Health I	inancial Systems	FRANCI SCAN HEAL	TH- DYFR	Inlie	」of Form CMS-2552-10
	port is required by law (42 USC 1395c				
	s made since the beginning of the cos		•		OMB NO. 0938-0050
					EXPI RES 09-30-2025
	L AND HOSPITAL HEALTH CARE COMPLEX CO	SI REPORT CERTIFICATION	Provider CCN: 15-0090	Period: From 01/01/2022	Worksheet S Parts  -
AND SET	TLEMENT SUMMARY			To 12/31/2022	Date/Time Prepared:
					5/10/2023 11:00 am
	- COST REPORT STATUS				
Provi de				Date: 5/10/20	23 Time: 11:00 am
use onl					
	3.[0]If this is an amended 4.[F]Medicare Utilization.	report enter the number Enter "F" for full, "L"	of times the provider re for low, or "N" for no.	esubmitted this co	ost report
Contrac		6. Date Received:		IPR Date:	
use onl	y (1) As Submitted	7. Contractor No.	11. C	Contractor's Vendo	r Code: 4
	(2) Settled without Audit	8. [ N ] Initial Report fo 9. [ N ] Final Report for	this Provider CCN 12. [		
	(5) Settred with Addit			number of tim	es reopened = 0-9.
	(4) Reopened (5) Amended				
	(5) Allended				
PART II	- CERTIFICATION BY A CHIEF FINANCIAL	OFFICER OR ADMINISTRATO	R OR PROVIDER(S)		
MI SREPR	ESENTATION OR FALSIFICATION OF ANY IN	FORMATION CONTAINED IN T	HIS COST REPORT MAY BE P	UNISHABLE BY CRIN	INAL, CIVIL AND
ADMI NI S	TRATIVE ACTION, FINE AND/OR IMPRISONN	IENT UNDER FEDERAL LAW.	FURTHERMORE, IF SERVICES	IDENTIFIED IN TH	IS REPORT WERE
PROVI DE	O OR PROCURED THROUGH THE PAYMENT DIF	ECTLY OR INDIRECTLY OF A	KICKBACK OR WERE OTHERW	ISE ILLEGAL, CRIN	INAL, CIVIL AND
ADMI NI S	TRATIVE ACTION, FINES AND/OR IMPRISON	IMENT MAY RESULT.			
	CERTIFICATION BY CHIEF FINANCIAL OFF	ICER OR ADMINISTRATOR OF	PROVI DER(S)		
	I HEREBY CERTIFY that I have read th	ne above certification st	atement and that I have	examined the acco	ompanyi ng
	electronically filed or manually sub				
	Statement of Revenue and Expenses pr	repared by FRANCISCAN HEA	LTH- DYER ( 15-0090 ) fo	or the cost report	ing period
	beginning 01/01/2022 and ending 12/3				
	are true, correct, complete and prep				
	applicable instructions, except as r				
	regarding the provision of health ca		e services identified ir	n this cost report	were
	provided in compliance with such law	vs and regulations.			
S	GNATURE OF CHIEF FINANCIAL OFFICER O	R ADMI NI STRATOR CHECK	BOX	ELECTRONI C	
	1	2	SIGN	IATURE STATEMENT	
1			I have read and agree	e with the above	certification 1
			statement. I certify	/that I intend my	electronic
			signature on this ce	ertification be th	ne legally

			Title	XVIII			
		Title V	Part A	Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPI TAL	0	459, 608	-67, 690	0	0	1.00
2.00	SUBPROVIDER - IPF	0	0	0		0	2.00
3.00	SUBPROVIDER - IRF	0	199, 346	-10		0	3.00
4.00	SUBPROVI DER (OTHER)						4.00

binding equivalent of my original signature.

0

3

5.00

6.00

0

0

200.00TOTAL0658,954-67,700000200.00The 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 itdisplays a valid OMB control number. The number for this information collection is OMB 0938-0050 and the number for theSupplement to Form CMS 2552-10, Worksheet N95, is OMB 0938-1425. The time required to complete and review the informationcollection is estimated 675 hours per response, including the time to review instructions, search existing resources, gather thedata needed, and complete and review the information collection. If you have any comments concerning the accuracy of the timeofficer, Mail Stop C4-26-05, Baltimore, Maryl and 21244-1850.

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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.

2 Signatory Printed Name 3 Signatory Title

SWING BED - SNF

SWING BED - NF

4 Date

5.00

6.00

	Financial Systems TAL AND HOSPITAL HEALTH CARE COMPLEX I	DENTIFICATION DATA	Provi de	er CCN:		Period: From 01/01/	2022	Workshe Part I		
						To 12/31/		Date/Ti 5/10/20		
	1.00	2.00		3.00			4.00			
00	Hospital and Hospital Health Care Con Street: 24 JOLIET STREET	PO Box:								1.
00	City: DYER	State: IN	Zin Code	. 46311	I-1799 Count	V. LAKE				2.
		Component Name	CCN	CBSA		Date	Payme	nt Syst	em (P,	
			Number	Number	r Type	Certified	Т,	0, or		
							V	XVIII		-
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
00	Hospital and Hospital-Based Componen <sup>•</sup> Hospital	FRANCI SCAN HEALTH- DYER	150090	23844	1	07/01/1966	N	Р	0	3.
00	Subprovider - IPF	FRANCISCAN HEALTH- DIER	130090	23044	+   I	0770171900	IN IN		0	4.
00		FRANCISCAN HEALTH -	15T090	23844	1 5	01/01/2002	N	P	Т	5.
		DYER -REHAB								
00	Subprovider - (Other)									6.
00	Swing Beds - SNF									7.
00	Swing Beds - NF									8.
00	Hospital-Based SNF									9.
. 00	Hospi tal -Based NF Hospi tal -Based OLTC									10.
. 00										12
	Separately Certified ASC									13.
	Hospi tal -Based Hospi ce							1		14.
. 00	Hospital-Based Health Clinic - RHC									15.
	Hospital-Based Health Clinic - FQHC									16.
. 00										17
	Renal Dialysis Other									18.
00						From:		То	:	19
						1.00		2. (		1
	Cost Reporting Period (mm/dd/yyyy)					01/01/2	022	12/31/		20
00	Type of Control (see instructions)					1			_	21
				-	1.00	2.00		3. (	00	-
	Inpatient PPS Information				1.00	2.00		5.0		
. 00	-	currently receiving pay	ments for		Y	N				22.
	disproportionate share hospital adjus									
	§412.106? In column 1, enter "Y" for									
	facility subject to 42 CFR Section §4		ndment							
01	hospital?) In column 2, enter "Y" for Did this hospital receive interim UCF		al IICPs 1	for	Y	Y				22
. 01	this cost reporting period? Enter in									22.
	for the portion of the cost reporting									
	1. Enter in column 2, "Y" for yes or									
	cost reporting period occurring on or	r after October 1. (see								
	instructions)									
. 02	Is this a newly merged hospital that				N	N				22.
	determined at cost report settlement? 1, "Y" for yes or "N" for no, for the	<pre>(see instructions) Enti- e portion of the cost re-</pre>	er in colu porting	umn						
	period prior to October 1. Enter in a	e portion of the cost re column 2 "Y" for ves or	יטונווט "N" for י	no						
	for the portion of the cost reporting									
. 03	Did this hospital receive a geographi	5 1			Ν	N		Ν		22
	rural as a result of the OMB standard	ds for delineating stati	stical are	eas						
	adopted by CMS in FY2015? Enter in co									
	for the portion of the cost reporting			r						
	in column 2, "Y" for yes or "N" for r reporting period occurring on or afte									
	Does this hospital contain at least			s						
	counted in accordance with 42 CFR 412									
	yes or "N" for no.									
	Did this has its a second to be a se	ic reclassification from								22
04	1 5 5 1	dolinostione for static								
04	rural as a result of the revised OMB		N TOT I							
04	rural as a result of the revised OMB adopted by CMS in FY 2021? Enter in a	column 1, "Y" for yes or	r 1 Enta	·						
. 04	rural as a result of the revised OMB adopted by CMS in FY 2021? Enter in a for the portion of the cost reporting	column 1, "Y" for yes or g period prior to Octobe								1
. 04	rural as a result of the revised OMB adopted by CMS in FY 2021? Enter in of for the portion of the cost reporting in column 2, "Y" for yes or "N" for	column 1, "Y" for yes or g period prior to Octobe no for the portion of th	e cost							
. 04	rural as a result of the revised OMB adopted by CMS in FY 2021? Enter in a for the portion of the cost reporting	column 1, "Y" for yes or g period prior to Octobe no for the portion of th er October 1. (see instr	e cost uctions)	s						
. 04	rural as a result of the revised OMB adopted by CMS in FY 2021? Enter in of for the portion of the cost reporting in column 2, "Y" for yes or "N" for reporting period occurring on or afte	column 1, "Y" for yes or g period prior to Octobe no for the portion of th er October 1. (see instr 100 but not more than 49	e cost uctions) 9 beds (as							
. 04	rural as a result of the revised OMB adopted by CMS in FY 2021? Enter in o for the portion of the cost reporting in column 2, "Y" for yes or "N" for reporting period occurring on or afte Does this hospital contain at least of counted in accordance with 42 CFR 412 yes or "N" for no.	column 1, "Y" for yes or g period prior to Octobe ho for the portion of th er October 1. (see instr 100 but not more than 49 2.105)? Enter in column	e cost uctions) 9 beds (as 3, "Y" fo	or						
	rural as a result of the revised OMB adopted by CMS in FY 2021? Enter in o for the portion of the cost reporting in column 2, "Y" for yes or "N" for reporting period occurring on or afte Does this hospital contain at least counted in accordance with 42 CFR 412 yes or "N" for no. Which method is used to determine Med	column 1, "Y" for yes or g period prior to Octobe no for the portion of th er October 1. (see instr 100 but not more than 49 2.105)? Enter in column dicaid days on lines 24	e cost uctions) 9 beds (as 3, "Y" fo and/or 25	or		3 N				23
	rural as a result of the revised OMB adopted by CMS in FY 2021? Enter in of for the portion of the cost reporting in column 2, "Y" for yes or "N" for r reporting period occurring on or afte Does this hospital contain at least counted in accordance with 42 CFR 412 yes or "N" for no. Which method is used to determine Med below? In column 1, enter 1 if date of	column 1, "Y" for yes or g period prior to Octobe no for the portion of th er October 1. (see instr 100 but not more than 49 2.105)? Enter in column dicaid days on lines 24 of admission, 2 if censu	e cost uctions) 9 beds (as 3, "Y" fo and/or 25 s days, on	or r 3		3 N				23.
	rural as a result of the revised OMB adopted by CMS in FY 2021? Enter in o for the portion of the cost reporting in column 2, "Y" for yes or "N" for reporting period occurring on or afte Does this hospital contain at least counted in accordance with 42 CFR 412 yes or "N" for no. Which method is used to determine Med	column 1, "Y" for yes or g period prior to Octobe no for the portion of th er October 1. (see instr 100 but not more than 49 2.105)? Enter in column dicaid days on lines 24 of admission, 2 if censu of identifying the days	e cost uctions) 9 beds (as 3, "Y" fo and/or 25 s days, ou in this co	or r 3		3 N				23

SPLL	Financial Systems         FRANCI           AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	SCAN HEALTH	Provider CC	N: 15-0090	Period: From 01/0	01/2022	Works Part		2
					To 12/3	31/2022	Date/ 5/10/	Time Pre 2023 11:	epared
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medi cai d pai d days	Out-of State Medi cai d el i gi bl e unpai d	Medi ca HMO da	d	Other edi cai d days	
. 00	If this provider is an IPPS hospital, enter the	1.00	2.00	3.00	4.00 541	5.00	656	<u>6.00</u> 132	2 24.0
. 00	in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid 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.	0					533	132	25.0
	nino para ana errgi bre bat anpara days fri cordinir 5.	<u> </u>		<u> </u>	Urban/F	Rural S	Date (	of Geogr	
00				ind an effect	1.	00	2	. 00	
	Enter your standard geographic classification (not wa cost reporting period. Enter "1" for urban or "2" for		at the beg	nning or	lne	1			26.0
. 00	Enter your standard geographic classification (not wa reporting period. Enter in column 1, "1" for urban or enter the effective date of the geographic reclassifi lf this is a sole community hospital (SCH), enter the	cation in	ural. If ap column 2.	pl i cabl e,		1 0			27. 35.
	effect in the cost reporting period.				Begi n	ni ng:	En	di ng:	
				<u></u>	1.	00		. 00	
	Enter applicable beginning and ending dates of SCH st of periods in excess of one and enter subsequent date		cript line	36 for numb	ber				36.
	If this is a Medicare dependent hospital (MDH), enter		r of period	ls MDH statu	JS	1			37.
	is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for th accordance with FY 2016 OPPS final rule? Enter "Y" fo								37
00	instructions) If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of				01/01	/2022	12/3	1/2022	38.
	enter subsequent dates.				Y/	/N	,	Y/N	
					1.		2	. 00	
	Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(1) 1 "Y" for yes or "N" for no. Does the facility meet a accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii) or "N" for no. (see instructions) Is this hospital subject to the HAC program reduction	), (İi), or the mileage i)? Enter n adjustmen	(iii)? Ent requiremen in column 2 t? Enter "Y	er in colur nts in ? "Y" for ye (" for yes o	nn es or N	N (		N	39. 40.
	"N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1.		,	ves or "N" 1	for				
		(see mist				V	XVII	_	
	Prospective Payment System (PPS)-Capital					1.00	2.0	0 3.00	
00	Does this facility qualify and receive Capital paymer	nt for disp	roporti onat	e share in	accordance	N	N	N	45.
00	with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exce pursuant to 42 CFR §412.348(f)? If yes, complete Wks1					N	N	N	46
00	Pt. III. Is this a new hospital under 42 CFR §412.300(b) PPS o Is the facility electing full federal capital payment	capital? E	nter "Y for	yes or "N'	' for no.	N N	N	N N	47
	Teachi ng Hospi tal s								
	Is this a hospital involved in training residents in periods beginning prior to December 27, 2020, enter ' cost reporting periods beginning on or after December the instructions. For column 2, if the response to co involved in training residents in approved GME progra and are you are impacted by CR 11642 (or applicable C "Y" for yes; otherwise, enter "N" for no in column 2.	'Y <sup>''</sup> for yes ~27, 2020, olumn 1 is ams in the   CRs) MA dire	or "N" for under 42 C "Y", or if prior year	no in colu CFR 413.78(k this hospitor or penultin	umn 1. For b)(2), see tal was nate year,	Y	Y		56.
	For cost reporting periods beginning prior to December is this the first cost reporting period during which at this facility? Enter "Y" for yes or "N" for no in residents start training in the first month of this of "N" for no in column 2. If column 2 is "Y", complete complete Wkst. D, Parts III & IV and D-2, Pt. II, if beginning on or after December 27, 2020, under 42 CFF	er 27, 2020 residents n column 1. cost report e Worksheet applicable	in approved If column ing period? E-4. If co . For cost	IGME progra 1 is "Y", ( P Enter "Y' Dumn 2 is ' reporting p	ams trained did 'for yes o 'N", periods				57

	Financial Systems         FRANCI           AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA	Provider CC	F	Period: From 01/01/2022	Worksheet S-2 Part I	
					o 12/31/2022	Date/Time Pre	pared 00 am
					1.00	XVIII XIX 0 2.00 3.00	
9.00	Are costs claimed on line 100 of Worksheet A? If yes	s, compl	ete Wkst. D-2,		N		59.0
				NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
				1.00	2.00	3.00	1
0. 00	Are you claiming nursing and allied health education any programs that meet the criteria under 42 CFR 413. instructions) Enter "Y" for yes or "N" for no in col is "V", are you impacted by CR 11642 (or subsequent C adjustment? Enter "Y" for yes or "N" for no in colum	85? (s umn 1. CR) NAHE	see If column 1	N			60. (
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
1.01	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) Enter the current year total unweighted primary care	N			0.00	0.00	61. ( 61. (
	FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions) Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.
	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). Enter the difference between the baseline primary						61. 61.
. 06	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) Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.
	care of general surgery. (see first uctions)	Pro	ogram Name	Program Code	Unweighted IME	Unweighted	
			5			Direct GME FTE Count	
10			1.00	2.00	3.00	4.00	
	Of the FTEs in line 61.05, specify each new program 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.				0.00		61.
. 20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.
						1.00	
. 00	ACA Provisions Affecting the Health Resources and Ser Enter the number of FTE residents that your hospital				iod for which	0.00	62.
	your hospital received HRSA PCRE funding (see instruc Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC prog	cti ons) a Teachi	ng Health Cent	ter (THC) into		0.00	62.
. 00	Teaching Hospitals that Claim Residents in Nonprovide Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, comple	er Setti ettings	ings during this co	ost reporting		N	63.

alth Financial Systems )SPITAL AND HOSPITAL HEALTH CARE COMPLE		ATA   Pro		CN: 15-0090	Peri od:	eu of Form CMS- Worksheet S-2	
					From 01/01/2022 To 12/31/2022	Part I	epared:
				Unwei ghted	Unwei ghted	Ratio (col. 1	/
				FTES	FTEs in	(col. 1 + col	
				Nonprovider Site	Hospi tal	2))	
				1.00	2.00	3.00	-
Section 5504 of the ACA Base Year	FTE Residents in N	lonprovi der Set	tinas				
period that begins on or after Ju				line base jou	, is jour cost	i opor tring	
4.00 Enter in column 1, if line 63 is in the base year period, the numb resident FTEs attributable to rot settings. Enter in column 2 the resident FTEs that trained in you of (column 1 divided by (column 1	yes, or your facili er of unweighted no ations occurring in number of unweighte r hospital. Enter i	ty trained res n-primary care all nonprovid d non-primary n column 3 the	i dents er care	0. (	0. 00	0. 00000	0 64.00
	Program Name	Program (	ode	Unweighted	Unweighted	Ratio (col. 3	/
	5			FTEs	FTEs in	(col. 3 + col	
				Nonprovi der	Hospi tal	4))	
				Si te			
	1.00	2.00		3.00	4.00	5.00	
5.00 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)				O.(	00 0. 01	0. 00000	
				FTEs Nonprovider Site	•	(col. 1 + col 2))	
Section 5504 of the ACA Current Y	ear FTE Posidonte i	n Nonnrovider	Setting	1.00	2.00	3.00	
beginning on or after July 1, 201		n nonprovraci	Set tring.	S Effective		ring perirous	
5.00 Enter in column 1 the number of u FTEs attributable to rotations oc Enter in column 2 the number of u	nweighted non-prima curring in all nonp nweighted non-prima	rovider settin ry care reside	gs. nt	0.0	4. 29	9 0. 00000	0 66.00
FTEs that trained in your hospita (column 1 divided by (column 1 +							
	Program Name	Program (	ode	Unweighted	Unweighted	Ratio (col. 3	/
		l i ograni o	240	FTEs	FTEs in	(col . 3 + col)	
				Nonprovi der		(4))	
				Si te			
	1.00	2.00		3.00	4.00	5.00	_
7.00 Enter in column 1, the program I 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	NTERN MEDICINE	3900		0. (		9 0. 00000	0 67.0

Heal th	Financial Systems FRANCISCAN HEALTH- DYER		In	Lieu	of Form (	CMS-2	552-10
			Peri od:		Worksheet		
			From 01/01/2 To 12/31/2		Part I Date/Time	Pre	ared:
					5/10/2023	11:0	00 am
				-	1.00		
	Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065						
68.00	For a cost reporting period beginning prior to October 1, 2022, did yo MAC to apply the new DGME formula in accordance with the FY 2023 IPPS				Ν		68.00
	(August 10, 2022)?	iinai kure, or ir	49003-4907	2			
			_				
	Inpatient Psychiatric Facility PPS			1.00	2.00 3	. 00	
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it o	ontain an IPF sub	oprovi der?	N		_	70.00
74 00	Enter "Y" for yes or "N" for no.						74 00
/1.00	If line 70 is yes: Column 1: Did the facility have an approved GME tea recent cost report filed on or before November 15, 2004? Enter "Y" fo					0	71.00
	42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train reside						
	program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" fo						
	Column 3: If column 2 is Y, indicate which program year began during t (see instructions)	nis cost reportin	ig period.				
	Inpatient Rehabilitation Facility PPS				· · ·		
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does i subprovider? Enter "Y" for yes and "N" for no.	t contain an IRF		Y			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME tea			Ν	N	0	76.00
	recent cost reporting period ending on or before November 15, 2004? Er						
	no. Column 2: Did this facility train residents in a new teaching prog CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3:						
	indicate which program year began during this cost reporting period. (						
				-	1.00		
	Long Term Care Hospital PPS				1.00		
	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" f				N		80.00
81.00	Is this a LTCH co-located within another hospital for part or all of t "Y" for yes and "N" for no.	he cost reporting	g period? En	ter	N		81.00
	TEFRA Providers						
	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? E			no.	Ν		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) ur §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.	der 42 CFR Sectio	on				86.00
87.00	Is this hospital an extended neoplastic disease care hospital classifi	ed under section			Ν		87.00
	1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		Approved	for	Number o	)f	
			Permane		Approve		
			Adj ustme	ent	Permaner		
			(Y/N) 1.00		Adjustmer 2.00	its	
88.00	Column 1: Is this hospital approved for a permanent adjustment to the	TEFRA target	1.00		2.00	0	88.00
	amount per discharge? Enter "Y" for yes or "N" for no. If yes, complet	e col. 2 and line	9				
	89. (see instructions) Column 2: Enter the number of approved permanent adjustments.						
		Wkst. A Line	e Effective	Date	Approve		
		No.			Permaner Adjustme		
					Amount P		
					Di scharg	je 🛛	
89 00	Column 1: If line 88, column 1 is Y, enter the Worksheet A line number	1.00	2.00		3.00	0	89.00
09.00	on which the per discharge permanent adjustment approval was based.	0.0				0	09.00
	Column 2: Enter the effective date (i.e., the cost reporting period						
	beginning date) for the permanent adjustment to the TEFRA target amour per discharge.	t					
	Column 3: Enter the amount of the approved permanent adjustment to the						
-	TEFRA target amount per discharge.		V	_	XI X	_	
			1.00		2.00		
00.00	Title V and XIX Services		N		N/		00.00
90.00	Does this facility have title V and/or XIX inpatient hospital services yes or "N" for no in the applicable column.	? Enter Y For	N		Y		90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost re		N		Y		91.00
92 00	full or in part? Enter "Y" for yes or "N" for no in the applicable col Are title XIX NF patients occupying title XVIII SNF beds (dual certifi				Ν		92.00
	instructions) Enter "Y" for yes or "N" for no in the applicable column						
93.00	Does this facility operate an ICF/IID facility for purposes of title V	and XIX? Enter	N		Ν		93.00
94.00	"Y" for yes or "N" for no in the applicable column. Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" fo	r no in the	N		Ν		94.00
	applicable column.				0.00		05 00
	If line 94 is "Y", enter the reduction percentage in the applicable co Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" fo		0. 00 N		0. 00 N		95.00 96.00
	applicable column.						
97.00	If line 96 is "Y", enter the reduction percentage in the applicable co	lumn.	0.00		0.00		97.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider C		eriod:	Worksheet S-2	2
			rom 01/01/2022 o 12/31/2022	Date/Time Pre	
			V	5/10/2023 11: XI X	00 am
			1.00	2.00	-
28.00 Does title V or XIX follow Medicare (title XVIII) for the i stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" column 1 for title V, and in column 2 for title XIX.	nterns and res for yes or "N"	idents post for no in	N	Y	98. C
28.01 Does title V or XIX follow Medicare (title XVIII) for the r C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for t title XIX.			N	Y	98.0
28.02 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 for title V, and in column 2 for title XIX.			N	Y	98.0
78.03 Does title V or XIX follow Medicare (title XVIII) for a cri reimbursed 101% of inpatient services cost? Enter "Y" for y for title V, and in column 2 for title XIX.			N	N	98.0
28.04 Does title V or XIX follow Medicare (title XVIII) for a CAH outpatient services cost? Enter "Y" for yes or "N" for no i in column 2 for title XIX.			N	N	98.0
P8.05 Does title V or XIX follow Medicare (title XVIII) and add b Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 2 for title XIX.			N	Y	98.0
28.06 Does title V or XIX follow Medicare (title XVIII) when cost Pts. I through IV? Enter "Y" for yes or "N" for no in colum column 2 for title XIX.			N	Y	98.0
Rural Providers 105.00 Does this hospital qualify as a CAH?			N		105.0
106.00 If this facility qualifies as a CAH, has it elected the all	-inclusive met	hod of payment	N		106. (
for outpatient services? (see instructions) 107.00 Column 1: If line 105 is Y, is this facility eligible for c 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	n 1. (see ins	tructions)	N		107.0
approved medical education program in the CAH's excluded I Enter "Y" for yes or "N" for no in column 2. (see instruct 108.00 Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	i ons)	.,	N		108. (
	Physi cal	Occupati onal	Speech	Respi ratory	
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	1.00 N	2.00 N	3.00 N	4.00 N	109. (
110 00 Did this been to be anti-size the Dural Community User it				1 00	
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.	"Y" for yes or	"N" for no. I	° yes,	1.00 N	110. (
Demonstration) for the current cost reporting period? Enter	"Y" for yes or	"N" for no. I	* yes, gh 215, as	N	110. (
Demonstration)for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wo	"Y" for yes or rksheet E-2, I the Frontier C ost reporting olumn 1 is Y,	"N" for no. I i nes 200 throug ommunity period? Enter enter the	° yes,		_
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	"Y" for yes or rksheet E-2, I the Frontier C ost reporting olumn 1 is Y, rticipating in	"N" for no. I i nes 200 throug ommunity period? Enter enter the column 2.	<sup>≈</sup> yes, gh 215, as 1.00	N	_
Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wo applicable. III.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	"Y" for yes or rksheet E-2, I the Frontier C ost reporting olumn 1 is Y, rticipating in	"N" for no. I i nes 200 throug ommunity period? Enter enter the column 2.	<sup>≈</sup> yes, gh 215, as 1.00	N	_
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	"Y" for yes or rksheet E-2, I the Frontier C ost reporting olumn 1 is Y, rticipating in dditional beds Ith Model eporting olumn 1 is pating in the	"N" for no. I i nes 200 throug ommuni ty period? Enter enter the column 2. ; and/or "C"	<sup>-</sup> yes, jh 215, as 1.00 N	N 2.00	111. (
<ul> <li>Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wo applicable.</li> <li>11.00 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.</li> <li>12.00 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 cell the context is the date the hospital began particid demonstration. In column 3, enter the date the hospital cell participate in the Community Health Access Transformation (CHART) model for any portion of the current reporting period? Enter "Y" for yes or "N" for no.</li> </ul>	"Y" for yes or rksheet E-2, I the Frontier C ost reporting olumn 1 is Y, rticipating in dditional beds I th Model eporting olumn 1 is pating in the ased s and Rural	"N" for no. I i nes 200 throug ommuni ty peri od? Enter enter the col umn 2. ; and/or "C" 1.00	<sup>-</sup> yes, jh 215, as 1.00 N	N 2.00	111.
<ul> <li>Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, Lines 200 through 218, and Wo applicable.</li> <li>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.</li> <li>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.</li> <li>113.00 Did this hospital participate in the Community Health Access Transformation (CHART) model for any portion of the current reporting period? Enter "Y" for yes or "N" for no. Miscel Laneous Cost Reporting Information</li> <li>115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or in column 3. enter the method used (A, in column 1. If column 2 is "E", enter the method used (A, in column 2. If column 2 is "E", enter the nospitals provide</li> </ul>	"Y" for yes or rksheet E-2, I the Frontier C ost reporting olumn 1 is Y, rticipating in dditional beds lth Model eporting olumn 1 is pating in the ased s and Rural cost r "N" for no B, or E only) 93" percent (includes	"N" for no. I i nes 200 throug ommuni ty peri od? Enter enter the col umn 2. ; and/or "C" 1.00	<sup>-</sup> yes, jh 215, as 1.00 N	N 2.00 3.00	- 111.   112.   113.
<ul> <li>Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, Lines 200 through 218, and Wo applicable.</li> <li>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.</li> <li>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.</li> <li>113.00 Did this nospital participate in the Community Health Access Transformation (CHART) model for any portion of the current reporting period? Enter "Y" for yes or "N" for no. Miscellaneous Cost Reporting Information</li> <li>115.00 Is this an all-inclusive rate provider? Enter "Y" for yes o in column 1. If column 1 is yes, enter the method used (A, in column 2. If column 1 is yes, enter in column 3 either " for short term hospital or "98" percent for long term care psychiatric, rehabilitation and long term hospitals provide the definition in CMS Pub. 15-1, chapter 22, §2208.1.</li> </ul>	"Y" for yes or rksheet E-2, I the Frontier C ost reporting olumn 1 is Y, rticipating in dditional beds lth Model eporting olumn 1 is pating in the ased s and Rural cost r "N" for no B, or E only) 93" percent (includes rs) based on	"N" for no. I in the second se	<sup>-</sup> yes, jh 215, as 1.00 N	N 2.00 3.00	111. ( 111. ( 112. ( 113. ( 0 115. (
<ul> <li>Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, Lines 200 through 218, and Wo applicable.</li> <li>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.</li> <li>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.</li> <li>113.00 Did this nospital participate in the Community Health Access Transformation (CHART) model for any portion of the current reporting period? Enter "Y" for yes or "N" for no.</li> <li>Miscellaneous Cost Reporting Information</li> <li>115.00 Is this an all-inclusive rate provider? Enter "Y" for yes o in column 1. If column 1 is yes, enter the method used (A, in column 2. If column 2 is "E", enter in column 3 either "for short term hospital or "98" percent for long term care psychiatric, rehabilitation and long term hospitals provide the definition in CMS Pub. 15-1, chapter 22, §2208.1.</li> <li>116.00 Is this facility classified as a referral center? Enter "Y" "N" for no.</li> </ul>	"Y" for yes or rksheet E-2, I the Frontier C ost reporting olumn 1 is Y, rticipating in dditional beds Ith Model eporting olumn 1 is pating in the ased s and Rural cost r "N" for no B, or E only) 93" percent (includes rs) based on for yes or	"N" for no. I i i nes 200 throug ommuni ty peri od? Enter enter the col umn 2. ; and/or "C" 1.00 N	<sup>-</sup> yes, jh 215, as 1.00 N	N 2.00 3.00	111. ( 111. ( 1112. ( 1113. ( 1115. ( 1116. (
<ul> <li>Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, Lines 200 through 218, and Wo applicable.</li> <li>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.</li> <li>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.</li> <li>113.00 Did this nospital participate in the Community Health Access Transformation (CHART) model for any portion of the current reporting period? Enter "Y" for yes or "N" for no. Miscellaneous Cost Reporting Information</li> <li>115.00 Is this an all-inclusive rate provider? Enter "Y" for yes o in column 1. If column 1 is yes, enter the method used (A, in column 2. If column 1 is yes, enter in column 3 either " for short term hospital or "98" percent for long term care psychiatric, rehabilitation and long term hospitals provide the definition in CMS Pub. 15-1, chapter 22, §2208.1.</li> </ul>	"Y" for yes or rksheet E-2, I the Frontier C ost reporting olumn 1 is Y, rticipating in dditional beds lth Model eporting olumn 1 is pating in the ased s and Rural cost r "N" for no B, or E only) 93" percent (incl udes rs) based on for yes or rance? Enter	"N" for no. I i nes 200 throug ommuni ty peri od? Enter enter the col umn 2. ; and/or "C" 1.00 N	<sup>-</sup> yes, jh 215, as 1.00 N	N 2.00 3.00	110. ( 110. ( 111. (

alth Financial Systems OSPITAL AND HOSPITAL HEALTH CARE COMPLEX	FRANCI SCAN HEAL I DENTIFI CATION DATA	Provi der CCN:		eriod: rom 01/01/2022	u of Form CM Worksheet S Part I Date/Time F 5/10/2023 1	-2 Prepared
			Premi ums	Losses	Insurance	
			1.00	2.00	3.00	_
18.01 List amounts of malpractice premiums	and paid losses:		692, 393		3.00	0118.0
				1.00	2.00	-
<ul> <li>8.02 Are malpractice premiums and paid lo Administrative and General? If yes, and amounts contained therein.</li> <li>9.00 DO NOT USE THIS LINE</li> </ul>				N	2.00	118. (
20.00 Is this a SCH or EACH that qualifies §3121 and applicable amendments? (se "N" for no. Is this a rural hospital Hold Harmless provision in ACA §3127 Enter in column 2, "Y" for yes or "N	e instructions) Enter in o with < 100 beds that qual and applicable amendments	column 1, "Y" f ifies for the	`or yes or Outpatient	N	Ν	120. (
21.00 Did this facility incur and report of patients? Enter "Y" for yes or "N" f		table devices o	charged to	Y		121. (
22.00 Does the cost report contain healthd Act?Enter "Y" for yes or "N" for no the Worksheet A line number where th	are related taxes as defir in column 1. If column 1 i			Y	5.04	122. 0
23.00 Did the facility and/or its subprovi services, e.g., legal, accounting, 1 management/consulting services, from for yes or "N" for no. If column 1 is "Y", were the majori1 professional services expenses, for located in a CBSA outside of the mai	ders (if applicable) purch ax preparation, bookkeepin an unrelated organization by of the expenses, i.e., g services purchased from un	ng, payroll, ar ? In column 1, greater than 50 nrelated organi	nd/or enter "Y" % of total zations			123. (
"N" for no. Certified Transplant Center Informat						
25.00 Does this facility operate a Medicar and "N" for no. If yes, enter certif 26.00 If this is a Medicare-certified kidr	ication date(s) (mm/dd/yy	/y) below.	5	N		125.
in column 1 and termination date, if 7.00 If this is a Medicare-certified hear	applicable, in column 2.					127.
in column 1 and termination date, if 8.00 If this is a Medicare-certified live	er transplant program, ente	er the certific	ation date			128.
in column 1 and termination date, if 9.00 If this is a Medicare-certified lung	, transplant program, enter	<sup>-</sup> the certifica	ntion date			129.
in column 1 and termination date, if 0.00  f this is a Medicare-certified pand date in column 1 and termination dat	reas transplant program, e e, if applicable, in colur	nn 2.				130.
1.00  f this is a Medicare-certified inte date in column 1 and termination dat 2.00  f this is a Medicare-certified isle	e, if applicable, in colur	nn 2.				131. 132.
in column 1 and termination date, if 3.00Removed and reserved	applicable, in column 2.					133.
4.00 If this is a hospital-based organ pr in column 1 and termination date, if All Providers		PO), enter the	0P0 number			134.
0.00 Are there any related organization of chapter 10? Enter "Y" for yes or "N" are claimed, enter in column 2 the h 1.00	for no in column 1. If ye	es, and home of	fice costs	Y 3. 00	158014	140.
If this facility is part of a chain	organization, enter on li				of the	
home office and enter the home office 1.00 Name: FRANCI SCAN ALLIANCE, INC	ce contractor name and con Contractor's Name: WISC SERV	ONSIN PHYSICIAI		's Number: 0810	1	141.
2.00 Street:1515 DRAGOON TRAIL 3.00 City: MISHAWAKA	PO Box: - State: IN		Zip Code:	4654	6	142. 143.
					1.00	
4.00 Are provider based physicians' costs	included in Worksheet A?				Y	144.
				1.00	2.00	
5.00 If costs for renal services are clai inpatient services only? Enter "Y" f no, does the dialysis facility inclu period? Enter "Y" for yes or "N" fo	for yes or "N" for no in co nde Medicare utilization fo	olumn 1. lf col	umn 1 is			145.
6.00 Has the cost allocation methodology Enter "Y" for yes or "N" for no in c yes, enter the approval date (mm/dd/	changed from the previous column 1. (See CMS Pub. 15-			N		146.

IOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	Provider CC	CN: 15-0090		1/01/2022	Worksheet S- Part I	-2
					2/31/2022		
						1.00	_
47.00Was there a change in the statisti	cal basis? Enter "Y" fo	r yes or "N" for	no.			N	147.0
48.00 Was there a change in the order of	allocation? Enter "Y"	for yes or "N" fo	or no.			N	148. 0
49.00Was there a change to the simplifi	ed cost finding method?					N	149.0
		Part A	Part	3 T	tle V	Title XIX	_
Does this facility contain a provi	dor that qualifier for	1.00	2.00	ication of	3.00	4.00	_
or charges? Enter "Y" for yes or '							
55. 00 Hospi tal		N	N		N	N	155. (
56.00 Subprovi der – IPF		Ν	N		Ν	N	156. (
57.00 Subprovi der – IRF		N	N		Ν	N	157. (
58. 00 SUBPROVI DER							158. (
59. 00 SNF		N	N		N	N	159. (
60. 00 HOME HEALTH AGENCY		N	N		N	N	160. (
51.00 CMHC			N		N	N	161.
						1.00	
Multicampus							
55.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	mpus nospitai that has	one or more campu	ises in di	TERENT CB	SAS?	N	165.0
	Name	County	State	Zip Code	CBSA	FTE/Campus	
	0	1.00	2.00	3.00	4.00	5.00	
66.00 fline 165 is yes, for each						0.0	00 166. 0
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)							
	I						
Health Information Tachnology (417	) inconting in the Amer	i can Bacavary an	d Doi puost	mont Act		1.00	
Health Information Technology (HI 67.00Is this provider a meaningful user						Y	167. (
68.00 f this provider is a CAH (line 10					the		168.0
reasonable cost incurred for the H				,,, ,,,			
68.01 If this provider is a CAH and is r			qualify	for a hard	shi p		168. (
exception under §413.70(a)(6)(ii)?							
69.00 If this provider is a meaningful ι		nd is not a CAH (	(line 105	s "N"), e	nter the	0.0	00169. (
transition factor. (see instruction	ins)			Bo	gi nni ng	Endi ng	
				,	1. 00	2.00	-
70.00 Enter in columns 1 and 2 the EHR b	eginning date and endin	q date for the re	eporting		1.00	2.00	170. (
period respectively (mm/dd/yyyy)							
					1.00	2.00	-
71.00 If line 167 is "Y", does this prov	ider have any days for	individuals enrol	ledin		N	2.00	0171.
			i cu i ii		1.1	1	J
section 1876 Medicare cost plans r			. 6? Ente	-			
	eported on Wkst. S-3, P	t. I, line 2, col					

iospi t	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-0090	Peri od: From 01/01/2022 To 12/31/2022		epared:
				Y/N	Date	
				1.00	2.00	
	PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSE General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS			er all dates in 1	he	
. 00	Provider Organization and Operation Has the provider changed ownership immediately prior to the reporting period? If yes, enter the date of the change in o			N		1.0
	reporting period. In yes, enter the date of the change in t	501 Gillin 2. (300	Y/N	Date	V/I	
			1.00	2.00	3.00	
. 00	Has the provider terminated participation in the Medicare F yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.		N			2.0
. 00	Is the provider involved in business transactions, includir contracts, with individuals or entities (e.g., chain home or or medical supply companies) that are related to the provid officers, medical staff, management personnel, or members of of directors through ownership, control, or family and other relationships? (see instructions)	offices, drug der or its of the board	N			3.0
			Y/N	Туре	Date	
			1.00	2.00	3.00	
1.00	Financial Data and Reports Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" f or "R" for Reviewed. Submit complete copy or enter date ava column 3. (see instructions) If no, see instructions.	°or Compiled,	Y	A	05/10/2023	4.0
5.00	Are the cost report total expenses and total revenues different those on the filed financial statements? If yes, submit reconcisional statements of the statement of the stateme		N	Y/N	Logal Open	5.0
				1.00	Legal Oper. 2.00	
	Approved Educational Activities			1.00	2.00	
. 00	Column 1: Are costs claimed for a nursing program? Column the legal operator of the program?	5	s the provider			6.0
7.00 3.00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing programs and/or allied health programs approve cost reporting period? If yes, see instructions.		wed during the	e N		7.0
. 00	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction	is.		N		9.0
0.00	Was an approved Intern and Resident GME program initiated cost reporting period? If yes, see instructions.			N		10.0
1.00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R In an App	proved	N	Y/N	11.0
					1,00	
	Bad Debts					
	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection p period? If yes, submit copy.			ost reporting	Y N	12. 0 13. 0
4.00	If line 12 is yes, were patient deductibles and/or coinsura instructions.	ance amounts wa	aived? If yes,	see	Ν	14.0
5.00	Bed Complement Did total beds available change from the prior cost reporti		yes, see inst rt A		Y t B	15.0
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
/	PS&R Data					
6. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N		16.0
7.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	04/24/2023	Y	04/24/2023	17.0
8. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		Ν		18.0
9. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		Ν		19.0

ealth Financial Systems FRANCISCAN H OSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	IEALTH- DYER Provider CC	N· 15_0000	Period:	u of Form CMS- Worksheet S-2	
USFITAL AND HUSFITAL HEALTH GARE REINIDURSENLINT QUESTIONNALRE	Frovider co	M. 15-0070	From 01/01/2022 To 12/31/2022	Part II Date/Time Pre 5/10/2023 11:	epared
	Descri	ption	Y/N	Y/N	
		)	1.00	3.00	
0.00 If line 16 or 17 is yes, were adjustments made to PS&R			N	N	20.
Report data for Other? Describe the other adjustments:	Y/N	Date	Y/N	Date	-
	1.00	2.00	3.00	4.00	
1.00 Was the cost report prepared only using the provider's	N N	2.00	N	4.00	21.
records? If yes, see instructions.		L			
				1.00	-
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	EPT CHILDRENS H	OSPI TALS)		1.00	
Capital Related Cost					
2.00 Have assets been relifed for Medicare purposes? If yes, see				Ν	22.
3.00 Have changes occurred in the Medicare depreciation expense	due to apprais	als made du	ring the cost	N	23.
reporting period? If yes, see instructions. 4.00 Were new leases and/or amendments to existing leases entered	ed into during	this cost ru	enorting period?	Ν	24.
If yes, see instructions	cu into uuring	1113 0031 10	eporting period:	i v	27.
5.00 Have there been new capitalized leases entered into during	the cost repor	ting period	?lfyes, see	Ν	25.
instructions.			LE		
6.00 Were assets subject to Sec. 2314 of DEFRA acquired during th instructions.	ne cost reporti	ng period? I	IT yes, see	N	26.
7.00 Has the provider's capitalization policy changed during the	e cost reportin	g period? It	f yes, submit	Ν	27.
сору.					
Interest Expense			*	N	1 20
8.00 Were new loans, mortgage agreements or letters of credit er period? If yes, see instructions.	ntered into dur	ing the cost	t reporting	Ν	28.
9.00 Did the provider have a funded depreciation account and/or	bond funds (De	bt Service A	Reserve Fund)	Ν	29.
treated as a funded depreciation account? If yes, see instr					
0.00 Has existing debt been replaced prior to its scheduled matu	urity with new	debt? If yes	s, see	N	30.
<ul><li>instructions.</li><li>Has debt been recalled before scheduled maturity without is</li></ul>	ssuance of new	debt? If ve	S SEE	Ν	31.
instructions.			-,		
Purchased Services					1
2.00 Have changes or new agreements occurred in patient care ser arrangements with suppliers of services? If yes, see instru		d through co	ontractual	Ν	32.
3.00 If line 32 is yes, were the requirements of Sec. 2135.2 app		a to competi	itive bidding? If		33.
no, see instructions.	P	5p			
Provi der-Based Physi ci ans					
4.00 Were services furnished at the provider facility under an a	arrangement wit	h provider-l	based physicians?	Y	34.
If yes, see instructions. 5.00 If line 34 is yes, were there new agreements or amended exi	isting agreemen	ts with the	nrovi der-based	Ν	35.
physicians during the cost reporting period? If yes, see in		to with the	provider based	N .	55.
			Y/N	Date	
			1.00	2.00	
Home Office Costs 6.00 Were home office costs claimed on the cost report?			Y		36.
7.00 If line 36 is yes, has a home office cost statement been pr	repared by the	home office			37.
If yes, see instructions.	1				
8.00 If line 36 is yes, was the fiscal year end of the home off			f N		38.
9.00 If line 36 is yes, did the provider render services to othe			s, N		39.
see instructions.		sints: in yes			37.
0.00 If line 36 is yes, did the provider render services to the	home office?	lf yes, see	Ν		40.
instructions.					
	1.0	00	2	00	-
Cost Report Preparer Contact Information	1.		Ζ.	00	
1.00 Enter the first name, last name and the title/position	HONG		YANG		41.
held by the cost report preparer in columns 1, 2, and 3,			1		11
held by the cost report preparer in columns 1, 2, and 3, respectively.					1 40
held by the cost report preparer in columns 1, 2, and 3, respectively. 2.00 Enter the employer/company name of the cost report	FRANCI SCAN ALL	IANCE INC			42.
held by the cost report preparer in columns 1, 2, and 3, respectively.	FRANCI SCAN ALL		Hong. Yang@Fran	CI SCANALLI ANCF	

Heal th	Financial Systems FRANCISCAN	HEALTH- DYER	In Lie	In Lieu of Form CMS-2552-10		
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0090	Peri od:	Worksheet S-2		
			From 01/01/2022 To 12/31/2022		pared: <u>00 am</u>	
		3.00				
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position	ADMIN DIR GOVT COST RP			41.00	
	held by the cost report preparer in columns 1, 2, and 3,	REIMBURSEMENT				
	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				43.00	
	report preparer in columns 1 and 2, respectively.					

OSPI T	Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC,	FRANCISCAN HE	Provider CC	CN: 15-0090	Peri od:	u of Form CMS-2 Worksheet S-3	
					From 01/01/2022 To 12/31/2022	Part I Date/Time Prep 5/10/2023 11:0	
						I/P Days / 0/P	
						Visits / Trips	
	Component	Worksheet A Line No.	No. of Beds	Bed Days Avai I abl e	CAH Hours	Title V	
		1.00	2.00	3.00	4.00	5.00	
. 00	PART I - STATISTICAL DATA Hospital Adults & Peds. (columns 5, 6, 7 and	30.00	103	36, 68	. 00	0	1.0
. 00	8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2	30.00	103	30, 00	54 0.00	0	1.1
00	for the portion of LDP room available beds)						
. 00 . 00	HMO and other (see instructions)						2.
. 00	HMO IPF Subprovider HMO IRF Subprovider						4.
. 00	Hospital Adults & Peds. Swing Bed SNF					0	4. 5.
. 00	Hospital Adults & Peds. Swing Bed Ski Hospital Adults & Peds. Swing Bed NF					0	6.
. 00	Total Adults and Peds. (exclude observation		103	36, 68	0.00	0	7.
. 00	beds) (see instructions)		100	00, 00	0.00	0	<i>'</i> .
. 00	INTENSIVE CARE UNIT	31.00	14	5, 11	0.00	0	8.
. 00	CORONARY CARE UNIT	32.00	0		0 0.00	0	9.
00 .C	BURN INTENSIVE CARE UNIT						10.
1.00	SURGICAL INTENSIVE CARE UNIT						11.
2.00	NEONATAL INTENSIVE CARE UNIT	35.00	8	2, 92	0.00	0	12.
3.00	NURSERY	43.00				0	13.
4.00	Total (see instructions)		125	44, 71	4 0.00	0	14.
5.00	CAH visits					0	15.
6.00	SUBPROVIDER - IPF	44.00		40.05			16.
7.00	SUBPROVIDER - IRF	41.00	30	10, 95	0	0	17.
3.00 9.00		42.00	0		0	0	18. 19.
). 00	SKILLED NURSING FACILITY NURSING FACILITY						20.
1.00	OTHER LONG TERM CARE						20.
2.00	HOME HEALTH AGENCY						22
3.00	AMBULATORY SURGICAL CENTER (D. P. )						23
1.00	HOSPICE						24
4. 10	HOSPICE (non-distinct part)	30.00					24.
5.00	CMHC - CMHC						25.
6.00	RURAL HEALTH CLINIC						26.
5. 25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.
7.00	Total (sum of lines 14-26)		155				27.
3. 00	Observation Bed Days					0	28
9.00	Ambul ance Trips						29
0.00	Employee discount days (see instruction)						30.
1.00	Employee discount days - IRF						31.
2.00	Labor & delivery days (see instructions)		0		0		32.
2. 01	Total ancillary labor & delivery room outpatient days (see instructions)						32.
3.00	LTCH non-covered days						33.
3.00	LTCH site neutral days and discharges						33.
4.00	Temporary Expansi on COVID-19 PHE Acute Care	30.00	0		0	0	34.

IOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC		Period: From 01/01/2022 To 12/31/2022	Date/Time Pre	pared:
		I/P Days	/ O/P Visits	/ Trips	Full Time	<u>5/10/2023_11:</u> Equi val ents	<u>00 am</u>
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
	PART I – STATISTICAL DATA						
. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and	7, 825	4, 898	20, 14	14		1.0
	Hospice days)(see instructions for col. 2						
	for the portion of LDP room available beds)						
. 00	HMO and other (see instructions)	1, 011	0				2.0
. 00	HMO I PF Subprovi der	0	0				3.0
. 00	HMO I RF Subprovi der	0	0				4.0
. 00	Hospital Adults & Peds. Swing Bed SNF	0	0		0		5.0
. 00	Hospital Adults & Peds. Swing Bed NF	7 005	0	00.44	0		6.0
. 00	Total Adults and Peds. (exclude observation	7, 825	4, 898	20, 14	14		7.0
00	beds) (see instructions)	1 052	0.25	2 21			
. 00 . 00	INTENSIVE CARE UNIT CORONARY CARE UNIT	1, 053 0	835 0	3, 31	0		8. C
0.00	BURN INTENSIVE CARE UNIT	0	0		0		10.0
1.00	SURGI CAL I NTENSI VE CARE UNI T						11.0
2.00	NEONATAL INTENSIVE CARE UNIT	о	244	30	18		12.0
3.00	NURSERY	0	446	72			13.0
4.00	Total (see instructions)	8, 878	6, 423	24, 49		692.00	
5.00	CAH visits	0,0,0	0, 120		0	072.00	15.0
6.00	SUBPROVIDER - IPF	Ŭ	Ŭ		° (		16.0
7.00	SUBPROVI DER – I RF	3, 592	215	3, 80	0. 00	49.00	
8.00	SUBPROVI DER	0,072	0	0,00	0 0.00		
9.00	SKILLED NURSING FACILITY						19.0
0.00	NURSING FACILITY						20.0
1.00	OTHER LONG TERM CARE						21. (
2.00	HOME HEALTH AGENCY						22. (
3.00	AMBULATORY SURGICAL CENTER (D. P.)						23. (
4.00	HOSPI CE						24.0
4. 10	HOSPICE (non-distinct part)				0		24.
5.00	CMHC - CMHC						25.0
6.00	RURAL HEALTH CLINIC						26.0
6. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0.00		
7.00	Total (sum of lines 14-26)				3. 72	741.00	
8.00	Observation Bed Days		0	2, 85	04		28.
9.00	Ambul ance Trips	0			0		29.0
0.00	Employee discount days (see instruction)				0		30.0
1.00	Employee discount days - IRF		100	1 1/	0		31.0
2.00	Labor & delivery days (see instructions)	0	132	1, 14	13 0		32.0
2. 01	Total ancillary labor & delivery room outpatient days (see instructions)				U		32.0
3. 00	LTCH non-covered days	0					33. (
3.00	LTCH non-covered days LTCH site neutral days and discharges	0					33. (
	Temporary Expansi on COVID-19 PHE Acute Care	0	0		0		34. 0

OSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider C	CN: 15-0090	Period: From 01/01/2022 To 12/31/2022	Worksheet S-3 Part I Date/Time Pre 5/10/2023 11:0	pared
		Full Time		Di s	charges		
		Equivalents	<b>T</b> : 11 1/		<b>T</b>	T 1 1 411	
	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	11.00	12.00	13.00	14.00	15.00	
. 00	Hospital Adults & Peds. (columns 5, 6, 7 and		0	1, 72	1, 264	5, 281	1 1.
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
. 00	HMO and other (see instructions)			87	76 0		2.
. 00	HMO IPF Subprovider				0		3.
. 00	HMO IRF Subprovider				0		4.
. 00	Hospital Adults & Peds. Swing Bed SNF						5.
. 00	Hospital Adults & Peds. Swing Bed NF						6.
. 00	Total Adults and Peds. (exclude observation						7.
	beds) (see instructions)						
. 00	INTENSIVE CARE UNIT						8.
. 00	CORONARY CARE UNIT						9.
0.00	BURN INTENSIVE CARE UNIT						10.
1.00 2.00	SURGICAL INTENSIVE CARE UNIT						11.
3.00	NEONATAL INTENSIVE CARE UNIT NURSERY						13.
4.00	Total (see instructions)	0, 00	0	1, 72	23 1, 264	5, 281	14.
5.00	CAH visits	0.00	0	1,72	1,204	5, 201	15.
6.00	SUBPROVIDER - IPF						16.
7.00	SUBPROVIDER - IRF	0.00	0	40	03 0	440	
8.00	SUBPROVI DER	0.00	0		0	0	18.
9.00	SKILLED NURSING FACILITY					-	19.
0. OO	NURSING FACILITY						20.
1.00	OTHER LONG TERM CARE						21.
2.00	HOME HEALTH AGENCY			1			22.
3.00	AMBULATORY SURGICAL CENTER (D. P.)						23.
4.00	HOSPI CE						24.
4. 10	HOSPICE (non-distinct part)						24.
5.00	CMHC - CMHC						25.
6.00	RURAL HEALTH CLINIC						26.
5.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.
7.00	Total (sum of lines 14-26)	0. 00					27.
3.00	Observation Bed Days						28.
9.00 0.00	Ambulance Trips						29. 30.
1.00	Employee discount days (see instruction) Employee discount days - IRF						30.
2.00	Labor & delivery days (see instructions)						31.
2.00	Total ancillary labor & delivery room						32.
2.01	outpatient days (see instructions)						32.
3.00	LTCH non-covered days				0		33.
3.01	LTCH site neutral days and discharges				0		33.
4.00	3						34.

	AL WAGE INDEX INFORMATION			Provider CO	F	Period: From 01/01/2022 Fo 12/31/2022		pare
		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adj usted Sal ari es (col . 2 ± col . 3)		Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II – WAGE DATA SALARIES							1
	Total salaries (see	200. 00	78, 665, 924	0	78, 665, 924	1, 646, 162. 00	47.79	1
0	instructions) Non-physician anesthetist Part		C	0		0.00	0.00	2
0	A		Ĺ			0.00	0.00	2
0	Non-physician anesthetist Part		C	0	(	0.00	0.00	3
0	B Physician-Part A -		C	0	(	0.00	0.00	4
0	Admi ni strati ve					0.00	0.00	
	Physicians - Part A - Teaching		C	-		0.00		
0	Physician and Non Physician-Part B		C	0	(	0.00	0.00	5
0	Non-physician-Part B for		C	0	(	0.00	0.00	6
	hospital-based RHC and FQHC							
0	services Interns & residents (in an	21.00	C	0		0.00	0.00	7
0	approved program)	21.00	C C			0.00	0.00	΄ ΄
1	Contracted interns and		C	0	(	0.00	0.00	7
	residents (in an approved programs)							
0	Home office and/or related		10, 571, 441	0	10, 571, 441	268, 849. 00	39. 32	8
	organization personnel			_				
	SNF	44.00	0 244 000	0		0.00		
00	Excluded area salaries (see instructions)		8, 344, 088	430	8, 344, 518	3 276, 070. 00	30. 23	10
Ī	OTHER WAGES & RELATED COSTS			1				
00	Contract Labor: Direct Patient		9, 101, 381	0	9, 101, 381	1 65, 780. 00	138.36	11
00	Care Contract Labor: Top Level		C	0	(	0.00	0.00	12
	management and other		-	_				
	management and administrative							
00	services Contract Labor: Physician-Part		179, 031	0	179, 03 <sup>-</sup>	1, 120. 00	159. 85	13
	A - Administrative		.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,					
00	Home office and/or related		C	0	(	0.00	0.00	14
	organization salaries and wage-related costs							
01	Home office salaries		11, 289, 189	0	11, 289, 189	287, 102. 00		
	Related organization salaries		C	-		0.00		
00	Home office: Physician Part A - Administrative		C	0	l l	0.00	0.00	15
00	Home office and Contract		C	0	(	0.00	0.00	16
0.1	Physicians Part A - Teaching						0.00	
01	Home office Physicians Part A - Teaching		C	0	l l	0.00	0.00	
	Home office contract		C	0	(	0.00	0.00	16
	Physicians Part A - Teaching							
	WAGE-RELATED COSTS Wage-related costs (core) (see		17, 856, 641	0	17, 856, 64	1		17
	instructions)							
00	Wage-related costs (other) (see instructions)							18
00	Excluded areas		2, 118, 792	0	2, 118, 792	2		19
	Non-physician anesthetist Part		C	0	(	ס		20
	A Non physician aposthatist Prot		~					1 21
50	Non-physician anesthetist Part B		Ĺ	, 0				21
00	Physician Part A -		C	0	(	ס		22
01	Administrative		C					22
	Physician Part A - Teaching Physician Part B		0	0	(			22
00	Wage-related costs (RHC/FQHC)		C	-	(	ט		24
00	Interns & residents (in an		C	0	(	ס		25
50	approved program) Home office wage-related		3, 450, 853	0	3, 450, 853	3		25
	(core)		3, 100, 000		3, 130, 030	-		
	Related organization		C	0	(	ס		25
	wage-related (core) Home office: Physician Part A		C	0	(			25
~~	- Administrative -		C	0		-1		1 - 3

Heal th	Financial Systems		FRANCI SCAN HE	EALTH- DYER		In Lieu of Form CMS-2552-10			
HOSPI T	AL WAGE INDEX INFORMATION			Provider C		Period: From 01/01/2022 To 12/31/2022			
		Wkst. A Line	Amount	Reclassi fi cati	Adj usted	Paid Hours	Average Hourly		
		Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷		
				(from Wkst.	(col.2 ± col.	Salaries in	col. 5)		
				A-6)	3)	col. 4			
	· · · ·	1.00	2.00	3.00	4.00	5.00	6.00		
25.53	Home office: Physicians Part A		0	0		0		25.53	
	- Teaching - wage-related								
	(core)								
	OVERHEAD COSTS - DIRECT SALARII								
26.00	Employee Benefits Department	4.00			147, 10			26.00	
27.00	Administrative & General	5.00	16, 799, 566	-75, 529					
28.00	Administrative & General under		767, 961	0	767, 96	1 5, 322. 00	144. 30	28.00	
	contract (see inst.)								
29.00	Maintenance & Repairs	6. 00		0	716, 55			29.00	
30.00	Operation of Plant	7.00	1, 565, 579	0	1, 565, 57			30.00	
31.00	Laundry & Linen Service	8.00	0	0		0 0.00		31.00	
32.00	Housekeepi ng	9.00	1, 859, 455	0	1, 859, 45	5 100, 089. 00		32.00	
33.00	Housekeeping under contract		0	0		0 0.00	0.00	33.00	
24.00	(see instructions)	10.00	1 242 0/5	74/ 0//	40/ 00	0 01 000 00	15 00	24.00	
34.00	Di etary	10.00	1, 242, 965	-746, 866	496, 09			34.00	
35.00	Dietary under contract (see instructions)		0	0		0 0.00	0.00	35.00	
36.00	Cafeteri a	11.00	4	746, 866	746, 87	0 27, 311.00	27.35	36.00	
37.00	Maintenance of Personnel	12.00	0	0		0 0.00	0.00	37.00	
38.00	Nursing Administration	13.00	2, 403, 996	0	2, 403, 99	6 47, 952.00	50. 13	38.00	
39.00	Central Services and Supply	14.00	373, 418	0	373, 41		27.51	39,00	
40.00	Pharmacy	15.00			1, 979, 77			40.00	
41.00	Medical Records & Medical	16.00	352, 245		352, 24			41.00	
	Records Library								
42.00	Soci al Servi ce	17.00	0	0		0 0.00	0.00	42.00	
43.00	Other General Service	18.00	0	0		0 0.00	0.00	43.00	

Heal th	Financial Systems		FRANCI SCAN H	EALTH- DYER		In Lieu of Form CMS-2552-10			
HOSPI T	AL WAGE INDEX INFORMATION			Provider CO		Period: From 01/01/2022 To 12/31/2022		pared:	
							5/10/2023 11:0	<u> 00 am</u>	
		Worksheet A	Amount	Recl assi fi cati			Average Hourly		
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷		
				(from	(col.2 ± col.	Salaries in	col. 5)		
				Worksheet A-6)	3)	col. 4			
		1.00	2.00	3.00	4.00	5.00	6.00		
	PART III - HOSPITAL WAGE INDEX	SUMMARY							
1.00	Net salaries (see		68, 862, 444	0	68, 862, 44	4 1, 382, 635.00	49.81	1.00	
	instructions)								
2.00	Excluded area salaries (see		8, 344, 088	430	8, 344, 51	8 276, 070. 00	30. 23	2.00	
	instructions)								
3.00	Subtotal salaries (line 1		60, 518, 356	-430	60, 517, 92	6 1, 106, 565. 00	54.69	3.00	
	minus line 2)								
4.00	Subtotal other wages & related		20, 569, 601	0	20, 569, 60	1 354, 002. 00	58. 11	4.00	
	costs (see inst.)								
5.00	Subtotal wage-related costs		21, 307, 494	0	21, 307, 49	4 0.00	35. 21	5.00	
	(see inst.)								
6.00	Total (sum of lines 3 thru 5)		102, 395, 451	-430	102, 395, 02	1 1, 460, 567.00	70. 11	6.00	
7.00	Total overhead cost (see		28, 208, 623	-75, 529	28, 133, 09	4 485, 986. 00	57.89	7.00	
	instructions)								
	,								

	Financial Systems AL WAGE RELATED COSTS	FRANCI SCAN HEAL	Provider	CCN:	15-0090	Period:	Worksheet S-3	
				00		From 01/01/2022	Part IV	
						To 12/31/2022	Date/Time Pre 5/10/2023 11:	
	· · · · · · · · · · · · · · · · · · ·		<u> </u>				Amount	T
							Reported	
							1.00	
	PART IV - WAGE RELATED COSTS							
	Part A - Core List							_
	RETIREMENT COST						1 001 001	_
00	401K Employer Contributions	+!					1, 281, 006	
00	Tax Sheltered Annuity (TSA) Employer Contribut						0	
00 00	Nonqualified Defined Benefit Plan Cost (see ir Qualified Defined Benefit Plan Cost (see instr						-	2  3
10	PLAN ADMINISTRATIVE COSTS (Paid to External Or						3, 023, 998	4
00	401K/TSA Plan Administration fees	gam zatron)					56, 517	7
00	Legal /Accounting/Management Fees-Pension Plan						30, 317	
00	Employee Managed Care Program Administration F							ő
	HEALTH AND INSURANCE COST							-
00	Health Insurance (Purchased or Self Funded)						(	5
01	Health Insurance (Self Funded without a Third	Party Administra	ator)				0	
)2	Health Insurance (Self Funded with a Third Par	rty Administrato	-)				11, 172, 610	)
)3	Heal th Insurance (Purchased)	5					(	
00	Prescription Drug Plan						(	D
00	Dental, Hearing and Vision Plan						255, 547	7   1
00	Life Insurance (If employee is owner or benefi	i ci ary)					13, 944	4 1
00	Accident Insurance (If employee is owner or be						0	)   1
00	Disability Insurance (If employee is owner or						316, 679	
00	Long-Term Care Insurance (If employee is owner	r or beneficiary)						)   1
00	'Workers' Compensation Insurance						1, 042, 216	
00	Retirement Health Care Cost (Only current year	r, not the extra	ordinary a	ccrua	al require	ed by FASB 106.	(	) 1
	Noncumulative portion) TAXES							-
00	FICA-Employers Portion Only						4, 552, 053	1
00	Medicare Taxes - Employers Portion Only							) 1 ) 1
00	Unemployment Insurance						-	) 1 ) 1
	State or Federal Unemployment Taxes						-	
00	OTHER							4 -
00	Executive Deferred Compensation (Other Than Re	etirement Cost Re	eported on	Line	es 1 throu	igh 4 above. (see	(	<u></u> 1 2
	instructions))					.g		-
00	Day Care Cost and Allowances						0	) 2
	Tuition Reimbursement						0	) 2
00	Total Wage Related cost (Sum of lines 1 -23)						21, 714, 570	2 2
	Part B - Other than Core Related Cost							
00	OTHER WAGE RELATED COSTS (SPECIFY)							72

Heal th	Financial Systems	FRANCISCAN HEALTH- DYER	In Lie	u of Form CMS-2	2552-10
H0SPI T	AL CONTRACT LABOR AND BENEFIT COST	Provider CCN: 15-0090	Peri od:	Worksheet S-3	
			From 01/01/2022 To 12/31/2022		narod
			10 12/31/2022	Date/Time Pre 5/10/2023 11:	
	Cost Center Description		Contract Labor		
			1.00	2.00	
	PART V - Contract Labor and Benefit Cost				
	Hospital and Hospital-Based Component Identif	i cati on:			
1.00	Total facility's contract labor and benefit of	cost	0	0	1.00
2.00	Hospi tal		0	0	2.00
3.00	SUBPROVIDER - IPF				3.00
4.00	SUBPROVIDER - IRF		0	0	4.00
5.00	Subprovider - (Other)		0	0	5.00
6.00	Swing Beds - SNF		0	0	6.00
7.00	Swing Beds - NF		0	0	7.00
8.00	SKILLED NURSING FACILITY				8.00
9.00	NURSING FACILITY				9.00
10.00	OTHER LONG TERM CARE I				10.00
11.00	Hospital-Based HHA				11.00
12.00	AMBULATORY SURGICAL CENTER (D. P.) I				12.00
13.00	Hospi tal -Based Hospi ce				13.00
14.00	Hospital-Based Health Clinic RHC				14.00
15.00	Hospital-Based Health Clinic FQHC				15.00
16.00	Hospital-Based-CMHC				16.00
17.00	RENAL DIALYSIS I				17.00
18.00	Other		0	0	18.00

Heal th	Financial Systems FRANCISCAN HEA	LTH- DYER		In Li€	eu of Form CMS-	2552-10
	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCI	N: 15-0090	Peri od:	Worksheet S-1	0
				From 01/01/2022 To 12/31/2022		
					1.00	
	Uncompensated and indigent care cost computation				1.00	
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 d	divided by lin	ne 202 columr	18)	0. 230559	1.00
	Medicaid (see instructions for each line)	2		,		
2.00	Net revenue from Medicaid				26, 743, 994	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		с. н. н.			3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemented			ni d?	0	4.00 5.00
5.00 6.00	If line 4 is no, then enter DSH and/or supplemental payments Medicaid charges	ITOM Medicald	1		140, 650, 608	
7.00	Medicaid cost (line 1 times line 6)		32, 428, 264			
8.00	Difference between net revenue and costs for Medicaid program	5, 684, 270				
	< zero then enter zero)	•				
	Children's Health Insurance Program (CHIP) (see instructions	for each line	:)			
9.00	Net revenue from stand-al one CHIP				0	
10. 00 11. 00	Stand-alone CHIP charges Stand-alone CHIP cost (line 1 times line 10)				0	10.00
12.00	Difference between net revenue and costs for stand-alone CHI	) (line 11 min	us line 9 <sup>,</sup> i	f < zero then	0	12.00
12.00	enter zero)				j ő	12.00
	Other state or local government indigent care program (see ir					
13.00	Net revenue from state or local indigent care program (Not in				0	
14.00	Charges for patients covered under state or local indigent ca	are program (N	lot included	in lines 6 or	0	14.00
15.00	10) State or local indigent care program cost (line 1 times line	14)			0	15.00
16.00	Difference between net revenue and costs for state or local i		program (Lir	ne 15 minus line	-	
101.00	13; if < zero then enter zero)	hargont our o	p. og. am (			
	Grants, donations and total unreimbursed cost for Medicaid, (	CHIP and state	e∕local indig	jent care prograi	ms (see	
17.00	instructions for each line) Private grants, donations, or endowment income restricted to	fundi na chari	ty care		0	17.00
18.00	Government grants, appropriations or transfers for support of				0	
19.00	Total unreimbursed cost for Medicaid , CHIP and state and loc 8, 12 and 16)			s (sum of lines	5, 684, 270	19.00
			Uni nsured	Insured	Total (col. 1	
		_	patients	patients	+ col. 2)	
	Uncomponented Core (coop instructions for each line)		1.00	2.00	3.00	
20.00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire 1	Facility	12, 926, 00	2, 461, 379	15, 387, 439	20.00
20.00	(see instructions)	donney	12, 720, 00	2, 101, 07,		20.00
21.00	Cost of patients approved for charity care and uninsured disc	counts (see	2, 980, 2	19 2, 461, 379	5, 441, 598	21.00
22.00	instructions) Payments received from patients for amounts previously writte	on off as		0 0	0	22.00
22.00	charity care			0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)		2, 980, 2	2, 461, 379	5, 441, 598	23.00
24.00	Deep the amount on Line 20 column 2 include charges for not	ant dava hava	und a langth	of atom limit	1.00	24.00
24.00	Does the amount on line 20 column 2, include charges for pati imposed on patients covered by Medicaid or other indigent car		nd a rength	or stay limit	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond stay limit		care program	n's length of	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see i	nstructions)			3, 741, 172	26.00
	Medicare reimbursable bad debts for the entire hospital complex (see h		ructions)		320, 011	1
27.01	Medicare allowable bad debts for the entire hospital complex				492, 325	
28.00	Non-Medicare bad debt expense (see instructions)				3, 248, 847	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt e	expense (see i	nstructions)		921, 365	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1 i ma 20)			6, 362, 963	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus	iine 30)			12, 047, 233	31.00

