This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 09-30-2025 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 15-0015 Worksheet S Peri od: From 01/01/2022 Parts I-III AND SETTLEMENT SUMMARY 12/31/2022 Date/Time Prepared: 4/13/2023 4: 18 pm PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 4/13/2023 4:18 pm] Manually prepared cost report use only Ilf this is an amended report enter the number of times the provider resubmitted this cost report [Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no. [1] Cost Report Status
[1] As Submitted
[2] Settled without Audit
[3] Settled with Audit
[4] Date Received:
[5] To. NPR Date:
[6] 10. NPR Date:
[7] 11. Contractor's Vendor Code:
[7] 12. [8] Initial Report for this Provider CCN
[9] [8] Final Report for this Provider CCN
[10] NPR Date:
[11] 12. NPR Date:
[12] 13. NPR Date:
[13] 14. NPR Date:
[14] 15. NPR Date:
[15] 15. NPR Date:
[16] 16. NPR Date:
[17] 17. NPR Date:
[18] 17. NPR Date:
[18] 18. NPR Date:
[18] 18. NPR Date:
[18] 19. NPR Contractor use only

number of times reopened = 0-9.

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

(3) Settled with Audit

(4) Reopened (5) Amended

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by FRANCISCAN HEALTH MICHIGAN CITY (15-0015) for the cost reporting period beginning 01/01/2022 and ending 12/31/2022 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

			Title	XVIII			
		Title V	Part A	Part B	HIT	Title XIX	
		1.00	2. 00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPI TAL	0	605, 750	-141, 937	0	0	1. 00
2.00	SUBPROVI DER - I PF	0	180	0		0	2. 00
3.00	SUBPROVI DER - I RF	0	0	0		0	3. 00
5.00	SWING BED - SNF	0	0	0		0	5. 00
6.00	SWING BED - NF	0				0	6. 00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7. 00
8.00	NURSING FACILITY	0				0	8. 00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9. 00
10.00	RURAL HEALTH CLINIC I	0		0		0	10. 00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11. 00
12.00	CMHC I	0		0		0	12. 00
200.00	TOTAL	0	605, 930	-141, 937	0	0	200. 00
The ab	ove amounts represent "due to" or "due from"	the applicable	program for th	e element of t	he above comple	ex indicated.	

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 674 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents , please contact 1-800-MEDICARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0015 Peri od: Worksheet S-2 From 01/01/2022 Part I Date/Time Prepared: 12/31/2022 4/13/2023 4:18 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 3500 FRANCISCAN WAY 1.00 PO Box: 1.00 State: IN 2.00 City: MICHIGAN CITY Zi p Code: 46360 County 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, 0, or N) Number Number Certi fi ed Type XVIII XIX 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 Hospi tal FRANCISCAN HEALTH 150015 33140 07/01/1966 Ν Р 0 3.00 1 MICHIGAN CITY Р 0 4.00 Subprovider - IPF FRANCISCAN HEALTH 15S015 33140 4 01/01/1998 N 4 00 MICHIGAN CITY 5.00 Subprovider - IRF 5.00 6.00 Subprovider - (Other) 6.00 Swi ng Beds - SNF Swi ng Beds - NF 7 00 7.00 8.00 8.00 9.00 Hospital -Based SNF 9.00 Hospi tal -Based NF 10.00 10.00 Hospi tal -Based OLTC 11.00 11.00 12.00 Hospi tal -Based HHA 12.00 Separately Certified ASC 13.00 13.00 14.00 Hospi tal -Based Hospi ce 14 00 15.00 Hospital-Based Health Clinic - RHC 15.00 16.00 Hospital-Based Health Clinic - FQHC 16.00 17.00 Hospital -Based (CMHC) I 17.00 17. 10 Hospital - Based (CORF) I 17.10 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From To: 1.00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2022 12/31/2022 20.00 21.00 Type of Control (see instructions) 21.00 1 1.00 2.00 3.00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for Υ N 22.00 disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim UCPs, including supplemental UCPs, for Υ 22.01 this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Is this a newly merged hospital that requires a final UCP to be 22.02 Ν 22.02 determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to Ν Ν Ν 22.03 rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 22.04 Did this hospital receive a geographic reclassification from urban to 22.04 rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for ves or "N" for no. 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 3 Ν 23 00 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.

10. 00	To this hospital subject to the line program reduction adjustment. Enter				10.00
	"N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for				
	no in column 2, for discharges on or after October 1. (see instructions)				
		V	XVIII	XIX	
		1.00	2. 00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance	N	N	N	45.00
	with 42 CFR Section §412.320? (see instructions)				
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances	N	N	N	46.00
	pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through				
	Pt. III.				
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals	•	•		1
56.00	Is this a hospital involved in training residents in approved GME programs? For cost reporting	N			56.00
	periods beginning prior to December 27, 2020, enter "Y" for yes or "N" for no in column 1. For				
	cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2), see				
	the instructions. For column 2, if the response to column 1 is "Y", or if this hospital was				
	involved in training residents in approved GME programs in the prior year or penultimate year,				
	and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter				
	"Y" for yes; otherwise, enter "N" for no in column 2.				
57.00	For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, is yes,				57.00
	is this the first cost reporting period during which residents in approved GME programs trained				
	at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", did				
	residents start training in the first month of this cost reporting period? Enter "Y" for yes or				
	"N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N",				
	complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting periods				
	beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of				
	which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y"				
	for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4.				
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as	N			58.00
	defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.				

	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.						
	, and the same of						
					1.00		
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00	Enter the number of FTE residents that your hospital	od for which	0. 00	62.00			
	your hospital received HRSA PCRE funding (see instruc	ctions)					
62. 01	Enter the number of FTE residents that rotated from a	a Teaching Health Cent	er (THC) into	your hospital	0.00	62. 01	
	during in this cost reporting period of HRSA THC prog	gram. (see instruction	s)				
	Teaching Hospitals that Claim Residents in Nonprovider Settings						
63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter N						63.00	
	"Y" for yes or "N" for no in column 1. If yes, comple	ete lines 64 through 6	7. (see instru	ctions)			

0.00

0.00 61.20

61.20 Of the FTEs in line 61.05, specify each expanded

program specialty, if any, and the number of FTE

Heal th	n Financial Systems	FRANCI SCAN	J HEALTH M	ICHIGAN CITY	,	In Lie	eu of Form CMS-2	2552-10
	TAL AND HOSPITAL HEALTH CARE COMP			Provi der Co	CN: 15-0015	Period: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part I	pared:
					Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospi tal	Ratio (col. 1/ (col. 1 + col. 2))	
	Section 5504 of the ACA Base Yea	ar FTE Residents in N	onprovi der	Settings	1.00 This base yea	2.00 r is your cost	3.00 reporting	
64. 00	period that begins on or after a Enter in column 1, if line 63 is in the base year period, the num resident FTEs attributable to ra settings. Enter in column 2 the resident FTEs that trained in yo	July 1, 2009 and before yes, or your faciliant of unweighted now that ions occurring in the number of unweighted our hospital. Enter in	re June 30 ty trained n-primary all nonpr d non-prim n column 3	o, 2010. I residents care covider hary care the ratio	0.0			64.00
	of (column 1 divided by (column	Program Name		ons) am Code	Unwei ghted	Unwei ghted	Ratio (col. 3/	,
					FTEs Nonprovi der Si te	FTEs in Hospital	(col. 3 + col. 4))	
45.00		1. 00	2	2. 00	3. 00	4.00	5.00	(5.00
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)				O. (Unweighted	0.000000	
					FTEs Nonprovi der Si te	FTEs in	(col. 1 + col. 2))	
					1. 00	2.00	3.00	
	Section 5504 of the ACA Current beginning on or after July 1, 20		n Nonprovi	der Setting	sEffective	for cost report	ing periods	
66. 00	Enter in column 1 the number of FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 +	occurring in all nonpount unweighted non-priman al. Enter in column (rovider se ry care re 3 the rati	ettings. esident o of	0. (0. 00	0. 000000	66. 00
		Program Name		ram Code	Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
67 00	Enter in column 1, the program	1. 00	2	2. 00	3. 00	4.00	5. 00 0. 000000	67.00
	name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)							

IOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN	: 15-0015	Period: From 01/01/ To 12/31/		Workshee Part I Date/Tir 4/13/202	me Prei	pared:
						1.0	0	
	Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 F	FR 49065-490	72 (August 1	0, 2022)		1.0	0	
8. 00	For a cost reporting period beginning prior to October 1, 2022, MAC to apply the new DGME formula in accordance with the FY 202 (August 10, 2022)?					N		68. 00
					1. 00	2.00	3. 00	
70 00	Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or do	nes it contai	n an IPF su	hnrovi der?	Υ			70. O
	Enter "Y" for yes or "N" for no. If line 70 is yes: Column 1: Did the facility have an approved recent cost report filed on or before November 15, 2004? Enter	GME teaching	program in	the most	N N	N	0	71.0
	42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility trair program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter Column 3: If column 2 is Y, indicate which program year began c(see instructions)	n residents i "Y" for yes	n a new tea or "N" for	chi ng no.				
5. 00	Inpatient Rehabilitation Facility PPS Is this facility an Inpatient Rehabilitation Facility (IRF), or subprovider? Enter "Y" for yes and "N" for no.	does it cor	itain an IRF		N			75. 0
6. 00	If line 75 is yes: Column 1: Did the facility have an approved				N	N	0	76. 0
	recent cost reporting period ending on or before November 15, 2 no. Column 2: Did this facility train residents in a new teachi CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Co indicate which program year began during this cost reporting pe	ng program i olumn 3: If o	n accordanc	e with 42 Y,				
	,			/		1.0	0	
	Long Term Care Hospital PPS					1. 0	U	
0. 00 1. 00	Is this a long term care hospital (LTCH)? Enter "Y" for yes ar Is this a LTCH co-located within another hospital for part or a "Y" for yes and "N" for no. TEFRA Providers			g period? E	nter	N N		80. 0 81. 0
	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TE Did this facility establish a new Other subprovider (excluded u				no.	N		85. C
7. 00	§413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. Is this hospital an extended neoplastic disease care hospital c 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	classified ur	nder section			N		87. C
				Approved Permand Adjustm (Y/N)	ent ent	Number Appro Permar Adjustm	ved nent ments	
8. 00	Column 1: Is this hospital approved for a permanent adjustment amount per discharge? Enter "Y" for yes or "N" for no. If yes, 89. (see instructions)			1.00 e		2. 0		88. 0
	Column 2: Enter the number of approved permanent adjustments.		Wkst. A Lin	e Effective	Date	Appro	ved	
			No.			Permar Adjusti Amount Discha	ment ment Per	
0.00	Column 1. If line 90, column 1 to V and the West-back A L'	numban	1. 00	2.00		3. 0		89. (
9.00	Column 1: If line 88, column 1 is Y, enter the Worksheet A line on which the per discharge permanent adjustment approval was be Column 2: Enter the effective date (i.e., the cost reporting pebeginning date) for the permanent adjustment to the TEFRA targe per discharge.	eri od	0. (00			U	89. (
	Column 3: Enter the amount of the approved permanent adjustment TEFRA target amount per discharge.	to the						
				V 1. 00		XI X		
2.00	Title V and XIX Services	20md 05=2. F. 1	on "V" E-					00.0
	Does this facility have title V and/or XIX inpatient hospital s yes or "N" for no in the applicable column. Is this hospital reimbursed for title V and/or XIX through the			N N		Y Y		90. (
	full or in part? Enter "Y" for yes or "N" for no in the applica Are title XIX NF patients occupying title XVIII SNF beds (dual	able column.		14		N		92. (
	instructions) Enter "Y" for yes or "N" for no in the applicable Does this facility operate an ICF/IID facility for purposes of	e column.		N		N		93. 0
4. 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	d "N" for no	in the	N		N		94. 0
	applicable column. If line 94 is "Y", enter the reduction percentage in the applic Does title V or XIX reduce operating cost? Enter "Y" for yes or			0. 00 N		0. 0 N	0	95. C
0. 00	applicable column.							

