This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 03-31-2022 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 15-0126 Worksheet S Peri od: From 01/01/2021 Parts I-III AND SETTLEMENT SUMMARY 12/31/2021 Date/Time Prepared: 5/30/2022 5:41 pm PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 5/30/2022 5:41 pm] Manually prepared cost report use only Ilf this is an amended report enter the number of times the provider resubmitted this cost report [Medicare Utilization. Enter "F" for full or "L" for low. [1] Cost Report Status
[1] As Submitted
[2] Settled without Audit
[3] Settled with Audit
[4] Date Received:
[5] To. NPR Date:
[6] 10. NPR Date:
[7] 11. Contractor's Vendor Code:
[7] 12. [8] Final Report for this Provider CCN
[9] [8] Final Report for this Provider CCN
[10] NPR Date:
[11] 12. Contractor's Vendor Code:
[11] 12. [8] 13. Contractor's Vendor Code:
[12] 13. NPR Date:
[13] 14. Contractor's Vendor Code:
[14] 15. Contractor's Vendor Code:
[15] 16. NPR Date:
[16] 17. Contractor's Vendor Code:
[17] 18. Contractor's Vendor Code:
[18] 19. Contractor's Vendor Code:
[19] 19. Contractor's Vendor Code:
[1 Contractor use only

number of times reopened = 0-9.

PART II - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OR PROVIDER(S)

(3) Settled with Audit

(4) Reopened (5) Amended

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by FRANCISCAN HEALTH CROWN POINT (15-0126) for the cost reporting period beginning 01/01/2021 and ending 12/31/2021 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.

	SIGNATURE OF CHIEF FINA	NCIAL OFFICER OR ADMINISTRATOR	CHECKBOX		
		1	2	SI GNATURE STATEMENT	
1				I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name				2
3	Signatory Title	DI VI SI ONAL CFO			3
4	Date				4

			Title XVIII				
	Cost Center Description		Part A	Part B	HIT	Title XIX	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	270, 870	-110, 092	0	0	1.00
2.00	Subprovi der - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3. 00
5.00	Swing Bed - SNF	0	0	0		0	5. 00
6.00	Swing Bed - NF	0				0	6.00
200.00	Total	0	270, 870	-110, 092	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.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0126 Peri od: Worksheet S-2 From 01/01/2021 Part I Date/Time Prepared: 12/31/2021 5/30/2022 5:41 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 1201 SOUTH MAIN STREET 1.00 PO Box: 1.00 State: IN 2.00 City: CROWN POINT Zip Code: 46307 County 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, O, or N)
V XVIII XIX Number Number Certi fi ed Type 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 FRANCISCAN HEALTH CROWN 150126 23844 12/31/1973 Ν 0 3.00 POI NT Subprovi der - IPF 4.00 4 00 5.00 Subprovider - IRF 5.00 Subprovi der - (Other) 6.00 6.00 Swing Beds - SNF 7 00 7 00 8.00 Swing Beds - NF 8.00 9.00 Hospi tal -Based SNF 9.00 10.00 Hospi tal -Based NF 10.00 11.00 Hospi tal -Based OLTC 11.00 12.00 Hospi tal -Based HHA 12.00 Separately Certified ASC 13.00 13.00 Hospi tal -Based Hospi ce 14.00 14.00 Hospital-Based Health Clinic - RHC 15.00 15 00 16.00 Hospital-Based Health Clinic - FQHC 16.00 17.00 Hospital-Based (CMHC) I 17.00 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: 2.00 1.00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2021 12/31/2021 20.00 21.00 Type of Control (see instructions) 21.00 1 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 Ν Ν 22.01 cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1.

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

Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) 22.02 22.02 N N Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to 22.03 N Ν 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 yes or "N" for no. Did this hospital receive a geographic reclassification from urban to 22.04 Ν Ν Ν rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? 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, yes or "N" for no. 23 00 Which method is used to determine Medicaid days on lines 24 and/or 25 23 00 3 Υ 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.

To 12/31/2021 Date/Time 5/30/2022								
	In-State	In-State	Out-of	Out-of	Medi cai	d 01	ther	
	Medicaid paid days	Medicaid eligible	State Medicaid	State Medicaid	HMO day		i cai d ays	
		unpai d	pai d days	eligible			-,,-	
	1.00	days 2. 00	3. 00	unpai d 4. 00	5. 00	6	. 00	
24.00 If this provider is an IPPS hospital, enter the	1.00			118	6, 4			24. 00
in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2,								
out-of-state Medicaid paid days in column 3,								
out-of-state Medicaid eligible unpaid days in column								
 Medicaid HMO paid and eligible but unpaid days ir column 5, and other Medicaid days in column 6. 	1							
25.00 If this provider is an IRF, enter the in-state	0	0	0	0		0		25. 00
Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2,								
out-of-state Medicaid days in column 3, out-of-state								
Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.								
				Urban/R	ural S [
26.00 Enter your standard geographic classification (not w	age) status	at the beg	inning of 1		1	2.0)()	26. 00
cost reporting period. Enter "1" for urban or "2" fo		-4 44		_				27.00
27.00 Enter your standard geographic classification (not wreporting period. Enter in column 1, "1" for urban co	nage) status or "2" for r	at the end ural. If ap	plicable,	st	'			27. 00
enter the effective date of the geographic reclassif	ication in	column 2.						25 00
35.00 If this is a sole community hospital (SCH), enter the effect in the cost reporting period.	e number or	periods sc	H Status II	1	0			35. 00
				Begi ni		Endi 2. C		
36.00 Enter applicable beginning and ending dates of SCH s	tatus. Subs	cript line	36 for numb		00	2. (<i>,</i>	36. 00
of periods in excess of one and enter subsequent dat		r of portod	lo MDII ototi		0			27.00
37.00 If this is a Medicare dependent hospital (MDH), entering is in effect in the cost reporting period.	er the numbe	r or period	IS MDH Statt	JS	U			37. 00
37.01 Is this hospital a former MDH that is eligible for t								37. 01
accordance with FY 2016 OPPS final rule? Enter "Y" finstructions)	or yes or	N FOF NO.	(See					
38.00 If line 37 is 1, enter the beginning and ending date								38. 00
greater than 1, subscript this line for the number of enter subsequent dates.	n perrous r	n excess or	one and					
				1. (Y/ 2. C		
39.00 Does this facility qualify for the inpatient hospita				ume N		N		39. 00
hospitals in accordance with 42 CFR §412.101(b)(2)(i 1 "Y" for yes or "N" for no. Does the facility meet				nn				
accordance with 42 CFR 412.101(b)(2)(i), (ii), or (i	ii)? Enter	in column 2	!"Y" for y∈	es				
or "N" for no. (see instructions) 40.00 Is this hospital subject to the HAC program reduction	n adiustmon	t2 Entor "V	" for yes o	or N		N		40. 00
"N" for no in column 1, for discharges prior to Octo						IV		40.00
no in column 2, for discharges on or after October 1	. (see inst	ructions)			V	XVIII	XI X	
						2. 00		
Prospective Payment System (PPS)-Capital 45.00 Does this facility qualify and receive Capital payment	ent for disn	ronorti onat	e share in	accordance	l N	Υ	N	45. 00
with 42 CFR Section §412.320? (see instructions)	•	·					"	
46.00 Is this facility eligible for additional payment exc pursuant to 42 CFR §412.348(f)? If yes, complete Wks					N	N	N	46. 00
Pt. III.	•		•	3				
47.00 Is this a new hospital under 42 CFR §412.300(b) PPS 48.00 Is the facility electing full federal capital paymer					N N	N N	N N	47. 00 48. 00
Teaching Hospitals						14	14	40.00
56.00 Is this a hospital involved in training residents in "N" for no in column 1. For column 2, if the respons	approved G	ME programs	? Enter "Y'	for yes or	- Y	N		56. 00
was involved in training residents in approved GME p	rograms in	the prior y	rear or penu	ultimate				
year, and are you are impacted by CR 11642 (or appli Enter "Y" for yes; otherwise, enter "N" for no in co	,	MA direct G	GME payment	reduction?				
57.00 If line 56 is yes, is this the first cost reporting	period duri				Y	Υ		57. 00
GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mor								
for yes or "N" for no in column 2. If column 2 is "	Y", complet	e Worksheet						
"N", complete Wkst. D, Parts III & IV and D-2, Pt. I 58.00 If line 56 is yes, did this facility elect cost rein			ns' service	es as	N			58. 00
defined in CMS Pub. 15-1, chapter 21, §2148? If yes,	complete W	kst. D-5.		==				
59.00 Are costs claimed on line 100 of Worksheet A? If ye	es, complete	WKSt. D-2,	Pt. I.		N			59. 00

		1.00	2.00	3.00	4.00	J. 00			
61. 00	Did your hospital receive FTE slots under ACA	N			0.00	0.00	61. 00		
	section 5503? Enter "Y" for yes or "N" for no in								
61 01	column 1. (see instructions) Enter the average number of unweighted primary care						61. 01		
01.01	FTEs from the hospital's 3 most recent cost reports						01.01		
	ending and submitted before March 23, 2010. (see								
	instructions)								
61. 02	Enter the current year total unweighted primary care						61. 02		
	FTE count (excluding OB/GYN, general surgery FTEs,								
	and primary care FTEs added under section 5503 of								
	ACA). (see instructions)								
61. 03	Enter the base line FTE count for primary care						61. 03		
	and/or general surgery residents, which is used for								
	determining compliance with the 75% test. (see								
(4.04	instructions)								
61.04	Enter the number of unweighted primary care/or						61. 04		
	surgery allopathic and/or osteopathic FTEs in the								
61 OF	current cost reporting period. (see instructions). Enter the difference between the baseline primary						61. 05		
01.03	and/or general surgery FTEs and the current year's						01.03		
	primary care and/or general surgery FTE counts (line								
	61. 04 minus line 61. 03). (see instructions)								
61. 06	Enter the amount of ACA §5503 award that is being						61. 06		
	used for cap relief and/or FTEs that are nonprimary								
	care or general surgery. (see instructions)								
		Pr	ogram Name	Program Code	Unweighted IME	Unwei ghted			
					FTE Count	Direct GME FTE			
						Count			
			1. 00	2. 00	3. 00	4. 00			
61. 10	Of the FTEs in line 61.05, specify each new program				0.00	0.00	61. 10		
	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.								
61 20	Of the FTEs in line 61.05, specify each expanded				0.00	0.00	61. 20		
01.20	program specialty, if any, and the number of FTE				0.00	0.00	01.20		
	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.								
						1.00			
	ACA Provisions Affecting the Health Resources and Ser								
62. 00	Enter the number of FTE residents that your hospital		d in this cost	reporting peri	od for which	0.00	62. 00		
	your hospital received HRSA PCRE funding (see instruc			(TUO) ! !		0.00			
62.01	Enter the number of FTE residents that rotated from a				your nospitai	0.00	62. 01		
	during in this cost reporting period of HRSA THC program. (see instructions) Teaching Hospitals that Claim Residents in Nonprovider Settings								
62 00	Has your facility trained residents in nonprovider se			et roporting r	ori od? Entor	N	63. 00		
03.00	"Y" for yes or "N" for no in column 1. If yes, comple	9	J	1 9 1		IN IN	03.00		
	The ses of Note to the column to the yes, comple	ete IIN	es of through 6	or. (see mstrt	icti ons)	ı l	I		

Health Financial Systems	FRANCI SCA	AN HEALTH CROWN POINT		In lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMP			Fr	eriod: com 01/01/2021 o 12/31/2021	Worksheet S-2 Part I Date/Time Pre 5/30/2022 5:4	pared: 1 pm
			Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			1. 00	2. 00	3.00	
Section 5504 of the ACA Base Ye period that begins on or after			This base year	is your cost r	reporting	
64.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)						
	Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col. 3/	
			FTEs Nonprovider Site	FTEs in Hospital	(col. 3 + col. 4))	
	1. 00	2.00	3. 00	4.00	5.00	
is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0. 00	0.000000 Ratio (col. 1/	65. 00
			FTEs Nonprovi der Si te	FTEs in Hospital	(col. 1 + col. 2))	
			1. 00	2. 00	3.00	
Section 5504 of the ACA Current		n Nonprovider Setting	sEffective fo	r cost reporti	ng peri ods	
beginning on or after July 1, 2 66.00 Enter in column 1 the number of FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospi (column 1 divided by (column 1	unweighted non-primal occurring in all nonpo unweighted non-primal tal. Enter in column + column 2)). (see in:	rovider settings. ry care resident 3 the ratio of structions)	0.00			
	Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
67.00 Enter in column 1, the program	1.00 EMERGEMCY MED	2.00	3. 00	4. 00 0. 98	5. 00 0. 000000	67 00
name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			3. 60	J. 70	3. 555500	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0126 Peri od: Worksheet S-2 From 01/01/2021 Part I Date/Time Prepared: 12/31/2021 5/30/2022 5:41 pm 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 Ν 71.00 Ν 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 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 75.00 75.00 Ν 0 Ν Ν 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 80.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. N 80.00 81.00 | Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter N 81.00 'Y" for yes and "N" for no. TEFRA Providers 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 N Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section 86.00 86.00 \$413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no. 87.00 N 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 Ν Υ 90.00 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 N 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. N 92.00 93.00 Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter Ν Ν 93.00 Y" for yes or "N" for no in the applicable column. 94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the N N 94.00 applicable column. 95.00 If line 94 is "Y", enter the reduction percentage in the applicable column.
96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the 0 00 0 00 95 00 96.00 Ν N 97.00 If line 96 is "Y", enter the reduction percentage in the applicable column. 0.00 0.00 97.00 98.00 Does title V or XIX follow Medicare (title XVIII) for the interns and residents post 98.00 Υ 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. Υ Υ 98.01 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 bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 Υ 98.02 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) Ν 98.03 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. 98.04 Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of Ν 98.04 N outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and 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, 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? Ν 105.00 106.00 of this facility qualifies as a CAH, has it elected the all-inclusive method of payment 106.00 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) 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)

Health Financial Systems FRANCISCAN HEALTH	_			eu of Form CMS	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der CC		eriod: rom 01/01/2021 o 12/31/2021		epared:
			V	XI X	41 0111
108.00 Is this a rural hospital qualifying for an exception to the C	CDNA foo schoo	dul o2 Soo 42	1. 00 N	2.00	108. 00
CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		uure? 3ee 42	IN		100.00
	Physi cal 1. 00	Occupational 2.00	Speech 3.00	Respiratory 4.00	_
109.00 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.	1.00	2.00	3.00	4.00	109.00
				1.00	
110.00 Did this hospital participate in the Rural Community Hospital Demonstration) for the current cost reporting period? Enter "Y complete Worksheet E, Part A, lines 200 through 218, and Work applicable.	" for yes or	"N" for no. If	yes,	N	110.00
			1. 00	2.00	4
111.00 If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this cosmy. "Y" for yes or "N" for no in column 1. If the response to columtegration prong of the FCHIP demo in which this CAH is part Enter all that apply: "A" for Ambulance services; "B" for add for tele-health services.	st reporting pumn 1 is Y, eticipating in	period? Enter enter the column 2.	N N	2.00	111.00
		1.00	2.00	2.00	
112.00 Did this hospital participate in the Pennsylvania Rural Healt demonstration for any portion of the current cost reporting participate "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 cease participation in the demonstration, if applicable.	oeri od? "Y", enter e	1. 00 N	2.00	3.00	112. 00
Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or in column 1. If column 1 is yes, enter the method used (A, B, in column 2. If column 2 is "E", enter in column 3 either "93" for short term hospital or "98" percent for long term care (ipsychiatric, rehabilitation and long term hospitals providers	or E only) 3" percent ncludes	N			0115.00
the definition in CMS Pub. 15-1, chapter 22, §2208.1. 116.00 Is this facility classified as a referral center? Enter "Y" f "N" for no.	,	N			116. 00
117.00 Is this facility legally-required to carry malpractice insura	ance? Enter	Y			117. 00
"Y" for yes or "N" for no. 118.00 Is the malpractice insurance a claims-made or occurrence poli if the policy is claim-made. Enter 2 if the policy is occurred.	,	2			118. 00
		Premi ums	Losses	Insurance	
		1.00	2.00	2.00	
118.01 List amounts of malpractice premiums and paid losses:		1. 00 972, 843	2.00 374,443	3.00	0 118. 01
		, , , , , , , , , , , , , , , , , , , ,			
118.02 Are malpractice premiums and paid losses reported in a cost of Administrative and General? If yes, submit supporting scheduland amounts contained therein.			1. 00 N	2.00	118. 02
119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qual Hold Harmless provision in ACA §3121 and applicable amendment	column 1, "Y' alifies for th	" for yes or he Outpatient	N	N	119. 00 120. 00
	ntable devices	s charged to	Υ		121. 00
 121.00 Did this facility incur and report costs for high cost implar patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain healthcare related taxes as defi Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. 			Y	5. 00	122.00
 121.00 Did this facility incur and report costs for high cost implar patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain healthcare related taxes as defi Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for 	is "Y", enter	r in column 2	Y N	5. 00	
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are claimed, enter in column 2 the home office chain number. (see instructions) 3.00		or home office costs as	defined in CMS I	Pub. 15-1,	Y		140. 00
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If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office and enter the home office and enter the home office and the provider the home office and the provider that have been seen that the provider between the provider based physicians. Costs included in Worksheet A? 1.00				ons)	3 00		
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145.00 f costs for renal services are claimed on Wkst. A, line 74, are the costs for vipage of the services only? Enter "" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. (See CUS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2. 146. 00Has the cost allocation methodology changed from the previously filed cost report? In the cost of the province of the	144 00 Are provider based physicians' cost	s included in Worksheet	Α?				144 00
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Multicampus 165.00 Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? N 165.00 Enter "Y" for yes or "N" for no. Name County State Zip Code CBSA FTE/Campus 0 1.00 2.00 3.00 4.00 5.00 166.00 If line 165 is yes, for each 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) Heal th Information Technology (HIT) incentive in the American Recovery and Reinvestment Act 167.00 Is this provider a meaningful user under \$1886(n)? Enter "Y" for yes or "N" for no. 168.00 If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions) 168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship			N			N	160. 00
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Multicampus Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? N 165.00						1 00	
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Name County State Zip Code CBSA FTE/Campus 0 1.00 2.00 3.00 4.00 5.00 166.00 If line 165 is yes, for each 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) Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act 167.00 Is this provider a meaningful user under \$1886(n)? Enter "Y" for yes or "N" for no. 168.00 If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions) 168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship		npus hospital that has o	ne or more campus	ses in differ	ent CBSAs?	N	165. 00
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166. 00 If line 165 is yes, for each 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) 1.00 Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act 167. 00 Is this provider a meaningful user under \$1886(n)? Enter "Y" for yes or "N" for no. 168. 00 If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions) 168. 01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship							
0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) 1.00 Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act 167.00 Is this provider a meaningful user under \$1886(n)? Enter "Y" for yes or "N" for no. 168.00 If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions) 168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship 168.01						0. (00 166. 00
col umn 2, zip code in col umn 3, CBSA in col umn 4, FTE/Campus in col umn 5 (see instructions) Heal th Information Technology (HIT) incentive in the American Recovery and Reinvestment Act 167.00 Is this provider a meaningful user under \$1886(n)? Enter "Y" for yes or "N" for no. 168.00 If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions) 168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship 168.01							
CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HIT) incentive in the American Recovery and Reinvestment Act Heal th Information Technology (HIT) incentive in the American Recovery and Reinvestment Act 167.00 Is this provider a meaningful user under \$1886(n)? Enter "Y" for yes or "N" for no.							
Heal th Information Technology (HIT) incentive in the American Recovery and Reinvestment Act 167.00 Is this provider a meaningful user under \$1886(n)? Enter "Y" for yes or "N" for no. 168.00 If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions) 168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship 1.00 1.00 1.00 168.00	CBSA in column 4, FTE/Campus in						
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act 167.00 Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no. 168.00 If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions) 168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship 168.01	column 5 (see instructions)						
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act 167.00 Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no. 168.00 If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions) 168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship 168.01						1, 00	
167.00 is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no. 168.00 if this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions) 168.01 if this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship 168.01					t Act		
reasonable cost incurred for the HIT assets (see instructions) 168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship 168.01	167.00 Is this provider a meaningful user	under §1886(n)? Enter	"Y" for yes or "I	N" for no.		Y	167. 00
168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship 168.01				167 is "Y"),	enter the		168. 00
				qualify for	a hardshi p		168. 01
exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)	exception under §413.70(a)(6)(ii)?	Enter "Y" for yes or "N	l" for no. (see i	nstructions)	•		
169.00 of this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the			d is not a CAH (ine 105 is "	'N"), enter t	he 9.	99169. 00
transition factor. (see instructions)	transition ractor. (See instruction	13)				I	I

Health Financial Systems					
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX I	DENTIFICATION DATA	Provider CCN: 15-0126	Peri od:	Worksheet S-2	
			From 01/01/2021	Part I	
			To 12/31/2021	Date/Time Pre	pared:
				5/30/2022 5: 4	1 pm
	Begi nni ng	Endi ng			
			1. 00	2.00	
170.00 Enter in columns 1 and 2 the EHR beg period respectively (mm/dd/yyyy)			170. 00		
			1. 00	2.00	1
171.00 If line 167 is "Y", does this provid	er have any days for indiv	viduals enrolled in	N	0	171. 00
section 1876 Medicare cost plans rep					
"Y" for yes and "N" for no in column	n				
1876 Medicare days in column 2. (see	instructions)				

	FRANCISCAN HEALT AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-0126	Peri od:	u of Form CMS- Worksheet S-2			
	TE THE TOTAL THE HEALTH OTHE RETHINGUISEMENT QUESTIONING RE	T. OVI GET C		From 01/01/2021 To 12/31/2021	Part II Date/Time Pro 5/30/2022 5:4	epared		
				Y/N	Date			
	Canada Instruction, Enter V for all VEC recogness. Enter N	for all NO so	ananasa Ent	1.00	2. 00			
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	TOT ALL NO FE	esponses. Ente	er arr dates in t	ne			
	Provider Organization and Operation							
00	Has the provider changed ownership immediately prior to the			N		1. (
	reporting period? If yes, enter the date of the change in co	olumn 2. (see	Y/N) Date	V/I			
			1.00	2. 00	3. 00			
. 00	Has the provider terminated participation in the Medicare Pryes, enter in column 2 the date of termination and in column voluntary or "I" for involuntary.		N			2. (
. 00	Is the provider involved in business transactions, including contracts, with individuals or entities (e.g., chain home of or medical supply companies) that are related to the provide officers, medical staff, management personnel, or members of of directors through ownership, control, or family and other relationships? (see instructions)	ffices, drug er or its f the board	N			3. (
			Y/N	Туре	Date			
	Einancial Data and Poports		1.00	2. 00	3. 00			
. 00	Financial Data and Reports Column 1: Were the financial statements prepared by a Certi Accountant? Column 2: If yes, enter "A" for Audited, "C" for "R" for Reviewed. Submit complete copy or enter date avai column 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues differ	or Compiled, ilable in	Y	A	05/06/2022	4. (
	those on the filed financial statements? If yes, submit reco					0.		
		Y/N 1. 00	Legal Oper. 2.00					
00	Approved Educational Activities Column 1: Are costs claimed for a nursing program? Column 2 is the Legal operator of the program?	r Y	Υ	6. (
00 00	Are costs claimed for Allied Health Programs? If "Y" see instructions. Were nursing programs and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.							
00	Are costs claimed for Interns and Residents in an approved of		cal education	Υ		9.		
0. 00	program in the current cost report? If yes, see instructions Was an approved Intern and Resident GME program initiated or		the current	Y		10.		
1. 00	cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	proved	N	V (N	11.		
					Y/N 1. 00			
	Bad Debts	: .		Т		1.0		
	Is the provider seeking reimbursement for bad debts? If yes, If line 12 is yes, did the provider's bad debt collection poperiod? If yes, submit copy.			ost reporting	Y N	12. 13.		
. 00	If line 12 is yes, were patient deductibles and/or co-paymer Bed Complement	nts waived? If	yes, see in:	structions.	N	14.		
5. 00	Did total beds available change from the prior cost reporting		yes, see ins t A	tructions. Par	N + R	15.		
		Y/N	Date	Y/N	Date			
		1.00	2.00	3. 00	4. 00			
5. 00	PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through	Y	03/08/2022	Y	03/08/2022	16.		
7. 00	date of the PS&R Report used in columns 2 and 4 (see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	N	03/08/2022	N	03/08/2022	17.		
3. 00	in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	N		N		18.		
9. 00	cost report? If yes, see instructions.	N		N		19.		

Heal th	Financial Systems FRANCISCAN HEALT	H CROWN POINT		In Lie	u of Form CMS-	2552-10
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CN: 15-0126	Peri od: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part II Date/Time Pre 5/30/2022 5:4	pared:
			pti on	Y/N	Y/N	
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R)	1. 00 N	3. 00 N	20.00
20.00	Report data for Other? Describe the other adjustments:			IN IN	IV	20.00
		Y/N	Date	Y/N	Date	
21. 00	Was the cost report prepared only using the provider's	1. 00 N	2.00	3. 00 N	4. 00	21. 00
21.00	records? If yes, see instructions.	IN		IN IN		21.00
					1. 00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCER	PT CHILDRENS H	OSPI TALS)			
00.00	Capi tal Related Cost				N.	00.00
22. 00 23. 00	Have assets been relifed for Medicare purposes? If yes, see Have changes occurred in the Medicare depreciation expense		ale mada dur	ing the cost	N N	22. 00 23. 00
23.00	reporting period? If yes, see instructions.	due to apprais	ars made dur	ing the cost	IN	23.00
24. 00	Were new leases and/or amendments to existing leases entered if yes, see instructions	d into during	this cost re	porting period?	N	24. 00
25. 00	Have there been new capitalized leases entered into during instructions.	If yes, see	N	25. 00		
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during the instructions.	e cost reporti	ng period? I	f yes, see	N	26. 00
27. 00	Has the provider's capitalization policy changed during the copy.	cost reportir	g period? If	yes, submit	N	27. 00
28. 00	Interest Expense Were new Loans, mortgage agreements or Letters of credit en	tered into dur	ing the cost	reporti ng	N	28. 00
29. 00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or I	eserve Fund)	N	29. 00		
30. 00	treated as a funded depreciation account? If yes, see instru Has existing debt been replaced prior to its scheduled matur	, see	N	30. 00		
31. 00	instructions. Has debt been recalled before scheduled maturity without issinstructions.	N	31. 00			
	Purchased Services					
32. 00	Have changes or new agreements occurred in patient care serv		d through co	ntractual	N	32. 00
33. 00	arrangements with suppliers of services? If yes, see instructions and is yes, were the requirements of Sec. 2135.2 applino, see instructions.		g to competi	tive bidding? If	N	33. 00
	Provi der-Based Physi ci ans					
34. 00	Are services furnished at the provider facility under an arilf yes, see instructions.	rangement with	provi der-ba	sed physi ci ans?	Υ	34. 00
35. 00	If line 34 is yes, were there new agreements or amended exisphysicians during the cost reporting period? If yes, see in:		its with the	provi der-based	N	35. 00
				Y/N	Date	
	Home Office Costs			1. 00	2. 00	
36. 00	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 prolef yes, see instructions.	epared by the	home office?			37. 00
38. 00	If line 36 is yes, was the fiscal year end of the home offithe provider? If yes, enter in column 2 the fiscal year end			. N		38. 00
39. 00	If line 36 is yes, did the provider render services to other see instructions.			, N		39. 00
40. 00	If line 36 is yes, did the provider render services to the linstructions.	home office?	If yes, see	N		40. 00
	Cost Report Preparer Contact Information	1.	00	2.	00	
41. 00		GLENN		JOHNSON		41. 00
42. 00	respecti vel y.	FRANCISCAN ALL	I ANCE			42. 00
40.00	preparer.	210407/20/		CLENN IOUNGON	EDANCI COAMALI.	42.00
43. 00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	2194076386		GLENN. JOHNSON@I ANCE. ORG	FRANCI SCANALLI	43. 00

Health Financial Systems	FRANCISCAN HEAL	TH CROWN POINT		In Lieu of Form CMS-2552-10				
HOSPITAL AND HOSPITAL HEALTH CARE REIMB	URSEMENT QUESTIONNAIRE	Provi der CO		Period: From 01/01/2021	Worksheet S-2 Part II			
				Γο 12/31/2021	Date/Time Pre 5/30/2022 5:4	pared: 1 pm		
		3.	00					
Cost Report Preparer Contact Info	ormati on	_						
41.00 Enter the first name, last name	and the title/position	MANAGER				41. 00		
held by the cost report preparer	in columns 1, 2, and 3,							
respecti vel y.								
42.00 Enter the employer/company name	of the cost report					42.00		
preparer.								
43.00 Enter the telephone number and en	mail address of the cost					43.00		
report preparer in columns 1 and	2, respecti vel y.							

| Peri od: | Worksheet S-3 | From 01/01/2021 | Part | To 12/31/2021 | Date/Time Prepared:
 Heal th Financial
 Systems
 FRANCISCA

 HOSPITAL
 AND HOSPITAL HEALTH CARE COMPLEX
 STATISTICAL DATA
 Provider CCN: 15-0126

						То	12/31/2021	Date/Time Pro 5/30/2022 5:4		
								I/P Days / 0/F		рш
								Visits / Trips		
	Component	Worksheet A	No.	of Beds	Bed Days		CAH Hours	Title V	+	
		Line Number			Avai I abl e					
		1.00		2. 00	3.00		4. 00	5. 00	T	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		150	54, 750	0	0. 00	()	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							(5.00
6.00	Hospital Adults & Peds. Swing Bed NF)	6.00
7.00	Total Adults and Peds. (exclude observation			150	54, 750	0	0. 00	()	7. 00
	beds) (see instructions)									
8. 00	INTENSIVE CARE UNIT	31. 00		22	8, 030	0	0. 00	(8. 00
9.00	CORONARY CARE UNIT									9. 00
10. 00	BURN INTENSIVE CARE UNIT								- 1	10. 00
11. 00	SURGICAL INTENSIVE CARE UNIT								- 1	11. 00
12. 00	NEONATAL INTENSIVE CARE UNIT	35. 00		20	7, 30	0	0. 00		- 1	12.00
13.00	NURSERY	43. 00						(- 1	13.00
14. 00	Total (see instructions)			192	70, 080	0	0. 00			14.00
15. 00	CAH visits							()	15.00
16. 00	SUBPROVI DER - I PF									16.00
17. 00	SUBPROVI DER - I RF								- 1	17. 00
18. 00	SUBPROVI DER								- 1	18. 00
19. 00	SKILLED NURSING FACILITY								- 1	19. 00
20.00	NURSING FACILITY								- 1	20.00
21. 00	OTHER LONG TERM CARE								- 1	21. 00
22. 00	HOME HEALTH AGENCY								- 1	22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)								- 1	23.00
24. 00	HOSPI CE								- 1	24.00
24. 10	HOSPICE (non-distinct part)	30. 00							- 1	24. 10
25. 00	CMHC - CMHC								- 1	25.00
26. 00	RURAL HEALTH CLINIC								- 1	26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00						(26. 25
27. 00	Total (sum of lines 14-26)			192					- 1	27. 00
28. 00	Observation Bed Days							(28. 00
29. 00	Ambul ance Tri ps									29. 00
30. 00	Employee discount days (see instruction)									30. 00
31. 00	Employee discount days - IRF								- 1	31. 00
32.00	Labor & delivery days (see instructions)			0		0			- 1	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				l	1	l			33. 01

Health Financial Systems FRANCISCAN HEALTH CROWN POINT HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CO

Provider CCN: 15-0126

| Peri od: | Worksheet S-3 | From 01/01/2021 | Part I | Date/Time Prepared: |

				'	0 12/31/2021	5/30/2022 5: 4	
		I/P Days	/ O/P Visits	/ Trips	Full Time I	Equi val ents	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
				Pati ents	& Residents	Payrol I	
		6.00	7. 00	8. 00	9. 00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	13, 231	336	29, 563			1.00
2.00	HMO and other (see instructions)	8, 318	6, 435				2. 00
3. 00	HMO IPF Subprovider	0	0				3. 00
4.00	HMO IRF Subprovider	o	0				4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF	o	0	0			5. 00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7. 00	Total Adults and Peds. (exclude observation	13, 231	336	29, 563			7. 00
	beds) (see instructions)			,			
8.00	INTENSIVE CARE UNIT	1, 807	22	4, 612			8. 00
9.00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12.00	NEONATAL INTENSIVE CARE UNIT	o	147	2, 920			12. 00
13.00	NURSERY		18	2, 184			13. 00
14.00	Total (see instructions)	15, 038	523	39, 279	0. 98	862.44	14. 00
15.00	CAH visits	o	0	0			15. 00
16.00	SUBPROVIDER - IPF						16. 00
17. 00	SUBPROVI DER - I RF						17. 00
18. 00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY						19. 00
20.00	NURSING FACILITY						20. 00
21. 00	OTHER LONG TERM CARE						21.00
22. 00	HOME HEALTH AGENCY						22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24. 00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)			0			24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00		
27. 00	Total (sum of lines 14-26)				0. 98	862.44	
28. 00	Observation Bed Days	_	547	4, 770			28. 00
29. 00	Ambul ance Tri ps	0		_			29. 00
30. 00	Employee discount days (see instruction)			0			30.00
31. 00	Employee discount days - IRF	_		0			31.00
32. 00	Labor & delivery days (see instructions)	0	153	3, 188			32. 00
32. 01	Total ancillary labor & delivery room			0			32. 01
22.00	outpatient days (see instructions)						22.00
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	ı Y			l	I	33. 01

| Peri od: | Worksheet S-3 | From 01/01/2021 | Part | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Health Financial Systems FRANCISCAN HEALTH CROWN POINT HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CO Provider CCN: 15-0126

				10	0 12/31/2021	Date/IIme Prep 5/30/2022 5:41	
		Full Time		Di sch	arges	07 007 2022 01 1	. p
		Equi val ents			Ü		
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
1.00	Tu	11. 00	12. 00	13.00	14.00	15. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and		0	3, 063	1, 376	9, 428	1. 00
	8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)			1, 267	٥		2. 00
3.00	HMO IPF Subprovider			1,20,	Ö		3. 00
4. 00	HMO IRF Subprovider				ol		4. 00
5. 00	Hospital Adults & Peds. Swing Bed SNF				Ĭ		5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						6. 00
7.00	Total Adults and Peds. (exclude observation						7. 00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12. 00	NEONATAL INTENSIVE CARE UNIT						12.00
13. 00	NURSERY						13. 00
14. 00	Total (see instructions)	0. 00	0	3, 063	1, 376	9, 428	14. 00
15. 00	CAH visits						15. 00
16.00	SUBPROVI DER - I PF						16. 00
17.00	SUBPROVI DER						17. 00 18. 00
18. 00 19. 00	SKILLED NURSING FACILITY						19. 00
20. 00	NURSING FACILITY						20. 00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY						22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24. 00	HOSPI CE						24.00
24. 10	HOSPICE (non-distinct part)						24. 10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0. 00					26. 25
27. 00	Total (sum of lines 14-26)	0. 00					27. 00
28. 00	Observation Bed Days						28. 00
29. 00	Ambul ance Tri ps						29. 00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31. 00
32.00	Labor & delivery days (see instructions)						32. 00
32. 01	Total ancillary labor & delivery room outpatient days (see instructions)						32. 01
33. 00	LTCH non-covered days			0			33. 00
	LTCH site neutral days and discharges			0			33. 01
30.01	12.5 5. to floati at days and at sorial gos	ı		١	ı	ı	50.01

| Peri od: | Worksheet S-3 | From 01/01/2021 | Part II | To 12/31/2021 | Date/Time Prepared: Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0126

					To	12/31/2021	Date/Time Prep 5/30/2022 5:4	
		Wkst. A Line Number	Amount Reported	Reclassification of Salaries	Sal ari es	Paid Hours Related to Salaries in	Average Hourly Wage (col. 4 ÷	
				(from Wkst. A-6)	(col.2 ± col. 3)	col. 4	col . 5)	
	PART II - WAGE DATA	1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
	SALARI ES							
1. 00	Total salaries (see instructions)	200. 00	84, 992, 206	C	84, 992, 206	2, 125, 719. 00	39. 98	1. 00
2. 00	Non-physician anesthetist Part		0	o	0	0.00	0. 00	2. 00
3. 00	Non-physician anesthetist Part		0	О	0	0.00	0. 00	3. 00
4. 00	Physician-Part A -		0	О	0	0.00	0.00	4. 00
4. 01 5. 00	Administrative Physicians - Part A - Teaching Physician and Non		0	0	0	0. 00 0. 00	1	4. 01 5. 00
6. 00	Physician-Part B Non-physician-Part B for hospital-based RHC and FQHC		0	O	0	0.00	0. 00	6. 00
7. 00	services Interns & residents (in an approved program)	21. 00	0	С	0	0.00	0. 00	7. 00
7. 01	Contracted interns and residents (in an approved		13, 357, 176	С	13, 357, 176	370, 614. 00	36. 04	7. 01
8. 00	programs) Home office and/or related organization personnel		0	С	0	0.00	0. 00	8. 00
9. 00 10. 00	SNF Excluded area salaries (see instructions)	44. 00	0 1, 978, 524	0		0. 00 34, 469. 00		9. 00 10. 00
11 00	OTHER WAGES & RELATED COSTS		020 244		020 244	(0.42 00	121 24	11 00
11. 00	Contract Labor: Direct Patient Care		830, 344			6, 842. 00		
12. 00	Contract labor: Top level management and other management and administrative		0	C	0	0.00	0.00	12. 00
13. 00	services Contract Labor: Physician-Part		395, 360	О	395, 360	2, 871. 00	137. 71	13. 00
14. 00	A - Administrative Home office and/or related organization salaries and		0	C	0	0.00	0.00	14. 00
14. 01	wage-related costs Home office salaries		17, 487, 708	C	17, 487, 708	485, 221. 00	36. 04	14. 01
14. 02	Related organization salaries		0	0	0	0.00	1	
15. 00	Home office: Physician Part A - Administrative		U		U	0.00	0.00	15. 00
16. 00	Home office and Contract Physicians Part A - Teaching		0	C	0	0.00	0.00	16. 00
16. 01	Home office Physicians Part A - Teaching		0	o	0	0.00	0.00	16. 01
16. 02	Home office contract Physicians Part A - Teaching		0	C	0	0.00	0.00	16. 02
17. 00	WAGE-RELATED COSTS Wage-related costs (core) (see		21, 452, 119	С	21, 452, 119			17. 00
18. 00	instructions) Wage-related costs (other)							18. 00
19. 00	(see instructions) Excluded areas		511, 284	О	511, 284			19. 00
20. 00	Non-physician anesthetist Part A		0	C	0			20. 00
21. 00	Non-physician anesthetist Part B		0	C	0			21. 00
22. 00	Physician Part A - Administrative		0	C	0			22. 00
22. 01 23. 00	Physician Part A - Teaching Physician Part B		0	0	0			22. 01 23. 00
24. 00 25. 00	Wage-related costs (RHC/FQHC) Interns & residents (in an		0	0	0			24. 00 25. 00
25. 50	approved program) Home office wage-related		5, 327, 538	C	5, 327, 538			25. 50
25. 51	(core) Related organization		0	C	0			25. 51
25. 52	wage-related (core) Home office: Physician Part A - Administrative -		0	C	0			25. 52
	wage-related (core)							

HOSPI T	AL WAGE INDEX INFORMATION			Provider CO		Period: From 01/01/2021 To 12/31/2021	Worksheet S-3 Part II Date/Time Pre 5/30/2022 5:4	pared:
		Wkst. A Line	Amount	Reclassi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Number	Reported	on of Salaries	Sal ari es		Wage (col. 4 ÷	
			'	(from Wkst.	(col.2 ± col.		col . 5)	
				A-6)	3)	col. 4		
		1.00	2. 00	3.00	4. 00	5. 00	6. 00	
25. 53	Home office: Physicians Part A		0	0		0		25. 53
	- Teaching - wage-related							
	(core)							
	OVERHEAD COSTS - DIRECT SALARIE							
26.00	Employee Benefits Department	4. 00	1, 039, 451	0	1, 039, 45			26. 00
27.00	Administrative & General	5. 00	17, 999, 747	0	17, 999, 74	485, 850. 00	37. 05	27. 00
28.00	Administrative & General under		1, 237, 897	0	1, 237, 89	11, 714. 00	105. 68	28. 00
	contract (see inst.)							
29. 00	Maintenance & Repairs	6. 00	472, 098	0	472, 09	32, 594. 00		29. 00
30.00	Operation of Plant	7. 00	2, 310, 671	0	2, 310, 67	71 54, 779. 00	42. 18	30. 00
31.00	Laundry & Linen Service	8. 00	373, 882	0	373, 88			31. 00
32.00	Housekeepi ng	9. 00	1, 694, 324	0	1, 694, 32	107, 953. 00		32. 00
33.00	Housekeeping under contract		0	0		0.00	0.00	33. 00
	(see instructions)							
34.00	Di etary	10. 00	1, 270, 217	-889, 157	381, 06	20, 696. 00	18. 41	34. 00
35.00	Dietary under contract (see		0	0		0.00	0.00	35. 00
	instructions)							
36.00	Cafeteri a	11. 00	0	889, 157	889, 15	48, 292. 00		36. 00
37.00	Maintenance of Personnel	12. 00		0		0.00		37. 00
38.00	Nursing Administration	13. 00	1, 953, 777	0	1, 953, 77	7 48, 842. 00	40.00	38. 00
39.00	Central Services and Supply	14. 00	389, 731	0	389, 73	19, 854. 00	19. 63	39. 00
40.00	Pharmacy	15. 00	2, 261, 923	0	2, 261, 92	55, 751. 00	40. 57	40.00
41.00	Medical Records & Medical	16. 00	468, 626	0	468, 62	13, 093. 00	35. 79	41. 00
	Records Library							
42.00	Social Service	17. 00	2, 122, 743	0	2, 122, 74	48, 431. 00	43. 83	42. 00
43.00	Other General Service	18. 00	0	0		0.00	0.00	43.00

	Trianoral Gyoromo					111 =10		
HOSPI 1	TAL WAGE INDEX INFORMATION			Provider CC		Period: From 01/01/2021 To 12/31/2021	Worksheet S-3 Part III Date/Time Prep 5/30/2022 5:4	pared:
		Worksheet A		Recl assi fi cati			Average Hourly	
		Line Number	Reported	on of Salaries			Wage (col. 4 ÷	
				(from	(col.2 ± col.	Salaries in	col . 5)	
				Worksheet A-6)	3)	col. 4		
		1. 00	2.00	3. 00	4. 00	5. 00	6. 00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		72, 872, 927	0	72, 872, 92	7 1, 766, 819. 00	41. 25	1.00
	instructions)							
2.00	Excluded area salaries (see		1, 978, 524	0	1, 978, 52	4 34, 469. 00	57. 40	2.00
	instructions)							
3.00	Subtotal salaries (line 1		70, 894, 403	0	70, 894, 40	3 1, 732, 350. 00	40. 92	3.00
	minus line 2)							
4.00	Subtotal other wages & related		18, 713, 412	0	18, 713, 41	2 494, 934. 00	37. 81	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		26, 779, 657	0	26, 779, 65	7 0.00	37. 77	5. 00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		116, 387, 472	0	116, 387, 47	2 2, 227, 284. 00	52. 26	6.00
7.00	Total overhead cost (see		33, 595, 087	0	33, 595, 08	7 964, 712. 00	34. 82	7. 00
	instructions)							

	To 12/31/2021	Date/Time Prep 5/30/2022 5:4	
		Amount	
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1. 00	401K Employer Contributions	1, 914, 006	1. 00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3. 00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	4, 097, 251	4. 00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	
6.00	Legal /Accounting/Management Fees-Pension Plan	0	6. 00
7. 00	Employee Managed Care Program Administration Fees	0	7. 00
	HEALTH AND INSURANCE COST		
8. 00	Health Insurance (Purchased or Self Funded)	0	
8. 01	Health Insurance (Self Funded without a Third Party Administrator)	0	8. 01
8. 02	Health Insurance (Self Funded with a Third Party Administrator)	8, 195, 967	8. 02
8. 03	Health Insurance (Purchased)	0	
9.00	Prescription Drug Plan	0	9. 00
10.00		346, 160	
11. 00		54, 869	
12.00		0	
	Disability Insurance (If employee is owner or beneficiary)	467, 299	
14. 00		0	
15. 00	· ·	1, 469, 676	
16. 00		0	16. 00
	Non cumulative portion)		
	TAXES		
	FICA-Employers Portion Only	5, 390, 156	
	Medicare Taxes - Employers Portion Only	0	
19. 00		28, 019	
20. 00	State or Federal Unemployment Taxes	0	20.00
	OTHER	_	
21. 00		0	21. 00
00.00	instructions))		00.00
	Day Care Cost and Allowances	0	
	Tuition Reimbursement	0	20.00
24. 00	Total Wage Related cost (Sum of lines 1 -23)	21, 963, 403	24. 00
25 62	Part B - Other than Core Related Cost		25 00
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25. 00

Health Financial Systems	FRANCISCAN HEALTH CROWN POINT	In Lie	u of Form CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provi der CCN: 15-0126	Peri od: From 01/01/2021 To 12/31/2021	Worksheet S-3 Part V Date/Time Prepared:

