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 09-30-2025 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 15-0090 Worksheet S Peri od: From 01/01/2023 Parts I-III AND SETTLEMENT SUMMARY 12/31/2023 Date/Time Prepared: 5/30/2024 3:45 pm PART I - COST REPORT STATUS Provi der 1. [ X ] Electronically prepared cost report Date: 5/30/2024 3:45 pm use only ] Manually prepared cost report Ilf this is an amended report enter the number of times the provider resubmitted this cost report [Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no. [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. NPR Date:
[12] 13. NPR Date:
[13] 14. NPR Date:
[14] 15. NPR Date:
[15] 15. NPR Date:
[16] 16. NPR Date:
[17] 17. NPR Date:
[18] 17. NPR Date:
[18] 18. NPR Date:
[18] 18. NPR Date:
[18] 19. NPR Da Contractor use only

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

(3) Settled with Audit

(4) Reopened (5) Amended

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

number of times reopened = 0-9.

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by FRANCISCAN HEALTH- DYER ( 15-0090 ) for the cost reporting period beginning 01/01/2023 and ending 12/31/2023 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

	·		Title	XVIII			
		Title V	Part A	Part B	HI T	Title XIX	
		1. 00	2.00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPI TAL	0	587, 037	51, 668	0	0	1. 00
2.00	SUBPROVI DER - I PF	0	0	0		0	2. 00
3.00	SUBPROVI DER - I RF	0	-96, 351	5		0	3. 00
4.00	SUBPROVI DER (OTHER)						4. 00
5.00	SWING BED - SNF	0	0	0		0	5. 00
6.00	SWING BED - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9. 00
200.00	TOTAL	0	490, 686	51, 673	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 number for this information collection is OMB 0938-0050 and the number for the Supplement to Form CMS 2552-10, Worksheet N95, is OMB 0938-1425. The time required to complete and review the information collection is estimated 675 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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

Health Financial Systems FRANCISCAN HEALTH- DYER In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0090 Peri od: Worksheet S-2 From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/30/2024 3:45 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 24 JOLIET STREET 1.00 PO Box: 1.00 State: IN Zip Code: 46311-1799 County: LAKE 2.00 City: DYER 2.00 Component Name CCN CBSA Provi der Date Payment System (P, Certi fi ed T, 0, or N) Number Number Type XVIII XIX 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 Hospi tal FRANCISCAN HEALTH- DYER 150090 23844 07/01/1966 Ν Р 0 3.00 1 Subprovider - IPF 4.00 4.00 5.00 Subprovider - IRF FRANCISCAN HEALTH - DYER 15T090 23844 5 01/01/2002 N Р Т 5.00 REHAB 6.00 Subprovider - (Other) 6 00 Swing Beds - SNF 7.00 7 00 8.00 Swing Beds - NF 8.00 9.00 Hospi tal -Based SNF 9.00 Hospi tal -Based NF 10.00 10.00 11.00 Hospi tal -Based OLTC 11.00 12.00 Hospi tal -Based HHA ST. MARGARET HOME CARE 157145 23844 01/01/2023 Ν Ρ Ν 12.00 Separately Certified ASC 13.00 13.00 Hospi tal -Based Hospi ce 14.00 14.00 Hospital-Based Health Clinic - RHC 15.00 15 00 16.00 Hospital-Based Health Clinic - FQHC 16.00 17.00 Hospital-Based (CMHC) I 17.00 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: 2.00 1.00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2023 12/31/2023 20.00 21.00 Type of Control (see instructions) 21.00 1. 00 2. 00 3.00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for Υ N 22.00 disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim UCPs, including supplemental UCPs, for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no 22.01 Υ 22.01 for the portion of the cost reporting period occurring prior to October 1 Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Is this a newly merged hospital that requires a final UCP to be determined 22.02 22.02 N Ν at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. Did this hospital receive a geographic reclassification from urban to rural as a result of the OBB standards for delineating statistical areas N 22.03 Ν Ν 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

22.04

23.00

3

Ν

MCRI F32 - 22. 2. 178. 3

for no.

22.04 Did this hospital receive a geographic reclassification from urban to

23.00 Which method is used to determine Medicaid days on lines 24 and/or 25

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"

below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.

December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for

58.00

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

yes in column 1, do not complete column 2, and complete Worksheet E-4.

Health Financial Systems FRANCISCAN HEALTH- DYER In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0090 Peri od: Worksheet S-2 From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/30/2024 3:45 pm XVIII XIX 1. 00 2.00 3.00 59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I Ν 59.00 NAHE 413.85 Worksheet A Pass-Through Y/N Line # Qual i fi cati on Criterion Code 1.00 2.00 3.00 60.00 Are you claiming nursing and allied health education (NAHE) costs for any 60.00 programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you Enter "Y" for yes or "N" for no in column 1. impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2. 60.01 If line 60 is yes, complete columns 2 and 3 for each program. (see 23.00 60.01 instructions) If line 60 is yes, complete columns 2 and 3 for each program. (see 23.01 60.02 60.02 1 instructions) 60.03 If line 60 is yes, complete columns 2 and 3 for each program. (see 23.02 60.03 instructions) Y/N IMF Direct GME IMF Direct GME 1. 00 2. 00 3 00 4 00 5 00 61.00 Did your hospital receive FTE slots under ACA section 0.00 0.00 61.00 Ν 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) Enter the average number of unweighted primary care 61.01 61.01 FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) 61.02 Enter the current year total unweighted primary care 61.02 FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA) (see instructions) 61.03 Enter the base line FTE count for primary care and/or 61 03 general surgery residents, which is used for determining compliance with the 75% test. (see instructions) Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost 61.04 61.04 reporting period.(see instructions). 61.05 Enter the difference between the baseline primary 61 05 and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions) 61.06 Enter the amount of ACA §5503 award that is being used 61.06 for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions) Program Name Program Code Unweighted IME Unweighted FTE Count Direct GME FTE Count 2.00 4.00 1.00 3.00 61.10 Of the FTEs in line 61.05, specify each new program 0.00 0.00 61.10 specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count Enter in column 4, the direct GME FTE unweighted count. 61.20 Of the FTEs in line 61.05, specify each expanded 0.00 61.20 0.00 program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. 1.00 ACA Provisions Affecting the Health Resources and Services Administration (HRSA) 62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which 0.00 62.00 your hospital received HRSA PCRE funding (see instructions) Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital 0.00 62.01 62.01

during in this cost reporting period of HRSA THC program. (see instructions)

63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter

for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)

N

63.00

Teaching Hospitals that Claim Residents in Nonprovider Settings

Health Financial Systems	FRANCI	SCAN HEALTH- DYER		In Lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMP				riod: com 01/01/2023	Worksheet S-2 Part I Date/Time Prep 5/30/2024 3:49	pared:
			Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			1. 00	2. 00	3.00	
Section 5504 of the ACA Base Yea	r FTE Residents in No	onprovider Settings				
period that begins on or after J 64.00 Enter in column 1, if line 63 is in the base year period, the num resident FTEs attributable to ro settings. Enter in column 2 the resident FTEs that trained in yo of (column 1 divided by (column	yes, or your facilit ber of unweighted nor tations occurring in number of unweighted ur hospital. Enter in	ty trained residents n-primary care all nonprovider d non-primary care n column 3 the ratio	0.00	5. 75	0. 000000	64. 00
	Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col. 3/	
			FTEs	FTEs in	(col. 3 + col.	
			Nonprovi der Si te	Hospi tal	4))	
	1. 00	2.00	3. 00	4. 00	5. 00	
65.00 Enter in column 1, if line 63	1.00	2.00	0.00	0. 00		65, 00
is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)						
			Unwei ghted FTEs Nonprovi der	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			Si te 1.00	2.00	2.00	
Section 5504 of the ACA Current	Vear FTE Residents in	n Nonnrovider Settings		2.00	3.00	
beginning on or after July 1, 20		p. evr de. eet tige	20010	. 0001 . 000. 1.	ing point due	
66.00 Enter in column 1 the number of attributable to rotations occurr column 2 the number of unweighte trained in your hospital. Enter by (column 1 + column 2)). (see	unweighted non-primar ing in all nonprovide d non-primary care re in column 3 the ratio	er settings. Enter ir esident FTEs that		5. 74	0. 000000	66. 00
	Program Name	Program Code	Unweighted	Unweighted FTEs in	Ratio (col. 3/	
			FTEs Nonprovi der	Hospi tal	(col. 3 + col. 4))	
			Si te	noop. tui	.,,	
	1.00	2.00	3. 00	4. 00	5.00	
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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	EALTH- DYER Provider C	CN: 15-0090 F	<u> </u>	u of Form CMS Worksheet S-	
IOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Frovider C	F	rom 01/01/2023 to 12/31/2023	Part I	epared:
			V 1. 00	XI X 2. 00	
98.00 Does title V or XIX follow Medicare (title XVIII) for the i stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" 1 for title V, and in column 2 for title XIX.			N	Υ	98. 0
P8.01 Does title V or XIX follow Medicare (title XVIII) for the report of the Pt. I? Enter "Y" for yes or "N" for no in column 1 for title XIX.				Y	98. 0
28.02 Does title V or XIX follow Medicare (title XVIII) for the costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "IV, and in column 2 for title XIX.				Y	98. 0
8.03 Does title V or XIX follow Medicare (title XVIII) for a cri reimbursed 101% of inpatient services cost? Enter "Y" for y for title V, and in column 2 for title XIX.			N	N	98. 0
8.04 Does title V or XIX follow Medicare (title XVIII) for a CAH services cost? Enter "Y" for yes or "N" for no in column 1 for title XIX.			nt N	N	98. 0
8.05 Does title V or XIX follow Medicare (title XVIII) and add b Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 2 for title XIX.			N	Y	98. (
18.06 Does title V or XIX follow Medicare (title XVIII) when cost through IV? Enter "Y" for yes or "N" for no in column 1 for title XIX.				Y	98. (
Rural Providers 05.00 Does this hospital qualify as a CAH?			N		105. (
06.00 of this facility qualifies as a CAH, has it elected the all for outpatient services? (see instructions)	-inclusive met	hod of payment	N		106. 0
07.00 Column 1: If line 105 is Y, is this facility eligible for course training programs? Enter "Y" for yes or "N" for no in column Column 2: If column 1 is Y and line 70 or line 75 is Y, do	n 1. (see ins	tructions)	N		107. (
medical education program in the CAH's excluded IPF and/or yes or "N" for no in column 2. (see instructions) 07.01   f this facility is a REH (line 3, column 4, is "12"), is i	IRF unit(s)?	Enter "Y" for			107. (
reimbursement for I&R training programs? Enter "Y" for yes instructions)  08.00 Is this a rural hospital qualifying for an exception to the	or "N" for no.	(see	CER N		107.
Section §412.113(c). Enter "Y" for yes or "N" for no.	1			Dooni ratory	
	Physi cal 1.00	0ccupational 2.00	Speech	Respi ratory	
OO OOLE this book to much fine CALL ''		2.00	3. 00	4. 00	
09.00  f this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" fo yes or "N" for no for each therapy.		N N	3. 00 N	4.00 N	109.
therapy services provided by outside supplier? Enter "Y" fo				N	109.
therapy services provided by outside supplier? Enter "Y" fo yes or "N" for no for each therapy.	al Demonstratio	N on project (§4 "N" for no. I	N 10A f yes, complete	1.00 N	
therapy services provided by outside supplier? Enter "Y" fo yes or "N" for no for each therapy.  10.00 Did this hospital participate in the Rural Community Hospital Demonstration) for the current cost reporting period? Enter	al Demonstratio	N on project (§4 "N" for no. I	N 10A f yes, complete s applicable.	1. 00 N	
therapy services provided by outside supplier? Enter "Y" fo yes or "N" for no for each therapy.  10.00 Did this hospital participate in the Rural Community Hospit Demonstration) for the current cost reporting period? Enter Worksheet E, Part A, Lines 200 through 218, and Worksheet E	al Demonstration "Y" for yes or -2, lines 200 of the Frontier Conting period? is Y, enter the in column 2. En	on project (§4 "N" for no. I through 215, a  ommunity Healt Enter "Y" for e integration nter all that	N  10A f yes, completes applicable.  1.00	1.00 N	110. (
therapy services provided by outside supplier? Enter "Y" fo yes or "N" for no for each therapy.  10.00 Did this hospital participate in the Rural Community Hospital Demonstration) for the current cost reporting period? Enter Worksheet E, Part A, lines 200 through 218, and Worksheet E  11.00 If this facility qualifies as a CAH, did it participate in Integration Project (FCHIP) demonstration for this cost replyes or "N" for no in column 1. If the response to column 1 prong of the FCHIP demo in which this CAH is participating apply: "A" for Ambulance services; "B" for additional beds;	al Demonstration "Y" for yes or -2, lines 200 of the Frontier Conting period? is Y, enter the in column 2. En	on project (§4 "N" for no. I through 215, a  ommunity Healt Enter "Y" for e integration nter all that	N  10A f yes, completes applicable.  1.00	1. 00 N	110. (
therapy services provided by outside supplier? Enter "Y" fo yes or "N" for no for each therapy.  10.00 Did this hospital participate in the Rural Community Hospit. Demonstration) for the current cost reporting period? Enter Worksheet E, Part A, lines 200 through 218, and Worksheet E  11.00 If this facility qualifies as a CAH, did it participate in Integration Project (FCHIP) demonstration for this cost repyes or "N" for no in column 1. If the response to column 1 prong of the FCHIP demo in which this CAH is participating apply: "A" for Ambulance services; "B" for additional beds; services.  12.00 Did this hospital participate in the Pennsylvania Rural Hea (PARHM) demonstration for any portion of the current cost reperiod? Enter "Y" for yes or "N" for no in column 1. If center in column 2, the date the hospital began participating demonstration. In column 3, enter the date the hospital center in the demonstration, if applicable.	al Demonstration "Y" for yes or -2, lines 200  the Frontier Coorting period? is Y, enter the in column 2. E and/or "C" for  Ith Model eporting olumn 1 is "Y" g in the	on project (§4 "N" for no. I through 215, a  ommunity Healt Enter "Y" for e integration nter all that r tele-health	N  10A f yes, completes applicable.  1.00 h	1. 00 N	110.
therapy services provided by outside supplier? Enter "Y" fo yes or "N" for no for each therapy.  10.00 Did this hospital participate in the Rural Community Hospital Demonstration) for the current cost reporting period? Enter Worksheet E, Part A, Lines 200 through 218, and Worksheet E  11.00 If this facility qualifies as a CAH, did it participate in Integration Project (FCHIP) demonstration for this cost replyes or "N" for no in column 1. If the response to column 1 prong of the FCHIP demo in which this CAH is participating apply: "A" for Ambulance services; "B" for additional beds; services.  12.00 Did this hospital participate in the Pennsylvania Rural Hea (PARHM) demonstration for any portion of the current cost reperiod? Enter "Y" for yes or "N" for no in column 1. If center in column 2, the date the hospital began participating demonstration. In column 3, enter the date the hospital center in column 1. In column 3, enter the date the hospital center in column 1. If column 1 is yes, enter the method used (A, B, column 2. If column 1 is yes, enter the method used (A, B, column 2. If column 2 is "E", enter in column 3 either "93" short term hospital or "98" percent for long term care (inc psychiatric, rehabilitation and long term hospitals provide	al Demonstratie "Y" for yes or -2, lines 200  the Frontier Corting period? is Y, enter the in column 2. En and/or "C" for  Ith Model eporting olumn 1 is "Y" g in the ased  r "N" for no in or E only) in percent for ludes	on project (§4 "N" for no. I through 215, a  ommunity Healt Enter "Y" for e integration nter all that r tele-health  1.00 N	N  10A f yes, completes applicable.  1.00 h	1. 00 N	110. (
yes or "N" for no for each therapy.    10.00   Did this hospital participate in the Rural Community Hospital Demonstration) for the current cost reporting period? Enter Worksheet E, Part A, lines 200 through 218, and Worksheet E    11.00   If this facility qualifies as a CAH, did it participate in Integration Project (FCHIP) demonstration for this cost repear yes or "N" for no in column 1. If the response to column 1 prong of the FCHIP demo in which this CAH is participating apply: "A" for Ambulance services; "B" for additional beds; services.    112.00   Did this hospital participate in the Pennsylvania Rural Hea (PARHM) demonstration for any portion of the current cost reperiod? Enter "Y" for yes or "N" for no in column 1. If contenter in column 2, the date the hospital began participating demonstration. In column 3, enter the date the hospital center in column 2, the demonstration, if applicable.    Miscellaneous Cost Reporting Information	al Demonstration "Y" for yes or -2, lines 200 or  the Frontier Conting period? is Y, enter the in column 2. En and/or "C" for  I the Model deporting of the ased  ""N" for no in or E only) in percent for ludes res) based on	on project (§4 "N" for no. I through 215, a  ommunity Healt Enter "Y" for e integration nter all that r tele-health  1.00 N	N  10A f yes, completes applicable.  1.00 h	1. 00 N	110. (
therapy services provided by outside supplier? Enter "Y" fo yes or "N" for no for each therapy.  110.00 Did this hospital participate in the Rural Community Hospital Demonstration) for the current cost reporting period? Enter Worksheet E, Part A, Lines 200 through 218, and Worksheet E  111.00 If this facility qualifies as a CAH, did it participate in Integration Project (FCHIP) demonstration for this cost replyes or "N" for no in column 1. If the response to column 1 prong of the FCHIP demoin which this CAH is participating apply: "A" for Ambulance services; "B" for additional beds; services.  112.00 Did this hospital participate in the Pennsylvania Rural Heal (PARHM) demonstration for any portion of the current cost reperiod? Enter "Y" for yes or "N" for no in column 1. If contenter in column 2, the date the hospital began participating demonstration. In column 3, enter the date the hospital contenter in the demonstration, if applicable.  115.00 Is this an all-inclusive rate provider? Enter "Y" for yes on column 1. If column 1 is yes, enter the method used (A, B, column 2. If column 2 is "E", enter in column 3 either "93" short term hospital or "98" percent for long term care (ince psychiatric, rehabilitation and long term hospitals provide the definition in CMS Pub. 15-1, chapter 22, §2208.1.	al Demonstratie "Y" for yes or -2, lines 200  the Frontier Corting period? is Y, enter the in column 2. En and/or "C" for  Ith Model eporting olumn 1 is "Y" g in the ased  r "N" for no in or E only) in percent for ludes rs) based on for yes or "N' rance? Enter	on project (§4 "N" for no. I through 215, a  ommunity Healt Enter "Y" for e integration nter all that r tele-health  1.00 N N N N	N  10A f yes, completes applicable.  1.00 h	1. 00 N	110. (

Health Financial Systems	FRANCISCAN HEAL	_TH- DYER		In Lie	u of Form CM	S-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDE		Provider CCN:	F	Period: From 01/01/2023 To 12/31/2023	Worksheet S Part I Date/Time P	1-2
					5/30/2024 3	
			Premi ums	Losses	Insurance	
		$\vdash$	1. 00	2.00	3. 00	
118.01 List amounts of malpractice premiums an	d paid Losses:		643, 060			321 118. 01
				1.00	2.00	
118.02 Are mal practice premiums and paid losse				N	2.00	118. 02
Administrative and General? If yes, su amounts contained therein.	bmit supporting schedu	le listing cost	centers an	d		
119.00 DO NOT USE THIS LINE						119. 00
120.00 s this a SCH or EACH that qualifies for §3121 and applicable amendments? (see i				N"'	N	120. 00
for no. Is this a rural hospital with <	100 beds that qualifi	es for the Outp	atient Hold			
Harmless provision in ACA §3121 and app column 2, "Y" for yes or "N" for no.	licable amendments? (s	ee instructions	s) Enter in			
121.00 Did this facility incur and report cost	s for high cost implan	table devices c	harged to	Υ		121. 00
patients? Enter "Y" for yes or "N" for		nod in \$1003(w)	(2) of the	Y	5. 04	122. 00
122.00 Does the cost report contain healthcare Act?Enter "Y" for yes or "N" for no in					5. 04	122.00
Worksheet A line number where these tax				V		100.00
123.00 Did the facility and/or its subprovider e.g., legal, accounting, tax preparation			iai services	, Y		123. 00
management/consulting services, from an			enter "Y"	for		
yes or "N" for no.  If column 1 is "Y", were the majority o	f the expenses. i.e	greater than 50	% of total			
professional services expenses, for ser	vices purchased from u	nrelated organi	zati ons			
located in a CBSA outside of the main h for no.	ospital CBSA? In colum	n 2, enter "Y"	for yes or	"N"		
Certified Transplant Center Information						
125.00 Does this facility operate a Medicare-o			for yes an	d N		125. 00
126.00 If this is a Medicare-certified kidney			cation date	i n		126. 00
column 1 and termination date, if appli 127.00 If this is a Medicare-certified heart t		or the cortific	ation data	in		127. 00
column 1 and termination date, if appli		er the certific	ation date			127.00
128.00 If this is a Medicare-certified liver t		er the certific	ation date	i n		128. 00
column 1 and termination date, if appli 129.00 If this is a Medicare-certified lung tr		r the certifica	ition date i	n n		129. 00
column 1 and termination date, if appli			£:+:	1		120.00
130.00  f this is a Medicare-certified pancrea		enter the certi	rication da	te		130. 00
131.00 If this is a Medicare-certified intesti			ti fi cati on			131. 00
date in column 1 and termination date, 132.00  f this is a Medicare-certified islet t	• • •		ation date	i n		132. 00
column 1 and termination date, if appli						
133.00 Removed and reserved 134.00 If this is a hospital-based organ procu	rement organization (0	PO). enter the	OPO number	i n		133. 00 134. 00
column 1 and termination date, if appli						
All Providers  140.00 Are there any related organization or h	ome office costs as de	fined in CMS Pu	ıb. 15-1.	Υ	158014	140. 00
chapter 10? Enter "Y" for yes or "N" fo	r no in column 1. If y	es, and home of		are		
claimed, enter in column 2 the home off	ice chain number. (see 2.00	instructions)		3.00		
If this facility is part of a chain org	anization, enter on li	0			of the	
home office and enter the home office of 141.00 Name: FRANCISCAN ALLIANCE, INC	contractor name and con Contractor's Name: WISC			r's Number: 0810	1	141. 00
	SERV	'I CES	.			
	PO Box: - State: IN		Zip Code:	4654	6	142. 00 143. 00
145. 00 of ty. Wil Stimming	State. TN		Zip code.	4004	0	143.00
144.00 Are provider based physicians' costs in	cluded in Workshoot A2				1. 00 Y	144. 00
144. OUNT & PLOVI del Based physicians Costs III	cruded iii worksneet A:				I	144.00
14E 00 I f costs for rorel complete on the inter-	on Wkst A Line 74	ara tha sasts f	for Innetice	1. 00	2. 00	145.00
145.00 If costs for renal services are claimed services only? Enter "Y" for yes or "N"						145. 00
dialysis facility include Medicare util						
for yes or "N" for no in column 2.  146.00 Has the cost allocation methodology cha	nged from the previous	ly filed cost r	eport? Ente	r N		146. 00
"Y" for yes or "N" for no in column 1.	(See CMS Pub. 15-2, ch.					
enter the approval date (mm/dd/yyyy) ir	COLUMNI Z.			1		I

Health Financial Systems	FRANCI SCAI	N HEALTH- DYER			In Lie	u of Form CMS	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	Provi der	CCN: 15-0090	Period: From 01/ To 12/	01/2023 31/2023	Worksheet S- Part I Date/Time Pr 5/30/2024 3:	epared:
						1.00	
147.00 Was there a change in the statist	cal basis? Enter "Y" f	or ves or "N" fo	or no.			1.00 N	147. 00
148.00 Was there a change in the order of						N	148. 00
149.00 Was there a change to the simplif	ed cost finding method	? Enter "Y" for	yes or "N" f	or no.		N	149. 00
		Part A	Part E		le V	Title XIX	
		1.00	2.00		. 00	4. 00	
Does this facility contain a prov or charges? Enter "Y" for yes or						3. 13)	
155.00 Hospi tal		N	N		N	N	155. 00
156.00 Subprovi der - I PF		N	N N		N	N	156. 00
157. 00 Subprovi der - IRF 158. 00 SUBPROVI DER		N	N		N	N	157. 00 158. 00
159. 00 SNF		N	N		N	N	159. 00
160.00 HOME HEALTH AGENCY		N N	N N		N	N N	160. 00
161. 00 CMHC		IN.	N N		N	N N	161. 00
		<u> </u>				1.00	
Multicampus						1.00	
165.00 Is this hospital part of a Multic "Y" for yes or "N" for no.	ampus hospital that has	one or more car	mpuses in dif	ferent CBS/	As? Ent	er N	165. 00
To yes of N To No.	Name	County	State	Zip Code	CBSA	FTE/Campus	
	0	1. 00	2.00	3.00	4. 00	5. 00	
166.00 If line 165 is yes, for each						O. C	0 166. 00
campus enter the name in column 0							
county in column 1, state in							
column 2, zip code in column 3, CBSA in column 4, FTE/Campus in							
column 5 (see instructions)							
cordinir 5 (see Tristructrons)							
h						1.00	
Health Information Technology (HI 167.00 Is this provider a meaningful use				ment Act		Υ	167. 00
168.00 If this provider is a CAH (line 1)				/"). enter	the	'	168. 00
reasonable cost incurred for the				,,			
168.01 If this provider is a CAH and is					ni p		168. 01
exception under §413.70(a)(6)(ii)							
169.00 If this provider is a meaningful		and is not a CAF	H (line 105 i	s "N"), en	ter the	0.0	169. 00
transition factor. (see instruction	ons)			Begi	nni ng	Endi ng	
					. 00	2.00	-
170.00 Enter in columns 1 and 2 the EHR respectively (mm/dd/yyyy)	peginning date and endi	ng date for the	reporting pe		. 00	2.00	170. 00
				1	. 00	2.00	
171.00 If line 167 is "Y", does this pro	vider have any days for	individuals en	rolled in sec		N		0 171, 00
1876 Medicare cost plans reported and "N" for no in column 1. If co	on Wkst. S-3, Pt. I, I	ine 2, col. 6? I	Enter "Y" for	yes			
days in column 2. (see instruction	ns)						

Health Financial Systems FRANCISCAN HEALTH- DYER In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provider CCN: 15-0090 Peri od: Worksheet S-2 From 01/01/2023 Part II Date/Time Prepared: 12/31/2023 5/30/2024 3:45 pm Y/N Date 1. 00 2.00 PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSEMENT QUESTIONNAIRE General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS Provider Organization and Operation 1 00 Has the provider changed ownership immediately prior to the beginning of the cost N 1.00 reporting period? If yes, enter the date of the change in column 2. (see instructions) Date V/I 1.00 2.00 3.00 Has the provider terminated participation in the Medicare Program? If yes 2.00 2.00 Ν enter in column 2 the date of termination and in column 3, "V" voluntary or "I" for involuntary. 3.00 Is the provider involved in business transactions, including management Ν 3.00 contracts, with individuals or entities (e.g., chain home offices, drug o medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions) Y/N Date Type 1.00 2.00 3.00 Financial Data and Reports
Column 1: Were the financial statements prepared by a Certified Public 4 00 04/17/2024 4 00 Α Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, o for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation. 5 00 5 00 Ν Y/N Legal Oper. 1.00 Approved Educational Activities 6.00 Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider Ν 6.00 the legal operator of the program? 7 00 Are costs claimed for Allied Health Programs? If "Y" see instructions. N 7 00 Were nursing programs and/or allied health programs approved and/or renewed during the Ν 8.00 8.00 cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved graduate medical education 9.00 Ν 9.00 program in the current cost report? If yes, see instructions.

Was an approved Intern and Resident GME program initiated or renewed in the current cost 10.00 Ν 10.00 reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Ν 11.00 Program on Worksheet A? If yes, see instructions Y/N 1.00 Bad Debts 12.00 Is the provider seeking reimbursement for bad debts? If yes, see instructions. 12.00 If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting 13.00 Ν 13.00 period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or coinsurance amounts waived? If yes, see instructions 14.00 Bed Complement Υ 15.00 Did total beds available change from the prior cost reporting period? If yes, 15.00 see instructions Part B Y/N Date Y/N Date 1.00 2.00 3.00 4.00 PS&R Data 16.00 Was the cost report prepared using the PS&R Report only? If N N 16.00 either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see instructions) Was the cost report prepared using the PS&R Report for 04/09/2024 04/09/2024 17.00 17.00 Υ totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in column's 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Ν 18.00 Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions. 19.00 If line 16 or 17 is yes, were adjustments made to PS&R N N 19.00 Report data for corrections of other PS&R Report information? If yes, see instructions.

Heal th	Financial Systems FRANCISCAN HE	ALTH- DYER		In Lie	u of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der Co	CN: 15-0090	Peri od: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part II Date/Time Pre 5/30/2024 3:4	pared:
		Descri	ipti on	Y/N	Y/N	
		(	)	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	Date	Y/N	Date	
		1.00	2. 00	3. 00	4. 00	
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21. 00
					1. 00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCER	PT CHILDRENS H	OSPI TALS)			
	Capital Related Cost					
22. 00	Have assets been relifed for Medicare purposes? If yes, see				N	22. 00
23. 00	Have changes occurred in the Medicare depreciation expense	due to apprais	als made dur	ing the cost	N	23. 00
04.00	reporting period? If yes, see instructions.				6 N	04.00
24. 00	Were new leases and/or amendments to existing leases entered yes, see instructions	a into during	this cost re	porting perioa? i	f N	24. 00
25. 00	Have there been new capitalized leases entered into during	the cost repor	ting period?	If yes, see	N	25. 00
24 00	instructions.	o cost roporti	na nori od2 l	f vos soo	N	26. 00
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during the instructions.	e cost reporti	ng perrou? r	i yes, see	N	20.00
27. 00	Has the provider's capitalization policy changed during the Interest Expense	cost reportin	g period? If	yes, submit copy	r. N	27. 00
28. 00	Were new Loans, mortgage agreements or Letters of credit en	tered into dur	ing the cost	reporting period	l? N	28. 00
29. 00	If yes, see instructions. Did the provider have a funded depreciation account and/or I	bond funds (De	bt Service R	eserve Fund)	N	29. 00
30. 00	treated as a funded depreciation account? If yes, see instru Has existing debt been replaced prior to its scheduled matur		dobt2 lf voc	coo i netrueti or	ıs. N	30.00
31. 00	Has debt been recalled before scheduled maturity without is:	,	,			31. 00
01.00	Purchased Services	Sudfice of flew	dest. 11 yes	, 300 111311 4011 61		01.00
32. 00	Have changes or new agreements occurred in patient care serv		d through co	ntractual	N	32. 00
33. 00	arrangements with suppliers of services? If yes, see instruction of Sec. 2135.2 applies a point of Sec. 2135.2 applies the requirements of Sec. 2135.2 applies the second of Sec		a to competi	tive hidding? If		33. 00
33.00	no, see instructions.	rred pertariiri	ig to competi	tive bruding: II		33.00
	Provi der-Based Physi ci ans					
34.00	Were services furnished at the provider facility under an a	rrangement wit	h provider-b	ased physicians?	If Y	34. 00
35. 00	yes, see instructions.	ctina aaroomon	to with the	provider based	N	35. 00
33.00	If line 34 is yes, were there new agreements or amended exisphysicians during the cost reporting period? If yes, see ins		its with the	pi ovi dei -based	IV	35.00
				Y/N	Date	
				1. 00	2. 00	
	Home Office Costs					
36. 00	Were home office costs claimed on the cost report?			Y		36. 00
37. 00	If line 36 is yes, has a home office cost statement been pro	epared by the	home office?	IF Y		37. 00
38. 00	yes, see instructions. If line 36 is yes , was the fiscal year end of the home offi	ice different	from that of	the N		38. 00
00.00	provider? If yes, enter in column 2 the fiscal year end of					00.00
39. 00	If line 36 is yes, did the provider render services to other see instructions.	r chain compon	ents? If yes	, N		39. 00
40. 00	If line 36 is yes, did the provider render services to the H	home office?	If yes, see	N		40. 00
	instructions.					
	Cook Donard Donard Control   C	1.	00	2.	00	
41 00	Cost Report Preparer Contact Information	JAI I		IAMES		41 00
41. 00	Enter the first name, last name and the title/position heldby the cost report preparer in columns 1, 2, and 3,	TALL		JAMES		41. 00
	respectively.					
42. 00	Enter the employer/company name of the cost report preparent	FRANCISCAN ALL	IANCE INC			42. 00
43. 00		(614) 565-2739		JAMES. HALL@FRAI	NCI SCANALLI ANCI	
	report preparer in columns 1 and 2, respectively.			. ORG		

Heal th	Financial Systems	FRANCISCAN HE	ALTH- DYER		In Lie	u of Form CMS-2	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QU	UESTI ONNAI RE	Provider CC		Period: From 01/01/2023	Worksheet S-2 Part II	
					To 12/31/2023	Date/Time Pre 5/30/2024 3:4	
			3. (	00			
	Cost Report Preparer Contact Information						
41.00	Enter the first name, last name and the tit	tle/position held	REIMBURSEMENT A	ANALYST			41.00
	by the cost report preparer in columns 1, 2	2, and 3,					
	respecti vel y.						
42.00	Enter the employer/company name of the cost	t report preparer					42. 00
43.00	Enter the telephone number and email addres	ss of the cost					43. 00
	report preparer in columns 1 and 2, respect	ti vel v.					

 
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 HOSPI TAL AND HOSPI TAL HEALTH CARE COMPLEX STATISTICAL DATA
 Provider CCN: 15-0090 

					'	0 12/31/2023	5/30/2024 3: 4	
							I/P Days / 0/P	O PIII
							Visits / Trips	
	Component	Worksheet A	No	of Beds	Bed Days	CAH/REH Hours	Title V	
	oomponent	Li ne No.	'''	or beas	Avai I abl e	O/MI/ REIT HOUTS	11 110 1	
		1.00		2. 00	3.00	4. 00	5. 00	
	PART I - STATISTICAL DATA	11 00	l	2.00	0.00	1. 00	0.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		145	52, 925	0.00	0	1.00
	8 exclude Swing Bed, Observation Bed and	00.00			02, 720	0.00	Ü	
	Hospice days) (see instructions for col. 2 for	•						
	the portion of LDP room available beds)							
2.00	HMO and other (see instructions)							2. 00
3.00	HMO IPF Subprovider							3. 00
4.00	HMO IRF Subprovider							4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF						0	5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						0	6. 00
7. 00	Total Adults and Peds. (exclude observation			145	52, 925	0.00	0	7. 00
	beds) (see instructions)							
8.00	INTENSIVE CARE UNIT	31. 00		14	5, 110	0.00	0	8. 00
9.00	CORONARY CARE UNIT	32. 00		0	0		0	9. 00
10.00	BURN INTENSIVE CARE UNIT	33. 00		0		0.00	0	10.00
11. 00	SURGICAL INTENSIVE CARE UNIT				_			11. 00
12. 00	NEONATAL INTENSIVE CARE UNIT	35. 00		7	2, 555	0.00	o	12. 00
13. 00	NURSERY	43. 00		-	_, -, -, -		0	13. 00
14. 00	Total (see instructions)			166	60, 590	0.00	0	14. 00
15. 00	CAH visits				1		0	15. 00
15. 10	REH hours and visits					0.00	0	15. 10
16. 00	SUBPROVI DER - I PF						_	16. 00
17. 00	SUBPROVIDER - IRF	41. 00		15	5, 475		0	17. 00
18. 00	SUBPROVI DER	42. 00		0	0		0	18. 00
19. 00	SKILLED NURSING FACILITY				_			19. 00
20.00	NURSING FACILITY							20. 00
21.00	OTHER LONG TERM CARE							21. 00
22. 00	HOME HEALTH AGENCY	101. 00					0	22. 00
23.00	AMBULATORY SURGICAL CENTER (D. P.)							23. 00
24.00	HOSPI CE							24. 00
24. 10	HOSPICE (non-distinct part)	30. 00						24. 10
25.00	CMHC - CMHC							25. 00
26.00	RURAL HEALTH CLINIC							26. 00
26, 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00					0	26, 25
27. 00	Total (sum of lines 14-26)			181				27. 00
28. 00	Observation Bed Days						0	28. 00
29. 00	Ambul ance Trips							29. 00
30. 00	Employee discount days (see instruction)							30.00
31. 00	Employee discount days - IRF							31. 00
32.00	Labor & delivery days (see instructions)			0	C			32. 00
32. 01	Total ancillary labor & delivery room				]			32. 01
	outpatient days (see instructions)							
33.00	LTCH non-covered days							33. 00
33. 01	LTCH site neutral days and discharges							33. 01
34.00	Temporary Expansion COVID-19 PHE Acute Care	30. 00		0	(		0	34. 00

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 HOSPI TAL AND HOSPI TAL HEALTH CARE COMPLEX STATISTICAL DATA

				'	0 12/31/2023	5/30/2024 3:4	
		I/P Days	/ O/P Visits	/ Trips	Full Time E	Equi val ents	D piii
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7. 00	8. 00	9. 00	10.00	
	PART I - STATISTICAL DATA	0.00	7.00	0.00	7, 00	101.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	7, 090	303	24, 760			1.00
	8 exclude Swing Bed, Observation Bed and	,,0,0	000	21,700			
	Hospice days) (see instructions for col. 2 for	-					
	the portion of LDP room available beds)						
2.00	HMO and other (see instructions)	5, 303	5, 823				2.00
3.00	HMO IPF Subprovider	0	0				3. 00
4.00	HMO IRF Subprovider	695	108				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	o	o	0			5. 00
6.00	Hospital Adults & Peds. Swing Bed NF		o	0			6.00
7.00	Total Adults and Peds. (exclude observation	7, 090	303	24, 760			7. 00
	beds) (see instructions)	,		.,			
8.00	INTENSIVE CARE UNIT	837	1, 044	2, 392			8. 00
9.00	CORONARY CARE UNIT	o	0	0			9. 00
10.00	BURN INTENSIVE CARE UNIT	o	o	0			10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11. 00
12.00	NEONATAL INTENSIVE CARE UNIT	0	305	350			12. 00
13.00	NURSERY		558	704			13. 00
14. 00	Total (see instructions)	7, 927	2, 210	28, 206	5. 74	836. 98	14. 00
15.00	CAH vi si ts	0	0	. 0			15. 00
15. 10	REH hours and visits	o	o	0			15. 10
16.00	SUBPROVI DER - I PF						16. 00
17. 00	SUBPROVI DER - I RF	2, 694	16	3, 964	0.00	0.00	17. 00
18.00	SUBPROVI DER		o	0	0.00	0.00	18. 00
19.00	SKILLED NURSING FACILITY						19. 00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY	23, 826	o	56, 477	0.00	0.00	22. 00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24.00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)			0			24. 10
25.00	CMHC - CMHC						25. 00
26.00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	O	0	0	0.00	0.00	26. 25
27.00	Total (sum of lines 14-26)				5. 74	836. 98	27. 00
28.00	Observation Bed Days		686	2, 797			28. 00
29.00	Ambul ance Trips	0					29. 00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	105	174			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
34.00	Temporary Expansion COVID-19 PHE Acute Care	0	o	0			34. 00

| Peri od: | Worksheet S-3 | From 01/01/2023 | Part | To 12/31/2023 | Date/Time Prepared: | Peri od: | Peri od

				10	) 12/31/2023	5/30/2024 3:4	
		Full Time	_	Di sch	arges	7 0 0 0 7 2 0 2 1 0 1 1	J
		Equi val ents					
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
		11. 00	12. 00	13. 00	14. 00	15. 00	
	PART I - STATISTICAL DATA			1			
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		0	1, 804	2, 000	5, 875	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)			906	0		2.00
3.00	HMO IPF Subprovider			700	0		3.00
4. 00	HMO IRF Subprovider						4. 00
5. 00	Hospital Adults & Peds. Swing Bed SNF				٩		5.00
6. 00	Hospital Adults & Peds. Swing Bed NF						6.00
7. 00	Total Adults and Peds. (exclude observation						7. 00
7.00	beds) (see instructions)						/. 00
8.00	INTENSIVE CARE UNIT						8. 00
9.00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11. 00
12.00	NEONATAL INTENSIVE CARE UNIT						12. 00
13.00	NURSERY						13. 00
14.00	Total (see instructions)	0. 00	0	1, 804	2, 000	5, 875	14. 00
15.00	CAH visits						15. 00
15. 10	REH hours and visits						15. 10
16. 00	SUBPROVI DER - I PF						16. 00
17. 00	SUBPROVIDER - IRF	0. 00	0	_	8	317	17. 00
18. 00	SUBPROVI DER	0. 00	0		0	0	18. 00
19.00	SKILLED NURSING FACILITY						19. 00
20.00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE	0.00					21.00
22. 00	HOME HEALTH AGENCY	0. 00					22. 00
23. 00 24. 00	AMBULATORY SURGICAL CENTER (D. P. ) HOSPICE						23. 00 24. 00
24. 00	HOSPICE (non-distinct part)						24. 00
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC						26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0. 00					26. 25
27. 00	Total (sum of lines 14-26)	0.00					27. 00
28. 00	Observation Bed Days	0.00					28. 00
29. 00	Ambul ance Trips						29. 00
30. 00	Employee discount days (see instruction)						30. 00
31. 00	Employee discount days - IRF						31. 00
32.00	Labor & delivery days (see instructions)						32. 00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
33. 00	LTCH non-covered days			0			33. 00
33. 01	LTCH site neutral days and discharges			0			33. 01
34. 00	Temporary Expansion COVID-19 PHE Acute Care						34.00

| Peri od: | Worksheet S-3 | From 01/01/2023 | Part | I | To 12/31/2023 | Date/Time Prepared: Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0090

					Т	o 12/31/2023	Date/Time Pre 5/30/2024 3:4	
		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst.	Adjusted Salaries (col.2 ± col.	Paid Hours Related to Salaries in	Average Hourly Wage (col. 4 ÷ col. 5)	
		1. 00	2.00	A-6) 3.00	3) 4.00	col . 4 5. 00	6. 00	
	PART II - WAGE DATA		2.00	0.00	1. 00	0.00	0.00	
1. 00	SALARIES Total salaries (see	200. 00	77, 968, 891	1 0	77, 968, 891	1, 740, 923. 00	44. 79	1.00
	instructions)	200. 00						
2. 00	Non-physician anesthetist Part A		C	0	0	0.00	0. 00	2.00
3.00	Non-physician anesthetist Part		C	0	0	0.00	0. 00	3.00
4.00	B Physician-Part A -		C	О	О	0.00	0.00	4.00
4. 01	Administrative Physicians - Part A - Teaching		61, 138	0	61, 138	2, 080. 00	29. 39	4. 01
5. 00	Physician and Non		7, 810, 504	l .	1			
6. 00	Physician-Part B Non-physician-Part B for		C	0	0	0.00	0.00	6.00
	hospital-based RHC and FQHC			_	_			
7. 00	services Interns & residents (in an	21. 00	57, 586	0	57, 586	2, 080. 00	27. 69	7.00
7. 01	approved program) Contracted interns and		(		0	0.00	0. 00	7. 01
7.01	residents (in an approved					0.00	0.00	7.01
8. 00	programs) Home office and/or related		C	0		0.00	0. 00	8.00
	organization personnel		-					
9. 00 10. 00	SNF Excluded area salaries (see	44. 00	13, 119, 237	0 -107, 947	0 13, 011, 290	0. 00 254, 239. 00	l .	
	instructions)							
11. 00	OTHER WAGES & RELATED COSTS  Contract labor: Direct Patient		7, 542, 122	0	7, 542, 122	70, 212. 00	107. 42	11.00
12. 00	Care Contract Labor: Top Level		(	0		0.00	0.00	12.00
12.00	management and other managemen	t				0.00	0.00	12.00
13. 00	and administrative services Contract Labor: Physician-Part		236, 423	0	236, 423	1, 882. 00	125. 62	13 00
	A - Administrative					·		
14. 00	Home office and/or related organization salaries and		C	0	0	0.00	0.00	14.00
14 01	wage-related costs		12 211 100		12 211 100	2/2 250 00	2/ 75	14. 01
14. 01 14. 02	Home office salaries Related organization salaries		13, 311, 189 C	0	13, 311, 189 0			
15. 00	Home office: Physician Part A Administrative	-	C	0	0	0.00	0. 00	15. 00
16. 00	Home office and Contract		C	0	О	0.00	0. 00	16. 00
16. 01	Physicians Part A - Teaching Home office Physicians Part A	_	C	0	0	0.00	0.00	16. 01
17 00	Teachi ng					0.00	0.00	14 0
16. 02	Home office contract Physicians Part A - Teaching	5		0		0.00	0.00	16. 02
17. 00	WAGE-RELATED COSTS Wage-related costs (core) (see		16, 548, 951	0	16, 548, 951			17. 00
	instructions)		10, 546, 751		10, 546, 951			
18. 00	Wage-related costs (other) (seinstructions)	e						18. 00
19.00	Excluded areas		3, 372, 388	0	3, 372, 388			19.00
20. 00	Non-physician anesthetist Part A		C	0	0			20.00
21. 00	Non-physician anesthetist Part		C	0	0			21. 00
22. 00	Physician Part A -		C	О	О			22. 00
22. 01	Administrative Physician Part A - Teaching		C	0	0			22. 01
23. 00	Physician Part B		1, 415, 732	Ö	1, 415, 732			23.00
24. 00 25. 00	Wage-related costs (RHC/FQHC) Interns & residents (in an		C	0	0			24. 00 25. 00
	approved program)		4 004 074		4 204 044			
25. 50 25. 51	Home office wage-related (core Related organization	)	4, 321, 961 C	0	4, 321, 961 0			25. 50 25. 51
	wage-related (core)							
25. 52	Home office: Physician Part A Administrative - wage-related		C		]			25. 52
25. 53	(core) Home office: Physicians Part A		^	_	_			25. 53
۷۵. ی	- Teaching - wage-related		·					20.00
	(core)			I	I		I	

| Peri od: | Worksheet S-3 | From 01/01/2023 | Part | I | To 12/31/2023 | Date/Time Prepared:

					1	0 12/31/2023	5/30/2024 3:4	
		Wkst. A Line	Amount	Reclassi fi cati	Adjusted	Pai d Hours	Average Hourly	
		Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from Wkst.	(col.2 ± col.	Salaries in	col . 5)	
				A-6)	3)	col. 4		
		1.00	2.00	3. 00	4. 00	5. 00	6. 00	
	OVERHEAD COSTS - DIRECT SALARII							
26.00	Employee Benefits Department	4. 00	-392, 931	801, 851	408, 920	28, 562. 00	14. 32	26. 00
27. 00	Administrative & General	5. 00	4, 870, 818	-801, 851	4, 068, 967	92, 019. 00	44. 22	27. 00
28. 00	Administrative & General under		1, 346, 701	0	1, 346, 701	8, 462. 00	159. 15	28. 00
	contract (see inst.)							
29. 00	Maintenance & Repairs	6. 00	2, 062, 403	0	2, 062, 403			29. 00
30.00	Operation of Plant	7. 00	361, 574	0	361, 574	22, 154. 00	16. 32	30.00
31. 00	Laundry & Linen Service	8. 00	0	0	0	0.00		31. 00
32.00	Housekeepi ng	9. 00	1, 982, 841	0	1, 982, 841	107, 663. 00	18. 42	32.00
33.00	Housekeeping under contract		0	0	0	0.00	0. 00	33.00
	(see instructions)							
34.00	Di etary	10. 00	1, 176, 951	-663, 234	513, 717	24, 326. 00	21. 12	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	663, 234	663, 234	31, 406. 00	21. 12	36.00
37.00	Maintenance of Personnel	12. 00	0	0	0	0.00	0. 00	37.00
38. 00	Nursing Administration	13. 00	2, 802, 259	0	2, 802, 259	48, 650. 00	57. 60	38. 00
39.00	Central Services and Supply	14. 00	469, 781	0	469, 781	17, 629. 00	26. 65	39. 00
40.00	Pharmacy	15. 00	2, 083, 852	114, 462	2, 198, 314	42, 074. 00	52. 25	40.00
41.00	Medical Records & Medical	16. 00	264, 666	0	264, 666	6, 611. 00	40. 03	41.00
	Records Library							
42.00	Social Service	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

Health Financial Systems FRANCISCAN HEALTH- DYER In Lieu of Form CMS-2552-10
HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0090 Period: From 01/01/2023 Part III

						o 12/31/2023	Date/Time Prep 5/30/2024 3:45	
		Worksheet A	Amount	Recl assi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Line Number	Reported	on of Salaries	Sal ari es	Related to	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 instructions	)	71, 386, 364	0	71, 386, 364	1, 709, 891. 00	41. 75	1.00
2.00	Excluded area salaries (see		13, 119, 237	-107, 947	13, 011, 290	254, 239. 00	51. 18	2.00
	instructions)							
3.00	Subtotal salaries (line 1 minu	5	58, 267, 127	107, 947	58, 375, 074	1, 455, 652. 00	40. 10	3.00
	line 2)							
4.00	Subtotal other wages & related		21, 089, 734	0	21, 089, 734	434, 344. 00	48. 56	4. 00
	costs (see inst.)							
5.00	Subtotal wage-related costs		20, 870, 912	0	20, 870, 912	0.00	35. 75	5. 00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		100, 227, 773	107, 947	100, 335, 720	1, 889, 996. 00	53. 09	6. 00
7.00	Total overhead cost (see		17, 028, 915	114, 462	17, 143, 377	469, 403. 00	36. 52	7. 00
	instructions)							

Health Financial Systems	FRANCISCAN HEALTH- DYER	In Lieu	u of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS		From 01/01/2023	Worksheet S-3 Part IV Date/Time Prepared

	To 12/31/2023	Date/Time Pre 5/30/2024 3:4	
		Amount	
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	2, 144, 512	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)	4, 947, 634	4. 00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5. 00
6.00	Legal /Accounting/Management Fees-Pension Plan	0	6. 00
7.00	Employee Managed Care Program Administration Fees	0	7. 00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8. 00
8. 01	Health Insurance (Self Funded without a Third Party Administrator)	0	8. 01
8. 02	Health Insurance (Self Funded with a Third Party Administrator)	7, 340, 154	8. 02
8. 03	Health Insurance (Purchased)	0	8. 03
9.00	Prescription Drug Plan	0	9. 00
10.00	Dental, Hearing and Vision Plan	270, 565	10. 00
11. 00	Life Insurance (If employee is owner or beneficiary)	29, 248	11. 00
12. 00	Accident Insurance (If employee is owner or beneficiary)	0	12. 00
13. 00	Disability Insurance (If employee is owner or beneficiary)	293, 826	13. 00
14. 00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14. 00
15. 00	'Workers' Compensation Insurance	1, 101, 174	
16. 00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16. 00
	Noncumulative portion)		
	TAXES		
	FICA-Employers Portion Only	5, 209, 958	
18. 00	Medicare Taxes - Employers Portion Only	0	18. 00
19. 00	Unemployment Insurance	0	19. 00
20. 00	State or Federal Unemployment Taxes	0	20. 00
	OTHER		
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see	0	21. 00
	<pre>instructions))</pre>		
22. 00	Day Care Cost and Allowances	0	22. 00
23. 00	Tuition Reimbursement	0	23. 00
24. 00	Total Wage Related cost (Sum of lines 1 -23)	21, 337, 071	24. 00
	Part B - Other than Core Related Cost		
25. 00	OTHER WAGE RELATED COSTS (SPECIFY)		25. 00

Heal th	Financial Systems	FRANCISCAN HEALTH- DYER	In Lie	u of Form CMS-	2552-10
HOSPI T	AL CONTRACT LABOR AND BENEFIT COST	Provi der CCN: 15-0090	Peri od: From 01/01/2023		
			To 12/31/2023	Date/Time Pre 5/30/2024 3:4	
	Cost Center Description		Contract Labor	Benefit Cost	
			1. 00	2. 00	
	PART V - Contract Labor and Benefit	Cost			
	Hospital and Hospital-Based Componer	t Identification:			
1.00	Total facility's contract labor and	benefit cost	8, 205, 671	21, 337, 071	1. 00
2.00	Hospi tal		8, 205, 671	21, 337, 071	2. 00
3.00	SUBPROVI DER - I PF				3. 00
4.00	SUBPROVI DER - I RF		0	0	4. 00
5.00	Subprovider - (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	SKILLED NURSING FACILITY				8. 00
9.00	NURSING FACILITY				9. 00
10.00	OTHER LONG TERM CARE I				10.00
11.00	Hospi tal -Based HHA		0	0	11. 00
12.00	AMBULATORY SURGICAL CENTER (D.P.) I				12. 00
12 00	Hanni tal Danad Hanni an				12 00

13.00 14. 00 15.00 16.00 17. 00 0 18. 00

13.00 | AMBULATORY SURGICAL CENTER (D.P.)
13.00 | Hospital - Based Hospice
14.00 | Hospital - Based Health Clinic RHC
15.00 | Hospital - Based Health Clinic FOHC
16.00 | Hospital - Based - CMHC
17.00 | RENAL DIALYSIS I
18.00 | Other

Heal th	Financial Systems	FRANCISCAN HE	ALTH- DYER		In Li€	eu of Form CMS-2	2552-10
HOME H	IEALTH AGENCY STATISTICAL DATA		Provi der Co		Peri od: From 01/01/2023	Worksheet S-4	
			Component		To 12/31/2023		pared: 5 pm
					Home Health Agency I	PPS	<u>o p</u>
						00	
0. 00	County						0.00
		Title V 1.00	Title XVIII 2.00	Title XIX 3.00	0ther 4.00	Total 5.00	
	HOME HEALTH AGENCY STATISTICAL DATA	1.00					
1. 00 2. 00	Home Health Aide Hours Unduplicated Census Count (see instructions)	0.00	38, 945 1, 365. 00				
2.00	onadpredict consus count (see Tristractions)	0.00	1, 303. 00		oloyees (Full Ti		2.00
				01.00	1		
		Enter the number		Staff	Contract	Total	
	HOME HEALTH ACENCY NUMBER OF EMPLOYEES	0		1.00	2. 00	3. 00	
3.00	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES Administrator and Assistant Administrator(s)		0.00	0.0	0 0.13		
4. 00 5. 00	Director(s) and Assistant Director(s) Other Administrative Personnel			0. 5 21. 4		l .	
6.00	Direct Nursing Service			7.5			1
7.00	Nursi ng Supervi sor			3.0			
8. 00 9. 00	Physical Therapy Service Physical Therapy Supervisor			0. 0 0. 0		l .	1
10.00	Occupational Therapy Service			0.8	7 0. 40	1. 27	10. 00
11. 00 12. 00	Occupational Therapy Supervisor Speech Pathology Service			0. 6 0. 0		l .	11. 00 12. 00
13. 00	Speech Pathology Supervisor			0.0		l .	13. 00
14. 00 15. 00	Medical Social Service Medical Social Service Supervisor			0. 0 0. 0			1
16. 00	Home Heal th Aide			0.0			
17. 00	Home Heal th Ai de Supervi sor			0.0			
18. 00	PTA - PHYSI CAL THERAPY ASSI STANT			0.0	0. 54	0.54 CBSA Data	18. 00
	HOME HEALTH AGENCY CBSA CODES					1.00	
19. 00	Enter in column 1 the number of CBSAs where	you provided sei	rvices during	the cost repo	rting period.	5	19. 00
20. 00	List those CBSA code(s) in column 1 serviced first code).	during this cos	st reporting p	eriod (line 2	o contains the	16984	20. 00
20. 01	in st code).					23844	20. 01
20. 02 20. 03						33140 43780	20. 02 20. 03
20. 04						99915	20. 03
		Full Ep Without	isodes With Outliers	 	PEP Only	Total (cols.	
		Outliers			Epi sodes	1-4)	
	PPS ACTIVITY DATA	1.00	2. 00	3. 00	4. 00	5. 00	
21. 00	Skilled Nursing Visits	8, 515	1, 409				
22. 00 23. 00	Skilled Nursing Visit Charges Physical Therapy Visits	3, 397, 485 8, 937	562, 191 1, 552				1
24.00	Physical Therapy Visit Charges	3, 699, 918	642, 528	32, 70		4, 385, 502	24. 00
25. 00 26. 00	Occupational Therapy Visits Occupational Therapy Visit Charges	985 407, 790	817 338, 238		6 2 4 828	1, 810 749, 340	
27. 00	Speech Pathology Visits	108	70		0 0		1
28. 00 29. 00	Speech Pathology Visit Charges Medical Social Service Visits	44, 712	28, 980		0 0 1	73, 692 15	
30. 00	Medical Social Service Visits  Medical Social Service Visit Charges	3, 360	3, 360		0 480		
31.00	Home Health Aide Visits	744	304		3 0		1
32. 00 33. 00	Home Health Aide Visit Charges Total visits (sum of lines 21, 23, 25, 27,	143, 592 19, 296	58, 672 4, 159				1
	29, and 31)		0		0		
34. 00 35. 00	Other Charges Total Charges (sum of lines 22, 24, 26, 28,	7, 696, 857	1, 633, 969		-	9, 472, 816	34. 00 35. 00
	30, 32, and 34) Total Number of Episodes (standard/non						
36. 00	outlier)	2, 426		19	6 8		
37. 00 38. 00	Total Number of Outlier Episodes Total Non-Routine Medical Supply Charges	122, 745	230 22, 620		1 0 110		37. 00 38. 00
50.00	Trotal Non-Noutrine Medical Supply Charges	122, /45	22, 020	1 2, 28	ο <sub>1</sub> 110	147,700	1 30.00

PART Uncom	I - HOSPITAL AND HOSPITAL COMPLEX DATA  Inpensated and Indigent Care Cost-to-Charge Ratio to charge ratio (see instructions) caid (see instructions for each line) revenue from Medicaid you receive DSH or supplemental payments from Medicaid? ine 3 is yes, does line 2 include all DSH and/or supplementatine 4 is no, then enter DSH and/or supplemental payments from the following of	see instructions for each lines see instructions for uded on lines program (Note)	s from Medica d ctions) ctions) or each line) nes 2, 5 or 9 lot included	)	Date/Ti me Prep 5/30/2024 3: 4: 1.00    0.236961   25,155,717   0   140,359,693   33,259,773   8,104,056   0   0   0   0   0   0   0   0   0	2. (3. (4. (6. (6. (6. (6. (6. (6. (6. (6. (6. (6		
.00   Cost   Medic   .00   Net   .00   Net   .00   If   Ii   .00   Medic   .00   Medic   .00   Medic   .00   Net   .00   Stand   .00   Stand   .00   Stand   .00   Other   .00   Stand   .00   Stand   .00   Other   .00   Stand   .00   Other   .00   Stand   .00   Stand   .00   Other   .00   Stand   .00   Stand   .00   Stand   .00   Other   .00   Stand   .00   Stand	to charge ratio (see instructions) aid (see instructions for each line) revenue from Medicaid you receive DSH or supplemental payments from Medicaid? ine 3 is yes, does line 2 include all DSH and/or supplemental ine 4 is no, then enter DSH and/or supplemental payments fro caid charges caid cost (line 1 times line 6) erence between net revenue and costs for Medicaid program (stern's Health Insurance Program (CHIP) (see instructions for revenue from stand-alone CHIP d-alone CHIP cost (line 1 times line 10) erence between net revenue and costs for stand-alone CHIP (see state or local government indigent care program (see instructions ges for patients covered under state or local indigent care e or local indigent care program cost (line 1 times line 14) erence between net revenue and costs for state or local indigent care	see instructions for each lines see instructions for uded on lines program (Note)	etions) etions) erions) erions) erions in each line) ess 2, 5 or 9 dot included	)	0. 236961 25, 155, 717 0 140, 359, 693 33, 259, 773 8, 104, 056 0 0 0	2. ( 3. ( 4. ( 5. ( 6. ( 7. ( 8. ( 9. ( 10. ( 11. ( 12. ( 13. ( 13. ( 14. ( 15. ( 16. ( 16		
.00   Cost   Medic   .00   Net   .00   Net   .00   If   Ii   .00   Medic   .00   Medic   .00   Medic   .00   Net   .00   Stand   .00   Stand   .00   Stand   .00   Other   .00   Stand   .00   Stand   .00   Other   .00   Stand   .00   Other   .00   Stand   .00   Stand   .00   Other   .00   Stand   .00   Stand   .00   Stand   .00   Other   .00   Stand   .00   Stand	to charge ratio (see instructions) aid (see instructions for each line) revenue from Medicaid you receive DSH or supplemental payments from Medicaid? ine 3 is yes, does line 2 include all DSH and/or supplemental ine 4 is no, then enter DSH and/or supplemental payments fro caid charges caid cost (line 1 times line 6) erence between net revenue and costs for Medicaid program (stern's Health Insurance Program (CHIP) (see instructions for revenue from stand-alone CHIP d-alone CHIP cost (line 1 times line 10) erence between net revenue and costs for stand-alone CHIP (see state or local government indigent care program (see instructions ges for patients covered under state or local indigent care e or local indigent care program cost (line 1 times line 14) erence between net revenue and costs for state or local indigent care	see instructions for each lines see instructions for uded on lines program (Note)	etions) etions) erions) erions) erions in each line) ess 2, 5 or 9 dot included	)	0. 236961 25, 155, 717 0 140, 359, 693 33, 259, 773 8, 104, 056 0 0 0	2. ( 3. ( 4. ( 5. ( 6. ( 7. ( 8. ( 9. ( 10. ( 11. ( 12. ( 13. ( 13. ( 14. ( 15. ( 16. ( 16		
.00   Cost   Medic   .00   Net   .00   Did   .00   If   Ii   .00   Medic   .00   Medic   .00   Medic   .00   Net   .00   Stand   .00   Stand   .00   Other   3.00   Net   4.00   Charg   5.00   State   6.00   Diffe   Grant   instr	to charge ratio (see instructions) caid (see instructions for each line) revenue from Medicaid you receive DSH or supplemental payments from Medicaid? ine 3 is yes, does line 2 include all DSH and/or supplementatine 4 is no, then enter DSH and/or supplemental payments from the first ocal cost (line 1 times line 6) erence between net revenue and costs for Medicaid program (stern's Health Insurance Program (CHIP) (see instructions for revenue from stand-alone CHIP d-alone CHIP charges d-alone CHIP cost (line 1 times line 10) erence between net revenue and costs for stand-alone CHIP (see instructions for revenue from state or local indigent care program (Not incluges for patients covered under state or local indigent care et or local indigent care program cost (line 1 times line 14) erence between net revenue and costs for state or local indigent care program cost (line 1 times line 14)	see instructions for each lines see instructions for uded on lines program (Note)	etions) etions) erions) erions) erions in each line) ess 2, 5 or 9 dot included	)	25, 155, 717  0 140, 359, 693 33, 259, 773 8, 104, 056  0 0 0 0 0 0	2. ( 3. ( 4. ( 5. ( 6. ( 7. ( 8. ( 9. ( 10. ( 11. ( 12. ( 13. ( 13. ( 14. ( 15. ( 16. ( 16		
Medic   OO   Net   I   OO   Did   S   OO   If   Ii   OO   Medic   OO   Diffe   Chilo   OO   Stand   OO   Stand   OO   Stand   OO   Stand   OO   OO   Stand   OO   OO   Stand   OO   OO   Stand   OO   OO   OO   OO   OO   OO   OO   O	caid (see instructions for each line) revenue from Medicaid you receive DSH or supplemental payments from Medicaid? ine 3 is yes, does line 2 include all DSH and/or supplementation ine 4 is no, then enter DSH and/or supplemental payments from ine 4 is no, then enter DSH and/or supplemental payments from ine 4 is no, then enter DSH and/or supplemental payments from ine 4 is no, then enter DSH and/or supplemental payments from ine 4 is no.  Caid charges Caid cost (line 1 times line 6) Berence between net revenue and costs for Medicaid program (stren's Health Insurance Program (CHIP) (see instructions for revenue from stand-alone CHIP Called and the cost (line 1 times line 10) Berence between net revenue and costs for stand-alone CHIP (see instructions)  Called a	see instructions for each lines see instructions for uded on lines program (Note)	etions) etions) erions) erions) erions in each line) ess 2, 5 or 9 dot included	)	25, 155, 717  0 140, 359, 693 33, 259, 773 8, 104, 056  0 0 0 0 0 0	2. ( 3. ( 4. ( 5. ( 6. ( 7. ( 8. ( 9. ( 10. ( 11. ( 12. ( 13. ( 13. ( 14. ( 15. ( 16. ( 16		
. 00 Net 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	revenue from Medicaid you receive DSH or supplemental payments from Medicaid? ine 3 is yes, does line 2 include all DSH and/or supplementatine 4 is no, then enter DSH and/or supplemental payments from aid charges caid cost (line 1 times line 6) erence between net revenue and costs for Medicaid program (starting from the stand-alone CHIP) (see instructions for revenue from stand-alone CHIP) d-alone CHIP charges d-alone CHIP cost (line 1 times line 10) erence between net revenue and costs for stand-alone CHIP (see instructions for state or local government indigent care program (see instructions for state or local indigent care program (see instructions for state or local indigent care et a indigent care program (see instructions).	see instructions for each lines see instructions for uded on lines program (Note)	etions) etions) erions) erions) erions in each line) ess 2, 5 or 9 dot included	)	0 140, 359, 693 33, 259, 773 8, 104, 056 0 0 0 0	3. (4. (6. (6. (6. (6. (6. (6. (6. (6. (6. (6		
.00 Did 1	you receive DSH or supplemental payments from Medicaid? ine 3 is yes, does line 2 include all DSH and/or supplementatine 4 is no, then enter DSH and/or supplemental payments from the following of the supplemental payments from the following of	see instructions for each lines see instructions for uded on lines program (Note)	etions) etions) erions) erions) erions in each line) ess 2, 5 or 9 dot included	)	0 140, 359, 693 33, 259, 773 8, 104, 056 0 0 0 0	3. (4. (6. (6. (6. (6. (6. (6. (6. (6. (6. (6		
.00	ine 3 is yes, does line 2 include all DSH and/or supplementations 4 is no, then enter DSH and/or supplemental payments from the second cost (line 1 times line 6) erence between net revenue and costs for Medicaid program (gren's Health Insurance Program (CHIP) (see instructions for revenue from stand-alone CHIP dealone CHIP charges dealone CHIP cost (line 1 times line 10) erence between net revenue and costs for stand-alone CHIP (see instructions for state or local government indigent care program (see instructions for patients covered under state or local indigent care ere or local indigent care program cost (line 1 times line 14) erence between net revenue and costs for state or local indigent care program cost (line 1 times line 14) erence between net revenue and costs for state or local indigent care	see instructions for each lines see instructions for uded on lines program (Note)	etions) etions) erions) erions) erions in each line) ess 2, 5 or 9 dot included	)	140, 359, 693 33, 259, 773 8, 104, 056 0 0 0 0	4. ( 5. ( 6. ( 7. ( 8. ( 9. ( 10. ( 11. ( 12. ( 13. ( 13. ( 13. ( 13. ( 13. ( 13. ( 14. ( 15. (		
.00	ine 4 is no, then enter DSH and/or supplemental payments from caid charges caid cost (line 1 times line 6) because the cost (line 1 times line 6) because the cost of the cost	see instructions for each lines see instructions for uded on lines program (Note)	etions) etions) erions) erions) erions in each line) ess 2, 5 or 9 dot included	)	140, 359, 693 33, 259, 773 8, 104, 056 0 0 0 0	5. (6. (6. (7. (6. (6. (6. (6. (6. (6. (6. (6. (6. (6		
. 00 Medic . 00 Medic . 00 Diffe Chilo . 00 Net I 0. 00 Stand 2. 00 Diffe Other 3. 00 Net I 4. 00 Charg 5. 00 Stand 6. 00 Diffe Grant instr	caid charges caid cost (line 1 times line 6) erence between net revenue and costs for Medicaid program (sizen's Health Insurance Program (CHIP) (see instructions for erevenue from stand-alone CHIP d-alone CHIP charges d-alone CHIP cost (line 1 times line 10) erence between net revenue and costs for stand-alone CHIP (see instructions for erevenue from state or local indigent care program (see instructions) erevenue from state or local indigent care program (Not includes for patients covered under state or local indigent care e or local indigent care program cost (line 1 times line 14) erence between net revenue and costs for state or local indigent	see instruc r each line see instruc ructions fo uded on lir program (N ) igent care	etions) etions) or each line) nes 2, 5 or 9 lot included		140, 359, 693 33, 259, 773 8, 104, 056 0 0 0 0	6. 6. 6. 6. 6. 6. 6. 6. 6. 6. 6. 6. 6. 6		
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. 00 Diffe Chilo . 00 Net I 0. 00 Stand 2. 00 Diffe Other 3. 00 Net I 4. 00 Charg 5. 00 State 6. 00 Diffe Grant instr	erence between net revenue and costs for Medicaid program (stern's Health Insurance Program (CHIP) (see instructions for revenue from stand-alone CHIP d-alone CHIP charges d-alone CHIP cost (line 1 times line 10) erence between net revenue and costs for stand-alone CHIP (state or local government indigent care program (see instructione) from state or local indigent care program (Not includes for patients covered under state or local indigent care eror local indigent care program cost (line 1 times line 14) erence between net revenue and costs for state or local indigent care	r each line see instruc ructions fo uded on lir program (N ) igent care	etions) or each line) nes 2, 5 or 9 lot included		8, 104, 056 0 0 0 0 0	8. ( 9. ( 10. ( 11. ( 12. ( 13. (		
Child OO Net 1 OO Stand 1.00 Stand 2.00 Diffe Other 3.00 Net 1 4.00 Charg 5.00 State 6.00 Diffe Grant i nstr	dren's Health Insurance Program (CHIP) (see instructions for revenue from stand-alone CHIP d-alone CHIP charges d-alone CHIP cost (line 1 times line 10) erence between net revenue and costs for stand-alone CHIP (see state or local government indigent care program (see instruction from state or local indigent care program (Not includes for patients covered under state or local indigent care eror local indigent care between net revenue and costs for state or local indigent care between net revenue and costs for state or local indigent care indigents.	r each line see instruc ructions fo uded on lir program (N ) igent care	etions) or each line) nes 2, 5 or 9 lot included		0 0 0 0	9. ( ) 10. ( ) 11. ( ) 12. (		
. 00 Net r 0. 00 Stand 1. 00 Stand 2. 00 Diffe Other 3. 00 Net r 4. 00 Charg 5. 00 State 6. 00 Diffe Grant i nstr	revenue from stand-alone CHIP d-alone CHIP charges d-alone CHIP cost (line 1 times line 10) erence between net revenue and costs for stand-alone CHIP (sometimes of the state or local government indigent care program (see institute of the state or local indigent care program (Not includes for patients covered under state or local indigent care et or local indigent care between net revenue and costs for state or local indigent care program cost (line 1 times line 14)	see instruc ructions fo uded on lir program (M ) igent care	ctions) or each line) nes 2, 5 or 9 Not included		0 0 0	10. (0) 11. (0) 12. (0)		
1. 00 Stand 2. 00 Di ffe Other 3. 00 Net 1 4. 00 Charg 5. 00 State 6. 00 Di ffe Grant i nstr	d-alone CHIP cost (line 1 times line 10) erence between net revenue and costs for stand-alone CHIP (see state or local government indigent care program (see instruevenue from state or local indigent care program (Not includes for patients covered under state or local indigent care e or local indigent care program cost (line 1 times line 14) erence between net revenue and costs for state or local indigent	ructions fo uded on lir program (N ) igent care	or each line) nes 2, 5 or 9 Not included		0 0	11. ( ) 12. ( ) 13. (		
1. 00 Stand 2. 00 Di ffe Other 3. 00 Net 1 4. 00 Charg 5. 00 State 6. 00 Di ffe Grant i nstr	d-alone CHIP cost (line 1 times line 10) erence between net revenue and costs for stand-alone CHIP (see state or local government indigent care program (see instruevenue from state or local indigent care program (Not includes for patients covered under state or local indigent care e or local indigent care program cost (line 1 times line 14) erence between net revenue and costs for state or local indigent	ructions fo uded on lir program (N ) igent care	or each line) nes 2, 5 or 9 Not included		0 0 0	12.0		
0ther 3.00 Net i 4.00 Charg 5.00 State 6.00 Diffe Grant i nstr	r state or local government indigent care program (see instruction from state or local indigent care program (Not includes for patients covered under state or local indigent care e or local indigent care program cost (line 1 times line 14) erence between net revenue and costs for state or local indigent care.	ructions fo uded on lir program (N ) igent care	or each line) nes 2, 5 or 9 Not included		0	13. (		
3.00 Net r 4.00 Charg 5.00 State 6.00 Diffe Grant instr	revenue from state or local indigent care program (Not incluges for patients covered under state or local indigent care or local indigent care or local indigent care program cost (line 1 times line 14) erence between net revenue and costs for state or local indi	uded on lir program (N ) igent care	nes 2, 5 or 9 Not included		)) 0			
4.00 Charg 5.00 State 6.00 Diffe Grant instr	ges for patients covered under state or local indigent care e or local indigent care program cost (line 1 times line 14 erence between net revenue and costs for state or local indi	program (N ) igent care	lot included		)) 0			
5.00 State 6.00 Diffe Grant instr	e or local indigent care program cost (line 1 times line 14 erence between net revenue and costs for state or local indi	) igent care		in lines 6 or 10	1			
6.00 Diffe Grant instr	erence between net revenue and costs for state or local indi	igent care			0			
Grant i nstr								
instr	is, donations and total unierinbursed cost for medicard, chir				0	16. 0		
	ructions for each line)	r and State	:/Tucal Illuly	ent care program	is (see			
7. 00   Pri va	ate grants, donations, or endowment income restricted to fu	ndi ng chari	tv care		0	17. 0		
1	rnment grants, appropriations or transfers for support of ho	-	-		0	18.0		
	I unreimbursed cost for Medicaid , CHIP and state and local nd 16)	indigent o	care programs	(sum of lines 8	8, 104, 056	19. (		
			Uni nsured	Insured	Total (col. 1			
		-	pati ents	pati ents	+ col . 2)	_		
Uncon	npensated care cost (see instructions for each line)		1. 00	2. 00	3. 00			
	ity care charges and uninsured discounts (see instructions)	T	10, 155, 09	2, 996, 594	13, 151, 688	20.0		
	of patients approved for charity care and uninsured discour	nts (see	2, 406, 36			1		
	ructions)	(11)	,	,				
2.00 Payme	ents received from patients for amounts previously written o	off as		0	0	22.0		
	ity care of charity care (see instructions)		2, 406, 36	2, 996, 594	5, 402, 955	22 (		
3.00   0031	or charry care (see riistructions)		2, 400, 30	2, 770, 374	5, 402, 755	23. 0		
					1. 00			
	the amount on line 20 col. 2, include charges for patient of		d a Length of	stay limit	N	24. 0		
	sed on patients covered by Medicaid or other indigent care pine 24 is yes, enter the charges for patient days beyond the t		care program	's length of sta	ay O	25. 0		
5. 01   Char	ges for insured patients' liability (see instructions)				0	25. (		
	debt amount (see instructions)				4, 548, 715			
	care reimbursable bad debts (see instructions)				290, 029			
	care allowable bad debts (see instructions)				446, 198			
8.00   Non-M	Medicare bad debt amount (see instructions)				4, 102, 517			
						1 00		
9.00 Cost	of non-Medicare and non-reimbursable Medicare bad debt amount of uncompensated care (line 23, col. 3, plus line 29)	unts (see i	nstructi ons)		1, 128, 306 6, 531, 261			

JULI 1741	Financial Systems FRANCISCAN HEALTH- L UNCOMPENSATED AND INDIGENT CARE DATA Pr	rovider CCN	l: 15-0090	Peri od:	u of Form CMS-2 Worksheet S-1		
	2 Grootill Eriottes this Theodetti Gritte Britis		. 10 0070	From 01/01/2023 To 12/31/2023	Parts I & II Date/Time Pre 5/30/2024 3:4	pare	
					1. 00		
	ART II - HOSPITAL DATA						
	Incompensated and Indigent Care Cost-to-Charge Ratio						
	Cost to charge ratio (see instructions)				0. 218578	1.	
	Medicaid (see instructions for each line)					,	
	Net revenue from Medicaid Did you receive DSH or supplemental payments from Medicaid?					3.	
	If line 3 is yes, does line 2 include all DSH and/or supplementa	l navments	from Medica	ai d?		4	
	If line 4 is no, then enter DSH and/or supplemental payments from	1 3				5	
00 Medicaid charges							
00 N	Medicaid cost (line 1 times line 6)						
Difference between net revenue and costs for Medicaid program (see instructions)							
	children's Health Insurance Program (CHIP) (see instructions for	each line	)				
	Net revenue from stand-alone CHIP					9.	
	Stand-alone CHIP charges Stand-alone CHIP cost (line 1 times line 10)					10 11	
	Difference between net revenue and costs for stand-alone CHIP (s	ee instruc	tions)			12	
	Other state or local government indigent care program (see instru					'-	
	Net revenue from state or local indigent care program (Not inclu					13	
	Charges for patients covered under state or local indigent care				))	14	
	State or local indigent care program cost (line 1 times line 14)					15	
	Difference between net revenue and costs for state or local indi					16	
	Grants, donations and total unreimbursed cost for Medicaid, CHIP	and state	/local indio	jent care progran	ıs (see		
	nstructions for each line) Private grants, donations, or endowment income restricted to fun-	dina chari	ty care			1 17	
- 1	Government grants, appropriations or transfers for support of ho	0	,			18	
	Total unreimbursed cost for Medicaid , CHIP and state and local			s (sum of lines 8	<b>3</b> .	19	
	12 and 16)	3	. 3	•		l	
j i							
[ .			Uni nsured	Insured	Total (col. 1		
			pati ents	pati ents	+ col . 2)		
·	Incommensated care cost (see instructions for each line)				•		
U	Incompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instructions)		pati ents 1.00	patients 2.00	+ col . 2) 3.00	20	
00 0	Incompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instructions) Cost of patients approved for charity care and uninsured discoun	ts (see	pati ents	pati ents 2.00 56 2,983,695	+ col . 2) 3.00		
00 C	Charity care charges and uninsured discounts (see instructions)	ts (see	pati ents 1.00	pati ents 2.00 56 2,983,695	+ col . 2) 3.00		
00 C 00 C i 00 F	Charity care charges and uninsured discounts (see instructions) Cost of patients approved for charity care and uninsured discoun Instructions) Payments received from patients for amounts previously written o	`	pati ents 1.00	pati ents 2.00 56 2,983,695	+ col . 2) 3.00	21	
00 C 00 C i	Charity care charges and uninsured discounts (see instructions) Cost of patients approved for charity care and uninsured discoun nstructions) Payments received from patients for amounts previously written ocharity care	`	pati ents 1.00 10, 113, 00 2, 210, 40	pati ents 2.00 56 2,983,695 2,983,695 0 0	+ col · 2) 3.00 13,096,751 5,194,187	21	
00 C 00 C i 00 F	Charity care charges and uninsured discounts (see instructions) Cost of patients approved for charity care and uninsured discoun Instructions) Payments received from patients for amounts previously written o	`	pati ents 1.00	pati ents 2.00 56 2,983,695 2,983,695 0 0	+ col · 2) 3.00 13,096,751 5,194,187	21	
00 C 00 C i 00 F	Charity care charges and uninsured discounts (see instructions) Cost of patients approved for charity care and uninsured discoun nstructions) Payments received from patients for amounts previously written ocharity care	`	pati ents 1.00 10, 113, 00 2, 210, 40	pati ents 2.00 56 2,983,695 2,983,695 0 0	+ col · 2) 3.00 13,096,751 5,194,187 0 5,194,187	21	
00 C 00 C i 00 F	Charity care charges and uninsured discounts (see instructions) Cost of patients approved for charity care and uninsured discoun nstructions) Payments received from patients for amounts previously written o charity care Cost of charity care (see instructions)	ff as	pati ents 1. 00 10, 113, 09 2, 210, 49 2, 210, 49	pati ents 2.00  56 2,983,695 2,983,695 0 0 22 2,983,695	+ col · 2) 3.00 13,096,751 5,194,187 0 5,194,187	21 22 23	
00 C 00 C 00 C 00 C	Charity care charges and uninsured discounts (see instructions) Cost of patients approved for charity care and uninsured discoun nstructions) Payments received from patients for amounts previously written ocharity care	ff as	pati ents 1. 00 10, 113, 09 2, 210, 49 2, 210, 49	pati ents 2.00  56 2,983,695 2,983,695 0 0 22 2,983,695	+ col · 2) 3.00 13,096,751 5,194,187 0 5,194,187	21 22 23	
00 C 00 C 00 C i 00 F 00 C	Charity care charges and uninsured discounts (see instructions) Cost of patients approved for charity care and uninsured discoun nstructions) Payments received from patients for amounts previously written or charity care Cost of charity care (see instructions)  Does the amount on line 20 col. 2, include charges for patient di mposed on patients covered by Medicaid or other indigent care p fline 24 is yes, enter the charges for patient days beyond the imit	ff as  ays beyond rogram?	patients 1.00  10, 113, 00 2, 210, 40  2, 210, 40  a Length of	pati ents 2.00  66 2,983,695 0 0 02 2,983,695  = stay limit	+ col · 2) 3.00  13,096,751 5,194,187  0 5,194,187  1.00  N	21 22 23 24 25	
00 C 00 C 00 C 00 C 00 C	Charity care charges and uninsured discounts (see instructions) Cost of patients approved for charity care and uninsured discoun nstructions) Payments received from patients for amounts previously written or charity care Cost of charity care (see instructions)  Does the amount on line 20 col. 2, include charges for patient dimposed on patients covered by Medicaid or other indigent care provided in the patient of the charges for patient days beyond the imit charges for insured patients' liability (see instructions)	ff as  ays beyond rogram?	patients 1.00  10, 113, 00 2, 210, 40  2, 210, 40  a Length of	pati ents 2.00  66 2,983,695 0 0 02 2,983,695  = stay limit	+ col · 2) 3.00  13,096,751 5,194,187  0 5,194,187  1.00  N	21 22 23 24 25 25	
. 00 C C C C C C C C C C C C C C C C C C	Charity care charges and uninsured discounts (see instructions) Cost of patients approved for charity care and uninsured discoun nstructions) Payments received from patients for amounts previously written or charity care Cost of charity care (see instructions)  Does the amount on line 20 col. 2, include charges for patient domposed on patients covered by Medicaid or other indigent care patient in the charges for patient days beyond the imit charges for insured patients' liability (see instructions)  Bad debt amount (see instructions)	ff as  ays beyond rogram?	patients 1.00  10, 113, 00 2, 210, 40  2, 210, 40  a Length of	pati ents 2.00  66 2,983,695 0 0 02 2,983,695  = stay limit	+ col. 2) 3.00  13,096,751 5,194,187  0 5,194,187  1.00 N  ay 0 4,517,688	21 22 23 24 25 25 26	
. 00 C C C C C C C C C C C C C C C C C C	Charity care charges and uninsured discounts (see instructions) Cost of patients approved for charity care and uninsured discount nstructions) Payments received from patients for amounts previously written of charity care Cost of charity care (see instructions)  Does the amount on line 20 col. 2, include charges for patient do mposed on patients covered by Medicaid or other indigent care patient in the charges for patient days beyond the imit charges for insured patients' liability (see instructions)  Bad debt amount (see instructions)  Medicare reimbursable bad debts (see instructions)	ff as  ays beyond rogram?	patients 1.00  10, 113, 00 2, 210, 40  2, 210, 40  a Length of	pati ents 2.00  66 2,983,695 0 0 02 2,983,695  = stay limit	+ col. 2) 3.00  13,096,751 5,194,187  0 5,194,187  1.00 N  ay 0 4,517,688 290,029	21 22 23 24 25 25 26 27	
. 00 C C C C C C C C C C C C C C C C C C	Charity care charges and uninsured discounts (see instructions) Cost of patients approved for charity care and uninsured discounnstructions) Payments received from patients for amounts previously written or charity care Cost of charity care (see instructions)  Does the amount on line 20 col. 2, include charges for patient domposed on patients covered by Medicaid or other indigent care public limit Charges for insured patients' liability (see instructions)  Bad debt amount (see instructions)  Medicare reimbursable bad debts (see instructions)  Medicare allowable bad debts (see instructions)	ff as  ays beyond rogram?	patients 1.00  10, 113, 00 2, 210, 40  2, 210, 40  a Length of	pati ents 2.00  66 2,983,695 0 0 02 2,983,695  = stay limit	+ col · 2) 3.00  13,096,751 5,194,187  0 5,194,187  1.00 N  1,517,688 290,029 446,198	21 22 23 24 25 25 26 27 27	
. 00 C C C C C C C C C C C C C C C C C C	Charity care charges and uninsured discounts (see instructions) Cost of patients approved for charity care and uninsured discoun nstructions) Payments received from patients for amounts previously written or charity care Cost of charity care (see instructions)  Does the amount on line 20 col. 2, include charges for patient downwood on patients covered by Medicaid or other indigent care purely fline 24 is yes, enter the charges for patient days beyond the imit Charges for insured patients' liability (see instructions) Bad debt amount (see instructions) Medicare reimbursable bad debts (see instructions) Medicare allowable bad debts (see instructions) Mon-Medicare bad debt amount (see instructions)	ays beyond rogram? indigent	patients 1.00  10,113,0 2,210,44  2,210,44  a Length of care program	patients 2.00  66 2,983,695 0 0 22 2,983,695  F stay limit o's length of sta	+ col · 2) 3.00  13,096,751 5,194,187  0 5,194,187  1.00  N  1y 0 4,517,688 290,029 446,198 4,071,490	21 22 23 24 25 25 26 27 27 27 28	
D. 00 C C C C C C C C C C C C C C C C C C	Charity care charges and uninsured discounts (see instructions) Cost of patients approved for charity care and uninsured discounnstructions) Payments received from patients for amounts previously written or charity care Cost of charity care (see instructions)  Does the amount on line 20 col. 2, include charges for patient domposed on patients covered by Medicaid or other indigent care public limit Charges for insured patients' liability (see instructions)  Bad debt amount (see instructions)  Medicare reimbursable bad debts (see instructions)  Medicare allowable bad debts (see instructions)	ays beyond rogram? indigent	patients 1.00  10,113,0 2,210,44  2,210,44  a Length of care program	patients 2.00  66 2,983,695 0 0 22 2,983,695  F stay limit o's length of sta	+ col · 2) 3.00  13,096,751 5,194,187  0 5,194,187  1.00 N  1,517,688 290,029 446,198	21 22 23 24 25 25 26 27 27 28 29	

	FINANCIAI SYSTEMS	FRANCISCAN HEAD		N. 15 0000 I		Workshoot A	2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der CC		Period: From 01/01/2023 To 12/31/2023	Worksheet A  Date/Time Pre	pared:
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	5/30/2024 3:4 Reclassified Trial Balance	5 pm
						(col. 3 +- col. 4)	
		1.00	2. 00	3.00	4. 00	5. 00	
1 00	GENERAL SERVICE COST CENTERS		0		7 070 027	7 070 027	1 00
1. 00 2. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP		0		7, 079, 937 4, 544, 448	7, 079, 937 4, 544, 448	1. 00 2. 00
3.00	00300 OTHER CAP REL COSTS		0	· ·	0	0	3. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-392, 931	19, 446, 342 45, 637, 320	19, 053, 41		19, 843, 278	4.00
5. 04 6. 00	00593 OTHER ADMINISTRATIVE AND GENERAL 00600 MAINTENANCE & REPAIRS	4, 870, 818 2, 062, 403	7, 449, 913	50, 508, 138 9, 512, 316		47, 563, 818 6, 769, 253	
7. 00	00700 OPERATION OF PLANT	361, 574	4, 420, 884	4, 782, 458	-2, 152, 906	2, 629, 552	7. 00
8. 00 9. 00	OO800   LAUNDRY & LINEN SERVICE   OO900   HOUSEKEEPING	0 1, 982, 841	642, 351 417, 231	642, 35° 2, 400, 07°		642, 351 2, 392, 102	
10.00	01000 DI ETARY	1, 176, 951	1, 174, 006			1, 021, 191	
11. 00	01100 CAFETERI A	О	0	(	1, 318, 409	1, 318, 409	11. 00
13. 00 14. 00	O1300   NURSI NG ADMI NI STRATI ON   O1400   CENTRAL SERVI CES & SUPPLY	2, 802, 259 469, 781	1, 521, 606 894, 953			4, 203, 219 801, 920	1
15. 00	01500 PHARMACY	2, 083, 852	4, 339, 557	6, 423, 40		2, 307, 705	1
16. 00	01600 MEDICAL RECORDS & LIBRARY	264, 666	247, 472			512, 138	
17. 00 21. 00	01700   SOCIAL SERVICE   02100   I&R SERVICES-SALARY & FRINGES APPRVD	0 57, 586	0 571	58, 15	0	0 58, 157	17. 00 21. 00
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRV	61, 138	73, 646			134, 784	
23. 00	02300 PARAMED ED PRGM - EMERGENCY MEDICINE	620	66, 577	67, 19	5, 780	72, 977	23. 00
23. 01 23. 02	O2301   PARAMED ED PRGM- LAB   O2302   PARAMED ED PRGM- PHARMACY	93, 100 323, 628	9, 748 10, 867			270, 499 220, 033	
23. 02	02303 PARAMED ED PRGM- PHARMACT	323, 020	10, 867	1	0 -114, 462		1
	INPATIENT ROUTINE SERVICE COST CENTERS	-					
30. 00 31. 00	03000   ADULTS & PEDI ATRI CS   03100   INTENSI VE CARE UNIT	20, 391, 668 2, 215, 277	7, 383, 158 980, 649			25, 901, 794 2, 753, 211	1
32.00	03200 CORONARY CARE UNIT	2, 213, 277	980, 649	3, 193, 920	0 -442,715	2, 755, 211	
33. 00	03300 BURN INTENSIVE CARE UNIT	O	0	(	0	0	33. 00
35. 00 41. 00	02060   NEONATAL INTENSIVE CARE UNIT   04100   SUBPROVIDER - IRF	1, 092, 012 2, 480, 378	938, 860 460, 479			1, 312, 602 2, 763, 605	
42.00	04200 SUBPROVI DER	2, 460, 376	460, 479		0 -177, 252	2, 763, 603	42.00
43.00	04300 NURSERY	0	0	(	1, 144, 319	1, 144, 319	43.00
50. 00	ANCILLARY SERVICE COST CENTERS    05000   OPERATING ROOM	1, 183, 725	9, 327, 018	10, 510, 74	3 -7, 263, 206	3, 247, 537	50.00
50. 01	05001 OUTPATIENT SURGERY	816, 070	393, 429	1, 209, 499	-325, 049	884, 450	50. 01
51. 00 53. 00	05100   RECOVERY   ROOM   05300   ANESTHESI OLOGY	461, 869 38, 551	48, 314			464, 500 3, 952, 967	
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 835, 392	4, 174, 460 1, 913, 827			2, 619, 616	
54. 01	05401 RADI OLOGY-SPECI AL PROCEDURES	1, 270, 962	1, 065, 325	2, 336, 28	-964, 391	1, 371, 896	54. 01
55. 00 56. 00	O5500   RADI OLOGY-THERAPEUTI C   O5600   RADI OI SOTOPE	0 300, 678	0 346, 825		0 3 -274, 255	0 373, 248	
60.00	06000 LABORATORY	0	7, 538, 719			7, 340, 157	
	06300 BLOOD STORING, PROCESSING & TRANS.	0	394, 878				
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	1, 737, 405 3, 656, 986	937, 133 636, 523	2, 674, 538 4, 293, 509		2, 397, 543 3, 777, 442	
67. 00	06700 OCCUPATI ONAL THERAPY	569, 246	2, 212	571, 458		571, 301	
68. 00	06800 SPEECH PATHOLOGY	445, 734	174, 663	1		562, 827	
69. 00 70. 00	06900   ELECTROCARDI OLOGY   07000   ELECTROENCEPHALOGRAPHY	858, 559 236, 979	210, 798 19, 287	1, 069, 35 <sup>-</sup> 256, 266		885, 037 239, 242	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		13, 382, 669	13, 382, 669	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	(	3, 546, 940	3, 546, 940	
73. 00 76. 00	O7300   DRUGS CHARGED TO PATIENTS   O3630   ULTRA SOUND	0 571, 075	0 111, 878	682, 95	4, 618, 938 -86, 501	4, 618, 938 596, 452	
76. 00	03951 PAIN CLINIC	640, 263	105, 540	745, 803		651, 343	
76. 02	03952 CATH LAB	2, 091, 847	6, 370, 756	8, 462, 603		2, 294, 156	
76. 03 76. 04	03953   ACTIVITY THERAPEUTIC   03954   WOUND CARE CENTER	1, 582, 792 561, 329	30, 756 136, 130	1, 613, 548 697, 459		1, 613, 224 569, 608	
76. 05	03340 BARI ATRI C CLI NI C	1, 500, 713	16, 974			1, 506, 914	
76. 06	03030 HEALTHY LIVING CENTER	0	0	(	0	0	
76. 07 76. 08	03950   CV RESOURCE CENTER   03955   OTHER ANCILLARY SERVICE COST CENTERS	0	0		0	0	76. 07 76. 08
76. 09	03956 LACTATION CLINIC	o o	0			0	76. 09
76. 10	03957 OTHER ANCILLARY SERVICE COST CENTERS	0	0	(	0	0	,
76. 11 76. 12	03958 OTHER ANCILLARY SERVICE COST CENTERS 03959 ANTICOAGULATION CLINIC	0 596, 801	0 55, 174	651, 97!	0 5 -51, 388	0 600, 587	76. 11 76. 12
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	(31, 77	0 0	0	
78. 00	07800 CAR T-CELL IMMUNOTHERAPY		0		0	0	78. 00
91. 00	OUTPATIENT SERVICE COST CENTERS O9100 EMERGENCY	4, 392, 783	2, 274, 521	6, 667, 304	-854, 568	5, 812, 736	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 11, 12, 123	,,	1, 221, 66	11., 300	1, 112, 100	92. 00
101.00	OTHER REIMBURSABLE COST CENTERS 10100 HOME HEALTH AGENCY	7, 070, 212	1, 425, 363	8, 495, 575	-412, 059	8, 083, 516	101.00
	1	1	., .23, 330		, 307	2,000,010	

Health Financial Systems	FRANCISCAN HE	ALTH- DYER		In Lie	u of Form CMS-2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der CC		Peri od: From 01/01/2023	Worksheet A
				Γο 12/31/2023	Date/Time Prepared: 5/30/2024 3:45 pm
Cost Center Description	Sal ari es	0ther	Total (col. 1	Recl assi fi cati	
			+ col. 2)	ons (See A-6)	Trial Balance
					(col. 3 +-
					col . 4)
	1. 00	2. 00	3. 00	4. 00	5. 00
102.00 10200 OPIOID TREATMENT PROGRAM	0	0		0	0 102. 00
SPECIAL PURPOSE COST CENTERS					
113.00 11300 INTEREST EXPENSE		-25, 974	-25, 97	4 25, 974	0 113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	74, 817, 592	133, 800, 719	208, 618, 31	1 2, 715	208, 621, 026 118. 00
NONREI MBURSABLE COST CENTERS					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	50, 509	114, 923	165, 43	2 0	165, 432 190. 00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	485, 703	-15, 145	470, 55	3 29	470, 587 192. 00
192. 01 19201 WORKI NG WELL	0	0		0	0 192. 01
192. 02 19202 PHYSI CLANS' PRI VATE OFFI CES	0	0		0	0 192. 02
192. 03 19203 MI SC	0	0		0	0 192. 03
194. 00 07950 RESI DENTI AL	2, 614, 086	175, 416	2, 789, 50	-2, 744	2, 786, 758 194. 00
194.01 07954 OTHER NONREIMBURSABLE COST CENTERS	0	40	4	0	40 194. 01
194. 02 07952 PSYCHI ATRI C	0	0		0	0 194. 02
194.03 07953 CENTER OF HOPE	1, 001	369	1, 37	0	1, 370 194. 03
200.00 TOTAL (SUM OF LINES 118 through 199)	77, 968, 891	134, 076, 322	212, 045, 21	3 0	212, 045, 213 200. 00

Peri od: From 01/01/2023 To 12/31/2023

Date/Time Prepared: 5/30/2024 3:45 pm

			5/30/2024 3:45 p	pm
Cost Center Description	Adjustments	Net Expenses		
	(See A-8)	For Allocation		
CENEDAL CEDILLOE COCT CENTEDO	6. 00	7. 00		
GENERAL SERVICE COST CENTERS	1 400 100	0 E70 104		1 00
1.00   00100   CAP REL COSTS-BLDG & FLXT 2.00   00200   CAP REL COSTS-MVBLE EQUIP	1, 498, 189		·	1. 00 2. 00
i i	0 0	4, 544, 448 0	·	
		_	·	3.00
4.00 O0400 EMPLOYEE BENEFITS DEPARTMENT	1, 570, 802			4.00
5. 04   00593 OTHER ADMINISTRATIVE AND GENERAL	-7, 153, 902			5. 04
6. 00 00600 MAI NTENANCE & REPAI RS	-3, 848		·	6.00
7. 00 00700 OPERATION OF PLANT	-908, 650			7.00
8. 00   00800   LAUNDRY & LINEN SERVICE	0		·	8.00
9. 00   00900   HOUSEKEEPI NG	0			9.00
10. 00 01000 DI ETARY	-1, 505		l .	10.00
11. 00   01100   CAFETERI A	-449, 526			11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	-1, 369, 118			13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	0		I	14.00
15. 00   01500   PHARMACY	304, 817			15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	858, 423			16. 00
17. 00   01700   SOCI AL SERVI CE	0	1		17. 00
21. 00   02100   1 &R SERVI CES-SALARY & FRI NGES APPRVD	0			21. 00
22. 00   02200   1 &R SERVI CES-OTHER PRGM COSTS APPRV	-27, 736			22. 00
23. 00   02300   PARAMED ED PRGM - EMERGENCY MEDICINE	-1, 250		·	23. 00
23. 01   02301   PARAMED ED PRGM- LAB	0	270, 499		23. 01
23. 02   02302   PARAMED ED PRGM- PHARMACY	0		·	23. 02
23. 03 O2303 PARAMED ED PRGM- RADI OLOGY	0	0	2	23. 03
I NPATIENT ROUTINE SERVICE COST CENTERS				
30. 00   03000   ADULTS & PEDI ATRI CS	-6, 624, 829			30. 00
31.00   03100   I NTENSI VE CARE UNIT	0			31. 00
32. 00   03200   CORONARY CARE UNIT	0	0		32. 00
33.00   03300   BURN INTENSIVE CARE UNIT	0	0	3	33. 00
35.00   02060   NEONATAL   NTENSIVE CARE UNIT	-809, 876	502, 726	3	35. 00
41. 00   04100   SUBPROVI DER - I RF	-848, 491	1, 915, 114	4	41. 00
42. 00   04200   SUBPROVI DER	0	0	4	42. 00
43. 00 04300 NURSERY	0	1, 144, 319	4	43. 00
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	-14, 580	3, 232, 957	5	50. 00
50. 01   05001   OUTPATI ENT SURGERY	0	884, 450	5	50. 01
51.00   05100   RECOVERY ROOM	-40	464, 460	5	51. 00
53. 00 05300 ANESTHESI OLOGY	-3, 935, 238		l .	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	-71	2, 619, 545	·	54. 00
54. 01 05401 RADI OLOGY-SPECI AL PROCEDURES	0			54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	1, 3, 1, 0, 0	l	55. 00
56. 00   05600 RADI 0I SOTOPE	0	_	l	56. 00
60. 00   06000   LABORATORY	-35, 363	,	·	50.00
	-35, 303		·	
	_	394, 878		63.00
	-23, 021	2, 374, 522	·	65.00
66. 00   06600   PHYSI CAL THERAPY	0	3, 777, 442	1	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	571, 301		67. 00
68. 00   06800   SPEECH PATHOLOGY	0			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0		·	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	239, 242	·	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	3, 546, 940		72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	4, 618, 938	·	73. 00
76.00   03630   ULTRA SOUND	-5	596, 447	·	76. 00
76. 01   03951   PAIN CLINIC	0	651, 343	7	76. 01
76. 02   03952   CATH LAB	-1, 000	2, 293, 156		76. 02
76. 03   03953   ACTI VI TY THERAPEUTI C	-19, 951	1, 593, 273	7	76. 03
76.04 03954 WOUND CARE CENTER	0	569, 608	7	76. 04
76. 05   03340 BARIATRIC CLINIC	-947, 500		·	76. 05
76.06 03030 HEALTHY LIVING CENTER	0	0	·	76. 06
76. 07 03950 CV RESOURCE CENTER	0	l o		76. 07
76. 08 03955 OTHER ANCILLARY SERVICE COST CENTERS	0	0		76. 08
76. 09 03956 LACTATION CLINIC	1 0	ا م	l	76. 09
76. 10 03957 OTHER ANCILLARY SERVICE COST CENTERS		ا م	·	76. 10
76. 11 03958 OTHER ANCILLARY SERVICE COST CENTERS	0		·	76. 11
76. 12 03959 ANTI COAGULATI ON CLINI C	-19, 273	581, 314	·	76. 12
77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION	-17,2/3	501, 314		77. 00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0	·	77. 00 78. 00
OUTPATIENT SERVICE COST CENTERS		<u> </u>		0.00
91. 00   O9100   EMERGENCY	-722, 050	5, 090, 686		91. 00
92.00   09200   OBSERVATION BEDS (NON-DISTINCT PART	-122,050	3, 090, 086		91.00 92.00
OTHER REIMBURSABLE COST CENTERS	1		9	, 2. 00
101.00 10100 HOME HEALTH AGENCY	0	8, 083, 516	10	01. 00
102. 00 10200 OPI OI D TREATMENT PROGRAM	0			02.00
	1	1	1	50