	FILIYSI Cal	Occupational	Speech	Respiratory	
	1.00	2.00	3.00	4.00	
09.00 f this hospital qualifies as a CAH or a cost provider, are					109.00
therapy services provided by outside supplier? Enter "Y"					107.0
for yes or "N" for no for each therapy.					
					_
				1.00	
10.00 Did this hospital participate in the Rural Community Hospit				N	110. 0
Demonstration) for the current cost reporting period? Enter					
complete Worksheet E, Part A, lines 200 through 218, and Wo	rksheet E-2, li	ines 200 throug	ıh 215, as		
applicable.	•	•	,		
Jack Communication (Communication Communication Communicat					
			1. 00	2.00	
111.00 f this facility qualifies as a CAH, did it participate in	the Frontier C	ommuni tv	1. 00 N	2.00	111.00
			IN IN		1111.00
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	rticipating in	column 2.			
Enter all that apply: "A" for Ambulance services; "B" for a	dditional beds	; and/or "C"			
for tele-health services.					
		1. 00	2. 00	3.00	
112.00Did this hospital participate in the Pennsylvania Rural Hea	Lth Model	N			112.00
(PARHM) demonstration for any portion of the current cost r		''			1112.00
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	ased				
participation in the demonstration, if applicable.					
113.00Did this hospital participate in the Community Health Acces	s and Rural				113.00
Transformation (CHART) model for any portion of the current	cost				
reporting period? Enter "Y" for yes or "N" for no.					
Miscellaneous Cost Reporting Information		1			
115.00 s this an all-inclusive rate provider? Enter "Y" for yes o	r "N" for no	T N			0115.00
in column 1. If column 1 is yes, enter the method used (A,		I IN			0113.00
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	rs) based on				
the definition in CMS Pub.15-1, chapter 22, §2208.1.					
116.00 Is this facility classified as a referral center? Enter "Y"	for yes or	Υ			116. 00
"N" for no.	,				
117.00 s this facility legally-required to carry malpractice insu	rance? Enter	Y			117. 00
"Y" for yes or "N" for no.	rance. Enter	'			117.00
118.00 s the malpractice insurance a claims-made or occurrence po	Liova Enton 1	2			118. 00
		2			118.00
if the policy is claim-made. Enter 2 if the policy is occur	rence.				-
CRI F32 - 18. 1. 175. 5					

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider Co		Period: From 01/01/2022 To 12/31/2022		Prepared
		Premi ums	Losses	Insurance	
		1. 00	2.00	3.00	
18.01 List amounts of malpractice premiums and paid losses:		1, 161, 5	18 197, 70)1	0 118. 0
			1. 00	2.00	$\overline{}$
18.02 Are malpractice premiums and paid losses reported in a cost of Administrative and General? If yes, submit supporting scheduland amounts contained therein. 19.00 DO NOT USE THIS LINE			N		118. (
20.00 s this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualified Harmless provision in ACA §3121 and applicable amendments. Enter in column 2, "Y" for yes or "N" for no.	column 1, "Y alifies for t	" for yes or he Outpatient		N	120. (
21.00 Did this facility incur and report costs for high cost impla	ntable device	s charged to	Y		121. (
patients? Enter "Y" for yes or "N" for no. 22.00 Does the cost report contain healthcare related taxes as defi Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included.					122. (
the worksheet Aline number where these taxes are included. 23.00 Did the facility and/or its subproviders (if applicable) pure services, e.g., legal, accounting, tax preparation, bookkeep management/consulting services, from an unrelated organization for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., professional services expenses, for services purchased from a located in a CBSA outside of the main hospital CBSA? In column "N" for no.	ing, payroll, on? In column greater than unrelated org	and/or 1, enter "Y" 50% of total ani zati ons			123.
Certified Transplant Center Information 25.00 Does this facility operate a Medicare-certified transplant of	ontor? Entor	"V" for yes	N		125.
and "N" for no. If yes, enter certification date(s) (mm/dd/y	yyy) below.	,			
26.00 f this is a Medicare-certified kidney transplant program, en in column 1 and termination date, if applicable, in column 2.		ification dat	e		126.
27.00 If this is a Medicare-certified heart transplant program, en in column 1 and termination date, if applicable, in column 2.	ter the certi	fication date	•		127.
28.00 If this is a Medicare-certified liver transplant program, en	ter the certi	fication date	•		128.
in column 1 and termination date, if applicable, in column 2. 29.00 If this is a Medicare-certified lung transplant program, ento		ication date			129.
in column 1 and termination date, if applicable, in column 2.80.00 If this is a Medicare-certified pancreas transplant program,		rtification			130.
date in column 1 and termination date, if applicable, in colu	umn 2.				
11.00 If this is a Medicare-certified intestinal transplant prograi date in column 1 and termination date, if applicable, in column		certi fi cati on	1		131.
22.00 If this is a Medicare-certified islet transplant program, en	ter the certi	fication date	•		132.
in column 1 and termination date, if applicable, in column 2.33.00 Removed and reserved 44.00 f this is a hospital-based organ procurement organization (OPO), enter t	he OPO number			133. 134.
in column 1 and termination date, if applicable, in column 2. All Providers					
0.00 Are there any related organization or home office costs as done chapter 10? Enter "Y" for yes or "N" for no in column 1. If yer are claimed, enter in column 2 the home office chain number.	yes, and home	office costs	Y	15H014	140.
1.00 2.00 If this facility is part of a chain organization, enter on I home office and enter the home office contractor name and co	ines 141 thro ntractor numb	er.			
1.00 Name: FRANCISCAN ALLIANCE Contractor's Name: WPS 2.00 Street: 1515 DRAGOON TRAIL PO Box:	i	Contract	or's Number: 800)1	141. 142.
3. 00 Ci ty: MI SHAWAKA State: IN		Zi p Code	: 465	546	143.
				1.00	
4.00 Are provider based physicians' costs included in Worksheet A	?			Υ Υ	144.
			1. 00	2.00	
5.00 f costs for renal services are claimed on Wkst. A, line 74, inpatient services only? Enter "Y" for yes or "N" for no in on, does the dialysis facility include Medicare utilization	column 1. If	column 1 is	1. 00	2.00	145.
period? Enter "Y" for yes or "N" for no in column 2. 6.00 Has the cost allocation methodology changed from the previous Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 1			N		146.

Health Financial Systems	FRANCISCAN HEALTH	MICHIGAN CITY		In Lie	eu of Form CMS	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	Provi der CC	Provider CCN: 15-0015 Per Fi		Worksheet S- Part I Date/Time Pr 4/13/2023 4:	epared:
					1.00	
147.00 Was there a change in the statisti 148.00 Was there a change in the order of					N N	147. 00 148. 00
149.00 Was there a change to the simplifi	ed cost finding method? Er				N	149. 00
		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
Does this facility contain a provi or charges? Enter "Y" for yes or		ent for Part A	and Part B	. (See 42 CFR §41	3. 13)	455.00
155. 00 Hospi tal		N	N N	N	N	155. 00
156. 00 Subprovi der – TPF 157. 00 Subprovi der – TRF		N N	N N	N N	N N	156. 00 157. 00
158. 00 SUBPROVI DER		IN	I IN	IN IN	IN IN	158. 00
159. 00 SNF		N	N	N	N	159. 00
160.00 HOME HEALTH AGENCY		N	N N	N N	N	160.00
161. 00 CMHC			l N	l N	N N	161. 00
161. 10 CORF			N	N	N	161. 10
	<u></u>					
Multicampus					1.00	
165.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	N	165. 00				
Effect 1 for yes of 14 for no.	Name	County	State 2	Zip Code CBSA	FTE/Campus	
	0	1. 00	2.00	3.00 4.00	5.00	
166.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)					0. 0	00 166. 00
					1.00	
Health Information Technology (HI	I) incentive in the America	an Pecovery and	d Dainvastm	ant Act	1.00	
167.00 Is this provider a meaningful user	under §1886(n)? Enter "Y	(" for yes or "	N" for no.		Y	167. 00
168.00 If this provider is a CAH (line 10 reasonable cost incurred for the H	HT assets (see instruction	ns)				168. 00
168.01 If this provider is a CAH and is r						168. 01
exception under §413.70(a)(6)(ii)' 169.00 If this provider is a meaningful u	user (line 167 is "Y") and				9. 9	99169.00
transition factor. (see instruction	ons)			Begi nni ng	Endi ng	
				1.00	2. 00	
170.00 Enter in columns 1 and 2 the EHR beginning period respectively (mm/dd/yyyy)	peginning date and ending o	date for the re	eporti ng			170. 00
				1.00	2.00	
171.00 If line 167 is "Y", does this proving section 1876 Medicare cost plans in "Y" for yes and "N" for no in column 1876 Medicare days in column 2.	reported on Wkst. S-3, Pt. umn 1. If column 1 is yes,	I, line 2, col	. 6? Enter	N on		0171.00

Heal th	Financial Systems FRANCISCAN HEALTI	H MICHIGAN CIT	Y	In Lie	eu of Form CMS-	2552-10
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CN: 15-0015 P	eriod: rom 01/01/2022	Worksheet S-2	
				o 12/31/2022		
		· · ·		Y/N	Date	
	PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSE	MENT QUESTIONN	IAI RE	1. 00	2. 00	
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	lfor all NO re	esponses. Enter	all dates in	the	
	Provider Organization and Operation					
1. 00	Has the provider changed ownership immediately prior to the reporting period? If yes, enter the date of the change in a			N		1.00
	proporting period. It yes, enter the date of the endinge in e	501 diii1 2. (500	Y/N	Date	V/I	
2. 00	Has the provider terminated participation in the Medicare F	Program? If	1. 00 N	2. 00	3. 00	2.00
	yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.	nn 3, "V" for				
3.00	1.00 Is the provider involved in business transactions, including management contracts, with individuals or entitles (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)					3.00
			Y/N	Туре	Date	
	Financial Data and Reports		1.00	2. 00	3. 00	
4. 00	Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" for "R" for Reviewed. Submit complete copy or enter date avacolumn 3. (see instructions) If no, see instructions.	for Compiled,	Y	А		4. 00
5.00	Are the cost report total expenses and total revenues differenthose on the filed financial statements? If yes, submit reconstructions are the cost report total expenses and total revenues differenthing to the cost report total expenses and total revenues differenthing to the cost report total expenses and total revenues differenthing total revenues differenthing to the cost report total expenses and total revenues differenthing total revenues differenthing to the cost report total expenses and total revenues differenthing differenthing total revenues differenthing differenthing differenthing differenthing differenthing differenthing differenthing		N			5. 00
	Those on the fired financial statements: If yes, submit rec	concriration.		Y/N	Legal Oper.	
	Approved Educational Activities			1. 00	2. 00	
6. 00	Column 1: Are costs claimed for a nursing program? Column the legal operator of the program?	2: If yes, is	s the provider	N		6. 00
7. 00 8. 00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing programs and/or allied health programs approve		wed during the	N N		7. 00 8. 00
9. 00	cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved		cal education	N		9. 00
10. 00	program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated of		the current	N		10. 00
11. 00	cost reporting period? If yes, see instructions. 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		11. 00
					Y/N 1. 00	
	Bad Debts				1.00	
12. 00 13. 00	, ,			t reporting	Y N	12. 00 13. 00
14. 00	period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or coinsura	ance amounts wa	aived? If ves.	see	N N	14. 00
	instructions.					
15. 00	Bed Complement Did total beds available change from the prior cost reporti	ng period? If	yes, see instr	uctions.	Y	15. 00
		Par	rt A	Par	t B	
		1. 00	2. 00	Y/N 3. 00	Date 4.00	
16. 00	PS&R Data	Y	02/20/2022	Υ	02/20/2022	14 00
16. 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)	r	02/20/2023	ľ	02/20/2023	16. 00
17. 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)	N	02/20/2023	N	02/20/2023	17. 00
18. 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	N		N		18. 00
19. 00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19. 00