		0 12/31/2021	5/30/2022 5: 4	
	Cost Center Description	Contract Labor	Benefit Cost	
		1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	0	0	1.00
2.00	Hospi tal	0	0	2.00
3.00	Subprovi der - I PF			3.00
4.00	Subprovi der - I RF			4. 00
5.00	Subprovi der - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6. 00
7.00	Swing Beds - NF	0	0	7. 00
8.00	Hospi tal -Based SNF			8. 00
9.00	Hospi tal -Based NF			9. 00
10.00	Hospi tal -Based OLTC			10.00
11. 00	Hospi tal -Based HHA			11. 00
12.00	Separately Certified ASC			12.00
13.00	Hospi tal -Based Hospi ce			13.00
14. 00	Hospital-Based Health Clinic RHC			14.00
15. 00	Hospital-Based Health Clinic FQHC			15.00
16. 00	Hospi tal -Based-CMHC			16.00
17. 00	Renal Di al ysi s	0	0	17. 00
18. 00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDICENT CARE DATA	Heal th	Financial Systems FRANCISCAN HEALTH CF	OWN POINT	In Lie	eu of Form CMS-2	2552-10		
Incorporated and Indigent care cost computation			Provider CCN: 15-0126		Worksheet S-1	0		
Uncompensated and Indigent care cost computation 1.00					Date/Time Pre	nared:		
Incompensated and Indigent care cost computation 1.00 Cost to charge ratio (Morksheet C., Part I Tiln 202 col umn 3 divided by line 202 col umn 8) 0.236/36 1.00 Cost charge ratio (Morksheet C., Part I Line) 202 col umn 3 divided by line 202 col umn 8 0.236/36 1.00 Cost charge ratio (Morksheet C., Part I Line) 202 col umn 3 divided by line 202 col umn 8 0.236/36 1.00 Cost charges (Morksheet C.) 28,899,371 2.00 2.00				10 12/01/2021				
1.00 Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8) 0.236/36 1.00 Medicaid (See instructions for each line) 28,839,371 2.00 Not revenue From Medicaid 28,839,371 2.00 2.					1.00			
Medicald (see Instructions for each line) 28,839,371 2.00 Not reversive from Medicaid? 28,839,371 3.00 17 17 18 18 18 18 18 18					1			
Net revenue from Medical 28,839,37 20,00 200 uncelve vo810 or supplemental payments from Medicald? 3,00 3,00 3,00 1f line 3 is yes, does line 2 include all DSII and/or supplemental payments from Medicald? 4,00 5,00 6,00	1. 00		ided by line 202 colum	n 8)	0. 236736	1.00		
3.00 10 d you receive DSN or supplemental payments from Medical d? 3.00 10 f line 3 is yes, does line 2 include all DSN and/or supplemental payments from Medical d? 4.00 5.00 1 f line 4 is no, then enter DSH and/or supplemental payments from Medical d? 0.50	2 00				28 830 371	2 00		
If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid? 0, 5,00					20, 037, 371	•		
Medicaid charges			al payments from Medic	ai d?		4. 00		
Medical d cost ((line 1 times line 6) No.	5.00	If line 4 is no, then enter DSH and/or supplemental payments fr	om Medicaid		0	5. 00		
8.00 Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if continues to the enter zero) 0 0.00								
Second the netter zero								
Children's Heal th Insurance Program (CHIP) (see instructions for each line)	8.00	, ,	line / minus sum of li	nes 2 and 5; if	0	8.00		
10.00 Stand-al one CHIP cost (line 1 times line 10) 10.00 11.0		Children's Health Insurance Program (CHIP) (see instructions fo	r each line)					
11.00	9.00	Net revenue from stand-alone CHIP			0	9. 00		
12.00 Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then onter zero) Other state or local government indigent care program (see instructions for each line) 13.00 Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9) 14.00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 0 14.00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 0 14.00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 0 14.00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 0 14.00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 0 14.00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 0 14.00 Charges for patients patients on the meter zero) Frivate grants, donations and total unrelimbursed cost for Medicaid, CHIP and state/local indigent care programs (see Instructions for each line) Private grants, donations, or endowment income restricted to funding charity care Private grants, donations, or endowment income restricted to funding charity care Discorrement grants, appropriations or transfers for support of hospital operations Discorrement grants, appropriations or transfers for support of hospital operations Discorrement grants, appropriations or transfers for support of hospital operations Discorrement grants, appropriations or transfers for support of hospital operations Discorrement grants, appropriations or transfers for support of hospital operations Discorrement grants, donations, or endowment income restricted to funding charge for patients approved for Medicare and uninsured discounts (see instructions) Discorrement grants, donations, or endowment income restricted to funding endower for fines and local indigent care programs (sum of lines 2 o								
enter zero				. 6				
Other state or local government indigent care program (see instructions for each line) 13.00 13.00 13.00 13.00 13.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 15.00 14.00 15.	12.00		line II minus IIne 9;	IT < zero then	0	12.00		
13.00 Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)			ructions for each line)				
10) 15. 00 State or local indigent care program cost (line 1 times line 14) 16. 00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 0 16.00 13; if < zero then enter zero) Grants, donations and total unrelmbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line) 17. 00 Private grants, donations, or endowment income restricted to funding charity care 0 18. 00 18. 00 Government grants, appropriations or transfers for support of hospital operations 0 18. 00 19. 00 Total unrelmbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 0 19. 00 19. 00 Total unrelmbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 0 19. 00 19. 00 Total unrelmbursed cost for Medicaid or the entire facility 10. 00 2. 00 3. 00 10. 00 Charity care charges and uninsured discounts for the entire facility 9, 911, 838 2. 043, 997 11, 955, 835 20. 00 10. 00 Cost of patients approved for charity care and uninsured discounts (see 2, 346, 489 2, 043, 997 4, 390, 486 21. 00 10. 00 Cost of charity care (line 21 minus line 22) 2, 346, 489 2, 043, 997 4, 390, 486 21. 00 10. 00 Cost of charity care (line 21 minus line 22) 2, 346, 489 2, 043, 997 4, 390, 486 23. 00 10. 00 Cost of charity care (line 21 minus line 22) 2, 346, 489 2, 043, 997 4, 390, 486 23. 00 10. 00 Cost of charity care (line 21 minus line 22) 2, 346, 489 2, 043, 997 4, 390, 486 23. 00 10. 00 Cost of charity care endourned to represent the charges for patient days beyond the lind gent care program's length of stay limit imposed on patients covered by Medicaid or other indigent care program's length of stay limit imposed on patients covered by Medicaid or other indigent care program's length of stay limit imposed on patients covered by Medicaid or other indigent care program's length of stay limit imposed on patients covered by Medicaid or other indigent care program's length of stay limit imposed on patients covered by M	13.00				0	13.00		
15.00 State or local indigent care program cost (line 1 times line 14) 0 15.00 16.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 0 16.00 13: if < zero then enter zero) 16.00 Total indigent care programs (see 17.00	14. 00		program (Not included	in lines 6 or	0	14. 00		
16.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 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 Private grants, donations, or endowment income restricted to funding charity care 0 18.00 Covernment grants, appropriations or transfers for support of hospital operations 0 18.00 Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 0 19.00 19.00 Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 0 19.00 19.00 Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 0 19.00 19.00 19.00 Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 0 19.00 1	15 00	,	\			15 00		
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)				no 15 minus Lino				
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line) 17. 00 Private grants, donations, or endowment income restricted to funding charity care 018.00 Government grants, appropriations or transfers for support of hospital operations 018.00 Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16) Uninsured patients Insured Insured patients Insured patients Insured patients Insured Insured patients Insured patients Insured patients Insured patients Insured patients Insured patients Insured Insured patients Insured patients Insured patients Insured Insured patients Insure	10.00		rgent care program (11	ne is minus inne		10.00		
17. 00 Private grants, donations, or endowment income restricted to funding charity care 8. 00 Government grants, appropriations or transfers for support of hospital operations 19. 00 Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 0 19. 00		Grants, donations and total unreimbursed cost for Medicaid, CHI	and state/local indi	gent care progra	ms (see			
18.00 Government grants, appropriations or transfers for support of hospital operations 19.00 Total unrelimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 0 19.00	17. 00		nding charity care		0	17. 00		
8, 12 and 16) Uncompensated Care (see instructions for each line) Uncompensated Care (see instructions for each line)		1	9			18. 00		
Uncompensated Care (see instructions for each line) 1.00 Uncompensated Care (see instructions for each line) Uncompensated Care (see instructions for each line) 1.00 Uncompensated Care (see instructions) 2.043,997 4.390,486 2.043,997 4.390,486 2.000 2.0	19. 00		indigent care program	s (sum of lines	0	19. 00		
Uncompensated Care (see instructions for each line) 20.00 Charity care charges and uninsured discounts for the entire facility (see instructions) 21.00 Cost of patients approved for charity care and uninsured discounts (see 2,346,489 2,043,997 4,390,486 21.00 instructions) 22.00 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) 2,346,489 2,043,997 4,390,486 23.00 24.00 Cost of charity care (line 21 minus line 22) 2,346,489 2,043,997 4,390,486 23.00 24.00 Cost of charity care (line 21 minus line 22) 2,346,489 2,043,997 4,390,486 23.00 24.00 Cost of charity care (line 21 minus line 22) 2,346,489 2,043,997 4,390,486 23.00 24.00 Cost of charity care (line 21 minus line 22) 2,346,489 2,043,997 4,390,486 23.00 24.00 Cost of charity care (line 21 minus line 22) 2,346,489 2,043,997 4,390,486 23.00 24.00 Cost of charity care (line 21 minus line 22) 2,346,489 2,043,997 4,390,486 23.00 24.00 Cost of charity care (line 21 minus line 22) 2,346,489 2,043,997 4,390,486 23.00 24.00 Cost of charity care (line 21 minus line 22) 2,346,489 2,043,997 4,390,486 23.00 24.00 Cost of charity care (line 21 minus line 22) 2,346,489 2,043,997 4,390,486 23.00 24.00 Cost of charity care (line 21 minus line 22) 2,346,489 2,043,997 4,390,486 23.00 24.00 24.00 25.00			Uni nsured	Insured	Total (col. 1			
Uncompensated Care (see instructions for each line) 20.00 Charity care charges and uninsured discounts for the entire facility (see instructions) 21.00 Cost of patients approved for charity care and uninsured discounts (see 2, 346, 489 2, 043, 997 4, 390, 486 21.00 instructions) 22.00 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) 2, 346, 489 2, 043, 997 4, 390, 486 23.00 24.00 Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit 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 stay limit total bad debt expense for the entire hospital complex (see instructions) 11, 625, 484 26.00 10 Total bad debt expense for the entire hospital complex (see instructions) 260, 468 27.00 27.01 Medicare allowable bad debts for the entire hospital complex (see instructions) 400, 720 27.01 Medicare bad debt expense (see instructions) 22, 797, 585 29, 00 30.00 Cost of uncompensated care (line 23 column 3 plus line 29) 7, 188, 044 30.00								
20.00 Charity care charges and uninsured discounts for the entire facility (see instructions) 21.00 Cost of patients approved for charity care and uninsured discounts (see instructions) 22.00 Payments received from patients for amounts previously written off as charity care 23.00 Cost of charity care (line 21 minus line 22) 24.00 Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit inposed 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 stay limit 26.00 Total bad debt expense for the entire hospital complex (see instructions) 27.00 Medicare elimbursable bad debts for the entire hospital complex (see instructions) 28.00 Non-Medicare bad debt expense (see instructions) 29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions) 20.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions) 20.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions) 20.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions) 20.00 Cost of uncompensated care (line 23 column 3 plus line 29) 21.00 Cost of uncompensated care (line 23 column 3 plus line 29) 22.00 Cost of uncompensated care (line 23 column 3 plus line 29)		Uncompared Care (ass instructions for each Line)	1.00	2. 00	3.00			
21.00 Cost of patients approved for charity care and uninsured discounts (see instructions) 22.00 Payments received from patients for amounts previously written off as charity care 23.00 Cost of charity care (line 21 minus line 22) 24.00 Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit 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 stay limit 26.00 Total bad debt expense for the entire hospital complex (see instructions) 27.01 Medicare reimbursable bad debts for the entire hospital complex (see instructions) 28.00 Non-Medicare bad debt expense (see instructions) 29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions) 20.00 Cost of uncompensated care (line 23 column 3 plus line 29) 29.01 Cost of uncompensated care (line 23 column 3 plus line 29)	20. 00		ility 9,911,8	38 2, 043, 997	11, 955, 835	20. 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) 2,346,489 2,043,997 4,390,486 23.00 24.00 Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit 25.00 If line 24 is yes, enter the charges for patient days beyond the indigent care program? 25.00 Total bad debt expense for the entire hospital complex (see instructions) 27.00 Medicare reimbursable bad debts for the entire hospital complex (see instructions) 28.00 Non-Medicare bad debt expense (see instructions) 29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions) 20.00 Cost of uncompensated care (line 23 column 3 plus line 29) 20.01 Payments received from patients for amounts previously written off as 0 2, 346, 489 2, 043, 997 4, 390, 486 23.00 1.00 1.00 2.04, 409 2.043, 997 4, 390, 486 23.00 1.00 2.00		1						
22. 00 Payments received from patients for amounts previously written off as charity care 23. 00 Cost of charity care (line 21 minus line 22) 24. 00 Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit 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 stay limit 26. 00 Total bad debt expense for the entire hospital complex (see instructions) 27. 01 Medicare reimbursable bad debts for the entire hospital complex (see instructions) 28. 00 Non-Medicare bad debt expense (see instructions) 29. 00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions) 20. 00 Cost of uncompensated care (line 23 column 3 plus line 29) 20. 01 O 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	21. 00		nts (see 2,346,4	89 2, 043, 997	4, 390, 486	21.00		
charity care Cost of charity care (line 21 minus line 22) 2, 346, 489 2, 043, 997 4, 390, 486 23. 00 24. 00 Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit 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 stay limit 26. 00 Total bad debt expense for the entire hospital complex (see instructions) 27. 01 Medicare reimbursable bad debts for the entire hospital complex (see instructions) 28. 00 Non-Medicare bad debt expense (see instructions) 29. 00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions) 20. 00 Cost of uncompensated care (line 23 column 3 plus line 29) 4, 390, 486 2, 043, 997 4, 390, 486 23. 00 1. 00 1. 00 11, 625, 484 26. 00 27. 01 400, 720 27. 01 11, 224, 764 28. 00 29. 00 Cost of uncompensated care (line 23 column 3 plus line 29) 7, 188, 044 30. 00	22 00	· · · · · · · · · · · · · · · · · · ·	off as	0	0	22 00		
24.00 Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit 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 stay limit 26.00 Total bad debt expense for the entire hospital complex (see instructions) 27.00 Medicare reimbursable bad debts for the entire hospital complex (see instructions) 27.01 Medicare allowable bad debts for the entire hospital complex (see instructions) 28.00 Non-Medicare bad debt expense (see instructions) 29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions) 20.00 Cost of uncompensated care (line 23 column 3 plus line 29) 11.00 124.00 125.00 11,625,484 26.00 260,468 27.00 400,720 27.01 11,224,764 28.00 27.701 28.00 Cost of uncompensated care (line 23 column 3 plus line 29) 29.00 Cost of uncompensated care (line 23 column 3 plus line 29)	22.00	" ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '				22.00		
24.00 Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit 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 stay limit 26.00 Total bad debt expense for the entire hospital complex (see instructions) 27.00 Medicare reimbursable bad debts for the entire hospital complex (see instructions) 27.01 Medicare allowable bad debts for the entire hospital complex (see instructions) 28.00 Non-Medicare bad debt expense (see instructions) 29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions) 20.00 Cost of uncompensated care (line 23 column 3 plus line 29) 24.00 25.00 25.00 11, 625, 484 26.00 26.00 27.	23. 00	Cost of charity care (line 21 minus line 22)	2, 346, 4	89 2, 043, 997	4, 390, 486	23. 00		
24.00 Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit 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 stay limit 26.00 Total bad debt expense for the entire hospital complex (see instructions) 27.00 Medicare reimbursable bad debts for the entire hospital complex (see instructions) 27.01 Medicare allowable bad debts for the entire hospital complex (see instructions) 28.00 Non-Medicare bad debt expense (see instructions) 29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions) 20.00 Cost of uncompensated care (line 23 column 3 plus line 29) 24.00 25.00 25.00 11, 625, 484 26.00 26.00 27.					1 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 stay limit 26.00 Total bad debt expense for the entire hospital complex (see instructions) 27.00 Medicare reimbursable bad debts for the entire hospital complex (see instructions) 27.01 Medicare allowable bad debts for the entire hospital complex (see instructions) 28.00 Non-Medicare bad debt expense (see instructions) 29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions) 20.00 Cost of uncompensated care (line 23 column 3 plus line 29) 25.00 25.00 25.00 25.00 25.00 25.00 26.00 27	24. 00	Does the amount on line 20 column 2, include charges for patien	t days beyond a Length	of stay limit		24. 00		
stay limit 26.00 Total bad debt expense for the entire hospital complex (see instructions) 27.00 Medicare reimbursable bad debts for the entire hospital complex (see instructions) 27.01 Medicare allowable bad debts for the entire hospital complex (see instructions) 28.00 Non-Medicare bad debt expense (see instructions) 29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions) 20.00 Cost of uncompensated care (line 23 column 3 plus line 29) 30.00 See instructions 20.00 Total bad debt expense for the entire hospital complex (see instructions) 20.00 Total bad debt expense for the entire hospital complex (see instructions) 20.00 Total bad debt expense for the entire hospital complex (see instructions) 20.00 Total bad debt expense for the entire hospital complex (see instructions) 20.00 Total bad debt expense for the entire hospital complex (see instructions) 20.00 Total bad debt expense for the entire hospital complex (see instructions) 20.00 Total bad debt expense for the entire hospital complex (see instructions) 20.00 Total bad debt expense for the entire hospital complex (see instructions) 20.00 Total bad debt expense for the entire hospital complex (see instructions) 20.00 Total bad debt expense for the entire hospital complex (see instructions) 20.00 Total bad debt expense for the entire hospital complex (see instructions) 20.00 Total bad debt expense for the entire hospital complex (see instructions) 20.00 Total bad debt expense for the entire hospital complex (see instructions) 20.00 Total bad debt expense for the entire hospital complex (see instructions) 20.00 Total bad debt expense for the entire hospital complex (see instructions) 20.00 Total bad debt expense for the entire hospital complex (see instructions) 20.00 Total bad debt expense for the entire hospital complex (see instructions) 20.00 Total bad debt expense for the entire hospital complex (see instructions) 20.00 Total bad debt expense for the entire hospital complex (see instructions		imposed on patients covered by Medicaid or other indigent care program?						
27.00 Medicare reimbursable bad debts for the entire hospital complex (see instructions) 260,468 27.00 Medicare allowable bad debts for the entire hospital complex (see instructions) 27.01 Medicare allowable bad debts for the entire hospital complex (see instructions) 28.00 Non-Medicare bad debt expense (see instructions) 29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions) 20.00 Cost of uncompensated care (line 23 column 3 plus line 29) 20.00 Cost of uncompensated care (line 23 column 3 plus line 29) 20.00 Cost of uncompensated care (line 23 column 3 plus line 29)		stay limit		-				
27.01 Medicare allowable bad debts for the entire hospital complex (see instructions) 400,720 27.01 28.00 Non-Medicare bad debt expense (see instructions) 29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions) 20.00 Cost of uncompensated care (line 23 column 3 plus line 29) 400,720 27.01 11,224,764 28.00 2,797,558 29.00 7,188,044 30.00						1		
28.00 Non-Medicare bad debt expense (see instructions) 11, 224, 764 28.00 29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions) 20, 00 Cost of uncompensated care (line 23 column 3 plus line 29) 11, 224, 764 28.00 20, 797, 558 29.00 7, 188, 044 30.00		· · ·						
29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions) 2,797,558 29.00 30.00 Cost of uncompensated care (line 23 column 3 plus line 29) 7,188,044 30.00				l .				
30.00 Cost of uncompensated care (line 23 column 3 plus line 29) 7,188,044 30.00			ense (see instructions)				
		·		,		1		
7, 100, 044 31.00	31. 00	Total unreimbursed and uncompensated care cost (line 19 plus li	ne 30)		7, 188, 044	31.00		

	n Financial Systems SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (FRANCISCAN HEALTH DE EXPENSES	Provider C	CN: 15_0126 P	In Lie eriod:	u of Form CMS-2 Worksheet A	2552-10
KLCLA	STITEATION AND ADJUSTMENTS OF TRIAL BALANCE C	JI LAFLINGLG	Frovider	F	rom 01/01/2021		
				T	o 12/31/2021	Date/Time Pre 5/30/2022 5:4	pared: 1 nm
	Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati	Reclassi fi ed	, piii
				+ col . 2)	ons (See A-6)	Trial Balance	
						(col. 3 +- col. 4)	
		1.00	2. 00	3.00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FLXT		13, 523, 677	1		11, 757, 297	1.00
2. 00 4. 00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT	1, 039, 451	0 1, 723, 461	1	-,,	5, 808, 247 2, 696, 943	2. 00 4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL	17, 999, 747	57, 848, 899			70, 946, 755	5. 00
6.00	00600 MAINTENANCE & REPAIRS	472, 098	2, 297, 838			2, 769, 936	6. 00
7. 00	00700 OPERATION OF PLANT	2, 310, 671	9, 330, 602			11, 641, 273	7. 00
7. 01 8. 00	00701 OPERATION OF PLANT - FP 00800 LAUNDRY & LINEN SERVICE	0 373, 882	789, 516 649, 593		_	789, 516 1, 023, 475	7. 01 8. 00
9. 00	00900 HOUSEKEEPING	1, 623, 463	1, 271, 448			2, 894, 911	9. 00
9. 01	01851 ENVIRONMENTAL SERVICES - FP	70, 861	71, 520			142, 381	9. 01
10. 00	01000 DI ETARY	1, 270, 217	1, 634, 582			891, 295	10. 00
11.00	01100 CAFETERI A	0	1 501 0/0	0	_, -, -, -,,	2, 013, 504	11.00
13. 00 14. 00	01300 NURSI NG ADMINI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	1, 953, 777 389, 731	1, 501, 868 638, 746			3, 454, 800 1, 032, 663	13. 00 14. 00
15. 00	01500 PHARMACY	2, 261, 923	7, 975, 493			2, 897, 587	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	468, 626	321, 160	789, 786	-97	789, 689	16. 00
17. 00	01700 SOCIAL SERVICE	2, 122, 743	1, 075, 996	1		3, 198, 739	17. 00
21. 00 22. 00	02100 &R SERVICES-SALARY & FRINGES APPRV 02200 &R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	-	0 122, 201	21. 00 22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	190, 383	224, 577	1		413, 526	23. 00
23. 01	02301 ECHOCARDI OLOGY EDUCATI ON PROGRAM	17, 287	28, 965			46, 252	23. 01
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	22, 632, 387	8, 685, 648				30.00
31. 00 35. 00	03100 INTENSIVE CARE UNIT 02060 NEONATAL INTENSIVE CARE UNIT	3, 735, 441 2, 082, 839	2, 320, 716 1, 563, 577			5, 906, 025 3, 600, 482	31. 00 35. 00
43. 00	04300 NURSERY	2,002,039	1, 303, 377	1			43.00
	ANCILLARY SERVICE COST CENTERS				, , , , , , , , , , , , , , , , , , , ,		
50.00	05000 OPERATING ROOM	5, 219, 556	27, 839, 582				50.00
51. 00 52. 00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	523, 792	203, 587 -8, 251			720, 474 108, 693	51. 00 52. 00
53. 00	05300 ANESTHESI OLOGY	116, 948 47, 982	1, 857, 564			1, 823, 036	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	4, 513, 417	6, 125, 330			10, 289, 155	54. 00
54. 01	05401 RADI OLOGY - I -65	406, 569	350, 154	756, 723	-776	755, 947	54. 01
54. 02	05402 RADIOLOGY DIAGNOSTIC - SJ	0	0	0	0	0	54. 02
54. 03 55. 00	05403 LOWELL RADI OLOGY 05500 RADI OLOGY - THERAPEUTI C	27, 365	26, 308	53, 673		53, 673 0	54. 03 55. 00
55. 01	05501 CARDI AC CATHERI ZATON LAB	1, 131, 544	4, 439, 557	1	_	2, 940, 218	55. 01
55. 02	03140 CARDI OLOGY	933, 955	754, 369			1, 570, 494	55. 02
55. 03	03450 NEURO-DI AGNOSTI CS	383, 347	209, 209			592, 202	55. 03
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	0	11, 863, 660	11, 863, 660		11, 854, 818 0	60. 00 60. 01
65. 00		1, 406, 717	935, 690	1	_		
66. 00	06600 PHYSI CAL THERAPY	517, 543	98, 662			616, 205	
66. 01	06601 PHYSI CAL THERAPY I -65	653, 211	152, 715			804, 425	66. 01
66. 02	06602 PHYSI CAL THERAPY ST JOHN	137, 062	59, 152			195, 934	66. 02
67. 00 67. 01	O6700 OCCUPATIONAL THERAPY O6701 OCCUPATION THERAPY I - 65	170, 733 81, 178	41, 739 17, 542			212, 472 98, 096	67. 00 67. 01
67. 02	06702 OCCUPATIONAL THERAPY ST. JOHN	12, 638	2, 994			15, 632	67. 02
68. 00	06800 SPEECH PATHOLOGY	159, 213	31, 451			190, 664	68. 00
68. 01	06801 SPEECH PATHOLOGY I -65	158, 860	31, 977			190, 837	68. 01
68. 02 69. 00	06802 SPEECH THERAPY ST. JOHN 06900 ELECTROCARDI OLOGY	4, 944 391, 362	826 128, 940			5, 770 520, 117	68. 02 69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	371, 302	120, 940	0 520, 302		3, 062, 045	71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	o	0	0	17, 793, 921	17, 793, 921	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	.,,	7, 829, 029	73. 00
74.00	07400 RENAL DI ALYSI S	0	448, 015			447, 721	74.00
76. 00 76. 01	03020 RADI ATI ON ONCOLOGY 03040 ANGI OCARDI OGRAPHY	430, 135 246, 562	761, 391 67, 576			1, 187, 470 314, 064	76. 00 76. 01
, 0, 0,	OUTPATIENT SERVICE COST CENTERS	2 10, 002	0.7070	, 311,100	, ,	011,7001	70.0.
90. 00	09000 CLI NI C	0	0			0	90.00
90. 01	09001 DI ABETES CLINI C	0	210	1		210	90. 01
90. 02 90. 03	09002 OUTPATIENT CLINICS 09003 OCCUPATIONAL MEDICINE CLINIC	986, 778	6, 063 435, 500			6, 063 1, 348, 618	90. 02 90. 03
90.03	09004 NEONATOLOGY CLINIC-FRANCISCAN POINT	12, 039	2, 599			14, 638	90.03
90. 05	09005 LACTATION CLINIC	18, 893	3, 345			22, 238	90. 05
91. 00	09100 EMERGENCY	3, 513, 482	3, 768, 054	7, 281, 536	-152, 571	7, 128, 965	91.00
91. 01	09101 EMERGENCY ROOM PHYSI CANS	0	0	0	0	0	91. 01
91. 02 92. 00	09102 EXPRESS CARE 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	O	0	91. 02 92. 00
,2.00	SPECIAL PURPOSE COST CENTERS			1	I		, , 2. 00
113.00	11300 NTEREST EXPENSE		-733, 286	-733, 286	733, 286	0	113. 00
-		·			·		

Health Financial Systems F	RANCISCAN HEALT	H CROWN POINT		In Lie	eu of Form CMS-:	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	OF EXPENSES Provid			Peri od:	Worksheet A	
				From 01/01/2021 Fo 12/31/2021	Date/Time Pre 5/30/2022 5:4	pared: 1 pm
Cost Center Description	Sal ari es	0ther		Recl assi fi cati		
			+ col . 2)	ons (See A-6)	Trial Balance	
					(col. 3 +-	
	1.00	2.00	2.00	4.00	col . 4)	
110 00 00000000000000000000000000000000	1.00	2.00	3.00	4. 00	5. 00	110.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	83, 221, 352	173, 400, 106	256, 621, 458	37, 403	256, 658, 861	1118.00
NONREI MBURSABLE COST CENTERS						1
190.00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	(0		190. 00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	1, 230, 954	205, 653	1, 436, 607	-56	1, 436, 551	192. 00
194. 00 07950 FHC	0	0	(0	0	194. 00
194. 01 07951 CONVENT	0	4, 456	4, 456	0	4, 456	194. 01
194.02 07952 OTHER NON REIMB - BUILDINGS	0	1, 540, 830	1, 540, 830	0	1, 540, 830	194. 02
194.03 07953 OTHR NON REIM-FHC BEHAVORIAL HEALTH	o	0	(o	0	194. 03
194. 04 07954 CENTER OF HOPE	314, 752	198, 855	513, 607	-31, 494	482, 113	194. 04
194. 05 07955 LAKESHORE JOINT VENTURE	102, 004	124, 450	226, 454	-5, 853	220, 601	194. 05
194.06 07957 COVID VACCINE CLINIC	123, 144	23, 841	146, 985	0	146, 985	194. 06
200.00 TOTAL (SUM OF LINES 118 through 199)	84, 992, 206	175, 498, 191	260, 490, 397	7 O	260, 490, 397	200. 00

Heal th	Financial Systems	FRANCI SCAN HEAL	TH CROWN POINT		In Lieu	u of Form CMS-25	552-10
	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE		Provi der CCN:	15-0126	Peri od:	Worksheet A	
					From 01/01/2021 To 12/31/2021	 Date/Time Prepa	arod:
					10 12/31/2021	5/30/2022 5:41	pm
	Cost Center Description	Adjustments	Net Expenses		<u> </u>		
		(See A-8)	For Allocation				
	T	6. 00	7.00				
	GENERAL SERVICE COST CENTERS	1 04/ 0/7					
1.00	00100 CAP REL COSTS-BLDG & FIXT	216, 267					1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	170 473					2. 00
4. 00 5. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	170, 472	1				4.00
6. 00	00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS	-9, 485, 884 -4, 270	1				5. 00 6. 00
7. 00	00700 OPERATION OF PLANT	-170, 000					7. 00
7. 01	00701 OPERATION OF PLANT - FP	-170,000	1				7. 01
8. 00	00800 LAUNDRY & LINEN SERVICE	-198, 824					8. 00
9. 00	00900 HOUSEKEEPI NG	-430, 842	1				9. 00
9. 01	01851 ENVIRONMENTAL SERVICES - FP	0					9. 01
10.00	01000 DI ETARY	0	1				10.00
11. 00	01100 CAFETERI A	-394, 078	1				11. 00
13.00	01300 NURSI NG ADMINI STRATI ON	-65, 772	1			I	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	-966, 807	65, 856				14.00
15.00	01500 PHARMACY	1, 016, 596	3, 914, 183				15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	1, 856, 655	2, 646, 344				16.00
17.00	01700 SOCIAL SERVICE	0	3, 198, 739				17.00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0			· · · · · · · · · · · · · · · · · · ·	21.00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0					22.00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	-121, 357	1			- I	23.00
23. 01	02301 ECHOCARDI OLOGY EDUCATI ON PROGRAM	-175, 433	-129, 181				23. 01
00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS		00 700				00 -
30.00	03000 ADULTS & PEDIATRICS	-56, 191	1				30.00
31.00	03100 I NTENSI VE CARE UNI T	0					31.00
35.00	02060 NEONATAL INTENSIVE CARE UNIT	-626, 701					35.00
43. 00	04300 NURSERY	-20	1, 266, 746				43.00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	-6, 369, 342	9, 388, 483				50.00
51. 00	05100 RECOVERY ROOM	-0, 309, 342	1			I	51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	-2, 448					52. 00
53. 00	05300 ANESTHESI OLOGY	-1, 567, 312	1				53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	-7, 710					54. 00
54. 01	05401 RADI OLOGY - I -65	7,710	1				54. 01
54. 02	05402 RADI OLOGY DI AGNOSTI C - SJ	Ö					54. 02
54. 03	05403 LOWELL RADIOLOGY	-583					54. 03
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	1			I	55. 00
55. 01	05501 CARDI AC CATHERI ZATON LAB	-1, 175					55. 01
55. 02	03140 CARDI OLOGY	-5, 300	1			I	55. 02
55. 03	03450 NEURO-DI AGNOSTI CS	0					55. 03
60.00	06000 LABORATORY	-3, 671	11, 851, 147				60.00
60. 01	06001 BLOOD LABORATORY	0	1				60. 01
65.00	06500 RESPI RATORY THERAPY	0	2, 317, 643				65.00
66. 00	06600 PHYSI CAL THERAPY	0				1	66.00
66. 01	06601 PHYSI CAL THERAPY I -65	0	804, 425			- I	66. 01
66. 02	06602 PHYSI CAL THERAPY ST JOHN	-1, 958	1			- I	66. 02
67. 00	06700 OCCUPATI ONAL THERAPY	-452	1			- I	67.00
67. 01	06701 OCCUPATION THERAPY I -65	-1, 675					67. 01
67. 02	06702 OCCUPATIONAL THERAPY ST. JOHN	0					67. 02
68. 00	06800 SPEECH PATHOLOGY	0				I .	68.00
68. 01	06801 SPEECH THERAPY ST. JOHN	0	190, 837				68. 01 68. 02
68. 02 69. 00	06802 SPEECH THERAPY ST. JOHN	0	5, 770 520, 117				69. 00
	06900 ELECTROCARDI OLOGY		1				
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	0	3, 062, 045 17, 793, 921			I	71. 00 72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS		1				73.00
74.00	07400 RENAL DIALYSIS						74.00
76.00	03020 RADI ATI ON ONCOLOGY		1				76. 00
76. 00	03040 ANGI OCARDI OGRAPHY	0				I	76. 00
. 5. 01	OUTPATIENT SERVICE COST CENTERS		5,001				. 5. 01
90.00	09000 CLINI C	-148, 738	-148, 738				90. 00
90. 01	09001 DI ABETES CLINIC	0	210			I	90. 01
90. 02	09002 OUTPATIENT CLINICS	0	1				90. 02
90. 03	09003 OCCUPATIONAL MEDICINE CLINIC	0	1			I	90. 03
90. 04	09004 NEONATOLOGY CLINIC-FRANCISCAN POINT	0					90. 04
90. 05	09005 LACTATION CLINIC	0	22, 238			· · · · · · · · · · · · · · · · · · ·	90.05
91.00	09100 EMERGENCY	-1, 593, 588	1			· · · · · · · · · · · · · · · · · · ·	91.00
91. 01	09101 EMERGENCY ROOM PHYSI CANS	0	o				91. 01
91. 02	09102 EXPRESS CARE	0	o			· · · · · · · · · · · · · · · · · · ·	91. 02
	09200 OBSERVATION BEDS (NON-DISTINCT PART					· · · · · · · · · · · · · · · · · · ·	92. 00
	SPECIAL PURPOSE COST CENTERS						
	11300 INTEREST EXPENSE	0	1			- I	113. 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117	') -19, 140, 141	237, 518, 720			1	118. 00

Heal th FinancialSystemsFRANCISCAN HEALTHCROWN POINTRECLASSIFICATIONAND ADJUSTMENTS OF TRIAL BALANCEOF EXPENSESProvider CO In Lieu of Form CMS-2552-10 Provider CCN: 15-0126

			5/30/2022 5: 41 pill
Cost Center Description	Adjustments	Net Expenses	
	(See A-8)	For Allocation	
	6. 00	7. 00	
NONREI MBURSABLE COST CENTERS			
190.00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	1, 436, 551	192. 00
194. 00 07950 FHC	0	0	194. 00
194. 01 07951 CONVENT	0	4, 456	194. 01
194.02 07952 OTHER NON REIMB - BUILDINGS	0	1, 540, 830	194. 02
194.03 07953 OTHR NON REIM-FHC BEHAVORIAL HEALTH	0	О	194. 03
194.04 07954 CENTER OF HOPE	0	482, 113	194. 04
194. 05 07955 LAKESHORE JOINT VENTURE	0	220, 601	194. 05
194.06 07957 COVID VACCINE CLINIC	0	146, 985	194. 06
200.00 TOTAL (SUM OF LINES 118 through 199)	-19, 140, 141	241, 350, 256	200. 00

Health Financial Systems RECLASSIFICATIONS | Peri od: | Worksheet A-6 | From 01/01/2021 | To 12/31/2021 | Date/Time Prepared: Provider CCN: 15-0126

Double Center 11 ms Setury Difference						To 12/31/2021	Date/Time Prepared: 5/30/2022 5:41 pm
A CASTTERN		Cost Contor		Coloru	O+box		
1.00							
0		A - CAFETERIA			<u> </u>		
1. D	1. 00	CAFETERI A					1.00
APP		D - CAPLTAL		889, 157	1, 124, 347		
1.00	1.00	CAP REL COSTS-MVBLE EQUIP	2.00		5, 606, 442		1.00
MITCHAL SUPPLIES CHARRED TO				0	5, 606, 442		
ATTINIT	1 00		71 00	0	3 062 045		1 00
3.00 4.00 5.00 5.00 6.00 6.00 6.00 6.00 6.00 6				1			
4.00							
5.00 6.00 7.00 7.00 7.00 7.00 7.00 7.00 7			I				
7. 00							
8. 00							
9.00 11.00 1				-1			
11,00			•				
12.00			•	-1			
13.00							
14.00			•	-			
10. 00	14.00		0.00	1			
17.00							
18. 00			•	- 1			
20.00 0.00 0 0 0 0 22.00 22.			•				
21.00				-1			
22 00			•				
23.00				-			
25.00	23.00		0. 00	0	0		23. 00
26, 00			I	0			
1.00			I	-			
1.00				0	0		
1.00				0	3, 062, 045		
2.00	1. 00		2.00	0	201, 805		1.00
1.00		•		0	<u>1, 084, 9</u> 21		
1.00		O LATERNIC AND DECLIDENTS		0	1, 286, 726		
COSTS APPRV	1. 00		22.00	0	122, 201		1.00
1.00							
1.00		0 L NUDSERV		0	122, 201		
1.00 DRUGS CHARGED TO PATIENTS 73.00 0 7,829,029	1. 00		43.00	1, 007, 794	258, 972		1. 00
1. 00 DRUGS CHARGED TO PATIENTS 73. 00 0 7,829,029 2.00 2.00 3.00 4.186 2.00 3.00 4.00 5.00 6.00 0.00 0 0 0 0 0 0 0				1, 007, 794			
2. 00 CENTRAL SERVI CES & SUPPLY	1 00		72 00	٥	7 920 020		1.00
3.00 0.00 0 0 3.00 4.00 0.00 0 0 4.00 5.00 0.00 0 0 5.00 6.00 0.00 0 0 6.00 7.00 8.00 0.00 0 0 7.00 8.00 9.00 0 0 9.00 0 10.00 0.00 0 0 9.00 11.00 0.00 0 0 11.00 12.00 0.00 0 0 11.00 12.00 0.00 0 0 12.00 13.00 0.00 0 0 13.00 14.00 0.00 0 0 13.00 15.00 0 0 0 14.00 15.00 0 0 0 15.00 16.00 0 0 0 17.00 18.00 0 0 0 17.00 19.00 0 0 0 19.00 20.00 0 0			I	i i			
5.00 0.00 0 0 5.00 6.00 0.00 0 0 6.00 7.00 0.00 0 0 7.00 8.00 0.00 0 0 8.00 9.00 0.00 0 0 9.00 10.00 0.00 0 0 10.00 11.00 0.00 0 0 11.00 12.00 0.00 0 0 11.00 13.00 0.00 0 0 12.00 13.00 0.00 0 0 13.00 14.00 0.00 0 0 14.00 15.00 0.00 0 0 14.00 15.00 0.00 0 0 15.00 16.00 0.00 0 0 17.00 18.00 0.00 0 0 17.00 18.00 0.00 0 0 18.00 19.00 0.00	3.00		0.00	•	0		1
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7.00 0.00 0.00 0 0.00 7.00 8.00 9.00 0.00 0 0 8.00 9.00 0.00 0 0 9.00 10.00 0.00 0 0 10.00 11.00 0.00 0 0 11.00 12.00 0.00 0 0 12.00 13.00 0.00 0 0 13.00 14.00 0.00 0 0 13.00 15.00 0.00 0 0 14.00 15.00 0.00 0 0 15.00 16.00 0.00 0 0 16.00 17.00 0.00 0 0 17.00 18.00 0.00 0 0 18.00 19.00 0.00 0 0 19.00 20.00 0.00 0 0 20.00 21.00 0.00 0 0 22.00 23.00 0.00 0 0 0 24.00							
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13.00 0.00 0 0 13.00 14.00 0.00 0 0 14.00 15.00 0.00 0 0 15.00 16.00 0.00 0 0 16.00 17.00 0.00 0 0 17.00 18.00 0.00 0 0 18.00 19.00 0.00 0 0 19.00 20.00 0.00 0 0 20.00 21.00 0.00 0 0 21.00 22.00 0.00 0 0 0 23.00 0.00 0 0 0 24.00 0.00 0 0 0				1			1
14. 00 0.00 0 0 14. 00 15. 00 0.00 0 0 15. 00 16. 00 0.00 0 0 16. 00 17. 00 0.00 0 0 17. 00 18. 00 0.00 0 0 18. 00 19. 00 0.00 0 0 19. 00 20. 00 0.00 0 0 20. 00 21. 00 0.00 0 0 22. 00 23. 00 0.00 0 0 23. 00 24. 00 0.00 0 0 24. 00				1			
15. 00 0.00 0 0 15. 00 16. 00 0.00 0 0 16. 00 17. 00 0.00 0 0 17. 00 18. 00 0.00 0 0 18. 00 19. 00 0.00 0 0 19. 00 20. 00 0.00 0 0 20. 00 21. 00 0.00 0 0 21. 00 22. 00 0.00 0 0 22. 00 23. 00 0.00 0 0 23. 00 24. 00 0.00 0 0 24. 00				1			
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18.00 0.00 0 0 18.00 19.00 0.00 0 0 19.00 20.00 0.00 0 0 20.00 21.00 0.00 0 0 21.00 22.00 0.00 0 0 22.00 23.00 0.00 0 0 23.00 24.00 0.00 0 0 24.00	16.00		0.00	1	0		16. 00
19. 00 0. 00 0 0 19. 00 20. 00 0. 00 0 0 20. 00 21. 00 0. 00 0 0 21. 00 22. 00 0. 00 0 0 22. 00 23. 00 0. 00 0 0 23. 00 24. 00 0 0 0 24. 00				1			
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22. 00 0. 00 0 0 22. 00 23. 00 0. 00 0 0 0 23. 00 24. 00 0. 00 0 0 0 24. 00	20.00		0.00	0	0		20.00
23. 00 24. 00 0. 00 0 0 23. 00 24. 00 0 0 0 24. 00				1			
24.00 0.00 0 0 24.00				1			
[0				О	О		
		0		0	7, 833, 215		

Heal th Financial Systems FRANCISCAN HEALTH CROWN POINT In Lieu of Form CMS-2552-10

RECLASSIFICATIONS Provider CCN: 15-0126 Provider CCN: 15-0126 From 01/01/2021 To 12/31/2021 Date/Time Prepared:

					5/30/2022 5:	
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
	2. 00	3.00	4. 00	5. 00		
	K - IMPLANT RECLASS					
1.00	IMPL. DEV. CHARGED TO	72. 00	0	17, 793, 921		1. 00
	PATI ENTS					
2.00		0.00	0	0		2. 00
3.00		0.00	0	0		3. 00
4.00		0.00	0	0		4. 00
5.00		0.00	0	0		5. 00
	0		0	17, 793, 921		
	L - INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1. 00	0	115, 446		1. 00
2.00	INTEREST EXPENSE	113. 00	0	5, 860, 074		2. 00
3.00	CAP REL COSTS-BLDG & FIXT	1.00	0	5, 011, 342		3. 00
	0		0	10, 986, 862		
500.00	Grand Total: Increases		1, 896, 951	48, 074, 731		500.00

Peri od: From 01/01/2021 To 12/31/2021 Date/Time Prepared: 5/30/2022 5:41 pm

						5/30/2021	
		Decreases					
	Cost Center	Li ne #	Sal ary	Other Other	Wkst. A-7 Ref.		
	6.00	7. 00	8. 00	9. 00	10.00		
1. 00	A - CAFETERI A DI ETARY	10.00	889, 157	1, 124, 347	7 0		1.00
1.00	0		889, 157	1, 124, 34			1.00
	D - CAPITAL		2217 1211	., . = .,			
1.00	CAP REL COSTS-BLDG & FIXT	1. 00	0	5, 606, 442	2 9		1. 00
	TOTALS		0	5, 606, 442	2		
	E - CHARGEABLE SUPPLIES						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	5, 533			1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	4, 194	1 1		2. 00
3. 00 4. 00	PHARMACY	15.00	0	27	1		3. 00 4. 00
5. 00	PARAMED ED PRGM-(SPECIFY) ADULTS & PEDIATRICS	23. 00 30. 00	0	1, 369 201, 848	1 1		5. 00
6. 00	INTENSIVE CARE UNIT	31.00	o	106, 893	1 1		6. 00
7. 00	NEONATAL INTENSIVE CARE UNIT	35.00	Ö	45, 206			7. 00
8.00	OPERATING ROOM	50.00	o	1, 742, 318	1 1		8. 00
9.00	RECOVERY ROOM	51.00	О	4, 926	1 1		9. 00
10.00	DELIVERY ROOM & LABOR ROOM	52.00	0	4	4 0		10. 00
11. 00	ANESTHESI OLOGY	53.00	0	41, 060	0		11. 00
12.00	RADI OLOGY-DI AGNOSTI C	54.00	0	276, 936	1		12. 00
13.00	RADI OLOGY - I -65	54. 01	0	530	1		13. 00
14. 00	CARDI AC CATHERI ZATON LAB	55. 01	0	461, 297	1		14. 00
15. 00	CARDI OLOGY	55. 02	0	2, 205	1		15. 00
16. 00 17. 00	NEURO-DI AGNOSTI CS LABORATORY	55. 03 60. 00	0	354 8, 802	1		16. 00 17. 00
18. 00	RESPIRATORY THERAPY	65. 00	0	23, 232	1 1		18. 00
19. 00	PHYSI CAL THERAPY I -65	66. 01	Ö	1, 50			19. 00
20. 00	PHYSI CAL THERAPY ST JOHN	66. 02	Ö	280	1 1		20. 00
21. 00	OCCUPATION THERAPY I -65	67. 01	0	624	1		21. 00
22.00	ELECTROCARDI OLOGY	69. 00	О	185	5 0		22. 00
23.00	RENAL DIALYSIS	74.00	0	136	6 0		23. 00
24.00	RADIATION ONCOLOGY	76. 00	0	4, 056	1 1		24. 00
25. 00	OCCUPATIONAL MEDICINE CLINIC	90. 03	0	5, 167	1 1		25. 00
26.00	EMERGENCY	91.00	0	123, 062	1 1		26. 00
27. 00	PHYSICIANS' PRIVATE OFFICES TOTALS	1 <u>92.</u> 00	0	56 3, 062, 045	+		27. 00
	F - PROPERTY INSURANCE		UU	3, 002, 043)		
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	201, 805	5 12		1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	o_	1, 084, 92	1 1		2. 00
	0		0	1, 286, 726	5		
1 00	G - INTERNS AND RESIDENTS	F 00		122 204	1		1 00
1. 00	ADMI NI STRATI VE & GENERAL		0	12 <u>2, 2</u> 01			1. 00
	I - NURSERY		ΟĮ	122, 20	1		
1.00	ADULTS & PEDIATRICS	30.00	1, 007, 794	258, 972	2 0		1.00
	0 — — — — —		1, 007, 794	258, 972			
	J - PHARMACY						
1.00	PHARMACY	15. 00	0	7, 339, 558			1. 00
2.00	PARAMED ED PRGM-(SPECIFY)	23. 00	0	65			2. 00
3.00	ADULTS & PEDIATRICS	30.00	0	84, 135			3. 00
4.00	INTENSIVE CARE UNIT	31. 00 50. 00	0	43, 239 84, 988			4. 00 5. 00
5. 00 6. 00	OPERATING ROOM RADIOLOGY-DIAGNOSTIC	54.00	0	33, 736	1 1		6. 00
7. 00	LABORATORY	60.00	o	35, 730	1		7. 00
8. 00	RESPIRATORY THERAPY	65. 00	Ö	1, 532	1		8. 00
9. 00	OCCUPATIONAL MEDICINE CLINIC	90. 03	o	68, 493	1 1		9. 00
10.00	EMERGENCY	91.00	О	28, 829			10.00
11.00	CENTER OF HOPE	194. 04	О	31, 494	4 0		11. 00
12.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	60, 436	6 0		12. 00
13.00	ADMINISTRATIVE & GENERAL	5. 00	0	343	1		13. 00
14. 00	NURSING ADMINISTRATION	13. 00	0	845	1		14. 00
15. 00	MEDICAL RECORDS & LIBRARY	16.00	0	97			15. 00
16.00	NEONATAL INTENSIVE CARE UNIT	35.00	0	728			16.00
17. 00 18. 00	RECOVERY ROOM ANESTHESIOLOGY	51. 00 53. 00	0	1, 979	1 1		17. 00 18. 00
19. 00	RADI OLOGY - I -65	54. 01	0	41, 450 24 <i>0</i>	1 1		19. 00
20. 00	CARDI AC CATHERI ZATON LAB	55. 01	0	4, 702	1 1		20. 00
21. 00	CARDI OLOGY	55. 02	0	195	1		21.00
22. 00	RENAL DI ALYSI S	74. 00	ol	158	1		22. 00
23. 00	ANGI OCARDI OGRAPHY	76. 01	О	74	4 0		23. 00
24. 00	LAKESHORE JOINT VENTURE	194. 05	•	<u>5, 8</u> 53			24. 00
	0		이	7, 833, 215			

Heal th Financial Systems FRANCISCAN HEALTH CROWN POINT In Lieu of Form CMS-2552-10
RECLASSIFICATIONS Provider CCN: 15-0126 From 01/01/2021 To 12/31/2021 Date/Time Prepared:

						5/30/2022 5:	41 pm
		Decreases					
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10.00		
	K - IMPLANT RECLASS						
1.00	OPERATING ROOM	50.00	0	15, 474, 007	0		1. 00
2.00	RADI OLOGY-DI AGNOSTI C	54.00	0	38, 920	0		2. 00
3.00	CARDIAC CATHERIZATON LAB	55. 01	0	2, 164, 884	. 0		3. 00
4.00	CARDI OLOGY	55. 02	0	115, 430	0		4. 00
5.00	EMERGENCY	91.00	0	680	0		5. 00
	0		0	17, 793, 921			
	L - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113. 00	0	115, 446	11		1. 00
2.00	ADMINISTRATIVE & GENERAL	5. 00	0	5, 860, 074	. 11		2. 00
3.00	INTEREST EXPENSE	113.00	0	5, 011, 342	11		3. 00
	0		0	10, 986, 862			
500.00	Grand Total: Decreases		1, 896, 951	48, 074, 731			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS Provider CCN: 15-0126 Peri od: Worksheet A-7 From 01/01/2021 Part I 12/31/2021 Date/Time Prepared: 5/30/2022 5:41 pm Acqui si ti ons Begi nni ng Purchases Donati on Total Di sposal s and Bal ances Retirements 2.00 3.00 4. 00 1 00 5 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 13, 914, 478 0 1.00 15, 865, 261 0 2.00 Land Improvements 104, 545 104, 545 0 2.00 0 7, 699, 999 3.00 156, 710, 268 954, 891 954, 891 3 00 Buildings and Fixtures 0 4.00 Building Improvements 796, 915 0 4.00 5.00 Fixed Equipment 0 5.00 0 6.00 Movable Equipment 173, 200, 106 4, 595, 314 4, 595, 314 10, 919, 959 6.00 0 7.00 HIT designated Assets 0 7.00 8.00 Subtotal (sum of lines 1-7) 360, 487, 028 5, 654, 750 5, 654, 750 18, 619, 958 8.00 9.00 Reconciling Items -11, 919, 238 -65, 339, 823 0 -65, 339, 823 9.00 372, 406, 266 70, <u>994, 573</u> 70, 9<u>94, 573</u> 1<u>8, 6</u>19, 958 Total (line 8 minus line 9) 10.00 10.00 Endi ng Bal ance Fully Depreciated Assets 6.00 7.00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 13, 914, 478 1.00 2.00 Land Improvements 15, 969, 806 6, 955, 689 2. 00 5, 472, 986 3.00 Buildings and Fixtures 149, 965, 160 3.00 796, 915 796, 915 4.00 Building Improvements 4.00 5.00 Fi xed Equipment 5.00 Movable Equipment 166, 875, 461 6.00 45, 558, 849 6.00 7.00 HIT designated Assets 7.00 Subtotal (sum of lines 1-7) 8.00 347, 521, 820 58, 784, 439 8.00 9.00 Reconciling Items -77, 259, 061 9.00 10.00 Total (line 8 minus line 9) 424, 780, 881 58, 784, 439 10.00

Health Financial Systems F		FRANCISCAN HEALT	H CROWN POINT			In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der CO	CN: 15-0126		ri od:	Worksheet A-7	
					Fr	om 01/01/2021	Part II Date/Time Pre	nared:
					10	12/31/2021	5/30/2022 5: 4	
			SU	JMMARY OF CAP	PI TA	\L		
					1.			
	Cost Center Description	Depreciation	Lease	Interest		nsurance (see		
		0.00	10.00	11 00		instructions)		
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	9.00	10.00	11.00 nd 2		12. 00	13. 00	
1.00	CAP REL COSTS-BLDG & FIXT	12, 067, 184		liu z		1, 456, 493	0	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	12,007,104	0		0	1, 430, 473	0	2. 00
3.00	Total (sum of lines 1-2)	12, 067, 184	0		0	1, 456, 493	0	3. 00
	(SUMMARY OF				.,,		
	Cost Center Description	0ther	Total (1) (sum					
		Capi tal -Relate						
		d Costs (see	through 14)					
		instructions)	45.00					
	DART II. DECONOLILATION OF ANOUNTO FROM WOR	14.00	15. 00	L.,				
4 00	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM		nd 2				4 00
1.00	CAP REL COSTS MAD F FOUND	0	13, 523, 677					1.00
2.00	CAP REL COSTS-MVBLE EQUIP		12 522 477					2.00
3.00	Total (sum of lines 1-2)	ا ا	13, 523, 677					3. 00

Heal th	n Financial Systems F	FRANCISCAN HEAL	TH CROWN POINT		In Lie	eu of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der Co		Period: From 01/01/2021 To 12/31/2021	Worksheet A-7 Part III Date/Time Pre 5/30/2022 5:4	pared:
		COM	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets		Insurance	
			Leases	for Ratio (col. 1 - col 2)	instructions)		
		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	0	0		0 1.000000		1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		0.000000		2. 00
3.00	Total (sum of lines 1-2)	0	0	DADI TAL	0 1.000000		3. 00
		ALLUCA	TION OF OTHER (CAPITAL	SUMMARY U	F CAPITAL	
	Cost Center Description	Taxes	Other	Total (sum o	f Depreciation	Lease	
			Capi tal -Relate				
			d Costs	through 7)		10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	6. 00	7. 00	8. 00	9. 00	10.00	
1. 00	CAP REL COSTS-BLDG & FIXT	ENTERS		1	0 6, 677, 137	0	1. 00
2.00	CAP REL COSTS-BLDG & FIXT	0			0 5, 606, 442		2.00
3.00	Total (sum of lines 1-2)				0 12, 283, 579	l .	3. 00
3.00	Total (Saill of Triles 1 2)		SI	JMMARY OF CAPI		·	3.00
	Cost Center Description	Interest	Insurance (see	Taxes (see	0ther	Total (2) (sum	
			instructions)	instructions			
					d Costs (see	through 14)	
		11 00	10.00	40.00	instructions)	45.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	11. 00	12.00	13. 00	14.00	15. 00	
1. 00	CAP REL COSTS-BLDG & FIXT	5, 126, 660	169, 767		0 0	11, 973, 564	1. 00
2.00	CAP REL COSTS-BLDG & FIXT	J, 120, 000	201, 805		0 0		2.00
3.00	Total (sum of lines 1-2)	5, 126, 660	· ·		0 0		
0.00	1.5.5. (54 61 111165 1 2)	0, 120, 000	071,072	ı	91	17,751,011	0.00

Health Financial Systems FRANCISCAN HEALTH CROWN POINT In Lieu of Form CMS-2552-10 ADJUSTMENTS TO EXPENSES Provider CCN: 15-0126 Peri od: Worksheet A-8 From 01/01/2021 12/31/2021 Date/Time Prepared: 5/30/2022 5:41 pm Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Basis/Code (2) Cost Center Description Amount Cost Center Line # Wkst. A-7 Ref. 1.00 2.00 3.00 4.00 5.00 1.00 Investment income - CAP REL -128 CAP REL COSTS-BLDG & FLXT В 1.00 11 COSTS-BLDG & FIXT (chapter 2) 2.00 Investment income - CAP REL OCAP REL COSTS-MVBLE EQUIP 2.00 COSTS-MVBLE EQUIP (chapter 2) 3.00 Investment income - other В OINTEREST EXPENSE 113.00 11 (chapter 2) Trade, quantity, and time 4 00 0 00 0 discounts (chapter 8) 5.00 Refunds and rebates of 0.00 expenses (chapter 8) Rental of provider space by 6.00 0.00 suppliers (chapter 8) Tel ephone servi ces (pay -62,097 OPERATION OF PLANT 7.00 Α 7.00 stations excluded) (chapter 8.00 Tel evi si on and radio servi ce 0 0.00 (chapter 21) Parking lot (chapter 21) 9.00 0.00 -10, 221, 974 10.00 Provider-based physician A-8-2 adj ustment 11.00 Sale of scrap, waste, etc. 0.00 (chapter 23)

ADJUSTMENTS TO EXPENSES Provi der CCN: 15-0126 Peri od: Worksheet A-8 | Period: | Worksheet A-8 | From 01/01/2021 | To 12/31/2021 | Date/Time Prepared:

				To	0 12/31/2021	Date/Time Prep 5/30/2022 5:4	
				Expense Classification on			Pill
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	1.00	Amount 2.00	Cost Center 3.00	Li ne # 4. 00	Wkst. A-7 Ref. 5.00	
33. 01	HAF FEES	1.00 B		ADMI NI STRATI VE & GENERAL	5. 00	5.00	33. 01
34. 00	ADVERTI SI NG	A		ADMI NI STRATI VE & GENERAL	5. 00		
35. 00	NON ALLOWABLE INTEREST EXP	В		CAP REL COSTS-BLDG & FIXT	1. 00	10	
36. 00	DEFERRED LEASE REVENUE	В		ADMINISTRATIVE & GENERAL	5. 00		36. 00
37. 00 38. 00	ADMINISTRATIVE FEE DIETARY	B A	·	ADMINISTRATIVE & GENERAL HOUSEKEEPING	5. 00 9. 00	0	37. 00 38. 00
39. 00	CONTRACT REVENUE	B	·	EMPLOYEE BENEFITS DEPARTMENT	4. 00	1	
40. 00	DI SCOUNTS EARNED/REBATES	В		ADMINISTRATIVE & GENERAL	5. 00		40.00
40. 01	DI SCOUNTS EARNED/REBATES	В		CENTRAL SERVICES & SUPPLY	14. 00		
40. 02	DI SCOUNTS EARNED/REBATES	В		PHARMACY	15. 00	0	40. 02
41.00	EDUCATION MISC REV	В		ADMI NI STRATI VE & GENERAL	5. 00		41. 00
42. 00	MI SC. SVCS/OTHER OPERATING. JOINT VE	В	16, 227	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	42. 00
42. 01	MI SC. SVCS/OTHER	В	-284, 718	ADMINISTRATIVE & GENERAL	5. 00	0	42. 01
42.02	OPERATING. JOINT VE	В	4 270	MAINTENANCE O DEDALDO	4 00	0	42.02
42. 02	MI SC. SVCS/OTHER OPERATING. JOINT VE	В	-4, 270	MAINTENANCE & REPAIRS	6. 00	U	42. 02
42. 03	MI SC. SVCS/OTHER OPERATING. JOINT VE	В	-107, 903	OPERATION OF PLANT	7. 00	0	42. 03
42. 04	MI SC. SVCS/OTHER	В	-198, 824	LAUNDRY & LINEN SERVICE	8. 00	О	42. 04
42. 05	OPERATING. JOINT VE MISC. SVCS/OTHER	В	-41, 459	HOUSEKEEPI NG	9. 00	0	42. 05
42. 06	OPERATI NG. JOI NT VE MI SC. SVCS/OTHER	В	42 420	NURSING ADMINISTRATION	13. 00	0	42. 06
	OPERATING. JOINT VE		·				
42. 07	MI SC. SVCS/OTHER OPERATING. JOINT VE	В	-95, 000	CENTRAL SERVICES & SUPPLY	14. 00	0	42. 07
42. 08	MI SC. SVCS/OTHER OPERATI NG. JOI NT VE	В	-2, 459	PHARMACY	15. 00	0	42. 08
42. 09	MI SC. SVCS/OTHER OPERATI NG. JOI NT VE	В	-41, 748	ADULTS & PEDIATRICS	30.00	О	42. 09
42. 10	MI SC. SVCS/OTHER	В	-1, 613	OPERATING ROOM	50.00	0	42. 10
42. 11	OPERATING. JOINT VE MISC. SVCS/OTHER	В	10, 951	RADI OLOGY-DI AGNOSTI C	54.00	0	42. 11
42. 12	OPERATING. JOINT VE MISC. SVCS/OTHER	В	-1, 175	CARDIAC CATHERIZATON LAB	55. 01	О	42. 12
42. 13	OPERATING. JOINT VE MISC. SVCS/OTHER	В	-452	OCCUPATI ONAL THERAPY	67. 00	0	42. 13
	OPERATING. JOINT VE						
42. 14	MI SC. SVCS/OTHER OPERATING. JOINT VE	В	-1,6/5	OCCUPATION THERAPY I-65	67. 01	0	42. 14
43. 00	LACTATION SERVICES	В		NURSERY	43.00	0	
44. 00	MEDICAL RECORDS	В		ADMINISTRATIVE & GENERAL	5. 00		
44. 01 45. 00	MEDICAL RECORDS PROGRAM FEES	B B		RADI OLOGY-DI AGNOSTI C PARAMED ED PRGM-(SPECI FY)	54. 00 23. 00		
45. 01	PROGRAM FEES	В		ECHOCARDIOLOGY EDUCATION	23. 01	0	
		[PROGRAM			
45. 02	PROPERTY RENTAL	В		ADMINISTRATIVE & GENERAL	5.00	0	
45. 03	ST. CLARE CLINIC PROPERTY TAXES	В	-148, 738	CLINIC	90. 00	0	45. 03
46. 00	PARAMED ED REV	В	-118, 648	PARAMED ED PRGM-(SPECIFY)	23. 00	0	46. 00
46. 01	PARAMED ED REV	В	-91, 555	ECHOCARDIOLOGY EDUCATION PROGRAM	23. 01	0	46. 01
47. 00	SOCIAL ACCOUNTABILITY	A	2 035	ADMINISTRATIVE & GENERAL	5. 00	0	47. 00
48. 00	DEPRECIATION ADJUSTMENT	A		ADMINISTRATIVE & GENERAL	5. 00		
49. 00	PROPERTY TAX ADJUSMTENT	A	-185, 762	ADMINISTRATIVE & GENERAL	5. 00	0	49. 00
49. 01	PROPERTY TAX ADJUSMTENT	A		ADULTS & PEDIATRICS	30.00	0	49. 01
49. 02	PROPERTY TAX ADJUSMTENT	A		DELIVERY ROOM & LABOR ROOM	52.00		49. 02
49. 03 49. 04	PROPERTY TAX ADJUSMTENT PROPERTY TAX ADJUSMTENT	A A		RADI OLOGY-DI AGNOSTI C LOWELL RADI OLOGY	54. 00 54. 03	0	49. 03 49. 04
49. 04 49. 05	PROPERTY TAX ADJUSMIENT	A A		PHYSICAL THERAPY ST JOHN	66. 02	0	49. 04
50. 00	TOTAL (sum of lines 1 thru 49)	1	-19, 140, 141		33. 32]	50.00
	(Transfer to Worksheet A, column 6, line 200.)		•				

[|] 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.

