This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 03-31-2022 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 15-0165 Worksheet S Peri od: From 01/01/2021 Parts I-III AND SETTLEMENT SUMMARY 12/31/2021 Date/Time Prepared: 5/31/2022 7:54 am PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 5/31/2022 7:54 am] Manually prepared cost report use only Ilf this is an amended report enter the number of times the provider resubmitted this cost report [Medicare Utilization. Enter "F" for full or "L" for low. [1] Cost Report Status
[1] As Submitted
[2] Settled without Audit
[3] Settled with Audit
[4] Date Received:
[5] To. NPR Date:
[6] 10. NPR Date:
[7] 11. Contractor's Vendor Code:
[7] 12. [8] Final Report for this Provider CCN
[9] [8] Final Report for this Provider CCN
[10] NPR Date:
[11] 12. Contractor's Vendor Code:
[11] 12. [8] 13. Contractor's Vendor Code:
[12] 13. NPR Date:
[13] 14. Contractor's Vendor Code:
[14] 15. Contractor's Vendor Code:
[15] 16. NPR Date:
[16] 17. Contractor's Vendor Code:
[17] 18. Contractor's Vendor Code:
[18] 19. Contractor's Vendor Code:
[19] 19. Contractor's Vendor Code:
[1 Contractor use only (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 MUNSTER (15-0165) for the cost reporting period beginning 01/01/2021 and ending 12/31/2021 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

| | SIGNATURE OF CHIEF FINA | NCIAL OFFICER OR ADMINISTRATOR | CHECKBOX | ELECTRONI C | |
|---|-------------------------|--------------------------------|----------|---|---|
| | | 1 | 2 | SIGNATURE 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 | CF0 | | | 3 |
| 4 | Date | | | | 4 |

| | | | Title | XVIII | | | |
|--------|-------------------------------------|---------|-------------|----------|-------|-----------|---------|
| | Cost Center Description | Title V | Part A | Part B | HIT | Title XIX | |
| | | 1.00 | 2. 00 | 3. 00 | 4. 00 | 5. 00 | |
| | PART III - SETTLEMENT SUMMARY | | | | | | |
| 1.00 | Hospi tal | 0 | 1, 302, 580 | -73, 344 | 0 | 0 | 1. 00 |
| 2.00 | Subprovi der - I PF | 0 | 0 | 0 | | 0 | 2. 00 |
| 3. 00 | Subprovi der - IRF | 0 | 0 | 0 | | 0 | 3. 00 |
| 5. 00 | Swing Bed - SNF | 0 | 0 | 0 | | 0 | 5. 00 |
| 6. 00 | Swing Bed - NF | 0 | | | | 0 | 6.00 |
| 7. 00 | SKILLED NURSING FACILITY | 0 | 0 | 0 | | 0 | 7. 00 |
| 8. 00 | NURSING FACILITY | 0 | | | | 0 | 8. 00 |
| 9. 00 | HOME HEALTH AGENCY I | 0 | 0 | 0 | | 0 | 9. 00 |
| 10. 00 | RURAL HEALTH CLINIC I | 0 | | 0 | | 0 | 10.00 |
| 11. 00 | FEDERALLY QUALIFIED HEALTH CENTER I | 0 | | 0 | | 0 | 11. 00 |
| 12. 00 | CMHC I | 0 | | 0 | | 0 | 12. 00 |
| 200.00 | Total | 0 | 1, 302, 580 | -73, 344 | 0 | 0 | 200. 00 |

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

| 22.03 Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 22.04 Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. | | Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. | | | | |
|--|--------|--|---|---|---|--------|
| rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost | 22. 03 | Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for | N | N | N | 22. 03 |
| below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost | 22. 04 | Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for | N | N | N | 22. 04 |
| | 23. 00 | Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost | 3 | N | | 23. 00 |

57.00 | If line 56 is yes, is this the first cost reporting period during which residents in approved

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.

GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" 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.

57 00

58 00

59.00

resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)

| | | | Nonprovi der Si te | Hospi tal | 4)) | |
|--|-------|------|-----------------------|-----------|-----------------|--------|
| | 1. 00 | 2.00 | 3. 00 | 4. 00 | 5. 00 | 1 |
| 67.00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) | | | 0.00 | 0.00 | 0. 000000 | 67. 00 |
| | | | | | | |
| | | | | 1.00 |) 2.00 3.00 | |

| | | 1.00 | 2.00 | 3.00 | |
|-------|--|------|------|------|--------|
| | Inpatient Psychiatric Facility PPS | | | | |
| 70.00 | Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? | N | | | 70.00 |
| | Enter "Y" for yes or "N" for no. | | | | |
| 71.00 | If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most | | | 0 | 71. 00 |
| | recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see | | | | |
| | 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching | | | | |
| | program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. | | | | |
| | Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. | | | | |
| | (see instructions) | | | | |
| | Inpatient Rehabilitation Facility PPS | | | | |
| 75.00 | Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF | N | | | 75. 00 |
| | subprovider? Enter "Y" for yes and "N" for no. | | | | |
| | If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most | | | 0 | 76. 00 |
| | recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for | | | | |
| | no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 | | | | |
| | CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, | | | | |
| | indicate which program year began during this cost reporting period. (see instructions) | | | | |

| SPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | MUNSTER Provider CCN: 15 | | Peri od: | u of Form CMS- Worksheet S-2 | |
|---|-----------------------------------|------------|----------------------------------|--|------------|
| | | | From 01/01/2021 To 12/31/2021 | Part I Date/Time Pro 5/31/2022 7:5 | |
| | | | | 1. 00 | |
| Long Term Care Hospital PPS Oo Is this a long term care hospital (LTCH)? Enter "Y" for yes an Is this a LTCH co-located within another hospital for part or a "Y" for yes and "N" for no. | | reportinç | period? Enter | N N | 80. 81. |
| TEFRA Providers OU Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TE OU Did this facility establish a new Other subprovider (excluded u | | | | N | 85. 86. |
| §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. 1 s this hospital an extended neoplastic disease care hospital control (1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no. | lassified under | secti on | | N | 87. |
| 1000(d)(1)(b)(v1): Enter 1 101 yes of W 101 ho. | | | V | XIX | |
| Title V and XIX Services | | | 1. 00 | 2. 00 | + |
| OD Does this facility have title V and/or XIX inpatient hospital s | ervices? Enter " | 'Y" for | N | Y | 90 |
| yes or "N" for no in the applicable column. 100 Is this hospital reimbursed for title V and/or XIX through the full or in part? Enter "Y" for yes or "N" for no in the application. | | ner in | N | N | 91 |
| 00 Are title XIX NF patients occupying title XVIII SNF beds (dual | certi fi cati on)? | (see | | N | 92 |
| instructions) Enter "Y" for yes or "N" for no in the applicable Does this facility operate an ICF/IID facility for purposes of "Y" for yes or "N" for no in the applicable column. | | ? Enter | N | N | 93 |
| 00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and applicable column. | "N" for no in t | the | N | N | 94 |
| 00 If line 94 is "Y", enter the reduction percentage in the applic 00 Does title V or XIX reduce operating cost? Enter "Y" for yes or | | the | 0. 00 N | 0. 00 N | 95 |
| applicable column. | | | 0.00 | 0.00 | 97 |
| 00 If line 96 is "Y", enter the reduction percentage in the applic 00 Does title V or XIX follow Medicare (title XVIII) for the inter stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for | ns and residents | | Y | V. 00 Y | 98 |
| column 1 for title V, and in column 2 for title XIX. 10 Does title V or XIX follow Medicare (title XVIII) for the repor C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title | | | Y | Y | 98 |
| title XIX. Does title V or XIX follow Medicare (title XVIII) for the calcubed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or " | | | Y | Y | 98 |
| for title V, and in column 2 for title XIX. O3 Does title V or XIX follow Medicare (title XVIII) for a critical reimbursed 101% of inpatient services cost? Enter "Y" for yes o | | | N | N | 98 |
| for title V, and in column 2 for title XIX. O4 Does title V or XIX follow Medicare (title XVIII) for a CAH rei outpatient services cost? Enter "Y" for yes or "N" for no in co | | e V, and | N | N | 98 |
| <pre>in column 2 for title XIX. 05 Does title V or XIX follow Medicare (title XVIII) and add back Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in colu column 2 for title XIX.</pre> | | | Y | Y | 98 |
| O6 Does title V or XIX follow Medicare (title XVIII) when cost rei Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 column 2 for title XIX. | | | Y | Y | 98 |
| Rural Providers .00 Does this hospital qualify as a CAH? | | | N | | 105 |
| .00 If this facility qualifies as a CAH, has it elected the all-inc for outpatient services? (see instructions) | | . , | | | 106 |
| .00 Column 1: If line 105 is Y, is this facility eligible for cost training programs? Enter "Y" for yes or "N" for no in column 1. Column 2: If column 1 is Y and line 70 or line 75 is Y, do you approved medical education program in the CAH's excluded IPF a | (see instructi train I&Rs in a | ons) an | | | 107 |
| Enter "Y" for yes or "N" for no in column 2. (see instructions .00 s this a rural hospital qualifying for an exception to the CRN |) | | N | | 108 |
| CFR Section §412.113(c). Enter "Y" for yes or "N" for no. | | upati onal | • | Respi ratory | |
| therapy services provided by outside supplier? Enter "Y" | 1.00 | 2. 00 | 3.00 | 4.00 | 109 |
| for yes or "N" for no for each therapy. | | | | | |
| | | | | 1.00 | |

| 110.00 Did this hospital participate in the Rural Community Hospital Demonstration project (§410A | N | 110. 00 |
|---|---|---------|
| Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, | | |
| complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as | | |
| appl i cabl e. | | |
| | | |
| | | |
| | | |
| | | |

| OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | TH MUNSTER Provider CC | N: 15-0165 | Peri od: | eu of Form CMS Worksheet S- | |
|--|--|---|----------------------------------|--------------------------------|-----------|
| | | | From 01/01/2021 To 12/31/2021 | Date/Time Pr | |
| | | | | 5/31/2022 7: | 54 am |
| 11.00 If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this cost "Y" for yes or "N" for no in column 1. If the response to coluintegration prong of the FCHIP demo in which this CAH is particular that apply: "A" for Ambulance services; "B" for addifor tele-health services. | t reporting p umn 1 is Y, e icipating in | period? Enter enter the column 2. | 1. 00 N | 2.00 | 111.0 |
| | | 1. 00 | 2. 00 | 3.00 | + |
| 12.00 Did this hospital participate in the Pennsylvania Rural Health demonstration for any portion of the current cost reporting portion of the current cost reporting portion (Property 1) in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital cease participation in the demonstration, if applicable. Miscellaneous Cost Reporting Information | eri od? "Y", enter | N | | | 112.0 |
| 15.00 Is this an all-inclusive rate provider? Enter "Y" for yes or 'in column 1. If column 1 is yes, enter the method used (A, B, in column 2. If column 2 is "E", enter in column 3 either "93" for short term hospital or "98" percent for long term care (in psychiatric, rehabilitation and long term hospitals providers) the definition in CMS Pub. 15-1, chapter 22, §2208.1. | or E only) " percent ncludes | N | | | 0 115. C |
| 16.00 Is this facility classified as a referral center? Enter "Y" fo "N" for no. | or yes or | N | | | 116. 0 |
| 17.00 s this facility legally-required to carry malpractice insurar "Y" for yes or "N" for no. | nce? Enter | Y | | | 117. C |
| 18.00 Is the malpractice insurance a claims-made or occurrence police if the policy is claim-made. Enter 2 if the policy is occurrence. | | | 1 | | 118. (|
| IT the portey is crafili-illade. Effet 2 IT the portey is occurred | nce. | Premi ums | Losses | Insurance | |
| | | | | | |
| | | 1. 00 | 2.00 | 3.00 | _ |
| 18.01 List amounts of malpractice premiums and paid losses: | | 238, 2 | 189 | 0 134, 02 | 26 118. (|
| 18.02 Are malpractice premiums and paid losses reported in a cost co | antan athan t | han tha | 1. 00 N | 2.00 | 118. |
| Administrative and General? If yes, submit supporting schedul and amounts contained therein. 19.00 DO NOT USE THIS LINE 20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold H §3121 and applicable amendments? (see instructions) Enter in C "N" for no. Is this a rural hospital with < 100 beds that qual Hold Harmless provision in ACA §3121 and applicable amendments | le listing co Harmless prov column 1, "Y" lifies for th | ost centers vision in ACA for yes or ne Outpatient | N N | N | 119. |
| Enter in column 2, "Y" for yes or "N" for no. 21.00 Did this facility incur and report costs for high cost implant | table devices | charged to | Υ | | 121. |
| patients? Enter "Y" for yes or "N" for no. 22.00 Does the cost report contain healthcare related taxes as defin Act?Enter "Y" for yes or "N" for no in column 1. If column 1 i | | | | | 122. |
| the Worksheet A line number where these taxes are included. Transplant Center Information | | | | | |
| 5.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. | yes and "N" | for no. If | N | | 125. |
| 6.00 If this is a Medicare certified kidney transplant center, enter in column 1 and termination date, if applicable, in column 2. | er the certif | ication date | | | 126. |
| 7.00 If this is a Medicare certified heart transplant center, enter | r the certifi | cation date | | | 127. |
| in column 1 and termination date, if applicable, in column 2. 8.00 f this is a Medicare certified liver transplant center, enter | r the certifi | cation date | | | 128. |
| | the certific | ation date i | n | | 129. |
| | | | | | 130. |
| 19.00 If this is a Medicare certified lung transplant center, enter column 1 and termination date, if applicable, in column 2. 10.00 If this is a Medicare certified pancreas transplant center, enter, enter | | ification | | | |
| 19.00 If this is a Medicare certified lung transplant center, enter column 1 and termination date, if applicable, in column 2. 10.00 If this is a Medicare certified pancreas transplant center, end date in column 1 and termination date, if applicable, in column 2. | mn 2. | | | | 131. |
| 19.00 If this is a Medicare certified lung transplant center, enter column 1 and termination date, if applicable, in column 2.00.00 If this is a Medicare certified pancreas transplant center, endate in column 1 and termination date, if applicable, in column 1.00 If this is a Medicare certified intestinal transplant center, date in column 1 and termination date, if applicable, in column date, if applicable, in column 1.00 If this is a Medicare certified intestinal transplant center, date in column 1.00 If this is a Medicare certified intestinal transplant center. | mn 2. enter the ce mn 2. | erti fi cati on | | | |
| 29.00 If this is a Medicare certified lung transplant center, enter column 1 and termination date, if applicable, in column 2. 30.00 If this is a Medicare certified pancreas transplant center, end date in column 1 and termination date, if applicable, in column 1. 31.00 If this is a Medicare certified intestinal transplant center, date in column 1 and termination date, if applicable, in column 1. 32.00 If this is a Medicare certified islet transplant center, enter in column 1 and termination date, if applicable, in column 2. 33.00 Removed and reserved | mn 2. enter the ce mn 2. r the certifi | ertification cation date | | | 131. l |
| 29.00 If this is a Medicare certified lung transplant center, enter column 1 and termination date, if applicable, in column 2. 30.00 If this is a Medicare certified pancreas transplant center, er date in column 1 and termination date, if applicable, in column 81.00 If this is a Medicare certified intestinal transplant center, date in column 1 and termination date, if applicable, in column 32.00 If this is a Medicare certified islet transplant center, enter | mn 2. enter the ce mn 2. r the certifi | ertification cation date | | | 132. |

Health Financial Systems FRANCISCAN HEALTH MUNSTER In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0165 Peri od: Worksheet S-2 From 01/01/2021 Part I 12/31/2021 Date/Time Prepared: To 5/31/2022 7:54 am 3.00 If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number 141 OO Name: FRANCISCAN ALLIANCE Contractor's Name: WISCONSIN PHYSICIAN Contractor's Number: 8001 141 00 SERVI CE 142.00 Street: 1515 DRAGOON TRAIL PO Box: 142.00 143.00 City: MISHAWAKA State: Zip Code: 46546 143.00 1.00 144.00 Are provider based physicians' costs included in Worksheet A? 144. 00 1.00 2.00 145.00|| f costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is 145.00 no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2. 146.00|Has the cost allocation methodology changed from the previously filed cost report? Ν 146, 00 Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2. 1.00 147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. 147. 00 N 148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. N 148.00 149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no Ν 149.00 Part A Part B Title V Title XIX 1 00 2 00 3.00 4 00 Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13) 155.00 Hospi tal Ν Ν Ν N 155 00 156.00 Subprovi der - IPF Ν 156. 00 Ν Ν Ν 157. 00 Subprovi der - IRF 157 00 Ν Ν Ν N 158. 00 SUBPROVI DER 158.00 159.00 SNF N Ν Ν N 159. 00 160.00 HOME HEALTH AGENCY 160.00 Ν Ν Ν Ν 161.00 CMHC Ν Ν N 161.00 161. 10 CORF N Ν 161. 10 1.00 Multicampus 165.00 s this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? N 165.00 Enter "Y" for yes or "N" for no. County CBSA FTE/Campus State Zip Code Name 0 1.00 2.00 3.00 4.00 5.00 166.00 If line 165 is yes, for each 0. 00 166. 00 campus enter the name in column O, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) 1.00 Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act 167.00 Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no. 167 00 168.00|If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the 168.00 reasonable cost incurred for the HIT assets (see instructions) 168.01 of this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship 168 01

| exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions) | nai usin p | | 100.01 |
|---|---------------|---------|-----------|
| 169.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N transition factor. (see instructions) | "), enter the | 9. | 99169.00 |
| | Begi nni ng | Endi ng | |
| | 1. 00 | 2.00 | |
| 170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy) | | | 170. 00 |
| | | | |
| | 1. 00 | 2. 00 | |
| 171.00 If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions) | N | | 0 171. 00 |

| | FI NANCI SCAN HE. AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | | F | eriod: rom 01/01/202° o 12/31/202° | 1 Date/Time Pro | 2 epared: |
|------|---|---|----------------|--|-----------------|----------------|
| | | | | V//NI | 5/31/2022 7: | 54 am |
| | | | | 1. 00 | 2. 00 | |
| | General Instruction: Enter Y for all YES responses. Enter N | l for all NO re | sponses. Enter | | | |
| | mm/dd/yyyy format. | | | | | |
| | COMPLETED BY ALL HOSPITALS | | | | | |
| 00 | Provider Organization and Operation | 1 | | | T | |
| 00 | Has the provider changed ownership immediately prior to the reporting period? If yes, enter the date of the change in a | beginning of | instructions) | N | | 1.0 |
| | reporting period: IT yes, enter the date of the change in t | corumir 2. (see | Y/N | Date | V/I | |
| | | | 1.00 | 2. 00 | 3. 00 | |
| 00 | Has the provider terminated participation in the Medicare F yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary. | | N | | | 2. 00 |
| 00 | Is the provider involved in business transactions, includir contracts, with individuals or entities (e.g., chain home or medical supply companies) that are related to the provide officers, medical staff, management personnel, or members of directors through ownership, control, or family and other relationships? (see instructions) | offices, drug der or its of the board | N | | | 3. 00 |
| | Terationships: (see Thistructions) | | Y/N | Type | Date | |
| | | | 1.00 | 2. 00 | 3. 00 | |
| | Financial Data and Reports | | | | | |
| 00 | Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" for "R" for Reviewed. Submit complete copy or enter date avacolumn 3. (see instructions) If no, see instructions. | for Compiled, | Y | A | 05/06/2022 | 4. 00 |
| 00 | Are the cost report total expenses and total revenues diffe | erent from | N | | | 5. 0 |
| | those on the filed financial statements? If yes, submit red | conciliation. | | | | |
| | | | | Y/N | Legal Oper. | |
| | Approved Educational Activities | | | 1. 00 | 2. 00 | |
| 00 | Column 1: Are costs claimed for a nursing program? Column is the legal operator of the program? | 2: If yes, is | the provider | N | | 6. 0 |
| 00 | Are costs claimed for Allied Health Programs? If "Y" see in Were nursing programs and/or allied health programs approve cost reporting period? If yes, see instructions. | | wed during the | N N | | 7. 00 8. 00 |
| 00 | Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction | is. | | N | | 9. 0 |
| 00 | Was an approved Intern and Resident GME program initiated cost reporting period? If yes, see instructions. | | | N | | 10.00 |
| . 00 | Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions. | & R in an App | proved | N | Y/N | 11. 0 |
| | | | | | 1.00 | |
| | Bad Debts | | | | 1.00 | |
| | Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection μ | | | t reporting | Y N | 12. 0 13. 0 |
| . 00 | period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or co-payme | ents waived? If | yes, see inst | ructi ons. | N | 14. 0 |
| 00 | Bed Complement Did total beds available change from the prior cost reporti | na neriod? If | ves see instr | uctions | Y | 15. 0 |
| . 00 | Bra total bodo avarrabio change from the prior boot reports | , | rt A | | rt B | 10.0 |
| | | Y/N | Date | Y/N | Date | |
| | | 1.00 | 2.00 | 3. 00 | 4. 00 | |
| 00 | Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see | N | | N | | 16. 0 |
| 00 | instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If | Y | 05/10/2022 | Y | 05/10/2022 | 17. 0 |
| . 00 | either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this | N | | N | | 18. 00 |
| . 00 | cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions. | N | | N | | 19. 00 |

| Heal th | Financial Systems FRANCISCAN HE. | ALTH MUNSTER | | In Lie | u of Form CMS- | 2552-10 |
|------------------|--|-----------------|--------------|--|--|---------------|
| HOSPI T | AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provi der Co | CN: 15-0165 | Peri od: From 01/01/2021 To 12/31/2021 | Worksheet S-2 Part II Date/Time Pre 5/31/2022 7:5 | epared: |
| | | Descri | pti on | Y/N | Y/N | , am |
| | | (| | 1. 00 | 3. 00 | |
| 20. 00 | If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments: | | | N | N | 20. 00 |
| | | Y/N 1.00 | Date 2.00 | Y/N 3. 00 | Date | |
| 21. 00 | Was the cost report prepared only using the provider's | N N | 2.00 | N N | 4. 00 | 21. 00 |
| | records? If yes, see instructions. | | | | | |
| | | | | | 1. 00 | |
| | COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE | EPT CHILDRENS H | OSPI TALS) | | | _ |
| 22.00 | Capital Related Cost | - ! | | | N | 22 00 |
| 22. 00 23. 00 | Have assets been relifed for Medicare purposes? If yes, see Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions. | | als made dur | ing the cost | N N | 22. 00 23. 00 |
| 24. 00 | Were new leases and/or amendments to existing leases entered if yes, see instructions | ed into during | this cost re | porting period? | N | 24. 00 |
| 25. 00 | Have there been new capitalized leases entered into during instructions. | the cost repor | ting period? | If yes, see | N | 25. 00 |
| 26. 00 | Were assets subject to Sec. 2314 of DEFRA acquired during thinstructions. | he cost reporti | ng period? I | f yes, see | N | 26. 00 |
| 27. 00 | Has the provider's capitalization policy changed during the copy. | e cost reportin | g period? If | yes, submit | N | 27. 00 |
| 28. 00 | Interest Expense Were new loans, mortgage agreements or letters of credit er | ntered into dur | ing the cost | reporti ng | N | 28. 00 |
| 29. 00 | period? If yes, see instructions. Did the provider have a funded depreciation account and/or | | bt Service R | eserve Fund) | N | 29. 00 |
| 30. 00 | treated as a funded depreciation account? If yes, see instr Has existing debt been replaced prior to its scheduled matu instructions. | urity with new | debt? If yes | , see | N | 30. 00 |
| 31. 00 | Has debt been recalled before scheduled maturity without is instructions. | ssuance of new | debt? If yes | , see | N | 31. 00 |
| 32. 00 | Purchased Services Have changes or new agreements occurred in patient care ser arrangements with suppliers of services? If yes, see instru | | d through co | ntractual | N | 32. 00 |
| 33. 00 | If line 32 is yes, were the requirements of Sec. 2135.2 app no, see instructions. | | g to competi | tive bidding? If | N | 33. 00 |
| | Provi der-Based Physi ci ans | | | | | |
| | Are services furnished at the provider facility under an arlf yes, see instructions. | 0 | • | . 3 | Y | 34.00 |
| 35. 00 | If line 34 is yes, were there new agreements or amended exi physicians during the cost reporting period? If yes, see in | | ts with the | | N | 35. 00 |
| | | | | Y/N | Date | |
| | Home Office Costs | | | 1. 00 | 2. 00 | |
| 36. 00 | Were home office costs claimed on the cost report? | | | Υ | | 36.00 |
| | If line 36 is yes, has a home office cost statement been pr | repared by the | home office? | | | 37. 00 |
| 38. 00 | If yes, see instructions. If line 36 is yes, was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end | | | N | | 38. 00 |
| 39. 00 | If line 36 is yes, did the provider render services to other see instructions. | | | N N | | 39. 00 |
| 40. 00 | If line 36 is yes, did the provider render services to the instructions. | home office? | If yes, see | N | | 40. 00 |
| | | 1. | 00 | 2. | 00 | - |
| | Cost Report Preparer Contact Information | | | | | |
| 41. 00 | Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. | GLENN | | JOHNSON | | 41. 00 |
| 42. 00 | Tespectively. Enter the employer/company name of the cost report preparer. | FRANCI SCAN HEA | LTH | | | 42. 00 |
| 43. 00 | | 219-940-6386 | | GLENN. JOHNSON@ ANC | FRANCI SCANALLI | 43. 00 |

| Heal th | Financial Systems FRANCISCAN HE | EALTH MUNSTER | In Lie | u of Form CMS- | 2552-10 |
|---------|--|-----------------------|----------------------------|--------------------------|----------------|
| HOSPI T | AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 15-0165 | Period: From 01/01/2021 | Worksheet S-2 Part II | |
| | | | To 12/31/2021 | | pared: 4 am |
| | | 2.00 | | | |
| | | 3.00 | | | |
| | Cost Report Preparer Contact Information | | | | 1 |
| 41.00 | Enter the first name, last name and the title/position | REIMBURSEMENT MANAGER | | | 41.00 |
| | held by the cost report preparer in columns 1, 2, and 3, | | | | |
| | respectively. | | | | |
| 42.00 | Enter the employer/company name of the cost report | | | | 42.00 |
| | . , , , , , , , , , , , , , , , , , , , | | | | 72.00 |
| | preparer. | | | | 40.00 |
| | Enter the telephone number and email address of the cost | | | | 43. 00 |
| | report preparer in columns 1 and 2, respectively. | | | | |

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

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

| S/31/2022 7:54 am S/31/202 7:54 a |
|---|
| Component Worksheet A Line Number No. of Beds Bed Days Available 1.00 2.00 3.00 4.00 5.00 1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 2.00 HM0 and other (see instructions) 3.00 HM0 IPF Subprovider 4.00 Hospital Adults & Peds. Swing Bed SNF 6.00 Hospital Adults & Peds. Swing Bed NF 7.00 Total Adults and Peds. (exclude observation beds) (see instructions) 8 exclude Swing Bed, Observation Bed and Bed SNF 6 0.00 Hospital Adults & Peds. Swing Bed SNF 6 0.00 Hospital Adults & Peds. (exclude observation beds) (see instructions) |
| Component Worksheet A Line Number 1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 2.00 HM0 and other (see instructions) 3.00 HM0 IPF Subprovider 4.00 Hospital Adults & Peds. Swing Bed SNF 6.00 Hospital Adults & Peds. Swing Bed NF 7.00 Total Adults and Peds. (exclude observation beds) CAH Hours Title V 1.00 A.00 A.00 A.00 D.00 3.00 A.00 A.00 A.00 4.00 A.00 A.00 A.00 5.00 A.00 A.00 6.00 A.00 A.00 A.00 6.00 A.00 A.00 7.00 Total Adults and Peds. (exclude observation beds) (see instructions) |
| Line Number Available 1.00 2.00 3.00 4.00 5.00 |
| 1.00 2.00 3.00 4.00 5.00 |
| 1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 2.00 HM0 and other (see instructions) 3.00 HM0 IPF Subprovider 4.00 Hospital Adults & Peds. Swing Bed SNF 5.00 Hospital Adults & Peds. Swing Bed NF 7.00 Total Adults and Peds. (exclude observation beds) (see instructions) 3.0.00 O O O O O O O O O O O O O O O O O |
| Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 2.00 HM0 and other (see instructions) 3.00 HM0 IPF Subprovider 4.00 Hospital Adults & Peds. Swing Bed SNF 6.00 Hospital Adults & Peds. Swing Bed NF 7.00 Total Adults and Peds. (exclude observation beds) (see instructions) 2.00 3.00 4.00 5.00 66 23,958 0.00 0 7.00 |
| for the portion of LDP room available beds) 2.00 HM0 and other (see instructions) 3.00 HM0 IPF Subprovider 4.00 Hospital Adults & Peds. Swing Bed SNF 6.00 Hospital Adults & Peds. Swing Bed NF 7.00 Total Adults and Peds. (exclude observation beds) (see instructions) 66 23,958 0.00 0 7.00 |
| 2.00 3.00 HM0 IPF Subprovider 4.00 HM0 IRF Subprovider 4.00 Hospital Adults & Peds. Swing Bed SNF 6.00 Hospital Adults & Peds. Swing Bed NF 7.00 Total Adults and Peds. (exclude observation beds) (see instructions) 2.00 3.00 4.00 5.00 6.00 6.00 7.00 |
| 3.00 4.00 HMO I PF Subprovi der 4.00 Hospi tal Adults & Peds. Swing Bed SNF 6.00 Hospi tal Adults & Peds. Swing Bed NF 7.00 Total Adults and Peds. (exclude observation beds) (see instructions) 3.00 4.00 5.00 6.00 7.00 |
| 4.00 HMO IRF Subprovider 5.00 Hospital Adults & Peds. Swing Bed SNF 6.00 Hospital Adults & Peds. Swing Bed NF 7.00 Total Adults and Peds. (exclude observation beds) (see instructions) 4.00 5.00 6.00 7.00 |
| 5.00 Hospital Adults & Peds. Swing Bed SNF 6.00 Hospital Adults & Peds. Swing Bed NF 7.00 Total Adults and Peds. (exclude observation beds) (see instructions) 0 5.00 6.00 7.00 beds) (see instructions) |
| 6.00 Hospital Adults & Peds. Swing Bed NF 7.00 Total Adults and Peds. (exclude observation beds) (see instructions) 0 6.00 7.00 6 00 7.00 |
| 7.00 Total Adults and Peds. (exclude observation beds) (see instructions) 66 23,958 0.00 0 7.00 |
| beds) (see instructions) |
| |
| 8.00 INTENSIVE CARE UNIT 31.00 9 3,285 0.00 0 8.00 |
| |
| 9. 00 CORONARY CARE UNIT 32. 00 0 0. 00 0 9. 00 |
| 10. 00 BURN INTENSIVE CARE UNIT 33. 00 0 0. 00 0 10. 00 |
| 11. 00 SURGICAL INTENSIVE CARE UNIT 34. 00 0 0. 00 11. 00 |
| 12. 00 OTHER SPECIAL CARE (SPECIFY) |
| 13. 00 NURSERY |
| 14.00 Total (see instructions) 75 27, 243 0.00 0 14.00 |
| 15. 00 CAH visits |
| 16. 00 SUBPROVI DER - PF 40. 00 0 0 16. 00 17. 00 SUBPROVI DER - RF 41. 00 0 0 17. 00 |
| 18. 00 SUBPROVI DER 41. 00 0 0 17. 00 18. 00 |
| 19. 00 SKILLED NURSING FACILITY |
| 20. 00 NURSING FACILITY 45. 00 0 0 0 20.00 |
| 21. 00 OTHER LONG TERM CARE 46. 00 0 21. 00 |
| 22. 00 HOME HEALTH AGENCY 101. 00 0 22. 00 |
| 23.00 AMBULATORY SURGI CAL CENTER (D. P.) 115.00 23.00 |
| 24.00 HOSPICE 116.00 0 0 24.00 |
| 24.10 HOSPICE (non-distinct part) 30.00 24.10 |
| 25. 00 CMHC - CMHC 0 99. 00 0 25. 00 |
| 25. 10 CMHC - CORF 99. 10 0 25. 10 |
| 26. 00 RURAL HEALTH CLINIC 88. 00 0 26. 00 |
| 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 89. 00 0 26. 25 |
| 27.00 Total (sum of lines 14-26) 75 27.00 |
| 28.00 Observation Bed Days 0 28.00 |
| 29.00 Ambul ance Tri ps 29.00 |
| 30.00 Employee discount days (see instruction) 30.00 |
| 31.00 Employee discount days - IRF |
| 32.00 Labor & delivery days (see instructions) 0 0 32.00 |
| 32.01 Total ancillary labor & delivery room 32.01 |
| outpatient days (see instructions) |
| 33. 00 LTCH non-covered days |
| 33.01 LTCH site neutral days and discharges 33.01 |

Health Financial Systems FRANCIS
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 15-0165 I/P Days / O/P Visits / Trips

| | | 17P Days | / U/P VISITS | / Irips | Full time b | equi vai 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 | 4, 060 | 1, 092 | 12, 819 | | | 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) | 3, 760 | 1, 121 | | | | 2.00 |
| 3.00 | HMO IPF Subprovi der | 0 | 0 | | | | 3. 00 |
| 4.00 | HMO IRF Subprovider | 0 | 0 | 0 | | | 4. 00 5. 00 |
| 5. 00 6. 00 | Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF | ۷ | 0 | 0 | | | 6.00 |
| 7. 00 | Total Adults and Peds. (exclude observation | 4, 060 | 1, 092 | U | | | 7. 00 |
| 7.00 | beds) (see instructions) | 4,000 | 1, 092 | 12,017 | | | 7.00 |
| 8. 00 | INTENSIVE CARE UNIT | 1, 229 | 0 | 1, 701 | | | 8. 00 |
| 9. 00 | CORONARY CARE UNIT | 1, 22, | 0 | 1, 701 | | | 9. 00 |
| 10. 00 | BURN INTENSIVE CARE UNIT | Ö | 0 | 0 | | | 10.00 |
| 11. 00 | SURGI CAL INTENSI VE CARE UNI T | 0 | 0 | 0 | | | 11. 00 |
| 12. 00 | OTHER SPECIAL CARE (SPECIFY) | | | | | | 12. 00 |
| 13.00 | NURSERY | | 0 | 0 | | | 13. 00 |
| 14.00 | Total (see instructions) | 5, 289 | 1, 092 | 14, 520 | 0.00 | 541.86 | 14. 00 |
| 15. 00 | CAH visits | 0 | 0 | 0 | | | 15. 00 |
| 16.00 | SUBPROVI DER - I PF | 0 | 0 | 0 | 0.00 | 0.00 | 16. 00 |
| 17. 00 | SUBPROVI DER - I RF | 0 | 0 | 0 | 0.00 | 0.00 | 17. 00 |
| 18. 00 | SUBPROVI DER | | | | | | 18. 00 |
| 19. 00 | SKILLED NURSING FACILITY | 0 | 0 | 0 | 0.00 | | 19. 00 |
| 20. 00 | NURSING FACILITY | | 0 | 0 | 0.00 | | |
| 21. 00 | OTHER LONG TERM CARE | | | 0 | 0. 00 | 0. 00 | |
| 22. 00 | HOME HEALTH AGENCY | 0 | 0 | 0 | 0.00 | | |
| 23. 00 | AMBULATORY SURGICAL CENTER (D. P.) | | | | 0.00 | | |
| 24. 00 | HOSPI CE | 0 | 0 | 0 | 0.00 | 0.00 | |
| 24. 10 25. 00 | HOSPICE (non-distinct part) | | 0 | 0 | 0.00 | 0.00 | 24. 10 25. 00 |
| 25. 00 | CMHC - CMHC CMHC - CORF | 0 | 0 | 0 | 0. 00 0. 00 | 0. 00 0. 00 | |
| 26. 00 | RURAL HEALTH CLINIC | 0 | 0 | 0 | 0.00 | 0.00 | |
| 26. 25 | FEDERALLY QUALIFIED HEALTH CENTER | 0 | 0 | 0 | 0.00 | | |
| 27. 00 | Total (sum of lines 14-26) | | J | O | 0.00 | | |
| 28. 00 | Observation Bed Days | | 461 | 3, 006 | | 011.00 | 28. 00 |
| 29. 00 | Ambul ance Tri ps | o | 101 | 2,000 | | | 29. 00 |
| 30. 00 | Employee discount days (see instruction) | | | 0 | | | 30.00 |
| 31. 00 | Employee discount days - IRF | | | 0 | | | 31. 00 |
| 32. 00 | Labor & delivery days (see instructions) | o | 0 | 0 | | | 32. 00 |
| 32. 01 | Total ancillary labor & delivery room | | | 0 | | | 32. 01 |
| | outpatient days (see instructions) | | | | | | |
| 33. 00 | LTCH non-covered days | 0 | | | | | 33. 00 |
| 33. 01 | LTCH site neutral days and discharges | 0 | | | | | 33. 01 |

| Peri od: | Worksheet S-3 | From 01/01/2021 | Part | | To 12/31/2021 | Date/Time Prepared: Provider CCN: 15-0165

| | | | | To | 12/31/2021 | Date/Time Prep 5/31/2022 7:54 | |
|------------------|--|---------------|---------|-------------|------------|----------------------------------|------------------|
| | | Full Time | | Di sch | arges | 0,01,2022 ,10 | Cim |
| | | Equi val ents | | | | | |
| | Component | Nonpai d | Title V | Title XVIII | Title XIX | Total All | |
| | | Workers | | | | Pati ents | |
| 1 00 | | 11. 00 | 12. 00 | 13.00 | 14. 00 | 15. 00 | 1 00 |
| 1. 00 | Hospital Adults & Peds. (columns 5, 6, 7 and | | 0 | 1, 129 | 233 | 2, 862 | 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) | | | 613 | 229 | | 2. 00 |
| 3.00 | HMO IPF Subprovider | | | 013 | 0 | | 3. 00 |
| 4. 00 | HMO IRF Subprovider | | | | 0 | | 4. 00 |
| 5. 00 | Hospital Adults & Peds. Swing Bed SNF | | | | | | 5. 00 |
| 6.00 | Hospital Adults & Peds. Swing Bed NF | | | | | | 6. 00 |
| 7.00 | Total Adults and Peds. (exclude observation | | | | | | 7. 00 |
| | beds) (see instructions) | | | | | | |
| 8.00 | INTENSIVE CARE UNIT | | | | | | 8. 00 |
| 9.00 | CORONARY CARE UNIT | | | | | | 9. 00 |
| 10.00 | BURN INTENSIVE CARE UNIT | | | | | | 10.00 |
| 11. 00 | SURGICAL INTENSIVE CARE UNIT | | | | | | 11. 00 |
| 12. 00 | OTHER SPECIAL CARE (SPECIFY) | | | | | | 12. 00 |
| 13. 00 | NURSERY | | _ | | | | 13. 00 |
| 14.00 | Total (see instructions) | 0. 00 | 0 | 1, 129 | 233 | 2, 862 | 14. 00 |
| 15. 00 | CAH visits | 0.00 | | | | | 15. 00 |
| 16.00 | SUBPROVIDER - I PF | 0.00 | 0 | | 0 | 0 | 16.00 |
| 17. 00 18. 00 | SUBPROVI DER - I RF SUBPROVI DER | 0. 00 | U | ١ | U | U | 17. 00 18. 00 |
| 19.00 | SKILLED NURSING FACILITY | 0. 00 | | | | | 19. 00 |
| 20.00 | NURSING FACILITY | 0.00 | | • | | | 20. 00 |
| 21. 00 | OTHER LONG TERM CARE | 0.00 | | | | 0 | 21. 00 |
| 22. 00 | HOME HEALTH AGENCY | 0. 00 | | | | Ü | 22. 00 |
| 23. 00 | AMBULATORY SURGICAL CENTER (D. P.) | 0. 00 | | | | | 23. 00 |
| 24. 00 | HOSPI CE | 0. 00 | | | | | 24. 00 |
| 24. 10 | HOSPICE (non-distinct part) | | | | | | 24. 10 |
| 25.00 | CMHC - CMHC | 0. 00 | | | | | 25. 00 |
| 25. 10 | CMHC - CORF | 0.00 | | | | | 25. 10 |
| 26.00 | RURAL HEALTH CLINIC | 0. 00 | | | | | 26. 00 |
| 26. 25 | FEDERALLY QUALIFIED HEALTH CENTER | 0. 00 | | | | | 26. 25 |
| 27. 00 | Total (sum of lines 14-26) | 0. 00 | | | | | 27. 00 |
| 28. 00 | Observation Bed Days | | | | | | 28. 00 |
| 29. 00 | Ambul ance Tri ps | | | | | | 29. 00 |
| 30. 00 | Employee discount days (see instruction) | | | | | | 30. 00 |
| 31.00 | Employee discount days - IRF | | | | | | 31. 00 |
| 32.00 | Labor & delivery days (see instructions) | | | | | | 32. 00 |
| 32. 01 | Total ancillary labor & delivery room | | | | | | 32. 01 |
| 33. 00 | outpatient days (see instructions) LTCH non-covered days | | | 0 | | | 33. 00 |
| | LTCH fion-covered days LTCH si te neutral days and discharges | | | 0 | | | 33. 00 |
| 55. 01 | 21011 31 to floati ai days and ai sonal ges | | | ١ | ı | | 33.01 |

| 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: | To 12/31/2021 | Date/ Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0165

| | | | | | | 0 12/31/2021 | Date/lime Prep 5/31/2022 7:54 | |
|------------------|--|------------------------|--------------------|---|---------------|-----------------|---|------------------|
| | | Wkst. A Line Number | Amount Reported | Reclassificati on of Salaries (from Wkst. A-6) | | | Average Hourly Wage (col. 4 ÷ col. 5) | |
| | | 1.00 | 2. 00 | 3. 00 | 4.00 | 5. 00 | 6. 00 | |
| | PART II - WAGE DATA SALARIES | | | | | | | 1 |
| 1.00 | Total salaries (see | 200. 00 | 45, 067, 340 | 0 | 45, 067, 340 | 1, 127, 074. 07 | 39. 99 | 1.00 |
| 2. 00 | instructions) Non-physician anesthetist Part | | 0 | 0 | 0 | 0. 00 | 0. 00 | 2. 00 |
| 3.00 | Non-physician anesthetist Part | | 0 | 0 | 0 | 0. 00 | 0. 00 | 3. 00 |
| 4.00 | Physician-Part A - Administrative | | 0 | 0 | 0 | 0. 00 | 0. 00 | 4. 00 |
| 4. 01 5. 00 | Physicians - Part A - Teaching Physician and Non | | 0 | 0 0 | 0 | 0. 00 0. 00 | | |
| 6. 00 | Physician-Part B Non-physician-Part B for hospital-based RHC and FQHC | | 0 | 0 | 0 | 0.00 | 0. 00 | 6. 00 |
| 7. 00 | services 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 programs) | | 0 | 0 | 0 | 0.00 | 0. 00 | 7. 01 |
| 8.00 | Home office and/or related organization personnel | | 7, 372, 838 | 0 | 7, 372, 838 | 214, 049. 59 | 34. 44 | 8. 00 |
| 9. 00 10. 00 | SNF Excluded area salaries (see instructions) | 44. 00 | 0 1, 862, 026 | 0 | _ | | 1 | |
| 11 00 | OTHER WAGES & RELATED COSTS | | 4/7 24/ | | 4/7 21/ | F 477 2F | 05.24 | 11 00 |
| 11. 00 | Contract Labor: Direct Patient Care | | 467, 316 | 0 | 467, 316 | 5, 476. 25 | 85. 34 | 11. 00 |
| 12. 00 | Contract labor: Top level management and other management and administrative services | | 0 | 0 | 0 | 0. 00 | 0.00 | 12. 00 |
| 13. 00 | Contract Labor: Physician-Part A - Administrative | | 0 | 0 | 0 | 0. 00 | 0.00 | 13. 00 |
| 14. 00 | Home office and/or related organization salaries and | | 0 | 0 | 0 | 0. 00 | 0. 00 | 14. 00 |
| 14. 01 | wage-related costs Home office salaries | | 8, 314, 875 | 0 | 8, 314, 875 | 241, 399. 00 | | 14. 01 |
| 14. 02 15. 00 | Related organization salaries Home office: Physician Part A | | 0 | 0 | 0 | 0. 00 0. 00 | | |
| 16. 00 | - Administrative Home office and Contract | | 0 | 0 | 0 | 0. 00 | 0. 00 | 16. 00 |
| 16. 01 | Physicians Part A - Teaching Home office Physicians Part A - Teaching | | 0 | 0 | 0 | 0. 00 | 0. 00 | 16. 01 |
| 16. 02 | Home office contract Physicians Part A - Teaching WAGE-RELATED COSTS | | 0 | 0 | 0 | 0.00 | 0.00 | 16. 02 |
| 17. 00 | Wage-related costs (core) (see instructions) | | 8, 438, 412 | 0 | 8, 438, 412 | | | 17. 00 |
| 18. 00 | Wage-related costs (other) (see instructions) | | | | | | | 18. 00 |
| 19. 00 20. 00 | Excluded areas Non-physician anesthetist Part | | 273, 367 0 | 0 | 273, 367 0 | | | 19. 00 20. 00 |
| 21. 00 | A Non-physician anesthetist Part | | 0 | 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 | | | 24. 00 25. 00 |
| 25. 50 | approved program) Home office wage-related | | 2, 533, 083 | 0 | 2, 533, 083 | | | 25. 50 |
| 25. 51 | (core) Related organization wage-related (core) | | 0 | 0 | 0 | | | 25. 51 |
| 25. 52 | , , | | 0 | 0 | 0 | | | 25. 52 |

| | | | | | T | o 12/31/2021 | Date/Time Prep | |
|--------|---------------------------------|--------------|--------------|-------------------|---------------|--------------|----------------------------------|--------|
| | | Wkst. A Line | Amount | Recl assi fi cati | Adj usted | Pai d Hours | 5/31/2022 7:54 Average Hourly | 4 alli |
| | | Number | | on of Salaries | | | Wage (col. 4 ÷ | |
| | | Number | Reported | (from Wkst. | (col.2 ± col. | Salaries in | col. 5) | |
| | | | | A-6) | 3) | col . 4 | (01. 3) | |
| | | 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 | ES | | | | | | |
| 26.00 | Employee Benefits Department | 4. 00 | 879, 648 | 0 | 879, 648 | 0.00 | | 26.00 |
| 27. 00 | Administrative & General | 5. 00 | 10, 426, 700 | 0 | 10, 426, 700 | 0.00 | 0.00 | 27.00 |
| 28. 00 | Administrative & General under | | 423, 870 | 0 | 423, 870 | 4, 303. 00 | 98. 51 | 28.00 |
| | contract (see inst.) | | | | | | | |
| 29. 00 | Maintenance & Repairs | 6. 00 | 724, 597 | 0 | 724, 597 | 24, 264. 23 | 29. 86 | 29.00 |
| 30.00 | Operation of Plant | 7. 00 | 0 | 0 | 0 | 0.00 | | 30.00 |
| 31. 00 | Laundry & Linen Service | 8. 00 | 122, 619 | 0 | 122, 619 | | 18. 08 | 31.00 |
| 32.00 | Housekeepi ng | 9. 00 | 803, 302 | 0 | 803, 302 | 45, 770. 53 | 17. 55 | 32.00 |
| 33.00 | Housekeeping under contract | | 0 | 0 | 0 | 0.00 | 0.00 | 33.00 |
| | (see instructions) | | | | | | | |
| 34.00 | Di etary | 10. 00 | 587, 049 | -362, 636 | 224, 413 | 11, 424. 59 | 19. 64 | 34.00 |
| 35.00 | Di etary under contract (see | | 0 | 0 | 0 | 0.00 | 0.00 | 35.00 |
| | instructions) | | | | | | | |
| 36. 00 | Cafeteri a | 11. 00 | 0 | 362, 636 | 362, 636 | | | 36.00 |
| 37. 00 | Maintenance of Personnel | 12. 00 | 0 | 0 | 0 | 0. 00 | | 37.00 |
| 38. 00 | Nursing Administration | 13. 00 | 1, 899, 458 | 0 | 1, 899, 458 | 40, 491. 37 | 46. 91 | 38.00 |
| 39. 00 | Central Services and Supply | 14. 00 | 215, 292 | 0 | 215, 292 | 8, 610. 16 | 25. 00 | 39.00 |
| 40.00 | Pharmacy | 15. 00 | 1, 229, 881 | 0 | 1, 229, 881 | 24, 322. 11 | 50. 57 | 40.00 |
| 41.00 | Medical Records & Medical | 16. 00 | 325, 949 | 0 | 325, 949 | 8, 007. 20 | 40. 71 | 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 |

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

| | | | | | 11 | 0 12/31/2021 | 5/31/2022 7:54 | |
|------|--------------------------------|-------------|--------------|-------------------|---------------|-----------------|----------------|-------|
| | | Worksheet A | Amount | Recl assi fi cati | Adj usted | Pai d Hours | Average Hourly | |
| | | Line Number | Reported | on of Salaries | | | Wage (col. 4 ÷ | |
| | | | | (from | (col.2 ± col. | Salaries in | col . 5) | |
| | | | | Worksheet A-6) | 3) | col. 4 | | |
| | | 1. 00 | 2. 00 | 3. 00 | 4. 00 | 5. 00 | 6. 00 | |
| | PART III - HOSPITAL WAGE INDEX | SUMMARY | | | | | | |
| 1.00 | Net salaries (see | | 38, 118, 372 | 0 | 38, 118, 372 | 917, 327. 48 | 41. 55 | 1.00 |
| | instructions) | | | | | | | |
| 2.00 | Excluded area salaries (see | | 1, 862, 026 | 0 | 1, 862, 026 | 35, 366. 45 | 52. 65 | 2.00 |
| | instructions) | | | | | | | |
| 3.00 | Subtotal salaries (line 1 | | 36, 256, 346 | 0 | 36, 256, 346 | 881, 961. 03 | 41. 11 | 3.00 |
| | minus line 2) | | | | | | | |
| 4.00 | Subtotal other wages & related | | 8, 782, 191 | 0 | 8, 782, 191 | 246, 875. 25 | 35. 57 | 4. 00 |
| | costs (see inst.) | | | | | | | |
| 5.00 | Subtotal wage-related costs | | 10, 971, 495 | 0 | 10, 971, 495 | 0. 00 | 30. 26 | 5.00 |
| | (see inst.) | | | | | | | |
| 6.00 | Total (sum of lines 3 thru 5) | | 56, 010, 032 | 0 | 56, 010, 032 | 1, 128, 836. 28 | 49. 62 | 6. 00 |
| 7.00 | Total overhead cost (see | | 17, 638, 365 | 0 | 17, 638, 365 | 192, 436. 72 | 91. 66 | 7. 00 |
| | instructions) | | | | | | | |

| Health Financial Systems | FRANCISCAN HEALTH MUNSTER | In Lie | u of Form CMS-2552-10 |
|-----------------------------|---------------------------|-----------------|-----------------------|
| HOSPITAL WAGE RELATED COSTS | Provi der CCN: 15-0165 | Peri od: | Worksheet S-3 |
| | | From 01/01/2021 | |
| | | T- 10/01/0001 | D-+- /T! D |

| | To 12/31/20 | Date/Time Prep 5/31/2022 7:5 | |
|--------|---|---------------------------------|--------|
| | | Amount | |
| | | Reported | |
| | | 1. 00 | |
| • | PART IV - WAGE RELATED COSTS | | |
| | Part A - Core List | | |
| | RETI REMENT COST | | |
| 1.00 | 401K Employer Contributions | 933, 567 | 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) | 1, 046, 721 | 4. 00 |
| | PLAN ADMINISTRATIVE COSTS (Paid to External Organization) | | 1 |
| 5.00 | 401K/TSA Plan Administration fees | 0 | 5.00 |
| 6.00 | Legal /Accounting/Management Fees-Pension Plan | 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) | 3, 452, 959 | 8. 02 |
| 8. 03 | Heal th Insurance (Purchased) | 0 | 1 |
| 9. 00 | Prescription Drug Plan | 0 | 9.00 |
| 10.00 | Dental, Hearing and Vision Plan | 144, 286 | 10.00 |
| | Life Insurance (If employee is owner or beneficiary) | 12, 708 | 1 |
| | Accident Insurance (If employee is owner or beneficiary) | 0 | ı |
| | Disability Insurance (If employee is owner or beneficiary) | 213, 680 | 13.00 |
| | Long-Term Care Insurance (If employee is owner or beneficiary) | 0 | 14. 00 |
| | 'Workers' Compensation Insurance | 512, 977 | 15. 00 |
| 16. 00 | · | 0 | 1 |
| | Non cumulative portion) | - 1 | |
| | TAXES | | |
| 17. 00 | FICA-Employers Portion Only | 2, 376, 342 | 17. 00 |
| 18. 00 | Medicare Taxes - Employers Portion Only | 0 | 18. 00 |
| | Unemployment Insurance | 9, 236 | 19.00 |
| | State or Federal Unemployment Taxes | 0 | 1 |
| | OTHER | | |
| 21. 00 | Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (s | ee 0 | 21. 00 |
| | instructions)) | | |
| 22. 00 | Day Care Cost and Allowances | 0 | 22. 00 |
| | Tuition Reimbursement | 9, 301 | 23. 00 |
| | Total Wage Related cost (Sum of lines 1 -23) | 8, 711, 777 | |
| | Part B - Other than Core Related Cost | | |
| 25. 00 | OTHER WAGE RELATED COSTS (SPECIFY) | | 25. 00 |
| | | | • |

| Health Financial Systems | FRANCISCAN HEALTH MUNSTER | In Lieu of Form CMS-2552-10 |
|--|---------------------------|---|
| HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 15-0165 | Period: Worksheet S-3 From 01/01/2021 Part V |
| | | To 12/31/2021 Date/Time Prepared: |

| | | Го 12/31/2021 | Date/Time Prep 5/31/2022 7:54 | |
|--------|---|----------------|----------------------------------|--------|
| | 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 | 467, 316 | 8, 711, 777 | 1. 00 |
| 2.00 | Hospi tal | 467, 316 | 8, 711, 777 | 2. 00 |
| 3.00 | Subprovi der - I PF | 0 | 0 | 3. 00 |
| 4.00 | Subprovi der - I RF | 0 | 0 | 4. 00 |
| 5. 00 | Subprovi der - (Other) | 0 | 0 | 5. 00 |
| 6. 00 | Swing Beds - SNF | 0 | 0 | 6. 00 |
| 7. 00 | Swing Beds - NF | 0 | 0 | 7. 00 |
| 8. 00 | Hospi tal -Based SNF | 0 | 0 | 8. 00 |
| 9. 00 | Hospi tal -Based NF | 0 | 0 | 7.00 |
| 10. 00 | Hospi tal -Based OLTC | | | 10.00 |
| 11. 00 | Hospi tal -Based HHA | 0 | 0 | 11. 00 |
| 12.00 | Separately Certified ASC | 0 | 0 | 12.00 |
| 13. 00 | Hospi tal -Based Hospi ce | 0 | 0 | 13.00 |
| 14. 00 | Hospital-Based Health Clinic RHC | 0 | 0 | 14.00 |
| 15. 00 | Hospital-Based Health Clinic FQHC | 0 | 0 | 15.00 |
| 16. 00 | Hospi tal -Based-CMHC | 0 | 0 | 16.00 |
| 16. 10 | Hospi tal -Based-CMHC 10 | 0 | 0 | 16. 10 |
| 17. 00 | Renal Di al ysi s | 0 | 0 | 17.00 |
| 18. 00 | Other | 0 | 0 | 18. 00 |

| 31 1 1 | AL UNCOMPENSATED AND INDIGENT CARE DATA Pro | ovider CCN | l: 15-0165 | Peri od: | Worksheet S-1 | 0 |
|--|---|--|---|--|--|--|
| | | | | From 01/01/2021 To 12/31/2021 | | |
| | | | | | 1. 00 | |
| | Uncompensated and indigent care cost computation | | | | | |
| 00 | Cost to charge ratio (Worksheet C, Part I line 202 column 3 divide | ed by line | e 202 colum | n 8) | 0. 202426 | 1. |
| | Medicaid (see instructions for each line) | | | | 10.057.010 | |
| 00 | Net revenue from Medicaid | | | | 13, 057, 819 N | |
| 00 00 | Did you receive DSH or supplemental payments from Medicaid? If line 3 is yes, does line 2 include all DSH and/or supplemental | navments | from Medic | ai d2 | IN IN | 3 |
| 00 | If line 4 is no, then enter DSH and/or supplemental payments from | | | ai a: | 0 | |
| 00 | Medi cai d charges | | | | 71, 849, 926 | |
| 00 | Medicaid cost (line 1 times line 6) | | | | 14, 544, 293 | 7 |
| 00 | Difference between net revenue and costs for Medicaid program (li | ne 7 minus | s sum of li | nes 2 and 5; if | 1, 486, 474 | 8 |
| | < zero then enter zero) | | | | | |
| 00 | Children's Health Insurance Program (CHIP) (see instructions for e | each line, |) | | 0 | ١., |
| 00 | Net revenue from stand-alone CHIP Stand-alone CHIP charges | | | | 0 | |
| 00 | Stand-alone CHIP cost (line 1 times line 10) | | | | 0 | |
| 00 | Difference between net revenue and costs for stand-alone CHIP (lin | ne 11 min | us line 9; | if < zero then | 0 | |
| | enter zero) | | | | | |
| | Other state or local government indigent care program (see instruc | | | | 1 | ١ |
| 00 | Net revenue from state or local indigent care program (Not include | | | | 0 | |
| 00 | Charges for patients covered under state or local indigent care policy. | rogram (w | ot inciuaea | III IIIles 6 01 | 0 | 14 |
| 00 | State or local indigent care program cost (line 1 times line 14) | | | | 0 | 15 |
| 00 | Difference between net revenue and costs for state or local indige | ent care | program (li | ne 15 minus line | | |
| | 13; if < zero then enter zero) | | | | | 1 |
| | | | | | | |
| | Grants, donations and total unreimbursed cost for Medicaid, CHIP a | and state | /local indi | gent care progra | ms (see | |
| 00 | Grants, donations and total unreimbursed cost for Medicaid, CHIP a instructions for each line) Private grants, donations, or endowment income restricted to fundi | | | gent care progra | ms (see | 17 |
| 00 | <u>instructions for each line)</u> Private grants, donations, or endowment income restricted to fundi Government grants, appropriations or transfers for support of hos | ing chari pital ope | ty care rations | | 0 0 | 18 |
| 00 | instructions for each line) Private grants, donations, or endowment income restricted to fundi Government grants, appropriations or transfers for support of hosp Total unreimbursed cost for Medicaid , CHIP and state and local in | ing chari pital ope | ty care rations | | 0 | 18 |
| 00 | <u>instructions for each line)</u> Private grants, donations, or endowment income restricted to fundi Government grants, appropriations or transfers for support of hos | ing chari pital ope | ty care rations are program | s (sum of lines | 0 0 1, 486, 474 | 18 19 |
| 00 | instructions for each line) Private grants, donations, or endowment income restricted to fundi Government grants, appropriations or transfers for support of hosp Total unreimbursed cost for Medicaid , CHIP and state and local in | ing chari pital ope | ty care rations | | 0 0 | 18 19 |
| 00 | <pre>instructions for each line) Private grants, donations, or endowment income restricted to fundi Government grants, appropriations or transfers for support of hosy Total unreimbursed cost for Medicaid , CHIP and state and local in 8, 12 and 16)</pre> | ing chari pital ope | ty care rations are program Uninsured | s (sum of lines | 0 0 1, 486, 474 Total (col. 1 | 18 19 |
| 00 | instructions for each line) Private grants, donations, or endowment income restricted to fundi Government grants, appropriations or transfers for support of hosp Total unreimbursed cost for Medicaid , CHIP and state and local in 8, 12 and 16) Uncompensated Care (see instructions for each line) | ing chari pital ope ndigent ca | ty care rations are program Uninsured patients 1.00 | s (sum of lines Insured patients 2.00 | 0 0 1, 486, 474 Total (col. 1 + col. 2) 3.00 | 18 19 |
| 00 00 | instructions for each line) Private grants, donations, or endowment income restricted to fundi Government grants, appropriations or transfers for support of hosp Total unreimbursed cost for Medicaid , CHIP and state and local in 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facili | ing chari pital ope ndigent ca | ty care rations are program Uninsured patients | s (sum of lines Insured patients 2.00 | 0 0 1, 486, 474 Total (col. 1 + col. 2) 3.00 | 18 19 |
| 00 00 | instructions for each line) Private grants, donations, or endowment income restricted to fundi Government grants, appropriations or transfers for support of hosy Total unreimbursed cost for Medicaid, CHIP and state and local in 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facili (see instructions) | ing chari pital open ndigent ca | ty care rations are program Uninsured patients 1.00 6,882,5 | s (sum of lines Insured patients 2.00 63 2,424,351 | Total (col. 1 + col. 2) 3.00 | 18 19 |
| 00 00 | instructions for each line) Private grants, donations, or endowment income restricted to fundi Government grants, appropriations or transfers for support of hosp Total unreimbursed cost for Medicaid , CHIP and state and local in 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facili | ing chari pital open ndigent ca | ty care rations are program Uninsured patients 1.00 | s (sum of lines Insured patients 2.00 63 2,424,351 | Total (col. 1 + col. 2) 3.00 | 18 19 |
| 00 00 00 | instructions for each line) Private grants, donations, or endowment income restricted to fundi Government grants, appropriations or transfers for support of hosy Total unreimbursed cost for Medicaid, CHIP and state and local in 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facili (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written of | ing charipital opendigent co | ty care rations are program Uninsured patients 1.00 6,882,5 | s (sum of lines Insured patients 2.00 63 2,424,351 | 0 0 1, 486, 474 Total (col. 1 + col. 2) 3. 00 9, 306, 914 3, 817, 561 | 20 21 |
| 00 00 00 00 | instructions for each line) Private grants, donations, or endowment income restricted to fundi Government grants, appropriations or transfers for support of hosy Total unreimbursed cost for Medicaid, CHIP and state and local in 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facili (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written of charity care | ing charipital opendigent co | ty care rations are program Uninsured patients 1.00 6,882,5 1,393,2 | Insured patients 2.00 63 2,424,351 0 0 | 0 0 1, 486, 474 Total (col. 1 + col. 2) 3.00 9, 306, 914 3, 817, 561 | 20 21 22 |
| 00 00 00 00 | instructions for each line) Private grants, donations, or endowment income restricted to fundi Government grants, appropriations or transfers for support of hosy Total unreimbursed cost for Medicaid, CHIP and state and local in 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facili (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written of | ing charipital opendigent co | ty care rations are program Uninsured patients 1.00 6,882,5 | S (sum of lines Insured patients 2.00 | 0 0 1, 486, 474 Total (col. 1 + col. 2) 3.00 9, 306, 914 3, 817, 561 | 20 21 22 |
| 00 00 00 00 | instructions for each line) Private grants, donations, or endowment income restricted to fundi Government grants, appropriations or transfers for support of hosy Total unreimbursed cost for Medicaid, CHIP and state and local in 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facili (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written of charity care | ing charipital opendigent co | ty care rations are program Uninsured patients 1.00 6,882,5 1,393,2 | Insured patients 2.00 63 2,424,351 0 0 | 0 0 1, 486, 474 Total (col. 1 + col. 2) 3.00 9, 306, 914 3, 817, 561 | 20 21 22 |
| 00 00 00 00 00 | instructions for each line) Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hosy Total unreimbursed cost for Medicaid, CHIP and state and local in 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facilia (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written of the charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patients | ing charipital opendigent calling ity s (see of as | Uni nsured patients 1.00 6,882,5 1,393,2 | S (sum of lines Insured patients 2.00 63 2,424,351 0 0 0 10 2,424,351 | 0 0 1, 486, 474 Total (col. 1 + col. 2) 3.00 9, 306, 914 3, 817, 561 | 20 21 22 23 |
| 00 00 00 00 00 | instructions for each line) Private grants, donations, or endowment income restricted to fundi Government grants, appropriations or transfers for support of hosy Total unreimbursed cost for Medicaid, CHIP and state and local in 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facili (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written of charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient of imposed on patients covered by Medicaid or other indigent care pro | ing charipital opendigent calling ity s (see f as days beyon ogram? | Uninsured patients 1.00 6,882,5 1,393,2 1,393,2 | S (sum of lines Insured patients 2.00 63 2,424,351 0 2,424,351 0 0 2,424,351 of stay limit | 0 0 1, 486, 474 Total (col. 1 + col. 2) 3.00 9, 306, 914 3, 817, 561 0 3, 817, 561 | 20 21 22 23 |
| 00 00 00 00 00 | Instructions for each line) Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hosy Total unreimbursed cost for Medicaid, CHIP and state and local in 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facilia (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written of the charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient of imposed on patients covered by Medicaid or other indigent care proof of the line 24 is yes, enter the charges for patient days beyond the interpretations. | ing charipital opendigent calling ity s (see f as days beyon ogram? | Uninsured patients 1.00 6,882,5 1,393,2 1,393,2 | S (sum of lines Insured patients 2.00 63 2,424,351 0 2,424,351 0 0 2,424,351 of stay limit | 0 0 1, 486, 474 Total (col. 1 + col. 2) 3.00 9, 306, 914 3, 817, 561 0 3, 817, 561 | 20 21 22 23 |
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| 00 00 00 00 00 00 00 | instructions for each line) Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hosy Total unreimbursed cost for Medicaid, CHIP and state and local in 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facilia (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written of charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient of imposed on patients covered by Medicaid or other indigent care prolifice 24 is yes, enter the charges for patient days beyond the istay limit | ing charipital open ndigent calling ity s (see fas days beyon ogram? indigent calling indigent calling indigent calling indigent calling its calling i | Uni nsured patients 1.00 6,882,5 1,393,2 1,393,2 nd a length | S (sum of lines Insured patients 2.00 63 2,424,351 0 2,424,351 0 0 2,424,351 of stay limit | 0 0 1, 486, 474 Total (col. 1 + col. 2) 3. 00 9, 306, 914 3, 817, 561 0 3, 817, 561 1. 00 N | 20 21 22 23 24 25 26 |
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| Cost Center Description | | FINANCIAL SYSTEMS | FRANCI SCAN HEAL | | CN. 1E 01/E | | Workshoot A | 2332-10 |
|--|--------|--|------------------|---------------|---------------|------------------|-------------|---------|
| Solidario Soli | RECLAS | STFICATION AND ADJUSTMENTS OF TRIAL BALANCE O | F EXPENSES | Provider Co | | | | |
| BIT 1.00 2.00 3.00 4.00 4.00 5 | | Cost Center Description | Sal ari es | Other | Total (col. 1 | Reclassi fi cati | | 4 am |
| SEMBRAL SERVICE COST CENTERS 1.00 | | Social Social Person | | 0 11101 | | | | |
| MATERIAL SERVICE ONT CURTURES 1.00 2.00 3.00 4.00 5.00 | | | | | | | | |
| DEMMAL SERVICE LOST-CHIENS | | | 1 00 | 2 00 | 3 00 | 4.00 | | |
| 1.00 1000 LAPER LOSIS-BLUKE & FINX 997,288 997,288 5,271,992 5,271,992 0,281,892 0 | | GENERAL SERVICE COST CENTERS | 1.00 | 2.00 | 3.00 | 4.00 | 5.00 | |
| 3.00 03000 OTHER CAP BEL COSTS 4.00 030400 EURIPE CAP BEL COSTS 5.00 03000 ANN INSTRATIVE & CENERAL 10.426, 70 0 10.0000 ANN INSTRATIVE & CENERAL 10.00 10.0000 ANN INSTRATIVE ANN INSTRATIVE ANN INSTRATIVE & CENERAL 10.00 10.0000 ANN INSTRATIVE ANN INSTRATIVE & C | 1.00 | | | 987, 258 | 987, 25 | 8 5, 271, 592 | 6, 258, 850 | 1.00 |
| 4.00 00000 DePLOYEE BEREFITS DEPARTMENT 979, 648 -525, 132 361, 516 11, 261, 245 11, 060, 701 4.00 | | | | 0 | | 0 | 0 | 2. 00 |
| 5.00 DRODG JAMM NI STRATIVE & GIFFIEND 10,476,700 70,000 7 | | | 070 (40 | 0 | 254.51 | 0 0 | - | |
| 0.00 0.0000 MAINTENANCE & REPAIR IS 724,597 10,575,235 11,290,832 -258,812 11,910,20 6.00 0.00 | | | 1 | | | | | |
| 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.000000 0.000000 0.000000 0.000000 0.00000000 | | | 1 | | | | | 6.00 |
| 9.00 0.000 DISENTEEPING | 7.00 | 00700 OPERATION OF PLANT | 1 | | | | | 7. 00 |
| 10.00 010000 DETARY 587,049 881,093 1,448,142 -1,234,375 213,767 10.00 10.00 01000 MAINTEANCE: OF PERSONNEL 0 0 0 0 0 0 0 0 0 | | | 1 | | | | | 8. 00 |
| 11.10 0 10100 CAFFTERIA 0 0 0 0 894,557 17.00 | | | | | | | | |
| 12.00 01200 MAYNTENNEC OF PERSONNEL 0 0 0 0 0 0 0 12.00 | | | 387, 049 | 001, 093 0 | 1, 440, 14. | | | |
| 14.00 01400 CENTRAL SERVICES & SUPPLY 215, 292 445, 734 641, 024 -164, 956 496, 666 14.00 16.00 16.00 MEDICAL RECORDS & LIBRARY 325, 949 132, 359 456, 308 -69, 251 389, 057 16.00 17.00 1700 01700 020 0.00 | | | o | 0 | | 0 0 | | 12.00 |
| 15.00 01500 HARMACY 1,229,881 3,564,532 4,794,413 -3,438,806 1,356,07 15,00 17.00 17.00 1700 SOCIAL SERVICE 0 0 0 0 0 0 0 0 0 | 13.00 | | 1, 899, 458 | 954, 951 | 2, 854, 40 | | 2, 467, 155 | |
| 16.00 1600 MEDICAL RECORDS & LIBRARY 325, 949 132, 359 458, 308 -60, 251 389, 057 16.00 170.00 | | | | | | | · · | |
| 17.00 01700 SOCIAL SERVICE 0 0 0 0 0 0 17.00 19.00 01900 NORPHYSTICIAN AMESTHETISTS 0 0 0 0 0 0 0 0 0 | | | 1 | | | | | 1 |
| 18.00 01860 OTHER CERN SERV 0 0 0 0 0 0 18.00 0 0 0 0 0 0 0 0 0 | | | 323, 747 | 132, 339 | 456, 50 | 0 -09, 231 | | 1 |
| 20.00 0.0000 MURSING PROGRAM 0 0 0 0 0 0 0 0 0 | | | 0 | 0 | | 0 0 | | 18. 00 |
| 21.00 02100 IAS SERVICES-SALARY & FRINCES APPRVD 0 0 0 0 0 0 0 0 22.00 | | | 0 | 0 | 1 | 0 0 | | 19. 00 |
| 22.00 0200 IAR SERVICES-OTHER PROM COSTS APPRVD 0 0 0 0 0 0 0 0 0 | | | 0 | 0 | 1 | 0 | | |
| 1.00 0.0 | | | 0 | 0 | | 0 | - | |
| IMPATI ENT BOUTINE SERVICE COST CENTERS 9,098,645 | | | | 0 | | 0 0 | | |
| 31.00 0 3000 (INTENSIVE CARE UNIT 1 1,669,932 611,471 2,281,403 557,452 1,723,951 31.00 33.00 33.00 03300 (BURN INTENSIVE CARE UNIT 0 0 0 0 0 0 0 33.00 40.00 33.00 33.00 BURN INTENSIVE CARE UNIT 0 0 0 0 0 0 0 0 33.00 40.00 40.00 SURGICAL INTENSIVE CARE UNIT 0 0 0 0 0 0 0 0 0 33.00 40.00 40.00 SURGICAL INTENSIVE CARE UNIT 0 0 0 0 0 0 0 0 0 40.00 4 | | INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | |
| 32.00 03200 COROMARY CARE UNIT 0 0 0 0 0 32.00 33.00 33.00 33.00 33.00 33.00 033.00 BURN INTENSIVE CARE UNIT 0 0 0 0 0 0 34.00 0 0 0 0 0 0 0 0 0 | | | | | | | | |
| 33.00 03300 BURN INTENSIVE CARE UNIT 0 0 0 0 0 0 3.4 00 40.00 0300 SURGIC CLA INTENSIVE CARE UNIT 0 0 0 0 0 0 0 0 0 3.4 00 40.00 04000 SURGIC CLA INTENSIVE CARE UNIT 0 0 0 0 0 0 0 0 0 0 0 0 40.00 04000 SURGIC CLA INTENSIVE CARE UNIT 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | | | 1, 669, 932 | 611, 4/1 | 2, 281, 40 | 3 -557, 452 | | |
| 34. 00 0 3400 SURGICAL INTENSIVE CARE UNIT 0 0 0 0 0 0 0 0 44. 00 0 10 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | | | | 0 | | 0 0 | | |
| 11 00 04100 SUBPROVI DER - 1 IRF | | | o | 0 | | 0 0 | | 34.00 |
| 43.00 04300 NURSERY 0 0 0 0 0 0 44.00 44.00 04400 SKILLER DIJESING FACILITY 0 0 0 0 0 0 0 44.00 45.00 04500 ONDESING FACILITY 0 0 0 0 0 0 0 0 46.00 04500 OTHER LONG TERM CARE 0 0 0 0 0 0 0 46.00 04500 OTHER LONG TERM CARE 0 0 0 0 0 0 0 46.00 04500 OTHER LONG TERM CARE 0 0 0 0 0 0 0 46.00 04500 OTHER LONG TERM CARE 0 0 0 0 0 0 0 46.00 04500 OTHER LONG TERM CARE 0 0 0 0 0 0 0 46.00 04500 OTHER LONG TERM CARE 0 0 0 0 0 0 0 46.00 04500 OTHER LONG TERM CARE 0 0 0 0 0 0 0 46.00 04500 OTHER LONG TERM CARE 0 0 0 0 0 0 0 46.00 04500 OTHER LONG TERM CARE 0 0 0 0 0 0 0 0 46.00 04500 OTHER LONG TERM CARE 0 0 0 0 0 0 0 0 46.00 04500 OTHER LONG TERM CARE 0 0 0 0 0 0 0 0 46.00 04500 OTHER LONG TERM CARE 0 0 0 0 0 0 0 46.00 04500 OTHER LONG TERM CARE 0 0 0 0 0 0 0 0 0 46.00 04500 OTHER LONG TERM CARE 0 0 0 0 0 0 0 0 0 46.00 04500 OTHER LONG TERM CARE 0 0 0 0 0 0 0 0 0 | | | 0 | 0 | | 0 0 | | |
| 44. 00 04400 SKILLED NURSING FACILITY | | | 0 | 0 | | 0 | | |
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| 46. 00 04600 O1FER LONG TERN CARE O O O O O O O O O | | | | 0 | | 0 0 | | 45. 00 |
| 50.00 OSD00 OSD00 PEPERATING ROOM 3,705,779 13,490,991 17,196,770 -10,395,577 6,801,193 50.00 | 46. 00 | | 0 | 0 | | 0 0 | 0 | 46. 00 |
| 51. 00 05100 RECOVERY ROOM 796, 428 231, 808 1, 028, 236 -199, 375 828, 861 51, 00 52, 00 05200 DELI VERY ROOM & LABOR ROOM 0 0 0 0 0 0 0 0 0 0 0 52, 00 0 0 0 0 0 0 52, 00 0 52, 00 0 0 0 52, 00 55, 00 | F0 00 | | 2 705 770 | 12 400 001 | 17 10/ 77 | 10 205 577 | / 001 102 | |
| 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 0 0 0 52.00 | | | 1 | | | | | |
| 53.00 05300 AINSTHESI OLOGY 34, 264 737, 149 771, 413 -159, 687 611, 726 53.00 | | | 1 | 0 | | | | 52. 00 |
| 55.00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 0 0 0 0 55.00 55.00 55.00 0 0 0 0 0 55.00 55.00 55.00 0 0 0 0 55.00 55.00 0 0 0 0 55.00 55.00 0 0 0 0 55.00 | | 05300 ANESTHESI OLOGY | | | 1 | | | 1 |
| 56. 00 0500 RADI OI SOTOPE 0 0 0 0 0 0 55. 00 55. 00 05700 CT SCAN 445, 369 726, 771 1,172, 140 -259, 262 912, 878 87. 00 59. 00 05800 MAGNETI C RESONANCE IMAGING (MRI) 804, 895 1,053, 266 1,858, 161 -478, 779 1,379, 382 58. 00 59. 00 05900 CARDI AC CATHETERI ZATION 1,106, 968 2,354, 738 3,461, 706 -1,977, 277 1,484, 429 59. 00 60. 01 06000 LABORATORY 0 6,050, 464 6,050, 464 -348, 211 5,702, 253 60. 00 61. 00 06000 BLOOD LABORATORY 0 | | | | 1, 906, 759 | 3, 477, 34 | 8 -1, 080, 032 | | |
| 57. 00 05700 CT SCAN 445, 369 726, 771 1, 172, 140 -259, 262 912, 878 57. 00 912, 878 57. 00 58. 00 05800 MAGNETIC RESONANCE I MAGI NG (MRI) 804, 895 1, 053, 266 1, 858, 161 -478, 777 1, 4784, 429 59. 00 00 00 05900 CARDI AC CATHETERI ZATI ON 1, 106, 968 2, 354, 738 3, 461, 706 -1, 977, 277 1, 484, 429 59. 00 0 00 00 0 0.00 0 0 </td <td></td> <td></td> <td>0</td> <td>0</td> <td></td> <td>0</td> <td></td> <td></td> | | | 0 | 0 | | 0 | | |
| 58. 00 05800 CARDIAC CATHETERI ZATION 804, 895 1, 053, 266 1, 858, 161 -478, 779 1, 379, 382 58. 00 05900 CARDIAC CATHETERI ZATION 1, 106, 968 2, 354, 738 3, 461, 706 -1, 977, 277 1, 484, 429 59. 00 0 0 0 0 0 0 0 0 0 | | | 445, 369 | 726, 771 | 1, 172, 14 | 0 -259, 262 | | |
| 60. 00 06000 LABORATORY 0 6,050,464 6,050,464 -348,211 5,702,253 60.00 06.01 06001 BLOOD LABORATORY 0 0 0 0 0 0 06.01 06001 BLOOD LABORATORY 0 0 0 0 0 07.00 06100 08001 18000 2000 0 0 0 0 08.00 08.00 08.00 08.00 0 0 0 0 08.00 08.00 08.00 0 0 0 0 08.00 08.00 08.00 08.00 0 0 0 0 08.00 08.00 08.00 08.00 0 0 0 0 08.00 08.00 08.00 0 0 0 0 08.00 08.00 08.00 08.00 0 0 0 08.00 08.00 08.00 08.00 0 0 0 08.00 08.00 08.00 08.00 0 0 0 08.00 08.00 08.00 08.00 0 0 0 08.00 08.00 08.00 08.00 08.00 0 08.00 08.00 08.00 08.00 08.00 0 0 08.00 | 58. 00 | | | | | | | 58. 00 |
| 60. 01 06001 | | | 1, 106, 968 | | | | | |
| 61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 0 0 0 0 0 0 62.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 0 0 0 0 63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 0 0 0 64. 00 06400 INTRAVENOUS THERAPY 0 0 0 0 0 0 65. 00 06500 RESPIRATORY THERAPY 1,073,705 452,898 1,526,603 -357,767 1,168,836 65.00 66. 00 06600 PHYSI CAL THERAPY 268,773 62,186 330,959 -61,334 269,625 66.00 67. 00 06700 0CCUPATI ONAL THERAPY 177,250 37,820 215,070 -36,499 178,571 67.00 69. 00 06900 ELECTROCARDI OLOGY 390,993 315,847 706,840 -195,634 511,206 69.00 70. 00 07000 ELECTROENCEPHALOGRAPHY 421,687 734,018 1,155,705 -128,262 1,027,443 70.00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 7,389,136 7,389,136 71.00 72. 00 07200 IMPL DEV. CHARGED TO PATI ENTS 0 0 0 0 0 75.00 74. 00 07400 RENAL DI ALYSI S 0 0 0 0 0 75.00 75. 00 07500 ASC (NON-DI STINCT PART) 0 0 0 0 0 0 76. 01 03950 OTHER ANCI LL SRVC 0 0 0 0 0 0 77. 00 00700 ALLOGENEIC STEM CELL ACQUISITION 0 0 0 0 0 77. 00 00700 ALLOGENEIC STEM CELL ACQUISITION 0 0 0 0 0 88. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 0 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 0 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 0 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER | | | 0 | 6, 050, 464 | 6, 050, 46 | -348, 211 | | 1 |
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| 64. 00 06400 INTRAVENOUS THERAPY 0 0 0 0 0 0 64. 00 65. 00 06500 RESPI RATORY THERAPY 1,073,705 452,898 1,526,603 -357,767 1,168,836 65. 00 66. 00 06600 PHYSI CAL THERAPY 268,773 62,186 330,959 -61,334 269,625 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 177,250 37,820 215,070 -36,499 178,571 67. 00 68. 00 06800 SPEECH PATHOLOGY 60,415 9,224 69,639 -8,870 60,769 68. 00 69. 00 06900 ELECTROCARDI OLOGY 390,993 315,847 706,840 -195,634 511,206 69. 00 71. 00 07000 ELECTROCEPHALOGRAPHY 421,687 734,018 1,155,705 -128,262 1,027,443 70. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 6,709,178 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 74. 00 74. 00 07400 RENAL DI ALYSIS 0 0 0 0 0 75. 00 76. 01 03950 OTHER ANCILL SRVC 0 0 0 0 0 0 76. 02 03952 WOUND CARE 3,774 12,006 15,780 -8,692 7,088 76. 02 77. 00 07700 ALIGENTE SERVICE COST CENTERS 88. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 0 89. 00 | | | 0 | 0 | | 0 0 | | 62.00 |
| 65. 00 | | | 0 | 0 | | 0 0 | 0 | 63. 00 |
| 66. 00 06600 PHYSI CAL THERAPY 268, 773 62, 186 330, 959 -61, 334 269, 625 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 177, 250 37, 820 215, 070 -36, 499 178, 571 67, 00 68. 00 6800 SPEECH PATHOLOGY 60, 415 9, 224 69, 639 -8, 870 60, 769 68. 00 6900 ELECTROCARDI OLOGY 390, 993 315, 847 706, 840 -195, 634 511, 206 69. 00 07000 ELECTROCARDI OLOGY 421, 687 734, 018 1, 155, 705 -128, 262 1, 027, 443 70. 00 7100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 7, 389, 136 7, 389, 136 7, 389, 136 71, 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 0 0 6, 709, 178 6, 709, 178 72. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 3, 779, 008 3, 779, 008 3, 779, 008 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 0 0 0 0 0 7400 RENAL DI ALYSI S 0 0 0 0 0 0 0 0 0 0 0 75. 00 07500 ASC (NON-DI STI NCT PART) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | | | 0 | 0 | 4 507 72 | 0 0 | 0 | 64.00 |
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| 68. 00 | | 1 | 1 | | | | | |
| 70. 00 07000 ELECTROENCEPHALOGRAPHY 421, 687 734, 018 1, 155, 705 -128, 262 1, 027, 443 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 7, 389, 136 7, 389, 136 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 6, 709, 178 6, 709, 178 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 3, 779, 008 3, 779, 008 73. 70 72. 00 74. 00 07400 RENAL DIALYSIS 0 0 0 0 0 0 74. 00 75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 0 0 75. 00 76. 01 03951 CARDI AC AND PULMONARY REHAB 224, 311 39, 982 264, 293 -36, 993 227, 300 76. 01 70. 02 03952 WOND ACE 3, 774 12, 006 15, 780 -8, 692 7, 088 76. 02 <td></td> <td>1 1</td> <td>1</td> <td></td> <td></td> <td></td> <td></td> <td></td> | | 1 1 | 1 | | | | | |
| 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 7, 389, 136 7, 389, 136 71. 00 72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS 0 0 0 6, 709, 178 6, 709, 178 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 3, 779, 008 3, 779, 008 73. 00 74. 00 07400 RENAL DIALYSIS 0 0 0 0 0 0 74. 00 75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 0 75. 00 76. 01 03950 OTHER ANCILL SRVC 0 0 0 0 0 0 0 76. 00 76. 02 03951 CARDI AC AND PULMONARY REHAB 224, 311 39, 982 264, 293 -36, 993 227, 300 76. 01 77. 00 07700 ALLOGENEI C STEM CELL ACQUI SITI ON 0 0 0 0 0 0 77. 08 76. 02 77. 00 07700 ALLOGENEI C STEM CELL ACQUI SITI ON 0 0 0 0 0 0 0 77. 00 77. 00 77. 00 < | | | 1 | | | | | |
| 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 6, 709, 178 6, 709, 178 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 3, 779, 008 3, 779, 008 73. 00 74. 00 07400 RENAL DIALYSIS 0 0 0 0 0 0 0 74. 00 75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 0 0 75. 00 76. 01 03950 OTHER ANCILL SRVC 0 0 0 0 0 0 0 0 76. 00 76. 01 03951 CARDI AC AND PULMONARY REHAB 224, 311 39, 982 264, 293 -36, 993 227, 300 76. 01 76. 02 03952 WOUND CARE 3, 774 12, 006 15, 780 -8, 692 7, 088 76. 02 77. 00 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON 0 0 0 0 0 0 77. 00 00 TPATI ENT SERVI CE COST CENTERS 0 0 0 0 | | 1 1 | 421, 687 | 734, 018 | 1, 155, 70 | | | |
| 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 3,779,008 3,779,008 73. 00 74. 00 07400 RENAL DIALYSIS 0 0 0 0 0 74. 00 75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 0 75. 00 76. 00 03950 OTHER ANCILL SRVC 0 0 0 0 0 0 76. 00 76. 01 03951 CARDI AC AND PULMONARY REHAB 224, 311 39, 982 264, 293 -36, 993 227, 300 76. 01 77. 00 07700 ALLOGENEI C STEM CELL ACQUI SITI ON 0 0 0 0 0 77. 00 0UTPATI ENT SERVI CE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC 0 0 0 0 0 88. 00 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 0 89. 00 | | | | 0 | | | | |
| 74. 00 07400 RENAL DIALYSIS 0 0 0 0 0 74. 00 75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 0 75. 00 76. 00 03950 OTHER ANCILL SRVC 0 0 0 0 0 0 0 76. 00 76. 01 03951 CARDI AC AND PULMONARY REHAB 224, 311 39, 982 264, 293 -36, 993 227, 300 76. 01 76. 02 03952 WOUND CARE 3, 774 12, 006 15, 780 -8, 692 7, 08 76. 02 77. 00 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON 0 0 0 0 0 77. 00 0UTPATI ENT SERVI CE COST CENTERS 089. 00 08900 FEDERALLY QUALI FI ED HEALTH CENTER 0 0 0 0 0 0 88. 00 | | | | 0 | | | | |
| 76. 00 | 74. 00 | 07400 RENAL DI ALYSI S | 0 | 0 | | 0 | 0 | 74. 00 |
| 76. 01 03951 CARDI AC AND PULMONARY REHAB 224, 311 39, 982 264, 293 -36, 993 227, 300 76. 01 76. 02 03952 WOUND CARE 3, 774 12, 006 15, 780 -8, 692 7, 088 76. 02 77. 00 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON 0 0 0 0 0 0 0 0 0 | | | 0 | 0 | 1 | 0 | | 75.00 |
| 76. 02 03952 WOUND CARE 3, 774 12, 006 15, 780 -8, 692 7, 088 76. 02 077. 00 0179AT I ENT SERVI CE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC 0 0 0 0 0 0 0 89. 00 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 0 0 89. 00 | | | 22/ 211 | 30 063 0 | 264 20 | 3 _26_002 | | |
| 77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION 0 0 0 0 0 77. 00 0 0 77. 00 0 0 0 0 77. 00 0 0 0 | | | | | | | | |
| 88. 00 08800 RURAL HEALTH CLINIC 0 0 0 0 0 88. 00 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 89. 00 | | 07700 ALLOGENEIC STEM CELL ACQUISITION | 1 | 0 | . 5, 75 | 0 0 | | 77. 00 |
| 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 89. 00 | 0.5 | OUTPATIENT SERVICE COST CENTERS | | | | | | |
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| | | t to the transfer of the trans | , 31 | | 1 | | | 1 -: 00 |

| Health Financial Systems | FRANCISCAN HEALT | TH MUNSTER | | | u of Form CMS- | 2552-10 |
|---|------------------|--------------|--------------|----------------------------------|--------------------------------|---------|
| RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O | F EXPENSES | Provi der CO | | Peri od: | Worksheet A | |
| | | | | From 01/01/2021 To 12/31/2021 | Date/Time Pre 5/31/2022 7:5 | |
| Cost Center Description | Sal ari es | 0ther | | Recl assi fi cati | Recl assi fi ed | |
| | | | + col . 2) | ons (See A-6) | Trial Balance | |
| | | | | | (col. 3 +- | |
| | 1.00 | 0.00 | 0.00 | 4.00 | col . 4) | |
| 00.04 00004 01.111.0 | 1.00 | 2.00 | 3.00 | 4.00 | 5. 00 | 00.01 |
| 90. 01 09001 CLI NI C 90. 02 09002 CLI NI C | 1, 628, 064 | 1, 365, 545 | 2, 993, 60 | · · | | |
| 91. 00 09100 EMERGENCY | 271, 086 | 304, 413 | | · · | | |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 2, 237, 892 | 2, 338, 148 | 4, 576, 04 | -911, 398 | 3, 664, 642 | 91.00 |
| OTHER REIMBURSABLE COST CENTERS | | | | | | 92.00 |
| 94. 00 09400 HOME PROGRAM DI ALYSI S | O O | 0 | | n n | 0 | 94.00 |
| 95. 00 09500 AMBULANCE SERVI CES | | 0 | | | 0 | |
| 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED | 0 | 0 | | 0 0 | , O | |
| 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD | 0 | 0 | | 0 0 | , O | |
| 98. 00 09850 OTHER REI MBURSE | o | 0 | | 0 0 | Ō | |
| 99. 00 09900 CMHC | 0 | 0 | | 0 | 0 | 99. 00 |
| 99. 10 09910 CORF | o | 0 | | 0 | 0 | 99. 10 |
| 100.00 10000 I&R SERVICES-NOT APPRVD PRGM | o | 0 | | 0 | 0 | 100. 00 |
| 101.00 10100 HOME HEALTH AGENCY | 0 | 0 | | 0 | 0 | 101. 00 |
| SPECIAL PURPOSE COST CENTERS | | | | | | |
| 105.00 10500 KIDNEY ACQUISITION | 0 | 0 | | 0 | | 105. 00 |
| 106. 00 10600 HEART ACQUI SI TI ON | 0 | 0 | | 0 | | 106. 00 |
| 107.00 10700 LIVER ACQUISITION | 0 | 0 | | 0 | | 107. 00 |
| 108.00 10800 LUNG ACQUISITION | 0 | 0 | | 0 | | 108. 00 |
| 109. 00 10900 PANCREAS ACQUISITION | 0 | 0 | | 0 | | 109. 00 |
| 110. 00 11000 I NTESTI NAL ACQUI SI TI ON | 0 | 0 | | 0 | | 110.00 |
| 111. 00 11100 I SLET ACQUI SI TI ON | 0 | 0 | | 0 | | 111. 00 |
| 113. 00 11300 NTEREST EXPENSE | | -3, 356 | -3, 35 | 6 3, 356 | | 113.00 |
| 114. 00 11400 UTI LI ZATI ON REVI EW-SNF | 0 | 0 | | 0 | | 114.00 |
| 115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.) | 0 | 0 | | 0 | | 115.00 |
| 116. 00 11600 HOSPI CE | 42 205 214 | 72 024 042 | 117 120 25 | (427.454 | | 116.00 |
| 118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS | 43, 205, 314 | 73, 924, 942 | 117, 130, 25 | 6 437, 456 | 117, 567, 712 |] 18.00 |
| 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN | 30, 311 | 46, 182 | 76, 49 | 3 -15, 777 | 60, 716 | 190. 00 |
| 191. 00 19100 RESEARCH | 593 | 0 | 59 | · · | | 191. 00 |
| 102 00 10200 PHYSICIANS' PRIVATE DEFICES | 1 531 3/15 | 625 205 | | | | |