CLASSIF	FICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	EXPENSES	Provider CO	CN: 15-0090 F	Period: From 01/01/2022	Worksheet A	
				Т	o 12/31/2022	Date/Time Pre 5/10/2023 11:	
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	NERAL SERVICE COST CENTERS		4 400 507	4 400 503	( (00.050	0 100 ( 10	
	100 CAP REL COSTS-BLDG & FIXT 200 CAP REL COSTS-MVBLE EQUIP		1, 420, 597 0	1, 420, 597 C		8, 100, 649 4, 135, 866	
	300 OTHER CAP REL COSTS		0	C		4, 133, 000	
	400 EMPLOYEE BENEFITS DEPARTMENT	147, 104	17, 443, 727	17, 590, 831	-4, 212	17, 586, 619	
	593 OTHER ADMINISTRATIVE AND GENERAL	16, 799, 566	28, 575, 355	45, 374, 921		40, 774, 027	
	600 MAINTENANCE & REPAIRS	716, 551	2, 690, 168	3, 406, 719		2, 745, 732	
	700 OPERATION OF PLANT 800 LAUNDRY & LINEN SERVICE	1, 565, 579 0	-88, 370 671, 751	1, 477, 209 671, 751		-3, 018, 354 671, 751	
	900 HOUSEKEEPI NG	1, 859, 455	479, 469	2, 338, 924		2, 332, 166	
	000 DI ETARY	1, 242, 965	688, 710	1, 931, 675		751, 396	
	100 CAFETERI A	4	728	732		1, 161, 426	11.
	300 NURSI NG ADMI NI STRATI ON	2, 403, 996	1, 847, 797	4, 251, 793		4, 209, 449	
	400 CENTRAL SERVI CES & SUPPLY 500 PHARMACY	373, 418 1, 979, 779	265, 286 4, 852, 130	638, 704 6, 831, 909		435, 815 6, 751, 711	
	600 MEDICAL RECORDS & LIBRARY	352, 245	4, 832, 130 94, 399	446, 644		446, 644	
	700 SOCI AL SERVI CE	002,210	0	C		0	17
	200 I&R SERVICES-OTHER PRGM COSTS APPRV	110, 279	81, 278	191, 557	83, 511	275, 068	22.
	PATIENT ROUTINE SERVICE COST CENTERS						
	000 ADULTS & PEDIATRICS 100 INTENSIVE CARE UNIT	15, 936, 918 2, 637, 831	6, 200, 091 1, 331, 070	22, 137, 009 3, 968, 901		19, 424, 212 3, 452, 764	
	200 CORONARY CARE UNIT	2,037,031	1, 331, 070	3, 900, 901		3, 432, 764	
	060 NEONATAL INTENSIVE CARE UNIT	972, 891	980, 964	1, 953, 855	-	1, 891, 559	
	100 SUBPROVIDER - IRF	3, 912, 876	1, 068, 834	4, 981, 710		4, 635, 600	
	200 SUBPROVI DER	0	0	C		0	
	300 NURSERY	0	0	C	1, 358, 382	1, 358, 382	43
	CILLARY SERVICE COST CENTERS	1, 466, 812	9, 410, 657	10, 877, 469	-8, 352, 169	2, 525, 300	50
	001 OUTPATI ENT SURGERY	778, 233	450, 635	1, 228, 868		846, 996	
	100 RECOVERY ROOM	337, 896	55, 894	393, 790		341, 610	
	300 ANESTHESI OLOGY	39, 820	5, 152, 009	5, 191, 829		4, 914, 335	
	400 RADI OLOGY - DI AGNOSTI C	1, 423, 788	1, 438, 721	2, 862, 509		1, 674, 457	
	401 RADI OLOGY-SPECI AL PROCEDURES 500 RADI OLOGY-THERAPEUTI C	1, 046, 921	2, 218, 888	3, 265, 809	-697, 458	2, 568, 351 0	54
	600 RADI OI SOTOPE	280, 435	290, 368	570, 803	-246, 992	323, 811	56
	000 LABORATORY	513, 172	6, 895, 578	7, 408, 750		7, 403, 918	
	300 BLOOD STORING, PROCESSING & TRANS.	0	391, 754	391, 754		0	
	500 RESPI RATORY THERAPY	1, 372, 975	1, 785, 712	3, 158, 687		2, 797, 179	
	600 PHYSI CAL THERAPY 700 OCCUPATI ONAL THERAPY	3, 635, 168 872, 675	640, 577 13, 331	4, 275, 745 886, 006		4, 210, 187 883, 457	
	800 SPEECH PATHOLOGY	514, 326	217, 109	731, 435		693, 036	
	900 ELECTROCARDI OLOGY	857, 375	181, 774			876, 047	
	000 ELECTROENCEPHALOGRAPHY	225, 593	26, 307	251, 900		227, 998	
	100 MEDI CAL SUPPLIES CHARGED TO PATIENT	0	0	C	10/110/2/0	10, 145, 276	
	200 IMPL. DEV. CHARGED TO PATIENTS 300 DRUGS CHARGED TO PATIENTS	0	0		8, 952, 561 561, 500	8, 952, 561 561, 500	
	630 ULTRA SOUND	545, 501	346, 422	891, 923		766, 520	
	951 PAIN CLINIC	545, 353	81, 253	626, 606		549, 774	
	952 CATH LAB	1, 857, 007	7, 564, 901	9, 421, 908	-7, 214, 095	2, 207, 813	76
	953 ACTIVITY THERAPEUTIC	1, 183, 722	62, 631	1, 246, 353		1, 245, 516	
	954 WOUND CARE CENTER 340 BARIATRIC CLINIC	426,070	127, 634	553, 704		439, 281	76
	030 HEALTHY LIVING CENTER	1, 266, 303 0	111, 007 0	1, 377, 310 (	- 10, 934	1, 366, 376 0	76
	950 CV RESOURCE CENTER	0	0	C	0	0	
	955 OTHER ANCILLARY SERVICE COST CENTERS	0	0	C	0	0	76
	956 LACTATION CLINIC	0	0	C	0	0	1
	957 OTHER ANCILLARY SERVICE COST CENTERS 958 OTHER ANCILLARY SERVICE COST CENTERS	0	0	C	0	0	
	959 ANTICOAGULATION CLINIC	337, 112	37, 182	374, 294		338, 183	
	700 ALLOGENEIC STEM CELL ACQUISITION	0	0	C (1, 2, 1	0	0	1
OU	TPATIENT SERVICE COST CENTERS						
	100 EMERGENCY	3, 696, 998	3, 215, 870	6, 912, 868	-866, 740	6, 046, 128	
	200 OBSERVATION BEDS (NON-DISTINCT PART						92
	200 OPI OI D TREATMENT PROGRAM	0	0	C	0	0	102
	ECIAL PURPOSE COST CENTERS					0	1.52
3.0011	300 INTEREST EXPENSE		5, 727	5, 727		2, 665, 635	
8.00	SUBTOTALS (SUM OF LINES 1 through 117)	74, 234, 712	109, 325, 925	183, 560, 637	133, 090	183, 693, 727	118
	NREIMBURSABLE COST CENTERS 000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	48, 084	54, 909	102, 993	-3, 304	99, 689	1100
	200 PHYSICIANS' PRIVATE OFFICES	48, 084 1, 422, 700	54, 909 337, 894	1, 760, 594		99, 689 1, 710, 256	
		.,	001,014	1, 100, 074	50, 550	1, 1, 0, 200	1.72

Health Financial Systems	FRANCI SCAN HEA	ALTH- DYER		In Lie	u of Form CMS-	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider CC		Period:	Worksheet A	
				From 01/01/2022 To 12/31/2022		
Cost Center Description	Sal ari es	Other	Total (col.	Reclassi fi cati	Recl assi fi ed	
			+ col. 2)	ons (See A-6)	Trial Balance	
					(col. 3 +-	
					col. 4)	
	1.00	2.00	3.00	4.00	5.00	
192. 02 19202 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0	0	192.02
192. 03 19203 MI SC	0	0		0 0	0	192.03
194. 00 07950 RESI DENTI AL	2, 954, 807	414, 100	3, 368, 90	7 -79, 448	3, 289, 459	194.00
194.01 07954 OTHER NONREIMBURSABLE COST CENTERS	0	0		0 0	0	194.01
194. 02 07952 PSYCHI ATRI C	0	0		0 0	0	194.02
194.0307953 CENTER OF HOPE	859	519	1, 37	8 0	1, 378	194.03
200.00 TOTAL (SUM OF LINES 118 through 199)	78, 665, 924	110, 133, 571	188, 799, 49	5 0	188, 799, 495	200. 00

	IFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	2 21020	Provider CO	 0 Period: From 01/01/202 To 12/31/202		
	Cost Center Description	Adjustments	Net Expenses		5/10/2023 1	1:00 a
	cost center bescription	(See A-8)	For Allocation			
0	GENERAL SERVICE COST CENTERS	6.00	7.00			
	DO100 CAP REL COSTS-BLDG & FIXT	117, 968	8, 218, 617			1.
	DO200 CAP REL COSTS-MVBLE EQUIP	0	4, 135, 866			2.
	DO300 OTHER CAP REL COSTS	0	0			3.
0 0	DO400 EMPLOYEE BENEFITS DEPARTMENT	1, 577, 157	19, 163, 776			4.
	00593 OTHER ADMINISTRATIVE AND GENERAL	-9, 125, 392	31, 648, 635			5.
	DO600 MAI NTENANCE & REPAI RS	0	2, 745, 732			6
	DO700 OPERATION OF PLANT	-944, 201	-3, 962, 555			7
	DO800 LAUNDRY & LINEN SERVICE	0	671, 751			8
	00900 HOUSEKEEPI NG 01000 DI ETARY	-6, 141 -416, 639	2, 326, 025 334, 757			9
	D1100 CAFETERI A	-410,039	1, 161, 408			11
	D1300 NURSI NG ADMI NI STRATI ON	-133,078	4, 076, 371			13
	D1400 CENTRAL SERVICES & SUPPLY	17	435, 832			14
	D1500 PHARMACY	289, 784	7,041,495			15
00 0	D1600 MEDICAL RECORDS & LIBRARY	813, 668	1, 260, 312			16
	D1700 SOCIAL SERVICE	0	0			17
	D2200 I &R SERVICES-OTHER PRGM COSTS APPRV	-16, 192	258, 876			22
	NPATIENT ROUTINE SERVICE COST CENTERS		10.101.110			
	03000 ADULTS & PEDIATRICS	-52	19, 424, 160			30
	D3100 I NTENSI VE CARE UNI T D3200 CORONARY CARE UNI T	-4, 416 0	3, 448, 348 0			31
	D2060 NEONATAL INTENSIVE CARE UNIT	-535, 299	1, 356, 260			35
	04100 SUBPROVI DER – I RF	-1, 880	4, 633, 720			41
	D4200 SUBPROVI DER	0	0			42
00 0	D4300 NURSERY	0	1, 358, 382			43
	ANCILLARY SERVICE COST CENTERS					
	D5000 OPERATING ROOM	0	2, 525, 300			50
	05001 OUTPATIENT SURGERY	0	846, 996			50
	D5100 RECOVERY ROOM	0	341, 610			51
		0	4, 914, 335			53
	D5400 RADI OLOGY-DI AGNOSTI C D5401 RADI OLOGY-SPECI AL PROCEDURES	-160 0	1, 674, 297 2, 568, 351			54 54
	05500 RADI OLOGY-THERAPEUTI C	0	2, 300, 331			55
	D5600 RADI OI SOTOPE	0	323, 811			56
	D6000 LABORATORY	-22, 241	7, 381, 677			60
00 0	D6300 BLOOD STORING, PROCESSING & TRANS.	0	0			63
00 0	D6500 RESPI RATORY THERAPY	0	2, 797, 179			65
	D6600 PHYSI CAL THERAPY	-23, 851	4, 186, 336			66
	06700 OCCUPATI ONAL THERAPY	-13	883, 444			67
	06800 SPEECH PATHOLOGY	-1, 148	691, 888			68
	D6900 ELECTROCARDI OLOGY D7000 ELECTROENCEPHALOGRAPHY	0	876, 047 227, 998			69 70
	D7100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	10, 145, 276			71
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	8, 952, 561			72
	D7300 DRUGS CHARGED TO PATIENTS	0	561, 500			73
00 0	D3630 ULTRA SOUND	-5	766, 515			76
	D3951 PAIN CLINIC	0	549, 774			76
	03952 CATH LAB	-4, 501	2, 203, 312			76
	03953 ACTIVITY THERAPEUTIC	-159, 751	1, 085, 765			76
	D3954 WOUND CARE CENTER D3340 BARI ATRI C CLI NI C	-41 453	439, 281			76
	D3030 HEALTHY LIVING CENTER	-41, 453	1, 324, 923			76
	D3950 CV RESOURCE CENTER	0	0			76
	03955 OTHER ANCI LLARY SERVICE COST CENTERS	0	0			76
	D3956 LACTATION CLINIC	Ő	0			76
10 0	03957 OTHER ANCILLARY SERVICE COST CENTERS	0	0			76
	03958 OTHER ANCILLARY SERVICE COST CENTERS	0	0			76
	03959 ANTI COAGULATI ON CLINI C	0	338, 183			76
	D7700 ALLOGENEIC STEM CELL ACQUISITION	0	0			77
	DUTPATIENT SERVICE COST CENTERS	EE 202	5 000 745			91
	D9100 EMERGENCY D9200 OBSERVATION BEDS (NON-DISTINCT PART	-55, 383	5, 990, 745			91
	DTHER REIMBURSABLE COST CENTERS					- 72
	10200 OPI OI D TREATMENT PROGRAM	0	0			102
	SPECIAL PURPOSE COST CENTERS		0			
	11300 INTEREST EXPENSE	-2, 665, 635	0			113
. 00	SUBTOTALS (SUM OF LINES 1 through 117)	-11, 358, 855				118
	NONREI MBURSABLE COST CENTERS					
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	99, 689			190
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	1, 710, 256			192
0111	19201 WORKING WELL	0	4, 986			192
	19202 PHYSI CLANS' PRI VATE OFFI CES	~	0			192

Health Financial Systems	FRANCI SCAN H	EALTH- DYER		In Lie	u of Form CMS-	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider CC	CN: 15-0090	Peri od:	Worksheet A	
				From 01/01/2022 To 12/31/2022	Date/Time Pre	narod
				10 12/ 51/ 2022	5/10/2023 11:	
Cost Center Description	Adjustments	Net Expenses				
	(See A-8)	For Allocation				
	6.00	7.00				
194. 00 07950 RESI DENTI AL	0	3, 289, 459				194.00
194.01 07954 OTHER NONREIMBURSABLE COST CENTERS	0	0				194.01
194. 02 07952 PSYCHI ATRI C	0	0				194.02
194.03 07953 CENTER OF HOPE	0	1, 378				194.03
200.00 TOTAL (SUM OF LINES 118 through 199)	-11, 358, 855	177, 440, 640				200. 00

Heal th Financial RECLASSIFICATIO			FRANCI SCAN HE	ALTH- DYER Provider CCN:	Period:	worksheet	
					rom 01/01/2022 o 12/31/2022	Date/Time	Prepared:
		Increases			 	5/10/2023	<u>11:00 am</u>
	Cost Center	Line #	Salary	Other			
A - CAPI	2.00	3.00	4.00	5.00	 		
		3.00           1.00           2.00           0.00		7, 042, 229 4, 135, 866 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 20.00 21.00 22.00 23.00 24.00 25.00 26.00 27.00 28.00 29.00 30.00 31.00 33.00 35.0
36. 00 38. 00 39. 00 41. 00 0 <u>B - INTE</u>	REST EXPENSE COSTS-BLDG & FIXT			0 0 0 <u>11, 178, 095</u> 364, 955			36. 0 38. 0 39. 0 41. 0
2.00 INTEREST		113.00	0	3, 359, 164			2.00
3.00		0.00	0	0			3.00
O C – CAFE	TERLA		0	3, 724, 119			_
1.00 CAFETERI		11.00	746, 866	413, 828			1.00
0			746, 866	413, 828			
1.00 OTHER AD GENERAL	RANCE EXPENSE MI NI STRATI VE AND	5.04		727, 132			1.00
O E – PATI	ENT TRANSPORT		0	727, 132			
2. 00 RADI OLOG 3. 00 RADI OI SO	ARDI OLOGY UND	30.00 54.00 56.00 69.00 76.00 76.02	14, 863 82, 925 25, 202 5, 814 10, 339 5, 490	88 490 149 34 61 32			1.00 2.00 3.00 4.00 5.00 6.00
7.00 EMERGENC 3.00 PHYSICIA 0		91.00 1 <u>92.</u> 00	9, 228 430 154, 291	55 3 912			7.00
1.00 MEDICAL	SUPPLIES CHARGED TO	71.00	0	19, 097, 837			1.00
PATI ENT 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 3. 00		0.00 0.00 0.00 0.00 0.00 0.00 0.00	0 0 0 0 0 0				2.00 3.00 4.00 5.00 6.00 7.00 8.00
9. 00 10. 00		0.00 0.00	0	0			9.00

	Financial Systems SIFICATIONS		FRANCI SCAN HE	Provider CCN:		eri od:	u of Form CN Worksheet A	
					Fr Tc	com 01/01/2022 12/31/2022	Date/Time F	
		Increases					5/10/2023 1	1:00 am
	Cost Center	Line #	Salary	Other				
	2.00	3.00	4.00	5.00				
00		0.00	0	0				11. (
00		0.00	0	0				12. (
00		0.00	0	0				13. (
00		0.00	0	0				14. (
00		0.00	0	0				15.0
00 00		0.00	0	0				16. (
00		0.00 0.00	0	0				17. (
00		0.00	0	0				19. (
00		0.00	0	0				20.0
00		0.00	0	0				21. (
00		0.00	0	0				22. (
00		0.00	0	0				23. (
00		0.00	0	0				24.0
00		0.00	0	0				25.0
00		0.00	0	0				26.0
00		0.00	0	0				27.0
00		0.00	0	0				28.0
00			<u>0</u>	0				29.0
	O G - DRUGS CHARGED TO PATIENTS		U	19, 097, 837				_
00	DRUGS CHARGED TO PATIENTS	73.00	0	561, 500				1. (
00	DROOS CHARGED TO TATTENTS	0.00	0	0				2.0
00		0.00	0	0				3.0
00		0.00	Ö	Ő				4. 0
00		0.00	0	0				5.0
00		0.00	О	0				6.0
00		0.00	0	0				7.0
00		0.00	0	0				8.0
00		0.00	0	0				9. (
00		0.00	0	0				10.0
00		0.00	0	0				11. (
00		0.00 0.00	0	0				12.0
00 00		0.00	0	0				13.0
00		0.00	0	0				15. 0
00		0.00	0	0				16. 0
00		0.00	0	0				17.0
00		0.00	0	0				18. 0
00		0.00	0	0				19. (
00	$\square \square \square \square \square \square$	0.00	0	<u>0</u>				20.0
	0		0	561, 500				
20	H - INTERNS AND RESIDENTS	00.00	75 500	7 000				
00	I &R SERVICES-OTHER PRGM	22.00	75, 529	7, 982				1. (
	COSTS APPRV	+	75, 529	7, 982				
	I – NURSERY		15, 529	1,702				-
00	NURSERY	43.00	1, 180, 884	177, 498				1.0
	TOTALS		1, 180, 884	177, 498				
	J - IMPLANTABLE DEVICES							
00	IMPL. DEV. CHARGED TO	72.00	0	8, 952, 561				1. (
	PATI ENTS		↓					
			0	8, 952, 561				
20	K - INTEREST ADJUSTMENT	E o d		224 224				
00	OTHER ADMINISTRATIVE AND	5.04	0	334, 301				1.0
	GENERAL	+						
	Grand Total: Increases		2, 157, 570	45, 175, 765				500. 0

Heal th	Fi nanci al	Systems
RECLAS	SIFICATION	IS

## FRANCI SCAN HEALTH- DYER

Heal th	Financial Systems						u of Form CN	of Form CMS-2552-10		
RECLASS	SI FI CATI ONS			Provider C		Period: From 01/01/2022	Worksheet A	A-6		
						To 12/31/2022	Date/Time F 5/10/2023			
		Decreases					1 57 107 2023			
	Cost Center 6.00	Line # 7.00	Salary	0ther 9.00	Wkst. A-7 Ref.	-				
	A - CAPITAL	7.00	8.00	9.00	10.00					
1.00		0.00	0	0				1.00		
2.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	4,212	ç			2.00		
3.00	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	2, 295, 369	(			3.00		
4.00	MAINTENANCE & REPAIRS	6.00	0	660, 987	C			4.00		
5.00 6.00	OPERATI ON OF PLANT HOUSEKEEPI NG	7.00 9.00	0	4, 419, 846				5.00 6.00		
7.00	DI ETARY	9.00 10.00	0	6, 758 19, 585	(			7.00		
8.00	NURSING ADMINISTRATION	13.00	0	42, 344	C			8.00		
9.00	CENTRAL SERVICES & SUPPLY	14.00	0	100, 303	0			9.00		
10. 00 11. 00	PHARMACY ADULTS & PEDIATRICS	15.00 30.00	0	21, 665 332, 358	(			10.00 11.00		
12.00	INTENSIVE CARE UNIT	31.00	0	66, 251	C			12.00		
13.00	NEONATAL INTENSIVE CARE UNIT	35.00	0	7,040	(			13.00		
14.00 15.00	SUBPROVIDER - IRF OPERATING ROOM	41.00 50.00	0	24, 289 756, 158				14.00 15.00		
16.00	OUTPATI ENT SURGERY	50.01	0	30, 700	C			16.00		
17.00	RECOVERY ROOM	51.00	0	37, 513				17.00		
18. 00 19. 00	ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C	53.00 54.00	0	3, 012 1, 120, 094	(			18.00 19.00		
20.00	RADI OLOGY-SPECI AL PROCEDURES	54.01	0	33, 723	0			20.00		
21.00	RADI OI SOTOPE	56.00	0	154, 182	(			21.00		
22.00 23.00	LABORATORY RESPI RATORY THERAPY	60.00 65.00	0	3, 735 92, 841	(			22.00 23.00		
24.00	PHYSICAL THERAPY	66.00	0	56, 490	(			24.00		
25.00	SPEECH PATHOLOGY	68.00	0	21, 234	C			25.00		
26.00 27.00	ELECTROCARDI OLOGY ELECTROENCEPHALOGRAPHY	69. 00 70. 00	0	154, 272 7, 835	(			26.00 27.00		
27.00	ULTRA SOUND	76.00	0	80, 865	0			27.00		
29.00	PAIN CLINIC	76.01	0	17, 347	C			29.00		
30.00	CATH LAB	76.02	0	350, 121	0			30.00		
31.00 32.00	ACTIVITY THERAPEUTIC WOUND CARE CENTER	76. 03 76. 04	0	600 4, 307	(			31.00 32.00		
33.00	BARI ATRI C CLI NI C	76.05	Ö	8, 934	C			33.00		
35.00	ANTICOAGULATION CLINIC	76.12	0	125	(			35.00		
36.00 38.00	EMERGENCY GIFT, FLOWER, COFFEE SHOP &	91.00 190.00	0	109, 477 3, 304	C C			36.00 38.00		
50.00	CANTEEN	170.00	0	3, 304				30.00		
39.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	50, 771	0			39.00		
41.00	RESIDENTIAL	<u>194.00</u>	0	7 <u>9, 448</u> 11, 178, 095				41.00		
	B - INTEREST EXPENSE	I	- 1							
1.00	INTEREST EXPENSE	113.00	0	364, 955				1.00		
2.00	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	3, 283, 447	C			2.00		
3.00	OPERATION OF PLANT	7.00	0	75, 717				3.00		
	O C – CAFETERIA		0	3, 724, 119				_		
1.00	DI ETARY	10.00	746, 866	413, 828	C	)		1.00		
	0		746, 866	413, 828						
1.00	D - INSURANCE EXPENSE CAP REL COSTS-BLDG & FIXT	1.00	0	727, 132	10			1.00		
1.00	0		— — — <del>0</del>	727, 132				1.00		
	E - PATIENT TRANSPORT	l	- 1							
1.00	EMERGENCY	91.00	154, 291	912				1.00		
2.00 3.00		0. 00 0. 00	0	0				2.00 3.00		
4.00		0.00	Ö	0				4.00		
5.00		0.00	0	0				5.00		
6.00 7.00		0. 00 0. 00	0	0				6.00 7.00		
8.00		0.00	0	0	0			8.00		
			154, 291	912						
1.00	F - CHARGEABLE SUPPLIES CENTRAL SERVICES & SUPPLY	14.00	0	102, 586	0			1.00		
2.00	PHARMACY	15.00	0	58, 533				2.00		
3.00	ADULTS & PEDIATRICS	30.00	0	968, 706				3.00		
4.00 5.00	INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE UNIT	31.00 35.00	0	402, 019 54, 868				4.00 5.00		
6.00	SUBPROVIDER - IRF	41.00	0	150, 025				6.00		
7.00	OPERATING ROOM	50.00	0	7, 578, 284	C			7.00		
8.00 9.00	OUTPATIENT SURGERY RECOVERY ROOM	50. 01 51. 00	0	344, 793 12, 983				8.00 9.00		
		51.00	Ч	12, 700		.1		1 7.00		

FCLASSIF	nancial Systems FICATIONS		FRANCI SCAN HE		CCN: 15-0090	Peri od:	u of Form CMS-255 Worksheet A-6
20210011						From 01/01/2022	
						To 12/31/2022	Date/Time Prepar 5/10/2023 11:00
		Decreases				1	
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref	<u>.</u>	
0. 00 AN	6.00 VESTHESI OLOGY	7.00	8.00	9.00	10.00	0	1
	ADI OLOGY-DI AGNOSTI C	53.00 54.00	0	205, 517 149, 650		0	1
	ADI OLOGY-DI AGNOSTI C ADI OLOGY-SPECI AL PROCEDURES	54.00	0	661, 982		0	1
	ADI OLOGIT-SPECTAL PROCEDORES	56.00	0	9, 551		0	1
	ABORATORY	60.00	0	1, 097		o	1
5.00 BL	LOOD STORING, PROCESSING & RANS.	63.00	0	391, 754		0	1
	ESPIRATORY THERAPY	65.00	o	264, 849		0	1
	HYSICAL THERAPY	66.00	o	9, 052		0	1
	CCUPATIONAL THERAPY	67.00	0	2, 549		o	1
	PEECH PATHOLOGY	68.00	o	17, 165		0	1
	LECTROCARDI OLOGY	69.00	0	14, 670		0	2
	LECTROENCEPHALOGRAPHY	70.00	o	16, 067		0	2
	LTRA SOUND	76.00	0	54, 918		0	2
	AIN CLINIC	76.01	Ö	58, 907		0	2
	ATH LAB	76.02	0	6, 863, 969		0	2
	CTI VI TY THERAPEUTI C	76.03	0	237		0	2
5.00 WC	OUND CARE CENTER	76.04	0	82, 964		0	2
. 00 BA	ARIATRIC CLINIC	76.05	0	1, 947		0	2
3. 00 AN	NTICOAGULATION CLINIC	76. 12	o	35, 986		o	2
. OO EN	MERGENCY	91.00	o	582, 209		o	2
0			0	19, 097, 837			
	- DRUGS CHARGED TO PATIENTS					1	
	DULTS & PEDIATRICS	30.00	0	68, 302		0	
	NTENSIVE CARE UNIT	31.00	0	47, 867		0	
	EONATAL INTENSIVE CARE UNIT	35.00	0	388		0	
	JBPROVIDER – IRF	41.00	0	171, 796		0	
	PERATING ROOM	50.00	0	17, 727		0	
	JTPATIENT SURGERY	50.01	0	6, 379		0	
	ECOVERY ROOM	51.00	0	1, 684		0	
	NESTHESI OLOGY ADI OLOGY-DI AGNOSTI C	53.00 54.00	0	68, 965		0	
	ADI OLOGY-DI AGNOSTI C ADI OLOGY-SPECI AL PROCEDURES	54.00	0	1, 723 1, 753		0	1
	ADI OLOGIT-SPECTAL PROCEDORES	56.00	0	108, 610		0	1
	ESPIRATORY THERAPY	65.00	0	3, 818		0	1
	HYSICAL THERAPY	66.00	0	16		0	1
	LECTROCARDI OLOGY	69.00	0	8		0	1
	LTRA SOUND	76.00	o	20		0	1
	AIN CLINIC	76.01	0	578		0	1
	ATH LAB	76.02	Ő	5, 527		0	1
	OUND CARE CENTER	76.04	o	27, 152		o	1
	ARIATRIC CLINIC	76.05	0	53		0	1
. 00 EN	MERGENCY	91.00	0	29, 134		0	2
0				561, 500			
Н	- INTERNS AND RESIDENTS						
то оо	THER ADMINISTRATIVE AND	5.04	75, 529	7, 982		0	
GE	ENERAL	+				4	
0	NUDGEDV		75, 529	7, 982			
	- NURSERY	20.00	1 100 004	177 400		ol	
	DULTS & PEDIATRICS	<u>30.</u> 00	1, 180, 884	17 <u>7,498</u>		Q	
			1, 180, 884	177, 498			
	- IMPLANTABLE DEVICES	71 00		0 050 5/1		ol	
	EDICAL SUPPLIES CHARGED TO	71.00	0	8, 952, 561		0	
	ATI ENT	+		8, 952, 561	<u> </u>	-	
ĸ	- INTEREST ADJUSTMENT		U	0, 702, 001	I	1	
	VTEREST EXPENSE	113.00	0	334, 301	1	1	
	DTALS		— — — <del>)</del>	<u>334, 301</u> 334, 301		4	
	rand Total: Decreases		2, 157, 570	45, 175, 765			50

Heal th	Financial Systems	FRANCI SCAN HE	ALTH- DYER			In Lie	u of Form CMS-2	2552-10
RECONO	CILIATION OF CAPITAL COSTS CENTERS		Provider CO	CN: 15-0090	Peri From To	od: 01/01/2022 12/31/2022		pared:
				Acqui si ti on	IS			
		Begi nni ng	Purchases	Donati on		Total	Disposals and	
		Bal ances					Retirements	
		1.00	2.00	3.00		4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	T BALANCES		_				
1.00	Land	3, 365, 801	0		0	0	2, 671, 437	1.00
2.00	Land Improvements	10, 343, 496	0		0	0	161, 106	2.00
3.00	Buildings and Fixtures	75, 013, 989	1, 684, 473		0	1, 684, 473	4, 871, 832	3.00
4.00	Building Improvements	178, 989	0		0	0	0	4.00
5.00	Fixed Equipment	178, 423, 776	2, 931, 554		0	2, 931, 554	3, 898, 625	5.00
6.00	Movable Equipment	973, 898	7, 443, 362		0	7, 443, 362	6, 070, 068	6.00
7.00	HIT designated Assets	0	0		0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	268, 299, 949	12, 059, 389		0	12, 059, 389	17, 673, 068	8.00
9.00	Reconciling Items	0	0		0	0	0	9.00
10.00	Total (line 8 minus line 9)	268, 299, 949	12,059,389		0	12,059,389	17, 673, 068	10.00
		Endi ng Bal ance	Fully				· · ·	
		5	Depreciated					
			Assets					
		6.00	7.00	1				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	T BALANCES		•				
1.00	Land	694, 364	0					1.00
2.00	Land Improvements	10, 182, 390	6, 955, 689					2.00
3.00	Buildings and Fixtures	71, 826, 630	5, 472, 986					3.00
4.00	Building Improvements	178, 989	796, 915					4.00
5.00	Fixed Equipment	177, 456, 705	0					5.00
6.00	Movable Equipment	2, 347, 192	45, 558, 849					6.00
7.00	HIT designated Assets	0	0					7.00
8.00	Subtotal (sum of lines 1-7)	262, 686, 270	58, 784, 439					8.00
9.00	Reconciling Items	0	0	1				9.00
10.00	Total (line 8 minus line 9)	262, 686, 270	58, 784, 439					10.00

Heal th	Financial Systems	FRANCI SCAN HE	ALTH- DYER		In Lie	u of Form CMS-2	2552-10
RECONO	CILIATION OF CAPITAL COSTS CENTERS		Provider C	CN: 15-0090	Peri od:	Worksheet A-7	
					From 01/01/2022 To 12/31/2022		narod
					10 12/31/2022	5/10/2023 11:	00 am
			SL	IMMARY OF CAP	I TAL		
		-					
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see	Taxes (see	
		9.00	10.00	11.00	instructions) 12.00	instructions) 13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK				12.00	13.00	
1.00	CAP REL COSTS-BLDG & FIXT	1, 420, 597			0 0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		0 0	0	2.00
3.00	Total (sum of lines 1-2)	1, 420, 597	0		0 0	0	3.00
		SUMMARY OF	CAPI TAL				
	Cost Center Description		Fotal (1) (sum				
		Capi tal -Rel ate	of cols. 9				
		d Costs (see	through 14)				
		instructions)	15.00				
	DADT LL DECONCLULATION OF ANOUNTS FROM WORK		15.00	nd 0			
1 00	PART II - RECONCILIATION OF AMOUNTS FROM WOR	SHEEL A, CULUM					1 00
1.00 2.00	CAP REL COSTS-BLDG & FIXT	0	1, 420, 597				1.00
2.00	Total (sum of lines 1-2)	0	1, 420, 597				2.00 3.00
3.00	Total (sum of Times 1-2)	9	1, 420, 397				J 3.00

Health Financial Systems	FRANCI SCAN HI	EALTH- DYER		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider CO		Period: From 01/01/2022 To 12/31/2022	Worksheet A-7 Part III Date/Time Pre 5/10/2023 11:0	pared:
	COMI	PUTATION OF RAT	TI OS	ALLOCATION OF		
Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets		Insurance	
		Leases	for Ratio (col. 1 - col 2)	instructions)		
	1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE						
1.00 CAP REL COSTS-BLDG & FIXT	0	0		0 1.000000	0	1.00
2.00 CAP REL COSTS-MVBLE EQUIP	0	0		0 0. 000000 0 1. 000000	0	2.00
3.00 Total (sum of lines 1-2)		TION OF OTHER (		SUMMARY C	0	3.00
	ALLUCA	TION OF OTHER (	APTTAL	SUMMART	F CAPITAL	
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
		Capi tal -Rel ate				
		d Costs	through 7)			
	6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE		-				
1.00 CAP REL COSTS-BLDG & FIXT	0	0		0 8, 580, 794		1.00
2.00 CAP REL COSTS-MVBLE EQUI P	0	0		0 4, 135, 866		2.00
3.00 Total (sum of lines 1-2)	0	0		0 12, 716, 660	-362, 177	3.00
		SL	JMMARY OF CAPI	IAL		
Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
		instructions)	instructions)	Capi tal -Rel ate	of cols. 9	
				d Costs (see	through 14)	
				instructions)		
	11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE	-	-			0.010 (17	1 00
1.00 CAP REL COSTS-BLDG & FIXT	0	-		0 0	8, 218, 617	1.00
2.00 CAP REL COSTS-MVBLE EQUIP 3.00 Total (sum of lines 1-2)	0	-		0 0 0 0	4, 135, 866 12, 354, 483	2.00 3.00
5.00  10tal (Suii 01 111ies 1-2)	0	0	I	0 0	12, 354, 483	3.00

	Financial Systems MENTS TO EXPENSES		FRANCI SCAN HE	Provi der CCN: 15-0090	Period:	worksheet A-8	
					From 01/01/2022 To 12/31/2022		
				Expense Classification o To/From Which the Amount is			
	Cost Center Description		Amount	Cost Center		Wkst. A-7 Ref.	
. 00	Investment income - CAP REL	1.00	2.00	3.00 CAP REL COSTS-BLDG & FIXT	4.00	5.00	1.0
. 00	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL			CAP REL COSTS-MVBLE EQUIP	2.00		
. 00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other	В	0		0.00	0	3. 0
00	(chapter 2) Trade, quantity, and time discounts (chapter 8)	В	0	CENTRAL SERVICES & SUPPLY	14.00	0	4.0
00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.0
. 00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.0
. 00	Telephone services (pay stations excluded) (chapter		0		0.00	0	7.0
. 00	21) Television and radio service (chapter 21)		0		0.00	0	8.0
. 00 0. 00	Parking lot (chapter 21) Provider-based physician	A-8-2	0 -973, 726		0.00	0	
1. 00	adjustment Sale of scrap, waste, etc.		0		0.00	0	11.0
2. 00	(chapter 23) Related organization	A-8-1	-2, 035, 528			0	12.0
3. 00	transactions (chapter 10) Laundry and linen service		0		0.00	0	13.0
4. 00 5. 00	Cafeteria-employees and guests Rental of quarters to employee		0 0	CAFETERI A	11.00 0.00		
6. 00	and others Sale of medical and surgical supplies to other than		0		0.00	0	16.0
7.00	patients Sale of drugs to other than		0		0.00	0	17.0
3. 00	patients Sale of medical records and	В	0	MEDI CAL RECORDS & LI BRARY	16.00		
9. 00	abstracts Nursing and allied health		0		0.00	0	19.0
D. 00	education (tuition, fees, books, etc.) Vending machines	В	0		0.00	0	20.0
	Income from imposition of interest, finance or penalty	U	0		0.00		
2. 00	charges (chapter 21) Interest expense on Medicare overpayments and borrowings to		0		0.00	0	22. 0
3. 00	repay Medicare overpayments Adjustment for respiratory therapy costs in excess of	A-8-3	0	RESPI RATORY THERAPY	65.00		23.0
4. 00	limitation (chapter 14) Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSI CAL THERAPY	66.00		24.0
5. 00	limitation (chapter 14) Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	114.00		25.0
6. 00	(chapter 21) Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26. 0
7. 00	COSTS-BLDG & FIXT Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.0
8.00 9.00	Non-physician Anesthetist Physicians' assistant		0	*** Cost Center Deleted ***	19.00 0.00		28. 0 29. 0
	Adjustment for occupational therapy costs in excess of	A-8-3	0	OCCUPATI ONAL THERAPY	67.00		30.0
D. 99	limitation (chapter 14) Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30. 9
1. 00	instructions) Adjustment for speech pathology costs in excess of	A-8-3	0	SPEECH PATHOLOGY	68.00		31.0
2. 00	I i mi tati on (chapter 14) CAH HIT Adjustment for		0		0.00	0	32.0
	Depreciation and Interest		0		0.00		

44.00       MI         55.00       HG         66.00       O <sup>-</sup> (37.00       AI         88.00       MI         60.00       MI         61.00       MI         62.00       MI         63.00       MI         64.00       MI         65.00       MI         65.00       MI         66.00       MI         66.00       MI         66.00       MI         66.00       MI         67.00       MI         68.00       MI         69.00       MI	Cost Center Description ENTAL INCOME ISC INCOME OUSEKEEPING THER ADJUSTMENTS (SPECIFY) 3) DVERTISING EXPENSE ISCELLANEOUS - RADILOGY	Basi s/Code (2) 1.00 B B B B	<u>Amount</u> 2.00 0	Expense CL assification o To/From Which the Amount is Cost Center 3.00 OTHER ADMINISTRATIVE AND	to be Adjusted	Date/Time Pre 5/10/2023 11:0	
44.00       MI         55.00       HG         66.00       O <sup>-</sup> (37.00       AI         88.00       MI         60.00       MI         61.00       MI         62.00       MI         63.00       MI         64.00       MI         65.00       MI         65.00       MI         66.00       MI         66.00       MI         66.00       MI         66.00       MI         67.00       MI         68.00       MI         69.00       MI	ENTAL INCOME ISC INCOME OUSEKEEPING THER ADJUSTMENTS (SPECIFY) 3) DVERTISING EXPENSE	1.00 B B	<u>Amount</u> 2.00 0	To/From Which the Amount is Cost Center 3.00	Li ne #		<u>00 ar</u>
44.00       MI         55.00       HG         66.00       O <sup>-</sup> (37.00       AI         88.00       MI         60.00       MI         61.00       MI         62.00       MI         63.00       MI         64.00       MI         65.00       MI         65.00       MI         66.00       MI         66.00       MI         66.00       MI         66.00       MI         67.00       MI         68.00       MI         69.00       MI	ENTAL INCOME ISC INCOME OUSEKEEPING THER ADJUSTMENTS (SPECIFY) 3) DVERTISING EXPENSE	1.00 B B	<u>Amount</u> 2.00 0	To/From Which the Amount is Cost Center 3.00	Li ne #		
44.00       MI         55.00       HG         66.00       O <sup>-</sup> (37.00       AI         88.00       MI         60.00       MI         61.00       MI         62.00       MI         63.00       MI         64.00       MI         65.00       MI         65.00       MI         66.00       MI         66.00       MI         66.00       MI         66.00       MI         67.00       MI         68.00       MI         69.00       MI	ENTAL INCOME ISC INCOME OUSEKEEPING THER ADJUSTMENTS (SPECIFY) 3) DVERTISING EXPENSE	1.00 B B	2.00 0	3.00		Wkst. A-7 Ref.	
44.00       MI         55.00       HG         66.00       O <sup>-</sup> (37.00       AI         88.00       MI         60.00       MI         61.00       MI         62.00       MI         63.00       MI         64.00       MI         65.00       MI         65.00       MI         66.00       MI         66.00       MI         66.00       MI         66.00       MI         67.00       MI         68.00       MI         69.00       MI	ISC INCOME OUSEKEEPING THER ADJUSTMENTS (SPECIFY) 3) DVERTISING EXPENSE	B B	0		4.00		
44.00       MI         55.00       HG         66.00       O <sup>-</sup> (37.00       AI         88.00       MI         60.00       MI         61.00       MI         62.00       MI         63.00       MI         64.00       MI         65.00       MI         65.00       MI         66.00       MI         66.00       MI         66.00       MI         66.00       MI         67.00       MI         68.00       MI         69.00       MI	ISC INCOME OUSEKEEPING THER ADJUSTMENTS (SPECIFY) 3) DVERTISING EXPENSE	В		OTHER ADMINISTRATIVE AND		5.00	
85.00         HG           86.00         O <sup>-</sup> 87.00         AI           88.00         MI           60.00         MI           61.00         MI           62.00         MI           63.00         MI           63.00         MI           64.00         MI           65.00         MI           66.00         MI           67.00         MI           67.00         MI	OUSEKEEPI NG THER ADJUSTMENTS (SPECI FY) 3) DVERTI SI NG EXPENSE			GENERAL	5.04	0	33.
36.00       0 <sup>-</sup> 37.00       AI         38.00       MI         30.00       MI         31.00       MI         31.00       MI	THER ADJUSTMENTS (SPECIFY) 3) DVERTISING EXPENSE	В		ACTI VI TY THERAPEUTI C	76.03	0	34.
67.00 AI 68.00 MI 60.00 MI 61.00 MI	3) DVERTI SI NG EXPENSE			HOUSEKEEPI NG	9.00	0	35.
87.00 AI 88.00 MI 0.00 MI 01 91.00 MI	DVERTISING EXPENSE		0		0.00	0	36.
0.00 MI OF 1.00 MI		А	0	OTHER ADMINISTRATIVE AND	5.04	0	37.
0.00 MI OF 1.00 MI		В	0	GENERAL RADI OLOGY-DI AGNOSTI C	54.00	0	38.
1.00 MI	I SCELLANEOUS - KADI LOGI I SCELLANEOUS - OTHER	В		OTHER ADMINISTRATIVE AND	5. 04		
		P			F 04		11
101	I SCELLANEOUS - OTHER PERATING	В	0	OTHER ADMI NI STRATI VE AND GENERAL	5.04	0	41.
	EHAB	В		SUBPROVIDER - IRF	41.00		
2.00 PI	ROGRAM FEES	В		OTHER ADMINISTRATIVE AND GENERAL	5.04	0	42
	NECESSARY BORROWING	А	-427, 379	INTEREST EXPENSE	113.00	11	43
4.00 L0	OBBYING EXPENSE	A	4, 936	OTHER ADMINISTRATIVE AND GENERAL	5.04	0	44
	THER ADJUSTMENTS (SPECIFY)		0	oenervie .	0.00	0	45
	3) ENSION ADJUSTMENT	А	1 577 337	EMPLOYEE BENEFITS DEPARTMEN	T 4.00	0	46
	I SCOUNTS EARNED/REBATES	В		EMPLOYEE BENEFITS DEPARTMEN			
	I SCOUNTS EARNED/REBATES	В	-1, 176, 601	OTHER ADMINISTRATIVE AND	5.04		
9.00 DI	I SCOUNTS EARNED/REBATES	В		GENERAL OPERATION OF PLANT	7.00	0	49
	I SCOUNTS EARNED/REBATES	В		HOUSEKEEPI NG	9.00	0	49
	I SCOUNTS EARNED/REBATES	В	-416, 639	DI ETARY	10.00	0	49
	I SCOUNTS EARNED/REBATES	В		CAFETERI A	11.00		
	I SCOUNTS EARNED/REBATES	В		NURSING ADMINISTRATION	13.00		
	I SCOUNTS EARNED/REBATES	В		CENTRAL SERVICES & SUPPLY	14.00		
1	I SCOUNTS EARNED/REBATES	В		PHARMACY	15.00		
1	I SCOUNTS EARNED/REBATES	В		ADULTS & PEDIATRICS	30.00		
	I SCOUNTS EARNED/REBATES I SCOUNTS EARNED/REBATES	B B		SUBPROVI DER – I RF RADI OLOGY-DI AGNOSTI C	41.00 54.00		
	I SCOUNTS EARNED/REBATES	В		PHYSICAL THERAPY	66.00		
	I SCOUNTS EARNED/REDATES	B		OCCUPATI ONAL THERAPY	67.00		
	I SCOUNTS EARNED/REBATES	В		SPEECH PATHOLOGY	68.00		
9.13 DI	I SCOUNTS EARNED/REBATES	В		ULTRA SOUND	76.00		49
9. 14 DI	I SCOUNTS EARNED/REBATES	В	-125, 410	ACTIVITY THERAPEUTIC	76.03	0	49
9. 15 DI	I SCOUNTS EARNED/REBATES	В	-41,453	BARIATRIC CLINIC	76.05	0	49
9.16 DI	I SCOUNTS EARNED/REBATES	В	-5, 545	EMERGENCY	91.00	0	49
	I SCOUNTS EARNED/REBATES	В		LAUNDRY & LINEN SERVICE	8.00		
	I SCOUNTS EARNED/REBATES	В		EMPLOYEE BENEFITS DEPARTMEN			
	NCENTIVE PAYMENT	A		OUTPATIENT SURGERY	50.01		
	ISCOUNTS EARNED/REBATES ET PERIODIC PENSION COST	A		CATH LAB INTEREST EXPENSE	76.02		
9. 22 MI	ISCELLANEOUS - OTHER	A A	-6, 766, 799	OTHER ADMINISTRATIVE AND	113.00 5.04		
	PERATING ET PERIODIC PENSION COST	А		GENERAL ADULTS & PEDIATRICS	30.00	0	49
1	ET PERIODIC PENSION COST	Â		EMERGENCY	91.00		
0. 00 T	OTAL (sum of lines 1 thru 49) Transfer to Worksheet A,		-11, 358, 855				50
C	olumn 6, line 200.)					<u> </u>	
	ription - all chapter referen s for adjustment (see instruc		umn pertain to	o CMS Pub. 15-1.			

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

Health Financial Systems FRANCISCAN HEALTH- DYER In Lieu of Form CMS-2552									
		RELATED ORGANIZATIONS AND HOM	IE Provider CCN: 15-0090	Peri od:	Worksheet A-8				
OFFICE	COSTS			From 01/01/2022					
				To 12/31/2022					
	Line No.	Cost Center	Expense Items	Amount of	5/10/2023 11: Amount	00 ani			
	Li ne no.	cost center	Expense i tellis	Allowable Cost					
					Wks. A, column				
					5 S				
	1.00	2.00	3.00	4.00	5.00				
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED								
	HOME OFFICE COSTS:								
1.00	113.00	INTEREST EXPENSE		1,004,279	3, 242, 535	1.00			
2.00	1.00	CAP REL COSTS-BLDG & FIXT		1, 289, 539	1, 171, 571	2.00			
3.00	5. 04	OTHER ADMINISTRATIVE AND GEN		21,001,278	22, 023, 257	3.00			
4.00	15.00	PHARMACY		293, 071	0	4.00			
4.01		MEDICAL RECORDS & LIBRARY		813, 668	0	4.01			
4.02	0.00			0	0	4. 02			
4.03	0.00			0	0	4.03			
4.04	0.00			0	0	4.04			
4.05	0.00			0	0	4.05			
4.06	0.00			0	0	4.06			
4.07	0.00			0	0	4.07			
4.08	0.00			0	0	4.08			
4.09	0.00			0	0	4.09			
4.10	0.00			0	-	4.10			
4.11	0.00			0	0	4.11			
4.12	0.00			0	-	4.12			
4.13	0.00			0	-	4.13			
4.14	0.00			0	-	4.14			
4.15	0.00			0	-	4.15			
4.16	0.00			0	-	4.16			
4.17	0.00			0	-	4.17			
4.18 4.19	0.00			0	-	4.18			
4.19 4.20	0.00			0	-	4. 19 4. 20			
4.20	0.00				-	4.20			
4.21	0.00			0	0	4.21			
4.22	0.00			0		4.22			
4.23	0.00			0	-	4.23			
4.25	0.00			0	0	4.25			
4.26	0.00			0	0	4.26			
4.27	0.00			0	0	4. 27			
4.28	0.00			0	0	4. 28			
4.29	0.00			0	-	4.29			
4.30	0.00			0	-	4.30			
5.00	TOTALS (sum of lines 1-4).			24, 401, 835	0	5.00			
2.00	Transfer column 6, line 5 to				,,	2.00			
	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.

1143	Silot	been posted to worksheet A,	corumns r anu/or z, the amount	it allowable sh		or this part.			
					Related Organization(s) and/	or Home Office			
		Symbol (1)	Name	Percentage of	Name	Percentage of			
				Ownershi p		Ownershi p			
		1.00	2.00	3.00	4.00	5.00			
		B INTERPELATIONSHIP TO RELATED OPCANIZATION(S) AND/OR HOME OFFICE							

B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE: The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

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

6.00	В	FRANCI SCAN ALLI	100.00	FRANCI SCAN ALLI	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or					100.00
	non-financial) specify:					

Health Financial Systems FRANCISCAN						HEALTH- DYER			In Lieu of Form CMS-2552-10			
	NT OF COSTS OF	SERVICES FR	OM RELATED	ORGANI ZATI ONS	AND HOM	IE Provider	CCN:		Peri od:	Worksheet A-8	3-1	
OFFICE	COSTS								From 01/01/2022 To 12/31/2022	Date/Time Pre		
							Rel	ated Organ	nization(s) and/o	or Home Office		
	Symbol	(1)		Name		Percentage o	f	Ν	lame	Percentage of		
						Ownership				Ownershi p		
	1. (	00		2.00		3.00		4	l. 00	5.00		

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

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

 E. Individual is director, officer, administrator, or key person of provider and related organization.
 F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provi der.

	Financial Syste		FRANCI SCAN HEAI RELATED ORGANI ZATI ONS AND HOME		CCN: 15-0090	Peri od:	J of Form CMS-25 Worksheet A-8-1
	COSTS	JERVICES TROWT	CEATED ORGANIZATIONS AND HOME	riovidei	CCN. 13-0070	From 01/01/2022	WOLKSHEEL A-0-
IIICL	00010					To 12/31/2022	Date/Time Prepa 5/10/2023 11:00
	Net	Wkst. A-7 Ref.					
	Adjustments						
	(col. 4 minus						
	col. 5)*						
	6.00	7.00					
	A. COSTS INCUR	RED AND ADJUSTM	ENTS REQUIRED AS A RESULT OF TRA	ANSACTI ONS	WITH RELATED	ORGANIZATIONS OR (	CLAIMED
	HOME OFFICE CO						
. 00	-2, 238, 256						
. 00	117, 968	9					
. 00	-1, 021, 979	0					
. 00	293, 071	0					
. 01	813, 668	0					
. 02	0	0					
. 03	0	0					
. 04	0	0					
. 05	0	0					
. 06	0	0					
. 07	0	0					
. 08	0	0					
. 09	0	0					
. 10	0	0					
. 11	0	0					
. 12	0	0					
. 13	0	0					
. 14	0	0					
. 15	0	0					
. 16	0	0					
. 17	0	0					
. 18	0	0					
. 19	0	0					
. 20	0	0					
. 21	0	0					
. 22	0	0					
. 23	0	0					
. 24	0	0					
. 25	0	0					
. 26	0	0					
. 27	0	0					
. 28	0	0					
. 29	0	0					
. 30	0	0					

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

Related Organization(s)		
and/or Home Office		
 Type of Business		
Type of Business		
 6.00		
0.00		
B. INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

1 OT IND G		
6.00	HEALTHCARE SERV	6.00
7.00		7.00
8.00		8.00
9.00		9.00
10.00		10.00
100.00		100.00

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

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.

B. Corporation, partnership, or other organization has financial interest in provider.

C. Provider has financial interest in corporation, partnership, or other organization.

D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.

E. Individual is director, officer, administrator, or key person of provider and related organization.

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

PROVIDE	ER BASED PHYSIC	LAN AD HISTMENT		Provider (	CN: 15-0090	Peri od:	Worksheet A-8	3-2
I NOVI DI	ER BASED THISTS	TAN ADJUSTMENT			Sent. 13 0070	From 01/01/2022	2	
						To 12/31/2022	2 Date/Time Pre 5/10/2023 11:	epared: 00 am
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		Identifier	Remuneration	Component	Component		ider Component	
	1.00	2.00	3.00	4.00	5.00	6.00	Hours 7.00	
. 00	5.04	OTHER ADMINISTRATIVE AND	164, 949	164, 949		0 0	0	1.00
		GENERAL						
. 00		NURSING ADMINISTRATION	888, 552					
. 00	22.00	I&R SERVICES-OTHER PRGM COSTS APPRV	65, 000	5, 000	60, 00	211, 500	480	3.00
. 00	31.00	INTENSIVE CARE UNIT	4, 416	4, 416		o o	0	4.00
00		NEONATAL INTENSIVE CARE UNIT	722, 699			211, 500	1, 874	
00	41.00	SUBPROVIDER - IRF	1, 877	1, 877		0 0	0	6.00
. 00	50.00	OPERATI NG ROOM	26, 402	0	26, 40	2 211, 500	1, 189	7.00
00		LABORATORY	22, 241	22, 241		0 0	0	8.00
. 00		PHYSI CAL THERAPY	7,000	7,000		0 0	-	9.00
0.00		CATH LAB	10, 500	0				
1.00		ACTIVITY THERAPEUTIC	39, 730	0	39, 73			11.00
2.00 00.00	91.00	EMERGENCY	59, 091 2, 012, 457	4, 836				12.00 200.00
0.00	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	878, 690	1,133,76 Cost of	/ Provi der	11,616 Physician Cost	200.00
	WKSL A LINE #	I denti fi er		Unadjusted RCE			of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Education	12		
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
00	5.04	OTHER ADMINISTRATIVE AND	0	0		0 0	0	1.00
00	12.00		000 040	40.010		0 0		2 00
. 00 . 00		NURSING ADMINISTRATION I&R SERVICES-OTHER PRGM	800, 243 48, 808	40, 012 2, 440				2.00 3.00
00	22.00	COSTS APPRV	40, 000	2,440		0	0	3.00
. 00	31.00	INTENSI VE CARE UNI T	0	0		o o	0	4.00
. 00		NEONATAL INTENSIVE CARE UNIT	190, 553	9, 528		0 0	0	5.00
. 00	41.00	SUBPROVIDER - IRF	0	0		o o	0	6.00
. 00	50.00	OPERATING ROOM	120, 901	6, 045		0 0	0	7.00
. 00		LABORATORY	0	0		0 0	0	8.00
. 00		PHYSI CAL THERAPY	0	0		0 0	0	9.00
0.00		CATH LAB	5, 999	300		0 0	0	10.00
1.00		ACTI VI TY THERAPEUTI C	5, 389	269		0 0	0	11.00
2.00	91.00	EMERGENCY	9, 253				-	12.00
00.00	Wkst. A Line #	Cost Center/Physician	1, 181, 146 Provi der	59,057 Adjusted RCE	RCE	Adjustment	0	200.00
	WKSL A LINE #	I denti fi er	Component	Limit	Di sal I owance	Aujustillerit		
			Share of col.	2.1.1.1	bi bai i bilanco			
			14					
	1.00	2.00	15.00	16.00	17.00	18.00		1 00
. 00	5.04	OTHER ADMI NI STRATI VE AND GENERAL	0	0		0 164, 949		1.00
. 00	13 00	NURSI NG ADMI NI STRATI ON	0	800, 243		133, 072		2.00
. 00		I&R SERVICES-OTHER PRGM	0					3.00
		COSTS APPRV	l	10,000		10,172		5.00
00		INTENSI VE CARE UNI T	0	0		0 4, 416		4.00
. 00	35.00	NEONATAL INTENSIVE CARE UNIT	0	190, 553		535, 299		5.00
00		SUBPROVIDER – IRF	0	0		0 1,877		6.00
00		OPERATING ROOM	0	120, 901		0 0		7.00
. 00		LABORATORY	0	0		0 22, 241		8.00
00		PHYSICAL THERAPY	0	0		7,000		9.00
0.00		CATH LAB	0	5, 999				10.00
1.00		ACTIVITY THERAPEUTIC	0	5, 389				11.00
2.00		EMERGENCY	0	9, 253				12.00 200.00
	1		1 0	1, 181, 146	95, 03	6 973, 726		∠∪∪. UU

ealth Financial Systems OST ALLOCATION – GENERAL SERVICE COSTS			Provider CC	F	eriod: rom 01/01/2022 o 12/31/2022	Worksheet B Part I Date/Time Pre	2552
						5/10/2023 11:	<u>00</u> a
			CAPITAL REL	LATED COSTS			
	Cost Center Description	Net Expenses for Cost	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFI TS	Subtotal	
		Allocation (from Wkst A			DEPARTMENT		
		col. 7)	1.00	2.00	4.00	4.0	<u> </u>
	GENERAL SERVICE COST CENTERS	0	1.00	2.00	4.00	4A	+
	00100 CAP REL COSTS-BLDG & FIXT	8, 218, 617	8, 218, 617				1 1
00	00200 CAP REL COSTS-MVBLE EQUIP	4, 135, 866		4, 135, 866			2
00	00400 EMPLOYEE BENEFITS DEPARTMENT	19, 163, 776	33, 927	1, 558	19, 199, 261		4
04	00593 OTHER ADMINI STRATI VE AND GENERAL	31, 648, 635	613, 084	849, 280	4, 089, 326	37, 200, 325	5
	00600 MAINTENANCE & REPAIRS	2, 745, 732	1, 240, 521	244, 563		4, 406, 026	
	00700 OPERATION OF PLANT	-3, 962, 555	351, 793	1, 635, 335		-1, 592, 615	
	00800 LAUNDRY & LINEN SERVICE	671, 751	0 01 000		0	671, 751	
	00900 HOUSEKEEPI NG 01000 DI ETARY	2, 326, 025 334, 757	94, 099 83, 011	2, 500 7, 246		2, 877, 294 546, 319	
	01100 CAFETERI A	1, 161, 408	119, 837	7,240	121, 303	1, 463, 868	
	01300 NURSI NG ADMI NI STRATI ON	4, 076, 371	12, 677	15, 667	587, 820	4, 692, 535	
	01400 CENTRAL SERVICES & SUPPLY	435, 832	106, 881	37, 112		671, 132	
. 00	01500 PHARMACY	7, 041, 495	59, 665	8, 016		7, 593, 268	15
. 00	01600 MEDICAL RECORDS & LIBRARY	1, 260, 312	85, 316	0	86, 130	1, 431, 758	16
	01700 SOCIAL SERVICE	0	0	0	0	0	17
. 00	02200 I & SERVICES-OTHER PRGM COSTS APPRV	258, 876	0	0	45, 433	304, 309	22
00	03000 ADULTS & PEDI ATRI CS	19, 424, 160	1, 384, 995	122, 971	3, 611, 750	24, 543, 876	30
	03100 I NTENSI VE CARE UNI T	3, 448, 348	173, 408	24, 513	644, 997	4, 291, 266	3
	03200 CORONARY CARE UNI T	0	0	0	-	0	
	02060 NEONATAL INTENSIVE CARE UNIT	1, 356, 260	9, 307	2, 605		1, 606, 061	
	04100 SUBPROVIDER - IRF	4, 633, 720	103, 685	8, 987	956, 769	5, 703, 161	
	04200 SUBPROVI DER	0	0	0	0	0	
	04300 NURSERY ANCI LLARY SERVICE COST CENTERS	1, 358, 382	0	0	288, 747	1, 647, 129	43
	05000 OPERATI NG ROOM	2, 525, 300	287, 902	279, 776	358, 662	3, 451, 640	50
	05001 OUTPATI ENT SURGERY	846, 996	245, 908	11, 359		1, 294, 555	
	05100 RECOVERY ROOM	341, 610	96, 928	13, 879		535, 039	
	05300 ANESTHESI OLOGY	4, 914, 335	0	1, 114		4, 925, 186	
. 00	05400 RADI OLOGY-DI AGNOSTI C	1, 674, 297	411, 266	414, 431	368, 418	2, 868, 412	54
	05401 RADI OLOGY-SPECI AL PROCEDURES	2, 568, 351	26, 925	12, 477	255, 991	2, 863, 744	54
	05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	
	05600 RADI OI SOTOPE	323, 811	86, 102	57, 047	74, 734	541, 694	
	06000 LABORATORY	7, 381, 677	120, 623	1, 382	125, 480 0	7, 629, 162	
	06300 BLOOD STORI NG, PROCESSI NG & TRANS. 06500 RESPI RATORY THERAPY	2, 797, 179	49, 433 37, 367	34, 351	335, 717	49, 433 3, 204, 614	
	06600 PHYSI CAL THERAPY	4, 186, 336		20, 901	888, 864	5, 121, 455	
	06700 OCCUPATI ONAL THERAPY	883, 444	9, 708			1, 106, 537	
	06800 SPEECH PATHOLOGY	691,888	0			825, 507	
	06900 ELECTROCARDI OLOGY	876, 047	66, 493	57, 080		1, 210, 685	
00	07000 ELECTROENCEPHALOGRAPHY	227, 998	91, 881	2, 899		377, 940	70
00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	10, 145, 276	0	0	0	10, 145, 276	7
	07200 IMPL. DEV. CHARGED TO PATIENTS	8, 952, 561	0	0	0	8, 952, 561	
	07300 DRUGS CHARGED TO PATIENTS	561, 500	0	0	0	561, 500	
	03630 ULTRA SOUND	766, 515	39, 969			972, 317	
	03951 PAIN CLINIC	549,774	215, 176			904, 717	
	03952 CATH_LAB 03953 ACTIVITY_THERAPEUTIC	2, 203, 312 1, 085, 765	157, 815 99, 634	129, 544 222	455, 414 289, 441	2, 946, 085 1, 475, 062	
	03954 WOUND CARE CENTER	439, 281	111, 124	1, 594		656, 181	
	03340 BARI ATRI C CLI NI C	1, 324, 923	33, 648			1, 671, 511	
	03030 HEALTHY LIVING CENTER	0	0	0	0	0	
	03950 CV RESOURCE CENTER	0	0	0	0	0	
80	03955 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	
	03956 LACTATION CLINIC	0	0	0	0	0	
	03957 OTHER ANCI LLARY SERVICE COST CENTERS	0	0	0	0	0	
	03958 OTHER ANCI LLARY SERVICE COST CENTERS	0	0	0	0	0	
	03959 ANTICOAGULATION CLINIC 07700 ALLOGENEIC STEM CELL ACQUISITION	338, 183	7,683	47	82, 430	428, 343 0	
	OUTPATIENT SERVICE COST CENTERS				0	0	1 ' '
00	09100 EMERGENCY	5, 990, 745	280, 813	40, 506	868, 512	7, 180, 576	
	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS					0	92
	10200 OPIOID TREATMENT PROGRAM	0	0	0	0	0	102
	SPECIAL PURPOSE COST CENTERS	· ~ ~	· · · · · · · · · · · · · · · · · · ·				
3.00 8.00	11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117)	172, 334, 872	6, 973, 958	4, 086, 463	18, 115, 646	169, 957, 195	113
	NONREI MBURSABLE COST CENTERS						a

Health Financial Systems	FRANCI SCAN HE	ALTH- DYER		In Lieu of Form CMS-2552-10			
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CO		Period: From 01/01/2022	Worksheet B Part I		
				To 12/31/2022			
		CAPI TAL REL	ATED COSTS				
Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Subtotal		
	for Cost			BENEFITS			
	Allocation			DEPARTMENT			
	(from Wkst A						
	col. 7)	1 00	0.00	4.00			
	0	1.00	2.00	4.00	4A		
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	1, 710, 256		18, 78	5 347, 981	2, 316, 189		
192.01 19201 WORKING WELL	4, 986	0		0 1, 164	6, 150	192.01	
192. 02 19202 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0	0	192.02	
192. 03 19203 MI SC	0	0		0 0	0	192.03	
194. 00 07950 RESI DENTI AL	3, 289, 459	529, 200	29, 39	6 722, 503	4, 570, 558	194.00	
194.01 07954 OTHER NONREI MBURSABLE COST CENTERS	0	0		0 0		194.01	
194. 02 07952 PSYCHI ATRI C	0	462, 393		0 0	462, 393	194.02	
194. 03 07953 CENTER OF HOPE	1, 378			0 210		194.03	
200.00 Cross Foot Adjustments	.,	-				200.00	
201.00 Negative Cost Centers		0		0		201.00	
202.00 TOTAL (sum lines 118 through 201)	177, 440, 640	8, 218, 617	4, 135, 86	6 19, 199, 261			
202.00 TOTAL (Sum THES TO THOUGH 201)	177, 440, 640	0,210,017	4, 155, 60	u 17, 199, 201	177, 440, 640	202.00	