Health Financial Systems FRANCISCAN HEALTH- DYER In Lieu of Form CMS-2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES Provider CCN: 15-0090 Period: From 01/2023 From 01/2023 Period: From 01/2023 Per

			То	12/31/2023	Date/Time Pro 5/30/2024 3:4	
Cost Center Description	Adjustments	Net Expenses	<u> </u>			
· ·	(See A-8)	or Allocation				
	6.00	7. 00				
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 I NTEREST EXPENSE	0	0				113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	-19, 684, 592	188, 936, 434				<u>_</u> 118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	165, 432				190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	-131, 200	339, 387				192. 00
192. 01 19201 WORKI NG WELL	0	0				192. 01
192. 02 19202 PHYSI CLANS' PRI VATE OFFI CES	0	0				192. 02
192. 03 19203 MI SC	0	0				192. 03
194. 00 07950 RESI DENTI AL	0	2, 786, 758				194. 00
194.01 07954 OTHER NONREIMBURSABLE COST CENTERS	0	40				194. 01
194. 02 07952 PSYCHI ATRI C	0	0				194. 02
194. 03 07953 CENTER OF HOPE	0	1, 370				194. 03
200.00   TOTAL (SUM OF LINES 118 through 199)	-19, 815, 792	192, 229, 421				200. 00

Health Financial Systems RECLASSIFICATIONS | Period: | Worksheet A-6 | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: 5/30/2024 3: 45 pm Provider CCN: 15-0090

					5/30/2024 3:	45 pm
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
	2. 00	3. 00	4. 00	5. 00		
	A - DEPRECIATION					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	5, 686, 657		1. 00
2. 00	CAP REL COSTS-MVBLE EQUIP	2. 00	0	3, 799, 560		2. 00
3.00	NURSING ADMINISTRATION	13. 00	0	5, 920		3. 00
4.00		0.00	0	0		4. 00
5.00		0.00	0	0		5. 00
6.00		0.00	0	0		6. 00
7.00		0.00	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	Ō		10.00
11. 00		0.00	o	Ö		11. 00
12. 00		0.00	ő	O		12. 00
13. 00		0.00	o	o		13. 00
14. 00		0.00	0	0		14. 00
			0	0		1
15. 00		0.00				15. 00
16.00		0.00	0	0		16.00
17. 00		0.00	0	0		17. 00
18. 00		0.00	0	0		18. 00
19. 00		0.00	0	0		19. 00
20. 00		0.00	0	0		20. 00
21. 00		0.00	0	0		21. 00
22. 00		0.00	0	0		22. 00
23.00		0.00	0	0		23. 00
24.00		0.00	0	0		24. 00
25.00		0.00	О	0		25. 00
26. 00		0.00	0	0		26. 00
27.00		0.00	o	0		27. 00
28. 00		0.00	o	Ō		28. 00
29. 00		0.00	o	Ö		29. 00
30. 00		0.00	0	o		30.00
31. 00		0.00	0	0		31.00
32. 00		0.00	0	0		1
			- 1	-		32. 00
33. 00		0.00	0	0		33.00
34. 00		0.00	0	0		34. 00
	U LNTEDECT CADITALLZED		U	9, 492, 137		_
1.00	B - INTEREST CAPITALIZED INTEREST EXPENSE	113.00	0	25, 974		1.00
1.00	n LKEST LAFLINGE		— — <del>)</del>	25, 974		1.00
	C - DI ETARY		<u> </u>	25, 774		
1.00	CAFETERI A	11.00	663, 234	655, 175		1. 00
1.00	0 = = = =	— — ····	663, 234	655, 175		1.00
	D - I NSURANCE		000, 201	000, 170		
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	747, 004		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	207, 648		2. 00
2.00	n REE COSTS MVBEE EQUIT		— — — #	954, 652		2.00
	E - PATIENT TRANSPORT		<u> </u>	754, 052		
1.00	ADULTS & PEDIATRICS	30.00	16, 493	19		1.00
		54.00	92, 022	106		
2.00	RADI OLOGY-DI AGNOSTI C	54.00				2.00
3.00	RADI OI SOTOPE		27, 966	32		3.00
4. 00 E. 00	ELECTROCARDI OLOGY	69.00	6, 451	7		4.00
5.00	ULTRA SOUND	76.00	11, 473	13		5. 00
6.00	CATH LAB	76. 02	6, 092	7		6. 00
7.00	EMERGENCY	91. 00	10, 240	12		7. 00
8.00	PHYSICIANS' PRIVATE OFFICES	192.00	478	<u>1</u>		8. 00
	CHARCEARLE MED CURRELESS	) IMDIANTO	171, 215	197		4
1 00	F - CHARGEABLE MED SUPPLIES &			10.000 (10		1 00
1. 00	MEDICAL SUPPLIES CHARGED TO	71.00	0	13, 382, 669		1. 00
	PATI ENT	70.00		0.544.040		
2.00	IMPL. DEV. CHARGED TO	72. 00	0	3, 546, 940		2. 00
2.00	PATI ENTS		_ ا	_		2.00
3.00		0.00	0	0		3. 00
4.00		0.00	0	0		4. 00
5.00		0.00	0	0		5. 00
6.00		0.00	0	0		6. 00
7.00		0.00	0	0		7. 00
8.00		0.00	0	0		8. 00
9.00		0.00	0	0		9. 00
10.00		0.00	О	0		10.00
11. 00		0.00	o	Ö		11. 00
12. 00		0.00	Ö	O		12. 00
13. 00		0.00	ő	o		13. 00
14. 00		0.00	0	O		14. 00
15. 00		0.00	0	0		15. 00
.5.50	I .	0.00	<u> </u>	U	l .	1 .0.00

Health Financial Systems RECLASSIFICATIONS In Lieu of Form CMS-2552-10
Worksheet A-6 Peri od: From 01/01/2023 To 12/31/2023 Provider CCN: 15-0090 Date/Time Prepared: 5/30/2024 3:45 pm

					 5/30/2024 3:45 pm	_
	Coot Conton	Increases	Calami	Othor		
	Cost Center 2.00	Li ne # 3.00	Sal ary 4.00	0ther 5.00		
16. 00	2.00	0.00	4.00	0	16. 0	00
17. 00		0.00	Ö	0	17. 0	
18. 00		0.00	o	0	18.0	
19. 00		0.00	o	0	19. 0	
20. 00		0.00	o	0	20.0	
21. 00		0.00	o	0	21.0	
22. 00		0.00	0	0	22. 0	
23.00		0.00	O	0	23. 0	
24.00		0.00	O	0	24. 0	00
25.00		0.00	0	0	25. 0	00
26.00		0.00	0	0	26. 0	00
27.00		0.00	0	0	27. 0	
28. 00		0. 00	0	0	28. 0	
29. 00		0. 00	0	0	29. 0	
30.00		0.00	0	0	30.0	
31. 00		0.00	•	0	31.0	00
	O DRIVER OHARDED TO DATH ENTE		0	16, 929, 609		
1 00	G - DRUGS CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS		ما	4 (10 020	1.0	00
1. 00 2. 00	CENTRAL SERVICES & SUPPLY	73. 00 14. 00	0	4, 618, 938 656	1. 0	
3. 00	CENTRAL SERVICES & SUPPLY	0.00	0	0	3.0	
4. 00		0.00	o	0	4.0	
5. 00		0.00	o	0	5.0	
6. 00		0.00	Ö	0	6. 0	
7. 00		0.00	0	O	7.0	
8.00		0.00	o	Ö	8.0	
9.00		0.00	0	0	9.0	
10.00		0.00	O	0	10.0	00
11.00		0.00	0	0	11.0	00
12.00		0.00	0	0	12. 0	00
13.00		0.00	0	0	13.0	
14.00		0.00	0	0	14.0	00
15.00		0.00	0	0	15. 0	
16. 00		0. 00	0	0	16. 0	
17. 00		0. 00	0	0	17. 0	
18. 00		0. 00	0	0	18.0	
19. 00		0.00	0	0	19. 0	
20.00		0.00	0	0	20.0	
21. 00		0.00	0	0	21. 0	
22. 00 23. 00		0. 00 0. 00	0	0	22. 0	
24. 00		0.00	0	0	23. 0 24. 0	
24.00			— — <del> </del>	4, 619, 594	24.0	50
	H - PARAMEDICAL		<u> </u>	1,017,071		
1.00	PARAMED ED PRGM - EMERGENCY	23.00	6, 037	0	1. 0	00
	MEDI CI NE					
2.00	PARAMED ED PRGM- LAB	23. 01	0	168, 324	2. 0	
3.00	PHARMACY	1500	114, 462	0	3. 0	00
	0		120, 499	168, 324		
1 00	I - NURSERY	25 00	2 240	140	1.0	00
1. 00 2. 00	NEONATAL INTENSIVE CARE UNIT NURSERY	35. 00 43. 00	2, 340 811, 821	148 332, 498	1. 0	
2.00	0	43.00	814, 161	332, 446	2.0	<i>J</i> U
	J - OPEN		814, 101	332, 040		
1. 00	3 OI EN	0.00	0	0	1.0	ററ
	<u> </u>		$$ $\overline{0}$	<u>o</u>		
	K - LEASES AND RENT		-,			
1.00	CAP REL COSTS-BLDG & FIXT	1. 00	0	672, 250	1.0	00
2.00	CAP REL COSTS-MVBLE EQUIP	2. 00	0	537, 240	2. 0	00
3.00	CENTRAL SERVICES & SUPPLY	14. 00	0	7, 960	3. 0	
4.00	RADI OLOGY-SPECI AL PROCEDURES	54. 01	0	1, 950	4. 0	
5.00		0. 00	0	0	5. 0	
6.00		0. 00	0	0	6. 0	
7.00		0.00	0	0	7. 0	
8. 00		0.00	0	0	8. 0	
9.00		0.00	0	0	9.0	
10.00		0.00	0	0	10.0	
11.00		0.00	0	0	11.0	
12. 00 13. 00		0. 00 0. 00	0	0	12. 0 13. 0	
13.00		0.00	0	0	13.0	
15. 00		0.00	0	0	14.0	
16. 00		0.00	0	0	16.0	
. 5. 55	<u> </u>	— — <del></del>	— — <del>ŏ</del>	1, 219, 400	10.0	- 0
	I	l	<u> </u>			

Heal th	Financial Systems		FRANCISCAN H	HEALTH- DYER		In Lie	u of Form CMS-	-2552-10
RECLASS	SIFICATIONS			Provi der (	CCN: 15-0090	Peri od: From 01/01/2023	Worksheet A-	5
							Date/Time Pro 5/30/2024 3:4	
		Increases						
	Cost Center	Li ne #	Sal ary	Other				
	2. 00	3. 00	4.00	5. 00				
	L - PTO RECLASS							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	<u>801, 8</u> 51	0				1. 00
	TOTALS		801, 851	0				
500.00	Grand Total: Increases	l	2, 570, 960	34, 397, 708				500.00

Peri od: From 01/01/2023 To 12/31/2023 Date/Time Prepared: 5/30/2024 3:45 pm

		Decreases				5/30/2024 3:4	45 pm
	Cost Center	Li ne #	Salary	Other	Wkst. A-7 Ref.		
	6. 00	7. 00	8.00	9. 00	10. 00		
	A - DEPRECIATION						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1, 994			1. 00
2.00	OTHER ADMINISTRATIVE AND	5. 04	0	1, 033, 504	9		2. 00
	GENERAL			0 700 407			
3.00	MAINTENANCE & REPAIRS	6.00	0	2, 733, 427	l 1		3.00
4. 00 5. 00	OPERATION OF PLANT HOUSEKEEPING	7. 00 9. 00	0	2, 150, 652 7, 970	· · · · · · · · · · · · · · · · · · ·		4. 00 5. 00
6. 00	DI ETARY	10.00	0	11, 357	0		6.00
7. 00	CENTRAL SERVICES & SUPPLY	14. 00	o	132, 464	l .		7. 00
8. 00	PHARMACY	15. 00	Ö	29, 763	-1		8. 00
9.00	PARAMED ED PRGM- LAB	23. 01	O	373			9. 00
10.00	ADULTS & PEDIATRICS	30.00	0	343, 898	O		10.00
11.00	INTENSIVE CARE UNIT	31.00	0	69, 512	0		11. 00
12.00	NEONATAL INTENSIVE CARE UNIT	35. 00	0	8, 340	l 1		12. 00
13. 00	SUBPROVI DER – I RF	41. 00	0	23, 024	l 1		13. 00
14.00	OPERATING ROOM	50.00	0	807, 176	l 1		14. 00
15. 00	OUTPATIENT SURGERY	50.01	0	21, 854			15.00
16. 00 17. 00	RECOVERY ROOM ANESTHESIOLOGY	51. 00 53. 00	0	37, 055 633			16. 00 17. 00
17. 00	RADI OLOGY-DI AGNOSTI C	54.00	o	1, 005, 345			18.00
19. 00	RADI OLOGY-SPECI AL PROCEDURES	54.00	0	68, 585	I		19.00
20. 00	RADI OI SOTOPE	56.00	o	149, 760	o		20.00
21. 00	LABORATORY	60.00	o	30, 172	I		21. 00
22. 00	RESPI RATORY THERAPY	65.00	O	79, 882	0		22. 00
23.00	PHYSI CAL THERAPY	66.00	0	68, 481	o		23. 00
24.00	SPEECH PATHOLOGY	68.00	0	22, 138	0		24. 00
25.00	ELECTROCARDI OLOGY	69. 00	0	160, 210			25. 00
26. 00	ELECTROENCEPHALOGRAPHY	70. 00	0	3, 264			26. 00
27. 00	ULTRA SOUND	76. 00	0	76, 234	l 1		27. 00
28. 00	PAIN CLINIC	76. 01	0	16, 677	l 1		28. 00
29. 00 30. 00	CATH LAB ACTIVITY THERAPEUTIC	76. 02 76. 03	0	292, 665 300			29. 00 30. 00
30.00	WOUND CARE CENTER	76. 03 76. 04	0	5, 335	l .		30.00
32. 00	BARI ATRI C CLI NI C	76. 05	0	8, 286			32.00
33. 00	EMERGENCY	91.00	0	60, 317	l 1		33. 00
34. 00	HOME HEALTH AGENCY	101.00	o	31, 490	1		34. 00
	0			9, 492, 137			
	B - INTEREST CAPITALIZED						
1.00	CAP REL COSTS-BLDG & FIXT		•_	2 <u>5, 9</u> 74			1. 00
	0		0	25, 974			
1 00	C - DI ETARY	10.00	442 224	/FE 17E			1 00
1. 00	DI ETARY		663, 234 663, 234	65 <u>5, 1</u> 75 655, 175			1.00
	D - INSURANCE		003, 234	000, 170			
1.00	OTHER ADMINISTRATIVE AND	5. 04	O	954, 652	12		1.00
	GENERAL	0.0.		70 17 002			
2.00		0.00	0	0	12		2. 00
	0		0	954, 652			
	E - PATIENT TRANSPORT						
1.00	EMERGENCY	91.00	171, 215	197	0		1. 00
2.00		0.00	0	0	· ·		2. 00
3.00		0.00	0	0	0		3. 00
4.00		0.00	0	0	0		4.00
5. 00 6. 00		0. 00 0. 00	O O	0	0		5. 00 6. 00
7. 00		0.00	0	0	0		7. 00
8. 00		0.00	0	0	o o		8. 00
0.00	<u> </u>		171, 215	<u>~</u> 197	<u> </u>		0.00
	F - CHARGEABLE MED SUPPLIES &	k IMPLANTS	, =				
1.00	NURSING ADMINISTRATION	13.00	0	116, 545	0		1. 00
2.00	CENTRAL SERVICES & SUPPLY	14.00	o	438, 966	0		2. 00
3.00	PHARMACY	15. 00	0	65, 775	0		3. 00
4.00	PARAMED ED PRGM - EMERGENCY	23. 00	0	257	0		4. 00
	MEDI CI NE		_		_		
5.00	ADULTS & PEDIATRICS	30.00	0	956, 134	l 1		5. 00
6.00	INTENSIVE CARE UNIT	31.00	0	328, 567	0		6.00
7.00	NEONATAL INTENSIVE CARE UNIT	35. 00 41. 00	0	37, 034	l 1		7.00
8. 00 9. 00	SUBPROVIDER - IRF OPERATING ROOM	41. 00 50. 00	0	63, 068 6, 007, 721	l 1		8. 00 9. 00
9. 00 10. 00	OUTPATIENT SURGERY	50.00	0	296, 702	l 1		10.00
11. 00	RECOVERY ROOM	51.00	0	7, 419	l 1		11.00
12. 00	ANESTHESI OLOGY	53.00	o	194, 587	I		12.00
13. 00	RADI OLOGY-DI AGNOSTI C	54.00	Ö	213, 884	l .		13. 00
14. 00	RADI OLOGY-SPECI AL PROCEDURES	54. 01	ō	895, 431	l .		14. 00
		·	·	•	<u> </u>		

Peri od: From 01/01/2023 To 12/31/2023 Date/Ti me Prepared: 5/30/2024 3:45 pm

						5/30/2024 3:4	45 pm
		Decreases					
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7.00	8. 00	9. 00	10. 00		
15. 00	RADI OI SOTOPE	56.00	0	9, 861	0		15. 00
16.00	LABORATORY	60.00	0	66	0		16.00
17.00	RESPIRATORY THERAPY	65.00	0	192, 809	0		17. 00
18.00	PHYSICAL THERAPY	66.00	0	13, 721	0		18. 00
19.00	OCCUPATIONAL THERAPY	67. 00	o	157	0		19. 00
20.00	SPEECH PATHOLOGY	68. 00	o	35, 432	0		20.00
21.00	ELECTROCARDI OLOGY	69. 00	o	30, 536	0		21.00
22. 00	ELECTROENCEPHALOGRAPHY	70.00	o	13, 760	0		22. 00
23. 00	ULTRA SOUND	76. 00	o	21, 680	o		23. 00
24. 00	PAIN CLINIC	76. 01	o	77, 110	0		24. 00
25. 00	CATH LAB	76. 02	Ö	5, 875, 307	0		25. 00
26. 00	ACTIVITY THERAPEUTIC	76. 02	o	24	0		26. 00
27. 00	WOUND CARE CENTER	76. 03 76. 04	0	106, 224	0		27. 00
28. 00	BARI ATRI C CLI NI C	76. 04 76. 05	0		0		28.00
	l .		- 1	2, 428			
29. 00	ANTI COAGULATION CLINIC	76. 12	0	51, 388	0		29. 00
30. 00	EMERGENCY	91. 00	0	591, 923	0		30. 00
31. 00	HOME HEALTH AGENCY	1 <u>01.</u> 00	•	28 <u>5, 0</u> 93			31. 00
	0		0	16, 929, 609			1
	G - DRUGS CHARGED TO PATIENTS						
1.00	NURSING ADMINISTRATION	13. 00	0	33			1. 00
2.00	PHARMACY	15. 00	0	4, 110, 859	0		2. 00
3.00	PARAMED ED PRGM- LAB	23. 01	0	300	0		3. 00
4.00	ADULTS & PEDIATRICS	30.00	0	70, 825	0		4. 00
5.00	INTENSIVE CARE UNIT	31.00	0	39, 404	0		5. 00
6.00	NEONATAL INTENSIVE CARE UNIT	35. 00	0	150	0		6. 00
7.00	SUBPROVI DER - I RF	41. 00	o	87, 340	0		7. 00
8.00	OPERATING ROOM	50.00	o	23, 641	o		8. 00
9. 00	OUTPATIENT SURGERY	50. 01	o	6, 493	o		9. 00
10. 00	RECOVERY ROOM	51.00	O	1, 209	0		10.00
11. 00	ANESTHESI OLOGY	53.00	o	64, 824	0		11.00
12. 00	RADI OLOGY-DI AGNOSTI C	54.00	o	2, 502	0		12. 00
13. 00	RADI OLOGY-SPECI AL PROCEDURES	54. 00 54. 01	0	2, 302	0		13. 00
			1		0		
14.00	RADI OI SOTOPE	56.00	0	142, 632			14. 00
15. 00	LABORATORY	60.00	0	0	0		15. 00
16. 00	RESPIRATORY THERAPY	65.00	0	2, 372	0		16. 00
17. 00	ELECTROCARDI OLOGY	69. 00	0	32	0		17. 00
18. 00	ULTRA SOUND	76. 00	0	73	0		18. 00
19. 00	PAIN CLINIC	76. 01	0	673	0		19. 00
20. 00	CATH LAB	76. 02	0	6, 574	0		20. 00
21. 00	WOUND CARE CENTER	76. 04	0	16, 292	0		21. 00
22. 00	BARIATRIC CLINIC	76. 05	0	59	0		22. 00
23.00	EMERGENCY	91.00	0	35, 131	0		23. 00
24.00	HOME HEALTH AGENCY	101.00	0	5, 851	0		24. 00
	0 — — — — — —		<sub>0</sub>	4, 619, 594			1
	H - PARAMEDICAL						
1.00	EMERGENCY	91. 00	6, 037	0	0		1.00
2.00	LABORATORY	60.00	0	168, 324			2. 00
3.00	PARAMED ED PRGM- PHARMACY	23. 02	114, 462	0			3. 00
0.00	0		120, 499	168, 324			0.00
	I - NURSERY		120, 177	100, 02 1			
1.00	ADULTS & PEDIATRICS	30.00	443, 457	28, 116	0		1.00
2. 00	NEONATAL INTENSIVE CARE UNIT	35. 00	370, 704	304, 530			2.00
2.00	0		814, 161	332, 646			2.00
	J - OPEN		014, 101	332, 040			-
1.00	J - UFLIN	0.00	0	0	ما		1.00
1.00			— — — <del>0</del>				1.00
	V LEACEC AND DEAT		U <sub>1</sub>	0			-
1 00	K - LEASES AND RENT	4 00		0.000	امه		1 00
1.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	9, 990	10		1.00
2.00	OTHER ADMINISTRATIVE AND	5. 04	0	154, 313	10		2. 00
	GENERAL						
3. 00	MAINTENANCE & REPAIRS	6. 00	0	9, 636			3. 00
4.00	OPERATION OF PLANT	7. 00	0	2, 254			4. 00
5.00	NURSING ADMINISTRATION	13. 00	0	9, 988	1		5. 00
6.00	PHARMACY	15. 00	0	23, 769	•		6. 00
7.00	ADULTS & PEDIATRICS	30.00	0	47, 114	0		7. 00
8.00	INTENSIVE CARE UNIT	31.00	o	5, 232	0		8. 00
9.00	SUBPROVI DER - I RF	41. 00	О	3, 820	0		9. 00
10.00	OPERATING ROOM	50.00	O	424, 668	- 1		10.00
11. 00	RESPIRATORY THERAPY	65. 00	Ö	1, 932	•		11. 00
12. 00	PHYSI CAL THERAPY	66.00	Ö	433, 865	0		12. 00
13. 00	WOUND CARE CENTER	76. 04	0	455, 665	0		13. 00
14. 00	HOME HEALTH AGENCY	101.00	0	89, 625			14. 00
15. 00	PHYSICIANS' PRIVATE OFFICES	192.00	0	450			15. 00
16. 00	RESI DENTI AL	192.00	0	2, 744	•		16.00
10.00	INCOLUENTIAL	1 74.00	<u> </u>	2, 144	υ <sub> </sub>		10.00

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

RECLASSIFICATIONS Provider CCN: 15-0090 Period: From 01/01/2023 To 12/31/2023 Date/Time Prepared: 5/30/2024 3: 45 pm

Decreases Other Line # Salary Other Wkst. A-7 Ref.

						3/30/2024 3	TO PIII
		Decreases					
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref.		
	6. 00	7.00	8. 00	9. 00	10.00		
	0		0	1, 219, 400			
	L - PTO RECLASS						
1.00	OTHER ADMINISTRATIVE AND	5. 04	801, 851	0	(		1. 00
	GENERAL			L			
	TOTALS		801, 851	0			
500.00	Grand Total: Decreases		2, 570, 960	34, 397, 708			500.00

				Ť	o 12/31/2023	Date/Time Pre 5/30/2024 3:4	
				Acqui si ti ons			
		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				_		
1.00	Land	694, 364	0	C	0	0	1. 00
2.00	Land Improvements	10, 182, 390	199, 631	C	199, 631	0	2. 00
3.00	Buildings and Fixtures	71, 826, 630	2, 782, 487	C	2, 782, 487	226, 289	3. 00
4.00	Building Improvements	178, 989	0	C	0	0	4. 00
5.00	Fi xed Equipment	177, 456, 706	1, 106, 417	C	1, 106, 417	1, 132, 614	5. 00
6.00	Movable Equipment	2, 347, 192	170, 420	C	170, 420	21, 313	6. 00
7.00	HIT designated Assets	0	0	C	0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	262, 686, 271	4, 258, 955	C	4, 258, 955	1, 380, 216	8. 00
9.00	Reconciling Items	0	0	C	0	0	9. 00
10.00	Total (line 8 minus line 9)	262, 686, 271	4, 258, 955	C	4, 258, 955	1, 380, 216	10.00
		Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
		6. 00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE						
1.00	Land	694, 364	0				1. 00
2.00	Land Improvements	10, 382, 021	5, 106, 643				2. 00
3.00	Buildings and Fixtures	74, 382, 828	32, 938, 868				3. 00
4.00	Building Improvements	178, 989	178, 989				4. 00
5.00	Fi xed Equipment	177, 430, 509	48, 463, 845				5. 00
6.00	Movable Equipment	2, 496, 299	522, 740				6. 00
7.00	HIT designated Assets	0	0				7. 00
8.00	Subtotal (sum of lines 1-7)	265, 565, 010	87, 211, 085				8. 00
9.00	Reconciling Items	0	0				9. 00
10.00	Total (line 8 minus line 9)	265, 565, 010	87, 211, 085				10. 00

Heal th	Financial Systems	FRANCISCAN HEALTH- DYER			In Lieu of Form CMS-2552-			
RECONG	CILIATION OF CAPITAL COSTS CENTERS		Provi der Co	CN: 15-0090	Peri od: From 01/01/2023 To 12/31/2023		pared:	
			Sl	JMMARY OF CAP	I 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	<u>IN 2, LINES 1 a</u>	ind 2				
1.00	CAP REL COSTS-BLDG & FLXT	0	0	)	0	0	1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	)	0	0	2. 00	
3.00	Total (sum of lines 1-2)	0	0	)	0 0	0	3. 00	
		SUMMARY O	F CAPITAL					
	Cost Center Description	Other	Total (1) (sum	n]				
		Capi tal -Rel ate	of cols. 9					
		d Costs (see	through 14)					
		instructions)						
		14.00	15. 00					
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM	IN 2, LINES 1 a	ind 2				
1.00	CAP REL COSTS-BLDG & FIXT	0	0				1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	)			2.00	
3.00	Total (sum of lines 1-2)	0	0	)			3. 00	

Health Financial Systems	FRANCISCAN HI	EALTH- DYER		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der C		Period: From 01/01/2023 To 12/31/2023		pared:
	COMI	PUTATION OF RA	TIOS	ALLOCATION OF	OTHER CAPITAL	y piii
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 CE	NTERS					
1.00 CAP REL COSTS-BLDG & FLXT	0	0	1	1. 000000	0	1. 00
2. 00 CAP REL COSTS-MVBLE EQUIP	0	0	1	0.000000		2.00
3.00 Total (sum of lines 1-2)	0	TION OF OTHER (	CADLEAL	1.000000	OF CAPITAL	3. 00
	ALLUCA	IION OF OTHER O	CAPITAL	SUMMARY	F CAPITAL	
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
		Capi tal -Relate				
	/ 00	d Costs 7.00	through 7) 8.00	9. 00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS OF	6.00	7.00	8.00	9.00	10. 00	
1.00 CAP REL COSTS-BLDG & FLXT	INTERS	0	1	7, 184, 846	672, 250	1. 00
2. 00 CAP REL COSTS-MVBLE EQUIP	0			3, 799, 560	·	
3.00 Total (sum of lines 1-2)	Ö	i o		10, 984, 406	·	3. 00
		SI	JMMARY OF CAPI	TAL		
Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
'				Capi tal -Rel ate		
				d Costs (see	through 14)	
				instructions)		
DADT III DECONCILIATION OF CARLTAL COCTO OF	11. 00	12.00	13.00	14. 00	15. 00	
PART III - RECONCILIATION OF CAPITAL COSTS CE	-25, 974	747, 004	1	0 (	8, 578, 126	1. 00
2. 00 CAP REL COSTS-BLDG & FIXT	-25, 9/4			0 0	4, 544, 448	2.00
3.00 Total (sum of lines 1-2)	-25, 974		1	0		
		, , , , , , , ,	į.	-1	., .==, ,	

| Period: | Worksheet A-8 | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: Provider CCN: 15-0090

				To	12/31/2023	Date/Time Prep 5/30/2024 3:45	pared:
				Expense Classification on		3/30/2024 3.43	o piii
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basi s/Code (2) 1.00	Amount 2.00	Cost Center 3.00	Li ne # 4. 00	Wkst. A-7 Ref. 5.00	
1.00	Investment income - CAP REL	1.00		CAP REL COSTS-BLDG & FIXT	1.00	0.00	1. 00
2.00	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	2. 00
3. 00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other	В	0		0.00	0	3. 00
	(chapter 2)			OFNITDAL CEDIMOSE A CHIDDLY			
4. 00	Trade, quantity, and time discounts (chapter 8)	В	0	CENTRAL SERVICES & SUPPLY	14. 00	0	4. 00
5. 00	Refunds and rebates of expense (chapter 8)	s	0		0. 00	0	5. 00
6.00	Rental of provider space by suppliers (chapter 8)		0		0. 00	О	6. 00
7.00	Tel ephone servi ces (pay		0		0. 00	0	7. 00
8. 00	stations excluded) (chapter 21 Television and radio service	}	0		0. 00	0	8. 00
9. 00	(chapter 21) Parking Lot (chapter 21)		0		0.00	0	9. 00
10. 00	Provi der-based physician	A-8-2	-15, 873, 163		0.00	0	10. 00
11. 00	adjustment Sale of scrap, waste, etc.		0		0. 00	0	11. 00
12. 00	(chapter 23) Related organization	A-8-1	4, 381, 082			0	12. 00
	transactions (chapter 10)		1, 001, 002		0.00		
13. 00 14. 00	Laundry and linen service Cafeteria-employees and guests	В	-429, 282	CAFETERI A	0. 00 11. 00	0	13. 00 14. 00
15. 00	Rental of quarters to employee and others		0		0. 00	0	15. 00
16. 00	Sale of medical and surgical		0		0.00	0	16. 00
17. 00	supplies to other than patient Sale of drugs to other than	5	0		0. 00	0	17. 00
18. 00	patients Sale of medical records and		0		0. 00	0	18. 00
19. 00	abstracts Nursing and allied health		0		0. 00	0	19. 00
17.00	education (tuition, fees,		O		0.00		17.00
20. 00	books, etc.) Vending machines	В	-20, 244	CAFETERI A	11. 00	0	20. 00
21. 00	Income from imposition of interest, finance or penalty		0		0.00	О	21. 00
	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	RESPI RATORY THERAPY	65. 00		23. 00
20.00	therapy costs in excess of limitation (chapter 14)		J		33. 33		20.00
24. 00	Adjustment for physical therap	y A-8-3	0	PHYSI CAL THERAPY	66. 00		24. 00
	costs in excess of limitation (chapter 14)						
25. 00	Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	114. 00		25. 00
04.00	(chapter 21)			OAD DEL COCTO DI DO A FLYT	1 00		04.00
26. 00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1. 00	0	26. 00
27. 00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	27. 00
28. 00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19. 00		28. 00
29. 00 30. 00	Physicians' assistant Adjustment for occupational	A-8-3	0	OCCUPATI ONAL THERAPY	0. 00 67. 00	0	29. 00 30. 00
	therapy costs in excess of limitation (chapter 14)						
30. 99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30. 99
31. 00	Adjustment for speech patholog	y A-8-3	0	SPEECH PATHOLOGY	68. 00		31. 00
	costs in excess of limitation (chapter 14)						
32. 00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32. 00
33. 00	RENTAL INCOME	В	-119, 069	OTHER ADMINISTRATIVE AND	5. 04	0	33. 00
33. 01	RENTAL INCOME	В	-953, 969	GENERAL OPERATION OF PLANT	7. 00	0	33. 01
					·	·	

ADJUSTMENTS TO EXPENSES Provi der CCN: 15-0090 Peri od: Worksheet A-8 From 01/01/2023 | To 12/31/2023 | Date/Time Prepared:

To 12/31/2023						Date/Time Pre 5/30/2024 3:4	
				Expense Classification on	Worksheet A	07 007 202 1 0. 1	о ріп
				To/From Which the Amount is			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
		1. 00	2. 00	3. 00	4. 00	5. 00	
34. 00	PROPERTY TAX ADJUSMTENT	В	-123, 692	OTHER ADMINISTRATIVE AND	5. 04	0	34. 00
				GENERAL			
34. 01	PROPERTY TAX ADJUSMTENT	В		PHARMACY	15. 00	0	34. 01
34. 02	PROPERTY TAX ADJUSMTENT	В		OPERATING ROOM	50.00	0	34. 02
34. 03	PROPERTY TAX ADJUSTMENT	В		ADULTS & PEDIATRICS	30.00	l	34. 03
35. 00	PHYSI CI AN RECRUI TMENT	A		DI ETARY	10.00	0	35. 00
35. 01	PHYSICIAN RECRUITMENT	A		EMERGENCY	91.00	1	35. 01
35. 02	PHYSI CI AN RECRUI TMENT	A		PHARMACY	15. 00	0	35. 02
35. 03	NRCC PHYLSICIANS	A		PHYSICIANS' PRIVATE OFFICES	192. 00	1	35. 03
36. 00	FALL OUT ACCOUNTS	A	-11, 839	OTHER ADMINISTRATIVE AND	5. 04	0	36. 00
07.00	ADVEDTICING EVENIOR		04.0	GENERAL	4 00		07.00
37. 00	ADVERTISING EXPENSE	A		EMPLOYEE BENEFITS DEPARTMENT	4.00	l e	37. 00
37. 01	ADVERTISING EXPENSE	A	-10, 110	OTHER ADMINISTRATIVE AND GENERAL	5. 04	0	37. 01
37. 02	ADVERTISING EXPENSE	Α	2 040	MAINTENANCE & REPAIRS	6. 00	0	37. 02
37. 02	ADVERTISING EXPENSE	A		OPERATION OF PLANT	7. 00		37. 02
37. 03	ADVERTISING EXPENSE	A		ADULTS & PEDIATRICS	30.00	0	37. 03
37. 04	ADVERTISING EXPENSE	A		NEONATAL INTENSIVE CARE UNIT	35. 00	0	37. 04
37. 05	ADVERTISING EXPENSE	A		RECOVERY ROOM	51. 00	0	37. 05
37. 00	ADVERTISING EXPENSE	A		LABORATORY	60.00	0	37.00
37. 07	ADVERTISING EXPENSE	A		ULTRA SOUND	76.00	0	37. 07
38. 00	OUTSOURCED STAFF	B		OTHER ADMINISTRATIVE AND	5. 04	0	38.00
30.00	OUTSOURCED STAFF	b	-301	GENERAL	5.04	0	30.00
38. 01	OUTSOURCED STAFF	В	_101 223	EMERGENCY	91.00	0	38. 01
39. 00	GI FTS/DONATI ONS	A	101, 220	EMERGENOT	0.00	0	39. 00
40. 00	NON PATIENT BILLING	B	111 411	EMERGENCY	91.00	· -	40.00
41. 00	340B PRESCRIPTION DRUG PROGRAM	1		PHARMACY	15. 00	Ö	41. 00
42. 00	HAF FEES	A		OTHER ADMINISTRATIVE AND	5. 04		42. 00
12.00	1771 1223		0, 711, 107	GENERAL	0.01	Ĭ	12.00
43. 00	UNECESSARY BORROWING	l A	0	02.112.11.12	0.00	0	43. 00
44. 00	LOBBYI NG EXPENSE	A	-5. 753	OTHER ADMINISTRATIVE AND	5. 04	0	44. 00
			-,	GENERAL		_	
45.00	PENSION ADJSUTMENT	A	1, 591, 415	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45. 00
46.00	DI SCOUNTS EARNED/REBATES	В	-850, 022	OTHER ADMINISTRATIVE AND	5. 04	0	46. 00
				GENERAL			
47.00	OTHER OPERATING REVENUE	В	-272	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	47.00
47.01	OTHER OPERATING REVENUE	В	-421, 003	OTHER ADMINISTRATIVE AND	5. 04	0	47. 01
				GENERAL			
47. 02	OTHER OPERATING REVENUE	В		OPERATION OF PLANT	7. 00	l .	
47. 03	OTHER OPERATING REVENUE	В		ADULTS & PEDIATRICS	30. 00	0	47. 03
47. 04	OTHER OPERATING REVENUE	В	0	SUBPROVI DER - I RF	41. 00	0	47. 04
47. 05	OTHER OPERATING REVENUE	В	-51	RADI OLOGY-DI AGNOSTI C	54. 00	0	47. 05
47. 06	OTHER ADJUSTMENTS (SPECIFY) (3		0		0.00	l e	
48. 00	PROGRAM FEES	В		EMPLOYEE BENEFITS DEPARTMENT	4. 00	l	
48. 01	PROGRAM FEES	В	-6, 865	OTHER ADMINISTRATIVE AND	5. 04	0	48. 01
				GENERAL			
48. 02	PROGRAM FEES	В		LABORATORY	60.00	0	
48. 03	PROGRAM FEES	В		BARIATRIC CLINIC	76. 05	l	
49. 00	DUES/FEES/EDUCATION	В		EMPLOYEE BENEFITS DEPARTMENT	4.00	l e	49. 00
49. 01	DUES/FEES/EDUCATI ON	В	-31, 251	OTHER ADMINISTRATIVE AND	5. 04	0	49. 01
40.00	DUEC (EEEC (EDUCAT: C):			GENERAL	40	_	40.00
49. 02	DUES/FEES/EDUCATION	В		DI ETARY	10.00	0	49. 02
49. 03	DUES/FEES/EDUCATION	В		RADI OLOGY-DI AGNOSTI C	54.00	ł	
49. 04	DUES/FEES/EDUCATION	В		LABORATORY	60.00	i e	49. 04
49. 05	DUES/FEES/EDUCATION	В		BARIATRIC CLINIC	76. 05	0	49. 05
50. 00	TOTAL (sum of lines 1 thru 49)		-19, 815, 792				50. 00
	(Transfer to Worksheet A,						
(4) 5	column 6, line 200.)			010 D L 45 4		1	L

<sup>(1)</sup> 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.

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

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

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

Provider CCN: 15-0090
Period: From 01/01/2023 To 12/31/2023 Date/Time Prepa

OTTTOL	00313		To 12/31/2023	Date/Time Pre 5/30/2024 3:4		
	Line No.	Cost Center	Expense I tems	Amount of Allowable Cost	Amount	
	1.00	2.00	3. 00	4. 00	5. 00	
	A. COSTS INCURRED AND ADJUSTI HOME OFFICE COSTS:	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED O	RGANI ZATI ONS OR	CLAI MED	
1.00	1.00	CAP REL COSTS-BLDG & FIXT		1, 498, 189	0	1.00
2.00	5. 04	OTHER ADMINISTRATIVE AND GEN		27, 618, 514	25, 929, 406	2.00
3.00	16. 00	MEDICAL RECORDS & LIBRARY		858, 423	0	3.00
4.00	15. 00	PHARMACY		335, 362	0	4.00
4.01	0.00			0	0	4. 01
4.02	0.00			0	0	4. 02
4.03	0.00			0	0	4. 03
4.04	0.00			0	0	4. 04
4. 05	0.00			0	0	4. 05
4.06	0.00			0	0	4. 06
4. 07	0.00			0	0	4. 07
4. 08	0.00	i i		0	0	4. 08
4. 09	0.00			0	0	4. 09
4. 10	0.00			0	0	4. 10
4. 11	0.00			0	0	4. 11
4. 12	0.00			0	0	4. 12
4. 13	0.00			0	0	4. 13
4. 14 4. 15	0.00			0	0	4. 14
4. 15 4. 16	0.00				0	4. 15 4. 16
4. 10	0.00				0	4. 10
4. 17	0.00				0	4. 17
4. 19	0.00				0	4. 19
4. 20	0.00				0	4. 20
4. 21	0.00				Ö	4. 21
4. 22	0.00				Ö	4. 22
4. 23	0.00				0	4. 23
4. 24	0.00			o	0	4. 24
4. 25	0.00			0	0	4. 25
4. 26	0.00			0	0	4. 26
4. 27	0.00			0	0	4. 27
4. 28	0.00			0	0	4. 28
4. 29	0.00			0	0	4. 29
4.30	0.00			0	0	4. 30
5.00	TOTALS (sum of lines 1-4).			30, 310, 488	25, 929, 406	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.

Symbol (1)

Name
Percentage of Ownership

1.00

2.00

3.00

Name
Percentage of Ownership

1.00

B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:

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

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

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

Heal th	Financial Systems	FRANCI SCAN H	FRANCISCAN HEALTH- DYER				In Lieu of Form CMS-2552-10			
STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME Provider CCN: 15-0090 Period: Workshe										
OFFICE	COSTS				To 12/31/2023					
		·		Related Organization(s) and/or Home Off						
	Symbol (1)	Name	Percentage of	Name		Percentage of				
			Ownershi p			Ownershi p				
	1. 00	2. 00	3.00	4	4. 00	5. 00				

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

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

Heal th	Financial Syste	ems		FRANCISCAN HEA	LTH- DYER			In Lie	u of Form (	CMS-2	2552-10
STATEME	NT OF COSTS OF	SERVICES FROM	RELATED	ORGANIZATIONS AND HOME	Provi der CCI	N: 15-0090	Peri		Worksheet	A-8	-1
OFFICE	COSTS							01/01/2023	D-+- /T:	D	
							То	12/31/2023	Date/Time 5/30/2024		
	Net	Wkst. A-7 Ref.							7 07 007 202 1		, p
	Adjustments										
	(col. 4 minus										
	col. 5)*										
	6. 00	7. 00									
	A. COSTS INCUR	RED AND ADJUSTN	MENTS REC	QUIRED AS A RESULT OF TR	ANSACTIONS WI	TH RELATED (	DRGANI	ZATIONS OR (	CLAI MED		
	HOME OFFICE CO	STS:									

$\rightarrow$	0.00	7.00	
		AND ADJUSTMENTS REC	UIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED
	HOME OFFICE COSTS:		
00	1, 498, 189	9	
00	1, 689, 108	0	
00	858, 423	0	
00	335, 362	0	
01	0	0	
)2	0	0	
)3	0	0	
04	0	0	
)5	0	0	
06	0	0	
07	0	0	
80	0	0	
09	0	0	
10	0	0	
11	0	0	
12	0	0	
13	0	0	
14	0	0	
5	0	0	
6	0	0	
7	0	0	
18	0	0	
19	0	0	
20	0	0	
21	0	0	
22	0	0	
23	0	0	
24	0	0	
25	0	0	
26	0	0	
27	0	0	
28	0	0	
9	0	0	
30	0	0	
00	4, 381, 082		

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

Related Organization(s)
and/or Home Office

Type of Business

6.00

B. INTERRELATIONSHIP TO 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.

	HEALTHCARE SERV	6. 00
7.00		7. 00
8.00		8.00
9.00		9.00
10.00		10.00
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.
- $\hbox{B. Corporation, partnership, or other organization has financial interest in provider.}\\$
- 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.

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT In Lieu of Form CMS-2552-10
Worksheet A-8-2 Provider CCN: 15-0090 

					-	Го 12/31/2023	Date/Time Pre 5/30/2024 3:4	
	Wkst. A Line #		Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	<u> </u>
		I denti fi er	Remuneration	Component	Component		ider Component Hours	
	1. 00	2.00	3. 00	4.00	5. 00	6. 00	7. 00	
1. 00	5. 04	AGGREGATE-OTHER ADMINISTRATIVE AND G	551, 336	551, 336	0	0	211, 500	1. 00
2.00	13. 00	AGGREGATE-NURSING ADMINISTRATION	1, 369, 118	1, 369, 118	0	0	211, 500	2. 00
3. 00	22. 00	AGGREGATE-I&R SERVICES-OTHER PRGM CO	27, 736	27, 736	0	0	197, 500	3. 00
4. 00	23. 00	AGGREGATE-PARAMED ED PRGM - EMERGENC	1, 250	1, 250	0	0	197, 500	4. 00
5. 00 6. 00		AGGREGATE-ADULTS & PEDIATRICS AGGREGATE-NEONATAL INTENSIVE CARE UN	6, 619, 212 809, 663				197, 500 237, 100	5. 00 6. 00
7. 00 8. 00		AGGREGATE-SUBPROVIDER - IRF AGGREGATE-OPERATING ROOM	848, 491 12, 827		0		197, 500 246, 400	7. 00 8. 00
9. 00		AGGREGATE-ANESTHESI OLOGY	3, 935, 238				239, 400	9. 00
10. 00		AGGREGATE-LABORATORY	C	0	_		260, 300	10.00
11. 00		AGGREGATE-RESPIRATORY THERAPY	23, 021	·	0		211, 500	11. 00
12. 00		AGGREGATE ACTIVITY	1, 000	·		-	211, 500	12.00
13. 00	76. 03	AGGREGATE-ACTI VI TY THERAPEUTI C	19, 951	19, 951	0	0	211, 500	13. 00
14. 00	76. 05	AGGREGATE-BARIATRIC CLINIC	903, 159	903, 159	0	0	211, 500	14.00
15. 00		AGGREGATE-ANTI COAGULATI ON	19, 273	19, 273	0	0	260, 300	15. 00
16. 00		CLINIC AGGREGATE-EMERGENCY	731, 888	731, 888	0	0	211, 500	16. 00
200.00	71.00		15, 873, 163	1		-	3, 514, 000	
	Wkst. A Line #	J		5 Percent of	Cost of	Provi der	Physician Cost	
		l denti fi er	Limit	Unadjusted RCE Limit	Memberships &	Component Share of col.	of Malpractice Insurance	
				LIIIII	Conti nui ng Educati on	12	Trisui ance	
	1. 00	2.00	8.00	9.00	12. 00	13. 00	14. 00	
1. 00	5. 04	AGGREGATE-OTHER ADMINISTRATIVE AND G	C	0	0	0	0	1. 00
2. 00	13. 00	AGGREGATE-NURSI NG	C	0	0	0	0	2. 00
3. 00		ADMINISTRATION AGGREGATE-I&R SERVICES-OTHER	C	0	0	0	0	3. 00
4. 00		PRGM CO AGGREGATE-PARAMED ED PRGM -	C	0	0	0	0	4. 00
5. 00	30. 00	EMERGENC AGGREGATE-ADULTS & PEDIATRICS	C	o	0	0	0	5. 00
6. 00	35. 00	AGGREGATE-NEONATAL INTENSIVE CARE UN	C	0	0	0	O	6. 00
7. 00		AGGREGATE-SUBPROVIDER - IRF	С	0	0	0	0	7. 00
8.00		AGGREGATE-OPERATING ROOM	C	0	0	_	0	8. 00
9.00		AGGREGATE - ANESTHESI OLOGY	C	0	0		0	9. 00
10. 00 11. 00		AGGREGATE DESPLICATION THERAD		0	0		0	10.00
12. 00		AGGREGATE-RESPIRATORY THERAPY AGGREGATE-CATH LAB			0	0	0	11. 00 12. 00
13. 00		AGGREGATE-CATT LAB AGGREGATE-ACTI VI TY THERAPEUTI C	C	Ö	0	o o	0	13. 00
14. 00	76. 05	AGGREGATE-BARIATRIC CLINIC	С	О	0	0	0	14. 00
15. 00	76. 12	AGGREGATE-ANTI COAGULATI ON	C	0	0	0	0	15. 00
16. 00	91. 00	CLINIC AGGREGATE-EMERGENCY	C	o	0	0	0	16. 00
200. 00	Wkst. A Line #	Coot Contor/Dhysician	Provi der	O Adimeted DCF	O RCE		0	200. 00
	WRSt. A LINE #	Cost Center/Physician I denti fi er	Component Share of col.	Adjusted RCE Limit	Di sal I owance	Adjustment		
	1. 00	2.00	14 15. 00	16. 00	17. 00	18. 00		
1. 00		AGGREGATE-OTHER	C	0	0			1. 00
2. 00	13. 00	ADMINISTRATIVE AND G AGGREGATE-NURSING	C	0	0	1, 369, 118		2. 00
3. 00	22. 00	ADMINISTRATION AGGREGATE-I&R SERVICES-OTHER	C	0	0	27, 736		3. 00
4. 00	23. 00	PRGM CO AGGREGATE-PARAMED ED PRGM -	C	0	0	1, 250		4. 00
5.00		EMERGENC AGGREGATE-ADULTS & PEDIATRICS	c	0	0	6, 619, 212		5. 00
6. 00		AGGREGATE-NEONATAL INTENSIVE CARE UN	C	0	0	809, 663		6. 00
7.00		AGGREGATE - SUBPROVI DER - I RF	C	0	0			7. 00
8. 00 9. 00		AGGREGATE-OPERATING ROOM AGGREGATE-ANESTHESIOLOGY	C	0	-	12, 827		8. 00 9. 00
9. 00 10. 00		AGGREGATE - ANESTHEST OLOGY AGGREGATE - LABORATORY		0		3, 935, 238 0		9. 00 10. 00
11. 00		AGGREGATE - RESPIRATORY THERAPY	Č			23, 021		11. 00

Heal th	Health Financial Systems			FRANCISCAN HEALTH- DYER			In Lieu of Form CMS-2552-10		
PROVI DE	R BASED PHYSIC	IAN ADJUSTMENT		Provi der (		Peri od: From 01/01/2023	Worksheet A-8	3-2	
						To 12/31/2023			
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment			
		l denti fi er	Component	Limit	Di sal I owance				
			Share of col.						
			14						
	1. 00	2.00	15. 00	16. 00	17. 00	18. 00			
12.00	76. 02	AGGREGATE-CATH LAB	0	0	(	1, 000		12. 00	
13.00	76. 03	AGGREGATE-ACTI VI TY	0	0		19, 951		13. 00	
		THERAPEUTI C							
14.00	76. 05	AGGREGATE-BARIATRIC CLINIC	0	0		903, 159		14.00	
15. 00	76. 12	AGGREGATE-ANTI COAGULATI ON	0	0		19, 273		15. 00	
		CLINIC							
16.00	91. 00	AGGREGATE-EMERGENCY	0	0		731, 888		16. 00	
200.00			0	0		15, 873, 163		200. 00	

	Financial Systems	FRANCISCAN HE				u of Form CMS-2	2552-10
COST A	ALLOCATION - GENERAL SERVICE COSTS		Provi der CC	F	eriod: rom 01/01/2023 o 12/31/2023	Worksheet B Part I Date/Time Pre 5/30/2024 3:4	pared:
			CAPI TAL REI	ATED COSTS		5/30/2024 3:4	5 piii
			ON TIME REE	LITTED COOTS			
	Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Subtotal	
		for Cost			BENEFI TS		
		Allocation			DEPARTMENT		
		(from Wkst A					
		col. 7)	1. 00	2.00	4. 00	4A	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT	8, 578, 126	8, 578, 126			I	1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUI P	4, 544, 448		4, 544, 448		I	2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	21, 414, 080				42 (54 002	4.00
5. 04 6. 00	00593 OTHER ADMINISTRATIVE AND GENERAL 00600 MAINTENANCE & REPAIRS	40, 409, 916 6, 765, 405	638, 061 1, 291, 060			42, 654, 093 8, 784, 191	5. 04 6. 00
7. 00	00700 OPERATION OF PLANT	1, 720, 902	366, 125			2, 211, 296	
8.00	00800 LAUNDRY & LINEN SERVICE	642, 351	0	0		642, 351	
9.00	00900 HOUSEKEEPI NG	2, 392, 102	97, 933	8, 136	555, 205	3, 053, 376	
10.00	01000 DI ETARY	1, 019, 686	86, 393				
11.00	01100 CAFETERIA	868, 883	124, 719				
13. 00 14. 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	2, 834, 101	13, 193 111, 235	•	,01,011	3, 631, 941	
15. 00	01500 PHARMACY	801, 920 2, 612, 522	58, 280			1, 178, 262 3, 300, 479	
16. 00	01600 MEDICAL RECORDS & LIBRARY	1, 370, 561	88, 792				
17. 00	01700 SOCIAL SERVICE	0	0	0		0	17. 00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	58, 157	0	0	16, 124	74, 281	
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	107, 048	0	0	,		1
23. 00	02300 PARAMED ED PRGM - EMERGENCY MEDICINE	71, 727	727		.,	74, 318	
23. 01 23. 02	02301 PARAMED ED PRGM- LAB 02302 PARAMED ED PRGM- PHARMACY	270, 499 220, 033	31, 275 3, 816		26, 068 58, 568		1
23. 02	02303 PARAMED ED PRGM- PHARMACT	220, 033	3, 810			202, 417	1
20.00	INPATIENT ROUTINE SERVICE COST CENTERS						20.00
30.00	03000 ADULTS & PEDIATRICS	19, 276, 965	1, 441, 420	318, 472	5, 590, 183	26, 627, 040	30. 00
31. 00	03100 I NTENSI VE CARE UNI T	2, 753, 211	180, 473	85, 240	620, 289	3, 639, 213	
32. 00	03200 CORONARY CARE UNIT	0	0	0		0	
33. 00 35. 00	03300 BURN INTENSIVE CARE UNIT 02060 NEONATAL INTENSIVE CARE UNIT	502, 726	9, 686	0 10, 252	-	0 725, 289	
41. 00	04100 SUBPROVI DER – I RF	1, 915, 114	107, 909				
42. 00	04200 SUBPROVI DER	0	0	0		2, 700, 700	42. 00
43.00	04300 NURSERY	1, 144, 319	0	0	227, 314	1, 371, 633	43. 00
F0 00	ANCI LLARY SERVI CE COST CENTERS	2 222 257	202 (24	070 000	224 440	4 040 040	F0 00
50. 00 50. 01	05000   OPERATI NG ROOM   05001   OUTPATI ENT SURGERY	3, 232, 957 884, 450	299, 631 255, 926				
51. 00	05100 RECOVERY ROOM	464, 460	100, 877				
53. 00	05300 ANESTHESI OLOGY	17, 729		1		29, 301	
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 619, 545					
54. 01	05401 RADI OLOGY-SPECI AL PROCEDURES	1, 371, 896	28, 022	84, 249	355, 876	1, 840, 043	
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55. 00
56.00		373, 248		1		649, 521	1
60. 00 63. 00	06000 LABORATORY 06300 BLOOD STORING, PROCESSING & TRANS.	7, 304, 794 394, 878	94, 262 51, 447			7, 436, 144 446, 325	
65. 00	06500 RESPIRATORY THERAPY	2, 374, 522	38, 890		_	2, 998, 086	
66.00	06600 PHYSI CAL THERAPY	3, 777, 442	26, 387			4, 865, 678	
67. 00	06700 OCCUPATI ONAL THERAPY	571, 301	10, 104		,	740, 797	1
68. 00	06800 SPEECH PATHOLOGY	562, 827	0	25, 875		713, 510	1
69. 00 70. 00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	885, 037	69, 202			1, 392, 169	
70.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	239, 242 13, 382, 669	95, 625 0	4, 012		405, 234 13, 382, 669	1
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	3, 546, 940	0		-	3, 546, 940	
73. 00	07300 DRUGS CHARGED TO PATIENTS	4, 618, 938	0	Ö	0	4, 618, 938	
76. 00	03630 ULTRA SOUND	596, 447	41, 597	93, 708	163, 116	894, 868	76. 00
76. 01	03951 PAIN CLINIC	651, 343	223, 942			1, 069, 840	1
76. 02	03952 CATH LAB	2, 293, 156	164, 245				
76. 03 76. 04	03953   ACTI VI TY THERAPEUTI C   03954   WOUND CARE CENTER	1, 593, 273 569, 608	103, 693 115, 651				
76. 04	03340 BARI ATRI C CLINI C	559, 414	35, 019			751, 714	
76. 06	03030 HEALTHY LIVING CENTER	0	0	2,3,7		0	1
76. 07	03950 CV RESOURCE CENTER	0	0	0	0	0	1
76. 08	03955 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	_	0	76. 08
76. 09	03956 LACTATION CLINIC	0	0	0	0	0	76. 09
76. 10	03957 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76. 10
76. 11 76. 12	03958 OTHER ANCILLARY SERVICE COST CENTERS 03959 ANTICOAGULATION CLINIC	581, 314	7, 996		167, 107	0 756, 417	
77.00		001, 314	7, <del>1</del> 90	1	107, 107	756, 417	1
	07800 CAR T-CELL IMMUNOTHERAPY	0	o	Ö	0	0	1
	OUTPATIENT SERVICE COST CENTERS		<u> </u>				
91.00	09100 EMERGENCY	5, 090, 686	291, 526	72, 569	1, 183, 237		
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART			I		. 0	92. 00

Health Financial Systems	FRANCI SCAN HE	EALTH- DYER		In Lieu of Form CMS-2552-10			
COST ALLOCATION - GENERAL SERVICE COSTS				Period: From 01/01/2023 To 12/31/2023	Worksheet B Part I Date/Time Prepared: 5/30/2024 3:45 pm		
		CAPI TAL REI	LATED COSTS				
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal		
	0	1. 00	2.00	4. 00	4A		
OTHER REIMBURSABLE COST CENTERS							
101. 00 10100 HOME HEALTH AGENCY	8, 083, 516	24, 679	1, 02	1, 979, 695			
102. 00 10200 OPI OI D TREATMENT PROGRAM	0	0		0 0	0	102. 00	
SPECIAL PURPOSE COST CENTERS			1			112 00	
113.00 11300 INTEREST EXPENSE 118.00  SUBTOTALS (SUM OF LINES 1 through 117	100 024 424	7 202 750	4 510 43	/ 20 5/0 220		113.00	
118.00 SUBTOTALS (SUM OF LINES 1 through 117 NONREIMBURSABLE COST CENTERS	188, 936, 434	7, 282, 759	4, 518, 43	6 20, 569, 328	186, 732, 542	118.00	
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	165, 432	14, 465	4, 06	1 14, 143	198, 101	100 00	
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	339, 387		•	0 136, 133			
192. 01 19201 WORKI NG WELL	337,307	240, 711		0 130, 133		192. 01	
192. 02 19202 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0		192. 02	
192. 03 19203 MI SC	0	0		0 0		192. 03	
194. 00 07950 RESI DENTI AL	2, 786, 758	550, 760	21, 95	731, 957			
194.01 07954 OTHER NONREIMBURSABLE COST CENTERS	40	0		0 0		194. 01	
194. 02 07952 PSYCHI ATRI C	0	481, 231		0 0	481, 231	194. 02	
194.03 07953 CENTER OF HOPE	1, 370	0		0 280	1, 650	194. 03	
200.00 Cross Foot Adjustments					0	200. 00	
201.00 Negative Cost Centers		0		0 0	0	201. 00	
202.00 TOTAL (sum lines 118 through 201)	192, 229, 421	8, 578, 126	4, 544, 44	8 21, 451, 841	192, 229, 421	202. 00	

						5/30/2024 3: 4	
	Cost Center Description	OTHER	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
		ADMI NI STRATI VE AND GENERAL	REPAI RS	PLANT	LINEN SERVICE		
		5. 04	6. 00	7. 00	8. 00	9. 00	
	GENERAL SERVICE COST CENTERS	,		,			
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2. 00 4. 00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2. 00 4. 00
5. 04	00593 OTHER ADMINISTRATIVE AND GENERAL	42, 654, 093					5. 04
6. 00	00600 MAI NTENANCE & REPAIRS	2, 504, 970					6.00
7.00	00700 OPERATION OF PLANT	630, 591	624, 953				7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	183, 178	C	0	825, 529		8. 00
9.00	00900 HOUSEKEEPI NG	870, 725	167, 165			4, 145, 610	9. 00
10.00	01000 DI ETARY	360, 326	147, 467			58, 239	10.00
11. 00 13. 00	01100 CAFETERIA 01300 NURSING ADMINISTRATION	336, 302 1, 035, 713	212, 888 22, 520		0	84, 076 8, 894	11. 00 13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	336, 003	189, 871		0	74, 986	14. 00
15. 00	01500 PHARMACY	941, 191	99, 480			39, 288	15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	437, 294	151, 562	49, 271	0	59, 857	16. 00
17. 00	01700 SOCIAL SERVICE	0	C	0	0	0	17. 00
21. 00	02100   &R SERVI CES-SALARY & FRINGES APPRVD	21, 183	C	0	0	0	21.00
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRV	35, 408	1 241	0	0	0	22.00
23. 00 23. 01	O2300   PARAMED ED PRGM - EMERGENCY MEDICINE   O2301   PARAMED ED PRGM - LAB	21, 193 93, 621	1, 241 53, 385			490 21, 083	23. 00 23. 01
23. 01	02302 PARAMED ED PRGM- PHARMACY	80, 536				2, 573	1
23. 03	02303 PARAMED ED PRGM- RADIOLOGY	0	0, 011			0	23. 03
	INPATIENT ROUTINE SERVICE COST CENTERS	'		,			
30.00	03000 ADULTS & PEDIATRICS	7, 593, 173	2, 460, 413	799, 863	628, 689	971, 696	30. 00
31. 00	03100 I NTENSI VE CARE UNI T	1, 037, 787	308, 056	100, 146	63, 541	121, 661	
32. 00	03200 CORONARY CARE UNIT	0	C	0	0	0	32. 00
33. 00	03300 BURN INTENSIVE CARE UNIT	0	4, 500	0	0	0	33. 00
35. 00	02060 NEONATAL INTENSIVE CARE UNIT	206, 829	16, 533			6, 530	35.00
41. 00 42. 00	04100 SUBPROVI DER - I RF 04200 SUBPROVI DER	779, 565 0	184, 195 		105, 300	72, 744 0	41. 00 42. 00
43. 00	04300 NURSERY	391, 146		1	18, 701	0	43.00
10.00	ANCI LLARY SERVI CE COST CENTERS	371,110		,	10, 701		10.00
50.00	05000 OPERATI NG ROOM	1, 381, 345	511, 452	166, 268	0	201, 988	50.00
50. 01	05001 OUTPATIENT SURGERY	397, 938	436, 849			172, 525	50. 01
51. 00	05100 RECOVERY ROOM	211, 044	172, 190	1	0	68, 003	51.00
53. 00	05300 ANESTHESI OLOGY	8, 356	0	0	0	0	53. 00
54.00	05400 RADI OLOGY - DI AGNOSTI C	1, 340, 450				288, 539	54.00
54. 01 55. 00	05401   RADI OLOGY-SPECI AL PROCEDURES   05500   RADI OLOGY-THERAPEUTI C	524, 721 0	47, 832 C	1	0	18, 890 0	54. 01 55. 00
56. 00	05600 RADI OLOGI - MERAPEUTI C	185, 223	152, 958	1	0	60, 408	56.00
60. 00	06000 LABORATORY	2, 120, 550			0	63, 544	1
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	127, 278			0	34, 682	1
65.00	06500 RESPI RATORY THERAPY	854, 958	66, 382	21, 580	0	26, 216	65. 00
66. 00	06600 PHYSI CAL THERAPY	1, 387, 536			0	17, 788	1
67. 00	06700 OCCUPATI ONAL THERAPY	211, 252	17, 247		0	6, 811	1
68. 00	06800 SPEECH PATHOLOGY	203, 470		1	0	0	68. 00 69. 00
69. 00 70. 00	06900   ELECTROCARDI OLOGY   07000   ELECTROENCEPHALOGRAPHY	397, 002				46, 650 64, 463	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	115, 560 3, 816, 309	103, 223	) 53,003	0	04, 403	71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	1, 011, 474			0	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	1, 317, 173	C	0	0	0	73. 00
76.00	03630 ULTRA SOUND	255, 188	71, 004	23, 083	0	28, 042	76. 00
76. 01	03951 PAIN CLINIC	305, 084	382, 255		0	150, 964	76. 01
76. 02	03952 CATH LAB	965, 524	280, 355		0	110, 721	76. 02
76. 03	03953 ACTIVITY THERAPEUTIC	610, 409	176, 998			69, 902	76. 03
76. 04	03954 WOUND CARE CENTER	241, 924	197, 409			77, 963	76. 04
76. 05 76. 06	03340 BARIATRIC CLINIC 03030 HEALTHY LIVING CENTER	214, 365	59, 775	19, 432	0	23, 607 0	76. 05 76. 06
76. 07	03950 CV RESOURCE CENTER				0	0	76.00
76. 08	03955 OTHER ANCILLARY SERVICE COST CENTERS	0			0	0	76. 08
76. 09	03956 LACTATION CLINIC	0	C	Ö	0	0	76. 09
76. 10	03957 OTHER ANCILLARY SERVICE COST CENTERS	0	C	0	0	0	76. 10
76. 11	03958 OTHER ANCILLARY SERVICE COST CENTERS	0	C	0	0	0	76. 11
76. 12	03959 ANTI COAGULATION CLINIC	215, 706	13, 649	4, 437	0	5, 390	76. 12
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	<u> </u>	0	0	0	77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0		0	0	0	78. 00
91. 00	OUTPATIENT SERVICE COST CENTERS 09100 EMERGENCY	1, 892, 950	497, 617	161, 771	0	196, 524	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 072, 730	471,017	101, 7/1		170, 324	91.00
, 2. 00	OTHER REIMBURSABLE COST CENTERS	1		1			, 2. 00
101.00	10100 HOME HEALTH AGENCY	2, 877, 035	42, 125	13, 694	0	16, 636	101. 00
102.00	10200 OPIOID TREATMENT PROGRAM	o	[ C	0		0	102. 00

Health Financial Systems	FRANCISCAN HI	EALTH- DYER		In Lie	eu of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CO		Peri od:	Worksheet B	
				From 01/01/2023 To 12/31/2023		narod:
			'	12/31/2023	5/30/2024 3: 4	
Cost Center Description	OTHER	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
	ADMI NI STRATI VE	REPAI RS	PLANT	LINEN SERVICE		
	AND GENERAL					
	5. 04	6. 00	7. 00	8. 00	9. 00	
SPECIAL PURPOSE COST CENTERS	T		T			
113. 00 11300 I NTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	41, 086, 558	9, 078, 050	2, 748, 028	825, 529	3, 272, 373	]118. 00
NONREI MBURSABLE COST CENTERS				1		
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	56, 492					190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	206, 585	424, 876	138, 123	0	167, 797	1
192. 01 19201 WORKI NG WELL	0	0	(	0		192. 01
192. 02 19202 PHYSI CLANS' PRI VATE OFFI CES	0	0	(	0		192. 02
192. 03 19203 MI SC	0	0	(	0		192. 03
194. 00 07950 RESI DENTI AL	1, 166, 744	940, 112	305, 622	0	371, 280	1
194. 01 07954 OTHER NONREI MBURSABLE COST CENTERS	11	0	(	0		194. 01
194. 02 07952 PSYCHI ATRI C	137, 232	821, 431	267, 040	0	324, 409	1
194. 03 07953 CENTER OF HOPE	471	0	(	0	0	194. 03
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	0	(	0	l .	201. 00
202.00   TOTAL (sum lines 118 through 201)	42, 654, 093	11, 289, 161	3, 466, 840	825, 529	4, 145, 610	202. 00

Provider CCN: 15-0090

In Lieu of Form CMS-2552-10

Period:	Worksheet B
From 01/01/2023	Part
To 12/31/2023	Date/Time Prepared:
5/30/2024 3:45 pm	

					) 12/31/2023	5/30/2024 3: 4	
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	
				ADMI NI STRATI ON	SERVI CES &		
		10.00	11. 00	13. 00	SUPPLY 14. 00	15. 00	
	GENERAL SERVICE COST CENTERS	10100		10.00	11100	10.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.04	00593 OTHER ADMINISTRATIVE AND GENERAL						5. 04
6.00	00600 MAINTENANCE & REPAIRS						6. 00
7. 00	00700 OPERATION OF PLANT						7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE						8. 00
9.00	00900 HOUSEKEEPI NG						9. 00
10. 00	01000 DI ETARY	1, 877, 528					10.00
11.00	01100 CAFETERI A	0	1, 881, 785	1			11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	57, 971		4 0/7 700		13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	24, 666		1, 867, 798	4 500 250	14. 00
15. 00	01500 PHARMACY	0	52, 366	1	43, 214	4, 508, 358	1
16.00	01600 MEDI CAL RECORDS & LI BRARY	0	8, 692	338	1, 466	0	
17. 00 21. 00	01700 SOCIAL SERVICES	0	0		٩	0	1
22. 00	02100   &R SERVICES-SALARY & FRINGES APPRVD 02200   &R SERVICES-OTHER PRGM COSTS APPRV	0	2, 787 3, 087	1	110	0	
23. 00	02300 PARAMED ED PRGM - EMERGENCY MEDICINE	0	3, 087	1	541	0	1
23. 00	02301 PARAMED ED PRGM- LAB	0	2, 659	1	2, 665	0	1
23. 02	02302 PARAMED ED PRGM- PHARMACY	0	12, 510		2, 003	0	1
23. 02	02303 PARAMED ED PRGM- RADIOLOGY	0	12, 310		0	0	1
23.03	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	<u> </u>		١	9		23.03
30. 00	03000 ADULTS & PEDI ATRI CS	1, 480, 046	536, 576	1, 920, 358	193, 807	0	30.00
31. 00	03100   NTENSI VE CARE UNI T	149, 588	66, 930		14, 333	0	1
32. 00	03200 CORONARY CARE UNIT	0	0		0	0	1
33. 00	03300 BURN INTENSIVE CARE UNIT	0	0	Ö	ol	0	1
35. 00	02060 NEONATAL INTENSIVE CARE UNIT	o	29, 260	213, 968	2, 499	0	1
41. 00	04100 SUBPROVI DER - I RF	247, 894	66, 876		16, 440	0	41.00
42.00	04200 SUBPROVI DER	0	. 0	0	o	0	42. 00
43. 00	04300 NURSERY	0	0	o	O	0	1
	ANCILLARY SERVICE COST CENTERS	<u>'</u>			<u> </u>		1
50.00	05000 OPERATING ROOM	0	38, 196	93, 916	344, 929	0	50.00
50. 01	05001 OUTPATIENT SURGERY	0	21, 491	164, 341	33, 542	0	50. 01
51.00	05100 RECOVERY ROOM	0	11, 611	70, 460	2, 753	0	51.00
53.00	05300 ANESTHESI OLOGY	0	2, 643	0	655	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	58, 917	1, 550	41, 010	0	54. 00
54. 01	05401 RADI OLOGY-SPECI AL PROCEDURES	0	35, 259	122, 675	67, 927	0	54. 01
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55. 00
56.00	05600  RADI 01 S0T0PE	0	8, 325	0	86	0	56. 00
60.00	06000 LABORATORY	0	0	0	1, 262	0	60.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	
65. 00	06500 RESPI RATORY THERAPY	0	53, 494	1	14, 258	0	
66. 00	06600 PHYSI CAL THERAPY	0	103, 103		41, 457	0	
67.00	06700 OCCUPATIONAL THERAPY	0	16, 873	1	458	0	67.00
68. 00	06800 SPEECH PATHOLOGY	0	10, 888	1	309, 239	0	
69. 00	06900 ELECTROCARDI OLOGY	0	27, 647		28, 958	0	
70.00	07000 ELECTROENCEPHALOGRAPHY	0	7, 240	0	1, 712	0	
71. 00 72. 00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	0	0		0	0	1
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS		0		0	0 4, 508, 358	1
76. 00	03630 ULTRA SOUND		17, 557	851	37, 699	4, 506, 556	1
76. 00 76. 01	03951 PAIN CLINIC		18, 853		19, 395	0	1
	03952 CATH LAB		52, 206		203, 030	0	76.01
76. 02	03953 ACTIVITY THERAPEUTIC		57, 940	1	3, 875	0	1
76. 03	03954 WOUND CARE CENTER		18, 000	1	7, 423	0	76.03
76. 05	03340 BARI ATRI C CLI NI C		23, 731		10, 544	0	1
76. 06	03030 HEALTHY LIVING CENTER	l o	25, 751	00,007	10, 514	0	1
76. 07	03950 CV RESOURCE CENTER	l o	n	ا م	ol o	0	1
76. 08	03955 OTHER ANCILLARY SERVICE COST CENTERS	l o	n		ol o	0	1
	03956 LACTATION CLINIC	ا م	0	l ol	ol	0	1
	03957 OTHER ANCILLARY SERVICE COST CENTERS	l ol	0	l ol	ol	0	1
76. 11	03958 OTHER ANCILLARY SERVICE COST CENTERS		O	Ō	o	0	76. 11
	03959 ANTI COAGULATI ON CLINI C		15, 834	o	4, 087	0	76. 12
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION		0	Ō	0	0	1
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	o	o	0	1
	OUTPATIENT SERVICE COST CENTERS	-,					]
91.00	09100 EMERGENCY	0	151, 396	590, 808	158, 433	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
	OTHER REIMBURSABLE COST CENTERS						1
	10100 HOME HEALTH AGENCY	0	92, 285	104, 443	104, 764		101. 00
102.00	10200 OPI OI D TREATMENT PROGRAM	0	0	) 0	0	0	102. 00

Heal	th Financial Systems	FRANCISCAN HE	:ALIH- DYER		In Lie	u of Form CMS-	<u> 2552-10</u>
COST	ALLOCATION - GENERAL SERVICE COSTS		Provi der C	CN: 15-0090 I	Peri od:	Worksheet B	
					From 01/01/2023	Part I	
				-	Γo 12/31/2023		
						5/30/2024 3: 4	5 pm
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	
				ADMI NI STRATI OI	N SERVICES &		
					SUPPLY		
		10.00	11. 00	13.00	14.00	15. 00	
	SPECIAL PURPOSE COST CENTERS						
113.	00 11300 I NTEREST EXPENSE						113. 00
118.	OO SUBTOTALS (SUM OF LINES 1 through 117)	1, 877, 528	1, 707, 911	4, 680, 07	1, 712, 571	4, 508, 358	118. 00
	NONREI MBURSABLE COST CENTERS						
190.	00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3, 099	(	112, 903	0	190. 00
192.	00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0	27, 245	14, 11	14, 730	0	192. 00

000000

1, 877, 528

143, 502

1, 881, 785

28

70, 169

4, 764, 360

0

0

27, 594

1, 867, 798

0 192. 01 0 192. 02

0 192. 03

0 194. 00

0 194. 01

0 194. 02

0 194. 03

4, 508, 358 202. 00

200. 00 0 201. 00

192. 01 19201 WORKING WELL 192. 02 19202 PHYSICIANS' PRIVATE OFFICES

194. 01 07954 OTHER NONREIMBURSABLE COST CENTERS 194. 02 07952 PSYCHIATRIC

Cross Foot Adjustments Negative Cost Centers

TOTAL (sum lines 118 through 201)

192. 03 19203 MI SC

200.00

201.00

202.00

194. 00 07950 RESI DENTI AL

194.03 07953 CENTER OF HOPE

| Peri od: | Worksheet B | From 01/01/2023 | Part | | To 12/31/2023 | Date/Time Prepared: Provider CCN: 15-0090

			T	12/31/2023	Date/Time Pre 5/30/2024 3:4	
			I NTERNS &	RESI DENTS		
Cost Center Description	MEDI CAL	SOCIAL SERVICE	SERVI CES-SALAR		PARAMED ED	
	RECORDS & LI BRARY		Y & FRINGES	PRGM COSTS APPRV	PRGM - EMERGENCY	
	1/ 00	17.00	21.00	22.00	MEDICINE	
GENERAL SERVICE COST CENTERS	16.00	17. 00	21.00	22. 00	23. 00	
1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00   00200   CAP REL COSTS-MVBLE EQUIP 4.00   00400   EMPLOYEE BENEFITS DEPARTMENT						2. 00 4. 00
5. 04 00593 OTHER ADMINISTRATIVE AND GENERAL						5. 04
6.00   00600   MAI NTENANCE & REPAI RS 7.00   00700   OPERATI ON OF PLANT						6. 00 7. 00
8.00   00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00   00900   HOUSEKEEPI NG 10. 00   01000   DI ETARY						9. 00 10. 00
11. 00 01100 CAFETERI A						11. 00
13. 00 O1300 NURSI NG ADMINI STRATI ON 14. 00 O1400 CENTRAL SERVI CES & SUPPLY						13. 00 14. 00
15. 00 01500 PHARMACY						15. 00
16. 00   01600   MEDI CAL RECORDS & LI BRARY 17. 00   01700   SOCI AL SERVI CE	2, 241, 941	0				16. 00 17. 00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	Ö	98, 361			21. 00
22.00   02200   1&R SERVICES-OTHER PRGM COSTS APPRV 23.00   02300   PARAMED ED PRGM - EMERGENCY MEDICINE	0	0		162, 662	98, 228	22. 00 23. 00
23. 01   02301 PARAMED ED PRGM- LAB	0	1			70, 220	23. 01
23. 02   02302   PARAMED ED PRGM- PHARMACY 23. 03   02303   PARAMED ED PRGM- RADI OLOGY	0	1				23. 02 23. 03
INPATIENT ROUTINE SERVICE COST CENTERS		-				
30. 00   03000   ADULTS & PEDIATRICS 31. 00   03100   NTENSIVE CARE UNIT	213, 950 30, 543			58, 558	0	30. 00 31. 00
32.00 03200 CORONARY CARE UNIT	0	Ö	ő	ō	0	32. 00
33. 00   03300   BURN INTENSIVE CARE UNIT 35. 00   02060   NEONATAL INTENSIVE CARE UNIT	5, 436	0	0	0	0	33. 00 35. 00
41. 00   04100   SUBPROVI DER -   RF	22, 174		ő	o	0	41. 00
42. 00   04200   SUBPROVI DER 43. 00   04300   NURSERY	3, 235		_	0	0	42. 00 43. 00
ANCILLARY SERVICE COST CENTERS				<u> </u>		43.00
50. 00   05000   0PERATING ROOM 50. 01   05001   OUTPATIENT SURGERY	242, 997 11, 153			0	0	50. 00 50. 01
51. 00 O5100 RECOVERY ROOM	47, 486		o o	o	0	51. 00
53. 00   05300   ANESTHESI OLOGY 54. 00   05400   RADI OLOGY-DI AGNOSTI C	54, 237 259, 700		0	0	0	53. 00 54. 00
54. 01 05401 RADI OLOGY-SPECI AL PROCEDURES	37, 433		o o	o	0	54. 01
55. 00   05500  RADI OLOGY-THERAPEUTI C 56. 00   05600  RADI OI SOTOPE	31, 398	1	0	0	0	55. 00 56. 00
60. 00   06000   LABORATORY	224, 372	Ö	o o	o	0	60.00
63. 00   06300   BLOOD STORI NG, PROCESSI NG & TRANS. 65. 00   06500   RESPI RATORY THERAPY	4, 609 40, 272		0	0	0	63. 00 65. 00
66. 00 06600 PHYSI CAL THERAPY	76, 614	0	o o	o	0	66. 00
67. 00   06700   0CCUPATI ONAL THERAPY 68. 00   06800   SPEECH PATHOLOGY	32, 806 25, 895		0	0	0	67. 00 68. 00
69. 00 06900 ELECTROCARDI OLOGY	78, 847	Ö	0	o	0	69. 00
70. 00   07000   ELECTROENCEPHALOGRAPHY 71. 00   07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENT	16, 376 155, 731	0	0	0	0	70. 00 71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	53, 104	Ö	0	o	0	72.00
73. 00   07300   DRUGS CHARGED TO PATIENTS 76. 00   03630   ULTRA SOUND	116, 602 40, 131	0	0	0	0	73. 00 76. 00
76. 01   03951   PALN CLINIC	28, 668		0	o	0	76. 00
76. 02   03952   CATH   LAB 76. 03   03953   ACTI VI TY   THERAPEUTI C	144, 518 9, 167	0	0	0	0	76. 02 76. 03
76.04 03954 WOUND CARE CENTER	12, 766	Ö	0	o	0	76. 03
76. 05   03340   BARI ATRI C   CLI NI C 76. 06   03030   HEALTHY   LI VI NG   CENTER	2, 439	0	0	0	0	76. 05 76. 06
76. 07 03950 CV RESOURCE CENTER	0	0	0	0	0	76. 07
76.08 03955 OTHER ANCILLARY SERVICE COST CENTERS 76.09 03956 LACTATION CLINIC	0	0	0	0	0	76. 08 76. 09
76. 10 03957 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76. 0 <del>9</del> 76. 10
76. 11 03958 OTHER ANCILLARY SERVICE COST CENTERS 76. 12 03959 ANTICOAGULATION CLINIC	0 4, 292	0	0	o	0	76. 11
76. 12 03959 ANTICOAGULATION CEINIC 77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION	4, 292		0	0	0	76. 12 77. 00
78.00 07800 CAR T-CELL IMMUNOTHERAPY OUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	78. 00
91. 00 09100 EMERGENCY	184, 593	0	62, 951	104, 104	98, 228	91. 00
92.00  09200 OBSERVATION BEDS (NON-DISTINCT PART	1	l				92. 00

Health Financial Systems	FRANCI SCAN HI			In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der C	F	Period: From 01/01/2023 To 12/31/2023	Worksheet B Part I Date/Time Pre 5/30/2024 3:4	
			INTERNS &	RESI DENTS		
Cost Center Description	MEDI CAL RECORDS & LI BRARY		Y & FRINGES	RSERVICES-OTHER PRGM COSTS APPRV	PARAMED ED PRGM - EMERGENCY MEDICINE	
	16. 00	17. 00	21. 00	22. 00	23. 00	
OTHER REIMBURSABLE COST CENTERS	T	T				
101.00 10100 HOME HEALTH AGENCY	30, 397	l	1			101. 00
102. 00 10200 OPI OI D TREATMENT PROGRAM	0	C	) (	)  0	0	102. 00
SPECIAL PURPOSE COST CENTERS	I					140.00
113.00 11300 INTEREST EXPENSE 118.00 SUBTOTALS (SUM OF LINES 1 through 117)	2, 241, 941	С	98, 361	162, 662		113. 00 118. 00
NONREI MBURSABLE COST CENTERS  190. 00   1900   GIFT, FLOWER, COFFEE SHOP & CANTEEN			\		0	190. 00
	0					190.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES 192.01 19201 WORKING WELL	0					192. 00
192. 01 1920   WORKING WELL 192. 02 19202 PHYSI CLANS' PRI VATE OFFI CES	0					192. 01
192. 03 19203 MISC	0					192. 02
194. 00 07950  RESI DENTI AL	0					194. 00
194. 01 07954 OTHER NONREIMBURSABLE COST CENTERS	0	7				194. 01
194. 02 07952  PSYCHI ATRI C	0	Ĭ		o o		194. 02
194. 03 07953 CENTER OF HOPE	0	Č				194. 03
200.00 Cross Foot Adjustments	1			o		200. 00
201.00 Negative Cost Centers	0	C		ol		201.00
202.00 TOTAL (sum lines 118 through 201)	2, 241, 941	l c	98, 361	162, 662	98, 228	202.00

| Period: | Worksheet B | From 01/01/2023 | Part | To 12/31/2023 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0090

					To 12/31/2023	Date/Time Pre	
Cost Center Desc	cription	PARAMED ED PRGM- LAB	PARAMED ED PRGM- PHARMACY	PARAMED ED PRGM- RADI OLOGY	Subtotal	Intern & Residents Cost & Post Stepdown	5 pm
			20.00	00.00		Adjustments	
GENERAL SERVICE COST	CENTERS	23. 01	23. 02	23. 03	24. 00	25. 00	
1.00 00100 CAP REL COSTS-BI	LDG & FIXT						1.00
2. 00   00200   CAP REL COSTS-M							2.00
4. 00   00400   EMPLOYEE BENEFI   5. 04   00593   OTHER ADMINISTRA							4. 00 5. 04
6. 00   00600 MAI NTENANCE & RI							6. 00
7.00 00700 OPERATION OF PLA							7. 00
8. 00   00800   LAUNDRY & LINEN 9. 00   00900   HOUSEKEEPING	SERVI CE						8. 00 9. 00
10. 00   01000 DI ETARY							10.00
11. 00 01100 CAFETERI A							11. 00
13. 00   01300   NURSI NG ADMI NI S							13.00
14. 00   01400   CENTRAL SERVI CES	S & SUPPLY						14. 00 15. 00
16. 00 01600 MEDI CAL RECORDS	& LI BRARY						16. 00
17. 00 01700 SOCIAL SERVICE							17. 00
21. 00   02100   1 &R SERVI CES-SAI 22. 00   02200   1 &R SERVI CES-OTI							21. 00 22. 00
23. 00   02200   TAK   SERVICES-011							23. 00
23. 01 02301 PARAMED ED PRGM	- LAB	519, 068					23. 01
23. 02   02302   PARAMED ED   PRGM			386, 668				23. 02
23. 03 02303 PARAMED ED PRGMI INPATIENT ROUTINE SER					0		23. 03
30. 00 03000 ADULTS & PEDI ATI		0	0		0 43, 519, 579	-93, 968	30. 00
31. 00   03100   INTENSIVE CARE		0	•		0 6, 001, 644	0	31.00
32. 00   03200   CORONARY CARE UI 33. 00   03300   BURN   INTENSIVE (		0	0		0 0	0	32. 00 33. 00
35. 00   02060   NEONATAL   INTENS		0	0		0 1, 221, 017	0	35. 00
41. 00   04100   SUBPROVI DER - 11	RF	0	0		0 4, 555, 491	0	41. 00
42. 00   04200   SUBPROVI DER		0			0 0 1. 784. 715	0	42.00
43. 00   04300   NURSERY   ANCI LLARY   SERVI CE   COS	T CENTERS	0	<u> </u>	<u> </u>	0 1, 784, 715	<u> </u>	43. 00
50. 00 05000 OPERATI NG ROOM		0	0		0 7, 825, 060	0	50. 00
50. 01   05001   0UTPATI ENT SURGI	ERY	0	1		0 2, 775, 307	0	50. 01
51. 00   05100   RECOVERY ROOM 53. 00   05300   ANESTHESI OLOGY		0	0		0 1, 379, 593 0 95, 192	0	51. 00 53. 00
54. 00   05400   RADI OLOGY - DI AGNO	OSTIC	Ö	Ö		0 7, 658, 847	Ö	54. 00
54. 01   05401   RADI OLOGY-SPECI		0			0 2, 710, 330	l .	54. 01
55. 00   05500   RADI OLOGY-THERAI 56. 00   05600   RADI OI SOTOPE	PEUTI C	0			0 0 1, 137, 644	0	55. 00 56. 00
60. 00   06000   LABORATORY		519, 068			0 10, 578, 146	1	60.00
63.00 06300 BLOOD STORING, I		0			0 729, 259	0	63. 00
65. 00 06500 RESPIRATORY THE		0			0 4, 075, 246		65. 00
66. 00   06600   PHYSI CAL THERAP' 67. 00   06700   OCCUPATI ONAL THI		0	1		0 6, 555, 636 0 1, 031, 851	0	66. 00 67. 00
68. 00 06800 SPEECH PATHOLOG		Ö			0 1, 263, 002	l	68. 00
69. 00 06900 ELECTROCARDI OLO		0	0		0 2, 197, 231	0	69. 00
70. 00   07000   ELECTROENCEPHALO		0	0		0 826, 873 0 17, 354, 709		70. 00 71. 00
72. 00 07200 I MPL. DEV. CHAR		Ö	Ö		0 4, 611, 518		72.00
73. 00 07300 DRUGS CHARGED TO	O PATIENTS	0	386, 668		0 10, 947, 739	0	73. 00
76. 00   03630   ULTRA SOUND 76. 01   03951   PALN CLINIC		0	0		0 1, 368, 423 0 2, 235, 980	0	76. 00 76. 01
76. 02   03952   CATH LAB		0	0		0 5, 505, 746	0	76. 01
76. 03 03953 ACTIVITY THERAPI		0	0		0 3, 126, 589	0	76. 03
76. 04   03954   WOUND CARE CENTI		0	0		0 1, 559, 403	0	76. 04
76. 05   03340   BARI ATRI C   CLI NI ( 76. 06   03030   HEALTHY   LI VI NG (		0	0		0 1, 189, 194 0 0	0	76. 05 76. 06
76. 07 03950 CV RESOURCE CEN		0	0		0 0	0	76. 07
76. 08 03955 OTHER ANCI LLARY		0	0		0	0	76. 08
76. 09   03956   LACTATION CLINI ( 76. 10   03957   OTHER ANCILLARY		0	0		0 0	0	76. 09 76. 10
76. 10 03958 OTHER ANCI LLARY					o o	0	76. 10
76. 12 03959 ANTI COAGULATI ON	CLINIC	0	0		0 1, 019, 812	0	76. 12
77. 00   07700   ALLOGENEI C STEM 78. 00   07800   CAR T-CELL I MMUI		0			0 0	0	77. 00 78. 00
78.00 07800 CAR T-CELL IMMUI			1 0		0	<u> </u>	70.00
91. 00 09100 EMERGENCY		0	0		0 10, 737, 393		91.00
92. 00 09200 OBSERVATI ON BEDS						0	92. 00
101. 00 10100 HOME HEALTH AGE		0	0		0 13, 370, 290	0	101. 00
-							

	EDANOL COAN LIE	EN THE DIVED			C E OUC OFFO 40
Health Financial Systems	FRANCI SCAN HE		N 45 0000		eu of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CO		Peri od: From 01/01/2023	Worksheet B Part I
				To 12/31/2023	
					5/30/2024 3:45 pm
Cost Center Description	PARAMED ED	PARAMED ED	PARAMED ED	Subtotal	Intern &
	PRGM- LAB	PRGM- PHARMACY			Residents Cost
			RADI OLOGY		& Post
					Stepdown
	00.01	20.00		0.4.00	Adjustments
400 00 40000 ODI OLD TDEATHENT DDOODAN	23. 01	23. 02	23. 03	24.00	25. 00
102. 00 10200 OPI OI D TREATMENT PROGRAM	0	0		0 0	0 102.00
SPECIAL PURPOSE COST CENTERS					110.00
113. 00 11300   INTEREST EXPENSE	F40.0(0	20/ //0		100 040 450	113.00
118. 00 SUBTOTALS (SUM OF LINES 1 through 117)	519, 068	386, 668		0 180, 948, 459	-261, 023 118. 00
NONREI MBURSABLE COST CENTERS   190. 00   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN		0		0 413, 065	0 190, 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFICES	0	0		0 1, 717, 905	
192. 00 19200 PHTSI CLANS PRI VATE OFFI CES	0	0		0 1,717,903	0 192.00
192. 01 19201 WORKING WELL  192. 02 19202 PHYSI CLANS' PRI VATE OFFI CES	0	0		0	0 192.01
192. 02 19202 PHTSTCTANS PREVATE OFFICES	0	0		0	0 192.02
194. 00 07950  RESI DENTI AL	0	0		0 7, 116, 449	
194. 01 07954 OTHER NONREI MBURSABLE COST CENTERS		0		0 7, 110, 449	0 194.00
194. 02 07952 PSYCHI ATRI C	0	0		0 2, 031, 343	
194. 03 07953 CENTER OF HOPE	0	0		0 2, 031, 343	0 194.02
200.00 Cross Foot Adjustments				0 2, 149	0 200.00
201.00 Negative Cost Centers					0 201.00
202.00 TOTAL (sum lines 118 through 201)	519, 068	386, 668		0 192, 229, 421	
202.00 TOTAL (Sum Titles 110 through 201)	317,000	300, 000	I	0 172, 227, 421	201, 023  202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0090

			5/30/2024 3: 4	5 pm
	Cost Center Description	Total		
		26. 00		
	GENERAL SERVICE COST CENTERS			
1.00	00100 CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP			2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT			4. 00
5. 04	00593 OTHER ADMINISTRATIVE AND GENERAL			5. 04
6. 00	00600 MAINTENANCE & REPAIRS			6. 00
7. 00	00700 OPERATION OF PLANT			7. 00
8.00	00800 LAUNDRY & LINEN SERVICE			8. 00
9. 00	00900 HOUSEKEEPI NG			9. 00
10.00	01000 DI ETARY			10. 00
11. 00	01100 CAFETERI A			11. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON			13. 00
	01400 CENTRAL SERVICES & SUPPLY			14. 00
	01500 PHARMACY			15. 00
	01600 MEDICAL RECORDS & LIBRARY			16. 00
	01700 SOCI AL SERVI CE			17. 00
21. 00	02100 I&R SERVICES-SALARY & FRINGES APPRVD			21. 00
22. 00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV			22. 00
23. 00	02300 PARAMED ED PRGM - EMERGENCY MEDICINE			23. 00
23. 01	02301 PARAMED ED PRGM- LAB			23. 01
23. 02	02302 PARAMED ED PRGM- PHARMACY			23. 02
23. 03	02303 PARAMED ED PRGM- RADIOLOGY			23. 03
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000 ADULTS & PEDIATRICS	43, 425, 611		30. 00
31.00	03100   NTENSIVE CARE UNIT	6, 001, 644		31. 00
32.00	03200 CORONARY CARE UNIT	0		32. 00
33.00	03300 BURN INTENSIVE CARE UNIT	0		33. 00
35. 00	02060 NEONATAL INTENSIVE CARE UNIT	1, 221, 017		35. 00
41.00	04100 SUBPROVI DER - I RF	4, 555, 491		41.00
42.00	04200 SUBPROVI DER	0		42. 00
43.00	04300 NURSERY	1, 784, 715		43. 00
	ANCILLARY SERVICE COST CENTERS			
50.00	05000   OPERATI NG ROOM	7, 825, 060		50.00
50. 01	05001  OUTPATI ENT SURGERY	2, 775, 307		50. 01
51. 00	05100 RECOVERY ROOM	1, 379, 593		51.00
53.00	05300 ANESTHESI OLOGY	95, 192		53.00
54.00	05400  RADI OLOGY-DI AGNOSTI C	7, 658, 847		54.00
54. 01	05401 RADI OLOGY-SPECI AL PROCEDURES	2, 710, 330		54. 01
55. 00	05500   RADI OLOGY-THERAPEUTI C	0		55. 00
56.00	05600 RADI 0I SOTOPE	1, 137, 644		56. 00
60.00	06000 LABORATORY	10, 578, 146		60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	729, 259		63. 00
65. 00	06500 RESPI RATORY THERAPY	4, 075, 246		65. 00
66. 00	06600 PHYSI CAL THERAPY	6, 555, 636		66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	1, 031, 851		67. 00
68. 00	06800 SPEECH PATHOLOGY	1, 263, 002		68. 00
69. 00	06900 ELECTROCARDI OLOGY	2, 197, 231		69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	826, 873		70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	17, 354, 709		71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	4, 611, 518		72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	10, 947, 739		73. 00
76. 00	03630 ULTRA SOUND	1, 368, 423		76. 00
76. 01	03951 PAIN CLINIC	2, 235, 980		76. 01
76. 02	03952  CATH LAB	5, 505, 746		76. 02
76. 03	03953 ACTI VI TY THERAPEUTI C	3, 126, 589		76. 03
76. 04	03954  WOUND CARE CENTER	1, 559, 403		76. 04
76. 05	03340 BARI ATRI C CLI NI C	1, 189, 194		76. 05
76.06	03030 HEALTHY LIVING CENTER	0		76. 06
76. 07	03950 CV RESOURCE CENTER	0		76. 07
76. 08	03955 OTHER ANCILLARY SERVICE COST CENTERS	o		76. 08
76. 09	03956 LACTATION CLINIC	0		76. 09
	03957 OTHER ANCILLARY SERVICE COST CENTERS	0		76. 10
	03958 OTHER ANCILLARY SERVICE COST CENTERS	0		76. 11
	03959 ANTI COAGULATI ON CLINIC	1, 019, 812		76. 12
	07700 ALLOGENEIC STEM CELL ACQUISITION	0		77. 00
	07800 CAR T-CELL IMMUNOTHERAPY	0		78. 00
	OUTPATIENT SERVICE COST CENTERS			
91.00	09100 EMERGENCY	10, 570, 338		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART			92. 00
	OTHER REIMBURSABLE COST CENTERS			
101.00	10100 HOME HEALTH AGENCY	13, 370, 290		101.00
	10200 OPIOID TREATMENT PROGRAM	0		102.00
	SPECIAL PURPOSE COST CENTERS			1
113.00	11300   NTEREST EXPENSE			113. 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	180, 687, 436		118. 00

Health Financial Systems	FRANCISCAN HEALTH- DYER	In Lieu of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS	Provi der CCN: 15-0090	Peri od: Worksheet B From 01/01/2023 Part I To 12/31/2023 Date/Time Prepared:

		5/30/2024 3: 4	15 pm
Cost Center Description	Total		
	26. 00		
NONREI MBURSABLE COST CENTERS			
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	413, 065		190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	1, 717, 905		192. 00
192. 01 19201 WORKI NG WELL	0		192. 01
192. 02 19202 PHYSI CLANS' PRI VATE OFFI CES	0		192. 02
192. 03 19203 MI SC	0		192. 03
194. 00 07950 RESI DENTI AL	7, 116, 449		194. 00
194.01 07954 OTHER NONREIMBURSABLE COST CENTERS	51		194. 01
194. 02 07952 PSYCHI ATRI C	2, 031, 343		194. 02
194.03 07953 CENTER OF HOPE	2, 149		194. 03
200.00 Cross Foot Adjustments	0		200. 00
201.00 Negative Cost Centers	0		201. 00
202.00 TOTAL (sum lines 118 through 201)	191, 968, 398		202. 00

| Peri od: | Worksheet B | From 01/01/2023 | Part | I | To | 12/31/2023 | Date/Time Prepared: Provider CCN: 15-0090

Cost Center Description				To	12/31/2023	Date/Time Pre 5/30/2024 3:4	
PRIMERIA   SENTICE COST CENTERS   1.00   2.00   2A   4.00			CAPI TAL REI	LATED COSTS		3/30/2024 3.4	J piii
EARLEST   CONTROL CENTERS	Cost Center Description		BLDG & FIXT	MVBLE EQUIP	Subtotal		
DEBROWL SERVICE DOST CENTERS		Capi tal					
1.00			1. 00	2. 00	2A	4. 00	
2.00							
0.000   0.0400   DARFO DATE INFOLITES INFORMANIAN   0   0.35, 310   2, 451   37, 761   4, 50   6, 60   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000000							
Description		0	35 310	2 451	37 761	37 761	
0.000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.00000   0.00000		0					
0.00   0.0000   CANIDRY & LINEN SERVICE   0   0   0   0   0   0   0   0   0		0					
0.00   0.0000   0.00000   0.00000   0.00000   0.00000000		0	366, 125	23, 026	389, 151		
0.000   01000   DETARY   0   86,39%   13,654   100,072   223   10.00   13.00		0	0	-	0		
11.00   0100 (CAFETRIA   0   124, 719   0   124, 719   37   11.00   130, 0130 (MIRS) (		0					
13.00   03000   NURSING ADMINISTRATION   0   13, 193   0   13, 193   1, 302   13, 00		_					
15.00 0 1500 [PHARMACY   0   58, 260   14, 138   72, 418   1. 004   15, 00   17, 00		1					
10.00   01000   MEDICAL RECORDS & LIBRARY   0   88,792   10   10.00   17.00   17.00   17.00   01.00   02.00		0					14. 00
17.00   01700   SOCIAL SERVICE   0   0   0   0   0   0   17.00		j					
21. 00		0	88, 792	0	88, 792		
22.00   02200   IAR SERVICES.OTHER PROM. OSTS APPRY   0   0   0   727   0   727   3   23.00		0	0	0	0		
23.01   02301   PARAMED ED PRIGUL - LAB   0   31, 275   0.58   13, 733   46   22.01		_	0	Ö	o		
23.02   02302  PARAMED ED PRIGH- PARAMACY   0   3,816   0   3,816   0   2.505	23.00 02300 PARAMED ED PRGM - EMERGENCY MEDICINE	0	727	0	727	3	
23, 02   02303  PARAMED ED PROM. RADI OLOGY   0   0   0   0   0   22, 03		1		1			
INPATI ENT ROUTI NE. SERVICE COST CENTERS   0   1, 441, 420   318, 472   1,759, 892   9, 832   30. 00   330. 00   30.00   AULITS & PEDIATRIC S   0   1, 441, 420   318, 472   1,759, 892   9, 832   30. 00   330. 00					3, 816		
30.00   030000   ADULTS & PEDIATRICS   0   1,441,420   318,472   1,799,892   9,832   30.00   32.00   03200   OXFORMARY CARE UNIT   0   0   0   0   0   0   0   0   0		0	0	0	0	0	23. 03
31.00		0	1, 441, 420	318, 472	1, 759, 892	9, 832	30. 00
33.00   03300   BURN INTENSIVE CARE UNIT   0   0   0   0   33.00     40.00   04100   04100   SUPPROVI DER - IRF   0   107, 909   16, 162   124, 071   1, 223   41, 00     40.00   04200   SUPPROVI DER   0   0   0   0   0   0   0   0     40.00   04200   SUPPROVI DER   0   0   0   0   0   0   0   0     40.00   04200   SUPPROVI DER   0   0   0   0   0   0   0   0   0     40.00   04200   SUPPROVI DER   0   0   0   0   0   0   0   0   0		0					31. 00
135.00   02000   NEONATAL INTENSIVE CARE UNIT   0   9,666   10,252   19,938   357   35,00		0	0	0	0		
41.00   04100   SUBPROVI DER   1FF   0   107, 999   16, 162   124, 077   1, 223   41, 00   242, 00   2400		0	0	1 4	10.030		
A2. 00   04.200   SUBPROVIDER   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0							
AS DO   ASSON   ANSERVE   0   0   0   0   0   400   43. 00			107, 909	10, 102	124, 071		
50.00   050000   05000   050000   050000   050000   050000   050000   05000   050000   050000   0500000   0500000   0500000   0500000000			0	0	0		
50.01   05001   05001   017PATI ENT SURGERY   0   255, 926   26, 572   282, 498   402   50.01     51.00   05100   REOVERPY ROOM   0   100, 877   45, 466   146, 283   228   51.00     53.00   05300   ANESTHESI OLOGY   0   0   778   778   778   19   53.00     54.00   05400   RADIO LOGY - DI AGNOSTI C   0   428, 021   11,13, 311   1,541, 332   950   54.00     54.01   05401   RADIO LOGY - SPECI AL PROCEDURES   0   28, 022   84, 249   112, 271   627   54.01     55.00   05500   RADIO LOGY - THERAPEUTI C   0   0   0   0   0   0   55.00     65.00   05600   RADIO LOGY - THERAPEUTI C   0   0   0   0   0   0   0   0   0		_					
51.00   05100   RECOVERY ROOM   0   100,877   45,406   146,283   228   51.00							
53.00   05.300   AMESTHESI OLOGY   0   0   778   778   19   53.00		_					
54.01   05401   RADI OLOGY-SPECI AL PROCEDURES   0   28,022   84,249   112,271   627   54,01			0				
55. 00   05500   RADI OLOGY-THERAPEUTIC   0   0   0   0   0   55. 00		0					
56. 00   05600   RADIO I SOTOPE   0   89,610   94,641   184,251   162   56. 00		0			112, 271		
60.00   06000   LABORATORY   0   94, 262   37, 088   131, 350   0   60.00   63.00   06300   BLOOD STORING, PROCESSING & TRANS.   0   51, 447   0   63.00   65.00   06500   RESPIRATORY THERAPY   0   38, 890   98, 192   137, 082   857   65.00   06600   PHYSI CAL THERAPY   0   26, 387   37, 875   64, 262   1, 803   66.00   06600   PHYSI CAL THERAPY   0   10, 104   281   67.00   67.00   000		0	_	-	104 251		
63.00   06300   BLODD STORI NG, PROCESSING & TRANS.   0   51, 447   0   63.00   65.00   06500   RESPIRATORY THERAPY   0   38,890   98,192   137,082   857   66.00   06600   PHYSI CAL THERAPY   0   26,387   37,875   64,262   1,803   66.00   06600   PHYSI CAL THERAPY   0   10,104   0   10,104   281   67.00   06700   0CCUPATI ONAL THERAPY   0   0   10,104   0   10,104   281   67.00   06700   0CCUPATI ONAL THERAPY   0   0   0   25,875   220   68.00   68.00   06600   PHYSI CAL THERAPY   0   0   0   0   25,875   226,875   220   68.00   69.00   06900   ELECTROCARDI OLOGY   0   0   0   0   0   0   70.00   07000   ELECTROENCEPHALOGRAPHY   0   95,625   4,012   99,637   117   70.00   71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENT   0   0   0   0   0   0   72.00   07200   IMPL DEV. CHARGED TO PATI ENTS   0   0   0   0   0   0   73.00   07300   DRUGS CHARGED TO PATI ENTS   0   0   0   0   0   0   76.01   03953   ULTRA SOUND   0   41,597   93,708   135,305   287   76.00   76.01   03951   PAIN CLINIC   0   223,942   15,278   239,220   316   76.01   76.02   03952   CATH LAB   0   164,245   340,973   505,218   1,034   76.02   76.04   03954   WOUND CARE CENTER   0   115,651   5,922   121,573   277   76.04   76.05   03330   BATRITI C CLINIC   0   35,019   2,379   37,398   273   76.05   76.06   03030   HEALTHY LIVING CENTER   0   0   0   0   0   0   0   76.07   03950   CV RESOURCE CENTER   0   0   0   0   0   0   0   76.08   03955   OTHER ANCI LLARY SERVICE COST CENTERS   0   0   0   0   0   0   0   76.11   03958   ATTICAL LARY SERVICE COST CENTERS   0   0   0   0   0   0   0   76.12   03959   ATTICAL LARY SERVICE COST CENTERS   0   0   0   0   0   0   0   76.13   03950   CAR T-CELL IMMUNOTHERAPY   0   0   0   0   0   0   77.00   07000   EMERGENCY   0   291,526   72,569   364,095   2,083   91.00		0					
66.00   06600   PHYSICAL THERAPY   0   26,387   37,875   64,262   1,803   66.00   67.00   06700   OCCUPATIONAL THERAPY   0   10,104   0   10,104   281   67.00   68.00   06800   SPEECH PATHOLOGY   0   0   0   25,875   25,875   220   68.00   69.00   06900   ELECTROCARDIOLOGY   0   69,202   195,723   264,925   426   69.00   70.00   07000   ELECTROENCEPHALOGRAPHY   0   95,625   4,012   99,637   117   70.00   71.00   07100   MEDICAL SUPPLIES CHARGED TO PATIENT   0   0   0   0   0   0   72.00   07200   IMPL. DEV. CHARGED TO PATIENTS   0   0   0   0   0   0   73.00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   0   76.00   03630   ULTRA SOUND   0   41,597   93,708   135,305   287   76.00   76.01   03951   PAIN CLINIC   0   223,942   15,278   239,220   316   76.01   76.02   03952   CATH LAB   0   164,245   340,973   505,218   1,034   76.02   76.03   03953   ACTIVITY THERAPEUTIC   0   103,693   369   104,062   780   76.03   76.04   03954   WOUND CARE CENTER   0   115,651   5,922   121,573   277   76.04   76.05   03340   BARI ATRIC CLINIC   0   35,019   2,379   37,398   273   76.05   76.06   03950   CV RESOURCE CENTER   0   0   0   0   0   0   0   76.07   03950   CV RESOURCE CENTER   0   0   0   0   0   0   0   76.09   03955   OTHER ANCILLARY SERVICE COST CENTERS   0   0   0   0   0   0   0   76.10   03959   OTHER ANCILLARY SERVICE COST CENTERS   0   0   0   0   0   0   0   76.11   03959   OTHER ANCILLARY SERVICE COST CENTERS   0   0   0   0   0   0   0   76.12   03959   OTHER ANCILLARY SERVICE COST CENTERS   0   0   0   0   0   0   0   76.12   03959   OTHER ANCILLARY SERVICE COST CENTERS   0   0   0   0   0   0   0   76.12   03959   OTHER ANCILLARY SERVICE COST CENTERS   0   0   0   0   0   0   0   76.12   03959   OTHER ANCILLARY SERVICE COST CENTERS   0   0   0   0   0   0   0   76.12   03959   OTHER ANCILLARY SERVICE COST CENTERS   0   0   0   0   0   0   0   76.12   03959   OTHER ANCILLARY SERVICE COST CENTERS   0   0   0   0   0   0   0   76.12   03959   OTHER ANCILLARY SERVICE COST CENTERS   0   0   0	· · · · · · · · · · · · · · · · · · ·	0					
67.00   06700   0CCUPATIONAL THERAPY   0   10, 104   291   67. 00   68.00   06800   SPEECH PATHOLOGY   0   0   0   25, 875   25, 875   220   68. 00   69.00   06900   ELECTROCARDIOLOGY   0   69, 202   195, 723   264, 925   426   69. 00   70.00   07000   ELECTROENCEPHALOGRAPHY   0   95, 625   4, 012   99, 637   117   70. 00   71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENT   0   0   0   0   0   0   72.00   07200   IMPL DEV. CHARGED TO PATIENTS   0   0   0   0   0   0   73.00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   0   76.00   03630   ULTRA SOUND   0   41, 597   93, 708   135, 305   287   76. 00   76.01   03951   PAIN CLINIC   0   223, 942   15, 278   239, 220   316   76. 01   76.02   03952   CATH LAB   0   164, 245   340, 973   505, 218   1, 034   76. 02   76.03   03953   ACTIVITY THERAPEUTIC   0   103, 693   369   104, 062   780   76. 03   76.04   03954   WOUND CARE CENTER   0   115, 651   5, 922   121, 573   277   76. 04   76.05   03340   BARIATRIC CLINIC   0   35, 019   2, 379   37, 398   273   76. 05   76.06   03950   CV RESOURCE CENTER   0   0   0   0   0   0   76.07   03950   OV RESOURCE CENTER   0   0   0   0   0   0   76.09   03955   OTHER ANCILLARY SERVICE COST CENTERS   0   0   0   0   0   0   76.10   03959   ANTICOAGUILARY SERVICE COST CENTERS   0   0   0   0   0   76.11   03959   OTHER ANCILLARY SERVICE COST CENTERS   0   0   0   0   0   76.12   03959   OTHER ANCILLARY SERVICE COST CENTERS   0   0   0   0   0   76.12   03959   OTHER ANCILLARY SERVICE COST CENTERS   0   0   0   0   0   76.12   03959   OTHER ANCILLARY SERVICE COST CENTERS   0   0   0   0   0   76.12   03959   OTHER ANCILLARY SERVICE COST CENTERS   0   0   0   0   0   76.12   03959   OTHER ANCILLARY SERVICE COST CENTERS   0   0   0   0   0   76.12   03959   OTHER ANCILLARY SERVICE COST CENTERS   0   0   0   0   0   76.12   03959   OTHER ANCILLARY SERVICE COST CENTERS   0   0   0   0   0   76.12   03959   OTHER ANCILLARY SERVICE COST CENTERS   0   0   0   0   0   0   76.12   OTTOOLOGICAL TENT SERVICE COST CENTERS		0					
68. 00   06800   SPEECH PATHOLOGY   0   0   25, 875   25, 875   220   68. 00   69. 00   06900   ELECTROCARDI OLOGY   0   69, 202   195, 723   264, 925   426   69. 00   70. 00   07000   ELECTROENCEPHALOGRAPHY   0   95, 625   4, 012   99, 637   117   70. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0   0   0   0   0   0   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0   0   0   0   0   0   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0   0   0   0   0   76. 00   03630   ULTRA SOUND   0   41, 597   93, 708   135, 305   287   76. 00   76. 01   03951   PAI N CLI NI C   0   223, 942   15, 278   239, 220   316   76. 01   76. 02   03952   CATH LAB   0   164, 245   340, 973   505, 218   1, 034   76. 02   76. 03   03953   ACTI VI TY THERAPEUTI C   0   103, 693   369   104, 062   780   76. 04   03954   WOUND CARE CENTER   0   115, 651   5, 922   121, 573   277   76. 04   76. 05   03340   BARI ATRI C CLI NI C   0   35, 019   2, 379   37, 398   273   76. 05   76. 07   03950   CV RESOURCE CENTER   0   0   0   0   0   0   0   76. 08   03955   OTHER ANCI LLARY SERVI CE COST CENTERS   0   0   0   0   0   0   0   76. 10   03959   OTHER ANCI LLARY SERVI CE COST CENTERS   0   0   0   0   0   0   76. 12   03959   OTHER ANCI LLARY SERVI CE COST CENTERS   0   0   0   0   0   0   76. 12   03959   OTHER ANCI LLARY SERVI CE COST CENTERS   0   0   0   0   0   0   76. 12   03959   OTHER ANCI LLARY SERVI CE COST CENTERS   0   0   0   0   0   0   76. 12   03959   OTHER ANCI LLARY SERVI CE COST CENTERS   0   0   0   0   0   0   76. 12   03959   OTHER ANCI LLARY SERVI CE COST CENTERS   0   0   0   0   0   0   76. 12   03959   OTHER ANCI LLARY SERVI CE COST CENTERS   0   0   0   0   0   0   76. 12   03959   OTHER ANCI LLARY SERVI CE COST CENTERS   0   0   0   0   0   0   76. 12   03959   OTHER ANCI LLARY SERVI CE COST CENTERS   0   0   0   0   0   0   76. 12   03959   OTHER ANCI LLARY SERVI CE COST CENTERS   0   0   0   0   0   0   76. 12   0700   OTHER ANCI LLARY SERVI CE COST CENTERS   0   0   0   0   0   0   76. 12		0		1			
69. 00   06900   ELECTROCARDI OLOGY   0   69, 202   195, 723   264, 925   426   69. 00   70. 00   7000   DO   ELECTROCROCEPHALOGRAPHY   0   95, 625   4, 012   99, 637   117   70. 00   71. 00   71. 00   71. 00   71. 00   71. 00   71. 00   72. 00   72. 00   72. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   74. 50   74. 50   74. 50		0	10, 104				
70.00   07000   ELECTROENCEPHALOGRAPHY   0   95,625   4,012   99,637   117   70.00   71.00   71.00   71.00   MEDI CAL SUPPLIES CHARGED TO PATIENT   0   0   0   0   0   0   71.00   72.00   72.00   70.200   MPL. DEV. CHARGED TO PATIENTS   0   0   0   0   0   0   0   73.00   73.		0	69. 202				
72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0   0   0   0   0   0   72. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   0   73. 00   76. 00   03630   ULTRA SOUND   0   41, 597   93, 708   135, 305   287   76. 00   76. 01   03951   PAI N CLINIC   0   223, 942   15, 278   239, 220   316   76. 01   76. 02   03952   CATH LAB   0   164, 245   340, 973   505, 218   1, 034   76. 02   76. 03   03953   ACTIVITY THERAPEUTIC   0   103, 693   369   104, 062   780   76. 03   76. 04   03954   WOUND CARE CENTER   0   115, 651   5, 922   121, 573   277   76. 04   76. 05   03340   BARIATRIC CLINIC   0   35, 019   2, 379   37, 398   273   76. 05   76. 06   03030   HEALTHY LIVING CENTER   0   0   0   0   0   0   76. 06   03955   OTHER ANCILLARY SERVICE COST CENTERS   0   0   0   0   0   76. 07   0.0   0.0   0   0   0   76. 08   03955   OTHER ANCILLARY SERVICE COST CENTERS   0   0   0   0   76. 10   03958   OTHER ANCILLARY SERVICE COST CENTERS   0   0   0   0   76. 11   03958   OTHER ANCILLARY SERVICE COST CENTERS   0   0   0   0   76. 11   03958   OTHER ANCILLARY SERVICE COST CENTERS   0   0   0   0   76. 11   03958   OTHER ANCILLARY SERVICE COST CENTERS   0   0   0   0   76. 11   03958   OTHER ANCILLARY SERVICE COST CENTERS   0   0   0   0   76. 11   03958   OTHER ANCILLARY SERVICE COST CENTERS   0   0   0   0   76. 11   03958   OTHER ANCILLARY SERVICE COST CENTERS   0   0   0   0   76. 12   03959   ANTICOAGULATION CLINIC   0   0   0   0   76. 11   03958   OTHER ANCILLARY SERVICE COST CENTERS   0   0   0   0   76. 12   03959   OTHER ANCILLARY SERVICE COST CENTERS   0   0   0   0   76. 12   03959   OTHER ANCILLARY SERVICE COST CENTERS   0   0   0   0   76. 10   03950   CART-CELL IMMUNOTHERAPY   0   0   0   0   77. 00   07800   CART-CELL IMMUNOTHERAPY   0   0   0   0   78. 00   09100   EMERGENCY   0   291, 526   72, 569   364, 095   2, 083   91. 00   78. 00   09100   EMERGENCY   0   291, 526   72, 569   364, 095   2, 083   91. 00   78. 00   00   00   00   00   00   00   79. 00   00   00   00   00   00		0					
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 73. 00 76. 00 03630 ULTRA SOUND 0 41, 597 93, 708 135, 305 287 76. 00 76. 01 03951 PAIN CLINIC 0 223, 942 15, 278 239, 220 316 76. 01 76. 02 03952 CATH LAB 0 164, 245 340, 973 505, 218 1, 034 76. 02 76. 03 03953 ACTIVITY THERAPEUTIC 0 103, 693 369 104, 062 780 76. 03 76. 04 03954 WOUND CARE CENTER 0 115, 651 5, 922 121, 573 277 76. 04 76. 05 03340 BARIATRIC CLINIC 0 35, 019 2, 379 37, 398 273 76. 05 76. 06 03030 HEALTHY LIVING CENTER 0 0 0 0 0 0 0 76. 06 76. 07 03950 CV RESOURCE CENTER 0 0 0 0 0 0 0 76. 06 76. 09 03956 LACTATION CLINIC 0 0 0 0 0 0 0 0 76. 08 76. 10 03957 OTHER ANCILLARY SERVICE COST CENTERS 0 0 0 0 0 0 0 76. 10 76. 11 03958 OTHER ANCILLARY SERVICE COST CENTERS 0 0 0 0 0 0 76. 11 76. 12 03959 ANTICOAGULATION CLINIC 0 7, 996 0 7, 996 294 76. 12 77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION 0 0 0 0 0 0 0 0 77. 00 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 291, 526 72, 569 364, 095 2, 083 91. 00		0	0	0	0		
76. 00		0	0	0	0		
76. 01 03951 PAIN CLINIC 0 223, 942 15, 278 239, 220 316 76. 01 76. 02 03952 CATH LAB 0 164, 245 340, 973 505, 218 1, 034 76. 02 76. 03 03953 ACTIVITY THERAPEUTIC 0 103, 693 369 104, 062 780 76. 03 76. 04 03954 WOUND CARE CENTER 0 115, 651 5, 922 121, 573 277 76. 04 03954 WOUND CARE CENTER 0 3340 BARI ATRIC CLINIC 0 35, 019 2, 379 37, 398 273 76. 05 76. 06 03030 HEALTHY LIVING CENTER 0 0 0 0 0 0 0 76. 06 76. 07 03950 CV RESOURCE CENTER 0 0 0 0 0 0 0 0 76. 07 76. 08 03955 OTHER ANCILLARY SERVICE COST CENTERS 0 0 0 0 0 0 0 0 0 76. 08 76. 09 03956 LACTATION CLINIC 0 0 0 0 0 0 0 0 0 0 0 76. 10 76. 10 03957 OTHER ANCILLARY SERVICE COST CENTERS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0	/11 507	03 708	135 305		
76. 02 03952 CATH LAB 0 164, 245 340, 973 505, 218 1, 034 76. 02 76. 03 03953 ACTI VI TY THERAPEUTI C 0 103, 693 369 104, 062 780 76. 03 76. 04 03954 WOUND CARE CENTER 0 115, 651 5, 922 121, 573 277 76. 04 76. 05 03340 BARI ATRI C CLI NI C 0 35, 019 2, 379 37, 398 273 76. 05 76. 06 03030 HEALTHY LI VI NG CENTER 0 0 0 0 0 0 0 0 76. 05 76. 06 03950 CV RESOURCE CENTER 0 0 0 0 0 0 0 0 76. 07 76. 08 03955 OTHER ANCI LLARY SERVI CE COST CENTERS 0 0 0 0 0 0 0 0 76. 09 76. 10 03950 CV RESOURCE CENTER 0 0 0 0 0 0 0 0 0 76. 09 76. 11 03958 OTHER ANCI LLARY SERVI CE COST CENTERS 0 0 0 0 0 0 0 0 0 76. 11 03958 OTHER ANCI LLARY SERVI CE COST CENTERS 0 0 0 0 0 0 0 0 76. 11 76. 12 03959 ANTI COAGULATI ON CLI NI C 0 7, 996 0 7, 996 294 76. 12 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					
76. 04 03954 WOUND CARE CENTER 0 115, 651 5, 922 121, 573 277 76. 04 76. 05 03340 BARI ATRI C CLI NI C 0 35, 019 2, 379 37, 398 273 76. 05 76. 06 03030 HEALTHY LI VING CENTER 0 0 0 0 0 0 0 0 76. 06 76. 07 03950 CV RESOURCE CENTER 0 0 0 0 0 0 0 0 76. 08 03955 OTHER ANCI LLARY SERVI CE COST CENTERS 0 0 0 0 0 0 0 76. 08 76. 09 03956 LACTATI ON CLI NI C 0 0 0 0 0 0 0 76. 09 76. 10 03957 OTHER ANCI LLARY SERVI CE COST CENTERS 0 0 0 0 0 0 0 0 76. 10 76. 11 03958 OTHER ANCI LLARY SERVI CE COST CENTERS 0 0 0 0 0 0 0 0 76. 11 76. 12 03958 OTHER ANCI LLARY SERVI CE COST CENTERS 0 0 0 0 0 0 0 0 0 76. 11 76. 12 03959 ANTI COAGULATI ON CLI NI C 0 7, 996 0 7, 996 294 76. 12 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					
76. 05		0					
76. 06 03030   HEALTHY LIVING CENTER 0 0 0 0 0 0 0 76. 06 76. 07 03950   CV RESOURCE CENTER 0 0 0 0 0 0 0 76. 07 76. 08 03955   OTHER ANCILLARY SERVICE COST CENTERS 0 0 0 0 0 0 0 0 76. 08 76. 09 03956   LACTATION CLINIC 0 0 0 0 0 0 0 76. 09 76. 10 03957   OTHER ANCILLARY SERVICE COST CENTERS 0 0 0 0 0 0 0 76. 10 76. 11 03958   OTHER ANCILLARY SERVICE COST CENTERS 0 0 0 0 0 0 0 76. 11 76. 12 03959   ANTICOAGULATION CLINIC 0 7, 996 0 7, 996 0 7, 996 294 76. 12 77. 00 07700   ALLOGENEIC STEM CELL ACQUISITION 0 0 0 0 7, 996 0 77. 00 78. 00 07800   CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 0 0 78. 00  OUTPATIENT SERVICE COST CENTERS 91. 00 09100   EMERGENCY 0 291, 526 72, 569 364, 095 2, 083 91. 00		0					
76. 07		0	35, 019	2, 3/9	37, 398		
76. 08 03955 OTHER ANCILLARY SERVICE COST CENTERS 0 0 0 0 0 0 0 76. 08 76. 09 03956 LACTATION CLINIC 0 0 0 0 0 0 76. 09 76. 10 03957 OTHER ANCILLARY SERVICE COST CENTERS 0 0 0 0 0 0 0 76. 10 76. 11 03958 OTHER ANCILLARY SERVICE COST CENTERS 0 0 0 0 0 0 0 76. 11 76. 12 03959 ANTICOAGULATION CLINIC 0 7, 996 0 7, 996 294 76. 12 77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION 0 0 0 0 77. 00 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 0 0 78. 00 0UTPATIENT SERVICE COST CENTERS 91. 00 09100 EMERGENCY 0 291, 526 72, 569 364, 095 2, 083 91. 00		0	0	0	0		
76. 09			o	l ő	ő		
76. 11 03958 OTHER ANCILLARY SERVICE COST CENTERS 0 0 0 0 0 0 76. 11 76. 12 03959 ANTI COAGULATI ON CLI NI C 0 7, 996 0 7, 996 294 76. 12 77. 00 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON 0 0 0 0 0 0 77. 00 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 0 78. 00  OUTPATI ENT SERVICE COST CENTERS  91. 00 09100 EMERGENCY 0 291, 526 72, 569 364, 095 2, 083 91. 00	76.09 03956 LACTATION CLINIC	0	0	O	O		
76. 12   03959   ANTI COAGULATI ON CLI NI C   0   7,996   0   7,996   294   76. 12   77. 00   07700   ALLOGENEI C STEM CELL ACQUI SI TI ON   0   0   0   0   0   0   77. 00   07800   CAR T-CELL I MMUNOTHERAPY   0   0   0   0   0   0   0   0   0		0	0	0	0		
77. 00   07700   ALLOGENEI C STEM CELL ACQUISITION   0   0   0   0   0   77. 00   07800   CAR T-CELL IMMUNOTHERAPY   0   0   0   0   0   0   0   0   0		0	0	0	7 00/		
78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 0 78. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0	/, <del>99</del> 6		7, 496		
OUTPATI ENT SERVICE COST CENTERS           91.00         09100 EMERGENCY         0         291,526         72,569         364,095         2,083         91.00			0		ol		
	OUTPATIENT SERVICE COST CENTERS	_					
92. UU  U92UU UBSEKVAITUN BEUS (NUN-DISTINCT PART	+ I	0	291, 526	72, 569			
	42. OO  O42OO OB3EKVAIION BED3 (NON-DI3IINCI PARI	1		ı	O		92. UU

Health Financial Systems	FRANCISCAN HE	EALTH- DYER		In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CO		Period: From 01/01/2023 To 12/31/2023	Worksheet B Part II Date/Time Pre 5/30/2024 3:4	pared: 5 pm
		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	
OTHER REIMBURSABLE COST CENTERS	,			_		
101.00 10100 HOME HEALTH AGENCY	0	24, 679	1, 02	1 25, 700		101. 00
102.00 10200 OPIOLD TREATMENT PROGRAM	0	0		0 0	0	102. 00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300   NTEREST EXPENSE		7 000 750				113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	0	7, 282, 759	4, 518, 43	6 11, 801, 195	36, 207	118. 00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	14, 465	4, 06	1 18, 526	) TE	190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	248, 911	4,00	0 248, 911		190.00
192. 01 19201 WORKI NG WELL	0	240, 911		0 246, 911		192. 00
192. 02 19202 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0		192. 02
192. 03 19203 MI SC	0	0		0 0		192. 03
194. 00 07950  RESI DENTI AL	0	550, 760	21, 95	1 572, 711		194. 00
194. 01 07954 OTHER NONREIMBURSABLE COST CENTERS	0	0	,	0 0	· ·	194. 01
194. 02 07952 PSYCHI ATRI C	0	481, 231		0 481, 231	0	194. 02
194.03 07953 CENTER OF HOPE	0	0		0	0	194. 03
200.00 Cross Foot Adjustments				0		200. 00
201.00 Negative Cost Centers		0		0	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	0	8, 578, 126	4, 544, 44	8 13, 122, 574	37, 761	202. 00

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2023 | Part II | To 12/31/2023 | Date/Time Prepared: | From 2004/2024 | Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0090

Coast Center Description					''	o 12/31/2023	Date/lime Pre 5/30/2024 3:4	
SEMBRIL SERVICE LOST CRIFTERS   5.04   6.00   7.00   8.00   9.00   9.00		Cost Center Description	OTHER		OPERATION OF			
10				REPAI RS	PLANT	LINEN SERVICE		
DEBRIAND SERVICE COST CENTERS   1.00   1.0				6, 00	7. 00	8. 00	9, 00	
2.00 000000 CAP REL OSTS-LMRUE EQUIP   2.00   4.00   6.00   6.00   7.00   6.00   6.00   7.00   6.00   6.00   7.00   7.00		GENERAL SERVICE COST CENTERS						
4.00 00000 EMPLOYEE BERKET IS CEPARTHENT 5.00 000000 FUNIT KAINING STATE AND								1
0.00   0.00		1						1
0.000   DOCOO   DOCO			1 10/ 053					1
7.00 007000   ORDANITY C.   16, 30   83, 445   489, 136   70, 00				1 507 323				1
8.00   000000   LAURIDRY & LI LINES SERVICE   4, 758   0   0   4,758   0   0.000000   1.00000   1.00000   1.0000   1.00000   1.00000   1.0		1	1					1
10.00   01000   DIETARY   9, 350   19, 690   6, 764   0   2, 243   10, 00   11.00   01100   024FERNA   8, 727   28, 425   9, 765   0   3, 237   11.00   01100   024FERNA   8, 727   28, 425   3, 007   1, 033   0   324   13.00   2, 371   10.00   01100   021		1 1						1
11.00 0 10100 CAFETERIA			22, 595	22, 320	7, 667	0	159, 629	9. 00
13.00 0 10300 MINSI NA CAMIN INSTRATION			1					1
14.00   01400  CENTRAL SERVICES & SUPPLY   8,71°    25,35°    8,70°    0   2,887   14,00°    16.00   101500  PRIMAINCY   24,424   13,283   4,562   0   1,573   15.00   10100  DEDICAL RECORDS & LIBRARY   11,348   20,234   6,552   0   0   0   17.00		1 1	1			_		1
15.00   01500 PINAMACY   24, 424   13, 283   4, 56.52   0   1, 513   15.00   17.00   01700   01700   0201   17.		1 I	1					1
10 00   101-600 MEDI CAL RECONDS & LIBRARY   11, 348   20, 236   6, 992   0   2, 305   16, 00   0   0   0   0   0   0   17, 00   1700   00   00   0   0   0   0   0   0			1					1
21 00   02100   BAR SERVICES-SALARY & FININGES APPRAY   919   0   0   0   0   21 00		1	1					1
22.00   02200   RR SERVICES-OTHER PROM COSTS APPREY   91	17. 00		o	0	0	0	0	17. 00
23.00			1	0		_	1	
23.01   02301   PARAMED ED PROM- PIADAMOY   2,990   870   299   0   99   23.01			1	0		_	1	1
23 02 (02302) PARAMED ED PROM. PAIDLOCKY 0 0 0 0 0 0 23 03 03 02303 parameter by Paid Prof. Paid Paid Paid Paid Paid Paid Paid Paid		1	1		•	_		1
12.30   10.303   PARAMED ED PREM. RADIOLOGY   0   0   0   0   0   0   23 .03								1
30.00   30.00   ADULT S & PEDIATRICS   197, 036   328, 512   112, 848   3, 619   37, 417   30, 00   31.00   03100   03200					•			
31.00 (03000 (INTERSIVE CARE UNIT 1 0 0 0 0 0 0 32.00 32.00 330.00 (33000 (SERONARY CARE UNIT 1 0 0 0 0 0 0 32.00 330.00 330.00 (3200.00 330.00 02006 (SERONARY LITERSIVE CARE UNIT 1 5.367 2.208 75.8 54 (251 35.00 40.00 60 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		INPATIENT ROUTINE SERVICE COST CENTERS						
32.00   03200   COROMARY CARE UNIT   0   0   0   0   0   0   32.00								1
33.00   03300   BURN INTENSIVE CARE UNIT   0   0   0   0   33.00     33.00   02060   BORDATAL INTENSIVE CARE UNIT   5.367   2.208   758   54   251   35.00     41.00   04100   SUBPROVIDER   0   0   0   0   0   0   0   0     42.00   04200   SUBPROVIDER   0   0   0   0   0   0   0   0   0     43.00   04200   SUBPROVIDER   0   0   0   0   0   0   0   0   0     42.00   04200   SUBPROVIDER   0   0   0   0   0   0   0   0   0			26, 930					
35.00			0	_		_		1
11.00   04100 SUBPROVI DER - I PR			5 367	_		_		
42.00   04200   NURSERY   10.150   0   0   0   0   0   24.2		1					•	1
ANCILLARY SERVICE COST CENTERS   50.00   50.00   0PRATI NG ROOM   35,845   68,289   23,459   0   7,778   50.00   50.00   0SOOD   0PRATI ENT SURGERY   10,326   58,328   20,037   0   6,643   50.01   51.00   51.00   0SOOD   0PRATI ENT SURGERY   10,326   58,328   20,037   0   6,643   50.01   51.00   53.00   0SOOD   0FECOVERY ROOM   5,477   22,991   0   0   0   0   0   53.00   53.00   0SOOD   ANESTHESI OLOGY   217   0   0   0   0   0   53.00   0SOOD   0		1	1					1
50.00   05000   0FEATI NG ROOM   35, 845   68, 289   23, 459   0   7, 778   50.00	43.00		10, 150	0	0	108	0	43.00
50.01   05001   0JTATI ENT SURGERY   10,326   58,328   20,037   0   6,643   50.01						_		
51.00   05100   RECOVERY ROOM   5, 477   22, 991   7, 898   0   2, 619   51.00   53.00   53.00   05300   ARSTHESI DLOGY   217   0   0   0   0   53.00   05300   ARSTHESI DLOGY   217   54.00   05400   ARDIDLOGY-DI ACNOSTIC   34, 784   97, 550   33, 511   0   11, 110   54.00   05401   ARDIDLOGY-SPECI ALI PROCEDURES   13, 616   6, 387   2, 194   0   727   54.01   55.00   05500   RADIDLOGY-THERAPEUTIC   0   0   0   0   0   0   0   0   0		1 1				_		
53.00   05300   ANESTHESI OLOGY   217   0   0   0   53.00   54.01   05401   RADI OLOGY-SPECIAL PROCEDURES   13,616   6,387   2,194   0   727   54.01   55.00   05500   RADI OLOGY-SPECIAL PROCEDURES   13,616   6,387   2,194   0   727   54.01   55.00   05500   RADI OLOGY-THERAPEUTIC   0   0   0   0   0   0   0   55.00   05500   RADI OLOGY-THERAPEUTIC   0   0   0   0   0   0   56.00   05600   RADI OLOGY-THERAPEUTIC   0   0   0   0   0   56.00   05600   RADI OLOGY-THERAPEUTIC   0   0   0   0   0   57.00   06000   LABORATORY   0   0   0   0   0   58.00   06000   LABORATORY   0   0   0   0   0   58.00   06000   LABORATORY   0   0   0   0   0   59.00   06500   RESPIRATORY THERAPY   22,186   8,863   3,045   0   1,099   65.00   69.00   06500   PRYSI CAL THERAPY   0   0   0   0   0   0   69.00   06500   PRYSI CAL THERAPY   0   0   0   0   0   0   69.00   06700   OCCUPATI OWAL THERAPY   0   0   0   0   0   0   0   69.00   06900   SPEECH PATHOLOGY   0   0   0   0   0   0   69.00   06900   SPEECH PATHOLOGY   0   0   0   0   0   0   69.00   06900   ELECTROCARDI OLOGY   10,302   15,772   5,418   0   1,796   90   71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENT   99,032   0   0   0   0   0   0   0   72.00   07200   MPLD. DEV. CHARGED TO PATIENT   99,032   0   0   0   0   0   0   0   73.00   07300   DRUGS CHARGED TO PATIENTS   26,247   0   0   0   0   0   0   74.00   07300   DRUGS CHARGED TO PATIENTS   26,247   0   0   0   0   0   0   75.00   03630   ULTAS SOUND   ORGANISH CLINIC   1   0   0   0   0   0   76.00   03950   PLIA COUNTER   0   0   0   0   0   0   0   76.00   03950   PLIA COUNTER   0   0   0   0   0   0   76.00   03950   CARREGE TO PATIENTS   0   0   0   0   0   0   76.00   03950   CARREGE TO PATIENTS   0   0   0   0   0   0   76.00   03950   CARREGE TO PATIENTS   0   0   0   0   0   0   76.00   03950   CARREGE TO PATIENTS   0   0   0   0   0   76.00   03950   CARREGE TO PATIENTS   0   0   0   0   0   0   76.00   03950   CARREGE TO PATIENTS   0   0   0   0   0   0   76.00   03950   CARREGE TO PATIENTS   0   0   0			1					
54. 00   05400   RADIOLOGY-DI AGNOSTIC   34, 784   97, 550   33, 511   0   11, 110   54, 00   40. 10   05401   RADIOLOGY-SPECIAL PROCEDURES   13, 616   6, 387   2, 194   0   727   54, 01   55. 00   05500   RADIOLOGY-THERAPEUTIC   0   0   0   0   0   0   55. 00   05500   RADIOLOGY-THERAPEUTIC   0   0   0   0   0   56. 00   05600   RADIOLOGY-THERAPEUTIC   0   0   0   0   0   63. 00   05600   RADIOLOGY-THERAPEUTIC   0   0   0   0   0   63. 00   05600   RADIOLOGY-THERAPEUTIC   0   0   0   0   63. 00   06300   BEDROID STORING   PROCESSING & TRANS.   3, 303   11, 725   4, 028   0   1, 335   63, 00   65. 00   06500   RESPIRATORY THERAPY   36, 006   6, 014   2, 066   0   665   66, 00   66. 00   06600   RESPIRATORY THERAPY   36, 006   6, 014   2, 066   0   665   66, 00   67. 00   06700   OCCUPATIONAL THERAPY   5, 482   2, 303   791   0   262   67, 00   68. 00   06800   SPEECH PATHOLOGY   5, 280   0   0   0   0   0   68, 00   69. 00   06900   ELECTROCARDIOLOGY   10, 302   15, 772   5, 418   0   1, 796   69, 00   71. 00   07000   DELECTROCARDIOLOGY   10, 302   15, 772   5, 418   0   1, 796   69, 00   72. 00   07200   INPL. DEV. CHARGED TO PATIENT   99, 032   0   0   0   0   0   0   0   73. 00   07300   IMPL. DEV. CHARGED TO PATIENT   99, 032   0   0   0   0   0   0   0   74. 00   07300   IMPL. DEV. CHARGED TO PATIENT   34, 180   0   0   0   0   0   0   75. 00   07300   IMPL. DEV. CHARGED TO PATIENT   34, 180   0   0   0   0   0   0   0   76. 00   03952   ATH LAB   25, 055   37, 433   17, 533   0   5, 813   76, 01   76. 00   03952   ATH LAB   25, 055   37, 433   17, 533   0   5, 813   76, 01   76. 00   03955   OTH LAB   CLINIC   5, 563   7, 981   2, 742   0   0   0   0   0   0   76. 00   03955   OTH RANICLIARY SERVICE COST CENTERS   0   0   0   0   0   0   0   0   76. 01   03957   OTHER ANCILLARY SERVICE COST CENTERS   0   0   0   0   0   0   0   0   76. 01   03959   OTHER ANCILLARY SERVICE COST CENTERS   0   0   0   0   0   0   0   0   76. 01   07000   OTHER RETURN SERVICE COST CENTERS   0   0   0   0   0   0   0   0   76		1 1	1				_, -,	1
55.00   OSDO  RADIO LOGY-THERAPEUTI C   0   0   0   0   55.00		1 I	1	97, 550	33, 511	0	11, 110	
56. 00   05600   RADIO I SOTOPE   4,806   20,423   7,016   0 2,326   56 00   06000   LABORATORY   55,027   21,483   7,380   0 2,447   60.00   06300   BLODD STORING, PROCESSING & TRANS.   3,303   11,725   4,028   0   1,335   63.00   065.00   06500   RESPIRATORY THERAPY   22,186   8,863   3,045   0   1,009   65.00   065.00   06500   PHYSI CAL THERAPY   36,006   6,014   2,066   0   6685   66.00   0600   06000   PHYSI CAL THERAPY   36,006   6,014   2,066   0   6685   66.00   07. 00   06700   0CCUPATI ONAL THERAPY   5,482   2,303   791   0   262   67.00   08.00   06800   SPECEH PARTHOLOGY   5,280   0   0   0   0   0   68.00   08.00   06800   SPECEH PARTHOLOGY   5,280   0   0   0   0   0   0   0   09. 00   07000   ELECTROCARDIOLOGY   10,302   15,772   5,418   0   1,796   69.00   09. 00   07000   ELECTROCREPHALOGRAPHY   2,999   21,794   7,487   0   2,482   70.00   070. 00   07000   MEDI CAL SUPPLIES CHARGED TO PATI ENT   99,032   0   0   0   0   0   0   72.00   072. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   34,180   0   0   0   0   0   0   73.00   073.00   07300   DRUGS CHARGED TO PATI ENTS   34,180   0   0   0   0   0   0   73.00   076. 01   03951   ALI N CLINIC   7,917   51,038   17,533   0   5,813   76.01   076. 02   03952   CATH LAB   25,055   37,433   17,533   0   5,813   76.01   076. 03   03952   CATH LAB   25,055   37,433   17,833   0   5,813   76.01   076. 04   03954   WOUND CARRE CENTER   6,278   26,358   9,055   0   3,002   76.04   076. 05   03340   BARIATRIC CLINIC   5,563   7,981   2,742   0   0   0   0   76.07   076. 08   03955   OTHER ANCILLARY SERVICE COST CENTERS   0   0   0   0   0   0   0   0   0   076. 07   03950   OTHER ANCILLARY SERVICE COST CENTERS   0   0   0   0   0   0   0   0   0	54. 01	05401 RADI OLOGY-SPECI AL PROCEDURES	13, 616	6, 387	2, 194	0	727	54. 01
60. 00   0c0000   LABORATORY   55, 027   21, 483   7, 380   0   2, 447   00, 00   0c300   0c500   0c50			0	_	1	_		1
63.00   06300   BLOOD STORI NG, PROCESSI NG & TRANS.   3, 303   11, 725   4, 028   0   1, 335   63, 00   65.00   06500   RESPI RATORY THERAPY   36, 006   6, 014   2, 066   0   685   66, 00   66.00   06600   PHYSI CAL THERAPY   36, 006   6, 014   2, 066   0   685   66, 00   67.00   06700   0CCUPATI ONAL THERAPY   5, 482   2, 303   791   0   262   67, 00   69.00   06900   DEECTROCARDI OLOGY   5, 280   0   0   0   0   0   69.00   06900   DEECTROCARDI OLOGY   10, 302   15, 772   5, 418   0   1, 796   69, 00   69.00   07000   ELECTROCARDI OLOGY   10, 302   15, 772   5, 418   0   1, 796   69, 00   69.00   07000   ELECTROCARDI OLOGY   10, 302   15, 772   5, 418   0   1, 796   69, 00   69.00   07000   ELECTROCARDI OLOGY   10, 302   15, 772   5, 418   0   0   0   0   67.00   07000   MEDI CAL SUPPLIES CHARGED TO PATI ENT   99, 032   0   0   0   0   0   0   67.00   07200   IMPL. DEV. CHARGED TO PATI ENT   99, 032   0   0   0   0   0   0   0   67.00   07200   IMPL. DEV. CHARGED TO PATI ENTS   34, 180   0   0   0   0   0   0   0   67.00   03630   ULTRA SOUND   6, 6, 622   9, 480   3, 257   0   1, 800   76, 00   67.01   03951   PAIN CLINIC   7, 917   51, 038   17, 533   0   5, 813   76, 01   67.02   03952   CATH LAB   25, 055   37, 433   12, 859   0   4, 263   76, 02   67.03   03953   ACTIVI TY THERAPEUTIC   15, 840   23, 633   8, 118   0   2, 692   76, 03   67.04   03954   WOUND CARE CENTER   6, 278   26, 358   9, 055   0   3, 002   76, 03   67.06   03395   OTHER ANCILLARY SERVICE COST CENTERS   0   0   0   0   0   0   0   0   67.00   03950   CV RESOURCE CENTER   0   0   0   0   0   0   0   0   67.00   03950   CV RESOURCE CENTER   0   0   0   0   0   0   0   0   0   67.01   03959   OTHER ANCILLARY SERVICE COST CENTERS   0   0   0   0   0   0   0   0   0   67.01   03959   OTHER ANCILLARY SERVICE COST CENTERS   0   0   0   0   0   0   0   0   0			1				_,	1
65.00   06500   RESPIRATORY THERAPY   22,186   8,863   3,045   0   1,009   65,00   66.00   06600   PHYSI CAL THERAPY   36,006   6,014   2,066   0   685   66.00   67.00   06700   OCCUPATI ONAL THERAPY   5,482   2,303   791   0   262   67.00   68.00   06800   SPEECH PATHOLOGY   5,280   0   0   0   0   0   68.00   69.00   06900   ELECTROCARDI OLOGY   10,302   15,772   5,418   0   1,796   69.00   70.00   07000   ELECTROCARDI OLOGY   10,302   15,772   5,418   0   1,796   69.00   71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENT   99,032   0   0   0   0   0   71.00   72.00   07200   IMPL. DEV. CHARGED TO PATI ENT   99,032   0   0   0   0   0   0   72.00   73.00   07300   ORUGS CHARGED TO PATI ENTS   26,247   0   0   0   0   0   73.00   76.00   03630   ULTRA SOUND   6,622   9,480   3,257   0   1,080   76.00   76.01   03951   PAIN CLINIC   7,917   51,038   17,533   0   5,813   76.00   76.02   03952   CATH LAB   25,055   37,433   12,859   0   4,263   76.00   76.03   03953   ACTIVITY THERAPEUTIC   15,840   23,633   8,118   0   2,692   76.03   76.04   03954   WOUND CARE CENTER   6,278   26,358   9,055   0   3,002   76.04   76.05   03340   BARI ATRIC CLINIC   5,563   7,981   2,742   0   909   76.06   76.07   03950   CVRESOURCE CENTER   0   0   0   0   0   0   0   76.08   03955   OTHER ANCI LLARY SERVICE COST CENTERS   0   0   0   0   0   0   0   76.09   03959   OTHER ANCI LLARY SERVICE COST CENTERS   0   0   0   0   0   0   0   76.10   03959   OTHER ANCI LLARY SERVICE COST CENTERS   0   0   0   0   0   0   0   76.11   03959   OTHER ANCI LLARY SERVICE COST CENTERS   0   0   0   0   0   0   0   77.00   07800   CART -CELL IMMUNOTHERAPY   0   0   0   0   0   0   78.00   00700   LARGENCY   0   0   0   0   0   0   78.00   00700   LARGENCY   0   0   0   0   0   0   78.00   00700   LARGENCY   0   0   0   0   0   0   78.00   00700   LARGENCY   0   0   0   0   0   0   78.00   00700   LARGENCY   0   0   0   0   0   0   78.00   00700   LARGENCY   0   0   0   0   0   0   78.00   00700   LARGENCY   0   0   0   0   0   0   0   78.00			1					1
66.00   06600   PHYSICAL THERAPY   36,006   6,014   2,066   0   685   66,00   67.00   06700   0CCUPATI ONAL THERAPY   5,482   2,303   791   0   262   67,00   68.00   06800   SPEECH PATHOLOGY   5,280   0   0   0   0   0   69.00   06900   ELECTROCARDI OLOGY   10,302   15,772   5,418   0   1,796   69,00   69.00   07000   ELECTROCARDI OLOGY   10,302   15,772   5,418   0   1,796   69,00   71.00   07000   ELECTROCARDI OLOGY   2,482   70,00   0   0   0   71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENT   99,032   0   0   0   0   0   72.00   07200   IMPL. DEV. CHARGED TO PATI ENTS   26,247   0   0   0   0   0   0   73.00   07300   DRUGS CHARGED TO PATI ENTS   34,180   0   0   0   0   0   76.01   03951   PAIN CLINIC   7,917   51,038   17,533   0   5,813   76.01   76.02   03952   CATH LAB   25,055   37,433   12,859   0   4,263   76.02   76.03   03953   ACTI VI TY THERAPEUTI C   15,840   23,633   8,118   0   2,692   76.03   76.04   03954   WOUND CARE CENTER   6,278   26,358   9,055   0   3,002   76.05   76.05   03340   BARIATRI C CLINIC   5,563   7,981   2,742   0   909   76.05   76.06   03955   OTHER ANCI LLARY SERVI CE COST CENTERS   0   0   0   0   0   0   76.01   03955   OTHER ANCI LLARY SERVI CE COST CENTERS   0   0   0   0   0   0   76.01   03959   OTHER ANCI LLARY SERVI CE COST CENTERS   0   0   0   0   0   0   76.02   03959   OTHER ANCI LLARY SERVI CE COST CENTERS   0   0   0   0   0   0   76.01   03959   OTHER ANCI LLARY SERVI CE COST CENTERS   0   0   0   0   0   0   76.02   03959   OTHER ANCI LLARY SERVI CE COST CENTERS   0   0   0   0   0   0   76.01   03959   OTHER ANCI LLARY SERVI CE COST CENTERS   0   0   0   0   0   0   76.01   03959   OTHER ANCI LLARY SERVI CE COST CENTERS   0   0   0   0   0   0   76.02   03950   OTHER ANCI LLARY SERVI CE COST CENTERS   0   0   0   0   0   0   76.03   07500   CART T-CELL IMMUNOTHERAPY   0   0   0   0   0   0   76.04   07500   CART T-CELL IMMUNOTHERAPY   0   0   0   0   0   0   76.05   07500   CART T-CELL IMMUNOTHERAPY   0   0   0   0   0   76.06   07500   CART T-CEL			1				.,	
68. 00   06800   SPECH PATHOLOGY   5, 280   0   0   0   0   68. 00   69. 00   06900   ELECTROCARDIOLOGY   10, 302   15, 772   5, 418   0   1, 766   69. 00   07000   ELECTROCARDIOLOGY   10, 302   15, 772   5, 418   0   1, 748   71. 00   07000   ELECTROCROEPHALOGRAPHY   2, 999   21, 794   7, 487   0   2, 482   70. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENT   99, 032   0   0   0   0   0   71. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   26, 247   0   0   0   0   0   72. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   34, 180   0   0   0   0   0   0   75. 00   07300   DRUGS CHARGED TO PATI ENTS   34, 180   0   0   0   0   0   76. 01   03951   PAIN CLI NI C   7, 917   51, 038   17, 533   0   5, 813   76. 01   76. 02   03952   CATH LAB   25, 055   37, 433   12, 859   0   4, 263   76. 02   76. 03   03953   ACTI VI TY THERAPEUTI C   15, 840   23, 633   8, 118   0   2, 692   76. 03   76. 04   03954   WOUND CARE CENTER   6, 278   26, 358   9, 055   0   3, 002   76. 04   76. 05   03340   BARI ATRIC CLI NI C   5, 563   7, 981   2, 742   0   909   76. 05   76. 06   03030   HEALTHY LI VI NG CENTER   0   0   0   0   0   0   76. 07   03950   CVARSOURCE CENTER   0   0   0   0   0   0   76. 08   03955   OTHER ANCI LLARY SERVI CE COST CENTERS   0   0   0   0   0   76. 09   03956   LACTATI ON CLI NI C   5, 597   1, 822   626   0   208   76. 12   76. 10   03958   OTHER ANCI LLARY SERVI CE COST CENTERS   0   0   0   0   0   76. 10   03958   OTHER ANCI LLARY SERVI CE COST CENTERS   0   0   0   0   0   76. 10   03958   OTHER ANCI LLARY SERVI CE COST CENTERS   0   0   0   0   0   76. 10   03950   OVERSOURCE CENTERS   0   0   0   0   0   76. 10   03950   OVERSOURCE CENTERS   0   0   0   0   0   76. 10   03950   OVERSOURCE CENTERS   0   0   0   0   0   76. 10   03950   OVERSOURCE CENTERS   0   0   0   0   0   76. 10   03950   OVERSOURCE CENTERS   0   0   0   0   0   76. 10   03950   OVERSOURCE CENTERS   0   0   0   0   0   76. 10   03950   OVERSOURCE CENTERS   0   0   0   0   0   77. 00   0700   OVERSOURCE			1					
69. 00   06900   ELECTROCARDI OLOGY   10, 302   15, 772   5, 418   0   1, 796   69. 00   70. 00   0   0   0   0   0   0   0   0				2, 303				1
70. 00   07000   CLECTROENCEPHALOGRAPHY   2,999   21,794   7,487   0   2,482   70. 00   71. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   99. 032   0   0   0   0   0   71. 00   72. 00   72. 00   72. 00   72. 00   73. 00   7300   DRUGS CHARGED TO PATI ENTS   34,180   0   0   0   0   0   0   73. 00   73. 00   73.00   03630   ULTRA SOUND   6.6 22   9,480   3,257   0   1,080   76. 00   76. 00   76. 01   03951   PAIN CLINIC   7,917   51,038   17,533   0   5,813   76. 01   76. 02   76. 03   03952   CATH LAB   25,055   37,433   12,859   0   4,263   76. 02   76. 03   03953   ACTI VI TY THERAPEUTIC   15,840   23,633   8,118   0   2,692   76. 03   76. 04   03954   WOUND CARE CENTER   6,278   26,358   9,055   0   30,002   76. 04   76. 05   76. 06   03340   BARI ATRI C CLINIC   5,563   7,981   2,742   0   909   76. 05   76. 06   033950   CV RESOURCE CENTER   0   0   0   0   0   0   0   0   0				_				
71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENT   99,032   0   0   0   0   0   71. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   26, 247   0   0   0   0   0   72. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   34,1180   0   0   0   0   0   73. 00   76. 00   03630   ULTRA SOUND   6, 622   9, 480   3, 257   0   1, 080   76. 00   76. 01   03951   PAIN CLINIC   7, 917   51, 038   17, 533   0   5, 813   76. 01   76. 02   03952   CATH LAB   25, 055   37, 433   12, 859   0   4, 263   76. 02   76. 03   03953   ACTIVITY THERAPEUTIC   15, 840   23, 633   8, 118   0   2, 692   76. 03   76. 04   03954   WOUND CARE CENTER   6, 278   26, 358   9, 055   0   3, 002   76. 04   76. 05   03340   BARI ATRIC CLINIC   5, 563   7, 981   2, 742   0   909   76. 05   76. 06   03303   HEALTHY LIVING CENTER   0   0   0   0   0   0   76. 05   76. 07   03950   CV RESOURCE CENTER   0   0   0   0   0   0   0   76. 08   03955   OTHER ANCI LLARY SERVICE COST CENTERS   0   0   0   0   0   0   76. 10   03958   OTHER ANCI LLARY SERVICE COST CENTERS   0   0   0   0   0   0   76. 10   03959   ATHER ANCI LLARY SERVICE COST CENTERS   0   0   0   0   0   0   76. 10   03959   ATHER ANCI LLARY SERVICE COST CENTERS   0   0   0   0   0   0   76. 10   03950   OTHER ANCI LLARY SERVICE COST CENTERS   0   0   0   0   0   0   76. 10   03950   OTHER ANCI LLARY SERVICE COST CENTERS   0   0   0   0   0   76. 10   03950   OTHER ANCI LLARY SERVICE COST CENTERS   0   0   0   0   0   76. 10   03950   OTHER ANCI LLARY SERVICE COST CENTERS   0   0   0   0   0   76. 10   03950   OTHER ANCI LLARY SERVICE COST CENTERS   0   0   0   0   0   76. 10   03950   OTHER ANCI LLARY SERVICE COST CENTERS   0   0   0   0   0   76. 10   03950   OTHER ANCI LLARY SERVICE COST CENTERS   0   0   0   0   0   76. 10   03950   OTHER ANCI LLARY SERVICE COST CENTERS   0   0   0   0   76. 10   03950   OTHER ANCI LLARY SERVICE COST CENTERS   0   0   0   0   76. 10   03950   OTHER ANCI LLARY SERVICE COST CENTERS   0   0   0   0   76. 10   03950   OTHER ANCI LLARY SERVICE COST CEN		1 1					.,	
72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   26, 247   0 0 0 0 0 0 0 72. 00 73. 00 73.00   07300   DRUGS CHARGED TO PATIENTS   34, 180 0 0 0 0 0 0 0 73. 00 76. 00 0 3630   ULTRA SOUND   6, 622 9, 480 3, 257 0 1, 080 76. 00 0 0 76. 00 0 0 75. 813 76. 01 03951   PAIN CLINIC   7, 917 51, 038 17, 533 0 5, 813 76. 01 76. 02 03952   CATH LAB   25, 055 37, 433 12, 859 0 4, 263 76. 02 76. 03 03953   ACTI VITY THERAPEUTIC   15, 840 23, 633 8, 118 0 2, 692 76. 03 76. 04 03954   WOUND CARE CENTER   6, 278 26, 358 9, 055 0 3, 002 76. 05 76. 06 03340   BARI ATRI C CLINI C   5, 563 7, 981 2, 742 0 909 76. 05 76. 06 03030   HEALTHY LIVING CENTER   0 0 0 0 0 0 0 76. 05 76. 06 03030   HEALTHY LIVING CENTER   0 0 0 0 0 0 0 76. 07 76. 07 76. 08 03955   OTHER ANCI LLARY SERVI CE COST CENTERS   0 0 0 0 0 0 0 0 0 76. 07 76. 09 76. 10 03958   OTHER ANCI LLARY SERVI CE COST CENTERS   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0								
73. 00   07300   DRUGS CHARGED TO PATIENTS   34, 180   0   0   0   0   73. 00   76. 00   03630   ULTRA SOUND   6, 622   9, 480   3, 257   0   1, 080   76. 00   76. 01   03951   PAIN CLINIC   7,917   51, 038   17, 533   0   5, 813   76. 01   76. 02   03952   CATH LAB   25, 055   37, 433   12, 859   0   4, 263   76. 02   76. 03   03953   ACTIVITY THERAPEUTIC   15, 840   23, 633   8, 118   0   2, 692   76. 03   76. 04   03954   WOUND CARE CENTER   6, 278   26, 358   9, 055   0   3, 002   76. 04   76. 05   03340   BARIATRIC CLINIC   5, 563   7, 981   2, 742   0   990   76. 05   76. 06   03030   HEALTHY LIVING CENTER   0   0   0   0   0   0   76. 06   76. 07   03950   CV RESOURCE CENTER   0   0   0   0   0   0   0   76. 08   03955   OTHER ANCILLARY SERVICE COST CENTERS   0   0   0   0   0   0   76. 10   03957   OTHER ANCILLARY SERVICE COST CENTERS   0   0   0   0   0   76. 11   03958   OTHER ANCILLARY SERVICE COST CENTERS   0   0   0   0   0   76. 12   03959   ANTICOAGULATION CLINIC   5, 597   1, 822   626   0   208   76. 12   77. 00   0700   ALLOGENEIC STEM CENTERS   0   0   0   0   0   0   78. 00   07800   CAR T-CELL IMMUNOTHERAPY   0   0   0   0   0   79. 00   0700   OSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS   0   0   0   0   70. 00   07000   OSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS   0   0   0   0   70. 00   10100   HOME HEALTH AGENCY   74,658   5,624   1,932   0   641   101. 00   70. 00   10100   HOME HEALTH AGENCY   74,658   5,624   1,932   0   641   101. 00   70. 00   00   00   00   00   00   00   0				0		_		
76. 01 03951 PAIN CLINIC 7, 917 51, 038 17, 533 0 5, 813 76. 01 76. 02 03952 CATH LAB 25, 055 37, 433 12, 859 0 4, 263 76. 02 76. 03 03953 ACTIVITY THERAPEUTIC 15, 840 23, 633 8, 118 0 2, 692 76. 03 76. 04 03954 WOUND CARE CENTER 6, 278 26, 358 9, 055 0 3, 002 76. 04 76. 05 03340 BARI ATRI C CLINI C 5, 563 7, 981 2, 742 0 909 76. 05 76. 06 03030 HEALTHY LIVING CENTER 0 0 0 0 0 0 76. 06 76. 07 03950 CV RESOURCE CENTER 0 0 0 0 0 0 0 76. 07 76. 08 03955 OTHER ANCILLARY SERVICE COST CENTERS 0 0 0 0 0 0 76. 08 76. 09 03956 LACTATI ON CLINI C 0 0 0 0 0 0 76. 10 76. 10 03957 OTHER ANCILLARY SERVICE COST CENTERS 0 0 0 0 0 0 76. 11 03958 OTHER ANCILLARY SERVICE COST CENTERS 0 0 0 0 0 0 0 76. 11 76. 12 03959 ANTI COAGULATI ON CLINI C 5, 597 1, 822 626 0 208 76. 12 77. 00 0700 ALLOGENEIC STEM CELL ACQUI SI TI ON 0 0 0 0 0 0 0 0 0 77. 00 0700 ALLOGENEIC STEM CELL ACQUI SI TI ON 0 0 0 0 0 0 0 0 77. 00 0700 CARE T-CELL IMMUNOTHERAPY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				0	Ō	0		
76. 02  03952		l l	6, 622					
76. 03  03953		l l						1
76. 04 03954 WOUND CARE CENTER 6, 278 26, 358 9, 055 0 3, 002 76. 04 76. 05 03340 BARI ATRI C CLI NI C 5, 563 7, 981 2, 742 0 909 76. 05 76. 06 03030 HEALTHY LI VI NG CENTER 0 0 0 0 0 0 0 76. 06 76. 07 03950 CV RESOURCE CENTER 0 0 0 0 0 0 0 0 76. 07 76. 08 03955 OTHER ANCI LLARY SERVI CE COST CENTERS 0 0 0 0 0 0 0 0 76. 08 76. 09 03956 LACTATI ON CLI NI C 0 0 0 0 0 0 0 76. 09 76. 10 03957 OTHER ANCI LLARY SERVI CE COST CENTERS 0 0 0 0 0 0 0 0 76. 10 76. 11 03958 OTHER ANCI LLARY SERVI CE COST CENTERS 0 0 0 0 0 0 0 76. 10 76. 12 03959 ANTI COAGULATI ON CLI NI C 5, 597 1, 822 626 0 208 76. 12 77. 00 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON 0 0 0 0 0 0 0 0 77. 00 78. 00 07800 CAR T-CELL I IMMUNOTHERAPY 0 0 0 0 0 0 0 77. 507 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART OTHER REI MBURSABLE COST CENTERS)  101. 00 10100 HOME HEALTH AGENCY 74, 658 5, 624 1, 932 0 641 101. 00			1					1
76. 05  03340 BARI ATRI C CLINI C		1						1
76. 06  03030 HEALTHY LIVING CENTER								1
76. 07 03950 CV RESOURCE CENTER 0 0 0 0 0 0 76. 07 76. 08 03955 OTHER ANCI LLARY SERVI CE COST CENTERS 0 0 0 0 0 0 0 76. 08 76. 09 03956 LACTATI ON CLI NI C 0 0 0 0 0 0 0 76. 09 76. 10 03957 OTHER ANCI LLARY SERVI CE COST CENTERS 0 0 0 0 0 0 0 76. 10 76. 11 03958 OTHER ANCI LLARY SERVI CE COST CENTERS 0 0 0 0 0 0 0 76. 11 76. 12 03959 ANTI COAGULATI ON CLI NI C 5,597 1,822 626 0 208 76. 12 77. 00 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON 0 0 0 0 0 0 0 77. 00 78. 00 07800 CAR T-CELL I IMMUNOTHERAPY 0 0 0 0 0 0 0 77. 507 78. 00 07800 OSBERVATI ON BEDS (NON-DI STI NCT PART 0THER REI MBURSABLE COST CENTERS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			3, 303	,, 361				1
76. 09 03956 LACTATION CLINIC 0 0 0 0 0 0 76. 09 76. 10 03957 OTHER ANCILLARY SERVICE COST CENTERS 0 0 0 0 0 0 0 76. 10 76. 11 03958 OTHER ANCILLARY SERVICE COST CENTERS 0 0 0 0 0 0 0 76. 11 76. 12 03959 ANTICOAGULATION CLINIC 5,597 1,822 626 0 208 76. 12 77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION 0 0 0 0 0 0 0 77. 00 78. 00 0700 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 0 0 78. 00  0000 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 77. 500  91. 00 09100 EMERGENCY 49,121 66,442 22,824 0 7,567 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0THER REIMBURSABLE COST CENTERS)  101. 00 10100 HOME HEALTH AGENCY 74,658 5,624 1,932 0 641 101. 00				0			1	1
76. 10 03957 OTHER ANCI LLARY SERVI CE COST CENTERS 0 0 0 0 0 0 0 76. 10 76. 11 03958 OTHER ANCI LLARY SERVI CE COST CENTERS 0 0 0 0 0 0 0 76. 11 76. 12 03959 ANTI COAGULATI ON CLI NI C 5, 597 1, 822 626 0 208 76. 12 77. 00 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON 0 0 0 0 0 0 77. 00 78. 00 07800 CAR T - CELL I IMMUNOTHERAPY 0 0 0 0 0 0 78. 00  OUTPATI ENT SERVI CE COST CENTERS  91. 00 09100 EMERGENCY 49, 121 66, 442 22, 824 0 7, 567 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0THER REI MBURSABLE COST CENTERS)  101. 00 10100 HOME HEALTH AGENCY 74, 658 5, 624 1, 932 0 641 101. 00	76. 08	03955 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76. 08
76. 11 03958 OTHER ANCI LLARY SERVI CE COST CENTERS 0 0 0 0 0 0 76. 11 76. 12 03959 ANTI COAGULATI ON CLI NI C 5, 597 1, 822 626 0 208 76. 12 77. 00 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON 0 0 0 0 0 0 77. 00 78. 00 07800 CAR T-CELL I MMUNOTHERAPY 0 0 0 0 0 0 0 78. 00  OUTPATI ENT SERVI CE COST CENTERS  91. 00 09100 EMERGENCY 49, 121 66, 442 22, 824 0 7, 567 91. 00  92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0THER REI MBURSABLE COST CENTERS)  101. 00 10100 HOME HEALTH AGENCY 74, 658 5, 624 1, 932 0 641 101. 00			0	0	0	0	1	1
76. 12 03959 ANTI COAGULATI ON CLI NI C 5, 597 1, 822 626 0 208 76. 12 77. 00 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON 0 0 0 0 0 0 77. 00 78. 00 07800 CAR T - CELL I MMUNOTHERAPY 0 0 0 0 0 0 0 78. 00  OUTPATI ENT SERVI CE COST CENTERS  91. 00 09100 EMERGENCY 49, 121 66, 442 22, 824 0 7, 567 91. 00  09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0THER REI MBURSABLE COST CENTERS)  101. 00 10100 HOME HEALTH AGENCY 74, 658 5, 624 1, 932 0 641 101. 00		1 I	0	0		_	1	1
77. 00   07700   ALLOGENEI C STEM CELL ACQUI SI TI ON   0   0   0   0   0   0   77. 00   78. 00   07800   CAR T-CELL   IMMUNOTHERAPY   0   0   0   0   0   0   78. 00   0UTPATI ENT SERVI CE COST CENTERS  91. 00   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART   0   0   0   0   0   0THER REI MBURSABLE COST CENTERS  101. 00   10100   HOME   HEALTH   AGENCY   74, 658   5, 624   1, 932   0   641   101. 00		1 1	5 507	1 222		_		1
78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 0 0 78. 00 0 0 78. 00 0 0 0 78. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			3, 397	1, 022 N	1			1
OUTPATIENT SERVICE COST CENTERS   91.00   09100   EMERGENCY   49,121   66,442   22,824   0   7,567   91.00   92.00   09200   0BSERVATI ON BEDS (NON-DI STI NCT PART   92.00   0THER REI MBURSABLE COST CENTERS   101.00   10100   HOME   HEALTH   AGENCY   74,658   5,624   1,932   0   641   101.00   101		07800 CAR T-CELL IMMUNOTHERAPY	l ől	Ö		_		1
91. 00		OUTPATIENT SERVICE COST CENTERS						
OTHER REIMBURSABLE COST CENTERS           101.00 10100 HOME HEALTH AGENCY         74,658         5,624         1,932         0         641 101.00		09100 EMERGENCY	49, 121	66, 442	22, 824	0	7, 567	1
101.00 10100 HOME HEALTH AGENCY 74,658 5,624 1,932 0 641 101.00	92. 00							92.00
	101 00		74 659	5 624	1 022	0	6/11	101 00
		1	74,030					
	, -		1	_	,		,	

Health Financial Systems	FRANCISCAN HI	EALTH- DYER		In Lie	u of Form CMS-:	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider Co		Period: From 01/01/2023	Worksheet B Part II	
				o 12/31/2023		
Cost Center Description	OTHER	MAINTENANCE &			HOUSEKEEPI NG	
	ADMINISTRATIVE AND GENERAL	REPAI RS	PLANT	LINEN SERVICE		
	5. 04	6.00	7. 00	8. 00	9. 00	
SPECIAL PURPOSE COST CENTERS						
113. 00 11300   NTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	1, 066, 175	1, 212, 097	387, 718	4, 753	126, 005	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1, 466	3, 297	1, 133	0	375	190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	5, 361	56, 729	19, 488	0	6, 461	192. 00
192. 01 19201 WORKI NG WELL	0	0	C	0	0	192. 01
192. 02 19202 PHYSI CLANS' PRI VATE OFFI CES	0	0	C	0	0	192. 02
192. 03 19203 MI SC	0	0	C	0	0	192. 03
194. 00 07950 RESI DENTI AL	30, 277	125, 523	43, 120	0	14, 296	194. 00
194.01 07954 OTHER NONREIMBURSABLE COST CENTERS	0	0	C	0	0	194. 01
194. 02 07952  PSYCHI ATRI C	3, 561	109, 677	37, 677	0	12, 492	194. 02
194.03 07953 CENTER OF HOPE	12	0	C	0	0	194. 03
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	0	[ C	0	0	201. 00
202.00   TOTAL (sum lines 118 through 201)	1, 106, 852	1, 507, 323	489, 136	4, 753	159, 629	202. 00

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2023 Part II
To 12/31/2023 Date/Time Prepared: 5/30/2024 3:45 pm Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0090

					12/31/2023	5/30/2024 3: 4	
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	
				ADMINISTRATION	SERVI CES & SUPPLY		
		10.00	11. 00	13. 00	14. 00	15. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUI P						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT 00593 OTHER ADMINISTRATIVE AND GENERAL						4.00
5. 04 6. 00	00600 MAINTENANCE & REPAIRS						5. 04 6. 00
7. 00	00700 OPERATION OF PLANT						7. 00
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY	138, 327					10. 00
11.00	01100 CAFETERI A	O	175, 200				11. 00
13.00	01300 NURSING ADMINISTRATION	0	5, 397	51, 230			13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	2, 296		293, 020		14. 00
15. 00	01500 PHARMACY	0	4, 875		6, 779	128, 939	15.00
16. 00 17. 00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	0	809 0	1	230 0	0	16. 00 17. 00
21. 00	02100   &R SERVICES-SALARY & FRINGES APPRVD	0	259		17	0	21. 00
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRV		287	0	0	0	22. 00
23. 00	02300 PARAMED ED PRGM - EMERGENCY MEDICINE	o	4	Ö	85	0	23. 00
23. 01	02301 PARAMED ED PRGM- LAB	0	248	0	418	0	23. 01
23. 02	02302 PARAMED ED PRGM- PHARMACY	O	1, 165	0	o	0	23. 02
23. 03	02303 PARAMED ED PRGM- RADIOLOGY	0	0	0	0	0	23. 03
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	109, 042	49, 960		30, 404	0	30.00
31. 00 32. 00	03100 I NTENSI VE CARE UNI T 03200 CORONARY CARE UNI T	11, 021	6, 231		2, 249	0	31. 00 32. 00
33. 00	03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	33. 00
35. 00	02060 NEONATAL INTENSIVE CARE UNIT	0	2, 724	-	392	0	35. 00
41. 00	04100 SUBPROVI DER - I RF	18, 264	6, 226		2, 579	0	41. 00
42.00	04200 SUBPROVI DER	0	0		0	0	42. 00
43.00	04300 NURSERY	0	0	0	0	0	43. 00
	ANCILLARY SERVICE COST CENTERS						
50. 00	05000 OPERATING ROOM	0	3, 556		54, 113	0	50.00
50. 01	05001 OUTPATI ENT SURGERY	0	2, 001		5, 262	0	50. 01
51. 00	05100 RECOVERY ROOM	0	1, 081	758	432	0	51.00
53. 00 54. 00	05300   ANESTHESI OLOGY   05400   RADI OLOGY-DI AGNOSTI C	0	246 5, 485		103 6, 434	0	53. 00 54. 00
54. 00	05401 RADI OLOGY-SPECI AL PROCEDURES	0	3, 283		10, 656	0	54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	3, 203	1,317	10, 030	0	55.00
56. 00	05600 RADI OI SOTOPE	o	775		13	0	56. 00
60.00	06000 LABORATORY	O	0	0	198	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	O	0	0	o	0	63. 00
65.00	06500 RESPI RATORY THERAPY	0	4, 980		2, 237	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	9, 599		6, 504	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	1, 571	0	72	0	67.00
68. 00 69. 00	06800   SPEECH PATHOLOGY   06900   ELECTROCARDI OLOGY	0	1, 014 2, 574		48, 513 4, 543	0	68. 00 69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	2, 574 674		269	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	l ol	0,1	1	0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	O	0	0	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	o	0	0	О	128, 939	73. 00
76. 00	03630 ULTRA SOUND	0	1, 635		5, 914	0	76. 00
76. 01	03951 PAIN CLINIC	0	1, 755		3, 043	0	76. 01
76. 02	03952 CATH LAB	0	4, 861		31, 851	0	76. 02
76. 03 76. 04	03953 ACTIVITY THERAPEUTIC 03954 WOUND CARE CENTER		5, 394 1, 676		608	0	76. 03 76. 04
76. 04 76. 05	03340 BARI ATRI C CLI NI C		1, 676 2, 209		1, 165 1, 654	0	76. 04
76. 05	03030 HEALTHY LIVING CENTER		2, 20 <del>9</del>	0 0	1, 034 N	0	76.05
76. 07	03950 CV RESOURCE CENTER		n	o o	o O	0	76. 07
76. 08	03955 OTHER ANCILLARY SERVICE COST CENTERS		0	Ö	Ö	0	76. 08
76. 09	03956 LACTATION CLINIC	o	0	0	О	0	76. 09
76. 10	03957 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76. 10
76. 11	03958 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76. 11
76. 12	03959 ANTI COAGULATI ON CLI NI C	0	1, 474		641	0	76. 12
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION		0	0	0	0	77.00
78. 00	O7800   CAR T-CELL IMMUNOTHERAPY   OUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	78. 00
91. 00	09100 EMERGENCY	O	14, 095	6, 353	24, 855	0	91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART		14, 075	0, 333	24, 000	0	92.00
	OTHER REIMBURSABLE COST CENTERS						]
	10100 HOME HEALTH AGENCY	0	8, 592		16, 435		101. 00
102.00	10200 OPIOID TREATMENT PROGRAM	0	0	0	O	0	102. 00

Health Financial Systems	FRANCISCAN HE	EALTH- DYER		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der Co		Period: From 01/01/2023 To 12/31/2023	Worksheet B Part II Date/Time Pre 5/30/2024 3:4	
Cost Center Description	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI O	CENTRAL N SERVI CES & SUPPLY	PHARMACY	

						5/30/2024 3:4	5 pm
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	
				ADMI NI STRATI ON	SERVICES &		
					SUPPLY		
		10.00	11. 00	13. 00	14. 00	15. 00	
SPECI A	AL PURPOSE COST CENTERS						
113. 00 11300	INTEREST EXPENSE						113. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	138, 327	159, 011	50, 323	268, 668	128, 939	118. 00
NONREI	MBURSABLE COST CENTERS						
190. 00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	288	0	17, 712	0	190. 00
192. 00 19200	PHYSICIANS' PRIVATE OFFICES	0	2, 537	152	2, 311	0	192. 00
192. 01 19201	WORKING WELL	0	0	0	0	0	192. 01
192. 02 19202	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192. 02
192. 03 19203	MISC	0	0	0	0	0	192. 03
194. 00 07950	RESI DENTI AL	o	13, 361	755	4, 329	0	194. 00
194. 01 07954	OTHER NONREIMBURSABLE COST CENTERS	o	0	0	o	0	194. 01
194. 02 07952	PSYCHI ATRI C	o	0	0	o	0	194. 02
194. 03 07953	CENTER OF HOPE	o	3	0	o	0	194. 03
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	О	o	0	201. 00
202.00	TOTAL (sum lines 118 through 201)	138, 327	175, 200	51, 230	293, 020	128, 939	202. 00

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2023 Part II
To 12/31/2023 Date/Time Prepared: 5/30/2024 3:45 pm Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0090

Crest Century Reserviption							0 12/31/2023	5/30/2024 3:4	
BERGARD SERVICE COST CERTERS						INTERNS &	RESI DENTS		
TIRRARY		Cost Ce	enter Description		SOCIAL SERVICE				
SEALOND. SERVICE. CORD. CERTIFIES   16.00   17.00   21.00   22.00   23.00						Y & FRINGES			
SERIENCE SCRIPTION   STATE   CONTINUES				LIBION			ATTICV		
1.00		OENEDAL CEDU	OF OOST OFNITEDS	16. 00	17. 00	21.00	22. 00	23. 00	
2.00	1 00			T		I	T		1 00
4.00   0000   DEPLOYEE BEREFITS DEPARTMENT		1 1							
0.00 000000000000000000000000000000000									
2.00   00700   DOPENTION OF PLANT	5.04	00593 OTHER A	ADMINISTRATIVE AND GENERAL						5. 04
0.00   0.000   JAUNIONY & LI NEN SERVICE   9.00   10.00   10.00   10.740   17.00   10.00   10.740   10.00   10.00   10.740   11.00   10.00   10.00   10.740   11.00   10.00		1 1							
9.00   0.0900   0.0950   EF INST 11.00   0.01000   DE FARY   0.00   0.00   17.00   0.01000   DE FARY   0.0		1 1							
10.00   01000   DETARY   11.00   1100   CAFETERIA     11.00		1 1							
11.00   0100   CAFETRIA   11.00   13.00   1300   MESIN		1 1							
14.00   01400   CENTRAL SERVICES & SUPPLY   1.00   01500   01600   MEDICAL RECORDS & LIBRARY   130,806   16.00   01600   MEDICAL RECORDS & LIBRARY   130,806   0   0   0   0   0   17.00   0700   01600   MEDICAL RECORDS & LIBRARY   150,806   0   0   0   0   0   0   0   0   0		1 1							
15.00   10500   PHANMACY   130, 806   150, 00   170		1 1							•
16.00   01-000   MEDICAL RECORDS & LIBRARY   130,806   0   0   0   17.00   170.00		1 1							
17.00   01700   SOCIAL SERVICE   0   0   894   1,236   221.00   2020   188 SERVICES-SALARY & FRINGES APPRVD   0   0   894   1,236   221.00   2020   188 SERVICES-STHER PROU COSTS APPRVD   0   0   0   1,236   221.00   2020   188 SERVICES-STHER PROU COSTS APPRVD   0   0   0   1,236   222.00   2020   188 SERVICES-STHER PROU COSTS APPRVD   0   0   0   1,611   23.00   23.01		1 1		130 806					
21.00   02100   IAS SERVICES-SALARY & FRINGES APPRVD   0   0   0   1,236   22.00   02200   IAS SERVICES-STHER PROKU OSTS APPRVD   0   0   0   1,236   1,236   02300   PARAMED ED PROM - EMERGENCY MEDICINE   0   0   0   0   0   1,236   02300   PARAMED ED PROM - EMERGENCY MEDICINE   0   0   0   0   0   0   0   0   0		1 1		130, 800	0				
23.00   02300   PARAMED ED PROM - LEREGENCY WEDICINE   0   0   1,611   23.00   23.01   02301   PARAMED ED PROM - LAB   0   0   0   23.01   23.				0	Ö	854			
1.00   1.00		1 1		0	0		1, 236		
23.02   02302   PARAMED ED PROM- PARIMACY   0   0   23.03		1 1		0	-	1		1, 611	
23.03				0					
INPAIL ENT ROUTH NE SERVICE COST CENTERS   30.00   0.00   0.00   0.01   0.00   0.01   0.00   0.01   0.00				0		•			
30.00	23.03								23.03
32.00   03200   ORROMARY CARE UNIT   0   0   33.00   33.00   33.00   0330   0300   BURN INTENSIVE CARE UNIT   0   0   35.00   35.00   02060   ROMANTAL INTENSIVE CARE UNIT   318   0   35.00   42.00	30.00			12, 517	0				30. 00
33. 00 03300 BURN INTENSIVE CARE UNIT 0 0 35.00 1 0350.00 CARED (NEONEATAL INTENSIVE CARE UNIT 31B 0 0 35.00 1 04.00 NEONEATAL INTENSIVE CARE UNIT 31B 0 0 41.00 41.00 41.00 1 04.00 04.00 04.00 SUBPROVI DER 0 0 42.00 04.00 04.00 SUBPROVI DER 0 0 42.00 04.00 NURSERY BURN 0 0 42.00 04.00 NURSERY BURN 0 0 42.00 04.00 NURSERY BURN 0 0 43.00 NURSERY BURN 0 0 43.00 NURSERY BURN 0 0 45.00 NURSERY BURN 0 0 55.00		1 1		1		1			
35.00   02060   NEONATAL INTENSIVE CARE UNIT   318   0   41.00   410.00   410.00   410.00   410.00   410.00   410.00   410.00   410.00   420.00		1 1		0	-	1			
1. 00   04100   SUBPROVI DER   1. PF   1. 297   0   42. 00   42. 00   42. 00   42. 00   42. 00   42. 00   42. 00   42. 00   42. 00   43. 00   43. 00   43. 00   43. 00   50.		1 1		318	Ŭ				
42 00   04200   SUBPROVI DER   0   0   43 00		1 1			_				
ANCILLARY SERVICE COST CENTERS   50.00   50.		1 1		1	0				
50.00   05000  05000  010TATI ENT SURGERY   5.52   0   50.01	43.00			189	0				43. 00
50.01   05001   010TATI ENT SURGERY   652   0   51.00   51.00   51.00   51.00   51.00   51.00   51.00   51.00   51.00   51.00   51.00   51.00   51.00   51.00   53.00   53.00   53.00   53.00   53.00   53.00   53.00   53.00   54.00   54.00   53.00   54.00   54.00   54.00   54.00   54.00   54.00   55.00   54.00   55.0	EO 00			14 214	0				E0 00
51.00   05100   RECOVERY ROOM   2,778   0   53.00									
53.00   05300   ANESTHESI OLOGY   3,173   0   54.00		1 1		1					
54. 01   05401   RADI OLOGY-SPECI AL PROCEDURES   2, 190   0   55. 00   05500   RADI OLOGY-THERAPEUTI C   0   0   0   0   0   0   0   0   0	53.00	05300 ANESTHE	ESI OLOGY	3, 173	0				53. 00
55. 00   05500   RADI OLOGY-THERAPEUTI C   0   0   56. 00   05600   RADI OLOGY-THERAPEUTI C   0   0   56. 00   05600   RADIO I OSTOPE   1, 837   0   0   06000   LABORATORY   13, 127   0   0   063. 00   06300   BLOOD STORI NG, PROCESSI NG & TRANS.   270   0   0   063. 00   06500   RESPIRATORY THERAPY   2, 356   0   065. 00   06500   RESPIRATORY THERAPY   2, 356   0   067. 00   067. 00   067. 00   067. 00   067. 00   067. 00   067. 00   067. 00   067. 00   067. 00   06800   SPEECH PATHOLOGY   1, 515   0   068. 00   06800   SPEECH PATHOLOGY   1, 515   0   068. 00   06800   SPEECH PATHOLOGY   1, 515   0   069. 00   069. 00   069. 00   069. 00   069. 00   069. 00   069. 00   069. 00   069. 00   069. 00   069. 00   071. 00   07000   ELECTROCARDI OLOGY   4, 613   0   071000   071000   071000   071000   071000   071000   071000   071000   071000   071000   071000		1 1		1					•
56.00   07.00   07.0		1 1		2, 190	_				
60. 00   06000   LABORATORY   13,127   0   60. 00   63.00   06500   RESPIRATORY THERAPY   2,356   0   65.00   66.00   06500   RESPIRATORY THERAPY   2,356   0   65.00   66.00   06600   PHYSI CAL THERAPY   4,482   0   66.00   06700   0CCUPATI ONAL THERAPY   1,919   0   67.00   06800   SPEECH PATHOLOGY   1,515   0   68.00   06800   SPEECH PATHOLOGY   1,515   0   68.00   06900   ELECTROCARDI OLOGY   4,613   0   69.00   07.		1 1		1 837		1			
63. 00   06300   BLOOD STORI NG, PROCESSING & TRANS.   270   0   06500   RESPIRATORY THERAPY   2,356   0   06500   RESPIRATORY THERAPY   4,482   0   06600   06600   PHYSI CAL THERAPY   4,482   0   06600   06600   PHYSI CAL THERAPY   1,919   0   0700   06700   0CCUPATI ONAL THERAPY   1,919   0   0700   069000   069000   06900   06900   069000   069000   069		1 1		1	_				
66. 00   06600   PHYSI CAL THERAPY   4, 482   0   66. 00   67. 00   06700   0CCUPATI ONAL THERAPY   1, 919   0   67. 00   68. 00   06800   SPEECH PATHOLOGY   1, 515   0   68. 00   69. 00   06900   ELECTROCARDI OLOGY   4, 613   0   69. 00   70. 00   07000   ELECTROENCEPHALOGRAPHY   958   0   70. 00   71. 00   07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENT   9, 111   0   71. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   3, 107   0   72. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   6, 822   0   73. 00   76. 00   03630   ULTRA SOUND   2, 348   0   76. 00   76. 01   03951   PAIN CLINIC   1, 677   0   76. 01   76. 02   03952   CATH LAB   8, 455   0   76. 02   76. 03   03953   ACTI VITY THERAPEUTIC   536   0   76. 02   76. 04   03954   WOUND CARE CENTER   747   0   76. 04   76. 05   03340   BARI ATRIC CLINIC   143   0   76. 04   76. 06   033030   HEALTHY LIVING CENTER   0   0   76. 06   76. 07   03950   CV RESOURCE CENTER   0   0   76. 07   76. 08   03955   OTHER ANCILLARY SERVICE COST CENTERS   0   0   76. 07   76. 10   03959   ATHER ANCILLARY SERVICE COST CENTERS   0   0   76. 10   76. 11   03958   ATHER ANCILLARY SERVICE COST CENTERS   0   0   76. 10   76. 12   03959   ATHER ANCILLARY SERVICE COST CENTERS   0   0   76. 10   76. 10   07700   ALLOGENEI C STEM CELL ACQUISITION   0   0   76. 12   77. 00   07800   CAR T-CELL IMMUNOTHERAPY   0   0   0   78. 00   07800   CAR T-CELL IMMUNOTHERAPY   0   0   0   00100   EMERGENCY   10, 799   0	63.00	06300 BL00D S	STORING, PROCESSING & TRANS.	270	0				63. 00
67. 00   06700   0CCUPATIONAL THERAPY   1,919   0   68. 00   06800   SPECCH PATHOLOGY   1,515   0   68. 00   68. 00   68. 00   68. 00   68. 00   69. 00   69. 00   69. 00   69. 00   69. 00   69. 00   69. 00   69. 00   69. 00   69. 00   69. 00   69. 00   69. 00   69. 00   69. 00   69. 00   69. 00   69. 00   69. 00   71. 00   710. 00   7		1 1		1					
68. 00   06800   SPEECH PATHOLOGY   1,515   0   68. 00   69. 00   69.00   CLECTROCARDI OLOGY   4,613   0   69. 00   70. 00   CLECTROCARCPHALOGRAPHY   958   0   70. 00   70. 00   CLECTROENCEPHALOGRAPHY   958   0   70. 00		1 1		1	-	1			
69. 00   06900   ELECTROCARDIOLOGY   4, 613   0   70. 00   7000   ELECTROENCEPHALOGRAPHY   958   0   70. 00   70. 00   7000   MEDI CAL SUPPLIES CHARGED TO PATIENT   9, 111   0   71. 00   72. 00   72. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   73. 00   74. 00   74. 00   75. 00   74. 00   75. 00   75. 00   76. 00   76. 01   76. 01   76. 01   76. 01   76. 01   76. 01   76. 01   76. 01   76. 01   76. 01   76. 01   76. 01   76. 01   76. 02   76. 03   76. 04   76. 04   76. 05   76. 05   76. 04   76. 05   76. 0		1 1		1		1			•
71. 00		1 1		1		1			
72. 00 07200   IMPL. DEV. CHARGED TO PATIENTS   3, 107   0   73. 00   73.00   07300   DRUGS CHARGED TO PATIENTS   6, 822   0   73. 00   76. 00   03630   ULTRA SOUND   2, 348   0   76. 01   76. 02   03951   PAI N CLINIC   1, 677   0   76. 01   76. 02   03952   CATH LAB   8, 455   0   76. 02   76. 03   03953   ACTIVITY THERAPEUTIC   536   0   76. 03   76. 04   03954   WOUND CARE CENTER   747   0   76. 04   76. 05   76. 06   03030   HEALTHY LIVING CENTER   0   0   0   76. 05   76. 06   76. 06   76. 06   76. 06   76. 06   76. 06   76. 06   76. 06   76. 07   76. 08   03955   OTHER ANCILLARY SERVICE COST CENTERS   0   0   0   76. 08   76. 09   03955   OTHER ANCILLARY SERVICE COST CENTERS   0   0   0   76. 10   03956   DATATION CLINIC   0   0   0   0   0   0   0   0   0				1		1			
73. 00				1	_				
76. 00				1	Ĭ				
76. 01		1 1				1			
76. 03		1 1							
76. 04		1 1							
76. 05									
76. 06		1 1		1					
76. 07		1 1		143	-				
76. 08		1 1		0	Ö				
76. 10 03957 OTHER ANCI LLARY SERVI CE COST CENTERS 0 0 0 76. 10 76. 11 03958 OTHER ANCI LLARY SERVI CE COST CENTERS 0 0 76. 11 76. 12 03959 ANTI COAGULATI ON CLI NI C 251 0 76. 12 77. 00 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON 0 0 778. 00 78. 00 07800 CAR T-CELL I IMMUNOTHERAPY 0 0 0 777. 00 00 00 00 00 00 00 00 00 00 00 00 00		1 1		0	0				
76. 11		1 1		0	0				1
76. 12 03959 ANTICOAGULATION CLINIC 251 0 76. 12 77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION 0 0 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 78. 00 00TPATIENT SERVICE COST CENTERS 91. 00 09100 EMERGENCY 10, 799 0 91. 00				0	_				•
77. 00   07700   ALLOGENEI C STEM CELL ACQUI SI TI ON   0   0   0   77. 00   78. 00   07800   CAR T-CELL I IMMUNOTHERAPY   0   0   0   0   0   0   0   0   0		1 1		251	ı .				•
78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 78. 00 78. 00 00 00 00 00 00 00 00 00 00 00 00 00		1 1		1					
91. 00   09100   EMERGENCY   10, 799   0   91. 00				0		•			
72. 00   אבי סטן סטטבת את דו סוג שביט לוויטוי ביו דו אינו די דו דו אינו ביו די אינו די		1 1		10, 799	0				
	7Z. UU	10 3200 ODSERVA	THOM DEDS (MON-DISTINCT PART	I	I	I	ı I		72.00

Health Financial Systems	FRANCISCAN H	EALTH- DYER		In Lie	eu of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der C		Peri od:	Worksheet B	
				From 01/01/2023 To 12/31/2023		narod:
				10 12/31/2023	5/30/2024 3: 4	
			INTERNS	& RESIDENTS		
Cost Center Description		SOCIAL SERVICE		R SERVI CES-OTHER		
	RECORDS &		Y & FRINGES	PRGM COSTS	PRGM -	
	LI BRARY			APPRV	EMERGENCY	
	16. 00	17. 00	21.00	22.00	MEDICINE 23.00	
OTHER REIMBURSABLE COST CENTERS	10.00	17.00	21.00	22.00	23.00	
101. 00 10100 HOME HEALTH AGENCY	1, 778	0				101.00
102. 00 10200 OPI OI D TREATMENT PROGRAM	0	0	)			102.00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 I NTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	130, 806	0		0 0	0	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	)			190. 00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	)			192. 00
192. 01 19201 WORKI NG WELL	0	0				192. 01
192. 02 19202 PHYSI CLANS' PRI VATE OFFI CES	0	0	)			192. 02
192. 03 19203 MI SC	0	0	1			192. 03
194. 00 07950 RESI DENTI AL	0	0	1			194. 00
194. 01 07954 OTHER NONREIMBURSABLE COST CENTERS	0	0				194. 01
194. 02 07952 PSYCHI ATRI C	0	0				194. 02
194. 03 07953 CENTER OF HOPE	0	0				194. 03
200.00 Cross Foot Adjustments			85	4 1, 236		200. 00
201.00 Negative Cost Centers	0	0	1	0		201. 00
202.00   TOTAL (sum lines 118 through 201)	130, 806	0	85	4 1, 236	1, 611	202. 00

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2023 | Part II | To 12/31/2023 | Date/Time Prepared: | From 2004/2024 | Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0090

				1	o 12/31/2023	Date/lime Prep 5/30/2024 3:4	
	Cost Center Description	PARAMED ED	PARAMED ED	PARAMED ED	Subtotal	Intern &	
		PRGM- LAB	PRGM- PHARMACY	PRGM-		Residents Cost	
				RADI OLOGY		& Post	
						Stepdown	
		23. 01	23. 02	23. 03	24.00	Adjustments 25.00	
	GENERAL SERVICE COST CENTERS	20.01	20.02	20.00	21.00	20.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.04	00593 OTHER ADMINISTRATIVE AND GENERAL						5. 04
6. 00 7. 00	00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT						6. 00 7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00	00900 HOUSEKEEPING						9. 00
10.00	01000 DI ETARY						10.00
11. 00	01100 CAFETERI A						11. 00
13. 00	01300 NURSING ADMINISTRATION						13. 00
14. 00	01400 CENTRAL SERVI CES & SUPPLY						14. 00
15. 00	01500 PHARMACY						15. 00
16.00	01600 MEDI CAL RECORDS & LI BRARY						16.00
17. 00 21. 00	01700 SOCIAL SERVICE 02100 I&R SERVICES-SALARY & FRINGES APPRVD						17. 00 21. 00
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRV						22. 00
23. 00	02300 PARAMED ED PRGM - EMERGENCY MEDICINE						23. 00
23. 01	02301 PARAMED ED PRGM- LAB	45, 263					23. 01
23. 02	02302 PARAMED ED PRGM- PHARMACY		8, 442				23. 02
23. 03	02303 PARAMED ED PRGM- RADIOLOGY			0			23. 03
	INPATIENT ROUTINE SERVICE COST CENTERS					_	
30.00	03000 ADULTS & PEDI ATRI CS				2, 671, 724	1	30.00
31. 00 32. 00	03100 I NTENSI VE CARE UNI T 03200 CORONARY CARE UNI T				380, 387	1	31. 00 32. 00
33. 00	03300 BURN INTENSIVE CARE UNIT					0	33. 00
35. 00	02060 NEONATAL INTENSIVE CARE UNIT				34, 668		35. 00
41. 00	04100 SUBPROVI DER – I RF				213, 206		41. 00
42.00	04200 SUBPROVI DER				0	0	42. 00
43.00	04300 NURSERY				10, 847	0	43. 00
	ANCI LLARY SERVI CE COST CENTERS						
50.00	05000 OPERATING ROOM				1, 488, 413	1	50.00
50. 01	05001 OUTPATIENT SURGERY				387, 916	1	50. 01
51. 00 53. 00	05100   RECOVERY   ROOM   05300   ANESTHESI OLOGY				190, 545 4, 536	1	51. 00 53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C				1, 746, 011		54. 00
54. 01	05401 RADI OLOGY-SPECI AL PROCEDURES				153, 270		54. 01
55. 00	05500 RADI OLOGY-THERAPEUTI C				0	1	55. 00
56. 00	05600 RADI OI SOTOPE				221, 609	0	56. 00
60.00	06000 LABORATORY				231, 012	0	60. 00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.				72, 108	1	63. 00
65. 00	06500 RESPI RATORY THERAPY				182, 615	1	65. 00
66.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY				131, 462 22, 785		66. 00 67. 00
	06800 SPEECH PATHOLOGY				82, 417		68. 00
69. 00	06900 ELECTROCARDI OLOGY				311, 116		69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY				136, 417	1	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT				108, 143		71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS				29, 354	1	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS				169, 941		73.00
76. 00	03630 ULTRA SOUND				165, 937	1	76. 00
76. 01 76. 02	03951 PAIN CLINIC 03952 CATH LAB				329, 781 633, 959		76. 01 76. 02
76. 02	03953 ACTIVITY THERAPEUTIC				161, 666	1	76. 02
76. 04	03954 WOUND CARE CENTER				171, 114	1	76. 03
76. 05	03340 BARI ATRI C CLI NI C				59, 771	l ol	76. 05
76. 06	03030 HEALTHY LIVING CENTER				0	0	76. 06
76. 07	03950 CV RESOURCE CENTER				0	0	76. 07
76. 08	03955 OTHER ANCILLARY SERVICE COST CENTERS				0	0	76. 08
76. 09	03956 LACTATION CLINIC				0	0	76. 09
	03957 OTHER ANCILLARY SERVICE COST CENTERS				0		76. 10
76. 11	03958 OTHER ANCILLARY SERVICE COST CENTERS 03959 ANTICOAGULATION CLINIC				0 18, 909		76. 11 76. 12
76. 12	07700 ALLOGENEIC STEM CELL ACQUISITION				18, 909	1	76. 12
78.00	07800 CAR T-CELL IMMUNOTHERAPY						78.00
, 5. 66	OUTPATIENT SERVICE COST CENTERS						, 5. 66
91. 00	09100 EMERGENCY				568, 234	0	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART					0	92. 00
_	OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY				139, 969	0	101. 00

