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: 14-1350 Worksheet S Peri od: From 07/01/2022 Parts I-III AND SETTLEMENT SUMMARY 06/30/2023 Date/Time Prepared: 1/24/2024 11:37 am PART I - COST REPORT STATUS Provi der 1. [ X ] Electronically prepared cost report Date: 1/24/2024 Time: 11:37 am ] Manually prepared cost report use only If 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 6. Date Received: 7. Contractor No. (2) Settled without Audit 8. [N] Initial Report for this Provider CCN (3) Settled with Audit 9. [N] Final Report for this Provider CCN (10. NPR Date: 11. Contractor's Vendor Code: 4. (2. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9. Contractor use only (3) Settled with Audit number of times reopened = 0-9. (4) Reopened

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

(5) Amended

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ST. FRANCIS HOSPITAL (14-1350) for the cost reporting period beginning 07/01/2022 and ending 06/30/2023 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 FINANC	CIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONI C	
	1		2	SI GNATURE STATEMENT	
1				I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name				2
3	Signatory Title				3
4	Date				4

			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	-449, 551	242, 347	0	0	1.00
2.00	SUBPROVI DER - I PF	0	0	0		0	2.00
3.00	SUBPROVI DER - I RF	0	0	0		0	3.00
5.00	SWING BED - SNF	0	7, 409	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
200.00	TOTAL	0	-442, 142	242, 347	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 ST. FRANCIS HOSPITAL In Lieu of Form CMS-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 14-1350 Period: Worksheet S-2

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA From 07/01/2022 Part I Date/Time Prepared: 06/30/2023 1/24/2024 11:37 am 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 1215 FRANCISCAN DRIVE 1.00 PO Box: 1.00 County: MONTGOMERY 2.00 City: LITCHFIELD State: IL Zi p Code: 62056 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, O, or N)

/ XVIII XIX Certi fi ed Number Number Type 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 Hospi tal ST. FRANCIS HOSPITAL 141350 99914 12/01/2005 Ν 0 3.00 Subprovi der - IPF 4.00 4.00 5.00 Subprovi der - IRF 5 00 Subprovi der - (Other) 6.00 6.00 7.00 Swing Beds - SNF ST. FRANCIS HOSPITAL 14Z350 99914 05/31/2007 N 0 0 7.00 Swing Beds - NF 8.00 8.00 9.00 Hospital -Based SNF 9.00 10.00 Hospi tal -Based NF 10.00 11.00 Hospital -Based OLTC 11 00 12.00 Hospital -Based HHA 12.00 13.00 Separately Certified ASC 13.00 14.00 Hospi tal -Based Hospi ce 14.00 15.00 Hospital -Based Health Clinic - RHC 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 To: 1.00 2.00 07/01/2022 06/30/2023 20.00 Cost Reporting Period (mm/dd/yyyy) 20 00 21.00 Type of Control (see instructions) 21.00 1 1.00 2. 00 3. 00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for Ν Ν 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. 22.01 Did this hospital receive interim UCPs, including supplemental UCPs, for Ν Ν 22.01 this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 22.02 Is this a newly merged hospital that requires a final UCP to be Ν 22.02 determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to Ν Ν N 22 03 rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 22.04 Did this hospital receive a geographic reclassification from urban to 22 04 rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 23.00 Ν 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.

Health Financial Systems ST. FRANCIS HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 14-1350 Peri od: Worksheet S-2 From 07/01/2022 Part I Date/Time Prepared: 06/30/2023 1/24/2024 11:37 am In-State In-State Out-of Out-of Medi cai d 0ther Medi cai d Medi cai d State State HMO days Medi cai d paid days eligible Medi cai d Medi cai d days unpai d pai d days el i gi bl e days unpai d 1.00 2. 00 3. 00 4. 00 5. 00 6. 00 24.00 If this provider is an IPPS hospital, enter the 0 24.00  $\cap$ Λ in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. 25.00 If this provider is an IRF, enter the in-state 0 0 0 0 0 25.00 Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5. Urban/Rural S Date of Geogr 2.00 1.00 26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural. 26.00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, 27.00 enter the effective date of the geographic reclassification in column 2. 35.00 If this is a sole community hospital (SCH), enter the number of periods SCH status in 0 35.00 effect in the cost reporting period. Begi nni ng: Endi ng: 1.00 2.00 36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates. 36 00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status 0 37.00 is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for the MDH transitional payment in 37.01 accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions) 38.00 | If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is 38.00 greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates. Y/N Y/N 1.00 2.00 39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume 39.00 Ν hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions) 40.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or Ν N 40.00 "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions) XVIII XIX V 1. 00 2.00 3.00 Prospective Payment System (PPS)-Capital 45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance N N N 45.00 with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exception for extraordinary circumstances 46.00 Ν Ν Ν 46.00 pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through 47.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no. N N N 47.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no. 48.00 Ν Ν Ν 48.00 Teachi ng Hospi tal s Is this a hospital involved in training residents in approved GME programs? For cost reporting Ν 56.00 periods beginning prior to December 27, 2020, enter "Y" for yes or "N" for no in column 1. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2), see the instructions. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter Y" for yes; otherwise, enter "N" for no in column 2. 57.00 For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, is yes, Ν 57.00 is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", did residents start training in the first month of this cost reporting period? Enter "Y" for yes or

"N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting periods beginning on or after 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 yes in column 1, do not complete column 2, and complete Worksheet E-4.

Health Financial Systems ST. FRANCIS HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 14-1350 Peri od: Worksheet S-2 From 07/01/2022 Part I Date/Time Prepared: 06/30/2023 1/24/2024 11: 37 am XVIII XIX 1. 00 2.00 3.00 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. Ν 58.00 Pt. I Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2 59.00 NAHE 413.85 Worksheet A Pass-Through Y/N Line # Qualification Cri teri on Code 1.00 2.00 3.00 60.00 Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see 60 00 N instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2. IME Direct GME IME Direct GME 1. 00 2.00 3. 00 4. 00 5.00 61.00 Did your hospital receive FTE slots under ACA 0.00 0.00 61.00 section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) 61.01 Enter the average number of unweighted primary care 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 61.03 and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions) Enter the number of unweighted primary care/or 61.04 surgery allopathic and/or osteopathic FTEs in the current cost 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 61.06 used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions) Program Name Program Code Unwei ghted Unwei ghted IME FTE Count Direct GME FTE Count 1.00 2.00 3.00 4.00 0.00 61.10 61.10 Of the FTEs in line 61.05, specify each new program 0. 00 specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. 61.20 Of the FTEs in line 61.05, specify each expanded 0.00 0.00 61.20 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) Teaching Hospitals that Claim Residents in Nonprovider Settings 63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter 63.00 Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)

Health Financial Systems	ST F	FRANCIS HOSPITAL		In lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMP				eriod: com 07/01/2022	Worksheet S-2 Part I Date/Time Pre	pared:
			Unwei ghted	Unwei ghted	1/24/2024 11: Ratio (col.	37 alli
			FTEs Nonprovider Site	FTEs in Hospital	1/ (col. 1 + col. 2))	
			1.00	2. 00	3. 00	
Section 5504 of the ACA Base Yea			-This base year	is your cost	reporti ng	
period that begins on or after of the following seriod that begins on or after of the following seriod the first seriod the following seriod that the following seriod seriod that the following seriod that the following seriod seri	s yes, or your facili aber of unweighted no otations occurring in e number of unweighte our hospital. Enter i	ty trained residents n-primary care all nonprovider d non-primary care n column 3 the ratio		0.00	0. 000000	64.00
[2. (22.2	Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col.	
			FTEs Nonprovider Site	FTEs in Hospital	3/ (col. 3 + col. 4))	
	1. 00	2. 00	3.00	4. 00	5. 00	
65.00 Enter in column 1, if line 63 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 Si te	Unwei ghted FTEs in Hospi tal	0.000000 Ratio (col. 1/ (col. 1 + col. 2))	65. 00
			1.00	2. 00	3. 00	
Section 5504 of the ACA Current beginning on or after July 1, 20		n Nonprovider Settin	gsEffective f	or cost report	ing periods	
66.00 Enter in column 1 the number of FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 divided b	unweighted non-prima occurring in all nonp unweighted non-prima al. Enter in column	rovider settings. ry care resident 3 the ratio of	0.00	0.00	0. 000000	66. 00
	Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
(7.00 Enton in column 1.11	1. 00	2. 00	3.00	4. 00	5. 00	47.00
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	0.00000	67.00

	Financial Systems ST. FRANCIS HOSPITAL AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCI		eriod: com 07/01/2	2022	of Form CMS- Worksheet S- Part I Date/Time Pro 1/24/2024 11	2 epared:			
					1. 00	1			
8. 00	Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-4900 For a cost reporting period beginning prior to October 1, 2022, did you obtained to apply the new DGME formula in accordance with the FY 2023 IPPS Final (August 10, 2022)?	otain permissio	on from you		N	68. 00			
	I pacti ant Davaki atri a Facili tu DDC			1. 00	2.00 3.00				
0.00	Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it conta	ain an IPF sub	orovi der?	N		70.00			
	Enter "Y" for yes or "N" for no.  If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412. 424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412. 424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no.  Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)								
.F 00	Inpatient Rehabilitation Facility PPS Is this facility an Inpatient Rehabilitation Facility (IRF), or does it co	ntoin on IDE		N		75. 00			
	If line 75 is yes: Column 1: Did the facility have an approved GME teachir recent cost reporting period ending on or before November 15, 2004? Enter no. Column 2: Did this facility train residents in a new teaching program CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If indicate which program year began during this cost reporting period. (see	ng program in "Y" for yes on in accordance column 2 is Y	r "N" for with 42	N	0	76. 00			
			·		1.00				
	Long Term Care Hospital PPS				1. 00				
	1.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. 1.00 Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter N 1.00 "Y" for yes and "N" for no. 1.00 TEFRA Providers								
86. 00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.  5.00 Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.								
37. 00	Is this hospital an extended neoplastic disease care hospital classified unaskid)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	under section			N	87. 00			
	Tioog(a) (T)(b) (VI): Enter 1 Tol yes of N Tol III.		Approved Permanen Adjustmen (Y/N) 1.00	nt	Number of Approved Permanent Adjustments 2.00				
88. 00	Column 1: Is this hospital approved for a permanent adjustment to the TEFF amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete instructions)  Column 2: Enter the number of approved permanent adjustments.		N			0 88.00			
	por amin 2. Error the number of approved permanent day astments.	Wkst. A Line No.	Effectiv Date	е	Approved Permanent Adjustment Amount Per Discharge				
0.00	Column 1. If line 00, column 1 is V, enter the Worksheet A line number	1. 00	2. 00		3. 00	0 89.00			
39.00	Column 1: If line 88, column 1 is Y, enter the Worksheet A line number on which the per discharge permanent adjustment approval was based.  Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge.	0.00			,	0 89.00			
	Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge.								
			V 1.00		XI X 2. 00				
0.00	Title V and XIX Services Does this facility have title V and/or XIX inpatient hospital services? Er	nter "Y" for	N		Υ	90.00			
	yes or "N" for no in the applicable column. Is this hospital reimbursed for title V and/or XIX through the cost report	t either in	N		N	91.00			
2. 00	full or in part? Enter "Y" for yes or "N" for no in the applicable column. Are title XIX NF patients occupying title XVIII SNF beds (dual certificati				N	92.00			
	instructions) Enter "Y" for yes or "N" for no in the applicable column.  Does this facility operate an ICF/IID facility for purposes of title V and	d XIX? Enter	N		N	93. 00			
3. 00	"Y" for yes or "N" for no in the applicable column.		N	94. 00					
	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no	applicable column.  P5.00 If line 94 is "Y", enter the reduction percentage in the applicable column.  0.00  0.00							
94. 00 95. 00	applicable column.	٦.				95. 00 96. 00			

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der CO	CN: 14-1350	Peri od: From 07/01/2022 To 06/30/2023		-2 repared:
			V	XIX	
98.00 Does title V or XIX follow Medicare (title XVIII) for the i	nterns and res	sidents post	1. 00 N	2. 00 N	98.00
stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y"					
column 1 for title V, and in column 2 for title XIX.  98.01 Does title V or XIX follow Medicare (title XVIII) for the r				Y	98. 01
C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for t title XIX.	itie v, and in	i corumn 2 ro	r		
98.02 Does title V or XIX follow Medicare (title XVIII) for the c bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes			N	Y	98. 02
for title V, and in column 2 for title XIX.  98.03 Does title V or XIX follow Medicare (title XVIII) for a cri reimbursed 101% of inpatient services cost? Enter "Y" for y				N	98. 03
for title V, and in column 2 for title XIX. 98.04 Does title V or XIX follow Medicare (title XVIII) for a CAH	roimburged 10	)1% of	N	N	98. 04
outpatient services cost? Enter "Y" for yes or "N" for no i in column 2 for title XIX.				IN IN	98.04
98.05 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				Y	98. 05
column 2 for title XIX. 98.06 Does title V or XIX follow Medicare (title XVIII) when cost	reimbursed fo	or Wkst. D,	N	Y	98. 06
Pts. I through IV? Enter "Y" for yes or "N" for no in colum					
column 2 for title XIX. Rural Providers					
105.00 Does this hospital qualify as a CAH?			Y		105.00
106.00  f this facility qualifies as a CAH, has it elected the all for outpatient services? (see instructions)	-inclusive met	thod of payme	nt N		106.00
107.00 Column 1: If line 105 is Y, is this facility eligible for c			N		107. 00
training programs? Enter "Y" for yes or "N" for no in colum Column 2: If column 1 is Y and line 70 or line 75 is Y, do					
approved medical education program in the CAH's excluded I	PF and/or IRF				
Enter "Y" for yes or "N" for no in column 2. (see instruct 108.00 s this a rural hospital qualifying for an exception to the		edule? See 4	2 N		108.00
CFR Section §412.113(c). Enter "Y" for yes or "N" for no.					
	Physi cal 1, 00	Occupationa 2.00	Speech 3.00	Respiratory 4.00	<u>'</u>
and policy and the state of the		Y			
109.00  f this hospital qualifies as a CAH or a cost provider, are	Υ	'	Y	Υ	109.00
therapy services provided by outside supplier? Enter "Y"	Y	'	Y	Y	109.00
	Y	'	Y		109.00
therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.				1. 00 N	
therapy services provided by outside supplier? Enter "Y"	al Demonstrati "Y" for yes or	on project (	\$410A If yes,	1.00	110.00
therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.  110.00 Did this hospital participate in the Rural Community Hospit Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wo	al Demonstrati "Y" for yes or	on project (	§410A If yes, ough 215, as	1.00 N	
therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.  110.00 Did this hospital participate in the Rural Community Hospit Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wo	al Demonstrati "Y" for yes or rksheet E-2, l	on project ( "N" for no. ines 200 thr	\$410A If yes,	1.00	
therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.  110.00 Did this hospital participate in the Rural Community Hospit Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wo applicable.  111.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this c	al Demonstrati "Y" for yes or rksheet E-2, I the Frontier C ost reporting	on project ( "N" for no. ines 200 thr	\$410A If yes, ough 215, as	1.00 N	110.00
therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.  110.00 Did this hospital participate in the Rural Community Hospit Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wo applicable.  111.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this c "Y" for yes or "N" for no in column 1. If the response to c integration prong of the FCHIP demo in which this CAH is pa	al Demonstrati "Y" for yes or rksheet E-2, I  the Frontier C ost reporting olumn 1 is Y, rticipating in	on project ( o "N" for no. i nes 200 thr  Community period? Ente enter the n column 2.	\$410A If yes, ough 215, as	1.00 N	110.00
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therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.  110.00 Did this hospital participate in the Rural Community Hospit Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wo applicable.  111.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this c "Y" for yes or "N" for no in column 1. If the response to c integration prong of the FCHIP demo in which this CAH is pa	al Demonstrati "Y" for yes or rksheet E-2, I  the Frontier C ost reporting olumn 1 is Y, rticipating in	on project ( o "N" for no. i nes 200 thr  Community period? Ente enter the n column 2.	§410A If yes, ough 215, as  1.00  N	1.00 N	110.00
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therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.  110.00 Did this hospital participate in the Rural Community Hospit Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wo applicable.  111.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this c "Y" for yes or "N" for no in column 1. If the response to c integration prong of the FCHIP demo in which this CAH is pa Enter all that apply: "A" for Ambulance services; "B" for a	al Demonstrati "Y" for yes or rksheet E-2, I  the Frontier C ost reporting olumn 1 is Y, rticipating ir dditional beds	on project ( "N" for no. ines 200 thr  Community period? Ente enter the n column 2. s; and/or "C"	§410A If yes, ough 215, as  1.00  N	1. 00 N	110.00
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therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.  110.00 Did this hospital participate in the Rural Community Hospit Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wo applicable.  111.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this c "Y" for yes or "N" for no in column 1. If the response to c integration prong of the FCHIP demo in which this CAH is pa Enter all that apply: "A" for Ambulance services; "B" for a for tele-health services.  112.00 Did this hospital participate in the Pennsylvania Rural Hea (PARHM) demonstration for any portion of the current cost r period? Enter "Y" for yes or "N" for no in column 1. If c "Y", enter in column 2, the date the hospital began partici demonstration. In column 3, enter the date the hospital ce participation in the demonstration, if applicable.  Miscellaneous Cost Reporting Information  115.00 Is this an all-inclusive rate provider? Enter "Y" for yes on in column 1. If column 1 is yes, enter the method used (A, in column 2. If column 1 is yes, enter the method used (A, in column 2. If column 1 is yes, enter the method used the definition in CMS Pub. 15-1, chapter 22, §2208. 1.  116.00 Is this facility classified as a referral center? Enter "Y" "N" for no.	al Demonstrati "Y" for yes or rksheet E-2, I  the Frontier Cost reporting olumn 1 is Y, rticipating in dditional beds  Ith Model eporting olumn 1 is pating in the ased  r "N" for no B, or E only) 93" percent (includes rs) based on	on project ( "N" for no. ines 200 thr  community period? Ente enter the n column 2. s; and/or "C"	§410A If yes, ough 215, as  1.00  N	1. 00 N	111.00
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Health Financial Systems ST.	FRANCIS HOSPITAL		In Lie	u of Form CMS-	-2552-10		
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION	DATA Provi der	F	Period: From 07/01/2022 To 06/30/2023	Worksheet S- Part I Date/Time Pr			
				1/24/2024 11			
		Premiums	Losses	Insurance			
		1.00	2. 00	3. 00	_		
118.01 List amounts of malpractice premiums and paid loss	es:	84, 22			5118.01		
			1.00	2.00			
118.02 Are mal practice premiums and paid losses reported	in a cost center other	r than the	N 1.00	2.00	118. 02		
Administrative and General? If yes, submit suppor	ting schedule listing	cost centers					
and amounts contained therein. 119.00DO NOT USE THIS LINE					119.00		
120.00 Is this a SCH or EACH that qualifies for the Outpa			N	N	120. 00		
§3121 and applicable amendments? (see instructions "N" for no. Is this a rural hospital with < 100 be							
Hold Harmless provision in ACA §3121 and applicable							
Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high	cost implantable dovi	cos sharged to	Y		121. 00		
patients? Enter "Y" for yes or "N" for no.	cost imprantable devi-	ces charged to	1		121.00		
122.00 Does the cost report contain healthcare related ta				5. 03	122. 00		
Act?Enter "Y" for yes or "N" for no in column 1. I the Worksheet A line number where these taxes are		ter in column 2					
123.00 Did the facility and/or its subproviders (if appli					123. 00		
services, e.g., legal, accounting, tax preparation management/consulting services, from an unrelated							
for yes or "N" for no.	G						
If column 1 is "Y", were the majority of the expen professional services expenses, for services purch.							
located in a CBSA outside of the main hospital CBS.							
"N" for no.		•					
Certified Transplant Center Information 125.00 Does this facility operate a Medicare-certified tr.	ansplant center? Ente	r "Y" for ves	N		125. 00		
and "N" for no. If yes, enter certification date(s	) (mm/dd/yyyy) below.	,					
126.00 If this is a Medicare-certified kidney transplant in column 1 and termination date, if applicable, i		rtification dat	Э		126. 00		
127.00 If this is a Medicare-certified heart transplant p	rogram, enter the cer	tification date			127. 00		
in column 1 and termination date, if applicable, i 128.00 If this is a Medicare-certified liver transplant p		tification data			128. 00		
in column 1 and termination date, if applicable, i		tirication date			120.00		
129.00 If this is a Medicare-certified lung transplant pr		ification date			129. 00		
in column 1 and termination date, if applicable, i 130.00 If this is a Medicare-certified pancreas transplan		certi fi cati on			130. 00		
date in column 1 and termination date, if applicab	le, in column 2.				101 00		
131.00  f this is a Medicare-certified intestinal transpl date in column 1 and termination date, if applicab		e certification			131.00		
132.00 If this is a Medicare-certified islet transplant p	rogram, enter the cer	tification date			132. 00		
in column 1 and termination date, if applicable, i 133.00 Removed and reserved	n column 2.				133.00		
134.00 If this is a hospital-based organ procurement orga		the OPO number			134. 00		
in column 1 and termination date, if applicable, i All Providers	n column 2.						
140.00 Are there any related organization or home office			Y	14H005	140. 00		
chapter 10? Enter "Y" for yes or "N" for no in col are claimed, enter in column 2 the home office cha							
1.00	2. 00	uctrons)	3. 00				
If this facility is part of a chain organization,		rough 143 the n	ame and address	of the home			
office and enter the home office contractor name a 141.00 Name: HOSPITAL SISTERS HEALTH SYSTEM Contractor's		MENT Contracto	r's Number: 0013	11	141. 00		
	SERVI CES						
142.00 Street: 4936 LAVERNA ROAD PO Box: 143.00 City: SPRINGFIELD State:	IL	Zi p Code:	6270	17	142. 00 143. 00		
Tro. color ty. Granding Educe.	12	El p code.	0270	.,	1 10. 00		
144.00 Are provider based physicians' costs included in W	orkshoot A2			1. 00 Y	144.00		
144. OOJALE PLOVI dei based physicians costs included in w	orksheet A:			T	144.00		
445 001 6	11		1.00	2. 00	4.45 .55		
145.00 If costs for renal services are claimed on Wkst. A inpatient services only? Enter "Y" for yes or "N"					145. 00		
no, does the dialysis facility include Medicare utilization for this cost reporting							
period? Enter "Y" for yes or "N" for no in column 146.00Has the cost allocation methodology changed from t		nst renort?	N		146. 00		
Enter "Y" for yes or "N" for no in column 1. (See	CMS Pub. 15-2, chapte				140.00		
yes, enter the approval date (mm/dd/yyyy) in colum	n 2.			l			

Health Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE COMPLI		NCIS HOSPITAL	or CCN	: 14-1350	) Po	In Li	eu of Form CMS Worksheet S	
NUSPITAL AND NUSPITAL HEALTH CARE COMPLI	ZA IDENTIFICATION DATA	Provide	er CCIV	1. 14-1330		om 07/01/202	2 Part I	repared:
							1.00	1. 07 diii
147.00 Was there a change in the statist	ical basis? Enter "Y"	for ves or "N"	for r	no.			1.00 N	147. 00
148.00 Was there a change in the order o							N	148.00
149.00 Was there a change to the simplif	ied cost finding metho						N	149.00
		Part A	١	Part		Title V	Title XIX	
		1.00		2.00		3. 00	4. 00	
Does this facility contain a prov or charges? Enter "Y" for yes or								
155. 00 Hospi tal		N		N	Ì	N	N	155. 00
156.00 Subprovi der – IPF		N		N	j	N	N	156.00
157.00 Subprovi der – IRF		N		N		N	N	157. 00
158. 00 SUBPROVI DER								158. 00
159. 00 SNF		N		N		N	N	159.00
160. 00 HOME HEALTH AGENCY		N		N		N	N	160.00
161. 00 CMHC				N		N	N	161.00
							1.00	
Mul ti campus								
165.00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no.	ampus hospital that ha	s one or more	campus	ses in d	i ffere	ent CBSAs?	N	165. 00
·	Name	County		State	Zip (		FTE/Campus	
	0	1. 00		2.00	3. (	00 4.00	5. 00	
166.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)							0.	00 166.00
cordiii 3 (3cc Tristractions)							1.00	
Health Information Technology (HI	T) incentive in the Am	neri can Recover	v and	Rei nves	tment	Act	1.00	
167.00 s this provider a meaningful use							Υ	167.00
168.00 f this provider is a CAH (line 1	05 is "Y") and is a me	aningful user	(line	167 is	"Y"),	enter the		168.00
reasonable cost incurred for the								
168.01 If this provider is a CAH and is	not a meaningful user,	does this pro	vi der	qual i fy	for a	a hardshi p	N	168. 0
exception under §413.70(a)(6)(ii) 169.00 If this provider is a meaningful	user (line 167 is "Y")	and is not a	CAH (I	line 105	ons) is "N	N"), enter th	e 0.	00169.00
transition factor. (see instructi	ons)					Pogi ppi pg	Ending	
					-	Begi nni ng 1, 00	Endi ng 2. 00	
170.00 Enter in columns 1 and 2 the EHR	peginning date and end	ing date for t	he re	portina		1.00	2.00	170. 0
period respectively (mm/dd/yyyy)		g date ter t						.,,,,,
						1. 00	2.00	+
171.00  fline 167 is "Y", does this pro	vider have any days fo	r individuals	enrol l	led in		N		0 171. 00
section 1876 Medicare cost plans "Y" for yes and "N" for no in col 1876 Medicare days in column 2. (	reported on Wkst. S-3, umn 1. If column 1 is	Pt. I, line 2	, col.	. 6? Ent				

Health Financial Systems ST. FRANCIS HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provider CCN: 14-1350 Peri od: Worksheet S-2 From 07/01/2022 Part II Date/Time Prepared: 06/30/2023 1/24/2024 11:37 am 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 Ν 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 2.00 Has the provider terminated participation in the Medicare Program? If N 2 00 yes, enter in column 2 the date of termination and in column  $\hat{\textbf{3}},$  "V" for voluntary or "I" for involuntary. 3.00 Is the provider involved in business transactions, including management 3.00 contracts, with individuals or entities (e.g., chain home offices, drug or 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 Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, 4.00 Α 4.00 or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions. 5.00 Are the cost report total expenses and total revenues different from 5.00 Ν those on the filed financial statements? If yes, submit reconciliation Legal Oper. Y/N 1.00 2.00 Approved Educational Activities 6.00 Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider N 6.00 the legal operator of the program? Are costs claimed for Allied Health Programs? If "Y" see instructions. 7 00 7 00 Ν 8.00 Were nursing programs and/or allied health programs approved and/or renewed during the Ν 8.00 cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved graduate medical education 9.00 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 10.00 N 10.00 cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I & R in an Approved 11.00 Ν Teaching 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 Ν 13.00 13.00 period? If yes, submit copy. 14.00 If line 12 is yes, were patient deductibles and/or coinsurance amounts waived? If yes, see Ν 14.00 instructions. Bed Complement 15.00 Did total beds available change from the prior cost reporting period? If yes, see instructions N 15.00 Part A 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? N N 16.00 If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions) Was the cost report prepared using the PS&R Report for 11/01/2023 11/01/2023 17.00 Υ Υ 17.00 totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R 18.00 Ν 18.00 N 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. If line 16 or 17 is yes, were adjustments made to PS&R 19.00 Ν Ν Report data for corrections of other PS&R Report information? If yes, see instructions.

]			Provider CCN: 14-1350		Part II Date/Time 1/24/2024		
1			_	Y/N	Y/N		
1			0	1. 00	3. 00		
	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.0	
		Y/N	Date	Y/N	Date		
		1. 00	2.00	3. 00	4. 00		
	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.0	
					1. 00		
C	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	PT CHI LDRENS	HOSPI TALS)		1.00		
	Capital Related Cost						
	Have assets been relifed for Medicare purposes? If yes, see				Υ	22.0	
	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.	due to apprai	sals made du	ring the cost	N	23.	
	Were new leases and/or amendments to existing leases entere If yes, see instructions	eporting period?	N	24.0			
	Have there been new capitalized leases entered into during instructions.	? If yes, see	N	25. (			
5. 00 N	Were assets subject to Sec. 2314 of DEFRA acquired during thinstructions.	e cost report	ing period?	If yes, see	N	26.	
7. 00 H	Has the provider's capitalization policy changed during the copy.	f yes, submit	N	27.			
3. 00 \	nterest Expense Were new loans, mortgage agreements or letters of credit en	N	28.				
i 00 .¢	period? If yes, see instructions. Did the provider have a funded depreciation account and/or	N	29.				
). 00   H	treated as a funded depreciation account? If yes, see instr Has existing debt been replaced prior to its scheduled matu	N	30.				
I. 00   I	instructions. Has debt been recalled before scheduled maturity without is instructions.	es, see	N	31.			
2. 00 T	Purchased Services Have changes or new agreements occurred in patient care ser		ned through c	ontractual	N	32.	
3.00   1	arrangements with suppliers of services? If yes, see instru If line 32 is yes, were the requirements of Sec. 2135.2 app no, see instructions.		ng to compet	itive bidding? If	N	33.	
	Provi der-Based Physi ci ans						
	Were services furnished at the provider facility under an a If yes, see instructions.	ırrangement wi	th provider-	based physicians?	Υ	34.	
	If line 34 is yes, were there new agreements or amended exi physicians during the cost reporting period? If yes, see in		ents with the	provi der-based	N	35.	
				Y/N	Date		
To the	lene 0661 0t-			1.00	2. 00		
	Home Office Costs			V/		24	
	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pr	opared by the	homo office	? Y Y		36. 0 37. 0	
	If yes, see instructions.						
-	If line 36 is yes, was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end	of the home	offi ce.			38.	
	If line 36 is yes, did the provider render services to othe see instructions.	·	,			39.	
	If line 36 is yes, did the provider render services to the instructions.	home office?	If yes, see	e N		40.	
		1	. 00	2.	00		
C	Cost Report Preparer Contact Information						
. 00 I	Enter the first name, last name and the title/position Fheld by the cost report preparer in columns 1, 2, and 3,	PATTY		RACHELL		41.	
2.00		FORVI S				42.	
	preparer. Enter the telephone number and email address of the cost 3	314-231-5544		PATTY. RACHELL@	FORVIS. COM	43.	

Heal th	Financial Systems ST. FRAN	CIS	HOSPI TAL	In Lieu of Form CMS-2552-10			
HOSPI T	TAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-1350	Peri od: From 07/01/2022			
				To 06/30/2023	Date/Time Pre 1/24/2024 11:	pared: 37 am	
		L					
			3. 00				
	Cost Report Preparer Contact Information						
41.00	Enter the first name, last name and the title/position	Λ	MANAGING DIRECTOR			41.00	
	held by the cost report preparer in columns 1, 2, and 3,						
	respecti vel y.						
42.00	Enter the employer/company name of the cost report					42.00	
	preparer.						
43.00	Enter the telephone number and email address of the cost	t				43.00	
	report preparer in columns 1 and 2, respectively.						

| In Lieu of Form CMS-2552-10 | Period: | Worksheet S-3 | From 07/01/2022 | Part | | To 06/30/2023 | Date/Time Prepared: Health Financial Systems ST. FINOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provi der CCN: 14-1350

				Т	o 06/30/2023	Date/Time Pre 1/24/2024 11:	
						1/P Days /	37 dili
						0/P Visits /	
						Tri ps	
	Component	Worksheet A	No. of Beds	Bed Days	CAH/REH Hours	Title V	
	·	Li ne No.		Avai I abl e			
		1. 00	2. 00	3.00	4. 00	5. 00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00	25	9, 125	72, 843. 08	0	1.00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovi der						3.00
4.00	HMO I RF Subprovi der					0	4.00
5. 00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6. 00 7. 00	Hospital Adults & Peds. Swing Bed NF		25	9, 125	72, 843. 08	0	6. 00 7. 00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		25	9, 125	12, 843. 08	U	7.00
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	OTHER SPECIAL CARE (SPECIFY)						12.00
13. 00	NURSERY	43.00				0	13.00
14. 00	Total (see instructions)	10.00	25	9, 125	72, 843. 08	Ö	14. 00
15. 00	CAH visits					0	15.00
15. 10	REH hours and visits						15. 10
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17. 00
18.00	SUBPROVI DER						18. 00
19.00	SKILLED NURSING FACILITY						19. 00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22. 00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24.00	HOSPI CE						24.00
24. 10	HOSPICE (non-distinct part)	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	0.5			0	26. 25
27. 00	Total (sum of lines 14-26)		25			0	27. 00
28. 00	Observation Bed Days					0	28. 00
29. 00	Ambulance Trips						29. 00 30. 00
30. 00 31. 00	Employee discount days (see instruction)						30.00
32.00	Employee discount days - IRF Labor & delivery days (see instructions)		0	0			31.00
32. 00	Total ancillary labor & delivery room		U	1	,		32.00
32.01	outpatient days (see instructions)						32.01
33. 00							33. 00
33. 01	LTCH site neutral days and discharges						33. 01
	Temporary Expansi on COVID-19 PHE Acute Care	30. 00	0	d		0	
5 55	1. Impairs and a source of the first floate out of	33.00		'	1	0	

Health Financial Systems ST. FR. HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Peri od: Worksheet S-3
From 07/01/2022 Part I
To 06/30/2023 Date/Time Prepared: 1/24/2024 11: 37 am

						<u>  1/24/2024 11:</u>	37 am
		1/P Days	/ O/P Visits	/ Irips	Full lime b	Equi val ents	
	Component	Title XVIII	T: +Lo VIV	Total All	Total Interne	Emplayees On	
	Component	II tie xviii	Title XIX	Total All	Total Interns	Employees On	
		4 00	7.00	Patients 8.00	& Residents 9.00	Payrol I 10.00	
	DADT I CTATICTICAL DATA	6. 00	7. 00	8.00	9.00	10.00	
1 00	PART I - STATISTICAL DATA Hospital Adults & Peds. (columns 5, 6, 7 and	1, 521	38	2, 944			1 00
1. 00		1,521	38	2, 944			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)	710	0				2.00
3. 00	HMO IPF Subprovider	710	0				3.00
4. 00	HMO IRF Subprovider		0				4.00
5. 00	Hospital Adults & Peds. Swing Bed SNF	251	0	338	,		5.00
6. 00	Hospital Adults & Peds. Swing Bed NF	251	0	39			6.00
7. 00	Total Adults and Peds. (exclude observation	1, 772	38	3, 321			7.00
7.00	beds) (see instructions)	1, 772	30	3, 321			7.00
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	OTHER SPECIAL CARE (SPECIFY)						12.00
13. 00	NURSERY		49	272	,		13.00
14. 00	Total (see instructions)	1, 772	87	3, 593		192. 04	
15. 00	CAH visits	1, 7,2	0	3,375	0.00	172.04	15.00
15. 10	REH hours and visits		Ŭ				15. 10
16. 00	SUBPROVIDER - I PF						16. 00
17. 00	SUBPROVIDER - IRF						17.00
18. 00	SUBPROVI DER						18.00
19. 00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE						21.00
22. 00	HOME HEALTH AGENCY						22.00
23. 00	AMBULATORY SURGICAL CENTER (D. P. )						23. 00
24. 00	HOSPI CE						24.00
24. 10	HOSPICE (non-distinct part)			15			24. 10
25. 00	CMHC - CMHC						25. 00
26.00	RURAL HEALTH CLINIC						26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	o	0		0. 00	0.00	26. 25
27. 00	Total (sum of lines 14-26)				0. 00		
28. 00	Observation Bed Days		12	617			28. 00
29. 00	Ambul ance Trips	o					29.00
30.00	Employee discount days (see instruction)			<del> </del>	,		30.00
31.00	Employee discount days - IRF			C	)		31.00
32.00	Labor & delivery days (see instructions)	o	34	84			32.00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
33.00	LTCH non-covered days	o					33.00
33. 01	LTCH site neutral days and discharges	o					33. 01
34.00	Temporary Expansion COVID-19 PHE Acute Care	o	0	C			34.00
			•		•		-

Provider CCN: 14-1350

| Peri od: | Worksheet S-3 | From 07/01/2022 | Part I | To 06/30/2023 | Date/Time Prepared:

					00/30/2023	1/24/2024 11:	
		Full Time Equivalents		Di sch	arges		
	Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11. 00	12. 00	13.00	14.00	15. 00	
	PART I - STATISTICAL DATA	'					
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		0	434	12	999	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)			214	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation						7. 00
	beds) (see instructions)						
8. 00	INTENSIVE CARE UNIT						8. 00
9.00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13. 00
14. 00	Total (see instructions)	0.00	0	434	12	999	
15. 00	CAH visits						15. 00
15. 10	REH hours and visits						15. 10
16. 00	SUBPROVIDER - IPF						16.00
17. 00	SUBPROVI DER - I RF						17.00
18. 00	SUBPROVI DER						18.00
19. 00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23. 00	AMBULATORY SURGICAL CENTER (D. P. )						23.00
24.00	HOSPICE						24.00
24. 10 25. 00	HOSPICE (non-distinct part) CMHC - CMHC						24. 10 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	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31. 00	Employee discount days (see l'istruction)						31.00
32. 00	Labor & delivery days (see instructions)						32.00
32. 00	Total ancillary labor & delivery room						32.00
32.01	outpatient days (see instructions)						32.01
33. 00	LTCH non-covered days			0			33.00
	LTCH site neutral days and discharges			Ö			33. 01
	Temporary Expansion COVID-19 PHE Acute Care						34.00

	Financial Systems ST. FRANCIS HOS		N. 14 12E0		u of Form CMS-2				
HUSPI I	TAL UNCOMPENSATED AND INDIGENT CARE DATA	Provi der CC	IN: 14-1350	Peri od: From 07/01/2022	Worksheet S-1	U			
				To 06/30/2023	Date/Time Pre 1/24/2024 11:				
					1. 00				
	Uncompensated and indigent care cost computation								
. 00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 di	vided by li	ne 202 colum	n 8)	0. 235628	1.0			
	Medicaid (see instructions for each line)								
2.00	Net revenue from Medicaid				5, 942, 473				
3. 00 4. 00	Did you receive DSH or supplemental payments from Medicaid? If line 3 is yes, does line 2 include all DSH and/or supplemen	tal navmont	s from Modic	ai d2	Y	3. 0 4. 0			
. 00	If line 4 is no, then enter DSH and/or supplemental payments f			ai u :	0	5.0			
. 00	Medi cai d charges	rom mearear	u .		36, 728, 110	1			
. 00	Medicaid cost (line 1 times line 6)				8, 654, 171	7.0			
3. 00	Difference between net revenue and costs for Medicaid program	(line 7 min	us sum of li	nes 2 and 5; if	2, 711, 698	8.0			
	< zero then enter zero)								
	Children's Health Insurance Program (CHIP) (see instructions for	or each lin	e)						
. 00	Net revenue from stand-alone CHIP				0				
	Stand-alone CHIP charges				0	1			
1.00	Stand-alone CHIP cost (line 1 times line 10) Difference between net revenue and costs for stand-alone CHIP	(line 11 mi	nus line 0:	if / zero then	0	11. C			
2.00	enter zero)	(TITIE IT IIII	ilus Title 7,	II \ Zero then	U	12.0			
	Other state or local government indigent care program (see ins	tructions f	or each line	)		İ			
3. 00	Net revenue from state or local indigent care program (Not inc				0	13.0			
4. 00	Charges for patients covered under state or local indigent care	e program (	Not included	in lines 6 or	0	14. (			
	10)								
5. 00			<b>41.1</b>	45 1 11	0	15.0			
6. 00	Difference between net revenue and costs for state or local in 13; if < zero then enter zero)	digent care	program (II	ne 15 minus line	0	16. (			
	Grants, donations and total unreimbursed cost for Medicaid, CH	IP and stat	e/local indi	gent care progra	ıms (see	-			
7 00	Instructions for each line) Private grants, donations, or endowment income restricted to fi	iundi na chan	i ty caro		0	   17. C			
	Government grants, appropriations or transfers for support of				0				
9. 00	Total unreimbursed cost for Medicaid , CHIP and state and loca			s (sum of lines	2, 711, 698				
	8, 12 and 16)		p9	. (	_, ,				
			Uni nsured	Insured	Total (col. 1				
			patients	patients	+ col . 2)				
	Uncompared Care (ass instructions for each line)		1. 00	2. 00	3. 00				
0. 00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire fa	ci Li ty	1, 213, 79	257, 306	1, 471, 102	20. C			
.0. 00	(see instructions)	Cirity	1, 215, 7	237, 300	1,471,102	20.0			
1. 00	Cost of patients approved for charity care and uninsured disco	unts (see	286, 00	257, 306	543, 310	21.0			
	instructions)	`	•	·					
2.00	Payments received from patients for amounts previously written	off as		0 0	0	22.0			
	charity care				540.040				
3.00	Cost of charity care (line 21 minus line 22)		286, 00	04 257, 306	543, 310	23.0			
					1. 00				
4. 00	Does the amount on line 20 column 2, include charges for patie	nt days hev	ond a Length	of stay limit	N N	24.0			
4. 00	imposed on patients covered by Medicaid or other indigent care		ond a rength	or stay rriiir t	.,	24.0			
5. 00	If line 24 is yes, enter the charges for patient days beyond t stay limit		care progra	m's length of	0	25. C			
6. 00	Total bad debt expense for the entire hospital complex (see in	structione)			3, 425, 532	26.0			
	Medicare reimbursable bad debts for the entire hospital complex		935, 046						
	mean ear e l'eliment each e bad debtes foi the chtiffe hospital comple								
7. 00	Medicare allowable bad debts for the entire hospital complex (	see instruc	· · · · · · · · · · · · · · · · · · ·						
27. 00 27. 01	Medicare allowable bad debts for the entire hospital complex (Non-Medicare bad debt expense (see instructions)	see instruc	tions)		1, 438, 532 1, 987, 000				
27. 00 27. 01 28. 00	1		ŕ	)		28.0			
27. 00 27. 01 28. 00 29. 00	Non-Medicare bad debt expense (see instructions) Cost of non-Medicare and non-reimbursable Medicare bad debt ex		ŕ	)	1, 987, 000	28. 0 29. 0 30. 0			

