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: 15-0090 Worksheet S Peri od: From 01/01/2021 Parts I-III AND SETTLEMENT SUMMARY 12/31/2021 Date/Time Prepared: 5/30/2022 7:58 pm PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 5/30/2022 7:58 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:
[12] [9] If line 5, column 1 is 4: Enter
[13] NPR Date:
[14] 12. Contractor's Vendor Code:
[15] 13. NPR Date:
[16] 13. NPR Date:
[17] 14. Contractor's Vendor Code:
[18] 15. Contractor's Vendor Code:
[18] 16. NPR Date:
[19] 17. Contractor's Vendor Code:
[19] 18. Contractor's Vendor Code:
[19] 19. Contractor's Vendor Code:
[19] Contractor use only (3) Settled with Audit number of times reopened = 0-9.

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

(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- DYER (15-0090) 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 FINANCIAL 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			3
4	Date			4

	Cost Center Description		Title	XVIII			
			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	-78, 591	-152, 023	0	0	1. 00
2.00	Subprovi der - IPF	0	0	0		0	2. 00
3.00	Subprovi der - I RF	0	-78, 652	-199		0	3. 00
4.00	SUBPROVI DER I						4. 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	-157, 243	-152, 222	0	0	200. 00
The al	pove amounts represent "due to" or "due from"	the applicable	program for th	a alament of t	he above compl	ev indicated	

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.

								10 12/31/		Date/11 5/30/20		
	1.00		2.00		3. 00)		4	1. 00			
1. 00	Hospital and Hospital Health Care Co Street: 24 JOLIET STREET	ilipi ex Adi	PO Box:									1. 00
2.00	City: DYER	-	State: IN				799 Count	ď	_			2. 00
		Com	oonent Name	CCN Number	Num	SSA ber	Provi der Type	Date Certified		nt Syst 0, or		
									V	XVIII	XIX	
	Hospital and Hospital-Based Componen	t Idonti:	1. 00	2. 00	2.00 3.00 4.00			5. 00	6. 00	7. 00	8. 00	
3.00	Hospi tal		AN HEALTH- DYER	150090	238	844	1	07/01/1966	N	Р	0	3. 00
4.00	Subprovi der - IPF	EDANOL CO	AN UEAL TU	457000	000	0.4.4	_	04 (04 (0000			_	4.00
5. 00	Subprovider - IRF	DYER -RE	AN HEALTH - HAB	15T090	238	844	5	01/01/2002	N	P	T	5. 00
6.00	Subprovider - (Other)											6. 00
7. 00 8. 00	Swing Beds - SNF Swing Beds - NF											7. 00 8. 00
9. 00	Hospi tal -Based SNF											9. 00
10.00	Hospi tal -Based NF											10. 00
11. 00 12. 00	Hospi tal -Based OLTC Hospi tal -Based HHA											11. 00 12. 00
13. 00	Separately Certified ASC											13.00
14.00	Hospi tal -Based Hospi ce											14. 00
15. 00 16. 00	Hospital Based Health Clinic - RHC		-									15. 00 16. 00
17. 00	Hospital-Based Health Clinic - FQHC Hospital-Based (CMHC) I											17. 00
18. 00	Renal Dialysis											18. 00
19. 00	Other							From:		To		19. 00
								1. 00		2. 0		
20. 00	Cost Reporting Period (mm/dd/yyyy)							01/01/20	021	12/31/	′2021	20.00
21. 00	Type of Control (see instructions)							1				21. 00
							1. 00	2. 00		3. 0	00	
22. 00	Inpatient PPS Information Does this facility qualify and is it	currentl	v receiving nav	ments for	-	Т	Y	N				22. 00
22.00	di sproporti onate share hospi tal adju						•					22.00
	§412. 106? In column 1, enter "Y" fo											
	facility subject to 42 CFR Section § hospital?) In column 2, enter "Y" fo			nament								
22. 01	Did this hospital receive interim un	compensa	ed care payment				Υ	Υ				22. 01
	cost reporting period? Enter in colu											
	the portion of the cost reporting pe Enter in column 2, "Y" for yes or "N											
	reporting period occurring on or after	er Octobe	er 1. (see instr	uctions)								
22. 02	Is this a newly merged hospital that payments to be determined at cost re						N	N				22. 02
	Enter in column 1, "Y" for yes or "N				13)							
	cost reporting period prior to Octob	er 1. En	er in column 2,	"Y" for								
	or "N" for no, for the portion of the October 1.	e cost re	eporting period	on or att	er							
22. 03	Did this hospital receive a geograph	ic reclas	sification from	urban to)		N	N		N		22. 03
	rural as a result of the OMB standard											
	adopted by CMS in FY2015? Enter in confor the portion of the cost reporting											
	in column 2, "Y" for yes or "N" for											
	reporting period occurring on or after Does this hospital contain at least				ıs							
	counted in accordance with 42 CFR 41.			•								
22. 04	yes or "N" for no.	ام حمما ما	alfication from	umban ta			N	N		N		22. 04
22. 04	Did this hospital receive a geograph rural as a result of the revised OMB						IN	IN IN		IV		22.04
	adopted by CMS in FY 2021? Enter in											
	for the portion of the cost reporting in column 2, "Y" for yes or "N" for				er							
	reporting period occurring on or after											
	Does this hospital contain at least											
	counted in accordance with 42 CFR 41. yes or "N" for no.	2. 105)?	Enter in column	ა, "Y" f	or							
23. 00	Which method is used to determine Me							3 N				23. 00
	below? In column 1, enter 1 if date if date of discharge. Is the method											
	reporting period different from the				ωsι							
	reporting period? In column 2, ente											
		popularing portion. The condition 2, content is for the second to the se										

for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.

N

N

58 00

59.00

58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.

59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.

Heal th	Financial Systems FRANCI:	SCAN HE	ALTH- DYER		In Lie	u of Form CMS-2	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA	Provider CO		eriod: rom 01/01/2021 o 12/31/2021	Worksheet S-2 Part I Date/Time Pre	
				NAHE 413.85	Worksheet A	5/30/2022 7:58 Pass-Through	
				Y/N	Li ne #	Qualification Criterion Code	
		· · · · · · · · · · · · · · · · · · ·		1. 00	2. 00	3.00	
	Are you claiming nursing and allied health education any programs that meet the criteria under 42 CFR 413. instructions) Enter "Y" for yes or "N" for no in col is "Y", are you impacted by CR 11642 (or subsequent C adjustement? Enter "Y" for yes or "N" for no in colu	85? (s umn 1. R) NAHE	see If column 1	N			60.00
	day astemente. Enter 1 101 yes of W 101 no 111 sort	Y/N	I ME	Direct GME	I ME	Direct GME	
61 00	Did your hospital receive FTE slots under ACA	1. 00 N	2. 00	3. 00	4.00	5.00	61. 00
	section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	IN			0.00	0.00	01.00
61. 01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61. 01
	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of						61. 02
61. 03	ACA). (see instructions) Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61. 03
61. 04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the						61. 04
	current cost reporting period (see instructions). Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line						61. 05
61. 06	61.04 minus line 61.03). (see instructions) Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61. 06
		Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
61 10	Of the FTEs in line 61.05, specify each new program		1.00	2. 00	3.00	4.00	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.				5. 55	5.00	00
61. 20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0. 00	61. 20
	the divisor one fire dimergined count.			1	1	1.00	
	ACA Provisions Affecting the Health Resources and Ser					1.00	
62. 00	Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instruc		d in this cost	reporting peri	od for which		62. 00
62. 01	Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC prog	ram. (s	<u>see instructio</u>		your hospi tal	0.00	62. 01
63. 00	Teaching Hospitals that Claim Residents in Nonprovide Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, comple	ttings	during this co			N	63. 00
				Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
	Section 5504 of the ACA Base Year FTE Residents in No			1. 00	2.00 is your cost r	3.00 reporting	
	period that begins on or after July 1, 2009 and befor Enter in column 1, if line 63 is yes, or your facilit in the base year period, the number of unweighted non resident FTEs attributable to rotations occurring in settings. Enter in column 2 the number of unweighted	y trair -primar all nor	ned residents ry care nprovider	0.00	0.00	0. 000000	64. 00
	resident FTEs that trained in your hospital. Enter in of (column 1 divided by (column 1 + column 2)). (see	col umr	n 3 the ratio				

	unweighted primary care resident FTEs that trained in											
	your hospital. Enter in column											
	5, the ratio of (column 3											
	divided by (column 3 + column											
	4)). (see instructions)											
	1,00 2,00 3,											
	Inpatient Psychiatric Facility PPS											
70. 00	Is this facility an Inpatient Ps	rovi der?	N			70. 00						
	Enter "Y" for yes or "N" for no											
71.00	If line 70 is yes: Column 1: Did	the facility have ar	n approved GME teachir	ng program in t	he most			0	71. 00			
	recent cost report filed on or b											
	42 CFR 412.424(d)(1)(iii)(c)) Co											
	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)											
75 00	Inpatient Rehabilitation Facilit		(105)				_		75 00			
75.00	Is this facility an Inpatient Re subprovider? Enter "Y" for yes		y (IRF), or does it co	ontain an ikf		Y			75. 00			
76 00	If line 75 is yes: Column 1: Did		a approved CME teachin	na program in t	ho most	N	N	0	76. 00			
70.00	recent cost reporting period end					IN.	I IN	0	70.00			
	no. Column 2: Did this facility											
	CFR 412. 424 (d)(1)(iii)(D)? Ente											
	indicate which program year bega											
MCRI F3	2 - 17. 4. 174. 1											

OSPITAL AND HOSPITAL HE	ALTH CARE COMPLEX IDENTIFICATION DATA	Provi der C	CN: 15-0090	Peri od: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part I Date/Time Pre 5/30/2022 7:5	epared:
					1.00	+
Long Term Care Ho						
1.00 Is this a LTCH co- "Y" for yes and "I	rm care hospital (LTCH)? Enter "Y" for yes -located within another hospital for part c U" for no.			g period? Enter	N N	80. 00 81. 00
6.00 Did this facility	oital under 42 CFR Section §413.40(f)(1)(i) establish a new Other subprovider (exclude ? Enter "Y" for yes and "N" for no.				N	85. 00 86. 00
7.00 Is this hospital a	an extended neoplastic disease care hospita ? Enter "Y" for yes or "N" for no.	ıl classified	under section	ı	N	87. 0
[1000(U)(1)(B)(VI)	Eliter 1 for yes of in for no.			V	XI X	
				1. 00	2.00	
Title V and XIX So 0.00 Does this facility	ervices y have title V and/or XIX inpatient hospita	ıl services? E	nter "Y" for	N	Υ	90.0
yes or "N" for no	in the applicable column. reimbursed for title V and/or XIX through t			N	Y	91. 0
full or in part? I	Enter "Y" for yes or "N" for no in the appl	icable column				
	patients occupying title XVIII SNF beds (du er "Y" for yes or "N" for no in the applica		ion)? (see		N	92.00
	y operate an ICF/IID facility for purposes for no in the applicable column.	of title V an	d XIX? Enter	N	N	93. 00
	X reduce capital cost? Enter "Y" for yes,	and "N" for n	o in the	N	N	94. 0
5.00 If line 94 is "Y",	enter the reduction percentage in the app			0.00	0.00	95.00
applicable column.				N	N	96. 0
	enter the reduction percentage in the app X follow Medicare (title XVIII) for the in			0. 00 N	0. 00 Y	97. 0 98. 0
stepdown adjustme	nts on Wkst. B, Pt. I, col. 25? Enter "Y" f					70.0
	e V, and in column 2 for title XIX. X follow Medicare (title XVIII) for the re	porting of ch	arges on Wkst	. N	Y	98. 0
C, Pt. I? Enter "' title XIX.	(" for yes or "N" for no in column 1 for ti	tle V, and in	column 2 for	,		
8.02 Does title V or X bed costs on Wkst.	X follow Medicare (title XVIII) for the ca D-1, Pt. IV, line 89? Enter "Y" for yes o			N	Y	98. 0
8.03 Does title V or XI reimbursed 101% o	n column 2 for title XIX. X follow Medicare (title XVIII) for a crit finpatient services cost? Enter "Y" for ye				N	98. 0
8.04 Does title V or X	n column 2 for title XIX. X follow Medicare (title XVIII) for a CAH es cost? Enter "Y" for yes or "N" for no in			N	N	98. 0
	tle XIX. X follow Medicare (title XVIII) and add ba bl. 4? Enter "Y" for yes or "N" for no in c				Y	98. 0
column 2 for title 8 06 Does title V or X	e XIX. X follow Medicare (title XVIII) when cost	reimbursed fo	r Wkst D	N	Y	98. 0
Pts. I through IV column 2 for title	? Enter "Y" for yes or "N" for no in column				·	
Rural Providers 05.00 Does this hospital	qualify as a CAH?			N		105. 0
06.00 If this facility (qualifies as a CAH, has it elected the all-	inclusive met	hod of paymer			106. 0
07.00 Column 1: If line	rvices? (see instructions) 105 is Y, is this facility eligible for co			N		107. 0
	? Enter "Y" for yes or "N" for no in column umn 1 is Y and line 70 or line 75 is Y, do					
approved medical	education program in the CAH's excluded IP or "N" for no in column 2. (see instructi	F and/or IRF				
08.00 is this a rural ho	ospital qualifying for an exception to the		dul e? See 42	! N		108.0
CFR Section §412.	I13(c). Enter "Y" for yes or "N" for no.	Physi cal	Occupati ona	ıl Speech	Respi ratory	
00 00 5 15	CALL ST	1.00	2.00	3.00	4.00	100.0
therapy services [qualifies as a CAH or a cost provider, are provided by outside supplier? Enter "Y" no for each therapy.	N	N	N	N	109. 0
					1.00	
10.00 Did this hospital	participate in the Rural Community Hospita	ıl Demonstrati	on project (§	410A	1.00 N	110. 00
	the current cost reporting period? Enter "					

SPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCM		ri od:	Worksheet S-	2
	Fr To	om 01/01/2021 12/31/2021	Part Date/Time Pr	epar
			5/30/2022 7:	58 p
		1. 00	2. 00	
1.00 If this facility qualifies as a CAH, did it participate in the Frontier Cor Health Integration Project (FCHIP) demonstration for this cost reporting per "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, er integration prong of the FCHIP demo in which this CAH is participating in CE Enter all that apply: "A" for Ambulance services; "B" for additional beds; for tele-health services.	eriod? Enter nter the column 2.	N		11
	1. 00	2. 00	3. 00	+
2.00 Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable. Mi scellaneous Cost Reporting Information	N			11:
.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no	N			011
in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-1, chapter 22, §2208.1.				
o.00 Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			11
7.00 Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Υ			11
3.00 Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2			118
in the porrey is craim made. Enter 2 in the porrey is decarrence.	Premi ums	Losses	Insurance	
	1. 00	2. 00	3.00	
3.01 List amounts of malpractice premiums and paid losses:	708, 263	0		011
		1. 00	2. 00	
8.02 Are malpractice premiums and paid losses reported in a cost center other the Administrative and General? If yes, submit supporting schedule listing cost and amounts contained therein. 9.00 D0 NOT USE THIS LINE		N		11
0.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provi §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Hold Harmless provision in ACA §3121 and applicable amendments? (see instru	for yes or e Outpatient	N	N	12
.00 Did this facility incur and report costs for high cost implantable devices patients? Enter "Y" for yes or "N" for no.	charged to	Υ		12
2.00 Does the cost report contain healthcare related taxes as defined in §1903(v	w)(3) of the	Υ	5. 04	12
Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter the Worksheet A line number where these taxes are included. Transplant Center Information	in column 2			
.00 Does this facility operate a transplant center? Enter "Y" for yes and "N" 1	for no. If	N		12
yes, enter certification date(s) (mm/dd/yyyy) below. .00 If this is a Medicare certified kidney transplant center, enter the certifi	ication date			12
in column 1 and termination date, if applicable, in column 2.				12
.00 If this is a Medicare certified heart transplant center, enter the certific in column 1 and termination date, if applicable, in column 2.				'2
.00 If this is a Medicare certified liver transplant center, enter the certific in column 1 and termination date, if applicable, in column 2.	cation date			12
	ation date in			12
.00 If this is a Medicare certified lung transplant center, enter the certifica				13
.00 If this is a Medicare certified lung transplant center, enter the certifical column 1 and termination date, if applicable, in column 200 If this is a Medicare certified pancreas transplant center, enter the certi	ITICATION		1	13
column 1 and termination date, if applicable, in column 2. 1.00 If this is a Medicare certified lung transplant center, enter the certification column 1 and termination date, if applicable, in column 2. 1.00 If this is a Medicare certified pancreas transplant center, enter the certified in this is a Medicare certified intestinal transplant center, enter the certified intestinal transplant center, enter the certified intestinal transplant center, enter the certified intestinal transplant center.				1,0
0.00 If this is a Medicare certified lung transplant center, enter the certification column 1 and termination date, if applicable, in column 2. 1.00 If this is a Medicare certified pancreas transplant center, enter the certified in column 1 and termination date, if applicable, in column 2. 1.00 If this is a Medicare certified intestinal transplant center, enter the certified in column 1 and termination date, if applicable, in column 2. 1.00 If this is a Medicare certified islet transplant center, enter the certification.	rti fi cati on		-	
0.00 If this is a Medicare certified lung transplant center, enter the certification column 1 and termination date, if applicable, in column 2. 0.00 If this is a Medicare certified pancreas transplant center, enter the certified in column 1 and termination date, if applicable, in column 2. 0.00 If this is a Medicare certified intestinal transplant center, enter the certified in column 1 and termination date, if applicable, in column 2. 0.00 If this is a Medicare certified islet transplant center, enter the certified in column 1 and termination date, if applicable, in column 2.	rti fi cati on			13
0.00 If this is a Medicare certified lung transplant center, enter the certification column 1 and termination date, if applicable, in column 2. 1.00 If this is a Medicare certified pancreas transplant center, enter the certified in column 1 and termination date, if applicable, in column 2. 1.00 If this is a Medicare certified intestinal transplant center, enter the certified in column 1 and termination date, if applicable, in column 2. 1.00 If this is a Medicare certified islet transplant center, enter the certification.	rtification cation date			13: 13: 13:

Health Financial Systems FRANCISCAN HEALTH- DYER In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0090 Peri od: Worksheet S-2 From 01/01/2021 Part I 12/31/2021 Date/Time Prepared: To 5/30/2022 7:58 pm 3.00 If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number 141.00 Name: FRANCISCAN ALLIANCE, INC Contractor's Name: WISCONSIN PHYSICIAN Contractor's Number: 08101 141 00 SERVI CES 142.00 Street: 1515 DRAGOON TRAIL PO Box: 142.00 143.00 City: MISHAWAKA State: ΙN Zip Code: 46546 143.00 1.00 144.00 Are provider based physicians' costs included in Worksheet A? 144. 00 2.00 1.00 145.00|| f costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is 145.00 no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2. 146.00 Has the cost allocation methodology changed from the previously filed cost report? Ν 146, 00 Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2. 1.00 147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. 147.00 N 148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. N 148.00 149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no Ν 149.00 Part A Part B Title V Title XIX 1 00 2 00 3.00 4 00 Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13) 155.00 Hospi tal N Ν Ν N 155. 00 156.00 Subprovi der - IPF 156. 00 Ν Ν Ν Ν 157.00 Subprovi der - IRF 157 00 N Ν Ν N 158. 00 SUBPROVI DER 158.00 159.00 SNF N Ν Ν Ν 159. 00 160.00 HOME HEALTH AGENCY 160.00 Ν Ν Ν Ν 161.00 CMHC Ν Ν Ν 161.00 1.00 Mul ti campus 165.00 Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no. Ν 165.00 FTE/Campus Zip Code Name County **CBSA** State | 3.00 0 1.00 2.00 4.00 5.00 166.00 If line 165 is yes, for each 0.00 166.00 campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) 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 Υ 167.00 168.00 reasonable cost incurred for the HIT assets (see instructions)

168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)			168. 01
169.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N transition factor. (see instructions)	0.00	0169. 00	
	Begi nni ng	Endi ng	
	1. 00	2.00	
170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170. 00
	1. 00	2. 00	
171.00 ffline 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	(171. 00

Heal th	Financial Systems FRANCISCAN H	EALTH- DYER		In Lie	eu of Form CMS-	2552-10
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C		Peri od:	Worksheet S-2	2
				From 01/01/2021 Fo 12/31/2021		enared:
			'	10 12/31/2021	5/30/2022 7:5	
				Y/N	Date	
				1. 00	2. 00	
	General Instruction: Enter Y for all YES responses. Enter M	N for all NO re	esponses. Enter	all dates in	the	
	mm/dd/yyyy format.					
	COMPLETED BY ALL HOSPITALS Provider Organization and Operation					_
1. 00	Has the provider changed ownership immediately prior to the	e heainning of	the cost	N		1.00
1.00	reporting period? If yes, enter the date of the change in a			14		1.00
	The provided and the same and t		Y/N	Date	V/I	
			1.00	2. 00	3. 00	
2.00	Has the provider terminated participation in the Medicare I		N			2. 00
	yes, enter in column 2 the date of termination and in column	mn 3, "V" for				
2 00	voluntary or "I" for involuntary.	na managaman+	N.			2 00
3. 00	Is the provider involved in business transactions, including contracts, with individuals or entities (e.g., chain home of		N			3. 00
	or medical supply companies) that are related to the provide					
	officers, medical staff, management personnel, or members					
	of directors through ownership, control, or family and other					
	relationships? (see instructions)					
			Y/N	Type	Date	
	I		1.00	2. 00	3. 00	
	Financial Data and Reports			1 .	1 05 (40 (0000	
4. 00	Column 1: Were the financial statements prepared by a Cer- Accountant? Column 2: If yes, enter "A" for Audited, "C"	tified Public	Y	A	05/12/2022	4. 00
	or "R" for Reviewed. Submit complete copy or enter date available.					
	column 3. (see instructions) If no, see instructions.	arrabre in				
5. 00	Are the cost report total expenses and total revenues diffe	erent from	N			5.00
0.00	those on the filed financial statements? If yes, submit rea					0.00
				Y/N	Legal Oper.	
				1. 00	2. 00	
	Approved Educational Activities				1	
6.00	Column 1: Are costs claimed for a nursing program? Column	2: If yes, is	s the provider	N		6. 00
7.00	is the legal operator of the program?					7.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see in		uad duud na +ha	N		7.00
8. 00	Were nursing programs and/or allied health programs approve cost reporting period? If yes, see instructions.	ed and/or renev	ved during the	N		8. 00
9. 00	Are costs claimed for Interns and Residents in an approved	araduate medic	ral education	N		9.00
7. 00	program in the current cost report? If yes, see instruction		our caacatron	1		7.00
10.00	Was an approved Intern and Resident GME program initiated		the current	N		10.00
	cost reporting period? If yes, see instructions.					
11. 00	Are GME cost directly assigned to cost centers other than	I & Rin an App	proved	N		11. 00
	Teaching Program on Worksheet A? If yes, see instructions.					
					Y/N	
	D-1 D-1+-				1. 00	
12. 00	Bad Debts Is the provider seeking reimbursement for bad debts? If yes	e eoo instruct	tions		Υ	12. 00
13. 00	If line 12 is yes, did the provider's bad debt collection			t reporting	l 'n	13.00
13.00	period? If yes, submit copy.	porrey change c	diring till 3 cos	st reporting	14	13.00
14. 00	If line 12 is yes, were patient deductibles and/or co-payment	ents waived? If	yes, see inst	ructions.	N	14.00
	Bed Complement					
15. 00	Did total beds available change from the prior cost report	, -			Υ	15. 00
			rt A		rt B	
		Y/N	Date	Y/N	Date	
	PS&R Data	1.00	2.00	3. 00	4. 00	
16. 00	Was the cost report prepared using the PS&R Report only?	N		N		16. 00
10.00	If either column 1 or 3 is yes, enter the paid-through	IV.		IN		10.00
	date of the PS&R Report used in columns 2 and 4 (see					
	instructions)					
17.00	Was the cost report prepared using the PS&R Report for	Υ	05/06/2022	Υ	05/06/2022	17. 00
	totals and the provider's records for allocation? If					
	either column 1 or 3 is yes, enter the paid-through date					
40.05	in columns 2 and 4. (see instructions)					10.00
18. 00	If line 16 or 17 is yes, were adjustments made to PS&R	N		N		18. 00
	Report data for additional claims that have been billed but are not included on the PS&R Report used to file this					
	cost report? If yes, see instructions.					
19. 00	If line 16 or 17 is yes, were adjustments made to PS&R	N		N		19. 00
	Report data for corrections of other PS&R Report			.,		
	information? If yes, see instructions.					
		-	-	•	•	•

OSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	EALTH- DYER Provider CO	N: 15-0090	Peri od:	w of Form CMS- Worksheet S-2			
			From 01/01/2021 To 12/31/2021	Part II Date/Time Pre			
	Descri	ntion	Y/N	5/30/2022 7:5 Y/N	58 pm		
	Descri		1. 00	3. 00			
0.00 If line 16 or 17 is yes, were adjustments made to PS&R			N	N	20. 0		
Report data for Other? Describe the other adjustments:	Y/N	Date	Y/N	Date			
	1.00	2.00	3. 00	4. 00			
.00 Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21. 0		
				1. 00	-		
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	PT CHILDRENS H	OSPLTALS)		1.00			
Capital Related Cost	om Eskeno m	30.111.20)					
2.00 Have assets been relifed for Medicare purposes? If yes, see	Have assets been relifed for Medicare purposes? If yes, see instructions						
Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.	N	23. 0					
Were new leases and/or amendments to existing leases entere If yes, see instructions	9			N	24.0		
5.00 Have there been new capitalized leases entered into during instructions.	the cost repor	ting period	? If yes, see	N	25. (
0.00 Were assets subject to Sec. 2314 of DEFRA acquired during th instructions.	ne cost reporti	ng period?	If yes, see	N	26.0		
7.00 Has the provider's capitalization policy changed during the copy.	e cost reportin	g period? I	f yes, submit	N	27.0		
Interest Expense 3.00 Were new Loans, mortgage agreements or Letters of credit en	ntered into dur	ing the cos	t reporting	N	28. (
period? If yes, see instructions. Did the provider have a funded depreciation account and/or	N	29. (
0.00 Has existing debt been replaced prior to its scheduled matu	treated as a funded depreciation account? If yes, see instructions Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see						
instructions. 1.00 Has debt been recalled before scheduled maturity without is	ssuance of new	debt? If ye	s, see	N	31. (
instructions. Purchased Services							
2.00 Have changes or new agreements occurred in patient care ser		d through c	ontractual	N	32. (
arrangements with suppliers of services? If yes, see instru 3.00 If line 32 is yes, were the requirements of Sec. 2135.2 app no, see instructions.		g to compet	itive bidding? If		33.		
Provi der-Based Physi ci ans							
I.00 Are services furnished at the provider facility under an ar	rangement with	provi der-b	ased physicians?	Y	34.0		
If yes, see instructions. If line 34 is yes, were there new agreements or amended exi		ts with the	provi der-based	N	35. (
physicians during the cost reporting period? If yes, see in	nstructions.		Y/N	Date			
			1. 00	2. 00			
Home Office Costs							
0.00 Were home office costs claimed on the cost report?	<u> </u>		Y		36.0		
7.00 If line 36 is yes, has a home office cost statement been pr	repared by the	home office	? Y		37. (
If yes, see instructions. 3.00 If line 36 is yes, was the fiscal year end of the home off			f N		38.		
the provider? If yes, enter in column 2 the fiscal year end 0.00 If line 36 is yes, did the provider render services to othe see instructions.			s, N		39. (
o.00 If line 36 is yes, did the provider render services to the instructions.	home office?	lf yes, see	N		40.0		
	1.	00	2.	00			
	GLENN		JOHNSON		41. 0		
held by the cost report preparer in columns 1, 2, and 3, respectively.	FRANCISCAN ALL	LANCE INC			42.0		
	ILITANUL JUAN ALL	TANCE INC			42. (
preparer.	541-290-2515		GLENN. JOHNSON@	EDANICI COANIALLI	43. (

Heal th	Financial Systems FR	ANCISCAN HEA	ALTH- DYER			In Lieu of Form CMS-2552-10			
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIO	NNAI RE	Provider C			od: 01/01/2021 12/31/2021	Worksheet Part II Date/Time 5/30/2022	Prepared:	
		-	3.	00					
	Cost Report Preparer Contact Information				_				
41. 00	Enter the first name, last name and the title/posheld by the cost report preparer in columns 1, 2, respectively.	I	MANAGER REIMBU	RSEMENT				41. 00	
42. 00	Enter the employer/company name of the cost reporpreparer.	rt						42. 00	
43. 00	Enter the telephone number and email address of report preparer in columns 1 and 2, respectively							43. 00	

| Period: | Worksheet S-3 | From 01/01/2021 | Part | To 12/31/2021 | Date/Time Prepared:
 Heal th Financial
 Systems
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 HOSPITAL
 AND
 HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA
 Provi der CCN: 15-0090

					-	Го 12/31/2021	Date/Time Pre 5/30/2022 7:5	
							I/P Days / 0/P	
							Visits / Trips	
	Component	Worksheet A	No. of Be	eds	Bed Days	CAH Hours	Title V	
	·	Line Number			Avai I abl e			
		1.00	2. 00		3. 00	4. 00	5. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		90	32, 468	0.00	0	1. 00
	8 exclude Swing Bed, Observation Bed and							
	Hospice days) (see instructions for col. 2							
	for the portion of LDP room available beds)							
2.00	HMO and other (see instructions)							2. 00
3.00	HMO IPF Subprovider							3. 00
4.00	HMO IRF Subprovider							4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF						0	5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						0	6. 00
7.00	Total Adults and Peds. (exclude observation			90	32, 468	0.00	0	7. 00
	beds) (see instructions)							
8. 00	INTENSIVE CARE UNIT	31. 00		14	5, 110			8. 00
9.00	CORONARY CARE UNIT	32. 00		0	(0.00	0	9. 00
10.00	BURN INTENSIVE CARE UNIT							10.00
11. 00	SURGICAL INTENSIVE CARE UNIT							11. 00
12.00	NEONATAL INTENSIVE CARE UNIT	35. 00		8	424	0.00	0	12.00
13.00	NURSERY	43. 00					0	13. 00
14. 00	Total (see instructions)			112	38, 002	0.00	•	14. 00
15. 00	CAH visits						0	15. 00
16. 00	SUBPROVIDER - IPF							16. 00
17. 00	SUBPROVI DER - I RF	41. 00		30		D	0	
18. 00	SUBPROVI DER	42. 00		0	(0	18. 00
19. 00	SKILLED NURSING FACILITY							19. 00
20.00	NURSING FACILITY							20. 00
21. 00	OTHER LONG TERM CARE							21. 00
22. 00	HOME HEALTH AGENCY							22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)							23. 00
24. 00	HOSPI CE							24. 00
24. 10	HOSPICE (non-distinct part)	30. 00						24. 10
25. 00	CMHC - CMHC							25. 00
26. 00	RURAL HEALTH CLINIC							26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00					0	
27. 00	Total (sum of lines 14-26)			142				27. 00
28. 00	Observation Bed Days						0	
29. 00	Ambul ance Tri ps							29. 00
30.00	Employee discount days (see instruction)							30. 00
31. 00	Employee discount days - IRF							31. 00
32.00	Labor & delivery days (see instructions)			0	(32. 00
32. 01	Total ancillary labor & delivery room							32. 01
	outpatient days (see instructions)							
33. 00	LTCH non-covered days							33. 00
33. 01	LTCH site neutral days and discharges						1	33. 01

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 HOSPITAL
 AND
 HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA
 Provi der CCN: 15-0090

				T	o 12/31/2021	Date/Time Pre 5/30/2022 7:5	
		I/P Days	/ O/P Visits	/ Tri ps	Full Time E	qui 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	7, 685	1, 838	18, 447			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)	4, 608	1, 913				2. 00
3.00	HMO IPF Subprovider	0	0				3. 00
4.00	HMO IRF Subprovider	1, 281	0				4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5. 00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6. 00
7.00	Total Adults and Peds. (exclude observation	7, 685	1, 838	18, 447			7. 00
	beds) (see instructions)		_				
8. 00	INTENSIVE CARE UNIT	849	0	2, 591			8. 00
9. 00	CORONARY CARE UNIT	0	0	0			9. 00
10. 00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT	_	_				11. 00
12. 00	NEONATAL INTENSIVE CARE UNIT	0	2	70			12. 00
13. 00	NURSERY		10	106			13. 00
14. 00	Total (see instructions)	8, 534	1, 850	21, 214		749. 95	
15. 00	CAH visits	0	O	0			15. 00
16. 00	SUBPROVI DER - I PF						16. 00
17. 00	SUBPROVI DER - I RF	5, 287	615	8, 277	0.00	0.00	
18. 00	SUBPROVI DER		0	0	0. 00	0. 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				0.00	0.00	26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	
27. 00	Total (sum of lines 14-26)		0.44	0.047	4. 55	749. 95	
28. 00	Observation Bed Days		264	3, 847			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		4.4	0			31.00
32.00	Labor & delivery days (see instructions)	0	14	164			32.00
32. 01	Total ancillary labor & delivery room			0			32. 01
22.00	outpatient days (see instructions)						22.00
33.00	,	0	ŀ				33.00
33.01	LTCH site neutral days and discharges	0	I				33. 01

| Peri od: | Worksheet S-3 | From 01/01/2021 | Part | To 12/31/2021 | Date/Time Prepared:

				To	12/31/2021	Date/Time Pre 5/30/2022 7:58	
		Full Time	<u>'</u>	Di sch	arges		
		Equi val ents					
	Component	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11. 00	12.00	13. 00	14.00	15. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		0	1, 739	364	4, 194	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)			723	257		2. 00
3.00	HMO IPF Subprovider				0		3. 00
4.00	HMO IRF Subprovider				0		4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation						7. 00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT						8. 00
9.00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	NEONATAL INTENSIVE CARE UNIT						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0. 00	0	1, 739	364	4, 194	14.00
15.00	CAH visits						15.00
16.00	SUBPROVI DER - I PF						16.00
17. 00	SUBPROVI DER - I RF	0. 00	0	421	54	665	17.00
18.00	SUBPROVI DER	0. 00	0		0	0	18.00
19. 00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY						22. 00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24.00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)						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	Ambulance Trips						29. 00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31. 00
32.00	Labor & delivery days (see instructions)						32.00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)	ļ					
33. 00	LTCH non-covered days			0			33. 00
33. 01	LTCH site neutral days and discharges			0			33. 01

Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0090

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet S-3 | From 01/01/2021 | Part II | To 12/31/2021 | Date/Time Prepared: | From 2002 | F

					11	0 12/31/2021	Date/lime Pre 5/30/2022 7:5	
		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst.	Salaries (col.2 ± col.	Salaries in	Average Hourly Wage (col. 4 ÷ col. 5)	
		1. 00	2. 00	A-6) 3. 00	3) 4.00	col . 4 5.00	6. 00	
	PART II - WAGE DATA							
1. 00	SALARIES Total salaries (see	200. 00	71, 185, 599	0	71, 185, 599	2, 017, 884. 00	35. 28	1.00
2. 00	instructions) Non-physician anesthetist Part		0	0		0.00	0. 00	
3. 00	A Non-physician anesthetist Part		0	0	0	0.00	0. 00	3. 00
4. 00	B Physician-Part A -		0	0	0	0. 00	0. 00	4. 00
4. 01 5. 00	Administrative Physicians - Part A - Teaching		0	0	0	0. 00 0. 00		
6. 00	Physician and Non Physician-Part B Non-physician-Part B for		0	0	0		0.00	
0.00	hospi tal -based RHC and FQHC services		Ü	· ·		0.00	0.00	0.00
7. 00	Interns & residents (in an approved program)	21. 00	0	0	0	0. 00	0. 00	7. 00
7. 01	Contracted interns and residents (in an approved		0	0	0	0. 00	0. 00	7. 01
8. 00	programs) Home office and/or related organization personnel		7, 406, 708	0	7, 406, 708	194, 096. 00	38. 16	8. 00
9. 00 10. 00	SNF Excluded area salaries (see	44. 00	0 13, 718, 379	0 388	_	0. 00 457, 848. 00		
	instructions) OTHER WAGES & RELATED COSTS							
11. 00	Contract labor: Direct Patient Care		1, 408, 719	0	1, 408, 719	12, 743. 00	110. 55	11. 00
12. 00	Contract labor: Top level management and other management and administrative		0	0	0	0.00	0. 00	12. 00
13. 00	services Contract Labor: Physician-Part A - Administrative		179, 031	0	179, 031	1, 120. 00	159. 85	13. 00
14. 00	Home office and/or related organization salaries and		0	0	0	0. 00	0. 00	14. 00
14. 01 14. 02 15. 00	wage-related costs Home office salaries Related organization salaries Home office: Physician Part A		9, 414, 179 0 0	0 0	0	246, 727. 00 0. 00 0. 00	0. 00	
16. 00	- Administrative Home office and Contract		0	0		0.00	0.00	
16. 01	Physicians Part A - Teaching Home office Physicians Part A		0	0	0	0. 00	0. 00	
16. 02	- Teaching Home office contract		0	0	0	0. 00	0. 00	16. 02
17.00	Physicians Part A - Teaching WAGE-RELATED COSTS		07.000.054		07.000.054			1
17. 00 18. 00	Wage-related costs (core) (see instructions) Wage-related costs (other)		37, 090, 851	0	37, 090, 851			17. 00 18. 00
19. 00	(see instructions) Excluded areas		8, 854, 512	0	8, 854, 512			19. 00
20. 00	Non-physician anesthetist Part A		0	0	0			20. 00
21. 00	Non-physician anesthetist Part B		0	0				21. 00
22. 00	Physician Part A - Administrative		0	0	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 0			24. 00 25. 00
25. 50	approved program) Home office wage-related		2, 867, 980	0	2, 867, 980			25. 50
25. 51	(core) Related organization wage-related (core)		0	0	0			25. 51
25. 52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	О			25. 52

					Т	o 12/31/2021	Date/Time Prep 5/30/2022 7:5	
		Wkst. A Line	Amount	Recl assi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from Wkst.	(col.2 ± col.	Salaries in	col . 5)	
				A-6)	3)	col. 4		
		1.00	2. 00	3. 00	4. 00	5. 00	6. 00	
25. 53	Home office: Physicians Part A		0	0	0			25. 53
	- Teaching - wage-related							
	(core)							
	OVERHEAD COSTS - DIRECT SALARIE		27/ 225			11 (00 00		
26. 00	Employee Benefits Department	4. 00	376, 085		376, 085	,		26. 00
27. 00	Administrative & General	5. 00	12, 876, 314			i i		
28. 00	Administrative & General under		444, 364	0	444, 364	3, 891. 00	114. 20	28. 00
00.00	contract (see inst.)	, 00	(00.440		(00.440	47 070 00	40.00	00.00
29. 00	Maintenance & Repairs	6.00	683, 148		683, 148	i i		29. 00
30.00	Operation of Plant	7. 00	1, 236, 515		1, 236, 515	i i		
31.00	Laundry & Linen Service	8. 00	188, 268		188, 268	i i		
32.00	Housekeepi ng	9. 00	1, 605, 739	0	1, 605, 739	i i		
33. 00	Housekeeping under contract (see instructions)		0	0	0	0.00	0. 00	33. 00
34.00	Di etary	10. 00	1, 070, 079	-545, 645	524, 434	28, 242. 00	18. 57	34.00
35. 00	Di etary under contract (see instructions)		0	0	0	0.00	0. 00	35. 00
36.00	Cafeteri a	11. 00	34, 726	545, 645	580, 371	30, 195. 00	19. 22	36. 00
37.00	Maintenance of Personnel	12. 00	0	0	0	0.00	0.00	37. 00
38.00	Nursing Administration	13. 00	2, 034, 619	0	2, 034, 619	46, 841. 00	43. 44	38. 00
39.00	Central Services and Supply	14. 00	296, 875	0	296, 875	12, 175. 00	24. 38	39. 00
40.00	Pharmacy	15. 00	1, 957, 981	0	1, 957, 981	41, 556. 00	47. 12	40. 00
41.00	Medical Records & Medical	16. 00	166, 991	0	166, 991	4, 185. 00	39. 90	41. 00
	Records Library							
42.00	Soci al Servi ce	17. 00	0	0	0	0.00	0. 00	42. 00
43.00	Other General Service	18. 00	0	0	0	0.00	0.00	43.00

| Period: | Worksheet S-3 | From 01/01/2021 | Part III | To 12/31/2021 | Date/Time Prepared:

					1	0 12/31/2021	5/30/2022 7:58	
		Worksheet A	Amount	Reclassi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Line Number	Reported	on of Salaries	Sal ari es		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		64, 223, 255	0	64, 223, 255	1, 827, 679. 00	35. 14	1.00
	instructions)							
2.00	Excluded area salaries (see		13, 718, 379	388	13, 718, 767	457, 848. 00	29. 96	2. 00
	instructions)							
3.00	Subtotal salaries (line 1		50, 504, 876	-388	50, 504, 488	1, 369, 831. 00	36. 87	3. 00
	minus line 2)							
4.00	Subtotal other wages & related		11, 001, 929	0	11, 001, 929	260, 590. 00	42. 22	4. 00
	costs (see inst.)							
5.00	Subtotal wage-related costs		39, 958, 831	0	39, 958, 831	0. 00	79. 12	5. 00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		101, 465, 636	-388	101, 465, 248	1, 630, 421. 00	62. 23	6. 00
7.00	Total overhead cost (see		22, 971, 704	-75, 529	22, 896, 175	662, 410. 00	34. 56	7. 00
	instructions)							

Health Financial Systems	FRANCISCAN HEALTH- DYER	In Lieu of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 15-0090	Peri od: Worksheet S-3
		From 01/01/2021 Part IV
		T- 10/01/0001 D-+-/T: D

	To 12/31/2021	Date/Time Prep 5/30/2022 7:58	
		Amount	
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	11, 992, 434	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	5, 881, 033	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8. 00
8. 01	Health Insurance (Self Funded without a Third Party Administrator)	0	8. 01
8. 02	Health Insurance (Self Funded with a Third Party Administrator)	17, 621, 652	8. 02
8. 03	Health Insurance (Purchased)	0	8. 03
9. 00	Prescription Drug Plan	0	9. 00
10.00	Dental, Hearing and Vision Plan	1, 127, 129	10.00
11. 00	Life Insurance (If employee is owner or beneficiary)	0	11. 00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15. 00	'Workers' Compensation Insurance	0	15. 00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16.00
	Non cumulative portion)		
	TAXES		
17.00	FICA-Employers Portion Only	9, 323, 115	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	0	19. 00
20.00	State or Federal Unemployment Taxes	0	20. 00
	OTHER		
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21. 00
22. 00	Day Care Cost and Allowances	0	22. 00
23.00	Tuition Reimbursement	0	23. 00
24.00	Total Wage Related cost (Sum of lines 1 -23)	45, 945, 363	24. 00
	Part B - Other than Core Related Cost		
25. 00	OTHER WAGE RELATED COSTS (SPECIFY)		25. 00

Health Financial Systems	FRANCISCAN HEALTH- DYER	In Lie	u of Form CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST		Period: From 01/01/2021 To 12/31/2021	Worksheet S-3 Part V Date/Time Prepared: 5/30/2022 7:58 pm
Cost Contor Docorintian		Contract Labor	Donofi + Coot

	l'	0 12/31/2021	5/30/2022 7:5	
	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	0	0	4. 00
5.00	Subprovi der - (Other)	0	0	5. 00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7. 00
8.00	Hospi tal -Based SNF			8. 00
9.00	Hospi tal -Based NF			9. 00
10.00	Hospi tal -Based OLTC			10.00
11. 00	Hospi tal -Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospi tal -Based Hospi ce			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15. 00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospi tal -Based-CMHC			16.00
17. 00	Renal Di al ysi s			17.00
18. 00	0ther	0	0	18. 00

Medicald (see instructions for each line) 16,152,266 2,00 3,00 10 dyou receive DSH or supplemental payments from Medicaid? N 4,00 10 11 in 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid? Y 4,00 4,00 11 in 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid? Y 4,00 4,00 10 11 in 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid? Y 4,00 4,00 0.00		Financial Systems FRANCISCAN HEALT			In Lie	u of Form CMS-2	2552-10
	HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provi der Co	CN: 15-0090		Worksheet S-1	0
						Date/Time Pre	pared:
Incompensated and indigent care cost computation						5/30/2022 7:5	8 pm
Cost to charge ratio (Vorksheet C, Part I line 202 column 3 divided by line 202 column 8) 0.233919 1.00						1. 00	
Medicaid (see instructions for each line)							
Not revenue from Medical 1,152,266 2,00 No 1 1 1 1 1 2 3 1 3 3 3 3 3 3 3 3	1.00		vided by li	ne 202 colum	n 8)	0. 233919	1.00
Did you receive DSH or supplemental payments from Medicaid? N 3,00 Filine 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid? Y 4,00 Filine 4 is no, then enter DSH and/or supplemental payments from Medicaid? Y 4,00 5,00 0 0 0 0 0 0 0 0 0	2 00	· · · · · · · · · · · · · · · · · · ·				1/ 150 0//	2 00
1							1
			tal payment	s from Medic	ai d?		4.00
Medicaid cost (line 1 times line 6) Medicaid cost (line 1 times line 6) R. 885, 409 No. 00 Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if						0	1
0						107, 035, 664	
Second the nether zero)		1					1
Children's Health Insurance Program (CHIP) (see instructions for each line) 0 9.00	8.00		(line 7 min	us sum of li	nes 2 and 5; if	8, 885, 409	8.00
Net revenue from stand-al one CHIP charges 0 9.00			or each lin	e)			1
10.00 Stand-al one CHIP cost (line 1 times line 10) 0 10.00 0 11.00 11.00	9. 00					0	9.00
12.00 Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter 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 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 15,00 are 10) 16.00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 0 16,00 are 11 or 20) 17.00 Forants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line) 18.10 Government grants, appropriations or transfers for support of hospital operations 10.00 are 11 or 11 or 12 or	10.00					0	10.00
enter 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) 0 13.00 14.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 16	11. 00					_	
Other state or local government indigent care program (see instructions for each line) 13.00 13.00 14.00 15.00 14.00 15.	12. 00		(line 11 mi	nus line 9;	if < zero then	0	12.00
Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)			tructions f	or each line)		1
14.00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10 col 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 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 O 17.00 Ocormment grants, appropriations or transfers for support of hospital operations O 18.00 Ocormment grants, appropriations or transfers for support of hospital operations O 19.00 Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 885, 409 19.00 Dincompensated Care (see instructions for each line) Uncompensated Care (see instructions for each line) O 10.00 Charity care charges and uninsured discounts for the entire facility 8, 125, 114 1, 428, 173 9, 553, 287 (see instructions) 10.00 Cost of patients approved for charity care and uninsured discounts (see 1, 900, 619 1, 428, 173 3, 328, 792 21.00 (cost of patients approved for charity care and uninsured discounts (see 1, 900, 619 1, 428, 173 3, 328, 792 23.00 (cost of charity care (line 21 minus line 22) 1, 900, 619 1, 428, 173 3, 328, 792 23.00 (cost of charity care (line 21 minus line 22) 1, 900, 619 1, 428, 173 3, 328, 792 23.00 (cost of charity care bendunt on line 20 column 2, include charges for patient days beyond a length of stay limit limposed on patients covered by Medicaid or other indigent care program? 11.00	13.00					0	13.00
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 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, adonations, or endowment income restricted to funding charity care 0 18.00 19.00 State lunreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 885, 409 19.00 19.00 State lunreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 885, 409 19.00 19.00 State lunreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 885, 409 19.00 19.00 State lunreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 885, 409 19.00 19.00 State lunreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 885, 409 19.00 19.00 State lunreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 885, 409 19.00 19.00 State lunreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 885, 409 19.00 19.00 State lunreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 885, 409 19.00 19.00 State lunreimbursed discounts for the entire facility 8, 125, 114 1, 428, 173 9, 553, 287 20.00 State lunreimbursed discounts for the entire facility 8, 125, 114 1, 428, 173 9, 553, 287 20.00 State lunreimbursed lunreimbursed discounts for the entire facility 8, 125, 114 1, 428, 173 3, 328, 792 21.00 State lunreimbursed lunreimbursed discounts for the entire days beyond a length of stay limit 1 N 24.00 State lunreimbursed	14.00					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 unrelimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line) 17. 00 Pivate grants, donations, or endowment income restricted to funding charity care 0 18. 00 Government grants, appropriations or transfers for support of hospital operations 0 18. 00 19. 00 8, 12 and 16) Uninsured patients patients Total unrelimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 885, 409 19. 00 19. 0							
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)		, , , , , , , , , , , , , , , , , , , ,	,	41.1	45 1 11	-	
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line) 17. 00 18. 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 8, 885, 409 19. 00 8, 12 and 16) Uninsured patients patients patients + col. 2) 1. 00 Charity care charges and uninsured discounts for the entire facility 8, 125, 114 1, 428, 173 9, 553, 287 (see instructions) 20. 00 Charity care charges and uninsured discounts for the entire facility 8, 125, 114 1, 428, 173 3, 328, 792 21. 00 (sot 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 (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 to the limposed on patients covered by Medicaid or other indigent care program? 26. 00 Total bad debt expense for the entire hospital complex (see instructions) 10. 24. 00 10. 25. 00 11. 23. 64. 26. 00 27. 00 Medicare all lowable bad debts for the entire hospital complex (see instructions) 10. 728, 266 10. 7	16.00		digent care	program (II	ne 15 minus line	0	16.00
instructions for each line) Private grants, donations, or endowment income restricted to funding charity care (a) Covernment grants, appropriations or transfers for support of hospital operations (b) Total unrelimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines are patients by a patients appropriations) (c) Line of the entire facility and the entire facility are charges and uninsured discounts for the entire facility (see instructions) (c) Cost of patients approved for charity care and uninsured discounts (see instructions) (c) Cost of patients approved for charity care and uninsured discounts (see instructions) (c) Cost of patients approved for charity care and uninsured discounts (see instructions) (c) Cost of patients approved for charity care and uninsured discounts (see instructions) (c) Cost of patients approved for charity care and uninsured discounts (see instructions) (c) Cost of patients approved for charity care and uninsured discounts (see instructions) (c) Cost of patients approved for charity care and uninsured discounts (see instructions) (c) Cost of charity care (line 21 minus line 22) (c) Cost of charity care (line 21 minus line 22) (c) Cost of charity care (line 21 minus line 22) (c) Cost of charity care (line 21 minus line 22) (c) Cost of charity care (line 21 minus line 22) (c) Cost of charity care charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program? (c) Cost of charity care charges for the entire hospital complex (see instructions) (c) Cost of charity care charges for the entire hospital complex (see instructions) (c) Cost of charity care charges for the entire hospital complex (see instructions) (c) Cost of on-Medicare and non-reimbursable Medicare bad debt expense (see instructions) (c) Cost of on-Medicare and non-reimbursable Medicare bad debt expense (see instructions) (c) Cost of on-Medicare and non-reimbursable Medicare bad debt expense (see instruct			P and stat	e/local indi	gent care progran	ns (see	
18. 00 Government grants, appropriations or transfers for support of hospital operations 19. 00 Total unrel mbursed cost for Medicald , CHIP and state and local indigent care programs (sum of lines 8, 885, 409 19. 00 8, 885, 409 19. 00		instructions for each line)				·	
19.00 Total unrelimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 885, 409 19.00							1
8, 12 and 16) Uninsured patients 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 instructions) 22.00 Payments received from patients for amounts previously written off as payments received from patients for amounts previously written off as payments received from patients for amounts previously written off as payments received from patients for amounts previously written off as payments received from patients for amounts previously written off as payments received from patients payments received from patients previously written off as payments as payments received from patients payments received from patients payments received from patients previously written off as payments received from patients payments payments received from p		1			s (sum of lines	_	
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 instructions) 22.00 Cost of patients approved for charity care and uninsured discounts (see instructions) 22.00 Cost of patients approved for charity care and uninsured discounts (see instructions) 22.00 Payments received from patients for amounts previously written off as 1,900,619 1,428,173 3,328,792 21.00 22.00 Cost of charity care (line 21 minus line 22) 1,900,619 1,428,173 3,328,792 23.00 24.00 Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit N 24.00 25.00 If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit 11,238,664 26.00 Total bad debt expense for the entire hospital complex (see instructions) 331,765 27.00 27.01 Medicare allowable bad debts for the entire hospital complex (see instructions) 510,408 27.01 28.00 Non-Medicare bad debt expense (see instructions) 10,728,256 28.00 29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions) 2,688,186 29.00 20.00 Cost of uncompensated care (line 23 column 3 plus line 29) 6,016,978 30.00	19.00		rnargent	care program	s (suii oi iiiles	0, 000, 409	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 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) 1,900,619 1,428,173 3,328,792 21.00 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 11,238,664 26.00 26.00 Total bad debt expense for the entire hospital complex (see instructions) 11,238,664 26.00 27.01 Medicare allowable bad debts for the entire hospital complex (see instructions) 510,408 27.01 28.00 Non-Medicare bad debt expense (see instructions) 20.00 20.00 20.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions) 2,688,186 29.00 20.00 Cost of uncompensated care (line 23 column 3 plus line 29) 6,016,978 30.00				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 1,900,619 1,428,173 3,328,792 21.00 instructions) 22.00 Payments received from patients for amounts previously written off as 0 0 0 0 22.00 charity care 23.00 (Cost of charity care (line 21 minus line 22) 1,900,619 1,428,173 3,328,792 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 1 1,238,664 26.00 Total bad debt expense for the entire hospital complex (see instructions) 331,765 27.00 (Medicare reimbursable bad debts for the entire hospital complex (see instructions) 510,408 27.01 (Medicare allowable bad debts for the entire hospital complex (see instructions) 510,408 27.01 (2,688,186 29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions) 6,016,978 30.00 (Cost of uncompensated care (line 23 column 3 plus line 29) 6,016,978 30.00							
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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) 1, 900, 619 1, 428, 173 3, 328, 792 21. 00 22. 00 23. 00 Cost of charity care (line 21 minus line 22) 1, 900, 619 1, 428, 173 3, 328, 792 23. 00 1. 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) 21. 00 22. 00 23. 00 24. 00 Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit N 24. 00 25. 00 26. 00 27. 00 28. 00 Non-Medicare and debt expense (see instructions) 10. 728, 256 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) 20. 00 Cost of uncompensated care (line 23 column 3 plus line 29)	20. 00	Charity care charges and uninsured discounts for the entire fac	cility	8, 125, 1	1, 428, 173	9, 553, 287	20. 00
instructions) Payments received from patients for amounts previously written off as charity care 23.00 Cost of charity care (line 21 minus line 22) 1,900,619 1,428,173 3,328,792 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) 77.00 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) 21.00 O O O O O O O O O O O O O O O O O O	21 00	1 '	ints (see	1 000 4	1 1 1 1 1 1 1 2 2 2 2 2 2 2 2 2 2 2 2 2	2 220 702	21 00
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 Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit N 24. 00 1. 00 1. 1, 428, 173 3, 328, 792 23. 00 1. 00 1. 00 24. 00 25. 00 25. 00 25. 00 27. 01 28. 00 Non-Medicare allowable bad debts for the entire hospital complex (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. 00 Cost of uncompensated care (line 23 column 3 plus line 29)	∠1.00		uits (See	1, 900, 0	1,420,1/3	3, 320, 192	21.00
23.00 Cost of charity care (line 21 minus line 22) 1,900,619 1,428,173 3,328,792 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) 77.00 Medicare reimbursable bad debts for the entire hospital complex (see instructions) 8331,765 11,238,664 26.00 27.01 Medicare allowable bad debts for the entire hospital complex (see instructions) 8331,765 27.00 29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions) 2,688,186 29.00 Cost of uncompensated care (line 23 column 3 plus line 29)	22. 00		off as		0 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) 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) 10.00 10.00 10.00 11.00 11.20 11.20 11.20 12.00							
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)	23. 00	Cost of charity care (line 21 minus line 22)		1, 900, 6	19 1, 428, 173	3, 328, 792	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)						1 00	
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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) 29.00 Cost of uncompensated care (line 23 column 3 plus line 29) 11, 238, 664 26.00 331, 765 27.00 10, 728, 256 28.00 2, 688, 186 29.00 6, 016, 978 30.00		imposed on patients covered by Medicaid or other indigent care	program?	_	•		
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, 238, 664 26.00 331, 765 27.00 10, 728, 256 28.00 29.00 6, 016, 978 30.00	25. 00		ne indigent	care progra	m's length of	0	25. 00
27.00 Medicare reimbursable bad debts for the entire hospital complex (see instructions) 331,765 27.00 27.01 Medicare allowable bad debts for the entire hospital complex (see instructions) 331,765 27.00 27.01 Medicare allowable bad debts for the entire hospital complex (see instructions) 30.00 Cost of non-Medicare bad debt expense (see instructions) 30.00 Cost of uncompensated care (line 23 column 3 plus line 29) 30.00 Cost of uncompensated care (line 23 column 3 plus line 29)	26. 00	1	structions)			11, 238, 664	26.00
28.00 Non-Medicare bad debt expense (see instructions) 10,728,256 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) 10,728,256 28.00 2,688,186 29.00 6,016,978 30.00	27. 00	1		ructions)		331, 765	27. 00
29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions) 2,688,186 29.00 30.00 Cost of uncompensated care (line 23 column 3 plus line 29) 6,016,978 30.00			see instruc	tions)			1
30.00 Cost of uncompensated care (line 23 column 3 plus line 29) 6,016,978 30.00		, , , , , , , , , , , , , , , , , , , ,		! no+nu-+! -	`		1
			bense (see	INSTRUCTIONS)		•
		, , , , , , , , , , , , , , , , , , , ,	ne 30)				