1, 531, 345

279, 109

20, 668

45, 067, 340

625, 295

213, 550

74, 811, 845

1, 772, 713 192. 00

0 192. 01 456, 783 192. 02

20, 668 194. 00

119, 879, 185 200. 00

0 193. 00

2, 156, 640

119, 879, 185

192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES

TOTAL (SUM OF LINES 118 through 199)

192. 01 19201 CENTER OF HOPE 192. 02 19202 OTHER FA FACILITIES NRCC

193. 00 19300 NONPALD WORKERS

194.00 07950 OTHER NRCC

200.00

| Heal th | Financial Systems | FRANCI SCAN HEA | ALTH MUNSTER | | In Lieu | of Form CMS-2552-10 |
|----------------------------|---|------------------------------|---------------------|-----------|----------------------------------|---------------------|
| RECLAS | SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE | OF EXPENSES | Provider CCN: | : 15-0165 | | Worksheet A |
| | | | | | From 01/01/2021 To 12/31/2021 | Date/Time Prepared: |
| | | | | | | 5/31/2022 7:54 am |
| | Cost Center Description | Adjustments | Net Expenses | | | |
| | | (See A-8) 6.00 | For Allocation 7.00 | | | |
| | GENERAL SERVICE COST CENTERS | 0.00 | 7.00 | | | |
| 1.00 | 00100 CAP REL COSTS-BLDG & FIXT | -107, 008 | 6, 151, 842 | | | 1. 00 |
| 2.00 | 00200 CAP REL COSTS-MVBLE EQUIP | 0 | 0 | | | 2. 00 |
| 3. 00 | 00300 OTHER CAP REL COSTS | 0 | 0 | | | 3. 00 |
| 4.00 | 00400 EMPLOYEE BENEFITS DEPARTMENT | -87, 191 | | | | 4.00 |
| 5. 00 6. 00 | 00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS | -9, 921, 308 0 | 1 | | | 5. 00 6. 00 |
| 7. 00 | 00700 OPERATION OF PLANT | 0 | | | | 7. 00 |
| 8.00 | 00800 LAUNDRY & LINEN SERVICE | -83, 884 | - | | | 8.00 |
| 9. 00 | 00900 HOUSEKEEPI NG | -43 | | | | 9. 00 |
| 10.00 | 01000 DI ETARY | -206, 068 | | | | 10.00 |
| 11.00 | 01100 CAFETERI A | 0 | 894, 557 | | | 11. 00 |
| 12.00 | 01200 MAINTENANCE OF PERSONNEL | 0 | 0 | | | 12. 00 |
| | 01300 NURSI NG ADMINI STRATI ON | -427 | 1 | | | 13. 00 |
| | 01400 CENTRAL SERVICES & SUPPLY | 0 | , | | | 14. 00 |
| | 01500 PHARMACY | 172, 696 | 1 | | | 15. 00 |
| 16. 00 17. 00 | 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE | 995, 256 | 1, 384, 313 | | | 16. 00 17. 00 |
| | 01850 OTHER GEN SERV | 0 | | | | 18. 00 |
| 19. 00 | 01900 NONPHYSI CI AN ANESTHETI STS | | | | | 19. 00 |
| | 02000 NURSI NG PROGRAM | Ö | o | | | 20.00 |
| 21. 00 | 02100 I &R SERVICES-SALARY & FRINGES APPRVD | 0 | o | | | 21. 00 |
| 22. 00 | 02200 I &R SERVICES-OTHER PRGM COSTS APPRVD | 0 | 0 | | | 22. 00 |
| 23. 00 | 02301 PARAMED ED PRGM | 0 | 0 | | | 23. 00 |
| | INPATIENT ROUTINE SERVICE COST CENTERS | | | | | |
| 30.00 | 03000 ADULTS & PEDI ATRI CS | -9, 657 | 1 | | | 30.00 |
| 31.00 | 03100 I NTENSI VE CARE UNI T | 0 | | | | 31.00 |
| 32. 00 33. 00 | 03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT | 0 | 0 | | | 32. 00 33. 00 |
| 34. 00 | 03400 SURGICAL INTENSIVE CARE UNIT | 0 | 0 | | | 34.00 |
| 40. 00 | 04000 SUBPROVI DER - I PF | 0 | 0 | | | 40. 00 |
| 41. 00 | 04100 SUBPROVI DER - I RF | 0 | O | | | 41. 00 |
| 43.00 | 04300 NURSERY | 0 | 0 | | | 43. 00 |
| 44.00 | 04400 SKILLED NURSING FACILITY | 0 | 0 | | | 44. 00 |
| 45. 00 | 04500 NURSING FACILITY | 0 | 1 | | | 45. 00 |
| 46. 00 | 04600 OTHER LONG TERM CARE | 0 | 0 | | | 46. 00 |
| 50. 00 | ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM | -994, 243 | 5, 806, 950 | | | 50.00 |
| 51. 00 | 05100 RECOVERY ROOM | -96 | 1 | | | 51. 00 |
| 52. 00 | 05200 DELIVERY ROOM & LABOR ROOM | 0 | 1 | | | 52. 00 |
| 53.00 | 05300 ANESTHESI OLOGY | -120, 640 | 491, 086 | | | 53. 00 |
| 54.00 | 05400 RADI OLOGY-DI AGNOSTI C | -5, 456 | 2, 391, 860 | | | 54. 00 |
| 55. 00 | 05500 RADI OLOGY-THERAPEUTI C | 0 | 1 | | | 55. 00 |
| 56.00 | 05600 RADI OI SOTOPE | 0 | | | | 56.00 |
| | 05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI) | 1, 880 | 1 | | | 57. 00 |
| 58. 00 59. 00 | 05900 CARDIAC CATHETERIZATION | 8, 657 -42, 315 | | | | 58. 00 59. 00 |
| 60.00 | 06000 LABORATORY | -19, 193 | | | | 60.00 |
| 60. 01 | 06001 BLOOD LABORATORY | 0 | 0 | | | 60. 01 |
| 61. 00 | 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY | 0 | o | | | 61. 00 |
| 62.00 | 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS | 0 | 0 | | | 62. 00 |
| 63. 00 | 06300 BLOOD STORING, PROCESSING & TRANS. | 0 | 0 | | | 63. 00 |
| 64.00 | 06400 I NTRAVENOUS THERAPY | 0 | 0 | | | 64. 00 |
| 65. 00 | 06500 RESPI RATORY THERAPY | 0 | | | | 65. 00 |
| 66.00 | 06600 PHYSI CAL THERAPY | 0 | 269, 625 | | | 66.00 |
| 67. 00 68. 00 | 06700 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY | | 178, 571 60, 769 | | | 67. 00 68. 00 |
| 69.00 | 06900 ELECTROCARDI OLOGY | | 511, 206 | | | 69.00 |
| | 07000 ELECTROENCEPHALOGRAPHY | -28, 238 | | | | 70.00 |
| | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | 7, 389, 136 | | | 71. 00 |
| 72. 00 | 07200 IMPL. DEV. CHARGED TO PATIENTS | 0 | 6, 709, 178 | | | 72. 00 |
| 73. 00 | 07300 DRUGS CHARGED TO PATIENTS | 0 | 3, 779, 008 | | | 73. 00 |
| 74. 00 | 07400 RENAL DIALYSIS | 0 | 0 | | | 74. 00 |
| | 07500 ASC (NON-DISTINCT PART) | 0 | 0 | | | 75. 00 |
| | 03950 OTHER ANCILL SRVC | 0 | 0 | | | 76.00 |
| | 03951 CARDI AC AND PULMONARY REHAB | 0 | | | | 76. 01 |
| | 03952 WOUND CARE 07700 ALLOGENEIC STEM CELL ACQUISITION | 0 | 1 ' 1 | | | 76. 02 77. 00 |
| , , . 00 | OUTPATIENT SERVICE COST CENTERS | | ı U | | | 77.00 |
| 00 00 | 08800 RURAL HEALTH CLINIC | 0 | 0 | | | 88. 00 |
| 88. 00 | 1 | 1 | | | | |
| 88.00 | 08900 FEDERALLY QUALIFIED HEALTH CENTER | 0 | 0 | | | 89.00 |
| 89. 00 90. 00 | 09000 CLI NI C | 0 | O | | | 90. 00 |
| 89. 00 90. 00 90. 01 | 1 1 | 0 0 -7, 247 -1, 591 | 0 2, 337, 300 | | | |

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

TOTAL (SUM OF LINES 118 through 199)

Provider CCN: 15-0165

Peri od: Worksheet A From 01/01/2021 To 12/31/2021 Date/Ti me Prepared:

200. 00

5/31/2022 7:54 am Cost Center Description Adjustments Net Expenses For Allocation (See A-8) 6.00 7.00 91. 00 09100 EMERGENCY 91. 00 -324, 325 3, 340, 317 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DIALYSIS 94.00 0 0 0 0 0 94.00 95 00 09500 AMBULANCE SERVICES 95.00 0 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 96.00 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD 0 97.00 0 98.00 09850 OTHER REIMBURSE 98.00 99. 00 09900 CMHC 0 99.00 99. 10 09910 CORF 0 99. 10 100.00 10000 I &R SERVICES-NOT APPRVD PRGM 0 0 100.00 101.00 10100 HOME HEALTH AGENCY 0 0 101.00 SPECIAL PURPOSE COST CENTERS 105. 00 10500 KIDNEY ACQUISITION 0 0 105.00 106. 00 10600 HEART ACQUISITION 0 0 0 0 0 0 0 0 0 106. 00 107. 00 10700 LIVER ACQUISITION 0 107. 00 108.00 10800 LUNG ACQUISITION 0 108.00 109. 00 10900 PANCREAS ACQUISITION 0 109. 00 110.00 11000 INTESTINAL ACQUISITION 0 110.00 111.00 11100 I SLET ACQUISITION 0 111. 00 113.00 11300 INTEREST EXPENSE 0 113. 00 114.00 11400 UTILIZATION REVIEW-SNF 0 114. 00 115.00 11500 AMBULATORY SURGICAL CENTER (D.P.) 115. 00 0 116. 00 11600 HOSPI CE 0 116. 00 SUBTOTALS (SUM OF LINES 1 through 117) -10, 780, 441 106, 787, 271 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190 00 60, 716 0 191. 00 19100 RESEARCH 593 191. 00 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 192. 00 0 0 1, 772, 713 192. 01 19201 CENTER OF HOPE 192. 01 C 192.02 19202 OTHER FA FACILITIES NRCC 192. 02 456, 783 0 193. 00 19300 NONPALD WORKERS 193. 00 194.00 07950 OTHER NRCC 194. 00 20,668

-10, 780, 441

109, 098, 744

200.00

Health Financial Systems RECLASSIFICATIONS Provider CCN: 15-0165

| | | 1 | | | 5/ | <u>′31/2022 7:54 a</u> |
|-----|-----------------------------|---------------------|----------------|-------------|----|------------------------|
| | Cost Center | Increases Line # | Sal ary | Other | | |
| | 2. 00 | 3.00 | 4.00 | 5. 00 | | |
| / | A - INSURANCE | | | | | |
| | CAP REL COSTS-BLDG & FIXT | 1. 00 | 0 | 1 | | |
| L | | 0.00 | 0 | | | 2 |
| (| 0 | | 0 | 46, 904 | | |
| | B - INTEREST EXPENSE | 1 00 | | F 224 (00 | | |
| - 1 | CAP REL COSTS-BLDG & FIXT | 1.00 | 0 | 1 1 | | |
| | NTEREST EXPENSE | 113.00 | $ \frac{0}{0}$ | | | 1 |
| ì | C - DRUG EXPENSE | | 0 | 3, 220, 044 | | |
| | DRUGS CHARGED TO PATIENTS | 73. 00 | 0 | 3, 779, 008 | | |
| | | 0.00 | 0 | 1 1 | | |
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| Ī | D - MED SUPPLIES EXPENSE | | | 0,7,7,000 | | |
| | MEDICAL SUPPLIES CHARGED TO | 71.00 | 0 | 7, 389, 136 | | |
| | PATI ENTS | | | | | |
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| ´ | $_{0}$ $ +$ | | 0 | | | 2 |
| ľ | E - IMPLANTABLE DEVICES | | 0 | 7,307,130 | | |
| | IMPL. DEV. CHARGED TO | 72. 00 | 0 | 6, 709, 178 | | |
| | PATI ENTS | | _ | | | |
| | | 0. 00 | 0 | 0 | | |
| | | 0.00 | 0 | 0 | | |
| | | 0.00 | 0 | 0 | | |
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Health Financial Systems RECLASSIFICATIONS FRANCISCAN HEALTH MUNSTER In Lieu of Form CMS-2552-10 Provider CCN: 15-0165

| | | | | | 10 | 12/31/2021 | Date/lime Prepared: 5/31/2022 7:54 am |
|--------|------------------------------|-----------|----------|--------------|----|------------|--|
| | | Increases | | | \ | | 070172022 7101 4111 |
| | Cost Center | Li ne # | Sal ary | 0ther | | | |
| | 2. 00 | 3. 00 | 4. 00 | 5. 00 | | | |
| | F - CAFE | | | | | | |
| 1.00 | CAFETERI A | 11. 00 | 362, 636 | 531, 921 | | | 1.00 |
| | 0 | | 362, 636 | 531, 921 | | | |
| | G - EMPLOYEE BENEFITS | | | | | | |
| 1.00 | EMPLOYEE BENEFITS DEPARTMENT | 4. 00 | 0 | 11, 276, 326 | | | 1. 00 |
| 2.00 | | 0.00 | o | 0 | | | 2. 00 |
| 3.00 | | 0.00 | o | 0 | | | 3.00 |
| 4.00 | | 0.00 | o | 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 | 0 | 0 | | | 11. 00 |
| 12.00 | | 0.00 | O | 0 | | | 12. 00 |
| 13.00 | | 0.00 | o | 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 | o | 0 | | | 19. 00 |
| 20. 00 | | 0.00 | 0 | 0 | | | 20. 00 |
| 21. 00 | | 0.00 | o | 0 | | | 21. 00 |
| 22. 00 | | 0.00 | o | 0 | | | 22. 00 |
| 23. 00 | | 0.00 | o | 0 | | | 23. 00 |
| 24. 00 | | 0.00 | o | 0 | | | 24. 00 |
| 25. 00 | | 0.00 | o | 0 | | | 25. 00 |
| 26.00 | | 0.00 | o | 0 | | | 26. 00 |
| 27. 00 | | 0.00 | o | 0 | | | 27. 00 |
| 28. 00 | | 0.00 | o | 0 | | | 28. 00 |
| 29. 00 | | 0.00 | o | 0 | | | 29. 00 |
| 30. 00 | | 0.00 | o | Ö | | | 30.00 |
| 31. 00 | | 0.00 | o | Ö | | | 31.00 |
| 32. 00 | | 0.00 | o | Ö | | | 32.00 |
| 33. 00 | | 0.00 | ol | Ö | | | 33. 00 |
| | TOTALS — — — | | | 11, 276, 326 | | | |
| 500.00 | Grand Total: Increases | | 362, 636 | 34, 960, 517 | | | 500. 00 |

Health Financial Systems RECLASSIFICATIONS | Peri od: | Worksheet A-6 | From 01/01/2021 | To 12/31/2021 | Date/Time Prepared: Provider CCN: 15-0165

| | | | | | To | o 12/31/2021 Date/Time Pr 5/31/2022 7: | |
|------------------|---|-------------------|----------|-------------------------------------|----------------|---|------------------|
| | Cost Center | Decreases Li ne # | Sal ary | Other | Wkst. A-7 Ref. | | |
| | 6. 00 | 7. 00 | 8. 00 | 9. 00 | 10. 00 | | |
| | A - INSURANCE | | | | | | |
| 1.00 | ADMINISTRATIVE & GENERAL | 5.00 | 0 | 22, 758 | | | 1.00 |
| 2. 00 | ADULTS & PEDIATRICS | 30.00 | 0 | 2 <u>4, 1</u> 4 <u>6</u> 46, 904 | | | 2. 00 |
| | B - INTEREST EXPENSE | | <u> </u> | 10, 701 | | | |
| 1.00 | ADMINISTRATIVE & GENERAL | 5.00 | 0 | 5, 228, 044 | 11 | | 1.00 |
| 2.00 | | 0.00 | 0 | 0 | 0 | | 2. 00 |
| | C - DRUG EXPENSE | | 0 | 5, 228, 044 | | | |
| 1. 00 | EMPLOYEE BENEFITS DEPARTMENT | 4, 00 | 0 | 17, 591 | 0 | | 1.00 |
| 2. 00 | ADMINISTRATIVE & GENERAL | 5. 00 | O | 1, 262 | | | 2. 00 |
| 3.00 | MAINTENANCE & REPAIRS | 6. 00 | 0 | 11 | 0 | | 3. 00 |
| 4.00 | NURSI NG ADMI NI STRATI ON | 13.00 | 0 | 299 | | | 4. 00 |
| 5. 00 6. 00 | CENTRAL SERVICES & SUPPLY PHARMACY | 14. 00 15. 00 | 0 | 158 3, 175, 892 | | | 5. 00 6. 00 |
| 7. 00 | ADULTS & PEDIATRICS | 30.00 | 0 | 37, 558 | | | 7. 00 |
| 8. 00 | INTENSIVE CARE UNIT | 31.00 | 0 | 29, 738 | | | 8. 00 |
| 9.00 | OPERATING ROOM | 50. 00 | 0 | 47, 669 | 0 | | 9. 00 |
| 10.00 | RECOVERY ROOM | 51.00 | 0 | 10 | | | 10.00 |
| 11. 00 12. 00 | ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C | 53. 00 54. 00 | 0 | 30, 372 258, 455 | | | 11. 00 12. 00 |
| 13. 00 | CT SCAN | 57.00 | 0 | 5, 521 | 0 | | 13. 00 |
| 14. 00 | MAGNETIC RESONANCE I MAGING | 58.00 | o | 967 | 0 | | 14. 00 |
| | (MRI) | | | | | | |
| 15. 00 | CARDI AC CATHETERI ZATI ON | 59.00 | 0 | 2, 410 | 1 | | 15. 00 |
| 16. 00 17. 00 | ELECTROCARDI OLOGY WOUND CARE | 69. 00 76. 02 | 0 | 72 7 | 0 | | 16. 00 17. 00 |
| 18. 00 | CLINIC | 90. 01 | 0 | 155, 345 | 0 | | 18. 00 |
| 19. 00 | CLINIC | 90. 02 | 0 | 3, 287 | | | 19. 00 |
| 20.00 | EMERGENCY | 91.00 | 0 | 12, 384 | | | 20. 00 |
| | 0 ENDELLEG EVDENCE | | 0 | 3, 779, 008 | | | |
| 1.00 | D - MED SUPPLIES EXPENSE EMPLOYEE BENEFITS DEPARTMENT | 4.00 | 0 | 7, 490 | 0 | | 1.00 |
| 2. 00 | ADMINISTRATIVE & GENERAL | 5. 00 | 0 | 118, 916 | | | 2. 00 |
| 3.00 | MAINTENANCE & REPAIRS | 6. 00 | 0 | 14, 223 | | | 3. 00 |
| 4.00 | LAUNDRY & LINEN SERVICE | 8. 00 | 0 | 1, 037 | | | 4. 00 |
| 5.00 | HOUSEKEEPI NG | 9.00 | 0 | 5, 453 | 0 | | 5. 00 |
| 6. 00 7. 00 | DI ETARY NURSI NG ADMI NI STRATI ON | 10. 00 13. 00 | 0 | 20, 015 19, 479 | 0 | | 6. 00 7. 00 |
| 8. 00 | CENTRAL SERVICES & SUPPLY | 14. 00 | o | 48, 295 | | | 8. 00 |
| 9. 00 | PHARMACY | 15. 00 | O | 25, 532 | 1 | | 9. 00 |
| 10.00 | ADULTS & PEDIATRICS | 30. 00 | 0 | 522, 604 | 0 | | 10.00 |
| 11.00 | INTENSIVE CARE UNIT | 31.00 | 0 | 166, 543 | 1 | | 11.00 |
| 12. 00 13. 00 | OPERATING ROOM RECOVERY ROOM | 50. 00 51. 00 | 0 | 3, 518, 630 40, 678 | 1 | | 12. 00 13. 00 |
| 14. 00 | ANESTHESI OLOGY | 53.00 | o | 112, 188 | 1 | | 14. 00 |
| 15. 00 | RADI OLOGY-DI AGNOSTI C | 54.00 | O | 353, 511 | 0 | | 15. 00 |
| 16. 00 | CT SCAN | 57. 00 | 0 | 131, 079 | 0 | | 16. 00 |
| 17. 00 | MAGNETIC RESONANCE I MAGING | 58. 00 | 0 | 290, 400 | 0 | | 17. 00 |
| 18. 00 | (MRI) CARDIAC CATHETERIZATION | 59. 00 | 0 | 959, 551 | 0 | | 18. 00 |
| 19. 00 | LABORATORY | 60.00 | o | 348, 211 | O | | 19. 00 |
| 20. 00 | RESPIRATORY THERAPY | 65. 00 | 0 | 129, 509 | 0 | | 20.00 |
| 21. 00 | PHYSI CAL THERAPY | 66.00 | 0 | 721 | 0 | | 21. 00 |
| 22. 00 23. 00 | OCCUPATI ONAL THERAPY ELECTROCARDI OLOGY | 67. 00 69. 00 | 0 | 151 86, 997 | 0 | | 22. 00 23. 00 |
| 23.00 | ELECTROCARDI OLOGY ELECTROENCEPHALOGRAPHY | 70.00 | 0 | 23, 510 | 1 | | 24. 00 |
| 25. 00 | CARDI AC AND PULMONARY REHAB | 76. 01 | o | 499 | | | 25. 00 |
| 26. 00 | WOUND CARE | 76. 02 | O | 4, 422 | | | 26. 00 |
| 27. 00 | CLINIC | 90. 01 | 0 | 25, 888 | | | 27. 00 |
| 28. 00 29. 00 | CLINIC EMERCENCY | 90. 02 91. 00 | 0 | 37, 824 375, 780 | | | 28. 00 29. 00 |
| ∠7. UU | EMERGENCY | 91.00 | 0 | <u>375, 780</u> 7, 389, 136 | | | 27.00 |
| | E - IMPLANTABLE DEVICES | | <u> </u> | | | | 1 |
| 1.00 | ADMINISTRATIVE & GENERAL | 5. 00 | 0 | 2, 880 | | | 1. 00 |
| 2.00 | CENTRAL SERVICES & SUPPLY | 14. 00 | 0 | 7, 247 | | | 2. 00 |
| 3. 00 4. 00 | ADULTS & PEDIATRICS OPERATING ROOM | 30. 00 50. 00 | 0 | 782 5, 936, 615 | | | 3. 00 4. 00 |
| 4. 00 5. 00 | RECOVERY ROOM | 51. 00 | 0 | 5, 936, 615 8, 108 | | | 5. 00 |
| 6.00 | MAGNETIC RESONANCE I MAGING | 58. 00 | o O | 550 | | | 6. 00 |
| | (MRI) | | [| | | | |
| 7.00 | CARDI AC CATHETERI ZATI ON | 59.00 | 0 | 752, 956 | 1 | | 7. 00 |
| 8. 00 | EMERGENCY | 91.00 | 0 | 40 6, 709, 178 | | | 8. 00 |
| | <u> </u> | | ٩ | 0, 707, 170 | <u> </u> | | |

Health Financial Systems RECLASSIFICATIONS Provider CCN: 15-0165

| | | | | | | То | 12/31/2021 | Date/Time 5/31/2022 | |
|--------|-------------------------------------|-----------------|----------|----------------|---------------|----|------------|------------------------|------------|
| | | Decreases | | | | | | 3/31/2022 | 7. 54 dili |
| | Cost Center | Li ne # | Salary | Other | Wkst. A-7 Ref | · | | | |
| | 6. 00 | 7. 00 | 8. 00 | 9. 00 | 10.00 | | | | |
| | F - CAFE | | | | | | | | |
| 1.00 | DI ETARY | 10.00 | 362, 636 | 531, 921 | | 0 | | | 1. 00 |
| | 0 | | 362, 636 | 531, 921 | | | | | |
| | G - EMPLOYEE BENEFITS | | | | | | | | |
| 1.00 | ADMINISTRATIVE & GENERAL | 5. 00 | 0 | 2, 576, 373 | 3 | 0 | | | 1. 00 |
| 2.00 | MAINTENANCE & REPAIRS | 6. 00 | 0 | 244, 578 | 3 | 0 | | | 2. 00 |
| 3.00 | LAUNDRY & LINEN SERVICE | 8. 00 | 0 | 40, 644 | | 0 | | | 3. 00 |
| 4.00 | HOUSEKEEPI NG | 9. 00 | 0 | 465, 461 | | 0 | | | 4. 00 |
| 5.00 | DI ETARY | 10.00 | 0 | 319, 803 | 3 | 0 | | | 5. 00 |
| 6.00 | NURSING ADMINISTRATION | 13. 00 | 0 | 367, 476 | | 0 | | | 6. 00 |
| 7.00 | CENTRAL SERVICES & SUPPLY | 14.00 | 0 | 109, 260 | | 0 | | | 7. 00 |
| 8.00 | PHARMACY | 15. 00 | 0 | 237, 382 | | 0 | | | 8. 00 |
| 9.00 | MEDICAL RECORDS & LIBRARY | 16. 00 | 0 | 69, 251 | | 0 | | | 9. 00 |
| 10.00 | ADULTS & PEDIATRICS | 30.00 | 0 | 2, 293, 398 | 3 | 0 | | | 10. 00 |
| 11. 00 | INTENSIVE CARE UNIT | 31.00 | 0 | 361, 171 | | 0 | | | 11. 00 |
| 12.00 | OPERATING ROOM | 50.00 | 0 | 892, 663 | 3 | 0 | | | 12. 00 |
| 13.00 | RECOVERY ROOM | 51.00 | 0 | 150, 579 | | 0 | | | 13. 00 |
| 14.00 | ANESTHESI OLOGY | 53.00 | 0 | 17, 127 | ' | 0 | | | 14. 00 |
| 15.00 | RADI OLOGY-DI AGNOSTI C | 54.00 | 0 | 468, 066 | | 0 | | | 15. 00 |
| 16.00 | CT SCAN | 57.00 | 0 | 122, 662 | | 0 | | | 16. 00 |
| 17. 00 | MAGNETIC RESONANCE I MAGING | 58. 00 | 0 | 186, 862 | 2 | 0 | | | 17. 00 |
| | (MRI) | | | | | | | | |
| 18. 00 | CARDIAC CATHETERIZATION | 59. 00 | 0 | 262, 360 | 1 | 0 | | | 18. 00 |
| 19. 00 | RESPI RATORY THERAPY | 65. 00 | 0 | 228, 258 | 1 | 0 | | | 19. 00 |
| 20.00 | PHYSI CAL THERAPY | 66.00 | 0 | 60, 613 | 1 | 0 | | | 20. 00 |
| 21. 00 | OCCUPATIONAL THERAPY | 67.00 | 0 | 36, 348 | | 0 | | | 21. 00 |
| 22. 00 | SPEECH PATHOLOGY | 68. 00 | 0 | 8, 870 | | 0 | | | 22. 00 |
| 23. 00 | ELECTROCARDI OLOGY | 69. 00 | 0 | 108, 565 | | 0 | | | 23. 00 |
| 24. 00 | ELECTROENCEPHALOGRAPHY | 70. 00 | 0 | 104, 752 | | 0 | | | 24. 00 |
| 25. 00 | CARDIAC AND PULMONARY REHAB | 76. 01 | 0 | 36, 494 | | 0 | | | 25. 00 |
| 26. 00 | WOUND CARE | 76. 02 | 0 | 4, 263 | | 0 | | | 26. 00 |
| 27. 00 | CLINIC | 90. 01 | 0 | 467, 829 | | 0 | | | 27. 00 |
| 28. 00 | CLI NI C | 90. 02 | 0 | 74, 568 | | 0 | | | 28. 00 |
| 29. 00 | EMERGENCY | 91.00 | 0 | 523, 194 | | 0 | | | 29. 00 |
| 30. 00 | GIFT, FLOWER, COFFEE SHOP & CANTEEN | 190. 00 | O | 15, 777 | | 0 | | | 30.00 |
| 31. 00 | PHYSICIANS' PRIVATE OFFICES | 192.00 | 0 | 383, 927 | | 0 | | | 31.00 |
| 32.00 | OTHER FA FACILITIES NRCC | 192. 02 | 0 | 35, 876 | | 0 | | | 32. 00 |
| 33.00 | OTHER NRCC | 1 <u>94.</u> 00 | 0 | <u>1, 8</u> 76 | | ol | | | 33. 00 |
| | TOTALS | | 0 | 11, 276, 326 | | | | | |
| 500.00 | Grand Total: Decreases | | 362, 636 | 34, 960, 517 | 7 | | | | 500.00 |

| | | | | | To 12/31/2021 | Date/Time Pre 5/31/2022 7:5 | |
|-------|---|------------------|--------------|-----------------|----------------|--------------------------------|--------|
| | | | | Acqui si ti ons | | 373172022 7.3 | T GIII |
| | | Begi nni ng | Purchases | Donati on | Total | Di sposal s and | |
| | | Bal ances | | | | Retirements | |
| | | 1.00 | 2. 00 | 3. 00 | 4. 00 | 5. 00 | |
| | PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET | T BALANCES | | | | | |
| 1.00 | Land | 9, 641, 227 | 0 | | 0 | 0 | 1. 00 |
| 2.00 | Land Improvements | 2, 710, 184 | 0 | | 0 0 | 0 | 2. 00 |
| 3.00 | Buildings and Fixtures | 84, 514, 988 | 13, 753, 551 | | 0 13, 753, 551 | 0 | 3. 00 |
| 4.00 | Building Improvements | 0 | 0 | | 0 0 | 0 | 4. 00 |
| 5.00 | Fi xed Equipment | 0 | 0 | | 0 0 | 0 | 5. 00 |
| 6.00 | Movable Equipment | 115, 983, 300 | 6, 676, 214 | | 0 6, 676, 214 | 3, 426, 918 | 6. 00 |
| 7.00 | HIT designated Assets | 0 | 0 | | 0 0 | 0 | 7. 00 |
| 8.00 | Subtotal (sum of lines 1-7) | 212, 849, 699 | 20, 429, 765 | | 0 20, 429, 765 | 3, 426, 918 | 8. 00 |
| 9.00 | Reconciling Items | -14, 937, 877 | 0 | | 0 0 | -13, 899, 411 | 9. 00 |
| 10.00 | Total (line 8 minus line 9) | 227, 787, 576 | 20, 429, 765 | | 0 20, 429, 765 | 17, 326, 329 | 10.00 |
| | | Endi ng Bal ance | Fully | | | | |
| | | | Depreci ated | | | | |
| | | | Assets | | | | |
| | | 6. 00 | 7. 00 | | | | |
| | PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET | | | | | | |
| 1.00 | Land | 9, 641, 227 | 0 | | | | 1. 00 |
| 2.00 | Land Improvements | 2, 710, 184 | 0 | | | | 2. 00 |
| 3.00 | Buildings and Fixtures | 98, 268, 539 | 2, 883, 047 | | | | 3. 00 |
| 4.00 | Building Improvements | 0 | 0 | | | | 4. 00 |
| 5.00 | Fi xed Equi pment | 0 | 0 | | | | 5. 00 |
| 6.00 | Movable Equipment | 119, 232, 596 | 19, 089, 533 | | | | 6. 00 |
| 7.00 | HIT designated Assets | 0 | 0 | | | | 7. 00 |
| 8.00 | Subtotal (sum of lines 1-7) | 229, 852, 546 | 21, 972, 580 | | | | 8. 00 |
| 9.00 | Reconciling Items | -1, 038, 466 | 0 | | | | 9. 00 |
| 10.00 | Total (line 8 minus line 9) | 230, 891, 012 | 21, 972, 580 | | | | 10. 00 |

| Heal th | Financial Systems | FRANCISCAN HEA | ALTH MUNSTER | | In lie | u of Form CMS-2 | 2552_10 |
|---------|---|------------------|----------------|----------------|---|--|---------|
| | CILIATION OF CAPITAL COSTS CENTERS | THO WOT SOME THE | Provider CC | | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-7 Part II Date/Time Pre 5/31/2022 7:5 | pared: |
| | | | SU | JMMARY OF CAPI | 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 | SHEET A, COLUM | N 2, LINES 1 a | nd 2 | | | |
| 1.00 | CAP REL COSTS-BLDG & FIXT | 255, 174 | 0 | 20, 46 | 8 686, 438 | 0 | 1. 00 |
| 2.00 | CAP REL COSTS-MVBLE EQUIP | 0 | 0 | | o o | 0 | 2. 00 |
| 3.00 | Total (sum of lines 1-2) | 255, 174 | 0 | 20, 46 | 8 686, 438 | 0 | 3. 00 |
| | | SUMMARY 0 | F CAPITAL | | | | |
| | Cost Center Description | Other | Total (1) (sum | | | | |
| | · | Capi tal -Relate | of cols. 9 | | | | |
| | | d Costs (see | through 14) | | | | |
| | | instructions) | | | | | |
| | | 14. 00 | 15. 00 | | | | |
| | PART II - RECONCILIATION OF AMOUNTS FROM WORK | KSHEET A, COLUM | N 2, LINES 1 a | nd 2 | | | |
| 1.00 | CAP REL COSTS-BLDG & FIXT | 25, 178 | 987, 258 | | | | 1. 00 |
| 2.00 | CAP REL COSTS-MVBLE EQUIP | 0 | 0 | | | | 2.00 |
| 0 00 | T 1 1 (C 1: 4 0) | 05 470 | 007 050 | 1 | | | 0 00 |

25, 178

987, 258

1. 00 2. 00 3. 00

3.00 Total (sum of lines 1-2)

| Heal th | n Financial Systems | FRANCI SCAN HEA | ALTH MUNSTER | | In Lie | eu of Form CMS-2 | 2552-10 |
|----------------|---|-----------------|------------------|----------------------|---|--|----------------|
| RECON | CILIATION OF CAPITAL COSTS CENTERS | | Provi der C | | Period: From 01/01/2021 To 12/31/2021 | Worksheet A-7 Part III Date/Time Pre 5/31/2022 7:5/ | pared: |
| | | COMI | PUTATION OF RAT | TI OS | ALLOCATION OF | OTHER CAPITAL | |
| | Cost Center Description | Gross Assets | Capi tal i zed | Gross Assets | | Insurance | |
| | | | Leases | for Ratio | instructions) | | |
| | | | | (col . 1 - col 2) | | | |
| | | 1. 00 | 2.00 | 3.00 | 4. 00 | 5. 00 | |
| | PART III - RECONCILIATION OF CAPITAL COSTS CI | | | | | | |
| 1.00 | CAP REL COSTS-BLDG & FLXT | 100, 978, 722 | 0 | 100, 978, 72 | 2 0. 465168 | 0 | 1. 00 |
| 2.00 | CAP REL COSTS-MVBLE EQUIP | 119, 232, 596 | 3, 131, 223 | 116, 101, 37 | | | 2. 00 |
| 3.00 | Total (sum of lines 1-2) | 220, 211, 318 | | | | | 3. 00 |
| | | ALLOCA | TION OF OTHER (| CAPI TAL | SUMMARY O | F CAPITAL | |
| | Cost Center Description | Taxes | 0ther | Total (sum of | Depreciation | Lease | |
| | | | Capi tal -Relate | | | | |
| | | | d Costs | through 7) | | | |
| | DART LLL BESCHOLLLATION OF SARITAL SOCTO OF | 6.00 | 7. 00 | 8. 00 | 9. 00 | 10. 00 | |
| 1. 00 | PART III - RECONCILIATION OF CAPITAL COSTS CI | INTERS | 1 0 | ı | 0 388, 166 | 0 | 1. 00 |
| 2. 00 | CAP REL COSTS-BLDG & FTXT | 0 | 0 | | 388, 100 | 0 | 2.00 |
| 3. 00 | Total (sum of lines 1-2) | 0 | 0 | | 0 388, 166 | | 3.00 |
| 3.00 | Total (sull of Titles 1-2) | U | SI SI | I JMMARY OF CAPI | | 0 | 3.00 |
| | | | 50 | DWWART OF CALL | IAL | | |
| | Cost Center Description | Interest | Insurance (see | Taxes (see | 0ther | Total (2) (sum | |
| | | | instructions) | instructions) | | | |
| | | | | | d Costs (see | through 14) | |
| | | | | | instructions) | | |
| | DART III DECONOLILIATION OF CARLTY COSTS OF | 11.00 | 12. 00 | 13. 00 | 14. 00 | 15. 00 | |
| 1 00 | PART III - RECONCILIATION OF CAPITAL COSTS CI | | (0/ 420 | ı | 0 214 022 | (151 042 | 1 00 |
| 1.00 | CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP | 5, 292, 060 | 686, 438 | | 0 -214, 822 | | 1. 00 2. 00 |
| 2. 00 3. 00 | Total (sum of lines 1-2) | 5, 292, 060 | 686, 438 | | 0 -214, 822 | 0 6, 151, 842 | |
| 3.00 | Tiotal (Sum Of Titles 1-2) | 3, 292, 000 | 1 000, 438 | 1 | U ₁ -214, 822 | 0, 101, 842 | J 3.00 |

| | | | | | To 12/31/2021 | Date/Time Prep | |
|------------------|--|-------------------------|--|----------------------------|------------------|------------------------|------------------|
| | | | | Expense Classification of | | 5/31/2022 7: 5 | 4 am |
| | | | | To/From Which the Amount i | s 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 COSTS-BLDG & FIXT (chapter 2) | | 0 | CAP REL COSTS-BLDG & FIXT | 1. 00 | 0 | 1. 00 |
| 2.00 | 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 | A | 20, 468 | CAP REL COSTS-BLDG & FIXT | 1.00 | 9 | 3. 00 |
| 4. 00 | (chapter 2) Trade, quantity, and time | | 0 | | 0.00 | 0 | 4. 00 |
| | discounts (chapter 8) | _ | | | | | |
| 5. 00 | Refunds and rebates of expenses (chapter 8) | В | -473, 768 | ADMINISTRATIVE & GENERAL | 5. 00 | 0 | 5. 00 |
| 6. 00 | Rental of provider space by suppliers (chapter 8) | | 0 | | 0.00 | 0 | 6. 00 |
| 7. 00 | Tel ephone servi ces (pay | | 0 | | 0.00 | 0 | 7. 00 |
| | stations excluded) (chapter 21) | | | | | | |
| 8. 00 | Television and radio service (chapter 21) | | 0 | | 0.00 | 0 | 8. 00 |
| 9.00 | Parking Lot (chapter 21) | | 0 | | 0.00 | | 9. 00 |
| 10. 00 | Provi der-based physician adjustment | A-8-2 | -1, 579, 744 | | | 0 | 10. 00 |
| 11. 00 | Sale of scrap, waste, etc. (chapter 23) | | 0 | | 0.00 | 0 | 11. 00 |
| 12. 00 | Related organization | A-8-1 | -1, 373, 768 | | | 0 | 12. 00 |
| 13. 00 | transactions (chapter 10) Laundry and linen service | | 0 | | 0.00 | | 13. 00 |
| 14. 00 15. 00 | Cafeteria-employees and guests Rental of quarters to employee | | -119, 199 0 | DI ETARY | 10. 00 0. 00 | | 14. 00 15. 00 |
| 16. 00 | and others Sale of medical and surgical | | 0 | | 0.00 | | 16. 00 |
| 10.00 | supplies to other than | | 0 | | 0.00 | 0 | 10.00 |
| 17. 00 | patients Sale of drugs to other than | | 0 | | 0.00 | 0 | 17. 00 |
| 18. 00 | patients Sale of medical records and | В | _ 907 | ADMINISTRATIVE & GENERAL | 5. 00 | 0 | 18. 00 |
| | abstracts | | | | | | |
| 19. 00 | Nursing and allied health education (tuition, fees, | | 0 | | 0.00 | 0 | 19. 00 |
| 20. 00 | books, etc.) Vending machines | В | -12, 391 | DI ETARY | 10.00 | 0 | 20. 00 |
| 21. 00 | Income from imposition of | | 0 | 5127,111 | 0.00 | | 21. 00 |
| | interest, finance or penalty charges (chapter 21) | | | | | | |
| 22. 00 | Interest expense on Medicare overpayments and borrowings to | | 0 | | 0.00 | 0 | 22. 00 |
| 23. 00 | repay Medicare overpayments Adjustment for respiratory | A-8-3 | 0 | DECDIDATODY THEDADY | 65. 00 | | 23. 00 |
| 23.00 | therapy costs in excess of | A-0-3 | 0 | RESPI RATORY THERAPY | 65.00 | | 23.00 |
| 24. 00 | limitation (chapter 14) Adjustment for physical | A-8-3 | 0 | PHYSI CAL THERAPY | 66. 00 | | 24. 00 |
| | therapy costs in excess of limitation (chapter 14) | | | | | | |
| 25. 00 | Utilization review - | | 0 | UTILIZATION REVIEW-SNF | 114. 00 | | 25. 00 |
| | physicians' compensation (chapter 21) | | | | | | |
| 26. 00 | Depreciation - CAP REL COSTS-BLDG & FLXT | | 0 | CAP REL COSTS-BLDG & FIXT | 1. 00 | 0 | 26. 00 |
| 27. 00 | Depreciation - CAP REL | | 0 | CAP REL COSTS-MVBLE EQUIP | 2.00 | 0 | 27. 00 |
| 28. 00 | COSTS-MVBLE EQUIP Non-physician Anesthetist | | 0 | NONPHYSICIAN ANESTHETISTS | 19. 00 | | 28. 00 |
| 29. 00 30. 00 | Physicians' assistant Adjustment for occupational | A-8-3 | 0 | OCCUPATI ONAL THERAPY | 0. 00 67. 00 | | 29. 00 30. 00 |
| | therapy costs in excess of | | , and the second | | | | |
| 30. 99 | limitation (chapter 14) Hospice (non-distinct) (see | | 0 | ADULTS & PEDIATRICS | 30. 00 | | 30. 99 |
| 31. 00 | instructions) Adjustment for speech | A-8-3 | 0 | SPEECH PATHOLOGY | 68. 00 | | 31. 00 |
| | pathology costs in excess of limitation (chapter 14) | | · | | | | |
| 32. 00 | CAH HIT Adjustment for | | 0 | | 0.00 | 0 | 32. 00 |
| 33. 00 | Depreciation and Interest RENTAL INCOME | В | -406, 757 | ADMINISTRATIVE & GENERAL | 5. 00 | 0 | 33. 00 |

| | | | | '' | 0 12/31/2021 | 5/31/2022 7:5 | |
|--------|--------------------------------|-----------------|---------------|---|-----------------|----------------|--------|
| | · | | | Expense Classification on | Worksheet A | 070172022 7.0 | T CITI |
| | | | | To/From Which the Amount is | | | |
| | | | | Toy I I dill mill dir till y mildarit I d | to bo haj dotod | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | Cost Center Description | Basi s/Code (2) | Amount | Cost Center | Line # | Wkst. A-7 Ref. | |
| | oost deliter bescription | 1.00 | 2.00 | 3.00 | 4. 00 | 5. 00 | |
| 33. 01 | RENTAL I NCOME | В | | CAP REL COSTS-BLDG & FIXT | 1.00 | 14 | 33. 01 |
| 33. 02 | MISC OTHER OPERATING | В | | EMPLOYEE BENEFITS DEPARTMENT | 4. 00 | 0 | 33. 02 |
| 33. 03 | MISC OTHER OPERATING | В | | ADMINISTRATIVE & GENERAL | 5. 00 | 0 | 33. 03 |
| 33. 04 | MISC OTHER OPERATING | В | | LAUNDRY & LINEN SERVICE | 8. 00 | 0 | 33. 04 |
| 33. 05 | MISC OTHER OPERATING | В | | HOUSEKEEPI NG | 9. 00 | 0 | 33. 05 |
| 33. 06 | MISC OTHER OPERATING | В | | DI ETARY | 10.00 | 0 | 33. 06 |
| 33. 00 | MISC OTHER OPERATING | В | | PHARMACY | | 0 | 33. 07 |
| | | | | 1 | 15.00 | 0 | |
| 33. 08 | MISC OTHER OPERATING | В | | ADULTS & PEDIATRICS | 30.00 | 0 | 33. 08 |
| 33. 09 | MISC OTHER OPERATING | В | | RECOVERY ROOM | 51.00 | 0 | 33. 09 |
| 33. 10 | MISC OTHER OPERATING | В | | ANESTHESI OLOGY | 53. 00 | 0 | 33. 10 |
| 33. 11 | MISC OTHER OPERATING | В | | RADI OLOGY-DI AGNOSTI C | 54.00 | 0 | 33. 11 |
| 33. 12 | MISC OTHER OPERATING | В | · | CARDIAC CATHETERIZATION | 59. 00 | 0 | 33. 12 |
| 33. 13 | SHARED SAVINGS | В | | ADMINISTRATIVE & GENERAL | 5. 00 | 0 | 33. 13 |
| 33. 14 | INSURANCE CLAIM PROCEEDS | В | | ADMINISTRATIVE & GENERAL | 5. 00 | 0 | 33. 14 |
| 33. 15 | RETAIL SERVICES | В | | DI ETARY | 10. 00 | 0 | 33. 15 |
| 33. 16 | RETAIL SERVICES | В | | PHARMACY | 15. 00 | 0 | 33. 16 |
| 33. 17 | MEDICAL STAFF DUES AND FEES | В | | ADMINISTRATIVE & GENERAL | 5. 00 | 0 | 33. 17 |
| 33. 18 | CAFETERI A | В | -1 | OPERATING ROOM | 50.00 | 0 | 33. 18 |
| 33. 19 | HAF ASSESSMENT FEES | A | -3, 857, 218 | ADMINISTRATIVE & GENERAL | 5. 00 | 0 | 33. 19 |
| 33. 20 | PENSION | A | -30, 143 | EMPLOYEE BENEFITS DEPARTMENT | 4.00 | 0 | 33. 20 |
| 33. 21 | ADVERTI SI NG | A | -396 | EMPLOYEE BENEFITS DEPARTMENT | 4.00 | 0 | 33. 21 |
| 33. 22 | ADVERTI SI NG | A | -20, 279 | ADMINISTRATIVE & GENERAL | 5. 00 | 0 | 33. 22 |
| 33. 23 | ADVERTI SI NG | A | 64 | DI ETARY | 10.00 | 0 | 33. 23 |
| 33. 24 | ADVERTI SI NG | A | -427 | NURSING ADMINISTRATION | 13.00 | 0 | 33. 24 |
| 33. 25 | ADVERTI SI NG | A | -78 | ADULTS & PEDIATRICS | 30.00 | 0 | 33. 25 |
| 33. 26 | ADVERTI SI NG | A | -1, 804 | MAGNETIC RESONANCE IMAGING | 58. 00 | 0 | 33. 26 |
| | | | , | (MRI) | | | |
| 33. 27 | ADVERTI SI NG | A | -95 | CARDÍAC CATHETERIZATION | 59.00 | 0 | 33. 27 |
| 33. 28 | ADVERTI SI NG | A | | CLINIC | 90. 01 | 0 | 33. 28 |
| 33. 29 | ADVERTI SI NG | A | -28 | CLINIC | 90. 02 | 0 | 33. 29 |
| 33. 30 | ADVERTI SI NG | A | | EMERGENCY | 91.00 | 0 | 33. 30 |
| 33. 31 | LOBBYI NG | A | | ADMINISTRATIVE & GENERAL | 5. 00 | 0 | 33. 31 |
| 33. 32 | PROPERTY TAXES | A | · | ADMINISTRATIVE & GENERAL | 5. 00 | 0 | 33. 32 |
| 33. 33 | PROPERTY TAXES | A | · | ADULTS & PEDIATRICS | 30.00 | ő | 33. 33 |
| 33. 34 | PROPERTY TAXES | A | | OPERATING ROOM | 50.00 | ő | 33. 34 |
| 33. 35 | PROPERTY TAXES | A | | CT SCAN | 57. 00 | 0 | 33. 35 |
| 33. 36 | PROPERTY TAXES | A | | MAGNETIC RESONANCE IMAGING | 58. 00 | 0 | 33. 36 |
| JJ. JU | I NOI ENTI TAXES | _ ^ | 10, 401 | (MRI) | 56.00 | | JJ. JU |
| 33. 37 | MEDICAL RECORDS | В | -5, 179 | RADI OLOGY-DI AGNOSTI C | 54.00 | 0 | 33. 37 |
| 33. 38 | MISC OTHER OPERATING | В | | DI ETARY | 10. 00 | o | 33. 38 |
| 33. 39 | MISC OTHER OPERATING | В | | RADI OLOGY-DI AGNOSTI C | 54.00 | o o | 33. 39 |
| 50. 00 | TOTAL (sum of lines 1 thru 49) | | -10, 780, 441 | | 21.00 | Ĭ | 50. 00 |
| | (Transfer to Worksheet A, | | | | | | |
| | column 6, line 200.) | | | | | | |
| | | | | | 1 | | |

⁽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.

| | | | | To 12/31/2021 | Date/Time Pre 5/31/2022 7:5 | |
|------|-------------------------------|-------------------------------|------------------------------|----------------|-----------------------------|-------|
| | Li ne No. | Cost Center | Expense Items | Amount of | Amount | |
| | | | | Allowable Cost | Included in | |
| | | | | | Wks. A, column | |
| | | | | | 5 | |
| | 1. 00 | 2. 00 | 3. 00 | 4. 00 | 5. 00 | |
| | A. COSTS INCURRED AND ADJUSTM | MENTS REQUIRED AS A RESULT OF | TRANSACTIONS WITH RELATED OR | GANIZATIONS OR | CLAI MED | |
| | HOME OFFICE COSTS: | | | | | |
| 1.00 | 5. 00 | ADMINISTRATIVE & GENERAL | I NTEREST | 1, 788, 250 | 5, 204, 221 | 1. 00 |
| 2.00 | 1.00 | CAP REL COSTS-BLDG & FIXT | ALLOWABLE NEW CAPITAL COSTS | 1, 066, 394 | 953, 870 | 2.00 |
| 3.00 | 5. 00 | ADMINISTRATIVE & GENERAL | A&G | 14, 664, 405 | 13, 904, 637 | 3.00 |
| 4.00 | 15. 00 | PHARMACY | COVP / PHARMACY | 174, 655 | 0 | 4.00 |
| 4.01 | 16.00 | MEDICAL RECORDS & LIBRARY | нім | 995, 256 | 0 | 4. 01 |
| 5.00 | TOTALS (sum of lines 1-4). | | | 18, 688, 960 | 20, 062, 728 | 5.00 |
| | Transfer column 6, line 5 to | | | | | |
| | Worksheet A-8, column 2, | | | | | |
| | line 12. | | | | | |

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

| 1103 110 | not been posted to worksheet A, cordinas i and/or 2, the amount arrowable should be indicated in cordina 4 or this part. | | | | | | | | |
|----------|--|-------|---------------|------------------------------|----------------|--|--|--|--|
| | | | | Related Organization(s) and/ | or Home Office | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | Symbol (1) | Name | Percentage of | Name | Percentage of | | | | |
| | | | Ownershi p | | Ownershi p | | | | |
| | 1. 00 | 2. 00 | 3.00 | 4. 00 | 5. 00 | | | | |
| | B. INTERRELATIONSHIP TO 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

| i ci ilibai | School dide title xviii. | | | | |
|-------------|--------------------------|-----------------|--------|-------|--------|
| 6.00 | В | FRANCISCAN ALLI | 100.00 | 0. 00 | 6. 00 |
| 7.00 | | | 0.00 | 0. 00 | 7. 00 |
| 8.00 | | | 0.00 | 0. 00 | 8. 00 |
| 9.00 | | | 0.00 | 0. 00 | 9. 00 |
| 10.00 | | | 0.00 | 0. 00 | 10. 00 |
| 100.00 | G. Other (financial or | | | | 100.00 |
| | non-financial) specify: | | | | |

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

| Heal th | Financial Syste | ems | | FRANCI SCAN HE | ALTH MUNST | ER | | In Lie | u of Form CMS | -2552-10 |
|---------|-----------------|----------------|----------|-----------------------|-------------|---------|-------------|----------------------------------|------------------------------|----------|
| STATEME | NT OF COSTS OF | SERVICES FROM | RELATED | ORGANIZATIONS AND HOM | IE Provid | er CCN | : 15-0165 | Peri od: | Worksheet A- | 8-1 |
| OFFICE | COSTS | | | | | | | From 01/01/2021 To 12/31/2021 | Date/Time Pr 5/31/2022 7: | |
| | Net | Wkst. A-7 Ref. | | | | | | | 3/31/2022 7. | J4 alli |
| | Adjustments | | | | | | | | | |
| | (col. 4 minus | | | | | | | | | |
| | col. 5)* | | | | | | | | | |
| | 6. 00 | 7. 00 | | | | | | | | |
| | A. COSTS INCUR | RED AND ADJUST | MENTS RE | QUIRED AS A RESULT OF | TRANSACTI (| NS WITI | H RELATED (| ORGANI ZATI ONS OR | CLAI MED | |
| | HOME OFFICE CO: | STS: | | | | | | | | |
| 1.00 | -3, 415, 971 | 1. | | | | | | | | 1. 00 |
| 2.00 | 112, 524 | | | | | | | | | 2. 00 |
| 3.00 | 759, 768 | (|) | | | | | | | 3. 00 |
| 4.00 | 174, 655 | (|) | | | | | | | 4. 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

4.01

5 00

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

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

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

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

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

4.01

5.00

995, 256

-1, 373, 768

0

Peri od: Worksheet A-8-2 From 01/01/2021 To 12/31/2021 Date/Time Prepared: 5/31/2022 7:54 am

| | | | | | | 10 12/31/2021 | 5/31/2022 7:5 | |
|--------|-----------------------------------|--------------------------|----------------|---------------|-----------------|---------------|------------------|--------|
| | Wkst. A Line # | Cost Center/Physician | Total | Professi onal | Provi der | RCE Amount | Physi ci an/Prov | |
| | | l denti fi er | Remuneration | Component | Component | | ider Component | |
| | | | | | | | Hours | |
| | 1. 00 | 2. 00 | 3.00 | 4.00 | 5. 00 | 6. 00 | 7. 00 | |
| 1.00 | 5. 00 | ADMINISTRATIVE & GENERAL | 46, 267 | 46, 267 | 0 | 0 | 0 | 1.00 |
| 2.00 | 30.00 | ADULTS & PEDIATRICS | 3, 375 | C | 3, 375 | 197, 500 | 25 | 2.00 |
| 3.00 | 30.00 | ADULTS & PEDIATRICS | 2, 178 | 2, 178 | 0 | 0 | 0 | 3. 00 |
| 4.00 | 50.00 | OPERATING ROOM | 188, 826 | 188, 826 | 0 | 0 | 0 | 4. 00 |
| 5.00 | 50.00 | OPERATING ROOM | 805, 095 | 805, 095 | 5 0 | 0 | 0 | 5.00 |
| 6.00 | 53. 00 | ANESTHESI OLOGY | 121, 005 | 121, 005 | 5 0 | 0 | 0 | 6. 00 |
| 7.00 | 59. 00 | CARDIAC CATHETERIZATION | 35, 690 | 35, 690 | 0 | 0 | 0 | 7. 00 |
| 8.00 | 60.00 | LABORATORY | 29, 079 | 18, 515 | 10, 564 | 260, 300 | 79 | 8. 00 |
| 9.00 | 70. 00 | ELECTROENCEPHALOGRAPHY | 28, 505 | 27, 255 | 1, 250 | 211, 500 | 10 | 9. 00 |
| 10.00 | 70.00 | ELECTROENCEPHALOGRAPHY | 750 | 750 | 0 | 0 | 0 | 10.00 |
| 11.00 | 90. 01 | CLINIC | 6, 835 | 1, 865 | 4, 970 | 211, 500 | 36 | 11. 00 |
| 12.00 | 90. 01 | CLINIC | 3, 450 | 3, 450 | 0 | 0 | 0 | 12.00 |
| 13.00 | 90. 02 | CLINIC | 1, 563 | 1, 563 | 0 | 0 | 0 | 13.00 |
| 14.00 | | EMERGENCY | 324, 064 | | | 0 | l 0 | 14. 00 |
| 200.00 | | | 1, 596, 682 | | | | 150 | |
| | Wkst. A Line # | Cost Center/Physician | Unadjusted RCE | | Cost of | | Physician Cost | |
| | | I denti fi er | | | Memberships & | Component | of Mal practice | |
| | | | | Limit | Continuing | Share of col. | Insurance | |
| | | | | | Educati on | 12 | | |
| | 1. 00 | 2.00 | 8. 00 | 9. 00 | 12. 00 | 13. 00 | 14. 00 | |
| 1. 00 | 5. 00 | ADMINISTRATIVE & GENERAL | 0 | | 0 | 0 | 0 | 1. 00 |
| 2.00 | 30.00 | ADULTS & PEDIATRICS | 2, 374 | 119 | 0 | 0 | 0 | 2. 00 |
| 3.00 | 30.00 | ADULTS & PEDIATRICS | 0 | [c | 0 | 0 | 0 | 3. 00 |
| 4.00 | 50.00 | OPERATING ROOM | 0 | l c | 0 | 0 | 0 | 4.00 |
| 5.00 | 50.00 | OPERATING ROOM | 0 | l | 0 | 0 | 0 | 5. 00 |
| 6.00 | 53. 00 | ANESTHESI OLOGY | 0 | l | 0 | 0 | 0 | 6. 00 |
| 7.00 | 59. 00 | CARDIAC CATHETERIZATION | 0 | l | 0 | 0 | 0 | 7. 00 |
| 8.00 | 60.00 | LABORATORY | 9, 886 | 494 | . 0 | 0 | 0 | 8. 00 |
| 9.00 | 70.00 | ELECTROENCEPHALOGRAPHY | 1, 017 | 51 | 0 | 0 | 0 | 9. 00 |
| 10.00 | 70.00 | ELECTROENCEPHALOGRAPHY | 0 | l c | 0 | 0 | 0 | 10.00 |
| 11. 00 | | CLINIC | 3, 661 | 183 | 0 | 0 | 0 | 11. 00 |
| 12.00 | 90. 01 | CLINIC | 0 | 1 | 0 | 0 | l 0 | 12. 00 |
| 13. 00 | | CLINIC | 0 | | 0 | 0 | 0 | 13. 00 |
| 14.00 | | EMERGENCY | 0 | | 0 | 0 | 0 | 14. 00 |
| 200.00 | | | 16, 938 | 847 | 0 | 0 | 0 | |
| | Wkst. A Line # | Cost Center/Physician | Provi der | Adjusted RCE | RCE | Adjustment | | |
| | | I denti fi er | Component | Limit | Di sal I owance | | | |
| | | | Share of col. | | | | | |
| | | | 14 | | | | | |
| | 1. 00 | 2. 00 | 15. 00 | 16. 00 | 17. 00 | 18. 00 | | |
| 1.00 | 5. 00 | ADMINISTRATIVE & GENERAL | 0 | C | 0 | 46, 267 | | 1. 00 |
| 2.00 | 30.00 | ADULTS & PEDIATRICS | 0 | 2, 374 | 1, 001 | 1, 001 | | 2. 00 |
| 3.00 | 30.00 | ADULTS & PEDIATRICS | 0 | C | 0 | 2, 178 | | 3. 00 |
| 4.00 | 50.00 | OPERATING ROOM | 0 | [c | 0 | 188, 826 | | 4.00 |
| 5.00 | 50.00 OPERATING ROOM | | 0 | C | 0 | 805, 095 | | 5.00 |
| 6.00 | 53. 00 ANESTHESI OLOGY | | 0 | C | 0 | 121, 005 | | 6. 00 |
| 7.00 | 59. 00 CARDI AC CATHETERI ZATI ON | | 0 | C | 0 | 35, 690 | | 7. 00 |
| 8.00 | 60. 00 LABORATORY | | 0 | 9, 886 | 678 | 19, 193 | | 8. 00 |
| 9.00 | 70. 00 ELECTROENCEPHALOGRAPHY | | 0 | | | | | 9. 00 |
| 10.00 | 70. 00 ELECTROENCEPHALOGRAPHY | | 0 | | 0 | 750 | | 10.00 |
| 11. 00 | 90. 01 CLI NI C | | 0 | | 1, 309 | 3, 174 | | 11. 00 |
| 12.00 | 90. 01 CLI NI C | | 0 | | 0 | 3, 450 | | 12.00 |
| 13.00 | 90. 02 CLI NI C | | 0 | | 0 | 1, 563 | | 13. 00 |
| 14.00 | 91. 00 | EMERGENCY | 0 | | 0 | 324, 064 | | 14. 00 |
| 200.00 | | | 0 | | 3, 221 | | | 200.00 |
| | | • | | • | • | • | | • |

| | Financial Systems | FRANCISCAN HEALTH MUNSTER In Lieu of Form C | | | | | <u>255</u> 2-10 |
|------------------|---|---|---------------------------------|-------------------------|---|----------------------------|------------------|
| | ALLOCATION - GENERAL SERVICE COSTS | | Provi der CCN: 15-0165 Pe Fr To | | Period: Worksheet E From 01/01/2021 Part I To 12/31/2021 Date/Time F 5/31/2022 T | | pared: 4 am |
| | Cost Center Description | Net Expenses for Cost Allocation (from Wkst A col. 7) | CAPITAL REL | ATED COSTS MVBLE EQUIP | EMPLOYEE BENEFI TS DEPARTMENT | Subtotal | |
| | | 0 | 1. 00 | 2.00 | 4. 00 | 4A | |
| | GENERAL SERVICE COST CENTERS | | | | | | |
| 1.00 | 00100 CAP REL COSTS-BLDG & FIXT | 6, 151, 842 | 6, 151, 842 | | | | 1.00 |
| 2. 00 4. 00 | 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT | 11, 518, 570 | 78, 565 | | 0 11, 597, 135 | | 2. 00 4. 00 |
| 5. 00 | 00500 ADMINISTRATIVE & GENERAL | 11, 620, 044 | 755, 095 | | 0 2, 736, 492 | l e | |
| 6.00 | 00600 MAINTENANCE & REPAIRS | 11, 041, 020 | 0 | | 0 190, 172 | l | |
| 7.00 | 00700 OPERATION OF PLANT | 102.004 | 0 | | 0 0 | 1 | |
| 8. 00 9. 00 | 00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG | 183, 986 1, 026, 541 | 0 | | 0 32, 182 0 210, 828 | | |
| 10.00 | 01000 DI ETARY | 7, 699 | 271, 342 | | 0 58, 898 | | |
| 11. 00 | 01100 CAFETERI A | 894, 557 | 0 | | 0 95, 175 | 1 | 1 |
| 12.00 | 01200 MAI NTENANCE OF PERSONNEL | 0 | 0 | 1 | 0 0 498, 517 | | |
| 13. 00 14. 00 | 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY | 2, 466, 728 496, 066 | 0 | | 0 498, 517 0 56, 504 | | 1 |
| 15. 00 | 01500 PHARMACY | 1, 528, 303 | 105, 396 | | 0 322, 785 | | |
| 16. 00 | 01600 MEDICAL RECORDS & LIBRARY | 1, 384, 313 | 4, 960 | | 0 85, 546 | 1 | |
| 17. 00 | 01700 SOCIAL SERVICE 01850 OTHER GEN SERV | 0 | 0 | | 0 | 0 | 17. 00 18. 00 |
| 19. 00 | 01900 NONPHYSICIAN ANESTHETISTS | 0 | 0 | | 0 0 | 0 | 19.00 |
| | 02000 NURSI NG PROGRAM | 0 | 0 | | o o | 0 | 20.00 |
| 21. 00 | 02100 I &R SERVI CES-SALARY & FRINGES APPRVD | 0 | 0 | | 0 0 | 0 | 21.00 |
| 22. 00 23. 00 | 02200 I &R SERVICES-OTHER PRGM COSTS APPRVD 02301 PARAMED ED PRGM | 0 | 0 | | 0 0 | 0 | 22. 00 23. 00 |
| 23.00 | I NPATI ENT ROUTI NE SERVI CE COST CENTERS | ı o | 0 | | 0 0 | 0 | 23.00 |
| 30. 00 | 03000 ADULTS & PEDIATRICS | 10, 361, 251 | 1, 322, 167 | | 0 2, 387, 958 | | |
| 31.00 | 03100 I NTENSI VE CARE UNI T | 1, 723, 951 | 318, 598 | | 0 438, 277 | | |
| 32.00 | 03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT | 0 | 0 | | 0 0 | 0 | |
| 34. 00 | 03400 SURGICAL INTENSIVE CARE UNIT | | 0 | | | 0 | 1 |
| 40.00 | 04000 SUBPROVI DER - I PF | 0 | 0 | | 0 0 | 0 | |
| 41.00 | 04100 SUBPROVI DER - I RF | 0 | 0 | | 0 | 0 | 41.00 |
| 43. 00 44. 00 | 04300 NURSERY 04400 SKILLED NURSING FACILITY | 0 | 0 | | 0 0 | 0 | 43. 00 44. 00 |
| 45. 00 | 04500 NURSING FACILITY | 0 | 0 | | 0 0 | Ö | 45. 00 |
| 46. 00 | | 0 | 0 | | 0 0 | 0 | 46. 00 |
| 50. 00 | ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM | 5, 806, 950 | 600, 067 | T | 0 972, 589 | 7, 379, 606 | 50.00 |
| 51. 00 | | 828, 765 | 263, 248 | • | 0 209, 024 | | |
| 52.00 | 05200 DELIVERY ROOM & LABOR ROOM | 0 | 0 | | 0 0 | 0 | 52.00 |
| | 05300 ANESTHESI OLOGY | 491, 086 | 0 | | 0 8, 993 | l | |
| 54.00 | 05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C | 2, 391, 860 | 278, 989 0 | | 0 412, 204 | 3, 083, 053 | 1 |
| 56. 00 | 05600 RADI OI SOTOPE | 0 | 0 | | 0 0 | Ö | 1 |
| 57. 00 | 05700 CT SCAN | 914, 758 | 0 | 1 | 0 116, 888 | 1 | 1 |
| 58. 00 | 05800 MAGNETIC RESONANCE I MAGING (MRI) 05900 CARDIAC CATHETERIZATION | 1, 388, 039 | 0 | | 0 211, 246 0 290, 526 | 1 | |
| 59. 00 60. 00 | 06000 LABORATORY | 1, 442, 114 5, 683, 060 | 566, 761 97, 405 | | 0 290, 526 0 0 | l | |
| 60. 01 | 06001 BLOOD LABORATORY | 0 | 0 | | o o | 0 | 1 |
| 61.00 | 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY | 0 | _ | | | 0 | |
| 62. 00 63. 00 | 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06300 BLOOD STORING, PROCESSING & TRANS. | 0 | 0 | | 0 | 0 | 62. 00 63. 00 |
| 64. 00 | | | 0 | | 0 0 | 0 | 64. 00 |
| 65.00 | 06500 RESPIRATORY THERAPY | 1, 168, 836 | 48, 530 | | 0 281, 796 | 1, 499, 162 | 1 |
| 66. 00 | | 269, 625 | 0 | | 0 70, 540 | | 1 |
| 67. 00 68. 00 | 06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY | 178, 571 60, 769 | 0 | | 0 46, 520 0 15, 856 | | 1 |
| 69. 00 | l i | 511, 206 | 0 | | 0 102, 617 | | 1 |
| 70.00 | 07000 ELECTROENCEPHALOGRAPHY | 999, 205 | 247, 680 | | 0 110, 673 | 1, 357, 558 | 70. 00 |
| | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 7, 389, 136 | 0 | | 0 | 7, 389, 136 | |
| 72.00 | 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS | 6, 709, 178 3, 779, 008 | 0 | | 0 0 | 6, 709, 178 3, 779, 008 | |
| 74.00 | 07400 RENAL DIALYSIS | 3, 777, 000 | 0 | | ŏ ŏ | 3, 779, 008 | 1 |
| 75. 00 | 07500 ASC (NON-DISTINCT PART) | | 0 | | 0 0 | Ō | 75. 00 |
| 76.00 | 03950 OTHER ANCILL SRVC | 0 | 0 | | 0 0 | 0 | |
| 76. 01 76. 02 | 03951 CARDI AC AND PULMONARY REHAB 03952 WOUND CARE | 227, 300 7, 088 | 0 | | 0 58, 871 0 990 | | 76. 01 76. 02 |
| 77. 00 | | 0 | | 1 | 0 0 | · · | 77. 00 |
| 0 | OUTPATIENT SERVICE COST CENTERS | | | | | | |
| 88. 00 | 08800 RURAL HEALTH CLINIC | 0 | 0 | 1 | 0 0 | 0 | 88. 00 |
| | | | | | | | |