Cost Center Description	Heal th	Financial Systems	ST. FRANCIS I	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COST CENTER* DESCRIPTION  Selection*  1.00  2.00  3.00  4.00  1.00  2.00  3.00  4.00  5.00  1.00  2.00  3.00  4.00  5.00  1.01  5.00  3.00  3.00  4.00  5.00  1.01  5.00  3.00	RECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der C	CN: 14-1350 F	eri od:	Worksheet A	
COST CENTER* DESCRIPTION  Selection*  1.00  2.00  3.00  4.00  1.00  2.00  3.00  4.00  5.00  1.00  2.00  3.00  4.00  5.00  1.01  5.00  3.00  3.00  4.00  5.00  1.01  5.00  3.00					l F	rom 07/01/2022		
Central Service Ost Center Description					1	o 06/30/2023	Date/Time Pre	
STATE   STAT		October Description	6.1	011	T. I. I. (I. 4	D I		3/ am
CENERAL SERVICE COST CENTERS   1.00   2.00   3.00   4.00   5.00		Cost Center Description	Sai ari es	Utner				
SEMERAL SENTICE COST CENTERS					+ COI . 2)			
SENERAL SERVICE COST CENTERS   1.00   2.00   3.00   4.00   5.00						A-6)	•	
GINERAL SERVICE COST CENTERS   1.00   00100 CAP REL COSTS-BUIGS # TAX   2.42, 398   4.42, 398   1,270, 207   1,712, 665   1.00   00100 CAP REL COSTS-BUIGE FOUNTY   2.200, 030   2.209, 030   -1,181,564   1,077, 466   2.00   0.30   0.300   0.0000 CHER CAP REL COSTS-BUIGE FOUNTY   2.200, 030   2.209, 030   -1,181,564   1,077, 466   2.00   0.30   0.0000 CHER CAP REL COSTS-BUIGE FOUNTY   2.00   0.50								
1.00			1. 00	2. 00	3.00	4.00	5. 00	
2.09   00200   CAP   REL COSTS-MMBLE BOULP     2.299   030   2.299   030   0.1   181   564   1   0.07   0.6   2.00   0.4   0.05   0.0								
0.0000   OHER CAP REL COSTS   0				442, 398			1, 712, 665	1.00
0.0000   EMPLOYEE BENEFITS DEPARTMENT	2.00			2, 209, 030	2, 209, 030	-1, 181, 564	1, 027, 466	2.00
DOSTO   ADMITTING   0	3.00	00300 OTHER CAP REL COSTS		0	C	0	0	3.00
5.02   00540   PATIENT ACCOUNTING   0   0   0   0   0   0   0   0   0	4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	4, 674, 419	4, 674, 419	0	4, 674, 419	4.00
5.03 00550 ADMIN STRATIU & & GENERAL 844, 208 8, 999, 163 9, 843, 371   -1-28, 542 9, 714, 829 5, 0.3    7.00 00700 (Demandary Comments of the	5. 01	00570 ADMI TTI NG	0	1, 688	1, 688	0	1, 688	5. 01
0.000   0.000   MAINTRANCE & REPAIR IRS   27, 053   0.91, 839   118, 892   56, 938   175, 273   6.00   0.00   0.000	5.02	00540 PATIENT ACCOUNTING	0	0		0	0	5. 02
7. 00         000700   DEPARTI ON OF PLANT         365, 810   1,460,049   1,825,859   58,714   1,884,573   7,00         9.00   03000   LAUNDRY & LINEN SERVICE         0   00   03000   03000   03373   133,33   333,33   338, 80         9.00   03000   045000   050000   05000   05000   05000   05000   05000   050000   050000   05000   050	5.03	00550 ADMINISTRATIVE & GENERAL	844, 208	8, 999, 163	9, 843, 371	-128, 542	9, 714, 829	5. 03
7.00         OOTOOD OPERATION OF PLANT         365,810         1, 460,049         1, 285,859         58,714         1, 884,573         7, 0           9.00         OBSOOL AUNDRY & LINEN SERVICE         0         0         133,733         133,733         13,733         13,733         13,733         13,733         13,733         13,733         13,733         13,773         0           0.10         0         0         0         0         0         349,035         349,035         11,00           11.00         0         0         0         0         349,035         349,035         111,00           15.00         0         0         0         0         349,035         349,035         111,00           15.00         0         0         0         0         349,035         349,035         111,00           15.00         0         0         0         0         0         0         0         150,00           17.00         0	6.00	00600 MAINTENANCE & REPAIRS	27, 053	91, 839	118, 892	56, 381	175, 273	6.00
B. 00   008000   LAUNDRY & LINEN SERVICE   0   0   0   0   133, 733   133, 733   8   .0   0   0   0   0   0   0   0   0	7.00	00700 OPERATION OF PLANT		1, 460, 049	1, 825, 859			7.00
0.000   000000   HOLDSKEFEPING   369, 870   319, 927   649, 317   0   649, 317   9 .00   11. 00   011000   DETARY   369, 870   319, 927   649, 797   -349, 035   349, 035   11. 00   11. 00   011000   CAFETERI A   0   0   0   349, 035   349, 035   11. 00   15. 00   01500   NURSI NG ADMINI STRATI ON   846, 403   -6, 622   839, 781   0   0   349, 035   11. 00   15. 00   01500   NURSI NG ADMINI STRATI ON   846, 403   -6, 622   839, 781   0   0   0   0   0   0   17. 00   01500   MEDI CAL ECRORDS & LI BRARY   0   603, 200   5, 498, 766   6, 101, 966   -5, 201, 582   900, 384   15. 00   17. 00   1000   MEDI CAL ECRORDS & LI BRARY   0   0   0   0   0   0   0   17. 00   INNERTI ENT ROUTINE SERVICE COST CENTERS   3   139, 130   382, 829   3, 521, 959   3, 521, 959   30. 00   30000   JURISTERY   0   0   0   0   136, 648   136, 648   330, 00   3000   ADULTS & PEDI ATRI COS   3   339, 130   382, 829   3, 521, 959   3, 521, 959   3, 521, 959   30. 00   5000   OPERATI NG ROOM   4   4   4   4   4   4   4   4   4				0				1
10. 00   010000   015ARY   339, 870   319, 927   689, 797   -349, 035   340, 762   10. 00   10. 00   10100   CAFETERIA   0   0   349, 035   131. 00   0. 00   1000   CAFETERIA   0   839, 781   13. 00   0. 00   1000   HADMACY   603, 200   5, 498, 766   6, 101, 966   -5, 201, 582   900, 384   13. 00   0. 00   1000   MEDICAL RECORDS & LI BRARY   0   0   0   0   0   0   0   0   0			361 973	287 344	649 317			
11.00   01100   CAPETERIA   0   0   0   349,035   349,035   11.00   15.00   01500   PHARMACY   603,200   5,498,766   6,101,966   -5,201,582   900,384   15.00   17.0								1
13. 00   01300   MURSING ADMINISTRATION   846, 403   -6, 622   839, 781   0   839, 781   13. 00   16. 00   01600   PHARMACY   603, 200   5, 498, 766   6, 101, 966   -5, 201, 582   900, 384   15. 00   16. 00   100   0   0   0   0   0   0   0		1 1		017, 727				1
15. 00   01500   PHARMACY   00   0   0   0   0   0   0   0   0		1 1	٧	6 622				
16. 00   01-600   MEDICAL RECORDS & LIBRARY   0   0   0   0   0   0   0   0   0								
17. 00   01700   01700   01700   01   0   0   0   0   0   0   0   0					1			
IMPATI ENT ROUTI NE SERVICE COST CENTERS   3, 139, 130   382, 829   3, 521, 959   -1, 366, 836   2, 155, 123   30, 00   3000   AUDITS & PEPÍA ATRIC S   3, 139, 130   0   0   0   0   0   0   0   0   0			-					
30.00   03000   ADULTS & PEDIATRICS   3, 139, 130   382, 829   3, 521, 959   -1, 366, 836   2, 155, 123   30.00	17.00		U	0		0	0	17.00
A3. 00   O3200 NURSERY   O   O   O   O   136, 648   136, 648   43. 00			0 100 100	200 000	0 504 050	1 0// 00/	0.455.400	
ANCILLARY SERVICE COST CENTERS								1
SOLO   050000   05000   05000   050000   050000   050000   050000   050000   050000   0500000   05000000   0500000000	43. 00		0	0		136, 648	136, 648	43.00
S2.00   05.200   DELI VERY ROOM & LABOR ROOM   0   0   954, 558   954, 558   52.00								
S3.00   05300   AMESTHESI OLOGY   0   1,477,670   -26,955   1,450,715   53.00			1, 359, 467	2, 400, 189	3, 759, 656			1
54.00   05400   RADI OLOGY-DI LAGNOSTIC   688, 441   160, 044   848, 485   -42, 710   805, 775   54, 00   05401   ULTRASOUND   206, 602   137, 049   343, 651   14, 552   358, 203   54. 01   54. 02   05402   ULCLEAR MEDI CINE   83, 722   112, 729   196, 451   5, 383   201, 834   54. 02   57. 00   05700   CT SCAN   76, 039   214, 671   290, 710   -575   290, 135   57. 00   05800   MAGNETIC RESONANCE IMAGING (MRI )   88, 256   152, 718   240, 974   2, 602   243, 576   58. 00   05800   MAGNETIC RESONANCE IMAGING (MRI )   88, 256   152, 718   240, 974   2, 602   243, 576   58. 00   05800   MAGNETIC RESONANCE IMAGING (MRI )   88, 256   152, 718   240, 974   2, 602   243, 576   58. 00   05800   MAGNETIC RESONANCE IMAGING (MRI )   88, 256   152, 718   240, 974   2, 602   243, 576   58. 00   05800   MAGNETIC RESONANCE IMAGING (MRI )   88, 256   152, 718   240, 974   2, 602   243, 576   58. 00   05800   MAGNETIC RESONANCE IMAGING (MRI )   88, 256   152, 718   240, 974   2, 602   243, 576   58. 00   05000   MAGNETIC RESONANCE IMAGING (MRI )   88, 256   152, 718   240, 974   2, 602   243, 576   58. 00   05000   ASTRONATIONAL THERAPY   0 0 0 350, 744   350, 744   40. 00   00, 00,		05200 DELIVERY ROOM & LABOR ROOM	0	0	(	954, 558	954, 558	52.00
S4.01   05401   ULTRASOUND   206, 602   137, 049   343, 651   14, 552   358, 203   54, 01	53.00	05300 ANESTHESI OLOGY	0	1, 477, 670	1, 477, 670	-26, 955	1, 450, 715	53.00
54.02   05402   NUCLEAR MEDICINE   83,722   112,729   196,451   5,383   201,834   54,02   57.00   05700   CT SCAN   76,039   214,671   290,710   -575   290,135   57,02   58.00   05800   MAGNETIC RESONANCE IMAGING (MRI)   88,256   152,718   240,974   2,602   243,576   58,00   60.00   06000   LABORATORY   864,870   1,214,249   2,079,119   209,657   2,288,776   60.00   60.00   06000   RESPIRATORY THERAPY   400   0   0   350,744   350,744   64.00   60.00   06500   RESPIRATORY THERAPY   496   946,203   946,699   -3,414   943,285   66.00   60.00   06000   PHYSI CAL THERAPY   496   946,203   946,699   -3,414   943,285   66.00   60.00   06000   PHYSI CAL THERAPY   496   946,203   946,699   -3,414   943,285   66.00   60.00   06000   06000   06000   06000   06000   06000   06000   60.00   07000   0CUEDATI IONAL THERAPY   496   946,203   946,699   -3,414   943,285   66.00   60.00   06000   06000   06000   06000   06000   06000   60.00   07000   07	54.00	05400 RADI OLOGY-DI AGNOSTI C	688, 441	160, 044	848, 485	-42, 710	805, 775	54.00
57. 00   05700   CT SCAN   76, 039   214, 671   290, 710   -575   290, 735   57. 00	54.01	05401 ULTRASOUND	206, 602	137, 049	343, 651	14, 552	358, 203	54.01
58. 00   05800   MAGNETIC RESONANCE IMAGING (MRI )   88, 256   152, 718   240, 974   2, 602   243, 576   58. 00	54.02	05402 NUCLEAR MEDICINE	83, 722	112, 729	196, 451	5, 383	201, 834	54.02
58. 00   05800   MAGNETIC RESONANCE IMAGING (MRI )   88, 256   152, 718   240, 974   2, 602   243, 576   58. 00	57.00	05700 CT SCAN	76, 039	214, 671	290, 710	-575	290, 135	57.00
60.00   0.6000   LABORATORY   864, 870   1, 214, 249   2, 079, 119   209, 657   2, 288, 776   60.00   64.00   0.6000   LABORATORY   0 0 0 0 350, 744   350, 744   64.00   65.00   0.6500   RESPI RATORY THERAPY   432, 112   405, 834   837, 946   -47, 208   79, 738   65.00   66.00   0.6600   PHYSI CAL THERAPY   496   946, 203   946, 699   -3, 414   943, 285   66.00   67.00   0.6700   0.0000   0.000   0.000   0.000   68.00   0.6600   PHYSI CAL THERAPY   45, 317   16, 546   61, 863   0 0   61, 863   67.00   68.00   0.6800   SPEECH PATHOLOGY   0 8, 744   8, 744   0 0 8, 744   68.00   68.00   0.6800   SPEECH PATHOLOGY   0 8, 744   8, 744   0 0 8, 744   68.00   0.6800   SPEECH PATHOLOGY   0 8, 744   8, 744   0 0 8, 744   68.00   0.710.00   DRIO CAL SUPPLIES CHARGED TO PATIENTS   0 126, 587   126, 587   230, 039   356, 626   71.00   72.00   0.7200   IMPL. DEV. CHARGED TO PATIENTS   0 0 0 0 444, 715   4444, 715   72.00   73.00   0.7300   DRUGS CHARGED TO PATIENTS   0 0 0 0 444, 715   4444, 715   72.00   74.97   0.7697   CARDIA CREHABILITATION   222, 694   16, 709   239, 403   0 239, 403   75.00   0.7697   CARDIA CREHABILITATION   222, 694   16, 709   239, 403   0 239, 403   0 239, 403   75.00   0.700   ALLOGENEIC HSCT ACQUISITION   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	88, 256	152, 718	240, 974	2, 602	243, 576	58.00
64.00   06400   INTRAVENOUS THERAPY   0   0   0   350, 744   350, 744   64.00   65.00   06500   RESPI RATORY THERAPY   432, 112   405, 834   837, 946   -47, 208   790, 738   65.00   66.00   06600   PHYSI CAL THERAPY   496   946, 203   946, 699   -3, 414   943, 285   66.00   67.00   06700   0CCUPATI ONAL THERAPY   45, 317   16, 546   61, 863   0   611, 863   67.00   68.00   06800   SPEECH PATHOLOGY   0   8, 744   8, 744   8, 744   0   8, 744   68.00   71.00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS   0   126, 587   126, 587   230, 039   356, 626   71.00   72.00   07200   IMPL. DEV. CHARGED TO PATIENTS   0   0   0   444, 715   444, 715   72.00   73.00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   5, 208, 488   53.00   76.00   03020   MOUND CARE   340, 080   629, 539   969, 619   -23   969, 599   76.00   76.97   07697   CARDI AC REHABI LI TATI ON   222, 694   16, 709   239, 403   0   239, 403   76. 97   76.98   07698   SLEEP LAB   90, 932   25, 008   115, 940   -1, 888   114, 042   76. 98   77.00   O7700   ALLOGENEI C HISCT ACQUI SITI ON   0   0   0   0   0   77.00   OUTPATI ENT SERVICE COST CENTERS   79.00   09000   CLI NI C   470, 179   748, 466   1, 218, 645   -325, 709   892, 936   90. 01   79.00   09000   DEMERGENCY   1, 835, 881   1, 810, 504   3, 646, 385   -107, 094   3, 539, 291   91.00   79.00   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART)   0   0   0   0   0   70   OTHER REI MBURSABLE COST CENTERS   700.00   10200   OPI OID TREATMENT PROGRAM   0   0   0   0   0   70   SPECI AL PURPOSE COST CENTERS   700.00   10200   OPI OID TREATMENT PROGRAM   0   0   0   0   0   0   70   OUTPATI ENT SERVICE COST CENTERS   700.00   10200   OPI OID TREATMENT PROGRAM   0   46, 423   46, 423   46, 423   0   46, 423   190.00   70   10200   OPI OID TREATMENT PROGRAM   0   46, 423   46, 423   46, 423   0   46, 423   4	60.00		864, 870					
65.00   06500   RESPI RATORY THERAPY   432, 112   405, 834   837, 946   -47, 208   790, 738   65.00   66.00   06600   PHYSI CAL THERAPY   496   9946, 203   946, 699   -3, 414   943, 285   66. 00   67.00   06700   05000   05000   05000   05000   05000   05000   05000   05000   05000   68.00   06800   SPEECH PATHOLOGY   45, 317   16, 546   61, 863   0   61, 863   67. 00   68.00   06800   SPEECH PATHOLOGY   0   8, 744   8, 744   0   8, 744   68. 00   71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0   126, 587   126, 587   230, 039   356, 626   71. 00   72.00   07200   MPL. DEV. CHARGED TO PATIENTS   0   0   0   444, 715   444, 715   72. 00   73.00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   0   444, 715   72. 00   76.00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   0   5, 208, 488   5, 208, 488   73. 00   76.00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   0   76.97   07697   CARDI AC REHABI LI TATI ON   222, 694   16, 709   239, 403   0   239, 403   0   239, 403   0   239, 403   0   239, 403   0   239, 403   0   239, 403   0   239, 403   0   239, 403   0   239, 403   0   239, 403   0   239, 403   0   239, 403   0   239, 403   0   239, 403   0   239, 403   0   0   0   0   0   0   0   77.00   0700   ALLOGENEI C HSCT ACQUI SI TI ON   0   0   0   0   0   0   0   0   0				0				
66.00   06600   PHYSICAL THERAPY   496   946, 203   946, 699   -3, 414   943, 285   66.00   67.00   06700   0CCUPATI ONAL THERAPY   45, 317   16, 546   61, 863   0   61, 863   67.00   68.00   06800   SPEECH PATHOLOGY   0   8, 744   68.00   0   8, 744   69.00   0   8, 744   68.00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS   0   126, 587   126, 587   230, 039   356, 626   71.00   72.00   72.00   1MPL. DEV. CHARGED TO PATIENTS   0   0   0   0   444, 715   444, 715   72.00   73.00			432, 112	405. 834	837. 946			
67. 00   06700   OCCUPATI ONAL THERAPY   45, 317   16, 546   61, 863   0   61, 863   67. 00   68. 00   06800   SPEECH PATHOLOGY   0   8, 744   8, 744   0   8, 744   68. 00   71. 00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS   0   126, 587   126, 587   230, 039   356, 626   71. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0   0   0   444, 715   444, 715   72. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   0   5, 208, 488   5, 208, 488   73. 00   76. 00   03020   WOUND CARE   340, 080   629, 539   969, 619   -23   969, 596   76. 00   76. 90   07697   CARDI AC REHABI LI TATI ON   222, 694   16, 709   239, 403   0   239, 403   0   239, 403   0   77. 00   07700   ALLOGENEIC HSCT ACQUI SI TI ON   0   0   0   0   0   0   0   77. 00   07700   ALLOGENEIC COST CENTERS    90. 00   09000   CLI NI C   649, 223   1, 205, 502   1, 854, 725   -2, 522   1, 852, 203   90. 01   91. 00   09001   ONCOLOGY CLI NI C   470, 179   748, 466   1, 218, 645   -325, 709   892, 936   90. 01   92. 00   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART)   1, 835, 881   1, 810, 504   3, 646, 385   -107, 094   3, 539, 291   91. 00    118. 00   SPEECI AL PURPOSE COST CENTERS    119. 00   O10   OI TEATMENT PROGRAM   0   0   0   0   0   0    110. 00   OTHER REI MBURSABLE COST CENTERS    110. 00   O10   OI TEATMENT PROGRAM   0   0   0   0   0   0   0    110. 00   OTHER REI MBURSABLE COST CENTERS    118. 00   NONREI MBURSABLE COST CENTERS    119. 00   O10   OI TEATMENT PROGRAM   0   0   0   0   0   0   0   0    110. 00   O10   OTHER REI MBURSABLE COST CENTERS    110. 00   O10   OTHER REI MBURSABLE COST CENTERS    110. 00   O10   OTHER REI MBURSABLE COST CENTERS    111. 00   O10   O10								
68. 00   06800   SPEECH PATHOLOGY   0   8, 744   8, 744   0   8, 744   68. 00   71. 00   71.00   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0   126, 587   126, 587   230, 039   356, 626   71. 00   70. 00			ŀ					
71. 00								
72. 00 07200   IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 444, 715 444, 715 72. 00 73300   DRUGS CHARGED TO PATIENTS 0 0 0 0 5, 208, 488 73. 00 76. 00 03020   WOUND CARE 340, 080 629, 539 969, 619 -23 969, 596 76. 00 76. 97 07697   CARDI AC REHABILITATION 222, 694 16, 709 239, 403 0 239, 403 76. 97 76. 98 07698   SLEEP LAB 90, 932 25, 008 115, 940 -1, 898 114, 042 76. 98 77. 00 07700   ALLOGENEI C HSCT ACQUI SITION 0 0 0 0 0 0 0 0 77. 00 0UTPATIENT SERVICE COST CENTERS 90. 01 09001   ONCOLOGY CLINI C 470, 179 748, 466 1, 218, 645 -325, 709 892, 936 90. 01 99. 01 09000   CLINI C 470, 179 748, 466 1, 218, 645 -325, 709 892, 936 90. 01 99. 00 09200   DRERGENCY 1, 835, 881 1, 810, 504 3, 646, 385 -107, 094 3, 539, 291 91. 00 9200   ODESERVATION BEDS (NON-DISTINCT PART) 97. 00 0700   ODESERVATION			0					
73. 00			0	120, 307	· .			
76. 00				0	· ·			1
76. 97   07697   CARDI AC REHABILITATION   222, 694   16, 709   239, 403   0   239, 403   76. 97   76. 98   07698   SLEEP LAB   90, 932   25, 008   115, 940   -1, 898   114, 042   76. 98   77. 00   0700   ALLOGENEI C HSCT ACQUI SI TI ON   0   0   0   0   0   0   0   0   0			-	420 520				
76. 98   07698   SLEEP LAB   90, 932   25, 008   115, 940   -1, 898   114, 042   76. 98   77. 00   07700   ALLOGENEI C HSCT ACQUI SI TI ON   0   0   0   0   0   0   0   0   0								
77. 00								
OUTPATIENT SERVICE COST CENTERS   OUTPATIENT SERVICE COST CENTERS							•	
90. 00	//. 00		0	0		0	0	17.00
90. 01								
91. 00   09100   EMERGENCY   1, 835, 881   1, 810, 504   3, 646, 385   -107, 094   3, 539, 291   91. 00   92. 00   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART)   92. 00   0THER REI MBURSABLE COST CENTERS   0   0   0   0   0   0   0   0   0						-2, 522		
92. 00   09200   0BSERVATI ON BEDS (NON-DISTINCT PART)   92. 00     OTHER REIMBURSABLE COST CENTERS   92. 00     102. 00   10200   0PI OI D TREATMENT PROGRAM   0   0   0   0   0   102. 00     SPECIAL PURPOSE COST CENTERS   118. 00   SUBTOTALS (SUM OF LINES 1 through 117)   14, 011, 958   36, 169, 869   50, 181, 827   117, 884   50, 299, 711     118. 00   NONREIMBURSABLE COST CENTERS   190. 00   19000								
OTHER REIMBURSABLE COST CENTERS   102. 00   10200   OPI 01 D TREATMENT PROGRAM   O   O   O   O   O   102. 00			1, 835, 881	1, 810, 504	3, 646, 385	-107, 094	3, 539, 291	1
102. 00 10200 OPI 0I D TREATMENT PROGRAM 0 0 0 0 0 0 102. 00 SPECI AL PURPOSE COST CENTERS  118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 14, 011, 958 36, 169, 869 50, 181, 827 117, 884 50, 299, 711 118. 00 NONREI MBURSABLE COST CENTERS  190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 46, 423 46, 423 0 46, 423 190. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 227, 433 171, 146 398, 579 -117, 884 280, 695 192. 00 194. 00 07950 OTHER NONALLOWABLE 76, 985 215, 994 292, 979 0 292, 979 194. 00	92.00							92.00
SPECIAL PURPOSE COST CENTERS   118.00   SUBTOTALS (SUM OF LINES 1 through 117)   14,011,958   36,169,869   50,181,827   117,884   50,299,711   118.00   NONREI MBURSABLE COST CENTERS   190.00   19000   GI FT, FLOWER, COFFEE SHOP & CANTEEN   0   46,423   46,423   0   46,423   190.00   192.00   19200   PHYSI CI ANS' PRI VATE OFFI CES   227,433   171,146   398,579   -117,884   280,695   192.00   194.00   07950   OTHER NONALLOWABLE   76,985   215,994   292,979   0   292,979   194.00								
118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 14, 011, 958 36, 169, 869 50, 181, 827 117, 884 50, 299, 711 118. 00 NONREI MBURSABLE COST CENTERS  190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 46, 423 46, 423 0 46, 423 190. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 227, 433 171, 146 398, 579 -117, 884 280, 695 192. 00 194. 00 07950 OTHER NONALLOWABLE 76, 985 215, 994 292, 979 0 292, 979 194. 00	102.00	10200 OPIOID TREATMENT PROGRAM	0	0	C	0	0	102.00
NONREI MBURSABLE COST CENTERS   190. 00   19000   GI FT, FLOWER, COFFEE SHOP & CANTEEN   0   46, 423   46, 423   190. 00   192. 00   19200   PHYSI CI ANS' PRI VATE OFFI CES   227, 433   171, 146   398, 579   -117, 884   280, 695   192. 00   194. 00   07950   OTHER NONALLOWABLE   76, 985   215, 994   292, 979   0   292, 979   194. 00								
NONREI MBURSABLE COST CENTERS   190. 00   19000   GI FT, FLOWER, COFFEE SHOP & CANTEEN   0   46, 423   46, 423   190. 00   192. 00   19200   PHYSI CI ANS' PRI VATE OFFI CES   227, 433   171, 146   398, 579   -117, 884   280, 695   192. 00   194. 00   07950   OTHER NONALLOWABLE   76, 985   215, 994   292, 979   0   292, 979   194. 00	118.00	SUBTOTALS (SUM OF LINES 1 through 117)	14, 011, 958	36, 169, 869	50, 181, 827	117, 884	50, 299, 711	118.00
190. 00     19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN     0     46, 423     46, 423     0     46, 423     190. 00       192. 00     19200 PHYSI CI ANS' PRI VATE OFFI CES     227, 433     171, 146     398, 579     -117, 884     280, 695     192. 00       194. 00     07950 OTHER NONALLOWABLE     76, 985     215, 994     292, 979     0     292, 979     194. 00								1
192. 00   19200   PHYSI CI ANS' PRI VATE OFFI CES       227, 433   171, 146   398, 579   -117, 884   280, 695   192. 00       280, 695   192. 00         194. 00   07950   OTHER NONALLOWABLE       76, 985   215, 994   292, 979   0       292, 979   194. 00	190. 00		n	46, 423	46, 423	0	46, 423	190.00
194. 00 07950 OTHER NONALLOWABLE 76, 985 215, 994 292, 979 0 292, 979 194. 00								
200.00   1.0.1.2 (30m of 21120 110 till ough 177)   11,010,070   30,000,402   30,717,000   0 30,717,000   200.00								
		, (22 2. 220 0 0 0	, = ,	11, 300, 102		, ,	, , , , , , , , , , , , , , , , , , ,	,

Provi der CCN: 14-1350

Peri od: Worksheet A From 07/01/2022 To 06/30/2023 Date/Time Prepared:

				10 00/30/2023	1/24/2024 11: 37 am
	Cost Center Description	Adjustments	Net Expenses		
		(See A-8)	For		
			Allocation		
		6. 00	7. 00		
4 00	GENERAL SERVICE COST CENTERS	70.40/	1 (04 550		1.00
1.00	00100 CAP REL COSTS BLDG & FLXT	-78, 106			1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	-73, 723	953, 743		2.00
3.00	00300 OTHER CAP REL COSTS	1 722 200	0		3.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-1, 723, 309	2, 951, 110		4.00
5. 01 5. 02	00570 ADMITTING 00540 PATIENT ACCOUNTING	189, 913 725, 656	191, 601 725, 656		5. 01 5. 02
5. 02	00550 ADMI NI STRATI VE & GENERAL	-3, 657, 224	6, 057, 605		5. 02
6. 00	00600 MAINTENANCE & REPAIRS	-3, 037, 224	175, 273		6.00
7. 00	00700 OPERATION OF PLANT	-6, 063	1, 878, 510		7.00
8. 00	00800 LAUNDRY & LINEN SERVICE	-24, 606	109, 127		8.00
9. 00	00900 HOUSEKEEPI NG	0	649, 317		9. 00
10.00	01000 DI ETARY	0	340, 762		10.00
11. 00	01100 CAFETERI A	0	349, 035		11.00
	01300 NURSING ADMINISTRATION	-1, 225	838, 556		13. 00
	01500 PHARMACY	0	900, 384		15.00
	01600 MEDICAL RECORDS & LIBRARY	514, 980	515, 058		16.00
	01700 SOCIAL SERVICE	0	0		17. 00
	INPATIENT ROUTINE SERVICE COST CENTERS		'		
30.00	03000 ADULTS & PEDIATRICS	-31, 000	2, 124, 123		30.00
43.00	04300 NURSERY	0	136, 648		43.00
	ANCILLARY SERVICE COST CENTERS				
	05000 OPERATING ROOM	-272, 571	2, 965, 120		50.00
	05200 DELIVERY ROOM & LABOR ROOM	0	954, 558		52.00
	05300 ANESTHESI OLOGY	-1, 429, 189	21, 526		53.00
	05400 RADI OLOGY-DI AGNOSTI C	0	805, 775		54.00
	05401 ULTRASOUND	0	358, 203		54. 01
54. 02	05402 NUCLEAR MEDICINE 05700 CT SCAN	0	201, 834		54. 02 57. 00
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	290, 135 243, 576		58.00
60.00	06000 LABORATORY	-45, 438	2, 243, 338		60.00
	06400 I NTRAVENOUS THERAPY	-43, 430	350, 744		64.00
	06500 RESPIRATORY THERAPY	-261, 975	528, 763		65.00
	06600 PHYSI CAL THERAPY	0	943, 285		66.00
	06700 OCCUPATI ONAL THERAPY	0	61, 863		67. 00
	06800 SPEECH PATHOLOGY	0	8, 744		68.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	356, 626		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	444, 715		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	5, 208, 488		73.00
76.00	03020 WOUND CARE	-121, 868	847, 728		76.00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	239, 403		76. 97
76. 98	07698 SLEEP LAB	0	114, 042		76. 98
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0		77. 00
	OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLI NI C	-1, 192, 664	659, 539		90.00
	09001 ONCOLOGY CLINIC	-640, 819			90. 01
	09100 EMERGENCY	-761, 828	2, 777, 463		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				92.00
102.00	OTHER REIMBURSABLE COST CENTERS 10200 OPIOID TREATMENT PROGRAM	0	0		102.00
102.00	SPECIAL PURPOSE COST CENTERS	U	U		102.00
118.00		-8, 891, 059	41, 408, 652		118.00
110.00	NONREI MBURSABLE COST CENTERS	-0,071,037	41,400,002	 	118.00
190. 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	46, 423		190.00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	Ö	280, 695		192. 00
	07950 OTHER NONALLOWABLE	Ö	292, 979		194. 00
200.00		-8, 891, 059			200. 00
			. '		•

Health Financial Systems RECLASSIFICATIONS ST. FRANCIS HOSPITAL In Lieu of Form CMS-2552-10

Peri od: Worksheet A-6 From 07/01/2022 To 06/30/2023 Date/Time Prepared: Provi der CCN: 14-1350

					10	06/30/2023	1/24/2024 11:37 am
		Increases			· ·		
	Cost Center	Li ne #	Sal ary	0ther			
	2. 00	3.00	4. 00	5. 00			
1. 00	A - L&D AND NURSERY SAL & OTH NURSERY	43.00	121, 672	14, 980			1.00
2. 00	DELIVERY ROOM & LABOR ROOM	52. 00	851, 940	104, 889			2.00
	0		973, 612	119, 869			
	B - DRUG COSTS						
1.00	DRUGS CHARGED TO PATIENTS	73. 00	0	5, 208, 488			1.00
2.00	ADULTS & PEDIATRICS	30. 00	0	97			2.00
3. 00 5. 00		0. 00 0. 00	0	0			3. 00 5. 00
7. 00		0.00	0	0			7.00
8. 00		0. 00	ő	0			8.00
10.00		0.00	0	0			10.00
11. 00		0. 00	0	0			11.00
14.00		0.00	0	0			14.00
15. 00		0.00	<del> </del>	000			15. 00
	C - CAFETERIA SALARIES & OTHE	R COSTS	O <sub>1</sub>	5, 206, 565			
1. 00	CAFETERI A	11. 00	187, 153	161, 882			1.00
	0		187, 153	161, 882			
	D - LAUNDRY COSTS						
1.00	LAUNDRY & LINEN SERVICE	8. 00	0	133, 733			1.00
4. 00 5. 00		0. 00 0. 00	0	0			4. 00 5. 00
6. 00		0.00	0	0			6.00
7. 00		0. 00	Ö	Ö			7. 00
8.00		0. 00	0	0			8.00
9. 00		0.00	0	0			9. 00
10.00		0.00	0	0			10.00
11. 00 12. 00		0. 00 0. 00	0	0			11. 00 12. 00
13. 00		0.00	0	0			13.00
14. 00		0. 00	Ö	Ö			14.00
15.00		0. 00	0	0			15.00
16.00		0. 00	0	0			16.00
17.00		0.00	0	0			17.00
18. 00 19. 00		0. 00 0. 00	0	0			18. 00 19. 00
20. 00		0.00	o	0			20.00
20.00				133, 733			25. 55
	E - MEDICAL SUPPLIES						
1. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	300, 290			1.00
2.00	PATIENTS	72.00	0	274 444			2.00
2. 00	IMPL. DEV. CHARGED TO PATIENTS	72. 00	U	374, 464			2. 00
3. 00	TATTENTS	0. 00	0	0			3.00
4.00		0. 00	0	0			4.00
5.00		0.00	•	0			5. 00
	O E LAB ADMINISTRATION COSTS		0	674, 754			
1. 00	F - LAB ADMINISTRATION COSTS LABORATORY	60.00	147, 273	23, 432			1.00
2. 00	LABORATORT	0. 00	147, 273	23, 432			2.00
3. 00		0. 00	O	0			3. 00
4.00		000	0	0			4.00
	0		147, 273	23, 432			
1 00	I - BUILDING INSURANCE	1 00	ما	75 554			1 00
1. 00 2. 00	CAP REL COSTS-BLDG & FLXT CAP REL COSTS-MVBLE EQUIP	1. 00 2. 00	0	75, 554 13, 143			1. 00 2. 00
2.00	0			<del>13, 143</del> 88, 697			2.00
	J - RADIOLOGY MANAGERS COST			55, 511			
1.00	ULTRASOUND	54. 01	15, 370	0			1.00
2.00	NUCLEAR MEDICINE	54. 02	6, 309	0			2. 00
3.00	CT SCAN	57. 00 58. 00	6, 712	0			3.00
4. 00	MAGNETIC RESONANCE IMAGING (MRI)	58. 00	6, 712	0			4.00
	0	+	35, 103	<sub>0</sub>			
	N - INTEREST		22, 100	<u> </u>			
1.00	CAP REL COSTS-BLDG & FLXT	1.00	0	6			1.00
	0		0	6			
1 00	O - IMPLANT COSTS	70.00	Ol.	70 051			1.00
1. 00	I MPL. DEV. CHARGED TO PATIENTS	72. 00	0	70, 251			1.00
	0	+		70, 251			
		1	-1	- / == -			ı

ST. FRANCIS HOSPITAL In Lieu of Form CMS-2552-10 Health Financial Systems RECLASSI FI CATI ONS Provi der CCN: 14-1350 Peri od: Worksheet A-6 From 07/01/2022 To 06/30/2023 Date/Time Prepared: 1/24/2024 11: 37 am Increases Cost Center Sal ary 0ther Li ne # 2.00 3.00 4.00 5.00 P - DEPRECIATION EXPENSE RECLASS 1.00 CAP REL COSTS-BLDG & FIXT 1.00 1, 194, 707 1.00 1, 194, 707 Q - MOB OVERHEAD 1.00 MAINTENANCE & REPAIRS 6.00 0 56, 521 1.00 0 2.00 OPERATION OF PLANT 7.00 58, 720 2.00 115, 241 R - COVID EXPENSES 1.00 LABORATORY 60.00 39, 845 1.00 39, 845 S - IV THERAPY INTRAVENOUS THERAPY 64. 00

325, 043

365, 008

1, 708, 149

39, 965

64. 00

0

0

Ō

7, 831, 002

1.00

2.00

500.00

1.00

2.00

INTRAVENOUS THERAPY

500.00 Grand Total: Increases

Health Financial Systems RECLASSIFICATIONS Provi der CCN: 14-1350

Peri od: Worksheet A-6 From 07/01/2022 To 06/30/2023 Date/Time Prepared:

						0 06/30/2023 Date/11lie 1/24/2024	
		Decreases					
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref.		
	6. 00 A - L&D AND NURSERY SAL & OTI	7.00	8. 00	9. 00	10.00		
1. 00	ADULTS & PEDIATRICS	30.00	973, 612	119, 869	0		1.00
2. 00	ADDETS & FEDIATRI 03	0.00	773, 012	117,007	o		2. 00
			973, 612	119, 869			
	B - DRUG COSTS						
1. 00		0.00	0	0			1.00
2.00	DUA DMA CV	0.00	0	0			2.00
3. 00 5. 00	PHARMACY OPERATING ROOM	15. 00 50. 00	0	5, 201, 582 326			3. 00 5. 00
7. 00	RADI OLOGY-DI AGNOSTI C	54.00	0	35			7. 00
8. 00	ULTRASOUND	54. 01	Ö	111	o		8.00
10.00	CT SCAN	57. 00	0	4, 513	O		10.00
11. 00	MAGNETIC RESONANCE IMAGING	58. 00	0	543	0		11.00
14 00	(MRI)	01.00		1 450			14.00
14. 00 15. 00	EMERGENCY WOUND CARE	91. 00 76. 00	0	1, 452 23			14. 00 15. 00
13.00	0	70.00	— — <u> </u>				13.00
	C - CAFETERIA SALARIES & OTHI	ER COSTS	<u> </u>	0,200,000			
1.00	DI ETARY	10.00	187, 153	161, 882	0		1.00
	0		187, 153	161, 882			
4 00	D - LAUNDRY COSTS		٥	4.40			1.00
1. 00 4. 00	MAINTENANCE & REPAIRS ADULTS & PEDIATRICS	6. 00 30. 00	0	140 67, 112			1. 00 4. 00
5. 00	NURSERY	43. 00	0	07, 112	0		5. 00
6. 00	OPERATING ROOM	50.00	Ö	18, 797			6.00
7. 00	DELIVERY ROOM & LABOR ROOM	52.00	0	30	0		7. 00
8.00	RADI OLOGY-DI AGNOSTI C	54. 00	0	7, 572	O		8. 00
9. 00	ULTRASOUND	54. 01	0	707			9. 00
10.00	NUCLEAR MEDICINE	54. 02	0	926			10.00
11. 00 12. 00	CT SCAN MAGNETIC RESONANCE IMAGING	57. 00 58. 00	0	2, 774 3, 567			11. 00 12. 00
12.00	(MRI)	38.00	U	3, 307	o o		12.00
13.00	LABORATORY	60.00	0	893	o		13.00
14.00	RESPI RATORY THERAPY	65. 00	0	2, 122	0		14.00
15.00	PHYSI CAL THERAPY	66. 00	0	3, 414			15.00
16.00	SLEEP LAB	76. 98	0	1, 898			16.00
17. 00 18. 00	CLINIC ONCOLOGY CLINIC	90. 00 90. 01	0	2, 522			17. 00 18. 00
19. 00	EMERGENCY	91.00	0	666 17, 946			19. 00
20.00	PHYSICIANS' PRIVATE OFFICES	192. 00	o	2, 643	-		20.00
	0		0	133, 733			
	E - MEDICAL SUPPLIES						
1.00	ADULTS & PEDIATRICS	30.00	0	42, 815			1.00
2. 00 3. 00	OPERATING ROOM ANESTHESIOLOGY	50. 00 53. 00	0	502, 842 26, 955			2. 00 3. 00
4. 00	EMERGENCY	91.00	0	57, 056			4.00
5. 00	RESPIRATORY THERAPY	65. 00	o	45, 086			5. 00
	0 — — — — — —		0	674, 754			
	F - LAB ADMINISTRATION COSTS						
1.00	ADULTS & PEDIATRICS	30.00	115, 257	8, 303			1.00
2. 00 3. 00	DELIVERY ROOM & LABOR ROOM INTRAVENOUS THERAPY	52. 00 64. 00	1, 995 14, 264	246 0	- 1		2. 00 3. 00
4. 00	EMERGENCY	91.00	15, 757	14, 883			4.00
00	0	— — <del>///</del>	147, 273	23, 432			
	I - BUILDING INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5. 03	0	88, 697			1.00
2.00		0.00	0	0	12		2. 00
	J - RADIOLOGY MANAGERS COST		0	88, 697			
1. 00	RADI OLOGY - DI AGNOSTI C	54. 00	35, 103	0	O		1.00
2. 00	INDI OLOGI BINGNOSTI C	0.00	0	0			2.00
3.00		0.00	0	0			3.00
4.00	L	0.00	0	0	0		4.00
	0		35, 103	0			
1 00	N - INTEREST	7.00	21		441		1.00
1. 00	OPERATION OF PLANT		0		11		1.00
	0 - IMPLANT COSTS		U	0	1		
1. 00	MEDICAL SUPPLIES CHARGED TO	71.00	0	70, 251	0		1.00
	PATI ENTS		]				
	0		0	70, 251			

Heal th Financial Systems

ST. FRANCIS HOSPITAL

Provider CCN: 14-1350

Provider CCN: 14-1350

Provider CCN: 14-1350

Provider CCN: 14-1350

Period:
From 07/01/2022
To 06/30/2023

Date/Time Prepared:
1/24/2024 11: 37 am

Decreases

Cost Center Line # Salary Other Wkst. A-7 Ref.

