This report is	s required by law (42 USC 1395g; 42 CFR 413.20(b)). Fai	ilure to report can re	sult in all interim	FORM APPROVED
payments made	since the beginning of the cost reporting period being	g deemed overpayments	(42 USC 1395g).	OMB NO. 0938-0050
				EXPIRES 03-31-2022
HOSPITAL AND H	HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION F SUMMARY	Provi der CCN: 15-0162	Peri od: From 01/01/2020 To 12/31/2020	
PART I - COST	REPORT STATUS			
Provi der	1. [X] Electronically prepared cost report		Date: 3/30/20	21 Time: 10:40 am
use only	2. [] Manually prepared cost report			
-	3.[0] If this is an amended report enter the number 4.[F] Medicare Utilization. Enter "F" for full or "	of times the provider L" for low.	resubmitted this o	cost report
Contractor use only	5. [1]Cost Report Status 6. Date Received: (1) As Submitted 7. Contractor No. (2) Settled without Audit 8. [N] Initial Report for (3) Settled with Audit 9. [N] Final Report for (4) Reopened (5) Amended	1° or this Provider CCN 12	O.NPR Date: 1.Contractor's Vendo 2.[0]If line 5, co number of tim	or Code: 4 Dumn 1 is 4: Enter nes reopened = 0-9.
DADT II CEDT	TI TI CATI ON			

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 ST. FRANCIŚ HOSPITAL & HEALTH CENTER (15-0162) for the cost reporting period beginning 01/01/2020 and ending 12/31/2020 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Si gned)	
	Officer or Administrator of Provider(s)
T: +1 -	
Title	
Date	

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HI T	Title XIX	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	1, 457, 024	-133, 676	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	70, 850	-28		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
200.00	Total	0	1, 527, 874	-133, 704	0	0	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0162 Peri od: Worksheet S-2 From 01/01/2020 Part I Date/Time Prepared: 12/31/2020 3/30/2021 10:40 am 3.00 4.00 Hospital and Hospital Health Care Complex Address: 1.00 Street: 8111 S. EMERSON AVENUE PO Box: 1.00 State: IN 2.00 City: INDIANAPOLIS Zip Code: 46237 County: MARION 2.00 Component Name Payment System (P, CCN CBSA Provi der Date T, 0, or N) Certi fi ed Number Number Type XVIII XIX 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 ST. FRANCIS HOSPITAL & 150162 26900 05/01/2006 Ν 3.00 1 HEALTH CENTER Subprovi der - IPF 4.00 4.00 5.00 Subprovi der - IRF REHAB UNIT 15T162 26900 01/01/2005 Р Р Ν 5.00 6.00 Subprovider - (Other) 6.00 Swing Beds - SNF 7 00 7 00 Swing Beds - NF 8.00 8.00 9.00 Hospital-Based SNF 9.00 Hospi tal -Based NF 10.00 10.00 11.00 Hospi tal -Based OLTC 11.00 12.00 Hospital -Based HHA 12.00 Separately Certified ASC 13.00 13.00 Hospi tal -Based Hospi ce HOSPI CE 14.00 151523 26900 01/01/2014 14.00 Hospital-Based Health Clinic - RHC 15.00 15 00 16.00 Hospital -Based Health Clinic - FQHC 16.00 17.00 Hospital -Based (CMHC) I 17.00 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From 1.00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2020 12/31/2020 20.00 21.00 Type of Control (see instructions) 21.00 1.00 2.00 3.00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for Υ N 22.00 disproportionate share hospital adjustment, in accordance with 42 CFR \$412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim uncompensated care payments for this 22.01 cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 22.02 Is this a newly merged hospital that requires final uncompensated care Ν 22.02 payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after 22.03 Did this hospital receive a geographic reclassification from urban to 22.03 Ν Ν rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for ves or "N" for no. 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 3 Ν 23.00 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? 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 el i gi bl e Medi cai d Medi cai d days unpai d el i gi bl e paid days 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 398 24.00 19, 159 837 226 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.

Health Financial Systems ST. FRAN	ICIS HOSPITAL &	HEALTH CEN	TER		In Lie	u of For	m CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATI	ON DATA	Provi der CO	CN: 15-0162	Period: From 01/0	11/2020	Workshe Part I	et S-2	
	In-State	In-State	Out-of	Out-of	Medi ca		ther	40 am
	Medi cai d	Medi cai d	State	State	HMO da	<i>-</i>	li cai d	
	paid days	el i gi bl e unpai d	Medicaid paid days	Medicaid eligible		C	lays	
		days	para days	unpai d				
05 00 16 111	1.00	2.00	3.00	4. 00	5. 00		. 00	05.00
25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state	1		0	0		707		25. 00
Medicaid eligible unpaid days in column 2,								
out-of-state Medicaid days in column 3, out-of-s Medicaid eligible unpaid days in column 4, Medic								
HMO paid and eligible but unpaid days in column								
				Urban/F		Date of 2.0		
26.00 Enter your standard geographic classification (r	not wage) statu	s at the be	eginning of		1	2. ()()	26. 00
cost reporting period. Enter "1" for urban or "2	2" for rural.		1 . 6 . 1			44.40	(0000	07.00
27.00 Enter your standard geographic classification (reporting period. Enter in column 1, "1" for urb	not wage) statu oan or "2" for	s at the en rural. If a	nd of the co applicable.	ST	2	11/13	/2020	27. 00
enter the effective date of the geographic recla	assification in	column 2.						
35.00 If this is a sole community hospital (SCH), entereffect in the cost reporting period.	er the number o	f periods S	SCH status i	n	0			35.00
orrest in the cost reporting period.				Begi n		Endi		
36.00 Enter applicable beginning and ending dates of \$	CCU status Sub	ecript line	26 for num	1.	00	2. (00	36.00
of periods in excess of one and enter subsequent		script rine	: 30 TOT TIUIII	bei				30.00
37.00 If this is a Medicare dependent hospital (MDH),	enter the numb	er of perio	ods MDH stat	us	0			37. 00
is in effect in the cost reporting period. 37.01 Is this hospital a former MDH that is eligible 1	for the MDH tra	nsitional p	pavment in					37. 01
accordance with FY 2016 OPPS final rule? Enter '								
instructions) 38.00 If line 37 is 1, enter the beginning and ending	dates of MDH s	tatus If I	ine 37 is					38. 00
greater than 1, subscript this line for the number								00.00
enter subsequent dates.				Υ/	/NI	Y/	NI	
				1.		2.0		
39.00 Does this facility qualify for the inpatient has					I	N		39. 00
hospitals in accordance with 42 CFR §412.101(b)(1 "Y" for yes or "N" for no. Does the facility				mn				
accordance with 42 CFR 412.101(b)(2)(i), (ii),	or (iii)? Enter	in column	2 "Y" for y	es				
or "N" for no. (see instructions) 40.00 Is this hospital subject to the HAC program redu	iction adjustme	nt? Enter "	Y" for ves	or \	,	Y		40. 00
"N" for no in column 1, for discharges prior to	October 1. Ent	er "Y" for						10.00
no in column 2, for discharges on or after Octob	oer 1. (see ins	tructions)			V	XVIII	XIX	
					1.00		3. 00	
Prospective Payment System (PPS)-Capital					- I N		N.	45.00
45.00 Does this facility qualify and receive Capital pwith 42 CFR Section §412.320? (see instructions)		proportiona	ite snare in	accordance	N	Y	N	45. 00
46.00 Is this facility eligible for additional payment	t exception for				N	N	N	46. 00
pursuant to 42 CFR §412.348(f)? If yes, complete Pt. III.	e WKSt. L, Pt.	III and Wks	st. L-1, Pt.	I through				
47.00 Is this a new hospital under 42 CFR §412.300(b)					N	N	N	47. 00
48.00 Is the facility electing full federal capital particles. Teaching Hospitals	ayment? Enter	"Y" for yes	or "N" for	no.	N	N	N	48. 00
56.00 Is this a hospital involved in training resident						N		56.00
"N" for no in column 1. If column 1 is "Y", are GME payment reduction? Enter "Y" for yes or "N'			(or subsequ	ent CR), M	4			
57.00 If line 56 is yes, is this the first cost report			esidents in	approved	N			57.00
GME programs trained at this facility? Enter "\ is "Y" did residents start training in the first	,							
for yes or "N" for no in column 2. If column 2								
"N", complete Wkst. D, Parts III & IV and D-2, F			!!-					F0 00
58.00 If line 56 is yes, did this facility elect cost defined in CMS Pub. 15-1, chapter 21, §2148? If			ans servic	es as	N			58. 00
59.00 Are costs claimed on line 100 of Worksheet A? I			1		N_			59. 00
			NAHE 413.8 Y/N	35 Worksh Lin		Pass-Th Qual i fi		
						Cri te	ri on	
			1.00	2	00	3. (
60.00 Are you claiming nursing and allied health educa	ation (NAHE) co	sts for	Y	Z.		3. (,,,	60.00
any programs that meet the criteria under 42 CFF	•							
<pre>instructions) Enter "Y" for yes or "N" for no i is "Y", are you impacted by CR 11642 (or subsequence</pre>								
adjustement? Enter "Y" for yes or "N" for no ir	n column 2.	. •			22.00	_		40.01
60.01 If line 60 is yes, complete columns 2 and 3 for instructions)	eacn program.	(see			23. 00	1		60. 01
•			•	•			'	

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

Health Financial Systems ST. FRANCIS HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		L & HEALTH CEN Provider C	CN: 15-0162 Pe	eriod: rom 01/01/2020	worksheet S-2 Part I Date/Time Pre 3/30/2021 10:	pared:
		'	NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	TO dill
(0.00 0.11 0.12 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.14 0.			1. 00	2. 00	3. 00	(0.00
60.02 If line 60 is yes, complete columns 2 and 3 for each instructions)	progra	ım. (see		23. 01	1	60. 02
60.03 If line 60 is yes, complete columns 2 and 3 for each instructions)	progra	ım. (see		23. 02	1	60. 03
60.04 If line 60 is yes, complete columns 2 and 3 for each instructions)				23. 03		60. 04
	Y/N	I ME	Direct GME	I ME	Direct GME	
(1 00 Did your boosital gooding FTF alata your ACA	1.00	2. 00	3. 00	4. 00	5. 00	(1.00
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)	Y			0. 81	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. 05
61.04 minus line 61.03). (see instructions) 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
	Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
(1 10 06 the FTFe in Line (1 0F energial for each entry		1. 00	2.00	3. 00	4. 00	(1.10
61.10 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.				0.00	0.00	61. 10
61.20 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. 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.				0.00	0. 00	61. 20
					1. 00	
ACA Provisions Affecting the Health Resources and Se 62.00 Enter the number of FTE residents that your hospital				iod for which		62. 00
your hospital received HRSA PCRE funding (see instructions) 62.01 Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC process.	a Teach	ing Health Cer		your hospital	0.00	62. 01
Teaching Hospitals that Claim Residents in Nonprovide	er Sett	tings			Υ	
63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)						63. 00

Health Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE	ST. FRANCIS		R HEALTH CEN		In Lie	u of Form CMS-2 Worksheet S-2	
NOSPITAL AND NOSPITAL NEALTH CARE	COMPLEX IDENTIFICATION L	JATA	Provider Co		om 01/01/2020	Part I	pared:
			'	Unwei ghted	Unwei ghted	Ratio (col.	
				FTEs Nonprovi der	FTEs in Hospital	1/ (col. 1 + col. 2))	
				Si te	oop. ca.	0011 277	
Section 5504 of the ACA Base	V FTF D!!	N =: -! -! -	- C-++!	1.00	2.00	3.00	
period that begins on or aft				inis base year	is your cost	reporting	
64.00 Enter in column 1, if line 6 in the base year period, the resident FTEs attributable t settings. Enter in column 2 resident FTEs that trained i of (column 1 divided by (col	3 is yes, or your facil number of unweighted no o rotations occurring in the number of unweight n your hospital. Enter umn 1 + column 2)). (see	ity traine on-primary n all nonp ed non-pri in column	d residents care rovider mary care 3 the ratio	0.00	0.00	0. 000000	64.00
	Program Name		ram Code	Unwei ghted	Unwei ghted	Ratio (col.	
				FTEs Nonprovi der Si te	FTEs in Hospital	3/ (col. 3 + col. 4))	
	1. 00		2. 00	3. 00	4. 00	5. 00	
65.00 Enter in column 1, if line is yes, or your facility trained residents in the bas year period, the program nan 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 column 4, the number of unweighted primary care resident FTEs that trained i your hospital. Enter in colu 5, the ratio of (column 3 divided by (column 3 + colum 4)). (see instructions)	e e in n mn	1350		9.00	13. 91 Unwei ghted	0. 392842	65. 00
				FTEs	FTEs in	1/ (col. 1 +	
				Nonprovi der	Hospi tal	col. 2))	
				Si te 1.00	2. 00	3. 00	
Section 5504 of the ACA Curr		in Nonprov	ider Setting				
66.00 Enter in column 1 the number FTEs attributable to rotatic Enter in column 2 the number FTEs that trained in your ho (column 1 divided by (column	of unweighted non-prim ns occurring in all non of unweighted non-prim spital. Enter in column 1 + column 2)). (see i	orovider so ary care ro 3 the rat astruction	ettings. esident io of s)	0.00			66.00
	Program Name	Progr	ram Code	Unwei ghted FTEs	Unweighted FTEs in	Ratio (col. 3 +	
				Nonprovider Site	Hospi tal	col. 4))	
(7.00 Enter in orland 1. the	1. 00		2. 00	3.00	4. 00	5. 00	47.00
67.00 Enter in column 1, the programme associated with each of your primary care programs i which you trained residents. Enter in column 2, the prograde. Enter in column 3, the number of unweighted primary care FTE residents attribute to rotations occurring in al	gENERAL am blee	1350		13. 45	10. 56	0. 560183	67.00

to rotations occurring in all non-provider settings. Enter in

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)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 15-0162 Peri od: Worksheet S-2 From 01/01/2020 Part I Date/Time Prepared: 12/31/2020 3/30/2021 10:40 am 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS 70.00 70.00 | Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no. If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most 71.00 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 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF 75 00 75 00 subprovider? Enter "Y" for yes and "N" for no. If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most Ν Ν 0 76.00 recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) 1.00 Long Term Care Hospital PPS Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. 80.00 N 80.00 Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter Ν 81.00 Y" for yes and "N" for no. TEFRA Providers 85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no. 85.00 86.00 Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section 86.00 $\S413.40(f)(1)(ii)$? Enter "Y" for yes and "N" for no. Is this hospital an extended neoplastic disease care hospital classified under section Ν 87.00 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no. V XIX 1. 00 2.00 Title V and XIX Services 90.00 Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for 90 00 Ν yes or "N" for no in the applicable column. 91.00 is this hospital reimbursed for title V and/or XIX through the cost report either in Ν Υ 91.00 full or in part? Enter "Y" for yes or "N" for no in the applicable column. 92.00 Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column. Ν 92.00 Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column. 93.00 Ν N 93.00 94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the 94.00 Ν Ν applicable column. 95.00 If line 94 is "Y", enter the reduction percentage in the applicable column. 0.00 0.00 95.00 96.00 | Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the Ν N 96.00 applicable column. 97.00 | If line 96 is "Y", enter the reduction percentage in the applicable column. 0.00 0.00 97.00 Does title V or XIX follow Medicare (title XVIII) for the interns and residents post Ν 98.00 stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 98.01 Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. 98.01 Ν C,Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V,and in column 2 for title XIX. 98.02 Does title V or XIX follow Medicare (title XVIII) for the calculation of observation 98.02 N bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 98.03 Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) 98.03 Ν reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and 98.04 Ν N 98.04 in column 2 for title XIX. 98.05 Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on 98.05 Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 98.06 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Ν Υ 98.06 Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Rural Providers 105.00 Does this hospital qualify as a CAH? 105 00 Ν 106.00 If this facility qualifies as a CAH, has it elected the all-inclusive method of payment 106.00 Ν for outpatient services? (see instructions) 107.00 Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) N 107.00 Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)

ealth Financial Systems ST. FRANCIS HOSPITAL OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		CN: 15-0162	Peri od:	w of Form CMS Worksheet S-	
			From 01/01/2020 To 12/31/2020		
			V	XIX). 40 aii
08.00 s this a rural hospital qualifying for an exception to the	CRNA fee sch	edul e? See 42	1. 00 N	2. 00	108.0
CFR Section §412.113(c). Enter "Y" for yes or "N" for no.					
-	Physi cal 1.00	Occupati onal 2.00	Speech 3. 00	Respiratory 4.00	'
09.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N N	N N	109.0
10.00 01.1.11.1.1.1.1.1.1.1.1.1.1.1.1.1.			4404	1.00	110.0
10.00 Did this hospital participate in the Rural Community Hospita Demonstration) for the current cost reporting period? Enter " complete Worksheet E, Part A, lines 200 through 218, and Worapplicable.	Y" for yes o	r "N" for no.	If yes,	N	110. (
			1.00	2.00	+
11.00 If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this community for yes or "N" for no in column 1. If the response to complete integration prong of the FCHIP demo in which this CAH is particle all that apply: "A" for Ambulance services; "B" for additional for tele-health services.	ost reporting Dlumn 1 is Y, rticipating in	period? Enter enter the n column 2.	N		111. (
		1.00	2.00	3.00	+
12.00 Did this hospital participate in the Pennsylvania Rural Heal demonstration for any portion of the current cost reporting Enter "Y" for yes or "N" for no in column 1. If column 1 is in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital cear participation in the demonstration, if applicable.	peri od? 5 "Y", enter ne	N			112. (
Miscellaneous Cost Reporting Information 15.00 s this an all-inclusive rate provider? Enter "Y" for yes or	"N" for no	l N			0115.
in column 1. If column 1 is yes, enter the method used (A, B in column 2. If column 2 is "E", enter in column 3 either "9 for short term hospital or "98" percent for long term care (psychiatric, rehabilitation and long term hospitals provider the definition in CMS Pub.15-1, chapter 22, §2208.1. 16.00 Is this facility classified as a referral center? Enter "Y" "N" for no. 17.00 Is this facility legally-required to carry malpractice insurance "Y" for yes or "N" for no. 18.00 Is the malpractice insurance a claims-made or occurrence pol	23" percent includes is) based on for yes or rance? Enter icy? Enter 1	Y N	2		116. (117. (118. (
if the policy is claim-made. Enter 2 if the policy is occurre	ence.	Premi ums	Losses	Insurance	
18.01 List amounts of malpractice premiums and paid losses:		1. 00 1, 450, 77	2. 00 644, 203	3. 00 3 961, 18	31 118.
18.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sched and amounts Total Laboratory and Administrative Laboratory and Administrative Laboratory and A			1. 00 N	2.00	118.
19.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA \$3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions)				N	119. 120.
Enter in column 2, "Y" for yes or "N" for no. 21.00 Did this facility incur and report costs for high cost impla	ıntable devic	es charged to	Y		121.
patients? Enter "Y" for yes or "N" for no. 22.00 Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.				5. 03	122.
Transplant Center Information 25.00 Does this facility operate a transplant center? Enter "Y" fo	or ves and "N	'for no If	N		125.
yes, enter certification date(s) (mm/dd/yyyy) below.	iter the certi	fication date			126.
26.00 If this is a Medicare certified kidney transplant center, en				i	1227
26.00 f this is a Medicare certified kidney transplant center, en in column 1 and termination date, if applicable, in column 2 27.00 f this is a Medicare certified heart transplant center, ent	er the certi	fication date			127.
26.00 If this is a Medicare certified kidney transplant center, en	!. er the certi [.] !.				127. 128.
26.00 If this is a Medicare certified kidney transplant center, en in column 1 and termination date, if applicable, in column 2 27.00 If this is a Medicare certified heart transplant center, entin column 1 and termination date, if applicable, in column 2	er the certical er the certical er the certical	fication date	n		

Health Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	ST. FRANCIS HOSPI X IDENTIFICATION DATA	TAL & HEALTH CENT	N: 15-0162 F	In Lie Period: From 01/01/2020 To 12/31/2020	Date/Time Pr	epared:
					3/30/2021 10	0: 40 am
130.00 If this is a Medicare certified podate in column 1 and termination of this is a Medicare certified in date in column 1 and termination of the second of this is a Medicare certified in column 1 and termination date,	date, if applicable, in ntestinal transplant cer date, if applicable, in slet transplant center,	column 2. nter, enter the co column 2. enter the certifi	erti fi cati on	1.00	2.00	130. 00 131. 00 132. 00
133.00 Removed and reserved 134.00 If this is an organ procurement o and termination date, if applicab All Providers		r the OPO number i	in column 1			133. 00 134. 00
140.00 Are there any related organization chapter 10? Enter "Y" for yes or are claimed, enter in column 2 the	'N" for no in column 1. e home office chain numb	If yes, and home	office costs	3. 00	158014	140.00
If this facility is part of a cha	in organization, enter (on lines 141 thro	ugh 143 the n		s of the home	
office and enter the home office 141.00 Name: SISTERS OF ST. FRANCIS HEA SERVIC			I ANS Contracto	r's Number: 0810	<u> </u>	141. 00
142.00 Street: 1515 W DRAGOON TRL	PO Box:	1290	7: - 0	475	4.4	142.00
143. 00 Ci ty: MI SHAWAKA	State:	IN	Zi p Code:	4654	14	143. 00
144.00 Are provider based physicians' co	sts included in Workshee	et A?			1. 00 Y	144. 00
				1.00	2. 00	
145.00 If costs for renal services are c inpatient services only? Enter "Y no, does the dialysis facility in period? Enter "Y" for yes or "N" 146.00 Has the cost allocation methodologenter "Y" for yes or "N" for no in the cost of the	'for yes or "N" for no clude Medicare utilizati for no in column 2. gy changed from the prev n column 1. (See CMS Pub	in column 1. If o ion for this cost viously filed cos	column 1 is reporting t report?	N		145. 00
yes, enter the approval date (mm/	udzyyyy) i ii corulliii 2.					
147.00 Was there a change in the statist	cal hasis? Enter "Y" fo	or ves or "N" for	no		1.00 N	147. 00
148.00 Was there a change in the order o	f allocation? Enter "Y"	for yes or "N" for	or no.		N	148. 00
149.00 Was there a change to the simplif	ed cost finding method	? Enter "Y" for ye	es or "N" for Part B	no.	N Title XIX	149. 00
Does this facility contain a prov	iden that qualifies for	1.00	2.00	3.00	4.00	
or charges? Enter "Y" for yes or					13. 13)	
155.00 Hospi tal 156.00 Subprovi der - TPF		N N	N N	N N	N N	155. 00 156. 00
157. 00 Subprovi der – IRF		N	N	N	N	157. 00
158. 00 SUBPR0VI DER 159. 00 SNF		N	N	N	N	158. 00 159. 00
160.00 HOME HEALTH AGENCY		N	N	N	N	160.00
161. 00 CMHC			N	l N	N	161. 00
					1. 00	
Multicampus 165.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	ampus hospital that has	one or more campu	uses in diffe	rent CBSAs?	N	165. 00
Effect 1 for yes of N for He.	Name	County		Code CBSA	FTE/Campus	
166.00 f line 165 is yes, for each	0	1. 00	2.00 3	. 00 4. 00	5.00	00166.00
campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)					0.0	100.00
					1.00	
Health Information Technology (HI 167.00 s this provider a meaningful use	T) incentive in the Amer	rican Recovery and	d Reinvestmen	t Act	Υ	167. 00
168.00 If this provider is a CAH (line 1	O5 is "Y") and is a mear	ningful user (line		, enter the	ī	168. 00
reasonable cost incurred for the			r qualify for	a hardshin		168. 01
exception under §413.70(a)(6)(ii)	? Enter "Y" for yes or '	"N" for no. (see i	instructions)	·		
169.00 f this provider is a meaningful transition factor. (see instruction		and is not a CAH ((iine 105 is '	"N"), enter the	9.5	99169. 00

Health Financial Systems	In Lie	u of Form CMS-	2552-10		
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	Peri od:	Worksheet S-2)		
			From 01/01/2020		
			To 12/31/2020	Date/Time Pre	
				3/30/2021 10:	40 am
			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				C	171.00
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	on		
1876 Medicare days in column 2. (see	instructions)				

	Financial Systems ST. FRANCIS HOSPITAL & HEALT AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provide		: 15-0162	Peri od: From 01/01/2020	worksheet S-2	2
				To 12/31/2020	Date/Time Pre 3/30/2021 10:	
				Y/N	Date	
				1.00	2. 00	
	General Instruction: Enter Y for all YES responses. Enter N for all mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	NO res	ponses. En	ter all dates in	the	4
	Provider Organization and Operation					
. 00	Has the provider changed ownership immediately prior to the beginning			N		1.0
	reporting period? If yes, enter the date of the change in column 2.	(see i				
		_	1. 00	Date	V/I	+
2. 00	Has the provider terminated participation in the Medicare Program? I	l f	1.00 N	2. 00	3. 00	2.0
. 00	yes, enter in column 2 the date of termination and in column 3, "V" voluntary or "I" for involuntary. Is the provider involved in business transactions, including manager contracts, with individuals or entities (e.g., chain home offices, or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the box of directors through ownership, control, or family and other similar relationships? (see instructions)	for ment drug s ard	Y			3.0
	Terationsinps: (see That detroits)		Y/N	Type	Date	
			1.00	2.00	3. 00	
	Financial Data and Reports					
. 00	Column 1: Were the financial statements prepared by a Certified Pub Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compil or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	l ed, n	Υ	A		4.0
. 00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliati		N	V (1)		5. (
				Y/N 1. 00	Legal Oper. 2.00	
	Approved Educational Activities			1.00	2.00	
. 00	Column 1: Are costs claimed for nursing school? Column 2: If yes, the legal operator of the program?	is the	provi der i	s N		6.0
. 00	Are costs claimed for Allied Health Programs? If "Y" see instruction Were nursing school and/or allied health programs approved and/or re		during the	N Y		7. (8. (
. 00	cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved graduate program in the current cost report? If yes, see instructions.	medi ca	l educatio	n Y		9. (
0. 00	Was an approved Intern and Resident GME program initiated or renewed cost reporting period? If yes, see instructions.	d in th	e current	N		10.0
1. 00	Are GME cost directly assigned to cost centers other than I & R in a Teaching Program on Worksheet A? If yes, see instructions.	an Appr	oved	N		11. (
					Y/N 1. 00	
2 00	Bad Debts	0+500+1			V	4 12 /
	Is the provider seeking reimbursement for bad debts? If yes, see institution 12 is yes, did the provider's bad debt collection policy chaperiod? If yes, submit copy.			cost reporting	Y N	12.0
	If line 12 is yes, were patient deductibles and/or co-payments waive	ed? If	yes, see i	nstructi ons.	N	14.0
	Bed Complement					
	Bed Complement Did total beds available change from the prior cost reporting period				Y	15. (
		Part			t B Date	15.

	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only?	N		N		16.00
	If either column 1 or 3 is yes, enter the paid-through					
	date of the PS&R Report used in columns 2 and 4 .(see					
	instructions)					
17.00	Was the cost report prepared using the PS&R Report for	Y	03/01/2021	Υ	03/01/2021	17.00
	totals and the provider's records for allocation? If					
	either column 1 or 3 is yes, enter the paid-through date					
	in columns 2 and 4. (see instructions)					
18. 00	If line 16 or 17 is yes, were adjustments made to PS&R	N		N		18. 00
	Report data for additional claims that have been billed					
	but are not included on the PS&R Report used to file this					
	cost report? If yes, see instructions.					
19. 00	If line 16 or 17 is yes, were adjustments made to PS&R	N		N		19. 00
	Report data for corrections of other PS&R Report					
	information? If yes, see instructions.					

Heal th	Financial Systems ST. FRANCIS HOSPITA	AL & HEALTH CEN	ITER	In Lie	u of Form CM	S-2552-10	
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	Provi der CCN: 15-0162 Per		Worksheet S	5-2	
		To		rom 01/01/2020 o 12/31/2020	Date/Time P		
		Doser	pti on	Y/N	3/30/2021 1 Y/N	0: 40 am	
			0	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	
		Y/N 3. 00	Date 4.00				
21. 00	Was the cost report prepared only using the provider's	1. 00 N	2. 00	3.00 N	4.00	21. 00	
	records? If yes, see instructions.						
					1. 00		
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC Capital Related Cost	EPT CHILDRENS	HOSPI TALS)				
22. 00	Have assets been relifed for Medicare purposes? If yes, se	e instructions			N	22. 00	
23. 00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.	due to apprai	sals made duri	ng the cost	N	23. 00	
24. 00	Were new leases and/or amendments to existing leases enter If yes, see instructions	ed into during	this cost repo	orting period?	N	24.00	
25. 00	Have there been new capitalized leases entered into during instructions.	the cost repo	rting period?	If yes, see	N	25. 00	
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during t instructions.	he cost report	ing period? If	yes, see	N	26. 00	
27. 00	Has the provider's capitalization policy changed during the copy.	ne cost reporti	ng period? If	yes, submit	N	27. 00	
	Interest Expense						
28. 00	Were new loans, mortgage agreements or letters of credit eperiod? If yes, see instructions.	reporti ng	N	28. 00			
29. 00	Did the provider have a funded depreciation account and/or treated as a funded depreciation account? If yes, see inst	serve Fund)	N	29. 00			
30. 00	Has existing debt been replaced prior to its scheduled mat instructions.	see	N	30. 00			
31. 00	Has debt been recalled before scheduled maturity without i instructions.	see	N	31.00			
	Purchased Services	N	32.00				
32. 00	2.00 Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.						
33. 00	If line 32 is yes, were the requirements of Sec. 2135.2 ap no, see instructions.		ng to competiti	ive bidding? If	,	33.00	
	Provi der-Based Physi ci ans						
34.00		arrangement wit	h provi der-base	ed physicians?	Υ	34.00	
35. 00	If yes, see instructions. If line 34 is yes, were there new agreements or amended ex		nts with the p	rovi der-based	N	35. 00	
	physicians during the cost reporting period? If yes, see i	nstructions.		Y/N	Date		
				1. 00	2. 00		
36 00	Home Office Costs Were home office costs claimed on the cost report?			Υ		36.00	
37. 00	If line 36 is yes, has a home office cost statement been p	prepared by the	home office?	N		37.00	
38. 00				N		38. 00	
39. 00	j '			Υ		39. 00	
40. 00	see instructions. If line 36 is yes, did the provider render services to the	home office?	If yes, see	Υ		40. 00	
	i nstructi ons.						
		1.	00	2.	00		
44.00	Cost Report Preparer Contact Information	lveppy		DE LABANO		44.00	
41. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	KERRY		BEJARANO		41.00	
42. 00	respectively. Enter the employer/company name of the cost report	BKD, LLP				42.00	
43. 00	preparer. Enter the telephone number and email address of the cost	317-383-4000		KBEJARANO@BKD.	COM	43.00	
	report preparer in columns 1 and 2, respectively.	I		I		II	

Health Financial Systems ST. FRANCIS HOSPI			& HEALTH CENT	ER	In Lieu of Form CMS-2552-10			
HOSPI	TAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE	STI ONNAI RE	Provi der CCM			01/01/2020	Worksheet S Part II Date/Time F 3/30/2021 1	repared:
		-	3.00	0				
			3.0	0				
	Cost Report Preparer Contact Information							
41.00	Enter the first name, last name and the title	e/position D	I RECTOR					41.00
	held by the cost report preparer in columns ?	1, 2, and 3,						
	respectively.							
42.00	Enter the employer/company name of the cost i	report						42.00
	preparer.							
43.00	Enter the telephone number and email address	of the cost						43.00
	report preparer in columns 1 and 2, respective							

Health Financial Systems ST. FRANCIS HOSPITAL & HEALTH CENTER
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 1 In Lieu of Form CMS-2552-10 | Peri od: | Worksheet S-3 | From 01/01/2020 | Part I | To 12/31/2020 | Date/Time Prepared: Provi der CCN: 15-0162

				''	0 12/31/2020	3/30/2021 10:	
						I/P Days /	
						0/P Visits /	
						Tri ps	
	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	304	111, 264	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		304	111, 264	0. 00	0	7.00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT	31. 00	67	24, 522	0. 00	0	8.00
8. 01	NEONATAL INTENSIVE CARE UNIT	31. 01	31	10, 742	0. 00	0	8. 01
9.00	CORONARY CARE UNIT	32. 00	66	24, 156	0. 00	0	9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT	34.00	31	11, 346	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)		499	182, 030	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVI DER - I PF						16.00
17.00	SUBPROVI DER - I RF	41. 00	20	7, 320		0	17.00
18.00	SUBPROVI DER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22. 00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24.00	HOSPI CE	116. 00	0	0			24.00
24. 10	HOSPICE (non-distinct part)	30.00					24. 10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00				0	26. 25
27.00	Total (sum of lines 14-26)		519				27. 00
28.00	Observation Bed Days					0	28. 00
29. 00	Ambulance Trips		•				29.00
30.00	Employee discount days (see instruction)		•				30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
33.00	LTCH non-covered days						33.00
33. 01	LTCH site neutral days and discharges						33. 01
	-	•		•			

33 00

33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-0162

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

3/30/2021 10:40 am I/P Days / O/P Visits / Trips Full Time Equivalents Title XVIII Title XIX Component Total ALL Total Interns Employees On Pati ents & Residents Payrol I 6.00 7.00 8.00 9.00 10.00 Hospital Adults & Peds. (columns 5, 6, 7 and 797 52, 024 1. 00 22, 236 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) 22, 179 18, 941 2.00 3.00 HMO IPF Subprovider 3.00 4.00 HMO IRF Subprovider 4.00 1, 253 707 5.00 Hospital Adults & Peds. Swing Bed SNF C 0 5.00 6.00 Hospital Adults & Peds. Swing Bed NF 6.00 Total Adults and Peds. (exclude observation 7.00 797 52,024 7.00 22, 236 beds) (see instructions) INTENSIVE CARE UNIT 8 00 3, 568 278 20, 500 8 00 8.01 NEONATAL INTENSIVE CARE UNIT 45 6, 322 8.01 9.00 CORONARY CARE UNIT 5, 353 46 12, 691 9.00 BURN INTENSIVE CARE UNIT 10.00 10.00 11.00 SURGICAL INTENSIVE CARE UNIT 3, 146 67 8, 247 11 00 12.00 OTHER SPECIAL CARE (SPECIFY) 12.00 13.00 NURSERY 172 3,738 13.00 14.00 Total (see instructions) 34, 303 1, 405 103, 522 24.01 2, 371. 22 14.00 15.00 CAH visits 15.00 16.00 SUBPROVIDER - IPF 16.00 SUBPROVIDER - IRF 17.00 2,539 25 5, 552 41. 15 17.00 0.00 18.00 SUBPROVI DER 18.00 19.00 SKILLED NURSING FACILITY 19.00 NURSING FACILITY 20.00 20.00 21.00 OTHER LONG TERM CARE 21.00 HOME HEALTH AGENCY 22.00 0 0 0 0.00 0.36 22.00 AMBULATORY SURGICAL CENTER (D. P.) 23.00 23.00 24.00 HOSPI CE 498 43 604 0.00 74.14 24.00 HOSPICE (non-distinct part) 24.10 C 24.10 25.00 CMHC - CMHC 25.00 RURAL HEALTH CLINIC 26.00 26.00 FEDERALLY QUALIFIED HEALTH CENTER 0.00 0.00 26 25 0 Ω 0 26 25 Total (sum of lines 14-26) 27.00 24.01 2, 486. 87 27.00 28.00 Observation Bed Days 1, 947 9,550 28.00 29.00 Ambulance Trips 0 29.00 Employee discount days (see instruction) 30 00 O 30.00 31.00 Employee discount days - IRF 0 31.00 32.00 Labor & delivery days (see instructions) 0 398 874 32.00 Total ancillary labor & delivery room outpatient days (see instructions) 32.01 32.01 C

33 00

LTCH non-covered days

33.01 LTCH site neutral days and discharges

Health Financial Systems ST. FRANCIS HOSPITAL & HEALTH CENTER
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 1

Provi der CCN: 15-0162

Peri od: Worksheet S-3
From 01/01/2020 Part I
To 12/31/2020 Date/Time Prepared: 3/30/2021 10: 40 am Peri od:

						3/30/2021 10:	40 am_
		Full Time		Di scha	arges		
	0	Equi val ents	T' 11 . \	T: 11	T' II VIV	T. I. I. All	
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers	12.00	12.00	14.00	Pati ents	
1 00	Illamital Adulta & Dada (asluma E. (7 and	11. 00	12. 00	13.00	14. 00	15. 00	1 00
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and		0	6, 283	372	18, 261	1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
2 00	for the portion of LDP room available beds)			2 (2(1 7/0		2 00
2.00	HMO and other (see instructions)			3, 626	1, 768		2.00
3.00	HMO I PF Subprovi der				0		3.00
4.00	HMO I RF Subprovi der				25		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7. 00	Total Adults and Peds. (exclude observation						7. 00
0.00	beds) (see instructions)						0.00
8.00	I NTENSI VE CARE UNI T						8.00
8. 01	NEONATAL INTENSIVE CARE UNIT						8. 01
9. 00	CORONARY CARE UNIT						9. 00
10. 00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGI CAL INTENSI VE 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	6, 283	372	18, 261	14.00
15. 00	CAH visits						15.00
16. 00	SUBPROVI DER - I PF						16. 00
17. 00	SUBPROVI DER - I RF	0.00	0	205	2	438	17. 00
18. 00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24. 00	HOSPI CE	0.00					24.00
24. 10	HOSPICE (non-distinct part)						24. 10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26. 25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambul ance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
33.00	LTCH non-covered days			0			33.00
33. 01	LTCH site neutral days and discharges			0			33. 01
		•			•		

Provi der CCN: 15-0162

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

					To	12/31/2020	Date/Time Pre 3/30/2021 10:	
		Wkst. A Line	Amount	Reclassi fi cat	Adjusted	Paid Hours	Average	
		Number	Reported	i on of Sal ari es	Salaries (col.2 ± col.	Related to Salaries in	Hourly Wage (col. 4 ÷	
				(from Wkst.	3)	col. 4	col. 5)	
	•	1. 00	2. 00	A-6) 3. 00	4. 00	5. 00	6. 00	
	PART II - WAGE DATA	1.00	2.00	3.00	4.00	5.00	0.00	
	SALARI ES							
1. 00	Total salaries (see instructions)	200. 00	170, 985, 927	0	170, 985, 927	5, 172, 709. 40	33. 06	1.00
2. 00	Non-physician anesthetist Part		0	0	0	0. 00	0.00	2.00
2 00	A					0.00	0.00	
3. 00	Non-physician anesthetist Part B		0	0	0	0. 00	0. 00	3.00
4.00	Physician-Part A -		0	0	0	0. 00	0. 00	4.00
4. 01	Administrative Physicians - Part A - Teaching		1, 550, 228	0	1, 550, 228	12, 683. 00	122. 23	4.0
5. 00	Physician and Non		2, 640, 255		.,,	9, 734. 14	271. 24	
4 00	Physician-Part B		0			0.00	0.00	
6. 00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0. 00	0. 00	6.00
7. 00	Interns & residents (in an	21. 00	5, 102, 949	-2, 896, 572	2, 206, 377	55, 201. 92	39. 97	7.00
7. 01	approved program) Contracted interns and		0	0	0	0. 00	0. 00	7.01
7.01	residents (in an approved programs)		O	O	J	0.00	0.00	7.0
8.00	Home office and/or related		0	0	0	0. 00	0. 00	8. 00
9. 00	organization personnel SNF	44. 00	0	0	0	0. 00	0. 00	9.00
10.00	Excluded area salaries (see		20, 912, 287	143, 864	21, 056, 151	593, 463. 53	35. 48	
	instructions) OTHER WAGES & RELATED COSTS							-
11.00	Contract labor: Direct Patient		6, 588, 727	0	6, 588, 727	98, 825. 00	66. 67	11.00
12. 00	Care Contract Labor: Top Level		0	0	0	0. 00	0.00	12.00
12.00	management and other		U		U	0.00	0.00	12.00
	management and administrative							
13. 00	services Contract Labor: Physician-Part		491, 243	0	491, 243	3, 546. 00	138. 53	13.00
	A - Administrative					·		
14. 00	Home office and/or related organization salaries and		0	0	0	0. 00	0. 00	14.00
	wage-related costs							
14. 01 14. 02	Home office salaries Related organization salaries		67, 816, 794	0		1, 815, 398. 73 217, 882. 70	37. 36 24. 69	14. 0°
15. 00	Home office: Physician Part A		5, 380, 592 0	0	-,,	0.00		15.00
4 / 00	- Administrative							
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. 0°
16. 02	- Teaching Home office contract		0	0	0	0. 00	0.00	16. 02
10.02	Physicians Part A - Teaching		0		Ŭ	0.00	0.00	10.02
17 00	WAGE-RELATED COSTS		EO 124 421	0	50 124 421			17. 00
17. 00	Wage-related costs (core) (see instructions)		50, 124, 421		50, 124, 421			17.00
18. 00	Wage-related costs (other)							18.00
19. 00	(see instructions) Excluded areas		7, 024, 419	0	7, 024, 419			19.00
20. 00	Non-physician anesthetist Part		0 0	ő	0			20.00
21 00	Non physician anosthatiat Darit		2	_				21 00
21. 00	Non-physician anesthetist Part B		0					21.00
22. 00	Physician Part A -		0	0	0			22.00
22. 01	Administrative Physician Part A - Teaching		373, 321	n	373, 321			22. 01
23.00	Physician Part B		1, 387, 566	0	1, 387, 566			23.00
24. 00 25. 00	Wage-related costs (RHC/FQHC)		0 1, 298, 313	0	0 1, 298, 313			24. 00 25. 00
20.00	approved program)		1, 270, 313		1, 270, 313			20.00
25. 50	Home office wage-related		22, 998, 791	0	22, 998, 791			25. 50
25. 51	(core) Rel ated organi zati on		1, 622, 234	0	1, 622, 234			25. 5°
	wage-related (core)			_				
25. 52	Home office: Physician Part A - Administrative -		0	0	0			25. 52
	wage-related (core)				ı			1

42.00

Social Service

43.00 Other General Service

HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0162 Peri od: Worksheet S-3 From 01/01/2020 Part II Date/Time Prepared: 12/31/2020 3/30/2021 10:40 am Wkst. A Line Amount Recl assi fi cat Adj usted Paid Hours Average Hourly Wage (col. 4 ÷ col. 5) Number Sal ari es Related to Reported ion of Sal ari es (col. 2 ± col. Salaries in (from Wkst. 3) col. 4 A-6) 1.00 2.00 3.00 4.00 5.00 6.00 25.53 Home office: Physicians Part A 0 25. 53 0 - Teaching - wage-related (core) OVERHEAD COSTS - DIRECT SALARIES 26.00 Employee Benefits Department 4.00 0 0 0.00 0. 00 26.00 27.00 Administrative & General 5.00 1, 781, 995 1, 781, 995 46, 520. 00 38. 31 27.00 28.00 Administrative & General under 2, 677, 904 2, 677, 904 24, 486. 81 109. 36 28.00 0 contract (see inst.) 29.00 29.00 Maintenance & Repairs 6.00 0.00 0.00 30.00 Operation of Plant 7.00 3, 779, 271 3, 779, 271 130, 762. 27 28. 90 30.00 14, 459. 81 31.00 Laundry & Linen Service 8.00 242, 343 242, 343 16. 76 31.00 0 17. 08 32.00 32.00 Housekeepi ng 9.00 3, 991, 630 C 3, 991, 630 233, 704. 90 33.00 Housekeeping under contract 0.00 0.00 33.00 (see instructions) 34.00 Dietary 10.00 2, 337, 218 -1, 320, 042 1, 017, 176 55, 331. 00 18. 38 34.00 Dietary under contract (see 35.00 0.00 0.00 35.00 instructions) 36.00 Cafeteri a 11.00 695, 193 1, 320, 042 2, 015, 235 111, 330. 98 18. 10 36.00 0.00 37.00 Maintenance of Personnel 12.00 0.00 37.00 Nursing Administration 38.00 13.00 4, 328, 850 94, 872. 95 38.00 4, 328, 850 45. 63 39.00 Central Services and Supply 14.00 678, 692 678, 692 31, 708. 61 21. 40 39.00 6, 800, 157 161, 606. 24 41. 20 40.00 Pharmacy 15.00 -142, 529 6, 657, 628 40.00 Medical Records & Medical Records Library 41.00 16.00 0 O 0.00 0.00 41.00

0

0

0

0

0

0.00

0.00

0.00 42.00

0.00 43.00

17.00

18.00

Health Financial Systems ST. FRANCIS HOSPITAL & HEALTH CENTER In Lieu of Form CMS-2552-10
HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0162 Period: Worksheet S-3

HOSPITAL WAGE INDEX INFORMATION				Provi der Co	Provi der CCN: 15-0162 Peri od: From 01/01/2020 To 12/31/2020				
		Worksheet A	Amount	Recl assi fi cat	Adj usted	Pai d Hours	Average		
		Line Number	Reported	ion of	Sal ari es	Related to	Hourly Wage		
				Sal ari es	(col.2 ± col.	Sal ari es in	(col. 4 ÷		
				(from	3)	col. 4	col. 5)		
				Worksheet					
				A-6)					
		1. 00	2. 00	3. 00	4. 00	5. 00	6. 00		
	PART III - HOSPITAL WAGE INDEX	SUMMARY				_			
1. 00	Net salaries (see		164, 370, 399	2, 896, 572	167, 266, 97	1 5, 119, 577. 15	32. 67	1.00	
	instructions)								
2.00	Excluded area salaries (see		20, 912, 287	143, 864	21, 056, 15	1 593, 463. 53	35. 48	2.00	
	instructions)								
3.00	Subtotal salaries (line 1		143, 458, 112	2, 752, 708	146, 210, 82	0 4, 526, 113. 62	32. 30	3.00	
	minus line 2)								
4. 00	Subtotal other wages & related		80, 277, 356	0	80, 277, 35	6 2, 135, 652. 43	37. 59	4.00	
	costs (see inst.)								
5.00	Subtotal wage-related costs		74, 745, 446	0	74, 745, 44	6 0.00	51. 12	5.00	
	(see inst.)								
6.00	Total (sum of lines 3 thru 5)		298, 480, 914	1					
7. 00	Total overhead cost (see		27, 313, 253	-142, 529	27, 170, 72	4 904, 783. 57	30. 03	7. 00	
	instructions)								

| Period: | Worksheet S-3 | From 01/01/2020 | Part IV | Date/Time Prepared: 3/30/2021 10: 40 am Health Financial Systems
HOSPITAL WAGE RELATED COSTS ST. FRANCIS HOSPITAL & HEALTH CENTER Provider CCN: 15-0162

		3/30/2021 10:	40 am_
		Amount	
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	3, 869, 591	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	o	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	16, 040, 864	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal /Accounting/Management Fees-Pension Plan	ol	6.00
7.00	Employee Managed Care Program Administration Fees	ol	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)	ol	8. 01
8. 02	Health Insurance (Self Funded with a Third Party Administrator)	24, 012, 067	8. 02
8.03	Health Insurance (Purchased)	ol	8.03
9.00	Prescription Drug Plan	ol	9.00
10.00	Dental, Hearing and Vision Plan	1, 288, 258	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	97, 765	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)	523, 325	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	1, 219, 117	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	13, 104, 597	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unempl oyment Insurance	52, 456	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see	0	21.00
	instructions))		
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	60, 208, 040	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25.00

Health Financial Systems	ST. FRANCIS HOSPITAL & HEALTH CENTER	In Lieu of Form CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provi der CCN: 15-0162	Period: Worksheet S-3

HUSPITAL CONTRACT LABOR	R AND BENEFIT COST	Provider CCN: 15-0162	Peri od:	Worksneet S-3	
			From 01/01/2020		norod.
			To 12/31/2020	Date/Time Pre 3/30/2021 10:	
Cost Conto	r Description		Contract	Benefit Cost	40 alli
cost center	Description		Labor	bellett Cost	
			1, 00	2. 00	
DADT V Control	+ Labor and Danafi + Coa+		1.00	2.00	
	t Labor and Benefit Cost				
-	pital-Based Component Identification:				
1	contract labor and benefit cost		6, 588, 727	60, 208, 040	1. 00
2.00 Hospi tal			6, 588, 727	53, 183, 622	2.00
3.00 Subprovider - IP					3.00
4.00 Subprovider - IR	RF		0	975, 678	4.00
5.00 Subprovider - (0	ther)		0	0	5.00
6.00 Swing Beds - SNF			0	0	6.00
7.00 Swing Beds - NF			o	0	7.00
8.00 Hospital -Based S	NF				8.00
9.00 Hospital-Based N	IF.				9.00
10.00 Hospital -Based 0					10.00
11.00 Hospi tal -Based H			0	0	11. 00
12.00 Separately Certi				ŭ	12.00
13. 00 Hospi tal -Based H				1, 930, 734	
14. 00 Hospi tal -Based H	•		٩	1, 730, 734	14. 00
15. 00 Hospi tal -Based H					15. 00
, ·					16. 00
16.00 Hospi tal -Based-C	INIUC			0	
17.00 Renal Dialysis			0	0	17.00
18.00 Other			0	4, 118, 006	18. 00

Heal th	ı Financial Systems	ST F	RANCIS HOSPITA	I & HEALTH CEN	TER	Inlie	u of Form CMS-2	2552_10
HOSPITAL-BASED HOSPICE IDENTIFICATION DATA			Provi der C	Provi der CCN: 15-0162 Hospi ce CCN: 15-1523		Worksheet S-9 D20 PARTS I THROUGH IV D20 Date/Time Prepared 3/30/2021 10:40 at		
						Hospi ce I		
		Unduplicated Days						
		Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility	All Other	Total (sum of cols. 1, 2 & 5)	
		1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
	PART I - ENROLLMENT DAYS FOR CO	OST REPORTING I	PERI ODS BEGINNI	NG BEFORE OCT	DBER 1, 2015			
1.00	Hospice Continuous Home Care							1.00
2.00	Hospice Routine Home Care							2. 00
3.00	Hospice Inpatient Respite Care							3. 00
4. 00	Hospice General Inpatient Care							4. 00
5. 00	Total Hospice Days							5.00
	Part II - CENSUS DATA FOR COST	REPORTING PER	ODS BEGINNING	BEFORE OCTOBER	R 1, 2015			
6. 00	Number of patients receiving hospice care						 	6. 00
7.00	Total number of unduplicated							7.00
	Continuous Care hours billable							
	to Medicare							
8.00	Average Length of Stay (line 5							8.00
	/ line 6)							
9. 00	Unduplicated census count							9.00
NOTE:	Parts I and II, columns 1 and 2	also include	the days repor	ted in columns	3 and 4.			
				Title XVIII	Title XIX	Other	Total (sum of	
							cols 1	

	Title XVIII	Title XIX	Other	Total (sum of		
				col s. 1		
				through 3)		
	1. 00	2.00	3. 00	4. 00		
PART III - ENROLLMENT DAYS FOR COST REPORTING PERIODS B	EGINNING ON OR AF	TER OCTOBER 1,	2015			
10.00 Hospice Continuous Home Care	0	0	0	0	10.00	
11.00 Hospice Routine Home Care	25, 710	1, 784	2, 958	30, 452	11.00	
12.00 Hospice Inpatient Respite Care	498	24	31	553	12.00	
13.00 Hospice General Inpatient Care	0	19	32	51	13.00	
14.00 Total Hospice Days	26, 208	1, 827	3, 021	31, 056	14.00	
PART IV - CONTRACTED STATISTICAL DATA FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015						
15.00 Hospice Inpatient Respite Care	0	0	0	0	15.00	
16.00 Hospice General Inpatient Care	0	0	0	0	16.00	

Heal th	Financial Systems ST. FRANCIS HOSPITAL &	HEALTH CENTER	In Lie	u of Form CMS-2	2552-10		
		Provider CCN: 15-0162	Peri od:	Worksheet S-1			
			From 01/01/2020	Doto/Time Dro	narad.		
			To 12/31/2020	Date/Time Pre 3/30/2021 10:			
				1. 00			
	Uncompensated and indigent care cost computation			1.00			
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 di	vided by line 202 colu	mn 8)	0. 196061	1.00		
	Medicaid (see instructions for each line)						
2.00	Net revenue from Medicaid			93, 502, 133	2.00		
3. 00 4. 00	Did you receive DSH or supplemental payments from Medicaid? If line 3 is yes, does line 2 include all DSH and/or supplemen	tal paymonts from Modi	cai d2	N N	3. 00 4. 00		
5. 00	If line 4 is no, then enter DSH and/or supplemental payments f		cai u :	0	5.00		
6. 00	Medicaid charges	i oiii mear ear a		457, 573, 025	6.00		
7. 00	Medicaid cost (line 1 times line 6)			89, 712, 225	7. 00		
8.00	Difference between net revenue and costs for Medicaid program	(line 7 minus sum of L	ines 2 and 5; if	0	8. 00		
	< 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	9.00		
10. 00 11. 00	Stand-alone CHIP charges Stand-alone CHIP cost (line 1 times line 10)			0 0	10. 00 11. 00		
12.00	Difference between net revenue and costs for stand-alone CHIP	(line 11 minus line 0:	if / zero then	0	12.00		
12.00	enter zero)	(Trie II milias Trie 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 care program (Not included in lines 6 or 0 14.0						
	10)						
15.00	State or local indigent care program cost (line 1 times line 1		45	0	15. 00 16. 00		
16. 00	O Difference between net revenue and costs for state or local indigent care program (line 15 minus line 0 1 13; if < zero then enter zero)						
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see						
	instructions for each line)						
17. 00	,			0	17. 00		
18.00	Government grants, appropriations or transfers for support of			0	18.00		
19. 00	Total unreimbursed cost for Medicaid , CHIP and state and loca 8, 12 and 16)	i indigent care progra	ms (sum of lines	0	19. 00		
		Uni nsured	Insured	Total (col. 1			
		patients	pati ents	+ col . 2) 3.00			
	Uncompensated Care (see instructions for each line)	1.00	2. 00	3.00			
20. 00	Charity care charges and uninsured discounts for the entire fa	cility 60,495,2	15 10, 864, 207	71, 359, 422	20.00		
	(see instructions)			,			
21. 00	Cost of patients approved for charity care and uninsured disco	unts (see 11,860,7	10, 864, 207	22, 724, 959	21. 00		
22. 00	instructions) Payments received from patients for amounts previously written	off as	0 0	0	22. 00		
	charity care						
23. 00	Cost of charity care (line 21 minus line 22)	11, 860, 7	52 10, 864, 207	22, 724, 959	23.00		
				1. 00			
24. 00	Does the amount on line 20 column 2, include charges for patie	nt days beyond a Lengt	h of stay limit	N	24. 00		
25 00	imposed on patients covered by Medicaid or other indigent care program? 25.00 If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of						
25.00	stay limit	ne margent care progr	all S religiti of	U	25. 00		
26. 00	Total bad debt expense for the entire hospital complex (see in			56, 014, 166			
27. 00	Medicare reimbursable bad debts for the entire hospital comple	` ,		907, 714			
27. 01	Medicare allowable bad debts for the entire hospital complex (see instructions)		1, 396, 483			
28. 00	Non-Medicare bad debt expense (see instructions)	nonco (coo notruot!	-)	54, 617, 683			
29. 00 30. 00	Cost of non-Medicare and non-reimbursable Medicare bad debt ex Cost of uncompensated care (line 23 column 3 plus line 29)	pense (see Enstruction	5)	11, 197, 167 33, 922, 126			
	Total unreimbursed and uncompensated care cost (line 19 plus l	ine 30)		33, 922, 126			
200	1	/		, ,22, ,20			

	Financial Systems ST. F SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	RANCIS HOSPITAL F EXPENSES	Provi der Co	CN: 15-0162 P	eri od:	u of Form CMS-2 Worksheet A	2552-10
				T T	rom 01/01/2020 o 12/31/2020	Date/Time Pre 3/30/2021 10:	pared:
	Cost Center Description	Sal ari es	0ther		Reclassificat	Recl assi fi ed	40 diii
				+ col . 2)	i ons (See A-6)	Trial Balance (col. 3 +-	
		1. 00	2. 00	2.00	4.00	col . 4) 5. 00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	3. 00	4. 00	5.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT		0	_	,,	22, 221, 497	
2. 00 4. 00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT	0	35, 440, 978 0	35, 440, 978 0		14, 957, 135 50, 219, 718	
5. 01	00570 ADMI TTI NG	О	4, 297	4, 297	-487	3, 810	5. 01
5. 02 5. 03	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 00590 OTHER ADMI N & GENERAL	0 1, 781, 995	0 38, 301, 447	0 40, 083, 442	·	0 39, 528, 044	
7. 00	00700 OPERATION OF PLANT	3, 779, 271	11, 205, 655			13, 815, 676	
8.00	00800 LAUNDRY & LINEN SERVICE	242, 343	1, 667, 693			1, 830, 780	1
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	3, 991, 630 2, 337, 218	3, 993, 988 2, 246, 711	7, 985, 618 4, 583, 929		6, 676, 417 956, 946	1
11.00	01100 CAFETERI A	695, 193	1, 095, 764	1, 790, 957	2, 595, 391	4, 386, 348	11.00
13. 00 14. 00	01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY	4, 328, 850 678, 692	1, 406, 385 2, 675, 409			4, 472, 077 2, 107, 882	1
15. 00	01500 PHARMACY	6, 800, 157	29, 058, 879			6, 985, 999	
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0	0	0	0	
21. 00 22. 00	02100 L&R SERVICES-SALARY & FRINGES APPRV 02200 L&R SERVICES-OTHER PRGM COSTS APPRV	5, 102, 949 0	2, 410, 288 0	7, 513, 237 0	-5, 307, 104 1, 869, 825	2, 206, 133 1, 869, 825	
23. 00	02300 MEDICAL LABORATORY SCIENTIST PRGM	86, 682	33, 606	_		80, 471	1
23. 01	02302 PHARMACY PRGM	380, 879	132, 636			699, 014	
23. 02 23. 03	02301 EMERGENCY MEDICAL SERVICES 02303 PARAMEDIC PRGM	996, 141 0	427, 542 0			373, 063 892, 627	
20.00	INPATIENT ROUTINE SERVICE COST CENTERS					0,2,02,	1 20.00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	30, 234, 107	13, 207, 122			32, 734, 952	1
31.00	02060 NEONATAL INTENSIVE CARE UNIT	6, 580, 301 3, 395, 716	3, 655, 701 2, 470, 708	10, 236, 002 5, 866, 424		7, 135, 718 4, 597, 863	1
32.00	03200 CORONARY CARE UNIT	8, 810, 548	3, 557, 263	12, 367, 811	-3, 310, 504	9, 057, 307	32.00
34.00	03400 SURGI CAL I NTENSI VE CARE UNI T	4, 549, 979	1, 807, 691			4, 704, 529	
41. 00 43. 00	04100 SUBPROVI DER - I RF 04300 NURSERY	2, 928, 631 26, 109	1, 043, 800 109, 622			3, 034, 010 505, 061	
	ANCILLARY SERVICE COST CENTERS						
50. 00 52. 00	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM	11, 771, 098 2, 773, 890	47, 107, 207 1, 486, 447			17, 904, 172 2, 816, 692	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	8, 655, 969	9, 146, 127			12, 807, 691	
55.00	05500 RADI OLOGY-THERAPEUTI C	1, 462, 148	8, 981, 238			9, 985, 946	1
56. 00 59. 00	05600 RADI OI SOTOPE 05900 CARDI AC CATHETERI ZATI ON	201, 920 2, 042, 559	847, 632 15, 983, 089			967, 932 2, 266, 707	
60.00	06000 LABORATORY	647, 440	26, 300, 788	26, 948, 228	-1, 419, 329	25, 528, 899	60.00
64.00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	2, 544, 678	40, 368, 434			3, 232, 677	
65. 00 66. 00	06600 PHYSI CAL THERAPY	5, 773, 199 4, 417, 949	4, 885, 880 2, 433, 995			6, 564, 759 5, 308, 255	
67.00	06700 OCCUPATI ONAL THERAPY	1, 935, 182	693, 972	2, 629, 154	-599, 011	2, 030, 143	67.00
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	759, 134 1, 369, 267	458, 264 852, 183			976, 141 1, 560, 046	
70.00	07000 ELECTROCARDI OLOGI 07000 ELECTROENCEPHALOGRAPHY	1, 499, 680	1, 181, 974		-522, 309	2, 159, 345	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	37, 364, 117	37, 364, 117	1
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0	0	28, 863, 696 64, 771, 451	28, 863, 696 64, 771, 451	
74. 00	07400 RENAL DIALYSIS	37, 840	987, 546	1, 025, 386		968, 405	
76. 97	07697 CARDI AC REHABI LI TATI ON	318, 096	172, 456	490, 552	-98, 799	391, 753	76. 97
90. 00	OUTPATIENT SERVICE COST CENTERS O9000 CLINIC	4, 261, 748	2, 024, 766	6, 286, 514	25, 200	6, 311, 714	90.00
90. 01	09001 I BMT JOI NT VENTURE	1, 583, 902	5, 951, 311		l .	6, 973, 789	1
90.05	09005 CV DI AGNOSTI C SERVI CES	7, 266, 290	5, 215, 130			10, 215, 416	
91. 00 92. 00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	7, 416, 593	3, 939, 973	11, 356, 566	-3, 395, 319	7, 961, 247	91.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	29, 894	60, 306	90, 200	-90, 200	0	101.00
113.00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE		0	0	ol	0	113.00
116.00	11600 HOSPI CE	5, 795, 361	3, 247, 658			7, 299, 363	116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	160, 291, 228	338, 279, 561	498, 570, 789	2, 712, 469	501, 283, 258	118. 00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	254, 045	240, 896	494, 941	-72, 582	422, 359	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	6, 164, 834	4, 047, 025	10, 211, 859	-1, 951, 466	8, 260, 393	192.00
10/ 00	07955 MARKETING & COMMUNITY RELATIONS	58, 565	5, 134	63, 699	l .	63, 699	194. 00 194. 01
		06 624	01 07/1				
194. 01	07952 WOMEN'S CENTER 07950 OTHER NONREIMBURSABLE COST CENTERS	96, 624 0	91, 974 0	188, 598 0	-2, 329	0	194. 02
194. 01 194. 02 194. 04	07952 WOMEN'S CENTER 07950 OTHER NONREIMBURSABLE COST CENTERS 07954 OTHER NRCC	0 4, 120, 631	91, 974 0 47, 277, 162	0	0 -685, 892	0 50, 711, 901	194. 02 194. 04
194. 01 194. 02 194. 04	07952 WOMEN'S CENTER 07950 OTHER NONREIMBURSABLE COST CENTERS 07954 OTHER NRCC 07956 FOUNDATION	0	0	0 51, 397, 793 0	-685, 892 0	0 50, 711, 901	194. 02 194. 04 194. 05

		RANCIS HOSPITA				eu of Form CMS-2552-
RECLASS	IFICATION AND ADJUSTMENTS OF TRIAL BALANCE C	F EXPENSES	Provi der C	CN: 15-0162	Period: From 01/01/2020	Worksheet A
					To 12/31/2020	
	Cost Center Description	Adjustments	Net Expenses			7 007 2021 101 10 4
		(See A-8)	For Allocation			
-	THE ALL OF THE STATE OF THE STA	6. 00	7. 00			
	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FLXT	10, 935, 625	33, 157, 122			1.0
	00200 CAP REL COSTS-MVBLE EQUIP	0	14, 957, 135	1		2.0
- 1	00400 EMPLOYEE BENEFITS DEPARTMENT	20, 439, 587	70, 659, 305	1		4.0
-	00570 ADMITTI NG 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	0				5. C 5. C
	00590 OTHER ADMIN & GENERAL	103, 712, 877	143, 240, 921	1		5.0
	00700 OPERATION OF PLANT	5, 253, 236		1		7.0
	00800 LAUNDRY & LINEN SERVICE	0	, ,	1		8.0
	00900 HOUSEKEEPI NG 01000 DI ETARY	0 -280, 173	6, 676, 417 676, 773			9. C 10. C
	01100 CAFETERI A	-1, 853, 439		1		11.0
	01300 NURSING ADMINISTRATION	909, 628	5, 381, 705			13.0
	01400 CENTRAL SERVICES & SUPPLY	-659, 513				14.0
- 1	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	612, 020 174, 487	7, 598, 019 174, 487	1		15. C
	02100 I&R SERVICES-SALARY & FRINGES APPRV	-345, 301	1, 860, 832	1		21. 0
2.00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV	-618, 534	1, 251, 291			22.0
	02300 MEDICAL LABORATORY SCIENTIST PRGM	-42, 139				23.0
1	02302 PHARMACY PRGM 02301 EMERGENCY MEDICAL SERVICES	0 -300, 731	699, 014 72, 332			23.0
1	2303 PARAMEDIC PRGM	-574, 080				23. 0
I	NPATIENT ROUTINE SERVICE COST CENTERS					
	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	-5, 309		1		30.0
- 1	02060 NEONATAL INTENSIVE CARE UNIT	-16, 100 -338, 363		1		31. C 31. C
	03200 CORONARY CARE UNIT	0	9, 057, 307	1		32.0
	03400 SURGICAL INTENSIVE CARE UNIT	0	4, 704, 529	1		34.0
- 1	04100 SUBPROVI DER - I RF 04300 NURSERY	0	3, 034, 010 505, 061	1		41. C 43. C
	NCILLARY SERVICE COST CENTERS	0	303, 001			43.0
50.00	05000 OPERATING ROOM	-4, 622, 984		1		50. C
	D5200 DELIVERY ROOM & LABOR ROOM	147.460		1		52.0
	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	147, 460 -3, 220, 202	12, 955, 151 6, 765, 744			54. C 55. C
	05600 RADI OI SOTOPE	0, 220, 202		1		56.0
	05900 CARDI AC CATHETERI ZATI ON	-27, 150		1		59.0
	06000 LABORATORY	-145, 305				60.0
- 1	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	-814, 321 -56, 906	2, 418, 356 6, 507, 853	1		64. C
- 1	06600 PHYSI CAL THERAPY	0	5, 308, 255	1		66.0
	06700 OCCUPATI ONAL THERAPY	0	2, 030, 143			67.0
	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	-4, 028 -159, 408				68. C
	07000 ELECTROCARDI OLOGI 07000 ELECTROENCEPHALOGRAPHY	-154, 408 -264, 314				70.0
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0		1		71. C
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	28, 863, 696	1		72.0
	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0	64, 771, 451 968, 405	1		73. C 74. C
6. 97	07697 CARDIAC REHABILITATION	-3, 950				76. 9
C	OUTPATIENT SERVICE COST CENTERS					
	09000 CLINIC 09001 IBMT JOINT VENTURE	-1, 761, 674 1 230		1		90.0
- 1	09005 CV DIAGNOSTIC SERVICES	1, 239 -883, 964		1		90.0
1	09100 EMERGENCY	-42, 896		1		91.0
	09200 OBSERVATION BEDS (NON-DISTINCT PART					92.0
	OTHER REIMBURSABLE COST CENTERS 10100 HOME HEALTH AGENCY	0	0	ı		101.0
	SPECIAL PURPOSE COST CENTERS					
	11300 I NTEREST EXPENSE	0	7 000 000			113.0
16. 00 1 18. 00	11600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117)	0 125, 145, 375		1		116. C 118. C
-	IONREI MBURSABLE COST CENTERS	125, 145, 375	020, 420, 033			118.0
90.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	422, 359			190.0
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0		1		192.0
	07955 MARKETING & COMMUNITY RELATIONS 07952 WOMEN'S CENTER	37, 775 0				194. C 194. C
	07952 WOMEN S CENTER 07950 OTHER NONREIMBURSABLE COST CENTERS	0	186,069	1		194. 0
194. 04	07954 OTHER NRCC	28, 526, 980	79, 238, 881			194. C
194. 05 (200. 00	07956 FOUNDATION	1, 889				194. 0
	TOTAL (SUM OF LINES 118 through 199)	153, 712, 019	714, 639, 698	1		200. C

Health Financial Systems RECLASSIFICATIONS ST. FRANCIS HOSPITAL & HEALTH CENTER
Provider CCN: 15-0162

Peri od: From 01/01/2020 To 12/31/2020

Date/Time Prepared: 3/30/2021 10:40 am

		Increases			3/30/2021 10:	: 40 am
	Cost Center	Li ne #	Sal ary	0ther		
	2. 00	3.00	4. 00	5. 00		
	A - MEDICAL SUPPLIES					
1. 00 2. 00	RADI OLOGY-THERAPEUTI C MEDI CAL SUPPLI ES CHARGED TO	55. 00 71. 00	0	1, 731 37, 364, 117		1. 00 2. 00
3. 00	PATIENT IMPL. DEV. CHARGED TO	72. 00	0	28, 863, 696		3. 00
4. 00	PATI ENTS	0.00	О	О		4.00
5. 00		0.00	0	0		5.00
6. 00 7. 00		0. 00 0. 00	0	0		6. 00 7. 00
8. 00		0.00	0	0		8.00
9. 00		0.00	Ö	Ö		9.00
10.00		0.00	О	0		10.00
11.00		0.00	0	0		11.00
12. 00 13. 00		0. 00 0. 00	0	0		12. 00 13. 00
14. 00		0.00	0	0		14.00
15.00		0. 00	О	0		15.00
16.00		0.00	0	0		16.00
17. 00 18. 00		0. 00 0. 00	0	0		17. 00 18. 00
19. 00		0.00	Ö	Ö		19.00
20.00		0.00	O	0		20.00
21.00		0.00	0	0		21.00
22. 00 23. 00		0. 00 0. 00	0	0		22. 00 23. 00
24. 00		0.00	o	0		24. 00
25. 00		0.00	0	0		25.00
26.00		0.00	0	0		26.00
27. 00 28. 00		0. 00 0. 00	0	0		27. 00 28. 00
29. 00		0.00	О	0		29. 00
30.00		0.00	0	0		30.00
31. 00 32. 00		0. 00 0. 00	0	0		31. 00 32. 00
33. 00		0.00	0	Ö		33.00
34.00		0.00	0	0		34.00
35.00		0.00	0	0		35.00
36. 00 37. 00		0. 00 0. 00	0	0		36. 00 37. 00
38. 00		0.00	O	0		38. 00
39. 00		0.00	0	0		39. 00
	B - DRUG		O _I	66, 229, 544		
1. 00 2. 00	DRUGS CHARGED TO PATIENTS	73. 00 0. 00	0	64, 771, 451 0		1.00 2.00
3. 00		0.00	0	0		3.00
4.00		0.00	О	0		4.00
5. 00		0.00	0	0		5.00
6. 00 7. 00		0. 00 0. 00	0	0		6. 00 7. 00
8. 00		0.00	0	0		8. 00
9.00		0.00	0	0		9.00
10. 00 11. 00		0. 00 0. 00	0	0		10. 00 11. 00
12. 00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0. 00 0. 00	0	0		14.00
15. 00 16. 00		0.00	0	0		15. 00 16. 00
17. 00		0.00	o	0		17. 00
18.00		0.00	0	0		18.00
19. 00 20. 00		0. 00 0. 00	0	0		19. 00 20. 00
20.00		0.00	0	0		21.00
22.00		0.00	О	0		22. 00
23. 00		0.00	0	0		23.00
24. 00 25. 00		0. 00 0. 00	0	0		24. 00 25. 00
26. 00		0.00	0	0		26.00
27.00		0.00	О	0		27. 00
28. 00		0.00	0	0		28.00
29. 00	0 — — — — —	0.00	0	0 64, 771, 451		29. 00
	I .	<u> </u>	ગ			