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0165 Peri od: Worksheet B From 01/01/2021 Part I 12/31/2021 Date/Time Prepared: 5/31/2022 7:54 am CAPITAL RELATED COSTS **EMPLOYEE** Cost Center Description Net Expenses BLDG & FIXT MVBLE EQUIP Subtotal **BENEFITS** for Cost DEPARTMENT Allocation (from Wkst A col. 7) 1.00 2.00 4. 00 4A 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 89. 00 0 0 0 09000 CLI NI C 90 00 90 00 0 0 90.01 09001 CLI NI C 2, 337, 300 0 427, 289 2, 764, 589 90.01 90. 02 09002 CLI NI C 458, 229 41, 573 0 71, 147 570, 949 90.02 09100 EMERGENCY 0 91.00 91 00 3, 340, 317 340, 986 587, 339 4, 268, 642 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 0 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0 0 0 94.00 0 0 0 0 0 09500 AMBULANCE SERVICES 95 00 95 00 Ω 0 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 0 96.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 0 0 0 97.00 97.00 0 0 98.00 09850 OTHER REIMBURSE 0 0 98.00 0 0 99.00 99.00 09900 CMHC 0 0 0 99. 10 09910 CORF 0 0 0 0 99. 10 100.00 10000 I &R SERVICES-NOT APPRVD PRGM 0 0 100.00 101.00 10100 HOME HEALTH AGENCY 0 0 0 0 0 101.00 SPECIAL PURPOSE COST CENTERS 105.00 10500 KIDNEY ACQUISITION 0 0 0 0 0 105. 00 106.00 10600 HEART ACQUISITION 0 0 0 0 106. 00 0 0 107. 00 10700 LIVER ACQUISITION 0 107. 00 0 0 108.00 10800 LUNG ACQUISITION 0 0 108. 00 Ω 0 109. 00 10900 PANCREAS ACQUISITION 0 0 0 109.00 0 110.00 11000 INTESTINAL ACQUISITION 0 0 110.00 0 0 111.00 11100 I SLET ACQUISITION C 0 0 111.00 113.00 11300 INTEREST EXPENSE 113.00 114.00 11400 UTILIZATION REVIEW-SNF 114. 00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 0 115.00 0 116. 00 11600 HOSPI CE 0 116.00 5, 3<u>41, 362</u> SUBTOTALS (SUM OF LINES 1 through 117) 106, 787, 271 11, 108, 442 105, 488, 098 118. 00 118, 00 NONREI MBURSABLE COST CENTERS 68, 671 190. 00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 7, 955 60,716 191. 00 19100 RESEARCH 593 156 749 191. 00 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 810, 480 0 401, 905 2, 985, 098 192. 00 1, 772, 713 192. 01 19201 CENTER OF HOPE 0 0 192. 01 192.02 19202 OTHER FA FACILITIES NRCC 0 530, 036 192. 02 456, 783 0 73, 253 193. 00 19300 NONPALD WORKERS 0 0 0 193. 00 194.00 07950 OTHER NRCC 20,668 0 5, 424 26, 092 194. 00 200.00 0 200.00 Cross Foot Adjustments 0 201.00 Negative Cost Centers 0 201.00

109, 098, 744

6, 151, 842

11, 597, 135

109, 098, 744 202. 00

202.00

TOTAL (sum lines 118 through 201)

| | | | | To | o 12/31/2021 | Date/Time Pre 5/31/2022 7:5 | |
|------------------|--|----------------------|-------------------------|----------------|-----------------------|-----------------------------|------------------|
| | Cost Center Description | ADMI NI STRATI VE | | | LAUNDRY & | HOUSEKEEPI NG | |
| | | & GENERAL 5.00 | REPAI RS 6. 00 | PLANT 7. 00 | LINEN SERVICE 8.00 | 9. 00 | |
| | GENERAL SERVICE COST CENTERS | 0.00 | 0.00 | 7.00 | 0.00 | 7. 00 | |
| 1.00 | 00100 CAP REL COSTS-BLDG & FLXT | | | | | | 1.00 |
| 2. 00 4. 00 | 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT | | | | | | 2. 00 4. 00 |
| 5. 00 | 00500 ADMINISTRATIVE & GENERAL | 15, 111, 631 | | | | | 5. 00 |
| 6.00 | 00600 MAINTENANCE & REPAIRS | 1, 825, 013 | 13, 056, 205 | 5 | | | 6. 00 |
| 7.00 | 00700 OPERATION OF PLANT | 0 | 0 | 0 | 251 204 | | 7. 00 |
| 8. 00 9. 00 | 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING | 35, 126 201, 066 | 0 | | 251, 294 | 1, 438, 435 | 8. 00 9. 00 |
| 10. 00 | 01000 DI ETARY | 54, 913 | 666, 149 | ő | 0 | 73, 391 | 10. 00 |
| 11. 00 | 01100 CAFETERI A | 0 | O | 0 | 0 | 0 | 11. 00 |
| 12. 00 | 01200 MAINTENANCE OF PERSONNEL | 0 | 0 | 0 | 0 | 0 | 12. 00 |
| 13.00 | 01300 NURSI NG ADMI NI STRATI ON | 481, 837 | 0 | 0 | 0 | 0 | 13.00 |
| 14. 00 15. 00 | 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY | 89, 790 317, 919 | 258, 748 | | 0 | 28, 507 | 14. 00 15. 00 |
| 16. 00 | 01600 MEDI CAL RECORDS & LI BRARY | 239, 651 | 12, 176 | 1 | Ö | 1, 342 | 16. 00 |
| 17. 00 | 01700 SOCI AL SERVI CE | 0 | O | 0 | 0 | 0 | 17. 00 |
| 18.00 | 01850 OTHER GEN SERV | 0 | 0 | 0 | 0 | 0 | 18.00 |
| 19. 00 20. 00 | 01900 NONPHYSI CI AN ANESTHETI STS 02000 NURSI NG PROGRAM | 0 | 0 | | 0 | 0 | 19. 00 20. 00 |
| 21. 00 | 02100 I &R SERVI CES-SALARY & FRINGES APPRVD | | 0 | | 0 | 0 | 21. 00 |
| 22. 00 | 02200 I &R SERVICES-OTHER PRGM COSTS APPRVD | 0 | O | 0 | 0 | 0 | 22. 00 |
| 23. 00 | 02301 PARAMED ED PRGM | 0 | O | 0 | 0 | 0 | 23. 00 |
| 30. 00 | I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS | 2, 286, 551 | 3, 245, 935 | i 0 | 221, 838 | 357, 614 | 30. 00 |
| 31. 00 | 03100 I NTENSI VE CARE UNI T | 403, 122 | 782, 163 | 1 | 221, 636 29, 456 | 86, 173 | 31. 00 |
| 32. 00 | 03200 CORONARY CARE UNIT | 0 | 0 | o o | 0 | 0 | 32. 00 |
| 33. 00 | 03300 BURN INTENSIVE CARE UNIT | 0 | O | 0 | 0 | 0 | 33. 00 |
| 34. 00 | 03400 SURGICAL INTENSIVE CARE UNIT | 0 | 0 | 0 | 0 | 0 | 34. 00 |
| 40. 00 41. 00 | 04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF | 0 | 0 | | 0 | 0 | 40. 00 41. 00 |
| 43. 00 | 04300 NURSERY | | 0 | | 0 | 0 | 43. 00 |
| 44.00 | 04400 SKILLED NURSING FACILITY | 0 | 0 | 0 | 0 | 0 | 44.00 |
| 45. 00 | 04500 NURSING FACILITY | 0 | 0 | 0 | 0 | 0 | 45. 00 |
| 46. 00 | 04600 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS | 0 | 0 | 0 | 0 | 0 | 46. 00 |
| 50. 00 | 05000 OPERATING ROOM | 1, 199, 149 | 1, 473, 173 | 8 0 | 0 | 162, 303 | 50. 00 |
| 51.00 | 05100 RECOVERY ROOM | 211, 412 | 646, 278 | 1 | 0 | 71, 202 | 51.00 |
| 52. 00 | 05200 DELIVERY ROOM & LABOR ROOM | 0 | 0 | 0 | 0 | 0 | 52. 00 |
| 53.00 | 05300 ANESTHESI OLOGY | 81, 260 | (04,021 | 0 | 0 | 75 450 | 53.00 |
| 54. 00 55. 00 | 05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C | 500, 981 | 684, 921 | | 0 | 75, 459 0 | 54. 00 55. 00 |
| 56. 00 | 05600 RADI OI SOTOPE | Ö | Ö | o o | 0 | 0 | 56. 00 |
| 57. 00 | 05700 CT SCAN | 167, 637 | O | 0 | 0 | 0 | 57. 00 |
| 58. 00 | 05800 MAGNETIC RESONANCE I MAGING (MRI) | 259, 876 | 0 | 0 | 0 | 0 | 58. 00 |
| 59. 00 60. 00 | 05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY | 373, 641 939, 297 | 1, 391, 405 239, 131 | | 0 | 153, 295 26, 346 | 59. 00 60. 00 |
| 60. 01 | 06001 BLOOD LABORATORY | 737, 277 | 237, 131 | | 0 | 20, 340 | 60. 01 |
| 61.00 | 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY | | | | | | 61.00 |
| 62. 00 | 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS | 0 | 0 | 0 | 0 | 0 | 62. 00 |
| 63. 00 64. 00 | 06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY | 0 | 0 | 0 | 0 | 0 | 63. 00 64. 00 |
| 65. 00 | 06500 RESPIRATORY THERAPY | 243, 606 | 119, 142 | | 0 | 13, 126 | 65. 00 |
| 66. 00 | 06600 PHYSI CAL THERAPY | 55, 275 | 0 | 0 | 0 | 0 | 66. 00 |
| 67. 00 | 06700 OCCUPATI ONAL THERAPY | 36, 576 | 0 | 0 | 0 | 0 | 67. 00 |
| 68. 00 | 06800 SPEECH PATHOLOGY | 12, 451 | 0 | 0 | 0 | 0 | 68. 00 |
| 69. 00 70. 00 | 06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY | 99, 743 220, 596 | 608, 058 | 0 | 0 | 66, 991 | 69. 00 70. 00 |
| 71. 00 | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 1, 200, 698 | 0 | o o | 0 | 0 | 71. 00 |
| 72. 00 | 07200 IMPL. DEV. CHARGED TO PATIENTS | 1, 090, 208 | O | 0 | 0 | 0 | 72. 00 |
| 73. 00 | 07300 DRUGS CHARGED TO PATIENTS | 614, 070 | 0 | 0 | 0 | 0 | 73. 00 |
| 74. 00 75. 00 | 07400 RENAL DI ALYSI S 07500 ASC (NON-DI STI NCT PART) | 0 | 0 | 0 | 0 | 0 | 74. 00 75. 00 |
| 76. 00 | 03950 OTHER ANCILL SRVC | | 0 | | 0 | 0 | 76.00 |
| 76. 01 | 03951 CARDI AC AND PULMONARY REHAB | 46, 501 | O | 0 | 0 | 0 | 76. 01 |
| 76. 02 | 03952 WOUND CARE | 1, 313 | 0 | 0 | 0 | 0 | 76. 02 |
| 77. 00 | 07700 ALLOGENEIC STEM CELL ACQUISITION | 0 | 0 | 0 | 0 | 0 | 77. 00 |
| 88. 00 | OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC | n | 0 | 0 | n | 0 | 88. 00 |
| 89. 00 | 08900 FEDERALLY QUALIFIED HEALTH CENTER | l ő | Ö | o o | ő | 0 | 89. 00 |
| 90.00 | 09000 CLI NI C | 0 | O | 0 | o | 0 | 90. 00 |
| 90. 01 | 09001 CLI NI C | 449, 232 | 102.00 | 0 | 0 | 11 244 | 90. 01 |
| 90. 02 91. 00 | 09002 CLI NI C 09100 EMERGENCY | 92, 776 693, 633 | 102, 062 837, 126 | 1 | 0 | 11, 244 92, 228 | 90. 02 91. 00 |
| , 1. 00 | 1 | 1 075, 055 | 557, 120 | ., 0 | <u>ا</u> | ,2,220 | , , , , , , , |

| Period: | Worksheet B | From 01/01/2021 | Part | To | 12/31/2021 | Date/Time Prepared:

| | | | Т | o 12/31/2021 | Date/Time Pre 5/31/2022 7:5 | |
|---|-------------------|---------------|--------------|---------------|-----------------------------|---------|
| Cost Center Description | ADMI NI STRATI VE | MAINTENANCE & | OPERATION OF | LAUNDRY & | HOUSEKEEPI NG | T GIII |
| 0000 000000 20000 1 pt 1 0 11 | & GENERAL | REPAI RS | PLANT | LINEN SERVICE | 110002112211110 | |
| | 5. 00 | 6. 00 | 7. 00 | 8. 00 | 9. 00 | |
| 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | | | | | | 92. 00 |
| OTHER REIMBURSABLE COST CENTERS | <u>'</u> | | | | | |
| 94. 00 09400 HOME PROGRAM DI ALYSIS | 0 | 0 | 0 | 0 | 0 | 94.00 |
| 95. 00 09500 AMBULANCE SERVICES | 0 | 0 | 0 | o | 0 | 95. 00 |
| 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED | 0 | 0 | 0 | o | 0 | 96.00 |
| 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD | 0 | 0 | 0 | o | 0 | 97. 00 |
| 98. 00 09850 OTHER REI MBURSE | 0 | 0 | 0 | 0 | 0 | 98. 00 |
| 99. 00 09900 CMHC | 0 | 0 | 0 | 0 | 0 | 99. 00 |
| 99. 10 09910 CORF | 0 | 0 | 0 | 0 | 0 | 99. 10 |
| 100.00 10000 I&R SERVICES-NOT APPRVD PRGM | 0 | 0 | 0 | 0 | 0 | 100.00 |
| 101.00 10100 HOME HEALTH AGENCY | 0 | 0 | 0 | 0 | 0 | 101.00 |
| SPECIAL PURPOSE COST CENTERS | <u>'</u> | | | | | |
| 105. 00 10500 KIDNEY ACQUISITION | 0 | 0 | 0 | 0 | 0 | 105. 00 |
| 106.00 10600 HEART ACQUISITION | 0 | 0 | 0 | 0 | 0 | 106. 00 |
| 107.00 10700 LIVER ACQUISITION | 0 | 0 | 0 | 0 | 0 | 107. 00 |
| 108.00 10800 LUNG ACQUISITION | 0 | 0 | 0 | 0 | 0 | 108. 00 |
| 109.00 10900 PANCREAS ACQUISITION | O | 0 | 0 | 0 | 0 | 109. 00 |
| 110.00 11000 INTESTINAL ACQUISITION | 0 | 0 | 0 | 0 | 0 | 110.00 |
| 111.00 11100 ISLET ACQUISITION | 0 | 0 | 0 | 0 | 0 | 111. 00 |
| 113.00 11300 INTEREST EXPENSE | | | | | | 113. 00 |
| 114.00 11400 UTILIZATION REVIEW-SNF | | | | | | 114. 00 |
| 115.00 11500 AMBULATORY SURGICAL CENTER (D.P.) | o | 0 | 0 | 0 | 0 | 115. 00 |
| 116. 00 11600 H0SPI CE | O | 0 | 0 | 0 | 0 | 116. 00 |
| 118.00 SUBTOTALS (SUM OF LINES 1 through 117) | 14, 524, 919 | 11, 066, 467 | 0 | 251, 294 | 1, 219, 221 | 118. 00 |
| NONREI MBURSABLE COST CENTERS | | | | | | |
| 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN | 11, 159 | 0 | 0 | 0 | 0 | 190. 00 |
| 191. 00 19100 RESEARCH | 122 | 0 | 0 | 0 | 0 | 191. 00 |
| 192.00 19200 PHYSICIANS' PRIVATE OFFICES | 485, 063 | 1, 989, 738 | 0 | 0 | 219, 214 | 192. 00 |
| 192.01 19201 CENTER OF HOPE | 0 | 0 | 0 | 0 | 0 | 192. 01 |
| 192.02 19202 OTHER FA FACILITIES NRCC | 86, 128 | 0 | 0 | 0 | 0 | 192. 02 |
| 193.00 19300 NONPALD WORKERS | 0 | 0 | 0 | 0 | 0 | 193. 00 |
| 194. 00 07950 OTHER NRCC | 4, 240 | 0 | 0 | 0 | 0 | 194. 00 |
| 200.00 Cross Foot Adjustments | | | | | | 200. 00 |
| 201.00 Negative Cost Centers | 0 | 0 | 0 | O | 0 | 201. 00 |
| 202.00 TOTAL (sum lines 118 through 201) | 15, 111, 631 | 13, 056, 205 | 0 | 251, 294 | 1, 438, 435 | 202. 00 |

| Period: | Worksheet B | From 01/01/2021 | Part | | Date/Time Prepared: | 5/31/2022 7:54 am

| 10.00 11.00 12.00 13.00 14.00 14.00 15.00 14.00 14.00 14.00 15.0 | 1. 00 2. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 360 14. 00 0 15. 00 0 16. 00 0 17. 00 |
|--|--|
| 1. 00 | 2.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 360 14.00 0 15.00 0 16.00 |
| 2. 00 00200 CAP REL COSTS-MVBLE EQUI P 4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 00 00500 ADMIN ISTRATI VE & GENERAL 6. 00 00500 ADMIN ISTRATI VE & GENERAL 6. 00 00500 ADMIN ISTRATI VE & GENERAL 6. 00 00700 OPERATI ON OF PLANT 8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG 1. 132, 392 11. 00 01100 CAFETERI A 0 989, 732 12. 00 01200 MAI NTENANCE OF PERSONNEL 0 0 0 0 0 0 0 0 0 | 2.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 360 14.00 0 15.00 0 16.00 |
| 4. 00 | 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 360 14.00 0 15.00 0 16.00 |
| 5.00 00500 ADMINISTRATIVE & GENERAL | 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 360 14. 00 0 15. 00 |
| 7. 00 | 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 360 14. 00 0 15. 00 0 16. 00 |
| 8. 00 | 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 360 14. 00 0 15. 00 0 16. 00 |
| 9. 00 | 9. 00 10. 00 11. 00 12. 00 13. 00 360 14. 00 0 15. 00 0 16. 00 |
| 10. 00 01000 DI ETARY 1, 132, 392 11. 00 01100 CAFETERI A 0 989, 732 12. 00 01200 MAI NTENANCE OF PERSONNEL 0 0 0 0 0 0 0 0 0 | 10. 00 11. 00 12. 00 13. 00 360 14. 00 0 15. 00 0 16. 00 |
| 11. 00 | 11. 00 12. 00 13. 00 360 14. 00 0 15. 00 0 16. 00 |
| 12. 00 | 12. 00 13. 00 360 14. 00 0 15. 00 0 16. 00 |
| 14. 00 | 360 14.00 0 15.00 0 16.00 |
| 15. 00 | 0 15.00 0 16.00 |
| 16. 00 | 0 16.00 |
| 17. 00 | |
| 18. 00 | 0 17.00 |
| 19. 00 | 0 18.00 |
| 21. 00 02100 I&R SERVICES-SALARY & FRINGES APPRVD 0 0 0 0 0 0 0 0 0 | 0 19.00 |
| 22. 00 02200 1&R SERVICES-OTHER PRGM COSTS APPRVD 0 0 0 0 0 0 0 0 0 | 0 20.00 |
| 23. 00 02301 PARAMED ED PRGM 0 0 0 0 0 | 0 21.00 |
| INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 999,656 873,718 0 1,516,569 31.00 03100 INTENSIVE CARE UNIT 132,736 116,014 0 433,673 32.00 03200 CORONARY CARE UNIT 0 0 0 0 | 0 22.00 |
| 30. 00 03000 ADULTS & PEDI ATRI CS 999, 656 873, 718 0 1, 516, 569 31. 00 03100 I NTENSI VE CARE UNI T 132, 736 116, 014 0 433, 673 32. 00 03200 CORONARY CARE UNI T 0 0 0 0 | 0 23.00 |
| 31. 00 03100 I NTENSI VE CARE UNI T 132, 736 116, 014 0 433, 673 32. 00 03200 CORONARY CARE UNI T 0 0 0 0 | 0 30.00 |
| | 0 31.00 |
| OO OO OOOOO BUBU LUTENOLUE OABE UNUT | 0 32.00 |
| 33.00 03300 BURN INTENSIVE CARE UNIT 0 0 0 0 | 0 33.00 |
| 34. 00 03400 SURGI CAL INTENSI VE CARE UNIT 0 0 0 | 0 34.00 |
| 40. 00 04000 SUBPROVI DER - I PF | 0 40.00 |
| 41. 00 04100 SUBPROVI DER - I RF 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | 0 41.00 0 43.00 |
| 44. 00 04400 SKI LLED NURSI NG FACI LI TY 0 0 0 | 0 44.00 |
| 45. 00 04500 NURSI NG FACI LI TY 0 0 0 0 | 0 45.00 |
| 46. 00 04600 OTHER LONG TERM CARE 0 0 0 0 | 0 46.00 |
| ANCILLARY SERVICE COST CENTERS | |
| 50. 00 05000 0FRATI NG ROOM 0 0 591, 867 151, 044 | 0 50.00 |
| 51. 00 05100 RECOVERY ROOM 0 0 151, 944 52. 00 05200 DELI VERY ROOM & LABOR ROOM 0 0 0 0 0 | 0 51.00 0 52.00 |
| 53. 00 05300 ANESTHESI OLOGY | 0 53.00 |
| 54. 00 05400 RADI 0LOGY-DI AGNOSTI C 0 0 0 1, 268 | 0 54.00 |
| 55. 00 05500 RADI 0LOGY-THERAPEUTI C 0 0 0 0 | 0 55.00 |
| 56. 00 05600 RADI 0I SOTOPE 0 0 0 0 | 0 56.00 |
| 57. 00 05700 CT SCAN | 0 57.00 |
| 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0 0 0 0 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 176, 249 | 0 58.00 0 59.00 |
| 60. 00 06000 LABORATORY 0 0 0 | 0 60.00 |
| 60. 01 06001 BLOOD LABORATORY 0 0 0 | 0 60.01 |
| 61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY | 61. 00 |
| 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 0 | 0 62.00 |
| 63. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 0 0 0 0 | 0 63.00 |
| 64. 00 06400 I NTRAVENOUS THERAPY 0 0 0 0 0 0 0 65. 00 06500 RESPI RATORY THERAPY 0 0 0 0 0 | 0 64.00 0 65.00 |
| 66. 00 06600 PHYSI CAL THERAPY 0 0 0 | 0 66.00 |
| 67. 00 06700 0CCUPATI ONAL THERAPY 0 0 0 | 0 67.00 |
| 68. OO O680O SPEECH PATHOLOGY O O O | 0 68.00 |
| 69. 00 06900 ELECTROCARDI OLOGY 0 0 484 | 0 69.00 |
| 70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 | 0 70.00 |
| 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 642, | |
| 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | 0 72.00 0 73.00 |
| 74. 00 07400 RENAL DI ALYSI S 0 0 0 0 | 0 74.00 |
| 75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 | 0 75.00 |
| 76.00 03950 OTHER ANCILL SRVC 0 0 0 0 | 0 76.00 |
| 76. 01 03951 CARDI AC AND PULMONARY REHAB 0 0 0 | 0 76.01 |
| 76. 02 03952 WOUND CARE 0 0 0 0 0 0 0 0 0 | 0 76.02 |
| 77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION 0 0 0 0 0 | |
| 0UTPATIENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC 0 0 0 0 | 0 77.00 |
| 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 | 0 77.00 |
| 90. 00 09000 CLI NI C 0 0 0 | |
| 90. 01 09001 CLINI C 0 0 63, 513 | 0 77.00 0 88.00 |
| 90. 02 09002 CLI NI C 0 0 0 52, 518 | 0 77.00 0 88.00 0 89.00 |

| | | | Т | o 12/31/2021 | Date/Time Pre 5/31/2022 7:5 | |
|--|-------------|------------|----------------|-------------------|-----------------------------|---------|
| Cost Center Description | DIETARY | CAFETERI A | MAINTENANCE OF | NURSI NG | CENTRAL | 1 4111 |
| 2002 201100 2000 1 p 1 c 1 c 1 | | | | ADMI NI STRATI ON | SERVICES & | |
| | | | | | SUPPLY | |
| | 10.00 | 11. 00 | 12.00 | 13. 00 | 14. 00 | |
| 91. 00 09100 EMERGENCY | 0 | 0 | 0 | 457, 886 | 0 | 91.00 |
| 92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART) | | | | | | 92.00 |
| OTHER REIMBURSABLE COST CENTERS | | | | | | |
| 94.00 09400 HOME PROGRAM DIALYSIS | 0 | 0 | 0 | 0 | 0 | 94. 00 |
| 95. 00 09500 AMBULANCE SERVICES | 0 | 0 | 0 | 0 | 0 | 95. 00 |
| 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED | 0 | 0 | 0 | 0 | 0 | 96. 00 |
| 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD | 0 | 0 | 0 | 0 | 0 | 97. 00 |
| 98. 00 09850 OTHER REI MBURSE | 0 | 0 | 0 | 0 | 0 | 98. 00 |
| 99. 00 09900 CMHC | 0 | 0 | 0 | 0 | 0 | 99. 00 |
| 99. 10 09910 CORF | 0 | 0 | 0 | 0 | 0 | 99. 10 |
| 100.00 10000 I &R SERVICES-NOT APPRVD PRGM | o | 0 | 0 | o | 0 | 100.00 |
| 101.00 10100 HOME HEALTH AGENCY | O | 0 | 0 | O | 0 | 101. 00 |
| SPECIAL PURPOSE COST CENTERS | | | | | | |
| 105.00 10500 KIDNEY ACQUISITION | 0 | 0 | 0 | 0 | 0 | 105. 00 |
| 106. 00 10600 HEART ACQUISITION | 0 | 0 | 0 | 0 | 0 | 106. 00 |
| 107.00 10700 LIVER ACQUISITION | 0 | 0 | 0 | 0 | 0 | 107. 00 |
| 108.00 10800 LUNG ACQUISITION | 0 | 0 | 0 | 0 | 0 | 108. 00 |
| 109.00 10900 PANCREAS ACQUISITION | 0 | 0 | 0 | 0 | 0 | 109. 00 |
| 110.00 11000 INTESTINAL ACQUISITION | 0 | 0 | 0 | 0 | 0 | 110. 00 |
| 111.00 11100 I SLET ACQUISITION | 0 | 0 | 0 | 0 | 0 | 111. 00 |
| 113. 00 11300 I NTEREST EXPENSE | | | | | | 113. 00 |
| 114.00 11400 UTILIZATION REVIEW-SNF | | | | | | 114. 00 |
| 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) | 0 | 0 | 0 | 0 | 0 | 115. 00 |
| 116. 00 11600 HOSPI CE | 0 | 0 | 0 | 0 | 0 | 116. 00 |
| 118.00 SUBTOTALS (SUM OF LINES 1 through 117) | 1, 132, 392 | 989, 732 | 0 | 3, 447, 082 | 642, 360 | 118. 00 |
| NONREI MBURSABLE COST CENTERS | | | | | | |
| 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN | 0 | 0 | 0 | 0 | | 190. 00 |
| 191. 00 19100 RESEARCH | 0 | 0 | 0 | 0 | | 191. 00 |
| 192.00 19200 PHYSICIANS' PRIVATE OFFICES | 0 | 0 | 0 | 0 | 0 | 192. 00 |
| 192. 01 19201 CENTER OF HOPE | 0 | 0 | 0 | 0 | 0 | 192. 01 |
| 192.02 19202 OTHER FA FACILITIES NRCC | 0 | 0 | 0 | 0 | 0 | 192. 02 |
| 193. 00 19300 NONPALD WORKERS | 0 | 0 | 0 | 0 | | 193. 00 |
| 194.00 07950 OTHER NRCC | 0 | 0 | 0 | 0 | 0 | 194. 00 |
| 200.00 Cross Foot Adjustments | | | | | | 200. 00 |
| 201.00 Negative Cost Centers | 0 | 0 | 0 | 0 | | 201. 00 |
| 202.00 TOTAL (sum lines 118 through 201) | 1, 132, 392 | 989, 732 | 0 | 3, 447, 082 | 642, 360 | 202. 00 |

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

| | | | | ' | 0 12/31/2021 | Date/lime Pre 5/31/2022 7:5 | |
|------------------|---|----------------|---------------------|----------------|----------------------------|----------------------------------|------------------|
| | | | | | OTHER GENERAL | | |
| | Cost Center Description | PHARMACY | MEDI CAL | SOCIAL SERVICE | SERVI CE OTHER GEN SERV | NONPHYSI CI AN | |
| | oust defined beschiptron | 11000000 | RECORDS & | SOOTAL SERVICE | OTTIER GEN GERV | ANESTHETI STS | |
| | | 45.00 | LI BRARY | 47.00 | 10.00 | 10.00 | |
| | GENERAL SERVICE COST CENTERS | 15. 00 | 16. 00 | 17. 00 | 18. 00 | 19. 00 | |
| 1.00 | 00100 CAP REL COSTS-BLDG & FIXT | T | | | | | 1.00 |
| 2.00 | 00200 CAP REL COSTS-MVBLE EQUIP | | | | | | 2. 00 |
| 4.00 | 00400 EMPLOYEE BENEFITS DEPARTMENT | | | | | | 4. 00 |
| 5.00 | 00500 ADMINISTRATIVE & GENERAL | | | | | | 5. 00 |
| 6. 00 7. 00 | 00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT | | | 1 | | | 6. 00 7. 00 |
| 8. 00 | 00800 LAUNDRY & LINEN SERVICE | | | | | | 8.00 |
| 9. 00 | 00900 HOUSEKEEPI NG | | | | | | 9. 00 |
| 10. 00 | 01000 DI ETARY | | | | | | 10.00 |
| 11.00 | 01100 CAFETERI A | | | | | | 11.00 |
| 12. 00 13. 00 | 01200 MAI NTENANCE OF PERSONNEL 01300 NURSI NG ADMI NI STRATI ON | | | | | | 12. 00 13. 00 |
| 14. 00 | 01400 CENTRAL SERVICES & SUPPLY | | | | | | 14. 00 |
| 15. 00 | 01500 PHARMACY | 2, 561, 658 | | | | | 15. 00 |
| 16. 00 | 01600 MEDICAL RECORDS & LIBRARY | 0 | 1, 727, 988 | 3 | | | 16. 00 |
| 17. 00 | 01700 SOCIAL SERVICE | 0 | 0 | C | | | 17. 00 |
| 18. 00 19. 00 | 01850 OTHER GEN SERV 01900 NONPHYSI CI AN ANESTHETI STS | 0 | 0 | | | 0 | 18. 00 19. 00 |
| 20. 00 | 02000 NURSI NG PROGRAM | 0 | 0 | | | O | 20.00 |
| 21. 00 | 02100 I&R SERVICES-SALARY & FRINGES APPRVD | O | 0 | o | o | | 21. 00 |
| 22. 00 | 02200 I &R SERVICES-OTHER PRGM COSTS APPRVD | 0 | 0 |) c | o | | 22. 00 |
| 23. 00 | 02301 PARAMED ED PRGM | 0 | 0 |) <u> </u> | 0 | | 23. 00 |
| 30. 00 | INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS | ol | 106, 071 | 1 0 | ol | 0 | 30.00 |
| 31. 00 | 03100 NTENSIVE CARE UNIT | 0 | 22, 257 | 1 | - | 0 | |
| 32. 00 | 03200 CORONARY CARE UNIT | O | 0 | 1 | - | 0 | |
| 33. 00 | 03300 BURN INTENSIVE CARE UNIT | 0 | 0 |) c | 0 | 0 | 1 |
| 34.00 | 03400 SURGI CAL INTENSI VE CARE UNI T | 0 | 0 | C | 0 | 0 | |
| 40. 00 41. 00 | 04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF | 0 | 0 | | | 0 | 1 |
| 43. 00 | 04300 NURSERY | o | 0 | | | 0 | |
| 44. 00 | 04400 SKILLED NURSING FACILITY | 0 | 0 |) c | o | 0 | 1 |
| 45. 00 | 04500 NURSING FACILITY | 0 | 0 |) c | 1 1 | 0 | 1 |
| 46. 00 | 04600 OTHER LONG TERM CARE | 0 | 0 |) <u> </u> | 0 | 0 | 46. 00 |
| 50. 00 | ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM | 0 | 253, 229 |) (| ol | 0 | 50.00 |
| 51. 00 | 05100 RECOVERY ROOM | o | 28, 742 | | | 0 | |
| 52.00 | 05200 DELIVERY ROOM & LABOR ROOM | 0 | 0 |) c | 0 | 0 | 52. 00 |
| 53.00 | 05300 ANESTHESI OLOGY | 0 | 65, 627 | | 0 | 0 | |
| 54.00 | 05400 RADI OLOGY - DI AGNOSTI C | 0 | 108, 904 | C | 0 | 0 | |
| 55. 00 56. 00 | 05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE | 0 | 0 | | | 0 | |
| 57. 00 | 05700 CT SCAN | ő | 150, 994 | | o o | 0 | |
| | 05800 MAGNETIC RESONANCE IMAGING (MRI) | 0 | 89, 636 | o | 0 | 0 | 58. 00 |
| | 05900 CARDI AC CATHETERI ZATI ON | 0 | 65, 093 | • | 0 | 0 | 1 |
| 60. 00 60. 01 | 06000 LABORATORY 06001 BLOOD LABORATORY | 0 | 205, 907 | | 0 | 0 | |
| 61. 00 | 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY | U | Ü | | , | U | 61.00 |
| 62. 00 | 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS | 0 | 0 |) c | o | 0 | 1 |
| 63.00 | 06300 BLOOD STORING, PROCESSING & TRANS. | 0 | 0 |) c | o | 0 | 63. 00 |
| 64. 00 | 06400 I NTRAVENOUS THERAPY | 0 | 1, 330 | | 0 | 0 | |
| 65. 00 | 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY | 0 | 18, 353 | 1 | 0 | 0 | 1 |
| 66. 00 67. 00 | 06700 OCCUPATI ONAL THERAPY | 0 | 8, 090 6, 736 | | | 0 | |
| 68. 00 | 06800 SPEECH PATHOLOGY | o | 2, 301 | | o o | 0 | |
| 69. 00 | 06900 ELECTROCARDI OLOGY | 0 | 57, 284 | | 0 | 0 | |
| 70. 00 | 07000 ELECTROENCEPHALOGRAPHY | 0 | 15, 032 | | 0 | 0 | 1 |
| | 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS | 0 | 70, 407 | | 0 | 0 | |
| 72. 00 73. 00 | 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS | 2, 561, 658 | 76, 193 101, 586 | | | 0 | 1 |
| 74.00 | 07400 RENAL DIALYSIS | 2, 301, 038 | 3, 097 | | | 0 | |
| 75. 00 | 07500 ASC (NON-DISTINCT PART) | o | 0 |) c | o | 0 | |
| 76. 00 | 03950 OTHER ANCILL SRVC | 0 | 0 |) c | o o | 0 | 76. 00 |
| 76. 01 | 03951 CARDI AC AND PULMONARY REHAB | 0 | 727 | | 0 | 0 | |
| | 03952 WOUND CARE | 0 | 144 | 1 | 0 | 0 | 1 |
| 77.00 | 07700 ALLOGENEIC STEM CELL ACQUISITION OUTPATIENT SERVICE COST CENTERS | O ₁ | 0 |) <u> </u> | 0 | 0 | 77. 00 |
| 88. 00 | 08800 RURAL HEALTH CLINIC | 0 | 0 |) c | o | 0 | 88. 00 |
| 89. 00 | 08900 FEDERALLY QUALIFIED HEALTH CENTER | Ō | 0 | C | - | 0 | 89. 00 |
| 90. 00 | 09000 CLI NI C | 0 | 0 |) C | ol ol | 0 | 90.00 |
| | | | | | | | |

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

| | | | T | o 12/31/2021 | Date/Time Prep 5/31/2022 7:54 | | | |
|--|-------------|-------------|----------------|----------------|-------------------------------|---------|--|--|
| | | | | OTHER GENERAL | 3/31/2022 7.3 | 4 aiii | | |
| | | | | SERVI CE | | | | |
| Cost Center Description | PHARMACY | MEDI CAL | SOCIAL SERVICE | OTHER GEN SERV | NONPHYSI CI AN | | | |
| | | RECORDS & | | | ANESTHETI STS | | | |
| | | LI BRARY | | | | | | |
| | 15. 00 | 16.00 | 17. 00 | 18. 00 | 19. 00 | | | |
| 90. 01 09001 CLI NI C | 0 | 101, 228 | | 0 | 0 | | | |
| 90. 02 09002 CLI NI C | 0 | 21, 373 | • | 0 | 0 | 90. 02 | | |
| 91. 00 09100 EMERGENCY | O | 147, 628 | 0 | 0 | 0 | | | |
| 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | | | | | | 92.00 | | |
| OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS | ٥ | 0 | 0 | O | 0 | 94. 00 | | |
| 95. 00 09500 AMBULANCE SERVICES | 0 | 0 | 0 | 0 | 0 | | | |
| 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED | 0 | 0 | | 0 | 0 | 96.00 | | |
| 97. 00 09700 DURABLE MEDICAL EQUIP-NUMBER 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD | 0 | 0 | | 0 | | 97.00 | | |
| 98. 00 09850 OTHER REI MBURSE | 0 | 0 | | 0 | 0 | 98.00 | | |
| 99. 00 09900 CMHC | 0 | 0 | 0 | 0 | Ö | 1 | | |
| 99. 10 09910 CORF | o | 0 | 0 | Ö | 0 | 1 | | |
| 100.00 10000 I &R SERVICES-NOT APPRVD PRGM | o | 0 | 0 | 0 | Ö | 1 | | |
| 101.00 10100 HOME HEALTH AGENCY | Ö | 0 | Ö | 0 | | 101. 00 | | |
| SPECIAL PURPOSE COST CENTERS | | | | | | | | |
| 105. 00 10500 KIDNEY ACQUISITION | 0 | 0 | 0 | 0 | 0 | 105. 00 | | |
| 106. 00 10600 HEART ACQUI SI TI ON | 0 | 0 | 0 | 0 | 0 | 106. 00 | | |
| 107.00 10700 LIVER ACQUISITION | 0 | 0 | 0 | 0 | 0 | 107. 00 | | |
| 108.00 10800 LUNG ACQUISITION | 0 | 0 | 0 | 0 | | 108. 00 | | |
| 109.00 10900 PANCREAS ACQUISITION | 0 | 0 | 0 | 0 | | 109. 00 | | |
| 110.00 11000 INTESTINAL ACQUISITION | 0 | 0 | 0 | 0 | | 110. 00 | | |
| 111. 00 11100 I SLET ACQUI SI TI ON | 0 | 0 | 0 | 0 | | 111. 00 | | |
| 113. 00 11300 I NTEREST EXPENSE | | | | | | 113. 00 | | |
| 114. 00 11400 UTI LI ZATI ON REVI EW-SNF | _ | _ | _ | _ | | 114. 00 | | |
| 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) | 0 | 0 | 0 | 0 | | 115.00 | | |
| 116. 00 11600 HOSPI CE | 0 5/1 /50 | 1 727 000 | | 0 | l . | 116.00 | | |
| 118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS | 2, 561, 658 | 1, 727, 988 | 0 | U U | . 0 | 118. 00 | | |
| 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN | ٥ | 0 | 0 | O | 0 | 190. 00 | | |
| 191. 00 19100 RESEARCH | 0 | 0 | | 0 | | 191. 00 | | |
| 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES | 0 | 0 | | 0 | | 192. 00 | | |
| 192.01 19201 CENTER OF HOPE | 0 | 0 | | 0 | | 192. 01 | | |
| 192. 02 19202 OTHER FA FACILITIES NRCC | 0 | 0 | 0 | 0 | | 192. 02 | | |
| 193. 00 19300 NONPALD WORKERS | ol | 0 | 0 | l ől | | 193. 00 | | |
| 194. 00 07950 OTHER NRCC | o | 0 | Ö | o | | 194. 00 | | |
| 200.00 Cross Foot Adjustments | | | 1 | | | 200. 00 | | |
| 201.00 Negative Cost Centers | O | 0 | 0 | o | | 201. 00 | | |
| 202.00 TOTAL (sum lines 118 through 201) | 2, 561, 658 | 1, 727, 988 | 0 | 0 | 0 | 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: | 5/31/2022 7:54 am

| | | | | | 7 12/31/2021 | 5/31/2022 7:5 | |
|------------------|--|----------|----------------|-----------------|--------------|----------------------------|------------------|
| | | | INTERNS & | RESI DENTS | | | |
| | Cost Center Description | NURSI NG | SERVICES-SALAR | SERVI CES-OTHER | PARAMED ED | Subtotal | |
| | oust defiter bescription | PROGRAM | Y & FRI NGES | PRGM COSTS | PRGM | Subtotal | |
| | | 20.00 | 21.00 | 22. 00 | 23. 00 | 24. 00 | |
| 1 00 | GENERAL SERVICE COST CENTERS | | 1 | 1 | | | 4 00 |
| 1. 00 2. 00 | 00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP | | | | | | 1. 00 2. 00 |
| 4.00 | 00400 EMPLOYEE BENEFITS DEPARTMENT | | | | | | 4.00 |
| 5. 00 | 00500 ADMINISTRATIVE & GENERAL | | | | | | 5. 00 |
| 6.00 | 00600 MAINTENANCE & REPAIRS | | | | | | 6. 00 |
| 7.00 | 00700 OPERATION OF PLANT | | | | | | 7. 00 |
| 8.00 | 00800 LAUNDRY & LINEN SERVICE | | | | | | 8.00 |
| 9.00 | 00900 HOUSEKEEPI NG | | | | | | 9.00 |
| 10. 00 11. 00 | 1 | | | | | | 10.00 |
| 12. 00 | l i | | | | | | 12.00 |
| 13. 00 | l i | | | | | | 13. 00 |
| 14. 00 | l i | | | | | | 14. 00 |
| 15. 00 | | | | | | | 15.00 |
| 16. 00 17. 00 | | | | | | | 16. 00 17. 00 |
| 18. 00 | | | | | | | 18.00 |
| 19. 00 | | | | | | | 19. 00 |
| 20.00 | | C | | | | | 20. 00 |
| 21. 00 | | | 0 | | | | 21. 00 |
| 22. 00 | | | | 0 | | | 22. 00 |
| 23. 00 | | | | | 0 | | 23. 00 |
| 30. 00 | INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS | | 0 | O | 0 | 23, 679, 328 | 30.00 |
| 31. 00 | | | | 1 | 0 | 4, 486, 420 | |
| 32. 00 | | | Ö | Ö | Ö | 0 | 32. 00 |
| 33.00 | 03300 BURN INTENSIVE CARE UNIT | C | 0 | 0 | 0 | 0 | 33. 00 |
| 34. 00 | l i | C | 0 | 0 | 0 | 0 | 34. 00 |
| 40.00 | | C | 0 | 0 | 0 | 0 | 40.00 |
| 41. 00 43. 00 | l i | | 0 | | 0 | 0 | 41. 00 43. 00 |
| 44. 00 | 1 1 | | | | 0 | 0 | 44.00 |
| 45. 00 | | | Ö | Ö | Ö | Ö | 45. 00 |
| 46.00 | 1 | C | 1 | O | 0 | 0 | 46. 00 |
| | ANCILLARY SERVICE COST CENTERS | | , | | | | |
| 50.00 | | C | l . | l l | 0 | 11, 059, 327 | |
| 51. 00 52. 00 | l i | C | 1 | 0 | 0 | 2, 410, 615 0 | 51. 00 52. 00 |
| 53. 00 | 1 | | | | 0 | 646, 966 | |
| 54. 00 | | | Ö | ő | Ö | 4, 454, 586 | |
| 55. 00 | | C | 0 | 0 | 0 | 0 | 55. 00 |
| 56. 00 | | C | 0 | 0 | 0 | 0 | 56. 00 |
| 57. 00 | | C | 0 | 0 | 0 | 1, 351, 388 | |
| 58. 00 59. 00 | | | 0 | 0 | 0 | 1, 948, 797 4, 459, 084 | |
| 60.00 | | | | 0 | 0 | 7, 191, 146 | 1 |
| 60. 01 | 06001 BLOOD LABORATORY | | | Ö | 0 | 7, 171, 140 | 60. 01 |
| 61. 00 | | | | | | 0 | 61.00 |
| 62.00 | 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS | C | 0 | 0 | 0 | 0 | 62. 00 |
| 63. 00 | | C | 0 | 0 | 0 | 0 | 63.00 |
| 64. 00 | l i | C | 0 | 0 | 0 | 1, 330 | |
| 65. 00 66. 00 | 1 | | | 0 | 0 | 1, 893, 389 403, 530 | 65. 00 66. 00 |
| 67. 00 | l i | | | | 0 | 268, 403 | |
| 68. 00 | l i | | Ö | ő | Ö | 91, 377 | 68. 00 |
| 69. 00 | 06900 ELECTROCARDI OLOGY | C | 0 | 0 | 0 | 771, 334 | |
| 70. 00 | l i | C | 0 | 0 | 0 | 2, 268, 235 | |
| 71. 00 | l i | <u>C</u> | 0 | 0 | 0 | 9, 302, 601 | |
| 72.00 | 1 | | 0 | | 0 | 7, 875, 579 | ı |
| 73. 00 74. 00 | | | 0 | | O O | 7, 056, 322 3, 097 | |
| 75. 00 | l i | | o o | | o | 3,047 | 75.00 |
| 76. 00 | | | o o | ol ol | ő | 0 | 76. 00 |
| 76. 01 | | C | 0 | o | o | 333, 399 | 76. 01 |
| 76. 02 | | C | 0 | 이 | 0 | 9, 535 | |
| 77. 00 | 07700 ALLOGENEIC STEM CELL ACQUISITION | C | 0 | 0 | 0 | 0 | 77. 00 |
| 88. 00 | OUTPATIENT SERVICE COST CENTERS O8800 RURAL HEALTH CLINIC | T C | 0 | 0 | ol | 0 | 88. 00 |
| 89. 00 | | | | | ol | 0 | 89. 00 |
| 90. 00 | 09000 CLI NI C | C | Ō | o | o | 0 | 90.00 |
| 90. 01 | 09001 CLI NI C | c | 0 | 0 | 0 | 3, 378, 562 | 90. 01 |
| | | | | | | | |

| | | | To | 12/31/2021 | Date/Time Pre 5/31/2022 7:5 | pared: |
|--|----------|-----------------|-----------------|------------|--------------------------------|---------|
| | | INTERNS & | RESIDENTS | | 3/31/2022 7.3 | 4 alli |
| | | THIEIMS U | RESTBENTS | | | |
| Cost Center Description | NURSI NG | SERVI CES-SALAR | SERVI CES-OTHER | PARAMED ED | Subtotal | |
| | PROGRAM | Y & FRINGES | PRGM COSTS | PRGM | | |
| | 20.00 | 21.00 | 22.00 | 23. 00 | 24.00 | |
| 90. 02 09002 CLI NI C | 0 | 0 | 0 | 0 | 850, 922 | 90. 02 |
| 91. 00 09100 EMERGENCY | 0 | o | 0 | 0 | 6, 497, 143 | 91.00 |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | | | | | | 92.00 |
| OTHER REIMBURSABLE COST CENTERS | | | | | | |
| 94.00 09400 HOME PROGRAM DIALYSIS | 0 | 0 | 0 | 0 | 0 | 94. 00 |
| 95. 00 09500 AMBULANCE SERVICES | 0 | 0 | 0 | 0 | 0 | 95. 00 |
| 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED | 0 | 0 | 0 | 0 | 0 | 96. 00 |
| 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD | 0 | 0 | 0 | 0 | 0 | 97. 00 |
| 98. 00 09850 OTHER REI MBURSE | 0 | 0 | 0 | 0 | 0 | 98. 00 |
| 99. 00 09900 CMHC | 0 | 0 | 0 | 0 | 0 | 99. 00 |
| 99. 10 09910 CORF | 0 | 0 | 0 | 0 | 0 | 99. 10 |
| 100.00 10000 I &R SERVICES-NOT APPRVD PRGM | 0 | 0 | 0 | 0 | 0 | 100.00 |
| 101.00 10100 HOME HEALTH AGENCY | 0 | 0 | 0 | 0 | 0 | 101. 00 |
| SPECIAL PURPOSE COST CENTERS | | | | | | |
| 105.00 10500 KIDNEY ACQUISITION | 0 | 0 | 0 | 0 | | 105. 00 |
| 106. 00 10600 HEART ACQUISITION | 0 | 0 | 0 | 0 | | 106. 00 |
| 107.00 10700 LIVER ACQUISITION | 0 | 0 | 0 | 0 | 0 | 107. 00 |
| 108.00 10800 LUNG ACQUISITION | 0 | 0 | 0 | 0 | 0 | 108. 00 |
| 109.00 10900 PANCREAS ACQUISITION | 0 | 0 | 0 | 0 | 0 | 109. 00 |
| 110.00 11000 INTESTINAL ACQUISITION | 0 | 0 | 0 | 0 | 0 | 110. 00 |
| 111.00 11100 I SLET ACQUI SI TI ON | 0 | 0 | 0 | 0 | 0 | 111. 00 |
| 113. 00 11300 I NTEREST EXPENSE | | | | | | 113. 00 |
| 114.00 11400 UTILIZATION REVIEW-SNF | | | | | | 114. 00 |
| 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) | 0 | 0 | 0 | 0 | 0 | 115. 00 |
| 116. 00 11600 HOSPI CE | 0 | | | 0 | 19 | 116. 00 |
| 118.00 SUBTOTALS (SUM OF LINES 1 through 117) | 0 | 0 | 0 | 0 | 102, 692, 434 | 118. 00 |
| NONREI MBURSABLE COST CENTERS | | | | | | |
| 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN | 0 | 0 | 0 | 0 | 79, 830 | |
| 191. 00 19100 RESEARCH | 0 | 0 | 0 | 0 | 871 | 191. 00 |
| 192.00 19200 PHYSICIANS' PRIVATE OFFICES | 0 | 0 | 0 | 0 | 5, 679, 113 | |
| 192. 01 19201 CENTER OF HOPE | 0 | 0 | 0 | 0 | 0 | 192. 01 |
| 192.02 19202 OTHER FA FACILITIES NRCC | 0 | 0 | 0 | 0 | 616, 164 | 192. 02 |
| 193. 00 19300 NONPALD WORKERS | 0 | 0 | 0 | 0 | | 193. 00 |
| 194. 00 07950 OTHER NRCC | 0 | 0 | 0 | 0 | 30, 332 | 194. 00 |
| 200.00 Cross Foot Adjustments | 0 | 0 | 0 | 0 | | 200. 00 |
| 201.00 Negative Cost Centers | 0 | 0 | 0 | 0 | | 201. 00 |
| 202.00 TOTAL (sum lines 118 through 201) | 0 | 0 | 0 | o | 109, 098, 744 | 202. 00 |

| Peri od: | Worksheet B | From 01/01/2021 | Part | | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Time Prepared: | To 12/31/2020 | To 12/31/202 Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0165

| | | | | | То | | ne Prepared: 2 7:54 am |
|------------------|-------|---|--------------------------|----------------------------|----------|--|---------------------------|
| | | Cost Center Description | Intern & | Total | | ,, ,, ,, ,, ,, ,, ,, ,, ,, ,, ,, ,, ,, | |
| | | | Residents Cost & Post | | | | |
| | | | Stepdown | | | | |
| | | | Adjustments | 24 00 | | | |
| | GENER | AL SERVICE COST CENTERS | 25. 00 | 26. 00 | | | |
| 1.00 | 00100 | CAP REL COSTS-BLDG & FIXT | | | | | 1. 00 |
| 2.00 | 1 | CAP REL COSTS-MVBLE EQUIP | | | | | 2.00 |
| 4. 00 5. 00 | 1 | EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL | | | | | 4. 00 5. 00 |
| 6. 00 | | MAINTENANCE & REPAIRS | | | | | 6. 00 |
| 7.00 | 1 | OPERATION OF PLANT | | | | | 7. 00 |
| 8. 00 9. 00 | | LAUNDRY & LINEN SERVICE HOUSEKEEPING | | | | | 8. 00 9. 00 |
| 10.00 | 1 | DIETARY | | | | | 10.00 |
| 11. 00 | 1 | CAFETERI A | | | | | 11. 00 |
| 12.00 | 1 | MAINTENANCE OF PERSONNEL | | | | | 12.00 |
| 13. 00 14. 00 | 1 | NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY | | | | | 13. 00 14. 00 |
| 15. 00 | 1 | PHARMACY | | | | | 15. 00 |
| 16.00 | 1 | MEDICAL RECORDS & LIBRARY | | | | | 16. 00 |
| 17. 00 18. 00 | 1 | SOCIAL SERVICE OTHER GEN SERV | | | | | 17. 00 18. 00 |
| 19. 00 | 1 | NONPHYSICIAN ANESTHETISTS | | | | | 19. 00 |
| 20.00 | | NURSI NG PROGRAM | | | | | 20. 00 |
| 21. 00 22. 00 | 1 | 1 &R SERVICES-SALARY & FRINGES APPRVD | | | | | 21. 00 22. 00 |
| 23. 00 | 1 | I&R SERVICES-OTHER PRGM COSTS APPRVD PARAMED ED PRGM | | | | | 23. 00 |
| | | IENT ROUTINE SERVICE COST CENTERS | | | | | |
| 30.00 | 1 | ADULTS & PEDIATRICS | 0 | 23, 679, 328 | | | 30.00 |
| 31. 00 32. 00 | | INTENSIVE CARE UNIT CORONARY CARE UNIT | 0 | 4, 486, 420 0 | | | 31. 00 32. 00 |
| 33. 00 | 1 | BURN INTENSIVE CARE UNIT | 0 | 0 | | | 33. 00 |
| 34.00 | 1 | SURGICAL INTENSIVE CARE UNIT | 0 | 0 | | | 34.00 |
| 40. 00 41. 00 | 1 | SUBPROVI DER - I PF SUBPROVI DER - I RF | 0 | 0 | | | 40. 00 41. 00 |
| 43. 00 | 1 | NURSERY | 0 | 0 | | | 43. 00 |
| 44. 00 | | SKILLED NURSING FACILITY | 0 | 0 | | | 44. 00 |
| 45. 00 46. 00 | 1 | NURSING FACILITY OTHER LONG TERM CARE | 0 | 0 | | | 45. 00 46. 00 |
| 10. 00 | | LARY SERVICE COST CENTERS | <u> </u> | 0 | | | 10.00 |
| 50.00 | 1 | OPERATING ROOM | 0 | 11, 059, 327 | | | 50.00 |
| 51. 00 52. 00 | 1 | RECOVERY ROOM DELIVERY ROOM & LABOR ROOM | 0 | 2, 410, 615 0 | | | 51. 00 52. 00 |
| 53.00 | | ANESTHESI OLOGY | 0 | 646, 966 | | | 53. 00 |
| 54. 00 | 1 | RADI OLOGY-DI AGNOSTI C | 0 | 4, 454, 586 | | | 54. 00 |
| 55. 00 56. 00 | | RADI OLOGY-THERAPEUTI C RADI OI SOTOPE | 0 | 0 | | | 55. 00 56. 00 |
| 57. 00 | | CT SCAN | | 1, 351, 388 | | | 57. 00 |
| 58. 00 | | MAGNETIC RESONANCE IMAGING (MRI) | 0 | 1, 948, 797 | | | 58. 00 |
| 59.00 | 1 | CARDI AC CATHETERI ZATI ON | 0 | 4, 459, 084 | | | 59.00 |
| 60. 00 60. 01 | 1 | LABORATORY BLOOD LABORATORY | 0 | 7, 191, 146 0 | | | 60. 00 60. 01 |
| 61. 00 | 06100 | PBP CLINICAL LAB SERVICES-PRGM ONLY | | 0 | | | 61. 00 |
| 62.00 | 1 | WHOLE BLOOD & PACKED RED BLOOD CELLS | 0 | 0 | | | 62.00 |
| 63. 00 64. 00 | 1 | BLOOD STORING, PROCESSING & TRANS. INTRAVENOUS THERAPY | 0 | 0 1, 330 | | | 63. 00 64. 00 |
| 65. 00 | | RESPI RATORY THERAPY | 0 | 1, 893, 389 | | | 65. 00 |
| 66.00 | | PHYSI CAL THERAPY | 0 | 403, 530 | | | 66. 00 |
| 67. 00 68. 00 | 1 | OCCUPATIONAL THERAPY SPEECH PATHOLOGY | 0 | 268, 403 91, 377 | | | 67. 00 68. 00 |
| 69.00 | | ELECTROCARDI OLOGY | Ö | 771, 334 | | | 69. 00 |
| 70.00 | | ELECTROENCEPHALOGRAPHY | 0 | 2, 268, 235 | | | 70. 00 |
| 71. 00 72. 00 | | MEDICAL SUPPLIES CHARGED TO PATIENTS IMPL. DEV. CHARGED TO PATIENTS | 0 | 9, 302, 601 7, 875, 579 | | | 71. 00 72. 00 |
| | | DRUGS CHARGED TO PATTENTS | | 7, 875, 379 7, 056, 322 | | | 73.00 |
| 74.00 | 07400 | RENAL DIALYSIS | 0 | 3, 097 | | | 74. 00 |
| | 1 | ASC (NON-DISTINCT PART) OTHER ANCILL SRVC | 0 | 0 | | | 75. 00 76. 00 |
| | 1 | CARDIAC AND PULMONARY REHAB | | 333, 399 | | | 76.00 |
| 76. 02 | 03952 | WOUND CARE | | 9, 535 | | | 76. 02 |
| 77. 00 | | ALLOGENEIC STEM CELL ACQUISITION | 0 | 0 | | | 77. 00 |
| 88. 00 | | TIENT SERVICE COST CENTERS RURAL HEALTH CLINIC | 0 | 0 | | | 88. 00 |
| 89. 00 | 08900 | FEDERALLY QUALIFIED HEALTH CENTER | 0 | 0 | | | 89. 00 |
| 90. 00 | 09000 | CLI NI C | 0 | 0 | <u> </u> | | 90.00 |
| | | | | | | | |

| | | | To 12/31/2021 Part 1 | |
|---|----------------|----------------|----------------------|--------------------|
| Cost Center Description | Intern & | Total | 5/31/2022 | 7:54 am |
| cost contor boson per on | Residents Cost | | | |
| | & Post | | | |
| | Stepdown | | | |
| | Adjustments | | | |
| | 25. 00 | 26. 00 | | |
| 90. 01 09001 CLI NI C | 0 | 3, 378, 562 | • | 90. 01 |
| 90. 02 09002 CLI NI C | 0 | 850, 922 | | 90. 02 |
| 91. 00 09100 EMERGENCY | 0 | 6, 497, 143 | | 91. 00 |
| 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 0 | | | 92. 00 |
| OTHER REIMBURSABLE COST CENTERS | | | | |
| 94. 00 09400 HOME PROGRAM DI ALYSI S | 0 | 0 | | 94. 00 |
| 95. 00 09500 AMBULANCE SERVICES | 0 | 0 | | 95. 00 |
| 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED | 0 | 0 | | 96. 00 |
| 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD | 0 | 0 | | 97. 00 |
| 98. 00 09850 OTHER REI MBURSE | 0 | 0 | | 98. 00 |
| 99. 00 09900 CMHC | 0 | 0 | | 99. 00 |
| 99. 10 09910 CORF | 0 | 0 | | 99. 10 |
| 100.00 10000 I &R SERVI CES-NOT APPRVD PRGM | 0 | 0 | | 100.00 |
| 101. 00 10100 HOME HEALTH AGENCY | 0 | 0 | | 101. 00 |
| SPECIAL PURPOSE COST CENTERS | | | | 405.00 |
| 105. 00 10500 KI DNEY ACQUI SI TI ON | 0 | 0 | l . | 105.00 |
| 106. 00 10600 HEART ACQUI SI TI ON | 0 | 0 | l . | 106.00 |
| 107. 00 10700 LI VER ACQUI SI TI ON | 0 | 0 | | 107. 00 108. 00 |
| 108. 00 10800 LUNG ACQUISITION | 0 | 0 | | |
| 109. 00 10900 PANCREAS ACQUISITION | 0 | 0 | | 109.00 |
| 110. 00 11000 I NTESTI NAL ACQUI SI TI ON | 0 | 0 | | 110.00 |
| 111. 00 11100 SLET ACQUI SI TI ON | U | U | | 111.00 |
| 113. 00 11300 NTEREST EXPENSE | | | | 113.00 |
| 114. 00 11400 UTI LI ZATI ON REVI EW-SNF | | 0 | | 114.00 |
| 115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.) 116. 00 11600 HOSPICE | 0 | 0 19 | l . | 115. 00 116. 00 |
| | | | | 118.00 |
| 118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS | U U | 102, 692, 434 | | 118.00 |
| 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN | | 79, 830 | | 190. 00 |
| 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN | | 79, 630 871 | | 191. 00 |
| 192. 00 19100 RESEARCH 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES | | 5, 679, 113 | | 192. 00 |
| 192. 01 1920 CENTER OF HOPE | | 5, 679, 113 | | 192. 01 |
| 192. 01 1920 CENTER OF HOPE 192. 02 19202 OTHER FA FACILITIES NRCC | | 616, 164 | | 192. 02 |
| 193. 00 19300 NONPALD WORKERS | | 010, 104 | | 193. 00 |
| 194. 00 07950 OTHER NRCC | | 30, 332 | | 194. 00 |
| 200.00 Cross Foot Adjustments | | 0, 332 | | 200. 00 |
| 201.00 Negative Cost Centers | | 0 | | 201. 00 |
| 202.00 TOTAL (sum lines 118 through 201) | | 109, 098, 744 | | 202. 00 |
| 202.00 TOTAL (Sum Titles TTO through 201) | ١ | 107, 070, 744 | I | 1202.00 |

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2021 | Part II | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Ti Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0165

| | | | | Ic | 12/31/2021 | Date/lime Pre 5/31/2022 7:5 | |
|--------------------------------------|--|--|-------------------------|-------------|------------------------------|------------------------------------|--------------------------------------|
| | | | CAPI TAL REI | 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 | |
| | GENERAL SERVICE COST CENTERS | | | | | | |
| 1. 00 2. 00 4. 00 5. 00 | 00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL | 0 | 78, 565 755, 095 | | 78, 565 755, 095 | 78, 565 18, 537 | 1. 00 2. 00 4. 00 5. 00 |
| 6. 00 7. 00 8. 00 9. 00 | 00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING | 0 0 | 0 0 | | 0 0 0 | 1, 288 0 218 1, 428 | 6. 00 7. 00 8. 00 9. 00 |
| 10. 00 11. 00 12. 00 13. 00 | 01200 MAINTENANCE OF PERSONNEL 01300 NURSING ADMINISTRATION | 0 0 | 271, 342 0 0 0 | 0 0 | 271, 342 0 0 0 | 399 645 0 3, 377 | 10. 00 11. 00 12. 00 13. 00 |
| 14. 00 15. 00 16. 00 17. 00 | 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE | 0 0 | 0 105, 396 4, 960 | 1 | 0 105, 396 4, 960 0 | 383 2, 187 580 0 | 14. 00 15. 00 16. 00 17. 00 |
| 18. 00 19. 00 20. 00 21. 00 | 01900 NONPHYSICIAN ANESTHETISTS 02000 NURSING PROGRAM 02100 I&R SERVICES-SALARY & FRINGES APPRVD | 0 0 0 | 0 0 0 | | 0 0 0 | 0 0 0 | 18. 00 19. 00 20. 00 21. 00 |
| 22. 00 23. 00 | | 0 | 0 | | 0 | 0 | 22. 00 23. 00 |
| | INPATIENT ROUTINE SERVICE COST CENTERS | | 1 000 1/3 | | | | |
| 30. 00 31. 00 | | 0 | 1, 322, 167 318, 598 | | 1, 322, 167 318, 598 | 16, 177 2, 969 | 30. 00 31. 00 |
| 32. 00 | 03200 CORONARY CARE UNIT | 0 | 0.0,070 | Ö | 0 | 0 | 32. 00 |
| 33. 00 34. 00 | | 0 | 0 | | 0 | 0 | 33. 00 34. 00 |
| 40. 00 | | | 0 | | 0 | 0 | 40.00 |
| 41. 00 | 04100 SUBPROVI DER - I RF | o | 0 | 0 | 0 | 0 | 41. 00 |
| 43. 00 | | 0 | 0 | 0 | 0 | 0 | 43.00 |
| 44. 00 45. 00 | | 0 | 0 | | 0 | 0 | 44. 00 45. 00 |
| 46. 00 | | Ö | Ö | o o | 0 | 0 | 46. 00 |
| | ANCILLARY SERVICE COST CENTERS | | | | | | |
| 50. 00 51. 00 | | 0 | 600, 067 263, 248 | | 600, 067 263, 248 | 6, 589 1, 416 | 50. 00 51. 00 |
| 52. 00 | | 0 | 203, 240 | | 203, 240 | 1, 410 | 52.00 |
| 53. 00 | | o | 0 | 0 | O | 61 | 53. 00 |
| 54. 00 | | 0 | 278, 989 | 0 | 278, 989 | 2, 793 | • |
| 55. 00 56. 00 | I I | 0 | 0 | | 0 | 0 | 55. 00 56. 00 |
| 57. 00 | | O | 0 | Ö | Ö | 792 | |
| 58. 00 | | 0 | 0 | 0 | 0 | 1, 431 | 1 |
| 59. 00 60. 00 | | 0 | 566, 761 97, 405 | | 566, 761 97, 405 | 1, 968 0 | 59. 00 60. 00 |
| 60. 00 | 1 | | 97, 403 | | 97, 403 | 0 | 60.00 |
| 61. 00 | | | | | 0 | | 61. 00 |
| 62. 00 63. 00 | | 0 | 0 | 0 | 0 | 0 | 62.00 |
| 64. 00 | The state of the s | 0 | 0 | | 0 | 0 | 63. 00 64. 00 |
| 65. 00 | | 0 | 48, 530 | 0 | 48, 530 | 1, 909 | 65. 00 |
| 66. 00 | | 0 | 0 | 0 | 0 | 478 | |
| 67. 00 68. 00 | | 0 | 0 | 0 | 0 | 315 107 | 67. 00 68. 00 |
| 69. 00 | | | 0 | | 0 | 695 | 1 |
| 70. 00 | | 0 | 247, 680 | 0 | 247, 680 | 750 | 70. 00 |
| 71. 00 | | 0 | 0 | 0 | 0 | 0 | 71.00 |
| 72. 00 73. 00 | | 0 | 0 | 0 | 0 | 0 | 72. 00 73. 00 |
| 74. 00 | | l o | Ö | o o | 0 | 0 | 74. 00 |
| 75. 00 | 07500 ASC (NON-DISTINCT PART) | o | 0 | 0 | 0 | 0 | 75. 00 |
| 76. 00 | | 0 | 0 | | 0 | 0 | 76.00 |
| 76. 01 76. 02 | | | 0 | | O O | 399 7 | 76. 01 76. 02 |
| 77. 00 | | 0 | 0 | 0 | 0 | 0 | 77. 00 |
| | OUTPATIENT SERVICE COST CENTERS | , | | | | | |
| 88.00 | 08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER | 0 | 0 | 1 | 0 | 0 | 88. 00 89. 00 |
| 57.00 | 190700 EDERALET CONETTIED HEALTH CENTER | 1 0 | 0 | 'i 0 | O _I | 0 | 1 07.00 |

Period: Worksheet B
From 01/01/2021 Part II
To 12/31/2021 Date/Time Prepared: Provider CCN: 15-0165

| | | | To | 12/31/2021 | Date/Time Prep 5/31/2022 7:54 | |
|--|---|----------------|-------------|----------------|------------------------------------|--------------------|
| | | CAPI TAL REI | ATED COSTS | | 3/31/2022 7.3 | 4 alli |
| Cost Center Description | Di rectly Assigned New Capital Related Costs | BLDG & FIXT | MVBLE EQUIP | Subtotal | EMPLOYEE BENEFITS DEPARTMENT | |
| | 0 | 1.00 | 2.00 | 2A | 4. 00 | |
| 90. 00 09000 CLI NI C | 0 | 0 | 0 | 0 | 0 | 90.00 |
| 90. 01 09001 CLI NI C | 0 | 0 | 0 | 0 | 2, 895 | 1 |
| 90. 02 09002 CLI NI C | 0 | 41, 573 | | 41, 573 | 482 | 90. 02 |
| 91. 00 09100 EMERGENCY | 0 | 340, 986 | 0 | 340, 986 | 3, 979 | |
| 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | | | | 0 | | 92. 00 |
| OTHER REIMBURSABLE COST CENTERS | | | | ام | | 04.00 |
| 94. 00 09400 HOME PROGRAM DI ALYSI S 95. 00 09500 AMBULANCE SERVI CES | 0 | 0 | 0 | 0 | 0 | 94. 00 95. 00 |
| 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED | | 0 | 0 | 0 | 0 | 96.00 |
| 97. 00 09700 DURABLE MEDICAL EQUIP-RENTED | | 0 | 0 | 0 | 0 | 97.00 |
| 98. 00 09850 OTHER REIMBURSE | 0 | 0 | 0 | 0 | 0 | 98.00 |
| 99. 00 09900 CMHC | | 0 | 0 | 0 | 0 | 99.00 |
| 99. 10 09910 CORF | o | 0 | 0 | 0 | 0 | 99. 10 |
| 100.00 10000 I&R SERVICES-NOT APPRVD PRGM | o | 0 | o | o | - | |
| 101.00 10100 HOME HEALTH AGENCY | O | 0 | 0 | O | | 101.00 |
| SPECIAL PURPOSE COST CENTERS | | | | | | |
| 105.00 10500 KIDNEY ACQUISITION | 0 | 0 | | 0 | | 105. 00 |
| 106. 00 10600 HEART ACQUI SI TI ON | 0 | 0 | 0 | 0 | | 106. 00 |
| 107. 00 10700 LIVER ACQUISITION | 0 | 0 | 0 | 0 | | 107. 00 |
| 108. 00 10800 LUNG ACQUISITION | 0 | 0 | 0 | 0 | | 108. 00 |
| 109. 00 10900 PANCREAS ACQUISITION | 0 | 0 | 0 | 0 | | 109. 00 |
| 110. 00 11000 INTESTINAL ACQUISITION | 0 | 0 | 0 | 0 | | 110.00 |
| 111. 00 11100 ISLET ACQUISITION 113. 00 11300 INTEREST EXPENSE | U | 0 | U | U | - | 111. 00 113. 00 |
| 114. 00 11400 UTI LI ZATI ON REVI EW-SNF | | | | | | 114. 00 |
| 115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.) | 0 | 0 | 0 | 0 | | 115. 00 |
| 116. 00 11600 HOSPI CE | | 0 | Ö | 0 | | 116.00 |
| 118.00 SUBTOTALS (SUM OF LINES 1 through 117) | o | 5, 341, 362 | Ö | 5, 341, 362 | 75, 254 | 1 |
| NONREI MBURSABLE COST CENTERS | | | | ., , , | | |
| 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN | 0 | 0 | 0 | 0 | 54 | 190. 00 |
| 191. 00 19100 RESEARCH | 0 | 0 | 0 | 0 | 1 | 191. 00 |
| 192.00 19200 PHYSICIANS' PRIVATE OFFICES | 0 | 810, 480 | 0 | 810, 480 | 2, 723 | 192. 00 |
| 192.01 19201 CENTER OF HOPE | 0 | 0 | 0 | 0 | | 192. 01 |
| 192. 02 19202 OTHER FA FACILITIES NRCC | 0 | 0 | 0 | 0 | | 192. 02 |
| 193. 00 19300 NONPALD WORKERS | 0 | 0 | 0 | 0 | | 193. 00 |
| 194. 00 07950 OTHER NRCC | 0 | 0 | 0 | 0 | 37 | 194. 00 |
| 200.00 Cross Foot Adjustments | | 0 | | 0 | | 200. 00 |
| 201.00 Negative Cost Centers 202.00 TOTAL (sum lines 118 through 201) | 0 | 0 6 151 042 |) 0 | 0 6 151 042 | 78, 565 | 201. 00 |
| 202.00 TOTAL (Suill TITIES TTO LITEOUGH 201) | ١ | 6, 151, 842 | ı Y | 6, 151, 842 | 10, 303 | 1202. UU |

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0165

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

| | | | | | '' | 0 12/31/2021 | Date/lime Pre 5/31/2022 7:5 | |
|------------------|-------|--|---------------------|-------------------|----------------|-----------------------|----------------------------------|------------------|
| | | Cost Center Description | ADMI NI STRATI VE | | | LAUNDRY & | HOUSEKEEPI NG | |
| | | | <u> </u> | REPAI RS 6. 00 | PLANT 7. 00 | LINEN SERVICE 8.00 | 9. 00 | |
| | GENER | AL SERVICE COST CENTERS | 3.00 | 0.00 | 7.00 | 0.00 | 7. 00 | |
| 1.00 | 00100 | CAP REL COSTS-BLDG & FIXT | | | | | | 1. 00 |
| 2.00 | 1 | CAP REL COSTS-MVBLE EQUIP | | | | | | 2. 00 |
| 4.00 | 1 | EMPLOYEE BENEFITS DEPARTMENT | 770 (00 | | | | | 4. 00 |
| 5. 00 6. 00 | 1 | ADMINISTRATIVE & GENERAL MAINTENANCE & REPAIRS | 773, 632 93, 432 | 94, 720 | | | | 5. 00 6. 00 |
| 7. 00 | | OPERATION OF PLANT | 73, 432 | 94, 720 | | | | 7. 00 |
| 8. 00 | 1 | LAUNDRY & LINEN SERVICE | 1, 798 | 0 | | 2, 016 | | 8. 00 |
| 9.00 | 00900 | HOUSEKEEPI NG | 10, 294 | 0 | 0 | 0 | 11, 722 | 9. 00 |
| 10.00 | 1 | DIETARY | 2, 811 | 4, 833 | | 0 | 598 | 1 |
| 11.00 | 1 | CAFETERI A | 0 | 0 | · - | 0 | 0 | 11. 00 |
| 12. 00 13. 00 | 1 | MAI NTENANCE OF PERSONNEL NURSI NG ADMI NI STRATI ON | 24, 668 | 0 | | 0 | 0 | 12. 00 13. 00 |
| 14. 00 | 1 | CENTRAL SERVICES & SUPPLY | 4, 597 | 0 | | 0 | 0 | 14. 00 |
| 15. 00 | 1 | PHARMACY | 16, 276 | 1, 877 | | 0 | 232 | 1 |
| 16. 00 | 01600 | MEDICAL RECORDS & LIBRARY | 12, 269 | 88 | 1 | 0 | 11 | 16. 00 |
| 17. 00 | | SOCIAL SERVICE | 0 | 0 | | 0 | 0 | • |
| 18.00 | | OTHER GEN SERV | 0 | 0 | 0 | 0 | 0 | 18. 00 |
| 19. 00 20. 00 | | NONPHYSICIAN ANESTHETISTS NURSING PROGRAM | 0 | 0 | 0 | 0 | 0 | 19. 00 20. 00 |
| 21. 00 | 1 | I &R SERVICES-SALARY & FRINGES APPRVD | 0 | 0 | 0 | 0 | 0 | 21.00 |
| 22. 00 | 1 | I&R SERVICES-OTHER PRGM COSTS APPRVD | 0 | Ō | Ō | 0 | 0 | 22. 00 |
| 23. 00 | | PARAMED ED PRGM | 0 | 0 | 0 | 0 | 0 | 23. 00 |
| | | IENT ROUTINE SERVICE COST CENTERS | 1 | | г | | | |
| 30. 00 31. 00 | 1 | ADULTS & PEDIATRICS | 117, 046 | | | | 2, 914 | 30.00 |
| 31.00 | | INTENSIVE CARE UNIT CORONARY CARE UNIT | 20, 638 | 5, 674 0 | i e | 236 | 702 0 | 31. 00 32. 00 |
| 33. 00 | | BURN INTENSIVE CARE UNIT | 0 | Ö | l ő | 0 | 0 | 33. 00 |
| 34.00 | 1 | SURGICAL INTENSIVE CARE UNIT | 0 | 0 | 0 | 0 | 0 | 34. 00 |
| 40. 00 | 1 | SUBPROVI DER - I PF | 0 | 0 | 0 | 0 | 0 | 40. 00 |
| 41.00 | | SUBPROVI DER - I RF | 0 | 0 | 0 | 0 | 0 | 41.00 |
| 43. 00 44. 00 | 1 | NURSERY SKILLED NURSING FACILITY | 0 | 0 | 0 | 0 | 0 | |
| 45. 00 | | NURSING FACILITY | 0 | 0 | | 0 | 0 | 45. 00 |
| 46. 00 | 1 | OTHER LONG TERM CARE | 0 | 0 | | 0 | Ö | 46. 00 |
| | | LARY SERVICE COST CENTERS | | | | | | |
| 50.00 | 1 | OPERATI NG ROOM | 61, 391 | 10, 688 | | 0 | 1, 323 | 1 |
| 51. 00 52. 00 | 1 | RECOVERY ROOM DELIVERY ROOM & LABOR ROOM | 10, 823 | 4, 689 0 | | 0 | 580 0 | 51. 00 52. 00 |
| 53. 00 | 1 | ANESTHESI OLOGY | 4, 160 | 0 | | 0 | 0 | 53.00 |
| 54. 00 | 1 | RADI OLOGY-DI AGNOSTI C | 25, 648 | 4, 969 | | 0 | 615 | • |
| 55.00 | 05500 | RADI OLOGY-THERAPEUTI C | 0 | 0 | 0 | 0 | 0 | 55. 00 |
| 56. 00 | 1 | RADI OI SOTOPE | 0 | 0 | 0 | 0 | 0 | 56. 00 |
| 57. 00 58. 00 | | CT SCAN MAGNETIC RESONANCE IMAGING (MRI) | 8, 582 | 0 | 0 | 0 | 0 | 57. 00 |
| 59.00 | 1 | CARDIAC CATHETERIZATION | 13, 304 19, 129 | 10, 094 | 1 | 0 | 0 1, 249 | 58. 00 59. 00 |
| 60.00 | 1 | LABORATORY | 48, 088 | 1, 735 | | 0 | 215 | 1 |
| | | BLOOD LABORATORY | 0 | 0 | | 0 | | 60. 01 |
| 61. 00 | | PBP CLINICAL LAB SERVICES-PRGM ONLY | | | | | | 61. 00 |
| 62.00 | | WHOLE BLOOD & PACKED RED BLOOD CELLS | 0 | 0 | 0 | 0 | 0 | |
| 63. 00 64. 00 | 1 | BLOOD STORING, PROCESSING & TRANS. INTRAVENOUS THERAPY | 0 | 0 | | 0 | 0 | 63. 00 64. 00 |
| 65. 00 | | RESPI RATORY THERAPY | 12, 472 | 864 | 1 | 0 | 107 | 65. 00 |
| 66.00 | | PHYSI CAL THERAPY | 2, 830 | | | 0 | 0 | 1 |
| 67. 00 | | OCCUPATI ONAL THERAPY | 1, 873 | 0 | 0 | 0 | 0 | |
| 68. 00 | | SPEECH PATHOLOGY | 637 | 0 | · · | 0 | 0 | |
| 69. 00 70. 00 | | ELECTROCARDI OLOGY ELECTROENCEPHALOGRAPHY | 5, 106 11, 294 | 0 4, 411 | 0 | 0 | 0 546 | |
| 71.00 | | MEDICAL SUPPLIES CHARGED TO PATIENTS | 61, 470 | 4, 411 | 0 | 0 | 0 | 1 |
| | | IMPL. DEV. CHARGED TO PATIENTS | 55, 814 | 0 | | 0 | Ö | • |
| 73.00 | 07300 | DRUGS CHARGED TO PATIENTS | 31, 438 | 0 | 0 | 0 | 0 | 73. 00 |
| 74. 00 | | RENAL DIALYSIS | 0 | 0 | 0 | 0 | 0 | |
| 75. 00 | | ASC (NON-DISTINCT PART) | 0 | 0 | 0 | 0 | 0 | |
| 76. 00 76. 01 | 1 | OTHER ANCILL SRVC CARDIAC AND PULMONARY REHAB | 2, 381 | 0 | 0 | 0 | 0 | |
| 76. 01 | | WOUND CARE | 2, 361 | 0 |] 0 | 0 | 0 | 1 |
| | | ALLOGENEIC STEM CELL ACQUISITION | 0 | 0 | | 0 | 0 | |
| | OUTPA | TIENT SERVICE COST CENTERS | | | · | | | |
| | | RURAL HEALTH CLINIC | 0 | 0 | 0 | 0 | 0 | |
| 89.00 | | FEDERALLY QUALIFIED HEALTH CENTER | 0 | 0 | 0 | 0 | 0 | |
| 90. 00 90. 01 | 1 | CLINIC CLINIC | 22, 999 | 0 | 0 | 0 | 0 | 90. 00 90. 01 |
| 90. 01 | | CLINIC | 4, 750 | 740 | | | 92 | 1 |
| | | EMERGENCY | 35, 511 | 6, 073 | | Ö | | 91.00 |
| | | | · | | | | | |