	Financial Systems LLOCATION - GENERAL SERVICE COSTS	FRANCI SCAN HE	ALTH- DYER Provider CC		eriod: rom 01/01/2022	Worksheet B Part I Date/Time Pre 5/10/2023 11:	epared:
	Cost Center Description	ADMI NI STRATI VE AND GENERAL	MAI NTENANCE & REPAI RS	OPERATI ON OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	
	GENERAL SERVICE COST CENTERS	5.04	6.00	7.00	8.00	9.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.04	00593 OTHER ADMINISTRATIVE AND GENERAL	37, 200, 325					5.04
6.00	00600 MAINTENANCE & REPAIRS	1, 155, 626	5, 561, 652				6.00
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	0 176, 189	309, 039 0	-1, 283, 576 0	847, 940		7.00
9.00	00900 HOUSEKEEPING	754, 665	82, 663	0	047, 740	3, 714, 622	
10.00	01000 DI ETARY	143, 290	72, 922	0	0	52, 395	
11.00	01100 CAFETERI A	383, 948	105, 273	0	0	75, 639	11.00
13.00	01300 NURSING ADMINISTRATION	1, 230, 772	11, 136	0	0	8, 001	
	01400 CENTRAL SERVICES & SUPPLY	176,027	93, 891	0	0	67, 461	1
	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	1, 991, 585 375, 526	52, 414 74, 947	0	0	37, 660 53, 850	
	01700 SOCIAL SERVICE	375, 520	74, 947	0	0	0	
	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	79, 815	0	0	0	0	
	INPATIENT ROUTINE SERVICE COST CENTERS	1	-1		-		
30.00	03000 ADULTS & PEDIATRICS	6, 437, 400	1, 216, 671	0	450, 754	874, 182	30.00
	03100 INTENSIVE CARE UNIT	1, 125, 526	152, 333		71, 437	109, 452	
32.00	03200 CORONARY CARE UNIT	0	0	0	0	0	
35.00	02060 NEONATAL INTENSIVE CARE UNIT	421, 242	8, 176	0	6, 631	5, 874	
41.00 42.00	04100 SUBPROVI DER – I RF 04200 SUBPROVI DER	1, 495, 842	91, 084 0	0	212, 738 0	65, 444 0	
	04300 NURSERY	432, 014	0	0	15, 524	0	
101.00	ANCI LLARY SERVI CE COST CENTERS	102/011			10, 02 1		101.00
50.00	05000 OPERATI NG ROOM	905, 306	252, 913	0	0	181, 718	50.00
50.01	05001 OUTPATI ENT SURGERY	339, 540	216, 022	0	0	155, 212	
51.00	05100 RECOVERY ROOM	140, 332	85, 148		0	61, 179	
53.00	05300 ANESTHESI OLOGY	1, 291, 793	0	0	0	0	
54.00 54.01	05400 RADI OLOGY-DI AGNOSTI C 05401 RADI OLOGY-SPECI AL PROCEDURES	752, 336	361, 284	0	0	259, 583	
55.00	05500 RADI OLOGY-THERAPEUTI C	751, 111	23, 653 0	0	0	16, 995 0	
56.00	05600 RADI OL SOTOPE	142,077	75, 638	0	0	54, 346	
60.00	06000 LABORATORY	2,000,999	105, 963	0	0	76, 135	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	12, 965	43, 425	0	0	31, 201	63.00
65.00	06500 RESPI RATORY THERAPY	840, 516	32, 826	0	0	23, 585	65.00
66.00	06600 PHYSI CAL THERAPY	1, 343, 271	22, 273	0	0	16, 003	
67.00	06700 OCCUPATI ONAL THERAPY	290, 226	8, 529	0	0	6, 128	
68.00 69.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	216, 516	0 E9 412	0	0	0 41, 969	
	07000 ELECTROENCEPHALOGRAPHY	317, 542 99, 127	58, 412 80, 715	0	0	57, 994	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2, 660, 933	00, 713	0	0		71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS	2, 348, 105	0	0	0	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	147, 272	0	0	0	0	73.00
	03630 ULTRA SOUND	255, 022	35, 111	0	0	25, 228	
	03951 PAIN CLINIC	237, 292	189, 025	0	0	135, 815	
	03952 CATH LAB	772, 708	138, 636	0	0	99,610	
	03953 ACTIVITY THERAPEUTIC 03954 WOUND CARE CENTER	386, 884 172, 105	87, 525 97, 619		0	62, 887 70, 139	
	03340 BARI ATRI C CLI NI C	438, 409	29, 559		0	21, 238	
	03030 HEALTHY LIVING CENTER	0	0	0	0	0	
76.07	03950 CV RESOURCE CENTER	0	0	0	0	0	
	03955 OTHER ANCI LLARY SERVICE COST CENTERS	0	0	0	0	0	
	03956 LACTATION CLINIC	0	0	0	0	0	
	03957 OTHER ANCI LLARY SERVICE COST CENTERS	0	0	0	0	0	
	03958 OTHER ANCI LLARY SERVICE COST CENTERS	112 247	0 4 740	0	0	0	
	03959 ANTICOAGULATION CLINIC 07700 ALLOGENEIC STEM CELL ACQUISITION	112, 347	6, 749	0	0	4, 849 0	
//.00	OUTPATIENT SERVICE COST CENTERS	<u> </u>	V	0	0	0	1 ,
91.00	09100 EMERGENCY	1, 883, 343	246, 685	0	0	177, 244	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
	OTHER REIMBURSABLE COST CENTERS						
102.00	10200 OPI OI D TREATMENT PROGRAM	0	0	0	0	0	102.00
110 00	SPECIAL PURPOSE COST CENTERS	1					110.00
113.00 118.00	11300 INTEREST EXPENSE	25 227 544	1 140 250	0	757, 084	2, 929, 016	113.00
	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	35, 237, 544	4, 468, 259	0	737,084	2, 929, 010	110.00
				0	0	0.772	1100 00
		33, 196	12, 210	0	0	8.773	1190.00
190. 00 192. 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	33, 196 607, 497	12, 210 210, 101	0	0	8, 773 150, 958	190.00 192.00
190. 00 192. 00 192. 01	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSI CLANS' PRI VATE OFFI CES 19201 WORKI NG WELL				0	150, 958 0	192. 00 192. 01
190. 00 192. 00 192. 01 192. 02	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	607, 497	210, 101		000000000000000000000000000000000000000	150, 958 0 0	192.00

Health Finan	cial Systems	FRANCI SCAN HE	FRANCI SCAN HEALTH- DYER			In Lieu of Form CMS-2552-10			
COST ALLOCATION - GENERAL SERVICE COSTS			Provider CO		Period: From 01/01/2022	Worksheet B Part I			
					To 12/31/2022		pared:		
						5/10/2023 11:	<u>00 am</u>		
	Cost Center Description	OTHER	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG			
		ADMI NI STRATI VE	REPAI RS	PLANT	LINEN SERVICE				
		AND GENERAL							
		5.04	6.00	7.00	8.00	9.00			
194.0007950	RESI DENTI AL	1, 198, 780	464, 885		0 0	334, 021	194.00		
194.0107954	OTHER NONREIMBURSABLE COST CENTERS	0	0		0 0	0	194.01		
194.0207952	PSYCHI ATRI C	121, 278	406, 197		0 90, 856	291, 854	194.02		
194.0307953	CENTER OF HOPE	417	0		0 0	0	194.03		
200.00	Cross Foot Adjustments						200.00		
201.00	Negative Cost Centers	0	0	-1, 283, 57	6 0	0	201.00		
202.00	TOTAL (sum lines 118 through 201)	37, 200, 325	5, 561, 652			3, 714, 622	202.00		

OST ALLOC	ancial Systems ATION - GENERAL SERVICE COSTS	FRANCI SCAN HEA		F	Period: From 01/01/2022	w of Form CMS-2 Worksheet B Part I	
					To 12/31/2022	Date/Time Pre 5/10/2023 11:0	pare 00 a
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVICES & SUPPLY	PHARMACY	
0515		10.00	11.00	13.00	14.00	15.00	
	ERAL SERVICE COST CENTERS						1 1.
	DO CAP REL COSTS-MVBLE EQUIP						2
	DO EMPLOYEE BENEFITS DEPARTMENT						4
	93 OTHER ADMINISTRATIVE AND GENERAL DO MAINTENANCE & REPAIRS						5
	DO OPERATION OF PLANT						6
	DO LAUNDRY & LINEN SERVICE						8
	DO HOUSEKEEPI NG						9
		814, 926	2 0 20 7 20				10
	DO CAFETERIA DO NURSING ADMINISTRATION	0	2, 028, 728 76, 314		3		11
	DO CENTRAL SERVICES & SUPPLY	0	21, 620				14
. 00 0150	DO PHARMACY	0	61, 879			10, 140, 293	15
	DO MEDICAL RECORDS & LIBRARY	0	13, 70			0	16
	DO SOCIAL SERVICE DO I&R SERVICES-OTHER PRGM COSTS APPRV	0 O	6, 12!		-	0	17
	ATIENT ROUTINE SERVICE COST CENTERS	0	0, 123		<u> </u>	0	22
	DO ADULTS & PEDI ATRI CS	444, 521	441, 195	5 2, 154, 182	2 57	98, 044	30
	DO INTENSIVE CARE UNIT	70, 557	97, 768			87, 476	
	CORONARY CARE UNIT	0			-	0	32
	50 NEONATAL INTENSIVE CARE UNIT DO SUBPROVIDER - IRF	0 210, 115	29, 30 <sup>-</sup> 161, 335			0 351, 263	35
	DO SUBPROVI DER	210, 113		0 202,033		0	42
	DO NURSERY	0	(	0 0		0	
	LLARY SERVICE COST CENTERS						
		0	57, 50			35, 822	
	D1 OUTPATIENT SURGERY D0 RECOVERY ROOM	0	27, 579 12, 482			7, 381 4, 461	50 51
	DO ANESTHESI OLOGY	0	3, 570			110, 794	
	DO RADI OLOGY-DI AGNOSTI C	0	64, 39				
	D1 RADI OLOGY-SPECI AL PROCEDURES	0	36, 386			2, 038	
	DO RADI OLOGY-THERAPEUTI C	0				0	55
	DO RADI OI SOTOPE DO LABORATORY	0	10, 164 25, 096			537, 970 0	56 60
	DO BLOOD STORING, PROCESSING & TRANS.	0	25,070			0	63
1	DO RESPI RATORY THERAPY	0	36, 088	3 0		20, 198	
	DO PHYSI CAL THERAPY	0	127, 36			0	66
	00 OCCUPATI ONAL THERAPY	0	29, 400		-	0	67
	DO SPEECH PATHOLOGY DO ELECTROCARDI OLOGY	0	17, 018 35, 459			0 39	68
	DO ELECTROENCEPHALOGRAPHY	0	8, 310			0	70
	DO MEDICAL SUPPLIES CHARGED TO PATIENT	0	(		0 0	0	71
	DO I MPL. DEV. CHARGED TO PATI ENTS	0	(		0 0	0	
	DO DRUGS CHARGED TO PATIENTS 30 ULTRA SOUND	0	( 20, 89	) ( 1 39	0 1 1 5 5	8, 731, 511 0	
	51 PAIN CLINIC	0	20, 89 19, 269			-	
	52 CATH LAB	Ö	56, 118				
	53 ACTI VI TY THERAPEUTI C	0	55, 986	6 4, 641		0	76
	54 WOUND CARE CENTER	0	17, 740		.,	82, 137	76
	40 BARIATRIC CLINIC 30 HEALTHY LIVING CENTER	0	26, 75 <sup>-</sup>	1 264, 214	1 3 D 0	6	76
	50 CV RESOURCE CENTER	0	(			0	76
	55 OTHER ANCI LLARY SERVICE COST CENTERS	o	(		0 0	0	76
	56 LACTATION CLINIC	О	(	o  (	0 0	0	76
	57 OTHER ANCI LLARY SERVICE COST CENTERS	0	(		0	0	76
	58 OTHER ANCILLARY SERVICE COST CENTERS 59 ANTICOAGULATION CLINIC	0	( 12, 316			0	76
	DO ALLOGENEIC STEM CELL ACQUISITION	0	12, 310			0	77
	PATIENT SERVICE COST CENTERS		`	· · · · · · · · · · · · · · · · · · ·			1.'
	DO EMERGENCY	0	141, 47	1 112, 622	2 441	49, 380	
	DO OBSERVATI ON BEDS (NON-DI STI NCT PART						92
	ER REIMBURSABLE COST CENTERS	0			0 0	0	102
	CIAL PURPOSE COST CENTERS	J	(		<u> </u>	0	1'02
	DO I NTEREST EXPENSE						113
3. 00	SUBTOTALS (SUM OF LINES 1 through 117)	725, 193	1, 750, 62	1 5, 327, 222	1, 030, 131	10, 140, 293	118
	REIMBURSABLE COST CENTERS		2 (0)				190
	DO GIFT, FLOWER, COFFEE SHOP & CANTEEN DO PHYSICIANS' PRIVATE OFFICES		3, 609 105, 813				190
	DI WORKING WELL	o	132		o o		192
	D2 PHYSI CI ANS' PRI VATE OFFI CES	Ö			0 0	0	192
1	D3 MI SC	0	,		0 0	-	192

Health Financial Systems	FRANCI SCAN HE	ALTH- DYER		In Lieu of Form CMS-2552-10			
COST ALLOCATION - GENERAL SERVICE COSTS		Provider C		Period: From 01/01/2022	Worksheet B Part I		
				Γο 12/31/2022	Date/Time Pre	pared:	
					5/10/2023 11:	<u>00 am</u>	
Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY		
			ADMI NI STRATI OI	SERVICES &			
				SUPPLY			
	10.00	11.00	13.00	14.00	15.00		
194. 00 07950 RESI DENTI AL	0	168, 520	61, 90	3 0	0	194.00	
194.0107954 OTHER NONREIMBURSABLE COST CENTERS	0	0	(	0 0	0	194.01	
194. 02 07952 PSYCHI ATRI C	89, 733	0	(	0 0	0	194. 02	
194.0307953 CENTER OF HOPE	0	33	(	0 0	0	194.03	
200.00 Cross Foot Adjustments						200.00	
201.00 Negative Cost Centers	0	0		0 0	0	201.00	
202.00 TOTAL (sum lines 118 through 201)	814, 926	2, 028, 728	6, 018, 75	1, 030, 131	10, 140, 293	202.00	

	Financial Systems NLLOCATION - GENERAL SERVICE COSTS	FRANCI SCAN H		CN: 15-0090	In Lie Period: From 01/01/2022 To 12/31/2022		epared:
	Cost Center Description	MEDI CAL RECORDS & LI BRARY	SOCI AL SERVI CE	PRGM COSTS APPRV		Intern & Residents Cost & Post Stepdown Adjustments	
	GENERAL SERVICE COST CENTERS	16.00	17.00	22.00	24.00	25.00	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 4.\ 00\\ 5.\ 04\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 10.\ 00\\ 11.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 22.\ 00 \end{array}$	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUI P 00400 EMPLOYEE BENEFITS DEPARTMENT 00593 OTHER ADMINISTRATIVE AND GENERAL 00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 02200 I&R SERVICES-OTHER PRGM COSTS APPRV	1, 949, 788 0 0	0		49		$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 4.\ 00\\ 5.\ 04\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 22.\ 00\\ \end{array}$
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	404 400		000.0	40 07 047 040	000.040	
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	196, 129 43, 068			49 37, 247, 260 0 6, 235, 602	-390, 249 0	
32.00	03200 CORONARY CARE UNI T	0	0		0 0	0	32.00
35.00	02060 NEONATAL INTENSIVE CARE UNIT	4,286	0		0 2, 113, 895	0	
41.00 42.00	04100 SUBPROVI DER – I RF 04200 SUBPROVI DER	64, 371			0 8, 557, 412 0 0	0	
43.00	04300 NURSERY	6, 164			0 2, 100, 831	0	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	187, 529			0 5, 807, 585	0	
50. 01 51. 00	05001 OUTPATIENT SURGERY 05100 RECOVERY ROOM	11, 539 22, 399			0 2, 559, 951 0 1, 279, 586	0	
53.00	05300 ANESTHESI OLOGY	50, 777			0 6, 382, 126	0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	181, 375	0		0 4, 503, 015		
54.01	05401 RADI OLOGY-SPECI AL PROCEDURES	26, 115	0		0 3, 816, 469	0	
55.00 56.00	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE	0 24, 667			0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0	
60.00	06000 LABORATORY	198, 840			0 1, 416, 206 0 10, 067, 856		
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	3, 807	0		0 157, 155		
65.00	06500 RESPIRATORY THERAPY	41, 686	0		0 4, 254, 493	0	
66.00 67.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	54, 141 13, 907			0 6, 684, 510 0 1, 454, 727		
68.00	06800 SPEECH PATHOLOGY	10, 547			0 1, 072, 228		
69.00	06900 ELECTROCARDI OLOGY	74, 678			0 2, 009, 014	0	
70.00	07000 ELECTROENCEPHALOGRAPHY	14,073			0 638, 159		
71.00 72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	114, 759 50, 105			0 12, 920, 968 0 11, 350, 771	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	102, 773	0		0 9, 543, 056		
76.00	03630 ULTRA SOUND	34, 916	0		0 1, 344, 679	0	
76. 01 76. 02	03951 PAIN CLINIC 03952 CATH LAB	26, 404 170, 917			0 1, 547, 936 0 4, 984, 722	0	
76.02	03953 ACTI VI TY THERAPEUTI C	16, 963			0 2, 089, 948		
76.04	03954 WOUND CARE CENTER	7, 511	0		0 1, 105, 200		
76.05	03340 BARIATRIC CLINIC	13, 551	0		0 2, 465, 242	0	
76.06 76.07	03030 HEALTHY LIVING CENTER 03950 CV RESOURCE CENTER	0				0	
76.08	03955 OTHER ANCILLARY SERVICE COST CENTERS	0			0 0	0	
76.09	03956 LACTATION CLINIC	0	0		0 0	0	76.09
76.10	03957 OTHER ANCI LLARY SERVICE COST CENTERS	0	0		0 0	0	
76. 11 76. 12	03958 OTHER ANCI LLARY SERVICE COST CENTERS 03959 ANTI COAGULATI ON CLI NI C	3, 255			0 567,859	0	
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION	0,200	0		0 0	0	
01 07	OUTPATIENT SERVICE COST CENTERS	470	-	J	0 0.070 0.07	-	01.00
91.00 92.00	09100 EMERGENCY 09200 OBSERVATI ON BEDS (NON-DI STINCT PART	178, 536	C		0 9, 970, 298	0	
72.00	OTHER REIMBURSABLE COST CENTERS		1	1		0	72.00
102.00	10200 OPI OI D TREATMENT PROGRAM	0	0		0 0	0	102.00
112 00	SPECIAL PURPOSE COST CENTERS						112 00
113.00	11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117)	1, 949, 788	C	390, 2	49 166, 248, 759	-390, 249	113.00 118.00
	NONREI MBURSABLE COST CENTERS		1	· · · · ·			
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	9	0 184, 355	0	190.00

Health Financial Systems	FRANCI SCAN HE	EALTH- DYER		In Lie	u of Form CMS-:	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider C		Period:	Worksheet B	
				From 01/01/2022 To 12/31/2022		nared
				10 12/31/2022	5/10/2023 11:	00 am
			INTERNS &			
			RESI DENTS			
Cost Center Description		SOCIAL SERVICE			Intern &	
	RECORDS &		PRGM COSTS		Residents Cost	
	LI BRARY		APPRV		& Post Stepdown	
					Adjustments	
	16.00	17.00	22.00	24.00	25.00	
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 4, 020, 191		192.00
192. 01 19201 WORKI NG WELL	0	0		0 7,895		192.01
192. 02 19202 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0	0	192. 02
192. 03 19203 MI SC	0	0		0 0	0	192. 03
194. 00 07950 RESI DENTI AL	0	0		0 6, 798, 667	0	194.00
194.01 07954 OTHER NONREIMBURSABLE COST CENTERS	0	0		0 0		194.01
194. 02 07952 PSYCHI ATRI C	0	0		0 1, 462, 311	-	194. 02
194.0307953CENTER OF HOPE	0	0		0 2, 038		194. 03
200.00 Cross Foot Adjustments				0 0		200.00
201.00 Negative Cost Centers	0	0		0 -1, 283, 576		201.00
202.00 TOTAL (sum lines 118 through 201)	1, 949, 788	0	390, 24	9 177, 440, 640	-390, 249	202.00

OST A	LLOCATION - GENERAL SERVICE COSTS		Provider CCN: 15-0090	Period: From 01/01/2022	Worksheet B Part I
				To 12/31/2022	Date/Time Prepare 5/10/2023 11:00 a
	Cost Center Description	Total		- <b>I</b>	
	GENERAL SERVICE COST CENTERS	26.00			
. 00	00100 CAP REL COSTS-BLDG & FIXT				1.
. 00	00200 CAP REL COSTS-MVBLE EQUIP				2.
. 00	00400 EMPLOYEE BENEFITS DEPARTMENT				4.
. 04	00593 OTHER ADMINISTRATIVE AND GENERAL				5.
. 00	00600 MAI NTENANCE & REPAI RS				6.
. 00	00700 OPERATION OF PLANT				7.
. 00	00800 LAUNDRY & LINEN SERVICE				8.
. 00	00900 HOUSEKEEPI NG				9.
0.00	01000 DI ETARY				10.
1.00					11.
3.00 4.00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY				13.
5.00	01500 PHARMACY				14.
6.00	01600 MEDICAL RECORDS & LIBRARY				16.
7.00	01700 SOCIAL SERVICE				17.
2.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV				22.
	INPATIENT ROUTINE SERVICE COST CENTERS	I			
0.00	03000 ADULTS & PEDIATRICS	36, 857, 011			30.
1.00	03100 INTENSIVE CARE UNIT	6, 235, 602			31.
2.00	03200 CORONARY CARE UNI T	0			32.
5.00	02060 NEONATAL INTENSIVE CARE UNIT	2, 113, 895			35.
1.00	04100 SUBPROVI DER – I RF	8, 557, 412			41.
2.00	04200 SUBPROVI DER	0			42.
3.00	04300 NURSERY	2, 100, 831			43.
0 00	ANCI LLARY SERVICE COST CENTERS	F 007 F0F			
0.00	05000 OPERATING ROOM	5,807,585			50.
1.00	05001 OUTPATIENT SURGERY 05100 RECOVERY ROOM	2, 559, 951 1, 279, 586			50. 51.
3.00	05300 ANESTHESI OLOGY	6, 382, 126			53.
4.00	05400 RADI OLOGY - DI AGNOSTI C	4, 503, 015 3, 816, 469			54. 54.
4.01 5.00	05401 RADI OLOGY-SPECI AL PROCEDURES 05500 RADI OLOGY-THERAPEUTI C	3, 810, 409			55.
6.00	05600 RADI OLOGI - THERAPEOTIC	1, 416, 206			56.
0.00	06000 LABORATORY	10, 067, 856			60.
3.00	06300 BLOOD STORING, PROCESSING & TRANS.	157, 155			63.
5.00	06500 RESPIRATORY THERAPY	4, 254, 493			65.
6.00	06600 PHYSI CAL THERAPY	6, 684, 510			66.
7.00	06700 OCCUPATI ONAL THERAPY	1, 454, 727			67.
8.00	06800 SPEECH PATHOLOGY	1,072,228			68.
9.00	06900 ELECTROCARDI OLOGY	2,009,014			69.
0.00	07000 ELECTROENCEPHALOGRAPHY	638, 159			70.
1.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	12, 920, 968			71.
2.00	07200 IMPL. DEV. CHARGED TO PATIENTS	11, 350, 771			72.
3.00	07300 DRUGS CHARGED TO PATIENTS	9, 543, 056			73.
6.00	03630 ULTRA SOUND	1, 344, 679			76.
6. 01	03951 PAIN CLINIC	1, 547, 936			76.
6. 02	03952 CATH LAB	4, 984, 722			76.
6. 03	03953 ACTI VI TY THERAPEUTI C	2, 089, 948			76.
	03954 WOUND CARE CENTER	1, 105, 200			76.
	03340 BARI ATRI C CLI NI C	2, 465, 242			76.
	03030 HEALTHY LIVING CENTER	0			76.
	03950 CV RESOURCE CENTER	0			76.
	03955 OTHER ANCI LLARY SERVICE COST CENTERS	0			76.
	03956 LACTATION CLINIC	0			76.
	03957 OTHER ANCI LLARY SERVICE COST CENTERS	0			76.
	03958 OTHER ANCI LLARY SERVICE COST CENTERS	0			76.
	03959 ANTI COAGULATI ON CLINI C	567, 859			76.
1.00	07700 ALLOGENEI C STEM CELL ACQUI SI TI ON	0			
1 00	OUTPATIENT SERVICE COST CENTERS	0.070.000			
	09100 EMERGENCY	9, 970, 298			91.
∠. UU	09200 OBSERVATION BEDS (NON-DISTINCT PART				92.
12 01	OTHER REIMBURSABLE COST CENTERS	0			100
JZ. UL	10200 OPI OI D TREATMENT PROGRAM	U			102.
13 00	11300 INTEREST EXPENSE				113.
13.00 18.00		165 050 510			113.
10.00	NONREIMBURSABLE COST CENTERS	165, 858, 510			
20 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	184, 355			190.
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	4, 020, 191			190.
	19200 PHYSICIANS PRIVATE OFFICES				192.
		7, 895			
	19202 PHYSI CLANS' PRI VATE OFFI CES	0			192.
	19203 MI SC 07950 RESI DENTI AL	-			192.
01 01		6, 798, 667			194.

Health Financial Systems	FRANCI SCAN HEA	ALTH- DYER	In Lie	u of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 15-0090	Period: From 01/01/2022	Worksheet B Part I
			To 12/31/2022	Date/Time Prepared:
				5/10/2023 11:00 am
Cost Center Description	Total			
	26.00			
194. 02 07952 PSYCHI ATRI C	1, 462, 311			194.02
194.0307953 CENTER OF HOPE	2, 038			194.03
200.00 Cross Foot Adjustments	0			200.00
201.00 Negative Cost Centers	-1, 283, 576			201.00
202.00 TOTAL (sum lines 118 through 201)	177, 050, 391			202.00

0CA	Financial Systems TION OF CAPITAL RELATED COSTS		Provider C		eriod: com 01/01/2022	u of Form CMS-: Worksheet B Part II Date/Time Pre	
			CAPI TAL REI	LATED COSTS		5/10/2023 11:	<u>00 ar</u>
	Cost Center Description	Directly Assigned New Capital	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFI TS DEPARTMENT	
		Related Costs 0	1.00	2.00	2A	4.00	
0	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1 1.
0 0 4 0 0 0	00200 CAP REL COSTS-BLOB & TTAT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00593 OTHER ADMINISTRATIVE AND GENERAL 00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	0 0 0 0 0	33, 927 613, 084 1, 240, 521 351, 793 0	244, 563	35, 485 1, 462, 364 1, 485, 084 1, 987, 128 0	35, 485 7, 555 324 708 0	2. 4. 5. 6. 7.
00 00 00	00900 HOUSEKEEPI NG 01000 DI ETARY 01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE 02200 I & SERVI CES-OTHER PRGM COSTS APPRV UNDATI ENT POUL OF COST OF APPRV	0 0 0 0 0 0 0 0	94, 099 83, 011 119, 837 12, 677 106, 881 59, 665 85, 316 0 0	7, 246 0 15, 667 37, 112 8, 016	96, 599 90, 257 119, 837 28, 344 143, 993 67, 681 85, 316 0 0	840 224 338 1,087 169 895 159 0 84	10. 11. 13. 14. 15. 16. 17.
00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS 03100 I NTENSI VE CARE UNI T 03200 CORONARY CARE UNI T 02060 NEONATAL I NTENSI VE CARE UNI T 04100 SUBPROVI DER - I RF 04200 SUBPROVI DER 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0 0 0 0 0 0	1, 384, 995 173, 408 0 9, 307 103, 685 0 0	0 2, 605 8, 987 0	1, 507, 966 197, 921 0 11, 912 112, 672 0 0	6, 676 1, 192 0 440 1, 769 0 534	31. 32. 35. 41. 42.
00 00 00 00 00 00 00 00 00 00 00 00 00	05000 OPERATING ROOM 05001 OUTPATIENT SURGERY 05100 RECOVERY ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05401 RADI OLOGY-DI AGNOSTI C 05401 RADI OLOGY-THERAPEUTI C 05600 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE 06000 LABORATORY 06300 BLOOD STORING, PROCESSI NG & TRANS. 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06600 PHYSI CAL THERAPY 06600 SPEECH PATHOLOGY 06700 OCCUPATI ONAL THERAPY 06600 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDI CAL SUPPLI ES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 03630 ULTRA SOUND 03951 PAI N CLI NI C 03952 CATH LAB 03953 ACTI VI TY THERAPEUTI C 03954 WOUND CARE CENTER 03340 BARI ATRI C CLI NI C 03030 HEALTHY LI VI NG CENTER 03950 CV RESOURCE CENTER 03955 OTHER ANCI LLARY SERVICE COST CENTERS		287, 902 245, 908 96, 928 0 411, 266 26, 925 0 86, 102 120, 623 49, 433 37, 367 25, 354 9, 708 0 66, 493 91, 881 0 0 39, 969 215, 176 157, 815 99, 634 111, 124 33, 648 0 0	$\begin{array}{c} 13,879\\ 1,114\\ 414,431\\ 12,477\\ 0\\ 57,047\\ 1,382\\ 0\\ 34,351\\ 20,901\\ 0\\ 7,857\\ 57,080\\ 2,899\\ 0\\ 0\\ 0\\ 29,920\\ 6,418\\ 129,544\\ 222\\ 1,594\end{array}$	$\begin{array}{c} 567,678\\ 257,267\\ 110,807\\ 1,114\\ 825,697\\ 39,402\\ 0\\ 143,149\\ 122,005\\ 49,433\\ 71,718\\ 46,255\\ 9,708\\ 7,857\\ 123,573\\ 94,780\\ 0\\ 0\\ 0\\ 69,889\\ 221,594\\ 287,359\\ 99,856\\ 112,718\\ 36,954\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\$	663 352 153 18 681 473 0 138 232 0 621 1, 643 394 232 390 102 0 0 0 0 0 0 0 251 246 842 535 193 572 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	50. 51. 53. 54. 55. 55. 56. 60. 63. 65. 66. 63. 65. 68. 69. 70. 71. 72. 73. 76. 76. 76. 76. 76. 76. 76. 76.
10 11 12 00	03956 LACTATION CLINIC 03957 OTHER ANCILLARY SERVICE COST CENTERS 03958 OTHER ANCILLARY SERVICE COST CENTERS 03959 ANTICOAGULATION CLINIC 07700 ALLOGENEIC STEM CELL ACQUISITION 0UTPATIENT SERVICE COST CENTERS 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	0 0 0 0	0 0 7, 683 0 280, 813	0 0 47 0 40, 506	0 0 7, 730 0 321, 319 0	0 0 152 0 1, 605	76. 76. 76. 77.
00	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	102.
	SPECIAL PURPOSE COST CENTERS		0				1113.
. 00		0	6, 973, 958	4, 086, 463	11, 060, 421	33, 482	118
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	13, 899	1, 222	15, 121		190

Health Financial Systems	FRANCI SCAN HE	ALTH- DYER		In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CC		Peri od:	Worksheet B	
				From 01/01/2022 To 12/31/2022		nared
				10 12/01/2022	5/10/2023 11:	
		CAPI TAL REL	ATED COSTS			
Cast Castan Description	Discretion			Cubtetel		
Cost Center Description	Directly Assigned New	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFI TS	
	Capi tal				DEPARTMENT	
	Rel ated Costs				DEFFRICTMENT	
	0	1.00	2.00	2A	4.00	
192.01 19201 WORKING WELL	0	0		0 0	2	192. 01
192. 02 19202 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0		192. 02
192. 03 19203 MI SC	0	0		0 0		192.03
194. 00 07950  RESI DENTI AL	0	529, 200	29, 39	6 558, 596		194.00
194.0107954 OTHER NONREI MBURSABLE COST CENTERS	0	0		0 0		194.01
194. 02 07952  PSYCHI ATRI C	0	462, 393		0 462, 393		194. 02
194.0307953 CENTER OF HOPE	0	0		0 0	0	194.03
200.00 Cross Foot Adjustments				0		200.00
201.00 Negative Cost Centers		0		0 0	0	201.00
202.00  TOTAL (sum lines 118 through 201)	0	8, 218, 617	4, 135, 86	6 12, 354, 483	35, 485	202.00

	TION OF CAPITAL RELATED COSTS		ALTH- DYER Provider CO		Period: From 01/01/2022 To 12/31/2022	u of Form CMS-: Worksheet B Part II Date/Time Pre 5/10/2023 11:	pared:
	Cost Center Description	OTHER ADMI NI STRATI VE AND GENERAL	MAI NTENANCE & REPAI RS	OPERATI ON OF PLANT	LINEN SERVICE	HOUSEKEEPI NG	
,		5.04	6.00	7.00	8.00	9.00	
1.00 2.00 4.00 5.04	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00593 OTHER ADMINISTRATIVE AND GENERAL	1, 469, 919					1.00 2.00 4.00 5.04
7.00 8.00	00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING	45, 664 0 6, 962 29, 820	1, 531, 072 85, 076 0 22, 756	2, 072, 912 (	2 0 6, 962 0 0	150, 015	6.00 7.00 8.00 9.00
11. 00 13. 00	01000 DI ETARY 01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	5, 662 15, 172 48, 633 6, 956	20, 075 28, 981 3, 066 25, 847		0 0 0 0 0 0 0 0	2, 116 3, 055 323 2, 724	11. 00 13. 00
15. 00 16. 00 17. 00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 02200 I&R SERVICES-OTHER PRGM COSTS APPRV	78, 697 14, 839 0 3, 154	14, 429 20, 632 0	(	0 0	1, 521 2, 175 0 0	15.00 16.00 17.00
	03200 ADULTS & PEDIATRICS	254, 333	334, 938	1	0 3, 701	35, 304	
31.00 32.00 35.00	03100 INTENSI VE CARE UNI T 03200 CORONARY CARE UNI T 02060 NEONATAL INTENSI VE CARE UNI T 04100 SUBPROVI DER - IRF	44, 475 44, 475 0 16, 645 59, 108	41, 936 0 2, 251		0 587 0 0 0 54	4, 420 0 237 2, 643	31.00 32.00 35.00
42.00 43.00	04200 SUBPROVI DER 04300 NURSERY	59, 108 0 17, 071	25, 075 0 0		0 1,747 0 0 0 127	2, 643 0 0	42.00
	ANCI LLARY SERVI CE COST CENTERS 05000 OPERATI NG ROOM	35, 773	69, 625		0 0	7, 339	50.00
	05001 OUTPATIENT SURGERY 05100 RECOVERY ROOM	13, 417 5, 545	59, 469 23, 440		0 0 0 0	6, 268 2, 471	50.01 51.00
53.00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	51, 045 29, 728	0 99, 458		0 0	0 10, 483	53.00
54.01	05401 RADI OLOGY-SPECI AL PROCEDURES	29, 680	6, 511	(	o c	686	54.01
	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE	0 5, 614	0 20, 822		0 0 0 0	0 2, 195	
	06000 LABORATORY 06300 BLOOD STORING, PROCESSING & TRANS.	79, 069 512	29, 171 11, 955			3, 075 1, 260	
65.00	06500 RESPI RATORY THERAPY	33, 213	9, 037		0 0	952	65.00
	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	53, 079 11, 468	6, 131 2, 348		0 0 0 0	646 247	66.00 67.00
	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	8, 556 12, 548	0 16, 080		0	0 1, 695	
70.00	07000 ELECTROENCEPHALOGRAPHY	3, 917	22, 220		0 0	2, 342	70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	105, 146 92, 784	0	`		0	71.00
73.00	07300 DRUGS CHARGED TO PATLENTS 03630 ULTRA SOUND	5, 819 10, 077	0		0 0	0	73.00
76. 01	03951 PAIN CLINIC	9, 376	9, 666 52, 037			1, 019 5, 485	
	03952 CATH LAB 03953 ACTIVITY THERAPEUTIC	30, 533 15, 288	38, 165 24, 095			4, 023 2, 540	
76.04	03954 WOUND CARE CENTER	6, 801	26, 874		0	2, 833	76.04
	03340 BARIATRIC CLINIC 03030 HEALTHY LIVING CENTER	17, 324 0	8, 137 0			858 0	
	03950 CV RESOURCE CENTER 03955 OTHER ANCI LLARY SERVICE COST CENTERS	0	0	(	0 0	0	
76.09	03956 LACTATION CLINIC	0	0			0	
	03957 OTHER ANCI LLARY SERVICE COST CENTERS 03958 OTHER ANCI LLARY SERVICE COST CENTERS	0	0			0 0	
76. 12	03959 ANTI COAGULATI ON CLINIC	4, 439	1, 858			196	76.12
	07700 ALLOGENEIC STEM CELL ACQUISITION OUTPATIENT SERVICE COST CENTERS	0	0		0 0	0	
92.00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS	74, 419	67, 910	(	0 0	7, 158	91.00 92.00
102.00	10200 OPI OI D TREATMENT PROGRAM SPECIAL PURPOSE COST CENTERS	0	0	(	0 0	0	102.00
113.00 118.00	11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117)	1, 392, 361	1, 230, 071	(	0 6, 216	118, 289	113. 00 118. 00
	NONREI MBURSABLE COST CENTERS 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN	1, 312	3, 361	(	0 0		190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	24,005	57,839	(	0 0	6, 096	192.00
192.00	19201 WORKING WELL	64	0	(			192.01

Health Financial Systems	FRANCI SCAN HI	EALTH- DYER		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CO		Period: From 01/01/2022	Worksheet B Part II	
				o 12/31/2022		pared:
					5/10/2023 11:	00 am
Cost Center Description	OTHER	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
	ADMI NI STRATI VE	REPAI RS	PLANT	LINEN SERVICE		
	AND GENERAL					
	5.04	6.00	7.00	8.00	9.00	
194. 00 07950 RESI DENTI AL	47, 369	127, 979	(	0 0	13, 489	194.00
194.01 07954 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0 0	0	194.01
194. 02 07952 PSYCHI ATRI C	4, 792	111, 822	(	746	11, 787	194.02
194.03 07953 CENTER OF HOPE	16	0	(	0 0	0	194.03
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0	2, 072, 912	2 0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	1, 469, 919	1, 531, 072	2, 072, 912	6, 962	150, 015	202.00

Health Financial Systems	FRANCI SCAN HE	ALTH- DYER		In Lieu	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider C		eriod: com 01/01/2022	Worksheet B Part II	
			To	12/31/2022	Date/Time Pre 5/10/2023 11:	pared: 00 am
Cost Center Description	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES &	PHARMACY	
				SUPPLY		
GENERAL SERVICE COST CENTERS	10.00	11.00	13.00	14.00	15.00	
1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						2.00 4.00
5. 04 00593 OTHER ADMINI STRATI VE AND GENERAL						5.04
6. 00 00600 MAI NTENANCE & REPAI RS 7. 00 00700 OPERATI ON OF PLANT						6.00 7.00
8.00 00800 LAUNDRY & LI NEN SERVI CE						8.00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY	118, 334					9.00 10.00
11. 00 01100 CAFETERI A	0	167, 383				11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON 14. 00 01400 CENTRAL SERVI CES & SUPPLY	0	6, 296 1, 784		181, 473		13.00 14.00
15. 00 01500 PHARMACY	0	5, 105		71, 056	239, 384	
16. 00 01600 MEDI CAL RECORDS & LI BRARY 17. 00 01700 SOCI AL SERVI CE	0	1, 131 0	0	0 0	0	16.00 17.00
22. 00 02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	505	0	0	0	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	64, 549	36, 402	31, 404	10	2, 315	30.00
31.00 03100 I NTENSI VE CARE UNI T	10, 245	8, 066	2, 715	82	2, 315	•
32.00 03200 CORONARY CARE UNIT 35.00 02060 NEONATAL INTENSIVE CARE UNIT	0	0	0 471	0	0	32.00 35.00
35. 00 02060 NEONATAL INTENSIVE CARE UNIT 41. 00 04100 SUBPROVIDER - IRF	30, 510	2, 417 13, 311	2, 946	6 0	8, 292	
42. 00 04200 SUBPROVI DER	0	0	0	0	0	42.00
43. 00 04300 NURSERY ANCI LLARY SERVICE COST CENTERS	0	0	0	<u> </u>	0	43.00
50.00 05000 OPERATING ROOM	0	4, 745		40, 685	846	50.00
50. 01 05001 0UTPATI ENT SURGERY 51. 00 05100 RECOVERY ROOM	0	2, 275 1, 030		1, 311 295	174 105	50.01 51.00
53. 00 05300 ANESTHESI OLOGY	0	295		0	2, 616	
54. 00 05400 RADI OLOGY-DI AGNOSTI C 54. 01 05401 RADI OLOGY-SPECI AL PROCEDURES	0	5, 313 3, 002	5 1, 129	616 3, 346	279 48	54.00 54.01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55.00
56. 00 05600 RADI 0I SOTOPE 60. 00 06000 LABORATORY	0	839 2, 071	0	5, 224 5, 579	12, 700 0	56.00 60.00
63. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS.	0	0	0	2, 876	0	63.00
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	0	2, 977 10, 509	0	9, 688 0	477 0	65.00 66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	2, 426	0	0	0	67.00
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	0	1, 404 2, 926	0 3, 923	465 198	0 1	68.00 69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	686		0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	206, 126	73.00
76.00 03630 ULTRA SOUND 76.01 03951 PALN CLINIC	0	1, 724 1, 590		203 154	0 27	76.00 76.01
76.02 03952 CATH LAB	0	4, 630	8, 293	39, 291	208	76. 02
76.03 03953 ACTIVITY THERAPEUTIC 76.04 03954 WOUND CARE CENTER	0	4, 619 1, 464		0 310	0 1, 939	
76. 05 03340 BARI ATRI C CLI NI C	0	2, 207		0	0	76.05
76. 06 03030 HEALTHY LIVING CENTER 76. 07 03950 CV RESOURCE CENTER	0	0	0	0	0	76.06 76.07
76.08 03955 OTHER ANCI LLARY SERVICE COST CENTERS	0	0	0	0	0	76.08
76.09 03956 LACTATION CLINIC 76.10 03957 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.09 76.10
76.11 03958 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	Ö	0	76. 11
76.12 03959 ANTI COAGULATI ON CLINIC 77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	1, 016	0	0	0	76. 12 77. 00
OUTPATIENT SERVICE COST CENTERS				3		
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	11, 672	1, 642	78	1, 166	91.00 92.00
OTHER REIMBURSABLE COST CENTERS						
102.00 10200 OPI OI D TREATMENT PROGRAM SPECI AL PURPOSE COST CENTERS	0	0	0	0	0	102.00
113. 00 11300 I NTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	105, 304	144, 437	77, 666	181, 473	239, 384	118.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	298		0		190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 192. 01 19201 WORKI NG WELL	0	8, 730 11		0		192. 00 192. 01
192. 02 19202 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0	0	192. 02
192. 03 19203 MI SC	0	0	0	0	0	192.03

Health Financial Systems	FRANCI SCAN HE	ALTH- DYER		In Lie	u of Form CMS-:	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CO		Period: From 01/01/2022	Worksheet B Part II	
				To 12/31/2022	Date/Time Pre	pared:
					5/10/2023 11:	<u>00 am</u>
Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	
			ADMI NI STRATI OI	SERVICES &		
				SUPPLY		
	10.00	11.00	13.00	14.00	15.00	
194. 00 07950 RESI DENTI AL	0	13, 904	903	3 0	0	194.00
194.0107954 OTHER NONREIMBURSABLE COST CENTERS	0	0	(	0 0	0	194.01
194. 02 07952 PSYCHI ATRI C	13, 030	0		0 0	0	194. 02
194.0307953 CENTER OF HOPE	0	3	(	0 0	0	194.03
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0	(	0 0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	118, 334	167, 383	87, 74	9 181, 473	239, 384	202.00

Health Financial Systems ALLOCATION OF CAPITAL RELATED COSTS	FRANCI SCAN H		CN: 15-0090	In Lie Period: From 01/01/2022 To 12/31/2022		epared:
Cost Center Description	MEDI CAL RECORDS & LI BRARY	SOCI AL SERVI CE	PRGM COSTS APPRV		Intern & Residents Cost & Post Stepdown Adjustments	
GENERAL SERVICE COST CENTERS	16.00	17.00	22.00	24.00	25.00	
1.00       00100       CAP REL COSTS-BLDG & FIXT         2.00       00200       CAP REL COSTS-MVBLE EQUIP         4.00       00400       EMPLOYEE BENEFITS DEPARTMENT         5.04       00593       OTHER ADMINISTRATIVE AND GENERAL         6.00       00600       MAINTENANCE & REPAIRS         7.00       00700       OPERATION OF PLANT         8.00       00800       LAUNDRY & LINEN SERVICE         9.00       00900       HOUSEKEEPING         10.00       01000       DIETARY         11.00       01100       CAFETERIA         13.00       01300       NURSI NG ADMINISTRATION         14.00       01400       CENTRAL SERVICES & SUPPLY         15.00       01600       MEDICAL RECORDS & LIBRARY         17.00       01700       SOCI AL SERVICE	124, 252 0	C		42		$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 4.\ 00\\ 5.\ 04\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 22.\ 00\\ \end{array}$
22. 00 02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	C	3, 7	43		22.00
INPATI ENT ROUTI NE SERVI CE COST CENTERS           30. 00         03000         ADULTS & PEDI ATRI CS           31. 00         03100         INTENSI VE CARE UNI T           32. 00         03200         CORONARY CARE UNI T           35. 00         02060         NEONATAL INTENSI VE CARE UNI T           41. 00         04100         SUBPROVI DER           42. 00         04200         SUBPROVI DER           43. 00         04300         NURSERY	12, 520 2, 749 0 274 4, 109 0 393			2, 290, 118 316, 453 0 34, 707 262, 182 0 18, 125	0 0 0 0 0 0 0 0	31.00 32.00 35.00 41.00 42.00
ANCI LLARY SERVICE COST CENTERS	0,0			10,120		101.00
50. 00       05000       OPERATI NG ROOM         50. 01       05001       OUTPATI ENT SURGERY         51. 00       05100       RECOVERY ROOM         53. 00       05300       ANESTHESI OLOGY         54. 00       05400       RADI OLOGY-DI AGNOSTI C         54. 01       05401       RADI OLOGY-SPECI AL PROCEDURES         55. 00       05500       RADI OLOGY-THERAPEUTI C         56. 00       05600       RADI OLOGY-THERAPEUTI C         56. 00       06300       BLOOD STORI NG, PROCESSI NG & TRANS.         65. 00       06500       RESPI RATORY THERAPY         66. 00       06600       PHYSI CAL THERAPY         67. 00       06700       OCCUPATI ONAL THERAPY         68. 00       06800       SPEECH PATHOLOGY         69. 00       06900       ELECTROCARDI OLOGY         70. 00       07000       ELECTROCARDI OLOGY         71. 00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENTS         73. 00       07300       DRUGS CHARGED TO PATI ENTS         73. 00       07300       DRUGS CHARGED TO PATI ENTS         76. 01       03951       PAI N CLI NI C         76. 02       03952       CATH LAB         76. 03       03953	11, 971 737 1, 430 3, 242 11, 579 1, 667 0 1, 575 12, 476 243 2, 661 3, 456 888 673 4, 767 898 7, 326 3, 199 6, 561 2, 229 1, 686 10, 911 1, 083 479 865 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			746, 677 348, 570 151, 354 58, 330 983, 839 85, 944 0 192, 256 253, 678 66, 279 131, 344 121, 719 27, 479 19, 187 166, 101 124, 945 112, 472 95, 983 218, 506 95, 059 292, 682 424, 255 148, 084 153, 611 70, 769 0 0 0 0 0 0 0 0 0 0 0 0 0		$\begin{array}{c} 50.\ 01\\ 51.\ 00\\ 53.\ 00\\ 54.\ 01\\ 55.\ 00\\ 56.\ 00\\ 60.\ 00\\ 63.\ 00\\ 65.\ 00\\ 65.\ 00\\ 67.\ 00\\ 68.\ 00\\ 70.\ 00\\ 70.\ 00\\ 71.\ 00\\ 72.\ 00\\ 73.\ 00\\ 76.\ 01\\ 76.\ 02\\ 76.\ 03\\ 76.\ 04\\ 76.\ 05\\ 76.\ 06\\ 76.\ 07\\ 76.\ 08\\ 76.\ 09\\ 76.\ 11\\ 76.\ 12\\ \end{array}$
0UTPATI ENT SERVICE COST CENTERS 91.00 09100 EMERGENCY	11, 397	C		498, 366	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS					0	92.00
102.00 10200 OPI OLD TREATMENT PROGRAM SPECIAL PURPOSE COST CENTERS	0	C		0	0	102.00
113.00 11300 INTEREST EXPENSE 118.00 SUBTOTALS (SUM OF LINES 1 through 117)	124, 252	C		0 8, 524, 673	0	113. 00 118. 00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	C		20, 468	0	190. 00

Health Financial Systems	FRANCI SCAN HI	EALTH- DYER		In Lie	eu of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider C		Period:	Worksheet B	
				From 01/01/2022 To 12/31/2022		pared:
					5/10/2023 11:	
			INTERNS &			
Cost Center Description	MEDI CAL	SOCI AL SERVI CE	RESI DENTS	R Subtotal	Intern &	
cost center bescription	RECORDS &	SUCIAL SERVICE	PRGM COSTS		Residents Cost	
	LIBRARY		APPRV		& Post	
					Stepdown	
					Adjustments	
	16.00	17.00	22.00	24.00	25.00	
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		364, 445		192.00
192.01 19201 WORKI NG WELL	0	0	)	77	0	192. 01
192. 02 19202 PHYSI CLANS' PRI VATE OFFI CES	0	0	)	0	0	192. 02
192. 03 19203 MI SC	0	0	)	0	0	192.03
194. 00 07950 RESI DENTI AL	0	0	)	763, 576	0	194.00
194.0107954 OTHER NONREIMBURSABLE COST CENTERS	0	0		0	0	194.01
194. 02 07952 PSYCHI ATRI C	0	0		604, 570	0	194. 02
194.0307953 CENTER OF HOPE	0	0		19	0	194. 03
200.00 Cross Foot Adjustments			3, 74	3 3, 743	0	200.00
201.00 Negative Cost Centers	0	0		0 2, 072, 912	0	201.00
202.00   TOTAL (sum lines 118 through 201)	124, 252	0	3, 74	3 12, 354, 483	0	202.00

	ncial Systems OF CAPITAL RELATED COSTS	FRANCI SCAN HEA	Provider CCN: 15-0090	Peri od:	of Form CMS-2552-1 Worksheet B
				From 01/01/2022 To 12/31/2022	Part II Date/Time Prepared:
	Cast Contor Description	Total			5/10/2023 11:00 am
	Cost Center Description	<u>Total</u> 26.00			
	RAL SERVICE COST CENTERS				
1	CAP REL COSTS-BLDG & FIXT				1.00
	CAP REL COSTS-MVBLE EQUIP				2.00
	O EMPLOYEE BENEFITS DEPARTMENT O OTHER ADMINISTRATIVE AND GENERAL				4.00
	MAINTENANCE & REPAIRS				6. 00
	OPERATION OF PLANT				7.00
	LAUNDRY & LINEN SERVICE				8.00
9.00 00900	HOUSEKEEPING				9.00
10.00 01000	DI ETARY				10.0
	CAFETERIA				11.0
	NURSING ADMINISTRATION				13.0
	CENTRAL SERVICES & SUPPLY				14.00
	D PHARMACY MEDI CAL RECORDS & LI BRARY				15. 00 16. 00
	SOCIAL SERVICE				17.00
	I&R SERVICES-OTHER PRGM COSTS APPRV				22.00
	TIENT ROUTINE SERVICE COST CENTERS	I			
30.00 03000	ADULTS & PEDIATRICS	2, 290, 118			30.00
31.00 03100	INTENSIVE CARE UNIT	316, 453			31.00
	CORONARY CARE UNIT	0			32.00
	NEONATAL INTENSIVE CARE UNIT	34, 707			35.00
	SUBPROVIDER - IRF	262, 182			41.00
	SUBPROVI DER NURSERY	0 18, 125			42.00
	LARY SERVICE COST CENTERS	10, 125			43.00
	OPERATING ROOM	746, 677			50.00
1	OUTPATI ENT SURGERY	348, 570			50.0
51.00 05100	RECOVERY ROOM	151, 354			51.00
	ANESTHESI OLOGY	58, 330			53.0
	RADI OLOGY-DI AGNOSTI C	983, 839			54.00
1	RADI OLOGY-SPECI AL PROCEDURES	85, 944			54.0
	RADI OLOGY-THERAPEUTI C	102.25(			55.00
	D RADI OI SOTOPE D LABORATORY	192, 256 253, 678			56.00 60.00
	BLOOD STORING, PROCESSING & TRANS.	66, 279			63.00
	RESPIRATORY THERAPY	131, 344			65.00
	PHYSI CAL THERAPY	121, 719			66.00
67.00 06700	OCCUPATIONAL THERAPY	27, 479			67.00
68.00 06800	SPEECH PATHOLOGY	19, 187			68.00
	ELECTROCARDI OLOGY	166, 101			69.00
	ELECTROENCEPHALOGRAPHY	124, 945			70.00
	MEDICAL SUPPLIES CHARGED TO PATIENT	112, 472 95, 983			71.00
	DRUGS CHARGED TO PATIENTS	218, 506			73.0
	ULTRA SOUND	95, 059			76.0
	PAIN CLINIC	292, 682			76.0
	2 CATH LAB	424, 255			76. 0
	ACTIVITY THERAPEUTIC	148, 084			76. 0
	4 WOUND CARE CENTER	153, 611			76. 04
	BARIATRIC CLINIC	70, 769			76.0
	HEALTHY LIVING CENTER	0			76.0
	CV RESOURCE CENTER	0			76. 0 76. 0
	5 OTHER ANCILLARY SERVICE COST CENTERS				76.0
	OTHER ANCILLARY SERVICE COST CENTERS	0			76. 10
	OTHER ANCI LLARY SERVICE COST CENTERS	0			76. 1
	ANTICOAGULATION CLINIC	15, 599			76. 12
	ALLOGENEIC STEM CELL ACQUISITION	0			77.00
	ATIENT SERVICE COST CENTERS				
91.00 09100		498, 366			91.00
	OBSERVATION BEDS (NON-DISTINCT PART				92.00
	R REIMBURSABLE COST CENTERS	0			102.0
	OPIOID TREATMENT PROGRAM AL PURPOSE COST CENTERS	0			102.00
	INTEREST EXPENSE				113. 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	8, 524, 673			118.00
	EIMBURSABLE COST CENTERS	5, 52 1, 075			110.0
	GIFT, FLOWER, COFFEE SHOP & CANTEEN	20, 468			190. 0
	PHYSICIANS' PRIVATE OFFICES	364, 445			192. 0
192.01 19201	WORKING WELL	77			192. O
	2 PHYSICIANS' PRIVATE OFFICES	0			192. 02
192.03 19203		0			192. 03
	RESIDENTIAL	763, 576			194.0
	4 OTHER NONREIMBURSABLE COST CENTERS	0			194. C

Health Finar	ncial Systems	FRANCI SCAN HE	ALTH- DYER	In Lieu of Form CMS-2552-10		
ALLOCATION	OF CAPITAL RELATED COSTS		Provider CCN: 15-0090	Peri od: From 01/01/2022 To 12/31/2022		
	Cost Center Description	Total	·			
		26.00				
194.0207952	PSYCHI ATRI C	604, 570			194.02	
194.0307953	CENTER OF HOPE	19			194.03	
200.00	Cross Foot Adjustments	3, 743			200.00	
201.00	Negative Cost Centers	2,072,912			201.00	
202.00	TOTAL (sum lines 118 through 201)	12, 354, 483			202.00	

	Financial Systems LLOCATION - STATISTICAL BASIS	FRANCI SCAN H			Period:	u of Form CMS-: Worksheet B-1	
					rom 01/01/2022 o 12/31/2022		
		CAPI TAL RE	LATED COSTS			5/10/2023 11:	
	Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUI P (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconci I i ati on	OTHER ADMI NI STRATI VE AND GENERAL (ACCUM. COST)	
		1.00	2.00	4.00	5A. 04	5.04	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT	470, 676					1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	170,070	11, 178, 096				2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	1, 943					4.00
5.04 6.00	00593 OTHER ADMINISTRATIVE AND GENERAL 00600 MAINTENANCE & REPAIRS	35, 111 71, 044				141, 832, 930 4, 406, 026	
7.00	00700 OPERATION OF PLANT	20, 147				4, 400, 020	1
8.00	00800 LAUNDRY & LINEN SERVICE	C	0	C		671, 751	1
9.00	00900 HOUSEKEEPING	5, 389				2, 877, 294	
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	4, 754 6, 863				546, 319 1, 463, 868	1
	01300 NURSI NG ADMI NI STRATI ON	726				4, 692, 535	1
	01400 CENTRAL SERVICES & SUPPLY	6, 121				671, 132	
	01500 PHARMACY	3, 417				7, 593, 268	
16. 00 17. 00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	4, 886				1, 431, 758 0	1
	02200 I &R SERVICES-OTHER PRGM COSTS APPRV		-		-	-	1
	INPATIENT ROUTINE SERVICE COST CENTERS	T	T		T		
	03000 ADULTS & PEDIATRICS	79, 318					
	03100 I NTENSI VE CARE UNI T 03200 CORONARY CARE UNI T	9, 931				4, 291, 266 0	
35.00	02060 NEONATAL INTENSIVE CARE UNIT	533	-			1, 606, 061	1
41.00	04100 SUBPROVI DER – I RF	5, 938	24, 289	3, 912, 876		5, 703, 161	
42.00	04200 SUBPROVI DER		°  °		-	0	
43.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	C	0	1, 180, 884	0	1, 647, 129	43.00
50.00	05000 OPERATI NG ROOM	16, 488	756, 158	1, 466, 812	0	3, 451, 640	50.00
	05001 OUTPATI ENT SURGERY	14, 083				1, 294, 555	1
	05100 RECOVERY ROOM 05300 ANESTHESI OLOGY	5, 551	37, 512 3, 012			535, 039 4, 925, 186	1
53.00 54.00	05400 RADI OLOGY-DI AGNOSTI C	23, 553				2, 868, 412	
54.01	05401 RADI OLOGY-SPECI AL PROCEDURES	1, 542				2, 863, 744	
55.00	05500 RADI OLOGY-THERAPEUTI C	C	°  °	005 (07	-	0	
56.00 60.00	05600 RADI OI SOTOPE 06000 LABORATORY	4, 931 6, 908				541, 694 7, 629, 162	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	2, 831				49, 433	
65.00	06500 RESPI RATORY THERAPY	2, 140				3, 204, 614	
	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	1, 452 556					1
	06800 SPEECH PATHOLOGY	0000	21, 234		-	825, 507	
69.00	06900 ELECTROCARDI OLOGY	3, 808				1, 210, 685	
	07000 ELECTROENCEPHALOGRAPHY	5, 262	7,835			377, 940	1
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS					10, 145, 276 8, 952, 561	
	07300 DRUGS CHARGED TO PATIENTS	C	0	C	-	561, 500	
	03630 ULTRA SOUND	2, 289				972, 317	
	03951 PAIN CLINIC 03952 CATH LAB	12, 323 9, 038				904, 717 2, 946, 085	
	03953 ACTIVITY THERAPEUTIC	5, 706				1, 475, 062	
76.04	03954 WOUND CARE CENTER	6, 364				656, 181	
	03340 BARIATRIC CLINIC	1, 927	8, 934			1, 671, 511	
	03030 HEALTHY LIVING CENTER 03950 CV RESOURCE CENTER				0	0	
	03955 OTHER ANCI LLARY SERVICE COST CENTERS				-	0	1
	03956 LACTATION CLINIC	C	0	C	0 0	0	
	03957 OTHER ANCILLARY SERVICE COST CENTERS 03958 OTHER ANCILLARY SERVICE COST CENTERS				-	0	
	03959 ANTICOAGULATION CLINIC	440	127		-	428, 343	76. 11 76. 12
	07700 ALLOGENEIC STEM CELL ACQUISITION	C	0			0	
	OUTPATIENT SERVICE COST CENTERS	16.000	100.177	0.551.005		7 400 574	
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	16, 082	109, 477	3, 551, 935	0	7, 180, 576	91.00 92.00
7Z. UU	OTHER REIMBURSABLE COST CENTERS	I	I	1		I	72.00
102.00	10200 OPI OI D TREATMENT PROGRAM	C	0	C	0 0	0	102.00
112 00	SPECIAL PURPOSE COST CENTERS	I	1	1	1	[	112 00
113.00	11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117)	399, 395	11, 044, 573	74, 087, 178	-35, 607, 710	134, 349, 485	113.00 118.00
	NONREI MBURSABLE COST CENTERS						
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	796	3, 304	48, 084	0	126, 567	1190.00

Health Financial Systems	FRANCI SCAN HI	EALTH- DYER		In Lie	eu of Form CMS-:	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider CC		Period:	Worksheet B-1	
				From 01/01/2022 To 12/31/2022	Date/Time Pre 5/10/2023 11:	
	CAPI TAL REI	ATED COSTS				
Cost Center Description	BLDG & FI XT (SQUARE FEET)	MVBLE EQUI P (DOLLAR VALUE)	EMPLOYEE BENEFI TS DEPARTMENT (GROSS SALARI ES)	Reconci l i ati on	OTHER ADMI NI STRATI VE AND GENERAL (ACCUM. COST)	
	1.00	2.00	4.00	5A. 04	5.04	
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	13, 697	50, 771	1, 423, 13		2, 316, 189	
192. 01 19201 WORKI NG WELL	0	0	4, 76	2 0		192.01
192. 02 19202 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 C		192. 02
192. 03 19203 MI SC	0	0		0 C		192. 03
194. 00 07950  RESI DENTI AL	30, 307	79, 448	2, 954, 80	7 0	4, 570, 558	
194.01 07954 OTHER NONREI MBURSABLE COST CENTERS	0	0		0 0		194.01
194. 02 07952 PSYCHI ATRI C	26, 481	0		0 0	462, 393	
194.03 07953 CENTER OF HOPE	0	0	85	9 0	1, 588	194.03
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0.010.017		40.400.07	-		201.00
202.00 Cost to be allocated (per Wkst. B, Part I)	8, 218, 617	4, 135, 866	19, 199, 26	1	37, 200, 325	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	17.461305	0. 369997	0. 24451	8	0. 262283	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)			35, 48	5	1, 469, 919	204.00
205.00 Unit cost multiplier (Wkst. B, Part			0. 00045	2	0. 010364	205.00
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

OST A	Financial Systems LLOCATION - STATISTICAL BASIS	FRANCI SCAN HE	Provi der C		eri od:	u of Form CMS-2 Worksheet B-1	
					rom 01/01/2022 o 12/31/2022	Date/Time Pre	
	Cost Center Description	MAI NTENANCE & REPAI RS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY)	HOUSEKEEPI NG (SQUARE FEET)	5/10/2023 11:1 DI ETARY (PATI ENT ME ALS)	
		6.00	7.00	8.00	9.00	10.00	
00	GENERAL SERVICE COST CENTERS						1 1 0
. 00 2. 00 3. 00 5. 04 5. 00 7. 00 3. 00 9. 00 1. 00 3. 00 4. 00 5. 00 6. 00 7. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00593 OTHER ADMINISTRATIVE AND GENERAL 00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	362, 578 20, 147 0 5, 389 4, 754 6, 863 726 6, 121 3, 417 4, 886 0	342, 431 0 5, 389 4, 754 6, 863 726 6, 121 3, 417 4, 886	462, 150 C C C C C C C C C C C C C C C C C C C	337, 042 4, 754 6, 863 726 6, 121 3, 417 4, 886	122, 048 0 0 0 0 0 0 0	11. 0 13. 0 14. 0 15. 0 16. 0
2.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0	c c		0	
	INPATIENT ROUTINE SERVICE COST CENTERS	70.040	70,010	045 (30	70.040		
0.00         1.00         2.00         5.00         1.00         2.00         3.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 03200 CORONARY CARE UNIT 02060 NEONATAL INTENSIVE CARE UNIT 04100 SUBPROVIDER - IRF 04200 SUBPROVIDER 04300 NURSERY	79, 318 9, 931 0 533 5, 938 0 0	79, 318 9, 931 0 533 5, 938 0 0	38, 935 C 3, 614 115, 948 C	9, 931 0 533 5, 938	66, 574 10, 567 0 31, 468 0 0	42.0
0. 00	ANCI LLARY SERVI CE COST CENTERS	16, 488	16, 488	c	16, 488	0	50.0
0. 01	05001 OUTPATI ENT SURGERY	14, 083	14, 083			0	50.0
1.00 3.00	05100 RECOVERY ROOM 05300 ANESTHESI OLOGY	5, 551	5, 551 0			0	51.0 53.0
4.00	05400 RADI OLOGY-DI AGNOSTI C	23, 553	23, 553	-	-	0	54.0
4. 01	05401 RADI OLOGY-SPECI AL PROCEDURES	1, 542	1, 542		., =	0	54.0
5.00	05500 RADI OLOGY-THERAPEUTI C	0	0		-	0	55.0
6.00 0.00	05600 RADI OI SOTOPE 06000 LABORATORY	4, 931 6, 908	4, 931 6, 908		.,	0	56.0 60.0
3.00	06300 BLOOD STORING, PROCESSING & TRANS.	2,831	2, 831			0	63.0
5.00	06500 RESPI RATORY THERAPY	2,140	2, 140		_,	0	65.0
6.00 7.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	1, 452	1, 452 556		.,=	0	66. C
8.00	06800 SPEECH PATHOLOGY	0	0			0	68.0
9.00	06900 ELECTROCARDI OLOGY	3, 808	3, 808	C		0	69.0
	07000 ELECTROENCEPHALOGRAPHY	5, 262			07202	0	1 / 0/ 0
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	
	07300 DRUGS CHARGED TO PATIENTS	0	0	c c	0	0	
6.00	03630 ULTRA SOUND	2, 289	2, 289		2, 289	0	76.0
	03951 PALN CLINIC	12, 323			12, 323	0	76.0
6. 02 6. 03	03952 CATH LAB 03953 ACTI VI TY THERAPEUTI C	9, 038 5, 706	9, 038 5, 706		9, 038 5, 706	0	76.0 76.0
	03954 WOUND CARE CENTER	6, 364			-	0	76.0
	03340 BARIATRIC CLINIC	1, 927	1, 927		1, 927	0	76.0
6.06	03030 HEALTHY LIVING CENTER	0	0	C	0	0	76.0
	03950 CV RESOURCE CENTER 03955 OTHER ANCI LLARY SERVICE COST CENTERS					0	76.0 76.0
	03956 LACTATION CLINIC	0	0		0	0	76.0
6. 10	03957 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76. 1
	03958 OTHER ANCI LLARY SERVICE COST CENTERS	0	0	0	0	0	76.1
	03959 ANTI COAGULATI ON CLINI C	440	440		440	0	
7.00	07700 ALLOGENEIC STEM CELL ACQUISITION OUTPATIENT SERVICE COST CENTERS	0	0		0	0	//.0
	09100 EMERGENCY	16, 082	16, 082	C	16, 082	0	91.0
2.00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS	1		I			92. C
02.00	10200 OPI OI D TREATMENT PROGRAM	0	0	C	0	0	102. 0
40.0-	SPECIAL PURPOSE COST CENTERS						-
13.00 18.00	11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	291, 297	271, 150	412, 631	265, 761	108, 609	113. C 118. C
90.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	796	796	C	796	0	190. 0
	19200 PHYSI CLANS' PRI VATE OFFI CES	13, 697	13, 697				192.0
	19201 WORKING WELL	0					192.0

lealth Financial Systems	FRANCI SCAN H	EALTH- DYER		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider C		Period:	Worksheet B-1	
				rom 01/01/2022 o 12/31/2022	Date/Time Pre 5/10/2023 11:	
Cost Center Description	MAINTENANCE &		LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	REPAI RS	PLANT	LINEN SERVICE	(SQUARE FEET)	(PATIENT ME	
	(SQUARE FEET)	(SQUARE FEET)	(POUNDS OF		ALS)	
			LAUNDRY)			
	6.00	7.00	8.00	9.00	10.00	
192. 03 19203 MI SC	0	0 0	(	0 0		192.03
194. 00 07950  RESI DENTI AL	30, 307	30, 307	(	30, 307		194.00
194.0107954 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0 0	-	194.01
194. 02 07952  PSYCHI ATRI C	26, 481	26, 481	49, 519	26, 481	13, 439	•
194.0307953CENTER OF HOPE	0	0	(	0 0	0	194.03
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B,	5, 561, 652	-1, 283, 576	847, 940	3, 714, 622	814, 926	202.00
Part I)						
203.00 Unit cost multiplier (Wkst. B, Part I	) 15. 339188	0. 000000	1.834772	11. 021244	6. 677094	203.00
204.00 Cost to be allocated (per Wkst. B,	1, 531, 072	2, 072, 912	6, 962	2 150, 015	118, 334	204.00
Part II) 205.00 Unit cost multiplier (Wkst. B, Part	4. 222738	6. 053517	0. 015064	0. 445093	0. 969569	205 00
205.00 Unit cost multiplier (Wkst. B, Part	4. 222738	0. 053517	0.015062	0. 445093	0. 909509	205.00
206.00 NAHE adjustment amount to be allocate	d					206. 00
(per Wkst. B-2)						
207.00 NAHE unit cost multiplier (Wkst. D,						207.00
Parts III and IV)						

