. 00 07500 ASC (NON-DISTINCT PART)	0. 000000				75. 00
	1				1
	0. 000000				76.00
76. 01 03951 CARDI AC AND PULMONARY REHAB	0. 641038				76. 01
76. 02 03952 WOUND CARE	0. 501256				76. 02
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000				77. 00
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC					88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER					89. 00
90. 00 09000 CLI NI C	0. 000000				90.00
90. 01 09001 CLI NI C	0. 145290				90. 01
90. 02 09002 CLI NI C	0. 167323				90. 02
91. 00 09100 EMERGENCY	0. 159024				91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART)	0. 287620				92. 00
OTHER REIMBURSABLE COST CENTERS					
94.00 09400 HOME PROGRAM DIALYSIS	0. 000000				94. 00
95. 00 09500 AMBULANCE SERVICES	0. 000000				95. 00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000				96. 00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0. 000000				97. 00
98. 00 09850 OTHER REI MBURSE	0. 000000				98.00
99. 00 09900 CMHC	0.000000				99.00
					99. 10
99. 10 09910 CORF					1
100.00 10000 I&R SERVICES-NOT APPRVD PRGM					100. 00
101.00 10100 HOME HEALTH AGENCY					101. 00
SPECIAL PURPOSE COST CENTERS					
105.00 10500 KIDNEY ACQUISITION					105. 00
106.00 10600 HEART ACQUISITION					106. 00
107. 00 10700 LIVER ACQUISITION	1				107. 00
108. 00 10800 LUNG ACQUISITION					108.00
109. 00 10900 PANCREAS ACQUISITION	1				109.00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON					110.00
111.00 11100 I SLET ACQUI SI TI ON					111. 00
113.00 11300 INTEREST EXPENSE					113. 00
114.00 11400 UTILIZATION REVIEW-SNF					114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)					115. 00
<u> </u>					

Health Financial Systems	_TH MUNSTER	In Lieu of Form CMS-2552-10			
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0165	Peri od: From 01/01/2020 To 12/31/2020	Worksheet C Part I Date/Time Pre 7/29/2021 4:4	
		Title XVIII	Hospi tal	PPS	
Cost Center Description	PPS Inpatient				
	Ratio				
	11. 00				
116. 00 11600 HOSPI CE					116. 00
200.00 Subtotal (see instructions)					200.00
201.00 Less Observation Beds					201. 00
202.00 Total (see instructions)					202. 00

		OF RATIO OF COSTS TO CHARGES	TIVANOT SOAN TIE		CN: 15-0165	Peri od:	Worksheet C	2002 10
						From 01/01/2020 To 12/31/2020	Date/Time Pre	pared:
				Ti tl	e XIX	Hospi tal	7/29/2021 4: 4 PPS	0 pm
		0 1 0 1 5 11	T		T. I. O. I.	Costs	T	
		Cost Center Description	Total Cost (from Wkst. B,	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
			Part I, col.	,				
			26) 1. 00	2. 00	3.00	4. 00	5. 00	
		IENT ROUTINE SERVICE COST CENTERS						
		ADULTS & PEDIATRICS INTENSIVE CARE UNIT	20, 683, 893 4, 678, 200		20, 683, 893 4, 678, 200		20, 683, 893 4, 678, 200	
		CORONARY CARE UNIT	4, 678, 200			0 0	4, 078, 200	32.00
	1	BURN INTENSIVE CARE UNIT	0			0	0	33. 00
		SURGICAL INTENSIVE CARE UNIT SUBPROVIDER - IPF	0			0	0	
		SUBPROVI DER - I RF	0			0 0	0	•
		NURSERY SKILLED NURSING FACILITY	0			0 0	0	
		NURSING FACILITY	0			0 0	0	44. 00 45. 00
	04600	OTHER LONG TERM CARE	0			0 0	0	46. 00
50 00		LARY SERVICE COST CENTERS OPERATING ROOM	9, 690, 948		9, 690, 94	8 3, 348	9, 694, 296	50.00
		RECOVERY ROOM	2, 234, 443		2, 234, 44			•
		DELIVERY ROOM & LABOR ROOM	0			0	0	
		ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C	1, 658, 862 4, 210, 313		1, 658, 862 4, 210, 313		1, 658, 862 4, 210, 313	
55.00	05500	RADI OLOGY-THERAPEUTI C	0			0 0	0	55. 00
		RADI OI SOTOPE CT SCAN	0			0	1 147 053	
		MAGNETIC RESONANCE IMAGING (MRI)	1, 147, 053 1, 897, 571		1, 147, 05; 1, 897, 57;		1, 147, 053 1, 897, 571	
59.00	05900	CARDI AC CATHETERI ZATI ON	4, 061, 424		4, 061, 42	4 0	4, 061, 424	59. 00
60. 00 60. 01		LABORATORY BLOOD LABORATORY	7, 841, 143		7, 841, 14	5, 814 0 0	7, 846, 957 0	
		PBP CLINICAL LAB SERVICES-PRGM ONLY	0			0 0	0	
		WHOLE BLOOD & PACKED RED BLOOD CELLS	0			0	0	62. 00
63. 00 64. 00		BLOOD STORING, PROCESSING & TRANS. INTRAVENOUS THERAPY	0			0 0	0	63. 00 64. 00
		RESPI RATORY THERAPY	1, 572, 473	C	1, 572, 47	-	1, 572, 473	
		PHYSI CAL THERAPY	401, 748		401, 74		401, 748	•
67. 00 68. 00		OCCUPATIONAL THERAPY SPEECH PATHOLOGY	214, 400 60, 009		214, 400		214, 400 60, 009	1
69.00	06900	ELECTROCARDI OLOGY	609, 612		609, 61	2 0	609, 612	69. 00
		ELECTROENCEPHALOGRAPHY MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 683, 417 2, 900, 382		2, 683, 41 ² 2, 900, 38 ²		2, 688, 430 2, 900, 382	ı
		IMPL. DEV. CHARGED TO PATIENTS	11, 992, 782		11, 992, 78	2 0	11, 992, 782	72. 00
		DRUGS CHARGED TO PATIENTS	6, 507, 362		6, 507, 36	2 0	6, 507, 362	
		RENAL DIALYSIS ASC (NON-DISTINCT PART)	0			0 0	0	ı
76.00	03950	OTHER ANCILL SRVC	0			0	0	76. 00
		CARDIAC AND PULMONARY REHAB	242, 606 67, 244		242, 600 67, 24		242, 606 67, 244	
		ALLOGENEIC STEM CELL ACQUISITION	07, 244			0 0		
		TIENT SERVICE COST CENTERS						
		RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER	0			0 0	0	88. 00 89. 00
90.00	09000	CLINIC	0			0	0	90.00
90. 01 90. 02		CLINIC CLINIC	3, 351, 610 1, 019, 962		3, 351, 610 1, 019, 96		3, 351, 610 1, 019, 962	
		EMERGENCY	5, 993, 439		5, 993, 43		5, 993, 439	
92. 00		OBSERVATION BEDS (NON-DISTINCT PART)	2, 601, 245		2, 601, 24	5	2, 601, 245	92. 00
94. 00		REIMBURSABLE COST CENTERS HOME PROGRAM DIALYSIS	0		1	0 0	0	94. 00
		AMBULANCE SERVICES	0		1	0 0	0	95. 00
		DURABLE MEDICAL EQUIP-RENTED	0		1	0 0	0	96.00
		DURABLE MEDICAL EQUIP-SOLD OTHER REIMBURSE	0			0 0	0	97. 00 98. 00
99. 00	09900	СМНС	0			0	0	
99. 10		CORF L&R SERVICES-NOT APPRVD PRGM	0			0	0	99. 10 100. 00
		HOME HEALTH AGENCY	0		1	0		101.00
105.00		AL PURPOSE COST CENTERS	1 -					105 00
	1	KIDNEY ACQUISITION HEART ACQUISITION	0			0		105. 00 106. 00
107.00	10700	LIVER ACQUISITION	0			0	0	107. 00
		LUNG ACQUISITION PANCREAS ACQUISITION	0		1	0		108. 00 109. 00
110.00	11000	INTESTINAL ACQUISITION	0			0	0	110. 00
111. 00	11100	ISLET ACQUISITION	0			0		111. 00

Health Financial Systems	FRANCI SCAN HEA	ALTH MUNSTER		In Lieu of Form CMS-2552-10		
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der Co	CN: 15-0165	Period: From 01/01/2020 To 12/31/2020	Worksheet C Part I Date/Time Pre 7/29/2021 4:4	
		Ti tl	e XIX	Hospi tal	PPS	
		·		Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Cost	s RCF	Total Costs	

		Ti tl	e XIX	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst. B,	Adj .		Di sal I owance		
	Part I, col.	·				
	26)					
	1.00	2.00	3. 00	4. 00	5. 00	
113. 00 11300 I NTEREST EXPENSE						113. 00
114.00 11400 UTILIZATION REVIEW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	o		0		0	115. 00
116. 00 11600 HOSPI CE	o		0		0	116. 00
200.00 Subtotal (see instructions)	98, 322, 141	0	98, 322, 141	14, 175	98, 336, 316	200. 00
201.00 Less Observation Beds	2, 601, 245		2, 601, 245		2, 601, 245	201.00
202.00 Total (see instructions)	95, 720, 896	0	95, 720, 896	14, 175	95, 735, 071	202. 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet C | From 01/01/2020 | Part | | To 12/31/2020 | Date/Time Prepared: | 7/29/2021 4:40 pm Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0165

		e XIX	Hospi tal	PPS	
			·		
Cost Center Description Inpatient	Charges Outpatient	Total (col. 6	Cost or Other	TEFRA	
The trent	output on	+ col . 7)	Ratio	Inpati ent	
		,		Rati o	
6.00	7. 00	8. 00	9. 00	10.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	al .	10 051 51	,		20.00
30. 00 03000 ADULTS & PEDI ATRI CS 19, 951, 51 31. 00 03100 NTENSI VE CARE UNI T 6, 083, 71		19, 951, 514			30. 00 31. 00
31. 00 03100 I NTENSI VE CARE UNI T 6, 083, 71 32. 00 03200 CORONARY CARE UNI T 6, 083, 71	0	6, 083, 713			32.00
33. 00 03300 BURN INTENSIVE CARE UNIT	0				33.00
34. 00 O3400 SURGI CAL INTENSIVE CARE UNIT	o				34. 00
40. 00 04000 SUBPROVI DER - 1 PF	0				40. 00
41. 00 04100 SUBPROVI DER - I RF	0				41. 00
43. 00 04300 NURSERY	0	()		43.00
44.00 04400 SKILLED NURSING FACILITY 45.00 04500 NURSING FACILITY	0				44.00
46. 00 04600 OTHER LONG TERM CARE	0				45. 00 46. 00
ANCI LLARY SERVI CE COST CENTERS	o _l		/		40.00
50. 00 05000 OPERATI NG ROOM 9, 986, 75	57 41, 801, 143	51, 787, 900	0. 187128	0.000000	50.00
51. 00 05100 RECOVERY ROOM 935, 79	4, 671, 238	5, 607, 032	0. 398507	0. 000000	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	1		0. 000000	52.00
53. 00 05300 ANESTHESI OLOGY				0.000000	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	19, 446, 499	23, 766, 020		0. 000000 0. 000000	54. 00 55. 00
56. 00 05600 RADI 0I SOTOPE			0. 000000	0.00000	56.00
57. 00 05700 CT SCAN 7, 313, 54	25, 699, 35	33, 012, 900		0. 000000	57.00
58. 00 05800 MAGNETI C RESONANCE MAGING (MRI) 1,702,07				0.000000	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON 11, 017, 29				0. 000000	59. 00
60. 00 06000 LABORATORY		1		0. 000000	60.00
60. 01 06001 BLOOD LABORATORY				0.000000	60. 01
61. 00 06100 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS			0. 000000 0. 000000	0. 000000 0. 000000	61. 00 62. 00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.			0. 000000	0. 000000	63.00
64. 00 06400 I NTRAVENOUS THERAPY			0. 000000	0. 000000	64.00
65. 00 06500 RESPI RATORY THERAPY 2,649,70	1, 284, 030	3, 933, 732		0. 000000	65. 00
66. 00 06600 PHYSI CAL THERAPY 1, 083, 65	508, 35	1, 592, 014	0. 252352	0. 000000	66. 00
67. 00 06700 0CCUPATI ONAL THERAPY 823, 87				0. 000000	67. 00
68. 00 06800 SPEECH PATHOLOGY 296, 43		1		0.000000	68. 00
69. 00 06900 ELECTROCARDI OLOGY 3, 663, 98 70. 00 07000 ELECTROENCEPHALOGRAPHY 61, 90				0. 000000 0. 000000	69. 00 70. 00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 7, 487, 88				0. 000000	71.00
72. 00 07200 MPL. DEV. CHARGED TO PATIENTS 7, 683, 67				0. 000000	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 11, 526, 69				0.000000	73. 00
74. 00 07400 RENAL DI ALYSI S	0		0.00000	0. 000000	74. 00
75. 00 07500 ASC (NON-DI STINCT PART)	0) (0.000000	0. 000000	75. 00
76. 00 03950 OTHER ANCI LL SRVC 76. 01 03951 CARDI AC AND PULMONARY REHAB	0 () (0.000000	76.00
76. 01 03951 CARDI AC AND PULMONARY REHAB 76. 02 03952 WOUND CARE 2, 41	378, 394 8 131, 733			0. 000000 0. 000000	76. 01 76. 02
77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION	0 131, 73.	1		0. 000000	77. 00
OUTPATIENT SERVICE COST CENTERS		,			
88. 00 08800 RURAL HEALTH CLINIC	0	0	0. 000000	0. 000000	
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0				
90. 00 09000 CLI NI C 90. 01 09001 CLI NI C 627, 63	22, 440, 81	23, 068, 448	0. 000000 0. 145290	0. 000000 0. 000000	90. 00 90. 01
90. 01 09001 CLI NI C 627, 63	0 6, 095, 779			0. 000000	90.01
91. 00 09100 EMERGENCY				0. 000000	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 1,000,00		9, 044, 036	0. 287620	0. 000000	92. 00
OTHER REIMBURSABLE COST CENTERS					
94. 00 09400 HOME PROGRAM DI ALYSI S			0.000000	0.000000	94.00
95. 00 09500 AMBULANCE SERVI CES 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED			0. 000000 0. 000000	0. 000000 0. 000000	95. 00 96. 00
97. 00 09700 DURABLE MEDICAL EQUI P-SOLD			0. 000000	0.00000	97.00
98. 00 09850 OTHER REI MBURSE	0		0. 000000	0. 000000	98. 00
99. 00 09900 CMHC	0				99. 00
99. 10 09910 CORF	0				99. 10
100. 00 10000 I &R SERVI CES-NOT APPRVD PRGM	0				100.00
101. 00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0 () ()		101. 00
105. 00 10500 KI DNEY ACQUI SI TI ON	0 (105. 00
106. 00 10600 HEART ACQUISITION	0				106.00
107. 00 10700 LIVER ACQUISITION	0				107. 00
108. 00 10800 LUNG ACQUISITION	0				108. 00
109. 00 10900 PANCREAS ACQUISITION	0				109.00
110.00 11000 I NTESTI NAL ACQUI SI TI ON 111.00 11100 I SLET ACQUI SI TI ON	U (,			110. 00 111. 00
113. 00 11300 NTEREST EXPENSE	9	1	ή		113.00
1 2221 2 2222	1	1	1		

Heal th Financial Systems	FRANCI SCAN HEAL	_TH MUNSTER		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CCN: 15-0165	Peri od: From 01/01/2020 To 12/31/2020	Worksheet C Part I Date/Time Pre 7/29/2021 4:4	
		Ti ti	le XIX	Hospi tal	PPS	
		Charges				
Cost Center Description	Inpati ent	Outpati ent	Total (col.	6 Cost or Other	TEFRA	

			litl	e XIX	Hospi tal	PPS	
			Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
				+ col. 7)	Ratio	I npati ent	
						Ratio	
		6.00	7. 00	8. 00	9. 00	10.00	
114. 00 1140	O UTILIZATION REVIEW-SNF						114. 00
115. 00 1150	O AMBULATORY SURGICAL CENTER (D. P.)	0	0	C			115. 00
116. 00 1160	O HOSPI CE	O	0	C			116. 00
200.00	Subtotal (see instructions)	125, 492, 620	274, 272, 493	399, 765, 113			200. 00
201.00	Less Observation Beds						201. 00
202.00	Total (see instructions)	125, 492, 620	274, 272, 493	399, 765, 113	1		202. 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet C | From 01/01/2020 | Part I | To 12/31/2020 | Date/Time Prepared: | 7/29/2021 4:40 pm | PPS | Title XIX