### AND HOSPITAL HRAITH CARE RIMMURSEMENT OURSTIONNAIRE Provider COX: 15-0015 Perform From 01/01/2002 Report John From 01/01/2002 Report John From 01/01/2003 Report John From	Heal th	Financial Systems FRANCISCAN HEALTH	H MICHIGAN CIT	Y	In Lie	u of Form CMS-:	2552-10
1.00 1.00 3.00 1.00 3.00 1.00 3.00 1.00 3.00 1.00 3.00 1.00			Provi der C	CN: 15-0015	Peri od: From 01/01/2022	Worksheet S-2 Part II Date/Time Pre	pared:
Page							
Report data for Other? Describe the other adjustments:	20.00	L6 Line 1/ on 17 in one many adjustments and to DC0D		0			20.00
21.00 Was the cost report prepared only using the provider's N 2.00 3.00 4.00 1 21.00 Was the cost report prepared only using the provider's N 2.00 N 2.00 4.00 2.00 COMPLETED BY COST BETIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)	20.00				IN IN	N	20.00
21.00 Was the cost report prepared only using the provider's N N 21.00 records? If yes, see instructions. COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS) 1.00		nobolit data for other. Describe the other day astments.	Y/N	Date	Y/N	Date	
records? If yes, see instructions. COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS) 22.00 Have assets been relifed for Medicare purposes? If yes, see instructions 1.00				2.00	3. 00	4. 00	
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copy.	26. 00		e cost reporti	ng period? I	f yes, see	N	26. 00
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29.00 bid the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions and an account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions. 30.00 Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see N 30.00 instructions. 31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see N 31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see N 31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see N 31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see N 31.00 Has debt been requirements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions. 32.00 Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions. 33.00 If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions. 34.00 Were services furnished at the provider facility under an arrangement with provider-based physicians? Y 34.00 If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians? Y 34.00 If line 36 is yes, has a home office cost statement been prepared by the home office? Y 37.00 If line 36 is yes, was the fiscal year end of the home office? Y 37.00 If line 36 is yes, was the fiscal year end of the home office. 34.00 If line 36 is yes, did the provider render services to other chain components? If yes, N 39.00 If line 36 is yes, did the provider render services to other chain components? If yes, N 39.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 Instruction	28. 00	Were new Loans, mortgage agreements or Letters of credit en	reporti ng	N	28. 00		
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Home Office Costs 36. 00 Were home office costs claimed on the cost report? 37. 00 If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions. 38. 00 If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office. 39. 00 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions. 40. 00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40. 00 instructions. 41. 00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. 42. 00 Enter the employer/company name of the cost report preparer. 43. 00 Enter the telephone number and email address of the cost 219-407-6568 HONG. YANG@FRANCISCANALLIANCE 43. 00							
36.00 37.00 Were home office costs claimed on the cost report? 37.00 If line 36 is yes, has a home office cost statement been prepared by the home office? 37.00 If line 36 is yes, has a home office cost statement been prepared by the home office? 38.00 If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office. 39.00 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions. 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 1.00 2.00 41.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. 42.00 Enter the employer/company name of the cost report preparer. 43.00 Enter the telephone number and email address of the cost 219-407-6568 HONG. YANG@FRANCISCANALLIANCE 43.00		Homo Offico Costs			1.00	2. 00	
37.00 If line 36 is yes, has a home office cost statement been prepared by the home office? 37.00 If yes, see instructions. 38.00 If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office. 39.00 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions. 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. Enter the employer/company name of the cost report FRANCISCAN ALLIANCE HONG. YANG@FRANCISCANALLIANCE 43.00 Enter the telephone number and email address of the cost 219-407-6568 HONG. YANG@FRANCISCANALLIANCE 43.00	36 00				Y		36.00
If yes, see instructions. If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office. 39.00 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions. 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 If line 36 is yes, did the provider render services to the home office? N 40.00 If line 36 is yes, did the provider render services to other chain components? If yes, N 39.00 If line 36 is yes, did the provider render services to other chain components? If yes, N 40.00 If line 36 is yes, did the provider render services to other chain components? If yes, N 40.00 If line 36 is yes, did the provider render services to other chain components? If yes, N 40.00 If line 36 is yes, did the provider render services to other chain components? If yes, N 40.00 If line 36 is yes, did the provider render services to other chain components? If yes, N 40.00 If line 36 is yes, did the provider render services to other chain components? If yes, N 40.00 If line 36 is yes, did the provider render services to other chain components? If yes, N 40.00 If line 36 is yes, did the provider render services to other chain components? If yes, N 40.00 If line 36 is yes, did the provider render services to other chain components? If yes, N 40.00 If line 36 is yes, did the provider render services to other chain components? If yes, N 40.00 If line 36 is yes, did the provid			epared by the	home office?			37. 00
the provider? If yes, enter in column 2 the fiscal year end of the home office. 39.00 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions. 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 Instructions. 1.00 2.00 Cost Report Preparer Contact Information 41.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. 42.00 Enter the employer/company name of the cost report preparer. 43.00 Enter the telephone number and email address of the cost 219-407-6568 HONG. YANG@FRANCISCANALLIANCE 43.00		If yes, see instructions.					
see instructions. 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 1.00 2.00 Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. 42.00 Enter the employer/company name of the cost report preparer. 43.00 Enter the telephone number and email address of the cost 219-407-6568 HONG. YANG@FRANCISCANALLIANCE 43.00		the provider? If yes, enter in column 2 the fiscal year end	of the home o	offi ce.			39. 00
Instructions. Cost Report Preparer Contact Information Enter the first name, I ast name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. 42.00 Enter the employer/company name of the cost report FRANCI SCAN ALLI ANCE FRANCI SCAN ALLI ANCE 43.00 Enter the telephone number and email address of the cost 219-407-6568 HONG. YANG@FRANCI SCANALLI ANCE 43.00		see instructions.	·	,			
Cost Report Preparer Contact Information 41.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. 42.00 Enter the employer/company name of the cost report preparer. 43.00 Enter the telephone number and email address of the cost 219-407-6568 HONG YANG YANG FRANCISCANALLIANCE 43.00			2				1 30
41.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. 42.00 Enter the employer/company name of the cost report preparer. 43.00 Enter the telephone number and email address of the cost 219-407-6568 HONG YANG YANG 41.00 42.00 42.00			1.	00	2.	00	
held by the cost report preparer in columns 1, 2, and 3, respectively. 42.00 Enter the employer/company name of the cost report preparer. 43.00 Enter the telephone number and email address of the cost 219-407-6568 HONG. YANG@FRANCI SCANALLI ANCE 43.00							
42.00 Enter the employer/company name of the cost report preparer. 43.00 Enter the telephone number and email address of the cost 219-407-6568 HONG. YANG@FRANCI SCANALLI ANCE 43.00	41. 00	held by the cost report preparer in columns 1, 2, and 3,	HONG		YANG		41. 00
43.00 Enter the telephone number and email address of the cost 219-407-6568 HONG. YANG@FRANCISCANALLIANCE 43.00	42. 00	Enter the employer/company name of the cost report	FRANCISCAN ALL	I ANCE			42. 00
	43. 00	Enter the telephone number and email address of the cost	219-407-6568			CI SCANALLI ANCE	43. 00

Health Financial Systems FRANCISCAN HEALT			MI CHI GAN CITY	In Lieu of Form CMS-2552-				
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE			Provider CCN: 15-0015		eri od:	Worksheet S-2		
				To	com 01/01/2022 o 12/31/2022	Part II Date/Time Pre 4/13/2023 4:1		
			3. 00					
	Cost Report Preparer Contact Information							
41.00	Enter the first name, last name and the title/position	DI	RECTOR - REIMBURSEMENT				41.00	
	held by the cost report preparer in columns 1, 2, and 3,							
	respecti vel y.							
42.00	Enter the employer/company name of the cost report						42.00	
	preparer.							
43.00	Enter the telephone number and email address of the cost						43.00	
	report preparer in columns 1 and 2, respectively.							
42. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. Enter the employer/company name of the cost report preparer. Enter the telephone number and email address of the cost	DI		To	0 12/31/2022		41. 00 42. 00	

 Heal th Financial
 Systems
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 HOSPITAL
 AND HOSPITAL HEALTH CARE COMPLEX
 STATISTICAL DATA
 | Peri od: | Worksheet S-3 | From 01/01/2022 | Part | To 12/31/2022 | Date/Time Prepared: Provider CCN: 15-0015

				''	J 12/31/2022	4/13/2023 4: 1	
						I/P Days / O/P	D III
						Visits / Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Title V	
	35pariant	Li ne No.		Avai I abl e	57.11 1.15 d.1 5		
		1. 00	2. 00	3.00	4. 00	5. 00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00	103	37, 595	0.00	0	1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)						2. 00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6. 00
7.00	Total Adults and Peds. (exclude observation		103	37, 595	0.00	0	7. 00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT	31. 00	16	5, 840	0.00	0	8. 00
9.00	CORONARY CARE UNIT	32. 00	0	0	0.00	0	9. 00
10.00	BURN INTENSIVE CARE UNIT	33. 00	0	0	0.00	0	10.00
11.00	SURGICAL INTENSIVE CARE UNIT	34. 00	0	0	0.00	0	11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43. 00				0	13.00
14.00	Total (see instructions)		119	43, 435	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVI DER - I PF	40. 00	14	5, 110		0	16.00
17.00	SUBPROVI DER - I RF	41. 00	0	0		0	17.00
18.00	SUBPROVI DER						18. 00
19.00	SKILLED NURSING FACILITY	44. 00	0	0		0	19.00
20.00	NURSING FACILITY	45. 00	0	0		0	20.00
21.00	OTHER LONG TERM CARE	46. 00	0	0			21.00
22. 00	HOME HEALTH AGENCY	101. 00				0	22. 00
23.00	AMBULATORY SURGICAL CENTER (D. P.)	115. 00					23.00
24.00	HOSPI CE	116. 00	0	0			24.00
24. 10	HOSPICE (non-distinct part)	30. 00					24. 10
25.00	CMHC - CMHC	99. 00				0	25.00
25. 10	CMHC - CORF	99. 10				0	25. 10
26.00	RURAL HEALTH CLINIC	88. 00				0	26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00				0	26. 25
27.00	Total (sum of lines 14-26)		133				27. 00
28.00	Observation Bed Days					0	28. 00
29.00	Ambul ance Tri ps						29. 00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
33.00	LTCH non-covered days						33. 00
33. 01	LTCH site neutral days and discharges						33. 01
34. 00	Temporary Expansion COVID-19 PHE Acute Care	30. 00	0	0		0	34. 00

Provider CCN: 15-0015

In Lieu of Form CMS-2552-10

Period:	Worksheet S-3	
From 01/01/2022	Part	
To 12/31/2022	Date/Time Prepared:	4/13/2023 4:18 pm

				'		4/13/2023 4: 1	8 pm
		I/P Days	/ O/P Visits	/ Trips	Full Time E		
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
				Pati ents	& Residents	Payrol I	
		6. 00	7. 00	8. 00	9. 00	10.00	
	PART I - STATISTICAL DATA						
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	9, 483	4, 862	24, 225	5		1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
0.00	for the portion of LDP room available beds)	, 707					0.00
2.00	HMO and other (see instructions)	6, 737	0				2.00
3.00	HMO IPF Subprovider	167	0				3.00
4.00	HMO I RF Subprovi der	0	0				4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	C			5. 00
6.00	Hospital Adults & Peds. Swing Bed NF	0.400	4 0/2	24 225			6.00
7. 00	Total Adults and Peds. (exclude observation beds) (see instructions)	9, 483	4, 862	24, 225			7. 00
8.00	INTENSIVE CARE UNIT	903	910	3, 531			8. 00
9.00	CORONARY CARE UNIT	0	0	C			9. 00
10.00	BURN INTENSIVE CARE UNIT	0	0	C			10.00
11. 00	SURGICAL INTENSIVE CARE UNIT	0	0	C			11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)						12. 00
13.00	NURSERY		469	760)		13. 00
14.00	Total (see instructions)	10, 386	6, 241	28, 516	0.00	884.00	14. 00
15. 00	CAH visits	0	0	C)		15. 00
16. 00	SUBPROVI DER - I PF	364	1, 439	2, 701	0.00	16. 91	16. 00
17. 00	SUBPROVI DER - I RF	0	0	C	0.00	0.00	17. 00
18. 00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY	0	0	C	0.00	0.00	19. 00
20. 00	NURSING FACILITY		0	C		0.00	
21. 00	OTHER LONG TERM CARE			C		0.00	21. 00
22. 00	HOME HEALTH AGENCY	0	0	C	0.00	0.00	
23. 00	AMBULATORY SURGICAL CENTER (D. P.)				0.00	0.00	23. 00
24.00	HOSPI CE	0	0	C	0.00	0.00	24. 00
24. 10	HOSPICE (non-distinct part)			C			24. 10
25. 00	CMHC - CMHC	0	0	C		0.00	
25. 10	CMHC - CORF	0	0	C	0.00	0.00	
26. 00	RURAL HEALTH CLINIC	0	0	C		0.00	
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	C	0.00		
27. 00	Total (sum of lines 14-26)				0.00	900. 91	27. 00
28. 00	Observation Bed Days		808	4, 074			28. 00
29. 00	Ambul ance Tri ps	0					29. 00
30.00	Employee discount days (see instruction)			C			30. 00
31. 00	Employee discount days - IRF			C	1		31.00
32. 00	Labor & delivery days (see instructions)	0	484	871			32. 00
32. 01	Total ancillary labor & delivery room			C			32. 01
	outpatient days (see instructions)						
33. 00	LTCH non-covered days	0					33. 00
33. 01	LTCH site neutral days and discharges	0					33. 01
34. 00	Temporary Expansion COVID-19 PHE Acute Care	0	0	C)		34.00

| Peri od: | Worksheet S-3 | From 01/01/2022 | Part | To 12/31/2022 | Date/Time Prepared:
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 Systems
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 HOSPITAL
 AND HOSPITAL HEALTH CARE COMPLEX
 STATISTICAL DATA
 Provider CCN: 15-0015