				Allowable Cost	Included in			
					Wks. A, column			
					5			
	1. 00	2.00	3. 00	4. 00	5. 00			
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED							
	HOME OFFICE COSTS:					l		
1.00	5. 00	ADMINISTRATIVE & GENERAL	INTEREST	946, 482	5, 797, 127	1. 00		
2.00	1.00	CAP REL COSTS-BLDG & FIXT	ALLOWABLE NEW CAPITAL COSTS	2, 399, 808	2, 183, 413	2. 00		
3.00	5. 00	ADMINISTRATIVE & GENERAL	ADMINISTRATIVE & GENERAL	31, 921, 005	27, 796, 001	3. 00		
4.00	14.00	CENTRAL SERVICES & SUPPLY	CENTRAL SERVICE & SUPPLIES	0	6, 197	4. 00		
4. 01	15. 00	PHARMACY	COEP / PHARMACY	502, 687	-519, 138	4. 01		
4.02	16. 00	MEDICAL RECORDS & LIBRARY	HI M	1, 857, 155	0	4. 02		
5.00	TOTALS (sum of lines 1-4).			37, 627, 137	35, 263, 600	5. 00		
	Transfer column 6, line 5 to					l		
	Worksheet A-8, column 2,					l		
	line 12.							
* TL-				-l + A 1 · · · · · ·	/ !!			

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

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

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

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

6. 00	В	FRANCISCAN ALLI	100.00	FRANCISCAN ALLI	100. 00	6. 00
7.00			0.00		0. 00	7. 00
8.00			0.00		0. 00	8. 00
9.00			0.00		0. 00	9. 00
10.00			0.00		0. 00	10.00
100.00	G. Other (financial or					100.00
	non-financial) specify:					

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

Financial Syste	ems	FRANCISCAN HEALIH CROWN POINI IN Lieu of Form CMS					2552-10
	SERVICES FROM	RELATED ORGANI	ZATIONS AND HOME	Provider CCN: 15-0126	Peri od:	Worksheet A-8	8-1
COSTS					To 12/31/2021	Date/Time Pre	
						5/30/2022 5: 4	1 pm
Net	Wkst. A-7 Ref.						
Adjustments							
(col. 4 minus							
col. 5)*							
6. 00	7. 00						
A. COSTS INCUR	RED AND ADJUST	MENTS REQUIRED	AS A RESULT OF TRA	ANSACTIONS WITH RELATED	ORGANIZATIONS OR (CLAIMED	
HOME OFFICE CO	STS:						
-4, 850, 645	1.	1					1.00
216, 395		9					2.00
4, 125, 004							3.00
-6, 197							4.00
1, 021, 825							4. 01
	NT OF COSTS OF COSTS Net Adjustments (col. 4 minus col. 5)* 6.00 A. COSTS INCUR HOME OFFICE CO -4,850,645 216,395 4,125,004 -6,197	Net Adjustments (col. 4 minus col. 5)* 6.00 7.00 A. COSTS INCURRED AND ADJUST HOME OFFICE COSTS:	Net	Net	Net	Net Adjustments (col. 4 minus col. 5)* 6.00 7.00 A. COSTS I NCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR (HOME OFFICE COSTS: -4,850,645 11 216,395 9 4,125,004 0 -6,197 0	NOT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME COSTS Not Adjustments (col. 4 minus col. 5)* 6.00 7.00 A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS: -4,850,645 216,395 9 4,125,004 -6,197 0 Worksheet A-8 From 01/01/2021 To 12/31/2021 Bate/Time Prosider CCN: 15-0126 Period: From 01/01/2021 To 12/31/2021 Bate/Time Prosider CCN: 15-0126 Period: From 01/01/2021 To 12/31/2021 Bate/Time Prosider CCN: 15-0126 Date/Time Prosider CCN: 15-0126 D

* 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.

4 02

5.00

nas no	been posted to norksheet A,	cordinate transfer 2, the amount arrowable should be mareated in cordinat to this part.		
	Related Organization(s)			
	and/or Home Office			
	Type of Business			
	6. 00			
	B. INTERRELATIONSHIP TO RELAT	FED ORGANIZATION(S) AND/OR HOME OFFICE:		

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

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

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

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

0

4 02

5.00

1, 857, 155

2, 363, 537

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

Provider CCN: 15-0126

Peri od:

From 01/01/2021

PROVIDER BASED PHYSICIAN ADJUSTMENT

12/31/2021 Date/Time Prepared: 5/30/2022 5:41 pm Wkst. A Line # Cost Center/Physician Total Professi onal Provi der RCE Amount Physi ci an/Prov I denti fi er ider Component Remuneration Component Component Hours 1. 00 2.00 3. 00 4.00 5. 00 6. 00 7.00 5. 00 ADMI NI STRATI VE & GENERAL 1. 00 1.00 38, 081 28, 456 197, 500 9.625 77 197, 500 2.00 13.00 NURSING ADMINISTRATION 22, 344 22, 344 0 2.00 3.00 16.00 MEDICAL RECORDS & LIBRARY 500 197, 500 0 500 3.00 57, 950 4.00 35. 00 NEONATAL INTENSIVE CARE UNIT 675. 147 617, 197 237, 100 425 4.00 50. 00 OPERATING ROOM 5.00 4, 302, 284 4, 211, 059 91, 225 246, 400 716 5.00 6.00 50. 00 OPERATING ROOM 2, 150, 264 2, 150, 264 246, 400 6.00 7.00 53. 00 ANESTHESI OLOGY 1, 593, 784 1, 565, 159 28, 625 239, 400 230 7.00 54. 00 RADI OLOGY-DI AGNOSTI C 271, 900 8.00 4.059 8.00 4.059 0 9.00 55. 02 CARDI OLOGY 5, 300 5, 300 239, 400 9.00 10.00 60. 00 LABORATORY 48, 348 48, 348 260, 300 357 10.00 91. 00 EMERGENCY 1, 373, 200 89,075 197, 500 11.00 1, 462, 275 580 11.00 91. 00 EMERGENCY 197, 500 487 12.00 232, 627 162, 114 70, 513 12.00 200.00 10, 535, 013 10, 139, 652 395, 361 2,872 200.00 Wkst. A Line # Cost Center/Physician Unadjusted RCE 5 Percent of Cost of Provi der Physician Cost Identi fi er Unadjusted RCE Memberships & of Malpractice Li mi t Component Conti nui ng Share of col . limit Insurance Educati on 1.00 2.00 8.00 9.00 12. 00 13.00 14.00 1.00 5. OO ADMINISTRATIVE & GENERAL 7, 311 366 1.00 13. OO NURSING ADMINISTRATION 0 0 0 2.00 2.00 0 3.00 16.00 MEDICAL RECORDS & LIBRARY 0 0 0 3.00 4.00 35. 00 NEONATAL INTENSIVE CARE UNIT 48, 446 2, 422 4.00 5.00 50. 00 OPERATING ROOM 84, 819 4, 241 0 5.00 0 0 0 0 0 50. 00 OPERATING ROOM 0 0 6.00 6.00 0 53. 00 ANESTHESI OLOGY 0 7.00 26, 472 1, 324 7.00 8.00 54. 00 RADI OLOGY-DI AGNOSTI C 0 0 8.00 0 0 0 9.00 55. 02 CARDI OLOGY 9.00 0 60. 00 LABORATORY ol 10.00 44, 677 2, 234 0 10.00 11.00 91. 00 EMERGENCY 55,072 2, 754 0 0 11.00 91. 00 EMERGENCY 46, 242 0 12.00 2, 312 12.00 200.00 313, 039 15, 653 200.00 Cost Center/Physician Provi der RCF Wkst. A Line # Adjusted RCE Adjustment Identi fi er Component Limit Di sal I owance Share of col. 14 1. 00 15. 00 2.00 16, 00 17.00 18.00 1 00 5. 00 ADMINISTRATIVE & GENERAL 7.311 2.314 30 770 1 00 22, 344 2.00 13. 00 NURSING ADMINISTRATION 2.00 3.00 16.00 MEDICAL RECORDS & LIBRARY o 0 500 3.00 35. 00 NEONATAL INTENSIVE CARE UNIT 0 4.00 48.446 9.504 626, 701 4.00 50. 00 OPERATING ROOM 5.00 84, 819 6,406 4, 217, 465 5.00 6.00 50.00 OPERATING ROOM 0 2, 150, 264 6.00 53. 00 ANESTHESI OLOGY o 7.00 26, 472 2, 153 1, 567, 312 7.00 4, 059 54. 00 RADI OLOGY-DI AGNOSTI C 0 8.00 0 8.00 9.00 55. 02 CARDI OLOGY 0 Λ 5, 300 9.00 10.00 60. 00 LABORATORY 44,677 3,671 3,671 10.00 0 11.00 91. 00 EMERGENCY 55, 072 34,003 1, 407, 203 11.00 12.00 91. 00 EMERGENCY 46, 242 24, 271 186, 385 12.00 200.00 313, 039 82, 322 10, 221, 974 200.00

Heal th Financial Systems	FRANCISCAN HEALT		CN: 1E 012/ D		u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der C		eriod: rom 01/01/2021 o 12/31/2021	Worksheet B Part I Date/Time Pre 5/30/2022 5:4	pared:
		CAPI TAL REI	LATED COSTS		5/30/2022 5.4	ı pili
		DI DO 4 511/7	1 10 (D) E EQUID	5451 0V55		
Cost Center Description	Net Expenses for Cost	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS	Subtotal	
	Allocation			DEPARTMENT		
	(from Wkst A			DEI / II (I III EI V I		
	col . 7)					
OSUSDAL OSDIA OS COOT OSUTEDO	0	1. 00	2.00	4. 00	4A	
GENERAL SERVICE COST CENTERS 1. 00 OO100 CAP REL COSTS-BLDG & FIXT	11, 973, 564	11, 973, 564				1.00
2.00 00200 CAP REL COSTS-BLDG & FIXT	5, 808, 247	11, 973, 304	5, 808, 247			2.00
4.00 O0400 EMPLOYEE BENEFITS DEPARTMENT	2, 867, 415	109, 217		2, 982, 304		4. 00
5.00 00500 ADMINISTRATIVE & GENERAL	61, 460, 871	l			65, 275, 445	5. 00
6.00 00600 MAINTENANCE & REPAIRS	2, 765, 666	22, 832	1, 655	16, 771	2, 806, 924	6. 00
7. 00 00700 OPERATION OF PLANT	11, 471, 273	1		82, 084	13, 630, 960	7.00
7. 01 00701 0PERATION OF PLANT - FP 8. 00 00800 LAUNDRY & LINEN SERVICE	789, 516 824, 651	133, 412	3, 074 3, 680		792, 590 975, 025	7. 01 8. 00
9. 00 00900 HOUSEKEEPI NG	2, 464, 069	l			2, 641, 056	9. 00
9. 01 01851 ENVI RONMENTAL SERVI CES - FP	142, 381	0		2, 517	144, 898	9. 01
10. 00 01000 DI ETARY	891, 295	368, 131	24, 756	13, 537	1, 297, 719	10.00
11. 00 01100 CAFETERI A	1, 619, 426		0	31, 586	1, 651, 012	11. 00
13.00 O1300 NURSING ADMINISTRATION 14.00 O1400 CENTRAL SERVICES & SUPPLY	3, 389, 028 65, 856	l		69, 406 13, 845	4, 209, 114 435, 615	13. 00 14. 00
15. 00 01500 PHARMACY	3, 914, 183	l			4, 041, 310	ł
16. 00 01600 MEDICAL RECORDS & LIBRARY	2, 646, 344				2, 841, 392	16.00
17.00 01700 SOCIAL SERVICE	3, 198, 739	l				17. 00
21. 00 02100 I &R SERVI CES-SALARY & FRINGES APPRV		0	0	0	0	21. 00
22. 00 02200 1 &R SERVI CES-OTHER PRGM COSTS APPRV		0	15 000	0	122, 201	22. 00
23. 00 02300 PARAMED ED PRGM-(SPECIFY) 23. 01 02301 ECHOCARDI OLOGY EDUCATI ON PROGRAM	292, 169 -129, 181	0			314, 020 -106, 528	23. 00 23. 01
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	-127, 101		22,037	014	- 100, 320	23.01
30. 00 03000 ADULTS & PEDIATRICS	29, 709, 095	1, 126, 697	482, 106	768, 157	32, 086, 055	30.00
31. 00 03100 INTENSIVE CARE UNIT	5, 906, 025			132, 698		31. 00
35. 00 02060 NEONATAL INTENSIVE CARE UNIT	2, 973, 781	285, 525			3, 455, 006	35. 00
43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	1, 266, 746	0	0	35, 801	1, 302, 547	43.00
50. 00 05000 OPERATING ROOM	9, 388, 483	519, 804	1, 472, 313	185, 420	11, 566, 020	50.00
51. 00 05100 RECOVERY ROOM	720, 474	l		18, 607	942, 673	
52.00 05200 DELIVERY ROOM & LABOR ROOM	106, 245		1	4, 154	396, 056	52. 00
53. 00 05300 ANESTHESI OLOGY	255, 724	l			331, 039	53.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C 54. 01 05401 RADI OLOGY - I -65	10, 281, 445 755, 947	622, 451 0		160, 335 14, 443	11, 949, 905 995, 891	1
54. 02 05402 RADI OLOGY DI AGNOSTI C - SJ	755, 747	1	223, 301	14, 443	995, 691	54.01
54. 03 05403 LOWELL RADI OLOGY	53, 090	Ö	17, 207	972	71, 269	54. 03
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55. 00
55. 01 05501 CARDI AC CATHERI ZATON LAB	2, 939, 043				3, 545, 429	55. 01
55. 02 03140 CARDI OLOGY 55. 03 03450 NEURO-DI AGNOSTI CS	1, 565, 194 592, 202					
60. 00 06000 LABORATORY	11, 851, 147			13, 010	12, 053, 516	
60. 01 06001 BLOOD LABORATORY	0	0	0	0	0	60. 01
65. 00 06500 RESPI RATORY THERAPY	2, 317, 643			49, 972	2, 536, 829	65. 00
66. 00 06600 PHYSI CAL THERAPY	616, 205				715, 634	66.00
66. 01 06601 PHYSI CAL THERAPY I -65 66. 02 06602 PHYSI CAL THERAPY ST JOHN	804, 425 193, 976	l e	15, 634 3, 813		843, 264 202, 658	66. 01 66. 02
67. 00 06700 OCCUPATI ONAL THERAPY	212, 020	l e	0,019	6, 065	218, 085	67. 00
67. 01 06701 OCCUPATION THERAPY I -65	96, 421	0	0	2, 884	99, 305	
67. 02 06702 OCCUPATIONAL THERAPY ST. JOHN	15, 632	l	0	449	16, 081	
68. 00 06800 SPEECH PATHOLOGY	190, 664	l e	0	5, 656	196, 320	68. 00
68. 01 06801 SPEECH PATHOLOGY I - 65 68. 02 06802 SPEECH THERAPY ST. JOHN	190, 837 5, 770	l .	0	5, 643 176	196, 480 5, 946	68. 01 68. 02
69. 00 06900 ELECTROCARDI OLOGY	520, 117	l	34, 503		651, 809	69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		l	0	0	3, 062, 045	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	17, 793, 921	0	0	0	17, 793, 921	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	7, 829, 029	ł	0	0	7, 829, 029	73. 00
74. 00 07400 RENAL DI ALYSI S	447, 721	l	1	15 200	459, 060	74.00
76. 00 03020 RADI ATI ON ONCOLOGY 76. 01 03040 ANGI OCARDI OGRAPHY	1, 187, 470 314, 064	ł	165, 248	15, 280 8, 759	1, 367, 998 322, 823	76. 00 76. 01
OUTPATIENT SERVICE COST CENTERS	314,004		. 0	0, 737	522, 625	, 5. 51
90. 00 09000 CLI NI C	-148, 738	0	0	0	-148, 738	90.00
90. 01 09001 DI ABETES CLINIC	210	l	1	_	2, 847	90. 01
90. 02 09002 00TPATIENT CLINICS	6,063	ł	8, 086		14, 149	90. 02
90. 03 09003 OCCUPATIONAL MEDICINE CLINIC 90. 04 09004 NEONATOLOGY CLINIC-FRANCISCAN POINT	1, 348, 618 14, 638	l	10, 747	35, 054 428	1, 624, 083 15, 066	90. 03 90. 04
90. 05 09005 LACTATION CLINIC	22, 238	l e	0	420 671	22, 909	90.04
91. 00 09100 EMERGENCY	5, 535, 377	l e	82, 632		6, 120, 710	ı
91. 01 09101 EMERGENCY ROOM PHYSI CANS	0		0	0	0	91. 01
91. 02 09102 EXPRESS CARE	0	0	0	0	0	91. 02

Health Financial Systems	FRANCISCAN HEAL	TH CROWN POINT		In Lie	u of Form CMS-25	552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der Co		Period: From 01/01/2021	Worksheet B Part I	·
				o 12/31/2021	Date/Time Prepa 5/30/2022 5:41	
		CAPI TAL REI	_ATED COSTS			
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
	0	1. 00	2.00	4. 00	4A	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	-				0	92. 00
SPECIAL PURPOSE COST CENTERS	•		•			
113. 00 11300 NTEREST EXPENSE					1	13.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	237, 518, 720	11, 158, 500	5, 751, 904	2, 919, 396	236, 584, 405 1	18. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	(0		90.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	1, 436, 551	151, 146	3, 425	43, 728		
194. 00 07950 FHC	0	0	(0		94.00
194. 01 07951 CONVENT	4, 456	0	(0	4, 456 1	
194.02 07952 OTHER NON REIMB - BUILDINGS	1, 540, 830	635, 658	47, 561	0	2, 224, 049 1	94. 02
194.03 07953 OTHR NON REIM-FHC BEHAVORIAL HEALTH	0	28, 260		0	28, 260 1	94. 03
194.04 07954 CENTER OF HOPE	482, 113	0	5, 357	11, 181	498, 651 1	94.04
194. 05 07955 LAKESHORE JOINT VENTURE	220, 601	0	(3, 624	224, 225 1	94. 05
194.06 07957 COVID VACCINE CLINIC	146, 985	0	(4, 375	151, 360 1	94.06
200.00 Cross Foot Adjustments					0 2	00.00
201.00 Negative Cost Centers		0	(0	0 2	01.00
202.00 TOTAL (sum lines 118 through 201)	241, 350, 256	11, 973, 564	5, 808, 247	2, 982, 304	241, 350, 256 2	02.00

Provider CCN: 15-0126

| Period: | Worksheet B | From 01/01/2021 | Part | | Date/Time Prepared: | 5/30/2022 5:41 pm

	Cook Cooker Doorsinking	ADMINI CTDATI VE	MAINTENANCE O	ODEDATION OF	ODEDATION OF	5/30/2022 5: 4	
	Cost Center Description	ADMINISTRATIVE & GENERAL	REPAIRS	OPERATION OF PLANT	OPERATION OF PLANT - FP	LAUNDRY & LINEN SERVICE	
		5. 00	6.00	7. 00	7. 01	8. 00	
1 00	GENERAL SERVICE COST CENTERS	1				T	1 00
1. 00 2. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1. 00 2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL	65, 275, 445					5. 00
6.00	00600 MAINTENANCE & REPAIRS	1, 039, 258	3, 846, 182				6. 00
7.00	00700 OPERATION OF PLANT	5, 046, 836	849, 978	19, 527, 774			7. 00
7. 01	00701 OPERATION OF PLANT - FP	293, 455	0	0	1, 086, 045	l	7. 01
8. 00 9. 00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	361, 001 977, 846	58, 618 35, 474		366, 272 75, 728		8. 00 9. 00
9. 01	01851 ENVI RONMENTAL SERVI CES - FP	53, 648	33, 474	231, 201	75, 726 N	190, 231	9. 00
10. 00	01000 DI ETARY	480, 478	161, 747	1, 054, 185	0	25, 791	10.00
11. 00	01100 CAFETERI A	611, 284	0	0	0	0	11. 00
13.00	01300 NURSING ADMINISTRATION	1, 558, 416	136, 276		0	0	13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	161, 286	133, 089		0	6, 223	
15. 00	01500 PHARMACY	1, 496, 287	16, 858		0	0	15.00
16. 00 17. 00	01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE	1, 052, 020 1, 235, 030	72, 280 26, 919		0	0	16. 00 17. 00
21. 00	02100 I &R SERVI CES-SALARY & FRINGES APPRV	1, 233, 030	20, 919	175, 446	0	0	21.00
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRV	45, 245	0	0	0	Ö	22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	116, 265	0	0	0	Ō	23. 00
23. 01	02301 ECHOCARDI OLOGY EDUCATI ON PROGRAM	0	0	0	0	0	23. 01
	INPATIENT ROUTINE SERVICE COST CENTERS			ı			
30.00	03000 ADULTS & PEDIATRICS	11, 879, 845	495, 040		0	.,,	30.00
31. 00 35. 00	03100 INTENSIVE CARE UNIT 02060 NEONATAL INTENSIVE CARE UNIT	2, 453, 195	102, 762		0		31.00
43. 00	04300 NURSERY	1, 279, 209 482, 265	125, 452 0		0		35. 00 43. 00
43.00	ANCILLARY SERVICE COST CENTERS	402, 200				22,274	43.00
50.00	05000 OPERATING ROOM	4, 282, 296	228, 388	1, 488, 520	0	234, 274	50. 00
51. 00	05100 RECOVERY ROOM	349, 023	86, 444	563, 402	0	0	51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	146, 639	125, 510		0	0	52.00
53. 00	05300 ANESTHESI OLOGY	122, 567	12, 272		0	0	53.00
54. 00 54. 01	05400 RADI OLOGY - DI AGNOSTI C 05401 RADI OLOGY - I -65	4, 424, 428 368, 727	273, 488	1, 782, 460	261, 194	53, 813 52, 906	54. 00 54. 01
54. 01	05401 RADI OLOGY = 1-05 05402 RADI OLOGY DI AGNOSTI C = SJ	300, 727	0	0	201, 194 0	32, 900	54. 01
54. 03	05403 LOWELL RADI OLOGY	26, 387	0	0	0	0	54. 03
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55. 00
55. 01	05501 CARDI AC CATHERI ZATON LAB	1, 312, 688	55, 325	360, 582	0	18, 764	55. 01
55. 02	03140 CARDI OLOGY	744, 358	27, 064		0	0	55. 02
55. 03	03450 NEURO-DI AGNOSTI CS	250, 288	16, 173		0	17, 165	55. 03
60.00	06000 LABORATORY	4, 462, 790	86, 985	566, 926	0	2, 471	60.00
60. 01 65. 00	06001 BLOOD LABORATORY 06500 RESPI RATORY THERAPY	939, 256	0 16, 974	0 110, 629	0	0	60. 01 65. 00
66. 00	06600 PHYSI CAL THERAPY	264, 962	35, 271	229, 879	0	62, 521	66.00
66. 01	06601 PHYSI CAL THERAPY I -65	312, 217	00, 2, 1	0	285, 466		66. 01
66. 02	06602 PHYSI CAL THERAPY ST JOHN	75, 034	0	0	0	Ō	66. 02
67.00	06700 OCCUPATIONAL THERAPY	80, 746	0	0	0	0	67. 00
	06701 OCCUPATION THERAPY I -65	36, 767	0	0	35, 109	l .	67. 01
67. 02	06702 OCCUPATIONAL THERAPY ST. JOHN	5, 954	0	0	0	0	67. 02
68. 00	06800 SPEECH PATHOLOGY	72, 687	0	0	(2.27/	0	68. 00
68. 01 68. 02	06801 SPEECH PATHOLOGY I -65 06802 SPEECH THERAPY ST. JOHN	72, 746 2, 201	0	0	62, 276		68. 01 68. 02
69. 00	06900 ELECTROCARDI OLOGY	241, 331	36, 594	238, 500	0	12, 743	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 133, 716	00, 374	230, 300	0	12,743	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	6, 588, 164	0	0	0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	2, 898, 682	0	0	0	0	73. 00
74. 00	07400 RENAL DI ALYSI S	169, 966	4, 982	32, 471	0	0	74. 00
76.00	03020 RADI ATI ON ONCOLOGY	506, 499	0	0	0	10, 793	76.00
76. 01	03040 ANGI OCARDI OGRAPHY OUTPATI ENT SERVI CE COST CENTERS	119, 525	0	0	0	0	76. 01
90. 00	09000 CLINIC	0	0	0	0	1, 291	90.00
90. 01	09001 DI ABETES CLINIC	1, 054	1, 159	7, 551	0	11, 459	90. 01
90. 02	09002 OUTPATIENT CLINICS	5, 239	0	0	0	60, 249	90. 02
90. 03	09003 OCCUPATIONAL MEDICINE CLINIC	601, 313	100, 908	657, 670	0	0	90. 03
90. 04	09004 NEONATOLOGY CLINIC-FRANCISCAN POINT	5, 578	0	0	0	0	90. 04
90.05	09005 LACTATION CLINIC	8, 482	0	0	0	152.700	90.05
91. 00 91. 01	09100 EMERGENCY 09101 EMERGENCY ROOM PHYSI CANS	2, 266, 181	166, 034	1, 082, 125	0	152, 799 0	91. 00 91. 01
91.01	09101 EMERGENCY ROOM PHYSICANS		0	0	0		91.01
91.02	09200 OBSERVATION BEDS (NON-DISTINCT PART	١	U		U		91.02
, 2. 00	SPECIAL PURPOSE COST CENTERS					1	, , 50
	11300 I NTEREST EXPENSE						113. 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	63, 521, 360	3, 488, 064	17, 193, 741	1, 086, 045	2, 142, 957	118. 00

					5/30/2022 5: 4	1 pm
Cost Center Description	ADMI NI STRATI VE	MAINTENANCE &	OPERATION OF	OPERATION OF	LAUNDRY &	
	& GENERAL	REPAI RS	PLANT	PLANT - FP	LINEN SERVICE	
	5.00	6.00	7.00	7. 01	8. 00	
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	605, 300	66, 410	432, 825	0	0	192. 00
194. 00 07950 FHC	0	0	0	0	0	194. 00
194. 01 07951 CONVENT	1, 650	0	0	0	0	194. 01
194.02 07952 OTHER NON REIMB - BUILDINGS	823, 450	279, 291	1, 820, 281	0	0	194. 02
194.03 07953 OTHR NON REIM-FHC BEHAVORIAL HEALTH	0	12, 417	80, 927	0	0	194. 03
194.04 07954 CENTER OF HOPE	184, 625	0	0	0	0	194. 04
194. 05 07955 LAKESHORE JOINT VENTURE	83, 019	0	0	0	0	194. 05
194.06 07957 COVID VACCINE CLINIC	56, 041	0	0	0	0	194. 06
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	0	0	0	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	65, 275, 445	3, 846, 182	19, 527, 774	1, 086, 045	2, 142, 957	202. 00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0126

Peri od: Worksheet B From 01/01/2021 Part I To 12/31/2021 Date/Ti me Prepared:

5/30/2022 5:41 pm Cost Center Description HOUSEKEEPING ENVIRONMENTAL CAFETERI A NURSI NG DI ETARY ADMI NI STRATI ON SERVICES - FP 9.00 10.00 11.00 9.01 13.00 GENERAL SERVICE COST CENTERS 1.00 1.00 00100 CAP REL COSTS-BLDG & FLXT 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5 00 5 00 6.00 00600 MAINTENANCE & REPAIRS 6.00 00700 OPERATION OF PLANT 7.00 7.00 7.01 00701 OPERATION OF PLANT - FP 7. 01 00800 LAUNDRY & LINEN SERVICE 8.00 8 00 9.00 00900 HOUSEKEEPI NG 4, 151, 536 9.00 9 01 01851 ENVIRONMENTAL SERVICES - FP 198, 546 9 01 01000 DI ETARY 10.00 3, 251, 302 10 00 231, 382 11.00 01100 CAFETERI A 2, 262, 296 11.00 13.00 01300 NURSING ADMINISTRATION 194, 946 0 77, 231 7, 064, 161 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 190.388 0 32, 308 14.00 0 0 01500 PHARMACY 24, 116 15.00 91, 867 0 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 103, 398 0 22, 753 0 16.00 01700 SOCIAL SERVICE 0 79, 024 117, 526 17.00 38, 508 17.00 02100 I &R SERVICES-SALARY & FRINGES APPRV 0 0 21.00 0 0 21.00 0 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 0 22 00 0 C 0 Λ 22 00 02300 PARAMED ED PRGM-(SPECIFY) 0 0 9, 235 22, 381 23.00 23.00 02301 ECHOCARDI OLOGY EDUCATI ON PROGRAM <u>15, 5</u>65 23.01 811 23.01 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 708.167 0 2, 906, 512 635, 011 3, 285, 312 30.00 31.00 03100 INTENSIVE CARE UNIT 147.003 0 344, 790 147, 291 843, 244 31.00 02060 NEONATAL INTENSIVE CARE UNIT 179, 462 0 77, 560 35.00 0 430, 662 35.00 04300 NURSERY 0 43, 744 43.00 0 Ω 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 326, 714 215, 267 1, 017, 452 50.00 81, 235 05100 RECOVERY ROOM 0 0 51.00 123, 661 19, 671 51.00 05200 DELIVERY ROOM & LABOR ROOM 179.545 0 52.00 C 124, 241 13, 362 52.00 53.00 05300 ANESTHESI OLOGY 17, 555 0 4, 299 11, 287 53.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 391, 231 0 221, 218 247, 489 54.00 54 01 05401 RADIOLOGY - 1-65 80 521 0 20.417 54 01 0 0 05402 RADIOLOGY DIAGNOSTIC - SJ 0 54.02 0 0 54.02 05403 LOWELL RADIOLOGY 0 0 54.03 0 1,620 0 54.03 55.00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 55.00 0 05501 CARDIAC CATHERIZATON LAB 0 155, 870 55.01 79.144 0 39, 802 55.01 03140 CARDI OLOGY 55.02 38, 716 0 0 37, 496 49, 104 55.02 03450 NEURO-DI AGNOSTI CS 55.03 23, 135 10, 895 0 55.03 60 00 06000 LABORATORY Ω 0 60 00 124, 434 0 0 60.01 06001 BLOOD LABORATORY C 0 0 60.01 06500 RESPIRATORY THERAPY 24, 282 68, 489 65.00 65.00 06600 PHYSI CAL THERAPY 50, 456 0 16, 518 66.00 0 66.00 0 06601 PHYSICAL THERAPY L-65 88.004 23 935 66.01 0 0 66.01 66.02 06602 PHYSI CAL THERAPY ST JOHN 0 6, 126 0 66.02 67.00 06700 OCCUPATIONAL THERAPY 0 6,533 67.00 2, 917 06701 OCCUPATION THERAPY I-65 0 67.01 10.823 67.01 0 06702 OCCUPATIONAL THERAPY ST. JOHN 0 67.02 479 0 67.02 68.00 06800 SPEECH PATHOLOGY 0 0 5, 914 0 68.00 06801 SPEECH PATHOLOGY I -65 0 5, 794 68.01 19, 198 68.01 06802 SPEECH THERAPY ST. JOHN 0 68.02 68.02 0 C 165 0 69 00 06900 ELECTROCARDI OLOGY 52.348 C 0 16,879 38.011 69 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 135 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 0 C 0 0 73.00 0 74.00 07400 RENAL DIALYSIS 7.127 Ω Λ 74 00 03020 RADIATION ONCOLOGY 0 27, 057 76.00 15, 349 76.00 03040 ANGI OCARDI OGRAPHY 0 8, 567 76.01 76.01 0 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 0 90.00 90. 01 09001 DIABETES CLINIC 1,657 0 0 10, 685 90.01 09002 OUTPATIENT CLINICS 0 90.02 0 90.02 30 0 0 90.03 09003 OCCUPATIONAL MEDICINE CLINIC 144, 351 0 2.777 Λ 90.03 09004 NEONATOLOGY CLINIC-FRANCISCAN POINT 90.04 417 699 90.04 90.05 09005 LACTATION CLINIC 0 0 90.05 Ω 09100 EMERGENCY 237, 515 0 672, 980 91.00 91.00 C 163, 766 09101 EMERGENCY ROOM PHYSICANS 91.01 0 91.01 09102 EXPRESS CARE 91.02 0 91.02 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 3, 639, 241 198, 546 3, 251, 302 2, 256, 551 7, 039, 921 118. 00

					5/30/2022 5:41 pm
Cost Center Description	HOUSEKEEPI NG	ENVI RONMENTAL	DI ETARY	CAFETERI A	NURSI NG
		SERVICES - FP			ADMI NI STRATI ON
	9. 00	9. 01	10.00	11. 00	13. 00
NONREI MBURSABLE COST CENTERS					
190.00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0 190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	95, 000	0	0	0	0 192.00
194. 00 07950 FHC	0	0	0	0	0 194. 00
194. 01 07951 CONVENT	0	0	0	0	0 194. 01
194.02 07952 OTHER NON REIMB - BUILDINGS	399, 532	0	0	0	0 194. 02
194.03 07953 OTHR NON REIM-FHC BEHAVORIAL HEALTH	17, 763	0	0	0	0 194. 03
194.04 07954 CENTER OF HOPE	0	0	0	0	24, 240 194. 04
194.05 07955 LAKESHORE JOINT VENTURE	0	0	0	0	0 194. 05
194.06 07957 COVID VACCINE CLINIC	0	0	0	5, 745	0 194. 06
200.00 Cross Foot Adjustments					200.00
201.00 Negative Cost Centers	0	0	0	0	0 201. 00
202.00 TOTAL (sum lines 118 through 201)	4, 151, 536	198, 546	3, 251, 302	2, 262, 296	7, 064, 161 202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provi der CCN: 15-0126

In Lieu of Form CMS-2552-10

Period:	Worksheet B
From 01/01/2021	Part
To 12/31/2021	Date/Time Prepared:
5/30/2022 5:41 pm	

				'	0 12/31/2021	5/30/2022 5: 4	
						I NTERNS & RESI DENTS	
	Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE		
	'	SERVICES &		RECORDS &		Y & FRINGES	
		SUPPLY 14.00	15. 00	16. 00	17. 00	21. 00	
	GENERAL SERVICE COST CENTERS	14.00	13.00	10.00	17.00	21.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00 6. 00	00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS						5. 00 6. 00
7. 00	00700 OPERATION OF PLANT						7. 00
7. 01	00701 OPERATION OF PLANT - FP						7. 01
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
9.00	00900 HOUSEKEEPI NG						9. 00
9. 01	01851 ENVIRONMENTAL SERVICES - FP						9. 01
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A						10. 00 11. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON						13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	1, 826, 321					14. 00
15. 00	01500 PHARMACY	162	5, 780, 474				15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	0	4, 562, 929			16. 00
17. 00	01700 SOCIAL SERVICE	0	0	C	5, 008, 135		17. 00
21. 00 22. 00	02100 1&R SERVICES-SALARY & FRINGES APPRV 02200 1&R SERVICES-OTHER PRGM COSTS APPRV	0	0			0	21. 00 22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	819	0				23. 00
23. 01	02301 ECHOCARDI OLOGY EDUCATI ON PROGRAM		0	Č	ol ol		23. 01
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDIATRICS	120, 774	0	322, 818		0	30. 00
31. 00	03100 I NTENSI VE CARE UNI T	63, 958	0	72, 670		0	31. 00
35. 00 43. 00	02060 NEONATAL INTENSIVE CARE UNIT 04300 NURSERY	27, 049	0	59, 969		0	35. 00 43. 00
43.00	ANCI LLARY SERVICE COST CENTERS	l ol	U	27, 177	29, 029	0	43.00
50. 00	05000 OPERATI NG ROOM	1, 042, 495	0	477, 514	524, 108	0	50. 00
51.00	05100 RECOVERY ROOM	2, 947	0	48, 986		0	51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	2	0	37, 405		0	52. 00
53. 00	05300 ANESTHESI OLOGY	24, 568	0	107, 433		0	53. 00
54. 00 54. 01	05400 RADI OLOGY - DI AGNOSTI C 05401 RADI OLOGY - I -65	165, 702 317	0	870, 139		0	54. 00 54. 01
54. 01	05401 RADI OLOGY - 1-65 05402 RADI OLOGY DI AGNOSTI C - SJ	317	0	114, 517	125, 691	0	54. 01
54. 03	05403 LOWELL RADI OLOGY		0	2, 983	3, 274	0	54. 03
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0	Ċ	0	0	55. 00
55. 01	05501 CARDI AC CATHERI ZATON LAB	276, 012	0	211, 748		0	55. 01
55. 02	03140 CARDI OLOGY	1, 319	0	84, 140		0	55. 02
55. 03	03450 NEURO-DI AGNOSTI CS	212	0	34, 872		0	55. 03
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	5, 267	0	709, 927 C		0	60. 00 60. 01
65. 00	06500 RESPI RATORY THERAPY	13, 901	0	96, 338	1 1	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0	0	8, 784		0	66. 00
66. 01	06601 PHYSI CAL THERAPY I -65	898	0	15, 213	16, 697	0	66. 01
66. 02	06602 PHYSI CAL THERAPY ST JOHN	168	0	4, 020		0	66. 02
67.00	06700 OCCUPATIONAL THERAPY	0	0	7, 671		0	67.00
67. 01 67. 02	06701 OCCUPATION THERAPY I -65 06702 OCCUPATIONAL THERAPY ST. JOHN	373	0	1, 513 367		0	67. 01 67. 02
68. 00	06800 SPEECH PATHOLOGY		0	7, 408		0	68. 00
68. 01	06801 SPEECH PATHOLOGY I -65	0	0	5, 946		0	68. 01
68. 02	06802 SPEECH THERAPY ST. JOHN	0	0	172	189	0	68. 02
69. 00	06900 ELECTROCARDI OLOGY	111	0	50, 966		0	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	73, 433		0	71. 00
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	5, 780, 474	233, 04 <i>6</i> 301, 467		0	72. 00 73. 00
74. 00	07400 RENAL DIALYSIS	81	0, 700, 474	5, 665		0	74. 00
76.00	03020 RADI ATI ON ONCOLOGY	2, 427	0	83, 344		0	76. 00
76. 01	03040 ANGI OCARDI OGRAPHY	0	0	4, 483	4, 920	0	76. 01
	OUTPATIENT SERVICE COST CENTERS		_				
90.00	09000 CLINIC	0	0	C		0	90.00
90. 01 90. 02	09001 DI ABETES CLINIC 09002 OUTPATIENT CLINICS	0	0	70	77	0	90. 01 90. 02
90. 02	09003 OCCUPATIONAL MEDICINE CLINIC	3, 092	0			0	90. 02
90. 04	09004 NEONATOLOGY CLINIC-FRANCISCAN POINT	0	0	146	161	0	90. 04
90. 05	09005 LACTATION CLINIC		0	77		0	90. 05
91. 00	09100 EMERGENCY	73, 633	0	480, 502	527, 388	0	91. 00
91. 01	09101 EMERGENCY ROOM PHYSI CANS	0	0	C .	0	0	91. 01
	09102 EXPRESS CARE 09200 OBSERVATION BEDS (NON-DISTINCT PART		O	[0	91. 02 92. 00
72.00	107200 ODDERVATION DEDO (NON-DISTINCI FART	ı I	l	I	1 1		/2.00

| Period: | Worksheet B | From 01/01/2021 | Part | To 12/31/2021 | Date/Time Prepared: | 5/30/2022 5:41 pm Provider CCN: 15-0126

					5/30/2022 5:4	1 pm
					INTERNS &	
					RESI DENTS	
Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	SERVI CES-SALAR	
	SERVICES &		RECORDS &		Y & FRINGES	
	SUPPLY		LI BRARY		APPRV	
	14. 00	15. 00	16. 00	17. 00	21. 00	
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 I NTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	1, 826, 287	5, 780, 474	4, 562, 929	5, 008, 135	0	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	C	0	0	190. 00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	34	0	C	0	0	192. 00
194. 00 07950 FHC	0	0	C	0	0	194. 00
194. 01 07951 CONVENT	0	0	C	0	0	194. 01
194.02 07952 OTHER NON REIMB - BUILDINGS	0	0	C	0	0	194. 02
194.03 07953 OTHR NON REIM-FHC BEHAVORIAL HEALTH	0	0	C	0	0	194. 03
194.04 07954 CENTER OF HOPE	0	0	C	0	0	194. 04
194.05 07955 LAKESHORE JOINT VENTURE	0	0	C	0	0	194. 05
194.06 07957 COVID VACCINE CLINIC	0	0	C	0	0	194. 06
200.00 Cross Foot Adjustments					0	200. 00
201.00 Negative Cost Centers	0	0	C	0	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	1, 826, 321	5, 780, 474	4, 562, 929	5, 008, 135	0	202. 00

		RANCI SCAN HEALI		011 45 0404 5		U OT FORM CMS-2	2552-10
COSTA	ALLOCATION - GENERAL SERVICE COSTS		Provider C	F	Period: From 01/01/2021 To 12/31/2021	Worksheet B Part I Date/Time Pre 5/30/2022 5:4	pared: 1 pm
	Cost Center Description	I NTERNS & RESI DENTS SERVI CES-OTHER PRGM COSTS APPRV	PARAMED ED PRGM	ECHOCARDI OLOGY EDUCATI ON PROGRAM		Intern & Residents Cost & Post Stepdown Adjustments	
		22. 00	23. 00	23. 01	24.00	25. 00	
	GENERAL SERVICE COST CENTERS						
1.00 2.00 4.00 5.00 6.00 7.01 8.00 9.01 10.00 11.00 13.00 14.00 15.00 17.00 21.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT 00701 OPERATION OF PLANT - FP 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01851 ENVIRONMENTAL SERVICES - FP 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE						1. 00 2. 00 4. 00 5. 00 7. 00 7. 01 8. 00 9. 00 9. 01 10. 00 11. 00 13. 00 14. 00 15. 00 17. 00 21. 00
22. 00 23. 00 23. 01	02200 &R SERVICES-OTHER PRGM COSTS APPRV 02300 PARAMED ED PRGM-(SPECIFY) 02301 ECHOCARDIOLOGY EDUCATION PROGRAM	167, 446	462, 720	-90, 152	2		22. 00 23. 00 23. 01
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	l	0		57, 102, 546	0	30.00
31. 00 35. 00 43. 00	03100 INTENSIVE CARE UNIT 02060 NEONATAL INTENSIVE CARE UNIT 04300 NURSERY	0 0	0	C	11, 623, 910 6, 568, 678	0 0 0	31. 00 35. 00 43. 00
FO 00	ANCI LLARY SERVI CE COST CENTERS	1 0			21 402 040	0	FO 00
50. 00 51. 00	O5000 OPERATI NG ROOM O5100 RECOVERY ROOM	0	0	1		0	50. 00 51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	l o	0			Ö	52.00
53.00	05300 ANESTHESI OLOGY	o	0	c		0	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	0	C	,,	0	54.00
54. 01	05401 RADI OLOGY - I -65	0	0		_, -,,	0	54. 01
54. 02 54. 03	05402 RADI OLOGY DI AGNOSTI C - SJ 05403 LOWELL RADI OLOGY		0		379 105, 533	0	54. 02 54. 03
55. 00	05500 RADI OLOGY-THERAPEUTI C	l o	0			Ö	55. 00
55. 01	05501 CARDI AC CATHERI ZATON LAB	o	0	c	6, 287, 774	0	55. 01
55. 02	03140 CARDI OLOGY	0	0	C	3, 261, 369	0	55. 02
55. 03 60. 00	03450 NEURO-DI AGNOSTI CS 06000 LABORATORY	0	0			0	55. 03 60. 00
60. 01	06001 BL00D LABORATORY		0		18, 791, 516 0	0	60.00
65.00	06500 RESPIRATORY THERAPY	o	0	c	3, 912, 437	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0	0	C	1, 393, 667	0	66.00
66. 01 66. 02	06601 PHYSI CAL THERAPY I -65 06602 PHYSI CAL THERAPY ST JOHN	0	0		1, 585, 694 292, 418	0	66. 01 66. 02
67. 00	06700 OCCUPATI ONAL THERAPY	l ő	0		321, 455	Ö	67. 00
67. 01	06701 OCCUPATION THERAPY I -65	o	0	c	188, 467	0	67. 01
67. 02	06702 OCCUPATIONAL THERAPY ST. JOHN	0	0	C	23, 284	0	67. 02
68. 00 68. 01	O6800 SPEECH PATHOLOGY O6801 SPEECH PATHOLOGY I - 65	0	0		290, 460 368, 967	0	68. 00 68. 01
68. 02	06802 SPEECH THERAPY ST. JOHN	o	0	Č	8, 673	0	68. 02
69. 00	06900 ELECTROCARDI OLOGY	o	0	c	1, 395, 231	0	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	C		0	71.00
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0		24, 870, 917 17, 140, 535	0	72. 00 73. 00
74. 00	07400 RENAL DIALYSIS		0		685, 570	0	74.00
76. 00	03020 RADIATION ONCOLOGY	o	0	c	2, 104, 944	0	76. 00
76. 01	03040 ANGI OCARDI OGRAPHY	0	0	<u> </u> C	460, 318	0	76. 01
90. 00	OUTPATIENT SERVICE COST CENTERS 09000 CLINIC	O	0	l c	-147, 447	0	90.00
90. 00	09001 DI ABETES CLINIC		0		36, 559	0	90.00
90. 02	09002 OUTPATIENT CLINICS		0	i c	79, 667	0	90. 02
90. 03	09003 OCCUPATIONAL MEDICINE CLINIC	0	0	C -	3, 134, 194	0	90. 03
90. 04 90. 05	09004 NEONATOLOGY CLINIC-FRANCISCAN POINT 09005 LACTATION CLINIC	0	0		22, 067 31, 553	0	90. 04 90. 05
91.00	09100 EMERGENCY	167, 446	462, 720		12, 573, 799		91.00
91. 01	09101 EMERGENCY ROOM PHYSICANS	o	0	C	0	0	91. 01
91. 02	09102 EXPRESS CARE	0	0	<u> </u>	0	0	91. 02
	<u> </u>						

Health Financial Systems F	RANCISCAN HEALT	H CROWN POINT		In Lie	u of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der C	F	Period: From 01/01/2021 Fo 12/31/2021	Worksheet B Part I Date/Time Prepared: 5/30/2022 5:41 pm
Cost Center Description	I NTERNS & RESI DENTS SERVI CES-OTHER PRGM COSTS APPRV	PARAMED ED PRGM	ECHOCARDI OLOG\ EDUCATI ON PROGRAM		Intern & Residents Cost & Post Stepdown Adjustments
	22. 00	23. 00	23. 01	24. 00	25. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART					0 92.00
SPECIAL PURPOSE COST CENTERS					
113.00 11300 I NTEREST EXPENSE					113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	167, 446	462, 720	(231, 686, 007	<u>-167, 446</u> 118. 00
NONREI MBURSABLE COST CENTERS					
190.00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	(0	0 190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	(2, 834, 419	
194. 00 07950 FHC	0	0	(0	0 194. 00
194. 01 07951 CONVENT	0	0	(6, 106	0 194. 01
194.02 07952 OTHER NON REIMB - BUILDINGS	0	0	(5, 546, 603	l l
194. 03 07953 OTHR NON REIM-FHC BEHAVORIAL HEALTH	0	0	(139, 367	l l
194. 04 07954 CENTER OF HOPE	0	0	(707, 516	l l
194. 05 07955 LAKESHORE JOINT VENTURE	0	0		307, 244	
194. 06 07957 COVI D VACCI NE CLI NI C	0	Ü		213, 146	
200.00 Cross Foot Adjustments	0	0	00.45	0 450	0 200.00
201.00 Negative Cost Centers	1/7 ///	4/2 720	-90, 152	1	
202.00 TOTAL (sum lines 118 through 201)	167, 446	462, 720	-90, 152	241, 350, 256	-167, 446 202. 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2021 | Part I | To 12/31/2021 | Date/Time Prepared: | 5/30/2022 5:41 pm Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0126

			5/30/2022 5:	41 pm
	Cost Center Description	Total		
		26. 00		
	GENERAL SERVICE COST CENTERS			
1.00	00100 CAP REL COSTS-BLDG & FIXT			1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP			2. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT			4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL			5. 00
6. 00	00600 MAINTENANCE & REPAIRS			6. 00
7. 00	00700 OPERATION OF PLANT			7. 00
7. 01	00701 OPERATION OF PLANT - FP			7. 01
8. 00	00800 LAUNDRY & LINEN SERVICE			8. 00
9. 00	00900 HOUSEKEEPI NG			9. 00
9. 01	01851 ENVIRONMENTAL SERVICES - FP			9. 01
10.00	01000 DI ETARY			10.00
11. 00	01100 CAFETERI A			11.00
13.00	01300 NURSI NG ADMI NI STRATI ON			13. 00
14. 00	01400 CENTRAL SERVI CES & SUPPLY			14. 00
15.00	01500 PHARMACY			15. 00
16.00	01600 MEDI CAL RECORDS & LI BRARY			16.00
17. 00	01700 SOCIAL SERVICE			17. 00
21. 00	02100 I &R SERVI CES-SALARY & FRI NGES APPRV			21. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV			22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)			23. 00
23. 01	02301 ECHOCARDI OLOGY EDUCATI ON PROGRAM I NPATI ENT ROUTI NE SERVI CE COST CENTERS			23. 01
20.00		E7 100 E44		30.00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	57, 102, 546 11, 623, 910		30. 00 31. 00
	02060 NEONATAL INTENSIVE CARE UNIT			
35. 00 43. 00	04300 NURSERY	6, 568, 678 1, 907, 856		35. 00 43. 00
43.00	ANCI LLARY SERVI CE COST CENTERS	1, 907, 630		43.00
50. 00	05000 OPERATING ROOM	21, 403, 048		50.00
51. 00	05100 RECOVERY ROOM	2, 271, 808		51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM			52.00
53. 00	05300 ANESTHESI OLOGY	1, 881, 826 828, 919		53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	21, 334, 885		54. 00
54. 00	05401 RADI OLOGY - I -65	2, 020, 181		54. 00
54. 01	05401 RADI OLOGY DI AGNOSTI C - SJ	379		54. 01
54. 03	05403 LOWELL RADIOLOGY	105, 533		54. 02
55. 00	05500 RADI OLOGY-THERAPEUTI C	105, 555		55. 00
55. 01	05501 CARDI AC CATHERI ZATON LAB	6, 287, 774		55. 01
55. 02	03140 CARDI OLOGY	3, 261, 369		55. 02
55. 03	03450 NEURO-DI AGNOSTI CS	1, 172, 423		55. 03
60. 00	06000 LABORATORY	18, 791, 516		60.00
60. 01	06001 BLOOD LABORATORY	0		60. 01
65. 00	06500 RESPI RATORY THERAPY	3, 912, 437		65. 00
66. 00	06600 PHYSI CAL THERAPY	1, 393, 667		66. 00
66. 01	06601 PHYSI CAL THERAPY I -65	1, 585, 694		66. 01
66. 02	06602 PHYSI CAL THERAPY ST JOHN	292, 418		66. 02
67.00	06700 OCCUPATI ONAL THERAPY	321, 455		67. 00
67. 01	06701 OCCUPATION THERAPY I -65	188, 467		67. 01
	06702 OCCUPATIONAL THERAPY ST. JOHN	23, 284		67. 02
68. 00	06800 SPEECH PATHOLOGY	290, 460		68. 00
68. 01	06801 SPEECH PATHOLOGY I -65	368, 967		68. 01
68. 02	06802 SPEECH THERAPY ST. JOHN	8, 673		68. 02
69. 00		1, 395, 231		69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	4, 349, 927		71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	24, 870, 917		72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	17, 140, 535		73. 00
74.00	07400 RENAL DIALYSIS	685, 570		74. 00
76. 00	03020 RADIATION ONCOLOGY	2, 104, 944		76. 00
76. 01	03040 ANGI OCARDI OGRAPHY	460, 318		76. 01
	OUTPATIENT SERVICE COST CENTERS			
90.00		-147, 447		90. 00
90. 01	09001 DI ABETES CLINIC	36, 559		90. 01
90. 02	09002 OUTPATIENT CLINICS	79, 667		90. 02
90. 03	09003 OCCUPATIONAL MEDICINE CLINIC	3, 134, 194		90. 03
90. 04	09004 NEONATOLOGY CLINIC-FRANCISCAN POINT	22, 067		90. 04
90. 05	09005 LACTATION CLINIC	31, 553		90. 05
91. 00	09100 EMERGENCY	12, 406, 353		91. 00
91. 01	09101 EMERGENCY ROOM PHYSI CANS	0		91. 01
91. 02	09102 EXPRESS CARE	0		91. 02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART			92. 00
	SPECIAL PURPOSE COST CENTERS			
113.00	11300 INTEREST EXPENSE			113. 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	231, 518, 561		118. 00
	NONREI MBURSABLE COST CENTERS			
190.00	19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0		190. 00