APATT FUT COURT DESCRIPTION PSS Input lent SQ10			Title XIX	Hospi tal	PPS	
11.00	Cost Center Description	PPS Inpatient				
MAIL BUT ITS SERVICE COST CENTERS 30 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		Ratio				
30.00 30.0		11. 00				
31.00 31.00 31.00 33.0	INPATIENT ROUTINE SERVICE COST CENTERS					
32.00	30. 00 03000 ADULTS & PEDIATRICS					30.00
33.00	31.00 03100 INTENSIVE CARE UNIT					31.00
34.00 (3400) SURGICAL INTERSIVE CARE UNIT	32. 00 03200 CORONARY CARE UNIT					32. 00
34.00 (3400) SURGICAL INTERSIVE CARE UNIT						
40.00 01000 SUBPROVIDER - I PF						
41.00 04100 SURPENDINE F - LIST						1
43.00 64500 MIRST NY 44.00 446.00 64500 MIRST NY 44.00 64600 MIRST NY 44.00 64500 MIRST NY 64.00 64500 MIRST NY 6400 MIRST						
0.400 SKI LLED NURSING FACILITY						
45.00 04600 MURSING FACILITY 45.00						
46.00						
MICHELARY SERVICE COST CATHERS 50 00 00 00000 GREATING ROOM 0 0.187102 51 00 01 5100 (RECOVERY ROOM 0 0.000000 51.00) 51 00 01 5100 (RECOVERY ROOM 0 0.000000 52.00) 52 00 05000 (RECOVERY ROOM 0 0.000000 52.00) 53 00 05000 (RECOVERY ROOM 0 0.000000 55.00) 55 00 05000 (RECOVERY ROOM 0 0.000000 55.00) 56 00 05000 (RECOVERY ROOM 0 0.000000 55.00) 56 00 05000 (RADIOLOGY TREARPOILE 0 0.000000 55.00) 56 00 05000 (RADIOLOGY TREARPOILE 0 0.000000 55.00) 57 00 05000 (CT SCAN 0 0.00000 55.00) 58 00 05000 (RADIOLOGY TREARPOILE 0 0.000000 56.00) 58 00 05000 (RADIOLOGY TREARPOILE 0 0.000000 56.00) 58 00 05000 (RADIOLOGY TREARPOILE 0 0.000000 56.00) 59 00 05000 (RADIOLOGY TREARPOILE 0 0.000000 56.00) 59 00 05000 (RADIOLOGY TREARPOILE 0 0.000000 56.00) 50 05000 (RADIOLOGY TREARPOILLOGY 0.000000 56.00) 50 05000 (RADIOLOGY TREARPOILLOGY 0.0000000 56.00) 50 05000 (RADIOLOGY 0.000000000000 56.000000000000000000000						
50.00 00000 OPERATINE ROOM 0.187192 50.00 51.00						46.00
51.00		0.407400				
52.00 52.00 52.00 52.00 53.0						1
53.00 03.00 AMESTHESTOLOGY 0.1276z1 53.00		1				1
54.00 54.00 AND DIROY-DIAGNOSTIC 0.1771575 55.00 55.00 66.00 6		1				
55.00		1 1				
56.00 05600 RADIO ISTORE 0.000000 0.003746 55.00 55.00 55.00 55.00 55.00 55.00 05500 MARNETIC RESONANCE IMAGING (MRI) 0.093746 55.00 05000 CRRI AC CARRI	1 1	1 1				
57.00 5700 CT SCAN 0.034746 55.00 580.00 580.00 59		0. 000000				55. 00
58. 00 08500 MAGNETIC RESONANCE INACIN (URL) 0. 095008 55. 00 09500 06500 CABRO LACENITERE (ATI NO) 0. 200644 59. 00 06000 LABORATORY 0. 167262 66. 0. 00 06000 LABORATORY 0. 067263 0. 000000 66. 01 06001 18000	56. 00 05600 RADI 01 SOTOPE	0. 000000				56.00
99 00 05900 CARDIAC CATHETER ZATION 0 206644 59 0 00 06000 LABORATORY 0 167262 66 0 00 06000 LABORATORY 0 060000 06001 060000 060000 060000 060000 060000 060000 060000 060000 060000 060000 060000 060000 060000 060000 0600000 0600000 0600000 0600000 06000000 06000000 060000000 060000000 060000000 0600000000	57. 00 05700 CT SCAN	0. 034746				57. 00
60.00	58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 095068				58. 00
60.01 60.001 BLODD LABORATORY 0.000000 66.001	59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 206644				59.00
1.00 06100 PBP CLI NI CAL LAB SERVI CES-PREM ONLY 0.000000 0.200000 0.630 00 0.6300 0.6300 0.6300 0.6300 0.6300 0.6300 0.6300 0.6300 0.6300 0.6400 0.6400 0.6400 0.6400 0.6400 0.6400 0.6400 0.6400 0.6400 0.6400 0.6400 0.6400 0.6500 0.6500 RESPI RATORY THERAPY 0.399741 0.55.00 0.6500 RESPI RATORY THERAPY 0.252362 0.66.00 0.6600 0.6500 PHIST CAL THERAPY 0.194698 0.6700	60. 00 06000 LABORATORY	0. 167262				60.00
1.0 0.0 0.0 0.0 PBP CLI NI CAL LAS ESERVI CES-PREM ONLY 0.000000 62.0 0.63 0.0 0.6300 MIGLE BLOOD & PACKEE RED BLOOD CELLS 0.000000 63.0 0.63 0.63 0.63 0.63 0.63 0.63 0.65 0.65 0.65 0.65 0.05 0.65 0.05 0.65 0.05 0.65 0.05 0.65 0.05 0.65 0.05 0.65 0.05	60. 01 06001 BLOOD LABORATORY	0. 000000				60. 01
C. 2. 00 06-200 MOLDE BLOOD & PACKED RED BLOOD CELLS 0. 0000000 63-00 63-00 64-00 06-400 10-178 10-180 10-1	61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY					61.00
63.00 06.500 06.000 STORINK, PROCESSING & TRANS. 0.0000000 64.00 06.00 0.01500 NIRADEVADIOS, THERAPY 0.399741 65.00 06.00 0.6500						62.00
64.00 0.0400 INTRAVENOUS THERAPY 0.997941 5.50.00 6.60 00 0.06000 RESPIRATORY THERAPY 0.252352 6.60 00 0.06000 RESPIRATORY THERAPY 0.252352 6.60 00 0.06000 RESPIRATORY THERAPY 0.194698 6.70 00 0.0600 0.00200471 IOAN THERAPY 0.194698 6.60 00 0.06000 SEECTROCARDIOLOGY 0.189817 6.60 00 0.00000 SEECTROCARDIOLOGY 0.094946 0.90 00 0.0000 SEECTROCARDIOLOGY 0.094946 0.90 00 0.00000 SEECTROCARDIOLOGY 0.094946 0.90 00 0.00000 SEECTROCARDEPHIALOGRAPHY 0.696725 7.00 0.0000 0.000000 0.00000 0.00000 0.00000 0.00000 0.000000 0.00000 0.00000 0.0000000 0.000000 0.000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00		1				
65.00 06.500 RESPIRATIORY THERAPY 0.259741 0.65.00						
66. 00 06-00 PHYSI CAL THERAPY 0. 252352 66. 00 06-00 07-00 ELECTROCARDIO LOGY 0. 49486 0. 69. 00 07-00 ELECTROCARDIO LOGY 0. 49486 0. 69-00 07-00 07-00 ELECTROCARDEPHIAL DORAPHISTS 0. 694725 77. 0. 00 07-20 IMPL DEV. CHARGED TO PATIENTS 0. 523710 72. 00 07-20 IMPL DEV. CHARGED TO PATIENTS 0. 523710 72. 00 07-20 IMPL DEV. CHARGED TO PATIENTS 0. 39335 73. 0. 07-30 07-30						
67.00 0670						
88. 00 06800 SPECCH PATHOLOGY 0. 189817 0. 06900 070. 00 070.						1
69. 00 0.6900 0.64CTROCARDIOLOGY 0. 0.49486 0. 0. 0.94986 70. 00 70. 0						
70. 00 070000 070000 070000 070000 070000 070000 070000 070000 070000 070000 070000 070000 070000 070000 0700000 0700000 0700000 07000000 0700000 0700000 0700000 0700000 07000000 0700000 07000000 07000000 07000000 07000000 07000000 070000000 07000000 07000000 07000000 070000000 070000000 070000000 0700000000						
17. 00 07100 MCDI CAL SUPPLIES CHARGED TO PATIENTS 0.168416 72.00 72.00 72.00 72.00 72.00 72.00 72.00 072						
17.2						1
73. 00 07300 DRUGS CHARGED TO PATIENTS 0.319335 73. 00 74. 00 74. 00 74. 00 74. 00 74. 00 75. 00 76. 00 03950 CARDI AC AND PULMONARY REHAB 0.641038 76. 01 76. 02 03952 WOUND CARE 0.501256 76. 02 76. 00 77. 00 77. 00 77. 00 77.00 ALUGGENEI C STEM CELL ACQUISITION 0.000000 0.000000 0.00000 0.000000 0.00000 0.0000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000		1				1
74. 00		1				
75. 00 07500 ASC (NON-DISTINCT PART) 0. 000000 75. 00 076. 00 03950 OTHER ANDILL SRYC 0. 0000000 76. 00 03951 076. 001 03951 076. 002 03952 076. 002 03952 076. 002 03952 076. 002 076. 002 077. 002		1				
76. 00 03950 OTHER ANCILL SRVC		1				
76. 01 03951 CARDI AC AND PULMONARY REHAB 0. 641038 76. 01 76. 02 03952 WOUND CARE 0. 501256 0. 501256 77. 00 07700 ALLOGENEI C STEM CELL ACQUISITION 0. 000000 000000 000000 000000 000000		0. 000000				75. 00
76. 02 03952 WOUND CARE 76. 02 77. 00 07070 ALLOSENEIC STEM CELL ACOUISITION 0.000000 77. 00 0UTPATIENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC 0.000000 88. 00 99. 00 09900 FEDERALLY QUALIFIED HEALTH CENTER 0.000000 99. 00 99. 00 09900 FEDERALLY QUALIFIED HEALTH CENTER 0.000000 99. 00 90. 01 099001 CLINIC 0.0145290 99. 01 90. 02 09002 CLINIC 0.145290 99. 01 90. 02 09002 CLINIC 0.145290 99. 02 91. 00 09100 EMERGENCY 0.159024 91. 00 0THER REI MBURSABLE COST CENTERS 92. 00 09000 MBULANCE SERVICES 0.000000 94. 00 95. 00 09500 AMBULANCE SERVICES 0.000000 95. 00 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED 0.000000 97. 00 97. 00 09700 DURABLE MEDICAL EQUIP-RENTED 0.000000 98. 00 99. 00 09900 CMHC 99. 00 01 LER SERVICES-NOT APPRVD PRGM 100. 00 0100. 01 1000 LINE REVEAUL ACOULS IT ION 105. 00 105. 00 10500 KI NDEV ACOULS IT ION 106. 00 107. 00 10700 LI VER ACOULS IT ION 108. 00 108. 00 10800 LUNG ACOULS IT ION 108. 00 109. 00 10900 PANGREAS ACQUIS IT ION 108. 00 109. 00 10900 PANGREAS ACQUIS IT ION 109. 00 111. 00 11100 INTEREST EXPENSE 1114. 00 111. 00 11100 UTLLE ZATI ON REVIEW-SNF		0. 000000				76. 00
77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION 0.0000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.0000000 0.0000000 0.00000000	76.01 03951 CARDIAC AND PULMONARY REHAB	0. 641038				76. 01
Name	76. 02 03952 WOUND CARE	0. 501256				76. 02
88. 00 08800 RURAL HEALTH CLINI C 0. 000000 89. 00 99. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0. 000000 99. 01 99. 01 99. 01 99. 01 99. 01 99. 01 99. 01 99. 01 99. 01 99. 02 99. 02 CLINI C 0. 147323 99. 02 99. 02 99. 02 20. 00 99. 02 20. 00 99. 02 20. 00 99. 02 20. 00 99. 02 99.	77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000				77. 00
89, 00 8900 FEDERALLY QUALIFIED HEALTH CENTER 0,0000000 90.0	OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLINIC 0.000000 90. 00 90	88. 00 08800 RURAL HEALTH CLINIC	0. 000000				88. 00
90. 00 09000 CLINIC 0.000000 90. 00 90	89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000				89. 00
90. 01 09001 CLINIC						90.00
90. 02 09002 CLINIC 0. 167323 0. 159024 91. 00 09200 DERERGENCY 0. 287620 92. 00 09200 DESERVATI ON BEDS (NON-DISTINCT PART) 0. 287620 92. 00 07000 DESERVATI ON BEDS (NON-DISTINCT PART) 0. 287620 92. 00 07000 DESERVATI ON BEDS (NON-DISTINCT PART) 0. 287620 92. 00 09500 AMBULANCE SERVI CES 0. 0000000 95. 00 09500 AMBULANCE SERVI CES 0. 0000000 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0. 0000000 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0. 0000000 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0. 0000000 97. 00 09900 CMHC 98. 00 09900 CMHC 99. 00 09900 CMHC 99. 00 09900 CMHC 99. 00 09900 CMF 100.000 100.000 18R SERVI CES-NOT APPRVD PRGM 100.000 101.000 10000 18R SERVI CES-NOT APPRVD PRGM 100.000 101.000 10000 18R SERVI CES-NOT APPRVD PRGM 100.0000 100.0000 100.0000 100.0000 100.0000 100.0000 100.0000 100.0000 100.0000 100.0000 100.0000 100.0000 100.0000 100.0000 100.0000 100.0000 100.00000 100.00000 100.00000 100.000000 100.0000000 100.0000000000	1	1				1
91. 00 09100 EMERGENCY 0.159024 92.00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 0.287620 92.00 09400 HOME PROGRAM DI ALYSIS 0.000000 94.00 95.00 09500 AMBULANCE SERVI CES 0.000000 95.00 96.00 09700 DURABLE MEDI CAL EQUI P-RENTED 0.000000 97.00 09700 DURABLE MEDI CAL EQUI P-SOLD 0.000000 98.00 9950 OTHER REI MBURSE 0.000000 99.00 99.00 09900 CMHC 99.00 99.00 09900 CMHC 99.10 000000 10000 ER SERVI CES-NOT APPRVD PRGM 100.00 10000 LORGE HEALTH AGENCY 101.00 10500 KI DNEY ACQUI SI TI ON 105.00 10500 KI DNEY ACQUI SI TI ON 107.00 108.00 10800 LIVER ACQUI SI TI ON 109.00 109.00 10900 PANCREAS ACQUI SI TI ON 109.00 110.00 110.00 INTERSTI NAL ACQUI SI TI ON 110.00 1110.00 INTERSTI NAL ACQUI SI TI ON 111.00 1110.00 INTERSTI NAL ACQUI SI TI ON 111.00 1110.00 INTERSTI EXPENSE 1114.00 1140.00 1140.00 INTERST EXPENSE 1114.00 1140.00 1140.00 INTERST EXPENSE 1114.00 1140.00 1140.00 1140.00 INTERST EXPENSE 1114.00 1140.00 1140.00 1140.00 1140.00 1140.00 1140.00 1141.00						
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 0. 287620 94. 00 09400 HOME PROGRAM DI ALYSI S 0. 000000 95. 00 09500 AMBULANCE SERVI CES 0. 000000 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0. 000000 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0. 000000 98. 00 09850 OTHER REI MBURSE 0. 000000 99. 00 09900 CMHC 99. 00 99. 10 09910 CORF 99. 10 100. 00 10000 IAR SERVI CES-NOT APPRVD PRGM 100. 00 101. 00 10100 HOME HEALTH AGENCY 101. 00 SPECI AL PURPOSE COST CENTERS 105. 00 10500 KI DNEY ACQUI SI TI ON 106. 00 107. 00 10700 LIVER ACQUI SI TI ON 107. 00 108. 00 10800 LUNG ACQUI SI TI ON 109. 00 109. 00 10900 PANCREAS ACQUI SI TI ON 109. 00 111. 00 11000 INTERSTI NAL ACQUI SI TI ON 110. 00 111. 00 11300 INTERSTI EXPENSE 113. 00 114. 00 11400 UTI LI ZATI ON REVIEW-SNF 114. 00						
OTHER REIMBURSABLE COST CENTERS 94.00 994.00 HOME PROGRAM DI ALYSIS 0.000000 95.00 99500 AMBULANCE SERVI CES 0.000000 95.00 99500 AMBULANCE SERVI CES 0.000000 95.00 996.00 09600 DURABLE MEDI CAL EQUI P-RENTED 0.000000 97.00 99.00 09700 DURABLE MEDI CAL EQUI P-SOLD 0.000000 97.00 98.00 99900 OTHER REI MBURSE 0.000000 98.00 99900 CMPC 99.00 99900 CMPC 99.10 009910 CORF 99.10 009910 CORF 99.10 000000 R. R. SERVI CES-NOT APPRVD PRGM 100.00 101.00 HOME HEALTH AGENCY 101.00 10500 KI DNEY ACQUI SI TI ON 105.00 10500 KI DNEY ACQUI SI TI ON 106.00 10700 LI VER ACQUI SI TI ON 108.00 10800 LUNG ACQUI SI TI ON 108.00 109.00 10900 PANCREAS ACQUI SI TI ON 109.00 110.00 INTESTI NAL ACQUI SI TI ON 109.00 110.00 INTESTI NAL ACQUI SI TI ON 110.00 111.00 INTESTI NAL ACQUI SI TI ON 110.00 111.00 INTESTI NAL ACQUI SI TI ON 111.00 111.00 111.00 INTESTI NAL ACQUI SI TI ON 111.00		1				
94. 00 95. 00 95. 00 95. 00 96. 00 96. 00 96. 00 96. 00 97. 00 98. 00 99. 00 100. 00 1		0. 207020				72.00
95. 00		0 000000				94 00
96. 00						1
97. 00						1
98. 00						
99. 00 09900 CMHC 99. 10 09910 CORF 99. 10 100. 00 100. 00 100. 00 10100 HOME HEALTH AGENCY 101. 00 10500 KI DNEY ACQUI SI TI ON 106. 00 107. 00 10700 LI VER ACQUI SI TI ON 108. 00 10800 LUNG ACQUI SI TI ON 108. 00 10900 PANCREAS ACQUI SI TI ON 109. 00 10900 PANCREAS ACQUI SI TI ON 109. 00 109. 00 10900 PANCREAS ACQUI SI TI ON 109. 00 110. 00 11000 I NTESTI NAL ACQUI SI TI ON 109. 00 111. 00 11100 I SLET ACQUI SI TI ON 111. 00 11100 11100 11100 I SLET ACQUI SI TI ON 111. 00 11100 11100 11100 11100 11100 11100 11100 11100 11100 11100 11100 11100 11100 11100 11100 11100 11100						
99. 10		0.000000				
100. 00						
101. 00 10100 HOME HEALTH AGENCY 101. 00 SPECIAL PURPOSE COST CENTERS 105. 00 10500 KI DNEY ACQUISITION 106. 00 10600 HEART ACQUISITION 106. 00 107. 00 10700 LIVER ACQUISITION 107. 00 108. 00 10800 LUNG ACQUISITION 108. 00 10900 PANCREAS ACQUISITION 109. 00 10900 PANCREAS ACQUISITION 109. 00 1000 INTESTINAL ACQUISITION 110. 00 111. 00 111. 00 111. 00 113. 00 113. 00 11300 INTEREST EXPENSE 113. 00 114. 00 114. 00 UTILIZATION REVIEW-SNF						
SPECIAL PURPOSE COST CENTERS 105. 00 10500 KI DNEY ACQUI SI TI ON 105. 00 106. 00 10600 HEART ACQUI SI TI ON 106. 00 107. 00 107. 00 107. 00 107. 00 108. 00 10800 LIVER ACQUI SI TI ON 108. 00 10800 LIVER ACQUI SI TI ON 108. 00 10900 PANCREAS ACQUI SI TI ON 109. 00 10900 PANCREAS ACQUI SI TI ON 109. 00 107. 00						
105. 00	'					J101. 00
106. 00						1
107. 00						1
108. 00	106. 00 10600 HEART ACQUISITION					106. 00
108. 00	107.00 10700 LIVER ACQUISITION					107.00
109. 00 10900 PANCREAS ACQUI SI TI ON 109. 00 11000 I NTESTI NAL ACQUI SI TI ON 110. 00 111. 00 11100 I SLET ACQUI SI TI ON 111. 00 113. 00 11300 I NTEREST EXPENSE 113. 00 114. 00 11400 UTI LI ZATI ON REVI EW-SNF 114. 00 114. 00 11400 UTI LI ZATI ON REVI EW-SNF]				
110. 00 11000 INTESTINAL ACQUISITION 110. 00 111. 00 11100 ISLET ACQUISITION 111. 00 113. 00 11300 INTEREST EXPENSE 113. 00 114. 00 11400 UTILIZATION REVIEW-SNF 114. 00 114. 00 11400 UTILIZATION REVIEW-SNF		1				
111. 00 11100 I SLET ACQUI SI TI ON						
113. 00 11300 I NTEREST EXPENSE 113. 00 11400 UTI LI ZATI ON REVI EW-SNF 114. 00 1140 UTI LI ZATI ON REVI EW-SNF	1 1	1				
114. 00 11400 UTI LI ZATI ON REVI EW-SNF 114. 00	1 I					
THE CONTROL OF THE CO	· · · · · · · · · · · · · · · · · · ·					
	113. 30 11300 MIBOLATON SONOTONE CENTER (D. F.)	<u> </u>				1110.00

Health Financial Systems	TH MUNSTER In Lieu of Form CMS-2552-			2552-10	
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CCN: 15-0165	Peri od: From 01/01/2020 To 12/31/2020	Worksheet C Part I Date/Time Pre 7/29/2021 4:4	
		Title XIX	Hospi tal	PPS	
Cost Center Description	PPS Inpatient				
	Ratio				
	11. 00				
116. 00 11600 HOSPI CE					116. 00
200.00 Subtotal (see instructions)					200.00
201.00 Less Observation Beds					201. 00
202.00 Total (see instructions)					202. 00

 Heal th Financial Systems
 FRANCISCAN HEALTH MUNSTER

 CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICALD ONLY
 Provider
 In Lieu of Form CMS-2552-10

Period: Worksheet C
From 01/01/2020 Part II
To 12/31/2020 Date/Time Prepared: 7/29/2021 4:40 pm Provider CCN: 15-0165

			10	12/31/2020	7/29/2021 4:4	
			e XIX	Hospi tal	PPS	
Cost Center Description	Total Cost		Operating Cost		Operating Cost	
			Net of Capital	Reduction	Reduction	
	I, col. 26)	11 COL. 26)	Cost (col. 1 - col. 2)		Amount	
	1.00	2. 00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	1.00	2.00	0.00	11.00	0.00	
50. 00 05000 OPERATING ROOM	9, 690, 948	1, 121, 794	8, 569, 154	0	0	50.00
51.00 05100 RECOVERY ROOM	2, 234, 443	463, 600	1, 770, 843	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	C	0	0	0	52.00
53. 00 05300 ANESTHESI OLOGY	1, 658, 862	21, 155	1, 637, 707	0	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	4, 210, 313	517, 491	3, 692, 822	0	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	C	0	0	0	55. 00
56. 00 05600 RADI 0I SOTOPE	0	C	0	0	0	56. 00
57. 00 05700 CT SCAN	1, 147, 053			0	0	57. 00
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	1, 897, 571		,	0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	4, 061, 424			0	0	59. 00
60. 00 06000 LABORATORY	7, 841, 143	259, 474	7, 581, 669	0	0	60.00
60. 01 06001 BLOOD LABORATORY	0			0	0	60. 01
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0			0	0	61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0			0	0 0	62. 00 63. 00
64. 00 06400 NTRAVENOUS THERAPY				0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	1, 572, 473	102, 181	1, 470, 292	0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	401, 748			0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	214, 400			0	Ö	67. 00
68. 00 06800 SPEECH PATHOLOGY	60, 009			0	Ö	68. 00
69. 00 06900 ELECTROCARDI OLOGY	609, 612			0	o o	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	2, 683, 417			0	Ö	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 900, 382			0	Ö	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	11, 992, 782			0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	6, 507, 362			0	0	73.00
74.00 07400 RENAL DIALYSIS	0	l c	0	0	0	74. 00
75.00 07500 ASC (NON-DISTINCT PART)	0	c	o	0	0	75. 00
76.00 03950 OTHER ANCILL SRVC	0	c c	0	0	0	76. 00
76.01 03951 CARDIAC AND PULMONARY REHAB	242, 606	3, 510	239, 096	0	0	76. 01
76. 02 03952 WOUND CARE	67, 244	l .	66, 288	0	0	76. 02
77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	<u>C</u>	0	0	0	77. 00
0UTPATI ENT SERVI CE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC	T 0		J o	0	0	00.00
88.00 08800 RURAL HEALTH CLINIC 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER				0	0	88. 00 89. 00
90. 00 09000 CLI NI C				0	0	90.00
90. 01 09001 CLI NI C	3, 351, 610	48, 712	3, 302, 898	0	Ö	90. 01
90. 02 09002 CLI NI C	1, 019, 962			0	Ö	90. 02
91. 00 09100 EMERGENCY	5, 993, 439			0	Ö	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 601, 245			0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DIALYSIS	0	C	0	0	0	94. 00
95. 00 09500 AMBULANCE SERVI CES	0	C	0	0	0	95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	C	0	0	0	96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0		0	0	0	97. 00
98. 00 09850 OTHER REI MBURSE	0		0	0	0	1
99. 00 09900 CMHC	0		0	0	0	99. 00
99. 10 09910 CORF	0			0	0	99. 10 100. 00
100.00 10000 1&R SERVICES-NOT APPRVD PRGM 101.00 10100 HOME HEALTH AGENCY	0		0	0		100.00
SPECIAL PURPOSE COST CENTERS			y O		0	101.00
105. 00 10500 KIDNEY ACQUISITION	0	C	0	0	0	105. 00
106. 00 10600 HEART ACQUISITION	0	1	o o	0		106. 00
107.00 10700 LIVER ACQUISITION	0	d	o	0		107. 00
108.00 10800 LUNG ACQUISITION	0	c	o	0	0	108. 00
109.00 10900 PANCREAS ACQUISITION	0	C	0	0	0	109. 00
110.00 11000 INTESTINAL ACQUISITION	0	C	0	0	0	110. 00
111.00 11100 ISLET ACQUISITION	0	C	0	0	0	111. 00
113.00 11300 INTEREST EXPENSE						113. 00
114.00 11400 UTILIZATION REVIEW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	(C	0	0		115. 00
116. 00 11600 HOSPI CE	0	C C	0	0		116.00
200.00 Subtotal (sum of lines 50 thru 199)	72, 960, 048			0		200.00
201.00 Less Observation Beds	2, 601, 245			0		201.00
202.00 Total (line 200 minus line 201)	70, 358, 803	5, 202, 496	65, 156, 307	0	0	202. 00