	FINANCIAI SYSTEMS	FRANCISCAN HEA		N. 1E 0000 I	Peri od:	Worksheet A	2332-10
RECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	F EXPENSES	Provider CC	F	rom 01/01/2021		
				1	To 12/31/2021	Date/Time Pre 5/30/2022 7:5	pared:
	Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati	Reclassi fi ed	o piii
	·			+ col . 2)	ons (See A-6)	Trial Balance	
						(col. 3 +-	
		1.00	2.00	3.00	4. 00	<u>col. 4)</u> 5. 00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	0.00	1. 00	0.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT		4, 073, 929	4, 073, 929		8, 556, 380	
2.00	00200 CAP REL COSTS-MVBLE EQUIP		0	(-, -, -, -, -, -	3, 312, 502	2.00
3. 00 4. 00	00300 OTHER CAP REL COSTS 00400 EMPLOYEE BENEFITS DEPARTMENT	376, 085	222, 340	598, 425	0 5 -12, 256	0 586, 169	3. 00 4. 00
5. 04	00593 OTHER ADMINISTRATIVE AND GENERAL	12, 876, 314	21, 993, 485	34, 869, 799		29, 964, 252	5. 04
6.00	00600 MAINTENANCE & REPAIRS	683, 148	2, 370, 672	3, 053, 820		2, 492, 395	
7.00	00700 OPERATION OF PLANT	1, 236, 515	8, 239, 842	9, 476, 357		7, 085, 310	
8. 00 9. 00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING	188, 268	355, 048	543, 316 2, 945, 918		543, 316 2, 939, 718	
10.00	01000 DI ETARY	1, 605, 739 1, 070, 079	1, 340, 179 1, 263, 883	2, 333, 962		1, 121, 330	
11. 00	01100 CAFETERI A	34, 726	68, 152	102, 878		1, 293, 171	
13.00	01300 NURSING ADMINISTRATION	2, 034, 619	1, 355, 639	3, 390, 258		3, 326, 703	
14.00	01400 CENTRAL SERVI CES & SUPPLY	296, 875	245, 114	541, 989		403, 700	
15. 00 16. 00	01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY	1, 957, 981 166, 991	5, 252, 262 150, 799	7, 210, 243 317, 790		3, 131, 108 317, 790	
17. 00	01700 SOCIAL SERVICE	100, 771	130, 777	317, 770		317, 790	17. 00
22. 00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV	26, 554	408, 884	435, 438	83, 511	518, 949	22. 00
	INPATIENT ROUTINE SERVICE COST CENTERS				_		
30.00	03000 ADULTS & PEDI ATRI CS	11, 192, 610	5, 770, 307	16, 962, 917		15, 481, 899	
31. 00 32. 00	03100 INTENSIVE CARE UNIT 03200 CORONARY CARE UNIT	2, 049, 748	1, 544, 624 0	3, 594, 372	-440, 292 0	3, 154, 080	31. 00 32. 00
35. 00	02060 NEONATAL INTENSIVE CARE UNIT	166, 000	76, 950	242, 950	1	242, 950	
41. 00	04100 SUBPROVI DER - I RF	3, 555, 165	2, 186, 676	5, 741, 84		5, 349, 856	
42.00	04200 SUBPROVI DER	O	0	(0	
43. 00	04300 NURSERY	0	0	(188, 252	188, 252	43. 00
50. 00	ANCILLARY SERVICE COST CENTERS O5000 OPERATING ROOM	1, 549, 982	9, 155, 631	10, 705, 613	-8, 045, 341	2, 660, 272	50.00
50. 01	05001 OUTPATIENT SURGERY	646, 044	516, 885	1, 162, 929		854, 136	
51.00	05100 RECOVERY ROOM	345, 095	145, 905	491, 000	-66, 761	424, 239	
53.00	05300 ANESTHESI OLOGY	35, 290	3, 094, 468	3, 129, 758		2, 836, 645	
54. 00 54. 01	05400 RADI OLOGY-DI AGNOSTI C 05401 RADI OLOGY-SPECI AL PROCEDURES	1, 245, 148 499, 807	1, 834, 760 699, 957	3, 079, 908 1, 199, 764		2, 071, 569 619, 282	
55. 00	05500 RADI OLOGY-THERAPEUTI C	499, 807	099, 937	1, 199, 702	-560, 462	019, 202	
56. 00	05600 RADI OI SOTOPE	316, 090	431, 813	747, 903	-309, 297	438, 606	
60.00	06000 LABORATORY	208, 621	6, 286, 360	6, 494, 981		6, 491, 662	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	289, 177	289, 177		13, 734	
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	1, 392, 303 3, 364, 463	1, 556, 297 4, 002, 749	2, 948, 600 7, 367, 212		2, 679, 556 7, 316, 471	
67. 00	06700 OCCUPATI ONAL THERAPY	722, 378	183, 783	906, 16		902, 557	
68. 00	06800 SPEECH PATHOLOGY	365, 704	214, 369	580, 073		528, 365	
69. 00	06900 ELECTROCARDI OLOGY	819, 593	411, 601	1, 231, 194		1, 069, 310	
70.00		166, 902	69, 997	236, 899		208, 145	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS		0	(9, 153, 767 8, 767, 489	9, 153, 767 8, 767, 489	
73. 00	07300 DRUGS CHARGED TO PATIENTS		ő	(4, 722, 051	4, 722, 051	
76. 00	03630 ULTRA SOUND	432, 959	233, 819	666, 778		570, 653	
76. 01	03951 PAIN CLINIC	591, 714	349, 033	940, 747		855, 367	
76. 02	03952 CATH LAB	1, 426, 140	6, 944, 556	8, 370, 696		1, 859, 802	1
76. 03 76. 04	03953 ACTIVITY THERAPEUTIC 03954 WOUND CARE CENTER	2, 250, 240 184, 723	612, 180 199, 997	2, 862, 420 384, 720		2, 861, 828 233, 682	
76. 05	03340 BARI ATRI C CLI NI C	1, 239, 178	301, 120	1, 540, 298		1, 526, 632	
76. 06	03030 HEALTHY LIVING CENTER	o	0		0	0	1
76. 07	03950 CV RESOURCE CENTER	0	0	(0	0	
76. 08	03955 OTHER ANCILLARY SERVICE COST CENTERS	0	0	(0	0	
76. 09 76. 10	03956 LACTATION CLINIC 03957 OTHER ANCILLARY SERVICE COST CENTERS		0	(0	76. 09 76. 10
76. 10	03958 OTHER ANCILLARY SERVICE COST CENTERS		Ö	,		0	76. 10
76. 12	03959 ANTI COAGULATI ON CLINIC	421, 777	134, 812	556, 589	-25, 276	531, 313	
	OUTPATIENT SERVICE COST CENTERS	0.000.047	0 400 004			4 500 700	
	O9100 EMERGENCY O9200 OBSERVATION BEDS (NON-DISTINCT PART	3, 280, 817	2, 198, 331	5, 479, 148	-948, 448	4, 530, 700	91. 00 92. 00
92.00	SPECIAL PURPOSE COST CENTERS						72.00
113.00	11300 NTEREST EXPENSE		29, 562	29, 562	3, 169, 918	3, 199, 480	113. 00
118.00		61, 022, 385	96, 815, 947	157, 838, 332	98, 811	157, 937, 143	118. 00
100 5	NONREI MBURSABLE COST CENTERS	0, 505	4, 30-1	70.00	J	77 /::	100 05
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	34, 583	44, 799	79, 382 12, 658, 350		77, 641 12, 615, 956	190.00
	19200 PHYSICIANS PRIVATE OFFICES	7, 732, 273 31, 619	4, 926, 077 614	12, 658, 350 32, 233			192. 00
	19202 PHYSI CI ANS' PRI VATE OFFI CES	0.,017	0	JZ, ZJ.			192. 02
192. 03	19203 MI SC	2, 364, 739	1, 404, 204	3, 768, 943		3, 767, 979	
194.00	07950 RESI DENTI AL	0	0	(-53, 712	-53, 712	194. 00

Health Financial Systems	FRANCISCAN HE	ALTH- DYER		In Li∈	eu of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der CO		eri od:	Worksheet A	
			F	rom 01/01/2021		
			7	o 12/31/2021	Date/Time Pre	pared:
					5/30/2022 7:5	8 pm
Cost Center Description	Sal ari es	0ther	Total (col. 1	Recl assi fi cati	Recl assi fi ed	
			+ col . 2)	ons (See A-6)	Trial Balance	
					(col. 3 +-	
					col. 4)	
	1.00	2.00	3. 00	4. 00	5. 00	
194. 01 07954 OTHER NONREIMBURSABLE COST CENTERS	0	0	(0	0	194. 01
194. 02 07952 PSYCHI ATRI C	0	0	(0	0	194. 02
194. 03 07953 CENTER OF HOPE	0	9, 203	9, 203	0	9, 203	194. 03
200.00 TOTAL (SUM OF LINES 118 through 199)	71, 185, 599	103, 200, 844	174, 386, 443	0	174, 386, 443	200. 00

Peri od: From 01/01/2021 To 12/31/2021 Date/Ti me Prepared: 5/30/2022 7:58 pm

			5/30/2022 7:5	8 pm
Cost Center Description	Adjustments	Net Expenses		
		For Allocation		
DENIEDAL DEDILLOS DOCT DENIEDO	6.00	7. 00		
GENERAL SERVICE COST CENTERS	I 404 (45	0.044.745		
1. 00 00100 CAP REL COSTS-BLDG & FLXT	-491, 615	8, 064, 765		1.00
2. 00 00200 CAP REL COSTS-MVBLE EQUIP	0	3, 312, 502		2.00
3. 00 00300 OTHER CAP REL COSTS	0	0		3.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT	1, 790, 068	2, 376, 237		4. 00
5. 04 00593 OTHER ADMINISTRATIVE AND GENERAL	-2, 416, 460	27, 547, 792		5. 04
6. 00 00600 MAI NTENANCE & REPAI RS	0	2, 492, 395		6.00
7. 00 00700 OPERATION OF PLANT	120 705	7, 085, 310		7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE	-128, 795	414, 521		8.00
9. 00 00900 HOUSEKEEPI NG	-6	2, 939, 712		9.00
10. 00 01000 DI ETARY	0	1, 121, 330		10.00
11. 00 01100 CAFETERI A	-352, 404	940, 767		11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	-141, 061	3, 185, 642		13.00
14. 00 01400 CENTRAL SERVI CES & SUPPLY	-213	403, 487		14. 00
15. 00 01500 PHARMACY	-231, 673	2, 899, 435		15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	888, 840	1, 206, 630		16.00
17. 00 01700 SOCI AL SERVI CE	221 742	207 204		17. 00
22. 00 02200 I &R SERVI CES-OTHER PRGM COSTS APPRV	-231, 743	287, 206		22. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	210,000	15 270 010		20.00
30. 00 03000 ADULTS & PEDI ATRI CS	-210, 989	15, 270, 910		30.00
31. 00 03100 I NTENSI VE CARE UNIT	0	3, 154, 080		31.00
32. 00 03200 CORONARY CARE UNIT	0	0		32.00
35. 00 02060 NEONATAL INTENSIVE CARE UNIT	0	242, 950		35. 00
41. 00 04100 SUBPROVI DER - I RF	2, 498, 526	7, 848, 382		41.00
42. 00 04200 SUBPROVI DER	0	0		42. 00
43. 00 04300 NURSERY	0	188, 252		43. 00
ANCILLARY SERVICE COST CENTERS	100 540	0.500.754		
50. 00 05000 OPERATI NG ROOM	-130, 518	2, 529, 754		50.00
50. 01 05001 0UTPATI ENT SURGERY	12, 919	867, 055		50. 01
51. 00 05100 RECOVERY ROOM	-1, 733	422, 506		51.00
53. 00 05300 ANESTHESI OLOGY	-2, 506	2, 834, 139		53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	-73, 030	1, 998, 539		54. 00
54. 01 05401 RADI OLOGY-SPECI AL PROCEDURES	-12, 517	606, 765		54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	О		55. 00
56. 00 05600 RADI 0I SOTOPE	-2, 729	435, 877		56. 00
60. 00 06000 LABORATORY	-486, 033	6, 005, 629		60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	-13, 037	697		63. 00
65. 00 06500 RESPIRATORY THERAPY	-136, 066	2, 543, 490		65. 00
66. 00 06600 PHYSI CAL THERAPY	-141, 404	7, 175, 067		66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	-725	901, 832		67. 00
68. 00 06800 SPEECH PATHOLOGY	-5, 744	522, 621		68.00
69. 00 06900 ELECTROCARDI OLOGY	-35, 557	1, 033, 753		69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	-2, 236	205, 909		70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2, 230	9, 153, 767		71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS				72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS		8, 767, 489 4, 722, 051		73.00
	1			
76. 00 03630 ULTRA SOUND	-22, 661	547, 992		76.00
76. 01 03951 PAIN CLINIC	-131, 857	723, 510		76. 01
76. 02 03952 CATH LAB	-2, 337	1, 857, 465		76. 02
76. 03 03953 ACTI VI TY THERAPEUTI C	-13, 737	2, 848, 091		76. 03
76. 04 03954 WOUND CARE CENTER	-211	233, 471		76. 04
76. 05 03340 BARI ATRI C CLI NI C	-45, 488	1, 481, 144		76. 05
76. 06 03030 HEALTHY LIVING CENTER	0	0		76.06
76. 07 03950 CV RESOURCE CENTER	0	O		76. 07
76. 08 03955 OTHER ANCILLARY SERVICE COST CENTERS	0	0		76. 08
76. 09 03956 LACTATION CLINIC	0	0		76. 09
76. 10 03957 OTHER ANCILLARY SERVICE COST CENTERS	0	0		76. 10
76. 11 03958 OTHER ANCILLARY SERVICE COST CENTERS	0	0		76. 11
76. 12 03959 ANTI COAGULATI ON CLINIC	0	531, 313		76. 12
OUTPATIENT SERVICE COST CENTERS				
91. 00 09100 EMERGENCY	-116, 336	4, 414, 364		91. 00
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART				92. 00
SPECIAL PURPOSE COST CENTERS				
113. 00 11300 I NTEREST EXPENSE	-3, 199, 480	0		113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	-3, 590, 548	154, 346, 595		118. 00
NONREI MBURSABLE COST CENTERS				
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	77, 641		190. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	Ö	12, 615, 956		192. 00
192. 01 19201 WORKI NG WELL	l o	32, 233		192. 01
192. 02 19202 PHYSI CI ANS' PRI VATE OFFI CES		0		192. 02
192. 03 19203 MI SC		3, 767, 979		192. 03
194. 00 07950 RESI DENTI AL		-53, 712		194. 00
194. 01 07954 OTHER NONREIMBURSABLE COST CENTERS		-53, 712		194. 00
194. 01 07934 OTHER NONRETWIDGESABLE COST CENTERS		0		194. 01
52/37/02/1 516/1////// 5	<u> </u>	<u> </u>		1.71.02

Health Financial Systems	FRANCISCAN H	EALTH- DYER			In Lie	u of Form CM	IS-2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (OF EXPENSES	Provider Co	CN: 15-0090	Peri	od: 01/01/2021	Worksheet A	1
				To	12/31/2021	Date/Time F 5/30/2022	
Cost Center Description	Adjustments	Net Expenses					,
	(See A-8)	For Allocation					
	6.00	7. 00					
194. 03 07953 CENTER OF HOPE	0	9, 203					194. 03
200.00 TOTAL (SUM OF LINES 118 through 199)	-3, 590, 548	170, 795, 895					200. 00

Health Financial Systems RECLASSIFICATIONS Peri od: From 01/01/2021 To 12/31/2021 Date/Ti me Prepared: 5/30/2022 7:58 pm Provider CCN: 15-0090

					5/30/2022 7: 5	8 pm
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
	2. 00	3.00	4. 00	5. 00		
	A - CAPITAL					
1. 00	CAP REL COSTS-BLDG & FIXT	1.00	0	5, 745, 232		1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	2. 00	0	3, 312, 502		2. 00
3.00		0.00	0	0		3. 00
4.00		0.00	0	0		4. 00
5.00	1	0.00	0	0		5. 00
6. 00	1	0.00	0	0		6. 00
7.00		0.00	0	0		7. 00
8.00		0.00	0	0		8. 00
9.00		0.00	0	0		9. 00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11. 00
12.00		0.00	0	0		12.00
13. 00 14. 00		0. 00 0. 00	0	0		13. 00 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	o	Ö		18. 00
19. 00		0.00	o	Ö		19. 00
20. 00		0.00	o	Ö		20. 00
21. 00		0.00	Ö	Ö		21. 00
22. 00		0.00	o	o		22. 00
23. 00		0.00	ő	Ö		23. 00
24. 00		0.00	Ö	o		24. 00
25. 00		0.00	o	Ö		25. 00
26. 00		0.00	Ö	Ö		26. 00
27. 00		0.00	ō	O		27. 00
28. 00		0.00	ō	O		28. 00
29. 00		0.00	O	0		29. 00
30.00		0.00	O	0		30.00
31.00		0.00	o	0		31.00
32.00		0.00	o	0		32.00
33.00		0.00	o	0		33.00
34.00		0.00	o	0		34.00
35.00		0.00	o	0		35.00
36.00		0.00	o	0		36.00
37.00		0.00	0	0		37.00
38. 00		0.00	0	0		38.00
	0		0	9, 057, 734		
	B - INTEREST EXPENSE					
1. 00	CAP REL COSTS-BLDG & FIXT	1.00	0	332, 033		1. 00
2.00	INTEREST EXPENSE	113.00	•	<u>3, 501, 9</u> 51		2.00
	0		0	3, 833, 984		
	C - CAFETERIA					
1. 00	CAFETERI A	11.00	545, 645	644, 648		1. 00
	0		545, 645	644, 648		
1 00	D - INSURANCE EXPENSE		-1	1 100 01-		4 00
1. 00	OTHER ADMINISTRATIVE AND	5. 04	0	1, 401, 860		1. 00
	GENERAL	++				
	E - PATIENT TRANSPORT		U	1, 401, 860		
1.00	ADULTS & PEDIATRICS	30.00	13, 412	8, 192		1. 00
2.00	RADI OLOGY-DI AGNOSTI C	54.00	74, 831	45, 708		2. 00
3.00	RADI OI SOTOPE	56.00	22, 742	13, 891		3. 00
4. 00	ELECTROCARDI OLOGY	69.00	5, 246	3, 204		4. 00
5. 00	ULTRA SOUND	76.00	9, 330	5, 699		5. 00
6. 00	CATH LAB	76.02	4, 954	3, 026		6. 00
7. 00	EMERGENCY	91.00	8, 327	5, 086		7. 00
8. 00	PHYSICIANS' PRIVATE OFFICES	192.00	388	237		8. 00
- -	0	<u></u>	139, 230	<u>85, 043</u>		
	F - CHARGEABLE SUPPLIES		,	.,		
1.00	MEDICAL SUPPLIES CHARGED TO	71.00	0	17, 921, 256		1.00
	PATI ENT					
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5. 00
6.00		0.00	0	0		6. 00
7.00		0.00	0	0		7. 00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9. 00
10.00		0.00	0	0		10.00
11. 00		0.00	0	0		11. 00

Peri od: Worksheet A-6 From 01/01/2021 To 12/31/2021 Date/Time Prepared: 5/30/2022 7:58 pm

					5/30/2022 7:5	8 pm
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
	2. 00	3. 00	4. 00	5. 00		
12.00		0.00	0	0		12. 00
13. 00		0.00	0	0		13.00
14.00		0. 00	0	0		14.00
15. 00		0.00	0	0		15. 00
16.00		0. 00	0	0		16. 00
17. 00		0.00	0	0		17. 00
18. 00		0.00	0	0		18. 00
19.00		0.00	0	0		19. 00
20. 00		0. 00	0	0		20. 00
21. 00		0.00	0	0		21. 00
22. 00		0. 00	0	0		22. 00
23. 00		0.00	0	0		23. 00
24. 00		0.00	0	0		24. 00
25. 00		0.00	0	0		25. 00
26. 00		0.00	0	0		26. 00
27. 00			0	0		27. 00
	C DDUCE CHARCED TO DATIENTS		U	17, 921, 256		
1.00	G - DRUGS CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS	73.00	0	4, 722, 051		1. 00
2.00	ACTIVITY THERAPEUTIC	75.00 76.03	o	4, 722, 031		2. 00
3.00	ACTIVITI ITIERAFEOTIC	0.00	0	0		3. 00
4.00		0.00	0	0		4. 00
5.00		0.00	o	0		5. 00
6. 00		0.00	o	0		6. 00
7. 00		0.00	o	0		7. 00
8. 00		0.00	o	0		8. 00
9. 00		0.00	o	0		9. 00
10. 00		0.00	o	0		10. 00
11. 00		0.00	o	0		11. 00
12. 00		0.00	Ö	0		12. 00
13. 00		0.00	o	0		13. 00
14. 00		0.00	o	0		14. 00
15. 00		0.00	o	0		15. 00
16.00		0.00	o	0		16. 00
17.00		0.00	o	0		17. 00
18.00		0.00	o	0		18. 00
	0 — — — — — —		<u> </u>	4, 722, 058		
	H - INTERNS AND RESIDENTS					
1.00	I&R SERVICES-OTHER PRGM	22. 00	75, 529	7, 982		1. 00
	COSTS APPRV					
	0		75, 529	7, 982		
	I - NURSERY		4551			
1. 00	NURSERY	<u>43.</u> 00	15 <u>5, 9</u> 83	32, 269		1. 00
	TOTALS		155, 983	32, 269		
1 00	J - IMPLANTABLE DEVICES IMPL. DEV. CHARGED TO	72.00	ol	0 7/7 /00		1 00
1. 00	PATI ENTS	72. 00	۷	8, 767, 489		1. 00
	0		— — — d	8, 767, 489		
500 00	Grand Total: Increases		916, 387			500. 00
555.00	o. aa .otal . Thereases	ı	, 10, 507	10, 17 1, 320	· · · · · · · · · · · · · · · · · · ·	200.00

Peri od: From 01/01/2021 To 12/31/2021

Date/Time Prepared: 5/30/2022 7:58 pm

		Decreases				5/30/2022 7:5	28 pm
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8. 00	9. 00	10. 00		
	A - CAPITAL						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	192, 954	l .		1. 00
2.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	12, 256	l 1		2. 00
3. 00	OTHER ADMINISTRATIVE AND	5. 04	0	2, 721, 945	0		3. 00
4.00	GENERAL MAINTENANCE & REPAIRS	6. 00	0	561, 425	o		4. 00
5. 00	OPERATION OF PLANT	7. 00	o	2, 391, 047	0		5. 00
6. 00	HOUSEKEEPI NG	9. 00	o	6, 200	- 1		6. 00
7.00	DI ETARY	10.00	0	22, 339	l .		7. 00
8.00	NURSING ADMINISTRATION	13. 00	0	63, 555	0		8. 00
9.00	CENTRAL SERVICES & SUPPLY	14. 00	0	64, 750	0		9. 00
10. 00	PHARMACY	15. 00	0	13, 418	l .		10.00
11.00	ADULTS & PEDIATRICS	30.00	0	303, 504	l 1		11.00
12. 00 13. 00	INTENSIVE CARE UNIT SUBPROVIDER - IRF	31. 00 41. 00	0	68, 640 34, 706	l 1		12. 00 13. 00
14. 00	OPERATING ROOM	50.00	0	465, 590	1		14. 00
15. 00	OUTPATIENT SURGERY	50. 01	o	24, 318	- 1		15. 00
16.00	RECOVERY ROOM	51.00	0	36, 955	l .		16. 00
17. 00	ANESTHESI OLOGY	53.00	О	52, 372	l 1		17. 00
18.00	RADI OLOGY-DI AGNOSTI C	54.00	0	957, 769	0		18. 00
19. 00	RADI OLOGY-SPECI AL PROCEDURES	54. 01	0	10, 123	l		19. 00
20.00	RADI OI SOTOPE	56.00	0	86, 112	0		20.00
21. 00	LABORATORY	60.00	0	1, 905			21. 00
22. 00 23. 00	RESPIRATORY THERAPY PHYSICAL THERAPY	65. 00 66. 00	0	71, 870 35, 836	l 1		22. 00 23. 00
24. 00	SPEECH PATHOLOGY	68. 00	0	8, 614	1		24. 00
25. 00	ELECTROCARDI OLOGY	69.00	ő	150, 064	l .		25. 00
26. 00	ELECTROENCEPHALOGRAPHY	70. 00	O	13, 014	1		26. 00
27. 00	ULTRA SOUND	76.00	O	68, 261	0		27. 00
28. 00	PAIN CLINIC	76. 01	0	13, 430			28. 00
29. 00	CATH LAB	76. 02	0	335, 946	l 1		29. 00
30. 00	ACTI VI TY THERAPEUTI C	76. 03	0	100	l .		30.00
31.00	WOUND CARE CENTER	76.04	0	5, 124			31.00
32. 00 33. 00	BARIATRIC CLINIC ANTICOAGULATION CLINIC	76. 05 76. 12	0	9, 774 255			32. 00 33. 00
34. 00	EMERGENCY	91.00	0	154, 127	0		34.00
35. 00	GIFT, FLOWER, COFFEE SHOP &	190. 00	o	1, 741	o		35. 00
	CANTEEN			,			
36.00	PHYSICIANS' PRIVATE OFFICES	192. 00	0	43, 019	0		36. 00
37. 00	MISC	192. 03	0	964	l		37. 00
38. 00	RESI DENTI AL	194.00	9	53, 712			38. 00
	B - INTEREST EXPENSE		0	9, 057, 734			-
1.00	INTEREST EXPENSE	113. 00	0	332, 033	10		1.00
2. 00	OTHER ADMINISTRATIVE AND	5. 04	ő	3, 501, 951	l 1		2. 00
	GENERAL						
	0 — — — — —			3, 833, 984			
	C - CAFETERIA						
1.00	DI ETARY	<u>10.</u> 00	545, 645	644, 648			1. 00
	D - INSURANCE EXPENSE		545, 645	644, 648			-
1.00	CAP REL COSTS-BLDG & FIXT	1. 00	0	1, 401, 860	10		1.00
	0		— — o	1, 401, 860			
	E - PATIENT TRANSPORT						
1.00	EMERGENCY	91.00	139, 230	85, 043			1. 00
2.00		0.00	0	0	- 1		2.00
3. 00 4. 00		0. 00 0. 00	0	0	0		3. 00 4. 00
5.00		0.00	0	0	0		5. 00
6.00		0.00	Ö	0	o		6. 00
7.00		0.00	0	0	0		7. 00
8.00		0. 00	o	0	0		8. 00
	0		139, 230	85, 043			
4 00	F - CHARGEABLE SUPPLIES	44.00	ما	70 500	٥		1 00
1.00	CENTRAL SERVICES & SUPPLY ADULTS & PEDIATRICS	14. 00 30. 00	0	73, 539 965, 213			1.00
2. 00 3. 00	INTENSIVE CARE UNIT	30.00	0	330, 920			3. 00
4. 00	SUBPROVI DER - I RF	41. 00	0	193, 718			4. 00
5. 00	OPERATING ROOM	50.00	o	7, 563, 071	l 1		5. 00
6.00	OUTPATIENT SURGERY	50. 01	O	281, 038	l 1		6. 00
7.00	RECOVERY ROOM	51.00	o	27, 729	l 1		7. 00
8.00	ANESTHESI OLOGY	53.00	0	188, 791	l 1		8. 00
9.00	RADI OLOGY - DI AGNOSTI C	54.00	0	165, 604			9.00
10. 00	RADI OLOGY-SPECI AL PROCEDURES	54. 01	0	569, 410	0		10.00

Period: Worksheet A-6
From 01/01/2021
To 12/31/2021 Date/Time Prepared: 5/30/2022 7:58 pm Provider CCN: 15-0090

COST Center							5.	/30/2022 7:58 pm
C. 00 C. 0			Decreases					
11.00 ABDIOL SOTOPE		Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
12.00 LABORATORY CO. 00 0 1, 414 0 13.00		6. 00	7. 00	8. 00	9. 00	10. 00		
13.0 00 BLOOD STORING, PROCESSING & 63.00 0 275, 443 0 13.0 00 14.00 14.00 14.00 14.00 15.00	11. 00	RADI OI SOTOPE	56.00	0	9, 319	0		11. 00
TRAMS	12.00	LABORATORY	60.00	0	1, 414			12. 00
14. 00 RESPIRATIONY THERAPY 65. 00 0 137, 769 0 14. 00 15. 00 16. 00 0 0 0 0 0 0 0 15. 00 0 16. 00 0 0 0 0 0 0 0 16. 00 0 0 16. 00 0 0 0 0 0 0 0 0 0	13.00	BLOOD STORING, PROCESSING &	63.00	0	275, 443	0		13. 00
15.00 PHYSICAL THERAPY								
16. 00 0CCUPATI ONAL THERAPY 67. 00 0 3, 604 0 17. 00 18. 00 18. 00 18. 00 0 42. 094 0 0 17. 00 18. 00 0 12. 052 0 18. 00 19. 00 1		RESPI RATORY THERAPY		0				
17. 00 SPEECH PATHOLOGY				0				
18. 00 ELECTROCARDI OLOGY 69. 00 0 20. 252 0 18. 00				0				
19 00 ELECTROENCEPHALOGRAPHY 70,00 0 15,7440 0 19,00 20,00 20 00 UITAS SOUND 76,00 0 42,893 0 22,00 21 00 PAIN CLINIC 76,01 0 71,427 0 21.00 22 00 ACTIVITY THERAPEUTIC 76,03 0 4.99 0 22.00 23 00 ACTIVITY THERAPEUTIC 76,03 0 4.99 0 22.00 25 00 BARI ATRIC CLINIC 76,05 0 3,889 0 25.00 26 00 BARI ATRIC CLINIC 76,05 0 3,889 0 25.00 26 00 ACTIVITY THERAPEUTIC 76,05 0 3,889 0 25.00 26 00 ACTIVITY THERAPEUTIC 76,05 0 3,889 0 25.00 26 00 ACTIVITY THERAPEUTIC 76,05 0 3,889 0 25.00 27 00 EMERGENCY 91,00 0 560,468 0 27.00 28 00 ACTIVITY THERAPEUTIC 76,12 0 25.001 29 00 ACTIVITY THERAPEUTIC 76,05 0 3,889 0 25.00 20 00 ACTIVITY THERAPEUTIC 76,05 0 3,889 0 25.00 20 00 ACTIVITY THERAPEUTIC 76,05 0 3,889 0 25.00 20 00 ACTIVITY THERAPEUTIC 76,05 0 3,889 0 25.00 20 00 ACTIVITY THERAPEUTIC 76,05 0 560,468 0 27.00 20 00 ACTIVITY THERAPEUTIC 76,05 0 560,468 0 27.00 20 00 ACTIVITY THERAPEUTIC 76,05 0 560,468 0 27.00 20 00 ACTIVITY THERAPEUTIC 76,05 0 4.065,717 0 1.00 20 00 ACTIVITY THERAPEUTIC 76,05 0 4.065,717 0 1.00 20 00 ACTIVITY THERAPEUTIC 76,05 0 4.055,717 0 1.00 20 00 ACTIVITY THERAPEUTIC 76,05 0 3 0 1.00 20 00 ACTIVITY THERAPEUTIC 76,05 0 3 0 1.00 20 00 ACTIVITY THERAPEUTIC 76,05 0 3 0 1.00 20 00 ACTIVITY THERAPEUTIC 76,05 0 3 0 1.00 20 00 ACTIVITY THERAPEUTIC 76,05 0 3 0 1.00 20 00 ACTIVITY THERAPEUTIC 76,05 0 3 0 1.00 20 00 ACT	17. 00	SPEECH PATHOLOGY	68. 00	0	43, 094			17. 00
20.00 ULTRA SOUND	18. 00	ELECTROCARDI OLOGY	69. 00	0	20, 252			18. 00
21 00 PAIN CLINIC 76.01 0 77.427 0 21.00 22.00 22.00 22.00 23.00 ACTIVITY THERAPEUTIC 76.03 0 4.799 0 23.00 24.00 25.00 26.00 27.00 26.00 27.00 26.00 27.00	19.00	ELECTROENCEPHALOGRAPHY	70.00	0	15, 740			19. 00
22 00 CATH LAB 76.02 0 6.178,818 0 22 00	20.00	ULTRA SOUND	76.00	0	42, 893	0		20. 00
23. 00 ACTI VITY THERAPEUTIC 76. 03 0 499 0 23. 00	21.00	PAIN CLINIC	76. 01	0	71, 427	0		21. 00
24 00 MOUND CARE CENTER 76 04 0 107,668 0 24,00	22.00	CATH LAB	76. 02	0	6, 178, 818	0		22. 00
25. 00	23.00	ACTIVITY THERAPEUTIC	76. 03	0	499	0		23. 00
26. 00 ANTI COAGULATION CLINIC 76. 12 0 25. 021 0 27. 00	24.00	WOUND CARE CENTER	76. 04	O	107, 668	o		24. 00
27.00 EMERGENCY	25.00	BARIATRIC CLINIC	76. 05	o	3, 889	o		25. 00
O	26.00	ANTI COAGULATION CLINIC		o	25, 021	o		26. 00
C DRUGS CHARGED TO PATIENTS 15.00	27. 00	EMERGENCY	91.00	o	560, 468	o		27. 00
1. 00 PHARMACY			1					
1. 00 PHARMACY		G - DRUGS CHARGED TO PATIENTS	'	<u>'</u>		'		
3.00	1.00		15. 00	0	4, 065, 717	0		1.00
3.00	2.00	ADULTS & PEDIATRICS	30.00	o	45, 653	o		2.00
4. 00 SUBPROVI DER - I RF 41. 00 0 163,561 0 0 0 0 0 0 0 0 0		•		o				
5.00 OPERATI NG ROOM 50.00 0 16,680 0 5.00 6.00 0 0.00 0.		•	41, 00	o		O		4. 00
6.00 OUTPATIENT SURGERY 50.01 0 3,437 0 6.00 7.00 RECOVERY ROOM 51.00 0 2,077 0 7.00 8.00 ANESTHESI OLOGY 53.00 0 51,950 0 8.00 9.00 RADI OLOGY-DI AGNOSTI C 54.00 0 5,505 0 9.00 10.00 RADI OLOGY-SPECI AL PROCEDURES 54.01 0 949 0 0 10.00 11.00 RADI OLOGY-SPECI AL PROCEDURES 54.01 0 949 0 11.00 12.00 RESPI RATORY THERAPY 65.00 0 250,499 0 11.00 13.00 ELECTROCARDI OLOGY 69.00 0 18 0 13.00 14.00 PAIN CLI INI C 76.01 0 523 0 14.00 15.00 CATH LAB 76.02 0 4,110 0 15.00 16.00 WOUND CARE CENTER 76.04 0 38,246 0 16.00 17.00 BARI ATRI C CLI INI C 76.05 0 3 0 17.00 18.00 EMERGENCY 91.00 0 22,993 0 18.00 18.00 H - INTERNS AND RESI DENTS		•	50.00	o		O		5. 00
7. 00 RECOVERY ROOM 51. 00 0 2, 077 0 8. 00 ANESTHESI OLOGY 53. 00 0 51, 950 0 8. 00 9. 00 RADI OLOGY-SPECI AL PROCEDURES 54. 01 0 949 0 10. 00 11. 00 RADI OLOGY-SPECI AL PROCEDURES 54. 01 0 949 0 10. 00 11. 00 RADI OLOGY-SPECI AL PROCEDURES 56. 00 0 250, 499 0 11. 00 11. 00 RADI OLOGY-SPECI AL PROCEDURES 56. 00 0 250, 499 0 11. 00 11. 00 RADI OLOGY-SPECI AL PROCEDURES 56. 00 0 250, 499 0 11. 00 11. 00 11. 00 RADI OLOGY-SPECI AL PROCEDURES 56. 00 0 250, 499 0 11. 00 11. 00 11. 00 RADI OLOGY 69. 00 0 9, 405 0 11. 00	6. 00	OUTPATIENT SURGERY		0		0		6. 00
8. 00 ANESTHESI OLOGY 53. 00 0 51, 950 0 8. 00 9. 00 75, 505 0 9. 00 9.				o		O		
9. 00 RADI OLOGY-DI AGNOSTI C 54. 00 0 5, 505 0 10. 00 RADI OLOGY-SPECI AL PROCEDURES 54. 01 0 949 0 110. 00 110. 00 110. 00 RADI OLOGY-SPECI AL PROCEDURES 54. 01 0 949 0 110. 00 110. 00 111. 00 RADI OLOGY-SPECI AL PROCEDURES 54. 01 0 949 0 110. 00 110. 00 111. 00 RADI OLOGY 56. 00 0 9. 405 0 112. 00 RESPI RATORY THERAPY 65. 00 0 9. 405 0 112. 00 113. 00 114. 00 PAIN CLINI C 76. 01 0 523 0 114. 00 115. 00 CATH LAB 76. 02 0 4. 110 0 0 15. 00 CATH LAB 76. 02 0 4. 110 0 0 15. 00 16. 00 WOUND CARE CENTER 76. 04 0 38, 246 0 16. 00 17. 00 BARI ATRI C CLINI C 76. 05 0 3 0 17. 00 BARI ATRI C CLINI C 76. 05 0 3 0 17. 00 EMERGENCY 91. 00 0 22. 993 0 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 17. 00 18. 00 17. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 19. 0		•		0				
10. 00 RADI OLOGY-SPECI AL PROCEDURES 54. 01 0 949 0 10. 00 11. 00 RADI OLOGY-SPECI AL PROCEDURES 56. 00 0 250, 499 0 11. 00 12. 00 RADI OL SOTOPE 56. 00 0 250, 499 0 11. 00 13. 00 ELECTROCARDI OLOGY 69. 00 0 18 0 13. 00 14. 00 PAIN CLINIC 76. 01 0 523 0 14. 00 15. 00 CATH LAB 76. 02 0 4. 110 0 15. 00 16. 00 WOUND CARE CENTER 76. 04 0 38, 246 0 16. 00 17. 00 BARI ATRI C CLINIC 76. 05 0 3 0 17. 00 18. 00 EMERGENCY 91.00 0 22, 993 0 18. 00 1 - INTERNS AND RESI DENTS		•		0		0		
11. 00 12. 00 12. 00 12. 00 13. 00 14. 00 13. 00 14. 00 15. 00 15. 00 15. 00 15. 00 15. 00 16. 00 16. 00 17. 00 18. 00 18. 00 18. 00 19				o				
12. 00 13. 00 14. 00 14. 00 14. 00 15. 00 15. 00 16. 00 16. 00 17. 00 18. 00 18. 00 18. 00 19				o		- 1		
13. 00 14. 00 14. 00 15. 00 15. 00 16. 00 16. 00 17. 00 18. 00 18. 00 19				Ö				
14. 00 PAIN CLINIC 76. 01 0 523 0 14. 00 15. 00 CATH LAB 76. 02 0 4, 110 0 15. 00 16. 00 WOUND CARE CENTER 76. 04 0 38, 246 0 16. 00 17. 00 BARI ATRI C CLINIC 76. 05 0 3 0 17. 00 18. 00 EMERGENCY 91. 00 0 22, 993 0 0 18. 00 18. 00 OTHER ADMI NI STRATI VE AND 5. 04 75, 529 7, 982 0 1. 00 10 TOTALS 70. 00 155, 983 32, 269 0 1. 00 10 ADULTS & PEDI ATRI CS 30. 00 155, 983 32, 269 0 1. 00 10 MEDI CAL SUPPLI ES CHARGED TO 71. 00 8, 767, 489 0 1. 00 PATI ENT 0 0 8, 767, 489 0 1. 00				0				
15. 00 CATH LAB 76. 02 0 4, 110 0 15. 00 16. 00 WOUND CARE CENTER 76. 04 0 38, 246 0 16. 00 17. 00 BARI ATRI C CLINI C 76. 05 0 3 0 17. 00 18. 00 EMERGENCY 91. 00 0 22, 993 0 18. 00 0 0 4, 722, 058 1 18. 00 0 THER ADMINISTRATI VE AND 5. 04 75, 529 7, 982 0 1. 00 0 TO TOTALS 155, 983 32, 269 0 1. 00 1 O TOTALS 155, 98				0				
16. 00 WOUND CARE CENTER 76. 04 0 38, 246 0 16. 00 17. 00 BARI ATRI C CLINI C 76. 05 0 3 0 17. 00 18. 00 EMERGENCY 91. 00 0 22, 993 0 18. 00 0 0 4, 722, 058 H - INTERNS AND RESIDENTS 1. 00 OTHER ADMINISTRATI VE AND GENERAL 0 75, 529 7, 982 I - NURSERY 1. 00 ADULTS & PEDI ATRI CS 30. 00 155, 983 32, 269 0 1. 00 TOTALS 1.00 ADULTS & PEDI ATRI CS 30. 00 155, 983 32, 269 0 1. 00 I - IMPLANTABLE DEVI CES 1. 00 MEDI CAL SUPPLI ES CHARGED TO 71. 00 0 8, 767, 489 0 1. 00 PATI ENT 0 0 8, 767, 489 0 1. 00				0				
17. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 18. 00 19. 00 10 10 10 10 10 10 10 10 10 10 10 10 1				0				
18.00 EMERGENCY 91.00 0 22,993 0 18.00 No.		•		0				
The contract of the contract				0	-			
H - INTERNS AND RESIDENTS OTHER ADMINISTRATIVE AND 5.04 75,529 7,982 0 1.00 GENERAL 0 75,529 7,982 1 1 - NURSERY 1.00 ADULTS & PEDIATRICS 30.00 155,983 32,269 0 1.00 TOTALS 155,983 32,269 1 1.00 MEDICAL SUPPLIES CHARGED TO 71.00 0 8,767,489 0 1.00 PATIENT 0 0 8,767,489	10.00	n		— — — }				18.00
1. 00 OTHER ADMINISTRATIVE AND 5. 04 75, 529 7, 982 0 1. 00 GENERAL 0 75, 529 7, 982 1 1. 00		H _ INTEDNS AND DESIDENTS		UU	4, 722, 030			
GENERAL	1 00		5 04	75 520	7 002			1 00
Totals	1.00		5. 04	75, 524	7, 702	٥		1.00
1 - NURSERY		OENCIAL	+	— 75 520				
1. 00 ADULTS & PEDI ATRI CS 30. 00 155, 983 32, 269 0 1. 00 TOTALS 155, 983 32, 269 1. 00 155, 983 32, 269 1. 00 155, 983 32, 269 1. 00 1. 00 MEDI CAL SUPPLI ES CHARGED TO 71. 00 0 8, 767, 489 0 1. 00 PATI ENT 0 0 8, 767, 489		I MIDSEDV		75, 524	7, 702			
TOTALS 155, 983 32, 269 J - IMPLANTABLE DEVICES 1. 00 MEDICAL SUPPLIES CHARGED TO 71. 00 0 8, 767, 489 0 1. 00 PATIENT 0 0 8, 767, 489	1 00		30 00	155 002	32 260			1 00
J - IMPLANTABLE DEVICES 1. 00 MEDICAL SUPPLIES CHARGED TO 71. 00 0 8, 767, 489 0 1. 00 PATIENT 0 0 8, 767, 489	1.00		— — 30. 00					1.00
1. 00 MEDI CAL SUPPLI ES CHARGED TO 71. 00 0 8, 767, 489 0 1. 00 PATI ENT 0 0 8, 767, 489				100, 703	32, 209			
PATI ENT	1 00		71 00	ما	0 747 400			1 00
0 8, 767, 489	1.00		/ 1.00	٩	0, 707, 489	١		1.00
		[FATI EIN]	+	+	0 767 400	 		
300. 00 pirana rotar. Decreases 710, 307 40, 474, 323	500 00	Grand Total: Docrosece		014 207				500.00
	300.00	pi and rotal. Decreases	l	710, 307	40, 474, 323	ı l		500.00

				To	12/31/2021	Date/Time Prep 5/30/2022 7:58	
				Acqui si ti ons		3/30/2022 7.30	5 pili
		Begi nni ng	Purchases	Donati on	Total	Disposals and	
		Bal ances				Retirements	
		1.00	2.00	3.00	4. 00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	T BALANCES					
1.00	Land	346, 472	0	0	0	0	1. 00
2.00	Land Improvements	9, 701, 677	0	0	0	0	2. 00
3.00	Buildings and Fixtures	68, 352, 523	0	0	0	276, 046	3. 00
4.00	Building Improvements	178, 989	0	0	0	0	4. 00
5.00	Fi xed Equipment	168, 737, 577	1, 869, 376	0	1, 869, 376	0	5. 00
6.00	Movable Equipment	0	0	0	0	0	6. 00
7.00	HIT designated Assets	0	0	0	0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	247, 317, 238	1, 869, 376	0	1, 869, 376	276, 046	
9.00	Reconciling Items	0	0	0	0	0	9. 00
10.00	Total (line 8 minus line 9)	247, 317, 238	1, 869, 376	0	1, 869, 376	276, 046	10.00
		Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
		6. 00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET		_1				
1.00	Land	346, 472	0				1.00
2.00	Land Improvements	9, 701, 677	4, 473, 171				2. 00
3.00	Buildings and Fixtures	68, 076, 477	32, 934, 048				3. 00
4.00	Building Improvements	178, 989	2, 893				4. 00
5. 00	Fi xed Equi pment	170, 606, 953	36, 333, 879				5. 00
6.00	Movable Equipment	0	0				6. 00
7.00	HIT designated Assets	0	0				7. 00
8.00	Subtotal (sum of lines 1-7)	248, 910, 568	73, 743, 991				8. 00
9.00	Reconciling Items	0	0				9.00
10. 00	Total (line 8 minus line 9)	248, 910, 568	73, 743, 991			l	10. 00

Heal th	Financial Systems	FRANCISCAN HE	ALTH- DYER		In Lie	u of Form CMS-2	2552-10
RECONC	CILIATION OF CAPITAL COSTS CENTERS		Provi der Co	CN: 15-0090	Peri od:	Worksheet A-7	
					From 01/01/2021 To 12/31/2021	Part II Date/Time Pre	narod:
					10 12/31/2021	5/30/2022 7:5	
			SL	JMMARY OF CAP	TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see		
					instructions)		
		9. 00	10.00	11. 00	12. 00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	4, 073, 929	0		0 0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		0 0	0	2. 00
3.00	Total (sum of lines 1-2)	4, 073, 929	0		0 0	0	3. 00
		SUMMARY OF	F CAPI TAL		<u>'</u>		
	Cost Center Description	Other	Total (1) (sum				
		Capi tal -Rel ate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14. 00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FLXT	0	4, 073, 929				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	O	0				2. 00
3. 00	Total (sum of lines 1-2)	l o	4, 073, 929				3. 00
		-1		1			

Provider CCN: 15-0090	Health Financial Systems	FRANCISCAN HE	EALTH- DYER		In Lie	eu of Form CMS-2	2552-10
Cost Center Description	RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der C		From 01/01/2021	Part III	
Cost Center Description					To 12/31/2021		
Leases For Ratio Instructions		COME	PUTATION OF RAT	TI 0S	ALLOCATION OF	OTHER CAPITAL	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS 1.00	Cost Center Description	Gross Assets				Insurance	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS 1.00			Leases		,		
Description Total (sum of Lease Total (sum of Lease Taxes Cap REL COSTS-BLDG & FIXT Cap REL COSTS-MVBLE EQUIP Cap REL COSTS-BLDG & FIXT Cap REL COSTS-MVBLE EQUIP Cap REL COSTS-MVBL					•		
1.00 CAP REL COSTS-BLDG & FIXT 78, 303, 615 0 78, 303, 615 0 314585 0 2.00			2. 00		4. 00	5. 00	
2.00 CAP REL COSTS-MVBLE EQUIP 170, 606, 953 0 170, 606, 953 0 248, 910, 568 1.000000 0 3.00							
Total (sum of lines 1-2) 248, 910, 568 0 248, 910, 568 1.000000 0 3.00						_	
ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL							
Cost Center Description	3.00 Total (sum of lines 1-2)						3. 00
Capital -Relate Col s. 5 through 7)		ALLOCA ⁻	TION OF OTHER (CAPI TAL	SUMMARY O	OF CAPITAL	
A Costs Cost Center Description Cost Center Description Center De	Cost Center Description				Depreciation	Lease	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
PART - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00 CAP REL COSTS-BLDG & FIXT 0 0 0 9, 134, 592 -1, 069, 827 1.00 2.00 3, 312, 502 0 2.00 3.00 Total (sum of lines 1-2) 0 0 0 0 12, 447, 094 -1, 069, 827 3.00 SUMMARY OF CAPITAL			7. 00	8.00	9. 00	10.00	
2. 00 CAP REL COSTS-MVBLE EQUIP 0 0 0 3, 312, 502 0 2. 00 3. 00 Total (sum of lines 1-2) 0 0 0 12, 447, 094 -1, 069, 827 3. 00 SUMMARY OF CAPITAL		ENTERS		1	0 404 500	1 0/0 007	4 00
3.00 Total (sum of lines 1-2)		0	0				
Cost Center Description		0	0			l .	
Cost Center Description	3.00 lotal (sum of lines 1-2)	0	0			-1, 069, 827	3. 00
instructions instructions Capital -Relate of cols. 9 through 14)			Sl	JMMARY OF CAPI	TAL		
d Costs (see instructions) 11.00 12.00 13.00 14.00 15.00	Cost Center Description	Interest	Insurance (see	Taxes (see	Other		
Instructions			instructions)	instructions)			
11.00 12.00 13.00 14.00 15.00						through 14)	
PART - RECONCILIATION OF CAPITAL COSTS CENTERS							
1. 00 CAP REL COSTS-BLDG & FIXT 0 0 0 0 8,064,765 1.00 2. 00 CAP REL COSTS-MVBLE EQUIP 0 0 0 3,312,502 2.00			12. 00	13.00	14. 00	15. 00	
2. 00 CAP REL COSTS-MVBLE EQUIP 0 0 0 3, 312, 502 2. 00				1			
				1			
3.00 Total (sum of lines 1-2) 0 0 0 0 11.377.267 3.00		_	_		-		
	3.00 Total (sum of lines 1-2)	0	0	1	0 0	11, 377, 267	3. 00

| Period: | Worksheet A-8 | From 01/01/2021 | To 12/31/2021 | Date/Time Prepared:

				T.	0 12/31/2021	Date/Time Prep 5/30/2022 7:58	
				Expense Classification on		373072022 7.30	<u> Биг</u>
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basi s/Code (2) 1.00	Amount 2.00	Cost Center 3.00	Li ne # 4.00	Wkst. A-7 Ref. 5.00	
1.00	Investment income - CAP REL	00		CAP REL COSTS-BLDG & FIXT	1.00	0	1. 00
2. 00	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2. 00
3. 00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other	В	0		0.00	0	3. 00
	(chapter 2)			OFNITRAL CERVILOES A CURRILY			
4. 00	Trade, quantity, and time discounts (chapter 8)	В	0	CENTRAL SERVICES & SUPPLY	14. 00	0	4. 00
5. 00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5. 00
6.00	Rental of provider space by		0		0.00	0	6. 00
7.00	suppliers (chapter 8) Telephone services (pay		0		0.00	0	7. 00
	stations excluded) (chapter 21)						
8.00	Television and radio service		0		0. 00	0	8. 00
9. 00	(chapter 21) Parking Lot (chapter 21)		0		0.00	0	9. 00
10. 00	Provider-based physician adjustment	A-8-2	-725, 573			0	10. 00
11. 00	Sale of scrap, waste, etc.		0		0. 00	0	11. 00
12. 00	(chapter 23) Related organization	A-8-1	4, 947, 279			0	12. 00
13. 00	transactions (chapter 10) Laundry and linen service		0		0.00	0	13. 00
14.00	Cafeteria-employees and guests		-352, 404	CAFETERI A	11. 00	O	14.00
15. 00	Rental of quarters to employee and others		0		0.00	0	15. 00
16. 00	Sale of medical and surgical supplies to other than		0		0.00	0	16. 00
17. 00	patients Sale of drugs to other than		0		0.00	0	17. 00
18. 00	patients Sale of medical records and	В	-78	MEDICAL RECORDS & LIBRARY	16. 00	0	18. 00
19. 00	abstracts Nursing and allied health		0		0.00	0	19. 00
	education (tuition, fees, books, etc.)						
20.00	Vending machines	В	0		0.00	0	20.00
21. 00	Income from imposition of interest, finance or penalty		0		0.00	0	21. 00
22. 00	charges (chapter 21) Interest expense on Medicare		0		0.00	0	22. 00
	overpayments and borrowings to						
23. 00	repay Medicare overpayments Adjustment for respiratory	A-8-3	0	RESPIRATORY THERAPY	65. 00		23. 00
	therapy costs in excess of limitation (chapter 14)						
24. 00	Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSI CAL THERAPY	66.00		24. 00
	limitation (chapter 14)		_				
25. 00	Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	114. 00		25. 00
26. 00	(chapter 21) Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1. 00	0	26. 00
	COSTS-BLDG & FLXT						
27. 00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27. 00
28. 00 29. 00	Non-physician Anesthetist Physicians' assistant		0	*** Cost Center Deleted ***	19. 00 0. 00	0	28. 00 29. 00
30. 00	Adjustment for occupational	A-8-3	0	OCCUPATIONAL THERAPY	67. 00		30. 00
	therapy costs in excess of limitation (chapter 14)						
30. 99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30. 99
31. 00	Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68. 00		31. 00
	pathology costs in excess of limitation (chapter 14)						
32. 00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32. 00
				ı	•	. '	

ADJUSTMENTS TO EXPENSES Provi der CCN: 15-0090 Peri od: Worksheet A-8 From 01/01/2021 | To 12/31/2021 | Date/Time Prepared:

Coat Genter Description Taski x/Code (2) Amount					To	12/31/2021	Date/Time Pre 5/30/2022 7:5	
COST Center Description Sed S/Code (2) Amount COST Denter Line 8 West A. 7 Ref.					Expense Classification on	Worksheet A	373072022 7.3	D pin
1.00								
1.00						•		
1.00								
1.00								
1.00								
33.00 RINTAL INCOME		Cost Center Description						
ORIGINAL		I						
34. 00 MISCELEPHING 9.00 0.35. 00 0 0 0 0 0 0 0 0 0	33. 00	RENTAL INCOME	В	-26, 737		5. 04	0	33. 00
10.00 10.0	04.00	MI CO I NOOME		20	1	7/ 00		04.00
0 0 HIRR ADJUSTINENTS (SPECIFY) 0 0 0 0 0 0 0 0 0								
33			В	-6	HUUSEKEEPI NG			
37.00 ADVERTIS IN GENERALS A	36.00			0		0.00	0	36.00
SCREAL S	27 00		Λ .	470 250	OTHER ARMINISTRATIVE AND	5.04	_	27 00
38.00 MISCELLAMEOUS - PADI LOGY B -1,535 RADI OLOGY-DI AGNOSTIC 54.00 0 30.00 0 40.00 MISCELLAMEOUS - OTHER B 0 80 THER ADMIN ISTRATI VE AND 0 41.00 0 MISCELLAMEOUS - OTHER B 0 80 THER ADMIN ISTRATI VE AND 0 41.00	37.00	ADVERTISING EXIENSE		-470, 230		3.04		37.00
A0. OD MISCELLANBOUS - OTHER B CORREAL D CONTROL	38 00	MISCELLANEOUS - RADILOGY	B	-1 535	1	54 00	0	38 00
OPERATING OPER			1		1			
1. 00 M SCELLANEOUS - OTHER B C-29, 910 OTHER ADM IN STRATI VE AND CCHERAL CCHER	10.00			100		0.01	Ĭ	10.00
OPERATING	41.00		В	-29, 910	1	5. 04	0	41.00
42. 00 PROGRAM FEES B								
CEMERAL	41.01	REHAB	В	2, 151	SUBPROVIDER - IRF	41.00	0	41. 01
43. 00 UNECESSARY BORROWING A -581, 652 NTEREST EXPENSE 113. 00 0 42. 00	42.00	PROGRAM FEES	В	-1, 118, 308	OTHER ADMINISTRATIVE AND	5. 04	0	42.00
44. 00 LOBBYING EXPENSE A -3,930 OTHER ADMINISTRATIVE AND 5.04 0 44. 00 0 45. 00 0 0 0 0 0 0 0 0 0					GENERAL			
GENERAL	43.00	UNECESSARY BORROWING	A	-581, 652	INTEREST EXPENSE	113.00	0	43.00
45. 00	44.00	LOBBYING EXPENSE	A	-3, 930	OTHER ADMINISTRATIVE AND	5. 04	0	44. 00
(3) (4) (6) (6) (7) (8) (8) (8) (8) (8) (8) (8) (8) (8) (8					GENERAL			
46. 00 PENSION ADJUSTMENT A 1,874,748 EMPLOYEE BENEFITS DEPARTMENT 4. 00 0 46. 00 47. 00 1 1. 87. 00 1	45.00	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	45. 00
A7. 00 DI SCOUNTS EARNED/REBATES B								
SENERAL			1					1
A8. 00 DI SCOUNTS EARNED/REBATES B -7, 513 OTHER ADMIN ISTRATI VE AND 0.4 0.4 0.0 0.4 0.0	47. 00	DI SCOUNTS EARNED/REBATES	В	-665, 960		5. 04	0	47. 00
CENERAL OPENDAMENT OPENDA		DI GOGUNITO, FARMER (REPATEO		7 540				
49.00 DISCOUNTS EARNED/REBATES B -1-yOPERATING ROOM 50.00 0.49.01 0.00	48. 00	DISCOUNTS EARNED/REBATES	B	-7, 513		5. 04	0	48.00
49. 01 DI SCOUNTS EARNED/REBATES B 0 RADIOLOGY-DI AGNOSTI C 54. 00 0 49. 01	40.00	DI CCOUNTE FARMER (REPATE)	D	0		15.00		40.00
49.02 DI SCOUNTS EARNED/REBATES B DIRADI OLOGY-DI AGNOSTI C 54.00 0 49.02					1			1
49.03 DI SCOUNTS EARNED/REBATES B		4						1
49. 04 DI SCOUNTS EARNED/REBATES B -4 RESPIRATORY THERAPY 66. 00 0 49. 04								
49.05 DI SCOUNTS EARNED/REBATES B OPHYSI CAL THERAPY 66.00 0 49.05								
49.06 RENTAL INCOME								1
49.07 DI ETETLI CINSTRUCTION B		•			1		l .	1
49. 08 PODI ATRIC TO HAMMOND					1		l .	1
A			1		1		l .	1
49. 09	49. 08	PODIATRIC TO HAMMOND	A	-231, 743		22.00	0	49.08
A	40.00	UNE EEES	Λ .	E 022 704	1	5.04	_	40.00
49. 10 PROPERTY TAX A -101, 165 OTHER ADMINISTRATIVE AND GENERAL 49. 11 MI SCELLANEOUS - OTHER OPERATING 49. 12 MI SC. PAYMENTS B OEMERGENCY 91. 00 49. 11 49. 13 MED STAFF FEES B OOTHER ADMINISTRATIVE AND GENERAL 49. 14 PROGRAM FEES B OINTEREST INCOME - PATIENTS B OOTHER ADMINISTRATIVE AND GENERAL 49. 15 INTEREST INCOME - PATIENTS B OINTEREST EXPENSE 113. 00 49. 15 49. 16 CONTRACT REVENUE B OOTHER ADMINISTRATIVE AND GENERAL 49. 17 PROGRAM FEES B OINTEREST EXPENSE 113. 00 0 49. 15 CONTRACT REVENUE B OOTHER ADMINISTRATIVE AND GENERAL 49. 17 PROGRAM FEES B OOTHER ADMINISTRATIVE AND SERVICE 49. 18 DISCOUNTS EARNED/REBATES B OOTHER ADMINISTRATIVE AND GENERAL 49. 19 INCOMPTER ADMINISTRATIVE AND GENERAL 49. 10 GENERAL 49	47. 07	ITAL TELS	A	-5, 632, 770		5.04		47.09
49. 11 MI SCELLANEOUS - OTHER OPERATI NG 49. 12 MI SC. PAYMENTS B OEMERGENCY 91. 00 49. 12 49. 13 MED STAFF FEES B OOTHER ADMINISTRATI VE AND GENERAL 49. 14 PROGRAM FEES B OINTEREST INCOME - PATIENTS B OINTEREST EXPENSE 10 SCOUNTS EARNED/REBATES B -128, 795 LAUNDRY & LI NEN SERVI CE GENERAL 49. 17 PROGRAM FEES B -128, 795 LAUNDRY & LI NEN SERVI CE B OINTEREST SUPPARTMENT 49. 19 INCENTIVE PAYMENT 49. 19 INCENTIVE PAYMENT 49. 20 AP. 21 NET PERI ODI C PENSI ON COST A ODI NTEREST EXPENSE 113. 00 AP. 16 GENERAL 49. 17 OF THE ADMINISTRATI VE AND GENERAL 49. 19 OUTHER ADMINISTRATI VE AND GENERAL 49. 19 OUTHER ADMINISTRATI VE AND GENERAL 49. 10 OTHER ADMINISTRATI VE AND GENERAL 49. 20 OCATH LAB 70. 00 OTHER ADMINISTRATI VE AND TO OTHER ADMINISTRATI VE AN	49 10	PROPERTY TAX	Δ	-101 165		5 04	0	49 10
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49. 12 MI SC. PAYMENTS B O EMERGENCY 91. 00 0 49. 12 49. 13 MED STAFF FEES B O OTHER ADMINISTRATIVE AND 5. 04 O 49. 13 49. 14 PROGRAM FEES B -3,725 PHYSICAL THERAPY 66. 00 0 49. 14 49. 15 INTEREST INCOME - PATIENTS B O INTEREST EXPENSE 113. 00 0 49. 15 49. 16 CONTRACT REVENUE B O OTHER ADMINISTRATIVE AND 5. 04 O 49. 16 49. 17 PROGRAM FEES B -128,795 LAUNDRY & LINEN SERVICE 8. 00 0 49. 17 49. 18 DI SCOUNTS EARNED/REBATES B -84,680 EMPLOYEE BENEFITS DEPARTMENT 4. 00 0 49. 18 49. 19 INCENTIVE PAYMENT A -9 OUTPATIENT SURGERY 50. 01 0 49. 19 49. 20 DI SCOUNTS EARNED/REBATES A 20 CATH LAB 76. 02 0 49. 20 49. 21 NET PERIODIC PENSION COST A O INTEREST EXPENSE 113. 00 0 49. 21 49. 22 MI SCELLANEOUS - OTHER A O OTHER ADMINISTRATIVE AND 5. 04 O 49. 22 49. 23 NET PERIODIC PENSION COST A O OTHER ADMINISTRATIVE AND 5. 04 O 49. 23 49. 24 NET PERIODIC PENSION COST A O O O O O O O 49. 24 OTHER ADMINISTRATIVE AND O O O O O O 50. 00 TOTAL (sum of lines 1 thru 49) O O O O O 50. 00 O TOTAL (sum of lines 1 thru 49) O O O O 50. 00 O O O O O O O 50. 00 O O O O O O 50. 00 O O O O O 50. 00 O O O O O O 50. 00 O O O			_	2,000		, 50		
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SENERAL 17 PROGRAM FEES B -128, 795 LAUNDRY & LI NEN SERVI CE 8.00 0 49.17	49. 15	INTEREST INCOME - PATIENTS	В	0	INTEREST EXPENSE	113.00	0	49. 15
49. 17 PROGRAM FEES B -128, 795 LAUNDRY & LINEN SERVICE 8. 00 0 49. 17 49. 18 DI SCOUNTS EARNED/REBATES B -84, 680 EMPLOYEE BENEFITS DEPARTMENT 4. 00 0 49. 18 49. 20 DI SCOUNTS EARNED/REBATES A -9 OUTPATIENT SURGERY 50. 01 0 49. 20 49. 21 NET PERIODI C PENSION COST A 0 INTEREST EXPENSE 113. 00 0 49. 21 49. 22 MI SCELLANEOUS - OTHER OPERATING A 0 OTHER ADMINISTRATIVE AND GENERAL 5. 04 0 49. 22 49. 23 NET PERIODIC PENSION COST A OADULTS & PEDIATRICS 30. 00 0 49. 23 49. 24 NET PERIODIC PENSION COST A OEMERGENCY 91. 00 0 49. 24 50. 00 TOTAL (sum of lines 1 thru 49) -3, 590, 548 -3, 590, 548 50. 00	49. 16	CONTRACT REVENUE	В	0	OTHER ADMINISTRATIVE AND	5. 04	0	49. 16
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49. 20 DISCOUNTS EARNED/REBATES A 20 CATH LAB 76. 02 0 49. 20 49. 21 NET PERIODIC PENSION COST A 0 INTEREST EXPENSE 113. 00 0 49. 21 49. 22 MI SCELLANEOUS - OTHER OPERATING A 0 OTHER ADMINISTRATIVE AND GENERAL 5. 04 0 49. 22 49. 23 NET PERIODIC PENSION COST A OADULTS & PEDIATRICS 30. 00 0 49. 23 49. 24 NET PERIODIC PENSION COST A OEMERGENCY 91. 00 0 49. 24 50. 00 TOTAL (sum of lines 1 thru 49) -3, 590, 548 -3, 590, 548 50. 00	49. 18	DI SCOUNTS EARNED/REBATES	В	-84, 680	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	49. 18
49. 21 NET PERIODIC PENSION COST A OINTEREST EXPENSE 113. 00 0 49. 21 49. 22 MI SCELLANEOUS - OTHER OPERATING SENERAL OF OLIVERAL OLIVERA OLIVERAL OLIVERAL OLIVERAL OLIVERAL OLIVERAL OLIVERA OLIVERA OLIVERA OLIVERA OLIVERA OLIVE	49. 19	INCENTIVE PAYMENT	A			50. 01	0	49. 19
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OPERATING 49. 23 49. 24 49. 24 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, (Tra		NET PERIODIC PENSION COST	A	0	INTEREST EXPENSE	113.00	0	
49. 23 NET PERIODIC PENSION COST A O ADULTS & PEDIATRICS 30. 00 0 49. 23 49. 24 NET PERIODIC PENSION COST A O EMERGENCY 91. 00 0 49. 24 50. 00 (Transfer to Worksheet A,	49. 22		A			5.04	0	49. 22
49. 24 NET PERIODIC PENSION COST A 0 EMERGENCY 91. 00 0 49. 24 50. 00 (Transfer to Worksheet A,								
50.00 TOTAL (sum of lines 1 thru 49) -3,590,548 50.00 (Transfer to Worksheet A,			1					
(Transfer to Worksheet A,						91. 00	0	
	50. 00	,		-3, 590, 548				50.00
COLUMN 6, LINE 200.)								
		column 6, line 200.)						Ь

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

⁽²⁾ Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

⁽³⁾ Additional adjustments may be made on lines 33 thru 49 and subscripts thereof. Note: See instructions for column 5 referencing to Worksheet A-7.