Hard the Firmanai at Combana	EDANICI CCAN III	EALTH DVED		1 1:-	6 F CMC /	0550 10
Health Financial Systems	FRANCI SCAN H		ON 15 0000		eu of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der CO	JN: 15-0090	Peri od: From 01/01/2023	Worksheet B	
				To 12/31/2023		pared:
					5/30/2024 3: 4	
Cost Center Description	PARAMED ED	PARAMED ED	PARAMED ED	Subtotal	Intern &	
	PRGM- LAB	PRGM- PHARMACY			Residents Cost	
			RADI OLOGY		& Post	
					Stepdown	
					Adjustments	
	23. 01	23. 02	23. 03	24. 00	25. 00	
102. 00 10200 OPI OI D TREATMENT PROGRAM				0	0	102. 00
SPECIAL PURPOSE COST CENTERS	<u> </u>		ı	1		
113. 00 11300   INTEREST EXPENSE				44 000 040	1	113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	C	) 0		0 11, 229, 842	] 0	118. 00
NONREI MBURSABLE COST CENTERS			ı	40.000		100.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN				42, 822	1	190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES				342, 190		192. 00
192. 01 19201 WORKI NG WELL				0		192. 01
192. 02 19202 PHYSI CLANS' PRI VATE OFFI CES				0		192. 02
192. 03 19203 MI SC				005 //4		192. 03
194. 00 07950 RESI DENTI AL				805, 661		194. 00
194. 01 07954 OTHER NONREI MBURSABLE COST CENTERS				0	1	194. 01
194. 02 07952 PSYCHI ATRI C				644, 638		194. 02
194. 03 07953 CENTER OF HOPE				15	1	194. 03
200.00 Cross Foot Adjustments	45, 263	1		0 57, 406	1	200. 00
201.00 Negative Cost Centers	C	ή		0		201. 00
202.00   TOTAL (sum lines 118 through 201)	45, 263	8, 442		0 13, 122, 574	0	202. 00

| In Lieu of Form CMS-2552-10 | Period: Worksheet B | From 01/01/2023 | Part II | To 12/31/2023 | Date/Time Prepared: 5/30/2024 3:45 pm Provider CCN: 15-0090

			5/30/2024 3:	: 45 pm
	Cost Center Description	Total		
		26. 00		
	GENERAL SERVICE COST CENTERS			
1.00	00100 CAP REL COSTS-BLDG & FIXT			1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP			2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT			4. 00
5.04	00593 OTHER ADMINISTRATIVE AND GENERAL			5. 04
6.00	00600 MAI NTENANCE & REPAI RS			6. 00
7.00	00700 OPERATION OF PLANT			7. 00
8.00	00800 LAUNDRY & LINEN SERVICE			8. 00
9.00	00900 HOUSEKEEPI NG			9. 00
10.00	01000 DI ETARY			10.00
11.00	01100 CAFETERI A			11.00
13.00	01300 NURSI NG ADMI NI STRATI ON			13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY			14. 00
15.00	01500 PHARMACY			15. 00
16.00	1 1			16.00
17. 00	01700 SOCIAL SERVICE			17. 00
21. 00	02100 I &R SERVI CES-SALARY & FRI NGES APPRVD			21. 00
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRV			22. 00
23. 00	02300 PARAMED ED PRGM - EMERGENCY MEDICINE			23. 00
23. 01	O2301   PARAMED ED PRGM - LAB			23. 01
23. 02	02302 PARAMED ED PRGM- PHARMACY			23. 02
23. 03	02303 PARAMED ED PRGM- RADIOLOGY			23. 03
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	2 (74 704		- 20 00
30.00	1	2, 671, 724		30.00
31.00	03100 I NTENSI VE CARE UNI T	380, 387		31.00
32.00	03200 CORONARY CARE UNIT	0		32.00
33. 00	03300 BURN INTENSIVE CARE UNIT	24.440		33.00
35. 00	02060 NEONATAL INTENSIVE CARE UNIT	34, 668		35. 00
41. 00	04100 SUBPROVI DER – I RF	213, 206		41. 00
42.00	04200 SUBPROVI DER	0		42.00
43. 00	04300 NURSERY	10, 847		43. 00
F0 00	ANCILLARY SERVICE COST CENTERS	4 400 440		
50.00	1	1, 488, 413		50.00
50. 01	05001 OUTPATI ENT SURGERY	387, 916		50. 01
51.00	05100 RECOVERY ROOM	190, 545		51.00
53. 00	05300 ANESTHESI OLOGY	4, 536		53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	1, 746, 011		54.00
54. 01	05401 RADI OLOGY-SPECI AL PROCEDURES	153, 270		54. 01
55. 00	05500 RADI OLOGY-THERAPEUTI C	0		55. 00
56. 00	05600 RADI OI SOTOPE	221, 609		56. 00
60.00	06000 LABORATORY	231, 012		60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	72, 108		63. 00
65. 00	06500 RESPI RATORY THERAPY	182, 615		65. 00
66.00	06600 PHYSI CAL THERAPY	131, 462		66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	22, 785		67. 00
68.00	06800 SPEECH PATHOLOGY	82, 417		68. 00
69. 00	06900 ELECTROCARDI OLOGY	311, 116		69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	136, 417		70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	108, 143		71. 00
72. 00		29, 354		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	169, 941		73.00
76. 00	03630 ULTRA SOUND	165, 937		76. 00
76. 01	03951 PAIN CLINIC	329, 781		76. 01
76. 02	03952 CATH LAB	633, 959		76. 02
76. 03	1	161, 666		76. 03
76. 04	03954 WOUND CARE CENTER	171, 114		76. 04
76. 05	03340 BARI ATRI C CLI NI C	59, 771		76. 05
76. 06	1 1	0		76. 06
76. 07	03950 CV RESOURCE CENTER	0		76. 07
76. 08	1	0		76. 08
76. 09	03956 LACTATION CLINIC	0		76. 09
76. 10				76. 10
76. 11	03958 OTHER ANCILLARY SERVICE COST CENTERS			76. 11
76. 12		18, 909		76. 12
77. 00	1	0		77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0		78. 00
	OUTPATIENT SERVICE COST CENTERS			
	09100 EMERGENCY	568, 234		91. 00
92.00	· ·			92. 00
	OTHER REIMBURSABLE COST CENTERS			
101.00	10100 HOME HEALTH AGENCY	139, 969		101. 00
	10200 OPIOID TREATMENT PROGRAM	0		102.00
	SPECIAL PURPOSE COST CENTERS			
113.00	11300   NTEREST EXPENSE			113. 00
118.00		11, 229, 842		118. 00

Health Financial Systems	FRANCISCAN HEALTH- DYER	In Lieu of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS	Provi der CCN: 15-0090	Peri od: Worksheet B From 01/01/2023 Part II To 12/31/2023 Date/Time Prepared:

		5/30/2024 3: 4	15 pm
Cost Center Description	Total		
	26. 00		
NONREI MBURSABLE COST CENTERS			
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	42, 822		190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	342, 190		192. 00
192. 01 19201 WORKI NG WELL	0		192. 01
192. 02 19202 PHYSICIANS' PRIVATE OFFICES	0		192. 02
192. 03 19203 MI SC	0		192. 03
194. 00 07950 RESI DENTI AL	805, 661		194. 00
194.01 07954 OTHER NONREIMBURSABLE COST CENTERS	0		194. 01
194. 02 07952 PSYCHI ATRI C	644, 638		194. 02
194. 03 07953 CENTER OF HOPE	15		194. 03
200.00 Cross Foot Adjustments	57, 406		200. 00
201.00 Negative Cost Centers	0		201. 00
202.00 TOTAL (sum lines 118 through 201)	13, 122, 574		202. 00

Peri od: From 01/01/2023 Provider CCN: 15-0090

						From 01/01/2023 o 12/31/2023		
			CAPITAL REI	LATED COSTS			5/30/2024 3: 4	5 pm
		Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	DEPARTMENT (GROSS	Reconci I i ati on	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	
			1.00	2.00	SALARI ES ADJ) 4.00	5A. 04	5. 04	
1 00		AL SERVICE COST CENTERS	470.004					
1. 00 2. 00		CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP	472, 034	3, 697, 036				1. 00 2. 00
4.00	1	EMPLOYEE BENEFITS DEPARTMENT	1, 943	1, 994	76, 612, 471			4. 00
5. 04 6. 00		OTHER ADMINISTRATIVE AND GENERAL MAINTENANCE & REPAIRS	35, 111 71, 044				149, 575, 328 8, 784, 191	5. 04 6. 00
7.00	00700	OPERATION OF PLANT	20, 147	18, 732	361, 574	0	2, 211, 296	7. 00
8. 00 9. 00		LAUNDRY & LINEN SERVICE HOUSEKEEPING	0 5, 389	0 6, 619	_		642, 351 3, 053, 376	8. 00 9. 00
10. 00	1	DI ETARY	4, 754				1, 263, 556	
11. 00 13. 00		CAFETERIA NURSING ADMINISTRATION	6, 863 726	l e			1, 179, 311	11. 00 13. 00
14. 00		CENTRAL SERVICES & SUPPLY	6, 121	108, 660			3, 631, 941 1, 178, 262	14. 00
15.00		PHARMACY	3, 207				3, 300, 479	•
16. 00 17. 00		MEDICAL RECORDS & LIBRARY SOCIAL SERVICE	4, 886 0	0			1, 533, 461 0	16. 00 17. 00
21. 00	1	I &R SERVICES-SALARY & FRINGES APPRVD	0	0			74, 281	21. 00
22. 00 23. 00		I &R SERVICES-OTHER PRGM COSTS APPRV PARAMED ED PRGM - EMERGENCY MEDICINE	40	0			124, 167 74, 318	
23. 01	02301	PARAMED ED PRGM- LAB	1, 721	373	93, 100	0	328, 300	23. 01
23. 02 23. 03		PARAMED ED PRGM- PHARMACY PARAMED ED PRGM- RADIOLOGY	210				282, 417 0	23. 02 23. 03
25.05	I NPAT	ENT ROUTINE SERVICE COST CENTERS						25.05
30. 00 31. 00		ADULTS & PEDIATRICS INTENSIVE CARE UNIT	79, 318 9, 931				26, 627, 040 3, 639, 213	
32. 00		CORONARY CARE UNIT	9, 431				3, 039, 213	32.00
33. 00		BURN INTENSIVE CARE UNIT	0	0		0	0	33.00
35. 00 41. 00		NEONATAL INTENSIVE CARE UNIT SUBPROVIDER - IRF	533 5, 938				725, 289 2, 733, 703	1
42.00		SUBPROVI DER	0	0	C	0	0	42. 00
43. 00		NURSERY LARY SERVICE COST CENTERS	0	0	811, 821	0	1, 371, 633	43. 00
50.00	05000	OPERATING ROOM	16, 488	· ·			4, 843, 969	•
50. 01 51. 00		OUTPATIENT SURGERY RECOVERY ROOM	14, 083 5, 551	21, 617 36, 939	1		1, 395, 452 740, 069	50. 01 51. 00
53.00	05300	ANESTHESI OLOGY	0	633	38, 551	0	29, 301	
54. 00 54. 01		RADI OLOGY-DI AGNOSTI C RADI OLOGY-SPECI AL PROCEDURES	23, 553 1, 542				4, 700, 563 1, 840, 043	
55. 00	05500	RADI OLOGY-THERAPEUTI C	0	0		0	0	55. 00
56. 00 60. 00		RADI OI SOTOPE LABORATORY	4, 931 5, 187	76, 993 30, 172			649, 521 7, 436, 144	56. 00 60. 00
63. 00	06300	BLOOD STORING, PROCESSING & TRANS.	2, 831	0	C	0	446, 325	63. 00
65. 00 66. 00		RESPI RATORY THERAPY PHYSI CAL THERAPY	2, 140 1, 452	· ·			2, 998, 086 4, 865, 678	
67. 00	06700	OCCUPATIONAL THERAPY	556	0	569, 246		740, 797	67. 00
68. 00 69. 00	1	SPEECH PATHOLOGY ELECTROCARDI OLOGY	3, 808		1		713, 510 1, 392, 169	•
70. 00	1	ELECTROENCEPHALOGRAPHY	5, 262				405, 234	•
71. 00 72. 00		MEDICAL SUPPLIES CHARGED TO PATIENT IMPL. DEV. CHARGED TO PATIENTS	0	0	(	0	13, 382, 669 3, 546, 940	
73. 00		DRUGS CHARGED TO PATTENTS	0	0		0	4, 618, 938	
76. 00	1	ULTRA SOUND	2, 289	l .			894, 868	
76. 01 76. 02		PAIN CLINIC CATH LAB	12, 323 9, 038				1, 069, 840 3, 385, 807	1
76. 03	03953	ACTIVITY THERAPEUTIC	5, 706	300	1, 582, 792	0	2, 140, 525	76. 03
76. 04 76. 05	1	WOUND CARE CENTER BARIATRIC CLINIC	6, 364 1, 927				848, 356 751, 714	1
76. 06	03030	HEALTHY LIVING CENTER	0	0	000, 210	o o	0	76. 06
76. 07 76. 08	1	CV RESOURCE CENTER OTHER ANCILLARY SERVICE COST CENTERS	0	0		0	0	76. 07 76. 08
76. 09	03956	LACTATION CLINIC	Ö	ő		o o	ő	76. 09
76. 10 76. 11	1	OTHER ANCILLARY SERVICE COST CENTERS	0	0	(	0	0	76. 10 76. 11
		OTHER ANCILLARY SERVICE COST CENTERS ANTICOAGULATION CLINIC	440	0			756, 417	76. 11
77. 00		ALLOGENEIC STEM CELL ACQUISITION	0	0		0	0	77.00
78. 00		CAR T-CELL IMMUNOTHERAPY TIENT SERVICE COST CENTERS		0	(	, <sub>1</sub>	0	78. 00
	09100	EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART	16, 042	59, 037	4, 225, 771	0	6, 638, 018	•
72.00	107200	ODSERVATION DEDS (NON-DISTINCT PART	I	I	I	<u> </u>	l	92. 00

COST ALLOC	ATION - STATISTICAL BASIS		Provi der CO		Peri od:	Worksheet B-1	
					From 01/01/2023	D-+- /T: D	
					To 12/31/2023	Date/Time Prep 5/30/2024 3:45	
		CAPITAL REL	ATED COSTS				
	Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Reconciliation	OTHER	
	cost center bescription		(DOLLAR VALUE)	BENEFITS		ADMI NI STRATI VE	
		(SQUARE TEET)	(DOLLAN VILOL)	DEPARTMENT		AND GENERAL	
				(GROSS		(ACCUM. COST)	
				SALARIES ADJ)		,	
		1. 00	2. 00	4. 00	5A. 04	5. 04	
	R REIMBURSABLE COST CENTERS						
	OO HOME HEALTH AGENCY	1, 358		7, 070, 21		10, 088, 911	
	OO OPIOID TREATMENT PROGRAM	0	0		0 0	0	102. 0
	TIAL PURPOSE COST CENTERS						
	OO I NTEREST EXPENSE						113. 0
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	400, 753	3, 675, 874	73, 460, 69	4 -42, 654, 093	144, 078, 449	J118. 0
	RELIMBURSABLE COST CENTERS	70/	0.004	F0 F0		400 404	100 0
	OO GIFT, FLOWER, COFFEE SHOP & CANTEEN	796	3, 304	50, 50		198, 101 724, 431	
	00 PHYSICIANS' PRIVATE OFFICES 01 WORKING WELL	13, 697	0	486, 18	0		192. 0 192. 0
	02 PHYSICIANS' PRIVATE OFFICES	0	0		0		192. 0
192. 02 1920		0	0		0		192. 0
	50 RESI DENTI AL	30, 307	17, 858	2, 614, 08	6	4, 091, 426	
	4 OTHER NONREIMBURSABLE COST CENTERS	30, 307	17,030	2,014,00	0		194. 0
	52 PSYCHI ATRI C	26, 481	0		0	481, 231	
	53 CENTER OF HOPE	20, 101	0	1, 00	1 0	1, 650	
200.00	Cross Foot Adjustments	ŭ	Ŭ	1, 00			200. 0
201. 00	Negative Cost Centers						201. 0
202.00	Cost to be allocated (per Wkst. B, Part	8, 578, 126	4, 544, 448	21, 451, 84	1	42, 654, 093	202. 0
	1)						
203. 00	Unit cost multiplier (Wkst. B, Part I)	18. 172687	1. 229214			0. 285168	
204. 00	Cost to be allocated (per Wkst. B, Part			37, 76	1	1, 106, 852	204. 0
205. 00	Unit cost multiplier (Wkst. B, Part II)			0. 00049	3	0. 007400	205. C
206. 00	NAHE adjustment amount to be allocated						206. 0
	(per Wkst. B-2)						
207. 00	NAHE unit cost multiplier (Wkst. D,						207. 0
	Parts III and IV)						l

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0090 

			T	0 12/31/2023	Date/Time Pre 5/30/2024 3:4	
Cost Center Description	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	REPAIRS (SQUARE FEET)	PLANT (SQUARE FEET)	LINEN SERVICE (POUNDS OF	(SQUARE FEET)	(PATIENT ME ALS)	
	,		LAUND)			
GENERAL SERVICE COST CENTERS	6. 00	7. 00	8. 00	9. 00	10. 00	
1. 00 00100 CAP REL COSTS-BLDG & FLXT						1.00
2. 00 00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00   OO400 EMPLOYEE BENEFITS DEPARTMENT 5.04   OO593 OTHER ADMINISTRATIVE AND GENERAL						4. 00 5. 04
5.04   00593 OTHER ADMINISTRATIVE AND GENERAL 6.00   00600 MAINTENANCE & REPAIRS	363, 936					6.00
7. 00 O0700 OPERATION OF PLANT	20, 147	1				7. 00
8.00   00800   LAUNDRY & LINEN SERVICE	0	0	575, 002			8. 00
9. 00   00900   HOUSEKEEPI NG 10. 00   01000   DI ETARY	5, 389		0	338, 400 4, 754	199, 277	9. 00 10. 00
11. 00   01100   CAFETERI A	4, 754 6, 863		0	6, 863	199, 211	11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	726		0	726	0	13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY	6, 121	6, 121	0	6, 121	0	14.00
15. 00   01500   PHARMACY 16. 00   01600   MEDI CAL RECORDS & LI BRARY	3, 207 4, 886	3, 207 4, 886	0	3, 207 4, 886	0	15. 00 16. 00
17. 00 01700 SOCIAL SERVICE	4,880		0	4, 880	0	17. 00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	o	0	21. 00
22. 00   02200   1 &R SERVI CES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22. 00
23. 00   O2300   PARAMED ED PRGM - EMERGENCY MEDICINE 23. 01   O2301   PARAMED ED PRGM- LAB	40 1, 721	40 1, 721	0	40 1, 721	0	23. 00 23. 01
23. 02   02302   PARAMED ED PRGM- PHARMACY	210		0	210	0	23. 01
23. 03 02303 PARAMED ED PRGM- RADIOLOGY	0	0	0	0	0	23. 03
INPATIENT ROUTINE SERVICE COST CENTERS	70.010	70.040		70.040	457.000	
30. 00   03000   ADULTS & PEDIATRICS 31. 00   03100   NTENSIVE CARE UNIT	79, 318 9, 931	79, 318 9, 931	437, 898 44, 258		157, 089 15, 877	30. 00 31. 00
32. 00   03200 CORONARY CARE UNIT	0, 731		0	0, 731	13, 077	32.00
33.00 03300 BURN INTENSIVE CARE UNIT	0	0	0	О	0	33. 00
35. 00   02060   NEONATAL   INTENSIVE CARE UNIT	533		6, 476	533	0	35. 00
41. 00   04100   SUBPROVI DER -   I RF 42. 00   04200   SUBPROVI DER	5, 938	5, 938	73, 344	5, 938 0	26, 311 0	41. 00 42. 00
43. 00   04300   NURSERY		0	13, 026	0	0	43. 00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	16, 488		0	16, 488	0	50.00
50. 01   05001   0UTPATI ENT SURGERY 51. 00   05100   RECOVERY ROOM	14, 083 5, 551	14, 083 5, 551	0	14, 083 5, 551	0	50. 01 51. 00
53. 00 05300 ANESTHESI OLOGY	0		Ö	0, 331	0	53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	23, 553		0	23, 553	0	54. 00
54. 01   05401   RADI OLOGY-SPECI AL PROCEDURES 55. 00   05500   RADI OLOGY-THERAPEUTI C	1, 542	1, 542	0	1, 542	0	54. 01 55. 00
56. 00   05600   RADI 01 SOTOPE	4, 931	4, 931	0	4, 931	0	56.00
60. 00   06000   LABORATORY	5, 187	5, 187	0	5, 187	0	60.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	2, 831	2, 831	0	2, 831	0	63. 00
65. 00   06500   RESPI RATORY   THERAPY   66. 00   06600   PHYSI CAL   THERAPY	2, 140 1, 452		0	2, 140 1, 452	0	65. 00 66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	556		0	556	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	
69. 00 06900 ELECTROCARDI OLOGY	3, 808		0	3, 808	0	69. 00
70. 00   07000   ELECTROENCEPHALOGRAPHY 71. 00   07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENT	5, 262	5, 262	0	5, 262	0	70. 00 71. 00
72. 00   07/100   MPL. DEV. CHARGED TO PATIENTS		0	0	0	0	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	O	0	Ö	0	73. 00
76. 00   03630   ULTRA SOUND	2, 289		0	2, 289	0	76. 00
76. 01   03951   PALN CLINIC 76. 02   03952   CATH LAB	12, 323 9, 038		0	12, 323 9, 038	0	76. 01 76. 02
76. 02   03952 CATH LAB  76. 03   03953   ACTIVITY THERAPEUTIC	5, 706		0	5, 706	0	76. 02
76. 04 03954 WOUND CARE CENTER	6, 364		0	6, 364	0	76. 04
76. 05   03340   BARI ATRI C   CLI NI C	1, 927	1	0	1, 927	0	76. 05
76.06   03030   HEALTHY LIVING CENTER 76.07   03950   CV RESOURCE CENTER	0	0	0	0	0	76. 06 76. 07
76. 07   03950   CV RESOURCE CENTER  76. 08   03955   OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.07
76. 09 03956 LACTATION CLINIC	0	O	0	Ö	0	76. 09
76. 10 03957 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	o	0	76. 10
76. 11   03958 OTHER ANCILLARY SERVICE COST CENTERS 76. 12   03959 ANTICOAGULATION CLINIC	0 440	0 440	0	0 440	0	76. 11 76. 12
77. 00   07700   ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77. 00
78. 00 07800 CAR T-CELL IMMUNOTHERAPY		o	o	o	0	78. 00
OUTPATIENT SERVICE COST CENTERS				4, 5:-1		04 00
91. 00   09100   EMERGENCY 92. 00   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART	16, 042	16, 042	0	16, 042	0	91. 00 92. 00
OTHER REIMBURSABLE COST CENTERS						72.00
101.00 10100 HOME HEALTH AGENCY	1, 358					101. 00
102.00 10200 0PI0ID TREATMENT PROGRAM	0	0	0	0	0	102. 00

		EDANOL COAN LIE				6.5. 046	0550 40
	cial Systems TION - STATISTICAL BASIS	FRANCISCAN HE	Provider C	CN. 15 0000 F	eriod:	u of Form CMS-: Worksheet B-1	
COST ALLOCA	TON - STATISTICAL BASIS		Provider Co		rom 01/01/2023	WOLKSHEEL D-1	
				Т	o 12/31/2023	Date/Time Pre	
	Cost Center Description	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	5/30/2024 3: 4 DI ETARY	5 pm
	cost center bescription	REPAIRS	PLANT	LINEN SERVICE		(PATLENT ME	
		(SQUARE FEET)	(SQUARE FEET)	(POUNDS OF	(SQUARE TEET)	ALS)	
		(000/11/2 / 22/)	(040/11/2 1221)	LAUND)		7.20)	
		6. 00	7. 00	8.00	9. 00	10.00	
	AL PURPOSE COST CENTERS						
	INTEREST EXPENSE						113. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	292, 655	272, 508	575, 002	267, 119	199, 277	118. 00
	MBURSABLE COST CENTERS						
	GIFT, FLOWER, COFFEE SHOP & CANTEEN	796			1 , , , ,		190. 00
	PHYSICIANS' PRIVATE OFFICES	13, 697	13, 697	C	13, 697		192. 00
	WORKI NG WELL	0	0	<u> </u>	0		192. 01
	PHYSICIANS' PRIVATE OFFICES	0	0		0	_	192. 02
192. 03 19203		0	0		0		192. 03
	RESI DENTI AL	30, 307	30, 307		30, 307		194. 00
	OTHER NONREIMBURSABLE COST CENTERS	0	0		0		194. 01
	PSYCHI ATRI C	26, 481	26, 481		26, 481		194. 02
-	CENTER OF HOPE	0	0		0	0	194. 03
200.00	Cross Foot Adjustments						200. 00
201. 00	Negative Cost Centers	44 000 4/4	0 4// 040	005 500	4 445 (40	4 077 500	201. 00
202. 00	Cost to be allocated (per Wkst. B, Part I)	11, 289, 161	3, 466, 840	825, 529	4, 145, 610	1, 877, 528	202.00
203. 00	)  Unit cost multiplier (Wkst. B, Part I)	31, 019633	10. 084209	1. 435698	12, 250621	9. 421699	303 00
204. 00	Cost to be allocated (per Wkst. B, Part				1	138, 327	
204.00		1, 507, 525	407, 130	4,750	137, 027	150, 527	204.00
205. 00	Unit cost multiplier (Wkst. B, Part II)	4. 141725	1. 422780	0. 008266	0. 471717	0. 694144	205. 00
206. 00	NAHE adjustment amount to be allocated						206. 00
	(per Wkst. B-2)						
207. 00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)						

Cost Conter Description		ALLOCATION - STATISTICAL BASIS	TRANCISCAN II	Provider CC	CN: 15-0090 P	eri od:	Worksheet B-1	
Cost Center Description					F	rom 01/01/2023		
CONTROL STATE   CONTROL							5/30/2024 3:4	5 pm
EDD   COMPAND   SUMPLY   CASS CAMP		Cost Center Description						
1.00     CENERAL SERVICE COST CENTERS   11.00   13.00   14.00   15.00   16.0			`					
DEMANDLE SERVICE ONLY CERTIFIES						0101)		
DEBURS SERVICE OST CERTERS				,			GES)	
1.00   00100CAN PALL COSTS-BULGE & FINX   2.00		OFNEDAL CERVILOE COCT OFNITERS	11. 00	13.00	14. 00	15. 00	16. 00	
2.00 00000 CAP REL COSTS-MPBLE EQUIP 4	1 00							1 00
4.00   ORADIC PARTYLE SHEPT IS SEPARHEN		l l						
5.04 00090 DITTER ADMINISTRATION AND GENTRAL  0. 000000 DOOD MATERIANCE SEPHINS  1.06 00000 DOOD CONTROLLED SEPHINS  1.06 000000 DOOD CONTROLLED SEPHINS  1.06 00000 DOOD CONTROLLED SEPHINS  1.07 0000 DOOD CONTROLLED SEPHINS  1.07 0000 DOOD CONTROLLED SEPHINS  1.07 0000 DOOD CONTROLLED SEPHINS  1.08 00000 DOOD CONTROLLED SEPHINS  1.08 00000 DOOD CONTROLLED SEPHINS  1.09 00000 DOOD CONTROLLED SEPHINS  1.00 0000 DOOD CONTROLLED SEPH								
0,000   0,00								
B.O.   OBOOD LAMBRY & LINEN SERVICE								
9.00   00900  MUSEKEEPI NS		1 1						
10.00   01000   DETARY								
13.00   10300   MIRSING AGMINN STRATION   39,064   408,663   13.00   10300								
14.00   01400  CENTRAL SERVICES & SUPPLY   16,627   196   676,345   100   1.5.048   1.5.048   1.5.04			The state of the s					
15.00   10500			The state of the s		.7. 0.5			
10.00   01000   MEDICAL RECORDS & LIBRARY   5,857   29   531   0   762,518,724   16,00   17.00   1700   02010   187 SERVICES-SALARY & FRINGES APPRIVD   1,878   0   40   0   0   21.00   22.								
17.00   01700   SOCI AL SERVICE   0   0   0   0   0   0   0   17.00			The state of the s				762 518 724	
21.00   02100   ARS SERVICES-SALARY & RIN NOES APPRVD   1,878   0   40   0   0   21.00   0220   0220   02200   02200   02300		l l		1				1
23.00   02300   PARAMED ED PROM - LAB ALTON STANDARD ED PROM LAB ALTON STAN	21. 00	02100 I&R SERVICES-SALARY & FRINGES APPRVD	1, 878	o o	40	0	0	21. 00
23.01 0 2301 PARAMED ED PROM. LAB		l l	1	1		0	_	
23.0 Q 0330Q PARAMED ED PRICA: PARIMACY Q Q Q Q Q Q Q Q Q Q Q Q Q Q Q Q Q Q Q			1				_	
23. 03 02303 PARAMED ED PROM- RADIOLOGY 0 0 0 0 23. 00 0 0 0 0 23. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		I I	1	1			0	
IMPATI ENT ROUTH NE SERVICE COST CENTERS   30.00   30.00   0.00   0.00   0.00   0.01   78.07   70.179   0   72.772, 173   30.00   31.00   31.00   0.00   0.00   0.00   0   0   0   0			1	1	-	-	0	
31.00   03100   INTENSIVE CARE UNIT				-		- 1		
32.00   03200   CORDMARY CARE UNIT   0   0   0   0   0   32.00			1					
33.00   03300   BURN INTENSIVE CARE UNIT   0   0   0   0   0   3.3 0.0			1					
35.00   02060 NEONATAL INTENSIVE CARE UNIT   19, 717   18, 254   905   0   1, 848, 900   35, 00   042, 0		l l				-		
41.00   04100   SUBPROVI DER   1   1   0   0   0   0   0   0   0   0			19, 717	18, 354			-	
43. 00   0.4300   NURSERY   0   0   0   0   0   1,100,400   42. 00			1			0		
ANCILLARY SERVICE COST CENTERS			C	0	0	-		
50. 00   05000   0FEATI NG ROOM   25, 738   8, 056   124, 901   0   82, 652, 204   50. 00	43.00		C	)  0	0	0	1, 100, 406	43.00
50. 01   05001   01074T1ENT SURGERY   14, 482	50. 00		25, 738	8, 056	124, 901	0	82, 652, 204	50.00
53.00   05300   AMSTHESI OLOGY   1, 781   0   227   0   18, 447, 799   53.00								1
54.00   05400   RADIO LOGY-DI AGNOSTIC   39, 701   133   14, 850   0   88, 287, 475   54.00   05.00   10, 05.00   10, 10, 10, 10, 10, 10, 10, 10, 10, 10,			The state of the s					
54.01   0.5401   RADI OLOGY-SPECI AL PROCEDURES   23,759   0.523   24,597   0.500			The state of the s					1
55. 00   05600   RADI OLOGY-THERAPEUTI C   0   0   0   0   0   0   55. 00								
0.0   0.0			C	0		0		1
63.00   06300   BLOOD STORING, PROCESSING & TRANS.   0   0   0   1,567,708   63.00		l l	5, 610	0		0		
65.00   065000   065000   065000   065000   065000   065000   065000   06500			C					1
66. 00   06600   PHYSICAL THERAPY   69,476   324   15,012   0   26,059,110   66,00   67.00   06700   0CCUPATI ONAL THERAPY   11,370   0   1166   0   11,158,417   67.00   68.00   06800   SPEECH PATHOLOGY   7,337   0   111,978   0   8,807,913   68.00   69.00   06900   ELECTROCARDI OLOGY   18,630   5,956   10,486   0   26,818,703   69.00   69.00   07000   ELECTROCARDI OLOGY   18,630   5,956   10,486   0   26,818,703   69.00   69.00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENT   0   0   0   0   5,570,089   70.00   69.00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0   0   0   0   0   18,062,685   72.00   69.00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0   0   0   0   0   18,062,685   72.00   69.00   07300   DRUGS CHARGED TO PATI ENTS   0   0   0   0   0   100   39,660,597   73.00   69.00   07300   DRUGS CHARGED TO PATI ENTS   0   0   0   0   0   0   0   0   69.00   07500   DRUGS CHARGED TO PATI ENTS   0   0   0   0   0   0   0   69.00   07500   DRUGS CHARGED TO PATI ENTS   0   0   0   0   0   0   0   0   69.00   07500   DRUGS CHARGED TO PATI ENTS   0   0   0   0   0   0   0   69.00   07500   DRUGS CHARGED TO PATI ENTS   0   0   0   0   0   0   0   69.00   07500   DRUGS CHARGED TO PATI ENTS   0   0   0   0   0   0   69.00   07500   DRUGS CHARGED TO PATI ENTS   0   0   0   0   0   0   69.00   07500   DRUGS CHARGED TO PATI ENTS   0   0   0   0   0   0   69.00   07500   DRUGS CHARGED TO PATI ENTS   0   0   0   0   0   0   69.00   07500   DRUGS CHARGED TO PATI ENTS   0   0   0   0   0   0   69.00   07500   DRUGS CHARGED TO PATI ENTS   0   0   0   0   0   0   69.00   07500   DRUGS CHARGED TO PATI ENTS   0   0   0   0   0   0   69.00   07500   DRUGS CHARGED TO PATI ENTS   0   0   0   0   0   0   69.00   07500   DRUGS CHARGED TO PATI ENTS   0   0   0   0   0   69.00   07500   DRUGS CHARGED TO PATI ENTS   0   0   0   0   0   0   69.00   07500   DRUGS CHARGED TO PATI ENTS   0   0   0   0   0   0   69.00   07500   DRUGS CHARGED TO PATI ENTS   0   0   0   0   0   0   69.00   07500   DRUGS CHARGED TO PATI ENTS   0				1 -1				
67. 00   06700   OCCUPATI IONAL THERAPY   11, 370   0   166   0   11, 158, 417   67, 00   68. 00   06800   SPEECH PATHOLOGY   7, 337   0   111, 978   0   8, 807, 316   69. 00   06900   ELECTROCARDI OLOGY   18, 630   5, 956   10, 486   0   26, 818, 703   69, 00   70. 00   07000   ELECTROENCEPHALGGRAPHY   4, 879   0   620   0   5, 570, 089   70, 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENT   0   0   0   0   52, 969, 791   71, 00   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0   0   0   0   0   18, 602, 685   72, 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0   0   0   0   100   39, 660, 597   73, 00   76. 00   03630   ULTRA SOUND   11, 831   73   13, 651   0   13, 649, 936   76, 00   76. 01   03951   PAIN CLINIC   12, 704   11, 722   7, 023   0   9, 751, 124   76, 01   76. 02   03952   CATH LAB   35, 179   23, 370   73, 519   0   49, 155, 719   76, 02   76. 03   03953   ACTI VITY THERAPEUTI C   39, 043   20   1, 403   0   3, 118, 083   76, 03   76. 04   03954   WOUND CARE CENTER   12, 129   7, 839   2, 688   0   4, 342, 175   76, 04   76. 05   03340   BARI ATRI C CLINI C   15, 991   7, 170   3, 818   0   829, 472   76, 05   76. 06   03303   HEALTHY LIVING CENTER   0   0   0   0   0   0   76, 06   76. 07   03950   CV RESOURCE CENTER   0   0   0   0   0   0   0   76. 08   03955   OTHER ANCI LLARY SERVI CE COST CENTERS   0   0   0   0   0   0   0   76. 10   03958   OTHER ANCI LLARY SERVI CE COST CENTERS   0   0   0   0   0   0   0   76. 10   03959   ANTI COAGULATI ON CLINI C   10,670   0   1,480   0   1,459,859   76, 12   77. 00   07000   CART -CELL I IMMUNOTHERAPY   0   0   0   0   0   0   78. 00   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART   00   0   0   0   0   0   00   09100   EMERGENCY   102,018   50,679   57,370   0   62,786,727   91,00   92. 00   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART   00   0   0   0   0   0   00   09100   EMERGENCY   102,018   50,679   57,370   0   62,786,727   91,00   92. 00   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART   00   0   0   0   0   0		l l				-		
69.00   06900   ELECTROCARDI OLOGY   18,630   5,956   10,486   0   26,818,703   69.00   70.00   07000   ELECTROENCEPHALOGRAPHY   4,879   0   620   0   5,570,089   70.00   71.			1	1				
70. 00 07000   ELECTROENCEPHALOGRAPHY   4,879   0   620   0   5,570,089   70.00   71.00   71.00   71.00   MEDI CAL SUPPLIES CHARGED TO PATIENT   0   0   0   0   52,969,791   71.00   71.00   71.00   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0   0   0   0   0   18,062,685   72.00   72.00   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0   0   0   0   0   0   39,660,597   73.00   73.00   73.00   73.00   73.00   RUGS CHARGED TO PATIENTS   0   0   0   0   0   0   39,660,597   73.00   76.00   33630   ULTRA SOUND   11,831   73   13,651   0   13,649,936   76.00   76.01   76.01   76.02   76.03   73.519   0   49,155,71   76.01   76.02   76.03   76.02   76.03   76.02   76.03   76.			1					
71. 00   07100   MEDICAL SUPPLIES CHARGED TO PATIENT   0   0   0   0   52,969,791   71,00   72.00   72.00   70200   MPL. DEV. CHARGED TO PATIENTS   0   0   0   0   0   18,062,685   72.00   73.00   7			1					
72. 00			4,879			0		
76. 00		1 1	C	ol ol		0		
76. 01 03951 PAIN CLINIC 12, 704 11, 722 7, 023 0 9, 751, 124 76. 01 76. 02 03952 CATH LAB 35, 179 23, 370 73, 519 0 49, 155, 719 76. 02 76. 03 03953 ACTIVITY THERAPEUTIC 39, 043 20 1, 403 0 3, 118, 083 76. 04 03954 WOUND CARE CENTER 12, 129 7, 839 2, 688 0 4, 342, 175 76. 04 76. 05 03340 BARIATRIC CLINIC 15, 991 7, 170 3, 818 0 829, 472 76. 05 76. 06 03030 HEALTHY LIVING CENTER 0 0 0 0 0 0 76. 06 76. 07 03950 CV RESOURCE CENTER 0 0 0 0 0 0 0 76. 07 76. 08 03955 OTHER ANCILLARY SERVICE COST CENTERS 0 0 0 0 0 0 0 76. 08 76. 09 03956 LACTATION CLINIC 0 0 0 0 0 0 0 76. 09 76. 10 03957 OTHER ANCILLARY SERVICE COST CENTERS 0 0 0 0 0 0 76. 10 76. 11 03958 OTHER ANCILLARY SERVICE COST CENTERS 0 0 0 0 0 0 0 76. 11 76. 12 03959 ANTICOAGULATION CLINIC 10, 670 0 1, 480 0 1, 459, 859 76. 12 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	73.00	07300 DRUGS CHARGED TO PATIENTS	C	o	0	100	39, 660, 597	73. 00
76. 02 03952 CATH LAB 35, 179 23, 370 73, 519 0 49, 155, 719 76. 02 76. 03 03953 ACTI VITY THERAPEUTIC 39, 043 20 1, 403 0 3, 118, 083 76. 03 76. 04 03954 WOUND CARE CENTER 12, 129 7, 839 2, 688 0 4, 342, 175 76. 04 76. 05 03340 BARI ATRI C CLI NI C 15, 991 7, 170 3, 818 0 829, 472 76. 05 76. 06 03030 HEALTHY LIVING CENTER 0 0 0 0 0 0 76. 06 76. 07 03950 CV RESOURCE CENTER 0 0 0 0 0 0 76. 07 76. 08 03955 OTHER ANCI LLARY SERVI CE COST CENTERS 0 0 0 0 0 0 0 76. 08 76. 10 03957 OTHER ANCI LLARY SERVI CE COST CENTERS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0					•			
76. 03			1			Ŭ		
76. 04  03954 WOUND CARE CENTER						0		1
76. 05		l l				0		1
76. 07	76. 05	1 1						1
76. 08		1 1	C	0	-	0		1
76. 09			C		0	0	0	1
76. 10					0	0	0	
76. 11		l l		ol ol	0	0	_	1
77. 00   07700   ALLOGENEI C STEM CELL ACQUI SI TI ON   0   0   0   0   0   0   77. 00   78. 00   07800   CAR T-CELL I MMUNOTHERAPY   0   0   0   0   0   0   00   07800   07800   07800   07800   07800   00   07800   07800   07800   07800   0   0   0   00   07800   07800   0   0   0   0   00   0   0   0   0	76. 11	03958 OTHER ANCILLARY SERVICE COST CENTERS	C	o	0	0	0	76. 11
78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 0 78. 00 0 0 0 78. 00 0 0 0 0 78. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		l l		1				
0UTPATIENT SERVICE COST CENTERS  91. 00		l l	1	1				
91. 00   09100   EMERGENCY   102, 018   50, 679   57, 370   0   62, 786, 727   91. 00   92. 00   09200   0BSERVATI ON BEDS (NON-DI STI NCT PART   0THER REI MBURSABLE COST CENTERS   92. 00   09200	78. UU			y U	0	U	0	, 78.00
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART 92. 00 OTHER REIMBURSABLE COST CENTERS	91. 00	09100 EMERGENCY	102, 018	50, 679	57, 370	0	62, 786, 727	91.00
	92. 00							1
1 02, 100 0, 737 37, 730 0 10, 537, 030 101. 00	101 00		62 104	Ω 050	27 024	٥	10 330 034	101 00
		1.0.00 HOME HEACHT MOUNT	1 02, 100	0, 737	31, 730	<u> </u>	13, 337, 030	1101.00

Health Financial Systems	FRANCISCAN HI	FALTH_ DVFR		Inlie	u of Form CMS-25	552_10
COST ALLOCATION - STATISTICAL BASIS	TRANCI SCAN TI	Provider CO	CN: 15-0090 P	eri od:	Worksheet B-1	332 10
			F	rom 01/01/2023 o 12/31/2023	Date/Time Prepa 5/30/2024 3:45	
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
	<b>\</b>	ADMI NI STRATI ON		(COSTED REQ	RECORDS &	
	ED)	(DI RECT NRS	SUPPLY	UISI)	LI BRARY	
		I NG)	(COSTED		(GROSS CHAR	
			REQUIS.)		GES)	
	11. 00	13. 00	14. 00	15. 00	16. 00	
102. 00 10200 OPI OI D TREATMENT PROGRAM	0	0	0	0	0 1	02. 00
SPECIAL PURPOSE COST CENTERS		ı	ı			
113.00 11300 INTEREST EXPENSE	4 450 074			400		13.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	1, 150, 874	401, 453	620, 136	100	762, 518, 724 1	18.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	2, 088	Ι ο	40, 883	0	0 1	90. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	18, 359		5, 334	0		92.00
192. 01 19201 WORKI NG WELL	10, 337	1, 211	0, 334	0		92. 00
192. 02 19202 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0		92. 01
192. 03 19203 MI SC	0	0	0	0		92. 03
194. 00 07950  RESI DENTI AL	96, 699	6, 019	9, 992	0		94. 00
194. 01 07954 OTHER NONREI MBURSABLE COST CENTERS	70, 077	0,017	7, 7,2	0		94. 01
194. 02 07952 PSYCHI ATRI C	0	0	0	0		94. 02
194. 03 07953  CENTER OF HOPE	19	0	0	0		94. 03
200.00 Cross Foot Adjustments	• •			J. Company		200.00
201.00 Negative Cost Centers						201. 00
202.00 Cost to be allocated (per Wkst. B, Part	1, 881, 785	4, 764, 360	1, 867, 798	4, 508, 358		
1)	., 00., 700	1,701,000	1,007,770	1,000,000	2,2,	.02.00
203.00 Unit cost multiplier (Wkst. B, Part I)	1. 484012	11. 657837	2. 761605	45, 083. 580000	0. 002940 2	203.00
204.00 Cost to be allocated (per Wkst. B, Part	175, 200	51, 230	293, 020	128, 939	130, 806 2	204. 00
205.00 Unit cost multiplier (Wkst. B, Part II)	0. 138166	0. 125354	0. 433240	1, 289. 390000	0. 000172 2	205.00
206.00 NAHE adjustment amount to be allocated					2	206. 00
(per Wkst. B-2)						
207.00 NAHE unit cost multiplier (Wkst. D,					2	207. 00
Parts III and IV)		l				

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0090 Peri od: Worksheet B-1 From 01/01/2023 12/31/2023 Date/Time Prepared: 5/30/2024 3:45 pm INTERNS & RESIDENTS SOCI AL SERVI CE SERVI CES-SALAR SERVI CES-OTHER PARAMED ED Cost Center Description PARAMED ED (GROSS CHAR Y & FRINGES PRGM COSTS PRGM PRGM- LAB **EMERGENCY** (ASSI GNED GES) (ASSI GNED **APPRV** (ASSI GNED TIME) MEDICINE TIME) TIME) (ASSI GNED TIME) 17.00 21.00 22.00 23.00 23.01 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00593 OTHER ADMINISTRATIVE AND GENERAL 5.04 5 04 00600 MAINTENANCE & REPAIRS 6.00 6.00 00700 OPERATION OF PLANT 7.00 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 00900 HOUSEKEEPI NG 9 00 9 00 10.00 01000 DI ETARY 10.00 11.00 01100 CAFETERI A 11.00 01300 NURSING ADMINISTRATION 13.00 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14 00 01500 PHARMACY 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16.00 01700 SOCIAL SERVICE 17.00 762, 518, 724 17.00 02100 I &R SERVICES-SALARY & FRINGES APPRVD 21.00 100 21.00 22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 0 100 22.00 0 02300 PARAMED ED PRGM - EMERGENCY MEDICINE 100 23.00 23.00 02301 PARAMED ED PRGM- LAB 0 100 23.01 23.01 02302 PARAMED ED PRGM- PHARMACY 0 23.02 23.02 02303 PARAMED ED PRGM- RADIOLOGY 23.03 23.03 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 72, 772, 173 36 36 0 30.00 03100 INTENSIVE CARE UNIT 31.00 10, 388, 787 0 0 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 35.00 02060 NEONATAL INTENSIVE CARE UNIT 1,848,900 0 0 0 35.00 0 04100 SUBPROVI DER - I RF 0 41.00 7, 542, 016 0 0 41.00 04200 SUBPROVI DER 0 42 00 Ω 0 42 00 04300 NURSERY 0 0 43.00 1, 100, 406 0 0 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 82, 652, 204 0 0 0 50.00 05001 OUTPATIENT SURGERY 3, 793, 528 0 Ω Ω 50 01 50 01 05100 RECOVERY ROOM 16, 151, 657 0 51.00 0 0 51.00 53.00 05300 ANESTHESI OLOGY 18, 447, 799 0 53.00 0 05400 RADI OLOGY-DI AGNOSTI C 88, 287, 475 0 54.00 54.00 0 05401 RADI OLOGY-SPECI AL PROCEDURES 12, 732, 253 0 0 54 01 54 01 0 55.00 05500 RADI OLOGY-THERAPEUTI C 0 0 55.00 05600 RADI OI SOTOPE 10, 679, 671 0 0 56.00 0 56.00 06000 LABORATORY 0 0 100 60.00 76, 316, 911 60.00 0 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 1, 567, 708 0 0 63.00 65.00 06500 RESPIRATORY THERAPY 13, 697, 800 0 0 0 65.00 06600 PHYSI CAL THERAPY 26, 059, 110 66.00 0 66.00 06700 OCCUPATIONAL THERAPY 11, 158, 417 0 67.00 0 67.00 0 68.00 06800 SPEECH PATHOLOGY 8, 807, 913 0 0 0 68.00 26, 818, 703 06900 ELECTROCARDI OLOGY 69.00 69.00 07000 ELECTROENCEPHALOGRAPHY 5, 570, 089 0 0 70.00 0 70.00 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 52, 969, 791 71.00 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 18, 062, 685 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73 00 39, 660, 597 0 0 73.00 03630 ULTRA SOUND 13, 649, 936 0 76.00 0 0 76.00 03951 PAIN CLINIC 9, 751, 124 Ω 0 76.01 0 76.01 03952 CATH LAB 49, 155, 719 0 0 76.02 76.02 03953 ACTIVITY THERAPEUTIC 76.03 3, 118, 083 0 76.03 03954 WOUND CARE CENTER 4, 342, 175 0 76.04 0 0 76.04 03340 BARIATRIC CLINIC 0 76.05 829, 472 0 0 76.05 03030 HEALTHY LIVING CENTER 76.06 76.06 0 76.07 03950 CV RESOURCE CENTER 0 0 0 76.07 03955 OTHER ANCILLARY SERVICE COST CENTERS 0 0 76.08 C 0 76.08 76.09 0 03956 LACTATION CLINIC 0 0 0 76.09 03957 OTHER ANCILLARY SERVICE COST CENTERS 0 0 76. 10 0 0 76.10 03958 OTHER ANCILLARY SERVICE COST CENTERS 0 0 76. 11 76.11 0 0 03959 ANTICOAGULATION CLINIC 0 1, 459, 859 0 76.12 0 76.12 77.00 07700 ALLOGENEIC STEM CELL ACQUISITION C 0 0 0 77.00 78.00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 78.00 OUTPATIENT SERVICE COST CENTERS 91. 00 | 09100 | EMERGENCY 62, 786, 727 64 64 100 0 91.00

COST ALLOCATION - STATISTICAL BASIS		Provi der CO	CN: 15-0090	Peri od:	Worksheet B-1	
				From 01/01/2023		
				To 12/31/2023	Date/Time Pre 5/30/2024 3:4	
		INTERNS &	RESI DENTS		7 07 007 202 1 01 1	J
Cost Center Description	SOCI AL SERVI CE				PARAMED ED	
	(GROSS CHAR	Y & FRINGES	PRGM COSTS	PRGM -	PRGM- LAB	
	GES)	(ASSI GNED TIME)	APPRV (ASSI GNED	EMERGENCY MEDICINE	(ASSIGNED TIME)	
		IIIWE)	TIME)	(ASSI GNED	IIWE)	
			I IIWE)	TIME)		
	17. 00	21. 00	22. 00	23. 00	23. 01	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100 HOME HEALTH AGENCY	10, 339, 036			0 0		101.00
102.00 10200 OPIOLD TREATMENT PROGRAM	0	0		0 0	0	102. 00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300   INTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	762, 518, 724	100	10	00 100	100	118. 00
NONREI MBURSABLE COST CENTERS  190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	Γ	ol ol	0	190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	•			190.00
192. 01 19201 WORKING WELL	0	0				192. 00
192. 02 19202 PHYSI CLANS' PRI VATE OFFI CES		0				192. 02
192. 03 19203 MI SC	o o	0				192. 03
194. 00 07950 RESI DENTI AL	0	0		ol ol		194. 00
194. 01 07954 OTHER NONREI MBURSABLE COST CENTERS	0	0		0 0	0	194. 01
194. 02 07952 PSYCHI ATRI C	0	0		0 0	0	194. 02
194. 03 07953 CENTER OF HOPE	0	0		0 0	0	194. 03
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B, Par	t 0	98, 361	162, 66	98, 228	519, 068	202. 00
203.00 Unit cost multiplier (Wkst. B, Part I)	0. 000000	983. 610000	1, 626. 62000	982. 280000	5, 190. 680000	203. 00
204.00 Cost to be allocated (per Wkst. B, Par	t o	854	1, 23	1, 611	45, 263	204.00
11)						
205.00 Unit cost multiplier (Wkst. B, Part II		8. 540000	12. 36000	16. 110000	452. 630000	205. 00
206.00 NAHE adjustment amount to be allocated				0	0	206. 00
(per Wkst. B-2)				0.005	0.005	
207.00 NAHE unit cost multiplier (Wkst. D,				0. 000000	0. 000000	207.00
Parts III and IV)	1		I			1

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

Peri od: Worksheet B-1 From 01/01/2023 To 12/31/2023 Date/Time Prepared: 5/30/2024 3: 45 pm Provider CCN: 15-0090

				5/30/2024 3: 4	
	Cost Center Description	PARAMED ED	PARAMED ED		
		PRGM- PHARMACY	PRGM-		
		(ASSI GNED TI ME)	RADI OLOGY (ASSI GNED		
		TTWL)	TIME)		
		23. 02	23. 03		
	GENERAL SERVICE COST CENTERS				
1.00	00100 CAP REL COSTS-BLDG & FIXT				1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT				4.00
5. 04 6. 00	00593 OTHER ADMINISTRATIVE AND GENERAL 00600 MAINTENANCE & REPAIRS				5. 04 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					10. 00
11.00					11.00
13.00					13.00
14. 00 15. 00					14. 00 15. 00
16. 00					16. 00
17. 00					17. 00
21. 00	02100 I&R SERVICES-SALARY & FRINGES APPRVD				21. 00
22. 00					22. 00
23. 00	1 1				23. 00
23. 01	1 1	100			23. 01
23. 02 23. 03		100	0		23. 02 23. 03
23.03	I NPATI ENT ROUTI NE SERVI CE COST CENTERS		0	J <sub> </sub>	23.03
30. 00		0	0		30.00
31.00		0	0		31.00
32. 00	1 1	0	0		32. 00
33. 00		0	0		33. 00
35. 00	1 1	0	0	1	35. 00
41. 00 42. 00		0	0	1	41. 00 42. 00
43. 00		0		·	43.00
	ANCILLARY SERVICE COST CENTERS				
50.00	1	0	-	·	50. 00
50. 01		0	0		50. 01
51. 00 53. 00		0	0		51. 00 53. 00
54. 00		0		1	54.00
54. 01		0	Ö		54. 01
55.00		0	0		55. 00
56.00	05600 RADI OI SOTOPE	0	0	D	56. 00
60.00	1	0	0		60.00
63. 00		0	0		63.00
65. 00 66. 00	1	0	0		65. 00 66. 00
67. 00	1 1	0	0	1	67. 00
68. 00		o o	Ö	1	68.00
69.00	1 1	0	0		69. 00
70.00		0	0	D	70. 00
71. 00		0	0	1	71. 00
72. 00	1	100	0		72.00
73. 00 76. 00	1	100	0	1	73. 00 76. 00
76. 00	1 1		0		76. 00
76. 02	1 1	0	0		76. 02
76. 03		0	0	D	76. 03
76. 04	1	0	0		76. 04
76. 05		0	0		76. 05
76. 06 76. 07			0		76. 06 76. 07
76. 07	1		0		76. 07
76. 09		0	Ö		76. 09
76. 10	03957 OTHER ANCILLARY SERVICE COST CENTERS	0	0		76. 10
76. 11		0	0		76. 11
	03959 ANTI COAGULATI ON CLINI C	0	0		76. 12
77. 00 78. 00		0	0		77. 00 78. 00
, 0. 00	OUTPATIENT SERVICE COST CENTERS	0		4	73.00
91. 00	09100 EMERGENCY	0	0		91. 00
92. 00					92. 00
101 00	OTHER REIMBURSABLE COST CENTERS O 10100 HOME HEALTH AGENCY	0	0		101. 00
101.00	OF TO TOO THOME HEALTH ADENOT	ı U	<u> </u>	<b>*</b> I	1101.00

Health Financial Systems	FRANCISCAN HE	ALTH DVED	In Lie	u of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS	FRANCI SCAN HE	Provider CCN: 15-0	090 Peri od:	Worksheet B-1
			From 01/01/2023 To 12/31/2023	Date/Time Prepared: 5/30/2024 3:45 pm
Cost Center Description	PARAMED ED PRGM- PHARMACY (ASSI GNED TI ME)	PARAMED ED PRGM- RADI OLOGY (ASSI GNED TI ME)		0.100,20210.10
100 00 10000 00 01 01 0 705174547 0000044	23. 02	23. 03		100.00
102. 00 10200 OPI OI D TREATMENT PROGRAM SPECIAL PURPOSE COST CENTERS	0	0		102.00
113. 00 11300 I NTEREST EXPENSE				113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	100	o		118.00
NONREI MBURSABLE COST CENTERS		- 1		
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0		192. 00
192. 01 19201 WORKI NG WELL	0	0		192. 01
192. 02 19202 PHYSI CLANS' PRI VATE OFFI CES	0	0		192. 02
192. 03 19203 MI SC	0	0		192. 03
194. 00 07950 RESI DENTI AL	0	0		194. 00
194.01 07954 OTHER NONREIMBURSABLE COST CENTERS	0	0		194. 01
194. 02 07952 PSYCHI ATRI C	0	O		194. 02
194. 03 07953 CENTER OF HOPE	0	O		194. 03
200.00 Cross Foot Adjustments				200. 00
201.00 Negative Cost Centers				201. 00
202.00   Cost to be allocated (per Wkst. B, Par	t 386, 668	0		202. 00
203.00 Unit cost multiplier (Wkst. B, Part I)	3, 866. 680000	0. 000000		203. 00
204.00 Cost to be allocated (per Wkst. B, Par	1 '	0		204.00
11)	]	<u> </u>		[231.00

0. 000000

0.000000

84. 420000

0.000000

205. 00

206. 00

207. 00

205.00

206.00

207.00

11)

(per Wkst. B-2)

Parts III and IV)

Unit cost multiplier (Wkst. B, Part II)
NAHE adjustment amount to be allocated

NAHE unit cost multiplier (Wkst. D,

			1	o 12/31/2023	Date/Time Pre 5/30/2024 3:4	
		Title	xVIII	Hospi tal	PPS	<u> </u>
		<u> </u>		Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst. B,	Adj .		Di sal I owance		
	Part I, col.					
	26)					
	1.00	2. 00	3. 00	4. 00	5. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		l				
30. 00   03000   ADULTS & PEDI ATRI CS	43, 425, 611		43, 425, 611	0	43, 425, 611	30. 00
31. 00   03100   INTENSIVE CARE UNIT	6, 001, 644		6, 001, 644	0	6, 001, 644	1
32. 00   03200   CORONARY CARE UNIT	0		0	0	0	32.00
33. 00 03300 BURN INTENSIVE CARE UNIT	1 221 017		0	0	1 221 017	33. 00
35. 00 02060 NEONATAL INTENSIVE CARE UNIT	1, 221, 017 4, 555, 491		1, 221, 017	0	1, 221, 017 4, 555, 491	35. 00
41. 00   04100   SUBPROVI DER -   1 RF 42. 00   04200   SUBPROVI DER	4, 555, 491		4, 555, 491 0			41. 00 42. 00
42. 00   04200  SUBPROVI DER 43. 00   04300  NURSERY	1, 784, 715				1 704 715	
ANCI LLARY SERVI CE COST CENTERS	1,764,713		1, 784, 715	U	1, 784, 715	43.00
50. 00 05000 OPERATING ROOM	7, 825, 060		7, 825, 060	O	7, 825, 060	50.00
50. 01   05001   0UTPATI ENT   SURGERY	2, 775, 307		2, 775, 307	0	2, 775, 307	50. 00
51. 00   05100   RECOVERY   ROOM	1, 379, 593		1, 379, 593	-	1, 379, 593	51. 00
53. 00   05300   ANESTHESI OLOGY	95, 192		95, 192	0	95, 192	53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	7, 658, 847		7, 658, 847	0	7, 658, 847	54. 00
54. 01 05401 RADI OLOGY-SPECI AL PROCEDURES	2, 710, 330		2, 710, 330		2, 710, 330	1
55. 00 05500 RADI OLOGY-THERAPEUTI C	2,710,000		2, 710, 000		2, 710, 000	55. 00
56. 00   05600   RADI OI SOTOPE	1, 137, 644		1, 137, 644	0	1, 137, 644	56. 00
60. 00   06000   LABORATORY	10, 578, 146		10, 578, 146	_	10, 578, 146	1
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	729, 259		729, 259		729, 259	63. 00
65. 00 06500 RESPI RATORY THERAPY	4, 075, 246				4, 075, 246	1
66. 00   06600   PHYSI CAL THERAPY	6, 555, 636	l			6, 555, 636	•
67. 00 06700 OCCUPATI ONAL THERAPY	1, 031, 851	Ö	1, 031, 851	0	1, 031, 851	67. 00
68. 00 06800 SPEECH PATHOLOGY	1, 263, 002	O		0	1, 263, 002	68. 00
69. 00 06900 ELECTROCARDI OLOGY	2, 197, 231		2, 197, 231	0	2, 197, 231	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	826, 873		826, 873	0	826, 873	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	17, 354, 709		17, 354, 709	0	17, 354, 709	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	4, 611, 518		4, 611, 518	0	4, 611, 518	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	10, 947, 739		10, 947, 739	0	10, 947, 739	73. 00
76.00 03630 ULTRA SOUND	1, 368, 423		1, 368, 423	0	1, 368, 423	76. 00
76. 01   03951   PAIN CLINIC	2, 235, 980		2, 235, 980	0	2, 235, 980	76. 01
76. 02   03952   CATH LAB	5, 505, 746		5, 505, 746	0	5, 505, 746	76. 02
76. 03   03953   ACTI VI TY THERAPEUTI C	3, 126, 589		3, 126, 589	0	3, 126, 589	76. 03
76.04   03954   WOUND CARE CENTER	1, 559, 403		1, 559, 403	0	1, 559, 403	76. 04
76. 05   03340   BARI ATRI C   CLI NI C	1, 189, 194		1, 189, 194	0	1, 189, 194	76. 05
76.06 03030 HEALTHY LIVING CENTER	0		0	0	0	76. 06
76. 07 03950 CV RESOURCE CENTER	0		0	0	0	76. 07
76. 08 03955 OTHER ANCILLARY SERVICE COST CENTERS	0		0	0	0	76. 08
76. 09   03956   LACTATION CLINIC	0		0	0	0	76. 09
76. 10 03957 OTHER ANCILLARY SERVICE COST CENTERS	0		0	0	0	76. 10
76. 11 03958 OTHER ANCILLARY SERVICE COST CENTERS	0		0	0	0	76. 11
76. 12 03959 ANTI COAGULATI ON CLINI C	1, 019, 812		1, 019, 812		1, 019, 812	1
77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION	0		0		0	
78. 00 07800 CAR T-CELL IMMUNOTHERAPY	0		0	U	0	78. 00
OUTPATIENT SERVICE COST CENTERS	10 570 220		10 570 220		10 570 220	01 00
91. 00 09100 EMERGENCY	10, 570, 338		10, 570, 338			
92.00   09200   OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS	4, 407, 652		4, 407, 652		4, 407, 652	92. 00
101.00 10100 HOME HEALTH AGENCY	13, 370, 290		13, 370, 290		13, 370, 290	101 00
102.00 10200 OPI OI D TREATMENT PROGRAM	13, 370, 290		13, 370, 290			101.00
SPECIAL PURPOSE COST CENTERS					U	1102.00
113. 00 11300   NTEREST EXPENSE						113. 00
200.00 Subtotal (see instructions)	185, 095, 088	0	185, 095, 088	0	185, 095, 088	
201. 00 Less Observation Beds	4, 407, 652	ł	4, 407, 652		4, 407, 652	
202. 00 Total (see instructions)	180, 687, 436	ł			180, 687, 436	
	1	'	1	۱		,

| In Lieu of Form CMS-2552-10 | Period: | Worksheet C | From 01/01/2023 | Part | | Date/Time Prepared: | 5/30/2024 3:45 pm |

						5/30/2024 3: 4	5 pm
				XVIII	Hospi tal	PPS	
			Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
				+ col. 7)	Rati o	I npati ent	
						Ratio	
		6.00	7. 00	8. 00	9. 00	10. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	63, 468, 258		63, 468, 258			30.00
31.00	03100 INTENSIVE CARE UNIT	10, 388, 787		10, 388, 787			31. 00
32.00	03200 CORONARY CARE UNIT	0		l c			32. 00
33.00	03300 BURN INTENSIVE CARE UNIT	0		l c			33. 00
35.00	02060 NEONATAL INTENSIVE CARE UNIT	1, 848, 900		1, 848, 900			35. 00
41.00	04100 SUBPROVI DER - I RF	7, 542, 016		7, 542, 016			41.00
42.00	04200 SUBPROVI DER	o					42.00
43.00	04300 NURSERY	1, 100, 406		1, 100, 406			43.00
	ANCI LLARY SERVI CE COST CENTERS	.,,		., ., ., ., ., ., ., ., ., ., ., ., ., .			
50.00	05000 OPERATI NG ROOM	34, 061, 809	48, 590, 395	82, 652, 204	0. 094675	0. 000000	50.00
50. 01	05001 OUTPATI ENT SURGERY	1, 815, 179	1, 978, 349			0. 000000	
51. 00	05100 RECOVERY ROOM	3, 358, 747	12, 792, 910			0. 000000	
53. 00	05300 ANESTHESI OLOGY	6, 993, 558	11, 454, 241			0. 000000	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	27, 304, 592	60, 982, 883			0. 000000	
54. 01	05401 RADI OLOGY-SPECI AL PROCEDURES	5, 148, 269	7, 583, 984			0. 000000	
55. 00	05500 RADI OLOGY-THERAPEUTI C	3, 140, 207	7, 303, 704	1		0. 000000	
56. 00	05600 RADI OI SOTOPE	1, 462, 800	9, 216, 871			0. 000000	
60.00	06000 LABORATORY	37, 511, 168	38, 805, 743			0. 000000	
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	1, 235, 537	332, 171	1, 567, 708		0. 000000	
65. 00	06500 RESPIRATORY THERAPY	12, 931, 033	766, 767			0. 000000	
66. 00	06600 PHYSI CAL THERAPY	6, 453, 385	19, 605, 725			0. 000000	
67. 00	06700 OCCUPATIONAL THERAPY	5, 569, 626	5, 588, 791			0. 000000	
	1						
68. 00 69. 00	06800 SPEECH PATHOLOGY	2, 989, 638	5, 818, 275 17, 347, 705			0.000000	
	06900   ELECTROCARDI OLOGY   07000   ELECTROENCEPHALOGRAPHY	9, 470, 998				0.000000	
70.00	l l	560, 292	5, 009, 797 27, 929, 391			0.000000	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	25, 040, 400				0.000000	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	7, 441, 880	10, 620, 805			0.000000	
73.00	07300 DRUGS CHARGED TO PATIENTS	27, 478, 045	12, 182, 552			0. 000000	
76.00	03630 ULTRA SOUND	4, 090, 978	9, 558, 958			0. 000000	
76. 01	03951 PAIN CLINIC	102, 132	9, 648, 992			0. 000000	
76. 02	03952 CATH LAB	16, 387, 210	32, 768, 509			0. 000000	
76. 03	03953 ACTI VI TY THERAPEUTI C	2, 992, 605	125, 478			0. 000000	
76. 04	03954 WOUND CARE CENTER	147, 826	4, 194, 349			0. 000000	
76. 05	03340 BARI ATRI C CLI NI C	1, 907	827, 565			0. 000000	
76. 06	03030 HEALTHY LIVING CENTER	0	0	0		0. 000000	
76. 07	03950 CV RESOURCE CENTER	0	0	0	0. 000000	0. 000000	
76. 08	03955 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0. 000000	0. 000000	
76. 09	03956 LACTATION CLINIC	0	0	0	0. 000000	0. 000000	
76. 10	03957 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0. 000000	0. 000000	
76. 11	03958 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0. 000000	0. 000000	
76. 12	03959 ANTI COAGULATI ON CLI NI C	8, 705	1, 451, 154	1, 459, 859	0. 698569	0.000000	76. 12
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	C	0. 000000	0.000000	77. 00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	C	0.000000	0.000000	78. 00
	OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	16, 944, 805	45, 841, 922	62, 786, 727	0. 168353	0. 000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	3, 095, 815	6, 208, 100	9, 303, 915		0.000000	92. 00
	OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	0	10, 339, 036	10, 339, 036			101. 00
102.00	10200 OPI OI D TREATMENT PROGRAM	0	0	C			102. 00
	SPECIAL PURPOSE COST CENTERS	· '					1
113.00	11300 I NTEREST EXPENSE						113. 00
200.00		344, 947, 306	417, 571, 418	762, 518, 724			200. 00
201.00	1 / /						201. 00
202.00		344, 947, 306	417, 571, 418	762, 518, 724			202. 00
50	1		. , , 710		1		

Heal th Financial Systems FRANCISCAN HEALTH- DYER In Lieu of Form CMS-2552-10 COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0090 Period: From 01/01/2023 To 12/31/2023 Part I Date/Time Prepared: 5/30/2024 3: 45 pm

COST Center Description					5/30/2024 3:45 pm
Ratio			Title XVIII	Hospi tal	
INPATIENT ROUTINE SERVICE COST CENTERS   30 .00	Cost Center Description	PPS Inpatient			
INPATLENT ROUTINE SERVICE COST CENTERS   30 00   00   000000		Ratio			
0.00   0.000   ADULTS & PEDIATRICS     30   0.00		11.00			
0.00   0.000   ADULTS & PEDIATRICS     30   0.00	INPATIENT ROUTINE SERVICE COST CENTERS				
2.00   3300   CORONARY CARE UNIT					30.00
2.00   3300   CORONARY CARE UNIT	31. 00 03100 INTENSIVE CARE UNIT				31.00
3.00   3.000   BURN   INTENSIVE CARE UNIT					
5.00   20260   INDENDATIAL INTENSIVE CARE UNIT					
1.00   0.1100 SUBPROVI DER - I IRF					
2.00   0.4200 SUBPROVIDER   42.00   0					
3.00   0.000   0.00000   0.0000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.00000000					
MARCILLARY SERVICE COST CENTERS   50.00					
0.00   0.5000   DERATI ING ROOM   0.094675   5.0					43.00
0.01   0.5001   OUTPATE IENT SURGERY   0.731590   5.0 of 1.00   510.00   53.00   ANESTHESI OLOGY   0.005415   5.1 of 0.00   53.00   ANESTHESI OLOGY   0.005160   53.00   53.00   ANESTHESI OLOGY   0.005160   53.00   53.00   ANESTHESI OLOGY   0.005160   53.00   53.00   53.00   ANESTHESI OLOGY   0.005160   54.01   54.01   54.01   54.01   55.00   5550   63.00   63.00   ADDI OLOGY-SPECI AL PROCEDURES   0.212871   54.01   54.01   56.00   55.00   5550   63.00   63					
1.00   05100   RECOVERY ROOM   0.08515   51.00   53.00   6300   ARSTHESIOLOGY   0.005160   53.00   6300   ARSTHESIOLOGY   0.086749   54.00   54.00   54.00   54.00   54.00   54.00   54.00   55.00		1			
3.00   05300   ANESTHESI OLOGY   0.005160   53.00   54.01   0.005400   54.01   0.005400   54.01   0.005400   54.01   0.005401   RADI OLOGY-SPECI AL PROCEDURES   0.212871   54.01   54.01   0.000000   55.00   0.0000   0.0000   0.0000   0.0000   0.0000   55.00   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.000000   0.000000   0.0000000   0.0000000   0.00000000		1			
4. 00   05400   RADI OLOGY -DI ACNOSTI C   0. 086749   54. 00   50500   RADI OLOGY -TERAPEUTI C   0. 0000000   55. 00   05500   RADI OLOGY -TERAPEUTI C   0. 0000000   55. 00   05600   RADI OLOGY -TERAPEUTI C   0. 0000000   55. 00   05. 00   05000   RADI OLOGY -TERAPEUTI C   0. 0000000   55. 00   05. 00   05000   RADI OLOGY -TERAPEUTI C   0. 0000000   0.00000   0.0000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.000000   0.000000   0.000000   0.0000000   0.0000000   0.00000000		0. 085415			51.00
4. 01   05401 RADI OLOGY-SPECI AL PROCEDURES   0. 212871   54. 07   6. 00   05600 RADI OLOGY-THERAPEUTI C   0. 000000   55. 00   6. 00   05600 RADI OLOGY-THERAPEUTI C   0. 000000   55. 00   6. 00   05600 RADI OLOGY-THERAPEUTI C   0. 000000   60. 00   6. 00   05600 RADI OLOGY-THERAPEUTI C   0. 000000   6. 00   05600 RADI OLOGY-THERAPEUTI C   0. 000000   6. 00   05600 RESPI RATORY THERAPY   0. 287511   65. 00   6. 00   05600 RESPI RATORY THERAPY   0. 281568   66. 00   6. 00   05600 RESPI RATORY THERAPY   0. 092473   67. 00   6. 00   05600 RESPI RATORY THERAPY   0. 092473   67. 00   6. 00   05600 RESPI RATORY THERAPY   0. 092473   67. 00   6. 00   05600 RESPI RATORY THERAPY   0. 148394   68. 00   6. 00   05600 RESPI RATORY THERAPY   0. 148449   69. 00   6. 00   05700 CELECTROCARDI OLOGY   0. 081929   69. 00   6. 00   00   07000 LELCTROCARDI OLOGY   0. 081929   7. 00   07000 IMPL DEV. CHARGED TO PATI ENTS   0. 255306   72. 00   7. 00   07000 IMPL DEV. CHARGED TO PATI ENTS   0. 255306   73. 00   7. 00   07000 INFL. DEV. CHARGED TO PATI ENTS   0. 276036   73. 00   7. 01   07000 INFL. DEV. CHARGED TO PATI ENTS   0. 229305   75. 00   7. 01   0. 00   03000 INTRA SOUND   0. 100251   76. 00   7. 02   03951 PAIN CLINIC   0. 229305   76. 00   7. 03   0. 03953 ACTI VITY THERAPEUTIC   1. 002728   76. 00   7. 04   03954 INTLANCE CENTER   0. 389129   76. 00   7. 05   0. 03340 BARI ATRIC CLINIC   1. 433676   76. 00   7. 05   0. 03330 BARI ATRIC CLINIC   0. 000000   76. 00   7. 06   0. 03955 OTHER ANGILLARY SERVICE COST CENTERS   0. 000000   76. 00   7. 06   0. 03955 OTHER ANGILLARY SERVICE COST CENTERS   0. 000000   76. 00   7. 07   0700 OTHER ANGILLARY SERVICE COST CENTERS   0. 000000   76. 00   7. 01   0700 OTHER ANGILLARY SERVICE COST CENTERS   0. 000000   76. 00   7. 01   0700 OTHER ANGILLARY SERVICE COST CENTERS   0. 000000   76. 00   7. 01   0700 OTHER ANGILLARY SERVICE COST CENTERS   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0.	53. 00   05300   ANESTHESI OLOGY	0. 005160			53.00
5.00   0.5500   RADI OLOCY-THERAPEUTI C   0.000000   5.5	54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 086749			54.00
0.00   0.5600   RADIO ISOTOPE   0.106524   0.106524   0.00   0.6000   LABORATOPE   0.138608   0.60   0.00   0.0000   LABORATOPE   0.138608   0.60   0.00   0.6000   RESPI RATORY   0.138608   0.60   0.0000   0.6000   RESPI RATORY   0.297511   0.50   0.00500   RESPI RATORY   0.297511   0.50   0.00500   RESPI RATORY   0.60   0.00000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.000000   0.00000   0.00000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.00000000	54. 01 05401 RADI OLOGY-SPECI AL PROCEDURES	0. 212871			54. 01
0.00   0.5600   RADIO ISOTOPE   0.106524   0.106524   0.00   0.6000   LABORATOPE   0.138608   0.60   0.00   0.0000   LABORATOPE   0.138608   0.60   0.00   0.6000   RESPI RATORY   0.138608   0.60   0.0000   0.6000   RESPI RATORY   0.297511   0.50   0.00500   RESPI RATORY   0.297511   0.50   0.00500   RESPI RATORY   0.60   0.00000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.000000   0.00000   0.00000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.00000000	55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000			55.00
0.00   0.000   LABORATORY   0.138608   6.0.00		1			56.00
0.300   0.0300   BLOOD STORING, PROCESSING & TRANS.   0. 465175   65.00		1			
0.500   0.6500   RESPI RATORY THERAPY   0.297511   65.00		1			
6.00   0.6600   PHYSI CAL THERAPY   0.251568   66.07     7.00   0.6700   OCCUPATI ONAL THERAPY   0.92473   67.00     8.00   0.6800   SPEECH PATHOLOGY   0.143394   68.00     8.00   0.6800   SPEECH PATHOLOGY   0.81929   69.00     9.00   0.0900   ELECTRORARDI LOGY   0.81929   69.00     1.00   0.07000   ELECTRORARDI LOGY   0.148449   70.00     1.00   0.07100   MEDI CAL SUPPLIES CHARGED TO PATIENT   0.327634   71.00     1.00   0.07100   MEDI CAL SUPPLIES CHARGED TO PATIENT   0.255306   72.00     1.00   0.07200   IMPL. DEV. CHARGED TO PATIENTS   0.255306   72.00     1.00   0.07300   DRUGS CHARGED TO PATIENTS   0.276036   73.00     1.00   0.07300   DRUGS CHARGED TO PATIENTS   0.276036   73.00     1.00   0.03510   LITRA SOUND   76.00     1.00   0.03510   LITRA SOUND   76.00     1.00   0.03510   ACTIVITY THERAPEUTIC   0.229305   76.00     1.00   0.0352   ACTIVITY THERAPEUTIC   1.002728   76.00     1.00   0.0354   MOUND CARE CENTER   0.359129   76.00     1.00   0.0354   MOUND CARE CENTER   0.000000   76.00     1.00   0.0358   DABRIATRIC CLINIC   0.3433676   76.00     1.00   0.0355   OTHER ANCILLARY SERVICE COST CENTERS   0.000000   76.00     1.00   0.0700   OTHER ANCILLARY SERVICE COST CENTERS   0.000000   76.00     1.00   0.0700   OTHER ANCILLARY SERVICE COST CENTERS   0.000000   76.00     1.00   0.0700   OTHER ANCILLARY SERVICE COST CENTERS   0.000000   76.00     1.00   0.0700   OTHER ANCILLARY SERVICE COST CENTERS   0.000000   76.00     1.00   0.0700   OTHER ANCILLARY SERVICE COST CENTERS   0.000000   76.00     1.00   0.0700   OTHER ANCILLARY SERVICE COST CENTERS   0.000000   0.00000   76.00     1.00   0.0700   OTHER ANCILLARY SERVICE COST CENTERS   0.000000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.0000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.0000000   0.0000000   0.00000000		1			
17.00   06700   OCCUPATIONAL THERAPY   0.092473   67.00     8.00   06800   SPEECH PATHOLOGY   0.143394   68.00     9.00   06900   ELECTROCARDIOLOGY   0.081929   69.00     0.00   07000   ELECTROENCEPHALOGRAPHY   0.148449   70.00     0.00   07000   MEDICAL SUPPLIES CHARGED TO PATIENT   0.327634   71.00     2.00   07200   IMPL DEV. CHARGED TO PATIENTS   0.255306   72.00     2.00   07200   IMPL DEV. CHARGED TO PATIENTS   0.255306   72.00     2.00   07300   DRUGS CHARGED TO PATIENTS   0.276036   73.00     2.00   07300   DRUGS CHARGED TO PATIENTS   0.276036   73.00     2.00   07300   DRUGS CHARGED TO PATIENTS   0.276036   73.00     2.00   07300   DRUGS CHARGED TO PATIENTS   0.276036   75.00     2.00   07300   DRUGS CHARGED TO PATIENTS   0.229305   76.00     2.00   03950   CATH LAB   0.1112006   76.00     2.00   03950   CATH LAB   0.1112006   76.00     2.00   03950   DATIEN CHARGED TO PATIENTS   0.359129   76.00     2.00   03300   HEALTHY LIVING CENTER   0.000000   76.00     2.00   03300   HEALTHY LIVING CENTER   0.000000   76.00     2.00   03300   HEALTHY LIVING CENTER   0.000000   76.00     2.00   07300   CALLARY SERVICE COST CENTERS   0.000000   76.00     2.00   07350   CVRESOURCE CENTERS   0.000000   76.00     2.00   07350   CVRESOURCE CENTERS   0.000000   76.00     2.00   07400   ALLOGENEIC STEM CELL ACQUISTION   0.000000   77.00     2.00   07400   ALLOGENEIC STEM CELL ACQUISTION   0.000000   77.00     2.00   07400   ALLOGENEIC STEM CELL ACQUISTION   0.000000   77.00     2.00   07400   DREATMENT PROGRAM   99.000000   90.00000   90.00000   90.00000   90.00000   90.00000   90.00000   90.00000   90.00000   90.00000   90.000000   90.000000   90.000000   90.000000   90.0000000   90.000000   90.0000000   90.00000000   90.00000000   90.00000000   90.0000000000		1 1			
8. 00   0.6800   SPECH PATHOLOGY   0. 143394   68. 00   6900   6900   ELECTROCARDIOLOGY   0. 081929   69. 00   00   00   00   00   00   00   00					
9, 00   69900   ELECTROCARDI OLOGY   0. 081929   70. 00   7000   ELECTROCARDI OLOGY   0. 148449   70. 00   70000   70000   70000   70000   70000   70000   70000   70000   70000   70000   700000   70					
0. 00 0 07000   CLECTROENCEPHALOGRAPHY   0. 148449   70. 00   70.		1			
1. 00		1			
2. 00   07200   IMPL DEV. CHARGED TO PATIENTS   0. 255306   73. 00   07300   DRUGS CHARGED TO PATIENTS   0. 276036   73. 00   07300   DRUGS CHARGED TO PATIENTS   0. 276036   73. 00   07300   DRUGS CHARGED TO PATIENTS   0. 276036   73. 00   07300   ULTRA SOUND   0. 100251   76. 00   03951   PAIN CLINIC   0. 229305   76. 00   03952   CATH LAB   0. 112006   76. 00   03953   ACTIVITY THERAPEUTIC   1. 002728   76. 00   03954   WOUND CARE CENTER   0. 359129   76. 00   03954   WOUND CARE CENTER   0. 359129   76. 00   03954   WOUND CARE CENTER   0. 3466   03030   HEALTHY LIVING CENTER   0. 000000   76. 00   03950   CV RESOURCE CENTER   0. 000000   76. 00   03950   CV RESOURCE CENTER   0. 000000   76. 00   03955   OTHER ANCILLARY SERVICE COST CENTERS   0. 000000   76. 10   03957   OTHER ANCILLARY SERVICE COST CENTERS   0. 000000   76. 10   03959   OTHER ANCILLARY SERVICE COST CENTERS   0. 000000   76. 10   03959   OTHER ANCILLARY SERVICE COST CENTERS   0. 000000   76. 10   03959   OTHER ANCILLARY SERVICE COST CENTERS   0. 000000   76. 10   03959   OTHER ANCILLARY SERVICE COST CENTERS   0. 000000   0700   0700   ALLOGENEIC STEM CELL ACQUISTION   0. 000000   0700   0700   CART T-CELL IMMUNOTHERAPY   0. 000000   07000   0700   CART T-CELL IMMUNOTHERAPY   0. 000000   07000   OSERVATION BEDS (NON-DISTINCT PART   0. 473742   0. 000000   09200   OBSERVATION BEDS (NON-DISTINCT PART   0. 473742   0. 000000   07000   OBSERVATION BEDS (NON-DISTINCT PART   0. 473742   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 00000000					
3. 00   07300   DRUGS CHARGED TO PATIENTS   0. 276036   73. 00   03630   ULTRA SOUND   0. 100251   76. 00   03630   ULTRA SOUND   0. 100251   76. 00   03951   PAIN CLINIC   0. 229305   76. 00   03952   CATH LAB   0. 112006   76. 00   03952   CATH LAB   0. 112006   76. 00   03954   WOUND CARE CENTER   0. 359129   76. 00   03950   HEALTHY LIVING CENTER   0. 000000   76. 00   03950   CV RESOURCE CENTER   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 00000000					
6. 00   03630   LITRA SOUND   0. 100251   76. 00   6. 01   03951   PAIN CLINIC   0. 229305   76. 00   6. 02   03952   CATH LAB   0. 112006   76. 00   6. 03   03953   ACTIVITY THERAPEUTIC   1. 002728   76. 00   6. 04   03954   WOUND CARE CENTER   0. 359129   76. 00   6. 05   03340   BARIATRIC CLINIC   1. 433676   76. 00   6. 06   03030   HEALTHY LIVING CENTER   0. 000000   76. 00   6. 07   03950   CV RESOURCE CENTER   0. 000000   76. 00   6. 08   03955   OTHER ANCILLARY SERVICE COST CENTERS   0. 000000   76. 00   6. 09   03956   LACTATION CLINIC   0. 000000   76. 00   6. 10   03957   OTHER ANCILLARY SERVICE COST CENTERS   0. 000000   76. 10   6. 11   03958   OTHER ANCILLARY SERVICE COST CENTERS   0. 000000   76. 10   6. 12   03959   ANTICOAGULATION CLINIC   0. 698569   76. 12   6. 12   07700   ALLOGENEIC STEM CELL ACQUISITION   0. 000000   77. 00   6. 10   07700   ALLOGENEIC STEM CELL ACQUISITION   0. 000000   77. 00   6. 10   07900   OBSERVATION BEDS (NON-DISTINCT PART   0. 473742   92. 00   6. 10   07100   MORE HEALTH AGENCY   0. 168353   91. 00   6. 10   0700   ODO   00000   00000   00000   00000   00000   00000   00000   00000   00000   00000   00000   00000   00000   00000   000000		1			
6. 01 03951 PAIN CLINIC 0. 229305 76. 01 03952 CATH LAB 0. 112006 76. 02 03952 CATH LAB 0. 112006 76. 03 03952 CATH LAB 0. 112006 76. 03 03953 ACTIVITY THERAPEUTIC 1. 02728 76. 04 03954 WOUND CARE CENTER 0. 359129 76. 04 03954 WOUND CARE CENTER 0. 359129 76. 04 03954 WOUND CARE CENTER 0. 000000 76. 06 06 06 03030 HEALTHY LIVING CENTER 0. 000000 76. 06 08 03955 OTHER ANCILLARY SERVICE COST CENTERS 0. 000000 76. 06 08 03955 OTHER ANCILLARY SERVICE COST CENTERS 0. 000000 76. 06 09 03956 LACTATION CLINIC 0. 000000 76. 06 0. 03957 OTHER ANCILLARY SERVICE COST CENTERS 0. 000000 76. 06 0. 03957 OTHER ANCILLARY SERVICE COST CENTERS 0. 000000 76. 06 0. 03957 OTHER ANCILLARY SERVICE COST CENTERS 0. 000000 76. 06 0. 03957 OTHER ANCILLARY SERVICE COST CENTERS 0. 000000 76. 05 0. 000000 76. 05 0. 000000 76. 05 0. 000000 76. 05 0. 000000 76. 05 0. 000000 76. 05 0. 000000 76. 05 0. 000000 76. 05 0. 000000 76. 05 0. 000000 76. 05 0. 000000 76. 05 0. 000000 76. 05 0. 000000 76. 05 0. 000000 76. 05 0. 000000 76. 05 0. 0000000 76. 05 0. 000000 76. 00 0000000 76. 00 000000 76. 00 000000 76. 00 000000 76. 00 000000 76. 00 0000000 76. 00 000000 76. 00 0000000 76. 00 0000000 76. 00 0000000 76. 00 0000000 76. 00 00000000 76. 00 00000000 76. 00 000000000 76. 00 00000000 76. 00 0000000000		0. 276036			73.00
6. 02   03952   CATH LAB	76. 00   03630   ULTRA SOUND	0. 100251			76. 00
6. 03   03953   ACTIVITY THERAPEUTIC	76. 01   03951   PAIN CLINIC	0. 229305			76. 01
6. 04   03954   WOUND CARE CENTER   0. 359129   76. 04   6. 05   03340   BARI ATRIC CLINIC   1. 433676   76. 06   6. 06   03030   HEALTHY LIVING CENTER   0. 000000   76. 06   6. 07   03950   CV RESOURCE CENTER   0. 000000   76. 06   6. 09   03955   OTHER ANCILLARY SERVICE COST CENTERS   0. 000000   76. 06   6. 09   03955   OTHER ANCILLARY SERVICE COST CENTERS   0. 000000   76. 06   6. 10   03957   OTHER ANCILLARY SERVICE COST CENTERS   0. 000000   76. 10   76. 11   03958   OTHER ANCILLARY SERVICE COST CENTERS   0. 000000   76. 11   03958   OTHER ANCILLARY SERVICE COST CENTERS   0. 000000   76. 11   03958   OTHER ANCILLARY SERVICE COST CENTERS   0. 000000   76. 11   03958   OTHER ANCILLARY SERVICE COST CENTERS   0. 000000   76. 11   03958   OTHER ANCILLARY SERVICE COST CENTERS   0. 000000   76. 11   03958   OTHER ANCILLARY SERVICE COST CENTERS   0. 000000   76. 12   03959   ANTICOAGULATION CLINIC   0. 698569   76. 12   03959   ANTICOAGULATION CLINIC   0. 698569   76. 12   03959   OTHER ANCILLARY SERVICE COST CENTERS   0. 000000   07000   CAR T-CELL IMMUNOTHERAPY   0. 0000000   07000   OTROO   CAR T-CELL IMMUNOTHERAPY   0. 0000000   07000   OTROO   CAR T-CELL IMMUNOTHERAPY   0. 0000000   07000   OTROO	76. 02 03952 CATH LAB	0. 112006			76. 02
6. 04 03954 WOUND CARE CENTER 0. 359129 76. 04   6. 05 03340 BARIATRIC CLINIC 1. 433676 76. 06   6. 06 03030 HEALTHY LIVING CENTER 0. 0.000000 76. 06   6. 07 03950 CV RESOURCE CENTER 0. 000000 76. 06   6. 08 03955 OTHER ANCILLARY SERVICE COST CENTERS 0. 000000 76. 06   6. 09 03956 LACTATION CLINIC 0. 0.000000 76. 06   6. 10 03957 OTHER ANCILLARY SERVICE COST CENTERS 0. 000000 76. 10   6. 11 03958 OTHER ANCILLARY SERVICE COST CENTERS 0. 000000 76. 10   6. 12 03959 ANTICOAGULATION CLINIC 0. 0698569 76. 12   6. 12 03959 ANTICOAGULATION CLINIC 0. 698569 76. 12   6. 12 03959 ANTICOAGULATION CLINIC 0. 0.00000 77. 00   6. 10 07700 ALLOGENEIC STEM CELL ACQUISITION 0. 000000 77. 00   00 07700 ALLOGENEIC STEM CELL ACQUISITION 0. 000000 77. 00   00 07800 CAR T-CELL IMMUNOTHERAPY 0. 0.000000 77. 00   00 07800 CAR T-CELL IMMUNOTHERAPY 0. 0.000000 77. 00   00 07800 CAR T-CELL IMMUNOTHERAPY 0. 0.000000 77. 00   00 07800 CAR T-CELL IMMUNOTHERAPY 0. 0. 473742 78. 00   00 09100 EMERGENCY 0. 168353 91. 00   00 09100 EMERGENCY 0. 168353 91. 00   00 09100 DOUTPATIENT SERVICE COST CENTERS 0. 0. 473742 92. 00   00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0. 473742 92. 00   00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0. 473742 92. 00   00 00 00 00 00 00 00 00 00 00 00 0	76. 03 03953 ACTIVITY THERAPEUTIC	1. 002728			76. 03
6. 05		1			76. 04
6. 06		1			
6. 07		1			
16. 08					
1.00   03956   LACTATI ON CLINI C   0.000000   76.000   76.100   76.000   76.100					
6. 10   03957   OTHER ANCILLARY SERVICE COST CENTERS   0. 000000   76. 10   03958   OTHER ANCILLARY SERVICE COST CENTERS   0. 000000   76. 11   03958   OTHER ANCILLARY SERVICE COST CENTERS   0. 000000   76. 12   03959   ANTICOAGULATION CLINIC   0. 698569   76. 12   07700   ALLOGENEIC STEM CELL ACQUISITION   0. 000000   77. 00   07800   CAR T-CELL IMMUNOTHERAPY   0. 000000   00TPATIENT SERVICE COST CENTERS   0. 000000   00TPATIENT SERVICE COST CENTERS   0. 000000   00TPATIENT SERVICE COST CENTERS   0. 0473742   92. 00   09200   0BSERVATION BEDS (NON-DISTINCT PART   0. 473742   92. 00   00000   01000   HOME HEALTH AGENCY   0. 473742   92. 00   00000   01000   DITEATMENT PROGRAM   102. 00   00000   01000   DITEATMENT PROGRAM   102. 00   000000   01000   DITEATMENT PROGRAM   102. 00   000000   01000   DITEATMENT PROGRAM   102. 00   000000   01000   DITEATMENT PROGRAM   102. 00   0000000   01000   DITEATMENT PROGRAM   102. 00   0000000   01000   DITEATMENT PROGRAM   102. 00   0000000   000000000000000000000					
6. 11   03958   OTHER ANCILLARY SERVICE COST CENTERS   0. 000000   76. 12   03959   ANTICOAGULATION CLINIC   0. 698569   76. 12   07700   ALLOGENEIC STEM CELL ACQUISITION   0. 000000   77. 00   07800   CAR T-CELL IMMUNOTHERAPY   0. 000000   00TPATIENT SERVICE COST CENTERS   0. 000000   09100   EMERGENCY   0. 168353   91. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART   0. 473742   92. 00   09200   OPIOLE REIMBURSABLE COST CENTERS   0. 000000   01000   HOME HEALTH AGENCY   0. 473742   92. 00   0200   OPIOLE TREATMENT PROGRAM   102. 00   0200   OPIOLE TREATMENT PROGRAM   5PECIAL PURPOSE COST CENTERS   113. 00   01300   INTEREST EXPENSE   13. 00   1000   Subtotal (see instructions)   Less Observation Beds   200. 00   000. 00   Less Observation Beds   201. 00   000.		1			
6. 12   03959   ANTI COAGULATI ON CLINI C   0. 698569   76. 12   77. 00   77.00   77					
77.00					
8. 00					
OUTPATIENT SERVICE COST CENTERS   O. 168353   91. 00					
1. 00		0. 000000			78. 00
2. 00   09200   0BSERVATI ON BEDS (NON-DISTINCT PART   0. 473742   92. 00   00   00   00   00   00   00   00					
OTHER REIMBURSABLE COST CENTERS   101.00   10100   HOME HEALTH AGENCY   102.00   10200   OPI OI D TREATMENT PROGRAM   102.00   SPECIAL PURPOSE COST CENTERS   113.00   11300   INTEREST EXPENSE   113.00   Subtotal (see instructions)   200.00   01.00   Less Observation Beds   201.00	91. 00 09100 EMERGENCY	0. 168353			91.00
OTHER REIMBURSABLE COST CENTERS	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 473742			92.00
01. 00		<u>'</u>			
02. 00   10200   OPI 0I D TREATMENT PROGRAM   102. 00   SPECI AL PURPOSE COST CENTERS   113. 00   11300   I NTEREST EXPENSE   500. 00   Subtotal (see instructions)   200. 00   01. 00   Less Observation Beds   201. 00					101.00
SPECIAL PURPOSE COST CENTERS     113.00   11300   I NTEREST EXPENSE     113.00   00.00     Subtotal (see i nstructions)   200.00   01.00   Less Observation Beds   201.00					
13. 00     11300     I NTEREST EXPENSE     113. 00       00. 00     Subtotal (see instructions)     200. 00       01. 00     Less Observation Beds     201. 00		1			102.00
Subtotal (see instructions)   200.00     Less Observation Beds   201.00					112 00
Column     Less Observation Beds					
102. 00					
	202. 00   Total (See HISTI UCTIONS)				J202. 00