	Financial Systems	ST. F	RANCIS HOSPITA	L & HEALTH CENTER	In Lieu of Form C	
RECLAS	SI FI CATI ONS			Provi der CCN: 15-010	From 01/01/2020	
					To 12/31/2020 Date/Time 3/30/2021	
	Cost Center	Increases Line #	Cal aru	Other		
	2. 00	3. 00	Sal ary 4. 00	5. 00		
1 00	C - EQUI PMENT LEASE	2 00		1 2/1 220		1.00
1. 00 2. 00	CAP REL COSTS-MVBLE EQUIP	2. 00 0. 00	0	1, 361, 330 0		1. 00 2. 00
3. 00		0.00	O	0		3.00
4. 00 5. 00		0. 00 0. 00	0	0		4. 00 5. 00
6.00		0. 00	0	0		6. 00
7. 00 8. 00		0. 00 0. 00	0	0		7. 00 8. 00
9. 00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11. 00 12. 00		0. 00 0. 00	0	0		11. 00 12. 00
13.00		0. 00	0	0		13. 00
14. 00 15. 00		0. 00 0. 00	0	0		14. 00 15. 00
16. 00		0.00	0	o O		16. 00
17. 00		0.00		0000		17. 00
	D - DEPRECIATION		UU	1, 301, 330		
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	22, 221, 497		1.00
2. 00 3. 00	CAP REL COSTS-MVBLE EQUIP	2. 00 0. 00	0	376, 324 0		2. 00 3. 00
4. 00		0.00	0	0		4. 00
	O E - CAFETERIA		0	22, 597, 821		
1. 00	CAFETERI A	1100	1, 320, 042	1, 499, 795		1.00
	O		1, 320, 042	1, 499, 795		
1. 00	MEDICAL LABORATORY SCIENTIST	23. 00	81, 027	23, 318		1.00
	PRGM	+	81, 027			
1 00	G - INTERNS AND RESIDENT I&R SERVICES-OTHER PRGM	22.00	1 550 220	210 507		1 00
1. 00	COSTS APPRV	22.00	1, 550, 228	319, 597		1.00
2. 00	CLI NI C	90.00	1, 34 <u>6, 3</u> 44 2, 896, 572	<u>298, 431</u> 618, 028		2.00
	H - EMPLOYEE BENEFITS					
1. 00 2. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00 0. 00	0	50, 219, 718 0		1. 00 2. 00
3.00		0. 00	0	0		3. 00
4. 00 5. 00		0. 00 0. 00	0	0		4. 00 5. 00
6. 00		0.00	0	0		6. 00
7. 00		0.00	0	0		7.00
8. 00 9. 00		0. 00 0. 00	0	0		8. 00 9. 00
10.00		0. 00	0	0		10. 00
11. 00 12. 00		0. 00 0. 00	0	0		11. 00 12. 00
13.00		0. 00	О	Ö		13. 00
14. 00 15. 00		0. 00 0. 00	0	0		14. 00 15. 00
16. 00		0.00	0	0		16.00
17. 00		0.00	O	0		17. 00
18. 00 19. 00		0. 00 0. 00	0	0		18. 00 19. 00
20.00		0. 00	О	Ö		20. 00
21. 00 22. 00		0. 00 0. 00	0	0		21. 00 22. 00
23. 00		0.00	0	0		23. 00
24.00		0. 00	О	0		24. 00
25. 00 26. 00		0. 00 0. 00	0	0		25. 00 26. 00
27.00		0. 00	О	0		27. 00
28. 00 29. 00		0. 00 0. 00	0	0		28. 00 29. 00
29. 00 30. 00		0.00	0	0		30.00
31.00		0. 00	О	0		31.00
32. 00 33. 00		0. 00 0. 00	0	0		32. 00 33. 00
34.00		0. 00	О	0		34.00
35. 00 36. 00		0. 00 0. 00	0	0		35. 00 36. 00
	ı	3. 30	9			1 20.00

In Lieu of Form CMS-2552-10

Health Financial Systems RECLASSIFICATIONS ST. FRANCIS HOSPITAL & HEALTH CENTER
Provider CCN: 15-0162

					3/30/2021 10:40 am
		Increases			
	Cost Center	Li ne #	Sal ary	0ther	
	2. 00	3.00	4. 00	5. 00	
37.00		0. 00	0	0	37.00
38.00		0.00	0	0	38.00
39.00		0. 00	0	0	39.00
40.00		0.00	O	0	40.00
41.00		0.00	O	0	41.00
42.00		0.00	O	0	42.00
43.00		0.00	O	0	43.00
			0	50, 219, 718	
	I - PHARMACY RESIDENCY				
1.00	PHARMACY PRGM	23. 01	142, 529	42, 970	1.00
			142, 529	42, 970	
	J - EMS & PARAMEDIC RECLASS				
1.00	PARAMEDIC PRGM	23. 03	667, 414	225, 213	1.00
2.00	EMERGENCY	91.00	79, 692	71, 649	2.00
			747, 106	296, 862	
	K - HOME HEALTH RECLASS				
1.00	OTHER NRCC	194. 04	29, 894	60, 306	1.00
			29, 894	60, 306	
	L - NURSERY				
1.00	NURSERY	43. 00	356, 588	107, 601	1.00
	TOTALS		356, 588	107, 601	
500.00	Grand Total: Increases		5, 573, 758	207, 828, 744	500.00
	'				'

Heal th	Financial Systems	ST. F	RANCIS HOSPIT	AL & HEALTH CE	ENTER	In Lieu of Form CM	IS-2552-10
RECLAS	SIFICATIONS			Provi der		Peri od: Worksheet A	A-6
						From 01/01/2020 Fo 12/31/2020 Date/Time F	Prepared:
						3/30/2021	
	Cost Center	Decreases Li ne #	Sal ary	Other	Wkst. A-7 Ref.		
	6.00	7. 00	8. 00	9. 00	10.00		
	A - MEDICAL SUPPLIES						
1. 00	ADMITTING	5. 01	0	487			1.00
2.00	OTHER ADMIN & GENERAL	5. 03	0	9, 659		•	2.00
3. 00 4. 00	OPERATION OF PLANT LAUNDRY & LINEN SERVICE	7. 00 8. 00	0	3, 878 4, 348		l .	3. 00 4. 00
5. 00	HOUSEKEEPI NG	9.00	0	53, 299		l .	5.00
6. 00	DI ETARY	10.00	Ö	67, 469		ł company of the comp	6.00
7. 00	CAFETERI A	11.00	0	676		l .	7. 00
8.00	NURSING ADMINISTRATION	13. 00	0	22, 242	2 0		8. 00
9.00	CENTRAL SERVICES & SUPPLY	14. 00	0	938, 259		•	9. 00
10.00	PHARMACY	15. 00	0	1, 192, 750		l .	10.00
11. 00	I &R SERVI CES-SALARY &	21. 00	0	27, 740	0		11.00
12. 00	FRINGES APPRV MEDICAL LABORATORY SCIENTIST	23. 00	0	200	o		12.00
12.00	PRGM	23.00	O	200			12.00
13.00	EMERGENCY MEDICAL SERVICES	23. 02	0	6, 652	2 0		13.00
14.00	ADULTS & PEDIATRICS	30.00	0	1, 617, 095	5 0		14.00
15.00	INTENSIVE CARE UNIT	31.00	0	842, 272	2 0		15.00
16. 00	NEONATAL INTENSIVE CARE UNIT	31. 01	0	254, 87		l .	16. 00
17. 00	CORONARY CARE UNIT	32.00	0	666, 706			17.00
18.00	SURGICAL INTENSIVE CARE UNIT	34.00	0	299, 180		l .	18.00
19. 00 20. 00	SUBPROVI DER - I RF NURSERY	41. 00 43. 00	0	66, 82´ 82, 156		l .	19. 00 20. 00
21. 00	OPERATING ROOM	50.00	0	36, 652, 76		l .	21.00
22. 00	DELIVERY ROOM & LABOR ROOM	52. 00	Ö	591, 836			22. 00
23. 00	RADI OLOGY-DI AGNOSTI C	54.00	0	2, 356, 604		l .	23. 00
24.00	RADI OI SOTOPE	56.00	0	25, 378	3 0		24. 00
25.00	CARDIAC CATHETERIZATION	59. 00	0	15, 132, 25 <i>6</i>		l .	25.00
26. 00	LABORATORY	60. 00	0	671, 319		l .	26. 00
27. 00	I NTRAVENOUS THERAPY	64. 00	0	812, 456		l .	27. 00
28. 00	RESPIRATORY THERAPY	65.00	0	1, 673, 029		1	28.00
29. 00 30. 00	PHYSI CAL THERAPY OCCUPATI ONAL THERAPY	66. 00 67. 00	0	45, 45° 39, 106		l .	29. 00 30. 00
31. 00	SPEECH PATHOLOGY	68. 00	0	17, 122		1	31.00
32. 00	ELECTROCARDI OLOGY	69.00	Ö	249, 175		l .	32.00
33. 00	ELECTROENCEPHALOGRAPHY	70. 00	0	70, 528		l .	33.00
34.00	RENAL DIALYSIS	74.00	0	26, 690			34.00
35.00	CARDIAC REHABILITATION	76. 97	0	2, 847		l .	35.00
36.00	CLINIC	90. 00	0	348, 997		l .	36.00
37.00	I BMT JOI NT VENTURE	90. 01	0	77, 472		ł czaraczania w przez pr	37.00
38. 00 39. 00	CV DIAGNOSTIC SERVICES EMERGENCY	90. 05 91. 00	0	276, 560 1, 003, 197		l .	38. 00 39. 00
37.00	0		— — <u> </u>	66, 229, 544			34.00
	B - DRUG	Į.	-		1		
1.00	OTHER ADMIN & GENERAL	5. 03	0	367	7 0		1.00
2.00	OPERATION OF PLANT	7. 00	0	53			2. 00
3. 00	CENTRAL SERVICES & SUPPLY	14. 00	0	1, 845			3.00
4. 00	PHARMACY	15.00	0	25, 444, 237		l .	4.00
5. 00	I &R SERVICES-SALARY & FRINGES APPRV	21. 00	0	233, 966	0		5. 00
6. 00	ADULTS & PEDIATRICS	30.00	0	25, 245	5 0		6.00
7. 00	INTENSIVE CARE UNIT	31.00	0	4, 536		l .	7. 00
8. 00	NEONATAL INTENSIVE CARE UNIT	31. 01	0		9 0	l .	8. 00
9. 00	CORONARY CARE UNIT	32. 00	0	8, 302		1	9. 00
10.00	SURGICAL INTENSIVE CARE UNIT	34.00	0	4, 427		l .	10.00
11.00	SUBPROVI DER - I RF	41.00	0	402		1	11.00
12. 00 13. 00	OPERATING ROOM DELIVERY ROOM & LABOR ROOM	50. 00 52. 00	0	148, 363 724		l .	12. 00 13. 00
14. 00	RADI OLOGY-DI AGNOSTI C	54.00	0	12, 639		l .	14.00
15. 00	RADI OI SOTOPE	56.00	Ö	343		l .	15.00
16.00	CARDI AC CATHETERI ZATI ON	59. 00	0	22, 042			16.00
17. 00	LABORATORY	60.00	0	62, 607		l .	17. 00
18.00	INTRAVENOUS THERAPY	64.00	0	38, 215, 523		•	18.00
19.00	RESPIRATORY THERAPY	65. 00	0	504, 966		l .	19.00
20.00	PHYSICAL THERAPY	66.00	0	264			20.00
21. 00 22. 00	OCCUPATIONAL THERAPY SPEECH PATHOLOGY	67. 00 68. 00	0	295 43 <i>6</i>		l .	21. 00 22. 00
23. 00	ELECTROCARDI OLOGY	69. 00	0	119		l .	23.00
24. 00	CARDI AC REHABI LI TATI ON	76. 97	n n	11.		l .	24.00
25. 00	RENAL DIALYSIS	74.00	0	9, 188		l .	25. 00
26.00	CLINIC	90. 00	0	2, 016	5 0	l .	26.00
27. 00	IBMT JOINT VENTURE	90. 01	0	1, 389		•	27. 00
28. 00	CV DIAGNOSTIC SERVICES	90.05	0	288		•	28.00
29. 00	EMERGENCY	91. 00	0	66, 858	3 0		29. 00

RECLASSI FI CATI ONS

Provider CCN: 15-0162

Peri od: From 01/01/2020 To 12/31/2020

Worksheet A-6
Date/Time Prepared:

3/30/2021 10:40 am Decreases Cost Center Sal ary 0ther Wkst. A-7 Ref. Line # 6.00 7.00 8.00 9.00 10.00 0 64, 771, 451 - EQUIPMENT LEASE 1.00 OPERATION OF PLANT 7. 00 0 720 10 1.00 2.00 DI FTARY 10.00 0 10.095 0 2.00 3.00 CENTRAL SERVICES & SUPPLY 14.00 0 92, 945 0 3.00 PHARMACY 0 0 4.00 15.00 378 4.00 o 5.00 I&R SERVICES-SALARY & 21.00 0 5.00 243 FRINGES APPRV 6.00 ADULTS & PEDIATRICS 30.00 0 31,660 0 6.00 311, 600 7.00 INTENSIVE CARE UNIT 31.00 0 7.00 8.00 CORONARY CARE UNIT 32.00 0 10,640 0 8.00 0 SURGICAL INTENSIVE CARE UNIT 6,099 0 9 00 34.00 9 00 0 10.00 OPERATING ROOM 50.00 0 688, 724 10.00 11.00 RADI OLOGY-DI AGNOSTI C 54.00 o 239 0 11.00 LABORATORY o 0 12.00 60.00 2.028 12.00 INTRAVENOUS THERAPY 64.00 0 13.00 8.866 13.00 14.00 RESPIRATORY THERAPY 65.00 0 191, 183 0 14.00 0 0 15.00 RENAL DIALYSIS 74.00 2, 181 15.00 0 3, 280 0 16, 00 ICLI NI C 90.00 16,00 CV DIAGNOSTIC SERVICES 17.00 90.05 449 0 17.00 o 1, 361, 330 D - DEPRECIATION CAP REL COSTS-MVBLE EQUIP 1.00 22, 221, 497 9 2.00 0 1.00 2.00 RADI OLOGY-DI AGNOSTI C 54.00 0 369 9 2.00 375, 399 3.00 LABORATORY 60.00 0 0 3.00 4.00 CV_DIAGNOSTIC_SERVICES 90.05 556 0 4.00 22, 597, 821 CAFETERI A 1.00 DI ETARY 10.00 1, 320, 042 1, 499, 795 0 1.00 1, 320, 042 1, 499, 795 PARAMEDI CAL ED 1.00 LABORATORY 60.00 81, 027 23, 318 0 1.00 81, 027 23, 318 G - INTERNS AND RESIDENT 1.00 I&R SERVICES-SALARY & 21.00 2, 896, 572 618, 028 0 1.00 FRINGES APPRV 2.00 0.00 0 2.00 2, 896, 572 618, 028 EMPLOYEE BENEFITS OTHER ADMIN & GENERAL 1.00 5. 03 545, 372 0 1.00 2.00 OPERATION OF PLANT 7.00 0 1.164.599 0 2.00 LAUNDRY & LINEN SERVICE 0 8.00 74.908 0 3 00 3 00 0 4.00 HOUSEKEEPI NG 9.00 0 1, 255, 902 4.00 5.00 DI ETARY 10.00 o 729, 582 0 5.00 o 223, 770 0 6.00 CAFETERLA 11.00 6.00 NURSING ADMINISTRATION 7.00 13.00 0 1, 240, 916 7.00 8.00 CENTRAL SERVICES & SUPPLY 14.00 0 213, 170 0 8.00 9.00 PHARMACY 15.00 o 2,050,173 0 9.00 I&R SERVICES-SALARY & 0 10.00 0 1, 530, 555 10.00 21.00 FRINGES APPRV MEDICAL LABORATORY SCIENTIST 11.00 23.00 0 143, 962 0 11.00 12.00 ADULTS & PEDIATRICS 30.00 0 8, 568, 088 0 12.00 INTENSIVE CARE UNIT 1, 941, 876 0 13 00 31.00 0 13 00 14.00 NEONATAL INTENSIVE CARE UNIT 31.01 0 1,013,681 0 14.00 CORONARY CARE UNIT 32.00 o 2, 624, 856 0 15.00 15.00 0 0 16.00 SURGICAL INTENSIVE CARE UNIT 34.00 1, 343, 435 16.00 SUBPROVIDER - IRF 41.00 871, 198 0 17 00 17 00 0 18.00 NURSERY 43.00 0 12, 703 18.00 OPERATING ROOM o 3, 484, 285 0 19.00 50.00 19.00 0 0 DELIVERY ROOM & LABOR ROOM 851, 085 20.00 52.00 20.00 RADI OLOGY-DI AGNOSTI C 54.00 2, 624, 554 21.00 21.00 22.00 RADI OLOGY-THERAPEUTI C 55.00 0 459, 171 0 22.00 0 23.00 RADI OI SOTOPE 56, 00 0 55.899 23.00 0 CARDIAC CATHETERIZATION 59 00 24.00 604, 643 24.00 0 25.00 LABORATORY 60.00 0 203, 631 25.00 o 0 26.00 INTRAVENOUS THERAPY 64.00 643, 590 26.00 0 27.00 RESPIRATORY THERAPY 65.00 0 1, 725, 142 27.00 28.00 PHYSI CAL THERAPY 66.00 0 1.497.974 28.00 29.00 OCCUPATIONAL THERAPY 67.00 0 559, 610 0 29.00 30.00 SPEECH PATHOLOGY 68.00 0 223, 699 0 30.00 0 0 ELECTROCARDI OLOGY 31.00 69.00 412, 110 31.00 ELECTROENCEPHALOGRAPHY 0 32.00 70.00 451, 781 32.00 33.00 RENAL DIALYSIS 74.00 18, 922 0 33.00

Health Financial Systems RECLASSIFICATIONS ST. FRANCIS HOSPITAL & HEALTH CENTER
Provider CCN: 15-0162 Period: Worksheet A-6 From 01/01/2020 To 12/31/2020 Date/Time Prepared: 3/30/2021 10:40 am

						3/30/2021 10:	<u>40 am</u>
		Decreases					
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
34.00	CARDIAC REHABILITATION	76. 97	0	95, 950	0		34.00
35.00	CLINIC	90.00	0	1, 265, 282	0		35.00
36.00	IBMT JOINT VENTURE	90. 01	0	482, 563	0		36.00
37.00	CV DIAGNOSTIC SERVICES	90. 05	0	1, 988, 151	0		37.00
38. 00	EMERGENCY	91. 00	0	2, 476, 605	0		38.00
39.00	HOSPI CE	116. 00	0	1, 743, 656	0		39.00
40. 00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190. 00	0	72, 582	0		40. 00
41.00	PHYSICIANS' PRIVATE OFFICES	192. 00	0	1, 951, 466	0		41.00
42.00	WOMEN'S CENTER	194. 01	0	2, 529	0		42.00
43.00	OTHER NRCC	194. 04	0	776, 092	0		43.00
	0			50, 219, 718			
	I - PHARMACY RESIDENCY						
1.00	PHARMACY	15. 00	142, 529	42, 970	0		1.00
	0		142, 529	42, 970			
	J - EMS & PARAMEDIC RECLASS						
1.00	EMERGENCY MEDICAL SERVICES	23. 02	747, 106	296, 862	0		1.00
2.00		0.00	0	0	0		2.00
	0	T	747, 106	296, 862			
	K - HOME HEALTH RECLASS						
1.00	HOME HEALTH AGENCY	101. 00	29, 894	60, 306	0		1.00
	0		29, 894	60, 306			
	L - NURSERY						
1.00	ADULTS & PEDIATRICS	30.00	356, 588	107, 601	0		1.00
	TOTALS		356, 588	107, 601			
500.00	Grand Total: Decreases		5, 573, 758	207, 828, 744			500.00

8.00

9.00

8.00

9.00

10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Subtotal (sum of lines 1-7)

Reconciling Items

10.00 Total (line 8 minus line 9)

Provider CCN: 15-0162

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

3/30/2021 10:40 am Acqui si ti ons Begi nni ng Disposals and Purchases Donati on Total Bal ances Retirements 2.00 3.00 4.00 5.00 1.00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 3, 236, 647 1.00 Land 19, 017, 757 3, 236, 647 0 34, 837, 862 0 2.00 Land Improvements 8, 349 8, 349 Ω 2.00 0 3.00 3.00 Buildings and Fixtures 245, 551, 581 1, 682, 217 0 1, 682, 217 0 4.00 Building Improvements 20, 263, 122 56, 216 56, 216 0 4.00 Fi xed Equi pment 278, 802, 400 2,095,995 0 2, 095, 995 5.00 0 5.00 6.00 Movable Equipment 185, 523, 687 10, 413, 051 0 10, 413, 051 0 6.00 0 7.00 HIT designated Assets 0 7.00 8.00 Subtotal (sum of lines 1-7) 783, 996, 409 17, 492, 475 0 17, 492, 475 0 8.00 9.00 Reconciling Items 0 0 9.00 783, 996, 409 Total (line 8 minus line 9) 17, 492, 475 17, 492, 475 10.00 10.00 0 0 Endi ng Ful I y Bal ance Depreciated Assets 6. 00 7.00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 22, 254, 404 1.00 5, 670, 453 2.00 Land Improvements 34, 846, 211 2.00 3.00 Buildings and Fixtures 247, 233, 798 24, 543, 991 3.00 4.00 Building Improvements 20, 319, 338 3, 359, 107 4.00 5.00 Fixed Equipment 280, 898, 395 30, 588, 373 5.00 6.00 Movable Equipment 195, 936, 738 91, 991, 425 6.00 HIT designated Assets 7.00 7.00

801, 488, 884

801, 488, 884

156, 153, 349

156, 153, 349

Health Financial Systems	ST. FRANCIS HOSPITAL 8	HEALTH CENTER	In Lie	u of Form CMS-2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider CCN: 15-0162	Peri od: From 01/01/2020	Worksheet A-7

To 12/31/2020 Part II
Date/Time Prepared: 3/30/2021 10: 40 am SUMMARY OF CAPITAL Insurance Cost Center Description Depreciation Lease Interest Taxes (see (see instructions) instructions) 9. 00 10.00 11.00 13.00 12.00 PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2
CAP REL COSTS-BLDG & FIXT
O
CAP REL COSTS-MVBLE EQUIP
35, 440, 978
0 0 1.00 0 1.00 0 2.00 0 2.00 35, 440, 978 0 3.00 Total (sum of lines 1-2) 0 3.00 SUMMARY OF CAPITAL Other Total (1) Capital-Relat (sum of cols Cost Center Description ed Costs (see 9 through 14) instructions) 14. 00 15. 00 PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2 1.00 CAP REL COSTS-BLDG & FIXT 1.00 2.00 CAP REL COSTS-MVBLE EQUIP 0 35, 440, 978 2.00 0 3.00 Total (sum of lines 1-2) 35, 440, 978 3.00

Health Financial Systems	ST. FRANCIS HOSPITAL 8	& HEALTH CENTER		In Lieu of Form CMS-2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider CCN: 15-0162	Peri od:	Worksheet A-7

Heal th	ı Financial Systems ST. F	FRANCIS HOSPITA	L & HEALTH CEN	ITER	In Lie	u of Form CMS-2	2552-10
RECONC	CILIATION OF CAPITAL COSTS CENTERS		Provi der Co		eri od:	Worksheet A-7	
				F	rom 01/01/2020		
				T	o 12/31/2020		
						3/30/2021 10:	40 am
		COME	PUTATION OF RAT	TI 0S	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tali zed	Gross Assets	Ratio (see	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	ENTERS					
1.00	CAP REL COSTS-BLDG & FLXT	605, 552, 145	0	605, 552, 145	0. 755526	0	1.00
2. 00	CAP REL COSTS-MVBLE EQUIP	195, 945, 738	l .	195, 945, 738			2. 00
3. 00	Total (sum of lines 1-2)	801, 497, 883		801, 497, 883			3. 00
	1.000. (00 0		TION OF OTHER (F CAPLTAL	0.00
		71220071		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	001111111111111111111111111111111111111	. 07.11	
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
			Capi tal -Rel at	cols. 5			
			ed Costs	through 7)			
		6, 00	7.00	8.00	9, 00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C						
1.00	CAP REL COSTS-BLDG & FLXT	0	0	C	22, 221, 497	0	1.00
2. 00	CAP REL COSTS-MVBLE EQUIP	0	0		13, 595, 805	1, 361, 330	2.00
3. 00	Total (sum of lines 1-2)	n n		ا ا	35, 817, 302		3. 00
3.00	Total (Sam of Trics 1 2)	0	U	JMMARY OF CAPIT		1, 301, 330	3.00
			30	DIVINIANCE OF CALL	IAL		
	Cost Center Description	Interest	Insurance	Taxes (see	Other	Total (2)	
	5051 5011101 50501 1 pt 1 011		(see	instructions)	Capi tal -Rel at		
			instructions)			9 through 14)	
			This tructrons)		instructions)	/ till odgil 14)	
		11. 00	12. 00	13.00	14. 00	15. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C		12.00	10.00	14.00	13.00	
1. 00	CAP REL COSTS-BLDG & FLXT	10, 935, 625	0		0	33, 157, 122	1. 00
2. 00	CAP REL COSTS-MUBLE EQUIP	10, 755, 025	0	1	_	14, 957, 135	2.00
3. 00	Total (sum of lines 1-2)	10, 935, 625	1	1	1	48, 114, 257	3. 00
3.00	Total (Suii 01 TITIES 1-2)	10, 935, 625	l 0	1	υ	48, 114, 257	3.00

Health Financial Systems
ADJUSTMENTS TO EXPENSES ST. FRANCIS HOSPITAL & HEALTH CENTER
Provider CCN: 15-0162 In Lieu of Form CMS-2552-10
Worksheet A-8 Peri od: From 01/01/2020

				Fr	rom 01/01/2020 12/31/2020		
				Expense Classification on		3/30/2021 10:	40 am
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
1. 00	Investment income - CAP REL	1. 00	2. 00	3.00 CAP REL COSTS-BLDG & FLXT	4. 00 1. 00	5. 00 0	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 (chapter 2)		0		0. 00	0	3. 00
4. 00	Trade, quantity, and time		0		0. 00	0	4. 00
5. 00	discounts (chapter 8) Refunds and rebates of		0		0. 00	0	5. 00
6. 00	expenses (chapter 8) Rental of provider space by		0		0. 00	0	6. 00
7. 00	suppliers (chapter 8) Telephone services (pay		0		0. 00	0	7. 00
7.00	stations excluded) (chapter		0		0.00	O	7.00
8. 00	21) Tel evi si on and radi o servi ce		0		0. 00	0	8. 00
9. 00	(chapter 21) Parking Lot (chapter 21)		0		0. 00	0	9. 00
10.00	Provi der-based physici an	A-8-2	-9, 016, 392		0.00	0	10.00
11. 00	adjustment Sale of scrap, waste, etc.		0		0. 00	0	11.00
12. 00	(chapter 23) Related organization	A-8-1	208, 150, 123			0	12. 00
13. 00	transactions (chapter 10) Laundry and linen service	-	0		0. 00	0	13. 00
14.00	Cafeteria-employees and guests		-1, 807, 270	CAFETERI A	11. 00	0	14.00
15. 00	Rental of quarters to employee and others		0		0.00	0	15. 00
16. 00	Sale of medical and surgical supplies to other than		0		0. 00	0	16. 00
17.00	patients		0		0.00		17.00
17. 00	Sale of drugs to other than patients		0		0. 00	0	17. 00
18. 00	Sale of medical records and abstracts		0		0. 00	0	18. 00
19. 00	Nursing and allied health education (tuition, fees,		0		0. 00	0	19. 00
	books, etc.)						
19. 01	Nursing and allied health education (tuition, fees,		0		0. 00	0	19. 01
20. 00	books, etc.) Vending machines	В	-46 169	CAFETERI A	11. 00	0	20. 00
21. 00	Income from imposition of		0	5711 2 1 211171	0. 00	0	21. 00
	interest, finance or penalty charges (chapter 21)						
22. 00	Interest expense on Medicare overpayments and borrowings to		0		0. 00	0	22. 00
23. 00	repay Medicare overpayments Adjustment for respiratory	A-8-3	0	RESPIRATORY THERAPY	65. 00		23. 00
23.00	therapy costs in excess of	A-0-3	0	RESITION ITEMAT	05.00		23.00
24. 00	limitation (chapter 14) Adjustment for physical	A-8-3	0	PHYSI CAL THERAPY	66. 00		24. 00
	therapy costs in excess of limitation (chapter 14)						
25. 00	Utilization review -		0	*** Cost Center Deleted ***	114. 00		25. 00
	physicians' compensation (chapter 21)						
26. 00	Depreciation - CAP REL COSTS-BLDG & FLXT		0	CAP REL COSTS-BLDG & FIXT	1. 00	0	26. 00
27. 00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	27. 00
28. 00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19. 00		28.00
29. 00 30. 00	Physicians' assistant Adjustment for occupational	A-8-3	0	OCCUPATI ONAL THERAPY	0. 00 67. 00	0	29. 00 30. 00
	therapy costs in excess of limitation (chapter 14)						
		'	•	, '	'	'	

0.00

33.32

50.00

Health Financial Systems ST. FRANCIS HOSPITAL & HEALTH CENTER In Lieu of Form CMS-2552-10 ADJUSTMENTS TO EXPENSES Provider CCN: 15-0162 Peri od: Worksheet A-8 From 01/01/2020 12/31/2020 Date/Time Prepared: 3/30/2021 10:40 am Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Basis/Code Cost Center Line # Wkst. A-7 Cost Center Description Amount Ref. (2) 1. 00 2.00 3.00 4.00 5. 00 30.99 Hospice (non-distinct) (see O ADULTS & PEDIATRICS 30.00 30.99 instructions) 31.00 Adjustment for speech OSPEECH PATHOLOGY 68.00 A - 8 - 331.00 pathology costs in excess of limitation (chapter 14) CAH HIT Adjustment for 32.00 0.00 32.00 Depreciation and Interest MI SCELLANEOUS I NCOME 33.00 -30, 757 OTHER ADMIN & GENERAL 5. 03 33.00 В 0 MISCELLANEOUS INCOME 33.01 В -280, 364 DI ETARY 10.00 O 33.01 MISCELLANEOUS INCOME -534, 107 OPERATION OF PLANT 7.00 33.02 33.02 В -659, 513 CENTRAL SERVICES & SUPPLY 33.03 MISCELLANEOUS INCOME В 14.00 33.03 MISCELLANEOUS INCOME -830, 032 PHARMACY 33.04 15.00 O 33 04 B 33.05 MISCELLANEOUS INCOME В -76, 433 I &R SERVI CES-SALARY & 21.00 33.05 FRINGES APPRV MISCELLANEOUS INCOME -42, 139 MEDI CAL LABORATORY SCIENTIST 33.06 В 23.00 33.06 PRGM MISCELLANEOUS INCOME -299, 746 EMERGENCY MEDICAL SERVICES 33.07 33.07 R 23.02 0 33.08 MISCELLANEOUS INCOME В -745, 133 OPERATING ROOM 50.00 33.08 MISCELLANEOUS INCOME -196, 156 RADI OLOGY-DI AGNOSTI C 33.09 В 54.00 33.09 MISCELLANEOUS INCOME -3, 220, 202 RADI OLOGY-THERAPEUTI C 55.00 ol 33.10 33 10 В -27, 150 CARDI AC CATHETERI ZATI ON MISCELLANEOUS INCOME 59.00 33.11 В 33.11 33. 12 MISCELLANEOUS INCOME В -70, 414 LABORATORY 60.00 33.12 33. 13 MISCELLANEOUS INCOME В -814, 077 I NTRAVENOUS THERAPY 64.00 33.13 MISCELLANEOUS INCOME -42, 505 RESPIRATORY THERAPY 65.00 33 14 33 14 В -236, 915 ELECTROENCEPHALOGRAPHY MISCELLANEOUS INCOME 33. 15 В 70.00 33.15 33.16 MISCELLANEOUS INCOME В -3, 950 CARDIAC REHABILITATION 76. 97 33.16 -67, 397 CLI NI C 33.17 MISCELLANEOUS INCOME В 90.00 33.17 -126, 186 CV DIAGNOSTIC SERVICES MISCELLANEOUS INCOME 90.05 33 18 O 33.18 B -4, 028 SPEECH PATHOLOGY 33. 19 MISCELLANEOUS INCOME В 68.00 33.19 MISCELLANEOUS INCOME -574, 080 PARAMEDIC PRGM 23. 03 33.20 33. 20 В MISCELLANEOUS INCOME -27, 000 EMERGENCY 91.00 o 33. 21 33, 21 В -4. 190 CV DI AGNOSTI C SERVI CES 33. 22 ADVERTI SI NG Α 90.05 33.22 33. 23 ADVERTI SI NG -102 OTHER ADMIN & GENERAL 5.03 33.23 Α ADVERTI SI NG -239 RESPI RATORY THERAPY 33.24 33 24 Α 65.00 NON-ALLOWABLE INTEREST -1, 145, 387 CAP REL COSTS-BLDG & FIXT 33. 25 11 33, 25 Α 1.00 33.26 PHYSICIAN RECRUITMET Α -38, 947 I &R SERVI CES-SALARY & 21.00 33.26 FRINGES APPRV NEUROLOGY TESTING EXPENSE -768 ELECTROENCEPHALOGRAPHY 70.00 0 33.27 ON CALL COVERAGE 33. 28 -33,000 OTHER ADMIN & GENERAL 0 33.28 Α 5.03 33. 29 HAF OFFSET -39, 055, 209 OTHER ADMIN & GENERAL 33, 29 Α 5.03 0 PENSION ADJ PER REGS 2142.5 5, 617, 853 EMPLOYEE BENEFITS DEPARTMENT 33.30 4.00 0 33.30 Α OTHER ADJUSTMENTS (SPECIFY) 33.31 Α 0.00 33.31

0

153, 712, 019

Α

TOTAL (sum of lines 1 thru 49)

OTHER ADJUSTMENTS (SPECIFY)

(Transfer to Worksheet A,

(3)

(3)

33.32

50.00

column 6, line 200.) (1) Description - all chapter references in this column pertain to CMS Pub. 15-1.

⁽²⁾ Basis for adjustment (see instructions)

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

B. Amount Received - if cost cannot be determined.

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME

Provider CCN: 15-0162

Worksheet A-8-1

Peri od: From 01/01/2020 OFFICE COSTS 12/31/2020 Date/Time Prepared:

					3/30/2021 10:	40 am_				
	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 ADJUST	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED O	RGANIZATIONS OF	R CLAIMED HOME					
	OFFICE COSTS:									
1.00	4. 00	EMPLOYEE BENEFITS DEPARTMENT	SHARED SERVICE ALLOCATION	14, 821, 734	0	1.00				
2.00	5. 03	OTHER ADMIN & GENERAL	SHARED SERVICE ALLOCATION	37, 664, 069	0	2.00				
3.00	7. 00	OPERATION OF PLANT	SHARED SERVICE ALLOCATION	5, 787, 343	0	3.00				
4.00	10.00	DI ETARY	SHARED SERVICE ALLOCATION	191	0	4.00				
4.01	13.00	NURSING ADMINISTRATION	SHARED SERVICE ALLOCATION	909, 628	0	4.01				
4.02	16.00	MEDICAL RECORDS & LIBRARY	SHARED SERVICE ALLOCATION	174, 487	0	4.02				
4.03	54.00	RADI OLOGY-DI AGNOSTI C	SHARED SERVICE ALLOCATION	1, 310, 220	0	4.03				
4.04	1.00	CAP REL COSTS-BLDG & FIXT	SHARED SERVICE ALLOCATION	208, 793	0	4.04				
4.05	194. 00	MARKETING & COMMUNITY RELATI	SHARED SERVICE ALLOCATION	37, 775	0	4.05				
4.06	194. 04	OTHER NRCC	SHARED SERVICE ALLOCATION	28, 526, 980	0	4.06				
4.07	194. 05	FOUNDATI ON	SHARED SERVICE ALLOCATION	1, 889	0	4.07				
4. 08	5. 03	OTHER ADMIN & GENERAL	FRANCISCAN HOME OFFICE	8, 995, 797	0	4.08				
4.09	1.00	CAP REL COSTS-BLDG & FIXT	FRANCISCAN HOME OFFICE	11, 872, 219	0	4.09				
4. 10	5. 03	OTHER ADMIN & GENERAL	FRANCISCAN HOME OFFICE	91, 707, 730	0	4. 10				
4. 11	5. 03	OTHER ADMIN & GENERAL	FRANCISCAN HOME OFFICE	4, 734, 986	0	4. 11				
4. 12	15. 00	PHARMACY	FRANCISCAN HOME OFFICE	1, 451, 390	0	4. 12				
4. 13	60.00	LABORATORY	SHARED SERVICE ALLOCATION	21, 372, 070	21, 427, 178	4. 13				
5.00	TOTALS (sum of lines 1-4).			229, 577, 301	21, 427, 178	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.

 been peeted to not kendet in condition and in an								
			Related Organization(s) and/	or Home Office				
6 (1)	Nicon		N	l D				
Symbol (1)	Name	Percentage of	Name	Percentage of				
		Ownershi p		Ownershi p				
1. 00	2. 00	3. 00	4. 00	5. 00				
 B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:								

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

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

6. 00	В	SISTERS	100.00		0. 00	6. 00	
7.00	В	APHL	100.00		0.00	7.00	
8.00			0.00		0.00	8. 00	
9.00			0.00		0. 00	9.00	
10.00			0.00		0.00	10.00	
100.00	G. Other (financial or					100.00	
	non-financial) specify:						

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

							3/30/2021 10:	40 am
	Net	Wkst. A-7 Ref.						
	Adjustments							
	(col. 4 minus							
	col. 5)*							
	6. 00	7. 00						
		RED AND ADJUSTME	ENTS REQUIRED AS A RES	ULT OF TRANSACTIONS	WITH RELATED	ORGANI ZATI ONS OR	CLAIMED HOME	
	OFFICE COSTS:							
1. 00	14, 821, 734							1.00
2.00	37, 664, 069							2.00
3.00	5, 787, 343	0						3. 00
4.00	191	0						4. 00
4. 01	909, 628							4. 01
4. 02	174, 487							4. 02
4.03	1, 310, 220							4. 03
4.04	208, 793							4. 04
4. 05	37, 775							4. 05
4. 06	28, 526, 980							4. 06
4. 07	1, 889							4. 07
4. 08	8, 995, 797							4. 08
4. 09	11, 872, 219							4. 09
4. 10	91, 707, 730							4. 10
4. 11	4, 734, 986							4. 11
4. 12	1, 451, 390							4. 12
4. 13	-55, 108							4. 13
5.00	208, 150, 123							5. 00

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

Related Organization(s) and/or Home Office		
Type of Business		
6. 00		
B. INTERRELATIONSHIP TO RELA	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	SHARED LAB		7.00
8.00			8.00
9.00			9.00
10.00		1	10.00
9. 00 10. 00 100. 00		10	00.00

- (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
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provi der

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT

Provi der CCN: 15-0162

							3/30/2021 10:	40 am
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component	
							Hours	
	1.00	2.00	3. 00	4. 00	5. 00	6. 00	7. 00	
1.00	5. 03	OTHER ADMIN & GENERAL	295, 142	258, 917	36, 225	211, 500	241	1.00
2.00	15. 00	PHARMACY	18, 693	4, 893	13, 800	211, 500	92	2.00
3.00	21. 00	I&R SERVICES-SALARY &	229, 921	229, 921	0	211, 500	0	3.00
		FRI NGES APPRV						
4.00	22. 00	I&R SERVICES-OTHER PRGM	1, 908, 176	0	1, 908, 176	211, 500	12, 683	4.00
		COSTS APPRV						
5.00	•	EMERGENCY MEDICAL SERVICES	20, 000				187	5.00
6.00		ADULTS & PEDIATRICS	14, 867			211, 500		6.00
7. 00	31.00	INTENSIVE CARE UNIT	41, 317	4, 117	37, 200	211, 500	248	7.00
8.00	31. 01	NEONATAL INTENSIVE CARE UNIT	338, 363	338, 363	0	211, 500	0	8.00
9.00	41.00	SUBPROVI DER - I RF	0	0	0	246, 400	0	9.00
10.00	50.00	OPERATING ROOM	3, 877, 851	3, 877, 851	0	271, 900	0	10.00
11. 00	54.00	RADI OLOGY-DI AGNOSTI C	974, 604	966, 604	8, 000	271, 900	192	11.00
12.00	59. 00	CARDIAC CATHETERIZATION	0	0	0	260, 300	0	12.00
13.00	60.00	LABORATORY	87, 300	-12, 225	99, 525	211, 500	664	13.00
14.00	64. 00	INTRAVENOUS THERAPY	244	244	0	211, 500	0	14.00
15.00	65. 00	RESPIRATORY THERAPY	20, 975	10, 925	10, 050	211, 500	67	15.00
16.00	66. 00	PHYSI CAL THERAPY	0	0	0	211, 500	0	16.00
17.00	69. 00	ELECTROCARDI OLOGY	159, 408	159, 408	0	211, 500	0	17.00
18.00	70.00	ELECTROENCEPHALOGRAPHY	31, 105	22, 745	8, 360	211, 500	44	18.00
19.00	74.00	RENAL DIALYSIS	0	0	0	211, 500	0	19.00
20.00	90.00	CLI NI C	1, 694, 277	1, 694, 277	O	211, 500	0	20.00
21.00	90. 01	IBMT JOINT VENTURE	137, 354	-65, 096	202, 450	211, 500	1, 363	21.00
22.00	90. 05	CV DIAGNOSTIC SERVICES	753, 588	753, 588	o	211, 500	0	22.00
23.00	91.00	EMERGENCY	51, 383	13, 383	38, 000	211, 500	349	23.00
200.00			10, 654, 568	8, 255, 149	2, 399, 419		16, 224	200.00

10.00

11.00

12.00

13.00

14.00

15.00

16.00

17.00

18.00

19.00

20.00

21.00 22.00

23.00

200.00

10.00

11.00

12.00

13.00

14.00

15.00

16.00

17.00

18.00

19.00

20.00

21.00

22.00

23.00

0 200.00

0

0

0

0

0

0

PROVIDER BASED PHYSICIAN ADJUSTMENT

54. 00 RADI OLOGY-DI AGNOSTI C

64. 00 I NTRAVENOUS THERAPY

65. 00 RESPIRATORY THERAPY

70. 00 ELECTROENCEPHALOGRAPHY

90. 05 CV DIAGNOSTIC SERVICES

66. 00 PHYSI CAL THERAPY

69. 00 ELECTROCARDI OLOGY

90. 01 BMT JOINT VENTURE

74.00 RENAL DIALYSIS

90. 00 CLI NI C

91. 00 EMERGENCY

60. 00 LABORATORY

59. 00 CARDI AC CATHETERI ZATI ON

Provider CCN: 15-0162

Λ

0

0

0

0

0

0

224

6, 930

1,774

82, 765

341

0

0

0 0 0

0 0 0

0

1, 255

3, 376

Peri od: Worksheet A-8-2 From 01/01/2020

0

0

0

0

0

0

0

0

12/31/2020 Date/Time Prepared: 3/30/2021 10:40 am Wkst. A Line # Cost Center/Physician Unadjusted RCE 5 Percent of Cost of Provi der Physician Cost I denti fi er Unadjusted RCE Memberships & of Mal practice Li mi t Component Conti nui ng Limit Share of col. Insurance Educati on 12 1. 00 8. 00 9. 00 13.00 14.00 2.00 12.00 1.00 5. 03 OTHER ADMIN & GENERAL 24, 505 1, 225 0 1.00 2.00 15. 00 PHARMACY 9, 355 0 0 0 2.00 468 3.00 21.00 I &R SERVICES-SALARY & 0 0 0 3.00 0 FRINGES APPRV 4.00 22.00 I &R SERVICES-OTHER PRGM 1, 289, 642 0 0 4.00 64, 482 0 COSTS APPRV 5.00 23. 02 EMERGENCY MEDICAL SERVICES 19,015 951 0 0 5.00 6.00 30. 00 ADULTS & PEDIATRICS 9, 558 0 0 6.00 478 0 31.00 INTENSIVE CARE UNIT 0 0 7.00 25, 217 1, 261 7.00 0 8.00 31. 01 NEONATAL INTENSIVE CARE UNIT 0 8.00 41. 00|SUBPROVIDER - IRF 0 0 9.00 ol 0 9.00 0 0 50. 00 OPERATING ROOM 0

25, 099

67, 517

6,813

4, 474

138, 593

35, 487

1, 655, 275

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT | Peri od: | Worksheet A-8-2 | From 01/01/2020 | To 12/31/2020 | Date/Time Prepared: Provi der CCN: 15-0162

						0 12/31/2020	3/30/2021 10:40 am
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment	
		l denti fi er	Component	Limit	Di sal I owance		
			Share of col.				
			14				
	1. 00	2. 00	15. 00	16. 00	17. 00	18. 00	
1.00		OTHER ADMIN & GENERAL	0	24, 505		270, 637	1.00
2.00		PHARMACY	0	9, 355	4, 445	·	2.00
3.00	21. 00	I &R SERVICES-SALARY &	0	(0	229, 921	3.00
		FRI NGES APPRV	_				
4.00		I &R SERVICES-OTHER PRGM	0	1, 289, 642	618, 534	618, 534	4.00
F 00		COSTS APPRV		10.01	2 005	005	F 00
5.00		EMERGENCY MEDICAL SERVICES	0	19, 015			5. 00
6.00	l .	ADULTS & PEDIATRICS	0	9, 558			6.00
7.00	1	INTENSIVE CARE UNIT	0	25, 217	11, 983		7.00
8. 00		NEONATAL INTENSIVE CARE UNIT	0	(0	338, 363	8.00
9.00	l .	SUBPROVI DER - I RF	0	(0	0 077 054	9.00
10.00	l .	OPERATING ROOM	0	05.000	0	3, 877, 851	10.00
11.00		RADI OLOGY-DI AGNOSTI C	0	25, 099	0	966, 604	11.00
12.00	1	CARDI AC CATHETERI ZATI ON	0	(7.54	0	10.700	12.00
13.00		LABORATORY	0	67, 517	32, 008	19, 783	13.00
14.00		I NTRAVENOUS THERAPY	0	(011	0	244	14.00
15.00		RESPIRATORY THERAPY	0	6, 813	3, 237	14, 162	15.00
16. 00 17. 00		PHYSI CAL THERAPY	0		0	150 400	16. 00 17. 00
17.00		ELECTROCARDI OLOGY ELECTROENCEPHALOGRAPHY	0	4 47	2 004	159, 408	17.00
19. 00		RENAL DI ALYSI S	0	4, 474	3, 886	26, 631	18.00
20.00		CLINIC	0			1, 694, 277	20.00
20.00		I BMT JOINT VENTURE	0	138, 593	63, 857	-1, 239	20.00
21.00		CV DIAGNOSTIC SERVICES	0	138, 593	03, 857	- 1, 239 753, 588	21.00
22.00	l .	EMERGENCY		35, 487	2, 513		22.00
200.00		LINERGENCT		1, 655, 275			200.00
200.00	1		l 0	1,000,270	701, 243	9,010,392	200.00

Provi der CCN: 15-0162

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

Not Expenses Cost Center Description Cost Cen				To	12/31/2020	Date/Time Pre 3/30/2021 10:	
SERRIAL SERVICE COST CEVTERS 1.00			CAPI TAL REI	LATED COSTS		37 307 2021 10.	40 diii
SERRIAL SERVICE COST CEVTERS 1.00	Overland Bernelotter	No. 1	DI DO A FLYT	MANDLE FOLLID	EMBLOVEE	ADMITTI NO	
Control Cont	Cost Center Description	•	BLDG & FIXI	MVBLE EQUIP		ADMITTING	
CENERAL SERVICE COST CENTERS 0							
Description Control					JEI / III CI III EI CI		
CARRIENT SERVICE COST CENTERS		`					
1.00 DOTION CAP REL COSIS-MEILS & LETY 13, 157, 122 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 957, 135 14, 95		0	1. 00	2. 00	4. 00	5. 01	
2.00		22 157 122	22 157 122		1		1 00
4.00 DOCORD PRIFF INTELT IS DEPARTWENT 70,699, 305 30,000 20,525 10 10 10 10 10 10 10 1				1			
5.00					70, 659, 305		
5.03 00590 OTHER ANNIN IN SCHEIGHAL 143, 240, 271 72, 184 32, 56.2 736, 50.0 0 5.0 5.0 17.0 00760 OPERATION OF PLANT 19, 068, 972 37.12, 339 1, 074, 631 1, 516, 769 0 7.0 00500 OPERATION OF PLANT 19, 068, 972 37.12, 339 1, 074, 631 1, 516, 516 0 10, 147 0 8.0 0 10, 00500 OPERATION OF PLANT 19, 068, 972 37.12, 339 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1, 128, 983 1,				62, 932		206, 251	
0.00000 ORDINO OPERATION OF PLANT	5. 02 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	0	41, 856	18, 881	o	0	5. 02
0.00 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.00000000							
9.00 0.0900 MUSINSEEPING 6.676, 717 249, 067 112, 354 1,649,575 0 9,00 0.00 110.00 0.000 0.100 CAFETERIA 2,552,590 495,232 223,399 332,788 0 11.00 11.00 0.100 CAFETERIA 1.800,000 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800 1.800							
10.00 01000 DETARY							
11.00 0100 CAPETERIA 2,532,000 405,222 223,300 832,788 0 11.00 13.00 1300 UNISSIN CARMINISTRATION 5,381,705 0 1.737,305 513,077 280.467 0 14.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00							
13.00 01300 JURES INC. ADMINISTRATION 5, 381,705 0 0 1,788,800 0 13.00							
14.00 01400 CENTRAL SERVICES & SUPPLY 1, 448, 369 1, 137, 395 513, 077 280, 467 0 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16							
10.00			1, 137, 395	513, 077		0	
21.00 02000 IAR SERVICES-SALARY & FRINCES APPRV 1,800,832 34,472 15,850 911,776 0 21.00 0200 IAR SERVICES-SALARY & FRINCES APPRV 1,251,291 0 0 0 640,026 0 22.00 0200 0300 MEDICAL LABORATORY SCIENTIST PROM 38,332 0 0 0 102,913 0 23.00 023.01 02300 PRAMACY PROEM 1,251,291 0 0 0 102,913 0 23.00 023.01 02300 02301 IMPROVED 1,251,291 0 0 0 102,913 0 23.00 023.01 02300 02301 IMPROVED 1,251,291 0 0 0 0 102,913 0 23.00 023.01 02300 02301 02300 02301 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300 02300	15. 00 01500 PHARMACY	7, 598, 019	440, 981	198, 926	2, 751, 238	0	15.00
22.00 02200 BIT SERVICES-OTHER PROM COSTS APPRV 1,251,291 0 0 640,626 0 22.00 0230 0230 BIT SERVICES 72,332 0 0 0 69,305 0 23.01 0230 PHARMACY PROM 699,014 0 0 0 216,726 0 23.01 0230 23.01 0230 PHARMACY PROM 699,014 0 0 0 216,726 0 23.01 0230 23.01 0230 PHARMACY PROM 699,014 0 0 0 275,806 0 23.01 0230 PHARMACY PROM 699,014 0 0 0 0 275,806 0 23.03 0230 PHARMACY PROM 699,014 0 0 0 0 0 0 0 0 0			0	_	0		
23.00 03200 MEDICAL LABORATORY SCIENTIST PRGM 38, 332 0 0 069, 305 029.00 23.01 23.02 03201 EMERGENCY MEDICAL SERVICES 72, 332 0 0 0 100, 913 0 23.02 23.03 20330 PARMAPOLE O PRGM 318, 547 0 0 0 275, 806 0 23.03 23.03 20330 PARMAPOLE O PRGM 318, 547 0 0 0 275, 806 0 23.03 23.03 20330 PARMAPOLE O PRGM 318, 547 0 0 0 0 275, 806 0 23.03 23.03 0 0 0 0 0 0 0 0 0			34, 472			-	
33.00 03300 PHARMACY PROM 699, O14 0 0 210, 2796 0 23.01 23.02 23.01 PHARMACY PROM 23.01 23.02 23.03 PARAMEDIC PROM 23.02 24.03 PARAMEDIC PROM 23.02 24.03 PARAMEDIC PROM 23.02 24.03 PARAMEDIC PROM 23.02 24.03 PARAMEDIC PROM 24.02 24.02 24.02 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03 24.03		1 ' '	0	_			
23.02 02301 BERERKINY WEDICAL SERVICES 72.332 0 0 102,913 0 23.03 23.03 20303 PARAMEDIC PROM 318,547 0 0 0 275,806 0 23.03 10 2000 ADULTS & PEDIDIATICS 32.729,643 7,042,622 3,176,916 12,346,819 22,721 30.00 31.00 ADULTS & PEDIDIATICS 7,119,618 792,258 357,387 2,19,283 5,174 31.00 31.01 02600 ROMONATAL INTERSIVE CARE UNIT 7,119,618 792,258 357,387 2,19,283 5,174 31.00 32.00 03200 CORDINARY CARE UNIT 9,057,307 1,725,721 778,471 3,640,924 4,955 32.00 32.00 CORDINARY CARE UNIT 9,057,307 1,725,721 778,471 3,640,924 4,955 32.00 34.00 03400 SUBRICAL INTERSIVE CARE UNIT 9,057,307 1,725,721 778,471 3,640,924 4,955 32.00 30.00 43000 MINEREY 3,034,010 643,934 290,478 1,510,245 2,193 41.00 31.00 43000 MINEREY 3,034,010 43000 MINEREY 4,000 MINEREY 505,061 136,118 61,403 158,146 596 43.00 43000 MINEREY 70000 REAL MEDIDIC REAL			0	1			
23. 02 02303 PARAMEDIC PROM 0 0 0 275, 806 0 22. 03		1	0				
INPATI ENT ROUTI NE SERVICE COST CENTERS 32, 729, 643 7, 042, 622 3, 176, 916 12, 346, 819 22, 721 30, 00 30, 00 30100 ADULTS & PEDIATRICS 32, 729, 643 7, 042, 622 3, 176, 916 12, 346, 819 22, 721 31, 00 31, 00 1NTENSI VE CARE UNIT 7, 119, 618 792, 258 357, 387 2, 719, 283 5, 174 31, 00 32, 00 03200 COROMARY CARE UNIT 9, 057, 307 1, 725, 721 778, 471 3, 640, 924 4, 955 32, 00 32, 00 03200 COROMARY CARE UNIT 9, 057, 307 1, 725, 721 778, 471 3, 640, 924 4, 955 32, 00 32, 00 03200 SURGICAL INTERSIVE CARE UNIT 4, 704, 529 975, 907 404, 271 1, 880, 261 3, 884 34, 00 41, 00 3400 SURGICAL INTERSIVE CARE UNIT 4, 704, 529 975, 907 404, 271 1, 880, 261 3, 884 34, 00 41, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00 410, 00							
13.1 00 03100 INTERSIVE CARE UNIT							
31.00 02060 NEONATAL INTENSIVE CARE UNIT 4, 259, 500 536, 109 241, 838 1, 403, 266 4, 394 31.00 3200 03200 O2000ARP CARE UNIT 9, 057, 307 1, 725, 721 778, 471 3, 460, 924 4, 955 32.00 34.00 03400 SURRICI CAL INTENSIVE CARE UNIT 9, 057, 307 1, 725, 721 7, 784, 771 3, 460, 924 4, 955 32.00 34.00 03400 SURRICI CAL INTENSIVE CARE UNIT 9, 057, 307 136, 118 61, 403 158, 148 956 43.00 43.00 04300 NURSERY 505, 061 136, 118 61, 403 158, 148 956 43.00 43.00 04300 NURSERY 505, 061 136, 118 61, 403 158, 148 956 43.00 43.00 43.00 04300 NURSERY 505, 061 136, 118 61, 403 158, 148 956 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00 43.00						· ·	
32.00 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 03200 0320							
34.00 03400 SURRICAL INTENSIVE CARE UNIT 4, 704, 529 975, 997 440, 271 1, 880, 261 3, 884 34.00 41.00 04300 SUBPROVID ERP 1 18 505, 061 136, 118 61, 403 188, 148 950 43.00 A3.00 O300 NURSERY SOST CENTERS SOST						· ·	
141 00 04100 SUBPROVI DER - 1 IRF 3, 034, 010 643, 934 290, 478 1, 210, 245 2, 193 41, 004 33, 004 330 04300 NURSERY 505, 061 136, 118 136, 118 956 43, 00 300 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000 000	• • • • • • • • • • • • • • • • • • •						
A3. OD OBSOON OBSTRICT COST CENTERS S05.061 136, 118 61, 03 158, 148 956 43. OD							
ANCILLARY SERVICE COST CENTERS S							
S2.00 05200 DELI VERY ROOM & LABOR ROOM 2.816, 692 978, 522 441, 410 1, 146, 299 6, 524 52.00					,		
54.00 05400 RADIO LOGY-DIAGNOSTIC 12,955,151 2,359,257 1,064,288 3,577,045 12,616 54.00 55.00 05500 03500 RADIO LOGY-THERAPEUTIC 6,765,744 1.65,203 74,523 604,227 439 55.00 55.00 05500 RADIO I SOTOPE 967,932 31,948 14,412 83,443 290 56.00 59.00 05900 CARDIO I SOTOPE 2,239,557 915,718 413,079 844,079 8.634 59.00 60.00 05000 LABORATORY 25,838,594 972,230 438,572 234,068 19,787 60.00 60.00 05000 LABORATORY 187APY 2,418,356 335,045 160,160 1,51,578 556 64.00 60.00 05000 RESPIRATORY 187APY 5,308,255 416,078 187,692 1,825,700 2,892 66.00 60.00 06000 RESPIRATORY 187APY 2,303,143 0 0 0 79,706 2,110 67.00 60.00 06000 RESPIRATORY 187APY 2,303,143 0 0 0 79,706 2,110 67.00 60.00 06000 RESPIRATORY 187APY 2,3384 33,293 313,709 938 68.00 60.00 06900 SPEECH PATHOLOGY 972,113 73,804 33,293 313,709 938 68.00 60.00 06900 SPEECH PATHOLOGY 972,113 73,804 33,293 313,709 938 68.00 60.00 06900 ELECTROCARDIO LOGRAPHY 1,400,638 518,477 233,884 565,844 3,679 69.00 71.00 07000 ELECTROCARDIO LOGRAPHY 1,400,638 518,477 233,884 565,844 3,679 69.00 71.00 07000 ELECTROCARDIO LOGRAPHY 1,400,638 518,477 0 0 0 0 0 2,2,694 71.00 70.00 07000 ELECTROCARDIO LOGRAPHY 37,364 117,451 0 0 0 0 0 0 2,2,694 71.00 70.00 07000 IBML DEV. CHARGED TO PATIENTS 64,771,451 0 0 0 0 0 0 0 25,977 73.00 70.00 07000 IBML DEV. CHARGED TO PATIENTS 4,550,040 704,665 317,874 2,317,522 98 90.00 70.00 07000 IBML JOINT VENTURE 6,975,028 90.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0							
55.00							
56.00 05600 RADIA CATHETER IZATION 2,239,577 915,718 413,079 844,079 8,634 59,00 0500 06000 CARDIA CATHETER IZATION 2,239,577 915,718 413,079 844,079 8,634 69,00 06000 06000 LABORATORY 25,383,594 972,230 438,572 234,068 19,787 60.00 06000 06000 06000 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,878 07,87							
59.00 05900 CARDIAC CATHETERIZATION 2,239,557 915,718 413,079 844,079 8,634 59,00 06000 LABORATORY 25,383,594 972,230 438,572 234,068 19,787 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00 60.00							
60.00 06000 LABORATORY 25, 383, 594 972, 230 438, 572 234, 068 19, 787 60.00 64.00 06400 INTRAVENDUS THERAPY 2, 418, 356 355, 045 160, 160 1, 051, 578 556 64.00 65.00 06500 RESPIRATORY THERAPY 6, 507, 853 317, 634 143, 284 2, 385, 751 7, 541 65.00 66.00 06600 PHYSI CAL THERAPY 5, 308, 255 416, 078 187, 692 1, 825, 700 2, 892 66.00 67.00 06700 0CCUPATIONAL THERAPY 2, 030, 143 0 0 0 799, 706 2, 110 67.00 68.00 06800 SPEECH PATHOLOGY 972, 113 73, 804 33, 293 313, 709 938 68.00 69.00 06900 ELECTROCARDIOLOGY 1, 400, 638 518, 477 233, 884 555, 844 3, 679 69. 00 69.00 06900 ELECTROCEPHALOGRAPHY 1, 895, 031 0 0 619, 737 6697 70.00 710.00 07000 ELECTROCEPHALOGRAPHY 1, 895, 031 0 0 0 0 0 22, 694 71.00 72.00 07200 IMPL DEV CHARGED TO PATIENTS 28, 863, 596 0 0 0 0 0 22, 694 71.00 73.00 07300 DRUGS CHARGED TO PATIENTS 64, 771, 451 0 0 0 0 0 25, 917 73.00 74.00 07400 RENAL DIALYSIS 968, 405 151, 037 68, 133 15, 637 1, 169 74.00 76.97 0797 CARDIA CREHABILITATION 387, 803 0 0 0 131, 452 28 7697 79.00 09000 CLINIC C 4, 550, 040 799, 080 40, 635 654, 541 73 90.01 79.00 09000 ELECTROCERCY S 9, 331, 452 0 0 0 3, 002, 765 46 90.05 79.00 09000 ELECTROCERCY S 9, 331, 452 0 0 0 0 0 0 79.00 09000 ELECTROCERCY S 9, 331, 452 0 0 0 0 0 0 79.00 09000 ELECTROCERCY S 9, 331, 452 0 0 0 0 0 0 79.00 09000 ELECTROCERCY S 9, 331, 452 0 0 0 0 0 0 79.00 09000 ELECTROCERCY S 0 0 0 0 0 0 0 79.00 09000 ELECTROCERCY S 0 0 0 0 0 0 0 79.00 09000 ELECTROCERCY S 0 0 0 0 0 0 0 0 79.00 09000 09000 09000 09000 09000 09000 09000 09000 09000 09000 09000 09000 09000 09000 09000 09000 09000 09000 09000							
64.00 06400 INTRAVENOUS THERAPY 2, 418, 356 355, 045 160, 160 1, 051, 578 556 64, 00 65.00 06500 RESPIRATORY THERAPY 6, 507, 853 317, 634 143, 284 2, 385, 751 7, 541 65. 00 66.00 06600 PHYSI CAL THERAPY 5, 308, 255 416, 078 187, 692 1, 825, 700 2, 892 66. 00 67.00 06700 0CCUPATI ONAL THERAPY 2, 030, 143 0 0 799, 706 2, 110 67. 00 68.00 06600 SPEECH PATHOLOGY 972, 113 73, 804 33, 293 313, 709 938 68. 00 69.00 06900 ELECTROCARDI OLOGY 1, 400, 638 518, 477 233, 884 565, 844 3, 679 69. 00 70.00 07000 ELECTROCARDI OLOGY 1, 895, 031 0 0 0 0 0 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 37, 364, 117 0 0 0 0 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 28, 863, 696 0 0 0 0 0 73.00 07300 DRUGS CHARGED TO PATIENTS 28, 863, 696 0 0 0 0 0 74.00 07400 RENAL DI ALYSI S 968, 405 151, 037 68, 133 15, 637 1, 169 74. 00 76.97 07697 CARDIA CR EHABELL TATION 387, 803 0 0 0 131, 452 28 76. 97 79.00 07000 IMPL JOINT VENTURE 6, 975, 028 90, 080 40, 635 654, 541 73 90. 01 79.00 07000 BESERVATION BEDS (NON-DISTINCT PART 7, 918, 351 1, 813, 578 818, 103 3, 097, 810 11, 662 91. 00 70.00 07000 DRESCENCY 0 0 0 0 0 0 70.00 07000 DRESCENCY 0 0 0 0 0 70.00 07000 07000 07000 07000 70.00 07000 07000 07000 07000 07000 70.00 07000 07000 07000 07000 07000 70.00 07000 07000 07000 07000 07000 70.00 07000 07000 07000 07000 07000 70.00 07000 07000 07000 07000 07000 07000 07000 70.00 07000 07000 07000 07000 07000 07000 07000 70.00 07000 07000 07000 07000 07000 07000 07000 70.00 07000 07000 07000 07000 07000 07000 07000 70.00 07000 07000 07000 07000 07000 07000 07000 70.00 07000 07000 07000 07000 07000 07000 07000		1 ' '					
66.00 06600 PHYSICAL THERAPY 5, 308, 255 416, 078 187, 692 1, 825, 700 2, 892 66. 00 67.00 06700 0CCUPATI ONAL THERAPY 2, 030, 143 0 0 799, 706 2, 110 67. 00 68.00 06800 SPEECH PATHOLOGY 972, 113 73, 804 33, 293 313, 709 938 68. 00 69.00 06900 ELECTROCARDI OLOGY 1, 400, 638 518, 477 233, 884 565, 844 3, 679 69. 00 69.00 07000 ELECTROCARDI OLOGY 1, 895, 031 0 0 0 619, 737 697 70. 00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 37, 364, 117 0 0 0 0 0 22, 694 71. 00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 28, 863, 696 0 0 0 0 0 22, 944 72. 00 73.00 07300 DRUGS CHARGED TO PATIENTS 28, 863, 696 0 0 0 0 0 25, 917 73. 00 74.00 07400 RENAL DI ALYSI S 968, 405 151, 037 68, 133 15, 637 1, 169 74.00 07400 RENAL DI ALYSI S 968, 405 151, 037 68, 133 15, 637 1, 169 74. 00 76.97 07697 CARDI AC REHABI LI TATI ON 387, 803 0 0 131, 452 28 76. 97 79.00 07900 CLI NI C 4, 550, 040 704, 665 317, 874 2, 317, 522 98 90. 00 79.01 09001 IBMT JOI INT VENTURE 6, 975, 028 90, 80 40, 635 654, 541 73 90. 01 79.05 09005 CV DI AGNOSTI C SERVI CES 9, 331, 452 0 0 3, 002, 765 46 90. 05 79.00 09200 DEBROENCY 7, 918, 351 1, 813, 578 818, 103 3, 097, 810 11, 662 91. 00 79.01 09001 BMT JOI NT VENTURE 7, 299, 363 0 0 2, 394, 910 0 116. 00 70 09000 09000 00000 00000 00000 00000 000000	64.00 06400 INTRAVENOUS THERAPY						64.00
67. 00 06700 OCCUPATI ONAL THERAPY 2, 030, 143 0 0 799, 706 2, 110 67. 00 68. 00 06800 SPEECH PATHOLOGY 972, 113 73, 804 33, 293 313, 709 938 68. 00 69. 00 06900 ELECTROCARDI OLOGY 1, 400, 638 518, 477 233, 884 565, 844 3, 679 69. 00 70. 00 07000 ELECTROENCEPHALOGRAPHY 1, 895, 031 0 0 0 619, 737 697 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 37, 364, 117 0 0 0 0 0 0 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 28, 863, 696 0 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATI ENTS 28, 863, 696 0 0 0 0 0 74. 00 07400 RENAL DI ALYSIS 968, 405 151, 037 68, 133 15, 637 1, 169 74. 00 76. 97 07697 CARDI AC REHABI LI TATI ON 387, 803 0 0 131, 452 28 76. 97 79. 00 09000 CLI NI C 4, 550, 040 704, 665 317, 874 2, 317, 522 98 90. 00 790. 01 09000 EMERGENCY 7, 918, 351 1, 813, 578 818, 103 3, 097, 810 11, 662 91. 00 792. 00 09200 OSSERVATI ON BEDS (NON-DI STI NCT PART 11, 813, 578 818, 103 3, 097, 810 11, 662 91. 00 718. 00 OSSERVATI ON BEDS (NON-DI STI NCT PART 1130 11300 INTEREST EXPENSE 1130 11300 INTEREST EXPENSE 1130 11300 INTEREST EXPENSE 1130 11300 INTEREST EXPENSE 1130 0 11400 1000 1000 101, 474 0 0 0 0 0 0 0 790. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 422, 359 77, 259 104, 983 0 190. 00 194, 00 194, 00 07955 07164 NOREH BIBURSABLE COST CENTERS 186, 069 93, 094 41, 995 39, 929 0 194, 00 194, 00 07950 07164 NOREH BIBURSABLE COST CENTERS 186, 069 93, 094 41, 995 39, 929 0 194, 00 194, 00 07950 07164 NOREH BIBURSABLE COST CENTERS 186, 069 93, 094 41, 995 39, 929 0 194, 00 194, 00 07950 07164 NOREH BIBURSABLE COST CENTERS 186, 069 93, 094 41, 995 39, 929 0 194, 00 07164, 00 07164, 00 07164, 00 0 0 0 0 0 0 0 0 0		6, 507, 853	317, 634			7, 541	
68.00 06800 SPEECH PATHOLOGY 972, 113 73, 804 33, 293 313, 709 938 68.00 69.00 06900 ELECTROCARDIOLOGY 1, 400, 638 518, 477 233, 884 565, 844 3, 679 69.00 70.00 07000 ELECTROCARDIOLOGY 1, 895, 031 0 0 0 619, 737 697 70.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 37, 364, 117 0 0 0 0 0 0 0 22, 694 71.00 72.00 07200 MEDI CAL SUPPLIES CHARGED TO PATIENT 37, 364, 117 0 0 0 0 0 0 0 22, 694 71.00 72.00 07200 MEDI CAL SUPPLIES CHARGED TO PATIENTS 28, 863, 696 0 0 0 0 0 0 12, 244 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 64, 771, 451 0 0 0 0 0 0 0 25, 917 73.00 73.00 07400 RENAL DI ALYSIS 968, 405 151, 037 68, 133 15, 637 1, 169 74.00 7697 CARDI AC REHABILITATION 387, 803 0 0 131, 452 28 76.97 0000 0000 0000 0 0 0 0							
69.00 06900 ELECTROCARDI OLOGY 1, 400, 638 518, 477 233, 884 565, 844 3, 679 69. 00 70.00 07000 ELECTROENCEPHALOGRAPHY 1, 895, 031 0 0 0 619, 737 697 70. 00 70.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 37, 364, 117 0 0 0 0 0 72.00 07200 IMPL DEV. CHARGED TO PATIENTS 28, 863, 696 0 0 0 0 0 73.00 07300 DRUGS CHARGED TO PATIENTS 64, 771, 451 0 0 0 0 74.00 07400 RENAL DI ALYSI S 968, 405 151, 037 68, 133 15, 637 1, 169 74, 00 76.97 07697 CARDI AC REHABI LI TATI ON 387, 803 0 0 131, 452 28 76. 97 90.00 09000 CLI IN C 4, 550, 040 704, 665 317, 874 2, 317, 522 98 90. 00 90.01 09001 IBMT JOI NT VENTURE 6, 975, 028 90, 080 40, 635 654, 541 73 90. 01 90.05 09005 CV DI AGNOSTI C SERVI CES 9, 331, 452 0 0 3, 002, 765 46 90. 05 91.00 09100 EMERGENCY 7, 918, 351 1, 813, 578 818, 103 3, 097, 810 11, 662 91. 00 92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART OTHER REI MBURSABLE COST CENTERS 113.00 11000 HOME HEALTH AGENCY 0 0 0 0 0 0 0 110.00 THER REI MEBURSABLE COST CENTERS 113.00 11000 HOME HEALTH AGENCY 0 0 0 0 0 0 0 110.00 1000 HOME SABLE COST CENTERS 113.00 1000 HOME SABLE COST CENTERS 14, 590, 078 66, 227, 410 206, 251 18. 00 190.00 19000 1910 1010 HOME RECOFFEE SHOP & CANTEEN 422, 359 171, 269 77, 259 104, 983 0 192. 00 194.00 19500 MARKETI NG & COMMUNI TY RELATIONS 101, 474 0 0 24, 202 0 194. 01 194.00 07952 WOMEN'S CENTER 186, 069 93, 094 41, 995 39, 929 0 194. 01 194.00 07952 WOMEN'S CENTERS 180, 069 93, 094 41, 995 39, 929 0 194. 01 194.00 07952 WOMEN'S CENTERS 0 0 0 0 0 0 0 0 0							
70. 00 07000 ELECTROENCEPHALOGRAPHY 1, 895, 031 0 0 619, 737 697 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 28, 863, 866 0 0 0 0 0 22, 694 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 28, 863, 866 0 0 0 0 0 22, 694 71. 00 72. 00 07300 DRUGS CHARGED TO PATI ENTS 28, 863, 866 0 0 0 0 0 25, 917 73. 00 74. 00 07400 RENAL DI ALYSIS 968, 405 151, 037 68, 133 15, 637 1, 169 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 0							
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 37, 364, 117 0 0 0 0 0 22, 694 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 28, 863, 696 0 0 0 0 12, 244 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 64, 771, 451 0 0 0 0 0 25, 917 73. 00 74. 00 07400 RENAL DIALYSIS 968, 405 151, 037 68, 133 15, 637 1, 169 74. 00 76. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97			518,477				
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 28, 863, 696 0 0 0 0 12, 244 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 64, 771, 451 0 0 0 0 25, 917 73. 00 74. 00 74. 00 07400 RENAL DI ALYSIS 968, 405 151, 037 68, 133 15, 637 1, 169 74. 00 74. 00 74. 00 07400 RENAL DI ALYSIS 968, 405 151, 037 68, 133 15, 637 1, 169 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 0			0		017, 737		
73. 00 07300 DRUGS CHARGED TO PATIENTS 64, 771, 451 0 0 0 0 25, 917 73. 00 74. 00 07400 RENAL DI ALYSIS 968, 405 151, 037 68, 133 15, 637 1, 169 74. 00 76. 97 07697 CARDI AC REHABI LI TATI ON 387, 803 0 0 0 131, 452 28 76. 97 90. 00 09000 CLI NI C 4, 550, 040 704, 665 317, 874 2, 317, 522 98 90. 00 90. 01 09001 I BMT JOI NT VENTURE 6, 975, 028 90, 080 40, 635 654, 541 73 90. 01 90. 05 09005 CV DI AGNOSTI C SERVI CES 9, 331, 452 0 0 3, 002, 765 46 90. 05 91. 00 09100 EMERGENCY 7, 918, 351 1, 813, 578 818, 103 3, 097, 810 11, 662 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 0 0 0 0 0 101. 00 TOTHER REI MBURSABLE COST CENTERS 113. 00 1300 1 NTEREST EXPENSE 113. 00 1300 1 NTEREST EXPENSE 116. 00 1000 HOME HEALTH AGENCY 0 0 0 0 0 0 116. 00 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 626, 428, 633 32, 343, 426 14, 590, 078 66, 227, 410 206, 251 18. 00 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 422, 359 171, 269 77, 259 104, 983 0 190. 00 194. 00 07955 MARKETI NG & COMMUNITY RELATIONS 101, 474 0 0 24, 202 0 194. 01 194. 01 07952 WOMEN' S CENTER MONTE IMBURSABLE COST CENTERS 186, 069 93, 094 41, 995 39, 929 0 194. 01 194. 02 07950 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 0 0 0 194. 02 07950 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 0 0 0 0 0 194. 02 07950 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 0 0 0 0 0			Ö	Ö	o		
76. 97 O7697 CARDI AC REHABILITATION 387, 803 0 0 131, 452 28 76. 97 OUTPATI ENT SERVICE COST CENTERS 90. 00 O9000 CLI NI C 4, 550, 040 704, 665 317, 874 2, 317, 522 98 90. 00 090. 01 09001 I BMT JOI NT VENTURE 6, 975, 028 90. 080 40, 635 654, 541 73 90. 01 90. 05 09005 CV DI AGNOSTIC SERVICES 9, 331, 452 0 0 3, 002, 765 46 90. 05 91. 00 09100 EMERGENCY 7, 918, 351 1, 813, 578 818, 103 3, 097, 810 11, 662 91. 00 09200 [OSSERVATION BEDS (NON-DISTINCT PART 92. 00 09200 [OSSERVATION BEDS (NON-DISTINCT PART 92. 00 10100 [HOME HEALTH AGENCY 0 0 0 0 0 0 0 0 0 0] 101. 00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113. 00 11600 HOSPICE 7, 299, 363 0 0 0 2, 394, 910 0 116. 00 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 626, 428, 633 32, 343, 426 14, 590, 078 66, 227, 410 206, 251 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 422, 359 171, 269 77, 259 104, 983 0 190. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 8, 260, 393 246, 241 111, 079 2, 547, 593 0 192. 00 194. 00 194. 00 197955 MARKETI NG & COMMUNI TY RELATIONS 101, 474 0 0 24, 202 0 194. 00 194. 00 194. 00 197950 OTHER NONREI MBURSABLE COST CENTERS 186, 669 93, 094 41, 995 39, 929 0 194. 01 194. 00 0 194. 00 0 194. 00 0 194. 00 0 194. 00 0 194. 00 0 194. 00 0 194. 00 0 194. 00 0 194. 00 0 194. 00 0 0 194. 00 0 0 194. 00 0 0 194. 00 0 0 194. 00 0 0 194. 00 0 0 194. 00 0 194. 00 0 0 194. 00 0 0 194. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	0	О		73.00
90. 00 09000 CLI NI C 4,550,040 704,665 317,874 2,317,522 98 90.00 90.01 09001 DMT JOI NT VENTURE 6,975,028 90.080 40,635 654,541 73 90.01 90.05 09005 CV DI AGNOSTI C SERVI CES 9,331,452 0 0 3,002,765 46 90.05 91.00 09100 EMERGENCY 7,918,351 1,813,578 818,103 3,097,810 11,662 91.00 92.00 09200 DBSERVATI ON BEDS (NON-DI STI NCT PART 92.00 09200 DBSERVATI ON BEDS (NON-DI STI NCT PART 92.00 09200 DBSERVATI ON BEDS (NON-DI STI NCT PART 92.00 09200 DI NON BEDS (NON-DI STI NCT PART 92.00 09200 DI NON BEDS (NON-DI STI NCT PART 92.00 09200 DI NON BEDS (NON-DI STI NCT PART 92.00 09200 DI NON BEDS (NON-DI STI NCT PART 92.00 09200 DI NON BEDS (NON-DI STI NCT PART 92.00 09200 DI NON BEDS (NON-DI STI NCT PART 92.00 09200 DI NON BEDS (NON-DI STI NCT PART 92.00 09200 DI NON BEDS (NON			151, 037	68, 133		· ·	
90. 00		387, 803	0	0	131, 452	28	76. 97
90. 01		4 550 040	704 445	217 074	2 217 522	00	00 00
90. 05							
91. 00		1 ' '		· ·			
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	· ·		1, 813, 578	_			
101. 00	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113. 00 11300 INTEREST EXPENSE 113. 00 11600 HOSPI CE 7, 299, 363 0 0 2, 394, 910 0 116. 00 116. 00 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 626, 428, 633 32, 343, 426 14, 590, 078 66, 227, 410 206, 251 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 422, 359 171, 269 77, 259 104, 983 0 190. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 8, 260, 393 246, 241 111, 079 2, 547, 593 0 192. 00 194. 00 194. 01 194. 02 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975 1975							
113. 00 11300 INTEREST EXPENSE 116. 00 11600 HOSPI CE 7, 299, 363 0 0 2, 394, 910 0 116. 00 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 626, 428, 633 32, 343, 426 14, 590, 078 66, 227, 410 206, 251 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 422, 359 171, 269 77, 259 104, 983 0 190. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 8, 260, 393 246, 241 111, 079 2, 547, 593 0 192. 00 194. 00 07955 MARKETI NG & COMMUNI TY RELATI ONS 101, 474 0 0 0 24, 202 0 194. 00 194. 01 07952 WOMEN' S CENTER 186, 069 93, 094 41, 995 39, 929 0 194. 01 194. 02 07950 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 194. 02		0	0	0	0	0	101. 00
116. 00							112 00
118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 626, 428, 633 32, 343, 426 14, 590, 078 66, 227, 410 206, 251 118. 00		7 299 363	0		2 394 910	0	
NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 422, 359 171, 269 77, 259 104, 983 0 190. 00 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19200 19							
190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 422,359 171,269 77,259 104,983 0 190. 00 192. 00 19200 19200 194. 01 194. 01 194. 01 194. 02 1950 196. 01 196. 02 196. 03 196. 04 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196. 05 196				., .,	22, ==7, .70		
194. 00 07955 MARKETING & COMMUNITY RELATIONS 101, 474 0 0 0 24, 202 0 194. 00 194. 01 07952 WOMEN'S CENTER 186, 069 93, 094 41, 995 39, 929 0 194. 01 194. 02 07950 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 194. 02	190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	422, 359	171, 269		104, 983		
194. 01 07952 WOMEN' S CENTER 186, 069 93, 094 41, 995 39, 929 0 194. 01 194. 02 07950 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 194. 02			246, 241				
194.02 07950 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 194.02			0				
			93, 094		39, 929		
177, 230, 001ן 303, 174ן 1, 173, 188ן 1, 173, 188ן 174, 175, 188ן 174, 175, 188ן 174, 175, 188ן 174, 175, 188ן		-	202 002		0 1 71E 100		
	177. OTIO1734 OTHER MICO	17, 230, 001	303, 092	130,724	1, / 10, 100	0	1 74. 04