						1/24/2024 11:	:37 am_
		Decreases					
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10.00		
	P - DEPRECIATION EXPENSE RECI	_ASS					
1.00	CAP REL COSTS-MVBLE EQUIP	2. 00	0	1, 194, 707	9		1.00
	0		0	1, 194, 707	7		
	Q - MOB OVERHEAD						
1.00	PHYSICIANS' PRIVATE OFFICES	192. 00	0	115, 241	0		1.00
2.00		0.00	0		0 0		2.00
	0		0	115, 241			
	R - COVID EXPENSES						
1.00	ADMI NI STRATI VE & GENERAL	5. 03	0	39, 845	5 0		1.00
	0		0	39, 845	5		
	S - IV THERAPY						
1.00	ONCOLOGY CLINIC	90. 01	325, 043	C	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	39, 965	C	0 0		2.00
	0		365, 008				
500.00	Grand Total: Decreases		1, 708, 149	7, 831, 002	2		500.00

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS ST. FRANCIS HOSPITAL

Provider CCN: 14-1350

				To	06/30/2023	Date/Time Pre 1/24/2024 11:	
				Acqui si ti ons		172472024 11.	57 diii
		Beginning	Purchases	Donati on	Total	Disposals and	
		Bal ances				Retirements	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	T BALANCES					
1.00	Land	462, 220	0	0	0	0	1.00
2.00	Land Improvements	1, 061, 051	183, 524	0	183, 524	0	2.00
3.00	Buildings and Fixtures	10, 852, 983	0	0	0	0	3.00
4.00	Building Improvements	10, 673	49, 997	0	49, 997	0	4. 00
5.00	Fixed Equipment	28, 204, 821	205, 050	0	205, 050	0	5.00
6.00	Movable Equipment	14, 280, 445	1, 145, 538	0	1, 145, 538	503, 398	6.00
7.00	HIT designated Assets	0	0	0	0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	54, 872, 193	1, 584, 109	0	1, 584, 109	503, 398	8. 00
9.00	Reconciling Items	487, 848	-90, 607	0	-90, 607	0	9. 00
10.00	Total (line 8 minus line 9)	54, 384, 345	1, 674, 716	0	1, 674, 716	503, 398	10.00
		Endi ng	Ful I y				
		Bal ance	Depreci ated				
			Assets				
		6. 00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE						
1. 00	Land	462, 220	0				1.00
2.00	Land Improvements	1, 244, 575	0				2.00
3.00	Buildings and Fixtures	10, 852, 983	0				3.00
4.00	Building Improvements	60, 670	0				4. 00
5.00	Fixed Equipment	28, 409, 871	0				5.00
6.00	Movable Equipment	14, 922, 585	0				6. 00
7.00	HIT designated Assets	0	0				7. 00
8.00	Subtotal (sum of lines 1-7)	55, 952, 904	0				8. 00
9.00	Reconciling Items	397, 241	0				9. 00
10. 00	Total (line 8 minus line 9)	55, 555, 663	0				10.00

Heal th	n Financial Systems	ST. FRANCIS	HOSPI TAL		In Lie	u of Form CMS-:	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der C		Peri od:	Worksheet A-7	'
					From 07/01/2022 To 06/30/2023	Part II Date/Time Pre	nared:
					10 00/30/2023	1/24/2024 11:	37 am
			SL	JMMARY OF CAPI	TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance	Taxes (see	
					(see	instructions)	
					instructions)		
		9. 00	10. 00	11. 00	12. 00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR		·	and 2		T	
1. 00	CAP REL COSTS-BLDG & FLXT	442, 398			0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2, 209, 030			0	0	2.00
3.00	Total (sum of lines 1-2)	2, 651, 428			0 0	0	3.00
		SUMMARY O	F CAPITAL				
	Cost Center Description	0ther	Total (1)				
		Capi tal -Relat	(sum of cols.				
		ed Costs (see	9 through 14)				
		instructions)					
		14. 00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUN	MN 2, LINES 1 a	and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	442, 398				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	2, 209, 030				2.00
3.00	Total (sum of lines 1-2)	0	2, 651, 428				3.00
				-			-

Heal th	n Financial Systems	ST. FRANCIS	HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der C		Period: From 07/01/2022 To 06/30/2023	Worksheet A-7 Part III Date/Time Pre 1/24/2024 11:	
		COMI	PUTATION OF RA	TIOS	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets		Insurance	
			Leases	for Ratio	instructions)		
				(col. 1 -			
		1. 00	2.00	col. 2) 3.00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C		2.00	3.00	4.00	5.00	
1. 00	CAP REL COSTS-BLDG & FLXT	41, 030, 319	0	41, 030, 31	9 0. 733301	0	1.00
2. 00	CAP REL COSTS-MVBLE EQUIP	14, 922, 585				0	2.00
3.00	Total (sum of lines 1-2)	55, 952, 904	0	55, 952, 90	1.000000	0	3.00
		ALLOCA <sup>-</sup>	TION OF OTHER (	CAPI TAL	SUMMARY C	F CAPITAL	
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
			Capi tal -Rel at				
			ed Costs	through 7)			
	DADT III DECONOLILATION OF CARLTAL COCTO	6. 00	7. 00	8. 00	9. 00	10.00	
1. 00	PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS	1 0	ı	2, 028, 188	-26, 785	1. 00
2. 00	CAP REL COSTS-BLDG & FIXT	0	l .		940, 600		2.00
3. 00	Total (sum of lines 1-2)	0			2, 968, 788		3. 00
0.00	Total (Sam of Times 1 2)	0	SI	JMMARY OF CAPI		20,700	0.00
	Cost Center Description	Interest	Insurance	Taxes (see	Other	Total (2)	
			(see	instructions)			
			instructions)		ed Costs (see instructions)	9 through 14)	
		11. 00	12. 00	13.00	14.00	15. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C		12.00	13.00	14.00	13.00	
1.00	CAP REL COSTS-BLDG & FIXT	-442, 398	75, 554		0 0	1, 634, 559	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1		0	953, 743	2.00
3.00	Total (sum of lines 1-2)	-442, 398	88, 697	1	0	2, 588, 302	3.00

Provider CCN: 14-1350 Worksheet A-8 From 07/01/2022 06/30/2023 Date/Time Prepared: 1/24/2024 11:37 am Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Basis/Code Cost Center Line # Wkst. A-7 Cost Center Description Amount (2) Ref. 1.00 2.00 3.00 4.00 5. 00 1.00 Investment income - CAP REL -442, 404 CAP REL COSTS-BLDG & FIXT 1. 00 11 1.00 COSTS-BLDG & FIXT (chapter 2) 2.00 Investment income - CAP REL OCAP REL COSTS-MVBLE EQUIP 2.00 2.00 COSTS-MVBLE EQUIP (chapter 2) 3.00 Investment income - other 0.00 3.00 (chapter 2) 4.00 Trade, quantity, and time 0.00 4.00 discounts (chapter 8) 5.00 Refunds and rebates of 5.00 0.00 expenses (chapter 8) Rental of provider space by 6.00 0.00 6.00 suppliers (chapter 8) Tel ephone servi ces (pay 7.00 0.007.00 stations excluded) (chapter 8.00 Television and radio service -6, 063 OPERATION OF PLANT 7.00 8.00 Α (chapter 21) 9.00 Parking lot (chapter 21) 0.00 9.00 -4, 457, 229 10.00 Provi der-based physici an 10.00 A-8-2 adjustment 11.00 Sale of scrap, waste, etc. 0 0.00 11.00 (chapter 23) Related organization -384, 682 12.00 12.00 A-8-1 transactions (chapter 10) 13.00 Laundry and linen service 0 0.00 13.00 Cafeteria-employees and guests 0 14.00 0.00 14.00 0 15.00 Rental of quarters to employee 0.00 15.00 and others Sale of medical and surgical 16.00 16.00 0.00 supplies to other than pati ents 17.00 Sale of drugs to other than 0.00 17.00 pati ents Sale of medical records and 18.00 18.00 0.00 abstracts 19.00 Nursing and allied health 0.00 19.00 education (tuition, fees, books, etc.) Nursing and allied health 19.01 0.00 19.01 education (tuition, fees, books, etc.) Vending machines 20.00 0.00 20.00 Income from imposition of 21 00 0 00 21 00 interest, finance or penalty charges (chapter 21) 22.00 Interest expense on Medicare 0.00 22.00 overpayments and borrowings to repay Medicare overpayments Adjustment for respiratory 23.00 -56, 986 RESPI RATORY THERAPY 23.00 A-8-3 65.00 therapy costs in excess of limitation (chapter 14) Adjustment for physical A-8-3 OPHYSICAL THERAPY 24.00 24.00 66.00 therapy costs in excess of limitation (chapter 14) 0 \*\*\* Cost Center Deleted \*\*\* 25.00 Utilization review 114.00 25.00 physicians' compensation (chapter 21) 26.00 Depreciation - CAP REL OCAP REL COSTS-BLDG & FIXT 1.00 26.00 COSTS-BLDG & FIXT Depreciation - CAP REL OCAP REL COSTS-MVBLE EQUIP 27.00 27.00 2.00 COSTS-MVBLE EQUIP Non-physician Anesthetist 19.00 0 \*\*\* Cost Center Deleted \*\*\* 28.00 Physicians' assistant 0.00 29.00 29.00 Adjustment for occupational 30.00 A-8-3 O OCCUPATIONAL THERAPY 67.00 30.00 therapy costs in excess of limitation (chapter 14)

Expense Classification on Worksheet A   To/From Which the Amount is to be Adjusted   To/From Which the Amount is to be Adjusted					Fr To	om 07/01/2022 0 06/30/2023	Date/Time Pre	pared:
Cost Center Description							1/24/2024 11:	37 am
Cost Center Description								
C2    Ref.     1.00   2.00   3.00   4.00   5.00   5.00					10/From which the Amount is	to be Adjusted		
C2    Ref.     1.00   2.00   3.00   4.00   5.00   5.00								
C2    Ref.     1.00   2.00   3.00   4.00   5.00   5.00								
C2    Ref.     1.00   2.00   3.00   4.00   5.00   5.00								
C2    Ref.     1.00   2.00   3.00   4.00   5.00   5.00								
C2    Ref.     1.00   2.00   3.00   4.00   5.00   5.00								
1.00   2.00   3.00   4.00   5.00   30.09   30.00   30.00   30.00   30.09   30.09   30.09   30.09   30.09   30.09   30.09   30.09   30.09   30.09   30.09   30.00   3		Cost Center Description	Basis/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
30.99   Hospice (non-distinct) (see     0   ADULTS & PEDIATRICS   30.00   30.09   31.00   31.00   31.00   31.00   31.00   32.00   31.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   32.00   33							Ref.	
Instructions    Adjustment for speech   A-8-3   OSPECH PATHOLOGY   68.00   31.00			1. 00				5. 00	
31.00   Adjustment for speech pathology costs in excess of pathology costs in excess of limitation (chapter 14)   32.00   CAH HIT Adjustment for Depreciation and Interest   A	30. 99			0	ADULTS & PEDIATRICS	30. 00		30. 99
Pathology costs in excess of		1		_				
I imitation (chapter 14)	31. 00		A-8-3	0	SPEECH PATHOLOGY	68. 00		31.00
32. 00   CAH HIT Adjustment for   Depreciation and Interest   Depreciation and Inter								
Depreciation and Interest	22 00			0		0.00	0	22.00
33. 00   COMMUNITY BENEFIT	32.00			U		0.00	Ü	32.00
33. 01   MISC INCOME	33 00		Δ	-600	ADMINISTRATIVE & GENERAL	5 03	0	33 00
33.02   RENTAL INCOME							-	
33. 03         BANK CHARGES         B         35, 658 ADMI NI STRATI VE & GENERAL         5. 03         0         33. 03           33. 04         HIS MISC INCOME         B         -3, 837 MEDI CAL RECORDS & LIBRARY         16. 00         0         33. 04           33. 05 LAB MISC INCOME         B         466 LABORATORY         60. 00         0         33. 05           33. 06 ADVERTI SI NG COST         A         -12, 800 ADMI NI STRATI VE & GENERAL         5. 03         0         33. 06           33. 07 DEFINED PENSION ADJUSTMENT         A         -418, 141 EMPLOYEE BENEFITS DEPARTMENT         4. 00         0         33. 06           33. 08 FUND DEVELOPMENT - SALARY         A         1, 922 ADMI NI STRATI VE & GENERAL         5. 03         0         33. 08           33. 10 FUND DEVELOPMENT - OTHER         A         -4, 827 ADMI NI STRATI VE & GENERAL         5. 03         0         33. 09           33. 11 SELF-INS TO HOSP/EMP CLIMS         A         -1, 105, 940 EMPLOYEE BENEFITS DEPARTMENT         4. 00         0         33. 11           33. 12 PHYSI CLAN RECRUIT MENT         A         -1, 105, 940 EMPLOYEE BENEFITS DEPARTMENT         4. 00         0         33. 12           33. 15 LOBBYI NG EXPENSES         A         -2, 14, 34, 389 ADMI NI STRATI VE & GENERAL         5. 03         0         33. 12<							-	1
33. 04								1
33. 05				· ·	1		0	
33. 07 DEFINED PENSION ADJUSTMENT 33. 08 FUND DEVELOPMENT - SALARY A 1, 922 ADMINISTRATIVE & GENERAL 5. 03 0, 33. 08 33. 09 FUND DEVELOPMENT - OTHER A -4, 827 ADMINISTRATIVE & GENERAL 5. 03 0, 33. 08 33. 09 FUND DEVELOPMENT - OTHER A -4, 827 ADMINISTRATIVE & GENERAL 5. 03 0, 33. 08 33. 10 FUND DEVELOPMENT - BENEFITS A 391 EMPLOYEE BENEFITS DEPARTMENT 4. 00 0, 33. 10 33. 11 SELF-INS TO HOSP/EMP CLIMS A -1, 105, 940 EMPLOYEE BENEFITS DEPARTMENT 4. 00 0, 33. 11 33. 12 PHYSICIAN RECRUITMENT A -249, 510 ADMINISTRATIVE & GENERAL 5. 03 0, 33. 12 33. 15 LOBBYING EXPENSES A -1, 743, 389 ADMINISTRATIVE & GENERAL 5. 03 0, 33. 13 33. 16 CHARITABLE CONTRIBUTIONS A -16, 528 ADMINISTRATIVE & GENERAL 5. 03 0, 33. 16 33. 17 NON-PATIENT TRAVEL A -2, 094 CLINIC 90. 00 0, 33. 17 33. 18 ASSET RELIFING-EQUIPMENT A -73, 723 CAP REL COSTS-BLDG & FIXT 1. 00 9, 33. 19 33. 20 GIFTS A -818 ADMINISTRATIVE & GENERAL 5. 03 0, 33. 19 33. 20 GIFTS A -18, 654 ADMINISTRATIVE & GENERAL 5. 03 0, 33. 12 33. 21 GIFTS A -810 ADMINISTRATIVE & GENERAL 5. 03 0, 33. 12 33. 22 GIFTS A -810 ADMINISTRATIVE & GENERAL 5. 03 0, 33. 16 33. 27 APRN PT B SALARIES A -118, 247 CLINIC 90. 00 0, 33. 27	33. 05		В	· ·	1		0	33. 05
33. 08 FUND DEVELOPMENT - SALARY A 1, 922 ADMI NI STRATI VE & GENERAL 5. 03 0 33. 08 33. 09 FUND DEVELOPMENT - OTHER A -4, 827 ADMI NI STRATI VE & GENERAL 5. 03 0 33. 09 33. 10 FUND DEVELOPMENT - BENEFI TS A 391 EMPLOYEE BENEFI TS DEPARTMENT 4. 00 0 33. 11 SELF-INS TO HOSP/EMP CLI MS A -1, 105, 940 EMPLOYEE BENEFI TS DEPARTMENT 4. 00 0 33. 11 SELF-INS TO HOSP/EMP CLI MS A -1, 105, 940 EMPLOYEE BENEFI TS DEPARTMENT 4. 00 0 33. 11 SELF-INS TO HOSP/EMP CLI MS A -1, 105, 940 EMPLOYEE BENEFI TS DEPARTMENT 4. 00 0 33. 11 SELF-INS TO HOSP/EMP CLI MS A -1, 743, 389 ADMI NI STRATI VE & GENERAL 5. 03 0 33. 12 SEMPLOYEE BENEFI TS DEPARTMENT 5. 03 0 33. 12 SEMPLOYEE BENEFI TS DEPARTMENT 5. 03 0 33. 12 SEMPLOYEE BENEFI TS DEPARTMENT 5. 03 0 33. 12 SEMPLOYEE BENEFI TS DEPARTMENT 5. 03 0 33. 12 SEMPLOYEE BENEFI TS DEPARTMENT 5. 03 0 33. 12 SEMPLOYEE BENEFI TS DEPARTMENT 5. 03 0 33. 12 SEMPLOYEE BENEFI TS DEPARTMENT 5. 03 0 33. 12 SEMPLOYEE BENEFI TS DEPARTMENT 5. 03 0 33. 12 SEMPLOYEE BENEFI TS DEPARTMENT 5. 03 0 33. 12 SEMPLOYEE BENEFI TS DEPARTMENT 5. 03 0 33. 12 SEMPLOYEE BENEFI TS DEPARTMENT 5. 03 0 33. 12 SEMPLOYEE BENEFI TS DEPARTMENT 5. 03 0 33. 12 SEMPLOYEE BENEFI TS DEPARTMENT 5. 03 0 33. 15 SEMPLOYEE BENEFI TS DEPARTMENT 5. 03 0 33. 16 SEMPLOYEE BENEFI TS DEPARTMENT 5. 03 0 33. 16 SEMPLOYEE BENEFI TS DEPARTMENT 5. 03 0 33. 16 SEMPLOYEE BENEFI TS DEPARTMENT 5. 03 0 33. 21 SEMPLOYEE BENEFI TS DEPARTMENT 5. 03 0 33. 22 SEMPLOYEE BENEFI TS DEPARTMENT 5. 03 0 33. 22 SEMPLOYEE BENEFI TS DEPARTMENT 5. 03 0 33. 25 SEMPLOYEE BENEFI TS DEPARTMENT 5. 03 0 33. 25 SEMPLOYEE BENEFI TS DEPARTMENT 5. 03 0 33. 25 SEMPLOYEE BENEFI TS DEPARTMENT 5. 00 0 33. 27 SEMPLOYEE BENEFI TS DEPARTMENT 5. 00 0 33. 27 SEMPLOYEE BENEFI TS DEPARTMENT 5. 00 0 33. 27 SEMPLOYEE BENEFI TS DEPARTMENT 5. 00 0 33. 27 SEMPLOYEE BENEFI TS DEPARTMENT 5. 00 0 33. 27 SEMPLOYEE BENEFI TS DEPARTMENT 5. 00 0 33. 27 SEMPLOYEE BENEFI TS DEPARTMENT 5. 00 0 33. 27 SEMPLOYEE BENEFI TS DEPARTMENT 5. 00 0 33. 27 SEMPLOYEE BENEFI TS DEPARTMENT 5. 00 0 33. 27 SEMPLOYEE BEN	33.06	ADVERTISING COST	A	-12, 800	ADMINISTRATIVE & GENERAL	5. 03	0	33.06
33. 09 FUND DEVELOPMENT - OTHER	33.07	DEFINED PENSION ADJUSTMENT	А	-418, 141	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33. 07
33. 10 FUND DEVELOPMENT - BENEFITS A 391 EMPLOYEE BENEFITS DEPARTMENT 4. 00 0 33. 10 33. 11 SELF-INS TO HOSP/EMP CLIMS A -1, 105, 940 EMPLOYEE BENEFITS DEPARTMENT 4. 00 0 33. 11 33. 12 PHYSI CI AN RECRUITMENT A -249, 510 ADMIN IS TRATI VE & GENERAL 5. 03 0 33. 12 33. 13 MEDI CAI D TAX ASSESSMENT A -1, 743, 389 ADMIN IS TRATI VE & GENERAL 5. 03 0 33. 15 10 EMPLOYEE BENEFITS DEPARTMENT 4. 00 0 33. 15 10 EMPLOYEE BENEFITS DEPARTMENT 4. 00 0 33. 11 10 EMPLOYEE BENEFITS DEPARTMENT 4. 00 0 33. 11 10 EMPLOYEE BENEFITS DEPARTMENT 4. 00 0 33. 11 11 EMPLOYEE BENEFITS DEPARTMENT 4. 00 0 33. 11 11 EMPLOYEE BENEFITS DEPARTMENT 4. 00 0 33. 11 11 EMPLOYEE BENEFITS DEPARTMENT 4. 00 0 33. 11 11 EMPLOYEE BENEFITS DEPARTMENT 4. 00 0 33. 11 11 EMPLOYEE BENEFITS DEPARTMENT 4. 00 0 33. 11 11 EMPLOYEE BENEFITS DEPARTMENT 4. 00 0 33. 11 11 EMPLOYEE BENEFITS DEPARTMENT 4. 00 0 33. 11 11 EMPLOYEE BENEFITS DEPARTMENT 4. 00 0 33. 11 11 EMPLOYEE BENEFITS DEPARTMENT 4. 00 0 33. 11 11 EMPLOYEE BENEFITS DEPARTMENT 4. 00 0 33. 11 11 EMPLOYEE BENEFITS DEPARTMENT 4. 00 0 33. 11 11 EMPLOYEE BENEFITS DEPARTMENT 4. 00 0 33. 21 11 EMPLOYEE BENEFITS DEPARTMENT 4. 00 0 33. 22 11 EMPLOYEE BENEFITS DEPARTMENT 4. 00 0 33. 25 11 EMPLOYEE BENEFITS DEPARTMENT 4. 00 0 33. 25 11 EMPLOYEE BENEFITS DEPARTMENT 4. 00 0 33. 25 11 EMPLOYEE BENEFITS DEPARTMENT 4. 00 0 33. 25 11 EMPLOYEE BENEFITS DEPARTMENT 4. 00 0 33. 25 11 EMPLOYEE BENEFITS DEPARTMENT 4. 00 0 33. 25 11 EMPLOYEE BENEFITS DEPARTMENT 4. 00 0 33. 25 11 EMPLOYEE BENEFITS DEPARTMENT 4. 00 0 33. 25 11 EMPLOYEE BENEFITS DEPARTMENT 4. 00 0 33. 25 11 EMPLOYEE BENEFITS DEPARTMENT 4. 00 0 33. 25 11 EMPLOYEE BENEFITS DEPARTMENT 4. 00 0 33. 27 11 EMPLOYEE BENEFITS DEPARTMENT 4. 00 0 33. 27 11 EMPLOYEE BENEFITS DEPARTMENT 4. 00 0 33. 27 11 EMPLOYEE BENEFITS DEPARTMENT 4. 00 0 33. 27 11 EMPLOYEE BENEFITS DEPARTMENT 4. 00 0 33. 27 11 EMPLOYEE BENEFITS DEPARTMENT 4. 00 0 33. 27 11 EMPLOYEE BENEFITS DEPARTMENT 4. 00 0 33. 27 11 EMPLOYEE BENEFITS DEPARTMENT 4. 00 0 33. 27 11 EMPLOYEE BENEFITS DEPARTMENT 4. 00 0 33. 27	33.08	FUND DEVELOPMENT - SALARY	A	1, 922	ADMINISTRATIVE & GENERAL	5. 03	0	33. 08
33. 11   SELF-INS TO HOSP/EMP CLIMS   A   -1, 105, 940   EMPLOYEE BENEFITS DEPARTMENT   4.00   0.33. 11   33. 12   PHYSICIAN RECRUITMENT   A   -249, 510   ADMINISTRATI VE & GENERAL   5.03   0.33. 12   33. 13   MEDICALD TAX ASSESSMENT   A   -1,743, 389   ADMINISTRATI VE & GENERAL   5.03   0.33. 13   33. 15   LOBBYING EXPENSES   A   -26, 314   ADMINISTRATI VE & GENERAL   5.03   0.33. 15   33. 16   CHARI TABLE CONTRIBUTIONS   A   -16, 528   ADMINISTRATI VE & GENERAL   5.03   0.33. 15   33. 17   NON-PATIENT TRAVEL   A   -2, 094   CLINIC   90.00   0.33. 17   33. 18   ASSET RELIFING-BUILDING   A   391, 083   CAP REL COSTS-BLDG & FIXT   1.00   9.33. 18   33. 20   GIFTS   A   -18, 654   ADMINISTRATI VE & GENERAL   5.03   0.33. 20   33. 21   GIFTS   A   -810   NURSING ADMINISTRATI ON   13.00   0.33. 21   33. 22   GIFTS   A   -810   NURSING ADMINISTRATI ON   13.00   0.33. 21   33. 24   TAX PENALTI ES   A   14, 229   ADMINISTRATI VE & GENERAL   5.03   0.33. 22   33. 25   APRN PT B BENEFITS   A   -49, 125 EMPLOYEE BENEFITS DEPARTMENT   4.00   0.33. 25   33. 27   APRN PT B SALARIES   A   -118, 247   CLINIC   90.00   0.33. 27	33. 09	FUND DEVELOPMENT - OTHER	A	-4, 827	ADMINISTRATIVE & GENERAL	5. 03	0	
33. 12 PHYSI CI AN RECRUI TMENT A -249, 510 ADMI NI STRATI VE & GENERAL 5. 03 0 33. 12 33. 13 MEDI CAI D TAX ASSESSMENT A -1, 743, 389 ADMI NI STRATI VE & GENERAL 5. 03 0 33. 13 13 14 15 LOBBYI NG EXPENSES A -26, 314 ADMI NI STRATI VE & GENERAL 5. 03 0 33. 15 15 16 CHARI TABLE CONTRI BUTI ONS A -16, 528 ADMI NI STRATI VE & GENERAL 5. 03 0 33. 16 16 16 16 16 16 17 17 18 18 18 18 18 18 18 18 18 18 18 18 18	33. 10	4	A		l l		0	33. 10
33. 13 MEDI CAI D TAX ASSESSMENT A -1, 743, 389 ADMI NI STRATI VE & GENERAL 5. 03 0 33. 13 33. 15 LOBBYI NG EXPENSES A -26, 314 ADMI NI STRATI VE & GENERAL 5. 03 0 33. 15 33. 16 CHARI TABLE CONTRI BUTI ONS A -16, 528 ADMI NI STRATI VE & GENERAL 5. 03 0 33. 16 33. 17 NON-PATI ENT TRAVEL A -2, 094 CLI NI C 90. 00 0 33. 17 33. 18 ASSET RELI FI NG-BUIL DI NG A 391, 083 CAP REL COSTS-BLDG & FI XT 1. 00 9 33. 18 33. 19 ASSET RELI FI NG-EQUI PMENT A -73, 723 CAP REL COSTS-MVBLE EQUI P 2. 00 9 33. 19 33. 20 GI FTS A -18, 654 ADMI NI STRATI VE & GENERAL 5. 03 0 33. 20 33. 21 GI FTS A -810 NURSI NG ADMI NI STRATI ON 13. 00 0 33. 21 33. 22 GI FTS A -344 ONCOLOGY CLI NI C 90. 01 0 33. 22 33. 23 MED GROUP PURCHSED SERVI CES A 9, 400 ADMI NI STRATI VE & GENERAL 5. 03 0 33. 23 33. 24 TAX PENALTI ES A -49, 125 EMPLOYEE BENEFI TS DEPARTMENT 4. 00 0 33. 25 33. 26 APRN PT B BALARI ES A -118, 247 CLI NI C 90. 00 0 33. 27		•					-	
33. 15 LOBBYING EXPENSES A -26, 314 ADMINISTRATIVE & GENERAL 5. 03 0 33. 15 33. 16 CHARITABLE CONTRIBUTIONS A -16, 528 ADMINISTRATIVE & GENERAL 5. 03 0 33. 16 33. 17 NON-PATIENT TRAVEL A -2, 094 CLINIC 90. 00 0 33. 17 33. 18 ASSET RELIFING-BUILDING A 391, 083 CAP REL COSTS-BLDG & FIXT 1. 00 9 33. 18 33. 19 ASSET RELIFING-EQUIPMENT A -73, 723 CAP REL COSTS-MVBLE EQUIP 2. 00 9 33. 19 33. 20 GIFTS A -18, 654 ADMINISTRATIVE & GENERAL 5. 03 0 33. 20 33. 21 GIFTS A -810 NURSING ADMINISTRATION 13. 00 0 33. 21 33. 22 GIFTS A -344 ONCOLOGY CLINIC 90. 01 0 33. 22 33. 23 MED GROUP PURCHSED SERVICES A 9, 400 ADMINISTRATIVE & GENERAL 5. 03 0 33. 23 33. 24 TAX PENALTIES A -49, 125 EMPLOYEE BENEFITS DEPARTMENT 4. 00 0 33. 25 33. 26 APRN PT B SALARIES A -122, 918 WOUND CARE 76. 00 0 33. 27 33. 27 APRN PT B SALARIES A -118, 247 CLINIC 90. 00 0 33. 27		4						1
33. 16 CHARI TABLE CONTRI BUTI ONS A -16, 528 ADMI NI STRATI VE & GENERAL 5. 03 0 33. 16 33. 17 NON-PATI ENT TRAVEL A 391, 083 CAP REL COSTS-BLDG & FIXT 1. 00 9 33. 18 33. 19 ASSET RELIFING-BUILDING A 391, 083 CAP REL COSTS-BLDG & FIXT 1. 00 9 33. 18 33. 20 GIFTS A -73, 723 CAP REL COSTS-MVBLE EQUIP 2. 00 9 33. 19 33. 21 GIFTS A -810 NURSI NG ADMI NI STRATI VE & GENERAL 5. 03 0 33. 21 33. 22 GIFTS A -810 NURSI NG ADMI NI STRATI ON 13. 00 0 33. 21 33. 23 MED GROUP PURCHSED SERVI CES A 9, 400 ADMI NI STRATI VE & GENERAL 5. 03 0 33. 22 33. 24 TAX PENALTI ES A 14, 229 ADMI NI STRATI VE & GENERAL 5. 03 0 33. 24 33. 25 APRN PT B BENEFI TS A -49, 125 EMPLOYEE BENEFI TS DEPARTMENT 4. 00 0 33. 25 33. 26 APRN PT B SALARI ES A -118, 247 CLI NI C 90. 00 0 33. 27		•					-	
33. 17 NON-PATIENT TRAVEL A -2, 094 CLINIC 90.00 0 33. 17 33. 18 ASSET RELIFING-BUILDING A 391, 083 CAP REL COSTS-BLDG & FIXT 1. 00 9 33. 18 33. 19 ASSET RELIFING-EQUIPMENT A -73, 723 CAP REL COSTS-MVBLE EQUIP 2. 00 9 33. 19 33. 20 GIFTS A -18, 654 ADMINISTRATIVE & GENERAL 5. 03 0 33. 20 33. 21 GIFTS A -810 NURSING ADMINISTRATION 13. 00 0 33. 21 33. 22 GIFTS A 9, 400 ADMINISTRATIVE & GENERAL 5. 03 0 33. 22 33. 23 MED GROUP PURCHSED SERVICES A 9, 400 ADMINISTRATIVE & GENERAL 5. 03 0 33. 22 33. 24 TAX PENALTIES A 14, 229 ADMINISTRATIVE & GENERAL 5. 03 0 33. 24 33. 25 APRN PT B BENEFITS A -49, 125 EMPLOYEE BENEFITS DEPARTMENT 4. 00 0 33. 25 33. 26 APRN PT B SALARIES A -118, 247 CLINIC 90. 00 0 33. 27				· ·	l l		-	
33. 18							-	
33. 19 ASSET RELIFING-EQUIPMENT A -73, 723 CAP REL COSTS-MVBLE EQUIP 2. 00 9 33. 19 33. 20 GI FTS A -18, 654 ADMINISTRATI VE & GENERAL 5. 03 0 33. 20 33. 21 GI FTS A -810 NURSI NG ADMINISTRATI ON 13. 00 0 33. 21 33. 22 GI FTS A -344 ONCOLOGY CLINIC 90. 01 0 33. 22 33. 23 MED GROUP PURCHSED SERVICES A 9, 400 ADMINISTRATI VE & GENERAL 5. 03 0 33. 23 33. 24 TAX PENALTI ES A 14, 229 ADMINISTRATI VE & GENERAL 5. 03 0 33. 23 33. 25 APRN PT B BENEFITS A -49, 125 EMPLOYEE BENEFITS DEPARTMENT 4. 00 0 33. 25 33. 26 APRN PT B SALARI ES A -122, 918 WOUND CARE 76. 00 0 33. 27 33. 27 APRN PT B SALARI ES A -118, 247 CLINIC 90. 00 0 33. 27							-	
33. 20       GIFTS       A       -18, 654 ADMINISTRATIVE & GENERAL       5. 03       0 33. 20         33. 21       GIFTS       A       -810 NURSING ADMINISTRATION       13. 00       0 33. 21         33. 22       GIFTS       A       -344 ONCOLOGY CLINIC       90. 01       0 33. 22         33. 24       MDRORUP PURCHSED SERVICES       A       9, 400 ADMINISTRATIVE & GENERAL       5. 03       0 33. 23         33. 24       TAX PENALTIES       A       14, 229 ADMINISTRATIVE & GENERAL       5. 03       0 33. 25         33. 25       APRN PT B BENEFITS       A       -49, 125 EMPLOYEE BENEFITS DEPARTMENT       4. 00       0 33. 25         33. 26       APRN PT B SALARIES       A       -112, 918 WOUND CARE       76. 00       0 33. 27         33. 27       APRN PT B SALARIES       A       -118, 247 CLINIC       90. 00       0 33. 27								
33. 21       33. 21         33. 22       GIFTS       A       -810 NURSING ADMINISTRATION       13. 00       0       33. 21         33. 22       GIFTS       A       -344 ONCOLOGY CLINIC       90. 01       0       33. 22         33. 23       MED GROUP PURCHSED SERVICES       A       9, 400 ADMINISTRATIVE & GENERAL       5. 03       0       33. 23         33. 24       TAX PENALTIES       A       14, 229 ADMINISTRATIVE & GENERAL       5. 03       0       33. 24         33. 25       APRN PT B B BENEFITS       A       -49, 125 EMPLOYEE BENEFITS DEPARTMENT       4. 00       0       33. 25         33. 27       APRN PT B SALARIES       A       -112, 918 WOUND CARE       76. 00       0       33. 26         33. 27       APRN PT B SALARIES       A       -118, 247 CLINIC       90. 00       0       33. 27		4						
33. 22       GIFTS       A       -344 ONCOLOGY CLINIC       90. 01       0 33. 22         33. 23       MED GROUP PURCHSED SERVICES       A       9, 400 ADMINISTRATIVE & GENERAL       5. 03       0 33. 23         33. 24       TAX PENALTIES       A       14, 229 ADMINISTRATIVE & GENERAL       5. 03       0 33. 24         33. 25       APRN PT B BENEFITS       A       -49, 125 EMPLOYEE BENEFITS DEPARTMENT       4. 00       0 33. 25         33. 26       APRN PT B SALARIES       A       -122, 918 WOUND CARE       76. 00       0 33. 26         33. 27       APRN PT B SALARIES       A       -118, 247 CLINIC       90. 00       0 33. 27								
33. 23 MED GROUP PURCHSED SERVICES A 9, 400 ADMINISTRATIVE & GENERAL 5. 03 0 33. 23 33. 24 TAX PENALTIES A 14, 229 ADMINISTRATIVE & GENERAL 5. 03 0 33. 24 33. 25 APRN PT B BENEFITS A -49, 125 EMPLOYEE BENEFITS DEPARTMENT 4. 00 0 33. 25 33. 26 APRN PT B SALARIES A -112, 918 WOUND CARE 76. 00 0 33. 26 33. 27 APRN PT B SALARIES A -118, 247 CLINIC 90. 00 0 33. 27					1		-	
33. 24     TAX PENALTIES     A     14, 229 ADMINISTRATIVE & GENERAL     5. 03     0 33. 24       33. 25     APRN PT B BENEFITS     A     -49, 125 EMPLOYEE BENEFITS DEPARTMENT     4. 00     0 33. 25       33. 26     APRN PT B SALARIES     A     -122, 918 WOUND CARE     76. 00     0 33. 26       33. 27     APRN PT B SALARIES     A     -118, 247 CLINIC     90. 00     0 33. 27					1		-	
33. 25 APRN PT B BENEFITS A -49, 125 EMPLOYEE BENEFITS DEPARTMENT 4. 00 0 33. 25 33. 26 APRN PT B SALARIES A -122, 918 WOUND CARE 76. 00 0 33. 26 33. 27 APRN PT B SALARIES A -118, 247 CLINIC 90. 00 0 33. 27				· ·	1		-	
33. 26 APRN PT B SALARIES A -122, 918 WOUND CARE 76. 00 0 33. 26 33. 27 APRN PT B SALARIES A -118, 247 CLINIC 90. 00 0 33. 27		APRN PT B BENEFITS	Α	· ·	1		0	33. 25
	33. 26		A	-122, 918	WOUND CARE	76. 00	0	33. 26
33. 28   ADVERTISING COST   A   -415   NURSING ADMINISTRATION   13. 00   0   33. 28			A		1		0	33. 27
	33. 28	ADVERTISING COST	A	-415	NURSING ADMINISTRATION	13. 00	0	33. 28
50.00 TOTAL (sum of lines 1 thru 49) -8,891,059 50.00	50.00	TOTAL (sum of lines 1 thru 49)		-8, 891, 059				50.00
(Transfer to Worksheet A,		*						
column 6, line 200.)  (1) Description all chapter references in this column portain to CMS Rub. 15.1		•						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: 14-1350

Worksheet A-8-1 From 07/01/2022

				To 06/30/2023		
	Li ne No.	Cost Center	Expense Items	Amount of	1/24/2024 11: Amount	37 am
	Little No.	Cost Center	Expense i tells	Allowable Cost		
					Wks. A, column	
					5 5	
	1.00	2. 00	3.00	4. 00	5. 00	
	A. COSTS INCURRED AND ADJUSTI	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED O	RGANI ZATI ONS OF	CLAIMED HOME	
	OFFICE COSTS:					
1.00	4. 00	EMPLOYEE BENEFITS DEPARTMENT	HEALTH & DENTAL PREMIUM	3, 398, 815	3, 399, 350	1.00
2.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HR FEE	84, 341	234, 300	2.00
3.00	5. 03	ADMINISTRATIVE & GENERAL	CONTRACTED SERVICES - ISC	2, 256, 003	1, 551, 972	3.00
3. 01	5. 01	ADMITTI NG	SBO FEES - ADMITTING	189, 913	0	3. 01
3. 02	5. 02	PATIENT ACCOUNTING	SBO FEES - PATIENT ACCOUNTIN	725, 656	0	3.02
3.03	5. 03	ADMINISTRATIVE & GENERAL	SBO FEES - A&G	0	2, 422, 476	3.03
3.04	16.00	MEDICAL RECORDS & LIBRARY	SBO FEES - MEDICAL RECORDS	518, 817	0	3.04
3.05	5. 03	ADMINISTRATIVE & GENERAL	CONTRACTED SERVICES - SSC	1, 355, 288	1, 114, 224	3.05
3.06			PURCHASED SERVICES	0	82, 552	3.06
3.07	5. 03	ADMINISTRATIVE & GENERAL	HSHS IL HOME OFFICE - OTHER	475, 815	561, 675	3.07
3.08	5. 03	ADMINISTRATIVE & GENERAL	HSHS IL HOME OFFICE - LIBRAR	12, 920	11, 095	3.08
4.00	8.00	LAUNDRY & LINEN SERVICE	LAUNDRY	107, 740	132, 346	4.00
5.00	TOTALS (sum of lines 1-4).			9, 125, 308	9, 509, 990	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.