	Financial Systems ALLOCATION - STATISTICAL BASIS	FRANCI SCAN H	EALTH- DYER Provider CC		eri od:	u of Form CMS-: Worksheet B-1	
					rom 01/01/2022 o 12/31/2022	Date/Time Pre 5/10/2023 11:	
	Cost Center Description	CAFETERIA (HOURS WORK ED)	NURSI NG ADMI NI STRATI ON (DI RECT NRS	CENTRAL SERVI CES & SUPPLY (COSTED REQUI S.)	PHARMACY (COSTED REQ UI SI )	MEDICAL RECORDS & LI BRARY (GROSS CHAR GES)	
		11.00	I NG) 13.00	14.00	15.00	16.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1.00
$\begin{array}{c} 2.\ 00\\ 4.\ 00\\ 5.\ 04\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 22.\ 00\\ \end{array}$	00200 CAP REL COSTS-MVBLE EQUI P 00400 EMPLOYEE BENEFI TS DEPARTMENT 00593 OTHER ADMI NI STRATI VE AND GENERAL 00600 MAI NTENANCE & REPAI RS 00700 OPERATI ON OF PLANT 00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG 01000 DI ETARY 01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE 02200 I &R SERVI CES-OTHER PRGM COSTS APPRV INPATI ENT ROUTI NE SERVI CE COST CENTERS	61, 276 2, 305 653 1, 869 414 0 185	309, 965 0 0 0 0 0 0	98, 758, 910 38, 683, 784 C C C	4, 721, 698 0 0 0	719, 376, 971 0 0	2.00 4.00 5.04 6.00 7.00 8.00 9.00 10.00 11.00 13.00 14.00 15.00 16.00 17.00 22.00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	13, 326 2, 953		5, 492 44, 670		72, 372, 439 15, 892, 355	
32.00	03200 CORONARY CARE UNIT	2, 733		C	0	0	
35.00 41.00	02060 NEONATAL INTENSIVE CARE UNIT 04100 SUBPROVIDER - IRF	885 4, 873		3, 120 0		1, 581, 420 23, 753, 000	
42.00	04200 SUBPROVI DER	C	0 0	C		23, 733, 000	1
43.00	04300 NURSERY ANCI LLARY SERVICE COST CENTERS	C	0	C	0	2, 274, 484	43.00
50.00	05000 OPERATI NG ROOM	1, 737			16, 680	69, 198, 843	
50. 01 51. 00	05001 OUTPATI ENT SURGERY 05100 RECOVERY ROOM	833 377				4, 258, 017	
53.00	05300 ANESTHESI OLOGY	108		160, 230 C	51, 590	8, 265, 498 18, 737, 042	
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 945		335, 190	5, 505	66, 928, 182	54.00
54.01 55.00	05401 RADI OLOGY-SPECI AL PROCEDURES 05500 RADI OLOGY-THERAPEUTI C	1,099		1, 820, 494	949	9, 636, 549 0	1
56.00	05600 RADI OLOGI - THERAPEOTIC	307	-	2, 842, 489	U U	9, 102, 386	1
60.00	06000 LABORATORY	758	3 O	3, 035, 269	0	73, 270, 506	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	1 000		1, 564, 986		1, 404, 643	
65.00 66.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	1, 090 3, 847		5, 270, 814 C	9, 405	15, 382, 450 19, 978, 323	
67.00	06700 OCCUPATI ONAL THERAPY	888		C	0	5, 131, 595	1
68.00	06800 SPEECH PATHOLOGY	514		253, 068		3, 891, 921	
69. 00 70. 00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	1, 071 251		107, 563 C		27, 556, 508 5, 192, 885	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	231		0	0	42, 346, 338	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	C	0	C	0	18, 489, 109	
73.00 76.00	07300 DRUGS CHARGED TO PATIENTS 03630 ULTRA SOUND	C 631	0	0 110, 700	4, 065, 717	37, 923, 463 12, 884, 112	
76.01	03951 PALN CLINIC	582		83, 666		9, 743, 027	
76.02	03952 CATH LAB	1, 695		21, 377, 007	4, 110	63, 068, 844	
76. 03 76. 04	03953 ACTIVITY THERAPEUTIC 03954 WOUND CARE CENTER	1, 691 536		C 168, 919	0 38, 246	6, 259, 406 2, 771, 666	
76.04	03340 BARIATRIC CLINIC	808	1	240		5, 000, 548	
76.06	03030 HEALTHY LIVING CENTER	C	0 0	C	0	0	76.06
76.07	03950 CV RESOURCE CENTER	C	0	C C	0	0	76.07
76. 08 76. 09	03955 OTHER ANCI LLARY SERVICE COST CENTERS 03956 LACTATI ON CLI NI C					0	76.08 76.09
76. 10	03957 OTHER ANCILLARY SERVICE COST CENTERS	C	o o	C	o o	0	76.10
76.11	03958 OTHER ANCI LLARY SERVICE COST CENTERS	070	0	C	0	0	76.11
76. 12 77. 00		372			0	1, 201, 052 0	1
77.00	OUTPATIENT SERVICE COST CENTERS		, <u> </u>		· · · · · ·		11.00
91.00	09100 EMERGENCY	4, 273	5, 800	42, 320	22, 993	65, 880, 360	
92.00	09200 OBSERVATI ON BEDS (NON-DI STI NCT PART OTHER REI MBURSABLE COST CENTERS	<u> </u>					92.00
102.00	10200 OPI OI D TREATMENT PROGRAM	C	0 0	C	0	0	102.00
112 00	SPECIAL PURPOSE COST CENTERS				1		112 00
113.00 118.00	11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	52, 876	274, 351	98, 758, 910	4, 721, 698	719, 376, 971	113.00 118.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	109		C	0	0	190.00
192.00	19200 PHYSI CLANS' PRI VATE OFFI CES	3, 196		C	o o	0	192.00
192.01	19201 WORKING WELL	4	O	C	0	0	192.01

Health Financial Systems	FRANCI SCAN H	EALTH- DYER		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider CC		Peri od:	Worksheet B-1	
				From 01/01/2022 To 12/31/2022	Date/Time Pre 5/10/2023 11:	
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		ADMI NI STRATI ON	SERVICES &	(COSTED REQ	RECORDS &	
	ED)		SUPPLY	UISI)	LI BRARY	
		(DI RECT NRS	(COSTED		(GROSS CHAR	
		I NG)	REQUIS.)		GES)	
	11.00	13.00	14.00	15.00	16.00	
192. 02 19202 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0		192. 02
192. 03 19203 MI SC	0	0 0		0 0	0	192. 03
194. 00 07950 RESI DENTI AL	5,090	3, 188		0 0	0	194.00
194.0107954 OTHER NONREIMBURSABLE COST CENTERS	0	0		0 0	0	194.01
194. 02 07952 PSYCHI ATRI C	0	0		0 0	0	194. 02
194.03 07953 CENTER OF HOPE	1	0		0 0	0	194.03
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B, Part I)	2, 028, 728	6, 018, 758	1, 030, 13	1 10, 140, 293	1, 949, 788	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	33. 108036	19. 417541	0.01043	1 2.147595	0.002710	203.00
204.00 Cost to be allocated (per Wkst. B,	167, 383	87, 749	181, 47	3 239, 384	124, 252	204.00
Part II)						
205.00 Unit cost multiplier (Wkst. B, Part	2. 731624	0. 283093	0. 00183	8 0. 050699	0.000173	205.00
11)						
206.00 NAHE adjustment amount to be allocated						206.00
(per Wkst. B-2)						
207.00 NAHE unit cost multiplier (Wkst. D,						207.00
Parts III and IV)						

	Financial Systems LLOCATION - STATISTICAL BASIS	FRANCI SCAN HE	Provider CCN: 15-009	0 Period:	u of Form CMS-2552-1 Worksheet B-1
				From 01/01/2022 To 12/31/2022	Date/Time Prepared:
			I NTERNS &		5/10/2023 11:00 am
	Cost Center Description	SOCI AL SERVI CE			
		(GROSS CHAR	PRGM COSTS APPRV		
		GES)	(ASSI GNED		
		17.00	TI ME) 22.00		
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT				1.0
2.00	00200 CAP REL COSTS-MVBLE EQUIP				2.0
4.00 5.04	00400 EMPLOYEE BENEFITS DEPARTMENT 00593 OTHER ADMINISTRATIVE AND GENERAL				4.00 5.0-
6.00	00600 MAI NTENANCE & REPAI RS				6. 0
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE				7.0
8.00 9.00	00900 HOUSEKEEPING				9.0
10. 00	01000 DI ETARY				10. 0
11.00 13.00	01100 CAFETERIA 01300 NURSING ADMINISTRATION				11.0
14.00	01400 CENTRAL SERVICES & SUPPLY				14. 0
15.00	01500 PHARMACY				15. 0
16.00 17.00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	719, 376, 971			16.00 17.00
22.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	/19, 376, 971	100		22. 0
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	-			
30.00	03000 ADULTS & PEDIATRICS	72, 372, 439	100		30.0
31.00 32.00	03100 INTENSIVE CARE UNIT 03200 CORONARY CARE UNIT	15, 892, 355 0	0		31.0
35.00	02060 NEONATAL INTENSIVE CARE UNIT	1, 581, 420	0		35.0
41.00	04100 SUBPROVIDER - IRF	23, 753, 000	0		41.0
42.00 43.00	04200 SUBPROVI DER 04300 NURSERY	02,274,484	0		42.0
101 00	ANCI LLARY SERVI CE COST CENTERS	2,2,1,101			
50.00	05000 OPERATING ROOM	69, 198, 843	0		50.0
50. 01 51. 00	05001 OUTPATI ENT SURGERY 05100 RECOVERY ROOM	4, 258, 017 8, 265, 498	0		50.0 51.0
53.00	05300 ANESTHESI OLOGY	18, 737, 042	0		53. 0
54.00	05400 RADI OLOGY-DI AGNOSTI C	66, 928, 182	0		54.0
54.01 55.00	05401 RADI OLOGY-SPECI AL PROCEDURES 05500 RADI OLOGY-THERAPEUTI C	9, 636, 549	0		54.0 55.0
56.00	05600 RADI OI SOTOPE	9, 102, 386	0		56.0
60.00	06000 LABORATORY	73, 270, 506	0		60.0
63.00 65.00	06300 BLOOD STORI NG, PROCESSI NG & TRANS. 06500 RESPI RATORY THERAPY	1, 404, 643 15, 382, 450	0		63. 0 65. 0
66.00	06600 PHYSI CAL THERAPY	19, 978, 323	0		66. 0
67.00	06700 OCCUPATIONAL THERAPY	5, 131, 595	0		67.0
68.00 69.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	3, 891, 921 27, 556, 508	0		68. 0 69. 0
70.00	07000 ELECTROENCEPHALOGRAPHY	5, 192, 885	Ö		70.0
71.00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	42, 346, 338	0		71.0
72.00 73.00	07200 I MPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS	18, 489, 109 37, 923, 463	0		72.0
76.00	03630 ULTRA SOUND	12, 884, 112	0		76.0
76.01	03951 PALN CLINIC	9, 743, 027	0		76.0
76.02 76.03	03952 CATH LAB 03953 ACTI VI TY THERAPEUTI C	63, 068, 844 6, 259, 406	0		76. 0 76. 0
76. 04	03954 WOUND CARE CENTER	2, 771, 666	0		76.0
76.05	03340 BARI ATRI C CLI NI C	5, 000, 548	0		76.0
76.06 76.07	03030 HEALTHY LIVING CENTER 03950 CV RESOURCE CENTER	0	0		76. 0 76. 0
76. 08	03955 OTHER ANCILLARY SERVICE COST CENTERS	0	0		76.0
76.09	03956 LACTATION CLINIC	0	0		76.0
76. 10 76. 11	03957 OTHER ANCILLARY SERVICE COST CENTERS 03958 OTHER ANCILLARY SERVICE COST CENTERS	0	0		76. 10 76. 1
76. 12	03959 ANTI COAGULATI ON CLINIC	1, 201, 052	Ō		76. 1
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0		77. 0
91.00	OUTPATIENT SERVICE COST CENTERS 09100 EMERGENCY	65, 880, 360	0		91.0
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART				92.0
100.00	OTHER REIMBURSABLE COST CENTERS				100.0
102.00	10200 OPI OI D TREATMENT PROGRAM SPECIAL PURPOSE COST CENTERS	0	0		102. 0
	11300 INTEREST EXPENSE				113. 0
118.00		719, 376, 971	100		118. 0
	NONREI MBURSABLE COST CENTERS	0	0		

Health Financial Systems	FRANCI SCAN HE	ALTH- DYER		In Lieu	J of Form CMS-2552	2-10
COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 15	5-0090	Peri od:	Worksheet B-1	
				From 01/01/2022 To 12/31/2022	Date/Time Prepar 5/10/2023 11:00	
		INTERNS &				
		RESIDENTS				
Cost Center Description	SOCI AL SERVI CE					
	(GROSS CHAR	PRGM COSTS APPRV				
	(GRUSS CHAR GES)	(ASSI GNED				
	ULS)	TIME)				
	17.00	22.00				
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0			192	2.00
192.01 19201 WORKING WELL	0	0			192	2. 01
192. 02 19202 PHYSI CLANS' PRI VATE OFFI CES	0	0				2. 02
192. 03 19203 MI SC	0	0				2. 03
194. 00 07950  RESI DENTI AL	0	0				4.00
194. 01 07954 OTHER NONREI MBURSABLE COST CENTERS	0	0				4.01
194. 02 07952 PSYCHI ATRI C	0	0				4.02
194. 03 07953 CENTER OF HOPE	0	0				4.03
200.00Cross Foot Adjustments201.00Negative Cost Centers						D. 00 1. 00
202.00 Cost to be allocated (per Wkst. B,	0	390, 249				2.00
Part I)	0	390, 249			202	2.00
203.00 Unit cost multiplier (Wkst. B, Part I)	0. 000000	3, 902. 490000			203	3.00
204.00 Cost to be allocated (per Wkst. B,	0	3, 743			204	4.00
Part II)						
205.00 Unit cost multiplier (Wkst. B, Part	0. 000000	37.430000			205	5.00
11)						
206.00 NAHE adjustment amount to be allocated					206	6.00
(per Wkst. B-2)						
207.00 NAHE unit cost multiplier (Wkst. D,					207	7.00
Parts III and IV)					I	

Health Financial Systems	FRANCI SCAN HE	ALTH- DYER		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period:	Worksheet C	
				From 01/01/2022 To 12/31/2022	Part I Date/Time Pre	pared.
					5/10/2023 11:	00 am
		Title	XVIII	Hospi tal	PPS	
Cont. Conton Decemintion	Tatal Cast	The second states the	Tatal Casta	Costs	Tatal Casta	
Cost Center Description	Total Cost (from Wkst. B,	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	Part I, col.	Adj .		Di Sal i Owanee		
	26)					
	1.00	2.00	3.00	4.00	5.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0 057 044		0 / 057 01		0/ 057 0//	
30. 00 03000 ADULTS & PEDIATRICS	36, 857, 011		36, 857, 01			•
31. 00 03100 I NTENSI VE CARE UNI T 32. 00 03200 CORONARY CARE UNI T	6, 235, 602 0		6, 235, 60	2 0 0 0	6, 235, 602 0	
35. 00 02060 NEONATAL INTENSIVE CARE UNIT	2, 113, 895		2, 113, 89	-	2, 113, 895	
41. 00 04100 SUBPROVI DER – I RF	8, 557, 412		8, 557, 41		8, 557, 412	•
42. 00 04200 SUBPROVI DER	0			0 0		
43. 00 04300 NURSERY	2, 100, 831		2, 100, 83	1 0	2, 100, 831	43.00
ANCI LLARY SERVI CE COST CENTERS						-
50. 00 05000 OPERATI NG ROOM	5, 807, 585		5, 807, 58			
50. 01 05001 0UTPATIENT SURGERY 51. 00 05100 RECOVERY ROOM	2, 559, 951 1, 279, 586		2, 559, 95			
53. 00 05300 ANESTHESI OLOGY	6, 382, 126		1, 279, 58 6, 382, 12		6, 382, 126	•
54. 00 05400 RADI OLOGY-DI AGNOSTI C	4, 503, 015		4, 503, 01			•
54. 01 05401 RADI OLOGY-SPECI AL PROCEDURES	3, 816, 469		3, 816, 46		3, 816, 469	•
55. 00 05500 RADI OLOGY-THERAPEUTI C	0			0 0	0	55.00
56. 00 05600 RADI OI SOTOPE	1, 416, 206		1, 416, 20	6 0	1, 416, 206	56.00
60. 00 06000 LABORATORY	10, 067, 856		10, 067, 85		10, 067, 856	
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	157, 155		157, 15			•
65. 00 06500 RESPIRATORY THERAPY	4, 254, 493	0			4, 254, 493	
66. 00 06600 PHYSICAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	6, 684, 510 1, 454, 727	0			6, 684, 510 1, 454, 727	1
68. 00 06800 SPEECH PATHOLOGY	1, 072, 228	0	1, 072, 22		1, 072, 228	1
69. 00 06900 ELECTROCARDI OLOGY	2,009,014	0	2, 009, 01		2,009,014	•
70.00 07000 ELECTROENCEPHALOGRAPHY	638, 159		638, 15		638, 159	•
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	12, 920, 968		12, 920, 96	8 0	12, 920, 968	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	11, 350, 771		11, 350, 77	1 0	11, 350, 771	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	9, 543, 056		9, 543, 05		9, 543, 056	•
76.00 03630 ULTRA SOUND	1, 344, 679		1, 344, 67		1, 344, 679	•
76.01 03951 PALN CLINIC 76.02 03952 CATH LAB	1, 547, 936		1, 547, 93		1, 547, 936	•
76. 03   03953   ACTI VI TY THERAPEUTI C	4, 984, 722 2, 089, 948		4, 984, 72 2, 089, 94		4, 989, 223 2, 124, 289	•
76. 04 03954 WOUND CARE CENTER	1, 105, 200		1, 105, 20		1, 105, 200	•
76. 05 03340 BARI ATRI C CLI NI C	2, 465, 242		2, 465, 24		2, 465, 242	•
76.06 03030 HEALTHY LIVING CENTER	0			0 0	0	76.06
76.07 03950 CV RESOURCE CENTER	0			0 0	0	76.07
76.08 03955 OTHER ANCI LLARY SERVICE COST CENTERS	0			0 0	0	
76. 09 03956 LACTATION CLINIC	0			0 0	0	76.09
76. 10 03957 OTHER ANCI LLARY SERVICE COST CENTERS 76. 11 03958 OTHER ANCI LLARY SERVICE COST CENTERS	0			0 0 0 0		
76. 12 03959 ANTI COAGULATI ON CLINIC	567, 859		567, 85		-	
77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION	0			0 0		
OUTPATIENT SERVICE COST CENTERS				<u> </u>		
91. 00 09100 EMERGENCY	9, 970, 298		9, 970, 29	8 45, 002	10, 015, 300	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	4, 573, 877		4, 573, 87	7	4, 573, 877	92.00
OTHER REIMBURSABLE COST CENTERS					-	
102.00 10200 OPI 0I D TREATMENT PROGRAM SPECI AL PURPOSE COST CENTERS	0			0	0	102.00
113. 00 11300 INTEREST EXPENSE	1					113.00
200.00 Subtotal (see instructions)	170, 432, 387	0	170, 432, 38	7 83, 844	170, 516, 231	
201.00 Less Observation Beds	4, 573, 877		4, 573, 87		4, 573, 877	
202.00 Total (see instructions)	165, 858, 510					

Health Financial Systems	FRANCI SCAN HE	ALTH- DYER		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2022 To 12/31/2022	Worksheet C Part I Date/Time Pre 5/10/2023 11:	
		Title	× XVIII	Hospi tal	PPS	
		Charges			110	
Cost Center Description	I npati ent	Outpati ent	Total (col. ( + col. 7)	6 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 & PEDI ATRI CS	62, 415, 690		62, 415, 69	0		30.00
31.00 03100 INTENSIVE CARE UNIT	15, 892, 355		15, 892, 35	5		31.00
32.00 03200 CORONARY CARE UNI T	0			0		32.00
35.00 02060 NEONATAL INTENSIVE CARE UNIT	1, 581, 420		1, 581, 42			35.00
41.00 04100 SUBPROVIDER - IRF	23, 753, 000		23, 753, 00	0		41.00
42. 00 04200 SUBPROVI DER	0			0		42.00
43. 00 04300 NURSERY	2, 274, 484		2, 274, 48	4		43.00
ANCI LLARY SERVICE COST CENTERS	21 745 201	47 452 552	(0.100.04	0 000000	0,000000	
50. 00 05000 OPERATING ROOM	21, 745, 291	47, 453, 552			0.00000	
50. 01 05001 0UTPATI ENT SURGERY 51. 00 05100 RECOVERY ROOM	2, 315, 653 2, 683, 128	1,942,364			0. 000000 0. 000000	
53. 00 05300 ANESTHESI OLOGY	2, 083, 128 7, 788, 484	5, 582, 370 10, 948, 558			0. 000000	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	22, 893, 048	44, 035, 134			0. 000000	
54. 01 05401 RADIOLOGY-SPECIAL PROCEDURES	4, 735, 864	4, 900, 685			0. 000000	
55. 00 05500 RADI OLOGY-THERAPEUTI C	4, 735, 804	4, 900, 005	7,030,34	0. 000000	0. 000000	
56. 00 05600 RADIOLOGI - MERALEUTIC	1, 269, 399	7, 832, 987	9, 102, 38		0. 000000	
60. 00 06000 LABORATORY	38, 034, 175	35, 236, 331			0. 000000	
63. 00 06300 BLOOD STORING, PROCESSING & TRAN		361, 955			0. 000000	
65. 00 06500 RESPI RATORY THERAPY	14, 699, 647	682, 803			0. 000000	
66. 00 06600 PHYSI CAL THERAPY	5, 124, 860	14, 853, 463			0. 000000	
67.00 06700 OCCUPATI ONAL THERAPY	4, 763, 729	367, 866			0.000000	
68.00 06800 SPEECH PATHOLOGY	2, 572, 946	1, 318, 975			0.00000	
69.00 06900 ELECTROCARDI OLOGY	9, 964, 299	17, 592, 209			0.00000	
70.00 07000 ELECTROENCEPHALOGRAPHY	619, 421	4, 573, 464	5, 192, 88	5 0. 122891	0. 000000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATI	ENT 22, 088, 621	20, 257, 717	42, 346, 33	8 0. 305126	0. 000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	14, 527, 276	3, 961, 833	18, 489, 10	9 0. 613917	0. 000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	28, 432, 187	9, 491, 276	37, 923, 46	3 0. 251640	0. 000000	73.00
76.00 03630 ULTRA SOUND	3, 913, 257	8, 970, 855	12, 884, 11	2 0. 104367	0. 000000	76.00
76.01 03951 PAIN CLINIC	38, 710	9, 704, 317	9, 743, 02	7 0. 158876	0.00000	76.01
76.02 03952 CATH LAB	22, 394, 660	40, 674, 184	63, 068, 84		0. 000000	
76. 03 03953 ACTI VI TY THERAPEUTI C	3, 176, 864	3, 082, 542			0. 000000	
76.04 03954 WOUND CARE CENTER	12, 788	2, 758, 878			0. 000000	
76. 05 03340 BARI ATRI C CLI NI C	1, 320	4, 999, 228			0.00000	
76.06 03030 HEALTHY LIVING CENTER	0	0		0 0.000000	0.00000	
76. 07 03950 CV RESOURCE CENTER	0	0		0 0.000000	0.00000	
76. 08 03955 OTHER ANCI LLARY SERVICE COST CEN	ITERS 0	0		0 0.000000	0.00000	
76. 09 03956 LACTATION CLINIC		0		0 0.000000	0. 000000	
76. 10 03957 OTHER ANCI LLARY SERVICE COST CEN		0		0 0.000000	0. 000000	
76. 11 03958 OTHER ANCILLARY SERVICE COST CEN	ITERS 0	0 1, 199, 392	1 201 05	0 0.000000	0. 000000 0. 000000	
76.12 03959 ANTICOAGULATION CLINIC 77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	1, 660 I 0	1, 199, 392		2 0. 472801 0 0. 000000		
OUTPATIENT SERVICE COST CENTERS		0	1	0 0.00000	0.00000	//.00
91. 00 09100 EMERGENCY	23, 948, 795	41, 931, 565	65, 880, 36	0 0. 151339	0. 000000	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT P		8, 539, 752			0. 000000	
OTHER REIMBURSABLE COST CENTERS	1,410,997	0, 337, 732	7, 700, 74	0.407370	0.00000	72.00
102.00 10200 OPI OI D TREATMENT PROGRAM	0	0		0		102.00
SPECIAL PURPOSE COST CENTERS		0	1	<u>~</u>		
113. 00 11300 I NTEREST EXPENSE						1113.00
200.00 Subtotal (see instructions)	366, 122, 716	353, 254, 255	719, 376, 97	1		200.00
201.00 Less Observation Beds	,,	, ,				201.00
202.00 Total (see instructions)	366, 122, 716	353, 254, 255	719, 376, 97	1		202.00
			•	1		

Heal th	Financial Systems	FRANCI SCAN HEA	LTH- DYER	In Lie	u of Form CMS-	2552-10
COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0090	Period: From 01/01/2022	Worksheet C Part I	
				To 12/31/2022	Date/Time Pre	
				llaoni tal	5/10/2023 11:	00 am
	Cost Center Description	PPS Inpatient	Title XVIII	Hospi tal	PPS	
		Ratio				
		11.00				
~~ ~~	INPATIENT ROUTINE SERVICE COST CENTERS					
	03000 ADULTS & PEDIATRICS					30.00
	03100 I NTENSI VE CARE UNI T 03200 CORONARY CARE UNI T					31.00
	02060 NEONATAL INTENSIVE CARE UNIT					35.00
41.00	04100 SUBPROVIDER - IRF					41.00
	04200 SUBPROVI DER					42.00
	04300 NURSERY					43.00
101.00	ANCI LLARY SERVICE COST CENTERS					101.00
50.00	05000 OPERATI NG ROOM	0. 083926				50.00
50.01	05001 OUTPATI ENT SURGERY	0.601207				50.01
51.00	05100 RECOVERY ROOM	0. 154811				51.00
53.00	05300 ANESTHESI OLOGY	0. 340615				53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 067281				54.00
54.01	05401 RADI OLOGY-SPECI AL PROCEDURES	0. 396041				54.01
55.00	05500 RADI OLOGY-THERAPEUTI C	0.000000				55.00
56.00	05600 RADI OI SOTOPE	0. 155586				56.00
60.00	06000 LABORATORY	0. 137407				60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 111883				63.00
65.00	06500 RESPI RATORY THERAPY	0. 276581				65.00
66.00	06600 PHYSI CAL THERAPY	0. 334588				66.00
67.00	06700 OCCUPATIONAL THERAPY	0. 283484				67.00
68.00		0. 275501				68.00
69.00		0.072905				69.00
	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 122891 0. 305126				70.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 613917				72.00
	07300 DRUGS CHARGED TO PATIENTS	0. 251640				73.00
	03630 ULTRA SOUND	0. 104367				76.00
	03951 PALN CLINIC	0. 158876				76.01
	03952 CATH LAB	0. 079108				76.02
	03953 ACTIVITY THERAPEUTIC	0. 339375				76.03
	03954 WOUND CARE CENTER	0. 398749				76.04
76.05	03340 BARIATRIC CLINIC	0. 492994				76.05
76.06	03030 HEALTHY LIVING CENTER	0.000000				76.06
76.07	03950 CV RESOURCE CENTER	0. 000000				76.07
	03955 OTHER ANCI LLARY SERVICE COST CENTERS	0. 000000				76.08
	03956 LACTATION CLINIC	0. 000000				76.09
	03957 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000				76.10
	03958 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000				76.11
	03959 ANTI COAGULATI ON CLINIC	0. 472801				76.12
77.00	07700 ALLOGENEI C STEM CELL ACQUI SI TI ON	0. 000000				77.00
01 00		0 150020				01 00
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 152023 0. 459375				91.00 92.00
92. UU	OTHER REIMBURSABLE COST CENTERS	0. 439375				↓ <del>9</del> 2.00
102 00	10200 OPI OI D TREATMENT PROGRAM					102.00
.02.00	SPECIAL PURPOSE COST CENTERS					1.02.00
113.00	11300 I NTEREST EXPENSE					113.00
200.00						200.00
						201.00
201.00	Less Observation Beds					201.00

Health Financial Systems	FRANCI SCAN HE	ALTH- DYER		In Lie	u of Form CMS-:	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2022 To 12/31/2022	Worksheet C Part I Date/Time Pre	pared:
		T; +1		Hocni tol	5/10/2023 11: Cost	<u>00 am</u>
			e XIX	<u>Hospi tal</u> Costs	COST	
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
cost center bescription	(from Wkst. B,	Adj.		Di sal I owance		
	Part I, col.	naj .		Di Sal i Onarice		
	26)					
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS			•			
30. 00 03000 ADULTS & PEDIATRICS	36, 857, 011		36, 857, 01	1 0	36, 857, 011	30.00
31. 00 03100 I NTENSI VE CARE UNI T	6, 235, 602		6, 235, 60	2 0	6, 235, 602	31.00
32.00 03200 CORONARY CARE UNI T	0			0 0	0	32.00
35.00 02060 NEONATAL INTENSIVE CARE UNIT	2, 113, 895		2, 113, 89	5 0	2, 113, 895	35.00
41. 00 04100 SUBPROVI DER – I RF	8, 557, 412		8, 557, 41		8, 557, 412	•
42.00 04200 SUBPROVI DER	0			0 0	0	
43.00 04300 NURSERY	2, 100, 831		2, 100, 83	1 0	2, 100, 831	43.00
ANCI LLARY SERVI CE COST CENTERS	5 007 505		5 007 50	-	5 007 505	
50. 00 05000 OPERATING ROOM	5, 807, 585		5, 807, 58		5, 807, 585	
50. 01 05001 OUTPATIENT SURGERY	2, 559, 951		2, 559, 95		2, 559, 951	•
51.00 05100 RECOVERY ROOM	1, 279, 586		1, 279, 58		1, 279, 586	•
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C	6, 382, 126		6, 382, 12		6, 382, 126	
	4, 503, 015		4, 503, 01		4, 503, 015 3, 816, 469	
54. 01 05401 RADI OLOGY-SPECI AL PROCEDURES 55. 00 05500 RADI OLOGY-THERAPEUTI C	3, 816, 469 0		3, 816, 46	9 0 0 0	3, 810, 409	
56. 00 05600 RADIOLOGI - THERAPEUTIC	1, 416, 206		1, 416, 20		1, 416, 206	•
60. 00 06000 LABORATORY	10, 067, 856		10, 067, 85		10, 067, 856	•
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	157, 155		157, 15		157, 155	
65. 00 06500 RESPIRATORY THERAPY	4, 254, 493	0			4, 254, 493	
66. 00 06600 PHYSI CAL THERAPY	6, 684, 510	0		-	6, 684, 510	1
67. 00 06700 OCCUPATIONAL THERAPY	1, 454, 727	0			1, 454, 727	1
68. 00 06800 SPEECH PATHOLOGY	1, 072, 228	0	1, 072, 22	-	1, 072, 228	1
69. 00 06900 ELECTROCARDI OLOGY	2,009,014	0	2,009,01		2,009,014	1
70. 00 07000 ELECTROENCEPHALOGRAPHY	638, 159		638, 15		638, 159	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT			12, 920, 96		12, 920, 968	•
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	11, 350, 771		11, 350, 77		11, 350, 771	•
73.00 07300 DRUGS CHARGED TO PATIENTS	9, 543, 056		9, 543, 05		9, 543, 056	•
76.00 03630 ULTRA SOUND	1, 344, 679		1, 344, 67	9 0	1, 344, 679	76.00
76.01 03951 PAIN CLINIC	1, 547, 936		1, 547, 93	6 0	1, 547, 936	76.01
76.02 03952 CATH LAB	4, 984, 722		4, 984, 72	2 4, 501	4, 989, 223	76.02
76. 03 03953 ACTI VI TY THERAPEUTI C	2, 089, 948		2, 089, 94	8 34, 341	2, 124, 289	76.03
76.04 03954 WOUND CARE CENTER	1, 105, 200		1, 105, 20	0 0	1, 105, 200	76.04
76. 05 03340 BARIATRIC CLINIC	2, 465, 242		2, 465, 24	2 0	2, 465, 242	76.05
76.06 03030 HEALTHY LIVING CENTER	0			0 0	0	•
76.07 03950 CV RESOURCE CENTER	0			0 0	0	
76.08 03955 OTHER ANCILLARY SERVICE COST CENTER	S 0			0 0	0	
76. 09 03956 LACTATION CLINIC	0			0 0	0	
76. 10 03957 OTHER ANCI LLARY SERVICE COST CENTER				0 0	0	•
76. 11 03958 OTHER ANCI LLARY SERVICE COST CENTER				0 0	0	
76. 12 03959 ANTI COAGULATI ON CLINI C	567, 859		567, 85		567, 859	
77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION	0			0 0	0	77.00
0UTPATI ENT SERVI CE COST CENTERS 91. 00 09100 EMERGENCY	9, 970, 298		9, 970, 29	8 45, 002	10, 015, 300	01 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART			4, 573, 87		4, 573, 877	
072.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	4, 373, 877		4, 373, 87	/	4, 373, 677	72.00
102.00 10200 OPI OI D TREATMENT PROGRAM	0			0	0	102.00
SPECIAL PURPOSE COST CENTERS					0	102.00
113. 00 11300 I NTEREST EXPENSE						113.00
200.00 Subtotal (see instructions)	170, 432, 387	0	170, 432, 38	7 83, 844	170, 516, 231	
201.00 Less Observation Beds	4, 573, 877	0	4, 573, 87		4, 573, 877	
202.00 Total (see instructions)	165, 858, 510	0				
		-				

Health Financial Systems	FRANCI SCAN HE	ALTH- DYER		In Lie	eu of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0090		Period: Worksheet C		
				From 01/01/2022 To 12/31/2022		nared
				10 12/31/2022	5/10/2023 11:	
			e XIX	Hospi tal	Cost	
		Charges				
Cost Center Description	I npati ent	Outpati ent	Total (col. d		TEFRA	
			+ col. 7)	Ratio	Inpati ent	
	6.00	7.00	8.00	9.00	Ratio 10.00	
INPATIENT ROUTINE SERVICE COST CENTERS	6.00	7.00	0.00	9.00	10.00	
30. 00 03000 ADULTS & PEDI ATRI CS	62, 415, 690		62, 415, 69	0		30.00
31. 00 03100 I NTENSI VE CARE UNI T	15, 892, 355		15, 892, 35			31.00
32. 00 03200 CORONARY CARE UNI T	0		10,072,00	0		32.00
35.00 02060 NEONATAL INTENSIVE CARE UNIT	1, 581, 420		1, 581, 42	0		35.00
41.00 04100 SUBPROVIDER - IRF	23, 753, 000		23, 753, 00			41.00
42. 00 04200 SUBPROVI DER	0			0		42.00
43. 00 04300 NURSERY	2, 274, 484		2, 274, 48	4		43.00
ANCI LLARY SERVI CE COST CENTERS				_		
50. 00 05000 OPERATI NG ROOM	21, 745, 291	47, 453, 552				
50. 01 05001 OUTPATI ENT SURGERY	2, 315, 653	1, 942, 364			0. 601207	50. 01
51.00 05100 RECOVERY ROOM	2, 683, 128	5, 582, 370			0. 154811	
53.00 05300 ANESTHESI OLOGY	7, 788, 484	10, 948, 558			0.340615	1
54. 00 05400 RADI OLOGY-DI AGNOSTI C	22, 893, 048	44,035,134			0.067281	54.00
54. 01 05401 RADI OLOGY-SPECI AL PROCEDURES	4, 735, 864	4, 900, 685	9, 636, 54		0. 396041	54.01
55. 00 05500 RADI OLOGY-THERAPEUTI C 56. 00 05600 RADI OI SOTOPE	0	0	0 100 00	0 0.00000	0. 000000	
	1, 269, 399 38, 034, 175	7,832,987	9, 102, 38 73, 270, 50			1
60.00 06000 LABORATORY 63.00 06300 BLOOD STORING, PROCESSING & TRANS.		35, 236, 331 361, 955			0. 137407	60.00 63.00
65. 00 06500 RESPIRATORY THERAPY	1, 042, 688 14, 699, 647	682, 803			0. 111883 0. 276581	65.00
66. 00 06600 PHYSI CAL THERAPY	5, 124, 860	14, 853, 463				
67. 00 06700 OCCUPATI ONAL THERAPY	4, 763, 729	367, 866			0. 283484	67.00
68. 00 06800 SPEECH PATHOLOGY	2, 572, 946	1, 318, 975			0. 275501	68.00
69. 00 06900 ELECTROCARDI OLOGY	9, 964, 299	17, 592, 209			0.072905	1
70. 00 07000 ELECTROENCEPHALOGRAPHY	619, 421	4, 573, 464			0. 122891	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	22, 088, 621	20, 257, 717			0. 305126	
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	14, 527, 276	3, 961, 833			0.613917	
73.00 07300 DRUGS CHARGED TO PATIENTS	28, 432, 187	9, 491, 276				
76. 00 03630 ULTRA SOUND	3, 913, 257	8, 970, 855			0. 104367	76.00
76.01 03951 PALN CLINIC	38, 710	9, 704, 317	9, 743, 02			
76.02 03952 CATH LAB	22, 394, 660	40, 674, 184			0.079036	76.02
76. 03 03953 ACTI VI TY THERAPEUTI C	3, 176, 864	3, 082, 542	6, 259, 40	6 0. 333889	0. 333889	76.03
76.04 03954 WOUND CARE CENTER	12, 788	2, 758, 878	2, 771, 66	6 0. 398749	0. 398749	76.04
76. 05 03340 BARI ATRI C CLI NI C	1, 320	4, 999, 228	5, 000, 54	8 0. 492994	0. 492994	76.05
76.06 03030 HEALTHY LIVING CENTER	0	0		0 0.000000	0.000000	76.06
76.07 03950 CV RESOURCE CENTER	0	0		0 0. 000000	0.000000	76.07
76.08 03955 OTHER ANCILLARY SERVICE COST CENTERS	0	0		0 0. 000000		
76.09 03956 LACTATION CLINIC	0	0		0 0.000000	0. 000000	
76.10 03957 OTHER ANCILLARY SERVICE COST CENTERS	0	0		0 0.000000	0.000000	
76.11 03958 OTHER ANCILLARY SERVICE COST CENTERS	0	0		0 0.00000	0.000000	
76. 12 03959 ANTI COAGULATI ON CLINIC	1,660	1, 199, 392			0. 472801	
77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0		0 0. 000000	0. 000000	77.00
	22 040 705	41 021 5/5	(E 000 3/	0 0 151000	0 151000	01 00
91.00 09100 EMERGENCY	23, 948, 795	41, 931, 565				
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART OTHER REI MBURSABLE COST CENTERS	1, 416, 997	8, 539, 752	9, 956, 74	9 0. 459375	0. 459375	92.00
				ol		102 00
102.00 10200 OPI OI D TREATMENT PROGRAM SPECI AL PURPOSE COST CENTERS	0	0	l	0	I	102.00
113. 00 11300 INTEREST EXPENSE						113.00
200.00 Subtotal (see instructions)	366, 122, 716	353, 254, 255	719, 376, 97	1		200.00
201.00 Less Observation Beds	500, 122, 710	555, 257, 255	, , , , , , , , , , , , , , , , , , , ,	'		201.00
202.00 Total (see instructions)	366, 122, 716	353, 254, 255	719, 376, 97	1		202.00
	,,,,		, , , , , ,	ļ.	1	

31.00       03100 [ INTENSI VE CARE UNI T       33.1         32.00       03200 [ ORONARY CARE UNI T       33.2         35.00       02006 NEONATAL INTENSI VE CARE UNI T       33.2         42.00       04200 SUBPROVI DER       43.1         42.00       04200 SUBPROVI DER       43.2         MACILLARY SERVICE COST CENTERS       43.0         MACILLARY SERVICE COST CENTERS       50.0         MACILLARY SERVICE COST CENTERS       0.000000         50.01       05000 [ OUTSATI ENT SURGERY       0.000000         51.00       05000 [ OUTSATI ENT SURGERY       0.000000         51.00       05000 [ ANESTRY       0.000000         51.00       05000 [ ANESTRY       0.000000         51.00       05000 [ ANESTRY       0.000000         55.00       05500 [ RADI OLOGY-THERAPUTI C       0.000000         55.00       05500 [ RADI OLOGY-THERAPUTI C       0.000000         66.00       06500 [ RESPI RATORY THERAPY       0.000000         67.00       05500 [ RESPI RATORY THERAPY       0.000000         66.00       06500 [ RESPI RATORY THERAPY       0.000000         67.00       05700 [ RESPI RATORY THERAPY       0.000000         67.00       05700 [ OUTSATI THERAPY       0.000000	Heal th	Financial Systems	FRANCI SCAN HEA	LTH- DYER	In Lie	u of Form CMS-2	2552-10
To         12/31/202         Date Time Prepared           INPATIENT ROUTINE SERVICE COST CENTERS         100/2023         11:00         000           100/2023         11:00         11:00         000         0000           100/2023         10:00         0000         0000         0000           100/2023         00:000         00000         00000         00000         00000           100/2023         00:0000         00000         00000         00000         00000         00000         00000         00000         000000         000000         000000         000000         0000000         0000000         0000000         0000000         0000000         0000000         00000000         00000000         00000000         00000000         0000000         00000000         0000000         000000000         000000000         00000	COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0090			
Cost Center Description         PPS Inpatient Ratio         Title XIX         Hospital         Cost           0         00000 AAULTS AF HELAKIN CS COST CENTERS         000000 AAULTS AF HELAKIN CS COST CENTERS         000000 AAULTS AF HELAKIN CS COST CENTERS         0000000 AAULTS AF							pared:
Cost Center Description         PPS Inpatient Ratio           Natio         11.00           11.00         11.00           11.00         30.00           30.00         30000 AuUTS & HEDLATRICS           31.00         31.00           32.00         30.00           32.00         30.00           32.00         30.00           32.00         30.00           32.00         30.00           32.00         30.00           32.00         30.00           32.00         30.00           32.00         30.00           32.00         30.00           32.00         30.00           32.00         30.00           32.00         91.00           32.00         91.00           32.00         91.00           33.00         91.00           33.00         91.00           33.00         91.00           33.00         91.00           33.00         91.00           33.00         91.00           33.00         91.00           33.00         91.00           33.00         91.00           33.00 <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td>00 am</td></td<>							00 am
PRATIENT ROUTINE SERVICE COST CENTERS         30.0           11.00         31.00         33.00         30.00           12.00         31.00         31.00         31.00         31.00           12.00         31.00         31.00         31.00         31.00         31.00           12.00         32.00         31.00 </td <td></td> <td>Cast Contar Description</td> <td>DDS Innationt</td> <td>litle XIX</td> <td>Hospital</td> <td>Cost</td> <td></td>		Cast Contar Description	DDS Innationt	litle XIX	Hospital	Cost	
INPATIENT ROUTINE SERVICE COST CENTERS         30.00         3000 ADULTS & PEDIATRICS         30.01           30.00         3000 ADULTS & PEDIATRICS         30.01         30.01         30.01           32.00         02200 CORMARY CARE UNIT         32.01         32.01         30.01           31.00         03100 DITESS VE CARE UNIT         32.01         32.01         30.01           32.00         03200 CORMARY CARE UNIT         32.01         32.		cost center bescription					
30.00         03000 ADULTS & PEDLATRICS         30.01           31.00         03100 (THENS VE CARE UNIT         31.0           32.00         03200 (CORNARY CARE UNIT         32.0           32.00         03200 (CORNARY CARE UNIT         32.0           41.00         04100 (SUBPRAVI DER - 1 RF         43.0           43.00         04300 (NURSERV         43.0           ARCICLARY SERVICE COST CENTERS         43.0           50.01         05000 (OPENATI IN ROM         0.000000           51.00         05000 (APENATI NO ROM         0.000000           51.00         05000 (APENATI NO ROM         0.000000           51.00         05100 (RECOVERY ROM         0.000000           51.00         05400 (ARDICLA'- DI ARMOSTI C         0.000000           52.00         05300 (RECOVERY ROM         0.000000           53.00         05300 (RECOVERY ROM         0.000000           54.00         05400 RADI CLA'- PHEAPEUTIC         0.000000           55.00         05500 ROM ROM THERAY         0.000000           56.00         05600 ROM ROM THERAY         0.000000           56.00         05600 ROM ROM THERAY         0.000000           56.00         05600 ROM ROM THERAY         0.0000000           56.00							
31.00       03100 [ INTENSI VE CARE UNI T       33.1         32.00       03200 [ ORONARY CARE UNI T       33.2         35.00       02006 NEONATAL INTENSI VE CARE UNI T       33.2         42.00       04200 SUBPROVI DER       43.1         42.00       04200 SUBPROVI DER       43.2         MACILLARY SERVICE COST CENTERS       43.0         MACILLARY SERVICE COST CENTERS       50.0         MACILLARY SERVICE COST CENTERS       0.000000         50.01       05000 [ OUTSATI ENT SURGERY       0.000000         51.00       05000 [ OUTSATI ENT SURGERY       0.000000         51.00       05000 [ ANESTRY       0.000000         51.00       05000 [ ANESTRY       0.000000         51.00       05000 [ ANESTRY       0.000000         55.00       05500 [ RADI OLOGY-THERAPUTI C       0.000000         55.00       05500 [ RADI OLOGY-THERAPUTI C       0.000000         66.00       06500 [ RESPI RATORY THERAPY       0.000000         67.00       05500 [ RESPI RATORY THERAPY       0.000000         66.00       06500 [ RESPI RATORY THERAPY       0.000000         67.00       05700 [ RESPI RATORY THERAPY       0.000000         67.00       05700 [ OUTSATI THERAPY       0.000000							
32:00       03200 COROMARY CARE UNIT       32:0         30:00       0300 NENATAL INTENSIVE CARE UNIT       41:0         41:00       04100 SUBPROVIDER - 1 RF       41:0         43:00       04300 NURSERY       42:0         AROULLARY SERVICE COST CENTERS       50:00         05:000 OPERATING ROOM       0.000000         05:000 RECOVERY ROOM       0.000000         05:000 SAGO RADIOLOGY - DIAGNOSTIC       0.000000         00:0000       0:0500 RADIOLOGY - DIAGNOSTIC       0.000000         0:0500 RADIOLOGY - DIAGNOSTIC       0.000000       0:0500 RADIOLOGY - DIAGNOSTIC         0:0500 RADIOLOGY - DIAGNOSTIC       0.000000       0:0500         0:0500 RADIOLOGY - DIAGNOSTIC       0.000000       0:0500         0:0500 RADIOLOGY - DIAGNOSTIC       0.000000       0:0500         0:0500 RADIOL							30.00
35.00       20200 NEONATAL INTENSIVE CARE UNIT       35.00       35.00       20200 NEOSENT       47.0         42.00       04200 SUBPROVIDER       47.0       47.0       47.0         ANCILLARY SERVICE COST CENTERS       50.0       50.00       50.00       50.00       50.00         50.00       05000 OPERATIN & ROM       0.000000       50.0       50.00       50.00       50.00       50.00         50.01       05001 OUTPATI ENT SURGERY       0.000000       50.0       50.0       50.00       50.0       50.00       50.00       50.00       50.0       50.00<							31.00
411.00         04100 SUBPROVI DER - I BF         41.0           42.00         42300 NURSERY         43.0           ANULLIARY SERVICE COST CENTERS         50.0           500.00         05000 OPEANTI NG ROOM         0.000000           51.00         05000 APESTHESI DUGGY         0.000000           51.00         05000 APESTHESI DUGGY         0.000000           51.00         05000 APESTHESI DUGGY         0.000000           54.00         05400 RADI DUGY-THERAPEUTI C         0.000000           55.00         05600 RADI OLOGY-THERAPEUTI C         0.000000           55.00         066000 RESPI RATORY THERAPEY         0.000000           56.00         066000 RADI OLOGY-THERAPEUTI C         0.000000           60.00         066000 RESPI RATORY THERAPEY         0.000000           63.00         06600 RESPI RATORY THERAPY         0.000000           63.00         06600 RESPI RATORY THERAPY         0.000000           63.00         06600 SEECH PATHOLOGY         0.000000           64.00         06700 OCUPATI ONAL THERAPY         0.000000           70.00         70.00         71.00           71.00         07000 DELECTRONENEHALORGRAPHY         0.000000         70.0           71.00         07000 DELECTRONENEHALORGRAPHY							
42.00         04200 SUBPROVIDER         42.0           A00         04200 NURSERY         43.0           ANDILLARY SERVICE COST CENTERS         50.0           50.00         50.00 OPERATINE ROM         0.000000           50.01         50.01 OUTPATIENT SURGERY         0.000000           51.00         50.00 RECOVERY ROM         0.000000           53.00         65.00 ANESTEV         0.000000           54.01         054.01 ARDI LOCY-JACANSTIC         0.000000           55.00         0550.00 RADI LOCY-JACANSTIC         0.000000           55.00         0550.00 RADI DISOTPE HEAPEUTIC         0.000000           55.00         05600 RADI DISOTPE HEAPEUTIC         0.000000           63.00         66.00 RADI DISOTPE HEAPEUTIC         0.000000           63.00         06600 RADI DISOTPE HEAPEUTIC         0.000000           63.00         06600 CUPATIONAL THERAPY         0.000000           66.00         06600 CUPATIONAL THERAPY         0.000000           66.00         06600 SPIESIN RING PROCESSING & TRANS.         0.000000           67.00         06700 CUPATIONAL THERAPY         0.000000           68.00         06600 SPIESIN RING PROLESCHARGE TO PATIENT         0.000000           70.00         07000 CUPATIONAL THERAPY							41.00
43.00         04300 NURSERY         43.00           ANOLLARY SERVIC COST CENTERS         50.00							42.00
50. 00         05000         0FEARTING ROOM         0.000000         50.           50. 00         0500         0FEARTING ROOM         0.000000         51.           51. 00         05100         PECOVERY ROOM         0.000000         53.           53. 00         05300         PESTANDARSTHES LOGY         0.000000         53.           54. 00         05400         PADI LOGY-FERRAPCULT         0.000000         54.           55. 00         05500         PADI LOGY-FERRAPEUTIC         0.000000         55.           56. 00         05600         PADI LOGY-FERRAPEUTIC         0.000000         66.           56. 00         06600         LBORATORY         0.000000         66.           56. 00         06600         RESPIRATORY         0.000000         66.           50. 00         06600         CESPIRATORY         0.000000         66.           60. 00         06600         SPEICH PATHOLOGY         0.000000         66.           50. 00         06600         CEECTROCARCHPAINGERAPHY         0.000000         66.           70. 00         OTOOD ELECTRORACEPHALOGRAPHY         0.000000         70.           71. 00         OTOOD ELECTRORACEPHALOGRAPHY         0.0000000         70.	43.00						43.00
50. 01         050. 01         050. 01         050. 01         050. 01         50. 00         560. 00         670. 00         670. 00         670. 00         670. 00         670. 00         670. 00         670. 00         670. 00         670. 00         670. 00         670. 00         710. 00         710. 00         710. 00         710. 00         710. 00         710. 00         710. 00         710. 00		ANCI LLARY SERVI CE COST CENTERS					
51.00         05100         PECOVERV ROOM         51.00         53.00         55.00         53.00							50.00
53.00       053.00       ANESTHESI OLOGY       0.000000       53.0         54.00       054.00       RADIOLOGY-SPECIAL PROCEDURES       0.000000       54.0         55.00       055.00       RADIOLOGY-SPECIAL PROCEDURES       0.000000       56.0         55.00       056.00       RADIOLOGY-SPECIAL PROCEDURES       0.000000       56.0         56.00       056.00       RADIOLOGY-SPECIAL PROCEDURES       0.000000       66.0         56.00       06600       RADIOLOGY-THERAPEUTIC       0.000000       66.0         50.00       06500       RADIOLOGY-THERAPEUTIC       0.000000       66.0         66.00       06600       PHYSICAL THERAPY       0.000000       66.0         66.00       06600       PHYSICAL THERAPY       0.000000       67.0         67.00       06700       CELEGTROCARDIOLOGY       0.000000       67.0         71.00       06700       CELEGTROCARDIOLOGY       0.000000       70.0         71.00       0700       HEIARAPY       0.000000       70.0         72.00       07200       ILEGTROCARDIOLOGY       0.000000       70.0         73.00       07000       IELEGTROCARDIOLOGY       0.000000       70.0         76.01       03951			1				50.01
54.00         OS400         RADIOLOGY-DI AGNOSTIC         0.000000         54.0           54.01         G5401         RADIOLOGY-THERAPEUTIC         0.000000         55.0           55.00         OS500         RADIOLOGY-THERAPEUTIC         0.000000         55.0           60.00         OS600         RADIOLOGY-THERAPEUTIC         0.000000         55.0           60.00         OS600         RADIOLOGY-THERAPEUTIC         0.000000         66.0           63.00         OS600         RESPI RATORY         0.000000         66.0           65.00         OS600         RESPI RATORY THERAPY         0.000000         66.0           65.00         OS600         RESPI RATORAL THERAPY         0.000000         66.0           66.00         OCCUPATIONAL THERAPY         0.000000         67.0           70.00         OCCUPATIONAL THERAPY         0.000000         70.0           71.00         OT000         FLECTROCARGED TO PATIENT         0.000000         70.0           71.00         OT000         FLECTROCARGED TO PATIENTS         0.000000         70.0           72.00         OT200         INPLIE SCHARGED TO PATIENTS         0.000000         70.0           73.00         OT3000         DUTAL SCHARGED TO PATIENTS         0							51.00
54.01       05401       RADI OLOGY-SPECIAL PROCEDURES       0.000000       55.0         55.00       05500       RADI OLOGY-SPECIAL PROCEDURES       0.000000       55.0         56.00       05600       RADI OLOGY-THERAPEUTIC       0.000000       55.0         60.00       06600       LABORATORY       0.000000       65.0         61.00       06600       PASID ANDRY THERAPY       0.000000       65.0         65.00       06500       PHYSI CAL THERAPY       0.000000       66.0         66.00       06600       DELECTROCARDI OLOGY       0.000000       66.0         66.00       06600       DELECTROCARDI OLOGY       0.000000       66.0         66.00       06600       DELECTROCARDI OLOGY       0.000000       70.0         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENT       0.000000       70.0         72.00       07200       DELECTROCARDI OLOGY       0.000000       70.0         73.00       07300       DELECTROCARDI OLOGY       0.000000       70.0         74.00       07200       MEDI CAL SUPPLIES CHARGED TO PATI ENT       0.000000       70.0         74.00       07300       DELECTROCARDI OLOGY       0.0000000       70.0         76.01<							
55.00         OS500         RADIO LOGY-THERAPEUTI C         0.000000         55.0           56.00         OS600         RADIO STOPE         0.000000         60.0           66.00         O6000         LABORATORY         0.000000         60.0           65.00         OS600         RESPI RATORY THERAPY         0.000000         65.0           65.00         OS600         PKSTI CAL THERAPY         0.000000         65.0           65.00         OS600         PKSTI CAL THERAPY         0.000000         65.0           65.00         OS600         PKSTI CAL THERAPY         0.000000         66.0           66.00         OCCUPATIONAL THERAPY         0.000000         66.0           70.00         OFECTROENCEPHALOGRAPHY         0.000000         67.0           70.00         OT200         ELECTROCARGED TO PATI ENTS         0.000000         70.0           71.00         OT200         INPLI ES CHARGED TO PATI ENTS         0.000000         73.0           73.00         OT300         DRUGS CHARGED TO PATI ENTS         0.000000         73.0           73.00         OT300         DRUGS CHARGED TO PATI ENTS         0.000000         76.0           74.00         OS430         ULTRA SOUND         0.000000         7			1				54.00
56.00         0s600         RADIO ISOTOPE         0.000000         65.0           60.00         0s000         LABORATORY         0.000000         65.0           63.00         0s000         BLODD STORI NG, PROCESSI NG & TRANS.         0.000000         65.0           66.00         0s600         PRESPIRATORY THERAPY         0.000000         65.0           66.00         0s600         PHYSI CAL THERAPY         0.000000         65.0           66.00         0s600         SPECET PATHOLOGY         0.000000         65.0           66.00         0s600         PEECETROCARDIOLOGY         0.000000         65.0           67.00         0s000         PEECETROCARDIOLOGY         0.000000         70.0           71.00         MEDICAL SUPPLIES CHARGED TO PATIENT         0.000000         70.0           73.00         07300         RAGED TO PATIENTS         0.000000         73.0           73.00         07300         RAGED TO PATIENTS         0.000000         76.0           76.00         33631         UTRA SOUND         0.000000         76.0           76.01         3351         PAIN CLINIC         0.000000         76.0           76.02         3352         ACTI VI TY THERAPEUTIC         0.000000							55.00
60.00         0.6000         LABORATORY         0.00000         63.0           63.00         0.6300         BLODD STORING, PROCESSING & TRANS.         0.000000         63.0           63.00         0.6600         RESPI RATORY THERAPY         0.000000         65.0           66.00         0.6600         RESPI RATORY THERAPY         0.000000         65.0           66.00         0.6600         SEPI RATORY THERAPY         0.000000         66.0           67.00         0.6700         OCUPATIONAL THERAPY         0.000000         66.0           68.00         0.6600         FEECH PATHOLOGY         0.000000         66.0           70.00         OTOO         ELECTROCARCHOLOGY         0.000000         70.0           71.00         OTOO         IELETROENCEPHALOGRAPHY         0.000000         71.0           72.00         07200         INPL. DEV. CHARGED TO PATI ENTS         0.000000         73.0           73.00         07300         DURUS CHARGED TO PATI ENTS         0.000000         76.0           76.01         0.3951         PAI N CLINIC         0.000000         76.0           76.02         0.3952         CATH LAB         0.000000         76.0           76.03         0.3953         ACTI VIT Y THE							56.00
65.00         0c500         RESPIRATORY THERAPY         0.000000         65.0           66.00         0c600         PHYSICAL THERAPY         0.000000         66.0           67.00         0c6700         0CCUPATIONAL THERAPY         0.000000         66.0           68.00         0c600         SPECH PATHOLOGY         0.000000         68.0           69.00         0c900         ELECTROCKAPILOGRAPHY         0.000000         70.0           71.00         OT000         ELECTROCKAPILOGRAPHY         0.000000         71.0           72.00         07200         IMPL. DEV. CHARGED TO PATIENTS         0.000000         72.0           73.00         07300         DRUSS CHARGED TO PATIENTS         0.000000         73.0           76.01         03531         UTN SOUND         0.000000         76.0           76.02         03522         CATH LAB         0.000000         76.0           76.03         03953         ACTI VI TY THERAPEUTIC         0.000000         76.0           76.04         03954         WOLND CARE CENTER         0.000000         76.0           76.05         03340         BALTHY LIVING CENTER         0.000000         76.0           76.06         033951         CLATH CLINIC         0							60.00
66.00         06000         PHYSICAL THERAPY         0.000000         66.0           67.00         06700         OCCUPATI ONAL THERAPY         0.000000         67.0           68.00         06800         SPECH PATHOLOGY         0.000000         680.0           69.00         06900         ELECTROCARDI OLOGY         0.000000         680.0           71.00         07100         MEDICAL SUPPLIES CHARGED TO PATIENT         0.000000         71.0           72.00         07200         IMPL. DEV. CHARGED TO PATIENTS         0.000000         73.0           73.00         07300         DRUSC ARAGED TO PATIENTS         0.000000         73.0           73.00         07300         DRUSC ARAGED TO PATIENTS         0.000000         76.0           76.01         0351 PAIN CLINIC         0.000000         76.0           76.02         03952         CATH LAB         0.000000         76.0           76.03         03953         ACTIVI TY THERAPEUTI C         0.000000         76.0           76.03         03954         MOUND CARE CENTER         0.000000         76.0           76.03         03954         MOUND CARE CENTER         0.000000         76.0           76.03         03955         OTHER ANCI LLARY SERVICE COST CE	63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000				63.00
67.00         06700         0CCUPATI ONAL THERAPY         0.000000         67.0           68.00         06800         SPEECH PATHOLOGY         0.000000         68.0           70.00         07000         ELECTROCARDI OLOGY         0.000000         70.0           71.00         07100         MPL DEV, CHARGED TO PATI ENT         0.000000         71.0           71.00         07300         DRUGS CHARGED TO PATI ENTS         0.000000         73.0           73.00         07300         DRUGS CHARGED TO PATI ENTS         0.000000         76.0           76.01         03301         ULTRA SOUND         0.000000         76.0           76.02         03951         PAIN CLINIC         0.000000         76.0           76.03         03952         CATL LAB         0.000000         76.0           76.04         03954         MAIN DCARE CENTER         0.000000         76.0           76.05         03304         BARI ATRI C CLINIC         0.000000         76.0           76.06         03304         BARI ATRI C CLINIC         0.000000         76.0           76.07         03950         CHEAPEAPUTIC         0.000000         76.0           76.08         03304         BARI ATRI C CLINIC         0.000000							65.00
68.00         06600         SPECH PATHOLOGY         0.000000         69.00           69.00         06900         ELECTROCARDIOLOGY         0.000000         69.00           71.00         07000         ELECTROENCEPHALOGRAPHY         0.000000         71.0           72.00         07200         ELECTROENCEPHALOGRAPHY         0.000000         71.0           72.00         07200         ELECTROENCEPHALOGRAPHY         0.000000         72.0           73.00         07300         DRUGS CHARGED TO PATIENTS         0.000000         73.0           76.00         03630         ULTRA SOUND         0.000000         76.0           76.01         03951 PAIN CLINIC         0.000000         76.0           76.02         03952         CATH LAB         0.000000         76.0           76.03         03953         ACTI VI TY THERAPEUTI C         0.000000         76.0           76.04         03954         WOUND CARE CENTER         0.000000         76.0           76.05         03300         HALTRY LIVI NG CENTER         0.000000         76.0           76.07         03950         CV RESOURCE CENTER         0.000000         76.0           76.08         03955         CHTHER ANCI LLARY SERVICE COST CENTERS         0							66.00
69:00       06900       ELECTROCARDIOLOGY       0.000000       70.00         70:00       07000       ELECTROENCEPHALOGRAPHY       0.000000       70.0         71:00       07100       MPL DEV. CHARGED TO PATI ENTS       0.000000       72.0         73:00       07300       DRUGS CHARGED TO PATI ENTS       0.000000       73.0         76:00       03630       ULTRA SOUND       0.000000       76.0         76:01       03951       PAI N CLINIC       0.000000       76.0         76:02       03952       CATH LAB       0.000000       76.0         76:03       03953       ACTI VI TY THERAPEUTI C       0.000000       76.0         76:04       03954       WOUND CARE CENTER       0.000000       76.0         76:05       0330       HEALTHY LI VIN G CENTER       0.000000       76.0         76:08       03955       OTHER ANCI LLARY SERVI CE COST CENTERS       0.000000       76.0         76:08       03955       OTHER ANCI LLARY SERVI CE COST CENTERS       0.000000       76.0         76:10       03959       OTHER ANCI LLARY SERVI CE COST CENTERS       0.000000       76.0         76:10       03959       OTHER ANCI LLARY SERVI CE COST CENTERS       0.000000       76.0			1				
70.00     07000     ELECTROENCEPHALOGRAPHY     0.000000     70.00       71.00     07100     MEDI CAL SUPPLIES CHARGED TO PATI ENT     0.000000     71.00       72.00     07200     IMPL. DEV. CHARGED TO PATI ENTS     0.000000     73.00       73.00     07300     DRUGS CHARGED TO PATI ENTS     0.000000     76.00       76.00     03630     ULTRA SOUND     0.000000     76.00       76.10     03951     PAIN CLINIC     0.000000     76.00       76.01     03952     CATH LAB     0.000000     76.00       76.02     03952     CATH LAB     0.000000     76.00       76.03     03953     ACTI VI TY THERAPEUTI C     0.000000     76.00       76.04     03954     WOUND CARE CENTER     0.000000     76.00       76.05     03300     HEALTRY LIVING CENTER     0.000000     76.00       76.06     03030     HEALTRY LIVING CENTER     0.000000     76.00       76.00     03950     OV RESOURCE CENTER     0.000000     76.00       76.00     03955     OTHER ANCI LLARY SERVICE COST CENTERS     0.000000     76.00       76.00     03956     ALCTATI ON CLINIC     0.000000     76.00       76.10     03957     OTHER ANCI LLARY SERVICE COST CENTERS     0.000000 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENT       0.000000       71.0         72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0.000000       73.0         73.00       07300       DRUSC CHARGED TO PATIENTS       0.000000       73.0         76.00       03350       ILTRA SOUND       0.000000       76.0         76.01       03951       PAIN CLINIC       0.000000       76.0         76.02       03952       CATH LAB       0.000000       76.0         76.03       03953       ACTIVITY THERAPEUTIC       0.000000       76.0         76.04       03954       WOUND CARE CENTER       0.000000       76.0         76.05       03340       BARIATRIC CLINIC       0.000000       76.0         76.06       03304       BARIATRIC CLINIC       0.000000       76.0         76.07       03950       CV RESOURCE CENTER       0.000000       76.0         76.08       03955       OTHER ANCILLARY SERVICE COST CENTERS       0.000000       76.0         76.10       03955       OTHER ANCILLARY SERVICE COST CENTERS       0.000000       76.0         76.11       03959       NTHE ANCILLARY SERVICE COST CENTERS       0.0000000         71.10       0.00							70.00
72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0.000000       73.00         73.00       DRUGS CHARGED TO PATIENTS       0.000000       76.00         76.00       03630       ULTRA SOUND       0.000000       76.00         76.01       03951       PAIN CLINIC       0.000000       76.00         76.02       03952       CATH LAB       0.000000       76.00         76.03       03953       ACTIVITY THERAPEUTIC       0.000000       76.00         76.04       03954       WOUND CARE CENTER       0.000000       76.00         76.05       03300       BARIATRIC CLINIC       0.000000       76.00         76.06       03030       HEALTRY LIVING CENTER       0.000000       76.00         76.07       03950       CV RESOURCE CENTER       0.000000       76.00         76.08       03955       OTHER ANCILLARY SERVICE COST CENTERS       0.000000       76.00         76.09       03956       LACTATION CLINIC       0.000000       76.00         76.10       03957       OTHER ANCILLARY SERVICE COST CENTERS       0.000000       76.00         76.10       03958       OTHER ANCILLARY SERVICE COST CENTERS       0.000000       76.00         76.10       03958<							71.00
76.00       03630       ULTRA SOUND       0.000000       76.00         76.01       03951       PAIN CLINIC       0.000000       76.00         76.03       03952       CATH LAB       0.000000       76.00         76.04       03954       ACTIVITY THERAPEUTIC       0.000000       76.00         76.05       03340       BARIATRIC CLINIC       0.000000       76.00         76.06       03304       BARIATRIC CLINIC       0.000000       76.00         76.07       03950       CV RESOURCE CENTER       0.000000       76.00         76.08       03955       OTHER ANCI LLARY SERVI CE COST CENTERS       0.000000       76.00         76.09       03956       LACTATI ON CLINIC       0.000000       76.00         76.10       03957       OTHER ANCI LLARY SERVI CE COST CENTERS       0.000000       76.00         76.11       03958       NTER ANCI LLARY SERVI CE COST CENTERS       0.000000       76.00         76.11       03959       OTHER ANCI LLARY SERVI CE COST CENTERS       0.000000       76.00         76.11       03959       NTI COAGULATI ON CLINIC       0.000000       76.00         77.00       0700       ALLOGENEI C STEM CELL ACQUI SI TI ON       0.000000       76.00							72.00
76. 01       03951       PAI N CLINIC       0.000000       76. 02         76. 02       03952       CATH LAB       0.000000       76. 02         76. 04       03953       ACTIVITY THERAPEUTIC       0.000000       76. 02         76. 04       03954       WOUND CARE CENTER       0.000000       76. 02         76. 05       03340       BARIATRIC CLINIC       0.000000       76. 02         76. 07       03950       CV RESOURCE CENTER       0.000000       76. 02         76. 08       03955       OTHER ANCILLARY SERVICE COST CENTERS       0.000000       76. 02         76. 09       03955       OTHER ANCILLARY SERVICE COST CENTERS       0.000000       76. 02         76. 10       03957       OTHER ANCILLARY SERVICE COST CENTERS       0.000000       76. 02         76. 10       03957       OTHER ANCILLARY SERVICE COST CENTERS       0.000000       76. 02         76. 11       03958       OTHER ANCILLARY SERVICE COST CENTERS       0.000000       76. 02         76. 12       03959       ANTI COAGULATION CLINIC       0.000000       76. 02         77. 00       OT700       ALLOGENEI C STEM CELL ACQUISITION       0.000000       76. 02         70. 00       09200       DBES (NON-DI STINCT PART	73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000				73.00
76.02       03952       CATH LAB       0.000000       76.02         76.03       03953       ACTI VI TY THERAPEUTI C       0.000000       76.02         76.04       03954       WOUND CARE CENTER       0.000000       76.02         76.05       03340       BARI ATRI C CLI NI C       0.000000       76.02         76.06       03030       HEALTHY LI VING CENTER       0.000000       76.02         76.07       03950       CV RESOURCE CENTER       0.000000       76.02         76.08       03955       OTHER ANCI LLARY SERVI CE COST CENTERS       0.000000       76.02         76.09       03956       LACTATI ON CLI NI C       0.000000       76.02         76.10       03957       OTHER ANCI LLARY SERVI CE COST CENTERS       0.000000       76.02         76.11       03958       OTHER ANCI LLARY SERVI CE COST CENTERS       0.000000       76.02         76.11       03959       ANTI CAGULARY SERVI CE COST CENTERS       0.000000       76.02         76.12       03959       ANTI CAGULARY SERVI CE COST CENTERS       0.000000       76.02         77.00       OUTPATI ENT SERVI CE COST CENTERS       0.000000       77.02         91.00       09100       EMEGENCY       0.000000       91.02     <			1				76.00
76.03       03953       ACTIVITY THERAPEUTIC       0.00000       76.0         76.04       03954       WOUND CARE CENTER       0.000000       76.0         76.05       0330       BARI ATRIC CLINIC       0.000000       76.0         76.07       03950       CV RESOURCE CENTER       0.000000       76.0         76.08       03955       OTHER ANCILLARY SERVICE COST CENTERS       0.000000       76.0         76.09       03956       LACTATION CLINIC       0.000000       76.0         76.10       03957       OTHER ANCILLARY SERVICE COST CENTERS       0.000000       76.0         76.10       03957       OTHER ANCILLARY SERVICE COST CENTERS       0.000000       76.0         76.11       03958       OTHER ANCILLARY SERVICE COST CENTERS       0.000000       76.0         76.12       03959       ANTICOAGULATION CLINIC       0.000000       76.0         71.00       OTTOOLALLAGENEIC STEM CELL ACQUISITION       0.000000       76.0         71.00       OP100       EMERGENCY       0.000000       76.0         71.00       OP100       EMERGENCY       0.000000       91.0         71.00       OP100       DEDS (NON-DISTINCT PART       0.000000       91.0         71.00			1				76.01
76.04       03954       WOUND CARE CENTER       0.000000       76.05         76.05       03340       BARI ATRI C CLI NI C       0.000000       76.05         76.06       03030       HEALTHY LI VI NG CENTER       0.000000       76.06         76.07       03950       CV RESOURCE CENTER       0.000000       76.07         76.08       03955       OTHER ANCI LLARY SERVICE COST CENTERS       0.000000       76.07         76.09       03956       LACTATI ON CLI NI C       0.000000       76.07         76.10       03957       OTHER ANCI LLARY SERVICE COST CENTERS       0.000000       76.07         76.11       03958       OTHER ANCI LLARY SERVICE COST CENTERS       0.000000       76.07         76.12       03959       ANTI COAGULATI ON CLI NI C       0.000000       76.07         77.00       07700       ALLOGENEI C STEM CELL ACQUI SI TI ON       0.000000       76.07         70.00       09100       EMERGENCY       0.000000       91.0         91.00       09200       OBSERVATI ON BEDS (NON-DI ST INCT PART       0.000000       91.0         92.00       09200       OBSERVATI ON BEDS (NON-DI ST INCT PART       0.000000       92.0         01200       OPI OI D TREATMENT PROGRAM       102.0							
76.05       03340       BARI ATRI C CLINI C       0.000000       76.05         76.06       03030       HEALTHY LIVING CENTER       0.000000       76.05         76.07       03950       CV RESOURCE CENTER       0.000000       76.06         76.08       03955       OTHER ANCI LLARY SERVICE COST CENTERS       0.000000       76.07         76.09       03956       LACTATI ON CLINIC       0.000000       76.07         76.10       03957       OTHER ANCI LLARY SERVICE COST CENTERS       0.000000       76.07         76.11       03958       OTHER ANCI LLARY SERVICE COST CENTERS       0.000000       76.07         76.12       03959       ANTI COAGULATI ON CLINIC       0.000000       76.07         76.12       03959       ANTI COAGULATI ON CLINIC       0.000000       76.07         70.00       07700       ALLOGENEI C STEM CELL ACOUI SI TI ON       0.000000       77.07         01000       EMERGENCY       0.000000       91.0       91.00         991.00       O9100 EMERGENCY       0.000000       91.0       91.0         92.00       0BSERVATI ON BEDS (NON-DI STINCT PART       0.000000       91.0         91.00       010200 OPI OI D TREATMENT PROGRAM       102.00       91.0			1				
76.06       03030       HEALTHY LIVING CENTER       0.000000       76.00         76.07       03950       CV RESOURCE CENTER       0.000000       76.00         76.08       03955       OTHER ANCILLARY SERVICE COST CENTERS       0.000000       76.00         76.09       03956       LACTATI ON CLINIC       0.000000       76.00         76.10       03957       OTHER ANCILLARY SERVICE COST CENTERS       0.000000       76.00         76.11       03958       OTHER ANCILLARY SERVICE COST CENTERS       0.000000       76.00         76.11       03959       ANTI COAGULATI ON CLINIC       0.000000       76.00         76.12       03959       ANTI COAGULATI ON CLINIC       0.000000       76.00         77.00       07100       ALLOGENEIC STEM CELL ACQUI SI TI ON       0.000000       76.00         71.00       09100       EMERGENCY       0.000000       91.00         91.00       OP100 I EMERGENCY       0.000000       92.00       005ERVATI ON BEDS (NON-DI STI NCT PART       0.000000       92.00         01200       OP10 ID TREATMENT PROGRAM       102.00       91.00       102.00       91.00       92.00         01200       OP1 OI D TREATMENT PROGRAM       102.00       102.00       0102.00       0102							76.04
76.07       03950       CV RESOURCE CENTER       0.000000       76.0         76.08       03955       OTHER ANCI LLARY SERVICE COST CENTERS       0.000000       76.0         76.09       03956       LACTATI ON CLI NI C       0.000000       76.0         76.10       03957       OTHER ANCI LLARY SERVICE COST CENTERS       0.000000       76.0         76.11       03958       OTHER ANCI LLARY SERVICE COST CENTERS       0.000000       76.7         76.11       03959       ANTI COAGULATI ON CLI NI C       0.000000       76.7         76.12       03959       ANTI COAGULATI ON CLI NI C       0.000000       76.7         71.00       07700       ALLOGENEI C STEM CELL ACQUI SI TI ON       0.000000       76.7         71.00       09100       EMERGENCY       0.000000       76.7         91.00       09100       EMERGENCY       0.000000       91.0         92.00       OBSERVATI ON BEDS (NON-DI STI NCT PART       0.000000       92.0         91.00       010200       IPI OI TREATMENT PROGRAM       91.0         92.00       IDSERVATI ON BEDS (COST CENTERS       102.00       92.00         91.100       INTEREST EXPENSE       113.00       11300       INTEREST EXPENSE         10200							76.06
76.08       03955       OTHER ANCI LLARY SERVICE COST CENTERS       0.000000       76.0         76.09       03956       LACTATI ON CLINIC       0.000000       76.0         76.10       03957       OTHER ANCI LLARY SERVICE COST CENTERS       0.000000       76.0         76.11       03958       OTHER ANCI LLARY SERVICE COST CENTERS       0.000000       76.7         76.11       03959       ANTI COAGULATI ON CLINIC       0.000000       76.7         76.12       03959       ANTI COAGULATI ON CLINIC       0.000000       76.7         70.00       OTTOO ALLOGENEIC STEM CELL ACQUI SITI ON       0.000000       76.7         000000       OUTPATI ENT SERVICE COST CENTERS       0.000000       76.7         91.00       09100       EMERGENCY       0.000000       76.7         91.00       09100       EMERGENCY       0.000000       92.0         92.00       OBSERVATI ON BEDS (NON-DI STINCT PART       0.000000       92.0         91.00       010200       OPI OI D TREATMENT PROGRAM       91.0         92.01       10200       OPI OI D TREATMENT PROGRAM       102.0         113.00       INTEREST EXPENSE       113.00       11300       INTEREST EXPENSE         200.00       Subtotal (see instruction			1				76.07
76. 10       03957       OTHER ANCI LLARY SERVICE COST CENTERS       0.000000       76. 7         76. 11       03958       OTHER ANCI LLARY SERVICE COST CENTERS       0.000000       76. 7         76. 12       03959 ANTI COAGULATI ON CLINIC       0.000000       76. 7         77. 00       OT700 ALLOGENEIC STEM CELL ACQUI SI TI ON       0.000000       76. 7         00TPATI ENT SERVICE COST CENTERS       0.000000       76. 7         91. 00       09100 [EMERGENCY       0.000000       70. 0         92. 00       09200 [OBSERVATI ON BEDS (NON-DI STINCT PART       0.000000       92. 0         012.00       102.00 [OPI OI D TREATMENT PROGRAM       102. 0       92. 0         SPECIAL PURPOSE COST CENTERS       113.00       11300 [NTEREST EXPENSE       113. 0         113. 00       11300 [NTEREST EXPENSE       200. 00       200. 0         201. 00       Less Observati on Beds       200. 0       201. 0	76.08	03955 OTHER ANCILLARY SERVICE COST CENTERS					76.08
76. 11       03958       OTHER ANCI LLARY SERVICE COST CENTERS       0.000000       76. 7         76. 12       03959       ANTI COAGULATI ON CLINIC       0.000000       76. 7         77. 00       07700       ALLOGENEIC STEM CELL ACQUI SITION       0.000000       77. 0         0UTPATI ENT SERVICE COST CENTERS       0.000000       77. 0         91.00       09100       EMERGENCY       0.000000       91. 0         92.00       09200       OBSERVATI ON BEDS (NON-DI STINCT PART       0.000000       92. 0         0THER REIMBURSABLE COST CENTERS       0.000000       92. 0       92. 0         01200       OPI OI D TREATMENT PROGRAM       102. 0         SPECIAL PURPOSE COST CENTERS       113. 0       11300       INTEREST EXPENSE       113. 0         102.00       Subtotal (see instructions)       200. 0       201. 0       Less Observation Beds       200. 0							76.09
76. 12       03959       ANTI COAGULATI ON CLINIC       0.000000       76. 7         77. 00       07700       ALLOGENEIC STEM CELL ACQUI SITI ON       0.000000       77. 0         0UTPATI ENT SERVICE COST CENTERS       91. 0       0.000000       91. 0         92. 00       09200       DBSERVATI ON BEDS (NON-DI STINCT PART       0.000000       92. 0         0THER REIMBURSABLE COST CENTERS       0.10200       91. 0       92. 0         01200       PIO ID TREATMENT PROGRAM       102. 0         SPECI AL PURPOSE COST CENTERS       113. 00       1NTEREST EXPENSE       113. 0         113. 00       1NTEREST EXPENSE       200. 0       201. 00       Less Observati on Beds       200. 0							76.10
77.00       07700       ALLOGENEIC STEM CELL ACQUISITION       0.000000       77.00         0UTPATI ENT SERVICE COST CENTERS       0.000000       91.00         91.00       09100       EMERGENCY       0.000000       91.00         92.00       09200       DBSERVATION BEDS (NON-DISTINCT PART       0.000000       92.00         0THER       REI MBURSABLE COST CENTERS       10200       0P101 D TREATMENT PROGRAM       102.00         102.00       10200       OP101 D TREATMENT PROGRAM       102.00       102.00       11300       INTEREST EXPENSE       113.00         113.00       11300       INTEREST EXPENSE       113.00       200.00       201.00       Less Observation Beds       200.00							76.11
OUTPATI ENT SERVICE COST CENTERS         0.000000         91.0           91.00         09100         EMERGENCY         0.000000         91.0           92.00         09200         DBSERVATI ON BEDS (NON-DI STI NCT PART         0.000000         92.0           0THER         REI MBURSABLE COST CENTERS         102.00         10200         0PI OI D TREATMENT PROGRAM         102.00           SPECI AL PURPOSE COST CENTERS         113.00         11300         INTEREST EXPENSE         113.0           200.00         Subtotal (see instructions)         200.00         201.00         Less Observation Beds         201.00							76.12
91.00       09100       EMERGENCY       0.000000       91.0         92.00       09200       0BSERVATION BEDS (NON-DISTINCT PART       0.000000       92.0         0THER       REI MBURSABLE COST CENTERS       102.00       10200       0PI 0I D TREATMENT PROGRAM       102.0         SPECI AL PURPOSE COST CENTERS       113.00       11300       INTEREST EXPENSE       113.00       200.00         201.00       Less Observation Beds       200.00       201.00       201.00       201.00       201.00	11.00		0.000000				_ //.00
92.00         09200         0BSERVATI ON BEDS (NON-DI STINCT PART         0.000000         92.0           OTHER         REIMBURSABLE COST CENTERS         102.00         10200/0PI 0I D TREATMENT PROGRAM         102.00           SPECIAL PURPOSE COST CENTERS         113.00         11300         INTEREST EXPENSE         113.00           200.00         Subtotal (see instructions)         200.00         201.00         Less Observation Beds         201.00	91,00		0, 000000				91.00
OTHER REIMBURSABLE COST CENTERS       102.00         102.00       10200 OPI OI D TREATMENT PROGRAM       102.00         SPECIAL PURPOSE COST CENTERS       113.00         113.00       11300 INTEREST EXPENSE       113.00         200.00       Subtotal (see instructions)       200.00         201.00       Less Observation Beds       201.00							92.00
SPECIAL PURPOSE COST CENTERS         113.00       INTEREST EXPENSE         200.00       Subtotal (see instructions)         201.00       Less Observation Beds		OTHER REIMBURSABLE COST CENTERS					
113.00       INTEREST EXPENSE       113.0         200.00       Subtotal (see instructions)       200.0         201.00       Less Observation Beds       201.0	102.00						102.00
200.00Subtotal (see instructions)200.00201.00Less Observation Beds201.00	110 00						110.00
201.00 Less Observation Beds 201.0							113.00
							200.00
	201.00						201.00