Health Financial Systems	ST. F	RANCIS HOSPITA	L & HEALTH CEN	TER	In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS			Provi der Co	CN: 15-0162	Peri od: From 01/01/2020	Worksheet B Part I	
					To 12/31/2020		epared: 40 am
			CAPI TAL REI	LATED COSTS			
Cost Center Description		Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	ADMI TTI NG	
		0	1.00	2.00	4. 00	5. 01	
194. 05 07956 FOUNDATI ON		1, 889	0		0 0	0	194. 05
200.00 Cross Foot Adjustments							200.00
201.00 Negative Cost Centers			0		0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	714, 639, 698	33, 157, 122	14, 957, 13	70, 659, 305	206, 251	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0162

Period: Worksheet B From 01/01/2020 Part I To 12/31/2020 Date/Time Prepared:

3/30/2021 10:40 am Cost Center Description Subtotal CASHI ERI NG/AC Subtotal OTHER ADMIN & OPERATION OF COUNTS **GENERAL PLANT** RECEI VABLE 5. 03 7. 00 5A 01 5A 02 5 02 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 5.01 00570 ADMLTTLNG 5.01 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 60, 737 60, 737 5.02 5.02 5.03 00590 OTHER ADMIN & GENERAL 144, 082, 069 12.246 144, 094, 315 144, 094, 315 5.03 32, 591, 309 7.00 00700 OPERATION OF PLANT 26, 019, 863 26, 017, 651 6, 571, 446 2.212 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 2, 337, 722 199 2, 337, 921 590, 454 312, 989 8.00 00900 HOUSEKEEPI NG 278, 077 9 00 8, 687, 363 738 8, 688, 101 2, 194, 223 9 00 01000 DI ETARY 1, 620, 989 402, 961 1, 620, 851 409.389 10.00 10.00 138 01100 CAFFTERI A 4, 084, 675 552, 915 11.00 4, 084, 328 347 1, 031, 605 11.00 13.00 01300 NURSING ADMINISTRATION 7, 170, 585 609 7, 171, 194 1, 811, 121 0 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 3, 379, 308 287 3, 379, 595 853, 534 1, 269, 874 14.00 15.00 01500 PHARMACY 10, 990, 098 492, 344 10, 989, 164 2, 775, 604 934 15 00 16.00 01600 MEDICAL RECORDS & LIBRARY 174, 487 15 174, 502 44,071 0 16.00 02100 I&R SERVICES-SALARY & FRINGES APPRV 2, 822, 870 712, 930 21.00 2,822,630 240 38, 487 21.00 02200 | &R SERVICES-OTHER PRGM COSTS APPRV 22.00 1, 891, 917 1, 892, 078 477, 854 22.00 161 0 02300 MEDICAL LABORATORY SCIENTIST PRGM 23 00 107, 637 107, 646 27, 187 0 23.00 02302 PHARMACY PRGM 915, 310 78 915, 388 231, 186 0 23.01 23.01 02301 EMERGENCY MEDICAL SERVICES 23.02 175, 245 15 175, 260 44, 263 0 23.02 02303 PARAMEDIC PRGM 23.03 594, 353 51 594, 404 150, 120 0 23.03 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 55, 318, 721 4, 702 55, 323, 423 13, 972, 207 7, 862, 917 30.00 03100 INTENSIVE CARE UNIT 10, 993, 720 10, 994, 654 31.00 934 2, 776, 755 884, 537 31.00 02060 NEONATAL INTENSIVE CARE UNIT 598, 553 31.01 6, 445, 107 548 6, 445, 655 1, 627, 882 31.01 1, 293 32.00 03200 CORONARY CARE UNIT 15, 207, 378 15, 208, 671 3, 841, 026 1, 926, 726 32.00 03400 SURGICAL INTENSIVE CARE UNIT 8,004,942 8,005,622 34.00 680 2, 021, 860 1,089,677 34.00 41.00 04100 SUBPROVI DER - I RF 5, 180, 860 5, 181, 300 1, 308, 563 718, 936 41.00 440 04300 NURSERY 151, 973 43.00 861, 686 73 861, 759 217, 642 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 23, 482, 404 1, 996 23, 484, 400 5, 931, 103 4, 089, 761 50.00 52 00 05200 DELIVERY ROOM & LABOR ROOM 5, 389, 447 458 5, 389, 905 1 361 247 1 092 496 52 00 19, 968, 327 05400 RADI OLOGY-DI AGNOSTI C 19, 970, 024 2, 634, 053 54.00 1,697 5, 043, 529 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 7, 610, 136 647 7, 610, 783 1, 922, 141 184, 445 55.00 05600 RADI OI SOTOPE 56.00 1, 098, 025 93 1,098,118 277, 335 35, 669 56.00 05900 CARDI AC CATHETERI ZATI ON 4, 421, 067 4, 421, 443 1, 116, 658 1, 022, 377 59 00 376 59 00 60.00 06000 LABORATORY 27, 048, 251 2, 299 27, 050, 550 6, 831, 752 1,085,471 60.00 06400 I NTRAVENOUS THERAPY 3, 985, 695 3, 986, 034 1,006,693 396, 399 64.00 339 64.00 65 00 06500 RESPIRATORY THERAPY 9, 362, 063 796 9. 362. 859 2, 364, 637 354, 631 65 00 06600 PHYSI CAL THERAPY 66.00 7, 740, 617 658 7, 741, 275 1, 955, 098 464, 541 66.00 06700 OCCUPATIONAL THERAPY 2, 831, 959 2, 832, 200 715, 286 67.00 241 0 67.00 68.00 06800 SPEECH PATHOLOGY 1, 393, 857 118 1, 393, 975 352,055 82, 401 68.00 06900 ELECTROCARDI OLOGY 2, 722, 753 687, 645 69 00 2, 722, 522 231 578, 868 69 00 70.00 07000 ELECTROENCEPHALOGRAPHY 2, 515, 465 214 2, 515, 679 635, 347 0 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 37, 386, 811 3, 178 37, 389, 989 9, 443, 029 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 28, 875, 940 28, 878, 394 7, 293, 383 72.00 2.454 72.00 0 07300 DRUGS CHARGED TO PATIENTS 64, 797, 368 5,508 73 00 64, 802, 876 16, 366, 290 0 73 00 74.00 07400 RENAL DIALYSIS 1, 204, 381 102 1, 204, 483 304, 198 168, 630 74.00 07697 CARDIAC REHABILITATION 519, 283 519, 327 76.97 44 131, 159 0 76.97 OUTPATIENT SERVICE COST CENTERS 7, 890, 199 786, 742 90.00 90 00 09000 CLINIC 671 7, 890, 870 1 992 879 90.01 09001 IBMT JOINT VENTURE 7, 760, 357 7, 761, 017 1, 960, 084 100, 572 90.01 660 90.05 09005 CV DIAGNOSTIC SERVICES 12, 334, 263 1,048 12, 335, 311 3, 115, 344 O 90.05 09100 EMERGENCY 2, 024, 816 91.00 13, 659, 504 1, 161 13, 660, 665 3, 450, 069 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 101. 00 10100 HOME HEALTH AGENCY 0 0 0 0 0 101.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 116. 00 11600 HOSPI CE 9, 694, 273 9, 695, 097 2, 448, 545 0 116,00 SUBTOTALS (SUM OF LINES 1 through 117)
NONREIMBURSABLE COST CENTERS 118.00 620, 815, 985 52, 762 620, 808, 010 120, 396, 428 31, 682, 838 118.00 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 775, 870 775, 936 195, 967 191, 217 190. 00 66 192.00 19200 PHYSICIANS' PRIVATE OFFICES 11, 165, 306 949 11, 166, 255 2, 820, 094 274, 922 192. 00 194.00 07955 MARKETING & COMMUNITY RELATIONS 125, 687 31, 743 0 194, 00 125, 676 11 194. 01 07952 WOMEN' S CENTER 361, 087 31 361, 118 91, 202 103, 937 194. 01 194. 02 07950 OTHER NONREI MBURSABLE COST CENTERS 0 194.02 0 338, 395 194. 04 194. 04 07954 OTHER NRCC 81, 393, 885 6, 918 81, 400, 803 20, 558, 404 194. 05 07956 FOUNDATI ON 1, 889 1, 889 0 194.05 C 477 200.00 Cross Foot Adjustments 0 200.00 0 201.00 Negative Cost Centers 0 201.00 202.00 714, 639, 698 60, 737 714, 639, 698 144, 094, 315 32, 591, 309 202. 00 TOTAL (sum lines 118 through 201)

Provi der CCN: 15-0162

In Lieu of Form CMS-2552-10

| Period: | Worksheet B |
| From 01/01/2020 | Part |
| To 12/31/2020 | Date/Time Prepared: 3/30/2021 10:40 am

		L ALINDRY &	HOUSEKEENING	D. 574.DV		3/30/2021 10:	
	Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI O	
		8. 00	9. 00	10.00	11. 00	N 13. 00	
	NERAL SERVICE COST CENTERS						
1	100 CAP REL COSTS-BLDG & FLXT						1.00
	200 CAP REL COSTS-MVBLE EQUIP 400 EMPLOYEE BENEFITS DEPARTMENT						2. 00 4. 00
	570 ADMITTING						5. 01
	580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5. 02
5. 03 00!	590 OTHER ADMIN & GENERAL						5. 03
	700 OPERATION OF PLANT						7. 00
	800 LAUNDRY & LINEN SERVICE	3, 241, 364	11 1/0 /01				8.00
	900 HOUSEKEEPI NG 000 DI ETARY	0	11, 160, 401 140, 537	2, 573, 876			9. 00 10. 00
	100 CAFETERI A	l o	192, 834	2,373,070	5, 862, 029		11.00
	300 NURSING ADMINISTRATION	0	0	0	121, 434	9, 103, 749	13.00
	400 CENTRAL SERVICES & SUPPLY	11, 164	442, 881	0	40, 586	0	14.00
	500 PHARMACY	0	171, 710	0	204, 080	0	15. 00
1	600 MEDICAL RECORDS & LIBRARY	0	12 422	0	70.704	0	16.00
	100 &R SERVICES-SALARY & FRINGES APPRV 200 &R SERVICES-OTHER PRGM COSTS APPRV	0	13, 423	0	70, 784 20, 134	0	21. 00 22. 00
	300 MEDICAL LABORATORY SCIENTIST PRGM		0	0	6, 111	0	23. 00
	302 PHARMACY PRGM	0	0	0	16, 959	0	23. 01
23. 02 023	301 EMERGENCY MEDICAL SERVICES	0	0	0	15, 174	0	23. 02
	303 PARAMEDIC PRGM	0	0	0	35, 671	0	23. 03
	PATIENT ROUTINE SERVICE COST CENTERS	1 270 24/	2 742 270	1 227 /27	1 211 102	4 242 121	20.00
	000 ADULTS & PEDIATRICS 100 INTENSIVE CARE UNIT	1, 278, 346 226, 820	2, 742, 270 308, 491	1, 227, 637 483, 749	1, 211, 102 253, 812	4, 342, 131 1, 711, 011	30. 00 31. 00
1	060 NEONATAL INTENSIVE CARE UNIT	22, 932	208, 751	149, 184	120, 150		31.00
	200 CORONARY CARE UNIT	232, 788	671, 965	299, 476	339, 119		32.00
34. 00 034	400 SURGICAL INTENSIVE CARE UNIT	153, 387	380, 036	194, 609	179, 212	688, 327	34.00
	100 SUBPROVI DER - I RF	71, 580	250, 736		109, 565	463, 392	41.00
	300 NURSERY	9, 863	53, 002	88, 208	14, 237	311, 988	43. 00
	CILLARY SERVICE COST CENTERS OOO OPERATING ROOM	270, 636	1, 426, 344	0	416, 653	0	50.00
	200 DELIVERY ROOM & LABOR ROOM	150, 970	381, 019		100, 610	0	52.00
	400 RADI OLOGY-DI AGNOSTI C	166, 651	918, 652	0	294, 004	0	54.00
	500 RADI OLOGY-THERAPEUTI C	0	64, 327	0	44, 392	0	55. 00
	600 RADI OI SOTOPE	6, 229	12, 440	0	5, 238	0	56.00
	900 CARDI AC CATHETERI ZATI ON	69, 099	356, 564	0	63, 121	0	59.00
	000 LABORATORY 400 INTRAVENOUS THERAPY	23	378, 569 138, 248	0	17, 004 93, 632	0	60. 00 64. 00
	500 RESPIRATORY THERAPY	810	123, 681	0	216, 059	0	65.00
	600 PHYSI CAL THERAPY	24, 684	162, 013	0	145, 907	ő	66.00
67. 00 06 ⁻	700 OCCUPATI ONAL THERAPY	0	0	0	69, 604	0	67. 00
	800 SPEECH PATHOLOGY	0	28, 738	1	28, 105	0	68. 00
	900 ELECTROCARDI OLOGY	13, 219	201, 886	0	53, 230	0	69.00
	000 ELECTROENCEPHALOGRAPHY 100 MEDICAL SUPPLIES CHARGED TO PATIENT	6, 238 0	0	0	54, 522 0	0	70. 00 71. 00
	200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0		71.00
	300 DRUGS CHARGED TO PATIENTS	l o	0	0	0	ő	73.00
	400 RENAL DIALYSIS	9, 786	58, 811	0	1, 030	0	74.00
	697 CARDIAC REHABILITATION	0	0	0	14, 364	0	76. 97
	TPATIENT SERVICE COST CENTERS	10.005	074 004		007.70/		00.00
	000 CLINIC 001 IBMT JOINT VENTURE	12, 935 9, 218	274, 384 35, 075	0	227, 786 53, 977	0	90. 00 90. 01
	005 CV DIAGNOSTIC SERVICES	9, 210	35, 075	0	353, 410	0	90.01
	100 EMERGENCY	467, 962	706, 175		296, 215	-	91.00
92.00 092	200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
	HER REIMBURSABLE COST CENTERS	1		- 1			
101. 00 10	100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00
113 00 11	ECIAL PURPOSE COST CENTERS 300 NTEREST EXPENSE						113. 00
	600 HOSPI CE	0	0	0	197, 389	0	116. 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	3, 215, 340	10, 843, 562	2, 573, 876	5, 504, 382		
	NREIMBURSABLE COST CENTERS						
	000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	66, 689	l	17, 855		190. 00
	200 PHYSI CI ANS' PRI VATE OFFI CES	9, 868	95, 882	0	165, 828		192.00
	955 MARKETING & COMMUNITY RELATIONS 952 WOMEN'S CENTER	16, 156	0 36, 249		2, 676 4, 635		194. 00 194. 01
	950 OTHER NONREIMBURSABLE COST CENTERS	10, 130	30, 249 N	0	4, 035 N		194. 01
	954 OTHER NRCC	0	118, 019		166, 653		194. 02
	956 FOUNDATI ON		0	O	0		194. 05
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)	3, 241, 364	11, 160, 401	2, 573, 876	5, 862, 029	9, 103, 749	202.00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provi der CCN: 15-0162

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

In Lieu of Form CMS-2552-10

3/30/2021 10:40 am INTERNS & RESIDENTS CENTRAL **PHARMACY** MEDI CAL SERVI CES-SALA SERVI CES-OTHE Cost Center Description RY & FRINGES R PRGM COSTS SERVICES & RECORDS & SUPPLY LI BRARY APPRV **APPRV** 14.00 15.00 16.00 21.00 22.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00570 ADMITTING 5.01 5.01 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5.02 5.02 5.03 00590 OTHER ADMIN & GENERAL 5.03 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 00900 HOUSEKEEPI NG 9 00 9 00 10.00 01000 DI ETARY 10.00 11.00 01100 CAFETERI A 11.00 01300 NURSING ADMINISTRATION 13.00 13.00 01400 CENTRAL SERVICES & SUPPLY 5, 997, 634 14.00 14.00 15.00 01500 PHARMACY 9, 127 14, 642, 963 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 218, 573 16.00 02100 I&R SERVICES-SALARY & FRINGES APPRV 21 00 1,440 0 3, 659, 934 21 00 22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 0 C 0 2, 390, 066 22.00 02300 MEDICAL LABORATORY SCIENTIST PRGM 23.00 80 0 0 23.00 02302 PHARMACY PRGM 0 0 23.01 23.01 80 02301 EMERGENCY MEDICAL SERVICES 23.02 565 C 0 23.02 23.03 02303 PARAMEDIC PRGM 277 0 23.03 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 03000 ADULTS & PEDIATRICS 15 869 n 14, 399 2 533 570 1 654 513 30.00 31.00 03100 INTENSIVE CARE UNIT 2, 571 0 2,552 109, 051 71, 214 31.00 02060 NEONATAL INTENSIVE CARE UNIT 1, 449 0 2, 167 0 31.01 31.01 03200 CORONARY CARE UNIT 32.00 3, 360 0 2,444 ol 0 32.00 03400 SURGICAL INTENSIVE CARE UNIT 34 00 Ω 1 916 0 34 00 1,636 0 04100 SUBPROVI DER - I RF 41.00 862 0 1,082 0 0 41.00 04300 NURSERY 0 43.00 1.202 471 0 0 43.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 153, 159 44, 085 0 19, 339 234, 535 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 1, 611 0 3, 231 0 52.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 31, 741 21, 595 0 0 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 35 0 5, 933 0 55.00 0 05600 RADI OI SOTOPE 56.00 64.392 C 529 0 0 56.00 1, 378 59.00 05900 CARDIAC CATHETERIZATION 10,738 0 0 59.00 60.00 06000 LABORATORY 920 22, 472 0 0 60.00 06400 I NTRAVENOUS THERAPY 64.00 4.529 0 2.324 64.00 0 0 06500 RESPIRATORY THERAPY 65.00 1.940 4.394 34, 359 22, 437 65.00 66.00 06600 PHYSI CAL THERAPY 1,717 2,801 256, 942 167, 792 66.00 06700 OCCUPATI ONAL THERAPY 1,552 67.00 67.00 393 0 06800 SPEECH PATHOLOGY 68.00 282 0 767 0 68.00 2, 172 69.00 06900 ELECTROCARDI OLOGY 2, 691 95,606 62, 434 69.00 70 00 07000 ELECTROENCEPHALOGRAPHY 585 1, 446 29, 877 19, 511 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 3, 227, 866 14.817 71.00 0 71.00 0 0 07200 IMPL. DEV. CHARGED TO PATIENTS 72 00 2, 493, 538 r 12, 287 0 0 72 00 07300 DRUGS CHARGED TO PATIENTS 14, 642, 963 36, 171 73.00 73.00 0 74.00 07400 RENAL DIALYSIS 107 C 599 28, 383 18, 535 74.00 07697 CARDI AC REHABILI TATI ON 76.97 454 113 0 76.97 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 1, 352 984 90.00 09001 I BMT JOINT VENTURE 90.01 90.01 524 0 653 0 0 09005 CV DIAGNOSTIC SERVICES 21, 928 4, 974 90.05 0 0 Λ 90.05 91.00 09100 EMERGENCY 5, 224 21, 282 264, 412 172,670 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 0 0 0 0 0 101.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE 113.00 116. 00 11600 HOSPI CE 13.914 1, 850 116 00 SUBTOTALS (SUM OF LINES 1 through 117) 118.00 5, 959, 205 14, 642, 963 218, 573 3, 586, 735 2, 342, 265 118.00 NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 11, 765 0 190.00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 47, 801 192. 00 0 73, 199 8.586 Ω 194.00 07955 MARKETING & COMMUNITY RELATIONS 0 0 0 194.00 0 0 194. 01 07952 WOMEN' S CENTER 0 194.01 244 0 0 0 194. 02 07950 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 194. 02 0 0 194. 04 07954 OTHER NRCC 17,834 C 0 0 194.04 194. 05 07956 FOUNDATI ON 0 0 194.05 200.00 Cross Foot Adjustments 0 200.00

Health Financial Systems	ST. FRANCIS HOSPITAL 8	HEALTH CENTER	In Lieu	u of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der CCN: 15-0162	From 01/01/2020	Worksheet B Part I Date/Time Prepared: 3/30/2021 10:40 am
			INTERNS &	RESIDENTS

						3/30/2021 10:	40 am
					INTERNS &	RESI DENTS	
	Cost Center Description	CENTRAL SERVICES &	PHARMACY	MEDI CAL RECORDS &	SERVI CES-SALA RY & FRI NGES	SERVICES-OTHE R PRGM COSTS	
		SUPPLY		LI BRARY	APPRV	APPRV	
		14. 00	15. 00	16.00	21.00	22. 00	
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202. 00	TOTAL (sum lines 118 through 201)	5, 997, 634	14, 642, 963	218, 573	3, 659, 934	2, 390, 066	202.00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provi der CCN: 15-0162 Period: Worksheet B From 01/01/2020 Part I To 12/31/2020 Date/Time Prepared:

			T	12/31/2020	Date/Time Pre 3/30/2021 10:	
Cost Center Description	MEDI CAL LABORATORY SCI ENTI ST PRGM	PHARMACY PRGM	EMERGENCY MEDI CAL SERVI CES	PARAMEDIC PRGM	Subtotal	TO dill
	23. 00	23. 01	23. 02	23. 03	24. 00	
GENERAL SERVICE COST CENTERS 1. 00 00100 CAP REL COSTS-BLDG & FLXT						1 00
1. 00 00100 CAP REL COSTS-BLDG & FIXT 2. 00 00200 CAP REL COSTS-MYBLE EQUIP 4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 01 00570 ADMITTING 5. 02 00580 CASHIERING/ACCOUNTS RECEIVABLE 5. 03 00590 OTHER ADMIN & GENERAL 7. 00 00700 OPERATION OF PLANT 8. 00 00800 LAUNDRY & LINEN SERVICE 9. 00 00900 DIETARY 11. 00 01100 CAPETERIA						1.00 2.00 4.00 5.01 5.02 5.03 7.00 8.00 9.00 10.00
13. 00	141, 024	1, 163, 613				13. 00 14. 00 15. 00 16. 00 21. 00 22. 00 23. 00 23. 01
23. 02 02301 EMERGENCY MEDI CAL SERVI CES 23. 03 02303 PARAMEDI C PRGM			235, 262	790 472		23. 02 23. 03
23. 03 02303 PARAMEDI C PRGM I NPATI ENT ROUTI NE SERVI CE COST CENTERS				780, 472		23.03
30. 00 03000 ADULTS & PEDIATRICS	C	1	0	0	92, 178, 384	1
31. 00 03100 INTENSIVE CARE UNIT 31. 01 02060 NEONATAL INTENSIVE CARE UNIT	C	0	0	0	17, 825, 217 9, 704, 382	1
32. 00 03200 CORONARY CARE UNIT	C	Ö	0	Ö	23, 584, 816	1
34. 00 03400 SURGICAL INTENSIVE CARE UNIT	C		0	0	12, 716, 282	1
41. 00 04100 SUBPROVI DER - I RF 43. 00 04300 NURSERY	C		0	0	8, 237, 029 1, 710, 345	
ANCILLARY SERVICE COST CENTERS		<u> </u>		<u> </u>	1, 710, 010	10.00
50. 00 05000 OPERATING ROOM	C		0	0	36, 070, 015	1
52. 00 05200 DELI VERY ROOM & LABOR ROOM 54. 00 05400 RADI OLOGY-DI AGNOSTI C	C	1	0	0	8, 481, 089 29, 080, 249	1
55. 00 05500 RADI OLOGY-THERAPEUTI C		Ö	0	o	9, 832, 056	1
56. 00 05600 RADI 0I SOTOPE	C	o	0	0	1, 499, 950	1
59. 00 05900 CARDI AC CATHETERI ZATI ON	141 024		0	0	7, 061, 378	1
60. 00 06000 LABORATORY 64. 00 06400 I NTRAVENOUS THERAPY	141, 024	1	0	0	35, 527, 785 5, 627, 859	1
65. 00 06500 RESPIRATORY THERAPY	C	1	0	o	12, 485, 807	1
66. 00 06600 PHYSI CAL THERAPY	C	o	0	0	10, 922, 770	1
67. 00 06700 0CCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	0		0	0	3, 619, 035	1
69. 00 06900 ELECTROCARDI OLOGY			0	0	1, 886, 323 4, 420, 504	1
70. 00 07000 ELECTROENCEPHALOGRAPHY		o o	0	Ö	3, 263, 205	1
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	C	0	0	0	50, 075, 701	
72.00 O7200 IMPL. DEV. CHARGED TO PATIENTS 73.00 O7300 DRUGS CHARGED TO PATIENTS	C		0	0 780, 472	38, 677, 602 97, 792, 385	
74. 00 07400 RENAL DIALYSIS		0	0	700, 472	1, 794, 562	
76. 97 O7697 CARDI AC REHABI LI TATI ON	C	o	0	0	665, 417	76. 97
OUTPATIENT SERVICE COST CENTERS 90. 00 09000 CLINIC	T C	ا	0	ol	11, 187, 932	90.00
90. 01 09001 I BMT JOI NT VENTURE			0	0	9, 921, 120	1
90. 05 09005 CV DIAGNOSTIC SERVICES	C	o	0	0	15, 830, 967	1
91. 00 09100 EMERGENCY	C	0	235, 262	0	21, 304, 752	1
92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92.00
101. 00 10100 HOME HEALTH AGENCY	C	o	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						1
113. 00 11300 INTEREST EXPENSE			0		10 05/ 705	113.00
116.00 11600 HOSPICE 118.00 SUBTOTALS (SUM OF LINES 1 through 117)	141, 024	1, 163, 613	235, 262	0 780, 472	12, 356, 795 595, 341, 713	1
NONREI MBURSABLE COST CENTERS	111/02	17 1007 010	2007 202	7007 172	0,0,011,710	
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	C		0	0	1, 259, 429	
192.00 19200 PHYSICIANS' PRIVATE OFFICES 194.00 07955 MARKETING & COMMUNITY RELATIONS	C		0	0	14, 662, 435 160, 106	
194.00 07955 MARKETING & COMMONTTY RELATIONS	0		0	0	613, 541	
194.02 07950 OTHER NONREIMBURSABLE COST CENTERS		ol ol	0	ō	0	194. 02
194. 04 07954 OTHER NRCC	C	0	0	0	102, 600, 108	
194.05 07956 FOUNDATION 200.00 Cross Foot Adjustments			0	0		194. 05 200. 00
201.00 Negative Cost Centers			0	0		201.00
	•					-

Health Financial Systems	ST.	FRANCIS HOSPITA	L & HEALTH CEN	TER	In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS			Provi der CC		Period: From 01/01/2020 To 12/31/2020		
Cost Center Description		MEDI CAL LABORATORY SCI ENTI ST PRGM	PHARMACY PRGM	EMERGENCY MEDI CAL SERVI CES	PARAMEDI C PRGM	Subtotal	
		23. 00	23. 01	23. 02	23. 03	24.00	
202.00 TOTAL (sum lines 118 through 201)		141, 024	1, 163, 613	235, 26	2 780, 472	714, 639, 698	202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Peri od: Worksheet B From 01/01/2020 Part I To 12/31/2020 Date/Ti me Prepared: Provider CCN: 15-0162

				3/30/2021	
	Cost Center Description	Intern &	Total		
		Resi dents			
		Cost & Post			
		Stepdown			
		Adjustments			
	OFFICE ALL OFFICE OF COOT OFFITEDS	25. 00	26. 00		
4 00	GENERAL SERVICE COST CENTERS				1.00
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. 01	00570 ADMITTING				5. 01
5. 02	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE				5.02
5. 03	00590 OTHER ADMIN & GENERAL				5. 03
7.00	00700 OPERATION OF PLANT				7.00
8. 00 9. 00	00800 LAUNDRY & LI NEN SERVI CE				8.00
10.00	00900 HOUSEKEEPI NG				9.00
11. 00	01000 DI ETARY				10.00
13. 00	01100 CAFETERI A				•
	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY				13. 00 14. 00
	01500 PHARMACY				15.00
	01600 MEDICAL RECORDS & LIBRARY				•
	1				16. 00 21. 00
	02100 I &R SERVICES SALARY & FRINGES APPRV				
	02200 I &R SERVICES-OTHER PRGM COSTS APPRV				22.00
23. 00	02300 MEDICAL LABORATORY SCIENTIST PRGM				23. 00
	02302 PHARMACY PRGM 02301 EMERGENCY MEDICAL SERVICES				•
23. 02	1 1				23. 02
23.03	02303 PARAMEDIC PRGM INPATIENT ROUTINE SERVICE COST CENTERS				23. 03
30. 00	03000 ADULTS & PEDIATRICS	-4, 188, 083	87, 990, 301		30.00
	03100 INTENSIVE CARE UNIT	-4, 180, 063	17, 644, 952		31.00
	02060 NEONATAL INTENSIVE CARE UNIT	- 180, 265	9, 704, 382		31.00
	03200 CORONARY CARE UNIT	0	23, 584, 816		32.00
	03400 SURGI CAL INTENSI VE CARE UNIT	0	12, 716, 282		34.00
41. 00	04100 SUBPROVI DER – I RF	0	8, 237, 029		41.00
	04300 NURSERY	0	1, 710, 345		43.00
43.00	ANCI LLARY SERVI CE COST CENTERS	<u> </u>	1, 710, 343		43.00
50.00	05000 OPERATING ROOM	-387, 694	35, 682, 321		50.00
	05200 DELIVERY ROOM & LABOR ROOM	-307, 074	8, 481, 089		52.00
	05400 RADI OLOGY-DI AGNOSTI C	o	29, 080, 249		54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	9, 832, 056		55.00
56. 00	05600 RADI OI SOTOPE	0	1, 499, 950		56.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	7, 061, 378		59.00
60. 00	06000 LABORATORY	Ö	35, 527, 785		60.00
64. 00	06400 I NTRAVENOUS THERAPY	0	5, 627, 859		64.00
65. 00	06500 RESPIRATORY THERAPY	-56, 796	12, 429, 011		65.00
66. 00	06600 PHYSI CAL THERAPY	-424, 734	10, 498, 036		66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0	3, 619, 035		67.00
68. 00	06800 SPEECH PATHOLOGY	0	1, 886, 323		68.00
	06900 ELECTROCARDI OLOGY	-158, 040	4, 262, 464		69.00
	07000 ELECTROENCEPHALOGRAPHY	-49, 388	3, 213, 817		70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	47, 300	50, 075, 701		71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	Ö	38, 677, 602		72.00
	07300 DRUGS CHARGED TO PATIENTS	o	97, 792, 385		73.00
	07400 RENAL DIALYSIS	-46, 918	1, 747, 644		74.00
	07697 CARDI AC REHABI LI TATI ON	0	665, 417		76. 97
70. 77	OUTPATIENT SERVICE COST CENTERS	<u> </u>	000, 117		10.77
90.00	09000 CLINIC	O	11, 187, 932		90.00
	09001 I BMT JOI NT VENTURE	o	9, 921, 120		90. 01
	09005 CV DI AGNOSTI C SERVI CES	o	15, 830, 967		90.05
	09100 EMERGENCY	-437, 082	20, 867, 670		91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	20,007,070		92.00
72.00	OTHER REIMBURSABLE COST CENTERS				72.00
101.00	10100 HOME HEALTH AGENCY	0	0		101.00
	SPECIAL PURPOSE COST CENTERS		٥,		
113.00	11300 NTEREST EXPENSE				113.00
	11600 HOSPI CE	o	12, 356, 795		116.00
118.00		-5, 929, 000	589, 412, 713		118.00
	NONREI MBURSABLE COST CENTERS	2, ,2,, 030	221, 112, 110		
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1, 259, 429		190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	-121, 000	14, 541, 435		192.00
	07955 MARKETING & COMMUNITY RELATIONS	0	160, 106		194.00
	07952 WOMEN' S CENTER	Ö	613, 541		194. 00
	07950 OTHER NONREIMBURSABLE COST CENTERS	Ö	013, 541		194. 02
	07954 OTHER NRCC	Ö	102, 600, 108		194. 04
	07956 FOUNDATION	n n	2, 366		194. 05
200.00		o	0		200.00
	, , , , , , , , , , , , , , , , , , ,	<u> </u>	٩١		

Health Financial Systems	ST. FRANCIS HOSPITA	L & HEALTH CEN	TER	In Lieu	of Form CMS-25	552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider Co	CN: 15-0162	From 01/01/2020		
Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total				
	25. 00	26. 00				
201.00 Negative Cost Centers 202.00 TOTAL (sum lines 118 through 201)) -6, 050, 000	0 708, 589, 698				01. 00 02. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 15-0162

				lo	12/31/2020	Date/lime Pre 3/30/2021 10:	
			CAPI TAL REI	LATED COSTS		07 007 2021 10.	TO GIII
	Cost Center Description	Directly Assigned New	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS	
		Capi tal				DEPARTMENT	
		Related Costs				DEI / II (TIMEI VI	
		0	1. 00	2.00	2A	4. 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	0	0	0	0	0	2. 00 4. 00
5. 01	00570 ADMITTING	0	139, 509	_	202, 441	Ö	5. 01
5. 02	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	0	41, 856		60, 737	0	5. 02
5. 03	00590 OTHER ADMIN & GENERAL	0	72, 184		104, 746	0	5. 03
7. 00	00700 OPERATION OF PLANT	0	3, 712, 339	1, 674, 631	5, 386, 970	0	7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	0	280, 336		406, 795		8. 00
9.00	00900 HOUSEKEEPI NG	0	249, 067		361, 421	0	9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	0	360, 922 495, 232		523, 734 718, 631	0	10. 00 11. 00
13. 00	01300 NURSING ADMINISTRATION	0	475, 252	223, 377	710,031	0	13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	1, 137, 395		1, 650, 472	Ö	14.00
15. 00	01500 PHARMACY	0	440, 981		639, 907	0	15.00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	0	1	0	0	16.00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	34, 472		50, 022	0	21.00
22. 00 23. 00	02200 1 &R SERVICES-OTHER PRGM COSTS APPRV 02300 MEDICAL LABORATORY SCIENTIST PRGM	0	0	0	0	0 0	22. 00 23. 00
23. 00	02302 PHARMACY PRGM	0	0		0	0	23. 00
23. 02	02301 EMERGENCY MEDICAL SERVICES	j o	Ö	Ö	0		23. 02
23. 03	02303 PARAMEDIC PRGM	0	0	0	0	0	23. 03
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	0	7, 042, 622		10, 219, 538		30.00
31. 00 31. 01	03100 I NTENSI VE CARE UNI T 02060 NEONATAL I NTENSI VE CARE UNI T	0	792, 258		1, 149, 645 777, 947	0	31. 00 31. 01
32. 00	03200 CORONARY CARE UNIT	0	536, 109 1, 725, 721		2, 504, 192		32.00
34. 00	03400 SURGICAL INTENSIVE CARE UNIT	0	975, 997		1, 416, 268		34.00
41. 00	04100 SUBPROVI DER - I RF	0	643, 934		934, 412		41.00
43.00	04300 NURSERY	0	136, 118	61, 403	197, 521	0	43.00
50.00	ANCILLARY SERVICE COST CENTERS	1	0 ((0 000	1 (50 440	5 045 547		
50. 00 52. 00	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM	0	3, 663, 098 978, 522		5, 315, 517 1, 419, 932	0	50. 00 52. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	2, 359, 257		3, 423, 515		54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	165, 203		239, 726		55.00
56.00	05600 RADI OI SOTOPE	0	31, 948	14, 412	46, 360	0	56.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	915, 718		1, 328, 797	0	59.00
60.00	06000 LABORATORY	0	972, 230		1, 410, 802	0	60.00
64. 00 65. 00	O6400 I NTRAVENOUS THERAPY O6500 RESPI RATORY THERAPY	0	355, 045 317, 634		515, 205 460, 918	0 0	64. 00 65. 00
66. 00	06600 PHYSI CAL THERAPY	0	416, 078		603, 770		66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	1	0	0	67.00
68.00		0	73, 804	33, 293	107, 097	0	68. 00
	06900 ELECTROCARDI OLOGY	0	518, 477		752, 361	0	69.00
	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71. 00 72. 00	O7100 MEDICAL SUPPLIES CHARGED TO PATIENT O7200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	71. 00 72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	73.00
74. 00	07400 RENAL DI ALYSI S	0	151, 037	68, 133	219, 170		74.00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0		0	0	76. 97
00.00	OUTPATIENT SERVICE COST CENTERS	1 -	704 //5	047.07	1 000 500		00.00
90. 00 90. 01	09000 CLINIC 09001 BMT JOINT VENTURE	0	704, 665 90, 080		1, 022, 539 130, 715		90. 00 90. 01
90.01	09005 CV DI AGNOSTI C SERVI CES	0	90,080	40, 635	130, 713	0	90.01
91. 00	09100 EMERGENCY	0	1, 813, 578	_	2, 631, 681	0	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART		., ,		0		92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00
113 00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE						113. 00
	11600 HOSPI CE	0	0	0	0		116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	32, 343, 426		46, 933, 504		118. 00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	171, 269		248, 528		190.00
	19200 PHYSICIANS' PRIVATE OFFICES 07955 MARKETING & COMMUNITY RELATIONS	0	246, 241	111, 079	357, 320		192. 00 194. 00
	07955 MARKETING & COMMUNITY RELATIONS		93, 094		135, 089		194.00
	207950 OTHER NONREIMBURSABLE COST CENTERS		73, 094	41, 773	135, 009		194. 01
	07954 OTHER NRCC	O	303, 092		439, 816	0	194. 04
194.05	07956 FOUNDATI ON	0	0	1	0	0	194. 05

Health Financial Systems	ST. FRANCIS HOSPITA	AL & HEALTH CEN	TER	In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der C		Peri od:	Worksheet B	
				From 01/01/2020		
				To 12/31/2020	Date/Time Pre 3/30/2021 10:	epared: _40_am
		CAPI TAL REI	LATED COSTS			
Cost Center Description	Di rectly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
	Assigned New				BENEFITS	
	Capi tal				DEPARTMENT	
	Related Costs					
	0	1.00	2.00	2A	4. 00	
200.00 Cross Foot Adjustments				0		200.00
201.00 Negative Cost Centers		0		0 0	0	201.00
202.00 TOTAL (sum lines 118 through 201) 0	33, 157, 122	14, 957, 13	5 48, 114, 257	0	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2020 Part II
To 12/31/2020 Date/Time Prepared:
3/30/2021 10:40 am

				0 12/31/2020	3/30/2021 10:	
Cost Center Description	ADMITTI NG		OTHER ADMIN &	OPERATION OF	LAUNDRY &	
		COUNTS RECEI VABLE	GENERAL	PLANT	LINEN SERVICE	
	5. 01	5. 02	5. 03	7. 00	8. 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 5. 01 00570 ADMITTING	202, 441					4. 00 5. 01
5. 02 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	202, 441	60, 737				5. 02
5. 03 00590 OTHER ADMI N & GENERAL	0	12, 246				5. 02
7. 00 00700 OPERATION OF PLANT	0	2, 212		5, 394, 516		7. 00
8.00 00800 LAUNDRY & LINEN SERVICE	0	199		51, 806		8. 00
9. 00 00900 HOUSEKEEPI NG	0	738	1, 781	46, 027	0	9. 00
10. 00 01000 DI ETARY	0	138	332	66, 698	0	10.00
11. 00 01100 CAFETERI A	0	347		91, 519	0	11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	0	609		0	0	13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	0	287			1, 582	14.00
15. 00 O1500 PHARMACY 16. 00 O1600 MEDI CAL RECORDS & LI BRARY	0	934 15	2, 253 36	81, 493	0	15. 00 16. 00
21.00 02100 1&R SERVICES-SALARY & FRINGES APPRV	0	240		6, 370	0	21.00
22. 00 02200 &R SERVICES-OTHER PRGM COSTS APPRV	0	161	388		0	22.00
23. 00 02300 MEDICAL LABORATORY SCIENTIST PRGM	0	9		0	Ö	23. 00
23. 01 02302 PHARMACY PRGM	0	78		0	0	23. 01
23. 02 02301 EMERGENCY MEDICAL SERVICES	0	15	36	0	0	23. 02
23. 03 02303 PARAMEDI C PRGM	0	51	122	0	0	23. 03
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	22, 414	4, 702		1, 301, 467	181, 133	30. 00
31. 00 03100 I NTENSI VE CARE UNI T	5, 104	934			32, 139	31.00
31. 01 02060 NEONATAL INTENSIVE CARE UNIT	4, 335	548	·	99, 073	3, 249	31. 01
32.00 03200 CORONARY CARE UNIT 34.00 03400 SURGICAL INTENSIVE CARE UNIT	4, 888 3, 832	1, 293 680		318, 912 180, 364	32, 984 21, 734	32. 00 34. 00
41. 00 04100 SUBPROVI DER - RF	2, 163	440		118, 998		41.00
43. 00 04300 NURSERY	943	73	·	25, 155	1, 398	43. 00
ANCILLARY SERVICE COST CENTERS	7.10	, , ,		20, 100	., 0,0	10.00
50. 00 05000 OPERATING ROOM	21, 051	1, 996	4, 814	676, 938	38, 347	50.00
52.00 O5200 DELIVERY ROOM & LABOR ROOM	6, 436	458	1, 105	180, 830	21, 391	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	12, 445	1, 697	4, 094	435, 989	23, 613	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	433	647	· ·		0	55.00
56. 00 05600 RADI 01 SOTOPE	286	93		5, 904	883	56.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	8, 517	376		·	9, 791	59.00
60. 00 06000 LABORATORY 64. 00 06400 NTRAVENOUS THERAPY	19, 519 549	2, 299 339		179, 667 65, 612	3	60. 00 64. 00
65. 00 06500 RESPI RATORY THERAPY	7, 439	796		58, 699	115	65. 00
66. 00 06600 PHYSI CAL THERAPY	2, 853	658		76, 891	3, 498	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	2, 082	241	581	0	0, 1,0	67.00
68. 00 06800 SPEECH PATHOLOGY	925	118		13, 639	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	3, 629	231	558	95, 814	1, 873	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	687	214	516	0	884	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	22, 387	3, 178			0	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	12, 078	2, 454		0	Ĭ	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	24, 547	5, 508			0	73.00
74. 00 07400 RENAL DI ALYSI S 76. 97 07697 CARDI AC REHABI LI TATI ON	1, 153 28	102 44		27, 912	1, 387 0	74. 00 76. 97
OUTPATIENT SERVICE COST CENTERS		44	100	U	0	70. 77
90. 00 09000 CLINIC	97	671	1, 618	130, 222	1, 833	90. 00
90. 01 09001 I BMT JOI NT VENTURE	72	660			1, 306	90. 01
90. 05 09005 CV DIAGNOSTIC SERVICES	45	1, 048			0	90.05
91. 00 09100 EMERGENCY	11, 504	1, 161	2, 800	335, 148	66, 307	91.00
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS	г		_			
101. 00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00
SPECIAL PURPOSE COST CENTERS						112 00
113. 00 11300 INTEREST EXPENSE 116. 00 11600 HOSPI CE	0	824	1, 987	0	0	113. 00 116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	202, 441	52, 762				
NONREI MBURSABLE COST CENTERS	202, 441	32, 702	71,123	3, 244, 140	433, 372	110.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	66	159	31, 650	0	190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	949				192.00
194.00 07955 MARKETING & COMMUNITY RELATIONS	0	11	26	0	0	194. 00
194. 01 07952 WOMEN' S CENTER	0	31		17, 204		194. 01
194. 02 07950 OTHER NONREI MBURSABLE COST CENTERS	0	0	0	0		194. 02
194. 04 07954 OTHER NRCC	0	6, 918	16, 719	56, 011		194. 04
194. 05 07956 FOUNDATI ON	0	0	0	0	0	194. 05
200.00 Cross Foot Adjustments	_	_	_	_	_	200.00
201.00 Negative Cost Centers 202.00 TOTAL (sum lines 118 through 201)	0 202, 441	0 60, 737	0 116, 992	0 5, 394, 516		201.00
202. 00 TOTAL (Suill TITIES TIS LITTOUGH 201)	202, 441	00, /3/	1 110, 992	5, 574, 516	409, 2/9	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0162

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

3/30/2021 10:40 am Cost Center Description HOUSEKEEPI NG DI ETARY CAFETERI A NURSI NG CENTRAL ADMI NI STRATI O SERVICES & Ν **SUPPLY** 9. 00 10.00 11.00 13.00 14.00 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 5.01 00570 ADMITTING 5.01 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5.02 5.02 5.03 00590 OTHER ADMIN & GENERAL 5.03 00700 OPERATION OF PLANT 7.00 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9 00 00900 HOUSEKEEPI NG 409, 967 9 00 01000 DI ETARY 5. 162 596,064 10.00 10.00 01100 CAFETERI A 818, 418 11.00 7.084 11.00 13.00 01300 NURSING ADMINISTRATION 16, 954 19,033 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 16, 269 5, 666 1, 885, 159 14.00 01500 PHARMACY 6, 308 15.00 28, 492 15.00 0 2,869 C 16.00 01600 MEDICAL RECORDS & LIBRARY C 0 0 16.00 02100 I&R SERVICES-SALARY & FRINGES APPRV 9.882 0 21.00 21 00 493 453 2, 811 0 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 22.00 0 0 22.00 0 02300 MEDICAL LABORATORY SCIENTIST PRGM 25 23 00 0 C 853 23.00 02302 PHARMACY PRGM 0 2, 368 0 25 23.01 23.01 02301 EMERGENCY MEDICAL SERVICES 0 23.02 0 2, 118 178 23.02 02303 PARAMEDIC PRGM 23.03 4,980 87 23.03 INPATIENT ROUTINE SERVICE COST CENTERS 169, 082 30.00 03000 ADULTS & PEDIATRICS 100, 737 284, 300 9.078 4, 988 30.00 03100 INTENSIVE CARE UNIT 31.00 11, 332 112, 028 35, 436 3,577 808 31.00 02060 NEONATAL INTENSIVE CARE UNIT 1, 103 31.01 7,668 34, 548 16, 775 455 31.01 32.00 03200 CORONARY CARE UNIT 24,684 69, 353 47, 346 2, 215 1,056 32.00 03400 SURGICAL INTENSIVE CARE UNIT 34.00 13, 960 45,068 25, 021 1, 439 514 34.00 04100 SUBPROVI DER - I RF 41.00 9. 211 30.340 15, 297 969 271 41.00 04300 NURSERY 43.00 1.947 20, 427 1, 988 652 378 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 52, 395 58, 170 13, 857 50.00 0 52 00 05200 DELIVERY ROOM & LABOR ROOM 13.996 Ω 14 047 506 52 00 05400 RADI OLOGY-DI AGNOSTI C 33, 746 54.00 0 41,047 9, 977 54.00 6, 198 55.00 05500 RADI OLOGY-THERAPEUTI C 2, 363 0 0 11 55.00 05600 RADI OI SOTOPE 0 56.00 457 0 731 20, 240 56.00 ō 59 00 05900 CARDI AC CATHETERI ZATI ON 13. 098 0 8, 813 59 00 433 0 60.00 06000 LABORATORY 13, 906 0 2, 374 289 60.00 06400 I NTRAVENOUS THERAPY 5,078 13,072 0 64.00 1, 424 64.00 0 65 00 06500 RESPIRATORY THERAPY 4.543 0 30 165 610 65 00 06600 PHYSI CAL THERAPY 66.00 5, 951 0 20, 371 540 66.00 0 06700 OCCUPATI ONAL THERAPY 9,718 124 67.00 67.00 68.00 06800 SPEECH PATHOLOGY 1,056 0 3, 924 0 0 89 68.00 06900 ELECTROCARDI OLOGY 0 69 00 7.432 683 69 00 7, 416 70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 7,612 184 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 0 0 1, 014, 565 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 72.00 72.00 0 0 783, 766 07300 DRUGS CHARGED TO PATIENTS 73 00 0 0 73 00 0 0 74.00 07400 RENAL DIALYSIS 2, 160 0 144 0 34 74.00 07697 CARDIAC REHABILITATION 76.97 2,005 143 76.97 OUTPATIENT SERVICE COST CENTERS 425 90 00 09000 CLINIC 10,079 0 31,802 0 90 00 90.01 09001 IBMT JOINT VENTURE 1, 288 0 7,536 0 165 90.01 90 05 09005 CV DIAGNOSTIC SERVICES 0 49, 341 0 6,892 90.05 09100 EMERGENCY 91.00 25, 941 0 91.00 41, 356 0 1,642 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 101. 00 10100 HOME HEALTH AGENCY 0 0 0 0 0 101.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 I NTEREST EXPENSE 113.00 116. 00 11600 HOSPI CE 27, 558 4, 373 116. 00 SUBTOTALS (SUM OF LINES 1 through 117)
NONREIMBURSABLE COST CENTERS 118.00 398, 328 596, 064 768, 485 19, 033 1, 873, 079 118. 00 2, 450 3, 698 190. 00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 2, 493 192.00 19200 PHYSICIANS' PRIVATE OFFICES o 2, 699 192. 00 3, 522 0 23, 152 194.00 07955 MARKETING & COMMUNITY RELATIONS 0 0 194, 00 0 0 374 194. 01 07952 WOMEN' S CENTER 1, 332 77 194. 01 C 647 0 194. 02 07950 OTHER NONREI MBURSABLE COST CENTERS o 0 194.02 0 0 194. 04 07954 OTHER NRCC 4.335 0 23, 267 0 5, 606 194. 04 194. 05 07956 FOUNDATI ON 0 194.05 0 0 C 0 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 0 201.00 202.00 TOTAL (sum lines 118 through 201) 409, 967 596,064 818, 418 19, 033 1, 885, 159 202. 00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0162

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

3/30/2021 10:40 am INTERNS & RESIDENTS **PHARMACY** MEDI CAL SERVI CES-SALA | SERVI CES-OTHE MEDI CAL Cost Center Description R PRGM COSTS LABORATORY RECORDS & RY & FRINGES LI BRARY APPRV **APPRV** SCI ENTI ST PRGM 15. 00 16.00 21.00 22.00 23.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FLXT 1.00 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00570 ADMITTING 5.01 5.01 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5.02 5.02 5.03 00590 OTHER ADMIN & GENERAL 5.03 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8 00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 10.00 01100 CAFETERI A 11.00 11.00 01300 NURSING ADMINISTRATION 13.00 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 01500 PHARMACY 15.00 762, 256 15.00 01600 MEDICAL RECORDS & LIBRARY 16 00 51 16 00 21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV 0 C 68,039 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 0 0 3, 360 22.00 22.00 02300 MEDICAL LABORATORY SCIENTIST PRGM 0 23.00 0 909 23.00 02302 PHARMACY PRGM 0 0 23 01 23 01 02301 EMERGENCY MEDICAL SERVICES 23.02 0 0 23.02 02303 PARAMEDIC PRGM 23.03 23.03 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 C 30.00 31.00 03100 INTENSIVE CARE UNIT 0 0 31.00 02060 NEONATAL INTENSIVE CARE UNIT 0 0 31.01 31.01 0 03200 CORONARY CARE UNIT 32.00 0 32.00 03400 SURGICAL INTENSIVE CARE UNIT 0 34.00 34 00 41.00 04100 SUBPROVI DER - I RF 0 0 41.00 43.00 04300 NURSERY 0 0 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 0 50.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 000000000000 0 54.00 05500 RADI OLOGY-THERAPEUTI C 55.00 0 55.00 56.00 05600 RADI OI SOTOPE 0 56.00 59 00 05900 CARDI AC CATHETERI ZATI ON 0 59.00 06000 LABORATORY 0 60.00 60.00 06400 I NTRAVENOUS THERAPY 64.00 0 64.00 65.00 06500 RESPIRATORY THERAPY 65.00 66.00 06600 PHYSI CAL THERAPY 66.00 06700 OCCUPATI ONAL THERAPY 67.00 0 67.00 68.00 06800 SPEECH PATHOLOGY C 68.00 69.00 06900 ELECTROCARDI OLOGY 69.00 0 70.00 07000 ELECTROENCEPHALOGRAPHY 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71 00 C 71 00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 C 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 762, 256 51 73.00 07400 RENAL DIALYSIS 74.00 74.00 0 C 07697 CARDIAC REHABILITATION 76. 97 0 0 76.97 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 90.00 09001 I BMT JOINT VENTURE 0 C 90 01 90 01 90.05 09005 CV DIAGNOSTIC SERVICES 0 C 90.05 09100 EMERGENCY 0 91.00 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 0 0 101.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | NTEREST EXPENSE 113 00 116. 00 11600 HOSPI CE 0 C 116.00 762, 256 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 51 0 0 118.00 0 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN n 190 00 0 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 0 192.00 194.00 07955 MARKETING & COMMUNITY RELATIONS 0 194.00 0 0 194. 01 07952 WOMEN' S CENTER 0 194. 01 194. 02 07950 OTHER NONREI MBURSABLE COST CENTERS 194.02 0 194. 04 07954 OTHER NRCC 0 0 194.04 194. 05 07956 FOUNDATI ON 194.05

Health Financial Systems	ST. FRANCIS HOSPITAL & HEALTH C	ENTER	In Lieu	ı of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS	Provi der	CCN: 15-0162	Peri od: From 01/01/2020	Worksheet B Part II

					0 12/31/2020	Date/IIme Pre	eparred:
						3/30/2021 10:	40 am
				INTERNS &	RESI DENTS		
	Cost Center Description	PHARMACY	MEDI CAL	SERVI CES-SALA	SERVI CES-OTHE	MEDI CAL	
	'		RECORDS &	RY & FRINGES	R PRGM COSTS	LABORATORY	
			LI BRARY	APPRV	APPRV	SCI ENTI ST	
			2.5.0	7	7	PRGM	
		15, 00	16, 00	21.00	22.00	23. 00	
200 00	O E I A I' I I .	10.00	10.00				000 00
200. 00	Cross Foot Adjustments			68, 039	3, 360	909	200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202. 00	TOTAL (sum lines 118 through 201)	762, 256	51	68, 039	3, 360	909	202.00

| Period: | Worksheet B | From 01/01/2020 | Part | I | To | 12/31/2020 | Date/Time | Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS ST. FRANCIS HOSPITAL & HEALTH CENTER
Provider CCN: 15-0162

				To 12/31/2020	Date/Time Pre	
Cost Center Description	PHARMACY PRGM	EMERGENCY MEDI CAL SERVI CES	PARAMEDI C PRGM	Subtotal	3/30/2021 10: Intern & Residents Cost & Post Stepdown	40 am
	23. 01	23. 02	23. 03	24.00	Adjustments 25.00	
GENERAL SERVICE COST CENTERS			1			
1. 00	2, 659	2, 347	1			1. 00 2. 00 4. 00 5. 01 5. 02 5. 03 7. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 21. 00 22. 00 23. 01 23. 02 23. 03
23. 03 02303 PARAMEDI C PRGM I NPATI ENT ROUTI NE SERVI CE COST CENTERS			5, 24	0		23.03
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 31. 01 02060 NEONATAL INTENSIVE CARE UNIT 32. 00 03200 CORONARY CARE UNIT 34. 00 03400 SURGICAL INTENSIVE CARE UNIT 41. 00 04100 SUBPROVIDER - IRF 43. 00 04300 NURSERY				12, 308, 780 1, 499, 666 947, 022 3, 010, 041 1, 710, 521 1, 123, 305 250, 659	0 0 0 0 0 0	30. 00 31. 00 31. 01 32. 00 34. 00 41. 00 43. 00
ANCI LLARY SERVI CE COST CENTERS 50 00 05000 OPERATING ROOM			I	6 183 085	0	50.00
50. 00 05000 OPERATI NG ROOM 52. 00 05200 DELI VERY ROOM & LABOR ROOM 54. 00 05400 RADI OLOGY-DI AGNOSTI C 55. 00 05500 RADI OLOGY-THERAPEUTI C 56. 00 05500 RADI OLOGY-THERAPEUTI C 56. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY 64. 00 06400 INTRAVENOUS THERAPY 65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 73. 00 07300 RUSS CHARGED TO PATI ENTS 74. 00 07400 RENAL DI ALYSI S 76. 97 07697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVI CE COST CENTERS 90. 00 09000 CLI NI C				6, 183, 085 1, 658, 701 3, 986, 123 281, 467 75, 179 1, 539, 955 1, 634, 404 602, 096 565, 204 716, 119 12, 746 127, 134 869, 997 10, 097 1, 047, 795 804, 218 805, 647 252, 309 2, 326	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	52. 00 54. 00 55. 00 56. 00 59. 00 60. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 71. 00 72. 00 73. 00 74. 00 76. 97
90. 01 09001 I BMT JOI NT VENTURE				159, 980	0	
90. 05 09005 CV DI AGNOSTI C SERVI CES 91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART OTHER REI MBURSABLE COST CENTERS				59, 855 3, 117, 540	0 0 0	90. 05 91. 00 92. 00
101.00 10100 HOME HEALTH AGENCY				0	0	101.00
SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 116.00 11600 HOSPI CE 118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	0	0		34, 742 0 46, 595, 999		113. 00 116. 00 118. 00
190.00 19000 GFT, FLOWER, COFFEE SHOP & CANTEEN 192.00 19200 PHYSICIANS' PRIVATE OFFICES 194.00 07955 MARKETING & COMMUNITY RELATIONS 194.01 07952 WOMEN'S CENTER 194.02 07950 OTHER NONREIMBURSABLE COST CENTERS 194.04 07954 OTHER NRCC 194.05 07956 FOUNDATION 200.00 Cross Foot Adjustments	2, 659	2, 347	5, 24	289, 044 436, 834 411 156, 743 0 552, 672 0 82, 554	0 0 0 0 0	190. 00 192. 00 194. 00 194. 01 194. 02 194. 04 194. 05 200. 00
	2,007	2, 547	3, 24	-1 02, 004	0	

Health Financial Systems	ST.	FRANCIS HOSPITA	L & HEALTH CEN	TER	In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS			Provi der Co	CN: 15-0162	Peri od:	Worksheet B	
					From 01/01/2020 To 12/31/2020		nared:
					10 12/31/2020	3/30/2021 10:	40 am
Cost Center Description		PHARMACY PRGM	EMERGENCY	PARAMEDI C	Subtotal	Intern &	
			MEDI CAL	PRGM		Resi dents	
			SERVI CES			Cost & Post	
						Stepdown	
						Adjustments	
		23. 01	23. 02	23. 03	24.00	25.00	
201.00 Negative Cost Centers		0	0		0	0	201.00
202.00 TOTAL (sum lines 118 through	າ 201)	2, 659	2, 347	5, 24	48, 114, 257	0	202.00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provi der CCN: 15-0162

| In Lieu of Form CMS-2552-10 | Period: Worksheet B | From 01/01/2020 | Part II | To 12/31/2020 | Date/Time Prepared: 3/30/2021 10: 40 am

			3/30/2021 10:	40 am
Cost	t Center Description	Total		
		26. 00		
GENERAL SE	ERVICE 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 EMPL	LOYEE BENEFITS DEPARTMENT			4.00
5. 01 00570 ADMI				5. 01
1 1	HI ERI NG/ACCOUNTS RECEI VABLE			5. 02
	ER ADMIN & GENERAL			5. 03
1 1		+		
	RATION OF PLANT			7.00
	NDRY & LINEN SERVICE			8.00
9. 00 00900 HOUS				9. 00
10. 00 01000 DI ET				10.00
11.00 01100 CAFE	ETERI A			11.00
13. 00 01300 NURS	SING ADMINISTRATION			13.00
14. 00 01400 CENT	TRAL SERVICES & SUPPLY			14.00
15. 00 01500 PHAR	RMACY			15.00
	ICAL RECORDS & LIBRARY			16.00
	SERVICES-SALARY & FRINGES APPRV			21.00
	SERVICES-OTHER PRGM COSTS APPRV	•		22.00
1 1				1
1 1	ICAL LABORATORY SCIENTIST PRGM			23.00
1 1	RMACY PRGM			23. 01
	RGENCY MEDICAL SERVICES			23. 02
23. 03 02303 PARA	AMEDIC PRGM			23. 03
I NPATI ENT	ROUTINE SERVICE COST CENTERS			
	LTS & PEDIATRICS	12, 308, 780		30.00
	ENSIVE CARE UNIT	1, 499, 666		31.00
	NATAL INTENSIVE CARE UNIT	947, 022		31.01
	ONARY CARE UNIT	3, 010, 041		32.00
	GICAL INTENSIVE CARE UNIT	1, 710, 521		34.00
1 1	PROVI DER - I RF	1, 123, 305		41.00
43. 00 04300 NURS		250, 659		43.00
	SERVICE COST CENTERS			
50.00 05000 OPER	RATING ROOM	6, 183, 085		50.00
52. 00 05200 DELI	IVERY ROOM & LABOR ROOM	1, 658, 701		52.00
54. 00 05400 RADI	I OLOGY-DI AGNOSTI C	3, 986, 123		54.00
1 1	I OLOGY-THERAPEUTI C	281, 467		55.00
56. 00 05600 RADI	1	75, 179		56.00
	DI AC CATHETERI ZATI ON	1, 539, 955		59.00
	1			1
	I I	1, 634, 404		60.00
1 1	RAVENOUS THERAPY	602, 096		64.00
1 1	PI RATORY THERAPY	565, 204		65.00
	SI CAL THERAPY	716, 119		66.00
67. 00 06700 0CCU	UPATI ONAL THERAPY	12, 746		67.00
68. 00 06800 SPEE	ECH PATHOLOGY	127, 134		68.00
69. 00 06900 ELEC	CTROCARDI OLOGY	869, 997		69.00
70.00 07000 ELEC	CTROENCEPHALOGRAPHY	10, 097		70.00
1 1	ICAL SUPPLIES CHARGED TO PATIENT	1, 047, 795		71.00
1 1	L. DEV. CHARGED TO PATIENTS	804, 218		72.00
1 1	GS CHARGED TO PATIENTS	805, 647		73.00
1 1				1
1 1	AL DIALYSIS	252, 309		74.00
	DI AC REHABILITATION	2, 326		76. 97
	T SERVICE COST CENTERS			
90. 00 09000 CLI N		1, 199, 286		90.00
90. 01 09001 I BMT	T JOINT VENTURE	159, 980		90. 01
90. 05 09005 CV D	DI AGNOSTI C SERVI CES	59, 855		90.05
91.00 09100 EMER		3, 117, 540		91.00
92 00 09200 OBSE	ERVATION BEDS (NON-DISTINCT PART	0, 117, 010		92.00
	MBURSABLE COST CENTERS			/2.00
		0		101 00
101. 00 10100 HOME		U		101.00
	URPOSE COST CENTERS			110 00
113. 00 11300 I NTE				113.00
116. 00 11600 HOSP	1	34, 742		116. 00
	TOTALS (SUM OF LINES 1 through 117)	46, 595, 999		118. 00
NONREI MBUF	RSABLE COST CENTERS			
	T, FLOWER, COFFEE SHOP & CANTEEN	289, 044		190. 00
	SICIANS' PRIVATE OFFICES	436, 834		192.00
	KETING & COMMUNITY RELATIONS	411		194.00
194. 00 07955 MARK				194.00
		156, 743		
	ER NONREIMBURSABLE COST CENTERS	0		194. 02
194. 04 07954 OTHE		552, 672		194. 04
194. 05 07956 FOUN	NDATI ON	0		194. 05
	ss Foot Adjustments	82, 554		200.00
	ative Cost Centers	0		201.00
	AL (sum lines 118 through 201)	48, 114, 257		202.00
202.00 1014	TE (Suil Titles TTO till ough 201)	70, 114, 237		1202.00