				Rel ated Organi zati on(s) and/	or Home Office	
	Symbol (1)	Name	Percentage of	Name	Percentage of	
			Ownershi p		Ownershi p	
	1. 00	2. 00	3. 00	4. 00	5. 00	
-	B. INTERRELATIONSHIP TO RELATE	TED ORGANIZATION(S) AND/OR HO	OME OFFICE:			

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

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

i ci ilibai	Schieff dider title XVIII.					
6.00	В	HSHS	100.00	HSHS	100.00	6. 00
7.00			0.00		0. 00	7.00
8.00			0.00		0. 00	8.00
9.00			0.00		0. 00	9.00
10.00			0.00		0. 00	10.00
100.00	G. Other (financial or					100.00
	non-financial) specify:					

- (1) Use the following symbols to indicate interrelationship to related organizations:
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- 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		ST. FRANCIS HOSP	PLTAL	In lieu	of Form CMS-	2552-10
STATEME	ENT OF COSTS OF		ROM F		rovi der CCN: 14-1350	Peri od:	Worksheet A-8	
OFFICE COSTS						From 07/01/2022 To 06/30/2023	Date/Time Pre	epared: 37 am
	Net	Wkst. A-7 F	Ref.	· · · · · ·				
	Adjustments							
	(col. 4 minus							
	col. 5)*							
	6. 00	7. 00						
	A. COSTS INCUR	RED AND ADJ	USTM	ENTS REQUIRED AS A RESULT OF TRANS	SACTIONS WITH RELATED (	ORGANI ZATI ONS OR	CLAIMED HOME	
	OFFICE COSTS:							
1.00	-535		0					1.00
2.00	-149, 959		0					2.00
3.00	704, 031		0					3.00
3. 01	189, 913		0					3. 01
3. 02	725, 656		o					3.02
3.03	-2, 422, 476		o					3.03
3.04	518, 817		o					3.04
3. 05	241, 064	1	o					3.05
3. 06	-82, 552	1	0					3.06
3. 07	-85, 860	1	o					3. 07
3. 08	1, 825		0					3. 08
4. 00	-24, 606		0					4. 00

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

5.00

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

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

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

	Sement under tritle xviii.		
	CORPORATE	6.	. 00
7.00		7.	7. 00
8.00		8.	3. 00
7. 00 8. 00 9. 00		9.	9. 00
10. 00 100. 00		10.	0. 00
100.00		100.	). 00

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

5.00

-384, 682

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-1350

Peri od: Worksheet A-8-2 From 07/01/2022 To 06/30/2023 Date/Time Prepared:

1/24/2024 11:37 am Wkst. A Line # Cost Center/Physician Total Professi onal Provi der RCE Amount Physi ci an/Prov I denti fi er der Component Remuneration Component Component Hours 1.00 2.00 4.00 5. 00 3 00 6 00 7 00 1.00 5. 03 ADMINI STRATI VE & GENERAL 41,609 41,609 1.00 2.00 90. 00 CLI NI C 1, 072, 323 1,072,323 0 0 2.00 90. 01 ONCOLOGY CLINIC 3.00 640, 475 640, 475 0 0 0 0 0 3.00 0 30.00 ADULTS & PEDIATRICS 31,000 31, 000 4 00 4 00 0 91. 00 EMERGENCY 5.00 48,000 48,000 0 5.00 6.00 91. 00 EMERGENCY 1, 598, 370 761, 828 836, 542 6.00 76. 00 WOUND CARE 7.00 -1,050 -1, 050 0 0 0 0 7.00 53. 00 ANESTHESI OLOGY 8.00 1, 429, 189 0 1, 429, 189 8.00 0 50. 00 OPERATING ROOM 9.00 272, 571 272, 571 0 9.00 10.00 65. 00 RESPIRATORY THERAPY 204, 989 204, 989 0 0 0 10.00 0 5. 03 ADMI NI STRATI VE & GENERAL 0 11.00 388 388 11.00 0 5. 03 ADMI NI STRATI VE & GENERAL 4,500 4, 500 0 12.00 0 12.00 72, 570 13.00 90. 01 ONCOLOGY CLINIC 72,570 0 13.00 14.00 60. 00 LABORATORY 55,000 45, 904 9,096 0 14.00 5, 469, 934 ol 200.00 4, 457, 229 1,012,705 200.00 Cost of Physician Cost Wkst. A Line # Cost Center/Physician Unadjusted RCE 5 Percent of Provi der I denti fi er Unadjusted RCE Memberships & of Mal practice Li mi t Component Conti nui ng Limit Share of col Insurance Educati on 12 8. 00 9. 00 14.00 1. 00 2 00 13. 00 12.00 1.00 5. 03 ADMINISTRATIVE & GENERAL 0 0 1.00 0 0 2.00 90. 00 CLI NI C 0 0 0 0 0 2.00 90. 01 ONCOLOGY CLINIC 0 0 0 3 00 0 3 00 30.00 ADULTS & PEDIATRICS 0 4.00 0 0 0 4.00 5.00 91. 00 EMERGENCY 0 0 5.00 91. 00 EMERGENCY 0 6.00 0 0 0 0 6.00 0 76. 00 WOUND CARE 0 7 00 0 7 00 53. 00 ANESTHESI OLOGY 0 8.00 0 0 8.00 0 9.00 50. 00 OPERATING ROOM o 0 9.00 0 65. 00 RESPIRATORY THERAPY 0 0 0 10.00 10.00 0 01 0 11.00 5. 03 ADMINISTRATIVE & GENERAL 11.00 12.00 5. 03 ADMINI STRATI VE & GENERAL 0 0 0 12.00 90. 01 ONCOLOGY CLINIC o 0 13.00 13.00 0 14.00 60. 00 LABORATORY C 14.00 0 0 200.00 200.00 Wkst. A Line # Cost Center/Physician Provi der Adjusted RCE RCE Adjustment Component I denti fi er Li mi t Di sal I owance Share of col. 14 1.00 2.00 15.00 16.00 17.00 18.00 1.00 5. 03 ADMI NI STRATI VE & GENERAL 0 0 0 1.00 0 2.00 90. 00 CLI NI C 0 0 1,072,323 2.00 O 90. 01 ONCOLOGY CLINIC 640, 475 3 00 0 0 3 00 4.00 30.00 ADULTS & PEDIATRICS 0 0 0 31,000 4.00 5.00 91. 00 EMERGENCY o 5.00 0 91. 00 EMERGENCY 0 6.00 0 761,828 6.00 0 7.00 76. 00 WOUND CARE -1,050 0 7 00 8.00 53. 00 ANESTHESI OLOGY 0 0 0 1, 429, 189 8.00 50. 00 OPERATING ROOM o 272, 571 9.00 9.00 0 204, 989 65. 00 RESPIRATORY THERAPY 0 10.00 10.00 0 11.00 5. 03 ADMI NI STRATI VE & GENERAL 0 0 C 11 00 12.00 5. 03 ADMINI STRATI VE & GENERAL 0 12.00 90. 01 ONCOLOGY CLINIC 0 0 13.00 0 0 13.00 60. 00 LABORATORY 0 14.00 0 0 45.904 14.00 200.00 4, 457, 229 200.00

REASON	Financial Systems ABLE COST DETERMINATION FOR THERAPY SERVICES E SUPPLIERS	ST. FRANCIS I FURNISHED BY	Provi der CC	CN: 14-1350	Peri od: From 07/01/2022	u of Form CMS-2 Worksheet A-8 Parts I-VI	-3
					To 06/30/2023	1/24/2024 11:	
					Physical Therapy	Cost	
						1. 00	
1. 00	PART I - GENERAL INFORMATION  Total number of weeks worked (excluding aide	s) (see instruct	ions)			52	1. 00
2. 00 3. 00 4. 00	Line 1 multiplied by 15 hours per week Number of unduplicated days in which supervi Number of unduplicated days in which therapy	sor or therapist assistant was c	was on provi			780 0 0	2. 00 3. 00 4. 00
. 00	nor therapist was on provider site (see inst Number of unduplicated offsite visits - supe Number of unduplicated offsite visits - ther assistant and on which supervisor and/or the	rvisors or thera apy assistants (	include only	visits made		0	5. 00 6. 00
. 00	instructions) Standard travel expense rate	aprot mas not p	n ocone dan me	,	,,, (555	5. 78	7. 00
3. 00	Optional travel expense rate per mile					0. 00	8. 00
		Supervi sors 1.00	Therapists 2.00	Assi stants 3.00	Ai des 4.00	Trai nees 5. 00	
. 00	Total hours worked	6, 195. 50	0.00	4, 639. 2		0.00	9. 00
1. 00	AHSEA (see instructions) Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	128. 46 0. 00	0. 00 0. 00	71. 3 35. 6	68	0.00	11. 00
	Number of travel hours (provider site)	0	0		0		12.00
	Number of travel hours (offsite) Number of miles driven (provider site)	0	0		0		12. 01 13. 00
	Number of miles driven (offsite)	0	0		0		13. 01
						1. 00	
	Part II - SALARY EQUIVALENCY COMPUTATION					1.00	
	Supervisors (column 1, line 9 times column 1					795, 874	
5. 00 6. 00	Therapists (column 2, line 9 times column 2, Assistants (column 3, line 9 times column 3,					0 331, 057	15. 00 16. 00
7. 00	Subtotal allowance amount (sum of lines 14 a		atory therapy	or lines 14	l-16 for all	1, 126, 931	17.00
3. 00	others) Aides (column 4, line 9 times column 4, line	10)				0	18. 00
	Trainees (column 5, line 9 times column 5, l					0	19.00
0. 00	Total allowance amount (sum of lines 17-19 f	or respiratory t	herapy or lir	nes 17 and 18	for all others)	1, 126, 931	20.00
	If the sum of columns 1 and 2 for respiratory occupational therapy, line 9, is greater than						
	amount from line 20. Otherwise complete line	es 21-23.					
1.00	Weighted average rate excluding aides and tr			um of columns	s 1 and 2, line 9	0.00	21. 00
2. 00	for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and train					0	22. 00
	Total salary equivalency (see instructions)	·				1, 126, 931	
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance	NANCE AND TRAVEL	EXPENSE COMP	PUTATION - PR	ROVI DER SITE		
1. 00	Therapists (line 3 times column 2, line 11)					0	24.00
5. 00	Assistants (line 4 times column 3, line 11)					0	25.00
	Subtotal (line 24 for respiratory therapy or				3 and 4 for all	0	26. 00 27. 00
. 00	Standard travel expense (line 7 times line 3 others)	roi respiratory	r therapy or s	sull OI IINES	s and 4 TOF all	O	∠1.UC
3. 00	Total standard travel allowance and standard 27)	·	at the provio	der site (sum	n of lines 26 and	0	28. 00
9. 00	Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum		1 2, line 12 )	)		0	29. 00
0. 00	Assistants (column 3, line 10 times column 3	, line 12)	•			0	30.00
	Subtotal (line 29 for respiratory therapy or				w or sum of	0	31.00
. 00	Optional travel expense (line 8 times column columns 1-3, line 13 for all others)	s i aliu Z, IINE	is for respir	atory therap	y OI SUIII OI	0	32.00
	Standard travel allowance and standard trave					0	33.00
	Optional travel allowance and standard trave					0	34.00
J. UU	Optional travel allowance and optional trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW				RVICES OUTSIDE PR		35. 00
	Standard Travel Expense						
5.00	Therapists (line 5 times column 2, line 11)					0	36.00
7. 00 8. 00	Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37)					0	37. 00 38. 00
	, (					O I	

	ABLE COST DETERMINATION FOR THERAPY SERVICES E SUPPLIERS	FURNI SHED BY	Provi der CO		Peri od: From 07/01/2022 To 06/30/2023	1/24/2024 11:	pared:
					Physi cal Therapy	Cost	
						1. 00	
5. 00	Optional travel allowance and optional travel						46.00
	•	Therapists 1.00	Assi stants 2.00	Ai des 3. 00	Trai nees 4.00	Total 5. 00	
	PART V - OVERTIME COMPUTATION	1.00	2.00	3.00	4.00	3.00	
	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not	0.00	0. 00	0. (	0.00	0.00	47.00
	complete lines 48-55 and enter zero in each column of line 56)						
3. 00	Overtime rate (see instructions)	0.00	0. 00	0. 0	0.00		48.00
	Total overtime (including base and overtime	0.00	0.00	0. (			49.00
	allowance) (multiply line 47 times line 48)						
	CALCULATION OF LIMIT						
0. 00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5,	0.00	0. 00	0. (	0.00	0.00	50.00
1. 00	line 47) Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0. 00	0. (	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						1
	Adjusted hourly salary equivalency amount (see instructions)	0. 00	71. 36	0. (	0.00		52.0
. 00	Overtime cost limitation (line 51 times line 52)	0	0		0 0		53.0
. 00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0		0 0		54.0
5. 00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0		0 0		55.0
5. 00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5	0	0		0 0	0	56. 0
	the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)						
						1. 00	
	Part VI - COMPUTATION OF THERAPY LIMITATION A	ND EXCESS COST	ADJUSTMENT				
	Salary equivalency amount (from line 23)	(f 1: 22	24 25))			1, 126, 931	
	Travel allowance and expense - provider site Travel allowance and expense - Offsite servio					0	58. 0 59. 0
0.00	Overtime allowance (from column 5, line 56)	Les (II OIII II II Ies	44, 45, 01 40	)		0	60.0
	Equipment cost (see instructions)					0	61.0
	Supplies (see instructions)					0	
	Total allowance (sum of lines 57-62)					1, 126, 931	
	Total cost of outside supplier services (from	n vour records)				904, 150	
	Excess over limitation (line 64 minus line 63		enter zero)			0	1
	LINE 33 CALCULATION						
	Line 26 = line 24 for respiratory therapy or						100.0
	Line 27 = line 7 times line 3 for respiratory	, therapy or sum	of lines 3 a	and 4 for all	others		100.0
0. 02	Line 33 = line 28 = sum of lines 26 and 27					0	100. 0
1 00	Line 27 = line 7 times line 3 for respirator	therany or sum	of lines 3 a	and 4 for all	others	0	1 101. 0
	Line 31 = line 29 for respiratory therapy or				others		101.0
	Line 34 = sum of lines 27 and 31	54iii 01 111163 27	and 50 101 6	ar a Others			101. 0
02	LINE 35 CALCULATION						1.50
	Line 31 = line 29 for respiratory therapy or	sum of lines 20	and 30 for a	all others		0	102. 0
2.00	Line 31 - Time 27 for respiratory therapy or	30III 01 1111C3 27	and so for a	iii otners		U	
	Line 32 = line 8 times columns 1 and 2, line				umns 1-3, line		102.0

литеи г	IABLE COST DETERMINATION FOR THERAPY SERVICES DE SUPPLIERS	FURNI SHED BY	Provider CCN: 14-13		/01/2022	Worksheet A-8 Parts I-VI	-3
JUISIL	JE SUPPLIERS				/30/2023	Date/Time Pre	
					ratory rapy	Cost	<u> </u>
					,	1.00	
	PART I - GENERAL INFORMATION					1. 00	
1. 00 2. 00	Total number of weeks worked (excluding aide Line 1 multiplied by 15 hours per week	s) (see instruct	i ons)			22 330	1.00 2.00
2. 00 3. 00 4. 00	Number of unduplicated days in which supervi Number of unduplicated days in which therapy					0	3.00
5. 00	nor therapist was on provider site (see inst Number of unduplicated offsite visits - supe	ructions)	•	·		0	5.0
5. 00	Number of unduplicated offsite visits - ther assistant and on which supervisor and/or the instructions)	apy assistants (	include only visits	madé by thera	ару	0	6.0
7.00	Standard travel expense rate					5. 78	7.0
3. 00	Optional travel expense rate per mile	Supervi sors	Therapists Assist	ants Ai	des	0.00 Trai nees	8.00
2.00	Transition of the control of the con	1.00	2.00 3.0		. 00	5. 00	0.0
9. 00 10. 00	Total hours worked AHSEA (see instructions)	0. 00 0. 00	656. 00 74. 73	0. 00 0. 00	0. 00 0. 00	0. 00 0. 00	9. 00 10. 00
11. 00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	37. 37	37. 37	0. 00			11.00
12.00	Number of travel hours (provider site)	О	О	0			12.0
12. 01 13. 00	Number of travel hours (offsite) Number of miles driven (provider site)	0	0	0			12. 0° 13. 00
13. 01	Number of miles driven (offsite)						13.0
						1. 00	
4 00	Part II - SALARY EQUIVALENCY COMPUTATION Supervisors (column 1, line 9 times column 1	Lino 10)				0	14.0
5. 00	Therapists (column 2, line 9 times column 2,					49, 023	
6. 00 7. 00	Assistants (column 3, line 9 times column 3, Subtotal allowance amount (sum of lines 14 a		ratory thorany or lin	oc 14 14 for		0 49, 023	16. 0 17. 0
	others)	·	atory therapy or ith	es 14-10 101	all	49, 023	
18. 00 19. 00	Aides (column 4, line 9 times column 4, line Trainees (column 5, line 9 times column 5, l					0	18. 00 19. 00
20.00	Total allowance amount (sum of lines 17-19 f	or respiratory t				49, 023	
	If the sum of columns 1 and 2 for respirator occupational therapy, line 9, is greater tha						
01 00	amount from line 20. Otherwise complete line	es 21-23.					21 0
21.00	Weighted average rate excluding aides and tr for respiratory therapy or columns 1 thru 3,			rumns rand 2	z, rine 9	0.00	21.00
22. 00 23. 00	Weighted allowance excluding aides and train Total salary equivalency (see instructions)	ees (line 2 time	es line 21)			0 49, 023	22. 00 23. 00
23. 00	PART III - STANDARD AND OPTIONAL TRAVEL ALLO	WANCE AND TRAVEL	EXPENSE COMPUTATION	- PROVIDER S	SITE	47, 023	25.00
24 00	Standard Travel Allowance Therapists (line 3 times column 2, line 11)					0	24.00
25. 00	Assistants (line 4 times column 3, line 11)					Ö	25.00
26. 00 27. 00	Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3				for all	0	26. 00 27. 00
	others)		. ,				
28. 00	Total standard travel allowance and standard 27)	·	at the provider site	(Sum of TIN	=5 26 and	0	28.00
29. 00	Optional Travel Allowance and Optional Trave Therapists (column 2, line 10 times the sum		1.2 line 12.)			0	29. 0
30.00	Assistants (column 3, line 10 times column 3		1 2, 1111e 12 )			0	30.0
31.00	Subtotal (line 29 for respiratory therapy or					0	31.00
32. 00	Optional travel expense (line 8 times column columns 1-3, line 13 for all others)	s i and 2, iine	is for respiratory t	nerapy or sur	n or	0	32.00
33.00	Standard travel allowance and standard travel Optional travel allowance and standard trave					0	33. 00 34. 00
34. 00 35. 00	Optional travel allowance and optional trave	, ,	,			0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW	ANCE AND TRAVEL	EXPENSE COMPUTATION	- SERVICES OU	JTSI DE PR	OVIDER SITE	
	Standard Travel Expense Therapists (line 5 times column 2, line 11)					0	36.00
36. 00	Assistants (line 6 times column 3, line 11)					0	37.00
37. 00	Subtotal (sum of 1: 200 24 200 27)					0	38. 00 39. 00
36. 00 37. 00 38. 00 39. 00	Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the su	m of Lines 5 and	1 6)				
37. 00 38. 00 39. 00	Standard travel expense (line 7 times the su Optional Travel Allowance and Optional Trave	Expense					1000
37. 00 38. 00 39. 00	Standard travel expense (line 7 times the su Optional Travel Allowance and Optional Trave Therapists (sum of columns 1 and 2, line 12.	Expense 01 times column				0	40. 00 41. 00
37. 00 38. 00 39. 00 40. 00 41. 00 42. 00	Standard travel expense (line 7 times the su Optional Travel Allowance and Optional Trave Therapists (sum of columns 1 and 2, line 12. Assistants (column 3, line 12.01 times colum Subtotal (sum of lines 40 and 41)	Expense 01 times column n 3, line 10)	2, line 10)			0 0 0	41. 00 42. 00
37. 00 38. 00 39. 00 40. 00 41. 00	Standard travel expense (line 7 times the su Optional Travel Allowance and Optional Trave Therapists (sum of columns 1 and 2, line 12. Assistants (column 3, line 12.01 times colum	Expense 01 times column n 3, line 10) m of columns 1-3	2, line 10) 3, line 13.01)	e followina :	three lin	0 0 0 0	41.0

	ABLE COST DETERMINATION FOR THERAPY SERVICES E SUPPLIERS	FURNI SHED BY	Provi der C	CN: 14-1350	Peri od: From 07/01/2022 To 06/30/2023		pared:
					Respi ratory Therapy	Cost	
						1. 00	
45. 00	Optional travel allowance and standard trave	expense (sum	of lines 39 a	nd 42 - see i	nstructions)	0	45.00
46. 00	Optional travel allowance and optional trave		of lines 42 a				46.00
	•	Therapi sts 1.00	Assi stants 2.00	Ai des 3.00	Trai nees 4.00	Total 5. 00	
	PART V - OVERTIME COMPUTATION	1.00	2.00	3.00	4.00	5.00	
7. 00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each	148. 00	0.00	0.0	0.00	148. 00	47.00
8. 00	column of line 56) Overtime rate (see instructions)	112. 10	0. 00	0. (	0. 00		48. 00
9.00	Total overtime (including base and overtime	16, 590. 80	0.00				49.00
7. 00	allowance) (multiply line 47 times line 48) CALCULATION OF LIMIT	10, 070. 00	0.00		0.00		
0. 00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	100. 00	0. 00	0.0	0. 00	100.00	50.00
1. 00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	2, 080. 00	0.00	0.0	0.00	2, 080. 00	51.00
2. 00	DETERMINATION OF OVERTIME ALLOWANCE Adjusted hourly salary equivalency amount	74. 73	0.00	0.0	0. 00		52. 00
3. 00	(see instructions) Overtime cost limitation (line 51 times line		0		0 0		53.00
4. 00	52) Maximum overtime cost (enter the lesser of line 49 or line 53)	16, 591	0		0 0		54.00
5. 00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	11, 060	0		0 0		55.00
6. 00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for	5, 531	0		0 0	5, 531	56.00
	respiratory therapy and columns 1 through 3 for all others.)						
						1. 00	
	Part VI - COMPUTATION OF THERAPY LIMITATION A	AND EXCESS COST	ADJUSTMENT				
	Salary equivalency amount (from line 23)	<b></b>				49, 023	
8. 00 9. 00	Travel allowance and expense - provider site Travel allowance and expense - Offsite servio			6)		0	58. 00 59. 00
	Overtime allowance (from column 5, line 56)	203 (110 111102	, , , , , , , , , , , ,	3)		5, 531	
1. 00	Equipment cost (see instructions)					0	
	Supplies (see instructions)					0	
	Total allowance (sum of lines 57-62)	m value essands)				54, 554	
	Total cost of outside supplier services (from Excess over limitation (line 64 minus line 65)					111, 540 56, 986	
3. 00	LINE 33 CALCULATION	3 - 11 Hegative	e, enter zero)			30, 700	05.00
00.00	Line 26 = line 24 for respiratory therapy or	sum of lines 2	24 and 25 for a	all others		0	100. 00
	Line 27 = line 7 times line 3 for respiratory Line 33 = line 28 = sum of lines 26 and 27 LINE 34 CALCULATION	y therapy or su	um of lines 3 a	and 4 for all	others		100. 01 100. 02
01 00	Line 27 = line 7 times line 3 for respirator	v therapy or su	um of lines 3	and 4 for all	others	0	1 101. 00
01. 01	Line 31 = line 29 for respiratory therapy or Line 34 = sum of lines 27 and 31					0	101. 01 101. 02
02.00	Line 35 CALCULATION	cum of lines	00 and 20 for	all others		^	102. OC
	Line 31 = line 29 for respiratory therapy or Line 32 = line 8 times columns 1 and 2, line 13 for all others				umns 1-3, line		102. 00
02. 02	Line 35 = sum of lines 31 and 32					0	102. 0

REASONABLE COS OUTSIDE SUPPLI	DETERMINATION FOR THERAPY SERVICES ERS	FURNI SHED BY	Provi der Co	CN: 14-1350	Peri od: From 07/01/2022 To 06/30/2023		
					To 06/30/2023 Occupati onal	Date/Time Pre 1/24/2024 11: Cost	
					Therapy	1	
						1.00	
	GENERAL INFORMATION  mber of weeks worked (excluding aide	s) (see instruc	tions)			17	1.0
.00   Line 1 m	ultiplied by 15 hours per week	, ,	ŕ			255	
	of unduplicated days in which supervi of unduplicated days in which therapy					0	
	apist was on provider site (see inst		on provider si	rte but hert	ner supervisor		4.0
	f unduplicated offsite visits - supe					0	
	of unduplicated offsite visits - them of and on which supervisor and/or the					0	6.0
i nstruct	i ons)	., ,	,				
1	travel expense rate travel expense rate per mile					5. 78 0. 00	
5. 00   OP 11 OHA1	traver expense rate per inire	Supervi sors	Therapi sts	Assi stants	Ai des	Trai nees	0.0
00   T-+-1   h-		1. 00	2.00	3.00	4.00	5. 00	0.0
1	urs worked ee instructions)	0. 00 0. 00	227. 00 90. 20				
11.00 Standard	travel allowance (columns 1 and 2,	45. 10	45. 10	33.	83		11.00
	of column 2, line 10; column 3, of column 3, line 10)						
1	of travel hours (provider site)	0	0		0		12.00
1	of travel hours (offsite)	0	0	•	0		12.0
1	of miles driven (provider site) of miles driven (offsite)	0	0		0		13.0
						1.00	
Part II	- SALARY EQUIVALENCY COMPUTATION					1.00	
	ors (column 1, line 9 times column 1						14.0
	ts (column 2, line 9 times column 2, its (column 3, line 9 times column 3,					20, 475 7, 272	1
1	allowance amount (sum of lines 14 a		ratory therapy	y or lines 1	4-16 for all	27, 747	
others) 8.00 Aides (d	column 4, line 9 times column 4, line	10)				0	18.0
	(column 5, line 9 times column 5, l					Ö	19. 0
	lowance amount (sum of lines 17-19 f						20.0
	um of columns 1 and 2 for respirator onal therapy, line 9, is greater tha						
	rom line 20. Otherwise complete line		P. C. L. L.		. 1		
	laverage rate excluding aides and tr iratory therapy or columns 1 thru 3,			um or corumn	s rand Z, rine v	0.00	21.0
	allowance excluding aides and train	ees (line 2 time	es line 21)			0	
	lary equivalency (see instructions) - STANDARD AND OPTIONAL TRAVEL ALLO	NANCE AND TRAVEL	EXPENSE COME	PIITATION - P	ROVIDER SITE	27, 747	23.0
Standard	Travel Allowance	WATER THE THEFT	EXI EIVOE GOIM	O I A I I I	NOVIDEN OF TE		
	ts (line 3 times column 2, line 11) ts (line 4 times column 3, line 11)					0 0	1
1	(line 24 for respiratory therapy or	sum of lines 24	4 and 25 for a	all others)		0	1
	I travel expense (line 7 times line 3	for respiratory	y therapy or s	sum of lines	3 and 4 for all	0	27. 0
others) 8.00 Total st	andard travel allowance and standard	travel expense	at the provid	der site (su	m of lines 26 and	0	28. 0
27)	Travel Allamana and Onti and Travel		·	·			
	Travel Allowance and Optional Travel its (column 2, line 10 times the sum		d 2, line 12	)		0	29.0
	ts (column 3, line 10 times column 3					0	
	(line 29 for respiratory therapy or travel expense (line 8 times column				ny or sum of	0 0	
col umns	1-3, line 13 for all others)			. a.co. y	py 0. 0 <b>u</b> 0.		
	travel allowance and standard trave travel allowance and standard trave			nd 31)		0 0	
1 '	travel allowance and optional trave	, ,		,		0	1
	- STANDARD AND OPTIONAL TRAVEL ALLOW	ANCE AND TRAVEL	EXPENSE COMPL	JTATION - SE	RVICES OUTSIDE PE	ROVI DER SITE	
	Travel Expense ::ts (line 5 times column 2, line 11)					0	36.0
1	its (line 6 times column 3, line 11)					0	1
1	(sum of lines 36 and 37) travel expense (line 7 times the su	m of lines 5 and	d 6)			0 0	
Opti onal	Travel Allowance and Optional Travel	Expense					
	its (sum of columns 1 and 2, line 12. its (column 3, line 12.01 times colum		2, line 10)			0 0	1
	(sum of lines 40 and 41)	11 3, TITIC 10 <i>)</i>				0	
	travel expense (line 8 times the su				I loui na thair	0	43.0
	avel Allowance and Travel Expense - ( ppropriate.	Jiisite Services	s; complete or	ie or the fo	rrowing three lif	ies 44, 45, or	
	travel allowance and standard trave	L expense (sum o	of lines 38 au	nd 39 - see	instructions)	0	44.0

	ABLE COST DETERMINATION FOR THERAPY SERVICES E SUPPLIERS	FURNI SHED BY	Provi der C		Peri od: From 07/01/2022 To 06/30/2023	Worksheet A-8 Parts I-VI Date/Time Pre 1/24/2024 11:	pared:
					Occupational Therapy	Cost	
						1. 00	
15. 00	Optional travel allowance and standard travel	expense (sum	of lines 39 a	nd 42 - see i	nstructions)	0	45.00
6. 00	Optional travel allowance and optional travel		of lines 42 a				46.00
		Therapists 1.00	Assi stants 2.00	Ai des 3.00	Trai nees 4.00	Total 5. 00	
	PART V - OVERTIME COMPUTATION		2.00	0.00		0.00	
7. 00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each	0.00	0. 00	0. 0	0.00	0. 00	47.00
8 00	column of line 56) Overtime rate (see instructions)	0. 00	0.00	0. 0	0. 00		48.00
9. 00	Total overtime (including base and overtime	0.00	0.00				49.00
	allowance) (multiply line 47 times line 48) CALCULATION OF LIMIT						
0. 00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0. 00	O. C	0. 00	0.00	50.00
1.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions) DETERMINATION OF OVERTIME ALLOWANCE	0.00	0.00	0. 0	0.00	0.00	51.00
2. 00	Adjusted hourly salary equivalency amount	90. 20	67. 65	0.0	0.00		52.00
3. 00	(see instructions) Overtime cost limitation (line 51 times line	0	0		0 0		53.00
4. 00	52) Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0		0 0		54.00
5. 00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	О	0		0 0		55.00
5. 00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for	О	0		0 0	0	56.00
	respiratory therapy and columns 1 through 3 for all others.)						
						1. 00	
	Part VI - COMPUTATION OF THERAPY LIMITATION A	AND EXCESS COST	ADJUSTMENT				
	Salary equivalency amount (from line 23)	(6 11 00	0.5			27, 747	
8. 00 9. 00	Travel allowance and expense - provider site Travel allowance and expense - Offsite servio			5)		0	58.00 59.00
	Overtime allowance (from column 5, line 56)	303 (110111111103	11, 10, 01 1	3)		Ö	
1. 00	Equipment cost (see instructions)					0	
	Supplies (see instructions)					0	
	Total allowance (sum of lines 57-62)	, ,,our roosedo)				27, 747	
	Total cost of outside supplier services (from Excess over limitation (line 64 minus line 65)					18, 203 0	1
3. 00	LINE 33 CALCULATION	o ii negative	, 611161 2616)				00.00
	Line 26 = line 24 for respiratory therapy or					0	100.00
	Line 27 = line 7 times line 3 for respiratory Line 33 = line 28 = sum of lines 26 and 27 LINE 34 CALCULATION	y therapy or su	m of lines 3 a	and 4 for all	others		100. 01 100. 02
01. 00	Line 27 = line 7 times line 3 for respiratory	y therapy or su	m of lines 3	and 4 for all	others	0	101.00
	Line 31 = line 29 for respiratory therapy or Line 34 = sum of lines 27 and 31	sum of lines 2	9 and 30 for a	all others			101. 01 101. 02
02.00	LINE 35 CALCULATION Line 31 = line 29 for respiratory therapy or	sum of lines 2	9 and 30 for :	all others		0	    102.00
02. 01	Line 32 = line 8 times columns 1 and 2, line 13 for all others				umns 1-3, line	0	102. 01
2. 02	Line 35 = sum of lines 31 and 32					0	102. C

Heal th Financial Systems

ST. FRANCIS HOSPITAL

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY

OUTSIDE SUPPLIERS

Provider CCN: 14-1350

Period:
From 07/01/2022
To 06/30/2023

Parts I - VI
Date/Time Prepared:
1/24/2024 11: 37 am

Speech Pathology

Cost

PART I - GENERAL INFORMATION

1.00

Total number of weeks worked (excluding aides) (see instructions)

2.00 Line 1 multiplied by 15 hours per week
3.00 Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)

4.00 Number of unduplicated days in which therapy assistant was on provider site but neither supervisor

0 4.00

2.00							
3. 00	Number of unduplicated days in which supervi	sor or theranis	st was on nrovi	ider site (see	instructions)	0	3.00
4. 00	Number of unduplicated days in which therapy						4.00
00	nor therapist was on provider site (see inst		o., p. o., do. o.		очро. 1. оо.		1.00
5.00	Number of unduplicated offsite visits - supe		apists (see in	nstructions)		0	5.00
6.00	Number of unduplicated offsite visits - ther				therapy	0	6.00
	assistant and on which supervisor and/or the	rapist was not	present during	g the visit(s))	(see		
	instructions)	•					
7.00	Standard travel expense rate					5. 78	7.00
8.00	Optional travel expense rate per mile					0.00	8. 00
		Supervi sors	Therapi sts	Assi stants	Ai des	Trai nees	
	T	1. 00	2. 00	3. 00	4. 00	5. 00	
9.00	Total hours worked	0.00	116. 03		0. 00		9.00
	AHSEA (see instructions)	0.00	86. 67		0. 00	0.00	10.00
11. 00	Standard travel allowance (columns 1 and 2,	43. 34	43. 34	0.00			11. 00
	one-half of column 2, line 10; column 3,						
12 00	one-half of column 3, line 10)		0	_			12 00
	Number of travel hours (provider site) Number of travel hours (offsite)	0	0				12. 00 12. 01
	` ′	0	0				13.00
	Number of miles driven (provider site) Number of miles driven (offsite)	0	0				13.00
13.01	Number of mires dirveil (offsite)	l o	0	l 0			13.01
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION					11.00	
14.00	Supervisors (column 1, line 9 times column 1	, line 10)				0	14.00
15.00						10, 056	15.00
16.00	Assistants (column 3, line 9 times column 3,	line10)				0	16.00
17.00	Subtotal allowance amount (sum of lines 14 a	nd 15 for respi	ratory therapy	y or lines 14-1	6 for all	10, 056	17. 00
	others)						
	Aides (column 4, line 9 times column 4, line					0	18. 00
	Trainees (column 5, line 9 times column 5, l					0	19. 00
20. 00	Total allowance amount (sum of lines 17-19 f						20.00
	If the sum of columns 1 and 2 for respirator						
	occupational therapy, line 9, is greater tha		no entries on	lines 21 and 2	22 and enter or	iline 23 the	
21 00	amount from line 20. Otherwise complete line		7 divided by a	um of columns 1	land O line (	0/ /7	21. 00
21. 00	Weighted average rate excluding aides and tr for respiratory therapy or columns 1 thru 3,			uiii oi coruiiiris	and 2, Time s	80.07	21.00
22. 00	Weighted allowance excluding aides and train					67, 603	22. 00
23. 00		ccs (TITIC 2 titl	iic3 TTTIC 21)			67, 603	
20.00	PART III - STANDARD AND OPTIONAL TRAVEL ALLO	WANCE AND TRAVE	EL EXPENSE COME	PUTATION - PROV	/LDER_SLTE	07,000	20.00
	Standard Travel Allowance						
24.00	Therapists (line 3 times column 2, line 11)					0	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25. 00
26.00	Subtotal (line 24 for respiratory therapy or	sum of lines 2	24 and 25 for a	all others)		0	26.00
27.00	Standard travel expense (line 7 times line 3	for respirator	ry therapy or s	sum of lines 3	and 4 for all	0	27.00
	others)						
28.00	Total standard travel allowance and standard	travel expense	e at the provid	der site (sum d	of lines 26 and	0	28. 00
	27)						
	Optional Travel Allowance and Optional Trave						
	Therapists (column 2, line 10 times the sum		nd 2, line 12 )	)		0	29.00
	Assistants (column 3, line 10 times column 3					0	30.00
	Subtotal (line 29 for respiratory therapy or					0	31.00
32. 00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of						

22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)	67,603	22.00			
23.00	Total salary equivalency (see instructions)	67, 603	23.00			
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE					
	Standard Travel Allowance					
24.00	Therapists (line 3 times column 2, line 11)	0	24.00			
25.00	Assistants (line 4 times column 3, line 11)	0	25.00			
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)	0	26.00			
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all	0	27.00			
	others)					
28.00		0	28. 00			
	27)					
	Optional Travel Allowance and Optional Travel Expense					
29. 00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)	0	29. 00			
30.00	Assistants (column 3, line 10 times column 3, line 12)	0				
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)	0				
32.00		0	32.00			
	columns 1-3, line 13 for all others)					
33.00		0				
34.00		0	011.00			
35.00						
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PR	OVIDER SITE				
	Standard Travel Expense					
36.00		0	00.00			
	Assistants (line 6 times column 3, line 11)	0				
	Subtotal (sum of lines 36 and 37)	0	00.00			
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)	0	39. 00			
	Optional Travel Allowance and Optional Travel Expense					
40.00		0	40.00			
	Assistants (column 3, line 12.01 times column 3, line 10)	0				
	Subtotal (sum of lines 40 and 41)	0				
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)	0	43.00			
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lir	nes 44, 45, or				
	46, as appropri ate.					
	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)		44. 00			
45. 00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)	0	45. 00			

Health Financial Systems	ST. FRANCIS	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
REASONABLE COST DETERMINATION FOR THERAPY SERVICES OUTSIDE SUPPLIERS		Provi der C	CN: 14-1350	Peri od: From 07/01/2022 To 06/30/2023	Worksheet A-8 Parts I-VI	-3 epared:
				Speech Pathology	Cost	
4 00 0 10 11 11 11 11 11		6.11			1. 00	11.00
46.00 Optional travel allowance and optional trave						46.00
	Therapi sts 1.00	Assi stants 2.00	Ai des 3. 00	Trai nees 4.00	Total 5. 00	
PART V - OVERTIME COMPUTATION	1.00	2.00	3.00	4.00	3.00	
47.00 Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each	0.00	0. 00	0. (	0. 00	0. 00	47. 00
column of line 56) 48.00 Overtime rate (see instructions)	0.00	0.00	0. (	0. 00		48. 00
49.00 Total overtime (including base and overtime	0.00	0.00				49.00
allowance) (multiply line 47 times line 48)	0.00	0.00		0.00		171.00
CALCULATION OF LIMIT	'					1
Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0. (	0.00	0.00	50.00
51.00 Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0. (	0.00	0.00	51.00
DETERMINATION OF OVERTIME ALLOWANCE	86. 67	0.00	0.0	0.00		F2 00
52.00 Adjusted hourly salary equivalency amount (see instructions)	86.67	0.00	0. (	0.00		52.00
53.00 Overtime cost limitation (line 51 times line 52)	0	0		0 0		53.00
54.00 Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0		0 0		54.00
55.00 Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0		0 0		55.00
56.00 Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0		0 0	0	56.00
					1. 00	
Part VI - COMPUTATION OF THERAPY LIMITATION	AND EXCESS COST	ADJUSTMENT				
Salary equivalency amount (from line 23)  Travel allowance and expense - provider site (from lines 33, 34, or 35))  Travel allowance and expense - Offsite services (from lines 44, 45, or 46)  Overtime allowance (from column 5, line 56)  Equipment cost (see instructions)  Supplies (see instructions)  Total allowance (sum of lines 57-62)  Total cost of outside supplier services (from your records)  Excess over limitation (line 64 minus line 63 - if negative, enter zero)  LINE 33 CALCULATION						57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00
100.00 Line 26 = line 24 for respiratory therapy or 100.01 Line 27 = line 7 times line 3 for respirator 100.02 Line 33 = line 28 = sum of lines 26 and 27 LINE 34 CALCULATION	0	100. 00 100. 01 100. 02				
101.00 Line 27 = line 7 times line 3 for respirator 101.01 Line 31 = line 29 for respiratory therapy or 101.02 Line 34 = sum of lines 27 and 31 LINE 35 CALCULATION				others	0	101. 00 101. 01 101. 02
102.00 Line 31 = line 29 for respiratory therapy or 102.01 Line 32 = line 8 times columns 1 and 2, line				umns 1-3, line		102. 00 102. 01
13 for all others   102.02   Line 35 = sum of lines 31 and 32					0	102. 02

Period: Worksheet B From 07/01/2022 Part I Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provi der CCN: 14-1350

				To	06/30/2023	Date/Time Pre	pared:
			CAPI TAL REI	LATED COSTS		1/24/2024 11:	37 am
	Coot Conton Decemintion	Not Evpopos	DIDC 0 FLVT	MANDLE FOLLID	EMDL OVEE	ADMITTI NO	
	Cost Center Description	Net Expenses for Cost	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS	ADMITTI NG	
		Allocation			DEPARTMENT		
		(from Wkst A col. 7)					
		0	1.00	2.00	4. 00	5. 01	
4 00	GENERAL SERVICE COST CENTERS	1 (04 550	4 (04 550	1			
1. 00 2. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP	1, 634, 559 953, 743	1, 634, 559	953, 743			1.00 2.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	2, 951, 110	811		2, 952, 619		4.00
5. 01	00570 ADMI TTI NG	191, 601	34, 223	870	0	226, 694	5. 01
5. 02	00540 PATIENT ACCOUNTING	725, 656	2, 036		0	0	5. 02
5. 03 6. 00	00550 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS	6, 057, 605 175, 273	199, 060 0		177, 472 5, 674	0	5. 03 6. 00
7. 00	00700 OPERATION OF PLANT	1, 878, 510	330, 688	-	76, 727	0	7.00
8. 00	00800 LAUNDRY & LINEN SERVICE	109, 127	0		0	0	8. 00
9. 00	00900 HOUSEKEEPI NG	649, 317	29, 076		75, 922	0	9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	340, 762 349, 035	79, 585 26, 017		38, 324 39, 255	0	10.00 11.00
13. 00	01300 NURSING ADMINISTRATION	838, 556	6, 205		177, 530	0	13.00
15. 00	01500 PHARMACY	900, 384	16, 578		126, 519	0	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	515, 058	0		0	0	16. 00
17. 00	01700 SOCIAL SERVICE	0	0	0	0	0	17. 00
30. 00	O3000 ADULTS & PEDIATRICS	2, 124, 123	166, 195	22, 374	421, 647	6, 731	30.00
43. 00	04300 NURSERY	136, 648	7, 756		25, 520	410	43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	2, 965, 120	131, 770		285, 143	16, 712	50.00
52. 00 53. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	954, 558 21, 526	39, 669 2, 732		178, 273 0	2, 861 9, 735	52.00 53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	805, 775	46, 112		137, 035	9, 358	ł
54. 01	05401 ULTRASOUND	358, 203	3, 252		46, 558	9, 142	54. 01
54.02	05402 NUCLEAR MEDICINE	201, 834	5, 808		18, 884	3, 301	54.02
57. 00 58. 00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	290, 135 243, 576	4, 698 15, 009		17, 357 19, 919	32, 673 10, 730	57. 00 58. 00
60. 00	06000 LABORATORY	2, 243, 338	41, 996		212, 293	29, 933	60.00
64.00	06400 I NTRAVENOUS THERAPY	350, 744	27, 048		73, 567	5, 098	64.00
65.00	06500 RESPI RATORY THERAPY	528, 763	36, 373		90, 634	5, 620	65.00
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	943, 285 61, 863	43, 054 2, 336		104 9, 505	8, 701 471	66. 00 67. 00
68. 00	06800 SPEECH PATHOLOGY	8, 744	159		9, 303	33	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	356, 626	22, 280		О	3, 448	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	444, 715	0		0	5, 201	72.00
73. 00 76. 00	07300 DRUGS CHARGED TO PATIENTS 03020 WOUND CARE	5, 208, 488 847, 728	0 15, 230		0 45, 549	34, 523 1, 749	73. 00 76. 00
76. 97	07697 CARDIAC REHABILITATION	239, 403	12, 383		46, 709	889	76. 97
76. 98	07698 SLEEP LAB	114, 042	1, 763		19, 073	1, 544	76. 98
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77. 00
90. 00	OUTPATIENT SERVICE COST CENTERS  09000 CLINIC	659, 539	14, 921	6, 370	111, 370	7, 504	90.00
90.00	09001 ONCOLOGY CLINIC	252, 117	10, 647		30, 442	819	90.00
91.00	09100 EMERGENCY	2, 777, 463	113, 182		381, 764	19, 508	1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
102 00	OTHER REIMBURSABLE COST CENTERS 10200 OPIOID TREATMENT PROGRAM	0	0	0	0	0	102. 00
102.00	SPECIAL PURPOSE COST CENTERS		<u> </u>		<u> </u>		102.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	41, 408, 652	1, 488, 652	927, 722	2, 888, 769	226, 694	118. 00
100 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	44 422	8, 267	20	ol	0	190. 00
	19000 BIFT, FLOWER, COFFEE SHOP & CANTEEN	46, 423 280, 695	136, 406		47, 703		190.00
	07950 OTHER NONALLOWABLE	292, 979	1, 234		16, 147		194. 00
200.00							200. 00
201. 00 202. 00		42, 028, 749	0 1, 634, 559		0 2, 952, 619		201.00
202.00	TOTAL (Suil Titles 110 till bugil 201)	42, 020, 149	1,034,339	1 700, 740	2, 702, 019	220, 094	<sub>1</sub> 202.00

Provider CCN: 14-1350

Peri od: Worksheet B From 07/01/2022 Part I To 06/30/2023 Date/Ti me Prepared:

			'	0 00/30/2023	1/24/2024 11:	
Cost Center Description	PATI ENT	Subtotal	ADMI NI STRATI V	MAINTENANCE &	OPERATION OF	
·	ACCOUNTI NG		E & GENERAL	REPAI RS	PLANT	
	5. 02	5A. 02	5. 03	6. 00	7. 00	
GENERAL SERVICE COST CENTERS						
1.00 O0100 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. 01 00570 ADMITTING						5. 01
5. 02 00540 PATIENT ACCOUNTING	727, 692					5. 02
5. 03 00550 ADMINISTRATIVE & GENERAL	0	6, 575, 354	6, 575, 354			5. 03
6. 00 00600 MAI NTENANCE & REPAI RS	ő	180, 947				6.00
7. 00   00700   OPERATION OF PLANT	o	2, 321, 615			2, 802, 918	7.00
8. 00 00800 LAUNDRY & LINEN SERVICE		109, 127			2,002,710	8.00
9. 00   00900   HOUSEKEEPI NG		754, 315			76, 326	9.00
	0					1
	0	459, 998			208, 919	10.00
11. 00 01100 CAFETERI A	0	415, 666			68, 298	11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	0	1, 063, 342			16, 288	13.00
15. 00   01500   PHARMACY	0	1, 046, 682			43, 519	15.00
16. 00 01600 MEDICAL RECORDS & LIBRARY	0	515, 107			0	16.00
17. 00 01700 SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00   03000   ADULTS & PEDIATRICS	21, 600	2, 762, 670			436, 278	30.00
43. 00 04300 NURSERY	1, 317	176, 064	32, 654	1, 190	20, 360	43.00
ANCILLARY SERVICE COST CENTERS						
50. 00   05000   OPERATI NG ROOM	53, 628	3, 724, 979			345, 908	50.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	9, 179	1, 215, 452			104, 136	52.00
53. 00   05300   ANESTHESI OLOGY	31, 240	95, 213	17, 659	419	7, 172	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	30, 031	1, 163, 892	215, 861	7, 073	121, 048	54.00
54. 01   05401   ULTRASOUND	29, 337	514, 599	95, 440	499	8, 537	54.01
54. 02 05402 NUCLEAR MEDICINE	10, 592	278, 179	51, 592	891	15, 247	54.02
57. 00 05700 CT SCAN	104, 846	449, 709	83, 405	721	12, 332	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	34, 432	324, 084			39, 401	58.00
60. 00   06000 LABORATORY	96, 052	2, 632, 976			110, 244	60.00
64.00 06400 INTRAVENOUS THERAPY	16, 359	472, 816			71, 005	64.00
65. 00 06500 RESPIRATORY THERAPY	18, 034	693, 965			95, 483	65.00
66. 00 06600 PHYSI CAL THERAPY	27, 922	1, 032, 100			113, 020	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	1, 512	75, 687			6, 131	67.00
68. 00 06800 SPEECH PATHOLOGY	104	9, 040			416	68.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	11, 065	393, 419			58, 488	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	16, 689	466, 605			0	72.00
73. 00 07300 DRUGS CHARGED TO PATTENTS	111, 024	5, 354, 035			0	73.00
	1 · 1				39, 979	76.00
76. 00   03020   WOUND CARE	5, 613	919, 277			-	
76. 97   07697   CARDI AC   REHABI LI TATI ON	2, 853	302, 237			32, 506	76. 97
76. 98   07698   SLEEP LAB	4, 954	147, 474			4, 627	76. 98
77. 00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77. 00
OUTPATIENT SERVICE COST CENTERS	0.001	000 705	150 700	0.000	00.440	
90. 00   09000   CLI NI C	24, 081	823, 785			39, 169	90.00
90. 01 09001 ONCOLOGY CLINIC	2, 628	307, 746			27, 948	90. 01
91. 00   09100   EMERGENCY	62, 600	3, 394, 718		17, 361	297, 114	91.00
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART)		0				92.00
OTHER REIMBURSABLE COST CENTERS						
102.00 10200 OPI OI D TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	727, 692	41, 172, 874	6, 416, 618	192, 126	2, 419, 899	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	54, 710		1, 268	21, 702	190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	477, 581	88, 575	20, 923	358, 078	
194.00 07950 OTHER NONALLOWABLE	o	323, 584			3, 239	194.00
200.00 Cross Foot Adjustments		. 0				200.00
201.00 Negative Cost Centers	o	0	l c	0		201.00
202.00 TOTAL (sum lines 118 through 201)	727, 692	42, 028, 749	6, 575, 354	214, 506		
						•