Health Financial Systems	FRANCI SCAN HE	EALTH- DYER		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider CO		Period: From 01/01/2022 To 12/31/2022	5/10/2023 11:	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,	-	Related Cost			
	Part II, col.		(col. 1 - col			
	26)		2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	2, 290, 118	0	2, 290, 11	8 22, 998	99.58	30.00
31.00 INTENSIVE CARE UNIT	316, 453		316, 45	3 3, 318	95.37	31.00
32.00 CORONARY CARE UNIT	0			0 0	0.00	32.00
35.00 NEONATAL INTENSIVE CARE UNIT	34, 707		34, 70	7 308	112.69	35.00
41.00 SUBPROVIDER - IRF	262, 182	0	262, 18	2 3, 807	68.87	41.00
42. 00 SUBPROVI DER	0	0	)	0 0	0.00	42.00
43.00 NURSERY	18, 125		18, 12	5 721	25.14	43.00
200.00 Total (lines 30 through 199)	2, 921, 585		2, 921, 58	5 31, 152		200.00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	7, 825		•			30.00
31.00 INTENSIVE CARE UNIT	1,053	100, 425				31.00
32.00 CORONARY CARE UNIT	0	0				32.00
35.00 NEONATAL INTENSIVE CARE UNIT	0	0				35.00
41.00 SUBPROVIDER – IRF	3, 592	247, 381				41.00
42. 00 SUBPROVI DER	0	0				42.00
43.00 NURSERY	0	0				43.00
200.00 Total (lines 30 through 199)	12, 470	1, 127, 020	1			200.00

Health Financial Systems	FRANCI SCAN H	EALTH- DYER		In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider C	CN: 15-0090	Period: From 01/01/2022 To 12/31/2022		pared: 00 am
		Title	e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
		(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	1	I	1		I	
50.00 05000 OPERATING ROOM	746, 677					1
50. 01 05001 OUTPATI ENT SURGERY	348, 570					
51.00 05100 RECOVERY ROOM	151, 354					
53.00 05300 ANESTHESI OLOGY	58, 330					
54.00 05400 RADI OLOGY-DI AGNOSTI C	983, 839	66, 928, 182			51, 558	54.00
54. 01 05401 RADI OLOGY-SPECI AL PROCEDURES	85, 944				-	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	010000		0	55.00
56. 00 05600 RADI OI SOTOPE	192, 256	9, 102, 386	0. 02112	21 597, 560	12, 621	56.00
60. 00 06000 LABORATORY	253, 678	73, 270, 506	0.00340	52 12, 996, 734	44, 995	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	66, 279	1, 404, 643	0. 04718	36 521, 713	24, 618	63.00
65. 00 06500 RESPI RATORY THERAPY	131, 344	15, 382, 450			45, 965	65.00
66. 00 06600 PHYSI CAL THERAPY	121, 719	19, 978, 323	0.00604	93 1, 242, 338	7, 570	66.00
67.00 06700 OCCUPATI ONAL THERAPY	27, 479	5, 131, 595	0.0053	55 1, 117, 294	5, 983	67.00
68.00 06800 SPEECH PATHOLOGY	19, 187	3, 891, 921	0.00493	30 646, 698	3, 188	68.00
69. 00 06900 ELECTROCARDI OLOGY	166, 101	27, 556, 508	0.00602	28 9, 826, 324	59, 233	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	124, 945	5, 192, 885	0. 02400	51 215, 382	5, 182	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	112, 472		0.0026	56 6, 351, 181	16, 869	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	95, 983	18, 489, 109	0.00519	3, 069, 551	15, 934	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	218, 506	37, 923, 463	0.00576	62 8, 544, 561	49, 234	73.00
76.00 03630 ULTRA SOUND	95, 059	12, 884, 112	0.0073	78 0	0	76.00
76.01 03951 PAIN CLINIC	292, 682	9, 743, 027	0. 03004	40 0	0	76.01
76. 02 03952 CATH LAB	424, 255	63, 068, 844	0.00672	27 634	4	76.02
76.03 03953 ACTIVITY THERAPEUTIC	148, 084	6, 259, 406	0. 02365	58 28, 602	677	76.03
76.04 03954 WOUND CARE CENTER	153, 611	2, 771, 666	0. 05542	22 0	0	76.04
76. 05 03340 BARI ATRI C CLI NI C	70, 769	5, 000, 548	0. 01415	52 0	0	76.05
76.06 03030 HEALTHY LIVING CENTER	0	0	0.0000	0 00	0	76.06
76.07 03950 CV RESOURCE CENTER	0	0	0.0000	0 00	0	76.07
76.08 03955 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.0000	0 00	0	76.08
76.09 03956 LACTATION CLINIC	0	0	0.0000	0 00	0	76.09
76.10 03957 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.0000	0 00	0	76.10
76. 11 03958 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.0000	0 00	0	76.11
76.12 03959 ANTI COAGULATI ON CLINIC	15, 599	1, 201, 052			0	76.12
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0			0 00	0	77.00
OUTPATIENT SERVICE COST CENTERS						1
91.00 09100 EMERGENCY	498, 366	65, 880, 360	0.00756	5, 284, 315	39, 976	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	284, 198	9, 956, 749	0. 02854	43 1, 416, 997	40, 445	92.00
200.00 Total (lines 50 through 199)	5, 887, 286	613, 460, 022		74, 046, 605	618, 736	200.00
	·		•	·		•

lealth Financial Systems	FRANCI SCAN HE				eu of Form CMS-	2552-1
APPORTIONMENT OF INPATIENT ROUTINE SERVICE	OTHER PASS THROUGH COST	rs Provider C		Period: From 01/01/2022 To 12/31/2022		pared: 00 am
		Title	e XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng	Nursi ng	Allied Healt	h Allied Health	All Other	
	Program	Program	Post-Stepdow	n Cost	Medi cal	
	Post-Stepdown		Adjustments		Education Cost	
	Adjustments					
	1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTER			1			
30. 00 03000 ADULTS & PEDIATRICS	0	0		0 0	-	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0		0 0	0	31.00
32.00 03200 CORONARY CARE UNIT	0	C		0 0	0	32.00
35.00 02060 NEONATAL INTENSIVE CARE UNIT	0	0		0 0	0	35.00
41. 00 04100 SUBPROVI DER – I RF	0	0		0 0	0	41.00
42. 00 04200 SUBPROVI DER	0	C		0 0	0	42.00
43.00 04300 NURSERY	0	C	)	0 0	0	43.00
200.00 Total (lines 30 through 199)	0	C		0 0	0	200.00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patien	t Per Diem (col.	I npati ent	
	Adjustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,				
		minus col. 4)				
	4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTER						
30. 00 03000 ADULTS & PEDI ATRI CS	0	C				
31.00 03100 INTENSIVE CARE UNIT		C	3, 31			
32.00 03200 CORONARY CARE UNI T		C		0 0.00		
35.00 02060 NEONATAL INTENSIVE CARE UNIT		C	30			
41.00 04100 SUBPROVIDER - IRF	0	C	3, 80			
42. 00 04200 SUBPROVI DER	0	C		0 0.00		1
43. 00 04300 NURSERY		C	72			
200.00   Total (lines 30 through 199)		0	31, 15	2	12, 470	200.00
Cost Center Description	Inpati ent					
	Program					
	Pass-Through					
	Cost (col. 7 x					
	col . 8)					
	9.00					
INPATIENT ROUTINE SERVICE COST CENTER	0					20.00
30. 00 03000 ADULTS & PEDIATRICS	-					30.00
31. 00 03100 I NTENSI VE CARE UNI T	0					31.00
32. 00 03200 CORONARY CARE UNIT	0					32.00
35. 00 02060 NEONATAL INTENSIVE CARE UNIT	0					35.00
41.00 04100 SUBPROVIDER - IRF	0					41.00
42. 00 04200 SUBPROVI DER	0					42.00
43. 00 04300 NURSERY	0					43.00
200.00 Total (lines 30 through 199)						

Health Financial Systems	FRANCI SCAN HE	ALTH- DYER		In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF THROUGH COSTS	RVICE OTHER PASS	Provider CO	CN: 15-0090	Period: From 01/01/2022 To 12/31/2022		
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Non Physician	Nursi ng	Nursi ng		Allied Health	
	Anesthetist	Program	Program	Post-Stepdown		
	Cost	Post-Stepdown	U U	Adjustments		
		Adjustments				
	1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0		0 (	0 0	50.00
50. 01 05001 OUTPATI ENT SURGERY	0	0		0 (	0 0	50.01
51.00 05100 RECOVERY ROOM	0	0		0 (	o o	51.00
53. 00 05300 ANESTHESI OLOGY	0	0		0 0	o o	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	o o	54.00
54. 01 05401 RADI OLOGY-SPECI AL PROCEDURES	0	0		0 0	o l	54.01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0 (	ol o	55.00
56. 00 05600 RADI OI SOTOPE	0	0		0 (	0	56.00
60. 00 06000 LABORATORY	0	0		0 0	ol o	
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0		1
65. 00 06500 RESPI RATORY THERAPY	0	0		0	ol o	
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0		66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		0 0		
68. 00 06800 SPEECH PATHOLOGY	0	0		0 0		
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0		
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0				1
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 0		1
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0		
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		0		
76.00 03630 ULTRA SOUND	0	0		0		•
76. 01 03951 PAIN CLINIC	0	0		0 0		
76. 02   03952  CATH_LAB	0	0		0 0		
	0	0		0 0		
76. 03 03953 ACTI VI TY THERAPEUTI C	0	0		0 0		
76.04 03954 WOUND CARE CENTER	0	0		0 0	-	
76. 05 03340 BARIATRIC CLINIC	0	0		0 0	0	
76. 06 03030 HEALTHY LIVING CENTER	0	0		0	0	
76.07 03950 CV RESOURCE CENTER	0	0		0 0	0	
76.08 03955 OTHER ANCI LLARY SERVICE COST CENTERS	0	0		0 0	0	
76. 09 03956 LACTATION CLINIC	0	0		0 0	0 0	
76. 10 03957 OTHER ANCI LLARY SERVICE COST CENTERS	0	0		0 0	0 0	
76. 11 03958 OTHER ANCI LLARY SERVICE COST CENTERS	0	0		U (	0 0	
76. 12 03959 ANTI COAGULATI ON CLINIC	0	0		0 (	-	
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0		0 (	0 0	77.00
OUTPATIENT SERVICE COST CENTERS	1		[]	-	-1	
91.00 09100 EMERGENCY	0	0		0 (		
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0	0	
200.00   Total (lines 50 through 199)	0	0		0	0 0	200.00

Health Financial Systems	FRANCI SCAN HI			In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SET THROUGH COSTS	RVICE OTHER PAS			Period: From 01/01/2022 To 12/31/2022	Date/Time Pre 5/10/2023 11:	
	_	Title	XVIII	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
	Education Cost	1, 2, 3, and	Cost (sum of		(col. 5 ÷ col.	
		4)	cols. 2, 3,	8)	7)	
			and 4)		(see	
					instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVI CE COST CENTERS		1	1		1	
50.00 05000 OPERATING ROOM	0	0		0 69, 198, 843	0. 000000	50.00
50. 01 05001 OUTPATI ENT SURGERY	0	0		0 4, 258, 017	0.000000	50.01
51.00 05100 RECOVERY ROOM	0	0		0 8, 265, 498	0.000000	51.00
53. 00 05300 ANESTHESI OLOGY	0	0		0 18, 737, 042	0.000000	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 66, 928, 182	0.000000	54.00
54. 01 05401 RADI OLOGY-SPECI AL PROCEDURES	0	0		0 9, 636, 549	0.000000	54.01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0 0	0.000000	55.00
56. 00 05600 RADI OI SOTOPE	0	0		0 9, 102, 386	0.000000	56.00
60. 00 06000 LABORATORY	0	0		0 73, 270, 506	0.000000	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	C		0 1, 404, 643	0.000000	63.00
65. 00 06500 RESPIRATORY THERAPY	0	c		0 15, 382, 450		
66. 00 06600 PHYSI CAL THERAPY	0	c		0 19, 978, 323		
67.00 06700 OCCUPATI ONAL THERAPY	0	c		0 5, 131, 595		
68.00 06800 SPEECH PATHOLOGY	0	c		0 3, 891, 921	0.000000	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	l a		0 27, 556, 508	0.000000	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	l d		0 5, 192, 885		
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	l d		0 42, 346, 338		
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	l d		0 18, 489, 109		
73.00 07300 DRUGS CHARGED TO PATIENTS	0	l d		0 37, 923, 463		
76.00 03630 ULTRA SOUND	0	l d		0 12, 884, 112		
76.01 03951 PAIN CLINIC	0			0 9, 743, 027	0.000000	1
76. 02 03952 CATH LAB	0			0 63, 068, 844		
76. 03 03953 ACTIVITY THERAPEUTIC	0			6, 259, 406		
76.04 03954 WOUND CARE CENTER	0	l d		0 2, 771, 666		
76. 05 03340 BARI ATRI C CLI NI C	0			0 5,000,548		1
76.06 03030 HEALTHY LIVING CENTER	0	0		0 0	0.000000	1
76. 07 03950 CV RESOURCE CENTER	0			0 0	0. 000000	
76.08 03955 OTHER ANCI LLARY SERVICE COST CENTERS	0			0 0	0. 000000	
76. 09 03956 LACTATION CLINIC	0	0		0 0	0. 000000	
76. 10 03957 OTHER ANCI LLARY SERVICE COST CENTERS	0	0		0 0	0. 000000	
76. 11 03958 OTHER ANCILLARY SERVICE COST CENTERS	0			0 0	0. 000000	
76. 12 03959 ANTI COAGULATI ON CLINIC	0			0 1, 201, 052		
77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION	0			0 1, 201, 032		
OUTPATIENT SERVICE COST CENTERS			1	-	0.00000	1 55
91. 00 09100 EMERGENCY	0	C		0 65, 880, 360	0.000000	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0 9, 956, 749		
200.00 Total (lines 50 through 199)	0			0 613, 460, 022		200.00
			I	SI 010, 100, 022	I	

Health Financial Systems	FRANCI SCAN HEA	ALTH- DYER		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SET THROUGH COSTS	RVICE OTHER PASS	Provider CO		Period: From 01/01/2022 To 12/31/2022	5/10/2023 11:	pared: 00 am
			XVIII	Hospi tal	PPS	
Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVI CE COST CENTERS	1		1			
50.00 05000 OPERATI NG ROOM	0. 000000	9, 501, 007		0 10, 688, 144		50.00
50. 01 05001 OUTPATI ENT SURGERY	0. 000000	851, 044		0 32, 958		50.01
51.00 05100 RECOVERY ROOM	0. 000000	877, 294		0 2, 855, 131	0	51.00
53.00 05300 ANESTHESI OLOGY	0. 000000	2,067,119		0 1, 613, 118		53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	3, 507, 356		0 5, 147, 110		54.00
54. 01 05401 RADI OLOGY-SPECI AL PROCEDURES	0. 000000	0		0 0	0	54.01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	0		0 0	0	55.00
56. 00 05600 RADI 0I SOTOPE	0. 000000	597, 560		0 3, 938, 492	0	56.00
60. 00 06000 LABORATORY	0. 000000	12, 996, 734		0 1, 749, 064	0	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	521, 713		0 87, 538	0	63.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	5, 382, 901		0 131, 395	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	1, 242, 338		0 11, 419	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	1, 117, 294		0 6, 428	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	646, 698		0 154, 636	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	9, 826, 324		0 17, 592, 209	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	215, 382		0 977, 024	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	6, 351, 181		0 4, 130, 550	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	3, 069, 551		0 3, 961, 833	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	8, 544, 561		0 2, 924, 623	0	73.00
76.00 03630 ULTRA SOUND	0. 000000	0		0 0	0	76.00
76.01 03951 PAIN CLINIC	0. 000000	0		0 0	0	76.01
76.02 03952 CATH LAB	0. 000000	634		0 0	0	76.02
76. 03 03953 ACTI VI TY THERAPEUTI C	0. 000000	28, 602		0 545, 636	0	76.03
76.04 03954 WOUND CARE CENTER	0. 000000	0		0 0	0	76.04
76. 05 03340 BARIATRIC CLINIC	0. 000000	0		0 0	0	76.05
76.06 03030 HEALTHY LIVING CENTER	0. 000000	0		0 0	0	76.06
76.07 03950 CV RESOURCE CENTER	0. 000000	0		0 0	0	76.07
76.08 03955 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000	0		0 0	0	76.08
76.09 03956 LACTATION CLINIC	0. 000000	0		0 0	0	76.09
76.10 03957 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000	0		0 0	0	76.10
76.11 03958 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000	0		0 0	0	76. 11
76.12 03959 ANTICOAGULATION CLINIC	0. 000000	0		0 0	0	76. 12
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000	0		0 0	0	77.00
OUTPATIENT SERVICE COST CENTERS						1
91.00 09100 EMERGENCY	0. 000000	5, 284, 315		0 6, 217, 948	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	1, 416, 997		0 1, 703, 916	0	92.00
200.00 Total (lines 50 through 199)		74, 046, 605		0 64, 469, 172	0	200.00
						•

Image: construction         Error Bit 2012/12/2222         Part Y monoport 2012/12/222         Start Y monoport 2012/12/22         Start	Health Financial Systems	FRANCI SCAN H				u of Form CMS-2	2552-10
Cost Center Description         Cost to Charge PS Reinbursed Ratio From Wirksheet C, Part I, col. 9         Title XVIII         Hospital         PS Services Cost         Cost S Reinbursed Subject To Ded & Cons         Cost S Reinbursed Subject To Subject To Ded & Cons         Cost S Reinbursed Subject To Subject Subject	APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	D VACCINE COST	Provider C	CN: 15-0090			narodi
Title XVIII         Hospital         PPS           Cost Center Description         Cost to Charge PS Reinbursed Art 1, col. 9         Cost Reinbursed Services, Cost Subject To Ded. & Cons.         PPS - Cost Reinbursed Subject To Reinbursed Subject To Reinbursed Subject To Ded. & Cons.         PPS - Cost Reinbursed Subject To Reinbursed Subject To Reinbursed Subject To Reinbursed Subject To Reinbursed Subject To Reinbursed Subject To Reinbursed Reinbursed Subject To Reinbursed Subject To R					10 12/31/2022		00 am
Cost Center Description         Cost to Charge PS Reinbursed Worksheet C, Part I, col. 9         Cost cost Reinbursed Subject To Ded. & Coins.         Cost Subject To Ded. & Coins.         PPS Services (see inst.)         PPS Services Subject To Ded. & Coins.           ANCI LLARY SERVICE COST CENTERS         1.00         2.00         3.00         4.00         5.00           05000 DFERATING ROW 00 05000 DFERATING ROW 00 05000 NETATING ROW 00 00 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			Title	e XVIII	Hospi tal		
Ratio From Bervices         Ratio From Services (see inst.)         Reimbursed Services (see inst.)         Reimbursed Services (see inst.)         (see inst.)           60.00         05000         0         0         0         0         0         0           50.01         05001         0				Charges		Costs	
Worksheet C, Part I, col. 9         inst. )         Subject To Subject To Subjec	Cost Center Description		PPS Reimbursed	Cost	Cost		
Part I. col. 9         Subject To Ded. & Coln S. (see inst.)         Subject To Ded. & Coln S. (see inst.)           50.00         0         2.00         3.00         4.00         5.00           50.00         05000 (DPERATI INC ROM 0.0000 (DPERATI INC ROM 50.01         0.083926         10.0688.144         0         0         897.013         50.0           50.01         05001 (DUTPAT LENT SURGERY 50.00         0.601207         32.958         0         0         19.815         50.0           51.00         05100 (AUCSTRES)         0.340615         1.613.118         0         0         54.91         55.00           55.00         05500 (RADI INSTOPE         0.340615         1.613.118         0         0         64.03         54.01           56.00         05600 (RADI INSTOPE         0.155586         3.938.492         0         0         24.03.34         60.0           66.00         06000 (DESPI RATORY THERAPEUTI C         0.000000         0         0         34.31         65.0           66.00         66000 (DESPI RATORY THERAPEUTI C         0.0334.600         0         4.207.334         60.0         34.22         60.0         63.23         65.00         65.00         65.00         65.00         65.00         65.00         65.00						(see inst.)	
NUMBER         Dec.         A COI ns. (see inst.)         Dec.         Sec inst.)           0.00         0.000         0.001         5.00         5.00           0.01         0.5000         0PRATING ROOM         0.033926         10.688, 144         0         0         897, 013         50.00           0.01         0.05001         0PRATING ROOM         0.154811         2, 958         0         0         19, 915         50.00           50.00         0.5000         RECOVERY ROOM         0.154811         2, 855, 131         0         0         442, 006         51.00           50.00         0.5000         RADIOLOGY - PROCEALL PROCEDURES         0.394041         0         0         946, 303         54.00           50.00         05500         RADIOLOGY - PREAVENTIC         0.000000         0         0         55.00         0         56.00         0.5000         113823         87, 538         0         0         9, 794         63.01         54.00         0.420, 334         60.0         36.341         65.00         56.00         0.5000         11383         87, 538         0         0         79, 794         63.00         63.00         63.01         52.00         56.00         56.00         56.00			· · ·				
Inclusion         Inclusion         Case Inst.         (see Inst.)         (see Inst.)           ANCILLARY SERVICE COST CENTERS         1.00         2.00         3.00         4.00         8.70         13.50           ANCILLARY SERVICE COST CENTERS         0.08392.61         10.688, 144         0         0.897, 013         50.01           50.01         005001 QUTPATIENT SURGERY         0.601207         32.958         0         0.19, 815         50.01           51.00         005300 ANESTHESIOLOGY         0.340615         1.613, 118         0         549, 452         53.00           54.01         05401 RADIOLOGY-JACANSTIC         0.067221         5, 147, 110         0         0         0         0         54.00           55.00         05500 RADIOLOGY-JACANSTIC         0.067021         1, 747, 664         0         0.203, 346, 60.0         65.00         65.00         66.00         66.00         66.00         9.794, 63.0         0         9, 794, 63.0         0         9, 794, 63.0           65.00         060500 RESPIRATIONY THERAPY         0.234588         11.419         0         0.3.821, 66.0         0         66.00         66.00         0.6000 PHYSICAL THERAPY         0.234588         1.419         0         1.282, 67.70.0         1.282, 67.70.0<		Part I, col. 9					
MACI LLARY SERVICE COST CENTERS         0.083926         0.0683926         0.0683926         0.0683926         0.0683926         0.0683926         0.0683926         0.0683926         0.0683926         0.0683926         0.0683926         0.0683926         0.0683926         0.0683926         0.0683926         0.0683926         0.0633926         0.06							
ANCILLARY SERVICE COST CENTERS		1.00	2.00	(see inst.)	(see inst.)	F 00	
50.00         05000         05000         05000         05000         05000         05000         05000         05000         05000         05000         05000         05000         05000         05100         05100         05100         05000         05100         05000         05100         05000         05100         05000         05400         05400         51.00         05000         05400         05400         05400         05400         05400         05400         05400         05400         05400         05400         05400         05400         05400         05400         05400         05500         05500         05500         05500         05500         05500         05500         05500         05500         05500         05600         06000         0 <t< td=""><td></td><td>1.00</td><td>2.00</td><td>3.00</td><td>4.00</td><td>5.00</td><td></td></t<>		1.00	2.00	3.00	4.00	5.00	
50.01         05001         01017PATIENT SURCERY         0.601207         32,958         0         0         19,815         50.0           51.00         05000         RECOVERY ROM         0.154811         2,855,131         0         0         442.006         51.0           54.00         05400         RADIOLOGY-DIAGNOSTIC         0.067281         5.147,110         0         0         346,33         54.0           55.01         05500         RADIOLOGY-THERAPUTIC         0.000000         0         0         0         55.0           05500         RADIOLOGY-THERAPUTIC         0.000000         0         0         0         54.0           05600         RADIOLOGY-THERAPUTIC         0.000000         0         0         0         0         55.0           05600         RADIOLOGY-THERAPUTIC         0.000000         0         0         0.03.344         60.0         60.00         60.00         60.00         60.00         9,794         63.0         63.01         51.04         7.749         0.0         38.241         65.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         70.00         1.262.56.0		0.002024	10 699 144	1	0	907 012	50 00
51:00       05100       RECOVERY ROOM       0.154811       2.855,131       0       0       442,006       51.0         54:00       05400       RADIOLOGY-OLACNOSTIC       0.067281       5.147,110       0       0       346,303       54.0         54:00       05400       RADIOLOGY-SPECIAL PROCEDURES       0.396041       0       0       0       54.0         05400       RADIOLOGY-FIREARPEUTIC       0.000000       0       0       0       55.0       0       05000       ADIOLAGY-FIREARPEUTIC       0.000000       0       0       66.0       0       66.00       0       66.00       0.6000 ESPIR ATORY       0.155586       3.938,492       0       0       63.0       0       66.00       66.00       66.00 CRESPIR ATORY       0.234588       11.313,395       0       0       3.821       66.00       0       66.00       0.6000 CCUPATIONAL THERAPY       0.234588       11.419       0       0       3.821       66.00       0       60.00       6.00       0.0000 CLECTROCARGRAPHY       0.228344       6.428       0       0       1.26.05       70.0       70.0       70.0       70.0       70.0       70.0       70.0       70.0       70.0       70.0       70.0       70.0							
53:00       05300       ANESTHESI OLOGY       0.340615       1, 613, 118       0       0       549, 452       53.0         54:00       05400       RADI OLOGY - SPECI AL PROCEDURES       0.396041       0       0       0       55.0         05500       RADI OLOGY - SPECI AL PROCEDURES       0.396041       0       0       0       55.0         05500       RADI OLOGY - THERAPEUTIC       0.000000       0       0       0       240, 334       60.0         05600       D6000       LABORATORY       0.137407       1.749, 064       0       240, 334       60.0       66.00       66.00       96.00       97.94       63.0       65.00       0.63.01       65.00       0.6000       0.774       56.00       0       63.01       56.00       0.6000       97.94       63.01       65.00       0.6000       97.94       63.01       65.00       0.6000       97.95       75.92       0       0       3.821       66.00       66.00       66.00       66.00       66.00       62.02       69.00       97.02       0       0       1.282, 560       69.00       7.051       73.592, 720       0       0       1.263, 381       70.07       07.00       07.000       1.282, 581, 70.00							
54:00         05400         RADIOLOGY-DIAGNOSTIC         0.067281         5.147,110         0         0         346,303         54.00           54:01         05401         RADIOLOGY-SPECIAL PROCEDURES         0.390641         0         0         0         55.00           05:00         05500         RADIOLOGY-THERAPEUTIC         0.000000         0         0         0         61.00           05:00         RADIOLOGY-THERAPEUTIC         0.0155586         3.938,492         0         0.71774         56.00           00:00         06000         LABORATORY         0.137407         1.749,064         0         240,334         60.0           06:00         06000         PESPIRATORY THERAPY         0.234588         11.149         0         3.6321         66.00           06:00         0CCUPATIONAL THERAPY         0.235501         1.54,636         0         0         4.2602         68.00           00:000         CCUPATIONAL THERAPY         0.275501         1.54,636         0         0         1.282,560         69.00           00:000         COUCPATIONAL THERAPY         0.275501         1.54,636         0         1.282,560         69.00           00:000         00:000         0.077205         17,529,20							•
64.01         64.01         64.01         64.01         0         0         0         0         54.00           55.00         05500         RADI OLOGY-SPECIAL PROCEDURES         0.000000         0         0         0         0         0         0         0         0         0         55.00         0.00000         0         0         0         55.00         0.00000         0         0         0         0         0         0         0         55.00         0.00000         0         0         0         0         0         0         0.0000         0         0         0         0         0.00000         0         0         0.00000         0         0         0.0000         0         0.00000         0         0         0.000000         0         0.000000         0         0.0000000         0         0.00000000         0         0.00000000         0         0.00000000         0         0.000000000         0         0.0000000000         0         0.0000000000         0         0.000000000000         0         0.00000000000000000000000000000000000					-		
55.00         05500         NADIO LOGY-THERAPEUTI C         0.00000         0         0         0         0         55.00         0         05600         NADIO LOGY-THERAPEUTI C         0.00000         0         0         612.774         56.00           66.00         0.6000         LABORATORY         0.157407         1.749,064         0         0         240.334         60.00           65.00         0.6000         RESPI RATORY THERAPY         0.276581         131.395         0         0         36.31         65.00           66.00         0.00000 OCCUPATIONAL THERAPY         0.234588         11.419         0         3.821         66.00           66.00         0.0000 CCUPATIONAL THERAPY         0.235501         154.636         0         0         1.822,560         69.00           67.00         0.7000 ELECTROCARD OLGGY         0.729051         17,592,209         0         1.282,550         69.00           71.00         07000 IRPL. DEV, CHARGED TO PATI ENT         0.30512         4.130,550         0         1.240,038         71.20           72.00         07200 IRPL. DEV, CHARGED TO PATI ENTS         0.241437         3.961,833         0         0.2432,237         72.00           73.00         07300 URLS         CHAR					-		•
56. 00         056. 00         Noil OI SOTOPE         0.155586         3.988. 492         0         0         612, 774         56. 00           60. 00         06000         LABORATORY         0.137407         1,749, 064         0         0240, 334         60. 0           60. 00         06000         PROCESSI NG & TRANS.         0.111883         87, 538         0         9, 794         63. 0           66. 00         06000         PHYSI CAL. THERAPY         0.234588         11, 419         0         0         3, 821         66. 0           66. 00         06000         SPEECH PATHOLOGY         0.275501         154, 636         0         0         1, 282, 560         69. 0           60. 0         06000         RECCH TRANCED TO PATI ENT         0.324581         1, 419         0         1, 282, 560         69. 0           70. 00         07000         LECTROCARDI OLOGY         0.275501         154, 636         0         0         1, 282, 560         69. 0         1, 282, 560         69. 0         1, 200, 67. 70. 0         1, 200, 67. 70. 0         1, 200, 67. 70. 0         1, 200, 67. 70. 0         1, 200, 67. 70. 0         1, 200, 67. 70. 0         1, 200, 67. 70. 0         1, 200, 67. 70. 0         1, 200, 57. 75. 75. 75. 75. 75. 75. 75. 75. 75.							
60:00         06:00         LBORATORY         0.137407         1,749,064         0         240,334         0.0           63:00         06:300         BLOOD STORING, PROCESSING & TRANS.         0.111883         87,538         0         0         9,794         63.0           66:00         06:500         RESPI RATORY THERAPY         0.334588         11,419         0         03,821         66.00           06:00         000         0000         0000         0000         17,592,209         0         1,282,660         69.00           06:00         0000         ELECTROCARDIOLOGY         0.2275501         17,592,209         0         1,280,371         0.67         0.00           000         07000         ELECTROCARDIOLOGY         0.325126         4,130,550         0         1,260,338         71.00         0.234030         0         2,432,237         72.00         0.200         0.000         0         0         0         0         76.00         76.00         0         0         0         0         76.00         76.00         76.00         76.00         76.00         76.00         76.00         76.00         76.00         76.00         76.00         76.00         76.00         76.00         76.00							
63:00         06300         Decode Strep NG, PROCESSING & TRANS.         0.111883         87,538         0         0         9,794         63.0           65:00         06500         RESPI RATORY THERAPY         0.234588         111,195         0         36.341         65.00           06500         PHYSI CAL THERAPY         0.234588         11,419         0         0         3.821         66.0           06600         SPEECH PATHOLOGY         0.275501         154,636         0         0         42,602         68.0           06800         SEECTROENCEPHALOGRAPHY         0.122891         977,024         0         122,067         69.0           071.00         OTOOD         MELCTROCARDIOLOGY         0.072905         17,592,209         0         1,226,038         71.0           071.00         OTOOD         MEDICAL SUPPLIES CHARGED TO PATIENT         0.05126         4,130,550         0         0         1,226,338         75.03           07300         DURUS CHARGED TO PATIENTS         0.251640         2,924,623         0         7,651         735,952         73.0           0         03951         PAIN CLINIC         0.158876         0         0         0         76.0           0.3953         ACT							•
65.00         06500         RESPIRATORY THERAPY         0.276581         131.395         0         0         36.341         65.0           66.00         06600         PHYSICAL THERAPY         0.334588         11,419         0         0         3,821         66.0           66.00         06600         PHYSICAL THERAPY         0.2334588         11,419         0         0         1,822         67.0           67.00         0C00         0CUPATIONAL THERAPY         0.275501         155,922,209         0         0         1,282,560         69.0           67.00         0F000         ELECTROCARDIOLOGY         0.72205         17,592,209         0         0         1,260,387         71.0           0.00         07000         IELECTROCARDIOLOGY         0.7205         4,130,550         0         0         1,260,387         72.0           0.00         07000         INUCAL SUPPLIES CHARGED TO PATIENTS         0.251640         2,924,623         0         7,651         735,952         73.0           0.03630         IULTRA SOUND         0.104367         0         0         0         0         0         76.0           0.3351 CH1 VITY THERAPUTIC         0.33874         90.00         0         0							
66.00         06600         PHYSICAL THERAPY         0.334588         11,419         0         0         3,821         66.00           67.00         06700         OCCUPATI ONAL THERAPY         0.283484         6,428         0         0         1,822         67.00           68.00         06800         SPEECH PATHOLOGY         0.275501         154,636         0         0         42,602         68.0           69.00         ELECTROCARDIOLOGY         0.072905         17,592,209         0         1,282,560         69.00           07.00         ELECTROENCEPHALOGRAPHY         0.122891         977,024         0         1,260,338         71.0           71.00         07100         MEDI CAL SUPPLIES CHARGED TO PATIENTS         0.613917         3,961,833         0         2,432,237         72.00           73.00         07300         DRUS CHARGED TO PATIENTS         0.134367         0         0         0         76.01           76.01         03651         PAI N CLINIC         0.158876         0         0         0         0         76.0           76.02         03952 ATH LAB         0.79036         0         0         0         0         76.0           76.04         03954 WOUND CARE CENTER </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>•</td>							•
67.00       06700       0CCUPATIONAL THERAPY       0.283484       6,428       0       0       1,822       67.0         68.00       06800       SPECH PATHOLOGY       0.275501       154,636       0       0       42,602       68.0         69.00       06900       ELECTROENCEPHALOGRAPHY       0.122891       977,024       0       0       1,282,237       72.0         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENT       0.30512       4,130,550       0       0       2,432,237       72.0       77.00       0       0       2,432,237       72.0       77.00       0       0       0       2,432,237       72.0       73.00       0.3053       ULTRA SOUND       0.104367       0       0       0       76.0							•
68.00         06800         SPECH PATHOLOGY         0.275501         154,636         0         0         42,602         68.0           69.00         06900         ELECTROCARDIOLOGY         0.275501         154,636         0         0         1,282,560         69.0           70.00         07000         ELCTROCARDIOLOGY         0.228911         977,024         0         0         1,280,530         71.00         1,260,338         71.0         72.00         071.00         ELCL SUPPLIES CHARGED TO PATIENT         0.305126         4,130,550         0         0         1,260,338         71.0           72.00         07300         DRUE.         CHARGED TO PATIENTS         0.251640         2,924,623         0         7,651         735.952         73.0           73.00         07300         DRUS CHARGED TO PATIENTS         0.251640         2,924,623         0         0         0         76.0           76.01         03951         PAIN CLINIC         0.104367         0         0         0         76.0         76.0         76.0         76.0         76.0         76.0         76.0         76.0         76.0         76.0         76.0         76.0         76.0         76.0         76.0         76.0         76.0							•
69:00         06900         ELECTROCARDIOLOGY         0.072905         17, 592, 209         0         0         1, 282, 560         69. 0           70.00         07000         ELECTROENCEPHALOGRAPHY         0.122901         977, 024         0         0         120, 067         70. 0           71.00         07100         MPL         LSUPPLIES CHARGED TO PATIENT         0.305126         4, 130, 550         0         0         2, 432, 237         72. 0           72.00         07300         DRUGS CHARGED TO PATIENTS         0.251640         2, 924, 623         0         7, 651         735, 952         73. 0           76.00         0350         ULTRA SOUND         0.104367         0         0         0         0         76. 0           76.01         03951         PAIN CLINIC         0.158876         0         0         0         76. 0           76.02         03952         CATH LAB         0.079036         0         0         0         76. 0         76. 0           76.04         03954         WOUND CARE CENTER         0.398749         0         0         0         76. 0           76.05         03300         HEALTHY LUVING CENTER         0.090000         0         0         76. 0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>•</td>							•
70.00       07000       ELECTROENCEPHALGGRAPHY       0.122891       977,024       0       0       120,067       70.0         71.00       07100       MEDICAL SUPPLIES CHARGED TO PATIENT       0.305126       4,130,550       0       0       1,260,338       71.00         72.00       07200       IMPL DEV. CHARGED TO PATIENTS       0.613917       3,961,833       0       2,432,237       72.0         73.00       03051       PAIN CLINIC       0.158876       0       0       0       76.00         76.01       03952       CATH LAB       0.079036       0       0       0       76.00         76.03       03953       ACTIVITY THERAPEUTIC       0.333889       545,636       0       0       0       76.00         76.04       03954       WOUND CARE CENTER       0.398749       0       0       0       76.00         76.05       03303       HEATHY LIVING CENTER       0.000000       0       0       0       76.00         76.04       03955       OTHER ANCI LLARY SERVICE COST CENTERS       0.000000       0       0       0       76.00         76.05       03300       HEATHY LIVING CENTER       0.000000       0       0       0       76.0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENT       0.305126       4, 130, 550       0       1, 260, 338       71.0         72.00       07200       IMPL.       DEV. CHARGED TO PATI ENTS       0.613917       3, 961, 833       0       0       2, 432, 237       72.0         73.00       07300       DR300       DRUSC CHARGED TO PATI ENTS       0.613917       3, 961, 833       0       0       2, 432, 237       72.0         76.00       03630       ULTRA SOUND       0.104367       0       0       0       76.0         76.02       03951       PAI N CLINIC       0.158876       0       0       0       76.0         76.03       03953       ACTIVITY THERAPEUTIC       0.333889       545, 636       0       0       76.0         76.04       03954       WOUND CARE CENTER       0.398749       0       0       0       76.0         76.05       0330       HEATITI C LINIC       0.492994       0       0       0       76.0         76.07       03955       OTHER ANCI LLARY SERVICE COST CENTER       0.000000       0       0       76.0         76.07       03956       CHERA ANCI LLARY SERVICE COST CENTERS       0.0000000       0       0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>•</td>							•
72.00       07200 IMPL.       DPL.       CHARGED TO PATI ENTS       0. 613917       3, 961, 833       0       0       2, 432, 237       72.00         73.00       07300 DRUGS CHARGED TO PATI ENTS       0. 251640       2, 924, 623       0       7, 651       735, 952       73.00         0       03630 ULTRA SOUND       0.104367       0       0       0       0       76.00         76.01       03951 PAIN CLINIC       0.158876       0       0       0       76.00         76.02       03952 CATH LAB       0.079036       0       0       0       76.00         76.03       03954 WOUND CARE CENTER       0.33889       545, 636       0       0       0       76.00         76.04       03954 WOUND CARE CENTER       0.398749       0       0       0       0       76.00         76.05       0330 HEALTHY LIVING CENTER       0.000000       0       0       0       76.00       76.00         76.06       03955 OTHER ANCI LLARY SERVICE COST CENTERS       0.000000       0       0       0       76.00         76.07       03956 OTHER ANCI LLARY SERVICE COST CENTERS       0.000000       0       0       0       76.00         76.08       03955 OTHER ANCI							
73.00       07300       DRUGS CHARGED TO PATIENTS       0.251640       2,924,623       0       7,651       735,952       73.0         76.00       03951       PAIN CLINIC       0.104367       0       0       0       76.00         03952       CATH LAB       0.079036       0       0       0       76.00       03952         76.01       03952       CATH LAB       0.079036       0       0       76.00       0       0       76.00         76.02       03953       ACTIVITY THERAPEUTIC       0.33889       545,636       0       0       76.00       76.00         76.04       03954       WOUND CARE CENTER       0.398749       0       0       0       76.00					-		72.00
76.00       03630       ULTRA SOUND       0.104367       0       0       0       76.00         76.01       03951       PAIN CLINIC       0.158876       0       0       0       76.00         76.02       03952       CATH LAB       0.079036       0       0       0       76.00         76.03       03953       ACTIVITY THERAPEUTIC       0.33889       545,636       0       0       182,182       76.00         76.04       03954       WOUND CARE CENTER       0.398749       0       0       0       76.00         76.05       03340       BARI ATRIC CLINIC       0.492994       0       0       0       76.00         76.06       03030       HEALTHY LIVING CENTER       0.000000       0       0       76.00         76.07       03955       CTHER ANCILLARY SERVICE COST CENTERS       0.000000       0       0       76.00         76.10       03955       OTHER ANCILLARY SERVICE COST CENTERS       0.000000       0       0       0       76.00         76.10       03956       LACTATI ON CLINIC       0.000000       0       0       0       76.00         76.10       03957       OTHER ANCILLARY SERVICE COST CENTERS       0.0							•
76. 01       03951       PAIN CLINIC       0.158876       0       0       0       0       76. 0         76. 02       03952       CATH LAB       0.079036       0       0       0       76. 0         76. 03       03953       ACTI VI TY THERAPEUTI C       0.333889       545, 636       0       0       182, 182       76. 0         76. 04       03954       WOUND CARE CENTER       0.398749       0       0       0       76. 0         76. 05       03340       BARI ATRI C CLINI C       0.492994       0       0       0       76. 0         76. 07       03950       CV RESOURCE CENTER       0.000000       0       0       0       76. 0         76. 08       03955       OTHER ANCI LLARY SERVICE COST CENTERS       0.000000       0       0       0       76. 0         76. 09       03956       ILACTATI ON CLI NI C       0.000000       0       0       0       76. 0         76. 10       03957       OTHER ANCI LLARY SERVICE COST CENTERS       0.000000       0       0       0       76. 1         76. 11       03958       OTHER ANCI LLARY SERVICE COST CENTERS       0.000000       0       0       0       76. 1							76.00
76. 02       03952       CATH LAB       0. 079036       0       0       0       76. 0         76. 02       03953       ACTI VI TY THERAPEUTI C       0. 33889       545, 636       0       0       182, 182       76. 0         76. 04       03954       WOUND CARE CENTER       0. 398749       0       0       0       0       76. 0         76. 05       03340       BAR TATI C CLI NIC       0. 492994       0       0       0       0       76. 0         76. 06       03030       HEALTHY LIVING CENTER       0. 000000       0       0       0       76. 0         76. 07       03950       CV RESOURCE CENTER       0. 000000       0       0       0       76. 0         76. 09       03955       OTHER ANCI LLARY SERVICE COST CENTERS       0. 000000       0       0       0       76. 0         76. 10       03957       OTHER ANCI LLARY SERVICE COST CENTERS       0. 000000       0       0       0       76. 1         76. 11       03958       OTHER ANCI LLARY SERVICE COST CENTERS       0. 000000       0       0       0       76. 1         77. 00       700       ALLOGENEI C STEM CELLACOUI SI TI ON       0. 000000       0       0       0							76.01
76.03       03953       ACTIVITY THERAPEUTIC       0.333889       545,636       0       0       182,182       76.0         76.04       03954       WOUND CARE CENTER       0.398749       0       0       0       76.0         76.05       03340       BARIATRIC CLINIC       0.492994       0       0       0       76.0         76.07       03950       CV RESOURCE CENTER       0.000000       0       0       0       76.0         76.08       03955       OTHER ANCI LLARY SERVICE COST CENTERS       0.000000       0       0       0       76.0         76.09       03956       LACTATI ON CLI NI C       0.000000       0       0       0       76.0         76.11       03957       OTHER ANCI LLARY SERVICE COST CENTERS       0.000000       0       0       0       76.0         76.11       03959       ANTI CAGULATI ON CLI NI C       0.000000       0       0       0       76.1         76.12       03959       ANTI CAGULATI ON CLI NI C       0.472801       0       0       76.1         76.12       03959       ANTI CAGULATI ON CLI NI C       0.472801       0       0       77.0         70.0       0700       EMERGENCY					0 0	0	76.02
76. 04       03954       WOUND CARE CENTER       0. 398749       0       0       0       76. 0         76. 05       03340       BARI ATRI C CLINI C       0. 492994       0       0       0       76. 0         76. 06       03030       HEALTHY LIVING CENTER       0. 000000       0       0       0       76. 0         76. 07       03950       CV RESOURCE CENTER       0. 000000       0       0       0       76. 0         76. 08       03955       OTHER ANCI LLARY SERVICE COST CENTERS       0. 000000       0       0       0       76. 0         76. 09       03956       LACTATI ON CLI NI C       0. 000000       0       0       0       76. 0         76. 10       03957       OTHER ANCI LLARY SERVICE COST CENTERS       0. 000000       0       0       0       76. 1         76. 11       03958       OTHER ANCI LLARY SERVICE COST CENTERS       0. 000000       0       0       0       76. 1         77. 0       03759       ANTI COAGULATI ON CLINIC       0. 472801       0       0       0       76. 1         77. 0       0770       ALLOGENEI C STEM CELL ACQUI SI TI ON       0. 000000       0       0       0       77. 0         017	76. 03 03953 ACTIVITY THERAPEUTIC				0 0	182, 182	76.03
76.06       03030       HEALTHY LIVING CENTER       0.000000       0       0       0       76.0         76.07       03950       CV RESOURCE CENTER       0.000000       0       0       0       76.0         76.08       03955       OTHER ANCI LLARY SERVICE COST CENTERS       0.000000       0       0       0       76.0         76.09       03956       LACTATI ON CLI NIC       0.000000       0       0       0       76.0         76.10       03957       OTHER ANCI LLARY SERVICE COST CENTERS       0.000000       0       0       0       76.0         76.11       03958       OTHER ANCI LLARY SERVICE COST CENTERS       0.000000       0       0       0       76.0         76.12       03959       ANTI COAGULATI ON CLINIC       0.472801       0       0       0       76.1         77.00       0700       ALLOGENEI C STEM CELL ACQUI SI TI ON       0.000000       0       0       0       77.0         07100       ALLOGENEI C STEM CELL ACQUI SI TI ON       0.000000       0       0       0       77.0         07100       EMERGENCY       0.151339       6,217,948       0       0       782,736       92.0         09200       OBSERVATI ON					0 0		76.04
76.07         03950         CV RESOURCE CENTER         0.000000         0         0         0         76.0           76.08         03955         OTHER ANCI LLARY SERVI CE COST CENTERS         0.000000         0         0         0         0         76.0           76.09         03956         LACTATI ON CLI NI C         0.000000         0         0         0         0         76.0           76.10         03957         OTHER ANCI LLARY SERVI CE COST CENTERS         0.000000         0         0         0         0         76.0           76.11         03957         OTHER ANCI LLARY SERVI CE COST CENTERS         0.000000         0         0         0         0         76.1           76.12         03958         OTHER ANCI LLARY SERVI CE COST CENTERS         0.000000         0         0         0         76.1           76.12         03959         ANTI COAGULATI ON CLI NI C         0.472801         0         0         0         76.1           77.00         0700         ALLOGENEI C STEM CELL ACQUI SI TI ON         0.000000         0         0         0         77.0           01000         EMERGENCY         0.151339         6, 217, 948         0         0         782, 736         92.0	76.05 03340 BARIATRIC CLINIC	0. 492994	0		0 0	0	76.05
76.08         03955         OTHER ANCILLARY SERVICE COST CENTERS         0.000000         0         0         0         76.0           76.09         03956         LACTATION CLINIC         0.000000         0         0         0         0         76.0           76.10         03957         OTHER ANCILLARY SERVICE COST CENTERS         0.000000         0         0         0         0         76.0           76.11         03958         OTHER ANCILLARY SERVICE COST CENTERS         0.000000         0         0         0         0         76.1           76.12         03959         ANTI COAGULATI ON CLINIC         0.472801         0         0         0         76.1           77.00         07700         ALLOGENEIC STEM CELL ACQUI SITION         0.000000         0         0         0         77.0           01700         ALLOGENEIC STEM CELL ACQUI SITION         0.000000         0         0         0         77.0           0100         EMERGENCY         0.151339         6,217,948         0         0         941,018         91.0           92.00         09200         OBSERVATION BEDS (NON-DI STINCT PART         0.459375         1,703,916         0         7,651         10,939,167         200.0	76.06 03030 HEALTHY LIVING CENTER	0. 000000	0		0 0	0	76.06
76.09         03956         LACTATION CLINIC         0.00000         0         0         0         76.0           76.10         03957         OTHER ANCILLARY SERVICE COST CENTERS         0.000000         0         0         0         0         76.0           76.11         03958         OTHER ANCILLARY SERVICE COST CENTERS         0.000000         0         0         0         0         76.1           76.12         03959         ANTI COAGULATI ON CLINIC         0.472801         0         0         0         76.1           77.00         07700         ALLOGENEIC STEM CELL ACQUISITION         0.472801         0         0         0         76.1           77.00         07700         ALLOGENEIC STEM CELL ACQUISITION         0.000000         0         0         0         77.0           01700         EMERGENCY         0.151339         6,217,948         0         0         941,018         91.0           92.00         09200         BSERVATION BEDS (NON-DISTINCT PART         0.459375         1,703,916         0         782,736         92.0           200.00         Subtotal (see instructions)         64,469,172         0         7,651         10,939,167         200.0           201.00         Less P	76.07 03950 CV RESOURCE CENTER	0. 000000	0		0 0	0	76.07
76. 10       03957       0THER ANCI LLARY SERVICE COST CENTERS       0.000000       0       0       0       76. 1         76. 11       03958       0THER ANCI LLARY SERVICE COST CENTERS       0.000000       0       0       0       0       76. 1         76. 12       03959       ANTI COAGULATI ON CLINIC       0.472801       0       0       0       76. 1         77. 0       0700       ALLOGENEI C STEM CELL ACQUISITION       0.472801       0       0       0       77. 0         0100000       0       0       0       0       0       0       0       77. 0         010000       ALLOGENEI C STEM CELL ACQUISITION       0.000000       0       0       0       0       77. 0         01000       EMERGENCY       0.151339       6, 217, 948       0       0       91. 0       782, 736       92. 0         09200       OBSERVATION BEDS (NON-DISTINCT PART       0.459375       1, 703, 916       0       782, 736       92. 0       0       7, 651       10, 939, 167       200. 0         201. 00       Less PBP Clinic Lab. Services-Program Only Charges       64, 469, 172       0       7, 651       10, 939, 167       201. 0	76.08 03955 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000	0		0 0	0	76.08
76. 11       03958       0THER ANCI LLARY SERVICE COST CENTERS       0.000000       0       0       0       76. 1         76. 12       03959       ANTI COAGULATI ON CLINIC       0.472801       0       0       0       76. 1         77. 0       07700       ALLOGENEIC STEM CELL ACQUISITION       0.000000       0       0       0       77. 0         01700       ALLOGENEIC STEM CELL ACQUISITION       0.000000       0       0       0       77. 0         01700       ALLOGENEIC STEM CELL ACQUISITION       0.000000       0       0       0       77. 0         01700       ALLOGENEIC STEM CELL ACQUISITION       0.000000       0       0       0       77. 0         01701       OUTPATIENT SERVICE COST CENTERS       0.151339       6, 217, 948       0       0       941, 018       91. 0         92.00       09200       OBSERVATION BEDS (NON-DISTINCT PART       0.459375       1, 703, 916       0       782, 736       92. 0         200.00       Subtotal (see instructions)       64, 469, 172       0       7, 651       10, 939, 167       200. 0         201.00       Less PBP Clinic Lab. Services-Program Only Charges       0       0       0       201. 0       0       201. 0 <td>76.09 03956 LACTATION CLINIC</td> <td>0. 000000</td> <td>0</td> <td></td> <td>0 0</td> <td>0</td> <td>76.09</td>	76.09 03956 LACTATION CLINIC	0. 000000	0		0 0	0	76.09
76. 12       03959       ANTI COAGULATI ON CLINIC       0. 472801       0       0       0       76. 1         77. 00       07700       ALLOGENEIC STEM CELL ACQUISITION       0. 000000       0       0       0       77. 0         00TPATIENT SERVICE COST CENTERS       0. 151339       6, 217, 948       0       941, 018       91. 0         92. 00       09200       OBSERVATION BEDS (NON-DISTINCT PART       0. 459375       1, 703, 916       0       782, 736       92. 0         200. 00       Less PBP Clinic Lab. Services-Program Only Charges       64, 469, 172       0       0       0       201. 0	76. 10 03957 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000	0		0 0	0	76.10
77. 00         07700         ALLOGENEIC STEM CELL ACQUISITION         0.00000         0         0         0         77. 0           0UTPATIENT SERVICE COST CENTERS         0.151339         6,217,948         0         941,018         91. 0         92.00         09200         OBSERVATION BEDS (NON-DISTINCT PART         0.459375         1,703,916         0         77. 0         782,736         92. 0         20. 00         201.00         Less PBP Clinic Lab. Services-Program Only Charges         64,469,172         0         7,651         10,939,167         200. 0         201. 0	76. 11 03958 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000	0		0 0	0	76.11
OUTPATI ENT SERVICE COST CENTERS           91.00         09100         EMERGENCY         0.151339         6,217,948         0         0         941,018         91.0           92.00         09200         OBSERVATION BEDS (NON-DISTINCT PART         0.459375         1,703,916         0         0         782,736         92.0           200.00         Subtotal (see instructions)         64,469,172         0         7,651         10,939,167         200.0         201.0           201.00         Less PBP Clinic Lab. Services-Program         0         0         0         201.0	76.12 03959 ANTI COAGULATION CLINIC	0. 472801	0		0 0	0	76.12
91.00         09100         EMERGENCY         0.151339         6,217,948         0         0         941,018         91.0           92.00         09200         OBSERVATION BEDS (NON-DISTINCT PART         0.459375         1,703,916         0         0         782,736         92.0         92.0           200.00         Subtotal (see instructions)         64,469,172         0         7,651         10,939,167         200.0         201.0           201.00         Only Charges         0         0         0         201.0         0         0         201.0		0. 000000	0		0 0	0	77.00
92.00         09200         OBSERVATION         BEDS (NON-DISTINCT PART         0.459375         1,703,916         0         782,736         92.0           200.00         Subtotal (see instructions)         64,469,172         0         7,651         10,939,167         200.0         201.00         0         201.00         201.00         0         0         201.00         0         201.00         0         0         201.00         0         0         201.00         201.00         0         0         201.00         0         0         201.00         201.00         0         0         201.00         0         0         201.00         201.00         0         0         0         0         201.00 <td< td=""><td></td><td></td><td></td><td></td><td>_</td><td></td><td></td></td<>					_		
200. 00         Subtotal (see instructions)         64,469,172         0         7,651         10,939,167         200. 0           201. 00         Less PBP Clinic Lab. Services-Program Only Charges         0         0         201. 0         201. 0						941, 018	
201.00 Less PBP Clinic Lab. Services-Program 0 0 201.0 Only Charges		0. 459375			-		•
Only Charges			64, 469, 172			10, 939, 167	
					0 0		201.00
202.00   Net Charges (line 200 - line 201)     64,469,172  0  7,651  10,939,167 202.0					-		
	202.00   Net Charges (line 200 - line 201)		64, 469, 172	I	U 7, 651	10, 939, 167	202.00