Health Financial Systems ST. FRANCIS HOSPITAL & HEALTH CENTER In Lieu of Form CMS-2552-10 COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0162 Peri od: Worksheet B-1 From 01/01/2020 12/31/2020 Date/Time Prepared: 3/30/2021 10:40 am CAPITAL RELATED COSTS ADMI TTI NG Cost Center Description BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Reconciliatio (SQUARE FEET) (SOUARE FEET) **BENEFITS** (INPATIENT n DEPARTMENT CHARGES) (GROSS SALARI ES) 1. 00 2.00 4.00 5. 01 5A. 02 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 880.093 1 00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 880, 093 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 170, 985, 927 4.00 5.01 00570 ADMITTING 3, 703 3.703 5.01 \cap 1, 389, 261, 404 5.02 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 1, 111 1, 111 C -60, 737 5.02 5.03 00590 OTHER ADMIN & GENERAL 1, 916 1, 916 1, 781, 995 0 0 5.03 00700 OPERATION OF PLANT 98.537 3, 779, 271 0 7.00 7 00 98, 537 0 00800 LAUNDRY & LINEN SERVICE 0 8.00 7, 441 7, 441 242, 343 0 8.00 6, 611 9.00 00900 HOUSEKEEPI NG 6, 611 3, 991, 630 0 0 9.00 10.00 01000 DI ETARY 9,580 9,580 1,017,176 0 0 0 10.00 01100 CAFETERI A 2 015 235 11 00 13, 145 11 00 13, 145 0 01300 NURSING ADMINISTRATION 13.00 4, 328, 850 0 13.00 01400 CENTRAL SERVICES & SUPPLY 30, 190 30, 190 678, 692 0 0 14.00 14.00 01500 PHARMACY 11, 705 0 0 15.00 15.00 11, 705 6, 657, 628 0 01600 MEDICAL RECORDS & LIBRARY 16.00 16.00 Ω 0 0 21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV 915 915 2, 206, 377 0 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 0 22.00 1, 550, 228 0 22.00 0 C 02300 MEDICAL LABORATORY SCIENTIST PRGM 0 0 23 00 0 167, 709 Ω 23 00 02302 PHARMACY PRGM 0 23.01 0 C 523, 408 0 23.01 02301 EMERGENCY MEDICAL SERVICES 0 249, 035 0 0 23.02 23.02 23.03 02303 PARAMEDIC PRGM 0 0 667, 414 0 23.03 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 186, 933 186, 933 29, 877, 519 153, 517, 968 0 30.00 03100 INTENSIVE CARE UNIT 21, 029 21, 029 6, 580, 301 34, 959, 936 0 31.00 31.00 02060 NEONATAL INTENSIVE CARE UNIT 14, 230 14, 230 3, 395, 716 29, 689, 793 31.01 0 31.01 03200 CORONARY CARE UNIT 45, 806 8, 810, 548 33, 477, 904 32 00 45, 806 0 32.00 34.00 03400 SURGICAL INTENSIVE CARE UNIT 25, 906 25, 906 4, 549, 979 26, 244, 402 0 34.00 04100 SUBPROVI DER - I RF 41 00 17,092 17,092 2, 928, 631 14, 817, 214 0 41.00 43.00 04300 NURSERY 3, 613 3, 613 382, 697 6, 456, 336 0 43.00 ANCILLARY SERVICE COST CENTERS 97, 230 11, 771, 098 50.00 05000 OPERATING ROOM 97, 230 144, 187, 696 0 50.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 25, 973 25, 973 2, 773, 890 44, 083, 876 0 52.00 05400 RADI OLOGY-DI AGNOSTI C 8, 655, 969 54.00 54.00 62,622 62, 622 85, 242, 123 0 05500 RADI OLOGY-THERAPEUTI C 55.00 4, 385 4, 385 1, 462, 148 2, 968, 046 0 55.00 56,00 05600 RADI OI SOTOPE 848 848 201, 920 1, 960, 555 0 56, 00 59.00 05900 CARDI AC CATHETERI ZATI ON 24, 306 24, 306 2, 042, 559 58, 337, 731 59.00 0 06000 LABORATORY 25, 806 133, 693, 180 25, 806 566, 413 60 00 60.00 0 06400 I NTRAVENOUS THERAPY 64.00 9, 424 9, 424 2, 544, 678 3, 757, 530 0 64.00 65.00 06500 RESPIRATORY THERAPY 8, 431 8, 431 5, 773, 199 50, 953, 990 0 65.00 06600 PHYSI CAL THERAPY 4, 417, 949 19, 538, 129 0 66.00 11.044 11.044 66.00 06700 OCCUPATIONAL THERAPY 1, 935, 182 14, 258, 454 67.00 0 67.00 68.00 06800 SPEECH PATHOLOGY 1, 959 1, 959 759, 134 6, 337, 786 68.00 69.00 06900 ELECTROCARDI OLOGY 13, 762 1, 369, 267 24, 859, 377 0 69.00 13, 762 07000 ELECTROENCEPHALOGRAPHY 1, 499, 680 4, 706, 509 70 00 70 00 0 C 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 C 153, 335, 853 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 0 C 0 82, 727, 769 0 72.00 07300 DRUGS CHARGED TO PATIENTS 170, 802, 832 73.00 73.00 0 0 0 07400 RENAL DIALYSIS 37, 840 74.00 4,009 4,009 7, 896, 114 0 74.00 76.97 07697 CARDIAC REHABILITATION 318, 096 189, 051 0 76.97 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLINIC 18 704 18. 704 5, 608, 092 662 591 0 90.00 09001 I BMT JOINT VENTURE 90.01 2, 391 2, 391 1, 583, 902 495, 465 0 90.01 09005 CV DIAGNOSTIC SERVICES 7, 266, 290 309, 254 0 90.05 90.05 91.00 09100 EMERGENCY 48, 138 48, 138 7, 496, 285 78, 793, 940 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92 00 92.00 OTHER RELMBURSABLE COST CENTERS 00 n 00

0	0	0	0	0 101. 00
				113. 00
0	0	5, 795, 361	0	0 116. 00
858, 495	858, 495	160, 261, 334	1, 389, 261, 404	-60, 737 118. 00
4, 546	4, 546	254, 045	0	0 190. 00
6, 536	6, 536	6, 164, 834	0	0 192. 00
0	0	58, 565	0	0 194. 00
2, 471	2, 471	96, 624	0	0 194. 0 ⁻
0	0	0	0	0 194. 0
8, 045	8, 045	4, 150, 525	0	0 194. 0
	4, 546 6, 536 0 2, 471	4, 546 6, 536 0 0 2, 471 2, 471 0 0	858, 495 858, 495 160, 261, 334 4, 546 4, 546 254, 045 6, 536 6, 536 6, 164, 834 0 0 58, 565 2, 471 2, 471 96, 624 0 0	858, 495 858, 495 160, 261, 334 1, 389, 261, 404 4, 546 254, 045 0 6, 536 6, 164, 834 0 58, 565 0 2, 471 2, 471 96, 624 0 0 0 0 0

Health Financial Systems	ST. FRANCIS HOSPITAL 8	HEALTH CENTER	In Lieu	u of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 15-0162	Peri od:	Worksheet B-1
			From 01/01/2020	
		I .	T- 10/01/0000	D-+- /T! D

					Γο 12/31/2020	Date/Time Pre 3/30/2021 10:	
		CAPI TAL REL	_ATED COSTS				
	Cost Center Description	BLDG & FLXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	ADMI TTI NG (I NPATI ENT CHARGES)	Reconciliatio n	
		1. 00	2.00	4. 00	5. 01	5A. 02	
194. 05 07	956 FOUNDATI ON	0	0	(0	0	194. 05
200.00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	33, 157, 122	14, 957, 135	70, 659, 30	206, 251		202. 00
203.00	Unit cost multiplier (Wkst. B, Part I)	37. 674566	16. 994948	0. 41324	0. 000148		203. 00
204. 00	Cost to be allocated (per Wkst. B, Part II)			(202, 441		204. 00
205. 00	Unit cost multiplier (Wkst. B, Part			0. 000000	0. 000146		205. 00
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

| Period: | Worksheet B-1 | From 01/01/2020 | To 12/31/2020 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0162

Count Center Description						o 12/31/2020		
		Cost Center Description	CASHI ERI NG/AC	Reconciliatio	OTHER ADMIN &	OPERATION OF		40 alli
### COUNT COST SA US S. US		·		n				
DEBUGN_SQUEET_COST_CAUSES FIRST 1.00					(ACCUM. COST)	(SQUARE FEET)		
SERBEAL SERVICE COST CENTERS 1 00 00000 CAP REL COSTS-RIVERS EDUTY 2 00 00000 CAP REL COSTS-RIVERS EDUTY 3 00 00000 CAP REL COSTS-RIVERS EDUTY 5 00 00000 CAP REL COSTS-RIVERS EDUTY 6 00 00000 CAP RAMIN A CAP CAP CAP CAP CAP CAP CAP CAP CAP C				5A. 03	5. 03	7. 00		
2.00 DOCODO CAP REL COSTS -APPELE EQUIT		GENERAL SERVICE COST CENTERS						
4.00 0.000 LMR-LYCE BEHEFT IS DEPARTMENT 14.001 0.001 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.00								1
5.01 000-FOLKAIN TITKES 5.01 5.01 5.02 000-FOLKAIN ST RECEIVABLE 714, 578, 961 -144, 1094, 315 570, 246, 339, 337 774, 1926 5.01 000-FOLKAIN A CREEKAL 144, 002, 069 -144, 1094, 315 570, 246, 339, 331 774, 1926 5.02 000-FOLKAIN A CREEKAL 144, 002, 069 -144, 1094, 315 570, 246, 339, 432 774, 1926 5.02 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 1926 774, 19								1
5.02 DOSSIG LOSSIS ESTREAMS/ACCIDATES SECTUMBLE 714, 578, 961 714, 094, 315 770, 364, 313 777, 854 770, 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700 700								1
5.03 0.0590 CITHER ADMIN & GENERAL 144.0HZ, CORP 144.0P4, 318 570, 345, 383 570, 482, 383 570, 482, 383 580, 380, 380, 380, 380, 380, 380, 380, 3			714, 578, 961					1
0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.000 0.00	5.03			-144, 094, 315	570, 545, 383	3		5. 03
0.000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.00000000		1 · · · · · · · · · · · · · · · · · · ·		-				•
0.00 01000 DETARY								•
11.00 0100 CAFETERIA 4,094,328 0 4,084,075 12,145 0 11 1.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00								
14.00 01400 CENTEM, SERVICES & SUPPLY 3, 379, 308 0 3, 379, 595 30, 190 9, 777 14.00 16.00 01600 MEDI CAL, RECORDS & LIBRARY 10, 699, 144 01, 090, 008 11, 705 0 0.16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00								
15.00 1500 PHARNACY 10.999, 164 0 10.990, 098 11.705 0 15.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 174.502 0 0 16.00 174.502 0 0 12.00 12.00 174.502 0 0 12.00 174.502 0 0 174.502 0 0 174.502 0 0 174.502 0 0 174.502 0 0 174.502 0 0 174.502 0 0 174.502 0 0 174.502 0 0 174.502 0 0 174.502 0 0 174.502 0 0 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00 0 23.00	13.00		7, 170, 585	0	7, 171, 194	0	0	13.00
10.00 0.000 MEDICAL, RECORDS & LIBRARY 1.14, 49F 0 1.14, 50Z 0 0 10 0.00								1
21.00 02100 IAS SERVICES-SALANY & FENNESS APPRY 2,822,630 0 2,822,870 915 0 21.00 22.00 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222.01 222		1 I	1 ' '					1
22.00 02000 IAR SERVICES-OTHER PROM COSTS APPRV 1,891,917 0 1,992,078 0 0 22.00 23.00 2300 02000 MEDICAL LABORATORY SCIENTIST PROM 107,637 0 107,646 0 0 23.00 23.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230.00 230		1 1	1					1
23.01 02302 PHARBARCY PROM								1
23.02 02301 PARAMEDIC PROM 0 0 23.02			1	0			0	1
23.03 PARABLED C PROM 594, 353 0 594, 404 0 0 0 23.03			1				•	1
IMPART ENT ROUTINE SERVICE COST CENTERS							1	1
30.00 30000 ADULTS & PEDIATRICS 55, 318, 721 0 55, 323, 423 186, 933 1, 119, 517 30, 00 310 01 01 18TENSIVE CARE UNIT 10, 993, 720 0 10, 994, 654 21, 020 2198, 639 31, 00 310 01 310 01 18TENSIVE CARE UNIT 1, 445, 107 0 6, 445, 655 14, 230 20, 083 31, 01 31, 20 01, 320 00, 32000 CRONARY CARE UNIT 15, 207, 378 0 15, 208, 671 45, 80 220, 866 32, 00 34, 00 33400 CRONARY CARE UNIT 8, 004, 942 0 8, 005, 622 25, 906 134, 330 34, 00 34, 00 03800 SURGICAL INTENSIVE CARE UNIT 8, 004, 942 0 8, 005, 622 25, 906 134, 330 34, 00 34, 00 34, 00 SURPROVIDER - IRF 8, 616, 666 0 861, 759 3, 613 8, 638 43, 00 34, 00 34, 00 MURSFEY 861, 666 0 861, 759 3, 613 8, 638 43, 00 34, 00 34, 00 MURSFEY 861, 666 0 861, 759 3, 613 8, 638 43, 00 34, 00 34, 00 MURSFEY 861, 666 0 861, 759 3, 613 8, 638 43, 00 34, 00 34, 00 MURSFEY 861, 666 0 861, 759 3, 613 8, 638 43, 00 34, 00 34, 00 MURSFEY 861, 666 0 861, 759 3, 613 8, 638 43, 00 34, 00 34, 00 34, 00 34, 00 34, 00 34, 00 34, 00 34, 00 34, 00 34, 00 34, 00 34, 00 34, 00 34, 00 34, 00 34, 00 34, 00 34, 00 34, 00 34, 00 34, 00 34, 00 34, 00 34, 00 34, 00 34, 00 34, 00 34, 00 34, 00 34, 00 34, 00 34, 00 34, 00 34, 00 34, 00 34, 00 34, 00 34, 00 34, 00 34, 00 34, 00 34, 00 34, 00 34, 00 34, 00 34, 00 34, 00 34, 00 34, 00 34, 00 34, 00 34, 00 34, 00 34, 00 34, 00 34, 00 34, 00 34, 00 34, 00 34, 00 34, 00 34, 00 34, 00 34, 00 34, 00 34, 00 34, 00 34, 00 34, 00 34, 00 34, 00 34, 00 34, 00 34, 00 34, 00 34, 00 34, 00 34, 00 34, 00 34, 00 34, 00 34, 00 34, 00 34, 00 34, 00 34, 00 34, 00 34, 00 34, 00 34, 00 34, 00 34, 00 34, 00 34, 00 34, 00 34, 00 34, 00 34, 00 34, 00 34, 00 34, 00	23.03		374, 333	0	374, 404		0	23.03
31 01 02000 NEONATAL INTENSIVE CARE UNIT 6. 445, 107 0 6. 445, 605 14, 230 20, 083 31, 01 32, 00 3320 03300 0760MAPY CARE UNIT 15, 207, 378 0 15, 086, 671 45, 866 20, 866 32, 00 34, 00 03400 SURGICAL INTENSIVE CARE UNIT 8, 004, 942 0 8, 005, 622 25, 906 134, 330 34, 00 43, 00 04300 NURSERY 861, 866 0 861, 759 3, 613 8, 638 43, 00 43, 00 04300 NURSERY 861, 866 0 861, 759 3, 613 8, 638 43, 00 43, 00 04300 NURSERY 861, 866 0 861, 759 3, 613 8, 638 43, 00 43, 00 05000 DELVIEW ROOM 23, 482, 404 0 23, 484, 400 97, 230 237, 011 50, 00 50, 00 05000 DELVIEW ROOM 2, 38, 447 0 5, 389, 905 25, 731 312, 213 52, 00 520, 00 520, 00 520, 00 520, 00 520, 00 520, 00 520, 00 520, 00 620, 00 620, 00 640, 00 640, 00 640, 00 640, 00 640, 00 640, 00 640, 00 640, 00 640, 00 640, 00 640, 00 640, 00 640, 00 640, 00 640, 00 640, 00 640, 00 640, 00 640, 00 640, 00 640, 00 640, 00 640, 00 640, 00 640, 00 640, 00 640, 00 640, 00 640, 00 640, 00 640, 00 640, 00 640, 00 640, 00 640, 00 640, 00 640, 00 640, 00 640, 00 640, 00 640, 00 640, 00 640, 00 640, 00 640, 00 640, 00 640, 00 640, 00 640, 00 640, 00 640, 00 640, 00 640, 00 640, 00 640, 00 640, 00 640, 00 640, 00 640, 00 640, 00 640, 00 640, 00 640, 00 640, 00 640, 00 640, 00 640, 00 640, 00 640, 00 640, 00 640, 00 640, 00 640, 00 640, 00 640, 00 640, 00 640, 00 640, 00 640, 00 640, 00 640, 00 640, 00 640, 00 640, 00 640, 00 640, 00 640, 00 640, 00 640, 00 640, 00 640, 00 640, 00 640, 00 640, 00 640, 00 640, 00 640, 00 640, 00 640, 00 640, 00 640, 00 640, 00 640, 00 640, 00 640, 00 640, 00 640, 00 640, 00 640, 00 640, 00 640, 00 640, 00 640, 00 640, 00 640, 00 640, 00 640, 00 640, 00 640, 00	30.00		55, 318, 721	0	55, 323, 423	186, 933	1, 119, 517	30.00
32.00 03200 ORROMARY CARE UNIT 15, 207, 378 0 15, 208, 671 45, 806 203, 866 32.00								1
34 00 03400 SURRIOL LINTENSIVE CARE UNIT 8, 004, 942 0 8, 005, 622 25, 006 134, 330 34, 00 4300 04300 SUBPROVIDER = I.RF 5, 180, 860 0 861, 759 3, 613 8, 638 43, 00 861, 759 3, 613 8, 638 43, 00 861, 759 3, 613 8, 638 43, 00 861, 759 3, 613 8, 638 43, 00 861, 759 3, 613 8, 638 43, 00 861, 759 3, 613 8, 638 43, 00 861, 759 3, 613 8, 638 43, 00 861, 759 3, 613 8, 638 43, 00 861, 759 3, 613 8, 638 43, 00 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 861, 759 8								1
A1, 00 04100 SUBPROVI DER - I RF 5, 180, 860 0 5, 181, 300 17, 092 22, 28, 87 41, 00								1
A3 00 04300 NURSERY B61, 686 0 B61, 759 3, 613 8, 638 43, 00								1
50.00 05000 05000 0FLATING ROOM 23, 482, 404 0 23, 484, 400 97, 230 237, 011 50, 00 52, 00 0500 0ELOVERY ROOM & LABOR ROOM 5, 389, 447 0 5, 389, 905 25, 973 132, 213 52, 00 54, 00 05400 RADIOLOGY-DI AGNOSTIC 19, 968, 327 0 19, 970, 024 62, 622 145, 946 54, 00 65, 00 05600 RADIOLOGY-THERAPEUTIC 7, 610, 136 0 7, 610, 783 4, 385 0 55, 00 55, 00 05600 RADIOLOGY-THERAPEUTIC 7, 610, 136 0 7, 610, 783 4, 385 0 55, 00 55, 00 5500 RADIOLOGY-THERAPEUTIC 7, 610, 136 0 7, 610, 783 4, 385 0 55, 00 55, 00 5500 RADIOLOGY-THERAPEUTIC 7, 610, 136 0 7, 610, 783 4, 385 0 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 00 55, 0			1 ' '					•
S2.00 OSCO DELLUTERY ROOM & LABOR ROOM 5, 389, 447 0 5, 389, 905 25, 973 132, 213 52.00								
54. 00 05400 RADIOLOGY-DIAGNOSTIC 19, 968, 327 0 19, 970, 024 62, 622 145, 946 54. 00 55. 00 05500 RADIOLOGY-DIAGNOSTIC 7, 610, 136 0 7, 610, 738 4, 385 0 55. 00 05500 RADIOLOGY-THERAPEUTIC 7, 610, 136 0 7, 610, 738 4, 385 0 55. 00 05900 CARDIA CATHETERI ZATION 4, 421, 405 0 1, 098, 118 848 5, 455 56. 00 0.00 0.000 0.0000 CARDIAC CATHETERI ZATION 4, 421, 405 0 1, 098, 118 848 5, 455 56. 00 0.00 0.000 0.0000 CARDIAC CATHETERI ZATION 4, 421, 405 0 27, 050, 550 25, 806 0.514 59. 00 0.00 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.000000 0.0000000 0.00000000								•
55. 00 05.00 CADIO LOGY-THERAPEUTIC 7, 610, 136 0 7, 610, 783 4, 385 0 55. 00		1						1
56.00 05000 RADIO I SOTOPE 1,098, 025 0 1,098, 118 848 5,455 56.00			1 ' '					1
60.00 06000 LABORATORY 27,048,251 0 27,050,550 25,866 20 60.00	56.00			0				56.00
64.00 06400 INTRAVENDUS THERAPY 3, 985, 695 0 3, 986, 034 9, 424 0 64, 00 65.00 06500 RESPI RATORY THERAPY 9, 362, 063 0 9, 362, 859 8, 431 709 65, 00 66.00 06600 PHYSI CAL THERAPY 7, 740, 617 0 7, 741, 275 11, 044 21, 617 66, 00 67.00 06700 0CUPATI ONAL THERAPY 2, 831, 959 0 2, 832, 200 0 0 67, 00 69.00 06900 ELECTROCARDI OLOGY 2, 722, 522 0 2, 722, 753 13, 762 11, 577 69, 00 69.00 06900 ELECTROCARDI OLOGY 2, 722, 525 0 2, 732, 753 13, 762 11, 577 69, 00 69.00 07000 0CHORNECPHALOGRAPHY 2, 815, 465 0 2, 515, 679 0 5, 463 70, 00 69.00 07000 0FECORROCEPHALOGRAPHY 2, 817, 465 0 2, 515, 679 0 0 5, 463 70, 00 69.00 07000 0FECORROCEPHALOGRAPHY 3, 386, 811 0 37, 389, 989 0 0 0 0 0 67.00 07000 IMDL DEV. CHARGED TO PATIENT 37, 386, 811 0 37, 389, 989 0 0 0 0 0 67.00 07000 IMDL DEV. CHARGED TO PATIENT 364, 797, 368 0 64, 802, 876 0 0 0 0 0 67.00 07000 07000 IMDL DEV. CHARGED TO PATIENT 54, 797, 368 0 64, 802, 876 0 0 0 0 0 0 0 69.00 07000 07000 07000 07000 07000 07000 07000 07000 07000 07000 07000 07000 07000 07000 07000 07000 07000 07000 07000 07000 07000 07000 07000 07000 07000 07000 07000 0								1
65. 00 06500 06500 06500 06500 06500 06500 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600 06600		l						1
66.00 06600 PHYSI CAL THERAPY 7,740,617 0 7,741,275 11,044 21,617 66.00 67.00 06700 0CCUPATI ONAL THERAPY 2,831,959 0 2,832,200 0 0 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 1,393,857 0 1,393,975 1,959 0 68.00 69.00 06900 ELECTROCARDI OLOGY 2,722,522 0 2,722,753 13,762 11,577 69.00 67.00 07000 ELECTROCRECPHALGGRAPHY 2,515,465 0 2,515,679 0 5,463 70.00 67.00 07000 ELECTROCRECPHALGGRAPHY 2,515,465 0 2,515,679 0 5,463 70.00 67.00 07000 ELECTROCRECPHALGGRAPHY 2,515,465 0 2,515,679 0 5,463 70.00 67.00 07000 ELECTROCRECPHALGGRAPHY 2,515,465 0 2,515,679 0 5,463 70.00 67.00 07000 ELECTROCRECPHALGGRAPHY 2,515,465 0 2,515,679 0 5,463 70.00 67.00 07000 ELECTROCRECPHALGGRAPHY 2,515,465 0 2,515,679 0 0,700 67.00 07000 ELECTROCRECPHALGGRAPHY 2,515,465 0 2,515,679 0 0,700 67.00 07000 IPHL. DEV. CHARGED TO PATIENTS 28,875,940 0 28,878,394 0 0 72.00 67.00 07300 DRUGS CHARGED TO PATIENTS 28,875,940 0 28,878,394 0 0 72.00 67.00 07400 RENAL DI ALYSI S 1,204,381 0 1,204,483 4,009 8,570 67.07 07097 CARDIA CR EHABILITATION 519,283 0 15,9327 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				-				1
68. 00 06800 SPECH PATHOLOGY 1, 393, 857 0 1, 393, 975 1, 959 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 2, 722, 522 0 2, 722, 753 13, 762 11, 577 69. 00 70. 00 07000 ELECTROCEPHALOGRAPHY 2, 515, 465 0 2, 515, 679 0 5, 463 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 37, 386, 811 0 37, 389, 989 0 0 0 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 28, 875, 940 0 28, 878, 394 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATIENTS 28, 875, 940 0 28, 878, 394 0 0 0 73. 00 74. 00 07400 RENAL DI ALYSI S 1, 204, 381 0 1, 204, 483 4, 009 8, 570 74. 00 74. 00 07400 RENAL DI ALYSI S 1, 204, 381 0 1, 204, 483 4, 009 8, 570 74. 00 76. 97 07697 CARDI AC REHABILITATION 519, 283 0 519, 327 0 0 0 0 0 79. 00 09000 CLINI C 0, 7, 890, 199 0 7, 890, 870 18, 704 11, 328 90. 00 79. 00 09000 CLINI C 0, 7, 890, 199 0 7, 761, 017 2, 391 8, 073 90. 01 79. 05 09005 CV DI AGNOSTIC SERVI CES 12, 334, 263 0 12, 335, 311 0 0 90. 05 79. 00 09000 09000 09000 09000 09000 09000 79. 00 09000 09000 090000 090000 090000 79. 00 090000 090000 090000 090000 79. 00 090000 090000 090000 090000 79. 00 090000 090000 090000 090000 79. 00 090000 090000 090000 090000 79. 00 090000 090000 090000 090000 79. 00 090000 090000 090000 090000 090000 79. 00 090000 090000 090000 090000 090000 090000 090000 79. 00 090000 090000 090000 090000 090000 090000 090000 090000 090000 090000 090000 090000 090000 090000 090000 090000 090000 090000 090000 090000 090000 090000 090000 090000 090000 090000 090000 090000 090000 090000 090000 090000 090000 090000 090000 090000 090000 090000 090000 090000 090000 090000 090000 090000 090000 090000 090000 090000 090000		1 I						1
69.00 06900 ELECTROCARDI OLOGY 2, 722, 522 0 2, 722, 753 13, 762 11, 577 69, 00 70.00 07000 ELECTROCARDIOLOGY 2, 515, 465 0 2, 515, 679 0 5, 463 70.00 71.00 71.00 71.00 71.00 71.00 71.00 71.00 71.00 71.00 MEDI CAL SUPPLIES CHARGED TO PATI ENT 37, 386, 811 0 37, 389, 989 0 0 72.00 72.00 72.00 72.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00	67.00			0	2, 832, 200		_	67.00
70.00 07000 CLECTROENCEPHALOGRAPHY 2, 515, 465 0 2, 515, 679 0 5, 463 70.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 37, 386, 811 0 37, 389, 989 0 0 71.00 72.00 73.00 7300 DRUGS CHARGED TO PATIENTS 28, 875, 940 0 28, 878, 394 0 0 72.00 73.00 7300 DRUGS CHARGED TO PATIENTS 28, 875, 940 0 28, 878, 394 0 0 72.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.								1
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 37, 386, 811 0 37, 389, 989 0 0 71. 00 72. 00 72. 00 72. 00 72. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 0		l						
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 28, 875, 940 0 28, 878, 394 0 0 72. 00 73. 00 7300 DRUGS CHARGED TO PATIENTS 64, 797, 368 0 64, 802, 876 0 0 73. 00 73. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 76. 97 74. 00 76. 97 74. 00 76. 97 74. 00 76. 97 74. 00 76. 97 74. 00 76. 97 74. 00 76. 97 74. 00 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 97 76. 9								ı
74. 00 07400 RENAL DI ALYSI S 1, 204, 381 0 1, 204, 483 4, 009 8, 570 74. 00 76. 97 07697 CARDI AC REHABI LITATION 519, 283 0 519, 327 0 0 0 76. 97 0017PATI ENT SERVICE COST CENTERS 90. 00 9000 CLINI C 7, 890, 199 0 7, 890, 870 18, 704 11, 328 90. 00 90. 01 9000 IBMT JOI NT VENTURE 7, 760, 357 0 7, 761, 017 2, 391 8, 073 90. 01 90. 05 90005 CV DI AGNOSTI C SERVICES 12, 334, 263 0 12, 335, 311 0 0 0 0 0 0 0 0 0							-	
76. 97 O7697 CARDI AC REHABILITATION 519, 283 0 519, 327 0 0 76. 97							_	1
OUTPAT1 ENT SERVICE COST CENTERS 90.00 OD00 CLINIC 7,890,199 0 7,890,870 18,704 11,328 90.00 0 0 0 0 0 0 0 0 0								
90. 00	76. 97		519, 283	0	519, 327	0	0	76.97
90. 05 09005 CV DI AGNOSTI C SERVI CES 12, 334, 263 0 12, 335, 311 0 0 90. 05 91. 00 09100 EMERGENCY 0 13, 660, 665 48, 138 409, 821 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 92. 00 101. 00 OTHER REI MBURSABLE COST CENTERS 113. 00 113. 00 11600 HOME HEALTH AGENCY 0 0 0 0 0 118. 00 SPECIAL PURPOSE COST CENTERS 113. 00 118. 00 SUBTOTALS (SUM OF LI NES 1 through 117) 620, 755, 248 -144, 094, 315 476, 713, 695 753, 228 2, 815, 854 118. 00 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 775, 870 0 775, 936 4, 546 0 190. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 11, 165, 306 0 11, 166, 255 6, 536 8, 642 192. 00 194. 01 07952 WOMEN' S CENTER 361, 087 0 361, 118 2, 471 14, 149 194. 01 194. 02 07950 OTHER NRCC 81, 393, 885 0 0 0 0 0 0 0 194. 04 07954 OTHER NRCC 81, 393, 885 0 1, 889 0 0 0 0 0 194. 05 07956 FOUNDATI ON 194. 05 000. 00 0 0 0 0 0 194. 05 07956 FOUNDATI ON 194. 05 000. 00 0 0 0 0 0 194. 05 07956 FOUNDATI ON 194. 05 000. 00 0 0 0 0 0 0 0	90. 00		7, 890, 199	0	7, 890, 870	18, 704	11, 328	90.00
91. 00	90. 01			0				90. 01
92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART 0 0 0 0 0 0 0 0 0								1
OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 0 0 0 0 0 0 101.00			13, 659, 504	0	13, 660, 665	48, 138	409, 821	1
101.00 10100 HOME HEALTH AGENCY 0 0 0 0 0 0 101.00	92.00	,						92.00
SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 9, 694, 273 0 9, 695, 097 0 0 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00 116.00	101.00		0	0	С	0	0	101.00
116. 00		SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1 through 117) 620, 755, 248 -144, 094, 315 476, 713, 695 753, 228 2, 815, 854 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 775, 870 0 775, 936 4, 546 0 190.00 192.00 192.00 194.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195		l		_		_	_	1
NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 775,870 0 775,936 4,546 0 190.00 192.00 192.00 192.00 192.00 192.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.00 193.								
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 775, 870 0 775, 936 4, 546 0 190. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 11, 165, 306 0 11, 166, 255 6, 536 8, 642 192. 00 194. 00 194. 01 195. 687 0 0 194. 00 194. 01 195. 687 0 0 194. 01 195. 687 0 0 0 0 194. 01 195. 687 0 0 0 0 0 194. 01 195. 687 0 0 0 0 0 0 195. 687 0 0 0 0 0 0 0 0 0	118.00		020, 755, 248	-144, 094, 315	4/0, /13, 095	153, 228	2,815,854] 18.00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 11, 165, 306 0 11, 166, 255 6, 536 8, 642 192. 00 194. 00 194. 00 194. 01 194. 01 194. 01 194. 02 194. 04 194. 04 194. 04 194. 04 194. 05 194. 05 19795 FOUNDATI ON 194. 05 194. 05 19795 194. 05 19795 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194. 05 194.	190.00		775, 870	0	775, 936	4, 546	0	190. 00
194. 01 07952 WOMEN' S CENTER 361, 087 0 361, 118 2, 471 14, 149 194. 01 194. 02 07950 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 0 194. 02 194. 04 07954 OTHER NRCC 81, 393, 885 0 81, 400, 803 8, 045 0 194. 04 194. 05 07956 FOUNDATI ON 1, 889 0 1, 889 0 0 194. 05 200. 00 Cross Foot Adjustments			11, 165, 306	0	11, 166, 255	6, 536	8, 642	192.00
194. 02 07950 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 194. 02 194. 04 07954 OTHER NRCC 81, 393, 885 0 81, 400, 803 8, 045 0 194. 04 194. 05 07956 FOUNDATION 1, 889 0 1, 889 0 0 194. 05 200. 00 Cross Foot Adjustments			1					
194. 04 07954 OTHER NRCC 81, 393, 885 0 81, 400, 803 8, 045 0 194. 04 194. 05 07956 FOUNDATION 1, 889 0 1, 889 0 0 194. 05 200. 00 Cross Foot Adjustments			1	-				
194. 05 07956 FOUNDATION 1,889 0 1,889 0 0 194. 05 200. 00 Cross Foot Adjustments			1			·		1
		l		0			0	194. 05
201.00 Negative Cost Centers 201.00								
	201.00	Negative Cost Centers	<u> </u>		<u> </u>	1	l	1201.00

Heal th I	Financial Systems ST. F	RANCIS HOSPITA	AL & HEALTH CEN	TER	In Lie	u of Form CMS-2	2552-10
COST AL	LOCATION - STATISTICAL BASIS		Provi der C		Peri od: From 01/01/2020	Worksheet B-1	
					To 12/31/2020	Date/Time Pre 3/30/2021 10:	
	Cost Center Description	CASHI ERI NG/AC	Reconciliatio	OTHER ADMIN 8	OPERATION OF	LAUNDRY &	
		COUNTS	n	GENERAL		LINEN SERVICE	
		RECEI VABLE		(ACCUM. COST)	(SQUARE FEET)	(POUNDS OF	
		(ACCUM. COST)				LAUNDRY)	
		5. 02	5A. 03	5. 03	7. 00	8. 00	
202.00	Cost to be allocated (per Wkst. B,	60, 737		144, 094, 31	5 32, 591, 309	3, 241, 364	202.00
	Part I)						
203.00	Unit cost multiplier (Wkst. B, Part I)	0. 000085		0. 25255	5 42. 062746	1. 141870	203.00
204.00	Cost to be allocated (per Wkst. B,	60, 737		116, 99	2 5, 394, 516	459, 279	204.00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part	0. 000085		0. 00020	6. 962229	0. 161795	205. 00
	11)						
206.00	NAHE adjustment amount to be allocated						206.00
	(per Wkst. B-2)						
207.00	NAHE unit cost multiplier (Wkst. D,						207.00
	Parts III and IV)						

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS ST. FRANCIS HOSPITAL & HEALTH CENTER In Lieu of Form CMS-2552-10 Period: Worksheet B-1 From 01/01/2020 To 12/31/2020 Date/Time Prepared: 3/30/2021 10: 40 am Provider CCN: 15-0162

Cost Center Description	HOUSEKEEPI NG (SQUARE FEET)	DI ETARY (TOTAL PATI ENT DAYS)	CAFETERI A (FTES)	NURSING ADMINISTRATION N (TOTAL PATIENT DAYS)	3/30/2021 10: CENTRAL SERVI CES & SUPPLY (COSTED REQUI S.)	40 am
GENERAL SERVICE COST CENTERS	9. 00	10. 00	11. 00	13. 00	14. 00	
1. 00	760, 774 9, 580 13, 145 0 30, 190 11, 705 0 915 0 0	109, 074 0 0 0 0 0 0 0 0	4, 579, 851 94, 873 31, 709 159, 442 0 55, 302 15, 730 4, 774 13, 250 11, 855 27, 869	0 0 0 0 0 0	69, 425, 324 105, 647 0 16, 671 924 922 6, 541 3, 201	1. 00 2. 00 4. 00 5. 01 5. 02 5. 03 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 16. 00 21. 00 22. 00 23. 00 23. 00 23. 01 23. 02 23. 03
INPATIENT ROUTINE SERVICE COST CENTERS	186, 933 21, 029 14, 230 45, 806 25, 906 17, 092 3, 613	52, 024 20, 500 6, 322 12, 691 8, 247 5, 552 3, 738	946, 202 198, 297 93, 870 264, 945 140, 014 85, 600 11, 123	20, 500 6, 322 12, 691 8, 247 5, 552	183, 688 29, 765 16, 769 38, 894 18, 934 9, 981 13, 916	30. 00 31. 00 31. 01 32. 00 34. 00 41. 00 43. 00
50. 00 05000 OPERATI NG ROOM 52. 00 05200 DELI VERY ROOM & LABOR ROOM 54. 00 05400 RADI OLOGY-DI AGNOSTI C 55. 00 05500 RADI OLOGY-THERAPEUTI C 56. 00 05600 RADI OLOGY-THERAPEUTI C 56. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY 64. 00 06400 INTRAVENOUS THERAPY 65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 72. 00 07300 RUGS CHARGED TO PATI ENTS 73. 00 07300 RUGS CHARGED TO PATI ENTS 74. 00 07697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVI CE COST CENTERS	97, 230 25, 973 62, 622 4, 385 848 24, 306 25, 806 9, 424 8, 431 11, 044 0 1, 959 13, 762 0 0 0 4, 009	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	325, 520 78, 604 229, 698 34, 682 4, 092 49, 315 13, 285 73, 152 168, 801 113, 993 54, 380 21, 958 41, 587 42, 597 0 0 8055 11, 222	0 0 0 0 0 0 0 0 0 0	510, 302 18, 643 367, 415 407 745, 360 15, 953 10, 655 52, 428 22, 455 19, 876 4, 551 3, 263 25, 142 6, 774 37, 364, 117 28, 863, 735 0 1, 241 5, 260	50. 00 52. 00 54. 00 55. 00 56. 00 59. 00 60. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 74. 00 76. 97
90. 00 09000 CLINIC 90. 01 09001 IBMT JOINT VENTURE 90. 05 09005 CV DI AGNOSTIC SERVICES 91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS	18, 704 2, 391 0 48, 138	0 0 0	177, 963 42, 171 276, 110 231, 425	0	15, 651 6, 062 253, 820 60, 465	90. 00 90. 01 90. 05 91. 00 92. 00
101. 00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00
SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 116.00 11600 HOSPICE 118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	0 739, 176	0 109, 074	154, 215 4, 300, 430		161, 055 68, 980, 483	
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192.00 19200 PHYSICIANS' PRIVATE OFFICES 194.00 07955 MARKETING & COMMUNITY RELATIONS 194.01 07952 WOMEN'S CENTER 194.02 07950 OTHER NONREIMBURSABLE COST CENTERS 194.04 07954 OTHER NRCC 194.05 07956 FOUNDATION 200.00 Cross Foot Adjustments	4, 546 6, 536 0 2, 471 0 8, 045	0 0 0 0 0 0	13, 950 129, 557 2, 091 3, 621 0 130, 202	0 0 0 0	2, 830 0 206, 437 0	192. 00 194. 00 194. 01 194. 02

Health Financial Systems	ST. FRANCIS HOSPITAL	& HEALTH CENT	TER	In Lie	u of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der CC		Peri od: From 01/01/2020	Worksheet B-1	
				To 12/31/2020	Date/Time Pre 3/30/2021 10:	
Cost Center Description	HUITSEKEEDI NG	DIFTARY	CAFETERIA	MIDSING	CENTRAL	

						3/30/2021 10:	
	Cost Center Description	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	
		(SQUARE FEET)	(TOTAL PATI	(FTES)	ADMI NI STRATI O	SERVICES &	
			ENT DAYS)		N	SUPPLY	
					(TOTAL PATI	(COSTED	
					ENT DAYS)	REQUIS.)	
		9. 00	10. 00	11.00	13.00	14.00	
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B,	11, 160, 401	2, 573, 876	5, 862, 029	9, 103, 749	5, 997, 634	202.00
	Part I)						
203.00	Unit cost multiplier (Wkst. B, Part I)	14. 669798	23. 597521	1. 279961	83. 463969	0. 086390	203.00
204.00	Cost to be allocated (per Wkst. B,	409, 967	596, 064	818, 418	19, 033	1, 885, 159	204.00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part	0. 538881	5. 464767	0. 178700	0. 174496	0. 027154	205.00
	11)						
206.00	NAHE adjustment amount to be allocated						206. 00
	(per Wkst. B-2)						
207.00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)						1

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS In Lieu of Form CMS-2552-10 Provi der CCN: 15-0162

			Ť	0 12/31/2020	Date/Time Pre 3/30/2021 10:	pared:
			INTERNS &	RESI DENTS	37 307 2021 10.	40 aiii
Cost Center Description	PHARMACY (COSTED REQUIS.)	MEDI CAL RECORDS & LI BRARY (GROSS CHARGES)	SERVI CES-SALA RY & FRI NGES APPRV (ASSI GNED TI ME)	SERVI CES-OTHE R PRGM COSTS APPRV (ASSI GNED TI ME)	MEDI CAL LABORATORY SCI ENTI ST PRGM (ASSI GNED TI ME)	
	15. 00	16. 00	21.00	22. 00	23. 00	
GENERAL SERVICE COST CENTERS 1. 00						1. 00 2. 00 4. 00 5. 01
5. 02 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5. 03 00590 OTHER ADMI N & GENERAL 7. 00 00700 OPERATI ON OF PLANT 8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A 13. 00 01300 NURSI NG ADMI NI STRATI ON 14. 00 01400 CENTRAL SERVI CES & SUPPLY 15. 00 01500 PHARMACY	100	2.004.270.400				5. 02 5. 03 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY 21. 00 02100 I&R SERVI CES-SALARY & FRI NGES APPRV 22. 00 02200 I&R SERVI CES-OTHER PRGM COSTS APPRV 23. 00 02302 MEDI CAL LABORATORY SCI ENTI ST PRGM 23. 02 02301 EMERGENCY MEDI CAL SERVI CES 02303 PARAMEDI C PRGM INPATI ENT ROUTI NE SERVI CE COST CENTERS	0 0 0 0 0	3, 006, 278, 609 0 0 0 0 0 0	2, 450	2, 450	100	16. 00 21. 00 22. 00 23. 00 23. 01 23. 02 23. 03
30. 00 03000 ADULTS & PEDIATRICS	0	197, 244, 567	1, 696		0	
31. 00 03100 INTENSI VE CARE UNI T 31. 01 02060 NEONATAL INTENSI VE CARE UNI T	0 0	34, 959, 936 29, 689, 793			0	31. 00 31. 01
32.00 03200 CORONARY CARE UNIT	0	33, 477, 904	0	-	0	32.00
34.00 03400 SURGI CAL INTENSI VE CARE UNIT 41.00 04100 SUBPROVI DER - IRF	0	26, 244, 402 14, 817, 214	0	_	0	34. 00 41. 00
43. 00 04300 NURSERY	0	6, 456, 336			0	1
ANCILLARY SERVICE COST CENTERS	ما	0/4 044 0/0	457	457		50.00
50.00 05000 0PERATING ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM	0	264, 914, 869 44, 259, 677	157 0	157	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	295, 826, 730			0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	81, 279, 420	1	О	0	55. 00
56. 00 05600 RADI 01 SOTOPE	0	7, 243, 622	0	-	0	56.00
59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY	0	147, 100, 158 307, 838, 767	0	_	0 100	59. 00 60. 00
64. 00 06400 I NTRAVENOUS THERAPY	0	31, 834, 595		_	0	1
65. 00 06500 RESPIRATORY THERAPY	0	60, 186, 493	23		0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	38, 371, 939	172	172	0	
67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	0	21, 266, 221 10, 511, 216		0	0	ı
69. 00 06900 ELECTROCARDI OLOGY	Ö	36, 866, 750		_	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	19, 812, 117		20	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	202, 976, 423		-	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS	0 100	168, 318, 773 507, 587, 955		_	0	72. 00 73. 00
74. 00 07400 RENAL DI ALYSI S	0	8, 199, 678		-	0	1
76. 97 O7697 CARDI AC REHABI LI TATI ON	0	1, 547, 213	0	0	0	76. 97
OUTPATIENT SERVICE COST CENTERS 90. 00 09000 CLINIC	O	13, 478, 991	Γ	O	0	90.00
90. 01 09001 I BMT JOI NT VENTURE	0	8, 948, 827	1	-	0	
90. 05 09005 CV DIAGNOSTIC SERVICES	0	68, 142, 020		0	0	90.05
91. 00 09100 EMERGENCY	0	291, 532, 173	177	177	0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92.00
101.00 10100 HOME HEALTH AGENCY	0	0	0	O	0	101. 00
SPECIAL PURPOSE COST CENTERS	<u> </u>			. •	Ţ	
113. 00 11300 NTEREST EXPENSE		05 040 000			0	113.00
116.00 11600 HOSPICE 118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0 100	25, 343, 830 3, 006, 278, 609		2, 401		116. 00 118. 00
NONREIMBURSABLE COST CENTERS	100	5, 555, 276, 609	2,401	2,401	100	, 13.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	49	49		192.00
194.00 07955 MARKETING & COMMUNITY RELATIONS 194.01 07952 WOMEN'S CENTER	0	0	0	0		194. 00 194. 01
194. 02 07950 OTHER NONREI MBURSABLE COST CENTERS	0	0		_		194. 01
<u> </u>	<u>'</u>			· · · · · · · · · · · · · · · · · · ·		

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

						3/30/2021 10:	
				INTERNS &	RESI DENTS		
	01. 01	DUADMAOV	MEDICAL	CEDVILOEC CALA	CEDVILOEC OTHE	MEDIONI	
	Cost Center Description	PHARMACY	MEDI CAL		SERVI CES-OTHE	MEDI CAL	
		(COSTED	RECORDS &	RY & FRINGES	R PRGM COSTS	LABORATORY	
		REQUIS.)	LI BRARY	APPRV	APPRV	SCI ENTI ST	
			(GROSS	(ASSI GNED	(ASSI GNED	PRGM	
			CHARGES)	TIME)	TIME)	(ASSI GNED	
		15.00	1/ 00	21.00	22.00	TIME)	
404 04 0705 4	OTHER MROO	15. 00	16. 00	21.00	22. 00	23. 00	101 01
	OTHER NRCC	0	0	0	0		194. 04
194. 05 07956	l control of the cont	0	0	0	0	0	194. 05
200.00	Cross Foot Adjustments						200. 00
201. 00	Negative Cost Centers						201. 00
202. 00	Cost to be allocated (per Wkst. B,	14, 642, 963	218, 573	3, 659, 934	2, 390, 066	141, 024	202. 00
	Part I)						
203. 00	Unit cost multiplier (Wkst. B, Part I)	146, 429. 63000	0. 000073	1, 493. 850612	975. 537143	1, 410. 240000	203. 00
		0					
204. 00	Cost to be allocated (per Wkst. B,	762, 256	51	68, 039	3, 360	909	204. 00
	Part II)						
205. 00	Unit cost multiplier (Wkst. B, Part	7, 622. 560000	0. 000000	27. 771020	1. 371429	9. 090000	205. 00
	[11]						
206. 00	NAHE adjustment amount to be allocated					0	206. 00
	(per Wkst. B-2)						
207. 00	NAHE unit cost multiplier (Wkst. D,					0.000000	207.00
	Parts III and IV)						

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0162

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

3/30/2021 10:40 am Cost Center Description PHARMACY PRGM **EMERGENCY** PARAMEDI C (ASSI GNED MEDI CAL PRGM TIME) SERVI CES (ASSI GNED (ASSI GNED TIME) TIME) 23. 01 23.02 23.03 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00570 ADMITTING 5.01 5.01 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5.02 5.02 00590 OTHER ADMIN & GENERAL 5.03 5.03 7.00 00700 OPERATION OF PLANT 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 00900 HOUSEKEEPI NG 9 00 9 00 10.00 01000 DI ETARY 10.00 11.00 01100 CAFETERI A 11.00 01300 NURSING ADMINISTRATION 13.00 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 15.00 01500 PHARMACY 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16.00 02100 I&R SERVICES-SALARY & FRINGES APPRV 21 00 21 00 22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 22.00 02300 MEDICAL LABORATORY SCIENTIST PRGM 23.00 02302 PHARMACY PRGM 100 23.01 23.01 02301 EMERGENCY MEDICAL SERVICES 23.02 100 23.02 02303 PARAMEDIC PRGM 23.03 100 23.03 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 03000 ADULTS & PEDIATRICS O 30.00 0 Ω 03100 INTENSIVE CARE UNIT 0 0 31.00 C 31.00 0 02060 NEONATAL INTENSIVE CARE UNIT 0 0 31.01 31.01 03200 CORONARY CARE UNIT 0 32.00 0 0 0 32.00 03400 SURGICAL INTENSIVE CARE UNIT 0 34 00 0 34 00 04100 SUBPROVI DER - I RF 41.00 C 41.00 04300 NURSERY 0 0 0 43.00 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 0 0 50.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 0000000000000 0 0 52.00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 0 0 55.00 0 05600 RADI OI SOTOPE 56.00 0 56.00 0 59.00 05900 CARDIAC CATHETERIZATION 0 59.00 60.00 06000 LABORATORY 0 0 60.00 06400 I NTRAVENOUS THERAPY 0 64.00 0 64.00 06500 RESPIRATORY THERAPY 0 65.00 65.00 66.00 06600 PHYSI CAL THERAPY 0 0 66.00 06700 OCCUPATI ONAL THERAPY 0 67.00 0 67.00 οl 06800 SPEECH PATHOLOGY 68.00 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0 0 69.00 70 00 07000 ELECTROENCEPHALOGRAPHY 0 70.00 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71.00 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 C 72 00 07300 DRUGS CHARGED TO PATIENTS 100 100 73.00 73.00 07400 RENAL DIALYSIS 74.00 0 0 0 74.00 07697 CARDIAC REHABILITATION 76.97 0 0 0 76.97 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 90.00 09001 I BMT JOINT VENTURE 0 0 90.01 90.01 C 09005 CV DIAGNOSTIC SERVICES 0 0 90.05 C 90.05 91.00 09100 EMERGENCY 0 100 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 0 0 0 101.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE 113.00 116. 00 11600 HOSPI CE 0 0 0 116 00 SUBTOTALS (SUM OF LINES 1 through 117) 118.00 100 100 100 118.00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190.00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 192 00 C 194.00 07955 MARKETING & COMMUNITY RELATIONS 0 0 0 194.00 0 194. 01 07952 WOMEN' S CENTER 0 0 194.01 194. 02 07950 OTHER NONREI MBURSABLE COST CENTERS 0 0 194. 02 0 0 194. 04 07954 OTHER NRCC C 194.04 194. 05 07956 FOUNDATI ON 0 194.05 200.00 Cross Foot Adjustments 200.00 Heal th Financial Systems ST. FRANCIS HOSPITAL & HEALTH CENTER In Lieu of Form CMS-2552-10

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0162
Period: From 01/01/2020 To 12/31/2020 Date/Time Prepared:

Date/Time Prepared: 3/30/2021 10:40 am PHARMACY PRGM EMERGENCY Cost Center Description PARAMEDI C (ASSI GNED MEDI CAL PRGM (ASSI GNED TIME) SERVI CES (ASSI GNED TIME) TIME) 23. 01 23. 03 23. 02 201.00 Negative Cost Centers 201.00 202.00 780, 472 Cost to be allocated (per Wkst. B, 1, 163, 613 235, 262 202.00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 11, 636. 130000 2, 352. 620000 7, 804. 720000 203.00 204.00 Cost to be allocated (per Wkst. B, 2, 659 5, 240 204.00 2, 347 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 26. 590000 23. 470000 52. 400000 205.00 11) 206.00 NAHE adjustment amount to be allocated 206.00 (per Wkst. B-2)

0. 000000

0.000000

0.000000

207.00

207.00

NAHE unit cost multiplier (Wkst. D,

Parts III and IV)

Health Financial Systems ST. FRANCIS HOSPITAL & HEALTH CENTER In Lieu of Form CMS-2552-10 COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0162 Peri od: Worksheet C From 01/01/2020 Part I Date/Time Prepared: 12/31/2020 3/30/2021 10:40 am Title XVIII Hospi tal PPS Costs Cost Center Description Total Cost Therapy Limit Total Costs RCE Total Costs Di sal I owance (from Wkst. Adj B, Part I, col. 26) 1. 00 4. 00 2.00 3.00 5.00 INPATIENT ROUTINE SERVICE COST CENTERS 30. 00 03000 ADULTS & PEDIATRICS 87, 990, 301 87, 990, 301 6,075 87, 996, 376 30.00 03100 INTENSIVE CARE UNIT 17, 644, 952 17, 644, 952 11, 983 17, 656, 935 31.00 31.00 9, 704, 382 31.01 02060 NEONATAL INTENSIVE CARE UNIT 9, 704, 382 9, 704, 382 0 31.01 03200 CORONARY CARE UNIT 23, 584, 816 23, 584, 816 23, 584, 816 32 00 0 32 00 34.00 03400 SURGICAL INTENSIVE CARE UNIT 12, 716, 282 12, 716, 282 0 12, 716, 282 34.00 41.00 04100 SUBPROVI DER - I RF 8, 237, 029 8, 237, 029 0 8, 237, 029 41.00 04300 NURSERY 1, 710, 345 1, 710, 345 1, 710, 345 43.00 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 35, 682, 321 35, 682, 321 0 35, 682, 321 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 8, 481, 089 8, 481, 089 0 8, 481, 089 52.00 29, 080, 249 05400 RADI OLOGY-DI AGNOSTI C 29, 080, 249 29, 080, 249 54.00 0 54.00 05500 RADI OLOGY-THERAPEUTI C 55.00 9, 832, 056 9, 832, 056 0 9, 832, 056 55.00 56, 00 05600 RADI OI SOTOPE 1, 499, 950 1, 499, 950 0 1, 499, 950 56.00 59.00 05900 CARDIAC CATHETERIZATION 7, 061, 378 7,061,378 0 7, 061, 378 59.00 06000 LABORATORY 35, 527, 785 35, 527, 785 32,008 35, 559, 793 60.00 60 00 64.00 06400 I NTRAVENOUS THERAPY 5, 627, 859 5, 627, 859 5, 627, 859 64.00 06500 RESPIRATORY THERAPY 12, 429, 011 12, 429, 011 12, 432, 248 65.00 3, 237 65.00 06600 PHYSI CAL THERAPY 10, 498, 036 0 10, 498, 036 10, 498, 036 66.00 66.00 06700 OCCUPATI ONAL THERAPY 3, 619, 035 67.00 3, 619, 035 0 0 3, 619, 035 67.00 68.00 06800 SPEECH PATHOLOGY 1,886,323 1,886,323 0 1,886,323 68.00 06900 ELECTROCARDI OLOGY 69.00 4, 262, 464 4, 262, 464 0 4, 262, 464 69.00 70 00 07000 ELECTROENCEPHALOGRAPHY 3 213 817 3, 213, 817 3 886 3, 217, 703 70 00 |07100|MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 50, 075, 701 50, 075, 701 0 50, 075, 701 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 38, 677, 602 38, 677, 602 0 38, 677, 602 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 97, 792, 385 97. 792. 385 ol 97. 792. 385 73.00 07400 RENAL DIALYSIS 1, 747, 644 1, 747, 644 1, 747, 644 74.00 0 74.00 76.97 07697 CARDIAC REHABILITATION 665, 417 665, 417 665, 417 76.97 OUTPATIENT SERVICE COST CENTERS 90 00 09000 CLINIC 11, 187, 932 11 187 932 0 11, 187, 932 90 00 09001 I BMT JOINT VENTURE 90.01 9, 921, 120 9, 921, 120 63, 857 9, 984, 977 90.01 90.05 09005 CV DIAGNOSTIC SERVICES 15, 830, 967 15, 830, 967 15, 830, 967 90.05 91.00 09100 EMERGENCY 20, 867, 670 20, 867, 670 2, 513 20, 870, 183 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 13, 648, 096 13, 648, 096 13, 648, 096 92.00 92 00 OTHER REIMBURSABLE COST CENTERS

0

12, 356, 795

13, 648, 096

603, 060, 809

589, 412, 713

0

123, 559

123, 559

12, 356, 795

13, 648, 096

589, 412, 713

603, 060, 809

0

0

0 101. 00

113 00

12, 356, 795 116. 00

603, 184, 368 200. 00

13, 648, 096 201. 00

589, 536, 272 202. 00

101.00 10100 HOME HEALTH AGENCY

113.00 11300 INTEREST EXPENSE

116. 00 11600 HOSPI CE

200.00

201.00

202.00

SPECIAL PURPOSE COST CENTERS

Subtotal (see instructions)

Less Observation Beds

Total (see instructions)

				10 12/31/2020	3/30/2021 10:	
		Title	XVIII	Hospi tal	PPS	
		Charges		·		
Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
		·	+ col. 7)	Rati o	I npati ent	
					Ratio	
	6. 00	7. 00	8. 00	9. 00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	146, 396, 820		146, 396, 820	1		30.00
31.00 03100 INTENSIVE CARE UNIT	34, 959, 936		34, 959, 93	1		31.00
31.01 02060 NEONATAL INTENSIVE CARE UNIT	29, 689, 793		29, 689, 79	3		31. 01
32. 00 03200 CORONARY CARE UNIT	33, 477, 904		33, 477, 90			32.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	26, 244, 402		26, 244, 40			34.00
41. 00 04100 SUBPROVI DER - I RF	14, 817, 214		14, 817, 21			41.00
43. 00 04300 NURSERY	6, 456, 336		6, 456, 33	6		43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	144, 187, 696	120, 727, 173			0. 000000	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	44, 083, 876	175, 801			0. 000000	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	85, 242, 123	210, 584, 607			0. 000000	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	2, 968, 046	78, 311, 374			0.000000	55.00
56. 00 05600 RADI 0I SOTOPE	1, 960, 555	5, 283, 067			0.000000	56.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	58, 337, 731	88, 762, 427			0.000000	59.00
60. 00 06000 LABORATORY	133, 693, 180	174, 145, 587			0.000000	60.00
64.00 06400 INTRAVENOUS THERAPY	3, 757, 530	28, 077, 065			0.000000	64.00
65. 00 06500 RESPIRATORY THERAPY	50, 953, 990	9, 232, 503			0.000000	65.00
66. 00 06600 PHYSI CAL THERAPY	19, 538, 129	18, 833, 810		1	0.000000	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	14, 258, 454	7, 007, 767		1	0.000000	67.00
68. 00 06800 SPEECH PATHOLOGY	6, 337, 786	4, 173, 430		1	0.000000	68. 00
69. 00 06900 ELECTROCARDI OLOGY	24, 859, 377	12, 007, 373		1	0.000000	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	4, 706, 509	15, 105, 608		1	0.000000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	153, 335, 853	49, 640, 570			0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	82, 727, 769	85, 591, 004			0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	170, 802, 832	336, 785, 123		1	0.000000	73.00
74. 00 07400 RENAL DI ALYSI S	7, 896, 114	303, 564			0.000000	74.00
76. 97 O7697 CARDI AC REHABI LI TATI ON	189, 051	1, 358, 162	1, 547, 21	0. 430075	0.000000	76. 97
OUTPATIENT SERVICE COST CENTERS	, , ,					
90. 00 09000 CLI NI C	662, 591	12, 816, 400		1	0. 000000	
90. 01 09001 I BMT JOINT VENTURE	495, 465	8, 453, 362		1	0. 000000	90. 01
90. 05 09005 CV DI AGNOSTI C SERVI CES	309, 254	67, 832, 766			0. 000000	90. 05
91. 00 09100 EMERGENCY	78, 793, 940	212, 738, 233			0. 000000	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	7, 121, 148	43, 726, 599	50, 847, 74	0. 268411	0. 000000	92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100 HOME HEALTH AGENCY	0	0	(O		101. 00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 I NTEREST EXPENSE						113. 00
116. 00 11600 HOSPI CE	0	25, 343, 830				116. 00
200.00 Subtotal (see instructions)	1, 389, 261, 404	1, 617, 017, 205	3, 006, 278, 60	9		200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	1, 389, 261, 404	1, 617, 017, 205	3, 006, 278, 60 ⁶	/		202. 00

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

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0162
Period:
From 01/01/2020
To 12/31/2020
Date/Time Prepared:
2/30/2021 10: 40 am

					3/30/2021 10:40 am
			Title XVIII	Hospi tal	PPS
	Cost Center Description	PPS Inpatient			
		Rati o			
		11. 00			
1	NPATIENT ROUTINE SERVICE COST CENTERS				
30.00 0	03000 ADULTS & PEDIATRICS				30.00
31.00 0	03100 INTENSIVE CARE UNIT				31.00
31. 01 0	02060 NEONATAL INTENSIVE CARE UNIT				31.0
32.00 0	03200 CORONARY CARE UNIT				32.00
34.00 0	03400 SURGICAL INTENSIVE CARE UNIT				34.00
41.00 0	04100 SUBPROVI DER – I RF				41.00
43.00 0	04300 NURSERY				43.00
A	NCILLARY SERVICE COST CENTERS				
	05000 OPERATING ROOM	0. 134694			50.00
52.00 0	05200 DELIVERY ROOM & LABOR ROOM	0. 191621			52.00
	05400 RADI OLOGY-DI AGNOSTI C	0. 098302			54.00
55.00 0	05500 RADI OLOGY-THERAPEUTI C	0. 120966			55.00
56.00 0	05600 RADI 0I SOTOPE	0. 207072			56.00
59.00 0	05900 CARDI AC CATHETERI ZATI ON	0. 048004			59.00
60.00 0	06000 LABORATORY	0. 115514			60.00
	06400 INTRAVENOUS THERAPY	0. 176784			64.00
	06500 RESPIRATORY THERAPY	0. 206562			65.00
	06600 PHYSI CAL THERAPY	0. 273586			66.00
67.00 0	06700 OCCUPATI ONAL THERAPY	0. 170178			67.00
	06800 SPEECH PATHOLOGY	0. 179458			68.00
	06900 ELECTROCARDI OLOGY	0. 115618			69.00
	07000 ELECTROENCEPHALOGRAPHY	0. 162411			70.00
71.00 0	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 246707			71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 229788			72.00
	07300 DRUGS CHARGED TO PATIENTS	0. 192661			73.00
1	07400 RENAL DIALYSIS	0. 213136			74.00
	07697 CARDI AC REHABI LI TATI ON	0. 430075			76. 9
	OUTPATIENT SERVICE COST CENTERS				
	09000 CLI NI C	0. 830027			90.00
	09001 I BMT JOINT VENTURE	1. 115786			90. 0
	09005 CV DIAGNOSTIC SERVICES	0. 232323			90. 05
	09100 EMERGENCY	0. 071588			91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 268411			92.00
	THER REIMBURSABLE COST CENTERS				
	0100 HOME HEALTH AGENCY				101.00
	SPECIAL PURPOSE COST CENTERS				
	1300 I NTEREST EXPENSE				113. 00
	1600 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
	, (1			1202.00

Heal th Financial Systems

ST. FRANCIS HOSPITAL & HEALTH CENTER

In Lieu of Form CMS-2552-10

Provider CCN: 15-0162

From 01/01/2020
To 12/31/2020

Date/Time Prepared: 3/30/2021 10: 40 am

Title XIX

Hospital

PPS

Cost Center Description

Total Cost (from Wkst. B, Part I, col. 26)

RCE

Disallowance

Disallowance

Disallowance

	,		11 61	C ALA	1103pi tai	113	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst.	Adj .		Di sal I owance		
		B, Part I,					
		col. 26)					
		1.00	2.00	3.00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS			•			
30. 00	03000 ADULTS & PEDIATRICS	87, 990, 301		87, 990, 301	6, 075	87, 996, 376	30.00
	03100 INTENSIVE CARE UNIT	17, 644, 952		17, 644, 952			
	02060 NEONATAL INTENSIVE CARE UNIT	9, 704, 382		9, 704, 382		9, 704, 382	
	03200 CORONARY CARE UNIT	23, 584, 816		23, 584, 816		23, 584, 816	
	03400 SURGICAL INTENSIVE CARE UNIT	12, 716, 282		12, 716, 282		12, 716, 282	
	04100 SUBPROVI DER – I RF	8, 237, 029		8, 237, 029		8, 237, 029	
		1					1
	04300 NURSERY	1, 710, 345		1, 710, 345	0	1, 710, 345	43.00
	ANCILLARY SERVICE COST CENTERS	05 (00 004	1	05 (00 004		05 (00 004	
	05000 OPERATING ROOM	35, 682, 321		35, 682, 321			
	05200 DELIVERY ROOM & LABOR ROOM	8, 481, 089		8, 481, 089		8, 481, 089	
	05400 RADI OLOGY-DI AGNOSTI C	29, 080, 249		29, 080, 249		29, 080, 249	
	05500 RADI OLOGY-THERAPEUTI C	9, 832, 056		9, 832, 056		9, 832, 056	
	05600 RADI OI SOTOPE	1, 499, 950		1, 499, 950		1, 499, 950	
59. 00	05900 CARDI AC CATHETERI ZATI ON	7, 061, 378		7, 061, 378		7, 061, 378	
60.00	06000 LABORATORY	35, 527, 785		35, 527, 785	32, 008	35, 559, 793	60.00
64. 00	06400 I NTRAVENOUS THERAPY	5, 627, 859		5, 627, 859	0	5, 627, 859	64.00
65. 00	06500 RESPI RATORY THERAPY	12, 429, 011	0	12, 429, 011	3, 237	12, 432, 248	65.00
66. 00	06600 PHYSI CAL THERAPY	10, 498, 036	0	10, 498, 036	0	10, 498, 036	66.00
	06700 OCCUPATI ONAL THERAPY	3, 619, 035		3, 619, 035		3, 619, 035	
	06800 SPEECH PATHOLOGY	1, 886, 323		1, 886, 323		1, 886, 323	
	06900 ELECTROCARDI OLOGY	4, 262, 464		4, 262, 464		4, 262, 464	
	07000 ELECTROENCEPHALOGRAPHY	3, 213, 817		3, 213, 817		3, 217, 703	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	50, 075, 701		50, 075, 701		50, 075, 701	
	07200 IMPL. DEV. CHARGED TO PATIENTS	38, 677, 602		38, 677, 602		38, 677, 602	
	07300 DRUGS CHARGED TO PATIENTS						
		97, 792, 385		97, 792, 385		97, 792, 385	
	07400 RENAL DIALYSIS	1, 747, 644		1, 747, 644		1, 747, 644	
	07697 CARDI AC REHABI LI TATI ON	665, 417		665, 417	0	665, 417	76. 97
	OUTPATIENT SERVICE COST CENTERS	11 107 000		11 107 000		11 107 000	
	09000 CLI NI C	11, 187, 932		11, 187, 932			
	09001 I BMT JOINT VENTURE	9, 921, 120		9, 921, 120			
	09005 CV DI AGNOSTI C SERVI CES	15, 830, 967		15, 830, 967		15, 830, 967	
	09100 EMERGENCY	20, 867, 670		20, 867, 670		20, 870, 183	
	09200 OBSERVATION BEDS (NON-DISTINCT PART	13, 648, 096		13, 648, 096		13, 648, 096	92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	0		0		0	101.00
	SPECIAL PURPOSE COST CENTERS						
113. 00	11300 I NTEREST EXPENSE						113. 00
116. 00	11600 H0SPI CE	12, 356, 795		12, 356, 795		12, 356, 795	116.00
200.00	Subtotal (see instructions)	603, 060, 809					
201. 00		13, 648, 096	ł .	13, 648, 096		13, 648, 096	
202.00		589, 412, 713					
	(222 11121 221 2112)	1,=,	,	,,,	. = = , 00 /		1

Health Financial Systems ST. FRANCIS HOSPITAL & HEALTH CENTER In Lieu of Form CMS-2552-10 COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0162 Peri od: Worksheet C From 01/01/2020 Part I Date/Time Prepared: 12/31/2020 3/30/2021 10:40 am Title XIX Hospi tal PPS Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other TEFRA + col. 7) Ratio Inpati ent Ratio 6. 00 7.00 8.00 9.00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 146, 396, 820 30.00 03000 ADULTS & PEDIATRICS 146, 396, 820 30.00 31.00 03100 INTENSIVE CARE UNIT 34, 959, 936 34, 959, 936 31.00 02060 NEONATAL INTENSIVE CARE UNIT 29, 689, 793 29, 689, 793 31.01 31.01 32.00 03200 CORONARY CARE UNIT 33, 477, 904 33, 477, 904 32.00 03400 SURGICAL INTENSIVE CARE UNIT 26, 244, 402 26, 244, 402 34.00 34.00 41.00 04100 SUBPROVI DER - I RF 14, 817, 214 14, 817, 214 41.00 43.00 04300 NURSERY 6, 456, 336 6, 456, 336 43 00 ANCILLARY SERVICE COST CENTERS 50 00 0.000000 05000 OPERATING ROOM 144, 187, 696 120, 727, 173 264, 914, 869 0.134694 52.00 05200 DELIVERY ROOM & LABOR ROOM 44, 083, 876 175, 801 44, 259, 677 0.191621 0.000000 54.00 05400 RADI OLOGY-DI AGNOSTI C 85, 242, 123 210, 584, 607 295, 826, 730 0.098302 0.000000 05500 RADI OLOGY-THERAPEUTI C 0. 120966 55 00 2, 968, 046 78, 311, 374 81, 279, 420 0.000000 55 00 56.00 05600 RADI OI SOTOPE 1, 960, 555 5, 283, 067 7, 243, 622 0.207072 0.000000 05900 CARDIAC CATHETERIZATION 147, 100, 158 0.048004 59 00 59 00 58, 337, 731 88, 762, 427 0.000000 06000 LABORATORY 174, 145, 587 307, 838, 767 0.115410 0.000000 60.00 133, 693, 180 60.00 06400 I NTRAVENOUS THERAPY 64.00 3.757.530 28, 077, 065 31, 834, 595 0.176784 0.000000 64 00 06500 RESPIRATORY THERAPY 50, 953, 990 9, 232, 503 60, 186, 493 0. 206508 0.000000 65.00 65.00 66.00 06600 PHYSI CAL THERAPY 19, 538, 129 18, 833, 810 38, 371, 939 0. 273586 0.000000 06700 OCCUPATI ONAL THERAPY 7,007,767 67.00 14, 258, 454 21, 266, 221 0.170178 0.000000 06800 SPEECH PATHOLOGY 68.00 6, 337, 786 4, 173, 430 10, 511, 216 0. 179458 0.000000 68.00 69.00 06900 ELECTROCARDI OLOGY 24, 859, 377 12,007,373 36, 866, 750 0. 115618 0.000000 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 4, 706, 509 15, 105, 608 19, 812, 117 0. 162215 0.000000 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71 00 153, 335, 853 49, 640, 570 202, 976, 423 0.246707 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 82, 727, 769 85, 591, 004 168, 318, 773 0. 229788 0.000000 07300 DRUGS CHARGED TO PATIENTS 170, 802, 832 336, 785, 123 507, 587, 955 0. 192661 73.00 0.000000 74.00 07400 RENAL DIALYSIS 7, 896, 114 303, 564 8, 199, 678 0.000000 0. 213136 07697 CARDIAC REHABILITATION 76.97 189,051 1, 358, 162 1, 547, 213 0.430075 0.000000 76.97 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 662, 591 12, 816, 400 13, 478, 991 0.830027 0.000000 90 01 09001 I BMT JOINT VENTURE 495 465 8, 453, 362 8 948 827 1 108650 0.000000 90 01 09005 CV DIAGNOSTIC SERVICES 90.05 309, 254 67, 832, 766 68, 142, 020 0.232323 0.000000 90.05 91.00 09100 EMERGENCY 78, 793, 940 212, 738, 233 291, 532, 173 0.071579 0.000000 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 7, 121, 148 43, 726, 599 50, 847, 747 0.268411 0.000000

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

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0162
Period:
From 01/01/2020
To 12/31/2020
Date/Time Prepared:
2/30/2021 10: 40 am

					3/30/2021 10:	40 am
			Title XIX	Hospi tal	PPS	
	Cost Center Description	PPS Inpatient				
		Ratio				
		11. 00				
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDI ATRI CS					30.00
31.00	03100 INTENSIVE CARE UNIT					31.00
31. 01	02060 NEONATAL INTENSIVE CARE UNIT					31.01
32.00	03200 CORONARY CARE UNIT					32.00
34.00	03400 SURGI CAL INTENSI VE CARE UNIT					34.00
41.00	04100 SUBPROVI DER - I RF					41.00
43.00	04300 NURSERY					43.00
	ANCILLARY SERVICE COST CENTERS					1
50.00	05000 OPERATING ROOM	0. 134694				50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0. 191621				52.00
	05400 RADI OLOGY-DI AGNOSTI C	0. 098302				54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0. 120966				55.00
	05600 RADI 0I SOTOPE	0. 207072				56.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 048004				59.00
60. 00	06000 LABORATORY	0. 115514				60.00
64. 00	06400 I NTRAVENOUS THERAPY	0. 176784				64.00
65. 00	06500 RESPIRATORY THERAPY	0. 206562				65.00
66. 00	06600 PHYSI CAL THERAPY	0. 273586				66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 170178				67.00
68. 00	06800 SPEECH PATHOLOGY	0. 179458				68.00
	06900 ELECTROCARDI OLOGY	0. 115618				69.00
	07000 ELECTROENCEPHALOGRAPHY	0. 162411				70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 246707				71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 229788				72.00
	07300 DRUGS CHARGED TO PATIENTS	0. 192661				73.00
	07400 RENAL DI ALYSI S	0. 213136				74.00
	07697 CARDI AC REHABI LI TATI ON	0. 213136				76. 97
70. 77	OUTPATIENT SERVICE COST CENTERS	0.430075				70. 77
90.00	09000 CLINIC	0. 830027				90.00
	09001 I BMT JOI NT VENTURE	1. 115786				90.00
	09005 CV DI AGNOSTI C SERVI CES	0. 232323				90.01
	09100 EMERGENCY	0. 232323				91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 071566				92.00
92.00	OTHER REIMBURSABLE COST CENTERS	0. 200411				92.00
101 00	10100 HOME HEALTH AGENCY					101.00
101.00	SPECIAL PURPOSE COST CENTERS					1101.00
112 00	11300 I NTEREST EXPENSE					113.00
	111600 HOSPI CE					116.00
200.00						
	,					200. 00 201. 00
201. 00 202. 00						201.00
202. UU	Tiotal (See Histiactions)					1202.00

Health Financial Systems ST. FRANCIS HOSPI CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICALD ONLY | Peri od: | Worksheet C | From 01/01/2020 | Part I I | To | 12/31/2020 | Date/Ti me | Prepared: Provi der CCN: 15-0162