Provider CCN: 14-1350

| Peri od: | Worksheet B | From 07/01/2022 | Part | To 06/30/2023 | Date/Time Prepared:

				10	06/30/2023	1/24/2024 11:	
	Cost Center Description	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	07 diii
	<b>'</b>	LINEN SERVICE				ADMI NI STRATI O	
						N	
		8. 00	9. 00	10.00	11.00	13. 00	
	GENERAL SERVICE COST CENTERS						
	00100 CAP REL COSTS-BLDG & FLXT						1.00
	00200 CAP REL COSTS-MVBLE EQUIP						2.00
	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
	00570 ADMI TTI NG						5. 01
	00540 PATIENT ACCOUNTING						5. 02
	00550 ADMINISTRATIVE & GENERAL						5. 03
	00600 MAINTENANCE & REPAIRS						6. 00
	00700 OPERATION OF PLANT	100.044					7.00
	00800 LAUNDRY & LINEN SERVICE	129, 366	075 000				8.00
	00900 HOUSEKEEPI NG	0	975, 000				9.00
	01000 DI ETARY	0	0		F/F 04/		10.00
	01100 CAFETERI A	0	0	0	565, 046		11.00
	01300 NURSI NG ADMI NI STRATI ON	0	0	0	31, 315		1
	01500 PHARMACY	0	0	0	21, 445		15.00
	01600 MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
	01700 SOCIAL SERVICE INPATIENT ROUTINE SERVICE COST CENTERS	U	U	0	0	0	17. 00
-	03000 ADULTS & PEDIATRICS	55, 518	157, 257	766, 439	102, 980	457, 487	30.00
	04300 NURSERY	1, 312	20, 288		4, 826		43.00
	ANCILLARY SERVICE COST CENTERS	1, 312	20, 200	U	4, 020	21,440	43.00
	05000 OPERATING ROOM	19, 347	176, 049	0	60, 162	267, 271	50.00
	05200 DELIVERY ROOM & LABOR ROOM	9, 192	142, 157		33, 819	150, 239	52.00
	05300 ANESTHESI OLOGY	7, 172	142, 137		03,017	0	53.00
	05400 RADI OLOGY-DI AGNOSTI C	2, 790	12, 996		37, 229	ő	54.00
	05401 ULTRASOUND	1, 314	5, 843		8, 890	ő	54. 01
	05402 NUCLEAR MEDICINE	1, 326	6, 077		3, 629	0	54. 02
	05700 CT SCAN	2, 801	3, 553		3, 883	0	57.00
	05800 MAGNETIC RESONANCE IMAGING (MRI)	3, 279	7, 152		3, 883	0	58.00
	06000 LABORATORY	1, 653	13, 416		47, 172	0	60.00
64. 00	06400 INTRAVENOUS THERAPY	0	0	1	19, 340	0	64.00
65.00	06500 RESPI RATORY THERAPY	2, 153	0	0	21, 010	0	65.00
66.00	06600 PHYSI CAL THERAPY	3, 733	52, 403	0	0	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	202	2, 852	0	1, 379	0	67.00
68. 00	06800 SPEECH PATHOLOGY	14	187	0	0	0	68. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
	03020 WOUND CARE	1, 421	17, 203	0	14, 006		1
	07697 CARDI AC REHABI LI TATI ON	0	0	0	8, 309	36, 915	1
	07698 SLEEP LAB	1, 873	9, 490		4, 717	0	76. 98
	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77. 00
	OUTPATIENT SERVICE COST CENTERS					_	
	09000 CLI NI C	2, 918	40, 950		36, 576		90.00
	09001 ONCOLOGY CLINIC	0	0		7, 693		90. 01
	09100 EMERGENCY	15, 618	171, 234	0	70, 576	313, 535	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS		0				100.00
	10200 OPI OI D TREATMENT PROGRAM	0	0	0	0	0	102. 00
	SPECIAL PURPOSE COST CENTERS	407.474	000 407	7// 400	F40, 000	4 000 440	440.00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	126, 464	839, 107	766, 439	542, 839	1, 309, 110	1118.00
	NONREI MBURSABLE COST CENTERS		^		^	^	100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	3 003	125 002		10 570		190. 00 192. 00
	07950 OTHER NONALLOWABLE	2, 902	135, 893	0	18, 578 3, 629		194.00
200.00	Cross Foot Adjustments		U	ا	3, 029		200.00
200.00	Negative Cost Centers	0	^	0	0		200.00
201.00	TOTAL (sum lines 118 through 201)	129, 366	975, 000		565, 046		
202.00	TOTAL (Sum TITIOS TTO CHI Gught 201)	127, 300	773,000	1 700, 437	303, 040	1, 307, 110	1202.00

ST. FRANCIS HOSPITAL In Lieu of Form CMS-2552-10 COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 14-1350 Peri od: Worksheet B From 07/01/2022 Part I Date/Time Prepared: 06/30/2023 1/24/2024 11:37 am Cost Center Description **PHARMACY** MEDI CAL SOCI AL Subtotal Intern & SERVI CE RECORDS & Resi dents LI BRARY Cost & Post Stepdown Adjustments 15. 00 16.00 17.00 24.00 25. 00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00570 ADMITTING 5.01 5.01 00540 PATIENT ACCOUNTING 5.02 5.02 00550 ADMINISTRATIVE & GENERAL 5.03 5.03 6.00 00600 MAINTENANCE & REPAIRS 6.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8 00 8 00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 10.00 01100 CAFETERI A 11.00 11.00 01300 NURSING ADMINISTRATION 13.00 13.00 15.00 01500 PHARMACY 1, 308, 312 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 16.00 0 610, 641 01700 SOCIAL SERVICE 17.00 0 0 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 18, 125 0 5, 294, 626 30.00 04300 NURSERY 0 0 279, 239 43.00 1, 105 0 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 45,000 0 5, 349, 781 0 50.00 05200 DELIVERY ROOM & LABOR ROOM 0 1, 894, 207 52.00 7, 703 0 0 52.00 53.00 05300 ANESTHESI OLOGY 0 0 26, 213 0 146, 676 Ω 53 00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 25, 199 1, 586, 088 0 54.00 54.01 05401 ULTRASOUND 24, 617 659, 739 0 54.01 54.02 05402 NUCLEAR MEDICINE 00000000 8,888 0 365, 829 0 54.02 05700 CT SCAN 0 57 00 87 978 644 382 57 00 0 05800 MAGNETIC RESONANCE IMAGING (MRI) 58.00 28, 892 469, 099 0 58.00 06000 LABORATORY 80, 599 0 3, 380, 827 0 60.00 60.00 64.00 06400 I NTRAVENOUS THERAPY 13, 727 0 668, 728 0 64.00 65.00 06500 RESPIRATORY THERAPY 0 0 65 00 15, 133 962, 029 0 66.00 06600 PHYSI CAL THERAPY 23, 430 1, 422, 708 0 66.00 06700 OCCUPATI ONAL THERAPY 101, 915 67.00 1, 269 67.00 0 68.00 06800 SPEECH PATHOLOGY 88 0 11, 446 0 68.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 9, 285 537.575 71.00 0 71.00 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 14,004 567, 148 0 72.00 73 00 07300 DRUGS CHARGED TO PATIENTS 1, 308, 312 93, 184 0 7, 748, 509 0 73.00 03020 WOUND CARE 0 4,710 1, 231, 649 76.00 0 76.00 0 0 07697 CARDIAC REHABILITATION 76.97 0 2, 394 440, 314 0 76.97 76.98 07698 SLEEP LAB 0 4, 157 0 199, 959 0 76.98 07700 ALLOGENEIC HSCT ACQUISITION 0 0 77.00 77.00 0 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 20, 206 0 1, 118, 676 0 90.00 90. 01 09001 ONCOLOGY CLINIC 0 2, 206 0 404, 302 0 90.01 09100 EMERGENCY 4, 962, 286 91.00 0 0 91.00 52, 529 0 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 0 92.00 OTHER REIMBURSABLE COST CENTERS 102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 0 0 102.00 SPECIAL PURPOSE COST CENTERS

1, 308, 312

1, 308, 312

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610, 641

610, 641

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0 0 40, 447, 737

1, 102, 530

42, 028, 749

87, 827

390, 655

0 118.00

0 190. 00

0 192.00

0 194.00 0 200.00

0 201.00

0 202.00

118.00

200.00

201.00

202.00

SUBTOTALS (SUM OF LINES 1 through 117)

TOTAL (sum lines 118 through 201)

NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN

192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES

Cross Foot Adjustments

Negative Cost Centers

194. 00 07950 OTHER NONALLOWABLE

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS In Lieu of Form CMS-2552-10 ST. FRANCIS HOSPITAL

| Peri od: | Worksheet B | From 07/01/2022 | Part | To 06/30/2023 | Date/Time Prepared: Provider CCN: 14-1350

			10 06/30/2023   Date/Trille Pi	
	Cost Center Description	Total		
		26. 00		
	GENERAL SERVICE COST CENTERS			
1.00	00100 CAP REL COSTS-BLDG & FLXT			1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT			4.00
5. 01	00570 ADMI TTI NG			5. 01
5.02	00540 PATIENT ACCOUNTING			5. 02
5.03	00550 ADMINISTRATIVE & GENERAL			5. 03
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 NURSING ADMINISTRATION			13.00
15. 00	01500 PHARMACY			15. 00
	01600 MEDI CAL RECORDS & LI BRARY			16. 00
	01700 SOCIAL SERVICE			17. 00
17.00	INPATIENT ROUTINE SERVICE COST CENTERS			- 17.00
20.00		E 204 424		30.00
30.00		5, 294, 626		30.00
43.00	04300 NURSERY	279, 239		43.00
F0 00	ANCILLARY SERVICE COST CENTERS	E 040 704		
	05000 OPERATING ROOM	5, 349, 781		50.00
52. 00	1	1, 894, 207		52.00
53. 00	1	146, 676		53.00
54. 00		1, 586, 088		54.00
54. 01	05401 ULTRASOUND	659, 739		54. 01
54. 02		365, 829		54. 02
57. 00	1	644, 382		57.00
58. 00	` '	469, 099		58. 00
60.00	06000 LABORATORY	3, 380, 827		60.00
64.00	06400 I NTRAVENOUS THERAPY	668, 728		64.00
65.00	06500 RESPI RATORY THERAPY	962, 029		65.00
66.00	06600 PHYSI CAL THERAPY	1, 422, 708		66.00
67.00	06700 OCCUPATI ONAL THERAPY	101, 915		67.00
68.00	06800 SPEECH PATHOLOGY	11, 446		68. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	537, 575		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	567, 148		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	7, 748, 509		73.00
76. 00	1	1, 231, 649		76.00
76. 97	07697 CARDI AC REHABI LI TATI ON	440, 314		76. 97
76. 98	07698 SLEEP LAB	199, 959		76. 98
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0		77.00
77.00	OUTPATIENT SERVICE COST CENTERS	o <sub>l</sub>		<b></b>
90 00	09000 CLINI C	1, 118, 676		90.00
90. 01	09001 ONCOLOGY CLINIC	404, 302		90.01
91. 00	1	4, 962, 286		91.00
92.00		4, 702, 200		92.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)			92.00
100.00	OTHER REIMBURSABLE COST CENTERS			100.00
102.00	10200 OPI OI D TREATMENT PROGRAM	0		102. 00
440 6	SPECIAL PURPOSE COST CENTERS	40 417 70-		
118.00		40, 447, 737		118. 00
	NONREI MBURSABLE COST CENTERS			
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	87, 827		190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	1, 102, 530		192. 00
	07950 OTHER NONALLOWABLE	390, 655		194. 00
200.00		0		200.00
201.00	Negative Cost Centers	0		201.00
202.00	TOTAL (sum lines 118 through 201)	42, 028, 749		202.00
		•		

| Peri od: | Worksheet B | From 07/01/2022 | Part | I | To 06/30/2023 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 14-1350

					То	06/30/2023	Date/Time Pre 1/24/2024 11:	pared:
				CAPI TAL REI	ATED COSTS		1/24/2024 11.	37 alli
		Cost Center Description	Directly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
			Assigned New Capital				BENEFITS DEPARTMENT	
			Related Costs				DELYMENT	
	_		0	1. 00	2. 00	2A	4. 00	
		AL SERVICE COST CENTERS						4 00
1. 00 2. 00		CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP						1. 00 2. 00
4. 00		EMPLOYEE BENEFITS DEPARTMENT	0	811	698	1, 509	1, 509	4.00
5. 01		ADMITTING	2, 030			37, 123	0	5. 01
5.02		PATIENT ACCOUNTING	7, 757	2, 036	0	9, 793	0	5. 02
5. 03	1	ADMI NI STRATI VE & GENERAL	1, 055, 950	·	1	1, 396, 227	91	5. 03
6.00	1	MAINTENANCE & REPAIRS OPERATION OF PLANT	0 220	220, 400		275 409	3	6. 00 7. 00
7. 00 8. 00	1	LAUNDRY & LINEN SERVICE	9, 230 6, 410	330, 688 0	1	375, 608 6, 410	0	8. 00
9. 00		HOUSEKEEPI NG	4, 060	29, 076	1	33, 136	39	9. 00
10.00	01000	DI ETARY	937	79, 585	1, 327	81, 849	20	10.00
11.00		CAFETERI A	0	26, 017		27, 376	20	11.00
13. 00 15. 00		NURSI NG ADMI NI STRATI ON	207	6, 205		47, 463	91	13.00
16. 00		PHARMACY MEDICAL RECORDS & LIBRARY	92, 313 5, 546	16, 578 0	1	112, 092 5, 595	65 0	15. 00 16. 00
17. 00	1	SOCIAL SERVICE	0, 540	0	1	0, 379	0	17. 00
		IENT ROUTINE SERVICE COST CENTERS			- 1	- 1		
30.00	03000	ADULTS & PEDIATRICS	7, 408			195, 977	215	30.00
43.00		NURSERY	0	7, 756	4, 413	12, 169	13	43. 00
50. 00		LARY SERVICE COST CENTERS OPERATING ROOM	5, 833	131, 770	272, 606	410, 209	145	50. 00
52. 00		DELIVERY ROOM & LABOR ROOM	0,033	39, 669		70, 581	91	52. 00
53.00		ANESTHESI OLOGY	516	2, 732		33, 228	0	53.00
54.00		RADI OLOGY-DI AGNOSTI C	1, 500	46, 112		183, 193	70	54.00
54. 01		ULTRASOUND	0	3, 252		71, 359	24	54. 01
54. 02 57. 00		NUCLEAR MEDICINE CT SCAN	0	5, 808 4, 698		43, 568 4, 698	10 9	54. 02 57. 00
58. 00		MAGNETIC RESONANCE IMAGING (MRI)	o 0	15, 009		15, 427	10	58. 00
60.00	1	LABORATORY	19, 330			70, 690	108	60.00
64.00		INTRAVENOUS THERAPY	0	27, 048		27, 048	38	64.00
65.00		RESPI RATORY THERAPY	41, 685	36, 373		92, 599	46	65.00
66. 00 67. 00	1	PHYSI CAL THERAPY OCCUPATI ONAL THERAPY	829 0	43, 054 2, 336		52, 917 2, 336	0	66. 00 67. 00
68. 00		SPEECH PATHOLOGY	0	159		159	0	68. 00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5, 654	22, 280		27, 934	0	71. 00
72.00		IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00		DRUGS CHARGED TO PATIENTS	0	15 220	0	10 (20	0	73.00
76. 00 76. 97		WOUND CARE CARDIAC REHABILITATION	829	15, 230 12, 383		18, 638 13, 212	23 24	76. 00 76. 97
76. 98		SLEEP LAB	0	1, 763		7, 861	10	76. 98
77. 00	07700	ALLOGENEIC HSCT ACQUISITION	0		1	0	0	77. 00
		TIENT SERVICE COST CENTERS						
90.00		CLINIC	8, 086			29, 377	57	
90. 01 91. 00		ONCOLOGY CLINIC EMERGENCY	2, 747 3, 261	10, 647 113, 182		24, 487 156, 644	16 195	90. 01 91. 00
92. 00		OBSERVATION BEDS (NON-DISTINCT PART)	3, 201	113, 102	40, 201	130, 044	173	92.00
	_	REIMBURSABLE COST CENTERS			<u> </u>	- 1		
102.00		OPIOID TREATMENT PROGRAM	0	0	0	0	0	102. 00
440.00		AL PURPOSE COST CENTERS	4 000 440	4 400 (50	007 700	2 (00 400	4 477	440.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117) IMBURSABLE COST CENTERS	1, 282, 118	1, 488, 652	927, 722	3, 698, 492	1,4//	118. 00
190. 00		GIFT, FLOWER, COFFEE SHOP & CANTEEN	18	8, 267	20	8, 305	0	190. 00
		PHYSICIANS' PRIVATE OFFICES	10, 410			159, 593		192. 00
194.00	07950	OTHER NONALLOWABLE	10, 663			25, 121	8	194. 00
200.00		Cross Foot Adjustments				0		200. 00
201.00		Negative Cost Centers	1 202 200	1 424 550		0 001 511		201. 00
202.00	J	TOTAL (sum lines 118 through 201)	1, 303, 209	1, 634, 559	953, 743	3, 891, 511	1, 509	202. 00

Provider CCN: 14-1350

						1/24/2024 11:	<u>37 am</u>
	Cost Center Description	ADMITTING	PATI ENT	ADMI NI STRATI V	MAINTENANCE &	OPERATION OF	
			ACCOUNTI NG	E & GENERAL	REPAI RS	PLANT	
		5. 01	5. 02	5. 03	6. 00	7. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01	00570 ADMITTING	37, 123					5. 01
	1 1	· · · · · · · · · · · · · · · · · · ·	0.702				
5. 02	00540 PATIENT ACCOUNTING	0	9, 793	1			5. 02
5. 03	00550 ADMINISTRATIVE & GENERAL	0	0	.,			5. 03
6.00	00600 MAINTENANCE & REPAIRS	0	0				6. 00
7. 00	00700 OPERATION OF PLANT	0	0	91, 437	1, 684	468, 768	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	0	4, 298	0	0	8.00
9.00	00900 HOUSEKEEPI NG	o	0	29, 709	148	12, 765	9.00
10.00	01000 DI ETARY	ol	0	1			10.00
11. 00	01100 CAFETERI A	o	0	1	133	11, 422	11.00
13. 00	01300 NURSING ADMINISTRATION	0	0	41, 880		2, 724	1
	1 1		0	1			1
15.00	01500 PHARMACY	0	0			7, 278	1
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0		0	0	16.00
17. 00	01700 SOCIAL SERVICE	0	0	0	0	0	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS				1		
30. 00	03000 ADULTS & PEDIATRICS	1, 101	290			72, 966	30.00
43.00	04300 NURSERY	67	18	6, 934	40	3, 405	43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	2, 733	721	146, 708	672	57, 851	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	468	123	47, 871	202	17, 416	52.00
53.00	05300 ANESTHESI OLOGY	1, 592	420	3, 750	14	1, 199	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 530	404			20, 244	54.00
54. 01	05401 ULTRASOUND	1, 495	394			1, 428	54. 01
54. 02	05402 NUCLEAR MEDICINE	540	142			2, 550	54. 02
57. 00	05700 CT SCAN	5, 342		1			57.00
			1, 410			2, 062	
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	1, 755	463			6, 590	58.00
60.00	06000 LABORATORY	4, 894	1, 292	1		18, 437	60.00
64. 00	06400 I NTRAVENOUS THERAPY	834	220				•
65. 00	06500 RESPI RATORY THERAPY	919	242	27, 332	185	15, 969	65.00
66.00	06600 PHYSI CAL THERAPY	1, 423	375	40, 649	220	18, 902	66.00
67.00	06700 OCCUPATI ONAL THERAPY	77	20	2, 981	12	1, 025	67.00
68.00	06800 SPEECH PATHOLOGY	5	1	356	1	70	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	564	149	1		9, 782	71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	850	224			0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	5, 700	1, 504			Ö	73.00
76.00	03020 WOUND CARE		75				ı
	1 1	286		1		6, 686	1
76. 97	07697 CARDI AC REHABI LI TATI ON	145	38			5, 436	1
76. 98	07698 SLEEP LAB	252	67	1		774	76. 98
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77. 00
	OUTPATIENT SERVICE COST CENTERS			1			
90.00	09000 CLI NI C	1, 227	324				90.00
90. 01	09001 ONCOLOGY CLINIC	134	35	12, 121	54	4, 674	90. 01
91.00	09100 EMERGENCY	3, 190	842	133, 701	577	49, 690	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS						1
102.00	10200 OPI OI D TREATMENT PROGRAM	0	0	0	0	0	102.00
	SPECIAL PURPOSE COST CENTERS			•			
118.00		37, 123	9, 793	1, 362, 609	6, 387	404, 711	118.00
	NONREI MBURSABLE COST CENTERS	0.7.20	7, 7, 7, 0	1,002,007	0,00.	1017711	
100 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	2, 155	42	3 620	190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	0	18, 810			192.00
			0	1			
	07950 OTHER NONALLOWABLE	0	0	12, 744	6	542	194.00
200.00		_	_		_	_	200.00
201.00		0	- 0	0	0		201.00
202.00	TOTAL (sum lines 118 through 201)	37, 123	9, 793	1, 396, 318	7, 130	468, 768	202.00

| Peri od: | Worksheet B | From 07/01/2022 | Part II | To 06/30/2023 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 14-1350

				To	06/30/2023	Date/Time Pre 1/24/2024 11:	
	Cost Center Description	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	07 diii
	<b>'</b>	LINEN SERVICE				ADMI NI STRATI O	
						N	
		8. 00	9. 00	10.00	11. 00	13. 00	
	GENERAL SERVICE COST CENTERS		Г			ı	
	00100 CAP REL COSTS-BLDG & FIXT						1.00
1	00200 CAP REL COSTS-MVBLE EQUIP						2.00
1	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
	00570 ADMITTING						5. 01
1	00540 PATIENT ACCOUNTING 00550 ADMINISTRATIVE & GENERAL						5. 02 5. 03
1	00600 MAINTENANCE & REPAIRS						6.00
	00700 OPERATION OF PLANT						7.00
	00800 LAUNDRY & LINEN SERVICE	10, 708					8.00
1	00900 HOUSEKEEPI NG	0	75, 797				9.00
	01000 DI ETARY	0	0				10.00
1	01100 CAFETERI A	0	0	0	55, 322		11.00
13.00	01300 NURSING ADMINISTRATION	0	0	0	3, 066	95, 256	13.00
15. 00	01500 PHARMACY	0	0	0	2, 100	0	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17. 00	01700 SOCIAL SERVICE	0	0	0	0	0	17. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDIATRICS	4, 595			10, 083		1
	04300 NURSERY	109	1, 577	0	473	1, 560	43.00
-	ANCILLARY SERVICE COST CENTERS	4 (04	10 (00		F 000	10.440	
1	05000 OPERATING ROOM	1, 601	13, 688	1	5, 890	l	1
	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	761 0	11, 051 0	0	3, 311 0	10, 932 0	1
1	05400 RADI OLOGY-DI AGNOSTI C	231	1, 010		3, 645		1
	05400 RADI OLOGI - DI AGNOSTI C	109	454		3, 043 870	0	54.00
	05402 NUCLEAR MEDICINE	110	ŀ		355	1	54. 02
1	05700 CT SCAN	232	276		380	ĺ	57.00
	05800 MAGNETIC RESONANCE IMAGING (MRI)	271	556		380	Ö	58.00
	06000 LABORATORY	137	1, 043		4, 618	O	60.00
1	06400 INTRAVENOUS THERAPY	0	0	1	1, 894	0	64.00
65.00	06500 RESPI RATORY THERAPY	178	0	0	2, 057	0	65.00
66.00	06600 PHYSI CAL THERAPY	309	4, 074	0	0	0	66.00
	06700 OCCUPATI ONAL THERAPY	17	222	0	135	0	67.00
	06800 SPEECH PATHOLOGY	1	15		0	0	68. 00
1	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	73.00
1	03020 WOUND CARE	118	1, 337		1, 371	4, 528	1
	07697 CARDIAC REHABILITATION 07698 SLEEP LAB	0	0	-	814	2, 686	1
	07698 SLEEP LAB 07700 ALLOGENEIC HSCT ACQUISITION	155 0	738 0		462 0	0	
<del>-</del>	OUTPATIENT SERVICE COST CENTERS			U	0		17.00
	09000 CLINIC	241	3, 183	0	3, 581	0	90.00
4	09001 ONCOLOGY CLINIC	0	0, 109		753		1
1	09100 EMERGENCY	1, 293	· -		6, 910	l .	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	,			,	, -	92.00
	OTHER REIMBURSABLE COST CENTERS						
102.00	10200 OPIOID TREATMENT PROGRAM	0	0	0	0	0	102. 00
	SPECIAL PURPOSE COST CENTERS						
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	10, 468	65, 233	135, 332	53, 148	95, 256	118. 00
	NONREI MBURSABLE COST CENTERS		·			г	
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		0	1 010	l e	190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	240	10, 564	0	1, 819	<b>l</b>	192.00
4	07950 OTHER NONALLOWABLE	0	0	0	355	0	194.00
200.00	Cross Foot Adjustments	_	_		0	_	200. 00 201. 00
201. 00 202. 00	Negative Cost Centers TOTAL (sum lines 118 through 201)	10, 708	75, 797	135, 332	0 55, 322		201.00
202.00	TOTAL (Suil TITIES 110 LITTUUGIT 201)	10, 708	15, 191	130, 332	აა, ა22	J 95, 250	1202. UU

Health Financial Systems ST. FRANCIS HOSPITAL In Lieu of Form CMS-2552-10 ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 14-1350 Peri od: Worksheet B From 07/01/2022 Part II Date/Time Prepared: 06/30/2023 1/24/2024 11:37 am Cost Center Description **PHARMACY** MEDI CAL SOCI AL Subtotal Intern & SERVI CE RECORDS & Resi dents LI BRARY Cost & Post Stepdown Adjustments 15. 00 16.00 17.00 24.00 25. 00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00570 ADMITTING 5.01 5.01 00540 PATIENT ACCOUNTING 5.02 5.02 00550 ADMINISTRATIVE & GENERAL 5.03 5.03 6.00 00600 MAINTENANCE & REPAIRS 6.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8 00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 10.00 01100 CAFETERI A 11.00 11.00 01300 NURSING ADMINISTRATION 13.00 13.00 15.00 01500 PHARMACY 162, 844 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 25, 882 16.00 0 01700 SOCIAL SERVICE 17.00 0 0 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 769 0 576, 496 30.00 04300 NURSERY 0 26, 412 43.00 0 47 0 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 1,910 0 661, 576 0 50.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 327 0 163, 134 0 52.00 53.00 05300 ANESTHESI OLOGY 0 0 0 41, 316 Ω 53 00 1 113 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 1,070 257, 472 0 54.00 54.01 05401 ULTRASOUND 1, 045 0 97, 462 0 54.01 54.02 05402 NUCLEAR MEDICINE 0 0 377 0 59, 110 0 54.02 05700 CT SCAN 0 57 00 3, 735 35 880 57 00 0 0 05800 MAGNETIC RESONANCE IMAGING (MRI) 58.00 1, 227 39, 520 0 58.00 06000 LABORATORY 0000 3, 422 0 208, 555 0 60.00 60.00 64.00 06400 I NTRAVENOUS THERAPY 583 0 61, 252 0 64.00 65.00 06500 RESPIRATORY THERAPY 0 140, 169 0 65 00 642 0 66.00 06600 PHYSI CAL THERAPY 995 119,864 0 66.00 06700 OCCUPATI ONAL THERAPY 67.00 54 6,884 67.00 0 68.00 06800 SPEECH PATHOLOGY 0 0 68.00 612 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 0 394 71.00 54, 432 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 594 0 20,045 0 72.00 73 00 07300 DRUGS CHARGED TO PATIENTS 162, 844 3, 914 0 384, 814 0 73.00 03020 WOUND CARE 0 69.546 76.00 0 76.00 0 200 οĺ 07697 CARDIAC REHABILITATION 76.97 0 102 34, 424 0 76.97 76.98 07698 SLEEP LAB 0 176 0 16, 312 0 76.98 07700 ALLOGENEIC HSCT ACQUISITION 0 0 77.00 77.00 0 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 858 0 77, 920 0 90.00 90. 01 09001 ONCOLOGY CLINIC 0 94 0 42, 368 0 90.01 09100 EMERGENCY 91.00 0 0 391, 398 91.00 2.230 0 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 0 92.00 OTHER REIMBURSABLE COST CENTERS 102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 0 0 102.00 SPECIAL PURPOSE COST CENTERS

162, 844

162,844

0

0

25, 882

25,882

C

C

0

0

0

0

0 0 3, 586, 973

14.131

251, 631

3, 891, 511

38, 776

0 118.00

0 190. 00

0 192.00

0 194.00 0 200.00

0 201.00

0 202.00

118.00

200.00

201.00

202.00

SUBTOTALS (SUM OF LINES 1 through 117)

TOTAL (sum lines 118 through 201)

NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN

192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES

Cross Foot Adjustments

Negative Cost Centers

194. 00 07950 OTHER NONALLOWABLE

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS ST. FRANCIS HOSPITAL Provider CCN: 14-1350

In Lieu of Form CMS-2552-10

| Period: | Worksheet B | From 07/01/2022 | Part II | Date/Time Prepared: 1/24/2024 11:37 am

STATE   CONTROL   CONTRO				1/24/2024 11:	
GENERAL SERVICE COST CENTERS   1.00   00100 CAP REL COSTS-ELDIC & FIXT   1.00   00100 CAP REL COSTS-ENUEL EQUIP   2.00   4.00   00400 CAP REL COSTS-ENUEL EQUIP   4.00   00400 CAP REL COSTS-ENUEL EQUIP   4.00   00400 CAP REL COSTS-ENUEL EQUIP   4.00   00570 ADMITTIRS   5.01		Cost Center Description	Total		
1.00   0.0100   CAP REL COSTS-BLOG & FIXT			26. 00		
2.00					
4.00   0.0400   PMPLOYER BENEFITS DEPARTEMENT   5.01   0.0570   0.00570   DMMITTIN 0   5.01   0.0570   DMMITTIN 0   5.02   5.02   5.03   0.0550   DMMITTIN CACCUNITIN 0   5.00   5.00   0.0500   DMMITTIN CACCUNITIN 0   5.00   5.00   0.0500   DMMITTIN CACCUNITIN 0   5.00   5.00   0.0000   DMMITTIN 0   0.00   0.0000   0.0000   DMMITTIN 0   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.00000   0.0000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000					1
D. 00   DOSTO   ADMITTIN O   S. 0.0   S. 0.0   S. 0.0   DOSTO   ADMITTIN O   S. 0.0   S. 0					1
5.02   0.0540   PATENT ACCOUNTING   5.02   5.03   0.0550   DAIN STRATILY E& GENERAL   5.03   6.00   0.0660   MAIN STRATILY E& GENERAL   5.03   6.00   0.0660   MAIN STRATILY E& GENERAL   7.00   6.00   0.0660   DERATION OF PLANT   7.00   6.00   0.0800   LANINGRY & LINEN SERVICE   9.00   7.00   0.0900   DERATION OF PLANT   10.00   7.00   0.0900   DETATE A   10.00   7.00   0.0000   DETATE A   10.00   7.00   0.0000   DETATE A   11.00   7.00   0.0000   DETATE A   7.00   0.000					1
5. 0.0         00500 (ADM IN STRANT VE & CENERAL         6. 00           6. 0.0         00500 (ADM IN STRANT CE & REPAIRS         6. 00           8. 0.0         00500 (JUNEN) TALL INLEN SERVICE         8. 00           9. 0.0         00900 (HOUSEKEEPI NG         10. 00           11. 0.0         01000 (DIT STANY         10. 00           11. 0.0         01000 (JETERTY         10. 00           11. 0.0         01000 (JETERTY         10. 00           15. 0.0         01000 (JETERTY         10. 00           15. 0.0         01000 (JETERTY         11. 00           15. 0.0         01000 (JETERTY         16. 00           16. 0.0         11. 0.0         11. 00           15. 0.0         01000 (JETERTY STANT)         16. 00           17. 0.0         11. 0.0         11. 0.0           18. 0.0         11. 0.0         11. 0.0           19. 0.0         10. 0.0         10. 0.0           10. 0.0         10. 0.0         10. 0.0           11. 0.0         11. 0.0         11. 0.0           12. 0.0         10. 0.0         10. 0.0           12. 0.0         10. 0.0         10. 0.0         10. 0.0           12. 0.0         10. 0.0         10. 0.0         10. 0.					
6.00       00000 MAI NETHANCE & REPAIR IS       7.00         7.00       007000 OPERATI NO PENATT       8.00         8.00       00000 UPERATI NO PENATY       10.00         10.00       010000 DIETARY       11.00         11.00       011000 CAFTERIA       11.00         13.00       01300 MURSI NG ADMINISTRATION       13.00         17.00       01700 CAFTERIA       11.00         17.00       01700 MURDI CAL RECORDS & LI BRARY       16.00         17.00       01700 SOCIAL SERVICE       17.00         IMPATE LET ROUTINE SERVICE COST CENTERS       17.00         30.00       03000 ADULTS & PEDIATRICS       576, 496         30.00       03000 MURSERY       26, 412         40.00       1600 OPERATI NG ROUM       661, 576         52.00       00       50.00         00       05200 DELIVERY ROUM & LABOR ROUM       163, 134         54.00       05400 RASIDICAGN MESTERS LOUGH SETTERS       51.00         54.00       0500 OR RADIOLOGY-DIAGNOSTIC       257, 472       54.00         54.00       0500 OR RADIOLOGY-DIAGNOSTIC       257, 472       54.00         54.00       0500 OR RADIOLOGY-DIAGNOSTIC       257, 472       54.00         54.00       05400 MISTERY		1			1
7. 00       00700   OPERATION OF PLANT       8. 80         8. 00       00800   LAINDRY & LINENS ESPICE       9. 00         9. 00       00900   HOUSEKEEPING       9. 00         11. 00       00 1000   CAFETERI A       11. 00         11. 00       01100   CAFETERI A       11. 00         15. 00       01500   PHARMACY       15. 00         15. 00       01500   PHARMACY       15. 00         17. 00       01700   SOCI AL SERVICE       17. 00         17. 00       01700   SOCI AL SERVICE       17. 00         43. 00       000   MURIS RETAIL ROUTH SERVICE COST CENTERS       17. 00         43. 00       000   MURIS RETAIL ROUTH SERVICE COST CENTERS       43. 00         50. 00       000   MURIS RETAIL ROUTH SERVICE COST CENTERS       43. 00         50. 00       000   OPERATING ROUND       661, 576         50. 00       000   OPERATING ROUND       671, 472         50. 00       000   OPERATING ROUND       671, 472         50. 00       000   A		1			1
B. 00   00000   LAUNDRY & LINEN SERVICE		1			1
9, 00 10.00   00000   BETARY		1			
10. 00   10000   DIETRRY		1			1
11.00   10.100   CAFETERIA		1			1
13. 00   10.100   NURSI NS ADMINI STRATION   15. 00   10. 00   PHARMACY   15. 00   10. 00   PHARMACY   15. 00   10. 00   PHARMACY   16. 00   10. 00   10. 00   PHARMACY   17. 00   10					
15.00   01500   PHARMACY					1
16. 00   104.00   MEDICAL RECORDS & LIBRARY		1			1
17. 00   1700   SOCIAL SERVICE					1
INPATI ENT ROUTINE SERVICE COST CENTERS   30.00   33.00   00   3300   00   3300   00					
30. 00	17. 00				17.00
A3. 00   O4300   NURSERY   26, 412   43. 00					
ANCILLARY SERVICE COST CENTERS   50.00   50.					1
50.00   05000  0PERATI INC ROOM   163, 134   52.00   53.00   05300   ANESTHESI OLOGY   41, 316   52.00   53.00   05400   ANESTHESI OLOGY   41, 316   53.00   54.00   054000   ANESTHESI OLOGY   41, 316   54.00   54.01   05401   ULTRASOUND   79, 462   54.01   54.01   54.01   ULTRASOUND   54.01   54.02   5402   NUCLEAR MEDI CI NE   59, 110   54.02   57.00   6700   CT SCAN   58.80   57.00   570.00   5700   CT SCAN   58.80   57.00   6700   CT SCAN   58.80   57.00   6700   CT SCAN   58.80   58.00   68000   LABORATORY   208, 555   60.00   60.	43.00		26, 412		43.00
S2.00   05200   DELIVERY ROOM & LABOR ROOM   1-63, 134   52, 00   05300   ANESTHESI OLOGY   41, 316   53, 00   05300   ANESTHESI OLOGY   41, 316   54, 00   54.00   05400   RADI OLLOGY-DI AGNOSTI C   257, 472   54, 00   54.00   54.00   05400   RUILEAR MEDI CI NE   59, 110   54.01   54.01   54.02   57.00   05700   CT SCAN   35, 880   57.00   58.00   05800   MAGNETIC RESONANCE IMAGING (MRI ) 39, 520   58.00   60.00   06.00   06.000   LABORATORY   208, 555   60.00   06.00   06.000   06.	EO 00		441 674		FO 00
53.00   05300   ABSTHESI OLOGY					1
54. 00					1
54. 01   05401   UITRASOUND   57. 462   05402   NUCLEAR MEDICINE   59.110   54. 02   05402   NUCLEAR MEDICINE   59.110   54. 02   05700   CT SCAN   35. 880   57. 00   05700   CT SCAN   35. 880   57. 00   06700   CT SCAN   35. 880   57. 00   06800   MAGNETIC RESONANCE IMAGING (MRI)   39. 520   58. 00   06400   000   CABORATORY   208, 555   60. 00   06000   LABORATORY   61. 252   64. 00   06400   RESPIRATORY THERAPY   140. 169   66. 00   06600   PHYSI CAL THERAPY   119, 864   66. 00   06600   PHYSI CAL THERAPY   119, 864   67. 00   0700   0CCUPATI ONAL THERAPY   68.84   67. 00   0700   0CCUPATI ONAL THERAPY   68.84   67. 00   07100   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS   54, 432   77. 00   07200   IMPL. De EV. CHARGED TO PATIENTS   384, 814   77. 00   07300   DRUGS CHARGED TO PATIENTS   384, 814   77. 00   07300   DRUGS CHARGED TO PATIENTS   384, 814   77. 00   07300   DRUGS CHARGED TO PATIENTS   384, 814   77. 00   07300   DRUGS CHARGED TO PATIENTS   384, 814   77. 00   07300   DRUGS CHARGED TO PATIENTS   384, 814   77. 00   07300   DRUGS CHARGED TO PATIENTS   384, 814   77. 00   07300   DRUGS CHARGED TO PATIENTS   384, 814   77. 00   07300   DRUGS CHARGED TO PATIENTS   384, 814   77. 00   07300   DRUGS CHARGED TO PATIENTS   384, 814   77. 00   07300   DRUGS CHARGED TO PATIENTS   384, 814   77. 00   07300   DRUGS CHARGED TO PATIENTS   394, 814   77. 00   07300   DRUGS CHARGED TO PATIENTS   394, 814   77. 00   07300   DRUGS CHARGED TO PATIENTS   394, 814   77. 00   07300   DRUGS CHARGED TO PATIENTS   394, 814   77. 00   07300   DRUGS CHARGED TO PATIENTS   394, 814   77. 00   07300   DRUGS CHARGED TO PATIENTS   394, 814   77. 00   07300   DRUGS CHARGED TO PATIENTS   394, 814   77. 00   07300   DRUGS CHARGED TO PATIENTS   394, 814   77. 00   07300   DRUGS CHARGED TO PATIENTS   07. 00   07300   DRUGS CHARGED TO PATIENTS   07. 00   07300   DRUGS CHARGED TO PATIENTS   07. 00   07300   07300   07300   07300   07300   07300   07300   07300   07300   07300   07300   07300   07300   07300   07300   07300   0730					1
54. 02   05400   NUCLEAR MEDICINE   59, 110   05700   CT SCAN   35, 880   57. 00   05700   CT SCAN   35, 880   58. 00   06800   MACMETIC RESONANCE IMAGING (MRI)   39, 520   58. 00   06800   MACMETIC RESONANCE IMAGING (MRI)   39, 520   60. 00   06600   ALBORATORY   208, 555   60. 00   06400   INTRAVENOUS THERAPY   61, 252   64. 00   66. 00					1
57.00   05700   CT SCAN   35,880   55.00   05800   MAGNETIC RESONANCE IMAGING (MRI)   39,520   58.00   06000   LABORATORY   208,555   60.00   64.00   06400   INTRAVENOUS THERAPY   61,252   64.00   66.50   06500   RESPIRATORY THERAPY   140,169   65.00   66500   RESPIRATORY THERAPY   119,864   66.00   6600   06700   OCCUPATI ONAL THERAPY   6,884   67.00   06700   OCCUPATI ONAL THERAPY   61,252   68.00   68.00   SPECER PATHOLOGY   612   71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   54,432   771.00   772.00   IMPL. DE V. CHARGED TO PATIENTS   20,045   72.00   772.00   IMPL. DE V. CHARGED TO PATIENTS   384,814   73.00   73.00   07300   ROUGS CHARGED TO PATIENTS   384,814   73.00   76.90   03020   MOUND CARE   69,546   76.90   76.97   07697   CARDI AC REHABILITATION   34,424   76.97   76.98   07698   SLEEP LAB   16,312   76.98   76.98   07698   SLEEP LAB   16,312   77.00   07700   ALLOGENEIC HSCT ACQUISITION   0   0   0   0   0   0   0   0   0					
58. 00   05.00   05.000   LABORATORY   208, 555   60. 00		1			1
60. 00   06.000   LABORATORY   208,555   60. 00   64. 00   06400   INTRAVENOUS THERAPY   61,252   65. 00   65. 00   65. 00   GESPI RATORY THERAPY   140, 169   65. 00   66. 00   06. 00   06.000   PREPIRATORY THERAPY   140, 169   66. 00   06. 00					1
64. 00   06400   INTRAVENOUS THERAPY   61, 252   64. 00   65. 00   06500   RESPI RATORY THERAPY   119, 864   65. 00   66. 00   06600   PHYSI CAL THERAPY   119, 864   65. 00   66. 00   06600   PHYSI CAL THERAPY   119, 864   67. 00   06700   0CCUPATI ONAL THERAPY   6. 884   67. 00   06800   SPECH PATHOLOGY   612   68. 00   06800   SPECH PATHOLOGY   67. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   54. 432   71. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   20. 045   72. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   384, 814   73. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   384, 814   73. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   384, 814   76. 97   76. 97   CARDI AC REHABI LITATI ON   34. 424   76. 97   76. 98   07698   SLEEP LAB   16. 312   77. 00   07700   ALLOGENEI C HSCT ACQUISITI ON   0   0   07100   0700   ALLOGENEI C HSCT ACQUISITI ON   0   0   07100   0700   0700   O700   O70					
65. 00   06500   RESPIRATORY THERAPY   110, 169   65. 00   666. 00   06600   PHYSI CAL THERAPY   119, 864   67. 00   66. 00   06700   OCCUPATI ONAL THERAPY   68. 884   67. 00   680. 00   06800   SPEECH PATHOLOGY   61.2   68. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   54. 432   71. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   20, 045   72. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   384, 814   73. 00   73.00   07300   DRUGS CHARGED TO PATI ENTS   384, 814   73. 00   76. 97   07697   CARDI AC REHABI LI TATI ON   34, 424   76. 97   76. 98   07698   SLEEP LAB   16, 312   77. 00   0000   0000   CLI NI C   77. 920   90. 00   0000   CLI NI C   77. 920   90. 00   0000   CLI NI C   77. 920   90. 00   0000   DRUGS CHORGENI C HSCT ACQUI SI TI ON   0   0000   0000   DRUGS CHORGENI C HSCT ACQUI SI TI ON   0   0000   0000   DRUGS CHORGENI C HSCT ACQUI SI TI ON   0   0000   0000   0000   DRUGS CHORGENI C HSCT ACQUI SI TI ON   0   0000   0					
66. 00   06600   PHYSI CAL THERAPY   119, 864   66. 00   67. 00   06700   0CCUPATI IONAL THERAPY   6. 884   67. 00   67. 00   06800   SPEECH PATHOLOGY   612   68. 00   6800   SPEECH PATHOLOGY   612   68. 00   67. 00   6					1
67. 00		1			1
68. 00		1			
71. 00		1			
72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   20, 045   73. 00   7300   DRUGS CHARGED TO PATIENTS   384, 814   73. 00   03020   WOUND CARE   69, 546   76. 00   03020   WOUND CARE   69, 546   76. 00   76. 97   76. 98   CARDI AC REHABILITATION   34, 424   76. 97   76. 98   SLEEP LAB   16, 312   76. 98   77. 00   07700   ALLOGENEIC HSCT ACQUISITION   0   00   00   00   00   00   00   0					
73. 00		1			1
76. 00 03020 WOUND CARE 69, 546 76. 97 07697 CARDI AC REHABILITATION 34, 424 76. 97 76. 98 07698 SLEEP LAB 16, 312 77. 00 07700 ALLOGENEI C HSCT ACQUI SITION 0 77. 00 00 00 00 0 0 0 0 0 0 0 0 0 0 0 0 0					
76. 97					
76. 98					1
77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON 0 0UTPATI ENT SERVI CE COST CENTERS  90. 00 09000 CLI NI C 77, 920 90. 00 90. 01 09001 0NCOLOGY CLI NI C 42, 368 90. 01 91. 00 09100 EMERGENCY 391, 398 91. 00 92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 92. 00 0THER REI MBURSABLE COST CENTERS  102. 00 10200 OPI OI D TREATMENT PROGRAM 0 102. 00 SPECIAL PURPOSE COST CENTERS  118. 00 SUBTOTALS (SUM OF LI NES 1 through 117) 3, 586, 973 NONREI MBURSABLE COST CENTERS  190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 14, 131 190. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 251, 631 192. 00 194. 00 07950 OTHER NONALLOWABLE 38, 776 200. 00 Cross Foot Adjustments 0 200. 00 201. 00 Negati ve Cost Centers 0 201. 00					1
OUTPATIENT SERVICE COST CENTERS   90.00   09000   CLINIC   77, 920   90.00   90.01   09001   0NCOLOGY CLINIC   42, 368   90.01   90.00   90.00   09100   EMERGENCY   391, 398   91.00   91.00   91.00   000000					
90. 00	,,,,,,		<u> </u>		1 /// 00
90. 01	90.00		77, 920		90.00
91. 00					1
92. 00 0710 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0					
OTHER REIMBURSABLE COST CENTERS   102.00   10200   OPI OI D TREATMENT PROGRAM   0   SPECI AL PURPOSE COST CENTERS   118.00   SUBTOTALS (SUM OF LINES 1 through 117)   3,586,973   118.00   NONREI MBURSABLE COST CENTERS   190.00   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   14,131   190.00   19200   PHYSI CI ANS' PRI VATE OFFI CES   251,631   192.00   194.00   O7950   OTHER NONALLOWABLE   38,776   194.00   200.00   Cross Foot Adjustments   0   Negative Cost Centers   0   201.00	92.00				92.00
SPECIAL PURPOSE COST CENTERS   118. 00   SUBTOTALS (SUM OF LINES 1 through 117)   3,586,973   118. 00   NONREI MBURSABLE COST CENTERS   190. 00   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   14,131   190. 00   19200   PHYSI CI ANS' PRI VATE OFFI CES   251,631   192. 00   194. 00   07950   OTHER NONALLOWABLE   38,776   194. 00   200. 00   Cross Foot Adjustments   0   200. 00   Negative Cost Centers   0   201. 00   190. 0			·		
SPECIAL PURPOSE COST CENTERS   118. 00   SUBTOTALS (SUM OF LINES 1 through 117)   3,586,973   118. 00   NONREI MBURSABLE COST CENTERS   190. 00   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   14,131   190. 00   19200   PHYSI CI ANS' PRI VATE OFFI CES   251,631   192. 00   194. 00   07950   OTHER NONALLOWABLE   38,776   194. 00   200. 00   Cross Foot Adjustments   0   200. 00   Negative Cost Centers   0   201. 00   190. 0	102.00	10200 OPIOID TREATMENT PROGRAM	0		102. 00
NONREI MBURSABLE COST CENTERS   190.00   19000   GI FT, FLOWER, COFFEE SHOP & CANTEEN   14, 131   190.00   192.00   19200   PHYSI CI ANS' PRI VATE OFFI CES   251, 631   192.00   194.00   07950   OTHER NONALLOWABLE   38, 776   194.00   200.00   Cross Foot Adjustments   0   200.00   Negative Cost Centers   0   201.00					
190. 00	118.00	SUBTOTALS (SUM OF LINES 1 through 117)	3, 586, 973		118. 00
192. 00     19200     PHYSI CI ANS' PRI VATE OFFI CES     251, 631       194. 00     07950     0THER NONALLOWABLE     38, 776       200. 00     Cross Foot Adjustments     0       201. 00     Negative Cost Centers     0					
194. 00     07950     OTHER NONALLOWABLE     38,776       200. 00     Cross Foot Adjustments     0       201. 00     Negative Cost Centers     0					
200.00     Cross Foot Adjustments     0       201.00     Negative Cost Centers     0					
201.00   Negative Cost Centers   0   201.00			38, 776		
		,	0		
202.00   TOTAL (sum lines 118 through 201)   3,891,511   202.00			o <sub>l</sub>		
	202.00		3, 891, 511		202.00