				10	0 12/31/2022	4/13/2023 4:1	
		Full Time		Di sch	arges	17 107 2020 1. 1	O PIII
		Equi val ents					
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
	·	Workers				Pati ents	
		11. 00	12.00	13.00	14. 00	15. 00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		(2, 368	1, 322	6, 566	1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)				_		
2.00	HMO and other (see instructions)			1, 253	0		2.00
3.00	HMO I PF Subprovi der				0		3. 00
4.00	HMO I RF Subprovi der				0		4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF						5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7. 00	Total Adults and Peds. (exclude observation						7. 00
8. 00	beds) (see instructions) INTENSIVE CARE UNIT						8. 00
9. 00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11.00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12.00
13. 00	NURSERY						13. 00
14. 00	Total (see instructions)	0.00	(2, 368	1, 322	6, 566	
15. 00	CAH visits	0.00		2, 300	1, 522	0, 300	15. 00
16. 00	SUBPROVIDER - I PF	0.00	(39	228	418	
17. 00	SUBPROVI DER - I RF	0. 00	(•	0	0	17. 00
18. 00	SUBPROVI DER	5. 5.			آ	_	18. 00
19. 00	SKILLED NURSING FACILITY	0. 00					19. 00
20. 00	NURSING FACILITY	0. 00					20. 00
21.00	OTHER LONG TERM CARE	0.00				0	21. 00
22.00	HOME HEALTH AGENCY	0. 00					22. 00
23.00	AMBULATORY SURGICAL CENTER (D. P.)	0.00					23. 00
24.00	HOSPI CE	0.00					24. 00
24. 10	HOSPICE (non-distinct part)						24. 10
25.00	CMHC - CMHC	0.00					25. 00
25. 10	CMHC - CORF	0.00					25. 10
26. 00	RURAL HEALTH CLINIC	0. 00					26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0. 00					26. 25
27. 00	Total (sum of lines 14-26)	0. 00					27. 00
28. 00	Observation Bed Days						28. 00
29. 00	Ambul ance Tri ps						29. 00
30. 00	Employee discount days (see instruction)						30. 00
31. 00	Employee discount days - IRF						31. 00
32. 00	Labor & delivery days (see instructions)						32. 00
32. 01	Total ancillary labor & delivery room						32. 01
22.00	outpatient days (see instructions)						22.00
33.00	LTCH non-covered days			0			33. 00
33. 01	LTCH site neutral days and discharges			0			33. 01
34.00	Temporary Expansion COVID-19 PHE Acute Care				l		34. 00

Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION

Provi der CCN: 15-0015

In Lieu of Form CMS-2552-10

Period: Worksheet S-3

From 01/01/2022 Part II

To 12/31/2022 Date/Time Prepared: 4/13/2023 4:18 pm

						12/31/2022	4/13/2023 4:1	
		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst.	Adjusted Salaries (col.2 ± col.		Average Hourly Wage (col. 4 ÷ col. 5)	·
				A-6)	3)	col. 4	,	
	DADT II WACE DATA	1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
	PART II - WAGE DATA SALARIES							1
1.00	Total salaries (see instructions)	200. 00	84, 565, 372	0	84, 565, 372	2, 243, 358. 00	37. 70	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0. 00	2. 00
3. 00	Non-physician anesthetist Part B		0	0	0	0.00	0. 00	3. 00
4. 00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4. 00
4. 01 5. 00	Physicians - Part A - Teaching Physician and Non		0	_		0. 00 0. 00	l e	
6. 00	Physician-Part B Non-physician-Part B for hospital-based RHC and FQHC		0	0	0	0.00	0.00	6. 00
7. 00	services Interns & residents (in an approved program)	21. 00	0	0	0	0.00	0. 00	7. 00
7. 01	Contracted interns and residents (in an approved programs)		0	О	0	0.00	0.00	7. 01
8. 00	Home office and/or related organization personnel		14, 198, 895	0	14, 198, 895	380, 220. 00	37. 34	8. 00
9. 00 10. 00	SNF Excluded area salaries (see	44. 00	0 3, 122, 619	-675, 958	0 2, 446, 661	0. 00 104, 273. 00		
	instructions) OTHER WAGES & RELATED COSTS							-
11. 00	Contract labor: Direct Patient Care		3, 260, 011	0	3, 260, 011	24, 209. 00	134. 66	11. 00
12. 00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0. 00	12.00
13. 00	Contract Labor: Physician-Part A - Administrative		1, 351, 971	0	1, 351, 971	7, 972. 00	169. 59	13. 00
14. 00	Home office and/or related organization salaries and		0	О	0	0.00	0.00	14. 00
14. 01	wage-related costs Home office salaries		17, 300, 642	0	17, 300, 642	463, 279. 00	37. 34	14. 01
14. 02	Related organization salaries		0		0	0.00	l e	
15. 00	Home office: Physician Part A - Administrative		0	0	0	0. 00	0.00	15. 00
16. 00	Home office and Contract Physicians Part A - Teaching		0	0	0	0. 00	0. 00	16. 00
16. 01	Home office Physicians Part A - Teaching		0	0	0	0. 00	0. 00	16. 01
16. 02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16. 02
17. 00	WAGE-RELATED COSTS Wage-related costs (core) (see		21, 126, 014	0	21, 126, 014			17. 00
18. 00	instructions) Wage-related costs (other) (see instructions)							18. 00
19. 00 20. 00	Excluded areas Non-physician anesthetist Part		818, 618	0	818, 618 0			19. 00 20. 00
21. 00	A Non-physician anesthetist Part		0	0	0			21. 00
22. 00	B Physician Part A -		0	0	0			22. 00
22. 01	Administrative Physician Part A - Teaching		0	0	0			22. 01
23. 00	Physician Part B		0	0	0			23. 00
24. 00 25. 00	Wage-related costs (RHC/FQHC) Interns & residents (in an		0	_	0			24. 00 25. 00
25. 50	approved program) Home office wage-related (core)		5, 288, 419	0	5, 288, 419			25. 50
25. 51	Related organization wage-related (core)		0	0	0			25. 51
25. 52	Wage-related (core) Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25. 52

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 15-0015 Period:

In Lieu of Form CMS-2552-10
Period: Worksheet S-3
From 01/01/2022 Part II

12/31/2022 Date/Time Prepared: 4/13/2023 4:18 pm Wkst. A Line Amount Recl assi fi cati Adj usted Paid Hours Average Hourly Number on of Salaries Sal ari es Related to Wage (col. 4 Reported col . 5) (from Wkst. (col.2 ± col. Salaries in A-6)3) col. 4 2.00 1.00 5.00 6.00 3.00 4.00 25.53 Home office: Physicians Part A 0 25.53 - Teaching - wage-related (core) OVERHÉAD COSTS - DIRECT SALARIES 26.00 Employee Benefits Department 4 00 976, 395 675, 958 1, 652, 353 20. 09 26.00 82, 261. 00 27.00 Administrative & General 5.00 19, 588, 964 19, 588, 964 527, 208. 00 37. 16 27.00 28.00 Administrative & General under 2, 899, 449 2, 899, 449 40, 927. 00 70.84 28.00 contract (see inst.) Maintenance & Repairs 6.00 29.00 29.00 0.00 0.00 Operation of Plant 3, 828, 360 3, 828, 360 127, 340.00 30.06 30.00 7.00 0 30.00 31.00 Laundry & Linen Service 8.00 105, 089 0 105, 089 5, 814. 00 18.08 31.00 92, 110. 00 32.00 Housekeepi ng 9.00 1, 734, 638 1, 734, 638 18. 83 32.00 33.00 Housekeeping under contract 0.00 0.00 33.00 (see instructions) 34.00 Di etary 10.00 1, 811, 672 -1, 177, 911 633, 761 28, 664. 00 22. 11 34.00 Di etary under contract (see instructions) 0.00 35.00 0.00 35.00 1, 177, 911 22. 11 36, 00 Cafeteri a 11.00 0 1, 177, 911 53, 275. 00 36.00 Maintenance of Personnel 0. 00 37.00 12.00 0 0.00 37.00 38.00 Nursing Administration 13.00 3, 162, 442 3, 162, 442 66, 971. 00 47. 22 38.00 39.00 Central Services and Supply 14.00 249, 798 0 249, 798 9, 770. 00 25. 57 39.00 2, 825, 924 2, 825, 924 60, 136. 00 46, 99 40.00 40.00 Pharmacy 15.00 0 41.00 Medical Records & Medical 16.00 6,881 6, 881 176.00 39. 10 41. 00 Records Library Social Service 17.00 0.00 0.00 42.00 42.00 0 43.00 Other General Service 18.00 0 0 0.00 43.00 0 00

Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0015

							4/13/2023 4: 1	8 pm
		Worksheet A	Amount	Recl assi fi cati	Adj usted	Paid Hours	Average Hourly	
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from	(col.2 ± col.	Salaries in	col. 5)	
				Worksheet A-6)	3)	col. 4		
		1.00	2. 00	3.00	4. 00	5. 00	6. 00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		73, 265, 926	0	73, 265, 926	1, 904, 065. 00	38. 48	1. 00
	instructions)							
2.00	Excluded area salaries (see		3, 122, 619	-675, 958	2, 446, 661	104, 273. 00	23. 46	2.00
	instructions)							
3.00	Subtotal salaries (line 1		70, 143, 307	675, 958	70, 819, 265	1, 799, 792. 00	39. 35	3.00
	minus line 2)							
4.00	Subtotal other wages & related		21, 912, 624	. 0	21, 912, 624	495, 460. 00	44. 23	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		26, 414, 433	0	26, 414, 433	0.00	37. 30	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		118, 470, 364	675, 958	119, 146, 322	2, 295, 252. 00	51. 91	6.00
7.00	Total overhead cost (see		37, 189, 612	675, 958	37, 865, 570	1, 094, 652. 00	34. 59	7. 00
	instructions)							

Health Financial Systems	FRANCISCAN HEALTH MICHIGAN CITY	In Lieu of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 15-0015	Peri od: Worksheet S-3
		From 01/01/2022 Part IV

	To 12/31/2022	Date/Time Prep 4/13/2023 4:18	
		Amount	5 p
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		1
	RETI REMENT COST		l
1.00	401K Employer Contributions	2, 740, 739	1. 00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2. 00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3. 00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	2, 747, 294	4. 00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5. 00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6. 00
7.00	Employee Managed Care Program Administration Fees	0	7. 00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	
8. 01	Health Insurance (Self Funded without a Third Party Administrator)	0	8. 01
8. 02	Health Insurance (Self Funded with a Third Party Administrator)	9, 620, 046	8. 02
8. 03	Health Insurance (Purchased)	0	8. 03
9.00	Prescription Drug Plan	0	9. 00
10.00	Dental, Hearing and Vision Plan	380, 115	
	Life Insurance (If employee is owner or beneficiary)	0	11. 00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12. 00
13.00	Disability Insurance (If employee is owner or beneficiary)	0	1
	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14. 00
15. 00		0	15. 00
16. 00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16. 00
	Noncumulative portion)		
	TAXES		
	FICA-Employers Portion Only	6, 456, 439	ı
	Medicare Taxes - Employers Portion Only	0	
	Unemployment Insurance	0	19. 00
20. 00	State or Federal Unemployment Taxes	0	20. 00
	OTHER		
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21. 00
22. 00	Day Care Cost and Allowances	0	22. 00
	Tuition Reimbursement	0	23. 00
24. 00	Total Wage Related cost (Sum of lines 1 -23)	21, 944, 633	1
	Part B - Other than Core Related Cost		
25. 00	OTHER WAGE RELATED COSTS (SPECIFY)		25. 00

FRANCISCAN HEALTH MICHIGAN CITY	In Lie	u of Form CMS-2552-10
Provi der CCN: 15-0015		Worksheet S-3
		Part V
		Provider CCN: 15-0015 Period: From 01/01/2022

		0 12/31/2022	4/13/2023 4: 18	
	Cost Center Description	Contract Labor		
		1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	0	0	1. 00
2.00	Hospi tal	0	0	2.00
3.00	SUBPROVI DER - I PF	0	0	3.00
4.00	SUBPROVI DER - I RF	0	0	4.00
5.00	Subprovi der - (Other)	0	0	5. 00
6.00	Swing Beds - SNF	0	0	6.00
7. 00	Swing Beds - NF	0	0	7. 00
8. 00	SKILLED NURSING FACILITY	0	0	8. 00
9. 00	NURSING FACILITY	0	0	9. 00
10. 00	OTHER LONG TERM CARE I			10.00
11. 00	Hospi tal -Based HHA	0	0	11.00
12.00	AMBULATORY SURGICAL CENTER (D. P.) I	0	0	12.00
13. 00	Hospi tal -Based Hospi ce	0	0	13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14.00
15. 00	Hospital-Based Health Clinic FQHC	0	0	15.00
16. 00	Hospi tal -Based-CMHC	0	0	16.00
16. 10	Hospi tal -Based-CMHC 10	0	0	16. 10
17. 00	RENAL DIALYSIS I	0	0	17.00
18. 00	Other	0	0	18.00