Health Financial Systems	FRANCISCAN HEALTH CROWN POINT	In Lie	u of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS	Provi der CCN: 15-0126	Peri od: From 01/01/2021 To 12/31/2021	Worksheet B Part I Date/Time Prepared:

		5/30/2022 5: 4	1 pm
Cost Center Description	Total		
	26. 00		
192. 00 19200 PHYSICIANS' PRIVATE OFFICES	2, 834, 419		192. 00
194. 00 07950 FHC	0		194. 00
194. 01 07951 CONVENT	6, 106		194. 01
194.02 07952 OTHER NON REIMB - BUILDINGS	5, 546, 603		194. 02
194.03 07953 OTHR NON REIM-FHC BEHAVORIAL HEALTH	139, 367		194. 03
194. 04 07954 CENTER OF HOPE	707, 516		194. 04
194.05 07955 LAKESHORE JOINT VENTURE	307, 244		194. 05
194.06 07957 COVID VACCINE CLINIC	213, 146		194. 06
200.00 Cross Foot Adjustments	0		200. 00
201.00 Negative Cost Centers	-90, 152		201. 00
202.00 TOTAL (sum lines 118 through 201)	241, 182, 810		202. 00

| Peri od: | Worksheet B | From 01/01/2021 | Part | I | To | 12/31/2021 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0126

				To	12/31/2021	Date/Time Prep 5/30/2022 5:4	
			CAPI TAL REI	LATED COSTS		07 007 2022 0. 1	, piii
	Cost Center Description	Di rectly	BLDG & FLXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
	occi conton posci i per on	Assigned New	5250 a 1771			BENEFI TS	
		Capital Related Costs				DEPARTMENT	
		0	1.00	2.00	2A	4. 00	
1 00	GENERAL SERVICE COST CENTERS OO100 CAP REL COSTS-BLDG & FIXT			I			1 00
1. 00 2. 00	00200 CAP REL COSTS-BLDG & FIXT						1. 00 2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	109, 217		114, 889		4. 00
5. 00 6. 00	OO5OO ADMINISTRATIVE & GENERAL OO6OO MAINTENANCE & REPAIRS	0	3, 087, 711 22, 832		3, 175, 151 24, 487		5. 00 6. 00
7. 00	00700 OPERATION OF PLANT	0	1, 934, 532		2, 077, 603		7. 00
7. 01	00701 OPERATION OF PLANT - FP	0	0	-,	3, 074		7. 01
8. 00 9. 00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING	0	133, 412 80, 737		137, 092 119, 315		8. 00 9. 00
9. 01	01851 ENVI RONMENTAL SERVI CES - FP	0	0	1	0	97	9. 01
10.00	01000 DI ETARY 01100 CAFETERI A	0	368, 131	24, 756 0	392, 887 0	521	10.00
11. 00 13. 00	01300 NURSI NG ADMI NI STRATI ON	0	310, 160	_	750, 680	1, 216 2, 673	11. 00 13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	302, 908	53, 006	355, 914	533	14. 00
15. 00 16. 00	01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY	0	38, 369 164, 507	1	46, 774 178, 401	3, 094 641	15. 00 16. 00
17. 00	01700 SOCI AL SERVI CE	0	61, 267		61, 535		17. 00
21.00	02100 &R SERVICES-SALARY & FRINGES APPRV	0	0		0	0	21. 00
22. 00 23. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV 02300 PARAMED ED PRGM-(SPECIFY)	0	0	0 15, 088	0 15, 088	0 260	22. 00 23. 00
23. 01	02301 ECHOCARDI OLOGY EDUCATI ON PROGRAM	0	0		22, 039		23. 01
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	0	1, 126, 697	482, 106	1, 608, 803	29, 626	30. 00
31. 00	03100 INTENSIVE CARE UNIT	0	233, 883		587, 094		31.00
35. 00	02060 NEONATAL INTENSIVE CARE UNIT	0	285, 525		407, 234		35. 00
43. 00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	0	0	0	1, 379	43. 00
50.00	05000 OPERATI NG ROOM	0	519, 804	1, 472, 313	1, 992, 117		50. 00
51. 00 52. 00	O5100 RECOVERY ROOM O5200 DELIVERY ROOM & LABOR ROOM	0	196, 745 285, 657		203, 592 285, 657	717 160	51. 00 52. 00
53. 00	05300 ANESTHESI OLOGY	0	27, 931	1	73, 610		53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	622, 451	885, 674	1, 508, 125	6, 174	54. 00
54. 01 54. 02	05401 RADI OLOGY - I - 65 05402 RADI OLOGY DI AGNOSTI C - SJ	0	0	,	225, 501 0	556 0	54. 01 54. 02
54. 03	05403 LOWELL RADI OLOGY	0	Ö	_	17, 207	37	54. 03
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55. 00
55. 01 55. 02	05501 CARDI AC CATHERI ZATON LAB 03140 CARDI OLOGY	0	125, 919 61, 597		566, 189 412, 060		55. 01 55. 02
55. 03	03450 NEURO-DI AGNOSTI CS	0	36, 809	33, 373	70, 182	524	55. 03
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	0	197, 976 0		202, 369 0	0	60. 00 60. 01
65. 00	06500 RESPIRATORY THERAPY	0	38, 633	_	169, 214		
	06600 PHYSI CAL THERAPY	0	80, 276		81, 044	708	
66. 01 66. 02	O6601 PHYSI CAL THERAPY I -65 O6602 PHYSI CAL THERAPY ST JOHN	0	0	15, 634 3, 813	15, 634 3, 813	894 188	66. 01 66. 02
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	0	0	234	67. 00
67. 01 67. 02	06701 OCCUPATION THERAPY I -65 06702 OCCUPATIONAL THERAPY ST. JOHN	0	0	0	0	111 17	67. 01 67. 02
68. 00	06800 SPEECH PATHOLOGY	0	0	Ö	0		68. 00
68. 01	06801 SPEECH PATHOLOGY I -65	0	0	0	0	217	68. 01
68. 02 69. 00	06802 SPEECH THERAPY ST. JOHN 06900 ELECTROCARDI OLOGY	0	83, 286	0 34, 503	0 117, 789	535	68. 02 69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	00, 200	0	0	0	71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0	11, 339		11, 339	0	73. 00 74. 00
76. 00	03020 RADI ATI ON ONCOLOGY	0	0		165, 248		76. 00
76. 01	O3040 ANGLOCARDLOGRAPHY OUTPATLENT SERVICE COST CENTERS	0	0	0	0	337	76. 01
90. 00	09000 CLINIC	0	0	O	0	0	90. 00
90. 01	09001 DI ABETES CLINIC	0	2, 637	1	2, 637	0	90. 01
90. 02 90. 03	O9002 OUTPATIENT CLINICS O9003 OCCUPATIONAL MEDICINE CLINIC	0	0 229, 664	8, 086 10, 747	8, 086 240, 411		90. 02 90. 03
90. 03	09004 NEONATOLOGY CLINIC-FRANCISCAN POINT		229, 004	0,747	240, 411	1, 330	90. 03
	09005 LACTATION CLINIC	0	077.000	0 (00	0	26	90. 05
91. 00 91. 01	09100 EMERGENCY 09101 EMERGENCY ROOM PHYSI CANS	0	377, 888 0	82, 632 0	460, 520 0	4, 806 0	91. 00 91. 01
91. 02	09102 EXPRESS CARE	0	0	o o	0	0	91. 02
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART				0		92. 00

Health Financial Systems F	RANCI SCAN HEALT	TH CROWN POINT		In Lie	u of Form CMS-2	552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CO	1	Period: From 01/01/2021 Fo 12/31/2021	Worksheet B Part II Date/Time Prep 5/30/2022 5:41	
		CAPI TAL REI	LATED COSTS			
Cost Center Description	Di rectly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
	0	1.00	2.00	2A	4. 00	
SPECIAL PURPOSE COST CENTERS	1					
113.00 11300 INTEREST EXPENSE 118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	11, 158, 500	5, 751, 90 ₄	16, 910, 404		113.00
NONREIMBURSABLE COST CENTERS	J O	11, 136, 300	5, 751, 90	10, 910, 404	112, 400	116.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		0	0	190. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	O	151, 146	3, 42	154, 571	1, 684	
194. 00 07950 FHC	0	0	. (0	0	194. 00
194. 01 07951 CONVENT	0	0		0	0	194. 01
194.02 07952 OTHER NON REIMB - BUILDINGS	0	635, 658	47, 56°	683, 219	0	194. 02
194.03 07953 OTHR NON REIM-FHC BEHAVORIAL HEALTH	0	28, 260	(28, 260	0	194. 03
194.04 07954 CENTER OF HOPE	0	0	5, 35	5, 357	431	194. 04
194.05 07955 LAKESHORE JOINT VENTURE	0	0	(0	140	194. 05
194.06 07957 COVID VACCINE CLINIC	0	0	(0	168	194. 06
200.00 Cross Foot Adjustments				0		200. 00
201.00 Negative Cost Centers		0		0		201. 00
202.00 TOTAL (sum lines 118 through 201)	0	11, 973, 564	5, 808, 24	7 17, 781, 811	114, 889	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0126

In Lieu of Form CMS-2552-10

| Period: | Worksheet B | From 01/01/2021 | Part II | To 12/31/2021 | Date/Time Prepared: | 5/30/2022 5:41 pm |

				''		5/30/2022 5: 4	
	Cost Center Description	ADMI NI STRATI VE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	OPERATION OF PLANT - FP	LAUNDRY & LINEN SERVICE	
		5. 00	6. 00	7. 00	7. 01	8. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT					 -	1.00
2.00	00200 CAP REL COSTS-MVBLE EQUI P					 -	2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	2 100 775				 -	4.00
5. 00 6. 00	OO5OO ADMINISTRATIVE & GENERAL OO6OO MAINTENANCE & REPAIRS	3, 199, 775 50, 943	76, 076			 -	5. 00 6. 00
7. 00	00700 OPERATION OF PLANT	247, 388	76, 676 16, 812			 -	7.00
7. 00	00701 OPERATION OF PLANT - FP	14, 385	10, 012		17, 459	 -	7. 01
8. 00	00800 LAUNDRY & LINEN SERVICE	17, 696	1, 159	_	5, 889	208, 224	8.00
9. 00	00900 HOUSEKEEPI NG	47, 933	702		1, 217	18, 484	1
9. 01	01851 ENVIRONMENTAL SERVICES - FP	2, 630	0	. 0	0	0	1
10.00	01000 DI ETARY	23, 552	3, 199	126, 590	0	2, 506	10.00
11.00	01100 CAFETERI A	29, 964	0		0	0	11. 00
13.00	01300 NURSING ADMINISTRATION	76, 391	2, 695	106, 656	0	0	13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	7, 906	2, 632		0	605	1
15. 00	01500 PHARMACY	73, 346	333		0	01	15. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	51, 568	1, 430		0	0	16.00
17. 00	01700 SOCIAL SERVICE	60, 539	532		0	0	17. 00
	02100 I &R SERVI CES-SALARY & FRINGES APPRV	0	0		0	0	
22. 00 23. 00	02200 1 & R SERVI CES-OTHER PRGM COSTS APPRV 02300 PARAMED ED PRGM-(SPECIFY)	2, 218 5, 699	0		0	0	
23. 00	02301 ECHOCARDI OLOGY EDUCATI ON PROGRAM	3,077	0		0	0	1
23.01	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0		1 0	<u> </u>	0	23.01
30.00	03000 ADULTS & PEDI ATRI CS	582, 404	9, 792	387, 441	0	105, 161	30.00
31.00	03100 INTENSIVE CARE UNIT	120, 252	2, 033		0	7, 158	31. 00
35.00	02060 NEONATAL INTENSIVE CARE UNIT	62, 705	2, 481	98, 184	0	4, 941	35. 00
43.00	04300 NURSERY	23, 640	0	0	0	2, 166	43. 00
	ANCI LLARY SERVI CE COST CENTERS						
50.00	05000 OPERATI NG ROOM	209, 912	4, 517		0	22, 764	1
51.00	05100 RECOVERY ROOM	17, 109	1, 710		0	0	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	7, 188	2, 483		0	0	52. 00
53. 00	05300 ANESTHESI OLOGY	6, 008	243		0	0	53.00
54. 00 54. 01	05400 RADI OLOGY - DI AGNOSTI C	216, 879	5, 409 0	214, 044	0 4, 199	5, 229 5, 141	1
54. 01	05401 RADI OLOGY - I - 65 05402 RADI OLOGY DI AGNOSTI C - SJ	18, 074	0		4, 199	37	1
54. 02	05403 LOWELL RADIOLOGY	1, 293	0	0	0	0	1
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0	_	0	0	1
55. 01	05501 CARDI AC CATHERI ZATON LAB	64, 346	1, 094	_	0	1, 823	1
55. 02	03140 CARDI OLOGY	36, 487	535		0	0	55. 02
55. 03	03450 NEURO-DI AGNOSTI CS	12, 269	320		0	1, 668	55. 03
60.00	06000 LABORATORY	218, 759	1, 721	68, 078	0	240	60.00
60. 01	06001 BLOOD LABORATORY	0	0	0	0	0	60. 01
65.00	06500 RESPI RATORY THERAPY	46, 041	336		0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	12, 988	698		0	6, 075	1
66. 01	06601 PHYSI CAL THERAPY I -65	15, 304	0	0	4, 589	0	
66. 02	06602 PHYSI CAL THERAPY ST JOHN	3, 678	0	0	0	0	
67. 00	06700 OCCUPATIONAL THERAPY	3, 958	0		0	0	
67. 01	06701 OCCUPATION THERAPY I -65	1, 802 292	0		564	0	
67. 02 68. 00	06702 OCCUPATIONAL THERAPY ST. JOHN 06800 SPEECH PATHOLOGY	3, 563	0		0	0	67. 02 68. 00
68. 01	06801 SPEECH PATHOLOGY I -65	3, 566	0		1, 001	0	68. 01
68. 02	06802 SPEECH THERAPY ST. JOHN	108	0		1,001	0	68. 02
	06900 ELECTROCARDI OLOGY	11, 830	724	_	0	1, 238	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	55, 573	0		0	0	1
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	322, 942	0	0	0	0	1
73.00	07300 DRUGS CHARGED TO PATIENTS	142, 089	0	0	0	0	73. 00
74.00	07400 RENAL DIALYSIS	8, 331	99	3, 899	0	0	74.00
76.00	03020 RADI ATI ON ONCOLOGY	24, 828	0	0	0	1, 049	76. 00
76. 01	03040 ANGI OCARDI OGRAPHY	5, 859	0	0	0	0	76. 01
	OUTPATIENT SERVICE COST CENTERS	_	_	_			
90.00	09000 CLINIC	0	0		0	125	1
90. 01	09001 DI ABETES CLINIC	52	23	907	0	1, 113	1
90. 02	09002 OUTPATIENT CLINICS	257	1 00/	70.075	0	5, 854	1
90. 03 90. 04	O9003 OCCUPATIONAL MEDICINE CLINIC O9004 NEONATOLOGY CLINIC-FRANCISCAN POINT	29, 475	1, 996	78, 975	0	0	90. 03 90. 04
90.04	09005 LACTATION CLINIC	273 416	0		0	0	90.04
91. 00	09100 EMERGENCY	111, 085	3, 284	129, 945	0	14, 847	1
91.00	09101 EMERGENCY ROOM PHYSI CANS	111,085	J, ∠04	127, 743 N	0	14, 647	1 .
	09101 EMERGENET ROOM FITTST CANS	1 0	0	0	0	0	1
	09200 OBSERVATION BEDS (NON-DISTINCT PART					۱	92.00
00	SPECIAL PURPOSE COST CENTERS			1			
113.00	11300 NTEREST EXPENSE						113. 00
118.00	1	3, 113, 793	68, 992	2, 064, 685	17, 459	208, 224	1

In Lieu of Form CMS-2552-10

| Period: | Worksheet B | From 01/01/2021 | Part II | To 12/31/2021 | Date/Time Prepared: | 5/30/2022 5:41 pm |

					5/30/2022 5:41	pm
Cost Center Description	ADMI NI STRATI VE	MAINTENANCE &	OPERATION OF	OPERATION OF	LAUNDRY &	
	& GENERAL	REPAI RS	PLANT	PLANT - FP	LINEN SERVICE	
	5. 00	6.00	7. 00	7. 01	8. 00	
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0 19	90. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	29, 671	1, 314	51, 975	0	0 19	92. 00
194. 00 07950 FHC	0	0	0	0	0 19	94. 00
194. 01 07951 CONVENT	81	0	0	0	0 19	94. 01
194.02 07952 OTHER NON REIMB - BUILDINGS	40, 364	5, 524	218, 586	0	0 19	94. 02
194.03 07953 OTHR NON REIM-FHC BEHAVORIAL HEALTH	0	246	9, 718	0	0 19	94. 03
194. 04 07954 CENTER OF HOPE	9, 050	0	0	0	0 19	94. 04
194. 05 07955 LAKESHORE JOINT VENTURE	4, 069	0	0	0	0 19	94. 05
194.06 07957 COVID VACCINE CLINIC	2, 747	0	0	0	0 19	94. 06
200.00 Cross Foot Adjustments					20	00.00
201.00 Negative Cost Centers	o	0	0	0	0 20	01. 00
202.00 TOTAL (sum lines 118 through 201)	3, 199, 775	76, 076	2, 344, 964	17, 459	208, 224 20	02. 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2021 | Part II | To 12/31/2021 | Date/Time Prepared: | 5/30/2022 5:41 pm Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0126

						12/31/2021	5/30/2022 5: 4	
		Cost Center Description	HOUSEKEEPI NG	ENVI RONMENTAL	DI ETARY	CAFETERI A	NURSI NG	
			0.00	SERVICES - FP	10.00		ADMI NI STRATI ON	
	GENED	AL SERVICE COST CENTERS	9. 00	9. 01	10.00	11. 00	13. 00	
1.00		CAP REL COSTS-BLDG & FIXT						1.00
2.00		CAP REL COSTS-MVBLE EQUIP						2. 00
4.00		EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500	ADMINISTRATIVE & GENERAL						5. 00
6.00	00600	MAINTENANCE & REPAIRS						6. 00
7.00		OPERATION OF PLANT						7. 00
7. 01		OPERATION OF PLANT - FP						7. 01
8. 00		LAUNDRY & LINEN SERVICE						8. 00
9.00		HOUSEKEEPI NG	217, 635					9. 00
9. 01	1	ENVIRONMENTAL SERVICES - FP	10 100	2, 727	F/1 20F			9. 01
10. 00 11. 00	1	DI ETARY CAFETERI A	12, 130	0	561, 385 0	31, 180		10. 00 11. 00
13. 00	1	NURSING ADMINISTRATION	10, 220	0	0	1, 064		13. 00
14. 00	1	CENTRAL SERVICES & SUPPLY	9, 981	0	0	445		14. 00
15. 00	1	PHARMACY	1, 264	Ö	Ö	1, 266		15. 00
16.00		MEDICAL RECORDS & LIBRARY	5, 420	0	0	314		16. 00
17.00	01700	SOCIAL SERVICE	2, 019	0	0	1, 089	15, 811	17. 00
21. 00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21. 00
22. 00		I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22. 00
23. 00		PARAMED ED PRGM-(SPECIFY)	0	0	0	127		23. 00
23. 01		ECHOCARDI OLOGY EDUCATI ON PROGRAM	0	0	0	11	2, 094	23. 01
20.00		I ENT ROUTI NE SERVI CE COST CENTERS	27.124		F01 0F0	0.752	141 000	20.00
30.00	1	ADULTS & PEDIATRICS	37, 124	0		8, 753		30.00
31. 00 35. 00		INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE UNIT	7, 706 9, 408			2, 030 1, 069		
43. 00	1	NURSERY	9, 400	0		603		43. 00
43.00		LARY SERVICE COST CENTERS	0	O O	0	003	0	43.00
50. 00		OPERATING ROOM	17, 127	0	0	2, 967	136, 883	50.00
51. 00	1	RECOVERY ROOM	6, 483	Ö		271		51. 00
52.00	1	DELIVERY ROOM & LABOR ROOM	9, 412	0	0	1, 712		
53.00	05300	ANESTHESI OLOGY	920	0	0	59	1, 519	53. 00
54.00	05400	RADI OLOGY-DI AGNOSTI C	20, 509	0	0	3, 049	33, 296	54. 00
54. 01		RADI OLOGY - I -65	0	1, 106	0	281	0	54. 01
54. 02		RADIOLOGY DIAGNOSTIC - SJ	0	0	0	0		54. 02
54. 03	1	LOWELL RADI OLOGY	0	0	0	22		54. 03
55. 00		RADI OLOGY-THERAPEUTI C	4 140	0	0	0	-	55. 00
55. 01		CARDI AC CATHERI ZATON LAB	4, 149		0	549		
55. 02 55. 03	1	CARDI OLOGY NEURO-DI AGNOSTI CS	2, 030 1, 213	0	0	517 150		55. 02 55. 03
60.00	1	LABORATORY	6, 523	0	0	0		60.00
60. 01		BLOOD LABORATORY	0, 323	0	0	0		60. 01
65. 00	1	RESPI RATORY THERAPY	1, 273	0		944		65. 00
66.00		PHYSI CAL THERAPY	2, 645	0	0	228		66. 00
66. 01	06601	PHYSICAL THERAPY I -65	0	1, 208	0	330	0	66. 01
66. 02	06602	PHYSICAL THERAPY ST JOHN	0	0	0	84	0	66. 02
67. 00		OCCUPATI ONAL THERAPY	0	0		90	•	67. 00
67. 01		OCCUPATION THERAPY I -65	0	149	0	40		
67. 02		OCCUPATIONAL THERAPY ST. JOHN	0	0	0	7	0	
68.00	1	SPEECH PATHOLOGY	0	0	0	82		68. 00
68. 01 68. 02	1	SPEECH PATHOLOGY I -65 SPEECH THERAPY ST. JOHN	0	264 0	0	80	0 0	68. 01 68. 02
69. 00		ELECTROCARDI OLOGY	2,744	0	0	233		69. 00
71. 00		MEDICAL SUPPLIES CHARGED TO PATIENT	2, 744	0	0	233	0	71.00
72. 00	1	IMPL. DEV. CHARGED TO PATIENTS	0	o	0	0	Ō	72. 00
73. 00		DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73. 00
74.00	07400	RENAL DIALYSIS	374	0	0	0	0	74. 00
76.00	03020	RADIATION ONCOLOGY	0	0	0	212	3, 640	76. 00
76. 01		ANGI OCARDI OGRAPHY	0	0	0	118	0	76. 01
		TIENT SERVICE COST CENTERS						
90. 00		CLI NI C	0	0	0	0	0	90. 00
90. 01	1	DI ABETES CLINIC	87	0	0	0	1, 438	
90. 02	1	OUTPATIENT CLINICS	0	0	0	0	0	90. 02
90. 03 90. 04	1	OCCUPATIONAL MEDICINE CLINIC	7, 567	0		38		90. 03 90. 04
90.04	1	NEONATOLOGY CLINIC-FRANCISCAN POINT LACTATION CLINIC		0		6	94	90.04
90.05		EMERGENCY	12, 451	0		2, 257	90, 540	
91.00		EMERGENCY ROOM PHYSICANS	12, 431	n		2, 237 N	90, 340	91. 00
91. 02	1	EXPRESS CARE	0	0	o o	0	Ö	91. 02
92. 00		OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		AL PURPOSE COST CENTERS					•	
	11300	INTEREST EXPENSE						113. 00
118.00)	SUBTOTALS (SUM OF LINES 1 through 117)	190, 779	2, 727	561, 385	31, 101	947, 118	118. 00

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2021 | Part II | To 12/31/2021 | Date/Time Prepared: | From 20020 | Prepared: | Pr

					5/30/2022 5:41 pm	_
Cost Center Description	HOUSEKEEPI NG	ENVI RONMENTAL	DI ETARY	CAFETERI A	NURSI NG	
		SERVICES - FP			ADMI NI STRATI ON	
	9. 00	9. 01	10.00	11. 00	13. 00	
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0 190. 0	0
192.00 19200 PHYSICIANS' PRIVATE OFFICES	4, 980	0	0	0	0 192. 0	0
194. 00 07950 FHC	0	0	0	0	0 194. 0	0
194. 01 07951 CONVENT	0	0	0	0	0 194. 0	1
194.02 07952 OTHER NON REIMB - BUILDINGS	20, 945	0	0	0	0 194. 0	2
194.03 07953 OTHR NON REIM-FHC BEHAVORIAL HEALTH	931	0	0	0	0 194. 0	3
194. 04 07954 CENTER OF HOPE	0	0	0	0	3, 261 194. 0	4
194.05 07955 LAKESHORE JOINT VENTURE	0	0	0	0	0 194. 0	5
194.06 07957 COVID VACCINE CLINIC	0	0	0	79	0 194. 0	6
200.00 Cross Foot Adjustments					200. 0	0
201.00 Negative Cost Centers	0	0	0	0	0 201. 0	0
202.00 TOTAL (sum lines 118 through 201)	217, 635	2, 727	561, 385	31, 180	950, 379 202. 0	0

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0126

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2021 | Part II | To 12/31/2021 | Date/Time Prepared: | From 20020 | Prepared: | Pr

				'	o 12/31/2021	Date/lime Prep 5/30/2022 5:4	
						INTERNS &	Pili
						RESI DENTS	
	Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	SERVI CES-SALAR	
		SERVICES &		RECORDS &		Y & FRINGES	
		SUPPLY		LI BRARY		APPRV	
	1	14. 00	15. 00	16. 00	17. 00	21. 00	
	GENERAL SERVICE COST CENTERS	T					
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						5. 00
6.00	00600 MAINTENANCE & REPAIRS						6. 00
7.00	00700 OPERATION OF PLANT						7. 00
7.01	00701 OPERATION OF PLANT - FP						7. 01
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
9.00	00900 HOUSEKEEPI NG						9. 00
9.01	01851 ENVIRONMENTAL SERVICES - FP						9. 01
10.00	01000 DI ETARY						10.00
11. 00	01100 CAFETERI A						11. 00
13.00	01300 NURSING ADMINISTRATION						13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY	482, 178					14. 00
15. 00	01500 PHARMACY	43	139, 314				15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	.07,011	294, 344			16. 00
17. 00	01700 SOCI AL SERVI CE	o o	0	271, 011			17. 00
21. 00	02100 &R SERVICES-SALARY & FRINGES APPRV	0	0			0	21. 00
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRV		0			U	22. 00
	1		0				23. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	216	0	C	-		
23. 01	02301 ECHOCARDI OLOGY EDUCATI ON PROGRAM	0	0	C)		23. 01
	INPATIENT ROUTINE SERVICE COST CENTERS	04.00(اء	20.000			
30. 00	03000 ADULTS & PEDI ATRI CS	31, 886	0	20, 838			30. 00
31. 00	03100 I NTENSI VE CARE UNI T	16, 886	0	4, 691			31. 00
35. 00	02060 NEONATAL INTENSIVE CARE UNIT	7, 141	0	3, 871			35. 00
43. 00	04300 NURSERY	0	0	1, 754	985		43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	275, 237	0	30, 824	17, 306		50.00
51.00	05100 RECOVERY ROOM	778	0	3, 162	1, 775		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1	0	2, 414	1, 356		52.00
53.00	05300 ANESTHESI OLOGY	6, 486	o	6, 935	3, 894		53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	43, 748	o	55, 973	31, 662		54.00
54. 01	05401 RADI OLOGY - I -65	84	o	7, 392			54. 01
54. 02	05402 RADIOLOGY DIAGNOSTIC - SJ	0	0				54. 02
54. 03	05403 LOWELL RADI OLOGY	O	o	193	108		54. 03
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0	.,,			55. 00
55. 01	05501 CARDI AC CATHERI ZATON LAB	72, 872	Ö	13, 668	1		55. 01
55. 02	03140 CARDI OLOGY	348	0	5, 431			55. 02
55. 03	03450 NEURO-DI AGNOSTI CS	56	0	2, 251			55. 03
60. 00	06000 LABORATORY	1	0				60.00
		1, 390	0	45, 826	25, 730		
60. 01	06001 BLOOD LABORATORY	2 (70	U	(210	2 400		60. 01
65. 00	06500 RESPI RATORY THERAPY	3, 670	U	6, 219			65.00
66. 00	06600 PHYSI CAL THERAPY	0	0	567			66.00
	06601 PHYSI CAL THERAPY I -65	237	0	982			66. 01
	06602 PHYSI CAL THERAPY ST JOHN	44	0	259			66. 02
67. 00	06700 OCCUPATI ONAL THERAPY	0	O	495			67. 00
67. 01	06701 OCCUPATION THERAPY I -65	99	0	98			67. 01
67. 02	06702 OCCUPATIONAL THERAPY ST. JOHN	0	0	24			67. 02
68. 00	06800 SPEECH PATHOLOGY	0	0	478			68. 00
68. 01	06801 SPEECH PATHOLOGY I -65	0	0	384			68. 01
68. 02	06802 SPEECH THERAPY ST. JOHN	0	0	11			68. 02
69. 00	06900 ELECTROCARDI OLOGY	29	0	3, 290			69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	o	4, 740	2, 661		71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	15, 043	8, 446		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	139, 314	19, 460	10, 926		73.00
74.00	07400 RENAL DIALYSIS	21	0	366	205		74.00
76.00	03020 RADIATION ONCOLOGY	641	o	5, 380	3, 021		76.00
76. 01	03040 ANGI OCARDI OGRAPHY	o	o	289	162		76. 01
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0	C	ol		90. 00
90. 01	09001 DI ABETES CLINIC	0	ol	5	3		90. 01
90. 02	09002 OUTPATIENT CLINICS	o	n n	ľ	ا ما		90. 02
90. 03	09003 OCCUPATIONAL MEDICINE CLINIC	816	n		ا م		90. 03
90. 03	09004 NEONATOLOGY CLINIC-FRANCISCAN POINT	0,10	٥		, E		90. 04
90.05	09005 LACTATION CLINIC		٥	,	3		90. 05
		10 440	o o	21 017	17 /15		
91.00	09100 EMERGENCY	19, 440	O	31, 017	17, 415		91.00
91. 01	09101 EMERGENCY ROOM PHYSI CANS		O		(91. 01
91. 02	1	ا	o		ή Θ		91. 02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	į l	l		1		92. 00

ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 15-0126 Peri od: Worksheet B From 01/01/2021 Part II Date/Time Prepared: 5/30/2022 5: 41 pm 12/31/2021 INTERNS & **RESI DENTS** CENTRAL PHARMACY MEDI CAL SOCIAL SERVICE SERVICES-SALAR Cost Center Description Y & FRINGES SERVICES & RECORDS & APPRV SUPPLY LI BRARY 15.00 17.00 14.00 16.00 21.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | NTEREST EXPENSE 113. 00 SUBTOTALS (SUM OF LINES 1 through 117) 482, 169 139, 314 294, 344 165, 497 0 118.00 118.00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN 0 9 190. 00 0 0 0 0 0 0 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 192. 00 194. 00 07950 FHC 0 0 0 0 0 0 194. 00 0 194. 01 07951 CONVENT 0 0 194. 01 194. 02 07952 OTHER NON REIMB - BUILDINGS 0 194. 02 194. 03 07953 OTHR NON REIM-FHC BEHAVORIAL HEALTH 0 0 194. 03 194. 04 07954 CENTER OF HOPE 0 0 194. 04 194.05 07955 LAKESHORE JOINT VENTURE 0 194. 05 194.06 07957 COVID VACCINE CLINIC 0 0 0 194. 06 Cross Foot Adjustments 200.00 0 200.00

0

139, 314

482, 178

0

294, 344

0

165, 497

0 201.00

0 202. 00

201.00

202.00

Negative Cost Centers

TOTAL (sum lines 118 through 201)

	n Financial Systems ATION OF CAPITAL RELATED COSTS	FRANCI SCAN HEALT	Provi der C		eriod: rom 01/01/2021	u of Form CMS-2 Worksheet B Part II Date/Time Pre 5/30/2022 5:4	pared:
	Cost Center Description	I NTERNS & RESI DENTS SERVI CES-OTHER PRGM COSTS APPRV	PARAMED ED PRGM	ECHOCARDI OLOGY EDUCATI ON PROGRAM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
	1	22. 00	23. 00	23. 01	24. 00	25. 00	
1 00	GENERAL SERVICE COST CENTERS						1 00
1.00 2.00 4.00 5.00 6.00 7.01 8.00 9.01 10.00 11.00 13.00 14.00 15.00 16.00 17.00 21.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT 00701 OPERATION OF PLANT - FP 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01851 ENVIRONMENTAL SERVICES - FP 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	2 210					1. 00 2. 00 4. 00 5. 00 6. 00 7. 01 8. 00 9. 01 10. 00 11. 00 13. 00 14. 00 15. 00 16. 00
22. 00 23. 00 23. 01	02200 L&R SERVICES-OTHER PRGM COSTS APPRV 02300 PARAMED ED PRGM-(SPECIFY) 02301 ECHOCARDIOLOGY EDUCATION PROGRAM INPATIENT ROUTINE SERVICE COST CENTERS	2, 218	24, 401	24, 168			22. 00 23. 00 23. 01
30. 00	03000 ADULTS & PEDI ATRI CS				3, 777, 370	0	30.00
31. 00 35. 00 43. 00	03100 INTENSIVE CARE UNIT 02060 NEONATAL INTENSIVE CARE UNIT 04300 NURSERY				1, 008, 999 659, 995 30, 527	0 0 0	31. 00 35. 00 43. 00
EO 00	ANCILLARY SERVICE COST CENTERS				2 005 541	0	F0 00
50. 00 51. 00	05000 OPERATI NG ROOM 05100 RECOVERY ROOM				2, 895, 541 314, 181	0	50. 00 51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM				410, 411	0	52.00
53.00	05300 ANESTHESI OLOGY				109, 345	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C				2, 144, 097	0	54.00
54. 01 54. 02	05401 RADI OLOGY - I - 65 05402 RADI OLOGY DI AGNOSTI C - SJ				266, 484 37	0	54. 01 54. 02
54. 02	05403 LOWELL RADI OLOGY				18, 860	0	54. 02
55. 00	05500 RADI OLOGY-THERAPEUTI C				0	0	55. 00
55. 01	05501 CARDI AC CATHERI ZATON LAB				798, 182	0	55. 01
55. 02	1				489, 522	0	
55. 03 60. 00	03450 NEURO-DI AGNOSTI CS 06000 LABORATORY				102, 555 570, 636	0	1
60. 01	06001 BLOOD LABORATORY				0 0	Ö	60.01
65. 00	06500 RESPI RATORY THERAPY				246, 398	0	65. 00
66. 00 66. 01	06600 PHYSI CAL THERAPY 06601 PHYSI CAL THERAPY I -65				132, 876 39, 729	0	66. 00 66. 01
66. 02	06602 PHYSI CAL THERAPY ST JOHN				8, 212	0	66. 02
67. 00	06700 OCCUPATI ONAL THERAPY				5, 055	0	67. 00
67. 01	06701 OCCUPATION THERAPY I -65				2, 918	0	67. 01
67. 02 68. 00	06702 OCCUPATIONAL THERAPY ST. JOHN 06800 SPEECH PATHOLOGY				353 4, 609	0	67. 02 68. 00
68. 01	06801 SPEECH PATHOLOGY I -65				5, 728	0	68. 01
68. 02	06802 SPEECH THERAPY ST. JOHN				134	0	68. 02
69. 00	1				174, 013	0	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT				62, 976 246, 421	0	71.00
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS				346, 431 311, 789	0	72.00
74. 00	07400 RENAL DI ALYSI S				24, 634	0	74. 00
76. 00	03020 RADI ATI ON ONCOLOGY				204, 607	0	76. 00
76. 01	03040 ANGI OCARDI OGRAPHY				6, 765	0	76. 01
90. 00	OUTPATIENT SERVICE COST CENTERS O9000 CLINIC				125	0	90.00
90. 01	09001 DI ABETES CLINIC				6, 265	0	
90. 02	09002 OUTPATIENT CLINICS				14, 197	0	90. 02
90. 03 90. 04	09003 OCCUPATIONAL MEDICINE CLINIC 09004 NEONATOLOGY CLINIC-FRANCISCAN POINT				360, 628	0	90. 03 90. 04
90. 04	09004 NEUNATOLOGY CLINIC-FRANCISCAN POINT				403 450	0	90.04
91. 00	09100 EMERGENCY				897, 607	0	
91. 01	09101 EMERGENCY ROOM PHYSI CANS				0	0	91. 01
91. 02	09102 EXPRESS CARE				0	0	91.02

Health Financial Systems F	RANCISCAN HEALT	H CROWN POINT		In lie	u of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der C		Period: From 01/01/2021 To 12/31/2021	Worksheet B Part II Date/Time Prepared: 5/30/2022 5:41 pm
Cost Center Description	I NTERNS & RESI DENTS SERVI CES-OTHER PRGM COSTS APPRV	PARAMED ED PRGM	ECHOCARDI OLOG EDUCATI ON PROGRAM		Intern & Residents Cost & Post Stepdown Adjustments
	22.00	23. 00	23. 01	24.00	25. 00
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART					0 92.00
SPECIAL PURPOSE COST CENTERS					
113. 00 11300 I NTEREST EXPENSE					113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	0)	0 16, 453, 644	0 118. 00
NONRE! MBURSABLE COST CENTERS					
190.00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN				0	0 190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES				244, 204	0 192. 00
194. 00 07950 FHC				0	0 194. 00
194. 01 07951 CONVENT				81	0 194. 01
194.02 07952 OTHER NON REIMB - BUILDINGS				968, 638	0 194. 02
194.03 07953 OTHR NON REIM-FHC BEHAVORIAL HEALTH				39, 155	0 194. 03
194.04 07954 CENTER OF HOPE				18, 099	0 194. 04
194.05 07955 LAKESHORE JOINT VENTURE				4, 209	0 194. 05
194.06 07957 COVID VACCINE CLINIC				2, 994	0 194. 06
200.00 Cross Foot Adjustments	2, 218	24, 401		0 26, 619	0 200. 00
201.00 Negative Cost Centers	0	0	24, 16	8 24, 168	0 201. 00
202.00 TOTAL (sum lines 118 through 201)	2, 218	24, 401	24, 16	8 17, 781, 811	0 202. 00

| In Lieu of Form CMS-2552-10 | Period: Worksheet B | From 01/01/2021 | Part II | To 12/31/2021 | Date/Time Prepared: 5/30/2022 5:41 pm Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0126

Cestate Selectic Dist Original 20.00 20.				5/30/2022 5:	41 pm
DEPENDENT SERVICE DIST CENTERS 1.00 1.		Cost Center Description	Total		
1.00 00100 CAR PEL COSTS-BUDG & FIXT			26. 00		
2 00 00000 CONTROLLED STANKINE FOULT CONTROLLED STANKINE SULPHAY MAIN CONTROLLED STANKINE SULPHAY SULPHAY CONTROLLED STANKINE SULPHAY CONTROLLED S					
4 - 00 000000	1.00	00100 CAP REL COSTS-BLDG & FIXT			1. 00
5.00 000000 AMIN INSTANT UNE SCRIPTAN 7.00 000000 PORPATTON OF PLANT 7.00		1 1			•
CODE CODE CONTROL					1
0.000 0.0000 0.0000 0.0000 0.0000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.00000000		1 1			1
7. 0.1 0.00701 (PERATT NO OF PLANT - FP		1 1			
B. DO DODGO LAURINGRY ALL LINES SHOVICE 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1 1			
9 0.00 10 0000 INDINSTRYTP IN C 10 000 10 0000 IETARY 11 0.00 11		1 1			1
9.01 0.00 10000 DEFAMEN 10.00 11.00					
10.00 101000 IDETARY		· · ·			1
11.00 01100 CAFETERIA 11.00 11.00 01100 CAFETERIA 11.00 11.00 01100 CAFTERIA SERVICES & SUPPLY 11.00 11.00 01100 CATTRAL SERVICES & SUPPLY 11.00 11.00 01100 CATTRAL SERVICES & SUPPLY 11.00 11.00 01100 CATTRAL SERVICES & SUPPLY 12.00 11.00 01100 CATTRAL SERVICES & SUPPLY 12.00 11.00 01100 CATTRAL SERVICES SALARY & FRINCES APPRY 22.00 02000 I RAS SERVICES-GALARY & FRINCES APPRY 23.00 02000 I RAS SERVICES-GALARY & FRINCES APPRY 23.00 02000 I RAS SERVICES APPRY 33.00 02000 I RAS SERVICES APPRY		1 1			
13.00 01300 NIRSING ASMINISTRATION 13.00 13.00 1300 NIRSING ASMINISTRATION 14.00 13.00 1300 PRABMACY 15.00 1300 PRABMACY 12.00 12.00 12.00 PRABMACY 12.00 12.00 PRABMACY 12.00 12.00 12.00 PRABMACY 12.00 PRABMA		1 1			1
14.00 01.000 CENTRAL SERVICES & SUPPLY 15.00 10.000 PHARMACY 15.00 10.000 PHARMACY 15.00 10.000 PHARMACY 17.00 17.		1 1			
15.00 101500 PHARMACY		1 1			1
16.00 10100 MEDICAL RECORDS & LIBRARY 17.00 10700 148 SERVICES SALARY & FRINCES APPROV 21.00 20200 20200 148 SERVICES SALARY & FRINCES APPROV 21.00 22.00 20200 148 SERVICES SALARY & FRINCES APPROV 21.00 22.00 22.00 20200 148 SERVICES SALARY & FRINCES APPROV 22.00 22.0		1 1			
17.00 1700 SOCI AL SERVICE		1 1			
21.00 2010 AR SERVICE-SALARY & FINNES APPRY		1 1			
22.00 02200 IAR SERVICES-OTHER PROM COSTS APPRY 22.00 23.01 02300 ECHOCARDI OLOCY EDUCATION PROGRAMS 22.01		1 1			- 1
23.00		1 1			- 1
		1 1			
IMPATIENT ROUTINE SERVICE COST CENTERS 3, 00.00 30.00 00.00		1 1			
30.00 3000 ABULTS & PEDIATRICS 3,777,370 31.00 35.00 2060 MEDNATAL INTERSIVE CARE UNIT 659,995 35.00 35.00 2060 MEDNATAL INTERSIVE CARE UNIT 659,995 35.00 2060 MEDNATAL INTERSIVE CARE UNIT 659,995 42.00 2060 MEDIA CARE UNIT 659,995 42.00 2060 MEDIA CARE UNIT 650,995 42.00 2060 MEDIA CARE UNIT 660,995 42.00 2060 MEDIA CARE UNIT 660,995 42.00 2060 MEDIA CARE UNIT 660,995 42.00 42.0	23.01				7 23.01
31.00	30 00		3 777 370		30.00
35.00 02000 NEOMATAL INTENSIVE CASE UNIT 659, 995 35, 000 500 08000 NURSERY 30, 527 34, 30 08000 NURSERY 30, 527 34, 30 08000 NURSERY 30, 527 34, 30 08000 NURSERY 30, 527 30, 30 08100 OPERATI NE ROOM 314, 1811 51, 00 51		1 1			
43.00 0.4500 NURSERY 30.527					
MOLILARY SERVICE COST CENTERS 50.00 50.00 50.00 6PEATING ROM 2,895,541 51.00 51.00 51.00 6FEATING ROM 314,181 51.00 52.00 52.00 6ELVERY ROM & LABOR ROM 410,411 52.00 52.00 53.00 65.0		1 1			
	10.00		30, 32.		10.00
51.00	50. 00		2, 895, 541		50.00
52 00 05200 DELIVERY ROOM & LABOR ROOM					1
53.00		1 1			
54. 00 05400 RADIOLOGY-DI AGNOSTIC 2, 144, 097 54. 00 54. 01 05401 RADIOLOGY 1-65 266, 814 54. 01 54. 02 54.02 54.02 54.03 56.03 CMPLIC RADIOLOGY 18,860 54. 03 55.00 05500 RADIOLOGY - THERAPEUTIC 0 55. 00 55.00 05500 RADIOLOGY-THERAPEUTIC 0 55. 00 55.00 CMPLIC REPRETATION LAB 79, 182 55. 01 55.01 CARDIA CCATTHERIZATION LAB 79, 182 55. 01 55.00 CARDIA CCATTHERIZATION LAB 79, 182 55. 01 CMPLICATION CONTROLOGY-THERAPEUTIC 70 60.00 60.00 CMPLICATION CONTROLOGY-THERAPEUTIC 70 70 70 70 70 70 70 7		1 1			
54. 01 05401 RADIOLOGY 1-65 266, 184 54. 02 54202 RADIOLOGY 91 RADIOLOGY 18, 1860 54. 02 54. 02 54. 02 55. 00 55. 00 05500 RADIOLOGY 71 RADIOLOGY 18, 1860 55. 00 05500 RADIOLOGY 71 RADIOLOGY 798, 182 55. 00 05500 RADIOLOGY 71 RADIOLOGY 798, 182 55. 00 05500 RADIOLOGY 75. 00 75.		1 1			
54. 02 05402 ADJILLOGY DIAGNOSTIC - SJ 37 54. 02 55. 00 55.00 ADJILLOGY CHERAPEUTIC 0 0 55.00 55.00 ADJILLOGY CHERAPEUTIC 0 0 55.00 ADJILLOGY CHERAPEUTIC 55. 01 05501 ADJILLOGY CHERAPEUTIC 1 0 55. 01 05501 ADJILLOGY CHERAPEUTIC 1 0 55. 01 05501 ADJILLOGY CHERIC ZATON LAB 798, 182 55. 01 05501 ADJILLOGY CHERIC ZATON LAB 798, 182 55. 02 03140 CARDILLOGY 489, 522 55. 03 03450 ADJILLOGY CHERIC ZATON LAB 55. 03 05000 ADJILLOGY CHERIC ZATON LAB 55. 03 05000 ADJILLOGY CHERIC ZATON CH		1 1			
54. 03 05403 LOWELL RADI OLOGY 18,860 55. 00 05500 RADI DLOGY-THERAPEUTIC 0 55. 00 05500 RADI DLOGY-THERAPEUTIC 55. 00 05500 RADI DLOGY 489, 522 55. 00 05400 RADI DLOGY 06000 RADI DLOGY 06000 RADI DLOGY 06000 RADIROTATICS 0.00 06000 RADIROTATICS 0.00 06000 RADIROTATICS 0.00 06000 RADIROTATICS 0.00 06500 RESPIRATORY 167, 00 06500 RESPIRATORY 167, 00 06500 RESPIRATORY 167, 00 06500 RESPIRATORY 167, 00 06600 PHYSI CAL THERAPY 165 39, 729 066, 01 06600 PHYSI CAL THERAPY 1.65 39, 729 066, 01 06600 PHYSI CAL THERAPY 1.65 39, 729 066, 01 06600 060000 060000 060000 060000 060000 060000 060000 060000 060000 060000 060000 060000 060000 0600000 06000000 0600000000	54. 02				
55. 01 05501 CARDI AC CATHERIZATION LAB 798, 182 55. 01 55. 02 03140 CARDI LOGY 489, 522 55. 03 03450 NEURO-DI AGNOSTICS 102, 555 03 03450 NEURO-DI AGNOSTICS 102, 555 03 03450 NEURO-DI AGNOSTICS 102, 555 03 03450 NEURO-DI AGNOSTICS 570, 636 06. 00 06001 BLODD LABORATORY 0 06. 01 05500 08500 RESPIRATORY 1468, 09 06. 01 05500 08500 RESPIRATORY 1468, 09 06. 01 05500 08500 NEURO LABORATORY 128, 876 06. 00 06600 08500 08501 NEURO LABORATORY 128, 876 06. 00 06600 08500 08501 NEURO LABORATORY 128, 876 06. 00 06600 08500 08501	54.03				54. 03
55. 02 03140 CARDIOLOGY	55.00	1 1			
55 03 03450 NEURO-DI AGNOSTI CS 102,555 03 060,00 06000 LABORATORY 570,636 060,00 06000 LABORATORY 060,00 06000 06500 RESPIRATORY 1870,00 06500 06500 RESPIRATORY 1870,00 06500 RESPIRATORY 1870,00 06500 RESPIRATORY 1870,00 06500 RESPIRATORY 1870,00 06500 PHYSICAL HERAPY 165 39,729 066,00 06600 07500 PHYSICAL HERAPY 165 39,729 066,00 0750	55. 01	05501 CARDI AC CATHERI ZATON LAB	798, 182		55. 01
60. 00 0.0000 LABORATORY 570, 636 60. 00 60.	55. 02	03140 CARDI OLOGY	489, 522		55. 02
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65. 00 06500 06500 06500 PHYSI CAL THERAPY 132, 876 66. 00 06600 PHYSI CAL THERAPY 131, 876 66. 01 06601 PHYSI CAL THERAPY 1-65 39, 729 66. 01 06601 PHYSI CAL THERAPY ST JOHN 8, 212 66. 02 06602 PHYSI CAL THERAPY ST JOHN 8, 212 67. 00 0700 0CCUPATI ONAL THERAPY 1-65 2, 918 67. 01 0701 0CCUPATI ONAL THERAPY ST JOHN 353 67. 01 0701 0CCUPATI ONAL THERAPY ST JOHN 353 67. 01 06800 SPEECH PATHOLOGY 4, 609 68. 00 06800 SPEECH PATHOLOGY 4, 609 68. 00 06800 SPEECH PATHOLOGY 5, 728 68. 01 0801 SPEECH PATHOLOGY 1-65 5, 728 68. 01 08020 SPEECH PATHOLOGY 174, 013 08020	60.00	06000 LABORATORY	570, 636		60.00
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67. 01 06701 0CCUPATI ON THERAPY I - 65 2, 918 67. 01 67. 02 0CCUPATI ONAL THERAPY ST. JOHN 353 67. 02 68. 00 06800 SPEECH PATHOLOGY 4, 609 68. 00 68. 01 06801 SPEECH PATHOLOGY 1-65 5, 728 68. 01 68. 02 06802 SPEECH PATHOLOGY 1-65 68. 01 69. 00 06900 ELECTROCARDI OLOGY 174, 013 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 62, 976 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 311, 789 73. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 311, 789 73. 00 74. 00 07400 RENAL DIALYSIS 24, 634 74. 00 76. 01 03020 RADIATION ONCOLOGY 204, 607 76. 00 76. 01 03040 ANGIOCARDI OGRAPHY 6, 765 76. 01 76. 01 09000 CLINIC 125 90. 01 79. 02 09000 CLINIC 90. 01 79. 03 09000 CLINIC 125 90. 01 79. 04 09000 MONATOLOGY 14, 197 90. 02 79. 03 09003 OCCUPATI IONAL MEDI CINE CLINIC 360, 628 90. 03 79. 04 09000 MONATOLOGY 14, 197 90. 03 79. 05 09005 LACTATI ON CLINIC 450 90. 04 79. 07 09000 LACTATI ON CLINIC 897, 607 91. 00 79. 07 09000 LACTATI ON CLINIC 897, 607 91. 00 79. 07 09000 ELERGENCY 97. 00 79. 08 09000 CLINIC 97. 00 79. 09 09000 LACTATI ON CLINIC 897, 607 91. 00 79. 00 09000 LACTATI ON CLINIC 897, 607 91. 00 79. 00 09000 LACTATI ON CLINIC 897, 607 91. 00 79. 00 09000 LACTATI ON CLINIC 897, 607 91. 00 79. 00 09000 ELERGENCY 89		1 1			
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Health Financial Systems	FRANCISCAN HEALTH CROWN POINT	In Lieu of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS	Provi der CCN: 15-0126	Peri od: Worksheet B From 01/01/2021 Part II To 12/31/2021 Date/Time Prepared:

		10 12/31/2021	5/30/2022 5:41 pm
Cost Center Description	Total		
	26. 00		
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	244, 204		192. 00
194. 00 07950 FHC	0		194. 00
194. 01 07951 CONVENT	81		194. 01
194.02 07952 OTHER NON REIMB - BUILDINGS	968, 638		194. 02
194.03 07953 OTHR NON REIM-FHC BEHAVORIAL HEALTH	39, 155		194. 03
194. 04 07954 CENTER OF HOPE	18, 099		194. 04
194. 05 07955 LAKESHORE JOINT VENTURE	4, 209		194. 05
194. 06 07957 COVID VACCINE CLINIC	2, 994		194. 06
200.00 Cross Foot Adjustments	26, 619		200. 00
201.00 Negative Cost Centers	24, 168		201. 00
202.00 TOTAL (sum lines 118 through 201)	17, 781, 811		202. 00