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

Provider CCN: 15-0090

Worksheet A-8-1 From 01/01/2021

12/31/2021 Date/Time Prepared: 5/30/2022 7:58 pm Li ne No. Cost Center Expense I tems Amount of Amount Allowable Cost Included in Wks. A, column 3.00 5.00 1.00 2.00 4.00 COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS 1.00 113.00 I NTEREST EXPENSE INTEREST 831, 020 3, 448, 848 1.00 1. 00 CAP REL COSTS-BLDG & FIXT ALLOWABLE NEW CAPITAL COSTS 2.00 1, 295, 586 1, 787, 201 2.00 5. 04 OTHER ADMINISTRATIVE AND GEN A&G 3.00 18, 316, 334 16, 961, 375 3.00 4.00 15. 00 PHARMACY COVP / PHARMACY 281, 218 4.00 4.01 16.00 MEDICAL RECORDS & LIBRARY нім 888, 918 4.01 5. 04 OTHER ADMINISTRATIVE AND GEN ELIMINATIONS 4 02 -4, 625, 479 4 02 C 14.00 CENTRAL SERVICES & SUPPLY 4.03 SPD 383 596 4.03 4.04 15. 00 PHARMACY PHARMACY 87.485 600, 376 4.04 4.05 30. 00 ADULTS & PEDI ATRI CS NEPHROLOGY 149.739 4.05 C 41.00 SUBPROVIDER - IRF REHABI LI TATI ON 4.06 4,670 4.06 4.07 50. 00 OPERATING ROOM OPERATING ROOM 10, 904 30, 410 4.07 4.08 0.00 4.08 0 50. 01 OUTPATIENT SURGERY ENDOSCOPY 8 632 4 09 21, 560 4 09 4.10 51.00 RECOVERY ROOM RECOVERY 427 2, 160 4.10 53. 00 ANESTHESI OLOGY ANESTHESI OLOGY 6, 205 8, 711 4.11 4.12 54. 00 RADI OLOGY-DI AGNOSTI C RADIOLOGY DIAGNOSTIC 46, 519 25, 160 4.12 54. 00 RADI OLOGY-DI AGNOSTI C COMPUTED TOMOGRAPHY 91, 124 4.13 49, 286 4 13 4.14 54. 00 RADI OLOGY-DI AGNOSTI C MRI 9,775 18,073 4.14 54. 01 RADI OLOGY-SPECI AL PROCEDURES RADI OLOGY-SPECI AL PROCEDURES 4.15 3,610 16, 127 4.15 0.00 4.16 4.16 60. 00 LABORATORY CHEMI STRY 588.538 4.17 112, 490 4 17 4.18 63.00 BLOOD STORING, PROCESSING & BLOOD BANK 697 13, 734 4. 18 65. 00 RESPIRATORY THERAPY 4.19 RESPIRATORY THERAPY 153, 311 289, 373 4.19 76. 01 PAIN CLINIC 4.20 PAIN CLINIC 120 4.20 25 66.00 PHYSI CAL THERAPY REHAB UNIT THERAPY 2, 532, 739 2, 670, 418 4.21 4 21 4.22 67. 00 OCCUPATIONAL THERAPY OCCUPATIONAL THERAPY 988 263 68. 00 SPEECH PATHOLOGY SPEECH THERAPY 4.23 9,846 15, 590 4 23 69. 00 ELECTROCARDI OLOGY NON INVASIVE VASCULAR 1,055 35, 555 4.24 4.24 69. 00 ELECTROCARDI OLOGY 4. 25 CARDIAC REHAB 32 1,071 4.25 4.26 70. 00 ELECTROENCEPHALOGRAPHY NEURO DIAGNOSTICS 68 2, 304 4.26 4.27 76. 00 ULTRA SOUND ULTRASOUND 3, 943 26, 604 4.27 56. 00 RADI OI SOTOPE NUCLEAR MEDICINE 4,047 4.28 1.318 4.28 4.29 41.00 SUBPROVIDER - IRF REHAB UNIT OVERHEAD 2,501,045 0 4.29 4.30 0.00 C 0 4.30 0.00 4.31 4.31 0 TOTALS (sum of lines 1-4). 5.00 27, 144, 703 22, 197, 424 5.00 Transfer column 6, line 5 to Worksheet A-8, column 2,

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 F	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:					

line 12.

STATEME OFFICE	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HOM	ME Provider (CCN: 15-0090	Peri od: From 01/01/2021	Worksheet A-8	3-1
					To 12/31/2021	Date/Time Pre 5/30/2022 7:5	
				Related Organ	nization(s) and/o	or Home Office	
	Symbol (1)	Name	Percentage of Ownership	١	Name	Percentage of Ownership	
	1. 00	2. 00	3. 00	4	1. 00	5. 00	

FRANCISCAN HEALTH- DYER

In Lieu of Form CMS-2552-10

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

Health Financial Systems

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

						Date/Time Prepar 5/30/2022 7:58 p	
	Net	Wkst. A-7 Ref.			<u> </u>		
	Adjustments						
	(col. 4 minus						
	col. 5)*						
	6. 00	7. 00					
			IENTS REQUIRED AS A RESULT OF TRAM	NSACTIONS WITH RELATED OF	RGANIZATIONS OR C	LAI MED	
	HOME OFFICE CO						
1.00	-2, 617, 828						1.00
2.00	-491, 615	9					2.00
3.00	1, 354, 959						3. 00
4.00	281, 218						4.00
4. 01	888, 918						4. 01
4. 02	4, 625, 479						4. 02
4.03	-213	0					4. 03
4.04	-512, 891						4. 04
4.05	-149, 739	0					4. 05
4.06	-4, 670						4. 06 4. 07
4. 07 4. 08	-19, 506 0	0					4. 07
4. 09	12, 928						4. 09
4. 09	-1, 733						4. 10
4. 10	-2, 506						4. 10
4. 11	-21, 359	0					4. 12
4. 13	-41, 838						4. 13
4. 14	-8, 298						4. 14
4. 15	-12, 517	3					4. 15
4. 16	0	Ö					4. 16
4. 17	-476, 048						4. 17
4. 18	-13, 037	Ö					4. 18
4. 19	-136, 062	0					4. 19
4. 20	-95	0					4. 20
4. 21	-137, 679						4. 21
4. 22	-725	0					4. 22
4. 23	-5, 744	0					4. 23
4. 24	-34, 500	0					4. 24
4. 25	-1, 039	0					4. 25
4. 26	-2, 236	0					4. 26
4. 27	-22, 661	0					4. 27
4. 28	-2, 729	0					4. 28
4. 29	2, 501, 045	0				4	4. 29
4.30	0	0					4. 30
4. 31	0	0					4. 31
5.00	4, 947, 279					Į	5. 00

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

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

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

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

reriiibur	Sement under title XVIII.		
	HEALTHCARE SERV	6	6. 00
7.00		7	7. 00
8.00		8	8. 00
9.00		9	9. 00
10.00		10	O. CO
100.00		100	0. 00

Health Financial Systems	FRANCISCAN HEAL	TH- DYER	In Lie	u of Form CMS-2552-10
STATEMENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HOME	Provi der CCN: 15-0090	Peri od:	Worksheet A-8-1
OFFICE COSTS			From 01/01/2021 To 12/31/2021	Date/Time Prepared: 5/30/2022 7:58 pm
Related Organization(s) and/or Home Office				
Type of Business				
6. 00				

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

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

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

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Provider CCN: 15-0090

						0 12/31/2021	5/30/2022 7:5	epared: 58 nm
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	о рііі
		I denti fi er	Remuneration	Component	Component	1102 711104111	ider Component	
				'	•		Hours	
	1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	7. 00	
1.00	5. 04	OTHER ADMINISTRATIVE AND	164, 000	104, 000	60, 000	197, 500	245	1. 00
		GENERAL						
2. 00		NURSI NG ADMI NI STRATI ON	143, 055		2, 870	197, 500		2. 00
3.00		ADULTS & PEDIATRICS	61, 250		0	197, 500		3. 00
4.00		OPERATING ROOM	140, 016		34, 327	246, 400	245	4. 00
5.00		LABORATORY	33, 818		33, 819	197, 500		5. 00
6.00		ELECTROCARDI OLOGY	208		208 0	197, 500	2	6. 00
7. 00 8. 00		PAIN CLINIC CATH LAB	131, 762 2, 357		0	197, 500	0	7. 00 8. 00
9.00		ACTIVITY THERAPEUTIC	46, 267	2, 357 0	46, 267	197, 500 197, 500	343	9. 00
10. 00		WOUND CARE CENTER	1, 540		1, 540	197, 500		10. 00
11. 00		EMERGENCY	113, 501	113, 501	1, 540	197, 500		11. 00
200.00	71.00	LWENGENCT	837, 774	658, 742	179, 031	177, 300	1, 121	
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physi ci an Cost	200.00
	mot. A Line "	I denti fi er	Li mi t	Unadjusted RCE		Component	of Malpractice	
		1 40.111 11 01	2	Li mi t	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1. 00	2. 00	8. 00	9. 00	12. 00	13. 00	14. 00	
1.00		OTHER ADMINISTRATIVE AND	23, 263	1, 163	0	0	0	1. 00
		GENERAL						
2. 00		NURSING ADMINISTRATION	1, 994	•	0	_		
3. 00		ADULTS & PEDIATRICS	0		0	0	l ~	3. 00
4.00		OPERATING ROOM	29, 023		0	0	0	4. 00
5.00		LABORATORY	23, 833		0	0	0	5. 00
6.00		ELECTROCARDI OLOGY PAIN CLINIC	190		0) 0	0	6. 00 7. 00
7. 00 8. 00		CATH LAB		0	0	0	0	7. 00 8. 00
9. 00		ACTIVITY THERAPEUTIC	32, 569	_	0	0	0	9. 00
10. 00		WOUND CARE CENTER	1, 329		0	0	0	
11. 00		EMERGENCY	1, 327	0	0	0	0	
200.00	71.00	EMERGENOT	112, 201	5, 610	0	0	0	
200.00	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		200.00
		I denti fi er	Component	Limit	Di sal I owance	.,		
			Share of col.					
			14					
	1. 00	2. 00	15. 00	16. 00	17. 00	18. 00		
1. 00	5. 04	OTHER ADMINISTRATIVE AND	0	23, 263	36, 737	140, 737		1. 00
2 00	12.00	GENERAL		1 004	07/	141 0/1		2 00
2.00		NURSING ADMINISTRATION ADULTS & PEDIATRICS	0	.,	876 0			2. 00
3. 00 4. 00		OPERATING ROOM		_	5, 304	61, 250 110, 993		3. 00 4. 00
4. 00 5. 00		LABORATORY		29, 023	5, 304 9, 986	9, 985		4. 00 5. 00
6.00		ELECTROCARDI OLOGY		23, 833	9, 986	9, 985		6. 00
7. 00		PAIN CLINIC		0	0	131, 762		7. 00
8. 00		CATH LAB		0	0	2, 357		8. 00
9. 00		ACTIVITY THERAPEUTIC		_	13, 698			9. 00
10. 00		WOUND CARE CENTER	0	1, 329	211	211		10.00
11. 00		EMERGENCY		0	0	113, 501		11. 00
200.00			0		66, 830			200. 00
'		•	-	•	•	-	•	

	ALLOCATION - GENERAL SERVICE COSTS	TRANCISCAN III	Provider Co	CN: 15-0090 PG	eriod: rom 01/01/2021 o 12/31/2021	Worksheet B Part I Date/Time Pre 5/30/2022 7:5	pared:
	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL REI	ATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		0	1.00	2.00	4. 00	4A	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT	8, 064, 765	8, 064, 765				1.00
2. 00 4. 00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT	3, 312, 502 2, 376, 237	33, 292	3, 312, 502 4, 988	2, 414, 517		2. 00 4. 00
5. 04	00593 OTHER ADMINISTRATIVE AND GENERAL	27, 547, 792	601, 607			29, 398, 128	5. 04
6. 00	00600 MAINTENANCE & REPAIRS	2, 492, 395	1, 217, 298			3, 961, 499	6.00
7.00	00700 OPERATION OF PLANT	7, 085, 310	345, 207		42, 164	8, 445, 885	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	414, 521	0	-	6, 420	420, 941	8. 00
9.00	00900 HOUSEKEEPI NG	2, 939, 712	92, 337			3, 089, 327	9. 00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	1, 121, 330 940, 767	81, 457 117, 594		17, 883 19, 790	1, 229, 762 1, 078, 151	10. 00 11. 00
13. 00	01300 NURSING ADMINISTRATION	3, 185, 642	12, 440			3, 293, 328	13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	403, 487	104, 880			544, 844	
15.00	01500 PHARMACY	2, 899, 435	58, 548	5, 461	66, 765	3, 030, 209	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	1, 206, 630	83, 719	0	5, 694	1, 296, 043	16. 00
17. 00	01700 SOCIAL SERVICE	0	0		- 1	0	17. 00
22. 00	02200 1 &R SERVI CES-OTHER PRGM COSTS APPRV INPATIENT ROUTINE SERVI CE COST CENTERS	287, 206	0	0	3, 481	290, 687	22. 00
30. 00	03000 ADULTS & PEDIATRICS	15, 270, 910	1, 368, 202	123, 532	376, 795	17, 139, 439	30.00
31. 00	03100 NTENSI VE CARE UNI T	3, 154, 080	170, 162			3, 422, 074	
32. 00	03200 CORONARY CARE UNIT	0	0		0	0	32. 00
35. 00	02060 NEONATAL INTENSIVE CARE UNIT	242, 950	0	0	5, 660	248, 610	35. 00
41.00	04100 SUBPROVIDER - I RF	7, 848, 382	101, 744	14, 126		8, 085, 480	41.00
42. 00 43. 00	04200 SUBPROVI DER 04300 NURSERY	0 188, 252	0	0	0 5, 319	0 193, 571	42. 00 43. 00
43.00	ANCI LLARY SERVI CE COST CENTERS	100, 232	0	0	5, 517	173, 371	43.00
50.00	05000 OPERATING ROOM	2, 529, 754	282, 512	189, 504	52, 853	3, 054, 623	50. 00
50. 01	05001 OUTPATIENT SURGERY	867, 055	241, 304	9, 898	22, 029	1, 140, 286	50. 01
51. 00	05100 RECOVERY ROOM	422, 506	95, 113			544, 427	51.00
53. 00	05300 ANESTHESI OLOGY	2, 834, 139	402.547	,		2, 856, 658	53.00
54. 00 54. 01	05400 RADI OLOGY-DI AGNOSTI C 05401 RADI OLOGY-SPECI AL PROCEDURES	1, 998, 539 606, 765	403, 567 26, 421			2, 836, 946 654, 349	54. 00 54. 01
55. 00	05500 RADI OLOGY-THERAPEUTI C	000,703	20, 421		0	034, 347	55. 00
56. 00	05600 RADI 0I SOTOPE	435, 877	84, 490	35, 049	11, 554	566, 970	56.00
60.00	06000 LABORATORY	6, 005, 629	118, 365		7, 114	6, 131, 883	60.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	697	48, 508		0	49, 205	
65. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	2, 543, 490 7, 175, 067				2, 656, 886 7, 329, 257	
66. 00 67. 00	06700 OCCUPATI ONAL THERAPY	901, 832	24, 879 9, 527			935, 991	66. 00 67. 00
68. 00	06800 SPEECH PATHOLOGY	522, 621	0,027			538, 597	
69. 00		1, 033, 753	65, 248			1, 188, 206	
70. 00	07000 ELECTROENCEPHALOGRAPHY	205, 909	90, 161	5, 297	5, 691	307, 058	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	9, 153, 767	0	0	0	9, 153, 767	71.00
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	8, 767, 489 4, 722, 051	0	0	0	8, 767, 489 4, 722, 051	72. 00 73. 00
76. 00	03630 ULTRA SOUND	547, 992	39, 221	27, 784	15, 082	630, 079	76.00
76. 01	03951 PAIN CLINIC	723, 510	211, 148		20, 177	960, 301	76. 01
76. 02	03952 CATH LAB	1, 857, 465	154, 861	136, 736	48, 799	2, 197, 861	76. 02
76. 03	03953 ACTIVITY THERAPEUTIC	2, 848, 091	97, 769		76, 731	3, 022, 632	76. 03
76. 04	03954 WOUND CARE CENTER	233, 471	109, 044		6, 299	350, 900	76. 04
76. 05 76. 06	03340 BARIATRIC CLINIC 03030 HEALTHY LIVING CENTER	1, 481, 144	33, 018	3, 978	42, 255	1, 560, 395 0	76. 05 76. 06
76. 00	03950 CV RESOURCE CENTER	0	0	0	0	0	76.00
76. 08	03955 OTHER ANCILLARY SERVICE COST CENTERS	0	Ö	o o	ő	0	76. 08
76. 09	03956 LACTATION CLINIC	0	0	0	0	0	76. 09
76. 10	03957 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76. 10
76. 11	03958 OTHER ANCILLARY SERVICE COST CENTERS	0	7 520	0	14 202	0	76. 11
76. 12	03959 ANTI COAGULATION CLINIC OUTPATIENT SERVICE COST CENTERS	531, 313	7, 539	104	14, 382	553, 338	76. 12
91. 00	09100 EMERGENCY	4, 414, 364	275, 556	62, 733	107, 409	4, 860, 062	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1,,	,	1=,	,	0	92.00
	SPECIAL PURPOSE COST CENTERS						
	11300 INTEREST EXPENSE	454.041.51		0.075	6 6/=	450 707	113.00
118.00		154, 346, 595	6, 843, 406	3, 272, 029	2, 067, 949	152, 738, 195	118.00
190 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	77, 641	13, 639	709	1, 179	93, 168	190 00
	19200 PHYSICIANS' PRIVATE OFFICES	12, 615, 956	234, 690			13, 131, 832	
192. 01	1 19201 WORKI NG WELL	32, 233	0	0	1, 078	33, 311	192. 01
192. 02	2 19202 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192. 02
							

Health Financial Systems	FRANCISCAN HE	EALTH- DYER		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der CCN: 15-0090			Worksheet B Part I Date/Time Pre 5/30/2022 7:5	
		CAPI TAL REL	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	
192. 03 19203 MI SC	3, 767, 979	0	39	2 80, 635	3, 849, 006	192. 03
194. 00 07950 RESI DENTI AL	-53, 712	519, 293	21, 86	2 0	487, 443	194. 00
194.01 07954 OTHER NONREIMBURSABLE COST CENTERS	0	0		0 0	0	194. 01
194. 02 07952 PSYCHI ATRI C	0	453, 737		0 0	453, 737	194. 02
194.03 07953 CENTER OF HOPE	9, 203	0		0 0	9, 203	194. 03
200.00 Cross Foot Adjustments					0	200. 00
201.00 Negative Cost Centers		0		0	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	170, 795, 895	8, 064, 765	3, 312, 50	2, 414, 517	170, 795, 895	202. 00

Provider CCN: 15-0090

				1	0 12/31/2021	Date/lime Pre 5/30/2022 7:5	
	Cost Center Description	OTHER ADMI NI STRATI VE AND GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	<u>Б.</u>
		5. 04	6. 00	7. 00	8. 00	9. 00	
	GENERAL SERVICE COST CENTERS				ı		
1. 00 2. 00 4. 00 5. 04 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 17. 00 22. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00593 OTHER ADMINISTRATIVE AND GENERAL 00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 02200 I&R SERVICES-OTHER PRGM COSTS APPRV INPATIENT ROUTINE SERVICE COST CENTERS	29, 398, 128 823, 639 1, 755, 992 87, 518 642, 305 255, 681 224, 159 684, 719 113, 279 630, 014 269, 462 0	4, 785, 138 265, 891 0 71, 122 62, 741 90, 575 9, 581 80, 782 45, 096 64, 483 0	10, 467, 768 0 164, 736 145, 325 209, 795 22, 193 187, 113 104, 454	508, 459 0 0 0 0 0 0 0	3, 967, 490 55, 962 80, 788 8, 546 72, 053 40, 223 57, 516 0	13. 00
30. 00	03000 ADULTS & PEDI ATRI CS	3, 563, 458	1, 053, 836	2, 440, 966	277, 022	939, 966	30.00
31. 00 32. 00 35. 00 41. 00 42. 00 43. 00	03100 INTENSIVE CARE UNIT 03200 CORONARY CARE UNIT 02060 NEONATAL INTENSIVE CARE UNIT 04100 SUBPROVIDER 04200 SUBPROVIDER 04300 NURSERY ANCILLARY SERVICE COST CENTERS	711, 487 0 51, 689 1, 681, 060 0 40, 246	131, 065 0 0 78, 367 0	303, 581 0 0	38, 546 0 1, 042 78, 683 0	116, 903 0 0 69, 899 0	31. 00 32. 00 35. 00 41. 00 42. 00 43. 00
50.00	05000 OPERATING ROOM	635, 090	217, 601	504, 021	0	194, 088	50.00
50. 01 51. 00 53. 00 54. 00 54. 01 55. 00 56. 00 60. 00	O5001 OUTPATI ENT SURGERY O5100 RECOVERY ROOM O5300 ANESTHESI OLOGY O5400 RADI OLOGY-DI AGNOSTI C O5401 RADI OLOGY-SPECI AL PROCEDURES O5500 RADI OLOGY-THERAPEUTI C O5600 RADI OLOGY-THERAPEUTI C O6000 LABORATORY	237, 078 113, 192 593, 931 589, 832 136, 046 0 117, 879 1, 274, 886	185, 861 73, 260 0 310, 842 20, 351 0 65, 077 91, 169	0 719, 991 47, 137 0 150, 736	0 0 0 0	165, 778 65, 344 0 277, 254 18, 152 0 58, 045 81, 318	50. 01 51. 00 53. 00 54. 00 54. 01 55. 00 56. 00 60. 00
63. 00 65. 00 66. 00 67. 00 68. 00 69. 00	06300 BLOOD STORING, PROCESSING & TRANS. 06500 RESPIRATORY THERAPY 06600 PHYSICAL THERAPY 06700 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDIOLOGY	10, 230 552, 396 1, 523, 833 194, 603 111, 980 247, 041	37, 362 28, 243 19, 163 7, 338 0 50, 256	65, 418 44, 386 16, 996 0 116, 407	0 0 0 0	33, 325 25, 191 17, 092 6, 545 0 44, 826	65. 00 66. 00 67. 00 68. 00 69. 00
76. 01 76. 02	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 03630 ULTRA SOUND 03951 PAIN CLINIC 03952 CATH LAB	63, 841 1, 903, 169 1, 822, 857 981, 766 131, 000 199, 657 456, 959	69, 445 0 0 0 30, 209 162, 633 119, 279	0 0 0 69, 972 376, 702 276, 282	0 0 0 0		76. 01 76. 02
76. 03 76. 04 76. 05 76. 06 76. 07 76. 08 76. 09	03953 ACTIVITY THERAPEUTIC 03954 WOUND CARE CENTER 03340 BARIATRIC CLINIC 03030 HEALTHY LIVING CENTER 03955 CV RESOURCE CENTER 03955 OTHER ANCILLARY SERVICE COST CENTERS 03956 LACTATION CLINIC 03957 OTHER ANCILLARY SERVICE COST CENTERS	628, 438 72, 956 324, 423 0 0 0	75, 305 83, 989 25, 432 0 0 0	194, 541		67, 168 74, 914 22, 684 0 0 0	76. 03 76. 04 76. 05 76. 06 76. 07 76. 08 76. 09 76. 10
76. 11 76. 12	03958 OTHER ANCILLARY SERVICE COST CENTERS 03959 ANTICOAGULATION CLINIC	0 115, 045	0 5, 807	0 13, 450	0	0 5, 179	76. 11 76. 12
91. 00	OUTPATIENT SERVICE COST CENTERS O9100 EMERGENCY O9200 OBSERVATION BEDS (NON-DISTINCT PART SPECIAL PURPOSE COST CENTERS	1, 010, 460	212, 243				91.00
113. 00 118. 00	11300 INTEREST EXPENSE	25, 643, 733	3, 844, 404	8, 288, 781	396, 871	3, 128, 406	113. 00 118. 00
192. 00 192. 01 192. 02	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES 19201 WORKING WELL 2 19202 PHYSICIANS' PRIVATE OFFICES	19, 371 2, 730, 252 6, 926 0	10, 505 180, 767 0 0			161, 234 0 0	192. 01 192. 02
194. 00 194. 01	3 19203 MISC 07950 RESI DENTI AL 07954 OTHER NONREIMBURSABLE COST CENTERS 2 07952 PSYCHI ATRI C	800, 251 101, 345 0 94, 337	0 399, 978 0 349, 484	0	0	356, 759 0	194. 01

Health Financial Systems	FRANCISCAN HE	ALTH- DYER		In Lieu of Form CMS-2552-10		
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der Co		Peri od:	Worksheet B	
				rom 01/01/2021	Part I	
				o 12/31/2021	Date/Time Pre	
					5/30/2022 7:5	8 pm
Cost Center Description	OTHER	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
	ADMI NI STRATI VE	REPAI RS	PLANT	LINEN SERVICE		
	AND GENERAL					
	5. 04	6. 00	7. 00	8. 00	9. 00	
194.03 07953 CENTER OF HOPE	1, 913	0	C	0	0	194. 03
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	o	0	C	0	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	29, 398, 128	4, 785, 138	10, 467, 768	508, 459	3, 967, 490	202. 00

Provider CCN: 15-0090

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 7:58 pm

			' ') 12/31/2021	5/30/2022 7:5	
Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	,
			ADMI NI STRATI ON	SERVICES &		
	10.00	11. 00	13.00	SUPPLY 14.00	15. 00	
GENERAL SERVICE COST CENTERS	10.00	11.00	13.00	14.00	15.00	
1. 00 O0100 CAP REL COSTS-BLDG & FLXT						1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.04 00593 OTHER ADMINISTRATIVE AND GENERAL						5. 04
6.00 00600 MAINTENANCE & REPAIRS						6. 00
7.00 00700 OPERATION OF PLANT						7. 00
8.00 00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00 00900 HOUSEKEEPI NG						9. 00
10. 00 01000 DI ETARY	1, 749, 471					10. 00
11. 00 01100 CAFETERI A	0	1, 683, 468	1			11. 00
13. 00 01300 NURSING ADMINISTRATION	0	50, 666				13.00
14. 00 01400 CENTRAL SERVI CES & SUPPLY	0	13, 423	1	1, 011, 494	2 002 720	14.00
15. 00 01500 PHARMACY 16. 00 01600 MEDI CAL RECORDS & LI BRARY		52, 733 8, 211	0	U O	3, 902, 729 0	15. 00 16. 00
17. 00 01700 SOCIAL SERVICE	0	0, 211		0	0	17. 00
22. 00 02200 I &R SERVI CES-OTHER PRGM COSTS APPRV		0		0	0	22. 00
INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>		ı	<u> </u>		22.00
30. 00 03000 ADULTS & PEDIATRICS	1, 010, 635	340, 770	1, 406, 773	56, 476	37, 735	30.00
31. 00 03100 I NTENSI VE CARE UNI T	140, 429	74, 397		19, 362	33, 667	31.00
32. 00 03200 CORONARY CARE UNIT	0	0	0	o	0	32.00
35.00 02060 NEONATAL INTENSIVE CARE UNIT	0	0	0	o	0	35. 00
41. 00 04100 SUBPROVI DER - I RF	191, 879	122, 326	465, 301	11, 335	135, 192	41.00
42. 00 04200 SUBPROVI DER	0	0	0	0	0	42.00
43. 00 04300 NURSERY	0	0	0	0	0	43. 00
ANCI LLARY SERVI CE COST CENTERS		47.404	105 044	440 500	40.707	F0 00
50. 00 05000 OPERATING ROOM	0	47, 434		442, 522	13, 787	50.00
50. 01 05001 0UTPATIENT SURGERY 51. 00 05100 RECOVERY ROOM	0	28, 681	101, 468	16, 444	2, 841	50. 01 51. 00
53. 00 05300 ANESTHESI OLOGY	0	6, 755 2, 504		1, 622 11, 046	1, 717 42, 642	53.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C		63, 128	1	9, 690	42, 642	54.00
54. 01 05401 RADI OLOGY-SPECI AL PROCEDURES		12, 608	1	33, 317	784	54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	12, 000	37, 774	33, 317	0	55. 00
56. 00 05600 RADI OI SOTOPE	0	9, 230	Ö	545	207, 050	56.00
60. 00 06000 LABORATORY	0	0	1, 146	83	0	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	16, 116	0	63. 00
65. 00 06500 RESPIRATORY THERAPY	O	41, 726	o	10, 987	7, 774	65. 00
66. 00 06600 PHYSI CAL THERAPY	O	88, 170	0	872	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	15, 957	0	211	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	8, 037	1	2, 521	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	23, 527	1	1, 185	15	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	4, 135	0	921	0	70. 00
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	U O	2 240 527	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS 76.00 03630 ULTRA SOUND	0	10, 424	0	2, 510	3, 360, 527 0	73. 00 76. 00
76. 00 03030 0ETRA 300ND 76. 01 03951 PALN CLINI C		15, 782	1	4, 179		76. 00
76. 02 03952 CATH LAB		34, 913		361, 529	3, 397	76. 02
76. 03 03953 ACTIVITY THERAPEUTIC	o o	85, 724		29	0, 0,7	76. 03
76. 04 03954 WOUND CARE CENTER	0	11, 473	1	6, 300	31, 612	76. 04
76. 05 03340 BARI ATRI C CLI NI C	0	15, 724	1	228	2	76. 05
76. 06 03030 HEALTHY LIVING CENTER		0	0	o	0	76. 06
76. 07 03950 CV RESOURCE CENTER	0	2, 446	0	o	0	76. 07
76.08 03955 OTHER ANCILLARY SERVICE COST CENTERS	0	11, 735	0	o	0	76. 08
76.09 03956 LACTATION CLINIC	0	0	0	0	0	76. 09
76. 10 03957 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76. 10
76. 11 03958 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76. 11
76. 12 03959 ANTI COAGULATI ON CLI NI C	0	0	0	0	0	76. 12
91. 00 O9100 EMERGENCY	0	122, 500	417, 379	1, 464	19, 005	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	١	122, 500	417, 379	1, 404	17, 003	92.00
SPECIAL PURPOSE COST CENTERS						72.00
113. 00 11300 I NTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	1, 342, 943	1, 325, 139	3, 605, 279	1, 011, 494	3, 902, 729	
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1, 485	1	0		190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	108, 407	8, 165	0		192. 00
192. 01 19201 WORKI NG WELL	0	0	0	0		192. 01
192. 02 19202 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0		192. 02
192. 03 19203 MI SC	0	0	9, 312	0		192. 03
194. 00 07950 RESI DENTI AL	0	135, 662	150, 515	0		194. 00
194. 01 07954 OTHER NONREI MBURSABLE COST CENTERS 194. 02 07952 PSYCHI ATRI C	406, 528	0 112, 775	0 295, 762	0		194. 01 194. 02
177. 02 07702 1 316 1 A1K1 6	400, 526	112, 773	275, 702	ળ	0	1174.02

Health Financial Systems	In Lie	u of Form CMS-	2552-10			
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der Co		Peri od:	Worksheet B	
				From 01/01/2021	Part I	
				Γo 12/31/2021	Date/Time Pre	
					5/30/2022 7:5	8 pm
Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	
			ADMI NI STRATI OI	SERVICES &		
				SUPPLY		
	10.00	11. 00	13. 00	14.00	15. 00	
194. 03 07953 CENTER OF HOPE	0	0	(0	0	194. 03
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	O	0		0	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	1, 749, 471	1, 683, 468	4, 069, 03	1, 011, 494	3, 902, 729	202. 00

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0090 Peri od: Worksheet B From 01/01/2021 Part I Date/Time Prepared: 12/31/2021 5/30/2022 7:58 pm INTERNS & **RESI DENTS** MEDI CAL SOCIAL SERVICE SERVICES-OTHER Subtotal Intern & Cost Center Description Residents Cost RECORDS & PRGM COSTS LI BRARY **APPRV** & Post Stepdown Adjustments 16.00 17. 00 22.00 24. 00 25. 00 GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00593 OTHER ADMINISTRATIVE AND GENERAL 5 04 5 04 6.00 00600 MAINTENANCE & REPAIRS 6.00 7.00 00700 OPERATION OF PLANT 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 00900 HOUSEKEEPI NG 9 00 9 00 10.00 01000 DI ETARY 10.00 01100 CAFETERI A 11.00 11.00 01300 NURSING ADMINISTRATION 13.00 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14 00 15.00 01500 PHARMACY 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 1,845,075 16.00 01700 SOCIAL SERVICE 17.00 17.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 22.00 0 0 351, 124 22 00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 195, 942 0 28, 463, 018 30.00 03100 INTENSIVE CARE UNIT 0 0 31.00 0 5, 497, 971 31.00 34, 767 0 32.00 03200 CORONARY CARE UNIT 0 0 32.00 02060 NEONATAL INTENSIVE CARE UNIT 0 35.00 35.00 1,023 0 302, 364 04100 SUBPROVI DER - I RF 41.00 0 0 11, 159, 670 41.00 58, 629 42.00 04200 SUBPROVI DER 0 0 42.00 0 04300 NURSERY 43.00 972 0 0 236, 367 0 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 166, 762 0 216, 734 5, 687, 973 -216, 734 50.00 05001 OUTPATIENT SURGERY 50.01 11, 858 0 0 2, 320, 798 0 50.01 05100 RECOVERY ROOM 18,688 0 1, 061, 076 51.00 51.00 0 53.00 05300 ANESTHESI OLOGY 45, 989 0 3, 553, 527 0 53.00 168, 990 05400 RADI OLOGY-DI AGNOSTI C 0 0 4. 981. 223 54 00 Λ 54 00 0 54.01 05401 RADI OLOGY-SPECI AL PROCEDURES 17, 240 0 979, 978 0 54.01 05500 RADI OLOGY-THERAPEUTI C 0 55.00 0 0 55.00 05600 RADI OI SOTOPE 35, 895 0 0 56.00 1, 211, 427 56.00 06000 LABORATORY 0 181,800 0 60.00 7, 973, 456 0 60.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 5, 928 0 0 238, 707 0 63.00 65.00 06500 RESPIRATORY THERAPY 29, 125 3, 417, 746 65.00 06600 PHYSI CAL THERAPY 0 0 66 00 62 632 9 085 405 0 66 00 06700 OCCUPATIONAL THERAPY 0 67.00 14,885 0 1, 192, 526 0 67.00 68.00 06800 SPEECH PATHOLOGY 8, 975 670, 110 0 68.00 06900 ELECTROCARDI OLOGY 69.00 68, 245 0 0 1, 811, 045 0 69.00 07000 ELECTROENCEPHALOGRAPHY 0 70 00 70 00 12 363 Ω 680 559 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 85, 952 11, 142, 888 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 46, 264 10, 636, 610 72.00 07300 DRUGS CHARGED TO PATIENTS 9, 165, 392 73.00 101,048 0 73.00 03630 ULTRA SOUND 0 76.00 940, 206 39,067 0 0 76.00 76. 01 03951 PAIN CLINIC 26,675 0 0 2,018,683 0 76.01 03952 CATH LAB 76.02 191, 379 3, 937, 785 76.02 03953 ACTIVITY THERAPEUTIC 0 76.03 16.159 0 4.069.882 76.03 0 03954 WOUND CARE CENTER 0 76.04 7.417 834, 102 0 76.04 76.05 03340 BARIATRIC CLINIC 8,965 2, 067, 439 76.05 0 03030 HEALTHY LIVING CENTER 76 06 0 0 76.06 76 07 03950 CV RESOURCE CENTER 0 0 76.07 2.446 0 76.08 03955 OTHER ANCILLARY SERVICE COST CENTERS 0 0 11, 735 0 76.08 03956 LACTATION CLINIC 0 76.09 76.09 0 0 0 03957 OTHER ANCILLARY SERVICE COST CENTERS 0 76. 10 0 0 0 0 76. 10 03958 OTHER ANCILLARY SERVICE COST CENTERS 0 76.11 C 0 76. 11 03959 ANTICOAGULATION CLINIC 696, 234 0 76.12 76.12 3, 415 OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 178, 026 0 134, 390 7, 636, 448 -134, 390 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 0 92.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117) 0 351, 124 <u>-351, 124</u> 118. 00 118.00 1,845,075 143, 684, 796 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 158, 232 0 190. 00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 16, 739, 360 0 192. 00 0 192. 01 19201 WORKING WELL 0 0 0 192. 01 40, 237 0 192. 02 19202 PHYSI CLANS' PRI VATE OFFI CES 0 0 192. 02

Hea	alth Financial	Systems	FRANCISCAN H	EALTI	H- DYER				In Lie	u of Form CMS-	2552-10
COS	ST ALLOCATION	- GENERAL SERVICE COSTS			Provi der	CCN:		Period: From 01/	01/2021	Worksheet B Part I	
								To 12/	31/2021	Date/Time Pre 5/30/2022 7:5	
							INTERNS &				
							RESI DENTS				
	Cost	Center Description	MEDI CAL	SOCI	AL SERVI		ERVI CES-OTHE	R Sub1	otal	Intern &	

			I NTERNS & RESI DENTS			
Cost Center Description	MEDI CAL	SOCIAL SERVICE	SERVI CES-OTHER	Subtotal	Intern &	
	RECORDS &		PRGM COSTS		Residents Cost	
	LI BRARY		APPRV		& Post	
					Stepdown	
					Adjustments	
	16. 00	17. 00	22. 00	24.00	25. 00	
192. 03 19203 MI SC	0	0	0	4, 658, 569	0	192. 03
194. 00 07950 RESI DENTI AL	0	0	0	2, 558, 156	0	194. 00
194. 01 07954 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194. 01
194. 02 07952 PSYCHI ATRI C	0	0	0	2, 945, 429	0	194. 02
194. 03 07953 CENTER OF HOPE	0	0	0	11, 116	0	194. 03
200.00 Cross Foot Adjustments			0	0	0	200. 00
201.00 Negative Cost Centers	0	0	0	0	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	1, 845, 075	0	351, 124	170, 795, 895	-351, 124	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 7:58 pm Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0090

			5/30/2022 7:5	
	Cost Center Description	Total		
	GENERAL SERVICE COST CENTERS	26. 00		
1.00	00100 CAP REL COSTS-BLDG & FLXT			1.00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP			2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT			4. 00
5.04	00593 OTHER ADMINISTRATIVE AND GENERAL			5. 04
6.00	00600 MAINTENANCE & REPAIRS			6. 00
7. 00	00700 OPERATION OF PLANT			7. 00
8.00	00800 LAUNDRY & LINEN SERVICE			8.00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY			9.00
11. 00	01100 CAFETERI A			11. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON			13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY			14. 00
15. 00	01500 PHARMACY			15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY			16. 00
17. 00	01700 SOCIAL SERVICE			17. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV			22. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	22 4/2 242		
30.00	03000 ADULTS & PEDI ATRI CS	28, 463, 018		30.00
31. 00 32. 00	03100 I NTENSI VE CARE UNI T	5, 497, 971 0		31.00
35. 00	03200 CORONARY CARE UNIT 02060 NEONATAL INTENSIVE CARE UNIT	302, 364		32. 00 35. 00
41. 00	04100 SUBPROVI DER - I RF	11, 159, 670		41. 00
42. 00	04200 SUBPROVI DER	0		42. 00
43. 00	04300 NURSERY	236, 367		43. 00
	ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	5, 471, 239		50. 00
50. 01	05001 OUTPATI ENT SURGERY	2, 320, 798		50. 01
51. 00	05100 RECOVERY ROOM	1, 061, 076		51. 00
53.00	05300 ANESTHESI OLOGY	3, 553, 527		53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	4, 981, 223		54.00
54. 01	05401 RADI OLOGY-SPECI AL PROCEDURES	979, 978		54. 01
55. 00 56. 00	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE	1 211 427		55.00
60.00	06000 LABORATORY	1, 211, 427 7, 973, 456		56. 00 60. 00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	238, 707		63.00
65. 00	06500 RESPIRATORY THERAPY	3, 417, 746		65. 00
66. 00	06600 PHYSI CAL THERAPY	9, 085, 405		66.00
67. 00	06700 OCCUPATI ONAL THERAPY	1, 192, 526		67. 00
68.00	06800 SPEECH PATHOLOGY	670, 110		68. 00
69. 00	06900 ELECTROCARDI OLOGY	1, 811, 045		69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	680, 559		70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	11, 142, 888		71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	10, 636, 610		72.00
73. 00 76. 00	07300 DRUGS CHARGED TO PATIENTS 03630 ULTRA SOUND	9, 165, 392		73. 00 76. 00
76. 00	03951 PAIN CLINIC	940, 206 2, 018, 683		76. 00
	03952 CATH LAB	3, 937, 785		76. 02
	03953 ACTIVITY THERAPEUTIC	4, 069, 882		76. 03
	03954 WOUND CARE CENTER	834, 102		76. 04
76. 05	03340 BARIATRIC CLINIC	2, 067, 439		76. 05
76.06	03030 HEALTHY LIVING CENTER	0		76. 06
76. 07	03950 CV RESOURCE CENTER	2, 446		76. 07
	03955 OTHER ANCILLARY SERVICE COST CENTERS	11, 735		76. 08
76. 09	03956 LACTATION CLINIC	0		76. 09
76. 10	03957 OTHER ANCILLARY SERVICE COST CENTERS	0		76. 10
76. 11	03958 OTHER ANCILLARY SERVICE COST CENTERS	0		76. 11
76. 12	03959 ANTI COAGULATI ON CLI NI C	696, 234		76. 12
91. 00	OUTPATIENT SERVICE COST CENTERS 09100 EMERGENCY	7, 502, 058		91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	7, 302, 038		91.00
72.00	SPECIAL PURPOSE COST CENTERS			72.00
113.00	11300 I NTEREST EXPENSE			113. 00
118.00		143, 333, 672		118. 00
	NONREI MBURSABLE COST CENTERS			
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	158, 232		190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	16, 739, 360		192. 00
	19201 WORKI NG WELL	40, 237		192. 01
	19202 PHYSICIANS' PRIVATE OFFICES	0		192. 02
	19203 MI SC	4, 658, 569		192. 03
	07950 RESIDENTIAL	2, 558, 156		194. 00
	07954 OTHER NONREIMBURSABLE COST CENTERS	2 045 420		194. 01 194. 02
	07952 PSYCHI ATRI C 07953 CENTER OF HOPE	2, 945, 429 11, 116		194. 02
200.00	1 1	11, 116		200. 00
200.00	or oss root haj astiliorits	U		1200.00

Health Fir	nancial Systems	FRANCISCAN HEAD	LTH- DYER	In Lie	u of Form CMS-2552-10
COST ALLO	CATION - GENERAL SERVICE COSTS		Provider CCN: 15-0090	Peri od: From 01/01/2021	Worksheet B Part I
					Date/Time Prepared: 5/30/2022 7:58 pm
	Cost Center Description	Total	·		
		26. 00			
201.00	Negative Cost Centers	0			201. 00
202. 00	TOTAL (sum lines 118 through 201)	170, 444, 771			202. 00

	Financial Systems	FRANCI SCAN HE				u of Form CMS-2	2552-10
ALLOCA	ITION OF CAPITAL RELATED COSTS		Provi der Co	Fr	eriod: com 01/01/2021	Worksheet B Part II Date/Time Pre	narod:
			CADITAL DEL	ATED COSTS	12/31/2021	5/30/2022 7:5	
				_ATED COSTS			
	Cost Center Description	Directly Assigned New	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS	
		Capi tal				DEPARTMENT	
		Related Costs 0	1.00	2.00	2A	4. 00	
1. 00	GENERAL SERVICE COST CENTERS O0100 CAP REL COSTS-BLDG & FLXT						1.00
2.00	00200 CAP REL COSTS-BLDG & FTXT						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0			38, 280	38, 280	4. 00
5. 04 6. 00	OO593 OTHER ADMINISTRATIVE AND GENERAL OO600 MAINTENANCE & REPAIRS	0			1, 413, 857 1, 445, 809	6, 899 370	5. 04 6. 00
7.00	00700 OPERATION OF PLANT	0	345, 207		1, 318, 411	669	7. 00
8. 00 9. 00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING	0	0 02 227	0 2, 524	04 941	102 869	8. 00 9. 00
10.00	01000 DI ETARY	0	92, 337 81, 457		94, 861 90, 549	284	•
11. 00	01100 CAFETERI A	0	117, 594	0	117, 594	314	1
13. 00 14. 00	O1300 NURSI NG ADMI NI STRATI ON O1400 CENTRAL SERVI CES & SUPPLY	0	12, 440 104, 880		38, 308 131, 234	1, 101 161	1
15. 00	01500 PHARMACY	0	58, 548		64, 009	1, 059	•
16. 00 17. 00	01600 MEDICAL RECORDS & LIBRARY	0			83, 719	90	16.00
22. 00	01700 SOCIAL SERVICE 02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0			0	0 55	17. 00 22. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 NTENSIVE CARE UNIT	0			1, 491, 734 198, 100	5, 978 1, 109	30. 00 31. 00
32. 00	03200 CORONARY CARE UNIT	0	0		0	0	32. 00
35. 00	02060 NEONATAL INTENSIVE CARE UNIT	0		0	0	90	•
41. 00 42. 00	04100 SUBPROVI DER	0		1	115, 870 0	1, 923 0	41. 00 42. 00
43. 00	04300 NURSERY	0			0	84	•
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	0	282, 512	189, 504	472, 016	839	50. 00
50. 00	05001 OUTPATI ENT SURGERY	0	l		251, 202	350	50. 00
51.00	05100 RECOVERY ROOM	0			110, 154	187	51.00
53. 00 54. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0	0 403, 567	= .,	21, 316 793, 397	19 714	53. 00 54. 00
54. 01	05401 RADI OLOGY-SPECI AL PROCEDURES	0	26, 421	4, 120	30, 541	270	54. 01
55. 00 56. 00	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE	0	0 84, 490	0 35, 049	0 119, 539	0 183	55. 00 56. 00
60.00	06000 LABORATORY	0	118, 365	·	119, 539	113	•
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0			48, 508	0	63. 00
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0	36, 668 24, 879		65, 920 39, 465	753 1, 820	65. 00 66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0			9, 527	391	67. 00
68.00	06800 SPEECH PATHOLOGY	0			3, 506	198	1
69. 00 70. 00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	0	65, 248 90, 161	61, 079 5, 297	126, 327 95, 458	446 90	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71. 00
72. 00 73. 00	O7200 IMPL. DEV. CHARGED TO PATIENTS O7300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	72. 00 73. 00
76. 00	03630 ULTRA SOUND	0	39, 221	27, 784	67, 005	239	76.00
76. 01	03951 PAIN CLINIC	0	211, 148		216, 614	320	76. 01
76. 02 76. 03	03952 CATH LAB 03953 ACTIVITY THERAPEUTIC	0	154, 861 97, 769	136, 736 41	291, 597 97, 810	774 1, 217	76. 02 76. 03
76. 04	03954 WOUND CARE CENTER	0	109, 044	2, 086	111, 130	100	76. 04
76. 05 76. 06	03340 BARIATRIC CLINIC 03030 HEALTHY LIVING CENTER	0	33, 018	3, 978 0	36, 996	670 0	76. 05 76. 06
76. 00	03950 CV RESOURCE CENTER	0	0	0	0	0	76.00
76. 08	03955 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76. 08
76. 09 76. 10	03956 LACTATION CLINIC 03957 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76. 09 76. 10
76. 11	03958 OTHER ANCILLARY SERVICE COST CENTERS	0	ő	Ö	Ö	0	76. 11
76. 12	03959 ANTI COAGULATI ON CLI NI C	0	7, 539	104	7, 643	228	76. 12
91. 00	OUTPATIENT SERVICE COST CENTERS O9100 EMERGENCY	0	275, 556	62, 733	338, 289	1, 704	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART				0		92. 00
113 00	SPECIAL PURPOSE COST CENTERS 11300 NTEREST EXPENSE						113. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	0	6, 843, 406	3, 272, 029	10, 115, 435	32, 782	•
190 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	13, 639	709	14, 348	10	190. 00
192.00	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	234, 690		252, 200	4, 183	192. 00
	19201 WORKING WELL 19202 PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192. 01 192. 02
	19202 PHYSICIANS PRIVATE OFFICES	0	0	-	392		192. 02 192. 03
							·

Health Financial Systems FRANCISCAN HEALTH- DYER				In Lie	u of Form CMS	-2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CO		Period: From 01/01/2021 To 12/31/2021	Worksheet B Part II Date/Time Pr 5/30/2022 7:	
		CAPI TAL REL	LATED COSTS			
Cost Center Description	Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
	0	1.00	2.00	2A	4. 00	
194. 00 07950 RESI DENTI AL	0	519, 293	21, 86	2 541, 155		0 194. 00
194.01 07954 OTHER NONREIMBURSABLE COST CENTERS	0	0		0		0 194. 01
194. 02 07952 PSYCHI ATRI C	0	453, 737		0 453, 737		0 194. 02
194. 03 07953 CENTER OF HOPE	0	0		0		0 194. 03
200.00 Cross Foot Adjustments				0		200. 00
201.00 Negative Cost Centers		0		0		0 201. 00
202.00 TOTAL (sum lines 118 through 201)	0	8, 064, 765	3, 312, 50	11, 377, 267	38, 28	0 202. 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: | Transfer | Transfer | Prepared: | Pre Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0090

				1	0 12/31/2021	Date/lime Pre 5/30/2022 7:5	
	Cost Center Description	OTHER ADMI NI STRATI VE AND GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	J
		5. 04	6. 00	7. 00	8. 00	9. 00	
1 00	GENERAL SERVICE COST CENTERS					ı	1 00
1. 00 2. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1. 00 2. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.04	00593 OTHER ADMINISTRATIVE AND GENERAL	1, 420, 756					5. 04
6.00	00600 MAINTENANCE & REPAIRS	39, 805	1, 485, 984	l.			6. 00
7.00	00700 OPERATION OF PLANT	84, 864	82, 570	1			7. 00
8. 00 9. 00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING	4, 230 31, 042	22, 086	ή	4, 332	172, 252	8. 00 9. 00
10. 00	01000 DI ETARY	12, 357	19, 484		0	2, 430	10.00
11. 00	01100 CAFETERI A	10, 833	28, 127		Ö	3, 507	11. 00
13. 00	01300 NURSING ADMINISTRATION	33, 091	2, 975			371	13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	5, 475	25, 086			3, 128	14.00
15. 00 16. 00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	30, 448 13, 023	14, 004 20, 025			1, 746 2, 497	15. 00 16. 00
17. 00	01700 SOCIAL SERVICE	13,023	20, 023	1		2,477	17. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	2, 921	O	Ö	0	Ō	22. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	172, 207	327, 260			40, 811	30.00
31. 00 32. 00	03100 I NTENSI VE CARE UNI T 03200 CORONARY CARE UNI T	34, 385	40, 701 0	1	328	5, 075 0	31. 00 32. 00
35. 00	02060 NEONATAL INTENSIVE CARE UNIT	2, 498	0		9	0	35.00
41. 00	04100 SUBPROVI DER - I RF	81, 243	24, 336	25, 777	670		
42. 00	04200 SUBPROVI DER	0	0	0	_	0	42. 00
43. 00	04300 NURSERY	1, 945	0) 0	13	0	43. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	30, 693	67, 574	71, 575	0	8, 427	50.00
50. 00	05001 OUTPATIENT SURGERY	11, 458	57, 718				50.00
51. 00	05100 RECOVERY ROOM	5, 470	22, 750		0	2, 837	51.00
53. 00	05300 ANESTHESI OLOGY	28, 704	0	ή	0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	28, 506	96, 529			12, 037	54.00
54. 01 55. 00	05401 RADI OLOGY-SPECI AL PROCEDURES 05500 RADI OLOGY-THERAPEUTI C	6, 575	6, 320	1	0	788 0	54. 01 55. 00
56. 00	05600 RADI OLOGI - ITIERAF LUTT C	5, 697	20, 209	1	0	2, 520	56.00
60.00	06000 LABORATORY	61, 613	28, 312			3, 530	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	494	11, 603	12, 290	0	1, 447	63. 00
65. 00	06500 RESPI RATORY THERAPY	26, 696	8, 771	1	0	1,0,1	65. 00
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	73, 644 9, 405	5, 951 2, 279			742 284	66. 00 67. 00
68. 00	06800 SPEECH PATHOLOGY	5, 412	2, 2/7		0	0	68.00
69. 00	06900 ELECTROCARDI OLOGY	11, 939	15, 607	16, 531	0	1, 946	1
70. 00	07000 ELECTROENCEPHALOGRAPHY	3, 085	21, 566	22, 843	0	2, 689	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	91, 977	0	0	0	0	71.00
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	88, 096 47, 447	0	0	0	0	72. 00 73. 00
	03630 ULTRA SOUND	6, 331	9, 381	9, 937	0	1, 170	
	03951 PAIN CLINIC	9, 649	50, 504				76. 01
	03952 CATH LAB	22, 084	37, 041			4, 619	76. 02
76. 03	03953 ACTIVITY THERAPEUTIC	30, 371	23, 385			2, 916	
76. 04 76. 05	03954 WOUND CARE CENTER 03340 BARI ATRI C CLI NI C	3, 526 15, 679	26, 082 7, 898			3, 252 985	76. 04 76. 05
76. 05	03030 HEALTHY LIVING CENTER	13, 079	7, 898	0, 303	0	0	76.05
76. 07	03950 CV RESOURCE CENTER	o	0	Ö	Ö	Ö	76. 07
76. 08	03955 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76. 08
76. 09	03956 LACTATION CLINIC	0	0	0	0	0	76. 09
76. 10	03957 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76. 10
76. 11 76. 12	03958 OTHER ANCILLARY SERVICE COST CENTERS 03959 ANTICOAGULATION CLINIC	5, 560	1, 803	1, 910	0	225	76. 11 76. 12
70. 12	OUTPATIENT SERVICE COST CENTERS	3,300	1,000	1, 710			70.12
91. 00	09100 EMERGENCY	48, 834	65, 910	69, 813	0	8, 219	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
112 00	SPECIAL PURPOSE COST CENTERS 11300 NTEREST EXPENSE			1		Ι	113. 00
118.00		1, 239, 312	1, 193, 847	1, 177, 078	3, 381	135, 822	
	NONREI MBURSABLE COST CENTERS	1,20,,012	17 1707 0 17	1,177,070	0,001	1.007.022	1110100
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	936	3, 262				190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	131, 949	56, 136	59, 460	0		192.00
	19201 WORKING WELL 19202 PHYSICIANS' PRIVATE OFFICES	335	0	0	0		192. 01 192. 02
	19202 PHYSICIANS PRIVATE OFFICES	38, 675	0	0	0		192. 02
194.00	07950 RESI DENTI AL	4, 898	124, 210	131, 565	0		194. 00
194. 01	07954 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194. 01
194. 02	2 07952 PSYCHI ATRI C	4, 559	108, 529	114, 956	951	13, 534	194. 02