Heal th	Financial Systems FRANCI	SCAN HEALTH MICHIGAN CITY	(In Lie	eu of Form CMS-2	2552-10
	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provi der C	CN: 15-0015	Peri od:	Worksheet S-10	
				From 01/01/2022 To 12/31/2022	Date/Time Pre	narod:
				10 12/31/2022	4/13/2023 4: 1	
					1. 00	
	Uncompensated and indigent care cost computation				1.00	
1.00	Cost to charge ratio (Worksheet C, Part I line 20	02 column 3 divided by li	ne 202 column	8)	0. 210186	1. 00
	Medicaid (see instructions for each line)					
2.00						2.00
3.00	Did you receive DSH or supplemental payments from	40	Y N	3.00		
4. 00 5. 00	If line 4 is no, then enter DSH and/or supplemen			ıur	11, 452, 015	4. 00 5. 00
6. 00	Medi cai d charges	tai payments it om mear car	u		220, 372, 680	
7. 00	Medicaid cost (line 1 times line 6)				46, 319, 252	
8. 00	Difference between net revenue and costs for Med	icaid program (line 7 min	us sum of lin	es 2 and 5; if	0	8. 00
	< zero then enter zero)		- >			
9. 00	Children's Health Insurance Program (CHIP) (see in Net revenue from stand-alone CHIP	instructions for each iin	е)		0	9. 00
10. 00	Stand-alone CHIP charges					10.00
11. 00	Stand-alone CHIP cost (line 1 times line 10)				Ö	
12.00	Difference between net revenue and costs for star	nd-alone CHIP (line 11 mi	nus line 9; i	f < zero then	0	12. 00
	enter zero)					
12 00	Other state or local government indigent care pro Net revenue from state or local indigent care pro			\	0	13. 00
13. 00 14. 00	Charges for patients covered under state or local	9 (
11.00	10)	i margent care program (Not Theradea	111 111103 0 01		11.00
15.00	State or local indigent care program cost (line	1 times line 14)			0	15. 00
16. 00	Difference between net revenue and costs for sta	te or local indigent care	program (lin	e 15 minus line	0	16. 00
	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for	s Modicaid CULD and stat	o/Local india	ont care program	me (eoo	
	instructions for each line)	wedicard, chir and stat	errocar riidigi	ent care program	113 (366	
17. 00	Private grants, donations, or endowment income re	estricted to funding char	ity care		0	17. 00
18. 00	Government grants, appropriations or transfers for				0	18. 00
19. 00	Total unreimbursed cost for Medicaid, CHIP and : 8, 12 and 16)	state and local indigent	care programs	(sum of lines	0	19. 00
			Uni nsured	Insured	Total (col. 1	
			patients	pati ents	+ col . 2)	
	Uncompensated Care (see instructions for each lin	26)	1.00	2. 00	3. 00	
20. 00	Charity care charges and uninsured discounts for		20, 128, 39	0 4, 283, 884	24, 412, 274	20. 00
	(see instructions)	,				
21. 00	Cost of patients approved for charity care and u	ni nsured di scounts (see	4, 230, 70	6 4, 283, 884	8, 514, 590	21. 00
22. 00	instructions) Payments received from patients for amounts previous	iously writton off as		0 0	0	22. 00
22.00	charity care	rousiy wirtten oli as		0		22.00
23. 00	1		4, 230, 70	6 4, 283, 884	8, 514, 590	23. 00
					1.00	
24 00	Does the amount on line 20 column 2, include char	race for notiont days have	and a Langth	of ctoy limit	1. 00 N	24. 00
24.00	imposed on patients covered by Medicaid or other		ond a rength	JI Stay IIIII t	IN	24.00
25. 00	of lf line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit					25. 00
26. 00						26. 00
27. 00	Medicare reimbursable bad debts for the entire h	ospital complex (see inst	ructions)		293, 042	1
27. 01	Medicare allowable bad debts for the entire hospi	ital complex (see instruc	tions)		450, 834	1
28. 00	Non-Medicare bad debt expense (see instructions)	no had dabt comment	l motmust! \		3, 548, 321	
29. 00 30. 00	Cost of non-Medicare and non-reimbursable Medical Cost of uncompensated care (line 23 column 3 plus		instructions)		903, 599 9, 418, 189	
	Total unreimbursed and uncompensated care cost (*			9, 418, 189	
	1				.,,,	, ,

Decision Property	Heal th	Financial Systems	FRANCI SCAN HEALTH	MICHIGAN CITY	/	In Lie	u of Form CMS-	2552-10
Cost Center Description	RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE	OF EXPENSES	Provi der CO	CN: 15-0015 F	Peri od:	Worksheet A	
Cost Center Description							Date/Time Pre	pared:
1.00 2.00 3.00 4.00 5.00 17.540 575 407 1.00 2.00 3.00 4.00 5.00 1.00 3.00 4.00 5.00 1.00 3.00 4.00 5.00 1.00 3.00 4.00 5.00 1.00 3.00 4.00 5.00 1.00 3.00 4.00 5.00 1.00 3.00 4.00 5.00 1.00 3.00 4.00 5.00 1.00 3.00 4.00 5.00 1.00 3.00 4.00 5.00 3.00 3.00 4.00 3.00		Cook Cooks Doors at a	C-1:	0+1	T-+-1 (1 1	DI: 6:+:		8 pm
		Cost Center Description	Sararres	otner				
Description 1.00 2.00 3.00 4.00 5.00						(000 // 0)		
DEFERMAL STRAYLE COST CENTERS 1, B34, 925 1, B34, 925 17, S40, 577 10, 375, 497 1								
1.00 001000 CAP REL COSTS-BLUE & FIX 1, 894, 922 1, 894, 925 17, 806, 972 19, 379, 907 1, 00 13, 301, 001 20 13, 301, 001 20 13, 301, 001 20 13, 301, 001 20 30 30 30 30 30 30 30		I	1.00	2. 00	3. 00	4. 00	5. 00	
2.00 000000018NTERISE COPIEL COSTS - MARIE EQUIP	1 00			1 024 025	1 024 020	17 540 572	10 275 407	1 00
3.00 DOSCO D				1, 834, 925 N				
4.00				0		0	0	
0.000 0.0000 LAMIDEN REPAIR ISS 0 0 0 0 0 0 0 0 0	4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	976, 395	19, 079, 607	20, 056, 002	792, 263	20, 848, 265	4. 00
2,00 00000 00000 00000 00000 00000 00000 000000			19, 588, 964	44, 567, 433	64, 156, 39	-15, 013, 963	49, 142, 434	
B.00 GORDOLLAMBRY & LILEN SERVICE 105,089 1,375,045 1,480,134 -1,470 1,478,644 8,00			2 929 240	17 547 045	21 274 201	0 075 104	0 12 201 101	
9.00 0.0990 MUSERCEP NS		l l	1					
11.00 01100 CAFFTERIA 0		l l	1					1
13.00 01300 NURSING ADMINISTRATION 3.102, 442 5.58, 743 8.701, 185 -26, 850 8.674, 335 13.00		l l	1, 811, 672	1, 029, 732	2, 841, 404			1
14.00 0 1400 CENTRAL SERVICES & SUPPLY 249, 708 726, 522 976, 232 -134, 574 841, 746 14.00 16.00 0 10.00 MEDICAL RECORDS & LIBRARY 6.881 -6.683 172 -225, 588 -24, 285, 372 2.885, 372 3.88			0	0				
15.00 O1500 PIMASMICY 2,855,924 24,439,664 27,265,588 -24,285,372 2,980,216 15.00 17.00 O1001 O1700 SOCIAL SERVICE COST CENTERS 0 0 0 0 0 0 0 0 0			1 I					
16. 00 01400 IEDICAL RECORDS & LIBRARY 6, 881								
18.00 01000 INSERVICE FOUCATION 0 0 0 0 0 18.00 20.00 20000 NURSING PROGRAM 0 0 0 0 0 0 0 0 20.00 20000 NURSING PROGRAM 0 0 0 0 0 0 0 0 22.00 22200 LRR SERVICES-SALARY & FRINGES APPRY 0 0 0 0 0 0 0 22.00 22200 LRR SERVICES-SALARY & FRINGES APPRY 0 0 0 0 0 0 22.00 22200 LRR SERVICES-SALARY & FRINGES APPRY 0 0 0 0 0 0 22.00 22200 LRR SERVICES-SALARY & FRINGES APPRY 0 0 0 0 0 22.00 22200 LRR SERVICES-SALARY & FRINGES APPRY 0 0 0 0 0 22.00 22200 LRR SERVICES-SALARY & FRINGES APPRY 0 0 0 0 0 22.00 22200 LRR SERVICES-SALARY & FRINGES APPRY 0 0 0 0 22.00 22200 LRR SERVICES-SALARY & FRINGES APPRY 0 0 0 0 22.00 22200 LRR SERVICES-SALARY & FRINGES APPRY 0 0 0 0 22.00 22200 LRR SERVICES-SALARY & FRINGES APPRY 0 0 0 0 0 22.00 22200 CREATION &								
19.00 0.900 NOMPHYSICI AN AMESTHETISTS 0 0 0 0 0 0 0 0 0			0	0	(0	0	
20.00 2000 MURSING PROGRAM 0 0 0 0 0 0 20.00			0	0	(0	0	
21.00 0200 IAR SERVICES-SALARY & FRINCES APPRV 0 0 0 0 0 0 0 0 0			0	0	(0	0	
22.00 02200 RAY SERVICES OTHER PROM COSTS APPRV 0			0	0			0	
INPATT ENT ROUTINE SERVICE COST CENTERS 19,040,734 3,372,773 22,413,507 -3,528,175 18,885,332 30.00 30.00 03000 AURITS & PEDIO LATRICS 3,736,698 842,812 4,416,510 -497,581 3,918,929 31.00 32.00 332.00 03200 CORROMAY CARE UNIT 0 0 0 0 0 0 0 0 32.00 32.00 330.00 03000 URRIO LINITENSIVE CARE UNIT 0 0 0 0 0 0 0 0 34.00 40.00 04.00 04.00 04.00 05.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			O	Ö		o o	Ō	
30.00 03000 ADULTS & PEDIATRICS 19, 040, 734 3, 372, 775 22, 413, 507 -3, 528, 175 18, 865, 332 30.00 32.00 03200 CORDMARY CARE UNIT 0 0 0 0 0 0 0 0 32.00 32.00 33.00	23. 00		0	0	(0	0	23. 00
31.00 03100 INTENSI VE CARE UNIT 3,573,698 842,812 4,416.510 -497.581 3,918,929 31.00 320.00 332.00 03200 0300 00 0 0 0 0 0 0								
32.00 03200C COROMARY CARE UNIT 0 0 0 0 0 0 32.00 03.0								1
33.00 33300 3USN INTENSIVE CARE UNIT 0 0 0 0 0 33.00			3, 3/3, 090	042, 012 0	4,410,510) -497, 361) 0	3, 910, 929 0	
40.00 04000 SUBPROVIDER - IPF 1, 244, 441 963, 940 2, 208, 381 -30, 600 2, 177, 781 40, 00 43, 00 43, 00 43, 00 44, 00 440, 00 4			0	0	Ö	o o	Ö	
41.00 04100 SUBROVI DER - 1 RF	34.00		0	0	(0	0	34. 00
43. 00 04300 NURSERY 0 0 0 0 634, 109 634, 109 43. 00 440 0 0440 0 0400 050 050 04500 04			1, 244, 441	963, 940	2, 208, 38	-30, 600	2, 177, 781	
44. 00 04400 SKILLED NURSING FACILITY			0	0		0	624 100	
45.00 04500 OURS ING TERM CARE		l l	0	0		034, 109		1
MACILLARY SERVICE COST CENTERS			o	Ö		o o	_	1
50, 00	46. 00		0	0	(0	0	46. 00
S1 00 05100 RECOVERY ROOM C C C C C C C C C	FO 00		/ 71/ /00	17 504 004	24 224 574	14 720 240	0 400 010	
S2 00 05200 DELI VERY ROOM & LABOR ROOM 0 0 3, 137, 038 52, 00 05300 ANESTHESI OLOGY 74, 714 3, 405, 821 3, 480, 535 -68, 771 3, 411, 764 53, 00 05400 RADI OLOGY-DI AGNOSTI C 3, 898, 550 2, 162, 997 6, 061, 547 -7, 728, 500 4, 333, 047 54, 00 05400 RADI OLOGY-DI AGNOSTI C 1, 307, 916 280, 714 1, 588, 630 -227, 235 1, 361, 395 54, 01 1, 550 05500 RADI OLOGY-THERAPEUTI C 567, 041 1, 456, 489 2, 023, 530 -816, 407 1, 207, 123 55, 00 05501 WOODLAND CANCER CARE CTR 387, 502 1111, 961 499, 463 -100, 865 398, 598 55, 01 05501 WOODLAND CANCER CARE CTR 387, 502 1111, 961 499, 463 -100, 865 398, 598 55, 01 05501 WOODLAND CANCER CARE CTR 0 0 0 0 0 0 0 0 0			0, 710, 000	17, 504, 664	24, 221, 372) -14, 739, 360		
S4 00 05400 R5400 CARDI OLOGY - DI AGNOSTI C 1, 307, 916 280, 714 1, 588, 630 -227, 235 1, 361, 395 54, 01 05500 R520 RADI OLOGY - DI AGNOSTI C 1, 307, 916 280, 714 1, 588, 630 -227, 235 1, 361, 395 54, 01 555, 01 05500 RADI OLOGY - THERAPEUTI C 567, 041 1, 456, 489 2, 023, 530 -816, 407 1, 207, 123 55, 00 05500 RADI OLOGY - THERAPEUTI C 387, 502 1111, 961 499, 463 -100, 865 398, 598 55, 01 05500 RADI OLOGY - THERAPEUTI C 387, 502 1111, 961 499, 463 -100, 865 398, 598 55, 01 05500 MS		l l	0	0	Ċ	1, 137, 038		
SA 01 05401 FSED RADI OLOGY - DI AGNOSTI C 1, 307, 916 280, 714 1, 588, 630 -227, 235 1, 361, 395 54, 01								
55. 00 05500 RADI OLOGY-THERAPEUTIC 567, O41 MODIAND CANCER CARE CTR 387, 502 MODIAND CANCER CARE CTR 388, 715 MODIAND CANCER CARE CTR 388, 715 MODIAND CANCER CARE CTR 388, 715 MODIAND CANCER CARE CTR 389, 502 MODIAND CANCER CARE CTR 389								
55.01 05501 05501 05000 RADIO CANCER CARE CTR 387,502 111,961 499,463 -100,865 398,598 55.01								
56. 00 05600 RADI OI SOTOPE 0 0 0 0 0 56. 00								
58. 00 05800 MRI			0	0	(0		
59. 00 05900 CARDI AC CATHETERI ZATION 861, 279 4, 750, 128 5, 611, 407 -4, 200, 661 1, 410, 746 59. 00 60. 00 06000 LABORATORY 0 11, 811, 630 -1729, 644 11, 081, 986 60. 00 60. 01 Octool BPD CLI NI CAL LAB SERVI CES-PRGM ONLY 0 0 0 0 0 0 0 0 60. 01 61. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 0 0 0 0 0 0 0 62. 00 63. 01 Os301 RED STORING, PROCESSING & TRANS. 0			0	0	(0	0	
60. 00 06000 LABORATORY 0 11, 811, 630 -729, 644 11, 081, 986 60. 00 60. 01 06001 FS ED LAB 0 307 307 307 307 307 0 60. 01 61. 00 61. 00 62. 00 62. 00 62. 00 62. 00 62. 00 62. 00 62. 00 62. 00 63. 00 64.			0	0	[(14 40	0	0	
60. 01 06001 FS ED LAB 0 307 307 -307 0 60. 01 61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 0 0 0 0 0 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 0 0 0 0 0 63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 0 0 63. 01 06301 FS ED BLOOD BANK 0 0 0 0 0 64. 00 06400 INTRAVENOUS THERAPY 0 0 0 0 65. 00 06500 RESPI RATORY THERAPY 1, 309, 389 902, 766 2, 212, 155 -323, 440 1, 888, 715 65. 00 66. 00 06600 PHYSI CAL THERAPY 959, 210 2, 328, 031 3, 287, 241 -206, 482 3, 080, 759 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 959, 210 2, 328, 031 3, 287, 241 -206, 482 3, 080, 759 66. 00 68. 00 06800 SPECH PATHOLOGY 0 0 0 0 0 69. 00 06900 ELECTROCARDI OLOGY 1, 028, 305 212, 681 1, 240, 986 -149, 706 1, 091, 280 69. 00 69. 00 07000 ELECTROCARDI OLOGY 1, 028, 305 212, 681 1, 240, 986 -149, 706 1, 091, 280 69. 00 67. 00 07000 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 0 0 0 67. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 0 67. 00 07400 RENAL DI ALYSI S 0 0 0 0 0 0 67. 00 07500 ASC (NON-DI STINCT PART) 0 0 0 0 0 67. 00 07700 ALLOGENEIC STEM CELL ACQUI SI TI ON 0 0 0 0 67. 00 07700 ALLOGENEIC STEM CELL ACQUI SI TI ON 0 0 0 0 68. 00 08900 FURBAL FIALTH CLINIC 0 0 0 0 0 69. 00 08900 FURBAL FIALTH CLINIC 0 0 0 0 69. 00 08900 FURBALLY QUALI FI ED HEALTH CENTER 0 0 0 0 69. 00 08900 FURBALLY QUALI FI ED HEALTH CENTER 0 0 0 0 0 69. 00 08900 FURBALLY QUALI FI ED HEALTH CENTER 0 0 0 0 0 69. 00 08900 FURBALLY QUALI FI ED HEALTH CENTER 0 0 0 0 0 0 0 69. 00 08900 FURBALLY QUALI FI ED HEALTH CENTER 0 0 0 0 0 0 0 69. 00 08900 FURBALLY QUALI FI ED HEALTH CENTER 0 0 0 0 0 0 69. 00 08900 FURBALLY QUA			861, 279					
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 0 0 0 0 0 0 61. 00 62. 00 63. 00 63.00 80.00 8 PACKED RED BLOOD CELL 0 0 0 0 0 0 62. 00 63. 00 63. 00 63.00 80.00 STORING, PROCESSING & TRANS. 0 0 0 0 0 0 0 63. 00 63. 01 64. 00 64.00 6			0					
63. 00				0	(0		
63. 01			0	0	(0	0	
64. 00			0	0	(0	0	
65. 00		l l	0	0	(0	0	
66. 00 06600 PHYSI CAL THERAPY 959, 210 2, 328, 031 3, 287, 241 -206, 482 3, 080, 759 66. 00 67. 00 06700 00 00 00 00 00 0			1, 309, 389	902. 766	2, 212, 15!	-323, 440	1. 888. 715	
68. 00 06800 SPEECH PATHOLOGY 0 0 0 0 0 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 1,028,305 212,681 1,240,986 -149,706 1,091,280 69. 00 70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 0 0 11,021,027 11,021,027 72. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 11,021,027 11,021,027 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 27,170,064 27,170,064 73. 00 74. 00 07400 RENAL DI ALYSI S 0 0 0 0 0 0 0 75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 0 76. 00 03020 CLI NI C 344,076 223,397 567,473 -8,238 559,235 76. 00 77. 00 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON 0 0 0 0 89. 00 08800 RURAL HEALTH CLI NI C 0 0 0 0 0 88.00 89. 00 08900 FEDERALLY QUALI FI ED HEALTH CENTER 0 0 0 0 0 0 89. 00 08900 FEDERALLY QUALI FI ED HEALTH CENTER 0 0 0 0 0 1, 028,305 212,681 1, 240,986 -149,706 1, 091,240 69.00 0 0 9 0 0 0 0 0 9 0 0 0 0 9 0 0 0 0 9								
69. 00 06900 ELECTROCARDI OLOGY 1, 028, 305 212, 681 1, 240, 986 -149, 706 1, 091, 280 69. 00 0 0 0 0 0 0 0 0 0			0	0	(0	0	
70. 00			0	0	(0		1
71. 00			1, 028, 305	212, 681	1, 240, 986	-149, /06		
72. 00			0	0		10. 108. 188	-	
74. 00	72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		0				
75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 0 75. 00 76. 00 0 0 0 0 0 0 0 0 0			0	0	(27, 170, 064		
76. 00			0	0	(0		ı
77. 00 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON 0 0 0 0 0 0 77. 00			344 076	0 772 202	567 /17	0 2 عور ع	-	
OUTPATI ENT SERVI CE COST CENTERS 88. 00 08800 RURAL HEALTH CLINI C 0 0 0 0 0 88. 00 89. 00 08900 FEDERALLY QUALI FI ED HEALTH CENTER 0 0 0 0 0 89. 00			344,076	223, 397 N	307, 473	-0, 238)		
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 89.00		OUTPATIENT SERVICE COST CENTERS	, ,		`			
	88. 00	08800 RURAL HEALTH CLINIC	0	0	(0	-	
70. 00 07000 01 01 01 01 00 00			0	0				
	70.00	07000 0E1 N1 0	ı ol	U	1	, 0	1 0	70.00