REDUCTIONS FOR MEDICALD ONLY

					7/29/2021 4: 4	O pm
	0 1 11 1 6		e XIX	Hospi tal	PPS	
Cost Center Description	Cost Net of	Total Charges				
	Capital and		Cost to Charge Ratio (col. 6			
	Reduction	8)	/ col. 7)			
	6.00	7.00	8.00			
ANCILLARY SERVICE COST CENTERS	0.00	7.00	0.00			
50. 00 05000 OPERATING ROOM	9, 690, 948	51, 787, 900	0. 187128			50.00
51.00 05100 RECOVERY ROOM	2, 234, 443	5, 607, 032	0. 398507			51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0.000000			52.00
53. 00 05300 ANESTHESI OLOGY	1, 658, 862	12, 998, 374	0. 127621			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	4, 210, 313	23, 766, 020	0. 177157			54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0				55.00
56. 00 05600 RADI 0I SOTOPE	0		0.000000			56. 00
57. 00 05700 CT SCAN	1, 147, 053					57. 00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	1, 897, 571		1			58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	4, 061, 424					59. 00
60. 00 06000 LABORATORY	7, 841, 143					60.00
60. 01 06001 BLOOD LABORATORY	0	1	0.000000			60. 01
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0				61.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0		0.000000			62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS. 64.00 06400 INTRAVENOUS THERAPY	0		0. 000000 0. 000000			63. 00 64. 00
65. 00 06500 RESPI RATORY THERAPY	1, 572, 473	3, 933, 732				65. 00
66. 00 06600 PHYSI CAL THERAPY	401, 748					66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	214, 400					67. 00
68. 00 06800 SPEECH PATHOLOGY	60, 009					68. 00
69. 00 06900 ELECTROCARDI OLOGY	609, 612		1			69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	2, 683, 417					70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 900, 382					71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	11, 992, 782		•			72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	6, 507, 362					73.00
74. 00 07400 RENAL DI ALYSI S	0		1			74. 00
75. 00 07500 ASC (NON-DISTINCT PART)	0	l o	0. 000000			75. 00
76. 00 03950 OTHER ANCILL SRVC	0	l o	0.000000			76.00
76. 01 03951 CARDIAC AND PULMONARY REHAB	242, 606	378, 458	1			76. 01
76. 02 03952 WOUND CARE	67, 244					76. 02
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0.000000			77. 00
OUTPATIENT SERVICE COST CENTERS						_
88. 00 08800 RURAL HEALTH CLINIC	0	-	0.000000			88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	1	0.000000			89. 00
90. 00 09000 CLINI C	0		0.000000			90.00
90. 01 09001 CLI NI C 90. 02 09002 CLI NI C	3, 351, 610					90. 01
91. 00 09100 EMERGENCY	1, 019, 962 5, 993, 439					91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 601, 245					92.00
OTHER REIMBURSABLE COST CENTERS	2,001,243	7, 044, 030	0.207020			72.00
94. 00 09400 HOME PROGRAM DI ALYSI S	0	С	0.000000			94. 00
95. 00 09500 AMBULANCE SERVICES	0	l c	1			95.00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0. 000000			96.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0.000000			97. 00
98. 00 09850 OTHER REI MBURSE	0	0	0.000000			98. 00
99. 00 09900 CMHC	0	0	0.000000			99. 00
99. 10 09910 CORF	0	0	0.000000			99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0					100.00
101.00 10100 HOME HEALTH AGENCY	0	0	0.000000			101. 00
SPECIAL PURPOSE COST CENTERS		1				
105. 00 10500 KI DNEY ACQUI SI TI ON	0	•				105. 00
106. 00 10600 HEART ACQUI SI TI ON	0		0.000000			106.00
107. 00 10700 LIVER ACQUISITION 108. 00 10800 LUNG ACQUISITION		1	0. 000000 0. 000000			107. 00 108. 00
109. 00 10900 PANCREAS ACQUISITION		-	0.000000			109.00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON		1	0.000000			110.00
111. 00 11100 SLET ACQUISITION			0.000000			111.00
113. 00 11300 NTEREST EXPENSE			J. 000000			113.00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF			1			114. 00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	l o	0. 000000			115. 00
116. 00 11600 HOSPI CE	0	1	0.000000			116. 00
200.00 Subtotal (sum of lines 50 thru 199)	72, 960, 048	373, 729, 886				200.00
201.00 Less Observation Beds	2, 601, 245					201.00
202.00 Total (line 200 minus line 201)	70, 358, 803	373, 729, 886	 			202. 00

Health Financial Systems APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	. COSTS	Provi der C	CN: 15-0165	Peri od: From 01/01/2020 To 12/31/2020	u of Form CMS-: Worksheet D Part I Date/Time Pre 7/29/2021 4:4	pared:
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swi ng Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cos			
	Part II, col.		(col. 1 - co	l.		
	26)		2)			
	1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	2, 844, 735		=1 = 1 1 1		234. 29	
31. 00 INTENSIVE CARE UNIT	649, 617		649, 6	17 1, 679	386. 91	31.00
32. 00 CORONARY CARE UNIT	0			0 0	0.00	32. 00
33.00 BURN INTENSIVE CARE UNIT	0			0 0	0.00	33. 00
34.00 SURGICAL INTENSIVE CARE UNIT	0			0 0	0.00	34. 00
40. 00 SUBPROVI DER - I PF	0	0		0 0	0.00	40.00
41. 00 SUBPROVI DER - I RF	0	0)	0 0	0.00	41.00
43. 00 NURSERY	0			0 0	0.00	43.00
44.00 SKILLED NURSING FACILITY	0			0 0	0.00	44. 00
45.00 NURSING FACILITY	0			0 0	0.00	45. 00
200.00 Total (lines 30 through 199)	3, 494, 352		3, 494, 3	52 13, 821		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 & PEDI ATRI CS	3, 737					30.00
31. 00 INTENSIVE CARE UNIT	1, 107	428, 309	9			31.00
32. 00 CORONARY CARE UNIT	0	0)			32. 00
33.00 BURN INTENSIVE CARE UNIT	0	0)			33.00
34.00 SURGICAL INTENSIVE CARE UNIT	0	0)			34.00
40. 00 SUBPROVI DER - I PF	0	0)			40.00
41. 00 SUBPROVI DER - I RF	0	0)			41. 00
43. 00 NURSERY	0	0)			43.00
44.00 SKILLED NURSING FACILITY	0	0)			44. 00
45.00 NURSING FACILITY	0	0	1			45. 00
200.00 Total (lines 30 through 199)	4, 844	1, 303, 851	1			200.00

Heal th	Financial Systems	FRANCISCAN HEALTH MUNSTER			In Lieu of Form CMS-2552-10			
	TIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der C		Peri od:	Worksheet D		
					rom 01/01/2020	Part II		
					Γο 12/31/2020	Date/Time Pre 7/29/2021 4:4	pared:	
			Ti +Lo	e XVIII	Hospi tal	7/29/2021 4: 4 PPS	U pili	
	Cost Center Description	Capi tal		Ratio of Cost		Capital Costs		
	cost center bescription	Related Cost	(from Wkst. C,		Program	(column 3 x		
		(from Wkst. B,	Part I, col.	(col . 1 ÷ col .		column 4)		
		Part II, col.	8)	2)	Charges	COT GIIIIT 4)		
		26)	0)					
		1.00	2.00	3.00	4. 00	5. 00		
	ANCILLARY SERVICE COST CENTERS	1.00	2.00	0.00	1. 00	0.00		
50.00	05000 OPERATING ROOM	1, 121, 794	51, 787, 900	0. 02166	5, 590, 189	121, 089	50.00	
51. 00	05100 RECOVERY ROOM	463, 600	5, 607, 032	1			ł	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0,007,002	0. 000000		0	52.00	
53. 00	05300 ANESTHESI OLOGY	21, 155	12, 998, 374	•		1, 539		
54. 00	05400 RADI OLOGY-DI AGNOSTI C	517, 491	23, 766, 020			42, 951		
55. 00	05500 RADI OLOGY-THERAPEUTI C	017, 171	20, 700, 020	0.00000		0	55.00	
56. 00	05600 RADI OI SOTOPE	Ŏ	Ö	0. 000000		Ö	56.00	
57. 00	05700 CT SCAN	16, 525	33, 012, 900			1, 494	ı	
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	26, 901	19, 960, 100			976		
59. 00	05900 CARDI AC CATHETERI ZATI ON	986, 945	19, 654, 170			110, 933		
60.00	06000 LABORATORY	•					60.00	
	1 1	259, 474	46, 914, 064			33, 402 0		
60. 01	06001 BLOOD LABORATORY	0	U	0.00000	0	U	60. 01	
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0.00000		0	62.00	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0.00000		0	63.00	
64. 00	06400 I NTRAVENOUS THERAPY	0	0	0.00000		0	64. 00	
65. 00	06500 RESPI RATORY THERAPY	102, 181	3, 933, 732			34, 122		
66. 00	06600 PHYSI CAL THERAPY	5, 752	1, 592, 014			1, 831	66. 00	
67. 00	06700 OCCUPATI ONAL THERAPY	3, 104	1, 101, 195			1, 096		
68. 00	06800 SPEECH PATHOLOGY	838	316, 141			373	1	
69. 00	06900 ELECTROCARDI OLOGY	8, 984	12, 318, 762			1, 265		
70.00	07000 ELECTROENCEPHALOGRAPHY	442, 426	3, 858, 670	1				
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	37, 250	17, 221, 561			4, 680		
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	150, 643	22, 899, 645			19, 216		
73.00	07300 DRUGS CHARGED TO PATIENTS	258, 835	20, 377, 871	0. 012702	5, 845, 639	74, 251	73. 00	
74.00	07400 RENAL DI ALYSI S	0	0	0.00000	0	0	74.00	
75. 00	07500 ASC (NON-DISTINCT PART)	0	0			0	75. 00	
76. 00	03950 OTHER ANCILL SRVC	0	0	0.00000	0	0	76. 00	
76. 01	03951 CARDI AC AND PULMONARY REHAB	3, 510	378, 458	0. 009274	1 0	0	76. 01	
76. 02	03952 WOUND CARE	956	134, 151	0.007126	742	5	76. 02	
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0.00000	0	0	77. 00	
	OUTPATIENT SERVICE COST CENTERS							
88. 00	08800 RURAL HEALTH CLINIC	0	O	0. 000000	0	0	88. 00	
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0. 000000	0	0	89. 00	
90.00	09000 CLI NI C	0	0	0.00000	0	0	90.00	
90. 01	09001 CLI NI C	48, 712	23, 068, 448	0. 002112	375, 141	792	90. 01	
90. 02	09002 CLI NI C	82, 308	6, 095, 779	0. 013502	2 0	0	90. 02	
91.00	09100 EMERGENCY	643, 112	37, 688, 863		3, 275, 003	55, 885	91.00	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	357, 760	9, 044, 036	0. 039558	813, 966	32, 199	92.00	
	OTHER REIMBURSABLE COST CENTERS							
94.00	09400 HOME PROGRAM DIALYSIS	0	O	0.00000	0	0	94. 00	
95.00	09500 AMBULANCE SERVICES						95. 00	
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0. 000000	0	0	96. 00	
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0. 000000		0	97. 00	
98.00	09850 OTHER REIMBURSE	0	O	0. 000000		0	98. 00	
200.00		5, 560, 256	373, 729, 886		40, 352, 991	573, 214	200. 00	
	•	'						

Health Financial Systems	FRANCISCAN HE	ALTH MUNSTER		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	ASS THROUGH COS	TS Provider Co	CN: 15-0165 F	Peri od:	Worksheet D	
			Į Ę	rom 01/01/2020	Part III	
				o 12/31/2020	Date/Time Pre 7/29/2021 4:4	parea:
		Title	e XVIII	Hospi tal	PPS	o piii
Cost Center Description	Nursing School			Allied Health	All Other	
oost ounter bosci per on	Post-Stepdown	liai si ng seneer	Post-Stepdown		Medi cal	
	Adjustments		Adjustments		Education Cost	
	1A	1.00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	C	0	C	0	0	30.00
31.00 03100 INTENSIVE CARE UNIT		0		0	0	31.00
32. 00 03200 CORONARY CARE UNIT		0	ıl c	0	0	32.00
33.00 03300 BURN INTENSIVE CARE UNIT		0		0	0	33. 00
34.00 03400 SURGICAL INTENSIVE CARE UNIT		0		0	0	34.00
40. 00 04000 SUBPROVI DER - 1 PF	C	0	ol c	0	0	40.00
41. 00 04100 SUBPROVI DER - I RF	C	0	ol c	0	0	41.00
43. 00 04300 NURSERY	C	0	ol c	0	0	43.00
44.00 04400 SKILLED NURSING FACILITY	C	0	ol c	0		44. 00
45.00 04500 NURSING FACILITY	C	0	ol c	0		45. 00
200.00 Total (lines 30 through 199)	C	0	ol c	0	0	200. 00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patient	Per Diem (col.	Inpati ent	
	Adjustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,				
	instructions)	minus col. 4)				
	4. 00	5. 00	6. 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	C	0			3, 737	30. 00
31. 00 03100 INTENSIVE CARE UNIT		0	, -		1, 107	31. 00
32.00 03200 CORONARY CARE UNIT		0	1		0	32. 00
33.00 03300 BURN INTENSIVE CARE UNIT		0	C		0	33. 00
34.00 03400 SURGICAL INTENSIVE CARE UNIT		0	C	0.00	0	34. 00
40. 00 04000 SUBPROVI DER - PF	C		C		0	40. 00
41. 00 04100 SUBPROVI DER - RF	C	-		0.00	0	41.00
43. 00 04300 NURSERY		0	1		0	43.00
44. 00 04400 SKILLED NURSING FACILITY		0	1		0	44.00
45. 00 04500 NURSI NG FACI LI TY		0		0.00	0	45. 00
200.00 Total (lines 30 through 199)		0	13, 821		4, 844	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	T c	\				30.00
31. 00 03100 NTENSIVE CARE UNIT		l .				31.00
32. 00 03200 CORONARY CARE UNIT		1				32.00
33. 00 03300 BURN INTENSIVE CARE UNIT		1				33. 00
34. 00 03400 SURGI CAL INTENSI VE CARE UNI T		1				34.00
40. 00 04000 SUBPROVI DER - PF						40.00
41. 00 04100 SUBPROVI DER - RF		1				41. 00
43. 00 04300 NURSERY		1				43.00
44. 00 04400 SKILLED NURSING FACILITY		1				44. 00
45. 00 04500 NURSI NG FACILITY						45. 00
200.00 Total (lines 30 through 199)		l .				200. 00
		1				

| In Lieu of Form CMS-2552-10 | Period: | Worksheet D | From 01/01/2020 | Part IV | To 12/31/2020 | Date/Time Prepared: | 7/29/2021 4:40 pm THROUGH COSTS

						7/29/2021 4: 40	O pm
			Ti tl e	: XVIII	Hospi tal	PPS	
	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						
50.00	05000 OPERATI NG ROOM	0	0		0 0	0	50. 00
51.00	05100 RECOVERY ROOM	0	0		0 0	0	51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	52. 00
53. 00	05300 ANESTHESI OLOGY	0	0		0 0	0	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	l ol	54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0		0 0		55. 00
56. 00	05600 RADI OI SOTOPE	0	0		0 0	0	56. 00
57. 00	05700 CT SCAN	0	0		0 0	ا	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		0 0	0	58. 00
59. 00	05900 CARDIAC CATHETERIZATION	0	0		0 0		59. 00
		0	0		0 0		
60.00	06000 LABORATORY	0	U		-	1	60.00
60. 01	06001 BLOOD LABORATORY	U	U		0	0	60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	Ü		0	1	62. 00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0	0	63. 00
64. 00	06400 I NTRAVENOUS THERAPY	0	0		0	1	64. 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		0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0		0	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 PATIENTS	0	0		0 0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73. 00
74.00	07400 RENAL DIALYSIS	0	Ō		0 0	0	74. 00
75.00	07500 ASC (NON-DISTINCT PART)	0	0		0 0	0	75. 00
76.00	03950 OTHER ANCILL SRVC	0	0		0 0	l ol	76. 00
76. 01	03951 CARDIAC AND PULMONARY REHAB	0	0		0 0	0	76. 01
76. 02	03952 WOUND CARE	0	0		0 0	l ol	76. 02
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0		0 0		77. 00
,,,,,,,	OUTPATIENT SERVICE COST CENTERS	<u> </u>			<u> </u>		,,,,,
88. 00	08800 RURAL HEALTH CLINIC	0	0		0 0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	Ö	•	0 0		89. 00
90.00	09000 CLINIC	0	0		0 0	ا	90.00
90. 01	09001 CLI NI C	0	0		0 0	0	90. 01
90. 01	09002 CLI NI C	0	0		0 0		90. 01
91.00	1 1	0	0		0 0		90.02
	09100 EMERGENCY	0	U		0		
92. 00	O9200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	J U			U	0	92. 00
94. 00	09400 HOME PROGRAM DI ALYSI S	0	0		0 0	0	94. 00
		l o	U		0	١	
95.00	09500 AMBULANCE SERVICES		^				95. 00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED		0		0	1	96.00
97. 00	09700 DURABLE MEDI CAL EQUI P-SOLD	0	0		0	0	97. 00
98. 00	09850 OTHER REIMBURSE	0	0		0		98. 00
200.00	Total (lines 50 through 199)	ا	0	1	0 0	1 0	200. 00

| Peri od: | Worksheet D | From 01/01/2020 | Part IV | To | 12/31/2020 | Date/Time Prepared: Provider CCN: 15-0165 THROUGH COSTS

			1	To 12/31/2020	Date/Time Prep 7/29/2021 4:40		
			Title	xVIII	Hospi tal	PPS	о рііі
	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	·	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
		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)	
	ANOLUL ADV. CEDVI OF COCT. CENTEDO	4. 00	5. 00	6. 00	7. 00	8. 00	
FO 00	ANCI LLARY SERVI CE COST CENTERS			1 /	F1 707 000	0.000000	
50.00	O5000 OPERATI NG ROOM O5100 RECOVERY ROOM	0	0				1
51. 00 52. 00		0	0				•
53. 00	05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	0	0			0. 000000 0. 000000	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0				1
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0			0. 000000	55.00
56. 00	05600 RADI OI SOTOPE	0	0		-	0. 000000	ı
57. 00	05700 CT SCAN	0	0				•
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0				58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0				
60.00	06000 LABORATORY	0	0				
60. 01	06001 BLOOD LABORATORY	0	0		0	0.000000	60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	(o	0.000000	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	(o	0.000000	63.00
64.00	06400 I NTRAVENOUS THERAPY	0	0	(0	0.000000	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	(3, 933, 732	0.000000	65. 00
66.00	06600 PHYSI CAL THERAPY	0	0	(1, 592, 014	0.000000	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	•			
68. 00	06800 SPEECH PATHOLOGY	0	0			0.000000	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0		,,		
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0				
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			0.000000	1
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0				
73. 00 74. 00	07300 DRUGS CHARGED TO PATIENTS	0	0			0.000000	
75.00	07400 RENAL DI ALYSI S 07500 ASC (NON-DI STI NCT PART)	0	0		-	0. 000000 0. 000000	
76. 00	03950 OTHER ANCILL SRVC	0	0		1	0.000000	76.00
76. 00	03951 CARDI AC AND PULMONARY REHAB	0	0		_		
76. 02	03952 WOUND CARE	0	0			0. 000000	1
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0		0 0		1
	OUTPATIENT SERVICE COST CENTERS	-	-		-	3.00000	
88. 00	08800 RURAL HEALTH CLINIC	0	0	(0	0.000000	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	(0	0.000000	89. 00
90.00	09000 CLI NI C	0	0	(o	0.000000	90.00
90. 01	09001 CLI NI C	0	0	(23, 068, 448	0.000000	90. 01
90. 02	09002 CLI NI C	0	0	(6, 095, 779	0.000000	90. 02
91. 00	09100 EMERGENCY	0	0		37, 688, 863	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	(9, 044, 036	0.000000	92. 00
	OTHER REIMBURSABLE COST CENTERS						
94. 00	09400 HOME PROGRAM DI ALYSI S	0	0	(0	0. 000000	•
95.00	09500 AMBULANCE SERVICES	_	_		_	0.005	95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	1	0	0.000000	•
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0		,	0.000000	97. 00
98.00	09850 OTHER REIMBURSE	0	0		1	0. 000000	•
200.00	Total (lines 50 through 199)	ı o	0	l (373, 729, 886	I I	200. 00