Cost Center Description			FRANCISCAN HEALT			In Lie	eu of Form CMS-:	
CAPTIMAL RELATED COSTS Series Description Cost Center Descript	COST A	ALLOCATION - STATISTICAL BASIS		Provi der CC			Worksheet B-1	
CAST Center Description							Date/Time Pre	pared:
Const. Center Description							5/30/2022 5: 4	1 pm
SOURCE PROPERTY CACHELON			CAPITAL REL	ATED COSTS				
SOURCE PROPERTY CACHELON								
		Cost Center Description				Reconciliation		
CEREBAL SERVICE COST CENTERS 1.00			(SQUARE FEET)	(DOLLAR VALUE)				
							(ACCUM. COST)	
Designation 1 00 2 200 4 00 54 5 5 00								
BRIBBOL SERVICE COST CERTIESS			1.00	2.00		ГА	F 00	
1.00		CENEDAL CEDALCE COCT CENTEDO	1.00	2.00	4.00	5A	5.00	
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4.00 00000 DEPLOYEE BEREFITS DEPARTMENT 4,970 4,255 83,962,755 10,00000 10,0000 10,0000 10,00000 10,00000 10,00000 10,00000 10,00000 10,00000 10		l l	344, 604	4 255 000				
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0.00 0.000 MAINTERMINEE & REPAIRS 1,039 1,241 472,098 0 2,806,924 6,70			1				174 201 017	
7.00 QOYZOL DERATION OF PLANT B8,032 107,274 2,310,671 0 13,630,960 7,00 70 10 70 10 70 10 70 10 70 11 70 11 70 10 70 11 14 14 40 14 14 40 14 40 14 40 14 14 40 14 14 40 14 14 40 14			1					
7. 01 (00701) DEPARTION OF PLANT - FP 0 2,305 (0) 0 792,599 (7.0) 2.8 2.0 0.00 (00801) LUBRIDRY & LINE SERVICE 6,071 (2.7) 2.75 (3.73,862) 0 75,000 (2.75) 8.0 0.00 (00801) LUBRISH & LINE SERVICES - FP 1 6 77,000 (1.63) 1.0 1		1	1					1
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13.00 01300 NIRES INC. ADMINI STRATI ON			0	0				
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17.00 01700 SOCIAL SERVICE 2,768 201 2,122,145 0 3,335,622 17.00 22.01 02.00 10.01 RS SERVICES-SALARY & FRINCES APPRV 0 0 0 0 0 122,201 22.00 23.01 23.00			1					
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31.00 03100 INTENSIVE CARE UNIT 10,643 264,836 3,735,441 0 6,625,817 31.00			<u>'</u>					
15.00 02600 NEONATAL INTENSIVE CARE UNIT 12.993 91.257 2.082,839 0 3.455,006 35.00	30.00	03000 ADULTS & PEDIATRICS	51, 271	361, 481	21, 624, 593	0	32, 086, 055	30.00
A3. 00 04300 NURSERY 0 0 1,007,794 0 1,302,547 43,00	31.00	03100 INTENSIVE CARE UNIT	10, 643	264, 836	3, 735, 441	0	6, 625, 817	31. 00
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50.00	43.00	04300 NURSERY	0	0	1, 007, 794	. 0	1, 302, 547	43.00
51.00 OSTOO RECOVERY ROOM & LABOR ROOM 12, 999 0 116, 948 0 396, 056 52, 00 53.00 OSTOO DELI LYEPR YROOM & LABOR ROOM 12, 999 0 116, 948 0 331, 039 53, 00 0STOO RADIOLOGY 1, 271 34, 250 47, 982 0 331, 039 53, 00 54, 00 0STOO RADIOLOGY 1, 265 0 0 0 0 0 0 0 0 0		ANCILLARY SERVICE COST CENTERS						
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53.00 05300 AMSTHESI OLOGY 1, 271 34, 250 47, 982 0 331, 039 53.00				5, 134			942, 673	
54. 00 05400 RADIO LOGY - DI AGNOSTI C 28, 325 664, 075 4, 513, 417 0 11, 949, 905 54. 00 54. 01 05401 RADIO LOGY C 1-65 0 0 169, 080 406, 569 0 995, 891 54. 01 54. 02 05402 RADIO LOGY DI AGNOSTI C - SJ 0 0 12, 902 27, 365 0 71, 269 54. 02 55. 00 05500 RADIO LOGY - THERAPEUTI C 0 0 0 0 0 0 0 0 0			12, 999	0			396, 056	
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54.03 05403 LOWELL RADI OLOGY 0 12,902 27,365 0 71,269 54.03 55.00 05500 ABDI OLOGY-THERAPEUTIC 0 0 0 0 0 0 0 0 0			0	169, 080	406, 569			
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Health Finar	ncial Systems F	RANCI SCAN HEAL	TH CROWN POINT		In lie	eu of Form CMS-:	2552_10
	TION - STATISTICAL BASIS	INNOT SOAN TIEAE	Provi der Co	F	Period: From 01/01/2021 To 12/31/2021	Worksheet B-1 Date/Time Pre	pared:
	,					5/30/2022 5: 4	1 pm
		CAPITAL REI	LATED COSTS				
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		(SQUARE FEET)	(DOLLAR VALUE)	BENEFITS		& GENERAL	
				DEPARTMENT (GROSS		(ACCUM. COST)	
				SALARI ES)			
		1.00	2.00	4. 00	5A	5. 00	
92 00 09200	OBSERVATION BEDS (NON-DISTINCT PART	1.00	2.00	1.00	- Ort	0.00	92. 00
	AL PURPOSE COST CENTERS						72.00
	INTEREST EXPENSE						113. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	507, 774	4, 312, 754	82, 181, 901	-65, 020, 179	171, 564, 226	118. 00
NONRE	I MBURSABLE COST CENTERS						
190. 00 19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	(0	0	190. 00
192. 00 19200	PHYSICIANS' PRIVATE OFFICES	6, 878	2, 568	1, 230, 954	1 0	1, 634, 850	192. 00
194. 00 07950		0	0	(0	0	194. 00
194. 01 07951		0	0	(0		194. 01
	OTHER NON REIMB - BUILDINGS	28, 926		(0	2, 224, 049	
	OTHR NON REIM-FHC BEHAVORIAL HEALTH	1, 286		(-28, 260		194. 03
	CENTER OF HOPE	0	4, 017	314, 752		498, 651	
	LAKESHORE JOINT VENTURE	0	0	102, 004		224, 225	
•	COVID VACCINE CLINIC	0	0	123, 144	1 0	151, 360	
200.00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers	44 070 5/4	F 000 047	0.000.00		1	201. 00
202.00	Cost to be allocated (per Wkst. B, Part I)	11, 973, 564	5, 808, 247	2, 982, 304	1	65, 275, 445	202.00
203. 00	Unit cost multiplier (Wkst. B, Part I)	21. 975326	1. 333696	0. 035524	1	0. 370248	203. 00
204.00	Cost to be allocated (per Wkst. B,			114, 889		3, 199, 775	204. 00
	Part II)						
205. 00	Unit cost multiplier (Wkst. B, Part			0. 001368	3	0. 018149	205. 00

206. 00

207. 00

206.00

207.00

11)

NAHE adjustment amount to be allocated (per Wkst. B-2)
NAHE unit cost multiplier (Wkst. D, Parts III and IV)

Health Financial Systems In Lieu of Form CMS-2552-10 FRANCISCAN HEALTH CROWN POINT COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0126 Peri od: Worksheet B-1 From 01/01/2021 12/31/2021 Date/Time Prepared: 5/30/2022 5:41 pm Cost Center Description MAINTENANCE & OPERATION OF OPERATION OF LAUNDRY & HOUSEKEEPI NG LINEN SERVICE REPAI RS PLANT PLANT - FP (SOUARE FEET) (SQUARE FEET) (SQUARE FEET) (ASSI GNED (POUNDS OF TIME) LAUNDRY) 6.00 7.00 9.00 7.01 8.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4 00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00600 MAINTENANCE & REPAIRS 6.00 398, 347 6.00 00700 OPERATION OF PLANT 7.00 310, 315 7.00 88,032 00701 OPERATION OF PLANT - FP 7.01 70.158 7.01 8.00 00800 LAUNDRY & LINEN SERVICE 6,071 6,071 23, 661 904.604 8.00 9.00 00900 HOUSEKEEPI NG 3, 674 4, 892 80, 302 300, 570 3,674 9.00 01851 ENVIRONMENTAL SERVICES - FP 9.01 0 Λ 9 01 10.00 01000 DI ETARY 16, 752 16, 752 0 10,887 16, 752 10.00 11.00 01100 CAFETERI A 11.00 01300 NURSING ADMINISTRATION 0 13.00 14.114 14, 114 13.00 14, 114 01400 CENTRAL SERVICES & SUPPLY 14.00 13, 784 13, 784 2,627 13, 784 14.00 15.00 01500 PHARMACY 1,746 1, 746 1, 746 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 7,486 7, 486 C 0 7, 486 16.00 01700 SOCIAL SERVICE 2, 788 0 17 00 2 788 0 2,788 17 00 21.00 02100 I &R SERVICES-SALARY & FRINGES APPRV 0 C 0 0 0 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 0 0 0 22.00 22.00 C 0 23.00 02300 PARAMED ED PRGM-(SPECIFY) 0 0 23.00 0 02301 ECHOCARDI OLOGY EDUCATI ON PROGRAM 0 23.01 0 23.01 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 51, 271 51, 271 456, 857 51, 271 30.00 31 00 03100 INTENSIVE CARE UNIT 0 10 643 31 00 10 643 10 643 31.097 0 35.00 02060 NEONATAL INTENSIVE CARE UNIT 12, 993 12, 993 21, 467 12, 993 35.00 04300 NURSERY 9, 411 43.00 0 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 23, 654 23, 654 0 98 894 23.654 50 00 0 51.00 05100 RECOVERY ROOM 8.953 8, 953 8, 953 51.00 05200 DELIVERY ROOM & LABOR ROOM 12, 999 12, 999 0 12, 999 52.00 0 52.00 53.00 05300 ANESTHESI OLOGY 1, 271 1, 271 0 0 1, 271 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 28, 325 28, 325 0 22.716 28, 325 54 00 54.01 05401 RADIOLOGY - I-65 16, 873 22, 333 54.01 0 05402 RADIOLOGY DIAGNOSTIC - SJ 54.02 0 160 54.02 54.03 05403 LOWELL RADIOLOGY 0 0 54.03 C 0 0 05500 RADI OLOGY-THERAPEUTI C 0 55.00 0 0 0 55.00 55.01 05501 CARDI AC CATHERI ZATON LAB 5,730 5, 730 7, 921 5,730 55.01 55 02 03140 CARDI OLOGY 2,803 2,803 0 2,803 55.02 03450 NEURO-DI AGNOSTI CS 0 55.03 1,675 1.675 7.246 1,675 55.03 06000 LABORATORY O 1, 043 60.00 9,009 9,009 9,009 60.00 60.01 06001 BLOOD LABORATORY 0 60.01 65.00 06500 RESPIRATORY THERAPY 1,758 1,758 1, 758 0 65.00 66.00 06600 PHYSI CAL THERAPY 26, 392 66.00 3,653 3, 653 0 3,653 66.01 06601 PHYSI CAL THERAPY I -65 0 C 18, 441 0 0 66.01 66.02 06602 PHYSI CAL THERAPY ST JOHN 0 66.02 0 0 06700 OCCUPATIONAL THERAPY 67.00 0 0 67.00 06701 OCCUPATION THERAPY I-65 0 0 67.01 C 2, 268 0 67.01 06702 OCCUPATIONAL THERAPY ST. JOHN 67.02 67.02 0 o 68.00 06800 SPEECH PATHOLOGY C C O 68.00 06801 SPEECH PATHOLOGY I-65 68.01 0 C 4,023 0 0 68.01 68.02 06802 SPEECH THERAPY ST. JOHN 0 C 0 0 68.02 06900 ELECTROCARDI OLOGY 3,790 3, 790 0 5, 379 3, 790 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 71.00 0 0 0 07200 I MPL. DEV. CHARGED TO PATIENTS 72.00 0 Ω 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 C 0 0 0 73.00 07400 RENAL DIALYSIS 74.00 516 516 0 516 74.00 03020 RADIATION ONCOLOGY 0 76.00 0 C 4.556 0 76.00 03040 ANGI OCARDI OGRAPHY 76.01 0 0 0 0 76.01 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 0 90.00 545 09001 DIABETES CLINIC 90 01 120 120 0 4 837 120 90 01 0 90.02 09002 OUTPATIENT CLINICS 25, 433 0 90.02 09003 OCCUPATIONAL MEDICINE CLINIC 10, 451 0 10, 451 90.03 90.03 10, 451 90.04 09004 NEONATOLOGY CLINIC-FRANCISCAN POINT 0 0 0 90.04 09005 LACTATION CLINIC 0 90.05 90.05 0 91.00 09100 EMERGENCY 17, 196 17, 196 0 64, 501 17, 196 91.00 09101 EMERGENCY ROOM PHYSICANS 91.01 91.01 91.02 09102 EXPRESS CARE 0 0 0 0 91.02

92.00

113.00

113. 00 11300 | INTEREST EXPENSE

92 00

09200 OBSERVATION BEDS (NON-DISTINCT PART

SPECIAL PURPOSE COST CENTERS

Heal th F	inancial Systems F	RANCISCAN HEAL	TH CROWN POINT		In Li€	eu of Form CMS-	2552-10
COST ALL	OCATION - STATISTICAL BASIS		Provi der C		Peri od:	Worksheet B-1	
					From 01/01/2021 To 12/31/2021	Date/Time Pre	narodi
					10 12/31/2021	5/30/2022 5: 4	
	Cost Center Description	MAINTENANCE &	OPERATION OF	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
		REPAI RS	PLANT	PLANT - FP	LINEN SERVICE	(SQUARE FEET)	
		(SQUARE FEET)	(SQUARE FEET)	(ASSI GNED	(POUNDS OF		
				TIME)	LAUNDRY)		
		6.00	7. 00	7. 01	8. 00	9. 00	
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	361, 257	273, 225	70, 15	904, 604	263, 480	118. 00
	ONREI MBURSABLE COST CENTERS						
1	9000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0)	0		190. 00
	9200 PHYSICIANS' PRIVATE OFFICES	6, 878	6, 878		0		192. 00
194. 00 07		0	0)	0		194. 00
	7951 CONVENT	0	0		0		194. 01
	7952 OTHER NON REIMB - BUILDINGS	28, 926		1	0		194. 02
	7953 OTHR NON REIM-FHC BEHAVORIAL HEALTH	1, 286	1, 286		0		194. 03
	7954 CENTER OF HOPE	0	0		0		194. 04
	7955 LAKESHORE JOINT VENTURE	0	0)	0		194. 05
1	7957 COVID VACCINE CLINIC	0	0)	0	0	194. 06
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)	3, 846, 182	19, 527, 774	1, 086, 04	5 2, 142, 957	4, 151, 536	202. 00
203.00	Unit cost multiplier (Wkst. B, Part I)	9. 655356	62. 928875	15. 47998	8 2. 368945	13. 812210	203. 00
204.00	Cost to be allocated (per Wkst. B,	76, 076	2, 344, 964	17, 45	9 208, 224	217, 635	204.00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part	0. 190979	7. 556721	0. 24885	3 0. 230182	0. 724074	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			1

	FINANCIAI SYSTEMS	FRANCI SCAN HEALT		N. 15 012/		Workshoot D 1	
COST	LLOCATION - STATISTICAL BASIS		Provi der CC	F	Period: From 01/01/2021 To 12/31/2021	Worksheet B-1 Date/Time Pre 5/30/2022 5:4	pared:
	Cost Center Description	ENVI RONMENTAL SERVI CES - FP	DI ETARY (PATI ENT ME	CAFETERI A (FTE' S)	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES &	Pill
		(ASSIGNED TIME)	ALS)		(DI RECT_NRSING	SUPPLY (COSTED	
		9. 01	10.00	11. 00	HRS) 13.00	REQUIS.) 14.00	
	GENERAL SERVICE COST CENTERS	7. 0.	10.00		.0.00		
1.00 2.00 4.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						1. 00 2. 00 4. 00
5. 00 6. 00 7. 00	00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT						5. 00 6. 00 7. 00
7. 01 8. 00	00701 OPERATION OF PLANT - FP 00800 LAUNDRY & LINEN SERVICE						7. 01 8. 00
9. 00 9. 01	O0900 HOUSEKEEPI NG O1851 ENVI RONMENTAL SERVI CES - FP	41, 605	1/0 501				9. 00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	0	168, 501 0	1, 354, 928	3		10.00
13.00	01300 NURSING ADMINISTRATION	0	0	46, 255	657, 154		13. 00
14. 00 15. 00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	0	0	19, 350 55, 021		3, 052, 319 271	1
16. 00	01600 MEDICAL RECORDS & LIBRARY	ő	Ö	13, 627	' o	0	16. 00
17. 00	01700 SOCIAL SERVICE 02100 I&R SERVICES-SALARY & FRINGES APPRV	0	0	47, 329		0	17. 00 21. 00
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRV	Ö	0	C	o o	0	22. 00
23. 00 23. 01	02300 PARAMED ED PRGM- (SPECIFY) 02301 ECHOCARDI OLOGY EDUCATION PROGRAM	0	0	5, 531 48 <i>6</i>		1, 369 0	
23.01	INPATIENT ROUTINE SERVICE COST CENTERS	0	U	400	1, 440	0	23.01
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	0	150, 632 17, 869	380, 319 88, 215		201, 848 106, 893	
35. 00	02060 NEONATAL INTENSIVE CARE UNIT	0	17, 809	46, 452		45, 206	
43. 00	04300 NURSERY	0	0	26, 199	0	0	43.00
50.00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	0	0	128, 927	94, 650	1, 742, 319	50.00
51. 00 52. 00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	0	0	11, 781 74, 410		4, 926 4	51. 00 52. 00
53. 00	05300 ANESTHESI OLOGY	0	0	2, 575		41, 060	
54. 00 54. 01	05400 RADI OLOGY - DI AGNOSTI C	0 16, 873	0	132, 491		276, 936 530	1
54. 01	05401 RADI OLOGY - I-65 05402 RADI OLOGY DI AGNOSTI C - SJ	10, 673	0	12, 228 (1	0	1
54. 03	05403 LOWELL RADI OLOGY	0	0	970	0	0	
55. 00 55. 01	05500 RADI OLOGY-THERAPEUTI C 05501 CARDI AC CATHERI ZATON LAB	0	0	23, 838	14, 500	0 461, 297	
55. 02	03140 CARDI OLOGY	0	0	22, 457		2, 205	1
55. 03 60. 00	03450 NEURO-DI AGNOSTI CS 06000 LABORATORY	0	0	6, 525 (354 8, 802	
60. 01	06001 BLOOD LABORATORY	0	0	(0	60. 01
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0	0	41, 019 9, 893		23, 232 0	1
66. 01	06601 PHYSI CAL THERAPY I -65	18, 441	O	14, 335	o	1, 501	66. 01
66. 02 67. 00	06602 PHYSICAL THERAPY ST JOHN 06700 OCCUPATIONAL THERAPY	0	0	3, 669 3, 913		280 0	1
67. 01	06701 OCCUPATION THERAPY I-65	2, 268	0	1, 747	o	624	67. 01
67. 02 68. 00	06702 OCCUPATIONAL THERAPY ST. JOHN 06800 SPEECH PATHOLOGY	0	0	287 3, 542		0	1
68. 01	06801 SPEECH PATHOLOGY I -65	4, 023	0	3, 470	o	0	68. 01
68. 02 69. 00	06802 SPEECH THERAPY ST. JOHN 06900 ELECTROCARDI OLOGY	0	0	99 10, 109		0 185	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	ő	Ö	81		0	71. 00
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0	(0	
74. 00	07400 RENAL DIALYSIS	ő	Ö	C	o o	136	74. 00
76. 00 76. 01	03020 RADI ATI ON ONCOLOGY 03040 ANGI OCARDI OGRAPHY	0	0	9, 193 5, 131		4, 056 0	1
	OUTPATIENT SERVICE COST CENTERS		J	3, 131		<u>_</u>	
90. 00 90. 01	09000 CLINIC 09001 DIABETES CLINIC	0	0	(0	
90. 02	09002 OUTPATIENT CLINICS	Ö	0	18		0	
90. 03 90. 04	09003 OCCUPATIONAL MEDICINE CLINIC 09004 NEONATOLOGY CLINIC-FRANCISCAN POINT	0	0	1, 663 250		5, 167 0	
90. 04	09005 LACTATION CLINIC	0	0	250	0	0	1
	09100 EMERGENCY	0	o	98, 082	62, 605	123, 062	1
91. 01 91. 02	O9101 EMERGENCY ROOM PHYSI CANS O9102 EXPRESS CARE	0	0	(0	
	09200 OBSERVATION BEDS (NON-DISTINCT PART				1		92. 00

Haalth Finan	piol Cyptomo	DANCICCAN HEALT	TI CDOWN DOINT		la lio	u of Form CMC	2552 10
Heal th Finan	TION - STATISTICAL BASIS	RANCI SCAN HEALT	Provider CC	`N: 15_0126 P	eriod:	u of Form CMS- Worksheet B-1	
COST ALLOCAT	TOW - STATISTICAL BASIS		Trovider co	F	rom 01/01/2021 o 12/31/2021	Date/Time Pre 5/30/2022 5:4	pared:
	Cost Center Description	ENVI RONMENTAL	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	
		SERVICES - FP	(PATIENT ME	(FTE' S)	ADMI NI STRATI ON	SERVICES &	
		(ASSI GNED	ALS)			SUPPLY	
		TIME)			(DI RECT NRSI NG	•	
		0.01	40.00	44.00	HRS)	REQUIS.)	
00501	U DUDDOGE GOOT GENTERO	9. 01	10. 00	11. 00	13. 00	14. 00	
	AL PURPOSE COST CENTERS	1					140.00
	INTEREST EXPENSE	41 (05	1/0 501	1 251 407	/F4 000	2 052 2/2	113.00
	SUBTOTALS (SUM OF LINES 1 through 117) MBURSABLE COST CENTERS	41, 605	168, 501	1, 351, 487	654, 899	3, 052, 263]118.00
	GIFT, FLOWER, COFFEE SHOP, & CANTEEN		ol	0	ا		190. 00
	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		190.00
194. 00 07950		0	0	0	0		194. 00
194. 01 07951			0	0	0		194. 00
	OTHER NON REIMB - BUILDINGS		0	0	0		194. 01
	OTHER NON REIM-FHC BEHAVORIAL HEALTH	0	0	0	0		194. 02
	CENTER OF HOPE		0	0	2, 255		194. 04
	LAKESHORE JOINT VENTURE		0	0	2, 233		194. 05
	COVID VACCINE CLINIC		Ö	3, 441			194. 06
	Cross Foot Adjustments		ĭ	0, 111	Ĭ	O	200.00
	Negative Cost Centers						201. 00
	Cost to be allocated (per Wkst. B,	198, 546	3, 251, 302	2, 262, 296	7, 064, 161	1, 826, 321	202 00
	Part I)	1,70,010	0, 201, 002	2/202/2/0	7,001,101	1,020,021	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	4. 772167	19. 295446	1. 669680	10. 749628	0. 598339	203. 00
204.00	Cost to be allocated (per Wkst. B,	2, 727	561, 385	31, 180	950, 379	482, 178	204.00
	Part II)			·		•	
205.00	Unit cost multiplier (Wkst. B, Part	0. 065545	3. 331642	0. 023012	1. 446204	0. 157971	205. 00
	11)						
206. 00	NAHE adjustment amount to be allocated						206. 00
	(per Wkst. B-2)						
	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)		l				

Health Financial Systems FRANCISCAN HEALT COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0126

Peri od: Worksheet B-1
From 01/01/2021
To 12/31/2021 Date/Time Prepared: 5/30/2022 5:41 pm

				LNITEDNE ®	5/30/2022 5: 4	
				INTERNS &	RESIDENTS	
Cost Center Description	PHARMACY		SOCIAL SERVICE	SERVI CES-SALAR		
	(COSTED REQUIS.)	RECORDS & LI BRARY	(GROSS CHAR	Y & FRINGES APPRV	PRGM COSTS APPRV	
	REQUIS.)	(GROSS CHAR	GES)	(ASSI GNED	(ASSI GNED	
	45.00	GES)	47.00	TIME)	TIME)	
GENERAL SERVI CE COST CENTERS	15. 00	16. 00	17. 00	21. 00	22. 00	
1. 00 O0100 CAP REL COSTS-BLDG & FIXT						1. 00
2. 00 00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 O0400 EMPLOYEE BENEFITS DEPARTMENT 5.00 O0500 ADMINISTRATIVE & GENERAL						4. 00 5. 00
6. 00 00600 MAINTENANCE & REPAIRS						6. 00
7.00 00700 OPERATION OF PLANT						7. 00
7. 01 00701 OPERATION OF PLANT - FP						7. 01
8.00 00800 LAUNDRY & LI NEN SERVI CE 9.00 00900 HOUSEKEEPI NG						8. 00 9. 00
9. 01 01851 ENVI RONMENTAL SERVI CES - FP						9. 01
10. 00 01000 DI ETARY						10. 00
11. 00 01100 CAFETERI A 13. 00 01300 NURSI NG ADMINI STRATI ON						11. 00 13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY						14. 00
15. 00 01500 PHARMACY	7, 829, 029					15. 00
16. 00 01600 MEDICAL RECORDS & LIBRARY	0	978, 584, 427	1			16.00
17. 00 01700 SOCIAL SERVICE 21. 00 02100 L&R SERVICES-SALARY & FRINGES APPRV	0	0	978, 584, 427 0	1, 001		17. 00 21. 00
22. 00 02200 I &R SERVICES-OTHER PRGM COSTS APPRV	O	0	ő	1,001	1, 001	
23.00 02300 PARAMED ED PRGM-(SPECIFY)	0	0	0			23. 00
23. 01 02301 ECHOCARDI OLOGY EDUCATI ON PROGRAM I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	0	0			23. 01
30. 00 03000 ADULTS & PEDI ATRI CS	0	69, 229, 622	69, 229, 622	0	0	30. 00
31.00 03100 INTENSIVE CARE UNIT	0	15, 584, 418			0	31. 00
35. 00 02060 NEONATAL INTENSIVE CARE UNIT 43. 00 04300 NURSERY	0	12, 860, 498 5, 828, 241		0	0	35. 00 43. 00
ANCI LLARY SERVI CE COST CENTERS	j Oj	5, 626, 241	5, 620, 241	U _I	0	43.00
50.00 05000 OPERATING ROOM	0	102, 404, 809		0	0	50. 00
51. 00 05100 RECOVERY ROOM	0	10, 505, 205		0	0	51.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY	0	8, 021, 570 23, 039, 521	1	0	0	52. 00 53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	O	186, 649, 714		Ö	0	54. 00
54. 01 05401 RADI OLOGY - I - 65	0	24, 558, 673	24, 558, 673	0	0	54. 01
54. 02 05402 RADI OLOGY DI AGNOSTI C - SJ 54. 03 05403 LOWELL RADI OLOGY	0	639, 617	639, 617	0	0	54. 02 54. 03
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	007,017	0	0	0	55. 00
55. 01 05501 CARDI AC CATHERI ZATON LAB	0	45, 410, 246	1	0	0	55. 01
55. 02 03140 CARDI OLOGY 55. 03 03450 NEURO-DI AGNOSTI CS	0	18, 044, 093 7, 478, 497	1	0	0	55. 02 55. 03
60. 00 06000 LABORATORY	0	152, 246, 891		0	0	60.00
60. 01 06001 BLOOD LABORATORY	0	0	0	0	0	60. 01
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	0	20, 660, 149		0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY 66. 01 06601 PHYSI CAL THERAPY 1-65	0	1, 883, 862 3, 262, 410		0	0	66. 00 66. 01
66. 02 06602 PHYSI CAL THERAPY ST JOHN	0	862, 045		Ō	0	66. 02
67. 00 06700 OCCUPATI ONAL THERAPY	0	1, 645, 169		0	0	67.00
67. 01 06701 0CCUPATION THERAPY 1-65 67. 02 06702 OCCUPATIONAL THERAPY ST. JOHN	0	324, 441 78, 806	l	0	0	67. 01 67. 02
68. 00 06800 SPEECH PATHOLOGY	O	1, 588, 744	1	Ö	0	68. 00
68. 01 06801 SPEECH PATHOLOGY 1 -65	0	1, 275, 245		0	0	68. 01
68. 02 06802 SPEECH THERAPY ST. JOHN 69. 00 06900 ELECTROCARDI OLOGY	0	36, 930 10, 929, 804		0	0	68. 02 69. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	15, 747, 984		0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	49, 977, 785	49, 977, 785	0	0	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	7, 829, 029	64, 650, 904	1	ı	0	73.00
74. 00 07400 RENAL DI ALYSI S 76. 00 03020 RADI ATI ON ONCOLOGY		1, 214, 879 17, 873, 533			0	74. 00 76. 00
76. 01 03040 ANGI OCARDI OGRAPHY	Ö	961, 397		Ö	0	76. 01
90. 00 OUTPATIENT SERVICE COST CENTERS 90. 00 OOOO CLINIC		0		ما	0	90.00
90. 00 09000 CLINIC 90. 01 09001 DI ABETES CLINIC		14, 994	14, 994	0	0	90.00
90. 02 09002 OUTPATIENT CLINICS	0	0	0	O	0	90. 02
90.03 09003 OCCUPATIONAL MEDICINE CLINIC 90.04 09004 NEONATOLOGY CLINIC-FRANCISCAN POINT	0	21 411	0	0	0	90. 03 90. 04
90. 04 09004 NEONATOLOGY CLINIC-FRANCISCAN POINT 90. 05 09005 LACTATION CLINIC	0	31, 411 16, 611	1	0	0	90.04
91. 00 09100 EMERGENCY	Ö	103, 045, 709	1	1, 001	1, 001	91. 00
91. 01 09101 EMERGENCY ROOM PHYSI CANS	0	0	1	0	0	91.01
91. 02 09102 EXPRESS CARE	0	0	'I U	ا	0	91. 02

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS | Period: | Worksheet B-1 | | To | 12/31/2021 | Date/Time | Prepared: | 5/30/2022 | 5:41 pm | | Provider CCN: 15-0126

					5/30/2022 5: 4	1 pm
				INTERNS &	RESI DENTS	
Cost Center Description	PHARMACY	MEDI CAL	SOCIAL SERVICE	SERVI CES-SALAR	SERVI CES-OTHER	
	(COSTED	RECORDS &		Y & FRINGES	PRGM COSTS	
	REQUIS.)	LI BRARY	(GROSS CHAR	APPRV	APPRV	
		(GROSS CHAR	GES)	(ASSI GNED	(ASSI GNED	
		GES)		TIME)	TIME)	
	15. 00	16.00	17.00	21. 00	22. 00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS						1
113. 00 11300 I NTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117	7, 829, 029	978, 584, 427	978, 584, 427	1, 001	1, 001	118. 00
NONREI MBURSABLE COST CENTERS						1
190.00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	C	0	0	0	190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	Ö	0	0	0	192. 00
194. 00 07950 FHC	0	d	0	0	0	194. 00
194. 01 07951 CONVENT	0	l o	0	0	0	194. 01
194.02 07952 OTHER NON REIMB - BUILDINGS	0	o	0	0	0	194. 02
194.03 07953 OTHR NON REIM-FHC BEHAVORIAL HEALTH	0	o	0	0	0	194. 03
194. 04 07954 CENTER OF HOPE	0	o	0	0	0	194. 04
194. 05 07955 LAKESHORE JOINT VENTURE	0	Ó	ol o	0	0	194. 05
194. 06 07957 COVID VACCINE CLINIC	0	Ó	ol o	0	0	194. 06
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B,	5, 780, 474	4, 562, 929	5, 008, 135	0	167, 446	202.00
Part I)		, , , , ,			,	
203.00 Unit cost multiplier (Wkst. B, Part I	0. 738339	0. 004663	0. 005118	0. 000000	167. 278721	203. 00
204.00 Cost to be allocated (per Wkst. B,	139, 314		1			204.00
Part II)					,	
205.00 Unit cost multiplier (Wkst. B, Part	0. 017795	0. 000301	0.000169	0. 000000	2. 215784	205. 00
206.00 NAHE adjustment amount to be allocate	ed					206. 00
(per Wkst. B-2)						
207.00 NAHE unit cost multiplier (Wkst. D,						207. 00
Parts III and IV)						
	•	•	•	•		

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS FRANCISCAN HEALTH CROWN POINT In Lieu of Form CMS-2552-10 Provider CCN: 15-0126

						12/ 51/ 2021	5/30/2022 5:41 pm	<u>m</u>
		Cost Center Description		ECHOCARDI OLOGY				
			PRGM	EDUCATI ON				
			(ASSI GNED	PROGRAM				
			TIME)	(ASSI GNED				
			23.00	TI ME) 23. 01				
	GENER	AL SERVICE COST CENTERS	23.00	23.01				
1.00		CAP REL COSTS-BLDG & FIXT					1.	. 00
2.00	1	CAP REL COSTS-MVBLE EQUIP						. 00
4.00	1	EMPLOYEE BENEFITS DEPARTMENT					4.	. 00
5.00	00500	ADMINISTRATIVE & GENERAL					5.	. 00
6.00	00600	MAINTENANCE & REPAIRS					6.	. 00
7.00		OPERATION OF PLANT						. 00
7. 01	1	OPERATION OF PLANT - FP						. 01
8. 00	1	LAUNDRY & LINEN SERVICE					l l	. 00
9.00	1	HOUSEKEEPI NG						. 00
9. 01	1	ENVIRONMENTAL SERVICES - FP					l l	01
10.00	1	DI ETARY					l l	00
11. 00 13. 00	1	CAFETERIA NURSING ADMINISTRATION						. 00
14. 00	1	CENTRAL SERVICES & SUPPLY						. 00
15. 00		PHARMACY						. 00
16. 00		MEDICAL RECORDS & LIBRARY						. 00
17. 00	1	SOCIAL SERVICE						. 00
21.00		I&R SERVICES-SALARY & FRINGES APPRV					ı	. 00
22. 00		I&R SERVICES-OTHER PRGM COSTS APPRV					22.	. 00
23. 00	02300	PARAMED ED PRGM-(SPECIFY)	1, 001				23.	. 00
23. 01		ECHOCARDIOLOGY EDUCATION PROGRAM		1, 001			23.	. 01
		ENT ROUTINE SERVICE COST CENTERS			Г			
30.00	1	ADULTS & PEDI ATRI CS	0	0				0.00
31. 00 35. 00	1	INTENSIVE CARE UNIT	0	0			l l	. 00
43. 00	1	NEONATAL INTENSIVE CARE UNIT NURSERY	0	0				. 00
43.00		LARY SERVICE COST CENTERS	0	0			45.	. 00
50.00		OPERATI NG ROOM	0	0			50.	. 00
51.00	05100	RECOVERY ROOM	0	0			51.	. 00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0			52.	. 00
53.00	1	ANESTHESI OLOGY	0	0	l .			. 00
54. 00		RADI OLOGY - DI AGNOSTI C	0	0				. 00
54. 01	1	RADI OLOGY - I -65	0	0			l l	. 01
54. 02 54. 03	1	RADIOLOGY DIAGNOSTIC - SJ LOWELL RADIOLOGY	0	0				. 02
55. 00	1	RADI OLOGY-THERAPEUTI C	0	0				. 00
55. 01	1	CARDI AC CATHERI ZATON LAB	0	0				. 01
55. 02	1	CARDI OLOGY	o	0				. 02
55. 03	1	NEURO-DI AGNOSTI CS	0	0			55.	. 03
60.00	06000	LABORATORY	0	0			60.	. 00
60. 01	06001	BLOOD LABORATORY	0	0			60.	. 01
65. 00	1	RESPI RATORY THERAPY	0	0				. 00
66.00	1	PHYSI CAL THERAPY	0	0				. 00
66. 01	1	PHYSICAL THERAPY I -65	0	0	1			. 01
66. 02 67. 00	1	PHYSI CAL THERAPY ST JOHN OCCUPATI ONAL THERAPY	0	0			ı	. 02 . 00
67. 00	1	OCCUPATIONAL INERAPY I -65	0	0			l l	. 00
67. 02	1	OCCUPATION THERAPY ST. JOHN		n				. 02
68. 00	1	SPEECH PATHOLOGY	ol	0				. 00
68. 01	1	SPEECH PATHOLOGY I-65	o	0			l l	. 01
68. 02	1	SPEECH THERAPY ST. JOHN	0	0			l l	. 02
69.00	1	ELECTROCARDI OLOGY	이	1, 001	1			. 00
71.00		MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	ł		l l	. 00
72. 00 73. 00	1	IMPL. DEV. CHARGED TO PATIENTS		0	ŀ			. 00
74.00	1	DRUGS CHARGED TO PATIENTS RENAL DIALYSIS		0	1			. 00
76.00		RADI ATI ON ONCOLOGY		0	l .		· · · · · · · · · · · · · · · · · · ·	. 00
76. 01	1	ANGI OCARDI OGRAPHY	l ol	Ö				. 01
		TIENT SERVICE COST CENTERS					. 01	
90.00		CLI NI C	0	0				. 00
90. 01	1	DIABETES CLINIC	0	0	1		l	. 01
90. 02	1	OUTPATIENT CLINICS	이	0			l	. 02
90. 03	1	OCCUPATIONAL MEDICINE CLINIC	0	0				0.03
90.04	1	NEONATOLOGY CLINIC-FRANCISCAN POINT		0				0.04
90. 05 91. 00	1	LACTATION CLINIC EMERGENCY	1, 001	0	l .			. 05
91.00	1	EMERGENCY ROOM PHYSICANS	1,001	0	1			. 00
	1	EXPRESS CARE		0			ı	. 02
		OBSERVATION BEDS (NON-DISTINCT PART						. 00
			'				,	

Health Financial Systems	FRANCISCAN HEALTH CROWN POINT	In Lieu of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS	Provi der CCN: 15-0126	Period: Worksheet B-1 From 01/01/2021

COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 15-0126	From 01/01/2021	rksneet B-1
			To 12/31/2021 Da	te/Time Prepared:
			5/	30/2022 5:41 pm
Cost Center Description		ECHOCARDI OLOGY		
	PRGM	EDUCATI ON		
	(ASSI GNED	PROGRAM		
	TIME)	(ASSI GNED		
	22.22	TIME)		
CDEOLAL DUDDOCE OCCT OFFITEDO	23. 00	23. 01		
SPECIAL PURPOSE COST CENTERS	1			110.00
113. 00 11300 I NTEREST EXPENSE	4 004	4 004		113.00
118. 00 SUBTOTALS (SUM OF LINES 1 through 117)	1, 001	1, 001		118. 00
NONREI MBURSABLE COST CENTERS				100.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		190. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0		192. 00
194. 00 07950 FHC	0	0		194. 00
194. 01 07951 CONVENT	0	0		194. 01
194. 02 07952 OTHER NON REIMB - BUILDINGS	0	0		194. 02
194. 03 07953 OTHR NON REIM-FHC BEHAVORIAL HEALTH	0	0		194. 03
194. 04 07954 CENTER OF HOPE	0	0		194. 04
194. 05 07955 LAKESHORE JOINT VENTURE	0	0		194. 05
194. 06 07957 COVID VACCINE CLINIC	0	O		194. 06
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)	462, 720	-90, 152		202. 00
203.00 Unit cost multiplier (Wkst. B, Part I)	462. 257742	0. 000000		203. 00
204.00 Cost to be allocated (per Wkst. B,	24, 401	24, 168		204. 00
Part II)				
205.00 Unit cost multiplier (Wkst. B, Part	24. 376623	24. 143856		205. 00
206.00 NAHE adjustment amount to be allocated	0	0		206. 00
(per Wkst. B-2)				
207.00 NAHE unit cost multiplier (Wkst. D,	0. 000000	0. 000000		207. 00
Parts III and IV)				

COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provider Co		Period: From 01/01/2021 To 12/31/2021	Worksheet C Part Date/Time Pre	pared:
			Ti +l o	XVIII	Hospi tal	5/30/2022 5: 4 ³ PPS	1 pm
			i ii ti e	AVIII	Hospi tal Costs	PFS	
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	·	(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.					
		26)	2. 00	2.00	4.00	F 00	
	INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3. 00	4. 00	5. 00	
30. 00	03000 ADULTS & PEDIATRICS	57, 102, 546		57, 102, 54	5 0	57, 102, 546	30. 00
31.00	03100 INTENSIVE CARE UNIT	11, 623, 910		11, 623, 910	1	11, 623, 910	
35. 00	02060 NEONATAL INTENSIVE CARE UNIT	6, 568, 678		6, 568, 67		6, 578, 182	
43. 00	04300 NURSERY	1, 907, 856		1, 907, 85	6 0	1, 907, 856	43. 00
FO 00	ANCI LLARY SERVI CE COST CENTERS	21 402 040		21 402 044	2 404	21 400 454	F0 00
50. 00 51. 00	O5000 OPERATING ROOM O5100 RECOVERY ROOM	21, 403, 048 2, 271, 808		21, 403, 048 2, 271, 808		21, 409, 454 2, 271, 808	•
52. 00	05200 DELIVERY ROOM & LABOR ROOM	1, 881, 826		1, 881, 82	1	1, 881, 826	•
53. 00	05300 ANESTHESI OLOGY	828, 919		828, 91	1	831, 072	•
54.00	05400 RADI OLOGY-DI AGNOSTI C	21, 334, 885		21, 334, 88	5 0	21, 334, 885	54.00
54. 01	05401 RADI OLOGY - I -65	2, 020, 181		2, 020, 18	1	2, 020, 181	
54. 02	05402 RADI OLOGY DI AGNOSTI C - SJ	379		379		379	54. 02
54. 03	O5403 LOWELL RADI OLOGY O5500 RADI OLOGY - THERAPEUTI C	105, 533		105, 53	0 0	105, 533 0	54. 03 55. 00
55. 00 55. 01	05501 CARDI AC CATHERI ZATON LAB	6, 287, 774		6, 287, 77	١	6, 287, 774	55. 00
55. 02	03140 CARDI OLOGY	3, 261, 369		3, 261, 36	1	3, 261, 369	
55. 03	03450 NEURO-DI AGNOSTI CS	1, 172, 423		1, 172, 42		1, 172, 423	
60.00	06000 LABORATORY	18, 791, 516		18, 791, 51	1	18, 795, 187	
60. 01	06001 BLOOD LABORATORY	0			0	0	60. 01
65. 00	06500 RESPI RATORY THERAPY	3, 912, 437	0	3, 912, 43		3, 912, 437	65. 00
66.00	06600 PHYSI CAL THERAPY	1, 393, 667	0	1, 393, 66	1	1, 393, 667	66. 00
66. 01 66. 02	06601 PHYSI CAL THERAPY I -65 06602 PHYSI CAL THERAPY ST JOHN	1, 585, 694 292, 418	0	1, 585, 69 292, 41		1, 585, 694 292, 418	•
67. 00	06700 OCCUPATI ONAL THERAPY	321, 455	0	321, 45		321, 455	•
67. 01	06701 OCCUPATION THERAPY I -65	188, 467	0	188, 46	1	188, 467	67. 01
67. 02	06702 OCCUPATIONAL THERAPY ST. JOHN	23, 284	0	23, 28		23, 284	67. 02
68. 00	06800 SPEECH PATHOLOGY	290, 460	0	290, 460		290, 460	
68. 01	06801 SPEECH PATHOLOGY I -65	368, 967	0	368, 96	1	368, 967	68. 01
68. 02	O6802 SPEECH THERAPY ST. JOHN O6900 ELECTROCARDI OLOGY	8, 673	0	8, 67	1	8, 673	•
69. 00 71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 395, 231 4, 349, 927		1, 395, 23 ⁻ 4, 349, 92 ⁻	1	1, 395, 231 4, 349, 927	69. 00 71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	24, 870, 917		24, 870, 91	1	24, 870, 917	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	17, 140, 535		17, 140, 53	1	17, 140, 535	
74.00	07400 RENAL DIALYSIS	685, 570		685, 570	o o	685, 570	74. 00
76. 00	03020 RADI ATI ON ONCOLOGY	2, 104, 944		2, 104, 94		2, 104, 944	
76. 01	03040 ANGI OCARDI OGRAPHY	460, 318		460, 31	3 0	460, 318	76. 01
90. 00	OUTPATIENT SERVICE COST CENTERS O9000 CLINIC	l ol			o lo	0	90. 00
90. 00	09001 DI ABETES CLINIC	36, 559		36, 55		36, 559	
90. 02	09002 OUTPATIENT CLINICS	79, 667		79, 66	1	79, 667	
90. 03	09003 OCCUPATIONAL MEDICINE CLINIC	3, 134, 194		3, 134, 19	1	3, 134, 194	
	09004 NEONATOLOGY CLINIC-FRANCISCAN POINT	22, 067		22, 06		22, 067	
90. 05		31, 553		31, 55		31, 553	
91. 00 91. 01	09100 EMERGENCY	12, 406, 353		12, 406, 35	58, 274	12, 464, 627	
91.01	O9101 EMERGENCY ROOM PHYSICANS O9102 EXPRESS CARE					0	91. 01 91. 02
91.02	09200 OBSERVATION BEDS (NON-DISTINCT PART	7, 933, 464		7, 933, 46		7, 933, 464	1
00	SPECIAL PURPOSE COST CENTERS	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		.,,,,,,,,,	-	.,,,,,,,,,,	
	11300 I NTEREST EXPENSE						113. 00
200.00		239, 599, 472	0			239, 679, 480	
201.00		7, 933, 464	^	7, 933, 46	1	7, 933, 464	
202.00	Total (see instructions)	231, 666, 008	0	231, 666, 00	80, 008	231, 746, 016	1202. UU

					From 01/01/2021 Fo 12/31/2021	Part I Date/Time Pre 5/30/2022 5:4	
			Title	XVIII	Hospi tal	PPS	трш
			Charges	7	1.0001 tu	1	
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
		6. 00	7. 00	8. 00	9. 00	10. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	58, 812, 183		58, 812, 183	3		30.00
31.00	03100 INTENSIVE CARE UNIT	15, 584, 418		15, 584, 418	3		31. 00
35.00	02060 NEONATAL INTENSIVE CARE UNIT	12, 860, 498		12, 860, 498	3		35.00
43.00	04300 NURSERY	5, 828, 241		5, 828, 24°	1		43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	38, 062, 873	64, 341, 936			0. 000000	50.00
51. 00	05100 RECOVERY ROOM	3, 485, 586	7, 019, 619			0. 000000	1
52. 00	05200 DELIVERY ROOM & LABOR ROOM	7, 964, 166	57, 404			0. 000000	
53. 00	05300 ANESTHESI OLOGY	8, 042, 025	14, 997, 496			0.000000	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	51, 614, 287	135, 035, 427			0.000000	1
54. 01	05401 RADI OLOGY - I -65	159, 473	24, 399, 200	1		0.000000	
54. 02	05402 RADI OLOGY DI AGNOSTI C - SJ	0	(22, 002	(20.71		0.000000	1
54. 03	05403 LOWELL RADI OLOGY	5, 734	633, 883	639, 617		0.000000	
55. 00 55. 01	05500 RADI OLOGY - THERAPEUTI C 05501 CARDI AC CATHERI ZATON LAB	21, 935, 114	23, 475, 132	1	0.00000	0. 000000 0. 000000	
55. 02	03140 CARDI OLOGY	6, 276, 972	11, 767, 121	18, 044, 093		0.000000	1
55. 03	03450 NEURO-DI AGNOSTI CS	1, 799, 329	5, 679, 168			0.000000	1
60. 00	06000 LABORATORY	57, 389, 359	94, 857, 532			0.000000	
60. 01	06001 BLOOD LABORATORY	0	74, 037, 332			0.00000	
65. 00	06500 RESPI RATORY THERAPY	17, 878, 496	2, 781, 653			0. 000000	
66. 00	06600 PHYSI CAL THERAPY	1, 671, 358	212, 504			0. 000000	1
66. 01	06601 PHYSI CAL THERAPY I -65	929	3, 261, 481	3, 262, 410		0. 000000	
66. 02	06602 PHYSI CAL THERAPY ST JOHN	306	861, 739			0. 000000	1
67. 00	06700 OCCUPATI ONAL THERAPY	1, 448, 159	197, 010			0. 000000	
67. 01	06701 OCCUPATION THERAPY I-65	0	324, 441			0.000000	1
67. 02	06702 OCCUPATIONAL THERAPY ST. JOHN	O	78, 806			0.000000	67. 02
68.00	06800 SPEECH PATHOLOGY	1, 459, 358	129, 386	1, 588, 74	0. 182824	0.000000	68. 00
68. 01	06801 SPEECH PATHOLOGY I -65	0	1, 275, 245			0.000000	68. 01
68. 02	06802 SPEECH THERAPY ST. JOHN	o	36, 930	36, 930	0. 234850	0.000000	68. 02
69.00	06900 ELECTROCARDI OLOGY	3, 039, 029	7, 890, 775	10, 929, 804	0. 127654	0.000000	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	11, 179, 609	4, 568, 375	15, 747, 984	0. 276221	0.000000	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	23, 156, 057	26, 821, 728	49, 977, 78!	0. 497639	0.000000	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	49, 000, 565	15, 650, 339	64, 650, 904	0. 265124	0. 000000	1
74.00	07400 RENAL DI ALYSI S	1, 144, 442	70, 437	1, 214, 879	0. 564311	0. 000000	74. 00
76. 00	03020 RADI ATI ON ONCOLOGY	151, 945	17, 721, 588			0. 000000	1
76. 01	03040 ANGI OCARDI OGRAPHY	1, 146	960, 251	961, 39	0. 478801	0. 000000	76. 01
	OUTPATIENT SERVICE COST CENTERS			Г			
90.00	09000 CLI NI C	0	0		0. 000000	0.000000	
90. 01	09001 DI ABETES CLI NI C	0	14, 994	i .		0.000000	
90. 02	09002 OUTPATIENT CLINICS	0	0	9	0.00000	0.000000	
90. 03	09003 OCCUPATIONAL MEDICINE CLINIC	0	21 411	21 41	0.000000	0.000000	
90. 04	09004 NEONATOLOGY CLINIC-FRANCISCAN POINT	0	31, 411			0.000000	
	09005 LACTATION CLINIC 09100 EMERGENCY	34, 200, 553	16, 611 68, 845, 156			0. 000000 0. 000000	1
91.00	09101 EMERGENCY ROOM PHYSI CANS	34, 200, 553	00, 043, 130			0.000000	
91.01	09102 EXPRESS CARE		0	•	0. 000000	0.000000	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	3, 271, 641	7, 145, 798			l	1
7Z. UU	SPECIAL PURPOSE COST CENTERS	3,2/1,041	7, 140, 790	10,417,43	, 0. 701330	0.00000	72.00
113 00	11300 INTEREST EXPENSE						113. 00
200.00		437, 423, 851	541, 160, 576	978, 584, 42	7		200. 00
201.00		121, 123, 301	2 , 100, 070	1			201. 00
202.00		437, 423, 851	541, 160, 576	978, 584, 42	7		202. 00
	1 (,			1	'	

			T: +1 o V// 1 1	Hooni tol	5/30/2022 5:41 pm PPS
	Cost Center Description	PPS Inpatient	Ti tle XVIII	Hospi tal	PPS
	cost center bescription	Ratio			
		11.00			
	INPATIENT ROUTINE SERVICE COST CENTERS	11.00			
	03000 ADULTS & PEDIATRICS				30, 00
	03100 NTENSI VE CARE UNI T				31.00
	02060 NEONATAL INTENSIVE CARE UNIT				35. 00
	04300 NURSERY				43. 00
	ANCI LLARY SERVI CE COST CENTERS				45.00
	05000 OPERATING ROOM	0. 209067			50. 00
	05100 RECOVERY ROOM	0. 216255			51.00
	05200 DELIVERY ROOM & LABOR ROOM	0. 234596			52. 00
	05300 ANESTHESI OLOGY	0. 036072			53.00
	05400 RADI OLOGY-DI AGNOSTI C	0. 114304			54. 00
	05401 RADI OLOGY - I -65	0. 082259			54. 01
	05402 RADI OLOGY DI AGNOSTI C - SJ	0. 000000			54. 02
	05403 LOWELL RADI OLOGY	0. 164994			54. 03
	05500 RADI OLOGY-THERAPEUTI C	0. 000000			55. 00
	05501 CARDI AC CATHERI ZATON LAB	0. 138466			55. 01
	03140 CARDI OLOGY	0. 180744			55. 02
4	03450 NEURO-DI AGNOSTI CS	0. 156773			55. 03
4	06000 LABORATORY	0. 123452			60.00
	06001 BLOOD LABORATORY	0. 000000			60. 01
	06500 RESPIRATORY THERAPY	0. 189371			65. 00
	06600 PHYSI CAL THERAPY	0. 739793			66. 00
	06601 PHYSI CAL THERAPY I -65	0. 486050			66. 01
	06602 PHYSI CAL THERAPY ST JOHN	0. 339214			66. 02
	06700 OCCUPATI ONAL THERAPY	0. 195393			67. 00
	06701 OCCUPATION THERAPY I -65	0. 580898			67. 01
	06702 OCCUPATI ONAL THERAPY ST. JOHN	0. 295460			67. 02
	06800 SPEECH PATHOLOGY	0. 182824			68. 00
	06801 SPEECH PATHOLOGY I -65	0. 289330			68. 01
	06802 SPEECH THERAPY ST. JOHN	0. 234850			68. 02
	06900 ELECTROCARDI OLOGY	0. 127654			69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 276221			71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 497639			72. 00
	07300 DRUGS CHARGED TO PATIENTS	0. 265124			73. 00
	07400 RENAL DIALYSIS	0. 564311			74. 00
	03020 RADI ATI ON ONCOLOGY	0. 117769			76. 00
	03040 ANGI OCARDI OGRAPHY	0. 478801			76. 01
	OUTPATIENT SERVICE COST CENTERS	0. 170001			75.51
	09000 CLI NI C	0. 000000			90.00
	09001 DI ABETES CLINIC	2. 438242			90. 01
	09002 OUTPATIENT CLINICS	0. 000000			90. 02
	09003 OCCUPATIONAL MEDICINE CLINIC	0. 000000			90. 03
4	09004 NEONATOLOGY CLINIC-FRANCISCAN POINT	0. 702525			90. 04
	09005 LACTATION CLINIC	1. 899524			90. 05
	09100 EMERGENCY	0. 120962			91.00
	09101 EMERGENCY ROOM PHYSICANS	0. 000000			91. 01
1	09102 EXPRESS CARE	0. 000000			91. 02
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 761556			92. 00
	SPECIAL PURPOSE COST CENTERS				
	11300 I NTEREST EXPENSE				113. 00
200.00	Subtotal (see instructions)				200. 00
201.00	Less Observation Beds				201. 00
202. 00	Total (see instructions)				202. 00
'		•			•