Health Financial Systems FR.	ANCISCAN HEALTH I	MICHIGAN CITY	,	In Lie	u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der CC		Peri od:	Worksheet A	
				From 01/01/2022 To 12/31/2022	Data/Timo Dro	narodi
				0 12/31/2022	Date/Time Pre 4/13/2023 4:1	
Cost Center Description	Sal ari es	0ther	Total (col. 1	Recl assi fi cati	Reclassi fi ed	, p
'			+ col . 2)	ons (See A-6)	Trial Balance	
					(col. 3 +-	
					col . 4)	
	1.00	2. 00	3. 00	4. 00	5. 00	
90. 03 09003 NFUSI ON OP SERVI CES	933, 964	3, 222, 371	4, 156, 33!		1, 511, 354	
91. 00 09100 EMERGENCY	4, 427, 525	2, 045, 305				
91. 01 09101 FREE STANDING EMERGENCY DEPT	1, 721, 999	1, 710, 281	3, 432, 280	-762, 512	2, 669, 768	
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92.00
94. 00 09400 HOME PROGRAM DIALYSIS	0	٥			0	94. 00
95. 00 09500 AMBULANCE SERVICES		0)		0	95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED		0			0	96.00
97. 00 09700 DURABLE MEDICAL EQUI P-SOLD		0	ì		Ö	97. 00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS		0	ì		ő	98. 00
99. 00 09900 CMHC	o	0		0	Ö	
99. 10 09910 CORF	ol ol	0		o o	Ō	
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	O	O		0	0	100.00
101.00 10100 HOME HEALTH AGENCY	o	o		0	0	101.00
102.00 10200 OPIOID TREATMENT PROGRAM	o	0	(0	0	102. 00
SPECIAL PURPOSE COST CENTERS						
105.00 10500 KIDNEY ACQUISITION	0	0	(0		105. 00
106. 00 10600 HEART ACQUI SI TI ON	0	0	(0		106. 00
107.00 10700 LIVER ACQUISITION	0	0	(0		107. 00
108. 00 10800 LUNG ACQUISITION	0	0	(0		108. 00
109. 00 10900 PANCREAS ACQUISITION	0	0	(0		109.00
110. 00 11000 NTESTI NAL ACQUI SI TI ON	0	0	(0	-	110.00
111. 00 11100 SLET ACQUISITION	0	0	(0		111.00
113. 00 11300 I NTEREST EXPENSE		0		0		113. 00 114. 00
114.00 11400 UTI LI ZATI ON REVI EW-SNF	0	0	,	0	-	115.00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.) 116. 00 11600 HOSPICE	0	0)			116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	82, 687, 194	174, 182, 524	256, 869, 718	1, 472, 559		
NONREI MBURSABLE COST CENTERS	02,007,174	174, 102, 324	230, 007, 710	1,472,337	230, 342, 277	1110.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	O	55, 451	55, 45	0	55, 451	190. 00
191. 00 19100 RESEARCH	ol ol	0		o o		191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	1, 988	29, 264	31, 25	-172, 899	-141, 647	192. 00
193.00 19300 NONPALD WORKERS	O	0	(0		193. 00
194.00 07950 BEACON JOINT VENTURE	o	0	(3, 482	3, 482	194. 00
194. 01 07951 WORKI NG WELL	1, 126, 597	613, 823	1, 740, 420	-1, 299, 681	440, 739	194. 01
194. 03 07953 MED WATCHER	0	0	(0	0	194. 03
194. 10 07960 DUNELAND FITNESS CTR	0	0	(0	0	
194.11 07961 OMNI HEALTH & FITNESS CHESTERTOWN	660, 013	261, 986				
194. 16 07966 PHYSI CLAN PRACTICE MD WISW	58, 269	792	59, 06	0	59, 061	
194. 19 07969 HEALTH PARTNERS	0	0	(0	-	194. 19
194. 20 07970 CENTER OF HOPE	31, 311	2, 805		1		194. 20
200.00 TOTAL (SUM OF LINES 118 through 199)	84, 565, 372	175, 146, 645	259, 712, 01	7 0	259, 712, 017	1200.00

Provider CCN: 15-0015

Peri od: Worksheet A From 01/01/2022 To 12/31/2022 Date/Time Prepared: 4/13/2023 4:18 pm