Period: Worksheet B From 01/01/2021 Part II Provider CCN: 15-0165

| | | | T | 0 12/31/2021 | Date/Time Pre 5/31/2022 7:5 | |
|---|-------------------|---------------|--------------|---------------|-----------------------------|---------|
| Cost Center Description | ADMI NI STRATI VE | MAINTENANCE & | OPERATION OF | LAUNDRY & | HOUSEKEEPI NG | 1 4111 |
| | & GENERAL | REPAI RS | PLANT | LINEN SERVICE | | |
| | 5. 00 | 6.00 | 7. 00 | 8. 00 | 9. 00 | |
| 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | | | | | | 92. 00 |
| OTHER REIMBURSABLE COST CENTERS | , | | | | | İ |
| 94. 00 09400 HOME PROGRAM DI ALYSI S | 0 | 0 | 0 | 0 | 0 | 94. 00 |
| 95. 00 09500 AMBULANCE SERVICES | o | 0 | 0 | 0 | 0 | 95. 00 |
| 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED | o | 0 | 0 | 0 | 0 | 96. 00 |
| 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD | o | 0 | 0 | 0 | 0 | 97. 00 |
| 98. 00 09850 OTHER REI MBURSE | o | 0 | 0 | 0 | 0 | 98. 00 |
| 99. 00 09900 CMHC | o | 0 | 0 | 0 | 0 | 99. 00 |
| 99. 10 09910 CORF | o | 0 | 0 | 0 | 0 | 99. 10 |
| 100.00 10000 I&R SERVICES-NOT APPRVD PRGM | o | 0 | 0 | 0 | 0 | 100.00 |
| 101.00 10100 HOME HEALTH AGENCY | o | 0 | 0 | 0 | 0 | 101.00 |
| SPECIAL PURPOSE COST CENTERS | | | | | | |
| 105. 00 10500 KIDNEY ACQUISITION | 0 | 0 | 0 | 0 | 0 | 105. 00 |
| 106. 00 10600 HEART ACQUI SI TI ON | 0 | 0 | 0 | 0 | 0 | 106. 00 |
| 107.00 10700 LIVER ACQUISITION | O | 0 | 0 | 0 | 0 | 107. 00 |
| 108.00 10800 LUNG ACQUISITION | O | 0 | 0 | 0 | 0 | 108. 00 |
| 109.00 10900 PANCREAS ACQUISITION | O | 0 | 0 | 0 | 0 | 109. 00 |
| 110.00 11000 INTESTINAL ACQUISITION | o | 0 | 0 | 0 | 0 | 110. 00 |
| 111.00 11100 ISLET ACQUISITION | o | 0 | 0 | 0 | 0 | 111. 00 |
| 113.00 11300 INTEREST EXPENSE | | | | | | 113. 00 |
| 114.00 11400 UTILIZATION REVIEW-SNF | | | | | | 114. 00 |
| 115.00 11500 AMBULATORY SURGICAL CENTER (D.P.) | o | 0 | 0 | 0 | 0 | 115. 00 |
| 116. 00 11600 HOSPI CE | o | 0 | 0 | 0 | 0 | 116. 00 |
| 118.00 SUBTOTALS (SUM OF LINES 1 through 117) | 743, 596 | 80, 285 | 0 | 2, 016 | 9, 936 | 118. 00 |
| NONREI MBURSABLE COST CENTERS | | | | | | |
| 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN | 571 | 0 | 0 | 0 | 0 | 190. 00 |
| 191. 00 19100 RESEARCH | 6 | 0 | 0 | 0 | 0 | 191. 00 |
| 192.00 19200 PHYSICIANS' PRIVATE OFFICES | 24, 833 | 14, 435 | 0 | 0 | 1, 786 | 192. 00 |
| 192.01 19201 CENTER OF HOPE | 0 | 0 | 0 | 0 | 0 | 192. 01 |
| 192.02 19202 OTHER FA FACILITIES NRCC | 4, 409 | 0 | 0 | 0 | 0 | 192. 02 |
| 193.00 19300 NONPALD WORKERS | 0 | 0 | 0 | 0 | 0 | 193. 00 |
| 194.00 07950 OTHER NRCC | 217 | 0 | 0 | 0 | 0 | 194. 00 |
| 200.00 Cross Foot Adjustments | | | | | | 200. 00 |
| 201.00 Negative Cost Centers | 0 | 0 | 0 | 0 | | 201. 00 |
| 202.00 TOTAL (sum lines 118 through 201) | 773, 632 | 94, 720 | 0 | 2, 016 | 11, 722 | 202. 00 |

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2021 Part II
To 12/31/2021 Date/Time Prepared: 5/31/2022 7:54 am

| | | | | | 0 12/31/2021 | 5/31/2022 7:5 | |
|------------------|---|----------|------------|--------------------------|-------------------------------|-----------------------|------------------|
| | Cost Center Description | DI ETARY | CAFETERI A | MAINTENANCE OF PERSONNEL | NURSI NG ADMI NI STRATI ON | CENTRAL SERVICES & | |
| | | | | PERSUNNEL | ADMINISTRATION | SUPPLY | |
| | | 10.00 | 11. 00 | 12.00 | 13. 00 | 14. 00 | |
| 1. 00 | GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT | | | | | | 1.00 |
| 2. 00 | 00200 CAP REL COSTS-MVBLE EQUIP | | | | | | 2. 00 |
| 4. 00 | 00400 EMPLOYEE BENEFITS DEPARTMENT | | | | | | 4. 00 |
| 5.00 | 00500 ADMINISTRATIVE & GENERAL | | | | | | 5. 00 |
| 6.00 | 00600 MAINTENANCE & REPAIRS | | | | | | 6. 00 |
| 7.00 | 00700 OPERATION OF PLANT | | | | | | 7. 00 |
| 8. 00 | 00800 LAUNDRY & LINEN SERVICE | | | | | | 8. 00 |
| 9.00 | 00900 HOUSEKEEPI NG | 270 002 | | | | | 9.00 |
| 10. 00 11. 00 | 01000 DI ETARY 01100 CAFETERI A | 279, 983 | 645 | | | | 10.00 |
| 12. 00 | 01200 MAINTENANCE OF PERSONNEL | | 04: | 1 | | | 12.00 |
| 13. 00 | 01300 NURSI NG ADMI NI STRATI ON | | (| | 28, 045 | | 13. 00 |
| 14. 00 | 01400 CENTRAL SERVICES & SUPPLY | o | Ċ | o o | 0 | 4, 980 | 1 |
| 15. 00 | 01500 PHARMACY | 0 | (| 0 | 0 | 0 | 15. 00 |
| 16. 00 | 01600 MEDICAL RECORDS & LIBRARY | 0 | (| 0 | 0 | 0 | 16. 00 |
| 17. 00 | 01700 SOCIAL SERVICE | 0 | (| 0 | 0 | 0 | |
| | 01850 OTHER GEN SERV | 0 | (| 0 | 0 | 0 | |
| | 01900 NONPHYSI CLAN ANESTHETI STS | 0 | (| 0 | 0 | 0 | |
| 20. 00 21. 00 | 02000 NURSING PROGRAM 02100 I&R SERVICES-SALARY & FRINGES APPRVD | 0 | (| | 0 | 0 | 20.00 |
| 21.00 | 02200 I &R SERVI CES-OTHER PRGM COSTS APPRVD | | (| | 0 | 0 | 22. 00 |
| 23. 00 | 02301 PARAMED ED PRGM | | (| | 0 | 0 | 1 |
| 20.00 | INPATIENT ROUTINE SERVICE COST CENTERS | <u> </u> | | ,1 | | | 20.00 |
| 30.00 | 03000 ADULTS & PEDI ATRI CS | 247, 164 | 569 | 9 0 | 12, 340 | 0 | 30. 00 |
| 31.00 | 03100 INTENSIVE CARE UNIT | 32, 819 | 76 | 6 0 | 3, 528 | 0 | 31.00 |
| 32. 00 | 03200 CORONARY CARE UNIT | 0 | (| 0 | 0 | 0 | |
| 33. 00 | 03300 BURN INTENSIVE CARE UNIT | 0 | (| 0 | 0 | 0 | |
| 34. 00 | 03400 SURGICAL INTENSIVE CARE UNIT | 0 | (| 0 | 0 | 0 | 34. 00 |
| 40.00 | 04000 SUBPROVI DER - I PF | 0 | (| | 0 | 0 | 40.00 |
| 41. 00 43. 00 | 04100 SUBPROVI DER - I RF 04300 NURSERY | 0 | (| | 0 | 0 | 41. 00 43. 00 |
| 44. 00 | 04400 SKI LLED NURSI NG FACI LI TY | | (| | 0 | 0 | 1 |
| 45. 00 | 04500 NURSING FACILITY | | (| | 0 | 0 | 1 |
| 46. 00 | 04600 OTHER LONG TERM CARE | o | (| 1 | 0 | 0 | |
| | ANCILLARY SERVICE COST CENTERS | | | | | | |
| 50.00 | 05000 OPERATING ROOM | 0 | (| | | 0 | 50. 00 |
| 51. 00 | 05100 RECOVERY ROOM | 0 | (| 0 | 1, 236 | 0 | 51. 00 |
| 52. 00 | 05200 DELIVERY ROOM & LABOR ROOM | 0 | (| 0 | 0 | 0 | 52. 00 |
| 53.00 | 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C | 0 | (| | 10 | 0 | 53.00 |
| 54. 00 55. 00 | 05500 RADI OLOGY - DI AGNOSTI C | | (| | 10 | 0 | 54. 00 55. 00 |
| 56. 00 | 05600 RADI OLOGI - THERAI EUTI C | | (| | 0 | 0 | 1 |
| 57. 00 | 05700 CT SCAN | o | (| | 9 | 0 | 1 |
| 58.00 | 05800 MAGNETIC RESONANCE I MAGING (MRI) | 0 | (| 0 | 0 | 0 | 58. 00 |
| 59. 00 | 05900 CARDI AC CATHETERI ZATI ON | 0 | (| 0 | 1, 434 | 0 | 59. 00 |
| 60.00 | 06000 LABORATORY | 0 | (| 0 | 0 | 0 | 60.00 |
| 60. 01 | 06001 BLOOD LABORATORY | 0 | (| 0 | 0 | 0 | |
| 61.00 | 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY | | | | | 0 | 61.00 |
| 62. 00 63. 00 | 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06300 BLOOD STORING, PROCESSING & TRANS. | 0 | (| | 0 | 0 | |
| 64. 00 | 06400 I NTRAVENOUS THERAPY | | (| | 0 | 0 | 1 |
| 65. 00 | 06500 RESPIRATORY THERAPY | 0 | (| | 0 | 0 | 1 |
| 66. 00 | 06600 PHYSI CAL THERAPY | o | (| ol o | 0 | 0 | 66. 00 |
| 67.00 | 06700 OCCUPATI ONAL THERAPY | 0 | (| 0 | 0 | 0 | 67. 00 |
| 68.00 | 06800 SPEECH PATHOLOGY | 0 | (| 0 | 0 | 0 | 68. 00 |
| 69. 00 | 06900 ELECTROCARDI OLOGY | 0 | (| 0 | 4 | 0 | 69. 00 |
| 70. 00 | 07000 ELECTROENCEPHALOGRAPHY | 0 | (| 0 | 0 | 0 | 70. 00 |
| | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | (| 0 | 0 | 4, 980 | 1 |
| 72.00 | 07200 NPL. DEV. CHARGED TO PATIENTS | 0 | (| | 0 | 0 | |
| 73. 00 74. 00 | 07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS | 0 | (| | 0 | 0 | |
| 74. 00 75. 00 | 07500 ASC (NON-DISTINCT PART) | | (| | | 0 | 75.00 |
| 76. 00 | 03950 OTHER ANCILL SRVC | | (| | 0 | 0 | 76.00 |
| 76. 01 | 03951 CARDI AC AND PULMONARY REHAB | | (| ol o | Ö | 0 | 76. 01 |
| | 03952 WOUND CARE | | Ć |) 0 | 0 | 0 | 1 |
| 77. 00 | 07700 ALLOGENEIC STEM CELL ACQUISITION | 0 | (| 0 | 0 | 0 | 77. 00 |
| | OUTPATIENT SERVICE COST CENTERS | , | | | 1 | | |
| 88. 00 | 08800 RURAL HEALTH CLINIC | 0 | (| 0 | 0 | 0 | |
| 89. 00 | 08900 FEDERALLY QUALIFIED HEALTH CENTER | 0 | (| 0 | 0 | 0 | |
| 90. 00 90. 01 | 09000 CLI NI C 09001 CLI NI C | | (| | 517 | 0 | 90. 00 90. 01 |
| 90. 01 | 09001 CLI NI C | | (| | 427 | 0 | 1 |
| . 0. 02 | | 1 9 | | | 127 | | 1 . 3. 32 |

Period: Worksheet B From 01/01/2021 Part II

| | | | To | 0 12/31/2021 | Date/Time Pre 5/31/2022 7:5 | |
|--|----------|----------------------|----------------|-------------------|-----------------------------|---------|
| Cost Center Description | DI ETARY | CAFETERI A | MAINTENANCE OF | NURSI NG | CENTRAL | T GIII |
| Cook Conton Dood (pti ci) | 51217111 | 57.11 E 1 E 1.11 7 1 | | ADMI NI STRATI ON | SERVICES & | |
| | | | | | SUPPLY | |
| | 10.00 | 11. 00 | 12.00 | 13. 00 | 14. 00 | |
| 91. 00 09100 EMERGENCY | 0 | 0 | 0 | 3, 725 | 0 | 91.00 |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | | | | | | 92.00 |
| OTHER REIMBURSABLE COST CENTERS | | | | | | |
| 94.00 09400 HOME PROGRAM DIALYSIS | 0 | 0 | 0 | 0 | 0 | 94. 00 |
| 95. 00 09500 AMBULANCE SERVICES | 0 | 0 | 0 | 0 | 0 | 95. 00 |
| 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED | 0 | 0 | 0 | 0 | 0 | 96. 00 |
| 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD | 0 | 0 | 0 | 0 | 0 | 97. 00 |
| 98. 00 09850 OTHER REI MBURSE | 0 | 0 | 0 | 0 | 0 | 98. 00 |
| 99. 00 09900 CMHC | 0 | 0 | 0 | 0 | 0 | 99. 00 |
| 99. 10 09910 CORF | 0 | 0 | 0 | 0 | 0 | 99. 10 |
| 100.00 10000 I&R SERVICES-NOT APPRVD PRGM | 0 | 0 | 0 | 0 | 0 | 100.00 |
| 101.00 10100 HOME HEALTH AGENCY | 0 | 0 | 0 | 0 | 0 | 101. 00 |
| SPECIAL PURPOSE COST CENTERS | | | | | | |
| 105.00 10500 KIDNEY ACQUISITION | 0 | 0 | 0 | 0 | | 105. 00 |
| 106.00 10600 HEART ACQUISITION | 0 | 0 | 0 | 0 | 0 | 106. 00 |
| 107.00 10700 LIVER ACQUISITION | 0 | 0 | 0 | 0 | | 107. 00 |
| 108.00 10800 LUNG ACQUISITION | 0 | 0 | 0 | 0 | 0 | 108. 00 |
| 109.00 10900 PANCREAS ACQUISITION | 0 | 0 | 0 | 0 | 0 | 109. 00 |
| 110.00 11000 INTESTINAL ACQUISITION | 0 | 0 | 0 | 0 | | 110. 00 |
| 111.00 11100 ISLET ACQUISITION | 0 | 0 | 0 | 0 | 0 | 111. 00 |
| 113.00 11300 I NTEREST EXPENSE | | | | | | 113. 00 |
| 114.00 11400 UTILIZATION REVIEW-SNF | | | | | | 114. 00 |
| 115.00 11500 AMBULATORY SURGICAL CENTER (D.P.) | 0 | 0 | 0 | 0 | | 115. 00 |
| 116. 00 11600 HOSPI CE | 0 | 0 | 0 | 0 | | 116. 00 |
| 118.00 SUBTOTALS (SUM OF LINES 1 through 117) | 279, 983 | 645 | 0 | 28, 045 | 4, 980 | 118. 00 |
| NONREI MBURSABLE COST CENTERS | | | | | | |
| 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN | 0 | 0 | 0 | 0 | | 190. 00 |
| 191. 00 19100 RESEARCH | 0 | 0 | 0 | 0 | | 191. 00 |
| 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES | 0 | 0 | 0 | 0 | | 192. 00 |
| 192.01 19201 CENTER OF HOPE | 0 | 0 | 0 | 0 | | 192. 01 |
| 192.02 19202 OTHER FA FACILITIES NRCC | 0 | 0 | 0 | 0 | | 192. 02 |
| 193. 00 19300 NONPALD WORKERS | 0 | 0 | 0 | 0 | | 193. 00 |
| 194. 00 07950 OTHER NRCC | 0 | 0 | 0 | 0 | 0 | 194. 00 |
| 200.00 Cross Foot Adjustments | | | | | | 200. 00 |
| 201.00 Negative Cost Centers | 0 | 0 | 0 | 0 | | 201. 00 |
| 202.00 TOTAL (sum lines 118 through 201) | 279, 983 | 645 | 0 | 28, 045 | 4, 980 | 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: | To 12/31/2021 | Date/Ti Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0165

| The Center Description | | | | | ' | 0 12/31/2021 | Date/lime Pre 5/31/2022 7:5 | |
|--|--------|------------------------------------|----------|----------|----------------|----------------|--------------------------------|----------|
| Control Cont | | | | <u> </u> | | | | |
| | | Cost Contor Doscription | DHVDWVCA | MEDICAL | SOCIAL SERVICE | | NONDUVSI CI AN | |
| 1.1 | | Cost Center Description | PHARMACY | | SUCTAL SERVICE | OTHER GEN SERV | | |
| DEARHAL SERVICE CUST CONTENTS 0 ORIGINATE DESCRIPTION 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | | | | | | | | |
| 1.00 001000 FOR PELL COSTS-PELLE & STEPN 2.00 0.0000 0.00 | | OFNEDAL CEDIMOS COST CENTEDO | 15. 00 | 16. 00 | 17. 00 | 18. 00 | 19. 00 | |
| 2 00 00000 CAP REL COSTS-LIVELE EQUIP | 1 00 | | | | I | | | 1 00 |
| 0,000 0,000 ADMIN ISTRATIVE & GENERAL | | 1 1 | | | | | | |
| 6.00 GROOD MAINTENDERS | 4.00 | 00400 EMPLOYEE BENEFITS DEPARTMENT | | | | | | 4. 00 |
| 7. 00 00 0000 (LAMINERY & LIFER SERVICE 00 0000 (LAMINERY & LIFER SERVICE 00 0000 (LAMINERY & LIFER SERVICE 01 01 0000 (LAMINERY & LIFER SERVICE) 12. 00 01 1200 (LAMINERY & LIFER SERVICE) 13. 00 1310 (LAMINERY & LIFER SERVICE) 14. 00 1310 (LAMINERY & LIFER SERVICE) 15. 00 1310 (LAMINERY & LIFER SERVICE) 16. 00 1310 (LAMINERY & LIFER SERVICE) 17. 00 1310 (LAMINERY & LIFER SERVICE) 18. 00 1310 (LAMINERY & LIFER SERVICE) 19. 00 1310 (LAMINERY & LAMINERY & LA | | | | | | | | 1 |
| 8.00 000000000000000000000000000000000 | | | | | | | | 1 |
| 9.00 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.000 | | | | | | | | ı |
| 11.00 01100 CAFETERIA 11.00 | 9.00 | | | | | | | 9. 00 |
| 12.00 01200/MIN NETAMEC OF PERSONNET 12.00 13. | | | | | | | | 1 |
| 13.00 13.00 MURSING ADMINISTRATION 14.00 1 | | 1 | | | | | | 1 |
| 14.00 14.00 14.00 14.00 15.00 15.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 17.0 | | | | | | | | 1 |
| 16. 00 14c0 MEDICAL RECORDS & LIBRARY 0 17, 908 16. 00 17. 00 170. 00 170. 00 170. 00 170. 00 180. 00 1 | | | | | | | | 1 |
| 17.00 01700 SOCIAL SERVICE 0 0 0 0 17.00 0 18.00 18.00 0180 0180 0180 01900 000PHYSICIAN ANSTHETISTS 0 0 0 0 0 0 0 0 19.00 02.00 | | | 125, 968 | | | | | 1 |
| 18.00 01800 OTHER CERN SERV 0 0 0 0 0 0 0 0 18.00 | | | 0 | 17, 908 | 1 | | | 1 |
| 19.00 1900 NOSPHYNSICI AN AMESINETISTS 0 0 0 0 0 19.00 21.00 2000 187 SERVICES-SALARY & FRINGES APPRVD 0 0 0 0 21.00 22.00 2020 188 SERVICES-SALARY & FRINGES APPRVD 0 0 0 0 0 22.00 23.00 2020 188 SERVICES-SALARY & FRINGES APPRVD 0 0 0 0 0 22.00 23.00 2020 188 SERVICES-SALARY & FRINGES APPRVD 0 0 0 0 0 22.00 23.00 2020 188 SERVICES-SALARY & FRINGES APPRVD 0 0 0 0 0 0 22.00 23.00 189 SERVICES-SALARY & FRINGES APPRVD 0 0 0 0 0 0 0 0 23.00 189 SERVICES-SALARY & FRINGES APPRVD 0 0 0 0 0 0 0 23.00 189 SERVICES-SALARY & FRINGES APPRVD 0 0 0 0 0 0 0 0 0 | | 1 | 0 | 0 | | | | 1 |
| 20.00 20.00 QUISTA INC PROGRAM 0 0 0 0 0 20.00 | | | 0 | 0 | · - | - | 0 | 1 |
| 22.00 02200 IAR SERVICES-OTHER PROM OCSTS APPRVD 0 0 0 0 22.00 0 0 0 0 0 0 0 0 0 | 20. 00 | 02000 NURSI NG PROGRAM | 0 | 0 | 0 | 0 | | 20. 00 |
| 22.0 0 0 0 0 0 0 0 0 0 | | | 0 | 0 | • | | | 1 |
| INPATI ENT ROUTI NE SERVICE COST CENTERS 0 1.090 0 0 33.00 0 30.00 0 0 0 0 1.090 0 0 0 31.00 31.00 31.00 31.00 0 0 0 0 0 0 0 0 31.00 32.00 32.00 0 0 0 0 0 0 0 0 0 | | | 0 | - | | _ | | |
| 30.00 30.00 ADULTS & PEDI ATRICS 0 1.090 0 30.00 | 23.00 | | J O | | 0 | 0 | | 23.00 |
| 32.00 03200 COROMARY CARE UNIT | 30. 00 | | 0 | 1, 090 | 0 | 0 | | 30. 00 |
| 33.00 03300 BURN INTERSIVE CARE UNIT 0 0 0 0 0 34.00 0 | | 1 | 0 | | | _ | | 1 |
| 34.00 03400 SURGICAL INTENSIVE CARE UNIT 0 0 0 0 0 40.00 | | 1 1 | 0 | 0 | | | | 1 |
| 40.00 04000 SUBPROVI DER - I PF 0 0 0 0 41.00 | | 1 | 0 | 0 | | _ | | 1 |
| 43.00 04300 NURSERY 0 0 0 0 0 43.00 44.00 04400 SKILLED NURSING FACILITY 0 0 0 0 0 44.00 44.00 04400 SKILLED NURSING FACILITY 0 0 0 0 0 0 44.00 04400 SKILLED NURSING FACILITY 0 0 0 0 0 0 45.00 04500 OHDRE NURSING FACILITY 0 0 0 0 0 45.00 04500 OHDRE NURSING FACILITY 0 0 0 0 0 46.00 04600 OHDRE NURSING FACILITY 0 0 0 0 0 ANCILLARY SERVICE COST CENTERS | 40.00 | | 0 | 0 | 0 | 0 | | 40. 00 |
| 44. 00 04400 SKILLED NURSING FACILITY | | | 0 | 0 | · - | 0 | | 1 |
| 45. 00 04-500 OURSING FACILITY | | 1 I | 0 | 0 | | 0 | | 1 |
| ANCILLARY SERVICE COST CENTERS | | | o | 0 | | _ | | 1 |
| 50.00 05000 05000 05000 05000 05000 0 | 46. 00 | | 0 | 0 | 0 | 0 | | 46. 00 |
| 51.00 05100 RECOVERY ROOM 0 0 0 0 0 51.00 | 50.00 | | | 2 754 | 1 0 | | | 50.00 |
| S2.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 52.00 | | | 0 | | | | | 1 |
| 54.00 05400 RADI OLOGY-DI AGNOSTIC 0 1,119 0 0 55.00 05500 RADI OLOGY-THERAPEUTIC 0 0 0 0 0 0 0 0 0 | | | 0 | | | 0 | | 1 |
| 55.00 05500 RADI OLOGY-THERAPEUTI C | | 1 | 0 | | | 0 | | 1 |
| 56. 00 05600 RADI OI SOTOPE 0 0 0 0 0 0 55. 00 | | | 0 | | | 0 | | |
| S8. 00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 921 0 0 59. 00 05900 CARDIAC CATHETERIZATION 0 669 0 0 0 0 0 0 0 0 0 | | | 0 | 0 | 0 | 0 | | 1 |
| 59.00 05900 CARDI AC CATHETERI ZATI ON 0 669 0 0 59.00 | | | 0 | 1, 552 | 0 | 0 | | 57. 00 |
| 60. 00 06000 LABORATORY 0 2, 116 0 0 0 0 0 0 0 0 0 | | | 0 | | | _ | | 1 |
| 60. 01 06001 | | | 0 | | | 0 | | 1 |
| 61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 0 0 0 62. 00 63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 0 0 0 64. 00 06400 INTRAVENOUS THERAPY 0 14 0 0 0 64. 00 65. 00 06500 RESPIRATORY THERAPY 0 189 0 0 0 65. 00 66. 00 06600 PHYSI CAL THERAPY 0 83 0 0 0 65. 00 66. 00 06600 PHYSI CAL THERAPY 0 83 0 0 0 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 0 69 0 0 67. 00 68. 00 06800 SPECH PATHOLOGY 0 24 0 0 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 589 0 0 69. 00 71. 00 07000 ELECTROENCEPHALOGRAPHY 0 154 0 0 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 723 0 0 71. 00 72. 00 07200 IMPL DEV. CHARGED TO PATI ENTS 0 783 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 125, 968 1, 044 0 0 73. 00 74. 00 07400 RENAL DI ALYSI S 0 32 0 0 74. 00 75. 00 07500 ASC (NON-DI STI NCT PART) 0 0 0 0 76. 00 76. 01 03951 CARDI AC AND PULMONARY REHAB 0 7 0 0 0 76. 02 03952 WOUND CARE 0 1 0 0 0 77. 00 00TPATI ENT SERVICE COST CENTERS 88. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 89. 00 08900 TENTALLY Q | | | | 2, 110 | | 0 | | 1 |
| 63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 0 0 63. 00 64. 00 06400 INTRAVENDUS THERAPY 0 14 0 0 64. 00 65. 00 06500 RESPI RATORY THERAPY 0 189 0 0 0 66. 00 06600 PHYSI CAL THERAPY 0 83 0 0 0 67. 00 06700 OCCUPATI ONAL THERAPY 0 69 0 0 0 68. 00 06800 SPEECH PATHOLOGY 0 24 0 0 69. 00 06900 ELECTROCARDI OLOGY 0 589 0 0 0 70. 00 07000 ELECTROENCEPHALOGRAPHY 0 154 0 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 723 0 0 72. 00 07300 DRUGS CHARGED TO PATIENTS 0 723 0 0 74. 00 07300 DRUGS CHARGED TO PATIENTS 0 733 0 0 74. 00 07400 RENAL DI ALYSIS 0 32 0 0 75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 76. 01 03951 CARDI AC AND PULMONARY REHAB 0 7 0 76. 02 03952 WOUND CARE 0 0 0 0 77. 00 07700 ALL OGENEL C STEM CELL ACQUISITION 0 0 0 88. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 144 | | 1 | | | | | | 1 |
| 64. 00 06400 INTRAVENOUS THERAPY 0 14 0 0 0 64. 00 65. 00 65. 00 RESPI RATORY THERAPY 0 189 0 0 0 65. 00 06. 00 | | 1 I | 0 | 0 | 0 | 0 | | 1 |
| 65. 00 06500 RESPIRATORY THERAPY 0 189 0 0 65. 00 66. 00 PHYSI CAL THERAPY 0 0 83 0 0 0 66. 00 PHYSI CAL THERAPY 0 0 83 0 0 0 66. 00 66. 00 PHYSI CAL THERAPY 0 0 69 0 0 0 66. 00 66. 00 66. 00 0 0 0 0 0 0 | | | 0 | - | · - | 0 | | 1 |
| 66. 00 06600 PHYSI CAL THERAPY 0 83 0 0 66. 00 67. 00 67. 00 67. 00 68. 00 06700 OCCUPATI ONAL THERAPY 0 69. 00 690 0 67. 00 68. 00 6800 SPEECH PATHOLOGY 0 24 0 0 68. 00 6900 ELECTROCARDI OLOGY 0 589 0 0 69. 00 69. 00 6900 ELECTROCARDI OLOGY 0 154 0 0 69. 00 69 | | | | | | 0 | | 1 |
| 68. 00 | | | Ö | | • | 0 | | 1 |
| 69. 00 | | | 0 | | • | 0 | | 1 |
| 70. 00 | | | 0 | | | 0 | | 1 |
| 71. 00 | | | | | | 0 | | 1 |
| 73. 00 07300 DRUGS CHARGED TO PATIENTS 125, 968 1, 044 0 0 0 73. 00 74. 00 07400 RENAL DI ALYSI S 0 32 0 0 0 74. 00 75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 76. 00 03950 OTHER ANCI LL SRVC 0 0 0 0 0 76. 01 03951 CARDI AC AND PULMONARY REHAB 0 7 0 0 0 76. 02 03952 WOUND CARE 0 1 0 0 0 76. 02 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON 0 0 0 77. 00 OUTPATIENT SERVI CE COST CENTERS 88. 00 08800 RURAL HEALTH CLINI C 0 0 0 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 89. 00 0 0 0 89. 00 0 0 0 89. 00 0 0 0 89. 00 0 0 89. 00 0 0 0 89. 00 0 89. 00 0 0 89. 00 89. 00 0 | | | o | 723 | 0 | o | | 71. 00 |
| 74. 00 | | | 0 | | | 0 | | 1 |
| 75. 00 | | | 125, 968 | • | | 0 | | 1 |
| 76. 00 | | | | 32 0 | | 0 | | |
| 76. 02 03952 WOUND CARE 0 1 0 0 76. 02 77. 00 07700 ALLOGENEI C STEM CELL ACQUISITION 0 0 0 0 0 77. 00 OUTPATIENT SERVICE COST CENTERS 88. 00 08900 RURAL HEALTH CLINIC 0 0 0 0 88. 00 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 89. 00 | | | | Ö | Ö | o o | | |
| 77. 00 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON 0 0 0 0 0 0 0 0 0 | | | 0 | 7 | 0 | 0 | | 1 |
| OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 0 0 88.00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 89.00 | | 1 | 0 | 1 | | _ | | 1 |
| 88. 00 08800 RURAL HEALTH CLINIC 0 0 0 0 88. 00 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 89. 00 | 77.00 | | 0 | 0 | 1 0 | 0 | | , //. UU |
| | | 08800 RURAL HEALTH CLINIC | O | 0 | 0 | 0 | | |
| 90. 00 09000 CETNIC 0 0 0 90. 00 | | | 0 | | | _ | | 1 |
| | 90.00 | UAOOO CELINI C | <u> </u> | 0 | 1 0 | <u> </u> | <u> </u> | J 90.00 |

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

| | | | T | o 12/31/2021 | Date/Time Pre 5/31/2022 7:5 | |
|--|----------|------------------|----------------|----------------|-----------------------------|--------------------|
| | | | | OTHER GENERAL | 373172022 7.3 | 7 (111) |
| | | | | SERVI CE | | |
| Cost Center Description | PHARMACY | | SOCIAL SERVICE | OTHER GEN SERV | | |
| | | RECORDS & | | | ANESTHETI STS | |
| | 15.00 | LI BRARY | 17.00 | 10.00 | 10.00 | |
| 90. 01 09001 CLI NI C | 15. 00 | 16. 00 1, 040 | 17. 00 | 18. 00 | 19.00 | 90. 01 |
| 90. 02 09002 CLI NI C | | 220 | | 0 | | 90.01 |
| 91. 00 09100 EMERGENCY | | 1, 517 | | 0 | | 91.00 |
| 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | | 1, 517 | | J | | 92.00 |
| OTHER REIMBURSABLE COST CENTERS | | | l | | | 72.00 |
| 94. 00 09400 HOME PROGRAM DIALYSIS | 0 | 0 | 0 | 0 | | 94. 00 |
| 95. 00 09500 AMBULANCE SERVICES | O | 0 | 0 | 0 | | 95. 00 |
| 96.00 09600 DURABLE MEDICAL EQUIP-RENTED | O | 0 | 0 | 0 | | 96. 00 |
| 97.00 09700 DURABLE MEDICAL EQUIP-SOLD | 0 | 0 | 0 | 0 | | 97. 00 |
| 98. 00 09850 OTHER REI MBURSE | 0 | 0 | 0 | 0 | | 98. 00 |
| 99. 00 09900 CMHC | 0 | 0 | 0 | 0 | | 99. 00 |
| 99. 10 09910 CORF | 0 | 0 | 0 | 0 | | 99. 10 |
| 100.00 10000 I&R SERVICES-NOT APPRVD PRGM | 0 | 0 | 0 | 0 | | 100. 00 |
| 101.00 10100 HOME HEALTH AGENCY | 0 | 0 | 0 | 0 | <u> </u> | 101. 00 |
| SPECIAL PURPOSE COST CENTERS | | | | | | 405 00 |
| 105. 00 10500 KI DNEY ACQUI SI TI ON | 0 | 0 | 0 | 0 | | 105. 00 |
| 106.00 10600 HEART ACQUISITION 107.00 10700 LIVER ACQUISITION | 0 | 0 | 0 | 0 | | 106. 00 107. 00 |
| 107. 00 10700 ELIVER ACQUISITION 108. 00 10800 LUNG ACQUISITION | | 0 | 0 | 0 | | 107.00 |
| 109. 00 10900 PANCREAS ACQUISITION | | 0 | | 0 | | 109.00 |
| 110. 00 11000 NTESTI NAL ACQUI SI TI ON | | 0 | 0 | 0 | | 110, 00 |
| 111. 00 11100 SLET ACQUI SI TI ON | | 0 | 0 | 0 | | 111.00 |
| 113. 00 11300 NTEREST EXPENSE | | O | Ĭ | J | | 113. 00 |
| 114. 00 11400 UTI LI ZATI ON REVI EW-SNF | | | | | | 114. 00 |
| 115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.) | o | 0 | 0 | 0 | | 115. 00 |
| 116. 00 11600 HOSPI CE | O | 0 | 0 | 0 | | 116. 00 |
| 118.00 SUBTOTALS (SUM OF LINES 1 through 117) | 125, 968 | 17, 908 | 0 | 0 | 0 | 118. 00 |
| NONREI MBURSABLE COST CENTERS | | | | | | |
| 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN | 0 | 0 | 0 | 0 | | 190. 00 |
| 191. 00 19100 RESEARCH | 0 | 0 | 0 | 0 | | 191. 00 |
| 192.00 19200 PHYSICIANS' PRIVATE OFFICES | 0 | 0 | 0 | 0 | | 192. 00 |
| 192. 01 19201 CENTER OF HOPE | 0 | 0 | 0 | 0 | | 192. 01 |
| 192. 02 19202 OTHER FA FACILITIES NRCC | 0 | 0 | 0 | 0 | | 192. 02 |
| 193. 00 19300 NONPAI D WORKERS | 0 | 0 | 0 | 0 | | 193. 00 |
| 194. 00 07950 OTHER NRCC | 0 | 0 | 0 | 0 | | 194. 00 |
| 200.00 Cross Foot Adjustments 201.00 Negative Cost Centers | | 0 | _ | | | 200. 00 201. 00 |
| 201.00 Negative Cost Centers 202.00 TOTAL (sum lines 118 through 201) | 125, 968 | 17, 908 | | 0 | | 201.00 |
| 202. 00 TOTAL (Suil TITIES TTO LIII OUGH 201) | 120, 908 | 17, 908 | 1 | ١ | , 0 | 1202.00 |

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2021 Part II
To 12/31/2021 Date/Time Prepared: 5/31/2022 7:54 am Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0165

| | | | | 10 |) 12/31/2021 | 5/31/2022 7:5 | |
|------------------|--|----------|----------------|-----------------|--------------|----------------------|------------------|
| | | | INTERNS & | RESI DENTS | | | |
| | Cost Center Description | NURSI NG | SEDVICES SALAD | SERVI CES-OTHER | PARAMED ED | Subtotal | |
| | cost center bescription | PROGRAM | Y & FRINGES | PRGM COSTS | PRGM | Subtotal | |
| | | 20.00 | 21.00 | 22. 00 | 23. 00 | 24.00 | |
| 4 00 | GENERAL SERVICE COST CENTERS | I | Ι | 1 | | | 1 00 |
| 1. 00 2. 00 | 00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP | | | | | | 1. 00 2. 00 |
| 4.00 | 00400 EMPLOYEE BENEFITS DEPARTMENT | | | | | | 4.00 |
| 5. 00 | 00500 ADMINISTRATIVE & GENERAL | | | | | | 5. 00 |
| 6.00 | 00600 MAINTENANCE & REPAIRS | | | | | | 6. 00 |
| 7.00 | 00700 OPERATION OF PLANT | | | | | | 7. 00 |
| 8.00 | 00800 LAUNDRY & LI NEN SERVI CE | | | | | | 8.00 |
| 9. 00 10. 00 | 00900 HOUSEKEEPI NG 01000 DI ETARY | | | | | | 9.00 |
| 11. 00 | 01100 CAFETERI A | | | | | | 10. 00 11. 00 |
| 12. 00 | 01200 MAINTENANCE OF PERSONNEL | | | | | | 12. 00 |
| 13. 00 | 01300 NURSING ADMINISTRATION | | | | | | 13. 00 |
| 14. 00 | 01400 CENTRAL SERVICES & SUPPLY | | | | | | 14. 00 |
| 15.00 | 01500 PHARMACY | | | | | | 15. 00 |
| 16. 00 17. 00 | 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE | | | | | | 16. 00 17. 00 |
| 18. 00 | 01850 OTHER GEN SERV | | | | | | 18. 00 |
| 19. 00 | 01900 NONPHYSICIAN ANESTHETISTS | | | | | | 19. 00 |
| 20.00 | 02000 NURSI NG PROGRAM | 0 | | | | | 20. 00 |
| 21. 00 | 02100 I &R SERVICES-SALARY & FRINGES APPRVD | | 0 | | | | 21. 00 |
| 22. 00 | 02200 I &R SERVI CES-OTHER PRGM COSTS APPRVD | | | 0 | | | 22. 00 |
| 23. 00 | 02301 PARAMED ED PRGM INPATIENT ROUTINE SERVICE COST CENTERS | | | | 0 | | 23. 00 |
| 30. 00 | 03000 ADULTS & PEDIATRICS | | | | | 1, 744, 797 | 30.00 |
| 31. 00 | 03100 I NTENSI VE CARE UNI T | | | | | 385, 469 | 1 |
| 32.00 | 03200 CORONARY CARE UNIT | | | | | 0 | 32. 00 |
| 33. 00 | 03300 BURN INTENSIVE CARE UNIT | | | | | 0 | 33. 00 |
| 34.00 | 03400 SURGI CAL INTENSI VE CARE UNI T | | | | | 0 | 34. 00 |
| 40. 00 41. 00 | 04000 SUBPROVI DER - PF 04100 SUBPROVI DER - RF | | | | | 0 | 40. 00 41. 00 |
| 43. 00 | 04300 NURSERY | | | | | 0 | 43.00 |
| 44. 00 | 04400 SKILLED NURSING FACILITY | | | | | Ö | 44. 00 |
| 45.00 | 04500 NURSING FACILITY | | | | | 0 | 45. 00 |
| 46. 00 | 04600 OTHER LONG TERM CARE | | | | | 0 | 46. 00 |
| EO 00 | ANCI LLARY SERVI CE COST CENTERS | I | I | | | 407 407 | F0 00 |
| 50. 00 51. 00 | 05000 OPERATI NG ROOM 05100 RECOVERY ROOM | | | | | 687, 627 282, 287 | 50. 00 51. 00 |
| 52. 00 | 05200 DELIVERY ROOM & LABOR ROOM | | | | | 0 | 52.00 |
| 53. 00 | 05300 ANESTHESI OLOGY | | | | | 4, 895 | ı |
| 54.00 | 05400 RADI OLOGY-DI AGNOSTI C | | | | | 314, 143 | 54. 00 |
| 55. 00 | 05500 RADI OLOGY-THERAPEUTI C | | | | | 0 | 55. 00 |
| 56.00 | 05600 RADI OI SOTOPE | | | | | 10.035 | 56.00 |
| 57. 00 58. 00 | 05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI) | | | | | 10, 935 15, 656 | 1 |
| 59. 00 | 05900 CARDIAC CATHETERIZATION | | | | | 601, 304 | |
| 60.00 | 06000 LABORATORY | | | | | 149, 559 | |
| 60. 01 | 06001 BLOOD LABORATORY | | | | | 0 | 60. 01 |
| 61. 00 | 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY | | | | | | 61. 00 |
| 62.00 | 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS | | | | | 0 | 62.00 |
| 63. 00 64. 00 | 06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY | | | | | 0 | 63. 00 64. 00 |
| 65. 00 | 06500 RESPIRATORY THERAPY | | | | | 64, 071 | 65.00 |
| 66. 00 | 06600 PHYSI CAL THERAPY | | | | | 3, 391 | 66.00 |
| 67. 00 | 06700 OCCUPATI ONAL THERAPY | | | | | 2, 257 | 67. 00 |
| 68. 00 | 06800 SPEECH PATHOLOGY | | | | | 768 | |
| 69.00 | 06900 ELECTROCARDI OLOGY | | | | | 6, 394 | 1 |
| 70. 00 71. 00 | 07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | | | | | 264, 835 67, 173 | |
| 71.00 | 07200 I MPL. DEV. CHARGED TO PATIENTS | | | | | 56, 597 | 1 |
| 73. 00 | 07300 DRUGS CHARGED TO PATIENTS | | | | | 158, 450 | |
| 74. 00 | 07400 RENAL DIALYSIS | | | | | 32 | 1 |
| 75. 00 | 07500 ASC (NON-DISTINCT PART) | | | | | 0 | 75. 00 |
| 76. 00 | 03950 OTHER ANCILL SRVC | | | | | 0 | 76.00 |
| 76. 01 | 03951 CARDI AC AND PULMONARY REHAB | | | | | 2, 787 | 1 |
| 76. 02 77. 00 | 03952 WOUND CARE 07700 ALLOGENEIC STEM CELL ACQUISITION | | | | | 75 0 | 1 |
| , , . 00 | OUTPATIENT SERVICE COST CENTERS | 1 | 1 | 1 | | | 1 , , . 50 |
| 88. 00 | | | | | | 0 | 88. 00 |
| 89. 00 | 08900 FEDERALLY QUALIFIED HEALTH CENTER | | | | | 0 | 89. 00 |
| 90.00 | 09000 CLINIC | | | | | 0 | 90.00 |
| 90. 01 | 09001 CLI NI C | <u> </u> | I | l l | | 27, 451 | 90. 01 |

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0165

| | | | To | 12/31/2021 | Date/Time Pre | pared: |
|--|----------|-----------------|-----------------|------------|---------------|---------|
| | | INTERNS & | RESI DENTS | | 3/31/2022 7.3 | 4 alli |
| | | | | | | |
| Cost Center Description | NURSI NG | SERVI CES-SALAR | SERVI CES-OTHER | PARAMED ED | Subtotal | |
| | PROGRAM | Y & FRINGES | PRGM COSTS | PRGM | | |
| | 20.00 | 21. 00 | 22. 00 | 23. 00 | 24.00 | |
| 90. 02 09002 CLI NI C | | | | | 48, 284 | 90. 02 |
| 91. 00 09100 EMERGENCY | | | | | 392, 543 | |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | | | | | | 92. 00 |
| OTHER REIMBURSABLE COST CENTERS | | | | | | |
| 94.00 09400 HOME PROGRAM DIALYSIS | | | | | 0 | 94. 00 |
| 95. 00 09500 AMBULANCE SERVI CES | | | | | 0 | 95. 00 |
| 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED | | | | | 0 | 96. 00 |
| 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD | | | | | 0 | 97. 00 |
| 98. 00 09850 OTHER REI MBURSE | | | | | 0 | 98. 00 |
| 99. 00 09900 CMHC | | | | | 0 | 99. 00 |
| 99. 10 09910 CORF | | | | | 0 | 99. 10 |
| 100.00 10000 I &R SERVICES-NOT APPRVD PRGM | | | | | | 100. 00 |
| 101.00 10100 HOME HEALTH AGENCY | | | | | 0 | 101. 00 |
| SPECIAL PURPOSE COST CENTERS | | 1 | | | | |
| 105. 00 10500 KI DNEY ACQUI SI TI ON | | | | | | 105. 00 |
| 106. 00 10600 HEART ACQUI SI TI 0N | | | | | | 106. 00 |
| 107. 00 10700 LI VER ACQUI SI TI ON | | | | | | 107. 00 |
| 108. 00 10800 LUNG ACQUISITION | | | | | | 108. 00 |
| 109. 00 10900 PANCREAS ACQUISITION | | | | | | 109. 00 |
| 110. 00 11000 I NTESTI NAL ACQUI SI TI ON | | | | | | 110.00 |
| 111. 00 11100 SLET ACQUI SI TI ON | | | | | 0 | 111. 00 |
| 113. 00 11300 INTEREST EXPENSE | | | | | | 113. 00 |
| 114. 00 11400 UTI LI ZATI ON REVI EW-SNF | | | | | | 114. 00 |
| 115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.) | | | | | | 115.00 |
| 116. 00 11600 HOSPI CE | | | | | | 116. 00 |
| 118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS | (| 0 | 0 | 0 | 5, 291, 794 | 118.00 |
| 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN | | | | 1 | 425 | 190. 00 |
| 191. 00 19100 RESEARCH | | | | | | 190.00 |
| 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES | | | | | 854, 257 | |
| 192. 01 19201 CENTER OF HOPE | | | | | | 192. 00 |
| 192. 02 19202 OTHER FA FACILITIES NRCC | | | | | | 192. 01 |
| 193. 00 19300 NONPALD WORKERS | | | | | | 193. 00 |
| 194. 00 07950 OTHER NRCC | | | | | | 194. 00 |
| 200.00 Cross Foot Adjustments | (| 0 | | ٥ | | 200. 00 |
| 201.00 Negative Cost Centers | (| | 1 | ol | | 201.00 |
| 202.00 TOTAL (sum lines 118 through 201) | (| | | _ | 6, 151, 842 | |
| | ` | -1 | 1 ~ | 9 | 5, .5., 612 | |

In Lieu of Form CMS-2552-10 Health Financial Systems FRANCISCAN HEALTH MUNSTER ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0165 Peri od: Worksheet B From 01/01/2021 Part II Date/Time Prepared: 12/31/2021 5/31/2022 7:54 am Cost Center Description Intern & Total Residents Cost & Post Stepdown Adjustments 25.00 26.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 00600 MAINTENANCE & REPAIRS 6.00 6.00 00700 OPERATION OF PLANT 7.00 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10 00 10 00 01100 CAFETERI A 11.00 11.00 12. 00 01200 MAINTENANCE OF PERSONNEL 12.00 13.00 01300 NURSING ADMINISTRATION 13.00 01400 CENTRAL SERVICES & SUPPLY 14 00 14 00 15.00 01500 PHARMACY 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16.00 01700 SOCIAL SERVICE 17 00 17 00 18.00 01850 OTHER GEN SERV 18.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 19.00 02000 NURSING PROGRAM 20.00 20.00 02100 I &R SERVICES-SALARY & FRINGES APPRVD 21 00 21 00 22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 22.00 02301 PARAMED ED PRGM 23.00 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 1, 744, 797 30.00 31.00 03100 INTENSIVE CARE UNIT 385, 469 31.00 0000000 03200 CORONARY CARE UNIT 32.00 32.00 03300 BURN INTENSIVE CARE UNIT 33.00 0 33.00 03400 SURGICAL INTENSIVE CARE UNIT 34.00 0 34 00 40.00 04000 SUBPROVI DER - I PF 0 40.00 04100 SUBPROVI DER - I RF 41.00 0 41.00 43.00 04300 NURSERY 0 43.00 04400 SKILLED NURSING FACILITY 44.00 Ω 44 00 0 04500 NURSING FACILITY 45.00 45.00 04600 OTHER LONG TERM CARE 0 46.00 46.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 687, 627 50.00 51.00 05100 RECOVERY ROOM 0 282, 287 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 53.00 05300 ANESTHESI OLOGY 4 895 53.00 314, 143 54.00 05400 RADI OLOGY-DI AGNOSTI C 00000000 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 55.00 56.00 05600 RADI OI SOTOPE 56.00 57.00 05700 CT SCAN 10, 935 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 15, 656 58.00 05900 CARDI AC CATHETERI ZATI ON 59.00 601, 304 59.00 06000 LABORATORY 60.00 149, 559 60.00 60.01 06001 BLOOD LABORATORY Ω 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 62.00 00000000000000000 0 62.00 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 Ω 63.00 64.00 06400 I NTRAVENOUS THERAPY 14 64.00 06500 RESPIRATORY THERAPY 65.00 64,071 65.00 66 00 06600 PHYSI CAL THERAPY 3 391 66 00 06700 OCCUPATIONAL THERAPY 67.00 2, 257 67.00 06800 SPEECH PATHOLOGY 768 68.00 68.00 69.00 06900 ELECTROCARDI OLOGY 6, 394 69.00 70 00 07000 ELECTROENCEPHALOGRAPHY 264, 835 70 00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 67, 173 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 56, 597 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 158, 450 73.00 74.00 07400 RENAL DIALYSIS 32 74.00 75.00 07500 ASC (NON-DISTINCT PART) 0 75.00 03950 OTHER ANCILL SRVC 76.00 76.00 76.01 03951 CARDIAC AND PULMONARY REHAB 2, 787 76.01

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76.02

77.00

88.00

89.00

90.00

90. 00 09000 CLINIC

03952 WOUND CARE

07700 ALLOGENEIC STEM CELL ACQUISITION

OUTPATIENT SERVICE COST CENTERS

89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER

08800 RURAL HEALTH CLINIC

76.02

77.00

88 00

In Lieu of Form CMS-2552-10 ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0165 Peri od: Worksheet B From 01/01/2021 Part II Date/Time Prepared: 12/31/2021 5/31/2022 7:54 am Cost Center Description Intern & Total Residents Cost & Post Stepdown Adjustments 26.00 25.00 90. 01 09001 CLINIC 27, 451 90.01 09002 CLI NI C 0 90. 02 48, 284 90.02 91.00 09100 EMERGENCY 0 392, 543 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0 94.00 09500 AMBULANCE SERVICES 0 0 0 0 0 95.00 95.00 0 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 96.00 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD 0 97.00 98. 00 | 09850 OTHER REIMBURSE 0 98.00 09900 CMHC 99.00 0 99.00 99. 10 09910 CORF 0 99. 10 0 100.00 10000 I &R SERVICES-NOT APPRVD PRGM 0 100.00 101.00 10100 HOME HEALTH AGENCY 101 00 0 SPECIAL PURPOSE COST CENTERS 105.00 10500 KIDNEY ACQUISITION 0 105. 00 0000000 106. 00 10600 HEART ACQUISITION 0 106. 00 107.00 10700 LIVER ACQUISITION 107. 00 0 108.00 10800 LUNG ACQUISITION 0 108.00 109.00 10900 PANCREAS ACQUISITION 0 109. 00 110.00 11000 INTESTINAL ACQUISITION 0 110 00 111.00 11100 I SLET ACQUISITION C 111. 00 113.00 11300 INTEREST EXPENSE 113. 00 114.00 11400 UTI LI ZATI ON REVI EW-SNF 114. 00 115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 0 115. 00 116. 00 11600 HOSPI CE 0 116. 00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 5, 291, 794 118.00 NONREI MBURSABLE COST CENTERS 190. 00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 625 191. 00 19100 RESEARCH 0 0 0 0 0 0 0 191. 00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 854, 257 192. 00 192. 01 19201 CENTER OF HOPE 192. 02 19202 OTHER FA FACILITIES NRCC 192. 01 4, 905 192. 02 193. 00 19300 NONPALD WORKERS 193. 00 194.00 07950 OTHER NRCC 194. 00 254 Cross Foot Adjustments 200.00 200.00 C

6, 151, 842

201. 00

202.00

201.00

202.00

Negative Cost Centers

TOTAL (sum lines 118 through 201)

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0165 Peri od: Worksheet B-1 From 01/01/2021 12/31/2021 Date/Time Prepared: 5/31/2022 7:54 am CAPITAL RELATED COSTS BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Reconciliation ADMINISTRATIVE Cost Center Description (SQUARE FEET) (SQUARE FEET) BENEFITS & GENERAL (ACCUM. COST) DEPARTMENT (GROSS SALARI ES) 1.00 2.00 5. 00 4.00 5A GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 178 609 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 178, 609 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 2, 281 2, 281 44, 187, 692 4.00 00500 ADMINISTRATIVE & GENERAL 21, 923 92, 997, 381 5 00 21, 923 10, 426, 700 -15, 111, 631 5 00 6.00 6.00 00600 MAINTENANCE & REPAIRS 0 724, 597 11, 231, 192 7.00 00700 OPERATION OF PLANT 0 7.00 00800 LAUNDRY & LINEN SERVICE 0 0 122, 619 8.00 8.00 0 216, 168 00900 HOUSEKEEPI NG 1, 237, 369 9 00 803.302 0 0 9 00 10.00 01000 DI ETARY 7,878 7,878 224, 413 337, 939 10.00 01100 CAFETERI A -989, 732 11.00 0 362, 636 11.00 01200 MAINTENANCE OF PERSONNEL 12.00 12.00 0 0 01300 NURSING ADMINISTRATION 1, 899, 458 2, 965, 245 13.00 0 C 0 13 00 14.00 01400 CENTRAL SERVICES & SUPPLY 215, 292 0 552, 570 14.00 0 01500 PHARMACY 0 15.00 3,060 3,060 1, 229, 881 1, 956, 484 15.00 0 01600 MEDICAL RECORDS & LIBRARY 325, 949 1, 474, 819 16,00 144 144 16,00 17 00 01700 SOCIAL SERVICE 0 C C 17 00 01850 OTHER GEN SERV 0 0 0 18.00 18.00 0 0 19 00 01900 NONPHYSICIAN ANESTHETISTS 0 C 0 O 19.00 0 02000 NURSI NG PROGRAM 20.00 0 20.00 C 0 0 0 0 21.00 02100 I &R SERVICES-SALARY & FRINGES APPRVD 0 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 0 22.00 0 0 22.00 02301 PARAMED ED PRGM 23.00 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 38, 387 38, 387 9, 098, 645 0 14, 071, 376 30.00 03100 INTENSIVE CARE UNIT 0 31.00 9, 250 9, 250 1, 669, 932 2, 480, 826 31.00 0 32.00 03200 CORONARY CARE UNIT 0 0 32.00 0 03300 BURN INTENSIVE CARE UNIT 33.00 0 C 0 0 33.00 03400 SURGICAL INTENSIVE CARE UNIT 0 0 34.00 0 34.00 04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF 0 40.00 0 0 0 0 40.00 0 0 41 00 C Λ 41 00 0 43.00 04300 NURSERY 0 0 43.00 04400 SKILLED NURSING FACILITY 0 0 0 44.00 0 44.00 04500 NURSING FACILITY 45.00 45.00 0 0 04600 OTHER LONG TERM CARE 46.00 0 46.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 17, 422 17, 422 3, 705, 779 7, 379, 606 50.00 o 05100 RECOVERY ROOM 796, 428 51 00 7 643 7 643 1, 301, 037 51 00 05200 DELIVERY ROOM & LABOR ROOM 52.00 \cap 0 52.00 53.00 05300 ANESTHESI OLOGY 34, 264 0 500, 079 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 8, 100 8, 100 1, 570, 589 0 3, 083, 053 54.00 05500 RADI OLOGY-THERAPEUTI C 55 00 55 00 Ω 0 56.00 05600 RADI OI SOTOPE 0 56.00 05700 CT SCAN 0 445, 369 1, 031, 646 57.00 0 57.00 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 804, 895 1, 599, 285 58.00 0 05900 CARDIAC CATHETERIZATION 16, 455 16, 455 2, 299, 401 59 00 1, 106, 968 59 00 60.00 06000 LABORATORY 2,828 2,828 0 5, 780, 465 60.00 C 06001 BLOOD LABORATORY 60.01 0 60.01 0 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 62 00 0 C 0 0 62.00 0 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 63.00 0 06400 I NTRAVENOUS THERAPY 0 64.00 64.00 0 06500 RESPIRATORY THERAPY 1,073,705 1, 499, 162 65 00 1, 409 1, 409 65 00 0 66.00 06600 PHYSI CAL THERAPY 268, 773 340, 165 66.00 225, 091 06700 OCCUPATIONAL THERAPY 0 67.00 0 177, 250 67.00 0 06800 SPEECH PATHOLOGY 68.00 0 0 60, 415 76, 625 68.00 06900 ELECTROCARDI OLOGY 390, 993 69.00 0 613, 823 69 00 07000 ELECTROENCEPHALOGRAPHY 7, 191 421, 687 0 0 0 1, 357, 558 70.00 70.00 7, 191 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71 00 7, 389, 136 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 6, 709, 178 72.00 0 0 72.00 0 07300 DRUGS CHARGED TO PATIENTS 0 73.00 C 0 3, 779, 008 73.00 07400 RENAL DIALYSIS 0 74.00 74.00 07500 ASC (NON-DISTINCT PART) 0 75.00 0 0 0 75.00 0 03950 OTHER ANCILL SRVC 76.00 C 0 0 76.00 76.01 03951 CARDIAC AND PULMONARY REHAB 0 224, 311 0 286, 171 76.01 76.02 03952 WOUND CARE 0 3,774 0 8,078 76.02 07700 ALLOGENEIC STEM CELL ACQUISITION 77.00 77.00 0 OUTPATIENT SERVICE COST CENTERS 0 88.00 08800 RURAL HEALTH CLINIC 0 0 0 0 88.00 Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0165 | Peri od: | From 01/01/2021 | To 12/31/2021 | Date/Ti me Prepared:

| | | | | Т | o 12/31/2021 | Date/Time Pre 5/31/2022 7:5 | |
|--------------------------|--|---------------|---------------|----------------------|----------------|-----------------------------|--------------------|
| | | CAPITAL REL | ATED COSTS | | | 3/31/2022 7.3 | 4 8111 |
| | Cost Center Description | BLDG & FIXT | MVBLE EQUIP | EMPLOYEE | Reconciliation | ADMI NI STRATI VE | |
| | | (SQUARE FEET) | (SQUARE FEET) | BENEFITS | | & GENERAL | |
| | | | | DEPARTMENT (GROSS | | (ACCUM. COST) | |
| | | | | SALARI ES) | | | |
| | , | 1.00 | 2. 00 | 4.00 | 5A | 5. 00 | |
| | FEDERALLY QUALIFIED HEALTH CENTER | 0 | 0 | | | 0 | |
| | CLINIC CLINIC | 0 | 0 | | | 0 7/4 500 | 90. 00 90. 01 |
| | CLINIC | 1, 207 | 0 1, 207 | | | 2, 764, 589 570, 949 | 90.01 |
| | EMERGENCY | 9, 900 | | | | 4, 268, 642 | • |
| | OBSERVATION BEDS (NON-DISTINCT PART) | | | , , , , , | | , | 92.00 |
| | R REIMBURSABLE COST CENTERS | | | | 1 | | |
| | HOME PROGRAM DIALYSIS | 0 | | | | l e | |
| | AMBULANCE SERVICES DURABLE MEDICAL EQUIP-RENTED | 0 | 0 | | | 0 0 | 95. 00 96. 00 |
| | DURABLE MEDICAL EQUIP-SOLD | 0 | 0 | | | 0 | • |
| | OTHER REIMBURSE | 0 | Ö | | | Ö | 98. 00 |
| | CMHC | 0 | 0 | C | 0 | 0 | |
| | CORF | 0 | 0 | | | 0 | 99. 10 |
| | I&R SERVICES-NOT APPRVD PRGM | 0 | 0 | | | | 100.00 |
| | AL PURPOSE COST CENTERS | 0 | 0 | | 0 | 0 | 101. 00 |
| | KIDNEY ACQUISITION | 0 | 0 | С | 0 | 0 | 105. 00 |
| | HEART ACQUISITION | 0 | 0 | C | 0 | | 106. 00 |
| | LIVER ACQUISITION | 0 | 0 | 1 | _ | | 107. 00 |
| | LUNG ACQUISITION | 0 | 0 | | 0 | | 108.00 |
| | PANCREAS ACQUISITION INTESTINAL ACQUISITION | 0 | 0 | | 0 | | 109. 00 110. 00 |
| | I SLET ACQUISITION | 0 | 0 | | 0 | | 111.00 |
| | I NTEREST EXPENSE | | _ | | _ | | 113. 00 |
| | UTILIZATION REVIEW-SNF | | | | | | 114. 00 |
| | AMBULATORY SURGICAL CENTER (D. P.) | 0 | 0 | C | 0 | l . | 115. 00 |
| 116. 00 11600 118. 00 | SUBTOTALS (SUM OF LINES 1 through 117) | 155, 078 | 0 155, 078 | 42, 325, 666 | 14 101 242 | | 116. 00 |
| | I MBURSABLE COST CENTERS | 155,076 | 155,076 | 42, 323, 000 | -16, 101, 363 | 07, 300, 733 | 1110.00 |
| | GIFT, FLOWER, COFFEE SHOP & CANTEEN | 0 | 0 | 30, 311 | 0 | 68, 671 | 190. 00 |
| 191. 00 19100 | | 0 | 0 | | | | 191. 00 |
| | PHYSICIANS' PRIVATE OFFICES | 23, 531 | 23, 531 | | | 2, 985, 098 | 1 |
| | CENTER OF HOPE OTHER FA FACILITIES NRCC | 0 | 0 | | 0 | l e | 192. 01 |
| | NONPALD WORKERS | 0 | 0 | | 0 | 530, 036 | 192. 02 |
| | OTHER NRCC | 0 | Ö | 1 | 0 | 26, 092 | |
| 200. 00 | Cross Foot Adjustments | | | · | | | 200. 00 |
| 201.00 | Negative Cost Centers | | | | | | 201. 00 |
| 202. 00 | Cost to be allocated (per Wkst. B, | 6, 151, 842 | 0 | 11, 597, 135 | | 15, 111, 631 | 202. 00 |
| 203. 00 | Part Unit cost multiplier (Wkst. B, Part) | 34. 443068 | 0. 000000 | 0. 262452 | | 0. 162495 | 203 00 |
| 204. 00 | Cost to be allocated (per Wkst. B, | 5 1. 443000 | 0.000000 | 78, 565 | | 773, 632 | |
| | Part II) | | | ., | | | |
| 205. 00 | Unit cost multiplier (Wkst. B, Part | | | 0. 001778 | | 0. 008319 | 205. 00 |
| 206. 00 | II) NAHE adjustment amount to be allocated | | | | | | 206. 00 |
| | (per Wkst. B-2) | | | | | | |
| 207. 00 | NAHE unit cost multiplier (Wkst. D, | | | | | | 207. 00 |
| Ţ | Parts III and IV) | | l | l | | l | l |

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS In Lieu of Form CMS-2552-10
Worksheet B-1 Provider CCN: 15-0165

| | | | | To | 12/31/2021 | Date/Time Pre 5/31/2022 7:5 | |
|------------------|--|--------------------------|------------------------|-----------------------------|-------------------|-----------------------------|------------------|
| | Cost Center Description | MAINTENANCE & | OPERATION OF | LAUNDRY & | HOUSEKEEPI NG | DI ETARY | |
| | | REPAIRS (SQUARE FEET) | PLANT (SQUARE FEET) | LINEN SERVICE (POUNDS OF | (SQUARE FEET) | (MEALS SERVED) | |
| | | (00 | 7.00 | LAUNDRY) | 0.00 | 10.00 | |
| | GENERAL SERVICE COST CENTERS | 6. 00 | 7. 00 | 8. 00 | 9. 00 | 10.00 | |
| 1.00 | 00100 CAP REL COSTS-BLDG & FIXT | | | | | | 1. 00 |
| 2. 00 4. 00 | OO200 CAP REL COSTS-MVBLE EQUIP OO400 EMPLOYEE BENEFITS DEPARTMENT | | | | | | 2. 00 4. 00 |
| 5. 00 | 00500 ADMINISTRATIVE & GENERAL | | | | | | 5. 00 |
| 6. 00 | 00600 MAINTENANCE & REPAIRS | 154, 405 | l e | | | | 6. 00 |
| 7. 00 8. 00 | OO700 OPERATION OF PLANT OO800 LAUNDRY & LINEN SERVICE | 0 | 154, 405 0 | | | | 7. 00 8. 00 |
| 9. 00 | 00900 HOUSEKEEPI NG | 0 | 0 | 0 | 154, 405 | | 9. 00 |
| 10.00 | 01000 DI ETARY | 7, 878 | 7, 878 | 0 | 7, 878 | | 10.00 |
| 11. 00 12. 00 | O1100 CAFETERI A O1200 MAI NTENANCE OF PERSONNEL | 0 | | 0 | 0 | 0 | 11. 00 12. 00 |
| 13.00 | 01300 NURSI NG ADMI NI STRATI ON | 0 | 0 | 0 | 0 | 0 | 13. 00 |
| 14. 00 15. 00 | O1400 CENTRAL SERVI CES & SUPPLY O1500 PHARMACY | 3, 060 | 0 2 040 | 0 | 3 040 | 1 | 14. 00 15. 00 |
| 16. 00 | 01600 MEDI CAL RECORDS & LI BRARY | 144 | 3, 060 144 | | 3, 060 144 | | 16. 00 |
| 17. 00 | 01700 SOCIAL SERVICE | 0 | 0 | _ | 0 | 1 | 17. 00 |
| 18. 00 19. 00 | O1850 OTHER GEN SERV O1900 NONPHYSI CI AN ANESTHETI STS | 0 | 0 | 0 | 0 | 0 | 18. 00 19. 00 |
| 20. 00 | 02000 NURSI NG PROGRAM | 0 | Ö | 0 | 0 | 0 | 20. 00 |
| 21. 00 | 02100 I &R SERVICES-SALARY & FRINGES APPRVD | 0 | 0 | 0 | 0 | 0 | 21.00 |
| 22. 00 23. 00 | O2200 I &R SERVI CES-OTHER PRGM COSTS APPRVD O2301 PARAMED ED PRGM | 0 | 0 | 0 | 0 | 0 | 22. 00 23. 00 |
| 20.00 | INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | 20.00 |
| 30.00 | 03000 ADULTS & PEDIATRICS | 38, 387 | 38, 387 | | 38, 387 | | 30.00 |
| 31. 00 32. 00 | 03100 INTENSIVE CARE UNIT 03200 CORONARY CARE UNIT | 9, 250 | 9, 250 0 | 36, 468 0 | 9, 250 0 | | 31. 00 32. 00 |
| 33. 00 | 03300 BURN INTENSIVE CARE UNIT | 0 | 0 | 0 | 0 | 0 | 33. 00 |
| 34. 00 40. 00 | 03400 SURGICAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF | 0 | 0 | 0 | 0 | 0 | 34. 00 40. 00 |
| 41. 00 | 04100 SUBPROVI DER - I RF | 0 | Ö | 0 | 0 | 0 | 41. 00 |
| 43. 00 | 04300 NURSERY | 0 | 0 | 0 | 0 | 0 | 43. 00 |
| 44. 00 45. 00 | 04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY | 0 | 0 | 0 | 0 | 0 | 44. 00 45. 00 |
| 46. 00 | 04600 OTHER LONG TERM CARE | 0 | Ö | | Ö | - | 46. 00 |
| EO 00 | ANCILLARY SERVICE COST CENTERS O5000 OPERATING ROOM | 17 422 | 17 422 | 0 | 17 422 | I 0 | E0 00 |
| 50. 00 51. 00 | 05100 RECOVERY ROOM | 17, 422 7, 643 | 17, 422 7, 643 | | 17, 422 7, 643 | | 50. 00 51. 00 |
| 52. 00 | 05200 DELIVERY ROOM & LABOR ROOM | 0 | 0 | 1 | 0 | | 52. 00 |
| 53. 00 54. 00 | 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C | 0 8, 100 | 0 8, 100 | 0 | 0 8, 100 | 0 | 53. 00 54. 00 |
| 55. 00 | 05500 RADI OLOGY-THERAPEUTI C | 0, 100 | 0, 100 | Ö | 0, 100 | ő | 55. 00 |
| 56.00 | 05600 RADI OI SOTOPE | 0 | 0 | 0 | 0 | 0 | 56.00 |
| 57. 00 58. 00 | 05700 CT SCAN 05800 MAGNETIC RESONANCE I MAGING (MRI) | 0 | | 0 | 0 | 0 | 57. 00 58. 00 |
| 59. 00 | 05900 CARDI AC CATHETERI ZATI ON | 16, 455 | 16, 455 | | 16, 455 | 0 | 59. 00 |
| 60.00 | 06000 LABORATORY | 2, 828 | 2, 828 | 0 | 2, 828 | | 60.00 |
| 60. 01 61. 00 | 06001 BLOOD LABORATORY 06100 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY | 0 | 0 | U | 0 | 0 | 60. 01 61. 00 |
| 62. 00 | 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS | 0 | 0 | 0 | 0 | 0 | 62. 00 |
| 63. 00 64. 00 | 06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY | 0 | 0 | 0 | 0 | 0 | 63. 00 64. 00 |
| 65. 00 | 06500 RESPIRATORY THERAPY | 1, 409 | 1, 409 | Ö | 1, 409 | | 65. 00 |
| 66.00 | 06600 PHYSI CAL THERAPY | 0 | 0 | 0 | 0 | 0 | 66.00 |
| 67. 00 68. 00 | O6700 OCCUPATI ONAL THERAPY O6800 SPEECH PATHOLOGY | 0 | | 0 | 0 | 0 | 67. 00 68. 00 |
| 69. 00 | 06900 ELECTROCARDI OLOGY | 0 | 0 | 0 | 0 | 0 | 69. 00 |
| 70. 00 71. 00 | 07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 7, 191 | 7, 191 | 0 | 7, 191 | 0 | 70. 00 71. 00 |
| 71.00 | 07200 I MPL. DEV. CHARGED TO PATIENTS | 0 | 0 | 0 | 0 | 0 | 71.00 |
| 73. 00 | 07300 DRUGS CHARGED TO PATIENTS | 0 | 0 | 0 | 0 | 0 | 73. 00 |
| 74. 00 75. 00 | 07400 RENAL DI ALYSI S 07500 ASC (NON-DI STI NCT PART) | 0 | 0 | 0 | 0 | 0 | 74. 00 75. 00 |
| 76. 00 | 03950 OTHER ANCILL SRVC | 0 | 0 | o o | 0 | o o | 76. 00 |
| 76. 01 | 03951 CARDI AC AND PULMONARY REHAB | 0 | 0 | 0 | 0 | 0 | 76. 01 |
| | 03952 WOUND CARE 07700 ALLOGENEIC STEM CELL ACQUISITION | 0 | | 0 | 0 | 0 | 76. 02 77. 00 |
| | OUTPATIENT SERVICE COST CENTERS | | | | | | |
| 88. 00 89. 00 | 08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER | 0 | 0 | 0 | 0 | 0 | 88. 00 89. 00 |
| | 09000 CLINIC | 0 | 0 | 0 | 0 | 0 | 90.00 |
| 90. 01 | 09001 CLI NI C | 0 | 0 | 0 | 0 | 0 | 90. 01 |
| | | | | | | | |

Health Financial Systems FRANCISCAN HEALTH MUNSTER In Lieu of Form CMS-2552-10 COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0165 Peri od: Worksheet B-1 From 01/01/2021 12/31/2021 Date/Time Prepared: 5/31/2022 7:54 am Cost Center Description MAINTENANCE & OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY LINEN SERVICE (SQUARE FEET) (MEALS SERVED) **REPAIRS** PLANT (SQUARE FEET) (SQUARE FEET) (POUNDS OF LAUNDRY) 10.00 6.00 9.00 7.00 8.00 90. 02 09002 CLINIC 1, 207 1, 207 0 1, 207 0 09100 EMERGENCY 9, 900 91.00 9,900 9,900 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0 09500 AMBULANCE SERVICES 0 95.00 00000 0 0 0 0 09600 DURABLE MEDICAL EQUIP-RENTED 0 96.00 0 0 09700 DURABLE MEDICAL EQUIP-SOLD 97.00 0 0 98.00 09850 OTHER REIMBURSE 0 0 0 0 99. 00 09900 CMHC 0 0 99. 10 09910 CORF 0 0 Ω 100.00 10000 I &R SERVICES-NOT APPRVD PRGM 0 0 C 0 0 101.00 10100 HOME HEALTH AGENCY 0 0 0 0 SPECIAL PURPOSE COST CENTERS 105. 00 10500 KI DNEY ACQUI SI TI ON 0 0 0 106.00 10600 HEART ACQUISITION 0 0 0 0 107. 00 10700 LIVER ACQUISITION 0 0 0 0 108.00 10800 LUNG ACQUISITION 0 109.00 10900 PANCREAS ACQUISITION 0 110.00 11000 INTESTINAL ACQUISITION 0 0 0 111.00 11100 I SLET ACQUISITION 0

| | Financial Systems LLOCATION - STATISTICAL BASIS | FRANCI SCAN HEA | Provi der | CCN | 15_0165 P | <u> </u> | u of Form CMS-2 Worksheet B-1 | 2552-10 |
|------------------|---|-----------------|--------------------|------|--------------------|-------------------|----------------------------------|------------------|
| C031 F | ELECTION - STATISTICAL BASIS | | Frovider | CCN. | | rom 01/01/2021 | Date/Time Pre | pared: |
| | Cost Center Description | CAFETERIA M | IAI NTENANCE | OF | NURSI NG | CENTRAL | 5/31/2022 7:5 PHARMACY | 4 am |
| | | (MEALS SERVED) | PERSONNEL | | MI NI STRATI ON | SERVICES & | (COSTED | |
| | | | (NUMBER HOUSED) | (D | I RECT NURS. | SUPPLY (COSTED | REQUIS.) | |
| | | 11.00 | 12.00 | - | HRS.) 13. 00 | REQUIS.) 14.00 | 15. 00 | |
| | GENERAL SERVICE COST CENTERS | 11.00 | 12.00 | | 13.00 | 14.00 | 13.00 | |
| 1. 00 2. 00 | 00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP | | | | | | | 1. 00 2. 00 |
| 4.00 | 00400 EMPLOYEE BENEFITS DEPARTMENT | | | | | | | 4. 00 |
| 5. 00 6. 00 | OO5OO ADMINISTRATIVE & GENERAL OO6OO MAINTENANCE & REPAIRS | | | | | | | 5. 00 6. 00 |
| 7.00 | 00700 OPERATION OF PLANT | | | | | | | 7.00 |
| 8. 00 9. 00 | O0800 LAUNDRY & LI NEN SERVI CE O0900 HOUSEKEEPI NG | | | | | | | 8. 00 9. 00 |
| 10. 00 11. 00 | 01000 DI ETARY 01100 CAFETERI A | 84, 484 | | | | | | 10. 00 11. 00 |
| 12.00 | 01200 MAINTENANCE OF PERSONNEL | 0 | | 0 | | | | 12. 00 |
| 13. 00 14. 00 | O1300 NURSI NG ADMI NI STRATI ON O1400 CENTRAL SERVI CES & SUPPLY | 0 | | 0 | 263, 662 0 | 100 | | 13. 00 14. 00 |
| 15. 00 | 01500 PHARMACY | 0 | | 0 | 0 | 0 | 100 | 15. 00 |
| 16. 00 17. 00 | O1600 MEDICAL RECORDS & LIBRARY O1700 SOCIAL SERVICE | 0 | | 0 | 0 | 0 | 0 | 16. 00 17. 00 |
| 18. 00 19. 00 | 01850 OTHER GEN SERV 01900 NONPHYSI CLAN ANESTHETI STS | 0 | | 0 | 0 | 0 | 0 | 18. 00 19. 00 |
| | 02000 NURSING PROGRAM | 0 | | 0 | 0 | 0 | 0 | 20.00 |
| 21. 00 22. 00 | 02100 &R SERVICES-SALARY & FRINGES APPRVD 02200 &R SERVICES-OTHER PRGM COSTS APPRVD | 0 | | 0 | 0 | = | 0 | 21. 00 22. 00 |
| | 02301 PARAMED ED PRGM | 0 | | o | 0 | | 0 | |
| 30. 00 | INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS | 74, 581 | | ol | 116, 000 | ol | 0 | 30.00 |
| 31.00 | 03100 INTENSIVE CARE UNIT | 9, 903 | | 0 | 33, 171 | 0 | 0 | 31.00 |
| 32.00 | 03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT | 0 | | 0 | 0 | 0 | 0 | 32. 00 33. 00 |
| 34. 00 40. 00 | 03400 SURGICAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF | 0 | | 0 | 0 | 0 | 0 | 34. 00 40. 00 |
| 41. 00 | 04100 SUBPROVI DER - I RF | 0 | | 0 | 0 | o | 0 | 41. 00 |
| 43. 00 44. 00 | 04300 NURSERY 04400 SKI LLED NURSI NG FACI LI TY | 0 | | 0 | 0 | 0 | 0 | 43. 00 44. 00 |
| 45. 00 | 04500 NURSING FACILITY | 0 | | 0 | 0 | 0 | 0 | 45. 00 |
| 46. 00 | O4600 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS | 0 | | U] | 0 | 0 | 0 | 46. 00 |
| 50. 00 51. 00 | 05000 OPERATING ROOM 05100 RECOVERY ROOM | 0 | | 0 | 45, 271 11, 622 | | 0 | |
| 52.00 | 05200 DELIVERY ROOM & LABOR ROOM | 0 | | 0 | 0 | | 0 | 52. 00 |
| 53. 00 54. 00 | 05300 ANESTHESI OLOGY 05400 RADI OLOGY - DI AGNOSTI C | 0 | | 0 | 97 | 0 | 0 | 53. 00 54. 00 |
| 55.00 | 05500 RADI OLOGY-THERAPEUTI C | 0 | | 0 | 0 | 0 | 0 | 55. 00 |
| 57. 00 | 05600 RADI 01 SOTOPE | 0 | | 0 | 85 | 0 | 0 | 56. 00 57. 00 |
| 58. 00 59. 00 | 05800 MAGNETIC RESONANCE I MAGING (MRI) 05900 CARDIAC CATHETERIZATION | 0 | | 0 | 0 13, 481 | 0 | 0 | 58. 00 59. 00 |
| 60.00 | 06000 LABORATORY | 0 | | O | 0 | 0 | 0 | 60.00 |
| 60. 01 61. 00 | 06001 BLOOD LABORATORY 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY | | | 0 | 0 | 0 | 0 | 60. 01 61. 00 |
| 62. 00 63. 00 | 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06300 BLOOD STORING, PROCESSING & TRANS. | 0 | | 0 | 0 | 0 | 0 | 62. 00 63. 00 |
| 64.00 | 06400 I NTRAVENOUS THERAPY | 0 | | 0 | 0 | 0 | 0 | 64. 00 |
| 65. 00 66. 00 | 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY | 0 | | 0 | 0 | 0 | 0 | 65. 00 66. 00 |
| 67. 00 | 06700 OCCUPATI ONAL THERAPY | 0 | | 0 | 0 | 0 | 0 | 67. 00 |
| 68. 00 69. 00 | O6800 SPEECH PATHOLOGY O6900 ELECTROCARDI OLOGY | 0 | | 0 | 37 | 0 | 0 | 68. 00 69. 00 |
| 70.00 | 07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | | 0 | 0 | 0 100 | 0 | 70. 00 71. 00 |
| 72.00 | 07200 IMPL. DEV. CHARGED TO PATIENTS | | | 0 | 0 | 0 | 0 | |
| | 07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS | 0 | | 0 | 0 | 0 | 100 0 | |
| 75.00 | 07500 ASC (NON-DISTINCT PART) | 0 | | O | 0 | 0 | 0 | 75. 00 |
| 76. 00 76. 01 | 03950 OTHER ANCILL SRVC 03951 CARDIAC AND PULMONARY REHAB | 0 | | 0 | 0 | 0 | 0 | 76. 00 76. 01 |
| 76. 02 | 03952 WOUND CARE | 0 | | 0 | 0 | 0 | 0 | 76. 02 |
| 11.00 | 07700 ALLOGENEIC STEM CELL ACQUISITION OUTPATIENT SERVICE COST CENTERS | 0 | | U | 0 | 0 | 0 | 77. 00 |
| | 08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER | 0 | | 0 | 0 | | 0 | |
| | 09000 CLINIC | | | 0 | 0 | | 0 | |
| | | | | | | | | |