			Į.	0 12/31/2023	5/30/2024 3: 4	
		Ti tl	e XIX	Hospi tal	Cost	<u>o p</u>
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst. B,	Adj .		Di sal I owance		
	Part I, col.					
	26)					
	1.00	2. 00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	43, 425, 611		43, 425, 611	0	43, 425, 611	30.00
31. 00 03100 I NTENSI VE CARE UNI T	6, 001, 644		6, 001, 644	ol	6, 001, 644	
32. 00 03200 CORONARY CARE UNIT	0		0	أم	0	32. 00
33. 00 03300 BURN INTENSIVE CARE UNIT	0		0	٥	0	33. 00
35. 00 02060 NEONATAL INTENSIVE CARE UNIT	1, 221, 017		1, 221, 017	ام	1, 221, 017	35. 00
41. 00   04100   SUBPROVI DER -   I RF	4, 555, 491		4, 555, 491	Ö	4, 555, 491	41. 00
42. 00   04200   SUBPROVI DER	4, 333, 471		4, 333, 471	o	4, 333, 471	42. 00
43. 00   04300   NURSERY	1, 784, 715		1, 784, 715		1, 784, 715	
ANCI LLARY SERVI CE COST CENTERS	1, 704, 713		1, 704, 713	<u> </u>	1, 704, 713	43.00
50. 00 05000 OPERATING ROOM	7, 825, 060		7, 825, 060	ol	7, 825, 060	50.00
50. 00   05000   0FERATING ROOM 50. 01   05001   0UTPATI ENT SURGERY	2, 775, 307		2, 775, 307	o		50. 00
				0	2, 775, 307	1
51. 00   05100   RECOVERY ROOM	1, 379, 593		1, 379, 593	ĭ	1, 379, 593	
53. 00   05300   ANESTHESI OLOGY	95, 192		95, 192	0	95, 192	53.00
54. 00   05400   RADI OLOGY - DI AGNOSTI C	7, 658, 847		7, 658, 847	U	7, 658, 847	54.00
54. 01   05401   RADI OLOGY-SPECI AL PROCEDURES	2, 710, 330		2, 710, 330	0	2, 710, 330	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0		0	0	0	55. 00
56. 00   05600   RADI 01 SOTOPE	1, 137, 644		1, 137, 644	0	1, 137, 644	56. 00
60. 00   06000   LABORATORY	10, 578, 146		10, 578, 146	0	10, 578, 146	
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	729, 259		729, 259	0	729, 259	
65. 00  06500   RESPI RATORY THERAPY	4, 075, 246			0	4, 075, 246	1
66. 00   06600   PHYSI CAL THERAPY	6, 555, 636	0	6, 555, 636	0	6, 555, 636	66. 00
67. 00   06700   OCCUPATI ONAL THERAPY	1, 031, 851	0	1, 031, 851	0	1, 031, 851	67. 00
68.00 06800 SPEECH PATHOLOGY	1, 263, 002	0	1, 263, 002	0	1, 263, 002	68. 00
69. 00   06900   ELECTROCARDI OLOGY	2, 197, 231		2, 197, 231	0	2, 197, 231	69. 00
70. 00   07000   ELECTROENCEPHALOGRAPHY	826, 873		826, 873	0	826, 873	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	17, 354, 709		17, 354, 709	0	17, 354, 709	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	4, 611, 518		4, 611, 518	0	4, 611, 518	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	10, 947, 739		10, 947, 739	0	10, 947, 739	73. 00
76.00   03630   ULTRA SOUND	1, 368, 423		1, 368, 423	0	1, 368, 423	76. 00
76. 01   03951   PAIN CLINIC	2, 235, 980		2, 235, 980	0	2, 235, 980	76. 01
76. 02   03952   CATH LAB	5, 505, 746		5, 505, 746	o	5, 505, 746	76. 02
76. 03 03953 ACTIVITY THERAPEUTIC	3, 126, 589		3, 126, 589	o	3, 126, 589	76. 03
76. 04 03954 WOUND CARE CENTER	1, 559, 403		1, 559, 403	o	1, 559, 403	76. 04
76. 05   03340   BARI ATRI C   CLI NI C	1, 189, 194		1, 189, 194	o	1, 189, 194	76. 05
76.06 03030 HEALTHY LIVING CENTER	0		0	o	0	76. 06
76. 07 03950 CV RESOURCE CENTER	0		l o	ol	0	76. 07
76.08 03955 OTHER ANCILLARY SERVICE COST CENTERS	0		0	ol	0	76. 08
76. 09 03956 LACTATION CLINIC	0		Ö	ol	0	76. 09
76. 10 03957 OTHER ANCILLARY SERVICE COST CENTERS	0		0	أم	0	76. 10
76. 11 03958 OTHER ANCILLARY SERVICE COST CENTERS	0		0	0	0	76. 11
76. 12 03959 ANTI COAGULATI ON CLINI C	1, 019, 812		1, 019, 812	Ö	1, 019, 812	1
77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION	0		0	l ő	0	1
78. 00 07800 CAR T-CELL IMMUNOTHERAPY	0				0	
OUTPATIENT SERVICE COST CENTERS				<u> </u>		70.00
91. 00 O9100 EMERGENCY	10, 570, 338		10, 570, 338	ol	10 E70 220	91. 00
					10, 570, 338	1
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS	4, 407, 652		4, 407, 652		4, 407, 652	92.00
101.00 10100 HOME HEALTH AGENCY	12 270 200		12 270 200		12 270 200	101 00
	13, 370, 290		13, 370, 290		13, 370, 290	
102. 00 10200 OPI OI D TREATMENT PROGRAM	0		0		0	102. 00
SPECIAL PURPOSE COST CENTERS		I				440.00
113. 00 11300   INTEREST EXPENSE	405		405		405	113. 00
200.00 Subtotal (see instructions)	185, 095, 088				185, 095, 088	
201.00 Less Observation Beds	4, 407, 652		4, 407, 652		4, 407, 652	
202.00 Total (see instructions)	180, 687, 436	0	180, 687, 436	0	180, 687, 436	J202. 00

Provider CCN: 15-0090 Title XIX

			Ti tl	e XIX	Hospi tal	Cost	
			Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
				+ col. 7)	Ratio	Inpati ent	
						Ratio	
		6.00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	63, 468, 258		63, 468, 258			30. 00
31.00	03100 INTENSIVE CARE UNIT	10, 388, 787		10, 388, 787			31.00
32.00	03200 CORONARY CARE UNIT	0		0			32. 00
33.00	03300 BURN INTENSIVE CARE UNIT	0		0			33. 00
35.00	02060 NEONATAL INTENSIVE CARE UNIT	1, 848, 900		1, 848, 900			35. 00
41.00	04100 SUBPROVI DER - I RF	7, 542, 016		7, 542, 016			41. 00
42.00	04200 SUBPROVI DER	0		0			42.00
43.00	04300 NURSERY	1, 100, 406		1, 100, 406			43. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	34, 061, 809	48, 590, 395		0. 094675	0. 094675	50. 00
50. 01	05001 OUTPATIENT SURGERY	1, 815, 179	1, 978, 349	3, 793, 528	0. 731590	0. 731590	50. 01
51.00	05100 RECOVERY ROOM	3, 358, 747	12, 792, 910	16, 151, 657	0. 085415	0. 085415	51.00
53.00	05300 ANESTHESI OLOGY	6, 993, 558	11, 454, 241	18, 447, 799	0. 005160	0. 005160	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	27, 304, 592	60, 982, 883	88, 287, 475	0. 086749	0. 086749	54.00
54. 01	05401 RADI OLOGY-SPECI AL PROCEDURES	5, 148, 269	7, 583, 984	12, 732, 253	0. 212871	0. 212871	54. 01
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	0	0.000000	0.000000	55. 00
56.00	05600 RADI OI SOTOPE	1, 462, 800	9, 216, 871	10, 679, 671	0. 106524	0. 106524	56.00
60.00	06000 LABORATORY	37, 511, 168	38, 805, 743	76, 316, 911	0. 138608	0. 138608	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	1, 235, 537	332, 171	1, 567, 708	0. 465175	0. 465175	63.00
65.00	06500 RESPI RATORY THERAPY	12, 931, 033	766, 767	13, 697, 800	0. 297511	0. 297511	65. 00
66.00	06600 PHYSI CAL THERAPY	6, 453, 385	19, 605, 725	26, 059, 110	0. 251568	0. 251568	66. 00
67.00	06700 OCCUPATIONAL THERAPY	5, 569, 626	5, 588, 791	11, 158, 417	0. 092473	0. 092473	67.00
68.00	06800 SPEECH PATHOLOGY	2, 989, 638	5, 818, 275	8, 807, 913	0. 143394	0. 143394	68. 00
69.00	06900 ELECTROCARDI OLOGY	9, 470, 998	17, 347, 705	26, 818, 703	0. 081929	0. 081929	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	560, 292	5, 009, 797	5, 570, 089	0. 148449	0. 148449	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	25, 040, 400	27, 929, 391	52, 969, 791	0. 327634	0. 327634	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	7, 441, 880	10, 620, 805	18, 062, 685	0. 255306	0. 255306	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	27, 478, 045	12, 182, 552	39, 660, 597	0. 276036	0. 276036	73. 00
76.00	03630 ULTRA SOUND	4, 090, 978	9, 558, 958	13, 649, 936	0. 100251	0. 100251	76. 00
76. 01	03951 PAIN CLINIC	102, 132	9, 648, 992			0. 229305	76. 01
76. 02	03952 CATH LAB	16, 387, 210	32, 768, 509	49, 155, 719	0. 112006	0. 112006	76. 02
76. 03	03953 ACTIVITY THERAPEUTIC	2, 992, 605	125, 478			1. 002728	76. 03
76. 04	03954 WOUND CARE CENTER	147, 826	4, 194, 349			0. 359129	
76. 05	03340 BARI ATRI C CLI NI C	1, 907	827, 565	829, 472	1. 433676	1. 433676	76. 05
76.06	03030 HEALTHY LIVING CENTER	o	0		0. 000000	0.000000	76. 06
76. 07	03950 CV RESOURCE CENTER	o	0	0	0. 000000	0.000000	76. 07
76. 08	03955 OTHER ANCILLARY SERVICE COST CENTERS	o	0	0	0. 000000	0.000000	76. 08
76. 09	03956 LACTATION CLINIC	o	0	0	0. 000000	0.000000	76. 09
76. 10	03957 OTHER ANCILLARY SERVICE COST CENTERS	o	0	0	0. 000000	0.000000	76. 10
76. 11	03958 OTHER ANCILLARY SERVICE COST CENTERS	o	0	0	0.000000	0.000000	76. 11
76. 12	03959 ANTI COAGULATI ON CLINIC	8, 705	1, 451, 154	1, 459, 859		0. 698569	76. 12
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION	o	0	1	0. 000000	0.000000	77. 00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	o	0	0		0. 000000	
	OUTPATIENT SERVICE COST CENTERS	,		•	'		
91.00	09100 EMERGENCY	16, 944, 805	45, 841, 922	62, 786, 727	0. 168353	0. 168353	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	3, 095, 815	6, 208, 100	9, 303, 915	0. 473742	0. 473742	92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	0	10, 339, 036	10, 339, 036			101. 00
102.00	10200 OPIOID TREATMENT PROGRAM	o	0				102.00
	SPECIAL PURPOSE COST CENTERS	-1					
113.00	11300   NTEREST EXPENSE						113. 00
200.00	1 1	344, 947, 306	417, 571, 418	762, 518, 724			200. 00
201.00	` '	,					201. 00
202.00		344, 947, 306	417, 571, 418	762, 518, 724			202. 00
			, , , , , , , ,		1		

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

COMPUTATION OF RATIO OF COSTS TO CHARGES
Provider CCN: 15-0090
From 01/01/2023
To 12/31/2023 Date/Time Prepared:

5/30/2024 3:45 pm Title XIX Hospi tal Cost PPS Inpatient Cost Center Description 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 35. 00 02060 NEONATAL INTENSIVE CARE UNIT 35.00 41.00 04100 SUBPROVI DER - I RF 41.00 04200 SUBPROVI DER 42.00 42.00 43.00 04300 NURSERY 43.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 0.000000 50 00 50.01 05001 OUTPATIENT SURGERY 0.000000 50.01 51.00 05100 RECOVERY ROOM 0.000000 51.00 05300 ANESTHESI OLOGY 0.000000 53.00 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 54.00 54.01 05401 RADI OLOGY-SPECI AL PROCEDURES 0.000000 54.01 05500 RADI OLOGY-THERAPEUTI C 0.000000 55.00 55.00 05600 RADI OI SOTOPE 0.000000 56, 00 56, 00 06000 LABORATORY 0.000000 60.00 60 00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0.000000 63.00 06500 RESPIRATORY THERAPY 65.00 0.000000 65.00 06600 PHYSI CAL THERAPY 66.00 0.000000 66.00 06700 OCCUPATI ONAL THERAPY 67.00 0.000000 67.00 68.00 68.00 06800 SPEECH PATHOLOGY 0.000000 06900 ELECTROCARDI OLOGY 69.00 0.000000 69.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 70.00 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.000000 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 0.000000 73.00 03630 ULTRA SOUND 0.000000 76.00 76.00 76.01 03951 PAIN CLINIC 0.000000 76.01 03952 CATH LAB 0.000000 76. 02 76.02 76 03 03953 ACTIVITY THERAPEUTIC 0.000000 76 03 03954 WOUND CARE CENTER 0.000000 76.04 76.04 76. 05 03340 BARIATRIC CLINIC 0.000000 76.05 76.06 03030 HEALTHY LIVING CENTER 0.000000 76.06 76.07 03950 CV RESOURCE CENTER 0.000000 76.07 0.000000 76.08 03955 OTHER ANCILLARY SERVICE COST CENTERS 76.08 76.09 03956 LACTATION CLINIC 0.000000 76.09 03957 OTHER ANCILLARY SERVICE COST CENTERS 03958 OTHER ANCILLARY SERVICE COST CENTERS 76 10 0.000000 76 10 76. 11 0.000000 76.11 03959 ANTI COAGULATION CLINIC 0.000000 76. 12 76. 12 77.00 07700 ALLOGENEIC STEM CELL ACQUISITION 0.000000 77.00 07800 CAR T-CELL IMMUNOTHERAPY 0.000000 78.00 78 00 OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 0.000000 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.000000 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 101.00 102.00 10200 OPI OID TREATMENT PROGRAM 102.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113 00 200.00 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 201. 00 Total (see instructions) 202.00 202.00

Health Financial Systems	FRANCISCAN HE	EALTH- DYER		In Li∈	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL		Provi der CO		Period: From 01/01/2023 To 12/31/2023	Worksheet D Part I Date/Time Pre 5/30/2024 3:4	pared:
		Title	: XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal Related Cost	Swing Bed Adjustment	Reduced Capi tal	Total Patient Days	Per Diem (col. 3 / col. 4)	
	(from Wkst. B,		Related Cost		,	
	Part II, col.		(col . 1 - col			
	26)		2)			
	1. 00	2. 00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDI ATRI CS	2, 671, 724	0	2, 671, 72	4 27, 557	96. 95	30. 00
31.00 INTENSIVE CARE UNIT	380, 387		380, 38	7 2, 392	159. 02	31.00
32. 00 CORONARY CARE UNIT	0			0	0.00	32. 00
33.00 BURN INTENSIVE CARE UNIT	0			0 0	0.00	33. 00
35.00 NEONATAL INTENSIVE CARE UNIT	34, 668		34, 66	8 350	99. 05	35. 00
41. 00 SUBPROVI DER - I RF	213, 206	0	213, 20	6 3, 964	53. 79	41.00
42. 00 SUBPROVI DER	0	0		0 0	0.00	42. 00
43. 00 NURSERY	10, 847		10, 84	7 704	15. 41	43.00
200.00 Total (lines 30 through 199)	3, 310, 832		3, 310, 83	2 34, 967		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						1
30. 00 ADULTS & PEDI ATRI CS	7, 090		•			30. 00
31.00   INTENSIVE CARE UNIT	837	133, 100				31. 00
32. 00 CORONARY CARE UNIT	0	0				32. 00
33.00 BURN INTENSIVE CARE UNIT	0	0				33. 00
35. 00 NEONATAL INTENSIVE CARE UNIT	0	0				35. 00
41. 00 SUBPROVI DER – I RF	2, 694	144, 910				41. 00
42. 00 SUBPROVI DER	0	0				42. 00
43. 00 NURSERY	0	0				43.00
200.00 Total (lines 30 through 199)	10, 621	965, 386	1			200. 00

				From 01/01/2023 To 12/31/2023	Part II Date/Time Prepared 5/30/2024 3:45 pm	
		Title	xVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cost	Inpatient	Capital Costs	
·	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(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   OPERATING ROOM	1, 488, 413	82, 652, 204	0. 01800	8 7, 929, 978	142, 803	50.00
50. 01  05001 OUTPATI ENT SURGERY	387, 916	3, 793, 528	0. 10225	781, 145	79, 878	50. 01
51.00   05100   RECOVERY ROOM	190, 545	16, 151, 657	0. 01179	769, 528	9, 078	51.00
53. 00 05300 ANESTHESI OLOGY	4, 536	18, 447, 799	0.00024	6 1, 735, 368	427	53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	1, 746, 011	88, 287, 475	0. 01977	6 10, 919, 638	215, 947	54.00
54. 01   05401 RADI OLOGY-SPECI AL PROCEDURES	153, 270	12, 732, 253	0. 01203	8 1, 551, 649	18, 679	54. 01
55. 00   05500 RADI OLOGY-THERAPEUTI C	0	0	0.00000	0	0	55. 00
56. 00   05600   RADI 0I SOTOPE	221, 609	10, 679, 671	0. 02075	1 589, 328	12, 229	56.00
60. 00   06000   LABORATORY	231, 012	76, 316, 911	0.00302	7 12, 417, 029	37, 586	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	72, 108	1, 567, 708	0.04599	6 421, 014	19, 365	63.00
65. 00 06500 RESPIRATORY THERAPY	182, 615				66, 683	65. 00
66. 00 06600 PHYSI CAL THERAPY	131, 462	26, 059, 110	0.00504	5 1, 601, 775	8, 081	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	22, 785				2, 684	67. 00
68.00 06800 SPEECH PATHOLOGY	82, 417	l			6, 420	68. 00
69. 00 06900 ELECTROCARDI OLOGY	311, 116			· ·		69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	136, 417					70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	108, 143		0. 00204		17, 461	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	29, 354	18, 062, 685	•		3, 673	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	169, 941	39, 660, 597			35, 667	73. 00
76. 00   03630   ULTRA SOUND	165, 937				18, 641	76. 00
76. 01   03951   PAIN CLINIC	329, 781	9, 751, 124			769	76. 01
76. 02   03952   CATH   LAB	633, 959		•		83, 661	76. 02
76. 03 03953 ACTIVITY THERAPEUTIC	161, 666		•		10, 122	76. 03
76. 04   03954   WOUND CARE CENTER	171, 114	4, 342, 175	•	· ·		76. 04
76. 05   03340   BARI ATRI C   CLI NI C	59, 771	829, 472	•		47	76. 05
76. 06 03030 HEALTHY LIVING CENTER	0,,,,,	027, 172			0	76. 06
76. 07   03950   CV   RESOURCE   CENTER	0	0	1		0	76. 07
76. 08 03955 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0. 00000		0	76. 08
76. 09   03956   LACTATION CLINIC	0	0	0. 00000		0	76. 09
76. 10 03957 OTHER ANCILLARY SERVICE COST CENTERS	0	١	0. 00000		0	76. 10
76. 11 03958 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0. 00000		0	76. 11
76. 12 03959 ANTI COAGULATI ON CLINIC	18, 909	1, 459, 859			_	76. 12
77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION	0				0	77. 00
78. 00 07800 CAR T-CELL IMMUNOTHERAPY	0	0			0	78. 00
OUTPATIENT SERVICE COST CENTERS			0.00000	0		70.00
91. 00 09100 EMERGENCY	568, 234	62, 786, 727	0. 00905	0 6, 337, 608	57, 355	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	271, 176					
200.00 Total (lines 50 through 199)	8, 050, 217			85, 164, 889		
200.00   10tal (11100 00 thi ough 177)	0,000,217	1 307, 001, 021	I	00, 101, 007	, , , , , , , , ,	1-50. 55

Health Financial Systems	FRANCISCAN HE	EALTH- DYER		In Li€	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COST	TS Provider C		Period: From 01/01/2023 To 12/31/2023		
		Titl∈	XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng	Nursi ng	Allied Healt	Allied Health	All Other	
	Program	Program	Post-Stepdow	n 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 & PEDI ATRI CS	0	0		0 0	0	30.00
31. 00   03100   NTENSI VE CARE UNIT	0	l o		0	o o	
32. 00   03200   CORONARY CARE UNIT	i o	Ö	1		o o	
33. 00 03300 BURN INTENSIVE CARE UNIT	0					1
35. 00 02060 NEONATAL INTENSIVE CARE UNIT						
41. 00   04100   SUBPROVI DER -	0	0	(			41.00
	0	U	<u>'</u>			
42. 00   04200   SUBPROVI DER	0	0	)	0	0	1
43. 00   04300   NURSERY	0	0	)	0	0	
200.00   Total (lines 30 through 199)	0			0 0		200. 00
Cost Center Description	Swi ng-Bed	Total Costs		t 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)				
	4. 00	5. 00	6. 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0				30.00
31.00  03100 INTENSIVE CARE UNIT		0	2, 39	2 0.00	837	31. 00
32. 00  03200 CORONARY CARE UNIT		0	)	0.00	0	32.00
33.00 03300 BURN INTENSIVE CARE UNIT		0		0.00	0	33. 00
35.00 02060 NEONATAL INTENSIVE CARE UNIT		0	35	0.00	0	35. 00
41. 00   04100   SUBPROVI DER - I RF	0	l	3, 96	4 0.00	2, 694	41.00
42. 00   04200   SUBPROVI DER	0	l		0.00	0	42.00
43. 00 04300 NURSERY		l o	70	4 0.00	0	43.00
200.00 Total (lines 30 through 199)		l o				200.00
Cost Center Description	Inpati ent		0.17.0	*1	10/02	200.00
5552 55.125. B6561 1 Pt 1 611	Program					
	Pass-Through					
	Cost (col. 7 x					
	col. 8)					
	9.00					

30.00

31. 00 32. 00 33. 00

35.00

41.00

42.00

43.00

200.00

30. 00 INPATIENT ROUTINE SERVICE COST CENTERS
30. 00 03000 ADULTS & PEDIATRICS

Total (lines 30 through 199)

31.00 | 03100 | NTENSIVE CARE UNIT 32.00 | 03200 | CORONARY CARE UNIT 33.00 | 03300 | BURN | NTENSIVE CARE UNIT

41. 00 | 04100 | SUBPROVI DER - I RF

42. 00 | 04200 | SUBPROVI DER

43. 00 | 04300 NURSERY

200.00

35. 00 02060 NEONATAL INTENSIVE CARE UNIT

Health Financial Systems	FRANCISCAN HEALTH- DYER	In Lieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS Provider CCN: 15-0090	Peri od: Worksheet D
THROUGH COSTS		From 01/01/2023   Part IV

THROUGH COSTS				To 12/31/2023	Date/Time Pre 5/30/2024 3:4	pared: 5 pm
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
	Anesthetist	Program	Program	Post-Stepdown		
		ost-Stepdown		Adjustments		
		Adjustments				
ANALLI ADV. OFDIN OF COOT OFFITEDO	1.00	2A	2. 00	3A	3. 00	
ANCI LLARY SERVI CE COST CENTERS		_	l	_1		
50. 00 05000 OPERATING ROOM	0	0		0	0	
50. 01   05001   OUTPATI ENT SURGERY	0	0		0	0	
51. 00   05100   RECOVERY ROOM	0	0		0	0	51.00
53. 00   05300   ANESTHESI OLOGY	0	0		0	0	53. 00
54. 00   05400   RADI OLOGY - DI AGNOSTI C	0	0		0	0	54.00
54. 01   05401   RADI OLOGY-SPECI AL PROCEDURES	0	0		0	0	54. 01
55. 00   05500   RADI OLOGY - THERAPEUTI C	0	0		0	0	55. 00
56. 00   05600   RADI 01 SOTOPE	0	0		0	0	56. 00
60. 00   06000   LABORATORY	0	0		0	519, 068	1
63. 00   06300   BLOOD STORING, PROCESSING & TRANS.	0	0		0	0	63. 00
65. 00 06500 RESPI RATORY THERAPY	0	0		0	0	
66. 00   06600   PHYSI CAL THERAPY	0	0		0	0	66. 00
67. 00   06700   OCCUPATI ONAL THERAPY	0	0		0	0	67. 00
68. 00   06800   SPEECH PATHOLOGY	0	0		0	0	68. 00
69. 00   06900   ELECTROCARDI OLOGY	0	0		0	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0	0	70. 00
71. 00   07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	0		0	0	71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		0	386, 668	1
76.00 03630 ULTRA SOUND	0	0		0	0	76. 00
76. 01   03951   PAIN CLINIC	0	0		0	0	
76. 02   03952   CATH LAB	0	0		0	0	76. 02
76. 03   03953   ACTI VI TY   THERAPEUTI C	0	0	1	0	0	76. 03
76. 04   03954   WOUND CARE CENTER	0	0		0	0	76. 04
76. 05   03340   BARI ATRI C   CLI NI C	0	0		0	0	76. 05
76. 06   03030   HEALTHY LIVING CENTER	0	0		0	0	76. 06
76. 07   03950   CV RESOURCE CENTER	0	0		0	0	76. 07
76. 08 03955 OTHER ANCILLARY SERVICE COST CENTERS	0	0		0	0	76. 08
76. 09 03956 LACTATION CLINIC	0	0		0	0	76. 09
76. 10 03957 OTHER ANCILLARY SERVICE COST CENTERS	0	0		0	0	76. 10
76. 11 03958 OTHER ANCILLARY SERVICE COST CENTERS	0	0		0	0	76. 11
76. 12 03959 ANTI COAGULATI ON CLINI C	0	0		0	0	76. 12
77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0		0	0	77. 00
78. 00 O7800 CAR T-CELL IMMUNOTHERAPY	0	0		0 0	0	78. 00
OUTPATIENT SERVICE COST CENTERS					00.000	01 00
91. 00   09100   EMERGENCY	0	0		0 0	70,220	1
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0	0	
200.00   Total (lines 50 through 199)	0	0		0	1, 003, 964	1200. 00

Heal th Financial	Systems		FRAI	NCI SCA	N HEAL	TH- DYER			In Lieu of Form CMS-25!		
APPORTI ONMENT OF THROUGH COSTS	I NPATI ENT/OUTPATI ENT	ANCILLARY S	SERVI CE(	OTHER	PASS	Provi der	CCN:	15-0090		Worksheet D Part IV Date/Time Prepared: 5/30/2024 3:45 pm	

Cost Center Description	THROUGH COSTS				To 12/31/2023	Date/Time Prep 5/30/2024 3:49	
Modical Education Cost   1, 2, 3, and 4   Cost (sum of cols. 2, 3, and 4)   Cost (sum of cols. 2, 3, and 4			Title	XVIII	Hospi tal		
AMCILLARY SERVICE COST CENTERS	Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
Education Cost   1, 2, 3, and   Cost (sum of cols 2, 2, 3)		Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
ANCILLARY SERVICE COST CENTERS		Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.		
ACCILLARY SERVICE COST CENTERS			4)	col s. 2, 3,	8)	7)	
ANCILLARY SERVICE COST CENTERS				and 4)		(see	
ANCILLARY SERVICE COST CENTERS   Service   COST CENTERS   Service   Servic							
SOLICID   CONTRICT		4. 00	5. 00	6. 00	7. 00	8. 00	
50.01   05001   01PATI ENT SURGERY   0   0   0   3,793,528   0,000000   50,01							
51.00   05100   RECOVERY ROOM   0   0   16,151,657   0,000000   51,00   0   053.00   05300   ANESTHESI OLOGY   0   0   0   0   0   18,447,799   0.000000   53.00   54.00   05400   RADI OLOGY-DI AGNOSTI C   0   0   0   0   0   12,732,253   0.000000   54.01   05401   RADI OLOGY-SPECI AL PROCEDURES   0   0   0   0   12,732,253   0.000000   54.01   05500   RADI OLOGY-THERAPEUTI C   0   0   0   0   0   0.000000   55.00   05500   RADI OLOGY-THERAPEUTI C   0   0   0   0   0.000000   55.00   05500   RADI OLOGY-THERAPEUTI C   0   0   0   0   0.000000   55.00   05500   RADI OLOGY-THERAPEUTI C   0   0   0   0   0.000000   55.00   05500   RADI OLOGY-THERAPEUTI C   0   0   0   0   0.000000   55.00   05500   RADI OLOGY-THERAPEUTI C   0   0   0   0   0.000000   55.00   05500   RADI OLOGY-THERAPEUTI C   0   0   0   0   0.000000   55.00   05500   RADI OLOGY-THERAPEUTI C   0   0   0   0   0   0.000000   05.00   05500   RADI OLOGY-THERAPEUTI C   0   0   0   0   0   0.000000   05.00   05500   RADI OLOGY-THERAPEUTI C   0   0   0   0   0   0   0.000000   05.00   05500   05500   RADI OLOGY-THERAPEUTI C   0   0   0   0   0   0   0   0   0			-	·			
S3.00   05300   AMESTHESI OLOGY   0   0   0   0   18, 447, 799   0.000000   53.00		0	0	·			
54.00   05400   RADI OLOGY-DI AGNOSTI C   0   0   0   0   12, 732, 253   0.000000   54.01   54.01   0.00000   0.000000   55.00   0.000000   55.00   0.0000000   0.0000000   0.0000000   0.000000   0.000000   0.000000   0		0	0	(			
54.01         05401 RADI OLOGY-SPECI AL PROCEDURES         0         0         0         12, 732, 253         0.000000         54.01           55.00         05500 RADI OLOGY-THERAPEUTI C         0         0         0         0         0.000000         55.00           66.00         05600 RADI OLOGY-THERAPEUTI C         0         0         0         0         0.000000         56.00           66.00         06500 RADI OLOGY-THERAPEUTI C         0         0         0         10,679,671         0.000000         56.00           63.00         06300 BLOOD STORI NG, PROCESSI NG & TRANS.         0         0         0         1,567,708         0.000000         63.00           65.00         06500 RESPI RATORY THERAPY         0         0         0         13,697,800         0.000000         66.00           66.00         06500 RESPI RATORY THERAPY         0         0         0         11,158,417         0.000000         66.00           66.00         06600 PHYSI CAL THERAPY         0         0         0         11,158,417         0.000000         66.00           68.00         06900 ELECTROCARDI OLOGY         0         0         0         11,158,417         0.000000         66.00           69.00         05900 E		0	0	(			
55. 00   05500   RADI OLOGY-THERAPEUTI C   0   0   0   0   0   0   0   0   0		0	0	(			
56. 00   05600   RADI OI SOTOPE   0   0   0   0   10, 679, 671   0.000000   56. 00   60. 00   06000   LABORATORY   0   0   519, 068   519, 068   76, 316, 911   0.006801   60. 00   63. 00   06500   RESPI RATORY THERAPY   0   0   0   0   13, 697, 800   0.000000   65. 00   66. 00   066000   0660000   0660000   066000   066000   066000   066000   066000   066000   0660		0	0	(	12, 732, 253		
60. 00   06000   LABORATORY   0   519, 068   76, 316, 911   0.006801   60.00   63.00   06300   06300   DLOD STORING, PROCESSING & TRANS.   0   0   0   0   1, 567, 708   0.000000   65.00   06500   RESPIRATORY THERAPY   0   0   0   0   0   13, 697, 800   0.000000   65.00   06500   0   0   0   0   0   0   0   0   0		0	0	(	0		
63. 00   06300   BLOOD STORING, PROCESSING & TRANS.   0   0   0   1,567,708   0.000000   63. 00   65. 00   06500   06500   RESPI RATORY THERAPY   0   0   0   0   26.059,110   0.000000   65. 00   67. 00   06700   0CCUPATI ONAL THERAPY   0   0   0   0   0   26.059,110   0.000000   66. 00   67. 00   06700   0CCUPATI ONAL THERAPY   0   0   0   0   0   11,158,417   0.000000   67. 00   68. 00   06800   SPECH PATHOLOGY   0   0   0   0   26.818,703   0.000000   68. 00   69. 00   06900   ELECTROCARDI OLOGY   0   0   0   0   26.818,703   0.000000   69. 00   70. 00   07000   ELECTROENCEPHALOGRAPHY   0   0   0   0   55.70, 089   0.000000   70. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENT   0   0   0   0   52.969,791   0.000000   71. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0   0   0   0   18.062, 685   0.000000   72. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   0   386, 668   386, 668   386, 668   39, 660, 597   0.009749   73. 00   76. 01   03951   PAIN CLINIC   0   0   0   9, 751, 124   0.000000   76. 00   76. 02   03952   CATH LAB   0   0   0   49, 155, 719   0.000000   76. 00   76. 03   03953   ACTIVITY THERAPEUTIC   0   0   0   49, 155, 719   0.000000   76. 00   76. 04   03954   WOUND CARE CENTER   0   0   0   49, 155, 719   0.000000   76. 00   76. 05   03340   BARI ATRIC CLINIC   0   0   0   49, 155, 719   0.000000   76. 00   76. 06   03955   OTHER ANCILLARY SERVICE COST CENTERS   0   0   0   0   0   0   0   0   76. 10   03955   OTHER ANCILLARY SERVICE COST CENTERS   0   0   0   0   0   0   0   0   0   76. 10   03955   OTHER ANCILLARY SERVICE COST CENTERS   0   0   0   0   0   0   0   0   0		0	0	(	10, 679, 671	0.000000	56. 00
65.00   06500   RESPIRATORY THERAPY   0   0   0   0   13, 697, 800   0.000000   65.00   66.00   06600   06700   000000   000000   000000   000000   000000		0	519, 068	519, 068	76, 316, 911	0. 006801	60.00
66. 00   06600   PHYSI CAL THERAPY   0   0   0   0   26, 059, 110   0   0   000000   66. 00   67. 00   06700   0CCUPATI ONAL THERAPY   0   0   0   0   0   11, 158, 417   0   000000   67. 00   68. 00   06800   SPECCH PATHOLOGY   0   0   0   0   8, 807, 913   0   000000   68. 00   69. 00   06900   ELECTROCARDI OLOGY   0   0   0   0   26, 818, 703   0   000000   69. 00   70. 00   07000   ELECTROENCEPHALOGRAPHY   0   0   0   0   5, 570, 089   0   000000   70. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENT   0   0   0   52, 969, 791   0   000000   71. 00   72. 00   07200   IMPL DEV. CHARGED TO PATI ENTS   0   0   0   18, 062, 685   0   000000   72. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0   386, 668   386, 668   39, 660, 597   0   009749   73. 00   76. 01   03952   CATH LAB   0   0   0   0   9, 751, 124   0   000000   76. 01   76. 02   03952   CATH LAB   0   0   0   0   49, 155, 719   0   0000000   76. 02   76. 03   03953   ACTI VI TY THERAPEUTI C   0   0   0   0   49, 155, 719   0   0000000   76. 02   76. 04   03954   WOUND CARE CENTER   0   0   0   0   4, 342, 175   0   0   0   76. 06   03030   HEALTHY LI VI NG CENTER   0   0   0   0   0   0   0   0   0   76. 07   03955   CV RESOURCE CENTER   0   0   0   0   0   0   0   0   0   76. 08   03955   OTHER ANCI LLARY SERVICE COST CENTERS   0   0   0   0   0   0   0   0   0	63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	(	1, 567, 708	0.000000	63.00
67. 00	65. 00 06500 RESPI RATORY THERAPY	0	0	(	13, 697, 800	0.000000	65. 00
68. 00   06800   SPEECH PATHOLOGY   0   0   0   0   8,807,913   0.000000   68. 00   69. 00   06900   ELECTROCARDI OLOGY   0   0   0   0   0   26,818,703   0.000000   69. 00   0   0   0   0   0   0   0   0   0	66. 00   06600 PHYSI CAL THERAPY	0	0	(	26, 059, 110	0.000000	66.00
69. 00 06900   ELECTROCARDI OLOGY	67. 00 06700 OCCUPATI ONAL THERAPY	0	0	(	11, 158, 417	0.000000	67.00
70. 00         07000         ELECTROENCEPHALOGRAPHY         0         0         0         5, 570, 089         0.000000         70.00           71. 00         07100         MEDI CAL SUPPLI ES CHARGED TO PATI ENTS         0         0         52, 969, 791         0.000000         71.00           72. 00         07200         IMPL. DEV. CHARGED TO PATI ENTS         0         0         18, 062, 685         0.000000         72.00           73. 00         07300         DRUGS CHARGED TO PATI ENTS         0         386, 668         386, 668         39, 660, 597         0.007400         72.00           76. 00         03630         ULTRA SOUND         0         0         0         13, 649, 936         0.000000         76.00           76. 01         03951         PALN CLINIC         0         0         0         9, 751, 124         0.000000         76.01           76. 02         03952         CATH LAB         0         0         0         49, 155, 719         0.000000         76.02           76. 04         03953         ACTI VI TY THERAPEUTI C         0         0         0         3, 118, 083         0.000000         76.02           76. 05         03340         BARI ATRI C CLINI C         0         0         <	68. 00 06800 SPEECH PATHOLOGY	0	0	(	8, 807, 913	0.000000	68. 00
71. 00	69. 00 06900 ELECTROCARDI OLOGY	0	0	(	26, 818, 703	0.000000	69. 00
72. 00         07200   IMPL. DEV. CHARGED TO PATIENTS         0         0         0         18, 062, 685   0.000000   72. 00           73. 00         07300   DRUGS CHARGED TO PATIENTS         0         386, 668   386, 668   39, 660, 597   0.009749   73. 00         76. 00   03630   ULTRA SOUND   0         0         0         0         13, 649, 936   0.000000   76. 00         76. 00   76. 00   0         0         0         0         0         76. 00   0.000000   76. 00         76. 01   0.000000   76. 01         0         0         0         9, 751, 124   0.000000   76. 01         0         0         0         9, 751, 124   0.000000   76. 01         0         0         0         9, 751, 124   0.000000   76. 01         0         0         0         9, 751, 124   0.000000   76. 01         0         0         0         9, 751, 124   0.000000   76. 01         0         0         0         9, 751, 124   0.000000   76. 01         0	70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	(	5, 570, 089	0.000000	70.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 386, 668 39, 660, 597 0.009749 73. 00 76. 00 03630 ULTRA SOUND 0 0 0 13, 649, 936 0.000000 76. 00 76. 01 03951 PAIN CLINIC 0 0 0 9, 751, 124 0.000000 76. 01 76. 02 03952 CATH LAB 0 0 0 49, 155, 719 0.000000 76. 02 76. 03 03953 ACTIVITY THERAPEUTIC 0 0 0 3, 118, 083 0.000000 76. 02 76. 04 03954 WOUND CARE CENTER 0 0 0 4, 342, 175 0.000000 76. 04 76. 05 03340 BARIATRIC CLINIC 0 0 0 4, 342, 175 0.000000 76. 05 76. 06 03030 HEALTHY LIVING CENTER 0 0 0 0 829, 472 0.000000 76. 05 76. 08 03955 OTHER ANCILLARY SERVICE COST CENTERS 0 0 0 0 0 0 0 0.000000 76. 08 76. 09 03956 LACTATION CLINIC 0 0 0 0 0 0 0 0.000000 76. 08 76. 11 03958 OTHER ANCILLARY SERVICE COST CENTERS 0 0 0 0 0 0 0.000000 76. 11 76. 12 03959 ANTICOAGULATION CLINIC 0 0 0 1, 459, 859 0.000000 76. 12 77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION 0 0 0 0 0.000000 77. 00	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	(	52, 969, 791	0.000000	71. 00
76. 00         03630 ULTRA SOUND         0         0         0         13, 649, 936         0.000000         76. 00           76. 01         03951 PAIN CLINIC         0         0         0         9, 751, 124         0.000000         76. 01           76. 02         03952 CATH LAB         0         0         0         49, 155, 719         0.000000         76. 02           76. 03         03953 ACTIVITY THERAPEUTIC         0         0         0         3, 118, 083         0.000000         76. 03           76. 04         03954 WOUND CARE CENTER         0         0         0         4, 342, 175         0.000000         76. 03           76. 05         03340 BARI ATRI C CLINI C         0         0         0         829, 472         0.000000         76. 04           76. 06         03030 HEALTHY LIVING CENTER         0         0         0         0         0.000000         76. 06           76. 07         03950 OTHER ANCI LLARY SERVICE COST CENTERS         0         0         0         0         0.000000         76. 08           76. 10         03955 OTHER ANCI LLARY SERVICE COST CENTERS         0         0         0         0         0.000000         76. 10           76. 11         03958 OTHER ANCI LLARY	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(	18, 062, 685	0.000000	72.00
76. 01 03951 PAIN CLINIC 0 0 0 9, 751, 124 0.000000 76. 01 76. 02 03952 CATH LAB 0 0 0 49, 155, 719 0.000000 76. 02 76. 03 03953 ACTIVITY THERAPEUTIC 0 0 0 3,118, 083 0.000000 76. 03 76. 04 03954 WOUND CARE CENTER 0 0 0 4, 342, 175 0.000000 76. 03 76. 05 03340 BARIATRIC CLINIC 0 0 0 4, 342, 175 0.000000 76. 05 76. 06 03030 HEALTHY LIVING CENTER 0 0 0 829, 472 0.000000 76. 06 76. 07 03950 CV RESOURCE CENTER 0 0 0 0 0 0.000000 76. 07 76. 08 03955 OTHER ANCILLARY SERVICE COST CENTERS 0 0 0 0 0 0.000000 76. 08 76. 10 03957 OTHER ANCILLARY SERVICE COST CENTERS 0 0 0 0 0 0.000000 76. 09 76. 11 03958 OTHER ANCILLARY SERVICE COST CENTERS 0 0 0 0 0.000000 76. 10 76. 12 03959 ANTI COAGULATION CLINIC 0 0 0 1, 459, 859 0.000000 76. 12 77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION 0 0 0 0.000000 77. 00	73.00 07300 DRUGS CHARGED TO PATIENTS	0	386, 668	386, 668	39, 660, 597	0.009749	73.00
76. 02       03952 CATH LAB       0       0       49, 155, 719       0.000000       76. 02         76. 03       03953 ACTI VI TY THERAPEUTI C       0       0       0       3, 118, 083       0.000000       76. 03         76. 04       03954 WOUND CARE CENTER       0       0       0       4, 342, 175       0.000000       76. 04         76. 05       03340 BARI ATRI C CLINI C       0       0       0       829, 472       0.000000       76. 05         76. 06       03030 HEALTHY LI VI NG CENTER       0       0       0       0       0.000000       76. 06         76. 07       03950 CV RESOURCE CENTER       0       0       0       0       0.000000       76. 07         76. 08       03955 OTHER ANCI LLARY SERVI CE COST CENTERS       0       0       0       0       0.000000       76. 08         76. 10       03957 OTHER ANCI LLARY SERVI CE COST CENTERS       0       0       0       0       0.000000       76. 10         76. 11       03958 OTHER ANCI LLARY SERVI CE COST CENTERS       0       0       0       0       0.000000       76. 11         76. 12       03959 ANTI COAGULATI ON CLI NI C       0       0       0       0       0.000000       76. 12     <	76.00 03630 ULTRA SOUND	0	0	(	13, 649, 936	0.000000	76. 00
76. 03         03953         ACTIVITY THERAPEUTIC         0         0         3, 118, 083         0.000000         76. 03           76. 04         03954         WOUND CARE CENTER         0         0         0         4, 342, 175         0.000000         76. 04           76. 05         03340         BARI ATRI C CLI NI C         0         0         0         829, 472         0.000000         76. 05           76. 06         03030         HEALTHY LI VI NG CENTER         0         0         0         0         0.000000         76. 06           76. 07         03950         CV RESOURCE CENTER         0         0         0         0         0.000000         76. 07           76. 08         03955         OTHER ANCI LLARY SERVI CE COST CENTERS         0         0         0         0         0.000000         76. 08           76. 10         03957         OTHER ANCI LLARY SERVI CE COST CENTERS         0         0         0         0         0.000000         76. 19           76. 11         03958         OTHER ANCI LLARY SERVI CE COST CENTERS         0         0         0         0         0.000000         76. 11           76. 12         03959         ANTI COAGULATI ON CLI NI C         0         0	76. 01   03951   PAIN CLINIC	0	0	(	9, 751, 124	0.000000	76. 01
76. 04 03954 WOUND CARE CENTER 0 0 0 4, 342, 175 0.000000 76. 04 76. 05 03340 BARI ATRI C CLI NI C 0 0 0 829, 472 0.000000 76. 05 76. 06 03030 HEALTHY LI VI NG CENTER 0 0 0 0 0 0.000000 76. 05 76. 07 03950 CV RESOURCE CENTER 0 0 0 0 0 0 0.000000 76. 07 76. 08 03955 OTHER ANCI LLARY SERVI CE COST CENTERS 0 0 0 0 0 0.000000 76. 08 76. 09 03956 LACTATI ON CLI NI C 0 0 0 0.000000 76. 10 76. 10 03957 OTHER ANCI LLARY SERVI CE COST CENTERS 0 0 0 0.000000 76. 10 76. 11 03958 OTHER ANCI LLARY SERVI CE COST CENTERS 0 0 0 0.000000 76. 11 76. 12 03959 ANTI COAGULATI ON CLI NI C 0 0 0 1, 459, 859 0.000000 76. 12 77. 00 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON 0 0 0 0.000000 77. 00	76. 02   03952   CATH LAB	0	0	(	49, 155, 719	0.000000	76. 02
76. 05         03340         BARI ATRI C CLINI C         0         0         829, 472         0.000000         76. 05           76. 06         03030         HEALTHY LIVING CENTER         0         0         0         0         0.000000         76. 06           76. 07         03950         CV RESOURCE CENTER         0         0         0         0         0.000000         76. 07           76. 08         03955         OTHER ANCI LLARY SERVI CE COST CENTERS         0         0         0         0         0.000000         76. 08           76. 10         03955         OTHER ANCI LLARY SERVI CE COST CENTERS         0         0         0         0         0.000000         76. 09           76. 11         03958         OTHER ANCI LLARY SERVI CE COST CENTERS         0         0         0         0         0.000000         76. 11           76. 12         03959         ANTI COAGULATI ON CLI NI C         0         0         0         0         0.000000         76. 12           77. 00         07700         ALLOGENEI C STEM CELL ACQUI SI TI ON         0         0         0         0         0.000000         77. 00	76. 03   03953   ACTIVITY THERAPEUTIC	0	0	(	3, 118, 083	0.000000	76. 03
76. 06         03030 ON DOTAIN TO THE RELATIVE LIVING CENTER         0         0         0         0         0.000000 ON	76.04 03954 WOUND CARE CENTER	0	0	(	4, 342, 175	0.000000	76. 04
76. 07 03950 CV RESOURCE CENTER 0 0 0 0 0 0.000000 76. 07 76. 08 03955 OTHER ANCI LLARY SERVI CE COST CENTERS 0 0 0 0 0 0.000000 76. 08 76. 09 03956 LACTATI ON CLI NI C 0 0 0 0 0.000000 76. 09 76. 10 03957 OTHER ANCI LLARY SERVI CE COST CENTERS 0 0 0 0 0.000000 76. 10 76. 11 03958 OTHER ANCI LLARY SERVI CE COST CENTERS 0 0 0 0 0.000000 76. 11 76. 12 03959 ANTI COAGULATI ON CLI NI C 0 0 0 1, 459, 859 0.000000 76. 12 77. 00 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON 0 0 0 0 0.000000 77. 00	76. 05   03340   BARI ATRI C   CLI NI C	0	0	(	829, 472	0.000000	76. 05
76. 08	76.06 03030 HEALTHY LIVING CENTER	0	0	(	0	0.000000	76.06
76. 09 03956 LACTATION CLINIC 0 0 0 0 0.000000 76. 09 76. 10 03957 OTHER ANCILLARY SERVICE COST CENTERS 0 0 0 0 0.000000 76. 10 76. 11 03958 OTHER ANCILLARY SERVICE COST CENTERS 0 0 0 0 0.000000 76. 11 76. 12 03959 ANTICOAGULATION CLINIC 0 0 0 1, 459, 859 0.000000 76. 12 77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION 0 0 0 0 0.000000 77. 00	76. 07 03950 CV RESOURCE CENTER	0	0	(	0	0.000000	76. 07
76. 10 03957 OTHER ANCILLARY SERVICE COST CENTERS 0 0 0 0 0 0.000000 76. 10 76. 11 03958 OTHER ANCILLARY SERVICE COST CENTERS 0 0 0 0 0.000000 76. 11 76. 12 03959 ANTICOAGULATION CLINIC 0 0 1, 459, 859 0.000000 76. 12 77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION 0 0 0 0 0 0.000000 77. 00	76.08 03955 OTHER ANCILLARY SERVICE COST CENTERS	0	0	(	0	0.000000	76. 08
76. 11 03958 OTHER ANCILLARY SERVICE COST CENTERS 0 0 0 0 0.000000 76. 11 76. 12 03959 ANTICOAGULATION CLINIC 0 0 1, 459, 859 0.000000 76. 12 77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION 0 0 0 0 0 0.000000 77. 00	76.09 03956 LACTATION CLINIC	o	0	(	o	0.000000	76. 09
76. 12 03959 ANTI COAGULATI ON CLINIC 0 0 1, 459, 859 0. 000000 76. 12 77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION 0 0 0 0 0. 000000 77. 00	76. 10 03957 OTHER ANCILLARY SERVICE COST CENTERS	0	0	(	0	0.000000	76. 10
77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION 0 0 0 0.000000 77. 00	76. 11 03958 OTHER ANCILLARY SERVICE COST CENTERS	o	0	(	0	0.000000	76. 11
	76. 12 03959 ANTI COAGULATION CLINIC	o	0		1, 459, 859	0.000000	76. 12
	77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	o	0		o	0.000000	77. 00
78. 00   07800   CAR T-CELL I MMUNOTHERAPY   0   0   0   0   0   0 0 0 0 0 0 0 0	78.00 07800 CAR T-CELL IMMUNOTHERAPY	o	0		o	0.000000	78. 00
OUTPATIENT SERVICE COST CENTERS	OUTPATIENT SERVICE COST CENTERS						
91. 00 09100 EMERGENCY 0 98, 228 98, 228 62, 786, 727 0. 001564 91. 00		0	98, 228	98, 228	62, 786, 727	0. 001564	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0 9, 303, 915 0.000000 92.00	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	o	0	(	9, 303, 915	0.000000	92.00
200.00   Total (lines 50 through 199)   0   1,003,964   1,003,964   667,831,321   200.00	200.00   Total (lines 50 through 199)	0	1, 003, 964	1, 003, 964	667, 831, 321		200. 00

Health Financial Systems	FRANCI SCAN HE	ALTH- DYER		In Lieu of Form CMS-2552-10		
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provi der CCN		Peri od: From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Prep 5/30/2024 3:45	
		Title >	XVIII	Hospi tal	PPS	
Cost Center Description	Outpati ent	Inpatient	Inpatient	Outpati ent	Outpati ent	

				0 12/31/2023	5/30/2024 3: 4	
		Title	XVIII	Hospi tal	PPS	<u> </u>
Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	Charges	Pass-Through	
	(col. 6 ÷ col.	3	Costs (col. 8		Costs (col. 9	
	7)		x col. 10)		x col . 12)	
	9.00	10. 00	11.00	12.00	13. 00	
ANCILLARY SERVICE COST CENTERS				1 1 2 2 2		
50. 00 05000 OPERATING ROOM	0. 000000	7, 929, 978	(	8, 995, 236	0	50.00
50. 01   05001   0UTPATI ENT SURGERY	0. 000000	781, 145		408, 750	0	50. 01
51. 00 05100 RECOVERY ROOM	0. 000000	769, 528		2, 775, 281	0	51.00
53. 00   05300   ANESTHESI OLOGY	0. 000000	1, 735, 368		1, 873, 138	0	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 000000	10, 919, 638		13, 787, 285		54.00
54. 01   05401 RADI OLOGY-SPECI AL PROCEDURES	0. 000000	1, 551, 649		2, 044, 530		54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	0,001,017		0	-	55. 00
56. 00   05600 RADI OI SOTOPE	0. 000000	589, 328		3, 425, 150	_	56. 00
60. 00   06000   LABORATORY	0. 006801	12, 417, 029				60.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	421, 014		50, 891	0	63. 00
65. 00   06500   RESPI RATORY THERAPY	0. 000000	5, 001, 716		141, 053	_	65. 00
66. 00   06600   PHYSI CAL THERAPY	0. 000000	1, 601, 715		29, 423	_	66.00
67. 00   06700 OCCUPATI ONAL THERAPY	0. 000000			6, 465		67.00
		1, 314, 391		· ·		
68. 00 06800 SPEECH PATHOLOGY	0.000000	686, 072		163, 124		68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	3, 969, 148		6, 384, 047	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	262, 348		1, 070, 400		70.00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT	0. 000000	8, 550, 864		6, 225, 064	0	71. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000	2, 260, 164		3, 577, 299		72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 009749	8, 323, 700			29, 964	73. 00
76. 00   03630   ULTRA SOUND	0. 000000	1, 533, 387		2, 303, 633		76. 00
76. 01  03951 PAIN CLINIC	0. 000000	22, 736		1, 748, 164	0	76. 01
76. 02   03952   CATH LAB	0. 000000	6, 486, 892		13, 687, 738		76. 02
76. 03 03953 ACTI VI TY THERAPEUTI C	0. 000000	195, 232		2, 943		76. 03
76.04 03954 WOUND CARE CENTER	0. 000000	61, 108		1, 232, 328	0	76. 04
76. 05   03340 BARI ATRI C CLI NI C	0. 000000	652		292, 801	0	76. 05
76.06 03030 HEALTHY LIVING CENTER	0. 000000	0		0	0	76. 06
76. 07 03950 CV RESOURCE CENTER	0. 000000	0		0	0	76. 07
76.08 03955 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000	0		0	0	76. 08
76.09 03956 LACTATION CLINIC	0. 000000	0		0	0	76. 09
76. 10 03957 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000	0		0	0	76. 10
76. 11 03958 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000	0		0	0	76. 11
76. 12 03959 ANTI COAGULATI ON CLINIC	0. 000000	2, 066		644, 856	0	76. 12
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000	0		0		77. 00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0. 000000	0		0	0	78. 00
OUTPATIENT SERVICE COST CENTERS						
91. 00 09100 EMERGENCY	0. 001564	6, 337, 608	9, 91:	6, 621, 090	10, 355	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	1, 440, 353		908, 134	0	92.00
200.00   Total (lines 50 through 199)		85, 164, 889	175, 50	83, 650, 704	55, 134	200. 00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0090 Peri od: Worksheet D From 01/01/2023 Part V Date/Time Prepared: 12/31/2023 5/30/2024 3:45 pm Title XVIII Hospi tal Charges Costs Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Ratio From Services (see Rei mbursed Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Part I, col. Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 1. 00 2.00 5. 00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 094675 8, 995, 236 851, 624 50.00 50.01 05001 OUTPATIENT SURGERY 0.731590 408, 750 0 0 299, 037 50.01 05100 RECOVERY ROOM 0 0 51 00 0.085415 2, 775, 281 51 00 237.051 0 53.00 05300 ANESTHESI OLOGY 0.005160 1, 873, 138 0 9,665 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.086749 13, 787, 285 0 1, 196, 033 54.00 435, 221 05401 RADI OLOGY-SPECI AL PROCEDURES 0. 212871 0 0 54 01 2,044,530 54 01 05500 RADI OLOGY-THERAPEUTI C 0 55.00 0.000000 55.00 56.00 05600 RADI OI SOTOPE 0.106524 3, 425, 150 364, 861 56.00 0 60.00 06000 LABORATORY 0.138608 2, 178, 300 0 301, 930 60.00 0 06300 BLOOD STORING, PROCESSING & TRANS. 63 00 0 465175 50, 891 23.673 63 00 65.00 06500 RESPIRATORY THERAPY 0.297511 141, 053 41, 965 65.00 06600 PHYSI CAL THERAPY 0. 251568 29, 423 0 0 7, 402 66.00 66.00 0 06700 OCCUPATIONAL THERAPY 0.092473 0 67.00 6.465 598 67.00 0 06800 SPEECH PATHOLOGY 23, 391 68 00 0.143394 163, 124 68 00 69.00 06900 ELECTROCARDI OLOGY 0.081929 6, 384, 047 0 0 523, 039 69.00 07000 ELECTROENCEPHALOGRAPHY 0 70.00 0. 148449 1,070,400 158, 900 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 2, 039, 543 71.00 0.327634 6, 225, 064 71.00 07200 I MPL. DEV. CHARGED TO PATIENTS 0 0 72 00 0.255306 3, 577, 299 913, 306 72 00 73.00 07300 DRUGS CHARGED TO PATIENTS 0. 276036 3, 073, 581 848, 419 73.00 03630 ULTRA SOUND 0 76.00 0.100251 2, 303, 633 0 230, 942 76.00 03951 PAIN CLINIC 0 400, 863 76.01 0. 229305 1.748.164 0 76.01 0 03952 CATH LAB 0 76.02 0.112006 13, 687, 738 1, 533, 109 76.02 76.03 03953 ACTIVITY THERAPEUTIC 1.002728 0 2, 951 2,943 76.03 03954 WOUND CARE CENTER 0 76. 04 0.359129 1, 232, 328 0 442, 565 76.04 03340 BARIATRIC CLINIC 0 76.05 1.433676 292, 801 419, 782 76.05 0 76.06 03030 HEALTHY LIVING CENTER 0.000000 C 0 76.06 03950 CV RESOURCE CENTER 0.000000 0 0 0 76.07 0 76.07 0 76.08 03955 OTHER ANCILLARY SERVICE COST CENTERS 0.000000 0 0 76.08 03956 LACTATION CLINIC 0 76 09 0.000000 C Ω 76.09 76. 10 0 03957 OTHER ANCILLARY SERVICE COST CENTERS 0.000000 C 0 76.10 0 03958 OTHER ANCILLARY SERVICE COST CENTERS 0 76. 11 0.000000 0 76. 11 0 0 03959 ANTICOAGULATION CLINIC 0.698569 450, 476 76. 12 644, 856 76. 12 77.00 07700 ALLOGENEIC STEM CELL ACQUISITION 0.000000 0 77.00 78.00 07800 CAR T-CELL IMMUNOTHERAPY 0.000000 0 0 78.00 OUTPATIENT SERVICE COST CENTERS 91 00 09100 EMERGENCY 91.00 0 168353 6, 621, 090 0 0 1, 114, 680 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0. 473742 908, 134 0 0 430, 221 92.00 200.00 Subtotal (see instructions) 83, 650, 704 0 6, 656 13, 301, 247 200.00 Less PBP Clinic Lab. Services-Program 0 201.00 201.00 Only Charges

0

6,656

83, 650, 704

13, 301, 247 202. 00

202.00

Net Charges (line 200 - line 201)

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

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0090 Period: Worksheet D From 01/01/2023 Part V

Date/Time Prepared: 12/31/2023 5/30/2024 3:45 pm Title XVIII Hospi tal PPS Costs Cost Center Description Cost Cost Rei mbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 6.00 7.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 50.00 50.01 05001 OUTPATIENT SURGERY 0 50.01 51. 00 05100 RECOVERY ROOM 0 51 00 53.00 05300 ANESTHESI OLOGY 0 53.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 54. 01 05401 RADI OLOGY-SPECI AL PROCEDURES 0 54.01 05500 RADI OLOGY-THERAPEUTI C 0 55.00 55.00 56.00 05600 RADI OI SOTOPE 0 56.00 06000 LABORATORY 0 60.00 60.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 63.00 63 00 65.00 06500 RESPIRATORY THERAPY 0 65.00 66.00 06600 PHYSI CAL THERAPY 0 66.00 06700 OCCUPATIONAL THERAPY 67.00 0 67.00 0 68.00 06800 SPEECH PATHOLOGY 68.00 69.00 06900 ELECTROCARDI OLOGY 0 69.00 07000 ELECTROENCEPHALOGRAPHY 0 70.00 70.00 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72 00 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 1,837 73.00 03630 ULTRA SOUND 76.00 0 76.00 03951 PAIN CLINIC 76. 01 0 76.01 03952 CATH LAB 76.02 0 76.02 76. 03 03953 ACTIVITY THERAPEUTIC 0 76.03 03954 WOUND CARE CENTER 76. 04 76.04 76. 05 03340 BARIATRIC CLINIC 0 76.05 03030 HEALTHY LIVING CENTER 0 76.06 76.06 76. 07 76. 07 03950 CV RESOURCE CENTER 03955 OTHER ANCILLARY SERVICE COST CENTERS 0 76. 08 76.08 03956 LACTATION CLINIC 76.09 0 76.09 76. 10 |03957| OTHER ANCILLARY SERVICE COST CENTERS 0 76. 10 03958 OTHER ANCILLARY SERVICE COST CENTERS 0 76. 11 76. 11 03959 ANTI COAGULATION CLINIC 76. 12 0 76.12 07700 ALLOGENEIC STEM CELL ACQUISITION 77.00 0 77.00 78.00 07800 CAR T-CELL IMMUNOTHERAPY 0 78.00 OUTPATIENT SERVICE COST CENTERS 91 00 09100 EMERGENCY 91.00 0 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 92.00 C 92.00 0 200.00 Subtotal (see instructions) 1,837 200.00 Less PBP Clinic Lab. Services-Program 201.00 201.00 Only Charges Net Charges (line 200 - line 201) 0 202.00 202.00 1, 837

Component CN: 15-T096   From 01/01/2023   Part II   To 12/31/2023   Data/Time Prepart To 12/31/2023   Data	Heal th	Financial Systems	FRANCISCAN H				eu of Form CMS-	<u>2552-10</u>
Cost Center Description	APPORT	IONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS			Period: From 01/01/2023 To 12/31/2023	Worksheet D Part II Date/Time Pre	pared:
Capital Related Cost (From Wisst. B, Part III, cel. Related Cost (From Wisst. C. to Charges Program (column 3 x column 4)				Title	xVIII		5/30/2024 3:4	5 pm
Related Cost			1	I =				
CFFORM MISSLE, B   Part II, col.   20   Col. 1 * Col.   Charges   Col umn 4)		Cost Center Description						
Part II, col.   8)   2)				,			,	
260						. charges	COLUMN 4)	
NAMELILARY SERVICE COST CENTERS				8)	2)			
ANCILLARY SERVICE COST CENTERS				2 00	3 00	4.00	5.00	
SO   00   00   00   00   00   00   00		ANCILLARY SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
SO   0510   05001   05001   017PATIENT SURGERY   387, 916   3,793,528   0,102257   9,089   929   50   50   50   05100   RECOVERY ROM   190,545   16,151,657   0,011797   4,892   58   51   53   00   05300   ANESTHESI OLOGY   4,536   18,447,799   0,000246   9,158   2   53   54   00   05400   RADI OLOGY-DI ARONSTI C   1,746,011   88,287,475   0,019776   226,583   4,481   54   01   5401   RADI OLOGY-SPECIAL PROCEDURES   153,270   12,732,253   0,012038   51,280   617   54   55   00   05500   RADI OLOGY-THERAPEUTI C   0   0,000000   0   0   56   60   00   000000   0   0   0   56   60   00   0	50 00		1 // 1/2	82 652 204	0.01800	11/ 206	2 058	50.00
51 00   05100   RECOVERY ROOM   190, 545   16, 151, 657   0, 011797   4, 892   58   51   53, 00   05300   ANESTHESI OLOGY   4, 536   18, 447, 799   0, 000246   9, 158   2   25   34   40   05401   RADI OLOGY-DI AGNOSTI C   1, 746, 011   88, 287, 475   0, 019776   226, 583   4, 481   54   54   01   05401   RADI OLOGY-SPECI AL PROCEDURES   153, 270   12, 732, 253   0, 012038   51, 280   617   54   55   00   05000   RADI OLOGY-SPECI AL PROCEDURES   153, 270   12, 732, 253   0, 012038   51, 280   617   54   56   00   0, 000000   0   0   0   0   0			1		1			1
S3-00   05300   AMESTHESI OLOGY   4, 536   18, 447, 799   0, 000246   9, 158   2   53								
S4.00   05400   RADI OLOGY-DI AGNOSTI C   1,746,011   88,287,475   0.019776   226,583   4,481   54   55.00   05400   RADI OLOGY-SPECIAL PROCEDURES   153,270   0.000000   0.000000   0.0550   05500   RADI OLOGY-THERAPEUTI C   0.0000000   0.000000   0.0550   0.05500   RADI OLOGY-THERAPEUTI C   0.0000000   0.000000   0.0000000   0.0550   0.05500   RADI OLOGY-THERAPEUTI C   0.00000000   0.0					1			
S4.01   05401   RADI OLOGY-SPECI AL PROCEDURES   153, 270   12, 732, 253   0.012038   51, 280   617   54   55.00   05500   RADI OLOGY-THERAPEUTI C   0   0   0.000000   0   0   0   55   60.00   05600   RADI OLOGY-THERAPEUTI C   221, 609   10, 679, 671   0.003027   474, 416   1, 436   60   63.00   6300   BLODD STORI NG, PROCESSI NG & TRANS.   72, 108   1, 567, 708   0.045996   7, 680   353   63.00   6300   BLODD STORI NG, PROCESSI NG & TRANS.   72, 108   1, 567, 708   0.045996   7, 680   353   63.65.00   06500   RESPI RATORY THERAPY   182, 615   13, 697, 800   0.013332   797, 055   10, 626   65   66.00   06600   PHYSI CAL THERAPY   131, 462   26, 659, 110   0.003027   474, 416   4.346   66.00   066000   066000   066000   066000   066000   066000   066000   066000   066000   066000   066000   066000   066000   066000   066000   066000   066000   066000   0660000   06600000   0660000000   06600000000								
55.00   05500   RADI OLOGY-THERAPEUTI C   0   0   0   0.000000   0   0   55								
56.00   05600   RADI OI SOTOPE   221, 609   10, 679, 671   0, 020751   0   0   56								
60.00   06000   LABORATORY   231, 012   76, 316, 911   0.003027   474, 416   1, 436   60   63.00   06300   BLDOD STORI NG, PROCESSI NG & TRANS.   72, 108   1, 567, 708   0.045996   7, 680   353   63   63   65.00   06500   RESPIRATORY THERAPY   182, 615   13, 697, 800   0.013332   797, 055   10, 626   65   66.00   06600   PHYSI CAL THERAPY   131, 462   26, 059, 110   0.005045   2, 051, 229   10, 348   66   67.00   06700   0CCUPATI ONAL THERAPY   22, 785   11, 158, 417   0.002042   1, 906, 691   3, 893   67   68.00   06800   SPEECH PATHOLOGY   82, 417   8, 807, 913   0.009357   881, 297   8, 246   68   69.00   06900   ELECTROCARDI OLOGY   311, 116   26, 818, 703   0.011601   30, 506   354   69   69.00   06900   ELECTROCARDI OLOGY   311, 116   26, 818, 703   0.011601   30, 506   354   69   71.00   07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENT   108, 143   52, 969, 791   0.002042   418, 268   854   71   72.00   07300   PROTECO CHARGED TO PATI ENTS   29, 354   18, 062, 685   0.001625   4, 979   8   72   73.00   07300   DRUGS CHARGED TO PATI ENTS   29, 354   18, 062, 685   0.001625   4, 979   8   72   73.00   07300   DRUGS CHARGED TO PATI ENTS   29, 354   18, 062, 685   0.001625   4, 979   8   72   73.00   07300   DRUGS CHARGED TO PATI ENTS   29, 354   18, 062, 685   0.001625   4, 979   8   72   73.00   07300   DRUGS CHARGED TO PATI ENTS   29, 354   18, 062, 685   0.001625   4, 979   8   72   73.00   07300   DRUGS CHARGED TO PATI ENTS   29, 354   18, 062, 685   0.001625   4, 979   8   72   73.00   07300   DRUGS CHARGED TO PATI ENTS   29, 354   18, 062, 685   0.001625   4, 979   8   72   73.00   07300   DRUGS CHARGED TO PATI ENTS   29, 354   18, 062, 685   0.001625   4, 979   8   72   73.00   07300   DRUGS CHARGED TO PATI ENTS   29, 354   18, 062, 685   0.001625   4, 979   8   72   73.00   07300   DRUGS CHARGED TO PATI ENTS   29, 371   39, 4751, 124   0.033820   61   27   66.00   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.00000			1	_				
63.00   06300   BLOOD STORING, PROCESSING & TRANS.   72, 108   1, 567, 708   0. 045996   7, 680   353   65.00   06500   RESPIRATORY THERAPY   182, 615   13, 697, 800   0. 013332   797, 055   10, 626   65.00   06600   PHYSI CAL THERAPY   131, 462   26, 059, 110   0. 005045   2, 051, 229   10, 348   66.00   06600   PHYSI CAL THERAPY   22, 785   11, 158, 417   0. 002042   1, 906, 691   3, 893   67   68.00   06900   CEUCATTIONAL THERAPY   22, 785   11, 158, 417   0. 002042   1, 906, 691   3, 893   67   68.00   06900   ELECTROCARDI OLOGY   311, 116   26, 818, 703   0.011601   30, 506   354   69   70.00   07000   ELECTROENCEPHALOGRAPHY   136, 417   5, 570, 089   0. 024491   13, 055   320   70   71.00   07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENT   108, 143   52, 969, 791   0. 002042   418, 268   854   71   72.00   07200   IMPL. DEV. CHARGED TO PATI ENTS   29, 354   18, 062, 685   0. 001625   4, 979   8   72   73.00   07300   DRUGS CHARGED TO PATI ENTS   29, 354   18, 062, 685   0. 001625   4, 979   8   72   73.00   07300   DRUGS CHARGED TO PATI ENTS   169, 941   39, 660, 597   0. 0024285   734, 760   3, 148   73   76.01   03951   PAI N CLINIC   329, 781   9, 751, 124   0. 033820   61   2   76   76.01   03951   PAI N CLINIC   329, 781   9, 751, 124   0. 033820   61   2   76   76.01   03951   PAI N CLINIC   59, 771   829, 472   0. 039407   6, 635   261   76   76.05   03340   BARIATRI C CLINIC   59, 771   829, 472   0. 072059   49   4   76   76.05   033950   CV RESOURCE CENTER   0   0   0. 000000   0   0   76   76   76.01   03955   OTHER ANCILLARY SERVICE COST CENTERS   0   0   0. 000000   0   0   76   76   76   77   78   77   78   77   78   77   78   77   78   77   78   77   78   77							1	
65.00   06500   RESPI RATORY THERAPY   182, 615   13, 697, 800   0, 013322   797, 055   10, 626   65   66.00   06600   06700   0CCUPATI ONAL THERAPY   22, 785   11, 158, 417   0, 002042   1, 906, 691   3, 893   67   68.00   06800   SPEECH PATHOLOGY   82, 417   8, 807, 913   0, 009357   881, 297   8, 246   68   69.00   06900   ELECTROCARDIOLOGY   311, 116   26, 818, 703   0, 001601   30, 506   354   69.00   07000   ELECTROCARDIOLOGY   311, 116   26, 818, 703   0, 001601   30, 506   354   69.00   07000   ELECTROCARDIOLOGY   311, 116   26, 818, 703   0, 001601   30, 506   354   69.00   07000   ELECTROCARDIOLOGY   311, 116   26, 818, 703   0, 001601   30, 506   354   69.00   07000   ELECTROCARDIOLOGY   313, 417   5, 570, 089   0, 024491   13, 055   320   70   71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENT   108, 143   52, 969, 791   0, 002042   418, 268   854   71   72.00   07300   DRUGS CHARGED TO PATI ENTS   29, 354   18, 062, 685   0, 001625   4, 979   8   72   73.00   07300   DRUGS CHARGED TO PATI ENTS   169, 941   39, 660, 597   0, 004285   734, 760   3, 148   73   76.01   03951   PAIN CLINI C   329, 781   36, 49, 936   0, 012157   44, 507   541   76   76.02   03952   CATH LAB   633, 959   49, 155, 719   0, 012897   52, 456   677   76   76.04   03954   WOIND CARE CENTER   171, 114   4, 342, 175   0, 039407   6, 635   261   76   76.05   03340   BARI ATRI C CLINI C   59, 771   829, 472   0, 072059   49   4   76   76.06   03950   CARSOURCE CENTER   0   0   0, 000000   0   0   76   76.07   03950   CARSOURCE CENTER   0   0   0, 000000   0   0   76   76.11   03958   OTHER ANCI LLARY SERVI CE COST CENTERS   0   0   0, 000000   0   0   76   76.12   03959   OTHER ANCI LLARY SERVI CE COST CENTERS   0   0   0, 000000   0   0   0   76   76.11   03958   OTHER ANCI LLARY SERVI CE COST CENTERS   0   0   0, 000000   0   0   0   76   76.12   03959   OTHER ANCI LLARY SERVI CE COST CENTERS   0   0, 000000   0   0   0   0   76.11   03950   OTHER ANCI LLARY SERVI CE COST CENTERS   0   0, 0000000   0   0   0   0   76.11   03			1					
66. 00   06600   PHYSI CAL THERAPY   131, 462   26,059, 110   0.005045   2,051,229   10,348   66   67.00   06700   0CCUPATI ONAL THERAPY   22,785   11,158,417   0.002042   1,906,691   3,893   67   68.00   06800   SPEECH PATHOLOGY   82,417   8,807,913   0.009357   881,297   8,246   68   69.00   06900   ELECTROCARDI OLOGY   311,116   26,818,703   0.011601   30,506   354   69   70.00   07000   ELECTROENCEPHALOGRAPHY   136,417   5,570,089   0.024491   13,055   320   70   70   70   00   TO 100   MEDI CAL SUPPLIES CHARGED TO PATI ENT   108,143   52,969,791   0.002042   418,268   854   71   72.00   07200   IMPL. DEV. CHARGED TO PATI ENTS   29,354   18,062,685   0.001625   4,979   8   72   73.00   07300   DRUGS CHARGED TO PATI ENTS   169,941   39,660,597   0.004285   734,760   3,148   73   76.00   3630   ULTRA SOUND   165,931   33,649,936   0.012157   44,507   541   76   76.01   3951   PAIN CLINIC   329,781   9,751,124   0.033820   61   2   76   76.02   3952   CATH LAB   633,959   49,155,719   0.012897   52,456   677   76   76.04   3953   ACTIVITY THERAPEUTIC   161,666   3,118,083   0,51848   0   0   76   76   76.05   03340   BARI ATRI C CLINIC   59,771   829,472   0.072059   49   4   76   76   76   76   76   76   76								
67. 00   06700   0CCUPATI ONAL THERAPY   22, 785   11, 158, 417   0.002042   1, 906, 691   3, 893   67   68. 00   06800   SPECCH PATHOLOGY   82, 417   8, 807, 913   0.009357   881, 297   8, 246   68   69. 00   06900   ELECTROCARDI OLOGY   311, 116   26, 818, 703   0.011601   30, 506   354   69   70. 00   7000   ELECTROENCEPHALOGRAPHY   136, 417   5, 570, 089   0.024491   13, 055   320   70   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENT   108, 143   52, 969, 791   0.002042   418, 268   854   71   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   29, 354   18, 062, 685   0.001625   4, 979   8   72   73. 00   07300   DRUGS CHARGED TO PATI ENTS   169, 941   39, 660, 597   0.004285   734, 760   3, 148   73   76. 00   03630   ULTRA SOUND   165, 937   13, 649, 936   0.012157   44, 507   541   76   76. 01   03951   PAIN CLINIC   329, 781   9, 751, 124   0.033820   61   2   76   76. 02   03952   CATH LAB   633, 959   49, 155, 719   0.012897   52, 456   677   76   76. 05   03340   BARI ATRI C CLI NI C   59, 771   829, 472   0.072059   49   4   76   76. 06   03030   HEALTHY LIVING CENTER   0   0.000000   0   0   76   76   76   76   03955   OTHER ANCILLARY SERVICE COST CENTERS   0   0.000000   0   0   0   76   76   77   78   77   00   0700   CART CENTER   0   0.000000   0   0   0   76   77   78   00   0700   000000   0   0   0   76   77   78   00   0700   000000   0   0   0   76   77   78   00   0700   000000   0   0   0   76   77   78   00   0700   000000   0   0   0   0								
68. 00 06800 SPEECH PATHOLOGY 82, 417 8, 807, 913 0.009357 881, 297 8, 246 68 69. 00 06900 ELECTROCARDIOLOGY 311, 116 26, 818, 703 0.011601 30, 506 354 69 70. 00 7000 ELECTROCARDIOLOGY 136, 417 5, 570, 089 0.024491 13, 055 320 70 71. 00 07000 ELECTROCACEPHALOGRAPHY 136, 417 5, 570, 089 0.024491 13, 055 320 70 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 108, 143 52, 969, 791 0.002042 418, 268 854 71 72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS 29, 354 18, 062, 685 0.001625 4, 979 8 72 73. 00 07300 DRUGS CHARGED TO PATIENTS 169, 941 39, 660, 597 0.004285 734, 760 3, 148 73 76. 00 07300 DRUGS CHARGED TO PATIENTS 169, 941 39, 660, 597 0.004285 734, 760 3, 148 73 76. 00 07300 DRUGS CHARGED TO PATIENTS 165, 937 13, 649, 936 0.012157 44, 507 541 76 76. 01 03951 PAIN CLINIC 329, 781 9, 751, 124 0.033820 61 2 76 76. 02 03952 CATH LAB 633, 959 49, 155, 719 0.012897 52, 456 677 76 76 76 76 76 76 76 76 76 76 76 7								
69.00   06900   ELECTROCARDI OLOGY   311, 116   26, 818, 703   0.011601   30, 506   354   69   70. 00   07000   ELECTROENCEPHALOGRAPHY   136, 417   5, 570, 089   0.024491   13, 055   320   70   71. 00   07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENT   108, 143   52, 969, 791   0.002042   418, 268   854   71   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   29, 354   18, 062, 685   0.001625   4, 979   8   72   73. 00   07300   DRUGS CHARGED TO PATI ENTS   169, 941   39, 660, 597   0.004285   734, 760   3, 148   73   76. 01   0.03630   ULTRA SOUND   165, 937   13, 649, 936   0.012157   44, 507   541   76   76. 01   0.03951   PAIN CLINIC   329, 781   9, 751, 124   0.033820   61   2 76   76   76   76   76   76   76								
70.00   07000   ELECTROENCEPHALOGRAPHY   136, 417   5, 570, 089   0.024491   13, 055   320   70   71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENT   108, 143   52, 969, 791   0.002042   418, 268   854   71   72.00   07200   IMPL. DEV. CHARGED TO PATIENTS   29, 354   18, 062, 685   0.001625   4, 979   8   72   73.00   07300   DRUGS CHARGED TO PATIENTS   169, 941   39, 660, 597   0.004285   734, 760   3, 148   73   76.00   03630   ULTRA SOUND   165, 937   13, 649, 936   0.012157   44, 507   541   76   76.01   03951   PAIN CLINIC   329, 781   9, 751, 124   0.033820   61   2   76   76   76   76   76   76   76								
71. 00								
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 29, 354 18, 062, 685 0. 001625 4, 979 8 72 73. 00 07300 DRUGS CHARGED TO PATIENTS 169, 941 39, 660, 597 0. 004285 734, 760 3, 148 73 76. 00 03630 ULTRA SOUND 165, 937 13, 649, 936 0. 012157 44, 507 541 76 76. 01 03951 PAIN CLINIC 329, 781 9, 751, 124 0. 033820 61 2, 76 76. 02 03952 CATH LAB 633, 959 49, 155, 719 0. 012897 52, 456 677 76 76. 03 03953 ACTIVITY THERAPEUTIC 161, 666 3, 118, 083 0. 051848 0 0 76 76. 04 03954 WOUND CARE CENTER 171, 114 4, 342, 175 0. 039407 6, 635 261 76 76. 05 03340 BARIATRIC CLINIC 59, 771 829, 472 0. 072059 49 4 76 76. 06 03030 HEALTHY LIVING CENTER 0 0 0. 000000 0 0 76 76. 07 03950 CV RESOURCE CENTER 0 0 0. 000000 0 0 76 76. 08 03955 OTHER ANCILLARY SERVICE COST CENTERS 0 0 0. 000000 0 0 76 76. 10 03957 OTHER ANCILLARY SERVICE COST CENTERS 0 0 0. 000000 0 0 76 76. 11 03958 OTHER ANCILLARY SERVICE COST CENTERS 0 0 0. 000000 0 0 76 76. 12 03959 ANTICOAGULATION CLINIC 18, 909 1, 459, 859 0. 012953 0 0 77 77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION 0 0 0.000000 0 0 77 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0. 000000 0 0 78 91. 00 EMERGENCY 568, 234 62, 786, 727 0. 00950 8, 839 80 91					1			
73. 00								
76. 00								
76. 01								1
76. 02 03952 CATH LAB 633, 959 49, 155, 719 0. 012897 52, 456 677 76 76. 03 03953 ACTIVITY THERAPEUTIC 161, 666 3, 118, 083 0. 051848 0 0 76 76. 04 03954 WOUND CARE CENTER 171, 114 4, 342, 175 0. 039407 6, 635 261 76 76. 05 03340 BARIATRIC CLINIC 59, 771 829, 472 0. 072059 49 4 76 76. 06 03030 HEALTHY LIVING CENTER 0 0 0.000000 0 0 76 76. 07 03950 CV RESOURCE CENTER 0 0 0.000000 0 0 76 76. 08 03955 OTHER ANCILLARY SERVICE COST CENTERS 0 0.000000 0 0 76 76. 09 03956 LACTATION CLINIC 0 0.000000 0 0 76 76. 10 03957 OTHER ANCILLARY SERVICE COST CENTERS 0 0.000000 0 0 76 76. 11 03958 OTHER ANCILLARY SERVICE COST CENTERS 0 0.000000 0 0 76 76. 12 03959 ANTICOAGULATION CLINIC 18, 909 1, 459, 859 0.012953 0 0 76 77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION 0 0 0.000000 0 0 78 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0.000000 0 0 78 78. 00 09100 EMERGENCY 568, 234 62, 786, 727 0.009050 8, 839 80 91					1			
76. 03								
76. 04								
76. 05								76. 04
76. 06					1			76. 05
76. 07								
76. 08				-				
76. 09				_				
76. 10				_	1		-	
76. 11   03958   OTHER ANCI LLARY SERVICE COST CENTERS   0   0   0.000000   0   0   76   76. 12   03959   ANTI COAGULATI ON CLI NI C   18,909   1,459,859   0.012953   0   0   76   77. 00   07700   ALLOGENEI C STEM CELL ACQUI SI TI ON   0   0   0.000000   0   0   0   78. 00   07800   CAR T-CELL I IMMUNOTHERAPY   0   0   0.000000   0   0   78   000   000   000   000   000   000   000   000   91. 00   09100   EMERGENCY   568,234   62,786,727   0.009050   8,839   80   91				ļ	1			
76. 12   03959   ANTI COAGULATI ON CLINI C   18,909   1,459,859   0.012953   0   0   76 77. 00   07700   ALLOGENEI C STEM CELL ACQUISITION   0   0   0.000000   0   0   77 78. 00   07800   CAR T-CELL I IMMUNOTHERAPY   0   0   0.000000   0   0   78  OUTPATI ENT SERVI CE COST CENTERS  91. 00   09100   EMERGENCY   568,234   62,786,727   0.009050   8,839   80   91							-	
77. 00   07700   ALLOGENEI C STEM CELL ACQUISITION   0   0   0.000000   0   0   77   78. 00   07800   CAR T-CELL IMMUNOTHERAPY   0   0   0.000000   0   0   78   78   78   78   78			1	_				1
78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0.000000 0 0 78  00TPATIENT SERVICE COST CENTERS  91. 00 09100 EMERGENCY 568, 234 62, 786, 727 0.009050 8, 839 80 91					1			
OUTPATI ENT         SERVI CE         COST         CENTERS           91. 00         09100   EMERGENCY         568, 234   62, 786, 727   0.009050   8, 839   80   91			1	_				
91. 00   09100   EMERGENCY   568, 234   62, 786, 727   0. 009050   8, 839   80   91	70.00			1 0	0.0000	50, 0		1 70.00
	91 00		568 234	62 786 727	0 00901	50 8 839	80	91.00
37 OO 1037001003EKVATION DED3 ONON-DE311NO PAKE   OF 3 303 313 O 0000000 OF OF OF	92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0 0 0		1		0	
200.00 Total (lines 50 through 199) 7,779,041 667,831,321 7,847,781 49,296,200					1			

APP0RT	Financial Systems IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	FRANCISCAN HEARVICE OTHER PASS	Provider C	CN: 15-0090		ri od:	worksheet D	2552-10
THROUG	H COSTS		Component	CCN: 15-T090	To	om 01/01/2023 12/31/2023	Part IV Date/Time Prep 5/30/2024 3:4	
			Title	: XVIII	S	ubprovider - IRF	PPS	·
	Cost Center Description	Non Physician Anesthetist Cost	Nursi ng Program Post-Stepdown Adj ustments	Nursi ng Program		Allied Health Post-Stepdown Adjustments	Allied Health	
		1.00	2A	2.00		3A	3. 00	
	ANCILLARY SERVICE COST CENTERS							
	05000 OPERATI NG ROOM	0	0		0	0	0	50.00
50. 01	05001 OUTPATIENT SURGERY	0	0		0	0	0	50. 01
51.00	05100 RECOVERY ROOM	0	0		0	0	0	51.00
53. 00 54. 00	05300   ANESTHESI OLOGY   05400   RADI OLOGY-DI AGNOSTI C	0	0		0	U O	0	53. 00 54. 00
54. 00 54. 01	05401 RADI OLOGY-SPECI AL PROCEDURES	0	0		0	0	0	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C		0		0	0	0	55.00
56. 00	05600 RADI OI SOTOPE		0		0	0	0	56.00
50.00	06000 LABORATORY		0		0	0	519, 068	60.00
33.00	06300 BLOOD STORING, PROCESSING & TRANS.		0		0	o	017,000	63.00
55.00	06500 RESPIRATORY THERAPY		0		Ö	o	0	65.00
66. 00	06600 PHYSI CAL THERAPY	o	0		0	o	0	66.00
57. 00	06700 OCCUPATI ONAL THERAPY	O	0		0	O	0	67.00
8. 00	06800 SPEECH PATHOLOGY	O	0		0	0	0	68.00
9. 00	06900 ELECTROCARDI OLOGY	0	0		0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0	0	0	70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0	0	0	71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0	0	72.00
3. 00	07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	386, 668	73.00
	03630 ULTRA SOUND	0	0		0	0	0	76.00
6. 01	03951 PAIN CLINIC	0	0		0	0	0	76. 01
	03952 CATH LAB	0	0		0	0	0	76. 02
	03953 ACTIVITY THERAPEUTIC	0	0		0	0	0	76. 03
	03954 WOUND CARE CENTER	0	0		0	0	0	76.04
	03340 BARIATRIC CLINIC   03030 HEALTHY LIVING CENTER	0	0		0	o	0	76. 05 76. 06
76. 07	03950 CV RESOURCE CENTER		0		0	0	0	76.07
	03955 OTHER ANCILLARY SERVICE COST CENTERS		0		0	0	0	76. 08
	03956 LACTATION CLINIC		0		0	o	0	76. 09
	03957 OTHER ANCILLARY SERVICE COST CENTERS	o	0		0	o	0	76. 10
76. 11	03958 OTHER ANCILLARY SERVICE COST CENTERS	O	0		0	0	0	76. 11
76. 12	03959 ANTICOAGULATION CLINIC	0	0		0	0	0	76. 12
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	o	0		0	0	0	77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0		0	0	0	78.00
	OUTPATIENT SERVICE COST CENTERS							
	09100 EMERGENCY	0	0		0	0	98, 228	
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0		0	92. 00
200.00	Total (lines 50 through 199)		0	I	0	O	1, 003, 964	1200 DC

llool +h	Financial Systems	FRANCISCAN HE	TALTU DVED		lm lia	u of Form CMC	2552 10
	Financial Systems TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER			N: 15 0000	Peri od:	wof Form CMS-: Worksheet D	2332-10
	SH COSTS	WICE UTILK FAS	Frovider Co	JN. 13-0090	From 01/01/2023		
TTIKOOC	11 00313		Component (	CCN: 15-T090	To 12/31/2023	Date/Time Pre	pared:
			·			5/30/2024 3: 4	5 pm
			Title	XVIII	Subprovi der  - I RF	PPS	
	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
		Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
		Education Cost	1, 2, 3, and	Cost (sum o		(col. 5 ÷ col.	
			4)	col s. 2, 3,	8)	7)	
			·	and 4)		(see	
						instructions)	
		4.00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0		0 82, 652, 204	0.000000	50.00
50. 01	05001 OUTPATI ENT SURGERY	0	0		0 3, 793, 528	0.000000	50. 01
51.00	05100 RECOVERY ROOM	0	0		0 16, 151, 657	0.000000	51.00
53.00	05300 ANESTHESI OLOGY	0	0		0 18, 447, 799	0.000000	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 88, 287, 475	0.000000	54.00
54.01	05401 RADI OLOGY-SPECI AL PROCEDURES	0	0		0 12, 732, 253	0.000000	54. 01
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0		0 0	0.000000	55. 00
56.00	05600 RADI OI SOTOPE	0	0		0 10, 679, 671	0.000000	56. 00
60.00	06000 LABORATORY	0	519, 068	519, 0	58 76, 316, 911	0. 006801	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 1, 567, 708	0. 000000	63.00
65.00	06500 RESPIRATORY THERAPY	0	0		0 13, 697, 800	0. 000000	65. 00
66.00	06600 PHYSI CAL THERAPY	0	0		0 26, 059, 110	0. 000000	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0 11, 158, 417	0. 000000	
68.00	06800 SPEECH PATHOLOGY	0	0		0 8, 807, 913	0.000000	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	0		0 26, 818, 703	0.000000	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0 5, 570, 089	0.000000	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 52, 969, 791	0.000000	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 18, 062, 685	0.000000	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	386, 668	386, 60	39, 660, 597	0.009749	73. 00
76.00	03630 ULTRA SOUND	0	0	1	0 13, 649, 936	0. 000000	76. 00
76. 01	03951 PAIN CLINIC	0	0		0 9, 751, 124	0. 000000	76. 01
76. 02	03952 CATH LAB	0	0		0 49, 155, 719	0.000000	76. 02
76. 03	03953 ACTIVITY THERAPEUTIC	0	0		0 3, 118, 083	0.000000	76. 03
76.04	03954 WOUND CARE CENTER	0	0		0 4, 342, 175	0.000000	76. 04
76.05	03340 BARI ATRI C CLI NI C	0	0		0 829, 472	0.000000	76. 05
76.06	03030 HEALTHY LIVING CENTER	0	0		0 0	0.000000	76. 06
76. 07	03950 CV RESOURCE CENTER	0	0		0 0	0.000000	76. 07
76. 08	03955 OTHER ANCILLARY SERVICE COST CENTERS	0	0		0 0	0.000000	76. 08
76. 09	03956 LACTATION CLINIC	0	0		0 0	0.000000	76. 09
76. 10	03957 OTHER ANCILLARY SERVICE COST CENTERS	0	0		0 0	0.000000	76. 10
76. 11	03958 OTHER ANCILLARY SERVICE COST CENTERS	0	0		0 0	0.000000	76. 11
76. 12		0	0		0 1, 459, 859	0.000000	
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0		0 0	0.000000	
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0	0		0 0	0.000000	
	OUTPATIENT SERVICE COST CENTERS						]
91.00	09100 EMERGENCY	0	98, 228	98, 2	28 62, 786, 727	0.001564	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0 9, 303, 915	0. 000000	92.00
200.00	Total (lines 50 through 199)	0	1, 003, 964	1, 003, 9	64 667, 831, 321		200. 00

	Financial Systems TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	FRANCISCAN HEA	Provider CO	CN: 15-0090	In Lie Period:	u of Form CMS-2 Worksheet D	2552-10
THROUG	H COSTS			CCN: 15-T090	From 01/01/2023 To 12/31/2023	Part IV Date/Time Pre 5/30/2024 3:4	
			Title	XVIII	Subprovi der - I RF	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-Through		Pass-Through	
		(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
		7)	10. 00	x col . 10) 11.00	12.00	x col . 12) 13.00	
	ANCILLARY SERVICE COST CENTERS	7.00	10.00	11.00	12.00	13.00	
50.00	05000 OPERATING ROOM	0. 000000	114, 296		0 0	0	50.00
50. 01	05001 OUTPATI ENT SURGERY	0. 000000	9, 089		0 0	0	1
51.00	05100 RECOVERY ROOM	0. 000000	4, 892		0 0	0	51.00
53.00	05300 ANESTHESI OLOGY	0. 000000	9, 158			0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	226, 583		o o	0	
54. 01	05401 RADI OLOGY-SPECI AL PROCEDURES	0. 000000	51, 280		o o	0	
55. 00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	0	1	o o	0	1
56.00	05600 RADI 0I SOTOPE	0. 000000	0		0 0	0	56. 00
60.00	06000 LABORATORY	0. 006801	474, 416	3, 2:	27 0	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	7, 680		0 0	0	63.00
65.00	06500 RESPIRATORY THERAPY	0. 000000	797, 055		0 0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0. 000000	2, 051, 229		0 0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000	1, 906, 691		0 0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0. 000000	881, 297		0	0	
69. 00	06900 ELECTROCARDI OLOGY	0. 000000	30, 506		0	0	
70. 00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	13, 055		0	0	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	418, 268		0	0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000	4, 979	•	0 0	0	
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 009749	734, 760	7, 10		1	73. 00
76.00	03630 ULTRA SOUND	0. 000000	44, 507		0 0	0	
76. 01	03951 PAIN CLINIC	0. 000000	61		0 0	0	76. 01
76. 02 76. 03	03952 CATH LAB	0.000000	52, 456 0		0 0	0	76. 02
76. 03	03953 ACTIVITY THERAPEUTIC 03954 WOUND CARE CENTER	0. 000000 0. 000000	6, 635		0 0	0	
76. 04	03340 BARI ATRI C CLI NI C	0. 000000	49		0 0	0	
76. 06	03030 HEALTHY LIVING CENTER	0. 000000	0		0 0	0	76.06
76. 07	03950 CV RESOURCE CENTER	0. 000000	0		0 0	0	76. 07
76. 08	03955 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000	0		0 0	0	
76. 09	03956 LACTATION CLINIC	0. 000000	0			0	1
76. 10	03957 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000	0			0	
76. 11	03958 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000	0		0 0	0	76. 11
76. 12	03959 ANTI COAGULATI ON CLINIC	0. 000000	0		0 0	0	
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000	0		0 0	0	
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0. 000000	0		0 0	0	
	OUTPATIENT SERVICE COST CENTERS	<u> </u>					
91.00	09100 EMERGENCY	0. 001564	8, 839		14 0	0	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0		0 0	0	92.00
	Total (lines 50 through 199)				04 87		200. 00

			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
·	Ratio From	Services (see	Rei mbursed	Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not	,	
	Part I, col. 9	,	Subject To	Subject To		
			Ded. & Coins.	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. 094675	0	C	0	0	50.00
50. 01   05001   OUTPATI ENT SURGERY	0. 731590	0	C	0	0	50. 01
51.00   05100   RECOVERY ROOM	0. 085415	o	C	0	0	51.00
53. 00   05300   ANESTHESI OLOGY	0. 005160	o	C	0	0	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 086749	o	C	0	0	54.00
54. 01   05401 RADI OLOGY-SPECI AL PROCEDURES	0. 212871	0	Ö	0	0	54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	o	C	0	0	55. 00
56. 00   05600   RADI 0I SOTOPE	0. 106524	o	C	0	0	56.00
60. 00   06000   LABORATORY	0. 138608	o	C	0	0	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRA	•	0	C	0	0	63.00
65. 00 06500 RESPIRATORY THERAPY	0. 297511	0	Ö	0	0	65.00
66. 00   06600   PHYSI CAL THERAPY	0. 251568	o	Ö	0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 092473	0	Ċ		0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 143394	o o	Ö		o o	68. 00
69. 00   06900   ELECTROCARDI OLOGY	0. 081929	-	Ö		o o	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 148449				o o	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PAT		0	Ö		0	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 255306	0			0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 276036	_		225	24	73. 00
76. 00   03630   ULTRA SOUND	0. 100251	0		0	1	76.00
76. 01 03951 PALN CLINIC	0. 229305				0	76. 01
76. 02   03952   CATH LAB	0. 112006		0		0	76. 01
76. 03 03953 ACTIVITY THERAPEUTIC	1. 002728	1			0	76. 02
76. 04   03954   WOUND CARE CENTER	0. 359129				0	76. 04
76. 05   03340 BARI ATRI C CLI NI C	1. 433676				0	76. 05
76. 06 03030 HEALTHY LIVING CENTER	0. 000000	· ·			0	76. 06
76. 07   03950 CV RESOURCE CENTER	0. 000000	1			0	76. 07
76. 08 03955 OTHER ANCILLARY SERVICE COST CE	1	-			0	76. 08
76. 09   03956   LACTATI ON CLI NI C	0. 000000 0. 000000				0	76. 09
76. 10 03957 OTHER ANCILLARY SERVICE COST CE	4				0	76. 10
76. 11 03958 OTHER ANCI LLARY SERVICE COST CE	4				0	76. 10
76. 12 03959 ANTI COAGULATI ON CLINI C	0. 698569				0	76. 11
77. 00 07700 ALLOGENEIC STEM CELL ACQUISITIO	•		0		1	77. 00
78. 00   07700   ALLOGENETC STEM CELL ACQUISITIO	•		0	_	· ·	
OUTPATIENT SERVICE COST CENTERS	0. 000000	U U	U	) 0	0	78.00
91. 00 09100 EMERGENCY	0. 168353	0	C	) 0	0	91. 00
i i	1		0			•
	CAN1 U. 4/3/42	87	0	_		92.00
	rogram	87		225	24	200. 00
201.00 Less PBP Clinic Lab. Services-P	i ogi aiii			)		201. 00
Only Charges 202.00 Net Charges (line 200 - line 20	1)	87	C	225	24	202. 00
202.00   Net Glarges (Trile 200 - Trile 20	'/	0/	1	/ 223	1 24	1202.00

Health Financial Systems	FRANCISCAN HE				u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST		CN: 15-0090 CCN: 15-T090	Peri od: From 01/01/2023 To 12/31/2023	Worksheet D Part V Date/Time Pre	
		Ti tl e	e XVIII	Subprovi der -	5/30/2024 3: 4 PPS	15 pm
	Cos	ste	I	I RF		
Cost Center Description	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.) 6.00	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.) 7.00				
ANCILLARY SERVICE COST CENTERS	0.00	7.00				
SO. 00	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	62 62 62 60 60 60 60 60 60 60 60 60 60 60 60 60				50. 00 50. 01 51. 00 53. 00 54. 00 54. 01 55. 00 66. 00 67. 00 68. 00 67. 00 68. 00 70. 00 71. 00 72. 00 73. 00 76. 01 76. 02 76. 03 76. 04 76. 05 76. 06 76. 07 76. 08 76. 09 76. 10 76. 11 76. 12 77. 00

0

0

62

62

91. 00

92.00

200. 00 201. 00

202. 00

200.00

201.00 202.00

OUTPATIENT SERVICE COST CENTERS
91. 00 09100 EMERGENCY

92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART

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

Net Charges (line 200 - line 201)

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0090 Peri od: Worksheet D From 01/01/2023 Part V Date/Time Prepared: 12/31/2023 5/30/2024 3:45 pm Title XIX Hospi tal Cost Charges Costs Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Ratio From Services (see Rei mbursed Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Part I, col. 9 Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 1. 00 2.00 5. 00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 094675 8, 757, 373 0 50.00 50.01 05001 OUTPATIENT SURGERY 0.731590 665, 555 50.01 05100 RECOVERY ROOM 2, 398, 436 51 00 0.085415 0 51 00 0 53.00 05300 ANESTHESI OLOGY 0.005160 0 2, 636, 448 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.086749 12, 668, 105 0 54.00 773, 325 54.01 05401 RADI OLOGY-SPECI AL PROCEDURES 0.212871 0 54.01 0 05500 RADI OLOGY-THERAPEUTI C 55.00 0.000000 0 0 55.00 56.00 05600 RADI OI SOTOPE 0.106524 659, 444 0 56.00 60.00 06000 LABORATORY 0.138608 9, 450, 108 0 60.00 06300 BLOOD STORING, PROCESSING & TRANS. 63 00 0 465175 111, 188 0 63 00 06500 RESPIRATORY THERAPY 65.00 0.297511 251, 265 0 65.00 06600 PHYSI CAL THERAPY 0. 251568 2, 490, 472 0 66.00 66.00 06700 OCCUPATIONAL THERAPY 0.092473 1, 468, 128 67.00 67.00 0 68.00 06800 SPEECH PATHOLOGY 0.143394 1, 662, 162 0 68 00 69.00 06900 ELECTROCARDI OLOGY 0.081929 0 1, 800, 245 0 69.00 07000 ELECTROENCEPHALOGRAPHY 727, 143 70.00 70.00 0. 148449 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 71.00 0.327634 5.480.891 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72 00 0.255306 687, 053 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0. 276036 1, 814, 791 0 73.00 03630 ULTRA SOUND 76.00 76.00 0.100251 1, 695, 456 0 03951 PAIN CLINIC 76.01 0. 229305 0 1, 642, 000 0 76.01 03952 CATH LAB 0 1, 185, 837 76.02 0.112006 0 76.02 76.03 03953 ACTIVITY THERAPEUTIC 1.002728 0 84, 497 0 76.03 03954 WOUND CARE CENTER 76. 04 0.359129 518, 113 0 76.04 03340 BARIATRIC CLINIC 0 201, 640 76.05 1.433676 0 76.05 03030 HEALTHY LIVING CENTER 0 76.06 0.000000 0 0 76.06 03950 CV RESOURCE CENTER 0.000000 76.07 76.07 0 0 76.08 03955 OTHER ANCILLARY SERVICE COST CENTERS 0.000000 0 0 76.08 76 09 03956 LACTATION CLINIC 0.000000 0 0 0 76.09 03957 OTHER ANCILLARY SERVICE COST CENTERS 76. 10 0.000000 0 0 0 76.10 03958 OTHER ANCILLARY SERVICE COST CENTERS 76. 11 0.000000 0 O 0 0 76. 11 03959 ANTI COAGULATION CLINIC 76.12 0.698569 0 100, 440 76. 12 0 07700 ALLOGENEIC STEM CELL ACQUISITION 77.00 0.000000 0 C 0 77.00 78.00 07800 CAR T-CELL IMMUNOTHERAPY 0.000000 0 78.00 OUTPATIENT SERVICE COST CENTERS 91 00 09100 EMERGENCY 17, 478, 454 91.00 0 168353 0 0 0 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0. 473742 C 1,666,602 0 92.00 0 200.00 Subtotal (see instructions) 79, 075, 171 0 200.00 Less PBP Clinic Lab. Services-Program 201.00 201.00