Health Financial Systems ST. FRANCIS HOSPITAL COST ALLOCATION - STATISTICAL BASIS Provider CCN: 14-1350 Peri od: Worksheet B-1 From 07/01/2022 06/30/2023 Date/Time Prepared: 1/24/2024 11:37 am CAPITAL RELATED COSTS ADMITTI NG BLDG & FIXT MVBLE EQUIP **EMPLOYEE** PATI ENT Cost Center Description (SQUARE FEET) (DOLLAR **BENEFLTS** (GROSS ACCOUNTLING DEPARTMENT CHARGES) VALUE) (GROSS (GROSS CHARGES) SALARIES) 1. 00 2.00 4.00 5. 01 5. 02 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 185, 462 1 00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 940, 602 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 14, 077, 133 4.00 92 4.00 688 00570 ADMITTING 5.01 3,883 858  $\cap$ 171, 659, 468 5.01 5.02 00540 PATIENT ACCOUNTING 231 0 171, 659, 468 5.02 5.03 00550 ADMINISTRATIVE & GENERAL 22, 586 139, 271 846, 130 5.03 0 00600 MAINTENANCE & REPAIRS 6 00 27 053 0 0 6 00 00700 OPERATION OF PLANT 0 7.00 37, 521 35, 198 365, 810 0 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 0 0 8.00 9.00 00900 HOUSEKEEPI NG 3, 299 361, 973 0 0 0 9.00 01000 DI FTARY 9 030 1, 309 182, 717 10 00 10 00 0 11.00 01100 CAFETERI A 2, 952 1, 340 187, 153 0 11.00 01300 NURSING ADMINISTRATION 704 40, 485 0 0 13.00 846, 403 13.00 ol 01500 PHARMACY 603, 200 15.00 15.00 1.881 3, 157 0 01600 MEDICAL RECORDS & LIBRARY 16.00 0 48 0 0 0 16.00 17.00 01700 SOCIAL SERVICE C 0 0 17.00 0 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 18, 857 2 010 296 5, 095, 584 5, 095, 584 30.00 03000 ADULTS & PEDIATRICS 22.066 43.00 04300 NURSERY 880 4, 352 121, 672 310, 674 310, 674 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 14, 951 268, 850 1, 359, 467 12, 651, 126 12, 651, 126 50.00 05200 DELIVERY ROOM & LABOR ROOM 30, 486 849, 945 2, 165, 479 2, 165, 479 52 00 4,501 52 00 53.00 05300 ANESTHESI OLOGY 310 29, 567 7, 369, 549 7, 369, 549 53.00 05400 RADI OLOGY-DI AGNOSTI C 7, 084, 388 7, 084, 388 54.00 5, 232 133, 713 653, 338 54.00 05401 ULTRASOUND 67, 169 221, 972 6, 920, 812 54.01 369 6, 920, 812 54.01 2, 498, 700 05402 NUCLEAR MEDICINE 90,031 2, 498, 700 54.02 659 37, 240 54.02 57.00 05700 CT SCAN 533 82, 751 24, 733, 735 24, 733, 735 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 58 00 1,703 412 94, 968 8, 122, 700 8, 122, 700 58 00 06000 LABORATORY 4, 765 1,012,143 22, 659, 173 22, 659, 173 60.00 9, 235 60.00 06400 INTRAVENOUS THERAPY 64.00 3.069 350, 744 3, 859, 135 3, 859, 135 64 00 06500 RESPIRATORY THERAPY 4, 127 14, 341 4, 254, 324 4, 254, 324 65.00 432, 112 65.00 66.00 06600 PHYSI CAL THERAPY 4,885 8, 910 496 6, 586, 938 6, 586, 938 66.00 06700 OCCUPATI ONAL THERAPY 67.00 45, 317 356, 661 356, 661 265 C 67.00 68.00 06800 SPEECH PATHOLOGY 18 C 0 24, 625 24, 625 68.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 2,528 C 0 2, 610, 291 2, 610, 291 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 3, 936, 974 3, 936, 974 72.00 C 0 72.00 0 26, 184, 233 07300 DRUGS CHARGED TO PATIENTS 26, 184, 233 73 00  $\cap$ 73.00 76.00 03020 WOUND CARE 1,728 3, 361 217, 162 1, 324, 046 1, 324, 046 76.00 76.97 07697 CARDIAC REHABILITATION 1, 405 222, 694 673, 121 673, 121 76.97 07698 SLEEP LAB 90, 932 76.98 76.98 200 6.014 1, 168, 735 1, 168, 735 07700 ALLOGENEIC HSCT ACQUISITION 77.00  $\cap$ 0 77.00 OUTPATIENT SERVICE COST CENTERS 90.00 1, 693 6, 282 530, 976 5, 680, 733 5, 680, 733 90.00 09000 CLI NI C 09001 ONCOLOGY CLINIC 10, 940 90.01 1.208 145, 136 620,046 620,046 90.01 91.00 09100 EMERGENCY 12,842 39, 647 1, 820, 124 14, 767, 686 14, 767, 686 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 0 102.00 102.00 10200 OPIOID TREATMENT PROGRAM 0 0 0 0 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 168, 907 914, 939 13, 772, 715 171, 659, 468 171, 659, 468 118. 00 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 938 20 0 190.00 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 12, 601 227, 433 0 0 192.00 15.477 140 194. 00 07950 OTHER NONALLOWABLE 13, 042 76, 985 ol 0 194.00 200 00 Cross Foot Adjustments 200 00 201.00 Negative Cost Centers 201.00 2, 952, 619 226, 694 727, 692 202. 00 202.00 Cost to be allocated (per Wkst. B, 1, 634, 559 953.743 Part I) Unit cost multiplier (Wkst. B, Part I) 0.209746 0.001321 0.004239 203.00 203.00 8.813444 1.013971 204.00 Cost to be allocated (per Wkst. B, 1,509 37, 123 9, 793 204. 00 Part II) 0.000057 205.00 205.00 Unit cost multiplier (Wkst. B, Part 0.000107 0.000216 II)

206.00

207.00

NAHE adjustment amount to be allocated

NAHE unit cost multiplier (Wkst. D,

(per Wkst. B-2)

Parts III and IV)

206.00

207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-1350 Peri od: Worksheet B-1 From 07/01/2022 06/30/2023 Date/Time Prepared: 1/24/2024 11:37 am Cost Center Description Reconciliatio ADMINISTRATIV MAINTENANCE & OPERATION OF LAUNDRY & **REPAIRS** LINEN SERVICE E & GENERAL PLANT n (ACCUM. COST) (SQUARE FEET) (SQUARE FEET) (POUNDS OF LAUNDRY) 5. 03 7. 00 5A. 03 6.00 8.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 2 00 00200 CAP REL COSTS-MVBLE EQUIP 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00570 ADMITTING 5.01 5.01 5.02 00540 PATIENT ACCOUNTING 5.02 35, 453, 395 00550 ADMINISTRATIVE & GENERAL -6, 575, 354 5.03 5 03 6.00 00600 MAINTENANCE & REPAIRS 180, 947 158, 670 6.00 7.00 00700 OPERATION OF PLANT 0 2, 321, 615 37, 521 121, 149 7 00 00800 LAUNDRY & LINEN SERVICE 109, 127 0 185, 521 8.00 8.00 00900 HOUSEKEEPI NG 0 9 00 754, 315 3 299 3 299 0 9 00 0 10.00 01000 DI ETARY 459, 998 9,030 9,030 0 10.00 11.00 01100 CAFETERI A 415, 666 2, 952 2, 952 0 11.00 0 01300 NURSING ADMINISTRATION 1,063,342 13.00 13.00 704 704 0 15.00 01500 PHARMACY 1,046,682 1,881 1,881 0 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 515, 107 0 16.00 17.00 01700 SOCIAL SERVICE 0 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 2, 762, 670 18, 857 18, 857 79, 617 30.00 04300 NURSERY 0 43.00 176,064 880 880 1,882 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATI NG ROOM 14, 951 50.00 0 3, 724, 979 14, 951 27, 745 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 1, 215, 452 4,501 4,501 13, 182 52.00 05300 ANESTHESI OLOGY 0 53.00 95, 213 310 310 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 54 00 0 0 1 163 892 5 232 5, 232 4.001 54 00 54.01 05401 ULTRASOUND 514, 599 369 369 1,885 54.01 54.02 05402 NUCLEAR MEDICINE 278, 179 659 659 1, 901 54.02 57.00 05700 CT SCAN 00000000000 449, 709 533 533 4.017 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 58.00 324, 084 1,703 1,703 4,703 58.00 2, 370 60.00 06000 LABORATORY 2, 632, 976 4,765 4,765 60.00 64.00 06400 I NTRAVENOUS THERAPY 472, 816 3,069 3,069 0 64.00 65 00 06500 RESPIRATORY THERAPY 693, 965 4 127 4 127 3 088 65 00 06600 PHYSI CAL THERAPY 66.00 1,032,100 4,885 4,885 5, 353 66.00 06700 OCCUPATI ONAL THERAPY 75, 687 265 290 67.00 67.00 265 68.00 06800 SPEECH PATHOLOGY 9,040 18 18 20 68.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 393, 419 71 00 2.528 2.528 71 00 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 466, 605 C 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 5, 354, 035 0 73.00 0 76.00 03020 WOUND CARE 919, 277 1,728 1.728 2,038 76.00 07697 CARDIAC REHABILITATION 76.97 76.97 302, 237 1, 405 1,405 0 76. 98 0 07698 SLEEP LAB 147, 474 200 200 2,686 76.98 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 77.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 823, 785 1, 693 1,693 4.184 90 00 90.01 09001 ONCOLOGY CLINIC 0 307, 746 1, 208 1, 208 0 90.01 91.00 09100 EMERGENCY 3, 394, 718 12, 842 12, 842 22, 397 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)
OTHER REIMBURSABLE COST CENTERS 92.00 92.00 102. 00 10200 OPI OI D TREATMENT PROGRAM 0 102.00 0 0 0 0 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) -6, 575, 354 34, 597, 520 181, 359 118. 00 118.00 142. 115 104.594 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 54, 710 938 938 0 190.00 4, 162 192.00 15, 477 15, 477 0 477.581 194.00 07950 OTHER NONALLOWABLE 0 323, 584 140 140 0 194.00 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, 6, 575, 354 214, 506 2, 802, 918 129, 366 202. 00 Part I) 203 00 Unit cost multiplier (Wkst. B, Part I) 0.185465 1.351900 23. 136122 0. 697312 203. 00 204.00 Cost to be allocated (per Wkst. B, 1, 396, 318 7, 130 468, 768 10, 708 204. 00 Part II) 0. 057719 205. 00 205.00 Unit cost multiplier (Wkst. B, Part 0.039385 0.044936 3 869351 II) 206.00 NAHE adjustment amount to be allocated 206.00 (per Wkst. B-2)

207.00

NAHE unit cost multiplier (Wkst. D,

Parts III and IV)

207.00

Heal th	Financial Systems	ST. FRANCIS	HOSPI TAL		In Lie	u of Form CMS-:	2552-10
COST A	LLOCATION - STATISTICAL BASIS		Provi der CC	F	Period: From 07/01/2022 To 06/30/2023	Worksheet B-1 Date/Time Pre 1/24/2024 11:	pared:
	Cost Center Description	HOUSEKEEPI NG (HOURS OF SERVI CE)	DI ETARY (MEALS SERVED)	CAFETERI A (FTE' S)	NURSI NG ADMI NI STRATI O N	PHARMACY (COSTED REQUIS.)	
					(DI RECT NURS. HRS. )		
	GENERAL SERVICE COST CENTERS	9. 00	10. 00	11.00	13. 00	15. 00	
1. 00 2. 00 4. 00 5. 01 5. 02	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00570 ADMITTING 00540 PATIENT ACCOUNTING						1. 00 2. 00 4. 00 5. 01 5. 02
5. 03 6. 00 7. 00 8. 00 9. 00	00550 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY	20, 857 0	27, 723				5. 03 6. 00 7. 00 8. 00 9. 00
11. 00 13. 00	01100   CAFETERI A   01300   NURSI NG   ADMI NI STRATI ON	0	0	15, 572 863			11.00
15. 00	01500 PHARMACY	o o	ő	591		100	1
16. 00 17. 00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	0	0	(	-	0	
17.00	INPATIENT ROUTINE SERVICE COST CENTERS	-	٥١				1
30. 00 43. 00	03000 ADULTS & PEDI ATRI CS 04300 NURSERY	3, 364 434	27, 723 0	2, 838 133		0	
	ANCILLARY SERVICE COST CENTERS		-1				
50. 00 52. 00	05000   OPERATING ROOM   05200   DELIVERY ROOM & LABOR ROOM	3, 766 3, 041	0	1, 658 932		0	
53.00	05300 ANESTHESI OLOGY	0	o	1 024		0	
54. 00 54. 01	05400  RADI OLOGY-DI AGNOSTI C   05401  ULTRASOUND	278 125	0	1, 02 <i>6</i> 245		0	54. 00 54. 01
54. 02	05402 NUCLEAR MEDICINE	130	o	100		0	54.02
57. 00 58. 00	05700  CT SCAN   05800  MAGNETIC RESONANCE IMAGING (MRI)	76 153	0	107 107		0	57. 00 58. 00
60. 00 64. 00	06000 LABORATORY 06400 I NTRAVENOUS THERAPY	287	0	1, 300 533		0	60. 00 64. 00
65. 00	06500 RESPIRATORY THERAPY	0	0	579		0	65.00
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	1, 121 61	0	38	-	0	66. 00 67. 00
68. 00	06800 SPEECH PATHOLOGY	4	o	(		0	68.00
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(	-	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	ő	(	0	100	•
76. 00 76. 97	03020   WOUND   CARE   07697   CARDI AC   REHABI LI TATI ON	368	0	38 <i>6</i> 229		0	
	07698 SLEEP LAB	203	o	130		0	1
77. 00	07700 ALLOGENEI C HSCT ACQUISITION	0	0		0	0	77. 00
90. 00	OUTPATIENT SERVICE COST CENTERS  09000 CLINIC	876	0	1, 008	3 0	0	90.00
	09001 ONCOLOGY CLINIC 09100 EMERGENCY	3, 663	0	212 1, 945		0	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	3,003		1, 743	1, 745	0	92.00
102 00	OTHER REIMBURSABLE COST CENTERS 10200 OPIOID TREATMENT PROGRAM	O	O	(	0	0	102. 00
	SPECIAL PURPOSE COST CENTERS						1
118. 00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	17, 950	27, 723	14, 960	8, 121	100	118. 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	(			190.00
	19200 PHYSICIANS' PRIVATE OFFICES 07950 OTHER NONALLOWABLE	2, 907	0	512 100			192. 00 194. 00
200.00	Cross Foot Adjustments						200.00
201. 00 202. 00		975, 000	766, 439	565, 046	1, 309, 110	1, 308, 312	201. 00 202. 00
203. 00	Part I)   Unit cost multiplier (Wkst. B, Part I)	46. 746896	27. 646323	36. 286026	161 200591	13, 083. 120000	203 00
204. 00	Cost to be allocated (per Wkst. B,	75, 797	135, 332	55, 322		162, 844	
205.00	Part II)   Unit cost multiplier (Wkst. B, Part	3. 634128	4. 881578	3. 552659	11. 729590	1, 628. 440000	205. 00
206.00							206. 00
207. 00	(per Wkst. B-2)						207. 00
	Parts III and IV)						

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS ST. FRANCIS HOSPITAL In Lieu of Form CMS-2552-10 Provider CCN: 14-1350 

				To 06/30/2023 Date/lime Pr 1/24/2024 11	
	Cost Center Description	MEDI CAL RECORDS & LI BRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	1727202111	. 67 '
	CENEDAL CEDIALCE COCT CENTEDO	16. 00	17. 00		
1. 00	GENERAL SERVICE COST CENTERS  00100 CAP REL COSTS-BLDG & FIXT				1.00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP				2.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT				4.00
5. 01	00570 ADMITTING				5. 01
5.02	00540 PATIENT ACCOUNTING				5. 02
5.03	00550 ADMINISTRATIVE & GENERAL				5. 03
6.00	00600 MAINTENANCE & REPAIRS				6.00
7. 00	00700 OPERATION OF PLANT				7.00
8. 00	00800 LAUNDRY & LINEN SERVICE				8.00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY				9. 00 10. 00
11. 00	01100 CAFETERI A				11.00
13. 00	01300 NURSI NG ADMI NI STRATI ON				13.00
15. 00	01500 PHARMACY				15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	171, 659, 468			16.00
17.00	01700 SOCIAL SERVICE	0	О		17. 00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDI ATRI CS	5, 095, 584	0		30.00
43. 00	04300 NURSERY	310, 674	0		43.00
F0 00	ANCILLARY SERVICE COST CENTERS	40 (54 40)			
50. 00 52. 00	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM	12, 651, 126 2, 165, 479	0		50. 00 52. 00
53.00	05300 ANESTHESI OLOGY	7, 369, 549	0		53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	7, 084, 388	0		54.00
54. 01	05401 ULTRASOUND	6, 920, 812	o		54. 01
54. 02	05402 NUCLEAR MEDICINE	2, 498, 700	O		54.02
57.00	05700 CT SCAN	24, 733, 735	o		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	8, 122, 700	0		58. 00
60.00	06000 LABORATORY	22, 659, 173	0		60.00
64.00	06400 I NTRAVENOUS THERAPY	3, 859, 135	0		64.00
65.00	06500 RESPI RATORY THERAPY	4, 254, 324	0		65.00
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	6, 586, 938 356, 661	0		66. 00 67. 00
68. 00	06800 SPEECH PATHOLOGY	24, 625	Ö		68.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 610, 291	ō		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	3, 936, 974	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	26, 184, 233	0		73.00
76. 00	03020 WOUND CARE	1, 324, 046	0		76. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	673, 121	0		76. 97
	07698 SLEEP LAB 07700 ALLOGENEIC HSCT ACQUISITION	1, 168, 735 0	0		76. 98 77. 00
77.00	OUTPATIENT SERVICE COST CENTERS	U U	U <sub>I</sub>		17.00
90.00	09000 CLI NI C	5, 680, 733	0		90.00
90. 01	09001 ONCOLOGY CLINIC	620, 046	0		90. 01
	09100 EMERGENCY	14, 767, 686	0		91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				92.00
102.00	OTHER REIMBURSABLE COST CENTERS 10200 OPIOID TREATMENT PROGRAM	0	0		102.00
102.00	SPECIAL PURPOSE COST CENTERS	U U	U <sub>I</sub>		102.00
118.00		171, 659, 468	0		118.00
	NONREI MBURSABLE COST CENTERS	, ,	- 1		
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		192.00
	07950 OTHER NONALLOWABLE	0	0		194. 00
200.00	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1				200.00
201.00		410 441			201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	610, 641	0		202. 00
203.00	1 1 /	0. 003557	0. 000000		203. 00
204.00		25, 882	0		204.00
	Part II)	.,			
205. 00	1 1	0. 000151	0. 000000		205. 00
20/ 2/	NAUE adjustment amount to be allegated				204 00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)				206. 00
207.00	1 1"				207. 00
3	Parts III and IV)				

Health Financial Systems	ST. FRANCIS HOSPITAL	In Lieu of Form CMS-2552-		
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 14-1350	Peri od: Worksheet C		
		From 07/01/2022 Part I		

					To 06/30/2023		pared:
			Title	XVIII	Hospi tal	Cost	37 alli
			11110	XVIII	Costs	0031	
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	<b>'</b>	(from Wkst.	Áďj.		Di sal I owance		
		B, Part I,					
		col. 26)					
		1. 00	2. 00	3. 00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDIATRICS	5, 294, 626		5, 294, 62		0	30.00
43. 00	04300 NURSERY	279, 239		279, 23	9 0	0	43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	5, 349, 781		5, 349, 78		0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1, 894, 207		1, 894, 20		0	52.00
53.00	05300 ANESTHESI OLOGY	146, 676		146, 67		0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 586, 088		1, 586, 08		0	54.00
54. 01	05401 ULTRASOUND	659, 739		659, 73		0	54. 01
54. 02 57. 00	05402 NUCLEAR MEDICINE 05700 CT SCAN	365, 829 644, 382		365, 82 644, 38		0	54. 02 57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	469, 099		469, 09		0	58.00
60.00	06000 LABORATORY	3, 380, 827		3, 380, 82		0	60.00
64. 00	06400 I NTRAVENOUS THERAPY	668, 728		668, 72		0	64.00
65. 00	06500 RESPIRATORY THERAPY	962, 029		962, 02		0	65.00
66. 00	06600 PHYSI CAL THERAPY	1, 422, 708		1, 422, 70		Ö	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	101, 915		101, 91		0	67.00
68. 00	06800 SPEECH PATHOLOGY	11, 446		11, 44		0	68. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	537, 575		537, 57		Ö	71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	567, 148		567, 14		0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	7, 748, 509		7, 748, 50		0	73.00
76.00	03020 WOUND CARE	1, 231, 649		1, 231, 64	9 0	0	76.00
76. 97	07697 CARDI AC REHABI LI TATI ON	440, 314		440, 31	4 0	0	76. 97
76. 98	07698 SLEEP LAB	199, 959		199, 95	9 0	0	76. 98
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0		(	0	0	77. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	1, 118, 676		1, 118, 67		0	90.00
90. 01	09001 ONCOLOGY CLINIC	404, 302		404, 30		0	90. 01
91.00	09100 EMERGENCY	4, 962, 286		4, 962, 28		0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	836, 609		836, 60	9	0	92.00
100.00	OTHER REIMBURSABLE COST CENTERS						100.00
	10200 OPI OI D TREATMENT PROGRAM	0					102. 00 200. 00
200.00		41, 284, 346		11,201,01			200.00
201. 00 202. 00	1	836, 609 40, 447, 737		836, 60 <sup>9</sup> 40, 447, 73			201.00
202.00	Trotal (See Histractions)	40, 447, 737	0	1 40,447,73	, i	, 0	1202.00

Health Financial Systems	ST. FRANCIS HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 14-1350	Period: Worksheet C From 07/01/2022 Part I

To 06/30/2023 Date/Time Prepared: 1/24/2024 11:37 am Title XVIII Hospi tal Cost Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other **TFFRA** + col. 7) Ratio I npati ent Ratio 6. 00 7.00 8.00 9.00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 30.00 3.864.664 3, 864, 664 43.00 04300 NURSERY 310, 674 310, 674 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 1, 028, 615 11, 622, 511 12, 651, 126 0.422870 0.000000 50.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 52 00 1.341.817 823, 662 2, 165, 479 0.874729 52 00 53.00 05300 ANESTHESI OLOGY 571, 321 6, 798, 228 7, 369, 549 0.019903 0.000000 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 278, 890 6, 805, 498 7, 084, 388 0.223885 0.000000 54.00 05401 ULTRASOUND 413, 169 6, 507, 643 6, 920, 812 0.095327 54.01 0.000000 54.01 05402 NUCLEAR MEDICINE 54.02 45.873 2, 452, 827 2, 498, 700 0.146408 0.000000 54 02 57.00 05700 CT SCAN 1,060,949 23, 672, 786 24, 733, 735 0.026053 0.000000 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 281, 238 7, 841, 462 8, 122, 700 0.057752 0.000000 58.00 60.00 06000 LABORATORY 3, 566, 040 22, 659, 173 0.000000 19, 093, 133 0.149203 60.00 64.00 06400 INTRAVENOUS THERAPY 313, 989 3, 545, 146 3, 859, 135 0.173284 0.000000 64.00 06500 RESPIRATORY THERAPY 65.00 1,020,619 3, 233, 705 4, 254, 324 0. 226130 0.000000 65.00 06600 PHYSI CAL THERAPY 389, 761 6, 197, 177 6, 586, 938 0.215989 0.000000 66.00 66,00 67 00 06700 OCCUPATI ONAL THERAPY 202.293 154, 368 356, 661 0.285748 0.000000 67 00 06800 SPEECH PATHOLOGY 14, 345 10, 280 24, 625 0.464812 0.000000 68.00 68.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 722, 574 1, 887, 717 2, 610, 291 0.205944 0.000000 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 300, 581 72.00 3, 636, 393 3, 936, 974 0.144057 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 2, 215, 365 23, 968, 868 26, 184, 233 0. 295923 0.000000 73.00 76.00 03020 WOUND CARE 3, 718 1, 320, 328 1, 324, 046 0.930216 0.000000 76.00 76. 97 07697 CARDIAC REHABILITATION 673, 121 673, 121 0.654138 76.97 0.000000 0 76.98 07698 SLEEP LAB 0 1, 168, 735 1, 168, 735 0.171090 0.000000 76. 98 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0 0.000000 0.000000 77.00 OUTPATIENT SERVICE COST CENTERS 90.00 0. 196925 0.000000 90.00 09000 CLI NI C 3.808 5, 676, 925 5, 680, 733 09001 ONCOLOGY CLINIC 90.01 375 619, 671 620,046 0.652052 0.000000 90.01 91.00 09100 EMERGENCY 310, 380 14, 457, 306 14, 767, 686 0.336023 0.000000 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 83, 422 1, 147, 498 1, 230, 920 0.679662 0.000000 92.00 OTHER REIMBURSABLE COST CENTERS 102. 00 10200 OPI OI D TREATMENT PROGRAM 102.00 200.00 Subtotal (see instructions) 18, 344, 480 153, 314, 988 171, 659, 468 200.00 201.00 Less Observation Beds 201.00 202.00 18.344.480 153, 314, 988 171, 659, 468 202.00 Total (see instructions)

Heal th Financial Systems

ST. FRANCIS HOSPITAL

In Lieu of Form CMS-2552-10

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1350
Francial Systems

Provid

			10 06/30/2023	Date/lime Prepared:   1/24/2024 11:37 am
		Title XVIII	Hospi tal	Cost
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00 03000 ADULTS & PEDIATRICS				30.00
43. 00 04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS				
50.00   05000   OPERATING ROOM	0. 000000			50.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	0. 000000			52.00
53. 00   05300   ANESTHESI OLOGY	0. 000000			53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 000000			54.00
54. 01  05401 ULTRASOUND	0. 000000			54. 01
54. 02   05402   NUCLEAR MEDICINE	0. 000000			54. 02
57.00  05700 CT SCAN	0. 000000			57.00
58.00   05800   MAGNETIC RESONANCE IMAGING (MRI)	0. 000000			58.00
60. 00  06000  LABORATORY	0. 000000			60.00
64.00   06400   I NTRAVENOUS THERAPY	0. 000000			64. 00
65. 00   06500   RESPI RATORY THERAPY	0. 000000			65. 00
66. 00  06600 PHYSI CAL THERAPY	0. 000000			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			67.00
68.00   06800   SPEECH PATHOLOGY	0. 000000			68. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73.00
76. 00   03020   WOUND CARE	0. 000000			76.00
76. 97   07697   CARDI AC   REHABI LI TATI ON	0. 000000			76. 97
76. 98   07698   SLEEP LAB	0. 000000			76. 98
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000			77. 00
OUTPATIENT SERVICE COST CENTERS				
90. 00   09000   CLI NI C	0. 000000			90.00
90. 01  09001 0NC0L0GY CLINIC	0. 000000			90. 01
91. 00   09100   EMERGENCY	0. 000000			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			92.00
OTHER REIMBURSABLE COST CENTERS				
102.00 10200 OPIOID TREATMENT PROGRAM				102. 00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
202.00   Total (see instructions)				202.00

Health Financial Systems	ST.	FRANCIS HO	SPI TAL		In Lieu	of Form CM	S-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES			Provi der	CCN: 14-1350	07/01/2022	Worksheet C Part I Date/Time P	repared:

					To 06/30/2023	Date/Time Pre 1/24/2024 11:	
			Ti tl	e XIX	Hospi tal	Cost	
	·				Costs		
	Cost Center Description	(from Wkst. B, Part I,	Γherapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
		col. 26)					
		1. 00	2. 00	3. 00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDIATRICS	5, 294, 626		5, 294, 62			
43.00	04300 NURSERY	279, 239		279, 23	9 0	279, 239	43.00
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	5, 349, 781		5, 349, 78		-, ,	
	05200 DELIVERY ROOM & LABOR ROOM	1, 894, 207		1, 894, 20		.,,	52.00
	05300 ANESTHESI OLOGY	146, 676		146, 67	6 0	146, 676	53.00
	05400   RADI OLOGY-DI AGNOSTI C	1, 586, 088		1, 586, 08	0 8	1, 586, 088	
54. 01	05401 ULTRASOUND	659, 739		659, 73		659, 739	
	05402 NUCLEAR MEDICINE	365, 829		365, 82	9 0	365, 829	
57.00	05700 CT SCAN	644, 382		644, 38	2 0	644, 382	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	469, 099		469, 09	9 0	469, 099	58. 00
60.00	06000 LABORATORY	3, 380, 827		3, 380, 82	7 0	3, 380, 827	60.00
64.00	06400 I NTRAVENOUS THERAPY	668, 728		668, 72	8 0	668, 728	64.00
65.00	06500 RESPI RATORY THERAPY	962, 029	0	962, 02	9 0	962, 029	65.00
66.00	06600 PHYSI CAL THERAPY	1, 422, 708	0	1, 422, 70	8 0	1, 422, 708	66.00
67.00	06700 OCCUPATI ONAL THERAPY	101, 915	0	101, 91	5 0	101, 915	67.00
68.00	06800 SPEECH PATHOLOGY	11, 446	0	11, 44	6 0	11, 446	68. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	537, 575		537, 57	5 0	537, 575	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	567, 148		567, 14	8 0	567, 148	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	7, 748, 509		7, 748, 50	9 0	7, 748, 509	73. 00
	03020 WOUND CARE	1, 231, 649		1, 231, 64	9 0	1, 231, 649	76. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	440, 314		440, 31	4 0	440, 314	76. 97
	07698 SLEEP LAB	199, 959		199, 95	9 0	199, 959	76. 98
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0			0 0	0	77. 00
	OUTPATIENT SERVICE COST CENTERS						1
90.00	09000 CLI NI C	1, 118, 676		1, 118, 67	6 0	1, 118, 676	90.00
90. 01	09001 ONCOLOGY CLINIC	404, 302		404, 30	2 0	404, 302	90. 01
91.00	09100 EMERGENCY	4, 962, 286		4, 962, 28	6 0	4, 962, 286	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	836, 609		836, 60	9	836, 609	92.00
	OTHER REIMBURSABLE COST CENTERS						1
102.00	10200 OPIOID TREATMENT PROGRAM	0			0	0	102.00
200.00	Subtotal (see instructions)	41, 284, 346	0	41, 284, 34	6 0	41, 284, 346	200.00
201.00		836, 609		836, 60		836, 609	201.00
202.00	Total (see instructions)	40, 447, 737	0				

Health Financial Systems	ST. FRANCIS HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 14-1350	Period: Worksheet C From 07/01/2022 Part I

	ATTOM OF NATIO OF GUSTS TO CHARGES		Trovider of	F	From 07/01/2022 To 06/30/2023	Part I Date/Time Pre 1/24/2024 11:	pared: 37 am
		_		e XIX	Hospi tal	Cost	
	Cost Center Description	I npati ent	Charges Outpati ent	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA I npati ent Rati o	
		6. 00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDIATRICS	3, 864, 664		3, 864, 664			30.00
43.00	04300 NURSERY	310, 674		310, 674	1		43.00
<b>50.00</b>	ANCILLARY SERVICE COST CENTERS	1 000 (45)	44 (00 544	10 (54 40)			
50.00	05000 OPERATING ROOM	1, 028, 615	11, 622, 511	12, 651, 126			
52.00	05200 DELIVERY ROOM & LABOR ROOM	1, 341, 817	823, 662				
53.00	05300 ANESTHESI OLOGY	571, 321	6, 798, 228			0.000000	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	278, 890	6, 805, 498			0.000000	
54. 01	05401 ULTRASOUND	413, 169	6, 507, 643			0.000000	
54. 02	05402 NUCLEAR MEDICINE	45, 873	2, 452, 827			0.000000	54. 02 57. 00
57. 00 58. 00	05700 CT SCAN   05800 MAGNETIC RESONANCE I MAGING (MRI)	1, 060, 949	23, 672, 786			0. 000000 0. 000000	
		281, 238	7, 841, 462				
60.00	06000 LABORATORY	3, 566, 040	19, 093, 133			0.000000	
64.00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	313, 989	3, 545, 146			0. 000000 0. 000000	64.00
65. 00 66. 00	06600 PHYSI CAL THERAPY	1, 020, 619	3, 233, 705			0. 000000	65. 00 66. 00
	06700 OCCUPATI ONAL THERAPY	389, 761	6, 197, 177				67.00
67. 00 68. 00	06800 SPEECH PATHOLOGY	202, 293	154, 368			0. 000000 0. 000000	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	14, 345	10, 280 1, 887, 717			0.000000	
71.00	07200 IMPL. DEV. CHARGED TO PATIENTS	722, 574 300, 581	3, 636, 393			0.000000	
73.00	07300 DRUGS CHARGED TO PATIENTS	2, 215, 365	23, 968, 868			0.000000	
76. 00	03020 WOUND CARE	3, 718	1, 320, 328			0.000000	
76. 00 76. 97	07697 CARDI AC REHABI LI TATI ON	3, 718	673, 121			0.000000	76. 97
76. 97 76. 98	07698 SLEEP LAB	0	1, 168, 735			0.000000	
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	1, 100, 733			0.000000	
77.00	OUTPATIENT SERVICE COST CENTERS	J U	0		0.000000	0.000000	77.00
90.00	09000 CLINIC	3, 808	5, 676, 925	5, 680, 733	0. 196925	0.000000	90.00
90. 01	09001 ONCOLOGY CLINIC	375	619, 671			0. 000000	
91. 00	09100 EMERGENCY	310, 380	14, 457, 306				91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	83, 422	1, 147, 498			0. 000000	
72.00	OTHER REIMBURSABLE COST CENTERS	00, 422	1, 147, 470	1, 200, 920	0.077002	0.000000	12.00
102.00	10200 OPI OI D TREATMENT PROGRAM	0	0	(			102.00
200.00		18, 344, 480	153, 314, 988				200.00
201.00		12,211,100	, , 700				201.00
202.00		18, 344, 480	153, 314, 988	171, 659, 468	3		202.00
		1			1	•	•

Heal th Financial Systems

ST. FRANCIS HOSPITAL

In Lieu of Form CMS-2552-10

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-1350
Francial Systems

Provid

				To 06/30/2023	Date/Time Prepared: 1/24/2024 11:37 am
			Title XIX	Hospi tal	Cost
	Cost Center Description	PPS Inpatient			
		Ratio			
		11. 00			
	INPATIENT ROUTINE SERVICE COST CENTERS				
	03000 ADULTS & PEDI ATRI CS				30.00
43.00	04300 NURSERY				43.00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000  OPERATI NG ROOM	0. 000000			50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52.00
	05300 ANESTHESI OLOGY	0. 000000			53.00
	05400  RADI OLOGY-DI AGNOSTI C	0. 000000			54.00
	05401 ULTRASOUND	0. 000000			54. 01
	05402  NUCLEAR MEDICINE	0. 000000			54. 02
57.00	05700  CT SCAN	0. 000000			57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000			58.00
60.00	06000 LABORATORY	0. 000000			60.00
64.00	06400 I NTRAVENOUS THERAPY	0. 000000			64.00
	06500 RESPI RATORY THERAPY	0. 000000			65.00
	06600 PHYSI CAL THERAPY	0. 000000			66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 000000			67.00
	06800 SPEECH PATHOLOGY	0. 000000			68. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000			72.00
	07300 DRUGS CHARGED TO PATIENTS	0. 000000			73.00
	03020 WOUND CARE	0. 000000			76.00
76. 97	07697 CARDI AC REHABI LI TATI ON	0. 000000			76. 97
	07698 SLEEP LAB	0. 000000			76. 98
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0. 000000			77. 00
	OUTPATIENT SERVICE COST CENTERS				
	09000  CLI NI C	0. 000000			90.00
90. 01	09001 ONCOLOGY CLINIC	0. 000000			90. 01
91.00	09100 EMERGENCY	0. 000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			92.00
	OTHER REIMBURSABLE COST CENTERS				
102.00	10200 OPIOID TREATMENT PROGRAM				102.00
200.00	Subtotal (see instructions)				200. 00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