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0165 Peri od: Worksheet B-1 From 01/01/2021 12/31/2021 Date/Time Prepared: 5/31/2022 7:54 am Cost Center Description CAFETERI A MAINTENANCE OF NURSI NG CENTRAL **PHARMACY** (MEALS SERVED) PERSONNEL ADMI NI STRATI ON SERVICES & (COSTED (NUMBER **SUPPLY** REQUIS.) (DIRECT NURS HOUSED) (COSTED REQUIS.) HRS.) 12.00 15.00 11.00 13.00 14.00 90. 01 09001 CLINIC 90.01 0 4,858 90. 02 09002 CLI NI C 0 4,017 0 90.02 0 0 09100 EMERGENCY 35, 023 91.00 91.00 0 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0 0 94.00 0 0 09500 AMBULANCE SERVICES 00000 95.00 95.00 0 0 0 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 0 0 96.00 97.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 0 0 97.00 98.00 09850 OTHER REIMBURSE 0 0 98.00 0 09900 CMHC 0 99.00 99.00 C 0 99. 10 09910 CORF 0 Ω 99. 10 100.00 10000 I &R SERVICES-NOT APPRVD PRGM 0 0 100.00 0 0 0 101.00 10100 HOME HEALTH AGENCY 0 Ω 0 0 0 101 00 SPECIAL PURPOSE COST CENTERS 105.00 10500 KIDNEY ACQUISITION 0 0 105. 00 000000 0 0 106. 00 10600 HEART ACQUISITION 0 0 106, 00 Ω 0 107. 00 10700 LIVER ACQUISITION 0 0 107, 00 108.00 10800 LUNG ACQUISITION 0 0 0 108. 00 109.00 10900 PANCREAS ACQUISITION 0 0 0 109. 00 110.00 11000 INTESTINAL ACQUISITION 0 0 0 110.00 Ω 111.00 11100 | SLET ACQUISITION 0 0 0 0 111.00 113.00 11300 INTEREST EXPENSE 113. 00 114.00 11400 UTILIZATION REVIEW-SNF 114. 00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 Ω 0 0 0 115.00 116. 00 11600 HOSPI CE 0 0 116.00 100 SUBTOTALS (SUM OF LINES 1 through 117) 263, 662 100 118.00 84, 484 NONREI MBURSABLE COST CENTERS 0 190, 00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN Ω 0 191. 00 19100 RESEARCH 0 0 0 0 0 191. 00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 0 192. 00 0 0 192. 01 19201 CENTER OF HOPE 0 0 0 192. 01 192.02 19202 OTHER FA FACILITIES NRCC 0 0 0 192. 02 Ω 193. 00 19300 NONPALD WORKERS 0 0 0 0 193.00 194.00 07950 OTHER NRCC 0 0 0 194.00 0 Cross Foot Adjustments 200. 00 200.00 201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, 989, 732 3, 447, 082 642, 360 2, 561, 658 202. 00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 0.000000 13.073867 6, 423. 600000 | 25, 616. 580000 | 203. 00 11 715023 204.00 Cost to be allocated (per Wkst. B, 645 28, 045 4, 980 125, 968 204. 00 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 0.007635 0.000000 0.106367 49. 800000 1, 259. 680000 205. 00 11) 206.00 206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) NAHE unit cost multiplier (Wkst. D, 207.00 207.00

Parts III and IV)

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0165 Peri od: Worksheet B-1 From 01/01/2021 12/31/2021 Date/Time Prepared: 5/31/2022 7:54 am OTHER GENERAL SERVI CE MEDI CAL SOCIAL SERVICE OTHER GEN SERV NONPHYSI CI AN NURSI NG Cost Center Description RECORDS & **ANESTHETISTS PROGRAM** (TIME SPENT) (ASSI GNED (ASSI GNED LI BRARY (TIME SPENT) (GROSS TIME) TIME) CHARGES) 17. 00 18.00 19. 00 20.00 16, 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 00500 ADMINISTRATIVE & GENERAL 5 00 5 00 6.00 00600 MAINTENANCE & REPAIRS 6.00 7.00 00700 OPERATION OF PLANT 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 00900 HOUSEKEEPI NG 9 00 9 00 10.00 01000 DI ETARY 10.00 01100 CAFETERI A 11.00 11.00 01200 MAINTENANCE OF PERSONNEL 12.00 12.00 01300 NURSING ADMINISTRATION 13.00 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 01500 PHARMACY 15.00 15.00 01600 MEDICAL RECORDS & LIBRARY 507, 309, 471 16,00 16,00 17 00 01700 SOCIAL SERVICE 17 00 18.00 01850 OTHER GEN SERV 18.00 19 00 01900 NONPHYSICIAN ANESTHETISTS 0 0 19.00 02000 NURSI NG PROGRAM 20.00 0 0 0 0 20.00 οĺ 0 21.00 02100 I &R SERVICES-SALARY & FRINGES APPRVD Ω 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 0 0 22.00 0 22.00 02301 PARAMED ED PRGM 0 23.00 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 31, 142, 325 0 0 0 30.00 03100 INTENSIVE CARE UNIT 0 31.00 6, 534, 613 0 31.00 32.00 03200 CORONARY CARE UNIT 0 0 0 32.00 03300 BURN INTENSIVE CARE UNIT 0 33.00 0 C 0 33.00 03400 SURGICAL INTENSIVE CARE UNIT 0 0 0 0 34.00 0 34.00 04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF 0 40.00 0 0 0 40.00 0 0 41 00 C 0 41 00 04300 NURSERY 0 43.00 C 0 43.00 0 04400 SKILLED NURSING FACILITY 0 0 44.00 44.00 0 0 04500 NURSING FACILITY 0 45.00 45.00 0 0 04600 OTHER LONG TERM CARE 0 46.00 0 46.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 74, 320, 998 0 50.00 05100 RECOVERY ROOM 0 0 0 0 0 0 0 0 0 0 0 51 00 8 438 720 0 51 00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 0 0 52.00 53.00 05300 ANESTHESI OLOGY 19, 268, 194 0 0 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 31, 974, 264 0 0 54.00 05500 RADI OLOGY-THERAPEUTI C 0 55 00 0 55 00 0 56.00 05600 RADI OI SOTOPE 0 0 0 56.00 05700 CT SCAN 44, 331, 858 0 0 57.00 57.00 0 05800 MAGNETIC RESONANCE I MAGING (MRI) 58.00 26, 317, 000 0 0 0 58.00 05900 CARDIAC CATHETERIZATION 19, 111, 259 0 59 00 Ω 0 59 00 60.00 06000 LABORATORY 60, 454, 259 0 0 0 60.00 06001 BLOOD LABORATORY 60.01 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS Ω 0 0 62 00 0 0 62.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 63.00 06400 I NTRAVENOUS THERAPY 0 64.00 390, 389 0 64.00 06500 RESPIRATORY THERAPY 65.00 5 388 400 Ω 0 0 65.00 66.00 06600 PHYSI CAL THERAPY 2, 375, 261 0 66.00 06700 OCCUPATIONAL THERAPY 1, 977, 604 0 67.00 0 67.00 06800 SPEECH PATHOLOGY 68.00 675.643 0 0 0 68.00 06900 ELECTROCARDI OLOGY 0 69.00 16, 818, 634 0 0 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 4, 413, 377 0 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71 00 20, 671, 354 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 22, 370, 173 0 72.00 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 29.825.577 C 0 73.00 07400 RENAL DIALYSIS 909, 149 74.00 74.00 0 07500 ASC (NON-DISTINCT PART) 75.00 0 0 0 0 75.00 03950 OTHER ANCILL SRVC 0 76.00 0 0 0 76.00 0 76.01 03951 CARDIAC AND PULMONARY REHAB 213, 534 0 0 76.01 76.02 03952 WOUND CARE 42, 406 0 0 0 76.02 07700 ALLOGENEIC STEM CELL ACQUISITION 77.00 77.00 0 0 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 0 0 0 88.00 Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0165

| | | | | 10 | 0 12/31/2021 | Date/lime Pre 5/31/2022 7:5 | |
|---|--------------|---------------|----------------|----------------|----------------|--------------------------------|---------|
| | | | | OTHER GENERAL | | 373172022 7.3 | - alli |
| | | | | SERVI CE | | | |
| Cost Center Description | | MEDI CAL | SOCIAL SERVICE | OTHER GEN SERV | NONPHYSI CI AN | NURSI NG | |
| p | | RECORDS & | | | ANESTHETI STS | PROGRAM | |
| | | LI BRARY | (TIME SPENT) | (TIME SPENT) | (ASSI GNED | (ASSI GNED | |
| | | (GROSS | , | \ | `TIME) | TIME) | |
| | | CHARGES) | | | ŕ | ŕ | |
| | | 16.00 | 17. 00 | 18. 00 | 19. 00 | 20.00 | |
| 89.00 08900 FEDERALLY QUALIFIED HEALTH | CENTER | 0 | O | 0 | 0 | 0 | 89. 00 |
| 90. 00 09000 CLI NI C | | 0 | 0 | 0 | 0 | 0 | 90.00 |
| 90. 01 09001 CLI NI C | | 29, 720, 433 | 0 | 0 | 0 | 0 | 90. 01 |
| 90. 02 09002 CLI NI C | | 6, 275, 161 | 0 | 0 | 0 | 0 | 90. 02 |
| 91. 00 09100 EMERGENCY | | 43, 343, 399 | 0 | 0 | 0 | 0 | 91.00 |
| 92. 00 09200 OBSERVATION BEDS (NON-DIST | INCT PART) | | | | | | 92. 00 |
| OTHER REIMBURSABLE COST CENTERS | | | | | | | |
| 94.00 09400 HOME PROGRAM DIALYSIS | | 0 | 0 | 0 | 0 | 0 | 94. 00 |
| 95. 00 09500 AMBULANCE SERVICES | | 0 | 0 | 0 | 0 | 0 | 95. 00 |
| 96. 00 09600 DURABLE MEDICAL EQUIP-RENT | ED | 0 | 0 | 0 | 0 | 0 | 96. 00 |
| 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD | | 0 | 0 | 0 | 0 | 0 | 97. 00 |
| 98. 00 09850 OTHER REIMBURSE | | 0 | 0 | 0 | 0 | 0 | 98. 00 |
| 99. 00 09900 CMHC | | 0 | 0 | 0 | 0 | 0 | 99. 00 |
| 99. 10 09910 CORF | | 0 | 0 | 0 | 0 | 0 | 99. 10 |
| 100.00 10000 I&R SERVICES-NOT APPRVD PR | GM | 0 | 0 | 0 | 0 | 0 | 100. 00 |
| 101.00 10100 HOME HEALTH AGENCY | | 0 | 0 | 0 | 0 | 0 | 101. 00 |
| SPECIAL PURPOSE COST CENTERS | <u>.</u> | | | | | | |
| 105.00 10500 KIDNEY ACQUISITION | | 0 | 0 | 0 | 0 | 0 | 105. 00 |
| 106.00 10600 HEART ACQUISITION | | 0 | 0 | 0 | 0 | 0 | 106. 00 |
| 107.00 10700 LIVER ACQUISITION | | 0 | 0 | 0 | 0 | 0 | 107. 00 |
| 108.00 10800 LUNG ACQUISITION | | 0 | 0 | 0 | 0 | 0 | 108. 00 |
| 109.00 10900 PANCREAS ACQUISITION | | 0 | 0 | 0 | 0 | 0 | 109. 00 |
| 110.00 11000 INTESTINAL ACQUISITION | | 0 | 0 | 0 | 0 | 0 | 110. 00 |
| 111.00 11100 ISLET ACQUISITION | | 0 | 0 | 0 | 0 | 0 | 111. 00 |
| 113.00 11300 INTEREST EXPENSE | | | | | | | 113. 00 |
| 114.00 11400 UTILIZATION REVIEW-SNF | | | | | | | 114. 00 |
| 115.00 11500 AMBULATORY SURGICAL CENTER | (D. P.) | 0 | 0 | 0 | 0 | 0 | 115. 00 |
| 116. 00 11600 HOSPI CE | | 5, 487 | 0 | 0 | | 0 | 116. 00 |
| 118.00 SUBTOTALS (SUM OF LINES 1 | through 117) | 507, 309, 471 | 0 | 0 | 0 | 0 | 118. 00 |
| NONREI MBURSABLE COST CENTERS | | | | | | | |
| 190.00 19000 GIFT, FLOWER, COFFEE SHOP | & CANTEEN | 0 | 0 | 0 | 0 | 0 | 190. 00 |
| 191. 00 19100 RESEARCH | | 0 | 0 | 0 | 0 | 0 | 191. 00 |
| 192.00 19200 PHYSICIANS' PRIVATE OFFICE | S | 0 | 0 | 0 | 0 | 0 | 192. 00 |
| 192.01 19201 CENTER OF HOPE | | 0 | 0 | 0 | 0 | 0 | 192. 01 |
| 192.02 19202 OTHER FA FACILITIES NRCC | | 0 | 0 | 0 | 0 | 0 | 192. 02 |
| 193.00 19300 NONPALD WORKERS | | 0 | 0 | 0 | 0 | 0 | 193. 00 |
| 194.00 07950 OTHER NRCC | | 0 | Ö | 0 | 0 | 0 | 194. 00 |
| 200.00 Cross Foot Adjustments | | | | | | | 200. 00 |
| 201.00 Negative Cost Centers | | | | | | | 201. 00 |
| 202.00 Cost to be allocated (per | Wkst. B, | 1, 727, 988 | Ö | 0 | 0 | 0 | 202. 00 |
| Part I) | | | | | | | |
| 203.00 Unit cost multiplier (Wkst | . B, Part I) | 0. 003406 | 0. 000000 | 0. 000000 | 0. 000000 | 0. 000000 | 203. 00 |
| 204.00 Cost to be allocated (per | Wkst. B, | 17, 908 | O | 0 | 0 | 0 | 204. 00 |
| Part II) | | · | | | | | |
| 205.00 Unit cost multiplier (Wkst | . B, Part | 0. 000035 | 0. 000000 | 0. 000000 | 0. 000000 | 0. 000000 | 205. 00 |
| | | | | | | | |
| 206.00 NAHE adjustment amount to | be allocated | | | | | 0 | 206. 00 |
| (per Wkst. B-2) | | | | | | | |
| 207.00 NAHE unit cost multiplier | (Wkst. D, | | | | | 0. 000000 | 207. 00 |
| Parts III and IV) | | | | | | | |
| | | | | | | | |

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS In Lieu of Form CMS-2552-10
Worksheet B-1 Peri od: From 01/01/2021 To 12/31/2021 Date/Time Prepared: 5/31/2022 7:54 am Provider CCN: 15-0165

| Cost Center Description Services Servi | | | | | | 5/31/2021 Date/11lie Pre | |
|--|--------|---|----------------|-----------------|------------|----------------------------|--------|
| PART CASH | | | INTERNS & | RESI DENTS | | | |
| PART CASH | | Cost Center Description | SERVICES_SALAR | SERVI CES_OTHER | PARAMED ED | | |
| REMERIAL SERVICE COST CENTERS 11 UP | | cost center bescription | | | | | |
| PRIEBLE SPRING COST CHIVTES 1,100 22,00 23,00 | | | | | | | |
| DECEMBER SERVICE COST CENTRES 1.00 1.0 | | | | | | | |
| 1.00 100 | | CENEDAL SEDVICE COST CENTEDS | 21.00 | 22.00 | 23. 00 | | |
| 2.00 | 1 00 | | | | | | 1 00 |
| 0.01400 EMPLOYEE BENEFIT IS DEPARTMENT 0.000 0. | | 1 I | | | | | 1 |
| 0.000 0.000 DIA INTERNACE & REPAIRS | 4.00 | 00400 EMPLOYEE BENEFITS DEPARTMENT | | | | | 4. 00 |
| 2.00 0700 OPERATION OF PLANT | | | | | | | 1 |
| 0.000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.00000000 | | 1 | | | | | • |
| 0.900 | | l | | | | | |
| 10.00 01000 DETARY | | 1 | | | | | 1 |
| 12.00 17200 MAINTENANCE OF PERSONNET. 12.00 17300 | | 1 | | | | | 1 |
| 13.00 1300 MURSING ADMINISTRATION 13.00 15 | 11. 00 | 01100 CAFETERI A | | | | | 11. 00 |
| 14. 00 01400 CENTRAL SERVICES & SUPPLY 15. 00 10500 MEDICAL RECORDS & LIBRARY 15. 00 10500 MEDICAL RECORDS & LIBRARY 15. 00 1070 | | 1 I | | | | | 1 |
| 15.00 | | 1 I | | | | | • |
| 10. 00 01000 MEDICAL RECORDS & LIBRARY 10. 00 10. 00 10. 00 11. 00 | | 1 | | | | | |
| 17.00 01700 SOCI AL SERVICE 17.00 19.00 1900 MORPHYSICI AN AMESTHETISTS 18.00 18.00 18150 OTHER CENT SERVICES 19.00 20.00 | | 1 I | | | | | 1 |
| 19.00 01900 NORPHYSIC IAN AMESTHETISTS 20.00 2020 187 SERVICES-SALARY & FRI NGES APPRVD 0 22.00 2020 187 SERVICES-SALARY & FRI NGES APPRVD 0 22.00 2020 187 SERVICES-SALARY & FRI NGES APPRVD 0 22.00 2020 187 SERVICES-SALARY & FRI NGES APPRVD 0 22.00 2020 187 SERVICES-SALARY & FRI NGES APPRVD 0 22.00 2020 187 SERVICES-SALARY & FRI NGES APPRVD 0 0 31.00 3 | | 1 I | | | | | |
| 20. 00 02000 NURSING PROCRAM 27. 00 22. 00 23. | | 1 I | | | | | |
| 21 00 02100 RA SERVI CES-SALARY & FRI NGES APPRUD 0 22,00 02201 RA SERVI CES-SOTHER PRIGH COSTS APPRUD 0 22,00 02301 RA SERVI CES-SOTHER PRIGH COSTS APPRUD 0 23,00 02301 PARAMED ED PRIGH 0 0 0 0 0 0 0 0 0 | | 1 I | | | | | 1 |
| 22.00 02200 RAR SERVICES-OTHER PROM COSTS APPRVD 0 22.00 1 1 1 1 1 1 1 1 1 | | | 0 | | | | |
| 123.00 | | 1 I | 0 | 1 | | | 1 |
| 30.00 03000 ADULTS & PEDIATRICS 0 0 0 33.00 31.00 03100 INTENSI VE CARE UNIT 0 0 0 32.00 32.00 03200 COROMARY CARE UNIT 0 0 0 0 32.00 33.00 03300 SUBROTO IDER OF LEAST VE CARE UNIT 0 0 0 0 34.00 40.00 04000 SUBPROTO IDER - IPF 0 0 0 0 0 0 41.00 04100 SUBPROTO IDER - IPF 0 0 0 0 0 0 42.00 04300 SUBPROTO IDER - IPF 0 0 0 0 0 0 43.00 04300 SUBPROTO IDER - IPF 0 0 0 0 0 0 44.00 04400 SUBPROTO IDER - IPF 0 0 0 0 0 0 44.00 04400 SUBLED NURSING FACILITY 0 0 0 0 0 0 45.00 04500 MUSEIN FACILITY 0 0 0 0 0 0 46.00 04400 SKILLED NURSING FACILITY 0 0 0 0 0 0 46.00 04400 ONLES IN FACILITY 0 0 0 0 0 0 46.00 04400 ONLES IN FACILITY 0 0 0 0 0 0 46.00 04400 ONLES IN FACILITY 0 0 0 0 0 0 47.00 04500 ONLES IN FACILITY 0 0 0 0 0 0 48.00 04500 ONLES IN FACILITY 0 0 0 0 0 0 49.00 04500 ONLES IN FACILITY 0 0 0 0 0 0 40.00 04500 ONLES IN FACILITY 0 0 0 0 0 0 40.00 04500 ONLES IN FACILITY 0 0 0 0 0 0 40.00 04500 ONLES IN FACILITY 0 0 0 0 0 0 40.00 04500 ONLES IN FACILITY 0 0 0 0 0 0 40.00 04500 ONLES IN FACILITY 0 0 0 0 0 0 40.00 04500 ONLES IN FACILITY 0 0 0 0 0 0 40.00 04500 ONLES IN FACILITY 0 0 0 0 0 0 40.00 04500 ONLES IN FACILITY 0 0 0 0 0 40.00 04500 ONLES IN FACILITY 0 0 0 0 0 40.00 04500 ONLES IN FACILITY 0 0 0 0 0 40.00 04500 ONLES IN FACILITY 0 0 0 0 0 40.00 04500 ONLES IN FACILITY 0 0 0 0 0 40.00 04500 ONLES IN FACILITY 0 0 0 0 0 40.00 04500 ONLES IN FACILITY 0 0 0 0 0 40.00 04 | | 1 I | | | 0 | | 1 |
| 31.00 03100 INTERSIVE CARE UNIT | | | | | | | |
| 22. 00 03200 03200 030 | | 1 I | | 1 | | | 1 |
| 33.00 03300 BURN INTENSIVE CARE UNIT | | 1 I | | 1 | | | |
| 34. 00 03400 SURGI CAL INTENSIVE CARE UNIT 0 0 0 34. 00 05. 00 05. 0 | | 1 | | | · · | | 1 |
| 40.00 04000 04000 04000 0 0 0 | | l | 0 | 1 | 0 | | 1 |
| 43. 00 04300 NURSERY 40. 00 440.00 SALOUS NULLED NURSI NO FACILITY 0 0 0 0 0 0 445. 00 445. 00 04500 NURSI NO FACILITY 0 0 0 0 0 0 0 45. 00 45. 00 04500 NURSI NO FACILITY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | | 1 | 0 | 0 | 0 | | 1 |
| 44. 00 04400 SKILLED NURSING FACILITY | | l | 0 | 0 | 0 | | 1 |
| 45. 00 04500 NURSI NG FACILITY | | l | 0 | 1 | 0 | | |
| 46. 00 04600 OTHER LONG TERM CARE | | l | | 1 | 0 | | |
| ANCILLARY SERVICE COST CENTERS School Cost Cost Cost Centers Cost | | 1 | | 1 | | | 1 |
| 51.00 05.100 RECOVERY ROOM & LABOR ROOM 0 0 0 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 52.00 53.00 05300 ANESTHESI GLOGY 0 0 0 0 53.00 54.00 05400 RADIO LOGY-DIAGNOSTI C 0 0 0 0 0 55.00 05500 RADIO LOGY-THERAPEUTI C 0 0 0 0 0 55.00 05500 RADIO LOGY-THERAPEUTI C 0 0 0 0 0 56.00 05500 RADIO LOGY-THERAPEUTI C 0 0 0 0 0 57.00 05700 CT SCAN 0 0 0 0 0 58.00 05500 RADIO LOGY-THERAPEUTI C 0 0 0 0 0 58.00 05800 MAGNETI C RESONANCE I MAGI NG MRI) 0 0 0 0 0 59.00 05900 CARDIA C CATHETERI ZATI ON 0 0 0 0 0 60.00 06000 LABORATORY 0 0 0 0 0 60.01 06000 LABORATORY 0 0 0 0 0 61.00 06100 DEPD CLI NI CAL LAB SERVI CES-PRGM ONLY 0 0 0 0 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 0 63.00 06300 BLOOD STORI NG, PROCESSING & TRANS. 0 0 0 0 64.00 06400 INTRAVENOUS THERAPY 0 0 0 0 65.00 06500 RESPI RATORY THERAPY 0 0 0 0 66.00 06600 PHYSI CAL THERAPY 0 0 0 0 67.00 06700 OCCUPATI ONAL THERAPY 0 0 0 0 68.00 06900 SPEECH PATHOLOGY 0 0 0 0 69.00 06900 SPEECH PATHOLOGY 0 0 0 0 69.00 06900 ELECTROCARDI OLOGY 0 0 0 69.00 06900 ELECTROCARDI OLOGY 0 0 0 70.00 07000 DELECTROCARDI OLOGY 0 0 0 71.00 07000 DRUGS CHARGED TO PATI ENTS 0 0 0 72.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 74.00 07400 RENAL DI ALYSIS 0 0 0 0 75.00 07500 ASC (NON-DISTINCT PART) 0 0 0 76.00 07500 ASC (NON-DISTINCT PART) 0 0 0 77.00 07700 ALLOGENEI C STEM CELL ACOUISITION 0 0 0 77.00 07700 ALLOGENEI C STEM CELL ACOUISITION 0 0 0 77.00 001700 ALLOGENEI C STEM CELL ACOUISITION 0 0 0 77.00 001700 ALLOGENEI C STEM CELL ACOUISITION 0 0 | | | | | | | |
| 52.00 05200 DELI VERY ROOM & LABOR ROOM 0 0 0 0 0 53.00 | | 1 I | | | | | 1 |
| 53. 00 05300 ANESTHESI OLOGY 53. 00 54. 00 54. 00 55. 00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 0 0 0 0 0 0 | | 1 I | | | | | |
| 54.00 05400 RADI OLOGY-JI AGNOSTIC 0 0 0 0 0 55.00 05500 RADI OLOGY-THERAPEUTIC 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | | | 0 | 0 | 0 | | • |
| 55.00 05500 RADIOLOCY-THERAPEUTIC 0 0 0 0 0 0 0 0 0 | | 1 I | 0 | 0 | 0 | | 1 |
| 57. 00 05700 CT SCAN 0 0 0 0 0 0 57. 00 | | 1 I | 0 | o | 0 | | |
| 58. 00 | | 1 I | 0 | 0 | 0 | | |
| 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 <td></td> <td>1 1</td> <td>-</td> <td>1</td> <td>0</td> <td></td> <td>1</td> | | 1 1 | - | 1 | 0 | | 1 |
| 60. 00 06000 LABORATORY 0 0 0 0 0 0 0 0 0 | | | 1 | | 0 | | |
| 60. 01 06001 BLOOD LABORATORY 0 0 0 0 0 61.00 660. 01 61.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 0 0 0 0 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 0 0 0 63.00 06400 INTRAVENDUS THERAPY 0 0 0 0 0 0 64.00 1NTRAVENDUS THERAPY 0 0 0 0 0 0 65.00 66.00 06600 RESPIRATORY THERAPY 0 0 0 0 0 0 0 0 66.00 06600 RESPIRATORY THERAPY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | | 1 I | 0 | 0 | 0 | | 1 |
| 62. 00 | | | 0 | o | 0 | | 1 |
| 63. 00 | | | | | | | |
| 64. 00 | | 1 | 0 | 0 | 0 | | 1 |
| 65. 00 | | 1 · · · · · · · · · · · · · · · · · · · | 0 | 0 | 0 | | 1 |
| 66. 00 06600 06600 06700 0CCUPATI ONAL THERAPY 0 0 0 0 0 0 0 0 0 | | 1 I | 0 | 0 | 0 | | 1 |
| 68. 00 06800 SPEECH PATHOLOGY 0 0 0 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 69. 00 0 0 0 0 0 0 0 0 0 | | l | Ö | o o | 0 | | 1 |
| 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0 70. 00 770 | 67. 00 | 06700 OCCUPATI ONAL THERAPY | 0 | 0 | 0 | | 67. 00 |
| 70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 0 0 0 0 | | l | 0 | 0 | 0 | | |
| 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 0 | | l | 0 | 0 | 0 | | |
| 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 07400 RENAL DI ALYSIS 0 0 0 0 0 0 0 0 0 | | | 0 | 0 | 0 | | 1 |
| 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 73. 00 74. 00 74. 00 75. 00 0 0 0 0 0 0 0 0 0 | | | | | 0 | | 1 |
| 74. 00 07400 RENAL DI ALYSI S 0 0 0 0 0 74. 00 75. 00 07500 ASC (NON-DI STI NCT PART) 0 0 0 0 0 0 0 0 0 | | | 0 | l ő | Ö | | 1 |
| 76. 00 03950 OTHER ANCILL SRVC 0 0 0 0 76. 00 76. 01 03951 CARDI AC AND PULMONARY REHAB 0 0 0 0 76. 01 76. 02 03952 WOUND CARE 0 0 0 0 0 77. 00 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | 74.00 | 07400 RENAL DIALYSIS | 0 | o | 0 | | 74. 00 |
| 76. 01 03951 CARDI AC AND PULMONARY REHAB 0 0 0 0 76. 01 76. 02 77. 00 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | | | 0 | 0 | 0 | | 1 |
| 76. 02 03952 WOUND CARE 0 0 0 0 77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | | 1 I | 0 | 0 | 0 | | • |
| 77. 00 07700 ALLOGENEI C STEM CELL ACQUISITION 0 0 0 0 0 0 0 0 0 | | | 0 | | 0 | | 1 |
| OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 0 88.00 | | | | 1 | J | | |
| | | OUTPATIENT SERVICE COST CENTERS | | | | | |
| 89.00 U890U FEDERALLY QUALIFIED HEALIH CENIER 0 0 0 89.00 | | | | | | | |
| | 89. 00 | U8900 FEDERALLY QUALIFIED HEALTH CENTER | 1 0 | <u> </u> 0 | 0 | | 89. 00 |

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS | Peri od: | Worksheet B-1 | From 01/01/2021 | To 12/31/2021 | Date/Time Prepared: Provider CCN: 15-0165

| | | | | | | lo | 12/31/2021 Date/lime Pr 5/31/2022 7: | |
|--------|-------|---|-----------------|-----------------|------------|----|---|--------------------|
| | | | INTERNS & | RESIDENTS | | | 3/31/2022 7. | J4 alli |
| | | | | | | | | |
| | | Cost Center Description | SERVI CES-SALAR | SERVI CES-OTHER | PARAMED ED | | | |
| | | | Y & FRINGES | PRGM COSTS | PRGM | | | |
| | | | (ASSI GNED | (ASSI GNED | (ASSI GNED | | | |
| | | | TIME) | TIME) | TIME) | | | |
| | 1 | I | 21. 00 | 22. 00 | 23. 00 | | | |
| 90.00 | 1 | CLINIC | 0 | 0 | | 0 | | 90. 00 |
| 90. 01 | | CLINIC | 0 | 0 | | 0 | | 90. 01 |
| 90. 02 | 1 | CLINIC | 0 | 0 | | 0 | | 90. 02 |
| 91.00 | | EMERGENCY | 0 | 0 | | 0 | | 91. 00 |
| 92. 00 | | OBSERVATION BEDS (NON-DISTINCT PART) | | | | | | 92. 00 |
| 94. 00 | | REIMBURSABLE COST CENTERS HOME PROGRAM DI ALYSI S | 0 | 0 | | ol | | 94. 00 |
| 95.00 | | AMBULANCE SERVICES | 0 | 0 | | 0 | | 95.00 |
| 96.00 | | DURABLE MEDICAL EQUIP-RENTED | 0 | 0 | | 0 | | 96. 00 |
| 97. 00 | 1 | DURABLE MEDICAL EQUIP-RENTED | 0 | 0 | | 0 | | 97. 00 |
| 98. 00 | | OTHER REIMBURSE | 0 | 0 | | 0 | | 98. 00 |
| 99. 00 | 09900 | | 0 | 0 | | 0 | | 99.00 |
| 99. 10 | | | 0 | 0 | | 0 | | 99. 10 |
| | | I&R SERVICES-NOT APPRVD PRGM | 0 | 0 | | 0 | | 100.00 |
| | | HOME HEALTH AGENCY | 0 | 0 | | 0 | | 101.00 |
| | | AL PURPOSE COST CENTERS | <u> </u> | <u> </u> | | | | |
| 105.00 | | KIDNEY ACQUISITION | 0 | 0 | | 0 | | 105. 00 |
| 106.00 | 10600 | HEART ACQUISITION | 0 | 0 | | 0 | | 106. 00 |
| | | LIVER ACQUISITION | 0 | 0 | | 0 | | 107. 00 |
| 108.00 | 10800 | LUNG ACQUISITION | 0 | 0 | | 0 | | 108. 00 |
| 109.00 | 10900 | PANCREAS ACQUISITION | 0 | 0 | | 0 | | 109. 00 |
| 110.00 | 11000 | INTESTINAL ACQUISITION | 0 | 0 | | 0 | | 110. 00 |
| 111.00 | 11100 | ISLET ACQUISITION | 0 | 0 | | 0 | | 111. 00 |
| | 1 | I NTEREST EXPENSE | | | | | | 113. 00 |
| | | UTILIZATION REVIEW-SNF | | | | | | 114. 00 |
| | | AMBULATORY SURGICAL CENTER (D. P.) | 0 | 0 | | 0 | | 115. 00 |
| | 1 | HOSPI CE | | | | 0 | | 116. 00 |
| 118.00 | | SUBTOTALS (SUM OF LINES 1 through 117) | 0 | 0 | | 0 | | 118. 00 |
| 400.00 | | I MBURSABLE COST CENTERS | | | | | | |
| | | GIFT, FLOWER, COFFEE SHOP & CANTEEN | 0 | 0 | | 0 | | 190. 00 |
| | | RESEARCH | 0 | 0 | | 0 | | 191. 00 |
| | | PHYSICIANS' PRIVATE OFFICES CENTER OF HOPE | 0 | 0 | | 0 | | 192. 00 192. 01 |
| | | OTHER FA FACILITIES NRCC | 0 | 0 | | 0 | | 192. 01 |
| | | NONPALD WORKERS | 0 | 0 | | 0 | | 192. 02 |
| | 1 | OTHER NRCC | 0 | 0 | | 0 | | 194. 00 |
| 200.00 | | Cross Foot Adjustments | U | U | | ٧ | | 200. 00 |
| 201.00 | | Negative Cost Centers | | | | | | 201. 00 |
| 202.00 | | Cost to be allocated (per Wkst. B, | 0 | 0 | | 0 | | 202. 00 |
| 202.00 | Ί | Part I) | Ŭ | J | | | | 202.00 |
| 203.00 | | Unit cost multiplier (Wkst. B, Part I) | 0. 000000 | 0. 000000 | 0. 00000 | 0 | | 203. 00 |
| 204.00 | 1 | Cost to be allocated (per Wkst. B, | 0 | 0 | | 0 | | 204. 00 |
| | | Part II) | | | | | | 1 |
| 205.00 |) | Unit cost multiplier (Wkst. B, Part | 0. 000000 | 0. 000000 | 0.00000 | 0 | | 205. 00 |
| | 1 | [11] | | | | | | |
| 206.00 | | NAHE adjustment amount to be allocated | | | | 0 | | 206. 00 |
| | | (per Wkst. B-2) | | | | | | |
| 207.00 | ין | NAHE unit cost multiplier (Wkst. D, | | | 0. 00000 | O | | 207. 00 |
| | T | Parts III and IV) | l | | | 1 | | 1 |

| Health Financial Systems COMPUTATION OF RATIO OF COSTS TO CHARGES | FRANCI SCAN HEA | ALTH MUNSTER Provider C | CN: 15-0165 F | In Lie Period: | u of Form CMS-: Worksheet C | 2552-10 |
|---|---|-------------------------|----------------------------|---------------------------------|--|--------------------|
| | | | | rom 01/01/2021 o 12/31/2021 | Part I Date/Time Pre 5/31/2022 7:5 | pared: |
| | | Title | XVIII | Hospi tal | PPS | 1 |
| Cost Center Description | Total Cost (from Wkst. B, Part I, col. 26) | Therapy Limit Adj. | Total Costs | Costs RCE Di sal I owance | Total Costs | |
| | 1. 00 | 2.00 | 3. 00 | 4. 00 | 5. 00 | |
| I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS | 23, 679, 328 | | 23, 679, 328 | 1, 001 | 23, 680, 329 | 30.00 |
| 31. 00 03100 NTENSI VE CARE UNI T | 4, 486, 420 | | 4, 486, 420 | | | |
| 32. 00 03200 CORONARY CARE UNIT | 0 | | (| 0 | | 32. 00 |
| 33. 00 03300 BURN I NTENSI VE CARE UNIT | 0 | | (| 0 | 0 | 33. 00 |
| 34. 00 03400 SURGI CAL INTENSIVE CARE UNIT 40. 00 04000 SUBPROVI DER - IPF | 0 | | (| 0 | 0 | 34. 00 40. 00 |
| 41. 00 04100 SUBPROVI DER - 1 FF | 0 | | | 0 | 0 | 41. 00 |
| 43. 00 04300 NURSERY | 0 | | | Ö | Ō | 43. 00 |
| 44.00 04400 SKILLED NURSING FACILITY | 0 | | (| 0 | 0 | 44. 00 |
| 45. 00 04500 NURSING FACILITY | 0 | | | 0 | 0 | 45. 00 |
| 46. 00 O4600 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS | 0 | | | 0 | 0 | 46. 00 |
| 50. 00 05000 OPERATI NG ROOM | 11, 059, 327 | | 11, 059, 327 | 0 | 11, 059, 327 | 50.00 |
| 51.00 05100 RECOVERY ROOM | 2, 410, 615 | | 2, 410, 615 | 0 | 2, 410, 615 | |
| 52. 00 05200 DELIVERY ROOM & LABOR ROOM | 0 | | (4/ 0/ | 0 | 0 | 52.00 |
| 53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C | 646, 966 4, 454, 586 | | 646, 966 4, 454, 586 | | 646, 966 4, 454, 586 | |
| 55. 00 05500 RADI OLOGY-THERAPEUTI C | 0 | | 1, 101, 000 | o o | 0 | 55. 00 |
| 56. 00 05600 RADI 0I SOTOPE | 0 | | (| 0 | 0 | 56. 00 |
| 57. 00 05700 CT SCAN | 1, 351, 388 | | 1, 351, 388 | | 1, 351, 388 | 1 |
| 58. 00 05800 MAGNETI C RESONANCE I MAGING (MRI) 59. 00 05900 CARDIAC CATHETERIZATION | 1, 948, 797 4, 459, 084 | | 1, 948, 797 4, 459, 084 | | 1, 948, 797 4, 459, 084 | |
| 60. 00 06000 LABORATORY | 7, 191, 146 | | 7, 191, 146 | | 7, 191, 824 | |
| 60. 01 06001 BLOOD LABORATORY | 0 | | (| 0 | 0 | 60. 01 |
| 61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY | 0 | | (| 0 | 0 | 61.00 |
| 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 63. 00 06300 BLOOD STORING, PROCESSING & TRANS. | 0 | | (| 0 | 0 | 62. 00 63. 00 |
| 64. 00 06400 I NTRAVENOUS THERAPY | 1, 330 | | 1, 330 | 0 | | 1 |
| 65. 00 06500 RESPIRATORY THERAPY | 1, 893, 389 | 0 | | | 1, 893, 389 | |
| 66. 00 06600 PHYSI CAL THERAPY | 403, 530 | 0 | | | 403, 530 | |
| 67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY | 268, 403 91, 377 | 0 | 268, 403 91, 377 | | 268, 403 91, 377 | |
| 69. 00 06900 ELECTROCARDI OLOGY | 771, 334 | | 771, 334 | | 771, 334 | 1 |
| 70. 00 07000 ELECTROENCEPHALOGRAPHY | 2, 268, 235 | | 2, 268, 235 | | 2, 268, 468 | |
| 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 9, 302, 601 | | 9, 302, 601 | | 9, 302, 601 | 1 |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS | 7, 875, 579 7, 056, 322 | | 7, 875, 579 7, 056, 322 | | 7, 875, 579 7, 056, 322 | |
| 74. 00 07400 RENAL DIALYSIS | 3, 097 | | 3, 097 | | 3, 097 | |
| 75.00 07500 ASC (NON-DISTINCT PART) | 0 | | (| 0 | | 1 |
| 76. 00 03950 OTHER ANCILL SRVC | 0 | | (| · | _ | |
| 76. 01 03951 CARDI AC AND PULMONARY REHAB 76. 02 03952 WOUND CARE | 333, 399 9, 535 | | 333, 399 9, 535 | | | |
| 77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION | 7, 333 | | 7, 555 | | | 1 |
| OUTPATIENT SERVICE COST CENTERS | | | | | | |
| 88. 00 08800 RURAL HEALTH CLINIC | 0 | | | 0 | 0 | |
| 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 90. 00 09000 CLINIC | 0 | | | 0 | 0 | 89. 00 90. 00 |
| 90. 01 09001 CLI NI C | 3, 378, 562 | | 3, 378, 562 | 1, 309 | 3, 379, 871 | 1 |
| 90. 02 09002 CLI NI C | 850, 922 | | 850, 922 | | 850, 922 | |
| 91. 00 09100 EMERGENCY | 6, 497, 143 | | 6, 497, 143 | | 6, 497, 143 | |
| 92. 00 O9200 OBSERVATI ON BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS | 4, 498, 148 | | 4, 498, 148 | 3 | 4, 498, 148 | 92.00 |
| 94. 00 09400 HOME PROGRAM DIALYSIS | 0 | | (| 0 | 0 | 94. 00 |
| 95. 00 09500 AMBULANCE SERVICES | 0 | | | 0 | _ | 95. 00 |
| 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED | 0 | | | 0 | 0 | 96.00 |
| 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 98. 00 09850 OTHER REI MBURSE | 0 | | | 0 | 0 | 97. 00 98. 00 |
| 99. 00 09900 CMHC | 0 | | | | Ō | 99. 00 |
| 99. 10 09910 CORF | 0 | | |) | 0 | 99. 10 |
| 100.00 10000 I &R SERVI CES-NOT APPRVD PRGM | 0 | | (| | | 100.00 |
| 101. 00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS | 0 | | |) | 0 | 101. 00 |
| 105. 00 10500 KI DNEY ACQUISITION | 0 | | | | 0 | 105. 00 |
| 106. 00 10600 HEART ACQUISITION | 0 | | 0 | | 0 | 106. 00 |
| 107. 00 10700 LI VER ACQUI SI TI ON | 0 | | | | | 107. 00 |
| 108.00 10800 LUNG ACQUISITION 109.00 10900 PANCREAS ACQUISITION | 0 | | | | | 108. 00 109. 00 |
| 110. 00 11000 NTESTINAL ACQUISITION | 0 | | | | | 1109.00 |
| 111.00 11100 I SLET ACQUI SITION | 0 | <u> </u> | | | | 111. 00 |
| | | | | | | |

| Health Financial Systems | | In Lieu of Form CMS-2552-10 | | | | |
|--|------------------------------|-----------------------------|-------------|---|---|--|
| COMPUTATION OF RATIO OF COSTS TO CHARGES | OF RATIO OF COSTS TO CHARGES | | | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I Date/Time Prepared: 5/31/2022 7:54 am | |
| | | Title | : XVIII | Hospi tal | PPS | |
| | | | | Costs | | |
| Cost Center Description | Total Cost (from Wkst. B, | Therapy Limit Adj. | Total Costs | RCE Di sal I owance | Total Costs | |

| | | litte | XVIII | Hospi tai | PP5 | |
|--|----------------|---------------|---------------|-----------------|---------------|---------|
| | | | | Costs | | |
| Cost Center Description | Total Cost | Therapy Limit | Total Costs | RCE | Total Costs | |
| | (from Wkst. B, | Adj . | | Di sal I owance | | |
| | Part I, col. | | | | | |
| | 26) | | | | | |
| | 1.00 | 2.00 | 3. 00 | 4. 00 | 5. 00 | |
| 113. 00 11300 I NTEREST EXPENSE | | | | | | 113. 00 |
| 114.00 11400 UTILIZATION REVIEW-SNF | | | | | | 114. 00 |
| 115.00 11500 AMBULATORY SURGICAL CENTER (D.P.) | 0 |) | 0 | | 0 | 115. 00 |
| 116. 00 11600 HOSPI CE | 19 | | 19 | | 19 | 116. 00 |
| 200.00 Subtotal (see instructions) | 107, 190, 582 | . 0 | 107, 190, 582 | 3, 221 | 107, 193, 803 | 200. 00 |
| 201.00 Less Observation Beds | 4, 498, 148 | 8 | 4, 498, 148 | | 4, 498, 148 | 201. 00 |
| 202.00 Total (see instructions) | 102, 692, 434 | . 0 | 102, 692, 434 | 3, 221 | 102, 695, 655 | 202. 00 |

| In Lieu of Form CMS-2552-10 | Period: | Worksheet C | From 01/01/2021 | Part | To 12/31/2021 | Date/Time Prepared: | 5/31/2022 7:54 am Health Financial Systems

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

| | | Title | e XVIII | Hospi tal | 5/31/2022 7:5 PPS | <u>4 am</u> |
|---|----------------------------|-----------------------------|------------------------------|------------------------|------------------------|--------------------|
| | | Charges | | | | |
| Cost Center Description | Inpatient | Outpati ent | lotal (col. 6 + col. 7) | Cost or Other Ratio | TEFRA Inpatient | |
| | | | 1 601. 77 | | Rati o | |
| INDATIENT DOUTING CEDVICE COST CENTEDS | 6. 00 | 7. 00 | 8. 00 | 9. 00 | 10.00 | |
| I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS | 19, 150, 072 | | 19, 150, 072 | | | 30.00 |
| 31. 00 03100 NTENSI VE CARE UNIT | 6, 534, 613 | | 6, 534, 613 | | | 31.00 |
| 32. 00 03200 CORONARY CARE UNIT | o | | (|) | | 32. 00 |
| 33. 00 03300 BURN INTENSIVE CARE UNIT | 0 | | | | | 33.00 |
| 34. 00 03400 SURGI CAL INTENSIVE CARE UNIT 40. 00 04000 SUBPROVI DER - IPF | | | |) | | 34. 00 40. 00 |
| 41. 00 04100 SUBPROVI DER - I RF | Ö | | | | | 41.00 |
| 43. 00 04300 NURSERY | 0 | | C |) | | 43. 00 |
| 44. 00 04400 SKILLED NURSING FACILITY 45. 00 04500 NURSING FACILITY | 0 | | | | | 44. 00 45. 00 |
| 46. 00 04600 OTHER LONG TERM CARE | | | |) | | 46.00 |
| ANCILLARY SERVICE COST CENTERS | -1 | | | | | |
| 50. 00 05000 OPERATING ROOM | 10, 115, 020 | 64, 205, 978 | | | 0.000000 | 50.00 |
| 51. 00 05100 RECOVERY ROOM 52. 00 05200 DELIVERY ROOM & LABOR ROOM | 1, 009, 796 | 7, 428, 924 | 8, 438, 720 | | 0. 000000 0. 000000 | 51. 00 52. 00 |
| 53. 00 05300 ANESTHESI OLOGY | 2, 860, 810 | 16, 407, 384 | 1 | | 0. 000000 | 53.00 |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C | 5, 617, 806 | 26, 356, 458 | | 0. 139318 | 0. 000000 | 54. 00 |
| 55. 00 05500 RADI OLOGY-THERAPEUTI C | 0 | 0 | 1 | | 0.000000 | 55.00 |
| 56. 00 05600 RADI 01 SOTOPE 57. 00 05700 CT SCAN | 0 8, 870, 845 | 35, 461, 013 | 44, 331, 858 | | 0. 000000 0. 000000 | 56. 00 57. 00 |
| 58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI) | 2, 341, 199 | 23, 975, 801 | 26, 317, 000 | | 0. 000000 | 58. 00 |
| 59. 00 05900 CARDI AC CATHETERI ZATI ON | 10, 949, 775 | 8, 161, 484 | | | 0. 000000 | 59. 00 |
| 60. 00 06000 LABORATORY 60. 01 06001 BLOOD LABORATORY | 19, 809, 571 | 40, 644, 688 | | | 0.000000 | 60.00 |
| 60. 01 06001 BLOOD LABORATORY 61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY | 0 | 0 | | 0. 000000 0. 000000 | 0. 000000 0. 000000 | 60. 01 61. 00 |
| 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS | o o | 0 | | 0. 000000 | 0. 000000 | 62.00 |
| 63.00 06300 BLOOD STORING, PROCESSING & TRANS. | o | 0 |) c | 0. 000000 | 0. 000000 | 63. 00 |
| 64. 00 06400 I NTRAVENOUS THERAPY | 2, 501 | 387, 888 | | | 0.000000 | 64.00 |
| 65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY | 4, 995, 680 1, 574, 879 | 392, 720 800, 382 | | | 0. 000000 0. 000000 | 65. 00 66. 00 |
| 67. 00 06700 OCCUPATI ONAL THERAPY | 1, 407, 241 | 570, 363 | | | 0. 000000 | 67. 00 |
| 68.00 06800 SPEECH PATHOLOGY | 588, 215 | 87, 428 | 675, 643 | 0. 135245 | 0. 000000 | 68. 00 |
| 69. 00 06900 ELECTROCARDI OLOGY | 4, 579, 099 | 12, 239, 535 | | | 0.000000 | 69.00 |
| 70.00 07000 ELECTROENCEPHALOGRAPHY 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 112, 783 7, 254, 743 | 4, 300, 594 13, 416, 611 | | | 0. 000000 0. 000000 | 70. 00 71. 00 |
| 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS | 4, 078, 547 | 18, 291, 626 | | | 0. 000000 | 72. 00 |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | 15, 874, 867 | 13, 950, 710 | 29, 825, 577 | 0. 236586 | 0. 000000 | 73. 00 |
| 74. 00 07400 RENAL DIALYSIS | 818, 766 | 90, 383 | 909, 149 | | 0.000000 | 74.00 |
| 75. 00 07500 ASC (NON-DISTINCT PART) 76. 00 03950 OTHER ANCILL SRVC | | 0 | | 0. 000000 | 0. 000000 0. 000000 | 75. 00 76. 00 |
| 76. 01 03951 CARDI AC AND PULMONARY REHAB | 4, 556 | 208, 978 | 213, 534 | | 0. 000000 | 76. 01 |
| 76. 02 03952 WOUND CARE | 371 | 42, 035 | 1 | | 0. 000000 | 76. 02 |
| 77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION OUTPATIENT SERVICE COST CENTERS | 0 | 0 | (| 0. 000000 | 0. 000000 | 77. 00 |
| 88. 00 08800 RURAL HEALTH CLINIC | O | 0 | | | | 88. 00 |
| 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER | o | 0 | C |) | | 89. 00 |
| 90. 00 09000 CLI NI C | 0 | 0 205 204 | 20 720 423 | 0.000000 | 0. 000000 0. 000000 | 90.00 |
| 90. 01 09001 CLI NI C 90. 02 09002 CLI NI C | 515, 139 0 | 29, 205, 294 6, 275, 161 | | | 0. 000000 | 90. 01 90. 02 |
| 91. 00 09100 EMERGENCY | 11, 593, 232 | 31, 750, 167 | | | 0. 000000 | 91.00 |
| 92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART) | 2, 444, 696 | 9, 547, 557 | 11, 992, 253 | 0. 375088 | 0. 000000 | 92. 00 |
| OTHER REIMBURSABLE COST CENTERS 94. 00 09400 HOME PROGRAM DI ALYSI S | l ol | | | 0. 000000 | 0. 000000 | 94. 00 |
| 95. 00 09500 AMBULANCE SERVICES | 0 | 0 | | | 0. 000000 | 95.00 |
| 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED | Ö | 0 | | 0. 000000 | 0. 000000 | 96. 00 |
| 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD | 0 | 0 | C | 0. 000000 | 0. 000000 | 97. 00 |
| 98. 00 09850 OTHER REI MBURSE 99. 00 09900 CMHC | 0 | 0 | | 0. 000000 | 0. 000000 | 98. 00 99. 00 |
| 99. 10 09910 CORF | | 0 | | | | 99. 10 |
| 100.00 10000 I&R SERVICES-NOT APPRVD PRGM | o | 0 | d | | | 100. 00 |
| 101. 00 10100 HOME HEALTH AGENCY | 0 | 0 | (|) | | 101. 00 |
| SPECIAL PURPOSE COST CENTERS 105.00 10500 KIDNEY ACQUISITION | O | 0 | | | | 105. 00 |
| 106. 00 10600 HEART ACQUISITION | 0 | 0 | | | | 105.00 |
| 107. 00 10700 LI VER ACQUI SI TI ON | 0 | 0 | d | | | 107. 00 |
| 108. 00 10800 LUNG ACQUISITION | 0 | 0 | 9 | | | 108.00 |
| 109. 00 10900 PANCREAS ACQUISITION 110. 00 11000 INTESTINAL ACQUISITION | 0 | 0 | | | | 109. 00 110. 00 |
| 111. 00 11100 I SLET ACQUISITION | | 0 | | | | 111.00 |
| 113.00 11300 INTEREST EXPENSE | <u> </u> | | | <u> </u> | | 113. 00 |
| | | | | | | |

| Health Financial Systems | FRANCI SCAN HEAI | LTH MUNSTER | | In Lie | u of Form CMS-2 | 2552-10 |
|--|------------------|-----------------------|----------------------------|---|---|---------|
| COMPUTATION OF RATIO OF COSTS TO CHARGES | | Provi der Co | | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I Date/Time Pre 5/31/2022 7:5 | |
| | | Title | XVIII | Hospi tal | PPS | |
| Cost Center Description | I npati ent | Charges Outpatient | Total (col. 6 + col. 7) | Cost or Other Ratio | TEFRA Inpatient | |

| 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 | |
| 114.00 11400 UTILIZATION REVIEW-SNF | | | | | | 114. 00 |
| 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) | O | 0 | 0 | | | 115. 00 |
| 116. 00 11600 HOSPI CE | 5, 487 | 0 | 5, 487 | | | 116. 00 |
| 200.00 Subtotal (see instructions) | 143, 110, 309 | 364, 199, 162 | 507, 309, 471 | | | 200. 00 |
| 201.00 Less Observation Beds | | | | | | 201. 00 |
| 202.00 Total (see instructions) | 143, 110, 309 | 364, 199, 162 | 507, 309, 471 | | | 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: | 5/31/2022 7:54 am | PPS | Title XVIII

| | | | Title XVIII | Hospi tal | PPS |
|--------|---|---------------|-------------|-----------|---------|
| | Cost Center Description | PPS Inpatient | | | |
| | · · | Ratio | | | |
| | | 11. 00 | | | |
| | INPATIENT ROUTINE SERVICE COST CENTERS | | | | |
| 30.00 | 03000 ADULTS & PEDIATRICS | | | | 30.00 |
| 31. 00 | 03100 INTENSIVE CARE UNIT | | | | 31.00 |
| 32.00 | 03200 CORONARY CARE UNIT | | | | 32.00 |
| 33. 00 | 03300 BURN INTENSIVE CARE UNIT | | | | 33.00 |
| 34.00 | 03400 SURGICAL INTENSIVE CARE UNIT | | | | 34.00 |
| 40.00 | 04000 SUBPROVI DER - I PF | | | | 40.00 |
| 41. 00 | 04100 SUBPROVI DER - I RF | | | | 41. 00 |
| 43.00 | 04300 NURSERY | | | | 43.00 |
| 44.00 | 04400 SKILLED NURSING FACILITY | | | | 44. 00 |
| 45.00 | 04500 NURSING FACILITY | | | | 45. 00 |
| 46.00 | 04600 OTHER LONG TERM CARE | | | | 46. 00 |
| | ANCILLARY SERVICE COST CENTERS | | | | |
| 50.00 | 05000 OPERATING ROOM | 0. 148805 | | | 50.00 |
| 51.00 | 05100 RECOVERY ROOM | 0. 285661 | | | 51.00 |
| 52.00 | 05200 DELIVERY ROOM & LABOR ROOM | 0. 000000 | | | 52.00 |
| 53.00 | 05300 ANESTHESI OLOGY | 0. 033577 | | | 53.00 |
| 54.00 | 05400 RADI OLOGY-DI AGNOSTI C | 0. 139318 | | | 54.00 |
| 55.00 | 05500 RADI OLOGY-THERAPEUTI C | 0. 000000 | | | 55. 00 |
| 56.00 | 05600 RADI OI SOTOPE | 0. 000000 | | | 56. 00 |
| 57. 00 | 05700 CT SCAN | 0. 030483 | | | 57. 00 |
| 58. 00 | 05800 MAGNETIC RESONANCE IMAGING (MRI) | 0. 074051 | | | 58. 00 |
| 59. 00 | 05900 CARDI AC CATHETERI ZATI ON | 0. 233322 | | | 59. 00 |
| 60. 00 | 06000 LABORATORY | 0. 118963 | | | 60.00 |
| 60. 01 | 06001 BLOOD LABORATORY | 0. 000000 | | | 60. 01 |
| 61. 00 | 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY | 0. 000000 | | | 61. 00 |
| 62. 00 | 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS | 0. 000000 | | | 62. 00 |
| | 06300 BLOOD STORING, PROCESSING & TRANS. | 1 1 | | | |
| 63. 00 | · · | 0.000000 | | | 63. 00 |
| 64. 00 | 06400 I NTRAVENOUS THERAPY | 0. 003407 | | | 64.00 |
| 65.00 | 06500 RESPI RATORY THERAPY | 0. 351382 | | | 65. 00 |
| 66. 00 | 06600 PHYSI CAL THERAPY | 0. 169889 | | | 66. 00 |
| 67. 00 | 06700 OCCUPATI ONAL THERAPY | 0. 135721 | | | 67. 00 |
| 68. 00 | | 0. 135245 | | | 68. 00 |
| 69. 00 | 06900 ELECTROCARDI OLOGY | 0. 045862 | | | 69. 00 |
| 70. 00 | 07000 ELECTROENCEPHALOGRAPHY | 0. 513998 | | | 70.00 |
| 71. 00 | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0. 450024 | | | 71.00 |
| 72.00 | 07200 IMPL. DEV. CHARGED TO PATIENTS | 0. 352057 | | | 72.00 |
| 73.00 | 07300 DRUGS CHARGED TO PATIENTS | 0. 236586 | | | 73.00 |
| 74. 00 | 07400 RENAL DIALYSIS | 0. 003406 | | | 74.00 |
| 75. 00 | 07500 ASC (NON-DISTINCT PART) | 0. 000000 | | | 75. 00 |
| 76. 00 | 03950 OTHER ANCILL SRVC | 0. 000000 | | | 76. 00 |
| 76. 01 | 03951 CARDI AC AND PULMONARY REHAB | 1. 561339 | | | 76. 01 |
| 76. 02 | 1 | 0. 224850 | | | 76. 02 |
| | 07700 ALLOGENEIC STEM CELL ACQUISITION | 0. 000000 | | | 77. 00 |
| | OUTPATIENT SERVICE COST CENTERS | | | | |
| 88. 00 | 08800 RURAL HEALTH CLINIC | | | | 88. 00 |
| 89. 00 | | | | | 89. 00 |
| 90. 00 | | 0. 000000 | | | 90, 00 |
| | 09001 CLINI C | 0. 113722 | | | 90. 01 |
| 90. 01 | | 0. 135602 | | | 90.02 |
| 91. 00 | l l | 0. 149899 | | | 91. 00 |
| | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 0. 375088 | | | 92.00 |
| 72.00 | | 0.373000 | | | 72.00 |
| 94. 00 | OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DI ALYSI S | 0.000000 | | | 94. 00 |
| | | 0. 000000 | | | • |
| 95. 00 | | 0.000000 | | | 95. 00 |
| 96.00 | | 0. 000000 | | | 96. 00 |
| 97. 00 | 09700 DURABLE MEDICAL EQUIP-SOLD | 0. 000000 | | | 97. 00 |
| | 09850 OTHER REI MBURSE | 0. 000000 | | | 98. 00 |
| | 09900 CMHC | | | | 99. 00 |
| | 09910 CORF | | | | 99. 10 |
| | 10000 I&R SERVICES-NOT APPRVD PRGM | | | | 100. 00 |
| 101.00 | 10100 HOME HEALTH AGENCY | | | | 101. 00 |
| | SPECIAL PURPOSE COST CENTERS | | | | |
| 105.00 | 10500 KIDNEY ACQUISITION | | | | 105. 00 |
| | 10600 HEART ACQUISITION | | | | 106. 00 |
| | 10700 LIVER ACQUISITION | | | | 107. 00 |
| | 10800 LUNG ACQUISITION | | | | 108. 00 |
| | 10900 PANCREAS ACQUISITION | | | | 109. 00 |
| | 11000 INTESTINAL ACQUISITION | | | | 110. 00 |
| | 11100 I SLET ACQUISITION | | | | 111.00 |
| | 11300 I NTEREST EXPENSE | | | | 113. 00 |
| | 11400 UTILIZATION REVIEW-SNF | | | | 114. 00 |
| | 11500 AMBULATORY SURGICAL CENTER (D. P.) | | | | 115. 00 |
| 113.00 | DITION AND DELATOR I SURGICAL CENTER (D. P.) | 1 | | | [113.00 |
| | | | | | |

| Health Finar | ncial Systems | FRANCI SCAN HEAL | TH MUNSTER | In Lieu of Form CMS-2552-10 | | |
|--------------|------------------------------|------------------|-----------------------|-----------------------------|--------------------------------|---------|
| COMPUTATI ON | OF RATIO OF COSTS TO CHARGES | | Provider CCN: 15-0165 | Peri od: | Worksheet C | |
| | | | | From 01/01/2021 | Part I | |
| | | | | To 12/31/2021 | Date/Time Pre 5/31/2022 7:5 | |
| | | | Title XVIII | Hospi tal | PPS | |
| | Cost Center Description | PPS Inpatient | | | | |
| | | Ratio | | | | |
| | | 11. 00 | | | | |
| 116.00 11600 | HOSPI CE | | | | | 116. 00 |
| 200.00 | Subtotal (see instructions) | | | | | 200. 00 |
| 201. 00 | Less Observation Beds | | | | | 201. 00 |
| 202. 00 | Total (see instructions) | | | | | 202. 00 |

| Health Financial Systems | FRANCI SCAN HEA | ALTH MUNSTER | | In Lie | eu of Form CMS- | 2552-10 |
|---|---|--------------------|-----------------------------|---|-----------------------------|--------------------|
| COMPUTATION OF RATIO OF COSTS TO CHARGES | Provi der CCN: 15-0165 | | F | Period: Worksheet C From 01/01/2021 Part I To 12/31/2021 Date/Time Pi | | pared: |
| | | Ti tl | e XIX | Hospi tal | 5/31/2022 7:5 PPS | 4 am |
| | | | | Costs | | |
| Cost Center Description | Total Cost (from Wkst. B, Part I, col. 26) | Therapy Limit Adj. | Total Costs | RCE Di sal I owance | Total Costs | |
| | 1.00 | 2.00 | 3.00 | 4. 00 | 5. 00 | |
| INPATIENT ROUTINE SERVICE COST CENTERS | 22 (70 220 | ı | 22 (70 220 | 1 001 | 22 (00 220 | 20.00 |
| 30. 00 03000 ADULTS & PEDI ATRI CS 31. 00 03100 NTENSI VE CARE UNI T | 23, 679, 328 4, 486, 420 | ł . | 23, 679, 328 4, 486, 420 | | 23, 680, 329 4, 486, 420 | 1 |
| 32. 00 03200 CORONARY CARE UNIT | 0 | | 1, 100, 120 | Ö | 0 | 1 |
| 33.00 03300 BURN INTENSIVE CARE UNIT | 0 | | C | 0 | 0 | 33. 00 |
| 34. 00 03400 SURGICAL INTENSIVE CARE UNIT | 0 | | C | 0 | 0 | |
| 40. 00 04000 SUBPROVI DER - PF 41. 00 04100 SUBPROVI DER - RF | 0 | | | 0 | 0 | |
| 43. 00 04300 NURSERY | Ö | | | o o | Ö | 1 |
| 44.00 04400 SKILLED NURSING FACILITY | 0 | | C | 0 | 0 | |
| 45. 00 04500 NURSI NG FACI LI TY | 0 | | C | 0 | 0 | |
| 46. 00 04600 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS | 0 | | C | 0 | 0 | 46. 00 |
| 50. 00 05000 OPERATING ROOM | 11, 059, 327 | | 11, 059, 327 | 0 | 11, 059, 327 | 50.00 |
| 51.00 05100 RECOVERY ROOM | 2, 410, 615 | | 2, 410, 615 | 0 | 2, 410, 615 | |
| 52. 00 05200 DELI VERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY | 0 | | (44, 044 | _ | 0 | |
| 53. 00 05300 ANESTHESTOLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C | 646, 966 4, 454, 586 | | 646, 966 4, 454, 586 | | 646, 966 4, 454, 586 | |
| 55. 00 05500 RADI OLOGY-THERAPEUTI C | 0 | | 0 | | 0 | 1 |
| 56. 00 05600 RADI OI SOTOPE | 0 | | 0 | 0 | 0 | |
| 57. 00 05700 CT SCAN | 1, 351, 388 | | 1, 351, 388 | | 1, 351, 388 | |
| 58. 00 05800 MAGNETI C RESONANCE I MAGING (MRI) 59. 00 05900 CARDIAC CATHETERIZATION | 1, 948, 797 4, 459, 084 | | 1, 948, 797 4, 459, 084 | | 1, 948, 797 4, 459, 084 | |
| 60. 00 06000 LABORATORY | 7, 191, 146 | | 7, 191, 146 | | 7, 191, 824 | |
| 60. 01 06001 BL00D LABORATORY | 0 | | C | 0 | 0 | |
| 61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY | 0 | | C | 0 | 0 | |
| 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 63. 00 06300 BLOOD STORING, PROCESSING & TRANS. | 0 | | | 0 | 0 | |
| 64. 00 06400 NTRAVENOUS THERAPY | 1, 330 | | 1, 330 | o o | 1, 330 | 1 |
| 65. 00 06500 RESPIRATORY THERAPY | 1, 893, 389 | 0 | 1, 893, 389 | 0 | 1, 893, 389 | 65. 00 |
| 66. 00 06600 PHYSI CAL THERAPY | 403, 530 | | 403, 530 | | 403, 530 | |
| 67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY | 268, 403 91, 377 | | 268, 403 91, 377 | | 268, 403 91, 377 | |
| 69. 00 06900 ELECTROCARDI OLOGY | 771, 334 | | 771, 334 | | 771, 334 | |
| 70.00 07000 ELECTROENCEPHALOGRAPHY | 2, 268, 235 | | 2, 268, 235 | 233 | 2, 268, 468 | |
| 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 9, 302, 601 | | 9, 302, 601 | | 9, 302, 601 | |
| 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 73. 00 07300 DRUGS CHARGED TO PATIENTS | 7, 875, 579 7, 056, 322 | | 7, 875, 579 7, 056, 322 | | 7, 875, 579 7, 056, 322 | |
| 74. 00 07400 RENAL DIALYSIS | 3, 097 | | 3, 097 | | 3, 097 | |
| 75.00 07500 ASC (NON-DISTINCT PART) | 0 | | C | 0 | 0 | |
| 76. 00 03950 OTHER ANCILL SRVC | 0 | | 222 200 | 0 | | 76.00 |
| 76. 01 03951 CARDI AC AND PULMONARY REHAB 76. 02 03952 WOUND CARE | 333, 399 9, 535 | | 333, 399 9, 535 | | 333, 399 9 535 | 76. 01 |
| 77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION | 0 | | C | | 0 | 1 |
| OUTPATIENT SERVICE COST CENTERS | 1 - | I | | _ | _ | |
| 88.00 08800 RURAL HEALTH CLINIC 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER | 0 | | 0 | 0 | 0 | |
| 90. 00 09000 CLINIC | | | | | 0 | 1 |
| 90. 01 09001 CLI NI C | 3, 378, 562 | | 3, 378, 562 | | 3, 379, 871 | 90. 01 |
| 90. 02 09002 CLI NI C | 850, 922 | | 850, 922 | | 850, 922 | |
| 91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) | 6, 497, 143 4, 498, 148 | ł c | 6, 497, 143 4, 498, 148 | | 6, 497, 143 4, 498, 148 | |
| OTHER REIMBURSABLE COST CENTERS | 4, 470, 140 | | 1, 470, 140 | | 1, 470, 140 | 72.00 |
| 94. 00 09400 HOME PROGRAM DIALYSIS | 0 | | C | _ | 0 | |
| 95. 00 09500 AMBULANCE SERVICES | 0 | | C | 0 | 0 | |
| 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD | 0 | | | 0 | 0 | |
| 98. 00 09850 OTHER REIMBURSE | | | | o o | ő | 1 |
| 99. 00 09900 CMHC | 0 | | 0 | | 0 | |
| 99. 10 09910 CORF | 0 | | 0 | | 0 | |
| 100.00 10000 1&R SERVICES-NOT APPRVD PRGM 101.00 10100 HOME HEALTH AGENCY | | | | | | 100. 00 101. 00 |
| SPECIAL PURPOSE COST CENTERS | | | | 1 | | 101.00 |
| 105. 00 10500 KIDNEY ACQUISITION | 0 | | C | | | 105. 00 |
| 106.00 10600 HEART ACQUISITION | 0 | | | | | 106. 00 107. 00 |
| 107. 00 10700 LIVER ACQUISITION 108. 00 10800 LUNG ACQUISITION | | | | | | 107.00 |
| 109. 00 10900 PANCREAS ACQUISITION | 0 | | | | 0 | 109. 00 |
| 110. 00 11000 NTESTI NAL ACQUI SI TI ON | 0 | | 0 | | | 110.00 |
| 111.00 11100 ISLET ACQUISITION | 0 | 1 | [C | 1 | 1 0 | 111. 00 |
| | | | | | | |

| Health Financial Systems | ALTH MUNSTER | | In Lieu of Form CMS-2552-10 | | | |
|--|--------------|---------------|-----------------------------|---|---|--|
| COMPUTATION OF RATIO OF COSTS TO CHARGES | | Provider Co | | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I Date/Time Pre 5/31/2022 7:5 | |
| | | Ti tl | e XIX | Hospi tal | PPS | |
| | | | | Costs | | |
| Cost Center Description | Total Cost | Therapy Limit | Total Costs | RCE Di sal Lowance | Total Costs | |

| | | | 11 11 | e XIX | Hospi tai | PPS | |
|-----|---|----------------|---------------|---------------|-----------------|---------------|---------|
| | | | | | Costs | | |
| | Cost Center Description | Total Cost | Therapy Limit | Total Costs | RCE | Total Costs | |
| | | (from Wkst. B, | Adj . | | Di sal I owance | | |
| | | Part I, col. | | | | | |
| | | 26) | | | | | |
| | | 1.00 | 2.00 | 3. 00 | 4. 00 | 5. 00 | |
| 113 | . 00 11300 I NTEREST EXPENSE | | | | | | 113. 00 |
| 114 | .00 11400 UTILIZATION REVIEW-SNF | | | | | | 114. 00 |
| 115 | . 00 11500 AMBULATORY SURGICAL CENTER (D. P.) | 0 | | 0 | | 0 | 115. 00 |
| 116 | . 00 11600 HOSPI CE | 19 | | 19 | | 19 | 116. 00 |
| 200 | .00 Subtotal (see instructions) | 107, 190, 582 | 0 | 107, 190, 582 | 3, 221 | 107, 193, 803 | 200. 00 |
| 201 | .00 Less Observation Beds | 4, 498, 148 | | 4, 498, 148 | | 4, 498, 148 | 201. 00 |
| 202 | .00 Total (see instructions) | 102, 692, 434 | 0 | 102, 692, 434 | 3, 221 | 102, 695, 655 | 202. 00 |

| Health Financial Systems | FRANCISCAN HEALTH MUNSTER | In Lie | eu of Form CMS-2552-10 |
|--|---------------------------|-----------------|------------------------|
| COMPUTATION OF RATIO OF COSTS TO CHARGES | Provi der CCN: 15-0 | | Worksheet C |
| | | From 01/01/2021 | |
| | | To 12/31/2021 | Date/Time Prepared: |
| | | | 5/31/2022 7:54 am |

| | | | | | 0 12/31/2021 | 5/31/2022 7:5 | |
|------------------|---|-----------------------------|------------------------------|-------------------|------------------------|------------------------|--------------------|
| | | | Charges | e XIX | Hospi tal | PPS | |
| | Cost Center Description | Inpati ent | Outpati ent | Total (col. 6 | Cost or Other | TEFRA | |
| | | | | + col . 7) | Ratio | Inpati ent | |
| | | 4.00 | 7.00 | 0.00 | 0.00 | Ratio | |
| | INPATIENT ROUTINE SERVICE COST CENTERS | 6.00 | 7. 00 | 8. 00 | 9. 00 | 10. 00 | |
| 30. 00 | 03000 ADULTS & PEDI ATRI CS | 19, 150, 072 | | 19, 150, 072 | | | 30. 00 |
| 31. 00 | 03100 INTENSIVE CARE UNIT | 6, 534, 613 | | 6, 534, 613 | | | 31. 00 |
| 32.00 | 03200 CORONARY CARE UNIT | 0 | | 0 | | | 32.00 |
| 33. 00 34. 00 | 03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT | | | 0 | | | 33. 00 34. 00 |
| 40. 00 | 04000 SUBPROVI DER - I PF | l o | | Ö | | | 40. 00 |
| 41. 00 | 04100 SUBPROVI DER - I RF | 0 | | 0 | | | 41. 00 |
| 43.00 | 04300 NURSERY | 0 | | 0 | | | 43. 00 |
| 44. 00 45. 00 | 04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY | | | | | | 44. 00 45. 00 |
| 46. 00 | 04600 OTHER LONG TERM CARE | l o | | Ö | | | 46. 00 |
| | ANCILLARY SERVICE COST CENTERS | | | I | | | |
| 50.00 | 05000 OPERATI NG ROOM | 10, 115, 020 | 64, 205, 978 | 1 | | | 1 |
| 51. 00 52. 00 | 05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM | 1, 009, 796 | 7, 428, 924 0 | | | 0. 000000 0. 000000 | |
| 53. 00 | 05300 ANESTHESI OLOGY | 2, 860, 810 | 16, 407, 384 | 1 | | 0. 000000 | 1 |
| 54.00 | 05400 RADI OLOGY-DI AGNOSTI C | 5, 617, 806 | 26, 356, 458 | 31, 974, 264 | | | |
| 55. 00 | 05500 RADI OLOGY-THERAPEUTI C | 0 | 0 | 0 | | 0.000000 | |
| 56. 00 57. 00 | 05600 RADI 0I SOTOPE 05700 CT SCAN | 8, 870, 845 | 35, 461, 013 | 0 44, 331, 858 | | 0. 000000 0. 000000 | 1 |
| 58. 00 | 05800 MAGNETIC RESONANCE I MAGING (MRI) | 2, 341, 199 | 23, 975, 801 | | | 0. 000000 | 1 |
| 59. 00 | 05900 CARDI AC CATHETERI ZATI ON | 10, 949, 775 | 8, 161, 484 | | 0. 233322 | 0. 000000 | 1 |
| 60.00 | 06000 LABORATORY | 19, 809, 571 | 40, 644, 688 | | | 0.000000 | 1 |
| 60. 01 61. 00 | 06001 BLOOD LABORATORY 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY | 0 | 0 | 0 | | 0. 000000 0. 000000 | |
| 62. 00 | 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS | | 0 | Ö | 0. 000000 | 0. 000000 | 1 |
| 63.00 | 06300 BLOOD STORING, PROCESSING & TRANS. | o | 0 | 0 | 0. 000000 | 0. 000000 | 1 |
| 64. 00 | 06400 I NTRAVENOUS THERAPY | 2, 501 | 387, 888 | 1 | | 0. 000000 | 1 |
| 65. 00 66. 00 | 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY | 4, 995, 680 | 392, 720 | | | 0.000000 | 1 |
| 67. 00 | 06700 OCCUPATI ONAL THERAPY | 1, 574, 879 1, 407, 241 | 800, 382 570, 363 | 1 | 0. 169889 0. 135721 | 0. 000000 0. 000000 | 1 |
| 68. 00 | 06800 SPEECH PATHOLOGY | 588, 215 | 87, 428 | 1 | | 0. 000000 | 1 |
| 69. 00 | 06900 ELECTROCARDI OLOGY | 4, 579, 099 | 12, 239, 535 | | | 0. 000000 | |
| 70.00 | 07000 ELECTROENCEPHALOGRAPHY | 112, 783 | 4, 300, 594 | | | | 1 |
| 71. 00 72. 00 | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS | 7, 254, 743 4, 078, 547 | 13, 416, 611 18, 291, 626 | | | 0. 000000 0. 000000 | |
| 73. 00 | 07300 DRUGS CHARGED TO PATIENTS | 15, 874, 867 | 13, 950, 710 | | | 0. 000000 | 1 |
| 74. 00 | 07400 RENAL DIALYSIS | 818, 766 | 90, 383 | 909, 149 | | 0. 000000 | 1 |
| 75. 00 | 07500 ASC (NON-DISTINCT PART) | 0 | 0 | _ | | 0.000000 | |
| 76. 00 76. 01 | 03950 OTHER ANCILL SRVC 03951 CARDI AC AND PULMONARY REHAB | 4, 556 | 0 208, 978 | 1 | | 0. 000000 0. 000000 | |
| 76. 02 | 03952 WOUND CARE | 371 | 42, 035 | | | | |
| 77. 00 | 07700 ALLOGENEIC STEM CELL ACQUISITION | 0 | 0 | 0 | 0. 000000 | 0. 000000 | 77. 00 |
| 00.00 | OUTPATIENT SERVICE COST CENTERS | 1 0 | | | 0.000000 | 0.000000 | 00.00 |
| 89. 00 | 08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER | | 0 | | | | |
| 90.00 | 09000 CLINIC | l o | 0 | Ö | | | |
| 90. 01 | 09001 CLI NI C | 515, 139 | 29, 205, 294 | | | | |
| 90. 02 | 09002 CLINIC | 0 | 6, 275, 161 | | 0. 135602 | 0.000000 | |
| 91. 00 92. 00 | 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 11, 593, 232 2, 444, 696 | 31, 750, 167 9, 547, 557 | | | | 1 |
| 72.00 | OTHER REIMBURSABLE COST CENTERS | 2, 444, 070 | 7, 547, 557 | 11, 772, 255 | 0.373000 | 0.00000 | 72.00 |
| 94.00 | I I | 0 | C | 0 | | | |
| 95. 00 | 09500 AMBULANCE SERVICES | 0 | 0 | | | | |
| 96. 00 97. 00 | I I | 0 | 0 | 0 | | | |
| 98. 00 | · · · · · · · · · · · · · · · · · · · | | 0 | Ö | | | |
| 99. 00 | 1 | o | 0 | Ö | | | 99. 00 |
| | 09910 CORF | 0 | 0 | 0 | | | 99. 10 |
| | D10000 1&R SERVICES-NOT APPRVD PRGM D10100 HOME HEALTH AGENCY | 0 | 0 | 0 | | | 100. 00 101. 00 |
| 101.00 | SPECIAL PURPOSE COST CENTERS | <u> </u> | | ·i0 | | | 101.00 |
| | 10500 KIDNEY ACQUISITION | 0 | O | 0 | | | 105. 00 |
| | 0 10600 HEART ACQUISITION | 0 | 0 | _ | | | 106.00 |
| | D 10700 LIVER ACQUISITION D 10800 LUNG ACQUISITION | 0 | 0 | 0 | | | 107. 00 108. 00 |
| | 010900 PANCREAS ACQUISITION | | 0 | 0 | | | 108.00 |
| 110.00 | 11000 INTESTINAL ACQUISITION | | 0 | Ö | | | 110. 00 |
| | 11100 SLET ACQUISITION | 0 | 0 | 0 | | | 111.00 |
| 113.00 | D 11300 INTEREST EXPENSE | <u> </u> | | <u> </u> | | 1 | 113. 00 |

| Health Financial Systems | FRANCISCAN HEA | LTH MUNSTER | | In Lie | u of Form CMS-2 | 2552-10 |
|--|----------------|-------------|-------------|---|---|---------|
| COMPUTATION OF RATIO OF COSTS TO CHARGES | | Provider Co | | Period: From 01/01/2021 To 12/31/2021 | Worksheet C Part I Date/Time Pre 5/31/2022 7:5 | |
| | | Ti tl | e XIX | Hospi tal | PPS | |
| | | Charges | | | | |
| Cost Center Description | Inpatient | Outpati ent | Total (col. | 6 Cost or Other | TEFRA | |

| | | | 1111 | e xi x | ноѕрі таі | PPS | |
|-----------------|----------------------------------|---------------|---------------|---------------|---------------|------------|---------|
| | | | Charges | | | | |
| C | 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 | |
| 114. 00 11400 U | ITILIZATION REVIEW-SNF | | | | | | 114. 00 |
| 115. 00 11500 A | MBULATORY SURGICAL CENTER (D.P.) | 0 | 0 | C | | | 115. 00 |
| 116. 00 11600 H | IOSPI CE | 5, 487 | 0 | 5, 487 | | | 116. 00 |
| 200.00 S | Subtotal (see instructions) | 143, 110, 309 | 364, 199, 162 | 507, 309, 471 | | | 200. 00 |
| 201.00 L | ess Observation Beds | | | | | | 201. 00 |
| 202.00 T | otal (see instructions) | 143, 110, 309 | 364, 199, 162 | 507, 309, 471 | | | 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: | 5/31/2022 7:54 am | PPS Title XIX

| | | | Title XIX | Hospi tal | PPS | |
|--------|--|---------------|-----------|-----------|-----|---------|
| | Cost Center Description | PPS Inpatient | | | | |
| | | Ratio | | | | |
| | | 11.00 | | | | |
| | INPATIENT ROUTINE SERVICE COST CENTERS | 11.00 | | | | |
| 20.00 | | | | | | 30.00 |
| 30.00 | 03000 ADULTS & PEDIATRICS | | | | | 30.00 |
| 31. 00 | 03100 I NTENSI VE CARE UNI T | | | | | 31. 00 |
| 32. 00 | 03200 CORONARY CARE UNIT | | | | | 32. 00 |
| 33. 00 | 03300 BURN INTENSIVE CARE UNIT | | | | | 33. 00 |
| 34.00 | 03400 SURGICAL INTENSIVE CARE UNIT | | | | | 34.00 |
| 40.00 | 04000 SUBPROVI DER - I PF | | | | | 40.00 |
| 41.00 | 04100 SUBPROVI DER - I RF | | | | | 41.00 |
| 43. 00 | 04300 NURSERY | | | | | 43. 00 |
| 44. 00 | 04400 SKILLED NURSING FACILITY | | | | | 44. 00 |
| | | | | | | 1 |
| 45. 00 | 04500 NURSING FACILITY | | | | | 45. 00 |
| 46. 00 | 04600 OTHER LONG TERM CARE | | | | | 46. 00 |
| | ANCILLARY SERVICE COST CENTERS | | | | | |
| 50.00 | 05000 OPERATING ROOM | 0. 148805 | | | | 50. 00 |
| 51.00 | 05100 RECOVERY ROOM | 0. 285661 | | | | 51.00 |
| 52.00 | 05200 DELIVERY ROOM & LABOR ROOM | 0. 000000 | | | | 52. 00 |
| 53.00 | 05300 ANESTHESI OLOGY | 0. 033577 | | | | 53. 00 |
| 54. 00 | 05400 RADI OLOGY-DI AGNOSTI C | 0. 139318 | | | | 54. 00 |
| 55. 00 | 05500 RADI OLOGY-THERAPEUTI C | 0. 000000 | | | | 55.00 |
| | | | | | | 1 |
| 56.00 | 05600 RADI OI SOTOPE | 0. 000000 | | | | 56.00 |
| 57. 00 | 05700 CT SCAN | 0. 030483 | | | | 57. 00 |
| 58. 00 | 05800 MAGNETIC RESONANCE I MAGING (MRI) | 0. 074051 | | | | 58. 00 |
| 59. 00 | 05900 CARDI AC CATHETERI ZATI ON | 0. 233322 | | | | 59. 00 |
| 60.00 | 06000 LABORATORY | 0. 118963 | | | | 60.00 |
| 60. 01 | 06001 BLOOD LABORATORY | 0. 000000 | | | | 60. 01 |
| 61.00 | 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY | 0. 000000 | | | | 61.00 |
| 62. 00 | 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS | 0. 000000 | | | | 62.00 |
| 63. 00 | 06300 BLOOD STORING, PROCESSING & TRANS. | 0. 000000 | | | | 63.00 |
| 64. 00 | 06400 I NTRAVENOUS THERAPY | 1 | | | | |
| | l l | 0. 003407 | | | | 64.00 |
| 65. 00 | 06500 RESPI RATORY THERAPY | 0. 351382 | | | | 65. 00 |
| 66. 00 | 06600 PHYSI CAL THERAPY | 0. 169889 | | | | 66. 00 |
| 67. 00 | 06700 OCCUPATI ONAL THERAPY | 0. 135721 | | | | 67. 00 |
| 68.00 | 06800 SPEECH PATHOLOGY | 0. 135245 | | | | 68. 00 |
| 69. 00 | 06900 ELECTROCARDI OLOGY | 0. 045862 | | | | 69. 00 |
| 70.00 | 07000 ELECTROENCEPHALOGRAPHY | 0. 513998 | | | | 70. 00 |
| 71. 00 | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0. 450024 | | | | 71. 00 |
| 72. 00 | 07200 IMPL. DEV. CHARGED TO PATIENTS | 0. 352057 | | | | 72.00 |
| | 1 1 | 1 | | | | |
| | 07300 DRUGS CHARGED TO PATIENTS | 0. 236586 | | | | 73.00 |
| 74. 00 | 07400 RENAL DI ALYSI S | 0. 003406 | | | | 74. 00 |
| | 07500 ASC (NON-DISTINCT PART) | 0. 000000 | | | | 75. 00 |
| 76. 00 | 03950 OTHER ANCILL SRVC | 0. 000000 | | | | 76. 00 |
| 76. 01 | 03951 CARDI AC AND PULMONARY REHAB | 1. 561339 | | | | 76. 01 |
| 76. 02 | 03952 WOUND CARE | 0. 224850 | | | | 76. 02 |
| 77. 00 | 07700 ALLOGENEIC STEM CELL ACQUISITION | 0. 000000 | | | | 77. 00 |
| | OUTPATIENT SERVICE COST CENTERS | | | | | |
| 88. 00 | 08800 RURAL HEALTH CLINIC | 0. 000000 | | | | 88. 00 |
| 89. 00 | 08900 FEDERALLY QUALIFIED HEALTH CENTER | 0. 000000 | | | | 89. 00 |
| | 1 1 | | | | | |
| | 09000 CLINIC | 0.000000 | | | | 90.00 |
| | 09001 CLI NI C | 0. 113722 | | | | 90. 01 |
| | 09002 CLI NI C | 0. 135602 | | | | 90. 02 |
| 91. 00 | 09100 EMERGENCY | 0. 149899 | | | | 91.00 |
| 92.00 | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 0. 375088 | | | | 92. 00 |
| | OTHER REIMBURSABLE COST CENTERS | | | | | |
| 94.00 | 09400 HOME PROGRAM DIALYSIS | 0. 000000 | | | | 94. 00 |
| 95.00 | 09500 AMBULANCE SERVICES | 0. 000000 | | | | 95. 00 |
| | 09600 DURABLE MEDICAL EQUIP-RENTED | 0. 000000 | | | | 96.00 |
| | 09700 DURABLE MEDICAL EQUIP-SOLD | 0. 000000 | | | | 97. 00 |
| | | | | | | 98.00 |
| 98. 00 | 09850 OTHER REIMBURSE | 0. 000000 | | | | |
| | 09900 CMHC | | | | | 99. 00 |
| | 09910 CORF | | | | | 99. 10 |
| 100.00 | 10000 I&R SERVICES-NOT APPRVD PRGM | | | | | 100. 00 |
| 101.00 | 10100 HOME HEALTH AGENCY | | | | | 101. 00 |
| | SPECIAL PURPOSE COST CENTERS | | | | | |
| 105.00 | 10500 KIDNEY ACQUISITION | | | | | 105. 00 |
| | 10600 HEART ACQUISITION | | | | | 106. 00 |
| | 10700 LIVER ACQUISITION | | | | | 107. 00 |
| | | | | | | |
| | 10800 LUNG ACQUISITION | | | | | 108.00 |
| | 10900 PANCREAS ACQUISITION | | | | | 109. 00 |
| | 11000 INTESTINAL ACQUISITION | | | | | 110. 00 |
| 111.00 | 11100 SLET ACQUISITION | | | | | 111. 00 |
| 113.00 | 11300 I NTEREST EXPENSE | | | | | 113. 00 |
| 114.00 | 11400 UTILIZATION REVIEW-SNF | | | | | 114. 00 |
| | 11500 AMBULATORY SURGICAL CENTER (D. P.) | | | | | 115. 00 |
| | · · · · · · · · · · · · · · · · · · · | | | | | • |

| | | ANCISCAN HEALTH MUNSTER In Lieu of Form C | | | 2552-10 |
|--|---------------|---|--|---|---------|
| COMPUTATION OF RATIO OF COSTS TO CHARGES | | Provider CCN: 15-0165 | Peri od: From 01/01/2021 To 12/31/2021 | Worksheet C Part I Date/Time Pre 5/31/2022 7:5 | |
| | | Title XIX | Hospi tal | PPS | |
| Cost Center Description | PPS Inpatient | | | | |
| | Ratio | | | | |
| | 11. 00 | | | | |
| 116. 00 11600 HOSPI CE | | | | | 116. 00 |
| 200.00 Subtotal (see instructions) | | | | | 200. 00 |
| 201.00 Less Observation Beds | | | | | 201. 00 |
| 202.00 Total (see instructions) | | | | | 202. 00 |