					10 12/31/2020	3/30/2021 10:	epared: 40 am
			Ti tl	e XIX	Hospi tal	PPS	10 4
	Cost Center Description	Total Cost	Capital Cost	Operating	Capi tal	Operating	
	•	(Wkst. B,	(Wkst. B,	Cost Net of	Reducti on	Cost	
		Part I, col.	Part II col.	Capital Cost		Reduction	
		26)	26)	(col. 1 -		Amount	
		, i		col . 2)			
		1. 00	2. 00	3. 00	4. 00	5. 00	
	LLARY SERVICE COST CENTERS						
	O OPERATING ROOM	35, 682, 321	6, 183, 085			0	
	O DELIVERY ROOM & LABOR ROOM	8, 481, 089	1, 658, 701	6, 822, 38	8 0	0	
	O RADI OLOGY-DI AGNOSTI C	29, 080, 249	3, 986, 123	25, 094, 12	6 0	0	
	O RADI OLOGY-THERAPEUTI C	9, 832, 056	281, 467	9, 550, 58	9 0	0	55.00
56.00 0560	O RADI OI SOTOPE	1, 499, 950	75, 179		1 0	0	56.00
59.00 0590	O CARDI AC CATHETERI ZATI ON	7, 061, 378	1, 539, 955	5, 521, 42	3 0	0	59.00
60.00 06000	O LABORATORY	35, 527, 785	1, 634, 404	33, 893, 38	1 0	0	60.00
64.00 0640	O INTRAVENOUS THERAPY	5, 627, 859	602, 096	5, 025, 76	3 0	0	64.00
65.00 0650	O RESPIRATORY THERAPY	12, 429, 011	565, 204	11, 863, 80	7 0	0	65.00
66.00 0660	O PHYSI CAL THERAPY	10, 498, 036	716, 119	9, 781, 91	7 0	0	66.00
67. 00 0670	O OCCUPATI ONAL THERAPY	3, 619, 035	12, 746	3, 606, 28	9 0	0	67.00
68.00 0680	O SPEECH PATHOLOGY	1, 886, 323	127, 134	1, 759, 18	9 0	0	68. 00
69.00 0690	O ELECTROCARDI OLOGY	4, 262, 464	869, 997	3, 392, 46	7 0	0	69.00
70.00 0700	O ELECTROENCEPHALOGRAPHY	3, 213, 817	10, 097	3, 203, 72	0	0	70.00
71.00 0710	O MEDICAL SUPPLIES CHARGED TO PATIENT	50, 075, 701	1, 047, 795	49, 027, 90	6 0	0	71.00
72.00 0720	O IMPL. DEV. CHARGED TO PATIENTS	38, 677, 602	804, 218	37, 873, 38	4 0	0	72.00
73.00 0730	O DRUGS CHARGED TO PATIENTS	97, 792, 385	805, 647		8 0	0	73.00
	O RENAL DIALYSIS	1, 747, 644	252, 309	1, 495, 33	5 0	0	74.00
76. 97 0769°	7 CARDIAC REHABILITATION	665, 417	2, 326	663, 09	1 0	0	76. 97
OUTPA	ATIENT SERVICE COST CENTERS	<u> </u>					1
90.00 0900	O CLI NI C	11, 187, 932	1, 199, 286	9, 988, 64	6 0	0	90.00
90. 01 0900	1 IBMT JOINT VENTURE	9, 921, 120	159, 980	9, 761, 14	0	0	90. 01
90. 05 0900	5 CV DIAGNOSTIC SERVICES	15, 830, 967	59, 855	15, 771, 11:	2 0	0	90.05
91.00 0910	O EMERGENCY	20, 867, 670	3, 117, 540	17, 750, 13	0	0	91.00
92.00 0920	O OBSERVATION BEDS (NON-DISTINCT PART	13, 648, 096	1, 909, 068	11, 739, 02	0	0	92.00
	R REIMBURSABLE COST CENTERS						1
101. 00 1010	O HOME HEALTH AGENCY	0	0		0 0	0	101.00
SPECI	I AL PURPOSE COST CENTERS				"		1
113. 00 1130	O I NTEREST EXPENSE						113. 00
116. 00 1160	O HOSPI CE	12, 356, 795	34, 742	12, 322, 05	3 0	0	116.00
200. 00	Subtotal (sum of lines 50 thru 199)	441, 472, 702	27, 655, 073	413, 817, 62	9 0	0	200.00
201.00	Less Observation Beds	13, 648, 096	1, 909, 068	11, 739, 02	3 0	0	201.00
202.00	Total (line 200 minus line 201)	427, 824, 606	25, 746, 005	402, 078, 60	1 0	0	202.00
	·			•			

Health Financial Systems ST. FRANCIS HOSPI CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICALD ONLY

					12/01/2020	3/30/2021 10: 40 am
			Ti tl	e XIX	Hospi tal	PPS
	Cost Center Description	Cost Net of	Total Charges	Outpati ent		
	·	Capital and	(Worksheet C,	Cost to		
		Operating	Part I,	Charge Ratio		
		Cost	column 8)	(col. 6 /		
		Reducti on		col. 7)		
		6. 00	7. 00	8. 00		
ANC	ILLARY SERVICE COST CENTERS					
50.00 050	000 OPERATING ROOM	35, 682, 321	264, 914, 869	0. 13469	94	50.00
52. 00 052	200 DELIVERY ROOM & LABOR ROOM	8, 481, 089	44, 259, 677	0. 19162	21	52.00
54.00 054	100 RADI OLOGY-DI AGNOSTI C	29, 080, 249	295, 826, 730	0. 09830)2	54.00
55. 00 055	500 RADI OLOGY-THERAPEUTI C	9, 832, 056	81, 279, 420	0. 12096	6	55.00
56. 00 056	500 RADI OI SOTOPE	1, 499, 950	7, 243, 622	0. 20707	'2	56.00
59. 00 059	POO CARDI AC CATHETERI ZATI ON	7, 061, 378	147, 100, 158	0. 04800)4	59.00
60.00 060	000 LABORATORY	35, 527, 785	307, 838, 767		0	60.00
64. 00 064	100 INTRAVENOUS THERAPY	5, 627, 859	31, 834, 595	0. 17678	34	64.00
	500 RESPIRATORY THERAPY	12, 429, 011	60, 186, 493			65. 00
	000 PHYSI CAL THERAPY	10, 498, 036				66.00
	OO OCCUPATIONAL THERAPY	3, 619, 035				67. 00
	300 SPEECH PATHOLOGY	1, 886, 323	10, 511, 216			68. 00
	200 ELECTROCARDI OLOGY	4, 262, 464				69. 00
	000 ELECTROENCEPHALOGRAPHY	3, 213, 817	19, 812, 117			70.00
	OO MEDICAL SUPPLIES CHARGED TO PATIENT	50, 075, 701	202, 976, 423			71.00
	200 IMPL. DEV. CHARGED TO PATIENTS	38, 677, 602				72.00
	BOO DRUGS CHARGED TO PATIENTS	97, 792, 385	507, 587, 955			73.00
	100 RENAL DI ALYSI S	1, 747, 644				74.00
	97 CARDI AC REHABI LI TATI ON	665, 417	1, 547, 213			76. 97
	PATIENT SERVICE COST CENTERS	000/11/	.,0.,,2.0	0. 10007	<u> </u>	7 5. 77
90.00 090		11, 187, 932	13, 478, 991	0. 83002	77	90.00
	001 IBMT JOINT VENTURE	9, 921, 120				90. 01
	005 CV DI AGNOSTI C SERVI CES	15, 830, 967				90.05
	OO EMERGENCY	20, 867, 670				91.00
	200 OBSERVATION BEDS (NON-DISTINCT PART	13, 648, 096				92.00
	IER REIMBURSABLE COST CENTERS	10/010/070	00/01/////	0.2001.	•	72.00
	OO HOME HEALTH AGENCY	0	0	0.00000	00	101.00
	CIAL PURPOSE COST CENTERS		_			12 22
	300 INTEREST EXPENSE					113.00
	000 HOSPI CE	12, 356, 795	25, 343, 830	0. 48756	6	116.00
200.00	Subtotal (sum of lines 50 thru 199)		2, 714, 236, 204			200.00
201.00	Less Observation Beds	13, 648, 096				201.00
202.00	Total (line 200 minus line 201)		2, 714, 236, 204			202. 00
	1		, , , 20 .	ı	T .	1===:00

Health Financial Systems		ST.	FRANCI S	HOSPI TAI	_ & HEALTH	CENT	ER	In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT	ROUTINE SERVICE	CAPI TAL	COSTS		Provi de	r CCN	N: 15-0162	Peri od: From 01/01/2020 To 12/31/2020	Worksheet D Part I Date/Time Pre 3/30/2021 10:	
					T	tle :	XVIII	Hospi tal	PPS	
01.01					C D .		D. I I	Talal Balland	D D'	

				From 01/01/2020 To 12/31/2020	Part I Date/Time Pre	pared:
					3/30/2021 10:	40 am_
			XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem	
	Related Cost	Adjustment	Capi tal	Days	(col. 3 /	
	(from Wkst.		Related Cost		col. 4)	
	B, Part II,		(col. 1 -			
	col. 26)		col. 2)			
	1. 00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	12, 308, 780	0	12, 308, 78			
31.00 INTENSIVE CARE UNIT	1, 499, 666		1, 499, 66	5 20, 500	73. 15	31.00
31.01 NEONATAL INTENSIVE CARE UNIT	947, 022		947, 02	6, 322	149. 80	31.01
32.00 CORONARY CARE UNIT	3, 010, 041		3, 010, 04	1 12, 691	237. 18	32.00
34.00 SURGICAL INTENSIVE CARE UNIT	1, 710, 521		1, 710, 52	1 8, 247	207. 41	34.00
41. 00 SUBPROVI DER - I RF	1, 123, 305	0	1, 123, 30	5, 552	202. 32	41.00
43. 00 NURSERY	250, 659		250, 65	9 3, 738	67. 06	43.00
200.00 Total (lines 30 through 199)	20, 849, 994		20, 849, 99	4 118, 624		200. 00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x				
		col. 6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	22, 236	4, 444, 976				30.00
31.00 INTENSIVE CARE UNIT	3, 568	260, 999				31.00
31.01 NEONATAL INTENSIVE CARE UNIT	0	0				31.01
32.00 CORONARY CARE UNIT	5, 353	1, 269, 625				32.00
34.00 SURGICAL INTENSIVE CARE UNIT	3, 146	652, 512				34.00
41. 00 SUBPROVI DER - I RF	2, 539	513, 690				41.00
43. 00 NURSERY	0	0				43.00
200.00 Total (lines 30 through 199)	36, 842	7, 141, 802				200.00

1, 909, 068

27, 620, 331 2, 688, 892, 374

50, 847, 747

0.037545

2, 768, 958

323, 182, 433

103, 961

3, 268, 187 200. 00

92.00

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART

Total (lines 50 through 199)

200.00

	FRANCIS HOSPITA			In Lie	u of Form CMS-2	<u> 2552-10</u>
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER F	PASS THROUGH COS	STS Provider C		Period: From 01/01/2020 To 12/31/2020	Worksheet D Part III Date/Time Pre 3/30/2021 10:	pared:
		Title	e XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng School	Nursi ng School	Allied Health Post-Stepdowr	Allied Health	All Other Medical	
	Post-Stepdown Adjustments		Adjustments		Education Cost	
	1A	1.00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	•			<u> </u>		
30. 00 03000 ADULTS & PEDI ATRI CS	C	0		0 0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	C	0		0 0	0	31.00
31. 01 02060 NEONATAL INTENSIVE CARE UNIT	0	0		o o	0	31. 01
32. 00 03200 CORONARY CARE UNIT	C	0		0	0	32.00
34. 00 03400 SURGI CAL INTENSI VE CARE UNI T		0		0	Ō	34.00
41. 00 04100 SUBPROVI DER - I RF				0 0	0	41.00
43. 00 04300 NURSERY				0 0	Ö	43.00
200.00 Total (lines 30 through 199)		1	1	0		200.00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patient	0	Inpati ent	200.00
cost center bescriptron	Adjustment	(sum of cols.	Days	(col. 5 ÷	Program Days	
	Amount (see	1 through 3,	buys	col. 6)	Trogram bays	
	instructions)	minus col. 4)		001.0)		
	4. 00	5.00	6.00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	1. 00	0.00	0.00	7.00	0.00	
30. 00 03000 ADULTS & PEDI ATRI CS	C	0	61, 57	4 0.00	22, 236	30.00
31. 00 03100 I NTENSI VE CARE UNI T		0				
31. 01 02060 NEONATAL INTENSIVE CARE UNIT		0	6, 32			31.01
32. 00 03200 CORONARY CARE UNIT		0	12, 69			
34. 00 03400 SURGI CAL INTENSI VE CARE UNIT		0	8, 24			1
41. 00 04100 SUBPROVI DER -	0					
43. 00 04300 NURSERY		0				43.00
200.00 Total (lines 30 through 199)			1			200.00
Cost Center Description	Inpatient	0	110,02	7	30, 042	200.00
cost center bescriptron	Program					
	Pass-Through					
	Cost (col. 7					
	x col. 8)					
	9. 00					
INPATIENT ROUTINE SERVICE COST CENTERS	7. 00					
30. 00 03000 ADULTS & PEDI ATRI CS	C	S				30.00
31. 00 03100 NTENSI VE CARE UNI T		1				31.00
31. 01 02060 NEONATAL NTENSI VE CARE UNIT						31.00
32. 00 03200 CORONARY CARE UNIT		•				32.00
34. 00 03400 SURGI CAL INTENSI VE CARE UNI T						34.00
41. 00 04100 SUBPROVI DER - I RF		l .				41.00
· · · · · · · · · · · · · · · · · · ·	1	1				
43.00 04300 NURSERY	C					43.00
200.00 Total (lines 30 through 199)		'				200. 00

Health Financial Systems ST. FRANCIS HOSPITAL & HEALTH CENTER

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 15-0162 | Peri od: | Worksheet D | From 01/01/2020 | Part IV | To 12/31/2020 | Date/Time Prepared: THROUGH COSTS

					10 12/31/2020	3/30/2021 10:	40 am
			Title	: XVIII	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
		Anesthetist	School	School	Post-Stepdown		
		Cost	Post-Stepdown		Adjustments		
			Adjustments				
		1. 00	2A	2. 00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0		0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	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	56.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0		0	0	59. 00
60.00	06000 LABORATORY	0	0		0	141, 024	60.00
64. 00	06400 I NTRAVENOUS THERAPY	0	0		0	0	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 PATIENT	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	1, 944, 085	
74.00	07400 RENAL DIALYSIS	0	0		0	0	74.00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0		0 0	0	76. 97
	OUTPATIENT SERVICE COST CENTERS	1		T			
90.00	09000 CLINIC	0	0		0	0	
90. 01	09001 I BMT JOINT VENTURE	0	0		0	0	90. 01
90.05	09005 CV DI AGNOSTI C SERVI CES	0	0		0	0	90.05
91.00	09100 EMERGENCY	0	0		0	235, 262	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0			U	0	92.00
200.00	Total (lines 50 through 199)	0	0	1	0 0	2, 320, 371	1200. OO

Health Financial Systems ST. FRANCIS HOSPITAL & HEALTH CENTER

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 15-0162 | Period: | Worksheet D | From 01/01/2020 | Part IV | To | 12/31/2020 | Date/Time | Prepared: THROUGH COSTS

				Т	o 12/31/2020	Date/Time Pre 3/30/2021 10:	
			Title	· XVIII	Hospi tal	PPS	10 G.II.
	Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
		Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
		Educati on	1, 2, 3, and	Cost (sum of	C, Part I,	(col. 5 ÷	
		Cost	4)	col s. 2, 3,	col . 8)	col. 7)	
				and 4)		(see	
						instructions)	
	T	4. 00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS	_		1			
	05000 OPERATING ROOM	0	0	0	·		
	05200 DELIVERY ROOM & LABOR ROOM	0	0	0		0. 000000	1
	05400 RADI OLOGY-DI AGNOSTI C	0	0	0	295, 826, 730		
	05500 RADI OLOGY-THERAPEUTI C	0	0	0	81, 279, 420		
56. 00		0	0	0	7, 243, 622		56.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	147, 100, 158		59.00
60.00	06000 LABORATORY	0	141, 024	141, 024	· · ·	0. 000458	60.00
64. 00	06400 I NTRAVENOUS THERAPY	0	0	0	31, 834, 595	0. 000000	64.00
65. 00	06500 RESPI RATORY THERAPY	0	0	0	60, 186, 493		65.00
66. 00	06600 PHYSI CAL THERAPY	0	0	0	38, 371, 939	0. 000000	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	0	21, 266, 221	0. 000000	67.00
68. 00	06800 SPEECH PATHOLOGY	0	0	0	10, 511, 216		68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0	0	36, 866, 750		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	19, 812, 117	0. 000000	70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	202, 976, 423	0. 000000	71.00
72.00		0	0	0	168, 318, 773		72.00
73.00		0	1, 944, 085	1, 944, 085			73.00
74.00	07400 RENAL DI ALYSI S	0	0	0	-, ,		74.00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	0	1, 547, 213	0.000000	76. 97
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	0	0	0		0. 000000	
90. 01	09001 I BMT JOINT VENTURE	0	0	0	8, 948, 827	0. 000000	90. 01
	09005 CV DI AGNOSTI C SERVI CES	0	0	0	68, 142, 020		1
	09100 EMERGENCY	0	235, 262				91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	, ,		1
200.00	Total (lines 50 through 199)	0	2, 320, 371	2, 320, 371	2, 688, 892, 374		200. 00

Health Financial Systems	nancial Systems ST. FRANCIS HOSPITAL 8		≩ HEALTH CENTER		In Lieu of Form CMS-2552-10	
ADDODTIONMENT OF INDATIEN	IT/OUTDATIENT ANCLILADY SED	VICE OTHER DASS Provide	r CCN: 15_0162	Pari ad:	Workshoot D	

From 01/01/2020 To 12/31/2020 Part IV THROUGH COSTS Date/Time Prepared: 3/30/2021 10:40 am Title XVIII Hospi tal PPS Outpati ent Cost Center Description Outpati ent I npati ent I npati ent Outpati ent Ratio of Cost Program Program Program Program to Charges Charges Pass-Through Charges Charges (col. 6 ÷ col. 7) Costs (col. 8 before Geo on/after Geo x col. 10) Recl assi fi cat Recl assi fi cat i on i on 9. 00 11.00 10. 00 12.00 12.01 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0.000000 43, 621, 216 23, 642, 661 0 50.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 0 0 52.00 52.00 126, 200 05400 RADI OLOGY-DI AGNOSTI C 0.000000 0 64, 957, 682 54.00 54.00 30, 083, 379 0 05500 RADI OLOGY-THERAPEUTI C 198, 489 55.00 0.000000 0 0 55.00 56.00 05600 RADI OI SOTOPE 0.000000 803, 469 0 1,093,642 0 56.00 59.00 05900 CARDI AC CATHETERI ZATI ON 0.000000 17, 303, 066 0 26, 804, 662 0 59.00 06000 LABORATORY 40, 240, 264 60.00 0.000458 18, 430 7, 478, 398 0 60.00 06400 I NTRAVENOUS THERAPY 64.00 0.000000 1, 142, 351 0 9, 839, 348 0 64.00 65.00 06500 RESPIRATORY THERAPY 0.000000 13, 769, 203 1, 903, 275 0 65.00 06600 PHYSI CAL THERAPY 0.000000 5, 651, 407 0 157, 974 0 66.00 66.00 06700 OCCUPATI ONAL THERAPY 0.000000 3, 820, 792 18, 403 67.00 67.00 0 68.00 06800 SPEECH PATHOLOGY 0.000000 1, 278, 921 24, 147 0 68.00 06900 ELECTROCARDI OLOGY 0.000000 8, 249, 959 1, 943, 512 69.00 69.00 0 07000 ELECTROENCEPHALOGRAPHY 0.000000 1, 297, 519 1, 188, 389 70.00 70 00 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.000000 44, 803, 258 0 21, 436, 492 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 33, 231, 644 0 12, 936, 539 0 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 0.003830 43, 732, 002 167, 494 102, 465, 482 0 73.00 07400 RENAL DIALYSIS 74 00 0.000000 3, 159, 086 O 162, 075 Ω 74 00 07697 CARDIAC REHABILITATION 76.97 0.000000 52, 166 0 359, 708 0 76.97 OUTPATIENT SERVICE COST CENTERS 2, 696, 523 90.00 09000 CLI NI C 0.000000 90, 847 0 90.00 09001 I BMT JOINT VENTURE 90 01 0.000000 13, 115 0 694, 994 90.01 0 90.05 09005 CV DIAGNOSTIC SERVICES 0.000000 50, 428 0 20, 082, 779 0 90.05 91.00 09100 EMERGENCY 0.000807 27, 893, 183 33, 114, 823 0 91.00 22, 510 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 2, 768, 958 1, 617, 017 92.00 0.000000 0 0

323, 182, 433

208. 434

334, 817, 014

0 200.00

200.00

Total (lines 50 through 199)

Health Financial Systems	ST. FRANCIS HOSPITAL 8	& HEALTH CENTER	In Lieu	of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0162	Peri od: From 01/01/2020 To 12/31/2020	Worksheet D Part IV Date/Time Prepared:

Cost Center Description					10 12/31/2020	3/30/2021 10:	
Program Pass-Through Costs (col. 9 x col. 12) Defore Geo Reclassificat For Indian Pass P			Title	XVIII	Hospi tal		
Pass - Through Costs (col. 9 x col. 12) before Geo Recl assi fi cat ion 13.00 13.01	Cost Center Description	Outpati ent	Outpati ent				
Costs (col. 9 x col. 12) y col. 12) on/after Go Recl assi fi cat ion 13.00 13.01		Program	Program				
ANCI LLARY SERVICE COST CENTERS 13.00 13.01							
NACILLARY SERVICE COST CENTERS 10 n							
Reclassificat ion 13.00 13.01							
I on 10							
ANCI LLARY SERVICE COST CENTERS 13.00 13.01							
ANCI LLARY SERVICE COST CENTERS							
50. 00 05000 OPERATING ROOM 0 0 0 0 52. 00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 0 0 52. 00 054. 00 05400 RADI OLOGY-DI AGNOSTIC 0 0 0 0 0 0 0 0 0		13. 00	13. 01				
52.00 05200 DELI VERY ROM & LABOR ROOM 0 0 0 54.00 ADI OLOGY-DI AGNOSTI C 0 0 0 55.00 O5500 RADI OLOGY-THERAPEUTI C 0 0 0 0 0 0 0 0 0		_	_	Т			
54.00		0	_				
55. 00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 0 0 0 0 0 0		0	0				
56. 00 05600 RADI OI SOTOPE 0 0 0 0 59. 00 59. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69		0	0				
59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 59. 00 60. 00 06000 LABORATORY 3, 425 0 60. 00 64. 00 06400 I NTRAVENOUS THERAPY 0 0 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 SPECH PATHOLOGY 0 0 67. 00 69. 00 06900 ELECTROCARDI OLOGY 0 0 69. 00 70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 72. 00 07000 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 0 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 392, 443 0 73. 00 74. 00 07400 RENAL DI ALYSI S 0 0 74. 00 07597 CARDI AC REHABI LI TATI ON 0 0 90. 01 90. 01 09001 ELBOR GRANCY 0 </td <td></td> <td>0</td> <td>0</td> <td></td> <td></td> <td></td> <td></td>		0	0				
60. 00		0	, and a				
64. 00 06400 INTRAVENOUS THERAPY 0 0 0 0 0 0 0 0 0		0	_				
65. 00			l .				
66. 00		0	0				
67. 00		0	0				
68. 00 06800 SPEECH PATHOLOGY 0 0 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 71. 00 07100 MDI CAL SUPPLIES CHARGED TO PATIENT 0 0 0 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 73. 00 07300 DRUGS CHARGED TO PATIENTS 392, 443 0 73. 00 74. 00 07400 RENAL DI ALYSIS 0 0 0 76. 97 07697 CARDI AC REHABILI TATI ON 0 0 0 76. 97 00TPATIENT SERVICE COST CENTERS 90. 00 09000 CLI NI C 0 0 90. 01 09001 IBMT JOI NT VENTURE 0 0 90. 05 09005 CV DI AGNOSTI C SERVI CES 0 0 91. 00 09100 EMERGENCY 26, 724 0 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 0 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 0 90. 00 00 00 90. 01 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 0 90. 01 09200 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 0 90. 01 09200 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 0 90. 01 09200 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 0 0 90. 01 09200 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 0 0 90. 01 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 092		0	0				
69. 00		0	0				
70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 0 0 0 0		0	0				
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0 0 0 72. 00 72. 00 72. 00 73. 00 73. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 392, 443 0 73. 00 74. 00 74. 00 76. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076.		0	0				
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 73. 00 73. 00 73. 00 73. 00 74. 00 74. 00 74. 00 74. 00 76. 97 76. 97 07697 CARDIAC REHABILITATION 0 0 0 0 0 0 0 0 0		0	0				
73. 00 07300 DRUGS CHARGED TO PATIENTS 392, 443 0 74. 00 74. 00 74. 00 76. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97		0	0				
74. 00 76. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97 076. 97		0	0				
76. 97 07697 CARDI AC REHABILITATION 0 0 0 00TPATIENT SERVICE COST CENTERS 90. 00 90. 00 90. 01 09001 IBMT JOINT VENTURE 0 0 90. 01 90. 05 09005 CV DI AGNOSTI C SERVICES 0 0 90. 05 91. 00 09100 EMERGENCY 26, 724 0 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 0 92. 00 76. 97 76. 97 76. 97 76. 97 76. 97 90. 00 90. 00 90. 00 90. 00 90. 00 90. 00 90. 01 90. 00 91. 00 92. 00 92. 00 92. 00 92. 00 92. 00 93. 00 93. 00 94. 00 94. 00 95. 00 95. 00 96. 00 96. 00 97. 00 97. 00 98. 00 98. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00		1	l .				
OUTPATIENT SERVICE COST CENTERS 90. 00 09000 CLI NI C 0 0 0 90. 00		1					
90. 00 09000 CLINIC 0 0 90. 00 90. 01 90. 01 90. 01 90. 05 90. 05 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0 92. 00 92. 00 92. 00 92. 00 93. 00 93. 00 94. 00 94. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00		0	0				76. 97
90. 01 09001 IBMT JOINT VENTURE 0 0 0 90. 01 90. 05 09005 CV DI AGNOSTI C SERVI CES 0 0 0 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 0 92. 00 09200 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 0 0 0 0 0 0 0 0			1				
90. 05 09005 CV DI AGNOSTI C SERVI CES 0 0 0 91. 00 91. 00 92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART 0 0 92. 00 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200 09200		0		i e			
91. 00 09100 EMERGENCY 26, 724 0 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0 0 0 0 0 0 0 0		0	0				
92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART 0 0 92. 00		0	0				
		26, 724					
200.00 Total (lines 50 through 199) 422,592 0 200.00	,	0					
	200.00 Total (lines 50 through 199)	422, 592	0				200.00

In Lieu of Form CMS-2552-10 Health Financial Systems ST. FRANCIS HOSPITAL & HEALTH CENTER APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0162 Peri od: Worksheet D From 01/01/2020 Part V 12/31/2020 Date/Time Prepared: 3/30/2021 10:40 am Title XVIII Hospi tal PPS Charges Costs PPS PPS Services Cost Center Description Cost to Cost Cost Charge Ratio Rei mbursed Rei mbursed Rei mbursed (see inst.) From Services (see Servi ces Services Not Worksheet C, Subject To Subject To inst.) Part I, col. Ded. & Coins. Ded. & Coins. 9 (see inst.) (see inst.) 1. 00 2.00 5.00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 134694 23, 642, 661 5, 922 3, 184, 525 50.00 05200 DELIVERY ROOM & LABOR ROOM 0 0.191621 52.00 0 52.00 0 05400 RADI OLOGY-DI AGNOSTI C 64, 957, 682 54.00 0.098302 6, 385, 470 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 0.120966 198, 489 0 0 24,010 55.00 56.00 05600 RADI OI SOTOPE 0. 207072 1, 093, 642 0 0 226, 463 56.00 0 05900 CARDI AC CATHETERI ZATI ON 26, 804, 662 1, 286, 731 59 00 0.048004 0 59 00 0 60.00 06000 LABORATORY 0. 115410 7, 478, 398 863, 082 60.00 64.00 06400 INTRAVENOUS THERAPY 0. 176784 9, 839, 348 0 0 0 1, 739, 439 64.00 0 06500 RESPIRATORY THERAPY 0. 206508 1, 903, 275 393, 042 65.00 65.00 157, 974 43, 219 06600 PHYSI CAL THERAPY 0 66.00 0. 273586 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0.170178 18, 403 0 3, 132 67.00 06800 SPEECH PATHOLOGY 0. 179458 0 68.00 24, 147 0 0 0 0 4, 333 68.00 1, 943, 512 06900 ELECTROCARDI OLOGY 224, 705 69 00 0 115618 0 69 00 70.00 07000 ELECTROENCEPHALOGRAPHY 0. 162215 1, 188, 389 0 192, 775 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0. 246707 21, 436, 492 2,000 5, 288, 533 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 0. 229788 12, 936, 539 2, 972, 661 72.00 0 07300 DRUGS CHARGED TO PATIENTS 0 73 00 0 192661 102, 465, 482 19, 741, 102 73 00 72.346 0 74.00 07400 RENAL DIALYSIS 0.213136 162, 075 0 34, 544 74.00 07697 CARDIAC REHABILITATION 0. 430075 359, 708 154, 701 76.97 76.97 0 OUTPATIENT SERVICE COST CENTERS 90 00 09000 CLI NI C 0.830027 2, 696, 523 2, 238, 187 90 00 09001 IBMT JOINT VENTURE 90.01 1.108650 694, 994 0 0 770, 505 90.01 09005 CV DIAGNOSTIC SERVICES 0. 232323 20, 082, 779 0 4, 665, 691 90.05 90.05 0 09100 EMERGENCY 0.071579 33, 114, 823 2, 370, 326 91.00 91.00 13, 518 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 0. 268411 1, 617, 017 0 434, 025 200.00 Subtotal (see instructions) 334, 817, 014 93, 786 0 53, 241, 201 200.00 ol 201.00 Less PBP Clinic Lab. Services-Program 0 201.00 Only Charges

334, 817, 014

93, 786

53, 241, 201 202. 00

202.00

Net Charges (line 200 - line 201)

				To 12/31/2020	Date/Time Pro 3/30/2021 10:	
		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						
50.00 05000 OPERATING ROOM	798	0				50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0				52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0				55.00
56. 00 05600 RADI 0I SOTOPE	0	0				56.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0				59.00
60. 00 06000 LABORATORY	0	0				60.00
64.00 06400 I NTRAVENOUS THERAPY	0	0				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	0				68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0				69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0				70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	493	0				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	13, 938	0				73.00
74.00 07400 RENAL DIALYSIS	0	0				74.00
76. 97 O7697 CARDI AC REHABI LI TATI ON	0	0				76. 97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0				90.00
90. 01 09001 I BMT JOINT VENTURE	0	0				90. 01
90. 05 09005 CV DI AGNOSTI C SERVI CES	0	0				90. 05
91. 00 09100 EMERGENCY	968	l .	l .			91.00
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART	0	"				92.00
200.00 Subtotal (see instructions)	16, 197	0				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201. 00
Only Charges		_				L
202.00 Net Charges (line 200 - line 201)	16, 197	0	1			202.00

Health Financial Systems ST. FRANCIS HOSPITAL & HEALTH CENTER In Lieu of Form CMS-2552-10							
Health Financial Systems ST. I APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA		Provider C		Period:	Worksheet D	2552-10	
ALLOCATION WIENE OF THE ATTEMPT AND LEARLY SERVICE CALLED	AL 00313	i i ovi dei ci		From 01/01/2020			
		·		To 12/31/2020	Date/Time Pre 3/30/2021 10:	pared: 40 am_	
		Title	XVIII	Subprovi der -	PPS		
				I RF			
Cost Center Description	Capi tal	Total Charges			Capital Costs		
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x		
	(from Wkst.	C, Part I,	(col . 1 ÷	Charges	column 4)		
	B, Part II,	col. 8)	col. 2)				
	col. 26)						
	1. 00	2. 00	3. 00	4. 00	5. 00		
ANCILLARY SERVICE COST CENTERS				00.550			
50. 00 05000 OPERATING ROOM	6, 183, 085		0. 02334				
52. 00 05200 DELI VERY ROOM & LABOR ROOM	1, 658, 701		0. 03747		"	52.00	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	3, 986, 123		0. 01347			54.00	
55. 00 05500 RADI OLOGY-THERAPEUTI C	281, 467		0. 00346		0	55.00	
56. 00 05600 RADI OI SOTOPE	75, 179		0. 01037		38	56.00	
59. 00 05900 CARDI AC CATHETERI ZATI ON	1, 539, 955		0. 01046		0	59. 00	
60. 00 06000 LABORATORY	1, 634, 404		0. 00530			60.00	
64.00 06400 I NTRAVENOUS THERAPY	602, 096		0. 01891			64.00	
65. 00 06500 RESPIRATORY THERAPY	565, 204		0. 00939			65.00	
66. 00 06600 PHYSI CAL THERAPY	716, 119		0. 01866			66.00	
67. 00 06700 OCCUPATI ONAL THERAPY	12, 746		0. 00059	,		67.00	
68. 00 06800 SPEECH PATHOLOGY	127, 134		0. 01209		8, 405	68. 00	
69. 00 06900 ELECTROCARDI OLOGY	869, 997		0. 02359		561	69. 00	
70. 00 07000 ELECTROENCEPHALOGRAPHY	10, 097		0. 00051			70.00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 047, 795		0. 00516			71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	804, 218	168, 318, 773	0. 00477	863	4	72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	805, 647	507, 587, 955	0. 00158	7 539, 652	856	73.00	
74.00 07400 RENAL DIALYSIS	252, 309	8, 199, 678	0. 03077	1 105, 290	3, 240	74.00	
76. 97 07697 CARDIAC REHABILITATION	2, 326	1, 547, 213	0. 00150	3 0	0	76. 97	
OUTPATIENT SERVICE COST CENTERS							
90. 00 09000 CLI NI C	1, 199, 286	13, 478, 991	0. 08897	4 0	0	90.00	
90. 01 09001 I BMT JOI NT VENTURE	159, 980	8, 948, 827	0. 01787	7 0	0	90. 01	
90. 05 09005 CV DIAGNOSTIC SERVICES	59, 855	68, 142, 020	0. 00087	8 0	0	90.05	
91. 00 09100 EMERGENCY	3, 117, 540	291, 532, 173	0. 01069	4 0	0	91.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	50, 847, 747	0. 00000	0 0	0	92.00	
200.00 Total (lines 50 through 199)	25, 711, 263	2, 688, 892, 374		6, 608, 898	59, 677	200.00	
	•	•	•	•		•	

		RANCIS HOSPITA				eu of Form CMS-	2552-10
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF SH COSTS	RVICE OTHER PAS	SS Provider C	CN: 15-0162	Peri od: From 01/01/202	Worksheet D 20 Part IV	
TTIKOOC	11 60313		Component	CCN: 15-T162	To 12/31/202		epared: 40 am
			Title	· XVIII	Subprovi der -		<u> 10 am</u>
	Cost Center Description	Non Physician	Nursi ng	Nursi ng		h Allied Health	
		Anestheti st	School	School	Post-Stepdow		
		Cost	Post-Stepdown		Adjustments		
			Adjustments				
		1. 00	2A	2. 00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS	1	1	1			
50.00	05000 OPERATING ROOM	0	1		0	0	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0		0	0	
56.00	05600 RADI OI SOTOPE	0	0		0	0	
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		0	0 141 034	07.00
60.00	06000 LABORATORY	0	0		0	0 141, 024	
64.00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	0	0		0	0	
65. 00 66. 00	06600 PHYSI CAL THERAPY	0	0		0	0	1
67. 00	06700 OCCUPATI ONAL THERAPY	0	0		0	0 0	
68. 00	06800 SPEECH PATHOLOGY	0	0		0		
69.00	06900 ELECTROCARDI OLOGY				0		
70.00	07000 ELECTROENCEPHALOGRAPHY				0		
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0			0		1
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0		
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0		0	0 1, 944, 085	
74. 00	07400 RENAL DI ALYSI S	0	ĺ		0	0 0	1
76. 97	07697 CARDI AC REHABI LI TATI ON	0			0		
	OUTPATIENT SERVICE COST CENTERS	-	-			-1	1
90.00	09000 CLI NI C	0	0		0	0 0	90.00
90. 01	09001 I BMT JOINT VENTURE	0	0		0	ol o	90.01
90. 05	09005 CV DI AGNOSTI C SERVI CES	0	0		0	0 0	90.05
91.00	09100 EMERGENCY	0	0		0	0 235, 262	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0	0	92.00
200.00	Total (lines 50 through 199)	0	l o		0	0 2, 320, 371	200 00

APPORT	Financial Systems ST. F TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER TH COSTS	RANCIS HOSPITA RVICE OTHER PAS	S Provider Co	CN: 15-0162 F	In Lie Period: From 01/01/2020 To 12/31/2020	Date/Time Pre	pared:
						3/30/2021 10:	40 am
			litie	XVIII	Subprovi der -	PPS	
	Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
		Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
		Educati on	1, 2, 3, and	Cost (sum of	C, Part I,	(col. 5 ÷	
		Cost	4)	col s. 2, 3,	col. 8)	col . 7)	
				and 4)		(see	
						instructions)	
		4. 00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	(0. 000000	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	(0. 000000	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	(0. 000000	
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	C	- 1, -1 1, 1-0	0. 000000	
56. 00	05600 RADI OI SOTOPE	0	0	C	., ,	0. 000000	
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	C	,	0. 000000	
60.00	06000 LABORATORY	0	141, 024	141, 024		0. 000458	
64.00	06400 I NTRAVENOUS THERAPY	0	0	(, ,	0. 000000	
65.00	06500 RESPI RATORY THERAPY	0	0	(001 1001 170	0. 000000	
66.00	06600 PHYSI CAL THERAPY	0	0	(, ,	0. 000000	
67.00	06700 OCCUPATI ONAL THERAPY	0	0	(21, 266, 221	0. 000000	
68.00	06800 SPEECH PATHOLOGY	0	0	(10, 511, 216	0. 000000	
69.00	06900 ELECTROCARDI OLOGY	0	0	(36, 866, 750	0. 000000	
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	C		0. 000000	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	C		0. 000000	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	(0. 000000	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	1, 944, 085			0. 003830	
74.00	07400 RENAL DIALYSIS	0	0	(-, ,	0. 000000	
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	(1, 547, 213	0. 000000	76. 97
	OUTPATIENT SERVICE COST CENTERS		_	_			
90.00	09000 CLINIC	0	0	C		0. 000000	
90. 01	09001 I BMT JOINT VENTURE	0	0	C	-,	0. 000000	90. 01
	09005 CV DI AGNOSTI C SERVI CES	0	0	0	,	0.000000	
91.00	09100 EMERGENCY	0	235, 262			0. 000807	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0 000 071	0 000 074	, ,	0. 000000	
200.00	Total (lines 50 through 199)	0	2, 320, 371	2, 320, 371	2, 688, 892, 374		200. 00

APPORT	Financial Systems ST. I IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI H COSTS	FRANCIS HOSPITAL RVICE OTHER PASS	Provider Component	CN: 15-0162 CCN: 15-T162	Period: From 01/01/2020 Fo 12/31/2020	Date/Time Pre 3/30/2021 10:	pared:
			Title	e XVIII	Subprovi der - I RF	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	
		(col. 6 ÷		Costs (col. 8		on/after Geo	
		col. 7)		x col. 10)	Recl assi fi cat		
					i on	i on	
		9. 00	10. 00	11. 00	12.00	12. 01	
	ANCILLARY SERVICE COST CENTERS			1	-1		
50.00	05000 OPERATI NG ROOM	0. 000000	29, 550		0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0	l .	0	0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	340, 798	1	0	0	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	0	1	0	0	55.00
56. 00	05600 RADI OI SOTOPE	0. 000000	3, 657	1	0	0	56.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	0	1	0	0	59.00
60. 00	06000 LABORATORY	0. 000458	659, 963	1		0	60.00
64. 00	06400 I NTRAVENOUS THERAPY	0. 000000	0	1	0	0	64.00
65. 00	06500 RESPI RATORY THERAPY	0. 000000	402, 339		٥	0	65.00
66. 00	06600 PHYSI CAL THERAPY	0. 000000	1, 546, 066		0	0	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 000000	1, 400, 444		0	0	67.00
68. 00	06800 SPEECH PATHOLOGY	0. 000000	694, 918	1	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 000000	23, 769		0	0	69.00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	28, 159		0	0	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	833, 430		0	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000	863	1	٥	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 003830	539, 652			0	73.00
74. 00	07400 RENAL DIALYSIS	0. 000000	105, 290	1	9	0	74.00
76. 97	07697 CARDI AC REHABI LI TATI ON	0. 000000	0	(0	0	76. 97
	OUTPATIENT SERVICE COST CENTERS			T .	J .		
90.00	09000 CLINIC	0. 000000	0	1	0	0	
90. 01	09001 I BMT JOINT VENTURE	0. 000000	0	1	0	0	90. 01
90.05	09005 CV DI AGNOSTI C SERVI CES	0.000000	0	1	0	0	90.05
91.00	09100 EMERGENCY	0. 000807	0	1	0	0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0		0	0	
200.00	Total (lines 50 through 199)	1	6, 608, 898	2, 36	9 0	l 0	200. 00

	Financial Systems ST. FIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEE		Component	CN: 15-0162 CCN: 15-T162	Peri od: From 01/01/2020 To 12/31/2020	u of Form CMS- Worksheet D Part IV Date/Time Pro 3/30/2021 10	epared:
			Titl€	xVIII	Subprovi der - I RF	PPS	
	Cost Center Description	Outpatient Program Pass-Through Costs (col. 9 x col. 12) before Geo Reclassificat ion	x col. 12) on/after Geo		TM		
		13. 00	13. 01	-			
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	-				50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	1	1			52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	C				54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	C				55.00
56.00	05600 RADI OI SOTOPE	0	C				56.00
59. 00 60. 00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0					59. 00 60. 00
64.00	06400 I NTRAVENOUS THERAPY	0					64.00
65.00	06500 RESPIRATORY THERAPY			1			65.00
66.00	06600 PHYSI CAL THERAPY						66.00
67.00	06700 OCCUPATI ONAL THERAPY	0		1			67.00
68.00	06800 SPEECH PATHOLOGY	0		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 PATIENT	0	l c				71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	l c				72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	C	1			73.00
74.00	07400 RENAL DIALYSIS	0	C)			74.00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	C				76. 97
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0	-	1			90.00
90. 01	09001 I BMT JOINT VENTURE	0					90. 01
	09005 CV DI AGNOSTI C SERVI CES	0					90.05
91.00	09100 EMERGENCY	0		1			91.00
92.00	O9200 OBSERVATION BEDS (NON-DISTINCT PART Total (lines 50 through 199)	0					92. 00 200. 00

Health Financial Systems	ST. FRANCIS HOSPITAI	L & HEALTH CENTER	In Lie	u of Form CMS-2	2552-10
APPORTI ONMENT OF MEDICAL, OTHER HEALTH	SERVICES AND VACCINE COST	Provider CCN: 15-0162	Peri od: From 01/01/2020	Worksheet D Part V	
		Component CCN: 15-T162			
		Title XVIII	Subprovi der -	PPS	
			IRF		

		Ti +Lo	XVIII	Subprovi der -	PPS	40 aiii
		II ti e	AVIII	I RF	PF3	
			Charges	IKF	Costs	
Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
cost center bescription	Charge Ratio	Rei mbursed	Rei mbursed	Rei mbursed	(see inst.)	
		Services (see	Servi ces	Services Not	(See Hist.)	
	Worksheet C.	inst.)	Subject To	Subject To		
	Part I, col.	HISt.)	Ded. & Coins.	Ded. & Coins.		
	9		(see inst.)	(see inst.)		
	1.00	2. 00	3.00	4.00	5. 00	
ANCILLARY SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
50. 00 05000 OPERATING ROOM	0. 134694	0		0	0	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 134694	0			0	
		0				
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 098302	0			0	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 120966	0	(0	0	55.00
56. 00 05600 RADI 0I SOTOPE	0. 207072	0	(0	0	56.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 048004	0	(0	0	59.00
60. 00 06000 LABORATORY	0. 115410	0	(0	0	60.00
64.00 06400 I NTRAVENOUS THERAPY	0. 176784	0		0	0	64.00
65. 00 06500 RESPIRATORY THERAPY	0. 206508	0	(0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 273586	0	(0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 170178	0	(0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0. 179458	0	(0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 115618	0	(0	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 162215	0	(0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 246707	0		0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 229788	0		0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 192661	0		680	0	73.00
74.00 07400 RENAL DIALYSIS	0. 213136	0		0	0	74.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 430075	0		0	0	76. 97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0. 830027	0		0	0	90.00
90. 01 09001 BMT JOINT VENTURE	1. 108650	0		0	l o	1
90. 05 09005 CV DI AGNOSTI C SERVI CES	0. 232323	0	ĺ		0	
91. 00 09100 EMERGENCY	0. 071579	0	1, 020		0	1
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 268411	0	1,02		0	1
200.00 Subtotal (see instructions)	0. 200411	0	1, 020	680		200.00
201.00 Less PBP Clinic Lab. Services-Program		0	1,020	000		201.00
Only Charges			·			201.00
202.00 Net Charges (line 200 - line 201)		0	1, 020	680	1	202.00
202.00 Net charges (Title 200 - Title 201)	1	U	1,020	000	ı	1202.00

llool +b	ı Financial Systems ST. I	FRANCIS HOSPITAL	o ligal til ogni	TED	la li o	, of Form CMC	2552 10
	APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-016 Component CCN: 15-11		CN: 15-0162	Peri od: From 01/01/2020 To 12/31/2020	worksheet D Part V Date/Time Pre 3/30/2021 10:	pared:	
			Title	XVIII	Subprovi der -	PPS	40 alli
	Cost Center Description	Subject To Ded. & Coins. D	Cost Reimbursed Services Not Subject To Oed. & Coins. (see inst.) 7.00		170		
52. 00 54. 00 55. 00 56. 00 59. 00 64. 00 65. 00 66. 00 67. 00 68. 00 70. 00 71. 00 72. 00 73. 00 74. 00 76. 97	06400 I NTRAVENOUS THERAPY 06500 RESPIRATORY THERAPY 06600 PHYSI CAL THERAPY 06700 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07000 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 07200 I MPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DI ALYSI S 07697 CARDI AC REHABI LI TATI ON 0UTPATIENT SERVI CE COST CENTERS	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				50. 00 52. 00 54. 00 55. 00 56. 00 60. 00 64. 00 65. 00 67. 00 68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 74. 00 76. 97
90. 01 90. 05	09000 CLINIC 09001 IBMT JOINT VENTURE 09005 CV DIAGNOSTIC SERVICES	0 0 0	0 0 0				90. 00 90. 01 90. 05

73

0

0

131

131

90. 05 91. 00 92. 00

200.00

201.00

202.00

91.00 09100 EMERGENCY

200.00

201.00

202.00

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART

Subtotal (see instructions)
Less PBP Clinic Lab. Services-Program
Only Charges
Net Charges (line 200 - line 201)

Health Financial Sy	ystems S	ST. FRANCIS HOSPITAL &	HEALTH C	CENTER	In Lieu	ı of Form CMS-2552-10
		=				

Health Financial Systems ST.	FRANCIS HOSPITA	L & HEALTH CEN	ITER	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der Co		Period: From 01/01/2020 To 12/31/2020		
			e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem	
	Related Cost	Adjustment	Capi tal	Days	(col. 3 /	
	(from Wkst.		Related Cost		col. 4)	
	B, Part II,		(col. 1 -			
	col . 26)	0.00	col . 2)			
LANDATI ENT. DOUTLINE OFFICE OF COOT OFFITEDO	1. 00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	10.000.700		10.000.70		100.00	
30. 00 ADULTS & PEDIATRICS	12, 308, 780		12,000,70			
31. 00 INTENSIVE CARE UNIT	1, 499, 666		1, 499, 66			
31. 01 NEONATAL INTENSIVE CARE UNIT	947, 022		947, 02			
32. 00 CORONARY CARE UNIT	3, 010, 041		3, 010, 04			
34. 00 SURGI CAL INTENSI VE CARE UNIT	1, 710, 521		1, 710, 52		•	
41.00 SUBPROVIDER - IRF 43.00 NURSERY	1, 123, 305		1 ., .20,00			
	250, 659	l e	250, 65		l	
200.00 Total (lines 30 through 199) Cost Center Description	20, 849, 994 Inpati ent	Inpati ent	20, 849, 99	118, 624		200. 00
Cost Center Description		Program				
	Program days	Capital Cost				
		(col. 5 x				
		col. 6)				
	6. 00	7.00	1			
INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00				
30. 00 ADULTS & PEDIATRICS	797	159, 320				30.00
31. 00 INTENSIVE CARE UNIT	278					31.00
31. 01 NEONATAL INTENSIVE CARE UNIT	45					31. 01
32. 00 CORONARY CARE UNIT	46					32.00
34. 00 SURGI CAL INTENSI VE CARE UNI T	67	13, 896				34.00
41. 00 SUBPROVI DER – I RF	25					41.00
43. 00 NURSERY	172					43.00
200.00 Total (lines 30 through 199)	1, 430					200. 00

59,855

27, 620, 331 2, 688, 892, 374

3, 117, 540

1, 909, 068

68, 142, 020

291, 532, 173

50, 847, 747

0.000878

0.010694

0.037545

13, 726

8, 294, 479

91, 766, 738

12

0 92.00

1, 241, 376 200. 00

88, 701

90.05

91.00

09005 CV DIAGNOSTIC SERVICES

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART

Total (lines 50 through 199)

90.05

200.00

91. 00 09100 EMERGENCY

Health Financial Systems	ST. FRANCIS HOSPITAL & HEALTH CENTER	In Lieu of Form CM

Health Financial Systems ST. F	FRANCIS HOSPITA	AL & HEALTH CEN	ITER	In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	ASS THROUGH COS	STS Provider C	CN: 15-0162	Peri od:	Worksheet D	
				From 01/01/2020	Part III	
				To 12/31/2020	Date/Time Pre 3/30/2021 10:	eparea:
		Ti tl	e XIX	Hospi tal	PPS	40 alli
Cost Center Description	Nursi ng	Nursi ng		Allied Health	All Other	
oost contor boson per on	School	School	Post-Stepdown		Medi cal	
	Post-Stepdown		Adjustments		Educati on	
	Adjustments		,		Cost	
	1A	1.00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	•			<u>'</u>		
30. 00 03000 ADULTS & PEDIATRICS	0	0	(0 0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0)	0	0	31.00
31.01 02060 NEONATAL INTENSIVE CARE UNIT	0	0)	0	0	31. 01
32. 00 03200 CORONARY CARE UNIT	0	0)	0	0	32.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	0	0)	0	0	34.00
41. 00 04100 SUBPROVI DER - I RF	0	0)	0	0	41.00
43. 00 04300 NURSERY	0	0)	0	0	43.00
200.00 Total (lines 30 through 199)	0	0)	0	0	200.00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patient	Per Diem	I npati ent	
	Adjustment	(sum of cols.	Days	(col. 5 ÷	Program Days	
	Amount (see	1 through 3,		col. 6)		
		minus col. 4)				
	4. 00	5. 00	6. 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	1					
30. 00 03000 ADULTS & PEDIATRICS	0	0	61, 57		797	
31.00 03100 INTENSIVE CARE UNIT		0	20, 500		278	
31. 01 02060 NEONATAL INTENSIVE CARE UNIT		0	6, 32		45	1
32.00 03200 CORONARY CARE UNIT		0	12, 69		46	
34.00 03400 SURGICAL INTENSIVE CARE UNIT		0	8, 24		67	
41. 00 04100 SUBPROVI DER - I RF	0		-,		•	
43. 00 04300 NURSERY		0			172	
200.00 Total (lines 30 through 199)		0	118, 62	4	1, 430	200.00
Cost Center Description	Inpatient					
	Program					
	Pass-Through					
	Cost (col. 7					
	x col. 8) 9.00	_				
INPATIENT ROUTINE SERVICE COST CENTERS	9.00					
30. 00 03000 ADULTS & PEDIATRICS	0					30.00
31. 00 03100 INTENSIVE CARE UNIT	0					31.00
31. 01 02060 NEONATAL INTENSIVE CARE UNIT	0					31.00
32. 00 03200 CORONARY CARE UNIT						32.00
34. 00 03400 SURGI CAL INTENSI VE CARE UNI T	0					34.00
41. 00 04100 SUBPROVI DER - I RF	0					41.00
43. 00 04300 NURSERY						43.00
200.00 Total (lines 30 through 199)						200.00
		1				1-30.00

Health Financial Systems ST. FRANCIS HOSPITAL & HEALTH CENTER

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 15-0162 | Peri od: | Worksheet D | From 01/01/2020 | Part IV | To 12/31/2020 | Date/Time Prepared: THROUGH COSTS

					10 12/31/2020	3/30/2021 10:	40 am
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
		Anesthetist	School	School	Post-Stepdown		
		Cost	Post-Stepdown		Adjustments		
			Adjustments				
		1. 00	2A	2. 00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0		0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0		0	0	55.00
56.00	05600 RADI 0I SOTOPE	0	0		0	0	56.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0		0	0	59. 00
60.00	06000 LABORATORY	0	0		0	141, 024	60.00
64. 00	06400 I NTRAVENOUS THERAPY	0	0		0	0	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 PATIENT	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	1, 944, 085	
74.00	07400 RENAL DI ALYSI S	0	0		0	0	74.00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0		0 0	0	76. 97
	OUTPATIENT SERVICE COST CENTERS	_		T			
90.00	09000 CLI NI C	0	0		0	0	
90. 01	09001 I BMT JOINT VENTURE	0	0		0	0	90. 01
90. 05	09005 CV DI AGNOSTI C SERVI CES	0	0		0	0	90.05
91.00	09100 EMERGENCY	0	0		0	235, 262	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	_		0	0	92.00
200.00	Total (lines 50 through 199)	0	0	1	0 0	2, 320, 371	J200. 00

Health Financial Systems ST. FRANCIS HOSPITAL & HEALTH CENTER

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 15-0162 | Peri od: | Worksheet D | From 01/01/2020 | Part IV | To | 12/31/2020 | Date/Time Prepared: THROUGH COSTS

					0 12/31/2020	3/30/2021 10:	
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
		Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
		Educati on	1, 2, 3, and	Cost (sum of	C, Part I,	(col. 5 ÷	
		Cost	4)	col s. 2, 3,	col. 8)	col. 7)	
				and 4)		(see	
						instructions)	
		4. 00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	0	0	0		l .	l
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	C	, = ,		52.00
54.00		0	0	0	295, 826, 730		54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0	0	81, 279, 420		55.00
56.00	05600 RADI OI SOTOPE	0	0	0	7, 243, 622		56.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	147, 100, 158		
60.00		0	141, 024	141, 024			
64.00		0	0	0			
65.00		0	0	0	60, 186, 493		
66.00		0	0	0	38, 371, 939	l e	ł
67.00		0	0	0	21, 266, 221	l e	
	06800 SPEECH PATHOLOGY	0	0	0	10, 511, 216		
	06900 ELECTROCARDI OLOGY	0	0	0	36, 866, 750		
	07000 ELECTROENCEPHALOGRAPHY	0	0	0	19, 812, 117		1
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	202, 976, 423	l	1
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	168, 318, 773	l	1
	07300 DRUGS CHARGED TO PATIENTS	0	1, 944, 085	1, 944, 085		•	1
74.00		0	0	0			
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	0	1, 547, 213	0.000000	76. 97
	OUTPATIENT SERVICE COST CENTERS			1			
	09000 CLI NI C	0	0	0		0.000000	1
90. 01	09001 IBMT JOINT VENTURE	0	0	0	-, ,	l	1
	09005 CV DI AGNOSTI C SERVI CES	0	0	0	68, 142, 020	l	
	09100 EMERGENCY	0	235, 262				
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	C			
200.00	Total (lines 50 through 199)	0	2, 320, 371	2, 320, 371	2, 688, 892, 374		200. 00

Health Financial Systems	ST. FRANCIS HOSPITAL &	HEALTH CENTER	1	n Lieu of Form CMS-2552-10
ADDODTI ONMENT OF LNDATI ENT/OUTDATLEN	IT ANCILLARY CERVICE OTHER DACC	Dravidor CCN, 1E 01/2	Donied.	Waskahaat D

Peri od: From 01/01/2020 To 12/31/2020 APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Worksheet D Part IV THROUGH COSTS Date/Time Prepared: 3/30/2021 10:40 am Title XIX Hospi tal PPS Outpati ent Cost Center Description Outpati ent I npati ent Inpati ent Outpati ent Ratio of Cost Program Program Program Program to Charges Charges Pass-Through Charges Charges (col. 6 ÷ col. 7) Costs (col. 8 before Geo on/after Geo x col. 10) Recl assi fi cat Recl assi fi cat i on i on 9. 00 11.00 10. 00 12.00 12.01 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0.000000 13, 276, 856 0 50.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 11, 282, 631 0 0 0 52.00 52.00 0 05400 RADI OLOGY-DI AGNOSTI C 0 0.000000 54.00 54.00 9, 516, 862 0 05500 RADI OLOGY-THERAPEUTI C 0 55.00 0.000000 0 55.00 56.00 05600 RADI OI SOTOPE 0.000000 155, 873 0 0 0 0 0 0 0 0 0 0 0 56.00 59.00 05900 CARDI AC CATHETERI ZATI ON 0.000000 3, 054, 824 0 0 59.00 06000 LABORATORY 15, 028, 810 60.00 0.000458 0 60.00 6,883 06400 I NTRAVENOUS THERAPY 64.00 0.000000 548, 884 0 0 64.00 65.00 06500 RESPIRATORY THERAPY 0.000000 5, 740, 252 0 0 65.00 06600 PHYSI CAL THERAPY 0.000000 198, 046 0 0 66.00 66.00 06700 OCCUPATI ONAL THERAPY 0.000000 1,014,258 0 67.00 67.00 0 68.00 06800 SPEECH PATHOLOGY 0.000000 285, 542 0 68.00 06900 ELECTROCARDI OLOGY 0.000000 0 0 69.00 69.00 2, 636, 525 07000 ELECTROENCEPHALOGRAPHY 0.000000 0 70.00 70 00 917, 860 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.000000 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 0 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 0.003830 19, 652, 123 75, 268 0 73.00 07400 RENAL DIALYSIS 0 74 00 0.000000 O Ω 74 00 07697 CARDIAC REHABILITATION 76.97 0.000000 8,700 0 0 0 76.97 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0.000000 138, 853 0 0 0 90.00 09001 I BMT JOINT VENTURE 0 90 01 0.000000 0 90.01 1, 634 0 90.05 09005 CV DIAGNOSTIC SERVICES 0.000000 13, 726 0 0 90.05 91.00 09100 EMERGENCY 0.000807 8, 294, 479 0 0 91.00 6,694 0 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 0.000000 0 0 91, 766, 738 88, 845 Total (lines 50 through 199) 0 200.00 200.00

Health Financial Systems

ST. FRANCIS HOSPITAL & HEALTH CENTER

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

ST. FRANCIS HOSPITAL & HEALTH CENTER

Provider CCN: 15-0162
From 01/01/2020
To 12/31/2020
Date/Time Prepared:

				10 12/31/2020	3/30/2021 10:	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Outpati ent	Outpati ent		<u> </u>		
	Program	Program				
	Pass-Through	Pass-Through				
	Costs (col. 9					
	x col. 12)	x col. 12)				
	before Geo	on/after Geo				
	Reclassi fi cat					
	i on	i on	-			
ANOLLI ADV. CEDVI CE COCT CENTEDO	13. 00	13. 01				
ANCILLARY SERVICE COST CENTERS 50.00 OPERATING ROOM	0	0	ı			50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	-				50.00
54. 00 05200 DELI VERT ROOM & LABOR ROOM 54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0					55.00
56. 00 05600 RADI OI SOTOPE		0				56.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	1			59.00
60. 00 06000 LABORATORY	0	0				60.00
64. 00 06400 I NTRAVENOUS THERAPY	0	0				64.00
65. 00 06500 RESPIRATORY 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	Ö	,			68.00
69. 00 06900 ELECTROCARDI OLOGY	0	o				69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0				70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0)			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0)			73.00
74.00 07400 RENAL DIALYSIS	0	0				74.00
76. 97 07697 CARDI AC REHABILI TATION	0	0				76. 97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0				90.00
90.01 09001 IBMT JOINT VENTURE	0	0	1			90. 01
90. 05 09005 CV DI AGNOSTI C SERVI CES	0	0	1			90. 05
91. 00 09100 EMERGENCY	0	0				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	1			92.00
200.00 Total (lines 50 through 199)	0	0	1			200.00

Health Financial Systems ST. F	FRANCIS HOSPITA	I & UEALTH CEN	TED	Inlio	u of Form CMS-2	2552 10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA		Provi der C		Peri od:	Worksheet D	2332-10
ALLOCATION OF THE ATTENT ANOTHER SERVICE CALLED	(L 00313			From 01/01/2020	Part II	
		'		To 12/31/2020	Date/Time Pre 3/30/2021 10:	pared: 40 am_
		Ti tl	e XIX	Subprovi der -	PPS	
				I RF		
Cost Center Description	Capi tal	Total Charges			Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col. 2)			
	col. 26)	0.00	0.00	4 00	5.00	
ANOULL ARV. OFFILE OF COOT, OFFITFING	1. 00	2.00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	/ 400 005	0/4 044 0/0	0.00004	000 740	F 400	
50. 00 05000 OPERATING ROOM	6, 183, 085					50.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM	1, 658, 701		0. 03747		"	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	3, 986, 123		0. 01347			54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	281, 467		0.00346		0	55.00
56. 00 05600 RADI 0I SOTOPE	75, 179		0. 01037		1	56.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	1, 539, 955		0. 01046		1 "	59.00
60. 00 06000 LABORATORY	1, 634, 404		0. 00530			60.00
64. 00 06400 I NTRAVENOUS THERAPY	602, 096					64.00
65. 00 06500 RESPI RATORY THERAPY	565, 204		0. 00939			65.00
66. 00 06600 PHYSI CAL THERAPY	716, 119			· · · · ·		66.00
67. 00 06700 OCCUPATI ONAL THERAPY	12, 746		0. 00059			67.00
68. 00 06800 SPEECH PATHOLOGY	127, 134		0. 01209			68. 00
69. 00 06900 ELECTROCARDI OLOGY	869, 997		0. 02359			69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	10, 097		0. 00051			
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 047, 795		0. 00516			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	804, 218					72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	805, 647		0. 00158		761	73.00
74. 00 07400 RENAL DI ALYSI S	252, 309				0	74.00
76. 97 O7697 CARDI AC REHABI LI TATI ON	2, 326	1, 547, 213	0. 00150	3 0	0	76. 97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	1, 199, 286	13, 478, 991	0. 08897	4 21, 783	1, 938	90.00
90. 01 09001 IBMT JOINT VENTURE	159, 980	8, 948, 827	0. 01787		0	90. 01
90. 05 09005 CV DI AGNOSTI C SERVI CES	59, 855	68, 142, 020	0. 00087	8 0	0	90.05
91. 00 09100 EMERGENCY	3, 117, 540				0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	00,017,17	0.00000	0	0	92.00
200.00 Total (lines 50 through 199)	25, 711, 263	2, 688, 892, 374		2, 950, 352	37, 052	200.00

Health Financial Systems ST. APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	FRANCIS HOSPITA RVICE OTHER PAS			Peri oc	d:	w of Form CMS-1 Worksheet D	2332-10
THROUGH COSTS		Component	CCN: 15-T162		01/01/2020 12/31/2020		
		Ti tl	e XIX	Subpr	rovider - IRF	PPS	
Cost Center Description	Non Physician		Nursi ng			Allied Health	
	Anesthetist	School	School		-Stepdown		
	Cost	Post-Stepdown		Adj	ustments		
		Adjustments					
ANOLLI ADV CEDVICE COCT CENTERS	1. 00	2A	2.00		3A	3. 00	
ANCILLARY SERVICE COST CENTERS			ı				
50. 00 05000 OPERATING ROOM 52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	1	•	0	0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0		0	0	0	
55. 00 05500 RADI OLOGY - DI AGNOSTI C		0		0	0	0	
56. 00 05600 RADI 0I SOTOPE		0		0	0	0	
59. 00 05900 CARDI AC CATHETERI ZATI ON		0		0	0	0	59.00
60. 00 06000 LABORATORY				0	0	141, 024	
64. 00 06400 I NTRAVENOUS THERAPY				0	0	141,024	1
65. 00 06500 RESPIRATORY THERAPY		0		0	0	0	1
66. 00 06600 PHYSI CAL THERAPY				0	0	0	
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	l o	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0	0	0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0	0	0	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0	0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	1, 944, 085	73.00
74. 00 07400 RENAL DI ALYSI S	0	0		0	0	0	74.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0	0	0	76. 97
OUTPATIENT SERVICE COST CENTERS							1
90. 00 09000 CLI NI C	0	0		0	0	0	90.00
90. 01 09001 I BMT JOINT VENTURE	0	0		0	0	0	
90. 05 09005 CV DI AGNOSTI C SERVI CES	0	0		0	0	0	90.05
91. 00 09100 EMERGENCY	0	0		0	0	235, 262	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0		0	
200.00 Total (lines 50 through 199)	0	0		0	0	2, 320, 371	200.00

Health Financial Systems ST. F APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SET THROUGH COSTS			CN: 15-0162 P	In Lie eriod: rom 01/01/2020 o 12/31/2020		
					3/30/2021 10:	40 am
		Ti tl	e XIX	Subprovi der -	PPS	
				I RF		
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
	Educati on	1, 2, 3, and	Cost (sum of	C, Part I,	(col. 5 ÷	
	Cost	4)	col s. 2, 3,	col. 8)	col . 7)	
			and 4)		(see	
				7.00	instructions)	
ANOLLI ADV. CEDVI OF COCT. OFNITEDO	4. 00	5. 00	6. 00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM				2/4 014 0/0	0.000000	F0 00
	0	0	0	264, 914, 869		
52. 00 05200 DELIVERY ROOM & LABOR ROOM 54. 00 05400 RADIOLOGY-DIAGNOSTIC		0	0	44, 259, 677 295, 826, 730		
55. 00 05500 RADI OLOGY-THERAPEUTI C		0	0	81, 279, 420		
56. 00 05600 RADI 01 SOTOPE			0	7, 243, 622	0.000000	
59. 00 05900 CARDI AC CATHETERI ZATI ON			0	147, 100, 158		
60. 00 06000 LABORATORY		141, 024	141, 024		0. 000458	
64. 00 06400 NTRAVENOUS THERAPY		141,024	141,024			
65. 00 06500 RESPIRATORY THERAPY			0	60, 186, 493		
66. 00 06600 PHYSI CAL THERAPY			0	38, 371, 939		
67. 00 06700 OCCUPATI ONAL THERAPY			0		0. 000000	
68. 00 06800 SPEECH PATHOLOGY			0	10, 511, 216		
69. 00 06900 ELECT TATHOLOGY			0	36, 866, 750		
70. 00 07000 ELECTROENCEPHALOGRAPHY			0			
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0	0			
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS		0	0	168, 318, 773		
73. 00 07300 DRUGS CHARGED TO PATIENTS		1, 944, 085	1, 944, 085			
74. 00 07400 RENAL DI ALYSI S		0	0			
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0	0	1, 547, 213		
OUTPATIENT SERVICE COST CENTERS	-	-		.,	0.00000	
90. 00 09000 CLINIC	0	0	0	13, 478, 991	0.000000	90.00
90. 01 09001 I BMT JOI NT VENTURE	0	0	0	8, 948, 827	0.000000	90. 01
90. 05 09005 CV DI AGNOSTI C SERVI CES	0	0	0	68, 142, 020		
91. 00 09100 EMERGENCY	0	235, 262	235, 262			
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	50, 847, 747		
200.00 Total (lines 50 through 199)	0	2, 320, 371	2, 320, 371	2, 688, 892, 374		200.00
	'					

		FRANCIS HOSPITAL	_			u of Form CMS-2	2552-10
	TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	RVICE OTHER PASS	Provi der C		Peri od:	Worksheet D	
THROUG	GH COSTS		·	CCN: 15-T162	From 01/01/2020 To 12/31/2020	Date/Time Pre 3/30/2021 10:	pared: 40 am
			Ti tl	e XIX	Subprovi der -	PPS	
					I RF		
	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	
		(col. 6 ÷		Costs (col. 8		on/after Geo	
		col. 7)		x col. 10)	Recl assi fi cat		
					i on	i on	
		9. 00	10. 00	11. 00	12. 00	12. 01	
	ANCILLARY SERVICE COST CENTERS	0.00000	000 740	T .			
50. 00	05000 OPERATING ROOM	0. 000000	232, 719		0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	148, 540		0	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	18, 649		0	0	56.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	0		0	0	59.00
60.00	06000 LABORATORY	0. 000458	330, 348		1 0	0	60.00
64.00	06400 I NTRAVENOUS THERAPY	0. 000000	23, 260		0	0	64.00
65.00	06500 RESPI RATORY THERAPY	0. 000000	86, 035		0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0. 000000	1, 132, 955		0	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000	14, 140		0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0. 000000	14, 483		0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0. 000000	23, 432		0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	50, 463		0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	80, 352		0	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000	293, 393		0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 003830	479, 800	1, 83	8 0	0	73.00
74.00	07400 RENAL DIALYSIS	0. 000000	0		0	0	74.00
76. 97	07697 CARDIAC REHABILITATION	0. 000000	0		0	0	76. 97
	OUTPATIENT SERVICE COST CENTERS						1
90.00	09000 CLI NI C	0. 000000	21, 783		0 0	0	90.00
90. 01	09001 I BMT JOINT VENTURE	0. 000000	0		0	0	90. 01
90.05	09005 CV DI AGNOSTI C SERVI CES	0. 000000	0		0	0	90. 05
91.00	09100 EMERGENCY	0. 000807	0		0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0		0	0	92.00
200.00	Total (lines 50 through 199)		2, 950, 352	1, 98	9 0	0	200. 00
		•			•		-

APPOR	Financial Systems ST. FITONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEE		Component	CN: 15-0162 CCN: 15-T162	Peri od: From 01/01/2020 To 12/31/2020	u of Form CMS- Worksheet D Part IV Date/Time Pro 3/30/2021 10	epared:
			Ti tl	e XIX	Subprovi der - I RF	PPS	
	Cost Center Description	Outpatient Program Pass-Through Costs (col. 9 x col. 12) before Geo Reclassificat ion	x col. 12) on/after Geo		IM		
		13. 00	13. 01	-			
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0					50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	1	1			52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0				55.00
56.00	05600 RADI OI SOTOPE	0	0				56.00
59. 00 60. 00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0					59. 00 60. 00
64.00	06400 I NTRAVENOUS THERAPY	0					64.00
65.00	06500 RESPIRATORY THERAPY			1			65.00
66.00	06600 PHYSI CAL THERAPY						66.00
67.00	06700 OCCUPATI ONAL THERAPY	0		1			67.00
68.00	06800 SPEECH PATHOLOGY	0		1			68.00
69.00	06900 ELECTROCARDI OLOGY	0					69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0		,			70.00
71.00		0	0				71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	O				72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	1			73.00
74.00	07400 RENAL DIALYSIS	0	0)			74.00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0				76. 97
	OUTPATIENT SERVICE COST CENTERS		T	I			
90.00	09000 CLINIC	0		1			90.00
90. 01	09001 I BMT JOINT VENTURE	0					90. 01
	09005 CV DI AGNOSTI C SERVI CES	0	1	1			90.05
91.00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	1	1			91. 00 92. 00
92.00	Total (lines 50 through 199)	0	0				200.00

Health Financial Systems	ST. FRANCIS HOSPITAL 8	u of Form CMS-2	2552-10		
COMPUTATION OF INPATIENT OPERATING COST		Provi der CCN: 15-0162	Peri od: From 01/01/2020	Worksheet D-1	
			To 12/31/2020	Date/Time Pre 3/30/2021 10:	
		Title XVIII	Hospi tal	PPS	
Cook Cooker December					