 Heal th Financial
 Systems
 FRANCISCAN HEALT

 APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY
 SERVICE OTHER PASS
 Provider CCN: 15-0165 THROUGH COSTS

			'	0 12/31/2020	7/29/2021 4:40		
			Title	XVIII	Hospi tal	PPS	
	Cost Center Description	Outpati ent	I npati ent	I npati ent	Outpati ent	Outpati ent	
	·	Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through	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 OPERATING ROOM	0. 000000	5, 590, 189			0	50. 00
51. 00	05100 RECOVERY ROOM	0. 000000	371, 723			0	51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		_	0	52. 00
53. 00	05300 ANESTHESI OLOGY	0. 000000	945, 593			0	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	1, 972, 560			0	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	0		0	0	55. 00
56. 00	05600 RADI OI SOTOPE	0. 000000	0	-		0	56. 00
57. 00	05700 CT SCAN	0. 000000	2, 982, 206			0	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 000000	723, 690		., ,	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	2, 209, 124		.,,	0	59. 00
60. 00	06000 LABORATORY	0. 000000	6, 039, 055			0	60. 00
60. 01	06001 BLOOD LABORATORY	0. 000000	0	0	0	0	60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	0	1	_	0	62.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0		0	0	63.00
64. 00	06400 I NTRAVENOUS THERAPY	0. 000000	0	ľ	_	0	64. 00
65. 00	06500 RESPI RATORY THERAPY	0. 000000	1, 313, 603			0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0. 000000	506, 876	•		0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 000000	388, 679			0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0. 000000	140, 736			0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 000000	1, 735, 163			0	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	38, 200			0	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	2, 163, 873			0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000	2, 921, 230	•		0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	5, 845, 639			0	73. 00
74. 00	07400 RENAL DIALYSIS	0. 000000	0	· -	0	0	74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0. 000000	0		0	0	75. 00
76. 00	03950 OTHER ANCILL SRVC	0. 000000	0	1	0	0	76. 00
76. 01	03951 CARDI AC AND PULMONARY REHAB	0. 000000	0		,	0	76. 01
76. 02	03952 WOUND CARE	0. 000000	742			0	76. 02
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000	0	0	0	0	77. 00
00.00	OUTPATIENT SERVICE COST CENTERS	0.000000		1		0	00.00
88. 00	08800 RURAL HEALTH CLINIC	0.000000	0			0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0			0	89. 00
90.00	09000 CLINIC	0.000000	0	-		0	90.00
90. 01	09001 CLINIC	0.000000	375, 141			0	90. 01
90. 02	09002 CLINIC	0.000000	0	-		0	90. 02
91.00	09100 EMERGENCY	0. 000000	3, 275, 003			0	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	813, 966	0	1, 657, 177	0	92. 00
04.00	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0		0	04.00
94. 00 95. 00	09400 HOME PROGRAM DI ALYSI S 09500 AMBULANCE SERVI CES	0. 000000	0	1	0	0	94. 00 95. 00
95. 00 96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000	0	0	0	0	95. 00 96. 00
96.00	09700 DURABLE MEDICAL EQUIP-RENTED	0. 000000	0	1	0	0	96. 00 97. 00
98.00	09850 OTHER REIMBURSE	0.000000	0			0	98.00
200.00	+ I	0.000000	40, 352, 991	1	132, 274, 021	-	200. 00
200.00	Total (Tilles 50 till ough 199)	1	40, 332, 991	ı	132, 214, 021	ا	200.00

APPORT	TONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der Co		Peri od:	Worksheet D	
					From 01/01/2020 Fo 12/31/2020		narod:
					10 12/31/2020	7/29/2021 4:4	pareu. O nm
			Title	XVIII	Hospi tal	PPS	о р
				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	,	
		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. 187128		(5, 598, 303	1
51. 00	05100 RECOVERY ROOM	0. 398507			0	1, 303, 492	1
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000		(0	52. 00
53. 00	05300 ANESTHESI OLOGY	0. 127621			0	656, 265	1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0. 177157			0	2, 313, 845	1
55. 00	05500 RADI OLOGY-THERAPEUTI C	0. 000000			0	0	55. 00
56. 00	05600 RADI OI SOTOPE	0. 000000		(9	0	56. 00
57. 00	05700 CT SCAN	0. 034746		(-	445, 223	1
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 095068		(449, 427	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 206644		(1, 009, 425	•
60.00	06000 LABORATORY	0. 167138		(479, 968	1
60. 01	06001 BLOOD LABORATORY	0. 000000			0	0	60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000			0		61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000		(-	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000		(-	0	63.00
64.00	06400 I NTRAVENOUS THERAPY	0.000000		(-	105 000	64.00
65. 00	06500 RESPIRATORY THERAPY	0. 399741	l ·	(-	125, 220	1
66.00	06600 PHYSI CAL THERAPY	0. 252352		(33, 467	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 194698		(9, 355	1
68.00	06800 SPEECH PATHOLOGY	0. 189817				2, 246	1
69. 00	06900 ELECTROCARDI OLOGY	0. 049486		(293, 490	1
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 695425 0. 168416				1, 311, 683 559, 320	1
71.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 523710			-	4, 389, 292	
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 319335			-	2, 361, 430	1
74.00	07400 RENAL DIALYSIS	0. 000000				2, 301, 430	74.00
75. 00	07500 ASC (NON-DISTINCT PART)	0. 000000	l .	1		0	75. 00
76. 00	03950 OTHER ANCILL SRVC	0. 000000)		0	76.00
76. 01	03951 CARDI AC AND PULMONARY REHAB	0. 641038				187, 568	•
76. 01	03952 WOUND CARE	0. 501256			-	37, 678	1
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000					1
77.00	OUTPATIENT SERVICE COST CENTERS	0.00000			<u> </u>		77.00
88. 00	08800 RURAL HEALTH CLINIC						88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER						89. 00
90.00	09000 CLI NI C	0. 000000	0		0	0	1
90. 01	09001 CLI NI C	0. 145290			0	2, 515, 510	1
90. 02	09002 CLI NI C	0. 167323		ĺ	0	0	
	09100 EMERGENCY	0. 159024			0	1, 403, 677	•
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 287620			0		1
	OTHER REIMBURSABLE COST CENTERS		, , , ,		-		
94.00	09400 HOME PROGRAM DI ALYSIS	0. 000000		(0		94. 00
95.00	09500 AMBULANCE SERVICES	0. 000000		(o l		95. 00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000	0	(0	0	96. 00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0. 000000		(0	0	97. 00
98.00	09850 OTHER REIMBURSE	0. 000000	0	(0	0	
200.00	Subtotal (see instructions)		132, 274, 021	(22, 254	25, 962, 521	200. 00
201.00	Less PBP Clinic Lab. Services-Program			(0		201. 00
	Only Charges						
202.00	Net Charges (line 200 - line 201)		132, 274, 021	(22, 254	25, 962, 521	202. 00

Peri od: Worksheet D From 01/01/2020 Part V To 12/31/2020 Date/Time Prepared: 7/29/2021 4:40 pm

					7/29/2021 4:40	pm
		Title	XVIII	Hospi tal	PPS	
	Cos	sts				
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	7.00				
ANCILLARY SERVICE COST CENTERS	0.00	7.00				
50. 00 05000 OPERATING ROOM	0	0				50.00
						51.00
51. 00 05100 RECOVERY ROOM						
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0					52. 00
53. 00 05300 ANESTHESI OLOGY	0	1				53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0				54. 00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0				55.00
56. 00 05600 RADI 0I SOTOPE	0	0				56.00
57. 00 05700 CT SCAN	0	ol ol				57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	o				58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0					59.00
60. 00 06000 LABORATORY	0	o				60.00
60. 01 06001 BLOOD LABORATORY		o o				60. 01
	0	()				
	0	,			l l	61.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0				62. 00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0			l l	63. 00
64.00 06400 I NTRAVENOUS THERAPY	0	0			l l	64.00
65. 00 06500 RESPI RATORY THERAPY	0	0				65.00
66. 00 06600 PHYSI CAL THERAPY	0	0				66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0				67.00
68. 00 06800 SPEECH PATHOLOGY	0	ol				68.00
69. 00 06900 ELECTROCARDI OLOGY	0	o				69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	o			l l	70. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	o o			l l	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS					l l	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	-			l l	
	0	7, 106			l l	73.00
74. 00 07400 RENAL DIALYSIS	0	0				74.00
75. 00 07500 ASC (NON-DISTINCT PART)	0	0				75. 00
76.00 03950 OTHER ANCILL SRVC	0	0			l l	76. 00
76.01 03951 CARDIAC AND PULMONARY REHAB	0					76. 01
76. 02 03952 WOUND CARE	0	0				76. 02
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0				77.00
OUTPATIENT SERVICE COST CENTERS						
88. 00 08800 RURAL HEALTH CLINIC						88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER					l l	89. 00
90. 00 09000 CLI NI C	0	o				90.00
90. 01 09001 CLI NI C		o o				90. 01
90. 02 09002 CLI NI C	0	o o				90. 02
					l l	91.00
	1	1				
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	0	0				92. 00
OTHER REIMBURSABLE COST CENTERS	-					04.00
94. 00 09400 HOME PROGRAM DI ALYSI S	0	1				94.00
95. 00 09500 AMBULANCE SERVICES	0	1				95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0			l l	96. 00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0				97. 00
98. 00 09850 OTHER REI MBURSE	0	o				98.00
200.00 Subtotal (see instructions)	0	7, 106			12	200. 00
201.00 Less PBP Clinic Lab. Services-Program	0	,				201. 00
Only Charges					-	
202.00 Net Charges (line 200 - line 201)	0	7, 106			2	202. 00
	1	,,,,,,,,,	1		-	

Health Financial Systems	FRANCI SCAN HEA	ALTH MUNSTER		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL (COSTS	Provi der C	CN: 15-0165	Peri od: From 01/01/2020 To 12/31/2020	Worksheet D Part I	pared:
		Ti tl	e XIX	Hospi tal	PPS	
	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capi tal Rel ated Cos (col . 1 - col 2)	ĺ.	3 / col. 4)	
	1. 00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS 31.00 INTENSIVE CARE UNIT 32.00 CORONARY CARE UNIT 33.00 BURN INTENSIVE CARE UNIT 34.00 SUBGICAL INTENSIVE CARE UNIT 40.00 SUBPROVIDER - IPF 41.00 SUBPROVIDER - IRF 43.00 NURSERY 44.00 SKILLED NURSING FACILITY 45.00 NURSING FACILITY 200.00 Total (lines 30 through 199) Cost Center Description	2,844,735 649,617 0 0 0 0 0 0 0 0 0 3,494,352 Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col.	2, 844, 7: 649, 6	17 1,679 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0.00 0.00 0.00 0.00 0.00 0.00 0.00	31. 00 32. 00 33. 00 34. 00 40. 00 41. 00 43. 00
	6. 00	6) 7. 00	-			
INPATIENT ROUTINE SERVICE COST CENTERS	6.00	7.00				
30.00 ADULTS & PEDIATRICS 31.00 INTENSIVE CARE UNIT 32.00 CORONARY CARE UNIT 33.00 BURN INTENSIVE CARE UNIT 34.00 SURGICAL INTENSIVE CARE UNIT 40.00 SUBPROVIDER - IPF 41.00 SUBPROVIDER - IRF 43.00 NURSERY 44.00 SKILLED NURSING FACILITY 45.00 NURSING FACILITY 200.00 Total (lines 30 through 199)	531 213 0 0 0 0 0 0 0 0 0					30. 00 31. 00 32. 00 33. 00 34. 00 40. 00 41. 00 43. 00 44. 00 45. 00 200. 00

Health Financial Systems	FRANCI SCAN HEA	ALTH MUNSTER		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der C	CN: 15-0165	Peri od:	Worksheet D	
				From 01/01/2020	Part II	
				To 12/31/2020	Date/Time Pre	
		Ti +I	e XIX	Hospi tal	7/29/2021 4: 4 PPS	U pili
Cost Center Description	Capi tal	Total Charges			Capital Costs	
cost center bescription	Related Cost	(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col		column 4)	
	Part II, col.	8)	2)	. Charges	COT UIIII 4)	
		0)	2)			
	26)	2. 00	2 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	1, 121, 794	51, 787, 900	0. 02166	1, 802, 155	39, 036	50.00
51. 00 05100 RECOVERY ROOM	463, 600		1		7, 251	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	403,000	3,007,032	0.00000		7, 231	52.00
53. 00 05300 ANESTHESI OLOGY	21, 155	12, 998, 374			363	53.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	517, 491	23, 766, 020			5, 971	54.00
	317, 491	23, 700, 020			5, 9/1	55.00
			0.00000		0	56.00
	_	22 012 000	0.00000		_	
57. 00 05700 CT SCAN	16, 525	33, 012, 900			235	57. 00
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	26, 901	19, 960, 100	1		168	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	986, 945				25, 704	59. 00
60. 00 06000 LABORATORY	259, 474	46, 914, 064			5, 316	60.00
60. 01 06001 BLOOD LABORATORY	0	C	0. 00000	0	0	60. 01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61. 00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	[C	0.00000		0	62. 00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	[C	0.00000		0	63. 00
64. 00 06400 I NTRAVENOUS THERAPY	0	C	0.00000	0 0	0	64. 00
65. 00 06500 RESPIRATORY THERAPY	102, 181	3, 933, 732	0. 02597	6 224, 567	5, 833	65. 00
66. 00 06600 PHYSI CAL THERAPY	5, 752	1, 592, 014	0. 00361	3 61, 972	224	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	3, 104	1, 101, 195	0. 00281	9 45, 993	130	67. 00
68. 00 06800 SPEECH PATHOLOGY	838	316, 141	0. 00265	13, 645	36	68. 00
69. 00 06900 ELECTROCARDI OLOGY	8, 984	12, 318, 762	0. 00072	9 179, 091	131	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	442, 426	3, 858, 670	0. 11465	8 0	0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	37, 250	17, 221, 561	0.00216	3 0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	150, 643		0. 00657	8 0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	258, 835	l			10, 849	73. 00
74. 00 07400 RENAL DIALYSIS	0		0. 00000		0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	l c	0. 00000		0	75. 00
76. 00 03950 OTHER ANCILL SRVC	0	l c			0	76. 00
76. 01 03951 CARDI AC AND PULMONARY REHAB	3, 510	378, 458			0	76. 01
76. 02 03952 WOUND CARE	956	134, 151			0	76. 02
77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION	0				0	77. 00
OUTPATIENT SERVICE COST CENTERS			, 0.0000	<u></u>		,,,,
88. 00 08800 RURAL HEALTH CLINIC	0	C	0.00000	0	0	88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0.00000		0	89. 00
90. 00 09000 CLI NI C	0		0.00000		0	90.00
90. 01 09001 CLI NI C	48, 712	23, 068, 448	1		119	90. 01
90. 02 09002 CLI NI C	82, 308				0	90. 02
91. 00 09100 EMERGENCY	643, 112	37, 688, 863			12, 157	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	357, 760	1	1		12, 137	92.00
OTHER REIMBURSABLE COST CENTERS	337,700	7, 044, 030	0.03730	0		72.00
94. 00 09400 HOME PROGRAM DI ALYSI S	0		0.00000	0	0	94. 00
95. 00 09500 AMBULANCE SERVICES						95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	l c	0. 00000	0	0	96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	ĺ	0.00000		0	97. 00
98. 00 09850 OTHER REI MBURSE	0	1 6	0. 00000		0	98.00
200.00 Total (lines 50 through 199)	5, 560, 256	373, 729, 886	1	6, 602, 861	_	
111111111111111111111111111111111111111	1, 111/200		1	1, 222, 00.	, 020	, , , , , ,

Health Financial Systems	FRANCI SCAN HE	ALTH MUNSTER		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COS	TS Provider Co	CN: 15-0165 F	Peri od:	Worksheet D	
			Į.	rom 01/01/2020	Part III	
				o 12/31/2020	Date/Time Pre 7/29/2021 4:4	parea:
		Ti +I	e XIX	Hospi tal	PPS	O pili
Cost Center Description	Nursing School	Nursing School		Allied Health	All Other	
cost center bescription	Post-Stepdown	livar string scribbin	Post-Stepdown		Medi cal	
	Adjustments		Adjustments		Education Cost	
	1A	1.00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0		0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0		o	0	31.00
32. 00 03200 CORONARY CARE UNIT	0			o	0	32. 00
33. 00 03300 BURN INTENSIVE CARE UNIT				1	Ö	33. 00
34. 00 03400 SURGI CAL INTENSI VE CARE UNI T		_		1	Ö	34.00
40. 00 04000 SUBPROVI DER - PF		_	1	1	0	40.00
41. 00 04100 SUBPROVI DER - I RF	0	0	1		Ö	41. 00
43. 00 04300 NURSERY	0	0	1		0	43. 00
44.00 04400 SKILLED NURSING FACILITY		0			Ŭ	44. 00
45. 00 04500 NURSI NG FACILITY		_				45. 00
200.00 Total (lines 30 through 199)					0	200.00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patient	Per Diem (col.	Inpati ent	200.00
oost ochter beschiptron	Adjustment	(sum of cols.	Days	5 ÷ col . 6)	Program Days	
	Amount (see	1 through 3,	Jajo	0 . 001. 07	g. a bajo	
	instructions)	mi nus col . 4)				
	4. 00	5. 00	6. 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	12, 142	0.00	531	30.00
31.00 03100 INTENSIVE CARE UNIT		0			213	31.00
32. 00 03200 CORONARY CARE UNIT		0	, ,		0	32. 00
33.00 03300 BURN INTENSIVE CARE UNIT		0			0	33. 00
34.00 03400 SURGICAL INTENSIVE CARE UNIT		0			0	34.00
40. 00 04000 SUBPROVI DER - I PF	0	0			0	40.00
41. 00 04100 SUBPROVI DER - I RF	0				0	41.00
43. 00 04300 NURSERY		0			0	43. 00
44.00 04400 SKILLED NURSING FACILITY		0			0	44. 00
45. 00 04500 NURSI NG FACILITY		Ö	-		0	45. 00
200.00 Total (lines 30 through 199)		0				200. 00
Cost Center Description	Inpati ent	J	.0,02		,	200.00
	Program					
	Pass-Through					
	Cost (col. 7 x					
	col . 8)					
	9. 00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0					30.00
31.00 03100 INTENSIVE CARE UNIT	0					31.00
32. 00 03200 CORONARY CARE UNIT	0					32. 00
33.00 03300 BURN INTENSIVE CARE UNIT	0					33. 00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	0					34.00
40. 00 04000 SUBPROVI DER - 1 PF	0					40.00
41. 00 04100 SUBPROVI DER - I RF	0					41. 00
43. 00 04300 NURSERY						43. 00
44.00 04400 SKILLED NURSING FACILITY						44. 00
45. 00 04500 NURSI NG FACILITY						45. 00
200.00 Total (lines 30 through 199)	0					200. 00
	•	•				

In Lieu of Form CMS-2552-10

Period: Worksheet D
From 01/01/2020 Part IV
To 12/31/2020 Date/Time Prepared: 7/29/2021 4:40 pm THROUGH COSTS

						7/29/2021 4:4	0 pm
			Ti	tle XIX	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursing School	Nursing School	ol Allied Health	Allied Health	
	·	Anestheti st	Post-Stepdow	n l	Post-Stepdown		
		Cost	Adjustments		Adjustments		
		1.00	2A	2.00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS			•			
50.00	05000 OPERATI NG ROOM	0		0	0 0	0	50. 00
51.00	05100 RECOVERY ROOM	0		o	0 0	0	51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0		0	0 0	0	52. 00
53. 00	05300 ANESTHESI OLOGY	0		0	0	0	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0			0 0	l o	54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0		0	0 0	0	55. 00
56. 00	05600 RADI OI SOTOPE	0			0 0	Ö	56. 00
57. 00	05700 CT SCAN	0			0 0		57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0				0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0				1	59.00
60.00	06000 LABORATORY				0 0	0	60.00
60. 01	06001 BLOOD LABORATORY					1	60.00
	1	0		٩	0	0	
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0		0			61.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0			0 0	0	62.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0		0	٥	0	63. 00
64. 00	06400 I NTRAVENOUS THERAPY	0		0	0 0	0	64. 00
65. 00	06500 RESPI RATORY THERAPY	0		0	0 0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0		0	0 0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0		0	0 0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0		O	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0		O	0	0	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0		0	0	0	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0	0	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0		0	0	0	73. 00
74.00	07400 RENAL DI ALYSI S	0		0	0	0	74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0		0	0	0	75. 00
76.00	03950 OTHER ANCILL SRVC	0		0	0 0	0	76. 00
76. 01	03951 CARDI AC AND PULMONARY REHAB	0		0	0 0	0	76. 01
76. 02	03952 WOUND CARE	0		0	0 0	0	76. 02
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION	0		0	0 0	0	77. 00
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0		0	0 0	0	88. 00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0		o	0 0	0	89. 00
90.00	09000 CLI NI C	0		О	0 0	0	90.00
90. 01	09001 CLI NI C	0		o	0 0	0	90. 01
90. 02	09002 CLI NI C	0		o	0 0	0	90. 02
91.00	09100 EMERGENCY	0		0	0 0	0	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	92. 00
,2,00	OTHER REIMBURSABLE COST CENTERS				<u> </u>		72.00
94. 00	09400 HOME PROGRAM DI ALYSI S	0		ol	0 0	0	94. 00
95. 00	09500 AMBULANCE SERVICES			Ĭ		Ĭ	95. 00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	0		o	0 0	0	96. 00
97. 00	09700 DURABLE MEDICAL EQUIP-RENTED			ŏ		1	97. 00
98. 00	09850 OTHER REIMBURSE			ŏ		-	98.00
200.00				0		-	200.00
200.00	1 10tai (111163 30 till ougil 177)	1	I	٩	9	1	200.00

| Peri od: | Worksheet D | From 01/01/2020 | Part IV | To 12/31/2020 | Date/Time Prepared: Provider CCN: 15-0165 THROUGH COSTS