 Heal th Financial Systems
 FRANCISCAN HEALTH MUNSTER

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

Period: Worksheet C
From 01/01/2021 Part II
To 12/31/2021 Date/Time Prepared: 5/31/2022 7:54 am Provider CCN: 15-0165

| | | | 10 | 12/31/2021 | 5/31/2022 7:5 | |
|---|-----------------------------|-------------|----------------|------------------------|-----------------------------|--------------------|
| | 1 | | e XIX | Hospi tal | PPS | |
| Cost Center Description | Total Cost | | Operating Cost | Capi tal Reducti on | Operating Cost Reduction | |
| | I, col. 26) | | Cost (col. 1 - | Reduction | Amount | |
| | 1, 661. 26) | 11 001. 20) | col. 2) | | 7 illiodi i e | |
| | 1.00 | 2.00 | 3.00 | 4. 00 | 5. 00 | |
| ANCI LLARY SERVI CE COST CENTERS | | | | | _ | |
| 50.00 05000 0PERATING ROOM 51.00 05100 RECOVERY ROOM | 11, 059, 327 | | | 0 | 0 | 50. 00 51. 00 |
| 52. 00 05200 DELI VERY ROOM & LABOR ROOM | 2, 410, 615 | 282, 287 | 2, 128, 328 | 0 | 0 | 52.00 |
| 53. 00 05300 ANESTHESI OLOGY | 646, 966 | 4, 895 | 642, 071 | 0 | Ö | 53. 00 |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C | 4, 454, 586 | 314, 143 | 4, 140, 443 | 0 | 0 | 54.00 |
| 55. 00 05500 RADI OLOGY-THERAPEUTI C | 0 | C | 0 | 0 | 0 | 55. 00 |
| 56. 00 05600 RADI OI SOTOPE | 1 251 200 | 10.00 | 0 | 0 | 0 | 56. 00 |
| 57.00 05700 CT SCAN 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) | 1, 351, 388 1, 948, 797 | | | 0 | 0 | 57. 00 58. 00 |
| 59. 00 05900 CARDI AC CATHETERI ZATI ON | 4, 459, 084 | l | | 0 | Ö | 59. 00 |
| 60. 00 06000 LABORATORY | 7, 191, 146 | l | | 0 | 0 | 60.00 |
| 60. 01 06001 BLOOD LABORATORY | 0 | C | 0 | 0 | 0 | 60. 01 |
| 61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY | 0 | C | 0 | 0 | 0 | 61.00 |
| 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 63.00 06300 BLOOD STORING, PROCESSING & TRANS. | 0 | | | 0 | 0 | 62. 00 63. 00 |
| 64. 00 06400 I NTRAVENOUS THERAPY | 1, 330 | 14 | 1, 316 | 0 | 0 | 64. 00 |
| 65. 00 06500 RESPIRATORY THERAPY | 1, 893, 389 | l e | | 0 | 0 | 65. 00 |
| 66. 00 06600 PHYSI CAL THERAPY | 403, 530 | | | 0 | 0 | 66. 00 |
| 67. 00 06700 OCCUPATI ONAL THERAPY | 268, 403 | | | 0 | 0 | 67. 00 |
| 68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY | 91, 377 | | | 0 | 0 | 68. 00 |
| 69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY | 771, 334 2, 268, 235 | 1 | | 0 | 0 | 69. 00 70. 00 |
| 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 9, 302, 601 | 67, 173 | , | 0 | Ö | 71. 00 |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS | 7, 875, 579 | 1 | | 0 | 0 | 72. 00 |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | 7, 056, 322 | l | | 0 | 0 | 73. 00 |
| 74. 00 07400 RENAL DIALYSIS | 3, 097 | 32 | 3, 065 | 0 | 0 | 74.00 |
| 75. 00 07500 ASC (NON-DISTINCT PART) 76. 00 03950 OTHER ANCILL SRVC | 0 | | | 0 | 0 0 | 75. 00 76. 00 |
| 76. 01 03951 CARDI AC AND PULMONARY REHAB | 333, 399 | 2, 787 | 330, 612 | 0 | 0 | 76. 00 |
| 76. 02 03952 WOUND CARE | 9, 535 | | | 0 | 0 | 76. 02 |
| 77.00 07700 ALLOGENEIC STEM CELL ACQUISITION | 0 | C | 0 | 0 | 0 | 77. 00 |
| OUTPATIENT SERVICE COST CENTERS | | | | 0 | 1 0 | 00.00 |
| 88.00 08800 RURAL HEALTH CLINIC 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER | 0 | | | 0 | 0 0 | 88. 00 89. 00 |
| 90. 00 09000 CLI NI C | 0 | | | 0 | Ö | 90. 00 |
| 90. 01 09001 CLI NI C | 3, 378, 562 | 27, 451 | 3, 351, 111 | 0 | 0 | 90. 01 |
| 90. 02 09002 CLI NI C | 850, 922 | l | | 0 | 0 | 90. 02 |
| 91. 00 09100 EMERGENCY | 6, 497, 143 | l | | 0 | 0 | 91.00 |
| 92. 00 O9200 OBSERVATI ON BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS | 4, 498, 148 | 331, 428 | 4, 166, 720 | 0 | 0 | 92. 00 |
| 94. 00 09400 HOME PROGRAM DI ALYSI S | 0 | C | 0 | 0 | 0 | 94. 00 |
| 95. 00 09500 AMBULANCE SERVICES | 0 | C | 0 | 0 | 0 | 95. 00 |
| 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED | 0 | C | 0 | 0 | 0 | 96. 00 |
| 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD | 0 | | | 0 | 0 | 97. 00 |
| 98. 00 09850 OTHER REI MBURSE 99. 00 09900 CMHC | 0 | | | 0 | 0 | 98. 00 99. 00 |
| 99. 10 09910 CORF | | | | 0 | | 99. 10 |
| 100.00 10000 I&R SERVICES-NOT APPRVD PRGM | 0 | C | 0 | 0 | 0 | 100. 00 |
| 101.00 10100 HOME HEALTH AGENCY | 0 | C | 0 | 0 | 0 | 101. 00 |
| SPECIAL PURPOSE COST CENTERS 105. 00 10500 KI DNEY ACQUI SI TI ON | | | | 0 | | 105. 00 |
| 106.00 10600 HEART ACQUISITION | 0 | | 0 | 0 | | 105.00 |
| 107. 00 10700 LI VER ACQUI SI TI ON | 0 | Ö | | 0 | l e | 107. 00 |
| 108.00 10800 LUNG ACQUISITION | 0 | C | 0 | 0 | 0 | 108. 00 |
| 109. 00 10900 PANCREAS ACQUISITION | 0 | C | 0 | 0 | | 109. 00 |
| 110. 00 11000 INTESTINAL ACQUISITION 111. 00 11100 ISLET ACQUISITION | 0 | | | 0 | l e | 110. 00 111. 00 |
| 113. 00 11300 NTEREST EXPENSE | | | ή | U | 0 | 111.00 |
| 114. 00 11400 UTI LI ZATI ON REVI EW-SNF | | | | | | 114. 00 |
| 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) | 0 | [c | 0 | 0 | | 115. 00 |
| 116. 00 11600 HOSPI CE | 19 | | 19 | 0 | | 116. 00 |
| 200.00 Subtotal (sum of lines 50 thru 199) 201.00 Less Observation Beds | 79, 024, 834 4, 498, 148 | | | 0 | | 200. 00 201. 00 |
| 202.00 Total (line 200 minus line 201) | 74, 526, 686 | l | | 0 | | 201.00 |
| (1.115 200 11.110 201) | , 525, 500 | -, , 520 | , 555, 156 | Ü | | 00 |

Provider CCN: 15-0165

| | | Ti tI | e XIX | Hospi tal | PPS | 1 uiii |
|---|----------------------------|------------------------------|------------------------|-----------|-----|--------------------|
| Cost Center Description | Cost Net of | Total Charges | | • | | |
| | Capital and | | Cost to Charge | | | |
| | Operating Cost | | | | | |
| | Reduction 6.00 | 8) 7. 00 | / col . 7) 8.00 | | | |
| ANCI LLARY SERVI CE COST CENTERS | 0.00 | 7.00 | 8.00 | | | |
| 50. 00 05000 OPERATI NG ROOM | 11, 059, 327 | 74, 320, 998 | 0. 148805 | | | 50.00 |
| 51. 00 05100 RECOVERY ROOM | 2, 410, 615 | 8, 438, 720 | | | | 51.00 |
| 52.00 05200 DELIVERY ROOM & LABOR ROOM | 0 | 0 | 0.000000 | | | 52. 00 |
| 53. 00 05300 ANESTHESI OLOGY | 646, 966 | 19, 268, 194 | 0. 033577 | | | 53. 00 |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C | 4, 454, 586 | 31, 974, 264 | | | | 54. 00 |
| 55. 00 05500 RADI OLOGY-THERAPEUTI C | 0 | 0 | | | | 55. 00 |
| 56. 00 05600 RADI 01 SOTOPE | 0 | 44 204 250 | 0.000000 | | | 56.00 |
| 57. 00 05700 CT SCAN 58. 00 05800 MAGNETI C RESONANCE I MAGING (MRI) | 1, 351, 388 1, 948, 797 | 44, 331, 858 26, 317, 000 | | | | 57. 00 58. 00 |
| 59. 00 05900 CARDI AC CATHETERI ZATI ON | 4, 459, 084 | 19, 111, 259 | | | | 59.00 |
| 60. 00 06000 LABORATORY | 7, 191, 146 | 60, 454, 259 | | | | 60.00 |
| 60. 01 06001 BLOOD LABORATORY | 0 | 00, 101, 20, | 0. 000000 | | | 60. 01 |
| 61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY | 0 | O | 0.000000 | | | 61.00 |
| 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS | 0 | 0 | 0.000000 | | | 62. 00 |
| 63.00 06300 BLOOD STORING, PROCESSING & TRANS. | 0 | 0 | 0. 000000 | | | 63. 00 |
| 64. 00 06400 I NTRAVENOUS THERAPY | 1, 330 | 390, 389 | | | | 64. 00 |
| 65. 00 06500 RESPIRATORY THERAPY | 1, 893, 389 | 5, 388, 400 | | | | 65. 00 |
| 66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY | 403, 530 | 2, 375, 261 | | | | 66. 00 67. 00 |
| 67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY | 268, 403 91, 377 | 1, 977, 604 675, 643 | | | | 68.00 |
| 69. 00 06900 ELECTROCARDI OLOGY | 771, 334 | 16, 818, 634 | | | | 69.00 |
| 70. 00 07000 ELECTROENCEPHALOGRAPHY | 2, 268, 235 | 4, 413, 377 | | | | 70.00 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 9, 302, 601 | 20, 671, 354 | | | | 71. 00 |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS | 7, 875, 579 | 22, 370, 173 | | | | 72. 00 |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | 7, 056, 322 | 29, 825, 577 | 0. 236586 | | | 73. 00 |
| 74. 00 07400 RENAL DI ALYSI S | 3, 097 | 909, 149 | | | | 74. 00 |
| 75. 00 07500 ASC (NON-DISTINCT PART) | 0 | 0 | 0.00000 | | | 75. 00 |
| 76. 00 03950 OTHER ANCILL SRVC | 0 | 212 524 | 0.000000 | | | 76.00 |
| 76. 01 03951 CARDI AC AND PULMONARY REHAB 76. 02 03952 WOUND CARE | 333, 399 | 213, 534 | | | | 76. 01 76. 02 |
| 76. 02 03952 WOUND CARE 77. 00 07700 ALLOGENEI C STEM CELL ACQUISITION | 9, 535 | 42, 406 | 0. 224850 0. 000000 | | | 77.00 |
| OUTPATIENT SERVICE COST CENTERS | 0 | | 0.000000 | | | 77.00 |
| 88. 00 08800 RURAL HEALTH CLINIC | 0 | 0 | 0. 000000 | | | 88. 00 |
| 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER | 0 | O | 0. 000000 | | | 89. 00 |
| 90. 00 09000 CLI NI C | 0 | O | 0. 000000 | | | 90.00 |
| 90. 01 09001 CLI NI C | 3, 378, 562 | 29, 720, 433 | | | | 90. 01 |
| 90. 02 09002 CLI NI C | 850, 922 | 6, 275, 161 | | | | 90. 02 |
| 91. 00 09100 EMERGENCY | 6, 497, 143 | 43, 343, 399 | | | | 91.00 |
| 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS | 4, 498, 148 | 11, 992, 253 | 0. 375088 | | | 92.00 |
| 94. 00 09400 HOME PROGRAM DI ALYSI S | 0 | 0 | 0.000000 | | | 94. 00 |
| 95. 00 09500 AMBULANCE SERVICES | 0 | Ö | 1 | | | 95. 00 |
| 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED | 0 | O | 0. 000000 | | | 96.00 |
| 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD | 0 | O | 0. 000000 | | | 97. 00 |
| 98. 00 09850 OTHER REI MBURSE | 0 | O | 0.000000 | | | 98. 00 |
| 99. 00 09900 CMHC | 0 | 0 | | | | 99. 00 |
| 99. 10 09910 CORF | 0 | 0 | | | | 99. 10 |
| 100. 00 10000 I &R SERVI CES-NOT APPRVD PRGM | 0 | 0 | | | | 100.00 |
| 101.00 10100 HOME HEALTH AGENCY | 0 | 0 | 0.000000 | | | 101. 00 |
| SPECIAL PURPOSE COST CENTERS 105. 00 10500 KI DNEY ACQUI SITI ON | 0 | O | 0. 000000 | | | 105. 00 |
| 106. 00 10600 HEART ACQUISITION | 0 | 0 | 0.000000 | | | 106.00 |
| 107. 00 10700 LI VER ACQUI SI TI ON | 0 | Ö | 0. 000000 | | | 107. 00 |
| 108.00 10800 LUNG ACQUISITION | 0 | O | 0.000000 | | | 108. 00 |
| 109.00 10900 PANCREAS ACQUISITION | 0 | 0 | 0. 000000 | | | 109. 00 |
| 110.00 11000 INTESTINAL ACQUISITION | 0 | 0 | 0.000000 | | | 110. 00 |
| 111. 00 11100 I SLET ACQUI SI TI ON | 0 | 0 | 0. 000000 | | | 111. 00 |
| 113. 00 11300 INTEREST EXPENSE | | | | | | 113.00 |
| 114. 00 11400 UTI LI ZATI ON REVI EW-SNF | | _ | 0.000000 | | | 114.00 |
| 115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.) 116. 00 11600 HOSPICE | 0 | 5, 487 | 0. 000000 0. 003463 | | | 115. 00 116. 00 |
| 200.00 Subtotal (sum of lines 50 thru 199) | 79, 024, 834 | 5, 487 481, 624, 786 | | | | 200.00 |
| 201.00 Less Observation Beds | 4, 498, 148 | 131, 324, 780 | | | | 201.00 |
| 202.00 Total (line 200 minus line 201) | 74, 526, 686 | 481, 624, 786 | , | | | 202. 00 |
| | | | • | | | |

| Health Financial Systems | FRANCI SCAN HEA | | | | u of Form CMS- | 2552-10 |
|---|-----------------|----------------|---------------|--|---|------------------|
| APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPI | TAL COSTS | Provider C | | Peri od: From 01/01/2021 To 12/31/2021 | Worksheet D Part I Date/Time Pre 5/31/2022 7:5 | epared: i4 am |
| | | Title | XVIII | Hospi tal | PPS | |
| Cost Center Description | Capi tal | Swing Bed | Reduced | Total Patient | Per Diem (col. | |
| | Related Cost | Adjustment | Capi tal | Days | 3 / col . 4) | |
| | (from Wkst. B, | | Related Cos | | | |
| | Part II, col. | | (col. 1 - col | 1. | | |
| | 26) | | 2) | | | |
| | 1.00 | 2.00 | 3.00 | 4. 00 | 5. 00 | |
| INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | |
| 30. 00 ADULTS & PEDI ATRI CS | 1, 744, 797 | 0 | , , , , , | | | |
| 31.00 INTENSIVE CARE UNIT | 385, 469 | | 385, 46 | 69 1, 701 | 226. 61 | |
| 32. 00 CORONARY CARE UNIT | 0 | | | 0 0 | 0.00 | |
| 33.00 BURN INTENSIVE CARE UNIT | 0 | | | 0 0 | 0.00 | 33. 00 |
| 34.00 SURGICAL INTENSIVE CARE UNIT | 0 | | | 0 0 | 0.00 | 34. 00 |
| 40. 00 SUBPROVI DER - I PF | 0 | 0 |) | 0 0 | 0.00 | 40.00 |
| 41. 00 SUBPROVI DER - I RF | 0 | 0 |) | 0 0 | 0.00 | 41.00 |
| 43. 00 NURSERY | 0 | | | 0 0 | 0.00 | 43.00 |
| 44.00 SKILLED NURSING FACILITY | 0 | | | 0 0 | 0.00 | |
| 45.00 NURSING FACILITY | 0 | | | 0 0 | 0.00 | 45. 00 |
| 200.00 Total (lines 30 through 199) | 2, 130, 266 | | 2, 130, 20 | 66 17, 526 | | 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 | 4, 060 | | | | | 30.00 |
| 31.00 INTENSIVE CARE UNIT | 1, 229 | 278, 504 | | | | 31.00 |
| 32. 00 CORONARY CARE UNIT | 0 | 0 |) | | | 32. 00 |
| 33.00 BURN INTENSIVE CARE UNIT | 0 | 0 |) | | | 33. 00 |
| 34.00 SURGICAL INTENSIVE CARE UNIT | 0 | 0 |) | | | 34.00 |
| 40. 00 SUBPROVI DER - I PF | 0 | 0 |) | | | 40.00 |
| 41. 00 SUBPROVI DER - I RF | 0 | 0 |) | | | 41.00 |
| 43. 00 NURSERY | 0 | 0 | 1 | | | 43.00 |
| 44.00 SKILLED NURSING FACILITY | 0 | 0 | | | | 44. 00 |
| 45.00 NURSING FACILITY | 0 | 0 | 1 | | | 45. 00 |
| 200.00 Total (lines 30 through 199) | 5, 289 | 726, 160 | d | | | 200.00 |

| Heal th | Financial Systems | FRANCI SCAN HEA | ALTH MUNSTER | | In Lie | eu of Form CMS- | 2552-10 |
|---------|--|-----------------|----------------|---------------|----------------------------------|-----------------------------|---------------------|
| APP0R1 | FIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA | L COSTS | Provi der C | | Peri od: | Worksheet D | |
| | | | | | From 01/01/2021 To 12/31/2021 | Part II | nanad. |
| | | | | | 10 12/31/2021 | Date/Time Pre 5/31/2022 7:5 | pareu. 4 am |
| | | | Title | xVIII | Hospi tal | PPS | |
| | Cost Center Description | Capi tal | Total Charges | | | Capital Costs | |
| | · | Related Cost | (from Wkst. C, | | Program | (column 3 x | |
| | | (from Wkst. B, | | (col. 1 ÷ col | . Charges | column 4) | |
| | | Part II, col. | 8) | 2) | | | |
| | | 26) | | | | | |
| | | 1.00 | 2. 00 | 3.00 | 4. 00 | 5. 00 | |
| | ANCILLARY SERVICE COST CENTERS | | | | | | |
| 50.00 | 05000 OPERATI NG ROOM | 687, 627 | 74, 320, 998 | | | 50, 853 | 1 |
| 51. 00 | 05100 RECOVERY ROOM | 282, 287 | 8, 438, 720 | | | 13, 403 | |
| 52.00 | 05200 DELIVERY ROOM & LABOR ROOM | 0 | 0 | 0.00000 | | 0 | |
| 53.00 | 05300 ANESTHESI OLOGY | 4, 895 | 19, 268, 194 | | | | |
| 54.00 | 05400 RADI OLOGY-DI AGNOSTI C | 314, 143 | 31, 974, 264 | | | 23, 139 | |
| 55.00 | 05500 RADI OLOGY-THERAPEUTI C | 0 | 0 | 0. 00000 | | 0 | |
| 56.00 | 05600 RADI OI SOTOPE | 0 | 0 | 0. 00000 | | 0 | |
| 57.00 | 05700 CT SCAN | 10, 935 | 44, 331, 858 | 0.00024 | 7 3, 524, 598 | 871 | 57. 00 |
| 58. 00 | 05800 MAGNETIC RESONANCE IMAGING (MRI) | 15, 656 | 26, 317, 000 | 0. 00059 | 5 818, 026 | 487 | 58. 00 |
| 59.00 | 05900 CARDI AC CATHETERI ZATI ON | 601, 304 | 19, 111, 259 | 0. 03146 | 3 1, 871, 378 | 58, 879 | 59. 00 |
| 60.00 | 06000 LABORATORY | 149, 559 | 60, 454, 259 | 0. 00247 | 4 7, 249, 328 | 17, 935 | 60.00 |
| 60. 01 | 06001 BLOOD LABORATORY | 0 | 0 | 0. 00000 | 0 | 0 | 60. 01 |
| 61.00 | 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY | | | | | | 61.00 |
| 62.00 | 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS | 0 | 0 | 0. 00000 | 0 0 | 0 | 62.00 |
| 63.00 | 06300 BLOOD STORING, PROCESSING & TRANS. | 0 | 0 | 0. 00000 | | 0 | 63.00 |
| 64.00 | 06400 I NTRAVENOUS THERAPY | 14 | 390, 389 | | | 0 | 64.00 |
| 65. 00 | 06500 RESPIRATORY THERAPY | 64, 071 | 5, 388, 400 | 1 | | 20, 153 | |
| 66. 00 | 06600 PHYSI CAL THERAPY | 3, 391 | 2, 375, 261 | | | | |
| 67. 00 | 06700 OCCUPATI ONAL THERAPY | 2, 257 | 1, 977, 604 | | | l e | |
| 68. 00 | 06800 SPEECH PATHOLOGY | 768 | 675, 643 | | | | 68.00 |
| 69. 00 | 06900 ELECTROCARDI OLOGY | 6, 394 | 16, 818, 634 | | | | 69.00 |
| 70. 00 | 07000 ELECTROENCEPHALOGRAPHY | 264, 835 | 4, 413, 377 | | | | |
| 71. 00 | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 67, 173 | 20, 671, 354 | | | | |
| 72. 00 | 07200 I MPL. DEV. CHARGED TO PATIENTS | 56, 597 | 22, 370, 173 | | | | |
| 73. 00 | 07300 DRUGS CHARGED TO PATIENTS | 158, 450 | 29, 825, 577 | 1 | | | |
| 74. 00 | 07400 RENAL DIALYSIS | 32 | 909, 149 | | | 0 | 74.00 |
| 75. 00 | 07500 ASC (NON-DISTINCT PART) | 0 | 0,147 | i | | 1 | ł |
| 76. 00 | 03950 OTHER ANCILL SRVC | 0 | 0 | 0. 00000 | | 0 | 76.00 |
| 76. 01 | 03951 CARDI AC AND PULMONARY REHAB | 2, 787 | 213, 534 | 1 | | 1 | 76. 01 |
| 76. 01 | 03952 WOUND CARE | 75 | 42, 406 | 1 | | i e | 76. 01 |
| 77. 00 | 07700 ALLOGENEIC STEM CELL ACQUISITION | 75 | 42, 400 | 1 | | | ł |
| 77.00 | OUTPATIENT SERVICE COST CENTERS | 0 | 0 | 0.00000 | 0 0 | 0 | 77.00 |
| 88. 00 | 08800 RURAL HEALTH CLINIC | 0 | 0 | 0. 00000 | 0 0 | 0 | 88. 00 |
| 89. 00 | 08900 FEDERALLY QUALIFIED HEALTH CENTER | 0 | 0 | ı | | l | 89. 00 |
| 90.00 | 09000 CLINIC | 0 | 0 | ı | | | 90.00 |
| 90.00 | 09000 CEINIC | | 29, 720, 433 | | | 271 | |
| 90. 01 | 09001 CLINI C | 27, 451 | | | | 2/1 | |
| | | 48, 284 | 6, 275, 161 | | | 1 | 90. 02 |
| 91.00 | 09100 EMERGENCY | 392, 543 | 43, 343, 399 | | | | |
| 92. 00 | 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS | 331, 428 | 11, 992, 253 | 0. 02763 | 7 1, 144, 736 | 31, 637 | 92. 00 |
| 04.00 | | 0 | 0 | 0.00000 | 0 0 | | 04.00 |
| 94. 00 | 09400 HOME PROGRAM DIALYSIS | 0 | 0 | 0. 00000 | 0 | 0 | |
| 95. 00 | 09500 AMBULANCE SERVICES | | _ | 0.0000 | | _ | 95. 00 |
| 96.00 | 09600 DURABLE MEDICAL EQUI P-RENTED | 0 | 0 | 0.0000 | | 0 | 96.00 |
| 97. 00 | 09700 DURABLE MEDI CAL EQUI P-SOLD | | 0 | 0.00000 | | 0 | 97.00 |
| 98.00 | 09850 OTHER REIMBURSE | 2 402 054 | 401 410 200 | 0. 00000 | | 202 274 | 98. 00 |
| 200.00 | Total (lines 50 through 199) | 3, 492, 956 | 481, 619, 299 | Ί | 43, 773, 299 | 302, 376 | ₁ 200.00 |

| | | | T | o 12/31/2021 | Date/Time Prep 5/31/2022 7:54 | |
|---|----------------------|---------------|---------------|----------------|-------------------------------|---------|
| | | Title | e XVIII | Hospi tal | PPS | 4 4111 |
| Cost Center Description | Nursi ng | Nursi ng | | Allied Health | All Other | |
| | Program | Program | Post-Stepdown | Cost | Medi cal | |
| | Post-Stepdown | J | Adjustments | | Education Cost | |
| | Adjustments | | | | | |
| | 1A | 1. 00 | 2A | 2. 00 | 3. 00 | |
| INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | |
| 30. 00 03000 ADULTS & PEDI ATRI CS | 0 | 0 | | 0 | 0 | 30. 00 |
| 31.00 03100 INTENSIVE CARE UNIT | 0 | 0 | 0 | 0 | 0 | 31. 00 |
| 32. 00 03200 CORONARY CARE UNIT | 0 | 0 | 0 | 0 | 0 | 32. 00 |
| 33.00 03300 BURN INTENSIVE CARE UNIT | 0 | 0 | 0 | 0 | 0 | 33. 00 |
| 34.00 03400 SURGICAL INTENSIVE CARE UNIT | 0 | 0 | 0 | 0 | 0 | 34. 00 |
| 40. 00 04000 SUBPROVI DER - I PF | 0 | 0 | 0 | 0 | 0 | 40. 00 |
| 41. 00 04100 SUBPROVI DER - I RF | 0 | 0 | 0 | 0 | 0 | 41. 00 |
| 43. 00 04300 NURSERY | 0 | 0 | 0 | 0 | 0 | 43.00 |
| 44.00 04400 SKILLED NURSING FACILITY | 0 | 0 | 0 | 0 | | 44.00 |
| 45.00 04500 NURSING FACILITY | 0 | 0 | 0 | 0 | | 45. 00 |
| 200.00 Total (lines 30 through 199) | 0 | 0 | 0 | 0 | 0 | 200. 00 |
| Cost Center Description | Swi ng-Bed | Total Costs | Total Patient | Per Diem (col. | I npati ent | |
| | Adjustment | (sum of cols. | Days | 5 ÷ col. 6) | Program Days | |
| | Amount (see | 1 through 3, | | | | |
| | instructions) | minus col. 4) | | | | |
| LADATI ENT. DOUTLING CERVILOG COCT. CENTERS | 4. 00 | 5. 00 | 6. 00 | 7. 00 | 8. 00 | |
| INPATIENT ROUTINE SERVICE COST CENTERS | | | 45.005 | 0.00 | 4.040 | 00.00 |
| 30. 00 03000 ADULTS & PEDI ATRI CS | 0 | 0 | | | | 30.00 |
| 31. 00 03100 INTENSIVE CARE UNIT | | 0 | 1 ., | 0.00 | | 31. 00 |
| 32. 00 03200 CORONARY CARE UNIT | | 0 | 1 | | | 32. 00 |
| 33. 00 03300 BURN INTENSIVE CARE UNIT | | 0 | 1 | | 0 | 33. 00 |
| 34. 00 03400 SURGI CAL INTENSI VE CARE UNIT | | 0 | 1 | | | 34. 00 |
| 40. 00 04000 SUBPROVI DER - I PF | 0 | 0 | 1 | | | 40.00 |
| 41. 00 04100 SUBPROVI DER - RF | 0 | 0 | 1 | | | 41. 00 |
| 43. 00 04300 NURSERY | | 0 | 1 | | 0 | 43.00 |
| 44. 00 04400 SKILLED NURSING FACILITY | | 0 | | | | 44. 00 |
| 45. 00 04500 NURSING FACILITY | | 0 | 1 | | | 45. 00 |
| 200. 00 Total (lines 30 through 199) | 1 | 0 | 17, 526 | | 5, 289 | 200. 00 |
| Cost Center Description | Inpatient Program | | | | | |
| | Pass-Through | | | | | |
| | Cost (col. 7 x | | | | | |
| | cost (cor. / x | | | | | |
| | 9.00 | | | | | |
| INPATIENT ROUTINE SERVICE COST CENTERS | 7,00 | | | | | |
| 30. 00 03000 ADULTS & PEDIATRICS | 0 | | | | | 30. 00 |
| 31. 00 03100 INTENSIVE CARE UNIT | 0 | | | | | 31. 00 |
| 32. 00 03200 CORONARY CARE UNIT | 0 | | | | l | 32. 00 |
| 33.00 03300 BURN INTENSIVE CARE UNIT | 0 | | | | ļ | 33. 00 |
| 34.00 03400 SURGICAL INTENSIVE CARE UNIT | 0 | | | | | 34.00 |
| 40. 00 04000 SUBPROVI DER - 1 PF | 0 | | | | l | 40. 00 |
| 41. 00 04100 SUBPROVI DER - I RF | l o | | | | ļ | 41. 00 |
| 43. 00 04300 NURSERY | l o | | | | ļ | 43. 00 |
| 44.00 04400 SKILLED NURSING FACILITY | 0 | | | | ļ | 44. 00 |
| 45. 00 04500 NURSI NG FACILITY | 0 | | | | l | 45. 00 |
| 200.00 Total (lines 30 through 199) | 0 | | | | l | 200. 00 |
| 1 (| ' | 1 | | | | |

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet D | From 01/01/2021 | Part IV | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | Date/Ti Provider CCN: 15-0165 THROUGH COSTS

| | | | | | 10 | 0 12/31/2021 | 5/31/2022 7:54 | |
|------------------|--|---------------|-------------|-----------|----|---------------|----------------|------------------|
| | | | Ti | tle XVIII | | Hospi tal | PPS | |
| | Cost Center Description | Non Physician | Nursi ng | Nursi no | 1 | | Allied Health | |
| | · | Anestheti st | Program | Program | ì | Post-Stepdown | | |
| | | Cost | Post-Stepdo | own | | Adjustments | | |
| | | | Adjustment | s | | , | | |
| | | 1.00 | 2A | 2.00 | | 3A | 3. 00 | |
| | ANCILLARY SERVICE COST CENTERS | | | | | | | |
| 50.00 | 05000 OPERATING ROOM | 0 | | 0 | 0 | | | 50. 00 |
| 51. 00 | 05100 RECOVERY ROOM | 0 | | 0 | 0 | | | 51. 00 |
| 52.00 | 05200 DELIVERY ROOM & LABOR ROOM | 0 | | 0 | 0 | | | 52. 00 |
| 53.00 | 05300 ANESTHESI OLOGY | 0 | | 0 | 0 | 0 | 0 | 53.00 |
| 54. 00 | 05400 RADI OLOGY-DI AGNOSTI C | 0 | | 0 | 0 | | - | 54.00 |
| 55. 00 | 05500 RADI OLOGY-THERAPEUTI C | 0 | | 0 | 0 | 0 | 0 | 55. 00 |
| 56. 00 | 05600 RADI 01 S0T0PE | 0 | | 0 | 0 | - | | 56. 00 |
| 57. 00 | 05700 CT SCAN | 0 | | 0 | 0 | | 0 | 57. 00 |
| 58. 00 | 05800 MAGNETIC RESONANCE IMAGING (MRI) | 0 | | 0 | 0 | 0 | 0 | 58. 00 |
| 59. 00 | 05900 CARDI AC CATHETERI ZATI ON | 0 | | 0 | 0 | | | 59. 00 |
| 60.00 | 06000 LABORATORY | 0 | | 0 | 0 | 0 | 0 | 60.00 |
| 60. 01 | 06001 BLOOD LABORATORY | 0 | | 0 | 0 | 0 | 0 | 60. 01 |
| 61. 00 | 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY | | | | | | | 61. 00 |
| 62. 00 | 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS | 0 | | 0 | 0 | 0 | 0 | 62. 00 |
| 63. 00 | 06300 BLOOD STORING, PROCESSING & TRANS. | 0 | | 0 | 0 | 0 | 0 | 63.00 |
| 64. 00 | 06400 I NTRAVENOUS THERAPY | 0 | | 0 | 0 | 0 | 0 | 64.00 |
| 65.00 | 06500 RESPI RATORY THERAPY | 0 | | 0 | 0 | | 0 | 65.00 |
| 66. 00 | 06600 PHYSI CAL THERAPY | 0 | | 0 | 0 | | 0 | 66.00 |
| 67. 00 | 06700 OCCUPATI ONAL THERAPY | 0 | | 0 | 0 | 0 | 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 | 70. 00 |
| 71. 00 | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | | 0 | 0 | 0 | 0 | 71. 00 |
| 72. 00 | 07200 I MPL. DEV. CHARGED TO PATIENTS | 0 | | 0 | 0 | | | 72.00 |
| 73. 00 | 07300 DRUGS CHARGED TO PATIENTS | 0 | | 0 | 0 | 0 | 0 | 73. 00 |
| 74. 00 | 07400 RENAL DI ALYSI S | 0 | | 0 | 0 | | | 74. 00 |
| 75. 00 | 07500 ASC (NON-DISTINCT PART) | 0 | | 0 | 0 | 0 | 0 | 75. 00 |
| 76. 00 | 03950 OTHER ANCILL SRVC | 0 | | 0 | 0 | 0 | 0 | 76. 00 |
| 76. 01 | 03951 CARDIAC AND PULMONARY REHAB | 0 | | 0 | 0 | | 0 | 76. 01 |
| 76. 02 | 03952 WOUND CARE | 0 | | 0 | 0 | - | | 76. 02 |
| 77. 00 | 07700 ALLOGENEIC STEM CELL ACQUISITION | 0 | | 0 | 0 | 0 | 0 | 77. 00 |
| | OUTPATIENT SERVICE COST CENTERS | | | ۵. | _ | | | |
| 88. 00 | 08800 RURAL HEALTH CLINIC | 0 | | 0 | 0 | | | 88. 00 |
| 89. 00 | 08900 FEDERALLY QUALIFIED HEALTH CENTER | 0 | | 0 | 0 | | | 89. 00 |
| 90.00 | 09000 CLI NI C | 0 | | 0 | 0 | 0 | 0 | 90.00 |
| 90. 01 | 09001 CLI NI C | 0 | | 0 | 0 | 0 | 0 | 90. 01 |
| 90. 02 | 09002 CLI NI C | 0 | | 0 | 0 | | 0 | 90. 02 |
| 91. 00 | 09100 EMERGENCY | 0 | | O | 0 | 0 | 0 | 91.00 |
| 92. 00 | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 0 | | | 0 | | 0 | 92. 00 |
| 04.00 | OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DIALYSIS | 0 | | ol | 0 | 0 | 0 | 04.00 |
| 94. 00 95. 00 | 09500 AMBULANCE SERVICES | 0 | | ٩ | U | U | U | 94. 00 95. 00 |
| 95. 00 96. 00 | 09600 DURABLE MEDICAL EQUIP-RENTED | | | 0 | 0 | 0 | o | 95. 00 96. 00 |
| 96.00 | 09700 DURABLE MEDICAL EQUIP-RENTED | | | | 0 | | 0 | 96. 00 97. 00 |
| 98.00 | 09850 OTHER REIMBURSE | | | | 0 | 0 | | 97. 00 98. 00 |
| 200.00 | l l | | | o | 0 | | | 200. 00 |
| 200.00 | Total (Tines 50 till bugil 177) | ı O | | ગ | U | U | ا | 200.00 |

From 01/01/2021 THROUGH COSTS Part IV 12/31/2021 Date/Time Prepared: 5/31/2022 7:54 am Title XVIII Hospi tal Cost Center Description All Other Total Cost Total Total Charges Ratio of Cost to Charges Medi cal (from Wkst. C, (sum of cols. Outpati ent Education Cost 1, 2, 3, and Cost (sum of Part I, col. l(col. 5 ÷ col 8) 4) col s. 2. 3. 7) and 4) (see instructions) 4.00 5.00 6.00 7. 00 8.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 74, 320, 998 0.000000 50.00 000000000000 05100 RECOVERY ROOM 0 0 8, 438, 720 0.000000 51.00 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0.000000 52.00 05300 ANESTHESI OLOGY 0 0 19 268 194 0.000000 53 00 53 00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 31, 974, 264 0.000000 54.00 05500 RADI OLOGY-THERAPEUTI C 0.000000 55.00 05600 RADI OI SOTOPE 0 0 0.000000 56 00 56 00 0 44, 331, 858 57.00 05700 CT SCAN 0 0.000000 57.00 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 26, 317, 000 0.000000 58.00 05900 CARDIAC CATHETERIZATION 59.00 0 19, 111, 259 0.000000 59.00 06000 LABORATORY 60 00 60, 454, 259 0.000000 60 00 60.01 06001 BLOOD LABORATORY 0 0.000000 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.000000 62.00 000000000000000000 0 62.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0.000000 63.00 0 63 00 64.00 06400 I NTRAVENOUS THERAPY 0 0 390, 389 0.000000 64.00 06500 RESPIRATORY THERAPY 5, 388, 400 0.000000 65.00 65.00 06600 PHYSI CAL THERAPY 0 2, 375, 261 0.000000 66.00 66, 00 06700 OCCUPATIONAL THERAPY 0 1, 977, 604 67.00 0 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 675, 643 0.000000 68.00 06900 ELECTROCARDI OLOGY 69.00 16, 818, 634 0.000000 69.00 07000 ELECTROENCEPHALOGRAPHY 0 70.00 4, 413, 377 0.000000 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0.000000 71.00 20, 671, 354 71 00 07200 IMPL. DEV. CHARGED TO PATIENTS 22, 370, 173 0.000000 72.00 07300 DRUGS CHARGED TO PATIENTS 73 00 29, 825, 577 0.000000 73.00 07400 RENAL DIALYSIS 0 909, 149 0.000000 74.00 0 74.00 07500 ASC (NON-DISTINCT PART) 0 75.00 C 0.000000 75.00 03950 OTHER ANCILL SRVC 0.000000 76.00 76.00 0 76.01 03951 CARDIAC AND PULMONARY REHAB 0 213, 534 0.000000 76.01 03952 WOUND CARE 0 76.02 Ω 42, 406 0.000000 76.02 07700 ALLOGENEIC STEM CELL ACQUISITION 77.00 0.00000077.00 OUTPATIENT SERVICE COST CENTERS 0 88.00 08800 RURAL HEALTH CLINIC 0 0.000000 88.00 0 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 0 0 0.00000089.00 90.00 09000 CLI NI C 0 0 0 0 0.000000 90.00 09001 CLI NI C 0 0 29, 720, 433 0.000000 90.01 90.01 09002 CLI NI C 0 0 6, 275, 161 0.000000 90.02 90.02 91.00 09100 EMERGENCY 0 C 0 43, 343, 399 0.000000 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 11, 992, 253 0.000000 92.00 OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DIALYSIS 94.00 0 0 0.000000 94.00 95. 00 09500 AMBULANCE SERVICES 95.00 09600 DURABLE MEDICAL EQUIP-RENTED 96.00 0 0 0 0.000000 96.00 0 0 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 0 0.000000 97.00 98. 00 09850 OTHER REIMBURSE 0 0 0.000000 98.00

0

481, 619, 299

200.00

200.00

Total (lines 50 through 199)

Provider CCN: 15-0165 Worksheet D From 01/01/2021 THROUGH COSTS Part IV 12/31/2021 Date/Time Prepared: 5/31/2022 7:54 am Title XVIII Hospi tal PPS Cost Center Description Outpati ent Inpatient I npati ent Outpati ent Outpati ent Program Ratio of Cost Program Program Program Pass-Through Pass-Through to Charges Charges Charges (col. 6 ÷ col Costs (col. Costs (col. x col . 12) 13.00 x col. 10) 7) 9.00 10.00 11. 00 12.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0.000000 5, 496, 434 20, 139, 624 50.00 0 05100 RECOVERY ROOM 0 51.00 0.000000 400, 684 2, 229, 399 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 0 52.00 0 52.00 05300 ANESTHESI OLOGY 0.000000 1,007,737 0 3, 774, 086 53.00 53.00 0 05400 RADI OLOGY-DI AGNOSTI C 0.000000 2, 355, 102 0 7, 063, 917 54.00 54.00 0 55.00 05500 RADI OLOGY-THERAPEUTI C 0.000000 0 0 55.00 56.00 05600 RADI OI SOTOPE 0.000000 0 56.00 05700 CT SCAN 0.000000 3, 524, 598 0 8, 522, 651 57.00 57 00 0 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 58.00 0.000000 818, 026 2, 656, 060 0 58.00 59.00 05900 CARDIAC CATHETERIZATION 0.000000 1, 871, 378 1, 567, 827 0 59.00 60.00 06000 LABORATORY 0.000000 7, 249, 328 0 1, 990, 424 0 60.00 06001 BLOOD LABORATORY 0.000000 60 01 Ω 60 01 61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 62.00 0.000000 0 0 62.00 06300 BLOOD STORING, PROCESSING & TRANS. 63 00 0.000000 0 0 0 63 00 64.00 06400 I NTRAVENOUS THERAPY 0.000000 0 64.00 06500 RESPI RATORY THERAPY 0.000000 1, 694, 833 145, 477 0 65.00 65.00 06600 PHYSI CAL THERAPY 66.00 0.000000 696, 012 126, 861 0 66.00 06700 OCCUPATIONAL THERAPY 0 67 00 0.000000 621, 133 64, 661 67 00 0 06800 SPEECH PATHOLOGY 0 68.00 0.000000 261, 250 10, 395 0 68.00 06900 ELECTROCARDI OLOGY 0.000000 1, 817, 216 3, 394, 184 69.00 69.00 0 70.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 41, 893 0 763, 318 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0.000000 2,041,294 2, 397, 762 71 00 71 00 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 2, 325, 275 7, 079, 785 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 6, 633, 863 5, 565, 940 73.00 73.00 0 07400 RENAL DIALYSIS 74.00 0.000000 0 74.00 07500 ASC (NON-DISTINCT PART) 0 0.000000 75.00 C 0 0 75.00 76.00 03950 OTHER ANCILL SRVC 0.000000 0 0 0 76.00 C 03951 CARDIAC AND PULMONARY REHAB 0 91 76 01 0.000000 1,814 76.01 76.02 03952 WOUND CARE 0.000000 0 0 76.02 C 21, 381 07700 ALLOGENEIC STEM CELL ACQUISITION 0 77.00 0.000000 0 77.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0.000000 0 0 0 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 89.00 89.00 0.000000 0 0 0 90.00 09000 CLI NI C 0.000000 0 90.00 90.01 09001 CLI NI C 0.000000 292, 761 0 9, 808, 807 0 90.01 90.02 09002 CLI NI C 0.000000 0 90.02 0 09100 EMERGENCY 0.000000 3, 477, 932 0 4, 657, 055 Ω 91.00 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.000000 1, 144, 736 963, 774 0 92.00 OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DIALYSIS 94.00 0.000000 0 0 0 94.00 09500 AMBULANCE SERVICES 95.00 95.00 09600 DURABLE MEDICAL EQUIP-RENTED 0.000000 0 96.00 0 97.00 09700 DURABLE MEDICAL EQUIP-SOLD 0.000000 0 97.00 0

0.000000

43, 773, 299

0

82, 943, 479

98.00

0 200.00

0

09850 OTHER REIMBURSE

Total (lines 50 through 199)

98.00

200.00

| APPOR | TIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND | VACCINE COST | Provi der C | CN: 15-0165 | Peri od: | Worksheet D | |
|------------------|--|----------------|----------------|--------------|----------------------------------|-------------------------|----------------|
| | | | | | From 01/01/2021 To 12/31/2021 | Part V Date/Time Pre | narod: |
| | | | | | 10 12/31/2021 | 5/31/2022 7:5 | pareu. 4 am |
| | | | Title | xVIII | Hospi tal | PPS | |
| | | | | Charges | | Costs | |
| | Cost Center Description | Cost to Charge | PPS Reimbursed | | Cost | PPS Services | |
| | | | Services (see | | Rei mbursed | (see inst.) | |
| | | Worksheet C, | inst.) | Servi ces | Services Not | , | |
| | | Part I, col. 9 | ŕ | Subject To | Subject To | | |
| | | | | Ded. & Coins | Ded. & Coins. | | |
| | | | | (see inst.) | (see inst.) | | |
| | | 1.00 | 2. 00 | 3. 00 | 4. 00 | 5. 00 | |
| | ANCILLARY SERVICE COST CENTERS | | | | | | |
| 50.00 | 05000 OPERATING ROOM | 0. 148805 | 20, 139, 624 | | 0 0 | 2, 996, 877 | 50.00 |
| 51.00 | 05100 RECOVERY ROOM | 0. 285661 | 2, 229, 399 | 1 | 0 0 | 636, 852 | 51.00 |
| 52.00 | 05200 DELIVERY ROOM & LABOR ROOM | 0. 000000 | 0 |) | 0 0 | 0 | 52.00 |
| 53.00 | 05300 ANESTHESI OLOGY | 0. 033577 | 3, 774, 086 | | 0 0 | 126, 722 | 53.00 |
| 54.00 | 05400 RADI OLOGY-DI AGNOSTI C | 0. 139318 | 7, 063, 917 | 1 | 0 0 | 984, 131 | 54.00 |
| 55.00 | 05500 RADI OLOGY-THERAPEUTI C | 0. 000000 | 0 |) | 0 0 | 0 | 55. 00 |
| 56.00 | 05600 RADI OI SOTOPE | 0. 000000 | 0 |) | 0 0 | 0 | 56. 00 |
| 57. 00 | 05700 CT SCAN | 0. 030483 | 8, 522, 651 | | 0 0 | 259, 796 | |
| 58. 00 | 05800 MAGNETIC RESONANCE IMAGING (MRI) | 0. 074051 | 2, 656, 060 | 1 | 0 0 | 196, 684 | |
| 59. 00 | 05900 CARDI AC CATHETERI ZATI ON | 0. 233322 | 1, 567, 827 | 1 | 0 39, 326 | | |
| 60. 00 | 06000 LABORATORY | 0. 118952 | 1, 990, 424 | 1 | 0 0 | | |
| 60. 01 | 06001 BLOOD LABORATORY | 0. 000000 | .,,,,,,,.2. | 1 | o o | 0 | |
| 61. 00 | 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY | 0. 000000 | | ì | o o | Ĭ | 61. 00 |
| 62. 00 | 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS | 0. 000000 | 0 | , | o o | 0 | 62. 00 |
| 63. 00 | 06300 BLOOD STORING, PROCESSING & TRANS. | 0. 000000 | 0 | | o o | o o | 63. 00 |
| 64. 00 | 06400 I NTRAVENOUS THERAPY | 0. 003407 | 0 | | o o | l o | 64. 00 |
| 65. 00 | 06500 RESPIRATORY THERAPY | 0. 351382 | 145, 477 | | 0 0 | 51, 118 | |
| 66. 00 | 06600 PHYSI CAL THERAPY | 0. 169889 | 126, 861 | 1 | 0 0 | 21, 552 | |
| 67. 00 | 06700 OCCUPATI ONAL THERAPY | 0. 109889 | 64, 661 | 1 | 0 0 | 8, 776 | |
| 68. 00 | 06800 SPEECH PATHOLOGY | 0. 135721 | 10, 395 | | 0 0 | 1, 406 | |
| 69. 00 | 06900 ELECTROCARDI OLOGY | 0. 135245 | 3, 394, 184 | 1 | 0 0 | 155, 664 | 1 |
| 70.00 | 07000 ELECTROENCEPHALOGRAPHY | 0. 513945 | 763, 318 | 1 | 0 0 | 392, 303 | |
| 71.00 | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0. 450024 | 2, 397, 762 | | 0 0 | l | |
| 71.00 | 07200 I MPL. DEV. CHARGED TO PATIENTS | 1 | | 1 | 0 0 | | 1 |
| 73. 00 | 07300 DRUGS CHARGED TO PATIENTS | 0. 352057 | 7, 079, 785 | | - | 2, 492, 488 | |
| 74.00 | | 0. 236586 | 5, 565, 940 | | 0 13, 877 | 1, 316, 823 0 | |
| | 07400 RENAL DIALYSIS | 0. 003406 | 0 | | 0 0 | 0 | |
| 75. 00 | 07500 ASC (NON-DISTINCT PART) | 0. 000000 | 0 | | | · - | |
| 76.00 | 03950 OTHER ANCILL SRVC | 0.000000 | 91 | 1 | 0 | 0 | 76.00 |
| 76. 01 | 03951 CARDI AC AND PULMONARY REHAB | 1. 561339 | | 1 | 0 | 142 | |
| 76. 02 | 03952 WOUND CARE | 0. 224850 | 21, 381 | | 0 | ., | |
| 77. 00 | 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON | 0. 000000 | 0 | 1 | 0 0 | 0 | 77. 00 |
| 00 00 | OUTPATIENT SERVICE COST CENTERS | | | | | | 00 00 |
| 88. 00 89. 00 | 08800 RURAL HEALTH CLINIC | | | | | | 88. 00 |
| | 08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC | 0.000000 | 0 | | 0 | 0 | 89.00 |
| 90. 00 90. 01 | 09000 CLI NI C | 0.000000 | 0 000 007 | | 0 | 1 | |
| | 1 1 | 0. 113678 | 9, 808, 807 | | 0 | 1, 115, 046 | |
| 90. 02 | 09002 CLINIC | 0. 135602 | 4 (57 055 | 1 | 0 | 0 698, 088 | |
| | 09100 EMERGENCY | 0. 149899 | 4, 657, 055 | | 0 0 | | |
| 92.00 | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 0. 375088 | 963, 774 | 1 | 0 0 | 361, 500 | 92.00 |
| 04.00 | OTHER REIMBURSABLE COST CENTERS | 0.000000 | | T | | Γ | 04.00 |
| 94. 00 | 09400 HOME PROGRAM DI ALYSI S | 0. 000000 | | | 0 | | 94.00 |
| 95. 00 | 09500 AMBULANCE SERVICES | 0. 000000 | 0 | | 0 | | 95. 00 |
| 96.00 | 09600 DURABLE MEDICAL EQUIP-RENTED | 0. 000000 | 0 | 1 | 0 | 0 | |
| 97. 00 | 09700 DURABLE MEDI CAL EQUI P-SOLD | 0. 000000 | 0 | 1 | 0 | 0 | |
| 98.00 | 09850 OTHER REIMBURSE | 0. 000000 | 0 040 470 | 1 | 0 0 | 0 | |
| 200.00 | | | 82, 943, 479 | 1 | 0 53, 203 | 13, 502, 400 | |
| 201.00 | | | | | 0 | | 201. 00 |
| 202.00 | Only Charges Net Charges (line 200 - line 201) | | 02 042 470 | | D 52 202 | 12 502 400 | 202.00 |
| 202.00 | net charges (Time 200 - Time 201) | 1 1 | 82, 943, 479 | Ί | 0 53, 203 | 13, 502, 400 | 1202.00 |
| | | | | | | | |

| In Lieu of Form CMS-2552-10 | Period: | Worksheet D | From 01/01/2021 | Part V | To 12/31/2021 | Date/Time Prepared: 5/31/2022 7:54 am Provider CCN: 15-0165

| | | | | | 5/31/2022 7:5 | 4 am |
|---|---------------|---------------------------------------|-------|-----------|---------------|---------|
| | | Title | XVIII | Hospi tal | PPS | |
| | Cos | sts | | | | |
| Cost Center Description | Cost | Cost | | | | |
| | Rei mbursed | Reimbursed | | | | |
| | Servi ces | Services Not | | | | |
| | Subject To | Subject To | | | | |
| | Ded. & Coins. | Ded. & Coins. | | | | |
| | (see inst.) | (see inst.) | | | | |
| | 6.00 | 7. 00 | | | | |
| ANCILLARY SERVICE COST CENTERS | 0.00 | 71.00 | | | | |
| 50. 00 05000 OPERATING ROOM | 0 | 0 | | | | 50.00 |
| 51. 00 05100 RECOVERY ROOM | 0 | 0 | | | | 51.00 |
| | | · · · · · · · · · · · · · · · · · · · | | | | • |
| 52. 00 05200 DELI VERY ROOM & LABOR ROOM | 0 | 0 | | | | 52.00 |
| 53. 00 05300 ANESTHESI OLOGY | 0 | 0 | | | | 53. 00 |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C | 0 | 0 | | | | 54.00 |
| 55. 00 05500 RADI OLOGY-THERAPEUTI C | 0 | 0 | | | | 55. 00 |
| 56. 00 05600 RADI 0I SOTOPE | 0 | 0 | | | | 56. 00 |
| 57. 00 05700 CT SCAN | 0 | 0 | | | | 57.00 |
| 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) | 0 | ol | | | | 58. 00 |
| 59. 00 05900 CARDI AC CATHETERI ZATI ON | 0 | 9, 176 | | | | 59.00 |
| 60. 00 06000 LABORATORY | 0 | 0 | | | | 60.00 |
| 60. 01 06001 BLOOD LABORATORY | 0 | o o | | | | 60. 01 |
| 61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY | 0 | Ĭ | | | | 61.00 |
| 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS | 1 | 0 | | | | • |
| | 0 | | | | | 62.00 |
| 63. 00 06300 BLOOD STORING, PROCESSING & TRANS. | 0 | 0 | | | | 63.00 |
| 64. 00 06400 I NTRAVENOUS THERAPY | 0 | 0 | | | | 64. 00 |
| 65. 00 06500 RESPIRATORY THERAPY | 0 | 0 | | | | 65. 00 |
| 66. 00 06600 PHYSI CAL THERAPY | 0 | 0 | | | | 66. 00 |
| 67. 00 06700 OCCUPATI ONAL THERAPY | 0 | 0 | | | | 67. 00 |
| 68.00 06800 SPEECH PATHOLOGY | 0 | 0 | | | | 68. 00 |
| 69. 00 06900 ELECTROCARDI OLOGY | 0 | 0 | | | | 69. 00 |
| 70. 00 07000 ELECTROENCEPHALOGRAPHY | 0 | ol | | | | 70. 00 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | o | | | | 71.00 |
| 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS | 0 | o | | | | 72. 00 |
| 73. 00 07300 DRUGS CHARGED TO PATIENTS | 0 | 3, 283 | | | | 73. 00 |
| 74. 00 07400 RENAL DI ALYSI S | 0 | 0, 203 | | | | 74.00 |
| 75. 00 07500 ASC (NON-DISTINCT PART) | 0 | 0 | | | | 75.00 |
| | 0 | | | | | |
| | | 0 | | | | 76. 00 |
| 76. 01 03951 CARDI AC AND PULMONARY REHAB | 0 | 0 | | | | 76. 01 |
| 76. 02 03952 WOUND CARE | 0 | 0 | | | | 76. 02 |
| 77.00 07700 ALLOGENEIC STEM CELL ACQUISITION | 0 | 0 | | | | 77. 00 |
| OUTPATIENT SERVICE COST CENTERS | | | | | | |
| 88. 00 08800 RURAL HEALTH CLINIC | | | | | | 88. 00 |
| 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER | | | | | | 89. 00 |
| 90. 00 09000 CLI NI C | 0 | 0 | | | | 90.00 |
| 90. 01 09001 CLI NI C | 0 | 0 | | | | 90. 01 |
| 90. 02 09002 CLI NI C | 0 | ol | | | | 90. 02 |
| 91. 00 09100 EMERGENCY | 0 | o | | | | 91.00 |
| 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 0 | o | | | | 92.00 |
| OTHER REIMBURSABLE COST CENTERS | | ٩ | | | | 72.00 |
| 94. 00 09400 HOME PROGRAM DI ALYSI S | 0 | 0 | | | | 94.00 |
| 95. 00 09500 AMBULANCE SERVICES | 0 | ١ | | | | 95.00 |
| | _ | | | | | |
| 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED | 0 | 0 | | | | 96.00 |
| 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD | 0 | 0 | | | | 97. 00 |
| 98. 00 09850 OTHER REI MBURSE | 0 | 0 | | | | 98. 00 |
| 200.00 Subtotal (see instructions) | 0 | 12, 459 | | | | 200. 00 |
| 201.00 Less PBP Clinic Lab. Services-Program | 0 | | | | | 201. 00 |
| Only Charges | | | | | | |
| 202.00 Net Charges (line 200 - line 201) | 0 | 12, 459 | | | | 202. 00 |
| | | | | | | |

| APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITA | _ COSTS | Provi der C | CN: 15-0165 | Peri od: From 01/01/2021 To 12/31/2021 | Worksheet D Part I Date/Time Pre | pared: |
|---|----------------|-----------------------------|---------------|--|--|---------|
| | | | | | 5/31/2022 7:5 | |
| | | | e XIX | Hospi tal | PPS | |
| Cost Center Description | Capi tal | Swing Bed | Reduced | Total Patient | | |
| | Related Cost | Adjustment | Capi tal | Days | 3 / col. 4) | |
| | (from Wkst. B, | | Related Cos | | | |
| | Part II, col. | | (col . 1 - co | l . | | |
| | 26) | | 2) | 4 00 | | |
| LUBLITATION POLITICAL OFFICE ASSOCIATION | 1. 00 | 2. 00 | 3.00 | 4. 00 | 5. 00 | |
| INPATIENT ROUTINE SERVICE COST CENTERS | 4 744 707 | | 1 4 744 7 | 07 45 005 | 440.04 | 1 00 00 |
| 30. 00 ADULTS & PEDIATRICS | 1, 744, 797 | | 1 ., , . | | 110. 26 | |
| 31. 00 INTENSIVE CARE UNIT | 385, 469 | l . | 385, 4 | • | 226. 61 | |
| 32. 00 CORONARY CARE UNIT | 0 | | | 0 0 | 0.00 | |
| 33. 00 BURN INTENSIVE CARE UNIT | 0 | | | 0 | 0.00 | |
| 34. 00 SURGICAL INTENSIVE CARE UNIT | 0 | 1 | | 0 | 0.00 | |
| 40. 00 SUBPROVI DER - I PF | 0 | |) | 0 | 0.00 | |
| 41. 00 SUBPROVI DER - I RF | 0 | |) | 0 | 0.00 | |
| 43. 00 NURSERY | 0 | | | 0 | 0.00 | |
| 44.00 SKILLED NURSING FACILITY | 0 | | | 0 | 0.00 | |
| 45. 00 NURSING FACILITY | 0 | | | 0 | 0.00 | 45. 00 |
| 200.00 Total (lines 30 through 199) | 2, 130, 266 | | 2, 130, 2 | 66 17, 526 | | 200. 00 |
| Cost Center Description | Inpatient | Inpatient | | | | |
| | Program days | Program | | | | |
| | | Capital Cost (col. 5 x col. | | | | |
| | | (COI. 5 x COI. | | | | |
| | 6.00 | 7.00 | + | | | |
| INPATIENT ROUTINE SERVICE COST CENTERS | 0.00 | 7.00 | | | | |
| 30. 00 ADULTS & PEDIATRICS | 1, 092 | 120, 404 | | | | 30.00 |
| 31. 00 INTENSIVE CARE UNIT | 1,072 | · · | | | | 31.00 |
| 32. 00 CORONARY CARE UNIT | | | | | | 32.00 |
| 33. 00 BURN INTENSIVE CARE UNIT | | | | | | 33. 00 |
| 34. 00 SURGI CAL I NTENSI VE CARE UNI T | | | | | | 34. 00 |
| 40. 00 SUBPROVI DER - I PF | | | | | | 40.00 |
| 41. 00 SUBPROVI DER – I RF | | | | | | 41. 00 |
| 43. 00 NURSERY | | l c | | | | 43.00 |
| 44.00 SKILLED NURSING FACILITY | | | | | | 44. 00 |
| 45. 00 NURSING FACILITY | | | 1 | | | 45. 00 |
| | | | | | | |

| Heal th | Financial Systems | FRANCI SCAN HEA | ALTH MUNSTER | | In Lie | eu of Form CMS-: | 2552-10 |
|---------|---|-----------------|----------------|-------------|-----------------|------------------|-------------|
| APPORT | TONMENT OF INPATIENT ANCILLARY SERVICE CAPITA | AL COSTS | Provi der C | CN: 15-0165 | Peri od: | Worksheet D | |
| | | | | | From 01/01/2021 | Part II | |
| | | | | | To 12/31/2021 | Date/Time Pre | |
| | | | | V/1.V/ | | 5/31/2022 7:5 | <u>4 am</u> |
| | | | | e XIX | Hospi tal | PPS | |
| | Cost Center Description | Capi tal | Total Charges | | | Capital Costs | |
| | | | (from Wkst. C, | | Program | (column 3 x | |
| | | (from Wkst. B, | Part I, col. | | . Charges | column 4) | |
| | | Part II, col. | 8) | 2) | | | |
| | | 26) | | | | | |
| | I | 1. 00 | 2.00 | 3. 00 | 4. 00 | 5. 00 | |
| | ANCILLARY SERVICE COST CENTERS | T | | | | | |
| 50.00 | 05000 OPERATING ROOM | 687, 627 | | | | 12, 158 | |
| 51. 00 | 05100 RECOVERY ROOM | 282, 287 | | | | 4, 387 | 51.00 |
| 52.00 | 05200 DELIVERY ROOM & LABOR ROOM | 0 | 0 | 0.0000 | | 0 | 52. 00 |
| 53.00 | 05300 ANESTHESI OLOGY | 4, 895 | | | | 91 | |
| 54.00 | 05400 RADI OLOGY-DI AGNOSTI C | 314, 143 | 31, 974, 264 | | | 7, 306 | |
| 55.00 | 05500 RADI OLOGY-THERAPEUTI C | 0 | 0 | 1 0.0000 | | 0 | 55. 00 |
| 56.00 | 05600 RADI OI SOTOPE | 0 | 0 | 0.00000 | 00 | 0 | 56. 00 |
| 57.00 | 05700 CT SCAN | 10, 935 | 44, 331, 858 | 0. 00024 | 1, 197, 258 | 296 | 57. 00 |
| 58.00 | 05800 MAGNETIC RESONANCE IMAGING (MRI) | 15, 656 | 26, 317, 000 | 0.00059 | 392, 185 | 233 | 58. 00 |
| 59.00 | 05900 CARDI AC CATHETERI ZATI ON | 601, 304 | 19, 111, 259 | 0. 03146 | 1, 212, 674 | 38, 154 | 59. 00 |
| 60.00 | 06000 LABORATORY | 149, 559 | 60, 454, 259 | 0.00247 | | 7, 264 | 60.00 |
| 60. 01 | 06001 BLOOD LABORATORY | 0 | 0 | 0. 00000 | 00 | 0 | 60. 01 |
| 61.00 | 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY | | | | | | 61.00 |
| 62. 00 | 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS | 0 | 0 | 0. 00000 | 0 0 | 0 | 62. 00 |
| 63. 00 | 06300 BLOOD STORING, PROCESSING & TRANS. | 0 | | 0.00000 | | 0 | 63. 00 |
| 64. 00 | 06400 I NTRAVENOUS THERAPY | 14 | | • | | 0 | 64. 00 |
| 65. 00 | 06500 RESPIRATORY THERAPY | 64, 071 | 5, 388, 400 | • | | 7, 403 | |
| 66. 00 | 06600 PHYSI CAL THERAPY | 3, 391 | 2, 375, 261 | | | 216 | |
| 67. 00 | 06700 OCCUPATI ONAL THERAPY | 2, 257 | 1, 977, 604 | | | 151 | 67.00 |
| 68. 00 | 06800 SPEECH PATHOLOGY | 768 | | | | 78 | |
| 69. 00 | 06900 ELECTROCARDI OLOGY | 6, 394 | 16, 818, 634 | | | 209 | |
| 70. 00 | 07000 ELECTROENCEPHALOGRAPHY | 264, 835 | | | | 1, 187 | |
| 71. 00 | | | | | | | |
| 71.00 | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS | 67, 173 | | | | 2, 188 1, 085 | 71.00 |
| | | 56, 597 | | | | | |
| 73.00 | 07300 DRUGS CHARGED TO PATIENTS | 158, 450 | | • | | | |
| 74.00 | 07400 RENAL DIALYSIS | 32 | | | | 2 | 74.00 |
| 75. 00 | 07500 ASC (NON-DISTINCT PART) | 0 | - | | | 0 | 75. 00 |
| 76. 00 | 03950 OTHER ANCILL SRVC | 0 | | 1 | | 0 | 76. 00 |
| 76. 01 | 03951 CARDI AC AND PULMONARY REHAB | 2, 787 | | | | 5 | 76. 01 |
| 76. 02 | 03952 WOUND CARE | 75 | | 1 | | 0 | 76. 02 |
| 77. 00 | 07700 ALLOGENEIC STEM CELL ACQUISITION | 0 | 0 | 0.00000 | 00 0 | 0 | 77. 00 |
| | OUTPATIENT SERVICE COST CENTERS | | | | | | |
| 88. 00 | 08800 RURAL HEALTH CLINIC | 0 | | | | 0 | |
| 89. 00 | 08900 FEDERALLY QUALIFIED HEALTH CENTER | 0 | 0 | 0.00000 | 0 0 | 0 | 89. 00 |
| 90.00 | 09000 CLI NI C | 0 | 0 | 0.00000 | 00 | 0 | 90.00 |
| 90. 01 | 09001 CLI NI C | 27, 451 | 29, 720, 433 | 0. 00092 | 24 42, 284 | 39 | 90. 01 |
| 90. 02 | 09002 CLI NI C | 48, 284 | 6, 275, 161 | 0.00769 | 0 | 0 | 90. 02 |
| 91.00 | 09100 EMERGENCY | 392, 543 | 43, 343, 399 | 0.00905 | 1, 345, 900 | 12, 190 | 91. 00 |
| 92.00 | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 331, 428 | 11, 992, 253 | 0. 02763 | | 5, 538 | 92.00 |
| | OTHER REIMBURSABLE COST CENTERS | <u>'</u> | | • | <u> </u> | | |
| 94.00 | 09400 HOME PROGRAM DI ALYSIS | 0 | 0 | 0.00000 | 00 0 | 0 | 94. 00 |
| 95. 00 | 09500 AMBULANCE SERVICES | |] | | | I | 95. 00 |
| 96. 00 | 09600 DURABLE MEDICAL EQUIP-RENTED | 0 | 0 | 0. 00000 | 00 | 0 | 96.00 |
| 97. 00 | 09700 DURABLE MEDICAL EQUIP-SOLD | 0 | | 1 | | 0 | 97. 00 |
| 98. 00 | 09850 OTHER REIMBURSE | 0 | 1 | 0.00000 | | Ö | 98. 00 |
| 200.00 | | 3, 492, 956 | 481, 619, 299 | • | 14, 872, 051 | | |
| _00.00 | 1 1 1 1 2 1 2 1 1 1 2 2 2 2 2 2 2 2 2 2 | 0,, 700 | 1 .5.,5.,,2,, | 1 | 1, 5.2, 661 | 1, 270 | 1-30.00 |

| | | | ' | | 5/31/2022 7:5 | 4 am |
|--|----------------|---------------|---------------|----------------|----------------|---------|
| | | Ti tl | e XIX | Hospi tal | PPS | |
| Cost Center Description | Nursi ng | Nursi ng | Allied Health | Allied Health | All Other | |
| | Program | Program | Post-Stepdown | Cost | Medi cal | |
| | Post-Stepdown | | Adjustments | | Education Cost | |
| | Adjustments | | | | | |
| | 1A | 1.00 | 2A | 2. 00 | 3.00 | |
| INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | |
| 30. 00 03000 ADULTS & PEDIATRICS | 0 | 0 | 0 | 0 | 0 | 30.00 |
| 31. 00 03100 I NTENSI VE CARE UNI T | 0 | Ö | | | | |
| 32. 00 03200 CORONARY CARE UNIT | 0 | | 1 | | | 32. 00 |
| 33. 00 03300 BURN INTENSIVE CARE UNIT | 0 | | | | | 33. 00 |
| 34. 00 03400 SURGI CAL INTENSIVE CARE UNIT | 0 | | | | | 1 |
| | 0 | | 1 | _ | _ | 1 |
| 40. 00 04000 SUBPROVI DER - PF | 0 | 0 | 0 | 0 | _ | 40.00 |
| 41. 00 04100 SUBPROVI DER - RF | 0 | | | 0 | 0 | 41. 00 |
| 43. 00 04300 NURSERY | 0 | 0 | 0 | 0 | 0 | 43. 00 |
| 44.00 04400 SKILLED NURSING FACILITY | 0 | 0 | 0 | 0 | | 44. 00 |
| 45.00 04500 NURSING FACILITY | 0 | 0 |) C | 0 | | 45. 00 |
| 200.00 Total (lines 30 through 199) | 0 | 0 |) C | 0 | | 200. 00 |
| Cost Center Description | Swi ng-Bed | Total Costs | Total Patient | Per Diem (col. | Inpati ent | |
| | Adjustment | (sum of cols. | Days | 5 ÷ col. 6) | Program Days | |
| | Amount (see | 1 through 3, | | | | |
| | instructions) | minus col. 4) | | | | |
| | 4. 00 | 5. 00 | 6. 00 | 7. 00 | 8. 00 | |
| INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | |
| 30. 00 03000 ADULTS & PEDIATRICS | 0 | C | 15, 825 | 0.00 | 1, 092 | 30.00 |
| 31.00 03100 INTENSIVE CARE UNIT | | | 1, 701 | 0.00 | 0 | 31. 00 |
| 32. 00 03200 CORONARY CARE UNIT | | 1 | | | 0 | 32. 00 |
| 33.00 03300 BURN INTENSIVE CARE UNIT | | | | | | |
| 34. 00 03400 SURGI CAL INTENSI VE CARE UNI T | | | | 0.00 | | 34. 00 |
| 40. 00 04000 SUBPROVI DER - PF | 0 | | | | | 40.00 |
| 41. 00 04100 SUBPROVI DER - | | | | | | |
| 43. 00 04300 NURSERY | 0 | | | | | 43.00 |
| | | | 1 | | | 44.00 |
| 44. 00 04400 SKILLED NURSING FACILITY | | 0 | ή | | | |
| 45. 00 04500 NURSING FACILITY | | 0 | | 0.00 | | 45. 00 |
| 200.00 Total (lines 30 through 199) | | 0 | 17, 526 | 1 | 1, 092 | 200. 00 |
| Cost Center Description | I npati ent | | | | | |
| | Program | | | | | |
| | Pass-Through | | | | | |
| | Cost (col. 7 x | | | | | |
| | col. 8) | | | | | |
| | 9. 00 | | | | | |
| INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | |
| 30. 00 03000 ADULTS & PEDI ATRI CS | 0 | | | | | 30.00 |
| 31.00 03100 INTENSIVE CARE UNIT | 0 | | | | | 31. 00 |
| 32. 00 03200 CORONARY CARE UNIT | 0 | | | | | 32. 00 |
| 33.00 03300 BURN INTENSIVE CARE UNIT | 0 | | | | | 33. 00 |
| 34.00 03400 SURGICAL INTENSIVE CARE UNIT | 0 | | | | | 34.00 |
| 40. 00 04000 SUBPROVI DER - 1 PF | 0 | | | | | 40.00 |
| 41. 00 04100 SUBPROVI DER - I RF | 0 | | | | | 41. 00 |
| 43. 00 04300 NURSERY | ١ | | | | | 43. 00 |
| 44.00 04400 SKILLED NURSING FACILITY | | | | | | 44. 00 |
| 45. 00 04500 NURSING FACILITY | | | | | | 45. 00 |
| 200.00 Total (lines 30 through 199) | | | | | | 200. 00 |
| 200.00 Total (Tries 30 tillough 199) | 1 | I | | | | 1200.00 |

In Lieu of Form CMS-2552-10

| Period: | Worksheet D |
| From 01/01/2021 | Part IV |
| To 12/31/2021 | Date/Time Prepared: |
| 5/31/2022 7:54 am |
 Heal th Financial
 Systems
 FRANCISCAN HEALTH MUNSTER