Health Financial Systems	ST. FRANCIS	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Peri od:	Worksheet D	
				From 07/01/2022 To 06/30/2023		nared:
				10 00/ 30/ 2023	1/24/2024 11:	37 am
			XVIII	Hospi tal	Cost	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col . 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col . 2)			
	col. 26)					
	1. 00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	//4 57/	40 /54 40/	0.05000	24 24 24 2	47, 050	   FO 00
50. 00 05000 OPERATING ROOM	661, 576	12, 651, 126			16, 358	
52. 00   05200   DELIVERY ROOM & LABOR ROOM	163, 134	2, 165, 479			0	52.00
53. 00   05300   ANESTHESI OLOGY	41, 316	7, 369, 549			992	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	257, 472	7, 084, 388	l .		4, 923	54.00
54. 01   05401   ULTRASOUND	97, 462	6, 920, 812			3, 246	
54. 02   05402   NUCLEAR   MEDI CI NE	59, 110	2, 498, 700			412	54.02
57. 00   05700   CT   SCAN	35, 880	24, 733, 735			613	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	39, 520	8, 122, 700			697	58. 00
60. 00   06000   LABORATORY	208, 555	22, 659, 173			12, 994	
64.00   06400   I NTRAVENOUS THERAPY	61, 252	3, 859, 135			· ·	
65. 00 06500 RESPI RATORY THERAPY	140, 169	4, 254, 324			· ·	1
66. 00 06600 PHYSI CAL THERAPY	119, 864	6, 586, 938			3, 226	
67. 00  06700 0CCUPATI ONAL THERAPY	6, 884	356, 661	0. 01930	101, 000	1, 949	67.00
68. 00 06800 SPEECH PATHOLOGY	612	24, 625			247	68. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	54, 432	2, 610, 291			6, 150	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	20, 045	3, 936, 974			846	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	384, 814	26, 184, 233			14, 980	
76. 00   03020   WOUND CARE	69, 546	1, 324, 046	0. 05252	5 0	0	76. 00
76. 97   07697   CARDI AC REHABI LI TATI ON	34, 424	673, 121	0. 05114	1 0	0	76. 97
76. 98   07698   SLEEP LAB	16, 312	1, 168, 735	0. 01395	7 0	0	76. 98
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	0. 00000	0	0	77. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00  09000  CLI NI C	77, 920	5, 680, 733	0. 01371	7 744	10	90.00
90. 01   09001   ONCOLOGY CLINIC	42, 368	620, 046	0. 06833	0	0	90. 01
91. 00 09100 EMERGENCY	391, 398	14, 767, 686	0. 02650	4 21, 319	565	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	91, 092	1, 230, 920	0. 07400	6, 708	496	92.00
200.00   Total (lines 50 through 199)	3, 075, 157	167, 484, 130		5, 311, 888	89, 119	200. 00

 
 Heal th Financial
 Systems
 ST. FRANCIS HOSPITAL

 APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
 Provider CCN: 14-1350
 THROUGH COSTS

					10 06/30/2023	1/24/2024 11:	
			Title	: XVIII	Hospi tal	Cost	
	Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
		Anesthetist	Program	Program	Post-Stepdown		
		Cost	Post-Stepdown		Adjustments		
			Adjustments				
	T	1. 00	2A	2. 00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS	_	_	1	_	_	
	05000 OPERATING ROOM	0	0		0	0	50.00
	05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	52.00
	05300 ANESTHESI OLOGY	0	0		0	0	53.00
	05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	54.00
	05401 ULTRASOUND	0	0		0	0	54. 01
	05402 NUCLEAR MEDICINE	0	0		0	0	54.02
	05700 CT SCAN	0	0		0	0	57.00
	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		0	0	58. 00
	06000 LABORATORY	0	0		0	0	60.00
	06400 I NTRAVENOUS THERAPY	0	0		0	0	64.00
	06500 RESPI RATORY THERAPY	0	0		0	0	65.00
	06600 PHYSI CAL THERAPY	0	0		0	0	66.00
	06700 OCCUPATI ONAL THERAPY	0	0		0	0	67.00
	06800 SPEECH PATHOLOGY	0	0		0	0	68. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	73. 00
	03020 WOUND CARE	0	0		0	0	76. 00
	07697 CARDI AC REHABI LI TATI ON	0	0		0	0	76. 97
	07698 SLEEP LAB	0	0		0	0	76. 98
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0		0 0	0	77. 00
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	0	0		0	-	90.00
	09001 ONCOLOGY CLINIC	0	0		0	0	90. 01
	09100 EMERGENCY	0	0		0	0	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	92.00
200.00	Total (lines 50 through 199)	0	) 0	1	0 0	0	200. 00

Health Financial Systems ST. FRANCIS HOSPITAL				In Lieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 14-1350	Peri od:	Worksheet D

From 07/01/2022 Part IV
To 06/30/2023 Date/Time Prepared: THROUGH COSTS 1/24/2024 11:37 am Title XVIII Hospi tal Cost All Other Ratio of Cost Cost Center Description Total Cost Total Total Charges to Charges Medi cal (sum of cols. Outpati ent (from Wkst. Educati on 1, 2, 3, and Cost (sum of C, Part I, (col. 5 ÷ 4) Cost col s. 2, 3, col. 8) col. 7) and 4) (see instructions) 4. 00 5.00 6.00 7. 00 8.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 12, 651, 126 0.000000 50.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 2, 165, 479 0.000000 52.00 52.00 05300 ANESTHESI OLOGY 7, 369, 549 0 53.00 0 0.000000 53.00 54. 00 | 05400 | RADI OLOGY-DI AGNOSTI C 0 0 7, 084, 388 0.000000 54.00 54.01 05401 ULTRASOUND 0 6, 920, 812 0.000000 54.01 54.02 05402 NUCLEAR MEDICINE 0 2, 498, 700 0.000000 54.02 05700 CT SCAN 57 00 0 0 24, 733, 735 0.000000 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 58.00 0 8, 122, 700 0.000000 58.00 60.00 06000 LABORATORY 22, 659, 173 0.000000 60.00 0 0 3, 859, 135 06400 I NTRAVENOUS THERAPY 0.000000 64.00 64.00 0 06500 RESPIRATORY THERAPY 4, 254, 324 0 0.000000 65.00 65.00 66.00 06600 PHYSI CAL THERAPY 0 6, 586, 938 0.000000 66.00 06700 OCCUPATI ONAL THERAPY 0 0.000000 67.00 356, 661 67.00 06800 SPEECH PATHOLOGY 0 0.000000 68 00 24, 625 68 00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 2, 610, 291 0.000000 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 3, 936, 974 0.000000 72.00 07300 DRUGS CHARGED TO PATIENTS 26, 184, 233 73.00 0 0.000000 73.00 03020 WOUND CARE 0 0 0.000000 76 00 76 00 1, 324, 046 07697 CARDIAC REHABILITATION 0 76.97 0 673, 121 0.000000 76.97 07698 SLEEP LAB 0 1, 168, 735 0.000000 76. 98 07700 ALLOGENEIC HSCT ACQUISITION 0 0 77.00 0 0.000000 77.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 0 5, 680, 733 0.000000 90.00 09001 ONCOLOGY CLINIC 0 0 0 620, 046 0.000000 90.01 91. 00 09100 EMERGENCY 0 0 14, 767, 686 91.00 0.000000 92.00 |09200 | OBSERVATION BEDS (NON-DISTINCT PART) 0 92.00

0

0

0

1, 230, 920

167, 484, 130

0

0.000000

200.00

200.00

Total (lines 50 through 199)

Health Financial Systems	ST. FRANCIS HO	SPI TAL		In Lieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 14-1350	Peri od:	Worksheet D

Part IV From 07/01/2022 THROUGH COSTS 06/30/2023 Date/Time Prepared: 1/24/2024 11:37 am Title XVIII Hospi tal Cost Cost Center Description I npati ent Outpati ent Outpati ent I npati ent Outpati ent Ratio of Cost Program Program Program Program Pass-Through to Charges Charges Pass-Through Charges (col. 6 ÷ col. 7) Costs (col. 8 Costs (col. x col . 12) 13.00 x col. 10) 9. 00 10.00 11.00 12.00 ANCILLARY SERVICE COST CENTERS 50 00 0.000000 50 00 05000 OPERATING ROOM 312, 812 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 0 52.00 05300 ANESTHESI OLOGY 0.000000 176, 900 0 53.00 53.00 0 05400 RADI OLOGY-DI AGNOSTI C 0 0.000000 54.00 135, 460 0 54.00 05401 ULTRASOUND 230, 514 54.01 0.000000 0 54.01 54.02 05402 NUCLEAR MEDICINE 0.000000 17, 400 0 0 54.02 57.00 05700 CT SCAN 0.000000 422, 803 0 0 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 143, 307 0 58.00 0.000000 0 58.00 60.00 06000 LABORATORY 0.000000 1, 411, 747 0 60.00 64.00 06400 INTRAVENOUS THERAPY 0.000000 84, 556 0 64.00 0 65.00 06500 RESPIRATORY THERAPY 0.000000 578, 896 0 65.00 06600 PHYSI CAL THERAPY 0 0.000000 177, 297 66.00 0 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0.000000 101,000 0 67.00 06800 SPEECH PATHOLOGY 0 68.00 0.000000 9, 934 0 68.00 294, 899 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71 00 0.000000 71.00 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 166, 257 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 1, 019, 335 0 0 73.00 73.00 0 0 0 0 03020 WOUND CARE 0.000000 76.00 76.00 0 0 76. 97 07697 CARDIAC REHABILITATION 0.000000 C 0 76.97 76.98 07698 SLEEP LAB 0.000000 0 0 76.98 07700 ALLOGENEIC HSCT ACQUISITION 0 77.00 77.00 0.000000 0 0 OUTPATIENT SERVICE COST CENTERS 90.00 90.00 09000 CLI NI C 0.000000 744 0 0 0 0 90.01 09001 ONCOLOGY CLINIC 0.000000 0 0 90.01 09100 EMERGENCY 0 0 91.00 91.00 0.000000 21, 319 0 0 0 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 0.000000 6, 708 Ω

5, 311, 888

0 200.00

200.00

Total (lines 50 through 199)

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 14-1350 Peri od: Worksheet D From 07/01/2022 Part V 06/30/2023 Date/Time Prepared: 1/24/2024 11:37 am Title XVIII Hospi tal Cost Charges Costs PPS PPS Services Cost Center Description Cost to Cost Cost Charge Ratio Rei mbursed Rei mbursed Rei mbursed (see inst.) From Services (see Servi ces Services Not Worksheet C, inst.) Subject To Subject To Part I, col. Ded. & Coins. Ded. & Coins. 9 (see inst.) (see inst.) 1. 00 2.00 5.00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 422870 3, 360, 166 50.00 05200 DELIVERY ROOM & LABOR ROOM 0 0.874729 52.00 0 52.00 0 1, 780, 839 53.00 05300 ANESTHESI OLOGY 0.019903 0 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0. 223885 1, 652, 192 0 0 0 0 0 0 0 0 54.00 54.01 05401 ULTRASOUND 0.095327 2, 314, 166 0 54.01 1, 045, 166 54.02 05402 NUCLEAR MEDICINE 0.146408 0 0 54.02 57.00 05700 CT SCAN 0.026053 0 8,025,558 0 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0.057752 2, 376, 414 0 58.00 60.00 06000 LABORATORY 0.149203 0 5, 878, 907 0 60.00 06400 I NTRAVENOUS THERAPY 0 1, 470, 717 64.00 0.173284 0 64.00 65.00 06500 RESPIRATORY THERAPY 0. 226130 1, 141, 871 0 65.00 06600 PHYSI CAL THERAPY 1, 920, 593 66.00 0. 215989 0 0 0 66.00 06700 OCCUPATIONAL THERAPY 0. 285748 67 00 60 443 0 67 00 68.00 06800 SPEECH PATHOLOGY 0.464812 0 4,860 0 68.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.205944 0 571, 685 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 0.144057 1, 196, 693 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 73 00 0 295923 0 10, 363, 982 2, 603 73 00 0 03020 WOUND CARE 76.00 0.930216 0 624, 558 0 0 76.00 76. 97 07697 CARDIAC REHABILITATION 0.654138 352, 204 0 0 76.97 76. 98 07698 SLEEP LAB 0.171090 0 332, 432 ol 0 76.98 07700 ALLOGENEIC HSCT ACQUISITION 0.000000 0 77.00 77.00 0 0 0 OUTPATIENT SERVICE COST CENTERS 90.00 0. 196925 1, 847, 201 0 90.00 09000 CLI NI C 09001 ONCOLOGY CLINIC 0.652052 270, 222 90.01 90.01 0 0 0 1, 008 91. 00 09100 EMERGENCY 0.336023 91.00 0 4, 155, 756 0 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.679662 0 613, 034 0 92.00 200.00 Subtotal (see instructions) 0 51, 359, 659 3.611 0 200.00 Less PBP Clinic Lab. Services-Program 201.00 201.00 Only Charges

0

51, 359, 659

3, 611

0 202.00

202.00

Net Charges (line 200 - line 201)

Health Financial Systems	ST. FRANCIS HO	OSPI TAL	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-1350	Peri od: From 07/01/2022	Worksheet D Part V

06/30/2023 Date/Time Prepared: To 1/24/2024 11:37 am Title XVIII Hospi tal Cost 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.) 7. 00 6.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 1, 420, 913 50.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 0 52.00 05300 ANESTHESI OLOGY 0 53.00 35, 444 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 369, 901 0 54.00 54.01 05401 ULTRASOUND 220, 603 0 54.01 0 54.02 05402 NUCLEAR MEDICINE 153, 021 54.02 0 57.00 05700 CT SCAN 209, 090 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 137, 243 58.00 0 60.00 06000 LABORATORY 877, 151 60.00 0 06400 I NTRAVENOUS THERAPY 254, 852 64.00 64.00 65.00 06500 RESPIRATORY THERAPY 258, 211 0 65.00 06600 PHYSI CAL THERAPY 414, 827 66.00 66.00 06700 OCCUPATIONAL THERAPY 0 17, 271 67 00 67 00 0 68.00 06800 SPEECH PATHOLOGY 2, 259 68.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 117, 735 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 172, 392 72.00 3, 066, 941 73.00 07300 DRUGS CHARGED TO PATIENTS 770 73 00 03020 WOUND CARE 76.00 580, 974 0 76.00 76. 97 07697 CARDIAC REHABILITATION 230, 390 0 76.97 76. 98 07698 SLEEP LAB 56, 876 0 76.98 07700 ALLOGENEIC HSCT ACQUISITION 77.00 77.00 0 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 363, 760 0 90.00 09001 ONCOLOGY CLINIC 90. 01 176, 199 90.01 0 91.00 09100 EMERGENCY 1, 396, 430 339 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 416, 656 92.00 200.00 Subtotal (see instructions) 10, 949, 139 1, 109 200.00 Less PBP Clinic Lab. Services-Program 201.00 201.00 Only Charges Net Charges (line 200 - line 201) 202.00 202.00 10, 949, 139 1, 109

Health Financial Systems	ST. FRANCIS HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der Co	CN: 14-1350 Period: From 07/01/2022	Worksheet D-1
			Date/Time Prepared: 1/24/2024 11:37 am
	Title	XVIII Hospi tal	Cost

		Title XVIII	Hospi tal	1/24/2024 11: Cost	37 am_
	Cost Center Description	THE AVIII	1103pi tai	0031	
	DADT I ALL DROWNER COMPONENTS			1. 00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				
1. 00	Inpatient days (including private room days and swing-bed day	rs, excluding newborn)		3, 938	1. 00
2.00	Inpatient days (including private room days, excluding swing-			3, 561	2.00
3.00	Private room days (excluding swing-bed and observation bed da	ys). If you have only pr	ivate room days,	0	3.00
4. 00	do not complete this line. Semi-private room days (excluding swing-bed and observation b	and days)		2, 944	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private ro		er 31 of the cost		5.00
	reporting period				
6.00	Total swing-bed SNF type inpatient days (including private ro	om days) after December	31 of the cost	169	6. 00
7 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private roo	m daya) thrayah Dagambar	21 of the cost	20	7 00
7. 00	reporting period	ili days) trii dugir beceiliber	31 Of the Cost	20	7. 00
8.00	Total swing-bed NF type inpatient days (including private roo	m days) after December 3	31 of the cost	19	8. 00
	reporting period (if calendar year, enter 0 on this line)				
9. 00	Total inpatient days including private room days applicable t newborn days) (see instructions)	o the Program (excluding	g swing-bed and	1, 521	9. 00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII o	nlv (includina private m	room davs)	136	10.00
	through December 31 of the cost reporting period (see instruc		,		
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII o		room days) after	115	11. 00
12. 00	December 31 of the cost reporting period (if calendar year, e Swing-bed NF type inpatient days applicable to titles V or XI		te room days)	0	12. 00
12.00	through December 31 of the cost reporting period	A only (Therading prival	te room days)	O	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XI			0	13.00
44.00	after December 31 of the cost reporting period (if calendar y				44.00
14. 00 15. 00	Medically necessary private room days applicable to the Progr Total nursery days (title V or XIX only)	am (excluding swing-bed	days)	0	14. 00 15. 00
16. 00	Nursery days (title V or XIX only)			0	16.00
	SWING BED ADJUSTMENT				
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	of the cost		17. 00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost		18. 00
	reporting period				10.00
19. 00	Medicaid rate for swing-bed NF services applicable to service reporting period	s through December 31 of	f the cost	201. 56	19. 00
20. 00	Medicaid rate for swing-bed NF services applicable to service	s after December 31 of t	the cost	201. 56	20.00
21. 00	reporting period Total general inpatient routine service cost (see instruction			5, 294, 626	21. 00
22. 00	Swing-bed cost applicable to SNF type services through Decemb		ting period (line		22. 00
	5 x line 17)				
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reportin	ng period (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through Decembe	r 31 of the cost reporti	ng period (line	4, 031	24. 00
25 00	7 x line 19)	21 of the cost reporting	noried (line 9	3, 830	25. 00
25. 00	Swing-bed cost applicable to NF type services after December x line 20)	31 of the cost reporting	j periou (iiile o	3, 630	25.00
26. 00	Total swing-bed cost (see instructions)			466, 165	
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		4, 828, 461	27. 00
28. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-be	d and observation bed ch	narges)	0	28. 00
29. 00	Pri vate room charges (excluding swing-bed charges)		9/	0	29. 00
30.00	Semi-private room charges (excluding swing-bed charges)			0	30.00
31. 00 32. 00	General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3)	÷ line 28)		0. 000000 0. 00	
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
34. 00	Average per diem private room charge differential (line 32 mi	nus line 33)(see instrud	ctions)	0.00	
35. 00	Average per diem private room cost differential (line 34 x li	ne 31)		0.00	
36.00	Private room cost differential adjustment (line 3 x line 35)		66	0	36.00
37. 00	General inpatient routine service cost net of swing-bed cost 27 minus line 36)	and private room cost di	rrerentiai (IINe	4, 828, 461	37. 00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ				
38.00	Adjusted general inpatient routine service cost per diem (see			1, 355. 93	
39. 00 40. 00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Progr	•		2, 062, 370 0	
	Total Program general inpatient routine service cost (line 39			2, 062, 370	

	Financial Systems	ST. FRANCIS	_			u of Form CMS-	
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der C	CN: 14-1350	Peri od: From 07/01/2022 To 06/30/2023		pared:
	Cost Center Description	Total I npati ent Cost 1.00	Title Total Inpatient Days 2.00	Average Per Diem (col. ÷ col. 2)		Cost Program Cost (col. 3 x col. 4) 5.00	
42.00	NURSERY (title V & XIX only)	0	0				42.00
43. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	; 		<u> </u>			43. 00
44. 00 45. 00 46. 00 47. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) Cost Center Description						44. 00 45. 00 46. 00 47. 00
	·					1. 00	
48. 00 48. 01 49. 00	Program inpatient ancillary service cost (We Program inpatient cellular therapy acquisiti Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	on cost (Worksh	eet D-6, Part		), column 1)	1, 036, 104 0 3, 098, 474	48. 01
50.00	Pass through costs applicable to Program inp	patient routine	servi ces (fro	m Wkst. D, su	ım of Parts I and	0	50.00
51. 00	<pre>III) Pass through costs applicable to Program inp and IV)</pre>	oatient ancillar	y services (f	rom Wkst. D,	sum of Parts II	0	51.00
52. 00 53. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu- medical education costs (line 49 minus line	uding capital re	lated, non-ph	ysician anest	hetist, and	0	
54. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	]   54. 00
55.00	Target amount per discharge					0. 00	55.00
55. 01 55. 02	Permanent adjustment amount per discharge Adjustment amount per discharge (contractor	use only)				0. 00 0. 00	
56. 00	Target amount (line 54 x sum of lines 55, 55	5. 01, and 55. 02)				0.00	56.00
57.00	Difference between adjusted inpatient operat	ting cost and ta	rget amount (	ine 56 minus	s line 53)	0	
58. 00 59. 00	Bonus payment (see instructions) Trended costs (lesser of line 53 ÷ line 54, updated and compounded by the market basket)		the cost rep	orting period	l ending 1996,	0 0. 00	
60.00							60.00
61. 00	market basket) Continuous improvement bonus payment (if lir 55.01, or line 59, or line 60, enter the les 53) are less than expected costs (lines 54 ) enter zero. (see instructions)	sser of 50% of t	he amount by w	which operati	ng costs (line	0	61.00
62. 00 63. 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	nent (see instru	ctions)			0 0	
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	sts through Dece	mber 31 of the	e cost report	ing period (See	184, 406	64. 00
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)</pre>	sts after Decemb	er 31 of the (	ost reportin	ng period (See	155, 932	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line	55)(title XVI	<pre>II only); for</pre>	340, 338	66. 00
67. 00	CAH, see instructions  Title V or XIX swing-bed NF inpatient routin	ne costs through	December 31	of the cost r	reporting period	0	67.00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	9				0	
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient					0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER N Skilled nursing facility/other nursing facil				')		70.00
71. 00	Adjusted general inpatient routine service o	cost per diem (I			•		71.00
72. 00 73. 00	Program routine service cost (line 9 x line		(line 14 v li	ine 35)			72.00
74.00	Medically necessary private room cost applications and application of the services of the services are serviced by the services are						73.00
75. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service			Part II, column		75. 00
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line						76. 00 77. 00
78.00	Inpatient routine service cost (line 74 minu						78.00
79.00	Aggregate charges to beneficiaries for exces	ss costs (from p					79.00
80. 00 81. 00	Total Program routine service costs for comp Inpatient routine service cost per diem limi		ost limitatio	า (line 78 mi	nus line 79)		80.00 81.00
82.00	Inpatient routine service cost per drem film Inpatient routine service cost limitation (I		)				81.00
83. 00	Reasonable inpatient routine service costs (	(see instruction	•				83.00
84. 00 85. 00	Program inpatient ancillary services (see in		nc)				84.00
	Utilization review - physician compensation						85. 00 86. 00
	LIOTAL PLOULAM IMPALLEM ODELATION COSTS ISSU						
	Total Program inpatient operating costs (sur PART IV - COMPUTATION OF OBSERVATION BED PAS						]

Health Financial Systems	ST. FRANCIS	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
				From 07/01/2022 To 06/30/2023	Date/Time Pre 1/24/2024 11:	
		Title	XVIII	Hospi tal	Cost	
Cost Center Description						
					1. 00	
89.00 Observation bed cost (line 87 x line 88) (se	e instructions				836, 609	89.00
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from Line	Observation Bed Pass Through Cost (col. 3 x	
				89)	col. 4) (see instructions)	
	1. 00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	576, 496	5, 294, 626	0. 10888	836, 609	91, 092	90.00
91.00 Nursing Program cost	O	5, 294, 626	0. 00000	836, 609	0	91.00
92.00 Allied health cost	0	5, 294, 626	0. 00000	836, 609	0	92.00
93.00 All other Medical Education	l o	5, 294, 626	0. 00000	836, 609	0	93.00

	inancial Systems ST. FRANCIS HO				u of Form CMS-	
INPATIEN	IT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 14-1350	Peri od:	Worksheet D-3	j
				From 07/01/2022 To 06/30/2023	Date/Time Pre 1/24/2024 11:	
		Title	XVIII	Hospi tal	Cost	
	Cost Center Description		Ratio of Cos	st Inpatient	I npati ent	
			To Charges		Program Costs	
				Charges	(col. 1 x	
					col . 2)	
			1.00	2. 00	3. 00	
	NPATIENT ROUTINE SERVICE COST CENTERS					4
	3000 ADULTS & PEDI ATRI CS			2, 055, 244		30.00
	4300 NURSERY					43.00
	NCILLARY SERVICE COST CENTERS					4
	OPERATING ROOM		0. 4228		132, 279	
	5200 DELIVERY ROOM & LABOR ROOM		0. 8747		0	
	5300 ANESTHESI OLOGY		0. 0199		3, 521	
	5400 RADI OLOGY-DI AGNOSTI C		0. 2238		30, 327	
	5401 ULTRASOUND		0. 0953		21, 974	
	5402 NUCLEAR MEDICINE		0. 1464			
	5700 CT SCAN		0. 0260		11, 015	
1	5800 MAGNETIC RESONANCE IMAGING (MRI)		0.0577		8, 276	
	6000 LABORATORY		0.1492		210, 637	
	6400 I NTRAVENOUS THERAPY		0. 1732			
	6500  RESPI RATORY THERAPY 6600  PHYSI CAL THERAPY		0. 2261 0. 2159			
	6700 OCCUPATI ONAL THERAPY		0. 2159			
	6800 SPEECH PATHOLOGY		0. 2857		4, 617	1
	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 4048			
	7200 IMPL. DEV. CHARGED TO PATIENTS		0. 2039		23, 950	
	7300 DRUGS CHARGED TO PATIENTS		0. 1440		301, 645	
	3020 WOUND CARE		0. 9302		0 301,043	1
	7697 CARDI AC REHABI LI TATI ON		0. 6541		0	
	7698 SLEEP LAB		0. 1710		0	1
	7700 ALLOGENEIC HSCT ACQUISITION		0.0000		0	
	JTPATI ENT SERVI CE COST CENTERS		0.0000	00  0		177.00
	9000 CLI NI C		0. 1969	25 744	147	90.00
	9001 ONCOLOGY CLINIC		0. 6520		0	
	9100 EMERGENCY		0. 3360		7, 164	
	9200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 6796			
200.00	Total (sum of lines 50 through 94 and 96 through 98)			5, 311, 888	1, 036, 104	
201.00	Less PBP Clinic Laboratory Services-Program only charges	(line 61)		0	, ,	201.00
202.00	Net charges (line 200 minus line 201)	. ,		5, 311, 888		202.00

	nancial Systems ST. FRANCIS H ANCILLARY SERVICE COST APPORTIONMENT		CN: 14-1350	Peri od:	u of Form CMS-2 Worksheet D-3	
INPAILENI	ANCILLARY SERVICE COST APPORTIONWEINT	Provider C		From 07/01/2022		,
		Component		To 06/30/2023		
		Titl∈		Swing Beds - SNF		
	Cost Center Description		Ratio of Cos		I npati ent	
			To Charges	Program	Program Costs	
				Charges	(col . 1 x	
			1.00	2.00	col . 2) 3.00	-
LNE	PATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	_
	DOO ADULTS & PEDIATRICS					30.0
	300 NURSERY					43.0
	CILLARY SERVICE COST CENTERS					45.0
	OOO OPERATING ROOM		0, 42287	70 3, 543	1, 498	50.0
	200 DELIVERY ROOM & LABOR ROOM		0. 87472			1
	300 ANESTHESI OLOGY		0. 01990		-	1
4.00 054	400 RADI OLOGY-DI AGNOSTI C		0. 22388	6, 187	1, 385	54.0
4. 01 054	401 ULTRASOUND		0. 09532	4, 914	468	54.0
4. 02 054	402 NUCLEAR MEDICINE		0. 14640	0 8	0	54.0
	700 CT SCAN		0. 02605		62	57.0
	BOO MAGNETIC RESONANCE IMAGING (MRI)		0. 05775			
	DOO LABORATORY		0. 14920			
	100 INTRAVENOUS THERAPY		0. 17328		_	
	RESPI RATORY THERAPY		0. 22613			1
	500 PHYSI CAL THERAPY		0. 21598			
	700 OCCUPATI ONAL THERAPY		0. 28574			
	BOO SPEECH PATHOLOGY 100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 46481 0. 20594			
	200 IMPL. DEV. CHARGED TO PATIENTS		0. 20592	·		1
	BOO DRUGS CHARGED TO PATIENTS		0. 14403			
	D20 WOUND CARE		0. 93021			
	697 CARDI AC REHABI LI TATI ON		0. 65413			1
	598 SLEEP LAB		0. 17109		1	
	700 ALLOGENEIC HSCT ACQUISITION		0.00000			
	TPATIENT SERVICE COST CENTERS		•	_	•	1
0.00 090	DOO CLINIC		0. 19692	25 0	0	90. (
	OO1 ONCOLOGY CLINIC		0. 65205		0	90. (
	100 EMERGENCY		0. 33602		_	1
	OBSERVATION BEDS (NON-DISTINCT PART)		0. 67966		_	
00.00	Total (sum of lines 50 through 94 and 96 through 98)		1	431, 738		
201.00	Less PBP Clinic Laboratory Services-Program only charge	s (line 61)		0		201.
202.00	Net charges (line 200 minus line 201)			431, 738		202.

ealth Financial Systems ST. FR NPATIENT ANCILLARY SERVICE COST APPORTIONMENT	RANCIS HOSPITAL  Provider C		Peri od:	u of Form CMS-2 Worksheet D-3	
	Component		From 07/01/2022 To 06/30/2023	Date/Time Pre 1/24/2024 11:	
	Ti tl	e XIX	Swing Beds - SNF		
Cost Center Description	<u> </u>	Ratio of Cos	t Inpatient	I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x	
				col . 2)	
		1. 00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		ı			
0. 00   03000   ADULTS & PEDI ATRI CS					30.0
3. 00 04300 NURSERY					43.
ANCILLARY SERVICE COST CENTERS		0.4000	10		
0. 00 05000 OPERATING ROOM		0. 42287		0	
2. 00 05200 DELIVERY ROOM & LABOR ROOM		0. 87472		0	
3. 00 05300 ANESTHESI OLOGY		0. 01990		0	
. 00   05400   RADI OLOGY-DI AGNOSTI C		0. 22388		0	1
. 01   05401   ULTRASOUND		0. 09532		0	
1. 02   05402   NUCLEAR MEDICINE 7. 00   05700   CT   SCAN		0. 14640 0. 02605		0	
7.00  05700 CT SCAN 3.00  05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 02605		0	
0.00 06000 LABORATORY		0.05775		0	
I. 00   06400   INTRAVENOUS THERAPY		0. 17328		0	
5. 00   06500   RESPI RATORY THERAPY		0. 17326		0	
5. 00   06600   PHYSI CAL THERAPY		0. 21598		0	1
7. 00 06700 OCCUPATI ONAL THERAPY		0. 21590		0	
3. 00 06800 SPEECH PATHOLOGY		0. 26374		0	
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 20594	_	0	1
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 14405		0	1
B. 00 07300 DRUGS CHARGED TO PATIENTS		0. 29592		0	1
5. 00 03020 WOUND CARE		0. 93021		Ö	
5. 97 07697 CARDI AC REHABI LI TATI ON		0. 65413		o o	
6. 98 07698 SLEEP LAB		0. 17109		Ö	1
7. 00 07700 ALLOGENEIC HSCT ACQUISITION		0. 00000			
OUTPATIENT SERVICE COST CENTERS					1
0.00 09000 CLI NI C		0. 19692	25 0	0	90.
0. 01 09001 0NCOLOGY CLINIC		0. 65205		Ö	
. 00   09100   EMERGENCY		0. 33602		0	
. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 67966		0	1
0.00 Total (sum of lines 50 through 94 and 96 through	າ 98)		0	0	200.
01.00 Less PBP Clinic Laboratory Services-Program only			0		201.
02.00 Net charges (line 200 minus line 201)	,		0		202.

Health Financial Systems	ST. FRANCIS HOSPITAL	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 14-1350	Peri od: From 07/01/2022 Part B To 06/30/2023 Date/Time Prepared:

			10 06/30/2023	1/24/2024 11:	
		Title XVIII	Hospi tal	Cost	
	DADT D. MEDICAL AND OTHER HEALTH OFFILIA			1. 00	
1. 00	PART B - MEDICAL AND OTHER HEALTH SERVICES  Medical and other services (see instructions)			10, 950, 248	1.00
2. 00	Medical and other services (see instructions)  Medical and other services reimbursed under OPPS (see instruc	tions)		10, 930, 246	1
3. 00	OPPS or REH payments	11 013)		0	•
4. 00	Outlier payment (see instructions)			0	
4. 01	Outlier reconciliation amount (see instructions)			0	1
5.00	Enter the hospital specific payment to cost ratio (see instru	ctions)		0.000	5.00
6.00	Line 2 times line 5			0	6. 00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0. 00	1
8. 00	Transitional corridor payment (see instructions)			0	
9.00	Ancillary service other pass through costs from Wkst. D, Pt.	IV, col. 13, line 200		0	
10.00	Organ acqui si ti ons			0	10.00
11. 00	Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES			10, 950, 248	11. 00
	Reasonable charges				
12 00	Ancillary service charges			0	12.00
	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, I	ine 69)		0	
	Total reasonable charges (sum of lines 12 and 13)	,		0	14.00
	Customary charges				
15.00	Aggregate amount actually collected from patients liable for	payment for services on	a charge basis	0	15. 00
16.00	Amounts that would have been realized from patients liable fo	. 3	n a chargebasis	0	16. 00
	had such payment been made in accordance with 42 CFR §413.13(	e)			
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	1
	Total customary charges (see instructions)	l ! & l.! 10	11) (	0	
19. 00	Excess of customary charges over reasonable cost (complete on instructions)	Ty IT Time 18 exceeds IT	ne II) (see	0	19. 00
20. 00	Excess of reasonable cost over customary charges (complete on	ly if line 11 exceeds li	na 18) (saa	0	20.00
20.00	instructions)	Ty IT TITLE IT EXCEEDS IT	116 10) (366	O	20.00
21.00	Lesser of cost or charges (see instructions)			11, 059, 750	21.00
22.00	Interns and residents (see instructions)			0	1
23.00	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			0	24. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25. 00	Deductibles and coinsurance amounts (for CAH, see instruction	•		135, 162	1
	Deductibles and Coinsurance amounts relating to amount on lin			9, 053, 936	1
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) instructions)	plus the sum of lines 22	and 23] (See	1, 870, 652	27. 00
28. 00	Direct graduate medical education payments (from Wkst. E-4, I	ine 50)		0	28. 00
	REH facility payment amount	The 30)		O	28. 50
	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	
30.00	Subtotal (sum of lines 27, 28, 28.50 and 29)			1, 870, 652	30.00
31.00	Primary payer payments			11	31.00
32.00	Subtotal (line 30 minus line 31)			1, 870, 641	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVI	CES)			
	Composite rate ESRD (from Wkst. I-5, line 11)			0	33.00
	Allowable bad debts (see instructions)			1, 354, 757	1
	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		880, 592 952, 262	1
37. 00	Subtotal (see instructions)	ructions)		2, 751, 233	1
38. 00	MSP-LCC reconciliation amount from PS&R			0	1
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	1
39. 50	Pioneer ACO demonstration payment adjustment (see instruction	s)			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 repla	ced devices (see instruc	tions)	0	
	RECOVERY OF ACCELERATED DEPRECIATION			0	39. 99
40.00	Subtotal (see instructions)			2, 751, 233	1
40. 01	Sequestration adjustment (see instructions)			55, 025	1
40. 02	Demonstration payment adjustment amount after sequestration			0	•
	Sequestration adjustment-PARHM pass-throughs Interim payments			2, 453, 861	40. 03 41. 00
41. 01	Interim payments Interim payments-PARHM			2, 433, 001	41.01
42. 00	Tentative settlement (for contractors use only)			0	
42. 01	Tentative settlement-PARHM (for contractor use only)			O	42. 01
43. 00	Balance due provider/program (see instructions)			242, 347	•
43. 01	Balance due provider/program-PARHM (see instructions)			•	43. 01
44.00	Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub. 15-2,	chapter 1,	0	44.00
	§115. 2				
06.5	TO BE COMPLETED BY CONTRACTOR				
	Original outlier amount (see instructions)			0	
91.00	Outlier reconciliation adjustment amount (see instructions)			0 0. 00	
92.00	The rate used to calculate the Time Value of Money Time Value of Money (see instructions)			0.00	1
	Total (sum of lines 91 and 93)				94.00
00	1 (			0	

Health Financial Systems	ST.	FRANCI	S HC	)SPI TAL	In Lie	u of Form CMS	-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT				Provider CCN: 14-1350	Peri od:	Worksheet E	
					From 07/01/2022		
					To 06/30/2023		
						1/24/2024 1	1:3/ am_
				Title XVIII	Hospi tal	Cost	
						1. 00	
MEDICARE PART B ANCILLARY COSTS							
200.00 Part B Combined Billed Days						-	0 200. 00

Health FinancialSystemsST.FRANCIS HOSPITALIn Lieu of Form CMS-2552-10ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDEREDProvider CCN: 14-1350Period:Worksheet E-1

From 07/01/2022 Part I 06/30/2023 Date/Time Prepared: 1/24/2024 11:37 am Title XVIII Hospi tal Cost Part B Inpatient Part A mm/dd/yyyy Amount mm/dd/yyyy Amount 4.00 1.00 2.00 3.00 3, 204, 255 1.00 Total interim payments paid to provider 2, 932, 441 1.00 Interim payments payable on individual bills, either 2 00 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 List separately each retroactive lump sum adjustment 3.00 3.00 amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 3.01 ADJUSTMENTS TO PROVIDER 0 3.01 0 3.02 0 3.02 0 3 03 0 3 03 3.04 0 0 3.04 3.05 3.05 0 0 Provider to Program 3.50 ADJUSTMENTS TO PROGRAM 03/01/2023 65, 079 03/01/2023 106, 888 3.50 06/23/2023 06/23/2023 3.51 3.51 27.258 371, 692 3.52 0 0 3.52 3 53 0 0 3 53 3.54 0 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines -92, 337 -478, 580 3.99 3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 3, 111, 918 2, 453, 861 4.00 (transfer to Wkst. E or Wkst. E-3, line and column as appropri ate) TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after 5.00 5.00 desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 5.01 TENTATI VE TO PROVI DER 0 0 5.01 0 5.02 0 5.02 0 5.03 0 5.03 Provider to Program 5.50 TENTATI VE TO PROGRAM 0 0 5.50 5.51 0 0 5. 51 5.52 0 0 5.52 0 5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 0 5.99 5. 50-5. 98) 6.00 Determined net settlement amount (balance due) based on 6.00 the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 242, 347 6.01 SETTLEMENT TO PROGRAM 449, 551 6.02 6.02 2, 696, 208 7.00 Total Medicare program liability (see instructions) 2, 662, 367 7.00 Contractor NPR Date

Number

1.00

(Mo/Day/Yr)

2.00

8.00

8.00 Name of Contractor

Health Financial Systems ST ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED In Lieu of Form CMS-2552-10 ST. FRANCIS HOSPITAL

Provider CCN: 14-1350 | Period: | Worksheet E-1 | Part | | Part |

					1/24/2024 11:	37 am
				ving Beds - SNF		
		I npati en	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		356, 785		0	1.00
2.00	Interim payments payable on individual bills, either		0		0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER	03/01/2023	55, 137		0	3. 01
3. 02		06/23/2023	15, 077		0	3. 02
3. 03			0		0	3.03
3.04			0		0	3. 04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3. 50
3. 51			0		0	3. 51
3. 52			0		0	3. 52
3. 53			0		0	3. 53
3. 54			0		0	3.54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		70, 214		0	3. 99
	3. 50-3. 98)					
4. 00	Total interim payments (sum of lines 1, 2, and 3.99)		426, 999		0	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
F 00	TO BE COMPLETED BY CONTRACTOR			I		
5. 00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
5. 01	Program to Provider TENTATIVE TO PROVIDER		0		0	5. 01
5. 01	TENTATIVE TO PROVIDER				0	5.01
5. 02					0	5.02
5.05	Provider to Program				U	3.03
5. 50	TENTATI VE TO PROGRAM		0		0	5.50
5. 51	TENTATI VE TO TROGRAM				0	5.51
5. 52			0		0	5.52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		0		Ö	5. 99
5. 77	5. 50-5. 98)		٥			3. //
6. 00	Determined net settlement amount (balance due) based on					6.00
0.00	the cost report. (1)					0.00
6. 01	SETTLEMENT TO PROVIDER		7, 409		0	6. 01
6. 02	SETTLEMENT TO PROGRAM		,, 107		0	6. 02
7. 00	Total Medicare program liability (see instructions)		434, 408		Ö	
			, 100	Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
		(	)	1. 00	2.00	
8. 00	Name of Contractor					8. 00
	•			•		•

Heal th	Financial Systems ST. FRANCIS H	HOSPI TAL	In Lie	u of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provi der CCN: 14-1350	Peri od:	Worksheet E-	
			From 07/01/2022		
			To 06/30/2023	Date/Time Pro 1/24/2024 11:	
		Title XVIII	Hospi tal	Cost	07 diii
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATIO	N			
1.00	Total hospital discharges as defined in AARA §4102 from Wkst	. S-3, Pt. I col. 15 lin	e 14		1.00
2.00	Medicare days (see instructions)				2.00
3.00	3.00   Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3.00
4.00	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 line 20					6. 00
7.00	7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt.				7. 00
	line 168				
8.00	Calculation of the HIT incentive payment (see instructions)				8. 00
9.00	Sequestration adjustment amount (see instructions)				9. 00
10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00
31.00	Other Adjustment (specify)				31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and	line 31) (see instructio	ns)		32.00

Health Financial Systems	ST. FR	ANCIS HOSPITAL	In Lieu	ı of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT -	SWING BEDS	Provider CCN: 14-1350	Peri od: From 07/01/2022	Worksheet E-2
		Component CCN: 14-Z350		

		Component CCN: 14-Z350	To 06/30/2023	Date/Time Pre 1/24/2024 11:	
		Title XVIII	Swing Beds - SNF		
			Part A	Part B	
	COMPUTATION OF NET COST OF COVERED SERVICES		1.00	2. 00	
1. 00	Inpatient routine services - swing bed-SNF (see instructions)		343, 741	0	1.00
2. 00	Inpatient routine services - swing bed-NF (see instructions)		0.07711	· ·	2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Par	· ·	102, 839	0	3.00
	Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swi	ng-bed pass-through, see			
3. 01	instructions) Nursing and allied health payment-PARHM (see instructions)				3. 01
4. 00	Per diem cost for interns and residents not in approved teach	ina program (see		0. 00	1
	instructions)	3 1 3 3 3 3 3			
5. 00	Program days		251	0	1
6. 00 7. 00	Interns and residents not in approved teaching program (see in Utilization review - physician compensation - SNF optional me		0	0	6. 00 7. 00
8. 00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	thou only	446, 580	0	1
9. 00	Primary payer payments (see instructions)		0	0	1
10.00	Subtotal (line 8 minus line 9)		446, 580	0	10.00
11. 00	Deductibles billed to program patients (exclude amounts appli	cable to physician	0	0	11.00
12. 00	professional services) Subtotal (line 10 minus line 11)		446, 580	0	12.00
13. 00	Coinsurance billed to program patients (from provider records	) (exclude coinsurance	3, 307	0	
	for physician professional services)				
14.00	80% of Part B costs (line 12 x 80%)			0	
	Subtotal (see instructions) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		443, 273	0	
16. 50	Pioneer ACO demonstration payment adjustment (see instruction:	5)		U	16.50
16. 55	Rural community hospital demonstration project (§410A Demonst	•	0		16. 55
	adjustment (see instructions)				
	Demonstration payment adjustment amount before sequestration		0	0	
	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)		0	0	
	Allowable bad debts for dual eligible beneficiaries (see inst	ructi ons)	o	0	1
	Total (see instructions)	•	443, 273	0	19.00
	Sequestration adjustment (see instructions)		8, 865	0	
	Demonstration payment adjustment amount after sequestration)		0	0	
19. 03	Sequestration adjustment-PARHM pass-throughs Sequestration for non-claims based amounts (see instructions)		0	0	19. 03 19. 25
	Interim payments		426, 999	0	20.00
	Interim payments-PARHM				20. 01
	Tentative settlement (for contractor use only)		0	0	
21. 01 22. 00	Tentative settlement-PARHM (for contractor use only)	2 10 2E 20 and 21)	7 400	0	21. 01 22. 00
22. 00	Balance due provider/program (line 19 minus lines 19.01, 19.0. Balance due provider/program-PARHM (see instructions)	2, 19.25, 20, and 21)	7, 409	U	22.00
23. 00	Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub. 15-2,	0	0	1
	chapter 1, §115.2				
200 00	Rural Community Hospital Demonstration Project (§410A Demonstr				200 00
200.00	Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no.	riod under the 21st			200.00
	Cost Reimbursement				İ
201.00	Medicare swing-bed SNF inpatient routine service costs (from	Wkst. D-1, Pt. II, line			201. 00
202.00	66 (title XVIII hospital))	m Wko+ D 2 and 2 lim			202 00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from 200 (title XVIII swing-bed SNF))	III WKSt. D-3, COL. 3, IIII	е		202.00
203.00	Total (sum of lines 201 and 202)				203.00
204.00	Medicare swing-bed SNF discharges (see instructions)				204. 00
	Computation of Demonstration Target Amount Limitation (N/A in period)	first year of the curre	nt 5-year demons	trati on	
205 00	Medicare swing-bed SNF target amount				205. 00
	Medicare swing-bed SNF inpatient routine cost cap (line 205 t	imes line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimburs				
	Program reimbursement under the §410A Demonstration (see inst	*			207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-land 3)	z, col. I, sum of lines	'		208. 00
209. 00	Adjustment to Medicare swing-bed SNF PPS payments (see instru	ctions)			209. 00
	Reserved for future use				210.00
04=	Comparision of PPS versus Cost Reimbursement	000			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line instructions)	209 plus line 210) (see			215. 00
	Thisti dott ons)		1		I .