COMPUT	COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CO	Provider CCN: 15-0126		Worksheet C Part I Date/Time Pre 5/30/2022 5:4	pared: 1 pm	
				Ti tl	e XIX	Hospi tal	Cost	
						Costs		
		Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
			(from Wkst. B,	Adj .		Di sal I owance		
			Part I, col.					
			26)					
			1.00	2.00	3. 00	4. 00	5. 00	
		ENT ROUTINE SERVICE COST CENTERS						
30.00		ADULTS & PEDIATRICS	57, 102, 546		57, 102, 54		57, 102, 546	
31.00		INTENSIVE CARE UNIT	11, 623, 910		11, 623, 91	0 0	11, 623, 910	31. 00
35.00		NEONATAL INTENSIVE CARE UNIT	6, 568, 678		6, 568, 67	9, 504	6, 578, 182	
43.00		NURSERY	1, 907, 856		1, 907, 85	6 0	1, 907, 856	43. 00
		LARY SERVICE COST CENTERS						
50.00		OPERATING ROOM	21, 403, 048		21, 403, 04		21, 409, 454	
51.00	05100	RECOVERY ROOM	2, 271, 808		2, 271, 80	8 0	2, 271, 808	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1, 881, 826		1, 881, 82	6 0	1, 881, 826	52.00
53.00	05300	ANESTHESI OLOGY	828, 919		828, 91	9 2, 153	831, 072	53.00
54.00	05400	RADI OLOGY-DI AGNOSTI C	21, 334, 885		21, 334, 88	5 0	21, 334, 885	54.00
54. 01	05401	RADI OLOGY - I -65	2, 020, 181		2, 020, 18	1 0	2, 020, 181	54. 01
54.02	05402	RADIOLOGY DIAGNOSTIC - SJ	379		37	9 0	379	54. 02
54.03	05403	LOWELL RADIOLOGY	105, 533		105, 53	3 0	105, 533	54. 03
55.00	05500	RADI OLOGY-THERAPEUTI C	0			0 0	0	55. 00
55. 01	05501	CARDI AC CATHERI ZATON LAB	6, 287, 774		6, 287, 77	4 0	6, 287, 774	55. 01
55. 02	03140	CARDI OLOGY	3, 261, 369		3, 261, 36	9 0	3, 261, 369	55. 02
55. 03	03450	NEURO-DI AGNOSTI CS	1, 172, 423		1, 172, 42	3 0	1, 172, 423	55. 03
60.00		LABORATORY	18, 791, 516		18, 791, 51		18, 795, 187	60.00
60. 01		BLOOD LABORATORY	0			o o	0	60. 01
65.00	06500	RESPI RATORY THERAPY	3, 912, 437	0	3, 912, 43	7 ol	3, 912, 437	65. 00
66.00		PHYSI CAL THERAPY	1, 393, 667	0			1, 393, 667	66. 00
66. 01	1	PHYSICAL THERAPY I-65	1, 585, 694	0	1, 585, 69		1, 585, 694	
66. 02		PHYSICAL THERAPY ST JOHN	292, 418	0			292, 418	
67.00		OCCUPATI ONAL THERAPY	321, 455	0			321, 455	
67. 01		OCCUPATION THERAPY I-65	188, 467	0			188, 467	67. 01
67. 02		OCCUPATIONAL THERAPY ST. JOHN	23, 284	0			23, 284	
68. 00		SPEECH PATHOLOGY	290, 460	0			290, 460	
68. 01		SPEECH PATHOLOGY I -65	368, 967	0			368, 967	68. 01
68. 02		SPEECH THERAPY ST. JOHN	8, 673	0			8, 673	
69. 00		ELECTROCARDI OLOGY	1, 395, 231	_	1, 395, 23		1, 395, 231	
71. 00		MEDICAL SUPPLIES CHARGED TO PATIENT	4, 349, 927		4, 349, 92		4, 349, 927	
72. 00		IMPL. DEV. CHARGED TO PATIENTS	24, 870, 917		24, 870, 91		24, 870, 917	
73. 00	07300	DRUGS CHARGED TO PATIENTS	17, 140, 535		17, 140, 53		17, 140, 535	
74. 00		RENAL DIALYSIS	685, 570		685, 57		685, 570	
76. 00		RADI ATI ON ONCOLOGY	2, 104, 944		2, 104, 94		2, 104, 944	
76. 01		ANGI OCARDI OGRAPHY	460, 318		460, 31		460, 318	
		TIENT SERVICE COST CENTERS				<u> </u>	,	
90.00		CLINIC	0			ol o	0	90. 00
90. 01		DI ABETES CLINIC	36, 559		36, 55	9 0	36, 559	90. 01
90. 02		OUTPATIENT CLINICS	79, 667		79, 66		79, 667	
		OCCUPATIONAL MEDICINE CLINIC	3, 134, 194		3, 134, 19		3, 134, 194	
	1	NEONATOLOGY CLINIC-FRANCISCAN POINT	22, 067		22, 06		22, 067	
90. 05	1	LACTATION CLINIC	31, 553		31, 55		31, 553	
91. 00	1	EMERGENCY	12, 406, 353		12, 406, 35		12, 464, 627	
91. 01	1	EMERGENCY ROOM PHYSICANS	n,,			0 00, 2, 1	0	91. 01
91. 02		EXPRESS CARE				o o	0	91. 02
92. 00		OBSERVATION BEDS (NON-DISTINCT PART	7, 933, 464		7, 933, 46		7, 933, 464	
,2.00		AL PURPOSE COST CENTERS	7,700,404		7, 700, 40	•1	7, 700, 404	, 2. 00
113 00		INTEREST EXPENSE						113. 00
200.00		Subtotal (see instructions)	239, 599, 472	0	239, 599, 47	2 80, 008	239, 679, 480	
201.00		Less Observation Beds	7, 933, 464	J	7, 933, 46		7, 933, 464	
202.00		Total (see instructions)	231, 666, 008	0				
		,						•

| Period: | Worksheet C | From 01/01/2021 | Part | Date/Time Prepared: | 5/30/2022 5:41 pm Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0126

						5/30/2022 5: 4	1 pm
			Ti tl	e XIX	Hospi tal	Cost	
			Charges				
	Cost Center Description	Inpati ent	Outpati ent	Total (col.	Cost or Other	TEFRA	
	,			+ col. 7)	Ratio	I npati ent	
				,	1	Ratio	
		6. 00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00	0.00	7. 00	10.00	
30. 00	03000 ADULTS & PEDI ATRI CS	58, 812, 183		58, 812, 18	3		30. 00
31. 00	03100 NTENSI VE CARE UNI T	15, 584, 418		15, 584, 41			31.00
							1
35. 00	02060 NEONATAL INTENSIVE CARE UNIT	12, 860, 498		12, 860, 49			35. 00
43. 00	04300 NURSERY	5, 828, 241		5, 828, 24	-1		43. 00
	ANCILLARY SERVICE COST CENTERS	00.040.070		400 404 00			
50. 00	05000 OPERATI NG ROOM	38, 062, 873	64, 341, 936				
51. 00	05100 RECOVERY ROOM	3, 485, 586	7, 019, 619				
52.00	05200 DELIVERY ROOM & LABOR ROOM	7, 964, 166	57, 404				
53.00	05300 ANESTHESI OLOGY	8, 042, 025	14, 997, 496	23, 039, 52			
54.00	05400 RADI OLOGY-DI AGNOSTI C	51, 614, 287	135, 035, 427	186, 649, 71	4 0. 114304	0.000000	54. 00
54. 01	05401 RADI OLOGY - I -65	159, 473	24, 399, 200	24, 558, 67	0. 082259	0.000000	54. 01
54.02	05402 RADIOLOGY DIAGNOSTIC - SJ	0	0		0.000000	0.000000	54. 02
54.03	05403 LOWELL RADI OLOGY	5, 734	633, 883	639, 61	7 0. 164994	0.000000	54. 03
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0		0.000000	0.000000	55. 00
55. 01	05501 CARDI AC CATHERI ZATON LAB	21, 935, 114	23, 475, 132	45, 410, 24		0. 000000	
55. 02	03140 CARDI OLOGY	6, 276, 972	11, 767, 121			0. 000000	
55. 03	03450 NEURO-DI AGNOSTI CS	1, 799, 329	5, 679, 168			0. 000000	
60. 00	06000 LABORATORY	57, 389, 359	94, 857, 532			0. 000000	
60. 01	06001 BL00D LABORATORY	37, 307, 337	74, 057, 552		0. 000000	0. 000000	
65. 00	06500 RESPIRATORY THERAPY	17 070 404	-			0.000000	
66. 00	06600 PHYSI CAL THERAPY	17, 878, 496	2, 781, 653				
		1, 671, 358	212, 504				1
66. 01	06601 PHYSI CAL THERAPY I -65	929	3, 261, 481			0.000000	
66. 02	06602 PHYSI CAL THERAPY ST JOHN	306	861, 739			0. 000000	
67. 00	06700 OCCUPATI ONAL THERAPY	1, 448, 159	197, 010			0. 000000	
67. 01	06701 OCCUPATION THERAPY I -65	0	324, 441			0. 000000	
67. 02	06702 OCCUPATI ONAL THERAPY ST. JOHN	0	78, 806			0. 000000	1
68. 00	06800 SPEECH PATHOLOGY	1, 459, 358	129, 386	1, 588, 74	4 0. 182824	0. 000000	68. 00
68. 01	06801 SPEECH PATHOLOGY I -65	0	1, 275, 245	1, 275, 24	5 0. 289330	0.000000	68. 01
68. 02	06802 SPEECH THERAPY ST. JOHN	0	36, 930	36, 93	0. 234850	0.000000	68. 02
69.00	06900 ELECTROCARDI OLOGY	3, 039, 029	7, 890, 775	10, 929, 80	0. 127654	0.000000	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	11, 179, 609	4, 568, 375	15, 747, 98	0. 276221	0.000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	23, 156, 057	26, 821, 728		0. 497639	0. 000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	49, 000, 565	15, 650, 339			0. 000000	
74.00	07400 RENAL DIALYSIS	1, 144, 442	70, 437			0. 000000	
76. 00	03020 RADI ATI ON ONCOLOGY	151, 945	17, 721, 588			0. 000000	
76. 01	03040 ANGI OCARDI OGRAPHY	1, 146	960, 251			0. 000000	
70.01	OUTPATIENT SERVICE COST CENTERS	1, 110	700, 201	701,0	0. 170001	0.000000	70.01
90. 00	09000 CLINIC	0	0		0. 000000	0. 000000	90. 00
90.00	09001 DI ABETES CLINIC		14, 994				
90. 01	09001 DIABETES CLINICS		14, 994	1	0.000000		
		0	-	•			
90. 03	09003 OCCUPATIONAL MEDICINE CLINIC	0	0		0.000000		
90. 04	09004 NEONATOLOGY CLINIC-FRANCISCAN POINT	0	31, 411				
90. 05	09005 LACTATION CLINIC	0	16, 611			0.000000	
91.00	09100 EMERGENCY	34, 200, 553	68, 845, 156			0. 000000	1
91. 01	09101 EMERGENCY ROOM PHYSI CANS	0	0		0.000000		1
91. 02	09102 EXPRESS CARE	0	0		0. 000000		1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	3, 271, 641	7, 145, 798	10, 417, 43	9 0. 761556	0. 000000	92. 00
	SPECIAL PURPOSE COST CENTERS						
113.00	11300 NTEREST EXPENSE						113. 00
200.00		437, 423, 851	541, 160, 576	978, 584, 42	.7		200. 00
201.00	, ,						201.00
202.00		437, 423, 851	541, 160, 576	978, 584, 42	.7		202. 00
					1	•	•

			10 12/31/2021	5/30/2022 5: 41 pm
		Title XIX	Hospi tal	Cost
Cost Center Description	PPS Inpatient			
	Ratio			
	11.00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDIATRICS				30.00
31.00 03100 INTENSIVE CARE UNIT	1			31.00
35. 00 02060 NEONATAL INTENSIVE CARE UNIT				35. 00
43. 00 04300 NURSERY				43. 00
ANCI LLARY SERVI CE COST CENTERS				45.00
50. 00 05000 OPERATING ROOM	0. 000000			50, 00
				51. 00
	0.000000			
52. 00 05200 DELI VERY ROOM & LABOR ROOM	0. 000000			52. 00
53. 00 05300 ANESTHESI OLOGY	0. 000000			53. 00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	0. 000000			54.00
54. 01 05401 RADI OLOGY - I -65	0. 000000			54. 01
54. 02 05402 RADI OLOGY DI AGNOSTI C - SJ	0. 000000			54. 02
54. 03 05403 LOWELL RADI OLOGY	0. 000000			54. 03
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000			55. 00
55. 01 05501 CARDI AC CATHERI ZATON LAB	0. 000000			55. 01
55. 02 03140 CARDI OLOGY	0. 000000			55. 02
55. 03 03450 NEURO-DI AGNOSTI CS	0. 000000			55. 03
60. 00 06000 LABORATORY	0. 000000			60.00
60. 01 06001 BL00D LABORATORY	0. 000000			60. 01
65. 00 06500 RESPI RATORY THERAPY	0. 000000			65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 000000			66. 00
66. 01 06601 PHYSI CAL THERAPY I -65	0. 000000			66. 01
66. 02 06602 PHYSI CAL THERAPY ST JOHN	0. 000000			66. 02
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			67. 00
67. 01 06701 OCCUPATION THERAPY I -65	0. 000000			67. 01
67. 02 06702 OCCUPATIONAL THERAPY ST. JOHN	0. 000000			67. 02
68. 00 06800 SPEECH PATHOLOGY	0. 000000			68. 00
68. 01 06801 SPEECH PATHOLOGY I -65	0. 000000			68. 01
68. 02 06802 SPEECH THERAPY ST. JOHN	0. 000000			68. 02
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73. 00
74. 00 07400 RENAL DIALYSIS	0. 000000			74. 00
76. 00 03020 RADIATION ONCOLOGY	0. 000000			76. 00
76. 01 03040 ANGI OCARDI OGRAPHY	0. 000000			76. 01
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLI NI C	0.000000			90. 00
90. 01 09001 DI ABETES CLI NI C	0. 000000			90. 01
90. 02 09002 0UTPATIENT CLINICS	0. 000000			90. 02
90. 03 09003 OCCUPATIONAL MEDICINE CLINIC	0. 000000			90. 03
90. 04 09004 NEONATOLOGY CLINIC-FRANCISCAN POINT	0. 000000			90. 04
90. 05 09005 LACTATION CLINIC	0. 000000			90. 05
91. 00 09100 EMERGENCY	0. 000000			91. 00
91. 01 09101 EMERGENCY ROOM PHYSICANS	0. 000000			91. 01
91. 02 09102 EXPRESS CARE	0. 000000			91. 02
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000			92.00
SPECIAL PURPOSE COST CENTERS	0.000000			72.00
113. 00 11300 I NTEREST EXPENSE				113. 00
200.00 Subtotal (see instructions)				200.00
201.00 Less Observation Beds				200.00
202.00 Total (see instructions)				201.00
202. 00 TOTAL (366 THSTI UCTIONS)	1			J202. 00

Health Financial Systems	FRANCI SCAN HEAL	TH CROWN POINT		In Lieu of Form CMS-2552-10		
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITA	L COSTS			Period: From 01/01/2021 To 12/31/2021	Worksheet D Part I Date/Time Pre 5/30/2022 5:4	pared: 1 pm
		Title XVIII		Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col . 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col . 1 - col			
	26)		2)			
	1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	3, 777, 370	0	3, 777, 37	34, 333	110. 02	30.00
31.00 INTENSIVE CARE UNIT	1, 008, 999		1, 008, 99	9 4, 612	218. 78	31.00
35.00 NEONATAL INTENSIVE CARE UNIT	659, 995		659, 99	5 2, 920	226. 03	35. 00
43. 00 NURSERY	30, 527		30, 52	7 2, 184	13. 98	43.00
200.00 Total (lines 30 through 199)	5, 476, 891		5, 476, 89	1 44, 049		200. 00
Cost Center Description	I npati ent	Inpati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6.00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDI ATRI CS	13, 231	1, 455, 675	5			30. 00
31.00 INTENSIVE CARE UNIT	1, 807	395, 335	5			31.00
35.00 NEONATAL INTENSIVE CARE UNIT						35. 00
43. 00 NURSERY						43.00
200.00 Total (lines 30 through 199)	15, 038	1, 851, 010	o			200. 00

APPORTIONMENT OF IMPATIENT ANCILLARY SERVICE CAPITAL COSTS Title XVIII	Health Financial Systems	FRANCISCAN HEAL	TH CROWN POINT		In Lie	u of Form CMS-2	2552-10
Cost Center Description	APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT	AL COSTS	Provi der C	CN: 15-0126	From 01/01/2021	Part II Date/Time Pre	pared: 1 pm
Cost Center Description			Title	xVIII	Hospi tal		. p
Related Cost	Cost Center Description	Capi tal				Capital Costs	
ANCILLARY SERVICE COST CENTERS	· ·	Related Cost				(column 3 x	
ANCILLARY SERVICE COST CENTERS		(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
NCT LARY SERVICE COST CENTERS		Part II, col.	8)	2)			
AMOLILARY SERVICE COST CENTERS		26)					
50.00		1.00	2.00	3. 00	4. 00	5. 00	
51.00 05100 RECOVERY ROOM 314, 181 10, 505, 205 0. 029907 1, 871, 125 55, 960 51.00 53.00 05300 DELIVERY ROOM & LABOR ROOM 410, 411 8, 021, 570 0. 051163 14, 612 748 52.00 53.00 05300 ANESTHESI OLOGY 109, 345 23, 039, 521 0. 004746 2, 870, 224 13, 622 53.00 0540 00 05400 RADI OLOGY - 1-65 246, 484 24, 578, 673 0. 011487 21, 704, 785 249, 232 54.00 05401 RADI OLOGY - 1-65 266, 484 24, 578, 673 0. 010851 21, 704, 785 249, 232 54.00 05401 RADI OLOGY - 1-65 0. 000000 0 0. 0 54.02 0. 000000 0 0.							
52.00 05200 DELIVERY ROOM & LABOR ROOM 410, 411 8, 021, 570 0.051163 14, 612 748 52.00 54.00 05400 RADILOGY 109, 345 23, 309, 521 0.004746 2, 870, 224 13, 622 53.00 54.00 05400 RADILOGY 16,000STIC 2, 144, 097 186, 649, 714 0.011487 21, 704, 785 249, 323 54.00 54.01 05401 RADILOGY 1-65 266, 484 24, 558, 673 0.0000000 0.0000000 0.0000000 0.000000 0.000000 0.000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000		2, 895, 541		1		487, 057	50.00
53.00 05300 ANESTHESI OLOGY 109, 345 23, 309, 521 0.004746 2.870, 224 13, 622 53.00							
54. 00 05400 RADIOLOGY-DI AGNOSTIC 2,144,097 186, 649, 714 0.011487 21,704,785 249,323 54. 00 54. 01 05401 RADIOLOGY OI - 1-65 266,484 24,558,673 0 0.000000 0 0 54. 02 54. 03 05403 LOWELL RADIOLOGY 18,860 639,617 0 0.000000 0 0 54. 02 54. 03 05500 RADIOLOGY-THERAPEUTIC 0 0 0.000000 0 0 55. 03 05500 RADIOLOGY-THERAPEUTIC 0 0 0.000000 0 0 55. 03 05500 RADIOLOGY-THERAPEUTIC 0 0 0.000000 0 0 0.000000 0							
54. 01 0.5401 NADIOLOCY - I - 65 266. 484 24, 558, 673 0. 010851 0 0 54. 01							
54. Q2 05402 RADI OLOGY DI AGNOSTIC - SJ 3,7 0 0,000000 0 0,54. Q3 0.003 0.005000 0.005000 0.00500 0.00500 0.00500 0.00500 0.0							
54. 03 05403 LOWELL RADI OLOCY 18, 860 639, 617 0.029486 0 0 54, 03 55. 00 05500 RADI OLOGY-THERAPEUTI C 0 0.000000 0 0 55. 03 55. 01 05501 CARDI AC CATHERI ZATON LAB 798, 182 45, 410, 246 0.017577 6, 503, 708 114, 316 55. 01 55. 02 03140 CARDI AC CATHERI ZATON LAB 798, 182 45, 410, 246 0.017577 6, 503, 708 114, 316 55. 01 55. 03 03140 CARDI AC CATHERI ZATON LAB 798, 182 18, 044, 093 0.027129 3, 083, 703 83, 658 55. 02 55. 03 03450 NEURO-DI AGNOSTI CS 102, 555 7, 478, 497 0.013713 615, 598 84, 42 55. 03 60. 00 066001 BLODO LABORATORY 570, 636 152, 246, 891 0.003748 25, 526, 074 95, 672 60. 00 65. 00 06500 BLODO LABORATORY 246, 398 20, 660, 149 0.011926 6, 808, 800 81, 202 65. 00 66. 01 06601 PHYSI CAL THERAPY 1-65 39, 729 3, 262, 410 0.012178 0 0.00600 66. 01 06601 PHYSI CAL THERAPY ST JOHN 8, 212 862, 045 0.009526 0 0 0.6000 67. 01 06701 0CCUPATI ONAL THERAPY ST JOHN 8, 212 862, 045 0.009526 0 0 0.67, 016 67. 02 06702 OCCUPATI ON HERAPY ST JOHN 353 78, 806 0.004479 0 0 67, 01 68. 00 06800 SPEECH PATHOLOGY 4, 609 1, 588, 744 0.008994 0 0 67, 01 68. 01 06801 SPEECH PATHOLOGY 1-65 5, 728 1, 275, 284 0.00492 0 0 68, 02 69. 00 06900 ELECTROCARDI OLOGY 174, 013 10, 929, 804 0.015921 1, 531, 242 24, 379 69, 00 69. 00 06900 DELICE TROCARDI OLOGY 24, 634 1, 214, 879 0.003999 8, 275, 520 33, 094 71, 00 71. 00 07100 MDICLAL SUPPLIE S CHARGED TO PATI ENTS 346, 431 49, 977, 785 0.006932 T, 455, 594 51, 682 72, 00 72. 00 07000 DIMEDI CAL SUPPLIE S CHARGED TO PATI ENTS 346, 431 49, 977, 785 0.006932 T, 455, 594 51, 682 72, 00 74. 00 07000 DIMEDI CAL SUPPLIE S CHARGED TO PATI ENTS 346, 431 49, 977, 785 0.006932 T, 455, 594 51, 682 72, 00 74. 00 07000 DIMEDI CAL SUPPLIE S CHARGED TO PATI			24, 558, 673				
55.00			0				
55.01 05501 CARDIA C CATHERIZATON LAB 798, 182 45, 410, 246 0. 017577 6, 503, 708 114, 316 55.00 55.02 03140 CARDIO LOGY 489, 52.2 18, 044, 093 0. 027129 3, 083, 703 83, 658 55.03 55.03 03450 NEURO-DIAGNOSTI CS 102, 555 7, 478, 497 0. 013713 615, 598 8, 442 55.03 60.00 060001 LABORATORY 570, 636 152, 246, 891 0. 003748 25, 526, 074 95, 672 60.00 65.00 Ologo Ol BLOOD LABORATORY 0 0. 000000 0		18, 860	639, 617				
55. 02 03140 CARDI OLOGY		0	0	0.00000	00	0	55. 00
S. D. 0.550 0.55		798, 182	45, 410, 246	0. 01757	6, 503, 708	114, 316	55. 01
60. 00 06000 LABORATORY 0 0.003748 25, 526, 074 95, 672 60. 00		489, 522	18, 044, 093	0. 02712	3, 083, 703	83, 658	55. 02
60.01 0600	55. 03 03450 NEURO-DI AGNOSTI CS			0. 01371	3 615, 598	8, 442	55. 03
65.00 0650	60. 00 06000 LABORATORY	570, 636	152, 246, 891	0.00374	18 25, 526, 074	95, 672	60.00
66. 00 06600 PHYSI CAL THERAPY 1-65 39,729 3,262,410 0.070534 732,275 51,650 66. 00 06601 PHYSI CAL THERAPY I -65 39,729 3,262,410 0.012178 0 0 0.0602 0.00602	60. 01 06001 BLOOD LABORATORY	0	0	0.00000	00	0	60. 01
66. 01 06601 PHYSI CAL THERAPY I - 65 39,729 3,262,410 0.012178 0 0 66. 01 66. 02 06602 PHYSI CAL THERAPY ST JOHN 8,212 862,045 0.009526 0 0 0 66. 02 67. 01 06701 0CCUPATI ONAL THERAPY - 65 2,918 324,441 0.008994 0 0 0 67. 02 67. 01 06702 0CCUPATI ONAL THERAPY ST JOHN 353 78,806 0.004479 0 0 0 67. 01 68. 01 06800 SPEECH PATHOLOGY 4,609 1,588,744 0.002901 575,463 1,669 68. 00 68. 01 06801 SPEECH PATHOLOGY 4,609 1,588,744 0.002901 575,463 1,669 68. 00 68. 02 06802 SPEECH PATHOLOGY 4,609 1,588,744 0.002901 575,463 1,669 68. 01 68. 02 06802 SPEECH PATHOLOGY 1-65 5,728 1,275,245 0.004492 0 0 68. 01 68. 02 06802 SPEECH PATHOLOGY 1-74,013 10,929,804 0.015921 1,531,242 24,379 69. 00 69. 00 06900 ELECTROCARDI OLOGY 174,013 10,929,804 0.015921 1,531,242 24,379 69. 00 67. 00 0700 MEDI CAL SUPPLIES CHARGED TO PATI ENT 62,976 15,747,984 0.003999 8,275,520 33,094 71. 00 67. 00 0700 DRUGS CHARGED TO PATI ENTS 311,789 64,650,904 0.004823 15,935,870 76,859 73. 00 67. 01 0700 RENAL DI ALYSI S 24,634 1,214,879 0.002077 573,246 11,624 74. 00 67. 02 0700 ORGANIZARIO OLOGY 204,607 17,873,533 0.011447 90,509 1,036 76. 01 67. 02 0700 ORGANIZARIO OLOGY 204,607 17,873,533 0.011447 90,509 1,036 76. 01 67. 02 0700 ORGANIZARIO OLOGY 204,607 71,873,533 0.011447 90,509 1,036 76. 01 67. 02 0700 ORGANIZARIO OLOGY 204,607 17,873,533 0.011447 90,509 1,036 76. 01 67. 02 0700 ORGANIZARIO OLOGY 204,607 17,873,533 0.011447 90,509 1,036 76. 01 67. 01 0700 ORGANIZARIO OLOGY 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000	65. 00 06500 RESPIRATORY THERAPY	246, 398	20, 660, 149	0. 01192	6, 808, 800	81, 202	65. 00
66. 02 06602 PHYSICAL THERAPY ST JOHN 8, 212 862, 045 0, 009526 0 0 66. 02 67. 00 06700 0CCUPATI ONAL THERAPY 5, 055 1, 645, 169 0.003073 738, 616 2, 270 67. 00 07. 01 07.	66. 00 06600 PHYSI CAL THERAPY	132, 876	1, 883, 862	0. 07053	732, 275	51, 650	66. 00
67. 00 06700 05700	66. 01 06601 PHYSI CAL THERAPY I -65	39, 729	3, 262, 410	0. 01217	78 0	0	66. 01
67. 01 06701 06701 0CCUPATI ON THERAPY I -65 2, 918 324, 441 0.008994 0 0 67. 01 67. 02 06702 0CCUPATI ONAL THERAPY ST. JOHN 353 78,806 0.004479 0 0 67. 02 68. 00 06800 SPEECH PATHOLOGY 4, 609 1, 588,744 0.002901 575, 463 1, 669 68. 00 68. 01 06801 SPEECH PATHOLOGY I -65 5, 728 1, 275, 245 0.004492 0 0 68. 01 68. 02 06802 SPEECH PATHOLOGY I -65 5, 728 1, 275, 245 0.004492 0 0 68. 01 68. 02 06802 SPEECH THERAPY ST. JOHN 134 36, 930 0.003628 0 0 68. 02 69. 00 06900 ELECTROCARDI OLOGY 174, 011 10, 929, 804 0.015921 1, 531, 242 24, 379 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 346, 431 49, 977, 785 0.006932 7, 455, 594 51, 682 72. 00 73. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 311, 789 64, 650, 904 0.003999 8, 275, 520 33, 094 71. 00 74. 00 07400 RENAL DI ALYSI S 311, 789 64, 650, 904 0.004823 15, 935, 870 76, 859 73. 00 75. 01 03040 ANGI OCARDI OGRAPHY 6, 765 961, 397 0.007037 0 0 76. 01 03040 ANGI OCARDI OGRAPHY 6, 765 961, 397 0.007037 0 0 70. 02 09002 CLI NI C 6, 265 14, 994 0.417834 0 0 90. 01 70. 02 09002 CLI NI C 6, 265 14, 994 0.417834 0 0 90. 01 70. 03 09003 OCCUPATI ONAL MEDI CI NE CLI NI C 450 14, 197 0 0.000000 0 0 0 0.00000 71. 00 09004 LI NI C 450 14, 197 0 0.000000 0 0 0 0.00000 71. 00 09005 LCATATI ON CLI NI C 450 16, 611 0.027090 0 0 0 0.00000 70. 05 09005 LCATATI ON CLI NI C 450 16, 611 0.027090 0 0 0 0.00000 71. 02 09101 EMERGENCY ROMP PHYSI CANS 0 0 0 0.000000 0 0 0 0.00000 71. 02 09102 EMERGENCY ROMP PHYSI CANS 0 0 0 0.000000 0 0 0 0.00000 71. 02 09102 OSSERVATI ON BEDS (NON-DI STINCT PART 524, 807 10, 417, 439 0.050378 1, 444, 042 72, 74 92. 00 71. 02 09002 OSSERVATI ON BEDS (NON-DI	66. 02 06602 PHYSI CAL THERAPY ST JOHN	8, 212	862, 045	0. 00952	26 0	0	66. 02
67. 02 06702 0CCUPATI ONAL THERAPY ST. JOHN 353 78, 806 0.004479 0 0 67. 02 68. 00 06800 SPEECH PATHOLOGY 4, 609 1, 588, 744 0.002901 575, 463 1, 669 68. 00 68. 01 06801 SPEECH PATHOLOGY 1-65 5, 728 1, 275, 245 0.004492 0 0 68. 01 68. 02 06802 SPEECH THERAPY ST. JOHN 134 36, 930 0.003628 0 0 68. 01 69. 00 06900 ELECTROCARDI OLOGY 174, 013 10, 929, 804 0.015921 1, 531, 242 24, 379 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 62, 976 15, 747, 984 0.003999 8, 275, 520 33, 094 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 346, 431 49, 977, 785 0.006932 7, 455, 594 51, 682 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 311, 789 64, 650, 904 0.004823 15, 935, 870 76, 859 73. 00 74. 00 07400 RENAL DI ALYSIS 24, 634 1, 214, 879 0.020277 573, 246 11, 624 74. 00 76. 01 03040 ANGI OCARDI OGRAPHY 6, 765 961, 397 0.007037 0 0 76. 01 79. 01 09001 DI ABETES CLI NI C 6, 265 14, 994 0.417834 0 0 90. 02 79. 02 09002 OUTPATI ENT CLI NI CS 14, 197 0 0.000000 0 0 90. 02 79. 03 09003 OCCUPATI ONAL MEDI CI NE CLI NI C 450 626 14, 994 0.417834 0 0 90. 03 79. 04 09004 NEONATOLOGY CLI NI C - FRANCI SCAN POI NT 403 31, 411 0.012830 0 0 90. 03 79. 00 09100 EMERGENCY ROM PHYSI CANS 0 0 0.000000 0 0 90. 04 79. 01 09101 EMERGENCY ROM PHYSI CANS 0 0 0.000000 0 0 91. 01 79. 02 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 524, 807 10, 417, 439 0.050378 1, 444, 042 72, 748 92. 00 79. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 524, 807 10, 417, 439 0.050378 1, 444, 042 72, 748 92. 00 79. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 524, 807 10, 417, 439 0.050378 1, 444, 042 72, 748 92. 00 79. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 524, 807 10, 417, 439 0.050378	67. 00 06700 OCCUPATI ONAL THERAPY	5, 055	1, 645, 169	0. 00307	738, 616	2, 270	67. 00
68. 00 06800 SPEECH PATHOLOGY 4,609 1,588,744 0.002901 575,463 1,669 68. 00 68. 01 68. 01 68. 01 58ECH PATHOLOGY 1-65 5,728 1,275,245 0.004492 0 0.68. 01 68. 01 68. 02 69. 00 68. 02 69. 00 68. 02 69. 00 68. 02 69. 00 69. 02 69. 00 69. 02 69. 00 69. 02 69. 00 69. 02 69. 00 69. 02 69. 00 69. 02 69. 00 69. 02 69. 00 69. 02 69. 00 69. 02 69. 00 69. 02 69. 00 69. 02 69. 00 69. 02 69. 00 69. 02 69. 00 69. 02 69. 00 69. 02 69. 00 69. 02 69. 00 69. 02		2, 918	324, 441	0.00899	0	0	67. 01
68. 01 06801 SPEECH PATHOLOGY I -65 5,728 1,275,245 0.004492 0 0 68. 01 68. 02 06802 SPEECH THERAPY ST. JOHN 134 36,930 0.003628 0 0 68. 02 69. 00 06900 ELECTROCARDIOLOGY 174,013 10,929,804 0.015921 1,531,242 24,379 69. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 62,976 15,747,984 0.003999 8,275,520 33,094 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 346,431 49,977,785 0.006932 7,455,594 51,682 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 311,789 64,650,904 0.004823 15,935,870 76,859 73. 00 74. 00 07400 RENAL DI ALYSI S 24,634 1,214,879 0.020277 573,246 11,624 74. 00 76. 01 03020 RADI ATI ON ONCOLOGY 204,607 17,873,533 0.011447 90,509 1,036 76. 00 76. 01 03040 ANGI OCARDI OGRAPHY 6,765 961,397 0.007037 0 0 0 76. 01 09000 CLI NI C 0 0 0.000000 0 0 0 0.000000 79. 02 09002 OUTPATI ENT SERVI CE COST CENTERS 79. 03 09003 OCUPATI ONAL MEDI CI NE CLI NI C 360,628 0 0.000000 0 0 0 0 0 79. 04 09004 NEONATOLOGY CLI NI C -FRANCI SCAN POI NT 403 31,411 0.012830 0 0 0 0 0 79. 05 09005 LACTATI ON CLI NI C 450 16,611 0.027090 0 0 0 0 79. 07 09100 EMERGENCY 897,607 103,045,709 0.008711 15,815,257 137,767 91.00 79. 02 09102 EMERGENCY ROOM PHYSI CANS 0 0 0 0.000000 0 0 91.02 79. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART 524,807 10,417,439 0.050378 1,444,042 72,748 92.00 70. 01 09200 OBSERVATI ON BEDS (NON-DISTINCT PART 524,807 10,417,439 0.050378 1,444,042 72,748 92.00 70. 02 09200 OBSERVATI ON BEDS (NON-DISTINCT PART 524,807 10,417,439 0.050378 1,444,042 72,748 92.00	67. 02 06702 OCCUPATIONAL THERAPY ST. JOHN	353	78, 806	0.00447	79 0	0	67. 02
68. 02 06802 SPEECH THERAPY ST. JOHN 134 36,930 0.003628 0 0 68.02 69. 00 06900 ELECTROCARDI OLOGY 174, 013 10,929,804 0.015921 1,531,242 24,379 69.00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 62,976 15,747,984 0.003999 8,275,520 33,094 71.00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 346,431 49,977,785 0.006932 7,455,594 51,682 72.00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 311,789 64,650,904 0.004823 15,935,870 76,859 73.00 74. 00 07400 RENAL DI ALYSI S 24,634 1,214,879 0.020277 573,246 11,624 74.00 76. 00 03020 RADI ATI ON ONCOLOGY 204,607 17,873,533 0.011447 90,509 1,036 76.00 76. 01 03020 RADI ATI ON ONCOLOGY 204,607 17,873,533 0.011447 90,509 1,036 76.00 76. 01 07400 OUTPATI ENT SERVICE COST CENTERS 90. 00 09000 CLI NI C 0 0 0.000000 0 0 90.00 90. 01 09001 DI ABETES CLI NI C 6,265 14,994 0.417834 0 0 90.01 90. 02 09002 OUTPATI ENT CLI NI CS 14,197 0 0.000000 0 0 90.02 90. 03 09003 OCCUPATI ONAL MEDI CI NE CLI NI C 360,628 0 0.000000 0 0 90.02 90. 04 09004 NEONATOLOGY CLI NI C-FRANCI SCAN POI NT 403 31,411 0.012830 0 0 90.05 91. 00 09100 EMERGENCY 897,607 103,045,709 0.008711 15,815,257 137,767 91.00 91. 01 09101 EMERGENCY ROOM PHYSI CANS 0 0 0.000000 0 0 91.01 91. 01 09101 EMERGENCY ROOM PHYSI CANS 0 0 0.000000 0 0 91.01 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 524,807 10,417,439 0.050378 1,444,042 72,748 92.00	68. 00 06800 SPEECH PATHOLOGY	4, 609	1, 588, 744	0.00290	575, 463	1, 669	68. 00
69. 00 06900 ELECTROCARDI OLOGY 174, 013 10, 929, 804 0. 015921 1, 531, 242 24, 379 69. 00 71. 00 71. 00 MEDI CAL SUPPLIES CHARGED TO PATI ENT 62, 976 15, 747, 984 0. 003999 8, 275, 520 33, 094 71. 00 72. 00 72.00 IMPL. DEV. CHARGED TO PATI ENTS 346, 431 49, 977, 785 0. 006932 7, 455, 594 51, 682 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 311, 789 64, 650, 904 0. 004823 15, 935, 870 76, 859 73. 00 74. 0	68. 01 06801 SPEECH PATHOLOGY I -65	5, 728	1, 275, 245	0.00449	0	0	68. 01
71. 00	68.02 06802 SPEECH THERAPY ST. JOHN	134	36, 930	0. 00362	28 0	0	68. 02
72. 00 07200 MPL. DEV. CHARGED TO PATIENTS 346, 431 49, 977, 785 0.006932 7, 455, 594 51, 682 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 311, 789 64, 650, 904 0.004823 15, 935, 870 76, 859 73. 00 74. 00 70400 RENAL DIALYSIS 24, 634 1, 214, 879 0.020277 573, 246 11, 624 74. 00 76. 01 03020 RADIATION ONCOLOGY 204, 607 17, 873, 533 0.011447 90, 509 1, 036 76. 00 76. 01 03040 ANGIOCARDIOGRAPHY 6, 765 961, 397 0.007037 0 0 76. 01 000000 0 0 000000 0 0		174, 013	10, 929, 804	0. 01592	1, 531, 242	24, 379	69. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS 311, 789 64, 650, 904 0. 004823 15, 935, 870 76, 859 73. 00 07400 RENAL DI ALYSI S 24, 634 1, 214, 879 0. 020277 573, 246 11, 624 74. 00 07400 RENAL DI ALYSI S 24, 634 1, 214, 879 0. 020277 573, 246 11, 624 74. 00 07400 RENAL DI ALYSI S 204, 607 17, 873, 533 0. 011447 90, 509 1, 036 76. 00 07400 ANGI OCARDI OGRAPHY 6, 765 961, 397 0. 007037 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	62, 976	15, 747, 984	0.00399	9 8, 275, 520	33, 094	71. 00
74. 00 07400 RENAL DIALYSIS 24, 634 1, 214, 879 0. 020277 573, 246 11, 624 74. 00 76. 00 03020 RADIATION ONCOLOGY 204, 607 17, 873, 533 0. 011447 90, 509 1, 036 76. 00 76. 01 03040 ANGIOCARDI OGRAPHY 6, 765 961, 397 0. 007037 0 0 0 0 0. 007037 0 0 0 0 0 0. 007037 0 0 0 0 0. 007037 0 0 0 0 0 0. 007037 0<		346, 431	49, 977, 785	0.00693	7, 455, 594	51, 682	72. 00
76. 00		311, 789	64, 650, 904	0.00482	15, 935, 870	76, 859	73. 00
76. 01 03040 ANGI OCARDI OGRAPHY 6, 765 961, 397 0. 007037 0 0 76. 01 OUTPATI ENT SERVI CE COST CENTERS 90. 00 09000 CLI NI C 0 0 0.000000 0 0 90. 00 90. 01 09001 DI ABETES CLI NI C 6, 265 14, 994 0. 417834 0 0 0 90. 01 90. 02 09002 OUTPATI ENT CLI NI CS 14, 197 0 0.000000 0 0 0 90. 02 90. 03 09003 OCCUPATI ONA MEDI CI NE CLI NI C 360, 628 0 0.000000 0 0 90. 03 90. 04 09004 NEONATOLOGY CLI NI C-FRANCI SCAN POI NT 403 31, 411 0. 012830 0 0 90. 04 90. 05 09005 LACTATI ON CLI NI C 450 16, 611 0.027090 0 0 0 90. 05 91. 00 09100 EMERGENCY 800M PHYSI CANS 0 0 0.000000 0 0 0 91. 01 91. 01 09101 EMERGENCY ROOM PHYSI CANS 0 0 0.000000 0 0 0 91. 01 91. 02 09102 EXPRESS CARE 0 0 0.000000 0 0 0 91. 02 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 524, 807 10, 417, 439 0.050378 1, 444, 042 72, 748 92. 00	74. 00 07400 RENAL DI ALYSI S	24, 634	1, 214, 879	0. 02027	7 573, 246	11, 624	74. 00
90. 00 09000 CLINIC 0 0 0.000000 0 0 0.000000 0	76. 00 03020 RADI ATI ON ONCOLOGY	204, 607	17, 873, 533	0. 01144	90, 509	1, 036	76. 00
90. 00 09000 CLINIC 0 0 0 0 0 0 0 0 0	76. 01 03040 ANGI OCARDI OGRAPHY	6, 765	961, 397	0.00703	0 0	0	76. 01
90. 01 09001 DI ABETES CLINI C 6, 265 14, 994 0. 417834 0 0 90. 01 90. 02 09002 0UTPATI ENT CLINI CS 14, 197 0 0. 000000 0 0 90. 02 90. 03 09003 0CCUPATI ONAL MEDI CINE CLINI C 360, 628 0 0. 000000 0 0 90. 03 90. 04 09004 NEONATOLOGY CLINI C-FRANCI SCAN POI NT 403 31, 411 0. 012830 0 0 90. 04 90. 05 09005 LACTATI ON CLINI C 450 16, 611 0. 027090 0 0 90. 05 91. 00 09100 EMERGENCY 897, 607 103, 045, 709 0. 008711 15, 815, 257 137, 767 91. 00 91. 01 09101 EMERGENCY ROOM PHYSI CANS 0 0 0. 000000 0 0 91. 01 91. 02 09102 EXPRESS CARE 0 0 0. 000000 0 0 91. 02 92. 00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART 524, 807 10, 417, 439 0. 050378 1, 444, 042 72, 748 92. 00	OUTPATIENT SERVICE COST CENTERS						
90. 02	90. 00 09000 CLI NI C	0	0	0.00000	00	0	90. 00
90. 03	90. 01 09001 DI ABETES CLINIC	6, 265	14, 994	0. 41783	0	0	90. 01
90. 04 09004 NEONATOLOGY CLINIC-FRANCISCAN POINT 403 31, 411 0.012830 0.027090 0.0	90. 02 09002 OUTPATIENT CLINICS	14, 197	0	0.00000	00	0	90. 02
90. 05 09005 LACTATI ON CLINIC 450 16, 611 0.027090 0 0 90. 05 91. 00 09100 EMERGENCY 897, 607 103, 045, 709 0.008711 15, 815, 257 137, 767 91. 00 91. 01 09101 EMERGENCY ROOM PHYSI CANS 0 0 0.000000 0 0 91. 01 91. 02 09102 EXPRESS CARE 0 0 0.000000 0 0 91. 02 92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART 524, 807 10, 417, 439 0.050378 1, 444, 042 72, 748 92. 00	90.03 09003 OCCUPATIONAL MEDICINE CLINIC	360, 628	0	0.00000	00 0	0	90. 03
91. 00 09100 EMERGENCY 897, 607 103, 045, 709 0.008711 15, 815, 257 137, 767 91. 00 91. 01 09101 EMERGENCY ROOM PHYSI CANS 0 0 0.000000 0 0 91. 01 91. 02 09102 EXPRESS CARE 0 0 0.000000 0 0 91. 02 92. 00 09200 09SERVATI ON BEDS (NON-DI STI NCT PART 524, 807 10, 417, 439 0.050378 1, 444, 042 72, 748 92. 00 092	90. 04 09004 NEONATOLOGY CLINIC-FRANCISCAN POINT	403	31, 411	0. 01283	0 0	0	90. 04
91. 01 09101 EMERGENCY ROOM PHYSI CANS	90.05 O9005 LACTATION CLINIC	450	16, 611	0. 02709	0 0	0	90. 05
91. 01 09101 EMERGENCY ROOM PHYSI CANS	91. 00 09100 EMERGENCY	897, 607	103, 045, 709	0. 00871	1 15, 815, 257	137, 767	91.00
92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART 524, 807 10, 417, 439 0. 050378 1, 444, 042 72, 748 92. 00	91. 01 09101 EMERGENCY ROOM PHYSICANS	0	0	0.00000	0 0		91. 01
	91. 02 09102 EXPRESS CARE	0	0	0.00000	0 0	0	91. 02
200.00 Total (lines 50 through 199) 11,501,435 885,499,087 139,391,977 1,654,778 200.00	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	524, 807	10, 417, 439	0. 05037	1, 444, 042	72, 748	92.00
	200.00 Total (lines 50 through 199)	11, 501, 435	885, 499, 087	1	139, 391, 977	1, 654, 778	200. 00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	ASS THROUGH COST	rs Provider C		Period: From 01/01/2021 To 12/31/2021	Worksheet D Part III Date/Time Pre	nared:
					5/30/2022 5: 4	1 pm
			XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng	Nursi ng		Allied Health	All Other	
	Program	Program	Post-Stepdowr		Medi cal	
	Post-Stepdown		Adjustments		Education Cost	
	Adjustments 1A	1. 00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	IA IA	1.00	ZA	2.00	3.00	
30. 00 03000 ADULTS & PEDIATRICS	0	0	n e		0	30.00
31. 00 03100 NTENSI VE CARE UNI T	0	0			0	31. 00
35. 00 02060 NEONATAL INTENSIVE CARE UNIT	0	Ö			0	35. 00
43. 00 04300 NURSERY	0	Ö			0	43. 00
200.00 Total (lines 30 through 199)	0	Ö				200.00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patient	Per Diem (col.	Inpati ent	
·	Adjustment	(sum of cols.	Days	5 ÷ col . 6)	Program Days	
	Amount (see	1 through 3,				
	instructions)	minus col. 4)				
LAUDATI ENT. DOUTLANE OFFICE COOT OFFITEDO	4. 00	5. 00	6.00	7. 00	8. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	1 0	0	24.22	0.00	12 221	30.00
30. 00 03000 ADULTS & PEDI ATRI CS 31. 00 03100 INTENSI VE CARE UNI T	0	0	34, 33		13, 231 1, 807	30.00
35. 00 02060 NEONATAL INTENSIVE CARE UNIT		0	2, 92		1,807	35.00
43. 00 04300 NURSERY		0	1		0	43.00
200.00 Total (lines 30 through 199)		0	44, 04		15, 038	
Cost Center Description	I npati ent		, ++, 0+	<u> </u>	13, 030	200.00
door don't or bood in particular	Program					
	Pass-Through					
	Cost (col. 7 x					
	Cost (col. 7 x					
INPATIENT ROUTINE SERVICE COST CENTERS	Cost (col. 7 x col. 8) 9.00					
30. 00 03000 ADULTS & PEDI ATRI CS	Cost (col. 7 x col. 8) 9.00					30.00
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT	Cost (col. 7 x col. 8) 9.00					31. 00
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 35. 00 02060 NEONATAL INTENSIVE CARE UNIT	Cost (col. 7 x col. 8) 9.00					31. 00 35. 00
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT	Cost (col. 7 x col. 8) 9.00					31.00

 Heal th Financial
 Systems
 FRANCISCAN HEALTH

 APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY
 SERVICE OTHER PASS
 Provi der CCN: 15-0126 THROUGH COSTS

				10 12/31/2021	5/30/2022 5: 4	
		Ti tl e	e XVIII	Hospi tal	PPS	
Cost Center Description	Non Physician	Nursi ng	Nursi ng		Allied Health	
μ	Anesthetist	Program	Program	Post-Stepdown		
	Cost	Post-Stepdown	9	Adjustments		
		Adjustments		.,		
	1.00	2A	2.00	3A	3. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	0	C)	0 0	0	50.00
51.00 05100 RECOVERY ROOM	0	l c		0 0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	l c		0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0			0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0			0	0	54.00
54. 01 05401 RADI OLOGY - I -65	0	آ ا		0	l o	54. 01
54. 02 05402 RADI OLOGY DI AGNOSTI C - SJ	0	آ ا		0 0	l o	54. 02
54. 03 05403 LOWELL RADI OLOGY	0	7		0	0	54. 03
55. 00 05500 RADI OLOGY-THERAPEUTI C					0	55.00
55. 01 05501 CARDI AC CATHERI ZATON LAB					0	55. 00
				0	0	1
	0			0	-	55. 02
55. 03 03450 NEURO-DI AGNOSTI CS	0			0	0	55. 03
60. 00 06000 LABORATORY	0)	0	0	60.00
60. 01 06001 BLOOD LABORATORY	0	C)	0	0	60. 01
65. 00 06500 RESPI RATORY THERAPY	0	C)	0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	C		0	0	66. 00
66. 01 06601 PHYSI CAL THERAPY I -65	0	[C)	0	0	66. 01
66. 02 06602 PHYSICAL THERAPY ST JOHN	0	C)	0	0	66. 02
67. 00 06700 OCCUPATI ONAL THERAPY	0	C)	0	0	67. 00
67.01 06701 0CCUPATION THERAPY I-65	0	C)	0	0	67. 01
67.02 06702 OCCUPATIONAL THERAPY ST. JOHN	0	C		0 0	0	67. 02
68. 00 06800 SPEECH PATHOLOGY	0	C		0 0	0	68. 00
68. 01 06801 SPEECH PATHOLOGY 1-65	0	l c		0 0	0	68. 01
68.02 06802 SPEECH THERAPY ST. JOHN	0	l		0 0	0	68. 02
69. 00 06900 ELECTROCARDI OLOGY	0			0 0	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	l c		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0			0 0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0			0	0	73. 00
74. 00 07400 RENAL DI ALYSI S	0			0	0	74. 00
76. 00 03020 RADI ATI ON ONCOLOGY	0	آ ا		0 0	l o	76. 00
76. 01 03040 ANGI OCARDI OGRAPHY	0	Ĭ		0 0	Ö	76. 01
OUTPATIENT SERVICE COST CENTERS			1	<u> </u>		70.0.
90. 00 09000 CLINIC	0	C		0 0	0	90.00
90. 01 09001 DI ABETES CLINI C	0		1	0 0	-	90. 01
90. 02 09002 OUTPATIENT CLINICS	0			0 0	l o	90. 02
90. 03 09003 OCCUPATIONAL MEDICINE CLINIC	0	آ ا		0	l o	90. 03
90. 04 09004 NEONATOLOGY CLINIC-FRANCISCAN POINT	0	7			0	90. 04
90. 05 09005 LACTATION CLINIC					0	90.05
91. 00 09100 EMERGENCY					462, 720	
			()		462, 720	91.00
	0		()	0	0	1
91. 02 09102 EXPRESS CARE	1		΄	U U		91. 02
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART	0	l	J	0	0	92.00
200.00 Total (lines 50 through 199)	0	C	' I	0 0	462, 720	₁ 200.00