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

| | | | | | '` | 12/01/2021 | 5/31/2022 7:5 | |
|------------------|--|---------------|-------------|----------|----|---------------|---------------|------------------|
| | | | Ti | tle XIX | | Hospi tal | PPS | |
| | Cost Center Description | Non Physician | Nursi ng | Nursi ng | | Allied Health | Allied Health | |
| | | Anesthetist | Program | Program | | Post-Stepdown | | |
| | | Cost | Post-Stepdo | vn | | Adjustments | | |
| | | | Adjustment | | | | | |
| | | 1.00 | 2A | 2. 00 | | 3A | 3. 00 | |
| | ANCILLARY SERVICE COST CENTERS | | | | | | | |
| 50. 00 | 05000 OPERATI NG ROOM | 0 | | 0 | 0 | 0 | | 50. 00 |
| 51. 00 | 05100 RECOVERY ROOM | 0 | | 0 | 0 | 0 | | 51. 00 |
| 52. 00 | 05200 DELIVERY ROOM & LABOR ROOM | 0 | | 0 | 0 | 0 | 0 | 52. 00 |
| 53. 00 | 05300 ANESTHESI OLOGY | 0 | | 0 | 0 | 0 | 0 | 53. 00 |
| 54. 00 | 05400 RADI OLOGY-DI AGNOSTI C | 0 | | 0 | 0 | 0 | | 54. 00 |
| 55. 00 | 05500 RADI OLOGY-THERAPEUTI C | 0 | | 0 | 0 | 0 | | 55. 00 |
| 56. 00 | 05600 RADI OI SOTOPE | 0 | | 0 | 0 | 0 | 0 | 56. 00 |
| 57. 00 | 05700 CT SCAN | 0 | | 0 | 0 | 0 | | 57. 00 |
| 58. 00 | 05800 MAGNETIC RESONANCE I MAGING (MRI) | 0 | | 0 | 0 | 0 | 0 | 58. 00 |
| 59. 00 | 05900 CARDI AC CATHETERI ZATI ON | 0 | | 0 | 0 | 0 | - 1 | 59. 00 |
| 60.00 | 06000 LABORATORY | 0 | | 0 | 0 | 0 | 0 | 60. 00 |
| 60. 01 | 06001 BLOOD LABORATORY | 0 | | 0 | 0 | 0 | 0 | 60. 01 |
| 61. 00 | 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY | | | | | | | 61. 00 |
| 62.00 | 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS | 0 | | 0 | 0 | 0 | | 62. 00 |
| 63. 00 | 06300 BLOOD STORING, PROCESSING & TRANS. | 0 | | 0 | 0 | 0 | 0 | 63. 00 |
| 64. 00 | 06400 I NTRAVENOUS THERAPY | 0 | | 0 | 0 | 0 | _ | 64. 00 |
| 65. 00 | 06500 RESPI RATORY THERAPY | 0 | | 0 | 0 | 0 | 0 | 65. 00 |
| 66. 00 | 06600 PHYSI CAL THERAPY | 0 | | 0 | 0 | 0 | _ | 66. 00 |
| 67. 00 | 06700 OCCUPATI ONAL THERAPY | 0 | | 0 | 0 | 0 | 0 | 67. 00 |
| 68. 00 | 06800 SPEECH PATHOLOGY | 0 | | 0 | 0 | 0 | | 68. 00 |
| 69. 00 | 06900 ELECTROCARDI OLOGY | 0 | | 0 | 0 | 0 | | 69. 00 |
| 70. 00 | 07000 ELECTROENCEPHALOGRAPHY | 0 | | 0 | 0 | 0 | 0 | 70. 00 |
| 71.00 | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | | 0 | 0 | 0 | 0 | 71. 00 |
| 72. 00 | 07200 IMPL. DEV. CHARGED TO PATIENTS | 0 | | 0 | 0 | 0 | 0 | 72. 00 |
| 73.00 | 07300 DRUGS CHARGED TO PATIENTS | 0 | | 0 | 0 | 0 | 0 | 73. 00 |
| 74.00 | 07400 RENAL DIALYSIS | 0 | | 0 | 0 | 0 | 0 | 74. 00 |
| 75. 00 | 07500 ASC (NON-DISTINCT PART) | 0 | | 0 | 0 | 0 | 0 | 75. 00 |
| 76. 00 | 03950 OTHER ANCILL SRVC | 0 | | 0 | 0 | 0 | 0 | 76. 00 |
| 76. 01 76. 02 | 03951 CARDI AC AND PULMONARY REHAB 03952 WOUND CARE | 0 | | 0 | 0 | 0 | | 76. 01 76. 02 |
| 77.00 | 07700 ALLOGENEIC STEM CELL ACQUISITION | 0 | | 0 | 0 | 0 | | 77. 00 |
| 77.00 | OUTPATIENT SERVICE COST CENTERS | l o | | <u> </u> | U | | l 0 | 77.00 |
| 88. 00 | 08800 RURAL HEALTH CLINIC | 0 | | ol | 0 | 0 | 0 | 88. 00 |
| 89. 00 | 08900 FEDERALLY QUALIFIED HEALTH CENTER | 0 | | o | 0 | 0 | | 89. 00 |
| 90.00 | 09000 CLINIC | 0 | | | 0 | 0 | 0 | 90.00 |
| 90. 01 | 09001 CLINI C | 0 | | | 0 | 0 | | 90. 01 |
| 90. 02 | 09002 CLINIC | 0 | | o | 0 | 0 | | 90. 02 |
| 91. 00 | 09100 EMERGENCY | 0 | | o | 0 | 0 | - 1 | 91. 00 |
| 92. 00 | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | o | | ٦ | 0 | ŭ | l o | 92. 00 |
| 00 | OTHER REIMBURSABLE COST CENTERS | <u> </u> | | 1 | اح | | | |
| 94.00 | 09400 HOME PROGRAM DIALYSIS | 0 | | ol | 0 | 0 | 0 | 94. 00 |
| 95. 00 | 09500 AMBULANCE SERVICES | | | | | · | | 95. 00 |
| 96.00 | 09600 DURABLE MEDICAL EQUIP-RENTED | o | | 0 | 0 | 0 | 0 | 96. 00 |
| 97.00 | 09700 DURABLE MEDICAL EQUIP-SOLD | o | | 0 | 0 | 0 | 0 | 97. 00 |
| 98. 00 | 09850 OTHER REIMBURSE | 0 | | 0 | 0 | 0 | 0 | 98. 00 |
| 200.00 | Total (lines 50 through 199) | 0 | | 0 | 0 | 0 | 0 | 200. 00 |
| | | | | | | | | |

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 15-0165 Peri od: Worksheet D From 01/01/2021 THROUGH COSTS Part IV 12/31/2021 Date/Time Prepared: 5/31/2022 7:54 am Title XIX Hospi tal Cost Center Description All Other Total Cost Total Total Charges Ratio of Cost to Charges Medi cal (from Wkst. C, (sum of cols. Outpati ent Education Cost 1, 2, 3, and Cost (sum of Part I, col. l(col. 5 ÷ col 8) 4) col s. 2, 3, 7) and 4) (see instructions) 4.00 5.00 6.00 7. 00 8.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 74, 320, 998 0.000000 50.00 000000000000 05100 RECOVERY ROOM 0 0 8, 438, 720 0.000000 51.00 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0.000000 52.00 05300 ANESTHESI OLOGY 0 0 19 268 194 0.000000 53 00 53 00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 31, 974, 264 0.000000 54.00 05500 RADI OLOGY-THERAPEUTI C 0.000000 55.00 05600 RADI OI SOTOPE 0 0 0.000000 56 00 56 00 0 44, 331, 858 57.00 05700 CT SCAN 0 0.000000 57.00 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 26, 317, 000 0.000000 58.00 05900 CARDIAC CATHETERIZATION 59.00 0 19, 111, 259 0.000000 59.00 06000 LABORATORY 60 00 60, 454, 259 0.000000 60 00 06001 BLOOD LABORATORY 60.01 0 0.000000 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.000000 62.00 000000000000000000 0 62.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0.000000 63.00 0 63 00 64.00 06400 I NTRAVENOUS THERAPY 0 0 390, 389 0.000000 64.00 06500 RESPIRATORY THERAPY 5, 388, 400 0.000000 65.00 65.00 06600 PHYSI CAL THERAPY 0 2, 375, 261 0.000000 66.00 66, 00 06700 OCCUPATIONAL THERAPY 0 1, 977, 604 67.00 0 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 675, 643 0.000000 68.00 06900 ELECTROCARDI OLOGY 69.00 16, 818, 634 0.000000 69.00 07000 ELECTROENCEPHALOGRAPHY 0 70.00 4, 413, 377 0.000000 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0.000000 71.00 20, 671, 354 71 00 07200 IMPL. DEV. CHARGED TO PATIENTS 22, 370, 173 0.000000 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 29, 825, 577 0.000000 73.00 07400 RENAL DIALYSIS 0 909, 149 0.000000 74.00 0 74.00 07500 ASC (NON-DISTINCT PART) 0 75.00 C 0.000000 75.00 03950 OTHER ANCILL SRVC 0.000000 76.00 76.00 0 76. 01 03951 CARDIAC AND PULMONARY REHAB 0 213, 534 0.000000 76.01 03952 WOUND CARE 0 76.02 Ω 42, 406 0.000000 76.02 07700 ALLOGENEIC STEM CELL ACQUISITION 77.00 0.00000077.00 OUTPATIENT SERVICE COST CENTERS 0 88.00 08800 RURAL HEALTH CLINIC 0 0.000000 88.00 0 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 0 0 0.00000089.00 90.00 09000 CLI NI C 0 0 0 0 0.000000 90.00 09001 CLI NI C 0 0 29, 720, 433 0.000000 90.01 90.01 09002 CLI NI C 0 0 6, 275, 161 0.000000 90.02 90.02 91.00 09100 EMERGENCY 0 C 0 43, 343, 399 0.000000 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 11, 992, 253 0.000000 92.00 OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DIALYSIS 94.00 0 0 0.000000 94.00 95. 00 09500 AMBULANCE SERVICES 95.00 09600 DURABLE MEDICAL EQUIP-RENTED 96.00 0 0 0 0.000000 96.00 0 0

0

0

0

0

0

0

481, 619, 299

0.000000

0.000000

97.00

98.00

200.00

97. 00 09700 DURABLE MEDICAL EQUIP-SOLD

Total (lines 50 through 199)

98. 00 09850 OTHER REIMBURSE

200.00

In Lieu of Form CMS-2552-10

Period: Worksheet D
From 01/01/2021 Part IV
To 12/31/2021 Date/Time Prepared: 5/31/2022 7:54 am
 Heal th Financial APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
 FRANCISCAN HEALTH MUNSTER Provider
 Provider CCN: 15-0165 THROUGH COSTS

| | | | | | | 5/31/2022 7:5 | 4 am |
|---------|--|----------------|--------------|-------------|-------------|---------------|---------|
| | | | Ti tl | e XIX | Hospi tal | PPS | |
| | Cost Center Description | Outpati ent | Inpati ent | Inpati ent | Outpati ent | Outpati ent | |
| | , , , , , , , , , , , , , , , , , , , | Ratio of Cost | Program | Program | Program | Program | |
| | | to Charges | Charges | Pass-Throug | | Pass-Through | |
| | | (col. 6 ÷ col. | onal ges | Costs (col. | | Costs (col. 9 | |
| | | ` | | | 0 | , | |
| | | 7) | 10.00 | x col . 10) | 12.00 | x col . 12) | |
| | ANOLLI ADV. CEDVI OF COCT OFFITEDS | 9.00 | 10.00 | 11.00 | 12.00 | 13.00 | |
| | ANCILLARY SERVICE COST CENTERS | 0.000000 | 1 011 000 | | | | |
| | O5000 OPERATING ROOM | 0. 000000 | 1, 314, 083 | 1 | 0 | 0 | 50.00 |
| 4 | 05100 RECOVERY ROOM | 0. 000000 | 131, 155 | | 0 | 0 | 51.00 |
| | 05200 DELIVERY ROOM & LABOR ROOM | 0. 000000 | 0 | | 0 | 0 | 52. 00 |
| 53.00 | D5300 ANESTHESI OLOGY | 0. 000000 | 359, 023 | | 0 | 0 0 | 53.00 |
| 54.00 | D5400 RADI OLOGY-DI AGNOSTI C | 0. 000000 | 743, 634 | | 0 | 0 0 | 54.00 |
| 55. 00 | 05500 RADI OLOGY-THERAPEUTI C | 0. 000000 | 0 | | 0 | ol o | 55. 00 |
| | 05600 RADI OI SOTOPE | 0. 000000 | 0 | | 0 | ol o | 56. 00 |
| 1 | 05700 CT SCAN | 0. 000000 | 1, 197, 258 | | o | | 57. 00 |
| | D5800 MAGNETIC RESONANCE IMAGING (MRI) | 0. 000000 | 392, 185 | l . | o | | 58.00 |
| | 05900 CARDI AC CATHETERI ZATI ON | 0. 000000 | 1, 212, 674 | | 0 | | 59.00 |
| 1 | | | | | 0 | | |
| 1 | 06000 LABORATORY | 0. 000000 | 2, 936, 060 | | -1 | -1 | 60.00 |
| 1 | 06001 BLOOD LABORATORY | 0. 000000 | 0 | | 0 | 0 | 60. 01 |
| 1 | 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY | | | | | | 61.00 |
| 62.00 | 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS | 0. 000000 | 0 | | 0 | 0 | 62. 00 |
| 63.00 | 06300 BLOOD STORING, PROCESSING & TRANS. | 0. 000000 | 0 | | 0 | 0 | 63. 00 |
| | 06400 INTRAVENOUS THERAPY | 0. 000000 | 0 | | 0 | ol o | 64.00 |
| 4 | 06500 RESPIRATORY THERAPY | 0. 000000 | 622, 532 | | 0 | ol o | 65. 00 |
| 4 | 06600 PHYSI CAL THERAPY | 0. 000000 | 151, 533 | l . | 0 | | 66.00 |
| | 06700 OCCUPATI ONAL THERAPY | 0. 000000 | 132, 517 | | Ö | | 67.00 |
| | 06800 SPEECH PATHOLOGY | 0. 000000 | | 1 | 0 | 0 0 | 68.00 |
| 4 | | | 68, 370 | 1 | | - | |
| 4 | 06900 ELECTROCARDI OLOGY | 0. 000000 | 551, 003 | 1 | 0 | 0 | 69.00 |
| | 07000 ELECTROENCEPHALOGRAPHY | 0. 000000 | 19, 773 | | 0 | 0 | 70. 00 |
| | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0. 000000 | 673, 143 | • | 0 | 0 | 71. 00 |
| | 07200 IMPL. DEV. CHARGED TO PATIENTS | 0. 000000 | 428, 947 | | 0 | 0 | 72. 00 |
| | 07300 DRUGS CHARGED TO PATIENTS | 0. 000000 | 2, 280, 318 | | 0 | 0 | 73. 00 |
| | 07400 RENAL DIALYSIS | 0. 000000 | 68, 880 | | 0 | 0 0 | 74.00 |
| 75.00 | D7500 ASC (NON-DISTINCT PART) | 0. 000000 | 0 | | 0 | 0 0 | 75. 00 |
| | 03950 OTHER ANCILL SRVC | 0. 000000 | 0 | | 0 | ol o | 76. 00 |
| 76. 01 | 03951 CARDIAC AND PULMONARY REHAB | 0. 000000 | 408 | | 0 | ol o | 76. 01 |
| | 03952 WOUND CARE | 0. 000000 | 0 | • | o | ol o | 76. 02 |
| 1 | 07700 ALLOGENEIC STEM CELL ACQUISITION | 0. 000000 | 0 | | o | 0 0 | 77. 00 |
| | DUTPATIENT SERVICE COST CENTERS | 0.000000 | | | 0 | 0 0 | 77.00 |
| - | D8800 RURAL HEALTH CLINIC | 0. 000000 | 0 | | 0 | 0 0 | 88. 00 |
| | 08900 FEDERALLY QUALIFIED HEALTH CENTER | 0. 000000 | 0 | | 0 | 0 0 | 89.00 |
| | | | - | | | 1 | |
| | 09000 CLI NI C | 0. 000000 | 0 | | 0 | 0 | 90.00 |
| | 09001 CLI NI C | 0. 000000 | 42, 284 | | 0 | 0 | 90. 01 |
| | 09002 CLI NI C | 0. 000000 | 0 | 1 | 0 | 0 | 90. 02 |
| 91.00 | 09100 EMERGENCY | 0. 000000 | 1, 345, 900 | | 0 | 0 | 91. 00 |
| 92.00 | 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 0. 000000 | 200, 371 | | 0 | 0 0 | 92. 00 |
| | OTHER REIMBURSABLE COST CENTERS | | | | <u> </u> | <u> </u> | 1 |
| | 09400 HOME PROGRAM DIALYSIS | 0. 000000 | 0 | | 0 | 0 0 | 94. 00 |
| | 09500 AMBULANCE SERVICES | | ŭ | | | | 95. 00 |
| 4 | 09600 DURABLE MEDICAL EQUIP-RENTED | 0. 000000 | 0 | | 0 | 0 0 | 96.00 |
| | 09700 DURABLE MEDICAL EQUIP-SOLD | 0. 000000 | 0 | | 0 | | 97.00 |
| 4 | 09850 OTHER REIMBURSE | 0. 000000 | 0 | | 0 | 0 0 | 98.00 |
| | | 0.000000 | - | | - | | |
| 200. 00 | Total (lines 50 through 199) | | 14, 872, 051 | I | 0 | 0 0 | 200. 00 |
| | | | | | | | |

| APPURI | TOWNENT OF MEDICAL, OTHER HEALTH SERVICES AND | VACCINE COST | Provider C | | From 01/01/2021 To 12/31/2021 | Part V Date/Time Pre | pared: |
|------------------|---|--------------------------------|-----------------|--------------------|----------------------------------|-----------------------------|------------------|
| | | | | | | 5/31/2022 7:5 | 4 am |
| | | | Ti tl | e XIX | Hospi tal | PPS | |
| | Coot Conton Decemintion | Coot to Change | ODC Doimburgood | Charges | Coot | Costs | |
| | Cost Center Description | Cost to Charge F Ratio From | Servi ces (see | Cost Reimbursed | Cost Reimbursed | PPS Services (see inst.) | |
| | | Worksheet C, | inst.) | Servi ces | Services Not | (See Hist.) | |
| | | Part I, col. 9 | 11131.) | Subject To | Subject To | | |
| | | | | Ded. & Coins | | | |
| | | | | (see inst.) | (see inst.) | | |
| | | 1. 00 | 2.00 | 3. 00 | 4. 00 | 5. 00 | |
| | ANCI LLARY SERVI CE COST CENTERS | | | 1 | | | |
| 50. 00 | 05000 OPERATING ROOM | 0. 148805 | 0 | ., | | 0 | |
| 51.00 | 05100 RECOVERY ROOM | 0. 285661 | 0 | 906, 84 | | 0 | |
| 52. 00 | 05200 DELIVERY ROOM & LABOR ROOM | 0. 000000 | 0 | 1 000 0/ | 0 0 | 0 | |
| 53.00 | 05300 ANESTHESI OLOGY | 0. 033577 | 0 | 1, 909, 96 | | 0 | |
| 54.00 | 05400 RADI OLOGY - DI AGNOSTI C | 0. 139318 | 0 | 3, 869, 03 | | 0 | 0 1. 00 |
| 55. 00 56. 00 | 05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE | 0. 000000 0. 000000 | 0 | | 0 0 | 0 | 55. 00 56. 00 |
| 57. 00 | 05700 CT SCAN | 0. 030483 | 0 | 5, 431, 39 | - | 0 | 1 |
| 58. 00 | 05800 MAGNETIC RESONANCE IMAGING (MRI) | 0. 074051 | 0 | 3, 431, 52 | | 0 | 1 |
| 59. 00 | 05900 CARDI AC CATHETERI ZATI ON | 0. 233322 | 0 | 671, 89 | | 0 | |
| 60. 00 | 06000 LABORATORY | 0. 118952 | 0 | 5, 979, 23 | | 0 | 1 |
| 60. 01 | 06001 BLOOD LABORATORY | 0. 000000 | 0 | ,, | 0 0 | 0 | 1 |
| 61.00 | 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY | 0. 000000 | | | 0 0 | 1 | 61.00 |
| 62.00 | 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS | 0. 000000 | 0 | | 0 0 | 0 | 62.00 |
| 63.00 | 06300 BLOOD STORING, PROCESSING & TRANS. | 0. 000000 | 0 |) | 0 0 | 0 | 63.00 |
| 64.00 | 06400 I NTRAVENOUS THERAPY | 0. 003407 | 0 | 37, 92 | 1 0 | 0 | 64. 00 |
| 65.00 | 06500 RESPI RATORY THERAPY | 0. 351382 | 0 | 79, 76 | 4 0 | 0 | 65. 00 |
| 66. 00 | 06600 PHYSI CAL THERAPY | 0. 169889 | 0 | 56, 60 | 0 | 0 | 66. 00 |
| 67. 00 | 06700 OCCUPATI ONAL THERAPY | 0. 135721 | 0 | 39, 39 | | 0 | |
| 68. 00 | 06800 SPEECH PATHOLOGY | 0. 135245 | 0 | 18, 93 | | 0 | |
| 69. 00 | 06900 ELECTROCARDI OLOGY | 0. 045862 | 0 | 1, 306, 62 | | 0 | 07.00 |
| 70. 00 | 07000 ELECTROENCEPHALOGRAPHY | 0. 513945 | 0 | 556, 51 | | 0 | |
| 71.00 | 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0. 450024 | 0 | 1, 016, 41 | | 0 | |
| 72.00 | 07200 I MPL. DEV. CHARGED TO PATIENTS | 0. 352057 | 0 | 2, 014, 18 | | 0 | |
| 73. 00 74. 00 | 07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS | 0. 236586 | 0 | 1, 575, 29 | | 0 | |
| 75. 00 | 07500 ASC (NON-DISTINCT PART) | 0. 003406 0. 000000 | 0 | 9, 44 | 0 0 | 0 | 1 |
| 76. 00 | 03950 OTHER ANCILL SRVC | 0. 000000 | 0 | | 0 0 | 1 0 | 76.00 |
| 76. 01 | 03951 CARDI AC AND PULMONARY REHAB | 1. 561339 | 0 | | o o | 0 | 1 |
| 76. 02 | 03952 WOUND CARE | 0. 224850 | 0 | 8, 78 | | Ö | |
| 77. 00 | 07700 ALLOGENEIC STEM CELL ACQUISITION | 0. 000000 | 0 | 1 | 0 0 | 0 | 1 |
| | OUTPATIENT SERVICE COST CENTERS | | | • | | | |
| 88. 00 | 08800 RURAL HEALTH CLINIC | | | | | | 88. 00 |
| 89. 00 | 08900 FEDERALLY QUALIFIED HEALTH CENTER | | | | | I | 89. 00 |
| 90.00 | 09000 CLI NI C | 0. 000000 | 0 |) | 0 | 0 | |
| 90. 01 | 09001 CLI NI C | 0. 113678 | 0 | 3, 043, 96 | | 0 | |
| 90. 02 | 09002 CLI NI C | 0. 135602 | 0 | 310, 72 | | 0 | |
| 91.00 | 09100 EMERGENCY | 0. 149899 | 0 | 9, 224, 49 | | 0 | |
| 92. 00 | 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) | 0. 375088 | 0 | 1, 941, 75 | 5 0 | 0 | 92.00 |
| 04.00 | OTHER REIMBURSABLE COST CENTERS | 0.000000 | | 1 | | | 04.00 |
| | 09400 HOME PROGRAM DIALYSIS 09500 AMBULANCE SERVICES | 0. 000000 0. 000000 | 0 | | 0 0 | 1 | 94. 00 95. 00 |
| | 09600 DURABLE MEDICAL EQUIP-RENTED | 0. 000000 | 0 | | 0 0 | 0 | 1 |
| | 09700 DURABLE MEDICAL EQUIP-SOLD | 0. 000000 | 0 | | 0 0 | 0 | 1 |
| 98. 00 | 09850 OTHER REIMBURSE | 0. 000000 | 0 | 1 | 0 0 | Ö | 1 |
| 200.00 | | | 0 | 1 | | | 200. 00 |
| 201.00 | 1 / | | | | 0 0 | 1 | 201.00 |
| | Only Charges | | | | | 1 | |
| 202.00 | Net Charges (line 200 - line 201) | | 0 | 50, 123, 04 | 7 0 | , 0 | 202. 00 |

 Heal th Financial
 Systems
 FRANCISCAN HE

 APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST
 Peri od: Worksheet D
From 01/01/2021
To 12/31/2021 Part V
Date/Time Prepared: 5/31/2022 7:54 am Provi der CCN: 15-0165

| Cost Center Description | | | | T: ±1 | - VIV | 11: +-1 | 5/31/2022 /: 5 | <u>4 am</u> |
|--|----------|---|---------------|---------------|-------|-----------|----------------|-------------|
| Cost Center Description | | | | | e XIX | Hospi tal | PPS | |
| Rel Imbursed Servi ces | | | | | | | | |
| Services Subject To Ded. & Coins. (See inst.) Ded. & Coins. (See inst.) | | Cost Center Description | | | | | | |
| Subject To Ded. & Coin is. Subject To Ded. & Coin is. See Inst.) Color See Inst. Color S | | | | | | | | |
| Ded. & Col ns. Ded. & Ded | | | Servi ces | Services Not | | | | |
| See Inst. See | | | Subject To | Subject To | | | | |
| See Inst. See | | | Ded. & Coins. | Ded. & Coins. | | | | |
| ANCILLARY SERVICE COST CENTERS | | | | | | | | |
| ANCILLARY SERVICE COST CENTERS 50.00 50. | | | | | 1 | | | |
| 50.00 | Λ | NCILLARY SERVICE COST CENTERS | 0.00 | 7.00 | 1 | | | |
| 51.00 05100 RECOVERY ROOM 259, 049 0 51.00 52.00 05200 DELI VERY ROOM & LABOR ROOM 0 0 0 53.00 05300 DELI VERY ROOM & LABOR ROOM 0 0 0 55.00 054.00 05400 ARDI OLGY - THERAPEUTI C 0 0 0 0 55.00 05500 RADI OLGY - THERAPEUTI C 0 0 0 0 0 0 0 0 0 | | | 1 055 072 | | 1 | | | 50.00 |
| S2 00 05200 05200 05200 05200 05200 05200 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05400 05400 05400 05400 05400 05400 05400 0550 | | | | | 1 | | | |
| 53.00 05300 ANESTHESI OLOGY 64, 131 0 53.00 55.0 | | | | | 1 | | | |
| 54.00 05400 RADIOLOGY-DIAGNOSTIC 539,027 0 55.00 555.00 555.00 05500 RADIOLOGY-THERAPEUTIC 0 0 0 55.00 05500 RADIOLOGY-THERAPEUTIC 0 0 0 0 0 0 0 0 0 | | | 1 | | 1 | | | |
| 55.00 0.5500 RADIO LOGY-THERAPEUTIC 0 0 0 55.00 55.00 56 | | | 64, 131 | (|) | | | 53.00 |
| 56. 00 05-600 RADIO I SOTOPE 0 0 0 55. 00 57. 00 57. 00 57. 00 57. 00 57. 00 57. 00 57. 00 57. 00 57. 00 57. 00 57. 00 57. 00 57. 00 57. 00 57. 00 57. 00 57. 00 57. 00 58. 00 58. 00 58. 00 58. 00 58. 00 58. 00 58. 00 58. 00 58. 00 58. 00 59. 00 68. | 54.00 0 | 5400 RADI OLOGY-DI AGNOSTI C | 539, 027 | [|) | | | 54.00 |
| 57. 00 05700 CT SCAN 55. 00 58. 00 058. 00 058. 00 059. 00 | 55.00 0 | 5500 RADI OLOGY-THERAPEUTI C | 0 | l c | | | | 55. 00 |
| 57. 00 05700 CT SCAN 55. 00 58. 00 058. 00 058. 00 059. 00 | 56, 00 0 | 5600 RADI OI SOTOPE | 0 | l c | ol | | | 56.00 |
| SB. 00 OSBOO MAGNETI C RESONANCE I IMAGING (MRI) 223, 450 0 59, 00 69, 00 69, 00 69, 00 69, 00 69, 00 69, 00 69, 00 69, 00 69, 00 69, 00 69, 00 69, 00 60 | 4 | | 165 565 | | | | | |
| S9-00 05900 CARDIAC CATHETERI ZATION 156, 767 0 0.00 | 4 | | 1 | l . | 1 | | | 1 |
| 60.00 06000 LABORATORY | 4 | | | | 1 | | | |
| 60. 01 0600 BLOOD LABORATORY 0 0 0 0 0 0 0 0 0 | 4 | | 1 | l . | 1 | | | 1 |
| 61. 00 06100 PBP CLINI CAL LAB SERVI CES-PRGM ONLY 0 06200 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 0 0 0 0 0 0 0 | | | 1 | l . | 1 | | | |
| 62. 00 66200 MINOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 63. 00 63. 00 640.00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 0 0 0 0 64.00 06400 INTRAVENOUS THERAPY 129 0 64. 00 06600 CONTROLE OF THE PACKED RESPONSIVE RESPON | | | 1 | |) | | | 1 |
| 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 64.00 64.00 06400 INTRAVENOUS THERAPY 129 0 0 64.00 65.00 06500 RESPIRATORY THERAPY 28,028 0 65.00 66.00 06600 PHYSI CAL THERAPY 9,616 0 0 0 67.00 06700 0CCUPATI ONAL THERAPY 5,347 0 0 68.00 06800 SPEECH PATHOLOGY 2,561 0 0 0 69.00 06900 ELECTROCARDIOLOGY 59,924 0 0 69.00 06900 ELECTROCARDIOLOGY 59,924 0 0 69.00 071.00 07000 ELECTROCARDIOLOGY 59,924 0 0 69.00 071.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 457,412 0 71.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 709,107 0 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 372,693 0 73.00 74.00 07400 RENAL DI ALYSI S 32 0 74.00 75.00 07500 ASC (NON-DI STINCT PART) 0 0 0 76.01 03951 CARDI AC AND PULMONARY REHAB 0 0 0 76.01 03952 WOUND CARE 1,975 0 76.01 77.00 0700 ALLOGENEIC STEM CELL ACQUISITION 0 0 77.00 0700 ALLOGENEIC STEM CELL ACQUISITION 0 0 77.00 0700 ALLOGENEIC STEM CELL ACQUISITION 0 0 77.01 0700 0700 0700 0700 0700 0700 77.01 0700 0700 0700 0700 0700 0700 78.00 0700 0700 0700 0700 0700 0700 79.00 0700 0700 0700 0700 0700 79.00 0700 0700 0700 0700 0700 79.00 0700 0700 0700 0700 0700 79.00 0700 0700 0700 0700 0700 79.00 0700 0700 0700 0700 0700 79.00 0700 0700 0700 0700 0700 79.00 0700 0700 0700 0700 0700 79.00 0700 0700 0700 0700 0700 79.00 0700 0700 0700 0700 0700 79.00 0700 0700 0700 0700 0700 79.00 0700 0700 0700 0700 0700 79.00 0700 0700 0700 0700 0700 79.00 0700 0700 0700 0700 0700 79.00 0700 0700 0700 0700 0700 79.00 0700 0700 0700 0700 0700 79.00 0700 0700 0700 0700 0700 79.00 0700 0700 0700 0700 79.00 0700 0700 0 | 4 | | 0 | | | | | |
| 64. 00 06400 INTRAVENOUS THERAPY 129 0 65. 00 65. 00 06500 RESPI RATORY THERAPY 28, 028 0 65. 00 66. 00 | 62.00 0 | 6200 WHOLE BLOOD & PACKED RED BLOOD CELLS | 0 | (|) | | | 62.00 |
| 65. 00 06500 RESPIRATORY THERAPY 28,028 0 66.00 06600 PHYSI CAL THERAPY 9,616 0 66.00 66 | 63.00 0 | 6300 BLOOD STORING, PROCESSING & TRANS. | 0 | l c | | | | 63.00 |
| 65. 00 06500 RESPIRATORY THERAPY 28,028 0 66.00 06600 PHYSI CAL THERAPY 9,616 0 66.00 66 | | | 129 | 1 | | | | 64.00 |
| 66. 00 06600 PHYSICAL THERAPY 9, 616 0 67. 00 677. 00 667. 00 6670 0 670. 00 0 670. 00 0 670. 00 670. 00 670. 00 670. 00 670. 00 670. 00 680. 00 0 0 0 0 0 0 0 0 | | | 1 | | 1 | | | 1 |
| 67. 00 06700 OCCUPATI ONAL THERAPY 5, 347 0 68. 00 06800 SPECH PATHOLOGY 2, 561 0 68. 00 06900 ELECTROCARDI OLOGY 259, 924 0 69. 00 07000 ELECTROCARDI OLOGY 286, 016 0 70. 00 07000 ELECTROENCEPHALOGRAPHY 286, 016 0 70. 00 07000 MEDI CAL SUPPLIES CHARGED TO PATIENTS 457, 412 0 71. 00 7100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 457, 412 0 772. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 372, 693 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 372, 693 0 73. 00 74. 00 07400 RENAL DIALYSIS 32 0 74. 00 740. 00 755. 00 755. 00 755. 00 755. 00 755. 00 755. 00 755. 00 755. 00 755. 00 755. 00 756. 00 756. 00 756. 00 756. 00 756. 00 756. 00 756. 00 756. 00 756. 00 756. 00 756. 00 756. 00 750. 00 756. 00 75 | | | | | 1 | | | |
| 68. 00 06800 SPEECH PATHOLOGY 2, 561 0 66. 00 69. 00 06900 ELECTROCARDI OLOGY 59, 924 0 67. 00 70. 00 7 | | | | | 1 | | | |
| 69. 00 06900 ELECTROCARDI OLOGY 59,924 0 69. 00 70. 00 7000 ELECTROENCEPHALOGRAPHY 286,016 0 70. 00 71. 00 71. 00 71. 00 71. 00 71. 00 71. 00 71. 00 71. 00 71. 00 71. 00 72. 00 72. 01 MPL. DEV. CHARGED TO PATI ENTS 709,107 0 72. 00 73. 00 73.00 DRUGS CHARGED TO PATI ENTS 372,693 0 73. 00 74. 00 74. 00 74. 00 74. 00 75. 00 75. 00 75. 00 75. 00 75. 00 75. 00 76. 00 75. 00 76. 00 76. 00 76. 00 76. 00 76. 00 76. 01 76. 01 76. 01 76. 01 76. 01 76. 02 77. 00 76. 01 76. 02 77. 00 | 4 | | 1 | | 1 | | | |
| 70. 00 07000 ELECTROENCEPHALOGRAPHY 286, 016 0 77. 00 | | | | | 1 | | | |
| 71. 00 | | | | | 1 | | | |
| 72. 00 | 70. 00 0 | 7000 ELECTROENCEPHALOGRAPHY | 286, 016 | (|) | | | 70. 00 |
| 73. 00 | 71.00 0 | 7100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 457, 412 | (|) | | | 71.00 |
| 73. 00 | 72.00 0 | 7200 IMPL. DEV. CHARGED TO PATIENTS | 709, 107 | | | | | 72. 00 |
| 74. 00 | | | 372, 693 | 1 | | | | 73.00 |
| 75. 00 | | | | l . | 1 | | | |
| 76. 00 | | | | | 1 | | | 1 |
| 76. 01 03951 CARDI AC AND PULMONARY REHAB 0 0 76. 01 76. 02 03952 WOUND CARE 1,975 0 76. 02 77. 00 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON 0 0 0 77. 00 OUTPATI ENT SERVI CE COST CENTERS 88. 00 08800 RURAL HEALTH CLINI C 89. 00 09000 CLINI C 90. 00 99000 PMERGENCY 90. 00 99000 PMERGENCY 90. 00 99000 OPENDER REIMBURSABLE COST CENTERS 90. 00 9000 OPENDER REIMBURSABLE MEDI CAL EQUI P-RENTED 0 0 90. 00 9000 OPENDER MEDI CAL EQUI P-RENTED 0 0 90. 00 9000 OPENDER MEDI CAL EQUI P-RENTED 0 0 90. 00 9000 OPENDER MEDI CAL EQUI P-RENTED 0 0 90. 00 9000 OPENDER MEDI CAL EQUI P-RENTED 0 0 90. 00 9000 OPENDER MEDI CAL EQUI P-RENTED 0 0 90. 00 9000 OPENDER MEDI CAL EQUI P-RENTED 0 0 90. 00 9000 OPENDER MEDI CAL EQUI P-RENTED 0 0 90. 00 9000 OPENDER MEDI CAL EQUI P-RENTED 0 0 90. 00 9000 OPENDER MEDI CAL EQUI P-RENTED 0 0 90. 00 9000 OPENDER MEDI CAL EQUI P-RENTED 0 0 90. 00 9000 OPENDER MEDI CAL EQUI P-RENTED 0 0 90. 00 9000 OPENDER MEDI CAL EQUI P-RENTED 0 0 90. 00 9000 OPENDER MEDI CAL EQUI P-RENTED 0 0 90. 00 9000 OPENDER MEDI CAL EQUI P-RENTED 0 0 90. 00 9000 OPENDER MEDI CAL EQUI P-RENTED 0 0 90. 00 9000 OPENDER MEDI CAL EQUI P-RENTED 0 0 90. 00 9000 OPENDER MEDI CAL EQUI P-RENTED 0 0 90. 00 9000 OPENDER MEDI CAL EQUI P-RENTED 0 90. 00 9000 OPENDER MEDI CAL EQUI P-RENTED 0 90. 00 9000 OPENDER MEDI CAL EQUI P-RENTED 90. 90. 00 9000 OPENDER MEDI CAL EQUI P-RENTED 90. 90. 00 9000 OPENDER MEDI CAL EQUI P-RENTED 90. 90. 00 9000 OPENDER MEDI CAL EQUI P-RENTED 90. 90. 00 9000 OPENDER P-RENTED 90. 90. 00 9000 OPENDER P-RENTED 90. 90. 90. 90. 90. 90. 90. 90. 90. 90. | | | | | 1 | | | |
| 76. 02 03952 WOUND CARE 1,975 0 76. 02 77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION 0 0 0 77. 00 OUTPATIENT SERVICE COST CENTERS 88. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89. 00 90. 00 09000 CLINIC 0 0 0 9000 CLINIC 99. 00 90. 01 09001 CLINIC 346,032 0 90. 01 90. 02 09002 CLINIC 346,032 0 90. 01 90. 02 09002 CLINIC 42,135 0 90. 02 91. 00 09100 EMERGENCY 1,382,743 0 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 728,329 0 92. 00 OTHER REIMBURSABLE COST CENTERS 94. 00 09400 HOME PROGRAM DIALYSIS 0 95. 00 95. 00 09500 AMBULANCE SERVICES 0 95. 00 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED 0 0 0 96. 00 | | | | | 1 | | | |
| 77. 00 | | | 1 | | 1 | | | 1 |
| SECTION SURVICE COST CENTERS SECTION | | • | | | 1 | | | 1 |
| 88. 00 89. 00 89. 00 89. 00 89. 00 90. 00 90. 01 90. 01 90. 02 90. 02 90. 02 90. 00 90. 01 90. 00 90. 01 90. 02 90. 02 90. 02 90. 00 90. 01 90. 02 90. 02 90. 02 90. 02 90. 02 90. 02 90. 03 90. 02 | | | 0 | (|) | | | 77. 00 |
| 89. 00 | O | UTPATIENT SERVICE COST CENTERS | | | | | | |
| 90. 00 | 88. 00 0 | 8800 RURAL HEALTH CLINIC | | | | | | 88. 00 |
| 90. 00 | 89. 00 0 | 8900 FEDERALLY QUALIFIED HEALTH CENTER | | | | | | 89. 00 |
| 90. 01 | | | 0 | 1 | | | | 90 00 |
| 90. 02 | | | 1 | | 1 | | | |
| 91. 00 | | | 1 | l . | 1 | | | |
| 92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 728, 329 0 92. 00 | | | 1 | l . | | | | |
| OTHER REI MBURSABLE COST CENTERS 94. 00 | | | | | 1 | | | |
| 94. 00 | | | 728, 329 | 1 0 |) | | | 92.00 |
| 95. 00 09500 AMBULANCE SERVI CES 0 95. 00 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 96. 00 | | | | | | | | |
| 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 96. 00 | 94.00 0 | 9400 HOME PROGRAM DIALYSIS | 0 | (|) | | | 94.00 |
| | 95.00 0 | 9500 AMBULANCE SERVICES | 0 | | | | | 95. 00 |
| | 96, 00 0 | 9600 DURABLE MEDICAL EQUIP-RENTED | 0 | l c | ol | | | 96. 00 |
| 97. 00 09700 DURABLE MEDI CAL FOUI P-SOLD 0 0 0 | | 9700 DURABLE MEDICAL EQUIP-SOLD | 0 | | 1 | | | 97. 00 |
| 98. 00 09850 OTHER REI MBURSE 0 0 98. 00 | | | 1 | _ | 1 | | | |
| | | | 1 | _ | 1 | | | |
| | | | 1 | | ή | | | |
| 201.00 Less PBP Clinic Lab. Services-Program 0 201.00 | 201.00 | | | | | | | 201.00 |
| Only Charges | 005 | 1 3 3 | | | | | | |
| 202.00 Net Charges (line 200 - line 201) 7,607,283 0 202.00 | 202.00 | Net Charges (line 200 - line 201) | /, 607, 283 | (| 기 | | | J202. 00 |

| Health Financial Systems | FRANCISCAN HEALTH MUNSTER | In Lie | u of Form CMS- | 2552-10 |
|---|---------------------------|-----------------------------|-----------------------------|---------|
| COMPUTATION OF INPATIENT OPERATING COST | Provi der CCN: 15-0165 | Peri od: From 01/01/2021 | Worksheet D-1 | |
| | | | Date/Time Pre 5/31/2022 7:5 | |
| | Title XVIII | Hospi tal | PPS | |
| Cost Center Description | | | | |

| - | | Title XVIII | Hospi tal | 5/31/2022 7: 54 PPS | <u>4 am</u> |
|------------------|--|--------------------------|------------------|------------------------|------------------|
| | Cost Center Description | I the Aviii | поѕрі таі | PPS | |
| | , | | | 1. 00 | |
| | PART I - ALL PROVIDER COMPONENTS | | | | |
| 1. 00 | INPATIENT DAYS Inpatient days (including private room days and swing-bed days | oveluding nowhern) | | 15, 825 | 1.00 |
| 2. 00 | Inpatient days (including private room days and swing-bed days Inpatient days (including private room days, excluding swing-b | | | 15, 825 | 2.00 |
| 3. 00 | Private room days (excluding swing-bed and observation bed day | | ivate room davs. | 13, 623 | 3.00 |
| | do not complete this line. | , -, | | | |
| 4.00 | Semi-private room days (excluding swing-bed and observation be | | | 12, 819 | 4. 00 |
| 5. 00 | Total swing-bed SNF type inpatient days (including private roo | om days) through Decembe | r 31 of the cost | 0 | 5. 00 |
| 6. 00 | reporting period Total swing-bed SNF type inpatient days (including private roo | om days) after December | 21 of the cost | 0 | 6. 00 |
| 0.00 | reporting period (if calendar year, enter 0 on this line) | on days) at tel becember | 31 OF THE COST | ١ | 0.00 |
| 7.00 | Total swing-bed NF type inpatient days (including private room | n days) through December | 31 of the cost | 0 | 7. 00 |
| | reporting period | | | _ | |
| 8. 00 | Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line) | n days) after December 3 | 1 of the cost | 0 | 8. 00 |
| 9. 00 | Total inpatient days including private room days applicable to | the Program (excluding | swing-bed and | 4, 060 | 9. 00 |
| | newborn days) (see instructions) | | | ., | |
| 10. 00 | Swing-bed SNF type inpatient days applicable to title XVIII or | | oom days) | 0 | 10. 00 |
| 11. 00 | through December 31 of the cost reporting period (see instruct Swing-bed SNF type inpatient days applicable to title XVIII or | | nom dave) after | 0 | 11. 00 |
| 11.00 | December 31 of the cost reporting period (if calendar year, er | | dom days) arter | ١ | 11.00 |
| 12.00 | Swing-bed NF type inpatient days applicable to titles V or XI) | only (including private | e room days) | 0 | 12. 00 |
| 40.00 | through December 31 of the cost reporting period | | | | 40.00 |
| 13. 00 | Swing-bed NF type inpatient days applicable to titles V or XI) after December 31 of the cost reporting period (if calendar ye | | | 0 | 13. 00 |
| 14. 00 | Medically necessary private room days applicable to the Progra | | | 0 | 14. 00 |
| 15.00 | Total nursery days (title V or XIX only) | , 3 | , | ol | 15. 00 |
| 16. 00 | Nursery days (title V or XIX only) | | | 0 | 16. 00 |
| 17 00 | SWING BED ADJUSTMENT | as through December 21 a | f the cost | 0.00 | 17. 00 |
| 17. 00 | Medicare rate for swing-bed SNF services applicable to service reporting period | es through becember 31 o | i the cost | 0.00 | 17.00 |
| 18. 00 | Medicare rate for swing-bed SNF services applicable to service | es after December 31 of | the cost | 0.00 | 18. 00 |
| | reporting period | | | | |
| 19. 00 | Medicaid rate for swing-bed NF services applicable to services | s through December 31 of | the cost | 0. 00 | 19. 00 |
| 20. 00 | reporting period Medicaid rate for swing-bed NF services applicable to services | s after December 31 of t | he cost | 0. 00 | 20. 00 |
| | reporting period | | | | |
| 21. 00 | Total general inpatient routine service cost (see instructions | | | 23, 680, 329 | |
| 22. 00 | Swing-bed cost applicable to SNF type services through December 5×1 line 17) | er 31 of the cost report | ing period (line | 0 | 22. 00 |
| 23. 00 | Swing-bed cost applicable to SNF type services after December | 31 of the cost reporting | a 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 reporti | ng period (line | 0 | 24. 00 |
| 25. 00 | 7 x line 19) Swing-bed cost applicable to NF type services after December 3 | 21 of the cost reporting | ported (line 9 | 0 | 25. 00 |
| 25.00 | x line 20) | of the cost reporting | perrou (Trile 8 | ١ | 25.00 |
| 26.00 | Total swing-bed cost (see instructions) | | | 0 | 26. 00 |
| 27. 00 | General inpatient routine service cost net of swing-bed cost (| (line 21 minus line 26) | | 23, 680, 329 | 27. 00 |
| 20 00 | PRIVATE ROOM DIFFERENTIAL ADJUSTMENT | d and observation had ab | orgos) | 0 | 20 00 |
| 29. 00 | General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges) | a and observation bed ch | arges) | 0 | 28. 00 29. 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 | |
| 33. 00 | Average semi-private room per diem charge (line 30 ÷ line 4) | 1: 22) (:+ | ±!> | 0.00 | |
| 34. 00 35. 00 | Average per diem private room charge differential (line 32 mir Average per diem private room cost differential (line 34 x lin | | tions) | 0. 00 0. 00 | |
| 36. 00 | Private room cost differential adjustment (line 3 x line 35) | 31) | | 0.00 | 36.00 |
| 37. 00 | General inpatient routine service cost net of swing-bed cost a | and private room cost di | fferential (line | 23, 680, 329 | 37. 00 |
| | 27 minus line 36) | | | | |
| | PART II - HOSPITAL AND SUBPROVIDERS ONLY | ICTMENTS | | | |
| 38. 00 | PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU Adjusted general inpatient routine service cost per diem (see | | | 1, 496. 39 | 38. 00 |
| 39. 00 | Program general inpatient routine service cost per drem (see | , | | 6, 075, 343 | |
| 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) | | 6, 075, 343 | 41.00 |
| | | | | | |

| Heal th | Financial Systems FRANCISCAN HEALTH MUNSTER In Li | eu of Form CMS-2 | 2552-10 |
|------------------|--|------------------------------------|------------------|
| COMPUT | FATION OF INPATIENT OPERATING COST Provider CCN: 15-0165 Period: From 01/01/202 | | |
| | To 12/31/202 | 1 Date/Time Prep 5/31/2022 7:54 | |
| | Title XVIII Hospital Cost Center Description Total Total Average Per Program Days | PPS Program Cost | |
| | Inpatient Cost Inpatient Days Diem (col. 1 ÷ | (col. 3 x col. | |
| | 1.00 2.00 3.00 4.00 | 4) 5. 00 | |
| 42. 00 | NURSERY (title V & XIX only) 0 0.00 | | 42. 00 |
| 43. 00 | Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT 4,486,420 1,701 2,637.52 1,22 | 9 3, 241, 512 | 43. 00 |
| 44. 00 | CORONARY CARE UNIT 0 0 0.00 | 0 0,211,312 | 44. 00 |
| 45. 00 | | 0 0 | 45.00 |
| 46. 00 47. 00 | SURGICAL INTENSIVE CARE UNIT 0 0.00 OTHER SPECIAL CARE (SPECIFY) | | 46. 00 47. 00 |
| | Cost Center Description | 1.00 | |
| 48. 00 | | 7, 993, 221 | 48. 00 |
| 49. 00 | Total Program inpatient costs (sum of lines 41 through 48)(see instructions) PASS THROUGH COST ADJUSTMENTS | 17, 310, 076 | 49. 00 |
| 50. 00 | Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and | 726, 160 | 50. 00 |
| 51. 00 | III Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II | 302, 376 | 51. 00 |
| F2 00 | and IV) | 1 020 52/ | F2 00 |
| 52. 00 53. 00 | Total Program excludable cost (sum of lines 50 and 51) Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and | 1, 028, 536 16, 281, 540 | |
| | medical education costs (line 49 minus line 52) | | |
| 54. 00 | TARGET AMOUNT AND LIMIT COMPUTATION Program discharges | 0 | 54. 00 |
| 55. 00 | | 0.00 | |
| 56. 00 57. 00 | | 0 | 56. 00 57. 00 |
| 58. 00 | Bonus payment (see instructions) | Ö | 58. 00 |
| 59. 00 | Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the | 0.00 | 59. 00 |
| 60. 00 | market basket Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket | 0.00 | 60. 00 |
| 61. 00 | · · · · · · · · · · · · · · · · · · · | 0 | 61. 00 |
| | which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions) | | |
| 62. 00 | Relief payment (see instructions) | 0 | |
| 63. 00 | Allowable Inpatient cost plus incentive payment (see instructions) PROGRAM INPATIENT ROUTINE SWING BED COST | 0 | 63. 00 |
| 64. 00 | Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See | 0 | 64. 00 |
| 65. 00 | instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See | 0 | 65. 00 |
| 66. 00 | instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For | 0 | 66. 00 |
| | CAH (see instructions) | | |
| 67. 00 | Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) | 0 | 67. 00 |
| 68. 00 | Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) | 0 | 68. 00 |
| 69. 00 | Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) | 0 | 69. 00 |
| 70. 00 | PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) | | 70. 00 |
| 71. 00 | Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2) | | 71. 00 |
| 72. 00 73. 00 | Program routine service cost (line 9 x line 71) Medically necessary private room cost applicable to Program (line 14 x line 35) | | 72. 00 73. 00 |
| 74. 00 | Total Program general inpatient routine service costs (line 72 + line 73) | | 74. 00 |
| 75. 00 | Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) | | 75. 00 |
| 76. 00 | Per diem capital-related costs (line 75 ÷ line 2) | | 76. 00 |
| 77. 00 78. 00 | | | 77. 00 78. 00 |
| 79. 00 | Aggregate charges to beneficiaries for excess costs (from provider records) | | 79. 00 |
| 80.00 | Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) | | 80.00 |
| 81. 00 82. 00 | Inpatient routine service cost per diem limitation [Inpatient routine service cost limitation (line 9 x line 81) | 1 | 81. 00 82. 00 |
| 83. 00 | Reasonable inpatient routine service costs (see instructions) | | 83. 00 |
| 84.00 | | | 84.00 |
| 85. 00 86. 00 | Utilization review - physician compensation (see instructions) Total Program inpatient operating costs (sum of lines 83 through 85) | | 85. 00 86. 00 |
| | PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST | 2.05: | |
| 87. 00 88. 00 | | 3, 006 1, 496. 39 | 87. 00 88. 00 |
| | Observation bed cost (line 87 x line 88) (see instructions) | 4, 498, 148 | |
| | | | |

| Health Financial Systems | FRANCI SCAN HEA | ALTH MUNSTER | | In Lie | u of Form CMS-2 | 2552-10 |
|---|-----------------|----------------|------------|----------------------------|----------------------------------|---------|
| COMPUTATION OF INPATIENT OPERATING COST | | Provi der CC | | Period: From 01/01/2021 | Worksheet D-1 | |
| | | | | To 12/31/2021 | Date/Time Prep 5/31/2022 7:54 | |
| | | Title | XVIII | Hospi tal | PPS | |
| Cost Center Description | Cost | Routine Cost | column 1 ÷ | Total | Observati on | |
| | | (from line 21) | column 2 | Observati on | Bed Pass | |
| | | | | Bed Cost (from | Through Cost | |
| | | | | line 89) | (col. 3 x col. | |
| | | | | | 4) (see | |
| | | | | | instructions) | |
| | 1.00 | 2.00 | 3. 00 | 4. 00 | 5. 00 | |
| COMPUTATION OF OBSERVATION BED PASS THROUGH | COST | | | | | |
| 90.00 Capital -related cost | 1, 744, 797 | 23, 680, 329 | 0. 07368 | 1 4, 498, 148 | 331, 428 | 90.00 |
| 91.00 Nursing Program cost | 0 | 23, 680, 329 | 0.00000 | 4, 498, 148 | 0 | 91.00 |
| 92.00 Allied health cost | 0 | 23, 680, 329 | 0.00000 | 4, 498, 148 | 0 | 92.00 |
| 93.00 All other Medical Education | 0 | 23, 680, 329 | 0.00000 | 4, 498, 148 | 0 | 93. 00 |

| Health Financial Systems | FRANCISCAN HEALTH MUNSTER | In Lie | u of Form CMS-2 | 2552-10 |
|---|---------------------------|-----------------------------|----------------------------------|---------|
| COMPUTATION OF INPATIENT OPERATING COST | Provi der CCN: 15-0165 | Peri od: From 01/01/2021 | Worksheet D-1 | |
| | | | Date/Time Prep 5/31/2022 7:54 | |
| | Title XIX | Hospi tal | PPS | |
| Cost Center Description | | | | |

| | | Title XIX | Hospi tal | 5/31/2022 7:5 PPS | 4 am |
|------------------|--|---|------------------|--|------------------|
| | Cost Center Description | | | 1.00 | |
| | PART I - ALL PROVIDER COMPONENTS | | | 1.00 | |
| | I NPATI ENT DAYS | | | 45.005 | |
| 1. 00 2. 00 | Inpatient days (including private room days and swing-bed days Inpatient days (including private room days, excluding swing-l | | | 15, 825 15, 825 | 1. 00 2. 00 |
| 3.00 | Private room days (excluding swing-bed and observation bed day | | vate room days. | 15, 625 | 3.00 |
| | do not complete this line. | , | | | |
| 4.00 | Semi-private room days (excluding swing-bed and observation be | | | 12, 819 | 4. 00 |
| 5.00 | Total swing-bed SNF type inpatient days (including private rooreporting period | om days) through December | 1 or the cost | 0 | 5. 00 |
| 6.00 | Total swing-bed SNF type inpatient days (including private roo | om days) after December 3 | 31 of the cost | 0 | 6. 00 |
| | reporting period (if calendar year, enter 0 on this line) | | | | |
| 7. 00 | Total swing-bed NF type inpatient days (including private roor reporting period | n days) through December | 31 of the cost | 0 | 7. 00 |
| 8. 00 | Teporting period Total_swing-bed_NF_type_inpatient_days (including private room | n davs) after December 3 | of the cost | 0 | 8. 00 |
| | reporting period (if calendar year, enter 0 on this line) | | | | |
| 9.00 | Total inpatient days including private room days applicable to | the Program (excluding | swi ng-bed and | 1, 092 | 9. 00 |
| 10. 00 | newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII or | nlv (including private r | nom days) | 0 | 10. 00 |
| | through December 31 of the cost reporting period (see instruc- | | som days) | , and the second | 10.00 |
| 11. 00 | Swing-bed SNF type inpatient days applicable to title XVIII or | | oom days) after | 0 | 11. 00 |
| 12. 00 | December 31 of the cost reporting period (if calendar year, en Swing-bed NF type inpatient days applicable to titles V or XI) | | e room days) | 0 | 12. 00 |
| 12.00 | through December 31 of the cost reporting period | Comy (Therearing private | 2 1 doil days) | | 12.00 |
| 13. 00 | Swing-bed NF type inpatient days applicable to titles V or XIX | | | 0 | 13. 00 |
| 14. 00 | after December 31 of the cost reporting period (if calendar you Medically necessary private room days applicable to the Progra | | | 0 | 14. 00 |
| 15. 00 | Total nursery days (title V or XIX only) | all (excluding swing-bed to | uays) | 0 | 15. 00 |
| 16. 00 | Nursery days (title V or XIX only) | | | 0 | 16. 00 |
| | SWING BED ADJUSTMENT | | | | |
| 17. 00 | Medicare rate for swing-bed SNF services applicable to service reporting period | es through December 31 of | the cost | 0.00 | 17. 00 |
| 18. 00 | Medicare rate for swing-bed SNF services applicable to service | es after December 31 of | the cost | 0. 00 | 18. 00 |
| | reporting period | | | | |
| 19. 00 | Medicaid rate for swing-bed NF services applicable to services reporting period | s through December 31 of | the cost | 0. 00 | 19. 00 |
| 20. 00 | Medicald rate for swing-bed NF services applicable to services | s after December 31 of th | ne cost | 0.00 | 20. 00 |
| | reporting period | | | | |
| 21. 00 22. 00 | Total general inpatient routine service cost (see instructions Swing-bed cost applicable to SNF type services through Decembe | | ng poriod (line | 23, 680, 329 0 | 21. 00 22. 00 |
| 22.00 | 5 x line 17) | si Si di the cost reporti | ng perrou (Trie | 0 | 22.00 |
| 23. 00 | Swing-bed cost applicable to SNF type services after December | 31 of the cost reporting | g period (line 6 | 0 | 23. 00 |
| 24. 00 | x line 18) Swing-bed cost applicable to NF type services through December | - 21 of the cost reportion | ag ported (Line | 0 | 24. 00 |
| 24.00 | 7 x line 19) | 31 of the cost reportin | ig perrou (Trile | O | 24.00 |
| 25. 00 | Swing-bed cost applicable to NF type services after December 3 | 31 of the cost reporting | period (line 8 | 0 | 25. 00 |
| 26. 00 | x line 20) Total swing-bed cost (see instructions) | | | 0 | 26. 00 |
| 27. 00 | General inpatient routine service cost net of swing-bed cost | (line 21 minus line 26) | | 23, 680, 329 | |
| | PRIVATE ROOM DIFFERENTIAL ADJUSTMENT | , | | -,, | |
| | General inpatient routine service charges (excluding swing-bed | d and observation bed cha | arges) | 0 | |
| 29. 00 30. 00 | Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) | | | 0 | 29. 00 30. 00 |
| 31. 00 | General inpatient routine service cost/charge ratio (line 27 - | - line 28) | | 0. 000000 | |
| 32.00 | Average private room per diem charge (line 29 ÷ line 3) | | | 0. 00 | |
| 33.00 | Average semi-private room per diem charge (line 30 ÷ line 4) | aug line 22) (eee inctrue | ti ana) | 0.00 | |
| 34. 00 35. 00 | Average per diem private room charge differential (line 32 min Average per diem private room cost differential (line 34 x lin | | 11 0115) | 0. 00 0. 00 | 34. 00 35. 00 |
| 36. 00 | Private room cost differential adjustment (line 3 x line 35) | 2., | | 0.00 | 36. 00 |
| 37. 00 | General inpatient routine service cost net of swing-bed cost a | and private room cost di | fferential (line | 23, 680, 329 | 37. 00 |
| | 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY | | | | |
| | PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU | ISTMENTS | | | |
| 38. 00 | Adjusted general inpatient routine service cost per diem (see | | | 1, 496. 39 | |
| 39.00 | Program general inpatient routine service cost (line 9 x line | • | | 1, 634, 058 | |
| 40. 00 41. 00 | Medically necessary private room cost applicable to the Progra Total Program general inpatient routine service cost (line 39 | | | 0 1, 634, 058 | 40.00 |
| 41.00 | Trotal Trogram general impatrent routine service cost (IIIIe 39 | 11116 40) | | 1, 034, 036 | 41.00 |

| | Financial Systems | FRANCI SCAN HEA | | | | eu of Form CMS- | |
|------------------|---|---------------------|-----------------|----------------|----------------------------|--------------------------------|------------------|
| COMPUT | ATION OF INPATIENT OPERATING COST | | Provi der C | CN: 15-0165 | Period: From 01/01/2021 | Worksheet D-1 | |
| | | | | | To 12/31/2021 | Date/Time Pre 5/31/2022 7:5 | |
| | | | Ti tl | e XIX | Hospi tal | PPS | - alli |
| | Cost Center Description | Total | Total | Average Per | | Program Cost | |
| | | Inpatient Cost | inpatrent bays | col. 2) | ÷ | (col. 3 x col. 4) | |
| 40.00 | DUDGEDY (1) H. M. O. W. M. J. D. | 1.00 | 2.00 | 3.00 | 4. 00 | 5. 00 | 40.00 |
| 42.00 | NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units | 0 | C | 0. | 00 0 | 0 | 42. 00 |
| 43.00 | INTENSIVE CARE UNIT | 4, 486, 420 | 1, 701 | | | | 43. 00 |
| 44. 00 45. 00 | CORONARY CARE UNIT BURN INTENSIVE CARE UNIT | 0 | C | • | | | |
| 46. 00 | | 0 | C | 1 | | ő | 1 |
| 47. 00 | OTHER SPECIAL CARE (SPECIFY) | | | | | | 47. 00 |
| | Cost Center Description | | | | | 1.00 | |
| 48. 00 | Program inpatient ancillary service cost (Wk | | | | | 2, 629, 609 | |
| 49. 00 | Total Program inpatient costs (sum of lines - PASS THROUGH COST ADJUSTMENTS | 41 through 48)(| see instructio | ons) | | 4, 263, 667 | 49. 00 |
| 50. 00 | Pass through costs applicable to Program inpa | atient routine | services (from | n Wkst. D, su | m of Parts I and | 120, 404 | 50.00 |
| E1 00 | III Pass through costs applicable to Program inp | ationt andillon | ni comileo (fr | som Wkot D | oum of Donto II | 112 205 | F1 00 |
| 51. 00 | and IV) | atrent anciliar | y services (II | OIII WKSt. D, | Sum of Parts II | 112, 295 | 51.00 |
| 52. 00 | Total Program excludable cost (sum of lines | | | | | 232, 699 | 1 |
| 53. 00 | Total Program inpatient operating cost exclumedical education costs (line 49 minus line ! | | lated, non-phy | sician anesti | netist, and | 4, 030, 968 | 53. 00 |
| | TARGET AMOUNT AND LIMIT COMPUTATION | <i>5</i> 2 <i>)</i> | | | | | |
| | Program discharges Target amount per discharge | | | | | 0 00 | 54. 00 55. 00 |
| 56. 00 | Target amount (line 54 x line 55) | | | | | | 56. 00 |
| 57. 00 | 1 | ing cost and ta | rget amount (I | ine 56 minus | line 53) | 0 | |
| 58. 00 59. 00 | Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost re | porting period | endi na 1996. u | updated and c | ompounded by the | 0.00 | 58. 00 59. 00 |
| | market basket | | | • | | | |
| 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 | | | | | 0.00 | 60.00 |
| 01.00 | which operating costs (line 53) are less than | | | | | | 01.00 |
| 62.00 | amount (line 56), otherwise enter zero (see Relief payment (see instructions) | instructions) | | | | 0 | 62.00 |
| | Allowable Inpatient cost plus incentive payment | ent (see instru | ctions) | | | | |
| | PROGRAM INPATIENT ROUTINE SWING BED COST | | | | | | |
| 64. 00 | Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only) | ts through Dece | mber 31 of the | e cost report | ing period (See | 0 | 64. 00 |
| 65. 00 | Medicare swing-bed SNF inpatient routine cos | ts after Decemb | er 31 of the d | cost reporting | g period (See | 0 | 65. 00 |
| 66. 00 | instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi | ne costs (line | 64 plus line 6 | 55)(title XVI | II only). For | 0 | 66. 00 |
| | CAH (see instructions) | ` | • | , , | 3, | - | |
| 67. 00 | Title V or XIX swing-bed NF inpatient routing (line 12 x line 19) | e costs through | December 31 c | of the cost re | eporting period | 0 | 67. 00 |
| 68. 00 | Title V or XIX swing-bed NF inpatient routing | e costs after D | ecember 31 of | the cost rep | orting period | 0 | 68. 00 |
| 69 00 | (line 13 x line 20) Total title V or XIX swing-bed NF inpatient | routine costs (| line 67 ± line | , 68) | | 0 | 69. 00 |
| 07.00 | PART III - SKILLED NURSING FACILITY, OTHER NU | | | | | | 07.00 |
| 70. 00 71. 00 | Skilled nursing facility/other nursing facili | | | |) | | 70.00 |
| 71.00 | Adjusted general inpatient routine service of Program routine service cost (line 9 x line | | THE 70 - TITLE | 2) | | | 71. 00 |
| 73.00 | Medically necessary private room cost application | | | | | | 73. 00 |
| 74. 00 75. 00 | Total Program general inpatient routine servicapital-related cost allocated to inpatient | • | | | Part II column | | 74. 00 75. 00 |
| 70.00 | 26, line 45) | | (110 | ior Rancet B, | art II, corumi | | |
| 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 | , , | , | | | | | 78. 00 |
| 79. 00 | Aggregate charges to beneficiaries for excess | | | | 1. 70) | | 79. 00 |
| 80. 00 81. 00 | Total Program routine service costs for compa Inpatient routine service cost per diem limi | | ost ilmitation | ı (ııne /8 mii | nus iine 79) | | 80.00 |
| 82. 00 | Inpatient routine service cost limitation (I | ine 9 x line 81 | * . | | | | 82. 00 |
| 83. 00 84. 00 | Reasonable inpatient routine service costs (Program inpatient ancillary services (see in: | | s) | | | | 83. 00 84. 00 |
| 85. 00 | Utilization review - physician compensation | | ins) | | | | 85. 00 |
| 86. 00 | Total Program inpatient operating costs (sum | of lines 83 th | | | | | 86. 00 |
| 87. 00 | PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions | | | | | 3, 006 | 87. 00 |
| 88. 00 | Adjusted general inpatient routine cost per | diem (line 27 ÷ | | | | 1, 496. 39 | 88. 00 |
| 89. 00 | Observation bed cost (line 87 x line 88) (see | e instructions) | | | | 4, 498, 148 | 89. 00 |

| Health Financial Systems | FRANCISCAN HEALTH MUNSTER | | | In Lieu of Form CMS-2552-10 | | |
|---|---------------------------|----------------|------------|-----------------------------|-----------------------------|-------|
| COMPUTATION OF INPATIENT OPERATING COST | | Provi der CC | | Period: From 01/01/2021 | Worksheet D-1 | |
| | | | | To 12/31/2021 | Date/Time Pre 5/31/2022 7:5 | |
| | | Ti tl | e XIX | Hospi tal | PPS | |
| Cost Center Description | Cost | Routine Cost | column 1 ÷ | Total | Observati on | |
| | | (from line 21) | column 2 | Observati on | Bed Pass | |
| | | | | Bed Cost (from | Through Cost | |
| | | | | line 89) | (col. 3 x col. | |
| | | | | | 4) (see | |
| | | | | | instructions) | |
| | 1.00 | 2.00 | 3. 00 | 4. 00 | 5. 00 | |
| COMPUTATION OF OBSERVATION BED PASS THROUGH | COST | | | | | |
| 90.00 Capital -related cost | 1, 744, 797 | 23, 680, 329 | 0. 07368 | 1 4, 498, 148 | 331, 428 | 90.00 |
| 91.00 Nursing Program cost | 0 | 23, 680, 329 | 0.00000 | 4, 498, 148 | 0 | 91.00 |
| 92.00 Allied health cost | 0 | 23, 680, 329 | 0.00000 | 4, 498, 148 | 0 | 92.00 |
| 93.00 All other Medical Education | 0 | 23, 680, 329 | 0.00000 | 4, 498, 148 | 0 | 93.00 |

| Health Financial Systems Franciscan | HEALIH MUNSIER | IN LIE | u of form CMS-2 | 2552-10 |
|--|----------------------------|---|-----------------------------------|------------------|
| INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provi der CCN: 15-0165 | Period: From 01/01/2021 To 12/31/2021 | Worksheet D-3 Date/Time Prepared: | |
| | 71.11.2001.1 | | 5/31/2022 7: 5 | 4 am |
| Coot Contan Decemintion | Title XVIII | Hospi tal | PPS | |
| Cost Center Description | Ratio of Cos To Charges | | Inpatient Program Costs | |
| | To charges | Charges | (col. 1 x col. | |
| | | Charges | 2) | |
| | 1.00 | 2. 00 | 3. 00 | |
| INPATIENT ROUTINE SERVICE COST CENTERS | | | | |
| 30. 00 03000 ADULTS & PEDI ATRI CS | | 9, 775, 204 | | 30. 00 |
| 31. 00 03100 I NTENSI VE CARE UNI T | | 2, 012, 563 | | 31.00 |
| 32. 00 03200 CORONARY CARE UNIT | | 0 | | 32.00 |
| 33. 00 03300 BURN INTENSIVE CARE UNIT | | 0 | | 33.00 |
| 34. 00 03400 SURGI CAL INTENSI VE CARE UNI T 40. 00 04000 SUBPROVI DER - IPF | ł | 0 | | 34. 00 40. 00 |
| 41. 00 04100 SUBPROVI DER = 1 FF | | | | 41. 00 |
| 43. 00 04300 NURSERY | | | | 43. 00 |
| ANCI LLARY SERVI CE COST CENTERS | <u> </u> | | | 10.00 |
| 50. 00 05000 OPERATING ROOM | 0. 1488 | 05 5, 496, 434 | 817, 897 | 50.00 |
| 51. 00 05100 RECOVERY ROOM | 0. 2856 | 61 400, 684 | 114, 460 | 51.00 |
| 52.00 05200 DELIVERY ROOM & LABOR ROOM | 0.0000 | 00 0 | 0 | 52.00 |
| 53. 00 05300 ANESTHESI OLOGY | 0. 0335 | 77 1, 007, 737 | 33, 837 | 53.00 |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C | 0. 1393 | | 328, 108 | 54.00 |
| 55. 00 05500 RADI OLOGY-THERAPEUTI C | 0.0000 | | 0 | 55. 00 |
| 56. 00 05600 RADI OI SOTOPE | 0.0000 | | 0 | 56. 00 |
| 57. 00 05700 CT SCAN | 0.0304 | | | 57. 00 |
| 58.00 05800 MAGNETI C RESONANCE I MAGING (MRI) 59.00 05900 CARDI AC CATHETERI ZATI ON | 0. 0740 0. 2333 | | | 58. 00 59. 00 |
| 60. 00 06000 LABORATORY | 0. 2333 | | | 60.00 |
| 60. 01 06001 BLOOD LABORATORY | 0.0000 | | 002, 402 | 60. 01 |
| 61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY | 0. 0000 | | Ö | 61. 00 |
| 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS | 0.0000 | | Ö | 62. 00 |
| 63.00 06300 BLOOD STORING, PROCESSING & TRANS. | 0.0000 | | 0 | 63.00 |
| 64. 00 06400 I NTRAVENOUS THERAPY | 0.0034 | 07 0 | 0 | 64.00 |
| 65. 00 06500 RESPI RATORY THERAPY | 0. 3513 | 1, 694, 833 | 595, 534 | 65.00 |
| 66. 00 06600 PHYSI CAL THERAPY | 0. 1698 | | 118, 245 | 66. 00 |
| 67. 00 06700 OCCUPATI ONAL THERAPY | 0. 1357 | | 84, 301 | 67. 00 |
| 68. 00 06800 SPEECH PATHOLOGY | 0. 1352 | | | 68. 00 |
| 69. 00 06900 ELECTROCARDI OLOGY | 0. 0458 | | | 69.00 |
| 70. 00 07000 ELECTROENCEPHALOGRAPHY 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | 0. 5139 0. 4500 | | 21, 533 918, 631 | 70. 00 71. 00 |
| 72. 00 07100 MPL. DEV. CHARGED TO PATIENTS | 0. 4500 | | 818, 629 | 71.00 |
| 73. 00 O7300 DRUGS CHARGED TO PATIENTS | 0. 2365 | | 1, 569, 479 | 73. 00 |
| 74. 00 07400 RENAL DI ALYSI S | 0.0034 | | 0 | 74. 00 |
| 75. 00 07500 ASC (NON-DISTINCT PART) | 0.0000 | | 0 | 75. 00 |
| 76. 00 03950 OTHER ANCILL SRVC | 0.0000 | 00 0 | 0 | 76. 00 |
| 76. 01 03951 CARDI AC AND PULMONARY REHAB | 1. 5613 | 39 1, 814 | 2, 832 | 76. 01 |
| 76. 02 03952 WOUND CARE | 0. 2248 | | 0 | 76. 02 |
| 77. 00 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON | 0.0000 | 00 0 | 0 | 77. 00 |
| OUTPATIENT SERVICE COST CENTERS | 0,000 | 00 | 0 | 00 00 |
| 88.00 08800 RURAL HEALTH CLINIC 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER | 0. 0000 0. 0000 | | 0 | 88. 00 89. 00 |
| 90. 00 09000 CLINIC | 0.0000 | | 0 | 90.00 |
| 90. 01 09001 CLI NI C | 0. 1137 | | 33, 293 | 90. 01 |
| 90. 02 09002 CLI NI C | 0. 1356 | | 0 | 90. 02 |
| 91. 00 09100 EMERGENCY | 0. 1498 | | | 91. 00 |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) | 0. 3750 | | | 92. 00 |
| OTHER REIMBURSABLE COST CENTERS | | | | |
| 94. 00 09400 HOME PROGRAM DIALYSIS | 0.0000 | 00 0 | 0 | 94. 00 |
| 95. 00 09500 AMBULANCE SERVI CES | | | | 95. 00 |
| 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED | 0.0000 | | 0 | 96.00 |
| 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 98. 00 09850 OTHER REI MBURSE | 0.0000 | | 0 | 97. 00 |
| 98.00 09850 OTHER REIMBURSE 200.00 Total (sum of lines 50 through 94 and 96 through 98 | 0.0000 | 43, 773, 299 | 0 7, 993, 221 | 98. 00 |
| 201.00 Less PBP Clinic Laboratory Services-Program only ch | | 43, 113, 299 ∩ | 1, 773, 221 | 200.00 |
| 202.00 Net charges (line 200 minus line 201) | 900 (11110 01) | 43, 773, 299 | | 201.00 |
| | ı | 1 .5, 775, 277 | | |

| Health Financial Systems | FRANCI SCAN HEALTH | MUNSTER | | In Lie | u of Form CMS-2 | 2552-10 |
|---|--------------------|------------|----------------------|-----------------|-----------------------------|------------------|
| INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | | Provider C | CN: 15-0165 | Peri od: | Worksheet D-3 | |
| | | | | From 01/01/2021 | Doto/Time Dro | norod. |
| | | | | To 12/31/2021 | Date/Time Pre 5/31/2022 7:5 | |
| | | Ti tl | e XIX | Hospi tal | PPS | ı dili |
| Cost Center Description | | | Ratio of Cos | | Inpati ent | |
| ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | | To Charges | Program | Program Costs | |
| | | | | | (col. 1 x col. | |
| | | | | ŭ | 2) | |
| | | | 1. 00 | 2. 00 | 3. 00 | |
| INPATIENT ROUTINE SERVICE COST CENTERS | | | | | | |
| 30. 00 03000 ADULTS & PEDI ATRI CS | | | | 3, 732, 318 | | 30. 00 |
| 31.00 03100 NTENSIVE CARE UNIT | | | | 1, 120, 963 | | 31. 00 |
| 32. 00 03200 CORONARY CARE UNIT | | | | 0 | | 32. 00 |
| 33.00 03300 BURN INTENSIVE CARE UNIT | | | | 0 | | 33. 00 |
| 34.00 O3400 SURGICAL INTENSIVE CARE UNIT | | | | 0 | | 34. 00 |
| 40. 00 04000 SUBPROVI DER - I PF | | | | 0 | | 40. 00 |
| 41. 00 04100 SUBPROVI DER - RF | | | | 0 | | 41.00 |
| 43. 00 04300 NURSERY | | | | 0 | | 43. 00 |
| ANCILLARY SERVICE COST CENTERS | | | 0.4400 | 4 044 000 | 405 540 | F0 00 |
| 50. 00 05000 OPERATI NG ROOM | | | 0. 14880 | | 195, 542 | 50.00 |
| 51. 00 05100 RECOVERY ROOM | | | 0. 28566 | | 37, 466 | 51.00 |
| 52. 00 05200 DELIVERY ROOM & LABOR ROOM | | | 0.00000 | | 12.055 | 52.00 |
| 53. 00 05300 ANESTHESI OLOGY | | | 0. 03357 | | 12, 055 | 53.00 |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C | | | 0. 13931 | | 103, 602 | 54.00 |
| 55. 00 05500 RADI OLOGY-THERAPEUTI C 56. 00 05600 RADI OI SOTOPE | | | 0.00000 | | 0 | 55.00 |
| | | | 0.00000 | | 0 | 56.00 |
| 57. 00 05700 CT SCAN | | | 0. 03048 | | 36, 496 | 57.00 |
| 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) | | | 0. 07405 | | 29, 042 | 58.00 |
| 59. 00 05900 CARDI AC CATHETERI ZATI ON | | | 0. 23332 | | 282, 944 | 59.00 |
| 60. 00 06000 LABORATORY | | | 0. 11896 | | 349, 283 | 60.00 |
| 60. 01 06001 BLOOD LABORATORY 61. 00 06100 PBP CLINI CAL LAB SERVI CES-PRGM ONLY | | | 0.00000 | | 0 | 60. 01 |
| 61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS | | | 0.00000 | | 0 | 61.00 |
| 63. 00 06300 BLOOD STORING, PROCESSING & TRANS. | | | 0. 00000 0. 00000 | | 0 | 62. 00 63. 00 |
| 64. 00 06400 I NTRAVENOUS THERAPY | | | 0.00340 | | 0 | 64.00 |
| 65. 00 06500 RESPIRATORY THERAPY | | | 0. 35138 | | 218, 747 | 65.00 |
| 66. 00 06600 PHYSI CAL THERAPY | | | 0. 16988 | | 25, 744 | 66.00 |
| 67. 00 06700 OCCUPATI ONAL THERAPY | | | 0. 13572 | | 17, 985 | 67.00 |
| 68. 00 06800 SPEECH PATHOLOGY | | | 0. 13524 | | 9, 247 | 68. 00 |
| 69. 00 06900 ELECTROCARDI OLOGY | | | 0. 04586 | | 25, 270 | 69.00 |
| 70. 00 07000 ELECTROENCEPHALOGRAPHY | | | 0. 51399 | | 10, 163 | 70.00 |
| 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS | | | 0. 45002 | | 302, 931 | 71.00 |
| 72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS | | | 0. 35205 | | 151, 014 | 72. 00 |
| 73.00 07300 DRUGS CHARGED TO PATIENTS | | | 0. 23658 | | 539, 491 | 73. 00 |
| 74.00 07400 RENAL DIALYSIS | | | 0.00340 | | 235 | 74. 00 |
| 75.00 07500 ASC (NON-DISTINCT PART) | | | 0.00000 | | 0 | 75. 00 |
| 76.00 03950 OTHER ANCILL SRVC | | | 0.00000 | | 0 | 76. 00 |
| 76.01 03951 CARDIAC AND PULMONARY REHAB | | | 1. 56133 | | 637 | 76. 01 |
| 76. 02 03952 WOUND CARE | | | 0. 22485 | | 0 | 76. 02 |
| 77.00 07700 ALLOGENEIC STEM CELL ACQUISITION | | | 0.00000 | 00 | 0 | 77. 00 |
| OUTPATIENT SERVICE COST CENTERS | | | | | | |
| 88. 00 08800 RURAL HEALTH CLINIC | | | 0.00000 | 00 | 0 | 88. 00 |
| 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER | | | 0.00000 | 00 | 0 | 89. 00 |
| 90. 00 09000 CLI NI C | | | 0. 00000 | 00 | 0 | 90.00 |
| 90. 01 09001 CLI NI C | | | 0. 11372 | 22 42, 284 | 4, 809 | 90. 01 |
| 90. 02 09002 CLI NI C | | | 0. 13560 | 0 | 0 | 90. 02 |
| 91. 00 09100 EMERGENCY | | | 0. 14989 | 1, 345, 900 | 201, 749 | 91. 00 |
| 92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART) | | | 0. 37508 | 38 200, 371 | 75, 157 | 92. 00 |
| OTHER REIMBURSABLE COST CENTERS | | | | | | |
| 94.00 O9400 HOME PROGRAM DIALYSIS | | | 0. 00000 | 00 | 0 | 94. 00 |
| 95. 00 09500 AMBULANCE SERVI CES | | | | | | 95. 00 |
| 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED | | | 0.00000 | | 0 | 96. 00 |
| 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD | | | 0.00000 | | 0 | 97. 00 |
| 98. 00 09850 OTHER REI MBURSE | | | 0. 00000 | | 0 | 98. 00 |
| 200.00 Total (sum of lines 50 through 94 and 9 | | | | 14, 872, 051 | 2, 629, 609 | |
| 201.00 Less PBP Clinic Laboratory Services-Pro | ogram only charges | (line 61) | | 0 | | 201. 00 |
| 202.00 Net charges (line 200 minus line 201) | | | I | 14, 872, 051 | | 202. 00 |
| | | | | | | |

| Health Financial Systems | FRANCISCAN HEALTH MUNSTER | In Lieu of Form CMS-2552-10 |
|---|---------------------------|---|
| CALCULATION OF REIMBURSEMENT SETTLEMENT | Provi der CCN: 15-0165 | Peri od: From 01/01/2021 To 12/31/2021 Worksheet E Part A Date/Ti me Prepared: 5/31/2022 7:54 am |