Health Financial Systems	FRANCISCAN H	IEALTH- DYER		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der Co		eri od:	Worksheet B	
			_	rom 01/01/2021	Part II	
			T T	o 12/31/2021	Date/Time Pre	
					5/30/2022 7:5	8 pm
Cost Center Description	OTHER	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
	ADMI NI STRATI VE	REPAI RS	PLANT	LINEN SERVICE		
	AND GENERAL					
	5. 04	6. 00	7. 00	8. 00	9. 00	
194.03 07953 CENTER OF HOPE	92	2 0	0	0	0	194. 03
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers		0	0	0	0	201. 00
202.00 TOTAL (sum lines 118 throug	gh 201) 1,420,756	1, 485, 984	1, 486, 514	4, 332	172, 252	202. 00

Provider CCN: 15-0090

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 7:58 pm

) 12/31/2021	5/30/2022 7:5	
Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	
			ADMI NI STRATI ON	SERVICES &		
	10.00	11. 00	13.00	SUPPLY 14. 00	15. 00	
GENERAL SERVICE COST CENTERS	10.00	11.00	13.00	14.00	13.00	
1.00 O0100 CAP REL COSTS-BLDG & FLXT						1. 00
2.00 00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.04 00593 OTHER ADMINISTRATIVE AND GENERAL						5. 04
6. 00 00600 MAI NTENANCE & REPAI RS						6. 00
7. 00 00700 OPERATION OF PLANT						7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY	145, 741					9. 00 10. 00
11. 00 01100 CAFETERI A	145, 741	190. 168				11. 00
13. 00 01300 NURSI NG ADMI NI STRATI ON	0	5, 723				13. 00
14. 00 01400 CENTRAL SERVI CES & SUPPLY	l ol	1, 516	1	193, 172		14. 00
15. 00 01500 PHARMACY	O	5, 957	1	o	132, 056	15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	O	928	0	o	0	16. 00
17. 00 01700 SOCI AL SERVI CE	0	0	0	0	0	17. 00
22. 00 02200 1 &R SERVI CES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	04.404	20.400		40 705	4 077	00.00
30. 00 03000 ADULTS & PEDI ATRI CS	84, 191	38, 492	,	10, 785 3, 698	1, 277	30.00
31. 00 03100 INTENSI VE CARE UNI T 32. 00 03200 CORONARY CARE UNI T	11, 699	8, 404	9, 821	3, 698	1, 139 0	31. 00 32. 00
35. 00 02060 NEONATAL INTENSIVE CARE UNIT	0	0		0	0	35. 00
41. 00 04100 SUBPROVI DER - I RF	15, 985	13, 818	9, 688	2, 165	4, 574	41. 00
42. 00 04200 SUBPROVI DER	0	0	7, 000	2, 100	0	42. 00
43. 00 04300 NURSERY	o	0	Ö	Ö	0	43. 00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	0	5, 358		84, 513	467	50.00
50. 01 05001 OUTPATI ENT SURGERY	0	3, 240		3, 140	96	50. 01
51. 00 05100 RECOVERY ROOM	0	763		310	58	51. 00
53. 00 05300 ANESTHESI OLOGY	0	283	1	2, 110	1, 443	53.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	0	7, 131	0	1, 850	154	54.00
54. 01 05401 RADI OLOGY-SPECI AL PROCEDURES 55. 00 05500 RADI OLOGY-THERAPEUTI C	0	1, 424	833	6, 363	27 0	54. 01 55. 00
56. 00 05600 RADI 01 SOTOPE	0	1, 043	1	104	7, 006	56. 00
60. 00 06000 LABORATORY	o o	1, 049		16	0	60. 00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	l ol	0	0	3, 078	0	63. 00
65. 00 06500 RESPIRATORY THERAPY	O	4, 713	0	2, 098	263	65. 00
66. 00 06600 PHYSI CAL THERAPY	O	9, 960	0	167	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	1, 803	0	40	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	908	1	482	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	2, 658	1	226	1	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	467	0	176	0	70.00
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	0	0	0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	U O	0 113, 708	72. 00 73. 00
76. 00 03630 ULTRA SOUND	0	1, 178	0	479	113, 706	76. 00
76. 01 03951 PAI N CLI NI C	0	1, 178		798	15	
76. 02 03952 CATH LAB	o o	3, 944		69, 042	115	76. 02
76. 03 03953 ACTIVITY THERAPEUTIC	o	9, 684		6	0	76. 03
76.04 03954 WOUND CARE CENTER	O	1, 296	1	1, 203	1, 070	76. 04
76. 05 03340 BARI ATRI C CLI NI C	O	1, 776	1, 055	43	0	76. 05
76.06 03030 HEALTHY LIVING CENTER	0	0		0	0	76. 06
76. 07 03950 CV RESOURCE CENTER	0	276		0	0	76. 07
76.08 03955 OTHER ANCILLARY SERVICE COST CENTERS	0	1, 326	0	0	0	76. 08
76. 09 03956 LACTATION CLINIC	0	0	0	0	0	76. 09
76. 10 03957 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76. 10
76. 11 03958 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	U O	0	76. 11
76. 12 03959 ANTI COAGULATI ON CLINI C OUTPATI ENT SERVI CE COST CENTERS	U U	0	ıj U	U _I	0	76. 12
91. 00 09100 EMERGENCY	0	13, 838	8, 690	280	643	91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		10,000	0,070	200	010	92. 00
SPECIAL PURPOSE COST CENTERS	<u>'</u>		'			
113. 00 11300 I NTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	111, 875	149, 690	75, 065	193, 172	132, 056	118. 00
NONREI MBURSABLE COST CENTERS	,		,	,		
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	168	1	0		190. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0	12, 246		0		192.00
192. 01 19201 WORKI NG WELL	0	0	0	0		192. 01
192. 02 19202 PHYSI CLANS' PRI VATE OFFI CES		0	0	O		192. 02
192. 03 19203 MI SC 194. 00 07950 RESI DENTI AL		15, 325	194 3, 134	o o		192. 03 194. 00
194. 01 07950 RESIDENTIAL 194. 01 07954 OTHER NONREIMBURSABLE COST CENTERS		10, 325 N	3, 134 ∩	0		194. 00 194. 01
194. 02 07952 PSYCHI ATRI C	33, 866	12, 739	6, 158	ol		194. 01
		, . 0,	2, .00	٩١		

Health Financial Systems	FRANCISCAN HE	ALTH- DYER		In Lie	u of Form CMS-:	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der C		Period: From 01/01/2021	Worksheet B Part II	
				Го 12/31/2021	Date/Time Pre 5/30/2022 7:5	
Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	
			ADMI NI STRATI OI	SERVICES &		
				SUPPLY		
	10.00	11. 00	13.00	14.00	15. 00	
194. 03 07953 CENTER OF HOPE	0	0)	0	0	194. 03
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	0)	o o	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	145, 741	190, 168	84, 72	1 193, 172	132, 056	202. 00

Health Financial Systems ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0090 Peri od: Worksheet B From 01/01/2021 Part II Date/Time Prepared: 12/31/2021 5/30/2022 7:58 pm INTERNS & **RESI DENTS** Cost Center Description MEDI CAL SOCIAL SERVICE SERVICES-OTHER Subtotal Intern & Residents Cost RECORDS & PRGM COSTS LI BRARY **APPRV** & Post Stepdown Adjustments 16.00 17. 00 22.00 24. 00 25. 00 GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00593 OTHER ADMINISTRATIVE AND GENERAL 5 04 5 04 00600 MAINTENANCE & REPAIRS 6.00 6.00 7.00 00700 OPERATION OF PLANT 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 00900 HOUSEKEEPI NG 9 00 9 00 10.00 01000 DI ETARY 10.00 01100 CAFETERI A 11.00 11.00 01300 NURSING ADMINISTRATION 13.00 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14 00 15.00 01500 PHARMACY 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 141, 492 16.00 01700 SOCIAL SERVICE 17.00 17.00 22.00 02200 L&R SERVICES-OTHER PRGM COSTS APPRV 0 0 2, 976 22 00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 14, 972 n 2, 565, 993 30.00 03100 INTENSIVE CARE UNIT 31.00 0 0 31.00 2,667 360, 237 03200 CORONARY CARE UNIT 32.00 0 0 0 32.00 02060 NEONATAL INTENSIVE CARE UNIT 35.00 35.00 79 0 2,676 04100 SUBPROVI DER - I RF 41.00 4, 498 0 0 41.00 303.582 42.00 04200 SUBPROVI DER 0 0 42.00 0 04300 NURSERY 43.00 75 C 2, 117 0 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 12, 794 0 758, 323 0 50.00 05001 OUTPATIENT SURGERY 50.01 910 0 398, 559 0 50.01 169, 442 05100 RECOVERY ROOM 1,434 51.00 51.00 0 53.00 05300 ANESTHESI OLOGY 3,528 0 57, 419 0 53.00 12, 965 05400 RADI OLOGY-DI AGNOSTI C 0 1, 055, 528 54 00 0 54 00 54.01 05401 RADI OLOGY-SPECI AL PROCEDURES 1, 323 0 61, 158 0 54.01 05500 RADI OLOGY-THERAPEUTI C 55.00 0 0 55.00 05600 RADI OI SOTOPE 2,754 0 180, 461 56.00 56.00 06000 LABORATORY 13, 947 0 60.00 256, 683 0 60.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 455 0 77,875 0 63.00 65.00 06500 RESPIRATORY THERAPY 2, 234 121, 832 0 65.00 06600 PHYSI CAL THERAPY 0 66 00 4 805 142 857 0 66 00 06700 OCCUPATIONAL THERAPY 67.00 1, 142 0 27, 285 0 67.00 68.00 06800 SPEECH PATHOLOGY 689 11, 195 0 68.00 06900 ELECTROCARDI OLOGY 69.00 5, 236 0 182, 402 0 69.00 07000 ELECTROENCEPHALOGRAPHY 147, 322 70 00 70 00 948 Ω 0 6, 594 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 98, 571 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 3, 549 91, 645 72.00 0 07300 DRUGS CHARGED TO PATIENTS 73.00 7,752 168, 907 0 73.00 03630 ULTRA SOUND 2, 997 76.00 Ω 98.717 0 76.00 76. 01 03951 PAIN CLINIC 2,046 0 344, 172 0 76.01 03952 CATH LAB 76.02 14,682 487, 085 76.02 03953 ACTIVITY THERAPEUTIC 191, 399 76. 03 76.03 1.240 0 0 03954 WOUND CARE CENTER 76.04 569 0 175, 855 0 76.04 76.05 03340 BARIATRIC CLINIC 688 74, 155 0 76.05 03030 HEALTHY LIVING CENTER 76 06 0 0 76.06 03950 CV RESOURCE CENTER 76.07 0 0 276 76.07 0 76.08 03955 OTHER ANCILLARY SERVICE COST CENTERS 0 0 1, 326 0 76.08 03956 LACTATION CLINIC 0 76.09 0 0 03957 OTHER ANCILLARY SERVICE COST CENTERS 0 76. 10 0 0 0 76. 10 03958 OTHER ANCILLARY SERVICE COST CENTERS 76.11 0 C 0 76. 11 03959 ANTI COAGULATION CLINIC 0 76.12 76.12 262 17,631 OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 0 91.00 13, 658 569.878 0 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 0 92.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113. 00 SUBTOTALS (SUM OF LINES 1 through 117) 141, 492 0 9, 202, 563 0 118.00 118.00 0 NONREIMBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 22, 595 0 190. 00 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 0 0 192. 00 523.344 0 192. 01 19201 WORKING WELL 0 0 192. 01

0

0

352

0

0 192. 02

192. 02 19202 PHYSI CLANS' PRI VATE OFFI CES

Health Financial Systems	FRANCI SCAN H	EALTH- DYER		In Lie	eu of Form CMS-:	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der CO		Peri od:	Worksheet B	
				From 01/01/2021 To 12/31/2021	Part II Date/Time Pre 5/30/2022 7:5	
			I NTERNS & RESI DENTS			
Cost Center Description		SOCIAL SERVICE			Intern &	
	RECORDS &		PRGM COSTS		Residents Cost	
	LI BRARY		APPRV		& Post Stepdown	
					Adjustments	
	16. 00	17. 00	22. 00	24.00	25. 00	
192. 03 19203 MI SC	0	0		40, 540	0	192. 03
194. 00 07950 RESI DENTI AL	0	0		835, 776	0	194. 00
194.01 07954 OTHER NONREIMBURSABLE COST CENTERS	0	0		0	0	194. 01
194. 02 07952 PSYCHI ATRI C	0	0		749, 029	0	194. 02
194.03 07953 CENTER OF HOPE	0	0		92	0	194. 03
200.00 Cross Foot Adjustments			2, 97	6 2, 976	0	200. 00
201.00 Negative Cost Centers	0	0		0	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	141, 492	비 이	2, 97	11, 377, 267	0	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Peri od: From 01/01/2021 To 12/31/2021 Provider CCN: 15-0090

		5/30/2022 /: 58 pm	<u>a</u>
Cost Center Description	Total		
GENERAL SERVICE COST CENTERS	26. 00		_
1. 00 00100 CAP REL COSTS-BLDG & FIXT		1	. 00
2. 00 00200 CAP REL COSTS-MVBLE EQUIP			. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT		4.	. 00
5. 04 00593 OTHER ADMINISTRATIVE AND GENERAL		5.	. 04
6.00 00600 MAINTENANCE & REPAIRS		6.	. 00
7.00 OO700 OPERATION OF PLANT			. 00
8.00 00800 LAUNDRY & LINEN SERVICE			. 00
9. 00 00900 HOUSEKEEPI NG			. 00
10. 00 01000 DI ETARY			. 00
11. 00 01100 CAFETERI A			. 00
13. 00 01300 NURSI NG ADMI NI STRATI ON 14. 00 01400 CENTRAL SERVI CES & SUPPLY			. 00 . 00
15. 00 01500 PHARMACY			. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY			. 00
17. 00 01700 SOCI AL SERVI CE			. 00
22.00 02200 I &R SERVICES-OTHER PRGM COSTS APPRV			. 00
INPATIENT ROUTINE SERVICE COST CENTERS			
30. 00 03000 ADULTS & PEDIATRICS	2, 565, 993	30.	. 00
31.00 03100 INTENSIVE CARE UNIT	360, 237		. 00
32. 00 03200 CORONARY CARE UNIT	0		. 00
35. 00 02060 NEONATAL INTENSIVE CARE UNIT	2, 676		. 00
41. 00 04100 SUBPROVI DER - I RF	303, 582		. 00
42. 00 04200 SUBPROVI DER	0 117		. 00
43. 00 04300 NURSERY	2, 117	43.	. 00
ANCILLARY SERVICE COST CENTERS 50. 00 05000 OPERATING ROOM	758, 323	50	. 00
50. 00 05000 OFERATING ROOM 50. 01 05001 OUTPATI ENT SURGERY	398, 559		. 01
51. 00 05100 RECOVERY ROOM	169, 442		. 00
53. 00 05300 ANESTHESI OLOGY	57, 419		. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 055, 528		. 00
54. 01 05401 RADI OLOGY-SPECI AL PROCEDURES	61, 158		. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0		. 00
56. 00 05600 RADI 0I SOTOPE	180, 461	56.	. 00
60. 00 06000 LABORATORY	256, 683	60.	. 00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	77, 875		. 00
65. 00 06500 RESPI RATORY THERAPY	121, 832		. 00
66. 00 06600 PHYSI CAL THERAPY	142, 857		. 00
67. 00 06700 OCCUPATI ONAL THERAPY	27, 285		. 00
68. 00 06800 SPEECH PATHOLOGY	11, 195		. 00
69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY	182, 402 147, 322		. 00 . 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	98, 571		. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	91, 645		. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	168, 907		. 00
76. 00 03630 ULTRA SOUND	98, 717		. 00
76. 01 03951 PAIN CLINIC	344, 172		. 01
76. 02 03952 CATH LAB	487, 085	76.	. 02
76.03 03953 ACTIVITY THERAPEUTIC	191, 399	76.	. 03
76.04 03954 WOUND CARE CENTER	175, 855	76.	. 04
76. 05 03340 BARI ATRI C CLI NI C	74, 155		. 05
76.06 03030 HEALTHY LIVING CENTER	0		. 06
76. 07 03950 CV RESOURCE CENTER	276		. 07
76. 08 03955 OTHER ANCILLARY SERVICE COST CENTERS	1, 326		. 08
76. 09 03956 LACTATION CLINIC	0		. 09 . 10
76. 10 03957 OTHER ANCILLARY SERVICE COST CENTERS 76. 11 03958 OTHER ANCILLARY SERVICE COST CENTERS	0		. 10 . 11
76. 12 03959 ANTI COAGULATI ON CLINI C	17, 631		. 11 . 12
OUTPATIENT SERVICE COST CENTERS	17,031	70.	. 12
91. 00 09100 EMERGENCY	569, 878	91.	. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	331,313		. 00
SPECIAL PURPOSE COST CENTERS	'		
113. 00 11300 I NTEREST EXPENSE		113.	. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	9, 202, 563	118.	. 00
NONREI MBURSABLE COST CENTERS			
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	22, 595	190.	
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	523, 344	192.	
192. 01 19201 WORKI NG WELL	352	192.	
192. 02 19202 PHYSI CLANS' PRI VATE OFFI CES	0	192.	
192. 03 19203 MI SC	40, 540	192.	
194. 00 07950 RESI DENTI AL	835, 776	194.	
194.01 07954 OTHER NONREIMBURSABLE COST CENTERS	740 020	194. 194.	
194. 02 07952 PSYCHI ATRI C 194. 03 07953 CENTER OF HOPE	749, 029 92	194.	
200.00 Cross Foot Adjustments	2, 976	200.	
255.50 of 555 1 Out Auj ustimonts	2,710	200.	. 55

Health Fin	ancial Systems	FRANCISCAN HEAD	LTH- DYER	In Lieu of Form CMS-2552-10		
ALLOCATI ON	OF CAPITAL RELATED COSTS		Provider CCN: 15-0090	Peri od: From 01/01/2021	Worksheet B	
					Date/Time Prepared: 5/30/2022 7:58 pm	
	Cost Center Description	Total	·			
		26. 00				
201.00	Negative Cost Centers	0			201. 00	
202.00	TOTAL (sum lines 118 through 201)	11, 377, 267			202. 00	

SSST NEESSATTON STATISTICS ENGINE		Trovider of	1	From 01/01/2021 From 12/31/2021	Date/Time Pre	pared:
	CAPITAL REL	ATED COSTS			5/30/2022 7:5	8 pm
Cost Center Description	BLDG & FLXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconci I i ati on	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	
	1.00	2. 00	4. 00	5A. 04	5. 04	
GENERAL SERVICE COST CENTERS 1. 00 00100 CAP REL COSTS-BLDG & FLXT	470, 676					1. 00
2. 00 00200 CAP REL COSTS-MVBLE EQUIP	470,070	8, 138, 443				2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	1, 943	12, 256	70, 809, 514	1		4. 00
5. 04 00593 OTHER ADMINISTRATIVE AND GENERAL	35, 111	1, 995, 608	12, 800, 78!		141, 397, 767	5. 04
6.00 00600 MAINTENANCE & REPAIRS 7.00 00700 OPERATION OF PLANT	71, 044 20, 147	561, 425 2, 391, 047	683, 148 1, 236, 51!	1	3, 961, 499 8, 445, 885	6. 00 7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE	0	0	188, 268	1	420, 941	8. 00
9. 00 00900 HOUSEKEEPI NG	5, 389	6, 200	1, 605, 739	1	3, 089, 327	9. 00
10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A	4, 754 6, 863	22, 339 0	524, 434 580, 37		1, 229, 762 1, 078, 151	10. 00 11. 00
13. 00 01300 NURSI NG ADMI NI STRATI ON	726	63, 555	2, 034, 619	1	3, 293, 328	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	6, 121	64, 750	296, 87		544, 844	14. 00
15. 00 01500 PHARMACY	3, 417	13, 418	1, 957, 98		3, 030, 209	15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY 17. 00 01700 SOCI AL SERVI CE	4, 886 0	0	166, 99°	0	1, 296, 043 0	16. 00 17. 00
22. 00 02200 I &R SERVI CES-OTHER PRGM COSTS APPRV	0	0	102, 08	3 0	290, 687	22. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	70.054	000 504	44 050 000	ما ما	47.400.400	
30. 00 03000 ADULTS & PEDI ATRI CS 31. 00 03100 NTENSI VE CARE UNI T	79, 851 9, 931	303, 504 68, 640	11, 050, 039 2, 049, 748		17, 139, 439 3, 422, 074	30. 00 31. 00
32. 00 03200 CORONARY CARE UNIT	0	00, 010		o o	0, 122, 0, 1	32. 00
35.00 02060 NEONATAL INTENSIVE CARE UNIT	0	0	166, 000	1	248, 610	35. 00
41. 00 04100 SUBPROVI DER - RF 42. 00 04200 SUBPROVI DER	5, 938 0	34, 706	3, 555, 16!	0	8, 085, 480 0	41. 00 42. 00
43. 00 04300 NURSERY	0	0	155, 983	3 0	193, 571	42.00
ANCILLARY SERVICE COST CENTERS	-	-			,	
50. 00 05000 OPERATING ROOM	16, 488	465, 590	1, 549, 982		3, 054, 623	50.00
50. 01 05001 0UTPATI ENT SURGERY 51. 00 05100 RECOVERY ROOM	14, 083 5, 551	24, 318 36, 955	646, 044 345, 09!	1	1, 140, 286 544, 427	50. 01 51. 00
53. 00 05300 ANESTHESI OLOGY	0	52, 372	35, 290	1	2, 856, 658	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	23, 553	957, 769	1, 319, 979	1	2, 836, 946	54. 00
54. 01 05401 RADI OLOGY-SPECI AL PROCEDURES 55. 00 05500 RADI OLOGY-THERAPEUTI C	1, 542 0	10, 123 0	499, 80	7 0	654, 349 0	54. 01 55. 00
56. 00 05600 RADI 01 SOTOPE	4, 931	86, 112	338, 832	2 0	566, 970	56.00
60. 00 06000 LABORATORY	6, 908	1, 905	208, 62	1	6, 131, 883	60. 00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	2, 831	71 070	1 202 203	٥ -	49, 205	63.00
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	2, 140 1, 452	71, 870 35, 836	1, 392, 303 3, 364, 463	1	2, 656, 886 7, 329, 257	65. 00 66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	556	0	722, 378	1	935, 991	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	8, 614	365, 70		538, 597	68. 00
69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY	3, 808 5, 262	150, 064 13, 014	824, 839 166, 902		1, 188, 206 307, 058	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0, 202	13, 014			9, 153, 767	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(0	8, 767, 489	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS 76. 00 03630 ULTRA SOUND	0 2, 289	0 68, 261	442, 28 ⁹	0	4, 722, 051 630, 079	73. 00 76. 00
76. 00 03030 0E1 NA 300ND	12, 323	13, 430	591, 71	1	960, 301	76. 00
76. 02 03952 CATH LAB	9, 038	335, 946	1, 431, 09		2, 197, 861	76. 02
76. 03 03953 ACTIVITY THERAPEUTIC	5, 706	100	2, 250, 240		3, 022, 632	76. 03
76. 04 03954 WOUND CARE CENTER 76. 05 03340 BARI ATRI C CLI NI C	6, 364 1, 927	5, 124 9, 774	184, 723 1, 239, 178	1	350, 900 1, 560, 395	76. 04 76. 05
76. 06 03030 HEALTHY LIVING CENTER	0	0	1, 20 , 1 , (0	76.06
76. 07 03950 CV RESOURCE CENTER	0	0	(0	0	76. 07
76. 08 03955 OTHER ANCILLARY SERVICE COST CENTERS 76. 09 03956 LACTATION CLINIC	0	0	(0	0	76. 08 76. 09
76. 10 03957 OTHER ANCILLARY SERVICE COST CENTERS	0	0	(0	76. 09
76. 11 03958 OTHER ANCILLARY SERVICE COST CENTERS	0	0	(o	0	76. 11
76. 12 03959 ANTI COAGULATI ON CLINI C	440	255	421, 77	7 0	553, 338	76. 12
OUTPATIENT SERVICE COST CENTERS 91. 00 09100 EMERGENCY	16, 082	154, 127	3, 149, 91	4 0	4, 860, 062	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	10, 302	101, 127	5, 117, 71		., 555, 562	92. 00
SPECIAL PURPOSE COST CENTERS						440 00
113.00 11300 INTEREST EXPENSE 118.00 SUBTOTALS (SUM OF LINES 1 through 117)	399, 395	8, 039, 007	60, 645, 912	2 -29, 398, 128	123, 340, 067	113.00
NONREI MBURSABLE COST CENTERS	377, 370	5, 037, 007	00, 040, 912	27, 370, 120	123, 340, 007	1.10.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	796	1, 741	34, 583	1	93, 168	
192.00 19200 PHYSICIANS' PRIVATE OFFICES 192.01 19201 WORKING WELL	13, 697	43, 019	7, 732, 66° 31, 61°	1	13, 131, 832 33, 311	
192. 01 19201 WORKING WELL 192. 02 19202 PHYSI CLANS' PRI VATE OFFI CES	0	0				192. 01
		1		, -,		·

Health Financial Systems	FRANCISCAN HEALTH- DYER	In Lieu of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS		Peri od: Worksheet B-1
		From 01/01/2021

				T	o 12/31/2021	Date/Time Pre 5/30/2022 7:5	
		CAPITAL REL	LATED COSTS				
	Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Reconciliation	OTHER	
	cost center bescriptron		(DOLLAR VALUE)			ADMI NI STRATI VE	
		(SQUARE TEET)	(DOLLAR VALUE)	DEPARTMENT		AND GENERAL	
				(GROSS		(ACCUM. COST)	
				SALARI ES)		(
		1.00	2. 00	4. 00	5A. 04	5. 04	
192. 03 192	03 MI SC	0	964	2, 364, 739	0	3, 849, 006	192. 03
194. 00 079	50 RESI DENTI AL	30, 307	53, 712	0	0	487, 443	194. 00
	54 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194. 01
	52 PSYCHI ATRI C	26, 481	0	0	0	453, 737	1
1	53 CENTER OF HOPE	0	0	0	0		194. 03
200. 00	Cross Foot Adjustments						200. 00
201. 00	Negative Cost Centers						201. 00
202. 00	Cost to be allocated (per Wkst. B, Part I)	8, 064, 765	3, 312, 502	2, 414, 517		29, 398, 128	202. 00
203. 00	Unit cost multiplier (Wkst. B, Part I)	17. 134430	0. 407019	0. 034099		0. 207911	203. 00
204.00	Cost to be allocated (per Wkst. B, Part II)			38, 280		1, 420, 756	204. 00
205. 00	Unit cost multiplier (Wkst. B, Part			0. 000541		0. 010048	205. 00
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207. 00	NÄHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS In Lieu of Form CMS-2552-10
Worksheet B-1 FRANCISCAN HEALTH- DYER Provider CCN: 15-0090

					To	12/31/2021	Date/Time Prep 5/30/2022 7:58	
		Cost Center Description	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
			(SQUARE FEET)	(SQUARE FEET)	LINEN SERVICE (POUNDS OF	(SQUARE FEET)	(PATIENT ME ALS)	
			6. 00	7. 00	LAUNDRY) 8. 00	9. 00	10.00	
(GENER	AL SERVICE COST CENTERS	0.00	7.00	8.00	9.00	10.00	
		CAP REL COSTS-BLDG & FIXT						1. 00
		CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT						2. 00 4. 00
		OTHER ADMINISTRATIVE AND GENERAL						5. 04
		MAINTENANCE & REPAIRS	362, 578					6. 00
		OPERATION OF PLANT	20, 147	342, 431	1			7. 00
		LAUNDRY & LI NEN SERVI CE HOUSEKEEPI NG	5, 389	0 5, 389	,	337, 042		8. 00 9. 00
		DI ETARY	4, 754	4, 754	1	4, 754	229, 963	10. 00
		CAFETERI A	6, 863	l		6, 863	0	11. 00
		NURSI NG ADMI NI STRATI ON CENTRAL SERVI CES & SUPPLY	726	l e	0	726	0	13.00
		PHARMACY	6, 121 3, 417	6, 121 3, 417	0	6, 121 3, 417	0	14. 00 15. 00
		MEDICAL RECORDS & LIBRARY	4, 886	l		4, 886	0	16. 00
		SOCIAL SERVICE	0	0		0	0	17. 00
-		I &R SERVICES-OTHER PRGM COSTS APPRV ENT ROUTINE SERVICE COST CENTERS	0	0	0	0	0	22. 00
		ADULTS & PEDIATRICS	79, 851	79, 851	251, 792	79, 851	132, 845	30. 00
31.00	03100	INTENSIVE CARE UNIT	9, 931	9, 931		9, 931	18, 459	31. 00
		CORONARY CARE UNIT	0	0	_	0	0	32. 00
		NEONATAL INTENSIVE CARE UNIT SUBPROVIDER - IRF	5, 938	5, 938	947 71, 517	5. 938	0 25, 222	35. 00 41. 00
		SUBPROVI DER	0	0		0, 750	0	42. 00
		NURSERY	0	0	1, 434	0	0	43.00
		_ARY SERVICE COST CENTERS OPERATING ROOM	1/ /00	17 400		17 400	0	FO 00
		OUTPATIENT SURGERY	16, 488 14, 083			16, 488 14, 083	0	50. 00 50. 01
		RECOVERY ROOM	5, 551	5, 551		5, 551	0	51. 00
		ANESTHESI OLOGY	0	0	1	0	0	53. 00
		RADI OLOGY-DI AGNOSTI C RADI OLOGY-SPECI AL PROCEDURES	23, 553 1, 542			23, 553 1, 542	0	54. 00 54. 01
		RADI OLOGY-SPECIAL PROCEDURES RADI OLOGY-THERAPEUTI C	1, 542	1, 342	1	1, 342	0	55. 00
		RADI OI SOTOPE	4, 931	4, 931	0	4, 931	0	56. 00
		LABORATORY	6, 908	l		6, 908	0	60.00
		BLOOD STORING, PROCESSING & TRANS. RESPIRATORY THERAPY	2, 831 2, 140	2, 831 2, 140		2, 831 2, 140	0	63. 00 65. 00
		PHYSI CAL THERAPY	1, 452	l		1, 452	0	66. 00
		OCCUPATI ONAL THERAPY	556	ŀ		556	0	67. 00
		SPEECH PATHOLOGY ELECTROCARDI OLOGY	0	0	_	0	0	68. 00 69. 00
		ELECTROENCEPHALOGRAPHY	3, 808 5, 262	3, 808 5, 262		3, 808 5, 262	0	70.00
		MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0	0	71. 00
		IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72. 00
		DRUGS CHARGED TO PATIENTS ULTRA SOUND	2, 289	0 2, 289	_	0 2, 289	0	73. 00 76. 00
		PAIN CLINIC	12, 323			12, 323	0	76. 00 76. 01
		CATH LAB	9, 038	9, 038	0	9, 038	0	76. 02
		ACTIVITY THERAPEUTIC	5, 706	l		5, 706	0	76. 03
		WOUND CARE CENTER BARIATRIC CLINIC	6, 364 1, 927	l		6, 364 1, 927	0	76. 04 76. 05
		HEALTHY LIVING CENTER	0	0		0	0	76. 06
		CV RESOURCE CENTER	0	0	0	0	0	76. 07
		OTHER ANCILLARY SERVICE COST CENTERS LACTATION CLINIC	0	0	0	0	0	76. 08 76. 09
		OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76. 09 76. 10
		OTHER ANCILLARY SERVICE COST CENTERS	0	Ö	0	O	0	76. 11
		ANTI COAGULATI ON CLINI C	440	440	0	440	0	76. 12
		TIENT SERVICE COST CENTERS EMERGENCY	16, 082	16, 082	0	16, 082	0	91. 00
		OBSERVATION BEDS (NON-DISTINCT PART	10,002	10,002		10, 002	O	92. 00
		AL PURPOSE COST CENTERS						
113. 00 ° 118. 00		INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117)	291, 297	271, 150	360, 725	265, 761	176, 526	113. 00 118. 00
1	NONRE	MBURSABLE COST CENTERS						
		GIFT, FLOWER, COFFEE SHOP & CANTEEN	796	l		796		190.00
		PHYSICIANS' PRIVATE OFFICES WORKING WELL	13, 697 0	13, 697 0		13, 697 0		192. 00 192. 01
		PHYSICIANS' PRIVATE OFFICES	0	0	1	ol		192. 01
192. 03 ⁻	19203	MISC	0	0	0	O	0	192. 03
		RESIDENTIAL OTHER NONREIMBURSABLE COST CENTERS	30, 307 0	1		30, 307 0		194. 00 194. 01
174.01	51754	OTHER MONNET MEDITARDEL COST CENTERS	<u> </u>	<u> </u>	1 0	- Ο _Ι	0	1.74.01

Health Financial Systems	FRANCISCAN HEALTH- DYER	In Lieu of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS	Provi der CCN: 15-0090	Period: Worksheet B-1 From 01/01/2021

				Ť	o 12/31/2021	Date/Time Pre 5/30/2022 7:5	
	Cost Center Description	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		REPAI RS	PLANT	LINEN SERVICE	(SQUARE FEET)	(PATIENT ME	
		(SQUARE FEET)	(SQUARE FEET)	(POUNDS OF		ALS)	
				LAUNDRY)			
		6. 00	7. 00	8. 00	9. 00	10.00	
194. 02	D7952 PSYCHI ATRI C	26, 481	26, 481	101, 425	26, 481	53, 437	194. 02
194. 03	07953 CENTER OF HOPE	0	0	0	0	0	194. 03
200.00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers						201. 00
202.00	Cost to be allocated (per Wkst. B,	4, 785, 138	10, 467, 768	508, 459	3, 967, 490	1, 749, 471	202. 00
	Part I)						
203.00	Unit cost multiplier (Wkst. B, Part I)	13. 197541	30. 568985	1. 100203	11. 771500	7. 607619	203. 00
204.00	Cost to be allocated (per Wkst. B,	1, 485, 984	1, 486, 514	4, 332	172, 252	145, 741	204. 00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part	4. 098384	4. 341061	0.009374	0. 511070	0. 633758	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)						

Hearth Financial Sy		FRANCI SCAN H		N 45 0000 D		U OT FORM CMS-	
COST ALLOCATION - S	TAITSTICAL BASIS		Provi der CC		eriod: rom 01/01/2021 o 12/31/2021	Worksheet B-1 Date/Time Pre 5/30/2022 7:5	pared:
Cost Ce	nter Description	CAFETERI A (HOURS WORK ED)	NURSI NG ADMI NI STRATI ON (DI RECT NRS I NG)	CENTRAL SERVI CES & SUPPLY (COSTED REQUI S.)	PHARMACY (COSTED REQ UISI)	MEDI CAL RECORDS & LI BRARY (GROSS CHAR GES)	J
		11.00	13. 00	14. 00	15. 00	16. 00	
	CE COST CENTERS		T T				
2. 00 00200 CAP REL 4. 00 00400 EMPLOYE 5. 04 00593 OTHER A 6. 00 00600 MAI NTEN 7. 00 00700 OPERATI 8. 00 00800 LAUNDRY 9. 00 00900 HOUSEKE 10. 00 01000 DI ETARY 11. 00 01100 CAFETER 13. 00 01300 NURSI NC 14. 00 01400 CENTRAL 15. 00 01500 PHARMAC 16. 00 01600 MEDI CAL 17. 00 01700 SOCI AL	A LINEN SERVICE EPING IA ADMINISTRATION SERVICES & SUPPLY Y RECORDS & LIBRARY SERVICE	57, 815 1, 740 461 1, 811 282 0	376, 234 0 0 0 0	17, 287, 249 0 0 0	4, 721, 698 0 0	612, 748, 574 0	17. 00
	VICES-OTHER PRGM COSTS APPRV JTINE SERVICE COST CENTERS		ı y	0	U _I	0	22. 00
30. 00 03000 ADULTS 31. 00 03100 I NTENSI 32. 00 03200 CORONAF 35. 00 02060 NEONATA 41. 00 04100 SUBPROV 42. 00 04200 SUBPROV 43. 00 04300 NURSERY	& PEDIATRICS VE CARE UNIT LY CARE UNIT LL INTENSIVE CARE UNIT TIDER - IRF	11, 703 2, 555 0 0 4, 201 0	43, 614 0 0 43, 023 0	965, 213 330, 920 0 0 193, 718 0	40, 732 0 0	65, 045, 760 11, 546, 769 0 339, 907 19, 471, 672 0 322, 748	31. 00 32. 00 35. 00 41. 00 42. 00
	NC POOM	1 620	19 050	7 562 071	16 600	EE 201 276	50.00
50. 00 05000 OPERATI 50. 01 05001 OUTPATI 51. 00 05100 RECOVEF 53. 00 05400 RADI OLC 54. 01 05401 RADI OLC 55. 00 05500 RADI OLC 55. 00 05600 RADI OLC 56. 00 06600 RADI OLC 60. 00 06600 RADI OLC 67. 00 06500 RESPI RADI OLC 67. 00 06600 PHYSI CA 67. 00 06600 PHYSI CA 67. 00 06600 PHYSI CA 67. 00 06900 ELECTRC 70. 00 07000 ELECTRC 70. 00 07100 MEDI CAL 72. 00 07200 IMPL. 73. 00 07300 DRUGS 07400 DRU	NG ROOM ENT SURGERY LY ROOM ENT SURGERY LY ROOM GY-DI AGNOSTI C GY-SPECI AL PROCEDURES GY-THERAPEUTI C OTOPE ORY TORNING, PROCESSI NG & TRANS. ITORNING, PROCESSI NG ATANS. ITORNING, PROCESSI NG ATANS. ITORNING, PROCESSI NG ATANS. ITORNING, PROCESSI	1, 629 985 232 86 2, 168 433 0 317 0 1, 433 3, 028 548 276 808 142 0 0 358 542 1, 199 2, 944 394 540 0 84 403 0 0 0 0 0 0 0	9, 382 6, 138 70 0 3, 698 0 106 0 0 6, 596 0 0 11, 767 17, 549 0 4, 686 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	7, 563, 071 281, 038 27, 729 188, 791 165, 604 569, 410 0 9, 319 1, 414 275, 443 187, 769 14, 905 3, 604 43, 094 20, 252 15, 740 0 42, 893 71, 427 6, 178, 818 499 107, 668 3, 889 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	3, 437 2, 077 51, 590 5, 505 949 0 250, 499 0 9, 405 0 18 0 0 4, 065, 717 52 4, 110	55, 384, 376 3, 938, 374 6, 206, 494 15, 273, 636 56, 124, 108 5, 725, 580 0 11, 921, 314 60, 378, 672 1, 968, 858 9, 672, 912 20, 801, 019 4, 943, 375 2, 980, 712 22, 665, 133 4, 106, 033 28, 545, 969 15, 364, 960 33, 559, 618 12, 974, 892 8, 859, 247 63, 559, 890 5, 366, 596 2, 463, 181 2, 977, 476 0 0 0 0 0 0 1, 134, 132	50. 01 51. 00 53. 00 54. 00 54. 01 55. 00 60. 00 65. 00 66. 00 67. 00 68. 00 69. 00 71. 00 72. 00 73. 00 76. 01 76. 02 76. 03 76. 04 76. 05 76. 06 76. 07 76. 08 76. 09 76. 10 76. 11
91. 00 09100 EMERGEN 92. 00 09200 OBSERVA		4, 207	38, 592	25, 021	22, 993	59, 125, 161	91. 00 92. 00
113. 00 11300 I NTERES 118. 00 SUBTOTA		45, 509	333, 354	17, 287, 249	4, 721, 698	612, 748, 574	113. 00 118. 00
190. 00 19000 GIFT, F 192. 00 19200 PHYSI CI 192. 01 19201 WORKI NO	LOWER, COFFEE SHOP & CANTEEN ANS' PRIVATE OFFICES WELL ANS' PRIVATE OFFICES	51 3, 723 0 0 0 4, 659	755 0 0 861	0 0 0 0 0	0 0 0	0 0 0 0	190. 00 192. 00 192. 01 192. 02 192. 03 194. 00

Health Financial Systems	FRANCISCAN HEALTH- DYER	In Lieu of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS	Provi der CCN: 15-0090	Peri od: Worksheet B-1
		From 01/01/2021

					1011 01/01/2021		
				Te	o 12/31/2021	Date/Time Pre	pared:
						5/30/2022 7:5	9 pm
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
	·	(HOURS WORK	ADMI NI STRATI ON	SERVICES &	(COSTED REQ	RECORDS &	
		ED)		SUPPLY	UISI)	LI BRARY	
			(DI RECT NRS	(COSTED		(GROSS CHAR	
			I NG)	REQUIS.)		GES)	
		11. 00	13. 00	14. 00	15. 00	16. 00	
194. 01 0795	4 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194. 01
194. 02 0795	52 PSYCHI ATRI C	3, 873	27, 347	0	0	0	194. 02
194. 03 0795	3 CENTER OF HOPE	0	0	0	0	0	194. 03
200.00	Cross Foot Adjustments						200. 00
201. 00	Negative Cost Centers						201. 00
202. 00	Cost to be allocated (per Wkst. B,	1, 683, 468	4, 069, 033	1, 011, 494	3, 902, 729	1, 845, 075	202. 00
	Part I)						
203. 00	Unit cost multiplier (Wkst. B, Part I)	29. 118187	10. 815166	0. 058511	0. 826552	0. 003011	203. 00
204.00	Cost to be allocated (per Wkst. B,	190, 168	84, 721	193, 172	132, 056	141, 492	204. 00
	Part II)						
205. 00	Unit cost multiplier (Wkst. B, Part	3. 289250	0. 225182	0. 011174	0. 027968	0. 000231	205. 00
	[1]						
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)						

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

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0090 Peri od: Worksheet B-1 From 01/01/2021 12/31/2021 Date/Time Prepared: 5/30/2022 7:58 pm INTERNS & **RESI DENTS** Cost Center Description SOCIAL SERVICE SERVICES-OTHER PRGM COSTS (GROSS CHAR **APPRV** GES) (ASSI GNED TIME) 17. 00 22. 00 GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00593 OTHER ADMINISTRATIVE AND GENERAL 5 04 5 04 6.00 00600 MAINTENANCE & REPAIRS 6.00 7.00 00700 OPERATION OF PLANT 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 00900 HOUSEKEEPI NG 9 00 9 00 10.00 01000 DI ETARY 10.00 01100 CAFETERI A 11.00 11.00 01300 NURSING ADMINISTRATION 13.00 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 15.00 01500 PHARMACY 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16.00 01700 SOCIAL SERVICE 17.00 612, 748, 574 17.00 |02200|1&R SERVICES-OTHER PRGM COSTS APPRV 22.00 452 22 00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 65, 045, 760 n 30.00 03100 INTENSIVE CARE UNIT 31.00 31.00 11, 546, 769 0 32.00 03200 CORONARY CARE UNIT 0 32.00 02060 NEONATAL INTENSIVE CARE UNIT 339, 907 0 35.00 35.00 04100 SUBPROVIDER - IRF 41.00 19, 471, 672 0 41.00 42.00 04200 SUBPROVI DER 0 42.00 04300 NURSERY 43.00 322, 748 0 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 55, 384, 376 279 50.00 05001 OUTPATIENT SURGERY 3, 938, 374 50.01 0 50.01 05100 RECOVERY ROOM 6, 206, 494 51.00 0 51.00 53.00 05300 ANESTHESI OLOGY 15, 273, 636 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 56, 124, 108 0 54 00 54 00 54.01 05401 RADI OLOGY-SPECI AL PROCEDURES 5, 725, 580 0 54.01 05500 RADI OLOGY-THERAPEUTI C 0 55.00 55.00 05600 RADI OI SOTOPE 11, 921, 314 0 56.00 56.00 06000 LABORATORY 60, 378, 672 0 60.00 60.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 1, 968, 858 0 63.00 65.00 06500 RESPIRATORY THERAPY 9, 672, 912 0 65.00 06600 PHYSI CAL THERAPY 20, 801, 019 0 66 00 66 00 4, 943, 375 06700 OCCUPATIONAL THERAPY 67.00 0 67.00 68.00 06800 SPEECH PATHOLOGY 2, 980, 712 0 68.00 06900 ELECTROCARDI OLOGY 69.00 22, 665, 133 0 69.00 07000 ELECTROENCEPHALOGRAPHY 0 70 00 4 106 033 70 00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 28, 545, 969 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 15, 364, 960 0 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 33, 559, 618 0 73.00 03630 ULTRA SOUND 12, 974, 892 76.00 0 76.00 76. 01 03951 PAIN CLINIC 8, 859, 247 0 76.01 63, 559, 890 03952 CATH LAB 76.02 76.02 03953 ACTIVITY THERAPEUTIC 0 76.03 5. 366. 596 76.03 03954 WOUND CARE CENTER 76.04 2, 463, 181 0 76.04 76.05 03340 BARIATRIC CLINIC 2, 977, 476 76.05 03030 HEALTHY LIVING CENTER 76.06 0 0 76.06 03950 CV RESOURCE CENTER 76 07 0 0 76 07 76.08 03955 OTHER ANCILLARY SERVICE COST CENTERS 0 0 76.08 03956 LACTATION CLINIC 0 0 76.09 03957 OTHER ANCILLARY SERVICE COST CENTERS 76. 10 0 0 76. 10 03958 OTHER ANCILLARY SERVICE COST CENTERS 76.11 0 76. 11 03959 ANTICOAGULATION CLINIC 1, 134, 132 76.12 C 76.12 OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 173 59, 125, 161 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113. 00 SUBTOTALS (SUM OF LINES 1 through 117) 452 118.00 612, 748, 574 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190.00 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 192. 00 0 0 192. 01 19201 WORKING WELL 0 192, 01 192. 02 19202 PHYSI CLANS' PRI VATE OFFI CES 0 0 192. 02

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

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0090 Period: From 01/01/2021 From 01/01/2021 Pote/Time Proposed

				To 12/31/2021	Date/Time Pre 5/30/2022 7:5	
	Cost Center Description	SOCI AL SERVI CE (GROSS CHAR GES)	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)			
		17. 00	22.00			
194. 01 07954	RESIDENTIAL OTHER NONREIMBURSABLE COST CENTERS	0 0	0 0			192. 03 194. 00 194. 01
	PSYCHIATRIC	0	0			194. 02 194. 03
200. 00 201. 00	CENTER OF HOPE Cross Foot Adjustments Negative Cost Centers	O O	O			200. 00 201. 00
202. 00	Cost to be allocated (per Wkst. B, Part I)	0	351, 124			202. 00
203. 00	Unit cost multiplier (Wkst. B, Part I)	0. 000000	776. 823009			203. 00
204. 00	Cost to be allocated (per Wkst. B, Part II)	0	2, 976			204. 00
205. 00	Unit cost multiplier (Wkst. B, Part	0. 000000	6. 584071			205. 00
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)					206. 00
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207. 00

			Ť	o 12/31/2021	Date/Time Pre 5/30/2022 7:5	pared: 8 pm
		Title	XVIII	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col.	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	26) 1.00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
30. 00 03000 ADULTS & PEDIATRICS	28, 463, 018		28, 463, 018	0	28, 463, 018	30. 00
31. 00 03100 INTENSIVE CARE UNIT	5, 497, 971		5, 497, 971	o	5, 497, 971	31.00
32. 00 03200 CORONARY CARE UNIT	0	•	0	0	0	32. 00
35. 00 02060 NEONATAL INTENSIVE CARE UNIT	302, 364		302, 364	0	302, 364	35. 00
41. 00 04100 SUBPROVI DER - I RF	11, 159, 670		11, 159, 670	0	11, 159, 670	41.00
42. 00 04200 SUBPROVI DER	0		0	0	0	42.00
43. 00 04300 NURSERY	236, 367		236, 367	0	236, 367	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	5, 471, 239		5, 471, 239	5, 304	5, 476, 543	50. 00
50. 01 05001 OUTPATIENT SURGERY	2, 320, 798		2, 320, 798	0	2, 320, 798	50. 01
51.00 05100 RECOVERY ROOM	1, 061, 076		1, 061, 076	0	1, 061, 076	51.00
53. 00 05300 ANESTHESI OLOGY	3, 553, 527		3, 553, 527	0	3, 553, 527	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	4, 981, 223		4, 981, 223	0	4, 981, 223	54. 00
54. 01 05401 RADI OLOGY-SPECI AL PROCEDURES	979, 978		979, 978	0	979, 978	54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0		0	0	0	55. 00
56. 00 05600 RADI OI SOTOPE	1, 211, 427		1, 211, 427	0	1, 211, 427	56. 00
60. 00 06000 LABORATORY	7, 973, 456		7, 973, 456	9, 986	7, 983, 442	60.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 65. 00 06500 RESPIRATORY THERAPY	238, 707	0	238, 707	0	238, 707	63. 00 65. 00
66. 00 06600 PHYSI CAL THERAPY	3, 417, 746	0	3, 417, 746	0	3, 417, 746	66.00
67. 00 06700 OCCUPATIONAL THERAPY	9, 085, 405 1, 192, 526	0	9, 085, 405 1, 192, 526	0	9, 085, 405 1, 192, 526	
68. 00 06800 SPEECH PATHOLOGY	670, 110	0	670, 110	0	670, 110	68. 00
69. 00 06900 ELECTROCARDI OLOGY	1, 811, 045		1, 811, 045	18	1, 811, 063	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	680, 559		680, 559	0	680, 559	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	11, 142, 888		11, 142, 888	o	11, 142, 888	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	10, 636, 610		10, 636, 610	o	10, 636, 610	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	9, 165, 392	•	9, 165, 392	0	9, 165, 392	73. 00
76. 00 03630 ULTRA SOUND	940, 206		940, 206	0	940, 206	76. 00
76. 01 03951 PAIN CLINIC	2, 018, 683		2, 018, 683	0	2, 018, 683	76. 01
76. 02 03952 CATH LAB	3, 937, 785		3, 937, 785	0	3, 937, 785	76. 02
76. 03 03953 ACTIVITY THERAPEUTIC	4, 069, 882		4, 069, 882	13, 698	4, 083, 580	76. 03
76. 04 03954 WOUND CARE CENTER	834, 102		834, 102	211	834, 313	76. 04
76. 05 03340 BARI ATRI C CLI NI C	2, 067, 439		2, 067, 439	0	2, 067, 439	76. 05
76.06 03030 HEALTHY LIVING CENTER	0		0	0	0	76. 06
76. 07 03950 CV RESOURCE CENTER	2, 446		2, 446	0	2, 446	76. 07
76.08 03955 OTHER ANCILLARY SERVICE COST CENTERS	11, 735		11, 735	0	11, 735	76. 08
76. 09 03956 LACTATION CLINIC	0		0	0	0	76. 09
76. 10 03957 OTHER ANCILLARY SERVICE COST CENTERS	0		0	0	0	76. 10
76. 11 03958 OTHER ANCILLARY SERVICE COST CENTERS	0		0	0	0	76. 11
76. 12 03959 ANTI COAGULATI ON CLINI C	696, 234		696, 234	0	696, 234	76. 12
OUTPATIENT SERVICE COST CENTERS 91. 00 09100 EMERGENCY	7 500 050		7 500 050		7 500 050	01 00
	7, 502, 058		7, 502, 058	0	7, 502, 058	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART SPECIAL PURPOSE COST CENTERS	4, 911, 503		4, 911, 503		4, 911, 503	92. 00
113. 00 11300 I NTEREST EXPENSE						113. 00
200.00 Subtotal (see instructions)	148, 245, 175	0	148, 245, 175	29, 217	148, 274, 392	
201.00 Less Observation Beds	4, 911, 503		4, 911, 503	27, 217	4, 911, 503	
202.00 Total (see instructions)	143, 333, 672	0		29, 217	143, 362, 889	
	1, 000, 072	•		2/,21/	5, 552, 567	,_000

Date/Time Prepared: 12/31/2021 5/30/2022 7:58 pm Title XVIII Hospi tal PPS Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other TFFRA + col . 7) Ratio Inpati ent Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 56, 780, 256 56, 780, 256 30.00 30.00 31.00 03100 INTENSIVE CARE UNIT 11, 546, 769 11, 546, 769 31.00 03200 CORONARY CARE UNIT 32.00 32.00 35.00 02060 NEONATAL INTENSIVE CARE UNIT 339, 907 339, 907 35.00 04100 SUBPROVIDER - IRF 41.00 19, 471, 672 19, 471, 672 41.00 42.00 04200 SUBPROVI DER 42.00 43.00 04300 NURSERY 322, 748 322, 748 43 00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 21, 440, 796 33, 943, 580 55, 384, 376 0.098787 0.000000 50.00 2, 116, 028 50.01 05001 OUTPATIENT SURGERY 1,822,346 3, 938, 374 0.589278 0.000000 50.01 51.00 05100 RECOVERY ROOM 2, 171, 243 4, 035, 251 6, 206, 494 0.170962 0.000000 51.00 5, 954, 228 9, 319, 408 05300 ANESTHESI OLOGY 15, 273, 636 0.000000 53.00 0.232658 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 18, 961, 315 37, 162, 793 56, 124, 108 0.088754 0.000000 54.00 05401 RADI OLOGY-SPECI AL PROCEDURES 3, 182, 229 2, 543, 351 5, 725, 580 0. 171158 0.000000 54.01 54.01 55.00 05500 RADI OLOGY-THERAPEUTI C 0.000000 0.000000 55.00 05600 RADI OI SOTOPE 1, 052, 835 10, 868, 479 11, 921, 314 56,00 0.101619 0.000000 56,00 60.00 06000 LABORATORY 29, 922, 738 30, 455, 934 60, 378, 672 0.132057 0.000000 60.00 06300 BLOOD STORING, PROCESSING & TRANS. 429, 980 0.000000 63.00 1, 538, 878 1, 968, 858 0.121241 63.00 06500 RESPIRATORY THERAPY 7, 198, 354 2, 474, 558 9, 672, 912 0.000000 65.00 0.353332 65.00 06600 PHYSI CAL THERAPY 66.00 5, 124, 564 15, 676, 455 20, 801, 019 0.436777 0.000000 66.00 67.00 06700 OCCUPATI ONAL THERAPY 4, 566, 476 376, 899 4, 943, 375 0.241237 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 1, 993, 533 987, 179 2, 980, 712 0. 224815 0.000000 68.00 69 00 06900 ELECTROCARDI OLOGY 7, 198, 057 15, 467, 076 22 665 133 0.079904 0 000000 69 00 70.00 07000 ELECTROENCEPHALOGRAPHY 511, 552 3, 594, 481 4, 106, 033 0.165746 0.000000 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 16, 146, 729 12, 399, 240 28, 545, 969 0. 390349 0.000000 71.00 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 5, 986, 226 9, 378, 734 15, 364, 960 0.692264 0.000000 72.00 07300 DRUGS CHARGED TO PATIENTS 23, 487, 242 33, 559, 618 73.00 10, 072, 376 0.273108 0.000000 73.00 76.00 03630 ULTRA SOUND 3, 133, 119 9, 841, 773 12, 974, 892 0.072463 0.000000 76.00 03951 PAIN CLINIC 76. 01 49, 893 8, 809, 354 8, 859, 247 0.227862 0.000000 76.01 76 02 03952 CATH LAB 21 470 141 42.089.749 63, 559, 890 0.061954 0 000000 76 02 03953 ACTIVITY THERAPEUTIC 5, 366, 596 76.03 3, 111, 575 2, 255, 021 0.758373 0.000000 76.03 03954 WOUND CARE CENTER 9, 111 2, 454, 070 2, 463, 181 0.338628 0.000000 76.04 76.04 76.05 03340 BARIATRIC CLINIC 747 2, 976, 729 2, 977, 476 0.694360 0.000000 76.05 03030 HEALTHY LIVING CENTER O 0.000000 76 06 0 C 0.000000 76 06 76.07 03950 CV RESOURCE CENTER 0 C 0 0.000000 0.000000 76.07 03955 OTHER ANCILLARY SERVICE COST CENTERS 0 0.000000 0.000000 76.08 0 76.08 76.09 03956 LACTATION CLINIC 0 0 0 0.000000 0.000000 76.09 03957 OTHER ANCILLARY SERVICE COST CENTERS 0 0 76.10 Ω 0.000000 0.000000 76.10 03958 OTHER ANCILLARY SERVICE COST CENTERS 0 0.000000 0.000000 76.11 76.11 76.12 03959 ANTICOAGULATION CLINIC 14,707 1, 119, 425 1, 134, 132 0.613892 0.000000 76.12 OUTPATIENT SERVICE COST CENTERS 91 00 09100 EMERGENCY 19, 866, 196 39, 258, 965 59, 125, 161 0.126884 0.000000 91 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 3, 123, 337 5, 142, 167 8, 265, 504 0.594217 0.000000 92.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113.00 297, 499, 519 315, 249, 055 200.00 Subtotal (see instructions) 612, 748, 574 200. 00 201.00 Less Observation Beds 201.00

297, 499, 519

315, 249, 055

612, 748, 574

202.00

202.00

Total (see instructions)

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

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0090
From 01/01/2021
To 12/31/2021
Date/Time Prepared:

NAME				10 12/31/2021	5/30/2022 7:58 pm
INPATIENT ROUTINE SERVICE COST CENTERS 30.00 30000 ABULTS & PEDIATRIC S 31.00 3100 30000 ABULTS & PEDIATRIC S 31.00 3100 32000 30000 ABULTS & PEDIATRIC S 31.00 32.00 30000 ABULTS & PEDIATRIC S 31.00 32.00 30000 ABULTS & PEDIATRIC S 32.00 32.00 32.00 30000 ABULTS & PEDIATRIC S 32.00			Title XVIII	Hospi tal	
INPATIENT ROUTINE SERVICE COST CENTERS 11.00	Cost Center Description	PPS Inpatient		· · · · · · · · · · · · · · · · · · ·	
IMPATIL ENT ROUTINE SERVICE COST CENTERS 30.00 30.00 03100 AULTIS & PEDIATRICS 31.00 31.		Ratio			
30.00 3000 ADULT'S & PEDIATRICS 30.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 32.00 AURISTE SEARE UNIT 32.00 32.00 CORDMARY CARE UNIT 32.00 41.0		11. 00			
31.00 03100 INTENSIVE CARE UNIT 32.00 03200 CRONARY CARE UNIT 32.00 03200 CRONARY CARE UNIT 32.00 035.00 02060 NEONATAL INTENSIVE CARE UNIT 41.00 41.0	INPATIENT ROUTINE SERVICE COST CENTERS				
32.00 33200 COROMARY CARE UNIT	30. 00 03000 ADULTS & PEDI ATRI CS				30.00
35. 00	31.00 03100 INTENSIVE CARE UNIT				31.00
11.00 04100 SUBPROVI DER - I RF 42.00 04200 SUBPROVI DER 42.00 04200 SUBPROVI DER 42.00 04200 SUBPROVI DER 43.00 4	32. 00 03200 CORONARY CARE UNIT				32.00
42.00 42200 SUBPROVI DER 42.00 ANCILLARY SERVICE COST CENTERS 43.00 43300 MINESERY 50.00 50.00 50.00 50.00 DEPATH IN GROWN 0.589278 50.00 50.00 DEPATH IN GROWN 0.17962 51.00	35.00 02060 NEONATAL INTENSIVE CARE UNIT				35.00
43. 00 A300 NURSERY	41. 00 04100 SUBPROVI DER - RF				41.00
ANCILLARY SERVICE COST CENTERS 50. 00	42. 00 04200 SUBPROVI DER				42.00
50.00 05000 OFECATI NG ROOM 0.09882 50.00 05001 UITPATI ENT SURGERY 0.589278 55.00 15.00 05100 RECOVERY ROOM 0.170942 51.00 51.00 05100 RECOVERY ROOM 0.232658 55.00 53.00 05300 ARISTHESI OLOGY 0.232658 55.00 55.00 05400 RADI OLOGY-DI AGNOSTI C 0.088754 54.00 05400 RADI OLOGY-SPECI AL PROCEDURES 0.171158 54.01 05500 RADI OLOGY-FREADEUT C 0.00000 55.00 05500 RADI OLOGY-FREADEUT C 0.00000 05500 RADI OLOGY-FREADEUT C 0.00000 05600 RADIO ISSTOPE 0.101619 05.00 05500 RADIO ISSTOPE 0.101619 0.00000 0.00000 0.480047087 1.68223 0.60000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000	43. 00 04300 NURSERY				43.00
50. 01 05001 017471 ENT SURGERY 0.589278 55. 01	ANCILLARY SERVICE COST CENTERS				
51.00 05100 RECOVERY ROOM 0.170962 51.00 53.00 05300 ARSTHEST OLIGY 0.232658 53.00 05300 ARSTHEST OLIGY 0.232658 53.00 05300 ARSTHEST OLIGY 0.5400 ARDD LOGY_DI ARDD LOGY_DI ARDD LOGY_DI ARDD LOGY_DI ARDD LOGY_DI ARDD LOGY_SPCI AL PROCEDURES 0.171158 54.01 55.00 05500 ARDD LOGY_THERAPEUTI C 0.000000 0.5500 ARDD LOGY_THERAPEUTI C 0.000000 0.5600 ARDD LOGY_THERAPEUTI C 0.353332 0.5600 ARDD LOGY_THERAPEUTI C 0.353332 0.5600 ARDD LOGY_THERAPEUTI C 0.46000000 0.5600 ARDD LOGY_THERAPEUTI C 0.460000000 0.5600 ARDD LOGY_THERAPEUTI C 0.5600000000 0.5600 ARDD LOGY_THERAPEUTI C 0.560000000000 0.5600 ARDD LOGY_THERAPEUTI C 0.5600000000000000000000000000000000000	50. 00 05000 OPERATING ROOM	0. 098882			50.00
53.00 OS300 ANESTHESI OLOCY 0.232658 53.00	50. 01 05001 OUTPATIENT SURGERY	0. 589278			50. 01
54. 00 05400 RADI OLOGY-DI AGNOSTI C 0. 088754 54. 01 55. 00 05401 RADI OLOGY-SPECI AL PROCEDURES 0. 171158 54. 01 55. 00 05500 RADI OLOGY-SPECI AL PROCEDURES 0. 1000000 55. 00 05600 RADI OLOGY-THERAPEUTI C 0. 000000 0. 000000 0. 05600 RADI OLOGY-THERAPEUTI C 0. 000000 0. 000000 0. 000000 0. 00000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 00000000	51.00 05100 RECOVERY ROOM	0. 170962			51.00
54.01 05401 RADI OLOGY-SPECIAL PROCEDURES 0. 171158 55.00 05500 RADI OLOGY-SPECIAL PROCEDURES 0. 1000000 55.00 05500 RADI OLOGY-THERAPEUTI C 0. 0000000 0.0000 LABORATORY 0. 132223 60.00 0.0000 CABORATORY 0. 132223 60.00 0.0000 CABORATORY 0. 000000 0. 000000 CABORATORY 0. 0000000 0. 000000 CABORATORY 0. 0000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 0000000 0. 000000 0. 0000000 0. 0000000 0. 0000000 0. 00000000	53. 00 05300 ANESTHESI OLOGY	0. 232658			53.00
55.00 05500 RADIOLOGY-THERAPEUTIC 0.000000 65.00 05600 RADIOLOGY-THERAPEUTIC 0.00000 66.00 06000 LABORATORY 0.132223 60.00 63.00 06300 BLODD STORING, PROCESSING & TRANS. 0.121241 63.00 65.00 06500 RESPIRATORY THERAPY 0.353332 65.00 66.00 066000 PHYSI CAL THERAPY 0.436777 66.00 67.00 067.00 06700 COUPATIONAL THERAPY 0.241237 67.00 68.00 06800 SPECH PATHOLOGY 0.224815 68.00 69.00 06900 ELECTROCARDIOLOGY 0.079905 69.00 70.00 07000 ELECTROCARDIOLOGY 0.079905 69.00 70.00 07000 ELECTROCARDIOLOGY 0.165746 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.69224 71.00 72.00 07200 IMPL. Dev. CHARGED TO PATIENTS 0.69224 72.00 73.00 07300 BLUS CHARGED TO PATIENTS 0.293108 73.00 76.01 03830 ULTRA SOUND 0.072463 76.00 76.02 03951 PAIN CLINIC 0.227862 76.00 76.03 03953 ACTIVITY THERAPEUTIC 0.760926 76.00 76.04 0.3954 WOUND CARE CENTER 0.394300 76.00 <td>54. 00 05400 RADI OLOGY-DI AGNOSTI C</td> <td>0. 088754</td> <td></td> <td></td> <td>54.00</td>	54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 088754			54.00
56.00 0500	54. 01 05401 RADI OLOGY-SPECI AL PROCEDURES	0. 171158			54. 01
60.00 06000 LABORATORY 0.13223 65.00	55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000			55.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 0. 121241 65. 00 06500 RESPIRATORY THERAPY 0. 353332 65. 00 06600 PHYSI CAL THERAPY 0. 436777 66. 00 06600 PHYSI CAL THERAPY 0. 436777 67. 00 0700 0CCUPATI ONAL THERAPY 0. 241237 67. 00 0700 0CCUPATI ONAL THERAPY 0. 241237 67. 00 0800 SPECIA PATHOLOGY 0. 224815 68. 00 0800 SPECIA PATHOLOGY 0. 079905 69. 00 07000 ELECTROCARDIOLOGY 0. 079905 69. 00 07000 ELECTROCARDIOLOGY 0. 079905 69. 00 07000 ELECTROCARDIOLOGY 0. 165746 70. 00 07000 ELECTROCARDIOLOGY 0. 165746 70. 00 07000 ELECTROCARDIOLOGY 0. 070000 0. 070000 0. 070000 0. 070000 0. 070000 0. 070000 0. 070000 0. 070000 0. 070000 0. 070000 0. 070000 0. 070000 0. 070000 0. 070000 0. 070000 0. 070000 0. 0700000 0. 070000 0. 0700000 0. 0700000 0. 0700000 0. 0700000 0. 0700000 0. 0700000 0. 0700000 0. 0700000 0. 0700000 0. 0700000 0. 0700000 0. 0700000 0. 0700000 0. 0700000 0. 0700000 0. 07000000 0. 07000000 0. 07000000 0. 07000000 0. 07000000 0. 07000000 0. 07000000 0. 070000000 0. 07000000 0. 07000000 0. 070000000 0. 070000000 0. 070000000 0. 070000000 0. 070000000 0. 0700000000 0. 070000000 0. 07000000000 0. 07000000000 0. 07000000000 0	56. 00 05600 RADI 0I SOTOPE	0. 101619			56. 00
65. 00 06500 RESPI RATORY THERAPY 0. 353332 65. 00 06600 PHYSI CAL THERAPY 0. 436777 66. 00 06700 0CCUPATI ONAL THERAPY 0. 241237 67. 00 08. 00 06800 SPEECH PATHOLOGY 0. 224815 68. 00 08600 SPEECH PATHOLOGY 0. 079905 69. 00 06900 ELECTROCARDI OLOGY 0. 079905 69. 00 07000 ELECTROCARDI OLOGY 0. 079905 69. 00 07000 ELECTROENCEPHALOGRAPHY 0. 165746 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0. 390349 71. 00 07200 MPL. DEV. CHARGED TO PATIENTS 0. 692264 72. 00 07200 MPL. DEV. CHARGED TO PATIENTS 0. 273108 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 273108 73. 00 03630 ULTRA SOUND 0. 072463 76. 00 03951 PAIN CLINIC 0. 227862 76. 01 03951 PAIN CLINIC 0. 227862 76. 01 03953 ACTIVITY THERAPEUTIC 0. 760926 76. 03 03953 ACTIVITY THERAPEUTIC 0. 760926 76. 03 03953 ACTIVITY THERAPEUTIC 0. 760926 76. 03 03953 ACTIVITY THERAPEUTIC 0. 760926 76. 04 03950 ULTRA SOUND 0. 07300 0. 0000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000	60. 00 06000 LABORATORY	0. 132223			60.00
65.00 06500 RESPI RATORY THERAPY 0. 353332 0. 60.00 06600 PHYSI CAL THERAPY 0. 436777 0. 436777 0. 67.00 06700 0CCUPATI ONAL THERAPY 0. 241237 0. 67.00 0. 00					63. 00
67. 00 06700 OCCUPATI ONAL THERAPY 0. 241237 67. 00 68. 00 06800 SPECH PATHOLOGY 0. 224815 68. 00 06900 SPECH PATHOLOGY 0. 079905 69. 00 06900 ELECTROCARDI OLOGY 0. 079905 0. 079905 0. 07000 ELECTROENCEPHALOGRAPHY 0. 165746 70. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0. 390349 71. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0. 692264 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0. 692264 72. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 072463 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 072463 76. 00 03630 ULTRA SOUND 0. 072463 76. 00 03630 ULTRA SOUND 0. 072463 76. 00 03951 PAI N CLI NI C 0. 227862 76. 01 03951 PAI N CLI NI C 0. 760926 76. 03 03953 ACTI VITY THERAPEUTI C 0. 760926 76. 03 03953 ACTI VITY THERAPEUTI C 0. 760926 76. 03 03953 MEALTHY LI VI NG CENTER 0. 338714 76. 04 03954 WOUND CARE CENTER 0. 338714 76. 04 03950 CV RESOURCE CENTER 0. 000000 76. 07 03950 CV RESOURCE CENTER 0. 000000 76. 07 03955 OTHER ANCI LLARY SERVI CE COST CENTERS 0. 000000 76. 07 03959 OTHER ANCI LLARY SERVI CE COST CENTERS 0. 000000 76. 10 03959 ATTI COLI NI C 0. 613892 076. 12 03959 MITE CANCILLARY SERVI CE COST CENTERS 0. 000000 0. 613892 076. 12 03959 MITE CANCILLARY SERVI CE COST CENTERS 0. 000000 0. 613892 076. 12 03959 076. 076. 076. 076. 076. 076. 076. 076.		0. 353332			65. 00
68. 00	66. 00 06600 PHYSI CAL THERAPY	0. 436777			66. 00
68. 00 06800 SPECH PATHOLOGY 0. 224815 68. 00 69. 00 06900 ELECTROCARDIOLOGY 0. 079905 69. 00 07000 ELECTROCARDIOLOGY 0. 079905 70. 00 07000 ELECTROCROCEPHALOGRAPHY 0. 165746 70. 00 71. 00 71. 00 71. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0. 390349 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 692264 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 692264 73. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 273108 73. 00 76. 01 03951 PAIN CLINIC 0. 227862 76. 01 03951 PAIN CLINIC 0. 227862 76. 01 03952 CATH LAB 0. 061954 76. 02 03952 CATH LAB 0. 061954 76. 02 03952 CATH LAB 0. 061954 76. 03 03953 ACTIVITY THERAPEUTIC 0. 760926 76. 03 03954 WOUND CARE CENTER 0. 338714 76. 04 76. 03 03954 WOUND CARE CENTER 0. 338714 76. 04 76. 03 03954 WOUND CARE CENTER 0. 000000 76. 05 76. 06 76. 07 03950 CVRESOURCE CENTER 0. 000000 76. 06 76. 07 76. 08 03955 OTHER ANCILLARY SERVICE COST CENTERS 0. 000000 76. 09 03956 LACTATION CLINIC 0. 000000 76. 09 03956 LACTATION CLINIC 0. 013892 0. 000000 76. 11 03958 OTHER ANCILLARY SERVICE COST CENTERS 0. 000000 76. 11 03958 OTHER ANCILLARY SERVICE COST CENTERS 0. 000000 76. 11 03958 OTHER ANCILLARY SERVICE COST CENTERS 0. 000000 76. 11 03958 OTHER ANCILLARY SERVICE COST CENTERS 0. 000000 76. 11 03958 OTHER ANCILLARY SERVICE COST CENTERS 0. 000000 070000 0700000 07000000 070000000 0700000000	67. 00 06700 OCCUPATI ONAL THERAPY	0. 241237			67. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY 0. 165746 70. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0. 390349 71. 00 07200 MPL. DEV. CHARGED TO PATIENTS 0. 692264 72. 00 07200 MPL. DEV. CHARGED TO PATIENTS 0. 273108 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 273108 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 273108 73. 00 76. 01 03951 PAIN CLINIC 0. 2727862 76. 01 07500 MPL. DEV. CHARGED TO PATIENTS 0. 2727862 76. 01 07500 MPL. DEV. CHARGED TO PATIENTS 0. 2727862 76. 01 07500 0750					68. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY 0. 165746 70. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0. 390349 71. 00 07200 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0. 692264 72. 00 73.00 07300 DRUGS CHARGED TO PATIENTS 0. 273108 73. 00 73.00 07300 DRUGS CHARGED TO PATIENTS 0. 273108 73. 00 76. 00 03630 ULTRA SOUND 0. 072463 76. 00 03951 PAIN CLINIC 0. 227862 76. 01 03951 PAIN CLINIC 0. 227862 76. 01 03953 ACTIVITY THERAPEUTIC 0. 760926 76. 03 03953 ACTIVITY THERAPEUTIC 0. 760926 76. 03 03953 ACTIVITY THERAPEUTIC 0. 694360 76. 04 03954 WOUND CARE CENTER 0. 0383714 76. 04 76. 05 03340 BARI ATRIC CLINIC 0. 694360 76. 05 76. 06 03030 HEALTHY LIVING CENTER 0. 000000 76. 06 76. 07 76. 08 03955 OTHER ANCILLARY SERVICE COST CENTERS 0. 000000 76. 09 76. 09 76. 09 76. 09 76. 09 76. 09 76. 09 76. 09 76. 09 76. 10 03957 OTHER ANCILLARY SERVICE COST CENTERS 0. 000000 0. 000000 76. 11 03958 OTHER ANCILLARY SERVICE COST CENTERS 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 00000000	69. 00 06900 ELECTROCARDI OLOGY	0. 079905			69. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 692264 72. 00 73.00 DRUGS CHARGED TO PATIENTS 0. 273108 73. 00 73.00 07300 DRUGS CHARGED TO PATIENTS 0. 273108 73. 00 76. 00 03630 ULTRA SOUND 0. 072463 76. 00 07500 0. 072463 76. 00 0. 072463 76. 00 0. 072463 76. 00 0. 072463 76. 00 0. 072463 76. 00 0. 072463 76. 00 0. 072463 76. 00 0. 072463 76. 00 0. 072463 76. 00 0. 072463 76. 00 0. 072463 76. 00 0. 072463 76. 00 0. 0. 072463 76. 00 0. 072463 76. 00 0. 072463 76. 00 0. 072463 76. 00 0. 0. 072463 76. 00 0. 0. 072463 76. 00 0. 0. 072463 76. 00 76. 00 0. 0. 072463 76. 00 0. 0. 072463 76. 00 0. 0. 072463 76. 00 76. 00 0. 0. 0. 072463 76. 00 0. 0. 0. 072463 76. 00 76. 00 0. 0. 0. 0. 0000 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0.		0. 165746			70.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 692264 72. 00 73.00 DRUGS CHARGED TO PATIENTS 0. 273108 73. 00 76. 00 03630 ULTRA SOUND 0. 072463 76. 00 03951 PAIN CLINIC 0. 227862 76. 01 03951 PAIN CLINIC 0. 27862 76. 01 03952 CATH LAB 0. 061954 76. 02 03952 CATH LAB 0. 061954 76. 02 03953 ACTIVITY THERAPEUTIC 0. 760926 76. 04 03954 WOUND CARE CENTER 0. 338714 76. 04 76. 05 03340 BARIATRIC CLINIC 0. 694360 76. 05 76. 06 03030 HEALTHY LIVING CENTER 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. 0000000 0. 0000000 0. 00000000	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 390349			71. 00
73. 00		1			72. 00
76. 00	73.00 07300 DRUGS CHARGED TO PATIENTS	0. 273108			73. 00
76. 01 03951 PAIN CLINIC 0. 227862 76. 01 76. 02 03952 CATH LAB 0. 061954 76. 02 76. 03 03953 ACTIVITY THERAPEUTIC 0. 760926 76. 03 03954 WOUND CARE CENTER 0. 338714 76. 05 03340 BARI ATRI C CLINIC 0. 694360 76. 05 76. 06 03030 HEALTHY LIVING CENTER 0. 000000 76. 06 76. 07 03950 CV RESOURCE CENTER 0. 000000 76. 09 03955 CV RESOURCE CENTER 0. 000000 76. 09 03955 CT RESOURCE CENTER 0. 000000 76. 09 03955 CT RESOURCE CENTERS 0. 000000 76. 09 03956 LACTATI ON CLINIC 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 00000000		0. 072463			76. 00
76. 03 03953 ACTIVITY THERAPEUTIC	76. 01 03951 PAIN CLINIC				76. 01
76. 04	76. 02 03952 CATH LAB	0. 061954			76. 02
76. 05	76. 03 03953 ACTIVITY THERAPEUTIC	0. 760926			76. 03
76. 06	76. 04 03954 WOUND CARE CENTER	0. 338714			76. 04
76. 06	76. 05 03340 BARI ATRI C CLI NI C	0. 694360			76. 05
76. 08	76.06 03030 HEALTHY LIVING CENTER				76. 06
76. 09	76. 07 03950 CV RESOURCE CENTER	0. 000000			76. 07
76. 09		1			
76. 10		1			76. 09
76. 11 76. 12 03958 OTHER ANCI LLARY SERVI CE COST CENTERS 0. 0000000 03959 ANTI COAGULATI ON CLI NI C 0. 613892 91. 00 991. 00 992. 00 99200 OBSERVATI ON BEDS (NON-DI STI NCT PART SPECIAL PURPOSE COST CENTERS) 113. 00 11300 INTEREST EXPENSE 200. 00 Subtotal (see instructions) Less Observation Beds 176. 11 0. 0000000 91. 00 92. 00 0. 0000000000000000000000000000000		1 1			76. 10
76. 12 03959 ANTI COAGULATI ON CLINI C 0. 613892 76. 12 00TPATIENT SERVI CE COST CENTERS 91. 00 09100 EMERGENCY 0. 126884 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0. 594217 92. 00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113. 00 200. 00 Subtotal (see instructions) 200. 00 201. 00 Less Observation Beds 201. 00		0. 000000			76. 11
91. 00 09100 EMERGENCY 0. 126884 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0. 594217 92. 00 SPECIAL PURPOSE COST CENTERS 113.00 INTEREST EXPENSE 200. 00 Subtotal (see instructions) 200. 00 201. 00 Less Observation Beds 201. 00	76. 12 03959 ANTI COAGULATION CLINIC	0. 613892			76. 12
91. 00 09100 EMERGENCY 0. 126884 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0. 594217 92. 00 SPECIAL PURPOSE COST CENTERS 113.00 INTEREST EXPENSE 200. 00 Subtotal (see instructions) 200. 00 201. 00 Less Observation Beds 201. 00					
92. 00 09200 08SERVATION BEDS (NON-DISTINCT PART 0. 594217 92. 00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 200. 00 Subtotal (see instructions) 200. 00 201. 00 Less Observation Beds 201. 00		0. 126884			91.00
SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 200.00 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 201.00	92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1			92.00
113.00 11300 INTEREST EXPENSE 113.00 200.00 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 201.00					
200.00 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 201.00					113. 00
201.00 Less Observation Beds 201.00	1 1				
	202.00 Total (see instructions)				202. 00

			Т	o 12/31/2021	Date/Time Pre 5/30/2022 7:5	
		Ti tl	e XIX	Hospi tal	Cost	<u> </u>
				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	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	28, 463, 018		28, 463, 018		28, 463, 018	30.00
31.00 03100 INTENSIVE CARE UNIT	5, 497, 971		5, 497, 971	0	5, 497, 971	31. 00
32. 00 03200 CORONARY CARE UNIT	0		0	0	0	32.00
35.00 02060 NEONATAL INTENSIVE CARE UNIT	302, 364		302, 364	0	302, 364	35. 00
41. 00 04100 SUBPROVI DER - I RF	11, 159, 670		11, 159, 670	0	11, 159, 670	41.00
42. 00 04200 SUBPROVI DER	0		0	0	0	42.00
43. 00 04300 NURSERY	236, 367		236, 367	0	236, 367	43.00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	5, 471, 239		5, 471, 239		5, 476, 543	50.00
50. 01 05001 OUTPATI ENT SURGERY	2, 320, 798		2, 320, 798		2, 320, 798	50. 01
51.00 05100 RECOVERY ROOM	1, 061, 076		1, 061, 076		1, 061, 076	51. 00
53. 00 05300 ANESTHESI OLOGY	3, 553, 527		3, 553, 527	0	3, 553, 527	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	4, 981, 223		4, 981, 223		4, 981, 223	54.00
54. 01 05401 RADI OLOGY-SPECI AL PROCEDURES	979, 978		979, 978		979, 978	54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0		0	0	0	55. 00
56. 00 05600 RADI 0I SOTOPE	1, 211, 427		1, 211, 427	0	1, 211, 427	56. 00
60. 00 06000 LABORATORY	7, 973, 456		7, 973, 456		7, 983, 442	60. 00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	238, 707		238, 707		238, 707	63. 00
65. 00 06500 RESPI RATORY THERAPY	3, 417, 746				3, 417, 746	65. 00
66. 00 06600 PHYSI CAL THERAPY	9, 085, 405	0			9, 085, 405	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	1, 192, 526		.,,		1, 192, 526	67. 00
68.00 06800 SPEECH PATHOLOGY	670, 110		0,0,1.0		670, 110	68. 00
69. 00 06900 ELECTROCARDI OLOGY	1, 811, 045		1, 811, 045		1, 811, 063	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	680, 559		680, 559		680, 559	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	11, 142, 888		11, 142, 888		11, 142, 888	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	10, 636, 610		10, 636, 610		10, 636, 610	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	9, 165, 392		9, 165, 392		9, 165, 392	73. 00
76.00 03630 ULTRA SOUND	940, 206		940, 206		940, 206	76. 00
76. 01 03951 PAIN CLINIC	2, 018, 683		2, 018, 683		2, 018, 683	76. 01
76. 02 03952 CATH LAB	3, 937, 785		3, 937, 785		3, 937, 785	76. 02
76. 03 03953 ACTIVITY THERAPEUTIC	4, 069, 882		4, 069, 882		4, 083, 580	76. 03
76. 04 03954 WOUND CARE CENTER	834, 102		834, 102		834, 313	76. 04
76. 05 03340 BARI ATRI C CLI NI C	2, 067, 439		2, 067, 439		2, 067, 439	76. 05
76.06 03030 HEALTHY LIVING CENTER	0		0	0	0	76. 06
76. 07 03950 CV RESOURCE CENTER	2, 446		2, 446		2, 446	76. 07
76.08 03955 OTHER ANCILLARY SERVICE COST CENTERS	11, 735		11, 735		11, 735	76. 08
76. 09 03956 LACTATION CLINIC	0		0	_	0	76. 09
76. 10 03957 OTHER ANCILLARY SERVICE COST CENTERS	0		0		0	76. 10
76. 11 03958 OTHER ANCILLARY SERVICE COST CENTERS	0		0		0	76. 11
76. 12 03959 ANTI COAGULATI ON CLINI C	696, 234		696, 234	0	696, 234	76. 12
OUTPATIENT SERVICE COST CENTERS	7 500 050	I	7 500 050	1	7 500 050	
91. 00 09100 EMERGENCY	7, 502, 058		7, 502, 058		7, 502, 058	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	4, 911, 503		4, 911, 503		4, 911, 503	92. 00
SPECIAL PURPOSE COST CENTERS						440.00
113. 00 11300 INTEREST EXPENSE	140 045 435		140 045 435	00.017	140 074 000	113. 00
200.00 Subtotal (see instructions)	148, 245, 175				148, 274, 392	
201.00 Less Observation Beds	4, 911, 503		4, 911, 503		4, 911, 503	
202.00 Total (see instructions)	143, 333, 672	1	143, 333, 672	29, 217	143, 362, 889	202.00

In Lieu of Form CMS-2552-10

Period: Worksheet C
From 01/01/2021 Part I
To 12/31/2021 Date/Time Prepared: 5/30/2022 7:58 pm

					10 12/01/2021	5/30/2022 7:5	8 pm
			Ti tl	e XIX	Hospi tal	Cost	
			Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
				+ col. 7)	Ratio	Inpati ent	
						Ratio	
		6. 00	7. 00	8. 00	9. 00	10. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDIATRICS	56, 780, 256		56, 780, 25			30. 00
31. 00	03100 I NTENSI VE CARE UNI T	11, 546, 769		11, 546, 76	9		31. 00
32.00	03200 CORONARY CARE UNIT	0			0		32. 00
35. 00	02060 NEONATAL INTENSIVE CARE UNIT	339, 907		339, 90			35. 00
41. 00	04100 SUBPROVI DER – I RF	19, 471, 672		19, 471, 67			41. 00
42. 00	04200 SUBPROVI DER	0			0		42. 00
43. 00	04300 NURSERY	322, 748		322, 74	8		43. 00
F0 00	ANCILLARY SERVICE COST CENTERS	04 440 70/	00 040 500	FF 004 07		0.000707	F0 00
50.00	05000 OPERATING ROOM	21, 440, 796	33, 943, 580			0. 098787	50.00
50. 01	05001 OUTPATI ENT SURGERY	1, 822, 346	2, 116, 028			0. 589278	
51.00	05100 RECOVERY ROOM	2, 171, 243	4, 035, 251			0. 170962	
53. 00	05300 ANESTHESI OLOGY	5, 954, 228	9, 319, 408			0. 232658	
54.00	05400 RADI OLOGY - DI AGNOSTI C	18, 961, 315	37, 162, 793			0.088754	
54. 01	05401 RADI OLOGY - SPECI AL PROCEDURES	3, 182, 229	2, 543, 351			0. 171158	
55.00	05500 RADI OLOGY-THERAPEUTI C	١	10.0(0.470		0.00000	0.000000	
56.00	05600 RADI OI SOTOPE	1, 052, 835	10, 868, 479			0. 101619	
60.00	06000 LABORATORY	29, 922, 738	30, 455, 934			0. 132057	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	1, 538, 878	429, 980			0. 121241	
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	7, 198, 354	2, 474, 558			0. 353332 0. 436777	65. 00 66. 00
67.00	06700 OCCUPATI ONAL THERAPY	5, 124, 564	15, 676, 455			0. 436777	
68. 00	06800 SPEECH PATHOLOGY	4, 566, 476 1, 993, 533	376, 899 987, 179			0. 241237	
69. 00	06900 ELECTROCARDI OLOGY	7, 198, 057	15, 467, 076			0. 224613	
70.00	07000 ELECTROENCEPHALOGRAPHY	511, 552	3, 594, 481			0. 165746	1
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	16, 146, 729	12, 399, 240			0. 390349	
71.00	07200 IMPL. DEV. CHARGED TO PATIENTS	5, 986, 226	9, 378, 734			0. 692264	
73. 00	07300 DRUGS CHARGED TO PATIENTS	23, 487, 242	10, 072, 376			0. 273108	
76.00	03630 ULTRA SOUND	3, 133, 119	9, 841, 773			0. 273108	
76. 01	03951 PAIN CLINIC	49, 893	8, 809, 354			0. 072403	
76. 01	03952 CATH LAB	21, 470, 141	42, 089, 749			0. 061954	
76. 02	03953 ACTIVITY THERAPEUTIC	3, 111, 575	2, 255, 021			0. 758373	
76. 04	03954 WOUND CARE CENTER	9, 111	2, 454, 070			0. 338628	
76. 05	03340 BARI ATRI C CLI NI C	747	2, 976, 729			0. 694360	
76. 06	03030 HEALTHY LIVING CENTER	7 7 7	2, 770, 727		0. 000000	0.000000	
76. 07	03950 CV RESOURCE CENTER		0		0. 000000	0. 000000	
76. 08	03955 OTHER ANCILLARY SERVICE COST CENTERS	0	0		0. 000000	0. 000000	
76. 09	03956 LACTATION CLINIC		0	•	0. 000000	0. 000000	
76. 10	03957 OTHER ANCILLARY SERVICE COST CENTERS		0	•	0. 000000	0. 000000	
76. 11	03958 OTHER ANCILLARY SERVICE COST CENTERS	o	0		0. 000000	0. 000000	
76. 12	03959 ANTI COAGULATI ON CLINIC	14, 707	1, 119, 425	1, 134, 13		0. 613892	
	OUTPATIENT SERVICE COST CENTERS			, , , , , ,			
91.00	09100 EMERGENCY	19, 866, 196	39, 258, 965	59, 125, 16	1 0. 126884	0. 126884	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	3, 123, 337	5, 142, 167			0. 594217	
	SPECIAL PURPOSE COST CENTERS				•		1
113.00	11300 I NTEREST EXPENSE						113. 00
200.00		297, 499, 519	315, 249, 055	612, 748, 57	4		200. 00
201.00	Less Observation Beds						201. 00
202.00	Total (see instructions)	297, 499, 519	315, 249, 055	612, 748, 57	4		202. 00

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

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0090
From 01/01/2021
To 12/31/2021
Date/Time Prepared:

10	12/31/2021	Date/lime Prep 5/30/2022 7:58	
Title XIX	Hospi tal	Cost	э рііі
Cost Center Description PPS Inpatient			
Ratio			
11.00			
INPATIENT ROUTINE SERVICE COST CENTERS			
30. 00 03000 ADULTS & PEDI ATRI CS			30.00
31.00 03100 NTENSI VE CARE UNIT			31.00
32.00 03200 CORONARY CARE UNIT			32.00
35. 00 02060 NEONATAL INTENSIVE CARE UNIT			35.00
41. 00 04100 SUBPROVI DER - RF			41.00
42. 00 04200 SUBPROVI DER			42.00
43. 00 04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS			
50. 00 05000 0PERATING ROOM 0. 000000			50.00
50. 01 05001 0UTPATI ENT SURGERY 0. 000000			50. 01
51. 00 05100 RECOVERY ROOM 0. 000000			51.00
53. 00 05300 ANESTHESI OLOGY 0. 000000			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 0. 000000			54.00
54. 01 05401 RADI OLOGY-SPECI AL PROCEDURES 0. 000000			54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C 0. 000000			55.00
56. 00 05600 RADI 0I SOTOPE 0. 0000000			56.00
60. 00 06000 LABORATORY 0. 000000			60.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 0. 0000000			63.00
65. 00 06500 RESPI RATORY THERAPY 0. 000000			65.00
66. 00 06600 PHYSI CAL THERAPY 0. 000000			66. 00
67. 00 06700 0CCUPATI ONAL THERAPY 0. 000000			67.00
68. 00 06800 SPEECH PATHOLOGY 0. 000000			68.00
69. 00 06900 ELECTROCARDI OLOGY 0. 000000			69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY 0. 000000			70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.000000			71. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS 0. 000000			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS 0.000000			73.00
76. 00 03630 ULTRA SOUND 0. 000000			76.00
76. 01 03951 PAIN CLINIC 0. 000000			76. 01
76. 02 03952 CATH LAB 0. 000000			76. 02
76. 03 03953 ACTIVITY THERAPEUTIC 0. 000000			76. 03
76. 04 03954 WOUND CARE CENTER 0. 000000			76. 04
76. 05 03340 BARI ATRI C CLI NI C 0. 000000			76. 05
76. 06 03030 HEALTHY LIVING CENTER 0. 000000			76.06
76. 07 03950 CV RESOURCE CENTER 0. 000000			76. 07
76.08 03955 OTHER ANCILLARY SERVICE COST CENTERS 0.000000			76. 08
76. 09 03956 LACTATI ON CLI NI C 0. 000000			76. 09
76. 10 03957 OTHER ANCILLARY SERVICE COST CENTERS 0. 0000000			76. 10
76. 11 03958 OTHER ANCILLARY SERVICE COST CENTERS 0. 0000000			76. 11
76. 12 03959 ANTI COAGULATI ON CLINI C 0. 000000			76. 12
OUTPATIENT SERVICE COST CENTERS			
91. 00 09100 EMERGENCY 0. 000000			91. 00
92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART 0. 000000			92. 00
SPECIAL PURPOSE COST CENTERS			
113. 00 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)		l	202. 00

Health Financial Systems	FRANCI SCAN HI	EALTH- DYER		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der C		Period: From 01/01/2021 To 12/31/2021	Worksheet D Part I Date/Time Pre 5/30/2022 7:5	pared: 8 pm
			XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced		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	2, 565, 993	0				
31.00 INTENSIVE CARE UNIT	360, 237		360, 23	7 2, 591	139. 03	
32.00 CORONARY CARE UNIT	0			0	0.00	
35.00 NEONATAL INTENSIVE CARE UNIT	2, 676		2, 67		38. 23	35. 00
41. 00 SUBPROVI DER - I RF	303, 582	0	303, 58	8, 277	•	
42. 00 SUBPROVI DER	0	0	1	0	0.00	
43. 00 NURSERY	2, 117		2, 11		l	43.00
200.00 Total (lines 30 through 199)	3, 234, 605		3, 234, 60	33, 338		200. 00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	7, 685		•			30. 00
31.00 INTENSIVE CARE UNIT	849	118, 036				31. 00
32.00 CORONARY CARE UNIT	0	0)			32. 00
35.00 NEONATAL INTENSIVE CARE UNIT	0	0)			35. 00
41. 00 SUBPROVI DER - I RF	5, 287	193, 927	1			41. 00
42. 00 SUBPROVI DER	0	0)			42. 00
43. 00 NURSERY	0	0)			43. 00
200.00 Total (lines 30 through 199)	13, 821	1, 196, 507	1			200. 00

Health Financial Systems	FRANCISCAN HE	EALTH	- DYER		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL	_ COSTS	F	rovi der C	CN: 15-0090	Peri od: From 01/01/2021 To 12/31/2021	Worksheet D Part II Date/Time Prep 5/30/2022 7:58	
			Titl∈	: XVIII	Hospi tal	PPS	
Cost Center Description	Capital Related Cost			Ratio of Cos		Capital Costs	

				rom 01/01/2021 o 12/31/2021	Date/Time Prep 5/30/2022 7:58	
		Title	e XVIII	Hospi tal	PPS	о рііі
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,		(col . 1 ÷ col .		column 4)	
	Part II, col.	8)	2)		ĺ	
	26)	ĺ	<u> </u>			
	1.00	2.00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	758, 323	55, 384, 376	0. 013692	5, 123, 329	70, 149	50. 00
50. 01 05001 0UTPATI ENT SURGERY	398, 559	3, 938, 374	0. 101199	1, 505, 849	152, 390	50. 01
51. 00 05100 RECOVERY ROOM	169, 442	6, 206, 494	0. 02730	603, 538	16, 477	51.00
53. 00 05300 ANESTHESI OLOGY	57, 419	15, 273, 636		1, 895, 441	7, 125	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 055, 528	56, 124, 108	0. 01880	8, 014, 691	150, 732	54.00
54. 01 05401 RADI OLOGY-SPECI AL PROCEDURES	61, 158	5, 725, 580	0. 010682	997, 039	10, 650	54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	0. 000000	0	0	55. 00
56. 00 05600 RADI 0I SOTOPE	180, 461	11, 921, 314	0. 015138	595, 106	9, 009	56. 00
60. 00 06000 LABORATORY	256, 683	60, 378, 672	0.004251	10, 616, 517	45, 131	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	77, 875	1, 968, 858				63. 00
65. 00 06500 RESPIRATORY THERAPY	121, 832	9, 672, 912	1			65. 00
66. 00 06600 PHYSI CAL THERAPY	142, 857	20, 801, 019	0. 006868	1, 295, 938	8, 901	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	27, 285	4, 943, 375	1			67. 00
68. 00 06800 SPEECH PATHOLOGY	11, 195	2, 980, 712				68. 00
69. 00 06900 ELECTROCARDI OLOGY	182, 402	22, 665, 133	1			69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	147, 322	4, 106, 033	1			70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	98, 571	28, 545, 969			19, 610	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	91, 645	15, 364, 960	1			72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	168, 907	33, 559, 618	1		40, 594	73. 00
76. 00 03630 ULTRA SOUND	98, 717	12, 974, 892	1			76. 00
76. 01 03951 PALN CLINIC	344, 172	8, 859, 247	1			76. 01
76. 02 03952 CATH LAB	487, 085	63, 559, 890				76. 02
76. 03 03953 ACTIVITY THERAPEUTIC	191, 399	5, 366, 596	1		244	76. 03
76. 04 03954 WOUND CARE CENTER	175, 855	2, 463, 181			636	76. 04
76. 05 03340 BARI ATRI C CLI NI C	74, 155	2, 977, 476				76. 05
76. 06 03030 HEALTHY LIVING CENTER	0	0	0.000000			76. 06
76. 07 03950 CV RESOURCE CENTER	276	0	0.000000		0	76. 07
76. 08 03955 OTHER ANCILLARY SERVICE COST CENTERS	1, 326	0	0. 000000		_	76. 08
76. 09 03956 LACTATION CLINIC	0	0	0. 000000		0	76. 09
76. 10 03957 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000		0	76. 10
76. 11 03958 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000		Ö	76. 11
76. 12 03959 ANTI COAGULATI ON CLINIC	17, 631	1, 134, 132	1			76. 12
OUTPATIENT SERVICE COST CENTERS	,				-	
91. 00 09100 EMERGENCY	569, 878	59, 125, 161	0.009639	7, 710, 488	74, 321	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	442, 782	8, 265, 504				
200.00 Total (lines 50 through 199)	6, 410, 740			75, 295, 956	826, 833	200. 00

Health Financial Systems APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	FRANCI SCAN HE SS THROUGH COS			In Lie Period: From 01/01/2021 To 12/31/2021	worksheet D Part III Date/Time Pre 5/30/2022 7:5	pared:
		Title	: XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng	Nursi ng		Allied Health	All Other	
	Program Post-Stepdown Adjustments	Program	Post-Stepdowr Adjustments	Cost	Medical Education Cost	
	1A	1. 00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 32. 00 03200 CORONARY CARE UNIT 35. 00 02060 NEONATAL INTENSIVE CARE UNIT 41. 00 04100 SUBPROVIDER - IRF 42. 00 04200 SUBPROVIDER 43. 00 04300 NURSERY	0 0 0 0 0 0	0 0 0 0 0			0 0 0 0 0	31. 00 32. 00 35. 00 41. 00 42. 00 43. 00
200.00 Total (lines 30 through 199) Cost Center Description	Swing-Bed Adjustment Amount (see instructions) 4.00	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days 6.00	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days 8.00	200. 00
INPATIENT ROUTINE SERVICE COST CENTERS				<u> </u>		
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 32. 00 03200 CORONARY CARE UNIT 35. 00 02060 NEONATAL INTENSIVE CARE UNIT 41. 00 04100 SUBPROVIDER - IRF 42. 00 04200 SUBPROVIDER 43. 00 04300 NURSERY 200. 00 Total (Lines 30 through 199)	0	0 0	2, 59 70 8, 27 10	1 0.00 0 0.00 0 0.00 7 0.00 0 0.00 6 0.00	849 0 0 5, 287 0	31. 00 32. 00 35. 00 41. 00 42. 00
Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00					
INPATIENT ROUTINE SERVICE COST CENTERS	0 0 0 0 0 0 0					30. 00 31. 00 32. 00 35. 00 41. 00 42. 00 43. 00 200. 00

Health Financial Systems	FRANCISCAN HEALTH- DYER			In Lieu of Form CMS-2552-10		
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0090	Peri od:	Worksheet D		
THROUGH COSTS			From 01/01/2021	Part IV		

THROUGH CUSTS				To 12/31/2021	Date/Time Pre 5/30/2022 7:5	pared: 8 pm
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
	Anesthetist	Program	Program	Post-Stepdown		
	Cost	Post-Stepdown		Adjustments		
	1.00	Adjustments	2.00	3A	2.00	
ANCILLARY SERVICE COST CENTERS	1.00	2A	2. 00	3A	3. 00	
50. 00 05000 OPERATING ROOM	O	0		0	0	50.00
50. 01 05000 01 ERATTING ROOM 50. 01 05001 0UTPATI ENT SURGERY		0		0 0	0	50. 00
51. 00 05100 RECOVERY ROOM		0		0 0	0	51.00
53. 00 05300 ANESTHESI OLOGY		0		0 0	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0		0 0	Ô	54. 00
54. 01 05401 RADI OLOGY-SPECI AL PROCEDURES		0		0 0	0	54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C		0		0 0	0	55. 00
56. 00 05600 RADI 0I SOTOPE		0		0 0	0	56. 00
60. 00 06000 LABORATORY		0		0 0	0	60.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0	0	63. 00
65. 00 06500 RESPIRATORY THERAPY	0	0		0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY		0		o o	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	o	0		0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0		0 0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73. 00
76.00 03630 ULTRA SOUND	0	0		0	0	76. 00
76. 01 03951 PAIN CLINIC	0	0		0	0	76. 01
76. 02 03952 CATH LAB	0	0		0	0	76. 02
76. 03 03953 ACTIVITY THERAPEUTIC	0	0		0	0	76. 03
76.04 03954 WOUND CARE CENTER	0	0		0 0	0	76. 04
76. 05 03340 BARI ATRI C CLI NI C	0	0		0 0	0	76. 05
76.06 03030 HEALTHY LIVING CENTER	0	0		0	0	76. 06
76. 07 03950 CV RESOURCE CENTER	0	0		0	0	76. 07
76.08 03955 OTHER ANCILLARY SERVICE COST CENTERS	0	0		0	0	76. 08
76. 09 03956 LACTATION CLINIC	0	0		0	0	76. 09
76. 10 03957 OTHER ANCILLARY SERVICE COST CENTERS	0	0		0	0	76. 10
76. 11 03958 OTHER ANCILLARY SERVICE COST CENTERS	0	0		0	0	76. 11
76. 12 03959 ANTI COAGULATI ON CLINIC	0	0		0 0	0	76. 12
OUTPATIENT SERVICE COST CENTERS			1			
91. 00 09100 EMERGENCY	0	0		0	0	,
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0		1	0	0	
200.00 Total (lines 50 through 199)	0	0	1	0 0	0	200. 00

lealth Financial Systems		FRANCISCAN HE	FALTH- DYFR		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SE				Period: From 01/01/2021 To 12/31/2021	Worksheet D Part IV	pared:
			Title	XVIII	Hospi tal	PPS	•
Cost Center Description		All Other	Total Cost	Total		Ratio of Cost	
		Medi cal	(sum of cols.		(from Wkst. C,		
		Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
			4)	col s. 2, 3,	8)	7)	
				and 4)		(see	
				,		instructions)	
		4.00	5. 00	6.00	7. 00	8. 00	

Cost Center Description	All Other	Total Cost	lotai		Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
	Education Cost		Cost (sum of		(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	
			and 4)		(see	
	4.00	F 00	/ 00	7.00	instructions)	
ANOLLI ADV. CEDVILOE, COCT. CENTEDO	4. 00	5. 00	6. 00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS			1	FF 004 074	0.000000	F0 00
50. 00 05000 OPERATING ROOM	0	0				50.00
50. 01 05001 0UTPATI ENT SURGERY	0					50. 01
51. 00 05100 RECOVERY ROOM	0	0	· -			l
53. 00 05300 ANESTHESI OLOGY	0	0	· -	, ,		53.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	0	0	-	,,		
54. 01 05401 RADI OLOGY-SPECI AL PROCEDURES	0	0	· -	-,,		1
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	· -	_	0.000000	1
56. 00 05600 RADI 0I SOTOPE	0	0	ľ	, . = . ,		56.00
60. 00 06000 LABORATORY	0	0				60.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	1	.,		63.00
65. 00 06500 RESPIRATORY THERAPY	0	0	· -	.,,		65.00
66. 00 06600 PHYSI CAL THERAPY	0	0	1			66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	1	.,		67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0	1	_,		68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	1			69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0				1
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	1	, ,		1
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	1	, ,		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0				73.00
76. 00 03630 ULTRA SOUND	0	0	1			
76. 01 03951 PAIN CLINIC	0	0	1	-,,		76. 01
76. 02 03952 CATH LAB	0	0	1	,,		76. 02
76. 03 03953 ACTIVITY THERAPEUTIC	0	0	1	-,,		1
76. 04 03954 WOUND CARE CENTER	0	0	· -	-1		76. 04
76. 05 03340 BARI ATRI C CLINI C	0	0	-			76. 05
76. 06 03030 HEALTHY LIVING CENTER	0	0		_	0.000000	1
76. 07 03950 CV RESOURCE CENTER	0	0	-	0	0.000000	76. 07
76. 08 03955 OTHER ANCILLARY SERVICE COST CENTERS	0	0	l	0	0. 000000	76. 08
76. 09 03956 LACTATION CLINIC	0	0	· -	0	0. 000000	76. 09
76. 10 03957 OTHER ANCILLARY SERVICE COST CENTERS	0	0	· -	_	0.000000	76. 10
76. 11 03958 OTHER ANCILLARY SERVICE COST CENTERS	0	0			0. 000000	76. 11
76. 12 03959 ANTI COAGULATI ON CLINIC	0	0	0	1, 134, 132	0. 000000	76. 12
OUTPATIENT SERVICE COST CENTERS	1		1			
91. 00 09100 EMERGENCY	0	1				1
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	-		-, -, -, -		ı
200.00 Total (lines 50 through 199)	0	0	0	524, 287, 222	1	200. 00

Health Financial Systems	FRANCISCAN HE				eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEITHROUGH COSTS	RVICE OTHER PASS	Provi der C		Peri od: From 01/01/2021 To 12/31/2021	Worksheet D Part IV Date/Time Pre 5/30/2022 7:5	
		Title	xVIII	Hospi tal	PPS	Орш
Cost Center Description	Outpati ent	Inpatient	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷ col.	3	Costs (col. 8		Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10, 00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	0. 000000	5, 123, 329		0 6, 079, 053	0	50.00
50. 01 05001 OUTPATIENT SURGERY	0. 000000	1, 505, 849		0 598, 236	l o	50. 01
51.00 05100 RECOVERY ROOM	0. 000000	603, 538		0 644, 376	l o	51.00
53. 00 05300 ANESTHESI OLOGY	0. 000000	1, 895, 441		0 1, 725, 984	l o	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	8, 014, 691		0 9, 171, 671	l o	54.00
54. 01 05401 RADI OLOGY-SPECI AL PROCEDURES	0. 000000	997, 039		0 286, 057	0	54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	0		0 0	0	55. 00
56. 00 05600 RADI OI SOTOPE	0. 000000	595, 106		0 4, 544, 517	0	56.00
60. 00 06000 LABORATORY	0. 000000	10, 616, 517		0 809, 128	0	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	794, 978		0 28, 767	0	63.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000	3, 687, 720		0 2, 263, 606	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	1, 295, 938		0 59, 936		66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	1, 164, 653	1	0 1, 251	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	563, 596		0 125, 396	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	3, 343, 612		0 4, 848, 538		69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	217, 576		0 697, 402		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	5, 679, 222		0 3, 791, 434		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	2, 783, 350	1	0 3, 667, 503		72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	8, 065, 521	1	0 2, 972, 508		73. 00
76. 00 03630 ULTRA SOUND	0. 000000	1, 294, 632		0 1, 455, 556		76.00
76. 01 03951 PAIN CLINIC	0. 000000	8, 149	1	0 2, 787, 258		76. 01
76. 02 03952 CATH LAB	0. 000000	9, 285, 293		0 16, 139, 273		76. 02
76. 03 03953 ACTIVITY THERAPEUTIC	0. 000000	6, 837	1	0 21, 149		76. 03
76. 04 03954 WOUND CARE CENTER	0. 000000	8, 911	1	0 924, 266		76. 04
76. 05 03340 BARI ATRI C CLINI C	0. 000000	95	1	0 57, 536		76. 05
76. 06 03030 HEALTHY LIVING CENTER	0. 000000	0	l .	0 0,000	,	76.06
76. 07 03950 CV RESOURCE CENTER	0. 000000	0	1	0 0	o o	76. 07
76. 08 03955 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000	0		0 0	0	76. 08
76. 09 03956 LACTATION CLINIC	0. 000000	0	l .	0 0	0	76.09
76. 10 03957 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000	0	1	0 0	0	76. 10
76. 11 03958 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000	0	1	0 0	0	76. 10
76. 12 03959 ANTI COAGULATI ON CLINI C	0. 000000	740	1	0 751, 048		76. 12
OUTDATION CERVICE COST CENTERS	3. 353000	7 + 0	1	7, 7, 0, 10		1 / 0. 12

0. 000000

0.000000

7, 710, 488

33, 135 75, 295, 956

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART

Total (lines 50 through 199)

OUTPATIENT SERVICE COST CENTERS

200.00

91. 00 09100 EMERGENCY

0 91.00 0 92.00

0 200. 00

6, 425, 531 1, 070, 979 71, 947, 959

0 0 0

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0090 Peri od: Worksheet D From 01/01/2021 Part V Date/Time Prepared: 12/31/2021 5/30/2022 7:58 pm Title XVIII Hospi tal PPS Charges Costs Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Ratio From Services (see Rei mbursed Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Part I, col. 9 Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 1.00 2.00 5. 00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0.098787 6, 079, 053 600, 531 50.00 50.01 05001 OUTPATIENT SURGERY 0.589278 598, 236 0 0 352, 527 50.01 05100 RECOVERY ROOM 0 51 00 0 170962 51 00 644.376 110, 164 0 0 53.00 05300 ANESTHESI OLOGY 0. 232658 1, 725, 984 401, 564 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.088754 9, 171, 671 0 814, 022 54.00 54.01 05401 RADI OLOGY-SPECI AL PROCEDURES 0.171158 0 0 48, 961 286, 057 54 01 05500 RADI OLOGY-THERAPEUTI C 0 55.00 0.000000 Λ 55.00 56.00 05600 RADI OI SOTOPE 0. 101619 4, 544, 517 461, 809 56.00 0 60.00 06000 LABORATORY 0.132057 809, 128 0 106, 851 60.00 0 06300 BLOOD STORING, PROCESSING & TRANS. 28, 767 63 00 0 121241 3, 488 63 00 06500 RESPIRATORY THERAPY 65.00 0.353332 2, 263, 606 799, 804 65.00 06600 PHYSI CAL THERAPY 0.436777 59, 936 0 0 26, 179 66.00 66.00 0 06700 OCCUPATIONAL THERAPY 0. 241237 1, 251 0 67.00 302 67.00 0 06800 SPEECH PATHOLOGY 125, 396 28, 191 68.00 0.224815 68 00 69.00 06900 ELECTROCARDI OLOGY 0.079904 4, 848, 538 0 0 387, 418 69.00 115, 592 07000 ELECTROENCEPHALOGRAPHY 697, 402 0 70.00 0. 165746 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.390349 3, 791, 434 0 0 1, 479, 982 71.00 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0.692264 3, 667, 503 0 2, 538, 880 72 00 72 00 73.00 07300 DRUGS CHARGED TO PATIENTS 0. 273108 2, 972, 508 20, 227 811, 816 73.00 03630 ULTRA SOUND 0 76.00 0.072463 1, 455, 556 0 105, 474 76.00 03951 PAIN CLINIC 0 76.01 0.227862 2, 787, 258 0 635, 110 76.01 0 03952 CATH LAB 0 999, 893 76.02 0.061954 16, 139, 273 76.02 76.03 03953 ACTIVITY THERAPEUTIC 0.758373 21, 149 0 0 16, 039 76.03 03954 WOUND CARE CENTER 0 76. 04 0. 338628 924, 266 0 312, 982 76.04 03340 BARIATRIC CLINIC 0 39, 951 76.05 0.694360 57, 536 76.05 0 03030 HEALTHY LIVING CENTER 76.06 0.000000 C 0 76.06 03950 CV RESOURCE CENTER 0.000000 0 0 0 76.07 76.07 0 0 76.08 03955 OTHER ANCILLARY SERVICE COST CENTERS 0.000000 0 0 76.08 76 09 03956 LACTATION CLINIC 0.000000 0 C Ω 76.09 0 76. 10 03957 OTHER ANCILLARY SERVICE COST CENTERS 0.000000 0 76. 10 03958 OTHER ANCILLARY SERVICE COST CENTERS 0 o 76. 11 0.000000 O 76. 11 03959 ANTI COAGULATION CLINIC 461, 062 0.613892 751, 048 0 76.12 76. 12 OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 0. 126884 6, 425, 531 0 0 815, 297 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.594217 1,070,979 0 636, 394 92.00 0 200.00 Subtotal (see instructions) 71, 947, 959 200.00 20, 227 13, 110, 283 0 201.00 Less PBP Clinic Lab. Services-Program 201.00 Only Charges

71, 947, 959

0

20, 227

13, 110, 283 202. 00

202.00

Net Charges (line 200 - line 201)

From 01/01/2021 Part V 12/31/2021 Date/Time Prepared: 5/30/2022 7:58 pm Title XVIII Hospi tal PPS Costs Cost Center Description Cost Cost Rei mbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 6.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 50.00 50.01 05001 OUTPATIENT SURGERY 0 50.01 51. 00 05100 RECOVERY ROOM 0 51 00 05300 ANESTHESI OLOGY 53.00 0 53.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 54. 01 05401 RADI OLOGY-SPECI AL PROCEDURES 0 54.01 05500 RADI OLOGY-THERAPEUTI C 0 55.00 55.00 56. 00 05600 RADI 0I SOTOPE 0 56.00 06000 LABORATORY 0 60.00 60.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 63 00 63.00 65.00 06500 RESPIRATORY THERAPY 0 65.00 66.00 06600 PHYSI CAL THERAPY 0 66.00 06700 OCCUPATIONAL THERAPY 67.00 0 67.00 0 68.00 06800 SPEECH PATHOLOGY 68.00 69.00 06900 ELECTROCARDI OLOGY 0 69.00 07000 ELECTROENCEPHALOGRAPHY 70.00 70.00 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 72.00 Ω 73.00 07300 DRUGS CHARGED TO PATIENTS 5, 524 73.00 03630 ULTRA SOUND 76.00 76.00 0 03951 PAIN CLINIC 76. 01 0 76.01 03952 CATH LAB 76.02 0 76.02 76. 03 03953 ACTIVITY THERAPEUTIC 0 76.03 03954 WOUND CARE CENTER 76. 04 76.04 76. 05 03340 BARIATRIC CLINIC 0 76.05 03030 HEALTHY LIVING CENTER 76.06 76.06 76. 07 03950 CV RESOURCE CENTER 76.07 03955 OTHER ANCILLARY SERVICE COST CENTERS 0 76. 08 76.08 76.09 03956 LACTATION CLINIC 0 76.09 03957 OTHER ANCILLARY SERVICE COST CENTERS 76. 10 0 76. 10 03958 OTHER ANCILLARY SERVICE COST CENTERS 0 76. 11 0 76. 11 03959 ANTI COAGULATION CLINIC 76.12 0 0 76. 12 OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 0 0 0 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 200.00 Subtotal (see instructions) 200.00 5, 524 201.00 Less PBP Clinic Lab. Services-Program 201. 00

5, 524

202.00

Only Charges

Net Charges (line 200 - line 201)

202.00

Health Financial Systems	FRANCI SCAN HI		ON 45 0000		eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	IL COSTS	Provi der C	CN: 15-0090	Peri od: From 01/01/2021	Worksheet D Part II	
		Component	CCN: 15-T090	To 12/31/2021	Date/Time Pre 5/30/2022 7:5	pared: 8 pm
		Title	× XVIII	Subprovi der - I RF	PPS	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,	9	Program	(column 3 x	
	(from Wkst. B,		(col . 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26) 1. 00	2.00	3.00	4. 00	5. 00	
ANCI LLARY SERVI CE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
50. 00 05000 OPERATING ROOM	758, 323	55, 384, 376	0. 0136	92 71, 917	985	50. 00
50. 01 05001 01PATI ENT SURGERY	398, 559		1			1
51. 00 05100 RECOVERY ROOM	169, 442					1
53. 00 05300 ANESTHESI OLOGY	57, 419					1
54. 00 05400 RADI OLOGY - DI AGNOSTI C	1, 055, 528				1	
54. 01 05401 RADI OLOGY-SPECI AL PROCEDURES	61, 158					1
55. 00 05500 RADI OLOGY-THERAPEUTI C	01, 130					
56. 00 05600 RADI OI SOTOPE	180, 461					56. 00
60. 00 06000 LABORATORY	256, 683					1
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	77, 875		1			1
65. 00 06500 RESPIRATORY THERAPY	121, 832		1			1
66. 00 06600 PHYSI CAL THERAPY	142, 857		1			1
67. 00 06700 OCCUPATI ONAL THERAPY	27, 285		1			
68.00 06800 SPEECH PATHOLOGY	11, 195			1, 287, 900	4, 837	68. 00
69. 00 06900 ELECTROCARDI OLOGY	182, 402	22, 665, 133	0.0080	48 98, 222	790	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	147, 322	4, 106, 033	0. 0358	79 18, 036	647	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	98, 571	28, 545, 969	0. 0034!	687, 308	2, 373	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	91, 645			55 10, 212	61	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	168, 907	33, 559, 618	0.0050	33 1, 187, 507	5, 977	73. 00
76.00 03630 ULTRA SOUND	98, 717	12, 974, 892	0.00760	08 93, 829	714	76. 00
76. 01 03951 PAIN CLINIC	344, 172				0	76. 01
76. 02 03952 CATH LAB	487, 085				_	
76. 03 03953 ACTIVITY THERAPEUTIC	191, 399					
76. 04 03954 WOUND CARE CENTER	175, 855		1			
76. 05 03340 BARI ATRI C CLI NI C	74, 155					
76. 06 03030 HEALTHY LIVING CENTER	0	1			_	
76. 07 03950 CV RESOURCE CENTER	276	l .				
76. 08 03955 OTHER ANCILLARY SERVICE COST CENTERS	1, 326	l	1 0.0000		_	
76. 09 03956 LACTATION CLINIC	0		0.0000		0	1
76. 10 03957 OTHER ANCILLARY SERVICE COST CENTERS	0	1			0	
76. 11 03958 OTHER ANCILLARY SERVICE COST CENTERS	0	0			_	
76. 12 03959 ANTI COAGULATI ON CLI NI C	17, 631	1, 134, 132	0. 0155	12, 365	192	76. 12
OUTPATIENT SERVICE COST CENTERS	E40 070	EO 10E 1/1	0.0007	20 254 041	2 477	01 00
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	569, 878 0					1
200.00 Total (lines 50 through 199)	5, 967, 958		1	12, 244, 812		200.00
200.00 Total (Titles 50 till ough 179)	3,707,930	J24, 201, 222	·I	12, 244, 012	1 04, 200	1200.00