				4/13/2023 4:1	
	Cost Center Description	Adjustments	Net Expenses		
			For Allocation		
	GENERAL SERVICE COST CENTERS	6. 00	7. 00		
1.00	00100 CAP REL COSTS-BLDG & FLXT	-7, 791, 070	11, 584, 427		1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	0	13, 301, 007		2. 00
3.00	00300 OTHER CAP REL COSTS	0	0		3. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	362, 979	21, 211, 244		4. 00
5. 00 6. 00	00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS	-7, 542, 854	41, 599, 580		5. 00 6. 00
7. 00	00700 OPERATION OF PLANT	-367, 425	11, 933, 676		7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	1, 478, 664		8.00
9.00	00900 HOUSEKEEPI NG	-38	2, 386, 540		9. 00
10.00	01000 DI ETARY	1, 627	960, 302		10. 00
11. 00	01100 CAFETERI A	-591, 276			11. 00
13.00	01300 NURSI NG ADMI NI STRATI ON	-4, 470, 298			13.00
14. 00 15. 00	01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY	-961, 182 984, 600	-119, 436 3, 964, 816		14. 00 15. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	1, 411, 168	1, 411, 366		16. 00
17. 00	01700 SOCIAL SERVICE	0	0		17. 00
18. 00	01080 I NSERVI CE EDUCATI ON	0	0		18. 00
19. 00	01900 NONPHYSI CI AN ANESTHETI STS	0	0		19. 00
20.00	02000 NURSI NG PROGRAM	0	0		20.00
21. 00 22. 00	02100 &R SERVICES-SALARY & FRINGES APPRV 02200 &R SERVICES-OTHER PRGM COSTS APPRV	0	0		21. 00 22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0	0		23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDI ATRI CS	-9, 494			30.00
31. 00	03100 INTENSIVE CARE UNIT	-747	3, 918, 182		31. 00
32. 00	03200 CORONARY CARE UNIT	0	0		32. 00
33. 00 34. 00	03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT	0	0		33. 00 34. 00
40. 00	04000 SUBPROVI DER - I PF	-266, 340	1, 911, 441		40.00
41. 00	04100 SUBPROVI DER - I RF	0	0		41. 00
43.00	04300 NURSERY	0	634, 109		43.00
44. 00	04400 SKILLED NURSING FACILITY	0	0		44. 00
45. 00	04500 NURSI NG FACILITY	0	0		45. 00
46. 00	04600 OTHER LONG TERM CARE ANCI LLARY SERVICE COST CENTERS	0	0		46. 00
50. 00	05000 OPERATI NG ROOM	-661, 538	8, 820, 674		50.00
51. 00	05100 RECOVERY ROOM	0	0		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	1, 137, 038		52. 00
53.00	05300 ANESTHESI OLOGY	-3, 310, 639	101, 125		53. 00
54. 00	05400 RADI OLOGY - DI AGNOSTI C	-9, 819	4, 323, 228		54.00
54. 01 55. 00	05401 FSED RADI OLOGY - DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	-5, 324 -1, 590	1, 356, 071 1, 205, 533		54. 01 55. 00
55. 00	05501 WOODLAND CANCER CARE CTR	-1, 590	398, 598		55. 01
56. 00	05600 RADI OI SOTOPE	0	0		56. 00
57.00	05700 CT SCAN	0	O		57. 00
58. 00		0	0		58. 00
	05900 CARDI AC CATHETERI ZATI ON	0	.,,		59.00
60. 00 60. 01	06000 LABORATORY 06001 FS ED LAB	-25, 195	11, 056, 791		60. 00 60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0		61.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	o		62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	o		63. 00
63. 01	06301 FS ED BLOOD BANK	0	0		63. 01
64. 00	06400 I NTRAVENOUS THERAPY	0	0		64. 00
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	-24	1, 888, 691 3, 080, 759		65. 00 66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	3,000,739		67. 00
68. 00	06800 SPEECH PATHOLOGY	0	o		68. 00
69. 00		0	1, 091, 280		69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	o		70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	10, 108, 188		71. 00
72.00	07200 DDUCS CHARCED TO PATIENTS	0	11, 021, 027		72.00
73. 00 74. 00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS		27, 170, 064		73. 00 74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0	0		75. 00
76. 00		-102, 386	456, 849		76. 00
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0		77. 00
	OUTPATIENT SERVICE COST CENTERS	1			
88. 00	08800 RURAL HEALTH CLINIC	0	0		88. 00
89. 00 90. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC	0			89. 00 90. 00
90.00	09000 CLINIC 09003 INFUSION OP SERVICES		1, 511, 354		90.00
91. 00		-535, 912			91.00
	i I		1		•

 Heal th Financial
 Systems
 FRANCISCAN HEALTH MI CHIGAN CITY

 RECLASSIFICATION
 AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES
 Provider CCM
 In Lieu of Form CMS-2552-10 Provider CCN: 15-0015

			4/13/2023	
Cost Center Description	Adjustments	Net Expenses	17 107 2020	77.10
, , , , , , , , , , , , , , , , , , ,		or Allocation		
	6.00	7. 00		
91. 01 09101 FREE STANDING EMERGENCY DEPT	-325, 617	2, 344, 151		91. 01
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART				92. 00
OTHER REIMBURSABLE COST CENTERS				
94.00 09400 HOME PROGRAM DIALYSIS	0	0		94. 00
95. 00 09500 AMBULANCE SERVICES	0	0		95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0		97. 00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0		98. 00
99. 00 09900 CMHC	0	0		99. 00
99. 10 09910 CORF	0	0		99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	o		100. 00
101.00 10100 HOME HEALTH AGENCY	o	o		101. 00
102.00 10200 OPIOID TREATMENT PROGRAM	o	o		102. 00
SPECIAL PURPOSE COST CENTERS				
105. 00 10500 KIDNEY ACQUISITION	0	0		105. 00
106.00 10600 HEART ACQUISITION	0	0		106. 00
107.00 10700 LIVER ACQUISITION	o	0		107. 00
108.00 10800 LUNG ACQUISITION	o	0		108. 00
109.00 10900 PANCREAS ACQUISITION	o	0		109. 00
110.00 11000 INTESTINAL ACQUISITION	o	0		110. 00
111.00 11100 I SLET ACQUI SI TI ON	o	o		111. 00
113.00 11300 INTEREST EXPENSE	o	o		113. 00
114.00 11400 UTILIZATION REVIEW-SNF	o	o		114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	o	o		115. 00
116. 00 11600 HOSPI CE	o	o		116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	-24, 218, 394	234, 123, 883		118. 00
NONREI MBURSABLE COST CENTERS				
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	55, 451		190. 00
191. 00 19100 RESEARCH	0	0		191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	-141, 647		192. 00
193. 00 19300 NONPALD WORKERS	0	0		193. 00
194.00 07950 BEACON JOINT VENTURE	0	3, 482		194. 00
194. 01 07951 WORKI NG WELL	0	440, 739		194. 01
194.03 07953 MED WATCHER	0	0		194. 03
194. 10 07960 DUNELAND FITNESS CTR	0	0		194. 10
194.11 07961 OMNI HEALTH & FITNESS CHESTERTOWN	-921, 999	-656		194. 11
194.16 07966 PHYSICIAN PRACTICE MD WISW	0	59, 061		194. 16
194. 19 07969 HEALTH PARTNERS	0	0		194. 19
194.20 07970 CENTER OF HOPE	0	31, 311		194. 20
200.00 TOTAL (SUM OF LINES 118 through 199)	-25, 140, 393	234, 571, 624		200. 00

Health Financial Systems RECLASSIFICATIONS Peri od: Worksheet A-6 From 01/01/2022 To 12/31/2022 Date/Time Prepared: Provider CCN: 15-0015

Cord Center						4/13/2023 4	
1.00 AURILLA COSTS-MURIC EQUIP 2.00 0 3.301.007 1.00			Increases				
A CAPITAL CA							
1.00			3. 00	4.00	5. 00		
1.00	4 00		0.00		40 004 007		4 00
1.00	1.00	CAP KET COSTS-WARTE EGOLD					1.00
1.00		D CAFETEDIA		U	13, 301, 007		_
1.00	1 00		11 00	1 177 011	660 F10		1 00
C -	1.00	CALLERIA — — — —					1.00
1.00		C - IMPLANTABLE DEVICES		1, 177, 711	007, 310		
NATIONAL SUPPLIES 0 11,027,027	1 00		72 00	0	11 021 027		1 00
			72.00	٩	, 02., 02.		
- MEDICAL SUPPLIES (JAMACH DID 71 OF 0 21,179,215 22,00 32,446 22,00 4					11, 021, 027		
ATTENT A		D - MEDICAL SUPPLIES	<u> </u>				
ATTENT A	1.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	21, 129, 215		1. 00
3.00 67HRAL SERVICES & SUPPLY 1.4 .00 5.00 6.00 6.00 6.00 6.00 6.00 6.00 6		PATI ENT					
4.00 5.00 6.00 6.00 6.00 6.00 6.00 6.00 6	2.00		•	0			2. 00
5.00 6.00 7.00 0.00 0.00 0.00 0.00 0.00 0	3.00	CENTRAL SERVICES & SUPPLY	14. 00	•	88, 780		3. 00
6.00					0		1
7. 00 8. 00 9. 00					-		1
B					0		1
9.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 11.00 1					0		
10.00					-		
11.00					-		
12.00					-		
13.00					-		
14. 00			I .		-		
15. 00 16. 00 17. 00 18. 00 17. 00 18. 00 17. 00 18. 00 19. 00 1					-		
16. 00					-		
17. 00 18. 00 19. 00 0 0 0 0 19. 00 19.					-		
18, 00 18, 00 0, 00 0 0 0 0 0 0				•	-		1
19,00 19,00 20,00 20,00 20,00 21,00 22,00 22,00 22,00 22,00 22,00 22,00 22,00 22,00 22,00 22,00 23,00 24,00 24,00 25,00 26,00 27,00 26,00 27,00					-		
20,00					-		
21.00 0.00 0 0 0 22.00 23.00 0.00 0 0 22.00 23.00 0.00 0 0 0 0 24.00 25.00 0.00 0 0 0 0 0 25.00 0.00 0 0 0 0 0 25.00 27.00 0 0 0 0 0 0 0 0 0					-		4
22.00 0.00 0.00 0 0 22.00 23.00 24.00 0.00 0 0 0 22.00 24.00 0.00 0 0 0 0 25.00 25.00 0.00 0 0 0 0 0 25.00 25.00 0.00 0 0 0 0 0 25.00 25.00 0.00 0 0 0 0 0 27.00 27.00 0 0 0 0 0 0 0 0 0			•	•	-		1
23.00				•	0		1
25.00 0.00 0 0 0 25.00 26.00 27.00 26.00 27.00				o	0		1
26. 00	24.00		0.00	o	0		24. 00
27.00 0 0 0 21,250,441	25.00		0.00	o	0		25. 00
C F - NURSERY AND L&D S21, 250, 441 S2 S44, 468 S2 S57, 623 S	26.00		0.00	o	0		26. 00
E - NURSERY NOD L&D	27. 00		0. 00	0	0		27. 00
1.00 NURSERY		0		0	21, 250, 441		
DELIVERY ROOM & LABOR ROOM 52.00 779,056 357,982 557,623 DEPRECIATION		E - NURSERY AND L&D					
Total Content of the Content of th							
F - DEPRECIATION CAP REL COSTS-BLDG & FIXT 1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 10.00 11.00 11.00 12.00 13.00 14.00 15.00 14.00 15.00 16.00 17.00 18.00 17.00 18.00 19.00 10.00 10.00 11.00 11.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 17.00 18.00 19.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 11.00 12.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00 19.00 10.00 0.	2. 00	DELIVERY ROOM & LABOR ROOM	52.00				2. 00
1. 00 CAP REL COSTS-BLDG & FIXT				1, 213, 524	557, 623		_
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Health Financial Systems RECLASSIFICATIONS In Lieu of Form CMS-2552-10
Worksheet A-6 FRANCISCAN HEALTH MICHIGAN CITY Provider CCN: 15-0015 Peri od: From 01/01/2022 To 12/31/2022 Date/Time Prepared: 4/13/2023 4:18 pm Increases Line # Cost Center Salary Other

	Cost Center	Line #	Sarary	otner		
	2. 00	3. 00	4. 00	5.00		
30. 00		0.00	0	0	3	30. 00
				20, 398, 228		
	G - INTEREST			., ,		
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	10, 443, 351		1. 00
	0	— — — †		10, 443, 351		
	H - DRUGS & PHARM		<u> </u>	107 1 107 00 1		
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	27, 170, 064		1. 00
2.00	CENTRAL SERVICES & SUPPLY	14. 00	0	965		2. 00
3.00	BEACON JOINT VENTURE	194. 00	ō	3, 852		3. 00
4. 00	Erissii seiii teiteile	0.00	o	0,002		4. 00
5. 00		0.00	o	0		5. 00
6. 00		0.00	Ö	0		6. 00
7. 00		0.00	Ö	0		7. 00
8. 00		0.00	Ö	0		8. 00
9. 00		0.00	Ö	0		9. 00
10. 00		0.00	Ö	0		10. 00
11. 00		0.00	0	0		11. 00
12. 00		0.00	0	0		12. 00
13. 00		0.00	0	0		13. 00
14. 00		0.00	0	0		14. 00
15. 00		0.00	0	0		15. 00
16. 00		0.00	0	0		16. 00
17. 00		0.00	0	0		17. 00
18. 00		0.00	0	0		18. 00
19. 00		0.00	0	0		19. 00
20. 00		0.00	0	0		20. 00
21. 00		0.00	0	0		20. 00 21. 00
21.00		0.00	0	0		21. 00 22. 00
			U	0		
23. 00		0.00				23. 00
	U WORKING WELL		0	27, 174, 881		
1 00	I - WORKING WELL	4 00	/7E 0E0	2/0 224		1 00
1. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	675, 958	<u>368, 294</u>		1. 00
F00 00	U Constant		675, 958	368, 294		00 00
500.00	Grand Total: Increases		3, 067, 393	105, 184, 362	50	00. 00