| PART A INPATEDIT HIGSPITAL SERVICES UNDER IPPS 1.00 | | | | 10 12/31/2021 | 5/31/2022 7:5 | |
|--|--------|--|---|-------------------|---------------|--------|
| Next A - IMPATIBN' HOSPITAL SERVICES UNDER IPPS | | | Title XVIII | Hospi tal | | |
| Next A - IMPATIBN' HOSPITAL SERVICES UNDER IPPS | | | | | 1.00 | |
| 1.00 BisS Amounts other than Outlier Payments for discharges occurring prior to October 1 (see 7.566,224 1.00 1 | | DADT A LINDATIENT HOSDITAL SEDVICES LINDED LDDS | | | 1.00 | |
| 1.01 DRG amounts other than outlier payments for discharges occurring prior to October 1 (see 7,556,234 1.01 Instructions) 1.02 DRG amounts other than outlier payments for discharges occurring on a rafter October 1 (see 3,532,500 1.00 1.03 1.03 1.06 1.08 1.00 1.03 1.00 | 1 00 | | | | 0 | 1 00 |
| DRC amounts other than outlifer payments for discharges occurring on or after October 1 (see 3,532,520 1.02 Instructions) DRC for Federal specific operating payment for Wodel 4 BPCI for discharges occurring prior to October DRC for Federal Specific Operating payment for Wodel 4 BPCI for discharges occurring on or after October 1 (see Instructions) Outlifer payments for discharges (see Instructions) Outlifer payments for discharges (see Instructions) Outlifer payments for discharges occurring prior to October 1 (see Instructions) Outlifer payments for discharges occurring prior to October 1 (see Instructions) Outlifer payments for discharges occurring prior to October 1 (see Instructions) Outlifer payments for discharges occurring prior to October 1 (see Instructions) Outlifer payments for discharges occurring prior to October 1 (see Instructions) Outlifer payments for discharges occurring prior to October 1 (see Instructions) Outlifer payments for discharges occurring prior of October 1 (see Instructions) Outlifer payments for discharges occurring prior of October 1 (see Instructions) Outlifer payments for discharges occurring prior of October 1 (see Instructions) Outlifer payments for discharges occurring prior of October 1 (see Instructions) Outlifer payments for discharges occurring prior of October 1 (see Instructions) Outlifer payments for discharges occurring prior of October 1 (see Instructions) Outlifer payments for discharges occurring prior of October 1 (see Instructions) Outlifer payments for discharges occurring prior of October 1 (see Instructions) Outlifer payments for discharges occurring prior of October 1 (see Instructions) Outlifer payments for discharges occurring prior of October 1 (see Instructions) Outlifer payments for discharges occurring prior occurri | | DRG amounts other than outlier payments for discharges occurring | prior to October 1 (| see | | |
| 1.03 16 (see instructions) 1.04 18 | 1. 02 | DRG amounts other than outlier payments for discharges occurring | on or after October | (see | 3, 532, 520 | 1. 02 |
| 1.04 Oktober Coeping | 1.03 | DRG for federal specific operating payment for Model 4 BPCI for | discharges occurring p | orior to October | 0 | 1. 03 |
| 2.00 Outlier payments for discharges (see Instructions) 0.10 0.1 | 1.04 | DRG for federal specific operating payment for Model 4 BPCI for | discharges occurring o | on or after | 0 | 1. 04 |
| 2.02 Outlier payment for discharges cocurring prior to October 1 (see Instructions) | 2.00 | | | | | |
| 2.03 Outlier payments for discharges occurring prior to October 1 (see instructions) | | | | | - | • |
| 2.04 Outlier payments for discharges occurring on or after October 1 (see instructions) 122,386 2.04 | | , , | • | | - 1 | |
| Managed Car's Simulated Payments | | | | | | |
| Bed days available divided by number of days in the cost reporting period (see instructions) 66.40 4.00 Indirect Medical Education Adjustment FIE count for all opathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/19/96, (see instructions) 6.00 6.00 FIE count for all opathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/19/96, (see instructions) 7.00 | | , , , | (see instructions) | | | |
| Indirect Medical Education Adjustment | | | ng pariod (see instru | stions) | | |
| FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/19/96, (see instructions) FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs. In accordance with 42 CFR 413, 79(e) 7.00 MAM Section 422 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(B)(1) 0.00 7.01 ACA \$5.5503 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see Instructions. Adjustment (increase or decrease) to the FTE count for all opathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1993), and 67 FR 50069 (August 1, 2002). The amount of increase if the hospital was awarded FTE cap slots under \$5500 of the ACA. If the cost under \$5500 of ACA. (see instructions) awarded FTE cap slots from a closed teaching hospital under \$5500 of ACA. (see instructions) awarded FTE cap slots from a closed teaching hospital under \$5500 of ACA. (see instructions) awarded FTE cap slots from a closed teaching hospital volume \$5500 of ACA. (see instructions) awarded FTE cap slots from a closed teaching hospital volume \$5500 of ACA. (see instructions) awarded FTE cap slots from a closed teaching hospital volume \$5500 of ACA. (see instructions) awarded FTE cap slots from a closed teaching hospital volume \$5500 of ACA. (see instructions) awarded FTE cap slots from a closed teaching hospital volume \$5500 of ACA. (see instructions) awarded FTE cap slots from a closed teaching hospital volume \$5500 of ACA. (see instructions) awarded FTE count for the program slot the current year from your records \$0.00 instructions \$0.00 of FTE count for the program slot the current year from your records \$0.00 instructions \$0.00 of FTE count for the program slot expression slots and slots | 4.00 | | ing period (see mistru | ti ons) | 00. 40 | 4.00 |
| FTE count for all opathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e) 7.00 MMA Section 422 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(B)(1) 0.00 7.00 7.01 AcA \$5.503 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions. Adjustment (increase or decrease) to the FTE count for all opathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b). 413.79(c)(2)(iv). 64 FR 26340 (May 12, 1998), and 67 FR 50060 (August 1, 2003). Both amount of increase if the hospital was awarded FTE cap slots under \$5503 of the ACA. If the cost report straddle sJuly 1, 2011, see instructions. Both Impulsion of increase if the hospital was awarded FTE cap slots from a closed teaching hospital was increased in the structions of the structions | 5.00 | FTE count for allopathic and osteopathic programs for the most r | recent cost reporting p | period ending on | 0.00 | 5. 00 |
| 7.00 IMMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) IF the cost report straddles July 1, 2011 then see instructions. 0.00 7.00 ACS §5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(i)(iv)(B)(B)(2) IF the cost report straddles July 1, 2011 then see instructions. 0.00 All systems (Increase or decrease) to the FIE count for all opathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002). 0.00 8.00 8.01 The amount of Increase if the hospital was awarded FIE cap slots under §5503 of the ACA. If the cost report straddles July 1, 2011, see instructions. 0.00 8.01 8.02 The amount of Increase if the hospital was awarded FIE cap slots from a closed teaching hospital under §5506 of ACA. (see Instructions) 0.00 1.00 9.00 Sum of Ilnes 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8, 01 and 8, 02) (see 0.00 0.00 10.00 FIE count for all opathic and osteopathic programs in the current year from your records 0.00 1.00 10.00 FIE count for all owable FIE (see instructions) 0.00 1.00 12.00 Current year allowable FIE count for the program for the program of the progr | 6.00 | FTE count for allopathic and osteopathic programs that meet the | criteria for an add-o | to the cap for | 0. 00 | 6. 00 |
| ACA \$ 5503 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(v)(B)(2) If the cost report straddles aluly 1, 2011 then see instructions. | 7 00 | | ler 42 CER 8412 105(f) | (1) (i y) (B) (1) | 0.00 | 7 00 |
| Aglustment (Increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413. 75(b). 413. 79(c)(2)(iv). 64 FR 26340 (May 12. 1998), and 67 FR 50069 (August 1, 2002). | | ACA § 5503 reduction amount to the IME cap as specified under 42 | | | | |
| 1998 , and 67 FR 50009 (August 1, 2002). | 8. 00 | | c and osteopathic pro | grams for | 0.00 | 8. 00 |
| 8.01 The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions. 1.02 The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions) 2.00 Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions) 3.00 FTE count for residents in dental and podiatric programs in the current year from your records 0.00 10,00 11,00 12,00 0.00 12,00 0.00 12,00 0. | | | (c)(2)(iv), 64 FR 26340 |) (May 12, | | |
| 8.02 The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions) | 8. 01 | The amount of increase if the hospital was awarded FTE cap slots | s under § 5503 of the A | NCA. If the cost | 0. 00 | 8. 01 |
| 9.00 Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see 0.00 9.00 9.00 10.00 FTE count for allopathic and osteopathic programs in the current year from your records 0.00 10.00 11.00 Current year allowable FTE (see instructions) 0.00 12.00 13.00 10.00 12.00 13.00 14.00 | 8. 02 | The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital | | | | 8. 02 |
| 10.00 FTE count for allopathic and osteopathic programs in the current year from your records 0.00 10. | 9. 00 | Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines | (8, 8,01 and 8,02) (s | see | 0. 00 | 9. 00 |
| 12.00 Current year allowable FTE (see instructions) 0.00 12.00 13.00 10.00 | 10. 00 | | year from your record | ls | 0.00 | 10.00 |
| 13.00 Total allowable FTE count for the prior year. 0.00 13.00 14.00 15.00 15.00 16.00 18.00 | 11. 00 | FTE count for residents in dental and podiatric programs. | | | 0. 00 | 11. 00 |
| 14.00 | | | | | | |
| therwise enter zero. Sum of lines 12 through 14 divided by 3. 15.00 Sum of lines 12 through 14 divided by 3. Adjustment for residents in initial years of the program | | | | | | |
| 15. 00 Sum of lines 12 through 14 divided by 3. 0. 00 15. 00 16. 00 17. 00 17. 00 18. 00 18. 00 19. 00 18. 00 19. | 14. 00 | | ended on or after Sep | ember 30, 1997, | 0. 00 | 14. 00 |
| 16.00 Adjustment for residents in initial years of the program 0.00 16.00 17.00 Adjustment for residents displaced by program or hospital closure 0.00 17.00 17.00 18.00 Adjusted rolling average FTE count 0.00 18.00 19. | 15 00 | | | | 0.00 | 15 00 |
| 17. 00 | | | | | | |
| 18. 00 Adjusted rolling average FTE count 0.00 18. 00 19. 00 Current year resident to bed ratio (line 18 divided by line 4). 0.000000 19. 00 20. 00 Prior year resident to bed ratio (see instructions) 0.000000 20. 00 21. 00 Enter the lesser of lines 19 or 20 (see instructions) 0.000000 21. 00 22. 01 IME payment adjustment (see instructions) 0.22. 00 1 IME payment adjustment - Managed Care (see instructions) 0.00 22. 01 1 Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA 0.00 23. 00 23. 00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412. 105 0.00 23. 00 (f)(1)(iv)(c). 0.1 0.00 24. 00 16 the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see 0.00 25. 00 25. 00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 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 amount see instructions) 0.000000 27. 00 28. 01 IME payments adjustment f | | | re | | | |
| 19.00 Current year resident to bed ratio (line 18 divided by line 4). 0.000000 19.00 20.00 Prior year resident to bed ratio (see instructions) 0.000000 20.00 21.00 Enter the lesser of lines 19 or 20 (see instructions) 0.000000 21.00 22.01 IME payment adjustment (see instructions) 0.000000 22.00 1 IME payment adjustment - Managed Care (see instructions) 0.00 22.01 1 IME payment adjustment for the Add-on for § 422 of the MMA 0.00 23.00 23.00 (f)(1)(iv)(C). 0.00 23.00 24.00 IME FTE Resident Count Over Cap (see instructions) 0.00 24.00 25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions) 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 28.01 IME add-on adjustment amount (see instructions) 0.000000 27.00 28.01 IME add-on adjustment amount - Managed Care (see instructions) 0.28.00 29.01 Total IME payment - Managed Care (sum of lines 22 and 28) <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> | | | | | | |
| 21.00 Enter the lesser of lines 19 or 20 (see instructions) 0.000000 21.00 22.00 IME payment adjustment (see instructions) 0.22.00 22.01 IME payment adjustment - Managed Care (see instructions) 0.22.01 Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA 23.00 Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA 23.00 Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA 23.00 Indirect Medical Education Adjustment and osteopathic IME FTE resident cap slots under 42 CFR 412.105 0.00 23.00 24.00 IME FTE Resident Count Over Cap (see instructions) 0.000 0.00000 0.00000 0.00000 0.00000 25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see 0.00 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.0000000 0.00000000 | 19.00 | | | | 0.000000 | 19. 00 |
| 22.00 IME payment adjustment (see instructions) 1 IME payment adjustment - Managed Care (see instructions) 1 IME payment adjustment - Managed Care (see instructions) 1 Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA 23.00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 24.00 IME FTE Resident Count Over Cap (see instructions) 25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see 26.00 Resident to bed ratio (divide line 25 by line 4) 27.00 IME payments adjustment factor. (see instructions) 28.00 IME add-on adjustment amount (see instructions) 29.00 IME add-on adjustment amount (see instructions) 29.00 Total IME payment (sum of lines 22 and 28) 29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 20.00 Sum of lines 30 and 31 31.00 Allowable disproportionate share percentage (see instructions) 31.00 Allowable disproportionate share percentage (see instructions) 32.00 Allowable disproportionate share percentage (see instructions) 32.00 Allowable disproportionate share percentage (see instructions) 32.00 Allowable disproportionate share percentage (see instructions) 33.00 Allowable disproportionate share percentage (see instructions) | 20.00 | Prior year resident to bed ratio (see instructions) | | | 0.000000 | 20. 00 |
| 22. 01 IME payment adjustment - Managed Care (see instructions) 1 Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA 23. 00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412. 105 24. 00 IME FTE Resident Count Over Cap (see instructions) 25. 00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see | | | | | | |
| Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA 23.00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 0.00 (f)(1)(iv)(C). 24.00 IME FTE Resident Count Over Cap (see instructions) 0.00 24.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see 0.00 instructions) 26.00 Resident to bed ratio (divide line 25 by line 4) 0.000000 26.00 IME payments adjustment factor. (see instructions) 0.000000 27.00 IME payments adjustment amount (see instructions) 0.000000 27.00 IME add-on adjustment amount (see instructions) 0.28.01 IME add-on adjustment amount - Managed Care (see instructions) 0.28.01 IME payment (sum of lines 22 and 28) 0.00 Total IME payment (sum of lines 22 and 28) 0.00 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 0.000000 29.01 Disproportionate Share Adjustment 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 15.24 31.00 Sum of lines 30 and 31 17.50 32.00 Allowable disproportionate share percentage (see instructions) 4.13 33.00 | | | | | | |
| 23. 00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412. 105 24. 00 IME FTE Resident Count Over Cap (see instructions) 25. 00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see 26. 00 Resident to bed ratio (divide line 25 by line 4) 27. 00 IME payments adjustment factor. (see instructions) 28. 01 IME payments adjustment amount (see instructions) 28. 01 IME add-on adjustment amount (see instructions) 29. 00 Total IME payment (sum of lines 22 and 28) 29. 01 Total IME payment - Managed Care (see instructions) 30. 00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 31. 00 Sum of lines 30 and 31 32. 00 Allowable disproportionate share percentage (see instructions) 4. 13 33. 00 | 22. 01 | | £ +bc MMA | | 0 | 22. 01 |
| 24.00 IME FTE Resident Count Over Cap (see instructions) 25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions) 26.00 Resident to bed ratio (divide line 25 by line 4) 27.00 IME payments adjustment factor. (see instructions) 28.00 IME add-on adjustment amount (see instructions) 28.01 IME add-on adjustment amount - Managed Care (see instructions) 29.00 Total IME payment (sum of lines 22 and 28) 29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 30.00 Percentage of Medicaid patient days (see instructions) 31.00 Sum of lines 30 and 31 33.00 Allowable disproportionate share percentage (see instructions) 4.13 33.00 | 23. 00 | Number of additional allopathic and osteopathic IME FTE resident | | R 412. 105 | 0. 00 | 23. 00 |
| 25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see 0.00 25.00 instructions) Resident to bed ratio (divide line 25 by line 4) 0.000000 26.00 IME payments adjustment factor. (see instructions) 1ME add-on adjustment amount (see instructions) 28.00 IME add-on adjustment amount - Managed Care (see instructions) 1ME add-on adjustment amount - Managed Care (see instructions) 29.00 Total IME payment (sum of lines 22 and 28) 1Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment 20.00 Sum of lines 30 and 31 25.00 Sum of lines 30 and 31 17.50 32.00 31.00 Allowable disproportionate share percentage (see instructions) 4.13 33.00 | 24 00 | | | | 0.00 | 24 00 |
| instructions | | | er of line 23 or line | 24 (See | | |
| 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) 0 29.00 29.01 Disproportionate Share Adjustment 29.01 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 2.26 30.00 31.00 Percentage of Medicaid patient days (see instructions) 15.24 31.00 32.00 Sum of lines 30 and 31 17.50 32.00 33.00 Allowable disproportionate share percentage (see instructions) 4.13 33.00 | 23.00 | | 101 11110 23 01 11110 | 24 (300 | 0.00 | 25.00 |
| 27.00 IME payments adjustment factor. (see instructions) 28.00 IME add-on adjustment amount (see instructions) 28.01 IME add-on adjustment amount - Managed Care (see instructions) 29.00 Total IME payment (sum of lines 22 and 28) 29.01 Disproportionate Share Adjustment 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 30.00 Percentage of Medicaid patient days (see instructions) 30.00 Sum of lines 30 and 31 30.00 Allowable disproportionate share percentage (see instructions) 31.00 Allowable disproportionate share percentage (see instructions) 4.13 33.00 | 26. 00 | · · | | | 0.000000 | 26. 00 |
| 28. 01 IME add-on adjustment amount - Managed Care (see instructions) 7 | 27.00 | IME payments adjustment factor. (see instructions) | | | 0.000000 | 27. 00 |
| 29.00 Total IME payment (sum of lines 22 and 28) 0 29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 0 29.01 Disproportionate Share Adjustment 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 2.26 30.00 31.00 Percentage of Medicaid patient days (see instructions) 15.24 31.00 Sum of lines 30 and 31 17.50 32.00 33.00 Allowable disproportionate share percentage (see instructions) 4.13 33.00 | 28. 00 | IME add-on adjustment amount (see instructions) | | | 0 | 28. 00 |
| 29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 31.00 Percentage of Medicaid patient days (see instructions) 32.00 Sum of lines 30 and 31 33.00 Allowable disproportionate share percentage (see instructions) 30.01 29.01 30.02 30.00 31.02 31.00 32.03 32.00 33.00 Allowable disproportionate share percentage (see instructions) 32.03 33.00 | | | | | | |
| Disproportionate Share Adjustment 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 31.00 Percentage of Medicaid patient days (see instructions) 32.00 Sum of lines 30 and 31 33.00 Allowable disproportionate share percentage (see instructions) 34.13 33.00 | | | | | | |
| 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 2.26 30.00 31.00 Percentage of Medicaid patient days (see instructions) 32.00 Sum of lines 30 and 31 33.00 Allowable disproportionate share percentage (see instructions) 4.13 33.00 | 29. 01 | | | | 0 | 29. 01 |
| 31.00 Percentage of Medicaid patient days (see instructions) 32.00 Sum of lines 30 and 31 33.00 Allowable disproportionate share percentage (see instructions) 15.24 31.00 17.50 32.00 33.00 | 30.00 | | ent days (see instruc | ions) | 2. 26 | 30.00 |
| 32.00 Sum of Lines 30 and 31 17.50 32.00 Allowable disproportionate share percentage (see instructions) 4.13 33.00 | | | , | • | | |
| | 32.00 | | | | 17. 50 | 32. 00 |
| 34.00 Disproportionate share adjustment (see instructions) 114,491 34.00 | | | | | | |
| | 34. 00 | טן sproporti onate share adjustment (see instructions) | | l | 114, 491 | 34.00 |

| | Financial Systems FRANCISCAN HEALT | | | u of Form CMS-2 | 2552-10 |
|------------------|---|-----------------------------|--|---|------------------|
| CALCUL | ATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 15-0165 | Peri od: From 01/01/2021 To 12/31/2021 | Worksheet E Part A Date/Time Prep 5/31/2022 7:54 | |
| | | Title XVIII | Hospi tal | PPS | |
| | | | Prior to 10/1 1.00 | 2. 00 | |
| | Uncompensated Care Adjustment | | 1.00 | 2.00 | |
| 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. 000146940 | 0. 000171650 | 35. 01 |
| 35. 02 | Hospital uncompensated care payment (If line 34 is zero, enteinstructions) | er zero on this line) (se | e 1, 218, 135 | 1, 234, 508 | 35. 02 |
| 35. 03 | Pro rata share of the hospital uncompensated care payment amo | , | 911, 098 | 311, 164 | 35. 03 |
| 36. 00 | Total uncompensated care (sum of columns 1 and 2 on line 35.0 Additional payment for high percentage of ESRD beneficiary di | | 1, 222, 262 ab. 46) | | 36. 00 |
| 40. 00 | Total Medicare discharges (see instructions) | senarges (Tries 40 till ou | 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 | fy for adjustment) | 0.00 | | 42.00 |
| 43.00 | Total Medicare ESRD inpatient days (see instructions) | | 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) | | 12, 982, 132 | | 47. 00 |
| 48. 00 | Hospital specific payments (to be completed by SCH and MDH, s only. (see instructions) | maii rurai nospitais | 0 | | 48. 00 |
| | only. (see That detrons) | | | Amount | |
| | | | | 1. 00 | |
| 49. 00 | Total payment for inpatient operating costs (see instructions | • | | 12, 982, 132 | 49. 00 |
| 50.00 | Payment for inpatient program capital (from Wkst. L, Pt. I an | | | 915, 928 | 50.00 |
| 51. 00 52. 00 | Exception payment for inpatient program capital (Wkst. L, Pt. Direct graduate medical education payment (from Wkst. E-4, Ii | | | 0 | 51. 00 52. 00 |
| 53. 00 | Nursing and Allied Health Managed Care payment | THE 49 See THISTITUCTIONS). | | 0 | 53. 00 |
| 54. 00 | Special add-on payments for new technologies | | | 166, 545 | 54. 00 |
| 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 | • | | 0 | 56.00 |
| 57. 00 | Routine service other pass through costs (from Wkst. D, Pt. I | | hrough 35). | 0 | 57. 00 |
| 58. 00 | Ancillary service other pass through costs from Wkst. D, Pt. | IV, col. 11 line 200) | | 14 0/4 /05 | 58. 00 |
| 59. 00 60. 00 | Total (sum of amounts on lines 49 through 58) Primary payer payments | | | 14, 064, 605 0 | 59. 00 60. 00 |
| 61. 00 | Total amount payable for program beneficiaries (line 59 minus | line 60) | | 14, 064, 605 | 61. 00 |
| 62. 00 | Deductibles billed to program beneficiaries | | | 1, 139, 180 | |
| 63.00 | Coinsurance billed to program beneficiaries | | | 35, 987 | 63.00 |
| 64.00 | Allowable bad debts (see instructions) | | | 163, 234 | 64.00 |
| 65. 00 | Adjusted reimbursable bad debts (see instructions) | | | 106, 102 | 65. 00 |
| 66.00 | Allowable bad debts for dual eligible beneficiaries (see inst | ructions) | | 80, 286 | 66.00 |
| | Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for | applicable to MS DDCs (s | oo instructions) | 12, 995, 540 0 | 67. 00 68. 00 |
| 69. 00 | Outlier payments reconciliation (sum of lines 93, 95 and 96). | | | 0 | 69. 00 |
| 70. 00 | OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) | (101 301 300 THST GOTTON | 3) | 0 | 70. 00 |
| 70. 50 | Rural Community Hospital Demonstration Project (§410A Demonst | ration) adjustment (see | instructions) | 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) | | ۾ ا | 70. 89 |
| 70. 90 70. 91 | HSP bonus payment HVBP adjustment amount (see instructions) | | | 0 | 70. 90 |
| 70. 91 70. 92 | HSP bonus payment HRR adjustment amount (see instructions) Bundled Model 1 discount amount (see instructions) | | | 0 | 70. 91 70. 92 |
| 70. 92 | HVBP payment adjustment amount (see instructions) | | | -22, 903 | 70. 92 |
| | HRR adjustment amount (see instructions) | | | -73, 398 | |
| 70. 94 | That day do thort amount (300 Thota do trong) | | | | |

| | Fig. 1. I. G. J. FDMOLGOM, III | JEALTH MUNICIED | | | C.F. ONC. | 0550 40 |
|--------|--|-----------------|-------------|-----------------|---------------------------------|---------|
| | Financial Systems FRANCISCAN H ATION OF REIMBURSEMENT SETTLEMENT | Provider C | CN: 15-0165 | Peri od: | eu of Form CMS-2 Worksheet E | 2552-10 |
| CALCUL | ATTON OF RETWIDORSEMENT SETTLEMENT | Frovider | CN. 15-0105 | From 01/01/2021 | | |
| | | | | To 12/31/2021 | Date/Time Prep 5/31/2022 7:54 | |
| | | Ti tl e | XVIII | Hospi tal | PPS | |
| | | | FFY | (yyyy) | Amount | |
| | | | | 0 | 1.00 | |
| 70. 96 | Low volume adjustment for federal fiscal year (yyyy) (Ento the corresponding federal year for the period prior to 10, | | | 0 |] O | 70. 96 |
| 70. 97 | Low volume adjustment for federal fiscal year (yyyy) (Enterthe corresponding federal year for the period ending on or | | | 0 | 0 | 70. 97 |
| 70. 98 | Low Volume Payment-3 | | | | 0 | 70. 98 |
| 70. 99 | HAC adjustment amount (see instructions) | | | | 139, 683 | 70. 99 |
| 71.00 | Amount due provider (line 67 minus lines 68 plus/minus lines 68 pl | nes 69 & 70) | | | 12, 759, 556 | 71.00 |
| 71. 01 | Sequestration adjustment (see instructions) | | | | 0 | 71. 01 |
| 71. 02 | Demonstration payment adjustment amount after sequestration | on | | | 0 | 71. 02 |
| 71. 03 | Sequestration adjustment-PARHM pass-throughs | | | | | 71.03 |
| 72.00 | Interim payments | | | | 11, 456, 976 | 72.00 |
| 72. 01 | Interim payments-PARHM | | | | | 72. 01 |
| 73 00 | Tentative settlement (for contractor use only) | | | | i O' | 73 00 |

1, 302, 580

327, 186

0

0 92.00 93.00

0 0.00 73.00

73.01

74.00

74.01

75.00

90.00

91.00

94.00

| 74.00 The rate used to carculate the trille value of lillolley (see this fuctions) | | | 0.00 | |
|--|---------------|----------------|---------------|---------|
| 95.00 Time value of money for operating expenses (see instructions) | | | 0 | 95.00 |
| 96.00 Time value of money for capital related expenses (see instructions) | | | 0 | 96.00 |
| | | Prior to 10/1 | On/After 10/1 | |
| | | 1. 00 | 2. 00 | |
| HSP Bonus Payment Amount | <u></u> | | | |
| 100.00 HSP bonus amount (see instructions) | | 0 | 0 | 100. 00 |
| HVBP Adjustment for HSP Bonus Payment | | | | 1 |
| 101.00 HVBP adjustment factor (see instructions) | | 0.0000000000 | 0.0000000000 | 101. 00 |
| 102.00 HVBP adjustment amount for HSP bonus payment (see instructions) | | 0 | 0 | 102.00 |
| HRR Adjustment for HSP Bonus Payment | | | | 1 |
| 103.00 HRR adjustment factor (see instructions) | | 0.0000 | 0.0000 | 103. 00 |
| 104.00 HRR adjustment amount for HSP bonus payment (see instructions) | | 0 | 0 | 104.00 |
| Rural Community Hospital Demonstration Project (§410A Demonstration) Adjus- | tment | ' | | 1 |
| 200.00 Is this the first year of the current 5-year demonstration period under the | e 21st | | | 200. 00 |
| Century Cures Act? Enter "Y" for yes or "N" for no. | | | | |
| Cost Reimbursement | <u> </u> | | | 1 |
| 201.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) | | | | 201. 00 |
| 202.00 Medicare discharges (see instructions) | | | | 202. 00 |
| 203.00 Case-mix adjustment factor (see instructions) | | | | 203. 00 |
| Computation of Demonstration Target Amount Limitation (N/A in first year of | f the current | 5-year demonst | ration | 1 |
| peri od) | | • | | |
| 204.00 Medicare target amount | | | | 204. 00 |
| 205.00 Case-mix adjusted target amount (line 203 times line 204) | | | | 205.00 |
| 206.00 Medicare inpatient routine cost cap (line 202 times line 205) | | | | 206. 00 |
| Adjustment to Medicare Part A Inpatient Reimbursement | <u>.</u> | | | 1 |
| 207.00 Program reimbursement under the §410A Demonstration (see instructions) | | | | 207. 00 |
| 208.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59) | | | | 208. 00 |
| 209.00 Adjustment to Medicare IPPS payments (see instructions) | | | | 209. 00 |
| 210.00 Reserved for future use | | | | 210.00 |
| 211.00 Total adjustment to Medicare IPPS payments (see instructions) | | | | 211. 00 |
| Comparision of PPS versus Cost Reimbursement | , | ' | | 1 |
| 212.00 Total adjustment to Medicare Part A IPPS payments (from line 211) | | | | 212. 00 |
| 213.00 Low-volume adjustment (see instructions) | | | | 213. 00 |
| 218.00 Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbo | ursement) | | | 218. 00 |
| (line 212 minus line 213) (see instructions) | , | | | |
| (= = = = = | 1 | ı | | 1 |

73.00

73.01

74.00

74. 01

75.00

90.00

91.00

92.00

93.00

73)

Tentative settlement (for contractor use only)

Capital outlier from Wkst. L, Pt. I, line 2

Tentative settlement-PARHM (for contractor use only)

Balance due provider/program-PARHM (see instructions)

Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and

Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2

Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)

Operating outlier reconciliation adjustment amount (see instructions)

Capital outlier reconciliation adjustment amount (see instructions)

94.00 The rate used to calculate the time value of money (see instructions)

| | AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA | TION EXHIBIT 5 | | | Period: From 01/01/2021 To 12/31/2021 | Worksheet E Part A Exhibi Date/Time Pre 5/31/2022 7:5 | pared: |
|--|--|--|--|--|---|--|--|
| | | | | XVIII | Hospi tal | PPS | |
| | | Wkst. E, Pt. A, line | Amt. from Wkst. E, Pt. A) | Period to 10/01 | Period on after 10/01 | Total (cols. 2 and 3) | |
| | | 0 | 1.00 | 2.00 | 3. 00 | 4. 00 | |
| 1. 00 1. 01 | DRG amounts other than outlier payments DRG amounts other than outlier payments for | 1. 00 1. 01 | 7, 556, 234 | 7, 556, 23 | 4 | 7, 556, 234 | 1. 00 1. 01 |
| 1. 02 | discharges occurring prior to October 1 DRG amounts other than outlier payments for discharges occurring on or after October 1 | 1. 02 | 3, 532, 520 | | 3, 532, 520 | 3, 532, 520 | 1. 02 |
| 1. 03 | DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October | 1. 03 | 0 | | 0 | 0 | 1. 03 |
| 1. 04 | DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1 | 1. 04 | 0 | | 0 | 0 | 1. 04 |
| 2. 00 | Outlier payments for discharges (see instructions) | 2.00 | | | | | 2. 00 |
| 2. 01 | Outlier payments for discharges for Model 4 BPCI | 2. 02 | 0 | | 0 | 0 | 2. 01 |
| 2. 02 | Outlier payments for discharges occurring prior to October 1 (see instructions) | 2. 03 | 434, 239 | 434, 23 | 9 | 434, 239 | 2. 02 |
| 2. 03 | Outlier payments for discharges occurring on or after October 1 (see instructions) | 2. 04 | 122, 386 | | 122, 386 | | |
| 3. 00 4. 00 | Operating outlier reconciliation Managed care simulated payments | 2. 01 3. 00 | 6, 723, 146 | 4, 471, 07 | 0 3 2, 252, 073 | 0 6, 723, 146 | 3. 00 4. 00 |
| 5. 00 | Indirect Medical Education Adjustment Amount from Worksheet E, Part A, line 21 (see instructions) | 21.00 | 0. 000000 | 0. 00000 | 0.000000 | | 5. 00 |
| 6. 00 6. 01 | IME payment adjustment (see instructions) IME payment adjustment for managed care (see instructions) | 22. 00 22. 01 | 0 | | 0 0 | 0 | 6. 00 6. 01 |
| | Ladinasa Madisal Education Adinatora Con the | Add on for Co | ction 122 of t | he MMA | | | 1 |
| | Indirect Medical Education Adjustment for the | Add-on for Se | CLI 011 422 01 L | LIC ININIA | | | |
| 7. 00 | IME payment adjustment factor (see instructions) | 27. 00 | 0. 000000 | | 0.000000 | | 7. 00 |
| 7. 00 8. 00 8. 01 | IME payment adjustment factor (see instructions) IME adjustment (see instructions) IME payment adjustment add on for managed | | | 0.00000 | 0.000000 | 0 | 8. 00 |
| 8. 00 | IME payment adjustment factor (see instructions) IME adjustment (see instructions) IME payment adjustment add on for managed care (see instructions) Total IME payment (sum of lines 6 and 8) Total IME payment for managed care (sum of | 27. 00 28. 00 | | 0.00000 | | _ | 8. 00 8. 01 9. 00 |
| 8. 00 8. 01 9. 00 | IME payment adjustment factor (see instructions) IME adjustment (see instructions) IME payment adjustment add on for managed care (see instructions) Total IME payment (sum of lines 6 and 8) Total IME payment for managed care (sum of lines 6.01 and 8.01) | 27. 00 28. 00 28. 01 29. 00 | | 0.00000 | | 0 | 8. 00 8. 01 9. 00 |
| 8. 00 8. 01 9. 00 9. 01 | IME payment adjustment factor (see instructions) IME adjustment (see instructions) IME payment adjustment add on for managed care (see instructions) Total IME payment (sum of lines 6 and 8) Total IME payment for managed care (sum of lines 6.01 and 8.01) Disproportionate Share Adjustment | 27. 00 28. 00 28. 01 29. 00 29. 01 | 0. 000000 0 0 | 0.00000 | | 0 | 8. 00 8. 01 9. 00 9. 01 |
| 8. 00 8. 01 9. 00 9. 01 | IME payment adjustment factor (see instructions) IME adjustment (see instructions) IME payment adjustment add on for managed care (see instructions) Total IME payment (sum of lines 6 and 8) Total IME payment for managed care (sum of lines 6.01 and 8.01) Disproportionate Share Adjustment Allowable disproportionate share percentage (see instructions) | 27. 00 28. 00 28. 01 29. 00 29. 01 | 0. 000000 0 0 0 0 | 0. 00000 | 0 | 0 0 | 8. 00 8. 01 9. 00 9. 01 |
| 8. 00 8. 01 9. 00 9. 01 10. 00 11. 00 | IME payment adjustment factor (see instructions) IME adjustment (see instructions) IME payment adjustment add on for managed care (see instructions) Total IME payment (sum of lines 6 and 8) Total IME payment for managed care (sum of lines 6.01 and 8.01) Disproportionate Share Adjustment Allowable disproportionate share percentage (see instructions) Disproportionate share adjustment (see instructions) | 27. 00 28. 00 28. 01 29. 00 29. 01 33. 00 34. 00 | 0. 000000 0 0 0 0. 0413 114, 491 | 0. 00000 0. 041 78, 01 | 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | 114, 491 | 8. 00 8. 01 9. 00 9. 01 10. 00 11. 00 |
| 8. 00 8. 01 9. 00 9. 01 | IME payment adjustment factor (see instructions) IME adjustment (see instructions) IME payment adjustment add on for managed care (see instructions) Total IME payment (sum of lines 6 and 8) Total IME payment for managed care (sum of lines 6.01 and 8.01) Disproportionate Share Adjustment Allowable disproportionate share percentage (see instructions) Disproportionate share adjustment (see instructions) Uncompensated care payments | 27. 00 28. 00 28. 01 29. 00 29. 01 33. 00 34. 00 36. 00 | 0. 000000 0 0 0 0. 0413 114, 491 1, 222, 262 | 0. 00000 0. 041 78, 01 | 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | 114, 491 | 8. 00 8. 01 9. 00 9. 01 10. 00 11. 00 |
| 8. 00 8. 01 9. 00 9. 01 10. 00 11. 00 | IME payment adjustment factor (see instructions) IME adjustment (see instructions) IME payment adjustment add on for managed care (see instructions) Total IME payment (sum of lines 6 and 8) Total IME payment for managed care (sum of lines 6.01 and 8.01) Disproportionate Share Adjustment Allowable disproportionate share percentage (see instructions) Disproportionate share adjustment (see instructions) Uncompensated care payments Additional payment for high percentage of ESF | 27. 00 28. 00 28. 01 29. 00 29. 01 33. 00 34. 00 36. 00 80 beneficiary | 0. 000000 0 0 0 0. 0413 114, 491 1, 222, 262 | 0. 00000 0. 041 78, 01 911, 09 | 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | 114, 491 1, 222, 262 | 8. 00 8. 01 9. 00 9. 01 10. 00 11. 00 |
| 8. 00 8. 01 9. 00 9. 01 10. 00 11. 00 11. 01 12. 00 | IME payment adjustment factor (see instructions) IME adjustment (see instructions) IME payment adjustment add on for managed care (see instructions) Total IME payment (sum of lines 6 and 8) Total IME payment for managed care (sum of lines 6.01 and 8.01) Disproportionate Share Adjustment Allowable disproportionate share percentage (see instructions) Disproportionate share adjustment (see instructions) Uncompensated care payments Additional payment for high percentage of ESR Total ESRD additional payment (see instructions) | 27. 00 28. 00 28. 01 29. 00 29. 01 33. 00 34. 00 36. 00 80 beneficiary 46. 00 | 0. 000000 0 0 0 0. 0413 114, 491 1, 222, 262 di scharges | 0. 00000 0. 041 78, 01 911, 09 | 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | 114, 491 1, 222, 262 | 8. 00 8. 01 9. 00 9. 01 10. 00 11. 00 11. 01 12. 00 |
| 8. 00 8. 01 9. 00 9. 01 10. 00 11. 00 | IME payment adjustment factor (see instructions) IME adjustment (see instructions) IME payment adjustment add on for managed care (see instructions) Total IME payment (sum of lines 6 and 8) Total IME payment for managed care (sum of lines 6.01 and 8.01) Disproportionate Share Adjustment Allowable disproportionate share percentage (see instructions) Disproportionate share adjustment (see instructions) Uncompensated care payments Additional payment for high percentage of ESR Total ESRD additional payment (see instructions) Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see | 27. 00 28. 00 28. 01 29. 00 29. 01 33. 00 34. 00 36. 00 80 beneficiary | 0. 000000 0 0 0 0. 0413 114, 491 1, 222, 262 | 0. 00000 0. 041 78, 01 911, 09 | 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | 114, 491 1, 222, 262 | 8. 00 8. 01 9. 00 9. 01 10. 00 11. 01 12. 00 13. 00 |
| 8. 00 8. 01 9. 00 9. 01 10. 00 11. 01 12. 00 13. 00 | IME payment adjustment factor (see instructions) IME adjustment (see instructions) IME payment adjustment add on for managed care (see instructions) Total IME payment (sum of lines 6 and 8) Total IME payment for managed care (sum of lines 6.01 and 8.01) Disproportionate Share Adjustment Allowable disproportionate share percentage (see instructions) Disproportionate share adjustment (see instructions) Uncompensated care payments Additional payment for high percentage of ESR Total ESRD additional payment (see instructions) Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions) Total payment for inpatient operating costs | 27. 00 28. 00 28. 01 29. 00 29. 01 33. 00 34. 00 36. 00 8D beneficiary 46. 00 47. 00 | 0. 000000 0 0 0 0. 0413 114, 491 1, 222, 262 di scharges | 0. 00000 0. 041 78, 01 911, 09 8, 979, 58 | 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | 114, 491 1, 222, 262 0 12, 982, 132 0 | 8. 00 8. 01 9. 00 9. 01 10. 00 11. 00 11. 01 12. 00 13. 00 14. 00 |
| 8. 00 8. 01 9. 00 9. 01 10. 00 11. 00 11. 01 12. 00 13. 00 14. 00 | IME payment adjustment factor (see instructions) IME adjustment (see instructions) IME payment adjustment add on for managed care (see instructions) Total IME payment (sum of lines 6 and 8) Total IME payment for managed care (sum of lines 6.01 and 8.01) Disproportionate Share Adjustment Allowable disproportionate share percentage (see instructions) Disproportionate share adjustment (see instructions) Uncompensated care payments Additional payment for high percentage of ESR Total ESRD additional payment (see instructions) Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions) Total payment for inpatient operating costs (see instructions) | 27. 00 28. 00 28. 01 29. 00 29. 01 33. 00 34. 00 36. 00 20 beneficiary 46. 00 47. 00 48. 00 | 0. 000000 0 0 0 0 0. 0413 114, 491 1, 222, 262 di scharges 0 12, 982, 132 0 | 0. 00000 0. 041 78, 01 911, 09 8, 979, 58 | 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | 114, 491 1, 222, 262 0 12, 982, 132 0 | 8. 00 8. 01 9. 00 9. 01 10. 00 11. 01 12. 00 13. 00 14. 00 |
| 8. 00 8. 01 9. 00 9. 01 10. 00 11. 01 12. 00 13. 00 14. 00 | IME payment adjustment factor (see instructions) IME adjustment (see instructions) IME payment adjustment add on for managed care (see instructions) Total IME payment (sum of lines 6 and 8) Total IME payment for managed care (sum of lines 6.01 and 8.01) Disproportionate Share Adjustment Allowable disproportionate share percentage (see instructions) Disproportionate share adjustment (see instructions) Uncompensated care payments Additional payment for high percentage of ESR Total ESRD additional payment (see instructions) Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions) Total payment for inpatient operating costs (see instructions) Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable) Special add-on payments for new technologies Net organ acquisition cost | 27. 00 28. 00 28. 01 29. 00 29. 01 33. 00 34. 00 36. 00 36. 00 47. 00 48. 00 49. 00 | 0. 0000000 0 0 0. 0413 114, 491 1, 222, 262 di scharges 0 12, 982, 132 0 12, 982, 132 | 0. 00000 0. 041 78, 01 911, 09 8, 979, 58 8, 979, 58 685, 06 | 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | 0 0 0 114, 491 1, 222, 262 0 12, 982, 132 0 12, 982, 132 915, 928 | 8. 00 8. 01 9. 00 9. 01 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 |
| 8. 00 8. 01 9. 00 9. 01 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 | IME payment adjustment factor (see instructions) IME adjustment (see instructions) IME payment adjustment add on for managed care (see instructions) Total IME payment (sum of lines 6 and 8) Total IME payment for managed care (sum of lines 6.01 and 8.01) Disproportionate Share Adjustment Allowable disproportionate share percentage (see instructions) Disproportionate share adjustment (see instructions) Uncompensated care payments Additional payment for high percentage of ESF Total ESRD additional payment (see instructions) Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions) Total payment for inpatient operating costs (see instructions) Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable) Special add-on payments for new technologies | 27. 00 28. 00 28. 01 29. 00 29. 01 33. 00 34. 00 36. 00 29. 00 47. 00 48. 00 49. 00 50. 00 | 0. 0000000 0 0 0 0 0. 0413 114, 491 1, 222, 262 di scharges 0 12, 982, 132 0 12, 982, 132 915, 928 | 0. 00000 0. 041 78, 01 911, 09 8, 979, 58 8, 979, 58 685, 06 80, 08 | 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | 0 0 0 114, 491 1, 222, 262 0 12, 982, 132 0 12, 982, 132 915, 928 | 8. 00 8. 01 9. 00 9. 01 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 17. 01 |
| 8. 00 8. 01 9. 00 9. 01 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 01 17. 02 18. 00 | IME payment adjustment factor (see instructions) IME adjustment (see instructions) IME payment adjustment add on for managed care (see instructions) Total IME payment (sum of lines 6 and 8) Total IME payment for managed care (sum of lines 6.01 and 8.01) Disproportionate Share Adjustment Allowable disproportionate share percentage (see instructions) Disproportionate share adjustment (see instructions) Uncompensated care payments Additional payment for high percentage of ESF Total ESRD additional payment (see instructions) Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions) Total payment for inpatient operating costs (see instructions) Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable) Special add-on payments for new technologies Net organ acquisition cost Credits received from manufacturers for | 27. 00 28. 00 28. 01 29. 00 29. 01 33. 00 34. 00 36. 00 46. 00 47. 00 48. 00 49. 00 50. 00 54. 00 | 0. 0000000 0 0 0 0 0. 0413 114, 491 1, 222, 262 di scharges 0 12, 982, 132 0 12, 982, 132 915, 928 | 0. 00000 0. 041 78, 01 911, 09 8, 979, 58 8, 979, 58 685, 06 80, 08 | 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | 114, 491 1, 222, 262 0 12, 982, 132 0 12, 982, 132 915, 928 166, 545 0 | 8. 00 8. 01 9. 00 9. 01 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 01 17. 02 18. 00 |

| Health Financial Systems | FRANCI SCAN HEA | ALTH MUNSTER | | In Lie | eu of Form CMS-2 | 2552-10 |
|--|-----------------|------------------------|----------|---|------------------|---------|
| HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCUL | ATION EXHIBIT 5 | Provider Co | F | Period: From 01/01/2021 To 12/31/2021 | | pared: |
| | | Title | XVIII | Hospi tal | PPS | |
| | Wkst. L, line | (Amt. from Wkst. L) | | · | | |
| | 0 | 1.00 | 2.00 | 3. 00 | 4. 00 | |
| 20.00 Capital DRG other than outlier | 1.00 | 847, 793 | 634, 103 | 213, 690 | 847, 793 | 20.00 |
| 20 01 M-1-1 4 DDCI C | 1 01 | _ | 1 . | ۸ . | | 20 01 |

| | | | | | | 5/31/2022 7:5 | 4 am |
|--------|--|-------------------------|----------------------------------|---------|------------|-----------------------------|---------|
| | | | Title | XVIII | Hospi tal | PPS | |
| | | Wkst. L, line | (Amt. from | | | | |
| | | | Wkst. L) | | | | |
| | | 0 | 1.00 | 2.00 | 3. 00 | 4. 00 | |
| 20.00 | Capital DRG other than outlier | 1.00 | 847, 793 | 634, 10 | 3 213, 690 | 847, 793 | 20.00 |
| 20. 01 | Model 4 BPCI Capital DRG other than outlier | 1. 01 | 0 | | 0 | 0 | 20. 01 |
| 21.00 | Capital DRG outlier payments | 2.00 | 68, 135 | 50, 96 | 1 17, 174 | 68, 135 | 21. 00 |
| 21. 01 | Model 4 BPCI Capital DRG outlier payments | 2. 01 | 0 | | 0 | 0 | 21. 01 |
| 22. 00 | Indirect medical education percentage (see instructions) | 5. 00 | 0. 0000 | 0.000 | 0.0000 | | 22. 00 |
| 23. 00 | Indirect medical education adjustment (see instructions) | 6. 00 | 0 | | 0 | 0 | 23. 00 |
| 24. 00 | | 10. 00 | 0. 0000 | 0.000 | 0.0000 | | 24. 00 |
| 25. 00 | Disproportionate share adjustment (see instructions) | 11. 00 | 0 | 1 | 0 | 0 | 25. 00 |
| 26. 00 | Total prospective capital payments (see instructions) | 12.00 | 915, 928 | 685, 06 | 230, 864 | 915, 928 | 26. 00 |
| | | Wkst. E, Pt. A, line | (Amt. from Wkst. E, Pt. A) | | | | |
| | | 0 | 1.00 | 2.00 | 3. 00 | 4. 00 | |
| 27. 00 | | | | | | | 27. 00 |
| 28. 00 | Low volume adjustment prior to October 1 | 70. 96 | 0 | | 0 | 0 | 28. 00 |
| 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 | -22, 903 | -17, 13 | -5, 773 | -22, 903 | 30.00 |
| 30. 01 | HVBP payment adjustment for HSP bonus payment (see instructions) | 70. 90 | 0 | | 0 | 0 | 30. 01 |
| 31.00 | HRR adjustment (see instructions) | 70. 94 | -73, 398 | -54, 89 | -18, 500 | -73, 398 | 31. 00 |
| 31. 01 | HRR adjustment for HSP bonus payment (see instructions) | 70. 91 | 0 | | 0 | 0 | 31. 01 |
| | | | | | | (Amt. to Wkst. E, Pt. A) | |
| | | 0 | 1.00 | 2.00 | 3. 00 | 4. 00 | |
| 32. 00 | HAC Reduction Program adjustment (see instructions) | 70. 99 | | 96, 52 | 7 43, 156 | 139, 683 | 32. 00 |
| 100.00 | Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A. | | Υ | | | | 100. 00 |
| | • | , | | : | , | • | • |

| Health Financial Systems | FRANCISCAN HEALTH MUNSTER | In Lieu of Form CMS-2552-10 |
|---|---------------------------|---|
| CALCULATION OF REIMBURSEMENT SETTLEMENT | Provi der CCN: 15-0165 | Peri od: Worksheet E From 01/01/2021 Part B Date/Time Prepared: 5/31/2022 7.54 am |

| | | 5/31/2022 7: 5 | 4 am |
|------------------|---|------------------------|------------------|
| | Title_XVIII Hospital | PPS | |
| | | 1.00 | |
| | PART B - MEDICAL AND OTHER HEALTH SERVICES | 11.00 | |
| 1.00 | Medical and other services (see instructions) | 12, 459 | 1. 00 |
| 2.00 | Medical and other services reimbursed under OPPS (see instructions) | 13, 502, 400 | 2. 00 |
| 3.00 | OPPS payments | 12, 394, 305 | 3. 00 |
| 4. 00 4. 01 | Outlier payment (see instructions) Outlier reconciliation amount (see instructions) | 27, 604 | 4. 00 4. 01 |
| 5. 00 | Enter the hospital specific payment to cost ratio (see instructions) | 0.000 | 5. 00 |
| 6. 00 | Line 2 times line 5 | 0.000 | 6. 00 |
| 7. 00 | Sum of lines 3, 4, and 4.01, divided by line 6 | 0.00 | 7. 00 |
| 8.00 | Transitional corridor payment (see instructions) | 0 | 8. 00 |
| 9.00 | Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200 | 0 | 9. 00 |
| 10. 00 | Organ acqui si ti ons | 0 | 10.00 |
| 11. 00 | Total cost (sum of lines 1 and 10) (see instructions) | 12, 459 | 11. 00 |
| | COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges | | |
| 12. 00 | Ancillary service charges | 53, 203 | 12 00 |
| 13. 00 | Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69) | 00,200 | 13. 00 |
| 14. 00 | Total reasonable charges (sum of lines 12 and 13) | 53, 203 | |
| | Customary charges | | |
| 15. 00 | Aggregate amount actually collected from patients liable for payment for services on a charge basis | 0 | 15. 00 |
| 16. 00 | Amounts that would have been realized from patients liable for payment for services on a chargebasis | 0 | 16. 00 |
| 17 00 | had such payment been made in accordance with 42 CFR §413.13(e) | 0.000000 | 17 00 |
| 17. 00 18. 00 | Ratio of line 15 to line 16 (not to exceed 1.000000) | 0. 000000 53, 203 | 17. 00 18. 00 |
| 19. 00 | Total customary charges (see instructions) Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see | 40, 744 | |
| 17.00 | instructions) | 10, 711 | 17.00 |
| 20.00 | Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see | 0 | 20. 00 |
| | instructions) | | |
| 21. 00 | Lesser of cost or charges (see instructions) | 12, 459 | 21. 00 |
| 22. 00 | Interns and residents (see instructions) | 0 | 22. 00 |
| 23. 00 | Cost of physicians' services in a teaching hospital (see instructions) | 0 | 23. 00 |
| 24. 00 | Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) COMPUTATION OF REIMBURSEMENT SETTLEMENT | 12, 421, 909 | 24. 00 |
| 25. 00 | Deductibles and coinsurance amounts (for CAH, see instructions) | 7, 865 | 25. 00 |
| 26. 00 | Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions) | 2, 169, 543 | 26. 00 |
| 27. 00 | Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see | 10, 256, 960 | 27. 00 |
| | instructions) | | |
| 28. 00 | Direct graduate medical education payments (from Wkst. E-4, line 50) | 0 | 28. 00 |
| 29. 00 | ESRD direct medical education costs (from Wkst. E-4, line 36) | 0 | 29. 00 |
| 30.00 | Subtotal (sum of lines 27 through 29) | 10, 256, 960 | 30.00 |
| 31. 00 32. 00 | Primary payer payments Subtotal (line 30 minus line 31) | 2, 400 10, 254, 560 | 31. 00 32. 00 |
| 32.00 | ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) | 10, 234, 300 | 32.00 |
| 33. 00 | Composite rate ESRD (from Wkst. I-5, line 11) | 0 | 33. 00 |
| 34.00 | Allowable bad debts (see instructions) | 168, 420 | 34. 00 |
| 35. 00 | Adjusted reimbursable bad debts (see instructions) | 109, 473 | 35. 00 |
| 36. 00 | Allowable bad debts for dual eligible beneficiaries (see instructions) | 86, 645 | |
| 37. 00 | Subtotal (see instructions) | 10, 364, 033 | |
| | MSP-LCC reconciliation amount from PS&R | 0 | 38. 00 |
| 39. 00 | OTHER ADJUSTMENTS (MSP RECON) | -146 | |
| 39. 50 | Pioneer ACO demonstration payment adjustment (see instructions) Demonstration payment adjustment amount before sequestration | | 39. 50 |
| 39. 97 39. 98 | Partial or full credits received from manufacturers for replaced devices (see instructions) | 0 | 39. 97 39. 98 |
| 39. 90 39. 99 | RECOVERY OF ACCELERATED DEPRECIATION | | 39. 96 39. 99 |
| 40. 00 | Subtotal (see instructions) | 10, 363, 887 | 40. 00 |
| 40. 01 | Sequestration adjustment (see instructions) | 0 | 40. 01 |
| 40. 02 | Demonstration payment adjustment amount after sequestration | 0 | 40. 02 |
| 40. 03 | Sequestration adjustment-PARHM pass-throughs | | 40. 03 |
| 41. 00 | Interim payments | 10, 437, 231 | 41.00 |
| 41. 01 | Interim payments-PARHM | | 41. 01 |
| 42.00 | Tentative settlement (for contractors use only) | 0 | 42.00 |
| 42. 01 | Tentative settlement-PARHM (for contractor use only) | 70.044 | 42. 01 |
| 43.00 | Balance due provider/program (see instructions) Balance due provider/program PAPHM (see instructions) | -73, 344 | 43.00 |
| 43. 01 44. 00 | Balance due provider/program-PARHM (see instructions) Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, | 0 | 43. 01 44. 00 |
| 44. UU | Frotested amounts (nonarrowable cost report rems) in accordance with cms Pub. 15-2, chapter 1, §115.2 | | 44.00 |
| | TO BE COMPLETED BY CONTRACTOR | <u> </u> | |
| 90.00 | Original outlier amount (see instructions) | 0 | 90. 00 |
| 91. 00 | Outlier reconciliation adjustment amount (see instructions) | 0 | 91. 00 |
| 92.00 | The rate used to calculate the Time Value of Money | 0.00 | 92. 00 |
| 93. 00 | Time Value of Money (see instructions) | 0 | 93. 00 |
| 94.00 | Total (sum of lines 91 and 93) | 1 0 | 94. 00 |

Health Financial Systems FRAN ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 15-0165

| | | | | | 5/31/2022 7:54 | 4 am |
|-------|--|------------|--------------|------------|----------------|-------|
| | | | XVIII | Hospi tal | PPS | |
| | | Inpatien | t Part A | Par | t B | |
| | | mm/dd/yyyy | Amount | mm/dd/yyyy | Amount | |
| | | 1. 00 | 2.00 | 3. 00 | 4.00 | |
| 1.00 | Total interim payments paid to provider | | 11, 456, 976 | 5 | 10, 437, 231 | 1. 00 |
| 2.00 | Interim payments payable on individual bills, either | | | | ol | 2. 00 |
| | submitted or to be submitted to the contractor for | | | | | |
| | services rendered in the cost reporting period. If none, | | | | | |
| | write "NONE" or enter a zero | | | | | |
| 3.00 | List separately each retroactive lump sum adjustment | | | | | 3. 00 |
| | amount based on subsequent revision of the interim rate | | | | | |
| | for the cost reporting period. Also show date of each | | | | | |
| | payment. If none, write "NONE" or enter a zero. (1) Program to Provider | | | | | |
| 3. 01 | ADJUSTMENTS TO PROVIDER | | | 1 | 0 | 3. 01 |
| 3. 01 | ADJUSTIMENTS TO PROVIDER | | | | 0 | 3. 01 |
| 3. 02 | | | | | | 3. 02 |
| 3. 04 | | | | - | | 3. 04 |
| 3. 05 | | | | | | 3. 05 |
| 3.03 | Provider to Program | | | 2 | 0 | 3.03 |
| 3. 50 | ADJUSTMENTS TO PROGRAM | | | | 0 | 3. 50 |
| 3. 51 | 7.65 CO TIME TO THOUSE IIII | | | | 0 | 3. 51 |
| 3. 52 | | | | | l ol | 3. 52 |
| 3. 53 | | | | | l ol | 3. 53 |
| 3.54 | | | | | l ol | 3. 54 |
| 3. 99 | Subtotal (sum of lines 3.01-3.49 minus sum of lines | | | | o | 3. 99 |
| | 3. 50-3. 98) | | | | | |
| 4.00 | Total interim payments (sum of lines 1, 2, and 3.99) | | 11, 456, 976 | 5 | 10, 437, 231 | 4.00 |
| | (transfer to Wkst. E or Wkst. E-3, line and column as | | | | | |
| | appropri ate) | | | | | |
| | TO BE COMPLETED BY CONTRACTOR | | ı | T | | |
| 5. 00 | List separately each tentative settlement payment after | | | | | 5. 00 |
| | desk review. Also show date of each payment. If none, | | | | | |
| | write "NONE" or enter a zero. (1) Program to Provider | | | | | |
| 5. 01 | TENTATI VE TO PROVI DER | | | 1 | 0 | 5. 01 |
| 5. 01 | TENTATIVE TO PROVIDER | | | | | 5. 01 |
| 5. 02 | | | | | 0 | 5. 02 |
| 5.05 | Provider to Program | | | <u> </u> | 0 | 3.03 |
| 5. 50 | TENTATI VE TO PROGRAM | | | | 0 | 5. 50 |
| 5. 51 | 12.17.11.12.10.11.00.10.11. | | | | Ö | 5. 51 |
| 5. 52 | | | | | l ol | 5. 52 |
| 5. 99 | Subtotal (sum of lines 5.01-5.49 minus sum of lines | | | | l ol | 5. 99 |
| | 5. 50-5. 98) | | | | | |
| 6.00 | Determined net settlement amount (balance due) based on | | | | | 6. 00 |
| | the cost report. (1) | | | | | |
| 6. 01 | SETTLEMENT TO PROVIDER | | 1, 302, 580 | O | 0 | 6. 01 |
| 6.02 | SETTLEMENT TO PROGRAM | | | | 73, 344 | 6. 02 |
| 7.00 | Total Medicare program liability (see instructions) | | 12, 759, 550 | 5 | 10, 363, 887 | 7. 00 |
| | | | | Contractor | NPR Date | |
| | | | | Number | (Mo/Day/Yr) | |
| | Tue Caracian in the Caracian i | |) | 1. 00 | 2. 00 | |
| 8.00 | Name of Contractor | | | 1 | i l | 8. 00 |

| Heal th | Financial Systems FRANCISCAN HEAL | TH MUNSTER | In lie | u of Form CMS-: | 2552-10 |
|---------|--|--------------------------|------------------|-----------------|---------|
| | CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 15-0165 From 01/01/2021 To 12/31/2021 | | | | |
| | | Title XVIII | Hospi tal | PPS | |
| | | | | | |
| | | | | 1. 00 | |
| | TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS | | | | |
| | HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION | | | | |
| 1. 00 | Total hospital discharges as defined in AARA §4102 from Wkst. | | | | 1. 00 |
| 2.00 | Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, and | 8 through 12, and plus f | for cost | | 2. 00 |
| | reporting periods beginning on or after 10/01/2013, line 32) | | | | |
| 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 lines | 1, and 8 through 12, and | l plus for cost | | 4. 00 |
| | reporting periods beginning on or after 10/01/2013, line 32) | | | | |
| 5.00 | Total hospital charges from Wkst C, Pt. I, col. 8 line 200 | | | | 5. 00 |
| 6.00 | Total hospital charity care charges from Wkst. S-10, col. 3 I | | | | 6. 00 |
| 7. 00 | CAH only - The reasonable cost incurred for the purchase of o | certified HIT technology | Wkst. S-2, Pt. I | | 7. 00 |
| | line 168 | | | | |
| 8. 00 | Calculation of the HIT incentive payment (see instructions) | | | | 8. 00 |
| 9. 00 | Sequestration adjustment amount (see instructions) | | | | 9. 00 |
| 10. 00 | Calculation of the HIT incentive payment after sequestration | (see instructions) | | | 10.00 |
| | INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH | | | | |
| 30. 00 | Initial/interim HIT payment adjustment (see instructions) | | | | 30. 00 |
| 31. 00 | 1 | | | | 31.00 |
| 32. 00 | Balance due provider (line 8 (or line 10) minus line 30 and l | ine 31) (see instruction | is) | | 32. 00 |

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

Provider CCN: 15-0165

Peri od: Worksheet G From 01/01/2021 To 12/31/2021 Date/Time Prepared: 5/31/2022 7:54 am

| OH y) | | | | | 5/31/2022 7:5 | 4 am |
|------------------|--|--------------------------------|--------------------------|----------------|---------------|------------------|
| | | General Fund | Specific Purpose Fund | Endowment Fund | Plant Fund | |
| | | 1.00 | 2.00 | 3. 00 | 4. 00 | |
| | CURRENT ASSETS | | | | | |
| 1.00 | Cash on hand in banks | 22, 124, 866 | | _ | _ | 1.00 |
| 2. 00 3. 00 | Temporary investments Notes receivable | 0 | 0 | _ | 0 | 2. 00 3. 00 |
| 4.00 | Accounts recei vable | 19, 123, 009 | 1 | _ | 0 | 4.00 |
| 5. 00 | Other recei vable | 107, 125, 007 | | Ö | Ö | 5.00 |
| 6. 00 | Allowances for uncollectible notes and accounts receivable | -12, 501 | | 0 | 0 | 6. 00 |
| 7.00 | Inventory | 2, 751, 656 | 0 | 0 | 0 | 7. 00 |
| 8.00 | Prepai d expenses | 635, 307 | | 0 | 0 | 8. 00 |
| 9.00 | Other current assets | 357, 861 | | _ | 0 | 9.00 |
| 10.00 | Due from other funds | 45 007 202 | 0 | | 0 | 10.00 |
| 11. 00 | Total current assets (sum of lines 1-10) FIXED ASSETS | 45, 087, 383 | 0 | 0 | 0 | 11. 00 |
| 12. 00 | Land | 9, 641, 227 | 'l o | 0 | 0 | 12. 00 |
| 13. 00 | Land improvements | 2, 710, 184 | | _ | 1 | 13. 00 |
| 14.00 | Accumul ated depreciation | 0 | 0 | 0 | 0 | 14.00 |
| 15.00 | Bui I di ngs | 93, 234, 021 | 0 | 0 | 0 | 15. 00 |
| 16. 00 | Accumulated depreciation | 0 | 0 | 0 | 0 | 16. 00 |
| 17. 00 | Leasehold improvements | 5, 034, 517 | 1 | _ | 0 | 17. 00 |
| 18.00 | Accumulated depreciation | 0 | 0 | _ | 0 | 18.00 |
| 19. 00 20. 00 | Fixed equipment Accumulated depreciation | 0 | 0 | 0 | 0 | 19. 00 20. 00 |
| 21. 00 | Automobiles and trucks | 0 | | 0 | 0 | 21.00 |
| 22. 00 | Accumulated depreciation | | | 0 | Ö | 22. 00 |
| 23. 00 | Major movable equipment | 119, 232, 595 | Ö | Ō | 0 | 23. 00 |
| 24.00 | Accumulated depreciation | -71, 744, 809 | 0 | 0 | 0 | 24. 00 |
| 25. 00 | Mi nor equi pment depreci abl e | 0 | 0 | 0 | 0 | 25. 00 |
| 26. 00 | Accumulated depreciation | 0 | 0 | 0 | 0 | 26. 00 |
| 27. 00 | HIT designated Assets | 0 | 0 | 0 | 0 | 27. 00 |
| 28. 00 | Accumulated depreciation | 1 020 444 | 0 | _ | 0 | 28. 00 |
| 29. 00 30. 00 | Minor equipment-nondepreciable Total fixed assets (sum of lines 12-29) | 1, 038, 466 159, 146, 201 | | _ | 1 | 29. 00 30. 00 |
| 30.00 | OTHER ASSETS | 139, 140, 201 | | 0 | | 30.00 |
| 31. 00 | Investments | 9, 136, 788 | 0 | 0 | 0 | 31.00 |
| 32.00 | Deposits on Leases | 3, 803, 554 | 0 | 0 | 0 | 32. 00 |
| 33. 00 | Due from owners/officers | 0 | 0 | 0 | 0 | 33. 00 |
| 34. 00 | Other assets | 5, 165, 195 | | | 0 | 34. 00 |
| 35. 00 | Total other assets (sum of lines 31-34) | 18, 105, 537 | 1 | _ | 0 | 35. 00 |
| 36. 00 | Total assets (sum of lines 11, 30, and 35) CURRENT LIABILITIES | 222, 339, 121 |] 0 | 0 | 0 | 36. 00 |
| 37. 00 | Accounts payable | 6, 364, 614 | . 0 | 0 | 0 | 37. 00 |
| 38. 00 | Salaries, wages, and fees payable | 4, 074, 364 | 1 | 0 | 1 | 38.00 |
| 39. 00 | Payroll taxes payable | 712, 505 | 1 | 0 | 0 | 39. 00 |
| 40.00 | Notes and Loans payable (short term) | 0 | 0 | 0 | 0 | 40. 00 |
| 41. 00 | Deferred income | 0 | 0 | 0 | 0 | 41.00 |
| 42. 00 | Accel erated payments | 6, 687, 503 | | | | 42.00 |
| 43.00 | Due to other funds | 1 524 701 | 0 | 0 | 0 | 43. 00 44. 00 |
| 44. 00 45. 00 | Other current liabilities Total current liabilities (sum of lines 37 thru 44) | 1, 526, 781 19, 365, 767 | | _ | | 45.00 |
| 43.00 | LONG TERM LIABILITIES | 17, 303, 707 | | 0 | | 45.00 |
| 46. 00 | Mortgage payable | 1, 250, 785 | 0 | 0 | 0 | 46. 00 |
| 47.00 | Notes payable | -266, 470 | 0 | 0 | 0 | 47. 00 |
| 48. 00 | Unsecured Loans | 455, 948 | | _ | | 48. 00 |
| 49. 00 | Other long term liabilities | 8, 312, 392 | | _ | _ | 49. 00 |
| 50.00 | Total long term liabilities (sum of lines 46 thru 49) | 9, 752, 655 | | | | 50.00 |
| 51. 00 | Total liabilities (sum of lines 45 and 50) CAPITAL ACCOUNTS | 29, 118, 422 | 2 0 | 0 | 0 | 51.00 |
| 52. 00 | General fund balance | 193, 220, 699 | | | | 52. 00 |
| 53. 00 | Specific purpose fund | 175, 220, 077 | 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 | | 1 | | 0 | 57. 00 |
| 58. 00 | Plant fund balance - reserve for plant improvement, | | | | 0 | 58. 00 |
| 59. 00 | replacement, and expansion | 102 220 400 | 0 | _ | 0 | 59. 00 |
| 60.00 | Total fund balances (sum of lines 52 thru 58) Total liabilities and fund balances (sum of lines 51 and | 193, 220, 699 222, 339, 121 | | 0 | | 60.00 |
| 55. 55 | [59] | 222, 337, 121 | | | | 55. 55 |
| | | | • | , | • | |

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-0165

Peri od: Worksheet G-1 From 01/01/2021

12/31/2021 Date/Time Prepared: 5/31/2022 7:54 am General Fund Special Purpose Fund Endowment Fund 1.00 3.00 4. 00 5. 00 2 00 1.00 Fund balances at beginning of period 180, 490, 154 0 1.00 2.00 Net income (loss) (from Wkst. G-3, line 29) 12, 730, 800 2.00 3.00 Total (sum of line 1 and line 2) 193, 220, 954 0 3.00 4.00 0 Additions (credit adjustments) (specify) 0 4.00 0 0 0 0 5.00 0 5.00 6.00 6.00 0 7.00 0 7.00 0 8.00 0 8.00 0 9.00 0 9.00 10.00 Total additions (sum of line 4-9) 10.00 Subtotal (line 3 plus line 10) 193, 220, 954 11.00 0 11.00 12.00 **ADJUSTMENT** 255 0 12.00 13.00 0000 13.00 14.00 0 14.00 0 15.00 0 15.00 16.00 0 16.00 17.00 17.00 18.00 Total deductions (sum of lines 12-17) 18.00 255 Fund balance at end of period per balance 193, 220, 699 19.00 19.00 sheet (line 11 minus line 18) Endowment Fund Plant Fund 7. 00 8.00 6. 00 1.00 Fund balances at beginning of period 0 0 1.00 Net income (loss) (from Wkst. G-3, line 29) 2.00 2.00 Total (sum of line 1 and line 2) 3.00 0 0 3.00 4.00 Additions (credit adjustments) (specify) 4.00 5.00 0 5.00 0 6.00 6.00 7.00 0 7 00 8.00 0 8.00 9.00 9.00 10.00 Total additions (sum of line 4-9) 0 0 10.00 11.00 Subtotal (line 3 plus line 10) 0 0 11.00 12.00 **ADJUSTMENT** 12.00 13.00 13.00 14.00 0 14.00 0 15.00 15.00 16.00 16.00 17.00 17.00 Total deductions (sum of lines 12-17) 18.00 18.00 0 0 0 19.00 Fund balance at end of period per balance 19.00 sheet (line 11 minus line 18)

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

| | | To | 12/31/2021 | Date/Time Pre 5/31/2022 7:5 | |
|--------|--|---------------|---------------|-----------------------------|--------|
| | Cost Center Description | Inpatient | Outpati ent | Total | |
| | | 1.00 | 2. 00 | 3. 00 | |
| | PART I - PATIENT REVENUES | • | • | | |
| | General Inpatient Routine Services | | | | |
| 1.00 | Hospi tal | 70, 798, 396 | | 70, 798, 396 | 1.00 |
| 2.00 | SUBPROVI DER - I PF | 0 | | 0 | 2. 00 |
| 3.00 | SUBPROVI DER - I RF | 0 | | 0 | 3. 00 |
| 4.00 | SUBPROVI DER | | | | 4. 00 |
| 5.00 | Swing bed - SNF | 0 | | 0 | 5. 00 |
| 6.00 | Swing bed - NF | 0 | | 0 | |
| 7.00 | SKILLED NURSING FACILITY | 0 | | 0 | 7. 00 |
| 8.00 | NURSING FACILITY | 0 | | 0 | 8. 00 |
| 9.00 | OTHER LONG TERM CARE | 0 | | 0 | 9. 00 |
| 10.00 | Total general inpatient care services (sum of lines 1-9) | 70, 798, 396 | | 70, 798, 396 | 10. 00 |
| | Intensive Care Type Inpatient Hospital Services | | | | |
| 11. 00 | INTENSIVE CARE UNIT | 6, 698, 386 | | 6, 698, 386 | |
| 12. 00 | CORONARY CARE UNIT | 0 | | 0 | 12. 00 |
| 13. 00 | BURN INTENSIVE CARE UNIT | 0 | | 0 | 13. 00 |
| 14. 00 | SURGICAL INTENSIVE CARE UNIT | 0 | | 0 | 14. 00 |
| 15. 00 | OTHER SPECIAL CARE (SPECIFY) | | | | 15. 00 |
| 16. 00 | Total intensive care type inpatient hospital services (sum of lines | 6, 698, 386 | | 6, 698, 386 | 16. 00 |
| | 11-15) | | | | |
| 17. 00 | Total inpatient routine care services (sum of lines 10 and 16) | 77, 496, 782 | | 77, 496, 782 | |
| 18. 00 | Ancillary services | 86, 375, 551 | 274, 542, 860 | 360, 918, 411 | |
| 19. 00 | Outpatient services | 12, 212, 988 | 67, 731, 605 | 79, 944, 593 | |
| 20. 00 | RURAL HEALTH CLINIC | 0 | 0 | 0 | 20. 00 |
| 21. 00 | FEDERALLY QUALIFIED HEALTH CENTER | 0 | 0 | 0 | |
| 22. 00 | HOME HEALTH AGENCY | _ | 0 | 0 | |
| 23. 00 | AMBULANCE SERVICES | 0 | 0 | 0 | |
| 24. 00 | CMHC | _ | 0 | 0 | |
| 24. 10 | CORF | 0 | 0 | 0 | |
| 25. 00 | AMBULATORY SURGICAL CENTER (D. P.) | 0 | 0 | 0 | |
| 26. 00 | HOSPI CE | 0 | 0 | 0 | 26. 00 |
| 27. 00 | OTHER REVENUE | 381 | 2, 178, 865 | 2, 179, 246 | |
| 28. 00 | Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. | 176, 085, 702 | 344, 453, 330 | 520, 539, 032 | 28. 00 |
| | G-3, line 1) | | | | |
| 29. 00 | PART II - OPERATING EXPENSES Operating expenses (per Wkst. A, column 3, line 200) | | 119, 879, 185 | | 29. 00 |
| 30. 00 | ADD (SPECIFY) | 0 | 119, 079, 100 | | 30.00 |
| 31. 00 | ADD (SPECIFF) | | | | 31.00 |
| 32. 00 | | | | | 32.00 |
| 33. 00 | | | | | 33. 00 |
| 34. 00 | | | | | 34.00 |
| 35. 00 | | | | | 35. 00 |
| 36. 00 | Total additions (sum of lines 30-35) | 0 | 0 | | 36. 00 |
| 37. 00 | DEDUCT (SPECIFY) | 0 | ٩ | | 37. 00 |
| 38. 00 | DEBOOT (SI ESTITY) | | | | 38. 00 |
| 39. 00 | | | | | 39.00 |
| 40. 00 | | | | | 40. 00 |
| 41. 00 | | | | | 41. 00 |
| 42. 00 | Total deductions (sum of lines 37-41) | | n | | 42. 00 |
| 43. 00 | Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer | | 119, 879, 185 | | 43. 00 |
| .5. 55 | to Wkst. G-3, line 4) | | , 5, 7, 105 | | .5. 55 |
| | | 1 | ı | | • |

| Heal t | n Financial Systems | FRANCI SCAN HEALTH | I MUNSTER | In Lie | u of Form CMS-2 | 2552-10 |
|------------------------------------|---|----------------------|-----------------------|----------------------------------|----------------------------------|----------|
| STATEMENT OF REVENUES AND EXPENSES | | | Provider CCN: 15-0165 | Peri od: | Worksheet G-3 | |
| | | | | From 01/01/2021 To 12/31/2021 | Date/Time Prep 5/31/2022 7:54 | |
| | | | | | 1 00 | |
| 1. 00 | Total patient revenues (from Wkst. G-2, Part | L column 2 line | 20) | | 1. 00 520, 539, 032 | 1. 00 |
| 2.00 | | | | | 392, 743, 244 | 2. 00 |
| 3.00 | | | | 127, 795, 788 | | |
| 4. 00 | | | | 119, 879, 185 | | |
| 5. 00 | Net income from service to patients (line 3 m | | 3) | | 7, 916, 603 | |
| 0.00 | OTHER I NCOME | iii iida i i iic i i | | | 7, 710, 000 | 0.00 |
| 6.00 | Contributions, donations, bequests, etc | | | | 0 | 6. 00 |
| 7.00 | Income from investments | | | | 0 | 7. 00 |
| 8.00 | Revenues from telephone and other miscellaneo | ous communication | servi ces | | 0 | 8. 00 |
| 9.00 | Revenue from television and radio service | | | | 0 | 9. 00 |
| 10.00 | Purchase di scounts | | | | 0 | 10.00 |
| 11.00 | Rebates and refunds of expenses | | | | 473, 768 | 11.00 |
| 12.00 | Parking Lot receipts | | | | 0 | 12.00 |
| 13.00 | Revenue from Laundry and Linen service | | | | 0 | 13.00 |
| 14.00 | Revenue from meals sold to employees and gues | sts | | | 0 | 14.00 |
| 15. 00 | Revenue from rental of living quarters | | | | 0 | 15. 00 |
| | Revenue from sale of medical and surgical sup | | an patients | | 0 | 16.00 |
| | Revenue from sale of drugs to other than pati | | | | 0 | 17.00 |
| | Revenue from sale of medical records and abst | | | | 6, 076 | |
| | Tuition (fees, sale of textbooks, uniforms, e | | | | 0 | 19. 00 |
| | Revenue from gifts, flowers, coffee shops, ar | nd canteen | | | 24, 923 | |
| | Rental of vending machines | | | | 12, 391 | |
| 22. 00 | · · | | | | 646, 757 | |
| 23. 00 | · · · · | | | | 0 | 23. 00 |
| 24.00 | | | | | 711, 758 | |
| | CAPITATION AND PREMIUM REVENUE | | | | 880, 719 | |
| | INSURANCE CLAIM PROCEEDS | | | | 2, 000, 000 | |
| | COVI D-19 PHE Fundi ng | | | | 57, 805 | |
| 25 00 | Total ather income (cum of lines 4 24) | | | | 4 014 107 | - 1E (M) |

57, 805 24. 50 4, 814, 197 25. 00

12, 730, 800 26. 00 0 27. 00

12, 730, 800 29. 00

0 28. 00

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

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

| Heal th | Financial Systems FRANCISCAN F | HEALTH MUNSTER | In Lie | u of Form CMS-2 | 2552-10 |
|------------------|---|---------------------------------|--|--|------------------|
| CALCUL | LATION OF CAPITAL PAYMENT | Provi der CCN: 15-0165 | Peri od: From 01/01/2021 To 12/31/2021 | Worksheet L Parts I-III Date/Time Prep 5/31/2022 7:54 | |
| | | Title XVIII | Hospi tal | PPS | |
| | | | | 1 00 | |
| | PART I - FULLY PROSPECTIVE METHOD | | | 1. 00 | |
| | CAPITAL FEDERAL AMOUNT | | | | |
| 1.00 | Capital DRG other than outlier | 847, 793 | 1.00 | | |
| 1.01 | Model 4 BPCI Capital DRG other than outlier | | | | 1. 01 |
| 2.00 | Capital DRG outlier payments | | | 68, 135 | |
| 2.01 | Model 4 BPCI Capital DRG outlier payments | | | 0 | 2. 01 |
| 3.00 | Total inpatient days divided by number of days in the cos | st reporting period (see inst | ructions) | 39. 78 0. 00 | |
| 4.00 | | | | | |
| 5.00 | Indirect medical education percentage (see instructions) Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and | | | | 5.00 |
| 6. 00 | 1.01) (see instructions) | the sum of fines I and I.O. | , corumns r and | 0 | 6. 00 |
| 7. 00 | Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions) | | | | 7. 00 |
| 8.00 | Percentage of Medicaid patient days to total days (see instructions) | | | | 8. 00 |
| 9.00 | Sum of Lines 7 and 8 | | | | 9. 00 |
| 10.00 | | | | | 10. 00 |
| 11. 00 | | | | | 11. 00 |
| 12.00 | Total prospective capital payments (see instructions) | | | 915, 928 | 12. 00 |
| | | | | 1. 00 | |
| | PART II - PAYMENT UNDER REASONABLE COST | | | 1.00 | |
| 1.00 | Program inpatient routine capital cost (see instructions) | | | 0 | 1.00 |
| 2.00 | Program inpatient ancillary capital cost (see instructions) | | | | 2.00 |
| 3.00 | Total inpatient program capital cost (line 1 plus line 2) | | | | 3. 00 |
| 4.00 | Capital cost payment factor (see instructions) | | | 0 | 4. 00 |
| 5.00 | Total inpatient program capital cost (line 3 x line 4) | | | 0 | 5. 00 |
| | | | | 1. 00 | |
| | PART III - COMPUTATION OF EXCEPTION PAYMENTS | | | | |
| 1.00 | Program inpatient capital costs (see instructions) | | | 0 | 1.00 |
| 2.00 | Program inpatient capital costs for extraordinary circumstances (see instructions) | | | 0 | 2.00 |
| 3. 00 4. 00 | Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) | | | 0 0. 00 | 3. 00 4. 00 |
| 5.00 | Capital cost for comparison to payments (line 3 x line 4) | | 0.00 | 5.00 | |
| 6.00 | Percentage adjustment for extraordinary circumstances (see instructions) | | | 0.00 | |
| 7. 00 | Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6) | | 0 | | |
| 8.00 | Capital minimum payment level (line 5 plus line 7) | | 0 | 8. 00 | |
| 9.00 | Current year capital payments (from Part I, line 12, as applicable) | | 0 | 9. 00 | |
| 10.00 | | | | 0 | 10.00 |
| 11. 00 | | | | | 11. 00 |
| 40.00 | Worksheet L, Part III, line 14) | | | | 40.00 |
| 12.00 | | | | | 12.00 |
| 13.00 | | | | | 13. 00 14. 00 |
| | (if line 12 is negative, enter the amount on this line) | rei capitai payillent nor the i | orrowing perrod | 0 | 14.00 |
| 14. 00 | | | | | i |
| 14. 00 15. 00 | , | e instructions) | | 0 | 15. 00 |
| 15. 00 | , | | | 0 0 | 15. 00 16. 00 |