PPORTI ONME	ENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-0090	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part V Date/Time Pre 5/10/2023 11:	epared: 00 am
			Title	e XVIII	Hospi tal	PPS	
		Cos	ts				
	Cost Center Description	Cost	Cost	1			
	•	Reimbursed	Reimbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
			Ded. & Coins.				
		(see inst.)	(see inst.)				
		6.00	7.00				
	LLARY SERVICE COST CENTERS						
	O OPERATING ROOM	0	C				50.0
	1 OUTPATI ENT SURGERY	0	C				50.0
1.00 0510	O RECOVERY ROOM	0	C				51.0
3.00 0530	0 ANESTHESI OLOGY	0	C				53.0
4.00 0540	0 RADI OLOGY-DI AGNOSTI C	0	C				54.0
4.01 0540	1 RADI OLOGY-SPECI AL PROCEDURES	0	C				54. C
5.00 0550	0 RADI OLOGY-THERAPEUTI C	0	C				55. C
6.00 0560	0 RADI OI SOTOPE	0	C				56.0
0600 0600	0 LABORATORY	0	C				60.0
3.00 0630	O BLOOD STORING, PROCESSING & TRANS.	0	C				63.0
5.00 0650	0 RESPI RATORY THERAPY	0	C				65.0
6. 00 0660	O PHYSI CAL THERAPY	0	C				66.0
7.00 0670	O OCCUPATI ONAL THERAPY	0	C				67.0
8. 00 0680	O SPEECH PATHOLOGY	0	C				68.0
	0 ELECTROCARDI OLOGY	0	C				69.0
0700 0700	0 ELECTROENCEPHALOGRAPHY	0	C				70.0
1.00 0710	O MEDICAL SUPPLIES CHARGED TO PATIENT	0	C				71. (
2.00 0720	OIMPL. DEV. CHARGED TO PATIENTS	0	C				72. (
3.00 0730	O DRUGS CHARGED TO PATIENTS	0	1, 925				73. (
6.00 0363	O ULTRA SOUND	0	C				76.0
6.01 0395	1 PAIN CLINIC	0	C				76. (
6. 02 0395	2 CATH LAB	0	C				76. (
6. 03 0395	3 ACTIVITY THERAPEUTIC	0	C				76.
6.04 0395	4 WOUND CARE CENTER	0	C				76. (
6. 05 0334	O BARIATRIC CLINIC	0	C				76.0
5. 06 0303	O HEALTHY LIVING CENTER	0	C				76.0
5.07 0395	O CV RESOURCE CENTER	0	C				76.
5.08 0395	5 OTHER ANCILLARY SERVICE COST CENTERS	0	C				76.0
	6 LACTATION CLINIC	0	C				76.0
5. 10 0395	7 OTHER ANCILLARY SERVICE COST CENTERS	0	C				76.
	8 OTHER ANCILLARY SERVICE COST CENTERS	0	C				76.
	9 ANTI COAGULATI ON CLINIC	0	C				76.
	O ALLOGENEIC STEM CELL ACQUISITION	0	C				77.0
	ATIENT SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·					1
	0 EMERGENCY	0	C	)			91.0
	O OBSERVATION BEDS (NON-DISTINCT PART	0	C				92.0
20.00	Subtotal (see instructions)	0	1, 925				200.0
01.00	Less PBP Clinic Lab. Services-Program	0	., 720				201.0
	Only Charges						[
02.00	Net Charges (line 200 - line 201)	0	1, 925				202. (

leal th Financial Systems		EALTH- DYER	In Lieu of Form CMS-2552-10			
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider C	CN: 15-0090	Period: From 01/01/2022	Worksheet D Part II	
		Component	CCN: 15-T090	To 12/31/2022	Date/Time Pre	pared:
				<u></u>	5/10/2023 11:	00 am
		ΠΤΙΕ	e XVIII	Subprovider - IRF	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos		Capital Costs	
	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS			1			
50. 00 05000 OPERATI NG ROOM	746, 677				1, 554	
50. 01 05001 OUTPATI ENT SURGERY	348, 570					
51.00 05100 RECOVERY ROOM	151, 354					
53. 00 05300 ANESTHESI OLOGY	58, 330				44	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	983, 839				4, 089	
54. 01 05401 RADI OLOGY-SPECI AL PROCEDURES	85, 944	9, 636, 549			0	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	0.0000	0 00	0	55.00
56. 00 05600 RADI OI SOTOPE	192, 256	9, 102, 386	0. 02112	21 14, 356	303	56.00
60. 00 06000 LABORATORY	253, 678	73, 270, 506	0.00346	52 1, 206, 067	4, 175	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	66, 279			36 19, 904	939	63.00
65. 00 06500 RESPI RATORY THERAPY	131, 344	15, 382, 450	0.00853	822, 045	7, 019	65.00
66. 00 06600 PHYSI CAL THERAPY	121, 719	19, 978, 323	0.00609	2, 734, 073	16, 659	66.00
67.00 06700 OCCUPATI ONAL THERAPY	27, 479	5, 131, 595	0.00535	55 2, 781, 941	14, 897	67.00
68.00 06800 SPEECH PATHOLOGY	19, 187	3, 891, 921	0.00493	30 1, 158, 874	5, 713	68.00
69. 00 06900 ELECTROCARDI OLOGY	166, 101	27, 556, 508	0.00602	28 137, 975	832	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	124, 945	5, 192, 885	0. 02406	6, 194	149	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	112, 472	42, 346, 338	0.00265	699, 761	1, 859	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	95, 983	18, 489, 109	0.00519	91 17, 874	93	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	218, 506	37, 923, 463	0.00576	52 1, 191, 390	6, 865	73.00
76.00 03630 ULTRA SOUND	95, 059	12, 884, 112	0.00737	78 0	0	76.00
76. 01 03951 PAIN CLINIC	292, 682	9, 743, 027	0. 03004	10 0	0	76.01
76.02 03952 CATH LAB	424, 255	63, 068, 844	0.00672	27 0	0	76.02
76. 03 03953 ACTI VI TY THERAPEUTI C	148, 084	6, 259, 406	0. 02365	58 0	0	76.03
76.04 03954 WOUND CARE CENTER	153, 611	2, 771, 666	0. 05542	22 0	0	76.04
76. 05 03340 BARIATRIC CLINIC	70, 769	5, 000, 548	0. 01415	52 0	0	76.05
76.06 03030 HEALTHY LIVING CENTER	0	0	0.0000	0 00	0	76.06
76. 07 03950 CV RESOURCE CENTER	0	c c	0.0000	0 00	0	76.07
76.08 03955 OTHER ANCILLARY SERVICE COST CENTERS	0	l o	0.0000	0 00	0	76.08
76.09 03956 LACTATION CLINIC	0	c c	0.0000	0 00	0	76.09
76. 10 03957 OTHER ANCILLARY SERVICE COST CENTERS	0	l o	0.0000	0 00	0	76.10
76. 11 03958 OTHER ANCILLARY SERVICE COST CENTERS	0	C			0	
76. 12 03959 ANTI COAGULATI ON CLINIC	15, 599	1, 201, 052			0	
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0				0	
OUTPATI ENT SERVI CE COST CENTERS						1
91. 00 09100 EMERGENCY	498, 366	65, 880, 360	0.00756	55 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	9, 956, 749	0.0000	0	0	92.00

Health Financial Systems	FRANCI SCAN HE				In Lieu	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE THROUGH COSTS	RVICE OTHER PASS	Provider C Component	CN: 15-0090 CCN: 15-T090	Period: From 01/0 To 12/3	01/2022 31/2022	Worksheet D Part IV Date/Time Prep 5/10/2023 11:0	
		Title	e XVIII	Subprovi		PPS	
Cost Center Description	Non Physician	Nursi ng	Nursi ng			Allied Health	
	Anestheti st	Program	Program	Post-St			
	Cost	Post-Stepdown		Adj ust	ments		
	1.00	Adjustments 2A	2.00	3.	٨	3.00	
ANCI LLARY SERVI CE COST CENTERS	1.00	28	2.00		A	3.00	
50. 00 05000 OPERATI NG ROOM	0	0		0	0	0	50.00
50. 01 05001 OUTPATIENT SURGERY	0	0		0	0	0	50.01
51.00 05100 RECOVERY ROOM	0	0		0	0	0	51.00
53. 00 05300 ANESTHESI OLOGY	0	0		0	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	o	0		0	0	0	54.00
54. 01 05401 RADI OLOGY-SPECI AL PROCEDURES	0	0		0	0	0	54.01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0	0	0	55.00
56. 00 05600 RADI OI SOTOPE	0	0		0	0	0	56.00
60. 00 06000 LABORATORY	0	0		0	0	0	60,00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0	0	0	63.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0	0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0	0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0	0	0	68.00
69.00 06900 ELECTROCARDI OLOGY	0	0		0	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	0	73.00
76.00 03630 ULTRA SOUND	0	0		0	0	0	76.00
76.01 03951 PAIN CLINIC	0	0		0	0	0	76.01
76. 02 03952 CATH LAB	0	0		0	0	0	76.02
76. 03 03953 ACTIVITY THERAPEUTIC	0	0		0	0	0	76.03
76.04 03954 WOUND CARE CENTER	0	0		0	0	0	76.04
76. 05 03340 BARIATRIC CLINIC	0	0		0	0	0	76.05
76.06 03030 HEALTHY LIVING CENTER	0	0		0	0	0	76.06
76.07 03950 CV RESOURCE CENTER	0	0		0	0	0	76.07
76.08 03955 OTHER ANCI LLARY SERVICE COST CENTERS	0	0		0	0	0	76.08
76.09 03956 LACTATION CLINIC	0	0		0	0	0	76.09
76. 10 03957 OTHER ANCI LLARY SERVICE COST CENTERS	0	0		0	0	0	76.10
76. 11 03958 OTHER ANCI LLARY SERVICE COST CENTERS	0	0		0	0	0	76.11
76. 12 03959 ANTI COAGULATI ON CLINIC	0	0		0	0	0	76.12
77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0		0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS							04.05
91.00 09100 EMERGENCY	0	0		0	0	0	91.00
92. 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

50.01         OSD1         OUTPATIENT SUBGERY         0         0         4         2.56, 107         0.000000         55           51.00         05300         RECOVERY ROM         0         0         0         8, 265, 498         0.000000         55           54.00         05400         RANDILLOGY-DIAGNOSTIC         0         0         0         66, 928, 182         0.000000         55           54.00         05400         RADILLOGY-SPECIAL PROCEDURES         0         0         0         0.000000         55           50.00         05600         RADILLOGY-THERAPEUTIC         0         0         0         0.000000         66           60.00         06000         RADRATORY         0         0         0         0         0.000000         66           60.00         06000         RESPI RATORY THERAPY         0         0         0         1.404, 643         0.000000         66           66.00         06500         RESPI RATORY THERAPY         0         0         0         1.532, 450         0.000000         66           66.00         06600         PHYSI CAL THERAPY         0         0         0         1.31, 595         0.0000000         72         756, 556	Health Financial Systems	FRANCI SCAN HE			In Lie	u of Form CMS-	2552-10
Component CCH: 15.1090         To         T2/31/2022         Date/Time Prepare 5/10/2023 11:00           Cost Center Description         All Other Medical Education Cost         Total Cost Will         Subprovider - It it e XVIII         Subprovider - Cost (sen of cols, and 4)         Retion Cost           ANCI LLARY SERVICE COST CENTERS         -         0		RVICE OTHER PASS	S Provider C	CN: 15-0090			
Cost Center Description         All Other Medical Education Cost         Total Cost (sum of cols. 4)         <	THROUGH COSTS		Component	CON. 15 TOOD	From 01/01/2022	Part IV	narad
Cost Center Description         All Other Medical Education Cost         Total Cost (sum of cost (sum of cost (sum of cost s) and 4)         Total Total Cost (sum of cost (sum of cost s) and 4)         Total Total Cost (sum of costs (sum of costs) 2, and 4,0         Total Cost (sum of costs) 2, and 4,0         Total Costs (sum of costs) 2, and 4,0         Total Cost (sum of costs) 2, and 4,0         Total Costs (sum of costs) 2, and 4,0         Total Costs (sum of costs) 2, and 4,0         Total Costs 2, and 4,0         Total Costs 4,0         Total Costs 4,0         Total Costs 4,0         Total Costs 4,0         Total Costs 4,0         Total Costs 4,0         Total Costs 4,0         Total Costs 4,0 <thtotal Costs 4,0         Total Costs 4,0</thtotal 			component	CCN: 15-1090	10 12/31/2022	5/10/2023 11:	00 am
Cost Center Description         All Other Medication Cost Education Cost Education Cost (sum of cost 4)         Total Cost (sum of cost (sum of co			Title	e XVIII	Subprovider -		
Medical Education Cost         (Sum of cols. 4)         Outpatient (Cost (sum of 4)         (Outpatient (cost (sum of 4))         (Prom Wkst, C, ol. (see instructions)         to Charges (see instructions)           ANCILLARY SERVICE COST CENTERS         4.00         5.00         6.00         7.00         8.00           0         0.000 (sec 00)         0         0         0         0         0.000000         5           0.00         <							
Education Cost (4)         Cost (4)         Cost (sum of (s)         Part I, col. (sol (sol (sol))         (col. (sol (sol (sol (sol (sol (sol (sol)))           ANCILLARY SERVICE COST CENTERS         4.00         5.00         6.00         7.00         8.00         7.00           50.00         05000 (DPEATING ROOM)         0         0         0         8.265,498         0.000000 (Sol (sol (sol (sol (sol (sol (sol (sol (s	Cost Center Description						
All         Col S. 2, 3, and 4)         B)         7) (see instructions)           ACILLARY SERVICE COST CENTERS         -         <							
ANCI LLARY SERVICE COST CENTERS         4.00         5.00         6.00         7.00         8.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00		Education Cost					
ANCI LLARY SERVICE COST CENTERS         4.00         5.00         6.00         7.00         8.00           NOCI LLARY SERVICE COST CENTERS         0         0         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00000         55.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00000         55.00         0.00         0.00         0.00         0.000000         55.00         0.000000         55.00         0.000000         55.00         0.000000         56.00         0.000000         56.00         0.000000         56.00         0.000000         56.00         0.000000         56.00         0.000000         56.00         0.000000         56.00         0.000000         56.00         0.000000         56.00         0.000000         56.00         0.000000         56.00         0.000000         50.00         56.00         0.000000         66.00         0.000000         66.00         0.000000         66.00         0.000000         66.00         0.000000         66.00         0.000000         66.00         0.000000         66.00         0.000000 <td></td> <td></td> <td>4)</td> <td></td> <td>8)</td> <td></td> <td></td>			4)		8)		
Image: Control of the contro				and 4)			
ANCILLARY SERVICE COST CENTERS         0 <th< td=""><td></td><td>4.00</td><td>F 00</td><td>( 00</td><td>7.00</td><td></td><td></td></th<>		4.00	F 00	( 00	7.00		
50. 00         05000 (DFEARTI NC ROM         0         0         69, 198, 843         0.000000 (S           50. 01         05001 (DTPAT IENT SURGERY         0         0         4, 258, 017         0.00000 (S           51. 00         05100 (RECOVERY ROM         0         0         8, 265, 498         0.000000 (S           53. 00         05300 ANESTHESI OLOGY         0         0         18, 737, 042         0.000000 (S           54. 01         05400 (RAD) OLOGY-14 GANOSTI C         0         0         66, 928, 182         0.000000 (S           55. 00         05500 (RAD) OLOGY-THERAPEUTI C         0         0         0         0.000000 (S           55. 00         05600 (RAD) OLOGY-THERAPEUTI C         0         0         0         0         0         0.000000 (S           56. 00         05600 (RAD) OLOGY-THERAPEUTI C         0		4.00	5.00	6.00	7.00	8.00	
50.01       00000       01       4.258.017       0.000000       51         51.00       05100       RECOVERY ROOM       0       0       0       8.265.498       0.000000       51         54.00       05300       ANESTHESI OLOGY       0       0       0       8.265.498       0.000000       55         54.00       05400       RADI OLOGY-DI AGNOSTI C       0       0       0       66.928       182       0.000000       55         55.00       05500       RADI OLOGY-THERAPEUTI C       0       0       0       0.000000       56         50.00       05600       RADI OLOGY-THERAPEUTI C       0       0       0       0.000000       66         60.00       06000       LABORATORY       0       0       0       7.3270.586       0.000000       66         61.00       06500       RESPI RATORY THERAPY       0       0       0       15.382.450       0.000000       66         62.00       06000       SEECH PATHOLOGY       0       0       0       13.1595       0.000000       67         63.00       06000       SEECH PATHOLOGY       0       0       0       2.756.586       0.0000000       77       73.00 <td></td> <td>0</td> <td>0</td> <td>1</td> <td>0 40 100 042</td> <td>0,00000</td> <td>50.00</td>		0	0	1	0 40 100 042	0,00000	50.00
51.00       05100       RECOVERY ROOM       0       0       8.265.498       0.000000       53         53.00       05300       ANESTHESI OLGGY       0       0       0       66,928,182       0.000000       55         54.00       05400       RADIOLOGY-SPECI AL       PROCEDURES       0       0       0       66,928,182       0.000000       55         55.00       05500       RADIOLOGY-SPECI AL       PROCEDURES       0       0       0       0.000000       55         50.00       05600       RADIOLOGY-THERAPEUTI C       0       0       0       0.000000       65         60.00       06000       LABORATORY       0       0       73,270,506       0.0000000       66         63.00       06000       PROCESSING & TRANS.       0       0       1,404,643       0.000000       66         66.00       06600       PROCIPATIONAL       THERAPY       0       0       15,382,450       0.000000       67         67.00       06/00       SPECET PATHOLOGY       0       0       35,921       0.000000       67       0       0       73,743,027       0.000000       77       75.05,508       0.000000       77       70.00       71,							•
53.00       los300       ANESTHESIOLOGY       0       0       18, 737, 042       0.000000       55         54.00       OS400       RADIOLOGY-DIAGNOSTIC       0       0       66, 928, 182       0.000000       55         55.00       OS500       RADIOLOGY-SPECIAL PROCEDURES       0       0       0       0.000000       55         56.00       OS600       RADIOLOGY-THERAPEUTIC       0       0       0       0.000000       56         60.00       OGON RADIOISTOPE       0       0       0       0.000000       56         60.00       OGONO LABORATORY       0       0       0       1.404, 643       0.000000       66         61.00       OGONO REDIOTORE       0       0       0       1.404, 643       0.000000       66       66       0.6000 PHYSICAL HERAPY       0       0       0       15, 382, 450       0.000000       66       66       0.6000 PHYSICAL HERAPY       0       0       0       5, 131, 595       0.000000       67       68.00       0.600000       77, 556, 506       0.000000       77       73.00       0.000000       77       73.00       0.000000       77       73.00       0.000000       77       73.00       0.000000		0	-				
54.00         OS400         RADIOLOGY-DIAGNOSTIC         O         O         6.6.928, 182         O.000000         5.4           54.01         OS401         RADIOLOGY-SPECIAL PROCEDURES         O         O         O         0         0.000000         5.6           55.00         DS500         RADIOLOGY-THERAPEUTIC         O         O         0         0.000000         5.6           65.00         DS600         LADIOSTOPE         O         O         0         0.000000         5.6           65.00         DS600         LADRATORY         O         O         0         0.000000         6.6         0.000000         6.6         0.000000         6.6         0.000000         6.6         0.000000         6.6         0.000000         6.6         0.000000         6.6         0.000000         6.6         0.000000         6.6         0.000000         6.6         0.000000         6.6         0.000000         6.6         0.000000         6.6         0.000000         6.6         0.000000         6.6         0.000000         6.6         0.000000         6.6         0.000000         6.6         0.000000         7.7         0.000000         6.6         0.000000         7.7         0.000000         7.7         0.		0	-				•
54.01       OSA01       RADI OLOGY-SPECIAL PROCEDURES       0       0       9,636,549       0.000000       55         55.00       OS500       RADI OLOGY-THERAPEUTI C       0       0       0       0.000000       55         65.00       OS600       RADI OLOGY-THERAPEUTI C       0       0       0       0.000000       55         60.00       OS600       RADI OLOGY-SPECIAL PROCESSING & TRANS.       0       0       73,270,506       0.000000       56         60.00       OS500       RESPI RATORY THERAPY       0       0       1,404,43       0.000000       66         66.00       O6500       RESPI RATORY THERAPY       0       0       0       5,332,450       0.000000       66         70.00       OCOUPATIONAL THERAPY       0       0       0       5,131,595       0.000000       66         69.00       OS000       ELECTROCARDI OLOGY       0       0       0       5,131,595       0.000000       77         71.00       OT000       ELECTROCARDI OLOGY       0       0       0       5,192,885       0.000000       77         72.00       OZO00       ILECTROCARDI OLOGY       0       0       18,489,199       0.000000       77		0	-				
55.00         OSSOO RADI OLOCY-THERAPEUTI C         O         O         O         O.0000000         55           56.00         05600 RADI OL SOTOPE         O         O         O         9,102,386         0.000000         56           60.00         06300 LABORATORY         O         O         073,270,506         0.000000         65           63.00         06300 RESPI RATORY         PROCESSI NG & TRANS.         O         O         1,404,463         0.000000         66           65.00         06500 RESPI RATORY THERAPY         O         O         15,382,450         0.000000         66           00         06000 SPECH PATHOLOCY         O         O         3,891,921         0.000000         67           69.00         06000 SPECH PATHOLOCY         O         O         3,891,921         0.000000         77           71.00         07100 IMEL DEV. CHARGED TO PATI ENTS         O         O         42,346,38         0.000000         73           73.00         07300 DRUGS CHARGED TO PATI ENTS         O         O         37,923,463         0.000000         73           74.00         03630 ULTRA SOUND         O         O         37,923,463         0.000000         76           75.01         03		0	-				•
56.00       RADIO I SOTOPE       0       9, 102, 386       0.00000       56         60.00       06000       LABORATORY       0       0       73, 270, 506       0.000000       66         60.00       06000       Stool RADOR STORING, PROCESSING & TRANS.       0       0       11, 404, 643       0.000000       66         65.00       06000       PHSI CAL THERAPY       0       0       15, 382, 450       0.000000       66         66.00       06000       PLYSI CAL THERAPY       0       0       0       19, 978, 323       0.000000       66         66.00       06000       SELECT ROCARDI JLOGY       0       0       3, 891, 921       0.000000       67         69.00       06900       ELECTROENCEPHALOGRAPHY       0       0       0       27, 556, 508       0.000000       77         71.00       07100       MEDICAL SUPPLIES CHARGED TO PATIENTS       0       0       37, 923, 463       0.000000       77         73.00       07300       DRUGS CHARGED TO PATIENTS       0       0       37, 923, 463       0.000000       77         76.01       03951       PAIN CLINIC       0       0       0       37, 923, 463       0.000000       76		0					
60.00       06000       LABORATORY       0       0       73, 270, 506       0.000000       66         63.00       06300       BLOOD STORING, PROCESSING & TRANS.       0       0       1, 404, 643       0.000000       66         65.00       06600       PHYSI CAL THERAPY       0       0       0       15, 382, 450       0.000000       66         66.00       06000       PHYSI CAL THERAPY       0       0       0       5, 131, 595       0.000000       67         67.00       06700       0CCUPATI ONAL THERAPY       0       0       0       3, 891, 921       0.000000       66         68.00       06800       SPEECH PATHOLOGY       0       0       0       5, 131, 595       0.000000       77         71.00       07100       LECTROENCEPHALOGRAPHY       0       0       0       5, 192, 885       0.000000       77         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0       0       0       37, 27, 566       0.000000       77         76.00       0330       ULTRA SOUND       0       0       0       37, 23, 463       0.000000       76         76.01       03951       PAIN CLINIC       0       0		0	-		0		
63:00       06300       BLOOD STORING, PROCESSING & TRANS.       0       0       1,404,643       0.000000       65         65:00       06500       RESPIRATORY THERAPY       0       0       15,382,450       0.000000       66         66:00       06600       PHYSICAL THERAPY       0       0       0       15,382,450       0.000000       66         67:00       0CCUPATIONAL THERAPY       0       0       0       3,891,921       0.000000       67         68:00       06800       SPECH PATHOLOGY       0       0       0       2,756,550       0.000000       67         70:00       00000       ELECTROCARDI OLOGY       0       0       0       2,346,338       0.000000       77         71:00       07100       MELOAL SUPPLIES CHARGED TO PATIENTS       0       0       18,489,109       0.000000       77         72:00       07200       IMPL       D.V       CHARGED TO PATIENTS       0       0       12,884,112       0.000000       77         76:00       03951       PAIN CLINIC       0       0       9,743,027       0.000000       76         76:02       03952       ACTI VI TY THERAPEUTIC       0       0       0       2,59,		0					•
65.00       06500       RESPI RATORY THERAPY       0       0       15, 382, 450       0.000000       66         66.00       06600       PHYSI CAL THERAPY       0       0       0       19, 978, 323       0.000000       66         67.00       06700       00 COUPATI IONAL THERAPY       0       0       0       5, 131, 595       0.000000       66         68.00       06800       SPEECH PATHOLOGY       0       0       0       3, 891, 921       0.000000       66         69.00       06900       ELECTROCARDIOLOGY       0       0       27, 556, 508       0.000000       77         71.00       O7000       ELECTROENCEPHALOGRAPHY       0       0       42, 346, 338       0.000000       77         72.00       07200       IMPL.       DEV. CHARGED TO PATI ENTS       0       0       37, 923, 463       0.000000       72         76.00       03351       PAIN CLINIC       0       0       9, 743, 027       0.000000       76         76.01       03951       PAIN CLINIC       0       0       0       63, 068, 844       0.000000       76         76.02       03952       CATH LAB       0       0       0       0       0 </td <td></td> <td>0</td> <td></td> <td></td> <td></td> <td></td> <td></td>		0					
66:00       06:00       PHYSI CAL THERAPY       0       0       19, 978, 323       0.000000       66         67:00       06:700       0CCUPATI ONAL THERAPY       0       0       0       5, 131, 595       0.000000       66         68:00       06:800       SPEECH PATHOLOGY       0       0       0       3, 891, 921       0.000000       66         69:00       06:900       ELECTROCARDI OLOGY       0       0       0       27, 556, 508       0.000000       67         70:00       07000       ELECTROENCEPHALOGRAPHY       0       0       0       42, 346, 338       0.000000       77         71:00       07100       MPL.       DEV. CHARGED TO PATI ENTS       0       0       0       37, 923, 463       0.000000       77         72:00       07300       DRUGS CHARGED TO PATI ENTS       0       0       0       12, 884, 112       0.000000       77         74:00       03630       ULTRA SOUND       0       0       0       9, 743, 027       0.000000       76         75:02       03952       CATH LAB       0       0       0       2, 71, 666       0.000000       76         76:02       03954       WOUND CARE CENTER		0	-				•
67.00       06700       CCUPATI ONAL THERAPY       0       0       5, 131, 595       0.000000       63         68.00       06800       SPECH PATHOLOGY       0       0       3, 891, 921       0.000000       66         69.00       06900       ELECTROCARDI OLOGY       0       0       27, 556, 508       0.000000       67         70.00       07000       ELECTROCARDI OLOGY       0       0       27, 556, 508       0.000000       77         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENTS       0       0       18, 489, 109       0.000000       72         72.00       07300       DRUCS CHARGED TO PATI ENTS       0       0       37, 923, 463       0.000000       72         76.00       03630       ULTRA SOUND       0       0       9, 743, 027       0.000000       76         76.02       03952       CATH LAB       0       0       0       63, 068, 844       0.000000       76         76.02       03953       ACTI VI TY THERAPEUTI C       0       0       0       62, 259, 406       0.000000       76         76.04       03954       WOIND CARE CENTER       0       0       0       0       0.000000       76		0	-				•
68:00       06800       SPEECH PATHOLOGY       0       0       3, 891, 921       0.000000       66         69:00       06900       ELECTROCARDIOLOGY       0       0       27, 556, 508       0.000000       67         70:00       07000       ELECTROCARDIOLOGY       0       0       27, 556, 508       0.000000       67         71:00       07100       MEDICAL SUPPLIES CHARGED TO PATIENT       0       0       42, 346, 338       0.000000       77         72:00       07200       IMPL. DEV. CHARGED TO PATIENTS       0       0       18, 489, 109       0.000000       77         73:00       07300       RUGS CHARGED TO PATIENTS       0       0       12, 884, 112       0.000000       77         76:01       03951       PAIN CLINIC       0       0       0       9, 743, 027       0.000000       76         76:02       03952       CATH LAB       0       0       0       63, 068, 844       0.000000       76         76:03       0349 BARI ARTIC CLINIC       0       0       0       63, 068, 844       0.000000       76         76:05       03340       BARI ARTIC CLINIC       0       0       0       0       0.000000       76		0					
69:00       06900       ELECTROCARDIOLOGY       0       0       27, 556, 508       0.000000       65         70:00       07000       ELECTROENCEPHALOGRAPHY       0       0       5, 192, 885       0.000000       77         71:00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENT       0       0       42, 346, 338       0.000000       77         72:00       07200       INPL. DEV. CHARGED TO PATIENTS       0       0       18, 489, 109       0.000000       72         73:00       07300       RRUSS CHARGED TO PATIENTS       0       0       37, 923, 463       0.000000       72         76:00       03630       ULTRA SOUND       0       0       9, 743, 027       0.000000       76         76:01       03951       PAIN CLINIC       0       0       0       9, 743, 027       0.000000       76         76:02       03952       CATH LAB       0       0       0       63, 068, 844       0.000000       76         76:03       03953       ACTI VI TY THERAPEUTI C       0       0       0       2, 771, 666       0.000000       76         76:05       03340       BARI ATRI C CLINI C       0       0       0       0.0000000       76<		0					•
70.00       07000       ELECTROENCEPHALOGRAPHY       0       0       5, 192, 885       0.000000       77         71.00       07100       MEDICAL SUPPLIES CHARGED TO PATIENT       0       0       42, 346, 338       0.000000       77         72.00       07200       IMPL.       DEV. CHARGED TO PATIENTS       0       0       18, 489, 109       0.000000       72         73.00       07300       DRUGS CHARGED TO PATIENTS       0       0       37, 923, 463       0.000000       72         76.00       03630       ULTRA SOUND       0       0       12, 884, 112       0.000000       76         76.01       03951       ACTI HAB       0       0       0       9, 743, 027       0.000000       76         76.02       03952       CATH LAB       0       0       0       63, 068, 844       0.000000       76         76.03       03953       ACTI VITY THERAPEUTIC       0       0       0       6, 259, 406       0.000000       76         76.04       03954       WOUND CARE CENTER       0       0       0       0, 000000       76         76.05       03340       BARI ATRI C LINI C       0       0       0       0       0, 0000000 </td <td></td> <td>0</td> <td>-</td> <td></td> <td></td> <td></td> <td></td>		0	-				
71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENT       0       0       42, 346, 338       0.000000       71         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0       0       18, 489, 109       0.000000       72         73.00       07300       DRUGS CHARGED TO PATI ENTS       0       0       37, 923, 463       0.000000       72         76.00       0330       ULTRA SOUND       0       0       0       12, 884, 112       0.000000       76         76.01       03951       PAI N CLINIC       0       0       0       9, 743, 027       0.000000       76         76.02       03952       CATH LAB       0       0       0       63, 068, 844       0.000000       76         76.04       03953       ACTI VI TY THERAPEUTI C       0       0       0       6, 259, 406       0.000000       76         76.05       03340       BARI ATRI C CLI NI C       0       0       0       0.000000       76         76.06       03954       WOUND CARE CENTER       0       0       0       0.000000       76         76.05       03340       BARI ATRI C CLI NI C       0       0       0       0.000000       76 </td <td></td> <td>0</td> <td></td> <td></td> <td></td> <td></td> <td></td>		0					
72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0       0       18, 489, 109       0.00000       72         73.00       07300       DRUGS CHARGED TO PATIENTS       0       0       37, 923, 463       0.00000       73         76.00       03630       ULTRA SOUND       0       0       0       12, 884, 112       0.000000       76         76.00       03951       PAI N CLINIC       0       0       9, 743, 027       0.000000       76         76.02       03952       CATH LAB       0       0       0       63, 068, 844       0.000000       76         76.03       03953       ACTIVITY THERAPEUTIC       0       0       0       62, 59, 406       0.000000       76         76.04       03954       WOUND CARE CENTER       0       0       0       2, 771, 666       0.000000       76         76.05       03340       BARIATRI C CLINIC       0       0       0       0.000000       76         76.04       03950       CV RESOURCE CENTER       0       0       0       0.000000       76         76.05       03340       BARIATRI C CLINIC       0       0       0       0.000000       76		0					
73.00       07300       DRUGS CHARGED TO PATIENTS       0       0       37,923,463       0.000000       73         76.00       03630       ULTRA SOUND       0       0       0       12,884,112       0.000000       76         76.01       03951       PAIN CLINIC       0       0       0       9,743,027       0.000000       76         76.02       03952       CATH LAB       0       0       0       63,068,844       0.000000       76         76.03       03953       ACTI VI TY THERAPEUTI C       0       0       0       6,259,406       0.000000       76         76.05       03340       BARI ATRI C CLINIC       0       0       0       2,771,666       0.000000       76         76.05       03340       BARI ATRI C CLINIC       0       0       0       0.000000       76         76.06       03030       HEALTHY LI VING CENTER       0       0       0       0.000000       76         76.07       03955       OTHER ANCI LLARY SERVI CE COST CENTERS       0       0       0       0.000000       76         76.08       03955       OTHER ANCI LLARY SERVI CE COST CENTERS       0       0       0       0.0000000       76<		0	-				
76.00       03630       ULTRA SOUND       0       0       12,884,112       0.000000       76         76.01       03951       PAI N CLINIC       0       0       9,743,027       0.000000       76         76.02       03952       CATH LAB       0       0       0       63,068,844       0.000000       76         76.03       03953       ACTIVITY THERAPEUTIC       0       0       6,259,406       0.00000       76         76.04       03954       WOND <care center<="" td="">       0       0       0       2,771,666       0.000000       76         76.05       0330       BARI ATRIC CLINIC       0       0       0       5,000,548       0.000000       76         76.06       03030       HEALTHY LIVING CENTER       0       0       0       0.000000       76         76.07       03955       OTHER ANCI LLARY SERVICE COST CENTERS       0       0       0       0.000000       76         76.08       03955       OTHER ANCI LLARY SERVICE COST CENTERS       0       0       0       0.000000       76         76.10       03956       LACTATION CLINIC       0       0       0       0.000000       76         76.10</care>		0	-				•
76.01       03951       PAIN CLINIC       0       0       9,743,027       0.000000       76         76.02       03952       CATH LAB       0       0       63,068,844       0.000000       76         76.03       03953       ACTIVITY THERAPEUTIC       0       0       6,259,406       0.000000       76         76.04       03954       WOUND CARE CENTER       0       0       0       2,771,666       0.000000       76         76.05       03340       BARI ATRI C CLINIC       0       0       0       5,000,548       0.000000       76         76.06       03030       HEALTHY LIVING CENTER       0       0       0       0.000000       76         76.07       03950       CV RESOURCE CENTER       0       0       0       0.000000       76         76.08       03955       OTHER ANCI LLARY SERVICE COST CENTERS       0       0       0       0.000000       76         76.10       03957       OTHER ANCI LLARY SERVICE COST CENTERS       0       0       0       0.000000       76         76.10       03957       OTHER ANCI LLARY SERVICE COST CENTERS       0       0       0       0.000000       76         76.11		0					•
76.02       03952       CATH LAB       0       0       63,068,844       0.000000       76         76.03       03953       ACTI VI TY THERAPEUTI C       0       0       6,259,406       0.000000       76         76.04       03954       WOUND CARE CENTER       0       0       0       2,771,666       0.000000       76         76.05       03340       BARI ATRI C CLI NI C       0       0       0       5,000,548       0.000000       76         76.06       03030       HEALTHY LI VI NG CENTER       0       0       0       0.000000       76         76.07       03950       CV RESOURCE CENTER       0       0       0       0.000000       76         76.08       03955       OTHER ANCI LLARY SERVICE COST CENTERS       0       0       0       0.000000       76         76.09       03956       LACTATI ON CLI NI C       0       0       0       0.000000       76         76.10       03957       OTHER ANCI LLARY SERVICE COST CENTERS       0       0       0       0.000000       76         76.11       03959       NTHE ANCI LLARY SERVICE COST CENTERS       0       0       0       0.000000       76         71.10		0					
76.03       03953       ACTIVITY THERAPEUTIC       0       0       6,259,406       0.000000       76         76.04       03954       WOUND CARE CENTER       0       0       0       2,771,666       0.000000       76         76.05       03340       BARIATRIC CLINIC       0       0       0       5,000,548       0.000000       76         76.06       03030       HEALTHY LIVING CENTER       0       0       0       0       0.000000       76         76.07       03950       CV RESOURCE CENTER       0       0       0       0.000000       76         76.08       03955       OTHER ANCI LLARY SERVICE COST CENTERS       0       0       0       0.000000       76         76.09       03956       LACTATI ON CLINIC       0       0       0       0.000000       76         76.10       03957       OTHER ANCI LLARY SERVICE COST CENTERS       0       0       0       0.000000       76         76.11       03958       OTHER ANCI LLARY SERVICE COST CENTERS       0       0       0       0.000000       76         76.12       03959       ANTI COAGULATI ON CLINIC       0       0       0       0.000000       76		0					
76.04       03954       WOUND CARE CENTER       0       0       2,771,666       0.000000       76         76.05       03340       BARI ATRI C CLI NI C       0       0       0       5,000,548       0.000000       76         76.06       03030       HEALTHY LI VING CENTER       0       0       0       0       0.000000       76         76.07       03950       CV RESOURCE CENTER       0       0       0       0       0.000000       76         76.08       03955       OTHER ANCI LLARY SERVICE COST CENTERS       0       0       0       0.000000       76         76.09       03956       LACTATI ON CLI NI C       0       0       0       0.000000       76         76.10       03957       OTHER ANCI LLARY SERVICE COST CENTERS       0       0       0       0.000000       76         76.11       03958       OTHER ANCI LLARY SERVICE COST CENTERS       0       0       0       0.000000       76         76.12       03959       ANTI COAGULATI ON CLI NI C       0       0       0       0.000000       76         77.00       ALLOGENEI C STEM CELL ACQUI SI TI ON       0       0       0       0       0.000000       76		0					•
76.05       03340       BARI ATRI C CLINIC       0       0       5,000,548       0.000000       76         76.06       03030       HEALTHY LIVING CENTER       0       0       0       0.000000       76         76.07       03950       CV RESOURCE CENTER       0       0       0       0.000000       76         76.08       03955       OTHER ANCI LLARY SERVICE COST CENTERS       0       0       0       0.000000       76         76.09       03956       LACTATI ON CLINIC       0       0       0       0.000000       76         76.10       03957       OTHER ANCI LLARY SERVICE COST CENTERS       0       0       0       0.000000       76         76.10       03957       OTHER ANCI LLARY SERVICE COST CENTERS       0       0       0       0.000000       76         76.11       03958       OTHER ANCI LLARY SERVICE COST CENTERS       0       0       0       0.000000       76         76.12       03959       ANTI COAGULATI ON CLINIC       0       0       0       0.000000       76         71.00       07700       ALLOGENEI C STEM CELL ACQUI SI TI ON       0       0       0       0.000000       76         71.00       0710		0					•
76.06       03030       HEALTHY LIVING CENTER       0       0       0       0.000000       76         76.07       03950       CV RESOURCE CENTER       0       0       0       0.000000       76         76.08       03955       OTHER ANCI LLARY SERVICE COST CENTERS       0       0       0       0.000000       76         76.09       03956       LACTATI ON CLI NIC       0       0       0       0.000000       76         76.10       03957       OTHER ANCI LLARY SERVICE COST CENTERS       0       0       0       0.000000       76         76.10       03957       OTHER ANCI LLARY SERVICE COST CENTERS       0       0       0       0.000000       76         76.11       03958       OTHER ANCI LLARY SERVICE COST CENTERS       0       0       0       0.000000       76         76.12       03959       ANTI COAGULATI ON CLI NI C       0       0       0       0.000000       76         71.00       03700       ALLGENEL C STEM CELL ACQUI SI TI ON       0       0       0       0.000000       77         71.00       07100       LLOGENEI C STEM CELL ACQUI SI TI ON       0       0       0       0.000000       77         71.00		0					•
76.07       03950       CV RESOURCE CENTER       0       0       0       0.000000       76         76.08       03955       OTHER ANCI LLARY SERVICE COST CENTERS       0       0       0       0.000000       76         76.09       03956       LACTATI ON CLI NI C       0       0       0       0.000000       76         76.10       03957       OTHER ANCI LLARY SERVICE COST CENTERS       0       0       0       0.000000       76         76.11       03958       OTHER ANCI LLARY SERVICE COST CENTERS       0       0       0       0.000000       76         76.12       03959       ANTI COAGULATI ON CLI NI C       0       0       0       0.000000       76         77.00       07700       ALLOGRUEI C STEM CELL ACQUI SI TI ON       0       0       0       0.000000       76         71.00       07100       ALLOGRUEI C STEM CELL ACQUI SI TI ON       0       0       0       0.000000       77         71.00       07100       ALLOGENEI C COST CENTERS       0       0       0       0.000000       77         91.00       OPHOL       EMERGENCY       0       0       0       0       0.000000       74         92.00 <t< td=""><td></td><td>0</td><td></td><td></td><td></td><td></td><td>•</td></t<>		0					•
76.08       03955       OTHER ANCI LLARY SERVICE COST CENTERS       0       0       0       0.000000       76         76.09       03956       LACTATI ON CLINIC       0       0       0       0.000000       76         76.10       03957       OTHER ANCI LLARY SERVICE COST CENTERS       0       0       0       0.000000       76         76.11       03957       OTHER ANCI LLARY SERVICE COST CENTERS       0       0       0       0.000000       76         76.12       03959       ANTI COAGULATI ON CLINIC       0       0       0       0.000000       76         77.00       07700       ALLOGENEI C STEM CELL ACQUISITI ON       0       0       0       0.000000       76         71.00       07700       ALLOGENEI C STEM CELL ACQUISITI ON       0       0       0       0.000000       76         71.00       07100       EMERGENCY       0       0       0       0.000000       77         91.00       09100       EMERGENCY       0       0       0       0.000000       92         92.00       09200       0BSERVATI ON BEDS (NON-DI STINCT PART       0       0       92, 956, 749       0.000000       92		0			-		
76.09       03956       LACTATI ON CLINIC       0       0       0       0.000000       76         76.09       03957       OTHER ANCI LLARY SERVICE COST CENTERS       0       0       0       0.000000       76         76.10       03957       OTHER ANCI LLARY SERVICE COST CENTERS       0       0       0       0.000000       76         76.11       03958       OTHER ANCI LLARY SERVICE COST CENTERS       0       0       0       0.000000       76         76.12       03959       ANTI COAGULATI ON CLINIC       0       0       0       0.000000       76         76.12       03959       ANTI COAGULATI ON CLINIC       0       0       0       0.000000       76         76.00       07700       ALLOGENEI C STEM CELL ACQUI SI TI ON       0       0       0       0.000000       76         00       0TTPATI ENT SERVICE COST CENTERS       0       0       0       0.000000       76         91.00       DEMERGENCY       0       0       0       0.000000       91         92.00       09200       OBSERVATI ON BEDS (NON-DI STINCT PART       0       0       92, 956, 749       0.0000000       92		0					
76. 10       03957       OTHER ANCI LLARY SERVICE COST CENTERS       0       0       0       0.000000       76         76. 11       03958       OTHER ANCI LLARY SERVICE COST CENTERS       0       0       0       0       0.000000       76         76. 12       03959       ANTI COAGULATI ON CLI NI C       0       0       0       0       0.000000       76         77. 00       07700       ALLOGENEI C STEM CELL ACQUI SI TI ON       0       0       0       0       0.000000       76         00       07700       ALLOGENEI C STEM CELL ACQUI SI TI ON       0       0       0       0.000000       76         01000       07100       EMERGENCY       0       0       0       0.000000       91         92. 00       09200       OBSERVATI ON BEDS (NON-DI STI NCT PART       0       0       0       92,956,749       0.000000       92			-		0 0		•
76.11       03958       OTHER ANCI LLARY SERVICE COST CENTERS       0       0       0       0.000000       76         76.12       03959       ANTI COAGULATI ON CLINIC       0       0       0       1, 201, 052       0.000000       76         77.00       07700       ALLOGENEI C STEM CELL ACQUISITION       0       0       0       0       0       0       77         0UTPATI ENT SERVICE COST CENTERS       0       0       0       0       0.000000       77         91.00       09100       EMERGENCY       0       0       0       0.000000       91         92.00       09200       OBSERVATI ON BEDS (NON-DI STINCT PART       0       0       0       9, 956, 749       0.000000       92			-		0		•
76. 12       03959       ANTI COAGULATI ON CLINIC       0       0       0       1, 201, 052       0.000000       76         77. 00       07700       ALLOGENEI C STEM CELL ACQUISITION       0       0       0       0       0       0       77         0UTPATI ENT SERVICE COST CENTERS       0       0       0       0       0       0.000000       91         91. 00       09100       EMERGENCY       0       0       0       0.000000       91         92. 00       09200       0BSERVATI ON BEDS (NON-DI STINCT PART       0       0       0       9, 956, 749       0.000000       92		0	-		-		•
77. 00         07700         ALLOGENEIC         STEM         CELL         ACQUISITION         0         0         0         0.000000         77           0UTPATIENT         SERVICE         COST         CENTERS         77         00         0         0         0.000000         77           91. 00         09100         EMERGENCY         0         0         0         65, 880, 360         0.000000         91           92. 00         09200         0BSERVATION         BEDS         (NON-DI STINCT PART)         0         0         9, 956, 749         0.000000         92		0	-		-		•
OUTPATI ENT SERVICE COST CENTERS           91. 00         09100         EMERGENCY         0         0         65, 880, 360         0. 000000         91           92. 00         09200         OBSERVATI ON BEDS (NON-DI STINCT PART         0         0         0         9, 956, 749         0. 000000         92		-					
91. 00         09100         EMERGENCY         0         0         65, 880, 360         0. 000000         91           92. 00         09200         0BSERVATI ON BEDS (NON-DI STINCT PART         0         0         0         9, 956, 749         0. 000000         92		0	0	1	<u>v</u> 0	0.00000	,,
92.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART 0 0 0 9, 956, 749 0.00000 92		0			0 65 880 360	0,00000	91.00
		-					•
200.00 Total (lines 50 through 199) 0 0 0 613,460,022 200		-					200.00

Health Financial Systems	FRANCI SCAN HEA				u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI	RVICE OTHER PASS	Provider C	CN: 15-0090	Peri od:	Worksheet D	
THROUGH COSTS		Component (	CCN: 15-T090	From 01/01/2022 To 12/31/2022	Part IV Date/Time Pre 5/10/2023 11:	
		Title	e XVIII	Subprovider - IRF	PPS	
Cost Center Description	Outpati ent	Inpati ent	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Throug		Pass-Through	
	(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVI CE COST CENTERS			1		-	
50. 00 05000 OPERATI NG ROOM	0. 000000	143, 995		0 0	0	1
50. 01 05001 OUTPATI ENT SURGERY	0. 000000	10, 126		0 0	0	
51.00 05100 RECOVERY ROOM	0. 000000	6, 850		0 0	0	
53. 00 05300 ANESTHESI OLOGY	0. 000000	13, 980		0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	278, 169		0 0	0	
54. 01 05401 RADI OLOGY-SPECI AL PROCEDURES	0. 000000	0		0 0	0	
55. 00 05500 RADI OLOGY - THERAPEUTI C	0. 000000	0		0 0	0	
56. 00 05600 RADI OI SOTOPE	0. 000000	14, 356		0 0	0	
60. 00 06000 LABORATORY	0. 000000	1, 206, 067		0 0	0	
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	19, 904		0 0	0	1
65. 00 06500 RESPI RATORY THERAPY	0. 000000	822, 045		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	2, 734, 073		0 0	0	
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	2, 781, 941		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	1, 158, 874		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	137, 975		0 0	0	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	6, 194		0 0	0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	699, 761		0 0	0	
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000	17, 874		0 0	0	
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	1, 191, 390		0 0	0	
76.00 03630 ULTRA SOUND	0. 000000	0		0 0	0	
76. 01 03951 PAIN CLINIC	0. 000000	0		0 0	0	1
76. 02 03952 CATH LAB	0. 000000	0		0 0	0	
76.03 03953 ACTIVITY THERAPEUTIC	0. 000000	0		0 0	0	
76.04 03954 WOUND CARE CENTER	0. 000000	0		0 0	0	
76.05 03340 BARI ATRI C CLI NI C	0. 000000	0		0 0	0	76.05
76.06 03030 HEALTHY LIVING CENTER	0. 000000	0		0 0	0	1
76.07 03950 CV RESOURCE CENTER	0. 000000	0		0 0	0	
76.08 03955 OTHER ANCI LLARY SERVICE COST CENTERS	0. 000000	0		0 0	0	
76.09 03956 LACTATION CLINIC	0. 000000	0		0 0	0	
76. 10 03957 OTHER ANCI LLARY SERVICE COST CENTERS	0. 000000	0		0 0	0	
76. 11 03958 OTHER ANCI LLARY SERVICE COST CENTERS	0.00000	0		0 0	0	
76. 12 03959 ANTI COAGULATI ON CLINIC	0. 000000	0		0 0	0	
77. 00 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON	0. 000000	0		0 0	0	77.00
	0.000000		1	0	~	01.00
91.00 09100 EMERGENCY	0. 000000	0		0 0	0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0		0 0 0 0	0	
200.00   Total (lines 50 through 199)	1	11, 243, 574	I	0	0	200.00

	Financial Systems	FRANCI SCAN H				u of Form CMS-	2552-10
APPORT	IONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	D VACCINE COST	Provider C	CN: 15-0090	Period: From 01/01/2022	Worksheet D Part V	
			Component	CCN: 15-T090	To 12/31/2022	Date/Time Pre 5/10/2023 11:	epared: 00 am
			Title	e XVIII	Subprovider - IRF	PPS	
				Charges		Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
		Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins			
				(see inst.)	(see inst.)		
		1.00	2.00	3.00	4.00	5.00	
	ANCI LLARY SERVICE COST CENTERS	1	•		-		
50.00	05000 OPERATING ROOM	0. 083926			0 0	0	
50. 01	05001 OUTPATI ENT SURGERY	0. 601207			0 0	0	50.01
51.00	05100 RECOVERY ROOM	0. 154811	0		0 0	0	51.00
53.00	05300 ANESTHESI OLOGY	0. 340615	C		0 0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 067281	0		0 0	0	54.00
54.01	05401 RADI OLOGY-SPECI AL PROCEDURES	0. 396041	0		0 0	0	54.01
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	0		0 0	0	55.00
56.00	05600 RADI OI SOTOPE	0. 155586	0		0 0	0	56.00
60.00	06000 LABORATORY	0. 137407	0		0 0	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 111883	c c		0 0	0	63.00
65.00	06500 RESPI RATORY THERAPY	0. 276581			0 0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0. 334588			0 0	0	
67.00	06700 OCCUPATI ONAL THERAPY	0. 283484			0 0	0	
68.00	06800 SPEECH PATHOLOGY	0. 275501	0		0 0	0	68.00
69.00	06900 ELECTROCARDI OLOGY	0. 072905			0 0	0	
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 122891			0 0	0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 305126			0 0	0	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 613917			0 0	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 251640			0 480	0	
76.00	03630 ULTRA SOUND	0. 104367			0 0	0	
76.01	03951 PALN CLINIC	0. 158876			0 0	0	
76.02	03952 CATH LAB	0. 079036			0 0	0	
76.02	03953 ACTI VI TY THERAPEUTI C	0. 333889			0 0	0	
76.03	03954 WOUND CARE CENTER	0. 398749	-		0 0	0	
76.05	03340 BARI ATRI C CLI NI C	0. 492994			0 0	0	
76.05	03030 HEALTHY LIVING CENTER	0. 000000			0 0	0	
76.07	03950 CV RESOURCE CENTER	0. 000000			0 0	0	
76.08	03955 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000			0 0	0	
76.08	03956 LACTATION CLINIC	0. 000000				0	
76.10	03957 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000			0 0	0	
76.11						0	
	03958 OTHER ANCI LLARY SERVICE COST CENTERS	0. 000000			0 0	0	
76.12	03959 ANTI COAGULATI ON CLINI C						
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000	C	1	0 0	0	77.00
01 00		0 151000			0		01 00
91.00	09100 EMERGENCY	0. 151339			0 0	0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 459375			0 0	0	
200.00			0		0 480	0	200.00
201.00	5				0 0		201.00
202.00	Only Charges				400	_	000 00
202.00	Net Charges (line 200 - line 201)	I	0	1	0 480	0	202.00

	ncial Systems ENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der	CCN: 15-0090	Peri od:	Worksheet D	2552
	ENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider	CCN. 13-0090	From 01/01/2022	Part V	
			Componen	t CCN: 15-T090	To 12/31/2022	Date/Time Pre	
			Tit	tle XVIII	Subprovi der –	5/10/2023 11: PPS	<u>00 a</u>
		Cas	***		I RF		
	Cost Center Description	Cost	Cost				
	cost center bescription	Reimbursed	Reimbursed				
		Servi ces	Servi ces No				
		Subject To	Subject To				
		Ded. & Coins.	Ded. & Coin	s.			
		(see inst.)	(see inst.	)			
		6.00	7.00				
	LLARY SERVICE COST CENTERS						
	O OPERATI NG ROOM	0		0			50
	1 OUTPATIENT SURGERY	0		0			50
	0 RECOVERY ROOM 0 ANESTHESI OLOGY	0		0			51
	0 RADI OLOGY – DI AGNOSTI C	0		0			54
	1 RADI OLOGY-DI AGNOSTI C	0		0			54
	0 RADI OLOGY-THERAPEUTI C	0		0			55
	0 RADI 0I SOTOPE	0		0			56
	0 LABORATORY	0		0			60
	0 BLOOD STORING, PROCESSING & TRANS.	0		0			63
	0 RESPI RATORY THERAPY	0		0			65
	0 PHYSI CAL THERAPY	0		0			66
	O OCCUPATIONAL THERAPY	0		0			67
. 00 0680	O SPEECH PATHOLOGY	0		0			68
. 00 0690	0 ELECTROCARDI OLOGY	0		0			69
. 00 0700	0 ELECTROENCEPHALOGRAPHY	0		0			70
. 00  0710	MEDICAL SUPPLIES CHARGED TO PATIENT	0		0			71
	OIMPL. DEV. CHARGED TO PATIENTS	0		0			72
	O DRUGS CHARGED TO PATIENTS	0	1	21			73
	O ULTRA SOUND	0		0			76
	1 PAIN CLINIC	0		0			76
	2 CATH LAB	0		0			76
	3 ACTIVITY THERAPEUTIC	0		0			76
	4 WOUND CARE CENTER 0 BARIATRIC CLINIC	0		0			76
	O HEALTHY LIVING CENTER	0		0			
	O CV RESOURCE CENTER	0		0			76
	5 OTHER ANCILLARY SERVICE COST CENTERS	0		0			76
	6 LACTATION CLINIC	0		0			76
	7 OTHER ANCILLARY SERVICE COST CENTERS	0		o			76
	8 OTHER ANGI LLARY SERVICE COST CENTERS	0		o			76
	9 ANTI COAGULATI ON CLINIC	0		0			76
	O ALLOGENEIC STEM CELL ACQUISITION	0		o			77
OUTP	ATIENT SERVICE COST CENTERS			-			
	0 EMERGENCY	0		0			91
	O OBSERVATION BEDS (NON-DISTINCT PART	0		0			92
0. 00	Subtotal (see instructions)	0	1	21			200
1.00	Less PBP Clinic Lab. Services-Program	0					201
1	Only Charges	1					1

leal th Financial Systems	FRANCI SCAN HE				u of Form CMS-2	2552-1
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT	AL COSTS	Provider C	CN: 15-0090	Period: From 01/01/2022	Worksheet D Part II	
		Component	CCN: 15-T090	To 12/31/2022		pared: 00 am
		Titl	e XIX	Subprovider - IRF	TEFRA	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos		Capital Costs	
	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col	L. Charges	column 4)	
	Part II, col. 26)	8)	2)			
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	746, 677	69, 198, 843	0. 0107	90 0	0	50.0
50. 01 05001 OUTPATI ENT SURGERY	348, 570	4, 258, 017	0. 0818	62 0	0	50.0
51.00 05100 RECOVERY ROOM	151, 354	8, 265, 498	0. 0183	12 0	0	51.0
53. 00 05300 ANESTHESI OLOGY	58, 330	18, 737, 042	0.0031	13 0	0	53.0
54. 00 05400 RADI OLOGY-DI AGNOSTI C	983, 839	66, 928, 182	0.01470	0 00	0	54.0
54. 01 05401 RADI OLOGY-SPECI AL PROCEDURES	85, 944	9, 636, 549	0.0089	19 0	0	54.0
5. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	0.0000	0 00	0	55.0
6. 00 05600 RADI 0I SOTOPE	192, 256	9, 102, 386	0. 02112	21 0	0	56. C
0. 00 06000 LABORATORY	253, 678	73, 270, 506	0.0034	62 0	0	60. C
3.00 06300 BLOOD STORING, PROCESSING & TRANS.	66, 279			86 0	0	63.0
5. 00 06500 RESPI RATORY THERAPY	131, 344	15, 382, 450	0.0085	39 0	0	65. C
6. 00 06600 PHYSI CAL THERAPY	121, 719	19, 978, 323	0.0060	93 0	0	66. C
7. 00 06700 OCCUPATI ONAL THERAPY	27, 479	5, 131, 595	0.0053	55 0	0	67. C
8.00 06800 SPEECH PATHOLOGY	19, 187	3, 891, 921	0.00493	30 0	0	68.0
9. 00 06900 ELECTROCARDI OLOGY	166, 101	27, 556, 508	0.0060	28 0	0	69.0
0. 00 07000 ELECTROENCEPHALOGRAPHY	124, 945	5, 192, 885	0. 0240		-	70.0
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	112, 472	42, 346, 338	0. 0026			71.0
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	95, 983	18, 489, 109	0.0051			72.0
3.00 07300 DRUGS CHARGED TO PATIENTS	218, 506	37, 923, 463	0.0057			73.0
6.00 03630 ULTRA SOUND	95, 059					76. (
6.01 03951 PAIN CLINIC	292, 682	9, 743, 027				76. (
6.02 03952 CATH LAB	424, 255					76.0
6. 03 03953 ACTIVITY THERAPEUTIC	148, 084				0	76.0
6.04 03954 WOUND CARE CENTER	153, 611					76.0
6.05 03340 BARIATRIC CLINIC	70, 769	5, 000, 548			-	76.0
6.06 03030 HEALTHY LIVING CENTER	0	-				76. (
6.07 03950 CV RESOURCE CENTER	0	0	0.0000			76.0
6.08 03955 OTHER ANCI LLARY SERVICE COST CENTERS	0	0				76.0
6.09 03956 LACTATION CLINIC	0	0	0.0000		0	76. (
6. 10 03957 OTHER ANCI LLARY SERVICE COST CENTERS	0	0	0.0000		0	76. '
6. 11 03958 OTHER ANCI LLARY SERVICE COST CENTERS	0	-	0.0000		0	76.
6. 12 03959 ANTI COAGULATI ON CLINIC	15, 599					76.
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0.0000	0 00	0	77. (
OUTPATIENT SERVICE COST CENTERS						
21.00 09100 EMERGENCY	498, 366					
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	.,				
200.00  Total (lines 50 through 199)	5, 603, 088	613, 460, 022		0	0	200. C

Health Financial Systems	FRANCI SCAN HE				eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE THROUGH COSTS	ERVICE OTHER PASS	Provider C	CN: 15-0090	Period: From 01/01/2022	Worksheet D Part IV	
		Component (	CCN: 15-T090	To 12/31/2022		
		Ti tl	e XIX	Subprovider - IRF	TEFRA	
Cost Center Description	Non Physician	Nursi ng	Nursi ng		Allied Health	
	Anesthetist	Program	Program	Post-Stepdown		
	Cost	Post-Stepdown Adjustments		Adj ustments		
	1.00	2A	2.00	3A	3.00	
ANCI LLARY SERVI CE COST CENTERS	1.00	20	2.00	0/1	0.00	
50. 00 05000 OPERATI NG ROOM	0	0		0 0	0	50.00
50. 01 05001 OUTPATI ENT SURGERY	0	0		0 0	0	50.01
51.00 05100 RECOVERY ROOM	0	0		0 0	0	51.00
53. 00 05300 ANESTHESI OLOGY	0	0		0 0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
54. 01 05401 RADI OLOGY-SPECI AL PROCEDURES	0	0		0 0	0	54.01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0 0	0	55.00
56. 00 05600 RADI 0I SOTOPE	0	0		0 0	0	56.00
60. 00 06000 LABORATORY	0	0		0 0	0	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 0	0	63.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	, o	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 0	0	
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 0	, o	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	
76. 00 03630 ULTRA SOUND	0	0		0 0	0	
76. 01 03951 PAIN CLINIC	0	0		0 0	0	
76. 02 03952 CATH LAB	0	0		0 0	-	
76. 03 03953 ACTIVITY THERAPEUTIC	0	0		0 0	0	
76. 04 03954 WOUND CARE CENTER 76. 05 03340 BARI ATRI C CLI NI C	0	0			, v	
76. 05 03340 BARI ATRI C CLI NI C 76. 06 03030 HEALTHY LI VI NG CENTER	0	0		0 0	-	
76. 07 03950 CV RESOURCE CENTER	0	0			-	76.00
76.08 03955 OTHER ANCILLARY SERVICE COST CENTERS	0	0			, o	
76. 09 03956 LACTATION CLINIC	0	0		0 0		76.08
76. 10 03957 OTHER ANCILLARY SERVICE COST CENTERS	0	0		0 0	0	
76. 11 03958 OTHER ANCI LLARY SERVICE COST CENTERS	0	0		0 0	0	76.10
76. 12 03959 ANTI COAGULATI ON CLINIC	0	0		0 0	-	76.12
77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0		0 0	-	
OUTPATIENT SERVICE COST CENTERS	UUUUUUU	0	1		0	1 / . 50
91. 00 09100 EMERGENCY	0	0		0 0	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0	0	
200.00 Total (lines 50 through 199)	0	0	1	0 0		200.00

Health Financial Systems	FRANCI SCAN HI	EALTH- DYER		In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	ERVICE OTHER PASS	S Provider C		Period:	Worksheet D	
THROUGH COSTS		Component		From 01/01/2022 To 12/31/2022	Part IV Date/Time Pre	narod
		component	CCN. 15-1090	10 12/31/2022	5/10/2023 11:	00 am
		Ti tl	e XIX	Subprovider -	TEFRA	<u></u>
				I RF		
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
	Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
		4)	cols. 2, 3,	8)	7)	
			and 4)		(see	
					instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS				1	i	
50.00 05000 OPERATING ROOM	0	C		0 69, 198, 843		1
50. 01 05001 OUTPATI ENT SURGERY	0	C		0 4, 258, 017		1
51.00 05100 RECOVERY ROOM	0	C		0 8, 265, 498		1
53. 00 05300 ANESTHESI OLOGY	0	C		0 18, 737, 042	0. 000000	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	C	)	0 66, 928, 182	0.00000	54.00
54. 01 05401 RADI OLOGY-SPECI AL PROCEDURES	0	C	)	0 9, 636, 549	0.00000	54.01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	C	)	0 0	0.00000	55.00
56. 00 05600 RADI OI SOTOPE	0	C		0 9, 102, 386	0.00000	56.00
60. 00 06000 LABORATORY	0	C		0 73, 270, 506	0. 000000	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	C C		0 1, 404, 643	0.000000	63.00
65. 00 06500 RESPI RATORY THERAPY	0	c c		0 15, 382, 450	0.00000	65.00
66. 00 06600 PHYSI CAL THERAPY	0	c c		0 19, 978, 323	0.000000	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	c c		0 5, 131, 595	0.000000	67.00
68.00 06800 SPEECH PATHOLOGY	0	l c		0 3, 891, 921	0.000000	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	l c		0 27, 556, 508	0.000000	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	l c		0 5, 192, 885	0.000000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	l c		0 42, 346, 338		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	l c		0 18, 489, 109		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	l c		0 37, 923, 463		73.00
76.00 03630 ULTRA SOUND	0	l c		0 12, 884, 112		
76.01 03951 PAIN CLINIC	0	l c		0 9, 743, 027		
76. 02 03952 CATH LAB	0			0 63, 068, 844		
76. 03 03953 ACTI VI TY THERAPEUTI C	0			6, 259, 406		
76. 04 03954 WOUND CARE CENTER	0			0 2, 771, 666		
76. 05 03340 BARI ATRI C CLI NI C	0			0 5,000,548		
76. 06 03030 HEALTHY LIVING CENTER	0			0 0,000,010	0.000000	
76. 07 03950 CV RESOURCE CENTER	0			0 0	0.000000	
76. 08 03955 OTHER ANCI LLARY SERVICE COST CENTERS	0				0.000000	
76. 09 03956 LACTATION CLINIC	0				0.000000	
76. 10 03957 OTHER ANCILLARY SERVICE COST CENTERS					0.000000	
76. 11 03958 OTHER ANCI LLARY SERVICE COST CENTERS					0.000000	
76. 12 03959 ANTI COAGULATI ON CLINIC				0 1, 201, 052		1
77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION	0			0 1, 201, 032		
OUTPATIENT SERVICE COST CENTERS	0		'I	<u> </u>	0.00000	,,
91. 00 09100 EMERGENCY	0	C		0 65, 880, 360	0.00000	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	-		0 9, 956, 749		1
200.00 Total (lines 50 through 199)	0	-		0 613, 460, 022		200.00
	0		П	010, 400, 022	1	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	DVICE ATHED DASS	Providor C	CN: 15-0090	Peri od:	Worksheet D	2552-10
THROUGH COSTS	RVICE UINER PASS	Provider C	CN. 13-0090	From 01/01/2022	Part IV	
		Component	CCN: 15-T090	To 12/31/2022	Date/Time Pre 5/10/2023 11:	
		Titl	e XIX	Subprovider - IRF	TEFRA	
Cost Center Description	Outpati ent	Inpatient	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Throug	h Charges	Pass-Through	
	(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVI CE COST CENTERS			1			
50. 00 05000 OPERATI NG ROOM	0. 000000	C		0 0	0	50.00
50. 01 05001 OUTPATI ENT SURGERY	0. 000000	C		0 0	0	50.01
51.00 05100 RECOVERY ROOM	0. 000000	C		0 0	0	51.00
53. 00 05300 ANESTHESI OLOGY	0. 000000	C		0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	C		0 0	0	54.00
54. 01 05401 RADI OLOGY-SPECI AL PROCEDURES	0. 000000	C		0 0	0	54.01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	C		0 0	0	55.00
56. 00 05600 RADI OI SOTOPE	0. 000000	C		0 0	0	56.00
60. 00 06000 LABORATORY	0. 000000	C		0 0	0	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	C		0 0	0	63.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	C		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	C		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	C		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	C		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	C		0 0	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	C		0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	C		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	C		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	C		0 0	0	73.00
76.00 03630 ULTRA SOUND	0. 000000	C		0 0	0	76.00
76.01 03951 PAIN CLINIC	0. 000000	C		0 0	0	76.01
76.02 03952 CATH LAB	0. 000000	C		0 0	0	76.02
76. 03 03953 ACTIVITY THERAPEUTIC	0. 000000	C		0 0	0	76.03
76.04 03954 WOUND CARE CENTER	0. 000000	C		0 0	0	76.04
76.05 03340 BARIATRIC CLINIC	0. 000000	C		0 0	0	76.05
76.06 03030 HEALTHY LIVING CENTER	0. 000000	C		0 0	0	76.06
76.07 03950 CV RESOURCE CENTER	0. 000000	C		0 0	0	76.07
76.08 03955 OTHER ANCI LLARY SERVICE COST CENTERS	0. 000000	C		0 0	0	76.08
76.09 03956 LACTATION CLINIC	0. 000000	C		0 0	0	76.09
76. 10 03957 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000	C		0 0	0	76.10
76. 11 03958 OTHER ANCI LLARY SERVICE COST CENTERS	0. 000000	C		0 0	0	76.11
76. 12 03959 ANTI COAGULATI ON CLINIC	0. 000000	C		0 0	0	76. 12
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0.000000	C	)	0 0	0	77.00
OUTPATIENT SERVICE COST CENTERS			T			
91. 00 09100 EMERGENCY	0. 000000	C		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	C	)	0 0	0	92.00
200.00 Total (lines 50 through 199)		C		0 0		200.00

	Financial Systems FRANCISCAN HEAL ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0090	Peri od:	u of Form CMS-2 Worksheet D-1	
			From 01/01/2022 To 12/31/2022	Date/Time Pre	noro
				5/10/2023 11:0	
	Cast Canton Description	Title XVIII	Hospital	PPS	
	Cost Center Description		·	1.00	
	PART I - ALL PROVIDER COMPONENTS				
~~	I NPATI ENT DAYS				
00 00	Inpatient days (including private room days and swing-bed day Inpatient days (including private room days, excluding swing-			22, 998 22, 998	
00	Private room days (excluding swing-bed and observation bed da		ivate room days,	22, 770	
	do not complete this line.		5		
00 00	Semi-private room days (excluding swing-bed and observation b Total swing-bed SNF type inpatient days (including private ro		r 21 of the cost	20, 144 0	
00	reporting period	on days) through becenbe	ST OF THE COST	0	5.
00	Total swing-bed SNF type inpatient days (including private ro	om days) after December	31 of the cost	0	6.
00	reporting period (if calendar year, enter 0 on this line)		01 - <del>C</del> + b +	0	_
00	Total swing-bed NF type inpatient days (including private roo reporting period	m days) through December	31 of the cost	0	7.
00	Total swing-bed NF type inpatient days (including private roo	m days) after December 3	1 of the cost	0	8.
~~	reporting period (if calendar year, enter 0 on this line)			7 005	
00	Total inpatient days including private room days applicable t newborn days) (see instructions)	o the Program (excluding	swing-bed and	7, 825	9.
0. 00	Swing-bed SNF type inpatient days applicable to title XVIII o	nly (including private r	room days)	0	10.
	through December 31 of the cost reporting period (see instruc	tions)		_	
1.00	Swing-bed SNF type inpatient days applicable to title XVIII o December 31 of the cost reporting period (if calendar year, e		room days) after	0	11.
2.00	Swing-bed NF type inpatient days applicable to titles V or XI		e room days)	0	12.
	through December 31 of the cost reporting period		5 /		
3. 00	Swing-bed NF type inpatient days applicable to titles V or XI			0	13.
1. 00	after December 31 of the cost reporting period (if calendar y Medically necessary private room days applicable to the Progr			0	14.
5.00	Total nursery days (title V or XIX only)	(		0	
5.00	Nursery days (title V or XIX only)			0	16.
7.00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to servic	es through December 31 (	of the cost	0.00	1 17
. 00	reporting period	es through becember 51 t	the cost	0.00	''.
3. 00	Medicare rate for swing-bed SNF services applicable to servic	es after December 31 of	the cost	0.00	18.
9. 00	reporting period Medicaid rate for swing-bed NF services applicable to service	s through Docombor 21 of	the cost	0.00	10
7.00	reporting period	s through becember 31 of	the cost	0.00	17.
0. 00	Medicaid rate for swing-bed NF services applicable to service	s after December 31 of 1	he cost	0.00	20.
1.00	reporting period Total general inpatient routine service cost (see instruction			36, 857, 011	21.
2.00	Swing-bed cost applicable to SNF type services through Decemb		ing period (line	30, 657, 011	
	5 x line 17)		01	-	
3. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	ng period (line 6	0	23.
1 00	x line 18) Swing-bed cost applicable to NF type services through Decembe	r 31 of the cost reporti	ng period (line	0	24.
	7 x line 19)				
5.00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	period (line 8	0	25.
5.00	x line 20) Total swing-bed cost (see instructions)			0	26.
	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		36, 857, 011	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		-		
3.00 7.00	General inpatient routine service charges (excluding swing-be Private room charges (excluding swing-bed charges)	d and observation bed ch	narges)	0	28.
	Semi-private room charges (excluding swing-bed charges)			0	
1.00	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0.00000	
2.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	
3.00 4.00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 mi	nus line 33)(see instruc	tions)	0.00 0.00	
4.00 5.00	Average per diem private room cost differential (line 34 x li			0.00	
5.00	Private room cost differential adjustment (line 3 x line 35)			0	36.
7.00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	36, 857, 011	37.
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				-
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	USTMENTS			1
				1 402 42	38.
	Adjusted general inpatient routine service cost per diem (see	-	I	1, 602. 62	
3.00 9.00 0.00	Program general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Progr	38)		1, 002, 02 12, 540, 502 0	39.