					0 12/31/2020	7/29/2021 4:4	
			Ti tl	e XIX	Hospi tal	PPS	<u> </u>
	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	·	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
		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)	
	I	4. 00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS	1		1			
50.00	05000 OPERATI NG ROOM	0	0			0.000000	
51.00	05100 RECOVERY ROOM	0	0			0.000000	51.00
52. 00 53. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0	1		0.000000	52. 00 53. 00
54.00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0	0	1		0. 000000 0. 000000	54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0	1	23, 766, 020 0	0.000000	
56. 00	05600 RADI OLOGI - THERAPEUTI C	0	0	1		0.00000	56. 00
57. 00	05700 CT SCAN	0	0		_	0.000000	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0	1		0.000000	
59. 00	05900 CARDIAC CATHETERIZATION	0	0			0.000000	59.00
60.00	06000 LABORATORY	0	0	1		0.000000	60.00
60. 01	06001 BLOOD LABORATORY	0	0	1	40, 714, 004	0.000000	60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY					0.00000	61. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	O		0	0. 000000	62.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	Ö		0	0. 000000	
64. 00	06400 I NTRAVENOUS THERAPY	0	Ö	·	0	0. 000000	
65. 00	06500 RESPIRATORY THERAPY	0	Ö		3, 933, 732	0. 000000	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	Ö	1		0. 000000	
67. 00	06700 OCCUPATI ONAL THERAPY	0	Ö			0. 000000	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	Ö			0. 000000	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	O	l c		0.000000	
70.00	07000 ELECTROENCEPHALOGRAPHY	0	O	C		0.000000	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	O	l c		0.000000	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	C	22, 899, 645	0.000000	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	C	20, 377, 871	0.000000	73. 00
74.00	07400 RENAL DIALYSIS	0	0	C	0	0.000000	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	C	0	0.000000	75. 00
76.00	03950 OTHER ANCILL SRVC	0	0	C	0	0.000000	76. 00
76. 01	03951 CARDI AC AND PULMONARY REHAB	0	0	C	378, 458	0.000000	76. 01
76. 02	03952 WOUND CARE	0	0			0.000000	
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	C	0	0. 000000	77. 00
	OUTPATIENT SERVICE COST CENTERS			1	1		
88. 00	08800 RURAL HEALTH CLINIC	0	0			0. 000000	
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	1	0	0.000000	89. 00
90.00	09000 CLI NI C	0	0	1	0	0.000000	90.00
90. 01	09001 CLI NI C	0	0	1		0.000000	
90. 02	09002 CLI NI C	0	0			0.000000	90. 02
91.00	09100 EMERGENCY	0	0			l e	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	U	0	C	9, 044, 036	0.000000	92. 00
94. 00	OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DIALYSIS	0	C		0	0.000000	94. 00
94. 00 95. 00	09500 AMBULANCE SERVICES	١	0			0.000000	95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	O	_	0	0. 000000	96.00
97.00	09700 DURABLE MEDICAL EQUIP-RENTED		0		0	0.00000	97.00
98. 00	09850 OTHER REIMBURSE		0	"	0	0.000000	98. 00
200.00		l o	Ö	1	U	l e	200.00
	, (,	,	'		ı	

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 Systems
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 APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY
 SERVICE OTHER PASS
 Provider CCN: 15-0165 THROUGH COSTS

				10	12/31/2020	7/29/2021 4:40	
			Titl	e XIX	Hospi tal	PPS	
	Cost Center Description	Outpati ent	I npati ent	Inpati ent	Outpati ent	Outpati ent	
	·	Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through	Charges	Pass-Through	
		(col. 6 ÷ 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 OPERATING ROOM	0. 000000	1, 802, 155	0	4, 843, 640	0	50.00
51.00	05100 RECOVERY ROOM	0. 000000	87, 698	0	530, 945	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0	o	o	0	52. 00
53.00	05300 ANESTHESI OLOGY	0. 000000	223, 259	o	1, 054, 229	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	274, 243	l o	2, 491, 575	0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	0		0	0	55. 00
56. 00	05600 RADI OI SOTOPE	0. 000000	0		0	0	56. 00
57. 00	05700 CT SCAN	0. 000000	469, 461	l o	2, 691, 958	0	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 000000	124, 653		1, 960, 292	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	511, 877		467, 420	0	59. 00
60.00	06000 LABORATORY	0. 000000	961, 095		3, 667, 023	0	60.00
60. 01	06001 BLOOD LABORATORY	0. 000000	901, 099		3, 007, 023	0	60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	U	١	U	U	61. 00
	1 1	0.000000	0		0	0	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	_	0	0	62.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0	_	0	0	63. 00
64. 00	06400 I NTRAVENOUS THERAPY	0. 000000	0	١	0	0	64. 00
65. 00	06500 RESPI RATORY THERAPY	0. 000000	224, 567		33, 656	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0. 000000	61, 972		33, 577	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 000000	45, 993		15, 610	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0. 000000	13, 645		414	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 000000	179, 091	0	690, 807	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	0	0	371, 381	0	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	0	0	223	0	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000	0	0	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	854, 143	0	640, 168	0	73. 00
74.00	07400 RENAL DIALYSIS	0. 000000	0	o	o	0	74. 00
75.00	07500 ASC (NON-DISTINCT PART)	0. 000000	0	o	o	0	75. 00
76.00	03950 OTHER ANCILL SRVC	0. 000000	0	l o	o	0	76. 00
76. 01	03951 CARDI AC AND PULMONARY REHAB	0. 000000	0	l o	o	0	76. 01
76. 02	03952 WOUND CARE	0. 000000	0	o	37, 264	0	76. 02
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000	0		0	0	77. 00
,,,,,,	OUTPATIENT SERVICE COST CENTERS	0.00000		<u> </u>	<u> </u>	5	77.00
88. 00	08800 RURAL HEALTH CLINIC	0. 000000	0	0	0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000	0		Ö	0	89. 00
90.00	09000 CLINIC	0. 000000	0		0	0	90.00
90. 01	09001 CLI NI C	0. 000000	56, 564		3, 743, 933	0	90.01
90. 01	09002 CLI NI C	0. 000000	30, 304		382, 624	0	90.01
91. 00	09100 EMERGENCY	0. 000000	712, 445		3, 853, 660	0	91.00
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	712, 445			0	91.00
92.00		0.000000	0	l O	0	U	92.00
94. 00	OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DI ALYSI S	0.000000	0	O	0	0	94. 00
94.00	1 1	0. 000000	0	ا ا	٩	U	95.00
	09500 AMBULANCE SERVICES	0.000000	^		0	0	
96.00	09600 DURABLE MEDICAL EQUI P-RENTED	0.000000	0	_	ĭ	-	96.00
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD	0.000000	0		0	0	97. 00
98. 00	09850 OTHER REIMBURSE	0. 000000	0	0	07 510 200	0	98. 00
200.00	Total (lines 50 through 199)	1 1	6, 602, 861	0	27, 510, 399	0	200. 00

APPORT	IONMENT OF MEDICAL, OTHER HEALTH SERVICES AND) VACCINE COST	Provider C	CN: 15-0165	Period: From 01/01/2020	Worksheet D Part V	
					To 12/31/2020	Date/Time Pre	pared:
			Ti +I	e XIX	Hospi tal	7/29/2021 4: 4 PPS	U pm
			11.01	Charges	110001 tu	Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
		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			
		1.00	2. 00	(see inst.) 3.00	(see inst.) 4.00	5. 00	
	ANCILLARY SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
50.00	05000 OPERATI NG ROOM	0. 187128	4, 843, 640		0 0	906, 381	50.00
51.00	05100 RECOVERY ROOM	0. 398507	530, 945		0	211, 585	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0	0	52. 00
53.00	05300 ANESTHESI OLOGY	0. 127621	1, 054, 229		0 0	134, 542	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 177157	2, 491, 575		0	441, 400	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	0		0	0	
56. 00	05600 RADI OI SOTOPE	0. 000000	0		0	0	
57. 00	05700 CT SCAN	0. 034746	2, 691, 958		0	93, 535	1
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 095068	1, 960, 292	1	0	186, 361	1
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 206644	467, 420	1	0	96, 590	
60.00	06000 LABORATORY	0. 167138	3, 667, 023		0	612, 899	
60. 01 61. 00	06001 BLOOD LABORATORY 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000 0. 000000	U		0 0	0	60.01
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	0		0 0	0	
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0		0 0	0	
64. 00	06400 I NTRAVENOUS THERAPY	0. 000000	0		0 0	0	
65. 00	06500 RESPIRATORY THERAPY	0. 399741	33, 656		0 0	13, 454	1
66. 00	06600 PHYSI CAL THERAPY	0. 252352	33, 577		0 0	8, 473	
67. 00	06700 OCCUPATI ONAL THERAPY	0. 194698	15, 610		0 0	3, 039	
68. 00	06800 SPEECH PATHOLOGY	0. 189817	414		o o	79	
69.00	06900 ELECTROCARDI OLOGY	0. 049486	690, 807		0 0	34, 185	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 695425	371, 381		0 0	258, 268	1
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 168416	223		0	38	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 523710	0		0 0	0	72. 00
	07300 DRUGS CHARGED TO PATIENTS	0. 319335	640, 168		0	204, 428	1
74.00	07400 RENAL DIALYSIS	0. 000000	0		0	0	
75. 00	07500 ASC (NON-DISTINCT PART)	0. 000000	0		0	0	
	03950 OTHER ANCILL SRVC	0.000000	0		0	0	
76. 01	03951 CARDI AC AND PULMONARY REHAB	0. 641038	27.244		0	0	
76. 02	03952 WOUND CARE	0. 501256	37, 264		0 0	18, 679 0	
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION OUTPATIENT SERVICE COST CENTERS	0. 000000			0 0		77.00
88. 00	08800 RURAL HEALTH CLINIC						88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER						89. 00
90. 00	09000 CLI NI C	0. 000000	0		0 0	0	
90. 01	09001 CLI NI C	0. 145290	3, 743, 933		0 0	543, 956	
90. 02	09002 CLI NI C	0. 167323	382, 624		0 0	64, 022	
91.00	09100 EMERGENCY	0. 159024	3, 853, 660		0 0	612, 824	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 287620	0		0 0	0	92. 00
	OTHER REIMBURSABLE COST CENTERS						
	09400 HOME PROGRAM DI ALYSI S	0. 000000			0 0		94. 00
	09500 AMBULANCE SERVICES	0.000000	0		0	_	95. 00
	09600 DURABLE MEDICAL EQUIP-RENTED	0.000000	0		0	0	
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD	0.000000	0		0	0	
98. 00 200. 00	09850 OTHER REIMBURSE	0. 000000	27 510 200		0 0	0	
200.00			27, 510, 399		0 0	4, 444, 738	200.00
201.00	Only Charges						201.00
202. 00			27, 510, 399		0 0	4, 444, 738	202.00
02.00	1 1 300 (1 200 1 201)	1	2,,0.0,077	1	-1	.,, , , ,	, 32. 30

Peri od: Worksheet D From 01/01/2020 Part V To 12/31/2020 Date/Time Prepared: 7/29/2021 4:40 pm

					7/29/2021 4:4	0 pm
		Ti tl	e XIX	Hospi tal	PPS	
	Co	sts		<u> </u>	.'	
Cost Center Description	Cost	Cost	1			
COST Center Description						
	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 OPERATI NG ROOM	C	0				1 50. 00
51. 00 05100 RECOVERY ROOM		1	1			51. 00
	1	1				
52.00 05200 DELIVERY ROOM & LABOR ROOM	C	-	1			52. 00
53. 00 05300 ANESTHESI OLOGY) 0				53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		ol o)			54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	1	ol o				55. 00
			1			1
56. 00 05600 RADI OI SOTOPE		0	1			56. 00
57.00 05700 CT SCAN		0	1			57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)		0				58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON		ol o				59.00
			1			
60. 00 06000 LABORATORY		1	1			60.00
60. 01 06001 BL00D LABORATORY		0	1			60. 01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		ol .				61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		ol o	i			62.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.						63. 00
			1			
64.00 06400 I NTRAVENOUS THERAPY	(0	1			64. 00
65. 00 06500 RESPIRATORY THERAPY) 0				65.00
66. 00 06600 PHYSI CAL THERAPY		ol o				66. 00
67. 00 06700 OCCUPATI ONAL THERAPY		l .	1			67. 00
	1	1	1			1
68.00 06800 SPEECH PATHOLOGY	C	1	1			68. 00
69. 00 06900 ELECTROCARDI OLOGY		0)			69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY		0)			70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		o	1			71. 00
		ól ő				
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS			1			72. 00
73.00 O7300 DRUGS CHARGED TO PATIENTS		0				73. 00
74. 00 07400 RENAL DIALYSIS) 0				74. 00
75.00 07500 ASC (NON-DISTINCT PART)		ol o				75. 00
76. 00 03950 OTHER ANCILL SRVC						76. 00
		-				1
76. 01 03951 CARDI AC AND PULMONARY REHAB		0	1			76. 01
76. 02 03952 WOUND CARE		0	1			76. 02
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION		0)			77. 00
OUTPATIENT SERVICE COST CENTERS	<u>'</u>					1
88. 00 08800 RURAL HEALTH CLINIC						88. 00
						1
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER						89. 00
90. 00 09000 CLI NI C		0	1			90.00
90. 01 09001 CLI NI C		ol o				90. 01
90. 02 09002 CLI NI C		ol o	1			90. 02
91. 00 09100 EMERGENCY	C	-	1			91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	C	0				92.00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DIALYSIS		0				94. 00
95. 00 09500 AMBULANCE SERVICES						95. 00
	1	l .				1
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	(C	-	1			96. 00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD		0)			97. 00
98. 00 09850 OTHER REIMBURSE		ol o	1			98. 00
200.00 Subtotal (see instructions)		ól ő	1			200. 00
,		()	Ί			1
201.00 Less PBP Clinic Lab. Services-Program	0	기 기				201. 00
Only Charges			1			1
202.00 Net Charges (line 200 - line 201)		0)			202. 00
	•	•	•			•

Health Financial Systems	FRANCISCAN HEALTH MUNSTER	In Lie	u of Form CMS-:	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0165	Peri od: From 01/01/2020	Worksheet D-1	
			Date/Time Pre 7/29/2021 4:4	
	Title XVIII	Hospi tal	PPS	
0 1 0 1 D : 1:				

		Title XVIII	Hospi tal	7/29/2021 4: 4: PPS	0 pm
	Cost Center Description				
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days			12, 142	1. 00 2. 00
2. 00 3. 00	Inpatient days (including private room days, excluding swing-bed and observation bed day do not complete this line.		ivate room days,	12, 142 0	3. 00
4.00	Semi-private room days (excluding swing-bed and observation be	ed days)		10, 615	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private rooreporting period	om days) through Decembe	r 31 of the cost	0	5. 00
6.00	Total swing-bed SNF type inpatient days (including private rooreporting period (if calendar year, enter 0 on this line)			0	6. 00
7. 00	Total swing-bed NF type inpatient days (including private room reporting period	n days) through December	31 of the cost	0	7. 00
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 3	1 of the cost	0	8. 00
9. 00	Total inpatient days including private room days applicable to newborn days) (see instructions)	the Program (excluding	swi ng-bed and	3, 737	9. 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or through December 31 of the cost reporting period (see instruct		oom days)	0	10. 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or December 31 of the cost reporting period (if calendar year, er	nter O on this line)	,	0	11. 00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX through December 31 of the cost reporting period	3 .	,	0	12. 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 years)	ear, enter O on this lin	e)	0	13. 00
14. 00 15. 00	Medically necessary private room days applicable to the Progra Total nursery days (title V or XIX only)	nm (excluding swing-bed	days)	0	14. 00 15. 00
16. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0	16. 00
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through December 31 o	f the cost	0.00	17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es after December 31 of	the cost	0. 00	18. 00
19. 00					19. 00
20. 00	Medical drate for swing-bed NF services applicable to services reporting period	after December 31 of t	he cost	0.00	
21. 00 22. 00	Total general inpatient routine service cost (see instructions Swing-bed cost applicable to SNF type services through Decembe		ing period (line	20, 683, 893 0	21. 00 22. 00
23. 00	$5\ x$ line 17) Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	g period (line 6	0	23. 00
24. 00	x line 18) Swing-bed cost applicable to NF type services through December	31 of the cost reporti	ng period (line	0	24. 00
25. 00	7 x line 19) Swing-bed cost applicable to NF type services after December $^{\circ}$	31 of the cost reporting	period (line 8	0	25. 00
26. 00	x line 20) Total swing-bed cost (see instructions)			0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)		20, 683, 893	
	General inpatient routine service charges (excluding swing-bed	and observation bed ch	arges)	0	
29. 00	Private room charges (excluding swing-bed charges)			0	29. 00
30. 00 31. 00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 =	line 28)		0. 000000	30. 00 31. 00
32. 00	Average private room per diem charge (line 29 ÷ line 3)	1111e 20)		0.00000	
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
34. 00	Average per diem private room charge differential (line 32 mir	nus line 33)(see instruc	tions)	0.00	
35. 00	Average per diem private room cost differential (line 34 x lir			0.00	35. 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 27 minus line 36)	and private room cost di	fferential (line	20, 683, 893	37. 00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	STMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see			1, 703. 50	38. 00
39. 00	Program general inpatient routine service cost per drem (see	•		6, 365, 980	
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)		6, 365, 980	41. 00

Heal th	Financial Systems FRANCISCAN HEALTH MUNSTER In Lie	eu of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST Provider CCN: 15-0165 Period: From 01/01/2020		
	To 12/31/2020	Date/Time Prep 7/29/2021 4:40	
	Title XVIII Hospital Cost Center Description Total Total Average Per Program Days	PPS Program Cost	
	Inpatient Cost Inpatient Days Diem (col. 1 ÷	(col. 3 x col.	
	1.00 2.00 3.00 4.00	4) 5. 00	
42. 00	NURSERY (title V & XIX only) 0 0 0.00 0 Intensive Care Type Inpatient Hospital Units	0	42. 00
43. 00	INTENSIVE CARE UNIT 4, 678, 200 1, 679 2, 786. 30 1, 107		43. 00
44. 00 45. 00	CORONARY CARE UNIT 0 0 0 0 0 0 0 0 0	۲ _ا "ا	44. 00 45. 00
46.00	SURGICAL INTENSIVE CARE UNIT 0 0.00		46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description		47. 00
40.00		1.00	40.00
48. 00 49. 00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200) Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	8, 742, 430 18, 192, 844	
50. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and	1, 303, 851	50. 00
	III)		
51. 00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	573, 214	51. 00
52. 00	Total Program excludable cost (sum of lines 50 and 51)	1, 877, 065	
53. 00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	16, 315, 779	53. 00
E4 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges	0	E4 00
55. 00		0.00	54. 00 55. 00
56. 00 57. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	56. 00 57. 00
58. 00	Bonus payment (see instructions)	0	58. 00
59. 00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59. 00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	
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	0	61. 00
62. 00	amount (line 56), otherwise enter zero (see instructions) Relief payment (see instructions)	0	62. 00
63. 00	Allowable Inpatient cost plus incentive payment (see instructions)	Ö	
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See	0	64. 00
	instructions)(title XVIII only)		
65. 00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period	0	67. 00
68. 00	(line 12 x line 19) Title V or XLX swing-bed NF inpatient routine costs after December 31 of the cost reporting period	0	68. 00
69 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69. 00
07.00	PART III - SKILLED NURSINĞ FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70. 00 71. 00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		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 applicable to Program (line 14 x line 35) Total Program general inpatient routine service costs (line 72 + line 73)		73. 00 74. 00
75. 00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column		75. 00
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ line 2)		76. 00
77. 00 78. 00	Program capital-related costs (line 9 x line 76) Inpatient routine service cost (line 74 minus line 77)		77. 00 78. 00
79. 00	Aggregate charges to beneficiaries for excess costs (from provider records)		79. 00
80. 00 81. 00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) Inpatient routine service cost per diem limitation		80. 00 81. 00
82. 00	Inpatient routine service cost limitation (line 9 x line 81)		82. 00
83. 00 84. 00	Reasonable inpatient routine service costs (see instructions) Program inpatient ancillary services (see instructions)		83. 00 84. 00
85.00	Utilization review - physician compensation (see instructions)		85. 00
86. 00	Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		86. 00
87. 00 88. 00		1, 527 1, 703. 50	87. 00 88. 00
	Observation bed cost (line 87 x line 88) (see instructions)	2, 601, 245	