		Title XVIII	Hospi tal	3/30/2021 10: - PPS	40 am_
	Cost Center Description	THE AVIII	1103pi tai	113	
	DADT I NIL DDOWN DED COMPONENTO			1. 00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				
1. 00 2. 00 3. 00	Inpatient days (including private room days and swing-bed day Inpatient days (including private room days, excluding swing-Private room days (excluding swing-bed and observation bed day do not complete this line.	bed and newborn days)	rivate room days,	61, 574 61, 574 0	1. 00 2. 00 3. 00
4. 00 5. 00	Semi-private room days (excluding swing-bed and observation b Total swing-bed SNF type inpatient days (including private ro reporting period		er 31 of the cost	52, 024 0	4. 00 5. 00
6. 00	Total swing-bed SNF type inpatient days (including private ro reporting period (if calendar year, enter 0 on this line)	31 of the cost	0	6. 00	
7. 00	Total swing-bed NF type inpatient days (including private roo reporting period	m days) through December	31 of the cost	0	7. 00
8. 00	Total swing-bed NF type inpatient days (including private roo reporting period (if calendar year, enter 0 on this line)	m days) after December 3	31 of the cost	0	8. 00
9. 00	Total inpatient days including private room days applicable t newborn days) (see instructions)	o the Program (excluding	g swing-bed and	22, 236	9. 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII o through December 31 of the cost reporting period (see instruc	tions)	,	0	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII o December 31 of the cost reporting period (if calendar year, e	nter 0 on this line)		0	11.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI through December 31 of the cost reporting period	3 .	,	0	
	Swing-bed NF type inpatient days applicable to titles V or XI after December 31 of the cost reporting period (if calendar y	ear, enter O on this lir	ne)	0	13. 00
14. 00 15. 00	Medically necessary private room days applicable to the Progr Total nursery days (title V or XIX only)	am (excluding swing-bed	days)	0	15.00
16. 00	Nursery days (title V or XLX only) SWING BED ADJUSTMENT			0	
17. 00	Medicare rate for swing-bed SNF services applicable to servic reporting period $$	9		0. 00	
18. 00	Medicare rate for swing-bed SNF services applicable to servic reporting period				18. 00
19. 00	Medicaid rate for swing-bed NF services applicable to service reporting period	0. 00			
20. 00	Medicaid rate for swing-bed NF services applicable to service reporting period		the cost	0. 00	
21. 00 22. 00	Total general inpatient routine service cost (see instruction $Swing-bed$ cost applicable to SNF type services through $Decemb$ 5 x line 17)		ting period (line	87, 996, 376 9 0	21. 00
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reporting	ng period (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through Decembe 7 x line 19) $$	r 31 of the cost reporti	ng period (line	0	24.00
25. 00	Swing-bed cost applicable to NF type services after December \mathbf{x} line 20)	31 of the cost reportino	g period (line 8	0	25. 00
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)		0 87, 996, 376	26. 00 27. 00
	General inpatient routine service charges (excluding swing-be Private room charges (excluding swing-bed charges)	d and observation bed ch	narges)	0	
30.00	Semi-private room charges (excluding swing-bed charges)			0	30.00
31. 00	General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0. 000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)	•		0. 00	1
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00	33.00
34.00	Average per diem private room charge differential (line 32 mi	nus line 33)(see instru	ctions)	0. 00	34.00
35.00	Average per diem private room cost differential (line 34 x li		•	0.00	1
36. 00	Private room cost differential adjustment (line 3 x line 35)	,		0	36.00
37. 00	General inpatient routine service cost net of swing-bed cost 27 minus line 36)	and private room cost di	fferential (line		37. 00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	JSTMENTS			
38.00	Adjusted general inpatient routine service cost per diem (see	instructions)		1, 429. 12	38. 00
39.00	Program general inpatient routine service cost (line 9 x line	38)		31, 777, 912	39. 00
	Medically necessary private room cost applicable to the Progr			0	40.00
41.00	Total Program general inpatient routine service cost (line 39	+ line 40)		31, 777, 912	41.00

		RANCIS HOSPITAL				u of Form CMS-2			
COMPUT	COMPUTATION OF INPATIENT OPERATING COST		Provider C		Period: From 01/01/2020 To 12/31/2020		pared:		
				XVIII	Hospi tal	PPS			
	Cost Center Description	Total Inpatient	Total Inpatient	Average Per Diem (col. 1	Program Days	Program Cost (col. 3 x			
		1. 00	Days 2. 00	÷ col . 2) 3.00	4. 00	col . 4) 5.00			
42. 00	NURSERY (title V & XIX only)	0	2.00				42.00		
	Intensive Care Type Inpatient Hospital Units			T	.T				
43.00	INTENSIVE CARE UNIT	17, 656, 935	20, 500			3, 073, 154	1		
43. 01 44. 00	NEONATAL INTENSIVE CARE UNIT CORONARY CARE UNIT	9, 704, 382 23, 584, 816	6, 322 12, 691			· ·	43. 01 44. 00		
45. 00	BURN INTENSIVE CARE UNIT	25, 504, 610	12,071	1,030.3	3,333	7, 747, 702	45. 00		
46.00	SURGICAL INTENSIVE CARE UNIT	12, 716, 282	8, 247	1, 541. 9	3, 146	4, 850, 912	46.00		
47. 00	OTHER SPECIAL CARE (SPECIFY)						47.00		
	Cost Center Description					1.00			
48. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3	B, line 200)			51, 791, 355	48. 00		
	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS			ons)		101, 441, 295	1		
50.00	Pass through costs applicable to Program inp	atient routine	services (fro	m Wkst. D, sun	of Parts I and	6, 628, 112	50.00		
51. 00	<pre>III) Pass through costs applicable to Program inp and IV)</pre>	3, 476, 621	51.00						
52. 00 53. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		elated non-ph	vsician anesth	netist and	10, 104, 733 91, 336, 562			
55. 50	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION			, 5. 5. an anosti	unu	, 1, 555, 552	55.00		
54.00	Program di scharges					0	54.00		
55.00	Target amount per discharge					0.00			
56.00	Target amount (line 54 x line 55)					0	56.00		
	Difference between adjusted inpatient operat	ing cost and ta	irget amount (line 56 minus	line 53)	0	57.00		
58. 00 59. 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost re	0.00	58. 00 59. 00						
60. 00	market basket Lesser of lines 53/54 or 55 from prior year	cost report. un	odated by the	market basket		0.00	60.00		
61. 00	If line 53/54 is less than the lower of line which operating costs (line 53) are less tha	0	61.00						
	amount (line 56), otherwise enter zero (see		,,,,,,						
62. 00 63. 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	0							
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	0	64.00						
	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	0	65. 00						
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	0	66.00						
	CAH (see instructions) Title V or XIX swing-bed NF inpatient routin	0							
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	0							
	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	0							
	PART III - SKILLED NURSING FACILITY, OTHER N								
70. 00 71. 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service c						70.00		
72. 00	Program routine service cost (line 9 x line		2 . 2	,			72.00		
73.00									
74.00	Total Program general inpatient routine serv			•	loot III		74.00		
75. 00	Capital-related cost allocated to inpatient 26, line 45)		COSIS (Trom	worksneet B, F	art II, COIUMN		75.00		
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ li		76.00						
77. 00 78. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu		77. 00 78. 00						
79. 00	Aggregate charges to beneficiaries for exces		79.00						
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)								
81.00									
82. 00 83. 00									
84. 00									
85.00	Utilization review - physician compensation	(see instruction					85.00		
86. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PAS:		rough 85)				86.00		
87. 00	Total observation bed days (see instructions					9, 550	87. 00		
	Adjusted general inpatient routine cost per	,				1, 429. 12	1		
89. UU	Observation bed cost (line 87 x line 88) (se	e instructions)				13, 648, 096	89.00		

Health Financial Systems ST.	FRANCIS HOSPITAL & HEALTH CENTER			In Lieu of Form CMS-2552-10				
COMPUTATION OF INPATIENT OPERATING COST		Provi der Co	Provider CCN: 15-0162		Worksheet D-1			
					Date/Time Prepared: 3/30/2021 10:40 am			
		Title	Title XVIII		PPS			
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation			
		(from line	column 2	Observati on	Bed Pass			
		21)		Bed Cost	Through Cost			
				(from line	(col. 3 x			
				89)	col. 4) (see			
					instructions)			
	1. 00	2.00	3.00	4. 00	5. 00			
COMPUTATION OF OBSERVATION BED PASS THROUGH COST								
90.00 Capi tal -related cost	12, 308, 780	87, 996, 376	0. 13987	8 13, 648, 096	1, 909, 068	90.00		
91.00 Nursing School cost	0	87, 996, 376	0.00000	0 13, 648, 096	0	91.00		
92.00 Allied health cost	0	87, 996, 376	0. 00000	0 13, 648, 096	0	92.00		
93.00 All other Medical Education	0	87, 996, 376	0. 00000	0 13, 648, 096	0	93. 00		

Health Financial Systems	ST. FRANCIS HOSPITAL 8	& HEALTH CENTER	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CCN: 15-0162	Peri od: From 01/01/2020	Worksheet D-1
		Component CCN: 15-T162	To 12/31/2020	Date/Time Prepared: 3/30/2021 10:40 am
		Title XVIII	Subprovi der -	PPS
			IRE	

		I RF		
	Cost Center Description		4 00	
	PART I - ALL PROVIDER COMPONENTS		1. 00	
	INPATIENT DAYS			
1. 00	Inpatient days (including private room days and swing-bed days, excluding newborn)		5, 552	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		5, 552	2. 00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only p	rivate room days,	0	3.00
	do not complete this line.			
4.00	Semi-private room days (excluding swing-bed and observation bed days)	04 6 11	5, 552	4.00
5. 00	Total swing-bed SNF type inpatient days (including private room days) through Decemb	er 31 of the cost	0	5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private room days) after December	31 of the cost	0	6. 00
0.00	reporting period (if calendar year, enter 0 on this line)	31 of the cost	O	0.00
7.00	Total swing-bed NF type inpatient days (including private room days) through Decembe	r 31 of the cost	0	7. 00
	reporting period			
8.00	Total swing-bed NF type inpatient days (including private room days) after December	31 of the cost	0	8. 00
	reporting period (if calendar year, enter 0 on this line)		0.500	
9. 00	Total inpatient days including private room days applicable to the Program (excluding private room days applicable to the Program (excluding private room days)	ig swing-bed and	2, 539	9. 00
10. 00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII only (including private	room days)	0	10.00
10.00	through December 31 of the cost reporting period (see instructions)	Toom days)	O	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private	room days) after	0	11.00
	December 31 of the cost reporting period (if calendar year, enter 0 on this line)			
12.00		ite room days)	0	12.00
40.00	through December 31 of the cost reporting period	1		10.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including prival after December 31 of the cost reporting period (if calendar year, enter 0 on this li		0	13. 00
14. 00			0	14. 00
15. 00		days)	0	15.00
	Nursery days (title V or XIX only)		0	16.00
	SWI NG BED ADJUSTMENT			
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31	of the cost	0. 00	17.00
	reporting period			
18. 00	3 11	the cost	0. 00	18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services through December 31 o	of the cost	0.00	19. 00
17.00	reporting period	in the cost	0.00	17.00
20.00		the cost	0. 00	20. 00
	reporting period			
21. 00			8, 237, 029	
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost repor	ting period (line	. 0	22. 00
23. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December 31 of the cost reporti	ng poriod (line 4	0	23. 00
23.00	x line 18)	ng perroa (Trie d	0	23.00
24. 00		ing period (line	0	24. 00
	7 x line 19)	3 1		
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reportin	g period (line 8	0	25. 00
	x line 20)		_	
26.00			0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		8, 237, 029	27. 00
28 00	General inpatient routine service charges (excluding swing-bed and observation bed o	harges)	0	28. 00
	Private room charges (excluding swing-bed charges)	a. goo)	0	
30.00	Semi -pri vate room charges (excluding swing-bed charges)		0	
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00			0. 00	
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instru	icti ons)	0.00	
35. 00 36. 00	Average per diem private room cost differential (line 34 x line 31) Private room cost differential adjustment (line 3 x line 35)		0.00	35. 00 36. 00
37.00		lifferential (line		
57.00	27 minus line 36)		5,251,027	07.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY			
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS			
38. 00			1, 483. 61	
39.00	Program general inpatient routine service cost (line 9 x line 38)		3, 766, 886	39.00
	Medically necessary private room cost applicable to the Program (line 14 x line 35)		2 766 996	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	l	3, 766, 886	1 41.00

Component COM: 15.1160 From 01/01/2000 Color 12/01/2000 Color		Financial Systems ST. F	RANCIS HOSPITA		ITER CN: 15-0162	In Lie	eu of Form CMS-2 Worksheet D-1	
Title XVIII Subgrivation PRS	COMITOT	ATTOM OF THE ATTEM OF ENVETTING GOST				From 01/01/2020	Date/Time Pre	pared:
Cost Center Description				Title	e XVIII			40 am
1.00		Cost Center Description	I npati ent	I npati ent	Diem (col.	Program Days	(col. 3 x	
Interest via Care type Inpatrient loop tal Units			1. 00	2. 00	3. 00		5. 00	
	42. 00		0	C	0.	00 0	0	42.00
44.00 CORONARY CARE UNIT 0 0 0.00 0 0.44 to 0 0.00 0 0.45 to 0 0.00 0 0.00 0 0.45 to 0 0.00 0 0.00 0 0.00 0 0.45 to 0 0.00 0 0.00 0 0.00 0 0.45 to 0 0.00 0 0.00 0 0.00 0 0.00 0	43.00		0	C	0.	00 0	0	43.00
45.00 BURN INTERSIVE CARE UNIT 0 0.00 0 0.40 0.00 0 0.40 0.00 0 0.40 0.00 0 0.40 0.00 0 0.40 0.00 0 0.40 0.00 0 0.40 0.00 0 0.40 0.00 0 0.40 0.00 0 0.40 0.00 0 0.40 0.00 0.40 0.00 0.00 0 0.40 0.00 0.40 0.00 0.00 0.00 0.00 0 0.40 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00					1			
100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100 100		•	O O	C	0.	00	0	
Cost Center Description	46.00	SURGICAL INTENSIVE CARE UNIT	О	C	0.	00 0	0	46.00
1	47. 00							47.00
40.00 Poss through costs applicable to Program Inpatient routine services (from West. D, sum of Parts I and 513.690 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.00 50.0		Cost Center Description					1.00	
PASS THROUGH COST ADJUSTMENTS					>			1
5.00 Pass through costs applicable to Program inpatient routine services (From West. 0, sum of Parts I and 1513,690 50.00 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 115 11	49.00		41 through 48)(see instructi	ons)		5, 090, 026	49.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D. sum of Parts II 62,046 51.00 and IV) 57.00 Total Program excludable cost (sum of lines 50 and 51) 575.736 52.00 57.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and 4.514,290 53.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00	50.00		atient routine	services (fro	m Wkst. D, sı	um of Parts I and	513, 690	50.00
	F1 00		ationt ancillar	sy sorvicos (f	rom Wkst D	sum of Darts II	62 046	F1 00
53.00 Total Program Inpatient operating costs excluding capital related, non-physician anesthetist, and 4,514,290 for medical education costs (line 49 minus line 52) 14RGET AMOUNT AND LINIT COMPUTATION 54.00 Program discharges 50.00 Target amount (line 54 x line 55) 50.00 Target amount (line 56) 61.00 Target amount (line 56) 61.00 Target amount (line 56) 61.00 Target amount (line 56) 62.00 Relief payment (see Instructions) 62.00 Relief payment (see Instructions) 63.00 Allowable Inpatient cost plus incentive payment (see Instructions) 64.00 Relief payment (see Instructions) 65.00 Target amount (line 56) 67.00 Target amount (line 56) 67.00 Target amount (line 56) 68.00 Target amount (line 56) 69.00 Target amount (l	51.00		ationi anciliai	y Services (I	I UIII WKST. D,	Juli Of FallS II	02, 046	31.00
medical education costs (line 49 minus line 52)								
TARCET MOUNT AND LIMIT COMPUTATION 54.00 Forgram discharge 0.54.00 Forgram discharge 0.55.00 Target amount per discharge 0.00 55.00 55.00 Target amount per discharge 0.00 55.00 55.00 Target amount (I line 54 x line 55) 0.56.00 55.00 0.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56	53.00			erated, non-ph	ysician anest	inetist, and	4, 514, 290	53.00
Section Sect		TARGET AMOUNT AND LIMIT COMPUTATION					,	
56.00 Target amount (line 54 x line 55) 57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 58.00 Bonus payment (see Instructions) 59.00 Lesser of Ilnes 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket 60.00 Lesser of Ilnes 53/54 or 55 from the cost report, updated by the market basket 61.00 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 amount (line 56), otherwise enter zero (see instructions) 62.00 Relief payment (see instructions) 63.00 Allowable Inpatient cost plus incentive payment (see instructions) 64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (tile XVIII only). 65.00 Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (tilt XVIII only). 66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (tilt XVIII only). 67.00 Total Medicare swing-bed NF inpatient routine costs through December 31 of the cost reporting period (See instructions) (tilt XVIII only). 68.00 Tilt V or XIX swing-bed NF inpatient routine costs (line 64 plus line 65) (tilt XVIII only). 69.00 Total Hill V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total till V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 12 X line 19) 69.00 Total till V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total till V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total till V or XIX swing-bed NF inpatient routine costs (line 77 + line 68) 69.00 Total Program engine and the value of till V or XIX swing-bed NF inpatient routine service costs (line 78 minus line 79) 60.00 Total Program engine and the value of till V or XIX swing-bed NF inpatient routine service co								
58.00 Bonus payment (see instructions) 60.00 Lesser of Ilines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket 60.00 Lesser of Ilines 53/54 is 185 from the cost report, updated by the market basket 60.01 Lines 53/54 is 185 from prior year cost report, updated by the market basket 60.01 Lines 53/54 is 185 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 amount (line 56), otherwise enter zero (see instructions) 60.00 Relicefle payment (see instructions) 60.01 Allowable Inpatient cost plus incentive payment (see instructions) 60.02 Medicare saing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (tile XVIII only) 60.00 Medicare saing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAM (see instructions) 60.01 Title V or XIX saing-bed NF inpatient routine costs through December 31 of the cost reporting period (See instructions) 60.02 Title V or XIX saing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 12 x line 19) 60.03 Title V or XIX saing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 60.04 Title V or XIX saing-bed NF inpatient routine costs (line 67 + line 68) 60.05 DARAT III - SKILLED NURSING FACILITY. ONLOW NOTE AND SKILLED NURSING FACILITY. And DICK/IID ONLY 60.00 PART III - SKILLED NURSING FACILITY. OTHER NURSING FACILITY. OTHER SAIN SAIN SAIN SAIN SAIN SAIN SAIN SAIN							1	1
19.00 Lesser of I lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the narket basket 0.00 60.00		1	ing cost and ta	arget amount (line 56 minus	s line 53)		
market basket 0.00 Lesser of lines 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 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 amount (line 56), otherwise enter zero (see instructions) 62.00 Relief payment (see instructions) 63.00 Allowable Inpatient cost plus incentive payment (see instructions) 64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See 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) 66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions) 67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 69.00 Total title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 69.01 Total title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 69.02 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.02 PART III - SKILLED NURSING FACILLITY, Office Nursing Facillity/Icf7IID routine service cost (line 37) 70.00 Program routine service cost (line 9 x line 76) 71.00 Program routine service cost (line 9 x line 77) 72.00 Program capital related costs (line 9 x line 77) 73.00 Inpatient routine service cost for comparison to the cost limitation (line 78 minus line 79) 80.00 Inpa			norting period	ending 1996	undated and o	compounded by the		
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 amount (line 56), otherwise enter zero (see instructions) 62.00 Relief payment (see instructions) 63.00 Allowable Inpatient cost plus incentive payment (see instructions) 64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See 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) 66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions) 67.00 Title Vor XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (Inc. 12 x line 19) 68.00 Title Vor XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (Inc. 12 x line 19) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 70.00 Skilled oursing facility/other pursing facility/(FVIP) routine service cost (line 37) 70.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 70.00 Captal reliated cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 70.00 Program contine service cost (line 9 x line 70) 70.00 Reasonable inpatient routine service costs (from provider records) 70.00 Reasonable inpatient routine service costs (from provider records) 70.00 Reasonable inpatient routine service costs (from provider records) 70.00 Reasonable inpatient routine service costs (see instructions) 70.01 Inpatient routine service cost (line 7 x line 2) 71.02 Program inpatient service cost per diem li	37.00	l .	por tring period	charing 1770,	apaatea ana (compounded by the	0.00	37.00
62.00 Relief payment (see instructions) 0.62.00 3.00 Allowable Inpatient cost plus incentive payment (see instructions) 0.63.00 Allowable Inpatient cost plus incentive payment (see instructions) 0.63.00 Allowable Inpatient routine costs through December 31 of the cost reporting period (See Instructions) (title XVIII only) 0.65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See Instructions) (title XVIII only) 0.65.00 Medicare swing-bed SNF inpatient routine costs (Ilne 64 plus Ilne 65) (title XVIII only). For CAH (see instructions) 0.66.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00 0.67.00	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					1	1	
Allowable Inpatient cost plus incentive payment (see instructions) PROGRAM INPATIENT ROUTINE SWING BED COST 64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See 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) 66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions) 67.00 Title V or XIX swing-bed NF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions) 68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 12 x line 19) 68.00 Title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICET/IID ONLY 70.00 Total title V or XIX swing-bed NF inpatient routine service cost (line 70 + line 2) Program routine service cost (line 9 x line 71) 71.00 Program routine service cost (line 9 x line 71) 72.00 Total Program general inpatient routine service costs (from Worksheet B, Part II, column 26, line 47) 73.00 Total Program general inpatient routine service costs (from Worksheet B, Part II, column 26, line 48) 74.00 Total Program routine service cost (line 9 x line 76) 75.00 Per diem capital-related costs (line 9 x line 76) 76.00 Per diem capital-related costs (line 9 x line 76) 77.00 Program capital related costs (line 9 x line 76) 78.00 Program capital related costs (line 9 x line 76) 78.00 Reasonable inpatient routine service costs (see instructions) 80.00 Reasonable inpatient routine service costs (see instructions) 81.00 Reasonable inpatient routine service costs (see instructions) 82.00 Reasonable inpatient routine service costs (see instructions) 83.00 Reasonable inpatient routine service cost (see instructions) 84.00 Reasonable inpatient routine service cost (see instructions) 85.00 Re			instructions)			-		
PROGRAM INPATIENT ROUTINE SWING BED COST		, , , , , , , , , , , , , , , , , , , ,	ent (see instru	uctions)				
instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See Instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions) 67. 00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 88. 00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 12 x line 19) 89. 00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 12 x line 12) 10		PROGRAM INPATIENT ROUTINE SWING BED COST						
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only) 66.00 1	64. 00	,	ts through Dece	ember 31 of th	e cost report	ting period (See	0	64.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions) 67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY 70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 71.00 Agusted general inpatient routine service cost east (line 70 + line 2) Program routine service cost (line 9 x line 71) 72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) Per diem capital -related costs (line 75 + line 2) 76.00 Program capital -related costs (line 75 + line 2) 77.00 Aggregate charges to beneficiaries for excess costs (from provider records) 78.00 Inpatient routine service cost [line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Inpatient routine service cost per diem limitation 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost fire sintructions) 83.00 Reasonable inpatient routine service s(see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physiclan compensation (see instructions) 76.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 76.00 Total program inpatient routine cost per diem (line 27 + line 2) 77.00 Total program inpatient routine cost per diem (line 27 + line 2)	65.00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	per 31 of the	cost reportin	ng period (See	0	65.00
CAH (see instructions) 7. 00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 8. 00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 69. 00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 70. 00 Skilled nursing facility/Corten rursing fac	66 00		no costs (lino	64 plus lino	65) (+i +l o VVI	II only) For	_	66 00
Cline 12 x line 19 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) One of title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	00.00		ne costs (Title	64 prus irrie	05)(11116 XVI	TI OHLY). FOI		86.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 70.00 Program routine service cost (line 9 x line 71) 71.00 Adjusted general inpatient routine service cost per diem (line 70 + line 2) Program routine service cost (line 9 x line 71) 71.00 Adjusted general inpatient routine service costs (line 72 + line 73) Capital -related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Program capital -related costs (line 75 + line 2) Program capital -related costs (line 9 x line 76) 77.00 Inpatient routine service cost (line 74 minus line 77) 80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost limitation (line 9 x line 81) 82.00 Reasonable inpatient routine service (see instructions) 83.00 Reasonable inpatient routine service (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Unit ization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 86.00 Adjusted general inpatient routine cost per diem (line 27 + line 2)	67. 00	1	e costs through	December 31	of the cost i	reporting period	0	67.00
(line 13 x line 20) Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY 70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 71.00 Adjusted general inpatient routine service cost per diem (line 70 + line 2) 72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital -related costs (line 75 + line 2) 77.00 Program capital -related costs (line 75 + line 2) 77.00 Program capital -related costs (line 75 + line 76) 80.01 Inpatient routine service cost (line 74 minus line 77) 80.02 Aggregate charges to beneficiaries for excess costs (from provider records) 80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost limitation (line 9 x line 81) 82.00 Reasonable inpatient proutine service (see instructions) 83.00 Reasonable inpatient ancillary services (see instructions) 84.00 Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total Observation bed days (see instructions) 84.00 Adjusted general inpatient routine cost per diem (line 27 + line 2) O 0 0 88.00 Adjusted general inpatient routine cost per diem (line 27 + line 2)	68. 00	1 '	e costs after [December 31 of	the cost re	porting period	0	68.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY 70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2) 72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 9 x line 76) 80.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 80.00 Total Program routine service cost for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost limitation (line 9 x line 81) 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Adjusted general inpatient routine cost per diem (line 27 + line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 + line 2)		(line 13 x line 20)			·	J .		
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2) 72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 75 ÷ line 2) 77.00 Aggregate charges to beneficiaries for excess costs (from provider records) 78.00 Total Program routine service cost for comparison to the cost limitation (line 78 minus line 79) 80.00 Total Program routine service cost jem diem limitation 81.00 Inpatient routine service cost limitation (line 9 x line 81) 82.00 Reasonable inpatient routine service costs (see instructions) 83.00 Reasonable inpatient routine service cost (see instructions) 84.00 Utilization review - physician compensation (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) 87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine service cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine service cost per diem (line 27 ÷ line 2) 89.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 89.00 Adjusted general inpatient routine service cost per diem (line 27 ÷ line 2) 89.00 Adjusted general inpatient routine service cost per diem (line 27 ÷ line 2) 89.00 Adjusted general inpatient routine service cost per diem (line 27 ÷ line 2) 89.00 Adjusted general inpatient routine service cost per diem (line 27 ÷ line 2) 89.00 Adjusted general inpatient routine service cost per diem (lin	69.00						0	09.00
72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 + line 2) 77.00 Program capital-related costs (line 9 x line 76) 78.00 Inpatient routine service cost (line 74 minus line 77) 78.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.01 Inpatient routine service cost per diem limitation 81.02 Inpatient routine service cost limitation (line 9 x line 81) 82.00 Reasonable inpatient routine service costs (see instructions) 83.00 Reasonable inpatient routine service (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 87.00 Total observation bed days (see instructions)		Skilled nursing facility/other nursing facil	ity/ICF/IID rou	ıtine service	cost (line 3	7)		70.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 9 x line 76) 78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost limitation 82.00 Inpatient routine service cost limitation 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 0 87.00 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				ine 70 ÷ line	2)			71.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2) 76.00 Program capital-related costs (line 9 x line 76) 77.00 Inpatient routine service cost (line 74 minus line 77) 78.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Inpatient routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 81.00 Reasonable inpatient routine service costs (see instructions) 82.00 Willization review - physician compensation (see instructions) 85.00 Utilization review - physician compensation (see instructions) 75.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 75.00 76.00 76.00 77.00 76.00 77.00 77.00 77.00 78.00 78.00 79.00 79.00 80.00 80.00 80.00 80.00 80.00 80.00 80.00		, ,	,	n (line 14 x l	ine 35)			73.00
26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 9 x line 76) 78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 81.00 Reasonable inpatient routine service costs (see instructions) 82.00 Reasonable inpatient ancillary services (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)		,			•	Dant III aaluma		74.00
76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 9 x line 76) 78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost per diem limitation 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	75.00		routine service	e costs (from	worksneet B,	Part II, column		75.00
78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Inpatient routine service costs for comparison to the cost limitation (line 78 minus line 79) 80.00 Inpatient routine service cost per diem limitation 81.00 Inpatient routine service cost limitation (line 9 x line 81) 82.00 Reasonable inpatient routine service costs (see instructions) 83.00 Reasonable inpatient ancillary services (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) 87.00 Total observation bed days (see instructions) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 87.00 Reasonable inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)			,					76. 00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Reasonable inpatient routine service cost (see instructions) 80.00 Utilization review - physician compensation (see instructions) 81.00 Reasonable inpatient operating costs (see instructions) 82.00 Utilization review - physician compensation (see instructions) 83.00 Reasonable inpatient ancillary services (see instructions) 84.00 Program inpatient operating costs (sum of lines 83 through 85) 85.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 87.00 Reasonable inpatient operating costs (sum of lines 27 ÷ line 2) 87.00 Reasonable inpatient operating costs (sum of lines 83 through 85) 88.00 Reasonable inpatient operating costs (sum of lines 83 through 85) 88.00 Reasonable inpatient operating costs (sum of lines 83 through 85) 88.00 Reasonable inpatient operating costs (sum of lines 83 through 85) 88.00 Reasonable inpatient operating costs (sum of lines 83 through 85) 88.00 Reasonable inpatient operating costs (sum of lines 83 through 85) 88.00 Reasonable inpatient operating costs (sum of lines 83 through 85) 88.00 Reasonable inpatient operating costs (sum of lines 83 through 85) 88.00 Reasonable inpatient operating costs (sum of lines 83 through 85) 88.00 Reasonable inpatient operating costs (sum of lines 83 through 85) 88.00 Reasonable inpatient operating costs (sum of lines 83 through 85) 88.00 Reasonable inpatient routine cost per diem (line 27 ÷ line 2)		,						
81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 82.00 Reasonable inpatient routine service costs (see instructions) 83.00 Program inpatient ancillary services (see instructions) 84.00 Utilization review - physician compensation (see instructions) 85.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 87.00 Reasonable inpatient routine service cost limitation 88.00 Reasonable inpatient routine service costs (see instructions) 87.00 Reasonable inpatient routine service cost limitation 88.00 Reasonable inpatient routine service cost limitation 89.00 Reasonable inpatient routine service cost stine 81) 89.00 Reasonable inpatient routine service cost (see instructions) 89.00 Reasonable inpatient routine service cost (see instructions) 89.00 Reasonable inpatient routine service cost (see instructions) 89.00 Reasonable inpatient routine service cost (see ins		1 .		provi der recor	ds)			79.00
82.00 Inpatient routine service cost limitation (line 9 x line 81) 82.00 Reasonable inpatient routine service costs (see instructions) 83.00 Program inpatient ancillary services (see instructions) 84.00 Utilization review - physician compensation (see instructions) 85.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				cost limitatio	n (line 78 mi	nus line 79)		80.00
83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Reasonable inpatient routine service costs (see instructions) 87.00 Reasonable inpatient routine service costs (see instructions) 88.00 Reasonable inpatient routine service costs (see instructions) 87.00 Reasonable inpatient routine service costs (see instructions) 88.00 Reasonable inpatient routine service costs (see instructions) 87.00 Reasonable inpatient routine service costs (see instructions) 88.00 Reasonable inpatient routine service costs (see instructions) 87.00 Reasonable inpatient routine service costs (see instructions) 88.00 Reasonable inpatient routine service costs (see instructions) 87.00 Reasonable inpatient routine service costs (see instructions) 88.00 Reasonable inpatient routine service costs (see instructions) 87.00 Reasonable inpatient routine services (see instructions) 88.00 Reasonable inpatient routine services (see instructio				1)				82.00
85.00 Utilization review - physician compensation (see instructions) 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 88.00 Representation review - physician compensation (see instructions) 88.00 88.00 Representation review - physician compensation (see instructions) 88.00 Representation review - physician review - ph		Reasonable inpatient routine service costs (see instruction	•				83.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)		1 -		ons)				
87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 87.00 88.00 87.00 88.00		Total Program inpatient operating costs (sum	of lines 83 th					86.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 0.00 88.00	07 00							07 00
				- line 2)				
							0	89.00

Health Financial Systems	ST. FRANCIS HOSPITA	AL & HEALTH CEN	TER	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
		Component (From 01/01/2020 To 12/31/2020		
		Title	XVIII	Subprovi der -	PPS	
				I RF		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
		,		(from line	(col. 3 x	
				89)	col. 4) (see	
				ŕ	instructions)	
	1. 00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THRO	DUGH COST					
90.00 Capi tal -related cost	1, 123, 305	8, 237, 029	0. 13637	3 0	0	90.00
91.00 Nursing School cost	C	8, 237, 029	0.00000	0 0	0	91.00
92.00 Allied health cost		8, 237, 029	0.00000	0 0	0	92.00
93.00 All other Medical Education		8, 237, 029	0.00000	0	0	93.00

Health Financial Systems	ST. FRANCIS HOSPITAL 8	& HEALTH CENTER	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0162	Peri od: From 01/01/2020	Worksheet D-1	
			To 12/31/2020	Date/Time Pre 3/30/2021 10:	
		Title XIX	Hospi tal	PPS	
Cost Center Description					
				1. 00	

		Title XIX	Hospi tal	3/30/2021 10: PPS	40 am_
	Cost Center Description	THE ALA	nospi tui	113	
				1. 00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				
1. 00	Inpatient days (including private room days and swing-bed day	s. excluding newborn)		61, 574	1.00
2. 00	Inpatient days (including private room days, excluding swing-			61, 574	2.00
3.00	Private room days (excluding swing-bed and observation bed da	ys). If you have only pr	ivate room days,	0	3.00
	do not complete this line.			50.004	
4. 00 5. 00	Semi-private room days (excluding swing-bed and observation b Total swing-bed SNF type inpatient days (including private ro		or 21 of the cost	52, 024 0	4. 00 5. 00
3.00	reporting period	olli days) tili odgir becellibe	i 31 OF THE COST	U	3.00
6. 00	Total swing-bed SNF type inpatient days (including private ro	om days) after December	31 of the cost	0	6. 00
	reporting period (if calendar year, enter 0 on this line)				
7. 00	Total swing-bed NF type inpatient days (including private roo	m days) through December	31 of the cost	0	7. 00
8. 00	reporting period Total swing-bed NF type inpatient days (including private roo	m days) after December 3	1 of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	iii days) arter beceiiber e	ii oi tiic cost	O	0.00
9.00	Total inpatient days including private room days applicable t	o the Program (excluding	swing-bed and	797	9. 00
	newborn days) (see instructions)			_	
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII o through December 31 of the cost reporting period (see instruc		room days)	0	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII o		noom davs) after	0	11. 00
	December 31 of the cost reporting period (if calendar year, e			_	
12.00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including privat	e room days)	0	12. 00
12.00	through December 31 of the cost reporting period	V (:		0	10.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XI after December 31 of the cost reporting period (if calendar y			0	13. 00
14. 00	Medically necessary private room days applicable to the Progr			0	14.00
15.00	Total nursery days (title V or XIX only)			3, 738	
16.00	Nursery days (title V or XIX only)			172	16. 00
17 00	SWING BED ADJUSTMENT	+b	E 11	0.00	17.00
17.00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through December 31 c	or the cost	0.00	17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to servic	es after December 31 of	the cost	0. 00	18. 00
	reporting period				
19. 00	Medicaid rate for swing-bed NF services applicable to service	s through December 31 of	the cost	0. 00	19. 00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to service	s after December 21 of t	ho cost	0. 00	20. 00
20.00	reporting period	s arter becember 51 or t	ile cost	0.00	20.00
21.00	1	s)		87, 996, 376	21. 00
22. 00	Swing-bed cost applicable to SNF type services through Decemb	er 31 of the cost report	ing period (line	. 0	22. 00
22.00	5 x line 17)	21 -6		0	22.00
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reporting	ig period (iine d	0	23. 00
24. 00		r 31 of the cost reporti	ng period (line	0	24. 00
	7 x line 19)	·			
25. 00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	period (line 8	0	25. 00
26. 00	x line 20) Total swing-bed cost (see instructions)			0	26. 00
	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		87, 996, 376	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(3171137313	
28. 00	General inpatient routine service charges (excluding swing-be	d and observation bed ch	arges)	0	
29. 00				0	
30.00	Semi - pri vate room charges (excluding swing-bed charges)	. Line 20)		0 000000	
31. 00 32. 00	General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3)	÷ 1111e 28)		0. 000000 0. 00	
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 mi	nus line 33)(see instruc	tions)	0.00	
35.00	Average per diem private room cost differential (line 34 x li	ne 31)		0. 00	35. 00
36.00	Private room cost differential adjustment (line 3 x line 35)	and naturate! "	fforonti-l (l'	07 004 274	36.00
37. 00	General inpatient routine service cost net of swing-bed cost 27 minus line 36)	and private room cost di	rrential (IIne	87, 996, 376	37. 00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	USTMENTS			
	Adjusted general inpatient routine service cost per diem (see	instructions)		1, 429. 12	
39.00	Program general inpatient routine service cost (line 9 x line	•		1, 139, 009	
	Medically necessary private room cost applicable to the Programal Total Program general inpatient routine service cost (line 39)	,		0 1, 139, 009	40.00 41.00
11.00	1.04 Sgram gonoral ripatront routine service cost (fille 57			1, 137, 007	1 11.00

COMPUT	ATION OF INPATIENT OPERATING COST		Provi der Co	-	Period: From 01/01/2020 To 12/31/2020	3/30/2021 10:	pared:
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	e XIX Average Per Diem (col. 1 ÷ col. 2)	Hospital Program Days	PPS Program Cost (col. 3 x col. 4)	
		1. 00	2. 00	3.00	4. 00	5. 00	
42. 00	NURSERY (title V & XIX only)	1, 710, 345	3, 738			78, 700	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	17, 656, 935	20, 500			239, 444	
43. 01 44. 00	NEONATAL INTENSIVE CARE UNIT CORONARY CARE UNIT	9, 704, 382 23, 584, 816	6, 322 12, 691	1, 535. 02 1, 858. 39		69, 076 85, 486	
45. 00	BURN INTENSIVE CARE UNIT	23, 364, 610	12, 091	1, 000. 3	40	03, 400	45.00
46. 00	SURGICAL INTENSIVE CARE UNIT	12, 716, 282	8, 247	1, 541. 93	67	103, 309	
47. 00	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description					1 00	
48. 00	Program inpatient ancillary service cost (Wk	st D_3 col 3	Line 200)			1. 00 13, 319, 460	48.00
	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS			ons)		15, 034, 484	
50. 00	Pass through costs applicable to Program inp	atient routine	services (fro	m Wkst. D, sum	of Parts I and	222, 737	50.00
51. 00	Pass through costs applicable to Program inp and IV)	atient ancillar	ry services (f	rom Wkst. D, s	um of Parts II	1, 330, 221	51.00
52. 00 53. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu medical education costs (line 49 minus line	ding capital re	lated, non-ph	ysician anesth	etist, and	1, 552, 958 13, 481, 526	
54.00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges	·				0	54.00
	Target amount per discharge					0. 00	
6. 00	Target amount (line 54 x line 55)					0	ı
	Difference between adjusted inpatient operat	ing cost and ta	irget amount (ine 56 minus	line 53)	0	57.0
8.00	Bonus payment (see instructions)					0	
59. 00	Lesser of lines 53/54 or 55 from the cost re market basket			•	mpounaea by the		
60. 00 61. 00	lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 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 amount (line 56), otherwise enter zero (see instructions)					0.00	60.00 61.00
52. 00 53. 00	0 Relief payment (see instructions)					0	
54. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 31 of the	e cost reporti	ng period (See	0	64.00
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)</pre>	ts after Decemb	er 31 of the (cost reporting	period (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)	ne costs (line	64 plus line	65)(title XVII	I only). For	0	66.00
57. 00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	e costs through	December 31	of the cost re	porting period	0	67.00
58. 00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)			•	rting period	0	
59. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N					0	69.00
70. 00	Skilled nursing facility/other nursing facil	ity/ICF/IID rou	itine service (cost (line 37)			70.00
71.00	Adjusted general inpatient routine service c		ine 70 ÷ line	2)			71.00
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost applic		(line 14 x Li	ne 35)			72.00
74.00	Total Program general inpatient routine serv						74.00
75. 00	Capital-related cost allocated to inpatient 26, line 45)	•			art II, column		75.00
76. 00	Per diem capital-related costs (line 75 ÷ li						76.00
77. 00 78. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu						77. 00 78. 00
79.00	Aggregate charges to beneficiaries for exces		rovi den recon	ds)			79.00
30.00	Total Program routine service costs for comp			*.	us line 79)		80.00
31. 00	Inpatient routine service cost per diem limi	tati on		•	ŕ		81.00
32.00	Inpatient routine service cost limitation (I		* .				82.00
83. 00 84. 00	Reasonable inpatient routine service costs (Program inpatient ancillary services (see in		is)				83. 00 84. 00
85.00	Utilization review - physician compensation		ons)				85.00
86. 00	Total Program inpatient operating costs (sum						86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS	S THROUGH COST					
27 00	Total observation bed days (see instructions	1				9, 550	. 07 0

9, 550 87. 00 1, 429. 12 88. 00 13, 648, 096 89. 00

87.00 Total observation bed days (see instructions)
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)
89.00 Observation bed cost (line 87 x line 88) (see instructions)

Health Financial Systems ST.	FRANCIS HOSPITA	L & HEALTH CEN	TER	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
				From 01/01/2020 To 12/31/2020		pared: 40 am_
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2. 00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	12, 308, 780	87, 996, 376	0. 13987	8 13, 648, 096	1, 909, 068	90.00
91.00 Nursing School cost	0	87, 996, 376	0.00000	0 13, 648, 096	0	91.00
92.00 Allied health cost	0	87, 996, 376	0.00000	0 13, 648, 096	0	92.00
93.00 All other Medical Education	0	87, 996, 376	0.00000	13, 648, 096	0	93. 00

Health Financial Systems	ST. FRANCIS HOSPITAL 8	k HEALTH CENTER	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CCN: 15-0162	Peri od: From 01/01/2020	Worksheet D-1
		Component CCN: 15-T162		
		Title XIX	Subprovi der -	PPS
			IRF	

		I RF		
	Cost Center Description		4 00	
	PART I - ALL PROVIDER COMPONENTS		1. 00	
	INPATIENT DAYS			
1.00	Inpatient days (including private room days and swing-bed days, excluding newbor	n)	5, 552	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn da		5, 552	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have on	ily private room days,	0	3.00
	do not complete this line.			
4. 00	Semi-private room days (excluding swing-bed and observation bed days)		5, 552	4.00
5. 00	Total swing-bed SNF type inpatient days (including private room days) through De	ecember 31 of the cost	0	5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private room days) after Dece	umbor 21 of the cost	0	6. 00
0.00	reporting period (if calendar year, enter 0 on this line)	iliber 31 of the cost	U	0.00
7. 00	Total swing-bed NF type inpatient days (including private room days) through Dec	ember 31 of the cost	0	7. 00
	reporting period		- 1	
8.00	Total swing-bed NF type inpatient days (including private room days) after Decem	ber 31 of the cost	0	8. 00
	reporting period (if calendar year, enter 0 on this line)			
9. 00	Total inpatient days including private room days applicable to the Program (excl	uding swing-bed and	25	9. 00
10. 00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII only (including priv	vate room days)	0	10.00
10.00	through December 31 of the cost reporting period (see instructions)	ate room days)	U	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including priv	ate room days) after	0	11.00
	December 31 of the cost reporting period (if calendar year, enter 0 on this line			
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including p	rivate room days)	0	12.00
	through December 31 of the cost reporting period		_	
13. 00			0	13. 00
14. 00	after December 31 of the cost reporting period (if calendar year, enter 0 on thi Medically necessary private room days applicable to the Program (excluding swing		0	14. 00
15. 00		j-bed days)	-	15.00
	Nursery days (title V or XIX only)		172	16.00
	SWI NG BED ADJUSTMENT	-		
17.00	Medicare rate for swing-bed SNF services applicable to services through December	31 of the cost	0.00	17. 00
	reporting period			
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 3	1 of the cost	0. 00	18. 00
19. 00	reporting period	21 of the cost	0.00	19. 00
19.00	Medicaid rate for swing-bed NF services applicable to services through December reporting period	31 of the cost	0.00	19.00
20. 00	Medicaid rate for swing-bed NF services applicable to services after December 31	of the cost	0. 00	20.00
	reporting period			
21.00	Total general inpatient routine service cost (see instructions)		8, 237, 029	21.00
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost r	eporting period (line	0	22. 00
22.00	5 x line 17)			22.00
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost rep x line 18)	forting period (line o	0	23. 00
24. 00		porting period (line	0	24. 00
21.00	7 x line 19)	per tring per real (rine	١	200
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost repo	rting period (line 8	0	25. 00
	x line 20)			
26. 00	,	0.()	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line	: 26)	8, 237, 029	27. 00
20 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed and observation b	and charges)	0	28. 00
	Private room charges (excluding swing-bed charges)	led charges)	0	
30.00	Semi -pri vate room charges (excluding swing-bed charges)		0	
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0. 000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)		0. 00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see in	structions)	0. 00	
35.00	Average per diem private room cost differential (line 34 x line 31)		0. 00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	st differential (!!-	0 227 020	36.00
37. 00	General inpatient routine service cost net of swing-bed cost and private room co 27 minus line 36)	ost un nerential (IINe 	8, 237, 029	37. 00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY			
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see instructions)		1, 483. 61	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line 38)		37, 090	39. 00
	Medically necessary private room cost applicable to the Program (line 14 x line	35)	0	40.00
41. 00	Total Program general inpatient routine service cost (line 39 + line 40)		37, 090	41.00

Component CDI: 15-T162 From 17/14/2000 M3/2002 Institute of 12/3/2000 M3/2002 Institute of 12/3/2001 M3/2002 Institute of 12/3/2001 M3/2002 Institute of 12/3/2001 M3/2001 M3/2002 M		Financial Systems ST. F	RANCIS HOSPITAL		ITER CN: 15-0162	In Lie	eu of Form CMS-2 Worksheet D-1	
Cost Center Description	COMITOT	ATTOM OF THE ATTEM OF ENVITTING GOST				From 01/01/2020	Date/Time Pre	pared:
Ost Center Description Total Inpatient Dami (col. 2) Dami (col. 3) Cent. 3 x Cent. 3 x Cent. 4				Ti tl	e XIX	· '		40 am_
1.00		Cost Center Description	Inpatient	I npati ent	Diem (col.	Program Days	(col. 3 x	
Interestive Care Type Inpartient Inegital Builts			1. 00	2. 00	3. 00		5. 00	
	42. 00		0	C	0.	00 0	0	42.00
A	43.00		0	C	0.	00 0	0	43.00
45.00 BURN INTENSIVE CARE UNIT			- 1		1			
40.00 DIRESPICAL CARE (DNIT) 0 0 0 0 0 0 0 0 0		•	U	C	0.	00	0	44.00
20.1 Cost Center Description 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.	46.00	SURGICAL INTENSIVE CARE UNIT	0	C	Ο.	00 0	0	46.00
1.00 Program inpatient ancillary service cost (West. D-3. col. 3, line 200) 633,485 48 0.0 10tal Program inpatient costs (sun of lines 41 through 64) (see instructions) 633,685 48 0.0 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,575 49 670,	47. 00							47.00
140.00 Total Program inpatient costs (sum of Flines 41 through 48) (see instructions) 200.00 Pass through costs applicable to Program inpatient routine services (from West. D. sum of Parts II and 5.058 50.00 III) 21.00 Total Program excludable cost (sum of Flines 50 and 51) 22.00 Total Program excludable cost (sum of Flines 50 and 51) 23.00 Total Program excludable cost (sum of Flines 50 and 51) 23.00 Total Program excludable cost (sum of Flines 50 and 51) 24.00 Total Program excludable cost (sum of Flines 50 and 51) 25.00 Total Program excludable cost (sum of Flines 52) 26.00 Total Program excludable cost (sum of Flines 52) 27.00 Total Program excludable cost (sum of Flines 52) 28.00 Total Program excludable cost (sum of Flines 52) 28.00 Total Program excludable cost (sum of Flines 52) 28.00 Total Program excludable cost (sum of Flines 52) 28.00 Total Program excludable cost (sum of Flines 52) 28.00 Total Program excludable cost (sum of Flines 52) 28.00 Total Program excludable cost (sum of Flines 52) 28.00 Total Program excludable cost (sum of Flines 52) 28.00 Total Program excludable cost (sum of Flines 52) 28.00 Total Program excludable cost (sum of Flines 52) 28.00 Total Program excludable cost (sum of Flines 52) 28.00 Total Program excludable cost (sum of Flines 52) 28.00 Total Program excludable cost (sum of Flines 52) 28.00 Total Program excludable cost (sum of Flines 52) 28.00 Total Program excludable cost (sum of Flines 52) 28.00 Total Program excludable cost (sum of Flines 52) 28.00 Total Program excludable cost (sum of Flines 52) 28.00 Total Program excludable cost (sum of Flines 52) 28.00 Total Program excludable cost (sum of Flines 52) 28.00 Total Program (sum of Flines 52) 28.00 Total Progr		Cost Center Description					1.00	
PARS THROUGH COST ADJUSTMENTS								
5.00 Pass through costs applicable to Program Inpatient routine services (from West. D. sum of Parts I and 15.05 So. 00 III) 5.100 Pass through costs applicable to Program Inpatient ancillary services (from West. D. sum of Parts II 39, 041 51.00 and IV) 5.100 Total Program excludable cost (sum of lines 50 and 51) 6.101 Program inpatient operating cost excluding capital related, non-physician anesthetist, and 626, 476 33.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and 626, 476 33.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and 626, 476 33.00 Program discharges 6.100 Program discharges 7.100 Program capital pold NF inpatient routine costs (line 64 plus line 65) (title XVIII only) Program cultine service cost (line 75 + line 26) 7.100 Program cultine service cost (line 75 + line 27) 7	49. 00		41 through 48)(see instructi	ons)		670, 575	49.00
39,041 51,00 and IV) 39,041 51,00 39,041 51,00 39,041 51,00 39,041 51,00 39,041 51,00 39,041 51,00 39,041 51,00 39,041 51,00 39,041 51,00 39,041 51,00 39,041 51,00 39,041 51,00 39,041 51,00 39,041 51,00 39,041 51,00 39,041 51,00 39,041 51,00 39,041 51,00 39,041 51,00 39,041 51,00 39,041 51,00 39,041 51,00 39,041 51,00 39,041 51,00 39,041 51,00 39,041 51,00 39,041 51,00 39,041 51,00 39,041 51,00 39,041 51,00 39,041 51,00 39,041 51,00 39,041 51,00 39,041 51,00 39,041 51,00 39,041 51,00 39,041 51,00 39,041 51,00 39,041 51,00 39,041 51,00 39,041 51,00 39,041 51,00 39,041 51,00 39,041 51,00 39,041 51,00 39,041 51,00 39,041 51,00 39,041 51,00 39,041 51,00 39,041 51,00 39,041 51,00 39,041 51,00 39,041 51,00 39,041 51,00 39,041 51,00 39,041 51,00 39,041 51,00 39,041 51,00 39,041 51,00 39,041 51,00 39,041 51,00 39,041 51,00 39,041 51,00 39,041 51,00 39,041 51,00 39,041 51,00 39,041 51,00 39,041 51,00 39,041 51,00 39,041 51,00 39,041 51,00 39,041 51,00 39,041 51,00 39,041 51,00 39,041 51,00 39,041 51,00 39,041 51,00 39,041 51,00 39,041 51,00 39,041 51,00 39,041 51,00 39,041 51,00 39,041 51,00 39,041 51,00 39,041 51,00 39,041 51,00 39,041 51,00 39,041 51,00 39,041 51,00 39,041 51,00 39,041 51,00 39,041 51,00 39,041 51,00 39,041 51,00 39,041 51,00 39,041 51,00 39,041 51,00 39,041 51,00 39,041 51,00 39,041 51,00 39,041 51,00 39,	50.00		atient routine	services (fro	m Wkst. D, sı	um of Parts I and	5, 058	50.00
	E4 00					C D	20.044	F4 00
10 10 10 10 10 10 10 10	51.00		atient ancillar	ry services (T	rom WKST. D,	sum of Parts II	39, 041	51.00
medical education costs (line 49 minus line 52)	52.00	Total Program excludable cost (sum of lines					44, 099	52.00
TARGET ANDUNT AND LIMIT COMPUTATION	53. 00		9 1	elated, non-ph	ysician anes	thetist, and	626, 476	53.00
54.00 Program di scharges 0.00 55.00 55.00 Target amount per di scharges 0.00 55.00 55.00 Target amount (line 54 x line 55) 0.56.00 55.00 56.00 Target amount (line 54 x line 55) 0.56.00 55.00 56.00 56.00 57.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.00 56.0			52)					1
56.00 Target amount (tine 54 x line 55) 57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 58.00 Bonus payment (see Instructions) 59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket 60.00 Lesser of lines 53/54 or 55 from the cost report, updated by the market basket 61.00 Lesser of lines 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 amount (line 56), otherwise enter zero (see instructions) 62.00 Relief payment (see instructions) 63.00 Allowable Inpatient cost plus Incentive payment (see instructions) 64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See Instructions) (tilt XVIII only). For CAH (see instructions) 65.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (tilt XVIII only). For CAH (see instructions) 67.00 Total Medicare swing-bed NF inpatient routine costs (line 64 plus line 65) (tilt XVIII only). For CAH (see instructions) 68.00 (line 12 X line 19) 69.00 Total Misser and the inpatient routine costs (line 64 plus line 65) (tilt XVIII only). For CAH (see instructions) 69.00 Total Medicare swing-bed NF inpatient routine costs (line 64 plus line 65) (tilt XVIII only). For CAH (see instructions) 69.00 Total Medicare swing-bed NF inpatient routine costs (line 64 plus line 65) (tilt XVIII only). For CAH (see instructions) 69.00 Total Medicare swing-bed NF inpatient routine costs (line 64 plus line 65) (tilt XVIII only). For CAH (see instructions) 69.00 Total Hill SAM (SAM) phode NF inpatient routine costs (line 64 plus line 65) (tilt XVIII only). For CAH (see instructions) 69.00 Total Program engeneral inpatient routine service costs (line 67 + line 68) 69.00 Total Program routine service (line 9 x line 11) 69.00 Total Program routine service cost (
57.00 DITFerence between adjusted inpatient operating cost and target amount (line 56 minus line 53) 0 57.00 58.00 Bonus payment (see instructions) 0 58.00 Easer of lines 52/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket basket 60.00 Lesser of lines 52/54 or 55 from prior year cost report, updated by the market basket 70.00 60.00 for 10.00 If line 53/54 is less than the lower of lines 55.59 or .pdated by the market basket 70.00 60.00 for 10.00 line 53/54 is less than the lower of lines 55.59 or .pdated by the market basket 70.00 60.00 for 10.00 for 1							1	
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket 60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 60.00 Lesser of lines 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 amount (line 55), otherwise enter zero (see instructions) 62.00 Relief payment (see instructions) 63.00 Allowable Impatient cost plus incentive payment (see instructions) 64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See Instructions) (lite XVIII only) 65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See Instructions) (lite XVIII only) 66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions) 67.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 12 x line 19) 68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICE/IID ONLY 70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 70.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 71.00 Total Program general inpatient routine service costs (line 72 + line 73) 72.00 Program routine service cost (line 9 x line 76) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital-related costs (line 9 x line 76) 77.00 Part III - SKILLED NURSING FACILITY, OTHER NURSING FACILI			ing cost and ta	arget amount (line 56 minus	s line 53)		
narket basket 60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 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 amount (line 56), otherwise enter zero (see instructions) 62.00 Relief payment (see instructions) 63.00 Allowable Inpatient cost plus incentive payment (see instructions) 63.00 Allowable Inpatient RolUTINE SWING BED COST 64.00 Medicare swing-bed SWF inpatient routine costs through December 31 of the cost reporting period (See instructions) title zWIII only) 65.00 Medicare swing-bed SWF inpatient routine costs after December 31 of the cost reporting period (See instructions) title zWIII only) 65.00 Total Medicare swing-bed SWF inpatient routine costs (line 64 plus line 65) (title zWIII only). For CAM (See instructions) 67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 69.00 Total title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 69.00 Total title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 PART III - SKILLED NURSING FACILITY, OTHER NURSING								
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser 50% of the amount by 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 Relief payment (see instructions) 63.00 Allowable Inpatient cost plus incentive payment (see instructions) 64.00 Medicare sking-bed SNF inpatient routine costs through December 31 of the cost reporting period (See Instructions) (title XVIII only) 65.00 Medicare sking-bed SNF inpatient routine costs after December 31 of the cost reporting period (See Instructions) (title XVIII only) 66.00 Total Medicare sking-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAM (see instructions) 67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period 68.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period 69.00 Title V or XIX swing-bed NF inpatient routine costs (line 64 plus line 65) (title XVIII only). 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 PART III - SXILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY 70.00 Algusted general inpatient routine service costs (line 70 + line 68) 71.00 Program routine service cost (line 9 x line 71) 72.00 Program general inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 73.00 Capital-related costs (line 9 x line 70) 74.00 Program ageneral inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 75.00 Capital-related cost (line 74 minus line 77) 76.00 Program ageneral inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 77.00 Program ageneral inpatient routine service costs (from provider records) 77.00 Program ageneral inpatient routine service costs (from provider re	59. 00		porting period	endi ng 1996,	updated and o	compounded by the	0.00	59.00
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 Relief payment (see instructions) 63.00 Allowable Inpatient cost plus incentive payment (see instructions) 64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (tilt ex VIII only) 65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (tilt ex VIII only) 66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions) (title XVIII only) in CAH (see instructions) 67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 64 plus line 65) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 70.00 Skilled nursing facility/other nursing facility/IOF/IID routine service cost (line 37) 71.00 Adjusted general inpatient routine service cost per diem (line 70 + line 2) 72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (from Worksheet B, Part II, column 26 line 45) 75.00 Per diem capital -related costs (line 75 + line 2) 76.00 Program capital -related costs (line 75 + line 2) 77.00 Program routine service cost (line 76 minus line 77) 78.00 Inpatient routine service cost (line 76 minus line 77) 78.00 Inpatient routine service cost (line 76 minus line 77) 79.00 Reasonable inpatient routine service costs (from provider records) 88.00 Medically necessary private room cost applicable to Program (routine service cost li	60.00							60.00
amount (IIne 56), otherwise enter zero (see instructions) 63.00 Allowable Inpatient cost plus incentive payment (see instructions) 63.00 Allowable Inpatient cost plus incentive payment (see instructions) 64.00 Allowable Inpatient cost plus incentive payment (see instructions) 64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See 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) 66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions) 67.00 Total Medicare swing-bed NF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions) 68.00 Total Medicare swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 68.00 Total Weswing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 69.00 Total title v or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total title v or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total title v or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total title vor XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total title vor XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total title vor XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total title vor XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total Wedically necessary private room cost applicable to Program (line 14 x line 35) 70.00 Capital operation service cost (line 9 x line 71) 70.00 Capital operation service cost (line 9 x line 71) 70.00 Capital operation service cost (line 9 x line 71) 70.00 Porgram routine service cost (line 74 minus line 77) 70.00 Porgram copital operation service cost (line 74 minus line 77) 70.00 Porgram inp	61. 00						0	61.00
Relief payment (see instructions) 0 62.00				.s (Tines 54 x	60), OF 1% (or the target		
PROCRAM INPATIENT ROUTINE SWING BED COST		Relief payment (see instructions)	·					
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See 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) 66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). 67.00 Title Vor XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 12 x line 19) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND IOF/IID ONLY 70.00 Algusted general inpatient routine service cost (line 37) 70.00 Total ville V or XIX swing-bed NF inpatient routine service cost (line 37) 70.00 Total ville V or XIX swing-bed NF inpatient routine service cost (line 37) 70.00 Algusted general inpatient routine service cost per diem (line 70 + line 2) 70.00 Total Program routine service cost (line 9 x line 71) 70.00 Algusted general inpatient routine service costs (line 72 + line 73) 70.00 Total Program general inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 70.00 Algusted general engal tell related costs (line 75 + line 7) 70.00 Program capital -related costs (line 9 x line 76) 70.00 Program capital -related costs (line 75 + line 76) 70.00 Program capital routine service costs (from provider records) 70.00 Inpatient routine service costs for comparison to the cost limitation (line 78 minus line 79) 70.00 Reasonable inpatient routine service cost (see instructions) 70.00 Reasonable inpatient routine service costs (see instructions) 70.00 Algusted general inpatient routine service costs (see instructions) 70.00 Algusted general inpatient routine service cost (see instructions) 70.00 Algusted general inpatient routine service cost (see instructions	63. 00		ent (see instru	ıcti ons)			0	63.00
Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)	64. 00		ts through Dece	ember 31 of th	e cost repor	ting period (See	0	64.00
instructions) (title XVIII only) Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions) 7.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 8.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 9.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 9.01 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 9.02 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 9.03 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 9.04 Total title V or XIX swing-bed NF inpatient routine service costs (line 37) 9.05 Total program facility/other nursing facility/ICF/IID routine service cost (line 37) 9.00 Total program routine service cost per diem (line 70 + line 2) Total program general inpatient routine service costs (line 70 + line 2) Total program general inpatient routine service costs (line 72 + line 73) Total program general inpatient routine service costs (line 72 + line 73) Total program general inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) Total program capital-related costs (line 75 + line 2) Total program capital-related costs (line 75 + line 2) Total program capital related costs (line 75 + line 2) Total program capital related costs (line 75 + line 2) Total program routine service cost (line 74 minus line 77) Total program routine service cost (line 74 minus line 77) Total program inpatient routine service costs (see instructions) Total program inpatient ancillary services (see instructions) Total program inpatient ancillary services (see instructions) Total program inpatient ancillary services (see instructions) Total program inpatient operating costs (sum of lines 83 through 85) Total program inpatient routine cost per diem (line 27 + line 2) Total program	/F 00		+ 	21 -6 +6-				/ F 00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions) 67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 70.00 Total title V or XIX swing-bed NF inpatient routine costs (line 70 + line 2) 70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 70.00 Program routine service cost (line 9 x line 71) 71.00 Total Program general inpatient routine service costs (line 70 + line 2) 72.00 Program general inpatient routine service costs (line 75 + line 2) 73.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 74.00 Program capital-related costs (line 75 + line 2) 75.00 Program capital-related costs (line 9 x line 76) 77.00 Aggregate charges to beneficiaries for excess costs (from provider records) 78.00 Inpatient routine service cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost limitation (line 9 x line 81) 82.00 Inpatient routine service cost limitation (line 9 x line 81) 82.00 Inpatient routine service cost limitation (see instructions) 83.00 Resonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compe	65.00		ts after Decemb	per 31 of the	cost reportii	ng period (See	0	65.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 0 69.00 PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY 70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 71.00 Agiusted general inpatient routine service cost per diem (line 70 + line 2) 72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 + line 2) 77.00 Program capital-related costs (line 9 x line 76) 78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 78.00 Total Program routine service cost from provider records) 78.00 Inpatient routine service cost per diem limitation 80.00 Inpatient routine service cost per diem limitation 80.00 Inpatient routine service cost from structions) 80.00 Inpatient routine service cost (see instructions) 80.00 Inpatient routine service cost (see instructions) 80.00 Utilization review - physician compensation (see instructions)	66. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line	65)(title XV	II only). For	0	66.00
Cline 12 x line 19 Cline 13 x line 20 Control title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) Control title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	67 00	1	e costs through	December 31	of the cost i	renorting period	0	67.00
Cline 13 x line 20 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY	07.00	1 .	c costs till ougi	i becember 31	or the cost i	cportring period		07.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY 70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 71.00 Adjusted general inpatient routine service cost per diem (line 70 + line 2) 72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital -related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) Per diem capital -related costs (line 75 + line 2) Program capital -related costs (line 9 x line 76) 10 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 10 Inpatient routine service cost per diem limitation 11 Inpatient routine service cost limitation (line 78 minus line 79) 12 Inpatient routine service cost limitation (line 9 x line 81) 13 Seasonable inpatient routine service costs (see instructions) 14 Computation review - physician compensation (see instructions) 15 Computation review - physician compensation (see instructions) 16 Computation review - physician compensation (see instructions) 17 Computation review - physician compensation (see instructions) 18 Seasonable inpatient operating costs (sum of lines 83 through 85) 18 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 18 Observation bed days (see instructions) 28 Observation bed days (see instructions) 29 Observation bed days (see instructions) 20 Observation bed days (see instructions) 20 Observation bed days (see instructions) 21 Observation bed days (see instructions) 22 Observation bed days (see instructions) 23 Observation bed days (see instructions) 24 Observation bed days (see instructions) 25 Observation bed days (see instructions) 26 Observation bed days (see instructions) 27 Obs	68. 00	1 .	e costs after [ecember 31 of	the cost rep	porting period	0	68. 00
70. 00 71. 00 72. 00 73. 00 74. 00 75. 00 75. 00 76. 00 76. 00 77. 00 77. 00 78. 00 78. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 79. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70	69. 00		routine costs (line 67 + lin	e 68)		0	69.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2) 72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 9 x line 76) 78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Total Program routine service cost for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 71.00 72.00 72.00 72.00 73.00 74.00 74.00 74.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00		PART III - SKILLED NURSING FACILITY, OTHER NU	JRSING FACILITY	, AND ICF/IID	ONLY	7)	1	
72. 00 Program routine service cost (line 9 x line 71) 73. 00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74. 00 Total Program general inpatient routine service costs (line 72 + line 73) 75. 00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76. 00 Per diem capital-related costs (line 75 + line 2) 77. 00 Program capital-related costs (line 9 x line 76) 78. 00 Inpatient routine service cost (line 74 minus line 77) 79. 00 Aggregate charges to beneficiaries for excess costs (from provider records) 79. 00 Total Program routine service cost per diem limitation 82. 00 Inpatient routine service cost limitation (line 9 x line 81) 83. 00 Reasonable inpatient routine service costs (see instructions) 84. 00 Program inpatient ancillary services (see instructions) 85. 00 Utilization review - physician compensation (see instructions) 86. 00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87. 00 Total observation bed days (see instructions) 88. 00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 87. 00 Total observation bed days (see instructions) 88. 00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88. 00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)			,			<i>(</i>)		1
74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 74 minus line 77) 78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine services (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) 87.00 Total observation bed days (see instructions) 87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	72. 00	Program routine service cost (line 9 x line	71)		•			72.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 9 x line 76) 78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Inpatient routine service costs for comparison to the cost limitation (line 78 minus line 79) 80.00 Inpatient routine service cost per diem limitation 81.00 Reasonable inpatient routine service costs (see instructions) 82.00 Utilization review - physician compensation (see instructions) 83.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 87.00 Total observation bed days (see instructions)		1 3 1 11	5	•	,			73.00
26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 9 x line 76) 1 Inpatient routine service cost (line 74 minus line 77) 80.00 Aggregate charges to beneficiaries for excess costs (from provider records) 80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Reasonable inpatient routine cost per diem (line 27 ÷ line 2) 87.00 Reasonable inpatient routine cost per diem (line 27 ÷ line 2) 87.00 Reasonable inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Reasonable inpatient routine cost per diem (line 27 ÷ line 2)		,			•	Part II. column		75.00
77. 00 Program capital-related costs (line 9 x line 76) 78. 00 Inpatient routine service cost (line 74 minus line 77) 79. 00 Aggregate charges to beneficiaries for excess costs (from provider records) 80. 00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81. 00 Inpatient routine service cost per diem limitation 82. 00 Inpatient routine service cost limitation (line 9 x line 81) 83. 00 Reasonable inpatient routine service costs (see instructions) 84. 00 Program inpatient ancillary services (see instructions) 85. 00 Utilization review - physician compensation (see instructions) 86. 00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 87. 00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88. 00 Oscillatory 89. 00 Oscill		26, line 45)		(,	,		
78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Inpatient routine service costs for comparison to the cost limitation (line 78 minus line 79) 80.00 Inpatient routine service cost per diem limitation 81.00 Inpatient routine service cost limitation (line 9 x line 81) 82.00 Reasonable inpatient routine service costs (see instructions) 83.00 Program inpatient ancillary services (see instructions) 84.00 Utilization review - physician compensation (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 87.00 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)			,					
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) 87.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Reasonable inpatient routine service costs (see instructions) 89.00 Reasonable inpatient routine service cost limitation (line 78 minus line 79) 89.00 Reasonable inpatient routine service cost limitation 81.00 Reasonable inpatient routine service cost limitation 81.00 Reasonable inpatient routine service cost limitation 82.00 Reasonable inpatient routine service cost limitation 83.00 Reasonable inpatient routine service cost limitation 84.00 Reasonable inpatient routine service cost (see instructions) 85.00 Reasonable inpatient routine service cost (see instructions) 86.00 Reasonable inpatient routine service cost limitation 87.00 Reasonable inpatient routine service cost (see instructions) 88.00 Reasonable inpatient routine service cost limitation 89.00 Reasonable inpatient routine service cost (see instructions) 89.00 Reasonable inpatient routin		,						78.00
81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Reasonable inpatient routine service costs (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 87.00 Reasonable inpatient routine service cost limitation 88.00 Reasonable inpatient routine service costs (see instructions) 88.00 Reasonable inpatient routine service costs (see instructions) 88.00 Reasonable inpatient routine service cost limitation 89.00 Reasonable inpatient routine service costs (see instructions) 89.00 Reasonable inpatient routine s		00 0				nue line 70)		79.00
82.00 Inpatient routine service cost limitation (line 9 x line 81) 82.00 83.00 Reasonable inpatient routine service costs (see instructions) 83.00 84.00 Program inpatient ancillary services (see instructions) 84.00 85.00 Utilization review - physician compensation (see instructions) 85.00 Total Program inpatient operating costs (sum of lines 83 through 85) 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 87.00 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 0.00 88.00				ost iiiiii täti 0	ii (iiile /8 Mi	nus IIIIe /9)		80.00
84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Representation of the servation of the servatio	82.00	Inpatient routine service cost limitation (ine 9 x line 81	•				82.00
85.00 Utilization review - physician compensation (see instructions) 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Representation review - physician compensation (see instructions) 88.00 Beautiful Zation review - physician compensation (see instructions) 88.00 Representation (see instructions)		1		ns)				83.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)		1 -		ons)				85.00
87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 87.00 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0 88.00 0		Total Program inpatient operating costs (sum	of lines 83 th					86.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 0.00 88.00	87 NN						0	87 00
89.00 Observation bed cost (line 87 x line 88) (see instructions) 0 89.00	88. 00	Adjusted general inpatient routine cost per	diem (line 27 ÷				0.00	88. 00
	89. 00	Observation bed cost (line 87 x line 88) (see	e instructions)	ı			0	89.00

Health Financial Systems	ST. FRANCIS HOSPI	TAL & HEALTH CEN	ITER	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der C		Peri od:	Worksheet D-1	
		Component		From 01/01/2020 To 12/31/2020		
		Ti tl	e XIX	Subprovi der - I RF	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
cost center bescription	0031	(from line	col umn 2	Observati on	Bed Pass	
		21)	COLUMNIA	Bed Cost	Through Cost	
		217		(from line	(col. 3 x	
				89)	col. 4) (see	
				,	instructions)	
	1. 00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THR	OUGH COST	<u>'</u>				
90. 00 Capi tal -rel ated cost	1, 123, 30	05 8, 237, 029	0. 13637	3 0	0	90.00
91.00 Nursing School cost		0 8, 237, 029	0. 00000	0	0	91.00
92.00 Allied health cost		0 8, 237, 029	0. 00000	0	0	92.00
93.00 All other Medical Education		0 8, 237, 029	0. 00000	0	0	93.00

Health Financial Systems ST. FRANCIS HOSP	ITAL & HEALTH CENTER		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der CCN: 15		Period: From 01/01/2020 To 12/31/2020	Worksheet D-3 Date/Time Pre	
				3/30/2021 10:	
	Title XVII		Hospi tal	PPS	
Cost Center Description		o of Cost		I npati ent	
	То	Charges	Program	Program Costs	
			Charges	(col. 1 x	
				col . 2)	
LANDATI FAIT DOUTLAND OFFICE COOK OFFITEDO		1. 00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS			15 110 705		
30. 00 03000 ADULTS & PEDI ATRI CS			45, 113, 725		30.00
31. 00 03100 INTENSI VE CARE UNI T			11, 957, 052		31.00
31. 01 02060 NEONATAL NTENSI VE CARE UNIT			10 0/4 540		31.01
32. 00 03200 CORONARY CARE UNIT			12, 061, 518		32.00
34. 00 03400 SURGI CAL I NTENSI VE CARE UNI T			8, 208, 874		34.00
41. 00 04100 SUBPROVI DER - RF			0		41.00
43. 00 O4300 NURSERY ANCI LLARY SERVI CE COST CENTERS					43.00
50. 00 O5000 OPERATING ROOM		0. 13469	4 43, 621, 216	5, 875, 516	E0 00
52. 00 05200 DELI VERY ROOM & LABOR ROOM		0. 13469	· · ·		
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 19102		2, 957, 256	
55. 00 05500 RADI OLOGY-THERAPEUTI C		0. 12096	· · ·	2, 937, 230	55.00
56. 00 05600 RADI OI SOTOPE		0. 20707		166, 376	56.00
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 04800		830, 616	
60. 00 06000 LABORATORY		0. 11551		4, 648, 314	
64. 00 06400 I NTRAVENOUS THERAPY		0. 17678		201, 949	
65. 00 06500 RESPIRATORY THERAPY		0. 20656		· ·	
66. 00 06600 PHYSI CAL THERAPY		0. 27358		1, 546, 146	
67. 00 06700 OCCUPATI ONAL THERAPY		0. 17017			
68. 00 06800 SPEECH PATHOLOGY		0. 17945		229, 513	
69. 00 06900 ELECTROCARDI OLOGY		0. 11561		· ·	
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 16241		·	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 24670			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	ļ	0. 22978	8 33, 231, 644	7, 636, 233	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	ļ	0. 19266	1 43, 732, 002	8, 425, 451	73.00
74 00 07400 DENAL DIALVOLO		0 04040	0 450 004	(70 045	74.00