In Lieu of Form CMS-2552-10 Health Financial Systems FRANCISCAN HEALTH CROWN POINT APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 15-0126 Peri od: Worksheet D From 01/01/2021 THROUGH COSTS Part IV Date/Time Prepared: 12/31/2021 5/30/2022 5:41 pm Title XVIII Hospi tal Cost Center Description All Other Total Cost Total Total Charges Ratio of Cost to Charges Medi cal (from Wkst. C, (sum of cols. Outpati ent Education Cost 1, 2, 3, and Cost (sum of Part I, col. l(col. 5 ÷ col 4) 8) col s. 2. 3. 7) and 4) (see instructions) 4.00 5.00 6.00 7. 00 8.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 102, 404, 809 0.00000050.00 05100 RECOVERY ROOM 0 0 10, 505, 205 0.000000 51.00 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 8, 021, 570 0.000000 52.00 05300 ANESTHESI OLOGY 0 0 23, 039, 521 0.000000 53 00 53 00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 186, 649, 714 0.000000 54.00 54.01 05401 RADI OLOGY - I -65 24, 558, 673 0.000000 54.01 05402 RADIOLOGY DIAGNOSTIC - SJ 0 0 0.000000 54 02 54 02 0 54.03 05403 LOWELL RADIOLOGY 0 639, 617 0.000000 54.03 55.00 05500 RADI OLOGY-THERAPEUTI C 0.000000 55.00 55.01 05501 CARDI AC CATHERI ZATON LAB 0 0 45, 410, 246 0.000000 55.01 03140 CARDLOLOGY 0 18, 044, 093 55 02 Ω 0.000000 55 02 03450 NEURO-DI AGNOSTI CS 55.03 0 0 7, 478, 497 0.000000 55.03 06000 LABORATORY 152, 246, 891 0.000000 60.00 60.00 06001 BLOOD LABORATORY 0 0.000000 60.01 60.01 0 65.00 06500 RESPIRATORY THERAPY 20, 660, 149 0 0.000000 65 00 66.00 06600 PHYSI CAL THERAPY 0 0 1, 883, 862 0.000000 66.00 06601 PHYSI CAL THERAPY I-65 0.000000 66.01 3, 262, 410 66.01 06602 PHYSI CAL THERAPY ST JOHN 0 0 862, 045 0.000000 66.02 66.02 06700 OCCUPATIONAL THERAPY 0 67.00 0 1, 645, 169 0.000000 67.00 06701 OCCUPATION THERAPY I -65 324, 441 0.000000 67.01 67.01 06702 OCCUPATIONAL THERAPY ST. JOHN 67.02 78, 806 0.000000 67.02 06800 SPEECH PATHOLOGY 68.00 0 1, 588, 744 0.000000 68.00 06801 SPEECH PATHOLOGY I -65 0 0.000000 68.01 1, 275, 245 68 01 36, 930 06802 SPEECH THERAPY ST. JOHN 0.000000 68.02 68.02 06900 ELECTROCARDI OLOGY 10, 929, 804 69.00 0.000000 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 15, 747, 984 0.000000 71.00 0 71.00 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS C 49, 977, 785 0.000000 72.00 07300 DRUGS CHARGED TO PATIENTS 64, 650, 904 0.000000 73.00 73.00 0 74.00 07400 RENAL DIALYSIS 0 1, 214, 879 0.000000 74.00 0 03020 RADIATION ONCOLOGY 76.00 Ω 17, 873, 533 0.000000 76.00 76. 01 03040 ANGI OCARDI OGRAPHY 961, 397 0.00000076.01 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLINIC 000000000 0.000000 90.00 0 09001 DIABETES CLINIC 90.01 0 14, 994 0.00000090.01 09002 OUTPATIENT CLINICS 0 0.000000 90.02 09003 OCCUPATIONAL MEDICINE CLINIC 0 0.000000 90.03 90.03 09004 NEONATOLOGY CLINIC-FRANCISCAN POINT O 31, 411 0.000000 90 04 90 04 Ω

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462, 720

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103, 045, 709

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885, 499, 087

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90.05

91.00

91.01

91.02

92.00

200.00

90.05

91.00

91.01

91.02

200.00

09005 LACTATION CLINIC

09101 EMERGENCY ROOM PHYSI CANS

92. 00 | 09200 | OBSERVATION BEDS (NON-DISTINCT PART

Total (lines 50 through 199)

09100 EMERGENCY

09102 EXPRESS CARE

Heal th	Financial Systems F	RANCISCAN HEALTH	CROWN POINT		In Lie	eu of Form CMS-2	2552-10
	TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	RVICE OTHER PASS	Provi der CO		Peri od:	Worksheet D	
THROUG	GH COSTS				From 01/01/2021	Part IV	
					To 12/31/2021	Date/Time Pre 5/30/2022 5:4	
			Title	: XVIII	Hospi tal	PPS	Григ
	Cost Center Description	Outpati ent	Inpati ent	Inpatient	Outpati ent	Outpati ent	
	cost contor boson per on	Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through		Pass-Through	
		(col. 6 ÷ col.	3 - 1	Costs (col. 8		Costs (col. 9	
		7)		x col. 10)		x col. 12)	
		9.00	10.00	11.00	12.00	13. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0. 000000	17, 225, 714		0 16, 949, 339	0	50.00
51.00	05100 RECOVERY ROOM	0. 000000	1, 871, 125		0 3, 236, 328	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	14, 612		0	0	52.00
53.00	05300 ANESTHESI OLOGY	0. 000000	2, 870, 224		0 2, 968, 072	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	21, 704, 785		0 45, 778, 685	0	54.00
54.01	05401 RADI OLOGY - I -65	0. 000000	0		0	0	54. 01
54.02	05402 RADIOLOGY DIAGNOSTIC - SJ	0. 000000	0		0	0	54. 02
54.03	05403 LOWELL RADI OLOGY	0. 000000	0		0	0	54. 03
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	0		0	0	55. 00
55. 01	05501 CARDI AC CATHERI ZATON LAB	0. 000000	6, 503, 708		0 6, 396, 435	0	55. 01
55. 02	03140 CARDI OLOGY	0. 000000	3, 083, 703		0 4, 110, 032	0	55. 02
55. 03	03450 NEURO-DI AGNOSTI CS	0. 000000	615, 598		0 1, 004, 220	0	55. 03
60.00	06000 LABORATORY	0. 000000	25, 526, 074		0 1, 885, 665	0	60.00
60. 01	06001 BLOOD LABORATORY	0. 000000	0		0	0	60. 01
65.00	06500 RESPI RATORY THERAPY	0. 000000	6, 808, 800		0 1, 004, 801	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0. 000000	732, 275		0 15, 155	0	66. 00
66. 01	06601 PHYSI CAL THERAPY I -65	0. 000000	0		0 0	0	66. 01
66. 02	06602 PHYSI CAL THERAPY ST JOHN	0. 000000	0		0 0	0	66. 02
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000	738, 616		0 4, 831	0	67. 00
67. 01	06701 OCCUPATION THERAPY I -65	0. 000000	0		0 0	0	67. 01
67. 02	06702 OCCUPATIONAL THERAPY ST. JOHN	0. 000000	0		0 0	0	67. 02

	RANCI SCAN HEAL				u or Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der Ci		Period: From 01/01/2021 To 12/31/2021	Worksheet D Part V Date/Time Pre 5/30/2022 5:4	pared: 1 pm
		Title	XVIII	Hospi tal	PPS	
		11110	Charges	nospi tai	Costs	
	0 1 1 01	DDC D 1 1 1				
Cost Center Description		PPS Reimbursed		Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins.	Ded. & Coins.		
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
	0.200004	1/ 040 220	1		2 542 400	F0 00
50. 00 05000 OPERATI NG ROOM	0. 209004			0		
51. 00 05100 RECOVERY ROOM	0. 216255			0	699, 872	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 234596	0		0	0	52. 00
53. 00 05300 ANESTHESI OLOGY	0. 035978	2, 968, 072		0	106, 785	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 114304	45, 778, 685		0	5, 232, 687	54.00
54. 01 05401 RADI OLOGY - I -65	0. 082259			0	0	54. 01
	1	l .		-	-	
54. 02 05402 RADI OLOGY DI AGNOSTI C - SJ	0. 000000	l .		0	0	54. 02
54. 03 05403 LOWELL RADI OLOGY	0. 164994		•	0		54. 03
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	0		0	0	55. 00
55. 01 05501 CARDI AC CATHERI ZATON LAB	0. 138466	6, 396, 435		0	885, 689	55. 01
55. 02 03140 CARDI OLOGY	0. 180744			0	742, 864	55. 02
55. 03 03450 NEURO-DI AGNOSTI CS	0. 156773			o o		
60. 00 06000 LABORATORY	0. 123428			0	232, 744	
60. 01 06001 BL00D LABORATORY	0. 000000	l control of the cont		0		60. 01
65. 00 06500 RESPI RATORY THERAPY	0. 189371	1, 004, 801		0	190, 280	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 739793	15, 155		0	11, 212	66. 00
66. 01 06601 PHYSI CAL THERAPY I -65	0. 486050	o l		0	0	66. 01
66. 02 06602 PHYSI CAL THERAPY ST JOHN	0. 339214		1	0 0	Ö	66. 02
67. 00 06700 OCCUPATI ONAL THERAPY	1	l control of the cont	i e	0 0	944	67.00
	0. 195393		i e	-		
67.01 06701 OCCUPATION THERAPY I-65	0. 580898		1	0	0	67. 01
67.02 06702 OCCUPATIONAL THERAPY ST. JOHN	0. 295460) 0		0	0	67. 02
68.00 06800 SPEECH PATHOLOGY	0. 182824	17, 156		0	3, 137	68. 00
68. 01 06801 SPEECH PATHOLOGY I - 65	0. 289330	0		0	0	68. 01
68.02 06802 SPEECH THERAPY ST. JOHN	0. 234850	l .		0 0	l 0	68. 02
69. 00 06900 ELECTROCARDI OLOGY	0. 127654			o o	377, 059	
				0 0	1, 098, 429	
	0. 276221			-		
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 497639			0	2, 700, 107	
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 265124	4, 070, 852		0 7, 750	1, 079, 281	73. 00
74.00 07400 RENAL DIALYSIS	0. 564311	28, 488		0	16, 076	74.00
76. 00 03020 RADI ATI ON ONCOLOGY	0. 117769	ol o		0	l 0	76. 00
76. 01 03040 ANGI OCARDI OGRAPHY	0. 478801			0 0	310, 361	
OUTPATIENT SERVICE COST CENTERS	0. 170001	0 10, 201	l	<u> </u>	010,001	70.01
90. 00 09000 CLINIC	0.000000	0		0 0	0	90.00
	0. 000000				_	
90. 01 09001 DI ABETES CLINIC	2. 438242			0	666	
90. 02 09002 OUTPATIENT CLINICS	0. 000000	0		0	0	90. 02
90.03 09003 OCCUPATIONAL MEDICINE CLINIC	0. 000000	0		0 0	0	90. 03
90. 04 09004 NEONATOLOGY CLINIC-FRANCISCAN POINT	0. 702525	o l		0	0	90. 04
90. 05 09005 LACTATION CLINIC	1. 899524			0	0	90.05
91. 00 09100 EMERGENCY				0 0		
	0. 120397		1	-	1, 720, 492	
91. 01 09101 EMERGENCY ROOM PHYSI CANS	0. 000000	I .	1	0	0	91. 01
91. 02 09102 EXPRESS CARE	0. 000000) 0		0	0	91. 02
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 761556	1, 398, 935		0	1, 065, 367	92.00
200.00 Subtotal (see instructions)		116, 743, 355		0 7, 750		
201.00 Less PBP Clinic Lab. Services-Program				0 .,	1	201. 00
Only Charges				ا ا	1	
202.00 Net Charges (line 200 - line 201)		116, 743, 355		0 7, 750	20, 462, 349	202 00
202.00 Net onal yes (11116 200 - 11116 201)	I	1 10, 743, 333	1	7,750	20, 402, 349	1202.00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet D | From 01/01/2021 | Part V | To 12/31/2021 | Date/Time Prepared: | 5/30/2022 5:41 pm
 Heal th Financial
 Systems
 FRANCISCAN HEAL

 APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST
 Provider CCN: 15-0126

							5/30/2022 5: 4	1 pm
				Title	XVIII	Hospi tal	PPS	
			Cos	sts				
		Cost Center Description	Cost	Cost				
		oost contor boost per on	Rei mbursed	Rei mbursed				
			Servi ces	Servi ces Not				
			Subject To	Subject To				
			Ded. & Coins.	Ded. & Coins.				
			(see inst.)	(see inst.)				
			6. 00	7. 00				
	ANCI L	LARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0				50.00
51.00	05100	RECOVERY ROOM	0	0				51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0				52.00
53.00		ANESTHESI OLOGY	0	0				53.00
54. 00		RADI OLOGY-DI AGNOSTI C	0	0				54. 00
54. 01		RADIOLOGY - I -65	0	0				54. 01
54. 02	1	RADIOLOGY DIAGNOSTIC - SJ		0				54. 02
			0					
54. 03		LOWELL RADI OLOGY	0	0				54. 03
55. 00		RADI OLOGY-THERAPEUTI C	0	0	•			55. 00
55. 01		CARDI AC CATHERI ZATON LAB	0	0				55. 01
55. 02	1	CARDI OLOGY	0	0				55. 02
55. 03	03450	NEURO-DI AGNOSTI CS	0	0				55. 03
60.00	06000	LABORATORY	0	0				60.00
60. 01	06001	BLOOD LABORATORY	0	0				60. 01
65.00	06500	RESPI RATORY THERAPY	0	0				65. 00
66. 00	1	PHYSI CAL THERAPY	0	0	1			66. 00
66. 01	1	PHYSICAL THERAPY I -65	i o	Ö				66. 01
66. 02		PHYSI CAL THERAPY ST JOHN	0	Ö	1			66. 02
67. 00		OCCUPATIONAL THERAPY	0	0				67.00
			0					
67. 01		OCCUPATION THERAPY I -65	0	0				67. 01
67. 02		OCCUPATIONAL THERAPY ST. JOHN	0	0				67. 02
68. 00		SPEECH PATHOLOGY	0	0				68. 00
68. 01		SPEECH PATHOLOGY I -65	0	0				68. 01
68. 02		SPEECH THERAPY ST. JOHN	0	0				68. 02
69. 00		ELECTROCARDI OLOGY	0	0				69. 00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0				71.00
72.00		IMPL. DEV. CHARGED TO PATIENTS	0	0				72. 00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2, 055				73. 00
74.00		RENAL DIALYSIS	0	0				74.00
76. 00		RADI ATI ON ONCOLOGY	o o	Ö				76. 00
76. 01	1	ANGI OCARDI OGRAPHY	0	l				76. 01
70.01		TIENT SERVICE COST CENTERS		<u> </u>				1 70.01
00.00			0	_				00.00
90.00		CLINIC	-		•			90.00
90. 01		DI ABETES CLINIC	0		•			90. 01
90. 02		OUTPATIENT CLINICS	0	l	•			90. 02
90. 03		OCCUPATIONAL MEDICINE CLINIC	0	0				90. 03
90. 04		NEONATOLOGY CLINIC-FRANCISCAN POINT	0	0				90. 04
90. 05	09005	LACTATION CLINIC	0	0				90. 05
91.00	09100	EMERGENCY	0	0				91.00
91. 01		EMERGENCY ROOM PHYSICANS	0	0				91. 01
91. 02		EXPRESS CARE	n	0				91. 02
92. 00	1	OBSERVATION BEDS (NON-DISTINCT PART	l n	0				92.00
200.00		Subtotal (see instructions)		2, 055				200.00
200.00	1			2,000				201. 00
201.UC	Ί	Less PBP Clinic Lab. Services-Program Only Charges						201.00
202.00		, ,	_	2 055				202 00
202.00	וי	Net Charges (line 200 - line 201)	0	2, 055	I			202. 00

Health Fina	ncial Systems - F	RANCISCAN HEALI	H CROWN POINT		In Lie	u of Form CMS-2	2552-10
	NT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der Co	CN: 15-0126	Peri od: From 01/01/2021 To 12/31/2021	Worksheet D Part V Date/Time Pre	pared:
			T: ±1	- VIV	11: 4-1	5/30/2022 5: 4	1 pm
			1111	e XIX	Hospi tal	Cost Costs	
	Cost Center Description	Cost to Charge	DDS Doimburged	Charges Cost	Cost	PPS Services	
	cost center bescription		Servi ces (see	Rei mbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Servi ces Not	(See Hist.)	
		Part I, col. 9	11131.)	Subject To	Subject To		
				Ded. & Coins			
				(see inst.)	(see inst.)		
		1.00	2. 00	3.00	4. 00	5. 00	
ANCIL	LARY SERVICE COST CENTERS			•			
	OPERATING ROOM	0. 209004	7, 775, 449		0 0	1, 625, 100	50.00
51.00 05100	RECOVERY ROOM	0. 216255	1, 438, 879		0 0	311, 165	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0. 234596	13, 890)	0 0	3, 259	52. 00
53.00 05300	ANESTHESI OLOGY	0. 035978	1, 428, 203		0 0	51, 384	53.00
54.00 05400	RADI OLOGY-DI AGNOSTI C	0. 114304	17, 289, 319		0 0	1, 976, 238	54.00
54. 01 0540°	1 RADI OLOGY - I -65	0. 082259	0)	0 0	0	54. 01
54. 02 05402	RADIOLOGY DIAGNOSTIC - SJ	0. 000000	0)	0 0	0	54. 02
54. 03 05403	B LOWELL RADIOLOGY	0. 164994	0)	0 0	0	54. 03
55. 00 05500	RADI OLOGY-THERAPEUTI C	0. 000000	0)	0 0	0	55.00
55. 01 0550°	1 CARDIAC CATHERIZATON LAB	0. 138466	0)	0 0	0	55. 01
55. 02 03140	CARDI OLOGY	0. 180744	2, 021, 229		0 0	365, 325	55. 02
	NEURO-DI AGNOSTI CS	0. 156773	336, 882		0 0	52, 814	55. 03
60.00 06000	LABORATORY	0. 123428	12, 390, 545		0 0	1, 529, 340	60.00
60. 01 0600°	1 BLOOD LABORATORY	0. 000000	0)	0 0	0	60. 01
65.00 06500	RESPIRATORY THERAPY	0. 189371	237, 471		0 0	44, 970	65.00
66.00 06600	PHYSI CAL THERAPY	0. 739793	0)	0 0	0	66.00
66. 01 0660°	PHYSICAL THERAPY I-65	0. 486050	463, 594		0 0	225, 330	66. 01
66. 02 06602	PHYSICAL THERAPY ST JOHN	0. 339214	0)	0 0	0	66. 02
67. 00 06700	OCCUPATIONAL THERAPY	0. 195393	44, 366	,	0 0	8, 669	67.00
	1 OCCUPATION THERAPY I-65	0. 580898	0)	0 0	0	67. 01
67. 02 06702	OCCUPATIONAL THERAPY ST. JOHN	0. 295460	0)	0 0	0	67. 02
	SPEECH PATHOLOGY	0. 182824	0)	0 0	0	68. 00
68. 01 0680°	1 SPEECH PATHOLOGY I -65	0. 289330	326, 248		0 0	94, 393	68. 01
68. 02 06802	SPEECH THERAPY ST. JOHN	0. 234850	0)	0 0	0	68. 02
69.00 06900	ELECTROCARDI OLOGY	0. 127654	656, 303		0 0	83, 780	69. 00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0. 276221	591, 743		0 0	163, 452	71. 00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0. 497639	3, 608, 169		0 0	1, 795, 566	72. 00
73.00 07300	DRUGS CHARGED TO PATIENTS	0. 265124	1, 324, 555		0 0	351, 171	73. 00
74.00 07400	RENAL DIALYSIS	0. 564311	1, 166	,	0 0	658	74.00
76. 00 03020	RADIATION ONCOLOGY	0. 117769	1, 278, 446	,	0 0	150, 561	76. 00
76. 01 03040	ANGI OCARDI OGRAPHY	0. 478801	0)	0 0	0	76. 01
OUTPA	ATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0. 000000	0		0 0	0	90.00
90. 01 0900°	DIABETES CLINIC	2. 438242	0)	0 0	0	90. 01
90. 02 09002	OUTPATIENT CLINICS	0. 000000	0)	0 0	0	90. 02
90. 03 09003	OCCUPATIONAL MEDICINE CLINIC	0. 000000	0	1	0 0	0	90. 03
90. 04 09004	NEONATOLOGY CLINIC-FRANCISCAN POINT	0. 702525	0)	0 0	0	90. 04
90. 05 0900!	LACTATION CLINIC	1. 899524	0)	0 0	0	90. 05
91.00 09100	EMERGENCY	0. 120397	14, 509, 320)	0 0	1, 746, 879	91.00
91. 01 0910°	1 EMERGENCY ROOM PHYSICANS	0. 000000	0)	0 0	0	91. 01
91. 02 09102	EXPRESS CARE	0. 000000	0	1	0 0	0	91. 02
	OBSERVATION BEDS (NON-DISTINCT PART	0. 761556	1, 052, 706	,	0 0	801, 695	
200.00	Subtotal (see instructions)		66, 788, 483	1	0 0	11, 381, 749	
201.00	Less PBP Clinic Lab. Services-Program			1	0 0		201.00
	Only Charges			1			
202. 00	Net Charges (line 200 - line 201)		66, 788, 483		0 0	11, 381, 749	202. 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet D | From 01/01/2021 | Part V | To 12/31/2021 | Date/Time Prepared: | 5/30/2022 5:41 pm Health Financial Systems FRANCISCAN HEAL APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0126

Cost Center Description							5/30/2022 5: 4	1 pm
Cost Center Description				Title X	(LX	Hospi tal	Cost	
NOT LLARY SERVICE COST CENTERS Services Subject 10 Ded. & Coins: Center inst.) Services (Subject 10 Ded. & Coins: Center inst.) Services (Subject 10 Ded. & Coins: Center inst.) Subject 10 Ded. & Coins: Center inst. De			Cos	sts				
NOT LLARY SERVICE COST CENTERS Services Subject 10 Ded. & Coins: Center inst.) Services (Subject 10 Ded. & Coins: Center inst.) Services (Subject 10 Ded. & Coins: Center inst.) Subject 10 Ded. & Coins: Center inst. De		Cost Center Description	Cost	Cost				
Services Services Subject To Ded. & Coins. Code. & Coins. Code		·	Rei mbursed	Reimbursed				
Subject To Ded. & Coins. Sobject To Ded. & Coins. See Inst.) Ded. & Coins. See Inst.) Subject To Ded. & Coins. See Inst.) See Inst.) See Inst.) See Inst. See Inst.) See Inst. See Inst.) See Inst. Se								
Decl. & Colins. Decl. & Decl.								
See Inst.			,					
MACILLARY SERVICE COST CENTERS								
MACILLARY SERVICE COST CENTERS								
50.00 050000 0FEATI NG ROOM 0 0 0 51.00 52.00 52.00 05200 DELIVERY ROOM 0 0 0 0 52.00 52.00 05200 DELIVERY ROOM 6 0 0 0 0 52.00 53.00 05300 DESTINES IOLOGY 0 0 0 0 53.00 05300 DESTINES IOLOGY 0 0 0 0 54.00 55.00			6.00	7.00				
15.1.00 05.100 RECOVERY ROOM S. LABOR ROOM 0 0 0 0 0 0 0 0 0								1
S2 00 05200 DELI VERY ROOM & LABOR ROOM 0 0 53.00 53.00 05300 0ARSTHESI OLOGY 0 0 54.00 54.00 05400 RADI DLOGY - 1-65 0 0 0 54.00 54.01 05401 RADI DLOGY - 1-65 0 0 0 54.00 54.01 05401 RADI DLOGY - 1-65 0 0 0 54.00 54.02 05402 RADI DLOGY - 1-65 0 0 0 54.00 54.03 05403 UMPEL RADI DLOGY - 0 0 0 54.00 55.00 05500 RADI DLOGY - THERAPEUTI C 0 0 0 55.00 55.01 05501 CARDI ACCATHERI ZATON LAB 0 0 0 55.00 55.01 05501 CARDI ACCATHERI ZATON LAB 0 0 0 55.00 55.02 03410 CARDI DLOGY - THERAPEUTI C 0 0 0 55.00 55.03 034501 VERIAP - DLOGOSTI CS 0 0 0 0 55.00 55.03 034501 VERIAP - DLOGOSTI CS 0 0 0 0 55.00 60.00 06000 LABORATORY 0 0 0 0 0 0 60.00 06000 LABORATORY 0 0 0 0 0 0 60.00 06000 PRSSI CAL THERAPY 0 0 0 0 0 0 60.00 06000 PRSSI CAL THERAPY 1-65 0 0 0 0 0 60.00 06000 PRSSI CAL THERAPY 1-65 0 0 0 0 60.00 06000 PRSSI CAL THERAPY 1-65 0 0 0 0 60.00 06000 PRSSI CAL THERAPY 1-65 0 0 0 0 60.00 06000 PRSSI CAL THERAPY 1-65 0 0 0 60.00 06000 SEPER PATHOLOGY 1-65 0 0 0 60.00 06000 SEPELP PATHOLOGY 1-65 0 0 0 60.00 07000 DRUGS CHARGED TO PATI ENTS 0 0 0 0 60.00 07000 DRUGS CHARGED TO PATI ENTS 0 0 0 0 60.00 07000 DRUGS CHARGED TO PATI ENTS 0 0 0 0 60.00 07000 DRUGS CHARGED TO PATI ENTS 0 0 0 0 60.00 07000 DRUGS CHARGED TO PATI ENTS 0 0 0 0 60.00 07000 DRUGS CHARGED TO PATI ENTS 0 0 0 0 60.00 07000 DRUGS CHARGED TO PATI ENTS 0 0 0 0 60.00 07000 DRUGS CHARGED TO PATI ENTS	50.00 050	000 OPERATING ROOM	0					50. 00
S3 00 05300 ANESTHESI OLOGY 0 0 53.00	51.00 051	00 RECOVERY ROOM	0	O				51.00
53.00 05300 ANESTHESI OLOGY 0 0 53.00 54.00 05400 RADIOLOGY + 1 - 65 0 0 0 54.00 54.00 05400 RADIOLOGY + 1 - 65 0 0 0 54.00 54.02 05402 RADIOLOGY 10 ANOSTIC - 5J 0 0 0 54.00 54.02 05402 RADIOLOGY 10 ANOSTIC - 5J 0 0 0 54.00 54.02 05402 RADIOLOGY 10 ANOSTIC - 5J 0 0 0 54.00 55.00 05500 RADIOLOGY + THERAPEUT C 0 0 0 55.00 55.00 05500 RADIOLOGY + THERAPEUT C 0 0 0 55.00 55.00 05500 RADIOLOGY + THERAPEUT C 0 0 0 55.00 55.00 303400 RADIOLOGY 0 0 0 55.00 55.00 303400 RADIOLOGY 0 0 0 55.00 55.00 303450 REURO-DI AGNOSTI CS 0 0 0 55.00 60.00 06600 LABORATORY 0 0 0 60.00 60.01 06600 RESPIRATORY + 10 0 0 60.00 60.00 06600 RESPIRATORY + 10 0 0 60.00 60.00 06600 RESPIRATORY + 10 0 0 65.00 60.00 06600 RESPIRATORY + 10 0 0 65.00 60.00 06600 RESPIRATORY + 10 0 0 65.00 60.00 06600 RESPIRATORY + 10 0 0 66.00 60.00 06600 PHYSICAL THERAPY 0 0 0 66.00 60.00 06600 PHYSICAL THERAPY 1-65 0 0 66.00 60.00 06600 PHYSICAL THERAPY 1-65 0 0 66.00 60.01 06600 OCCUPATI OLAT THERAPY 1-65 0 0 66.00 60.01 06600 OCCUPATI OLAT THERAPY 1-65 0 0 67.00 60.01 06600 SPEECH PATHOLOGY -65 0 0 67.00 60.01 06600 SPEECH PATHOLOGY -65 0 0 67.00 60.01 06600 LECTROCARDIOLOGY 0 0 68.00 60.01 06600 SPEECH PATHOLOGY -65 0 0 0 60.01 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 60.01 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 60.01 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 60.01 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 60.01 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 60.01 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 60.01 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 60.01 07100 MEDI	52. 00 052	200 DELIVERY ROOM & LABOR ROOM	0	o				52. 00
54.00 05400 RADI DLOGY-DI AGNOSTIC 0 0 54.01 54.01 05401 RADI DLOGY 1-65 0 0 54.01 54.02 05402 RADI DLOGY DI AGNOSTIC - SJ 0 0 54.01 54.03 05403 LOWELL RADI DLOGY 0 0 54.03 55.00 05500 RADI DLOGY-THERAPEUTIC 0 0 0 55.01 55.01 05501 CARDI AC CATHERI ZATON LAB 0 0 55.01 55.02 03140 CARDI DLOGY-THERAPEUTIC 0 0 0 55.01 55.03 03450 NCURO-DI AGNOSTIC S 0 0 0 55.01 55.03 03450 NCURO-DI AGNOSTIC S 0 0 0 55.03 60.00 06000 LABORATORY 0 0 0 0 0 60.00 06000 LABORATORY 0 0 0 0 0 65.00 06500 PRSIS RATORY THERAPY 0 0 0 0 0 65.00 06500 PRSIS RATORY THERAPY -65 0 0 0 0 0 66.01 06600 PRSIS CAL THERAPY T-65 0 0 0 0 66.02 06600 PRSIS CAL THERAPY ST. JOHN 0 0 0 0 67.00 06700 0CCUPATI ONAL THERAPY ST. JOHN 0 0 0 0 0 67.01 06701 0CCUPATI ONAL THERAPY ST. JOHN 0 0 0 0 0 67.02 06700 0CCUPATI ONAL THERAPY ST. JOHN 0 0 0 0 0 68.02 06600 SPEECH PATHOLOGY -65 0 0 0 0 0 68.02 06600 SPEECH PATHOLOGY -65 0 0 0 0 68.02 06600 SPEECH PATHOLOGY -65 0 0 0 0 68.02 06600 SPEECH PATHOLOGY -65 0 0 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 72.00 07200 MEDICAL SURPLIES CHARGED TO PATIENTS 0 0 0 0 73.00 07300 ORGUS CHARGED TO PATIENTS 0 0 0 0 74.00 07400 REFLACE COST CENTERS 0 0 0 0 00100 07400 REFLACE COST CENTERS 0 0 0 0 00100 07400 MEDICAL SURPLIES CHARGED TO PATIENTS 0 0 0 0 00100 07400 MEDICAL SURPLIES CHARGED TO PATIENTS 0 0 0 0 00100 07400 MEDICAL SURPLIES CHARGED TO PATIENTS 0 0 0 0 00100 07400 MEDICAL SURPLIES CHARGED TO PATIENTS 0 0 0 0 0 00100 07400 MEDICAL SURPLIES CHARGED TO PATIENTS 0 0 0 0 0 00100			0	O				
54.01 Os401 RADI OLOCY - I - 65 0 0 54.02 54.02 Os402 RADI OLOCY DI AGNOSTI C - SJ 0 0 54.02 54.02 Os402 RADI OLOCY DI AGNOSTI C - SJ 0 0 0 55.01 Os501 Os601 RADI OLOCY 0 0 0 55.01 Os501 Os601 Os6			0					1
54. 02 05402 RADI DLOGY DI AGNOSTIC - SJ			0					1
S4. 03 OS403 LOWELL RADI OLOGY 0 0 54. 03			0	1				1
55. 00 0.5500 ADJI OLOGY-THERAPEUTIC			0	1				1
55. 01 05501 CARDI AC CATHERI ZATON LAB 0 0 0 55. 02 55. 02 03450 NEURO-DI AGNOSTI CS 0 0 0 0 55. 02 55. 03 03450 NEURO-DI AGNOSTI CS 0 0 0 0 0 60. 00 06000 LABORATORY 0 0 0 0 60. 01 06001 BLODD LABORATORY 0 0 0 0 60. 01 06001 BLODD LABORATORY 0 0 0 60. 01 06001 BLODD LABORATORY 0 0 0 60. 01 06000 BLODD LABORATORY 0 0 0 60. 01 06000 PHYSI CAL THERAPY 0 0 0 60. 01 06000 PHYSI CAL THERAPY 0 0 0 60. 01 06000 PHYSI CAL THERAPY 0 0 0 60. 01 06000 PHYSI CAL THERAPY 0 0 0 60. 01 06000 PHYSI CAL THERAPY 0 0 0 60. 01 06000 PHYSI CAL THERAPY 0 0 0 60. 01 06000 PHYSI CAL THERAPY 0 0 0 60. 01 06000 PHYSI CAL THERAPY 0 0 0 60. 01 06000 PHYSI CAL THERAPY 0 0 0 60. 02 06000 PHYSI CAL THERAPY 0 0 0 60. 01 06000 PHYSI CAL THERAPY 0 0 0 60. 01 06000 PHYSI CAL THERAPY 0 0 0 60. 01 06000 07000 0CCUPATI ONAL THERAPY 0 0 0 60. 01 07000 0CCUPATI ONAL THERAPY 0 0 0 60. 01 06000 SPEECH PATHOLOGY 0 0 60. 01 07100 MEDICAL SUPPLIES CHARGED TO PATI ENTS 0 0 60. 01 07100 07100 MEDICAL SUPPLIES CHARGED TO PATI ENTS 0 0 60. 01 07100 07100 07100 07100 07100 60. 01 07100 07100 07100 07100 07100 07100 60. 01 07100 07100 07100 07100 07100 07100 60. 01 07100 07100 07100 07100 07100 07100 60. 01 07100 07100 07100 07100 07100 07100 60. 01 07100 07100 07100 07100 07100 07100 07100 60. 01 07100 07100 07100 07100 07100 07100 07100 60. 01 07100 07100 07100 07100 07100 07100 60. 01 07100 07100 07100 07100 07100 07100 07100 60. 01 07100 07100 07100 07100 07100 07100 07			0					
55. 02 03140 CARDI OLOCY 0 0 0 55. 02			0	1				
55. 03 03450 NEURO-DI AGNOSTICS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	55. 01 055	501 CARDI AC CATHERI ZATON LAB	0	0				55. 01
60. 00 06000 LABORATORY 0 0 0 0 0 0 0 0 0	55. 02 031	40 CARDI OLOGY	0	O				55. 02
60. 00 06000 LABORATORY 0 0 0 0 0 0 0 0 0	55. 03 034	150 NEURO-DI AGNOSTI CS	0	l ol				55. 03
60.01 06001 BLOOD LABORATORY 0 0 0 0 0 0 0 0 0			0					1
65.00 06500 RESPI RATORY THERAPY 0 0 66.00 66.01 06600 PHYSI CAL THERAPY 1-65 0 0 0 66.01 06601 PHYSI CAL THERAPY 1-65 0 0 0 66.02 06602 PHYSI CAL THERAPY 1-65 0 0 0 67.00 06700 0CCUPATI ONAL THERAPY 1-65 0 0 0 67.01 06701 0CCUPATI ONAL THERAPY 1-65 0 0 0 67.02 06702 0CCUPATI ONAL THERAPY 1-65 0 0 0 67.02 06702 0CCUPATI ONAL THERAPY 1-65 0 0 0 68.01 06800 SPEECH PATHOLOGY 6-6 0 0 68.01 06801 SPEECH PATHOLOGY 1-65 0 0 0 68.02 06802 SPEECH PATHOLOGY 1-65 0 0 0 68.03 06802 SPEECH THERAPY ST. JOHN 0 0 0 68.04 06803 SPEECH PATHOLOGY 1-65 0 0 0 68.05 06804 SPEECH STATORY 0 0 0 68.00 06900 ELECTROCARDIOLOGY 0 0 0 69.00 07000 0700 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 72.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 73.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 73.00 74.00 07400 RENAL DIALYSI S 0 0 0 75.01 03040 ANGIOCARDIOGRAPHY 0 0 0 76.01 03040 ANGIOCARDIOGRAPHY 0 0 0 76.01 03040 ANGIOCARDIOGRAPHY 0 0 0 76.01 09000 CLINIC C 0 0 76.01 09000 UNIVER THENT SERVICE COST CENTERS 0 0 76.01 09000 UNIVERSE CLINIC 0 0 76.02 09000 LACTATION CLINIC C 0 0 76.03 09000 LACTATION CLINIC C 0 0 76.04 09000 LACTATION CLINIC C 0 0 76.05 09005 LACTATION CLINIC C 0 0 76.06 09005 LACTATION CLINIC C 0 0 77.00 09100 EMERGENCY 0 0 77.00 09100			0					1
66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 0 0 0 0 0				1				1
66. 01 06601 PHYSICAL THERAPY I -65			0	1				1
66. 02 06602 PHYSICAL THERAPY ST JOHN 0 0 0 67.00 67.00 67.00 67.00 67.00 06.00 67.00 06.00 67.00 06.00 67.00 06.00 67.00 06.00 67.00 67.00 06.00 67.00 06.00 67.00 06.00 67.00 06.00 67.00 06.00 67.00 06.00 67.00 06.00 67.00 06.00 67.00 06.00 67.00 68.00 68.00 68.00 5PECH PATHOLOGY 68.00 68.01 68.01 5PECH PATHOLOGY 1-65 0 0 0 68.01 5PECH PATHOLOGY 1-65 0 0 0 68.01 68.00 68.01 5PECH PATHOLOGY 1-65 0 0 0 68.01 68.00 68.01 5PECH PATHOLOGY 1-65 0 0 0 68.00		·	0					1
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91. 02 09102 EXPRESS CARE 0 0 0 0 91. 02 92. 00 08SERVATI ON BEDS (NON-DISTINCT PART 0 0 0 0 200. 00 201. 00 Less PBP Clinic Lab. Services-Program 0 0 0 0 201. 00 01 y Charges			0					91.00
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92. 00 09200 08SERVATI ON BEDS (NON-DISTINCT PART 0 0 0 0 0 0 0 0 0		•	0	l ol				91. 02
200.00 Subtotal (see instructions) 0 0 0 200.00 201.00 Less PBP Clinic Lab. Services-Program Only Charges 0 201.00 201.00		·	0	ام				1
201.00 Less PBP Ĉlinic Lab. Servićes-Program 0 201.00 ly Charges		,						1
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	Financial Systems FRANCISCAN HEALTH			u of Form CMS-2	
COMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0126	Peri od: From 01/01/2021	Worksheet D-1	
			To 12/31/2021	Date/Time Prep 5/30/2022 5:4	
		Title XVIII	Hospi tal	PPS	
	Cost Center Description				
	DADT I DESCRIPTION			1. 00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				ł
1.00	Inpatient days (including private room days and swing-bed day	vs. excluding newborn)		34, 333	1.00
2. 00	Inpatient days (including private room days, excluding swing-			34, 333	
3. 00	Private room days (excluding swing-bed and observation bed days		ivate room days,	0	
	do not complete this line.		-		1
1. 00	Semi-private room days (excluding swing-bed and observation be			29, 563	
5. 00	Total swing-bed SNF type inpatient days (including private ro	oom days) through Decembe	r 31 of the cost	0	5. 00
5. 00	reporting period Total swing-bed SNF type inpatient days (including private ro	oom days) after December	21 of the cost	0	6. 00
3. 00	reporting period (if calendar year, enter 0 on this line)	dolli days) al tei beceilbei	31 OF THE COST	U	0.00
7. 00	Total swing-bed NF type inpatient days (including private roo	om davs) through December	31 of the cost	0	7.00
	reporting period	3 , 3			l
3. 00	Total swing-bed NF type inpatient days (including private roo	om days) after December 3	1 of the cost	0	8. 0
	reporting period (if calendar year, enter 0 on this line)				
9. 00	Total inpatient days including private room days applicable t	to the Program (excluding	swing-bed and	13, 231	9. 0
0. 00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII of	only (including private r	oom days)	0	10.0
10.00	through December 31 of the cost reporting period (see instruc		oom days)	O	10.0
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII o		oom days) after	0	11. 0
	December 31 of the cost reporting period (if calendar year, e				l
2. 00	Swing-bed NF type inpatient days applicable to titles V or XI $$	X only (including privat	e room days)	0	12.0
12.00	through December 31 of the cost reporting period	V (!!		0	12.0
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI after December 31 of the cost reporting period (if calendary			0	13. C
14. 00	Medically necessary private room days applicable to the Progr			0	14.0
	Total nursery days (title V or XIX only)	am (and all ing and a		0	
	Nursery days (title V or XIX only)			0	16. C
	SWING BED ADJUSTMENT				
7. 00	Medicare rate for swing-bed SNF services applicable to service	ces through December 31 o	f the cost	0. 00	17. C
10 00	reporting period	oo often December 21 of	the east	0.00	18. 0
18. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	ces arter becember 31 or	the cost	0.00	18.0
19. 00	Medicaid rate for swing-bed NF services applicable to service	es through December 31 of	the cost	0.00	19.0
,, 00	reporting period	or the dag. Processor of the		0.00	
0.00	Medicaid rate for swing-bed NF services applicable to service	es after December 31 of t	he cost	0.00	20.0
	reporting period				
1.00	Total general inpatient routine service cost (see instruction			57, 102, 546	
2. 00	Swing-bed cost applicable to SNF type services through Decemb 5×1 ine 17)	per 31 of the cost report	ing period (line	0	22.0
3. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	a period (line 6	0	23. 0
	x line 18)	or or the cost reporting	g perrou (rine o	o .	20.0
24. 00	Swing-bed cost applicable to NF type services through December	er 31 of the cost reporti	ng period (line	0	24.0
	7 x line 19)	·			1
25. 00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	period (line 8	0	25. C
	x line 20)				۵. ۵
	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost	(line 21 minus line 24)		0 57, 102, 546	
. 7 . UU	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(TITIE 21 IIITIUS TITIE 26)		37, 102, 546	21.0
8. 00	General inpatient routine service charges (excluding swing-be			0	28.0

	do not complete this line.		
4.00	Semi-private room days (excluding swing-bed and observation bed days)	29, 563	4. 00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	0	5. 00
	reporting period		
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	o	6. 00
	reporting period (if calendar year, enter 0 on this line)		
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	0	7. 00
7.00	reporting period	O	7.00
0.00		0	0.00
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	U	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 (excluding swing-bed and	13, 231	9. 00
	newborn days) (see instructions)		
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10.00
	through December 31 of the cost reporting period (see instructions)		
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11. 00
	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 private room days)	0	12. 00
	through December 31 of the cost reporting period	ŭ	12.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13. 00
13.00		U	13.00
14.00	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	14 00
14. 00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14. 00
15. 00	Total nursery days (title V or XIX only)	0	15. 00
16. 00	Nursery days (title V or XIX only)	0	16. 00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0.00	17. 00
	reporting period		
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0.00	18. 00
10.00	reporting period	0.00	10.00
19. 00		0.00	19. 00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	0.00	19.00
	reporting period		
20. 00	Medicald 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)	57, 102, 546	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	0	22. 00
	5 x line 17)		
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	0	23. 00
20.00	x line 18)	ŭ	20.00
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24. 00
24.00		U	24.00
25 00	7 x line 19)	0	25 00
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25. 00
	x line 20)		
26. 00	Total swing-bed cost (see instructions)	0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	57, 102, 546	27. 00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28. 00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)	0	29. 00
30.00	Semi - pri vate room charges (excluding swing-bed charges)	0	30.00
		0. 000000	
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		
32. 00	Average private room per diem charge (line 29 ÷ line 3)	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 instructions)	0.00	34.00
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)	0	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	57, 102, 546	
37.00	27 minus line 36)	57, 102, 340	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, 663. 20	
39. 00	Program general inpatient routine service cost (line 9 x line 38)	22, 005, 799	39. 00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40. 00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	22, 005, 799	41.00

	Financial Systems	FRANCISCAN HEALT	H CROWN POINT Provider CC	N: 15 012/		eu of Form CMS-2 Worksheet D-1	
COMPUT	ATTON OF INPATIENT OPERATING COST		Provider CC	N: 15-U126	Period: From 01/01/2021 To 12/31/2021		
			T: 11	V4.1.1		5/30/2022 5:4	
	Cost Center Description	Total	Ti tl e	Average Per	Hospital Program Days	PPS Program Cost	
			Inpatient Days	Diem (col. 1		(col. 3 x col.	
		1.00	2.00	col. 2) 3.00	4. 00	4) 5. 00	
42. 00	NURSERY (title V & XIX only)	1.00	2.00	0.1			42. 00
	Intensive Care Type Inpatient Hospital Units						1
43. 00 44. 00	INTENSIVE CARE UNIT	11, 623, 910	4, 612	2, 520.	1, 807	4, 554, 291	43.00
44. 00 45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44. 00 45. 00
46. 00	SURGICAL INTENSIVE CARE UNIT						46. 00
47. 00	NEONATAL INTENSIVE CARE UNIT	6, 578, 182	2, 920	2, 252.	80 0	0	47. 00
	Cost Center Description					1.00	
48. 00	Program inpatient ancillary service cost (Wk					27, 143, 610	1
49. 00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48)(see instruction	ıs)		53, 703, 700	49. 00
50. 00	Pass through costs applicable to Program inp	atient routine	services (from	Wkst. D, sur	m of Parts I and	1, 851, 010	50.00
	111)		·				
51. 00	Pass through costs applicable to Program inpland IV)	oatient ancillar	y services (fro	om Wkst. D, s	sum of Parts II	1, 725, 789	51.00
52. 00	Total Program excludable cost (sum of lines	50 and 51)				3, 576, 799	52. 00
53. 00	Total Program inpatient operating cost exclu		lated, non-phys	sician anestI	netist, and	50, 126, 901	53. 00
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					1
	Program di scharges					0	54. 00
	Target amount per discharge					0.00	1
56. 00 57. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operat	ing cost and ta	rget amount (li	ne 56 minus	line 53)	0 0	1
58. 00	Bonus payment (see instructions)	Ü			ŕ	0	
59. 00	Lesser of lines 53/54 or 55 from the cost remarket basket	porting period	endi ng 1996, up	odated and co	ompounded by the	0.00	59. 00
60.00	Lesser of lines 53/54 or 55 from prior year	cost report, up	dated by the ma	arket basket		0.00	60.00
61. 00	If line 53/54 is less than the lower of line					0	61. 00
	which operating costs (line 53) are less that amount (line 56), otherwise enter zero (see		s (lines 54 x 6	50), or 1% of	f the target		
62.00	Relief payment (see instructions)	This tructrums)				0	62. 00
63. 00	Allowable Inpatient cost plus incentive paym	ent (see instru	ctions)			0	63. 00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Dece	mber 31 of the	cost reporti	na period (See	1 0	64. 00
	instructions)(title XVIII only)	Ü		•			
65. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	its after Decemb	er 31 of the co	ost reportino	g period (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line 65	(title XVI	I only). For	0	66. 00
/7.00	CAH (see instructions)		D 21 -4	S 46-1 4			/7.00
67. 00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	ie costs through	December 31 01	the cost re	eporting period	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routin	e costs after D	ecember 31 of t	he cost rep	orting period	0	68. 00
69 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routine costs (line 67 + line	68)		0	69. 00
07.00	PART III - SKILLED NURSING FACILITY, OTHER N						37.00
70.00	Skilled nursing facility/other nursing facil)		70.00
71. 00 72. 00	Adjusted general inpatient routine service of Program routine service cost (line 9 x line	1 ,	ine 70 ÷ iine ∠	2)			71. 00
73. 00	Medically necessary private room cost applic	able to Program		ne 35)			73. 00
74. 00	Total Program general inpatient routine serv	•		veltabaat D. I	Don't II. oolumn		74.00
75. 00	Capital-related cost allocated to inpatient 26. line 45)	routine service	COSTS (Trom WC	orksneet B, I	Part II, column		75. 00
76. 00	Per diem capital-related costs (line 75 ÷ li	ne 2)					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 der records	s)			79.00
80.00	,		ost limitation	(line 78 mi	nus line 79)		80.00
81. 00 82. 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I)				81. 00 82. 00
83. 00	Reasonable inpatient routine service costs (83. 00
84. 00	Program inpatient ancillary services (see in	structions)					84. 00
85. 00 86. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum						85. 00 86. 00
55. 00	PART IV - COMPUTATION OF OBSERVATION BED PAS		. sagn 60 <i>)</i>] 55. 60
87. 00	Total observation bed days (see instructions	5)	1: 0			4, 770	1
88. 00 89. 00	Adjusted general inpatient routine cost per Observation bed cost (line 87 x line 88) (se	•	iine 2)			1, 663. 20 7, 933, 464	1
50	(30)					1 ., , 55, 154	1 - 2

Health Financial Systems	FRANCI SCAN HEAL	TH CROWN POINT		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2021 To 12/31/2021	Date/Time Prep 5/30/2022 5:4	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	3, 777, 370	57, 102, 546	0. 06615	1 7, 933, 464	524, 807	90.00
91.00 Nursing Program cost	0	57, 102, 546	0.00000	7, 933, 464	0	91.00
92.00 Allied health cost	0	57, 102, 546	0.00000	7, 933, 464	0	92.00
93 00 All other Medical Education	0	57 102 546	0.00000	7 933 464	0	93 00

<u> </u>	FRANCISCAN HEALTH CROWN POINT			u of Form CMS-2	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der CC	CN: 15-0126	Peri od: From 01/01/2021	Worksheet D-3	
			To 12/31/2021	5/30/2022 5: 4	pared: 1 pm
	Title	XVIII	Hospi tal	PPS	
Cost Center Description		Ratio of Cos To Charges	t Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2. 00	3. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS			20, 074, 088		30. 00
31. 00 03100 INTENSIVE CARE UNIT			6, 156, 480		31. 00
35. 00 02060 NEONATAL INTENSIVE CARE UNIT			0		35. 00
43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS					43. 00
50. 00 05000 OPERATING ROOM		0. 20906	17, 225, 714	3, 601, 328	50.00
51. 00 05100 RECOVERY ROOM		0. 21625			
52. 00 05200 DELIVERY ROOM & LABOR ROOM		0. 23459		3, 428	
53. 00 05300 ANESTHESI OLOGY		0. 03607		103, 535	
54. 00 05400 RADI OLOGY - DI AGNOSTI C		0. 11430			
54. 01 05401 RADI OLOGY - I -65		0. 08225		2, 100, 111	1
54. 02 05402 RADI OLOGY DI AGNOSTI C - SJ		0. 00000		0	54. 02
54. 03 05403 LOWELL RADI OLOGY		0. 16499		0	54. 03
55. 00 05500 RADI OLOGY-THERAPEUTI C		0.00000	00	0	55. 00
55. 01 05501 CARDI AC CATHERI ZATON LAB		0. 13846	6, 503, 708	900, 542	55. 01
55. 02 03140 CARDI OLOGY		0. 18074	3, 083, 703	557, 361	55. 02
55. 03 03450 NEURO-DI AGNOSTI CS		0. 15677	73 615, 598	96, 509	55. 03
60. 00 06000 LABORATORY		0. 12345		3, 151, 245	60.00
60. 01 06001 BLOOD LABORATORY		0.00000		0	
65. 00 06500 RESPI RATORY THERAPY		0. 18937	71 6, 808, 800	1, 289, 389	65. 00
66. 00 06600 PHYSI CAL THERAPY		0. 73979		541, 732	66. 00
66. 01 06601 PHYSI CAL THERAPY I -65		0. 48605	50 0	0	66. 01
66. 02 06602 PHYSI CAL THERAPY ST JOHN		0. 33921		0	66. 02
67. 00 06700 OCCUPATI ONAL THERAPY		0. 19539		144, 320	67. 00
67. 01 06701 0CCUPATION THERAPY I -65		0. 58089		0	
67. 02 06702 OCCUPATI ONAL THERAPY ST. JOHN		0. 29546		0	67. 02
68. 00 06800 SPEECH PATHOLOGY		0. 18282		105, 208	
68. 01 06801 SPEECH PATHOLOGY I -65		0. 28933		0	68. 01
68. 02 06802 SPEECH THERAPY ST. JOHN		0. 23485		0	68. 02
69. 00 06900 ELECTROCARDI OLOGY		0. 12765		195, 469	
71 ON O7100 MEDICAL SUPPLIES CHARGED TO PATIENT	l l	0 27623	21 8 275 520	2 285 872	. /1 ()∩

Health Financial Systems	FRANCISCAN HEALTH CROWN POINT	In Li	eu of Form CMS-2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der CCN: 15-0126	Peri od:	Worksheet D-3

Heal th Financial Systems Franciscan Health	CROWN POINT		III LIE	u or Form CWS	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0126	Peri od: From 01/01/2021	Worksheet D-3	
			To 12/31/2021	Date/Time Pre	
	T: 41	- VIV	11: 4-1	5/30/2022 5: 4	1 pm
Cost Center Description	11 11	e XIX Ratio of Cost	Hospi tal I npati ent	Cost Inpatient	
cost center bescription		To Charges	Program	Program Costs	
		l .o onal goo		(col. 1 x col.	
			ű	2)	
		1. 00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		1		I	
30. 00 03000 ADULTS & PEDI ATRI CS			3, 382, 871		30.00
31.00 03100 INTENSIVE CARE UNIT 35.00 02060 NEONATAL INTENSIVE CARE UNIT			2, 246, 179		31. 00 35. 00
43. 00 04300 NURSERY		•	5, 741, 241 903, 785		43. 00
ANCI LLARY SERVI CE COST CENTERS			703, 703		1 43.00
50. 00 05000 OPERATING ROOM		0. 20900	4 3, 725, 010	778, 542	50.00
51. 00 05100 RECOVERY ROOM		0. 21625	5 689, 833	149, 180	51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 23459	6 1, 380, 169	323, 782	52. 00
53. 00 05300 ANESTHESI OLOGY		0. 03597			
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 11430		385, 693	
54. 01 05401 RADI OLOGY - 1-65		0. 08225		0	54. 01
54. 02 05402 RADI OLOGY DI AGNOSTI C - SJ 54. 03 05403 LOWELL RADI OLOGY		0. 00000 0. 16499		0	54. 02 54. 03
55. 00 05500 RADI OLOGY-THERAPEUTI C		0. 10444		0	55. 00
55. 01 O5501 CARDI AC CATHERI ZATON LAB		0. 13846		0	55. 01
55. 02 03140 CARDI OLOGY		0. 18074		168, 601	
55. 03 03450 NEURO-DI AGNOSTI CS		0. 15677		14, 062	1
60. 00 06000 LABORATORY		0. 12342	8 5, 669, 987	699, 835	60.00
60. 01 06001 BL00D LABORATORY		0.00000	0 0	0	60. 01
65. 00 06500 RESPI RATORY THERAPY		0. 18937			1
66. 00 06600 PHYSI CAL THERAPY		0. 73979		l	1
66. 01 06601 PHYSI CAL THERAPY 1-65		0. 48605		0	66. 01 66. 02
66. 02 06602 PHYSI CAL THERAPY ST JOHN 67. 00 06700 OCCUPATI ONAL THERAPY		0. 33921 0. 19539		0 23, 157	
67. 01 06701 0CCUPATION THERAPY -65		0. 19339		23, 137	67. 00
67. 02 06702 OCCUPATI ONAL THERAPY ST. JOHN		0. 29546		Ö	67. 02
68. 00 06800 SPEECH PATHOLOGY		0. 18282		77, 207	1
68. 01 06801 SPEECH PATHOLOGY I -65		0. 28933	0 0	0	68. 01
68.02 06802 SPEECH THERAPY ST. JOHN		0. 23485	0 0	0	68. 02
69. 00 06900 ELECTROCARDI OLOGY		0. 12765			
71. 00 O7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 27622		625, 950	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 49763		1 070 515	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 74. 00 07400 RENAL DIALYSIS		0. 26512 0. 56431		1, 070, 515 29, 802	
74. 00 07400 RENAL DI ALTSI 3 76. 00 03020 RADI ATI ON ONCOLOGY		0. 30431		344	ı
76. 01 03040 ANGI OCARDI OGRAPHY		0. 47880		i e	ı
OUTPATIENT SERVICE COST CENTERS			·,		
90. 00 09000 CLI NI C		0.00000	0 0	0	90.00
90. 01 09001 DI ABETES CLI NI C		2. 43824	2 0	0	90. 01
90. 02 09002 0UTPATI ENT CLI NI CS		0. 00000			90. 02
90. 03 09003 OCCUPATI ONAL MEDI CI NE CLI NI C		0.00000		l	
90. 04 09004 NEONATOLOGY CLINI C-FRANCI SCAN POINT 90. 05 09005 LACTATI ON CLINI C		0.70252		0	1
90. 05 09005 LACTATI ON CLI NI C 91. 00 09100 EMERGENCY		1. 89952 0. 12039		0 337, 037	1
91. 01 09101 EMERGENCY ROOM PHYSI CANS		0. 12039		337,037	1
91. 02 09102 EXPRESS CARE		0.00000		0	1
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 76155		203, 383	
Total (sum of lines 50 through 94 and 96 through 98)			28, 137, 255		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)			28, 137, 255		202. 00