0

79, 075, 171

0 202.00

0

Only Charges

Net Charges (line 200 - line 201)

202.00

				10 12/31/2023	5/30/2024 3:45 pm
		Ti tl	e XIX	Hospi tal	Cost
	Cos	sts			
Cost Center Description	Cost	Cost			
· ·	Rei mbursed	Rei mbursed			
	Servi ces	Services Not			
	Subject To	Subject To			
	Ded. & Coins.	Ded. & Coins.			
	(see inst.)	(see inst.)			
	6. 00	7. 00			
ANCILLARY SERVICE COST CENTERS					
50.00   05000   OPERATING ROOM	829, 104	0			50.00
50. 01  05001 OUTPATIENT SURGERY	486, 913	0			50. 01
51. 00   05100   RECOVERY ROOM	204, 862	0			51.00
53. 00   05300   ANESTHESI OLOGY	13, 604	0			53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	1, 098, 945	0			54. 00
54. 01   05401   RADI OLOGY-SPECI AL PROCEDURES	164, 618	0			54. 01
55. 00  05500  RADI OLOGY-THERAPEUTI C	0	0			55.00
56. 00   05600   RADI 0I SOTOPE	70, 247	0			56. 00
60. 00   06000   LABORATORY	1, 309, 861	0			60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	51, 722	0			63.00
65. 00  06500 RESPI RATORY THERAPY	74, 754	0			65. 00
66. 00 06600 PHYSI CAL THERAPY	626, 523	0			66. 00
67. 00  06700 OCCUPATI ONAL THERAPY	135, 762	0			67. 00
68. 00   06800   SPEECH PATHOLOGY	238, 344	0			68. 00
69. 00   06900   ELECTROCARDI OLOGY	147, 492	0	l .		69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	107, 944	0			70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 795, 726	0			71. 00
72.00 07200 MPL. DEV. CHARGED TO PATIENTS	175, 409	0			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	500, 948	0			73. 00
76. 00   03630   ULTRA SOUND	169, 971	0	l .		76. 00
76. 01  03951   PAIN CLINIC	376, 519	0			76. 01
76. 02  03952 CATH_LAB	132, 821	0			76. 02
76. 03 03953 ACTIVITY THERAPEUTIC	84, 728	0			76. 03
76. 04 03954 WOUND CARE CENTER	186, 069	0			76. 04
76. 05   03340   BARI ATRI C   CLI NI C	289, 086	0			76. 05
76.06 03030 HEALTHY LIVING CENTER	0	0			76. 06
76. 07 03950 CV RESOURCE CENTER	0	0			76. 07
76. 08 03955 OTHER ANCILLARY SERVICE COST CENTERS	0	0			76. 08
76. 09   03956   LACTATION CLINIC	0	0			76. 09
76. 10 03957 OTHER ANCILLARY SERVICE COST CENTERS	0	0			76. 10
76. 11 03958 OTHER ANCILLARY SERVICE COST CENTERS	0	0			76. 11
76. 12 03959 ANTI COAGULATION CLINIC	70, 164	0			76. 12
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0			77. 00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0			78. 00
OUTPATIENT SERVICE COST CENTERS	1				
91. 00   09100   EMERGENCY	2, 942, 550	0			91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	789, 539	0			92.00
200.00 Subtotal (see instructions)	13, 074, 225	0			200. 00
201.00 Less PBP Clinic Lab. Services-Program	0				201. 00
Only Charges	10.074.005	_			000 00
202.00   Net Charges (line 200 - line 201)	13, 074, 225	0	1		202.00

	Financial Systems	FRANCISCAN HI		CN 15 0000		u of Form CMS-:	2552-10
APPURI	TIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der C	CN: 15-0090	Peri od: From 01/01/2023	Worksheet D Part II	
			Component	CCN: 15-T090	To 12/31/2023	Date/Time Pre 5/30/2024 3:4	pared: 5 pm
			Ti tl	e XIX	Subprovi der - I RF	TEFRA	
	Cost Center Description	Capi tal	Total Charges	Ratio of Cos		Capital Costs	
			(from Wkst. C,	to Charges	Program	(column 3 x	
		(from Wkst. B,		(col. 1 ÷ col	. Charges	column 4)	
		Part II, col.	8)	2)			
		26)					
	ANOLILARY OF BUILDE COOK OF STATERS	1.00	2.00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS	1 100 110					
50. 00	05000 OPERATING ROOM	1, 488, 413				0	
50. 01	05001 OUTPATI ENT SURGERY	387, 916		1		0	
51. 00	05100 RECOVERY ROOM	190, 545				0	
53. 00	05300 ANESTHESI OLOGY	4, 536				0	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	1, 746, 011				0	
54. 01	05401 RADI OLOGY-SPECI AL PROCEDURES	153, 270				0	
55. 00	05500 RADI OLOGY-THERAPEUTI C	0		0.00000		0	
56. 00	05600 RADI OI SOTOPE	221, 609				0	
60.00	06000 LABORATORY	231, 012				2	
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	72, 108				0	63.00
65. 00	06500 RESPI RATORY THERAPY	182, 615				0	65. 00
66. 00	06600 PHYSI CAL THERAPY	131, 462				0	
67. 00	06700 OCCUPATI ONAL THERAPY	22, 785				0	
68. 00	06800 SPEECH PATHOLOGY	82, 417				0	68.00
69. 00	06900 ELECTROCARDI OLOGY	311, 116				0	
70.00	07000 ELECTROENCEPHALOGRAPHY	136, 417				0	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	108, 143				0	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	29, 354		1		0	
73.00	07300 DRUGS CHARGED TO PATIENTS	169, 941		1		0	1
76.00	03630 ULTRA SOUND	165, 937				0	
76. 01	03951 PAIN CLINIC	329, 781				0	
76. 02	03952 CATH LAB	633, 959				0	
76. 03	03953 ACTIVITY THERAPEUTIC	161, 666				0	76. 03
76. 04	03954 WOUND CARE CENTER	171, 114			3.	0	
76. 05	03340 BARI ATRI C CLI NI C	59, 771	1	1		0	1
76. 06	03030 HEALTHY LIVING CENTER	0	· -			0	
76. 07	03950 CV RESOURCE CENTER	0	1			0	
76. 08	03955 OTHER ANCILLARY SERVICE COST CENTERS	0	1			0	76. 08
76. 09	03956 LACTATION CLINIC	0	1			0	
76. 10	03957 OTHER ANCILLARY SERVICE COST CENTERS	0	1	0.0000		0	
76. 11	03958 OTHER ANCILLARY SERVICE COST CENTERS	10,000	,			0	
76. 12	03959 ANTI COAGULATION CLINIC	18, 909				0	
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0				0	
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	1 0	0.00000	0	0	78. 00
91. 00	OUTPATIENT SERVICE COST CENTERS O9100 EMERGENCY	E40 224	42 704 727	0.00905	50 0	0	01 00
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	568, 234 0				0	
92. 00 200. 00		7, 779, 041		1	792		200.00
∠UU. UL	I local (Titles 30 tillough 199)	1, 119, 041	1 001,031,321	1	192	2	1200. U

	Financial Systems	FRANCI SCAN HE	_				u of Form CMS-2	2552-10
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	Provi der CC	CN: 15-0090		riod: om 01/01/2023	Worksheet D Part IV	
THROUG	H COSTS		Component (	CCN: 15-T090	То		Date/Time Pre 5/30/2024 3:4	pared: 5 pm
			Ti tl	e XIX	Sı	ubprovi der  - I RF	TEFRA	•
	Cost Center Description	Non Physician	Nursi ng	Nursi ng		Allied Health	Allied Health	
		Anesthetist	Program	Program		Post-Stepdown		
		Cost	Post-Stepdown Adjustments			Adjustments		
		1.00	2A	2.00		3A	3. 00	
	ANCILLARY SERVICE COST CENTERS	11.00						
50.00	05000 OPERATI NG ROOM	0	0		0	0	0	50.00
50. 01	05001 OUTPATIENT SURGERY	0	0		0	O	0	50. 01
51.00	05100 RECOVERY ROOM	0	0		0	0	0	51.00
53.00	05300 ANESTHESI OLOGY	0	0		0	0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	0	54.00
54. 01	05401 RADI OLOGY-SPECI AL PROCEDURES	0	0		0	0	0	54. 01
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0		0	0	0	55. 00
56.00	05600 RADI 0I SOTOPE	0	0		0	0	0	56. 00
60.00	06000 LABORATORY	0	0		0	0	519, 068	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0	0	0	63. 00
65.00	06500 RESPI RATORY THERAPY	0	0		0	0	0	
66. 00	06600 PHYSI CAL THERAPY	0	0		0	0	0	
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
	06900 ELECTROCARDI OLOGY	0	0		0	0	0	
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0		0	0	0	
	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	0		0	0	0	
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0	0	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	386, 668	
	03630 ULTRA SOUND	0	0		0	0	0	
76. 01	03951 PAIN CLINIC	0	0		0	0	0	1
76. 02 76. 03	03952 CATH LAB 03953 ACTIVITY THERAPEUTIC		0		0	0	0	76. 02 76. 03
76. 03	03954 WOUND CARE CENTER		0		0	0	0	
	03340 BARI ATRI C CLI NI C		0		0	0	0	
	03030 HEALTHY LIVING CENTER	0	0		0	0	0	1
76. 07	03950 CV RESOURCE CENTER	0	0		0	0	0	
	03955 OTHER ANCILLARY SERVICE COST CENTERS	0	0		0	0	0	
76. 09	03956 LACTATION CLINIC	o o	0		0	o	0	
	03957 OTHER ANCILLARY SERVICE COST CENTERS	0	0		0	0	0	
	03958 OTHER ANCILLARY SERVICE COST CENTERS	0	0		0	o	0	
76. 12	03959 ANTI COAGULATION CLINIC	0	0		0	0	0	76. 12
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0		0	0	0	77.00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	O	0		0	0	0	78. 00
	OUTPATIENT SERVICE COST CENTERS	·						
91. 00	09100 EMERGENCY	0	0		0	0	98, 228	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	O			0		0	92.00
,		0			0			

Heal th	Financial Systems	FRANCISCAN HI	FALTH- DYFR		In li <i>e</i>	eu of Form CMS-:	2552-10
APPORT	TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER H COSTS		S Provider Co		Peri od: From 01/01/2023	Worksheet D Part IV	
			Component	CCN: 15-T090	To 12/31/2023	Date/Time Pre 5/30/2024 3:4	
			Ti tl	e XIX	Subprovi der - I RF	TEFRA	у рііі
	Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	'	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
		Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
			4)	col s. 2, 3,	8)	7)	
				and 4)		(see	
						instructions)	
	I	4.00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS				00 (50 00)		
50.00	05000 OPERATI NG ROOM	0			0 82, 652, 204	l .	1
50. 01	05001 OUTPATI ENT SURGERY	0	1		0 3, 793, 528	l .	1
51.00	05100 RECOVERY ROOM	0	0		0 16, 151, 657	0.000000	1
53. 00 54. 00	05300 ANESTHESI OLOGY	0	0		0 18, 447, 799 0 88, 287, 475		
54. 00	05400  RADI OLOGY-DI AGNOSTI C   05401  RADI OLOGY-SPECI AL PROCEDURES	0	0			l .	1
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0		0 12, 732, 253	0. 000000 0. 000000	
56. 00	05600 RADI OI SOTOPE		0		0 10, 679, 671	0.00000	
60.00	06000 LABORATORY	0	1			0.006801	
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	317,000	317,00	0 1, 567, 708	l e	
65. 00	06500 RESPIRATORY THERAPY	0	ĺ		0 13, 697, 800		
66. 00	06600 PHYSI CAL THERAPY	0	0		0 26, 059, 110	0. 000000	
67. 00	06700 OCCUPATI ONAL THERAPY	0	0		0 11, 158, 417	0. 000000	
68. 00	06800 SPEECH PATHOLOGY	0	0		0 8, 807, 913	•	1
69. 00	06900 ELECTROCARDI OLOGY	0	Ö		0 26, 818, 703		
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0 5, 570, 089	0.000000	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 52, 969, 791	0. 000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 18, 062, 685	0.000000	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	386, 668	386, 66	39, 660, 597	0.009749	73. 00
76.00	03630 ULTRA SOUND	0	0		0 13, 649, 936	0. 000000	76. 00
76. 01	03951 PAIN CLINIC	0	0		0 9, 751, 124	0. 000000	76. 01
76. 02	03952  CATH LAB	0	0		0 49, 155, 719	0. 000000	76. 02
76. 03	03953 ACTIVITY THERAPEUTIC	0	0		0 3, 118, 083		
76. 04	03954  WOUND CARE CENTER	0	0		0 4, 342, 175		
76. 05	03340 BARI ATRI C CLI NI C	0	0		0 829, 472	0. 000000	
76. 06	03030 HEALTHY LIVING CENTER	0	0		0	0. 000000	
76. 07	03950 CV RESOURCE CENTER	0			0	0. 000000	
76. 08	03955 OTHER ANCILLARY SERVICE COST CENTERS	0	0		0	0. 000000	
76. 09	03956 LACTATION CLINIC	0	0		0	0.000000	
76. 10	03957 OTHER ANCILLARY SERVICE COST CENTERS	0	0		0	0.000000	
76. 11	03958 OTHER ANCILLARY SERVICE COST CENTERS	0	0		0 1 450 950	0.000000	
76. 12	03959 ANTI COAGULATI ON CLINI C	0	ı		0 1, 459, 859	0.000000	
77. 00 78. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0			0 0	0. 000000 0. 000000	1
70.00	O7800   CAR T-CELL IMMUNOTHERAPY   OUTPATIENT SERVICE COST CENTERS		<u> </u>		0	0.00000	10.00
91. 00	09100 EMERGENCY	0	98, 228	98, 22	8 62, 786, 727	0. 001564	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0		70, 22	0 9, 303, 915		
200.00	,	0		1, 003, 96		l	200. 00
_00.00	1.5ta. (11165 55 thi bugh 177)	1	1,000,704	1, 000, 70	007,001,021	ı	1230.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASTHROUGH COSTS  Cost Center Description  Cost Center Description  Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7) 9.00  ANCILLARY SERVICE COST CENTERS  50.00   05000  OPERATING ROOM   0.000000 50.01   05001  OUTPATIENT SURGERY   0.000000	Component  Titl  Inpatient Program Charges  10.00	CN: 15-0090 CCN: 15-T090 e XIX  Inpatient Program Pass-Through Costs (col. x col. 10) 11.00		Worksheet D Part IV Date/Time Pre 5/30/2024 3:4 TEFRA  Outpatient Program Pass-Through Costs (col. 9 x col. 12)	pared: 5 pm
Ratio of Cost to Charges (col . 6 ÷ col . 7)   9.00	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9	5 pm
Ratio of Cost to Charges (col . 6 ÷ col . 7)   9.00	Program Charges	Program Pass-Through Costs (col. x col. 10)	Outpatient Program Charges	Program Pass-Through Costs (col. 9	
to Charges (col . 6 ÷ col . 7)	Charges 10.00	Pass-Through Costs (col. x col. 10)	n Charges 8	Pass-Through Costs (col. 9	
(col . 6 ÷ col . 7)   9.00	10.00	Costs (col. x col. 10)	8	Costs (col. 9	
7) 9.00  ANCI LLARY SERVI CE COST CENTERS  50. 00 05000 OPERATI NG ROOM 0.000000		x col. 10)		•	
9. 00  ANCI LLARY SERVI CE COST CENTERS  50. 00   05000   0PERATI NG ROOM   0. 0000000			12.00	v col 12)	
ANCI LLARY SERVICE COST CENTERS		11.00	12 00		
50. 00 05000 OPERATING ROOM 0. 000000	) C		12.00	13. 00	
	)  C				
50 01 05001 0HTDATI ENT SUDGEDV	1		0	0	50. 00
	1		0	0	50. 01
51. 00   05100   RECOVERY ROOM	) c	)	0 0	0	51. 00
53. 00   05300   ANESTHESI OLOGY	) c		0	0	53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C 0. 000000	) c		0	0	54.00
54. 01   05401   RADI OLOGY-SPECI AL PROCEDURES	) c	)	0 0	0	54. 01
55. 00   05500   RADI OLOGY-THERAPEUTI C 0. 000000	) c	)	0 0	0	55. 00
56. 00   05600   RADI 0I SOTOPE   0. 000000	) c		0 0	0	56. 00
60. 00   06000   LABORATORY	792	2	5 0	0	60.00
63. 00   06300   BLOOD STORING, PROCESSING & TRANS.   0. 000000	) c		0 0	0	63. 00
65. 00   06500   RESPIRATORY THERAPY	) c		0 0	0	65. 00
66. 00   06600   PHYSI CAL THERAPY	) c		0 0	0	66. 00
67. 00   06700   OCCUPATI ONAL THERAPY 0. 000000	ol c		0 0	0	67. 00
68. 00   06800   SPEECH PATHOLOGY	ol c		0 0	0	68. 00
69. 00   06900   ELECTROCARDI OLOGY	ol c		0 0	0	69. 00
70. 00   07000   ELECTROENCEPHALOGRAPHY	ol c		0 0	0	70. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0. 000000	ol c		0 0	0	71. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS 0. 000000	ol c		0 0	0	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 009749	ol c		0 0	0	73. 00
76. 00 03630 ULTRA SOUND 0. 000000	ol c		0 0	0	76. 00
76. 01   03951   PALN CLINIC 0. 000000	ol c		0 0	0	76. 01
76. 02 03952 CATH LAB 0. 000000	ol c		0 0	0	76. 02
76. 03   03953   ACTIVITY THERAPEUTIC 0. 000000	ol c		0 0	0	76. 03
76. 04   03954   WOUND CARE CENTER 0. 000000	) c		0 0	0	76. 04
76. 05   03340   BARI ATRI C CLI NI C 0. 000000	ol c		0 0	0	76. 05
76. 06   03030   HEALTHY LIVING CENTER	) c		0 0	0	76. 06
76. 07   03950   CV RESOURCE CENTER   0. 000000	ol c		0 0	0	76. 07
76.08 03955 OTHER ANCILLARY SERVICE COST CENTERS 0.000000			0 0	0	76. 08
76. 09 03956 LACTATION CLINIC 0. 000000			0 0	0	76. 09
76. 10 03957 OTHER ANCILLARY SERVICE COST CENTERS 0. 000000			0 0	0	76. 10
76. 11 03958 OTHER ANCILLARY SERVICE COST CENTERS 0. 000000	1		0 0	0	76. 11
76. 12   03959   ANTI COAGULATI ON CLINI C   0. 000000	1		0 0	0	76. 12
77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION 0. 000000	l .		0 0	0	77. 00
78. 00   07800   CAR T-CELL   IMMUNOTHERAPY   0. 000000			0 0	0	
OUTPATIENT SERVICE COST CENTERS		•			1
91. 00 09100 EMERGENCY 0. 001564	l C		0 0	0	91. 00
92. 00   09200   0BSERVATI ON   BEDS   (NON-DI STINCT   PART   0. 000000	1		0 0	0	92.00
200.00 Total (lines 50 through 199)	792	2	5 0	0	200. 00

			11 (1	e viv	I RF	ILIKA	
				Charges	INI	Costs	
	Cost Center Description	Cost to Chargo	PPS Reimbursed		Cost	PPS Services	
	cost center bescription	Ratio From	Services (see	Rei mbursed	Rei mbursed	(see inst.)	
		Worksheet C,	,	Servi ces	Services Not	(See Hist.)	
			inst.)				
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins.	Ded. & Coins.		
		4.00	0.00	(see inst.)	(see inst.)	5.00	
	ANOLLI ADV. CEDVI OF COCT. CENTERS	1. 00	2. 00	3. 00	4. 00	5. 00	
FO 00	ANCILLARY SERVICE COST CENTERS	0.004/75	1 0	1	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		F0 00
50.00	05000 OPERATING ROOM	0. 094675					50.00
50. 01	05001 OUTPATI ENT SURGERY	0. 731590		1		-	50. 01
51.00	05100 RECOVERY ROOM	0. 085415	0	,	1	0	51. 00
53. 00	05300 ANESTHESI OLOGY	0. 005160	0	(	-	0	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0. 086749	0	1	-		54. 00
54. 01	05401 RADI OLOGY-SPECI AL PROCEDURES	0. 212871	0	(	-	0	54. 01
55. 00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	0	(	0	0	55. 00
56.00	05600 RADI OI SOTOPE	0. 106524	0	(	0	0	56. 00
60.00	06000 LABORATORY	0. 138608	0	(	0	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 465175	0	(	0	0	63. 00
65.00	06500 RESPIRATORY THERAPY	0. 297511	0	(	0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0. 251568	0		0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0. 092473	l o	(	0	o	67. 00
68. 00	06800 SPEECH PATHOLOGY	0. 143394	0		0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 081929	0		0	Ö	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0. 148449	0		-		70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 327634	1		-	l o	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 255306					72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 276036			1	0	73.00
76. 00	03630 ULTRA SOUND	0. 276036			-	_	76.00
	1	· ·	0			_	•
76. 01	03951 PAIN CLINIC	0. 229305	0	(		0	76. 01
76. 02	03952 CATH LAB	0. 112006	0			-	76. 02
76. 03	03953 ACTIVITY THERAPEUTIC	1. 002728	0		-	_	76. 03
76. 04	03954 WOUND CARE CENTER	0. 359129	0	1		_	76. 04
76. 05	03340 BARI ATRI C CLI NI C	1. 433676	0	(	-	0	76. 05
76. 06	03030 HEALTHY LIVING CENTER	0. 000000	0	(	-	0	76. 06
76. 07	03950 CV RESOURCE CENTER	0. 000000	0	(	-	0	76. 07
76. 08	03955 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000	0	(	-	0	76. 08
76. 09	03956 LACTATION CLINIC	0. 000000	0	(	0	0	76. 09
76. 10	03957 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000	0	(	0	0	76. 10
76. 11	03958 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000	0	(	0	0	76. 11
76. 12	03959 ANTICOAGULATION CLINIC	0. 698569	0	(	0	0	76. 12
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000	0	(	0	0	77. 00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0. 000000	0	(	0	0	78. 00
	OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	0. 168353	0	(	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 473742	0	(	0	0	92.00
200.00			0		0	0	200.00
201.00	,				o o		201.00
	Only Charges						
202.00			0	(	0	0	202. 00

Health Financial Systems	FRANCISCAN HE	EALTH- DYER		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST		CN: 15-0090 CCN: 15-T090	Peri od: From 01/01/2023 To 12/31/2023	Worksheet D Part V Date/Time Pre 5/30/2024 3:4	epared:
		Ti tl	e XIX	Subprovi der - I RF	TEFRA	
Cost Center Description	Cost Rei mbursed Servi ces Subj ect To Ded. & Coins. (see inst.) 6.00	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.) 7.00				
ANCILLARY SERVICE COST CENTERS  50. 00   05000   OPERATING ROOM   50. 01   05001   OSDOOT   OSTOOT   51. 00   05100   RECOVERY ROOM   53. 00   05300   ANESTHESI OLOGY   54. 00   05400   RADI OLOGY-DI AGNOSTI C   54. 01   05401   RADI OLOGY-SPECI AL PROCEDURES   55. 00   05500   RADI OLOGY-THERAPEUTI C   60. 00   06600   RADI OLOGY-THERAPEUTI C   61. 00   06500   RADI OLOGY-THERAPEUTI C   62. 00   06500   RESPIRATORY   63. 00   06300   BLOOD STORING, PROCESSING & TRANS.   64. 00   06600   PHYSI CAL THERAPY   65. 00   06600   PHYSI CAL THERAPY   66. 00   06600   OCCUPATIONAL THERAPY   67. 00   06600   OCCUPATIONAL THERAPY   68. 00   06800   SPEECH PATHOLOGY   69. 00   06900   ELECTROCARDI OLOGY   70. 00   07000   ELECTROENCEPHALOGRAPHY   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENT   72. 00   07200   IMPL. DEV. CHARGED TO PATIENT   73. 00   07300   DRUGS CHARGED TO PATIENTS   74. 01   03951   PAIN CLINI C   75. 02   03952   CATH LAB   76. 03   03953   ACTIVITY THERAPEUTI C   76. 04   03954   WOUND CARE CENTER   76. 05   03340   BARI ATRI C CLINI C   76. 06   03956   CV RESOURCE CENTER   76. 07   03956   CV RESOURCE CENTER   76. 09   03956   CV RESOURCE CENTER   76. 01   03957   OTHER ANCILLARY SERVICE COST CENTERS   76. 11   03958   OTHER ANCILLARY SERVICE COST CENTERS   76. 12   03959   ANTI COAGULATI ON CLINI C   77. 00   07700   ALLOGENEI C STEM CELL ACQUI SI TI ON   78. 00   OTHER ANCILLARY SERVICE COST CENTERS   76. 11   ONTO   ALLOGENEI C STEM CELL ACQUI SI TI ON   77. 00   OTHER ANCILLARY SERVICE COST CENTERS   76. 11   ONTO   ALLOGENEI C STEM CELL ACQUI SI TI ON   77. 00   OTHER ANCILLARY SERVICE COST CENTERS   76. 11   ONTO   ALLOGENEI C STEM CELL ACQUI SI TI ON   77. 00   OTHER ANCILLARY SERVICE COST CENTERS   76. 11   ONTO   ALLOGENEI C STEM CELL ACQUI SI TI ON   77. 00   OTHER ANCILLARY SERVICE COST CENTERS   76. 11   ONTO   ALLOGENEI C STEM CELL ACQUI SI TI ON   77. 00   OTHER ANCILLARY SERVICE COST CENTERS   76. 11   ONTO   ALLOGENEI C STEM CELL ACQUI SI TI ON   77. 00   OTHER ANCILLARY SER	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				50. 00 50. 00 50. 01 51. 00 53. 00 54. 01 55. 00 66. 00 66. 00 67. 00 68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 76. 01 76. 02 76. 03 76. 04 76. 05 76. 06 76. 07 76. 08 76. 09 76. 10 76. 10 76. 11 76. 12 77. 00 78. 00

0

0

0

0

91. 00

92.00

200. 00 201. 00

202. 00

200.00

201.00

202.00

OUTPATIENT SERVICE COST CENTERS
91. 00 09100 EMERGENCY

Only Charges

92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART

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

Net Charges (line 200 - line 201)

Health Financial Systems FRANCISCAN HEALTH- DYER			YER	In Lie	u of Form CMS-2	2552-10		
COMPUT	TATION OF INPATIENT OPERATING COST	Prov	ider CCN: 15-0090	Peri od:	Worksheet D-1			
				From 01/01/2023				
				To 12/31/2023	Date/Time Pre			
			TI . I		5/30/2024 3: 4	5 pm		
			Title XVIII	Hospi tal	PPS			
	Cost Center Description							
	_				1. 00			
	PART I - ALL PROVIDER COMPONENTS							
	I NPATI ENT DAYS							
1.00	Inpatient days (including private room days an	nd swing-bed days, exc	cluding newborn)		27, 557	1. 00		
2.00	Inpatient days (including private room days, e	excluding swing-bed ar	nd newborn days)		27, 557	2. 00		
3.00	Private room days (excluding swing-bed and obs	servation bed days). I	f vou have only pr	ivate room davs.	do 0	3. 00		
	not complete this line.	<i>3</i> ,	3	, , , , , , , , , , , , , , , , , , ,				
4.00	Semi-private room days (excluding swing-bed an	nd observation bed dav	vs)		24, 760	4. 00		
5. 00	Total swing-bed SNF type inpatient days (inclu			r 31 of the cost	0	5. 00		
0.00	reporting period	anng private reem dag	, e, e eag.: 200020	. 0. 0 0001	Ü	0.00		
6. 00	Total swing-bed SNF type inpatient days (inclu	iding private room day	vs) after December	31 of the cost	0	6. 00		
0.00	Total Swing-bed Swi type Theatrent days (There		y3) arter becember	or or the cost	0	0.00		

Health Financial Systems COMPUTATION OF INPATIENT OPERATING COST	FRANCI SCAN HI	EALTH- DYER Provi der CCN:		eri od:	of Form CMS-2 Worksheet D-1	2552-10		
			Fi Ti	rom 01/01/2023 o 12/31/2023	Date/Time Pre 5/30/2024 3:4			
		Title X		Hospi tal	PPS			
Cost Center Description	Total	Total A Inpatient DaysDi	Average Per em (col 1 ÷		Program Cost col. 3 x col.			
	impatrent oost	,	col . 2)		4)			
10.00	1.00	2. 00	3. 00	4. 00	5. 00	10.00		
42.00 NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	0	0. 00	0	0	42. 00		
43. 00 INTENSIVE CARE UNIT	6, 001, 644	2, 392	2, 509. 05	837	2, 100, 075	43. 00		
44. 00 CORONARY CARE UNIT	0	0	0. 00	0	0	44. 00		
45.00 BURN INTENSIVE CARE UNIT 46.00 SURGICAL INTENSIVE CARE UNIT	0	0	0. 00	0	0	45. 00 46. 00		
47. 00 NEONATAL INTENSIVE CARE UNIT	1, 221, 017	350	3, 488. 62	o	0	1		
Cost Center Description								
48.00 Program inpatient ancillary service cost (Wk	at D.2 aal 2	line 200)			1. 00 15, 660, 439	40.00		
48.00 Program inpatient ancillary service cost (Wk 48.01 Program inpatient cellular therapy acquisiti			I. line 10. (	column 1)	15, 660, 439	48. 00 48. 01		
49.00 Total Program inpatient costs (sum of lines				.,	28, 933, 291	•		
PASS THROUGH COST ADJUSTMENTS					200 17/			
50.00 Pass through costs applicable to Program inp	atient routine	services (Trom Wi	KST. D, SUM (	or Parts I and	820, 476	50. 00		
51.00 Pass through costs applicable to Program inp	atient ancillar	y services (from	Wkst. D, sur	n of Parts II ar	nd 1, 119, 651	51. 00		
52.00 Total Program excludable cost (sum of lines					1, 940, 127	52. 00		
53.00 Total Program inpatient operating cost exclued education costs (line 49 minus line 52)	ding capital re	lated, non-physic	cian anesthe	tist, and medi¢a	al 26, 993, 164	53. 00		
TARGET AMOUNT AND LIMIT COMPUTATION								
54.00 Program discharges					0	54. 00		
55.00 Target amount per discharge					0.00	1		
55.01 Permanent adjustment amount per discharge 55.02 Adjustment amount per discharge (contractor	use only)				0. 00 0. 00	ı		
56.00 Target amount (line 54 x sum of lines 55, 55					0.00	56. 00		
57.00 Difference between adjusted inpatient operat	ing cost and ta	rget amount (line	e 56 minus li	ne 53)	0	57. 00		
58.00 Bonus payment (see instructions)	or line EE from	the cost report	ing ported of	ndi ng 1004	0.00	58. 00 59. 00		
59.00 Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)								
60.00 Expected costs (lesser of line 53 ÷ line 54,	0.00	60. 00						
61.00 Continuous improvement bonus payment (if lin 55.01, or line 59, or line 60, enter the les	0	61. 00						
are less than expected costs (lines 54 x 60) zero. (see instructions)	, OF 1 % OF THE	target amount (	iine so), ou	ier wi se enter				
62.00 Relief payment (see instructions)								
63.00 Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instru	ctions)			0	63. 00		
64.00 Medicare swing-bed SNF inpatient routine cos	ts through Dece	mber 31 of the co	ost reporting	g period (See	0	64. 00		
instructions)(title XVIII only) 65.00 Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the cos	t reporting (	period (See	0	65. 00		
instructions)(title XVIII only)					0			
see instructions	•	,	•	,	O	66. 00		
67.00 Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period							
68.00 Title V or XIX swing-bed NF inpatient routin	00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line							
69.00 Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N			,		0	69. 00		
70.00 Skilled nursing facility/other nursing facil			t (line 37)			70.00		
71.00 Adjusted general inpatient routine service of 72.00 Program routine service cost (line 9 x line	,	ine 70 ÷ line 2)				71. 00 72. 00		
73. 00 Medically necessary private room cost applic		(line 14 x line	35)			73.00		
74.00 Total Program general inpatient routine serv	•					74. 00		
75.00 Capital-related cost allocated to inpatient line 45)	routine service	costs (from Worl	ksheet B, Pai	rt II, column 26	b,	75. 00		
76.00 Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 00		
77.00 Program capital-related costs (line 9 x line						77. 00		
78.00 Inpatient routine service cost (line 74 minu		الملمومون عمل أربوت				78.00		
79.00 Aggregate charges to beneficiaries for exces 80.00 Total Program routine service costs for comp		*.	line 78 minu	s line 79)		79. 00 80. 00		
81.00 Inpatient routine service cost per diem limi	tati on	·		- /		81. 00		
82.00 Inpatient routine service cost limitation (I		•				82.00		
83.00 Reasonable inpatient routine service costs ( 84.00 Program inpatient ancillary services (see in		15)				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		
PART IV - COMPUTATION OF OBSERVATION BED PAS 87.00 Total observation bed days (see instructions					2, 797	87. 00		
88.00 Adjusted general inpatient routine cost per	diem (line 27 ÷				1, 575. 85	88. 00		
89.00 Observation bed cost (line 87 x line 88) (se	e instructions)				4, 407, 652	89. 00		

Health Financial Systems FRANCISCAN HEALTH			TH- DYER In Lieu			2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2023 To 12/31/2023	Date/Time Prep 5/30/2024 3:49	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (	COST					
90.00 Capital-related cost	2, 671, 724	43, 425, 611	0. 06152	4, 407, 652	271, 176	90.00
91.00 Nursing Program cost	0	43, 425, 611	0.00000	0 4, 407, 652	0	91.00
92.00 Allied health cost	0	43, 425, 611	0.00000	0 4, 407, 652	0	92.00
93.00 All other Medical Education	0	43, 425, 611	0. 00000	0 4, 407, 652	0	93. 00

Health Financial Systems	FRANCISCAN HEALTH- DYER	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0090	Peri od: From 01/01/2023	Worksheet D-1
	Component CCN: 15-T090	To 12/31/2023	Date/Time Prepared: 5/30/2024 3:45 pm
	Title XVIII	Subprovider -	PPS

		litle XVIII	Subprovider -	PPS	
	Cost Center Description		TKI		
				1. 00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days	s excluding newborn)		3, 964	1. 00
2. 00	Inpatient days (including private room days, excluding swing-			3, 964	2. 00
3.00	Private room days (excluding swing-bed and observation bed day		ivate room days, d	lo 0	3. 00
	not complete this line.				
4.00	Semi-private room days (excluding swing-bed and observation be		. 21 -6 +6	3, 964	4. 00
5.00	Total swing-bed SNF type inpatient days (including private roof reporting period	om days) through becembe	1 31 OF the Cost	0	5. 00
6.00	Total swing-bed SNF type inpatient days (including private ro	om days) after December	31 of the cost	0	6. 00
	reporting period (if calendar year, enter 0 on this line)	-			
7.00	Total swing-bed NF type inpatient days (including private room	m days) through December	31 of the cost	0	7. 00
8. 00	reporting period Total swing-bed NF type inpatient days (including private room	m days) after December 2	1 of the cost	0	8. 00
8.00	reporting period (if calendar year, enter 0 on this line)	ii days) ai tei beceilibei 3	i or the cost	U	8.00
9.00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	2, 694	9. 00
	newborn days) (see instructions)				
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or	nly (including private r	oom days) through	0	10. 00
11. 00	December 31 of the cost reporting period (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII on	alv (including private r	nom days) after	0	11. 00
	December 31 of the cost reporting period (if calendar year, en		oom dayo, arror	Ü	
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX		e room days)	0	12. 00
12.00	through December 31 of the cost reporting period	/ /:			12.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX December 31 of the cost reporting period (if calendar year, en		e room days) arter	. 0	13. 00
14. 00	Medically necessary private room days applicable to the Progra	am (excluding swing-bed	davs)	0	14. 00
15. 00	Total nursery days (title V or XIX only)			0	15. 00
16. 00	Nursery days (title V or XIX only)			0	16. 00
47.00	SWING BED ADJUSTMENT		6.11	0.00	47.00
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through December 31 o	r 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 reporting	0.00	18. 00
	peri od "		'	•	
19. 00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost reportin	ig 0.00	19. 00
20. 00	period Medicaid rate for swing-bed NF services applicable to services	after December 31 of t	he cost reporting	0.00	20. 00
20.00	period	s arter becember 31 or t	ne cost reporting	0.00	20.00
21. 00	Total general inpatient routine service cost (see instructions			4, 555, 491	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December	er 31 of the cost report	ing period (line 5	0	22. 00
23. 00	x line 17) Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	a period (line 6)	. 0	23. 00
23.00	line 18)	31 of the cost reportin	g period (Title of	. 0	23.00
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reporti	ng period (line 🕇	x 0	24. 00
	line 19)				05.00
25. 00	Swing-bed cost applicable to NF type services after December 3 line 20)	31 of the cost reporting	period (line 8 x	0	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)		4, 555, 491	27. 00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
	General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges)	d and observation bed ch	arges)	0	28. 00
29. 00 30. 00	Semi - pri vate 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	32. 00
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	•
34.00	Average per diem private room charge differential (line 32 mil	, ,	tions)	0.00	•
35. 00 36. 00	Average per diem private room cost differential (line 34 x line Private room cost differential adjustment (line 3 x line 35)	ne 31)		0.00	35. 00 36. 00
37. 00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line 2	-	37. 00
	minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	ICTAFAITO			
20 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU			1 140 22	20 00
38. 00 39. 00	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line			1, 149. 22 3, 095, 999	
40. 00	Medically necessary private room cost applicable to the Progra			0, 0, 0, 7, 7	
41.00	Total Program general inpatient routine service cost (line 39	+ line 40)		3, 095, 999	41. 00

	Financial Systems ATION OF INPATIENT OPERATING COST	FRANCISCAN HEAL	Provi der CCN: 15-0090	Peri od: From 01/01/2023	u of Form CMS-: Worksheet D-1	
			Component CCN: 15-T090	To 12/31/2023	Date/Time Pre 5/30/2024 3:4	
			Title XVIII	Subprovi der  - I RF	PPS	
	Cost Center Description	Total Inpatient CostIn	Total Average Per patient Days Diem (col. 1 col. 2)	÷	Program Cost (col. 3 x col. 4)	
42. 00	NURSERY (title V & XIX only)	1.00	2.00 3.00	4.00	5. 00	42.00
43. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	ol	0 0.0	ool ol	0	43.00
	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT	0	0 0.0	00	0	
46. 00	SURGICAL INTENSIVE CARE UNIT				_	46.00
47. 00	NEONATAL INTENSIVE CARE UNIT  Cost Center Description	0	0 0.1	0 0	0	47. 00
48. 00	Program inpatient ancillary service cost (Wks	st D-3 col 3	Line 200)		1. 00 1, 533, 544	48. 00
48. 01	Program inpatient cellular therapy acquisition	on cost (Workshee	t D-6, Part III, line 10,	column 1)	0	48. 0
49. 00	Total Program inpatient costs (sum of lines 4 PASS THROUGH COST ADJUSTMENTS	11 through 48.01)	(see instructions)		4, 629, 543	49. 0
50. 00	Pass through costs applicable to Program inpa	atient routine se	rvices (from Wkst. D, sur	n of Parts I and	144, 910	50.00
51. 00	III) Pass through costs applicable to Program inpa IV)	atient ancillary	services (from Wkst. D, s	sum of Parts II a	nd 59, 700	51.00
52. 00 53. 00	Total Program excludable cost (sum of lines 5 Total Program inpatient operating cost exclud		tod non nhysician anostl	notist and modic	204, 610 al 4, 424, 933	1
33. 00	education costs (line 49 minus line 52)			letist, and medic	4, 424, 755	33.00
54. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges				0	54.00
55. 00 55. 01	Target amount per discharge Permanent adjustment amount per discharge				0. 00 0. 00	
	Adjustment amount per discharge (contractor u	ıse only)			0.00	
	Target amount (line 54 x sum of lines 55, 55.		-+	11 52)	0	
57. 00 58. 00	Difference between adjusted inpatient operati Bonus payment (see instructions)	ng cost and targ	et amount (line 56 minus	line 53)	0	
59. 00	Trended costs (lesser of line 53 ÷ line 54, c	or line 55 from t	he cost reporting period	endi ng 1996,	0.00	
60. 00	updated and compounded by the market basket) Expected costs (lesser of line 53 ÷ line 54, market basket)	or line 55 from	prior year cost report, u	updated by the	0. 00	60.00
61. 00	Continuous improvement bonus payment (if line $55.01$ , or line $59$ , or line $60$ , enter the less are less than expected costs (lines $54 \times 60$ ),	ser of 50% of the	amount by which operation	ng costs (line 53	0	61.00
62. 00	zero. (see instructions) Relief payment (see instructions)				0	62. 00
63. 00	Allowable Inpatient cost plus incentive payme PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instruct	i ons)		0	63.00
64. 00	Medicare swing-bed SNF inpatient routine cost instructions)(title XVIII only)	s through Decemb	er 31 of the cost reporti	ng period (See	0	64. 00
65. 00	Medicare swing-bed SNF inpatient routine cost	s after December	31 of the cost reporting	g period (See	0	65. 00
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routir	ne costs (line 64	plus line 65)(title XVI	I only); for CAH	, 0	66. 00
67. 00	see instructions Title V or XIX swing-bed NF inpatient routine	e costs through D	ecember 31 of the cost re	eporting period	0	67. 00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routine 13 x line 20)	e costs after Dec	ember 31 of the cost repo	orting period (li	ne 0	68. 00
	Total title V or XIX swing-bed NF inpatient r PART III - SKILLED NURSING FACILITY, OTHER NU	RSING FACILITY, A	AND ICF/IID ONLY		0	69. 00
	Skilled nursing facility/other nursing facili					70.00
	Adjusted general inpatient routine service co Program routine service cost (line 9 x line 7		e /U ÷ line 2)			71. 00
73. 00	Medically necessary private room cost applica	able to Program (				73. 0
74. 00 75. 00	Total Program general inpatient routine servi Capital-related cost allocated to inpatient r			Part II column 1	6	74. 00 75. 00
	line 45) Per diem capital-related costs (line 75 ÷ lir		usts (11 om worksheet B, 1	-art II, Corumii 2	0,	76. 00
	Program capital related costs (line 9 x line					77. 00
	Inpatient routine service cost (line 74 minus		ui dan maganda)			78. 0
	Aggregate charges to beneficiaries for excess Total Program routine service costs for compa			nus line 79)		79. 00 80. 00
31. 00	Inpatient routine service cost per diem limit	ati on	•	<i>'</i>		81.0
32. 00 33. 00	Inpatient routine service cost limitation (li					82. 00 83. 00
	Reasonable inpatient routine service costs (s Program inpatient ancillary services (see ins					84.00
85. 00	Utilization review - physician compensation (	(see instructions				85.00
36. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		ugn 85)			86.00
37. 00	Total observation bed days (see instructions)				0	87. 00
	Adjusted general inpatient routine cost per o		ine 2)		0.00	88. 0

Health Financial Systems	FRANCI SCAN HI	EALTH- DYER		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Peri od:	Worksheet D-1	
		Component (	CCN: 15-T090	From 01/01/2023 To 12/31/2023		
		Title	XVIII	Subprovi der -	PPS	
				I RF		
Cost Center Description						
					1.00	
89.00 Observation bed cost (line 87 x line 88) (se	e instructions)				0	89. 00
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	213, 206	4, 555, 491	0. 04680	0	0	90.00
91.00 Nursing Program cost	0	4, 555, 491	0.00000	0 0	0	91.00
92.00 Allied health cost	0	4, 555, 491	0. 00000	0	0	92.00
93.00 All other Medical Education	0	4, 555, 491	0. 00000	0 0	0	93. 00

Heal th	Financial Systems	FRANCISCAN HEAL	TH- DYER	In Lie	u of Form CMS-	<u>2552-10</u>
COMPUT	ATION OF INPATIENT OPERATING COST		Provider CCN: 15-0090	Peri od:	Worksheet D-1	
				From 01/01/2023 To 12/31/2023	Date/Time Pre 5/30/2024 3:4	
			Title XIX	Hospi tal	Cost	о рііі
	Cost Center Description					
	<u> </u>				1. 00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS					
1. 00	Inpatient days (including private room days	s and swing had day	s oveluding nowborn)		27. 557	1.00
2.00	Inpatient days (including private room days				27, 557 27, 557	
3. 00	Private room days (excluding swing-bed and			ivate room days		1
0.00	not complete this line.	oboo. rati on bod da	ус) уса пате ст. у р.	. vato . com dayo,	uo 0	0.00
4.00	Semi-private room days (excluding swing-bed	d and observation b	ed days)		24, 760	4. 00
5.00	Total swing-bed SNF type inpatient days (ir	ncluding private ro	om days) through Decembe	r 31 of the cost	0	5. 00
	reporting period					
6. 00	Total swing-bed SNF type inpatient days (ir		om days) after December	31 of the cost	0	6. 00
7.00	reporting period (if calendar year, enter (			21 -6	0	7 00
7. 00	Total swing-bed NF type inpatient days (increporting period	ciuding private roo	m days) through December	31 of the cost	0	7. 00
8. 00	Teporting period  Total swing-bed NF type inpatient days (inc	cludina private roo	m days) after December 3	1 of the cost	0	8.00
0.00	reporting period (if calendar year, enter (		iii days) al tel becembel 3	To the cost	O	0.00
9.00	Total inpatient days including private room		o the Program (excluding	swing-bed and	303	9. 00
	newborn days) (see instructions)					
10.00						10.00
	December 31 of the cost reporting period (see instructions)					
11. 00						11. 00
12.00	December 31 of the cost reporting period (if calendar year, enter 0 on this line)				0	10.00
12. 00	OO Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period					12. 00
13. 00	Swing-bed NF type inpatient days applicable		Y only (including privat	e room days) afte	r 0	13. 00
10.00	December 31 of the cost reporting period (i	if calendar vear, e	nter 0 on this line)	c room days) area		10.00
14.00	Medically necessary private room days appli	icable to the Progr	am (excluding swing-bed	days)	0	14. 00
15. 00	Total nursery days (title V or XIX only)				704	15. 00
16. 00	Nursery days (title V or XIX only)				558	16. 00
	SWING BED ADJUSTMENT					
17. 00	Medicare rate for swing-bed SNF services ap	pplicable to servic	es through December 31 o	f the cost	0. 00	17. 00
10.00	reporting period		<del></del>	46	- 0.00	10.00
18. 00	Medicare rate for swing-bed SNF services apperiod	ppircable to servic	es after December 31 of	the cost reportin	g 0.00	18. 00
19. 00	Medicaid rate for swing-bed NF services app	nlicable to service	s through December 31 of	the cost reporti	ng 0.00	19. 00
17.00	peri od	pricable to service	3 through becember 31 or	the cost reporti	ng 0.00	17.00
20.00	Medicald rate for swing-bed NF services app	plicable to service	s after December 31 of t	he cost reporting	0.00	20. 00
	peri od			· Í		
21. 00	Total general inpatient routine service cos				43, 425, 611	21. 00
22. 00	Swing-bed cost applicable to SNF type servi	ices through Decemb	er 31 of the cost report	ing period (line	5 0	22. 00
	x line 17)					
23. 00	Swing-bed cost applicable to SNF type servi	ices after December	31 of the cost reportin	g period (line 6	x 0	23. 00
24. 00	line 18) Swing-bed cost applicable to NF type servio	cas through Dacombo	r 31 of the cost reporti	ng period (line 7	x 0	24. 00
Z4. UU	line 19)	ccs through becellibe	i 31 of the cost reporti	ing period (Title /	^ 0	24.00
25. 00	Swing-bed cost applicable to NF type service	ces after December	31 of the cost reporting	period (line 8 x	0	25. 00
	line 20)		2.1.2	` ` ` ` ` `		
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)		43, 425, 611	27. 00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			, I		
28. 00	General inpatient routine service charges (	(excluding swing-be	a and observation bed ch	arges)	0	28. 00

	Cost Center Description	1.00	
	DADT I ALL DOWN DED COMPONENTS	1. 00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS		
1. 00	Inpatient days (including private room days and swing-bed days, excluding newborn)	27, 557	1. 00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	27, 557	2. 00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days,		3. 00
0.00	not complete this line.		0.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	24, 760	4. 00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	0	5. 00
	reporting period		
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6. 00
7. 00	reporting period (if calendar year, enter 0 on this line)	o	7. 00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	١	7.00
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	Ĭ	0.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	303	9. 00
	newborn days) (see instructions)		
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through	0	10. 00
	December 31 of the cost reporting period (see instructions)		44.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11. 00
12. 00	December 31 of the cost reporting period (if calendar year, enter 0 on this line) Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12. 00
12.00	through December 31 of the cost reporting period	,	12.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after	er o	13. 00
	December 31 of the cost reporting period (if calendar year, enter 0 on this line)		
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14. 00
	Total nursery days (title V or XIX only)	704	15. 00
16. 00	Nursery days (title V or XIX only)	558	16. 00
47.00	SWING BED ADJUSTMENT	0.00	47.00
17. 00		0.00	17. 00
18. 00	reporting period  Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting	0.00	18. 00
10.00	period	.g 0.00	10.00
19. 00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporti	na 0.00	19. 00
	peri od		
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting	0.00	20. 00
	peri od		
21. 00	Total general inpatient routine service cost (see instructions)	43, 425, 611	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	5 0	22. 00
23. 00	x line 17)   Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	x 0	23. 00
23.00	line 18)	^	23.00
24. 00		' x 0	24. 00
	line 19)		
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x	0	25. 00
	line 20)		
26. 00		0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	43, 425, 611	27. 00
20 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28. 00
28. 00 29. 00		0	28.00
30.00	Semi -pri vate room charges (excluding swing-bed charges)	0	
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	
32. 00	Average private room per diem charge (line 29 ÷ line 3)	0.00	
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	•
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	•
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35. 00
36. 00	Private room cost differential adjustment (line 3 x line 35)	0	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	27 43, 425, 611	37. 00
	minus line 36)		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
38. 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  Adjusted general inpatient routine service cost per diem (see instructions)	1, 575. 85	38. 00
39.00	Adjusted general inpatient routine service cost per diem (see instructions)  Program general inpatient routine service cost (line 9 x line 38)	477, 483	
	Medically necessary private room cost applicable to the Program (line 14 x line 35)	477, 403	40.00
	Total Program general inpatient routine service cost (line 39 + line 40)	477, 483	

	Financial Systems ATION OF INPATIENT OPERATING COST	FRANCISCAN HEA	LTH- DYER Provider CCN:	15-0090 Per	In Lieu iod:	of Form CMS-2 Worksheet D-1	2552-10
					m 01/01/2023 12/31/2023	Date/Time Pre	nared:
						5/30/2024 3: 4	
	Cook Cooker Decorieties	T-+-1	Title X		Hospi tal	Cost	
	Cost Center Description	Total	Total A npatient DaysDie			Program Cost col. 3 x col.	
		rnpatrent costri	ipatrent baysbre	col . 2)		4)	
		1.00	2. 00	3. 00	4. 00	5. 00	
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	1, 784, 715	704	2, 535. 11	558	1, 414, 591	42.00
43. 00	INTENSIVE CARE UNIT	6, 001, 644	2, 392	2, 509. 05	1, 044	2, 619, 448	43. 00
44.00	CORONARY CARE UNIT	0	0	0.00	0	0	44. 00
45. 00	BURN INTENSIVE CARE UNIT	0	0	0. 00	0	0	45. 00
46.00	SURGICAL INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE UNIT	1, 221, 017	350	3, 488. 62	305	1, 064, 029	46. 00 47. 00
47.00	Cost Center Description	1, 221, 017	330	3, 400. 02	303	1,004,027	47.00
						1. 00	
48. 00 48. 01	Program inpatient ancillary service cost (Wks Program inpatient cellular therapy acquisition			line 10 co	Lump 1)	8, 525, 335 0	48. 00 48. 01
49. 00	Total Program inpatient costs (sum of lines 4				ruilli 1)	14, 100, 886	
	PASS THROUGH COST ADJUSTMENTS		, , , , , , , , , , , , , , , , , , , ,	,		.,,	
50.00	Pass through costs applicable to Program inpa	atient routine s	ervices (from Wk	st. D, sum of	Parts I and	0	50.00
51. 00		atient ancillary	services (from	Wkst D sum	of Parts II ar	nd 0	51.00
	IV)				T		
52.00	Total Program excludable cost (sum of lines 5					0	52.00
53. 00	Total Program inpatient operating cost excluded education costs (line 49 minus line 52)	ng capitai rei	ated, non-pnysic	ian anestneti	st, and medica	al 0	53. 00
	TARGET AMOUNT AND LIMIT COMPUTATION						
	Program di scharges					0	
55. 00 55. 01	Target amount per discharge Permanent adjustment amount per discharge					0. 00 0. 00	
55. 02	Adjustment amount per discharge (contractor i	use onl v)				0.00	
56. 00	Target amount (line 54 x sum of lines 55, 55.					0	56. 00
57. 00	Difference between adjusted inpatient operati	ng cost and tar	get amount (line	56 minus lin	e 53)	0	57. 00
58. 00 59. 00	Bonus payment (see instructions) Trended costs (lesser of line 53 ÷ line 54, o	or line 55 from	the cost reporti	ng period end	ing 1996	0.00	58. 00 59. 00
37.00	updated and compounded by the market basket)	7 11110 33 11 0111	the cost reporti	ng perrou end	1119 1770,	0.00	37.00
60.00	Expected costs (lesser of line 53 ÷ line 54,	or line 55 from	prior year cost	report, upda	ted by the	0.00	60.00
61. 00	market basket) Continuous improvement bonus payment (if line 55.01, or line 59, or line 60, enter the less					0	61. 00
	are less than expected costs (lines 54 x 60),	or 1 % of the	target amount (I	ine 56), othe	rwise enter		
62. 00	zero. (see instructions) Relief payment (see instructions)					0	62. 00
	Allowable Inpatient cost plus incentive payme	ent (see instruc	tions)			0	
	PROGRAM INPATIENT ROUTINE SWING BED COST						l
64. 00	Medicare swing-bed SNF inpatient routine cost instructions)(title XVIII only)	s through Decem	ber 31 of the co	st reporting	period (See	0	64. 00
65.00	Medicare swing-bed SNF inpatient routine cost	s after Decembe	r 31 of the cost	reporting pe	riod (See	0	65. 00
// 00	instructions)(title XVIII only)		4 -l li (F) (	+:+!- \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\		0	
66. 00	Total Medicare swing-bed SNF inpatient routing see instructions	ie costs (Title 6	4 prus rine 65)(	title xviii d	mry); for CAH,	0	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routing	costs through	December 31 of t	he cost repor	ting period	0	67. 00
40.00	(line 12 x line 19)	aceta often De	aambar 21 af +ba	anat manamti	na nominal (lin	ne 0	40.00
68. 00	Title V or XIX swing-bed NF inpatient routine 13 x line 20)	costs after be	cember 31 of the	cost reporti	ng perrou (iii	ie 0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient r					0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facili						70.00
71.00	Adjusted general inpatient routine service of			(Title 37)			71.00
72. 00	Program routine service cost (line 9 x line 7		,				72. 00
73.00	Medically necessary private room cost applica			35)			73.00
74. 00 75. 00	Total Program general inpatient routine servi Capital-related cost allocated to inpatient r	•	•	sheet B Part	II column 26	ń	74. 00 75. 00
70.00	line 45)	outine service	costs (11 om work	Shoot B, Turt	11, 001 41111 20	,	70.00
76. 00	Per diem capital-related costs (line 75 ÷ lir						76. 00
77. 00 78. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minus						77. 00 78. 00
79. 00	Aggregate charges to beneficiaries for excess	.*	ovi der records)				79.00
80.00	Total Program routine service costs for compa	arison to the co		ine 78 minus	line 79)		80.00
81.00	Inpatient routine service cost per diem limit						81.00
82. 00 83. 00	Inpatient routine service cost limitation (li Reasonable inpatient routine service costs (s		)		-		82. 00 83. 00
84. 00	Program inpatient ancillary services (see ins		,				84. 00
85.00	Utilization review - physician compensation (						85.00
86. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		ougn 85)				86. 00
87. 00	Total observation bed days (see instructions)					2, 797	87. 00
88. 00	Adjusted general inpatient routine cost per d	diem (line 27 ÷	line 2)			1, 575. 85 4, 407, 652	88. 00
89.00	Observation bed cost (line 87 x line 88) (see						89.00

Health Financial Systems	FRANCISCAN HE	EALTH- DYER		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2023 To 12/31/2023	Date/Time Prep 5/30/2024 3:49	
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (	COST					
90.00 Capital-related cost	2, 671, 724	43, 425, 611	0. 06152	4, 407, 652	271, 176	90.00
91.00 Nursing Program cost	0	43, 425, 611	0.00000	0 4, 407, 652	0	91.00
92.00 Allied health cost	0	43, 425, 611	0.00000	0 4, 407, 652	0	92.00
93.00 All other Medical Education	0	43, 425, 611	0. 00000	0 4, 407, 652	0	93. 00

Health Financial Systems	FRANCISCAN HEALTH- DYER	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0090	Peri od: From 01/01/2023	Worksheet D-1
	Component CCN: 15-T090	To 12/31/2023	Date/Time Prepared: 5/30/2024 3:45 pm
	Title XIX	Subprovi der -	TEFRA
		IRF	

		TI LI E XIX	I RF	ILIKA	
	Cost Center Description				
	DADT I ALL DOOM DED COMPONIENTS			1. 00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				
1. 00	Inpatient days (including private room days and swing-bed days	s. excludina newborn)		3, 964	1. 00
2. 00	Inpatient days (including private room days, excluding swing-b			3, 964	2. 00
3.00	Private room days (excluding swing-bed and observation bed day	s). If you have only pri	vate room days, d	o ol	3. 00
	not complete this line.				
4.00	Semi-private room days (excluding swing-bed and observation be		21 -6	3, 964	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private rooreporting period	om days) through becember	31 Of the Cost	0	5. 00
6.00	Total swing-bed SNF type inpatient days (including private roo	om days) after December 3	1 of the cost	0	6. 00
	reporting period (if calendar year, enter 0 on this line)	<b>3</b> .			
7. 00	Total swing-bed NF type inpatient days (including private room	n days) through December	31 of the cost	0	7. 00
8. 00	reporting period Total swing-bed NF type inpatient days (including private room	days) after December 21	of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	i days) ai tei beceilibei 31	of the cost	٥	6.00
9.00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	16	9. 00
	newborn days) (see instructions)				
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or	nly (including private ro	om days) through	0	10. 00
11. 00	December 31 of the cost reporting period (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII or	alv (including private ro	om days) after	0	11. 00
11.00	December 31 of the cost reporting period (if calendar year, er		oiii days) artei	٥	11.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI>		room days)	0	12. 00
	through December 31 of the cost reporting period				
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI)		room days) after	- 0	13. 00
14. 00	December 31 of the cost reporting period (if calendar year, er Medically necessary private room days applicable to the Progra		ave)	0	14. 00
15. 00	Total nursery days (title V or XIX only)	ill (excluding swing-bed d	ays)	704	
16. 00	Nursery days (title V or XIX only)				16. 00
	SWING BED ADJUSTMENT		,		
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 of	the cost	0. 00	17. 00
10.00	reporting period	o often December 21 of t	ha agat manamti na	. 0.00	10 00
18. 00	Medicare rate for swing-bed SNF services applicable to service period	es after becember 31 of t	ne cost reporting	0.00	18. 00
19. 00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost reportin	ng 0.00	19. 00
	peri od	3	'		
20. 00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of th	e cost reporting	0. 00	20. 00
21 00	period Total general inpatient routine service cost (see instructions	-)		4, 555, 491	21. 00
21. 00 22. 00	Swing-bed cost applicable to SNF type services through December		na period (line 5		22. 00
22.00	x line 17)	or or the cost reporti	ng perrod (Trie		22.00
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	period (line 6 x	( 0	23. 00
	line 18)			ا	
24. 00	Swing-bed cost applicable to NF type services through December line 19)	31 of the cost reportin	g period (line /	x 0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8 x	0	25. 00
20.00	line 20)	or the edet reperting	po ou ( o	١	20.00
26. 00	Total swing-bed cost (see instructions)			0	
27. 00	General inpatient routine service cost net of swing-bed cost (	(line 21 minus line 26)		4, 555, 491	27. 00
28. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed	d and observation had cha	race)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)	a and observation bed cha	i ges)	0	
30. 00	Semi -private room charges (excluding swing-bed charges)			0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 =	- line 28)		0.000000	
32. 00	Average private room per diem charge (line 29 ÷ line 3)			0. 00	
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	1: 00) (	. ,	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 lir	, ,	i ons)	0. 00 0. 00	
36. 00	Private room cost differential adjustment (line 3 x line 35)	IE 31)		0.00	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost dif	ferential (line 2		37. 00
	minus line 36)			., , . , .	
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
20.00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU			1 110 00	20.00
38. 00 39. 00	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line			1, 149. 22 18, 388	
40. 00	Medically necessary private room cost applicable to the Progra			18, 388	40. 00
	Total Program general inpatient routine service cost (line 39			18, 388	
	, , , , , , , , , , , , , , , , , , , ,	,	'	.,	

	ATION OF INPATIENT OPERATING COST		Provider CCN: 15-0090	Peri od:	Worksheet D-1	
			Component CCN: 15-T090	From 01/01/2023 To 12/31/2023	Date/Time Prep 5/30/2024 3:49	
			Title XIX	Subprovider - IRF	TEFRA	о р
	Cost Center Description	Total Inpatient CostInp	Total Average Per patient Days Diem (col. 1 col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
42.00	NUIDCEDY (+i+lo V & VIV only)	1.00	2.00 3.00	4.00	5. 00	42.00
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	0 0.0	00 0	0	42. 0
43. 00 44. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT	0	0 0.0	I I	0	
	BURN INTENSIVE CARE UNIT	0	0 0.0	I I	0	1
	SURGICAL INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE UNIT	0	0 0.0	0 0	0	46. 0 47. 0
47.00	Cost Center Description	0	<u> </u>	50  0		47.0
48. 00	Program inpatient ancillary service cost (Wk	st D-3 col 3 l	ine 200)		1. 00	48. 0
48. 01	Program inpatient cellular therapy acquisiti	on cost (Workshee	t D-6, Part III, line 10,	column 1)	0	48. 0
49. 00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48.01)	(see instructions)		18, 498	49. 0
50. 00	Pass through costs applicable to Program inp	atient routine se	rvices (from Wkst. D, sur	n of Parts I and	0	50.0
51. 00	<pre>III) Pass through costs applicable to Program inp</pre>	atient ancillary s	services (from Wkst. D. s	sum of Parts II a	nd 7	51.0
	IV)	,			·	
52. 00 53. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		ted, non-physician anesth	 netist, and medic	al 18, 491	52. 00 53. 00
	education costs (line 49 minus line 52) TARGET AMOUNT AND LIMIT COMPUTATION			·		
54. 00	Program discharges				8	54.0
55. 00	Target amount per discharge Permanent adjustment amount per discharge				0.00	
	Adjustment amount per discharge (contractor	use only)			0. 00 0. 00	
	Target amount (line 54 x sum of lines 55, 55		-tt (line 5/ minus	1: 52)	0	
57. 00 58. 00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and targe	et amount (line 56 minus	11 ne 53)	-18, 491 0	
59. 00	Trended costs (lesser of line 53 ÷ line 54,		ne cost reporting period	endi ng 1996,	0. 00	59. 0
60. 00	updated and compounded by the market basket) Expected costs (lesser of line 53 ÷ line 54, market basket)		orior year cost report, u	updated by the	0. 00	60. 0
61. 00	Continuous improvement bonus payment (if lir 55.01, or line 59, or line 60, enter the les are less than expected costs (lines 54 x 60)	ser of 50% of the	amount by which operating	ng costs (line 53	0	61.0
62. 00	zero. (see instructions) Relief payment (see instructions)				0	62. 0
63. 00	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instructi	ons)		7	63. 0
64. 00	Medicare swing-bed SNF inpatient routine cos	ts through Decembe	er 31 of the cost reporti	ng period (See	0	64. 0
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos</pre>	ts after December	31 of the cost reporting	period (See	0	65.0
// 00	instructions)(title XVIII only)					44.0
66. 00	Total Medicare swing-bed SNF inpatient routi see instructions	ne costs (Time 64	prus rine obj(title xvii	i only); for CAH	, 0	66. 0
67. 00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	e costs through De	ecember 31 of the cost re	eporting period	0	67. 0
68. 00	Title V or XIX swing-bed NF inpatient routin 13 x line 20)	e costs after Dec	ember 31 of the cost repo	orting period (li	ne 0	68. 0
	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N	URSING FACILITY, A	AND ICF/IID ONLY		0	
	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service of			)		70.00
72. 00	Program routine service cost (line 9 x line	71)	•			72. 0
73. 00 74. 00	Medically necessary private room cost applic Total Program general inpatient routine serv					73.0
75. 00	Capital -related cost allocated to inpatient line 45)			Part II, column 2	6,	75. 0
	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line	. *				76. 0 77. 0
78. 00	Inpatient routine service cost (line 74 minu	s line 77)				78. 0
	Aggregate charges to beneficiaries for exces Total Program routine service costs for comp			nus lina 70)		79. 0 80. 0
	Inpatient routine service costs for comp Inpatient routine service cost per diem limi		tation (iine 70 mil	143 TITE /7)		80.0
82. 00	Inpatient routine service cost limitation (I	ine 9 x line 81)				82. 0
83. 00 84. 00	Reasonable inpatient routine service costs ( Program inpatient ancillary services (see in					83. 0
85. 00	Utilization review - physician compensation	(see instructions)				85. 0
	Total Program inpatient operating costs (sum	of Lines 83 thro	Jan 85)			86.0
86. 00	PART IV - COMPUTATION OF OBSERVATION BED PAS			·		

Health Financial Systems	FRANCISCAN HE	EALTH- DYER		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
		Component (	CCN: 15-T090	From 01/01/2023 To 12/31/2023		
		Ti tl	e XIX	Subprovi der -	TEFRA	
				I RF		
Cost Center Description						
					1. 00	
89.00 Observation bed cost (line 87 x line 88) (see	e instructions)				0	89. 00
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.	
				, in the second second	4) (see	
					instructions)	
	1.00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH O	COST					
90.00 Capital -related cost	0	4, 555, 491	0.00000	00 0	0	90. 00
91.00 Nursing Program cost	0	4, 555, 491	0. 00000	0 0	0	91. 00
92.00 Allied health cost	0	4, 555, 491	0. 00000	0 0	0	92. 00
93.00 All other Medical Education	0	4, 555, 491	0. 00000	0 0	0	93. 00

Health Financial Systems	FRANCISCAN HEAL	TH- DYER		In Lie	eu of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provi der (	CCN: 15-0090	Peri od: From 01/01/2023	Worksheet D-3	
				To 12/31/2023	Date/Time Pre 5/30/2024 3:4	pared: 5 pm
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description			Ratio of Cos	t Inpatient	Inpati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
				Ŭ	2)	
			1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS			·			
30. 00 03000 ADULTS & PEDIATRICS				16, 043, 792		30. 00
31. 00 03100 I NTENSI VE CARE UNIT				3, 710, 757		31.00
32 OO 03200 CORONARY CARE LINLT				1		32 00

Cost Center Description Ratio o	of Cost	Inpatient Program	Inpatient Program Costs	
TO CIR	ai ges	Charges	(col. 1 x col.	
		g	2)	
1.0	00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00   03000   ADULTS & PEDI ATRI CS		16, 043, 792		30.00
31. 00   03100   I NTENSI VE CARE UNI T		3, 710, 757		31. 00
32. 00   03200   CORONARY CARE UNIT		0		32. 00
33. 00   03300   BURN INTENSIVE CARE UNIT		0		33. 00
35. 00   02060   NEONATAL INTENSIVE CARE UNIT		0		35. 00
41. 00   04100   SUBPROVI DER -   I RF		0		41.00
42. 00   04200   SUBPROVI DER		0		42.00
43. 00 O4300 NURSERY				43. 00
ANCI LLARY SERVI CE COST CENTERS  50. 00 05000 OPERATI NG ROOM 0.	. 094675	7, 929, 978	750, 771	50. 00
	. 731590	7, 929, 976 781, 145	571, 478	50. 00
	. 085415	761, 143 769, 528	65, 729	51.00
	. 005160	1, 735, 368	8, 954	53.00
	. 086749	10, 919, 638	947, 268	54. 00
	. 212871	1, 551, 649	330, 301	54. 00
	. 000000	1, 551, 649	330, 301	55. 00
	. 106524	589, 328	62, 778	56. 00
	. 138608	12, 417, 029	1, 721, 100	60.00
	. 465175	421, 014	1, 721, 100	63.00
	. 297511	5, 001, 716	1, 488, 066	65. 00
	. 251568	1, 601, 775	402, 955	66. 00
	. 092473	1, 314, 391	121, 546	67. 00
	. 143394	686, 072	98, 379	68. 00
	. 081929	3, 969, 148	325, 188	69. 00
	. 148449	262, 348	38, 945	70.00
	. 327634	8, 550, 864	2, 801, 554	71. 00
	. 255306	2, 260, 164	577, 033	72.00
	. 276036	8, 323, 700	2, 297, 641	73. 00
	. 100251	1, 533, 387	153, 724	76. 00
	. 229305	22, 736	5, 213	76. 01
	. 112006	6, 486, 892	726, 571	76. 02
	. 002728	195, 232	195, 765	76. 03
	. 359129	61, 108	21, 946	76. 04
	. 433676	652	935	76. 05
	. 000000	0	0	76. 06
76. 07 03950 CV RESOURCE CENTER 0.	. 000000	0	0	76. 07
	. 000000	0	0	76. 08
76. 09 03956 LACTATION CLINIC 0.	. 000000	0	0	76. 09
76. 10 03957 OTHER ANCILLARY SERVICE COST CENTERS 0.	. 000000	0	0	76. 10
76. 11 03958 OTHER ANCILLARY SERVICE COST CENTERS 0.	. 000000	0	0	76. 11
76. 12 O3959 ANTI COAGULATI ON CLINIC 0.	. 698569	2, 066	1, 443	76. 12
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION 0.	. 000000	0	0	77. 00
	. 000000	0	0	78. 00
OUTPATIENT SERVICE COST CENTERS				
91. 00   09100   EMERGENCY   0.	. 168353	6, 337, 608	1, 066, 955	91. 00
	. 473742	1, 440, 353	682, 356	92. 00
200.00 Total (sum of lines 50 through 94 and 96 through 98)		85, 164, 889	15, 660, 439	
201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201. 00
202.00   Net charges (line 200 minus line 201)		85, 164, 889		202. 00

Health Financial Systems FRANCISCAN H INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Peri od:	wof Form CMS-3 Worksheet D-3	
	Component		From 01/01/2023 To 12/31/2023	Date/Time Pre	pared:
	·			5/30/2024 3: 4 PPS	
	11 (16	e XVIII	Subprovi der  - I RF	PPS	
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program Charges	Program Costs (col. 1 x col.	
			Charges	2)	
		1. 00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00   03000   ADULTS & PEDIATRICS 31. 00   03100   INTENSIVE CARE UNIT					30. 0 31. 0
32. 00   03200   CORONARY CARE UNIT					32.0
33.00 03300 BURN INTENSIVE CARE UNIT					33. 0
35. 00   02060   NEONATAL   INTENSIVE CARE UNIT					35. 0
41. 00   04100   SUBPROVI DER -   RF			5, 121, 282		41.0
42. 00   04200   SUBPROVI DER					42.0
43. 00 04300 NURSERY					43.0
ANCILLARY SERVICE COST CENTERS			.=	10.001	
50.00  05000 0PERATING ROOM 50.01  05001 0UTPATIENT SURGERY		0. 09467		10, 821 6, 649	50.0
50. 01  05001 0UTPATIENT SURGERY 51. 00  05100 RECOVERY ROOM		0. 73159 0. 08541		418	1
53. 00   05300   ANESTHESI OLOGY		0.00516		47	53.0
54. 00   05400   RADI OLOGY-DI AGNOSTI C		0. 08674		19, 656	1
54. 01   05401   RADI OLOGY-SPECI AL PROCEDURES		0. 21287		10, 916	
55. 00   05500   RADI OLOGY-THERAPEUTI C		0.00000	0 0	0	55.0
56. 00   05600   RADI 0I SOTOPE		0. 10652	24 0	0	56. 0
60. 00   06000   LABORATORY		0. 13860		65, 758	60.0
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 46517		3, 573	
65. 00   06500   RESPI RATORY THERAPY		0. 29751		237, 133	
66.00   06600   PHYSI CAL THERAPY 67.00   06700   OCCUPATI ONAL THERAPY		0. 25156 0. 09247		516, 024 176, 317	66. C
68. 00   06800   SPEECH   PATHOLOGY		0. 14339		126, 373	1
69. 00 06900 ELECTROCARDI OLOGY		0. 08192		2, 499	
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 14844		1, 938	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 32763	418, 268	137, 039	71.0
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 25530		1, 271	
73. 00   07300   DRUGS CHARGED TO PATIENTS		0. 27603		202, 820	
76. 00   03630   ULTRA SOUND		0. 10025		4, 462	1
76.01   03951   PALN CLINIC 76.02   03952   CATH LAB		0. 22930		14	1
76. 03   03953   ACTI VI TY   THERAPEUTI C		0. 11200 1. 00272		5, 875 0	76. (
76. 04   03954   WOUND CARE CENTER		0. 35912		2, 383	1
76. 05   03340 BARI ATRI C CLI NI C		1. 43367		70	1
76. 06 03030 HEALTHY LIVING CENTER		0.00000		0	76.0
76. 07 03950 CV RESOURCE CENTER		0.00000	0 0	0	76. C
76.08 03955 OTHER ANCILLARY SERVICE COST CENTERS		0.00000		0	76. C
76. 09   03956   LACTATI ON CLINI C		0.00000		0	1
76. 10 03957 OTHER ANCILLARY SERVICE COST CENTERS		0.00000		0	
76. 11 03958 OTHER ANCILLARY SERVICE COST CENTERS		0.00000		0	76. 1
76.12   03959   ANTICOAGULATION CLINIC 77.00   07700   ALLOGENEIC STEM CELL ACQUISITION		0. 69856 0. 00000		0	76. 1 77. 0
78. 00   07700   ALLOGENET C STEW CELL ACQUISITION 78. 00   07800   CAR T-CELL IMMUNOTHERAPY		0.00000		0	78. C
OUTPATIENT SERVICE COST CENTERS		0.00000			1 , 5. 6
91. 00 09100 EMERGENCY		0. 16835	3 8, 839	1, 488	91.0
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 47374		0	92.0
200 00 Total (sum of lines 50 through 94 and 96 through 98)		1	7 847 781	1 533 544	I200 0

1, 533, 544 200. 00 201. 00 202. 00

Total (sum of lines 50 through 94 and 96 through 98)
Less PBP Clinic Laboratory Services-Program only charges (line 61)
Net charges (line 200 minus line 201)

200. 00 201. 00 202. 00

Health Financial Systems F	RANCISCAN HEALTH- DYER	In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der CCN: 15-00	090 Peri od: From 01/01/2023	Worksheet D-3	
		To 12/31/2023	Date/Time Prep 5/30/2024 3:45	
	Title XIX	Hospi tal	Cost	
Cost Center Description	Ratio o	of Cost   Inpatient	I npati ent	
	To Cha	arges Program	Program Costs	

			12/01/2020	5/30/2024 3: 4:	5 pm
	Titl	e XIX	Hospi tal	Cost	
Cost Center Description		Ratio of Cost	Inpati ent	Inpati ent	
'		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
			3	2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS			16, 562, 984		30.00
31. 00   03100   NTENSI VE CARE UNI T			2, 032, 146		31. 00
32. 00   03200   CORONARY CARE UNI T			0		32. 00
33. 00 03300 BURN INTENSIVE CARE UNIT			0		33. 00
35. 00   02060   NEONATAL   INTENSIVE CARE UNIT			900, 146		35. 00
41. 00   04100   SUBPROVI DER -   RF			700, 110		41. 00
42. 00   04200   SUBPROVI DER			0		42. 00
43. 00   04300   NURSERY			604, 234		43. 00
ANCI LLARY SERVI CE COST CENTERS		l l	004, 234		43.00
50. 00   05000   OPERATI NG ROOM		0. 094675	5, 509, 724	521, 633	50.00
50. 01   05001   0UTPATI ENT SURGERY		0. 731590	303, 666	222, 159	50. 00
51. 00   05100  RECOVERY ROOM		0. 085415	607, 988	51, 931	51. 00
53. 00   05300  ANESTHESI OLOGY		0.005160	1, 190, 038	6, 141	53. 00
54. 00   05400   RADI OLOGY - DI AGNOSTI C			4, 011, 694	348, 010	54. 00
		0. 086749			
54. 01   05401   RADI OLOGY - SPECI AL PROCEDURES		0. 212871	786, 911	167, 511	54. 01
55. 00   05500   RADI OLOGY-THERAPEUTI C		0.000000	157.450	0	55. 00
56. 00   05600   RADI 01 SOTOPE		0. 106524	157, 450	16, 772	56.00
60. 00   06000   LABORATORY		0. 138608	7, 399, 696	1, 025, 657	60.00
63. 00   06300   BLOOD STORING, PROCESSING & TRANS.		0. 465175	240, 004	111, 644	63.00
65. 00 06500 RESPI RATORY THERAPY		0. 297511	1, 696, 926	504, 854	65. 00
66. 00 06600 PHYSI CAL THERAPY		0. 251568	381, 550	95, 986	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 092473	311, 910	28, 843	67. 00
68. 00   06800   SPEECH PATHOLOGY		0. 143394	311, 332	44, 643	68. 00
69. 00   06900   ELECTROCARDI OLOGY		0. 081929	1, 284, 736	105, 257	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 148449	53, 573	7, 953	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 327634	3, 484, 779	1, 141, 732	71. 00
72.00 O7200 IMPL. DEV. CHARGED TO PATIENTS		0. 255306	887, 607	226, 611	72. 00
73.00 O7300 DRUGS CHARGED TO PATIENTS		0. 276036	5, 310, 293	1, 465, 832	73.00
76.00   03630   ULTRA SOUND		0. 100251	664, 614	66, 628	76.00
76. 01   03951   PAIN CLINIC		0. 229305	2, 526	579	76. 01
76. 02  03952  CATH LAB		0. 112006	1, 170, 029	131, 050	76. 02
76. 03   03953   ACTIVITY THERAPEUTIC		1. 002728	1, 459, 417	1, 463, 398	76. 03
76. 04   03954   WOUND CARE CENTER		0. 359129	34, 751	12, 480	76. 04
76. 05   03340   BARI ATRI C   CLI NI C		1. 433676	0	0	76. 05
76.06   03030   HEALTHY LIVING CENTER		0.000000	0	0	76.06
76. 07   03950   CV RESOURCE CENTER		0.000000	0	0	76. 07
76.08 03955 OTHER ANCILLARY SERVICE COST CENTERS		0.000000	0	0	76.08
76. 09   03956   LACTATI ON CLI NI C		0.000000	0	0	76.09
76. 10 03957 OTHER ANCILLARY SERVICE COST CENTERS		0.000000	0	0	76. 10
76. 11 03958 OTHER ANCILLARY SERVICE COST CENTERS		0.000000	0	0	76. 11
76. 12 03959 ANTI COAGULATI ON CLINIC		0. 698569	6, 409	4, 477	76. 12
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION		0.000000	0	0	77.00
78.00 07800 CAR T-CELL IMMUNOTHERAPY		0.000000	0	0	78.00
OUTPATIENT SERVICE COST CENTERS					
91. 00 09100 EMERGENCY		0. 168353	3, 353, 574	564, 584	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 473742	398, 887	188, 970	92. 00
200.00 Total (sum of lines 50 through 94 and 96 through 98)			41, 020, 084	8, 525, 335	
201.00 Less PBP Clinic Laboratory Services-Program only charges	(line 61)		0	.,, .00	201. 00
202.00 Net charges (line 200 minus line 201)			41, 020, 084		202. 00
		1	, 525, 501		

PATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C		Peri od: From 01/01/2023	Worksheet D-3	
	Component		To 12/31/2023	Date/Time Prep 5/30/2024 3:4	
	Ti tl	e XIX	Subprovi der – I RF	TEFRA	
Cost Center Description	· · · · · ·	Ratio of Cos	t Inpatient	Inpatient	
		To Charges	Program Charges	Program Costs (col. 1 x col.	
		1.00	ű	2)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2. 00	3. 00	
0.00 O3000 ADULTS & PEDIATRICS					30.
. 00 03100 I NTENSI VE CARE UNI T					31.
2. 00   03200   CORONARY CARE UNIT					32.
. 00   03300   BURN INTENSIVE CARE UNIT . 00   02060   NEONATAL INTENSIVE CARE UNIT					33. 35.
. 00   04100   SUBPROVI DER -   IRF			125, 598		41.
1. 00   04200   SUBPROVI DER			120, 070		42
. 00   04300   NURSERY					43
ANCILLARY SERVICE COST CENTERS					4
0.00 05000 OPERATI NG ROOM		0. 09467		0	
0. 01   05001   0UTPATI ENT SURGERY		0. 73159	1	0	
. 00   05100   RECOVERY ROOM 3. 00   05300   ANESTHESI OLOGY		0. 08541 0. 00516	1	0	
. 00   05400   RADI OLOGY-DI AGNOSTI C		0. 08674		0	
. 01   05401 RADI OLOGY-SPECI AL PROCEDURES		0. 21287		0	
0. 00   05500   RADI OLOGY-THERAPEUTI C		0.00000		0	
. 00   05600   RADI 0I SOTOPE		0. 10652	24 0	0	56
0. 00   06000   LABORATORY		0. 13860		110	
06300 BLOOD STORING, PROCESSING & TRANS.		0. 46517	1	0	
5. 00   06500   RESPI RATORY THERAPY		0. 29751		0	
DO O6600 PHYSI CAL THERAPY OO O6700 OCCUPATI ONAL THERAPY		0. 25156 0. 09247		0	
1. 00   06800   SPEECH PATHOLOGY		0. 14339		0	
2. 00   06900   ELECTROCARDI OLOGY		0. 08192		0	
0. 00 07000 ELECTROENCEPHALOGRAPHY		0. 14844		0	
. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 32763		0	
07200 MPL. DEV. CHARGED TO PATIENTS		0. 25530	0	0	72
07300 DRUGS CHARGED TO PATIENTS		0. 27603		0	
0. 00   03630   ULTRA SOUND		0. 10025		0	
0. 01   03951   PALN CLINIC		0. 22930		0	
D. 02   03952   CATH LAB D. 03   03953   ACTIVITY THERAPEUTIC		0. 11200 1. 00272		0	
03 03 03 03 03 03 03 03 03 03 03 03 03 0		0. 35912		0	
0. 05   03340   BARI ATRI C CLI NI C		1. 43367		0	
0.06 03030 HEALTHY LIVING CENTER		0.00000		0	
0. 07   03950   CV RESOURCE CENTER		0.00000	0 0	0	76
.08 03955 OTHER ANCILLARY SERVICE COST CENTERS		0.00000	0 0	0	76
. 09 03956 LACTATION CLINIC		0.00000		0	
1. 10   03957   OTHER ANCILLARY SERVICE COST CENTERS		0.00000		0	
. 11   03958   OTHER ANCILLARY SERVICE COST CENTERS . 12   03959   ANTICOAGULATION CLINIC		0. 00000 0. 69856		0	
7.00 07700 ALLOGENEIC STEM CELL ACQUISITION		0.00000		0	
8. 00 07800 CAR T-CELL IMMUNOTHERAPY		0.00000		0	
OUTPATIENT SERVICE COST CENTERS					1
. 00 09100 EMERGENCY		0. 16835		0	
. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 47374		0	
10.00 Total (sum of lines 50 through 94 and 96 through 98) 11.00 Less PBP Clinic Laboratory Services-Program only cha			792	110	200 201

	Title XVIII Hospital	PPS	5 piii
		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS	1. 00	
1.00	DRG Amounts Other than Outlier Payments	0	1. 00
1. 01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	14, 120, 607	1. 01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see	4, 603, 695	1. 02
4 00	instructions)	ا ا	4 00
1. 03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October (see instructions)	1 0	1. 03
1.04	DRG for federal specific operating payment for Model 4 BPCL for discharges occurring on or after Octob	er O	1. 04
	1 (see instructions)	٠. ١	
2.00	Outlier payments for discharges. (see instructions)		2. 00
2. 01	Outlier reconciliation amount	0	2. 01
2. 02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2. 02
2. 03 2. 04	Outlier payments for discharges occurring prior to October 1 (see instructions) Outlier payments for discharges occurring on or after October 1 (see instructions)	289, 382 194, 322	2. 03 2. 04
3. 00	Managed Care Si mulated Payments	10, 944, 943	3. 00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	158. 34	4. 00
	Indirect Medical Education Adjustment		
5. 00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on	or 7.80	5. 00
5. 01	before 12/31/1996. (see instructions)  FTE cap adjustment for qualifing hospitals under §131 of the CAA 2021 (see instructions)	0. 00	5. 01
6. 00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for	0.00	6. 00
	new programs in accordance with 42 CFR 413.79(e)		
6. 26	Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of $t$	he 0.00	6. 26
7.00	CAA 2021 (see instructions)	0.00	7 00
7. 00 7. 01	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)  ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the	0. 89 0. 00	7. 00 7. 01
7.01	cost report straddles July 1, 2011 then see instructions.	0.00	7.01
7.02	Adjustment (increase or decrease) to the hospital's rural track program FTE limitation(s) for rural	0.00	7. 02
	track programs with a rural track for Medicare GME affiliated programs in accordance with 413.75(b) and	d	
0.00	87 FR 49075 (August 10, 2022) (see instructions)	0.00	0.00
8. 00	Adjustment (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),	0. 00	8. 00
	and 67 FR 50069 (August 1, 2002).		
8. 01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost	0.00	8. 01
	report straddles July 1, 2011, see instructions.		
8. 02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under	§ 0.00	8. 02
8. 21	5506 of ACA. (see instructions) The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see	0. 00	8. 21
0. 21	instructions)	0.00	0.21
9.00	Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or	6. 91	9. 00
	minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions)		
	FTE count for allopathic and osteopathic programs in the current year from your records	2. 09	
11.00	FTE count for residents in dental and podiatric programs.  Current year allowable FTE (see instructions)		11. 00 12. 00
13. 00	Total allowable FTE count for the prior year.	4. 12	
14. 00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997,		14. 00
	otherwise enter zero.		
	Sum of lines 12 through 14 divided by 3.		15. 00
16. 00	Adjustment for residents in initial years of the program (see instructions)		16.00
	Adjustment for residents displaced by program or hospital closure Adjusted rolling average FTE count		17. 00 18. 00
	Current year resident to bed ratio (line 18 divided by line 4).	0. 030378	
	Prior year resident to bed ratio (see instructions)	0. 033048	
	Enter the lesser of lines 19 or 20 (see instructions)	0. 030378	21. 00
	IME payment adjustment (see instructions)	308, 239	
22. 01	IME payment adjustment - Managed Care (see instructions)	180, 176	22. 01
23. 00	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA  Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105	0.00	23. 00
23.00	(f)(1)(iv)(C).	0.00	23.00
24.00	IMÉ FTE Resident Count Over Cap (see instructions)	-4. 82	24. 00
25. 00	If the amount on line 24 is greater than -O-, then enter the lower of line 23 or line 24 (see	0.00	25. 00
0, 00	instructions)		
26. 00	Resident to bed ratio (divide line 25 by line 4)	0.000000	
27. 00 28. 00	IME payments adjustment factor. (see instructions)  IME add-on adjustment amount (see instructions)	0. 000000 0	27. 00 28. 00
	IME add-on adjustment amount (see instructions)	0	28. 01
29. 00	Total IME payment ( sum of lines 22 and 28)	308, 239	
29. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	180, 176	29. 01
20.22	Disproportionate Share Adjustment		20.00
	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	4.00	
31. 00 32. 00	Percentage of Medicaid patient days (see instructions) Sum of lines 30 and 31	28. 68 32. 68	31. 00 32. 00
33. 00	Allowable disproportionate share percentage (see instructions)	16. 17	
	Disproportionate share adjustment (see instructions)	756, 930	

CALCIII	Financial Systems FRANCISCAN HEAD ATION OF REIMBURSEMENT SETTLEMENT	LTH- DYER Provider CCN: 15-0090	Peri od:	u of Form CMS-2 Worksheet E	1002 10
CALCUL	ATTOM OF RETWINDURSEWIERT SETTEMBERT	Frovider Con. 13-0070	From 01/01/2023 To 12/31/2023	Part A Date/Time Pre	
		Title XVIII	Hospi tal	PPS	
			Prior to 10/1		
			1. 00	2. 00	
25 00	Uncompensated Care Payment Adjustment		( 074 402 450	E 020 00/ 7E7	25 00
35. 00 35. 01	Total uncompensated care amount (see instructions) Factor 3 (see instructions)		0. 000243131	5, 938, 006, 757 0, 000225055	
35. 01	Hospital UCP, including supplemental UCP (see instructions)		1, 671, 379	1, 336, 380	
35. 02	Pro rata share of the hospital UCP, including supplemental UC	P (see instructions)	1, 250, 100	335, 920	1
36. 00	Total UCP adjustment (sum of columns 1 and 2 on line 35.03)	or (see That do trons)	1, 586, 020	000, 720	36.00
	Additional payment for high percentage of ESRD beneficiary di	scharges (lines 40 throu			
40.00	Total Medicare discharges (see instructions)	<u> </u>	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	tions)	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	by line 41 divided by 7	0. 000000		44. 00
45. 00	days) Average weekly cost for dialysis treatments (see instructions	s)	0.00		45. 00
46. 00	Total additional payment (line 45 times line 44 times line 41	•	0		46. 00
47. 00	Subtotal (see instructions)	•	21, 859, 195		47. 00
48.00	Hospital specific payments (to be completed by SCH and MDH, s		48. 00		
	only. (see instructions)			A +	
				Amount 1.00	
49. 00	Total payment for inpatient operating costs (see instructions	5)		30, 217, 949	49. 00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I ar			1, 575, 083	50. 00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt.	III, see instructions)		0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, li	ne 49 see instructions).		184, 649	52. 00
53. 00	Nursing and Allied Health Managed Care payment			0	53. 00
54.00	Special add-on payments for new technologies			80, 501	54.00
54. 01	Islet isolation add-on payment	(0)		0	54. 01
55. 00 55. 01	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 6	59)		0	55. 00 55. 01
56. 00	Cellular therapy acquisition cost (see instructions) Cost of physicians' services in a teaching hospital (see intr	cuctions)		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.		in ough oo).	175, 508	•
59. 00	Total (sum of amounts on lines 49 through 58)	,		32, 233, 690	1
60.00	Primary payer payments			0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus	s line 60)		32, 233, 690	61. 00
62. 00	Deductibles billed to program beneficiaries			1, 849, 204	1
63.00	Coinsurance billed to program beneficiaries			54, 378	1
64.00	Allowable bad debts (see instructions)			297, 946	1
65. 00 66. 00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see inst	tructions)		193, 665 282, 051	1
67. 00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	tructrons)		30, 523, 773	•
68. 00	Credits received from manufacturers for replaced devices for	applicable to MS-DRGs (s	ee instructions)	0	
69. 00	Outlier payments reconciliation (sum of lines 93, 95 and 96).			0	69. 00
70. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		-,	0	70. 00
70. 50	Rural Community Hospital Demonstration Project (§410A Demonst	tration) adjustment (see	instructions)	0	70. 50
70. 75	N95 respirator payment adjustment amount (see instructions)			0	70. 75
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	tructions)		40 =:=	70. 89
70. 90	HSP bonus payment HVBP adjustment amount (see instructions)			-13, 513	1
70. 91 70. 92	HSP bonus payment HRR adjustment amount (see instructions)			-26, 013 0	70. 91 70. 92
70. 92 70. 93	Bundled Model 1 discount amount (see instructions) HVBP payment adjustment amount (see instructions)			-30, 177	•
10.73	1				1
70. 94	HRR adjustment amount (see instructions)			-59, 442	1 /0.94

Health Fin	ancial Systems	FRANCISCAN HEAL	TH- DYFR		In lie	u of Form CMS-:	2552-10
	ON OF REIMBURSEMENT SETTLEMENT	TIMINOT SOAN TIEAE	Provider Co	CN: 15-0090	Peri od:	Worksheet E	2332 10
					From 01/01/2023	Part A	
					To 12/31/2023	Date/Time Pre 5/30/2024 3:4	
-			Title	: XVIII	Hospi tal	PPS	o piii
			11 11 0		(уууу)	Amount	
					0	1. 00	
70. 96 Low	volume adjustment for federal fiscal year	(yyyy) (Enter ir	column 0		0	0	70. 96
	corresponding federal year for the period						
	volume adjustment for federal fiscal year				0	0	70. 97
	corresponding federal year for the period	lending on or aft	er 10/1)				
	Volume Payment-3				0	0	
	adjustment amount (see instructions)		0 0 70)			239, 808	
	ount due provider (line 67 minus lines 68 p	olus/minus lines 6	9 & 70)			30, 154, 820	1
	uestration adjustment (see instructions)					603, 096	1
	onstration payment adjustment amount after Juestration adjustment-PARHM pass-throughs	sequestration				0	71.02
	erim payments					28, 964, 687	
	erim payments erim payments-PARHM					20, 904, 007	72. 00
	erriii payiilerits-rakkiiii Itative settlement (for contractor use only	v)				0	1
	tative settlement-PARHM (for contractor us					Ü	73. 01
	ance due provider/program (line 71 minus l		2. 72. and			587, 037	
73)			.,,				
74. 01 Baĺ	ance due provider/program-PARHM (see instr	ructions)					74. 01
75.00 Pro	tested amounts (nonallowable cost report i	tems) in accordar	nce with CMS			7, 905, 933	75. 00
	. 15-2, chapter 1, §115.2						
	BE COMPLETED BY CONTRACTOR (lines 90 throu			T			
	erating outlier amount from Wkst. E, Pt. A,	line 2, or sum o	of 2.03 plus			0	90. 00
	4 (see instructions)					0	01 00
	oital outlier from Wkst. L, Pt. I, line 2 Prating outlier reconciliation adjustment a	mount (coo instri	ictions)			0	
1 '	nating outlier reconciliation adjustment amo	•	,			0	1
	rate used to calculate the time value of					0.00	
	ne value of money for operating expenses (s		10 (1 0113)			0.00	
	ne value of money for capital related expenses		ions)			0	96.00
70.00 111	is varies or money for superior for a construction oxport	1000 (000 111011 401			Prior to 10/1	On/After 10/1	70.00
					1. 00	2. 00	
HSP	Bonus Payment Amount				<u> </u>		
100.00 HSP	bonus amount (see instructions)				6, 117, 128	2, 061, 450	100. 00
	P Adjustment for HSP Bonus Payment						
	P adjustment factor (see instructions)				1. 0000000000	0. 9934449361	
	P adjustment amount for HSP bonus payment	(see instructions	5)		0	-13, 513	102. 00
	Adjustment for HSP Bonus Payment						
	adjustment factor (see instructions)				0. 9975	0. 9948	
	adjustment amount for HSP bonus payment (				-15, 293	-10, 720	104.00
	al Community Hospital Demonstration Projecthis the first year of the current 5-year				ru.		200 00
	res Act? Enter "Y" for yes or "N" for no.	demonstration per	roa unaer t	ne zist centu	'Y		200. 00
	t Reimbursement						1
	licare inpatient service costs (from Wkst.	D-1 Pt II line	49)		T		201. 00
	licare discharges (see instructions)	D 1, 1 C. 11, 11110	, , , ,				202.00
	e-mix adjustment factor (see instructions)						203. 00
	putation of Demonstration Target Amount Li		first year	of the curren	t 5-year demonst	ration	1
	i od)						
204 00 Mad	licare target amount						1204 no

102. Objeved adjustillent allount for HSP bonus payment (see fristructions)	٠	-13, 513	102.00
HRR Adjustment for HSP Bonus Payment			
103.00 HRR adjustment factor (see instructions)	0. 9975	0. 9948 1	103.00
104.00 HRR adjustment amount for HSP bonus payment (see instructions)	-15, 293	-10, 720 1	104.00
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00 Is this the first year of the current 5-year demonstration period under the 21st Century	,		200. 00
Cures Act? Enter "Y" for yes or "N" for no.			
Cost Reimbursement			
201.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)		2	201. 00
202.00 Medicare discharges (see instructions)		2	202. 00
203.00 Case-mix adjustment factor (see instructions)		2	203. 00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current	5-year demonstrat	ti on	
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)		2	206. 00
Adjustment to Medicare Part A Inpatient Reimbursement			
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)		2	211. 00
Comparision of PPS versus Cost Reimbursement			
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 reimbursement) (li	ie	2	218. 00
212 minus line 213) (see instructions)			

Provider CCN: 15-0090

				T: +1 -	V(/IIII	11: 4-1	5/30/2024 3: 4	5 pm
		W/S F Dart A	Amounts (from	Pre/Post	Period Prior	Hospi tal Peri od	PPS Total (Col 2	
		line	E, Part A)	Entitlement		On/After 10/01	through 4)	
		0	1.00	2.00	3.00	4. 00	5. 00	
1.00	DRG amounts other than outlier	1. 00	0	0	0	0	0	1. 00
1. 01	payments DRG amounts other than outlier payments for discharges	1. 01	14, 120, 607	0	14, 120, 607		14, 120, 607	1. 01
1. 02	occurring prior to October 1 DRG amounts other than outlier payments for discharges	1. 02	4, 603, 695	0		4, 603, 695	4, 603, 695	1. 02
1.03	occurring on or after October DRG for Federal specific operating payment for Model 4 BPCI occurring prior to Octobe	1.03	0	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	0	1. 04
2. 00	Outlier payments for discharge (see instructions)							2. 00
2. 01	Outlier payments for discharge for Model 4 BPCI		0	0	_		0	2. 01
2. 02	Outlier payments for discharge occurring prior to October 1 (see instructions)	5 2.03	289, 382	0	289, 382		289, 382	2. 02
2. 03	Outlier payments for discharge occurring on or after October (see instructions)	s 2. 04 1	194, 322	0		194, 322	194, 322	2. 03
3.00	Operating outlier reconciliation	2. 01	0	0	0	0	0	3. 00
4.00	Managed care simulated payments Indirect Medical Education Adju		10, 944, 943	0	8, 203, 456	2, 741, 487	10, 944, 943	4. 00
5.00	Amount from Worksheet E, Part	21. 00	0. 030378	0. 030378	0. 030378	0. 030378		5. 00
6. 00	A, line 21 (see instructions)  IME payment adjustment (see	22. 00	308, 239	0	232, 453	75, 786	308, 239	6. 00
6. 01	instructions) IME payment adjustment for managed care (see instructions)	22. 01	180, 176	0	135, 046	45, 130	180, 176	6. 01
	Indirect Medical Education Adju		Add-on for Se	ction 422 of t	he MMA			
7.00	IME payment adjustment factor	27. 00	0. 000000	0. 000000	0.000000	0. 000000		7. 00
8. 00	(see instructions) IME adjustment (see	28. 00	0	0	0	0	0	8. 00
8. 01	instructions) IME payment adjustment add on	28. 01	0	0	0	0	0	8. 01
9. 00	for managed care (see instructions) Total IME payment (sum of lines	s 29.00	308, 239	0	232, 453	75, 786	308, 239	9. 00
9. 01	6 and 8) Total IME payment for managed	29. 01	180, 176	0			180, 176	
	care (sum of lines 6.01 and 8.01)		·		·	·	·	
	Disproportionate Share Adjustme							
10. 00	Allowable disproportionate share percentage (see	33. 00	0. 1617	0. 1617	0. 1617	0. 1617		10. 00
11. 00	instructions) Disproportionate share adjustment (see instructions)	34.00	756, 930	0	570, 826	186, 104	756, 930	11. 00
11. 01	Uncompensated care payments	36. 00	1, 586, 020	0	1, 250, 100	335, 920	1, 586, 020	11. 01
12. 00	Additional payment for high per Total ESRD additional payment	centage of ESF 46.00	ש beneficiary ס	di scharges 0	0	0	0	12. 00
	(see instructions)							
13. 00 14. 00	Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.)	47. 00 48. 00	21, 859, 195 32, 763, 965	0		5, 395, 827 0	21, 859, 195 0	13. 00 14. 00
15. 00	(see instructions) Total payment for inpatient operating costs (see instructions)	49. 00	30, 217, 949	0	24, 776, 992	5, 440, 957	30, 217, 949	15. 00
16. 00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1, 575, 083	0	1, 178, 890	396, 193	1, 575, 083	16. 00
17. 00	Special add-on payments for new technologies	v 54.00	80, 501	0	80, 501	0	80, 501	17. 00
17. 01	Net organ aquisition cost							17. 01

Heal th	Financial Systems		FRANCISCAN HE	ALTH- DYER		In Lie	u of Form CMS-2	2552-10
LOW VO	ILUME CALCULATION EXHIBIT 4			Provider Co	F	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part A Exhibi Date/Time Pre 5/30/2024 3:4	pared:
				Title	XVIII	Hospi tal	PPS	
		W/S E, Part A	Amounts (from	Pre/Post	Period Prior	Peri od	Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	On/After 10/01	through 4)	
		0	1.00	2.00	3.00	4. 00	5. 00	
17. 02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68. 00	0	0	C	0	0	17. 02
18. 00	Capital outlier reconciliation adjustment amount (see instructions)		O	0	C	0	0	18. 00
19.00	SUBTOTAL			0	26, 036, 383	5, 837, 150	31, 873, 533	19. 00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4. 00	5. 00	
20. 00	Capital DRG other than outlier	1. 00	1, 422, 103	0	1, 065, 110	356, 993	1, 422, 103	20. 00
20. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	0	0	(	0	0	20. 01
21.00	Capital DRG outlier payments	2. 00	29, 968	0	21, 648	8, 320	29, 968	21. 00
21. 01	Model 4 BPCI Capital DRG outlier payments	2. 01	0	0	C	0	0	21. 01
22. 00	Indirect medical education percentage (see instructions)	5. 00	0. 0181	0. 0181	0. 0181	0. 0181		22. 00
23. 00	Indirect medical education adjustment (see instructions)	6. 00	25, 740	0	19, 278	6, 462	25, 740	23. 00
24. 00	Allowable disproportionate share percentage (see instructions)	10. 00	0. 0684	0. 0684	0. 0684	0. 0684		24. 00
25. 00	Disproportionate share adjustment (see instructions)	11. 00	97, 272	0	72, 854	24, 418	97, 272	25. 00
26. 00	Total prospective capital payments (see instructions)	12. 00	1, 575, 083	0	1, 178, 890	396, 193	1, 575, 083	26. 00
		W/S E, Part A						
		1:00	Dos+ A)					

Part A) 1.00

2.00

3.00

0.000000

4. 00

0. 000000

5. 00

27. 00 28. 00

29. 00 100. 00

line

0

70. 96

70. 97

27.00 Low volume adjustment factor
28.00 Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)

29.00 Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)
100.00 Transfer low volume adjustments to Wkst. E, Pt. A.