	Financial Systems ATION OF INPATIENT OPERATING COST	FRANCI SCAN HE	ALTH- DYER Provider C	CN: 15-0090	Peri od:	worksheet D-1	
					From 01/01/2022 To 12/31/2022		
	Cost Center Description	Total Inpatient Costl	Total	XVIII Average Per		PPS Program Cost (col. 3 x col.	
				col. 2)		4)	
42.00	NUDSEDV (title V & VIV only)	1.00	2.00	3.00	4.00	5.00	42.00
42.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	U	0	0.0		0	42.00
43.00	I NTENSI VE CARE UNI T	6, 235, 602	3, 318				43.00
44.00	CORONARY CARE UNI T BURN INTENSIVE CARE UNI T	0	0	0.0	0 0	0	
45.00 46.00	SURGICAL INTENSIVE CARE UNIT						45.00 46.00
	NEONATAL INTENSIVE CARE UNIT	2, 113, 895	308	6, 863. 3	30 0	0	
	Cost Center Description					1.00	
48.00	Program inpatient ancillary service cost (Wks	st. D-3. col. 3.	Line 200)			1.00 14,900,883	48.00
48.01	Program inpatient cellular therapy acquisitio			III, line 10,	column 1)	0	1
49.00	Total Program inpatient costs (sum of lines 4	11 through 48.01	l)(see instruc	tions)		29, 420, 319	49.00
50.00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inpa	atient routine s	services (from	Wkst D sun	of Parts L and	879, 639	50.00
00.00				intot. D, Sui			00.00
51.00	Pass through costs applicable to Program inpa	atient ancillary	/ services (fr	om Wkst. D, s	sum of Parts II	618, 736	51.00
52.00	and IV) Total Program excludable cost (sum of lines !	50 and 51)				1, 498, 375	52.00
53.00	Total Program inpatient operating cost exclude		ated, non-phy	sician anesth	netist, and	27, 921, 944	
	medical education costs (line 49 minus line !	52)					
54.00	TARGET AMOUNT AND LIMIT COMPUTATION Program di scharges					0	54.00
55.00	Target amount per discharge					0.00	
55.01	Permanent adjustment amount per discharge					0.00	
55. 02 56. 00	Adjustment amount per discharge (contractor u Target amount (line 54 x sum of lines 55, 55.					0.00	55.02 56.00
57.00	Difference between adjusted inpatient operati		get amount (I	ine 56 minus	line 53)	0	
58.00	Bonus payment (see instructions)	0	0		,	0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or updated and compounded by the market basket)	endi ng 1996,	0.00	59.00			
60.00	Expected costs (lesser of line 53 ÷ line 54,	updated by the	0.00	60.00			
61.00	market basket) Continuous improvement bonus payment (if line 55.01, or line 59, or line 60, enter the less					0	61.00
	53) are less than expected costs (lines 54 x enter zero. (see instructions)	0 .					
62.00 63.00	Relief payment (see instructions) Allowable Inpatient cost plus incentive payment	ont (coo instruc	tionc)			0	
03.00	PROGRAM INPATIENT ROUTINE SWING BED COST					0	03.00
64.00	Medicare swing-bed SNF inpatient routine cos	s through Decem	nber 31 of the	cost reporti	ng period (See	0	64.00
65.00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)</pre>	s after Decembe	er 31 of the c	ost reporting	g period (See	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routin	ne costs (line 6	64 plus line 6	5)(title XVII	l only); for	0	66.00
67.00	CAH, see instructions Title V or XIX swing-bed NF inpatient routine (line 12 x line 19)	e costs through	December 31 o	f the cost re	eporting period	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine (line 13 x line 20)	e costs after De	ecember 31 of	the cost repo	orting period	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient ( PART III - SKILLED NURSING FACILITY, OTHER NU	· · ·		/		0	69.00
70.00	Skilled nursing facility/other nursing facili	2					70.00
71.00 72.00	Adjusted general inpatient routine service co Program routine service cost (line 9 x line		ne /U ÷ line	2)			71.00
73.00	Medically necessary private room cost application		(line 14 x li	ne 35)			73.00
74.00	Total Program general inpatient routine servi	•					74.00
75.00	Capital-related cost allocated to inpatient ( 26, line 45)	outine service	costs (from W	orksheet B, F	Part II, column		75.00
76.00	Per diem capital-related costs (line 75 ÷ lin	ne 2)					76.00
77.00	Program capital-related costs (line 9 x line						77.00
78.00 79.00	Inpatient routine service cost (line 74 minus Aggregate charges to beneficiaries for excess		ovider record	s)			78.00 79.00
80.00	Total Program routine service costs for compa	• •		· · ·	nus line 79)		80.00
81.00	Inpatient routine service cost per diem limi						81.00
82.00 83.00	Inpatient routine service cost limitation (li Reasonable inpatient routine service costs (s	,					82.00 83.00
84.00	Program inpatient ancillary services (see ins		- /				84.00
85.00	Utilization review - physician compensation	see instruction					85.00
86.00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		ough 85)				86.00
87.00	Total observation bed days (see instructions)					2, 854	87.00
88.00	Adjusted general inpatient routine cost per	diem (line 27 ÷	line 2)			1, 602. 62	88.00
89.00	Observation bed cost (line 87 x line 88) (see	e instructions)				4, 573, 877	89.00

Health Financial Systems	FRANCI SCAN HI	EALTH- DYER		In Lieu of Form CMS-255			
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period:	Worksheet D-1		
				From 01/01/2022 To 12/31/2022	Date/Time Pre 5/10/2023 11:		
		Title	XVIII	Hospi tal	PPS		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on		
		(from line 21)	column 2	Observati on	Bed Pass		
				Bed Cost (from	Through Cost		
				line 89)	(col. 3 x col.		
					4) (see		
					instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH (	COST						
90.00 Capital-related cost	2, 290, 118	36, 857, 011	0. 06213	5 4, 573, 877	284, 198	90.00	
91.00 Nursing Program cost	0	36, 857, 011	0. 00000	0 4, 573, 877	0	91.00	
92.00 Allied health cost	0	36, 857, 011	0. 00000	0 4, 573, 877	0	92.00	
93.00 All other Medical Education	0	36, 857, 011	0.00000			93.00	

MPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0090 Component CCN: 15-T090	Period: From 01/01/2022 To 12/31/2022	Worksheet D-1 Date/Time Pre 5/10/2023 11:	pare
		Title XVIII	Subprovider - IRF	PPS	
	Cost Center Description		-	1.00	
	PART I – ALL PROVIDER COMPONENTS				-
	Inpatient days (including private room days and swing-bed days	, excluding newborn)		3, 807	1 1
00	Inpatient days (including private room days, excluding swing-b	ed and newborn days)		3, 807	2
00	Private room days (excluding swing-bed and observation bed day	vs). If you have only pr	ivate room days,	0	3
00	do not complete this line. Semi-private room days (excluding swing-bed and observation be	(aveb be		3, 807	4
00	Total swing-bed SNF type inpatient days (including private roc		r 31 of the cost	3,007	
	reporting period	<u> </u>		-	
00	Total swing-bed SNF type inpatient days (including private roc	om days) after December	31 of the cost	0	6
00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room	days) through December	31 of the cost	0	7
00	reporting period	r days) thi ough becember	ST OF the cost	0	'
00	Total swing-bed NF type inpatient days (including private room	n days) after December 3	1 of the cost	0	8
00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to	the Program (avaluet as	swing had and	3, 592	9
00	newborn days) (see instructions)	the riogram (excluding	swillig-bed allu	3, 392	`
. 00	Swing-bed SNF type inpatient days applicable to title XVIII or	nly (including private r	oom days)	0	10
	through December 31 of the cost reporting period (see instruct			0	1 1 1
	Swing-bed SNF type inpatient days applicable to title XVIII or December 31 of the cost reporting period (if calendar year, er		oom days) arter	0	11
	Swing-bed NF type inpatient days applicable to titles V or XIX		e room days)	0	12
	through December 31 of the cost reporting period				
	Swing-bed NF type inpatient days applicable to titles V or XIX			0	13
	after December 31 of the cost reporting period (if calendar ye Medically necessary private room days applicable to the Progra			0	14
. 00	Total nursery days (title V or XIX only)	···· (-···· -=····g -····g·-		0	
	Nursery days (title V or XIX only)			0	16
	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to service	s through December 21 o	f the cost	0.00	1 17
. 00	reporting period	s through becember 31 0	T the cost	0.00	''
. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0.00	18
. 00	reporting period	through December 21 of	the east	0.00	10
. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	s through becember 31 of	the cost	0.00	19
. 00	Medicaid rate for swing-bed NF services applicable to services	after December 31 of t	he cost	0.00	20
	reporting period			0 557 440	
	Total general inpatient routine service cost (see instructions Swing-bed cost applicable to SNF type services through Decembe		ing period (line)	8, 557, 412 0	
. 00	5 x line 17)	a si oi the cost report	ring period (rine	0	22
. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	g period (line 6	0	23
00	x line 18) Swing had aget appliable to NE type conviges through December	21 of the east report	ng pariod (line	0	2
. 00	Swing-bed cost applicable to NF type services through December 7 x line 19)	31 OF the cost report	ng period (inne	0	24
. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25
~~	x line 20)			0	
	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (	line 21 minus line 26)		0 8, 557, 412	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			0,007,112	1 2 1
	General inpatient routine service charges (excluding swing-bed	l and observation bed ch	arges)	0	
	Private room charges (excluding swing-bed charges)			0	
	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷	line 28)		0.000000	
	Average private room per diem charge (line 29 ÷ line 3)			0.00	
00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
	Average per diem private room charge differential (line 32 mir		tions)	0.00	
	Average per diem private room cost differential (line 34 x lir Private room cost differential adjustment (line 3 x line 35)	ie 31)		0.00	
	General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	8, 557, 412	
	27 minus line 36)				1
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	CTMENITS			-
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU Adjusted general inpatient routine service cost per diem (see			2, 247. 81	38
	Program general inpatient routine service cost (line 9 x line			8, 074, 134	
00	Medically necessary private room cost applicable to the Progra	m (line 14 x line 35)		0	40
00	Total Program general inpatient routine service cost (line 39	+ line 40)		8, 074, 134	41

	Financial Systems ATION OF INPATIENT OPERATING COST	FRANCI SCAN HEAL	TH- DYER Provider C	CN: 15-0090	In Lie Period:	eu of Form CMS- Worksheet D-1		
				CCN: 15-T090	From 01/01/2022 To 12/31/2022	Date/Time Pre	pared:	
			Title	× XVIII	Subprovider -	5/10/2023 11: PPS	<u>00 am</u>	
	Cost Center Description	Total	Total	Average Pe	IRF Program Days	Program Cost		
		Inpatient CostIn		Diem (col. 1		(col. 3 x col.		
		1.00	2.00	<u>col.2)</u> 3.00	4.00	4) 5.00		
42.00	NURSERY (title V & XIX only)	0	С	0.	00 0	0	42.00	
43.00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	0	C	0.	00 0	0	43.00	
44.00	CORONARY CARE UNI T	0	0	0.	00 0	0	44.00	
45.00 46.00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45.00 46.00	
47.00	NEONATAL INTENSIVE CARE UNIT	0	0	0.	00 0	0	1	
	Cost Center Description					1.00		
48.00	Program inpatient ancillary service cost (Wk					2, 998, 059		
48. 01 49. 00	Program inpatient cellular therapy acquisiti Total Program inpatient costs (sum of lines				, column 1)	0 11, 072, 193	48.01 49.00	
	PASS THROUGH COST ADJUSTMENTS	,,	`	,				
50.00	Pass through costs applicable to Program inp	atient routine se	rvices (from	ı Wkst. D, su	m of Parts I and	247, 381	50.00	
51.00	Pass through costs applicable to Program inp and IV)	atient ancillary :	services (fr	om Wkst. D,	sum of Parts II	66, 144	51.00	
52.00	Total Program excludable cost (sum of lines					313, 525		
53.00	Total Program inpatient operating cost exclu medical education costs (line 49 minus line		ted, non-phy	sícian anest	hetist, and	10, 758, 668	53.00	
F 4 00	TARGET AMOUNT AND LIMIT COMPUTATION						54.00	
54.00 55.00	Program discharges Target amount per discharge					0.00		
55.01	Permanent adjustment amount per discharge					0.00		
55.02 56.00	Adjustment amount per discharge (contractor Target amount (line 54 x sum of lines 55, 55					0.00	55.02 56.00	
57.00	Difference between adjusted inpatient operat	0	1					
58.00	Bonus payment (see instructions)	0.00	58.00 59.00					
59.00	.00 Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)							
60.00	Expected costs (lesser of line 53 ÷ line 54, market basket)		prior year c	ost report,	updated by the	0.00	60.00	
61.00	Continuous improvement bonus payment (if lin 55.01, or line 59, or line 60, enter the les 53) are less than expected costs (lines 54 x enter zero. (see instructions)	0	61.00					
62.00 63.00	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ent (see instruct	ions)			0		
64.00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos			cost report	ing pariod (Saa	0		
	instructions)(title XVIII only)							
65.00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts after December	31 of the c	ost reportin	g period (See	0	65.00	
66.00	Total Medicare swing-bed SNF inpatient routi CAH, see instructions	ne costs (line 64	plus line 6	5)(title XVI	ll only); for	0	66.00	
67.00	Title V or XIX swing-bed NF inpatient routin	e costs through D	ecember 31 c	of the cost r	eporting period	0	67.00	
68.00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	e costs after Dec	ember 31 of	the cost rep	orting period	0	68.00	
69.00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient					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 c	ost per diem (lin			-		71.00	
72.00 73.00	Program routine service cost (line 9 x line		lipo 14 v li	po 2E)			72.00	
74.00	Medically necessary private room cost applic Total Program general inpatient routine serv						74.00	
75.00	Capital-related cost allocated to inpatient 26, line 45)	•			Part II, column		75.00	
76.00	Per diem capital-related costs (line 75 ÷ li						76.00	
77.00 78.00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu						77.00	
79.00	Aggregate charges to beneficiaries for exces		vider record	ls)			79.00	
80.00	Total Program routine service costs for comp		t limitatior	ı (line 78 mi	nus line 79)		80.00	
81.00 82.00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I						81.00 82.00	
83.00	Reasonable inpatient routine service cost (						83.00	
84.00	Program inpatient ancillary services (see in		<b>`</b>				84.00	
85.00 86.00	Utilization review - physician compensation Total Program inpatient operating costs (sum						85.00 86.00	
	PART IV - COMPUTATION OF OBSERVATION BED PAS	S THROUGH COST	<u> </u>				1	
87.00 88.00	Total observation bed days (see instructions Adjusted general inpatient routine cost per		ine 2)			0.00	87.00 88.00	
35.00	ing actor general inputiont routine cost per					0.00	00.00	

Health Financial Systems	FRANCI SCAN HE	EALTH- DYER		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC	Provider CCN: 15-0090 Period:		Worksheet D-1	
		Component (	CCN: 15-T090	From 01/01/2022 To 12/31/2022	Date/Time Pre 5/10/2023 11:	pared: 00 am
		PPS				
Cost Center Description						
					1.00	
89.00 Observation bed cost (line 87 x line 88) (	see instructions)		-		0	89.00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUG	H COST					
90.00 Capital-related cost	262, 182	8, 557, 412	0. 03063	8 0	0	90.00
91.00 Nursing Program cost	0	8, 557, 412	0.00000	0 0	0	91.00
92.00 Allied health cost	0	8, 557, 412	0.00000	0 0	0	92.00
93.00 All other Medical Education	0	8, 557, 412	0.00000	0 0	0	93.00

. 00 . 00 . 00 . 00 . 00 . 00	Cost Center Description PART I - ALL PROVIDER COMPONENTS NPATIENT DAYS Inpatient days (including private room days and swing-bed day Inpatient days (including private room days, excluding swing- Private room days (excluding swing-bed and observation bed day do not complete this line.		I RF	1.00	
. 00 . 00 . 00 . 00 . 00 . 00	NPATIENT DAYS Inpatient days (including private room days and swing-bed day Inpatient days (including private room days, excluding swing- Private room days (excluding swing-bed and observation bed day				-
. 00 . 00 . 00 . 00 . 00 . 00	Inpatient days (including private room days and swing-bed day Inpatient days (including private room days, excluding swing- Private room days (excluding swing-bed and observation bed da				
. 00 . 00 . 00 . 00 . 00	Inpatient days (including private room days, excluding swing- Private room days (excluding swing-bed and observation bed da			2.007	
. 00 . 00 . 00 . 00	Private room days (excluding swing-bed and observation bed da			3, 807 3, 807	1.
00 00 00	do not complete this line	ays). If you have only pr	ivate room days,	0	
00 00			-		
00	Semi-private room days (excluding swing-bed and observation b Total swing-bed SNF type inpatient days (including private ro	5 7	r 31 of the cost	3, 807 0	4
00	reporting period	Join days) thi ough becember	I SI OI LIE COST	0	
	Total swing-bed SNF type inpatient days (including private ro	oom days) after December 3	31 of the cost	0	6
00 1	reporting period (if calendar year, enter 0 on this line)		01 - <del>C</del> + b +		_
	Total swing-bed NF type inpatient days (including private roo reporting period	om days) through December	31 of the cost	0	7
	Total swing-bed NF type inpatient days (including private roo	om days) after December 3	1 of the cost	0	8
	reporting period (if calendar year, enter 0 on this line)				
	Total inpatient days including private room days applicable † newborn days) (see instructions)	to the Program (excluding	swing-bed and	215	9
	Swing-bed SNF type inpatient days applicable to title XVIII (	only (including private r	oom days)	0	10
	through December 31 of the cost reporting period (see instruc				
	Swing-bed SNF type inpatient days applicable to title XVIII o December 31 of the cost reporting period (if calendar year, o		oom days) after	0	11
	Swing-bed NF type inpatient days applicable to titles V or XI		e room days)	0	12
	through December 31 of the cost reporting period		3 /		
	Swing-bed NF type inpatient days applicable to titles V or XI			0	13
	after December 31 of the cost reporting period (if calendar y Medically necessary private room days applicable to the Prog			0	14
	Total nursery days (title V or XIX only)			721	
	Nursery days (title V or XIX only)			446	16
-	WING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to servic	res through December 31 o	f the cost	0.00	1 17
	reporting period			0.00	''
	Medicare rate for swing-bed SNF services applicable to servic	ces after December 31 of	the cost	0.00	18
9.00	reporting period Medicaid rate for swing-bed NF services applicable to service	es through December 31 of	the cost	0.00	19
	reporting period Medicaid rate for swing-bed NF services applicable to service	as after December 31 of t	he cost	0.00	20
	reporting period		ne cost	0.00	20
	Total general inpatient routine service cost (see instruction			8, 557, 412	
	Swing-bed cost applicable to SNF type services through Decemb 5 x line 17)	per 31 of the cost report	ing period (line	0	22
	Swing-bed cost applicable to SNF type services after December	r 31 of the cost reporting	g period (line 6	0	23
	x line 18) Swing had east applicable to NE type conviges through Decemb	an 21 of the east report.	ng partial (line	0	1
1.00	Swing-bed cost applicable to NF type services through Decembe 7 x line 19)	er al of the cost reportin	ng period (inne	0	24
	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	period (line 8	0	25
	x line 20) Total swing-bed cost (see instructions)			0	26
	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		8, 557, 412	
]	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	· · · · · · · · · · · · · · · · · · ·			
	General inpatient routine service charges (excluding swing-be	ed and observation bed ch	arges)	0	
1	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	
	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0. 000000	
. 00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32
	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 22 mi	nuc line 22) (and instance	tions)	0.00	
	Average per diem private room charge differential (line 32 mi Average per diem private room cost differential (line 34 x li		(10115)	0.00 0.00	
	Private room cost differential adjustment (line 3 x line 35)			0	
. 00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	8, 557, 412	37
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD.	JUSTMENTS			
. 00	Adjusted general inpatient routine service cost per diem (see	e instructions)		2, 247. 81	
1	Program general inpatient routine service cost (line 9 x line			483, 279	
1	Medically necessary private room cost applicable to the Progn Total Program general inpatient routine service cost (line 34			0 483, 279	

	Financial Systems ATION OF INPATIENT OPERATING COST	FRANCI SCAN HEAL	TH- DYER Provider C	CN: 15-0090	Peri od:	worksheet D-1	
			Component	CCN: 15-T090	From 01/01/2022 To 12/31/2022	Date/Time Pre	
			Ti tl	e XIX	Subprovider -	5/10/2023 11: TEFRA	<u>oo am</u>
	Cost Center Description	Total Inpatient CostIn	Total patient Days			Program Cost (col. 3 x col.	
		1.00	2.00	<u>col.2)</u> 3.00	4.00	4) 5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.	00 0	0	42.00
43.00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	0	0	0.	00 0	0	43.00
44.00	CORONARY CARE UNI T	0	0	0.	00 0	0	
45.00 46.00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45.00
47.00	NEONATAL INTENSIVE CARE UNIT	0	0	0.	00 0	0	
	Cost Center Description					1.00	
48.00	Program inpatient ancillary service cost (Wk					0	
48.01 49.00	Program inpatient cellular therapy acquisiti Total Program inpatient costs (sum of lines				, column 1)	0 483, 279	
	PASS THROUGH COST ADJUSTMENTS	<b>Q</b> ,					
50.00	Pass through costs applicable to Program inp []])	oatient routine se	rvices (from	ı Wkst. D, su	m of Parts I and	0	50.00
51.00	Pass through costs applicable to Program inp	batient ancillary	services (fr	om Wkst. D,	sum of Parts II	0	51.00
52.00	and IV) Total Program excludable cost (sum of lines	50 and 51)				0	52.00
53.00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	uding capital rela	ted, non-phy	sician anest	hetist, and	483, 279	
54.00	Program di scharges					0	54.00
55.00 55.01	Target amount per discharge Permanent adjustment amount per discharge					0.00	
55.02	Adjustment amount per discharge (contractor	use only)				0.00	
56.00	Target amount (line 54 x sum of lines 55, 55		-++ (1	· · · · · · · · · · · · · · · · · · ·		0	
57.00 58.00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ting cost and targ	et amount (I	ine 56 minus	TThe 53)	-483, 279 0	
59.00	Trended costs (lesser of line $53 \div$ line $54$ , updated and compounded by the market basket)	1		0.	0	0.00	59.00
60. 00	Expected costs (lesser of line 53 ÷ line 54, market basket)	of TTHE 55 TROM	prior year c	ost report,	updated by the	0.00	60.00
61. 00	Continuous improvement bonus payment (if lin 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 the	amount by w	hich operati	ng costs (İine	0	
52.00 53.00	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ment (see instruct	ions)			0	
	PROGRAM INPATIENT ROUTINE SWING BED COST	·				1	
54.00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	sts through Decemb	er 31 of the	cost report	ing period (See	0	64.00
65.00	Medicare swing-bed SNF inpatient routine cos	sts after December	31 of the c	ost reportin	g period (See	0	65.00
66.00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	ne costs (line 64	plus line 6	5)(title XVI	ll only): for	0	66.00
	CAH, see instructions				5,		
67.00	Title V or XIX swing-bed NF inpatient routir (line 12 x line 19)	ne costs through D	ecember 31 c	or the cost r	eporting period	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routir (line 13 x line 20)	ne costs after Dec	ember 31 of	the cost rep	orting period	0	68.00
69. 00	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 of	cost per diem (lin					71.00
72.00 73.00	Program routine service cost (line 9 x line Medically necessary private room cost applic		line 14 x li	ne 35)			72.00
74.00	Total Program general inpatient routine serv	/ice costs (line 7	2 + line 73)	ŗ			74.00
75.00 76.00	Capital-related cost allocated to inpatient 26, line 45) Per diem capital-related costs (line 75 ÷ li		osts (from W	lorksheet B,	Part II, column		75.00
7.00	Program capital-related costs (line 9 x line						77.00
8.00	Inpatient routine service cost (line 74 minu Aggregate charges to hereficiaries for even	,	uidor record	lc)			78.0
79.00 30.00	Aggregate charges to beneficiaries for exces Total Program routine service costs for comp	• •		· · · · · · · · · · · · · · · · · · ·	nus line 79)		79.00 80.00
31. 00	Inpatient routine service cost per diem limi	tati on			,		81.00
32.00 33.00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (						82.00 83.00
34. 00	Program inpatient ancillary services (see in	• • •					84.00
85.00	Utilization review - physician compensation						85.00
50. UU	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PAS		uyn 85)			I	86.00
							87.00

Health Financial Systems	FRANCI SCAN HI	EALTH- DYER		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC	CN: 15-0090	Peri od:	Worksheet D-1	
		Component (	CCN: 15-T090	From 01/01/2022 To 12/31/2022		pared: 00 am
		Ti tl	e XIX	Subprovider - IRF	TEFRA	
Cost Center Description						
					1.00	
89.00 Observation bed cost (line 87 x line 88) (see	e instructions)				0	89.00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (	COST					
90.00 Capital-related cost	0	8, 557, 412	0.0000	0 00	0	90.00
91.00 Nursing Program cost	0	8, 557, 412	0.0000	0 00	0	91.00
92.00 Allied health cost	0	8, 557, 412	0.0000	0 00	0	92.00
93.00 All other Medical Education	0	8, 557, 412	0.0000	0 00	0	93.00

PATIENT ANCILLAF	Y SERVICE COST APPORTIONMENT	Provider C	CN: 15-0090	Peri od:	Worksheet D-3	;
				From 01/01/2022		
				To 12/31/2022	Date/Time Pre 5/10/2023 11:	
		Title	e XVIII	Hospi tal	PPS	
Cost (	enter Description		Ratio of Cos		Inpati ent	
			To Charges		Program Costs	
				Charges	(col. 1 x col.	
			1.00	2.00	2)	-
INPATIENT R	DUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
	& PEDI ATRI CS			16, 664, 218		30.
	IVE CARE UNIT			5, 103, 405		31.
. 00 03200 CORON	RY CARE UNI T			0		32.
. 00 02060 NEONA	AL INTENSIVE CARE UNIT			0		35.
. 00 04100 SUBPR				0		41.
. 00 04200 SUBPR	VIDER			0		42.
. 00 04300 NURSEI	Y					43.
ANCI LLARY S	RVI CE COST CENTERS		•		•	
. 00 05000 0PERA			0. 0839	26 9, 501, 007	797, 382	
	I ENT SURGERY		0.6012	07 851, 044	511, 654	50
. 00 05100 RECOVI	RY ROOM		0. 1548	11 877, 294	135, 815	51
. 00 05300 ANESTI	ESI OLOGY		0. 3406	15 2, 067, 119	704, 092	53
. 00 05400 RADI 0I	OGY-DI AGNOSTI C		0.0672	81 3, 507, 356	235, 978	54
01 05401 RADI 0I	OGY-SPECIAL PROCEDURES		0. 3960	41 0	0	54
. 00 05500 RADI 0I	OGY-THERAPEUTI C		0.0000	00 0	0	55
. 00 05600 RADI 01	SOTOPE		0. 1555			56
. 00 06000 LABOR/	TORY		0. 1374	07 12, 996, 734	1, 785, 842	60
	STORING, PROCESSING & TRANS.		0. 1118		58, 371	63
	ATORY THERAPY		0. 2765	81 5, 382, 901	1, 488, 808	65
. 00 06600 PHYSI (	AL THERAPY		0. 3345	88 1, 242, 338	415, 671	66
	TI ONAL THERAPY		0. 2834	84 1, 117, 294	316, 735	67
. 00  06800  SPEECI			0. 2755		178, 166	68
. 00 06900 ELECTI			0. 0729			
	OENCEPHALOGRAPHY		0. 1228			
	L SUPPLIES CHARGED TO PATIENT		0. 3051			
	DEV. CHARGED TO PATIENTS		0. 6139			
	CHARGED TO PATIENTS		0. 2516		2, 150, 153	
. 00 03630 ULTRA			0. 1043			
. 01 03951 PALN (			0. 1588			
.02 03952 CATH I			0. 0791			
	TY THERAPEUTIC		0. 3393			
. 04 03954 WOUND			0. 3987			
05 03340 BARI A			0. 4929			
	Y LIVING CENTER		0.0000			
	OURCE CENTER		0.0000			
	ANCILLARY SERVICE COST CENTERS		0.0000			
09 03956 LACTA			0.0000			
	ANCI LLARY SERVICE COST CENTERS		0.0000			
	ANCILLARY SERVICE COST CENTERS		0.0000			
	AGULATION CLINIC		0. 4728			
	NEIC STEM CELL ACQUISITION		0.0000	00 0	0	77
	SERVICE COST CENTERS		1			
. 00 09100 EMERGI			0. 1520			
	ATION BEDS (NON-DISTINCT PART		0. 4593			
	(sum of lines 50 through 94 and 96 through 98)			74, 046, 605	14, 900, 883	
	BP Clinic Laboratory Services-Program only charge	s (line 61)		0		201
2.00 Net cl	arges (line 200 minus line 201)		1	74, 046, 605	1	202

NPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0090	Peri od:	Worksheet D-3	3
			From 01/01/2022		
	Component	CCN: 15-T090	To 12/31/2022	Date/Time Pre 5/10/2023 11:	
	Title	e XVIII	Subprovider - IRF	PPS	00 411
Cost Center Description		Ratio of Cos		I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		1.00	2.00	2) 3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDI ATRI CS					30. 00
31. 00 03100 INTENSIVE CARE UNIT					31.00
32.00 03200 CORONARY CARE UNIT					32.00
35.00 02060 NEONATAL INTENSIVE CARE UNIT					35.00
1.00 O4100 SUBPROVIDER - IRF			8, 448, 074		41.00
12. 00 04200 SUBPROVI DER					42.00
I3. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS				<u> </u>	43.00
50. 00 05000 OPERATING ROOM		0.08392	26 143, 995	12, 085	50.00
50. 01 05001 OUTPATIENT SURGERY		0. 60120			
51.00 O5100 RECOVERY ROOM		0. 1548			
53. 00 05300 ANESTHESI OLOGY		0. 3406			
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0.06728	31 278, 169	18, 715	54.00
54. 01 05401 RADI OLOGY-SPECI AL PROCEDURES		0. 39604	41 0	0	54.01
55. 00 05500 RADI OLOGY-THERAPEUTI C		0.0000		0	
56. 00 05600 RADI 0I SOTOPE		0. 15558			
50.00 O6000 LABORATORY		0. 13740		165, 722	
53.00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 11188			
55. 00  06500  RESPI RATORY THERAPY 56. 00  06600  PHYSI CAL_THERAPY		0. 27658			
57. 00 06700 OCCUPATI ONAL THERAPY		0. 28348		788, 636	
58. 00 06800 SPEECH PATHOLOGY		0. 27550			
59.00 06900 ELECTROCARDI OLOGY		0. 07290			1
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 12289			
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 30512		213, 515	71.00
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 6139	17, 874	10, 973	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 25164		299, 801	
76.00 03630 ULTRA SOUND		0. 10430		0	
76.01 03951 PAIN CLINIC		0. 1588		0	
		0.07910		-	
76. 03   03953  ACTI VI TY THERAPEUTI C 76. 04   03954  WOUND CARE CENTER		0. 3393		-	
76. 05 03340 BARI ATRI C CLI NI C		0. 49299		-	
76. 06 03330 HEALTHY LIVING CENTER		0. 00000		-	
76. 07 03950 CV RESOURCE CENTER		0.00000			
76. 08 03955 OTHER ANCI LLARY SERVICE COST CENTERS		0.00000			
76. 09 03956 LACTATION CLINIC		0.00000		0	
76. 10 03957 OTHER ANCI LLARY SERVICE COST CENTERS		0.00000			
76. 11 03958 OTHER ANCI LLARY SERVICE COST CENTERS		0.0000		0	76. 11
76.12 03959 ANTICOAGULATION CLINIC		0. 47280			
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION		0.0000	0 00	0	77.00
OUTPATIENT SERVICE COST CENTERS					
01.00 09100 EMERGENCY		0. 15202			
22.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0)	0. 4593			
200.00Total (sum of lines 50 through 94 and 96 through 94201.00Less PBP Clinic Laboratory Services-Program only cl			11, 243, 574	2, 998, 059	200.00
		1	0		1201. UL

Image: Second		Financial Systems FRANCISCAN HEALTH- DY ATION OF REIMBURSEMENT SETTLEMENT Prov.	YER ider CCN: 15-0090	In Lie Period:	u of Form CMS-2 Worksheet E	2552-10
It the XVIII         Hospital         PPS           PRATA - INPARTENT INSPIRAL SERVICES LADGE INPS         1.00         1.00         1.00           DB RD Amounts Other than Outlier payments for discharges occurring or or after Dectober 1 (see         1.00         5.028.09         1.00           DB RD Amounts Other than Outlier payments for discharges occurring or or after Dectober 1 (see         5.028.09         1.00           DB RD FOR Federal specific operating payment for Wolel 4 APPCI for discharges occurring on or after Dectober 1 (see         1.00         0.00           DB RD FOR Federal specific operating payment for Wolel 4 APPCI for discharges occurring on or after Dectober 1 (see Instructions)         0.00         2.00         0.00         2.00         0.00         2.00         0.00         2.00         0.00         0.00         2.00         0.00 <td< td=""><td>CALCUL</td><td>ATTON OF REFINIDORSEMENT SETTLEMENT FTOV</td><td>Tuel CCN. 13-0090</td><td>From 01/01/2022</td><td>Part A Date/Time Pre</td><td></td></td<>	CALCUL	ATTON OF REFINIDORSEMENT SETTLEMENT FTOV	Tuel CCN. 13-0090	From 01/01/2022	Part A Date/Time Pre	
Not A         Learning that Start Into Starts Into Starts         Less Starts         J.           1.00         Bit A         District Start Into Starts         Starts			Title XVIII	Hospi tal		<u>00 am</u>
Not A         Learning that Start Into Starts Into Starts         Less Starts         J.           1.00         Bit A         District Start Into Starts         Starts					1 00	
1.01       DKB anounts other than outlier payments for discharges occurring on or after October 1 (see       14, 14, 58, 32       1.01         1.02       DKB anounts other than outlier payments for discharges occurring on or after October 1 (see       5, 028, 905       1.02         1.03       DKB for factors (separating payment for Model 4 APC) for discharges occurring on or after       0       1.04         1.04       DKB for factors (separating payment for Model 4 APC) for discharges occurring on or after       0       0         1.05       DKB for factors (separating payment for Model 4 APC) for discharges occurring on or after       0       0         1.04       DKB for factors (separating payment for Model 4 APC) for discharges occurring on or after       0       0         1.04       DKB discharges occurring on a after factors (see instructions)       2.00       0						
1.22       BK anouts other than outlier payment for discharges occurring or after Utaber 1 (see instructions)       5.028,909       1.02         1.33       BK for faberal specific operating payment for Model 4 BPCI for discharges occurring on a strer fabration of the payments for discharges (see instructions)       2         0.40       Different specific operating payment for Model 4 BPCI for discharges occurring on a strer fabration of the payments for discharges occurring on a file fabrations)       2         0.40       Different specific operating payment for Model 4 BPCI (see instructions)       5.675,252         0.40       Different specific operating payment for Model 4 BPCI (see instructions)       5.675,252         0.40       Different specific operating particle of the cost reporting period (see instructions)       7.60         0.40       Different for all costing the payments for discharges occurring on a file fabration of the fabration of the payments for discharges occurring period (see instructions)       7.60         0.40       Different for all costing the reports that meet the carboting period generic on other payment fabration on a street fabrating and other payments for discharges occurring period (see instructions)       0.60         0.40       TH2 count for all costing the represens that meet the carboting period generic on the fabration of the payments fabration of the payments fabration of the payments fabration on a fibration of the fabration of the payments fabration of the payments fabration on a fabration of the payments fabratin the payments fabratin the payments fabration of the payments fa		DRG amounts other than outlier payments for discharges occurring pr	rior to October 1 (	see		
1.203       Bike for freeneds specific operating payment for Model 4 BPCI for discharges occurring on or after       0       1.304         1.204       Disc for freeneds specific operating payment for Model 4 BPCI for discharges occurring on or after       0       1.304         1.304       Disc for freeneds specific operating payment for Model 4 BPCI for discharges occurring on or after       0       2.00         2.00       Duttler payment for discharges for Model 4 BPCI for discharges occurring on or after       0       2.00         2.01       Duttler payment for discharges for Model 4 BPCI for discharges occurring on or after       0       2.00         3.00       Duttler payment for discharges for Model 4 BPCI for discharges occurring on or after       0       2.00         3.01       Duttler payment for discharges for Model 4 BPCI for the totation of See Instructions)       10.84       2.00         3.01       Differene discharge for qualiting hospin for the most ruent cost reporting period ending on on an programs. In accordance with 42 CH 310 / 760       7.00       6.00	1.02	DRG amounts other than outlier payments for discharges occurring on	n or after October	1 (see	5, 028, 905	1. 02
1.04       DBC for Federal specific operating payment for Wolei 4 BPCI for discharges occurring un or after       0       0.01         2.00       Duiller payments for discharges. (see instructions)       0       2.00         2.00       Duiller payments for discharges courring or or to totober 1 (see instructions)       0       2.00         2.00       Duiller payments for discharges courring or or the totober 1 (see instructions)       10.94,4224       3.00         3.00       Handged Care Shunlated Payments       10.94,4244       3.00       10.94,4224       3.00         5.00       FE count for allopathic and solopathic programs for the most recent cost reporting period unding on or before 12/31/96, cse instructions)       7.80       5.00         5.01       FE count for allopathic and solopathic programs for the most recent cost reporting period unding on or before 12/31/96, cse instructions)       0.00       6.00         6.20       Maral track program FE cap line latis undire fills of distarges occurring or runal track for aga aspecified under 42 CFR 8412.105(71(1)(1)(8)(2)(1)       0.00       6.00         7.00       MA Social on economic to the HE cap as specified under 42 CFR 8412.105(71(1)(1)(8)(2)(1)       0.00       7.00         7.02       Adjustment (increase or decrease) to the hegic track programs fir train for an along the cost or provement or track program FE cap line on the 22 CFR 8412.105(71(1)(1)(8)(2)(2) lifthe 0.00       7.00         7.02	1.03	DRG for federal specific operating payment for Model 4 BPCI for dis	scharges occurring	prior to October	0	1. 03
2.00       Outlier payments for discharges (see instructions)       0.01	1.04	DRG for federal specific operating payment for Model 4 BPCI for dis	scharges occurring	on or after	0	1.04
2.02       Outlier payments for discharges for Model 4 BPCI (see instructions)       0       2.03         2.04       Outlier payments for discharges accurring prior or October 1 (see instructions)       28, 992       2.04         0.00       Managed Care Similated Hayments       10, 994, 233       300         0.01       File count for allopathic and ostepathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)       0.06       5.00         0.01       File count for allopathic and ostepathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)       0.00       6.00         0.01       File count for allopathic and ostepathic programs that meet the criteria for an add-on tone cased under \$127 of 0.00       6.00         0.02       Bayed Law Low Low Low Low Low Low Low Low Low Lo		Outlier payments for discharges. (see instructions)			0	2.00
2.04       Utiliar poyents for discharges accurring on or after October 1 (see instructions)       28.992       2.04         3.00       Maraged Care Simulated Payments       114.64       4.00         600       Bed days available divided by number of days in the cost reporting period (see instructions)       114.64       4.00         5.00       FIE count for all opathic and ostoppthic programs for the most recent cost reporting period ending on on other cap for payment for qualiting hosticals under \$131 of the CAA 2021 (see instructions)       0.00       6.00         6.00       FIE count for all opathic and ostoppthic programs that meet the criteria for an add on to the cap for 0.00       6.00       6.00         6.00       FIE count for all opathic and ostoppthic programs that meet the criteria for an add on to the cap for 0.00       6.00       6.00         7.00       Max Section 420 reads instructions       10.984 (set 10.984)       7.00         7.01       Adjustment (increase or decrease) to the hospital's rural track programs [FIE IIII attain(s) for rural track programs in accordance with 42 CFR 413.75(b), 101(v)(10(v)(3)(2) if the 0.00       7.00         7.01       Adjustment (increase or decrease) to the hospital's rural track programs in accordance with 42 CFR 413.75(b), 101.97(b)(2)(2)(0, 0) (FR 2030)       7.00         8.00       Adjustment (increase or decrease) to the HE count for all opathic and ostoppthic programs for accordance with 42 CFR 413.75(b), 10.97(b)(2)(2)(10.00)       0.00       7.0					-	2.01
3.00       Managed Care Simulated Payments       10, 984,224       3.00         4.00       Bod days available divided by number of days in the cost reporting period (see instructions)       114.68       4.00         0.11       FIE cap adjustment for qualifing hospitals under \$131 of the CAA 2021 (see instructions)       0.00       5.00         0.01       FIE cap adjustment for qualifing hospitals under \$131 of the CAA 2021 (see instructions)       0.00       6.00         0.02       Rural frack program FII cap limitation adjustment after the cap-building window closed under \$127 of       0.00       6.00         0.01       FIE cap adjustment for qualifing hospitals under \$131 of the CAA 2021 (see instructions)       0.00       7.00         0.02       Rural frack program Sin accordance with 42 CER 413.79(s)       0.00       7.00       6.28         0.02       Rural frack program Sin and the cap as specified under 42 CER \$112.105(f)(1)(1)(9)(1)       0.00       7.00         0.03       Add Sin Sol reduction and under to the hospital's rural track programs if a cordance with 43.75(b)       7.00       7.00         1.01       Ration (for cardance with 42 CER 413.75(b), 413.79(c)(2)(i), 64 FR 26300 (May 12, 1096)       7.00       7.00         1.02       The amount of increase if the hospital was awarded FE cap slots under \$1503 of the AA. If the cost reduction and under structions)       8.00       8.00 <t< td=""><td></td><td></td><td></td><td></td><td></td><td>•</td></t<>						•
4.00       bed days avail able divided by number of days in the cost reporting period (see instructions)       114.68       4.00         5.00       FIE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/10% (see instructions)       5.00       5.00         5.01       FTE cap adjustment for qual fing hospit dy number \$131 of the CAA 221 (see instructions)       0.00       5.00         5.01       FTE cap adjustment for qual fing hospit dy number \$131 of the CAA 221 (see instructions)       0.00       5.00         6.02       Rural track programs in accordance with A2 CR 413.79(c)       0.00       6.20       6.20         7.00       WA Section 422 reduction amount to the IME cap as specified under 42 CR \$412.105(f)(1)(iv)(0)(1)(1) fb 0.00       7.00       7.00         7.01       WA Section 422 reduction amount to the IME cap as specified under 42 CR \$412.105(f)(1)(iv)(0)(0)(2) if the 0.00       7.00         7.02       Adjustment (increase or decrease) to the FIC count for allopathic and osteopathic programs for artificated programs in accordance with 431.75(b) and 57.70 (August 10.2022) (see instructions)       0.00       7.00         8.01       TR admount of increase if the hospit all was marded FIE cap slots under \$120 of the CAA 201 (see 10.00       8.01         8.02       The admount of increase if the hospit all was marded FIE cap slots from a closed teaching hospit all under \$550 of ACA. (see instructions)       0.00       8.01			e instructions)			
5.00       FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1994 (see instructions)       5.00       5.00         5.01       FTE cap adjustment for qualifing hospitals under \$131 of the CAA 2021 (see instructions)       0.00       5.01         5.01       FTE cap adjustment for qualifing hospitals under \$131 of the CAA 2021 (see instructions)       0.00       6.00         6.02       Burd accordance with 42 CFR 413.70(2)       0.00       6.26         7.00       WAA Section 422 reduction amount to the IME cap as specified under 42 CFR \$412.105(7)(1)(1)(1)(0)(0)(1)       0.09       7.00         7.01       ACA 5503 reduction amount to the IME cap as specified under 42 CFR \$412.105(7)(1)(1)(1)(0)(2)(1)(1)       0.00       7.00         7.02       Adjustment (increase or decrease) to the hospital's rural track programs for rural track programs for mean advance or decrease) to the 12 count for all programs for decrease or decrease) to the 12 count for all programs for the Cap allost under \$503 of the ACA. If the cest report straddle sup 1, 2011, see instructions).       0.00       8.00         8.01       The amount of increase if the hospital was awarded FTE cap slots under \$126 of the CAA 2021 (see 0.00       8.01         9.02       Sam of increases if the hospital was awarded FTE cap slots under \$126 of the CAA 2021 (see 0.00       8.01         9.02       Sam of increases if the hospital was awarded FTE cap slots under \$126 of the CAA 2021 (see 0.00		Bed days available divided by number of days in the cost reporting	period (see instru	ctions)		
5.01       FTE cap adjustment for qualiting hospitals under §131 of the CAA 2021 (see instructions)       0.00       5.00         6.00       FTE count for allogabilic and ostemphile programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)       0.00       6.00         6.01       Track programs from the ME cap as specified under 42 CFR §412.105(f)(1)(19(B)(2) 1f the cost report stradiles July 1, 2011 then see instructions.       0.00       7.00         7.01       RCA Stool reduction amount to the ME cap as specified under 42 CFR §412.105(f)(1)(19(B)(2) 1f the cost report stradiles July 1, 2011 then see instructions.       0.00       7.00         7.02       Adjustment (increase or decrease) to the hospital's rural track programs in accordance with 43.75(b)       0.00       7.00         7.03       Adjustment (increase or decrease) to the hospital's rural track programs in accordance with 43.75(b)       0.00       8.00         8.00       Adjustment (increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report stradiles July 1, 2011, see instructions.       0.00       8.00         8.01       The amount of increase if the hospital was awarded FTE cap slots under § 526 of the CAA 2021 (see instructions).       0.00       8.01         8.02       The amount of increase if the hospital was awarded FTE cap slots under § 526 of the CAA 2021 (see instructions).       0.00       0.00       0.00       0.00       0.00       0.00	5.00	FTE count for allopathic and osteopathic programs for the most rece	ent cost reporting	period ending on	7.80	5.00
new programs in accordance with 42 CFR 413.75(e)         0.00         6.26           cols         Reviral track programs IFE cap limitation adjustment after the cap-building window closed under \$127 of the CAA 2021 (see instructions)         0.00         6.26           cols         Reviral track programs IFE cap limitation adjustment after the cap-building window closed under \$127 of the CAA 2021 (see instructions)         0.00         7.01           cols         Adjustment (increase or decrease) to the hospital's rural track programs In accordance with 413.75(b)         0.00         7.02           adjustment (increase or decrease) to the PTE count for all opathic and osteopathic programs for artificated programs in accordance with 42 CFR 43075 (August 1, 2002) (see instructions)         1.00         8.00           attrack programs in accordance with 42 CFR 4313.75(b). 413.79(c)(2)(iv). 44 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002) (see instructions)         0.00         8.00           attrack programs in accordance with 42 CFR 4313.75(b). 413.79(c)(2)(iv). 45 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002)         0.00         8.00           attrack programs in accordance with 42 CFR 4313.75(b). 413.79(c)(2)(iv). 45 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002)         0.00         8.01           attrack programs in accordance with 42 CFR 431.75(b). 413.79(c)(2)(iv). 45 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002)         0.00         8.01           attrack programs in accordance with 42 CFR 413.75(b). 413.75(b). 413.75(b).		FTE cap adjustment for qualifing hospitals under §131 of the CAA 20				
the CAA 2021 (see Instructions)         0.00         ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(1)(8)(2) If the cost report straddles July 1, 2011 then see instructions.         7.00         ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(1)(8)(2) If the cost report straddles July 1, 2011 then see instructions.         7.00         Adjustment (increase or decrease) to the hospital's rural track programs FTE IImitation(s) for rural track programs in accordance with 413.75(b)         0.00         7.02           4.01 Stiment (increase or decrease) to the hospital's rural track programs in accordance with 413.75(b)         0.00         8.00           8.00 and B' FR 4007. (August 10.2022) (see Instructions:         0.11 Instructions in accordance with 42 CFR §413.75(c), 2(2)(iv). 64 FR 2630 (May 12, 12, 1998), and 67 FR 50069 (August 1, 2002).         0.00         8.00           8.00 the mount of increase if the hospital was awarded FTE cap slots under §1500 of the ACA. If the cost instructions.         0.00         8.00           8.21 The amount of increase if the hospital was awarded FTE cap slots under §120 of the CAA 2021 (see instructions)         0.00         8.01           9.00 Sin of 11 en 2.02 jurvinus lines 6, plus lines 6.24 through 6.40, minus lines 7 and 7.01, plus or sinstructions)         6.91         9.00           10.00 FTE count for rail opathic and osteopathic programs. In the current year from your records         3.79         11.00           10.00 Total allowable FTE count for the prior year.         3.79         2.		new programs in accordance with 42 CFR 413.79(e)				
7.01       ACA § 5803 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) if the cost cost and the sult 1, 2011 then see instructions.       0.00       7.01         7.02       Adjustment (Increase or decrease) to the hospital's rural track programs in accordance with 1413.75(b) and 87 FR 49075 (August 10, 2022) (see instructions)       0.00       7.02         8.04       Adjustment (Increase or decrease) to the FIE count for all opathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b). 413.79(c)(2)(iv), 64 FR 76340 (May 12, 1998), and 67 FR 80069 (August 1, 2002).       0.00       8.00         8.04       Adjustment (Increase of the hospital was awarded FIE cap slots under \$ 5503 of the ACA. If the cost report istradie sult 1, 2001).       0.00       8.00         8.01       The amount of increase if the hospital was awarded FIE cap slots under \$126 of the CAA 201 (see instructions)       0.00       8.00         8.02       The amount of increase if the hospital was awarded FIE cap slots under \$126 of the CAA 201 (see instructions)       0.00       8.00         8.01       The amount of increase is in dental and podiatric programs.       0.00       8.01         9.02       Sum of lines 5.01 puts line 6, plus lines 8.01 through 8.27 (see instructions)       0.00       1.00         10.00       FE count for residents in initial was awarded FIE cap slots under 3.01, plus or minus line 7.02, plus/minus line 7.02, plus/minus line 7.02       1.00       1.00		the CAA 2021 (see instructions)	0	-		
7.02       Adjustment (increase or decrease) to the hospital's rural track program TFE limitation(s) for rural track for Medicare (AE affiliated programs in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see instructions)       0.00       7.02         8.0A       Adjustment (increase or decrease) to the FE count for all opathic and osteopathic programs for affiliated programs in accordance with 413.75(b), 413.79(c) (2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 80000 (August 1, 2002).       0.00       8.01         8.0A       Adjustment (increase or decrease) to the FE count for all opathic and osteopathic programs for report stradide shup 1, 2011, see instructions.       0.00       8.01         8.02       The amount of increase if the hospital was awarded FE cap slots from a closed teaching hospital uns 5 500 of AAC. (see instructions)       0.00       8.01         8.03       Instructions)       10.00       FE count for allopathic and osceopathic programs.       0.00       8.01         8.04       Instructions)       11.00       FE count for residents in dental and podiatric programs.       0.00       10.00		ACA § 5503 reduction amount to the IME cap as specified under 42 CF	,			•
8.00       Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for afflined programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).       0.00       8.00         8.01       The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.       0.00       8.00         8.11       The amount of increase if the hospital was awarded FTE cap slots under § 126 of the CAA 2021 (see instructions)       0.00       8.21         9.00       Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions)       0.00       0.00       0.00         0.00       TFE count for residents in dental and podiatric programs.       3.79       11.00       0.00       3.79       12.00         1.00       Tradial lowable FTE count for the prior year.       4.56       13.40       14.50       15.41       15.00       16.00       16.00       16.00       16.00       17.02       14.00       16.00       16.00       17.00       14.00       16.00       16.00       16.00       17.00       14.00       17.00       14.00       17.00       14.00       17.00       14.00       16.00       16.00       16.00       16.00       16.00       <	7.02	Adjustment (increase or decrease) to the hospital's rural track pro track programs with a rural track for Medicare GME affiliated progr			0.00	7. 02
8.01The amount of increase if the hospital was awarded FIE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.0.008.018.02The amount of increase if the hospital was awarded FIE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)0.008.218.01The amount of increase if the hospital was awarded FIE cap slots under §126 of the CAA 2021 (see instructions)0.008.219.00Sum of Ilnes 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions)0.0010.0010.00FIE count for allopathic and osteopathic programs in the current year from your records0.0010.0012.00Current year allowable FIE count for the prior year.3.7912.0013.00Total allowable FIE count for the prior year.5.1415.0014.00Total allowable FIE count for the prior year.5.1415.0015.00Sum of lines 12 through 14 divided by 3.5.1415.0016.00Adjustment for residents in initial years of the program (see instructions)0.0010.0016.00Prior year resident to bed ratio (line 18 divided by line 4).0.04482010.0010.00Current year resident to bed ratio (line 18 divided by line 4).0.04482010.0010.00Current year resident to bed ratio (see instructions)0.04482010.0010.00The payment adjustment for the Add-on for § 422 of the MMA0.0023.0010.00Current yea	8.00	Adjustment (increase or decrease) to the FTE count for allopathic a affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(			0.00	8.00
8.02The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital0.008.028.21The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)0.008.219.00Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or minus line 7.02 plus/minus line 8, 0.01 through 8.27 (see instructions)0.008.2110.00FTE count for residents in dental and podiatric programs.0.0010.000.0012.00Current year allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.3.7911.0015.00Sum of lines 12 through 14 divided by 3.5.1415.0016.0016.00Adjustment for residents in initial years of the program (see instructions)0.0016.0017.00Adjustment for resident sip laced by program or hospital closure0.04872820.0010.00Prior year resident to bed ratio (line 18 divided by line 4).0.0448209.0020.00Prior year resident to bed ratio (see instructions)0.04872820.0021.00Nume of additional allopathic and osteopathic IME FTE resident caps lots under 42 CFR 412.1050.0022.00Number of additional allopathic and osteopathic IME FTE resident caps lots under 42 CFR 412.1050.0023.00Number of additional allopathic and osteopathic IME FTE resident caps lots under 42 CFR 412.1050.0024.00Number of additional allopathic and osteopathic IME FTE resident caps lots under 42 CFR 412.1050.00<	8.01	The amount of increase if the hospital was awarded FTE cap slots un	nder § 5503 of the	ACA. If the cost	0.00	8. 01
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23.00Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.1050.0023.0024.00IME FTE Resident Count Over Cap (see instructions)-6.9124.0025.00If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see0.0025.0026.00Resident to bed ratio (divide line 25 by line 4)0.00000026.0027.00IME payments adjustment factor. (see instructions)0.00000027.0028.00IME add-on adjustment amount (see instructions)028.0029.01Total IME payment ( sum of lines 22 and 28)463,77929.0029.01Total IME payment - Managed Care (sum of lines 22.01 and 28.01)26.5730.0020.00Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)2.6530.0030.00Allowable disproportionate share percentage (see instructions)28.5733.00	22. 01		bo MMA		265, 675	22.01
24.00IME FTE Resident Count Over Cap (see instructions)-6.9124.0025.00If the amount on Line 24 is greater than -0-, then enter the Lower of Line 23 or Line 24 (see0.0025.0026.00Resident to bed ratio (divide Line 25 by Line 4)0.00000026.0027.00IME payments adjustment factor. (see instructions)0.00000027.0028.00IME add-on adjustment amount (see instructions)028.0028.01IME add-on adjustment amount (see instructions)028.0029.01Total IME payment (sum of Lines 22 and 28)463,77929.0029.01Total IME payment - Managed Care (sum of Lines 22.01 and 28.01)265,67529.01Disproportionate Share Adjustment026.5731.0030.00Percentage of Medicaid patient days (see instructions)2.6530.0032.00Sum of Lines 30 and 3128.2232.0033.00Allowable disproportionate share percentage (see instructions)12.5033.00	23.00	Number of additional allopathic and osteopathic IME FTE resident ca		FR 412.105	0.00	23.00
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28.00IME add-on adjustment amount (see instructions)028.0028.01IME add-on adjustment amount - Managed Care (see instructions)028.0129.00Total IME payment (sum of lines 22 and 28)463,77929.0029.01Total IME payment - Managed Care (sum of lines 22.01 and 28.01)265,67529.01Disproportionate Share Adjustment265,67529.0130.00Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)2.6530.0031.00Percentage of Medicaid patient days (see instructions)25.5731.0032.00Sum of lines 30 and 3128.2232.0033.00Allowable disproportionate share percentage (see instructions)12.5033.00						
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Disproportionate Share Adjustment30.00Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)2.6531.00Percentage of Medicaid patient days (see instructions)25.5732.00Sum of lines 30 and 3128.2233.00Allowable disproportionate share percentage (see instructions)12.50		Total IME payment ( sum of lines 22 and 28)				
30. 00Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)2.6530. 0031. 00Percentage of Medicaid patient days (see instructions)25. 5731. 0032. 00Sum of lines 30 and 3128. 2232. 0033. 00Allowable disproportionate share percentage (see instructions)12. 5033. 00	29. 01				265, 675	29.01
32.00         Sum of lines 30 and 31         28.22         32.00           33.00         Allowable disproportionate share percentage (see instructions)         12.50         33.00		Percentage of SSI recipient patient days to Medicare Part A patient	t days (see instruc	tions)		
33.00Allowable disproportionate share percentage (see instructions)12.5033.00						

	Financial Systems FRANCISCAN HEAL	LTH- DYER	In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT		Period: From 01/01/2022	Worksheet E Part A	
			To 12/31/2022	Date/Time Pre	
		Title XVIII	Hocpi tal	5/10/2023 11:0 PPS	00 am
			Hospital Prior to 10/1		
			1.00	2.00	
	Uncompensated Care Payment Adjustment				
35.00	Total uncompensated care amount (see instructions)			6, 874, 403, 459	
35. 01 35. 02	Factor 3 (see instructions) Hospital UCP, including supplemental UCP (If line 34 is zero,	enter zero on this line)	0. 000244105 1, 755, 609	0. 000243131 1, 671, 379	
JJ. 02	(see instructions)	enter zero on this rine)	1, 755, 007	1, 071, 379	33.02
35.03	Pro rata share of the hospital UCP, including supplemental UC	CP (see instructions)	1, 313, 099	421, 279	35.03
36.00	Total UCP adjustment (sum of columns 1 and 2 on line 35.03)		1, 734, 378		36.00
40.00	Additional payment for high percentage of ESRD beneficiary di	scharges (lines 40 through	0		40.00
40. 00 41. 00	Total Medicare discharges (see instructions) Total ESRD Medicare discharges (see instructions)		0		40.00
41.01	Total ESRD Medicare covered and paid discharges (see instruct	tions)	0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not quali		0.00		42.00
43.00	Total Medicare ESRD inpatient days (see instructions)		0.000000		43.00
44.00	Ratio of average length of stay to one week (line 43 divided		44.00		
45.00	days) Average weekly cost for dialysis treatments (see instructions	3)	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41		0		46.00
47.00	Subtotal (see instructions)		22, 557, 891		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, s	small rural hospitals	33, 278, 180		48.00
	only. (see instructions)			Amount	
				1.00	
49.00	Total payment for inpatient operating costs (see instructions	6)		30, 863, 783	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I an			1, 505, 234	
51.00 52.00	Exception payment for inpatient program capital (Wkst. L, Pt.			104 457	51.00 52.00
52.00 53.00	Direct graduate medical education payment (from Wkst. E-4, li Nursing and Allied Health Managed Care payment	The 49 see first uctions).		184, 457 0	1
54.00	Special add-on payments for new technologies			170, 353	1
54.01	Islet isolation add-on payment			0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 6	59)		0	55.00
55. 01 56. 00	Cellular therapy acquisition cost (see instructions) Cost of physicians' services in a teaching hospital (see intr	suctions)		0	55.01 56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. I		rough 35).	0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt.			0	58.00
59.00	Total (sum of amounts on lines 49 through 58)			32, 723, 827	
60.00	Primary payer payments			14, 199	
61.00 62.00	Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries	s Tine 60)		32, 709, 628 1, 798, 636	
63.00	Coinsurance billed to program beneficiaries			81, 301	63.00
64.00	Allowable bad debts (see instructions)			342, 089	
65.00	Adjusted reimbursable bad debts (see instructions)			222, 358	1
66.00	Allowable bad debts for dual eligible beneficiaries (see inst	tructions)		235, 111	
67.00 68.00	Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for	applicable to MS_DRGs (see	instructions)	31, 052, 049 0	
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).			0	
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	-		0	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demonst	tration) adjustment (see in	nstructions)	0	70.50
70.75	N95 respirator payment adjustment amount (see instructions)			0	70.75
70. 87 70. 88	Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only)			0	70.87 70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see inst	tructions)		0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)	,		0	
70.91	HSP bonus payment HRR adjustment amount (see instructions)			-31, 526	
	Bundled Model 1 discount amount (see instructions)			0	70.92
70. 92	· · · · ·		I	~ ~	70 02
70. 92 70. 93	HVBP payment adjustment amount (see instructions) HRR adjustment amount (see instructions)			0 -75, 529	70. 93 70. 94

	TION OF REIMBURSEMENT SETTLEMENT	TH- DYER Provider C	CN: 15-0090	Peri od:	Worksheet E	2552-1
				From 01/01/2022 To 12/31/2022	Date/Time Pre	
					5/10/2023 11:	00 am
		11116	e XVIII	Hospi tal	PPS	
				<u>(yyyy)</u> 0	Amount 1.00	
0.96	Low volume adjustment for federal fiscal year (yyyy) (Enter i	n column O		0	0	70.9
	the corresponding federal year for the period prior to 10/1)					
	Low volume adjustment for federal fiscal year (yyyy) (Enter in			0	0	70.9
	the corresponding federal year for the period ending on or af	ter 10/1)			_	
	Low Volume Payment-3				0	
	HAC adjustment amount (see instructions)	(0 % 70)			232, 773	
	Amount due provider (line 67 minus lines 68 plus/minus lines Sequestration adjustment (see instructions)	69 & 70)			30, 712, 221 386, 974	
	Demonstration payment adjustment amount after sequestration				0	
	Sequestration adjustment-PARHM or CHART pass-throughs				0	71.0
	Interim payments				29, 865, 639	
	Interim payments-PARHM or CHART					72.0
3.00	Tentative settlement (for contractor use only)				0	73.0
3. 01	Tentative settlement-PARHM or CHART (for contractor use only	)				73.0
	Balance due provider/program (line 71 minus lines 71.01, 71.0	2, 72, and			459, 608	74.0
	73)	、 、				
1	Balance due provider/program-PARHM or CHART (see instructions)	·			0 140 410	74.0
	Protested amounts (nonallowable cost report items) in accorda CMS Pub. 15-2, chapter 1, §115.2	nce with			8, 148, 419	75.0
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum (	of 2.03			0	90.0
	plus 2.04 (see instructions)				_	
1.00	Capital outlier from Wkst. Ĺ, Pt. I, line 2				0	91. (
2.00	Operating outlier reconciliation adjustment amount (see instru	uctions)			0	92.
	Capital outlier reconciliation adjustment amount (see instruc				0	
	The rate used to calculate the time value of money (see instru	uctions)			0.00	
	Time value of money for operating expenses (see instructions)	+:)			0	
96.00	Time value of money for capital related expenses (see instruc	tions)		Prior to 10/1	0	96.0
	HSP Bonus Payment Amount			1.00	2.00	
	HSP Bonus Payment Amount HSP bonus amount (see instructions)				2.00	100. (
00.00				1.00	2.00	100. (
00. 00 01. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions)			1.00 6,013,642 1.000000000	2.00 2,026,575 1.000000000	101. (
00. 00 01. 00 02. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions	s)		1.00	2.00 2,026,575 1.000000000	101. (
00. 00 01. 00 02. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction: HRR Adjustment for HSP Bonus Payment	s)		1.00 6,013,642 1.0000000000 0	2.00 2,026,575 1.0000000000 0	101. C 102. C
00. 00 01. 00 02. 00 03. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions)			1.00 6,013,642 1.0000000000 0 0.9956	2.00 2,026,575 1.000000000 0 0.9975	101. ( 102. ( 103. (
00.00 01.00 02.00 03.00 04.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions)	)	ictmont	1.00 6,013,642 1.0000000000 0	2.00 2,026,575 1.000000000 0 0.9975	101. 0 102. 0 103. 0
00.00 01.00 02.00 03.00 04.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr	) ration) Adju		1.00 6,013,642 1.0000000000 0 0.9956	2.00 2,026,575 1.000000000 0 0.9975	101. ( 102. ( 103. ( 104. (
00.00 01.00 02.00 03.00 04.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration pe	) ration) Adju		1.00 6,013,642 1.0000000000 0 0.9956	2.00 2,026,575 1.000000000 0 0.9975	101. ( 102. ( 103. ( 104. (
00.00 01.00 02.00 03.00 04.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr	) ration) Adju		1.00 6,013,642 1.0000000000 0 0.9956	2.00 2,026,575 1.000000000 0 0.9975	101. ( 102. ( 103. ( 104. (
00. 00 01. 00 02. 00 03. 00 04. 00 00. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no.	) ration) Adju riod under 1		1.00 6,013,642 1.0000000000 0 0.9956	2.00 2,026,575 1.000000000 0 0.9975	101. ( 102. ( 103. ( 104. ( 200. (
00. 00 01. 00 02. 00 03. 00 04. 00 00. 00 01. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration per Contury Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement	) ration) Adju riod under 1		1.00 6,013,642 1.0000000000 0 0.9956	2.00 2,026,575 1.000000000 0 0.9975	101. ( 102. ( 103. ( 104. ( 200. ( 201. ( 202. (
00. 00 01. 00 02. 00 03. 00 04. 00 00. 00 01. 00 02. 00 03. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions)	) ration) Adju riod under t e 49)	he 21st	1.00 6,013,642 1.000000000 0 0.9956 -26,460	2.00 2,026,575 1.000000000 0 0.9975 -5,066	101. ( 102. ( 103. ( 104. ( 200. ( 201. ( 202. (
00. 00 01. 00 02. 00 03. 00 04. 00 200. 00 200. 00 201. 00 202. 00 203. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment factor (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Curees Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in	) ration) Adju riod under t e 49)	he 21st	1.00 6,013,642 1.000000000 0 0.9956 -26,460	2.00 2,026,575 1.000000000 0 0.9975 -5,066	101. ( 102. ( 103. ( 104. ( 200. ( 201. ( 202. (
00. 00 01. 00 02. 00 03. 00 04. 00 200. 00 201. 00 202. 00 203. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment factor (see instructions) HVBP adjustment for HSP Bonus Payment HRR adjustment for HSP Bonus Payment HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period)	) ration) Adju riod under t e 49)	he 21st	1.00 6,013,642 1.000000000 0 0.9956 -26,460	2.00 2,026,575 1.000000000 0 0.9975 -5,066	101. 0 102. 0 103. 0 104. 0 200. 0 201. 0 202. 0 203. 0
00.00 01.00 02.00 03.00 04.00 200.00 201.00 202.00 203.00 204.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment factor (see instructions) HVBP adjustment for HSP Bonus Payment HRR adjustment for HSP Bonus Payment HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount	) ration) Adju riod under t e 49)	he 21st	1.00 6,013,642 1.000000000 0 0.9956 -26,460	2.00 2,026,575 1.000000000 0 0.9975 -5,066	101. ( 102. ( 103. ( 104. ( 200. ( 201. ( 202. ( 203. ( 203. (
00. 00 01. 00 02. 00 03. 00 04. 00 00. 00 01. 00 02. 00 03. 00 03. 00 03. 00 03. 00 04. 00 03. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204)	) ration) Adju riod under t e 49)	he 21st	1.00 6,013,642 1.000000000 0 0.9956 -26,460	2.00 2,026,575 1.000000000 0 0.9975 -5,066	101. ( 102. ( 103. ( 104. ( 200. ( 201. ( 202. ( 203. ( 203. ( 204. ( 205. (
D0.00         D1.00         D2.00         D3.00         D4.00         D0.00         D1.00         D2.00         D3.00         D4.00         D5.00         D5.00         D5.00         D5.00         D5.00         D6.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205)	) ration) Adju riod under t e 49)	he 21st	1.00 6,013,642 1.000000000 0 0.9956 -26,460	2.00 2,026,575 1.000000000 0 0.9975 -5,066	101. 102. 103. 104. 200. 201. 202. 203. 203.
D0.00         D1.00         D2.00         D3.00         D4.00         D2.00         D3.00         D4.00         D5.00         D5.00         D6.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in Deriod) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement	) ration) Adju riod under 1 e 49) first year	he 21st	1.00 6,013,642 1.000000000 0 0.9956 -26,460	2.00 2,026,575 1.000000000 0 0.9975 -5,066	101. 102. 103. 104. 200. 201. 202. 203. 203. 204. 205. 206.
>0.00         >1.00         >2.00         >3.00         >4.00         >2.00         >3.00         >4.00         >2.00         >3.00         3.00         3.00 </td <td>HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions)</td> <td>) ration) Adju riod under t e 49) first year ructions)</td> <td>he 21st</td> <td>1.00 6,013,642 1.000000000 0 0.9956 -26,460</td> <td>2.00 2,026,575 1.000000000 0 0.9975 -5,066</td> <td>101. 102. 103. 200. 201. 202. 203. 204. 205. 206. 207.</td>	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions)	) ration) Adju riod under t e 49) first year ructions)	he 21st	1.00 6,013,642 1.000000000 0 0.9956 -26,460	2.00 2,026,575 1.000000000 0 0.9975 -5,066	101. 102. 103. 200. 201. 202. 203. 204. 205. 206. 207.
D0.00         D1.00         D2.00         D3.00         D3.00         D4.00         D2.00         D3.00         D4.00         D5.00         D4.00         D5.00         D5.00         D6.00         D7.00         D8.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in Deriod) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement	) ration) Adju riod under t e 49) first year ructions)	he 21st	1.00 6,013,642 1.000000000 0 0.9956 -26,460	2.00 2,026,575 1.000000000 0 0.9975 -5,066	101. 102. 103. 104. 200. 201. 202. 203. 203. 204. 205. 206. 207. 208.
>00.00         >1.00         >2.00         >2.00         >3.00         >0.000         >1.000         >2.000         >1.000         >2.000         >1.000         >2.000         >1.000         >2.000         >1.000         >2.000	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment factor (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Curees Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in beriod) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Medicare Part A inpatient service costs (from Wkst. E, Pt. A,	) ration) Adju riod under t e 49) first year ructions)	he 21st	1.00 6,013,642 1.000000000 0 0.9956 -26,460	2.00 2,026,575 1.000000000 0 0.9975 -5,066	101. 102. 103. 104. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209.
00.00 01.00 02.00 03.00 04.00 00.00 01.00 02.00 03.00 03.00 04.00 05.00 05.00 06.00 07.00 08.00 09.00 10.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment factor (see instructions) HVBP adjustment for HSP Bonus Payment (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in beriod) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions)	) ration) Adju riod under t e 49) first year ructions)	he 21st	1.00 6,013,642 1.000000000 0 0.9956 -26,460	2.00 2,026,575 1.000000000 0 0.9975 -5,066	101. ( 102. ( 103. ( 104. ) 200. ( 201. ( 202. ( 203. ( 204. ( 205. ( 206. ( 207. ( 208. ( 209. ( 209. ( 209. ( 209. ( 209. ( 201. ( 20
00.00 01.00 02.00 03.00 04.00 00.00 01.00 02.00 03.00 03.00 04.00 03.00 04.00 03.00 04.00 01.00 00.00 00.00 00.00 00.00 00.00 00.00 00.00 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in Deeriod) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement	) ration) Adju riod under 1 e 49) first year first year ructions) line 59)	he 21st	1.00 6,013,642 1.000000000 0 0.9956 -26,460	2.00 2,026,575 1.000000000 0 0.9975 -5,066	101. 102. 103. 104. 104. 200. 201. 202. 203. 204. 205.
00. 00 01. 00 02. 00 03. 00 04. 00 00. 00 01. 00 01. 00 03. 00 03. 00 04. 00 05. 00 06. 00 07. 00 08. 00 09. 00 10. 00 11. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment factor (see instructions) HRR adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement Total adjustment to Medicare Part A IPPS payments (from line 1975) Comparision of PPS versus Cost Reimbursement	) ration) Adju riod under 1 e 49) first year first year ructions) line 59)	he 21st	1.00 6,013,642 1.000000000 0 0.9956 -26,460	2.00 2,026,575 1.000000000 0 0.9975 -5,066	101. ( 102. ( 103. ( 104. ( 200. ( 201. ( 202. ( 203. ( 203. ( 204. ( 205. ( 207. ( 208. ( 207. ( 208. ( 209. ( 207. ( 208. ( 209. ( 201. ( 20
00. 00 01. 00 02. 00 03. 00 04. 00 00. 00 01. 00 01. 00 03. 00 03. 00 04. 00 05. 00 06. 00 07. 00 08. 00 09. 00 10. 00 11. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in Deeriod) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement	) ration) Adju riod under t e 49) first year ructions) line 59) 211)	of the curren	1.00 6,013,642 1.000000000 0 0.9956 -26,460	2.00 2,026,575 1.000000000 0 0.9975 -5,066	101. 102. 103. 104. 200. 201. 202. 203. 204. 205. 206. 205. 206. 205. 206. 205. 206. 201.