Health Financial Systems	FRANCI SCAN HEA	ALTH MUNSTER		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Period: From 01/01/2020	Worksheet D-1	
				To 12/31/2020	Date/Time Pre 7/29/2021 4:4	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	2, 844, 735	20, 683, 893	0. 13753	4 2, 601, 245	357, 760	90.00
91.00 Nursing School cost	0	20, 683, 893	0.00000	2, 601, 245	0	91.00
92.00 Allied health cost	0	20, 683, 893	0.00000	2, 601, 245	0	92. 00
93.00 All other Medical Education	0	20, 683, 893	0.00000	2, 601, 245	0	93.00

Health Financial Systems	FRANCISCAN HEALTH MUNSTER	In Lie	u of Form CMS-	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0165	Peri od: From 01/01/2020	Worksheet D-1	
			Date/Time Pre 7/29/2021 4:4	
	Title XIX	Hospi tal	PPS	
Cost Center Description				

		Title XIX	Hospi tal	7/29/2021 4: 40 PPS	o piii
	Cost Center Description				
				1. 00	
	PART I - ALL PROVIDER COMPONENTS				
1. 00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days	eveluding newborn)		12, 142	1. 00
2.00	Inpatient days (including private room days, excluding swing-based days			12, 142	2. 00
3.00	Private room days (excluding swing-bed and observation bed day		vate room days,	0	3. 00
	do not complete this line.		•		
4.00	Semi-private room days (excluding swing-bed and observation be			10, 615	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private rooreporting period	om days) through becember	31 of the cost	0	5. 00
6.00	Total swing-bed SNF type inpatient days (including private roo	om days) after December 3	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	n days) through December	31 of the cost	0	7. 00
8. 00	reporting period Total swing-bed NF type inpatient days (including private room	n days) after December 21	of the cost	0	8. 00
8.00	reporting period (if calendar year, enter 0 on this line)	i days) al tel becellbel 31	or the cost	U	0.00
9.00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	531	9. 00
	newborn days) (see instructions)				
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or through December 31 of the cost reporting period (see instruct	nly (including private ro	oom days)	0	10. 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or	ilons) Ny (includina nrivate ra	nom days) after	0	11. 00
11.00	December 31 of the cost reporting period (if calendar year, er		om days) arter	· ·	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XI>		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 XI) 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)	(gg		0	15. 00
16. 00	Nursery days (title V or XIX only)			0	16. 00
47.00	SWING BED ADJUSTMENT			0.00	47.00
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through December 31 of	the cost	0.00	17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of t	he cost	0.00	18. 00
	reporting period				
19. 00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0.00	19. 00
20. 00	reporting period	after December 21 of th	o cost	0.00	20. 00
20.00	Medicaid rate for swing-bed NF services applicable to services reporting period	arter beceiiber 31 01 tr	ie cost	0. 00	20.00
21. 00	Total general inpatient routine service cost (see instructions	5)		20, 683, 893	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December	er 31 of the cost reporti	ng 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 reporting	period (iine 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reportin	ng period (line	0	24. 00
	7 x line 19)	•			
25. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25. 00
26 00	x line 20) 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)		20, 683, 893	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28. 00	General inpatient routine service charges (excluding swing-bed	l and observation bed cha	irges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)			0	29. 00
30.00	Semi-private room charges (excluding swing-bed charges)	line 20)		0. 000000	30.00
31. 00 32. 00	General inpatient routine service cost/charge ratio (line 27 ± Average private room per diem charge (line 29 ± line 3)	- TTNe 28)		0.00000	
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
34.00	Average per diem private room charge differential (line 32 mir	nus line 33)(see instruct	i ons)	0.00	
35. 00	Average per diem private room cost differential (line 34 x lin	ne 31)		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 27 minus line 36)	ina private room cost dif	Terential (line	20, 683, 893	37. 00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	STMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see	i nstructi ons)		1, 703. 50	
39. 00	Program general inpatient routine service cost (line 9 x line	-		904, 559	
40.00	Medically necessary private room cost applicable to the Progra Total Program general inpatient routine service cost (line 39	•		0 904, 559	40.00
41.00	Trotal Trogram general impatrent routine service cost (ITHE 39	11116 40)		704, 559	1 41.00

Heal th	Financial Systems	FRANCISCAN HEA	ITH MUNSTER		In lie	eu of Form CMS-2	2552-10
	ATION OF INPATIENT OPERATING COST	7 10 11 10 1 00 7 11 1 11 12 1		CCN: 15-0165	Peri od:	Worksheet D-1	
					From 01/01/2020 To 12/31/2020	Date/Time Pre	nared:
						7/29/2021 4: 4	
	Cost Center Description	Total	Ti t Total	le XIX Average Per	Hospital Program Days	PPS Program Cost	
	cost center bescription	Inpatient Cost				(col. 3 x col.	
		·		col . 2)		4)	
42.00	NUDCEDY (+i+lo V 0 VIV only)	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	4, 678, 200	1, 67	9 2, 786.	30 213	593, 482	43. 00
44. 00	CORONARY CARE UNIT	0		0. (-	
45. 00 46. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT	0		0 0 0			45. 00 46. 00
	OTHER SPECIAL CARE (SPECIFY)			0.1	50	0	47. 00
	Cost Center Description			•			
40.00	December 1 and 1 a	-+ D 21 2	11 - 200)			1.00	40.00
48. 00 49. 00	Program inpatient ancillary service cost (Wk Total Program inpatient costs (sum of lines			ons)		1, 264, 155 2, 762, 196	•
.,. 00	PASS THROUGH COST ADJUSTMENTS	11 till ough 10) (c				27,027170	
50. 00	Pass through costs applicable to Program inp	atient routine s	services (fro	m Wkst. D, sur	n of Parts I and	206, 820	50. 00
51. 00		atient ancillarv	/ services (f	rom Wkst. D. s	sum of Parts II	113, 523	51. 00
	and IV)	Ĩ	,	,			
52. 00 53. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu-		atad non nh	vei ei an anaeti	actict and	320, 343	•
33.00	medical education costs (line 49 minus line	9 1	ateu, non-pii	ysi ci aii allesti	letist, and	2, 441, 853	33.00
	TARGET AMOUNT AND LIMIT COMPUTATION	,					
54. 00	, 3					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	ing cost and tar	get amount (line 56 minus	line 53)	0	57. 00
58. 00	Bonus payment (see instructions)					0	58. 00
59. 00	Lesser of lines 53/54 or 55 from the cost remarket basket	porting period 6	ending 1996,	updated and co	ompounded by the	0.00	59. 00
60.00	Lesser of lines 53/54 or 55 from prior year					0.00	60. 00
61. 00	If line 53/54 is less than the lower of line					0	61. 00
	which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						
62. 00	2.00 Relief payment (see instructions)						62. 00
63. 00							63. 00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Decem	mber 31 of th	e cost reporti	na period (See	0	64. 00
	instructions)(title XVIII only)			•			
65. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts after Decembe	er 31 of the	cost reporting	g period (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line 6	64 plus line	65)(title XVI	I only). For	0	66. 00
47.00	CAH (see instructions)		D 21	-6			/7.00
67. 00	Title V or XIX swing-bed NF inpatient routing (line 12 x line 19)	e costs through	December 31	or the cost re	eporting period	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routing	e costs after De	ecember 31 of	the cost repo	orting period	0	68. 00
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routine costs (1	ine 67 + lin	e 68)		0	69. 00
07.00	PART III - SKILLED NURSING FACILITY, OTHER NI						07.00
70.00	Skilled nursing facility/other nursing facil)		70.00
71. 00 72. 00	Adjusted general inpatient routine service of Program routine service cost (line 9 x line		ne /U ÷ IIne	2)			71. 00 72. 00
73. 00	Medically necessary private room cost applic		(line 14 x l	ine 35)			73. 00
74. 00	Total Program general inpatient routine serv						74. 00
75. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service	costs (from	Worksheet B, I	Part 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	,	rovi der recor	de)			78. 00 79. 00
80.00	Total Program routine service costs for comp				nus line 79)		80.00
81. 00	Inpatient routine service cost per diem limi	tati on			•		81. 00
82. 00 83. 00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (82. 00 83. 00
84. 00	Program inpatient ancillary services (see in		<i>3)</i>				84.00
85.00	Utilization review - physician compensation	(see instruction					85. 00
86. 00			ough 85)				86. 00
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions					1, 527	87. 00
88. 00	Adjusted general inpatient routine cost per	diem (line 27 ÷	line 2)			1, 703. 50	88. 00
89. 00	Observation bed cost (line 87 x line 88) (se	e instructions)				2, 601, 245	89. 00

Health Financial Systems	FRANCI SCAN HEA	ALTH MUNSTER		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		
		Ti tl	e XIX	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 O	COST					
90.00 Capital -related cost	2, 844, 735	20, 683, 893	0. 13753	4 2, 601, 245	357, 760	90.00
91.00 Nursing School cost	0	20, 683, 893	0.00000	0 2, 601, 245	0	91.00
92.00 Allied health cost	0	20, 683, 893	0.00000	0 2, 601, 245	0	92.00
93.00 All other Medical Education	0	20, 683, 893	0. 00000	0 2, 601, 245	0	93. 00

Health Financial Systems FRANCISCAN HEALT	TH MUNSTER	In Lie	u of Form CMS-2	2552-10
I NPATIENT ANCILLARY SERVICE COST APPORTIONMENT	F	Period: From 01/01/2020 o 12/31/2020	Worksheet D-3 Date/Time Pre	pared:
	Title XVIII	Hocni tal	7/29/2021 4: 4: PPS	U pm
Cost Conton Decemintion		Hospi tal		
Cost Center Description	Ratio of Cost		Inpatient	
	To Charges	Program	Program Costs	
		Charges	(col. 1 x col.	
	1.00	2.00	2) 3. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	1.00	2. 00	3.00	
30. 00 03000 ADULTS & PEDI ATRI CS		8, 300, 776		30.00
31. 00 03100 NTENSI VE CARE UNI T		2, 014, 390		31.00
32. 00 03200 CORONARY CARE UNIT		2,011,070		32.00
33. 00 03300 BURN INTENSIVE CARE UNIT		0		33. 00
34. 00 03400 SURGI CAL INTENSI VE CARE UNI T		0		34. 00
40. 00 04000 SUBPROVI DER - PF		0		40.00
41. 00 04100 SUBPROVI DER - I RF		0		41.00
43. 00 04300 NURSERY				43. 00
ANCI LLARY SERVI CE COST CENTERS				10.00
50. 00 05000 OPERATI NG ROOM	0. 187192	5, 590, 189	1, 046, 439	50.00
51. 00 05100 RECOVERY ROOM	0. 398507		148, 134	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000		0	52.00
53. 00 05300 ANESTHESI OLOGY	0. 12762		120, 678	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 17715		349, 453	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000		0	55. 00
56. 00 05600 RADI OI SOTOPE	0.00000		0	56. 00
57. 00 05700 CT SCAN	0. 034746		103, 620	57.00
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 095068		68, 800	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 206644		456, 502	59.00
60. 00 06000 LABORATORY	0. 167262		1, 010, 104	60.00
60. 01 06001 BLOOD LABORATORY	0. 000000		0	60. 01
61. 00 06100 PBP CLINI CAL LAB SERVI CES-PRGM ONLY	0. 000000		0	61.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000		0	62.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000		0	63.00
64. 00 06400 I NTRAVENOUS THERAPY	0. 000000		0	64. 00
65. 00 06500 RESPI RATORY THERAPY	0. 39974		525, 101	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 252352		127, 911	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 194698		75, 675	67.00
68. 00 06800 SPEECH PATHOLOGY	0. 18981		26, 714	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 049486		85, 866	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 696725		26, 615	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 168416		364, 431	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 523710		1, 529, 877	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 319335		1, 866, 717	73. 00
74. 00 07400 RENAL DI ALYSI S	0.000000		0	74. 00
75. 00 07500 ASC (NON-DISTINCT PART)	0. 000000		0	75. 00
76. 00 03950 OTHER ANCILL SRVC	0.00000		0	76. 00
76. 01 03951 CARDI AC AND PULMONARY REHAB	0. 641038		0	76. 01
76. 02 03952 WOUND CARE	0. 501256		372	76. 02
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000		0	77. 00
OUTPATIENT SERVICE COST CENTERS	·			
88. 00 08800 RURAL HEALTH CLINIC	0.000000)	0	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000		0	89. 00
90. 00 09000 CLI NI C	0.000000	0	0	90. 00
90. 01 09001 CLI NI C	0. 145290	375, 141	54, 504	90. 01
90. 02 09002 CLI NI C	0. 167323	0	0	90. 02
91. 00 09100 EMERGENCY	0. 159024	3, 275, 003	520, 804	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 287620	813, 966	234, 113	92.00
OTHER REIMBURSABLE COST CENTERS				
94.00 09400 HOME PROGRAM DIALYSIS	0. 000000	0	0	94.00
95. 00 09500 AMBULANCE SERVI CES				95. 00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0.000000		0	96. 00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0.000000		0	97. 00
98. 00 09850 OTHER REI MBURSE	0. 000000		0	98. 00
200.00 Total (sum of lines 50 through 94 and 96 through 98)		40, 352, 991	8, 742, 430	
201.00 Less PBP Clinic Laboratory Services-Program only charges	s (line 61)	0		201. 00
202.00 Net charges (line 200 minus line 201)	1	40, 352, 991		202. 00

Health Financial Systems FRANCISCAN	HEALTH MUNSTER	In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Period: From 01/01/2020	Worksheet D-3	
		o 12/31/2020	Date/Time Pre	pared:
			7/29/2021 4: 40	0 pm
C+ C+ D+:	Title XIX	Hospi tal	PPS	
Cost Center Description	Ratio of Cost To Charges	Inpatient Program	Inpatient Program Costs	
	To charges	Charges	(col. 1 x col.	
		charges	2)	
	1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS		1, 266, 013		30.00
31. 00 03100 I NTENSI VE CARE UNI T		330, 570		31.00
32. 00 03200 CORONARY CARE UNIT		0		32.00
33.00 03300 BURN INTENSIVE CARE UNIT 34.00 03400 SURGICAL INTENSIVE CARE UNIT		0		33. 00 34. 00
40. 00 04000 SUBPROVI DER - PF		0		40.00
41. 00 04100 SUBPROVI DER - RF		0		41.00
43. 00 04300 NURSERY		0		43. 00
ANCI LLARY SERVI CE COST CENTERS	'			
50. 00 05000 OPERATI NG ROOM	0. 187192	1, 802, 155	337, 349	50.00
51.00 05100 RECOVERY ROOM	0. 398507		34, 948	51.00
52.00 O5200 DELIVERY ROOM & LABOR ROOM	0. 000000		0	52. 00
53. 00 05300 ANESTHESI OLOGY	0. 127621		28, 493	53. 00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	0. 177157		48, 584	54.00
55. 00 05500 RADI OLOGY - THERAPEUTI C	0.000000		0	55.00
56. 00 05600 RADI 01 SOTOPE 57. 00 05700 CT SCAN	0. 000000 0. 034746		14 212	56. 00 57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 095068		16, 312 11, 851	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 206644		105, 776	59.00
60. 00 06000 LABORATORY	0. 167262		160, 755	60.00
60. 01 06001 BLOOD LABORATORY	0. 000000		0	60. 01
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0.00000		0	61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	0	0	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0	0	63. 00
64. 00 06400 I NTRAVENOUS THERAPY	0. 000000		0	64. 00
65. 00 06500 RESPI RATORY THERAPY	0. 399741		89, 769	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 252352		15, 639	66.00
67. 00 06700 OCCUPATIONAL THERAPY	0. 194698		8, 955	67.00
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	0. 189817 0. 04948 <i>6</i>		2, 590 8, 862	68. 00 69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 696725		0, 002	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 168416		0	71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 523710		0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 319335	854, 143	272, 758	73. 00
74. 00 07400 RENAL DI ALYSI S	0. 000000	0	0	74. 00
75. 00 07500 ASC (NON-DISTINCT PART)	0. 000000		0	75. 00
76. 00 03950 OTHER ANCI LL SRVC	0.000000		0	76. 00
76. 01 03951 CARDI AC AND PULMONARY REHAB	0. 641038		0	76. 01
76. 02 03952 WOUND CARE 77. 00 07700 ALLOGENEI C STEM CELL ACQUISITION	0. 50125 <i>6</i> 0. 000000		0	76. 02 77. 00
OUTPATIENT SERVICE COST CENTERS] 0.00000	<u>, </u>	U	77.00
88. 00 08800 RURAL HEALTH CLINIC	0.00000	0	0	88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89. 00
90. 00 09000 CLI NI C	0.000000	0	0	90.00
90. 01 09001 CLI NI C	0. 145290	56, 564	8, 218	90. 01
90. 02 09002 CLI NI C	0. 167323		0	90. 02
91. 00 09100 EMERGENCY	0. 159024		113, 296	91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	0. 287620	0	0	92. 00
OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DI ALYSI S	0.00000) 0	0	94. 00
95. 00 09500 AMBULANCE SERVI CES	0.00000	J	U	95.00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0. 000000		0	96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0.000000		0	97. 00
98. 00 09850 OTHER REI MBURSE	0.000000		0	98. 00
200.00 Total (sum of lines 50 through 94 and 96 through 98		6, 602, 861	1, 264, 155	
201.00 Less PBP Clinic Laboratory Services-Program only ch	arges (line 61)	0		201. 00
202.00 Net charges (line 200 minus line 201)		6, 602, 861		202. 00

Health Financial Systems	FRANCISCAN HEALTH MUNSTER	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0165	Peri od: Worksheet E From 01/01/2020 Part A To 12/31/2020 Date/Time Prepared: 7/29/2021 4:40 pm

				7/29/2021 4:4	0 pm
		Title XVIII	Hospi tal	PPS	
				1 00	
	DADT A LABATIENT HOCKITAL CERVICES HARED LDDS			1. 00	
1. 00	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS DRG Amounts Other than Outlier Payments			0	1.00
1. 00	DRG amounts other than outlier payments for discharges occurri	ing prior to October 1 (300	6, 916, 311	1. 00
1.01	instructions)				1.01
1.02	DRG amounts other than outlier payments for discharges occurri	3, 049, 983	1. 02		
	instructions)	3	\	.,,	
1.03	DRG for federal specific operating payment for Model 4 BPCI fo	or discharges occurring p	orior to October	0	1. 03
	1 (see instructions)				
1. 04	DRG for federal specific operating payment for Model 4 BPCI fo	or discharges occurring (on or after	0	1. 04
	October 1 (see instructions)				
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 instruction	•		0	2. 02
2. 03	Outlier payments for discharges occurring prior to October 1			372, 214	2. 03
2.04	Outlier payments for discharges occurring on or after October	1 (see instructions)		133, 816	2. 04
3.00	Managed Care Simulated Payments			0	3. 00
4. 00	Bed days available divided by number of days in the cost report	rting period (see instru	ctions)	58. 83	4. 00
F 00	Indirect Medical Education Adjustment			0.00	F 00
5. 00	FTE count for allopathic and osteopathic programs for the mos	t recent cost reporting p	period ending on	0. 00	5. 00
/ 00	or before 12/31/1996. (see instructions)			0.00	/ 00
6.00	FTE count for allopathic and osteopathic programs that meet the	ne criteria for an add-oi	n to the cap for	0. 00	6. 00
7 00	new programs in accordance with 42 CFR 413.79(e)		(1) (!) (D) (1)	0.00	7 00
7.00	MMA Section 422 reduction amount to the IME cap as specified u			0.00	7.00
7. 01	ACA § 5503 reduction amount to the IME cap as specified under	42 CFR 9412. 105(T)(1)(I)	7)(B)(2) IT the	0. 00	7. 01
0.00	cost report straddles July 1, 2011 then see instructions.		6	0.00	0.00
8. 00	Adjustment (increase or decrease) to the FTE count for allopa			0. 00	8. 00
	affiliated programs in accordance with 42 CFR 413.75(b), 413.	79(C)(2)(TV), 64 FR 26340) (May 12,	ļ	
0 01	1998), and 67 FR 50069 (August 1, 2002).	ata undan S EEOO of the	1CA f +ba aaa+	0.00	0.01
8. 01	The amount of increase if the hospital was awarded FTE cap sloreport straddles July 1, 2011, see instructions.	ots under 9 5503 of the /	ACA. II the cost	0. 00	8. 01
8. 02	The amount of increase if the hospital was awarded FTE cap slo	ats from a closed teachin	na hosni tal	0. 00	8. 02
0. 02	under § 5506 of ACA. (see instructions)	ots from a crosed teachin	ig nospi tai	0.00	0.02
9. 00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus line	es (8 8 01 and 8 02) (200	0. 00	9. 00
7. 00	instructions)	(3 (0, 0,01 and 0,02)	300	0.00	7.00
10.00	FTE count for allopathic and osteopathic programs in the curre	ent vear from your record	ds	0. 00	10. 00
	FTE count for residents in dental and podiatric programs.	5 yeae yeaeee.			11. 00
	Current year allowable FTE (see instructions)				12.00
13. 00	Total allowable FTE count for the prior year.			0.00	1
14. 00	Total allowable FTE count for the penultimate year if that year	ar ended on or after Sen	tember 30 1997	0.00	•
14.00	otherwise enter zero.	ar ended on or arter sep	Ciliber 30, 1777,	0.00	14.00
15. 00	Sum of lines 12 through 14 divided by 3.			0.00	15. 00
	Adjustment for residents in initial years of the program				16. 00
	Adjustment for residents displaced by program or hospital clos	sure			17. 00
	Adjusted rolling average FTE count	341 6			18. 00
	Current year resident to bed ratio (line 18 divided by line 4))		0. 000000	
	Prior year resident to bed ratio (see instructions)	<i>)</i> .		0. 000000	1
	Enter the lesser of lines 19 or 20 (see instructions)			0. 000000	
	IME payment adjustment (see instructions)			0.000000	1
	IME payment adjustment (see Fristructions)			0	1
22.01	Indirect Medical Education Adjustment for the Add-on for § 422	Onf the MMA		0	22.01
23. 00	Number of additional allopathic and osteopathic IME FTE reside		P /12 105	0.00	23. 00
23.00	(f)(1)(iv)(C).	ent cap siots under 42 ci	K 412. 103	0.00	23.00
24. 00	IME FTE Resident Count Over Cap (see instructions)			0. 00	24. 00
	If the amount on line 24 is greater than -0-, then enter the	lower of line 23 or line	24 (SEE	0. 00	ı
20.00	instructions)	Tower of Time 20 of Time	21 (300	0.00	20.00
26. 00	Resident to bed ratio (divide line 25 by line 4)			0. 000000	26. 00
	IME payments adjustment factor. (see instructions)			0. 000000	1
	IME add-on adjustment amount (see instructions)			0.000000	28. 00
	IME add-on adjustment amount - Managed Care (see instructions))		0	1
29. 00	Total IME payment (sum of lines 22 and 28)	,		0	
	Total IME payment - Managed Care (sum of lines 22.01 and 28.0	1)		0	29. 01
_,	Di sproporti onate Share Adjustment	.,		0	1 0 .
30. 00	Percentage of SSI recipient patient days to Medicare Part A pa	atient days (see instruc	tions)	2. 29	30. 00
31. 00	Percentage of Medicaid patient days (see instructions)	21. 2 44,5 (300 11131140	,	10. 62	1
32. 00	Sum of lines 30 and 31			12. 91	1
	Allowable disproportionate share percentage (see instructions))		0.00	ı
	Disproportionate share adjustment (see instructions)	•			34. 00
00			ı	٥١	,