Heal th Financial SystemsFRANCISCAN HEADHOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 Provider CCN: 15-0090

				10	) 12/31/2023	5/30/2024 3: 4!	
			Title	XVIII	Hospi tal	PPS	<u> </u>
		Wkst. E, Pt.	Amt. from	Period to	Period on	Total (cols. 2	
		A, line	Wkst. E, Pt.	10/01	after 10/01	and 3)	
			A)				
		0	1. 00	2. 00	3. 00	4. 00	
1. 00	DRG amounts other than outlier payments	1. 00					1. 00
1. 01	DRG amounts other than outlier payments for	1. 01	14, 120, 607	14, 120, 607		14, 120, 607	1. 01
	discharges occurring prior to October 1						
1. 02	DRG amounts other than outlier payments for	1. 02	4, 603, 695		4, 603, 695	4, 603, 695	1. 02
1. 03	discharges occurring on or after October 1 DRG for Federal specific operating payment	1. 03		0		0	1. 03
1.03	for Model 4 BPCI occurring prior to October 1	1.03		U		U	1. 03
1. 04	DRG for Federal specific operating payment	1. 04	0		0	0	1. 04
	for Model 4 BPCI occurring on or after				ŭ	, and the second se	
	October 1						
2.00	Outlier payments for discharges (see	2.00					2.00
	instructions)						
2.01	Outlier payments for discharges for Model 4	2. 02	0	0	0	0	2. 01
	BPCI						
2. 02	Outlier payments for discharges occurring	2. 03	289, 382	289, 382		289, 382	2. 02
0.00	prior to October 1 (see instructions)	0.04	404 000		404 000	404 000	0.00
2. 03	Outlier payments for discharges occurring on	2. 04	194, 322		194, 322	194, 322	2. 03
3.00	or after October 1 (see instructions) Operating outlier reconciliation	2. 01	0	0	0	0	3. 00
4.00	Managed care simulated payments	3. 00	10, 944, 943	8, 203, 456	2, 741, 487	10, 944, 943	4. 00
4.00	Indirect Medical Education Adjustment	3.00	10, 744, 743	0, 203, 430	2, 741, 407	10, 744, 743	4.00
5.00	Amount from Worksheet E, Part A, Line 21 (see	21.00	0. 030378	0. 030378	0. 030378		5. 00
0.00	instructions)	21.00	0.000070	0.000070	0.000070		0.00
6.00	IME payment adjustment (see instructions)	22. 00	308, 239	232, 453	75, 786	308, 239	6. 00
6. 01	IME payment adjustment for managed care (see	22. 01	180, 176	135, 046	45, 130	180, 176	6. 01
	instructions)						
	Indirect Medical Education Adjustment for the						
7.00	IME payment adjustment factor (see	27. 00	0. 000000	0. 000000	0. 000000		7. 00
	instructions)		_	_	_	_	
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8. 00
8. 01	IME payment adjustment add on for managed	28. 01	0	0	0	0	8. 01
9. 00	care (see instructions) Total IME payment (sum of lines 6 and 8)	29. 00	308, 239	232, 453	75, 786	308, 239	9. 00
9. 01	Total IME payment for managed care (sum of	29. 01	180, 176	135, 046	45, 130	180, 176	9. 00
7. 01	lines 6.01 and 8.01)	27.01	100, 170	133, 040	45, 150	100, 170	7. 01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage	33.00	0. 1617	0. 1617	0. 1617		10.00
	(see instructions)						
11. 00	Di sproporti onate share adjustment (see	34.00	756, 930	570, 826	186, 104	756, 930	11.00
	instructions)						
11. 01	Uncompensated care payments	36.00	1, 586, 020	1, 250, 100	335, 920	1, 586, 020	11. 01
10.00	Additional payment for high percentage of ESR			0		0	10.00
12. 00	Total ESRD additional payment (see	46. 00	0	0	0	U	12. 00
13. 00	instructions) Subtotal (see instructions)	47.00	21, 859, 195	16, 463, 368	5, 395, 827	21, 859, 195	13. 00
14. 00	Hospital specific payments (completed by SCH	48.00	32, 763, 965	24, 695, 088	8, 068, 877	32, 763, 965	
14.00	and MDH, small rural hospitals only.) (see	40.00	32, 703, 703	24, 075, 000	0,000,011	32, 703, 703	14.00
	instructions)						
15.00	Total payment for inpatient operating costs	49. 00	30, 217, 949	22, 772, 204	7, 445, 745	30, 217, 949	15. 00
	(see instructions)						
16.00	Payment for inpatient program capital (from	50.00	1, 575, 083	1, 178, 890	396, 193	1, 575, 083	16.00
	Wkst. L, Pt. I, if applicable)						
17. 00	Special add-on payments for new technologies	54.00	80, 501	80, 501	0	80, 501	17. 00
17. 01	Net organ acquisition cost						17. 01
17. 02	Credits received from manufacturers for	68. 00	0	0	0	0	17. 02
10 00	replaced devices for applicable MS-DRGs	02.00		0	0		10 00
18. 00	Capital outlier reconciliation adjustment amount (see instructions)	93. 00	0	U	0	0	18. 00
19. 00	SUBTOTAL			24, 031, 595	7, 841, 938	31, 873, 533	19. 00
17.00	333.3	ı	ı	21,031,070	7,041,730	01,070,000	17.00

Heal th	Financial Systems	FRANCISCAN HI	EALTH- DYER		In Lie	eu of Form CMS-2	2552-10
HOSPI T	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5	Provi der C	F	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part A Exhibi Date/Time Pre 5/30/2024 3:4	pared:
				XVIII	Hospi tal	PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3. 00	4. 00	
20. 00	Capital DRG other than outlier	1.00	1, 422, 103	1, 065, 110	356, 993	1, 422, 103	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	29, 968	21, 648	8, 320	29, 968	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. 0181	0. 0181	0. 0181		22. 00
23. 00	Indirect medical education adjustment (see instructions)	6. 00	25, 740	19, 278	6, 462	25, 740	23. 00
24. 00	Allowable disproportionate share percentage (see instructions)	10.00	0. 0684	0. 0684	0.0684		24. 00
25. 00	Disproportionate share adjustment (see instructions)	11.00	97, 272	72, 854	24, 418	97, 272	25. 00
26. 00	Total prospective capital payments (see instructions)	12.00	1, 575, 083	1, 178, 890	396, 193	1, 575, 083	26. 00
	,	Wkst. E, Pt.	(Amt. from				
		A, line	Wkst. E, Pt.				
			A)				
		0	1. 00	2.00	3. 00	4. 00	
27. 00							27. 00
28. 00	Low volume adjustment prior to October 1	70. 96	0	(		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	-30, 177	•	,	· ·	30. 00
30. 01	HVBP payment adjustment for HSP bonus paymen (see instructions)		-13, 513	(	-13, 513	-13, 513	
31.00	HRR adjustment (see instructions)	70. 94	-59, 442	-35, 504	-23, 938	-59, 442	31. 00
31. 01	HRR adjustment for HSP bonus payment (see	70. 91	-26, 013	-15, 293	-10, 720	-26, 013	31. 01

0

70. 99

1.00

Υ

2.00

239, 808

3.00

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

4.00

239, 808

32. 00

100. 00

instructions)

32.00 HAC Reduction Program adjustment (see

instructions)

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

Health Financial Systems	FRANCISCAN HEALTH- DYER	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0090	Peri od: From 01/01/2023	
		To 12/31/2023	Date/Time Prepared: 5/30/2024 3:45 pm
	T		550

			Title XVIII	Hospi tal	5/30/2024 3: 45 PPS	5 pm
Medical and other services (see Instructions)					1. 00	
Medical and other services rienbursed under OPPS (see instructions)   13,246,113   2,00						
1.00   Out for payment (see instructions)   1.200, 319   3.00		, , , , , , , , , , , , , , , , , , ,	ons)			
0.000   0.00			5.1.0)			
Enter the hospital specific payment to cost ratio (see instructions)						
Line 2   Times   Line 5   0.00   0.00		, , , , , , , , , , , , , , , , , , ,	ions)			
1			10113)			
9.00   Ancil lary service other pass through costs including REH direct graduate medical education costs from   9.01   10.00   Organ acquisitions   0.10.00   10.00						
Wisst. D, *Pt. IV, cal. 13, line 200   10.00   10.00   10.01   10.00		1 3 1	araduato modical oduca	ation costs from		
10.00   Organ acquisitions   0   10.00   10.	9.00		graduate medicar educa	TITOH COSTS TIOH	55, 154	9.00
COMPUTATION OF LESSER OF COST OR CHARGES   Reasonable   Re	10.00				0	10. 00
Reasonable charges	11. 00				1, 837	11. 00
12.00   Ancil l'ary service charges   6,656   12.00   13.00   10.10						
14. 00   Total reasonable charges (sum of lines 12 and 13)	12.00				6, 656	12. 00
Substanting Charges   Conting   Co			e 69)			
15.00   Aggregate amount actually collected from patients liable for payment for services on a charge basis   0   16.00	14. 00				6, 656	14. 00
16.00   Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)   0.0000000   17.00   0.0000000   17.00   0.0000000   17.00   0.0000000   17.00   0.0000000   17.00   0.0000000   17.00   0.0000000   17.00   0.0000000   17.00   0.0000000   17.00   0.0000000   17.00   0.0000000   17.00   0.0000000   17.00   0.0000000   17.00   0.0000000   17.00   0.0000000   17.00   0.0000000   17.00   0.0000000   17.00   0.0000000   0.00000000   0.00000000	15. 00		yment for services on a	charge basis	0	15. 00
17.00	16.00	Amounts that would have been realized from patients liable for p	,	~	iad 0	16. 00
18.00   Total customary charges (see Instructions)	17 00				0.000000	17 00
19.00   Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see   4,819   19.00   instructions)   Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see   0   20.00   instructions)   1,837   21.00   22.00   Cost of physic lans' services in a teaching hospital (see instructions)   0   22.00   22.00   Cost of physic lans' services in a teaching hospital (see instructions)   0   22.00   Cost of physic lans' services in a teaching hospital (see instructions)   0   22.00   Cost of physic lans' services in a teaching hospital (see instructions)   1,303,735   24.00   Computation of RELMBURSEMENT SETTLEMENT   11,306,735   24.00   Computation of RELMBURSEMENT SETTLEMENT   1,306,735   24.00   Computation of RELMBURSEMENT SETTLEMENT   1,306,735   24.00   Computation of RELMBURSEMENT SETTLEMENT   1,306,735   24.00   Computation of Instructions   1,307,318   26.00   Computation of Instructions   2,308   2.00   Computation of Instructions   2,308   2.00   Computation of Instructions   2,308   2.00   Computation of Instructions   2,309   2.00   Computation of Instructions   2,309   2.00   Computation of Instructions   2,309   2.00   2.						
20.00   Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see   1,837   21.00   22.00   2			if line 18 exceeds lin	ne 11) (see		
Instructions    1,837   21.00	20.00		if line 11 evenede lin	20 10) (222		20.00
21.00   Lesser of cost or charges (see instructions)   0.22.00   Cost of physicians' services in a teaching pospital (see instructions)   0.22.00   Cost of physicians' services in a teaching pospital (see instructions)   0.23.00   Cost of physicians' services in a teaching pospital (see instructions)   11, 306, 735   24.00   Computation of Reimbursement (sum of lines 3, 4, 4.01, 8 and 9)   11, 306, 735   24.00   Computation of Reimbursement (sum of lines 3, 4.01, 8 and 9)   11, 306, 735   24.00   Computation of Reimbursement Settlement   25.00   Deductible sand Coinsurance amounts (for CAH, see instructions)   1, 873, 18   26.00   Computation of Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)   1, 873, 18   26.00   Computation endical education payments (from Wkst. E-4, line 50)   7, 318   28.00   Computation endical education payments (from Wkst. E-4, line 50)   7, 318   28.00   Computation endical education costs (from Wkst. E-4, line 36)   29.00   Computation of lines 27, 28, 28.50 and 29)   29.00   29.0	20.00		II TITTLE IT EXCEEDS ITT	ie 18) (See	٥	20.00
23.00   Cost of physicians' services in a teaching hospital (see instructions)   1.0   23.00	21.00				1, 837	21. 00
24. 00   Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)   11, 306, 735   24. 00   COMPUTATION OF REIMBURSEMENT SETTLEMENT   25. 00   Deductibles and coinsurance amounts (for CAH, see instructions)   0, 25. 00   26. 00   Deductibles and Coinsurance amounts (for CAH, see instructions)   1, 873, 118   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 instructions)   73, 183   28. 00   28. 50   REH facility payment amount (see instructions)   28. 50   28. 50   REH facility payment amount (see instructions)   28. 50   28. 50   REB facility payment amount (see instructions)   28. 50   29. 00   ESRD direct medical education costs (from Wkst. E-4, line 36)   29. 00   28. 50   REB facility payment amount (see instructions)   9, 508, 637   30. 00   30. 00   Subtotal (sum of lines 27, 28, 28, 50 and 29)   1, 087   31. 00   31. 00   7 mary payments   9, 508, 637   30. 00   30. 00   Subtotal (line 30 minus line 31)   9, 507, 550   32. 00   30. 0			-+!>			
COMPUTATION OF REIMBURSEMENT SETTLEMENT   Deductibles and coinsurance amounts (for CAH, see instructions)   0   25.00   26.00   Deductibles and Coinsurance amounts (for CAH, see instructions)   1,873,118   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   9,435,454   27.00   28.00   Direct graduate medical education payments (from Wkst. E-4, line 50)   73,183   28.00   28.00   ESRD direct medical education costs (from Wkst. E-4, line 36)   29.00   29.00   ESRD direct medical education costs (from Wkst. E-4, line 36)   9,508,637   30.00   30.00   Subtotal (sum of lines 27, 28, 28.50 and 29)   9,508,637   30.00   31.00   Primary payer payments   1,087   31.00   32.00   AUDITOR (line 30 minus line 31)   1,087   31.00   33.00   Subtotal (line 30 minus line 31)   0   33.00   34.00   Allowable Bab DBTS (EXCLUDE BAD DBTS FOR PROFESSIONAL SERVICES)   35.00   Adjusted reimbursable bad debts (see instructions)   96,364   35.00   35.00   Adjusted reimbursable bad debts (see instructions)   96,344   35.00   37.00   Subtotal (see instructions)   9,603,914   37.00   38.00   MSP-LCC reconciliation amount from PS&R   9,603,914   37.00   39.50   Pioneer ACO demonstration payment adjustment (see instructions)   9,39.75   39.75   No respirator payment adjustment amount (see instructions)   9,603,914   39.90   39.75   No respirator payment adjustment amount before sequestration   9,900   39.99   40.00   Subtotal (see instructions)   9,603,916   40.00   40.01   Sequestration adjustment (see instructions)   9,603,916   40.00   40.02   Demonstration payment adjustment amount after sequestration   9,30,717   40.00   40.01   Sequestration adjustment (see instructions)   9,603,916   40.00   40.01   Sequestration adjustment (for contractors use only)   42.00   42.01   Tentative settlement (for contractors use only)   42.00   42.01   Tentative settlement (for contractor use only)   42.01   42.01   Tentative settlement (for contractor use only)   42.01   42.01   Tentative			CTIONS)			
26.00   Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)   1,873,118   26.00   Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)   73,183   28.00	21.00				11,000,700	21.00
27. 00   Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)   73, 183   28. 00     28. 00   Direct graduate medical education payments (from Wkst. E-4, line 50)   73, 183   28. 00     28. 50   REH facility payment amount (see instructions)   28. 50     29. 00   ESRD direct medical education costs (from Wkst. E-4, line 36)   0. 29. 00     30. 00   Subtotal (sum of lines 27, 28, 28. 50 and 29)   9,508, 637   30. 00     31. 00   Primary payer payments   1,087   31. 00     32. 00   Subtotal (line 30 minus line 31)   9,507,550   32. 00     32. 00   AlLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)   148, 252   34. 00     33. 00   Composite rate ESRD (from Wkst. I-5, line 11)   0   33. 00     34. 00   Allowable bad debts (see instructions)   148, 252   34. 00     35. 00   Adjusted reimbursable bad debts (see instructions)   9,6,364   35. 00     36. 00   Allowable bad debts for dual eligible beneficiaries (see instructions)   9,603, 41   37. 00     39. 00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   39. 00     39. 50   Pioneer ACO demonstration payment adjustment (see instructions)   9,603, 49   40. 00     39. 99   RECOVERY OF ACCELERATED DEPRECIATION   9,903, 91   40. 00     40. 01   Sequestration adjustment (see instructions)   9,603, 91   40. 00     40. 01   Sequestration adjustment (see instructions)   9,900, 31,91   40. 00     40. 01   Sequestration adjustment (see instructions)   9,603, 91   40. 00     40. 01   Interim payments   9,360,170   41. 00     40. 02   Tentative settlement (for contractors use only)   42. 01     40. 01   Tentative settlement (For contractors use only)   42. 01     40. 01   Tentative settlement (For contractors use only)   42. 01     40. 02   Tentative settlement (For contractors use only)   42. 01     40. 02   Tentative settlement (For contractors use only)   42. 01     40. 01   Tentative settlement (For contractors use only)   42. 01     40. 02   Tentative settlement (For contractors use only)   4						
instructions) Direct graduate medical education payments (from Wkst. E-4, line 50) REH facility payment amount (see instructions) 28. 50 REH facility payment amount (see instructions) 29. 00 ESRD direct medical education costs (from Wkst. E-4, line 36) 30. 00 Subtotal (sum of lines 27, 28, 28, 50 and 29) 9, 508, 637, 30, 00 Primary payer payments 1, 087, 31, 00 Primary payer payments 1, 087, 31, 00 Direct graduate medical education costs (from Wkst. E-4, line 36) 1, 087, 31, 00 Direct graduate medical education costs (from Wkst. E-4, line 36) 1, 087, 31, 00 Direct graduate medical education costs (from Wkst. E-4, line 36) 1, 087, 31, 00 Direct graduate medical education costs (from Wkst. E-4, line 36) 1, 087, 31, 00 Direct graduate medical education costs (from Wkst. E-4, line 36) 1, 087, 31, 00 Direct graduate medical education costs (from Wkst. E-4, line 36) 1, 087, 31, 00 Direct graduate medical education costs (from Wkst. E-4, line 36) 1, 087, 31, 00 Direct graduate medical education costs (from Wkst. E-4, line 36) 1, 087, 31, 00 Direct graduate medical education costs (from Wkst. E-4, line 36) 1, 087, 31, 00 Direct graduate medical education costs (from Wkst. E-4, line 36) 1, 087, 50 Direct graduate medical education costs (from Wkst. E-4, line 36) 1, 087, 50 Direct graduate medical education costs (from Wkst. E-4, line 36) 1, 087, 50 Direct graduate medical education form Skst. E-4, line 36) 1, 087, 50 Direct graduate medical education form Skst. E-4, line 36) 1, 087, 50 Direct graduate medical education form Skst. E-4, line 36) 1, 087, 50 Direct graduate medical education form Skst. E-4, line 36) 1, 087, 50 Direct graduate medical education form Skst. E-4, line 36) 1, 087, 50 Direct graduate medical education form Skst. E-4, line 36) 1, 087, 50 Direct graduate from Skst. E-4, line 36) 1, 087, 50 Direct graduate from Skst. E-4, line 36) 1, 097, 50 Direct graduate from Skst. E-4, line 36) 1, 097, 50 Direct graduate from Skst. E-4, line 36) 1, 097, 50 Direct graduate from Skst. E-4, line 36) 1, 097, 50 Dire			•			
28. 50       REH Facility payment amount (see instructions)       28. 50         29. 00       ESRD direct medical education costs (from Wkst. E-4, line 36)       0         30. 00       Subtotal (sum of lines 27, 28, 28. 50 and 29)       9, 508, 637         31. 00       Primary payer payments       1, 087         32. 00       Subtotal (line 30 minus line 31)       9, 507, 550         32. 00       Composite rate ESRD (from Wkst. I -5, line 11)       0         33. 00       Composite rate ESRD (from Wkst. I -5, line 11)       0         35. 00       Adj usable bad debts (see instructions)       148, 252         36. 00       All lowable bad debts for dual eligible beneficiaries (see instructions)       96, 364         36. 00       All lowable bad debts for dual eligible beneficiaries (see instructions)       9, 603, 914         37. 00       Subtotal (see instructions)       9, 603, 914         38. 00       MSP-LCC reconcilliation amount from PS&R       -2         39. 00       THER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)       0         39. 75       N95 respirator payment adjustment amount (see instructions)       9, 50         39. 75       N95 respirator payment adjustment amount before sequestration       0       39, 97         39. 99       PecovERY OF ACCELERATED DEPRECIATION       0       9, 99	27.00		us the sum of filles 22	and 25] (See	7, 433, 434	27.00
29. 00   SRD direct medical education costs (from Wkst. E-4, line 36)   9, 90   03   00   05   00   00   05   00   00   05   00		· · · · · · · · · · · · · · · · · · ·	e 50)		73, 183	
30.00   Subtotal (sum of lines 27, 28, 28.50 and 29)   9,508,637   30.00   31.00   Primary payer payments   1,087   31.00   20.00		, , ,			0	
32. 00   Subtotal (line 30 minus line 31)   9,507,550   32. 00   ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)   0   33. 00   34. 00   34. 00   Allowable bad debts (see instructions)   148, 252   34. 00   35. 00   Adjusted reimbursable bad debts (see instructions)   96, 364   35. 00   37. 00   38. 00   Allowable bad debts for dual eligible beneficiaries (see instructions)   9, 603, 914   37. 00   38. 00   MSP-LCC reconciliation amount from PS&R   9, 603, 914   37. 00   39. 00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   39. 50   39. 75   39. 75   Demonstration payment adjustment amount (see instructions)   0   39. 75   39. 97   Demonstration payment adjustment amount before sequestration   9   Partial or full credits received from manufacturers for replaced devices (see instructions)   9, 603, 916   40. 00		· · · · · · · · · · · · · · · · · · ·				
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)   33. 00   Composite rate ESRD (from Wkst. 1-5, line 11)   0   33. 00     34. 00   Allowable bad debts (see instructions)   148, 252   34. 00     35. 00   Adjusted reimbursable bad debts (see instructions)   96, 364   35. 00     36. 00   Allowable bad debts for dual eligible beneficiaries (see instructions)   111, 199   36. 00     37. 00   Subtotal (see instructions)   9, 603, 914   37. 00     38. 00   MSP-LCC reconciliation amount from PS&R   -2   38. 00     39. 00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   39. 00     39. 50   Pioneer ACO demonstration payment adjustment (see instructions)   39. 75     39. 75   N95 respirator payment adjustment amount (see instructions)   0   39. 97     39. 98   Partial or full credits received from manufacturers for replaced devices (see instructions)   19, 000   39. 98     39. 99   RECOVERY OF ACCELERATED DEPRECIATION   0   39. 98     40. 00   Subtotal (see instructions)   9, 603, 916   40. 00     40. 01   Sequestration adjustment (see instructions)   99, 603, 916   40. 00     40. 02   Demonstration payment adjustment amount after sequestration   99, 360, 170   41. 00     41. 01   Interim payments Algustment (for contractors use only)   42. 01     42. 01   Tentative settlement (for contractors use only)   42. 01     43. 00   Balance due provider/program (see instructions)   51, 668   43. 00						
33. 00 Composite rate ESRD (from Wkst. I-5, line 11)  34. 00 Al I lowable bad debts (see instructions)  35. 00 Adj usted reimbursable bad debts (see instructions)  36. 00 Al lowable bad debts for dual eligible beneficiaries (see instructions)  37. 00 Adj usted reimbursable bad debts (see instructions)  38. 00 MSP-LCC reconciliation amount from PS&R  39. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  39. 50 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  39. 50 Pi oneer ACO demonstration payment adj ustment (see instructions)  39. 75 MSP respirator payment adj ustment amount (see instructions)  39. 97 Partial or full credits received from manufacturers for replaced devices (see instructions)  39. 98 RECOVERY OF ACCELERATED DEPRECIATION  40. 00 Subtotal (see instructions)  40. 01 Sequestration adj ustment (see instructions)  40. 02 Demonstration payment adj ustment amount after sequestration  40. 03 Sequestration adj ustment (see instructions)  40. 01 Interim payments  40. 03 Interim payments  40. 03 Interim payments-PARHM  41. 01 Interim payments-PARHM (for contractors use only)  42. 01 Tentative settl ement (for contractor use only)  43. 00 Balance due provider/program (see instructions)  51, 668 43. 00	32. 00		2)		9, 507, 550	32. 00
34.00 Allowable bad debts (see instructions) 35.00 Adjusted reimbursable bad debts (see instructions) 36.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 37.00 Subtotal (see instructions) 38.00 MSP-LCC reconciliation amount from PS&R 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39.50 Pioneer ACO demonstration payment adjustment (see instructions) 39.75 N95 respirator payment adjustment amount (see instructions) 39.97 Demonstration payment adjustment amount before sequestration 39.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 39.99 RECOVERY OF ACCELERATED DEPRECIATION 40.00 Subtotal (see instructions) 40.01 Sequestration adjustment (see instructions) 40.03 Sequestration adjustment (see instructions) 40.03 Sequestration adjustment (see instructions) 40.03 Sequestration adjustment amount after sequestration 40.03 Sequestration adjustment amount after sequestration 40.03 Sequestration adjustment (see instructions) 41.00 Interim payments 41.01 Interim payments 41.01 Interim payments-PARHM 42.00 Tentative settlement (for contractors use only) 42.01 Tentative settlement (for contractor use only) 43.00 Balance due provider/program (see instructions) 51,668 d3.00	33. 00		)		0	33. 00
36. 00 Allowable bad debts for dual eligible beneficiaries (see instructions) 37. 00 Subtotal (see instructions) 38. 00 MSP-LCC reconciliation amount from PS&R 39. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39. 50 Pioneer ACO demonstration payment adjustment (see instructions) 39. 75 Pomonstration payment adjustment amount (see instructions) 39. 97 Demonstration payment adjustment amount before sequestration 39. 98 Partial or full credits received from manufacturers for replaced devices (see instructions) 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 40. 00 Subtotal (see instructions) 40. 01 Sequestration adjustment (see instructions) 40. 02 Demonstration payment adjustment amount after sequestration 40. 03 Sequestration adjustment (see instructions) 41. 00 Interim payments 41. 01 Interim payments 41. 01 Interim payments-PARHM 42. 00 Tentative settlement (for contractors use only) 43. 00 Balance due provider/program (see instructions) 51, 668 43. 00		Allowable bad debts (see instructions)				
37.00 Subtotal (see instructions) 38.00 MSP-LCC reconciliation amount from PS&R 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39.50 Pioneer ACO demonstration payment adjustment (see instructions) 39.75 N95 respirator payment adjustment amount (see instructions) 39.75 Demonstration payment adjustment amount before sequestration 39.97 Demonstration payment adjustment amount before sequestration 39.98 RECOVERY OF ACCELERATED DEPRECIATION 39.99 RECOVERY OF ACCELERATED DEPRECIATION 40.00 Subtotal (see instructions) 40.01 Sequestration adjustment (see instructions) 40.02 Demonstration payment adjustment amount after sequestration 40.03 Sequestration adjustment (see instructions) 41.00 Interim payments 41.01 Interim payments-PARHM 42.00 Tentative settlement (for contractors use only) 43.00 Balance due provider/program (see instructions) 51,668 43.00			ationa)			
38. 00 MSP-LCC reconciliation amount from PS&R 39. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39. 50 Pi oneer ACO demonstration payment adjustment (see instructions) 39. 75 N95 respirator payment adjustment amount (see instructions) 39. 97 Demonstration payment adjustment amount before sequestration 39. 98 Partial or full credits received from manufacturers for replaced devices (see instructions) 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 40. 00 Subtotal (see instructions) 40. 01 Sequestration adjustment (see instructions) 40. 02 Demonstration payment adjustment amount after sequestration 40. 02 Demonstration payment adjustment amount after sequestration 40. 03 Sequestration adjustment -PARHM pass-throughs 41. 00 Interim payments 41. 01 Interim payments-PARHM 42. 00 Tentative settlement (for contractor use only) 43. 00 Bal ance due provider/program (see instructions) 51, 668 43. 00			2110115)			
39. 50 Pi oneer ACO demonstration payment adjustment (see instructions) 39. 75 N95 respirator payment adjustment amount (see instructions) 39. 97 Demonstration payment adjustment amount before sequestration 39. 98 Partial or full credits received from manufacturers for replaced devices (see instructions) 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 40. 00 Subtotal (see instructions) 40. 01 Sequestration adjustment (see instructions) 40. 02 Demonstration payment adjustment amount after sequestration 40. 02 Demonstration payment adjustment amount after sequestration 40. 03 Sequestration adjustment-PARHM pass-throughs 41. 00 Interim payments 41. 01 Interim payments-PARHM 42. 00 Tentative settlement (for contractors use only) 42. 01 Tentative settlement-PARHM (for contractor use only) 43. 00 Bal ance due provider/program (see instructions) 51, 668 43. 00						
39.75 39.97 Demonstration payment adjustment amount (see instructions) 39.97 Demonstration payment adjustment amount before sequestration 39.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 39.99 RECOVERY OF ACCELERATED DEPRECIATION 40.00 Subtotal (see instructions) 40.01 Sequestration adjustment (see instructions) 40.02 Demonstration payment adjustment amount after sequestration 40.03 Sequestration adjustment—PARHM pass-throughs 41.00 Interim payments 42.00 Tentative settlement—PARHM (for contractors use only) 42.01 Tentative settlement—PARHM (for contractor use only) 43.00 Bal ance due provider/program (see instructions)  0 39.75 0 39.97 0 39.98 0 39.99 0 40.02 0 9,603,916 0 40.02 0 192,078 0 40.01 0 40.02 0 40.02 0 40.03 0		, , , , ,			0	
39. 97 39. 98 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 40. 00 Subtotal (see instructions) 50. 39. 97 40. 00 Subtotal (see instructions) 40. 01 Sequestration adjustment (see instructions) 40. 02 Demonstration payment adjustment amount after sequestration 40. 03 Sequestration adjustment amount after sequestration 40. 03 Sequestration adjustment amount after sequestration 40. 03 Sequestration adjustment amount after sequestration 40. 01 Interim payments 41. 01 Interim payments-PARHM 42. 00 Tentative settlement (for contractors use only) 43. 00 Bal ance due provider/program (see instructions)  0 39. 97 40. 00 9, 603, 916 40. 00 40. 01 9, 603, 916 40. 00 40. 02 40. 02 40. 02 40. 03 41. 01 42. 00 Tentative settlement (for contractors use only) 42. 01 43. 00 Bal ance due provider/program (see instructions) 51, 668 43. 00					0	
39. 98 Partial or full credits received from manufacturers for replaced devices (see instructions) 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 40. 00 Subtotal (see instructions) 40. 01 Sequestration adjustment (see instructions) 40. 02 Demonstration payment adjustment amount after sequestration 40. 03 Sequestration adjustment-PARHM pass-throughs 41. 00 Interim payments 41. 00 Interim payments-PARHM 42. 00 Tentative settlement (for contractors use only) 42. 01 Tentative settlement-PARHM (for contractor use only) 43. 00 Bal ance due provider/program (see instructions)  19, 000 39. 98 0, 603, 916 0, 000 192, 078 0, 603, 916 0, 000 192, 078 0, 603, 916 0, 000 192, 078 0, 603, 916 0, 000 192, 078 0, 603, 916 0, 000 192, 078 0, 603, 916 0, 000 192, 078 0, 603, 916 0, 000 192, 078 0, 603, 916 0, 000 192, 078 0, 603, 916 0, 000 192, 078 0, 603, 916 0, 000 192, 078 0, 603, 916 0, 000 192, 078 0, 603, 916 0, 000 192, 007 0, 603, 916 0, 000 192, 007 0, 603, 916 0, 000 192, 007 0, 603, 916 0, 000 0, 603, 916 0, 000 0, 603, 916 0, 000 0, 603, 916 0, 000 0, 603, 916 0, 000 0, 603, 916 0, 000 0, 603, 916 0,						
40.00       Subtotal (see instructions)       9, 603, 916       40.00         40.01       Sequestration adjustment (see instructions)       192, 078       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       9, 360, 170       41.00         41.01       Interim payments-PARHM       41.00         42.00       Tentative settlement (for contractors use only)       0 42.00         42.01       Tentative settlement-PARHM (for contractor use only)       42.01         43.00       Bal ance due provider/program (see instructions)       51,668       43.00		Partial or full credits received from manufacturers for replaced	d devices (see instruct	i ons)		
40.01       Sequestration adjustment (see instructions)       192,078       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       9, 360, 170       41.00         41.01       Interim payments-PARHM       41.01         42.01       Tentative settlement (for contractors use only)       0       42.00         43.00       Bal ance due provider/program (see instructions)       51,668       43.00						
40.02 Demonstration payment adjustment amount after sequestration 40.03 Sequestration adjustment-PARHM pass-throughs 41.00 Interim payments 41.01 Interim payments-PARHM 42.00 Tentative settlement (for contractors use only) 42.01 Tentative settlement-PARHM (for contractor use only) 43.00 Balance due provider/program (see instructions)  0 40.02 40.03 41.00 41.00 41.01 41.01 42.01 51,668 43.00						
41.00       Interim payments       9, 360, 170       41.00         41.01       Interim payments-PARHM       41.01         42.00       Tentative settlement (for contractors use only)       0       42.00         42.01       Tentative settlement-PARHM (for contractor use only)       42.01         43.00       Bal ance due provider/program (see instructions)       51,668       43.00		· · · · · · · · · · · · · · · · · · ·				
41.01 Interim payments-PARHM 42.00 Tentative settlement (for contractors use only) 42.01 Tentative settlement-PARHM (for contractor use only) 43.00 Balance due provider/program (see instructions) 41.01 42.00 42.00 42.01 51,668 43.00					0.040.470	
42.00 Tentative settlement (for contractors use only) 42.01 Tentative settlement-PARHM (for contractor use only) 43.00 Balance due provider/program (see instructions)  0 42.00 42.01 51,668 43.00		1 3			9, 360, 170	
43.00 Balance due provider/program (see instructions) 51,668 43.00					0	
	42. 01	Tentative settlement-PARHM (for contractor use only)			ļ	42. 01
43. UT [parance due provider/program-PARIM (See FIISTructions) The Fig. UT					51, 668	
44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2 0 44.00			e with CMS Pub 15-2 o	hapter 1 §115 1		
TO BE COMPLETED BY CONTRACTOR	00			1/ 3/10/4		55
90.00 Original outlier amount (see instructions) 0 90.00		, ,				
91.00 Outlier reconciliation adjustment amount (see instructions)  92.00 The rate used to calculate the Time Value of Money  0 91.00 0 0 92.00						
93.00 Time Value of Money (see instructions) 0.00 93.00						
94.00 Total (sum of lines 91 and 93) 0 94.00	94. 00				o	94. 00

Health Financial Systems	FRANCISCAN HEAL	TH- DYER	In Lie	u of Form CMS	-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0090	Peri od:	Worksheet E	
			From 01/01/2023		
			To 12/31/2023	Date/Time Pr	epared:
				5/30/2024 3:	
		Title XVIII	Hospi tal	PPS	
				1. 00	
MEDICARE PART B ANCILLARY COSTS					
200.00 Part B Combined Billed Days					0 200. 00

Health Financial Systems	FRANCISCAN HEALTH- DYER	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0090	Period: From 01/01/2023	Worksheet E
	Component CCN: 15-T090	To 12/31/2023	
	Title XVIII	Subprovi der -	PPS

Martical and other services (sent instructions)		Title XVIII   Subprovider   IRF	- PPS	
Mark   F - NEUICAL AND OTHER HEALT SERVICES   1.00   Medical and other services (see instructions)   2.5   1.00   2.00			1 00	
Medical and other services reinbursed under OPPS (see Instructions)		PART B - MEDICAL AND OTHER HEALTH SERVICES	1.00	
200   OPES or BER payment (see instructions)   120   3.00		· · · · · · · · · · · · · · · · · · ·		
0.01   Outlier payment (see instructions)		· · · · · · · · · · · · · · · · · · ·	1	
0.000   0.00				
Infant the hospital appetitic payment to cost ratio (see instructions)				
Line 2   Times   1 in 6   0   0   0   0   0   0   0   0   0		· · · · · · · · · · · · · · · · · · ·		
Transit foral corridor payment (see instructions)   0   8.00   0   0   0   0   0   0   0   0   0	6.00		0	6. 00
Ancil Flary service orther pass through costs including REH direct graduate medical education costs from   1 0,00				
Misst. D, Prt. IV, col. 13. Line 200   10.00				
10.00   Organ acqui st it ons   1.00   10.00	9. 00		om   1	9. 00
11.00	10 00			10 00
COMPUTATION OF LISSER OF COST OR CHARGES   200   Ancillary service charges   225   12 0.00   Ancillary service charges   225   12 0.00   Ancillary service charges   226   12 0.00   13 0.00   Cogna acquisition charges (from Wist. D4, Pt. 111, col. 4, line 69)   225   14 0.00   226   14 0.00   226   14 0.00   226   14 0.00   226   14 0.00   226				
12.00   Ancillary service charges   225   12.00   12.00   10				
13.00   Organ acquisition charges (From Wist. D4, Pt. III. col. 4, line 69)   0   13.00		Reasonable charges		
14.00   Total reasonable charges (sum of lines 12 and 13)   25   14.00   25   25   25   25   25   25   25			1	
Customary_charges			1	
15.00   Aggregate amount actually collected from patients     16.00   Agornis   14m   14m   16m   16	14.00		225	14.00
16.00   Amount's that would have been realized from patients liable for payment for services on a chargebasis and support been made in accordance with 14 CER \$413.13(e)   0.000000   17.00	15 00		1	15 00
Such payment been made in accordance with 42 CFR \$413.13(e)   0.000000   17.			1	
18.00   Total customary charges (see instructions)   225   18.00   226   18.00   226   18.00   226   18.00   226   18.00   226   2				
19.00   Excess of customarry charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)   20.00   Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)   20.00   2	17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17. 00
Instructions			1	
20.00   Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see   0   20.00	19. 00		163	19. 00
instructions    62 21.00	20.00			20.00
2.1.00   Lesser of cost or charges (see instructions)   6.2 2.0.0	20.00			20.00
23.00   Cost of physicians' services in a teaching hospital (see instructions)   123   24.00   124	21. 00	,	62	21. 00
24. 00   Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)   123   24. 00	22. 00	Interns and residents (see instructions)		22. 00
COMPUTATION OF RELIMBURSEMENT SETTLEMENT   0   25.00   25.00   26.00   26.00   26.00   26.00   26.00   26.00   26.00   26.00   26.00   26.00   26.00   26.00   26.00   26.00   26.00   26.00   26.00   27.00				
25.00   Deductibles and coinsurance amounts (for CAH, see instructions)   0 25.00	24. 00		123	24. 00
26. 00   Deductible sand Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)   0   26. 00	25 00			25 00
27. 00   Subtotal [Clines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)   185   27. 00   instructions)   0   28. 00   28. 00   Direct graduate medical education payments (from Wkst. E-4, line 50)   0   28. 00   28. 00   REH facility payment amount (see instructions)   0   29. 00   29				
Instructions				
28. 50   REH facility payment amount (see instructions)   28. 50   29. 00   ESRD direct medical education costs (from Wkst. E-4, line 36)   30. 00   30. 00   Subtotal (sum of lines 27, 28, 28. 50 and 29)   185   30. 00   31. 00   70   70   70   70   70   70   70				
99, 00         ESRD direct medical education costs (from Wkst. E-4, line 36)         0         29, 00           30. 00         Subtotal (sum of lines 27, 28, 28, 50 and 29)         185         30, 00           31. 00         Primary payer payments         0         31, 00           32. 00         Subtotal (line 30 minus line 31)         185         32, 00           4. 100 Mal (Markle Bab DeBTS (EVELUBE BAD DEBTS FOR PROFESSIONAL SERVICES)         32, 00           33. 00         Composite rate ESRD (from Wkst. I-5, line 11)         0         33, 00           34. 00         All owable bad debts (see instructions)         0         34, 00           35. 00         All owable bad debts for dual eligible beneficiaries (see instructions)         0         36, 00           36. 00         All owable bad debts (see instructions)         0         36, 00           37. 00         Subtotal (see instructions)         0         36, 00           38. 00         MSP-LCC reconciliation amount from PS&R         0         38, 00           39. 00         OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)         0         39, 00           39. 50         Ploneer ACO demonstration payment adjustment amount (see instructions)         0         39, 75           39. 79         Pomonstration payment adjustment amount before sequestration <t< td=""><td></td><td></td><td>0</td><td></td></t<>			0	
Subtotal (sum of lines 27, 28, 28. 50 and 29)   185   30. 00   31. 00   31. 00   31. 00   31. 00   31. 00   31. 00   31. 00   32. 00   32. 00   32. 00   32. 00   32. 00   33. 00   33. 00   33. 00   34. 00   3				
1.00				
32.00			1	
33.00   Composite rate ESRD (from Wkst. 1-5, line 11)   0   34.00   All lowable bad debts (see instructions)   0   34.00   34.00   All lowable bad debts (see instructions)   0   35.00   36.00   All lowable bad debts for dual eligible beneficiaries (see instructions)   0   35.00   37.00   Subtotal (see instructions)   185   37.00   38.00   MSP-LCC reconciliation amount from PS&R   0   38.00   39.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   39.00   39.50   39.50   70.00   Pioneer ACO demonstration payment adjustment (see instructions)   0   39.50   39.50   Pioneer ACO demonstration payment adjustment (see instructions)   0   39.75   39.75   N95 respirator payment adjustment amount before sequestration   0   39.97   Pertial or full credits received from manufacturers for replaced devices (see instructions)   0   39.97   39.98   Partial or full credits received from manufacturers for replaced devices (see instructions)   0   39.99   40.00   Subtotal (see instructions)   185   40.00   40.01   Sequestration adjustment (see instructions)   40.02   Demonstration payment adjustment amount after sequestration   40.01   40.02   Demonstration payment adjustment amount after sequestration   40.03   40.01   40.01   40.02   40.03   40		1 3 1 3 1 1 3 1 1 1		
34.00		ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
35.00				
36. 00		· · · · · · · · · · · · · · · · · · ·		
37.00   Subtotal (see instructions)   185   37.00   38.00   MSP-LCC reconciliation amount from PS&R   0   38.00   39.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   39.50   Pioneer ACO demonstration payment adjustment (see instructions)   39.50   39.75   N95 respirator payment adjustment amount (see instructions)   0   39.75   39.97   Demonstration payment adjustment amount before sequestration   0   39.98   Partial or full credits received from manufacturers for replaced devices (see instructions)   0   39.99   39.99   RECOVERY OF ACCELERATED DEPRECIATION   0   39.99   40.00   Subtotal (see instructions)   185   40.00   40.01   Sequestration adjustment (see instructions)   4   40.01   40.01   Sequestration adjustment amount after sequestration   40.02   Demonstration payment adjustment amount after sequestration   40.02   40.03   Sequestration adjustment-PARHM pass-throughs   40.03   40.03   40.03   40.04   40.05   40.0		, , , , , , , , , , , , , , , , , , , ,		
38.00       MSP-LCC reconciliation amount from PS&R       0       38.00         39.00       OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)       0       39.00         39.50       Pioneer ACO demonstration payment adjustment (see instructions)       39.50         39.75       N95 respirator payment adjustment amount (see instructions)       0       39.75         39.97       Demonstration payment adjustment amount before sequestration       0       39.97         39.98       Partial or full credits received from manufacturers for replaced devices (see instructions)       0       39.98         39.99       RECOVERY OF ACCELERATED DEPRECIATION       0       39.99         40.01       Subtotal (see instructions)       185       40.00         40.01       Sequestration adjustment (see instructions)       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       176       41.00         42.01       Tentative settlement (for contractors use only)       42.01         43.01       Tentative settlement -PARHM (for contractor use only)       42.01         43.01       Bal ance due provider/program (see instructions)       43.00				
39. 00         OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)         39. 00           39. 50         Pioneer ACO demonstration payment adjustment (see instructions)         39. 50           39. 75         N95 respirator payment adjustment amount (see instructions)         0         39. 75           39. 97         Demonstration payment adjustment amount before sequestration         0         39. 97           39. 98         Partial or full credits received from manufacturers for replaced devices (see instructions)         0         39. 98           39. 99         RECOVERY OF ACCELLERATED DEPRECIATION         0         39. 99           40. 00         Subtotal (see instructions)         185         40. 00           40. 01         Sequestration adjustment (see instructions)         40. 00           40. 02         Demonstration payment adjustment amount after sequestration         0         40. 02           40. 03         Sequestration adjustment-PARHM pass-throughs         176         41. 00           41. 00         Interim payments-PARHM         176         41. 00           42. 01         Tentative settlement (for contractors use only)         42. 00           43. 01         Bal ance due provider/program (see instructions)         5         43. 00           44. 00         To BE COMPLETED BY CONTRACTOR         44. 00			I .	
39. 75       N95 respirator payment adjustment amount (see instructions)       0       39. 75         39. 97       Demonstration payment adjustment amount before sequestration       0       39. 97         39. 98       Partial or full credits received from manufacturers for replaced devices (see instructions)       0       39. 97         39. 99       RECOVERY OF ACCELERATED DEPRECIATION       0       39. 99         40. 00       Subtotal (see instructions)       185       40. 00         40. 01       Sequestration adjustment (see instructions)       4       40. 01         40. 02       Demonstration payment adjustment amount after sequestration       0       40. 02         40. 03       Sequestration adjustment amount after sequestration       0       40. 02         40. 03       Interim payments       40. 03         41. 00       Interim payments       41. 00         42. 01       Tentative settlement (for contractors use only)       42. 00         43. 01       Bal ance due provider/program (see instructions)       5       43. 00         44. 00       Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115. 2       0       44. 00         70. 00       Original outlier amount (see instructions)       0       90. 00         90. 00			0	
39. 97 39. 98 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 0 39. 99 40. 00 Subtotal (see instructions) 185 40. 00 40. 01 Demonstration adjustment (see instructions) 185 40. 00 40. 02 40. 03 186 187 40. 00 Sequestration adjustment (see instructions) 187 40. 00 188 189 40. 00 1	39. 50	Pioneer ACO demonstration payment adjustment (see instructions)		39. 50
39. 98 Partial or full credits received from manufacturers for replaced devices (see instructions)  39. 98 RECOVERY OF ACCELERATED DEPRECIATION  40. 00 Subtotal (see instructions)  40. 01 Demonstration adjustment (see instructions)  40. 02 Demonstration payment adjustment amount after sequestration  40. 03 Sequestration adjustment-PARHM pass-throughs  41. 00 Interim payments  41. 01 Interim payments-PARHM  41. 01 Interim payments-PARHM  42. 00 Tentative settlement (for contractors use only)  43. 00 Bal ance due provider/program (see instructions)  43. 00 Bal ance due provider/program-PARHM (see instructions)  43. 01 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115. 2  90. 00 Original outlier amount (see instructions)  91. 00 Outlier reconciliation adjustment amount (see instructions)  91. 00 Outlier reconciliation adjustment amount (see instructions)  91. 00 Outlier reconciliation adjustment amount (see instructions)  92. 00 Outlier reconciliation adjustment amount (see instructions)  93. 99  44. 00 Outlier reconciliation adjustment amount (see instructions)  94. 00 Outlier reconciliation adjustment amount (see instructions)  95. 00 Outlier reconciliation adjustment amount (see instructions)  97. 00 Outlier reconciliation adjustment amount (see instructions)			I .	
39. 99   RECOVERY OF ACCELERATED DEPRECIATION   0   39. 99   40. 00   5   5   5   5   5   5   5   5   5			I .	
40.00       Subtotal (see instructions)       185       40.00         40.01       Sequestration adjustment (see instructions)       4       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       176       41.00         41.01       Interim payments-PARHM       41.01       41.01         42.00       Tentative settlement (for contractors use only)       0       42.00         43.00       Balance due provider/program (see instructions)       42.01         43.01       Balance due provider/program (see instructions)       5       43.00         43.01       Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2       0       44.00         70       Demonstration payments       0       90.00         90.00       Original outlier amount (see instructions)       0       90.00         91.00       Outlier reconciliation adjustment amount (see instructions)       0       91.00				
40.01       Sequestration adjustment (see instructions)       4 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       176         41.01       Interim payments-PARHM       41.01         42.00       Tentative settlement (for contractors use only)       42.00         42.01       Tentative settlement-PARHM (for contractor use only)       42.01         43.00       Balance due provider/program (see instructions)       5 43.00         43.01       Balance due provider/program-PARHM (see instructions)       43.01         44.00       Protested amounts (nonall lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2       0         44.00       Original outlier amount (see instructions)       90.00         90.00       Outlier reconciliation adjustment amount (see instructions)       0 90.00				
40.02 Demonstration payment adjustment amount after sequestration  Sequestration adjustment-PARHM pass-throughs  40.03  Interim payments  Interim payments-PARHM  Interim payments-PARHM  Tentative settlement (for contractors use only)  Tentative settlement-PARHM (for contractor use only)  Balance due provider/program (see instructions)  Balance due provider/program-PARHM (see instructions)  Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2  Original outlier amount (see instructions)  90.00  91.00  Outlier reconciliation adjustment amount (see instructions)  0 40.02  40.03  41.00  41.00  41.01  41.01  42.00  42.00  42.01  42.01  43.00  42.01  43.00  43.01  Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2  0 44.00  0 90.00  91.00  91.00			1	
41.00				
41. 01       Interim payments-PARHM       41. 01         42. 00       Tentative settlement (for contractors use only)       0 42. 00         42. 01       Tentative settlement-PARHM (for contractor use only)       42. 01         43. 00       Bal ance due provider/program (see instructions)       5 43. 00         43. 01       Bal ance due provider/program-PARHM (see instructions)       43. 01         44. 00       Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115. 2       0         70 BE COMPLETED BY CONTRACTOR       0       90. 00         90. 00       Original outlier amount (see instructions)       0       90. 00         91. 00       Outlier reconciliation adjustment amount (see instructions)       0       91. 00	40. 03	Sequestration adjustment-PARHM pass-throughs		40. 03
42.00 Tentative settlement (for contractors use only)  42.01 Tentative settlement-PARHM (for contractor use only)  43.00 Balance due provider/program (see instructions)  43.01 Balance due provider/program-PARHM (see instructions)  44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2  70 BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions)  91.00 Outlier reconciliation adjustment amount (see instructions)  91.00	41. 00	Interim payments	176	41. 00
42.01 Tentative settlement-PARHM (for contractor use only) 43.00 Balance due provider/program (see instructions) 5 43.00 43.01 Balance due provider/program-PARHM (see instructions) 64.01 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2 0 70 BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 91.00		· ·	_	
43.00 Balance due provider/program (see instructions)  43.01 Balance due provider/program-PARHM (see instructions)  43.01  44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2  90.00 Original outlier amount (see instructions)  91.00 Outlier reconciliation adjustment amount (see instructions)  91.00		3,	0	
43.01 Balance due provider/program-PARHM (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2 0 44.00  TO BE COMPLETED BY CONTRACTOR  90.00 Outlier reconciliation adjustment amount (see instructions) 0 90.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		·	_	
44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2 0 44.00 TO BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions) 0 90.00 0utlier reconciliation adjustment amount (see instructions) 0 91.00			ا "	
TO BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions)  91.00 Outlier reconciliation adjustment amount (see instructions)  91.00 Outlier reconciliation adjustment amount (see instructions)			5. <b>½</b> ol	
91.00 Outlier reconciliation adjustment amount (see instructions) 0 91.00				
		, , ,		
92.00 The rate used to calculate the lime Value of Money		· · · · · · · · · · · · · · · · · · ·		
		,		
93.00   Time Value of Money (see instructions)   0   93.00	73.00	Time value of molicy (See Histractions)	١	73.00

Health Financial Systems	FRANCISCAN HEAL	TH- DYER	In Lie	u of Form CMS-	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0090	Peri od:	Worksheet E	
		0 1 00N 45 T000	From 01/01/2023		
		Component CCN: 15-T090	To 12/31/2023	5/30/2024 3:4	
		Title XVIII	Subprovi der -	PPS	
			I RF		
				1. 00	
94.00 Total (sum of lines 91 and 93)				0	94.00
				1. 00	
MEDICARE PART B ANCILLARY COSTS					
200.00 Part B Combined Billed Days					200. 00

Peri od: Worksheet E-1
From 01/01/2023 Part I
To 12/31/2023 Date/Time Prepared: 5/30/2024 3: 45 pm Provider CCN: 15-0090

Title XVIII						5/30/2024 3: 45	o pm
mm/dd/yyyy							
1.00			Inpatien	t Part A	Par	rt B	
1.00			mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
InterIm payments payable on Individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero List separately each retroactive lump sum adjustment amount based on subsequent revision of the Interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			1. 00	2.00	3. 00	4. 00	
Submitted for to be Submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero   3.00	1.00	Total interim payments paid to provider		28, 964, 68	7	9, 360, 170	1. 00
rendered in the cost reporting period. If none, write	2.00	Interim payments payable on individual bills, either			0	0	2.00
**NONE" or enter a zero		submitted or to be submitted to the contractor for services					
List separately each retroactive Lump sum adjustment amount be abased on subsequent revision of the intertin rate for the cost reporting period. Also show date of each payment. If none, write "NNE" or enter a zero. (1)		rendered in the cost reporting period. If none, write					
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)		"NONE" or enter a zero					
Cost reporting period. Also show date of each payment. If none, write "NoNE" or enter a zero. (1)   Program to Provider	3.00	List separately each retroactive lump sum adjustment amount					3.00
none, write *NONE* or enter a zero. (1)							
Program to Provider							
ADJUSTMENTS TO PROVIDER							
3.02   3.03   3.04   0   0   3.02   3.03   3.04   0   0   3.03   3.04   3.05							
3.03   3.04   3.05   3.04   3.06   3.03   3.04   3.05   3.04   3.05   3.04   3.05		ADJUSTMENTS TO PROVIDER					
3. 04   0   0   0   3. 04   3. 05							
3.05							
Provider to Program   ADJUSTMENTS TO PROGRAM   0   0   3 . 50							
3. 50   ADJUSTMENTS TO PROGRAM   0   0   3. 50     3. 51   3. 52   0   0   0   0   3. 51     3. 52   3. 53   0   0   0   0   3. 52     3. 53   3. 54   0   0   0   0   3. 53     3. 50 - 3. 98   0   0   0   0   3. 53     3. 50 - 3. 98   0   0   0   0   3. 54     3. 99   3. 50 - 3. 98   0   0   0   0     4. 00   Total interim payments (sum of lines 1, 2, and 3. 99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)   To BE COMPLETED BY CONTRACTOR	3.05				0	0	3. 05
3.51							
3.52   3.53   3.54   3.99   3.50-3.98		ADJUSTMENTS TO PROGRAM					
3.53   3.54   3.54   3.54   3.54   3.54   3.54   3.54   3.54   3.55   3.59   3.50-3.98   3.50-3.98   3.50-3.98   3.50-3.98   3.50-3.98   3.50-3.98   3.50-3.98   3.50-3.98   3.50-3.98   3.50-3.98   3.50-3.98   3.50-3.98   3.50-3.98   3.50-3.98   3.50-3.99   3.50-3.98							
3.54   3.99   Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)   3.50-3.98)   4.00   Total interim payments (sum of lines 1, 2, and 3.99)   28,964,687   9,360,170   4.00   (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)   TO BE COMPLETED BY CONTRACTOR					~	1	
Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)							
3.50-3.98)   Total interim payments (sum of lines 1, 2, and 3.99)   28,964,687   9,360,170   4.00					~	١	
A. 00   Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)   TO BE COMPLETED BY CONTRACTOR	3. 99				0	0	3. 99
(transfer to Wkst. E or Wkst. E-3, line and column as appropriate)   TO BE COMPLETED BY CONTRACTOR		1 2 2 2 2 2 2			_	0.040.470	
appropriate   TO BE COMPLETED BY CONTRACTOR	4.00			28, 964, 68	/	9, 360, 170	4. 00
TO BE COMPLÉTED BY CONTRACTOR							
List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)   Program to Provider							
Proview. Also show date of each payment. If none, write "NONE" or enter a zero. (1)   Program to Provider	E 00		·				E 00
"NONE" or enter a zero. (1)   Program to Provider   Solution   S	5.00						5.00
Program to Provider							
TENTATI VE TO PROVI DER							
Solition   Settlement 10 Program   Solition   Settlement 20 Provider to Program   Solition   Settlement 30 Provider to Program   Solition   Settlement 30 Provider to Program   Solition   Settlement 30 Provider to Program   Solition   Solition   Settlement 30 Provider to Program   Solition   Solition   Settlement 30 Provider to Program   Solition   Solition   Solition   Solition   Solition   Solition   Settlement 30 Provider   Solition   Solition   Solition   Solition   Solition   Solition   Solition   Settlement 30 Provider   Solition   Solit	5 01					0	5 01
Description		TENTATIVE TO TROVIDER					
Provider to Program							
TENTATI VE TO PROGRAM	0.00	Provider to Program			<u> </u>	Ü	0.00
5.51   5.52   0	5. 50				0	0	5. 50
Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.52   Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)   Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)   Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)   Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)   Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)   Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)   Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)   Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)   Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)   Subtotal (sum of lines 5.01-5.49 minus sum of lines 6.00   Subtotal (sum of lines 5.01-5.49 minus sum of lines 6.00   Subtotal (sum of lines 5.01-5.49 minus sum of lines 6.00   Subtotal (sum of lines 5.01-5.49 minus sum of lines 6.00   Subtotal (sum of lines 5.01-5.49 minus sum of lines 6.00   Subtotal (sum of lines 5.01-5.49 minus sum of lines 6.00   Subtotal (sum of lines 5.01-5.49 minus sum of lines 6.00   Subtotal (sum of lines 5.01-5.49 minus sum of lines 6.00   Subtotal (sum of lines 6.00   Subtotal (subtotal (sum of lines 6.00   Subtotal (subtotal					0	l ol	5. 51
5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions)  Contractor Number (Mo/Day/Yr)  0 1.00 2.00					0	l ol	
5.50-5.98) Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions)  Contractor NPR Date (Mo/Day/Yr)  O 1.00 2.00	5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	l ol	5. 99
Cost report. (1)   SETTLEMENT TO PROVIDER   SETTLEMENT TO PROGRAM   SETTLEME							
Cost report. (1)   SETTLEMENT TO PROVIDER   SETTLEMENT TO PROGRAM   SETTLEME	6.00						6.00
6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions)  Contractor Number (Mo/Day/Yr)  0 1.00 2.00							
7.00 Total Medicare program liability (see instructions)  29,551,724  9,411,838 7.00  Contractor Number (Mo/Day/Yr)  0 1.00 2.00	6. 01			587, 03	7	51, 668	6. 01
7.00 Total Medicare program liability (see instructions)  29,551,724  9,411,838 7.00  Contractor Number (Mo/Day/Yr)  0 1.00 2.00	6. 02	SETTLEMENT TO PROGRAM		·			6. 02
Contractor   NPR Date   Number   (Mo/Day/Yr)     0   1.00   2.00	7.00	Total Medicare program liability (see instructions)		29, 551, 72	4	9, 411, 838	7. 00
Number         (Mo/Day/Yr)           0         1.00         2.00							
						(Mo/Day/Yr)	
8.00 Name of Contractor 8.00			(	)	1. 00	2. 00	
	8.00	Name of Contractor					8. 00

Component CCN: 15-T090

		Title	XVIII	Subprovi der – I RF	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		5, 474, 856		176	1. 00
2.00	Interim payments payable on individual bills, either		C		0	2. 00
	submitted or to be submitted to the contractor for services					
	rendered in the cost reporting period. If none, write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment amount					3. 00
3.00	based on subsequent revision of the interim rate for the					3.00
	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		C		0	3. 01
3.02			C		0	3. 02
3. 03 3. 04			[		0	3. 03
3. 04 3. 05					0	3. 04 3. 05
3.03	Provider to Program				U	3. 03
3.50	ADJUSTMENTS TO PROGRAM		С		0	3. 50
3. 51			C		0	3. 51
3.52			C		0	3. 52
3.53			C		0	3. 53
3. 54			C		0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		C		0	3. 99
4. 00	3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99)		5, 474, 856		176	4. 00
4.00	(transfer to Wkst. E or Wkst. E-3, line and column as		3, 474, 630		170	4.00
	appropriate)					
	TO BE COMPLÉTED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk					5. 00
	review. Also show date of each payment. If none, write					
	"NONE" or enter a zero. (1)					
5. 01	Program to Provider TENTATIVE TO PROVIDER		C		0	5. 01
5. 01	TENTATIVE TO PROVIDER				0	5. 01
5. 03			Ö		o o	5. 03
	Provider to Program					
5.50	TENTATI VE TO PROGRAM		C		0	5. 50
5. 51			C		0	5. 51
5. 52			C		0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		C		0	5. 99
6.00	Determined net settlement amount (balance due) based on the					6. 00
	cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		0		5	6. 01
6. 02	SETTLEMENT TO PROGRAM		96, 351		0	6. 02
7. 00	Total Medicare program liability (see instructions)		5, 378, 505	Contractor	NPR Date	7. 00
				Number	(Mo/Day/Yr)	
		(	)	1. 00	2.00	
8.00	Name of Contractor					8. 00

Heal th	Financial Systems FRANCISCAN HEAD	LTH- DYER	In Lie	u of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0090	Peri od: From 01/01/2023	Worksheet E-1	
				Date/Time Pre 5/30/2024 3:4	
		Title XVIII	Hospi tal	PPS	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				4
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				4
1. 00	Total hospital discharges as defined in AARA §4102 from Wkst.	S-3, Pt. I col. 15 line	e 14		1. 00
2.00	Medicare days (see instructions)				2. 00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3. 00
4.00	Total inpatient days (see instructions)				4. 00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5. 00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 I	ine 20			6. 00
7. 00	CAH only - The reasonable cost incurred for the purchase of cline 168	certified HIT technology	Wkst. S-2, Pt. I		7. 00
8.00	Calculation of the HIT incentive payment (see instructions)				8. 00
9.00	Sequestration adjustment amount (see instructions)				9. 00
10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)				30. 00
31.00	Other Adjustment (specify)				31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and l	ine 31) (see instruction	ıs)		32.00
			,		•

Health Financial Systems	FRANCISCAN HEALTH- DYER	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT			Worksheet E-3
		From 01/01/2023	
	Component CCN: 15-T090	To 12/31/2023	Date/Time Prepared:
	·		5/30/2024 3:45 pm
	Title XVIII	Subprovi der -	PPS
		IRF	

DART 111		IRF		
Name				
1.00   Net Federal PPS Payment (see Instructions)   0.00   0.038   2.00		PART LLL MEDICARE DATA ACRIVICES LEE DOS	1. 00	
2.00         Medit care SSI ratio (TRF PSS only) (see instructions)         0.038 2.00           3.00         Inpatr tent Rehabil Intation LIP Payments (see instructions)         37.28 3.00           4.00         Outlier Payments         37.28 3.00           5.00         Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to complete the count of the counted without a temporary cap adjustment under 42 CFB           5.01         New Teaching program (and in a tould not be counted without a temporary cap adjustment under 42 CFB 412.242(d) (1)(11)(F)(T) (7) (7) (2) (see instructions)         0.00           6.00         New Teaching program adjustment (see instructions)         0.00           7.00         Current year's unweighted FTE count of IAR excluding FTEs in the new program growth period of a "new teaching program" (see instructions)         0.00           8.00         Current year's unweighted IAR FTE count for residents within the new program growth period of a "new teaching program" (see instructions)         0.00           10.00         Average Bail y Census (see instructions)         0.00           10.00         Average Bail y Census (see instructions)         0.00           10.00         Teaching program" (see instructions)         0.00           10.00         Teaching program" (see instructions)         0.00           10.00         Teaching program (see instructions)         0.00	1 00		F 100 4F0	1 00
Inpatient Rehabilitation LIP Payments (see instructions)		y , ,		
341,688 4.00		, , , , , , , , , , , , , , , , , , , ,		
Display   University   Univer				
November 15, 2004 (see instructions) 0.00 program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR 9412-424(d)(1)(11(11)(11)(11) or (2) (see instructions) 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.				
Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFB \$412,424(0)(1)(11)(f)(1) or (2) (see instructions)				
2.00   Current year's unweighted FTE count of IAR excluding FTES in the new program growth period of a "new to teaching program" (see instructions)   0.00   0.00	5. 01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR		5. 01
teaching program" (see instructions)   0.00   8.00	6.00	New Teaching program adjustment. (see instructions)	0.00	6.00
	7.00		0. 00	7. 00
0.00   Notern and resident count for IRF PPS medical education adjustment (see instructions)   0.00   0.0	8. 00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new	0. 00	8. 00
10. 00   Average Dail y Census (see instructions)   10. 860274   10. 00	0.00		0.00	0.00
1. 00		· · · · · · · · · · · · · · · · · · ·		
12.00   Teaching Adjustment (see instructions)   5,529,866   63.00   14.00   14.01   PSP Payment (see instructions)   5,529,866   13.00   14.00   14.00   14.00   15				
13. 00   Total PPS Payment (see instructions)   5, 529, 866   3. 00   14. 00   14. 00   15. 00   0   0   0   0   0   0   0   0   0		, , ,		
14. 00   Nursing and Allied Health Managed Care payments (see instruction)   0   14. 00   15. 00   1		, ,		
15. 00   Organ acquisition (DO NOT USE THIS LINE)   15. 00   16. 00   16. 00   16. 00   16. 00   16. 00   16. 00   16. 00   17. 00   18. 00   18. 00   18. 00   19.				
17. 00   Subtotal (see instructions)   5,529,866   17. 00   18. 00   19. 00   Subtotal (line 17 less line 18).   5,529,866   19. 00   18. 00   19. 00   Subtotal (line 17 less line 18).   5,529,866   19. 00   19. 00   Subtotal (line 17 less line 18).   5,529,866   19. 00   19. 00   19. 00   Subtotal (line 19 minus line 20)   5,486,666   21. 00   22. 00   Coinsurance   8,800   22. 00   23. 00   Subtotal (line 21 minus line 22)   5,477,866   23. 00   24. 00   Allowable bad debts (exclude bad debts for professional services) (see instructions)   0,24. 00   24. 00   25. 00   27. 00   Allowable bad debts (exclude bad debts (see instructions)   0,25. 00   28. 00   29. 00   2	15. 00			15.00
18. 00	16.00	Cost of physicians' services in a teaching hospital (see instructions)	0	16.00
19.00     19.0	17. 00		5, 529, 866	17.00
20. 00   Deductibles				
21.00   Subtotal (line 19 minus line 20)   5,486,666   21.00   22.00		· · · · · · · · · · · · · · · · · · ·		
22.00   Coinsurance   8.800   22.00   23.00   24.00   24.00   24.00   24.00   24.00   24.00   24.00   25.00   26.00   25.00   26.00				
23.00   Subtotal (line 21 minus line 22)   5,477,866   23.00   24.00   Allowable bad debts (exclude bad debts for professional services) (see instructions)   0   24.00   25.00   Allowable bad debts (exclude bad debts (see instructions)   0   25.00   26.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   0   26.00   27.00   28.00   28.00   29.00				
24.00   All lowable bad debts (exclude bad debts for professional services) (see instructions)   0   24.00				
25. 00		·		
26. 00       Allowable bad debts for dual eligible beneficiaries (see instructions)       0       26. 00         27. 00       Subtotal (sum of lines 23 and 25)       5, 477, 866       27. 00         28. 00       Direct graduate medical education payments (from Wkst. E-4, line 49)       0       28. 00         29. 00       Other pass through costs (see instructions)       10, 404       29. 00         30. 00       Outlier payments reconciliation       0       30. 00         31. 00       OTHER ADUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)       0       31. 00         31. 50       Pioneer ACO demonstration payment adjustment (see instructions)       0       31. 50         31. 98       Recovery of accelerated depreciation.       0       31. 98         90 bemonstration payment adjustment amount before sequestration       0       31. 99         92. 00       Total amount payable to the provider (see instructions)       5, 488, 270       32. 01         32. 01       Sequestration adjustment (see instructions)       109, 765       32. 01         32. 02       Demonstration payment adjustment amount after sequestration       93. 00         34. 00       10, 404       10, 404       10, 404         32. 01       10 benostration adjustment amount after sequestration       10, 404       10, 404			-	
27. 00   Subtotal (sum of lines 23 and 25)   5, 477, 866   27. 00   28. 00   Direct graduate medical education payments (from Wkst. E-4, line 49)   0   28. 00   28. 00   29. 00   0   0   0   0   0   0   0   0   0		, , , , , , , , , , , , , , , , , , , ,	-	
29.00   Other pass through costs (see instructions)   10,404   29.00   30.00   00   00   00   00   00   0		ÿ , ,	5, 477, 866	
30.00 Outlier payments reconciliation 0 0 31.00 Outlier payments reconciliation 0 0 31.00 Outlier payments reconciliation 0 0 31.00 Outlier payments (SEE INSTRUCTIONS) (SPECIFY) 0 31.00 Outlier payment adjustment adjustment (see instructions) 0 31.50 Recovery of accelerated depreciation. 0 31.98 Recovery of accelerated depreciation. 0 31.99 Outlier payment adjustment amount before sequestration 0 0 31.99 Outlier amount payable to the provider (see instructions) 0 31.99 Outlier amount payable to the provider (see instructions) 0 32.02 Outlier amount adjustment amount after sequestration 0 0 32.02 Outlier amount adjustment amount after sequestration 0 0 32.02 Outlier amount adjustment amount after sequestration 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	28.00
31.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 31.50 Pi oneer ACO demonstration payment adjustment (see instructions) 31.98 Recovery of accelerated depreciation. 31.99 Demonstration payment adjustment amount before sequestration 31.99 Total amount payable to the provider (see instructions) 32.00 Total amount payable to the provider (see instructions) 32.01 Sequestration adjustment (see instructions) 32.02 Demonstration payment adjustment amount after sequestration 32.02 Interim payments 33.00 Interim payments 34.00 Tentative settlement (for contractor use only) 35.00 Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34) 36.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$115.2 0 36.00 To BE COMPLETED BY CONTRACTOR  50.00 Original outlier amount from Wkst. E-3, Pt. III, line 4 341,688 50.00 51.00 Outlier reconciliation adjustment amount (see instructions) 51.00 Outlier reconciliation adjustment amount (see instructions) 52.00 The rate used to calculate the Time Value of Money 53.00 Time Value of Money (see instructions) 54.00 FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING ON OR BEFORE MAY 11, 2023 (THE END OF THE COVID-19 PHE)  99.00 Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.	29. 00	Other pass through costs (see instructions)	10, 404	29. 00
31. 50 31. 98 Recovery of accelerated depreciation. 31. 99 Demonstration payment adjustment (see instructions) 31. 99 31. 99 Total amount payable to the provider (see instructions) 32. 00 32. 01 32. 02 Demonstration payment adjustment (see instructions) 32. 02 Demonstration adjustment (see instructions) 32. 03 33. 01 Demonstration payment adjustment amount after sequestration 32. 02 33. 00 Demonstration payment adjustment amount after sequestration 32. 02 33. 00 Demonstration payment adjustment amount after sequestration 32. 02 33. 00 Demonstration payment adjustment (see instructions) 32. 01 Demonstration payment adjustment amount after sequestration 32. 02 33. 00 Demonstration payment adjustment amount after sequestration 32. 02 33. 00 Demonstration payment (see instructions) 32. 02 33. 00 Demonstration payment adjustment amount after sequestration 32. 02 33. 02 Demonstration adjustment amount after sequestration 32. 02 33. 04 Demonstration payment adjustment amount after sequestration 32. 02 33. 05 Demonstration payment adjustment amount (see only) 32. 02 33. 05 Demonstration payment adjustment amount (see instructions) 32. 02 33. 01 Demonstration payment adjustment amount see instructions) 32. 02 33. 02 Demonstration payment adjustment amount (see instructions) 32. 02 Demonstration payment adjustment amount (see instructions) 32. 02 33. 00 Demonstration payment adjustment amount (see instructions) 32. 02 33. 00 Demonstration payment adjustment amount (see instructions) 32. 02 33. 00 Demonstration payment adjustment amount (see instructions) 32. 02 Demonstration payment adjustment amount (see instructions) 33. 00 Demonstration payment adjustment amount (see instructions) 33. 00 Demonstration payment sequestration 34. 00 35. 00 Demonstration payment adjustment amount see instructions) 32. 02 Demonstration payment sequestration 34. 02 Demons	30.00	Outlier payments reconciliation	0	30.00
31. 98 31. 99 31. 99 31. 99 32. 00 31. 99 32. 00 32. 01 32. 01 32. 01 32. 01 32. 01 32. 01 32. 02 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 38. 00 38. 00 39. 00 30				
31. 99 32. 00 32. 01 32. 02 32. 01 32. 02 32. 02 32. 02 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 38. 00 39. 00			-	
Total amount payable to the provider (see instructions)  Sequestration adjustment (see instructions)  Sequestration adjustment (see instructions)  Demonstration payment adjustment amount after sequestration  Interim payments  Tentative settlement (for contractor use only)  Seal ance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)  Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$115. 2  To BE COMPLETED BY CONTRACTOR  To BE COMPLETED BY CONTRACTOR  To BE COMPLETED BY CONTRACTOR  The rate used to calculate the Time Value of Money  Time Value of Money (see instructions)  Time Value of Money (see instructions)  To BE COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING ON OR BEFORE MAY 11, 2023 (THE END OF THE COVID-19 PHE)  Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.  O 0.0000000 99.00		· ·		
32.01 Sequestration adjustment (see instructions) 32.02 Demonstration payment adjustment amount after sequestration 32.03 Demonstration payments 32.01 Demonstration payments 32.01 Interim payments 32.01 Interim payments 32.02 Sequestration 33.00 Interim payments 34.00 Tentative settlement (for contractor use only) 35.00 Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34) 36.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115. 2 36.00 To BE COMPLETED BY CONTRACTOR  50.00 Original outlier amount from Wkst. E-3, Pt. III, line 4 341, 688 51.00 Outlier reconciliation adjustment amount (see instructions) 52.00 The rate used to calculate the Time Value of Money 53.00 Time Value of Money (see instructions) 54.00 FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING ON OR BEFORE MAY 11, 2023 (THE END OF THE COVID-19 PHE)  99.00 Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.  0.0000000 99.00		' ' '		
32. 02 33. 00 Interim payments 32. 02 Interim payments 33. 00 Interim payments 34. 00 Interim payment (for contractor use only) 35. 00 Bal ance due provider/program (line 32 minus lines 32. 01, 32. 02, 33, and 34) Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115. 2  TO BE COMPLETED BY CONTRACTOR  50. 00 Original outlier amount from Wkst. E-3, Pt. III, line 4 Outlier reconciliation adjustment amount (see instructions)  Time Value of Money (see instructions)  Time Value of Money (see instructions)  FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING ON OR BEFORE MAY 11, 2023 (THE END OF THE COVID-19 PHE)  99. 00 Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.  0. 0000000 0, 44. 00 0, 44				
33.00 Interim payments 33.00 Interim payments 33.00 Tentative settlement (for contractor use only) 35.00 Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34) 36.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2 0 36.00  TO BE COMPLETED BY CONTRACTOR  50.00 Original outlier amount from Wkst. E-3, Pt. III, line 4  0utlier reconciliation adjustment amount (see instructions) 51.00 The rate used to calculate the Time Value of Money 52.00 Time Value of Money (see instructions) 53.00 FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING ON OR BEFORE MAY 11, 2023 (THE END OF THE COVID-19 PHE)  99.00 Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020. 0.0000000 99.00				
34.00 Tentative settlement (for contractor use only) 35.00 Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34) -96, 351 35.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2 0 36.00 TO BE COMPLETED BY CONTRACTOR  Original outlier amount from Wkst. E-3, Pt. III, line 4 0utlier reconciliation adjustment amount (see instructions) 0 Universe used to calculate the Time Value of Money 0.00 Time Value of Money (see instructions) 0 Time Value of Money (see instructions) 0 THE COVID-19 PHE)  99.00 Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020. 0.0000000 0 34.00 34.00 35.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 36.00 37.00 36.00 36.00 36.00 37.00 36.00 36.00 36.00 36.00 37.00 36.00 36.00 36.00 36.00 36.00 36.00 37.00 36.00		· · · · · · · · · · · · · · · · · · ·		
35.00 Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)  -96, 351  35.00  Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2  0 36.00  TO BE COMPLETED BY CONTRACTOR  50.00 Original outlier amount from Wkst. E-3, Pt. III, line 4  0 outlier reconciliation adjustment amount (see instructions)  1 The rate used to calculate the Time Value of Money  1 Time Value of Money (see instructions)  5 Time Value of Money (see instructions)  FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING ON OR BEFORE MAY 11, 2023 (THE END OF THE COVID-19 PHE)  99.00 Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				
36.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115. 2 0  TO BE COMPLETED BY CONTRACTOR  50.00 Original outlier amount from Wkst. E-3, Pt. III, line 4 50.00  51.00 Outlier reconciliation adjustment amount (see instructions) 0 51.00  The rate used to calculate the Time Value of Money 0.00  53.00 Time Value of Money (see instructions) 0 52.00  FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING ON OR BEFORE MAY 11, 2023 (THE END OF THE COVID-19 PHE)  99.00 Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020. 0.000000 99.00		, , , , , , , , , , , , , , , , , , , ,		
50.00 Original outlier amount from Wkst. E-3, Pt. III, line 4 51.00 Outlier reconciliation adjustment amount (see instructions) 52.00 The rate used to calculate the Time Value of Money 53.00 Time Value of Money (see instructions) 60.00 FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING ON OR BEFORE MAY 11, 2023 (THE END OF THE COVID-19 PHE) 60.00 Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020. 60.00 0.000000 99.00	36. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	
51.00 Outlier reconciliation adjustment amount (see instructions)  The rate used to calculate the Time Value of Money  Time Value of Money (see instructions)  FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING ON OR BEFORE MAY 11, 2023 (THE END OF THE COVID-19 PHE)  99.00 Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.  0.000000 99.00	50.00		341, 688	50.00
53.00 Time Value of Money (see instructions)  FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING ON OR BEFORE MAY 11, 2023 (THE END OF THE COVID-19 PHE)  99.00 Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.  0.000000 99.00				
FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING ON OR BEFORE MAY 11, 2023 (THE END OF THE COVID-19 PHE)  99.00 Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.  0.000000 99.00		7	0. 00	
THE COVID-19 PHE)  99.00 Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020. 0.000000 99.00	53. 00			53.00
99.00 Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020. 0.000000 99.00		·	END OF	
	00.00		0.00000	00.00
77. OF [Carculated reaching Adjustment ractor for the current year. (See Instructions)   0.000000[99.01				
	77. UI	paradrated readming haj astiment ractor for the current year. (See Thistractions)	0.000000	77. UI

Health Financial Systems	In Lie	u of Form CMS-2552-10		
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0090	From 01/01/2023	Worksheet E-3 Part VII Date/Time Prepared: 5/30/2024 3:45 pm	
	Ti +l o VI V	∐ocni tal	Cost	

		'	0 12/31/2023	5/30/2024 3: 4	
		Title XIX	Hospi tal	Cost	
			Inpatient	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SER	VICES FOR TITLES V OR XIX	SERVI CES		
	COMPUTATION OF NET COST OF COVERED SERVICES				1
1.00	Inpatient hospital/SNF/NF services		14, 100, 886		1.00
2.00	Medical and other services			13, 074, 225	2.00
3.00	Organ acquisition (certified transplant programs only)		o		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		14, 100, 886	13, 074, 225	4.00
5.00	Inpatient primary payer payments		l ol		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		14, 100, 886	13, 074, 225	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e Charges				
8.00	Routine service charges		0		8. 00
9.00	Ancillary service charges		41, 020, 084	79, 075, 171	9. 00
10.00	Organ acquisition charges, net of revenue		O		10.00
11. 00	Incentive from target amount computation		o		11. 00
12.00	Total reasonable charges (sum of lines 8 through 11)		41, 020, 084	79, 075, 171	12. 00
	CUSTOMARY CHARGES				1
13.00	Amount actually collected from patients liable for payment for	services on a charge bas	s 0	0	13. 00
14.00	Amounts that would have been realized from patients liable for	payment for services on	a 0	0	14. 00
	charge basis had such payment been made in accordance with 42	CFR §413. 13(e)			
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15. 00
16.00	Total customary charges (see instructions)		41, 020, 084	79, 075, 171	16. 00
17.00	Excess of customary charges over reasonable cost (complete onl	y if line 16 exceeds line	26, 919, 198	66, 000, 946	17. 00
	4) (see instructions)				
18. 00	Excess of reasonable cost over customary charges (complete onl	y if line 4 exceeds line	0	0	18. 00
	16) (see instructions)				
19. 00	Interns and Residents (see instructions)		0	0	19. 00
20.00	Cost of physicians' services in a teaching hospital (see instr		0	0	20. 00
21. 00	Cost of covered services (enter the lesser of line 4 or line 1		14, 100, 886	13, 074, 225	21. 00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be	completed for PPS provide			
22. 00	Other than outlier payments		0	0	22. 00
23. 00	Outlier payments		0	0	23. 00
24. 00	Program capital payments		0		24. 00
25. 00	Capital exception payments (see instructions)		0		25. 00
26. 00	Routine and Ancillary service other pass through costs		0	0	26. 00
27. 00	Subtotal (sum of lines 22 through 26)		0	0	27. 00
28. 00	Customary charges (title V or XIX PPS covered services only)		0	0	28. 00
29. 00	Titles V or XIX (sum of lines 21 and 27)		14, 100, 886	13, 074, 225	29. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		, , , , , , , , , , , , , , , , , , , ,		
30. 00	Excess of reasonable cost (from line 18)		0	0	30.00
31. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		14, 100, 886	13, 074, 225	
32. 00	Deducti bl es		0	0	32. 00
33. 00	Coinsurance		0	0	33. 00
34. 00	Allowable bad debts (see instructions)		0	0	34. 00
35. 00	Utilization review		0		35. 00
36. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	33)	14, 100, 886	13, 074, 225	
37. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37. 00
38. 00	Subtotal (line 36 ± line 37)		14, 100, 886	13, 074, 225	
39. 00	Direct graduate medical education payments (from Wkst. E-4)		0	40 074 0	39. 00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		14, 100, 886	13, 074, 225	
41. 00	Interim payments		14, 100, 886	13, 074, 225	
42.00	Balance due provider/program (line 40 minus line 41)	' II ONG D I 45 G	0	0	42.00
43. 00	Protested amounts (nonallowable cost report items) in accordan	ice with CMS Pub 15-2,	0	0	43. 00
	chapter 1, §115.2				l

Health Financial Systems	FRANCISCAN HEALTH- DYER	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0090	Peri od: From 01/01/2023	Worksheet E-3
	Component CCN: 15-T090		Date/Time Prepared:   5/30/2024 3:45 pm
	Title XIX	Subprovi der -	TEFRA

		II ti e xi x	I RF	IEFRA	
			Inpatient	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVIC	ES FOR TITLES V OR XIX	SERVI CES		
	COMPUTATION OF NET COST OF COVERED SERVICES				1
1.00	Inpatient hospital/SNF/NF services		7		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant programs only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		7	0	4.00
5.00	Inpatient primary payer payments		0		5. 00
6.00	Outpatient primary payer payments			0	
7.00	Subtotal (line 4 less sum of lines 5 and 6)		7	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES				1
	Reasonable Charges				1
8.00	Routine service charges		0		8.00
9. 00	Ancillary service charges		792	0	
10.00	Organ acquisition charges, net of revenue		0		10.00
11. 00	Incentive from target amount computation		0		11. 00
12. 00	Total reasonable charges (sum of lines 8 through 11)		792	0	12. 00
	CUSTOMARY CHARGES		_1		
13.00	Amount actually collected from patients liable for payment for se			0	
14. 00	Amounts that would have been realized from patients liable for pa		a 0	0	14. 00
15 00	charge basis had such payment been made in accordance with 42 CFF	( §413. 13(e)	0. 000000	0.000000	15.00
15. 00 16. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)			0. 000000	
17. 00	Total customary charges (see instructions)  Excess of customary charges over reasonable cost (complete only i	fline 14 eyeards line	792 785	0	
17.00	4) (see instructions)	I Time to exceeds time	/85	Ü	17.00
18. 00	Excess of reasonable cost over customary charges (complete only i	fline / evceeds line	0	0	18.00
10.00	16) (see instructions)	Title 4 exceeds Title	O	O	10.00
19. 00	Interns and Residents (see instructions)		o	0	19.00
20. 00	Cost of physicians' services in a teaching hospital (see instruct	tions)	0	0	
21. 00	Cost of covered services (enter the lesser of line 4 or line 16)		7	0	
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be con	npleted for PPS provide	rs.		1
22. 00	Other than outlier payments		0	0	22. 00
	Outlier payments		0	0	
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		O	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		O	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28. 00
29. 00	Titles V or XIX (sum of lines 21 and 27)		7	0	29. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)		0	0	
31. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		7	0	
32.00	Deducti bl es		0	0	
33.00	Coi nsurance		0	0	
34. 00	Allowable bad debts (see instructions)		0	0	
	Utilization review	-	0		35.00
	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33	3)	7	0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	
	Subtotal (line 36 ± line 37)		7	0	
	Direct graduate medical education payments (from Wkst. E-4)		0	=	39.00
40.00			7	0	
41.00	Interim payments		7	0	
42.00	Balance due provider/program (line 40 minus line 41)	: II ONG D I 45 G	0	0	
43. 00	Protested amounts (nonallowable cost report items) in accordance	with CMS Pub 15-2,	0	0	43. 00
	chapter 1, §115.2		ı		I

	n Financial Systems FRANCISCAN HEAL T GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provider CO	CN: 15-0090	Peri od:	u of Form CMS- Worksheet E-4	
/IEDI C	AL EDUCATION COSTS			From 01/01/2023 To 12/31/2023	Date/Time Pre	pared:
		Title	XVIII	Hospi tal	5/30/2024 3: 4 PPS	5 pm
					1. 00	
	COMPUTATION OF TOTAL DIRECT GME AMOUNT				1.00	
1.00	Unweighted resident FTE count for allopathic and osteopathic on or before December 31, 1996.	programs for	cost reporti	ng periods endir	ng 7. 76	1. 00
. 01	FTE cap adjustment under §131 of the CAA 2021 (see instruction	,			0.00	1
. 00 . 26	Unweighted FTE resident cap add-on for new programs per 42 CFI Rural track program FTE cap limitation adjustment after the car CAA 2021 (see instructions)				0.00 the 0.00	1
. 00 . 01	Amount of reduction to Direct GME cap under section 422 of MM. Direct GME cap reduction amount under ACA §5503 in accordance		8/12 70 (m)	(soo instruction	0. 86 ons 0. 00	
	for cost reporting periods straddling 7/1/2011)		. ,			
. 02	Adjustment (increase or decrease) to the hospital's rural trace programs with a rural track Medicare GME affiliation agreement 49075 (August 10, 2022) (see instructions)				0. 00	3. 02
00	Adjustment (plus or minus) to the FTE cap for allopathic and	osteopathi c	programs due	to a Medicare GN	IE 0.00	4. 00
. 01	affiliation agreement (42 CFR §413.75(b) and § 413.79 (f)) ACA Section 5503 increase to the Direct GME FTE Cap (see instistraddling 7/1/2011)	ructions for	cost reporti	ng periods	0. 00	4. 01
. 02	ACA Section 5506 number of additional direct GME FTE cap slots	s (see inst	ructions for	cost reporting	0. 00	4. 02
. 21	periods straddling 7/1/2011) The amount of increase if the hospital was awarded FTE cap slinstructions)	ots under §1	26 of the CA	A 2021 (see	0. 00	4. 21
00	FTE adjusted cap (line 1 plus and 1.01, plus line 2, plus line 3.01, plus or minus line 3.02, plus or minus line 4, plus line			nus lines 3 and	6. 90	5. 00
00	Unweighted resident FTE count for allopathic and osteopathic records (see instructions)		J	year from your	2. 09	6.00
. 00	Enter the lesser of line 5 or line 6				2. 09	7. 00
			Primary Card	e <u>Other</u> 2.00	<u>Total</u> 3. 00	
. 00	Weighted FTE count for physicians in an allopathic and osteop	athic progra				8. 00
00	for the current year.  If line 6 is less than 5 enter the amount from line 8, otherw line 8 times the result of line 5 divided by the amount on lin cost reporting periods beginning on or after October 1, 2022,	ne 6. For	y 0. (	2. 09	2. 09	9. 00
						1
0. 00	Worksheet S-2, Part I, line 68, is "Y", see instructions. Weighted dental and podiatric resident FTE count for the curre	ent year		3. 65		10.00
0. 01	Weighted dental and podiatric resident FTE count for the currulnweighted dental and podiatric resident FTE count for the cu			3. 65		10. 0°
0. 01 1. 00	Weighted dental and podiatric resident FTE count for the currulnweighted dental and podiatric resident FTE count for the currotal weighted FTE count	ırrent year	0. (	3. 65 5. 74		10. 0°
0. 01 1. 00 2. 00	Weighted dental and podiatric resident FTE count for the currounweighted dental and podiatric resident FTE count for the currotal weighted FTE count Total weighted resident FTE count for the prior cost reporting instructions)	ng year (see	0. (	3. 65 5. 74 00 3. 79		10. 0° 11. 0° 12. 0°
0. 01 1. 00 2. 00	Weighted dental and podiatric resident FTE count for the currounweighted dental and podiatric resident FTE count for the currotal weighted FTE count Total weighted resident FTE count for the prior cost reporting instructions)	ng year (see	0. (	3. 65 5. 74 00 3. 79		10. 0° 11. 0° 12. 0°
0. 01 1. 00 2. 00 3. 00	Weighted dental and podiatric resident FTE count for the currend unweighted dental and podiatric resident FTE count for the currend weighted FTE count  Total weighted resident FTE count for the prior cost reporting instructions)  Total weighted resident FTE count for the penultimate cost reporting the cost of the penultimate cost reporting the cost of the penultimate cost of the penultim	nrent year ng year (see eporting year	0. ( 0. : 0. (	3. 65 5. 74 20 3. 79 21 4. 76		10. 0° 11. 00 12. 00 13. 00
0. 01 1. 00 2. 00 3. 00 4. 00 5. 00	Weighted dental and podiatric resident FTE count for the currend unweighted dental and podiatric resident FTE count for the current weighted FTE count  Total weighted resident FTE count for the prior cost reporting instructions)  Total weighted resident FTE count for the penultimate cost reporting instructions)  Rolling average FTE count (sum of lines 11 through 13 divided Adjustment for residents in initial years of new programs	urrent year  ng year (see  eporting year  l by 3).	0. ( 0. ( 0. (	3. 65 5. 74 00 3. 79 21 4. 76 00 0. 00		10. 0° 11. 00 12. 00 13. 00 14. 00 15. 00
0. 01 1. 00 2. 00 3. 00 4. 00 5. 00 5. 01	Weighted dental and podiatric resident FTE count for the currend unweighted dental and podiatric resident FTE count for the currend weighted FTE count  Total weighted resident FTE count for the prior cost reporting instructions)  Total weighted resident FTE count for the penultimate cost region (see instructions)  Rolling average FTE count (sum of lines 11 through 13 divided Adjustment for residents in initial years of new programs  Unweighted adjustment for residents in initial years of new programs	urrent year  ng year (see eporting year  l by 3).  programs	0. ( 0. ( 0. ( 0. (	3. 65 5. 74 00 3. 79 21 4. 76 00 0. 00 00 0. 00		10. 0° 11. 00 12. 00 13. 00 14. 00 15. 00
0. 01 1. 00 2. 00 3. 00 4. 00 5. 00 5. 01 6. 00	Weighted dental and podiatric resident FTE count for the currounweighted dental and podiatric resident FTE count for the currotal weighted FTE count Total weighted resident FTE count for the prior cost reporting instructions) Total weighted resident FTE count for the penultimate cost reporting instructions) Rolling average FTE count (sum of lines 11 through 13 divided Adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new programs of the program or hospital closure of the program of the program or hospital closure of the program of the program or hospital closure of the program of the program or hospital closure of the program of the program or hospital closure of the program of the program or hospital closure of the program of the program or hospital closure of the program of the program or hospital closure of the program of the program or hospital closure of the program of the program or hospital closure of the program of the program or hospital closure of the program of the p	urrent year  ng year (see eporting year  l by 3).  programs psure	0. ( 0. ( 0. (	3. 65 5. 74 20 3. 79 21 4. 76 27 4. 76 20 0. 00 20 0. 00		10. 0° 11. 00 12. 00 13. 00 14. 00 15. 0° 16. 00
0. 01 1. 00 2. 00 3. 00 4. 00 5. 00 5. 01 6. 00 6. 01	Weighted dental and podiatric resident FTE count for the curre. Unweighted dental and podiatric resident FTE count for the curre. Total weighted FTE count Total weighted resident FTE count for the prior cost reporting instructions) Total weighted resident FTE count for the penultimate cost reg (see instructions) Rolling average FTE count (sum of lines 11 through 13 divided Adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new p. Adjustment for residents displaced by program or hospital closure Adjusted rolling average FTE count	urrent year  ng year (see eporting year  l by 3).  programs psure	0.1 0.1 0.1 0.1 0.1	3. 65 5. 74 20 3. 79 21 4. 76 27 4. 76 20 0. 00 00 0. 00 00 0. 00 00 0. 00		10. 0° 11. 00 12. 00 13. 00 14. 00 15. 0° 16. 0° 16. 0° 17. 00
0. 01 1. 00 2. 00 3. 00 4. 00 5. 00 5. 01 6. 00 6. 01 7. 00 3. 00	Weighted dental and podiatric resident FTE count for the curre. Unweighted dental and podiatric resident FTE count for the curre. Total weighted FTE count Total weighted resident FTE count for the prior cost reporting instructions) Total weighted resident FTE count for the penultimate cost reg (see instructions) Rolling average FTE count (sum of lines 11 through 13 divided Adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new p Adjustment for residents displaced by program or hospital closure Unweighted adjustment for residents displaced by program or hospital closure Adjusted rolling average FTE count Per resident amount	urrent year  ng year (see eporting year  l by 3).  programs psure	0.1 0.1 0.1 0.1 0.1 0.1 106, 358.4	3. 65 5. 74 20 3. 79 21 4. 76 27 4. 76 20 0. 00 00 0. 00 00 0. 00 00 0. 00 00 0. 00 00 0. 00 00 0. 00		10. 01 11. 00 12. 00 13. 00 14. 00 15. 00 15. 01 16. 00 16. 01
0. 01 1. 00 2. 00 3. 00 4. 00 5. 00 5. 01 6. 00 6. 01 7. 00 8. 00 8. 01	Weighted dental and podiatric resident FTE count for the curre. Unweighted dental and podiatric resident FTE count for the curre. Total weighted FTE count Total weighted resident FTE count for the prior cost reporting instructions) Total weighted resident FTE count for the penultimate cost reg (see instructions) Rolling average FTE count (sum of lines 11 through 13 divided Adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new p. Adjustment for residents displaced by program or hospital closure Adjusted rolling average FTE count	urrent year  ng year (see eporting year  l by 3).  programs psure	0.1 0.1 0.1 0.1 0.1	3. 65 5. 74 00 3. 79 21 4. 76 00 00 00 00 00 00 00 00 00 00 00 00 00		10. 01 11. 00 12. 00 13. 00 14. 00 15. 01 16. 00 16. 01 17. 00 18. 00 18. 01
0. 01 1. 00 2. 00 3. 00 4. 00 5. 00 5. 01 6. 00 6. 01 7. 00 8. 00 8. 01	Weighted dental and podiatric resident FTE count for the curre. Unweighted dental and podiatric resident FTE count for the curre. Total weighted FTE count Total weighted resident FTE count for the prior cost reporting instructions) Total weighted resident FTE count for the penultimate cost register instructions. Rolling average FTE count (sum of lines 11 through 13 divided Adjustment for residents in initial years of new programs. Unweighted adjustment for residents in initial years of new p. Adjustment for residents displaced by program or hospital closure. Unweighted adjustment for residents displaced by program or hospital closure. Adjusted rolling average FTE count. Per resident amount.	urrent year  ng year (see eporting year  l by 3).  programs psure	0.1 0.1 0.1 0.1 0.1 0.1 106, 358.	3. 65 5. 74 00 3. 79 21 4. 76 00 00 00 00 00 00 00 00 00 00 00 00 00		10. 00 10. 01 11. 00 12. 00 13. 00 14. 00 15. 00 16. 01 17. 00 18. 00 18. 01 19. 00
0.000 0.000	Weighted dental and podiatric resident FTE count for the curre. Unweighted dental and podiatric resident FTE count for the curre. Total weighted FTE count Total weighted resident FTE count for the prior cost reporting instructions) Total weighted resident FTE count for the penultimate cost reg (see instructions) Rolling average FTE count (sum of lines 11 through 13 divided Adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new p. Adjustment for residents displaced by program or hospital closure Adjusted rolling average FTE count Per resident amount Per resident amount under §131 of the CAA 2021 Approved amount for resident costs  Additional unweighted allopathic and osteopathic direct GME F. Sec. 413.79(c)(4)	errent year  ng year (see eporting year  by 3).  programs essure enospital	0.1 0.1 0.1 0.1 0.1 0.1 106, 358.1 0.1	3. 65 5. 74 20 3. 79 21 4. 76 00 0. 00 0. 00 00 00 00 00 00 00 00 00 00 00 00 00	496, 735 1.00 0.00	10. 0° 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00
0. 01 11. 00 22. 00 44. 00 55. 00 55. 01 66. 00 77. 00 88. 00 89. 00 99. 00	Weighted dental and podiatric resident FTE count for the currounweighted dental and podiatric resident FTE count for the currotal weighted FTE count Total weighted resident FTE count for the prior cost reporting instructions) Total weighted resident FTE count for the penultimate cost reg (see instructions) Rolling average FTE count (sum of lines 11 through 13 divided Adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new programs Unweighted adjustment for residents displaced by program or hoclosure Adjusted rolling average FTE count Per resident amount Per resident amount Per resident amount under §131 of the CAA 2021 Approved amount for resident costs  Additional unweighted allopathic and osteopathic direct GME F Sec. 413.79(c)(4) Direct GME FTE unweighted resident count over cap (see instructions)	errent year  ag year (see eporting year  by 3).  brograms sure epospital  TE resident  actions)	0.1 0.1 0.1 0.1 0.1 0.1 106, 358.1 0.1	3. 65 5. 74 20 3. 79 21 4. 76 00 0.	496, 735 1.00 0.00 0.00	10. 0° 11. 00 12. 00 13. 00 14. 00 15. 00 16. 0° 16. 0° 17. 00 18. 0° 19. 00 20. 00 21. 00
6. 01 7. 00 8. 00 8. 01 9. 00 0. 00 1. 00 2. 00	Weighted dental and podiatric resident FTE count for the currounweighted dental and podiatric resident FTE count for the currotal weighted FTE count Total weighted resident FTE count for the prior cost reporting instructions) Total weighted resident FTE count for the penultimate cost reporting instructions) Rolling average FTE count (sum of lines 11 through 13 divided Adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new productions. Adjustment for residents displaced by program or hospital closure Adjusted rolling average FTE count Per resident amount Per resident amount Per resident amount for resident costs  Additional unweighted allopathic and osteopathic direct GME F Sec. 413.79(c)(4) Direct GME FTE unweighted resident count over cap (see instructional direct GME FTE Resident Count (see ins	arrent year  ag year (see eporting year  by 3).  brograms broure bospi tal  arrent year  arrent year  arrent year  by 3).  brograms  brograms  broure  cospi tal	0.0 0.0 0.0 0.0 0.1 106, 358. 0.1 7, 4	3. 65 5. 74 20 3. 79 21 4. 76 00 0.	496, 735 1.00 0.00 0.00 0.00	10. 01 11. 00 12. 00 13. 00 14. 00 15. 00 15. 01 16. 00 18. 00 18. 01 19. 00 20. 00 21. 00 22. 00
0. 01 11. 00 22. 00 33. 00 44. 00 55. 00 55. 01 66. 00 66. 01 77. 00 88. 00 88. 01 99. 00 11. 00 22. 00 33. 00	Weighted dental and podiatric resident FTE count for the currounweighted dental and podiatric resident FTE count for the currotal weighted FTE count  Total weighted resident FTE count for the prior cost reporting instructions)  Total weighted resident FTE count for the penultimate cost reporting instructions)  Rolling average FTE count (sum of lines 11 through 13 divided Adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new programs Unweighted adjustment for residents displaced by program or hoclosure  Adjusted rolling average FTE count  Per resident amount  Per resident amount  Per resident amount under §131 of the CAA 2021  Approved amount for resident costs  Additional unweighted allopathic and osteopathic direct GME F  Sec. 413.79(c)(4)  Direct GME FTE unweighted resident count over cap (see instructional sections)	arrent year  ag year (see eporting year  by 3).  brograms broure bospi tal  arrent year  arrent year  arrent year  by 3).  brograms  brograms  broure  cospi tal	0.0 0.0 0.0 0.0 0.1 106, 358. 0.1 7, 4	3. 65 5. 74 20 3. 79 21 4. 76 00 0.	496, 735 1.00 0.00 0.00 0.00	10. 0° 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00 22. 00 23. 00