W VC	DLUME CALCULATION EXHIBIT 4			Provider CO		Period: From 01/01/2022 To 12/31/2022	Worksheet E Part A Exhibi Date/Time Pre 5/10/2023 11:	pared
					XVIII	Hospi tal	PPS	
			Amounts (from	Pre/Post	Period Prior		Total (Col 2	
		line 0	<u>E, Part A)</u> 1.00	Entitlement 2.00	to 10/01 3.00	0n/After 10/01 4.00	through 4) 5.00	
00	DRG amounts other than outlier	1.00	0	0		0 0	0.00	1.
01	payments DRG amounts other than outlier	1. 01	14, 145, 832	0	14, 145, 83	2	14, 145, 832	1.
)2	payments for discharges occurring prior to October 1 DRG amounts other than outlier payments for discharges occurring on or after October	1. 02	5, 028, 905	0		5, 028, 905	5, 028, 905	1
3	1 DRG for Federal specific operating payment for Model 4	1.03	0	0		0	0	1
14	BPCI occurring prior to October 1 DRG for Federal specific operating payment for Model 4 BPCI occurring on or after	1. 04	0	0		0	0	1
00	October 1 Outlier payments for	2.00						2
)1	discharges (see instructions) Outlier payments for	2. 02	0	0		o 0	0	2
)2	discharges for Model 4 BPCI Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	556, 795	0	556, 79	5	556, 795	2
)3	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	28, 992	0		28, 992	28, 992	2
0	Operating outlier reconciliation	2.01	0	0		0 0	0	3
0	Managed care simulated payments	3.00	10, 984, 224	0	7, 940, 36	9 3, 043, 855	10, 984, 224	4
0	Indirect Medical Education Adju Amount from Worksheet E, Part	21.00	0. 044820	0. 044820	0. 04482	0 0. 044820		5
00	A, line 21 (see instructions) IME payment adjustment (see instructions)	22.00	463, 779	0	342, 14	5 121, 634	463, 779	6
1	IME payment adjustment for managed care (see instructions)	22. 01	265, 675	0		3 73, 622	265, 675	6
0	Indirect Medical Education Adju IME payment adjustment factor (see instructions)	27.00	0. 000000	0. 000000	0.00000			7
)0 )1	IME adjustment (see instructions) IME payment adjustment add on	28.00 28.01	0	0		0 0 0 0	0	
,	for managed care (see instructions)	20.01		U U				
)0 )1	Total IME payment (sum of lines 6 and 8) Total IME payment for managed	29.00 29.01	463, 779	0			463, 779 265, 675	
, ,	care (sum of lines 6.01 and 8.01)	29.01	265, 675	0	192, 05	3 73, 622	203, 075	
_	Disproportionate Share Adjustme							
00	Allowable disproportionate share percentage (see instructions)	33.00	0. 1250	0. 1250	0. 125	0 0. 1250		10
00	Disproportionate share adjustment (see instructions)	34.00	599, 210	0				
01 00	Uncompensated care payments Additional payment for high per Total ESRD additional payment	36.00 centage of ESR 46.00	1, 734, 378 RD beneficiary	0 di scharges 0		9 421, 279	1, 734, 378	
00	(see instructions) Subtotal (see instructions)	48.00	0 22, 557, 891	0			22, 557, 891	
00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	33, 278, 180	0		0 0	0	14
00	Total payment for inpatient operating costs (see instructions)	49.00	30, 863, 783	0	25, 032, 19	8 5, 831, 585	30, 863, 783	15
00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1, 505, 234	0	1, 118, 00	8 387, 226	1, 505, 234	16

	Financial Systems		FRANCI SCAN HE				u of Form CMS-	2552-1
LOW VO	LUME CALCULATION EXHIBIT 4			Provider C	CN: 15-0090	Period: From 01/01/2022 To 12/31/2022		pared:
				Title	× XVIII	Hospi tal	PPS	
		W/S E, Part A	Amounts (from	Pre/Post	Period Prior	Period	Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	0n/After 10/01	through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
17.00	Special add-on payments for new technologies	54.00	170, 353	0	152, 21	9 18, 134	170, 353	17.00
17. 01 17. 02	Net organ aquisition cost Credits received from manufacturers for replaced	68.00	0	0		0 0	0	17.0 <sup>2</sup> 17.02
18. 00	devices for applicable MS-DRGs Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0		0 0	0	18.00
19.00	SUBTOTAL			0	26, 302, 42	6, 236, 945	32, 539, 370	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20. 00 20. 01	Capital DRG other than outlier Model 4 BPCI Capital DRG other than outlier	1. 00 1. 01	1, 452, 802 0	0		20 377, 032 0 0		20. 00 20. 01
21. 00 21. 01	Capital DRG outlier payments Model 4 BPCI Capital DRG	2. 00 2. 01	21, 197 0			09 2, 088 0 0	21, 197 0	
22. 00	outlier payments Indirect medical education percentage (see instructions)	5.00	0. 0215	0. 0215	0. 021	5 0. 0215		22. 0
23.00	Indirect medical education adjustment (see instructions)	6.00	31, 235	0	23, 12	8, 106	31, 235	23. 0
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0. 0000	0.0000	0.000	0.0000		24.0
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0		0 0	0	25. 0
26.00	Total prospective capital payments (see instructions)	12.00	1, 505, 234	0	1, 118, 00	387, 226	1, 505, 234	26.00
		line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27. 00 28. 00	Low volume adjustment factor Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 96			0. 00000	0 0.000000	0	27.00 28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100. 00

	Financial Systems	FRANCI SCAN H				u of Form CMS-2	2552-10
HOSPI T	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5	Provider CC	F	Period: From 01/01/2022 Fo 12/31/2022	Date/Time Pre	pared:
				XV/1.1.1	llaanital	5/10/2023 11:0	00 am
	· · · · · · · · · · · · · · · · · · ·	Wkst. E, Pt.	Amt. from	XVIII Period to	Hospital Period on	PPS Total (cols. 2	
		A, line	Wkst. E, Pt. A)	10/01	after 10/01	and 3)	
		0	1.00	2.00	3.00	4.00	
1.00 1.01	DRG amounts other than outlier payments DRG amounts other than outlier payments for	1. 00 1. 01	14, 145, 832	14, 145, 832	2	14, 145, 832	1.00 1.01
1.02	discharges occurring prior to October 1 DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	5, 028, 905		5, 028, 905	5, 028, 905	1. 02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October	1.03	0	(	כ	0	1. 03
1. 04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1. 04
2.00	Outlier payments for discharges (see instructions)	2.00					2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	(	0 0	0	2. 01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	556, 795	556, 795	5	556, 795	2. 02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	28, 992		28, 992		
3.00 4.00	Operating outlier reconciliation Managed care simulated payments	2.01 3.00	0 10, 984, 224	7, 940, 369	0 0 9 3, 043, 855	0 10, 984, 224	3.00 4.00
5.00	Indirect Medical Education Adjustment Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0. 044820	0. 044820	0. 044820		5.00
6. 00 6. 01	IME payment adjustment (see instructions) IME payment adjustment for managed care (see	22. 00 22. 01	463, 779 265, 675	342, 145 192, 053			6. 00 6. 01
	instructions) Indirect Medical Education Adjustment for the	Add_on for Se	action 422 of t	he MMA			
7.00	IME payment adjustment factor (see i instructions)	27.00	0. 000000	0.00000	0.00000		7.00
8. 00 8. 01	IME adjustment (see instructions) IME payment adjustment add on for managed care (see instructions)	28. 00 28. 01	0 0	(		0 0	8. 00 8. 01
9. 00 9. 01	Total IME payment (sum of lines 6 and 8) Total IME payment for managed care (sum of	29.00 29.01	463, 779 265, 675	342, 145 192, 053			9. 00 9. 01
	lines 6.01 and 8.01) Disproportionate Share Adjustment					i	
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0. 1250	0. 1250	0. 1250		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	599, 210	442, 05	7 157, 153	599, 210	11.00
11. 01	Uncompensated care payments Additional payment for high percentage of ESF	36.00	1, 734, 378	1, 313, 099	421, 279	1, 734, 378	11.01
12.00	Total ESRD additional payment (see instructions)	46. 00	0	(	0 0	0	12.00
13. 00 14. 00	Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see	47.00 48.00	22, 557, 891 33, 278, 180	16, 799, 928 (	5, 757, 963 0 0	22, 557, 891 0	
15.00	instructions) Total payment for inpatient operating costs	49.00	30, 863, 783	25, 032, 198	5, 831, 585	30, 863, 783	15.00
16.00	(see instructions) Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1, 505, 234	1, 118, 008	3 387, 226	1, 505, 234	16.00
17. 00 17. 01	Special add-on payments for new technologies Net organ acquisition cost	54.00	170, 353	152, 219	9 18, 134	170, 353	17.00 17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	(	0 0	0	
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	(	-	0	
19.00	SUBTOTAL			26, 302, 425	6, 236, 945	32, 539, 370	19.00

Health Financial Systems	FRANCI SCAN HI	EALTH- DYER		In Lie	u of Form CMS-	2552-10
HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5	Provider CC		Period: From 01/01/2022 To 12/31/2022		epared:
		Title	XVIII	Hospi tal	PPS	
	Wkst. L, line	(Amt. from Wkst. L)				
	0	1.00	2.00	3.00	4.00	
20.00 Capital DRG other than outlier	1.00	1, 452, 802	1, 075, 7	70 377, 032	1, 452, 802	20.00
20.01 Model 4 BPCI Capital DRG other than outlier	1.01	0		0 0	0	
21.00 Capital DRG outlier payments	2.00	21, 197	19, 10	2, 088	21, 197	21.00
21.01 Model 4 BPCI Capital DRG outlier payments	2.01	0		0 0	0	
22.00 Indirect medical education percentage (see	5.00	0. 0215	0. 02	15 0. 0215		22.00
23.00 Indirect medical education adjustment (see instructions)	6.00	31, 235	23, 12	29 8, 106	31, 235	23.00
24.00 Allowable disproportionate share percentage (see instructions)	10.00	0. 0000	0.000	0.0000		24.00
25.00 Disproportionate share adjustment (see instructions)	11.00	0		0 0	0	25.00
26.00 Total prospective capital payments (see instructions)	12.00	1, 505, 234	1, 118, 00	387, 226	1, 505, 234	26.00
	Wkst. E, Pt.	(Amt. from				
	A, line	Wkst. E, Pt. A)				
	0	1.00	2.00	3.00	4,00	
27.00			2.00	0100		27.00
28.00 Low volume adjustment prior to October 1	70, 96	0		0	0	
29.00 Low volume adjustment on or after October 1	70.97	0		0	0	
30.00 HVBP payment adjustment (see instructions)	70, 93	0		0 0	0	
30.01 HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0		0 0	0	
31.00 HRR adjustment (see instructions)	70, 94	-75, 529	-62, 9	-12, 618	-75, 529	31.00
31.01 HRR adjustment for HSP bonus payment (see instructions)	70. 91	-31, 526				
					(Amt. to Wkst.	
					E, Pt. A)	
	0	1.00	2.00	3.00	4.00	
32.00 HAC Reduction Program adjustment (see instructions)	70. 99		262, 13	31 0	262, 131	32.00
100.00 Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100. 00

	Financial Systems FRANCISCAN HEAL ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0090	Period: From 01/01/2022	u of Form CMS-2 Worksheet E Part B	2002-10
			To 12/31/2022	Date/Time Pre	
		Title XVIII	Hospi tal	5/10/2023 11: PPS	ou ani
				1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
1.00	Medical and other services (see instructions)	ti ana)		1, 925	1.00
2.00 3.00	Medical and other services reimbursed under OPPS (see instruc OPPS payments	tions)		10, 939, 167 10, 639, 644	2.00 3.00
4.00	Outlier payment (see instructions)			92, 605	4.00
4.01 5.00	Outlier reconciliation amount (see instructions) Enter the hospital specific payment to cost ratio (see instru	ctions)		0 0. 000	
6.00	Line 2 times line 5			0.000	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	
8.00 9.00	Transitional corridor payment (see instructions) Ancillary service other pass through costs from Wkst. D, Pt.	IV col 13 line 200		0	8.00 9.00
10.00	Organ acqui si ti ons	TV, COL. 13, THE 200		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			1, 925	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges				
12.00	Ancillary service charges			7, 651	12.00
	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, I	ine 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13) Customary charges			7, 651	14.00
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	r payment for services o		0	16.00
17.00	had such payment been made in accordance with 42 CFR §413.13( Ratio of line 15 to line 16 (not to exceed 1.000000)	e)		0.000000	17.00
18.00	Total customary charges (see instructions)			7,651	
19.00	Excess of customary charges over reasonable cost (complete on	ly if line 18 exceeds li	ne 11) (see	5, 726	19.00
20. 00	instructions) Excess of reasonable cost over customary charges (complete on	ly if line 11 exceeds li	no 19) (coo	0	20.00
20.00	instructions)	i y i i i i exceeds i i	The To) (See	0	20.00
21.00	Lesser of cost or charges (see instructions)			1, 925	
22.00 23.00	Interns and residents (see instructions) Cost of physicians' services in a teaching hospital (see inst	ructions)		0	22.00 23.00
23.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	ructrons)		10, 732, 249	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00 26.00	Deductibles and coinsurance amounts (for CAH, see instruction Deductibles and Coinsurance amounts relating to amount on lin	-	uctions)	0 1, 759, 771	
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26)			8, 974, 403	
	instructions)				
28.00 29.00	Direct graduate medical education payments (from Wkst. E-4, I ESRD direct medical education costs (from Wkst. E-4, line 36)	ine 50)		49, 857 0	
30.00	Subtotal (sum of lines 27 through 29)			9, 024, 260	
31.00	Primary payer payments			426	
32.00	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVIO	(FS)		9, 023, 834	32.00
	Composite rate ESRD (from Wkst. 1-5, line 11)	020)		0	33.00
34.00	Allowable bad debts (see instructions)			150, 236	
35.00 36.00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		97, 653 99, 438	
37.00	Subtotal (see instructions)			9, 121, 487	
38.00	MSP-LCC reconciliation amount from PS&R			0	
39.00 39.50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instruction	s)		0	39.00 39.50
39.75	N95 respirator payment adjustment amount (see instructions)	5)		0	39.75
39.97	Demonstration payment adjustment amount before sequestration			0	39.97
39. 98 39. 99	Partial or full credits received from manufacturers for repla RECOVERY OF ACCELERATED DEPRECIATION	ced devices (see instruc	tions)	0	39.98 39.99
40.00	Subtotal (see instructions)			9, 121, 487	40.00
40. 01	Sequestration adjustment (see instructions)			114, 931	
40. 02 40. 03	Demonstration payment adjustment amount after sequestration Sequestration adjustment-PARHM or CHART pass-throughs			0	40. 02 40. 03
40.03	Interim payments			9, 074, 246	
41.01	Interim payments-PARHM or CHART				41.01
42. 00 42. 01	Tentative settlement (for contractors use only) Tentative settlement-PARHM or CHART (for contractor use only)			0	42.00 42.01
42.01	Balance due provider/program (see instructions)			-67, 690	
43.01	Balance due provider/program-PARHM (see instructions)				43.01
44.00	Protested amounts (nonallowable cost report items) in accorda §115.2	nce with CMS Pub. 15-2,	chapter 1,	0	44.00
	TO BE COMPLETED BY CONTRACTOR				
	Original outlier amount (see instructions)			0	
	Outlier reconciliation adjustment amount (see instructions)			0	
92.00 93.00	The rate used to calculate the Time Value of Money Time Value of Money (see instructions)			0.00	92.00 93.00
	Total (sum of lines 91 and 93)			-	94.00

Health Financial Systems	FRANCI SCAN HEAL	TH- DYER	In Lie	u of Form CMS-	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT			Peri od:	Worksheet E	
			From 01/01/2022 To 12/31/2022	Date/Time Pre	narod
			10 12/31/2022	5/10/2023 11:	
		Title XVIII	Hospi tal	PPS	
				1.00	
MEDICARE PART B ANCILLARY COSTS					
200.00 Part B Combined Billed Days				0	200.00
			1		

LCUL	Financial         Systems         FRANCISCAN         HEAL           ATI ON OF         REI MBURSEMENT         SETTLEMENT         SETTLEMENT	Provider CCN: 15-0090	Period: From 01/01/2022	u of Form CMS-2 Worksheet E Part B	
		Component CCN: 15-T090	To 12/31/2022	Date/Time Pre 5/10/2023 11:	
		Title XVIII	Subprovider - IRF	PPS	
				1.00	
00	PART B - MEDICAL AND OTHER HEALTH SERVICES Medical and other services (see instructions)			121	1.
00	Medical and other services (see instructions) Medical and other services reimbursed under OPPS (see instruct	tions)		0	
00	OPPS payments			198	
00	Outlier payment (see instructions)			0	
01 00	Outlier reconciliation amount (see instructions) Enter the hospital specific payment to cost ratio (see instru-	rtions)		0.000	
00	Line 2 times line 5			0	
00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	
00 00	Transitional corridor payment (see instructions) Ancillary service other pass through costs from Wkst. D, Pt.	IV col 12 lino 200		0	
. 00	Organ acquisitions	IV, COL. 13, TIME 200		0	
. 00	Total cost (sum of lines 1 and 10) (see instructions)			121	11
	COMPUTATION OF LESSER OF COST OR CHARGES				
. 00	Reasonable charges Ancillary service charges			480	1 12
. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, I	ne 69)			13
. 00	Total reasonable charges (sum of lines 12 and 13)			480	14
00	Customary charges Aggregate amount actually collected from patients liable for	navment for services on	a charge basis	0	15
. 00	Amounts that would have been realized from patients liable for				16
	had such payment been made in accordance with 42 CFR §413.13(	e)	-		
. 00 . 00	Ratio of line 15 to line 16 (not to exceed 1.000000) Total customary charges (see instructions)			0. 000000 480	
. 00	Excess of customary charges over reasonable cost (complete on	yifline 18 exceeds li	ne 11) (see	359	
	instructions)			_	
. 00	Excess of reasonable cost over customary charges (complete on instructions)	y if line 11 exceeds li	ne 18) (see	0	20
00	Lesser of cost or charges (see instructions)			121	21
. 00	Interns and residents (see instructions)			0	
. 00	Cost of physicians' services in a teaching hospital (see insti-	ructions)		0	
. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) COMPUTATION OF REIMBURSEMENT SETTLEMENT			198	24
. 00	Deductibles and coinsurance amounts (for CAH, see instruction	s)		0	25
. 00	Deductibles and Coinsurance amounts relating to amount on line			0	
. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26)   instructions)	DIUS THE SUM OF TIMES 22	and 23] (see	319	27
. 00	Direct graduate medical education payments (from Wkst. E-4, 1	ne 50)		0	28
. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	
. 00 . 00	Subtotal (sum of lines 27 through 29) Primary payer payments			319	
. 00	Subtotal (line 30 minus line 31)			319	
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVIO	CES)			
. 00 . 00	Composite rate ESRD (from Wkst. 1-5, line 11) Allowable bad debts (see instructions)			0	
. 00	Adjusted reimbursable bad debts (see instructions)			0	
00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	36
00	Subtotal (see instructions)			319	
00	MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
. 50	Pioneer ACO demonstration payment adjustment (see instruction	5)		Ū	39
. 75	N95 respirator payment adjustment amount (see instructions)			0	
. 97 . 98	Demonstration payment adjustment amount before sequestration Partial or full credits received from manufacturers for repla	red devices (see instruc	tions)	0	
. 99	RECOVERY OF ACCELERATED DEPRECIATION			0	
. 00	Subtotal (see instructions)			319	
01	Sequestration adjustment (see instructions)			4	40
02	Demonstration payment adjustment amount after sequestration Sequestration adjustment-PARHM or CHART pass-throughs			0	40
	Interim payments			325	
01	Interim payments-PARHM or CHART			_	41
00	Tentative settlement (for contractors use only) Tentative settlement-PARHM or CHART (for contractor use only)			0	42
. 00	Balance due provider/program (see instructions)			-10	
. 01	Balance due provider/program-PARHM (see instructions)				43
. 00	Protested amounts (nonallowable cost report items) in accordar §115.2	nce with CMS Pub. 15-2,	chapter 1,	0	44
	TO BE COMPLETED BY CONTRACTOR				
	Original outlier amount (see instructions)				90
. 00 . 00	Outlier reconciliation adjustment amount (see instructions)			0 0.00	91
. 00	The rate used to calculate the Time Value of Money Time Value of Money (see instructions)				92
	Total (sum of lines 91 and 93)				94

Health Financial Systems	FRANCI SCAN HEALTH- DYER	In Lie	u of Form CMS	-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0090	Period: From 01/01/2022	Worksheet E	
	Component CCN: 15-T090	To 12/31/2022		epared: :00 am
	Title XVIII	Subprovider - IRF	PPS	
			1.00	
MEDICARE PART B ANCILLARY COSTS				
200.00 Part B Combined Billed Days				200. 00

NALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC		Period: From 01/01/2022 To 12/31/2022	2 Date/Time Prep 5/10/2023 11:0	pared:
		Title		Hospi tal	PPS	
		Inpatien	t Part A	Pa	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
. 00	Total interim payments paid to provider		29, 865, 63	39	9, 074, 246	1.0
2. 00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none,			0	0	2.0
8. 00	write "NONE" or enter a zero List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3. 0
01	Program to Provider			0		2.0
6. 01 6. 02 6. 03	ADJUSTMENTS TO PROVIDER			0 0 0	0 0 0	3.0 3.0 3.0
. 04				0	0	3.0
. 05				0	0	3.0
50	Provider to Program			0		3.5
. 50 . 51	ADJUSTMENTS TO PROGRAM			0	0	3.5
. 52				0	0	3.5
. 53				0	0	3.5
54				0	0	3.5
. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0	0	3.9
. 00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		29, 865, 63	39	9, 074, 246	4. (
~ ~	TO BE COMPLETED BY CONTRACTOR					-
. 00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5. (
	Program to Provider					
. 01	TENTATI VE TO PROVIDER			0	0	5.0
. 02 . 03				0	0	5. 5.
03	Provider to Program			<u> </u>	0	5.1
50	TENTATI VE TO PROGRAM			0	0	5.
. 51				0	0	5.
. 52				0	0	5.
99 00	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Determined net settlement amount (balance due) based on			0	0	5. 6.
00	the cost report. (1) SETTLEMENT TO PROVIDER		459, 60	08	0	о. 6.
02	SETTLEMENT TO PROGRAM			0	67, 690	6.
00	Total Medicare program liability (see instructions)		30, 325, 24		9, 006, 556	7.
				Contractor Number	NPR Date (Mo/Day/Yr)	
. 00	Name of Contractor	C		1.00	2.00	8. (

VALY:	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		CN: 15-0090 CCN: 15-T090	Period: From 01/01/2022 To 12/31/2022		pared DO am
		Title	e XVIII	Subprovider - IRF	PPS	
		Inpatier	nt Part A		rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
00	Total interim payments paid to provider	1.00	2.00	3.00	4.00	1. C
00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		9,401,1	0	0	2.0
00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3. (
01	ADJUSTMENTS TO PROVIDER			0	0	3.0
02				0	0	3. (
03 04				0	0	3. 3.
04				0	0	3.
	Provider to Program		1	-1	-	
50	ADJUSTMENTS TO PROGRAM			0	0	3.
51				0	0	3.
52				0	0	3.
53 54				0	0	3. 3.
99	Subtotal (sum of lines 3.01–3.49 minus sum of lines 3.50–3.98)			0	0	3.
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		9, 401, 1	05	325	4.
	TO BE COMPLETED BY CONTRACTOR		i i i i i i i i i i i i i i i i i i i			
00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.
	Program to Provider		T			
01 02	TENTATI VE TO PROVIDER			0	0	5. 5.
02				0	0	5. 5.
00	Provider to Program				Ŭ	0.
50	TENTATI VE TO PROGRAM			0	0	5.
51				0	0	5.
52				0	0	5.
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	0	5.
00	Determined net settlement amount (balance due) based on the cost report. (1)					6.
01	SETTLEMENT TO PROVIDER		199, 3	46	0	6.
02	SETTLEMENT TO PROGRAM			0	10	6.
00	Total Medicare program liability (see instructions)		9, 600, 4		315	7.
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1.00	2.00	

Heal th	Financial Systems FRANCI SCAN HEA	ALTH- DYER	In Lie	u of Form CMS	-2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0090	Peri od:	Worksheet E-	1
			From 01/01/2022 To 12/31/2022		onarod
			10 12/31/2022	5/10/2023 11	
		Title XVIII	Hospi tal	PPS	
		·			
				1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATIC				
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	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3.00
4.00	Total inpatient days (see instructions)				4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3				6.00
7.00	CAH only - The reasonable cost incurred for the purchase of line 168	certified HIT technology	Wkst. S-2, Pt. I		7.00
8.00	Calculation of the HIT incentive payment (see instructions)				8.00
9.00	Sequestration adjustment amount (see instructions)				9.00
10.00	Calculation of the HIT incentive payment after sequestration	n (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 instruction	is)		32.00

LCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0090	Period: From 01/01/2022	Worksheet E-3 Part III	
		Component CCN: 15-T090	To 12/31/2022	Date/Time Prep 5/10/2023 11:0	
		Title XVIII	Subprovider - IRF	PPS	
				1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS			1.00	-
00	Net Federal PPS Payment (see instructions)			9, 095, 453	1 1
00	Medicare SSI ratio (IRF PPS only) (see instructions)			0. 0288	2
00	Inpatient Rehabilitation LIP Payments (see instructions)			501, 159	3
00	Outlier Payments			241, 103	
00	Unweighted intern and resident FTE count in the most recent of	cost reporting period en	ding on or prior	0.00	5
01	to November 15, 2004 (see instructions)			0.00	
01	Cap increases for the unweighted intern and resident FTE cour program or hospital closure, that would not be counted without			0.00	5
	CFR §412. 424(d)(1)(iii)(F)(1) or (2) (see instructions)	ut a temporary cap aujust	ment under 42		
00	New Teaching program adjustment. (see instructions)			0.00	6
00 00	Current year's unweighted FTE count of I&R excluding FTEs in	the new program growth p	eriod of a "new	0.00	7
	teaching program" (see instructions)				
00	Current year's unweighted I&R FTE count for residents within	the new program growth p	eriod of a "new	0.00	8
	teaching program" (see instructions)				
00	Intern and resident count for IRF PPS medical education adjust	stment (see instructions)		0.00	
00	Average Daily Census (see instructions)			10. 430137	
00	Teaching Adjustment Factor (see instructions)			0.000000	
00 00	Teaching Adjustment (see instructions)			0 927 715	12
00	Total PPS Payment (see instructions) Nursing and Allied Health Managed Care payments (see instruct	tion		9, 837, 715 0	
00	Organ acquisition (DO NOT USE THIS LINE)			0	1!
00	Cost of physicians' services in a teaching hospital (see ins	tructions)		0	
00	Subtotal (see instructions)			9, 837, 715	
00	Primary payer payments			0	1
00	Subtotal (line 17 less line 18).			9, 837, 715	10
00	Deducti bl es			32, 676	20
00	Subtotal (line 19 minus line 20)			9, 805, 039	2'
00	Coinsurance			82, 079	
00	Subtotal (line 21 minus line 22)			9, 722, 960	
00	Allowable bad debts (exclude bad debts for professional servi	ices) (see instructions)		0	24
00	Adjusted reimbursable bad debts (see instructions)			0	2!
00	Allowable bad debts for dual eligible beneficiaries (see ins	tructions)		0	20
00 00	Subtotal (sum of lines 23 and 25) Direct graduate medical education payments (from Wkst. E-4, I	line (0)		9, 722, 960 0	2
00	Other pass through costs (see instructions)	11110 49)		0	2
00	Outlier payments reconciliation			0	3
00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	3
50	Pioneer ACO demonstration payment adjustment (see instruction	ns)		0	3
98	Recovery of accelerated depreciation.			0	3
99	Demonstration payment adjustment amount before sequestration			0	3
00	Total amount payable to the provider (see instructions)			9, 722, 960	
. 01	Sequestration adjustment (see instructions)			122, 509	
02	Demonstration payment adjustment amount after sequestration			0	
00	Interim payments			9, 401, 105	
00	Tentative settlement (for contractor use only)			0	34
00	Balance due provider/program (line 32 minus lines 32.01, 32.0		chaptor 1	199, 346	
00	Protested amounts (nonallowable cost report items) in accorda §115.2	ance with Gw3 Mub. 13-2,		0	36
	TO BE COMPLETED BY CONTRACTOR				
00	Original outlier amount from Wkst. E-3, Pt. III, line 4			241, 103	
00	Outlier reconciliation adjustment amount (see instructions)			0	51
00	The rate used to calculate the Time Value of Money			0.00	
00	Time Value of Money (see instructions)	DECLANALAC DECODE THE EN		0	53
00	FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND Teaching Adjustment Factor for the cost reporting period imme			0, 000000	99
	TEACHING AUTUSTINETT FACTOR FOR THE COST FEDOLETIN DEFIOR FINING	euratery preceurny rebrua	iy 27, 2020.	0.000000	1 25

	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0090	Peri od:	Worksheet E-3	2552-10
UNLOUL			From 01/01/2022 To 12/31/2022	Part VII	
				5/10/2023 11:0	00 am
		Title XIX	Hospital Inpatient	Cost Outpati ent	
			1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SER	VICES FOR TITLES V OR X		2100	
	COMPUTATION OF NET COST OF COVERED SERVICES				1
1.00	Inpatient hospital/SNF/NF services		0		1.00
2.00	Medical and other services			0	2.00
3.00 4.00	Organ acquisition (certified transplant programs only) Subtotal (sum of lines 1, 2 and 3)		0	0	3.00 4.00
4.00 5.00	Inpatient primary payer payments		0	0	5.00
6.00	Outpatient primary payer payments		Ū	0	
7.00	Subtotal (line 4 less sum of lines 5 and 6)		0	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e Charges				
8.00	Routine service charges		0	0	8.00
9.00 10.00	Ancillary service charges Organ acquisition charges, net of revenue		0	0	9.00 10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		0	0	1
	CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13.00
4.4 . 0.0	basi s				44.00
14.00	Amounts that would have been realized from patients liable for a charge basis had such payment been made in accordance with 4		n U	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	2 617 3413. 13(e)	0. 000000	0.000000	15.00
16.00	Total customary charges (see instructions)		0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete onl	y if line 16 exceeds	0	0	17.00
	line 4) (see instructions)				
18.00	Excess of reasonable cost over customary charges (complete onl	y if line 4 exceeds lin	e 0	0	18.00
19.00	16) (see instructions) Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instr	ructions)	0	0	
21.00	Cost of covered services (enter the lesser of line 4 or line 1		0	0	
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be		ders.		
22.00	Other than outlier payments		0	0	
	Outlier payments		0	0	23.00
24.00 25.00	Program capital payments Capital exception payments (see instructions)		0		24.00 25.00
25.00 26.00	Routine and Ancillary service other pass through costs		0	0	
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		0	0	29.00
~~ ~~	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)		0	0	
31.00 32.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) Deductibles		0	0	
	Coi nsurance		0	0	
	Allowable bad debts (see instructions)		0	0	
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	1 33)	0	0	1
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00 39.00	Subtotal (line 36 ± line 37) Direct graduate medical education payments (from Wkst. E-4)		0	0	38.00 39.00
39.00 40.00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	
41.00	Interim payments		0	0	
				Ő	
42.00	Balance due provider/program (line 40 minus line 41)		U	0	42.00
	Balance due provider/program (line 40 minus line 41) Protested amounts (nonallowable cost report items) in accordan chapter 1, §115.2	nce with CMS Pub 15-2,	0	0	

CUL.	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0090 Component CCN: 15-T090	Period: From 01/01/2022 To 12/31/2022	Worksheet E-3 Part VII Date/Time Prep
		•		5/10/2023 11:0
		Title XIX	Subprovider - IRF	TEFRA
			Inpatient 1.00	Outpatient 2.00
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SER	RVICES FOR TITLES V OR X		2.00
	COMPUTATION OF NET COST OF COVERED SERVICES			
00	Inpatient hospital/SNF/NF services		0	
00	Medical and other services			0
00	Organ acquisition (certified transplant programs only)		0	
00	Subtotal (sum of lines 1, 2 and 3)		0	0
00	Inpatient primary payer payments		0	_
00	Outpatient primary payer payments			0
00	Subtotal (line 4 less sum of lines 5 and 6)		0	0
	COMPUTATION OF LESSER OF COST OR CHARGES			
0	Reasonable Charges		0	
)0 )0	Routine service charges Ancillary service charges		0	0
00	Organ acquisition charges, net of revenue		0	0
00	Incentive from target amount computation		0	
00	Total reasonable charges (sum of lines 8 through 11)		0	0
00	CUSTOMARY CHARGES			
00	Amount actually collected from patients liable for payment for	services on a charge	0	0
	basi s	5		
00	Amounts that would have been realized from patients liable for	payment for services o	n 0	0
	a charge basis had such payment been made in accordance with 4	12 CFR §413.13(e)		
	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0. 000000
	Total customary charges (see instructions)		0	0
00	Excess of customary charges over reasonable cost (complete onl	y if line 16 exceeds	0	0
	line 4) (see instructions)			
00	Excess of reasonable cost over customary charges (complete onl	y IT line 4 exceeds line	e U	0
00	16) (see instructions) Interns and Residents (see instructions)		0	0
00	Cost of physicians' services in a teaching hospital (see instructions)	ructions)	0	0
00	Cost of covered services (enter the lesser of line 4 or line 1		0	o
00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be			
00	Other than outlier payments		0	0
00	Outlier payments		0	0
00	Program capital payments		0	
00	Capital exception payments (see instructions)		0	
00	Routine and Ancillary service other pass through costs		0	0
00	Subtotal (sum of lines 22 through 26)		0	0
00	Customary charges (title V or XIX PPS covered services only)		0	0
00	Titles V or XIX (sum of lines 21 and 27)		0	0
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
00	Excess of reasonable cost (from line 18)		0	0
	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	1	0	0
00	Deducti bl es Coi nsurance		0	0
00	Allowable bad debts (see instructions)		0	0
00	Utilization review		0	0
00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	33)	0	0
00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0
00	Subtotal (line 36 ± line 37)		0	0
00	Direct graduate medical education payments (from Wkst. E-4)		0	-
00	Total amount payable to the provider (sum of lines 38 and 39)		0	0
00	Interim payments		0	0
00	Balance due provider/program (line 40 minus line 41)		0	0
	Protested amounts (nonallowable cost report items) in accordar		ol	0

	Financial Systems FRANCISCAN HEALT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	H- DYER Provider CCN: 15-009	0 Per	iod:	u of Form CMS-2 Worksheet E-4	
	AL EDUCATION COSTS		Fro To	m 01/01/2022 12/31/2022	Date/Time Prep 5/10/2023 11:0	
		Title XVIII		Hospi tal	PPS	
					1.00	
1.00	COMPUTATION OF TOTAL DIRECT GME AMOUNT Unweighted resident FTE count for allopathic and osteopathic p	rograms for cost ror	ortina	poriode	7.76	1.00
1.00	ending on or before December 31, 1996.	0	or tring	perrous		
1.01 2.00	FTE cap adjustment under §131 of the CAA 2021 (see instruction Unweighted FTE resident cap add-on for new programs per 42 CFR		netruct	i onc)	0.00 0.00	
2.26	Rural track program FTE cap limitation adjustment after the ca				0.00	2.00
2 00	the CAA 2021 (see instructions)				0.04	2.00
3.00 3.01	Amount of reduction to Direct GME cap under section 422 of MMA Direct GME cap reduction amount under ACA §5503 in accordance		(m). (s	ee	0.86 0.00	
	instructions for cost reporting periods straddling 7/1/2011)					
3.02	Adjustment (increase or decrease) to the hospital's rural trac programs with a rural track Medicare GME affiliation agreement					3. 02
	49075 (August 10, 2022) (see instructions)					
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and o GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))		due to	a Medicare	0.00	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instr		orting	peri ods	0.00	4.01
4.02	straddling 7/1/2011)	(coo instructions	for cor	t roporting	0.00	4. 02
4.02	ACA Section 5506 number of additional direct GME FTE cap slots periods straddling 7/1/2011)	(see instructions	TOF COS	t reporting	0.00	4.02
4.21	The amount of increase if the hospital was awarded FTE cap slo	ts under §126 of the	e CAA 20	21 (see		4. 21
5.00	instructions) FTE adjusted cap (line 1 plus and 1.01, plus line 2, plus line	s 2.26 through 2.49.	minus	lines 3 and	6. 90	5.00
	3.01, plus or minus line 3.02, plus or minus line 4, plus line	s 4.01 through 4.27				
6.00	Unweighted resident FTE count for allopathic and osteopathic p records (see instructions)	rograms for the curr	rent yea	r from your	0.00	6.00
7.00	Enter the lesser of line 5 or line 6				0. 00	7.00
		Pri mary		Other	Total	
8.00	Weighted FTE count for physicians in an allopathic and osteopa	1.00 thic	0.00	2.00	3.00	8.00
	program for the current year.					
9.00	If line 6 is less than 5 enter the amount from line 8, otherwi multiply line 8 times the result of line 5 divided by the amou		0.00	0.00	0.00	9.00
	6. For cost reporting periods beginning on or after October 1,					
10.00	if Worksheet S-2, Part I, line 68, is "Y", see instructions. Weighted dental and podiatric resident FTE count for the curre	nt voar		3. 79		10.00
10.00	Unweighted dental and podratric resident FTE count for the curre			3.79		10.00
11.00	Total weighted FTE count	5	0.00	3. 79		11.00
12.00	Total weighted resident FTE count for the prior cost reporting	year (see	0. 21	4.15		12.00
13.00	instructions) Total weighted resident FTE count for the penultimate cost rep	orting	0. 41	6.33		13.00
	year (see instructions)	0				
14.00	Rolling average FTE count (sum of lines 11 through 13 divided	by 3).	0.21	4.76		14.00
15.00 15.01	Adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new pr	ograme	0. 00 0. 00	0. 00 0. 00		15.00 15.01
16.00	Adjustment for residents displaced by program or hospital clos		0.00	0.00		16.00
16.01	Unweighted adjustment for residents displaced by program or hospital cross		0.00	0.00		16.01
17 00	closure		0.01	4 7/		17.00
17.00 18.00	Adjusted rolling average FTE count Per resident amount	104.0	0. 21 026. 58	4. 76 100, 538. 21		17.00 18.00
18.01	Per resident amount under §131 of the CAA 2021			,		18.01
19.00	Approved amount for resident costs	2	21, 846	478, 562	500, 408	19.00
					1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FT	E resident cap slots	s receiv	ed under 42		20.00
21.00	Sec. 413.79(c)(4) Direct GME FTE unweighted resident count over cap (see instruc	tions)			0.00	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instruc	-				21.00
	Enter the locality adjustment national average per resident am	-	nns)			23.00
23.00			/13)	1	0.00	
24.00	Multiply line 22 time line 23 Total direct GME amount (sum of lines 19 and 24)		,113)		0 500, 408	24.00

Health Financial Systems FRANCISCAN HEA DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT		CN: 15-0090	Peri od:	u of Form CMS-2 Worksheet E-4	
MEDICAL EDUCATION COSTS			From 01/01/2022 To 12/31/2022	Date/Time Pre 5/10/2023 11:0	
	Title	e XVIII	Hospi tal	PPS	
			rt Managed Care	Total	
		A 1.00	2.00	3.00	
COMPUTATION OF PROGRAM PATIENT LOAD		1			
26.00 Inpatient Days (see instructions) (Title XIX - see S-2 Part 3.02, column 2)	IX, line	12, 4	70 1, 011		26.00
27.00 Total Inpatient Days (see instructions)		28, 7	20 28, 720		27.00
28.00 Ratio of inpatient days to total inpatient days		0. 4341	92 0. 035202		28.00
29.00 Program direct GME amount		217, 2	73 17, 615	234, 888	29.00
29.01 Percent reduction for MA DGME			3.26		29.01
30.00 Reduction for direct GME payments for Medicare Advantage			574	574	30.00
31.00 Net Program direct GME amount				234, 314	31.00
				1.00	
DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITI	LE XVIII ONLY	(NURSING PR	DGRAM AND PARAMED		
EDUCATION COSTS)					
32.00 Renal dialysis direct medical education costs (from Wkst. B, and 94)				0	
33.00 Renal dialysis and home dialysis total charges (Wkst. C, Pt.			74 and 94)	0	
34.00 Ratio of direct medical education costs to total charges (li	ne 32 ÷ line	33)		0.00000	•
35.00 Medicare outpatient ESRD charges (see instructions)				0	
36.00 Medicare outpatient ESRD direct medical education costs (lin		35)		0	36.00
APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVII Part A Reasonable Cost	IONLY				
37.00 Reasonable cost (see instructions)				40, 492, 512	37.00
38.00 Organ acquisition and HSCT acquisition costs (see instruction	ns)			40, 472, 312	
39.00 Cost of physicians' services in a teaching hospital (see ins				0	
40.00 Primary payer payments (see instructions)	,			14, 199	
41.00 Total Part A reasonable cost (sum of lines 37 through 39 min	us line 40)			40, 478, 313	
Part B Reasonable Cost					
42.00 Reasonable cost (see instructions)				10, 941, 213	42.00
43.00 Primary payer payments (see instructions)				426	
14.00 Total Part B reasonable cost (line 42 minus line 43)				10, 940, 787	44.00
45.00 Total reasonable cost (sum of lines 41 and 44)				51, 419, 100	45.00
46.00 Ratio of Part A reasonable cost to total reasonable cost (li				0. 787223	
47.00 Ratio of Part B reasonable cost to total reasonable cost (li		45)		0. 212777	47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PA	ART B				
48.00 Total program GME payment (line 31)				234, 314	•
49.00 Part A Medicare GME payment (line 46 x 48) (title XVIII only				184, 457	
50.00 Part B Medicare GME payment (line 47 x 48) (title XVIII only	) (see instru	uctions)		49, 857	1 50 00

Health Fir	nancial Systems	FRANCI SCAN HEAL	TH- DYER	In Lie	u of Form CMS-2	552-10
OUTLIER RECONCILIATION AT TENTATIVE SETTLEMENT Provider CCN: 15-0090 Period: From 01/01/2022						
				To 12/31/2022	Date/Time Prep 5/10/2023 11:0	oared: 00 am
			Title XVIII		PPS	
					1.00	
ТО	BE COMPLETED BY CONTRACTOR					
1.00 Ope	erating outlier amount from Wkst. E, Pt. A,	line 2, or sum o	of 2.03 plus 2.04 (see i	nstructions)	0	1.00
2.00 Ca	pital outlier from Wkst. L, Pt. I, line 2				0	2.00
3.00 Ope	erating outlier reconciliation adjustment am	nount (see instru	uctions)		0	3.00
4.00 Ca	pital outlier reconciliation adjustment amou	int (see instruct	tions)		0	4.00
5.00 The	e rate used to calculate the time value of m	noney (see instru	uctions)		0.00	5.00
6.00 Tir	me value of money for operating expenses (se	e instructions)			0	6.00
	me value of money for capital related expens		ti ons)		0	7.00

	Financial Systems FRANCISCAN HE E SHEET (If you are nonproprietary and do not maintain we accounting reagands, complete the Constal Fund column	Provider C	CN: 15-0090	Period: From 01/01/2022	Worksheet G	
ind-ty nl y)	ype accounting records, complete the General Fund column			To 12/31/2022	Date/Time Pre 5/10/2023 11:	
		General Fund	Specific Purpose Fund	Endowment Fund		
	CURRENT ASSETS	1.00	2.00	3.00	4.00	
00	Cash on hand in banks	-24, 522, 358		0 0	0	1 1
00	Temporary investments	0		0 0	0	
00	Notes receivable	0		0 0	0	3
	Accounts receivable	98, 949, 500		0 0	0	
	Other receivable	0		0 0	0	
	Allowances for uncollectible notes and accounts receivable	-76, 418, 041		0 0	0	6
	Inventory Prepaid expenses	4, 532, 786		0 0	0	7   8
	Other current assets	4, 098, 805		0 0	0	9
	Due from other funds	0		0 0	0	10
00	Total current assets (sum of lines 1-10)	6, 640, 692		0 0	0	11
	FIXED ASSETS			-		
	Land	694, 364		0 0	0	
	Land improvements	10, 182, 390		0 0	0	
	Accumul ated depreciation Buildings	71, 826, 630		0 0	0	14
	Accumul ated depreciation	, i, 020, 030 N		0 0	0	16
	Leasehold improvements	178, 989		0 0	0	17
	Accumul ated depreciation	0		0 0	0	18
	Fixed equipment	177, 456, 706		0 0	0	19
	Accumulated depreciation	-170, 535, 809		0 0	0	20
	Automobiles and trucks	0		0 0	0	21
	Accumulated depreciation Major movable equipment	2, 347, 192		0 0	0	22
	Accumul ated depreciation	2, 347, 192		0 0	0	24
	Minor equipment depreciable	0		0 0	0	25
	Accumulated depreciation	0		0 0	0	26
. 00	HIT designated Assets	0		0 0	0	27
	Accumulated depreciation	0		0 0	0	28
	Minor equipment-nondepreciable	0		0 0	0	29
	Total fixed assets (sum of lines 12-29) OTHER ASSETS	92, 150, 462		0 0	0	30
	Investments	0		0 0	0	31
	Deposits on Leases	0		0 0	0	32
. 00	Due from owners/officers	0		0 0	0	33
	Other assets	-56, 733, 256		0 0	0	
	Total other assets (sum of lines 31-34)	-56, 733, 256		0 0	0	
	Total assets (sum of lines 11, 30, and 35)	42, 057, 898		0 0	0	36
	CURRENT LI ABI LI TI ES Accounts payabl e	7, 998, 364		0 0	0	37
	Salaries, wages, and fees payable	1, 770, 304		0 0	0	38
	Payroll taxes payable	4, 715, 618		0 0	0	
	Notes and loans payable (short term)	286, 085		0 0	0	40
	Deferred income	0		0 0	0	
	Accel erated payments	0		_	-	42
	Due to other funds	0		0 0	0	
	Other current liabilities Total current liabilities (sum of lines 37 thru 44)	2, 171, 442 15, 171, 509		0 0 0 0	0	
	LONG TERM LIABILITIES	10, 171, 509	I	<u> </u>	0	45
	Mortgage payable	0		0 0	0	46
	Notes payable	0		0 0	0	
	Unsecured Loans	0		0 0	0	
	Other long term liabilities	3, 396, 984		0 0	0	
	Total long term liabilities (sum of lines 46 thru 49)	3, 396, 984		0 0	0	
	Total liabilities (sum of lines 45 and 50) CAPITAL ACCOUNTS	18, 568, 493		0 0	0	51
	General fund balance	23, 489, 405				52
	Specific purpose fund	20, 407, 400		0		53
	Donor created - endowment fund balance - restricted			0		54
	Donor created - endowment fund balance - unrestricted			0		55
	Governing body created - endowment fund balance			0		56
	Plant fund balance - invested in plant				0	
. 00	Plant fund balance - reserve for plant improvement,				0	58
00	replacement, and expansion Total fund balances (sum of lines 52 thru 58)	22 400 405		0 0	0	6
	Total fund balances (sum of lines 52 thru 58) Total liabilities and fund balances (sum of lines 51 and	23, 489, 405 42, 057, 898		0 0	0	
		I +∠, ∪J/, 098		0 0	0	1 00

Health Financial Systems	FRANCI SCAN HE	ALTH- DYER			In Lie	u of Form CMS	-2552-10
STATEMENT OF CHANGES IN FUND BALANCES		Provider CC	CN: 15-0090		iod: m 01/01/2022 12/31/2022	Worksheet G- Date/Time Pr 5/10/2023 11	1 epared: :00 am
	General	Fund	Speci al	Purp	oose Fund	Endowment Fur	d
	1.00	2,00	3.00		4.00	5.00	
<pre>1.00 Fund balances at beginning of period 2.00 Net income (loss) (from Wkst. G-3, line 29) 3.00 Total (sum of line 1 and line 2) 4.00 ADDITIONS 5.00 6.00 7.00 8.00 9.00 10.00 Total additions (sum of line 4-9) 11.00 Subtotal (line 3 plus line 10) 12.00 ADJUSTMENT TO BALANCE 13.00 14.00 15.00 16.00 17.00 18.00 Total deductions (sum of lines 12-17) 19.00 Fund balance at end of period per balance</pre>	1.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2.00 49,378,664 -25,392,872 23,985,792 0 23,985,792 496,382 23,489,410			4.00 0 0 0 0 0 0		1.00           2.00           3.00           0           5.00           0           0           0           0           0           0           10.00           0           0           0           0           10.00           11.00           12.00           13.00           14.00           15.00           16.00           17.00           18.00           19.00
sheet (line 11 minus line 18)	Frankrument, Frank				0		19.00
	Endowment Fund	PI ant					
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) 3.00 Total (sum of line 1 and line 2) 4.00 ADDITIONS 5.00 6.00 7.00 8.00 9.00	0	0 0 0 0 0		0			2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
<ul> <li>10.00 Total additions (sum of line 4-9)</li> <li>11.00 Subtotal (line 3 plus line 10)</li> <li>12.00 ADJUSTMENT TO BALANCE</li> <li>13.00</li> <li>14.00</li> <li>15.00</li> <li>16.00</li> <li>17.00</li> <li>18.00 Total deductions (sum of lines 12-17)</li> <li>19.00 Fund balance at end of period per balance</li> </ul>	000000000000000000000000000000000000000	0 0 0 0 0 0		0 0 0 0			10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00

STATEM	Financial Systems FRANCISCAN HEA	LTH- DYER Provider CC	N. 15_0000	Dor	i od:	u of Form CMS- Worksheet G-2	
STATEN	LINI OF FATTENT REVENUES AND OFERATING EAFENSES		N. 13-0090		m 01/01/2022 12/31/2022	Parts I & II	epared:
	Cost Center Description		Inpati ent		Outpati ent	Total	
			1.00		2.00	3.00	
	PART I - PATIENT REVENUES						
	General Inpatient Routine Services						
1.00	Hospi tal		69, 636, 9	13		69, 636, 913	1.00
2.00	SUBPROVIDER - IPF						2.00
3.00	SUBPROVIDER - IRF			0		C	3.00
4.00	SUBPROVI DER			0		C	4.00
5.00	Swing bed - SNF			0		C	5.00
6.00	Swing bed - NF			0		C	6.00
7.00	SKILLED NURSING FACILITY						7.00
8.00	NURSING FACILITY						8.00
9.00	OTHER LONG TERM CARE						9.00
10.00	Total general inpatient care services (sum of lines 1-9)		69, 636, 9	13		69, 636, 913	10.00
	Intensive Care Type Inpatient Hospital Services						
11.00	INTENSIVE CARE UNIT		17, 203, 0			17, 203, 019	
12.00	CORONARY CARE UNIT			0		C	
13.00	BURN INTENSIVE CARE UNIT						13.00
14.00	SURGICAL INTENSIVE CARE UNIT						14.00
15.00	NEONATAL INTENSIVE CARE UNIT			0		C	
16.00	Total intensive care type inpatient hospital services (sum o	flines	17, 203, 0	19		17, 203, 019	16.00
	11-15)						
17.00	Total inpatient routine care services (sum of lines 10 and 1	6)	86, 839, 9			86, 839, 932	
18.00	Ancillary services		233, 225, 1		318, 262, 567	551, 487, 735	
19.00	Outpati ent services		26, 918, 9		44, 648, 999	71, 567, 925	
20.00	RURAL HEALTH CLINIC			0	0	0	
21.00	FEDERALLY QUALIFIED HEALTH CENTER			0	0	0	
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULANCE SERVICES						23.00
24.00							24.00
25.00	AMBULATORY SURGICAL CENTER (D. P. )						25.00
26.00 27.00	HOSPI CE OTHER		11, 249, 8	1 /	438, 797	11, 688, 611	26.00
27.00	Total patient revenues (sum of lines 17-27)(transfer column	2 to Wkct	358, 233, 8		438, 797 363, 350, 363		
26.00	G-3. Line 1)	S LU WKSL.	300, 233, 0	40	303, 300, 303	721, 364, 203	20.00
	PART II - OPERATING EXPENSES						
29.00	Operating expenses (per Wkst. A, column 3, line 200)				188, 799, 495		29.00
30.00	ADD			0	100, 11, 1, 1, 1, 0		30.00
31.00				0			31.00
32.00				0			32.00
33.00				0			33.00
34.00				0			34.00
35.00				0			35.00
36.00	Total additions (sum of lines 30-35)				о		36.00
37.00	DEDUCT			0	-		37.00
38.00				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)				0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line	42)(transfer			188, 799, 495		43.00
	to Wkst. G-3, line 4)			1			1

Heal th	Financial Systems	FRANCI SCAN HEAL	TH- DYER	In Lie	u of Form CMS-2	2552-10
STATE	IENT OF REVENUES AND EXPENSES		Provider CCN: 15-0090	Period: From 01/01/2022	Worksheet G-3	
				To 12/31/2022	Date/Time Pre	bared:
					5/10/2023 11:	
1 00					1.00	1.00
1.00	Total patient revenues (from Wkst. G-2, Part				721, 584, 203	1.00
2.00 3.00	Less contractual allowances and discounts on Net patient revenues (line 1 minus line 2)	patrents account	.5		548, 883, 042 172, 701, 161	2.00 3.00
3.00 4.00	Less total operating expenses (from Wkst. G-	2 Part II lino /	12)		188, 799, 495	
4.00 5.00	Net income from service to patients (line 3		(5)		-16, 098, 334	
5.00	OTHER I NCOME				-10, 070, 334	5.00
6.00	Contributions, donations, bequests, etc				147, 883	6.00
7.00	Income from investments				0	7.00
8.00	Revenues from telephone and other miscellane	ous communication	servi ces		0	8.00
9.00	Revenue from television and radio service				0	9.00
10.00	Purchase di scounts				0	10.00
11.00	Rebates and refunds of expenses				873, 862	11.00
12.00	Parking lot receipts				0	12.00
13.00	· · · · · · · · · · · · · · · · · · ·				0	13.00
14.00		sts			0	14.00
	Revenue from rental of living quarters				0	15.00
16.00			nan patients		0	16.00
17.00					0	17.00
18.00					7	18.00
	Tuition (fees, sale of textbooks, uniforms,	,			0	19.00
20.00		nd canteen			0	20.00
21.00	5				19, 365	
22.00					1, 061, 351	
23.00 24.00					044 252	23.00
24.00 24.50					946, 252 0	24.00 24.50
	Total other income (sum of lines 6-24)				3, 048, 720	
	Total (line 5 plus line 25)				-13, 049, 614	
	OTHER EXPENSE				12, 343, 258	
	Total other expenses (sum of line 27 and sub	scripts)			12, 343, 258	
	Net income (or loss) for the period (line 26				-25, 392, 872	
				I		

	Financial         Systems         FRANCISCAN           ATION OF         CAPITAL         PAYMENT         FRANCISCAN	HEALTH- DYER Provider CCN: 15-0090	Peri od:	u of Form CMS-2 Worksheet L		
			From 01/01/2022 To 12/31/2022			
		Title XVIII	Hospi tal	5/10/2023 11: PPS	00 a	
			illoopi tui	110		
				1.00		
	PART I - FULLY PROSPECTIVE METHOD					
	CAPITAL FEDERAL AMOUNT					
00	Capital DRG other than outlier			1, 452, 802	1.	
D1	Model 4 BPCI Capital DRG other than outlier					
00						
D1	Model 4 BPCI Capital DRG outlier payments			0 68.25		
00	Total inpatient days divided by number of days in the cost reporting period (see instructions)					
00	Number of interns & residents (see instructions)				4.	
00	Indirect medical education percentage (see instructions) Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and				5	
00	1.01)(see instructions)			31, 235		
00	Percentage of SSI recipient patient days to Medicare Part 30) (see instructions)		, part A line	0.00		
00	Percentage of Medicaid patient days to total days (see in	structions)		0.00		
00	Sum of lines 7 and 8					
00	Allowable disproportionate share percentage (see instruct	i ons)		0.00		
. 00	Disproportionate share adjustment (see instructions)			0		
00	Total prospective capital payments (see instructions)			1, 505, 234	12	
				1.00		
	PART II - PAYMENT UNDER REASONABLE COST					
00	Program inpatient routine capital cost (see instructions)			0	1	
00	Program inpatient ancillary capital cost (see instruction	s)		0	2	
00	Total inpatient program capital cost (line 1 plus line 2)			0	3	
00	Capital cost payment factor (see instructions)			0	4	
00	Total inpatient program capital cost (line 3 x line 4)			0	5	
				1.00		
	PART III - COMPUTATION OF EXCEPTION PAYMENTS					
00	Program inpatient capital costs (see instructions)			0		
00	Program inpatient capital costs for extraordinary circums			0		
00	Net program inpatient capital costs (line 1 minus line 2)			0	-	
00	Applicable exception percentage (see instructions)			0.00		
00	Capital cost for comparison to payments (line 3 x line 4)			0		
	Percentage adjustment for extraordinary circumstances (se			0.00		
	Adjustment to capital minimum payment level for extraordi	nary circumstances (line 2 x	line 6)	0		
00				0	-	
00 00	Capital minimum payment level (line 5 plus line 7)				9	
00 00 00	Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as a			0		
00 00 00 00	Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as a Current year comparison of capital minimum payment level	to capital payments (line 8	,	0	10	
00 00 00 00 00	Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as a Current year comparison of capital minimum payment level Carryover of accumulated capital minimum payment level ov Worksheet L, Part III, line 14)	to capital payments (line 8 er capital payment (from pri	or year	0	10 11	
00 00 00 . 00 . 00 . 00	Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as a Current year comparison of capital minimum payment level Carryover of accumulated capital minimum payment level ov Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capita	to capital payments (line 8 er capital payment (from pri l payments (line 10 plus lin	or year e 11)	000000000000000000000000000000000000000	10 11 12	
00 00 00 . 00 . 00 . 00 . 00	Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as a Current year comparison of capital minimum payment level Carryover of accumulated capital minimum payment level ov Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capita Current year exception payment (if line 12 is positive, e	to capital payments (line 8 er capital payment (from pri I payments (line 10 plus lin nter the amount on this line	or year e 11) )	0 0 0 0	10 11 12 13	
00 00 00 . 00 . 00 . 00 . 00	Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as a Current year comparison of capital minimum payment level Carryover of accumulated capital minimum payment level ov Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capita Current year exception payment (if line 12 is positive, e Carryover of accumulated capital minimum payment level ov	to capital payments (line 8 er capital payment (from pri I payments (line 10 plus lin nter the amount on this line	or year e 11) )	000000000000000000000000000000000000000	10 11 12 13	
00 00 00 . 00 . 00 . 00 . 00 . 00	Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as a Current year comparison of capital minimum payment level Carryover of accumulated capital minimum payment level ov Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capita Current year exception payment (if line 12 is positive, e Carryover of accumulated capital minimum payment level ov (if line 12 is negative, enter the amount on this line)	to capital payments (line 8 er capital payment (from pri l payments (line 10 plus lin nter the amount on this line er capital payment for the f	or year e 11) )	0 0 0 0	10 11 12 13 14	
00 00 00 00 . 00 . 00 . 00 . 00 . 00	Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as a Current year comparison of capital minimum payment level Carryover of accumulated capital minimum payment level ov Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capita Current year exception payment (if line 12 is positive, e Carryover of accumulated capital minimum payment level ov	to capital payments (line 8 er capital payment (from pri l payments (line 10 plus lin nter the amount on this line er capital payment for the f instructions)	or year e 11) )	0 0 0 0	10 11 12 13 14 15	