	FI NANCI SCAN HEALTH ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0165	Peri od: From 01/01/2020 To 12/31/2020		pared:
		Title XVIII	Hospi tal	PPS	
			Prior to 10/1	On/After 10/1	
			1. 00	2.00	
	Uncompensated Care Adjustment				
5. 00	Total uncompensated care amount (see instructions)		0	0	35. 0
5. 01	Factor 3 (see instructions)	zama an thia lina) (aas	0. 000000000		35. 0
5. 02	Hospital uncompensated care payment (If line 34 is zero, enter instructions)	zero on this line) (see	9	0	35. 0
5. 03	Pro rata share of the hospital uncompensated care payment amou	unt (see instructions)	0	o	35. 0
6. 00	Total uncompensated care (sum of columns 1 and 2 on line 35.03		0		36. 0
	Additional payment for high percentage of ESRD beneficiary dis		jh 46)		
0.00	Total Medicare discharges, excluding MS-DRGs 652, 682, 683, 68		0		40. 0
	instructions)				
1. 00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 68	33, 684 an 685. (see	0		41. 0
1 01	instructions)	NDC- /F2 /02 /02 /04			41 0
1. 01	Total ESRD Medicare covered and paid discharges excluding MS-Dan 685. (see instructions)	JKUS 052, 082, 683, 684	0		41. 0
2. 00	Divide line 41 by line 40 (if less than 10%, you do not qualif	v for adjustment)	0.00		42. 0
3. 00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682	, ,	0.00		43. 0
	instructions)				
4. 00	Ratio of average length of stay to one week (line 43 divided b	by line 41 divided by 7	0. 000000		44. 0
	days)				
5. 00	Average weekly cost for dialysis treatments (see instructions)		0.00		45. 0
6. 00	Total additional payment (line 45 times line 44 times line 41.	01)	10 472 224		46. 0
7. 00 8. 00	Subtotal (see instructions) Hospital specific payments (to be completed by SCH and MDH, sm	all rural bashitals	10, 472, 324		47. 0 48. 0
8.00	only. (see instructions)	iai i rurai nospitais	0		48.0
	join y. (See That detrons)			Amount	
				1. 00	
9. 00	Total payment for inpatient operating costs (see instructions)			10, 472, 324	49. 0
0.00	Payment for inpatient program capital (from Wkst. L, Pt. I and			794, 087	50. 0
1. 00	Exception payment for inpatient program capital (Wkst. L, Pt.			0	51.0
2. 00	Direct graduate medical education payment (from Wkst. E-4, lir	ne 49 see instructions).		0	52. 0
3.00	Nursing and Allied Health Managed Care payment			0	53.0
4.00	Special add-on payments for new technologies			62, 564	54. 0 54. 0
4. 01 5. 00	Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69	0)		0	55. 0
6. 00	Cost of physicians' services in a teaching hospital (see intru	•		0	56. 0
7. 00	Routine service other pass through costs (from Wkst. D, Pt. II	*	rough 35).	Ö	57. 0
	Ancillary service other pass through costs from Wkst. D, Pt. I		,	0	58. 0
8.00	Total (sum of amounts on lines 49 through 58)			11, 328, 975	59.0
8. 00 9. 00	Primary payer payments			0	60. 0
				11, 328, 975	61.0
9. 00 0. 00 1. 00	Total amount payable for program beneficiaries (line 59 minus	line 60)			
9. 00 0. 00 1. 00 2. 00	Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries	line 60)		1, 056, 836	
9. 00 0. 00 1. 00 2. 00 3. 00	Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries	line 60)		28, 512	63.0
9. 00 0. 00 1. 00 2. 00 3. 00 4. 00	Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions)	line 60)		28, 512 186, 122	63. 0 64. 0
9. 00 0. 00 1. 00 2. 00 3. 00 4. 00 5. 00	Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)	·		28, 512 186, 122 120, 979	63. 0 64. 0 65. 0
9. 00 0. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00	Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instr	·		28, 512 186, 122 120, 979 69, 334	63. C 64. C 65. C
9. 00 0. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions (subtotal (line 61 plus line 65 minus lines 62 and 63)	ructions)	e instructions)	28, 512 186, 122 120, 979 69, 334 10, 364, 606	63. 0 64. 0 65. 0 66. 0
9. 00 0. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00	Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions) Credits received from manufacturers for replaced devices for a	ructions) applicable to MS-DRGs (se		28, 512 186, 122 120, 979 69, 334 10, 364, 606	63. 0 64. 0 65. 0 66. 0 67. 0 68. 0
9. 00 0. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions) Credits received from manufacturers for replaced devices for a Outlier payments reconciliation (sum of lines 93, 95 and 96).	ructions) applicable to MS-DRGs (se		28, 512 186, 122 120, 979 69, 334 10, 364, 606	63. 0 64. 0 65. 0 66. 0 67. 0 68. 0
9. 00 0. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 0. 00	Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions) Credits received from manufacturers for replaced devices for a	ructions) applicable to MS-DRGs (se For SCH see instructions	3)	28, 512 186, 122 120, 979 69, 334 10, 364, 606 0	63. 0 64. 0 65. 0 66. 0 67. 0 68. 0 69. 0
9. 00 0. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 0. 50	Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions) Credits received from manufacturers for replaced devices for a Outlier payments reconciliation (sum of lines 93, 95 and 96). OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	ructions) applicable to MS-DRGs (se For SCH see instructions	3)	28, 512 186, 122 120, 979 69, 334 10, 364, 606 0 0	63. 0 64. 0 65. 0 66. 0 67. 0 68. 0 70. 0
9. 00 0. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 0. 50 0. 87 0. 88	Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions) Credits received from manufacturers for replaced devices for a Outlier payments reconciliation (sum of lines 93, 95 and 96). (OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demonstr	ructions) applicable to MS-DRGs (se For SCH see instructions	3)	28, 512 186, 122 120, 979 69, 334 10, 364, 606 0 0	63. 0 64. 0 65. 0 66. 0 67. 0 68. 0 70. 0 70. 8 70. 8
9. 00 0. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 0. 50 0. 87 0. 88 0. 89	Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions) Credits received from manufacturers for replaced devices for a Outlier payments reconciliation (sum of lines 93, 95 and 96). (OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see instructions)	ructions) applicable to MS-DRGs (se For SCH see instructions ration) adjustment (see i	3)	28, 512 186, 122 120, 979 69, 334 10, 364, 606 0 0 0	63. 0 64. 0 65. 0 66. 0 67. 0 68. 0 70. 0 70. 0 70. 8 70. 8
9. 00 0. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 0. 50 0. 87 0. 88 0. 89 0. 90	Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions) Credits received from manufacturers for replaced devices for a Outlier payments reconciliation (sum of lines 93, 95 and 96). (OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demonstruction Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see instructions)	ructions) applicable to MS-DRGs (se For SCH see instructions ration) adjustment (see i	3)	28, 512 186, 122 120, 979 69, 334 10, 364, 606 0 0 0 0	63. 0 64. 0 65. 0 66. 0 67. 0 68. 0 70. 0 70. 8 70. 8 70. 8
9. 00 0. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 0. 50 0. 87 0. 88 0. 89 0. 91	Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions) Credits received from manufacturers for replaced devices for a Outlier payments reconciliation (sum of lines 93, 95 and 96). (OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demonstruction payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions)	ructions) applicable to MS-DRGs (se For SCH see instructions ration) adjustment (see i	3)	28, 512 186, 122 120, 979 69, 334 10, 364, 606 0 0 0 0	63. 0 64. 0 65. 0 66. 0 67. 0 68. 0 70. 0 70. 8 70. 8 70. 8
9. 00 0. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 0. 50 0. 50 0. 87 0. 88 0. 89 0. 90 0. 91 0. 92	Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions) Credits received from manufacturers for replaced devices for a Outlier payments reconciliation (sum of lines 93, 95 and 96). OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demonstruction payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions) Bundled Model 1 discount amount (see instructions)	ructions) applicable to MS-DRGs (se For SCH see instructions ration) adjustment (see i	3)	28, 512 186, 122 120, 979 69, 334 10, 364, 606 0 0 0 0	63. 0 64. 0 65. 0 66. 0 67. 0 68. 0 70. 5 70. 8 70. 8 70. 9 70. 9
9. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 0. 50 0. 87 0. 88 0. 89 0. 90 0. 91	Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions) Credits received from manufacturers for replaced devices for a Outlier payments reconciliation (sum of lines 93, 95 and 96). (OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demonstruction payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions)	ructions) applicable to MS-DRGs (se For SCH see instructions ration) adjustment (see i	3)	28, 512 186, 122 120, 979 69, 334 10, 364, 606 0 0 0 0	63. 0 64. 0 65. 0 66. 0 67. 0 68. 0 70. 5 70. 8 70. 8 70. 9 70. 9

Health Financial Systems	FRANCI SCAN HEALTH	H MUNSTER		In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der C		Peri od: From 01/01/2020 To 12/31/2020	Worksheet E Part A Date/Time Pre 7/29/2021 4:4	
		Titl∈	XVIII	Hospi tal	PPS	
			FFY	(уууу)	Amount	
				0	1. 00	
70.96 Low volume adjustment for federal fiscal year	r (yyyy) (Enter in	column 0		0	0	70. 96

					7/29/2021 4:4	0 pm
		Titl∈	XVIII	Hospi tal	PPS	
			FFY	(уууу)	Amount	
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter in	column 0		0	1. 00	70. 96
70. 70	the corresponding federal year for the period prior to 10/1)	COI UIIII O		0	U	70. 90
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					
70. 98	Low Volume Payment-3				0	70. 98
70. 99	HAC adjustment amount (see instructions)				112, 644	
71. 00	Amount due provider (line 67 minus lines 68 plus/minus lines 69	9 & 70)			10, 187, 311	1
71. 01	Sequestration adjustment (see instructions)				67, 236	1
71. 02	Demonstration payment adjustment amount after sequestration				0	1
71. 03	Sequestration adjustment-PARHM pass-throughs					71. 03
72.00	Interim payments				9, 998, 453	1
72. 01	Interim payments-PARHM					72. 01
73. 00	Tentative settlement (for contractor use only)				0	
73. 01 74. 00	Tentative settlement-PARHM (for contractor use only)	72 and			101 (00	73. 01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 73)	72, and			121, 622	74. 00
74. 01	Balance due provider/program-PARHM (see instructions)					74. 01
75. 00	Protested amounts (nonallowable cost report items) in accordance	e with			183, 426	1
75.00	CMS Pub. 15-2, chapter 1, §115.2	oc wi tii			103, 420	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)		1			1
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 instruc	ctions)			0	92. 00
93.00	Capital outlier reconciliation adjustment amount (see instructi	ons)			0	
94.00	The rate used to calculate the time value of money (see instruc	ctions)			0.00	
95. 00	Time value of money for operating expenses (see instructions)				0	
96. 00	Time value of money for capital related expenses (see instructi	ons)			0	96. 00
				Prior to 10/1		
	HSP Bonus Payment Amount			1. 00	2. 00	
100.00	HSP bonus amount (see instructions)			0	0	100.00
100.00	This bolius allount (see thistructions)			U	U	
	HVRP Adjustment for HSP Ropus Payment					
101 00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions)			0.0000000000	0 0000000000	
	HVBP adjustment factor (see instructions)			0.000000000	0. 000000000	101. 00
	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions)	<u> </u>		0.0000000000		
102.00	HVBP adjustment factor (see instructions)			0.0000000000	0	101. 00
102.00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment			0	0. 0000	101. 00 102. 00
102.00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions)		stment	0	0. 0000	101. 00 102. 00 103. 00
102.00 103.00 104.00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration Is this the first year of the current 5-year demonstration peri	ition) Adju		0	0. 0000	101. 00 102. 00 103. 00
102.00 103.00 104.00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration this the first year of the current 5-year demonstration pericentury Cures Act? Enter "Y" for yes or "N" for no.	ition) Adju		0	0. 0000	101. 00 102. 00 103. 00 104. 00
102.00 103.00 104.00 200.00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstra Is this the first year of the current 5-year demonstration peri Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement	ition) Adju od under t		0	0. 0000	101. 00 102. 00 103. 00 104. 00 200. 00
102. 00 103. 00 104. 00 200. 00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration this the first year of the current 5-year demonstration pericentury Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line	ition) Adju od under t		0	0. 0000	101. 00 102. 00 103. 00 104. 00 200. 00
102. 00 103. 00 104. 00 200. 00 201. 00 202. 00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstra Is this the first year of the current 5-year demonstration peri Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions)	ition) Adju od under t		0	0. 0000	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00
102. 00 103. 00 104. 00 200. 00 201. 00 202. 00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration to the first year of the current 5-year demonstration perion Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions)	od under t	he 21st	0.0000	0.0000	101. 00 102. 00 103. 00 104. 00 200. 00
102. 00 103. 00 104. 00 200. 00 201. 00 202. 00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demon	od under t	he 21st	0.0000	0.0000	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00
102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration this the first year of the current 5-year demonstration pericentury Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in fperiod)	od under t	he 21st	0.0000	0.0000	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00
102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstra Is this the first year of the current 5-year demonstration peri Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in f period) Medicare target amount	od under t	he 21st	0.0000	0.0000 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00
102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstra Is this the first year of the current 5-year demonstration peri Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in f period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204)	od under t	he 21st	0.0000	0.0000 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00
102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration perion this the first year of the current 5-year demonstration perion Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in fine) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205)	od under t	he 21st	0.0000	0.0000 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00
102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration perion Cost Reimbursement Is this the first year of the current 5-year demonstration perion Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in fperiod) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement	od under t 49) First year	he 21st	0.0000	0.0000 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00
102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration perion this the first year of the current 5-year demonstration perion Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in fine) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205)	od under t 49) First year	he 21st	0.0000	0.0000 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00
102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration Project Pro	od under t 49) First year	he 21st	0.0000	0.0000 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00
102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration	od under t 49) First year	he 21st	0.0000	0.0000 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00
102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration perion Cost Reimbursement Is this the first year of the current 5-year demonstration perion Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in fine period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions)	od under t 49) First year	he 21st	0.0000	0.0000 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00
102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration to this the first year of the current 5-year demonstration periodentury Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in fperiod) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Reserved for future use	od under t 49) First year	he 21st	0.0000	0.0000 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00
102. 00 103. 00 104. 00 200. 00 201. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 211. 00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration perion Cost Reimbursement Is this the first year of the current 5-year demonstration perion Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in fine period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions)	od under t 49) First year uctions) ine 59)	he 21st	0.0000	0.0000 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00
102. 00 103. 00 104. 00 200. 00 201. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 211. 00 212. 00 213. 00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration	od under t 49) First year actions) ine 59)	of the curren	0.0000	0.0000 0.ration	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00 211. 00 211. 00
102. 00 103. 00 104. 00 200. 00 201. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 211. 00 212. 00 213. 00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration (Project (Project (§410A Demonstration (Project (Proje	od under t 49) First year actions) ine 59)	of the curren	0.0000	0.0000 0.ration	101. 00 102. 00 103. 00 104. 00 200. 00 202. 00 203. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00 211. 00
102. 00 103. 00 104. 00 200. 00 201. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 211. 00 212. 00 213. 00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration	od under t 49) First year actions) ine 59)	of the curren	0.0000	0.0000 0.ration	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00 211. 00 211. 00

Health Financial Systems	FRANCISCAN HEALTH MUNSTER	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0165	Peri od: From 01/01/2020 To 12/31/2020	Worksheet E Part B Date/Time Prepared: 7/29/2021 4:40 pm

		Title XVIII	Hospi tal	7/29/2021 4: 4 PPS	<u> </u>
				1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
1.00	Medical and other services (see instructions)			7, 106	
2. 00 3. 00	Medical and other services reimbursed under OPPS (see instruct OPPS payments	ions)		25, 962, 521 9, 704, 359	2. 00 3. 00
4. 00	Outlier payment (see instructions)			19, 295	
4. 01	Outlier reconciliation amount (see instructions)			0	1
5.00	Enter the hospital specific payment to cost ratio (see instruc	tions)		0. 000	
6.00	Line 2 times line 5			0	
7. 00 8. 00	Sum of lines 3, 4, and 4.01, divided by line 6 Transitional corridor payment (see instructions)			0. 00 0	ı
9. 00	Ancillary service other pass through costs from Wkst. D, Pt. I	V, col. 13, line 200		ő	1
10.00	Organ acquisitions			0	ı
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			7, 106	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges				-
12. 00	Ancillary service charges			22, 254	12. 00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, Ii	ne 69)		0	1
14. 00	Total reasonable charges (sum of lines 12 and 13)			22, 254	14. 00
15. 00	Customary charges Aggregate amount actually collected from patients liable for p	aymont for sorvices on	a chargo basis	0	15. 00
16. 00	Amounts that would have been realized from patients liable for	3	•	0	
.0.00	had such payment been made in accordance with 42 CFR §413.13(e		. a ona gozaoro	, and the second	10.00
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	1
	Total customary charges (see instructions)	v if line 10 evenede liv	20 11) (000	22, 254	
19. 00	Excess of customary charges over reasonable cost (complete onlinstructions)	y II IIIIe 18 exceeds III	ie II) (See	15, 148	19. 00
20.00	Excess of reasonable cost over customary charges (complete onl	y if line 11 exceeds lin	ne 18) (see	0	20. 00
	instructions)				
	Lesser of cost or charges (see instructions) Interns and residents (see instructions)			7, 106 0	21. 00 22. 00
	Cost of physicians' services in a teaching hospital (see instr	ructions)		0	1
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	,		9, 723, 654	1
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25. 00 26. 00	Deductibles and coinsurance amounts (for CAH, see instructions Deductibles and Coinsurance amounts relating to amount on line	•	ictions)	0 1, 791, 974	
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) p			7, 938, 786	
	instructions)] (.,,	
28. 00	Direct graduate medical education payments (from Wkst. E-4, li	ne 50)		0	
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36) Subtotal (sum of lines 27 through 29)			0 7, 938, 786	
31. 00	Primary payer payments			7, 730, 700	ı
32. 00	Subtotal (line 30 minus line 31)			7, 938, 786	32. 00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVIC	ES)			
	Composite rate ESRD (from Wkst. I-5, line 11) Allowable bad debts (see instructions)			0 231, 885	
	Adjusted reimbursable bad debts (see instructions)			150, 725	1
	Allowable bad debts for dual eligible beneficiaries (see instr	ructions)		101, 546	1
	Subtotal (see instructions)			8, 089, 511	1
38.00	MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			541	38. 00 39. 00
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)			39. 50
39. 97	Demonstration payment adjustment amount before sequestration	,		0	1
39. 98	Partial or full credits received from manufacturers for replac	ed devices (see instruc	tions)	0	
39. 99 40. 00	RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions)			0 8, 088, 970	
40. 00	Sequestration adjustment (see instructions)			53, 387	1
40. 02	Demonstration payment adjustment amount after sequestration			0	1
	Sequestration adjustment-PARHM pass-throughs				40. 03
	Interim payments			7, 885, 117	
41. 01 42. 00	Interim payments-PARHM Tentative settlement (for contractors use only)			0	41. 01 42. 00
42. 01	Tentative settlement-PARHM (for contractor use only)				42. 01
43.00	Balance due provider/program (see instructions)			150, 466	
43. 01	Balance due provider/program-PARHM (see instructions)	' II ONO D.I. 45 O			43. 01
44. 00	Protested amounts (nonallowable cost report items) in accordar §115.2	ice with CMS Pub. 15-2, (Liapter I,	0	44. 00
	TO BE COMPLETED BY CONTRACTOR				f
	Original outlier amount (see instructions)			0	
91.00	Outlier reconciliation adjustment amount (see instructions)			0	
92. 00 93. 00	The rate used to calculate the Time Value of Money Time Value of Money (see instructions)			0. 00 0	1
	Total (sum of lines 91 and 93)				94. 00