Heal th	Financial Systems	FRANCISCAN HE	EALTH- DYER		In Li∈	eu of Form CMS-2	2552-10
	TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	Provider CC	CN: 15-0090	Peri od:	Worksheet D	
THROUG	GH COSTS		Component (CCN: 15-T090	From 01/01/2021 To 12/31/2021	Part IV Date/Time Pre 5/30/2022 7:5	
			Title	XVIII	Subprovi der -	PPS	о рііі
	Cost Center Description	Non Physician	Nursi ng	Nursi ng		Allied Health	
		Anesthetist	Program	Program	Post-Stepdown		
		Cost	Post-Stepdown		Adjustments		
		1.00	Adjustments 2A	2.00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS	1.00	ZN	2.00	J.A.	3.00	
50. 00	05000 OPERATI NG ROOM	0	0		0 0	0	50.00
50. 01	05001 OUTPATIENT SURGERY	0	0		0 0	0	50. 01
51.00	05100 RECOVERY ROOM	0	0		0 0	0	51.00
53.00	05300 ANESTHESI OLOGY	0	0		0 0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
54.01	05401 RADI OLOGY-SPECI AL PROCEDURES	0	0		0 0	0	54. 01
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0		0 0	0	55.00
56.00	05600 RADI OI SOTOPE	0	0		0 0	0	56.00
60.00	06000 LABORATORY	0	0		0 0	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 0	0	63.00
65.00	06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0	0		0	0	
67. 00	06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	
68. 00	06800 SPEECH PATHOLOGY	0	0		0 0	0	
69. 00	06900 ELECTROCARDI OLOGY	0	0		0 0	0	
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 0	0	
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	
76.00	03630 ULTRA SOUND	0	0		0 0	0	
76. 01 76. 02	O3951 PAIN CLINIC O3952 CATH LAB	0	0		0 0	0	
76. 02	03953 ACTIVITY THERAPEUTIC	0	0		0 0	0	
76. 03	03954 WOUND CARE CENTER	0	0		0 0	0	
76. 05	03340 BARI ATRI C CLI NI C	0	0		0 0	Ö	
76. 06	03030 HEALTHY LIVING CENTER	0	0		0 0	Ö	
76. 07	03950 CV RESOURCE CENTER	0	0		0 0	Ö	
76. 08	03955 OTHER ANCILLARY SERVICE COST CENTERS	0	0		0 0	o o	
76. 09	03956 LACTATION CLINIC	0	0		0 0	0	
76. 10	03957 OTHER ANCILLARY SERVICE COST CENTERS	0	0		0 0	0	76. 10
76. 11	03958 OTHER ANCILLARY SERVICE COST CENTERS	0	0		0 0	0	76. 11
76. 12	03959 ANTI COAGULATION CLINIC	0	0		0 0	0	76. 12
	OUTPATIENT SERVICE COST CENTERS						
91. 00	09100 EMERGENCY	0	0		0 0	0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0	0	
200.00	Total (lines 50 through 199)	l ol	0		0 0	1 0	200.00

Heal th	Financial Systems	FRANCISCAN HI	EALTH- DYER		In Lie	eu of Form CMS-2	2552-10
	ONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	RVICE OTHER PASS		CN: 15-0090 CCN: 15-T090	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part IV Date/Time Pre 5/30/2022 7:5	
			Title	XVIII	Subprovi der – I RF	PPS	
	Cost Center Description	All Other	Total Cost	Total	Total Charges (from Wkst. C,	Ratio of Cost	
		Medical Education Cost	(sum of cols.	Outpatient Cost (sum of		to Charges (col. 5 ÷ col.	
		Luucati on cost	1, 2, 3, and 4)	cols. 2, 3,	8)	7)	
			'/	and 4)		(see	
						instructions)	
		4.00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0		0 55, 384, 376	0.000000	50.00
	05001 OUTPATI ENT SURGERY	0			0 3, 938, 374	0.000000	50. 01
	05100 RECOVERY ROOM	0	0		0 6, 206, 494	0.000000	51. 00
	05300 ANESTHESI OLOGY	0	0		0 15, 273, 636		
	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 56, 124, 108		
	05401 RADI OLOGY-SPECI AL PROCEDURES	0	-		0 5, 725, 580	0. 000000	
	05500 RADI OLOGY-THERAPEUTI C	0	0		0	0. 000000	
	05600 RADI OI SOTOPE	0	-		0 11, 921, 314		
	06000 LABORATORY	0	0		0 60, 378, 672	0.000000	
	06300 BLOOD STORING, PROCESSING & TRANS.	0			0 1, 968, 858		
	06500 RESPI RATORY THERAPY	0	1		0 9, 672, 912	0.000000	
	06600 PHYSI CAL THERAPY	0 0	0		0 20, 801, 019 0 4, 943, 375	l	1
	06700 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY	0			0 4, 943, 375 0 2, 980, 712	0. 000000 0. 000000	
	06900 ELECTROCARDI OLOGY				0 22, 665, 133	l	
	07000 ELECTROCARDI OLOGI 07000 ELECTROENCEPHALOGRAPHY	0			0 4, 106, 033		
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0			0 28, 545, 969	1	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 15, 364, 960	l	
	07300 DRUGS CHARGED TO PATIENTS	0	Ö		0 33, 559, 618	1	1
	03630 ULTRA SOUND	0	Ö		0 12, 974, 892	l	1
	03951 PAIN CLINIC	0	Ö		0 8, 859, 247	0. 000000	•
	03952 CATH LAB	0	0		0 63, 559, 890	l	•
76. 03	03953 ACTIVITY THERAPEUTIC	0	0		0 5, 366, 596		
76. 04	03954 WOUND CARE CENTER	0	0		0 2, 463, 181	0.000000	76. 04
76. 05	03340 BARIATRIC CLINIC	0	0		0 2, 977, 476	0.000000	76. 05
76. 06	03030 HEALTHY LIVING CENTER	0	0		0 0	0.000000	76. 06
	03950 CV RESOURCE CENTER	0	0		0	0.000000	76. 07
	03955 OTHER ANCILLARY SERVICE COST CENTERS	0	0		0	0.000000	
	03956 LACTATION CLINIC	0	-		0	0. 000000	
	03957 OTHER ANCILLARY SERVICE COST CENTERS	0	0		0 0	0.000000	
	03958 OTHER ANCILLARY SERVICE COST CENTERS	0			0 0	0.000000	1
	03959 ANTI COAGULATI ON CLINI C	0	0		0 1, 134, 132	0.000000	76. 12
	OUTPATIENT SERVICE COST CENTERS		_		0 50 105 111	0.000000	01 00
	09100 EMERGENCY	0 0			0 59, 125, 161 0 8, 265, 504		
92. 00 200. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART Total (lines 50 through 199)	0			0 8, 265, 504 0 524, 287, 222	l e	200. 00
200.00	Total (Titles 50 till bugli 177)	1	ı	I	0 324, 201, 222	I	1200.00

Health Financial Systems		FRANCISCAN HEA	ΔΙΤΗ ₋ DVER		In lie	u of Form CMS-	2552_10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	NT ANCILLARY SER		Provi der Co	CN: 15-0090 CCN: 15-T090	Peri od: From 01/01/2021 To 12/31/2021	Worksheet D Part IV Date/Time Pre 5/30/2022 7:5	pared:
			Title	: XVIII	Subprovi der - I RF	PPS	- P.::
Cost Center Description		Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through		Pass-Through	
		(col . 6 ÷ col .		Costs (col.	8	Costs (col. 9	
		7)	10.00	x col. 10)	10.00	x col . 12)	
ANOLULARY OFRICAS COOT OFFITE		9. 00	10. 00	11. 00	12. 00	13. 00	
ANCILLARY SERVICE COST CENTER	RS .	0.000000	74 047	1			
50. 00 05000 OPERATING ROOM		0. 000000	71, 917		0 0	0	
50. 01 05001 OUTPATIENT SURGERY		0. 000000	30, 172		0 0	0	
51. 00 05100 RECOVERY ROOM		0. 000000	4, 680	1	0 0	0	51. 00
53. 00 05300 ANESTHESI OLOGY		0. 000000	14, 220	1	0 0	0	53. 00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	DUDEO	0. 000000	476, 676	1	0 0	0	54.00
54. 01 05401 RADI OLOGY-SPECI AL PROCE	DURES	0. 000000	0	•	0 0	0	
55. 00 05500 RADI OLOGY-THERAPEUTI C		0. 000000	0	1	0 0	0	
56. 00 05600 RADI 0I SOTOPE		0. 000000	4, 665		0 0	0	
60. 00 06000 LABORATORY		0. 000000	1, 094, 820	1	0 0	0	
63. 00 06300 BLOOD STORING, PROCESSI	NG & TRANS.	0. 000000	17, 949	•	0 0	0	63.00
65. 00 06500 RESPI RATORY THERAPY		0. 000000	779, 950	l .	0 0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY		0. 000000	3, 047, 736	l .	0 0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 000000	3, 049, 439	l .	0 0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY		0. 000000	1, 287, 900	l .	0 0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY		0. 000000	98, 222	•	0 0	0	
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 000000	18, 036	l .	0 0	0	
71. 00 07100 MEDI CAL SUPPLI ES CHARGE		0. 000000	687, 308	1	0 0	0	
72. 00 07200 MPL. DEV. CHARGED TO P		0. 000000	10, 212		0 0	0	
73. 00 07300 DRUGS CHARGED TO PATIEN	15	0. 000000	1, 187, 507		0 0	0	
76. 00 03630 ULTRA SOUND		0. 000000	93, 829		0 0	0	76. 00
76. 01 03951 PAIN CLINIC		0. 000000	0		0 0	0	76. 01
76. 02 03952 CATH LAB		0. 000000	0		0 0	0	76. 02
76. 03 03953 ACTIVITY THERAPEUTIC		0. 000000	268		0 0	0	
76. 04 03954 WOUND CARE CENTER		0. 000000	0		0 0	0	
76. 05 03340 BARI ATRI C CLINI C		0. 000000	0		0 0	0	
76. 06 03030 HEALTHY LIVING CENTER		0. 000000	0		0 0	0	
76. 07 03950 CV RESOURCE CENTER		0. 000000	0	•	0 0	0	
76. 08 03955 OTHER ANCILLARY SERVICE	COST CENTERS	0. 000000	0	•	0 0	0	76. 08
76. 09 03956 LACTATION CLINIC	0007 054755	0. 000000	0		0 0	0	
76. 10 03957 OTHER ANCILLARY SERVICE		0. 000000	0		0 0	0	76. 10
76. 11 03958 OTHER ANCILLARY SERVICE	COST CENTERS	0. 000000	0	•	0 0	0	76. 11
76. 12 03959 ANTI COAGULATI ON CLINI C	:DC	0. 000000	12, 365		0 0	0	76. 12
OUTPATIENT SERVICE COST CENTE	.KS	0.000000	05/ 2/1		0		04.00
91. 00 09100 EMERGENCY	LCTINCT DADT	0. 000000	256, 941	1	0 145	0	
92. 00 09200 OBSERVATION BEDS (NON-D		0. 000000	12 244 912		0 0 145	0	
200.00 Total (lines 50 through	177)	1	12, 244, 812	I	U 145	ı ⁰	200. 00

Health Financial Systems	FRANCISCAN HE	ALTH- DYER		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES A	ND VACCINE COST	Provi der CO		Peri od:	Worksheet D	
				From 01/01/2021	Part V	
		Component	CCN: 15-T090	Γο 12/31/2021	Date/Time Pre 5/30/2022 7:5	parea:
		Title	XVIII	Subprovi der -	PPS	о рііі
		11 11 0	7,111	IRF	110	
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	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		
50. 00 05000 OPERATI NG ROOM	0. 098787	0	(٥ -	0	
50. 01 05001 0UTPATI ENT SURGERY	0. 589278	0		0	1	
51. 00 05100 RECOVERY ROOM	0. 170962	0	(1	0	
53. 00 05300 ANESTHESI OLOGY	0. 232658	0	(0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 088754	0	(0	0	
54. 01 05401 RADI OLOGY-SPECI AL PROCEDURES	0. 171158	0	(0	0	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0.000000	0	(0	0	00.00
56. 00 05600 RADI OI SOTOPE	0. 101619	0		0	0	
60. 00 06000 LABORATORY	0. 132057	0	·	٥	0	00.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 121241	0		0	0	
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	0. 353332	0	1		1	
67. 00 06700 OCCUPATI ONAL THERAPY	0. 436777 0. 241237	0			1	67.00
68. 00 06800 SPEECH PATHOLOGY	0. 241237	0				1
69. 00 06900 ELECTROCARDI OLOGY	0. 224813	0				69.00
70. 00 07000 ELECTROCARDI OLOGI 70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 165746	0			0	1
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 390349	0			0	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 692264	0		-	0	1
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 273108	0		415	0	73. 00
76. 00 03630 ULTRA SOUND	0. 072463	0			1	1
76. 01 03951 PAIN CLINIC	0. 227862	0			0	1
76. 02 03952 CATH LAB	0. 061954	0	ì	-	0	1
76. 03 03953 ACTIVITY THERAPEUTIC	0. 758373	0			0	1
76. 04 03954 WOUND CARE CENTER	0. 338628	0	ì	-	0	1
76. 05 03340 BARI ATRI C CLI NI C	0. 694360	0	i	0	0	1
76. 06 03030 HEALTHY LIVING CENTER	0. 000000	0		-	Ö	1
76. 07 03950 CV RESOURCE CENTER	0. 000000	0		o o	Ö	1
76. 08 03955 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000	0		o o	Ö	1
76. 09 03956 LACTATION CLINIC	0. 000000	0		0	0	1
76. 10 03957 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000	0		ol o	Ō	1
76. 11 03958 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000	0		0	0	1
76. 12 03959 ANTI COAGULATION CLINIC	0. 613892	0		0	0	76. 12
OUTDATIONT SERVICE COST CENTERS					_	1

0. 126884

0. 594217

145

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0 0 0

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0

18 91.00

0 92.00 18 200.00

18 202. 00

201. 00

200.00

201.00

202.00

91. 00 09100 EMERGENCY

Only Charges

OUTPATIENT SERVICE COST CENTERS

92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART

Subtotal (see instructions)

Less PBP Clinic Lab. Services-Program

Net Charges (line 200 - line 201)

	Financial Systems	FRANCISCAN H				u of Form CMS-	2552-10
APPORT	IONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der C	CN: 15-0090	Peri od: From 01/01/2021	Worksheet D Part V	
			Component	CCN: 15-T090	To 12/31/2021	Date/Time Pre	pared:
			Ti +Lo	xVIII	Subprovi der -	5/30/2022 7:5 PPS	58 pm
			IIIIe	: AVIII	I RF	PP3	
			sts				
	Cost Center Description	Cost	Cost				
		Rei mbursed	Rei mbursed				
		Servi ces	Services Not				
		Subject To Ded. & Coins.	Subject To Ded. & Coins.				
		(see inst.)	(see inst.)				
		6.00	7.00				
	ANCILLARY SERVICE COST CENTERS	0.00	7.00	l			
50.00	05000 OPERATI NG ROOM	0	0				50.00
50. 01	05001 OUTPATIENT SURGERY	0	0				50. 01
51.00	05100 RECOVERY ROOM	0	0				51.00
53.00	05300 ANESTHESI OLOGY	0	0				53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
54.01	05401 RADI OLOGY-SPECI AL PROCEDURES	0	0				54. 01
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0				55. 00
56.00	05600 RADI OI SOTOPE	0	0				56.00
	06000 LABORATORY	0	_	1			60.00
	06300 BLOOD STORING, PROCESSING & TRANS.	0	_	1			63. 00
	06500 RESPI RATORY THERAPY	0		•			65.00
	06600 PHYSI CAL THERAPY	0		•			66. 00
	06700 OCCUPATI ONAL THERAPY	0	l .	1			67.00
	06800 SPEECH PATHOLOGY	0	_	1			68. 00
	06900 ELECTROCARDI OLOGY	0	_	1			69.00
	07000 ELECTROENCEPHALOGRAPHY	0	_	•			70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT			•			71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS			1			72. 00 73. 00
	03630 ULTRA SOUND			1			76.00
	03951 PAIN CLINIC			•			76. 00
	03952 CATH LAB		_				76. 02
	03953 ACTIVITY THERAPEUTIC			1			76. 02
	03954 WOUND CARE CENTER		1	1			76. 04
	03340 BARI ATRI C CLI NI C		_				76. 05
	03030 HEALTHY LIVING CENTER	1	Ö	l .			76. 06
	03950 CV RESOURCE CENTER		Ö				76. 07
	03955 OTHER ANCILLARY SERVICE COST CENTERS		0				76. 08
	03956 LACTATION CLINIC	0	0				76. 09
76. 10	03957 OTHER ANCILLARY SERVICE COST CENTERS	0	0				76. 10
76. 11	03958 OTHER ANCILLARY SERVICE COST CENTERS	0	0				76. 11
	03959 ANTI COAGULATI ON CLINIC	0	0				76. 12
	OUTPATIENT SERVICE COST CENTERS						
91 00	09100 FMFRGFNCY	0	0				91.00

0 0 0 0

0

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113

91. 00

92. 00 200. 00

201. 00

202. 00

91. 00 09100 EMERGENCY

200.00

201.00

202.00

92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART

Subtotal (see instructions)
Less PBP Clinic Lab. Services-Program

Only Charges Net Charges (line 200 - line 201)

Heal th	Financial Systems	FRANCISCAN HE	ALTH- DYER		In Lie	u of Form CMS-2	2552-10
APP0R1	FIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der Co	CN: 15-0090	Peri od:	Worksheet D	
					From 01/01/2021	Part V	
					To 12/31/2021	Date/Time Pre 5/30/2022 7:5	pared:
			T: +1	o VIV	Hooni tol		в рііі
			11 (1	e XIX	Hospi tal	Cost	
	Cook Cooks Doors at the	0+ +- 0	DDC Dailed	Charges	0+	Costs	
	Cost Center Description	Cost to Charge			Cost	PPS Services	
			Services (see		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.)			
		1.00	2. 00	3.00	(see inst.) 4.00	5. 00	
	ANCILLARY SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
50. 00	05000 OPERATING ROOM	0. 098787	6, 446, 303		0 0	636, 811	50.00
50. 00	05001 OUTPATI ENT SURGERY	0. 589278	368, 986		0 0	217, 435	
51. 00	05100 RECOVERY ROOM	0. 170962	888, 768	1	0 0	151, 946	
		1					
53.00	05300 ANESTHESI OLOGY	0. 232658	1, 481, 893	1	-	344, 774	
54.00	05400 RADI OLOGY - DI AGNOSTI C	0. 088754	3, 082, 640	1	0 0	273, 597	
54. 01	05401 RADI OLOGY-SPECI AL PROCEDURES	0. 171158	214, 199	1	0 0	36, 662	
55. 00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	0	1	0 0	0	
56. 00	05600 RADI OI SOTOPE	0. 101619	413, 964		0 0	42, 067	1
60. 00	06000 LABORATORY	0. 132057	3, 380, 178	1	0	446, 376	
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 121241	51, 184	1	0	6, 206	
65.00	06500 RESPI RATORY THERAPY	0. 353332	63, 364	1	0	22, 389	
66. 00	06600 PHYSI CAL THERAPY	0. 436777	4, 043, 273		0	1, 766, 009	
67. 00	06700 OCCUPATI ONAL THERAPY	0. 241237	9, 504	1	0	2, 293	
68. 00	06800 SPEECH PATHOLOGY	0. 224815	174, 686	1	0	39, 272	
69. 00	06900 ELECTROCARDI OLOGY	0. 079904	745, 657		0	59, 581	
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 165746	561, 283		0	93, 030	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 390349	19	1	0 0	7	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 692264	0)	0 0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 273108	765, 255	i	0 0	208, 997	73. 00
76.00	03630 ULTRA SOUND	0. 072463	711, 551		0 0	51, 561	76. 00
76. 01	03951 PAIN CLINIC	0. 227862	1, 179, 656	,	0 0	268, 799	76. 01
76. 02	03952 CATH LAB	0. 061954	2, 309, 831		0 0	143, 103	76. 02
76. 03	03953 ACTIVITY THERAPEUTIC	0. 758373	126, 458	1	0 0	95, 902	76. 03
76. 04	03954 WOUND CARE CENTER	0. 338628	139, 378	1	0 0	47, 197	76. 04
76. 05	03340 BARI ATRI C CLI NI C	0. 694360	197, 978	1	0 0	137, 468	76. 05
76. 06	03030 HEALTHY LIVING CENTER	0. 000000	0	1	0 0	0	76. 06
76. 07	03950 CV RESOURCE CENTER	0. 000000	0)	0 0	0	76. 07
76. 08	03955 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000	0)	0 0	0	76. 08
76. 09	03956 LACTATION CLINIC	0. 000000	0	,	0 0	0	76. 09
76. 10	03957 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000	0	1	0 0	0	76. 10
76. 11	03958 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000	0	,	0 0	0	76. 11
76. 12	03959 ANTI COAGULATI ON CLINIC	0. 613892	18, 546		0 0	11, 385	
70. 12	OUTPATIENT SERVICE COST CENTERS	0.013072	10, 540	1	0 0	11, 303	70.12
91. 00	09100 EMERGENCY	0. 126884	3, 709, 123		0 0	470, 628	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 120884	5, 709, 123 A	J	0 0		92.00
200.00	,	0. 374217	31, 083, 677		0 0		
200.00	,	1	31,003,077	1		3, 373, 473	201.00
201.00	Only Charges			1	٦		201.00
202.00			31, 083, 677		0 0	5, 573, 495	202 00
202.00	, 1 Shar gos (11110 200 11110 201)	1 1	01,000,011	I .	٥,	0, 0, 0, 4, 0	1-32. 00

Title XIX Hospital Cost					From 01/01/2021 To 12/31/2021	Part V Date/Time Pre 5/30/2022 7:5	
Cost Cost Cost Cost Cost Cost Rel imbursed Services Subject To Ded. & Coins. Cost C			Ti tl	e XIX	Hospi tal		о рііі
Cost Center Description		Cos					
Reinbursed Services Not South Color Not No	Cost Center Description	Cost	Cost				
ANCILLARY SERVICE COST CENTERS	, and the second	Rei mbursed	Rei mbursed				
Ded. & Colns. See Inst.		Servi ces	Services Not				
See inst. See		Subject To	Subject To				
ANCILLARY SERVICE COST CENTERS		Ded. & Coins.	Ded. & Coins.				
ANCILLARY SERVICE COST CENTERS		(see inst.)	(see inst.)				
50.00		6.00	7. 00				
50.01 05001 017471 ENT SURGERY 0 0 0 51.00 05.10 06.00 65.00 05.10 05.00 05.							
51.00 05100 RECOVERY ROOM 0 0 0 0 0 0 0 0 0		0	0				50. 00
53.00 05300 ADSTHESI OLOGY 0 0 53.00 54.01 05400 RADIOLOGY-SPECIAL PROCEDURES 0 0 0 54.01 05401 RADIOLOGY-SPECIAL PROCEDURES 0 0 0 55.00 05500 RADIOLOGY-THERAPEUTI C 0 0 0 55.00 05500 RADIOLOGY-THERAPEUTI C 0 0 0 60.00 06000 06000 06000 06000 0	50. 01 05001 0UTPATI ENT SURGERY	0	0				50. 01
54. 00 05400 RADI OLOCY-DI CARNOSTI C 0 0 54. 01 54. 01 05500 RADI OLOCY-SPECIAL PROCEDURES 0 0 0 54. 01 55. 00 05500 RADI OLOCY-SPECIAL PROCEDURES 0 0 0 0 55. 00 56. 00 05500 RADI OLOCY-SPECIAL PROCEDURES 0 0 0 0 0 56. 00 05600 RADI OLOCY-SPECIAL PROCEDURES 0 0 0 0 56. 00 05600 RADI OLOCY-SPECIAL PROCEDURES 0 0 0 0 66. 00 05600 CABORATORY 0 0 0 0 66. 00 06600 LABORATORY THERAPY 0 0 0 0 66. 00 06600 RESPIRATORY THERAPY 0 0 0 0 67. 00 06700 OCCUPATI ONAL THERAPY 0 0 0 0 68. 00 06800 SPECH PATHOLOGY 0 0 0 0 69. 00 06900 LECETROCEADI OLOCY 0 0 0 0 69. 00 06900 LECETROCEADI OLOCY 0 0 0 69. 00 06900 LECETROCEADI OLOCY 0 0 0 69. 00 07000 LECETROCEADI OLOCY 0 0 0 69. 00 07000 LECETROCEADI OLOCY 0 0 0 69. 00 07000 OLOCUPATI LES CHARGED TO PATI ENT 0 0 0 71. 00 07100 IMPL. DEV. CHARGED TO PATI ENT 0 0 72. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 73. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 74. 00 74. 01 03951 PAI N CLINIC 0 0 76. 00 75. 01 03952 CATH LAB 0 0 76. 00 76. 02 03952 CATH LAB 0 0 0 76. 03 03953 ACTI VI TY THERAPEUTI C 0 0 76. 00 76. 04 03954 MOUND CARE CENTER 0 0 76. 00 76. 08 03955 OTHER ANCI LLARY SERVICE COST CENTERS 0 0 76. 00 76. 00 03950 CV RESOURCE CENTERS 0 0 0 76. 10 03959 AUTITAL OLINIC 0 0 76. 00 76. 10 03959 OTHER ANCI LLARY SERVICE COST CENTERS 0 0 0 76. 10 03959 OTHER ANCI LLARY SERVICE COST CENTERS 0 0 0 76. 10 03959 OTHER ANCI LLARY SERVICE COST CENTERS 0 0 0 76. 10 03959 OTHER ANCI LLARY SERVICE COST CENTERS 0 0 0 76. 10 03959 OTHER ANCI LLARY SERVICE COST CENTERS 0 0 0 76. 10 03959 OTHER ANCI LLARY SERVICE COST CENTERS 0 0 0 76. 10 03959 OTH	51.00 05100 RECOVERY ROOM	0	0				51.00
54. 01 05401 RADI 0.0CY -SPECI AL PROCEDURES 0 0 0 55. 00 05500 RADI 0.0CY -THERAPEUTI C 0 0 0 0 0 0 0 0 0	53. 00 05300 ANESTHESI OLOGY	0	0				53. 00
55. 00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 0 0 0 0 0 0	54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
56. 00 05600 RADI OI SOTOPE 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	54. 01 05401 RADI OLOGY-SPECI AL PROCEDURES	0	0				54. 01
60. 00 06000 LABORATORY 0 0 0 0 63.00 65.00 06500 RESPIRATORY THERAPY 0 0 0 0 65.00 06500 RESPIRATORY THERAPY 0 0 0 0 65.00 06500 RESPIRATORY THERAPY 0 0 0 0 66.00 066.00 06600 PHYSI CAL THERAPY 0 0 0 0 0 66.00 066.00 06600 PHYSI CAL THERAPY 0 0 0 0 0 66.00 066	55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0				55. 00
63. 00 06300 BLODD STORING, PROCESSING & TRANS. 0 0 0 0 0 0 0 0 0	56. 00 05600 RADI 0I SOTOPE	0	0				56. 00
65. 00 06500 RESPIRATORY THERAPY 0 0 0 066. 00 66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 67. 00 06700 0CCUPATI ONAL THERAPY 0 0 0 68. 00 06800 SPEECH PATHOLOGY 0 0 0 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 69. 00 07000 ELECTROCARDI OLOGY 0 0 0 70. 00 07000 ELECTROCARDI OLOGY 0 0 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 0 0 72. 00 07200 MPLD DEV. CHARGED TO PATI ENTS 0 0 0 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 74. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 75. 00 03630 ULTRA SOUND 0 0 0 76. 01 03951 PAIN CLINIC 0 0 0 76. 02 03952 CATH LAB 0 0 0 76. 03 03953 ACTI VI TY THERAPEUTI C 0 0 0 76. 04 03954 WOUND CARE CENTER 0 0 0 76. 04 03954 WOUND CARE CENTER 0 0 0 76. 06 03030 BARI ATRI C CLINIC 0 0 0 76. 07 03950 CV RESOURCE CENTER 0 0 0 76. 08 03955 OTHER ANCILLARY SERVICE COST CENTERS 0 0 76. 09 03955 OTHER ANCILLARY SERVICE COST CENTERS 0 0 76. 10 03959 ATTHOR ANCILLARY SERVICE COST CENTERS 0 0 76. 11 03959 ATTHOR ANCILLARY SERVICE COST CENTERS 0 0 76. 12 03959 ATTHOR ANCILLARY SERVICE COST CENTERS 0 0 76. 11 03959 OTHER ANCILLARY SERVICE COST CENTERS 0 0 76. 12 04959 ANTICOAGULATION CLINIC 0 0 76. 10 09100 DERREGENCY 0 0 77. 10 09100 DERREGENC	60. 00 06000 LABORATORY	0	0				60.00
66. 00	63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0				63. 00
67. 00 66700 OCCUPATIONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDIOLOGY 70. 00 07000 ELECTROCARDIOLOGY 70. 00 07000 ELECTROENCEPHALLOGRAPHY 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 72. 00 07300 DRUGS CHARGED TO PATIENTS 73. 00 07300 DRUGS CHARGED TO PATIENTS 74. 00 07300 DRUGS CHARGED TO PATIENTS 75. 00 07300 DRUGS CHARGED TO PATIENTS 76. 00 03630 ULTRA SOUND 76. 01 03951 PAIN CLINIC 76. 02 03952 CATH LAB 76. 03 03953 ACTIVITY THERAPEUTIC 76. 04 03954 WOUND CARE CENTER 76. 04 03954 WOUND CARE CENTER 76. 05 03340 BARI ATRIC CLINIC 76. 06 03030 HEALTHY LIVING CENTER 76. 07 03950 CV RESOURCE CENTER 76. 08 03955 OTHER ANCILLARY SERVICE COST CENTERS 76. 09 03956 LACTATION CLINIC 76. 10 03957 OTHER ANCILLARY SERVICE COST CENTERS 76. 10 03958 OTHER ANCILLARY SERVICE COST CENTERS 76. 10 03959 OTHER ANCILLARY SERVICE COST CENTERS 76. 11 03959 OTHER ANCILLARY SERVICE COST CENTERS 76. 12 000000 DEBERGENCY 76. 10 000000 DEBERGENCY 76. 10 0000000 DEBERGENCY 76. 10 0000000000000000000000000000000000	65. 00 06500 RESPIRATORY THERAPY	0	0				65. 00
68. 00 06800 SPECH PATHOLOGY 0 0 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 70. 00 07000 ELECTROCARDI OLOGY 0 0 0 71. 00 07000 ELECTROCARDI OLOGY 0 0 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0 0 0 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 76. 00 03630 ULTRA SOUND 0 0 0 76. 01 03951 PAIN CLINIC 0 0 0 76. 02 03952 CATH LAB 0 0 76. 03 03953 ACTIVITY THERAPEUTIC 0 0 0 76. 04 03954 WOUND CARE CENTER 0 0 0 76. 05 03340 BARIATRI C CLINIC 0 0 0 76. 06 03030 HEALTHY LIVING CENTER 0 0 0 76. 07 03950 CV RESOURCE CENTER 0 0 0 76. 08 03955 CV RESOURCE CENTER 0 0 0 76. 09 03956 LACTATION CLINIC 0 0 76. 10 03959 ANTICOAGULATION CLINIC 0 0 76. 11 03959 ANTICOAGULATION CLINIC 0 0 76. 12 00TPATIENT SERVICE COST CENTERS 0 0 76. 12 00TPATIENT SERVICE COST CENTERS 0 0 79. 00 09200 0SERNATION BEDS (NON-DISTINCT PART 0 0 70010 CLESS PBP CLINIC Lab. Services-Program 0 7010 Only Charges 0 7010 00 00 00 7010 00 00	66. 00 06600 PHYSI CAL THERAPY	0	0				66. 00
69. 00 06900 ELECTROCARDIOLOGY	67. 00 06700 OCCUPATI ONAL THERAPY	0	0				67. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 71. 00 771. 00 771. 00 771. 00 7710 MEDI CAL SUPPLIES CHARGED TO PATIENT 0 0 0 720. 00 7200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 720. 00 730. 00 730. 00 730. 00 730. 00 DRUGS CHARGED TO PATIENTS 0 0 0 0 73. 00 730. 00 0730. 00 ULTRA SOUND 0 0 0 0 76. 00 76. 00 76. 00 76. 01 03951 PAIN CLINIC 0 0 0 0 76. 01 76. 01 76. 02 76. 03 03952 CATH LAB 0 0 0 0 0 76. 01 76. 02 76. 03 03953 ACTIVITY THERAPEUTIC 0 0 0 0 76. 03 03953 ACTIVITY THERAPEUTIC 0 0 0 0 0 76. 03 03953 ACTIVITY THERAPEUTIC 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	68. 00 06800 SPEECH PATHOLOGY	0	0				68. 00
71. 00	69. 00 06900 ELECTROCARDI OLOGY	0	0				69. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 0	70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0				70. 00
73. 00	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0				71. 00
76. 00	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72. 00
76. 01	73.00 07300 DRUGS CHARGED TO PATIENTS	0	0				73. 00
76. 02	76.00 03630 ULTRA SOUND	0	0				76. 00
76. 03 03953 ACTIVITY THERAPEUTIC 0 0 0 76. 03 76. 04 03954 WOUND CARE CENTER 0 0 0 0 76. 04 76. 05 03340 BARI ATRIC CLINIC 0 0 0 0 76. 06 76. 06 03030 HEALTHY LIVING CENTER 0 0 0 76. 06 76. 06 76. 07 03950 CV RESOURCE CENTER 0 0 0 0 76. 07 76. 08 03955 OTHER ANCILLARY SERVICE COST CENTERS 0 0 0 76. 09 76. 09 76. 10 03956 LACTATION CLINIC 0 0 0 76. 09 76. 11 03958 OTHER ANCILLARY SERVICE COST CENTERS 0 0 0 76. 11 76. 11 03958 OTHER ANCILLARY SERVICE COST CENTERS 0 0 0 76. 11 76. 12 03959 ANTICOAGULATION CLINIC 0 0 0 76. 12 00TPATIENT SERVICE COST CENTERS 0 0 0 76. 12 00TPATIENT SERVICE COST CENTERS 0 0 0 0 76. 12 00TPATIENT SERVICE COST CENTERS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	76. 01 03951 PALN CLINIC	0	0				76. 01
76. 04	76. 02 03952 CATH_LAB	0	0				76. 02
76. 05 76. 06 76. 06 76. 07 76. 08 76. 07 76. 08 76. 09 76. 09 76. 09 76. 09 76. 09 76. 09 76. 00 76. 10 76. 11 76. 12 76	76. 03 03953 ACTI VI TY THERAPEUTI C	0	0				76. 03
76. 06 03030 HEALTHY LIVING CENTER 0 0 0 0 0 0 0 0 0 0 0	76.04 03954 WOUND CARE CENTER	0	0				76. 04
76. 07 76. 08 76. 09 76. 09 76. 09 76. 09 76. 09 76. 10 76. 10 76. 11 76. 12 76. 12 00 00 00 00 00 00 00 00 00 00 00 00 00	76. 05 03340 BARI ATRI C CLI NI C	0	0				76. 05
76. 08	76.06 03030 HEALTHY LIVING CENTER	0	0				76. 06
76. 09	76. 07 03950 CV RESOURCE CENTER	0	0				76. 07
76. 10 76. 10 76. 11 76. 12 03958 OTHER ANCI LLARY SERVI CE COST CENTERS 0 0 0 76. 11 76. 12 03959 ANTI COAGULATI ON CLI NI C 0 09100 EMERGENCY 91. 00 92. 00 92. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 200. 00 201. 00 Less PBP Cli ni c Lab. Servi ces-Program 0 0 0 0 0010 Center Anci LLARY SERVI CE COST CENTERS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	76.08 03955 OTHER ANCILLARY SERVICE COST CENTERS	0	0				76. 08
76. 11 76. 12 03959 ANTI COAGULATI ON CLI NI C 0UTPATI ENT SERVI CE COST CENTERS 91. 00 92. 00 92. 00 920. 00 Subtotal (see instructions) 201. 00 Less PBP Cli ni c Lab. Servi ces-Program Onl y Charges 76. 11 76. 12 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	76. 09 03956 LACTATI ON CLINI C	0	0				76. 09
76. 12 03959 ANTI COAGULATI ON CLINI C 0 0 0 76. 12 0UTPATI ENT SERVI CE COST CENTERS 91. 00 09100 EMERGENCY 0 0 92.00 0BSERVATI ON BEDS (NON-DI STINCT PART 0 0 92.00 200.00 Subtotal (see instructions) 0 0 0 201.00 Less PBP Clinic Lab. Servi ces-Program 0 0nl y Charges	76. 10 03957 OTHER ANCILLARY SERVICE COST CENTERS	0	0				76. 10
OUTPATIENT SERVICE COST CENTERS 91.00 92.00 92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART 0 0 0 0 0 0 0 0 0	76. 11 03958 OTHER ANCILLARY SERVICE COST CENTERS	0	0				76. 11
91. 00	76. 12 03959 ANTI COAGULATI ON CLINIC	0	0				76. 12
92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	OUTPATIENT SERVICE COST CENTERS						
200.00 Subtotal (see instructions) 0 0 0 201.00 Less PBP Clinic Lab. Services-Program 0 0 0 1 0 0 0 1 0 0 0 0 0 0 0 0 0 0 0	91. 00 09100 EMERGENCY	0	0				91.00
201.00 Less PBP Ĉlinic Lab. Servićes-Program 0 201.00 Only Charges	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0				92.00
Only Charges	200.00 Subtotal (see instructions)	0	0				200.00
	201.00 Less PBP Clinic Lab. Services-Program	0					201.00
202.00 Net Charges (line 200 - line 201) 0 0 202.00	Only Charges	1					
	202.00 Net Charges (line 200 - line 201)	0	0				202. 00

		55.W01.00.W1.W				6.5	
	Financial Systems TONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	FRANCISCAN HE		ON 15 0000		eu of Form CMS-:	2552-10
APPURI	TUNMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L C0515	Provi der C	CN: 15-0090	Period: From 01/01/2021	Worksheet D Part II	
			Component	CCN: 15-T090	To 12/31/2021	Date/Time Pre 5/30/2022 7:5	pared: 8 pm
				e XIX	Subprovi der - I RF	TEFRA	
	Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
		Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
		(from Wkst. B,		(col . 1 ÷ co	I. Charges	column 4)	
		Part II, col.	8)	2)			
		26)					
	TANGLEL ARY OF BUILDING COOK OF STATE DO	1.00	2. 00	3.00	4. 00	5. 00	
F0 00	ANCILLARY SERVICE COST CENTERS	750.000	FF 004 07/	0.0407	00		F0 00
50.00	05000 OPERATI NG ROOM	758, 323		0. 0136		0	
50. 01	05001 OUTPATI ENT SURGERY	398, 559		0. 1011		0	
51.00	05100 RECOVERY ROOM	169, 442	6, 206, 494			0	51.00
53.00	05300 ANESTHESI OLOGY	57, 419		1		0	
54.00	05400 RADI OLOGY - DI AGNOSTI C	1, 055, 528		1		0	
54. 01	05401 RADI OLOGY-SPECI AL PROCEDURES	61, 158				0	
55. 00 56. 00	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE	180, 461	0 11, 921, 314	0.0000		0	
60.00	06000 LABORATORY	256, 683		1		0	
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	77, 875	1, 968, 858	1		0	63.00
65. 00	06500 RESPIRATORY THERAPY	121, 832	9, 672, 912			0	65. 00
66. 00	06600 PHYSI CAL THERAPY	142, 857	20, 801, 019	1		0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	27, 285		1		0	1
68. 00	06800 SPEECH PATHOLOGY	11, 195		1		0	
69. 00	06900 ELECTROCARDI OLOGY	182, 402	22, 665, 133	1		Ö	
70. 00	07000 ELECTROENCEPHALOGRAPHY	147, 322	4, 106, 033	1		Ö	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	98, 571	28, 545, 969	1		Ō	1
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	91, 645		1		0	1
73.00	07300 DRUGS CHARGED TO PATIENTS	168, 907	33, 559, 618			0	73. 00
76.00	03630 ULTRA SOUND	98, 717	12, 974, 892	0.0076	08 0	0	76. 00
76. 01	03951 PAIN CLINIC	344, 172	8, 859, 247	0. 0388	49 0	0	76. 01
76. 02	03952 CATH LAB	487, 085	63, 559, 890	0. 0076	63 0	0	76. 02
76. 03	03953 ACTIVITY THERAPEUTIC	191, 399	5, 366, 596	0. 0356	65 0	0	76. 03
76. 04	03954 WOUND CARE CENTER	175, 855	2, 463, 181		93 0	0	76. 04
76. 05	03340 BARI ATRI C CLI NI C	74, 155	2, 977, 476			0	1
76. 06	03030 HEALTHY LIVING CENTER	0	0	0.0000	00 0	0	76. 06
76. 07	03950 CV RESOURCE CENTER	276	0	0.0000		0	76. 07
76. 08	03955 OTHER ANCILLARY SERVICE COST CENTERS	1, 326	0	0.0000		0	
76. 09	03956 LACTATION CLINIC	0	0	0.0000		0	
76. 10	03957 OTHER ANCILLARY SERVICE COST CENTERS	0	0			0	
76. 11	03958 OTHER ANCILLARY SERVICE COST CENTERS	0	0			0	
76. 12	03959 ANTI COAGULATI ON CLINI C OUTPATI ENT SERVI CE COST CENTERS	17, 631	1, 134, 132	0. 0155	46 0	0	76. 12
91. 00	09100 EMERGENCY	569, 878	59, 125, 161	0.0096	39 0	0	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	8, 265, 504				
200.00	1	5, 967, 958		1	0		200. 00

	LONDENT OF INDATIENT/OUTDATIENT ANGLILADY OFF		ALTH- DYER	ON 45 0000		W I I I D	2552-10
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER SH COSTS	WICE UTHER PASS	Provi der Co	JN: 15-0090	Peri od: From 01/01/2021	Worksheet D Part IV	
IHKUUC	in COSTS		Component	CCN: 15-T090	To 12/31/2021	Date/Time Pre 5/30/2022 7:5	
			Ti tl	e XIX	Subprovi der - I RF	TEFRA	
	Cost Center Description	Non Physician	Nursi ng	Nursi ng		Allied Health	
		Anesthetist	Program	Program	Post-Stepdown		
		Cost	Post-Stepdown		Adjustments		
		1.00	Adjustments	2.00	2.4	2.00	
	ANCILLARY CERVICE COCT CENTERS	1.00	2A	2.00	3A	3. 00	
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	0	0	I	0 0	0	50.00
50. 00	05000 OPERATING ROOM 05001 OUTPATIENT SURGERY	0	0				
51. 00	05100 RECOVERY ROOM		0		0 0	0	
53.00	05300 ANESTHESI OLOGY		0		0 0	0	
54. 00	05400 RADI OLOGY-DI AGNOSTI C		0		0 0	0	
54. 01	05401 RADI OLOGY-SPECI AL PROCEDURES		0		0 0	0	
55. 00	05500 RADI OLOGY-THERAPEUTI C		0		0 0	Ö	
56. 00	05600 RADI OI SOTOPE		0		0 0	Ö	
50.00	06000 LABORATORY		0		0 0	Ö	
53. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 0	Ö	
55.00	06500 RESPIRATORY THERAPY	0	0		0 0	ő	
56. 00	06600 PHYSI CAL THERAPY	o	0		0 0	0	1
57. 00	06700 OCCUPATI ONAL THERAPY	o	0		0 0	o o	
58. 00	06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
59. 00	06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	o	0		0 0	0	71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	o	0		0 0	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	o	0		0 0	0	73.00
76. 00	03630 ULTRA SOUND	0	0		0 0	0	76.00
76. 01	03951 PAIN CLINIC	0	0		0 0	0	76. 01
76. 02	03952 CATH LAB	0	0		0 0	0	76. 02
76. 03	03953 ACTIVITY THERAPEUTIC	0	0		0 0	0	
76. 04	03954 WOUND CARE CENTER	0	0		0 0	0	
76. 05	03340 BARI ATRI C CLI NI C	0	0		0 0	0	
76. 06	03030 HEALTHY LIVING CENTER	0	0		0 0	0	
76. 07	03950 CV RESOURCE CENTER	0	0		0 0	0	1
76. 08	03955 OTHER ANCILLARY SERVICE COST CENTERS	0	0		0 0	0	
76. 09	03956 LACTATION CLINIC	0	0		0 0	0	
76. 10	03957 OTHER ANCILLARY SERVICE COST CENTERS	0	0		0 0	0	1
76. 11	03958 OTHER ANCILLARY SERVICE COST CENTERS	0	0		0 0		
76. 12	03959 ANTI COAGULATI ON CLI NI C	0	0	L	0 0	0	76. 12
11 00	OUTPATIENT SERVICE COST CENTERS				0 0	0	01 00
91.00	O9100 EMERGENCY O9200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0 0		
92. 00 200. 00	,	0	0		0 0		200.00

Heal th Financial Systems	FRANCISCAN H		ON 45 0000		eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY S	ERVICE OTHER PAS	S Provider C	CN: 15-0090	Peri od: From 01/01/2021	Worksheet D Part IV	
THROUGH COSTS		Component	CCN: 15-T090	To 12/31/2021		nared·
					5/30/2022 7:5	8 pm
		Ti tl	e XIX	Subprovi der -	TEFRA	
	111 011	T		I RF		
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpatient	(from Wkst. C,	to Charges	
	Education Cost		Cost (sum of		(col. 5 ÷ col.	
		4)	col s. 2, 3, and 4)	8)	7) (see	
			and 4)		instructions)	
	4.00	5.00	6. 00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS	11.00	0.00	0.00	7.00	0.00	
50. 00 05000 OPERATI NG ROOM	0	C)	0 55, 384, 376	0.000000	50.00
50. 01 05001 OUTPATIENT SURGERY	0	0)	0 3, 938, 374		
51.00 05100 RECOVERY ROOM	0	l c	1	0 6, 206, 494	0.000000	51.00
53. 00 05300 ANESTHESI OLOGY	0	o c	,	0 15, 273, 636	0.000000	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	l c	1	0 56, 124, 108	0.000000	54. 00
54. 01 05401 RADI OLOGY-SPECI AL PROCEDURES	0	l c	1	0 5, 725, 580		54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	l c	1	0 0	0.000000	55. 00
56. 00 05600 RADI 0I SOTOPE	0	O)	0 11, 921, 314	0.000000	56. 00
60. 00 06000 LABORATORY	0	l c	1	0 60, 378, 672	0.000000	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0)	0 1, 968, 858	0.000000	63. 00
65. 00 06500 RESPIRATORY THERAPY	0	0)	0 9, 672, 912	0.000000	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0)	0 20, 801, 019	0.000000	66. 00
67. 00 06700 OCCUPATIONAL THERAPY	0	0)	0 4, 943, 375	0.000000	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0)	0 2, 980, 712	0.000000	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0)	0 22, 665, 133	0.000000	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	C)	0 4, 106, 033	0. 000000	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	1	0 28, 545, 969	0.000000	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0)	0 15, 364, 960		
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0)	0 33, 559, 618		73. 00
76. 00 03630 ULTRA SOUND	0	0)	0 12, 974, 892		
76. 01 03951 PAIN CLINIC	0	0)	0 8, 859, 247	0. 000000	1
76. 02 03952 CATH LAB	0	0		0 63, 559, 890		
76. 03 03953 ACTI VI TY THERAPEUTI C	0	0	1	0 5, 366, 596		
76. 04 03954 WOUND CARE CENTER	0	0	1	0 2, 463, 181	0. 000000	
76. 05 03340 BARI ATRI C CLI NI C	0	0		0 2, 977, 476		
76.06 03030 HEALTHY LIVING CENTER	0	0		0	0. 000000	
76. 07 03950 CV RESOURCE CENTER	0	0		0	0. 000000	1
76. 08 03955 OTHER ANCILLARY SERVICE COST CENTERS	0	0		0 0	0. 000000	
76. 09 03956 LACTATION CLINIC	0	0		0 0	0.000000	
76. 10 03957 OTHER ANCILLARY SERVICE COST CENTERS	0	0		0 0	0.000000	
76. 11 03958 OTHER ANCILLARY SERVICE COST CENTERS	0	_	1	0 0	0.000000	
76. 12 03959 ANTI COAGULATI ON CLI NI C	0	0	1	0 1, 134, 132	0.000000	76. 12
91.00 O9100 EMERGENCY	0	0	1	0 59, 125, 161	0. 000000	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0 59, 125, 161 0 8, 265, 504		
200.00 Total (lines 50 through 199)				0 524, 287, 222		200.00
255. 50 10tal (11163 50 till bugil 177)	1	1	1	0 027, 201, 222	I	1200.00

	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER H COSTS	RVICE OTHER PASS	Component	CN: 15-0090 CCN: 15-T090	Peri od: From 01/01/2021 To 12/31/2021	Worksheet D Part IV Date/Time Pre 5/30/2022 7:5	
			Titl	e XIX	Subprovi der - I RF	TEFRA	
	Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
		Ratio of Cost to Charges	Program Charges	Program Pass-Throug	Program h Charges	Program Pass-Through	
		(col. 6 ÷ col.	chai ges	Costs (col.		Costs (col. 9	
		7)		x col . 10)	٥	x col . 12)	
		9.00	10.00	11.00	12.00	13.00	
	ANCILLARY SERVICE COST CENTERS	1.22					
50. 00	05000 OPERATI NG ROOM	0. 000000	C		0 0	0	50.00
50. 01	05001 OUTPATIENT SURGERY	0. 000000	C		0 0	0	50. 01
51. 00	05100 RECOVERY ROOM	0. 000000	C		0 0	0	51.00
53. 00	05300 ANESTHESI OLOGY	0. 000000	C		0 0	0	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	C		0 0	0	54.00
54. 01	05401 RADI OLOGY-SPECI AL PROCEDURES	0. 000000	C		0 0	0	54. 01
55. 00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	C		0 0	0	55.00
56. 00	05600 RADI 0I SOTOPE	0. 000000	C		0	0	56.00
60.00	06000 LABORATORY	0. 000000	C		0 0	0	60.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	C)	0	0	63.00
65. 00	06500 RESPI RATORY THERAPY	0. 000000	C	1	0	0	
66. 00	06600 PHYSI CAL THERAPY	0. 000000	C	1	0 0	0	
67. 00	06700 OCCUPATI ONAL THERAPY	0. 000000	C	1	0	0	
68. 00	06800 SPEECH PATHOLOGY	0. 000000	C	1	0 0	0	
69. 00	06900 ELECTROCARDI OLOGY	0. 000000	C	1	0 0	0	
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	C	1	0 0	0	
71.00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0.000000	C	1	0 0	0	71.00
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0. 000000 0. 000000	(1	0 0	0	72.00
73. 00 76. 00	03630 ULTRA SOUND	0. 000000	(0 0	0	
76. 00 76. 01	03951 PAIN CLINIC	0. 000000	(0 0	0	
76. 02	03952 CATH LAB	0. 000000		1		0	
76. 03	03953 ACTIVITY THERAPEUTIC	0. 000000	(1		0	
76. 04	03954 WOUND CARE CENTER	0. 000000	C			0	
76. 05	03340 BARI ATRI C CLI NI C	0. 000000	C	1	0 0	0	
76. 06	03030 HEALTHY LIVING CENTER	0. 000000	(0 0	0	76.06
76. 07	03950 CV RESOURCE CENTER	0. 000000	Č		0	0	76.07
76. 08	03955 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000	C	1		0	76. 08
76. 09	03956 LACTATION CLINIC	0. 000000	C		0 0	0	76. 09
76. 10	03957 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000	Č		0 0	0	76. 10
76. 11	03958 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000	C		0 0	0	
76. 12	03959 ANTI COAGULATI ON CLINIC	0. 000000	C		0 0	0	76. 12
	OUTPATIENT SERVICE COST CENTERS						
91. 00	09100 EMERGENCY	0. 000000	C		0 0	0	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	C		0 0	0	
200.00	Total (lines 50 through 199)	1	C	NI.	0 0		200.00

Health Financial Systems	FRANCISCAN HEALTH- DYER	In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15	-0090 Peri od: From 01/01/2021	Worksheet D-1	
		To 12/31/2021	Date/Time Pre 5/30/2022 7:5	pared: 8 pm
	Title XVII	I Hospi tal	PPS	
Cost Center Description				
			1. 00	
PART I - ALL PROVIDER COMPONENTS				
I NPATI ENT DAYS				
1.00 Inpatient days (including private room days	and swing-bed days, excluding newb	orn)	22, 294	1. 00
2 00 Innatient days (including private room days	excluding swing-hed and newhorn	days)	22 294	2 00

	Coot Contar Recepiation	I PPS	
	Cost Center Description	1. 00	
	PART I - ALL PROVIDER COMPONENTS	1.00	
	I NPATI ENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	22, 294	1.00
2. 00 3. 00	Inpatient days (including private room days, excluding swing-bed and newborn days) Private room days (excluding swing-bed and observation bed days). If you have only private room days,	22, 294 0	2. 00 3. 00
3.00	do not complete this line.	O	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	18, 447	4. 00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	0	5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6. 00
6.00	reporting period (if calendar year, enter 0 on this line)	U	0.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	0	7. 00
	reporting period		
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8. 00
9. 00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to the Program (excluding swing-bed and	7, 685	9. 00
7.00	newborn days) (see instructions)	,, 555	7.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10. 00
11. 00	through December 31 of the cost reporting period (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11. 00
11.00	December 31 of the cost reporting period (if calendar year, enter 0 on this line)	U	11.00
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	_	
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13. 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	ı
16. 00	Nursery days (title V or XIX only)	0	16. 00
17 00	SWING BED ADJUSTMENT	0.00	17. 00
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0.00	18. 00
	reporting period		
19. 00	Medical drate for swing-bed NF services applicable to services through December 31 of the cost	0. 00	19. 00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	0.00	20. 00
	reporting period		
21. 00	Total general inpatient routine service cost (see instructions)	28, 463, 018	
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5×1) x line 17)	0	22. 00
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	0	23. 00
	x line 18)		
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24. 00
25. 00	7 x line 19) Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25. 00
20.00	x line 20)	· ·	20.00
26. 00	Total swing-bed cost (see instructions)	0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	28, 463, 018	27. 00
28 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28. 00
	Pri vate room charges (excluding swing-bed charges)	0	
30.00	Semi -pri vate room charges (excluding swing-bed charges)	0	30. 00
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	1
32.00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	1
33. 00 34. 00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0. 00 0. 00	ı
35. 00	Average per diem private room cost differential (line 34 x line 31)	0.00	1
36. 00	Private room cost differential adjustment (line 3 x line 35)	0	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	28, 463, 018	37. 00
	27 minus line 36) 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, 276. 71	1
39. 00	Program general inpatient routine service cost (line 9 x line 38)	9, 811, 516	1
40. 00 41. 00	Medically necessary private room cost applicable to the Program (line 14 x line 35) Total Program general inpatient routine service cost (line 39 + line 40)	0 9, 811, 516	
- 1. 00	1 ocal in ognam general impatient routine service cost (Tille 37 + Tille 40)	7, 011, 310	1 -1.00

13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13. 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)		15. 00
16. 00	Nursery days (title V or XIX only)		16. 00
10.00	SWING BED ADJUSTMENT		10.00
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0.00	17. 00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0.00	18. 00
16.00	reporting period		
19. 00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0. 00	19. 00
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)	28, 463, 018	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	0	22. 00
22.00	5 x line 17)		22.00
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	0	23. 00
	x line 18)		
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24.00
	7 x line 19)		
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25.00
	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)	28, 463, 018	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-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		33.00
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	28, 463, 018	37.00
	27 minus line 36)		
	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, 276. 71	
39.00	Program general inpatient routine service cost (line 9 x line 38)	9, 811, 516	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)	9, 811, 516	41.00
	·	•	

<u>Heal th</u>	Financial Systems	FRANCISCAN HEA	ALTH- DYER		In Lie	eu of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der CC	CN: 15-0090	Peri od: From 01/01/2021	Worksheet D-1	
					To 12/31/2021		
			Title	XVIII	Hospi tal	5/30/2022 7: 5 PPS	8 pm_
	Cost Center Description	Total	Total	Average Per		Program Cost	
		Inpatient Cost	npatient Days		÷	(col. 3 x col.	
		1.00	2. 00	col . 2) 3.00	4. 00	4) 5. 00	
42. 00	NURSERY (title V & XIX only)	0	0	0.0	00 C	0	42. 00
43. 00	Intensive Care Type Inpatient Hospital Units	5, 497, 971	2, 591	2, 121. 9	95 849	1, 801, 536	43. 00
44. 00	CORONARY CARE UNIT	5, 497, 971	2, 391	2, 121. 9		1, 601, 536	•
45. 00	BURN INTENSIVE CARE UNIT		آ ۔				45. 00
46. 00		202 274	70	4 210 /	10		46.00
47.00	NEONATAL INTENSIVE CARE UNIT Cost Center Description	302, 364	70	4, 319. 4	[9] C	0	47. 00
	·					1. 00	
48. 00	Program inpatient ancillary service cost (Wk			`		14, 984, 802	48. 00
49.00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48)(S	see instruction	ns)		26, 597, 854	49.00
50.00	Pass through costs applicable to Program inp.	atient routine s	services (from	Wkst. D, sum	of Parts I and	1, 002, 580	50.00
F1 00		-+:+: ! !	! /6	WI+ D -	£ Dt- II	00/ 000	F1 00
51. 00	Pass through costs applicable to Program inpland IV)	attent ancillary	services (Tr	om wkst. D, S	sum or Parts II	826, 833	51. 00
52.00	Total Program excludable cost (sum of lines					1, 829, 413	52.00
53. 00	Total Program inpatient operating cost exclu		ated, non-phy	sician anesth	etist, and	24, 768, 441	53. 00
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					
	Program di scharges					0	54.00
	Target amount per discharge					0.00	•
56. 00 57. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operat	ing cost and tar	rget amount (Li	ine 56 minus	Line 53)	0	
58. 00	Bonus payment (see instructions)	ing oost and tar	got amount (i			0	
59. 00	Lesser of lines 53/54 or 55 from the cost re	porting period e	endi ng 1996, u	pdated and co	empounded by the	0.00	59. 00
60. 00	market basket Lesser of lines 53/54 or 55 from prior year	cost report. upo	lated by the ma	arket basket		0.00	60.00
61. 00	If line 53/54 is less than the lower of line				the amount by	0	1
	which operating costs (line 53) are less tha		(lines 54 x	60), or 1% of	the target		
62. 00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	instructions)				0	62. 00
	Allowable Inpatient cost plus incentive paym	ent (see instruc	tions)			0	63.00
44.00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Dosom	hor 21 of the	cost reporti	ng pariod (Saa	T 0	64. 00
64. 00	instructions)(title XVIII only)	ts through becen	iber 31 01 the	cost reporti	ng perrou (see		04.00
65. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decembe	er 31 of the c	ost reporting	period (See	0	65. 00
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	na costs (lina A	Minlus line 6	5)(+i+l_ Y\/II	Lonly) For	0	66. 00
00.00	CAH (see instructions)	ne costs (Title c	94 prus rine o	5)(title XVII	i only). Tol		00.00
67. 00	Title V or XIX swing-bed NF inpatient routing	e costs through	December 31 o	f the cost re	porting period	0	67. 00
68 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routing	e costs after De	cember 31 of	the cost reno	orting period	0	68. 00
00.00	(line 13 x line 20)	o dosts di toi be		the cost repe	a tring period		00.00
69. 00	Total title V or XIX swing-bed NF inpatient					0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facil	<u>_</u>					70.00
71. 00	Adjusted general inpatient routine service of						71.00
72.00	Program routine service cost (line 9 x line		(II: 14 II:	25)			72.00
73. 00 74. 00	Medically necessary private room cost application. Total Program general inpatient routine serv			ne 35)			73. 00 74. 00
75. 00	Capital-related cost allocated to inpatient	•		orksheet B, F	art II, column		75. 00
74 00	26, line 45)	no 2)					76. 00
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line	,					77.00
78. 00	Inpatient routine service cost (line 74 minu	s line 77)					78. 00
79.00	Aggregate charges to beneficiaries for exces Total Program routine service costs for comp.				ue lino 70)		79. 00 80. 00
80.00	Inpatient routine service costs for comp.		ısı ııııı tatıon	(IIIIe /8 MIN	ius IIIIe /9)		80.00
82. 00	Inpatient routine service cost limitation (I	ine 9 x line 81)					82. 00
83.00	Reasonable inpatient routine service costs (5)				83.00
84. 00 85. 00	Program inpatient ancillary services (see in Utilization review - physician compensation		ıs)				84. 00 85. 00
	Total Program inpatient operating costs (sum	of lines 83 thr					86. 00
07.00	PART IV - COMPUTATION OF OBSERVATION BED PASS					2.047	07.00
87. 00 88. 00	Total observation bed days (see instructions Adjusted general inpatient routine cost per		line 2)			3, 847 1, 276. 71	
	Observation bed cost (line 87 x line 88) (se	•	•			4, 911, 503	