	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provi der (	CCN: 15-0090	Peri od: From 01/01/2023	Worksheet E-4	
EDI CA	L EDUCATION COSTS			To 12/31/2023	Date/Time Pre 5/30/2024 3:49	
		Ti tl	e XVIII	Hospi tal	PPS	
			Inpatient Par	rt Managed Care	Total	
			1.00	2. 00	3. 00	
	COMPUTATION OF PROGRAM PATIENT LOAD					
6. 00	Inpatient Days (see instructions) (Title XIX - see S-2 Part I)	K, line 3.0	2, 10, 62	21 5, 998		26. 0
	column 2)					
7. 00	Total Inpatient Days (see instructions)		31, 64			27. 0
8. 00	Ratio of inpatient days to total inpatient days		0. 33568			28. 0
9. 00	Program direct GME amount		166, 74	·	260, 911	
	Percent reduction for MA DGME			3. 27		29. 0
0.00	Reduction for direct GME payments for Medicare Advantage			3, 079		
1.00	Net Program direct GME amount				257, 832	31.0
					1. 00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE	VIII ONI	V (NIIDSING DDO	CDAM AND DADAMED		
	EDUCATION COSTS)	. AVIII ONL	I (NUKSING FKC	JORAW AND FARAWLL	JI CAL	
2. 00	Renal dialysis direct medical education costs (from Wkst. B, F	Pt I SUM	of col 20 and	d 23 lines 74 ar	nd 0	32. C
	94)	,		,	-	
3. 00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I	, col . 8,	sum of lines 7	74 and 94)	0	33.0
4. 00	Ratio of direct medical education costs to total charges (line	e 32 ÷ line	33)	ŕ	0.000000	34.0
5. 00	Medicare outpatient ESRD charges (see instructions)				0	35.0
6. 00	Medicare outpatient ESRD direct medical education costs (line		35)		0	36.0
	APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII	ONLY				
	Part A Reasonable Cost					ļ
7. 00	Reasonable cost (see instructions)				33, 562, 834	
8. 00	Organ acquisition and HSCT acquisition costs (see instructions				0	38.0
9. 00	Cost of physicians' services in a teaching hospital (see instr	ructions)			0	39. (
0.00	Primary payer payments (see instructions)				0	
1. 00	Total Part A reasonable cost (sum of lines 37 through 39 minus	s line 40)			33, 562, 834	41. (
	Part B Reasonable Cost Reasonable cost (see instructions)				10 202 170	40.6
2.00					13, 303, 170	
3. 00 4. 00	Primary payer payments (see instructions) Total Part B reasonable cost (line 42 minus line 43)				1, 087 13, 302, 083	
5. 00	Total reasonable cost (sum of lines 41 and 44)				46, 864, 917	1
5. 00	Ratio of Part A reasonable cost to total reasonable cost (line	A1 ∸ lino	45)		0. 716161	
	Ratio of Part B reasonable cost to total reasonable cost (line				0. 710101	
, . 00	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PAR		10)		0. 203037	1 7/. (
3. 00	Total program GME payment (line 31)	5			257, 832	48. (
9. 00	Part A Medicare GME payment (line 46 x 48) (title XVIII only)	(see instr	uctions)		184, 649	
	1. I. I. I. III III III III III III III	(200			.0.,017	50.0

Health Financial Systems FRANCISCAN HEALTH- DYER In Lieu			u of Form CMS-2	552-10	
			Worksheet E-5		
			From 01/01/2023 To 12/31/2023	Date/Time Prep 5/30/2024 3:45	
		Title XVIII		PPS	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR				
1.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum	of 2.03 plus 2.04 (see i	nstructions)	0	1.00
2.00	Capital outlier from Wkst. L, Pt. I, line 2			0	2.00
3.00	Operating outlier reconciliation adjustment amount (see instr	ructions)		0	3.00
4.00 Capital outlier reconciliation adjustment amount (see instructions)				0	4.00
5.00 The rate used to calculate the time value of money (see instructions)			0.00	5.00	
6.00 Time value of money for operating expenses (see instructions)				0	6.00
7.00 Time value of money for capital related expenses (see instructions)				0	7.00

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

					5/30/2024 3: 4	5 pm
		General Fund	Speci fi c	Endowment Fund	Plant Fund	
			Purpose Fund			
		1. 00	2.00	3. 00	4. 00	
1 00	CURRENT ASSETS	07.0/0.540	J .			4 00
1.00	Cash on hand in banks	-97, 069, 518	1	0	0	1.00
2.00	Temporary investments	0	0	0	-	2.00
3.00	Notes recei vabl e	0	0	0	0	3. 00
4.00	Accounts receivable	113, 493, 435		0	0	1
5.00	Other receivable	04 504 000		0	0	
6.00	Allowances for uncollectible notes and accounts receivable	-84, 584, 998		0	0	1
7. 00 8. 00	Inventory Prepai d expenses	3, 301, 871		0	0	7. 00 8. 00
9.00	Other current assets	2 520 024		0	0	9.00
10. 00	Due from other funds	3, 530, 934		0	0	10.00
11. 00	Total current assets (sum of lines 1-10)	-61, 328, 276	1	_		11.00
11.00	FIXED ASSETS	-01, 320, 270	)	0		11.00
12. 00	Land	694, 364	· O	0	0	12. 00
13. 00	Land improvements	10, 382, 022			1	
14. 00	Accumul ated depreciation	10, 362, 022		_		14. 00
15. 00	Buildings	74, 382, 828			0	15. 00
16. 00	Accumulated depreciation	14, 302, 020		_	0	16.00
17. 00	Leasehold improvements	178, 989	1	0	0	17. 00
18. 00	Accumul ated depreciation	170,707		0	Ö	18. 00
19. 00	Fi xed equipment	Ô		0	0	19. 00
20. 00	Accumulated depreciation	Ô		0	0	20.00
21. 00	Automobiles and trucks	0	ol o	0	Ö	21.00
22. 00	Accumulated depreciation	0	ol o	_	Ö	22. 00
23. 00	Major movable equipment	0		_	o o	23. 00
24. 00	Accumulated depreciation	0		0	l o	24. 00
25. 00	Mi nor equipment depreciable	179, 926, 808		0	l o	25. 00
26. 00	Accumulated depreciation	-177, 693, 107		0	l o	26. 00
27. 00	HIT designated Assets	0		0	0	27. 00
28. 00	Accumulated depreciation	0	o	0	0	28. 00
29. 00	Mi nor equi pment-nondepreci abl e	0	o	0	0	
30.00	Total fixed assets (sum of lines 12-29)	87, 871, 904	. 0	0	0	30.00
	OTHER ASSETS					]
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on Leases	0	0	0	0	32. 00
33.00	Due from owners/officers	0	0	0	0	33. 00
34.00	Other assets	45, 303, 830	0	0	0	34. 00
35.00	Total other assets (sum of lines 31-34)	45, 303, 830	0	0	0	35. 00
36.00	Total assets (sum of lines 11, 30, and 35)	71, 847, 458	3 0	0	0	36. 00
	CURRENT LI ABI LI TI ES					
37. 00	Accounts payable	8, 931, 205	1			37. 00
38. 00	Salaries, wages, and fees payable	0	0	_	0	38. 00
39. 00	Payroll taxes payable	7, 848, 556	1	0	0	39. 00
40. 00	Notes and Loans payable (short term)	508, 866	0	0	0	40. 00
41. 00	Deferred income	0	) 0	0	0	41.00
42.00	Accel erated payments	0	)			42.00
43.00	Due to other funds	0	0	0	0	
44. 00	Other current liabilities	819, 799	•	_	0	
45. 00	Total current liabilities (sum of lines 37 thru 44)	18, 108, 426	0	0	0	45. 00
47.00	LONG TERM LIABILITIES		J 0		1 0	4,, 00
46. 00	Mortgage payable	0	0	0	0	
47. 00	Notes payable	0	0			
48. 00	Unsecured Loans	0 405 000	0		-	48. 00
49. 00	Other long term liabilities	3, 425, 333	1		-	1
50.00	Total long term liabilities (sum of lines 46 thru 49)	3, 425, 333				
51. 00	Total liabilities (sum of lines 45 and 50)	21, 533, 759	) 0	0	0	51.00
52. 00	CAPITAL ACCOUNTS General fund balance	50, 313, 699			I	52.00
53. 00	Specific purpose fund	50, 515, 699	Ί ο			53.00
54. 00	Donor created - endowment fund balance - restricted			0		54.00
55. 00	Donor created - endowment fund balance - restricted			0		55.00
56. 00	Governing body created - endowment fund balance			0		56.00
57. 00	Plant fund balance - invested in plant				0	
58. 00	Plant fund balance - reserve for plant improvement,				0	
30.00	replacement, and expansion					30.00
59. 00	Total fund balances (sum of lines 52 thru 58)	50, 313, 699	0	0	0	59. 00
	Total liabilities and fund balances (sum of lines 51 and 59		1	0		
	·		•	•	•	

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES FRANCISCAN HEALTH- DYER In Lieu of Form CMS-2552-10

Peri od: Worksheet G-1 From 01/01/2023 Provider CCN: 15-0090

					To		Date/Time Pre 5/30/2024 3:4	
		General	Fund	Speci al	Pui	rpose Fund	Endowment Fund	
		1.00	2. 00	3.00		4. 00	5. 00	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) ADJSUTMENT TO BALANCE ADJUMENT TO BALANCE  Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	496, 376 1 0 0 0 0 0 0	23, 489, 410 26, 327, 912 49, 817, 322 496, 377 50, 313, 699		0 0 0 0 0 0 0 0 0 0 0 0	0 0 0	0 0 0 0 0 0	8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00
19. 00	Fund balance at end of period per balance sheet (line 11 minus line 18)	Endowment Fund	50, 313, 699 Pl ant			0		19. 00
		6.00	7. 00	8. 00				
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) ADJSUTMENT TO BALANCE ADJUMENT TO BALANCE  Total additions (sum of line 4-9)	0	7.00 0 0 0 0 0		0			1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)  Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0	0 0 0 0 0		0			10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00

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

			To 12/31/2023	Date/Time Pre 5/30/2024 3:4	
	Cost Center Description	I npati ent	Outpati ent	Total	J piii
		1.00	2. 00	3.00	
	PART I - PATIENT REVENUES		<u> </u>		
	General Inpatient Routine Services				
1.00	Hospi tal	70, 066, 1	55	70, 066, 155	1. 00
2.00	SUBPROVI DER - I PF				2. 00
3.00	SUBPROVI DER - I RF	7, 542, C	16	7, 542, 016	3. 00
4.00	SUBPROVI DER		0	0	4. 00
5.00	Swing bed - SNF		0	0	5. 00
6.00	Swing bed - NF		0	0	6. 00
7.00	SKILLED NURSING FACILITY				7. 00
8.00	NURSING FACILITY				8. 00
9.00	OTHER LONG TERM CARE				9. 00
10.00	Total general inpatient care services (sum of lines 1-9)	77, 608, 1	71	77, 608, 171	10.00
	Intensive Care Type Inpatient Hospital Services				
11. 00	INTENSIVE CARE UNIT	10, 388, 7	87	10, 388, 787	11. 00
12. 00	CORONARY CARE UNIT		0	0	
13. 00	BURN INTENSIVE CARE UNIT		0	0	
	SURGICAL INTENSIVE CARE UNIT				14. 00
15. 00	NEONATAL INTENSIVE CARE UNIT	1, 241, 0		1, 241, 031	1
16. 00	31.			11, 629, 818	
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	89, 237, 9		89, 237, 989	1
18. 00	Ancillary services	239, 052, 6			
19. 00	· ·	19, 998, 9			
20. 00	RURAL HEALTH CLINIC		0	_	
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		0 0	1	
22. 00	HOME HEALTH AGENCY		0	0	22. 00
23. 00	AMBULANCE SERVI CES				23. 00
24. 00	CMHC				24.00
25. 00	AMBULATORY SURGICAL CENTER (D. P. )				25. 00
26. 00	HOSPI CE				26. 00
27. 00	OTHER (SPECIFY)		0	0	
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst	348, 289, 6	15 436, 148, 194	784, 437, 809	28. 00
	G-3, line 1) PART II - OPERATING EXPENSES				
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		212, 045, 213	1	29. 00
30. 00	ADD (SPECIFY)		0	1	30.00
31. 00	ADD (SECTION)		0		31. 00
32. 00			0		32. 00
33. 00			0		33. 00
34. 00			0		34. 00
35. 00			0		35. 00
36. 00	Total additions (sum of lines 30-35)			,	36.00
37. 00	DEDUCT (SPECIFY)			1	37. 00
38. 00	DEDUCT (SECOTE)		0		38. 00
39. 00			0		39.00
40. 00			0		40. 00
41. 00			o l		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)(trans	fer	212, 045, 213		43. 00
	to Wkst. G-3, line 4)		, , =		

	Financial Systems FRANCISCAN HE			u of Form CMS-2	2552-10
STATEM	ENT OF REVENUES AND EXPENSES	Provider CCN: 15-0090	Peri od: From 01/01/2023	Worksheet G-3	
			To 12/31/2023	Date/Time Pre	pared:
	<u> </u>			5/30/2024 3: 4	5 pm
				4 00	
1. 00	Total patient revenues (from Wkst. G-2, Part I, column 3, li	no 20)		1. 00 784, 437, 809	1. 00
2.00	Less contractual allowances and discounts on patients' accounts			552, 077, 364	
3.00	Net patient revenues (line 1 minus line 2)	airts		232, 360, 445	
4. 00	Less total operating expenses (from Wkst. G-2, Part II, line	- 43)		212, 045, 213	
5.00	Net income from service to patients (line 3 minus line 4)	= 43)		20, 315, 232	
0.00	OTHER I NCOME			20, 010, 202	0.00
6.00	Contributions, donations, beguests, etc			0	6. 00
7.00	Income from investments			0	7. 00
8.00	Revenues from telephone and other miscellaneous communication	on services		0	8. 00
9.00	Revenue from television and radio service			0	9. 00
10.00	Purchase di scounts			0	10.00
11. 00	Rebates and refunds of expenses			0	11. 00
12.00	Parking lot receipts			0	12. 00
13.00	Revenue from Laundry and Linen service			0	13. 00
14.00	Revenue from meals sold to employees and guests			0	
	Revenue from rental of living quarters			0	
	Revenue from sale of medical and surgical supplies to other	than patients			16. 00
	Revenue from sale of drugs to other than patients			0	17. 00
	Revenue from sale of medical records and abstracts			0	
	Tuition (fees, sale of textbooks, uniforms, etc.)			0	
20. 00	Revenue from gifts, flowers, coffee shops, and canteen			0	
21. 00	Rental of vending machines			0	
	Rental of hospital space			0	
23. 00	Governmental appropriations			0	
24. 00	OTHER OPERATING REVENUE			5, 095, 422	
24. 01	OTHER NON OPERATING REVENUE			917, 258	
24. 50	COVI D-19 PHE Fundi ng			0	24. 50
25. 00	Total other income (sum of lines 6-24)			6, 012, 680	
	Total (line 5 plus line 25)			26, 327, 912	
27. 00	OTHER EXPENSES (SPECIFY)			0	
	Total other expenses (sum of line 27 and subscripts)			0	
29.00	Net income (or loss) for the period (line 26 minus line 28)			26, 327, 912	29.00

Heal th	Financial Systems		FRANCISCAN HE	ALTH- DYER		In Lie	u of Form CMS-	2552-10
	LLOCATION - HHA GENERAL SERVICE	COST			CN: 15-0090	Peri od:	Worksheet H-1	
				HHA CCN:	15-7145	From 01/01/2023 To 12/31/2023	Part     Date/Time Pre	pared:
							5/30/2024 3: 4	
						Home Health Agency I	PPS	
			Capital Rela	ated Costs				
		Not Eypopoo	DI dec 0	Mayrahla	Diant	Transpartation	Cubtotal	-
		Net Expenses for Cost	Bl dgs & Fi xtures	Movable Equipment	Plant Operation 8	Transportation	Subtotal (cols. 0-4)	
		Allocation	TTATUTES	Equi piliciti	Mai ntenance		(6013. 0 4)	
		(from Wkst. H,						
		col . 10) 0	1.00	2. 00	2.00	4.00	4A. 00	
	GENERAL SERVICE COST CENTERS	0 1	1.00	2.00	3.00	4. 00	4A. 00	
1.00	Capital Related - Bldg. &	0	0				0	1.00
	Fixtures	_		_			_	
2. 00	Capital Related - Movable Equipment	0		O	)		0	2. 00
3.00	Plant Operation & Maintenance	51, 825	0	0	51, 8	25	0	3.00
4.00	Transportati on	43, 285	0	0		0 43, 285		4. 00
5.00	Administrative and General	1, 874, 284	0	0	51, 8	25 43, 285	1, 969, 394	5. 00
6. 00	HHA REIMBURSABLE SERVICES Skilled Nursing Care	2, 932, 106	0	0	1	0 0	2, 932, 106	6. 00
7. 00	Physical Therapy	2, 534, 974	ő	Ö	•	0 0	2, 534, 974	
8.00	Occupational Therapy	329, 917	0	0		0 0	329, 917	1
9.00	Speech Pathology	37, 629	0	0		0 0	37, 629	
10. 00 11. 00	Medical Social Services Home Health Aide	170, 999 108, 497	0	0	1	0 0	170, 999 108, 497	1
12. 00	Supplies (see instructions)	0	o	0	1	0 0	100, 497	1
13. 00	Drugs	0	O	0		0	0	13. 00
14. 00	DME	0	0	0	)	0 0	0	14. 00
15. 00	HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services	0	0	C	\	0 0	0	15. 00
16. 00	Respiratory Therapy		0	0	•	0 0	0	1
17. 00	Private Duty Nursing	Ö	Ö	0	•	0 0	0	1
18. 00	Clinic	0	0	0	1	0 0	0	
19. 00	Health Promotion Activities	0	0	0	•	0 0	0	
20. 00 21. 00	Day Care Program Home Delivered Meals Program		0	0	•	0 0	0	
22. 00	Homemaker Service	l o	Ö	Ö	1	0 0	Ö	1
23. 00	All Others (specify)	0	0	0	•	0 0	0	23. 00
23. 50	Tel emedi ci ne	0	0	0	•	0 0	0 000 51/	
24. 00	Total (sum of lines 1-23)	8,083,516 Admi ni strati ve	Total (cols.	0	51, 8	25 43, 285	8, 083, 516	24. 00
		& General	4A + 5)					
		5. 00	6. 00					
1 00	GENERAL SERVICE COST CENTERS							1.00
1. 00	Capital Related - Bldg. & Fixtures							1.00
2.00	Capital Related - Movable							2. 00
	Equi pment							
3. 00 4. 00	Plant Operation & Maintenance Transportation							3. 00 4. 00
5. 00	Administrative and General	1, 969, 394						5. 00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	944, 447	3, 876, 553					6.00
7. 00 8. 00	Physical Therapy Occupational Therapy	816, 530 106, 268	3, 351, 504 436, 185					7. 00 8. 00
9. 00	Speech Pathology	12, 121	49, 750					9. 00
10.00	Medical Social Services	55, 080	226, 079					10.00
11. 00	Home Health Aide	34, 948	143, 445					11. 00
12.00	Supplies (see instructions)	0	0					12.00
13. 00 14. 00	Drugs DME		0					13. 00 14. 00
00	HHA NONREI MBURSABLE SERVI CES	1 0	<u> </u>					1 00
15. 00	Home Dialysis Aide Services	0	0					15. 00
16.00	Respiratory Therapy	0	0					16.00
17. 00 18. 00	Private Duty Nursing Clinic		0					17. 00 18. 00
19. 00	Health Promotion Activities		0					19. 00
20. 00			o					20. 00
21.00	Home Delivered Meals Program	0	0					21.00
22. 00 23. 00	Homemaker Service All Others (specify)	0	0					22. 00 23. 00
23. 50			0					23. 50
	Total (sum of lines 1-23)		8, 083, 516					24. 00

Heal th	Financial Systems		FRANCISCAN HI	EALTH- DYER		In Lie	eu of Form CMS-2	2552-10
COST A	LLOCATION - HHA STATISTICAL BAS	il S		Provider Co	CN: 15-0090 15-7145	Peri od: From 01/01/2023 To 12/31/2023		pared:
						Home Health Agency I	PPS	•
		Capital Rel	ated Costs					
		BI dgs & Fixtures (SQUARE FEET)	Movable Equi pment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MI LEAGE)	onReconciliation	Administrative & General (ACCUM. COST)	
		1. 00	2. 00	3.00	4. 00	5A. 00	5. 00	
	GENERAL SERVICE COST CENTERS							
1. 00	Capital Related - Bldg. & Fixtures	0				0		1. 00
2. 00	Capital Related - Movable Equipment		0			0		2. 00
3.00	Plant Operation & Maintenance	0	0	100		0		3.00
4.00	Transportation (see	0	0	0	10	00		4. 00
F 00	instructions)			400		4 0/0 004		F 00
5. 00	Administrative and General HHA REIMBURSABLE SERVICES	0	0	100	10	00 -1, 969, 394	6, 114, 122	5.00
6. 00	Skilled Nursing Care	0	0	0		0 0	2, 932, 106	6.00
7. 00	Physical Therapy	Ö	0	l .				
8.00	Occupational Therapy	0	0	o		0 0		
9.00	Speech Pathology	0	0	0		0 0	37, 629	9. 00
10.00	Medical Social Services	0	0	0		0	170, 999	10.00
11. 00	Home Health Aide	0	0	0		0	108, 497	11. 00
12.00	Supplies (see instructions)	0	0	0		0	0	
13.00	Drugs	0	0	0		0		
14. 00	DME HHA NONREI MBURSABLE SERVI CES	0	0	0		0 0	0	14. 00
15. 00	Home Dialysis Aide Services	0	0	0		0 0	0	15. 00
16. 00	Respiratory Therapy	0	0				-	
17. 00	Private Duty Nursing	o o	0	Ö			l o	1
18.00	Clinic	0	0	O		0 0	0	1
19.00	Health Promotion Activities	0	0	0		0 0	0	19. 00
20.00	Day Care Program	0	0	0		0	0	20. 00
21.00	Home Delivered Meals Program	0	0	0		0	0	1
22. 00	Homemaker Service	0	0	0		0	0	00
23. 00	All Others (specify)	0	0	0		0	0	20.00
23. 50 24. 00	Telemedicine	0	0	100	1,	0 0 -1, 969, 394	0	
25. 00	Total (sum of lines 1-23) Cost To Be Allocated (per		0	51, 825			6, 114, 122 1, 969, 394	
23.00	Worksheet H-1, Part I)		0	31,023	75, 20	, ,	1, 707, 374	25.00
26. 00	Unit Cost Multiplier	0. 000000	0. 000000	518. 250000	432. 85000	00	0. 322106	26. 00

Home Health

PPS

						Agency I	PP5	
			CAPITAL REL	ATED COSTS		Agency 1		
	Cost Center Description	HHA Trial Balance (1)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	OTHER ADMI NI STRATI VE AND GENERAL	
		0	1.00	2. 00	4. 00	4A	5. 04	
1. 00	Administrative and General	0	5, 761	237	460, 835	466, 833		1. 00
2.00	Skilled Nursing Care	3, 876, 553	9, 723	404	780, 369	4, 667, 049		2. 00
3.00	Physical Therapy	3, 351, 504	7, 705	319	618, 695	3, 978, 223	1, 134, 462	3.00
4.00	Occupational Therapy	436, 185	818	33	64, 945	501, 981	143, 149	4.00
5.00	Speech Pathology	49, 750	36	1	3, 383	53, 170	15, 162	5.00
6.00	Medical Social Services	226, 079	563	23	45, 511	272, 176		6. 00
7. 00	Home Heal th Ai de	143, 445	73	4	5, 957	149, 479		7. 00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8. 00
9.00	Drugs DME	0	0	0	0	0	0	9. 00 10. 00
10. 00 11. 00	Home Dialysis Aide Services	0	0	0	0	0	0	11. 00
12. 00	Respiratory Therapy	0	0	0	0	0		12. 00
13. 00	Private Duty Nursing	o o	0	0	Ö	0	l ől	13. 00
14. 00	Clinic	0	0	0	0	0	o	14. 00
15. 00	Health Promotion Activities	0	0	0	0	0	o	15.00
16. 00	Day Care Program	0	0	0	0	0	0	16.00
17. 00	Home Delivered Meals Program	0	0	0	0	0	0	17. 00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19. 00 19. 50	All Others (specify) Telemedicine	0	0	0	0	0	0	19. 00 19. 50
20. 00	Total (sum of lines 1-19) (2)	8, 083, 516	24, 679	1, 021	1, 979, 695	10, 088, 911	2, 877, 035	20. 00
21. 00	Unit Cost Multiplier: column	0,003,310	24, 077	1, 021	1, 97 9, 093	0. 000000		21. 00
21100	26, line 1 divided by the sum					0.00000		211.00
	of column 26, line 20 minus							
	column 26, line 1, rounded to	6						
	decimal places.  Cost Center Description	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
	cost center bescription	REPAIRS	PLANT	LI NEN SERVI CE	HOUSEKEEFING	DILIAKI	CALLILA	
		6. 00						
1.00			7. 00	8. 00	9. 00	10. 00	11. 00	
0 00	Administrative and General	9, 833	3, 197	0	3, 883	0	21, 483	1. 00
2.00	Skilled Nursing Care	9, 833 16, 596	3, 197 5, 394	0 0	3, 883 6, 554		21, 483 36, 378	2. 00
3.00	Skilled Nursing Care Physical Therapy	9, 833 16, 596 13, 152	3, 197 5, 394 4, 276	0 0 0	3, 883 6, 554 5, 194	0	21, 483 36, 378 28, 840	2. 00 3. 00
3. 00 4. 00	Skilled Nursing Care Physical Therapy Occupational Therapy	9, 833 16, 596 13, 152 1, 396	3, 197 5, 394 4, 276 454	0 0	3, 883 6, 554 5, 194 551	0 0 0 0	21, 483 36, 378 28, 840 3, 027	2. 00 3. 00 4. 00
3. 00 4. 00 5. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology	9, 833 16, 596 13, 152 1, 396 62	3, 197 5, 394 4, 276 454 20	0 0 0	3, 883 6, 554 5, 194 551 25	0	21, 483 36, 378 28, 840 3, 027 157	2. 00 3. 00 4. 00 5. 00
3. 00 4. 00	Skilled Nursing Care Physical Therapy Occupational Therapy	9, 833 16, 596 13, 152 1, 396	3, 197 5, 394 4, 276 454	0 0 0	3, 883 6, 554 5, 194 551	0 0 0 0	21, 483 36, 378 28, 840 3, 027 157	2. 00 3. 00 4. 00
3. 00 4. 00 5. 00 6. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services	9, 833 16, 596 13, 152 1, 396 62 962	3, 197 5, 394 4, 276 454 20 313	0 0 0	3, 883 6, 554 5, 194 551 25 380	0 0 0 0	21, 483 36, 378 28, 840 3, 027 157 2, 122	2. 00 3. 00 4. 00 5. 00 6. 00
3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide	9, 833 16, 596 13, 152 1, 396 62 962 124	3, 197 5, 394 4, 276 454 20 313 40 0	0 0 0	3, 883 6, 554 5, 194 551 25 380 49	0 0 0 0	21, 483 36, 378 28, 840 3, 027 157 2, 122 278	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00
3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME	9, 833 16, 596 13, 152 1, 396 62 962 124	3, 197 5, 394 4, 276 454 20 313 40 0 0	0 0 0 0 0 0 0	3, 883 6, 554 5, 194 551 25 380 49 0 0	0 0 0 0	21, 483 36, 378 28, 840 3, 027 157 2, 122 278 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services	9, 833 16, 596 13, 152 1, 396 62 962 124	3, 197 5, 394 4, 276 454 20 313 40 0 0	0 0 0	3, 883 6, 554 5, 194 551 25 380 49 0 0	0 0 0 0	21, 483 36, 378 28, 840 3, 027 157 2, 122 278 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00
3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy	9, 833 16, 596 13, 152 1, 396 62 962 124	3, 197 5, 394 4, 276 454 20 313 40 0 0 0	0 0 0 0 0 0 0	3, 883 6, 554 5, 194 551 25 380 49 0 0	0 0 0 0	21, 483 36, 378 28, 840 3, 027 157 2, 122 278 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00
3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing	9, 833 16, 596 13, 152 1, 396 62 962 124	3, 197 5, 394 4, 276 454 200 313 40 0 0 0 0 0	0 0 0 0 0 0 0	3, 883 6, 554 5, 194 551 25 380 49 0 0	0 0 0 0	21, 483 36, 378 28, 840 3, 027 157 2, 122 278 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00
3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic	9, 833 16, 596 13, 152 1, 396 62 962 124	3, 197 5, 394 4, 276 454 20 313 40 0 0 0 0 0 0	0 0 0 0 0 0 0	3, 883 6, 554 5, 194 551 25 380 49 0 0	0 0 0 0	21, 483 36, 378 28, 840 3, 027 157 2, 122 278 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00
3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities	9, 833 16, 596 13, 152 1, 396 62 962 124	3, 197 5, 394 4, 276 454 200 313 40 0 0 0 0 0	0 0 0 0 0 0 0	3, 883 6, 554 5, 194 551 25 380 49 0 0	0 0 0 0	21, 483 36, 378 28, 840 3, 027 157 2, 122 278 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00
3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program	9, 833 16, 596 13, 152 1, 396 62 962 124 0 0 0 0	3, 197 5, 394 4, 276 454 20 313 40 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0	3, 883 6, 554 5, 194 551 25 380 49 0 0 0 0	0 0 0 0 0 0 0 0 0 0	21, 483 36, 378 28, 840 3, 027 1, 172 2, 122 278 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00
3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities	9, 833 16, 596 13, 152 1, 396 62 962 124 0 0 0 0	3, 197 5, 394 4, 276 454 20 313 40 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0	3, 883 6, 554 5, 194 551 25 380 49 0 0 0 0	0 0 0 0 0 0 0 0 0 0	21, 483 36, 378 28, 840 3, 027 157 2, 122 278 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00
3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 17.00 18.00 19.00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify)	9, 833 16, 596 13, 152 1, 396 62 962 124 0 0 0 0	3, 197 5, 394 4, 276 454 20 313 40 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0	3, 883 6, 554 5, 194 551 25 380 49 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0	21, 483 36, 378 28, 840 3, 027 157 2, 122 278 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00
3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 50	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine	9, 833 16, 596 13, 152 1, 396 62 962 124 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	3, 197 5, 394 4, 276 454 20 313 40 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0	3, 883 6, 554 5, 194 551 25 380 49 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0	21, 483 36, 378 28, 840 3, 027 157 2, 122 278 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 50
3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 13.00 14.00 15.00 16.00 17.00 18.00 19.50 20.00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2)	9, 833 16, 596 13, 152 1, 396 62 962 124 0 0 0 0	3, 197 5, 394 4, 276 454 20 313 40 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0	3, 883 6, 554 5, 194 551 25 380 49 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0	21, 483 36, 378 28, 840 3, 027 157 2, 122 278 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 50 20. 00
3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 50	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column	9, 833 16, 596 13, 152 1, 396 62 962 124 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	3, 197 5, 394 4, 276 454 20 313 40 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0	3, 883 6, 554 5, 194 551 25 380 49 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0	21, 483 36, 378 28, 840 3, 027 157 2, 122 278 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 17. 00 18. 00 19. 00 19. 50
3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 13.00 14.00 15.00 16.00 17.00 18.00 19.50 20.00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum	9, 833 16, 596 13, 152 1, 396 62 962 124 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	3, 197 5, 394 4, 276 454 20 313 40 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0	3, 883 6, 554 5, 194 551 25 380 49 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0	21, 483 36, 378 28, 840 3, 027 157 2, 122 278 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 50 20. 00
3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 14.00 15.00 16.00 17.00 18.00 19.50 20.00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus	9, 833 16, 596 13, 152 1, 396 62 962 124 0 0 0 0 0 0 0 0 42, 125	3, 197 5, 394 4, 276 454 20 313 40 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0	3, 883 6, 554 5, 194 551 25 380 49 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0	21, 483 36, 378 28, 840 3, 027 157 2, 122 278 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 50 20. 00
3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 13.00 14.00 15.00 16.00 17.00 18.00 19.50 20.00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum	9, 833 16, 596 13, 152 1, 396 62 962 124 0 0 0 0 0 0 0 0 42, 125	3, 197 5, 394 4, 276 454 20 313 40 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0	3, 883 6, 554 5, 194 551 25 380 49 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0	21, 483 36, 378 28, 840 3, 027 157 2, 122 278 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 50 20. 00

<sup>(1)</sup> Column O, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns O through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

						Home Health Agency I	PPS	
						Agency	INTERNS &	
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	RESI DENTS SERVI CES-SALAR	
		ADMI NI STRATI ON	SERVICES &		RECORDS &		Y & FRINGES	
		13. 00	SUPPLY 14.00	15. 00	16. 00	17. 00	21. 00	
1. 00	Administrative and General	24, 307	24, 385	0	7, 076	0	0	1. 00
2. 00 3. 00	Skilled Nursing Care Physical Therapy	41, 175 32, 642	41, 296 32, 742	0	11, 982 9, 500		0	2. 00 3. 00
4. 00	Occupati onal Therapy	3, 427	3, 438	0	9, 500		0	4. 00
5.00	Speech Pathology	175	180	0			o	5. 00
6. 00 7. 00	Medical Social Services Home Health Aide	2, 402	2, 408 315	0	699 91		0	6. 00 7. 00
8. 00	Supplies (see instructions)	0	0	0	0	_	0	8. 00
9. 00	Drugs	0	o	0	C	0	0	9. 00
10. 00 11. 00	DME Home Dialysis Aide Services	0	O  O	0		0	0	10. 00 11. 00
12. 00	Respiratory Therapy	0	ō	0	, c	_	Ö	12. 00
13. 00 14. 00	Private Duty Nursing Clinic	0	0	0	C	_	0	13. 00 14. 00
15. 00	Health Promotion Activities	O	o	0	Č	0	o o	15. 00
16.00	Day Care Program	0	0	0	C	0	0	16.00
17. 00 18. 00	Home Delivered Meals Program Homemaker Service	0	0	0		0	0	17. 00 18. 00
19. 00	All Others (specify)	0	O	0	C	0	O	19.00
19. 50 20. 00	Telemedicine Total (sum of lines 1-19) (2)	104, 443	0 104, 764	0	30, 397	0	0	19. 50 20. 00
21. 00	Unit Cost Multiplier: column	101,110	101,701	J	00,077			21. 00
	26, line 1 divided by the sum of column 26, line 20 minus							
	column 26, line 1, rounded to	6						
	decimal places.	INTERNS &						
		RESI DENTS						
	Cost Center Description	SERVICES-OTHER PRGM COSTS	PARAMED ED PRGM -	PARAMED ED PRGM- LAB	PARAMED ED PRGM- PHARMACY	PARAMED ED PRGM-	Subtotal	
		APPRV	EMERGENCY	TROW LAD	THARMACT	RADI OLOGY		
		22. 00	MEDICINE 23.00	23. 01	23. 02	23. 03	24.00	
1. 00	Administrative and General	0	0	0	23.02		694, 123	1. 00
2. 00 3. 00	Skilled Nursing Care	0	0	0	C	0	6, 157, 317	2. 00 3. 00
4. 00	Physical Therapy Occupational Therapy	0	0	0		0	5, 239, 031 658, 420	4. 00
5.00	Speech Pathology	0	0	0	C		69, 003	5. 00
6. 00 7. 00	Medical Social Services Home Health Aide	0	0	0	0	0	359, 078 193, 318	6. 00 7. 00
8. 00	Supplies (see instructions)	l o	o	0	Č	0	0	8. 00
9. 00 10. 00	Drugs DME	0	0	0	C	0	0	9. 00 10. 00
11. 00	Home Dialysis Aide Services	0	0	0	C	0	0	11. 00
12.00		0	o	0	C	0	0	12.00
13. 00 14. 00	Private Duty Nursing Clinic	0	0	0	C	0	0	13. 00 14. 00
15.00	Health Promotion Activities	0	ō	0	, c	0	Ö	15.00
16. 00 17. 00	Day Care Program Home Delivered Meals Program	0	0	0	O C	0	0	16. 00 17. 00
18. 00	Homemaker Service	O	o	0	Č	0	o o	18. 00
19. 00	All Others (specify)	0	0	0	C	0	0	19.00
19. 50 20. 00	Telemedicine Total (sum of lines 1-19) (2)	0	0	0		0	13, 370, 290	19. 50 20. 00
21. 00	Unit Cost Multiplier: column							21. 00
	column 26, line 1, rounded to	6						
	aecimal places.	1	I		I	l		
20.00	Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus	6	0	0	C	0	13, 370, 290	20.00

<sup>(1)</sup> Column O, line 20 must agree with Wkst. A, column 7, line 101.(2) Columns O through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

13, 370, 290

13, 370, 290

20.00

21.00

694, 123

0.054758

Total (sum of lines 1-19) (2)

Unit Cost Multiplier: column

decimal places.

26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to

20.00

<sup>(1)</sup> Column O, line 20 must agree with Wkst. A, column 7, line 101. (2) Columns O through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

							5/30/2024 3: 4!	o pm
						Home Health Agency I	PPS	
		CAPITAL REI	ATED COSTS			//geney i		
	Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES ADJ)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	MAI NTENANCE & REPAI RS (SQUARE FEET)	
		1.00	2.00	4. 00	5A. 04	5. 04	6. 00	
1.00	Administrative and General	317	193	1, 645, 810			317	1. 00
2. 00	Skilled Nursing Care	535	328	2, 786, 981	1			2. 00
3. 00	Physical Therapy	424	260	2, 209, 587		1		3. 00
4. 00	Occupational Therapy	45	27	231, 943			45	4. 00
5. 00	Speech Pathology	2	1	12, 082	1			5. 00
6. 00	Medical Social Services	31	19	162, 536				6. 00
7. 00	Home Heal th Aide	4	3	21, 273				7. 00
8. 00	Supplies (see instructions)	i o	0	0			o o	8. 00
9. 00	Drugs	0	0	0			l o	9. 00
10. 00	DME	0	0	0			o	10. 00
11. 00	Home Dialysis Aide Services	0	0	0		0	o	11. 00
12.00	Respiratory Therapy	0	0	0	1		0	12.00
13.00	Private Duty Nursing	0	0	0	) c	0	0	13.00
14.00	Clinic	0	0	0	) c	0	0	14.00
15. 00	Health Promotion Activities	0	0	0	) c	0	0	15.00
16.00	Day Care Program	0	0	0	) c	0	o	16.00
17.00	Home Delivered Meals Program	0	0	0	) c	0	o	17.00
18.00	Homemaker Service	0	0	0	) c	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19. 50	Tel emedi ci ne	0	0	0	) C	0	0	19. 50
20. 00	Total (sum of lines 1-19)	1, 358	831	7, 070, 212	•	10, 088, 911	1, 358	20. 00
21. 00	Total cost to be allocated	24, 679	1, 021	1, 979, 695	1	2, 877, 035		
22. 00	Unit cost multiplier	18. 173049	1. 228640	0. 280005	j	0. 285168	31. 019882	
	1	18. 173049 OPERATION OF	1. 228640 LAUNDRY &	0. 280005 HOUSEKEEPI NG	DI ETARY	0. 285168 CAFETERI A	31. 019882 NURSI NG	
	Unit cost multiplier	18. 173049 OPERATI ON OF PLANT	1. 228640 LAUNDRY & LINEN SERVICE	0. 280005	DI ETARY (PATI ENT ME	0. 285168 CAFETERI A (HOURS WORK	31. 019882 NURSI NG ADMI NI STRATI ON	
	Unit cost multiplier	18. 173049 OPERATION OF	1. 228640 LAUNDRY & LINEN SERVICE (POUNDS OF	0. 280005 HOUSEKEEPI NG	DI ETARY	0. 285168 CAFETERI A	31. 019882 NURSI NG ADMI NI STRATI ON (DI RECT NRS	
	Unit cost multiplier	18. 173049 OPERATI ON OF PLANT	1. 228640 LAUNDRY & LINEN SERVICE	0. 280005 HOUSEKEEPI NG	DI ETARY (PATI ENT ME	0. 285168 CAFETERI A (HOURS WORK	31. 019882 NURSI NG ADMI NI STRATI ON	
	Unit cost multiplier	18. 173049  OPERATI ON OF PLANT (SQUARE FEET)  7. 00  317	1. 228640 LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUND) 8. 00	0. 280005 HOUSEKEEPI NG (SQUARE FEET) 9. 00	DI ETARY (PATI ENT ME ALS)  10.00	O. 285168 CAFETERI A (HOURS WORK ED)	31. 019882 NURSI NG ADMI NI STRATI ON (DI RECT NRS I NG) 13. 00	
1. 00 2. 00	Unit cost multiplier Cost Center Description  Administrative and General Skilled Nursing Care	18. 173049  OPERATI ON OF PLANT (SQUARE FEET)  7. 00  317 535	1. 228640 LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUND) 8. 00	0. 280005 HOUSEKEEPI NG (SQUARE FEET) 9. 00 317 535	DI ETARY (PATI ENT ME ALS)	0. 285168 CAFETERI A (HOURS WORK ED) 11. 00 14, 476 24, 513	31. 019882 NURSI NG ADMI NI STRATI ON (DI RECT NRS I NG) 13. 00 2, 085 3, 532	22. 00 1. 00 2. 00
1. 00 2. 00 3. 00	Administrative and General Skilled Nursing Care Physical Therapy	18. 173049  OPERATI ON OF PLANT (SOUARE FEET)  7. 00  317 535 424	1. 228640 LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUND) 8. 00	0. 280005 HOUSEKEEPI NG (SQUARE FEET) 9. 00 317 535 424	DI ETARY (PATI ENT ME ALS)	0. 285168 CAFETERI A (HOURS WORK ED)  11. 00 14, 476 24, 513 19, 434	31. 019882 NURSI NG ADMI NI STRATI ON (DI RECT NRS I NG) 13. 00 2, 085 3, 532 2, 800	1. 00 2. 00 3. 00
1. 00 2. 00 3. 00 4. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy	18. 173049  OPERATI ON OF PLANT (SOUARE FEET)  7. 00  317 535 424 45	1. 228640  LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUND)  8. 00  0  0 0 0	0. 280005 HOUSEKEEPI NG (SQUARE FEET) 9. 00 317 535	DI ETARY (PATI ENT ME ALS)  10.00	0. 285168 CAFETERI A (HOURS WORK ED)  11. 00 14, 476 24, 513 19, 434 2, 040	31. 019882 NURSI NG ADMI NI STRATI ON (DI RECT NRS I NG) 13. 00 2, 085 3, 532 2, 800 294	1. 00 2. 00 3. 00 4. 00
1. 00 2. 00 3. 00 4. 00 5. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology	18. 173049  OPERATION OF PLANT (SOUARE FEET)  7. 00  317 535 424 45	1. 228640  LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUND)  8. 00  0  0  0  0  0	0. 280005 HOUSEKEEPI NG (SQUARE FEET) 9. 00 317 535 424 45	DI ETARY (PATI ENT ME ALS)  10.00	0. 285168 CAFETERI A (HOURS WORK ED)  11. 00 14, 476 24, 513 19, 434 2, 040 106	31. 019882 NURSI NG ADMI NI STRATI ON (DI RECT NRS I NG) 13. 00 2, 085 3, 532 2, 800 294 15	1. 00 2. 00 3. 00 4. 00 5. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00	Unit cost multiplier  Cost Center Description  Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services	18. 173049  OPERATI ON OF PLANT (SOUARE FEET)  7. 00  317 535 424 45	1. 228640  LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUND)  8. 00  0  0 0 0	0. 280005 HOUSEKEEPI NG (SQUARE FEET) 9. 00 317 535 424	DI ETARY (PATI ENT ME ALS)  10.00	0. 285168 CAFETERI A (HOURS WORK ED)  11. 00 14, 476 24, 513 19, 434 2, 040 106 1, 430	31. 019882 NURSI NG ADMI NI STRATI ON (DI RECT NRS I NG) 13. 00 2, 085 3, 532 2, 800 294 15 206	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide	18. 173049  OPERATION OF PLANT (SOUARE FEET)  7. 00  317 535 424 45	1. 228640  LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUND)  8. 00  0  0  0  0  0	0. 280005 HOUSEKEEPI NG (SQUARE FEET) 9. 00 317 535 424 45	DI ETARY (PATI ENT ME ALS)  10.00	0. 285168 CAFETERI A (HOURS WORK ED)  11. 00 14, 476 24, 513 19, 434 2, 040 106 1, 430 187	31. 019882 NURSI NG ADMI NI STRATI ON (DI RECT NRS I NG) 13. 00 2, 085 3, 532 2, 800 294 15 206 27	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions)	18. 173049  OPERATION OF PLANT (SOUARE FEET)  7. 00  317 535 424 45	1. 228640  LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUND)  8. 00  0  0  0  0  0  0  0  0  0  0 0	0. 280005 HOUSEKEEPI NG (SQUARE FEET) 9. 00 317 535 424 45 2 311 4	DI ETARY (PATI ENT ME ALS)  10.00	0. 285168 CAFETERI A (HOURS WORK ED)  11. 00 14, 476 24, 513 19, 434 2, 040 106 1, 430 187 0	31. 019882 NURSI NG ADMI NI STRATI ON (DI RECT NRS I NG) 13. 00 2, 085 3, 532 2, 800 294 15 206 27 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs	18. 173049  OPERATION OF PLANT (SOUARE FEET)  7. 00  317 535 424 45	1. 228640  LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUND)  8. 00  0  0  0  0  0	0. 280005 HOUSEKEEPI NG (SQUARE FEET) 9. 00 317 535 424 45 2 31 40 0	DI ETARY (PATI ENT ME ALS)  10.00	0. 285168 CAFETERI A (HOURS WORK ED)  11. 00 14, 476 24, 513 19, 434 2, 040 106 1, 430 187 0	31. 019882 NURSI NG ADMI NI STRATI ON (DI RECT NRS I NG) 13. 00 2, 085 3, 532 2, 800 294 15 206 27 0	1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME	18. 173049  OPERATION OF PLANT (SOUARE FEET)  7. 00  317 535 424 45	1. 228640  LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUND)  8. 00  0  0  0  0  0  0  0  0  0  0 0	0. 280005 HOUSEKEEPI NG (SQUARE FEET) 9. 00 317 535 424 45 2 311 4	DI ETARY (PATI ENT ME ALS)  10.00	0. 285168 CAFETERI A (HOURS WORK ED)  11. 00  14, 476 24, 513 19, 434 2, 040 106 1, 430 187 0 0 0	31. 019882  NURSI NG  ADMI NI STRATI ON  (DI RECT NRS  I NG)  13. 00  2, 085  3, 532  2, 800  294  15  206  27  0  0  0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services	18. 173049  OPERATION OF PLANT (SOUARE FEET)  7. 00  317 535 424 45	1. 228640  LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUND)  8. 00  0  0  0  0  0  0  0  0  0  0 0	0. 280005 HOUSEKEEPI NG (SQUARE FEET) 9. 00 317 535 424 45 2 31 40 0	DI ETARY (PATI ENT ME ALS)  10.00	0. 285168 CAFETERI A (HOURS WORK ED)  11. 00 14, 476 24, 513 19, 434 2, 040 106 1, 430 187 0 0 0 0 0	31. 019882 NURSI NG ADMI NI STRATI ON (DI RECT NRS I NG) 13. 00 2, 085 3, 532 2, 800 294 15 206 27 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00	Unit cost multiplier  Cost Center Description  Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy	18. 173049  OPERATION OF PLANT (SOUARE FEET)  7. 00  317 535 424 45	1. 228640  LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUND)  8. 00  0  0  0  0  0  0  0  0  0  0  0  0	0. 280005 HOUSEKEEPI NG (SQUARE FEET) 9. 00 317 535 424 45 2 31 40 0	DI ETARY (PATI ENT ME ALS)  10.00	0. 285168 CAFETERI A (HOURS WORK ED)  11. 00 14, 476 24, 513 19, 434 2, 040 106 1, 430 187 0 0 0 0 0	31. 019882 NURSI NG ADMI NI STRATI ON (DI RECT NRS I NG) 13. 00  2, 085 3, 532 2, 800 294 15 206 27 0 0 0 0	1. 00 2. 00 3. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing	18. 173049  OPERATI ON OF PLANT (SQUARE FEET)  7. 00  317 535 424 45 2 31 4 0 0 0 0 0	1. 228640  LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUND)  8. 00  0  0  0  0  0  0  0  0  0  0 0	0. 280005 HOUSEKEEPI NG (SQUARE FEET) 9. 00 317 535 424 45 2 31 40 0	DI ETARY (PATI ENT ME ALS)  10.00	0. 285168 CAFETERI A (HOURS WORK ED)  11. 00 14, 476 24, 513 19, 434 2, 040 106 1, 430 187 0 0 0 0 0 0	31. 019882  NURSI NG  ADMI NI STRATI ON  (DI RECT NRS  I NG)  13. 00  2, 085  3, 532  2, 800  294  15  206  27  0  0  0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing	18. 173049  OPERATI ON OF PLANT (SQUARE FEET)  7. 00  317 535 424 45 2 31 4 0 0 0 0 0	1. 228640  LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUND)  8. 00  0  0  0  0  0  0  0  0  0  0  0  0	0. 280005 HOUSEKEEPI NG (SQUARE FEET) 9. 00 317 535 424 45 2 31 40 0	DI ETARY (PATI ENT ME ALS)  10.00	0. 285168 CAFETERI A (HOURS WORK ED)  11. 00 14, 476 24, 513 19, 434 2, 040 106 1, 430 187 0 0 0 0 0 0 0 0	31. 019882 NURSI NG ADMI NI STRATI ON (DI RECT NRS I NG) 13. 00 2, 085 3, 532 2, 800 294 15 206 27 0 0 0 0 0	1. 00 2. 00 3. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic	18. 173049  OPERATI ON OF PLANT (SQUARE FEET)  7. 00  317 535 424 45 2 31 4 0 0 0 0 0	1. 228640  LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUND)  8. 00  0  0  0  0  0  0  0  0  0  0  0  0	0. 280005 HOUSEKEEPI NG (SQUARE FEET) 9. 00 317 535 424 45 2 31 40 0	DI ETARY (PATI ENT ME ALS)  10.00	0. 285168 CAFETERI A (HOURS WORK ED)  11. 00  14, 476 24, 513 19, 434 2, 040 106 1, 430 0 0 0 0 0 0 0 0 0 0 0 0 0	31. 019882 NURSI NG ADMI NI STRATI ON (DI RECT NRS I NG) 13. 00 2, 085 3, 532 2, 800 294 155 206 27 0 0 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities	18. 173049  OPERATI ON OF PLANT (SQUARE FEET)  7. 00  317 535 424 45 2 31 4 0 0 0 0 0	1. 228640  LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUND)  8. 00  0  0  0  0  0  0  0  0  0  0  0  0	0. 280005 HOUSEKEEPI NG (SQUARE FEET) 9. 00 317 535 424 45 2 31 40 0	DI ETARY (PATI ENT ME ALS)  10.00	0. 285168 CAFETERI A (HOURS WORK ED)  11. 00  14, 476 24, 513 19, 434 2, 040 106 1, 430 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	31. 019882 NURSI NG ADMI NI STRATI ON (DI RECT NRS I NG) 13. 00 2, 085 3, 532 2, 800 294 15 206 27 0 0 0 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 14. 00 15. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service	18. 173049  OPERATI ON OF PLANT (SQUARE FEET)  7. 00  317 535 424 45 2 31 4 0 0 0 0 0	1. 228640  LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUND)  8. 00  0  0  0  0  0  0  0  0  0  0  0  0	0. 280005 HOUSEKEEPI NG (SQUARE FEET) 9. 00 317 535 424 45 2 31 40 0	DI ETARY (PATI ENT ME ALS)  10.00	0. 285168 CAFETERI A (HOURS WORK ED)  11. 00 14, 476 24, 513 19, 434 2, 040 106 1, 430 187 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	31. 019882 NURSI NG ADMI NI STRATI ON (DI RECT NRS I NG) 13. 00 2, 085 3, 532 2, 800 294 15 206 27 0 0 0 0 0 0 0 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 17. 00 18. 00 19. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify)	18. 173049  OPERATI ON OF PLANT (SQUARE FEET)  7. 00  317 535 424 45 2 31 4 0 0 0 0 0	1. 228640  LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUND)  8. 00  0  0  0  0  0  0  0  0  0  0  0  0	0. 280005 HOUSEKEEPI NG (SQUARE FEET) 9. 00 317 535 424 45 2 31 40 0	DI ETARY (PATI ENT ME ALS)  10.00	0. 285168 CAFETERI A (HOURS WORK ED)  11. 00  14, 476 24, 513 19, 434 2, 040 106 1, 430 187 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	31. 019882  NURSI NG  ADMI NI STRATI ON  (DI RECT NRS  I NG)  13. 00  2, 085  3, 532  2, 800  294  15  206  27  0  0  0  0  0  0  0  0  0  0  0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine	18. 173049  OPERATI ON OF PLANT (SQUARE FEET)  7. 00  317 535 424 45 2 311 4 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1. 228640  LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUND)  8. 00  0  0  0  0  0  0  0  0  0  0  0  0	0. 280005 HOUSEKEEPI NG (SQUARE FEET)  9. 00  317 535 424 45 22 311 40 00 00 00 00 00 00 00 00 00 00 00 00	DI ETARY (PATI ENT ME ALS)  10.00	0. 285168 CAFETERI A (HOURS WORK ED)  11. 00  14, 476 24, 513 19, 434 2, 040 106 1, 430 187 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	31. 019882  NURSI NG  ADMI NI STRATI ON  (DI RECT NRS  I NG)  13. 00  2, 085  3, 532  2, 800  294  155  206  27  0  0  0  0  0  0  0  0  0  0  0  0  0	1. 00 2. 00 3. 00 4. 00 5. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 50 20. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19)	18. 173049  OPERATI ON OF PLANT (SQUARE FEET)  7. 00  317 535 424 45 2 311 4 0 0 0 0 0 0 0 0 0 1, 358	1. 228640  LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUND)  8. 00  0  0  0  0  0  0  0  0  0  0  0  0	0. 280005 HOUSEKEEPI NG (SQUARE FEET)  9. 00  317 535 424 45 2 31 4 0 0 0 0 0 0 0 0 1, 358	DI ETARY (PATI ENT ME ALS)  10.00	0. 285168 CAFETERI A (HOURS WORK ED)  11. 00  14, 476 24, 513 19, 434 2, 040 106 1, 430 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	31. 019882  NURSI NG  ADMI NI STRATI ON  (DI RECT NRS  I NG)  13. 00  2, 085  3, 532  2, 800  294  15  206  27  0  0  0  0  0  0  0  0  0  0  0  0  0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 12. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 50 20. 00 21. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine	18. 173049  OPERATI ON OF PLANT (SQUARE FEET)  7. 00  317 535 424 45 2 311 4 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1. 228640  LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUND)  8. 00  0  0  0  0  0  0  0  0  0  0  0  0	0. 280005 HOUSEKEEPI NG (SQUARE FEET)  9. 00  317 535 424 45 22 311 40 00 00 00 00 00 00 00 00 00 00 00 00	DI ETARY (PATI ENT ME ALS)  10.00	0. 285168 CAFETERI A (HOURS WORK ED)  11. 00  14, 476 24, 513 19, 434 2, 040 106 1, 430 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	31. 019882  NURSI NG  ADMI NI STRATI ON  (DI RECT NRS  I NG)  2, 085  3, 532  2, 800  294  15  206  0  0  0  0  0  0  0  0  0  0  0  0	1. 00 2. 00 3. 00 4. 00 5. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00

| Period: | Worksheet H-2 | Part II | Date/Time Prepared: 5/30/2024 3:45 pm | PPS | BASIS HHA CCN: 15-7145

Cost Center Description							Home Health	PPS	
Cost Center Description   CENTRAL SERVICES & (COSTED RE)   COSTED RE (COSTED RE)   COSTED RE (COSTED RE)   COSTED RE)   COSTED RECORDS   COSTED RE)   COSTED RECORDS   COSTED							Agency I		
Cost Center Description   CENTRAL   PHASHACY   COSTED RED   UIS1)   COSTED RED									
SERVICES & SERVICES & SERVICES   COSTED RED   RECORDS & CORSOS CHAR   COSTS   CARS CHAR   COSTS   CARS CHAR   COSTS   CARS CHAR   CASSIONED   TIME)   TIME)   TIME   TIM		Cost Contor Dosorintion	CENTRAL	DHADMACV	MEDICAL	COCIAI SEDVICE		CEDVI CEC OTHED	
SUPPLY   COSTED   REQUIS   COSTED   TIME   COS		cost center bescription							
COSTED   COSTED   COSTED   COSTED   COSTED   TIME									
1.00				0131)		023)	,		
1.00   Administrative and General   8,830   15,00   16,00   17,00   2,406,730   0   0,00   1,00   2,00   1,00   2,406,730   0   0,100   0,00									
1.00   Admin istrative and General   8,830   0   2,406,730   2,406,730   0   0   1,00				15. 00		17. 00	21. 00		
3.00   Physical Therapy   11,856   0   3,231,162   3,231,162   0   0   3.00   5.00   Speech Pathology   6.5   0   17,668   0   0   5.00   5.00   Speech Pathology   6.5   0   17,668   0   0   5.00   6.00   Medical Social Services   872   0   237,668   2   237,662   0   0   6   0   7.00   Home Heal th Aide   114   0   31,108   31,108   0   0   0   0   0   7.00   Home Heal th Aide   114   0   31,108   31,108   0   0   0   0   7.00   Home Heal th Aide   114   0   31,108   31,108   0   0   0   0   7.00   Home Dial ysis Aide Services   0   0   0   0   0   0   0   7.00   Respiratory Therapy   0   0   0   0   0   0   0   7.00   Respiratory Therapy   0   0   0   0   0   0   0   7.00   Respiratory Therapy   0   0   0   0   0   0   7.00   Respiratory Therapy   0   0   0   0   0   0   7.00   Rospiratory Therapy   0   0   0   0   0   0   7.00   Rospiratory Therapy   0   0   0   0   0   0   7.00   Rospiratory Therapy   0   0   0   0   0   0   7.00   Rospiratory Therapy   0   0   0   0   0   0   7.00   Rospiratory Therapy   0   0   0   0   0   0   7.00   Rospiratory Therapy   0   0   0   0   0   0   7.00   Rospiratory Therapy   0   0   0   0   0   0   7.00   Rospiratory Therapy   0   0   0   0   0   0   7.00   Rospiratory Therapy   0   0   0   0   0   0   7.00   Rospiratory Therapy   0   0   0   0   0   0   7.00   Rospiratory Therapy   0   0   0   0   0   0   7.00   Rospiratory Therapy   0   0   0   0   0   0   7.00   Rospiratory Therapy   0   0   0   0   0   0   7.00   Rospiratory Therapy   0   0   0   0   0   0   7.00   Rospiratory Therapy   0   0   0   0   0   0   7.00   Rospiratory Therapy   0   0   0   0   0   0   7.00   Rospiratory Therapy   0   0   0   0   0   0   7.00   Rospiratory Therapy   0   0   0   0   0   0   7.00   Rospiratory Therapy   0   0   0   0   0   7.00   Rospira	1.00	Administrative and General	8, 830	0	2, 406, 730	2, 406, 730	0	0	1. 00
4.00	2.00	Skilled Nursing Care	14, 954	0	4, 075, 507	4, 075, 507	0	0	2. 00
5.00   Speech Pathology	3.00	Physical Therapy	11, 856	0	3, 231, 162	3, 231, 162	0	0	3. 00
6.00   Medical Social Services   872   0   237,682   237,682   0   0   6.00			1	0					
1.00		1		-					
8.00   Supplies (see instructions)   0   0   0   0   0   0   0   0   0				-					
9.00   Drugs   0   0   0   0   0   0   0   0   0			1	-	31, 108	31, 108	0		
10.00   DNE		1	· -	-	0	0	0		
11.00   Home Dialysis Aide Services   0   0   0   0   0   0   11.00		- C	0		0		0		
12.00   Respiratory Therapy   0   0   0   0   0   0   0   12.00     13.00   Private Duty Nursing   0   0   0   0   0   0   0   0     14.00   Clinic   0   0   0   0   0   0   0   0   0     15.00   Healt th Promotion Activities   0   0   0   0   0   0   0   0     16.00   Day Care Program   0   0   0   0   0   0   0   0     16.00   Day Care Program   0   0   0   0   0   0   0   0     18.00   Homemaker Service   0   0   0   0   0   0   0   0     19.00   All Others (specify)   0   0   0   0   0   0   0   0     19.50   Tel emedic line   0   0   0   0   0   0   0   0   0     19.50   Tel emedic line   0   0   0   0   0   0   0   0     19.00   All Others (specify)   0   0   0   0   0   0   0     19.00   Total csum of lines 1-19)   37,936   0   0   0   0   0   0   0     19.00   Total csum of lines 1-19)   37,936   0   0   0   0   0   0   0     10.00   Total csum of lines 1-19)   37,936   0   0   0   0   0   0   0     10.00   Total csum of lines 1-19)   37,936   0   0   0   0   0   0   0     10.00   Total csum of lines 1-19)   37,936   0   0   0   0   0   0   0     10.00   Total csum of lines 1-19)   37,936   0   0   0   0   0   0     10.00   Total csum of lines 1-19)   37,936   0   0   0   0   0   0     10.00   Administrative and General   23.00   23.01   23.02   23.03     10.00   Skilled Nursing Care   0   0   0   0   0   0     10.00   Skilled Nursing Care   0   0   0   0   0   0     10.00   Speech Pathology   0   0   0   0   0   0     10.00   Home Health Aide   0   0   0   0   0   0     10.00   Duts   0   0   0   0   0   0   0     10.00   Duts   0   0   0   0   0   0   0     10.00   Total csum of the program   0   0   0   0   0   0     10.00   Home Deli verd Meals Program   0   0   0   0   0   0     10.00   Home Deli verd Meals Program   0   0   0   0   0   0     10.00   Home Deli verd Meals Program   0   0   0   0   0   0     10.00   Total (sum of lines 1-19)   0   0   0   0   0   0     10.00   Total (sum of lines 1-19)   0   0   0   0   0   0     10.00   Total (sum of lines 1-19)   0   0   0   0   0     10.00   Tot			0	-	0		0	_	
13.00   Private Dufy Nursing			0	-	_	1	_		
14. 00   Clinic   15. 00   16. 100   16. 100   16. 100   16. 100   16. 100   16. 100   16. 100   16. 100   16. 100   16. 100   16. 100   17. 100   17. 100   18. 100			0	-	_	_	_		
15. 00   Heal th Promotion Activities   0   0   0   0   0   0   0   0   15. 00		3	0		-		0		
16. 00   Day Care Program		1	0	-	0		0	_	
17. 00		1	0	0	0		0	_	
18.00		1 3	Ö	0	0	Ö	0		
19.00	18. 00	S S	O	0	0	o	0	0	18. 00
20.00   Total (sum of lines 1-19)   37,936   10,339,036   0   0   20.00	19. 00		0	0	0	0	0	О	
21.00   Total cost to be all located   104.764   2.761598   0.000000   0.00940   0.0000000   0.00000000	19. 50	Tel emedi ci ne	0	0	0	0	0	0	19. 50
22.00   Unit cost multiplier   2.761598   0.0000000   0.0000000   0.0000000   0.00000000	20.00	,	37, 936	0	10, 339, 036	10, 339, 036	0	0	
Cost Center Description		1		0			0	0	
PRCM	22. 00						0.000000	0. 000000	22. 00
EMERGENCY   MEDICINE   CASSIGNED   TIME)   TIME)   TIME)   CASSIGNED   TIME)   TIME)   TIME)   CASSIGNED   TIME)   T		cost center bescription							
MEDICINE (ASSIGNED TIME)									
TIME    23.00   23.01   23.02   23.03				•					
1.00			(ASSI GNED	ŕ	,	TIME)			
1.00									
2.00	1.00								1.00
3.00 Physical Therapy		•			-	1			
4.00       Occupational Therapy       0       0       0       0       4.00         5.00       Speech Pathology       0       0       0       0       0       5.00         6.00       Medical Social Services       0       0       0       0       0       6.00         7.00       Home Heal th Aide       0       0       0       0       0       0       7.00         8.00       Supplies (see instructions)       0       0       0       0       0       0       7.00         9.00       Drugs       0       0       0       0       0       0       9.00       0       9.00       0       9.00       0       9.00       0       9.00       0       9.00       0       9.00       0       9.00       0       9.00       0       9.00       0       9.00       0       9.00       0       9.00       0       9.00       0       9.00       0       9.00       11.00       0       9.00       11.00       0       11.00       0       11.00       0       11.00       0       11.00       0       11.00       0       12.00       13.00       0       13.00       14.00		_	0	-	-				
5.00         Speech Pathology         0         0         0         0         0         6.00         7.00         8.00         9.		1 3	0	_	_	_			
6.00 Medical Social Services 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1		-	_	_			
7.00 Home Health Aide			0	-	0	Ö			
9.00 Drugs 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		•	O	0	0	o			
10. 00       DME       0       0       0       0       10. 00         11. 00       Home Dialysis Aide Services       0       0       0       0       0       11. 00         12. 00       Respiratory Therapy       0       0       0       0       0       12. 00         13. 00       Private Duty Nursing       0       0       0       0       0       13. 00         14. 00       Clinic       0       0       0       0       0       13. 00         15. 00       Heal th Promotion Activities       0       0       0       0       0       15. 00         16. 00       Day Care Program       0       0       0       0       0       16. 00         17. 00       Home Delivered Meals Program       0       0       0       0       0       17. 00         18. 00       Homemaker Service       0       0       0       0       0       18. 00         19. 00       All Others (specify)       0       0       0       0       19. 00         19. 50       Tel emedicine       0       0       0       0       0       19. 00         20. 00       Total cost to be allocated	8.00	Supplies (see instructions)	o	0	0	0			8. 00
11. 00       Home Dialysis Aide Services       0       0       0       0       11. 00         12. 00       Respiratory Therapy       0       0       0       0       0       12. 00         13. 00       Private Duty Nursing       0       0       0       0       0       13. 00         14. 00       Clinic       0       0       0       0       0       14. 00         15. 00       Heal th Promotion Activities       0       0       0       0       0       15. 00         16. 00       Day Care Program       0       0       0       0       0       16. 00         17. 00       Home Delivered Meals Program       0       0       0       0       17. 00         18. 00       Homemaker Service       0       0       0       0       17. 00         19. 00       All Others (specify)       0       0       0       0       19. 50         19. 50       Tel emedicine       0       0       0       0       0       19. 50         20. 00       Total (sum of lines 1-19)       0       0       0       0       0       0       20. 00         21. 00       Total cost to be allo	9.00	Drugs	0	0	0	0			9. 00
12.00       Respiratory Therapy       0       0       0       0       0       12.00         13.00       Private Duty Nursing       0       0       0       0       0       13.00         14.00       Clinic       0       0       0       0       0       14.00         15.00       Health Promotion Activities       0       0       0       0       0       15.00         16.00       Day Care Program       0       0       0       0       0       16.00         17.00       Home Delivered Meals Program       0       0       0       0       17.00         18.00       Homemaker Service       0       0       0       0       17.00         19.00       All Others (specify)       0       0       0       0       19.00         19.50       Tel emedicine       0       0       0       0       0       19.50         20.00       Total (sum of lines 1-19)       0       0       0       0       0       20.00         21.00       Total cost to be allocated       0       0       0       0       0       0       0	10.00	DME	0	0	0	0			10. 00
13.00     Private Duty Nursing     0     0     0     0     0     13.00       14.00     Clinic     0     0     0     0     0     14.00       15.00     Health Promotion Activities     0     0     0     0     0       16.00     Day Care Program     0     0     0     0     0       17.00     Home Delivered Meals Program     0     0     0     0     17.00       18.00     Homemaker Service     0     0     0     0     18.00       19.00     All Others (specify)     0     0     0     0     19.50       19.50     Telemedicine     0     0     0     0     19.50       20.00     Total (sum of lines 1-19)     0     0     0     0     20.00       21.00     Total cost to be allocated     0     0     0     0     21.00			0	0	0	0			
14.00       Clinic       0       0       0       0       14.00         15.00       Health Promotion Activities       0       0       0       0       0       15.00         16.00       Day Care Program       0       0       0       0       0       16.00         17.00       Home Delivered Meals Program       0       0       0       0       17.00         18.00       Homemaker Service       0       0       0       0       18.00         19.00       All Others (specify)       0       0       0       0       19.50         19.50       Telemedicine       0       0       0       0       0       19.50         20.00       Total (sum of lines 1-19)       0       0       0       0       20.00         21.00       Total cost to be allocated       0       0       0       0       21.00			0	0	0	0			
15.00     Health Promotion Activities     0     0     0     0     15.00       16.00     Day Care Program     0     0     0     0     0     16.00       17.00     Home Delivered Meals Program     0     0     0     0     0     17.00       18.00     Homemaker Service     0     0     0     0     18.00       19.00     All Others (specify)     0     0     0     19.50       19.50     Telemedicine     0     0     0     0     19.50       20.00     Total (sum of lines 1-19)     0     0     0     0     20.00       21.00     Total cost to be allocated     0     0     0     0     21.00			0	0	0	0			
16. 00     Day Care Program     0     0     0     0     0     16. 00       17. 00     Home Delivered Meals Program     0     0     0     0     0     17. 00       18. 00     Homemaker Service     0     0     0     0     0     18. 00       19. 00     All Others (specify)     0     0     0     0     19. 00       19. 50     Telemedicine     0     0     0     0     19. 50       20. 00     Total (sum of lines 1-19)     0     0     0     0     20. 00       21. 00     Total cost to be allocated     0     0     0     0     21. 00			0	-	0	0			
17. 00     Home Delivered Meals Program     0     0     0     0     0     17. 00       18. 00     Homemaker Service     0     0     0     0     0     18. 00       19. 00     All Others (specify)     0     0     0     0     0     19. 00       19. 50     Tel emedicine     0     0     0     0     19. 50       20. 00     Total (sum of lines 1-19)     0     0     0     0     20. 00       21. 00     Total cost to be allocated     0     0     0     0     21. 00		1		-	0				
18. 00     Homemaker Service     0     0     0     0     18. 00       19. 00     All Others (specify)     0     0     0     0     19. 00       19. 50     Tel emedicine     0     0     0     0     19. 50       20. 00     Total (sum of lines 1-19)     0     0     0     0     0     20. 00       21. 00     Total cost to be allocated     0     0     0     0     21. 00				-					
19. 00     All Others (specify)     0     0     0     0       19. 50     Tel emedicine     0     0     0     0       20. 00     Total (sum of lines 1-19)     0     0     0     0       21. 00     Total cost to be allocated     0     0     0     0				-	0				
19. 50     Tel emedicine     0     0     0     0     0     19. 50       20. 00     Total (sum of lines 1-19)     0     0     0     0     0     20. 00       21. 00     Total cost to be allocated     0     0     0     0     0     21. 00				-	0	0			
20.00       Total (sum of lines 1-19)       0       0       0       0       0       20.00         21.00       Total cost to be allocated       0       0       0       0       0       21.00			ا م	_	0	l o			
21.00 Total cost to be allocated 0 0 0 0 21.00			o	-	Ö	Ö			
22.00   Unit cost multiplier   0.000000   0.000000   0.000000   22.00		Total cost to be allocated	O	0	0	0			
	22. 00	Unit cost multiplier	0. 000000	0. 000000	0. 000000	0.000000			22. 00

	Financial Systems		FRANCISCAN HE				u of Form CMS-2	
APPORT	TIONMENT OF PATIENT SERVICE COST	ΓS		Provi der C	CN: 15-0090	Period: From 01/01/2023	Worksheet H-3 Part I	
				HHA CCN:	15-7145	To 12/31/2023	Date/Time Prep 5/30/2024 3:4	pared:
				Ti tle	e XVIII	Home Health Agency I	PPS	<u>о р</u>
	Cost Center Description		Facility Costs		Total HHA	Total Visits	Average Cost	
		H-2, Part I,	(from Wkst.	Ancillary	Costs (cols.	1	Per Visit	
		col. 28, line	H-2, Part I)	Costs (from Part II)	+ 2)		(col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4. 00	5. 00	
	PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION	OF AGGREGATE F	PROGRAM COST, A	GGREGATE OF TH	HE PROGRAM LIN	MITATION COST, OF	2	
	Cost Per Visit Computation							
1. 00	Skilled Nursing Care	2. 00			6, 494, 4		260. 08	1. 00
2.00	Physical Therapy	3.00		(			218. 45	
3.00	Occupational Therapy	4. 00		(			170. 76	
4. 00 5. 00	Speech Pathology Medical Social Services	5. 00 6. 00	1	(	72, 78 378, 79		147. 33 8, 607. 73	4. 00 5. 00
6. 00	Home Health Aide	7. 00			203, 9		127. 04	6.00
7. 00	Total (sum of lines 1-6)	7.00	13, 370, 290	(	13, 370, 2		127.01	7.00
	, , , , , , , , , , , , , , , , , , , ,		.0,0.0,=.0		Program Visi			
						art B		
	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Not Subject Deductibles Coinsurance	& Deductibles		
		0	1.00	2.00	3.00	4. 00	5. 00	
	Limitation Cost Computation							
8. 00 8. 01	Skilled Nursing Care		16984	(	•	45		8. 00 8. 01
8. 01 8. 02	Skilled Nursing Care Skilled Nursing Care	l .	23844 33140	(				8.02
8. 03	Skilled Nursing Care	l .	43780	(		3		8. 0
8. 04	Skilled Nursing Care	l .	99915	(	1	Ö		8. 04
9. 00	Physical Therapy		16984	(		21		9.00
9. 01	Physical Therapy		23844	(	7, 0	52		9.0
9. 02	Physical Therapy	1	33140	(				9. 02
9. 03	Physical Therapy		43780	(	1	7		9. 0
9. 04 10. 00	Physical Therapy Occupational Therapy		99915 16984	(	1	17 0		9. 04 10. 00
10. 00	Occupational Therapy		23844	(		-		10.0
10. 02	Occupational Therapy	1	33140	(	1	07		10. 0
10. 03	Occupational Therapy	1	43780	(		5		10. 0
10. 04	Occupational Therapy	1	99915	(		0		10.0
11. 00	Speech Pathology		16984	(		0		11.0
11. 01	Speech Pathology		23844	(	1	66		11. 0
11. 02	Speech Pathology		33140	(		12		11. 0
11. 03	Speech Pathology	1	43780	(		0		11.00
11. 04 12. 00	Speech Pathology Medical Social Services		99915 16984	(	•	0	-	11. 0. 12. 0
12. 00	1		23844	(		15		12.00
12. 01	Medical Social Services		33140			0		12. 0
12. 03	Medical Social Services		43780	(	1	0		12. 0
12. 04	Medical Social Services	l .	99915	(	1	0		12. 0
13. 00	Home Health Aide		16984	(		0		13. 0
13. 01	Home Health Aide		23844	(		76		13. 0
13. 02	Home Health Aide		33140	(		75		13. 02
13. 03	Home Health Aide		43780	(	1	0		13. 0
13. 04 14. 00	Home Health Aide Total (sum of lines 8-13)		99915	(	1	0		13. 04 14. 00
17.00	Cost Center Description	From Wkst. H-2	Facility Costs	Shared	Total HHA	Total Charges	Ratio (col. 3	14.0
	,	Part I, col.	(from Wkst.	Ancillary	Costs (cols.		÷ col . 4)	
		28, line	H-2, Part I)	Costs (from	+ 2)	Records)		
			1.00	Part II)	2 00	4.00	E 00	
	Supplies and Drugs Cost Comput	0 ations	1.00	2. 00	3.00	4. 00	5. 00	
	Cost of Medical Supplies Cost of Drugs	8. 00 9. 00		(		0 0		

<b>PPORT</b>	<u>Financial Systems</u> TONMENT OF PATIENT SERVICE COSTS	)	FRANCISCAN HE	Provi der CC	N: 15-0090	Peri od:	eu of Form CMS-2 Worksheet H-3	
				HHA CCN:	15-7145	From 01/01/2023 To 12/31/2023	Part I Date/Time Pre 5/30/2024 3:4	pared
				Title	XVIII	Home Health	PPS	э рііі
			Program Visits		Cost of	Agency I		
					Servi ces			
	Cost Center Description	Part A	Not Subject to		Part A	Part B Not Subject to	Subject to	
	cost center bescription	rait A	Deductibles &		rait A	Deductibles &		
			Coi nsurance	Coi nsurance		Coi nsurance	Coi nsurance	
		6. 00	7. 00	8. 00	9. 00	10.00	11.00	
	PART I - COMPUTATION OF LESSER	OF AGGREGATE I	PROGRAM COST, A	GGREGATE OF TH	E PROGRAM LI	MITATION COST, O	R	
	BENEFICIARY COST LIMITATION  Cost Per Visit Computation							1
. 00	Skilled Nursing Care	C	10, 162			0 2, 642, 933		1.
00	Physical Therapy	0	10, 593			0 2, 314, 041		2.
00	Occupational Therapy	0	1, 810			0 309, 076		3.
00	Speech Pathology	0	178			0 26, 225		4.
00	Medical Social Services Home Health Aide	0	15			0 129, 116		5.
00	Total (sum of lines 1-6)	0	1, 051 23, 809			0 133, 519 0 5, 554, 910		6. 7.
- 00	Cost Center Description		23,007			3, 334, 710		<u> </u>
		6.00	7. 00	8. 00	9. 00	10.00	11.00	
	Limitation Cost Computation							
00	Skilled Nursing Care							8.
01	Skilled Nursing Care							8.
02 03	Skilled Nursing Care Skilled Nursing Care							8. 8.
04	Skilled Nursing Care							8.
00	Physical Therapy							9.
01	Physical Therapy							9.
. 02	Physi cal Therapy							9.
03	Physical Therapy							9.
04	Physical Therapy							9.
0. 00 0. 01	Occupational Therapy Occupational Therapy							10. 10.
0. 02	Occupational Therapy							10.
0. 03	Occupational Therapy							10.
0. 04	Occupational Therapy							10.
1. 00	Speech Pathology							11.
1. 01	Speech Pathology							11.
1. 02	1 ' 99							11.
1. 03 1. 04	Speech Pathology Speech Pathology							11.
2. 00	Medical Social Services							12.
2. 01	Medical Social Services							12.
2. 02	Medical Social Services							12.
2. 03	Medical Social Services							12.
2. 04	Medical Social Services							12.
3.00	Home Health Aide							13.
3. 01 3. 02	Home Health Aide Home Health Aide							13. 13.
3. 02	Home Health Aide							13.
3. 04	Home Health Aide							13.
4. 00	1							14.
		Prog	ram Covered Cha	rges	Cost of			
					Servi ces			
			Par	t B		Part B		
	Cost Center Description	Part A	Not Subject to		Part A	Not Subject to	Subject to	
	2222 223. 2000 pt 1011		Deductibles &			Deductibles &		
			Coi nsurance	Coi nsurance		Coi nsurance	Coi nsurance	
	Cumpling and Druss Cost Co	6.00	7. 00	8. 00	9. 00	10.00	11.00	
00	Supplies and Drugs Cost Computa Cost of Medical Supplies	tions C	147, 755	O		0 0	0	15.
. 00	Cost of Drugs	U	147,733	0				

(PPORT	TIONMENT OF PATIENT SERVICE COST	-S		Provider CCN: 15-009 HHA CCN: 15-71	From 01/01/2023	
				Title XVIII	Home Health	5/30/2024 3: 45 pn PPS
				THE AVIII	Agency I	113
	Cost Center Description	Total Program				
		Cost (sum of				
		col s. 9-10) 12.00				
	PART I - COMPUTATION OF LESSER		ROGRAM COST. AGG	REGATE OF THE PROGRAM	LIMITATION COST. OF	3
	BENEFICIARY COST LIMITATION					
	Cost Per Visit Computation					
. 00	Skilled Nursing Care	2, 642, 933				1
. 00	Physi cal Therapy	2, 314, 041				2
. 00	Occupational Therapy	309, 076				3
. 00	Speech Pathology	26, 225				4
. 00 . 00	Medical Social Services Home Health Aide	129, 116 133, 519				5 6
. 00	Total (sum of lines 1-6)	5, 554, 910				7
00	Cost Center Description	3, 334, 710				
	oost center bescription	12. 00				
	Limitation Cost Computation					
00	Skilled Nursing Care					8
01	Skilled Nursing Care					8
02	Skilled Nursing Care					8
03	Skilled Nursing Care					8
04	Skilled Nursing Care					8
00	Physical Therapy					9
01 02	Physical Therapy Physical Therapy					9
03	Physical Therapy					9
04	Physical Therapy					9
0.00	Occupational Therapy					10
0. 01	Occupational Therapy					10
0. 02	Occupational Therapy					10
0. 03	Occupational Therapy					10
. 04	Occupational Therapy					10
. 00	Speech Pathology					11
. 01	Speech Pathology					11
1. 02	Speech Pathology					11
. 03	Speech Pathology					11
1. 04 2. 00	Speech Pathology Medical Social Services					12
2. 00	Medical Social Services					12
2. 02	Medical Social Services					12
2. 03	Medical Social Services					12
2. 04	Medical Social Services					12
3. 00	Home Health Aide					13
3. 01	Home Health Aide					13
3. 02	Home Health Aide					13
3. 03	Home Health Aide					13
3. 04	Home Heal th Aide					13
1 ()()	Total (sum of lines 8-13)	1				14

Heal th	Financial Systems		FRANCISCAN HE	EALTH- DYER		In Lie	u of Form CMS-2	2552-10
APPORT	IONMENT OF PATIENT SERVICE COST	S		Provi der C	CN: 15-0090	Peri od:	Worksheet H-3	
				HHA CCN:	15-7145	From 01/01/2023 To 12/31/2023	Part II Date/Time Prep 5/30/2024 3:4	pared: 5 pm
						Home Health	PPS	
						Agency I		
	Cost Center Description	From Wkst. C,	Cost to Charge	Total HHA	HHA Shared	Transfer to		
		Part I, col.	Ratio	Charge (from	Ancillary	Part I as		
		9, line		provi der	Costs (col.	1 Indicated		
				records)	x col. 2)			
		0	1.00	2. 00	3.00	4. 00		
	PART II - APPORTIONMENT OF COST	T OF HHA SERVIO	CES FURNI SHED B	Y SHARED HOSPI	TAL DEPARTMEN	NTS		
1.00	Physi cal Therapy	66. 00	0. 251568	0		Ocol. 2, line 2	. 00	1. 00
2.00	Occupati onal Therapy	67. 00	0. 092473	0	)	Ocol. 2, line 3	. 00	2. 00
3.00	Speech Pathology	68. 00	0. 143394	0	)	0 col. 2, line 4	. 00	3. 00
4.00	Cost of Medical Supplies	71. 00	0. 327634	0	)	0 col. 2, line 1	5. 00	4. 00
5.00	Cost of Drugs	73. 00	0. 276036	0	)	0 col. 2, line 1	6. 00	5. 00

	inancial Systems FRANCISCAN HEALT FION OF HHA REIMBURSEMENT SETTLEMENT	Provider CC	`N: 15_0000	Peri od:	ieu of Form CMS-2 Worksheet H-4	
ILCULA	TON OF THE RETWINDORSEMENT SETTEMBENT	HHA CCN:	15-7145	From 01/01/202 To 12/31/202	23 Part I-II	
					5/30/2024 3: 4 PPS	
		II ti e	XVIII	Home Health Agency I		
			Part A	Not Subject	art B to Subject to	
				Deducti bl es		
		+	1.00	Coi nsurance 2. 00	Coi nsurance 3.00	
P	ART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTO	MARY CHARGES		2.00	J 5. 00	
	easonable Cost of Part A & Part B Services					1
	leasonable cost of services (see instructions) otal charges			0	0 0	1
	ustomary Charges				<u></u>	1 -
	mount actually collected from patients liable for payment for	servi ces o	n	0	0 0	3.
	charge basis (from your records) mount that would have been realized from patients liable for	navment for		0	0 0	4.
S	ervices on a charge basis had such payment been made in accor 2 CFR §413.13(b)					''
	atio of line 3 to line 4 (not to exceed 1.000000)		0.0000	0. 0000	0. 000000	5.
0 T	otal customary charges (see instructions)			0	0 0	1
	excess of total customary charges over total reasonable cost (	complete		0	0	7.
0 E	nly if line 6 exceeds line 1) xcess of reasonable cost over customary charges (complete onl	y if line 1		0	0 0	8.
	exceeds line 6)				0 0	0
0 F	rimary payer amounts			0 Part A	0 0 Part B	9.
				Servi ces	Servi ces	
D	ART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			1.00	2. 00	
	otal reasonable cost (see instructions)				0 0	10.
	otal PPS Reimbursement - Full Episodes without Outliers				0 5, 113, 677	11.
	otal PPS Reimbursement - Full Episodes with Outliers				0 481, 016	
1	otal PPS Reimbursement - LUPA Episodes otal PPS Reimbursement - PEP Episodes				0 52, 003 0 8, 614	
1	fotal PPS Outlier Reimbursement - Full Episodes with Outliers				0 127, 700	
	otal PPS Outlier Reimbursement - PEP Episodes				0 401	
	otal Other Payments ME Payments				0 0	1
	xygen Payments					1
4	rosthetic and Orthotic Payments				0 0	20
1	Part B deductibles billed to Medicare patients (exclude coinsu	ırance)			0	
- 1	ubtotal (sum of lines 10 thru 20 minus line 21) excess reasonable cost (from line 8)				0 5, 783, 411 0 0	1
- 1	Subtotal (line 22 minus line 23)				0 5, 783, 411	
	oinsurance billed to program patients (from your records)				0	25
	let cost (line 24 minus line 25)				0 5, 783, 411	
	llowable bad debts (from your records) djusted reimbursable bad debts (see instructions)				0	
	Illowable bad debts for dual eligible (see instructions)				ő	
4	otal costs - current cost reporting period (see instructions)				0 5, 783, 411	
	THER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	. \			0 0	
	ioneer ACO demonstration payment adjustment (see instructions Jemonstration payment adjustment amount before sequestration	•)			0 0	
	Subtotal (see instructions)				0 5, 783, 411	
	equestration adjustment (see instructions)				0 115, 666	
	memonstration payment adjustment amount after sequestration	.+			0 0	
1	equestration adjustment for non-claims based amounts (see ins nterim payments (see instructions)	structions)			0 0 5, 667, 745	
	entative settlement (for contractor use only)				0 5, 667, 745	1
	alance due provider/program (line 31 minus lines 31.01, 31.02	., 31. 75, 32	, and 33)		0 0	
	rotested amounts (nonallowable cost report items) in accordan				0 0	1

Heal th Financial Systems FRANCISCAN HEALTH- DYER

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAS FOR SERVICES RENDERED TO Provider CCN: 15-0090 In Lieu of Form CMS-2552-10

Peri od: From 01/01/2023 To 12/31/2023 Worksheet H-5 PROGRAM BENEFICIARIES Date/Time Prepared: 5/30/2024 3:45 pm HHA CCN: 15-7145

				Home Health Agency I	PPS	
		Inpatien	t Part A	Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
1.00	T	1. 00	2. 00	3. 00	4.00	1.00
1. 00 2. 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero			0	5, 667, 745 0	1. 00 2. 00
3. 00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  Program to Provider					3. 00
3. 01				0	0	3. 01
3. 02				0	0	3. 02
3. 03 3. 04				0	0 0	3. 03 3. 04
3. 04				0		3. 04
0.00	Provider to Program			<u> </u>	Ü	0.00
3.50	, and the second			0	0	3. 50
3. 51				0	0	3. 51
3. 52				0	0	3. 52
3. 53 3. 54				0	0	3. 53 3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0		3. 99
3. 77	3. 50-3. 98)					5. 77
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)	<b>;</b>		0	5, 667, 745	4. 00
	TO BE COMPLETED BY CONTRACTOR					
5. 00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)	(				5. 00
5. 01	Program to Provider			0	0	5. 01
5. 02				0		5. 02
5. 03				0	l ol	5. 03
	Provider to Program					
5. 50				0	0	5. 50
5. 51 5. 52				0	0	5. 51 5. 52
5. 52 5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5. 52 5. 99
6. 00	5.50-5.98) Determined net settlement amount (balance due) based on the					6. 00
	cost report. (1)				_	
6. 01 6. 02	SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM			0	0	6. 01 6. 02
6. 02 7. 00	Total Medicare program liability (see instructions)			0	5, 667, 745	6. 02 7. 00
7.00	Total modification program (Tubility (300 Histiactions)			Contractor	NPR Date	7.00
				Number	(Mo/Day/Yr)	
		(	)	1. 00	2. 00	
8. 00	Name of Contractor					8. 00

	Financial Systems FRANCISCAN HEA			u of Form CMS-2	2552-10			
CALCUL	ATION OF CAPITAL PAYMENT	Provider CCN: 15-0090	Peri od: From 01/01/2023 To 12/31/2023	Worksheet L Parts I-III Date/Time Pre 5/30/2024 3:4				
		Title XVIII	Hospi tal	PPS				
				1. 00				
	PART I - FULLY PROSPECTIVE METHOD			1.00				
	CAPITAL FEDERAL AMOUNT							
1.00	Capital DRG other than outlier				1.00			
1.01	Model 4 BPCI Capital DRG other than outlier				1. 01			
2.00	Capital DRG outlier payments	29, 968						
2. 01	Model 4 BPCI Capital DRG outlier payments	0	2. 01					
3. 00 4. 00	Total inpatient days divided by number of days in the cost r Number of interns & residents (see instructions)	75. 82 4. 81	3. 00 4. 00					
5. 00	Indirect medical education percentage (see instructions)	1.81	5.00					
6. 00	Indirect medical education adjustment (multiply line 5 by the	25, 740						
	1.01) (see instructions)		,					
7.00	Percentage of SSI recipient patient days to Medicare Part A	patient days (Worksheet E	E, part A line 30)	4.00	7. 00			
	(see instructions)			28. 68				
8.00	Percentage of Medicaid patient days to total days (see instructions)							
9. 00 10. 00	Sum of lines 7 and 8				9. 00 10. 00			
11. 00					11.00			
12. 00								
	prospective depictal payments (see thetraetrone)			1, 575, 083	12.00			
				1. 00				
	PART II - PAYMENT UNDER REASONABLE COST							
1.00	Program inpatient routine capital cost (see instructions)			0	1.00			
2. 00 3. 00	Program inpatient ancillary capital cost (see instructions) Total inpatient program capital cost (line 1 plus line 2)			0				
4. 00	Capital cost payment factor (see instructions)			0				
5. 00	Total inpatient program capital cost (line 3 x line 4)			0				
0.00	Trotal Tripatrone program capital cost (Trib o x Trib )				0.00			
				1. 00				
1 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS			0	1 00			
1. 00 2. 00	Program inpatient capital costs (see instructions)  Program inpatient capital costs for extraordinary circumstar	ocos (soo instructions)		0	1. 00 2. 00			
3. 00	Net program inpatient capital costs (line 1 minus line 2)	ices (see mistructions)		0				
4. 00	Applicable exception percentage (see instructions)			0.00				
5.00	Capital cost for comparison to payments (line 3 x line 4)			0	5. 00			
6.00	Percentage adjustment for extraordinary circumstances (see i	nstructions)		0.00	6.00			
7.00	Adjustment to capital minimum payment level for extraordinar	ry circumstances (line 2 $ ightarrow$	(line 6)	0				
8. 00	Capital minimum payment level (line 5 plus line 7)			0				
9.00	Current year capital payments (from Part I, line 12, as appl			0	9.00			
10.00					10.00			
11. 00	L, Part III, line 14)	capital payment (from pri	or year worksneet	0	11. 00			
12. 00	Net comparison of capital minimum payment level to capital p	payments (line 10 plus lin	ne 11)	0	12. 00			
13. 00					13. 00			
14.00	Carryover of accumulated capital minimum payment level over	capital payment for the f	following period (	if 0	14. 00			
	line 12 is negative, enter the amount on this line)							
15.00	Current year allowable operating and capital payment (see in	nstructions)		0	15.00			
16.00				0	16. 00 17. 00			
17.00	Current year exception offset amount (see instructions)			Ü	I/.U(			