Health Financial Systems FRAN 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: 15-0165

				10 12/31/2020	7/29/2021 4: 40	
		Title	XVIII	Hospi tal	PPS	
		Inpatien	Inpatient Part A		t 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		9, 998, 45		7, 885, 117	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
0.00	amount based on subsequent revision of the interim rate					0.00
	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				0	0	3. 02
3. 03				0	0	3. 03
3.04				0	0	3. 04
3. 05	Durand days to Discourse			0	0	3. 05
3. 50	Provider to Program ADJUSTMENTS TO PROGRAM			0	0	3. 50
3. 50	ADJUSTWENTS TO PROGRAW			0	0	3. 50
3. 52				0	0	3. 52
3. 53				0	0	3. 53
3. 54				0	o l	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		9, 998, 45	3	7, 885, 117	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
5. 00	TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after					5. 00
5.00	desk review. Also show date of each payment. If none,					5.00
	write "NONE" or enter a zero. (1)					
	Program to Provider			"		
5. 01	TENTATI VE TO PROVI DER			0	0	5. 01
5.02				0	0	5. 02
5.03				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 5. 99				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		121, 62	2	150, 466	6. 01
6. 02	SETTLEMENT TO PROGRAM			0	0	6. 02
7.00	Total Medicare program liability (see instructions)		10, 120, 07	5	8, 035, 583	7. 00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
0.00	Name of Contractor	()	1. 00	2. 00	0.00
8. 00	Name of Contractor			1		8. 00

Heal th	Financial Systems FRANCISCAN HEALT	TH MUNSTER	In Lie	u of Form CMS-	2552-10	
CALCUL					epared:	
		Title XVIII	Hospi tal	PPS		
				1. 00		
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				4	
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				4	
1.00	Total hospital discharges as defined in AARA §4102 from Wkst.	S-3, Pt. I col. 15 line	e 14		1. 00	
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8	-12			2. 00	
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3. 00	
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8	-12			4. 00	
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5. 00	
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 l	ine 20			6. 00	
7. 00	CAH only - The reasonable cost incurred for the purchase of c line 168	ertified HIT technology	Wkst. S-2, Pt. I		7. 00	
8.00	Calculation of the HIT incentive payment (see instructions)				8. 00	
9.00	Sequestration adjustment amount (see instructions)				9. 00	
10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)			10.00	
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH	,			1	
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00	
	Other Adjustment (specify)				31.00	
22 00	31. 00 Utilet Augustiliett (Specify) 31. 00 Delange due provider (Line 0 (on Line 10) minus Line 20 and Line 21) (one instructions)					

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

30. 00 31. 00 32. 00

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

Provi der CCN: 15-0165

Peri od: Worksheet G From 01/01/2020 To 12/31/2020 Date/Ti me Prepared: 7/29/2021 4:40 pm

					7/29/2021 4:4	O pm
		General Fund	Speci fi c	Endowment Fund	Plant Fund	
		1.00	Purpose Fund	2 00	4.00	
	CURRENT ASSETS	1.00	2. 00	3. 00	4. 00	
1. 00	Cash on hand in banks	-23, 674	Ιο	0	0	1.00
2. 00	Temporary investments	12, 684, 024			0	
3. 00	Notes receivable	12,004,024		٦	0	
4. 00	Accounts receivable	16, 586, 464	-		0	
5. 00	Other recei vable	10, 300, 404			0	
6. 00	Allowances for uncollectible notes and accounts receivable	-2, 923, 326	-		0	6. 00
7. 00	Inventory	1, 886, 828			0	
8. 00	Prepai d expenses	1,000,020			0	8.00
9. 00	Other current assets	785, 370			0	
10. 00	Due from other funds	, 00, 070		i o	0	10.00
11. 00	Total current assets (sum of lines 1-10)	28, 995, 686	-	-	0	11.00
11.00	FIXED ASSETS	20, 770, 000		· · · · · · · · · · · · · · · · · · ·		11.00
12. 00	Land	9, 641, 227	0	0	0	12. 00
13. 00	Land improvements	2, 710, 184		1	0	13. 00
14. 00	Accumul ated depreciation	2,710,101		1	0	14. 00
15. 00	Bui I di ngs	79, 480, 471	1		0	15. 00
16. 00	Accumulated depreciation	77,400,471			0	16.00
17. 00	Leasehold improvements	5, 034, 517			0	17. 00
18. 00	Accumulated depreciation	0,034,317			0	18. 00
19. 00	Fi xed equipment				0	19.00
20. 00	Accumulated depreciation		0		0	20.00
21. 00	Automobiles and trucks				0	21.00
22. 00	Accumulated depreciation		0		0	22.00
23. 00	Major movable equipment	115, 983, 300	1		0	23. 00
24. 00	Accumul ated depreciation	-61, 997, 489			0	24.00
25. 00	Mi nor equi pment depreci abl e	-01, 997, 409			0	25. 00
26. 00	Accumulated depreciation				0	26.00
27. 00	HIT designated Assets				0	27. 00
28. 00	Accumulated depreciation	0			0	28.00
29. 00	Mi nor equi pment-nondepreci abl e	14, 937, 878		0	0	29.00
30. 00	1	165, 790, 088		1	0	30.00
30.00	Total fixed assets (sum of lines 12-29) OTHER ASSETS	100, 790, 000	0	u U	U	30.00
31. 00	Investments	8, 588, 000	0	ol	0	31.00
32. 00	Deposits on Leases	3, 803, 554			0	32.00
33. 00	Due from owners/officers	3, 603, 554		-	0	33.00
34. 00	Other assets	E 242 217	· · · · · ·		0	34.00
35. 00	Total other assets (sum of lines 31-34)	5, 262, 317 17, 653, 871		0	0	35.00
36. 00	Total assets (sum of lines 11, 30, and 35)	212, 439, 645		1	0	
30.00	CURRENT LIABILITIES CURRENT LIABILITIES	212, 439, 043		o _l	U	30.00
37. 00	Accounts payable		0	ol	0	37. 00
38. 00	Salaries, wages, and fees payable	0		-	0	
39. 00	Payrol I taxes payable	4 140 420			0	39.00
40. 00		4, 169, 430			0	1
	Notes and Loans payable (short term) Deferred income	10, 818, 428			0	40.00
41. 00		10, 818, 428	•	· O	U	41.00
42.00	Accel erated payments		•		_	42.00
43.00	Due to other funds	5, 395, 502			0	
44. 00	Other current liabilities	401, 680		ا.	0	
45. 00	Total current liabilities (sum of lines 37 thru 44)	22, 346, 110	0	0	0	45. 00
47.00	LONG TERM LIABILITIES	1 (52 402	1 0	J	0	47 00
46. 00	Mortgage payable	1, 653, 493		-	0	46.00
47. 00	Notes payable	-289, 260			0	47. 00
48. 00	Unsecured Loans	398, 172		-	0	
49. 00	Other long term liabilities	7, 841, 231			0	
50.00	Total long term liabilities (sum of lines 46 thru 49)	9, 603, 636		1	0	
51. 00	Total liabilities (sum of lines 45 and 50)	31, 949, 746	0	0	0	51.00
	CAPI TAL ACCOUNTS			1		
52. 00	General fund balance	180, 489, 899				52. 00
53. 00	Specific purpose fund		0			53. 00
54. 00	Donor created - endowment fund balance - restricted			0		54. 00
55. 00	Donor created - endowment fund balance - unrestricted			0		55. 00
56.00	Governing body created - endowment fund balance			0		56. 00
57.00	Plant fund balance - invested in plant				0	1
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
	repl acement, and expansi on					l
59. 00	Total fund balances (sum of lines 52 thru 58)	180, 489, 899		-	0	59. 00
60. 00	Total liabilities and fund balances (sum of lines 51 and	212, 439, 645	0	0	0	60.00
	[59]	I	I	ı l		I

Provider CCN: 15-0165

					То	12/31/2020	Date/Time Prep 7/29/2021 4:40	
		General	Fund	Speci al	Pur	pose Fund	Endowment Fund	5 p
				·				
		1.00		0.00				
1 00	Trund halanan at hankankan as anni ad	1.00	2.00	3. 00		4. 00	5. 00	1 00
1.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29)		55, 636, 385 5, 353, 697			0		1. 00 2. 00
2. 00 3. 00	Total (sum of line 1 and line 2)		60, 990, 082			0		2. 00 3. 00
4. 00	EQUITY TRANSFERS TO/FROM AFFILIATES,	119, 473, 167	00, 990, 002		0	U	0	4. 00
5.00	CONTRIBUTIONS OF PPE	26, 905			0		Ö	5. 00
6.00	CONTRIBUTIONS OF THE	20, 700			0		0	6. 00
7. 00		o			Ō		ol	7. 00
8.00		0			0		0	8. 00
9.00		0			0		0	9. 00
10.00	Total additions (sum of line 4-9)		119, 500, 072			0		10.00
11.00	Subtotal (line 3 plus line 10)		180, 490, 154			0		11.00
12.00	Deductions (debit adjustments) (specify)	0			0		0	12.00
13.00		0			0		0	13.00
14. 00		0			0		0	14. 00
15. 00		0			0		0	15. 00
16.00		0			0		0	16. 00
17. 00	T	O			O		0	17. 00
18.00	Total deductions (sum of lines 12-17)		100 400 154			0		18.00
19. 00	Fund balance at end of period per balance sheet (line 11 minus line 18)		180, 490, 154			U		19. 00
	Taricet, (Title 11 millids 11 ne 10)	Endowment Fund	PI ant	Fund				
		6.00	7. 00	8. 00				
1.00	Fund balances at beginning of period	0			0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)							2. 00
3.00	Total (sum of line 1 and line 2)	0	_		0			3. 00
4.00	EQUITY TRANSFERS TO/FROM AFFILIATES,		0					4.00
5.00	CONTRIBUTIONS OF PPE		0					5. 00
6.00			0					6. 00
7. 00 8. 00			0					7. 00 8. 00
9. 00			0					9. 00
10. 00	Total additions (sum of line 4-9)		O		0			10. 00
11. 00	Subtotal (line 3 plus line 10)				0			11. 00
12. 00	Deductions (debit adjustments) (specify)		0					12. 00
13. 00	beddetrons (debrt day detiments) (specify)		0					13. 00
14. 00			0					14. 00
15. 00			0					15. 00
16.00			o					16.00
17. 00			o					17.00
18. 00	Total deductions (sum of lines 12-17)	0			0		ļ	18.00
19. 00	Fund balance at end of period per balance	0			0			19. 00
	sheet (line 11 minus line 18)	1		1			l	

Health Financial Systems FATTEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-0165

		T	o 12/31/2020	Date/Time Pre 7/29/2021 4:4	
	Cost Center Description	Inpati ent	Outpati ent	Total	O PIII
	p	1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES	•			
	General Inpatient Routine Services				
1.00	Hospi tal	26, 433, 094		26, 433, 094	1. 00
2.00	SUBPROVI DER - I PF	0		0	2. 00
3.00	SUBPROVI DER - I RF	0		0	3. 00
4.00	SUBPROVI DER				4. 00
5.00	Swing bed - SNF	0		0	5. 00
6.00	Swing bed - NF	0		0	6. 00
7.00	SKILLED NURSING FACILITY	0		0	7. 00
8.00	NURSING FACILITY	0		0	8. 00
9.00	OTHER LONG TERM CARE	0		0	9. 00
10.00	Total general inpatient care services (sum of lines 1-9)	26, 433, 094		26, 433, 094	10. 00
	Intensive Care Type Inpatient Hospital Services				
11. 00	INTENSIVE CARE UNIT	0		0	11. 00
12.00	CORONARY CARE UNIT	0		0	12. 00
13.00	BURN INTENSIVE CARE UNIT	0		0	13. 00
14.00	SURGI CAL INTENSI VE CARE UNI T	0		0	14. 00
15.00	OTHER SPECIAL CARE (SPECIFY)				15. 00
16. 00	Total intensive care type inpatient hospital services (sum of lines	0		0	16. 00
	11-15)				
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	26, 433, 094		26, 433, 094	17. 00
18. 00	Ancillary services	101, 059, 526	276, 368, 305	377, 427, 831	18. 00
19. 00	Outpati ent servi ces	0	o	0	19. 00
20.00	RURAL HEALTH CLINIC	0	o	0	20. 00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER	0	o	0	21. 00
22. 00	HOME HEALTH AGENCY		o	0	22. 00
23. 00	AMBULANCE SERVICES	0	o	0	23. 00
24.00	СМНС		o	0	24. 00
24. 10	CORF	0	o	0	24. 10
25. 00	AMBULATORY SURGICAL CENTER (D. P.)	0	o	0	25. 00
26.00	HOSPI CE	0	0	0	26. 00
27. 00	OTHER (SPECIFY)	0	0	0	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.	127, 492, 620	276, 368, 305	403, 860, 925	28. 00
	G-3, line 1)				
	PART II - OPERATING EXPENSES				
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		103, 738, 101		29. 00
30. 00	ADD (SPECIFY)	0			30. 00
31. 00		0			31. 00
32. 00		0			32. 00
33. 00		0			33. 00
34.00		0			34. 00
35. 00		0			35. 00
36. 00	Total additions (sum of lines 30-35)		0		36. 00
37. 00	OTHER	255			37. 00
38. 00		0			38. 00
39. 00		0			39. 00
40. 00		0			40. 00
41. 00		0			41. 00
42.00	Total deductions (sum of lines 37-41)		255		42. 00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer	-	103, 737, 846		43. 00
	to Wkst. G-3, line 4)				

		RANCISCAN HEALTH MUNSTER		u of Form CMS-2	
STATEMENT OF REVENUES AND EXPENSES		Provi der CCN: 15-0165	Peri od:	Worksheet G-3	
			From 01/01/2020 To 12/31/2020	Date/Time Pre	nared·
			10 12/01/2020	7/29/2021 4:40	
	_			1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I,			403, 860, 925	
2.00	Less contractual allowances and discounts on patients' accounts		299, 741, 235		
3.00	Net patient revenues (line 1 minus line 2)		104, 119, 690		
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)		103, 737, 846		
5.00	Net income from service to patients (line 3 min	nus line 4)		381, 844	5. 00
	OTHER I NCOME				
6.00	Contributions, donations, bequests, etc			1, 128, 072	6. 00
7.00	Income from investments			20, 602	7. 00
8.00	Revenues from telephone and other miscellaneous	s communication services		6, 734	8. 00
9.00	Revenue from television and radio service			0	9. 00
10.00	Purchase di scounts			0	10.00
11.00	Rebates and refunds of expenses			0	11. 00
12.00	Parking Lot receipts			0	12. 00
13.00	Revenue from Laundry and Linen service			0	13. 00
14.00	Revenue from meals sold to employees and guests	5		0	14. 00
15.00	Revenue from rental of living quarters			0	15. 00
16.00	Revenue from sale of medical and surgical suppl	lies to other than patients		0	16. 00
17.00	Revenue from sale of drugs to other than patien	nts		0	17. 00
18.00	Revenue from sale of medical records and abstra	acts		0	18. 00
19.00	Tuition (fees, sale of textbooks, uniforms, etc	c.)		0	19. 00
20.00	Revenue from gifts, flowers, coffee shops, and	canteen		0	20. 00
21.00	Rental of vending machines			0	21. 00
22.00	Rental of hospital space			0	22. 00
23. 00	Governmental appropriations			134, 000	23. 00
24.00	CAPITATION AND PREMIUM REVENUE			1, 724, 300	24. 00
	COVI D-19 PHE Fundi ng			1, 958, 145	
	Total other income (sum of lines 6-24)			4, 971, 853	
	Total (line 5 plus line 25)			5, 353, 697	1
	NON OPERATING			0	1

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

0 27. 00 0 28. 00 5, 353, 697 29. 00

CALCULATION OF CAPITAL PAYMENT Provider CCN: 15-0165 Period:				u of Form CMS-2 Worksheet L	
From 01/01/2020					
			To 12/31/2020	Date/Time Prep 7/29/2021 4:40	
		Title XVIII	Hospi tal	PPS	о рііі
		THE XVIII	1103pt tui	113	
				1. 00	
	PART I - FULLY PROSPECTIVE METHOD				
	CAPITAL FEDERAL AMOUNT				1
1.00	Capital DRG other than outlier			773, 459	1.00
1.01	Model 4 BPCI Capital DRG other than outlier			0	1. 01
2.00	Capital DRG outlier payments			20, 628	2. 00
2.01	Model 4 BPCI Capital DRG outlier payments			0	2. 01
3.00	Total inpatient days divided by number of days in the cost repo	orting period (see inst	ructions)	33. 59	3. 00
4.00	Number of interns & residents (see instructions)			0.00	
5.00	Indirect medical education percentage (see instructions)			0.00	
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and			0	6. 00
	1.01) (see instructions)				
7. 00	Percentage of SSI recipient patient days to Medicare Part A pat	ient days (Worksheet E	, part A line	0. 00	7. 00
0.00	30) (see instructions)			0.00	0.00
8.00				0.00	
9.00	Sum of lines 7 and 8			0.00	
10. 00 11. 00				0. 00 0	
12. 00				794, 087	
12.00	Total prospective capital payments (see instructions)			794,007	12.00
				1. 00	
	PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)			0	1. 00
2.00	Program inpatient ancillary capital cost (see instructions)			0	2. 00
3.00	Total inpatient program capital cost (line 1 plus line 2)			0	3. 00
4.00	Capital cost payment factor (see instructions)			0	
5.00	Total inpatient program capital cost (line 3 x line 4)			0	5. 00
				1. 00	
				1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS				1
1. 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions)			0	1.00
1.00	Program inpatient capital costs (see instructions)	s (see instructions)		0	1.00
1. 00 2. 00 3. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstances	s (see instructions)		_	2. 00
2. 00 3. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstances Net program inpatient capital costs (line 1 minus line 2)	s (see instructions)		0	2. 00 3. 00
2.00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstances Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions)	s (see instructions)		0	2. 00 3. 00
2. 00 3. 00 4. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstances Net program inpatient capital costs (line 1 minus line 2)	,		0 0 0. 00	2. 00 3. 00 4. 00 5. 00
2. 00 3. 00 4. 00 5. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstances Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4)	ructions)	:line 6)	0 0 0. 00 0	2. 00 3. 00 4. 00 5. 00 6. 00
2. 00 3. 00 4. 00 5. 00 6. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstances Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see inst	ructions)	:line 6)	0 0 0. 00 0 0. 00	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstances Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see inst Adjustment to capital minimum payment level for extraordinary comparisons.	cructions) circumstances (line 2 x	:line 6)	0 0 0.00 0 0.00	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstances Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see inst Adjustment to capital minimum payment level for extraordinary c Capital minimum payment level (line 5 plus line 7)	cructions) Sircumstances (line 2 x	ŕ	0.00 0.00 0.00 0.00 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstances Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see inst Adjustment to capital minimum payment level for extraordinary c Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as applica Current year comparison of capital minimum payment level to cap Carryover of accumulated capital minimum payment level over cap	cructions) circumstances (line 2 x able) oital payments (line 8	less line 9)	0.00 0.00 0.00 0.00 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstances Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see inst Adjustment to capital minimum payment level for extraordinary c Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as applica Current year comparison of capital minimum payment level to cap Carryover of accumulated capital minimum payment level over cap Worksheet L, Part III, line 14)	cructions) circumstances (line 2 x able) pital payments (line 8 pital payment (from pri	less line 9) or year	0.00 0.00 0.00 0.00 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstances Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see inst Adjustment to capital minimum payment level for extraordinary c Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as applica Current year comparison of capital minimum payment level to cap Carryover of accumulated capital minimum payment level over cap Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital payment	cructions) circumstances (line 2 x able) pital payments (line 8 pital payment (from pri	less line 9) or year ne 11)	0.00 0.00 0.00 0.00 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstances Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see inst Adjustment to capital minimum payment level for extraordinary c Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as applica Current year comparison of capital minimum payment level to cap Carryover of accumulated capital minimum payment level over cap Worksheet L, Part III, line 14)	cructions) circumstances (line 2 x able) bital payments (line 8 bital payment (from pri ments (line 10 plus lir che amount on this line	less line 9) or year ne 11)	0.00 0.00 0.00 0.00 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00

15.00 0 16.00 0 17.00

(if line 12 is negative, enter the amount on this line)

15.00 Current year allowable operating and capital payment (see instructions)
16.00 Current year operating and capital costs (see instructions)
17.00 Current year exception offset amount (see instructions)