0. 213136

0. 430075

0.830027

1.115786

0. 232323

0.071588

0. 268411

3, 159, 086

52, 166

90, 847

13, 115

50, 428

27, 893, 183

2, 768, 958

323, 182, 433

323, 182, 433

74.00

76. 97

90.00

90.01

90.05

91.00

92.00

201.00

202.00

673, 315

22, 435

75, 405

14, 634

11, 716

1, 996, 817

743, 219

51, 791, 355 200. 00

74. 00 07400 RENAL DIALYSIS 76. 97 07697 CARDIAC REHABILITATION

90. 01 | 09001 | I BMT | JOI NT | VENTURE 90. 05 | 09005 | CV | DI AGNOSTI C | SERVI CES

09000 CLI NI C

09100 EMERGENCY

90.00

91.00

200.00

201.00

202.00

OUTPATIENT SERVICE COST CENTERS

92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART

Net charges (line 200 minus line 201)

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

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

Heal th	Financial Systems ST. FRANCIS HOSPITAL	& HFALTH CFN	ITFR	In Lie	u of Form CMS-:	2552-10
	ENT ANCILLARY SERVICE COST APPORTIONMENT		CN: 15-0162	Peri od:	Worksheet D-3	
	ZIV PRIOREZIANI GENTIGE GOOT PRI GIVIT GIAMENT			From 01/01/2020 To 12/31/2020		
		· ·	CCN: 15-T162		3/30/2021 10:	
		Titl€	e XVIII	Subprovi der – I RF	PPS	
	Cost Center Description	<u> </u>	Ratio of Cos	t Inpatient	I npati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x	
					col . 2)	
			1.00	2. 00	3. 00	
00.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS					00.00
30.00	03000 ADULTS & PEDIATRICS			0		30.00
31.00	03100 INTENSIVE CARE UNIT			0		31.00
31. 01	02060 NEONATAL INTENSIVE CARE UNIT			0		31. 01
32. 00 34. 00	03200 CORONARY CARE UNIT 03400 SURGI CAL I NTENSI VE CARE UNIT			0		32.00 34.00
41. 00	04100 SUBPROVI DER – I RF			5, 929, 744		41.00
	04300 NURSERY			5, 929, 744		43.00
43.00	ANCI LLARY SERVI CE COST CENTERS					43.00
50.00	05000 OPERATING ROOM		0. 1346	94 29, 550	3, 980	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM		0. 1916	·	3, 700	52.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C		0. 0983		33, 501	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C		0. 1209		0 33, 301	1
56.00	05600 RADI OI SOTOPE		0. 2070		757	56.00
59. 00	05900 CARDI AC CATHETERI ZATI ON		0. 0480		0	1
60.00	06000 LABORATORY		0. 1155		76, 235	1
64.00	06400 I NTRAVENOUS THERAPY		0. 1767		0	64.00
65.00	06500 RESPI RATORY THERAPY		0. 2065	62 402, 339	83, 108	65.00
66.00	06600 PHYSI CAL THERAPY		0. 2735	86 1, 546, 066	422, 982	66.00
67.00	06700 OCCUPATI ONAL THERAPY		0. 1701	78 1, 400, 444	238, 325	67.00
68.00	06800 SPEECH PATHOLOGY		0. 1794	58 694, 918	124, 709	68.00
69.00	06900 ELECTROCARDI OLOGY		0. 1156	18 23, 769	2, 748	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY		0. 1624	11 28, 159	4, 573	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 2467	·		1
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		0. 2297		198	
73.00	07300 DRUGS CHARGED TO PATIENTS		0. 1926	·	103, 970	1
74.00	07400 RENAL DI ALYSI S		0. 2131	·	22, 441	74.00
76. 97	07697 CARDI AC REHABI LI TATI ON		0. 4300	75 0	0	76. 97
	OUTPATIENT SERVICE COST CENTERS				_	
90.00	09000 CLINI C		0. 8300		0	
90. 01	09001 I BMT JOI NT VENTURE		1. 1157		0	
90.05	09005 CV DI AGNOSTI C SERVI CES		0. 2323		0	
91. 00 92. 00	O9100		0. 0715 0. 2684		0	91.00 92.00
92. 00 200. 00	1		0. 2684		1	
200.00		s (line 61)		6, 608, 898	1, 323, 140	200.00
201.00		3 (1116 01)		6, 608, 898		201.00
202.00	inet charges (Title 200 millios Title 201)		I	0, 000, 070	I	1202.00

Health Financial Systems	ST. FRANCIS HOSPITAL	_ & HEALTH CENTER	In Lie	u of Form CMS-2552-10
INPATIENT ANCILLARY SERVICE COST APPO	RTI ONMENT	Provider CCN: 15-0162	Peri od: From 01/01/2020	Worksheet D-3
			To 12/31/2020	Date/Time Prepared: 3/30/2021 10:40 am
		T1 11 1/11/		200

			From 01/01/2020	5 . (7) 5	
			To 12/31/2020	Date/Time Pre 3/30/2021 10:	pared:
		Title XIX	Hospi tal	PPS	40 alli
	Cost Center Description	Ratio of Cos		Inpatient	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x	
			3.1	col . 2)	
		1.00	2.00	3. 00	
I	NPATIENT ROUTINE SERVICE COST CENTERS				
30.00 0	3000 ADULTS & PEDIATRICS		21, 281, 223		30.00
31.00 0	3100 INTENSIVE CARE UNIT		4, 895, 836		31.00
31. 01 0	2060 NEONATAL INTENSIVE CARE UNIT		10, 196, 322		31.01
32.00 0	3200 CORONARY CARE UNIT		2, 262, 889		32.00
34.00 0	3400 SURGICAL INTENSIVE CARE UNIT		1, 980, 881		34.00
41.00 0	4100 SUBPROVI DER - I RF		0		41.00
43.00 0	4300 NURSERY		3, 152, 325		43.00
A	NCILLARY SERVICE COST CENTERS				
	5000 OPERATING ROOM	0. 1346	94 13, 276, 856	1, 788, 313	50.00
52.00 0	5200 DELIVERY ROOM & LABOR ROOM	0. 1916	21 11, 282, 631	2, 161, 989	52.00
54.00 0	5400 RADI OLOGY-DI AGNOSTI C	0. 0983	9, 516, 862	935, 527	54.00
55.00 0	5500 RADI OLOGY-THERAPEUTI C	0. 1209	66 0	0	55.00
56.00 0	5600 RADI OI SOTOPE	0. 2070	72 155, 873	32, 277	56.00
59.00 0	5900 CARDI AC CATHETERI ZATI ON	0. 0480	3, 054, 824	146, 644	59.00
	6000 LABORATORY	0. 1155	14 15, 028, 810	1, 736, 038	60.00
	6400 I NTRAVENOUS THERAPY	0. 1767	548, 884	97, 034	64.00
	6500 RESPI RATORY THERAPY	0. 2065	5, 740, 252	1, 185, 718	65.00
66.00 0	6600 PHYSI CAL THERAPY	0. 2735	36 198, 046	54, 183	
	6700 OCCUPATI ONAL THERAPY	0. 1701	78 1, 014, 258	172, 604	67.00
	6800 SPEECH PATHOLOGY	0. 1794		51, 243	68.00
	6900 ELECTROCARDI OLOGY	0. 1156	· · ·		1
70.00 0	7000 ELECTROENCEPHALOGRAPHY	0. 1624	11 917, 860	149, 071	70.00
	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 2467		0	71.00
	7200 IMPL. DEV. CHARGED TO PATIENTS	0. 2297		0	72.00
	7300 DRUGS CHARGED TO PATIENTS	0. 1926	· · ·	3, 786, 198	73.00
	7400 RENAL DIALYSIS	0. 2131		0	74.00
	7697 CARDI AC REHABI LI TATI ON	0. 4300	75 8, 700	3, 742	76. 97
	UTPAȚI ENT SERVI CE COST CENTERS				
	9000 CLI NI C	0. 8300	27 138, 853	115, 252	90.00
	9001 I BMT JOINT VENTURE	1. 1157			90. 01
	9005 CV DI AGNOSTI C SERVI CES	0. 2323			
	9100 EMERGENCY	0. 0715			1
	9200 OBSERVATION BEDS (NON-DISTINCT PART	0. 2684		0	
200.00	Total (sum of lines 50 through 94 and 96 through 98)		91, 766, 738	13, 319, 460	1
201.00	Less PBP Clinic Laboratory Services-Program only charges	(line 61)	0		201. 00
202. 00	Net charges (line 200 minus line 201)	1	91, 766, 738		202. 00

	Financial Systems ST. FRANCIS HOSPITAL & ENT ANCILLARY SERVICE COST APPORTIONMENT		CN: 15-0162	Peri od:	u of Form CMS-2 Worksheet D-3	
INFAII	ENT ANGIELARI SERVICE COST AFFORTIONWENT	riovidei C	CN. 13-0102	From 01/01/2020	WOLKSHEET D-3	
			CCN: 15-T162	To 12/31/2020	3/30/2021 10:	pared: 40 am
		Ti tl	e XIX	Subprovi der - I RF	PPS	
	Cost Center Description		Ratio of Cos		I npati ent	
			To Charges	Program	Program Costs	
				Charges	(col . 1 x	
			1.00	0.00	col . 2)	
	INDATIONS DOUBLING CODY OF COCT CENTERS		1.00	2. 00	3. 00	
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS			0		30.00
30.00	03100 INTENSIVE CARE UNIT			0		31.00
31.00	02060 NEONATAL INTENSIVE CARE UNIT			0		31.00
32.00	03200 CORONARY CARE UNIT			0		32.00
34.00	03400 SURGI CAL INTENSI VE CARE UNI T			0		34.00
41.00	04100 SUBPROVI DER - I RF			1, 675, 584		41.00
43.00	04300 NURSERY			1, 073, 304		43.00
43.00	ANCI LLARY SERVI CE COST CENTERS			<u> </u>		43.00
50.00	05000 OPERATI NG ROOM		0. 1346	94 232, 719	31, 346	50.00
	05200 DELIVERY ROOM & LABOR ROOM		0. 1916		01,010	1
54.00	05400 RADI OLOGY-DI AGNOSTI C		0. 0983		14, 602	
55.00	05500 RADI OLOGY-THERAPEUTI C		0. 1209		0	1
56. 00	05600 RADI OI SOTOPE		0. 2070		3, 862	
59.00	05900 CARDI AC CATHETERI ZATI ON		0. 0480		0	1
60.00	06000 LABORATORY		0. 1155		38, 160	60.00
64.00	06400 I NTRAVENOUS THERAPY		0. 1767		4, 112	64.00
65.00	06500 RESPI RATORY THERAPY		0. 2065	62 86, 035	17, 772	65.00
66.00	06600 PHYSI CAL THERAPY		0. 2735	86 1, 132, 955	309, 961	66.00
67.00	06700 OCCUPATI ONAL THERAPY		0. 1701	78 14, 140	2, 406	67.00
68.00	06800 SPEECH PATHOLOGY		0. 1794	58 14, 483	2, 599	68.00
69. 00	06900 ELECTROCARDI OLOGY		0. 1156	18 23, 432	2, 709	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY		0. 1624	11 50, 463	8, 196	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 2467		19, 823	1
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS		0. 2297		67, 418	
	07300 DRUGS CHARGED TO PATIENTS		0. 1926		92, 439	1
74. 00	07400 RENAL DI ALYSI S		0. 2131		0	
76. 97	07697 CARDI AC REHABI LI TATI ON		0. 4300	75 0	0	76. 97
	OUTPATIENT SERVICE COST CENTERS					
	09000 CLINIC		0. 8300		18, 080	
90. 01	09001 I BMT JOI NT VENTURE		1. 1157		0	
90.05	09005 CV DI AGNOSTI C SERVI CES		0. 2323		0	
91.00	09100 EMERGENCY		0. 0715		0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 2684		(22,405	
200.00	Total (sum of lines 50 through 94 and 96 through 98) Less PBP Clinic Laboratory Services-Program only charges	(lino 41)		2, 950, 352	633, 485	200.00
201. 00 202. 00		(TITIE 61)		2, 950, 352		201.00
2U2. UU			1	2, 900, 352		12U2. UU

Heal th	Financial Systems ST. FRANCIS HOSPITAL & HEAL	_TH CENTER	In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT Prov	1	Period: From 01/01/2020 To 12/31/2020	Date/Time Pre	pared:
		Title XVIII	Hospi tal	3/30/2021 10: PPS	40 am_
			Before GEO	On/After GEO	
			Recl ass	Recl ass	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		1. 00	1. 01	
1. 00	DRG Amounts Other than Outlier Payments		0	0	1. 00
1. 01	DRG amounts other than outlier payments for discharges occurring p	rior to October 1	55, 125, 858	0	1. 01
	(see instructions)				
1. 02	DRG amounts other than outlier payments for discharges occurring o (see instructions)	n or after October 1	9, 580, 256	11, 325, 990	1. 02
1. 03	DRG for federal specific operating payment for Model 4 BPCI for di	scharges occurring	0	0	1. 03
	prior to October 1 (see instructions)	o o			
1. 04	DRG for federal specific operating payment for Model 4 BPCI for di	scharges occurring	0	0	1. 04
2. 00	on or after October 1 (see instructions) Outlier payments for discharges. (see instructions)				2. 00
2. 01	Outlier reconciliation amount		0	0	2. 01
2. 02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0	0	2. 02
2. 03	Outlier payments for discharges occurring prior to October 1 (see Outlier payments for discharges occurring on or after October 1 (s		2, 486, 555	421 042	2.03
2. 04 3. 00	Managed Care Simulated Payments	ee mstructions)	580, 277 38, 677, 035	431, 062 7, 121, 964	2. 04 3. 00
4. 00	Bed days available divided by number of days in the cost reporting	period (see	471. 26	7, 121, 701	4.00
	instructions)				
5. 00	Indirect Medical Education Adjustment FTE count for allopathic and osteopathic programs for the most rec	ont cost reporting	17. 43		5. 00
3.00	period ending on or before 12/31/1996. (see instructions)	ent cost reporting	17. 43		3.00
6.00	FTE count for allopathic and osteopathic programs that meet the cr	iteria for an add-or	0.00		6. 00
7 00	to the cap for new programs in accordance with 42 CFR 413.79(e)	. 42 CED	0.33		7.00
7. 00	MMA Section 422 reduction amount to the IME cap as specified under $\$412.105(f)(1)(iv)(B)(1)$	42 CFR	0. 32		7. 00
7. 01	ACA § 5503 reduction amount to the IME cap as specified under 42 C	:FR	0.00		7. 01
	\$412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011	then see			
8. 00	instructions. Adjustment (increase or decrease) to the ETE count for all enables	and actoonathic	-0. 05		8. 00
6.00	Adjustment (increase or decrease) to the FTE count for allopathic programs for affiliated programs in accordance with 42 CFR 413.75(-0.05		6.00
	413.79(c)(2)(i v), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (Aug				
8. 01	The amount of increase if the hospital was awarded FTE cap slots u	inder § 5503 of the	0. 81		8. 01
8. 02	ACA. If the cost report straddles July 1, 2011, see instructions. The amount of increase if the hospital was awarded FTE cap slots f	rom a closed	0.00		8. 02
0.02	teaching hospital under § 5506 of ACA. (see instructions)	Tom a crosca	0.00		0.02
9. 00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8	, 8,01 and 8,02)	17. 87		9. 00
10. 00	(see instructions) FTE count for allopathic and osteopathic programs in the current y	your from your	24. 01		10. 00
10.00	records	ear from your	24.01		10.00
11. 00	FTE count for residents in dental and podiatric programs.		0.00		11.00
12.00	Current year allowable FTE (see instructions)		17. 87		12.00
13. 00 14. 00	Total allowable FTE count for the prior year. Total allowable FTE count for the penultimate year if that year en	ided on or after	22. 68 17. 14		13. 00 14. 00
14.00	September 30, 1997, otherwise enter zero.	aca on or arter	17.14		14.00
15.00	Sum of lines 12 through 14 divided by 3.		19. 23		15.00
16.00	Adjustment for residents in initial years of the program		0.00		16.00
17. 00 18. 00	Adjustment for residents displaced by program or hospital closure Adjusted rolling average FTE count		0. 00 19. 23		17. 00 18. 00
19. 00	Current year resident to bed ratio (line 18 divided by line 4).		0. 040806		19.00
20.00	Prior year resident to bed ratio (see instructions)		0. 042470		20.00
21. 00 22. 00	Enter the lesser of lines 19 or 20 (see instructions)		0.040806	249, 693	21. 00 22. 00
22. 00	IME payment adjustment (see instructions) IME payment adjustment - Managed Care (see instructions)		1, 426, 511 852, 674	157, 011	22. 00
	Indirect Medical Education Adjustment for the Add-on for § 422 of	the MMA	332,31.		
23. 00	Number of additional allopathic and osteopathic IME FTE resident c	ap slots under 42	0.00		23.00
24. 00	CFR 412.105 (f)(1)(iv)(C). IME FTE Resident Count Over Cap (see instructions)		6. 14		24. 00
	If the amount on line 24 is greater than -0-, then enter the lower	of line 23 or line	0.00		25. 00
	24 (see instructions)				
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000		26.00
27. 00 28. 00	IME payments adjustment factor. (see instructions) IME add-on adjustment amount (see instructions)		0.000000	0	27. 00 28. 00
28. 01	IME add-on adjustment amount - Managed Care (see instructions)		Ö	0	28. 01
29. 00	Total IME payment (sum of lines 22 and 28)		1, 426, 511	249, 693	
29. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		852, 674	157, 011	29. 01
30. 00	Disproportionate Share Adjustment Percentage of SSI recipient patient days to Medicare Part A patien	it days (see	3.09		30. 00
	instructions)		3.37		
31.00	Percentage of Medicaid patient days (see instructions)		19. 87		31.00
32. 00 33. 00	Sum of lines 30 and 31 Allowable disproportionate share percentage (see instructions)		22. 96 8. 16	۸ ۱۸	32. 00 33. 00
	Disproportionate share adjustment (see instructions)		1, 320, 005	231, 050	
	, , , , , , , , , , , , , , , , , , ,		,	, 230	

	Financial Systems ST. FRANCIS HOSPITAL & ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0162	Peri od:	u of Form CMS-2 Worksheet E	
			From 01/01/2020 To 12/31/2020	Date/Time Pre	
		Title XVIII	Hospi tal	3/30/2021 10: PPS	40 c
			Prior to 10/1		
			1.00	2. 00	
00	Uncompensated Care Adjustment		0.050.500.007	0 000 014 501	١٠٠
. 00	Total uncompensated care amount (see instructions) Factor 3 (see instructions)		0. 000896187	8, 290, 014, 521 0. 001080121	35.
. 02	Hospital uncompensated care payment (If line 34 is zero, ente	er zero on this line) (s		l e	
. 02	instructions)		7, 100, 077	0,701,210	00.
. 03	Pro rata share of the hospital uncompensated care payment amo		5, 602, 552	2, 256, 955	35.
. 00	Total uncompensated care (sum of columns 1 and 2 on line 35.0		7, 859, 507		36.
. 00	Additional payment for high percentage of ESRD beneficiary di Total Medicare discharges, excluding MS-DRGs 652, 682, 683, 6		ugn 46)		40.
. 00	instructions)	304 and 003. (See			40.
			Before GEO	On/After GEO	
			Recl ass	Recl ass	
	Tatal FCDD Madianas di adendara avaludi as MC DDCa (F2 (02 (02 (04 == (05 (===	1.00	1. 01	41
. 00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 6 instructions)	583, 684 an 685. (See	0	0	41.
. 01	·	DRGs 652, 682, 683, 68	4 0	0	41
	an 685. (see instructions)	, , , , , , , , , , , , , , , , , , , ,			
. 00	Divide line 41 by line 40 (if less than 10%, you do not quali	3	0.00		42
. 00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 68	32, 683, 684 an 685. (se	9 0		43
. 00	instructions) Ratio of average length of stay to one week (line 43 divided	by line 41 divided by 7	0. 000000		44
. 00	days)	by Time 41 di vided by 7	0.00000		
. 00	Average weekly cost for dialysis treatments (see instructions	5)	0.00	0.00	45
00	Total additional payment (line 45 times line 44 times line 41	. 01)	0		46
00	Subtotal (see instructions)		77, 326, 738	l	
. 00	Hospital specific payments (to be completed by SCH and MDH, sonly. (see instructions)	smaii rurai nospitais	0	0	48
	only. (See That dottons)			Amount	
				1. 00	
.00	Total payment for inpatient operating costs (see instructions			91, 626, 449	
.00	Payment for inpatient program capital (from Wkst. L, Pt. I an)	6, 855, 539	50 51
00	Exception payment for inpatient program capital (Wkst. L, Pt. Direct graduate medical education payment (from Wkst. E-4, Ii			0 805, 359	
00	Nursing and Allied Health Managed Care payment	THE 47 SEE THISTITUE HOUSE		165, 142	
00	Special add-on payments for new technologies			169, 754	
01	Islet isolation add-on payment			0	54
	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 6	9)		0	55
					I
00	Cost of physicians' services in a teaching hospital (see intr	ructions)	through 2E)	0	
00 00	Routine service other pass through costs (from Wkst. D, Pt. I	ructions) II, column 9, lines 30	through 35).	0	57
00 00 00	Routine service other pass through costs (from Wkst. D, Pt. I Ancillary service other pass through costs from Wkst. D, Pt.	ructions) II, column 9, lines 30	through 35).	0 208, 434	57 58
00 00 00 00 00	Routine service other pass through costs (from Wkst. D, Pt. I	ructions) II, column 9, lines 30	through 35).	0	57 58 59
00 00 00 00 00 00	Routine service other pass through costs (from Wkst. D, Pt. I Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus	ructions) II, column 9, lines 30 IV, col. 11 line 200)	through 35).	0 208, 434 99, 830, 677 14, 948 99, 815, 729	57 58 59 60 61
00 00 00 00 00 00 00	Routine service other pass through costs (from Wkst. D, Pt. I Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries	ructions) II, column 9, lines 30 IV, col. 11 line 200)	through 35).	0 208, 434 99, 830, 677 14, 948 99, 815, 729 6, 299, 744	57 58 59 60 61 62
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Routine service other pass through costs (from Wkst. D, Pt. I Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries	ructions) II, column 9, lines 30 IV, col. 11 line 200)	through 35).	0 208, 434 99, 830, 677 14, 948 99, 815, 729 6, 299, 744 254, 848	57 58 59 60 61 62 63
00 00 00 00 00 00 00	Routine service other pass through costs (from Wkst. D, Pt. I Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions)	ructions) II, column 9, lines 30 IV, col. 11 line 200)	through 35).	0 208, 434 99, 830, 677 14, 948 99, 815, 729 6, 299, 744 254, 848 444, 119	57 58 59 60 61 62 63 64
00 00 00 00 00 00 00 00	Routine service other pass through costs (from Wkst. D, Pt. I Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments 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)	ructions) II, column 9, lines 30 IV, col. 11 line 200) S line 60)	through 35).	0 208, 434 99, 830, 677 14, 948 99, 815, 729 6, 299, 744 254, 848 444, 119 288, 677	57 58 59 60 61 62 63 64 65
00 00 00 00 00 00 00 00 00	Routine service other pass through costs (from Wkst. D, Pt. I Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions)	ructions) II, column 9, lines 30 IV, col. 11 line 200) S line 60)	through 35).	0 208, 434 99, 830, 677 14, 948 99, 815, 729 6, 299, 744 254, 848 444, 119	57 58 59 60 61 62 63 64 65
00 00 00 00 00 00 00 00 00 00	Routine service other pass through costs (from Wkst. D, Pt. I Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments 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 inst	ructions) II, column 9, lines 30 IV, col. 11 line 200) S line 60)	J ,	0 208, 434 99, 830, 677 14, 948 99, 815, 729 6, 299, 744 254, 848 444, 119 288, 677 139, 325 93, 549, 814	57 58 59 60 61 62 63 64 65 66
00 00 00 00 00 00 00 00 00 00 00	Routine service other pass through costs (from Wkst. D, Pt. I Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments 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 inst Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96).	ructions) II, column 9, lines 30 IV, col. 11 line 200) S line 60) Cructions) applicable to MS-DRGs (see instructions)	0 208, 434 99, 830, 677 14, 948 99, 815, 729 6, 299, 744 254, 848 444, 119 288, 677 139, 325 93, 549, 814 0	57 58 59 60 61 62 63 64 65 66 67
00 00 00 00 00 00 00 00 00 00 00 00 00	Routine service other pass through costs (from Wkst. D, Pt. I Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments 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 inst Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96). OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	ructions) II, column 9, lines 30 IV, col. 11 line 200) S line 60) Tructions) applicable to MS-DRGs ((For SCH see instructio	see instructions) ns)	0 208, 434 99, 830, 677 14, 948 99, 815, 729 6, 299, 744 254, 848 444, 119 288, 677 139, 325 93, 549, 814 0 0	577 588 599 600 611 622 633 644 655 666 677 688
00 00 00 00 00 00 00 00 00 00 00 00 00	Routine service other pass through costs (from Wkst. D, Pt. I Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments 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 inst Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96). OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demonst	ructions) II, column 9, lines 30 IV, col. 11 line 200) S line 60) Tructions) applicable to MS-DRGs ((For SCH see instructio	see instructions) ns)	0 208, 434 99, 830, 677 14, 948 99, 815, 729 6, 299, 744 254, 848 444, 119 288, 677 139, 325 93, 549, 814 0 0	577 588 599 600 611 622 633 644 655 666 677 688 699 700
00 00 00 00 00 00 00 00 00 00 00 00 00	Routine service other pass through costs (from Wkst. D, Pt. I Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments 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 inst Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96). OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demonst Demonstration payment adjustment amount before sequestration	ructions) II, column 9, lines 30 IV, col. 11 line 200) S line 60) Tructions) applicable to MS-DRGs ((For SCH see instructio	see instructions) ns)	0 208, 434 99, 830, 677 14, 948 99, 815, 729 6, 299, 744 254, 848 444, 119 288, 677 139, 325 93, 549, 814 0 0	575 586 599 600 611 622 633 644 655 666 677 700 700
00 00 00 00 00 00 00 00 00 00 00 00 00	Routine service other pass through costs (from Wkst. D, Pt. I Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments 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 inst Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96). OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demonst Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only)	ructions) II, column 9, lines 30 IV, col. 11 line 200) S line 60) ructions) applicable to MS-DRGs ((For SCH see instruction) ration) adjustment (see	see instructions) ns)	0 208, 434 99, 830, 677 14, 948 99, 815, 729 6, 299, 744 254, 848 444, 119 288, 677 139, 325 93, 549, 814 0 0	575 586 596 616 626 636 646 676 686 6970 7070
00 00 00 00 00 00 00 00 00 00 00 00 00	Routine service other pass through costs (from Wkst. D, Pt. I Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments 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 inst Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96). OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demonst Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see inst	ructions) II, column 9, lines 30 IV, col. 11 line 200) S line 60) ructions) applicable to MS-DRGs ((For SCH see instruction) ration) adjustment (see	see instructions) ns)	0 208, 434 99, 830, 677 14, 948 99, 815, 729 6, 299, 744 254, 848 444, 119 288, 677 139, 325 93, 549, 814 0 0	57 58 59 60 61 62 63 64 65 66 67 68 69 70 70 70
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Routine service other pass through costs (from Wkst. D, Pt. I Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments 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 inst Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96). OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demonst Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only)	ructions) II, column 9, lines 30 IV, col. 11 line 200) S line 60) ructions) applicable to MS-DRGs ((For SCH see instruction) ration) adjustment (see	see instructions) ns)	0 208, 434 99, 830, 677 14, 948 99, 815, 729 6, 299, 744 254, 848 444, 119 288, 677 139, 325 93, 549, 814 0 0	575 586 599 600 611 622 633 644 655 666 677 700 700 700 700
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Routine service other pass through costs (from Wkst. D, Pt. I Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments 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 inst Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96). OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demonst Demonstration 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) II, column 9, lines 30 IV, col. 11 line 200) S line 60) ructions) applicable to MS-DRGs ((For SCH see instructions) ration) adjustment (see	see instructions) ns)	0 208, 434 99, 830, 677 14, 948 99, 815, 729 6, 299, 744 254, 848 444, 119 288, 677 139, 325 93, 549, 814 0 0 0	59 600 611 622 633 644 655 666 677 700 700 700 700 700 700
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Routine service other pass through costs (from Wkst. D, Pt. I Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments 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 inst Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96). OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demonst Demonstration 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) II, column 9, lines 30 IV, col. 11 line 200) S line 60) ructions) applicable to MS-DRGs ((For SCH see instructions) ration) adjustment (see	see instructions) ns)	0 208, 434 99, 830, 677 14, 948 99, 815, 729 6, 299, 744 254, 848 444, 119 288, 677 139, 325 93, 549, 814 0 0 0	577 588 599 600 611 622 633 644 655 666 677 700 700 700 700 700 700 700 700

Health Financial Systems	ST. FRANCIS HOSPITAL 8	HEALTH CENTER	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0162	Peri od: From 01/01/2020 To 12/31/2020	Worksheet E Part A Date/Time Prepared: 3/30/2021 10:40 am
		T		222

				From 01/01/2020 To 12/31/2020	Part A Date/Time Pre 3/30/2021 10:	
		Title	XVIII	Hospi tal	PPS	
			FFY	(yyyy)	Amount	
				0	1. 00	
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter i	n column 0		0	0	70. 96
70. 97	the corresponding federal year for the period prior to 10/1) Low volume adjustment for federal fiscal year (yyyy) (Enter i			0	0	70. 97
70. 98	the corresponding federal year for the period ending on or af Low Volume Payment-3	tei 10/1)			0	70. 98
70. 99	HAC adjustment amount (see instructions)				1, 101, 604	
71. 00	Amount due provider (line 67 minus lines 68 plus/minus lines	69 & 70)			92, 115, 258	
71. 01	Sequestration adjustment (see instructions)				607, 961	
71. 02	Demonstration payment adjustment amount after sequestration				0	71. 02
71. 03	Sequestration adjustment-PARHM pass-throughs					71.03
72.00	Interim payments				90, 050, 273	
72. 01	Interim payments-PARHM					72. 01
73.00	Tentative settlement (for contractor use only)				0	
73. 01	Tentative settlement-PARHM (for contractor use only)	2 72			1 457 004	73. 01
74. 00	Balance due provider/program (line 71 minus lines 71.01, 71.0	2, 72, and			1, 457, 024	74. 00
74. 01	73) Balance due provider/program-PARHM (see instructions)					74. 01
75. 00	Protested amounts (nonallowable cost report items) in accorda	nce with			973, 211	
70.00	CMS Pub. 15-2, chapter 1, §115.2	nee wi tii			770,211	70.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)		•	'		
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum	of 2.03			0	90.00
	plus 2.04 (see instructions)					
91.00	Capital outlier from Wkst. L, Pt. I, line 2				0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instr				0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instruc				0	93.00
94. 00 95. 00	The rate used to calculate the time value of money (see instructions)	uctions)			0.00	94. 00 95. 00
	Time value of money for operating expenses (see instructions) Time value of money for capital related expenses (see instruc	tions)			0	96.00
70.00	Trine varies of morey for capital related expenses (see mistrue	11 0113)		Prior to 10/1		70.00
				1. 00	2. 00	
	UCD Development Association					
	HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)			0	0	100. 00
	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment					
101. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions)	,		0. 0000000000	0. 0000000000	101. 00
101. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction	s)			0. 0000000000	
101. 00 102. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment	s)		0. 0000000000	0. 0000000000	101. 00 102. 00
101. 00 102. 00 103. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions)			0. 0000000000	0. 000000000 0 0. 0000	101. 00 102. 00 103. 00
101. 00 102. 00 103. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions))	ustment	0. 0000000000	0. 000000000 0 0. 0000	101. 00 102. 00
101. 00 102. 00 103. 00 104. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction 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 Demonst) ration) Adju		0. 0000000000	0. 0000000000 0 0. 0000 0	101. 00 102. 00 103. 00 104. 00
101. 00 102. 00 103. 00 104. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions)) ration) Adju		0. 0000000000	0. 0000000000 0 0. 0000 0	101. 00 102. 00 103. 00
101. 00 102. 00 103. 00 104. 00 200. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction 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 Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement) ration) Adji riod under		0. 0000000000	0. 0000000000 0 0. 0000 0	101. 00 102. 00 103. 00 104. 00
101. 00 102. 00 103. 00 104. 00 200. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) RURA adjustment amount for HSP bonus payment (see instructions) RURA adjustment amount for HSP bonus payment (see instructions) RURA adjustment amount for HSP bonus payment (see instructions) RURA adjustment amount for HSP bonus payment (see instructions) RURA adjustment amount for HSP bonus payment (see instructions) RURA adjustment amount for HSP bonus payment (see instructions) RURA adjustment amount for HSP bonus payment (see instruction) RURA adjustment factor (see instructions) RURA adjustment fac) ration) Adji riod under		0. 0000000000	0. 0000000000 0 0. 0000 0	101. 00 102. 00 103. 00 104. 00 200. 00
101. 00 102. 00 103. 00 104. 00 200. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) RURA adjustment amount for HSP bonus payment (see instructions) RURA adjustment amount for HSP bonus payment (see instructions) RURA adjustment amount for HSP bonus payment (see instructions) RURA adjustment amount for HSP bonus payment (see instructions) RURA adjustment amount for HSP bonus payment (see instructions) RURA adjustment amount for HSP bonus payment (see instructions) HRR adjustment factor (see instructions)) ration) Adji riod under		0. 0000000000	0. 0000000000 0 0. 0000 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00
101. 00 102. 00 103. 00 104. 00 200. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction 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 Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions)) ration) Adju riod under e 49)	the 21st	0. 0000000000 0 0. 0000 0	0. 000000000 0 0. 0000 0	101. 00 102. 00 103. 00 104. 00 200. 00
101. 00 102. 00 103. 00 104. 00 200. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction 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 Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in) ration) Adju riod under e 49)	the 21st	0. 0000000000 0 0. 0000 0	0. 000000000 0 0. 0000 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction 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 Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period)) ration) Adju riod under e 49)	the 21st	0. 0000000000 0 0. 0000 0	0. 0000000000 0 0. 0000 0 0. 0000	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction 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 Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount) ration) Adju riod under e 49)	the 21st	0. 0000000000 0 0. 0000 0	0. 0000000000 0 0. 0000 0 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction 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 Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period)) ration) Adju riod under e 49)	the 21st	0. 0000000000 0 0. 0000 0	0. 0000000000 0 0. 0000 0 tration	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction) HRB 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 Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204)) ration) Adju riod under e 49)	the 21st	0. 0000000000 0 0. 0000 0	0. 0000000000 0 0. 0000 0 tration	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction 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 Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in 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	ration) Adjuriod under e 49) first year	the 21st	0. 0000000000 0 0. 0000 0	0. 0000000000 0 0. 0000 0 0. tration	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00
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	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction 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 Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in 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 inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A,	ration) Adjuriod under e 49) first year	the 21st	0. 0000000000 0 0. 0000 0	0. 0000000000 0 0. 0000 0 o.	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
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	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction 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 Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in 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 inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions)	ration) Adjuriod under e 49) first year	the 21st	0. 0000000000 0 0. 0000 0	0. 0000000000 0 0. 0000 0 o.	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
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	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction 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 Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in 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 inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use	ration) Adjuriod under e 49) first year	the 21st	0. 0000000000 0 0. 0000 0	0. 0000000000 0 0. 0000 0 o. tration	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
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	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction 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 Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in 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 inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions)	ration) Adjuriod under e 49) first year	the 21st	0. 0000000000 0 0. 0000 0	0. 0000000000 0 0. 0000 0 o. tration	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
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. 00 211. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction) HRBR 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 Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in 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 inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement	ration) Adjuriod under e 49) first year ructions) line 59)	the 21st	0. 0000000000 0 0. 0000 0	0.0000000000 0 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. 00 211. 00
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	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction) 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 Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in 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 inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement Total adjustment to Medicare Part A IPPS payments (from line	ration) Adjuriod under e 49) first year ructions) line 59)	the 21st	0. 0000000000 0 0. 0000 0	0. 0000000000 0 0. 0000 0 tration	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
101. 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. 00 211. 00 213. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction) HRBR 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 Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in 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 inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare Part A IPPS payments (from line Low-volume adjustment (see instructions)	ration) Adjuriod under e 49) first year ructions) line 59)	of the curre	0. 0000000000 0 0. 0000 0	0. 0000000000 0 0. 0000 0 o.	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. 00 212. 00 213. 00
101. 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. 00 211. 00 213. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction) 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 Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in 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 inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement Total adjustment to Medicare Part A IPPS payments (from line	ration) Adjuriod under e 49) first year ructions) line 59)	of the curre	0. 0000000000 0 0. 0000 0	0. 0000000000 0 0. 0000 0 o.	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

Health Financial Systems	ST. FRANCIS HOSPITAL 8	k HEALTH CENTER	In Lieu	of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0162		Worksheet E Part B Date/Time Prepared: 3/30/2021 10:40 am

		3/30/2021 10:	40 am
	Title XVIII Hospital	PPS	
		1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	16, 197	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	52, 818, 609	2.00
3. 00 4. 00	OPPS payments Outlier payment (see instructions)	47, 959, 948 311, 190	3. 00 4. 00
4. 01	Outlier reconciliation amount (see instructions)	311, 170	4. 01
5. 00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6. 00	Line 2 times line 5	0	6.00
7. 00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7. 00
8. 00	Transitional corridor payment (see instructions)	0	8.00
9. 00 10. 00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200 Organ acquisitions	422, 592	9. 00 10. 00
	Total cost (sum of lines 1 and 10) (see instructions)	16, 197	
11.00	COMPUTATION OF LESSER OF COST OR CHARGES	10, 177	11.00
	Reasonable charges		
	Ancillary service charges	93, 786	12.00
	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14. 00	Total reasonable charges (sum of lines 12 and 13)	93, 786	14. 00
15. 00	Customary charges Aggregate amount actually collected from patients liable for payment for services on a charge basi	s 0	15. 00
	Amounts that would have been realized from patients liable for payment for services on a chargebas		16.00
10.00	had such payment been made in accordance with 42 CFR §413.13(e)		10.00
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
	Total customary charges (see instructions)	93, 786	18. 00
19. 00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see	77, 589	19. 00
20. 00	instructions) Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see	o	20.00
20.00	instructions)	ا	20.00
21. 00	Lesser of cost or charges (see instructions)	16, 197	21.00
	Interns and residents (see instructions)	0	22.00
23. 00	Cost of physicians' services in a teaching hospital (see instructions)	0	23. 00
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	48, 693, 730	24.00
05.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT	4 505	05.00
	Deductibles and coinsurance amounts (for CAH, see instructions) Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	1, 595 8, 314, 139	
	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see		
27.00	instructions)	10, 071, 170	27.00
28. 00	Direct graduate medical education payments (from Wkst. E-4, line 50)	402, 705	28. 00
	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29. 00
	Subtotal (sum of lines 27 through 29)	40, 796, 898	1
	Primary payer payments Subtotal (line 30 minus line 31)	5, 713 40, 791, 185	
32.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)	40, 791, 165	32.00
33. 00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
	Allowable bad debts (see instructions)	952, 364	
	Adjusted reimbursable bad debts (see instructions)	619, 037	
	Allowable bad debts for dual eligible beneficiaries (see instructions)	496, 843	
	Subtotal (see instructions)	41, 410, 222	
	MSP-LCC reconciliation amount from PS&R	208	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions)	١	39. 50
	Demonstration payment adjustment amount before sequestration	0	1
	Partial or full credits received from manufacturers for replaced devices (see instructions)	Ö	39. 98
	RECOVERY OF ACCELERATED DEPRECIATION	0	39. 99
	Subtotal (see instructions)	41, 410, 014	
	Sequestration adjustment (see instructions)	273, 306	
	Demonstration payment adjustment amount after sequestration Sequestration adjustment_PAPHM pass_throughs	0	40. 02 40. 03
	Sequestration adjustment-PARHM pass-throughs Interim payments	41, 270, 384	
	Interim payments-PARHM	41, 270, 304	41.01
	Tentative settlement (for contractors use only)	0	42.00
	Tentative settlement-PARHM (for contractor use only)		42. 01
	Balance due provider/program (see instructions)	-133, 676	
	Balance due provider/program-PARHM (see instructions)	_	43. 01
44. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	0	44.00
	§115. 2 TO BE COMPLETED BY CONTRACTOR		
			90.00
90.00		0	
	Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions)	0	
91. 00 92. 00	Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money	0 0.00	91. 00 92. 00
91. 00 92. 00 93. 00	Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions)	0 0. 00 0	91. 00 92. 00

Health Financial Systems	ST. FRANCIS HOSPITAL 8	HEALTH CENTER	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0162		Worksheet E
			From 01/01/2020	
		Component CCN: 15-T162	To 12/31/2020	
				3/30/2021 10:40 am
		Title XVIII	Subprovi der -	PPS

		litle XVIII	Subprovi der - I RF	PPS	
				1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
1.00	Medical and other services (see instructions)			204	1.00
2.00	Medical and other services reimbursed under OPPS (see instruction	ns)		0	2.00
3. 00 4. 00	OPPS payments Outlier payment (see instructions)			537 0	3. 00 4. 00
4. 00	Outlier reconciliation amount (see instructions)			0	4. 00
5. 00	Enter the hospital specific payment to cost ratio (see instructi	ons)		0. 000	5. 00
6.00	Line 2 times line 5			0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0. 00	7.00
8. 00 9. 00	Transitional corridor payment (see instructions)	col 12 lino 200		0	8. 00 9. 00
10.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, Organ acquisitions	COL. 13, TITIE 200		0	10.00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			204	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		,		
10.00	Reasonable charges			4 700	40.00
12. 00 13. 00	Ancillary service charges Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line	. 60)		1, 700	12. 00 13. 00
	Total reasonable charges (sum of lines 12 and 13)	, 07)		1, 700	
00	Customary charges			1,700	
15. 00	Aggregate amount actually collected from patients liable for pay		9	0	
16. 00	Amounts that would have been realized from patients liable for p	ayment for services o	on a chargebasis	0	16. 00
17. 00	had such payment been made in accordance with 42 CFR §413.13(e) Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	17. 00
	Total customary charges (see instructions)			1, 700	
19. 00	Excess of customary charges over reasonable cost (complete only	if line 18 exceeds li	ne 11) (see	1, 496	
20. 00	instructions) Excess of reasonable cost over customary charges (complete only	if line 11 exceeds li	no 19) (soo	0	20.00
	instructions)	TI TITIE TI EXCEEUS TI	116 10) (366	-	
21. 00	Lesser of cost or charges (see instructions)			204	
	Interns and residents (see instructions) Cost of physicians' services in a teaching hospital (see instruc	·tions)		0	22. 00 23. 00
	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	ti ons)		537	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)			0	25.00
	Deductibles and Coinsurance amounts relating to amount on line 2			0	26.00
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plu instructions)	is the sum of lines 22	and 23] (see	741	27. 00
28. 00	Direct graduate medical education payments (from Wkst. E-4, line	50)		0	28. 00
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)	•		0	29. 00
	Subtotal (sum of lines 27 through 29)			741	30.00
	Primary payer payments			0	31.00
32.00	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		741	32.00
33. 00	Composite rate ESRD (from Wkst. I-5, line 11))		0	33.00
	Allowable bad debts (see instructions)			0	34.00
	Adjusted reimbursable bad debts (see instructions)			0	35.00
	Allowable bad debts for dual eligible beneficiaries (see instruc	tions)		0	36.00
	Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R			741	37. 00 38. 00
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			o l	
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)				39. 50
39. 97	Demonstration payment adjustment amount before sequestration			0	
39. 98	Partial or full credits received from manufacturers for replaced	devices (see instruc	ctions)	0	39. 98
39. 99 40. 00	RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions)			0 741	39. 99 40. 00
	Sequestration adjustment (see instructions)			5	40.00
40. 02	Demonstration payment adjustment amount after sequestration			0	40. 02
	Sequestration adjustment-PARHM pass-throughs				40. 03
	Interim payments			764	
	Interim payments-PARHM Tentative settlement (for contractors use only)			0	41. 01 42. 00
42. 00	Tentative settlement (for contractors use only)			٥	42.00
43. 00	Balance due provider/program (see instructions)			-28	
43. 01	Balance due provider/program-PARHM (see instructions)			ļ	43. 01
44. 00	Protested amounts (nonallowable cost report items) in accordance §115.2	with CMS Pub. 15-2,	chapter 1,	0	44.00
	TO BE COMPLETED BY CONTRACTOR				
	Original outlier amount (see instructions)			0	
	Outlier reconciliation adjustment amount (see instructions)			0 00	
92.00	The rate used to calculate the Time Value of Money Time Value of Money (see instructions)			0.00	92. 00 93. 00
	Total (sum of lines 91 and 93)				94.00
	·		'	- 1	-

In Lieu of Form CMS-2552-10

| Period: | Worksheet E-1 |
| From 01/01/2020 | Part |
| To 12/31/2020 | Date/Time Prepared: 3/30/2021 10:40 am
 Heal th
 Financial
 Systems
 ST.
 FRANCIAL

 ANALYSIS
 OF
 PAYMENTS
 TO
 PROVIDERS
 FOR
 SERVICES
 RENDERED
 Provider CCN: 15-0162

					3/30/2021 10: 4	40 am
		Title	XVIII	Hospi tal	PPS	
		Inpatien	t Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1. 00	Total interim payments paid to provider		90, 050, 27	'3	41, 270, 384	1. 00
2. 00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none,			0	0	2. 00
3. 00	write "NONE" or enter a zero List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate					3. 00
	for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER			0	0	3. 01
3. 02				0	0	3. 02
3. 03				0	0	3. 03
3.04				0	0	3.04
3. 05	Decide to December 1			0	0	3. 05
2 50	Provider to Program ADJUSTMENTS TO PROGRAM			0	0	3. 50
3. 50 3. 51	ADJUSTMENTS TO PROGRAM			0		3. 50
3. 51				0		3. 52
3. 53				0		3. 53
3. 54				0	o o	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0	Ö	3. 99
4. 00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		90, 050, 27	73	41, 270, 384	4. 00
	TO BE COMPLETED BY CONTRACTOR					
5. 00	List separately each tentative settlement payment after 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 PROVIDER			0	0	5. 01
5. 02				0	0	5. 02
5. 03	Decide to December 1			0	0	5. 03
E E0	Provider to Program TENTATIVE TO PROGRAM			0	0	5. 50
5. 50 5. 51	TENTATIVE TO PROGRAM			0	0	5. 50
5. 51				0	0	5. 51
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	0	5. 99
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER		1, 457, 02	24	0	6. 01
6. 02	SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM		1,457,02	0	133, 676	6. 02
7. 00	Total Medicare program liability (see instructions)		91, 507, 29	07	41, 136, 708	7. 00
7.00	Total most out o program traditity (see this traditions)		1 71,507,27	Contractor Number	NPR Date (Mo/Day/Yr)	,.00
		()	1. 00	2. 00	
8. 00	Name of Contractor			., 00		8. 00
	i L				, ,	

Health Financial Systems	ST. FRANCIS HOSPITAL 8	k HEALTH CENTER	In Lieu	of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO PROVIDERS	FOR SERVICES RENDERED	Provider CCN: 15-0162	Peri od:	Worksheet E-1

| From 01/01/2020 | Part | From 01/01/2020 | Part |

		Title	XVIII	Subprovi der - I RF	PPS	
		Inpatien	t 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		4, 648, 399		764	1. 00
2.00	Interim payments payable on individual bills, either		0		0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3. 00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER		0		0	3. 01
3. 02	THE STATE OF THE THE TENT OF T		0		0	3. 02
3. 03			Ö		0	3. 03
3. 04			Ö		0	3. 04
3.05			0		0	3.05
	Provider to Program	•	•	•		
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3. 51			0		0	3.51
3. 52			0		0	3. 52
3. 53			0		0	3. 53
3. 54			0		0	3.54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		0		0	3. 99
4 00	3. 50-3. 98)		4 (40 200		7/4	4 00
4. 00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as		4, 648, 399		764	4. 00
	appropriate)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5.00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		0		0	5. 01
5. 02			0		0	5. 02
5. 03	Dec. 1 Lea Le Berrare		0		0	5. 03
E E0	Provi der to Program		0		1 0	E E0
5. 50 5. 51	TENTATI VE TO PROGRAM		0			5. 50 5. 51
5. 52						5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines					5. 99
0. 77	5. 50-5. 98)				Ĭ	0. , ,
6. 00	Determined net settlement amount (balance due) based on					6.00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		70, 850		0	6. 01
6. 02	SETTLEMENT TO PROGRAM		0		28	6. 02
7. 00	Total Medicare program liability (see instructions)		4, 719, 249		736	7.00
				Contractor	NPR Date	
			2	Number	(Mo/Day/Yr)	
8. 00	Name of Contractor)	1. 00	2. 00	8. 00
0.00	Invaline of collection	I		I	ı l	0.00

Heal th	Financial Systems ST. FRANCIS HOSPITAL	& HEALTH CENTER	In Lie	u of Form CMS-	2552-10
CALCUI	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0162	Peri od: From 01/01/2020 To 12/31/2020	Date/Time Pro	epared:
		Title XVIII	Hospi tal	3/30/2021 10: PPS	40 am_
		II the XVIII	поѕрі таі	PPS	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS			11.00	
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION	V			1
1.00	Total hospital discharges as defined in AARA §4102 from Wkst.	. S-3, Pt. I col. 15 lin	e 14		1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8	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	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 I				6. 00
7. 00	CAH only - The reasonable cost incurred for the purchase of colline 168	certified 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
	Balance due provider (line 8 (or line 10) minus line 30 and I	line 31) (see instructio	ns)		32.00

Health Financial Systems	ST. FRANCIS HOSPITAL	& HEALTH CENTER	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 15-0162	Peri od: From 01/01/2020	Worksheet E-3
		Component CCN: 15-T162		
		Title XVIII	Subprovi der -	PPS
			I RF	

	IRF		
	DADT LLL MEDICADE DADT A SERVICES LDE DDS	1. 00	
1. 00	PART III - MEDICARE PART A SERVICES - IRF PPS Net Federal PPS Payment (see instructions)	4, 493, 627	1.00
2. 00	Medicare SSI ratio (IRF PPS only) (see instructions)	0. 0309	2. 00
3. 00	Inpatient Rehabilitation LIP Payments (see instructions)	214, 795	3.00
4. 00	Outlier Payments	92, 166	4. 00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior	·	5.00
	to November 15, 2004 (see instructions)		
5. 01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0. 00	5. 01
6.00	New Teaching program adjustment. (see instructions)	0. 00	6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new	0.00	7.00
	teaching program" (see instructions)		
8. 00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)	0. 00	8. 00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0. 00	9.00
10. 00	Average Daily Census (see instructions)	15. 169399	
11. 00	Teaching Adjustment Factor (see instructions)	0. 000000	
12.00	Teaching Adjustment (see instructions)	0	12.00
13.00	Total PPS Payment (see instructions)	4, 800, 588	13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)	0	14.00
15. 00 16. 00	Organ acquisition (DO NOT USE THIS LINE) Cost of physicians' services in a teaching hospital (see instructions)	o	15. 00 16. 00
17. 00	Subtotal (see instructions)	4, 800, 588	
18. 00	Primary payer payments	19, 266	
19. 00	Subtotal (line 17 less line 18).	4, 781, 322	
20. 00		15, 488	
21.00	Subtotal (line 19 minus line 20)	4, 765, 834	
22.00	Coinsurance	17, 600	22.00
23.00	Subtotal (line 21 minus line 22)	4, 748, 234	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	0	24.00
25.00	Adjusted reimbursable bad debts (see instructions)	0	25.00
	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	26.00
27.00	Subtotal (sum of lines 23 and 25)	4, 748, 234	
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	28.00
30.00	Other pass through costs (see instructions) Outlier payments reconciliation	2, 369 0	29. 00 30. 00
31. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	31.00
31. 50	, , , , , ,	0	31.50
31. 99	Demonstration payment adjustment amount before sequestration	0	31. 99
32. 00	Total amount payable to the provider (see instructions)	4, 750, 603	
32. 01	Sequestration adjustment (see instructions)	31, 354	
32.02	Demonstration payment adjustment amount after sequestration	0	32.02
33.00	Interim payments	4, 648, 399	33.00
34.00	Tentative settlement (for contractor use only)	0	34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)	70, 850	35.00
36. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	0	36.00
	§115. 2 TO BE COMPLETED BY CONTRACTOR		
50 00	Original outlier amount from Wkst. E-3, Pt. III, line 4	92, 166	50.00
	Outlier reconciliation adjustment amount (see instructions)	92, 100	51.00
	The rate used to calculate the Time Value of Money	0. 00	52.00
	Time Value of Money (see instructions)		53.00
		-1	

Health Financial Systems	ST.	FRANCIS HOSPITAL 8	HEALTH CENTER	In Lieu	of Form CN	MS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT			Provi der CCN: 15-0162	01/01/2020	Worksheet Part VII Date/Time	

			o 12/31/2020	Date/Time Pre 3/30/2021 10:	pared: 40 am_
	Ti	tle XIX	Hospi tal	PPS	
			I npati ent	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FO	R TITLES V OR XI	X SERVICES		
	COMPUTATION OF NET COST OF COVERED SERVICES		_		
1.00	Inpatient hospital/SNF/NF services		0	_	1.00
2.00	Medical and other services			0	
3.00	Organ acquisition (certified transplant centers only)		0	0	3.00
4. 00	Subtotal (sum of lines 1, 2 and 3)		0	0	
5. 00 6. 00	Inpatient primary payer payments		0	0	5. 00 6. 00
7. 00	Outpatient primary payer payments Subtotal (line 4 less sum of lines 5 and 6)		0	0	1
7.00	COMPUTATION OF LESSER OF COST OR CHARGES			0	7.00
	Reasonable Charges				
8. 00	Routine service charges		0		8.00
9. 00	Ancillary service charges		91, 766, 738	0	1
10.00	Organ acquisition charges, net of revenue		0	_	10.00
11. 00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		91, 766, 738	0	12.00
	CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for service	s on a charge	0	0	13.00
	basis				
14. 00	Amounts that would have been realized from patients liable for payment		0	0	14. 00
	a charge basis had such payment been made in accordance with 42 CFR §4	13. 13(e)			
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0. 000000	1
16.00	Total customary charges (see instructions)	- 1/	91, 766, 738	0	•
17. 00	Excess of customary charges over reasonable cost (complete only if lin line 4) (see instructions)	e 16 exceeds	91, 766, 738	0	17. 00
18. 00	Excess of reasonable cost over customary charges (complete only if lin	a 1 avcaads lina	0	0	18. 00
10.00	16) (see instructions)	e 4 exceeds fine	0	0	10.00
19. 00	Interns and Residents (see instructions)		0	0	19.00
20. 00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		0	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be complete	d for PPS provid	ers.		
22. 00	Other than outlier payments		0	0	22. 00
23. 00	Outlier payments		0	0	
	Program capital payments		0		24.00
25. 00	Capital exception payments (see instructions)		0		25.00
26. 00	Routine and Ancillary service other pass through costs		88, 845	0	
27. 00 28. 00	Subtotal (sum of lines 22 through 26) Customary charges (title V or XIX PPS covered services only)		88, 845 0	0	
29. 00	Titles V or XIX (sum of lines 21 and 27)		88, 845	0	
27.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT		00,043	0	27.00
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		88, 845	0	
32.00	Deducti bl es		0	0	32.00
33.00	Coi nsurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		88, 845	0	36.00
37. 00	TO ZERO OUT MEDICALD		-88, 845	0	37.00
38. 00	Subtotal (line 36 ± line 37)		0	0	38.00
	Direct graduate medical education payments (from Wkst. E-4)		0	_	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39) Interim payments		0	0	40. 00 41. 00
41.00	Balance due provider/program (line 40 minus line 41)		0	0	
42.00	Protested amounts (nonallowable cost report items) in accordance with	CMS Pub 15-2	0	0	
13.00	chapter 1, §115.2	55 T GD TO Z,			10.00
	• • • • • • • •		•	•	•

Health Financial Systems	ST. FRANCIS HOSPITAL &	HEALTH CENTER	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 15-0162	Peri od: From 01/01/2020	Worksheet E-3
		Component CCN: 15-T162		
		Title XIX	Subprovi der -	PPS
			I RF	

		THE XIX	IRF	113	
			Inpatient	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES	FOR TITLES V OR XI	X SERVICES		
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		0		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		0	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		0	0	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable Charges				
8.00	Routine service charges		0		8. 00
9.00	Ancillary service charges		2, 950, 352	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		2, 950, 352	0	12.00
	CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for serv	ices on a charge	0	0	13.00
	basis				
14.00	Amounts that would have been realized from patients liable for paym	ment for services on	0	0	14.00
	a charge basis had such payment been made in accordance with 42 CFR	R §413. 13(e)			
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		2, 950, 352	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if	line 16 exceeds	2, 950, 352	0	17.00
	line 4) (see instructions)				
18. 00	Excess of reasonable cost over customary charges (complete only if	line 4 exceeds line	0	0	18. 00
	16) (see instructions)				
19. 00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instruction	ons)	0	0	
21. 00	Cost of covered services (enter the lesser of line 4 or line 16)		0	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be compl	eted for PPS provid			
22. 00	Other than outlier payments		0	0	
23. 00	Outlier payments		0	0	23. 00
24. 00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25. 00
26. 00	Routine and Ancillary service other pass through costs		1, 989	0	
27. 00	Subtotal (sum of lines 22 through 26)		1, 989	0	27.00
28. 00	Customary charges (title V or XIX PPS covered services only)		0	0	28. 00
29. 00	Titles V or XIX (sum of lines 21 and 27)		1, 989	0	29. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30. 00	Excess of reasonable cost (from line 18)		0	0	
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		1, 989	0	31.00
32.00	Deducti bl es		0	0	
33. 00	Coinsurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	
35. 00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		1, 989	0	
37. 00	TO ZERO OUT MEDICALD		-1, 989	0	37.00
38. 00	Subtotal (line 36 ± line 37)		0	0	38.00
39. 00	Direct graduate medical education payments (from Wkst. E-4)		0	•	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	
41.00	Interim payments		0	0	
42.00	Balance due provider/program (line 40 minus line 41)	THE CMC DUT AT O	0	0	42.00
43. 00	Protested amounts (nonallowable cost report items) in accordance wi	in CMS Pub 15-2,	0	0	43. 00
	chapter 1, §115.2		1		I

Health Financial Systems ST. FRANCIS HOSPITAL 8	HEALTH CEN	TER	In Lie	u of Form CMS-2	2552-10
DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provi der CO		eriod: rom 01/01/2020	Worksheet E-4	
MEDICAL EDUCATION COSTS			o 12/31/2020	Date/Time Pre 3/30/2021 10:	
	Title	XVIII	Hospi tal	PPS	
				1. 00	
COMPUTATION OF TOTAL DIRECT GME AMOUNT				1.00	
1.00 Unweighted resident FTE count for allopathic and osteopathic ending on or before December 31, 1996.	programs for	r cost reporti	ng periods	19. 50	1.00
2.00 Unweighted FTE resident cap add-on for new programs per 42 CF		(1) (see instr	uctions)	0.00	2.00
3.00 Amount of reduction to Direct GME cap under section 422 of MM 3.01 Direct GME cap reduction amount under ACA §5503 in accordance		R §413.79 (m).	(see	0. 94 0. 00	
instructions for cost reporting periods straddling 7/1/2011) 4.00 Adjustment (plus or minus) to the FTE cap for allopathic and GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f)		programs due	to a Medicare	-0. 05	4. 00
4.01 ACA Section 5503 increase to the Direct GME FTE Cap (see inst straddling 7/1/2011)	,	r cost reporti	ng periods	0. 00	4. 01
4.02 ACA Section 5506 number of additional direct GME FTE cap slot periods straddling 7/1/2011)	s (see inst	tructions for	cost reporting	0. 00	4. 02
5.00 FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 pl 4.02 plus applicable subscripts	us or minus	line 4 plus l	ines 4.01 and	18. 51	5. 00
Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)				24. 01	6. 00
7.00 Enter the lesser of line 5 or line 6				18. 51	7. 00
		Primary Care 1.00	0ther 2.00	Total 3. 00	
8.00 Weighted FTE count for physicians in an allopathic and osteop	athi c	24. 01		24. 01	8. 00
program for the current year. 9.00 If line 6 is less than 5 enter the amount from line 8, otherw		18. 51	0.00	18. 51	9. 00
multiply line 8 times the result of line 5 divided by the amo 6.	unt on line				
10.00 Weighted dental and podiatric resident FTE count for the curr			0.00		10.00
10.01 Unweighted dental and podiatric resident FTE count for the cu 11.00 Total weighted FTE count	rrent year	18. 51	0. 00 0. 00		10. 01 11. 00
12.00 Total weighted ris count 12.00 Total weighted resident FTE count for the prior cost reportin [instructions]	g year (see		1		12.00
13.00 Total weighted resident FTE count for the penultimate cost re year (see instructions)	porti ng	18. 46	0.00		13. 00
14.00 Rolling average FTE count (sum of lines 11 through 13 divided	by 3).	18. 48	0.00		14.00
15.00 Adjustment for residents in initial years of new programs		0.00			15.00
15.01 Unweighted adjustment for residents in initial years of new p		0.00			15. 01
16.00 Adjustment for residents displaced by program or hospital clo 16.01 Unweighted adjustment for residents displaced by program or h		0. 00 0. 00	1		16. 00 16. 01
closure 17.00 Adjusted rolling average FTE count	uspi tai	18. 48			17. 00
18.00 Per resident amount		121, 887. 58			18.00
19.00 Approved amount for resident costs		2, 252, 482	0	2, 252, 482	19.00
				1. 00	
20.00 Additional unweighted allopathic and osteopathic direct GME F Sec. 413.79(c)(4)	TE resident	cap slots rec	eived under 42		20.00
21.00 Direct GME FTE unweighted resident count over cap (see instru	ctions)			5. 50	21.00
22.00 Allowable additional direct GME FTE Resident Count (see instr				0. 00	•
23.00 Enter the locality adjustment national average per resident a	mount (see i	instructions)		0. 00	•
				0	
24.00 Multiply line 22 time line 23 25.00 Total direct GME amount (sum of lines 19 and 24)			I	2, 252, 482	
		Inpatient Part A	Managed Care	Total	
25.00 Total direct GME amount (sum of lines 19 and 24)			Managed Care 2.00		
25.00 Total direct GME amount (sum of lines 19 and 24) COMPUTATION OF PROGRAM PATIENT LOAD		Part A 1.00	2.00	Total	
25.00 Total direct GME amount (sum of lines 19 and 24) COMPUTATION OF PROGRAM PATIENT LOAD Inpatient Days (see instructions)		Part A 1.00	2. 00	Total	26. 00
25.00 Total direct GME amount (sum of lines 19 and 24) COMPUTATION OF PROGRAM PATIENT LOAD		Part A 1.00	2. 00 23, 432 106, 210	Total	
25.00 Total direct GME amount (sum of lines 19 and 24) COMPUTATION OF PROGRAM PATIENT LOAD 1 Inpatient Days (see instructions) Total Inpatient Days (see instructions)		Part A 1.00 36,842 106,210	2. 00 23, 432 106, 210 0. 220620	Total	26. 00 27. 00
25.00 Total direct GME amount (sum of lines 19 and 24) COMPUTATION OF PROGRAM PATIENT LOAD 26.00 Inpatient Days (see instructions) 7.00 Total Inpatient Days (see instructions) Ratio of inpatient days to total inpatient days Program direct GME amount Percent reduction for MA DGME		Part A 1.00 36,842 106,210 0.346879	2. 00 23, 432 106, 210 0. 220620 496, 943	Total 3. 00 1, 278, 282	26. 00 27. 00 28. 00 29. 00 29. 01
25.00 Total direct GME amount (sum of lines 19 and 24) COMPUTATION OF PROGRAM PATIENT LOAD 26.00 Inpatient Days (see instructions) 7.00 Total Inpatient Days (see instructions) Ratio of inpatient days to total inpatient days Program direct GME amount		Part A 1.00 36,842 106,210 0.346879	2. 00 23, 432 106, 210 0. 220620	Total 3.00	26. 00 27. 00 28. 00 29. 00 29. 01 30. 00