Health Financial Systems	FRANCISCAN HE	ALTH- DYER		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2021		
				To 12/31/2021	Date/Time Prep 5/30/2022 7:58	
		Ti +Lo	XVIII	Hospi tal	PPS	э рііі
· · · · · · · · · · · · · · · · · · ·						
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	2, 565, 993	28, 463, 018	0. 09015	2 4, 911, 503	442, 782	90.00
91.00 Nursing Program cost	0	28, 463, 018	0.00000	0 4, 911, 503	0	91.00
92.00 Allied health cost	0	28, 463, 018	0.00000	0 4, 911, 503	0	92.00
93.00 All other Medical Education	O	28, 463, 018	0.00000	0 4, 911, 503	0	93. 00

Health Financial Systems	FRANCISCAN HEALTH- DYER	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0090		Worksheet D-1
	Component CCN: 15-T090	From 01/01/2021 To 12/31/2021	
	Title XVIII	Subprovi der -	PPS

Cost Center Description No.			Title XVIII	Subprovi der - I RF	PPS	
PART 1 - ALL PROVIDER COMPONENTS		Cost Center Description		1100	1.00	
INPATEENT DAYS		PART I - ALL PROVIDER COMPONENTS			1.00	
Impatient days (including private room days, excluding swing-bed and neberor days) 1.9 purisher room days (excluding swing-bed and observation bed days) 1.7 you have only private room days. 0.3 0.0 do not complete this line. 0.5 Somi-private room days (excluding swing-bed and observation bed days) 1.9 you have only private room days. 0.5 Somi-private room days (excluding swing-bed and observation bed days) 1.9 you have not reporting period 0.5 Somi-private room days. 0.5 Somi-private room da						
Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this lice. Use I use						
do not complete this line. 4. 00 Semi-private room days (sexcluding sening-head and observation bed days) through December 31 of the cost				ivate room days	•	
Total 'swing bed SNF 'type inpatient days' (including private room days) after December 31 of the cost operating period (if callendar year, enter 0 on this line) or caporting period or caporting period (if callendar year, enter 0 on this line) or caporting period (if callendar year, enter 0 on this line) or caporting period or caporting period (if callendar year, enter 0 on this line) or caporting period (if callendar year, enter 0 on this line) or caporting period (if callendar year, enter 0 on this line) or caporting period (if callendar year, enter 0 on this line) or caporting period (if callendar year, enter 0 on this line) or caporting period (if callendar year) or cap	3.00		ys). IT you have only pr	I vate 100m days,	O	3.00
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x line 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 0 25.00 x line 20) 26.00 Total swing-bed cost (see instructions) 0 26.00 Total swing-bed cost (see instructions) 0 26.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 11, 159,670 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 Semi-private room charges (excluding swing-bed charges) 0 29.00 31.00 General inpatient routine service cost/charge ratio (line 27 * line 28) 0.00000 31.00 General inpatient routine service cost/charge ratio (line 27 * line 28) 0.0000 31.00 32.00 Average private room per diem charge (line 30 * line 4) 0.00 32.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 0.00 34.00 Average per diem private room cost differential (line 34 x line 31) 0.00 35.00 Average per diem private room cost differential (line 34 x line 31) 0.00 35.00 Average per diem private room cost differential (line 34 x line 35) 0.00 Average linpatient routine service cost net of swing-bed cost and private room cost differential (line 11, 159, 670 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Agiusted general inpatient routine service cost per diem (see instructions) 7, 128, 303 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0, 40.00 40.00		1				
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x line 20) 26. 00 Total swing-bed cost (see instructions) 27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29. 00 Private room charges (excluding swing-bed charges) 30. 00 Semi-private room charges (excluding swing-bed charges) 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) 33. 00 Average semi-private room per diem charge (line 30 * line 4) 34. 00 Average per diem private room cost differential (line 32 minus line 33) (see instructions) 35. 00 Average per diem private room cost differential (line 34 x line 31) 36. 00 Private room cost differential adjustment (line 3 x line 35) 37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 11, 159, 670) 27. 00 PART II - HOSPITAL AND SUBPROVI DERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38. 00 Adjusted general inpatient routine service cost per diem (see instructions) 39. 00 Program general inpatient routine service cost (line 9 x line 38) 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40. 00	05 00					05.00
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37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) 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) Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 37.00 11, 159, 670 27.00 11, 159, 670 37.00 11, 159, 670 37.00 11, 159, 670 37.00 11, 159, 670 37.00		,	ne 31)		0.00	•
27 minus line 36) 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, 348.27 38.00 Program general inpatient routine service cost (line 9 x line 38) 7, 128, 303 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00			and private room cost di	fferential (line	0 11 150 670	
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1, 348. 27 38. 00 Program general inpatient routine service cost (line 9 x line 38) 7, 128, 303 39. 00 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40. 00	57.00	27 minus line 36)				37.00
38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,348.27 39.00 Program general inpatient routine service cost (line 9 x line 38) 7,128,303 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00			IOTUENTO			
39.00 Program general inpatient routine service cost (line 9 x line 38) 7, 128, 303 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00	30 00				1 2/0 27	30 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) 7,128,303 41.00	40.00	Medically necessary private room cost applicable to the Progra	am (line 14 x line 35)		0	40. 00
	41. 00	Total Program general inpatient routine service cost (line 39	+ line 40)		7, 128, 303	41.00

	Financial Systems	FRANCISCAN HEAD		0000		u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provider CCN: 15 Component CCN: 1	Fr	eriod: com 01/01/2021 o 12/31/2021	Worksheet D-1	narod:
			'			Date/Time Pre 5/30/2022 7:5	
			Title XVII		Subprovider - IRF	PPS	
	Cost Center Description	Total Inpatient CostIn	patient Days Diem	rage Per (col. 1 ÷ ol. 2)	Program Days	Program Cost (col. 3 x col. 4)	
42.00	NUDCEDY (+; +l o V & VI V only)	1.00	2.00	3.00	4. 00	5. 00	42. 00
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	j oj	U U	0.00	U	0	42.00
43. 00	INTENSIVE CARE UNIT	0	0	0.00	0	0	
44. 00 45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT	0	0	0. 00	0	0	44. 00 45. 00
46. 00	SURGI CAL INTENSIVE CARE UNIT						46. 00
47. 00	NEONATAL INTENSIVE CARE UNIT	0	0	0. 00	0	0	47. 00
	Cost Center Description					1. 00	
48. 00	Program inpatient ancillary service cost (Wks					3, 508, 365	1
49. 00	Total Program inpatient costs (sum of lines a PASS THROUGH COST ADJUSTMENTS	<u> </u>	,			10, 636, 668	49. 00
50. 00	Pass through costs applicable to Program inpa	atient routine se	ervices (from Wkst	D, sum o	of Parts I and	193, 927	50. 00
51. 00	Pass through costs applicable to Program inpa and IV)	atient ancillary	services (from Wk	st. D, sum	of Parts II	84, 285	51. 00
52. 00 53. 00	Total Program excludable cost (sum of lines ! Total Program inpatient operating cost exclud		ated, non-physicia	n anesthet	ist, and	278, 212 10, 358, 456	•
00.00	medical education costs (line 49 minus line !		p.i.ye. e. e		ara ara	.5,555,155	00.00
54. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54.00
55. 00	Target amount per discharge					0.00	
56. 00	Target amount (line 54 x line 55)				50)	0	56.00
57. 00 58. 00	Difference between adjusted inpatient operati Bonus payment (see instructions)	ing cost and targ	get amount (line 5	6 Minus II	ne 53)	0	57. 00 58. 00
59. 00	Lesser of lines 53/54 or 55 from the cost re	oorting period er	nding 1996, update	ed and comp	ounded by the	0.00	
40.00	market basket	and manage unde	stad by the market	. bookst		0.00	40.00
60. 00 61. 00	Lesser of lines 53/54 or 55 from prior year of line 53/54 is less than the lower of lines				e amount by	0.00	60. 00 61. 00
	which operating costs (line 53) are less that amount (line 56), otherwise enter zero (see	n expected costs					
62. 00	Relief payment (see instructions)	riisti ucti olis)				0	62. 00
63. 00	Allowable Inpatient cost plus incentive payme	ent (see instruct	i ons)			0	63. 00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cost	ts through Decemb	per 31 of the cost	reporting	period (See	0	64. 00
65. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after December	31 of the cost r	eporting p	eriod (See	0	65. 00
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	ne costs (line 64	l plus line 65)(ti	tle XVIII	only). For	0	66. 00
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routing	e costs through [ecember 31 of the	cost repo	orting period	0	67. 00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routing	e costs after Dec	cember 31 of the c	ost report	ing period	0	68. 00
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient :	routine costs (li	ne 67 + line 68)			0	69. 00
	PART III - SKILLED NURSING FACILITY, OTHER NU						
70. 00 71. 00	Skilled nursing facility/other nursing facili Adjusted general inpatient routine service co			line 37)			70. 00 71. 00
72. 00	Program routine service cost (line 9 x line		10 70 1 11110 2)				72. 00
73.00	Medically necessary private room cost applica	•		5)			73.00
74. 00 75. 00	Total Program general inpatient routine servi Capital-related cost allocated to inpatient	•	,	neet B, Par	t II, column		74. 00 75. 00
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 00
77. 00	Program capital-related costs (line 9 x line						77. 00
78. 00 79. 00	Inpatient routine service cost (line 74 minus Aggregate charges to beneficiaries for excess		ovi der records)				78. 00 79. 00
80. 00	Total Program routine service costs for compa	· · · · · ·		ne 78 minus	line 79)		80.00
81.00	Inpatient routine service cost per diem limit						81.00
82. 00 83. 00	Inpatient routine service cost limitation (li Reasonable inpatient routine service costs (· · · · · · · · · · · · · · · · · · ·	ı				82. 00 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
50.00	PART IV - COMPUTATION OF OBSERVATION BED PASS		,gii 00 <i>)</i>				
87.00	Total observation bed days (see instructions)		ino 2)			0 00	
88. 00 89. 00	Adjusted general inpatient routine cost per of Observation bed cost (line 87 x line 88) (see	•	THE 2)			0.00	89.00
		ŕ					

Health Financial Systems	FRANCISCAN HE	EALTH- DYER		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
				From 01/01/2021	D 1 /T' D	
		Component	CCN: 15-T090	To 12/31/2021	Date/Time Pre 5/30/2022 7:5	
		Title	XVIII	Subprovi der -	PPS	o piii
				I RF		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2. 00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	303, 582	11, 159, 670	0. 02720	0	0	90. 00
91.00 Nursing Program cost	0	11, 159, 670	0. 00000	0 0	0	91. 00
92.00 Allied health cost	0	11, 159, 670	0.00000	0 0	0	92.00
93.00 All other Medical Education	0	11, 159, 670	0. 00000	0 0	0	93. 00

Health Financial Systems	FRANCISCAN HEALTH- DYER	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0090	Peri od: From 01/01/2021	Worksheet D-1
	Component CCN: 15-T090	To 12/31/2021	Date/Time Prepared: 5/30/2022 7:58 pm
	Title XIX	Subprovi der -	TEFRA
		IRF	

		litie xix	I RF	TEFRA	
	Cost Center Description	<u> </u>	TRI	L	
	T			1. 00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days	s excluding newborn)		8, 277	1. 00
2. 00	Inpatient days (including private room days, excluding swing-			8, 277	2. 00
3.00	Private room days (excluding swing-bed and observation bed day		ivate room days,	0	3.00
	do not complete this line.				
4.00	Semi-private room days (excluding swing-bed and observation be		. 21 -6 +6	8, 277	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private roof reporting period	om days) through Decembe	r 31 or the cost	0	5. 00
6.00	Total swing-bed SNF type inpatient days (including private roo	om days) after December	31 of the cost	0	6. 00
	reporting period (if calendar year, enter 0 on this line)	- '			
7. 00	Total swing-bed NF type inpatient days (including private roor	n days) through December	31 of the cost	0	7. 00
8. 00	reporting period Total swing-bed NF type inpatient days (including private room	days) after December 3	1 of the cost	0	8. 00
8.00	reporting period (if calendar year, enter 0 on this line)	ii days) ai tei beceilibei 3	i or the cost	U	6.00
9.00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	615	9. 00
	newborn days) (see instructions)				
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or	nly (including private r	oom days)	0	10. 00
11. 00	through December 31 of the cost reporting period (see instructions). Swing-bed SNF type inpatient days applicable to title XVIII or	iions) Ny (includina nrivate r	nom days) after	0	11. 00
11.00	December 31 of the cost reporting period (if calendar year, er		days) arter	O	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX		e room days)	0	12.00
	through December 31 of the cost reporting period			_	
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX after December 31 of the cost reporting period (if calendar year)			0	13. 00
14. 00	Medically necessary private room days applicable to the Progra			0	14. 00
15. 00	Total nursery days (title V or XIX only)	dir (exer during swring bed	days)	-	15. 00
16.00	Nursery days (title V or XIX only)			10	16.00
	SWING BED ADJUSTMENT				
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	f the cost	0. 00	17. 00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0.00	18. 00
10.00	reporting period	arter becomber or or	the cost	0.00	10.00
19. 00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0.00	19. 00
	reporting period	6. 5			
20. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	s after December 31 of t	he cost	0.00	20. 00
21. 00	Total general inpatient routine service cost (see instructions	5)		11, 159, 670	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December		ing period (line	0	
	5 x line 17)			_	
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reportin	g period (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reporti	na period (line	0	24. 00
	7 x line 19)			_	
25. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25. 00
24 00	x line 20)			0	24 00
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost	Tine 21 minus line 26)		0 11, 159, 670	26. 00 27. 00
27.00	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT	(Trile 21 milles Trile 20)		11, 107, 070	27.00
28. 00	General inpatient routine service charges (excluding swing-bed	d and observation bed ch	arges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)			0	
30.00	Semi -pri vate room charges (excluding swing-bed charges)	1. 00)		0	30.00
31. 00 32. 00	General inpatient routine service cost/charge ratio (line 27 - Average private room per diem charge (line 29 ÷ line 3)	FII ne 28)		0. 000000 0. 00	
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
34. 00	Average per diem private room charge differential (line 32 min	nus line 33)(see instruc	tions)	0.00	
35. 00	Average per diem private room cost differential (line 34 x line		,	0.00	
36. 00	Private room cost differential adjustment (line 3 x line 35)			0	36.00
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	11, 159, 670	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	JSTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see			1, 348. 27	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line			829, 186	
40.00	Medically necessary private room cost applicable to the Program	•		0 0 104	
41. 00	Total Program general inpatient routine service cost (line 39	+ ITHE 40)		829, 186	41.00

	Financial Systems	FRANCISCAN HEA				u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provider CCN:	Fi	eriod: rom 01/01/2021	Worksheet D-1	
			Component CCN:			Date/Time Prep 5/30/2022 7:58	
			Title X	IX	Subprovi der - I RF	TEFRA	
	Cost Center Description	Total Inpatient CostIn	npatient Days Die	verage Per m (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
10.00	Indipositive Annual	1.00	2. 00	3. 00	4. 00	5. 00	10.00
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	0	0. 00	0	0	42. 00
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44. 00 45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT	0	0	0. 00	0	0	44. 00 45. 00
46.00	1			0.00			46.00
47.00	NEONATAL INTENSIVE CARE UNIT Cost Center Description	0	0	0. 00	0	0	47. 00
40.00	Drogram i proti est escillary corrigo cost (Wk	n+ D 2 and 2	Line 200)			1.00	40.00
48. 00 49. 00	Program inpatient ancillary service cost (Wk Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS					829, 186	48. 00 49. 00
50.00	Pass through costs applicable to Program inp	atient routine se	ervices (from Wk	st. D, sum o	of Parts I and	0	50. 00
51. 00	Pass through costs applicable to Program inpland IV)	atient ancillary	services (from \	Wkst. D, sur	n of Parts II	0	51. 00
52.00	Total Program excludable cost (sum of lines					0	52. 00
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION		ated, non-physic	ian anesthe	tist, and	829, 186	53. 00
	Program di scharges					54	
55. 00 56. 00	Target amount per discharge Target amount (line 54 x line 55)					0.00	55. 00 56. 00
57.00	Difference between adjusted inpatient operat	ing cost and targ	get amount (line	56 minus li	ne 53)	-829, 186	
58. 00 59. 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost re market basket	porting period er	ndi ng 1996, upda	ted and comp	bounded by the	0 0. 00	58. 00 59. 00
60. 00 61. 00	Lesser of lines 53/54 or 55 from prior year of line 53/54 is less than the lower of line				ne amount by	0. 00 0	60. 00 61. 00
/2.00	which operating costs (line 53) are less tha amount (line 56), otherwise enter zero (see		(lines 54 x 60)	, or 1% of ⁻	the target	0	42.00
62. 00 63. 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ent (see instruct	tions)			0	62. 00 63. 00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Decemb	per 31 of the cos	st reportino	g period (See	0	64. 00
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)</pre>	ts after December	31 of the cost	reporting p	period (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)	ne costs (line 64	1 plus line 65)(title XVIII	only). For	0	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	e costs through [December 31 of t	he cost repo	orting period	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routing (line 13 x line 20)	e costs after Dec	cember 31 of the	cost repor	ting period	0	
69. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N					0	69. 00
70. 00	Skilled nursing facility/other nursing facil	ity/ICF/IID routi	ne service cost				70. 00
71. 00 72. 00	Adjusted general inpatient routine service of Program routine service cost (line 9 x line	,	ne 70 ÷ line 2)				71. 00 72. 00
73.00	Medically necessary private room cost application	able to Program (35)			73.00
74. 00 75. 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient 26, line 45)	•	,	sheet B, Pai	rt II, column		74. 00 75. 00
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line	. *					76. 00 77. 00
78. 00 79. 00	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces	,	wider records)				78. 00 79. 00
80.00	Total Program routine service costs for comp.			ine 78 minus	s line 79)		80. 00
81. 00 82. 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (81. 00 82. 00
83. 00	Reasonable inpatient routine service cost (· ·	1				82.00
84. 00 85. 00	Program inpatient ancillary services (see in Utilization review - physician compensation		:)				84. 00 85. 00
	Total Program inpatient operating costs (sum	of lines 83 thro					86. 00
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions					0	87. 00
88. 00	Adjusted general inpatient routine cost per	diem (line 27 ÷ l	ine 2)			0. 00	88. 00
89. 00	Observation bed cost (line 87 x line 88) (se	e instructions)			l	0	89. 00

Health Financial Systems	FRANCISCAN H	EALTH- DYER		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
				From 01/01/2021	D 1 (T' D	
		Component	CCN: 15-T090	To 12/31/2021	Date/Time Prep 5/30/2022 7:58	
		Ti +I	e XIX	Subprovi der -	TEFRA	э рііі
			C XIX	I RF	121101	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	0	11, 159, 670	0.00000	0 0	0	90.00
91.00 Nursing Program cost	0	11, 159, 670	0.00000	0 0	0	91.00
92.00 Allied health cost	0	11, 159, 670	0.00000	0 0	0	92.00
93.00 All other Medical Education	0	11, 159, 670	0. 00000	0 0	0	93.00

	ISCAN HEALTH- DYER			u of Form CMS-2	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN		Peri od:	Worksheet D-3	
			From 01/01/2021 To 12/31/2021	Date/Time Pre 5/30/2022 7:5	
	Title	XVIII	Hospi tal	PPS	о рііі
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
		Ü	Charges	(col. 1 x col.	
				2)	
		1. 00	2. 00	3. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS			17, 105, 992		30.00
31. 00 03100 INTENSIVE CARE UNIT			4, 356, 699		31. 00
32. 00 03200 CORONARY CARE UNIT			0		32. 00
35.00 02060 NEONATAL INTENSIVE CARE UNIT			0		35. 00
41. 00 04100 SUBPROVI DER - I RF			0		41.00
42. 00 04200 SUBPROVI DER			0		42.00
43. 00 04300 NURSERY					43. 00
ANCI LLARY SERVI CE COST CENTERS		0.00000	E 100 000	FO/ /OF	FO 00
50.00 05000 0PERATING ROOM 50.01 05001 0UTPATIENT SURGERY		0. 09888		506, 605	
51. 00 05100 RECOVERY ROOM		0. 58927 0. 17096		887, 364 103, 182	
53. 00 05100 RECOVERT ROOM 53. 00 05300 ANESTHESI OLOGY		0. 17096		440, 990	
54. 00 05400 RADI OLOGY - DI AGNOSTI C		0. 23203		711, 336	
54. 01 05401 RADI OLOGY-SPECI AL PROCEDURES		0. 17115		170, 651	
55. 00 05500 RADI OLOGY-THERAPEUTI C		0. 00000		170, 031	55. 00
56. 00 05600 RADI OI SOTOPE		0. 10161		60, 474	
60. 00 06000 LABORATORY		0. 13222		1, 403, 748	1
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 12124		96, 384	1
65. 00 06500 RESPIRATORY THERAPY		0. 35333		1, 302, 989	
66. 00 06600 PHYSI CAL THERAPY		0. 43677		566, 036	
67. 00 06700 OCCUPATI ONAL THERAPY		0. 24123		280, 957	
68. 00 06800 SPEECH PATHOLOGY		0. 22481		126, 705	
69. 00 06900 ELECTROCARDI OLOGY		0. 07990		267, 171	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 16574		36, 062	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 39034	9 5, 679, 222	2, 216, 879	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 69226	4 2, 783, 350	1, 926, 813	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 27310	8, 065, 521	2, 202, 758	
76. 00 03630 ULTRA SOUND		0. 07246	3 1, 294, 632	93, 813	76. 00
76. 01 03951 PAIN CLINIC		0. 22786	2 8, 149	1, 857	76. 01
76. 02 03952 CATH LAB		0. 06195	9, 285, 293	575, 261	
76. 03 03953 ACTIVITY THERAPEUTIC		0. 76092	6, 837	5, 202	
76. 04 03954 WOUND CARE CENTER		0. 33871	4 8, 911	3, 018	
76. 05 03340 BARI ATRI C CLI NI C		0. 69436		66	
76.06 03030 HEALTHY LIVING CENTER		0.00000		0	76. 06
76. 07 03950 CV RESOURCE CENTER		0.00000		0	
74 00 020EE OTHED ANCILLADY SERVICE COST CENTERS	1	0 00000	ı∩ı ∧l	^	76 00

0.000000

0.000000

0. 000000 0. 000000

0.613892

0. 126884

0. 594217

0 76.08

0 76.09

0

0

454

14, 984, 802 200. 00

978, 338

19, 689

76. 10

76. 11

76. 12

91.00

92.00

201. 00

202. 00

7, 710, 488

75, 295, 956

75, 295, 956

33, 135

76.09

76. 10

76. 11

76. 12

91.00

92.00

200.00

201.00

202.00

03955 OTHER ANCILLARY SERVICE COST CENTERS

03957 OTHER ANCILLARY SERVICE COST CENTERS 03958 OTHER ANCILLARY SERVICE COST CENTERS

09200 OBSERVATION BEDS (NON-DISTINCT PART

Net charges (line 200 minus line 201)

Total (sum of lines 50 through 94 and 96 through 98) Less PBP Clinic Laboratory Services-Program only charges (line 61)

03956 LACTATION CLINIC

09100 EMERGENCY

03959 ANTI COAGULATION CLINIC OUTPATIENT SERVICE COST CENTERS

PATIENT ANCILLARY SERVICE COST APPORTIONMENT		CN: 15-0090	Peri od: From 01/01/2021	Worksheet D-3	
	component	CCN: 15-T090	To 12/31/2021	Date/Time Pre 5/30/2022 7:5	
	Ti tl e	e XVIII	Subprovi der - I RF	PPS	
Cost Center Description		Ratio of Cos To Charges	st Inpatient	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2. 00	3. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS				I	1 20
.00 03000 ADULTS & PEDIATRICS .00 03100 INTENSIVE CARE UNIT .00 03200 CORONARY CARE UNIT .00 02060 NEONATAL INTENSIVE CARE UNIT .00 04100 SUBPROVIDER - IRF .00 04200 SUBPROVIDER .00 04300 NURSERY			8, 513, 850		30. 31. 32. 35. 41. 42. 43.
ANCILLARY SERVICE COST CENTERS . 00 05000 OPERATING ROOM		0. 0988	82 71, 917	7, 111	50
.01 05001 OUTPATIENT SURGERY .00 05100 RECOVERY ROOM		0. 5892 0. 1709	78 30, 172	17, 780	50
. 00 05300 ANESTHESI OLOGY . 00 05400 RADI OLOGY-DI AGNOSTI C		0. 2326 0. 0887			
01 05401 RADI OLOGY-SPECI AL PROCEDURES		0. 1711		42, 307	1
. 00 05500 RADI OLOGY-THERAPEUTI C		0.0000		0	
. 00 05600 RADI OI SOTOPE . 00 06000 LABORATORY		0. 1016 0. 1322			
. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 1322			
. 00 06500 RESPI RATORY THERAPY		0. 3533			
. 00 06600 PHYSI CAL THERAPY		0. 4367			
. 00 06700 OCCUPATI ONAL THERAPY		0. 2412			
. 00 06800 SPEECH PATHOLOGY . 00 06900 ELECTROCARDI OLOGY		0. 2248 0. 0799		289, 539 7, 848	
00 07000 ELECTROCARDI OLOGI		0. 1657			
. OO O7100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 3903			
.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 6922	64 10, 212	7, 069	7:
00 07300 DRUGS CHARGED TO PATIENTS		0. 2731		324, 318	
. 00 03630 ULTRA SOUND		0.0724			
.01 03951 PALN CLINIC .02 03952 CATH LAB		0. 2278 0. 0619		0 0	1
03 03953 ACTIVITY THERAPEUTIC		0. 7609			
04 03954 WOUND CARE CENTER		0. 3387		0	
. 05 03340 BARI ATRI C CLI NI C		0. 6943	60 0	0	70
.06 03030 HEALTHY LIVING CENTER		0.0000		0	
. 07 03950 CV RESOURCE CENTER		0.0000			1
08 03955 OTHER ANCILLARY SERVICE COST CENTERS 09 03956 LACTATION CLINIC		0. 0000 0. 0000			1 ' '
. 10 03957 OTHER ANCI LLARY SERVI CE COST CENTERS		0.0000			
. 11 03958 OTHER ANCILLARY SERVICE COST CENTERS		0.0000		Ö	
. 12 03959 ANTI COAGULATI ON CLINIC		0. 6138			
OUTPATIENT SERVICE COST CENTERS			1		4
. 00 09100 EMERGENCY		0. 1268		32, 602	
.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART 0.00 Total (sum of lines 50 through 94 and 96 through 98)		0. 5942	17 0 12, 244, 812		92
0.00 Total (sum of lines 50 through 94 and 96 through 98) 1.00 Less PBP Clinic Laboratory Services-Program only charges	(line 61)		12, 244, 812	3, 508, 365	201
2.00 Net charges (line 200 minus line 201)	(11110 01)		12, 244, 812		202

Health Financial Systems	FRANCISCAN HEAL	TU DVED		In Lie	eu of Form CMS-2	2EE2 10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	FRANCI SCAN HEAL			Peri od:	Worksheet D-3	
				From 01/01/2021 To 12/31/2021	Date/Time Pre 5/30/2022 7:5	pared: 8 pm
		Ti t	le XIX	Hospi tal	Cost	
Cost Center Description			Ratio of Cos	t Inpatient	Inpati ent	
·			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
					2)	
			1.00	2.00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS			•			
30. 00 03000 ADULTS & PEDI ATRI CS				4, 566, 971		30.00
31. 00 03100 INTENSIVE CARE UNIT				1, 137, 549		31.00
22 00 02200 CORONARY CARE HALT			i			22 00

	Cost Center Description	Ratio of Cost	Inpati ent	Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2. 00	3. 00	
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS				
30.00	03000 ADULTS & PEDI ATRI CS		4, 566, 971		30. 00
31. 00	03100 INTENSIVE CARE UNIT		1, 137, 549		31. 00
32.00	03200 CORONARY CARE UNIT		0		32. 00
35.00	02060 NEONATAL INTENSIVE CARE UNIT		202, 363		35. 00
41.00	04100 SUBPROVI DER - I RF		435, 305		41. 00
42.00	04200 SUBPROVI DER		0		42. 00
43.00	04300 NURSERY		65, 791		43. 00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0. 098787	4, 753, 731	469, 607	50.00
50. 01	05001 OUTPATIENT SURGERY	0. 589278	167, 278	98, 573	50. 01
51.00	05100 RECOVERY ROOM	0. 170962	329, 564	56, 343	51.00
53.00	05300 ANESTHESI OLOGY	0. 232658	784, 480		53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 088754	1, 425, 650		54. 00
54. 01	05401 RADI OLOGY-SPECI AL PROCEDURES	0. 171158	368, 583		
55. 00	05500 RADI OLOGY-THERAPEUTI C	0.000000	0		55. 00
56. 00	05600 RADI 0I S0T0PE	0. 101619	71, 080	7, 223	56. 00
60.00	06000 LABORATORY	0. 132057	4, 021, 520		60.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 121241	171, 960		63. 00
65. 00	06500 RESPI RATORY THERAPY	0. 353332	900, 705		65. 00
66. 00	06600 PHYSI CAL THERAPY	0. 436777	317, 467		66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 241237	310, 457		67. 00
68. 00	06800 SPEECH PATHOLOGY				68. 00
		0. 224815	142, 037		
69. 00	06900 ELECTROCARDI OLOGY	0. 079904	554, 586		69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 165746	30, 520		70.00
71. 00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0. 390349	2, 849	1	71.00
72. 00	07200 I MPL. DEV. CHARGED TO PATI ENTS	0. 692264	0	_	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 273108	2, 688, 136		73. 00
76. 00	03630 ULTRA SOUND	0. 072463	284, 998	20, 652	76. 00
76. 01	03951 PAIN CLINIC	0. 227862	0	0	76. 01
	03952 CATH LAB	0. 061954	1, 162, 908		76. 02
76. 03	03953 ACTIVITY THERAPEUTIC	0. 758373	1, 396, 242	1, 058, 872	76. 03
76. 04	03954 WOUND CARE CENTER	0. 338628	0	0	76. 04
76.05	03340 BARI ATRI C CLI NI C	0. 694360	249	173	76. 05
76. 06	03030 HEALTHY LIVING CENTER	0.000000	0	0	76. 06
76. 07	03950 CV RESOURCE CENTER	0.000000	0	0	76. 07
76. 08	03955 OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	76. 08
76. 09	03956 LACTATION CLINIC	0.000000	0	0	76. 09
	03957 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000	0	Ō	76. 10
76. 11	03958 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000	0	_	76. 11
76. 12	03959 ANTI COAGULATI ON CLI NI C	0. 613892	0		76. 12
70.12	OUTPATIENT SERVICE COST CENTERS	0.010072			70. 12
91. 00	09100 EMERGENCY	0. 126884	2, 394, 980	303, 885	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 594217	2, 374, 700	0	92. 00
200.00		0.374217	22, 279, 980	_	
200.00			ZZ, Z17, 70U	4, 337, 600	200.00
201.00			22, 279, 980		201.00
202.00	Inet charges (Title 200 IIII hus Title 201)	l l	22, 217, 980	T .	ZUZ. UU

Health Financial Systems	FRANCISCAN HEALTH- DYER	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0090	Peri od: From 01/01/2021 To 12/31/2021	Worksheet E Part A Date/Time Prepared: 5/30/2022 7:58 pm

				5/30/2022 7:5	8 pm
		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	ng prior to October 1 (s	ee	13, 701, 265	1. 01
	instructions)				
1. 02	DRG amounts other than outlier payments for discharges occurring	ng on or after October 1	(see	4, 463, 532	1. 02
1 02	instructions)		riar ta Oatabar	0	1 02
1. 03	DRG for federal specific operating payment for Model 4 BPCI for (see instructions)	0	1. 03		
1.04	DRG for federal specific operating payment for Model 4 BPCI for	0	1. 04		
	October 1 (see instructions)	ar a a a a a a a a a a a a a a a a a a		_	
2.00	Outlier payments for discharges. (see instructions)				2.00
2.01	Outlier reconciliation amount			0	2. 01
2.02	Outlier payment for discharges for Model 4 BPCI (see instruction			0	2. 02
2. 03	Outlier payments for discharges occurring prior to October 1 (s			364, 469	2. 03
2.04	Outlier payments for discharges occurring on or after October	l (see instructions)		91, 303	2. 04
3.00	Managed Care Simulated Payments			8, 224, 410	3. 00
4. 00	Bed days available divided by number of days in the cost report	ting period (see instruc	TI ONS)	93. 58	4. 00
5. 00	Indirect Medical Education Adjustment FTE count for allopathic and osteopathic programs for the most	recent cost reporting r	oriod anding on	7. 80	5. 00
5.00	or before 12/31/1996. (see instructions)	recent cost reporting p	errou enaring on	7. 60	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the	e criteria for an add-on	to the cap for	0.00	6. 00
0.00	new programs in accordance with 42 CFR 413.79(e)	s errierra rer am ada en	to the cap roll	0.00	0.00
7.00	MMA Section 422 reduction amount to the IME cap as specified un	nder 42 CFR §412.105(f)(1) (i v) (B) (1)	0.89	7. 00
7.01	ACA § 5503 reduction amount to the IME cap as specified under	42 CFR §412.105(f)(1)(iv	(B)(2) If the	0.00	7. 01
	cost report straddles July 1, 2011 then see instructions.				
8.00	Adjustment (increase or decrease) to the FTE count for allopath			0.00	8. 00
	affiliated programs in accordance with 42 CFR 413.75(b), 413.79	9(c)(2)(iv), 64 FR 26340	(May 12,		
0.01	1998), and 67 FR 50069 (August 1, 2002).		CA 16 111	0.00	0.01
8. 01	The amount of increase if the hospital was awarded FTE cap slot	is under § 5503 of the A	.ca. 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 slo	ts from a closed teachin	n hosnital	0.00	8. 02
0.02	under § 5506 of ACA. (see instructions)	ts from a crosed teachin	g nospi tai	0.00	0.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines	s (8. 8.01 and 8.02) (s	ee	6. 91	9. 00
	instructions)	()			
10.00	FTE count for allopathic and osteopathic programs in the curren	nt year from your record	s	1. 81	10.00
11. 00	FTE count for residents in dental and podiatric programs.			2. 75	
12. 00	Current year allowable FTE (see instructions)			4. 56	
13.00	Total allowable FTE count for the prior year.			7. 07	13.00
14. 00	Total allowable FTE count for the penultimate year if that year	r ended on or after Sept	ember 30, 1997,	8. 67	14. 00
15. 00	otherwise enter zero.			6. 77	15. 00
16. 00	Sum of lines 12 through 14 divided by 3. Adjustment for residents in initial years of the program				16. 00
17. 00	Adjustment for residents in this trail years of the program Adjustment for residents displaced by program or hospital closu	ire			17. 00
18. 00	Adjusted rolling average FTE count	31.0		6. 77	
19. 00	Current year resident to bed ratio (line 18 divided by line 4).			0. 072345	
20. 00	Prior year resident to bed ratio (see instructions)			0. 075704	
21.00	Enter the lesser of lines 19 or 20 (see instructions)			0.072345	21. 00
22.00	IME payment adjustment (see instructions)			703, 595	22. 00
22. 01				318, 564	22. 01
	Indirect Medical Education Adjustment for the Add-on for § 422				
23. 00	Number of additional allopathic and osteopathic IME FTE resider	nt cap slots under 42 CF	R 412. 105	0.00	23. 00
24.00	(f)(1)(iv)(C).			F 10	24.00
24. 00	IME FTE Resident Count Over Cap (see instructions)		24 (-5. 10	24. 00
25. 00	If the amount on line 24 is greater than -0-, then enter the lo instructions)	ower of time 23 of time	24 (See	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)			703, 595	29. 00
29. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01))		318, 564	29. 01
	Disproportionate Share Adjustment				
30. 00	Percentage of SSI recipient patient days to Medicare Part A pa	tient days (see instruct	i ons)	2. 45	30. 00
31.00	Percentage of Medicaid patient days (see instructions)			17. 67	31.00
32.00	Sum of lines 30 and 31			20. 12	32. 00
33.00	Allowable disproportionate share percentage (see instructions)			5. 83	
34. UU	Disproportionate share adjustment (see instructions)		I	264, 752	34.00

	ATION OF REIMBURSEMENT SETTLEMENT		Peri od: From 01/01/2021 To 12/31/2021	Worksheet E Part A Date/Time Prep 5/30/2022 7:58	
		Title XVIII	Hospi tal	PPS	<u>o piii</u>
			Prior to 10/1	On/After 10/1	
			1. 00	2. 00	
	Uncompensated Care Adjustment				
35. 00	Total uncompensated care amount (see instructions)		8, 290, 014, 521	7, 192, 008, 710	35. 00
35. 01	Factor 3 (see instructions)		0. 000315558	0. 000244105	35. 01
35. 02	Hospital uncompensated care payment (If line 34 is zero, ente	r zero on this line) (see	2, 615, 979	1, 755, 609	35. 02
35. 03	Instructions) Pro rata share of the hospital uncompensated care payment amo Total uncompensated care (sum of columns 1 and 2 on line 35.0		1, 956, 608	442, 510	
36. 00	Additional payment for high percentage of ESRD beneficiary dis		2, 399, 118		36. 00
40. 00	Total Medicare discharges (see instructions)	scharges (Tries 40 throug	0		40. 00
41. 00	Total ESRD Medicare discharges (see instructions)		0		41. 00
41. 01	Total ESRD Medicare covered and paid discharges (see instruct	ions)	0		41. 01
42. 00	Divide line 41 by line 40 (if less than 10%, you do not quali		0.00		42.00
43. 00	Total Medicare ESRD inpatient days (see instructions)	. y	0		43. 00
44. 00	Ratio of average length of stay to one week (line 43 divided days)	by line 41 divided by 7	0.000000		44. 00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00		45. 00
46.00	Total additional payment (line 45 times line 44 times line 41	. 01)	0		46. 00
47.00	Subtotal (see instructions)		21, 988, 034		47. 00
48. 00	Hospital specific payments (to be completed by SCH and MDH, s	mall rural hospitals	0		48. 00
	only. (see instructions)				
				Amount	
49. 00	Total payment for inpatient operating costs (see instructions	1		1. 00 22, 306, 598	49. 00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and	•		1, 457, 844	
51. 00	Exception payment for inpatient program capital (Wkst. L, Pt.	• • • • • • • • • • • • • • • • • • • •		0	51.00
52. 00	Direct graduate medical education payment (from Wkst. E-4, li			260, 732	
53. 00	Nursing and Allied Health Managed Care payment	,.		0	53. 00
54.00	Special add-on payments for new technologies			181, 052	
54.01	Islet isolation add-on payment			0	54. 01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 6	9)		0	55. 00
56.00	Cost of physicians' services in a teaching hospital (see intr	uctions)		0	56. 00
57.00	Routine service other pass through costs (from Wkst. D, Pt. I		ırough 35).	0	57. 00
58. 00	Ancillary service other pass through costs from Wkst. D, Pt.	IV, col. 11 line 200)		0	58. 00
59. 00	Total (sum of amounts on lines 49 through 58)			24, 206, 226	59. 00
60.00	Primary payer payments	1: (0)		0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus	Tine 60)		24, 206, 226	
62. 00 63. 00	Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries			1, 698, 764 165, 837	62. 00 63. 00
64. 00	Allowable bad debts (see instructions)			370, 515	
65. 00	Adjusted reimbursable bad debts (see instructions)			240, 835	
66. 00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		206, 404	66. 00
67. 00	,	ructions)		22, 582, 460	
	Credits received from manufacturers for replaced devices for	applicable to MS-DRGs (se	e instructions)	0	68. 00
69. 00	Outlier payments reconciliation (sum of lines 93, 95 and 96).	11		0	
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		,	0	70. 00
70. 50	Rural Community Hospital Demonstration Project (§410A Demonst	ration) adjustment (see i	nstructions)	0	70. 50
70. 87	Demonstration payment adjustment amount before sequestration	· · ·	•	0	70. 87
70. 88	SCH or MDH volume decrease adjustment (contractor use only)			0	70. 88
70. 89	Pioneer ACO demonstration payment adjustment amount (see inst	ructions)			70. 89
70. 90				0	70. 90
70. 91	HSP bonus payment HRR adjustment amount (see instructions)			0	70. 91
	Bundled Model 1 discount amount (see instructions)			0	70. 92
70. 92	· · · · · · · · · · · · · · · · · · ·				
70. 92 70. 93 70. 94	HVBP payment adjustment amount (see instructions) HRR adjustment amount (see instructions)			-174, 049 -68, 311	70. 93 70. 94

Health Financial Systems	FRANCISCAN HEALT	H_ DVFR		Inlie	u of Form CMS-2	2552_10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CO	CN: 15-0090 F	Peri od:	Worksheet E	2332-10
SALESCENTION OF THE IMPONDEMENT SETTEMENT				rom 01/01/2021	Part A	
			7	Γo 12/31/2021	Date/Time Pre	
-		Ti +Lo	XVIII	Hospi tal	5/30/2022 7:5 PPS	8 pm
		11 11 6		(yyyy)	Amount	
				0	1. 00	
70.96 Low volume adjustment for federal fiscal	year (yyyy) (Enter in	column 0		0	0	70. 96
the corresponding federal year for the part of the par		cor anni o			O	70.70
70. 97 Low volume adjustment for federal fiscal		column 0		0	0	70. 97
the corresponding federal year for the p						
70. 98 Low Volume Payment-3	9	,			0	70. 98
70.99 HAC adjustment amount (see instructions)					237, 032	70. 99
71.00 Amount due provider (line 67 minus lines	68 plus/minus lines 69	9 & 70)			22, 103, 068	
71.01 Sequestration adjustment (see instruction	ns)	·			0	71. 01
71.02 Demonstration payment adjustment amount	after sequestration				0	71. 02
71.03 Sequestration adjustment-PARHM pass-thro	ughs					71. 03
72.00 Interim payments					22, 181, 659	72. 00
72.01 Interim payments-PARHM						72. 01
73.00 Tentative settlement (for contractor use	3,				0	73. 00
73.01 Tentative settlement-PARHM (for contract	3,					73. 01
74.00 Balance due provider/program (line 71 mi	nus lines 71.01, 71.02	72, and			-78, 591	74. 00
73)						
74.01 Balance due provider/program-PARHM (see						74. 01
75.00 Protested amounts (nonallowable cost rep	ort items) in accordan	ce with			664, 390	75. 00
CMS Pub. 15-2, chapter 1, §115.2	th					-
TO BE COMPLETED BY CONTRACTOR (lines 90 190.00 Operating outlier amount from Wkst. E, P		F 2 02	Ι		0	90.00
plus 2.04 (see instructions)	t. A, Title 2, Of Sull O	1 2.03			U	90.00
91.00 Capital outlier from Wkst. L, Pt. I, line	e 2				0	91.00
92.00 Operating outlier reconciliation adjustm		rtions)			0	
93.00 Capital outlier reconciliation adjustmen					0	1
94.00 The rate used to calculate the time value	•				0.00	
95.00 Time value of money for operating expense					0	
96.00 Time value of money for capital related		ons)			0	
		Í		Prior to 10/1	On/After 10/1	
				1. 00	2. 00	
HSP Bonus Payment Amount						
100.00 HSP bonus amount (see instructions)				0	0	100. 00
HVBP Adjustment for HSP Bonus Payment						
101.00 HVBP adjustment factor (see instructions)				0.0000000000		
102.00 HVBP adjustment amount for HSP bonus pay	ment (see instructions)		0	0	102. 00
HRR Adjustment for HSP Bonus Payment						
103.00 HRR adjustment factor (see instructions)				0.0000		103. 00
104.00 HRR adjustment amount for HSP bonus paym				0	0	104. 00
Rural Community Hospital Demonstration Pr						
200.00 Is this the first year of the current 5-		od under t	he 21st			200. 00
Century Cures Act? Enter "Y" for yes or	"N" for no.					1
Cost Reimbursement	L-+ D 1 D: !!	40)				201 20
201.00 Medicare inpatient service costs (from W	κst. D-I, Pt. II, line	49)				201. 00
202.00 Medicare discharges (see instructions) 203.00 Case-mix adjustment factor (see instruct	i one)					202. 00 203. 00
Computation of Demonstration Target Amour		firet year	of the current	5-year domonat	ration	1203.00
Somparation of Demonstration ranger Amoun	TE ETHILLIACTOR (N/A TIT	i i st year	or the current	. J-year delilonst	.1 4 1 1 011	1

71. 02	Sequestration adjustment (see instructions)				71.01
	Demonstration payment adjustment amount after sequestration			0	
71. 03	Sequestration adjustment-PARHM pass-throughs				71. 03
72. 00	Interim payments			22, 181, 659	
72. 01	Interim payments-PARHM				72. 01
73. 00	Tentative settlement (for contractor use only)			0	
73. 01	Tentative settlement-PARHM (for contractor use only)				73. 01
74. 00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and			-78, 591	74.00
	[73]				
74. 01	Balance due provider/program-PARHM (see instructions)				74. 01
75. 00	Protested amounts (nonallowable cost report items) in accordance with			664, 390	75. 00
	CMS Pub. 15-2, chapter 1, §115.2				
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90. 00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03			0	90.00
	plus 2.04 (see instructions)				
91. 00	Capital outlier from Wkst. L, Pt. I, line 2			0	1
92. 00	Operating outlier reconciliation adjustment amount (see instructions)			0	
93. 00				0	
94. 00	The rate used to calculate the time value of money (see instructions)			0.00	
95. 00	Time value of money for operating expenses (see instructions)			0	
96. 00	Time value of money for capital related expenses (see instructions)			0	96. 0
		Pri	or to 10/1	On/After 10/1	
			1. 00	2. 00	
	HSP Bonus Payment Amount				
100.00	HSP bonus amount (see instructions)		0	0	100. 0
	HVBP Adjustment for HSP Bonus Payment				
101.00	HVBP adjustment factor (see instructions)	0	. 0000000000		
102 00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	l n	102.0
102.00					1102.0
	HRR Adjustment for HSP Bonus Payment				
103.00	HRR adjustment factor (see instructions)		0. 0000	0. 0000	103. 0
103.00				0. 0000	103. 0
103.00	HRR adjustment factor (see instructions)		0. 0000	0. 0000	103. 00
103.00 104.00	HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions)		0. 0000	0. 0000	103. 00 104. 00
103.00 104.00	HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment		0. 0000	0. 0000	103. 0 104. 0
103.00 104.00	HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment Is this the first year of the current 5-year demonstration period under the 21st		0. 0000	0. 0000	103. 00 104. 00
103. 00 104. 00 200. 00	HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.		0. 0000	0. 0000	103. 00 104. 00 200. 00
103. 00 104. 00 200. 00	HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement		0. 0000	0. 0000	103. 00 104. 00 200. 00
103. 00 104. 00 200. 00 201. 00 202. 00	HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)		0. 0000	0. 0000	103. 0 104. 0 200. 0 201. 0 202. 0
103. 00 104. 00 200. 00 201. 00 202. 00	HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions)	urrent 5-y	0.0000	0.0000	103. 0 104. 0 200. 0 201. 0 202. 0
103. 00 104. 00 200. 00 201. 00 202. 00	HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions)	urrent 5-y	0.0000	0.0000	103. 00 104. 00 200. 00 201. 00 202. 00
103. 00 104. 00 200. 00 201. 00 202. 00 203. 00	HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of the cu	urrent 5-y	0.0000	0.0000	103. 00 104. 00 200. 00 201. 00 202. 00 203. 00
103. 00 104. 00 200. 00 201. 00 202. 00 203. 00	HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of the cuperiod)	urrent 5-y	0.0000	0.0000	103. 0 104. 0 200. 0 201. 0 202. 0 203. 0
103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00	HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of the cuperiod) Medicare target amount	urrent 5-y	0.0000	0.0000	103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00
103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00	HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of the cuperiod) Medicare target amount Case-mix adjusted target amount (line 203 times line 204)	urrent 5-y	0.0000	0.0000	103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00
103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00	HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of the cuperiod) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205)	urrent 5-y	0.0000	0.0000	103. 0 104. 0 200. 0 201. 0 202. 0 203. 0 204. 0 205. 0 206. 0
103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00	HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of the cuperiod) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement	urrent 5-y	0.0000	0.0000	103. 00 104. 00 200. 00 201. 00 203. 00 204. 00 205. 00 206. 00
103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00	HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of the cuperiod) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Line 59)	urrent 5-y	0.0000	0.0000	
103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00	HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of the cuperiod) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59) Adjustment to Medicare IPPS payments (see instructions)	urrent 5-y	0.0000	0.0000	200. 0 200. 0 201. 0 202. 0 203. 0 204. 0 205. 0 206. 0 207. 0 208. 0 209. 0
103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00	HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of the cuperiod) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59) Adjustment to Medicare IPPS payments (see instructions) Reserved for future use	urrent 5-y	0.0000	0.0000	103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 209. 00 210. 00
103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00	HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of the cuperiod) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59) Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions)	urrent 5-y	0.0000	0.0000	103. 00 104. 00 200. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00
103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00 211. 00	HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of the cuperiod) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59) Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement	urrent 5-y	0.0000	0.0000	201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 211. 00
103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 211. 00 212. 00	HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of the cuperiod) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59) Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement Total adjustment to Medicare Part A IPPS payments (from line 211)	urrent 5-y	0.0000	0.0000	201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 211. 00
103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 211. 00 211. 00 213. 00	HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of the cuperiod) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59) Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare Part A IPPS payments (from line 211) Low-volume adjustment to Medicare Part A IPPS payments (from line 211) Low-volume adjustment (see instructions)		0.0000	0.0000	200. 0 201. 0 202. 0 203. 0 204. 0 205. 0 206. 0 207. 0 208. 0 209. 0 211. 0 212. 0 213. 0
103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 211. 00 211. 00 213. 00	HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of the cuperiod) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59) Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement Total adjustment to Medicare Part A IPPS payments (from line 211)		0.0000	0.0000	201. 0 202. 0 203. 0 204. 0 205. 0 206. 0 207. 0 208. 0 209. 0 211. 0

HOSPI T	TAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT					Period: From 01/01/2021 To 12/31/2021		pared:
					XVIII	Hospi tal	PPS	
		Wkst. E, Pt. A, line	Amt. fro Wkst. E, A		Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00		2.00	3. 00	4. 00	
1. 00 1. 01	DRG amounts other than outlier payments DRG amounts other than outlier payments for discharges occurring prior to October 1	1. 00 1. 01	13, 701,	, 265	13, 701, 26	5	13, 701, 265	1. 00 1. 01
1. 02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	4, 463,	, 532		4, 463, 532	4, 463, 532	1. 02
1. 03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October	1. 03		0		0	0	1. 03
1. 04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1. 04		0		C	0	1. 04
2.00	Outlier payments for discharges (see instructions)	2. 00						2. 00
2. 01	Outlier payments for discharges for Model 4 BPCI	2.02		0		0 0		2. 01
2. 02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03		, 469			364, 469	2. 02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2. 04	91,	, 303		91, 303		2. 03
3. 00 4. 00	Operating outlier reconciliation Managed care simulated payments Indirect Medical Education Adjustment	2. 01 3. 00	8, 224,	, 410	5, 921, 42	0 0 0	1	3. 00 4. 00
5. 00	Amount from Worksheet E, Part A, line 21 (see instructions)	21. 00	0. 072	2345	0. 07234	5 0. 072345	5	5. 00
6. 00 6. 01	IME payment adjustment (see instructions) IME payment adjustment for managed care (see instructions)	22. 00 22. 01		, 595 , 564				6. 00 6. 01
	Indirect Medical Education Adjustment for the	Add-on for Se	ction 422	of t	he MMA			
7. 00	IME payment adjustment factor (see instructions)	27. 00	0.000	0000	0.00000	0.000000		7. 00
8.00	IME adjustment (see instructions)	28. 00		0		0		8. 00
8. 01	IME payment adjustment add on for managed care (see instructions)	28. 01		0	500 70	0 0		8. 01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	1	, 595		· ·	1	9. 00
9. 01	Total IME payment for managed care (sum of lines 6.01 and 8.01) Disproportionate Share Adjustment	29. 01	318,	, 564	229, 36	89, 204	318, 564	9. 01
10. 00	Allowable disproportionate share percentage	33.00	0.0	0583	0. 058	0. 0583	3	10.00
	(see instructions) Disproportionate share adjustment (see	34. 00		, 752				
11. 01	instructions) Uncompensated care payments	36. 00	2, 399,		1, 956, 60	8 442, 510	2, 399, 118	11. 01
40.05	Additional payment for high percentage of ESF		di scharges			-	-	40.00
12.00	Total ESRD additional payment (see instructions)	46. 00	04.000	0		0 0		
13. 00 14. 00	Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	47. 00 48. 00	21, 988,	, 034	16, 752, 74	3 5, 235, 291 0 C	21, 988, 034 0	13. 00 14. 00
15. 00	Total payment for inpatient operating costs (see instructions)	49. 00	22, 306,	, 598	16, 982, 10	5, 324, 495	22, 306, 598	15. 00
16. 00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50. 00	1, 457,	, 844	1, 108, 09	349, 745	1, 457, 844	16. 00
17. 00 17. 01	Special add-on payments for new technologies Net organ acquisition cost	54. 00	181,	, 052	87, 66	93, 385	181, 052	17. 01
17. 02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68. 00		0		0 0		
18. 00	Capital outlier reconciliation adjustment amount (see instructions)	93. 00		0	40.477.	0 0		18.00
19.00	SUBTOTAL		l		18, 177, 86	5, 767, 625	23, 945, 494	19.00

Heal th	Financial Systems	FRANCI SCAN HI	FALTH- DYFR		In Lie	u of Form CMS-:	2552-10
	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5	Provi der CC	F	eriod: rom 01/01/2021 o 12/31/2021	Worksheet E Part A Exhibi Date/Time Pre 5/30/2022 7:5	t 5 pared:
				XVIII	Hospi tal	PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2. 00	3. 00	4. 00	
20.00	Capital DRG other than outlier	1.00	1, 391, 733	1, 057, 538	334, 195	1, 391, 733	20. 00
20. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	0	C	0	0	20. 01
21.00	Capital DRG outlier payments	2.00	19, 766	15, 345	4, 421	19, 766	21. 00
21. 01	Model 4 BPCI Capital DRG outlier payments	2. 01	0	C	0	0	21. 01
22. 00	Indirect medical education percentage (see instructions)	5. 00	0. 0333	0. 0333	0. 0333		22. 00
23. 00	Indirect medical education adjustment (see instructions)	6. 00	46, 345	35, 216	11, 129	46, 345	23. 00
24. 00	Allowable disproportionate share percentage (see instructions)	10.00	0. 0000	0.0000	0.0000		24. 00
25. 00	Disproportionate share adjustment (see instructions)	11.00	0	С	0	0	25. 00
26. 00	Total prospective capital payments (see instructions)	12.00	1, 457, 844	1, 108, 099	349, 745	1, 457, 844	26. 00
		Wkst. E, Pt.	(Amt. from				
		A, line	Wkst. E, Pt.				
			A)				
		0	1. 00	2.00	3. 00	4. 00	
27.00							27. 00
28. 00	Low volume adjustment prior to October 1	70. 96	0	C)	0	
29. 00	Low volume adjustment on or after October 1	70. 97	0		0	0	29. 00
30.00	HVBP payment adjustment (see instructions)	70. 93	-174, 049	-174, 049	0	-174, 049	1
30. 01	HVBP payment adjustment for HSP bonus payment (see instructions)	70. 90	0	C	0	0	30. 01
31.00	HRR adjustment (see instructions)	70. 94	-68, 311	-48, 261	-20, 050	-68, 311	31. 00
31. 01	HRR adjustment for HSP bonus payment (see	70. 91	0	C	0	0	31. 01

0

70. 99

1.00

Υ

2.00

179, 556

3.00

57, 476

(Amt. to Wkst. E, Pt. A)

4.00

237, 032

32. 00

100.00

instructions)

32.00 HAC Reduction Program adjustment (see

instructions)

100.00 Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.