Component CCN: 14-Z350 06/30/2023 Date/Time Prepared: 1/24/2024 11:37 am Title XIX Swing Beds - SNF Cost Part B Part A 1.00 2.00 COMPUTATION OF NET COST OF COVERED SERVICES Inpatient routine services - swing bed-SNF (see instructions) 0 1.00 Inpatient routine services - swing bed-NF (see instructions) o 2.00 2.00 Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, 0 3.00 3.00 Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see Nursing and allied health payment-PARHM (see instructions) 3.01 3.01 4.00 Per diem cost for interns and residents not in approved teaching program (see 0.00 4.00 instructions) 5.00 Program days 5 00 6.00 Interns and residents not in approved teaching program (see instructions) 0 6.00 7.00 Utilization review - physician compensation - SNF optional method only 0 7.00 0 8.00 Subtotal (sum of lines 1 through 3 plus lines 6 and 7) 8.00 9.00 Primary payer payments (see instructions) 9.00 0 10.00 Subtotal (line 8 minus line 9) 10.00 11.00 11.00 Deductibles billed to program patients (exclude amounts applicable to physician professional services) 12.00 Subtotal (line 10 minus line 11) 0 12.00 Coinsurance billed to program patients (from provider records) (exclude coinsurance 0 13.00 13.00 for physician professional services) 0 14.00 14.00 80% of Part B costs (line 12 x 80%) 15.00 Subtotal (see instructions) 0 15 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 16.00 16.50 Pioneer ACO demonstration payment adjustment (see instructions) 16.50 Rural community hospital demonstration project (§410A Demonstration) payment 16.55 16.55 adjustment (see instructions) 16.99 Demonstration payment adjustment amount before sequestration 16.99 17.00 Allowable bad debts (see instructions) 0 0 0 0 0 17.00 17.01 Adjusted reimbursable bad debts (see instructions) 17.01 18.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 18.00 Total (see instructions) 19.00 19.00 19.01 Sequestration adjustment (see instructions) 19.01 Demonstration payment adjustment amount after sequestration) 19.02 19.02 19.03 Sequestration adjustment-PARHM pass-throughs 19.03 0 Sequestration for non-claims based amounts (see instructions) 19. 25 19.25 Interim payments 20 00 20.00 Interim payments-PARHM 20.01 20.01 Tentative settlement (for contractor use only) 21.00 Tentative settlement-PARHM (for contractor use only) 21.01 21.01 Balance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21) 22 00 22 00 0 22.01 Balance due provider/program-PARHM (see instructions) 22.01 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, 23.00 chapter 1, §115.2 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 Cures Act? Enter "Y" for yes or "N" for no. 200.00 Cost Reimbursement 201.00 Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 201.00 66 (title XVIII hospital)) 202.00 Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 202.00 200 (title XVIII swing-bed SNF)) 203.00 Total (sum of lines 201 and 202) 203.00 204.00 Medicare swing-bed SNF discharges (see instructions) 204.00 Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration 205.00 Medicare swing-bed SNF target amount 206.00 Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204) 205.00 206.00 Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement 207.00 Program reimbursement under the §410A Demonstration (see instructions) 207.00 208.00 Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 208.00 and 3) 209.00 Adjustment to Medicare swing-bed SNF PPS payments (see instructions) 209 00 210.00 Reserved for future use 210.00 Comparision of PPS versus Cost Reimbursement 215.00 Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see 215.00

instructions)

Health Financial Systems	ST. FRANCIS HOSPITAL	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 14-1350	Peri od: From 07/01/2022 Part V To 06/30/2023 Part V Date/Ti me Prepared: 1/24/2024 11:37 am

2.00					1/24/2024 11:	37 am
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT			Title XVIII	Hospi tal	Cost	
PART V - CALCULATION OF REINBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REINBURSEMENT						
Inpatient services   3,098,474   1.0   2.0   0					1. 00	
2.00			PART A SERVICES - COST	REI MBURSEMENT		
3.00   Collular therapy acquisition cost (see instructions)   3.00   3		·				
Collular therapy acquisition cost (see instructions)   3.098,474   4.00		9	ons)		_	
4.00   Subtotal (sum of lines 1 through 3.01)   3,098,474   4.00   6.00   Total cost (line 4 less line 5). For CAH (see instructions)   3,129,459   6.00   COMPUTATION OF LESSER OF COST OR CHARGES   COST OR CH					_	
Primary payer payments						
Total cost (line 4 less line 5). For CAH (see instructions)   3,129,459   6.0		,				
COMPUTATION OF LESSER OF COST OR CHARGES					_	5. 00
Reasonable charges	6.00				3, 129, 459	6. 00
7.00						1
8.00   Ancillary service charges   0   8.0   0   9.0   0   0.0	7.00				0	7 00
9.00   Organ acquisition charges, net of revenue   0   9.0		o a contract of the contract o				
10.00   Total reasonable charges   0   10.00   Customary charges   10.00   Aggregate amount actually collected from patients liable for payment for services on a charge basis   12.00   Amounts that would have been realized from patients liable for payment for services on a charge basis   12.00   Amounts that would have been realized from patients liable for payment for services on a charge basis   12.00   Amounts that would have been realized from patients liable for payment for services on a charge basis   12.00   Amounts that would have been realized from patients liable for payment for services on a charge basis   12.00   Amounts that would have been realized from patients liable for payment for services on a charge basis   12.00   Amounts that would have been realized from patients liable for payment for services on a charge basis   12.00   Amounts that would have been realized from patients liable for payment for services on a charge basis   0   12.00   Amounts that would have been realized from patients liable for payment for services on a charge basis   0   12.00   Amounts that would have been realized from patients liable for payment for services on a charge basis   0   12.00   Amounts liable for payments (from loops of payments (from loops of payments (from loops of payments (from loops of payments)   0   14.0		3				
Customary charges  11. 00 Aggregate amount actually collected from patients liable for payment for services on a charge basis   0   11. 0   12. 00 Amounts that would have been realized from patients liable for payment for services on a charge basis   0   12. 0   13. 00 Ratio of line 11 to line 12 (not to exceed 1.000000)   0.000000   14. 00 Total customary charges (see instructions)   0.000000   15. 00 Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see   0   15. 0   15. 00 Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see   15. 0   15. 00 Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see   15. 0   15. 00 Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see   15. 0   15. 00 Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see   15. 0   16. 00 Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see   15. 0   17. 00 Cost of physicians' services in a teaching hospital (see instructions)   0   17. 0   18. 00 Incert graduate medical education payments (from Worksheet E-4, line 49)   0   18. 0   19. 00 Eductibles (exclude professional component)   407, 212   20. 0   20. 00 Deductibles (exclude professional component)   407, 212   20. 0   21. 00 Excess reasonable cost (from line 16)   22. 06, 24. 0   22. 00 Subtotal (line 19 minus line 20 and 21)   2. 662, 247   22. 0   23. 00 Colnisurance   2. 2					_	
11.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis 12.00 Amounts that would have been realized from patients liable for payment for services on a charge basis 12.00 Amounts that would have been realized from patients liable for payment for services on a charge basis 12.00 Amounts that would have been realized from patients liable for payment for services on a charge basis 12.00 Amounts that would have been realized from patients liable for payment for services on a charge basis 12.00 Amounts that would have been realized from patients liable for payment for services on a charge basis 12.00 Amounts that would have been realized from patients liable for payment for services on a charge basis 12.00 Amounts that would have been realized from payment for services on a charge basis 12.00 and charge for liable for payment for services on a charge basis 12.00 and charge for liable for payment for services on a charge basis 12.00 and charge for liable for payment for services on a charge basis 12.00 and charge for liable for payment for services on a charge basis 12.00 and charge for liable for payment for services on a charge basis 12.00 and charge for liable for payment for services on a charge basis 12.00 and 12.00 an	10.00				0	10.00
Amount's that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)  13.00 Ratio of line 11 to line 12 (not to exceed 1.000000)  14.00 Total customary charges (see instructions)  15.00 Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)  16.00 Excess of customary charges over reasonable cost (complete only if line 6 exceeds line 14) (see instructions)  17.00 Cost of physicians' services in a teaching hospital (see instructions)  18.00 Direct graduate medical education payments (from Worksheet E-4, line 49)  19.00 Cost of covered services (sum of lines 6, 17 and 18)  20.00 Deductibles (exclude professional component)  19.00 Cost of covered services (sum of lines 6, 17 and 18)  20.00 Excess reasonable cost (from line 16)  21.00 Excess reasonable cost (from line 16)  22.00 Subtotal (line 19 minus line 20 and 21)  23.00 Coinsurance  24.00 Subtotal (line 22 minus line 23)  25.00 Allowable bad debts (exclude bad debts for professional services) (see instructions)  28.00 Allowable bad debts (exclude bad debts (see instructions)  38.3, 775 25.0  29.00 Subtotal (sum of lines 24 and 25, or line 26)  29.90 Differ ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  29.50 Pioneer ACO demonstration payment adjustment (see instructions)  30.01 Sequestration payment adjustment (see instructions)  59.475 27.00 Pioneer ACO demonstration payment adjustment (see instructions)  50.29.99 Pemonstration payment adjustment amount before sequestration  50.29.99 Pemonstration payment adjustment amount after sequestration  50.29.99 Pemonstration payment adjustment amount after sequestration  50.29.99 Pemonstration payment adjustment amount after sequestration  50.20 Demonstration adjustment (See instructions)  50.20 Demonstration adjustment (See instructions)  50.30 Subtotal (Inter in payments A)  50.31 Inter mayments A)  50.31 Inter mayments A)	11 00		normant for compless on	a abanga basi s	0	11 00
had such payment been made in accordance with 42 CFR 413.13(e)   Ratio of line 11 to line 12 (not to exceed 1.000000)   13.00   Ratio of line 11 to line 12 (not to exceed 1.000000)   13.00   13.00   14.00   Total customary charges (see instructions)   0.14.00   15.00   Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see						
13. 00   Ratio of line 11 to line 12 (not to exceed 1.000000)   0.000000   13. 0   14. 00   Total customary charges (see instructions)   0.14. 00   15. 00   Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)   15. 00   Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)   0.00   16. 00   Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)   0.00   16. 00   Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)   0.00   16. 00   Excess of reasonable cost cost of physicians' services in a teaching hospital (see instructions)   0.00   17. 00   Extensional Computation of the line 14   17. 00   18. 00   18. 00   19	12.00			ni a charge basis	U	12.00
14.00 Total customary charges (see instructions) Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)  10.00 Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)  17.00 Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see on 16.00 linestructions)  18.00 Direct graduate medical education payments (from Worksheet E-4, line 49)  19.00 Cost of covered services (sum of lines 6, 17 and 18)  19.00 Excess reasonable cost (from line 16)  20.00 Deductibles (exclude professional component)  21.00 Excess reasonable cost (from line 16)  22.00 Subtotal (line 19 minus line 20 and 21)  23.00 Coinsurance  24.00 Subtotal (line 22 minus line 23)  24.00 Subtotal (line 22 minus line 23)  25.00 Allowable bad debts (exclude bad debts for professional services) (see instructions)  27.00 Allowable bad debts for dual eligible beneficiaries (see instructions)  28.00 Subtotal (sum of lines 24 and 25, or line 26)  29.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  29.50 Pioneer ACO demonstration payment adjustment (see instructions)  30.01 Sequestration adjustment amount before sequestration  30.02 Demonstration payment adjustment amount after sequestration  30.03 Sequestration adjustment -PARHM  31.00 Interim payments  31.11, 118	13 00	1 3	:)		0 000000	13 00
15.00 Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)  16.00 Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)  17.00 Cost of physicians' services in a teaching hospital (see instructions)  18.00 Direct graduate medical education payments (from Worksheet E-4, line 49)  19.00 Cost of covered services (sum of lines 6, 17 and 18)  20.00 Deductibles (exclude professional component)  21.00 Excess reasonable cost (from line 16)  22.00 Subtotal (line 19 minus line 20 and 21)  23.00 Coinsurance  24.00 Subtotal (line 22 minus line 23)  25.00 Allowable bad debts (exclude bad debts for professional services) (see instructions)  26.00 Agiusted reimbursable bad debts (see instructions)  27.00 Allowable bad debts for dual eligible beneficiaries (see instructions)  29.00 Subtotal (sum of lines 24 and 25, or line 26)  29.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  29.98 Recovery of accelerated depreciation.  29.99 Demonstration payment adjustment (see instructions)  30.01 Sequestration adjustment (see instructions)  30.02 Demonstration payment adjustment amount before sequestration  30.03 Sequestration adjustment (see instructions)  30.04 Interim payments 3  30.05 Interim payments 3  30.07 Interim payments 3  30.08 Interim payments 3  30.09 Interim payments (for contractor use only)		· · · · · · · · · · · · · · · · · · ·				1
Instructions   Instructions   Instructions   Instructions   Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see   Instructions   Instruction		, ,	lv if line 14 exceeds li	ne 6) (see	_	
16.00   Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)   16.00   16.00   17.0	13.00		if y it time 14 exceeds it	116 0) (366	U	13.00
Instructions   Cost of physicians' services in a teaching hospital (see instructions)   Cost of physicians' services in a teaching hospital (see instructions)   Cost of physicians' services in a teaching hospital (see instructions)   Cost of physicians' services in a teaching hospital (see instructions)   Cost of physicians' services in a teaching hospital (see instructions)   Cost of covered services (sum of lines 6, 17 and 18)   Subtotal (see instructions)   Cost of covered services (sum of lines 6, 17 and 18)   Subtotal (see instructions)   Cost of covered services (sum of lines 6, 17 and 18)   Cost of covered services (sum of lines 20 and 18)   Cost of covered services (sum of line 16)   Cost of covered services (see instructions)   Cost of c	16 00		lv if line 6 exceeds lir	ne 14) (see	0	16. 00
17.00	10.00	, , ,	if it time o exceeds iti	10 11) (300	0	10.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT   18.00   Direct graduate medical education payments (from Worksheet E-4, line 49)   18.00   Cost of covered services (sum of lines 6, 17 and 18)   3,129,459   19.00   Cost of covered services (sum of lines 6, 17 and 18)   3,129,459   19.00   Cost of covered services (sum of lines 6, 17 and 18)   3,129,459   19.00   Cost of covered services (sum of lines 6, 17 and 18)   3,129,459   19.00   Cost of covered services (sum of lines 6, 17 and 18)   3,129,459   19.00   21.00   Cost of covered services (from line 16)   0 21.00   Cost of covered services (from line 16)   0 21.00   Cost of covered services (see instructions)   2,662,247   22.00   Cost of covered services (see instructions)   2,716,701   22.00   22.00   Cost of covered services (see	17. 00		ructions)		0	17. 00
18.00       Direct graduate medical education payments (from Worksheet E-4, line 49)       0       18.00         19.00       Cost of covered services (sum of lines 6, 17 and 18)       3,129,459       19.00         20.00       Deductibles (exclude professional component)       467,212       20.00         21.00       Excess reasonable cost (from line 16)       0       21.00         22.00       Subtotal (line 19 minus line 20 and 21)       2,662,247       22.00         23.00       Coinsurance       2.662,247       24.00         24.00       Subtotal (line 22 minus line 23)       2,662,247       24.00         25.00       Allowable bad debts (exclude bad debts for professional services) (see instructions)       83,775       25.00         26.00       Adjusted reimbursable bad debts (see instructions)       54,454       26.00         27.00       Allowable bad debts for dual eligible beneficiaries (see instructions)       59,675       27.00         28.00       Subtotal (sum of lines 24 and 25, or line 26)       2,716,701       28.00         29.00       OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)       0       29.00         29.99       Recovery of accelerated depreciation       0       29.9         29.99       Demonstration payment adjustment amount before sequestration       0       2					_	
20.00       Deductibles (exclude professional component)       467, 212       20.0         21.00       Excess reasonable cost (from line 16)       0       21.0         22.00       Subtotal (line 19 minus line 20 and 21)       2,662,247       22.0         23.00       Coinsurance       2,662,247       24.0         25.00       Subtotal (line 22 minus line 23)       2,662,247       24.0         25.00       Allowable bad debts (exclude bad debts for professional services) (see instructions)       83,775       25.0         26.00       Adjusted reimbursable bad debts (see instructions)       54,454       26.0         27.00       Allowable bad debts for dual eligible beneficiaries (see instructions)       59,675       27.0         28.00       Subtotal (sum of lines 24 and 25, or line 26)       2,716,701       28.0         29.00       OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)       0       29.0         29.50       Recovery of accelerated depreciation.       0       29.5         29.99       Demonstration payment adjustment amount before sequestration       0       29.9         30.01       Sequestration adjustment (see instructions)       2,716,701       30.0         30.02       Demonstration payment adjustment amount after sequestration       0       30.0	18.00	Direct graduate medical education payments (from Worksheet E-	4, line 49)		0	18.00
21.00   Excess reasonable cost (from line 16)   0   21.00   22.00   Subtotal (line 19 minus line 20 and 21)   2,662,247   22.00   23.00   Coinsurance   0   23.00   23.00   Coinsurance   24.00   Subtotal (line 22 minus line 23)   2,662,247   24.00   25.00   Allowable bad debts (exclude bad debts for professional services) (see instructions)   83,775   25.00   Allowable bad debts (see instructions)   54,454   26.00   27.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   59,675   27.00   28.00   Subtotal (sum of lines 24 and 25, or line 26)   2,716,701   28.00   29.50   Pioneer ACO demonstration payment adjustment (see instructions)   0   29.50   29.50   Pioneer ACO demonstration payment adjustment (see instructions)   0   29.50   29.90   Demonstration payment adjustment amount before sequestration   29.90	19. 00	Cost of covered services (sum of lines 6, 17 and 18)	•		3, 129, 459	19.00
22. 00       Subtotal (line 19 minus line 20 and 21)       2, 662, 247       22. 0         23. 00       Coinsurance       0 23. 0         24. 00       Subtotal (line 22 minus line 23)       2, 662, 247       24. 0         25. 00       Allowable bad debts (exclude bad debts for professional services) (see instructions)       83, 775       25. 0         26. 00       Adjusted reimbursable bad debts (see instructions)       54, 454       26. 0         27. 00       Allowable bad debts for dual eligible beneficiaries (see instructions)       59, 675       27. 0         28. 00       Subtotal (sum of lines 24 and 25, or line 26)       2, 716, 701       28. 0         29. 00       OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)       0 29. 0         29. 50       Pioneer ACO demonstration payment adjustment (see instructions)       0 29. 9         29. 98       Recovery of accelerated depreciation.       0 29. 9         29. 99       Demonstration payment adjustment amount before sequestration       0 29. 9         30. 01       Sequestration adjustment (see instructions)       2,716,701       30. 0         30. 02       Demonstration payment adjustment amount after sequestration       0 30. 0       30. 0         30. 03       Sequestration adjustment-PARHM       30. 0       31. 01       1nterim payments       31. 01	20.00	Deductibles (exclude professional component)			467, 212	20.00
23.00 Coinsurance 24.00 Subtotal (line 22 minus line 23) 2, 662, 247 24.00 25.00 Allowable bad debts (exclude bad debts for professional services) (see instructions) 26.00 Adjusted reimbursable bad debts (see instructions) 27.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 28.00 Subtotal (sum of lines 24 and 25, or line 26) 29.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 29.50 Pioneer ACO demonstration payment adjustment (see instructions) 29.98 Recovery of accelerated depreciation. 29.99 Demonstration payment adjustment amount before sequestration 30.00 Subtotal (see instructions) 30.01 Sequestration adjustment (see instructions) 30.02 Demonstration payment adjustment amount after sequestration 30.03 Sequestration adjustment (see instructions) 30.04 Interim payments 31.01 Interim payments 31.01 Interim payments (for contractor use only) 30.05 Coinsurance 30.06 2, 662, 247 24.00 24.00 24.00 25.00 24.00 27.01 28.00 27.06, 701 28.00 27.01 28.00 27.06, 701 28.00 27.01 28.00 27.06, 701 28.00 29.0	21.00	Excess reasonable cost (from line 16)			0	21.00
24.00 Subtotal (line 22 minus line 23) 25.00 Allowable bad debts (exclude bad debts for professional services) (see instructions) 26.00 Adjusted reimbursable bad debts (see instructions) 27.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 28.00 Subtotal (sum of lines 24 and 25, or line 26) 29.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 29.50 Pioneer ACO demonstration payment adjustment (see instructions) 29.98 Recovery of accelerated depreciation. 29.99 Demonstration payment adjustment amount before sequestration 30.01 Sequestration adjustment (see instructions) 30.02 Demonstration payment adjustment amount after sequestration 30.03 Sequestration adjustment -PARHM 31.01 Interim payments 31.01 Interim payments -PARHM 32.00 Tentative settlement (for contractor use only) 30.05 Adjusted reimbursable bad debts (exclude bad debts for professional services) (see instructions) 31.00 Interim payments (see instructions) 32.60 Subtotal (see instructions) 32.60 Subtotal (see instructions) 32.60 Subtotal (see instructions) 33.01 Interim payments 33.111,918 31.01 Interim payments (for contractor use only)	22.00	Subtotal (line 19 minus line 20 and 21)			2, 662, 247	22. 00
25. 00 Allowable bad debts (exclude bad debts for professional services) (see instructions) 26. 00 Adjusted reimbursable bad debts (see instructions) 27. 00 Allowable bad debts for dual eligible beneficiaries (see instructions) 28. 00 Subtotal (sum of lines 24 and 25, or line 26) 29. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 29. 00 Pioneer ACO demonstration payment adjustment (see instructions) 29. 98 Recovery of accelerated depreciation. 29. 99 Demonstration payment adjustment amount before sequestration 29. 99 Subtotal (see instructions) 30. 01 Sequestration adjustment (see instructions) 30. 02 Demonstration payment adjustment amount after sequestration 30. 03 Sequestration adjustment-PARHM 31. 01 Interim payments 31. 01 Interim payments-PARHM 32. 00 Tentative settlement (for contractor use only) 30 Adjusted reimbursable bad debts (see instructions) 54, 454 26. 0 52. 00 54, 454 26. 0 559, 675 27. 0 57, 716, 701 28. 0 59, 675 27. 0	23.00	Coi nsurance			0	23.00
26.00 Adjusted reimbursable bad debts (see instructions) 27.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 28.00 Subtotal (sum of lines 24 and 25, or line 26) 29.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 29.50 Pioneer ACO demonstration payment adjustment (see instructions) 29.98 Recovery of accelerated depreciation. 29.99 Demonstration payment adjustment amount before sequestration 30.00 Subtotal (see instructions) 30.01 Sequestration adjustment (see instructions) 30.02 Demonstration payment adjustment amount after sequestration 30.03 Sequestration adjustment-PARHM 31.01 Interim payments 31.01 Interim payments-PARHM 32.00 Tentative settlement (for contractor use only) 35.01 Sequestration adjustment (for contractor use only) 36.02 Sequestration adjustment (for contractor use only) 37.03 Sequestration adjustment (for contractor use only) 38.04 Sequestration (for contractor use only) 39.05 Sequestration (for contractor use only) 30.06 Sequestration (for contractor use only) 30.07 Sequestration (for contractor use only) 30.08 Sequestration (for contractor use only)	24.00	Subtotal (line 22 minus line 23)			2, 662, 247	24.00
27. 00       Allowable bad debts for dual eligible beneficiaries (see instructions)       59, 675       27.0         28. 00       Subtotal (sum of lines 24 and 25, or line 26)       2,716,701       28.0         29. 00       OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)       0       29.0         29. 50       Pioneer ACO demonstration payment adjustment (see instructions)       0       29.5         29. 98       Recovery of accelerated depreciation.       0       29.9         29. 99       Demonstration payment adjustment amount before sequestration       0       29.9         30. 00       Subtotal (see instructions)       2,716,701       30.0         30. 01       Sequestration adjustment (see instructions)       54,334       30.0         30. 02       Demonstration payment adjustment amount after sequestration       0       30.0         30. 03       Sequestration adjustment-PARHM       30.0         31. 01       Interim payments       3,111,918       31.0         31. 01       Interim payments-PARHM       31.0         32. 00       Tentative settlement (for contractor use only)       0       32.0	25.00	Allowable bad debts (exclude bad debts for professional servi	ces) (see instructions)		83, 775	25.00
28. 00       Subtotal (sum of lines 24 and 25, or line 26)       2,716,701       28.00         29. 00       OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)       0 29.00         29. 50       Pi oneer ACO demonstration payment adjustment (see instructions)       0 29.50         29. 98       Recovery of accelerated depreciation.       0 29.90         29. 99       Demonstration payment adjustment amount before sequestration       0 29.90         30. 00       Subtotal (see instructions)       2,716,701         30. 01       Sequestration adjustment (see instructions)       54,334         30. 02       Demonstration payment adjustment amount after sequestration       0 30.00         30. 03       Sequestration adjustment-PARHM       30.00         31. 01       Interim payments       3, 111, 918         31. 01       Interim payments-PARHM       31.00         32. 00       Tentative settlement (for contractor use only)       0 32.00	26.00	Adjusted reimbursable bad debts (see instructions)			54, 454	26.00
29.00       OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)       0       29.00         29.50       Pi oneer ACO demonstration payment adjustment (see instructions)       0       29.50         29.98       Recovery of accelerated depreciation.       0       29.99         29.99       Demonstration payment adjustment amount before sequestration       0       29.99         30.01       Sequestration adjustment (see instructions)       2,716,701       30.0         30.02       Demonstration payment adjustment amount after sequestration       0       30.0         30.03       Sequestration adjustment-PARHM       30.0         31.01       Interim payments       3,111,918       31.0         31.01       Interim payments-PARHM       31.0       31.0         32.00       Tentative settlement (for contractor use only)       0       32.0	27.00	Allowable bad debts for dual eligible beneficiaries (see inst	ructi ons)		59, 675	27. 00
29.50 Pi oneer ACO demonstration payment adjustment (see instructions)  29.98 Recovery of accelerated depreciation.  29.99 Demonstration payment adjustment amount before sequestration  30.00 Subtotal (see instructions)  30.01 Sequestration adjustment (see instructions)  30.02 Demonstration payment adjustment amount after sequestration  30.03 Sequestration adjustment amount after sequestration  31.00 Interim payments  31.01 Interim payments-PARHM  32.00 Tentative settlement (for contractor use only)	28.00	Subtotal (sum of lines 24 and 25, or line 26)			2, 716, 701	28. 00
29. 98 Recovery of accelerated depreciation.  29. 99 Demonstration payment adjustment amount before sequestration  30. 00 Subtotal (see instructions)  30. 01 Sequestration adjustment (see instructions)  30. 02 Demonstration payment adjustment amount after sequestration  30. 03 Sequestration adjustment-PARHM  31. 00 Interim payments  31. 01 Interim payments-PARHM  32. 00 Tentative settlement (for contractor use only)	29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
29. 99 Demonstration payment adjustment amount before sequestration 30. 00 Subtotal (see instructions) 30. 01 Sequestration adjustment (see instructions) 30. 02 Demonstration payment adjustment amount after sequestration 30. 03 Sequestration adjustment-PARHM 31. 00 Interim payments 31. 01 Interim payments-PARHM 32. 00 Tentative settlement (for contractor use only)  0 29. 9 27. 716, 701 30. 0 30. 0 30. 0 30. 0 30. 0 31. 01 31. 01 31. 01 32. 00			s)		0	
30.00       Subtotal (see instructions)       2,716,701       30.0         30.01       Sequestration adjustment (see instructions)       54,334       30.0         30.02       Demonstration payment adjustment amount after sequestration       0       30.0         30.03       Sequestration adjustment-PARHM       30.0         31.00       Interim payments       3,111,918       31.0         31.01       Interim payments-PARHM       31.0       31.0         32.00       Tentative settlement (for contractor use only)       0       32.0					_	
30.01 Sequestration adjustment (see instructions) 30.02 Demonstration payment adjustment amount after sequestration 30.03 Sequestration adjustment-PARHM 31.00 Interim payments 31.01 Interim payments-PARHM 32.00 Tentative settlement (for contractor use only) 54, 334 30.0 30.0 30.0 31.0 31.0 32.0					_	
30.02 Demonstration payment adjustment amount after sequestration 30.03 Sequestration adjustment-PARHM 31.00 Interim payments 31.01 Interim payments-PARHM 32.00 Tentative settlement (for contractor use only) 30.02 30.03 30		·				
30.03 Sequestration adjustment-PARHM 31.00 Interim payments 31.01 Interim payments-PARHM 32.00 Tentative settlement (for contractor use only) 30.00 30						
31. 00 Interim payments       3, 111, 918 31.0         31. 01 Interim payments-PARHM       31. 0         32. 00 Tentative settlement (for contractor use only)       0 32.0		. ,			0	
31.01 Interim payments-PARHM 32.00 Tentative settlement (for contractor use only) 31.01 Interim payments-PARHM 31.02 On 32.03 On						30. 03
32.00 Tentative settlement (for contractor use only) 0 32.0		. ,			3, 111, 918	
						31.01
32.01   Tentative settlement-PARHM (for contractor use only)   32.0					0	
					=-	32. 01
					-449, 551	
					_	33. 01
	34. 00		nce with CMS Pub. 15-2,	chapter 1,	0	34.00
§115. 2		9115. 2				I

lealth Financial Systems ST. FRANCIS HOSPITAL In Lieu of Form CMS-2552-10

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

Provi der CCN: 14-1350

Peri od: Worksheet G From 07/01/2022 To 06/30/2023 Date/Time Prepared: 1/24/2024 11: 37 am

——————————————————————————————————————					1/24/2024 11:	37 am
		General Fund	Speci fi c	Endowment	Plant Fund	
		1.00	Purpose Fund 2.00	3. 00	4. 00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	82, 084	1	0	0	
2.00	Temporary investments	0	0	0		
3. 00 4. 00	Notes recei vabl e Accounts recei vabl e	15, 248, 106	0	0	0	3. 00 4. 00
5.00	Other receivable	928, 678	1	0	0	5.00
6. 00	Allowances for uncollectible notes and accounts receivable			0	ő	
7.00	Inventory	977, 811	0	0	0	7. 00
8.00	Prepai d expenses	428, 287	1	0	0	
9. 00	Other current assets	1, 248, 642	1	0	0	
10.00	Due from other funds	-121, 041	1	0	0	
11. 00	Total current assets (sum of lines 1-10) FIXED ASSETS	11, 064, 547	0	0	0	11.00
12. 00	Land	462, 220	O	0	0	12.00
13.00	Land improvements	1, 244, 575	- 1	0	Ö	13. 00
14.00	Accumulated depreciation	-760, 056	1	0	0	14.00
15.00	Bui I di ngs	39, 323, 525	0	0	0	15. 00
16. 00	Accumulated depreciation	-19, 008, 516	1	0	0	16. 00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19. 00 20. 00	Fixed equipment Accumulated depreciation		0	0	0	19. 00 20. 00
21. 00	Automobiles and trucks			0	0	21.00
22. 00	Accumulated depreciation		Ö	0	Ö	22. 00
23.00	Major movable equipment	14, 586, 013	0	0	0	23.00
24.00	Accumulated depreciation	-10, 222, 034	0	0	0	24. 00
25.00	Mi nor equi pment depreci abl e	0	0	0	0	25. 00
26. 00	Accumulated depreciation	0	0	0	0	26. 00
27. 00	HIT designated Assets	0	0	0	0	27.00
28. 00	Accumulated depreciation	0	0	0	0	28. 00 29. 00
29. 00 30. 00	Minor equipment-nondepreciable Total fixed assets (sum of lines 12-29)	25, 625, 727	0	0		30.00
30.00	OTHER ASSETS	25, 025, 727	] 0		<u> </u>	30.00
31.00	Investments	105, 465, 416	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	-912, 071		0	0	34.00
35. 00 36. 00	Total other assets (sum of lines 31-34) Total assets (sum of lines 11, 30, and 35)	104, 553, 345	1	0	0	35. 00 36. 00
30.00	CURRENT LIABILITIES	141, 243, 619	1 0	0	0	30.00
37. 00	Accounts payable	2, 033, 533	0	0	0	37. 00
38.00	Salaries, wages, and fees payable	1, 435, 379	1	0	0	38.00
39. 00	Payroll taxes payable	0	0	0	0	39. 00
40.00	Notes and Loans payable (short term)	1, 391, 711	0	0	0	40.00
41.00	Deferred income	32, 589	0	0	0	41.00
42.00	Accel erated payments	200 101		0	0	42.00
43. 00 44. 00	Due to other funds Other current liabilities	390, 101 1, 489, 523		0	0	43.00
45. 00	Total current liabilities (sum of lines 37 thru 44)	6, 772, 836		0		
.0.00	LONG TERM LIABILITIES	0,772,000	<u> </u>			10.00
46.00	Mortgage payable	0	0	0	0	46. 00
47.00	Notes payable	7, 122, 951	0	0	0	47. 00
48. 00	Unsecured Loans	0	0	0		1
49.00	Other long term liabilities	-304, 382		0	0	
50.00	Total long term liabilities (sum of lines 46 thru 49)	6, 818, 569	1	0		50.00
51. 00	Total liabilities (sum of lines 45 and 50) CAPITAL ACCOUNTS	13, 591, 405	0	0	0	51.00
52. 00	General fund balance	127, 652, 214				52.00
53. 00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	
58. 00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58. 00
59. 00	Total fund balances (sum of lines 52 thru 58)	127, 652, 214		n	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and	141, 243, 619		0	0	
	59)			_		

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES ST. FRANCIS HOSPITAL In Lieu of Form CMS-2552-10

| Peri od: | Worksheet G-1 | From 07/01/2022 | To 06/30/2023 | Date/Time Prepared: Provider CCN: 14-1350

					То	06/30/2023	Date/Time Pre 1/24/2024 11:	
		Genera	Fund	Speci al I	Pur	pose Fund	Endowment	
							Fund	
		1, 00	2. 00	3.00		4. 00	5. 00	
1. 00	Fund balances at beginning of period		110, 585, 891	0.00		0	2. 22	1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)		17, 494, 931					2.00
3.00	Total (sum of line 1 and line 2)		128, 080, 822			0		3. 00
4. 00	Additions (credit adjustments) (specify)	0			0		0	4. 00
5. 00		0			0		0	5.00
6.00		0			0		0	6.00
7. 00 8. 00		0			0		0	7. 00 8. 00
9. 00		0			0		0	9.00
10.00	Total additions (sum of line 4-9)	٩	0		۷	o	0	10.00
11. 00	Subtotal (line 3 plus line 10)		128, 080, 822			ol		11.00
12.00	TRANSFER OF ASSETS	428, 608	.,,		0		0	12.00
13.00		o			0		0	13.00
14.00		0			0		0	14.00
15.00		0			0		0	15. 00
16.00		0			0		0	16.00
17.00	T-+-1 d-dusting ( of lines 12 17)	O	420 (00		O		0	17.00
18. 00 19. 00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance		428, 608 127, 652, 214			0		18. 00 19. 00
17.00	sheet (line 11 minus line 18)		127, 052, 214			ď		19.00
	Torrest (Trite Triminae Trite Te)	Endowment	PI ant	Fund				
		Fund						
		4.00	7.00	0.00	_			
1. 00	Fund balances at beginning of period	6. 00	7. 00	8. 00	0			1.00
2. 00	Net income (loss) (from Wkst. G-3, line 29)	٩			٧			2.00
3. 00	Total (sum of line 1 and line 2)	ol			0			3.00
4.00	Additions (credit adjustments) (specify)		0					4.00
5.00			0					5.00
6.00			0					6. 00
7. 00			0					7. 00
8.00			0					8.00
9.00	T-+-1		0					9.00
10. 00 11. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10)	0			0			10. 00 11. 00
12. 00	TRANSFER OF ASSETS	١	0		U			12.00
13. 00	THOUSE EN OF FROSE TO		0					13.00
14.00			0					14.00
15.00			0					15. 00
16. 00			0					16.00
17. 00			0					17.00
18.00	Total deductions (sum of lines 12-17)	0			0			18.00
19. 00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0			0			19. 00
	Sheer (Tine II millus IIIe 10)	ı I		I	- 1			I

ST. FRANCIS HOSPITAL

Health Financial Systems
STATEMENT OF PATLENT REVENUES AND OPERATING EXPENSES Provider CCN: 14-1350

		To	06/30/2023	Date/Time Pre 1/24/2024 11:	
	Cost Center Description	Inpatient	Outpati ent	Total	
	<b>'</b>	1.00	2.00	3. 00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1. 00	Hospi tal	4, 045, 062		4, 045, 062	1.00
2. 00	SUBPROVI DER - I PF				2.00
3. 00	SUBPROVI DER - I RF				3.00
4. 00	SUBPROVI DER				4.00
5. 00	Swing bed - SNF	124, 722		124, 722	5.00
6. 00	Swing bed - NF	14, 391		14, 391	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE	4 404 475		4 404 475	9.00
10. 00	Total general inpatient care services (sum of lines 1-9)	4, 184, 175		4, 184, 175	10.00
11. 00	Intensive Care Type Inpatient Hospital Services INTENSIVE CARE UNIT	T			11. 00
12. 00	CORONARY CARE UNIT				12.00
13. 00	BURN INTENSIVE CARE UNIT				13.00
	SURGICAL INTENSIVE CARE UNIT				14. 00
15. 00	OTHER SPECIAL CARE (SPECIFY)				15.00
	Total intensive care type inpatient hospital services (sum of lines	0		0	16.00
10.00	11-15)			J	10.00
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	4, 184, 175		4, 184, 175	17.00
18. 00	Ancillary services	13, 824, 866	133, 408, 609	147, 233, 475	18.00
19.00	Outpati ent servi ces	407, 350	22, 102, 319	22, 509, 669	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	O	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGI CAL CENTER (D. P. )				25.00
26.00	HOSPI CE				26.00
27. 00	PROF FEE	161, 243	3, 447, 338	3, 608, 581	27.00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.	18, 577, 634	158, 958, 266	177, 535, 900	28. 00
	G-3, line 1)				
00.00	PART II - OPERATING EXPENSES		F0 010 000		00.00
29. 00 30. 00	Operating expenses (per Wkst. A, column 3, line 200)		50, 919, 808		29.00
30.00	ADD (SPECIFY)	0			30. 00 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)		0		36.00
37. 00	DEDUCT (SPECIFY)	0	٩		37.00
38. 00	(3. 23.1.1)	0			38. 00
39. 00		0			39.00
40.00		0			40.00
41. 00		0			41.00
42.00	Total deductions (sum of lines 37-41)		o		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer		50, 919, 808		43.00
	to Wkst. G-3, line 4)				

		RANCIS HOSPITAL		u of Form CMS-2	
SIAIEN	ENT OF REVENUES AND EXPENSES	Provi der CCN: 14-1350	Peri od: From 07/01/2022	Worksheet G-3	
			To 06/30/2023	Date/Time Pre	pared
	<u> </u>			1/24/2024 11:	37 am
	Tatal wat: art revenue (from What C 2 Dart L and w	2 1: 20)		1.00	1 (
. 00	Total patient revenues (from Wkst. G-2, Part I, colu			177, 535, 900	
2. 00	Less contractual allowances and discounts on patients	s accounts		115, 923, 896	
3. 00	Net patient revenues (line 1 minus line 2)	11 12 40		61, 612, 004	
. 00	Less total operating expenses (from Wkst. G-2, Part			50, 919, 808	
. 00	Net income from service to patients (line 3 minus li	ne 4)		10, 692, 196	5.0
00	OTHER I NCOME			0	, ,
. 00	Contributions, donations, bequests, etc			752.045	
. 00	Income from investments			753, 865	1
. 00	Revenues from telephone and other miscellaneous communications and madia acquires	unication services		0	
. 00 0. 00	Revenue from television and radio service			0	
	Purchase di scounts			0	
1.00	Rebates and refunds of expenses			0	11.
2.00	Parking lot receipts			0	
3.00	Revenue from laundry and linen service Revenue from meals sold to employees and quests			0 1, 757	
5.00	Revenue from rental of living quarters	a ather than notionts			15.
	Revenue from sale of medical and surgical supplies to Revenue from sale of drugs to other than patients	o other than patrents			16.
	Revenue from sale of medical records and abstracts			0 3, 837	
8.00	Tuition (fees, sale of textbooks, uniforms, etc.)			3, 837	
	Revenue from gifts, flowers, coffee shops, and canter	on		62, 812	
	Rental of vending machines	en		02, 812	
2.00	Rental of hospital space			328, 580	
	Governmental appropriations			117, 308	
	MISC INCOME			628, 572	
	COVID-19 PHE Funding			159, 223	
	Total other income (sum of lines 6-24)			2, 055, 954	
	Total (line 5 plus line 25)			12, 748, 150	
7. 00	NON-OPERATING EXPENSES			34, 632	
	GAIN/LOSS ON ASSET DISPOSAL			12, 931	
	PENSION			-1, 927, 078	
	NON-OPERATING LOSS			-1, 927, 078 -2, 867, 266	
	Total other expenses (sum of line 27 and subscripts)			-2, 867, 266 -4, 746, 781	
	Net income (or loss) for the period (line 26 minus li	ino 20)		-4, 746, 781 17, 494, 931	
7. 00	The Friconic (or 1055) for the berron (Title 20 IIII lus Fi	1116 20)	I	17, 474, 931	l ∠7.