Health Financial Systems	FRANCISCAN HEALTH CROWN POINT	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0126		Worksheet E Part A Date/Time Prepared: 5/30/2022 5:41 pm
	T		222

			10 12/31/2021	5/30/2022 5: 4	
		Title XVIII	Hospi tal	PPS	
				1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS			1. 00	
1.00	DRG Amounts Other than Outlier Payments			0	1. 00
1. 01	DRG amounts other than outlier payments for discharges occurring prinstructions)	prior to October 1 (s	see	25, 521, 353	1. 01
1. 02	DRG amounts other than outlier payments for discharges occurring of	on or after October	l (see	8, 903, 623	1. 02
1.03	<pre>instructions) DRG for federal specific operating payment for Model 4 BPCI for di</pre>	ischarges occurring	orior to October	0	1. 03
1. 04	1 (see instructions) DRG for federal specific operating payment for Model 4 BPCI for di	ischarges occurring (on or after	0	1. 04
2. 00	October 1 (see instructions) Outlier payments for discharges. (see instructions)				2. 00
2. 01	Outlier reconciliation amount			0	2. 01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions))		0	2. 02
2.03	Outlier payments for discharges occurring prior to October 1 (see	instructions)		1, 545, 827	2. 03
2.04	Outlier payments for discharges occurring on or after October 1 (s	see instructions)		407, 566	2. 04
3.00	Managed Care Simulated Payments			16, 736, 798	3. 00
4.00	Bed days available divided by number of days in the cost reporting	g period (see instru	ctions)	178. 93	4. 00
5.00	Indirect Medical Education Adjustment FTE count for allopathic and osteopathic programs for the most rec	cent cost reporting	period ending on	2. 08	5. 00
	or before 12/31/1996. (see instructions)				
6. 00	FTE count for allopathic and osteopathic programs that meet the conew programs in accordance with 42 CFR 413.79(e)	riteria for an add-o	n to the cap for	0. 00	6. 00
7.00	MMA Section 422 reduction amount to the IME cap as specified under			0. 43	7. 00
7. 01	ACA § 5503 reduction amount to the IME cap as specified under 42 (cost report straddles July 1, 2011 then see instructions.	CFR §412.105(f)(1)(i	/)(B)(2) If the	0. 00	7. 01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic			0. 00	8. 00
	affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c))(2)(iv), 64 FR 26340) (May 12,		
8. 01	1998), and 67 FR 50069 (August 1, 2002). The amount of increase if the hospital was awarded FTE cap slots u	under § 5503 of the A	ACA. If the cost	0.00	8. 01
8. 02	report straddles July 1, 2011, see instructions. The amount of increase if the hospital was awarded FTE cap slots 1	from a closed teachi	ng hospital	0. 00	8. 02
0.00	under § 5506 of ACA. (see instructions)			1 / 5	0.00
9. 00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8 instructions)			1. 65	9. 00
10.00	FTE count for allopathic and osteopathic programs in the current y	year from your record	ds	0. 98	
11.00	FTE count for residents in dental and podiatric programs.				11.00
12. 00 13. 00	Current year allowable FTE (see instructions)			0. 98 0. 96	
14. 00	Total allowable FTE count for the prior year. Total allowable FTE count for the penultimate year if that year en	nded on or after Sen	tombor 20 1007	1. 98	14. 00
14.00	otherwise enter zero.	nded on or arter sep	Leiliber 30, 1997,	1. 70	14.00
15. 00	Sum of lines 12 through 14 divided by 3.			1. 31	15. 00
16. 00	Adjustment for residents in initial years of the program				16. 00
17.00	Adjustment for residents displaced by program or hospital closure			0.00	17. 00
18. 00	Adjusted rolling average FTE count			1. 31	
19. 00	Current year resident to bed ratio (line 18 divided by line 4).			0. 007321	
20. 00	Prior year resident to bed ratio (see instructions)			0. 004458	
21. 00	Enter the lesser of lines 19 or 20 (see instructions)			0. 004458	
22. 00 22. 01	IME payment adjustment (see instructions) IME payment adjustment - Managed Care (see instructions)			83, 790 40, 737	
22.01	Indirect Medical Education Adjustment for the Add-on for § 422 of	the MMA		40, 737	22.01
23. 00	Number of additional allopathic and osteopathic IME FTE resident of		FR 412. 105	0.00	23. 00
24. 00	<pre>(f)(1)(iv)(C). IME FTE Resident Count Over Cap (see instructions)</pre>			-0. 67	24. 00
25. 00	If the amount on line 24 is greater than -0-, then enter the lower	r of line 23 or line	24 (See	0.00	
23.00	instructions)	1 01 11110 23 01 11110	24 (300	0.00	25.00
26. 00	Resident to bed ratio (divide line 25 by line 4)			0.000000	26. 00
27.00	IME payments adjustment factor. (see instructions)			0.000000	27. 00
28. 00	IME add-on adjustment amount (see instructions)			0	28. 00
28. 01	IME add-on adjustment amount - Managed Care (see instructions)			0	28. 01
29. 00	Total IME payment (sum of lines 22 and 28)			83, 790	29. 00
29. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment			40, 737	29. 01
30. 00	Percentage of SSI recipient patient days to Medicare Part A patier	nt days (see instruc	tions)	1. 62	30.00
31. 00	Percentage of Medicaid patient days (see instructions)	J (<i>'</i>	16. 74	•
32.00	Sum of lines 30 and 31			18. 36	
33. 00	Allowable disproportionate share percentage (see instructions)				33. 00
34. 00	Disproportionate share adjustment (see instructions)			402, 773	34.00

	,	TH CROWN POINT		u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0126	Peri od: From 01/01/2021 To 12/31/2021	Worksheet E Part A Date/Time Pre	
		Title XVIII	Hospi tal	5/30/2022 5: 4° PPS	ı pm
		11 21 3 71111	Prior to 10/1		
			1. 00	2. 00	
05 00	Uncompensated Care Adjustment		0.000.044.504	7 400 000 740	05.00
35. 00 35. 01	Total uncompensated care amount (see instructions) Factor 3 (see instructions)		0. 000385265	7, 192, 008, 710 0. 000351941	35.00
35. 02	1	iter zero on this line) (s		2, 531, 163	
35. 03 36. 00	Total uncompensated care (sum of columns 1 and 2 on line 35	i. 03)	2, 388, 826 3, 026, 818		35. 03 36. 00
	Additional payment for high percentage of ESRD beneficiary	discharges (lines 40 thro	<u> </u>		
40.00	Total Medicare discharges (see instructions)		0		40.00
41. 00 41. 01	Total ESRD Medicare discharges (see instructions) Total ESRD Medicare covered and paid discharges (see instru	uctions)	0		41. 00 41. 01
42. 00	Divide line 41 by line 40 (if less than 10%, you do not qua		0.00		42.00
43. 00	Total Medicare ESRD inpatient days (see instructions)	irry for adjustment)	0.00		43. 00
44. 00	Ratio of average length of stay to one week (line 43 divide days)	ed by line 41 divided by 7	0. 000000		44. 00
45.00	Average weekly cost for dialysis treatments (see instruction	ons)	0.00		45. 00
46. 00	Total additional payment (line 45 times line 44 times line	41. 01)	0		46. 00
47. 00	Subtotal (see instructions)		39, 891, 750		47. 00
48. 00	Hospital specific payments (to be completed by SCH and MDH, only. (see instructions)	small rural nospitals	0		48. 00
	John y. (See Tristructrons)			Amount	
				1. 00	
49. 00	Total payment for inpatient operating costs (see instruction	ons)		39, 932, 487	49. 00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I)	2, 824, 556	
51.00	Exception payment for inpatient program capital (Wkst. L, P			0	
52. 00 53. 00	Direct graduate medical education payment (from Wkst. E-4, Nursing and Allied Health Managed Care payment	line 49 see instructions)	•	46, 585 79, 525	
54. 00	Special add-on payments for new technologies			487, 301	1
54. 01	Islet isolation add-on payment			0	1
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line	: 69)		0	
56.00	Cost of physicians' services in a teaching hospital (see in	itructi ons)		0	56. 00
57.00	Routine service other pass through costs (from Wkst. D, Pt.		through 35).	0	57. 00
58. 00	Ancillary service other pass through costs from Wkst. D, Pt	. IV, col. 11 line 200)		71, 011	1
59.00	Total (sum of amounts on lines 49 through 58)			43, 441, 465	1
60. 00 61. 00	Primary payer payments Total amount payable for program beneficiaries (line 59 min	us line 60)		7, 497 43, 433, 968	1
62. 00	Deductibles billed to program beneficiaries	ids Title 00)		3, 103, 772	1
63. 00	Coinsurance billed to program beneficiaries			119, 967	
64.00	Allowable bad debts (see instructions)			221, 457	
65.00	Adjusted reimbursable bad debts (see instructions)			143, 947	65. 00
66.00	Allowable bad debts for dual eligible beneficiaries (see in	structions)		28, 841	1
67. 00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			40, 354, 176	1
68. 00	· '			0	
69. 00 70. 00	Outlier payments reconciliation (sum of lines 93, 95 and 96 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)), (FUL SCH See FIISTRUCTIO	115)	0	69. 00 70. 00
70. 50	Rural Community Hospital Demonstration Project (§410A Demon	stration) adjustment (see	instructions)	0	
70. 87	Demonstration payment adjustment amount before sequestration	, ,		0	1
70. 88	SCH or MDH volume decrease adjustment (contractor use only)			0	1
70. 89	Pioneer ACO demonstration payment adjustment amount (see in				70. 89
70. 90	HSP bonus payment HVBP adjustment amount (see instructions)			0	
70. 91	HSP bonus payment HRR adjustment amount (see instructions)			0	
70. 92 70. 93				0 -89, 812	
10.73	HVBP payment adjustment amount (see instructions)				
70. 94	HRR adjustment amount (see instructions)			-239, 377	1 /() 92

	Financial Systems FRANCISCAN HEALTH			In Lie	u of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider C	CN: 15-0126	Peri od: From 01/01/2021 To 12/31/2021	Worksheet E Part A Date/Time Pre 5/30/2022 5:4	
		Ti tl e	e XVIII	Hospi tal	PPS	т ріп
		11 (1)		(уууу)	Amount	
				0	1. 00	
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter i	n column 0		0	0	70. 90
	the corresponding federal year for the period prior to 10/1)					
70. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter i			0	0	70. 9
	the corresponding federal year for the period ending on or af	ter 10/1)				
70. 98	Low Volume Payment-3				0	1
70. 99	HAC adjustment amount (see instructions)				0	1
71. 00	Amount due provider (line 67 minus lines 68 plus/minus lines	69 & 70)			40, 024, 987	1
	Sequestration adjustment (see instructions)				0	1 /
71. 02	Demonstration payment adjustment amount after sequestration				0	
	Sequestration adjustment-PARHM pass-throughs					71.0
	Interim payments				39, 754, 117	
	Interim payments-PARHM					72.0
	Tentative settlement (for contractor use only)				0	
73. 01	Tentative settlement-PARHM (for contractor use only)	2 72			270 070	73.0
74. 00	Balance due provider/program (line 71 minus lines 71.01, 71.0.73)	2, 72, and			270, 870	74. 0
74. 01	Balance due provider/program-PARHM (see instructions)					74. 0
75. 00	Protested amounts (nonallowable cost report items) in accorda	nce with			654, 593	
73.00	CMS Pub. 15-2, chapter 1, §115.2	ince with			034, 373	73.0
	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	90.0
	plus 2.04 (see instructions)					
91. 00	Capital outlier from Wkst. L, Pt. I, line 2				0	91.0
92. 00	Operating outlier reconciliation adjustment amount (see instr	ucti ons)			0	92.0
93. 00	Capital outlier reconciliation adjustment amount (see instruc	tions)			0	93.0
94. 00	The rate used to calculate the time value of money (see instr	ucti ons)			0.00	94.0
95. 00	Time value of money for operating expenses (see instructions)				0	1 ,0.0
96. 00	Time value of money for capital related expenses (see instruc	tions)			0	96. 0
				Prior to 10/1		
	LICE B B A A A			1. 00	2. 00	
100 00	HSP Bonus Payment Amount					100 0
100.00	HSP bonus amount (see instructions)			0	0	100. 00
101 00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions)			0. 000000000	0. 0000000000	101 0
	HVBP adjustment amount for HSP bonus payment (see instruction	e)		0.000000000		102.00
102.00	HRR Adjustment for HSP Bonus Payment (see First detroit	3)		U	0	102.0
103 00	HRR adjustment factor (see instructions)			0.0000	0.0000	103 0
	HRR adjustment amount for HSP bonus payment (see instructions)		0.0000		104. 0
54.00	Rural Community Hospital Demonstration Project (§410A Demonstr		ıstment			1.07.0
200 00	Is this the first year of the current 5-year demonstration pe					200. 0
0.00	Century Cures Act? Enter "Y" for yes or "N" for no.		2.00			-00.0
	Cost Doi moursoment					1

Health Financial Systems	FRANCISCAN HEALTH CROWN POINT	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0126		Worksheet E Part B Date/Time Prepared: 5/30/2022 5:41 pm

Description		Ti tl e	XVIII	Hospi tal	5/30/2022 5: 4 PPS	1 pm
Mox B - MOX Dec Mox Dec Mox Dec				noop: ta:		
		DART R. MEDICAL AND OTHER HEALTH CERVILORS			1. 00	
Medical and other services relabursed under DPPS (see Instructions) 20, 398, 186 2.00 OPPS pagments 50, 1971, 191 3.00 OPPS pagments 50, 1971, 191 3.00 OPPS pagments 50, 1971, 191 3.00 0.00 5.00 6	1 00				2 055	1 1 00
1.5 1.0 1.5		· · · · · · · · · · · · · · · · · · ·				
0.000 Comparison 0.000						
Inster the hospit hal specific payment to cost ratio (see instructions) 0.00 0.0	4.00	Outlier payment (see instructions)			48, 082	4. 00
Line 2 times line 5						
2.00 Amounts That soul of Fines 3 4, and 4.01, divided by line 6 0.00 7						1
1.00 Comparison Compariso						1
						1
1.00 Total cost (sum of lines 1 and 10) (see instructions) 2,085 1.00		, , , , , , , , , , , , , , , , , , , ,	line 200			1
COMPUTATION OF LISSER OF LOST OR CHARGES	10.00	Organ acqui si ti ons			0	10.00
Reasonable charges	11. 00				2, 055	11. 00
2.00 Ancil lary service charges 7,750 12.00 13.00 Organ acquisition charges (from West. D4, Pt. III, col. 4, line 69) 7,750 14.00 1011 reasonable charges (sum of lines 12 and 13) 7,750 14.00 15.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis 0 16.00 1						
3.00 Organ acquisition charges (from Wist. D-4, Pt. III., col. 4, line 69)	12 00				7 750	12 00
1.00 Total reasonable chargés (sum of lines 12 and 13) 7.750 14.00						1
15.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis 0 15.00						ł
16.00 Amounts that would have been real ized from patients liable for payment for services on a chargebasis 0 16.00 had south payment been made in accordance with 42 CFR \$413.13(e) 0.000000 17.00 0.000000 17.00 0.000000 17.00 0.000000 17.00 0.000000 17.00 0.000000 17.00 0.000000 17.00 0.000000 0.000000 0.00000 0.000000 0.000000 0.00000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.0000000 0.00000000						
had such payment been made in accordance with 42 CFR §413.13(e) 0.000000 17.00						ı
17.00 Ratio of line 1s to line 16 (not to exceed 1.000000) 17.00 17.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00 18.00 17.00 18.00	16.00		services of	n a chargebasis	0	16.00
18. 00 Total customary charges (see instructions) 7,750 18. 00 19	17 00				0 000000	17 00
19. 00 Excess of customary Charges over reasonable cost (complete only if line 18 exceeds line 11) (see 19. 00		· · · · · · · · · · · · · · · · · · ·				ł
20.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see 0 20.00	19. 00		exceeds li	ne 11) (see		1
Instructions 2,055 21.00						
21.00 Lesser of cost or charges (see instructions) 2.055 21.00	20. 00		exceeds li	ne 18) (see	0	20.00
22.00 Interns and residents (see instructions) 0 22.00 23.00 23.00 Cost of physicians' services in a teaching hospital (see instructions) 16.083.260 24.00 25.00	21 00				2 055	21 00
24.00 Total prospective payment (sum of lines 3, 4, 4, 01, 8 and 9) 10,083,260 24.00 25.00 Deductibles and coinsurance amounts (for CAH, see instructions) 136,373 25.00 26.00 Deductibles and coinsurance amounts (For CAH, see instructions) 2,692,976 26.00 27.00 Subtotal ((lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see linstructions) 17,753 28.00 29.00 ESRD direct medical education payments (From Wkst. E-4, line 50) 17,753 28.00 29.00 ESRD direct medical education costs (From Wkst. E-4, line 50) 13,273,719 30.00 30.00 Subtotal (sum of lines 27 through 29) 13,273,719 30.00 31.00 Primary payer payments 1,514 31.00 31.00 7.00		g ,				
COMPUTATION OF REINBURSEMENT SETTLEMENT 136, 373 25. 00					-	
25.00 Deductible sand coinsurance amounts (For CAH, see instructions) 136,373 25.00	24. 00				16, 083, 260	24. 00
26.00 Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions) 2, 692,976 26.00	25.00				127 272	1 25 00
27.00 Subtotal [(I ines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see 13, 255, 966 27.00			l see instr	uctions)		
28.00 Direct graduate medical education payments (from Wkst. E-4, line 50) 17, 753 28.00 29.00 25RD direct medical education costs (from Wkst. E-4, line 36) 0.99.00 30.00 3		· ·				
29.00 ESRO direct medical education costs (from Wkst. E-4, line 36) 29.00 30.0				2 (
30. 00 Subtotal (sum of lines 27 through 29) 13,273,719 30. 00 Primary payer payments 1,514 31. 00 31. 00 Subtotal (line 30 minus line 31) 1,514 31. 00 32. 00 Subtotal (line 30 minus line 31) 3,272,205 32. 00 Composite rate ESRD (From West. I -5, line 11) 0 33. 00 33. 00 All lowable bad debts (see instructions) 179, 263 34. 00 35. 00 All lowable bad debts (see instructions) 116, 521 35. 00 37. 00 38. 00 All lowable bad debts for dual eligible beneficiaries (see instructions) 111, 362 36. 00 37. 00 Subtotal (see instructions) 111, 362 37. 00 38. 00 MSP-LCC reconciliation amount from PS&R 13, 388, 726 37. 00 39. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39. 50 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39. 50 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39. 97 39. 98 Partial or full credits received from manufacturers for replaced devices (see instructions) 39. 98 99. 90 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) 13, 388, 784 40. 00 40. 01 Sequestration and justment (see instructions) 13, 388, 784 40. 00 40. 02 40. 03 40. 02 40. 03 40. 02 40. 03 40. 02 40. 03 4						
31.00 Primary payer payments 1,514 31.00 Subtotal (line 30 minus line 31) 13.272.205 32.00 ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) 33.00 Composite rate ESRD (from Wkst. I -5, line 11) 179.263 34.00 35.00 Adjusted reimbursable bad debts (see instructions) 179.263 34.00 35.00 Adjusted reimbursable bad debts (see instructions) 116.521 35.00 36.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 111.362 36.00 37.00 Subtotal (see instructions) 13.388, 726 37.00 38.00 MSP-LCC reconciliation amount from PS&R -58 38.00 MSP-LCC reconciliation amount from PS&R -58 38.00 MSP-LCC reconciliation amount from PS&R -58 38.00 99.00 Demonstration payment adjustment (see instructions) 39.50 99.90 Pioneer ACO demonstration payment adjustment (see instructions) 39.97 99.90 Private of the payment adjustment amount before sequestration 39.97 99.90 RECOVERY OF ACCELERATED DEPRECIATION 0.39.99 RECOVERY OF ACCELERATED DEPRECIATION 0.39.90 0.30		,				1
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34. 00						
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36. 00		· · · · · · · · · · · · · · · · · · ·				
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39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39.00 39.00 39.50 50.00 50.		,				
39.50 Pioneer ACO demonstration payment adjustment (see instructions) 39.50	38. 00	MSP-LCC reconciliation amount from PS&R			-58	38. 00
39. 97 Demonstration payment adjustment amount before sequestration 39. 97 Partial or full credits received from manufacturers for replaced devices (see instructions) 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 40. 00 Subtotal (see instructions) 40. 01 Sequestration adjustment (see instructions) 40. 02 Demonstration payment adjustment amount after sequestration 40. 03 Sequestration adjustment amount after sequestration 40. 03 Sequestration adjustment amount after sequestration 40. 03 Interim payments 40. 03 Interim payments 41. 01 Interim payments 42. 00 Tentative settlement (for contractors use only) 42. 01 Tentative settlement (for contractor use only) 43. 00 Bal ance due provider/program (see instructions) 44. 00 Bal ance due provider/program (see instructions) 44. 00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 044. 00 Protested amounts (see instructions) 40. 00 Outlier reconciliation adjustment amount (see instructions) 40. 02 Outlier reconciliation adjustment amount (see instructions) 40. 03 Outlier reconciliation adjustment amount (s					0	
Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39.98 39.99 RECOVERY OF ACCELERATED DEPRECIATION 0 39.99 40.00 Subtotal (see instructions) 13,388,784 40.00 40.01 40.02 Demonstration payment adjustment amount after sequestration 0 40.02 40.03 Sequestration adjustment-PARHM pass-throughs 41.00 Interim payments 41.00 Interim payments 41.00 Tentative settlement (for contractors use only) 42.01 Tentative settlement (for contractor use only) 42.01 Tentative settlement (for contractor use only) 42.01 43.00 Bal ance due provider/program (see instructions) 43.01 Bal ance due provider/program (see instructions) 43.01 44.00 Fortested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 15.2 To BE COMPLETED BY CONTRACTOR 90.00 Outlier amount (see instructions) 0 90.00 91.00 Outlier reconciliation adjustment amount (see instructions) 0 92.00 The rate used to calculate the Time Value of Money (see instructions) 0 93.00 93.00 Time Value of Money (see instructions) 0 93.00 9		i i i i i i i i i i i i i i i i i i i				
39. 99 40. 00 Subtotal (see instructions) 40. 01 Sequestration adj ustment (see instructions) 40. 02 Demonstration payment adj ustment amount after sequestration 40. 03 Sequestration adj ustment -PARHM pass-throughs 41. 00 Interim payments Interim payments Interim payments-PARHM 42. 00 Tentative settlement (for contractors use only) 42. 01 Tentative settlement -PARHM (for contractor use only) 43. 00 Balance due provider/program (see instructions) 43. 01 Balance due provider/program-PARHM (see instructions) 43. 01 Tentative settlement (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, S115. 2 TO BE COMPLETED BY CONTRACTOR 90. 00 Q1. 01 Q1. 01 The rate used to calculate the Time Value of Money Q2. 00 Time Value of Money (see instructions) Q3. 99 Q4. 00 Q4. 00 Q4. 01 Q4. 00 Q4. 02 Q4. 00 Q4. 00 Q4. 01 Q4. 00 Q4. 00 Q4. 01 Q4. 00 Q4.			eoo instruc	tions)		•
40.00 Subtotal (see instructions) 13, 388, 784 40.00 40.01 Sequestration adjustment (see instructions) 0 40.01 40.02 Demonstration payment adjustment amount after sequestration 0 40.02 40.03 Sequestration adjustment-PARHM pass-throughs 13, 498, 876 41.00 41.01 Interim payments 13, 498, 876 41.00 41.01 Interim payments-PARHM 41.01 42.00 Tentative settlement (for contractors use only) 0 42.00 42.01 Tentative settlement-PARHM (for contractor use only) 42.01 43.01 Balance due provider/program (see instructions) -110,092 43.00 43.01 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 43.01 44.00 S115.2 0 44.00 TO BE COMPLETED BY CONTRACTOR 0 44.00 90.00 Outlier reconciliation adjustment amount (see instructions) 0 90.00 92.00 The rate used to calculate the Time Value of Money 0.00 92.00 71 me Value of Money (see instructions) 0 93.00			see mstruc	tions)		•
40.01 Sequestration adjustment (see instructions) 40.02 Demonstration payment adjustment amount after sequestration Sequestration adjustment-PARHM pass-throughs 1.00 Interim payments Interim payments-PARHM 1.01 Interim payments-PARHM 1.02 Tentative settlement (for contractors use only) 1.03 Tentative settlement-PARHM (for contractor use only) 1.04 Sequestration adjustment-PARHM 1.05 Tentative settlement (for contractors use only) 1.06 Tentative settlement-PARHM (for contractor use only) 1.07 Tentative settlement-PARHM (see instructions) 1.08 Bal ance due provider/program (see instructions) 1.09 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 (since instructions) 1.00 Outlier reconciliation adjustment amount (see instructions) 1.00 Outlier reconciliation adjustment amount (see instructions) 1.00 The rate used to calculate the Time Value of Money 1.01 Time Value of Money (see instructions) 1.02 Outlier reconciliation adjustment amount (see instructions) 1.03 Outlier reconciliation adjustment amount (see instructions) 1.04 Outlier reconciliation adjustment amount (see instructions) 1.00 Outlier reconciliation adjustment amount (see instructions) 1.01 Outlier reconciliation adjustment amount (see instructions) 1.02 Outlier reconciliation adjustment amount (see instructions) 1.03 Outlier reconciliation adjustment amount (see instructions) 1.04 Outlier reconciliation adjustment amount (see instructions) 1.02 Outlier reconciliation adjustment amount (see instructions) 1.03 Outlier reconciliation adjustment amount (see instructions) 1.04 Outlier reconciliation adjustment amount (see instructions) 1.00 Outlier reconciliation adjustment amount (see instructions) 1.01 Outlier reconciliation adjustment amount (see instructions) 1.01 Outlier reconciliation adjustment amount (see instructions)						1
40.03 Sequestration adjustment-PARHM pass-throughs 40.03 41.00 Interim payments 13,498,876 41.00 41.01 Interim payments-PARHM 41.01 42.00 Tentative settlement (for contractor use only) 42.01 43.00 Bal ance due provider/program (see instructions) 43.00 43.01 Bal ance 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 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 Original outlier amount (see instructions) 0 90.00 44.00 Outlier reconciliation adjustment amount (see instructions) 0 91.00 45.00 The rate used to calculate the Time Value of Money 0.00 46.01 47.02 43.03 47.02 47.03 44.03 48.03 49.04 49.04 49.04 49.05 49.05 49.05 49.05 49.05 49.06 49.06 49.06 49.07 49.07 49.07 49.08 49.08 49.08 49.09 49.08 49.00 49.08 49.08 49.00 49.08 49	40. 01	Sequestration adjustment (see instructions)			0	40. 01
11.00					0	•
41.01 Interim payments-PARHM					40 400 07/	•
42.00 Tentative settlement (for contractors use only) 42.01 Tentative settlement-PARHM (for contractor use only) 43.00 Balance due provider/program (see instructions) 43.01 Balance due provider/program-PARHM (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2 70 BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 94.00 Value of Money (see instructions) 95.00 Value of Money (see instructions) 96.00 Value of Money (see instructions) 97.00 Value of Money (see instructions) 98.00 Value of Money (see instructions) 99.00 Value of Money (see instructions)					13, 498, 876	1
42.01 Tentative settlement-PARHM (for contractor use only) 43.00 Balance due provider/program (see instructions) 43.01 Balance due provider/program-PARHM (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 94.00 Time Value of Money (see instructions) 95.00 Time Value of Money (see instructions) 96.00 Time Value of Money (see instructions) 97.00 Time Value of Money (see instructions)					0	1
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44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 \$\frac{\f	43.00	Balance due provider/program (see instructions)			-110, 092	43. 00
\$115.2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0 93.00						
TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 90.00 93.00	44. 00		Pub. 15-2,	chapter 1,	0	44. 00
90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0 90.00 91.00 92.00 93.00						
91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0 91.00 92.00 93.00 0 93.00	90. 00				n	90.00
93.00 Time Value of Money (see instructions) 0 93.00		, ,				•
94. 00 10tai (Suiii 01 11fies 91 and 93) 0 94. 00		,				
	94.00	Tiotai (Suiii Oi Tities 41 and 43)			0	J 94. UU

Health Financial Systems FRANCI ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Peri od: Worksheet E-1
From 01/01/2021 Part I
To 12/31/2021 Date/Time Prepared: 5/30/2022 5: 41 pm Provider CCN: 15-0126

					5/30/2022 5: 4	ı pm
		Title	XVIII	Hospi tal	PPS	
	<u> </u>	Inpatien	t Part A	Par	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		39, 754, 117		13, 498, 876	1. 00
2.00	Interim payments payable on individual bills, either		07,701,117		0	2. 00
2.00	submitted or to be submitted to the contractor for			,	ا	2.00
	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	3. 01
3. 02					l ol	3. 02
3. 03						3. 02
3. 04			(0	3. 04
3.05			()	0	3. 05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		(0	3. 50
3. 51			()	0	3. 51
3.52			(0	3. 52
3.53					l ol	3. 53
3. 54			(اه	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines				ام	3. 99
3. 77	3. 50-3. 98)				Ĭ	5. 77
4. 00	Total interim payments (sum of lines 1, 2, and 3.99)		39, 754, 117	,	13, 498, 876	4. 00
4.00	(transfer to Wkst. E or Wkst. E-3, line and column as		37, 734, 117		13, 470, 670	4.00
	appropri ate)					
F 00	TO BE COMPLETED BY CONTRACTOR					F 00
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	5. 01
5.02			()	0	5. 02
5.03			(0	5. 03
	Provider to Program					
5.50	TENTATI VE TO PROGRAM		()	0	5. 50
5. 51					l ol	5. 51
5. 52					0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines				0	5. 99
3. 77	5. 50-5. 98)			'	١	J. 77
4 00						4 00
6. 00	Determined net settlement amount (balance due) based on					6. 00
. 01	the cost report. (1)		070 07			,
6. 01	SETTLEMENT TO PROVIDER		270, 870	ין	0	6. 01
6.02	SETTLEMENT TO PROGRAM		()	110, 092	6. 02
7.00	Total Medicare program liability (see instructions)		40, 024, 987	'	13, 388, 784	7. 00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
		()	1. 00	2.00	
8. 00	Name of Contractor					8. 00
		1		1		

Heal th	Financial Systems FRANCISCAN HEALTH	CROWN POINT	In Lie	u of Form CMS-	2552-10
	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provi der CCN: 15-0126	Peri od: From 01/01/2021 To 12/31/2021	Worksheet E-1 Part II Date/Time Pre 5/30/2022 5:4	pared:
		Title XVIII	Hospi tal	PPS	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				1
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst.				1.00
2. 00	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, and	8 through 12, and plus f	or cost		2. 00
2 00	reporting periods beginning on or after 10/01/2013, line 32)				2 00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	1 0 +			3.00
4. 00	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines	i, and 8 through 12, and	prus for cost		4. 00
5. 00	reporting periods beginning on or after 10/01/2013, line 32) 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	ino 20			6.00
7. 00	CAH only - The reasonable cost incurred for the purchase of c		Wkc+ \$ 2 D+ I		7.00
7.00	line 168	ertified Hir technology	WKS1. 3-2, Pt. 1		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
32. 00	Balance due provider (line 8 (or line 10) minus line 30 and l	ine 31) (see instruction	s)		32. 00

	Financial Systems FRANCISCAN HEALTH		ON 45 C10/		u of Form CMS-2	
	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT L EDUCATION COSTS	Provi der CO		Peri od: From 01/01/2021	Worksheet E-4	
				To 12/31/2021	Date/Time Prep 5/30/2022 5:4	
		Title	XVIII	Hospi tal	PPS	
					1. 00	
1. 00	COMPUTATION OF TOTAL DIRECT GME AMOUNT Unweighted resident FTE count for allopathic and osteopathic	programs for	cost reporti	na peri ods	0.00] 1.00
2 00	ending on or before December 31, 1996.	. 0	·		0. 00	2.00
2. 00 3. 00	Unweighted FTE resident cap add-on for new programs per 42 CF Amount of reduction to Direct GME cap under section 422 of MM		i) (see riisti	uctions)	0. 00	
3. 01	Direct GME cap reduction amount under ACA §5503 in accordance instructions for cost reporting periods straddling 7/1/2011)	with 42 CFR	§413.79 (m).	(see	0. 00	3. 01
4. 00	Adjustment (plus or minus) to the FTE cap for allopathic and		programs due	to a Medicare	1. 39	4. 00
4. 01	GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f) ACA Section 5503 increase to the Direct GME FTE Cap (see inst straddling 7/1/2011)		cost reporti	ng periods	0. 00	4. 01
4. 02	ACA Section 5506 number of additional direct GME FTE cap slot	s (see inst	ructions for	cost reporting	0.00	4. 02
5. 00	periods straddling 7/1/2011) 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	0. 95	5. 00
6. 00	Unweighted resident FTE count for allopathic and osteopathic records (see instructions)	programs for	the current	year from your	0. 98	6. 00
7. 00	Enter the lesser of line 5 or line 6		Dri mary Care	e Other	0. 95 Total	7. 00
			Primary Care 1.00	2.00	3. 00	
8. 00	Weighted FTE count for physicians in an allopathic and osteop program for the current year.	athi c	0.0	0. 98	0. 98	8. 00
9. 00	If line 6 is less than 5 enter the amount from line 8, otherw multiply line 8 times the result of line 5 divided by the amo		0.0	0. 95	0. 95	9. 00
10. 00	6. Weighted dental and podiatric resident FTE count for the curr	ent vear		0.00	-	10.00
10. 01	Unweighted dental and podiatric resident FTE count for the cu	rrent year		0.00		10. 01
11. 00 12. 00	Total weighted FTE count Total weighted resident FTE count for the prior cost reportin instructions)	g year (see	0. C 0. C			11. 00 12. 00
13. 00	Total weighted resident FTE count for the penultimate cost re year (see instructions)		O. C	1. 91		13.00
14. 00 15. 00	Rolling average FTE count (sum of lines 11 through 13 divided Adjustment for residents in initial years of new programs	by 3).	0. C 0. C			14. 00 15. 00
15. 01	Unweighted adjustment for residents in initial years of new p	rograms	0.0	0.00		15. 0
16. 00 16. 01	Adjustment for residents displaced by program or hospital clo Unweighted adjustment for residents displaced by program or h		0. C 0. C			16. 00 16. 01
17. 00	closure Adjusted rolling average FTE count		0. 0	1. 27		17. 00
18. 00	Per resident amount		87, 695. 6	92, 004. 57	44.04.	18.00
19.00	Approved amount for resident costs			0 116, 846	116, 846	19.00
20.00	Additional unweighted allopathic and osteopathic direct GME F	TE rocidont	can clote roo	rai yad undar 42	1. 00	20.00
20. 00	Sec. 413. 79(c)(4)	ie resident	cap siots rec	erved under 42	0.00	20.00
	Direct GME FTE unweighted resident count over cap (see instru				0. 03 0. 00	
	Allowable additional direct GME FTE Resident Count (see instr Enter the locality adjustment national average per resident a		nstructions)		0.00	
24. 00	Multiply line 22 time line 23		,		0	24.00
25. 00	Total direct GME amount (sum of lines 19 and 24)		Inpatient Par	t Managed Care	116, 846 Total	25. 00
			. A	Ŭ .		
	COMPUTATION OF PROGRAM PATIENT LOAD		1.00	2. 00	3. 00	
	Inpatient Days (see instructions) (Title XIX - see S-2 Part I 3.02, column 2)	X, line	15, 03	8, 318		26.00
27. 00	Total Inpatient Days (see instructions)		40, 28 0. 37330			27. 00 28. 00
28. 00	Ratio of inpatient days to total inpatient days Program direct GME amount		43, 62		67, 747	
29.00	i		1	1		1 20 01
29. 00 29. 01	Percent reduction for MA DGME Reduction for direct GME payments for Medicare Advantage			3, 409	3, 409	29. 01 30. 00

	Financial Systems FRANCISCAN HEALTH			u of Form CMS-2	
	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provider CCN: 15-0126	Peri od:	Worksheet E-4	
MEDI CA	AL EDUCATION COSTS		From 01/01/2021 To 12/31/2021	Date/Time Prep 5/30/2022 5:4	
		Title XVIII	Hospi tal	PPS	
				1. 00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITL EDUCATION COSTS)	E XVIII ONLY (NURSING PR	OGRAM AND PARAMED	II CAL	
32. 00	Renal dialysis direct medical education costs (from Wkst. B, and 94)	Pt. I, sum of col. 20 an	d 23, lines 74	0	32. 00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt.	I, col. 8, sum of lines	74 and 94)	1, 214, 879	33.00
34.00			, i	0.000000	
35.00	Medicare outpatient ESRD charges (see instructions)			0	35.00
36. 00	Medicare outpatient ESRD direct medical education costs (line			0	36.00
	APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII	ONLY			
	Part A Reasonable Cost				
37. 00				53, 703, 700	
38. 00	1 3			0	38. 00
	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	39. 00
	Primary payer payments (see instructions)			7, 497	
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minu	is line 40)		53, 696, 203	41.00
42.00	Part B Reasonable Cost			20, 464, 404	1 42 00
	Reasonable cost (see instructions) Primary payer payments (see instructions)			1, 514	
44. 00	,			20, 462, 890	
45. 00	Total reasonable cost (sum of lines 41 and 44)			74, 159, 093	
46. 00	,	ne 41 ÷ Line 45)		0. 724068	
	Ratio of Part B reasonable cost to total reasonable cost (lin			0. 275932	
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PA				
48.00	Total program GME payment (line 31)			64, 338	48. 00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only)	(see instructions)		46, 585	49. 00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only)	(see instructions)		17, 753	50.00

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

Provider CCN: 15-0126

| Period: | Worksheet G | From 01/01/2021 | To 12/31/2021 | Date/Time Prepared: 5/30/2022 5:41 pm |

oni y)					5/30/2022 5: 4	1 pm
		General Fund	Speci fi c	Endowment Fund	Plant Fund	
		1.00	Purpose Fund 2.00	3. 00	4.00	
	CURRENT ASSETS	1.00	2.00	3.00	4.00	
1.00	Cash on hand in banks	28, 065, 709) (0	0	1.00
2.00	Temporary investments	0)	-		
3.00	Notes recei vable	0		0	0	
4. 00 5. 00	Accounts recei vabl e Other recei vabl e	48, 105, 280			0	
6.00	Allowances for uncollectible notes and accounts receivable	-7, 853, 367			0	
7. 00	Inventory	5, 764, 721			l ő	
8.00	Prepaid expenses	0		0	0	
9.00	Other current assets	-1, 126, 548	3	0	0	9. 00
10.00	Due from other funds	0	1	0	0	1
11. 00	Total current assets (sum of lines 1-10)	72, 955, 795	5	0	0	11. 00
12 00	FIXED ASSETS Land	12 014 470	3	0	0	12 00
12. 00 13. 00	Land improvements	13, 914, 478 15, 969, 806			1	
14. 00	Accumulated depreciation	13, 707, 000	1			
15. 00	Bui I di ngs	149, 965, 160		o o	Ö	
16.00	Accumulated depreciation	-214, 481, 630	1	0	0	16. 00
17. 00	Leasehold improvements	796, 915	5 (0	0	17. 00
18. 00	Accumul ated depreciation	0) (0	0	
19.00	Fixed equipment	0		0	0	
20.00	Accumulated depreciation	0		0	0	
21. 00 22. 00	Automobiles and trucks Accumulated depreciation	0	1	0	0	
23. 00	Major movable equipment		1		0	
24. 00	Accumulated depreciation	ĺ			0	
25. 00	Mi nor equi pment depreci abl e	244, 134, 522	2	o o	Ō	
26.00	Accumulated depreciation	0) (0	0	26. 00
27. 00	HIT designated Assets	0	(0	0	
28. 00	Accumulated depreciation	0)	1	0	
29. 00	Mi nor equi pment-nondepreci abl e	0		٦	0	
30. 00	Total fixed assets (sum of lines 12-29) OTHER ASSETS	210, 299, 251		0	0	30.00
31. 00	Investments	6, 584, 720		0	0	31. 00
32. 00	Deposits on Leases	0,001,720			1	
33.00	Due from owners/officers	0		0	0	
34.00	Other assets	12, 096, 889		0	0	34.00
35. 00	Total other assets (sum of lines 31-34)	18, 681, 609		٦	0	1
36. 00	Total assets (sum of lines 11, 30, and 35)	301, 936, 655	5	0	0	36. 00
27 00	CURRENT LIABILITIES	22 000 070	,	o o		27.00
37. 00 38. 00	Accounts payable Salaries, wages, and fees payable	23, 989, 978	1		0 0	
39. 00	Payroll taxes payable	8, 240, 670	1		0	
40. 00	Notes and Loans payable (short term)	992, 804	1	o o	0	
41.00	Deferred income	0		0	0	41.00
42.00	Accel erated payments	0)			42. 00
43.00	Due to other funds	0) (0	0	
44.00	Other current liabilities	16, 670, 848	1	0	0	
45. 00	Total current liabilities (sum of lines 37 thru 44)	49, 894, 300) (0	0	45. 00
46. 00	LONG TERM LIABILITIES Mortgage payable	1		<u> </u>	0	46. 00
47. 00	Notes payable		1			
48. 00	Unsecured Loans	0			l .	1
49.00	Other long term liabilities	-8, 200, 339) (0	0	49. 00
50.00	Total long term liabilities (sum of lines 46 thru 49)	-8, 200, 339		0		
51. 00	Total liabilities (sum of lines 45 and 50) CAPITAL ACCOUNTS	41, 693, 961	(0	0	51.00
52.00	General fund balance	260, 242, 694				52. 00
53. 00	Specific purpose fund		(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 57. 00	Governing body created - endowment fund balance Plant fund balance - invested in plant		1		0	56. 00 57. 00
58. 00	Plant fund balance - reserve for plant improvement,				0	
30.00	replacement, and expansion		1			30.00
59. 00	Total fund balances (sum of lines 52 thru 58)	260, 242, 694	. (0	0	59. 00
60.00	Total liabilities and fund balances (sum of lines 51 and	301, 936, 655	5 (0	0	60. 00
	[59]	I	1		l	

Health Financial Systems FRANCISCAN HEALTH CROWN POINT In Lieu of Form CMS-2552-10
STATEMENT OF CHANGES IN FUND BALANCES
Provider CCN: 15-0126
Period: From 01/01/2021
To 12/31/2021 Date/Time Prepared:

					To 12/31/2021	Date/Time Pre 5/30/2022 5:4	
		General	Fund	Special P	urpose Fund	Endowment Fund	
		1.00	2. 00	3. 00	4. 00	5. 00	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0 0 0 0	0 49, 082, 190 49, 082, 190		0		1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17) Fund balance at end of period per balance	0 0 0 0 0	0 49, 082, 190 0 49, 082, 190		0 0 0 0 0 0 0 0 0	0 0 0 0 0	10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00
	sheet (line 11 minus line 18)	Endowment Fund	PI ant	Fund			
		4.00	7.00	0.00			
1. 00	Fund balances at beginning of period	6.00	7. 00	8. 00	0		1. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0	0 0 0 0		0		2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17)	0	0 0 0 0 0		0		10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00
19. 00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0			0		19. 00

Health Financial Systems FRASTATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-0126

		'	0 12/31/2021	5/30/2022 5: 4	
	Cost Center Description	Inpatient	Outpati ent	Total	
		1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospi tal	64, 640, 424		64, 640, 424	1.00
2.00	SUBPROVI DER - I PF				2.00
3.00	SUBPROVI DER - I RF				3. 00
4.00	SUBPROVI DER				4. 00
5.00	Swing bed - SNF)	0	5. 00
6.00	Swing bed - NF	()	0	6. 00
7.00	SKILLED NURSING FACILITY				7. 00
8.00	NURSING FACILITY				8. 00
9. 00	OTHER LONG TERM CARE				9. 00
10.00	Total general inpatient care services (sum of lines 1-9)	64, 640, 424		64, 640, 424	
	Intensive Care Type Inpatient Hospital Services	1 2., 2.2, .=		2 1/ 2 12/ 12 1	
11. 00	INTENSIVE CARE UNIT	115, 584, 418		115, 584, 418	11. 00
12. 00	CORONARY CARE UNIT			.,	12.00
13. 00	BURN INTENSIVE CARE UNIT				13. 00
14. 00	SURGI CAL INTENSI VE CARE UNI T				14. 00
15. 00	NEONATAL INTENSIVE CARE UNIT	12, 860, 498		12, 860, 498	
16. 00				128, 444, 916	
10.00	111-15)	120, 111, 710		120, 111, 710	10.00
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	193, 085, 340)	193, 085, 340	17. 00
18. 00	Ancillary services	193, 915, 158		711, 397, 222	18. 00
19. 00	Outpati ent servi ces	37, 472, 194		113, 526, 164	
20. 00	RURAL HEALTH CLINIC	37, 472, 17-		113, 320, 104	20.00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER			Ö	21. 00
22. 00	HOME HEALTH AGENCY			O	22. 00
23. 00	AMBULANCE SERVICES				23. 00
24. 00	CMHC				24. 00
25. 00	AMBULATORY SURGICAL CENTER (D. P.)				25. 00
26. 00	HOSPI CE				26. 00
27. 00	OTHER (SPECIFY)	,	0	0	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to	Wkst. 424, 472, 692	503 536 034	1, 018, 008, 726	28. 00
20.00	G-3, line 1)	7 WK31. 424, 472, 072	. 373, 330, 034	1,010,000,720	20.00
	PART II - OPERATING EXPENSES	I			
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		260, 490, 397		29. 00
30. 00	ADD (SPECIFY)		1		30.00
31. 00	(6. 26.7.1)				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)	transfer	260, 490, 397		43. 00
13.00	to Wkst. G-3, line 4)		200, 470, 377		10.00
	100	1	1		1

∐oal +b	Financial Systems FRANCISCAN HEALTH	CDOWN DOLNT	In Lie	u of Form CMS-2	0552 10
	ENT OF REVENUES AND EXPENSES	Provider CCN: 15-0126	Peri od:	Worksheet G-3	2332-10
SIAILN	ENT OF REVENUES AND EXITENSES	11 0VI del CON. 13-0120	From 01/01/2021 To 12/31/2021		
				3/30/2022 3.4	ı pili
				1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, lir	ne 28)		1, 018, 008, 726	1. 00
2.00	Less contractual allowances and discounts on patients' accour	nts		722, 467, 061	2. 00
3.00	Net patient revenues (line 1 minus line 2)			295, 541, 665	3. 00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		260, 490, 397	4. 00
5.00	Net income from service to patients (line 3 minus line 4)	•		35, 051, 268	5. 00
	OTHER INCOME				
6.00	Contributions, donations, bequests, etc			0	6. 00
7.00	Income from investments			2, 354, 544	7.00
8.00	Revenues from telephone and other miscellaneous communication	n servi ces		0	8.00
9.00	Revenue from television and radio service			0	9.00
10.00	Purchase di scounts			0	10.00
11.00	Rebates and refunds of expenses			0	11.00
12.00	Parking lot receipts			0	12.00
13.00	Revenue from Laundry and Linen service			0	13.00
14.00	Revenue from meals sold to employees and guests			0	14.00
15.00	Revenue from rental of living quarters			0	15.00
16.00	Revenue from sale of medical and surgical supplies to other t	than patients		0	16.00
17. 00	Revenue from sale of drugs to other than patients			0	17.00
18.00	Revenue from sale of medical records and abstracts			0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	20.00
21.00	Rental of vending machines			0	21.00
22. 00	Rental of hospital space			0	22. 00
23.00	Governmental appropriations			0	23.00
24.00	CAPITATION AND PREMIUM REVENUE			1, 114, 494	24.00
24. 01	OTHER OPERATING REVENUE			8, 896, 535	24. 01
24. 02	OTHER NON-OPERATING REVENUE			1, 665, 687	24. 02
24. 50	COVI D-19 PHE Fundi ng			-338	24. 50
25 00	Total other income (sum of lines 4.24)			14 020 022	25 00

14, 030, 922

49, 082, 190

0

0 28.00

49, 082, 190 29. 00

25. 00 26. 00 27. 00

25.00 Total other income (sum of lines 6-24) 26.00 Total (line 5 plus line 25) 27.00 OTHER EXPENSES (SPECIFY)

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

ALCUL	ATION OF CAPITAL PAYMENT	Provi der CCN: 15-0126	Peri od: From 01/01/2021 To 12/31/2021	Worksheet L Parts I-III Date/Time Pre	
		Title XVIII	Hospi tal	5/30/2022 5: 4 PPS	ı pm
				1. 00	
	PART I - FULLY PROSPECTIVE METHOD				1
	CAPITAL FEDERAL AMOUNT				
00	Capital DRG other than outlier			2, 629, 513	
01	Model 4 BPCI Capital DRG other than outlier			0 0 707	1.
00 01	Capital DRG outlier payments			86, 707 0	1
00	Model 4 BPCI Capital DRG outlier payments Total inpatient days divided by number of days in the cos	t reporting period (see inst	rustions)	110. 36	
00	Number of interns & residents (see instructions)	t reporting period (see ins	.ructrons)	1.31	4.
00	Indirect medical education percentage (see instructions)			0. 33	
. 00	Indirect medical education adjustment (multiply line 5 by	the sum of lines 1 and 1 0	columns 1 and	8, 677	6.
. 00	1.01) (see instructions)	the sum of fiftes f and f. o	i, corumns r and	0,077	0.
00	Percentage of SSI recipient patient days to Medicare Part 30) (see instructions)	A patient days (Worksheet E	E, part A line	1. 62	7.
00	Percentage of Medicaid patient days to total days (see in	structions)		16. 74	8.
00	Sum of lines 7 and 8	,		18. 36	9.
0. 00	Allowable disproportionate share percentage (see instruct	i ons)		3. 79	10.
1.00	Disproportionate share adjustment (see instructions)			99, 659	11
2. 00	Total prospective capital payments (see instructions)			2, 824, 556	12.
				1 00	
	PART II - PAYMENT UNDER REASONABLE COST			1. 00	
00	Program inpatient routine capital cost (see instructions)			0	1.
00	Program inpatient ancillary capital cost (see instruction			0	
00	Total inpatient program capital cost (line 1 plus line 2)			0	
00	Capital cost payment factor (see instructions)			0	
00	Total inpatient program capital cost (line 3 x line 4)			0	
				1. 00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS			1.00	
00	Program inpatient capital costs (see instructions)			0] 1
00	Program inpatient capital costs for extraordinary circums	tances (see instructions)		0	2
00	Net program inpatient capital costs (line 1 minus line 2)			0	_
00	Applicable exception percentage (see instructions)			0.00	
00	Capital cost for comparison to payments (line 3 x line 4)			0	
00	Percentage adjustment for extraordinary circumstances (se			0. 00	
00	Adjustment to capital minimum payment level for extraordi	nary circumstances (line 2)	(line 6)	0	
00	Capital minimum payment level (line 5 plus line 7)			0	
. 00	Current year capital payments (from Part I, line 12, as a Current year comparison of capital minimum payment level		1 aaa 1 i ma ()	0	
. 00	Carryover of accumulated capital minimum payment level ov			0	
. 00	Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capita	I navments (line 10 plus lir	na 11)	0	12
. 00	Current year exception payment (if line 12 is positive, e			0	
. 00	Carryover of accumulated capital minimum payment level ov			0	
. 00	(if line 12 is negative, enter the amount on this line)	er capital payment for the l	orrowing perrod		14
	TO THE 12 13 HOGGET VC, CITTED THE AMOUNT ON THIS TIME)				1 4-
5. 00	Current year allowable operating and capital payment (see	instructions)		(1)	1.5
5. 00 5. 00	Current year allowable operating and capital payment (see Current year operating and capital costs (see instruction	•		0	