Health Financial Systems	FRANCISCAN HEALTH- DYER	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0090	Peri od: From 01/01/2021 To 12/31/2021	Worksheet E Part B Date/Time Prepared: 5/30/2022 7:58 pm

		Title XVIII	Hospi tal	5/30/2022 7: 5 PPS	8 pm
				1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
1.00	Medical and other services (see instructions)			5, 524	1
2. 00 3. 00	Medical and other services reimbursed under OPPS (see instruct OPPS payments	ions)		13, 110, 283 9, 936, 187	2. 00 3. 00
4. 00	Outlier payment (see instructions)			59, 125	1
4. 01	Outlier reconciliation amount (see instructions)			0 77 1.20	1
5.00	Enter the hospital specific payment to cost ratio (see instruc	tions)		0. 000	
6.00	Line 2 times line 5			0	
7. 00 8. 00	Sum of lines 3, 4, and 4.01, divided by line 6 Transitional corridor payment (see instructions)			0. 00 0	1
9. 00	Ancillary service other pass through costs from Wkst. D, Pt. I	V. col. 13. line 200		0	1
10.00	Organ acqui si ti ons	.,,		0	ı
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			5, 524	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				-
12. 00	Reasonable charges Ancillary service charges			20 227	12. 00
13. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, Ii	ne 69)		0	1
14.00	Total reasonable charges (sum of lines 12 and 13)	·		20, 227	14. 00
45.00	Customary charges				45.00
15. 00 16. 00	Aggregate amount actually collected from patients liable for p Amounts that would have been realized from patients liable for			0	
10.00	had such payment been made in accordance with 42 CFR §413.13(e		i a ciiai gebasi s		10.00
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)	,		0. 000000	17. 00
	Total customary charges (see instructions)			20, 227	
19. 00	Excess of customary charges over reasonable cost (complete onl	y if line 18 exceeds lir	ne 11) (see	14, 703	19. 00
20. 00	instructions) Excess of reasonable cost over customary charges (complete onl	vifline 11 exceeds lin	ne 18) (see	0	20.00
20.00	instructions)	y II IIIle II execeds III	10 (300	Ŭ	20.00
	Lesser of cost or charges (see instructions)			5, 524	1
	Interns and residents (see instructions)			0	
23.00	Cost of physicians' services in a teaching hospital (see instr Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	uctions)		0 9, 995, 312	
24.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			7, 773, 312	24.00
25. 00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25. 00
26. 00	Deductibles and Coinsurance amounts relating to amount on line			1, 609, 325	
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) p	lus the sum of lines 22	and 23] (see	8, 391, 511	27. 00
28. 00	instructions) Direct graduate medical education payments (from Wkst. E-4, li	ne 50)		91, 838	28. 00
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	ı
30.00	Subtotal (sum of lines 27 through 29)			8, 483, 349	30. 00
31. 00	Primary payer payments			700	1
32.00	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVIC	FS)		8, 482, 649	32. 00
33. 00	Composite rate ESRD (from Wkst. I-5, line 11)			0	33. 00
34.00	Allowable bad debts (see instructions)			139, 893	34.00
	Adjusted reimbursable bad debts (see instructions)			90, 930	
	Allowable bad debts for dual eligible beneficiaries (see instr Subtotal (see instructions)	uctions)		76, 576 8, 573, 579	
	MSP-LCC reconciliation amount from PS&R			0, 373, 379	1
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)			39. 50
39. 97	Demonstration payment adjustment amount before sequestration			0	
39. 98 39. 99	Partial or full credits received from manufacturers for replac RECOVERY OF ACCELERATED DEPRECIATION	ed devices (see instruct	(ions)	0	
40. 00	Subtotal (see instructions)			8, 573, 579	
40. 01	Sequestration adjustment (see instructions)			0	1
40. 02	Demonstration payment adjustment amount after sequestration			0	1
	Sequestration adjustment-PARHM pass-throughs			0.705 (00	40. 03
41.00	Interim payments Interim payments-PARHM			8, 725, 602	41. 00 41. 01
	Tentative settlement (for contractors use only)			0	
42. 01	Tentative settlement-PARHM (for contractor use only)				42. 01
43. 00	Balance due provider/program (see instructions)			-152, 023	
43. 01	Balance due provider/program-PARHM (see instructions)			,	43. 01
44. 00	Protested amounts (nonallowable cost report items) in accordan §115.2	ce with CMS Pub. 15-2, o	cnapter I,	2	44. 00
	TO BE COMPLETED BY CONTRACTOR				1
90. 00	Original outlier amount (see instructions)			0	
91. 00	Outlier reconciliation adjustment amount (see instructions)			0	
92. 00 93. 00	The rate used to calculate the Time Value of Money			0. 00 0	1
	Time Value of Money (see instructions) Total (sum of lines 91 and 93)				94.00
				,	

Health Financial Systems	FRANCISCAN HEALTH- DYER	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0090 Component CCN: 15-T090	From 01/01/2021	Worksheet E Part B Date/Time Prepared: 5/30/2022 7:58 pm
	Title XVIII	Subprovi der -	PPS

MRT 8 - MEDICAL AND OTHER HEALTH SERVICES 1.00			litle XVIII	Subprovi der - I RF	PPS	
Mode and other services (see instructions)					1.00	
Medical and other services (see instructions)		PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
0.00 0.00	1.00				113	1. 00
0.01 in Payment (see Instructions)		· ·	ns)			
0.000 0.0						
Internet the hospit tal specific payment to cost ratio (see instructions)					-	
2.00 Acciding strong contents 0.00 7		,	ons)			
7.00 Ancil Tarnst tional corridor payent (see Instructions) 0 8.00 0.						
Ancil lary service other pass through costs from Wist. D. Pt. IV, col. 13, line 200 0.0 0 0.0 0 10.00						
0 0.00 0 0 0 0 0 0 0		, , , , , , , , , , , , , , , , , , , ,	col 13 line 200			
Total cost (sun of lines 1 and 10) (see instructions) 11.00			COI. 13, TITIE 200			
Reasonable charges		9				
12.00 Ancil lary service charges 415 12.00 12.01 10.10 10.01 1						
3.00 Organ acquistion charges (from Wist, D-4, Pt. III), col. 4, line 69)	12 00				/15	12 00
14.00			: 69)			
15.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis 0 15.00			,			
16.00 Amount's that would have been realized from patients liable for payment for services on a churgebasis 0 16.00 Nature payment been made in accordance with 42 CFR §413. 13(e) 0.000000 17.00 0.000000 17.00 0.000000 17.00 0.00000 17.00 0.00000 17.00 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.00000000						
nad such payment been made in accordance with 42 CFR §413. 13(e)		55 5		9		
17.00 Ratio of line 15 to line 16 (not to exceed 1.000000) 17.00 14.15 18.00 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 17.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00 18.00 17.00 18.00	16.00		ayment for services on	i a chargebasis	U	16.00
19. 00 Excess of customerry charges over reasonable cost (complete only if line 18 exceeds line 11) (see 1302 19. 00 Instructions) 20. 00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see 0. 20. 00 1313 21. 00 22. 00 22. 00 23. 00 24. 00 24. 00 24. 00 25.	17. 00				0. 000000	17. 00
instructions						
20.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see 0 20.00	19. 00		if line 18 exceeds lin	ie 11) (see	302	19. 00
Instructions	20 00	,	if line 11 exceeds lir	ie 18) (see	0	20 00
22.00 Interns and residents (see instructions) 0 22.00 23.00	20.00		TT TIME TO CACCOGO TIME	, (333		20.00
23.00 Cost of physicians' services in a teaching hospital (see instructions) 0 24.00		,				
24.00 Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		· · · · · · · · · · · · · · · · · · ·	etions)			
COMPUTATION OF RELIMBURSEMENT SETTLEMENT			tions)			
26.00 Deductible sand Coinsurance amounts relating to amount on line 24 (for CAH, see instructions) 0 26.00	2 00					21.00
27.00 Subtotal [(I ines 21 and 24 minus the sum of i ines 25 and 26) plus the sum of i ines 22 and 23] (see instructions) 13 27.00						
Instructions		,		,		
28.00 Direct graduate medical education payments (from Wkst. E-4, line 50) 0 28.00 0 29.00 SERR direct medical education costs (from Wkst. E-4, line 36) 0 29.00 30.00 Subtotal (sum of lines 27 through 29) 113 30.00 31.00 Primary payer payments 0 31.00 31.00 29.00 20.00	27.00		s the sum of lines 22	and 23] (See	113	27.00
29.00 ESRD direct medical education costs (from Wkst. E-4, line 36) 0 29.00 0 0 0 0 0 0 0 0 0	28. 00		50)		0	28. 00
31.00		ESRD direct medical education costs (from Wkst. E-4, line 36)				
32.00		, ,				
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) 33.00 Composite rate ESRD (from Wkst. I-5, line 11) 0 34.00 34.00 34.00 Adjusted reimbursable bad debts (see instructions) 0 35.00 Adjusted reimbursable bad debts (see instructions) 0 36.00 37.00 Adjusted reimbursable bad debts for dual eligible beneficiaries (see instructions) 0 36.00 37.00 Subtotal (see instructions) 113 37.00 38.00 MSP-LCC reconciliation amount from PS&R 0 38.00 MSP-LCC reconciliation amount from PS&R 0 38.00 MSP-LCT reconciliation amount before sequestration 0 39.00 39.00 MSP-LCT reconciliation payment adjustment (see instructions) 0 39.97 MSP-LCT reconciliation payment adjustment sequestration replaced devices (see instructions) 0 39.97 MSP-LCT reconciliation payment amount before sequestration replaced devices (see instructions) 0 39.97 MSP-LCT reconciliation adjustment sequestration 0 40.01						
34. 00 All owable bad debts (see instructions) 34. 00 35. 00 Adjusted reimbursable bad debts (see instructions) 0 36. 00 36. 00 All owable bad debts for dual eligible beneficiaries (see instructions) 0 36. 00 37. 00 Subtotal (see instructions) 113 37. 00 38. 00 MSP-LCC reconciliation amount from PS&R 0 38. 00 39. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39. 00 39. 50 Pioneer ACO demonstration payment adjustment (see instructions) 39. 97 Demonstration payment adjustment (see instructions) 39. 97 Pioneer ACO demonstration payment adjustment (see instructions) 39. 97 39. 98 Partial or full credits received from manufacturers for replaced devices (see instructions) 39. 99 Paccovery of ACCELERATED DEPRECIATION 39. 99 Paccovery of ACC	02.00)		110	02.00
35.00						
36.00						
37.00 Subtotal (see instructions) 113 37.00 38.00 MSP-LCC reconciliation amount from PS&R 0 38.00 38.00 MSP-LCC reconciliation amount from PS&R 0 38.00 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.00 39.50 39.97 39.97 39.97 39.97 39.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39.97 39.99 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39.99 40.00 Subtotal (see instructions) 0 39.99 40.00 Subtotal (see instructions) 0 40.01 40.00 40.01 40.00 40.01 40.00 40.01 40.00 40.01 40.00 40.01 40.00 40.01 40.00 40.01 40.00 40.01 40.00 40.01 40.00		, ,	tions)			
39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39.00 39.00 39.50 90 90 90 90 90 90 90			11 0113)			
39.50 Pi oneer ACO demonstration payment adjustment (see instructions) 39.50					-	
39. 97 39. 98 39. 98 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 0 39. 98 40. 00 Subtotal (see instructions) 113 40. 00 40. 01 Demonstration payment adjustment amount after sequestration 30. 99 40. 01 Demonstration payment adjustment (see instructions) 30. 99 40. 01 Demonstration payment adjustment (see instructions) 30. 99 40. 01 Demonstration adjustment (see instructions) 30. 99 40. 01 Demonstration adjustment (see instructions) 30. 99 40. 01 Demonstration payment adjustment (see instructions) 30. 40. 01 Demonstration payment (see instructions) 31. 10 Demonstration payment (see instructions) 31. 10 Demonstration adjustment (see instructions) 31. 10 Demonstration payment (see instructions) 31. 10 Demonstration payment (see instructions) 31. 10 Demonstration (see instructions) 31. 10 Demonstration payment (see instructions) 31. 10 Demonstration (see instructions) 31. 10 Dem		, , , , ,			0	
39. 98 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) 0 40. 01 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 40. 03 41. 01 Interim payments 312 41. 00 42. 00 Tentative settlement (for contractors use only) 41. 01 42. 00 42. 01 Tentative settlement (for contractor use only) 42. 01 42. 01 43. 00 Bal ance due provider/program (see instructions) -199 43. 00 43. 01 Bal ance due provider/program-PARHM (see instructions) 43. 01 44. 00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44. 00 90. 00 Original outlier amount (see instructions) 0 90. 00 91. 00 Outlier reconciliation adjustment amount (see instructions) 0 90. 00 <		, , , , , , , , , , , , , , , , , , , ,			0	
40.00 Subtotal (see instructions) 40.01 Sequestration adjustment (see instructions) 5equestration adjustment (see instructions) 40.02 Demonstration payment adjustment amount after sequestration 5equestration adjustment-PARHM pass-throughs 41.00 Interim payments 6 Interim payments 7 Interim payments 8 Interim payments 9 Interim payments 9 Interim payments-PARHM 9 Interim payments 9 In		, , , , , , , , , , , , , , , , , , , ,	devices (see instruct	i ons)		
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 40.03 41.00 Interim payments 312 41.00 41.01 Interim payments-PARHM 41.01 41.01 42.00 Tentative settlement (for contractor use only) 0 42.00 42.01 Tentative settlement-PARHM (for contractor use only) 42.01 43.00 Bal ance due provider/program (see instructions) -199 43.00 43.01 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 80.00 Si15.2 0 44.00 70.00 Diginal outlier amount (see instructions) 0 90.00 90.00 The rate used to calculate the Time Value of Money 0 90.00 93.00 Time Value of Money (see instructions) 0 93.00	39. 99	RECOVERY OF ACCELERATED DEPRECIATION	•		0	39. 99
40.02 Demonstration payment adjustment amount after sequestration Sequestration adjustment-PARHM pass-throughs 41.00 Interim payments Interim payments Interim payments-PARHM 1.00 Interim payments-PARHM Interim payments Interim paymen						
40.03 Sequestration adjustment-PARHM pass-throughs 40.03 41.00 Interim payments 41.00 Interim payments 41.00 41.01 42.00 Tentative settlement (for contractor use only) 42.01 Tentative settlement-PARHM (for contractor use only) 42.01 43.00 Balance due provider/program (see instructions) 43.01 Balance due provider/program-PARHM (see instructions) 43.01 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 4						
41.00		1			U	
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) 0 42.00 42.01 42.01 42.01 43.00 42.01 43.00 43.01 44.00 91.00 91.00 91.00 91.00 92.00 93.00		, ,			312	
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, 0 44.00 \$\frac{115.2}{10 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 Outlier reconciliation adjustment amount (see instructions) 94.00 Outlier reconciliation adjustment amount (see instructions) 95.00 Outlier reconciliation adjustment amount (see instructions) 96.00 Outlier reconciliation adjustment amount (see instructions) 97.00 Outlier reconciliation adjustment amount (see instructions)						
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, 0 44.00 91.00 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 Outlier reconciliation adjustment amount (see instructions) 94.00 Outlier reconciliation adjustment amount (see instructions) 94.00 Outlier reconciliation adjustment amount (see instructions) 95.00 Outlier reconciliation adjustment amount (see instructions) 96.00 Outlier reconciliation adjustment amount (see instructions) 97.00 Outlier reconciliation adjustment amount (see instructions) 97.00 Outlier reconciliation adjustment amount (see instructions) 98.00 Outlier reconciliation adjustment amount (see instructions) 99.00 Outlier reconciliation adjustment amount (see instructions) 99.00 Outlier reconciliation adjustment amount (see instructions) 99.00 Outlier reconciliation adjustment amount (see instructions)					0	
43.01 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 \$\frac{\text{5115.2}}{\text{10 BE COMPLETED BY CONTRACTOR}} 90.00 Original outlier amount (see instructions) 0 utlier reconciliation adjustment amount (see instructions) 0 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1					-199	
44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 \$\frac{\f					.,,	
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) 10 90.00 91.00 92.00 93.00 Time Value of Money (see instructions) 10 90.00 92.00 93.00		, , , , , , , , , , , , , , , , , , , ,	with CMS Pub. 15-2, c	hapter 1,	0	
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	90 00				Ω	90 00
92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0.00 92.00 93.00						
		The rate used to calculate the Time Value of Money				92. 00
94. 00 Total (Suiii of Titles 91 and 93)						
	74. UU	TOTAL (Sum OF LITTES 71 and 73)			0	74.00

Health Financial Systems FRA
ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Peri od: Worksheet E-1
From 01/01/2021
To 12/31/2021 Part I
Date/Time Prepared: 5/30/2022 7:58 pm Provider CCN: 15-0090

2.00 Interim submitted services write "I amount I for the payment Program	nterim payments paid to provider m payments payable on individual bills, either ted or to be submitted to the contractor for es rendered in the cost reporting period. If none, 'NONE" or enter a zero eparately each retroactive lump sum adjustment based on subsequent revision of the interim rate e cost reporting period. Also show date of each t. If none, write "NONE" or enter a zero. (1)	Inpatien mm/dd/yyyy 1.00	XVIII t Part A Amount 2.00 22, 181, 377	mm/dd/yyyy 3.00	PPS t B Amount 4.00 8,725,602 0	1.00
2.00 Interim submitted services write "1 3.00 List se amount I for the payment Program 3.01 ADJUSTM	m payments payable on individual bills, either ted or to be submitted to the contractor for es rendered in the cost reporting period. If none, 'NONE" or enter a zero eparately each retroactive lump sum adjustment based on subsequent revision of the interim rate e cost reporting period. Also show date of each	mm/dd/yyyy	Amount 2.00 22,181,377	mm/dd/yyyy 3.00	Amount 4.00 8,725,602	
2.00 Interim submitted services write "1 3.00 List see amount I for the payment Program 3.01 ADJUSTM	m payments payable on individual bills, either ted or to be submitted to the contractor for es rendered in the cost reporting period. If none, 'NONE" or enter a zero eparately each retroactive lump sum adjustment based on subsequent revision of the interim rate e cost reporting period. Also show date of each		2. 00 22, 181, 377	3. 00	4. 00 8, 725, 602	
2.00 Interim submitted services write "1 3.00 List see amount I for the payment Program 3.01 ADJUSTM	m payments payable on individual bills, either ted or to be submitted to the contractor for es rendered in the cost reporting period. If none, 'NONE" or enter a zero eparately each retroactive lump sum adjustment based on subsequent revision of the interim rate e cost reporting period. Also show date of each	1.00	22, 181, 377		8, 725, 602	
2.00 Interim submitted services write "1 3.00 List see amount I for the payment Program 3.01 ADJUSTM	m payments payable on individual bills, either ted or to be submitted to the contractor for es rendered in the cost reporting period. If none, 'NONE" or enter a zero eparately each retroactive lump sum adjustment based on subsequent revision of the interim rate e cost reporting period. Also show date of each					
submitted services write "I 3.00 List sell amount I for the payment Program 3.01 ADJUSTM	ted or to be submitted to the contractor for es rendered in the cost reporting period. If none, 'NONE" or enter a zero eparately each retroactive lump sum adjustment based on subsequent revision of the interim rate e cost reporting period. Also show date of each		0		0	2. 00
3.00 Services write "I List sel amount I for the payment Program 3.01 ADJUSTM	es rendered in the cost reporting period. If none, 'NONE" or enter a zero eparately each retroactive lump sum adjustment based on subsequent revision of the interim rate e cost reporting period. Also show date of each					
3.00 write "I List sepamount I for the payment Program 3.01 ADJUSTM	'NONE" or enter a zero eparately each retroactive lump sum adjustment based on subsequent revision of the interim rate e cost reporting period. Also show date of each					
3.00 List se amount I for the payment Program 3.01 ADJUSTM	eparately each retroactive lump sum adjustment based on subsequent revision of the interim rate e cost reporting period. Also show date of each				(
amount for the payment Program 3.01 ADJUSTM	based on subsequent revision of the interim rate e cost reporting period. Also show date of each					
for the payment Program 3.01 ADJUSTM	e cost reporting period. Also show date of each					3. 00
payment Program 3.01 ADJUSTM						
Program 3.01 ADJUSTM	t. It none, write none of enterazero, (1)					
3. 01 ADJUSTMI						
	MENTS TO PROVIDER	12/31/2021	282		0	3. 01
	MENTS TO TROVIDER	12/31/2021	0		ان	3. 02
3. 03			0			3. 03
3. 04			0			3. 04
3. 05			0			3. 05
	er to Program		-		_	
	MENTS TO PROGRAM		0		0	3. 50
3. 51			0		0	3. 51
3. 52			0		0	3. 52
3. 53			0		0	3. 53
3. 54			0		0	3. 54
	al (sum of lines 3.01-3.49 minus sum of lines		282		0	3. 99
3. 50-3.						
	nterim payments (sum of lines 1, 2, and 3.99)		22, 181, 659		8, 725, 602	4. 00
	fer to Wkst. E or Wkst. E-3, line and column as					
appropri	COMPLETED BY CONTRACTOR					
	eparately each tentative settlement payment after					5. 00
	eview. Also show date of each payment. If none,					3.00
	'NONE" or enter a zero. (1)					
	to Provider					
5. 01 TENTATI	VE TO PROVIDER		0		0	5. 01
5. 02			0		0	5. 02
5. 03			0		0	5. 03
	er to Program					
	VE TO PROGRAM		0		0	5. 50
5. 51			0		0	5. 51
5. 52			0		0	5. 52
	al (sum of lines 5.01-5.49 minus sum of lines		0		0	5. 99
5. 50-5. 9	ned net settlement amount (balance due) based on					6. 00
	st report. (1)					0.00
	MENT TO PROVIDER		0		0	6. 01
	MENT TO PROGRAM		78, 591		152, 023	6. 02
· ·	Medicare program liability (see instructions)		22, 103, 068		8, 573, 579	7. 00
7. 1. 2. 2. 3. 11.	(222.000)		,, 000	Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
		(1. 00	2. 00	
8.00 Name of	f Contractor					8. 00

Component CCN: 15-T090

Title XVIII

		Title	e XVIII	Subprovi der - I RF	PPS	
		Inpatien	it Part A		t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2.00	3. 00	4. 00	
1. 00 2. 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none,		9, 713, 466	5	312 0	1. 00 2. 00
3.00	write "NONE" or enter a zero List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3. 00
	Program to Provider		T	T		
3. 01	ADJUSTMENTS TO PROVIDER		(0	3. 01
3. 02			(0	3. 02
3. 03			(0	3. 03
3.04			(0	3. 04
3. 05			()	0	3. 05
0 50	Provi der to Program		1 /	J		0.50
3.50	ADJUSTMENTS TO PROGRAM		(0	3. 50
3.51			(0	3. 51
3.52			(0	3. 52
3.53					0	3. 53 3. 54
3.54	Subtatal (sum of lines 2 01 2 40 minus sum of lines					
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98))	U	3. 99
4. 00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		9, 713, 466	5	312	4. 00
	TO BE COMPLETED BY CONTRACTOR					
5. 00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5. 00
	Program to Provider					
5. 01	TENTATI VE TO PROVIDER		(0	5. 01
5. 02			(0	5. 02
5. 03			()	0	5. 03
E	Provider to Program TENTATIVE TO PROGRAM				0	E F0
5. 50 5. 51	I ENTATIVE TO PROGRAM					5. 50 5. 51
5. 51 5. 52						5. 51
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines					5. 99
6. 00	5.50-5.98) Determined net settlement amount (balance due) based on			,		6. 00
0.00	the cost report. (1)					0.00
6. 01	SETTLEMENT TO PROVIDER		(o	6. 01
6. 02	SETTLEMENT TO PROGRAM		78, 652	2	199	6. 02
7. 00	Total Medicare program liability (see instructions)		9, 634, 814		113	7. 00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		()	1. 00	2. 00	
8.00	Name of Contractor					8. 00

Heal th	Health Financial Systems FRANCISCAN HEALTH- DYER In Lieu				2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 15-0090 Period: From 01/01/2021					
			To 12/31/2021	Date/Time Pre 5/30/2022 7:5	
		Title XVIII	Hospi tal	PPS	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPOR				1
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCUL				
1. 00	Total hospital discharges as defined in AARA §4102 from				1. 00
2.00	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1,		for cost		2. 00
0.00	reporting periods beginning on or after 10/01/2013, line	2 32)			0.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3.00
4. 00	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of I		a plus for cost		4. 00
г оо	reporting periods beginning on or after 10/01/2013, line				F 00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 2				5. 00
6.00	Total hospital charity care charges from Wkst. S-10, col		W . C O D. I		6.00
7. 00	CAH only - The reasonable cost incurred for the purchase line 168	e of certified Hil technology	WKST. S-2, PT. I		7. 00
8.00	Calculation of the HIT incentive payment (see instruction	ons)			8. 00
9.00	Sequestration adjustment amount (see instructions)				9. 00
10.00	Calculation of the HIT incentive payment after sequestra	ation (see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions	s)			30.00
31.00	Other Adjustment (specify)				31.00
32. 00	Balance due provider (line 8 (or line 10) minus line 30	and line 31) (see instructio	ns)		32. 00

Health Financial Systems	FRANCISCAN HEALTH- DYER	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0090	Peri od: From 01/01/2021	Worksheet E-3
	Component CCN: 15-T090		Date/Time Prepared: 5/30/2022 7:58 pm
	Title XVIII	Subprovi der -	PPS
		IRF	

			IRF	
į			_	1. 00
	PART III - MEDICARE PART A SERVICES - IRF PPS			
)	Net Federal PPS Payment (see instructions)			9, 330, 771
)	Medicare SSI ratio (IRF PPS only) (see instructions)			0. 0182
0	Inpatient Rehabilitation LIP Payments (see instructions)			265, 927
0	Outlier Payments			212, 705
0	Unweighted intern and resident FTE count in the most recent cost to November 15, 2004 (see instructions)	t reporting period en	ding on or prior	0. 00
)1	Cap increases for the unweighted intern and resident FTE count program or hospital closure, that would not be counted without a CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0. 00
0	New Teaching program adjustment. (see instructions)			0.00
0	Current year's unweighted FTE count of I&R excluding FTEs in the teaching program" (see instructions)	e new program growth p	eriod of a "new	0. 00
0	Current year's unweighted I&R FTE count for residents within the	e new program growth p	eriod of a "new	0. 00
	teaching program" (see instructions)			
00	Intern and resident count for IRF PPS medical education adjustments	ent (see instructions)		0.00
00	Average Daily Census (see instructions)			22. 676712
	Teaching Adjustment Factor (see instructions)			0. 000000
	Teaching Adjustment (see instructions)			0
	Total PPS Payment (see instructions)			9, 809, 403
	Nursing and Allied Health Managed Care payments (see instruction	n)		0
	Organ acquisition (DO NOT USE THIS LINE)	ationa)		0
	Cost of physicians' services in a teaching hospital (see instructions)	Ctrons)		0 9, 809, 403
	Primary payer payments			9, 609, 403
	Subtotal (line 17 less line 18).			9, 809, 403
	Deductibles			140, 828
	Subtotal (line 19 minus line 20)			9, 668, 575
	Coi nsurance			33, 761
	Subtotal (line 21 minus line 22)			9, 634, 814
	Allowable bad debts (exclude bad debts for professional services	s) (see instructions)		7, 054, 014
	Adjusted reimbursable bad debts (see instructions)	3) (300 111311 4011 6113)		0
	Allowable bad debts for dual eligible beneficiaries (see instruc	ctions)		0
	Subtotal (sum of lines 23 and 25)	01.0		9, 634, 814
	Direct graduate medical education payments (from Wkst. E-4, line	e 49)		0
	Other pass through costs (see instructions)			0
	Outlier payments reconciliation			0
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0
50	Pioneer ACO demonstration payment adjustment (see instructions)			0
98	Recovery of accelerated depreciation.			0
99	Demonstration payment adjustment amount before sequestration			0
00	Total amount payable to the provider (see instructions)			9, 634, 814
01	Sequestration adjustment (see instructions)			0
02	Demonstration payment adjustment amount after sequestration			0
00	Interim payments			9, 713, 466
00	Tentative settlement (for contractor use only)			0
00	Balance due provider/program (line 32 minus lines 32.01, 32.02,	33, and 34)		-78, 652
00	Protested amounts (nonallowable cost report items) in accordance §115.2	e with CMS Pub. 15-2,	chapter 1,	0
00	TO BE COMPLETED BY CONTRACTOR			212 705
	Original outlier amount from Wkst. E-3, Pt. III, line 4			212, 705
00	Outlier reconciliation adjustment amount (see instructions)			0 00
	The rate used to calculate the Time Value of Money			0.00
00	Time Value of Money (see instructions)	CLINNING DEFORE THE EN	D OF THE COVED 10	0
00	FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BE			
1 11 1	Teaching Adjustment Factor for the cost reporting period immedia	atery preceding rebrua	ı y 29, 2020.	0.000000

Health Financial Systems	FRANCISCAN HEALTH- DYER	H- DYER In Lieu		
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0090		Worksheet E-3 Part VII Date/Time Prepared: 5/30/2022 7:58 pm	

			10 12/31/2021	5/30/2022 7:5	
		Title XIX	Hospi tal	Cost	<u> </u>
			Inpati ent	Outpati ent	
			1. 00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SEF	RVICES FOR TITLES V OR XI			
	COMPUTATION OF NET COST OF COVERED SERVICES				1
1.00	Inpatient hospital/SNF/NF services		0		1.00
2.00	Medical and other services			0	
3.00	Organ acquisition (certified transplant centers only)		0		3. 00
4.00	Subtotal (sum of lines 1, 2 and 3)		o	0	4.00
5.00	Inpatient primary payer payments		o		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		0	0	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				1
	Reasonabl e Charges				1
8.00	Routi ne servi ce charges		0		8.00
9.00	Ancillary service charges		22, 279, 980	31, 083, 677	9. 00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11. 00
12.00	Total reasonable charges (sum of lines 8 through 11)		22, 279, 980	31, 083, 677	12.00
	CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13. 00
	basi s				
14. 00	Amounts that would have been realized from patients liable for		0	0	14. 00
	a charge basis had such payment been made in accordance with	42 CFR §413.13(e)			
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0. 000000	
16. 00	Total customary charges (see instructions)		22, 279, 980	31, 083, 677	
17. 00	Excess of customary charges over reasonable cost (complete onl	y if line 16 exceeds	22, 279, 980	31, 083, 677	17. 00
40.00	line 4) (see instructions)				40.00
18. 00	Excess of reasonable cost over customary charges (complete onl	y IT line 4 exceeds line	0	0	18. 00
10.00	16) (see instructions)			0	10.00
19. 00	Interns and Residents (see instructions)	quati ana)	0	0	
21. 00	Cost of physicians' services in a teaching hospital (see instr		0	0	
21.00	Cost of covered services (enter the lesser of line 4 or line 1 PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be			0	21. 00
22. 00	3	Compreted for PPS provide	0	0	22. 00
	Outlier payments		0	0	
			0	O	24.00
	Capital exception payments (see instructions)		0		25. 00
	Routine and Ancillary service other pass through costs		0	0	
	Subtotal (sum of lines 22 through 26)		o o	0	
28. 00	Customary charges (title V or XIX PPS covered services only)		ő	0	
	Titles V or XIX (sum of lines 21 and 27)		0	0	
27.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT		_i		1 27.00
30. 00	Excess of reasonable cost (from line 18)		0	0	30.00
31. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6))	o	0	
32. 00	Deducti bl es	•	o	0	
33. 00			0	0	
34.00	Allowable bad debts (see instructions)		o	0	34.00
35.00	Utilization review		0		35. 00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	33)	0	0	36. 00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37. 00
38.00	Subtotal (line 36 ± line 37)		0	0	38. 00
39. 00	Direct graduate medical education payments (from Wkst. E-4)		0		39. 00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	40. 00
41.00			0	0	41. 00
42.00	Balance due provider/program (line 40 minus line 41)		0	0	42. 00
43.00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub 15-2,	0	0	43. 00
	chapter 1, §115.2				I

Health Financial Systems	FRANCISCAN HEALTH- DYER	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0090	Peri od: From 01/01/2021	Worksheet E-3 Part VII
	Component CCN: 15-T090	To 12/31/2021	Date/Time Prepared: 5/30/2022 7:58 pm
	Title XIX	Subprovi der -	TEFRA
		IRF	

		I RF		
		I npati ent	Outpati ent	
		1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX	SERVI CES		
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	0		1. 00
2.00	Medical and other services		0	2. 00
3.00	Organ acquisition (certified transplant centers only)	0		3. 00
4.00	Subtotal (sum of lines 1, 2 and 3)	0	0	4. 00
5. 00	Inpatient primary payer payments	0	_	5. 00
6.00	Outpatient primary payer payments		0	6. 00
7. 00	Subtotal (line 4 less sum of lines 5 and 6)	0	0	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES			
0.00	Reasonabl e Charges			0.00
8.00	Routi ne servi ce charges	0	0	8. 00
9.00	Ancillary service charges	0	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11. 00	Incentive from target amount computation	0	0	11.00
12. 00	Total reasonable charges (sum of lines 8 through 11)	0	0	12. 00
12 00	CUSTOMARY CHARGES	l	0	12.00
13. 00	Amount actually collected from patients liable for payment for services on a charge basis	٥	Ü	13. 00
14. 00	Amounts that would have been realized from patients liable for payment for services on	o	0	14. 00
14.00	a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	J	O	14.00
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0. 000000	0. 000000	15. 00
16. 00	Total customary charges (see instructions)	0.000000	0.000000	16. 00
17. 00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds	l o	0	17. 00
17.00	line 4) (see instructions)	٩	O	17.00
18. 00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line	0	0	18. 00
10.00	16) (see instructions)		O	10.00
19. 00	Interns and Residents (see instructions)	o	0	19. 00
20. 00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20. 00
21. 00	Cost of covered services (enter the lesser of line 4 or line 16)	o	0	21. 00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS provide			
22. 00	Other than outlier payments	0	0	22. 00
23.00	Outlier payments	0	0	23. 00
24.00	Program capital payments	0		24. 00
25.00	Capital exception payments (see instructions)	0		25. 00
26.00	Routine and Ancillary service other pass through costs	0	0	26. 00
27. 00	Subtotal (sum of lines 22 through 26)	0	0	27. 00
28. 00	Customary charges (title V or XIX PPS covered services only)	0	0	28. 00
29. 00	Titles V or XIX (sum of lines 21 and 27)	0	0	29. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT	<u>'</u>		
30.00	Excess of reasonable cost (from line 18)	0	0	30. 00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	0	31. 00
32.00	Deducti bl es	0	0	32. 00
33.00	Coinsurance	0	0	33. 00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35. 00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	0	36. 00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37. 00
38.00	Subtotal (line 36 ± line 37)	0	0	38. 00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39. 00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	o	0	40. 00
41.00	Interim payments	o	0	41. 00
42.00	Balance due provider/program (line 40 minus line 41)	o	0	42. 00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,	o	0	43.00
	chapter 1, §115.2			

	RADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT EDUCATION COSTS	Provi der CC	CN: 15-0090	Peri od: From 01/01/2021 To 12/31/2021	Worksheet E-4 Date/Time Prep 5/30/2022 7:58	pared:
		Title	XVIII	Hospi tal	PPS	
					1. 00	
	MPUTATION OF TOTAL DIRECT GME AMOUNT					
	weighted resident FTE count for allopathic and osteopathic ding on or before December 31, 1996.	programs for	cost reporti	ng periods	7. 76	1.00
. 00 Un	weighted FTE resident cap add-on for new programs per 42 CF		1) (see instr	ructions)	0. 00	2.00
- 1	nount of reduction to Direct GME cap under section 422 of MM			,	0. 86	3.00
	rect GME cap reduction amount under ACA §5503 in accordance structions for cost reporting periods straddling 7/1/2011)	WITH 42 CFR	9413.79 (m).	(see	0. 00	3. 0°
00 Ad	justment (plus or minus) to the FTE cap for allopathic and		programs due	to a Medicare	0. 00	4.00
	UE affiliation agreement (42 CFR §413.75(b) and § 413.79 (f) OA Section 5503 increase to the Direct GME FTE Cap (see inst		cost reporti	na neri ods	0.00	4.0
	raddling 7/1/2011)	ructions for	cost reporti	ng perrous	0.00	4.0
02 AC	A Section 5506 number of additional direct GME FTE cap slot	s (see inst	ructions for	cost reporting	0. 00	4. 02
	riods straddling 7/1/2011) E adjusted cap (line 1 plus line 2 minus line 3 and 3.01 pl	us or minus	line 4 nlus l	ines 4 01 and	6. 90	5.00
	02 plus applicable subscripts	us or illinus	Time 4 prus i	11103 4.01 dild	0. 70	3.00
	weighted resident FTE count for allopathic and osteopathic	programs for	the current	year from your	1. 81	6. 0
	cords (see instructions) ter the lesser of line 5 or line 6				1. 81	7.00
			Primary Care		Total	
00 Wo	ighted FTE count for physicians in an allopathic and osteop	athi c	1.00	2.00	3.00	0 0
	egram for the current year.	atnic	0. 2	21 1. 40	1. 61	8.0
mu	line 6 is less than 5 enter the amount from line 8, otherw Oltiply line 8 times the result of line 5 divided by the amo		0.2	21 1. 40	1. 61	9. 0
0.00 We	ighted dental and podiatric resident FTE count for the curr	ent vear		2. 75		10.0
	weighted dental and podiatric resident FTE count for the cu			2. 75		10.0
	tal weighted FTE count		0. 2			11.0
	tal weighted resident FTE count for the prior cost reportinestructions)	g year (see	0. 4	6. 33		12.0
3. 00 To	tal weighted resident FTE count for the penultimate cost re	porti ng	0. 5	7. 31		13.00
12	ar (see instructions) Hling average FTE count (sum of lines 11 through 13 divided	hv 3)	0. 4	5. 93		14. 0
	justment for residents in initial years of new programs	23 37.	0. (15. 0
	weighted adjustment for residents in initial years of new p		0. (15. 0
	ljustment for residents displaced by program or hospital clo weighted adjustment for residents displaced by program or h		0. (0. (16. 0 16. 0
	osure	ospi tai	0. (0.00		10.0
1 -	justed rolling average FTE count		0. 4			17. 00
- 1	r resident amount proved amount for resident costs		90, 010. § 36, 00		551, 868	18.0
7. 00 JAP	proved amount for resident costs		30, 00	313, 004	331, 000	17.0
					1. 00	
	lditional unweighted allopathic and osteopathic direct GME F oc. 413.79(c)(4)	IE resident	cap slots red	ceived under 42	0.00	20. 0
1	rect GME FTE unweighted resident count over cap (see instru	ctions)			0. 00	21.0
- 1	lowable additional direct GME FTE Resident Count (see instr				0.00	
1	ter the locality adjustment national average per resident a	mount (see i	nstructions)		0.00	
- 1	ltiply line 22 time line 23 tal direct GME amount (sum of lines 19 and 24)				0 551, 868	ı
0.00 10	rear arrest sine amount (sam of fines fr and 21)		Inpatient Pa	rt Managed Care	Total	20.00
			1. 00	2. 00	3. 00	
CON	MPUTATION OF PROGRAM PATIENT LOAD		1.00	2.00	3. 00	
3.	patient Days (see instructions) (Title XIX - see S-2 Part I 02, column 2)	X, line	13, 82			26. 00
1	tal Inpatient Days (see instructions)		29, 54			27. 0
1	tio of inpatient days to total inpatient days ogram direct GME amount		0. 46773 258, 12		368, 111	28. 0 29. 0
7. UU [IT	5		250, 12	107, 705	300, 111	29.00
9. 01 Pe	rcent reduction for MA DGME					
0. 00 Re	duction for direct GME payments for Medicare Advantage the Program direct GME amount			15, 541	15, 541 352, 570	30.00

Heal th	Financial Systems FRANCISCAN HEAL	TH- DYER	In Lie	u of Form CMS-2	2552-10
	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provider CCN: 15-0090	Peri od:	Worksheet E-4	
MEDI CA	MEDICAL EDUCATION COSTS From 01/01/2021 To 12/31/2021				
		Title XVIII	Hospi tal	PPS	
				1. 00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE EDUCATION COSTS)	E XVIII ONLY (NURSING PR	OGRAM AND PARAMED	II CAL	
32.00	Renal dialysis direct medical education costs (from Wkst. B, I	Pt. I, sum of col. 20 an	d 23, lines 74	0	32. 00
	and 94)				
33. 00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. 1		74 and 94)	0	
	Ratio of direct medical education costs to total charges (line	e 32 ÷ line 33)		0.000000	
	00 Medicare outpatient ESRD charges (see instructions)			0	
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			07.004.500	
37. 00				37, 234, 522 0	
38. 00					
	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	
	Primary payer payments (see instructions)			0	
41.00					
40.00	Part B Reasonable Cost			12 115 020	40.00
42. 00 43. 00				13, 115, 938 700	
	Primary payer payments (see instructions)			13, 115, 238	
	00 Total Part B reasonable cost (line 42 minus line 43)			50, 349, 760	
	00 Total reasonable cost (sum of lines 41 and 44) 00 Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)			0. 739517	
	Ratio of Part B reasonable cost to total reasonable cost (line	,		0. 739317	
47.00	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PAR			0. 200463	47.00
48 00	Total program GME payment (line 31)	(I D		352, 570	48 00
	Part A Medicare GME payment (line 46 x 48) (title XVIII only)	(see instructions)		260, 732	
	Part B Medicare GME payment (line 47 x 48) (title XVIII only)			91, 838	
50.00	Trait b medicale ome payment (Title 47 x 40) (title xviii only)	(See Thisti deti ons)	'	71,030	30.00

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

Provi der CCN: 15-0090 | Peri od: | From 01/01/2021 | To 12/31/2021 |

Date/Time Prepared: 5/30/2022 7:58 pm

——————————————————————————————————————					5/30/2022 7:5	8 pm
		General Fund		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	3, 176, 607	0	0	0	1. 00
2.00	Temporary investments	0	0	0	0	2. 00
3. 00	Notes receivable	0	0	0	0	3. 00
4.00	Accounts receivable	23, 414, 439	0	0	0	4. 00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	4 170 100	0	0	0	6. 00 7. 00
7. 00 8. 00	Inventory Prepai d expenses	4, 179, 108	0	0	0	8.00
9. 00	Other current assets	3, 000, 200	0	0	0	9. 00
10.00	Due from other funds	0	ő	ol	0	10.00
11. 00	Total current assets (sum of lines 1-10)	33, 770, 354		o	0	
	FIXED ASSETS					
12.00	Land	3, 365, 801		0	0	12.00
13.00	Land improvements	10, 343, 496	0	0	0	13. 00
14. 00	Accumulated depreciation	0	0	0	0	14. 00
15.00	Bui I di ngs	75, 013, 989	0	0	0	15. 00
16.00	Accumulated depreciation	170,000	0	0	0	16.00
17. 00 18. 00	Leasehold improvements Accumulated depreciation	178, 989	0	0	0	17. 00 18. 00
19. 00	Fi xed equipment	0	0	0	0	19. 00
20. 00	Accumul ated depreciation	0	o o	ol Ol	0	20.00
21. 00	Automobiles and trucks	l o	Ö	ol	0	21. 00
22. 00	Accumul ated depreciation	0	0	o	0	22. 00
23.00	Major movable equipment	179, 397, 674	0	o	0	23. 00
24. 00	Accumul ated depreciation	0	0	0	0	24. 00
25. 00	Mi nor equi pment depreci abl e	0	0	0	0	25. 00
26. 00	Accumulated depreciation	-165, 518, 277	0	0	0	26. 00
27. 00	HIT designated Assets	0	0	0	0	27. 00
28. 00	Accumulated depreciation	0	0	0	0	28. 00
29. 00 30. 00	Minor equipment-nondepreciable	102 701 472	0	0	0	29. 00 30. 00
30.00	Total fixed assets (sum of lines 12-29) OTHER ASSETS	102, 781, 672	U	<u> </u>	0	30.00
31. 00	Investments	0	0	o	0	31. 00
32. 00	Deposits on Leases	Ö	Ō	ō	0	32. 00
33.00	Due from owners/officers	431, 847	0	o	0	33. 00
34.00	Other assets	0	0	o	0	34.00
35.00	Total other assets (sum of lines 31-34)	431, 847		0	0	35. 00
36. 00	Total assets (sum of lines 11, 30, and 35)	136, 983, 873	0	0	0	36. 00
27.00	CURRENT LIABILITIES	7 112 000		ما	0	27.00
37. 00 38. 00	Accounts payable Salaries, wages, and fees payable	7, 113, 088		0	0	37. 00 38. 00
39. 00	Payroll taxes payable	7, 313, 142	0	0	0	39.00
40. 00	Notes and Loans payable (short term)	539, 762		0	0	40.00
41. 00	Deferred income	0 0	Ö	ol	0	41. 00
42.00	Accel erated payments	0				42.00
43.00	Due to other funds	0	0	o	0	43. 00
44.00	Other current liabilities	11, 670, 504	0	0	0	44. 00
45.00	Total current liabilities (sum of lines 37 thru 44)	26, 636, 496	0	0	0	45. 00
	LONG TERM LIABILITIES	1	1 -	ما		
46. 00	Mortgage payable	0		0	0	
47. 00	Notes payable Unsecured Loans	1, 669, 417		0	0	
48. 00 49. 00	Other long term liabilities	59, 299, 296	0	0	0	49. 00
50.00	Total long term liabilities (sum of lines 46 thru 49)	60, 968, 713		o	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	87, 605, 209		o	0	51.00
	CAPI TAL ACCOUNTS	0.70007201		-1		
52.00	General fund balance	49, 378, 664				52.00
53.00	Specific purpose fund		0			53. 00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55. 00
56. 00	Governing body created - endowment fund balance			0		56.00
57. 00	Plant fund balance - invested in plant				0	57. 00
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
59. 00	replacement, and expansion Total fund balances (sum of lines 52 thru 58)	49, 378, 664	0	o	0	59. 00
60.00	Total liabilities and fund balances (sum of lines 51 and	136, 983, 873		o	0	
	59)			٦	· ·	
			•	·		

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES FRANCISCAN HEALTH- DYER

Provider CCN: 15-0090

					To 12/31/202		
		Genera	I Fund	Speci al	Purpose Fund	Endowment Fund	
	T	1.00	2. 00	3. 00	4. 00	5. 00	
1. 00 2. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29)		45, 585, 851 -2, 979, 263	l .		0	1. 00 2. 00
3. 00	Total (sum of line 1 and line 2)		42, 606, 588	l .		0	3.00
4. 00	EQUITY TRANSFERS	6, 772, 076			0	0	4. 00
5.00		0			0	0	5. 00
6.00		0			0	0	6. 00
7. 00 8. 00		0			0	0	
9. 00		0			0		
10. 00	Total additions (sum of line 4-9)		6, 772, 076		-	o	10. 00
11. 00	Subtotal (line 3 plus line 10)		49, 378, 664			0	11. 00
12. 00	Deductions (debit adjustments) (specify)	0			0	0	
13. 00 14. 00		0			0	0	
15. 00		0			0		
16. 00		0			O	0	16. 00
17. 00		0			0	0	17. 00
18. 00	Total deductions (sum of lines 12-17)					0	18. 00
19. 00	Fund balance at end of period per balance sheet (line 11 minus line 18)		49, 378, 664			0	19. 00
	Tancer (Time II militas Time 10)	Endowment Fund	PI ant	Fund		_	
		6.00	7. 00	8. 00	_		
1. 00	Fund balances at beginning of period	6.00		8.00	0		1. 00
2. 00	Net income (loss) (from Wkst. G-3, line 29)						2. 00
3.00	Total (sum of line 1 and line 2)	0			0		3. 00
4.00	EQUITY TRANSFERS		0				4. 00
5. 00 6. 00			0				5. 00 6. 00
7. 00							7. 00
8.00			o				8. 00
9.00			0				9. 00
10. 00 11. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10)	0			0		10. 00 11. 00
12.00	Deductions (debit adjustments) (specify)	0	0		0		12.00
13. 00	beddetrons (debrt day detiments) (specify)		Ö				13. 00
14.00			0				14. 00
15. 00			0				15. 00
16. 00 17. 00			0				16. 00 17. 00
17.00	Total deductions (sum of lines 12-17)	0			0		18.00
19. 00	Fund balance at end of period per balance	0			Ö		19. 00
	sheet (line 11 minus line 18)						

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

			To 12/31/2021	Date/Time Pre 5/30/2022 7:5	
	Cost Center Description	Inpati ent	Outpati ent	Total	o piii
	oost ochter beschiptron	1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES			0.00	
	General Inpatient Routine Services				
1.00	Hospi tal	43, 378, 4	47	43, 378, 447	1.00
2.00	SUBPROVIDER - I PF				2. 00
3.00	SUBPROVI DER - I RF	19, 471, 6	72	19, 471, 672	3. 00
4.00	SUBPROVI DER		0	0	1
5.00	Swing bed - SNF		0	l o	5.00
6.00	Swing bed - NF		0	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)	62, 850, 1	19	62, 850, 119	10.00
	Intensive Care Type Inpatient Hospital Services		.		
11. 00	INTENSIVE CARE UNIT	11, 546, 7	69	11, 546, 769	11. 00
12.00	CORONARY CARE UNIT		0	0	12.00
13.00	BURN INTENSIVE CARE UNIT				13. 00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	NEONATAL INTENSIVE CARE UNIT	339, 9	07	339, 907	15. 00
16.00	Total intensive care type inpatient hospital services (sum of lines	11, 886, 6	76	11, 886, 676	16. 00
	11-15)				
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	74, 736, 7		74, 736, 795	
18.00	Ancillary services	188, 008, 8	65 264, 356, 686	452, 365, 551	18. 00
19. 00	Outpatient services	22, 989, 5	33 44, 389, 968		
20.00	RURAL HEALTH CLINIC		0		
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	21. 00
22. 00	HOME HEALTH AGENCY				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	NON REIMBURSEABLE COST CENTERS	10, 061, 0	· · ·		
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.	295, 796, 1	95 320, 488, 921	616, 285, 116	28. 00
	G-3, line 1)				
	PART II - OPERATING EXPENSES		174 004 440	ı	
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		174, 386, 443		29. 00
30.00	ADD (SPECIFY)		0		30.00
31.00			0		31.00
32. 00			0		32. 00
33. 00			0		33. 00
34.00			0		34.00
35. 00	T		0		35. 00
36.00	Total additions (sum of lines 30-35)		0		36.00
37. 00	DEDUCT (SPECIFY)		0		37. 00
38. 00			0		38. 00
39. 00			0		39.00
40.00			0		40.00
41. 00	T-t-1 d-d-t-t (6 line - 27 41)		0		41.00
42. 00	Total deductions (sum of lines 37-41)		174 204 442		42.00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfe	91	174, 386, 443		43. 00
	to Wkst. G-3, line 4)	I	I	I	I

Health Financial Systems FRANCISCAN HEALTH- DYER In Lie	u of Form CMS-2	2552-10
STATEMENT OF REVENUES AND EXPENSES Provider CCN: 15-0090 Period:	Worksheet G-3	
From 01/01/2021 To 12/31/2021	Date/Time Prep 5/30/2022 7:58	
	1.00	
1.00 Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	1. 00 616, 285, 116	1, 00
2.00 Less contractual allowances and discounts on patients' accounts	454, 519, 872	2. 00
3.00 Net patient revenues (line 1 minus line 2)	161, 765, 244	3. 00
4.00 Less total operating expenses (from Wkst. G-2, Part II, Line 43)	174, 386, 443	
5.00 Net income from service to patients (line 3 minus line 4)	-12, 621, 199	
OTHER INCOME	-12,021,199	5.00
6.00 Contributions, donations, bequests, etc	0	6. 00
7.00 Income from investments	0	7. 00
8.00 Revenues from telephone and other miscellaneous communication services	o	
9.00 Revenue from television and radio service	0	9. 00
10.00 Purchase discounts	763, 993	
11.00 Rebates and refunds of expenses	0	
12.00 Parking Lot receipts	О	12. 00
13.00 Revenue from Laundry and Linen service	128, 795	13. 00
14.00 Revenue from meals sold to employees and quests	352, 404	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 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	78	18. 00
19.00 Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00 Revenue from gifts, flowers, coffee shops, and canteen	68, 831	20.00
21.00 Rental of vending machines	0	21.00
22.00 Rental of hospital space	1, 329, 890	22. 00
23.00 Governmental appropriations	0	23.00
24.00 FITNESS CENTER	259, 675	
24. 01 OTHER MISC REVENUE	6, 738, 270	24. 01
24. 50 COVI D-19 PHE Funding	0	24. 50
25.00 Total other income (sum of lines 6-24)	9, 641, 936	
26.00 Total (line 5 plus line 25)	-2, 979, 263	
27. 00 OTHER EXPENSES (SPECIFY)	0	
28.00 Total other expenses (sum of line 27 and subscripts)	0	28. 00
29.00 Net income (or loss) for the period (line 26 minus line 28)	-2, 979, 263	29. 00

Provider CCN: 15-0990 Period:	Heal th	Financial Systems FRANCISCAN HEAD	LTH- DYER	In Lie	u of Form CMS-2	2552-10
PART I - FULLY PROSPECTIVE WETHOD 1.00	CALCUL	ATION OF CAPITAL PAYMENT	Provider CCN: 15-0090	From 01/01/2021	Parts I-III Date/Time Pre	
PART I - FULLY PROSPECTIVE METHOD CAPITAL FEDERAL ADDOUNT			Title XVIII	Hospi tal	PPS	
PART I - FULLY PROSPECTIVE METHOD CAPITAL FEDERAL ADDOUNT						
CAPITAL FEDERAL ANDUNT 1.00 Capital DRG other than outlier 1,391,733 1.00 1.01 1.00 Capital DRG other than outlier 1,391,733 1.00 1.01 1.00 Capital DRG outlier payments 19,766 2.00 Capital DRG outlier payments 19,766 2.00 Capital DRG outlier payments 19,766 2.00 Capital DRG outlier payments 10,766 2.00 Capital DRG outlier payments 10,00 1.00 Capital DRG outlier payments 10,00 Capital DRG outlier payment 10,00 Capital DRG outlier payment 10,00 Capital DRG outlier payments 10,00 Capital Capital DRG outlier 10,00 Capital Capi		DART I FILLY PROCEETIVE METHOD			1.00	
1.00 Capital DRC Other than outlier						
1.01 Wodel 4 BPCI Capit tal DRG other than outlier 0 1.07 1.00 Capital DRG outlier payments 0 2.01 Wodel 4 BPCI Capit tal DRG outlier payments 0 2.01 Wodel 4 BPCI Capit tal DRG outlier payments 0 2.01 Wodel 4 BPCI Capit tal DRG outlier payments 0 2.01 Wodel 4 BPCI Capit tal DRG outlier payments 0 2.01 Wodel 4 BPCI Capit tal DRG outlier payments 0 2.01 Wodel 4 BPCI Capit tal DRG outlier payments 0 2.01 Wodel 4 BPCI Capit tal DRG outlier payments 0 2.01 Wodel 4 BPCI Capit tal DRG outlier payments 0 2.01 0.01 Value tal DRG outlier payments 0 2.01 Value tal DRG	1 00				1 201 722	1 00
2.00 Capital DRG outilier payments 19,766 2.00 2.01 Model 4 BPCI Capital DRG outilier payments 0.2 2.01 3.00 Total inpatient days divided by number of days in the cost reporting period (see instructions) 58.28 3.00 3.00 4.00 Number of interns & residents (see instructions) 6.77 4.00 4.00 Number of interns & residents (see instructions) 3.33 5.00 1ndi rect medical education percentage (see instructions) 3.33 5.00 1.01) (see instructions) 46.345 6.00 1.01) (see instructions) 46.345 6.00 1.01) (see instructions) 7.00 Percentage of SE recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions) 7.00 9.00						1
Nodel 4 BPCI Capit Inf Countrier payments 0 2 .01					-	1
Total inpatient days divided by number of days in the cost reporting period (see instructions) 58. 28 3. 0.0						1
Number of interns & residents (see instructions) 3.33 5.00			eporting period (see inst	ructions)	58. 28	1
1.01 Content	4.00			,	6. 77	4. 00
1.01)(see instructions) 0.00	5.00	Indirect medical education percentage (see instructions)			3. 33	5. 00
Procentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 3) (see instructions) Percentage of Medicaid patient days to total days (see instructions) 0.00 8.00 8.00 9.00	6.00		e sum of lines 1 and 1.01	, columns 1 and	46, 345	6. 00
30) (see instructions)						
Receive the properties of Medicaid patient days to total days (see instructions) 0.00 8.00 0	7. 00		oatient days (Worksheet E	i, part A line	0.00	7. 00
0.00 0.00	0.00		+:>		0.00	0.00
10.00 Allowable disproportionate share percentage (see instructions) 0.00 10.00 11.00 11.00 11.00 12.00 10.100 10.		, , , , , , , , , , , , , , , , , , , ,	ictions)			
11.00 Disproportionate share adjustment (see instructions) 1.00 1.00 1.00 1.457,844 12.00 1.457,844 12.00 1.457,844 12.00 1.457,844 12.00 1.457,844 12.00 1.457,844 12.00 1.457,844 12.00 1.457,844 12.00 1.457,844 12.00 1.457,844 12.00 1.457,844 12.00 1.457,844 12.00 1.457,844 12.00 1.457,844 12.00 1.00			-)			
1, 457, 844 12.00		' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '	>)			
PART II - PAYMENT UNDER REASONABLE COST						
PART II - PAYMENT UNDER REASONABLE COST 2.00 Program inpatient routine capital cost (see instructions) 2.00 Total inpatient program capital cost (line 1 plus line 2) 3.00 Total inpatient program capital cost (line 1 plus line 2) 4.00 Capital cost payment factor (see instructions) 5.00 Total inpatient program capital cost (line 3 x line 4) PART III - COMPUTATION OF EXCEPTION PAYMENTS 1.00 Program inpatient capital costs (see instructions) 2.00 Program inpatient capital costs (see instructions) 3.00 Net program inpatient capital costs (see instructions) 3.00 Net program inpatient capital costs (line 1 minus line 2) 4.00 Applicable exception percentage (see instructions) 5.00 Capital cost for comparison to payments (line 3 x line 4) 6.00 Percentage adjustment for extraordinary circumstances (see instructions) 6.00 Percentage adjustment for extraordinary circumstances (see instructions) 6.00 Capital inimium payment level for extraordinary circumstances (line 2 x line 6) 7.00 Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6) 8.00 Capital minimum payment level (line 5 plus line 7) 9.00 Current year capital payments (from Part I, line 12) 9.00 Current year comparison of capital minimum payment level to capital payments (line 8 less line 9) 9.00 Current year comparison of capital minimum payment level to capital payments (line 8 less line 9) 9.01 Net comparison of capital minimum payment level to capital payments (line 10 plus line 11) 9.00 Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line) 9.15.00 Current year exception payment (if line 12 is positive, enter the amount on this line) 9.15.00 Current year operating and capital payment (see instructions) 9.16.00 Current year operating and capital payment (see instructions) 9.16.00 Current year operating and capital payment (see instructions) 9.16.00 Current year operating and capital costs (see instructions) 9.16.00 Curr	12.00	rotal prospective capital payments (see metrons)	,		1, 107, 011	12.00
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PART III - COMPUTATION OF EXCEPTION PAYMENTS 1.00 Program inpatient capital costs (see instructions) 2.00 Program inpatient capital costs (for extraordinary circumstances (see instructions) 3.00 Net program inpatient capital costs (line 1 minus line 2) 4.00 Applicable exception percentage (see instructions) 5.00 Capital cost for comparison to payments (line 3 x line 4) 6.00 Percentage adjustment for extraordinary circumstances (see instructions) 7.00 Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6) 8.00 Capital minimum payment level (line 5 plus line 7) 9.00 Current year capital payments (from Part I, line 12, as applicable) 9.00 Current year comparison of capital minimum payment level to capital payments (line 8 less line 9) 9.00 Carryover of accumulated capital minimum payment level over capital payment (from prior year 9.00 Worksheet L, Part III, line 14) 9.00 Current year exception payment (if line 12 is positive, enter the amount on this line) 9.01 Current year exception payment (if line 12 is positive, enter the amount on this line) 9.01 Current year allowable operating and capital payment (see instructions) 9.02 Current year allowable operating and capital payment (see instructions) 9.03 Current year operating and capital payment (see instructions) 9.04 Outrent year operating and capital payment (see instructions) 9.05 Current year operating and capital payment (see instructions) 9.06 Current year operating and capital payment (see instructions) 9.07 Outrent year operating and capital payment (see instructions) 9.08 Outrent year operating and capital payment (see instructions) 9.09 Outrent year operating and capital payment (see instructions) 9.00 Current year operating and capital payment (see instructions) 9.01 Outrent year operating and capital payment (see instructions) 9.01 Outrent year operating and capital payment (see instructions) 9.01 Outrent year operating and capital payment (see instructions)	5.00	Total inpatient program capital cost (line 3 x line 4)			0	5. 00
PART III - COMPUTATION OF EXCEPTION PAYMENTS 1.00 Program inpatient capital costs (see instructions) 2.00 Program inpatient capital costs (for extraordinary circumstances (see instructions) 3.00 Net program inpatient capital costs (line 1 minus line 2) 4.00 Applicable exception percentage (see instructions) 5.00 Capital cost for comparison to payments (line 3 x line 4) 6.00 Percentage adjustment for extraordinary circumstances (see instructions) 7.00 Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6) 8.00 Capital minimum payment level (line 5 plus line 7) 9.00 Current year capital payments (from Part I, line 12, as applicable) 9.00 Current year comparison of capital minimum payment level to capital payments (line 8 less line 9) 9.00 Carryover of accumulated capital minimum payment level over capital payment (from prior year 9.00 Worksheet L, Part III, line 14) 9.00 Current year exception payment (if line 12 is positive, enter the amount on this line) 9.01 Current year exception payment (if line 12 is positive, enter the amount on this line) 9.01 Current year allowable operating and capital payment (see instructions) 9.02 Current year allowable operating and capital payment (see instructions) 9.03 Current year operating and capital payment (see instructions) 9.04 Outrent year operating and capital payment (see instructions) 9.05 Current year operating and capital payment (see instructions) 9.06 Current year operating and capital payment (see instructions) 9.07 Outrent year operating and capital payment (see instructions) 9.08 Outrent year operating and capital payment (see instructions) 9.09 Outrent year operating and capital payment (see instructions) 9.00 Current year operating and capital payment (see instructions) 9.01 Outrent year operating and capital payment (see instructions) 9.01 Outrent year operating and capital payment (see instructions) 9.01 Outrent year operating and capital payment (see instructions)					1 00	
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