Heal th Financial Systems ST. FRANCIS HOSPITAL & HEALTH CENTER In Lie of Form CMS-2552-10	111-6-	CT FDANCIC HOCDITAL	O LIEALTH CENTED	1 11		2552 10
MEDICAL EDUCATION COSTS From 01/01/2020 To 12/31/2020 Date/Time Prepared: 3/30/2021 10:40 am						
Title XVIII Hospital PPS		• ,	Trovider cent. 13-0102	From 01/01/2020		
Title XVIII Hospital PPS				To 12/31/2020		
DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS) 32.00 Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74			Title XVIII	Hospi tal		40 diii
DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS) 32.00 Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74						
EDUCATION COSTS) Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94) 32.00 and 94) 33.00 Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94) 8, 199, 678 33.00 34.00 Ratio of direct medical education costs to total charges (line 32 + line 33) 0.000000 34.00 35.00 Medicare outpatient ESRD charges (see instructions) 0 35.00 Medicare outpatient ESRD direct medical education costs (line 34 x line 35) 0 36.00 APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY Part A Reasonable Cost 106, 531, 321 37.00 Reasonable cost (see instructions) 106, 531, 321 37.00 39.00 Cost of physicians' services in a teaching hospital (see instructions) 38.00 39.00 Cost of physicians' services in a teaching hospital (see instructions) 34.214 40.00 41.00 Total Part A reasonable cost (sum of lines 37 through 39 minus line 40) 106, 497, 107 Part B Reasonable Cost 53, 251, 889 44.00 44.00 45.00 Total Part B reasonable cost (line 42 minus line 43) 53, 251, 889 44.00 45.00 Total Part B reasonable cost (line 42 minus line 43) 53, 251, 889 44.00 45.00 Ratio of Part B reasonable cost to total reasonable cost (line 44 + line 45) 0.333347 47.00 Allocation of Part B reasonable cost to total reasonable cost (line 44 + line 45) 0.333347 47.00 Allocation of Part B reasonable cost to total reasonable cost (line 44 + line 45) 0.333347 47.00 Allocation of Part B reasonable cost to total reasonable cost (line 44 + line 45) 0.333347 47.00 Allocation of Part B reasonable cost to total reasonable cost (line 44 + line 45) 0.333347 47.00 Allocation of Part B reasonable cost to total reasonable cost (line 44 + line 45) 0.333347 47.00 Allocation of Part B reasonable cost to total reasonable cost (line 44 + line 45) 0.333347 47.00 Allocation of Part B reasonable cost to total reasonable cost (line 44 + line 45) 0						
and 94) 33.00 Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94) 34.00 Ratio of direct medical education costs to total charges (line 32 ± line 33) 35.00 Medicare outpatient ESRD charges (see instructions) 36.00 Medicare outpatient ESRD direct medical education costs (line 34 x line 35) APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY Part A Reasonable Cost 37.00 Reasonable cost (see instructions) 0 0 rogan acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69) 10 0 cost of physicians' services in a teaching hospital (see instructions) 10 0 rotal Part A reasonable cost (sum of lines 37 through 39 minus line 40) 10 1 Total Part B reasonable cost (see instructions) 10 2 3 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2			LE XVIII ONLY (NURSING S	CHOOL AND PARAMED	I CAL	
34.00 Ratio of direct medical education costs to total charges (line 32 ÷ line 33) 0.0000000 34.00 35.00 Medicare outpatient ESRD charges (see instructions) 0 35.00 36.00 Medicare outpatient ESRD direct medical education costs (line 34 x line 35) 0 36.00 APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY Part A Reasonable Cost 37.00 Reasonable cost (see instructions) 106, 531, 321 37.00 38.00 Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69) 0 38.00 39.00 Cost of physicians' services in a teaching hospital (see instructions) 0 39.00 40.00 Primary payer payments (see instructions) 34, 214 40.00 41.00 Total Part A reasonable cost (sum of lines 37 through 39 minus line 40) 106, 497, 107 41.00 42.00 Reasonable cost (see instructions) 53, 257, 602 42.00 43.00 Primary payer payments (see instructions) 53, 257, 602 42.00 45.00 Total Part B reasonable cost (line 42 minus line 43) 53, 257, 602 42.00 45.00 Total Part B reasonable cost to total reasonable cost (line 41 ÷ line 45) 0.666653 <td>32. 00</td> <td></td> <td>Pt. I, sum of col. 20 a</td> <td>nd 23, lines 74</td> <td>0</td> <td>32.00</td>	32. 00		Pt. I, sum of col. 20 a	nd 23, lines 74	0	32.00
35.00 Medicare outpatient ESRD charges (see instructions) Medicare outpatient ESRD direct medical education costs (line 34 x line 35) APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY Part A Reasonable Cost Reasonable cost (see instructions) Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69) Cost of physicians' services in a teaching hospital (see instructions) Organ y payre payments (see instructions) 106, 531, 321 37.00 Roasonable cost of physicians' services in a teaching hospital (see instructions) Organ y payre payments (see instructions) 106, 531, 321 37.00 Roasonable cost (wkst. D-4, Pt. III, col. 1, line 69) Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69) Organ acquisition costs (wast. D-4, Pt. III, col. 1, line 69) Organ acquisition costs (wast. D-4, Pt. III, col. 1, line 69) Organ acquisition costs (wast. D-4, Pt. III, col. 1, line 69) Organ acquisition costs (wast. D-4, Pt. III, col. 1, line 69) Organ acquisition costs (wast. D-4, Pt. III, col. 1, line 69) Organ acquisition costs (wast. D-4, Pt. III, col. 1, line 69) Organ acquisition costs (wast. D-4, Pt. III, col. 1, line 69) Organ acquisition costs (wast. D-4, Pt. III, col. 1, line 69) Organ acquisition costs (wast. D-4, Pt. III, col. 1, line 69) Organ acquisition costs (wast. D-4, Pt. III, col. 1, line 69) Organ acquisition costs (wast. D-4, Pt. III, col. 1, line 69) Organ acquisition costs (wast. D-4, Pt. III, col. 1, line 69) Organ acquisition costs (wast. D-4, Pt. III, col. 1, line 69) Organ acquisition costs (wast. D-4, Pt. III, col. 1, line 69) Organ acquisition costs (wast. D-4, Pt. III, col. 1, line 69) Organ acquisition costs (wast. D-4, Pt. III, col. 1, line 69) Organ acquisition costs (wast. D-4, Pt. III, col. 1, line 69) Organ acquisition costs (wast. D-4, Pt. III, col. 1, line 69) Organ acquisition costs (wast. D-4, Pt. III, col. 1, line 69) Organ acquisition costs (wast. D-4, Pt. III, col. 1, line 69) Organ acquisition costs (wast. D-4, Pt. III, col. 1, lin	33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt.	I, col. 8, sum of lines	74 and 94)	8, 199, 678	33.00
36.00 Medicare outpatient ESRD direct medical education costs (line 34 x line 35) APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY Part A Reasonable Cost 37.00 Reasonable cost (see instructions) Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69) Cost of physicians' services in a teaching hospital (see instructions) 40.00 Primary payer payments (see instructions) Total Part A reasonable cost (sum of lines 37 through 39 minus line 40) Part B Reasonable Cost Reasonable cost (see instructions) Total Part B reasonable cost (line 42 minus line 43) 45.00 Total Part B reasonable cost (sum of lines 41 and 44) Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45) Ratio of Part B reasonable cost to total reasonable cost (line 44 + line 45) Ratio of Part B reasonable cost to total reasonable cost (line 44 + line 45) Total program GME payment (line 31) Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions) 80.00 Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)			ne 32 ÷ line 33)		0.000000	
APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY Part A Reasonable Cost	35.00				0	
Part A Reasonable Cost Reasonable cost (see instructions) 106,531,321 37.00 38.00 Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69) 0 38.00 0 39.00 Cost of physicians' services in a teaching hospital (see instructions) 0 39.00 40.00 Primary payer payments (see instructions) 34,214 40.00 Total Part A reasonable cost (sum of lines 37 through 39 minus line 40) 106, 497, 107 41.00 Part B Reasonable Cost Reasonable Cost Reasonable cost (see instructions) 53, 257, 602 42.00 43.00 Primary payer payments (see instructions) 5,713 43.00 44.00 Total Part B reasonable cost (line 42 minus line 43) 53, 251, 889 44.00 45.00 Total reasonable cost (sum of lines 41 and 44) 159, 748, 996 45.00 46.00 Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45) 0.333347 47.00 ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B 1,208,064 48.00 Part A Medicare GME payment (line 31) 1,208,064 48.00 Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions) 805,359 49.00	36.00				0	36.00
37.00 Reasonable cost (see instructions) 106, 531, 321 37.00 38.00 Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69) 0 38.00 39.00 Cost of physicians' services in a teaching hospital (see instructions) 0 39.00 40.00 Primary payer payments (see instructions) 34, 214 40.00 Total Part A reasonable cost (sum of lines 37 through 39 minus line 40) Part B Reasonable Cost Reasonable Cost (see instructions) 53, 257, 602 42.00 Reasonable cost (see instructions) 53, 257, 602 42.00 Primary payer payments (see instructions) 53, 251, 889 44.00 Total Part B reasonable cost (line 42 minus line 43) 53, 251, 889 44.00 45.00 Total reasonable cost (sum of lines 41 and 44) 159, 748, 996 45.00 47.00 Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45) 0.666653 46.00 47.00 Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45) 0.333347 47.00 ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B 1, 208, 064 48.00 Part A Medicare GME payment (line 31) 1, 208, 064 48.00 Part A Medicare GME payment (line 48 × 48) (title XVIII only) (see instructions) 805, 359 49.00			ONLY			
38.00 Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69) 39.00 Cost of physicians' services in a teaching hospital (see instructions) 40.00 Primary payer payments (see instructions) 41.00 Total Part A reasonable cost (sum of lines 37 through 39 minus line 40) 42.00 Reasonable cost (see instructions) 42.00 Reasonable cost (see instructions) 43.00 Primary payer payments (see instructions) 44.00 Total Part B reasonable cost (line 42 minus line 43) 45.00 Total reasonable cost (sum of lines 41 and 44) 46.00 Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45) 47.00 Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45) 48.00 Total program GME payment (line 31) 48.00 Total program GME payment (line 43) 48.00 Part A Medicare GME payment (line 48) (title XVIII only) (see instructions) 805, 359 49.00						
39. 00 Cost of physicians' services in a teaching hospital (see instructions) 40. 00 Primary payer payments (see instructions) 41. 00 Total Part A reasonable cost (sum of lines 37 through 39 minus line 40) 42. 00 Reasonable cost (see instructions) 43. 00 Primary payer payments (see instructions) 43. 00 Primary payer payments (see instructions) 53, 257, 602 42. 00 43. 00 Primary payer payments (see instructions) 53, 257, 602 42. 00 43. 00 Total Part B reasonable cost (line 42 minus line 43) 53, 251, 889 44. 00 45. 00 Total reasonable cost (sum of lines 41 and 44) 46. 00 Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45) 70 Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45) 81. 00 ALLOCATION OF MEDICARE DIRECT CME COSTS BETWEEN PART A AND PART B 48. 00 Total program GME payment (line 31) 92 Part A Medicare GME payment (line 44 × 48) (title XVIII only) (see instructions) 805, 359 94. 00						1
40.00 Primary payer payments (see instructions) 41.00 Total Part A reasonable cost (sum of lines 37 through 39 minus line 40) 42.00 Reasonable cost (see instructions) 43.00 Primary payer payments (see instructions) 44.00 Total Part B reasonable cost (line 42 minus line 43) 45.00 Total reasonable cost (sum of lines 41 and 44) 46.00 Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45) 47.00 Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45) 48.00 Total program GME payment (line 31) 48.00 Part A Medicare GME payment (line 48) (title XVIII only) (see instructions) 49.00 Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions) 40.00 Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)						
41.00 Total Part A reasonable cost (sum of lines 37 through 39 minus line 40) Part B Reasonable Cost 42.00 Reasonable cost (see instructions) 43.00 Primary payer payments (see instructions) 44.00 Total Part B reasonable cost (line 42 minus line 43) 45.00 Total reasonable cost (sum of lines 41 and 44) 46.00 Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45) 47.00 Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45) ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B 48.00 Total program GME payment (line 31) 49.00 Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions) 106, 497, 107 41.00 42.00 53, 257, 602 42.00 53, 257, 602 42.00 53, 257, 602 42.00 54.00 55, 713 43.00 159, 748, 996 45.00 ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B 48.00 Total program GME payment (line 31) 90.00 Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)			tructions)			
Part B Reasonable Cost 42.00 Reasonable cost (see instructions) 53, 257, 602 42.00 43.00 Primary payer payments (see instructions) 5,713 43.00 44.00 Total Part B reasonable cost (line 42 minus line 43) 53,251,889 44.00 45.00 Total reasonable cost (sum of lines 41 and 44) 159,748,996 45.00 46.00 Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45) 0.666653 46.00 47.00 Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45) 0.333347 47.00 ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B 48.00 Total program GME payment (line 31) 1,208,064 48.00 49.00 Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions) 805,359 49.00			. 11		·	
42. 00 Reasonable cost (see instructions) 53, 257, 602 42. 00 43. 00 Primary payer payments (see instructions) 5, 713 43. 00 44. 00 Total Part B reasonable cost (line 42 minus line 43) 53, 251, 889 44. 00 45. 00 Total reasonable cost (sum of lines 41 and 44) 159, 748, 996 45. 00 46. 00 Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45) 0. 666653 46. 00 47. 00 Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45) 0. 333347 47. 00 ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B 48. 00 Total program GME payment (line 31) 1, 208, 064 48. 00 49. 00 Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions) 805, 359 49. 00	41.00		us iine 40)		106, 497, 107	41.00
43.00 Primary payer payments (see instructions) 5,713 43.00 44.00 Total Part B reasonable cost (line 42 minus line 43) 53,251,889 44.00 45.00 Total reasonable cost (sum of lines 41 and 44) 159,748,996 45.00 46.00 Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45) 0.666653 46.00 47.00 Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45) 0.333347 47.00 ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B 48.00 Total program GME payment (line 31) 1,208,064 48.00 49.00 Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions) 805,359 49.00	42 00				F2 2F7 602	12 00
44. 00 Total Part B reasonable cost (line 42 minus line 43) 53, 251, 889 44. 00 45. 00 Total reasonable cost (sum of lines 41 and 44) 159, 748, 996 45. 00 46. 00 Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45) 0. 666653 46. 00 47. 00 Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45) 0. 333347 47. 00 ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B 48. 00 Total program GME payment (line 31) 1, 208, 064 48. 00 49. 00 Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions) 805, 359 49. 00						1
45. 00 Total reasonable cost (sum of lines 41 and 44) 46. 00 Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45) 47. 00 Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45) 48. 00 Total program GME payment (line 31) 49. 00 Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions) 159, 748, 996 45. 00 0. 666653 46. 00 47. 00 48. 00 17. 208, 064 48. 00 48. 00 49. 00 Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions) 805, 359 49. 00						
46.00 Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45) Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45) ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B 48.00 Total program GME payment (line 31) Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions) 0.666653 46.00 0.333347 47.00 47.00 ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B 1,208,064 48.00 805,359 49.00						1
47. 00 Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45) 47. 00 ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B 48. 00 Total program GME payment (line 31) 49. 00 Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions) 805, 359 49. 00					1	
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B 48.00 Total program GME payment (line 31) 1,208,064 48.00 49.00 Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions) 805,359 49.00		· ·	,			1
49.00 Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions) 805,359 49.00						
49.00 Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions) 805,359 49.00	48.00	Total program GME payment (line 31)			1, 208, 064	48. 00
50.00 Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions) 402,705 50.00			(see instructions)		805, 359	49.00
	50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only)	(see instructions)		402, 705	50.00

Health Financial Systems ST. FRANCIS HOSPI
BALANCE SHEET (If you are nonproprietary and do not maintain
fund-type accounting records, complete the General Fund column onl y)

Provider CCN: 15-0162

Peri od: From 01/01/2020 To 12/31/2020 Date/Ti me Prepared: 3/30/2021 10:40 am

——————————————————————————————————————					3/30/2021 10:	40 am_
		General Fund	Speci fi c	Endowment	Plant Fund	
		1.00	Purpose Fund 2.00	Fund 3. 00	4. 00	
	CURRENT ASSETS	1.00	2.00	3.00	4.00	
1.00	Cash on hand in banks	97, 239, 452	. 0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3. 00
4.00	Accounts receivable	503, 731, 585		0	0	4.00
5. 00	Other receivable	-964, 146		0	0	5.00
6. 00 7. 00	Allowances for uncollectible notes and accounts receivable Inventory	-370, 158, 667 13, 598, 507	1	0	0	6. 00 7. 00
8. 00	Prepaid expenses	1, 867, 972		0	0	8.00
9. 00	Other current assets	0	0	Ö	0	9. 00
10.00	Due from other funds	18, 007, 626	0	0	0	10.00
11. 00	Total current assets (sum of lines 1-10)	263, 322, 329	0	0	0	11.00
	FI XED ASSETS	T		_1		
12.00	Land	E7 100 (1E	0	0	0	12.00
13. 00 14. 00	Land improvements Accumulated depreciation	57, 100, 615 -26, 785, 035		0	0	13. 00 14. 00
15. 00	Buildings	528, 132, 193		0	0	15.00
16. 00	Accumulated depreciation	-227, 558, 626		0	0	16.00
17. 00	Leasehold improvements	17, 574, 309		0	0	17. 00
18.00	Accumulated depreciation	-14, 397, 410	0	0	0	18. 00
19. 00	Fixed equipment	0	0	0	0	19. 00
20.00	Accumul ated depreciation	0	0	0	0	20.00
21. 00	Automobiles and trucks	0	0	0	0	21.00
22. 00 23. 00	Accumulated depreciation	198, 690, 765	0	0	0	22. 00 23. 00
24.00	Major movable equipment Accumulated depreciation	-148, 350, 314		0	0	24.00
25. 00	Mi nor equipment depreciable	140, 330, 314		0	0	25. 00
26. 00	Accumulated depreciation	0	Ö	Ö	0	26. 00
27.00	HIT designated Assets	0	0	0	0	27. 00
28. 00	Accumulated depreciation	0	0	0	0	28. 00
29. 00	Mi nor equi pment-nondepreci abl e	0	0	0	0	29. 00
30. 00	Total fixed assets (sum of lines 12-29)	384, 406, 497	0	0	0	30.00
31. 00	OTHER ASSETS Investments	19, 421, 096	ol ol	0	0	31.00
32. 00	Deposits on Leases	17, 421, 070		0	0	32.00
33. 00	Due from owners/officers	0	O	0	0	33.00
34.00	Other assets	60, 700, 199	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	80, 121, 295		0	0	35.00
36. 00	Total assets (sum of lines 11, 30, and 35)	727, 850, 121	0	0	0	36. 00
37. 00	CURRENT LIABILITIES Accounts payable	44, 976, 582	. 0	O	0	37. 00
38. 00	Salaries, wages, and fees payable	1 44, 770, 302		0	0	38.00
39. 00	Payrol I taxes payable	28, 842, 959	1	Ö	0	39.00
40.00	Notes and Loans payable (short term)	918, 648	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accel erated payments	0				42.00
43.00	Due to other funds	115, 625, 103		0	0	43. 00 44. 00
44. 00 45. 00	Other current liabilities Total current liabilities (sum of lines 37 thru 44)	190, 363, 292	1	0		45.00
43.00	LONG TERM LIABILITIES	170, 303, 272		<u> </u>	0	43.00
46.00	Mortgage payable	0	0	0	0	46. 00
47.00	Notes payable	0	0	0	0	47. 00
48.00	Unsecured Loans	0	0	0	0	48. 00
49. 00	Other long term liabilities	-28, 438, 299		0	0	49. 00
50.00	Total long term liabilities (sum of lines 46 thru 49)	-28, 438, 299		0	0	50.00
51. 00	Total liabilities (sum of lines 45 and 50) CAPITAL ACCOUNTS	161, 924, 993	0	0	0	51.00
52. 00	General fund balance	565, 925, 128				52.00
53. 00	Specific purpose fund	000, 720, 120	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	57.00
58. 00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58. 00
59. 00	Total fund balances (sum of lines 52 thru 58)	565, 925, 128		n	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and	727, 850, 121		o	0	60.00
	59)					

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES

Provi der CCN: 15-0162

					10 12/31/2020	3/30/2021 10:	
	·	Genera	Fund	Speci al	Purpose Fund	Endowment	
						Fund	
	T=	1. 00	2. 00	3. 00	4. 00	5. 00	
1.00	Fund balances at beginning of period		576, 296, 353		0		1.00
2. 00	Net income (loss) (from Wkst. G-3, line 29)		274, 177, 769		_		2.00
3. 00	Total (sum of line 1 and line 2)		850, 474, 122		0	_	3.00
4.00	FUND EQUITY CHANGES	21, 398, 775			0	0	
5.00		0			0	0	
6.00		0			0	0	
7.00		0			0	0	
8. 00 9. 00		0			0		
10.00	Total additions (sum of line 4-9)	۷	21, 398, 775			0	10.00
11. 00	Subtotal (line 3 plus line 10)		871, 872, 897		0		11.00
12. 00	SHARED SERVICES	305, 947, 769	0/1,0/2,09/			0	
13. 00	SHARED SERVICES	0			0		
14. 00					0		
15. 00					0	Ö	
16. 00					0	Ö	
17. 00		l ol			0	0	
18. 00	Total deductions (sum of lines 12-17)	_	305, 947, 769		0	_	18.00
19. 00	Fund balance at end of period per balance		565, 925, 128		0		19.00
	sheet (line 11 minus line 18)						
		Endowment	PI ant	Fund			
		Fund					
		4 00	7.00	2.22			
1 00	Te all haloman at the development of the development	6. 00	7. 00	8. 00			1.00
1.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29)	0			0		1.00
2. 00 3. 00	Total (sum of line 1 and line 2)	0			0		2.00
4. 00	FUND EQUITY CHANGES	۷	0		U		4.00
5. 00	FUND EQUITY CHANGES		0				5.00
6. 00			0				6.00
7. 00			0				7.00
8. 00			0				8.00
9. 00			0				9.00
10.00	Total additions (sum of line 4-9)	o	J		0		10.00
11. 00	Subtotal (line 3 plus line 10)	ol			0		11.00
12.00	SHARED SERVICES		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	o			0		18.00
19. 00	Fund balance at end of period per balance	0			0		19.00
	sheet (line 11 minus line 18)			l			

Health Financial Systems ST. FRA In Lieu of Form CMS-2552-10 Provi der CCN: 15-0162

		1	o 12/31/2020	Date/Time Pre	pared: 40 am
	Cost Center Description	Inpatient	Outpati ent	Total	40 aiii
	oost conton bood per on	1.00	2.00	3. 00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospi tal	194, 831, 364		194, 831, 364	1.00
2.00	SUBPROVI DER - I PF				2.00
3.00	SUBPROVI DER - I RF	23, 982, 164		23, 982, 164	3.00
4.00	SUBPROVI DER				4.00
5.00	Swing bed - SNF			0	5.00
6.00	Swing bed - NF)	0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSI NG FACI LI TY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	218, 813, 528	1	218, 813, 528	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	37, 011, 910		37, 011, 910	11.00
11. 01	NEONATAL INTENSIVE CARE UNIT	42, 353, 072		42, 353, 072	11.01
12.00	CORONARY CARE UNIT			0	12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGI CAL I NTENSI VE CARE UNI T	59, 489, 434		59, 489, 434	14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lin	es 138, 854, 416	,	138, 854, 416	16.00
	11-15)				
17.00	Total inpatient routine care services (sum of lines 10 and 16)	357, 667, 944		357, 667, 944	17.00
18.00	Ancillary services	983, 372, 251	1, 239, 499, 281	2, 222, 871, 532	18.00
19.00	Outpati ent servi ces	80, 216, 011	306, 684, 384	386, 900, 395	19.00
20.00	RURAL HEALTH CLINIC		0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	21.00
22.00	HOME HEALTH AGENCY		0	0	22.00
23. 00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D. P.)				25.00
26.00	HOSPI CE		25, 343, 830	25, 343, 830	26.00
27.00	OTHER REVENUE	14, 789, 789	122, 928, 801	137, 718, 590	27.00
28.00	Total patient revenues (sum of lines 17-27) (transfer column 3 to	Wkst. 1,436,045,995	1, 694, 456, 296	3, 130, 502, 291	28.00
	G-3, line 1)				
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		560, 927, 679		29.00
30.00	ADD (SPECIFY)				30.00
31.00					31.00
32.00					32.00
33.00					33.00
34.00					34.00
35.00					35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY))		37.00
38.00					38.00
39.00					39.00
40.00					40.00
41.00					41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(t	ransfer	560, 927, 679		43.00
	to Wkst. G-3, line 4)				

Health Financial Systems	ST. FRANCIS HOSPITAL & HEALTH CENTER	In Lieu of Form CMS-2552-10
STATEMENT OF REVENUES AND EXPENSES	Provi der CCN: 15-0162	Period: Worksheet G-3 From 01/01/2020

STATEM	ENT OF REVENUES AND EXPENSES	Provider CCN: 15-0162	Period: From 01/01/2020 To 12/31/2020	Worksheet G-3 Date/Time Pre 3/30/2021 10:	pared:
				1. 00	
1. 00	Total patient revenues (from Wkst. G-2, Part I, column 3,	Line 29)		3, 130, 502, 291	1.00
2.00	Less contractual allowances and discounts on patients' ac	•		2, 327, 753, 031	2.00
3. 00	Net patient revenues (line 1 minus line 2)	CCounts		802, 749, 260	3.00
4. 00	Less total operating expenses (from Wkst. G-2, Part II, I	line 43)		560, 927, 679	4.00
5. 00	Net income from service to patients (line 3 minus line 4)			241, 821, 581	5. 00
0.00	OTHER I NCOME	,		211,021,001	0.00
6.00	Contributions, donations, bequests, etc			152, 322	6.00
7. 00	Income from investments			0	7.00
8.00	Revenues from telephone and other miscellaneous communication	ation services		0	8. 00
9.00	Revenue from television and radio service			0	9. 00
10.00	Purchase di scounts			3, 730, 242	10.00
11.00	Rebates and refunds of expenses			0	11.00
12.00	Parking lot receipts			50	12.00
	Revenue from Laundry and Linen service			0	13.00
14.00	Revenue from meals sold to employees and guests			2, 053, 373	14.00
	Revenue from rental of living quarters			0	15.00
	Revenue from sale of medical and surgical supplies to oth	ner than patients		0	16.00
	Revenue from sale of drugs to other than patients			0	17.00
	Revenue from sale of medical records and abstracts			0	18. 00
	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19. 00
	Revenue from gifts, flowers, coffee shops, and canteen			227, 366	
	Rental of vending machines			47, 334	
	Rental of hospital space			4, 066, 085	
	Governmental appropriations			0	23.00
	IDENTIFIED ON TRIAL BALANCE			22, 079, 416	
	COVI D-19 PHE Fundi ng			0	24. 50
	Total other income (sum of lines 6-24)			32, 356, 188	
	Total (line 5 plus line 25)			274, 177, 769	
	OTHER EXPENSES (SPECIFY)			0	27.00
	Total other expenses (sum of line 27 and subscripts)	20)		0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 2	28)	l	274, 177, 769	29.00

Health Financial Systems
ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS Provi der CCN: 15-0162 Peri od: Worksheet 0 From 01/01/2020 To 12/31/2020 Date/Time Prepared: 3/30/2021 10:40 am Hospi ce CCN: 15-1523

						3/30/2021 10:	40 alli
					Hospi ce I		
		SALARI ES	OTHER	SUBTOTAL	RECLASSIFI -	SUBTOTAL	
				(col. 1 plus	CATI ONS		
				col. 2)			
		1. 00	2. 00	3. 00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT*		0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP*		0	0	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	1, 743, 656	1, 743, 656	-1, 743, 656	0	3.00
4. 00	ADMINISTRATIVE & GENERAL*	3, 243, 569	237, 380		-2, 756, 603	724, 346	4.00
5. 00	PLANT OPERATION & MAINTENANCE*	0,210,007	207,000	0, 100, 717	2, 700, 000	721, 310	5. 00
		0	17 252	17 252	0		
6.00	LAUNDRY & LINEN SERVICE*	0	17, 352	17, 352	0	17, 352	6.00
7. 00	HOUSEKEEPI NG*	0	0	04 507	U	0	7.00
8. 00	DI ETARY*	0	21, 507	21, 507	0	21, 507	8. 00
9.00	NURSI NG ADMI NI STRATI ON*	0	0	0	0	0	9. 00
10. 00	ROUTINE MEDICAL SUPPLIES*	0	0	0	0	0	10.00
11.00	MEDI CAL RECORDS*	0	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION*	0	74, 384	74, 384	0	74, 384	12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	. 0	ا ، ا	48, 128	48, 128	13.00
14. 00	PHARMACY*	0	319, 580	319, 580	.0, .20	319, 580	14.00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	317, 300	317,300	0	0	15. 00
16. 00	OTHER GENERAL SERVICE*		0		0	0	16.00
		٩	U	١	U	U	
17. 00	PATIENT/RESIDENTIAL CARE SERVICES						17. 00
	DIRECT PATIENT CARE SERVICE COST CENTERS	1			_1		
25. 00	I NPATI ENT CARE-CONTRACTED**		0	0	0	0	25. 00
26. 00	PHYSICIAN SERVICES**	0	0	0	0	0	26. 00
27.00	NURSE PRACTITIONER**	0	0	0	0	0	27. 00
28. 00	REGI STERED NURSE**	0	27, 986	27, 986	1, 784, 983	1, 812, 969	28. 00
29.00	LPN/LVN**	0	0	0	0	0	29. 00
30.00	PHYSI CAL THERAPY**	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY**	l ol	0	l o	o	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	o	0	l o	o	0	32.00
33. 00	MEDICAL SOCIAL SERVICES**	0	0	0	322, 729	322, 729	33.00
34. 00	SPI RI TUAL COUNSELI NG**	0	0	اً	147, 442	147, 442	34.00
35. 00	DI ETARY COUNSELI NG**	٥	0	١	,	0	35. 00
36. 00	COUNSELING - OTHER**		0		0	0	36.00
37. 00	HOSPICE AIDE & HOMEMAKER SERVICES**	0	0		390, 646	390, 646	37.00
38. 00		0	210 204	210 204	370, 040		38.00
	DURABLE MEDI CAL EQUI PMENT/OXYGEN**	0	219, 386	219, 386	0	219, 386	
39.00	PATI ENT TRANSPORTATI ON**	0	0	0	U	0	39.00
40. 00	I MAGING SERVICES**	0	0	0	0	0	40.00
41. 00	LABS & DI AGNOSTI CS**	0	0	0	0	0	41.00
42.00	MEDI CAL SUPPLI ES-NON-ROUTI NE**	0	133, 572	133, 572	0	133, 572	42.00
42. 50	DRUGS CHARGED TO PATIENTS**	0	0	0	0	0	42. 50
43.00	OUTPATIENT SERVICES**	0	377, 959	377, 959	0	377, 959	43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0	0	0	0	44.00
45.00	PALLI ATI VE CHEMOTHERAPY**	o	0	l o	o	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY) **	0	0	0	o	0	46.00
	NONREI MBURSABLE COST CENTERS	· · · · · · · · · · · · · · · · · · ·			-,		
60.00	BEREAVEMENT PROGRAM *	0	0	0	62, 675	62, 675	60.00
61. 00	VOLUNTEER PROGRAM *	0	0	ا	02,070	0	61.00
62. 00	FUNDRAI SI NG*	0	0	١	0	0	62.00
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0		0	0	63.00
		2 551 702	74 004	2 424 400	0		
64.00	PALLIATIVE CARE PROGRAM*	2, 551, 792	74, 896	2, 626, 688	0	2, 626, 688	
65.00	OTHER PHYSICIAN SERVICES*	0	0	0	U	0	65.00
66.00	RESI DENTI AL CARE*	0	0	0	0	0	66.00
67. 00	ADVERTI SI NG*	0	0	0	0	0	67. 00
68. 00	TELEHEALTH/TELEMONI TORI NG*	0	0	0	0	0	68. 00
69. 00	THRI FT STORE*	0	0	0	0	0	69. 00
70.00	NURSING FACILITY ROOM & BOARD*	0	0	0	0	0	70.00
	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	0	0	0	71.00
100.00	TOTAL	5, 795, 361	3, 247, 658	9, 043, 019	-1, 743, 656	7, 299, 363	100.00
* Tran	nsfer the amounts in column 7 to Wkst. 0-5, co	lumn 1, line as	appropriate.				

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

Peri od: From 01/01/2020 To 12/31/2020 Date/Ti me Prepared: 3/30/2021 10: 40 am Hospi ce CCN: 15-1523

				Hospi ce I	
		ADJUSTMENTS	TOTAL (col. 5		
			± col. 6)	_	
	OFFICE AND ADDRESS OF A SENTENCE	6. 00	7. 00		
4 00	GENERAL SERVICE COST CENTERS			ı	1.00
1.00	CAP REL COSTS-BLDG & FIXT*	0	0	•	1.00
2.00	CAP REL COSTS-MVBLE EQUIP*	0	0		2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	704.046)	3.00
4.00	ADMI NI STRATI VE & GENERAL*	0	724, 346		4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	47.050		5.00
6.00	LAUNDRY & LINEN SERVICE*	0	17, 352		6.00
7.00	HOUSEKEEPI NG*	0	04 507		7.00
8. 00 9. 00	DI ETARY*	0	21, 507		8. 00 9. 00
	NURSING ADMINISTRATION* ROUTINE MEDICAL SUPPLIES*	0	0		10.00
10. 00 11. 00	MEDICAL RECORDS*		0		11.00
12.00	STAFF TRANSPORTATION*		74, 384	1	12.00
13. 00	VOLUNTEER SERVICE COORDINATION*	0	48, 128	1	13.00
14. 00	PHARMACY*	0	319, 580	1	14. 00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	319, 360	1	15.00
16. 00	OTHER GENERAL SERVICES	0	0		16.00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES	J	U	1	17.00
17.00	DIRECT PATIENT CARE SERVICE COST CENTERS				17.00
25. 00	I NPATI ENT CARE -CONTRACTED**	O	0		25. 00
26. 00	PHYSI CI AN SERVI CES**	o o	0	•	26.00
27. 00	NURSE PRACTITIONER**	o o	0		27. 00
28. 00	REGI STERED NURSE**	o o	1, 812, 969		28.00
29. 00	LPN/LVN**	0	0		29.00
30.00	PHYSI CAL THERAPY**	0	0		30.00
31. 00	OCCUPATIONAL THERAPY**	o	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	o	0		32.00
33.00	MEDICAL SOCIAL SERVICES**	o	322, 729		33.00
34.00	SPIRITUAL COUNSELING**	o	147, 442	l .	34.00
35.00	DI ETARY COUNSELI NG**	o	0)	35.00
36.00	COUNSELING - OTHER**	0	0)	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	0	390, 646		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	219, 386		38.00
39.00	PATI ENT TRANSPORTATI ON**	o	0)	39.00
40.00	I MAGING SERVICES**	0	0		40.00
41.00	LABS & DI AGNOSTI CS**	0	0		41.00
42.00	MEDI CAL SUPPLI ES-NON-ROUTI NE**	0	133, 572		42.00
42. 50	DRUGS CHARGED TO PATIENTS**	0	0		42. 50
43.00	OUTPATIENT SERVICES**	0	377, 959		43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0)	44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0	1	45. 00
46. 00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0		46. 00
	NONREI MBURSABLE COST CENTERS			_	
60.00	BEREAVEMENT PROGRAM *	0	62, 675		60.00
61.00	VOLUNTEER PROGRAM *	0	0	1	61.00
62.00	FUNDRAI SI NG*	0	0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0		63.00
64.00	PALLIATIVE CARE PROGRAM*	0	2, 626, 688		64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0	1	65.00
66.00	RESI DENTI AL CARE*	0	0		66.00
67.00	ADVERTI SI NG*	0	0		67.00
68. 00	TELEHEALTH/TELEMONI TORI NG*	0	0		68.00
69.00	THRIFT STORE*	0	0		69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0		70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	7 200 212		71.00
100.00	/ IUIAL	0	7, 299, 363	1	100.00

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

 Heal th
 Financial
 Systems
 ST.
 FRANCIS HOSPITAL

 ANALYSIS
 OF
 HOSPITAL-BASED
 HOSPICE
 COSTS
 FOR
 HOSPICE
 ROUTINE
 HOME
 Peri od: From 01/01/2020 To 12/31/2020 Date/Ti me Prepared: 3/30/2021 10: 40 am Provi der CCN: 15-0162 Peri od: CARE Hospi ce CCN: 15-1523

				Hospice I		
	SALARI ES	OTHER	SUBTOTAL	RECLASSI FI -	SUBTOTAL	
			(col. 1 +	CATI ONS		
			col. 2)			
	1. 00	2.00	3.00	4. 00	5. 00	
DIRECT PATIENT CARE SERVICE COST CENTERS						
25. 00 I NPATI ENT CARE-CONTRACTED						25.00
26. 00 PHYSI CI AN SERVI CES	0	0	0	0	0	26.00
27. 00 NURSE PRACTITIONER	0	0	0	0	0	27. 00
28. 00 REGI STERED NURSE	0	27, 328	27, 328	79, 019	106, 347	28. 00
29. 00 LPN/LVN	0	0	0	0	0	29. 00
30. 00 PHYSI CAL THERAPY	0	0	0	0	0	30.00
31. 00 OCCUPATI ONAL THERAPY	0	0	0	0	0	31.00
32.00 SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00 MEDICAL SOCIAL SERVICES	0	0	0	322, 729	322, 729	33.00
34.00 SPIRITUAL COUNSELING	0	0	0	147, 442	147, 442	34.00
35. 00 DI ETARY COUNSELI NG	0	0	0	0	0	35.00
36. 00 COUNSELI NG - OTHER	0	0	0	0	0	36.00
37.00 HOSPICE AIDE & HOMEMAKER SERVICES	0	0	0	369, 081	369, 081	37.00
38. 00 DURABLE MEDI CAL EQUI PMENT/OXYGEN	0	214, 595	214, 595	0	214, 595	38. 00
39. 00 PATI ENT TRANSPORTATI ON	0	0	0	0	0	39.00
40.00 I MAGING SERVICES	0	0	0	0	0	40.00
41.00 LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42. 00 MEDI CAL SUPPLI ES-NON-ROUTI NE	0	130, 433	130, 433	0	130, 433	42.00
42.50 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50
43. 00 OUTPATIENT SERVICES	0	368, 713	368, 713	0	368, 713	43.00
44.00 PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00 PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45. 00
46.00 OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100. 00 TOTAL *	0	741, 069	741, 069	918, 271	1, 659, 340	100.00
* Transfer the amount in column 7 to Wkst 0-5 col	umn 1 line 51					

 $^{^{\}star}$ Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.

	ADJUSTMENTS	TOTAL (col. 5	
		± col. 6)	
	6. 00	7. 00	
DIRECT PATIENT CARE SERVICE COST CENTERS			
25. 00 I NPATI ENT CARE-CONTRACTED			25. 0
26. 00 PHYSI CI AN SERVI CES	C	0	26. 0
27. 00 NURSE PRACTITIONER	C	0	27. 0
28. 00 REGI STERED NURSE	C	106, 347	28.0
29. 00 LPN/LVN	C	0	29. 0
30. 00 PHYSI CAL THERAPY	C	0	30.0
31. 00 OCCUPATI ONAL THERAPY	C	0	31.0
32.00 SPEECH/LANGUAGE PATHOLOGY	C	0	32.0
33.00 MEDICAL SOCIAL SERVICES	C	322, 729	33.0
34. 00 SPIRITUAL COUNSELING	C	147, 442	34.0
35. 00 DI ETARY COUNSELING	C	0	35.0
36. 00 COUNSELING - OTHER	C	0	36.0
37.00 HOSPICE AIDE & HOMEMAKER SERVICES	C	369, 081	37.0
38. 00 DURABLE MEDICAL EQUIPMENT/OXYGEN	C	214, 595	38.0
39. 00 PATIENT TRANSPORTATION	C	0	39.0
40.00 I MAGING SERVICES	C	0	40.0
41. 00 LABS & DI AGNOSTI CS	C	0	41.0
42. 00 MEDI CAL SUPPLI ES-NON-ROUTI NE	C	130, 433	42.0
42.50 DRUGS CHARGED TO PATIENTS	C	0	42.5
43. 00 OUTPATIENT SERVICES	C	368, 713	43.0
44.00 PALLIATIVE RADIATION THERAPY	C	0	44.0
45. 00 PALLIATIVE CHEMOTHERAPY	C	0	45. 0
46.00 OTHER PATIENT CARE SERVICES (SPECIFY)	C	0	46.0
100. 00 TOTAL *	C	1, 659, 340	100.0

^{*} Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.

					Hospi ce I		
		SALARI ES	OTHER	SUBTOTAL	RECLASSI FI -	SUBTOTAL	
				(col. 1 +	CATI ONS		
				col. 2)			
		1. 00	2. 00	3. 00	4. 00	5. 00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25. 00	I NPATI ENT CARE-CONTRACTED		0	0	0	0	25.00
26. 00	PHYSI CI AN SERVI CES	0	0	0	0	0	26.00
27. 00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28. 00	REGI STERED NURSE	0	610	610	170, 789	171, 399	
29. 00	i i	0	0	0	0	0	/
30.00	PHYSI CAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATI ONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	0	0	0	33.00
34.00		0	0	0	0	0	34.00
35.00	DI ETARY COUNSELI NG	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	0	0	2, 159	2, 159	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	4, 791	4, 791	0	4, 791	38. 00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39. 00
40.00	I MAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DI AGNOSTI CS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	2, 912	2, 912	0	2, 912	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50
43.00	OUTPATI ENT SERVI CES	0	8, 231	8, 231	0	8, 231	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLI ATI VE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	0	16, 544	16, 544	172, 948	189, 492	100.00
* Tran	nsfer the amount in column 7 to Wkst. 0-5, col	umn 1. line 52.					

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

		ADJUSTMENTS	TOTAL (col. 5	
		ADSOSTMENTO	± col. 6)	
		6. 00	7.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS			
25.00	I NPATI ENT CARE-CONTRACTED	0	0	25. 00
26.00	PHYSI CI AN SERVI CES	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	27.00
28.00	REGI STERED NURSE	0	171, 399	28. 00
29.00	LPN/LVN	0	0	29.00
30.00	PHYSI CAL THERAPY	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	33.00
34.00	SPI RI TUAL COUNSELI NG	0	0	34.00
35.00	DI ETARY COUNSELI NG	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	2, 159	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	4, 791	38. 00
39. 00	PATI ENT TRANSPORTATION	0	0	39.00
40.00	I MAGING SERVICES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	2, 912	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	42. 50
43.00	OUTPATI ENT SERVI CES	0	8, 231	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46.00
100.00	TOTAL *	0	189, 492	100.00

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

0

1,015

1, 290

1,015

0

0

0

, 290

0

0

1, 554, 581 1,015

0

0

0

1, 555, 871 100. 00

43.00

44.00

45.00

46.00

OUTPATIENT SERVICES

PALLIATIVE RADIATION THERAPY

46.00 OTHER PATIENT CARE SERVICES (SPECIFY)

PALLIATIVE CHEMOTHERAPY

43.00

44.00

45.00

100. 00 TOTAL

		ADJUSTMENTS	TOTAL (col. 5	
		6. 00	± col . 6) 7.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS	0.00	7.00	
25. 00	I NPATI ENT CARE-CONTRACTED	0	0	25. 00
26. 00	PHYSI CI AN SERVI CES	0	0	26.00
27. 00	NURSE PRACTITIONER	0	0	27. 00
28. 00	REGI STERED NURSE	0	1, 535, 223	28. 00
29.00	LPN/LVN	0	0	29. 00
30.00	PHYSI CAL THERAPY	0	0	30.00
31.00	OCCUPATI ONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	33.00
34.00	SPIRITUAL COUNSELING	0	0	34.00
35.00	DI ETARY COUNSELING	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	19, 406	37.00
38. 00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38. 00
39. 00	PATI ENT TRANSPORTATION	0	0	39.00
40.00	I MAGING SERVICES	0	0	40.00
41. 00	LABS & DI AGNOSTI CS	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	227	42.00
42. 50	DRUGS CHARGED TO PATIENTS	0	0	42. 50
43.00	OUTPATI ENT SERVI CES	0	1, 015	43.00
44. 00	PALLIATIVE RADIATION THERAPY	0	0	44. 00
45. 00	PALLI ATI VE CHEMOTHERAPY	0	0	45. 00
46. 00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46. 00
100.00	TOTAL *	0	1, 555, 871	100.00

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

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

Health Financial Systems	ST.	FRANCIS	HOSPITAL 8	HEALTH CEN	ITER	In Lieu	u of Form CMS-2552-10
COST ALLOCATION - DETERMINATION OF EXPENSES FOR ALLOCATION	HOSPI TAL-BASED	HOSPI CE	NET		CN: 15-0162 N: 15-1523	From 01/01/2020	Worksheet 0-5 Date/Time Prepared: 3/30/2021 10:40 am

EM ENG	ES FOR ALLESSATION	Hospi ce CCI	N: 15-1523 T	o 12/31/2020	Date/Time Pre 3/30/2021 10:	
				Hospi ce I		
	Descriptions		HOSPI CE	GENERAL	TOTAL	
			DI RECT	SERVI CE	EXPENSES (sum	
			EXPENSES (see	EXPENSES FROM	of cols. 1 +	
			instructions)	WKST B PART I	2)	
				(see		
				instructions)		
			1.00	2.00	3. 00	
	GENERAL SERVICE COST CENTERS					
1.00	CAP REL COSTS-BLDG & FIXT		C	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP		C	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT		C	2, 394, 910	2, 394, 910	3.00
4.00	ADMI NI STRATI VE & GENERAL		724, 346	2, 646, 758	3, 371, 104	4.00
5.00	PLANT OPERATION & MAINTENANCE			0	0	5.00
6.00	LAUNDRY & LINEN SERVICE		17, 352	0	17, 352	6.00
7. 00	HOUSEKEEPI NG			0	0	7.00
8. 00	DIETARY		21, 507	0	21, 507	8.00
9. 00	NURSI NG ADMI NI STRATI ON		2.,00,	0	0	9.00
10.00	ROUTI NE MEDI CAL SUPPLI ES			13, 914	13, 914	10.00
11. 00	MEDICAL RECORDS			1, 850		11.00
12. 00	STAFF TRANSPORTATION		74, 384		74, 384	12.00
13. 00	VOLUNTEER SERVICE COORDINATION		48, 128		48, 128	13.00
14. 00	PHARMACY		319, 580		319, 580	
			i .			14.00
15.00	PHYSI CI AN ADMI NI STRATI VE SERVI CES		C		0	15.00
16.00	OTHER GENERAL SERVICE		C	_	0	16.00
17. 00	PATI ENT/RESI DENTI AL CARE SERVI CES LEVEL OF CARE			0	0	17. 00
EO 00	HOSPICE CONTINUOUS HOME CARE		T 0	\		FO 00
50.00					0	50.00
51.00	HOSPICE ROUTINE HOME CARE		1, 659, 340		1, 659, 340	51.00
52.00	HOSPICE INPATIENT RESPITE CARE		189, 492		189, 492	52.00
53. 00	HOSPI CE GENERAL I NPATI ENT CARE		1, 555, 871		1, 555, 871	53.00
(0.00	NONREI MBURSABLE COST CENTERS BEREAVEMENT PROGRAM		(2.75		(2.775	/ 0 00
60.00			62, 675		62, 675	60.00
61.00	VOLUNTEER PROGRAM		C		0	61.00
62.00	FUNDRAI SI NG		C)	0	62.00
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS)	0	63.00
64. 00	PALLIATIVE CARE PROGRAM		2, 626, 688	3	2, 626, 688	64.00
65. 00	OTHER PHYSICIAN SERVICES		C)	0	65.00
66. 00	RESI DENTI AL CARE		C		0	66. 00
67.00	ADVERTI SI NG		[C		0	67.00
68.00	TELEHEALTH/TELEMONI TORI NG		C)	0	68.00
69.00	THRI FT STORE		[C)	0	69. 00
70.00	NURSING FACILITY ROOM & BOARD		[C)	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)		C)	0	71.00
99.00	NEGATIVE COST CENTER		C)	0	99. 00
100.00	TOTAL		7, 299, 363	5, 057, 432	12, 356, 795	100.00

62, 675

3, 674, 497

0

0 62.00

0

0 65.00

0

0 68.00

0

0

0

12, 356, 795 100. 00

0

0

0

0

0

0

0

1, 047, 809

2, 394, 910

60.00

61.00

63.00

64.00

66.00

67 00 0

69.00

70.00

71.00

99.00

Health Financial Systems ST. FRANCIS HOSPITAL & HEALTH CENTER In Lieu of Form CMS-2552-10 COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS Provider CCN: 15-0162 Peri od: Worksheet 0-6 From 01/01/2020 Part I Hospi ce CCN: 12/31/2020 Date/Time Prepared: 15-1523 To 3/30/2021 10:40 am Hospi ce I TOTAL CAP REL BLDG CAP REL MVBLE EMPLOYEE SUBTOTAL Descriptions **EXPENSES** & FIX EQUI P **BENEFITS DEPARTMENT** 0 1.00 2.00 3.00 ЗА GENERAL SERVICE COST CENTERS 1.00 CAP REL COSTS-BLDG & FIXT 0 1.00 2 00 CAP REL COSTS-MVBLE EQUIP 0 2.00 0 0 3.00 EMPLOYEE BENEFITS DEPARTMENT 2, 394, 910 0 2, 394, 910 3.00 ADMINISTRATIVE & GENERAL 3, 371, 104 0 240, 925 3, 612, 029 4.00 4.00 5.00 PLANT OPERATION & MAINTENANCE 0 0 5.00 0 LAUNDRY & LINEN SERVICE 0 0 6.00 17.352 0 17, 352 6.00 7.00 HOUSEKEEPI NG 0 7.00 8.00 DI ETARY 21, 507 0 0 0 21, 507 8.00 NURSING ADMINISTRATION 0 9.00 0 0 9.00 0 0 ROUTINE MEDICAL SUPPLIES 0 0 13, 914 10.00 13.914 10.00 11.00 MEDICAL RECORDS 1,850 0 0 1,850 11.00 12.00 STAFF TRANSPORTATION 74, 384 0 74, 384 12.00 13.00 VOLUNTEER SERVICE COORDINATION 0 48.128 0 19, 762 67,890 13.00 14.00 PHARMACY 319, 580 0 0 319, 580 14.00 15.00 PHYSICIAN ADMINISTRATIVE SERVICES 0 0 0 15.00 OTHER GENERAL SERVICE 0 16.00 0 C 0 16.00 0 PATIENT/RESIDENTIAL CARE SERVICES 0 17.00 C 0 17.00 EVEL OF CARE HOSPICE CONTINUOUS HOME CARE 50.00 n 50.00 HOSPICE ROUTINE HOME CARE 2, 036, 399 1,659,340 377, 059 51.00 51.00 52.00 HOSPICE INPATIENT RESPITE CARE 189, 492 C 0 71, 016 260, 508 52.00 53.00 HOSPICE GENERAL INPATIENT CARE 1, 555, 871 0 0 638, 339 2, 194, 210 53.00 NONREI MBURSABLE COST CENTERS

62, 675

2, 626, 688

12, 356, 795

0

0

0

0

0

0

0

0

0

0

0

0

0

0

0

0

0

0

0

0

0

0

0

0

0

0

0

0

0

0

0

O

0

BEREAVEMENT PROGRAM

PALLIATIVE CARE PROGRAM

OTHER PHYSICIAN SERVICES

TELEHEALTH/TELEMONI TORI NG

NURSING FACILITY ROOM & BOARD

OTHER NONREIMBURSABLE (SPECIFY)

HOSPICE/PALLIATIVE MEDICINE FELLOWS

VOLUNTEER PROGRAM

RESIDENTIAL CARE

FUNDRAI SI NG

ADVERTI SI NG

THRIFT STORE

99.00 NEGATIVE COST CENTER

60.00

61.00

62.00

63.00

64.00

65.00

66.00

67 00

68.00

69.00

70.00

71 00

100.00 TOTAL

Heal th FinancialSystemsST.FRANCIS HOSPICOST ALLOCATION- HOSPITAL-BASED HOSPICEGENERALSERVICE COSTS Provider CCN: 15-0162 | Peri od: From 01/01/2020 | Worksheet 0-6 | Part I | To 12/31/2020 | Date/Time Prepared: 3/30/2021 10: 40 am

			,			3/30/2021 10:	40 am_
					Hospi ce I		
	Descriptions	ADMI NI STRATI V	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		E & GENERAL	OPERATION &	LINEN SERVICE			
			MAI NTENANCE				
		4. 00	5. 00	6.00	7. 00	8. 00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL	3, 612, 029					4.00
5.00	PLANT OPERATION & MAINTENANCE	o	C				5.00
6.00	LAUNDRY & LINEN SERVICE	7, 167	C	24, 519			6.00
7.00	HOUSEKEEPI NG	o	C		0		7.00
8.00	DI ETARY	8, 883	C		0	30, 390	8.00
9.00	NURSING ADMINISTRATION	o	C		0		9.00
10.00	ROUTINE MEDICAL SUPPLIES	5, 747	C		O		10.00
11. 00	MEDI CAL RECORDS	764	C		0		11.00
12. 00	STAFF TRANSPORTATION	30, 724	C		0		12.00
13. 00	VOLUNTEER SERVICE COORDINATION	28, 042	C		0		13.00
14. 00	PHARMACY	132, 003	C		0		14.00
15. 00	PHYSI CI AN ADMI NI STRATI VE SERVI CES	0	Ċ		0		15. 00
16. 00	OTHER GENERAL SERVICE	o	Ċ		0		16. 00
17. 00	PATI ENT/RESI DENTI AL CARE SERVI CES	0	C		0		17. 00
.,, 00	LEVEL OF CARE	<u> </u>		1	<u> </u>		
50.00	HOSPICE CONTINUOUS HOME CARE	0					50.00
51. 00	HOSPICE ROUTINE HOME CARE	841, 135					51.00
52. 00	HOSPICE INPATIENT RESPITE CARE	107, 603	C	22, 449	0	27, 824	
53. 00	HOSPICE GENERAL INPATIENT CARE	906, 318	C	1		2, 566	53.00
00.00	NONREI MBURSABLE COST CENTERS	7007010		2,0,0	<u> </u>	2,000	00.00
60.00	BEREAVEMENT PROGRAM	25, 888			0		60.00
61. 00	VOLUNTEER PROGRAM	0	C		0		61.00
62.00	FUNDRAI SI NG		C		0		62.00
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS		C		0		63.00
64. 00	PALLIATIVE CARE PROGRAM	1, 517, 755	Ċ		0		64.00
65. 00	OTHER PHYSICIAN SERVICES	0	C		0		65. 00
66. 00	RESI DENTI AL CARE		C	ol o	0	0	66.00
67. 00	ADVERTI SI NG		C		0	, , ,	67.00
68. 00	TELEHEALTH/TELEMONI TORI NG		C		0		68. 00
69. 00	THRI FT STORE		C		0		69.00
70.00	NURSING FACILITY ROOM & BOARD		_				70.00
71. 00	OTHER NONREIMBURSABLE (SPECIFY)		C	ol o	n	0	71.00
99. 00	NEGATI VE COST CENTER		Č		n	0	99.00
	TOTAL	3, 612, 029	C	24, 519	o	30, 390	
		-, -, -, -, -,			١	, -,	

19, 661

2, 614

0

0

105, 108

99.00

0

95, 932 100. 00

99.00 NEGATIVE COST CENTER

100.00 TOTAL

Heal th FinancialSystemsST.FRANCIS HOSPICOST ALLOCATION- HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS ST. FRANCIS HOSPITAL & HEALTH CENTER In Lieu of Form CMS-2552-10 Worksheet 0-6 Part I Date/Time Prepared: 3/30/2021 10:40 am Provider CCN: 15-0162 Peri od: From 01/01/2020 To 12/31/2020 Hospi ce CCN: 15-1523 PHARMACY PHYSICIAN OTHER GENERAL PATIENT/ TOTAL Descriptions

	beschi pti ons	FIIARWACT	ADMI NI STRATI V	SERVI CE	RESI DENTI AL	TOTAL	
			E SERVICES		CARE SERVICES		
	T	14. 00	15. 00	16. 00	17. 00	18. 00	
	GENERAL SERVICE COST CENTERS	1					
1. 00	CAP REL COSTS-BLDG & FLXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPI NG						7.00
8.00	DI ETARY						8.00
9. 00	NURSI NG ADMI NI STRATI ON						9. 00
10.00	ROUTINE MEDICAL SUPPLIES						10.00
11.00	MEDI CAL RECORDS						11.00
12.00	STAFF TRANSPORTATION						12.00
13.00	VOLUNTEER SERVICE COORDINATION						13.00
	PHARMACY	451, 583					14.00
	PHYSICIAN ADMINISTRATIVE SERVICES	0	l e)			15.00
	OTHER GENERAL SERVICE	0		1 0			16.00
	PATI ENT/RESI DENTI AL CARE SERVI CES				0		17.00
171.00	LEVEL OF CARE			1	<u> </u>		
50.00	HOSPICE CONTINUOUS HOME CARE	0	C	0		0	50.00
	HOSPICE ROUTINE HOME CARE	442, 800		1		3, 541, 350	
52. 00	HOSPICE INPATIENT RESPITE CARE	8, 041	l d		o	428, 530	1
	1	742		1	-	3, 106, 100	1
00.00	NONREI MBURSABLE COST CENTERS	, , , ,		<u> </u>	٥١	0,100,100	00.00
60.00		0		0		88, 563	60.00
	VOLUNTEER PROGRAM	0		0		0	61.00
62.00	FUNDRAI SI NG	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
	PALLIATIVE CARE PROGRAM	0		0		5, 192, 252	
	OTHER PHYSICIAN SERVICES	0		0		0,,	65.00
	RESI DENTI AL CARE	0	l c	0	o	0	66.00
67. 00	ADVERTI SI NG	0		0	_	0	67.00
	TELEHEALTH/TELEMONI TORI NG	0		0		0	68.00
	THRI FT STORE	0		0		0	69.00
	NURSING FACILITY ROOM & BOARD					0	70.00
	OTHER NONREIMBURSABLE (SPECIFY)	0	l c	0	0	0	71.00
	NEGATI VE COST CENTER	0		1		0	•
	TOTAL	451, 583	_			-	
	1	1 .5.,000	1	1	١	.2, 555, 776	1.30.00

Health Financial Systems	ST. FRANCIS HOSPITAL	& HEALTH CENTER	In Lie	u of Form CMS-2552-10
COST ALLOCATION - HOSPITAL-BASED	HOSPICE GENERAL SERVICE COSTS	Provider CCN: 15-0162	Peri od:	Worksheet 0-6

From 01/01/2020 Part II To 12/31/2020 Date/Time Prepared: STATISTICAL BASIS Hospi ce CCN: 15-1523 3/30/2021 10:40 am Hospi ce I Cost Center Descriptions CAP REL BLDG CAP REL MVBLE **EMPLOYEE** RECONCILIATIO ADMINISTRATIV & FIX EQUI P **BENEFITS** E & GENERAL Ν (SQUARE FEET) (DOLLAR DEPARTMENT (ACCUMULATED VALUE) (GROSS COSTS) SALARI ES) 1. 00 2.00 4.00 3.00 4A GENERAL SERVICE COST CENTERS 1 00 CAP REL COSTS-BLDG & FLXT 0 1 00 2.00 CAP REL COSTS-MVBLE EQUIP 2.00 EMPLOYEE BENEFITS DEPARTMENT 0 5, 832, 459 3.00 0 3.00 ADMINISTRATIVE & GENERAL 0000000000 -3, 612, 029 586, 738 4.00 0 8, 744, 766 4.00 PLANT OPERATION & MAINTENANCE 0 5.00 0 5.00 6.00 LAUNDRY & LINEN SERVICE 0 17, 352 6.00 7.00 HOUSEKEEPI NG 0 0 7.00 0 0 8.00 DI FTARY 0 0 21, 507 8.00 NURSING ADMINISTRATION 0 9.00 C 0 0 9.00 10.00 ROUTINE MEDICAL SUPPLIES 13, 914 10.00 11.00 MEDICAL RECORDS 0 0 0 0 1,850 11.00 STAFF TRANSPORTATION 74, 384 12.00 12.00 C 0 13.00 VOLUNTEER SERVICE COORDINATION 48, 128 67,890 13.00 0 14.00 **PHARMACY** 0 0 0 0 319, 580 14.00 PHYSICIAN ADMINISTRATIVE SERVICES 0 C 15.00 15.00 0 Ω 16.00 OTHER GENERAL SERVICE C 0 0 0 16.00 PATIENT/RESIDENTIAL CARE SERVICES 0 17.00 17.00 0 LEVEL OF CARE 50.00 HOSPICE CONTINUOUS HOME CARE 0 Ω 50.00 51.00 HOSPICE ROUTINE HOME CARE 918, 271 0 2,036,399 51.00 HOSPICE INPATIENT RESPITE CARE 172, 948 0 52.00 0 260, 508 52.00 53 00 HOSPICE GENERAL INPATIENT CARE 0 0 1, 554, 581 0 2, 194, 210 53.00 NONREI MBURSABLE COST CENTERS 60.00 BEREAVEMENT PROGRAM 0 0 0 0 62, 675 60.00 VOLUNTEER PROGRAM 0 0 0 61.00 00000000 0 61.00 0 62 00 FUNDRAI SI NG 0 0 62 00 0 HOSPICE/PALLIATIVE MEDICINE FELLOWS 63.00 0 0 0 63.00 64.00 PALLIATIVE CARE PROGRAM 2, 551, 793 0 3, 674, 497 64.00 OTHER PHYSICIAN SERVICES 65.00 0 0 0 0 0 65.00 66.00 RESIDENTIAL CARE 0 0 66.00 0 67.00 ADVERTI SI NG 0 0 0 67.00 TELEHEALTH/TELEMONI TORI NG 0 0 68.00 68.00 0 0 69.00 THRIFT STORE 0 0 0 69.00 NURSING FACILITY ROOM & BOARD 70.00 70.00 71.00 OTHER NONREIMBURSABLE (SPECIFY) 0 0 71.00 99.00 NEGATIVE COST CENTER 99.00

0.000000

2, 394, 910

0.410618

0.000000

3, 612, 029 100. 00

0. 413050 101. 00

100.00 COST TO BE ALLOCATED (per Wkst. 0-6, Part I)

101.00 UNIT COST MULTIPLIER

Health Financial Systems	ST. FRANCIS HOSPITAL	& HEALTH CENTER		In Lieu of Form CMS-2552-10
COST ALLOCATION - HOSPITAL-BA	SED HOSPICE GENERAL SERVICE COSTS	Provi der CCN: 15-0162	Peri od:	Worksheet 0-6

From 01/01/2020 | Part II
To 12/31/2020 | Date/Time Prepared: STATISTICAL BASIS Hospi ce CCN: 15-1523 3/30/2021 10:40 am Hospi ce I Cost Center Descriptions PLANT LAUNDRY & HOUSEKEEPI NG DI ETARY NURSI NG LINEN SERVICE OPERATION & (SQUARE FEET) (IN-FACILITY ADMI NI STRATI O (IN-FACILITY MAI NTENANCE DAYS) (DI RECT NURS. (SQUARE FEET) DAYS) HRS.) 5. 00 6.00 7.00 8.00 9.00 GENERAL SERVICE COST CENTERS 1 00 CAP REL COSTS-BLDG & FIXT 1 00 2.00 CAP REL COSTS-MVBLE EQUIP 2.00 EMPLOYEE BENEFITS DEPARTMENT 3.00 3.00 ADMINISTRATIVE & GENERAL 4.00 4.00 PLANT OPERATION & MAINTENANCE 5.00 5.00 6.00 LAUNDRY & LINEN SERVICE 00000000000 604 6.00 7.00 HOUSEKEEPI NG 7.00 0 8.00 DI FTARY 604 8.00 NURSING ADMINISTRATION 9.00 31,056 9.00 10.00 ROUTINE MEDICAL SUPPLIES 10.00 MEDICAL RECORDS 0 11.00 11.00 0 0 STAFF TRANSPORTATION 12.00 12.00 0 VOLUNTEER SERVICE COORDINATION 13.00 0 13.00 0 14.00 **PHARMACY** 0 14.00 PHYSICIAN ADMINISTRATIVE SERVICES 15.00 0 15.00 0 16.00 OTHER GENERAL SERVICE 0 0 16.00 PATIENT/RESIDENTIAL CARE SERVICES 17.00 17.00 0 LEVEL OF CARE HOSPICE CONTINUOUS HOME CARE 50.00 Λ 50.00 51.00 HOSPICE ROUTINE HOME CARE 30, 452 51.00 HOSPICE INPATIENT RESPITE CARE 52.00 0 553 0 553 553 52.00 53.00 HOSPICE GENERAL INPATIENT CARE 0 51 0 51 51 53.00 NONREIMBURSABLE COST CENTERS 60.00 BEREAVEMENT PROGRAM 0 0 0 60.00 VOLUNTEER PROGRAM 0 61.00 00000000 0 61.00 0 FUNDRAI SI NG 62 00 62.00 0 HOSPICE/PALLIATIVE MEDICINE FELLOWS 63.00 0 63.00 64.00 PALLIATIVE CARE PROGRAM 0 0 64.00 OTHER PHYSICIAN SERVICES 65.00 0 0 65.00 0 66.00 RESIDENTIAL CARE Ω 0 66.00 0 0 67.00 ADVERTI SI NG 0 67.00 TELEHEALTH/TELEMONI TORI NG 0 68.00 68.00 0 0 69.00 THRIFT STORE 0 69.00 NURSING FACILITY ROOM & BOARD 70.00 70.00

0

0.000000

24.519

40. 594371

0

0.000000

30.390

50. 314570

0 71.00

0.000000 101.00

99.00

0 100.00

71.00

99.00

OTHER NONREIMBURSABLE (SPECIFY)

100.00 COST TO BE ALLOCATED (per Wkst. 0-6, Part I)

NEGATIVE COST CENTER

101.00 UNIT COST MULTIPLIER

Health Financial Systems	ST. FRANCIS HOSPITAL	& HEALTH CENTER	In Lie	u of Form CMS-2552-10
COST ALLOCATION - HOSPITAL-BASED HOS	SPICE GENERAL SERVICE COSTS	Provi der CCN: 15-0162	Peri od:	Worksheet 0-6

From 01/01/2020 Part II
To 12/31/2020 Date/Time Prepared: STATISTICAL BASIS Hospi ce CCN: 15-1523 3/30/2021 10:40 am Hospi ce I Cost Center Descriptions ROUTI NE MEDI CAL STAFF VOLUNTEER PHARMACY RECORDS MEDI CAL TRANSPORTATIO SERVI CE (CHARGES) (PATI ENT SUPPLI ES COORDI NATI ON (MI LEAGE) (PATIENT DAYS) (HOURS OF DAYS) SERVICE) 10. 00 11. 00 12.00 14.00 13.00 GENERAL SERVICE COST CENTERS 1 00 CAP REL COSTS-BLDG & FIXT 1 00 2.00 CAP REL COSTS-MVBLE EQUIP 2.00 EMPLOYEE BENEFITS DEPARTMENT 3.00 3.00 ADMINISTRATIVE & GENERAL 4.00 4.00 PLANT OPERATION & MAINTENANCE 5.00 5.00 6.00 LAUNDRY & LINEN SERVICE 6.00 7.00 HOUSEKEEPI NG 7.00 8.00 DI FTARY 8.00 NURSING ADMINISTRATION 9.00 9.00 10.00 ROUTINE MEDICAL SUPPLIES 31, 056 10.00 11.00 MEDICAL RECORDS 31,056 11.00 STAFF TRANSPORTATION 100 12.00 12.00 VOLUNTEER SERVICE COORDINATION 13.00 0 31,056 13.00 0 14.00 **PHARMACY** 31,056 14.00 0 PHYSICIAN ADMINISTRATIVE SERVICES 0 15.00 15.00 0 0 16.00 OTHER GENERAL SERVICE 0 0 16.00 PATIENT/RESIDENTIAL CARE SERVICES 17.00 17.00 LEVEL OF CARE HOSPICE CONTINUOUS HOME CARE 50.00 0 Λ 50.00 100 51.00 HOSPICE ROUTINE HOME CARE 30, 452 30, 452 30, 452 30, 452 51.00 HOSPICE INPATIENT RESPITE CARE 52.00 553 553 0 553 553 52.00 0 53 00 HOSPICE GENERAL INPATIENT CARE 51 51 51 51 53.00 NONREI MBURSABLE COST CENTERS 60.00 BEREAVEMENT PROGRAM 0 0 0 60.00 VOLUNTEER PROGRAM 0 0 61.00 0 61.00 0 0 62 00 FUNDRAI SI NG 62.00 0 HOSPICE/PALLIATIVE MEDICINE FELLOWS 63.00 0 63.00 64.00 PALLIATIVE CARE PROGRAM 0 0 64.00 0 0 0 0 OTHER PHYSICIAN SERVICES 65.00 0 0 65.00 0 66.00 RESIDENTIAL CARE 0 66.00 0 67.00 ADVERTI SI NG 0 67.00 TELEHEALTH/TELEMONI TORI NG 0 0 68.00 68.00 0 69.00 THRIFT STORE 0 0 69.00 NURSING FACILITY ROOM & BOARD 70.00 70.00 71.00 OTHER NONREIMBURSABLE (SPECIFY) 0 0 71.00 99. 00 NEGATI VE COST CENTER 99.00 100.00 COST TO BE ALLOCATED (per Wkst. 0-6, Part I) 451, 583 100. 00 19.661 95. 932 2,614 105.108

0.633082

0. 084171 1, 051. 080000

14. 540926 101. 00

3.089001

101.00 UNIT COST MULTIPLIER

Heal th FinancialSystemsST. FRANCIS HOSPICOST ALLOCATION - HOSPITAL-BASEDHOSPICE GENERALSERVICE COSTSSTATISTICALBASIS ST. FRANCIS HOSPITAL & HEALTH CENTER In Lieu of Form CMS-2552-10

Provi der CCN: 15-0162 | Peri od: From 01/01/2020 | Part II | To 12/31/2020 | Date/Time Prepared: 3/30/2021 10: 40 am

			·			3/30/2021 10:	:40 am_
					Hospi ce I		
	Cost Center Descriptions	PHYSI CI AN	OTHER GENERAL	PATI ENT/			
	'	ADMI NI STRATI V	SERVI CE	RESI DENTI AL			
		E SERVICES	(SPECI FY	CARE SERVICES			
		(PATI ENT	BASIS)	(IN-FACILITY			
		DAYS)		DAYS)			
		15. 00	16. 00	17. 00			
	GENERAL SERVICE COST CENTERS	10.00	10.00	17.00			
1. (1.00
2. (2.00
3. (3.00
4. (4.00
5. (5.00
6. (6.00
7. (7. 00
8. (8. 00
9. (9. 00
10.							10.00
11.							11.00
12.	OO STAFF TRANSPORTATION						12.00
13.	OO VOLUNTEER SERVICE COORDINATION						13.00
14.	OO PHARMACY						14.00
15.	OO PHYSICIAN ADMINISTRATIVE SERVICES	31, 056					15.00
16.							16.00
17.	OO PATIENT/RESIDENTIAL CARE SERVICES						17.00
	LEVEL OF CARE		•	•			
50.		C) C				50.00
51.		30, 452		1			51.00
52.		553		1			52.00
53.		51					53.00
00.	NONREI MBURSABLE COST CENTERS	0.	· · · · · · · · · · · · · · · · · · ·	,ı	1		1 00.00
60.			С	nl			60.00
61.			Č	1			61.00
62.				1			62.00
63.	4			1			63.00
64.				1			64.00
				1			
65.			_	1			65.00
66.	·	C	٧ -	Ί "			66.00
67.			C	2			67.00
68.				<u>'</u>			68.00
69.			C	7			69. 00
70.							70.00
	00 OTHER NONREIMBURSABLE (SPECIFY)	C) C	0	1		71. 00
	OO NEGATI VE COST CENTER						99. 00
	0.00 COST TO BE ALLOCATED (per Wkst. 0-6, Part I)) C	0			100.00
101	. OO UNIT COST MULTIPLIER	0. 000000	0. 000000	0. 000000			101.00

LEVEL OF GARE		Hospi ce CCI	N: 15-1523 T	o 12/31/2020	Date/Time Pre 3/30/2021 10:	
				Hospi ce I		
		·	Charges by I	_OC (from Provi	der Records)	
Cost Center Descriptions	From Wkst. C, Part I, Col. 9 line	Cost to Charge Ratio	НСНС	HRHC	HI RC	
	0	1.00	2. 00	3. 00	4. 00	
ANCILLARY SERVICE COST CENTERS	1		1 -	_		
1. 00 PHYSI CAL THERAPY	66. 00			0	0	1.00
2. 00 OCCUPATI ONAL THERAPY	67.00			0	0	2.00
3.00 SPEECH PATHOLOGY 4.00 DRUGS CHARGED TO PATLENTS	68. 00 73. 00		1	0	0	3. 00 4. 00
5. OO DURABLE MEDICAL EQUIP-RENTED	73.00 96.00		C) U	0	5.00
6. 00 LABORATORY	60.00				0	6.00
7. 00 MEDICAL SUPPLIES CHARGED TO PATIENT	71.00				0	7.00
8. 00 OTHER OUTPATIENT SERVICE COST CENTER	93. 00				Ŭ	8.00
9. 00 RADI OLOGY-THERAPEUTI C	55. 00			0	0	ı
10. 97 CARDI AC REHABI LI TATI ON	76. 97			0	Ō	10. 97
11.00 Totals (sum of lines 1-11)						11.00
	Charges by		Shared Servic	e Costs by LOC		
	LOC (from					
	Provi der					
	Records)		Lunium ()			
Cost Center Descriptions	HGI P	HCHC (col. 1		,	HGIP (col. 1	
	5. 00	x col. 2) 6.00	x col. 3) 7.00	x col. 4) 8.00	x col. 5) 9.00	
ANCILLARY SERVICE COST CENTERS	3.00	0.00	7.00	0.00	7.00	
1. 00 PHYSI CAL THERAPY	0	0		0	0	1.00
2. 00 OCCUPATI ONAL THERAPY	0	l o	d	0	0	2.00
3.00 SPEECH PATHOLOGY	0	0		0	0	3.00
4.00 DRUGS CHARGED TO PATIENTS	0	0	d c	0	0	4.00
5.00 DURABLE MEDICAL EQUIP-RENTED						5.00
6. 00 LABORATORY	0	0	C	0	0	6. 00
7.00 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	C	0	0	
8.00 OTHER OUTPATIENT SERVICE COST CENTER						8. 00
9. 00 RADI OLOGY-THERAPEUTI C	0	0	1	1	0	
10. 97 CARDI AC REHABI LI TATI ON	0	0	· ·	_	0	10. 97
11.00 Totals (sum of lines 1-11)		0	() C	0	0	11.00

Health Financial Systems	ST. FRANCIS HOSPITAL &	HEALTH CENTER	In Lieu	u of Form CMS-2552-10
CALCULATION OF HOSPITAL-BASED HOSPICE PER D	OLEM COST	Provider CCN: 15-0162	Peri od:	Worksheet 0-8

					3/30/2021 10.	40 alli
				Hospi ce I		
			TITLE XVIII	TITLE XIX	TOTAL	
			MEDI CARE	MEDI CAI D		
			1. 00	2. 00	3. 00	
	HOSPICE CONTINUOUS HOME CARE					
1.00	Total cost (Wkst. 0-6, Part I, col. 18, line 50 plus Wkst. 0-	7, col. 6,			0	1.00
	line 11)					
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 10)				0	2.00
3.00	Total average cost per diem (line 1 divided by line 2)				0.00	3.00
4.00	Unduplicated program days (Wkst. S-9 col. as appropriate, lin	e 10)		0		4.00
5.00	Program cost (line 3 times line 4)			0		5.00
	HOSPICE ROUTINE HOME CARE					
6.00	Total cost (Wkst. 0-6, Part I, col. 18, line 51 plus Wkst. 0-	7, col. 7,			3, 541, 350	6.00
	line 11)					
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)				30, 452	7. 00
8.00	Total average cost per diem (line 6 divided by line 7)				116. 29	8. 00
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, li	ne 11)	25, 710	1, 784		9. 00
10.00	Program cost (line 8 times line 9)		2, 989, 81	207, 461		10.00
	HOSPICE INPATIENT RESPITE CARE					
11.00	Total cost (Wkst. 0-6, Part I, col. 18, line 52 plus Wkst. 0-	7, col. 8,			428, 530	11.00
	line 11)					
12.00	Total unduplicated days (Wkst. S-9, col. 4, line 12)				553	12.00
13.00	Total average cost per diem (line 11 divided by line 12)				774. 92	13.00
14.00	Unduplicated program days (Wkst. S-9, col. as appropriate, li	ne 12)	498			14.00
15.00	Program cost (line 13 times line 14)		385, 910	18, 598		15.00
	HOSPICE GENERAL INPATIENT CARE					
16.00		7, col. 9,			3, 106, 100	16.00
	line 11)					
17.00	Total unduplicated days (Wkst. S-9, col. 4, line 13)				51	
18. 00	Total average cost per diem (line 16 divided by line 17)				60, 903. 92	1
19.00	Unduplicated program days (Wkst. S-9, col. as appropriate, li	ne 13)		19		19.00
20.00	Program cost (line 18 times line 19)		(1, 157, 174		20.00
	TOTAL HOSPICE CARE			_		
	Total cost (sum of line 1 + line 6 + line 11 + line 16)				7, 075, 980	1
22.00					31, 056	1
23. 00	Average cost per diem (line 21 divided by line 22)				227. 85	23.00

		Peri od:	u of Form CMS-2 Worksheet L	2002-10	
0,12002			From 01/01/2020	Parts I-III	
To 12/31/2020			Date/Time Pre 3/30/2021 10:		
Title XVIII Hospital				PPS	
			Urban	Rural 1. 01	
	PART I - FULLY PROSPECTIVE METHOD				
	CAPITAL FEDERAL AMOUNT				
1. 00	Capital DRG other than outlier 5,095.241			847, 846	1.00
1. 01	Model 4 BPCI Capital DRG other than outlier			017,010	1.01
2.00	Capital DRG outlier payments				2.00
2.01	Model 4 BPCI Capital DRG outlier payments				2. 01
3.00	Total inpatient days divided by number of days in the cost reporting period (see 275.02				3.00
	instructions) Number of interns & residents (see instructions) 19.23				
4. 00	Number of interns & residents (see instructions)				4. 00
5. 00	Indirect medical education percentage (see instructions)		1. 99		5.00
6. 00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01,				6. 00
7. 00	columns 1 and 1.01)(see instructions) Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, 3.09)				7. 00
7.00	part A line 30) (see instructions)				7.00
8. 00	Percentage of Medicaid patient days to total days (see instructions) 19.87				8.00
9. 00					9.00
10.00	Allowable disproportionate share percentage (see instructions) 4.7				10.00
11.00	Disproportionate share adjustment (see instructions)		242, 533		11.00
12.00	2.00 Total prospective capital payments (see instructions) 6,855,539				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	
3.00	g i			0	
4. 00				0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)			0	1
DADT LLL COMPUTATION OF EVOEDTION DANGENTO				1. 00	
4 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS				1 00
1.00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstances (see instructions)			0	
2. 00 3. 00	Net program inpatient capital costs (line 1 minus line 2)			0	2. 00 3. 00
4. 00	Applicable exception percentage (see instructions)			0. 00	•
5. 00	Capital cost for comparison to payments (line 3 x line 4)			0.00	5.00
6. 00	Percentage adjustment for extraordinary circumstances (see instructions)			0. 00	
7. 00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)			0.00	7.00
8. 00				0	•
9. 00	Current year capital payments (from Part I, line 12, as applicable)			0	
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)			0	10.00
11.00	Carryover of accumulated capital minimum payment level over ca			0	11.00
	Worksheet L, Part III, line 14)				
12 00	200 Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)			0	12 00

0 12.00

0 13.00

0 15.00

14.00

0 16.00

0 17.00

12.00 Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)
13.00 Current year exception payment (if line 12 is positive, enter the amount on this line)

16.00 Current year operating and capital costs (see instructions)

17.00 Current year exception offset amount (see instructions)

14.00 Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)

15.00 Current year allowable operating and capital payment (see instructions)