Provider CCN: 15-0015

Peri od: From 01/01/2022 To 12/31/2022 Date/Ti me Prepared: 4/13/2023 4:18 pm

						4/13/2023 4: 1	8 pm
		Decreases					
	Cost Center	Li ne #	Sal ary		Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
	A - CAPITAL						
1. 00	CAP REL COSTS-BLDG & FIXT	1.00	0_	<u>13, 301, 0</u> 07	9		1. 00
	0		0	13, 301, 007			
	B - CAFETERIA						
1.00	DI ETARY	10. 00	1, 177, 911	669, 510	0		1. 00
	0 = = = = = =	$ \top$	1, 177, 911	669, 510	1		
	C - IMPLANTABLE DEVICES						
1.00	MEDICAL SUPPLIES CHARGED TO	71.00	0	11, 021, 027	0		1. 00
	PATI ENT		1	,,	1		
				11, 021, 027			
	D - MEDICAL SUPPLIES			,,			
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	38, 199	0		1. 00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	59, 489	0		2. 00
3.00	OPERATION OF PLANT	7.00	0	65, 886	0		3. 00
		8.00	0		0		1
4.00	LAUNDRY & LINEN SERVICE	· ·	٩	292	-		4. 00
5.00	HOUSEKEEPI NG	9.00	0	8, 508	0		5. 00
6. 00	DI ETARY	10.00	0	9, 616	0		6. 00
7. 00	PHARMACY	15. 00	0	150, 030	0		7. 00
8. 00	ADULTS & PEDIATRICS	30.00	0	1, 054, 918	0		8. 00
9.00	INTENSIVE CARE UNIT	31.00	0	336, 513	0		9. 00
10. 00	SUBPROVI DER - I PF	40.00	0	5, 581	0		10. 00
11. 00	OPERATING ROOM	50.00	0	12, 795, 002	0		11. 00
12.00	RADI OLOGY-DI AGNOSTI C	54.00	0	716, 679	0		12. 00
13.00	FSED RADIOLOGY - DIAGNOSTIC	54. 01	0	51, 564	0		13. 00
14.00	RADI OLOGY-THERAPEUTI C	55.00	o	381, 726	0		14. 00
15. 00	WOODLAND CANCER CARE CTR	55. 01	o	91, 851	0		15. 00
16. 00	CARDIAC CATHETERIZATION	59.00	0	3, 703, 886	0		16. 00
17. 00	LABORATORY	60.00	o	588, 093	0		17. 00
18. 00	RESPIRATORY THERAPY	65.00	Ö	250, 063	0		18. 00
19. 00	PHYSICAL THERAPY	66.00	0		0		19. 00
	l control of the cont		1	26, 895	0		
20.00	ELECTROCARDI OLOGY	69.00	0	37, 356	-		20.00
21. 00	CLINIC	76. 00	0	645	0		21. 00
22. 00	INFUSION OP SERVICES	90. 03	0	115, 600	0		22. 00
23. 00	EMERGENCY	91.00	0	645, 038	0		23. 00
24. 00	FREE STANDING EMERGENCY DEPT	91. 01	0	93, 042	0		24. 00
25.00	OMNI HEALTH & FITNESS	194. 11	0	656	0		25. 00
	CHESTERTOWN						
26.00	BEACON JOINT VENTURE	194. 00	0	370	0		26. 00
27.00	WORKING WELL	194. 01	0	22, 943	0		27. 00
				21, 250, 441			
	E - NURSERY AND L&D						
1.00	ADULTS & PEDIATRICS	30.00	1, 213, 524	557, 623	0		1. 00
2. 00		0.00	0	0	o		2. 00
2.00		— — - : : : : +	1, 213, 524	557, 623			2.00
	F - DEPRECIATION	L	1, 210, 024	337, 023			
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	136, 335	9		1. 00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	4, 510, 533	0		2. 00
	1 1	i i	- 1				
3.00	OPERATION OF PLANT	7. 00	0	9, 008, 784	0		3. 00
4. 00	LAUNDRY & LINEN SERVICE	8. 00	0	1, 178	0		4. 00
5. 00	HOUSEKEEPI NG	9. 00	0	79, 955	0		5. 00
6. 00	DI ETARY	10.00	0	25, 692	0		6. 00
7.00	NURSING ADMINISTRATION	13. 00	0	58, 824	0		7. 00
8.00	CENTRAL SERVICES & SUPPLY	14. 00	0	224, 319	0		8. 00
9.00	PHARMACY	15. 00	0	14, 131	0		9. 00
10.00	ADULTS & PEDIATRICS	30.00	0	603, 398	0		10. 00
11. 00	INTENSIVE CARE UNIT	31.00	О	118, 139	0		11. 00
12. 00	SUBPROVI DER - I PF	40.00	O	24, 898	o		12. 00
13. 00	OPERATING ROOM	50.00	o	1, 849, 634	o		13. 00
14. 00	ANESTHESI OLOGY	53.00	0	40, 218	0		14. 00
15. 00	RADI OLOGY-DI AGNOSTI C	54.00	0	996, 950	0		15. 00
16. 00	FSED RADIOLOGY - DIAGNOSTIC	54. 00	O O	174, 694	0		16. 00
		· ·	- 1				1
17. 00	RADI OLOGY-THERAPEUTI C	55.00	0	420, 418	0		17. 00
18.00	CARDIAC CATHETERIZATION	59.00	0	487, 379	0		18. 00
19. 00	LABORATORY	60.00	0	138, 581	0		19. 00
20. 00	FS ED LAB	60. 01	0	307	0		20. 00
21. 00	RESPI RATORY THERAPY	65. 00	0	73, 239	0		21. 00
22. 00	PHYSI CAL THERAPY	66. 00	0	179, 244	0		22. 00
23.00	ELECTROCARDI OLOGY	69.00	0	111, 952	0		23. 00
24.00	CLINIC	76.00	О	7, 593	0		24. 00
25. 00	INFUSION OP SERVICES	90. 03	0	24, 732	0		25. 00
26. 00	EMERGENCY	91.00	o	130, 768	o		26. 00
27. 00	FREE STANDING EMERGENCY DEPT	91. 01	Ö	663, 263	0		27. 00
28. 00	PHYSICIANS' PRIVATE OFFICES	192.00	o	172, 899	0		28. 00
29. 00	WORKING WELL	194. 01	0	117, 366	0		29. 00
27.00	MOUNTING MEET	174.01	Ч	117, 300	U _I		27.00

Health Financial Systems RECLASSIFICATIONS Period: Worksheet A-6
From 01/01/2022
To 12/31/2022 Date/Time Prepared: 4/13/2023 4:18 pm Provider CCN: 15-0015

						4/13/2023 4:18 pm
		Decreases				
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref.	
	6. 00	7. 00	8.00	9. 00	10. 00	
30.00	CENTER OF HOPE	194. 20	0		0	30.
	0		0	20, 398, 228		
	G - INTEREST					
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	10, 443, 351	11	1.
		- $ +$	0	10, 443, 351		
	H - DRUGS & PHARM					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	77, 455	0	1.
2.00	ADMINISTRATIVE & GENERAL	5. 00	o	590	o	2.
3.00	OPERATION OF PLANT	7.00	o	434	.l o	3.
4.00	NURSING ADMINISTRATION	13.00	o	472	el o	4.
5.00	PHARMACY	15. 00	o	24, 121, 211	O	5.
6.00	ADULTS & PEDIATRICS	30.00	O	98, 712	el o	6.
7.00	INTENSIVE CARE UNIT	31.00	O	42, 929	o	7.
8.00	SUBPROVI DER - I PF	40.00	O	121	0	8.
9.00	OPERATING ROOM	50.00	O	94, 724	. 0	9.
10.00	ANESTHESI OLOGY	53.00	O	28, 553	o	10.
11.00	RADI OLOGY-DI AGNOSTI C	54.00	0	14, 871	0	11.
12.00	FSED RADIOLOGY - DIAGNOSTIC	54. 01	0	977	o	12.
13.00	RADI OLOGY-THERAPEUTI C	55. 00	0	14, 263	o	13.
14.00	WOODLAND CANCER CARE CTR	55. 01	0	9, 014	. 0	14.
15.00	CARDI AC CATHETERI ZATI ON	59. 00	o	9, 396	ol ol	15.
16.00	LABORATORY	60.00	0	2, 970	o	16.
17.00	RESPIRATORY THERAPY	65.00	o	138	o	17.
18. 00	PHYSI CAL THERAPY	66.00	o	343	1	18.
19. 00	ELECTROCARDI OLOGY	69.00	o	398	1	19.
20.00	INFUSION OP SERVICES	90. 03	o	2, 504, 649	o	20.
21. 00	EMERGENCY	91.00	o	31, 334	1	21.
22. 00	FREE STANDING EMERGENCY DEPT	91. 01	0	6, 207	1	22.
23. 00	WORKING WELL	194. 01	0	115, 120		23.
		— — · · · · †		<u>27, 174, 881</u>		
	I - WORKING WELL		91	,,		
1.00	WORKING WELL	194. 01	675, 958	368, 294	. 0	1.
		+	675, 958	368, 294		
500.00	Grand Total: Decreases		3, 067, 393	105, 184, 362		500.

					To 12/31/2022		
				Acqui si ti ons			
		Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances				Retirements	
		1.00	2. 00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
1.00	Land	9, 737, 278	5, 771, 688		0 5, 771, 688		1. 00
2.00	Land Improvements	5, 472, 756	453, 580		0 453, 580		2. 00
3.00	Buildings and Fixtures	317, 720, 603	7, 616, 474		0 7, 616, 474	3, 232, 235	3. 00
4.00	Building Improvements	0	0		0	0	4. 00
5.00	Fi xed Equi pment	62, 375, 932	52, 521		0 52, 521	5, 445, 725	5.00
6.00	Movable Equipment	79, 268, 294	6, 070, 941		0 6, 070, 941	-9, 022, 359	6. 00
7.00	HIT designated Assets	0	0		0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	474, 574, 863	19, 965, 204		0 19, 965, 204		8. 00
9.00	Reconciling Items	-9, 335, 651	-72, 282		0 -72, 282	-7, 736, 140	9. 00
10.00	Total (line 8 minus line 9)	483, 910, 514	20, 037, 486		0 20, 037, 486	13, 133, 452	10.00
		Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
	T	6.00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET		_				
1.00	Land	9, 491, 736	0				1. 00
2.00	Land Improvements	6, 201, 855	2, 694, 002				2. 00
3.00	Buildings and Fixtures	322, 104, 842	33, 853, 333				3. 00
4.00	Building Improvements	0	0				4. 00
5.00	Fixed Equipment	56, 982, 728	33, 330, 995				5. 00
6.00	Movable Equipment	94, 361, 594	24, 883, 624				6. 00
7.00	HIT designated Assets	0	0				7. 00
8.00	Subtotal (sum of lines 1-7)	489, 142, 755	94, 761, 954				8. 00
9.00	Reconciling Items	-1, 671, 793	0				9. 00
10.00	Total (line 8 minus line 9)	490, 814, 548	94, 761, 954			ļ	10.00

Heal th	Financial Systems FR	ANCISCAN HEALTI	H MICHIGAN CIT	Υ	In Lie	u of Form CMS-2	2552-10
RECONC	ELLIATION OF CAPITAL COSTS CENTERS		Provi der C	CCN: 15-0015	Peri od: From 01/01/2022 To 12/31/2022		pared:
			S	UMMARY OF CAP	'I TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)		
		9. 00	10.00	11. 00	12.00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM	IN 2, LINES 1 a	and 2			
1.00	CAP REL COSTS-BLDG & FLXT	0	(-26, 2	1, 861, 137	0	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	()	0 0	0	2. 00
3.00	Total (sum of lines 1-2)	0	(-26, 2	12 1, 861, 137	0	3. 00
		SUMMARY O	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum	n			
		Capi tal -Relate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14. 00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM		and 2			
1.00	CAP REL COSTS-BLDG & FLXT	0	1, 834, 925	5			1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	()			2. 00
3.00	Total (sum of lines 1-2)	0	1, 834, 925	5			3. 00

Health Financial Systems	FRANCISCAN HEALT	H MICHIGAN CITY	Y	In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der C	F	Period: From 01/01/2022 Fo 12/31/2022	Worksheet A-7 Part III Date/Time Prep 4/13/2023 4:18	oared:
	COM	PUTATION OF RAT	TIOS	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi talized Leases	Gross Assets for Ratio (col. 1 - col. 2)		Insurance	
DADT III DESCRIPTION OF OLD TA	1.00	2. 00	3. 00	4. 00	5. 00	
PART III - RECONCILIATION OF CAPITAL 1.00 CAP REL COSTS-BLDG & FIXT	COSTS CENTERS	V 0	J	1.000000	0	1. 00
2.00 CAP REL COSTS-BLDG & FIXT				0.000000	·	2.00
3.00 Total (sum of lines 1-2)				1. 000000		3. 00
5.55 1.5ta. (5a 51 1.1.155 1.2)	ALLOCA	TION OF OTHER (CAPI TAL		F CAPITAL	0.00
Cost Center Description	Taxes	Other Capital-Relate d Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
	6. 00	7. 00	8. 00	9. 00	10.00	
PART III - RECONCILIATION OF CAPITAL	COSTS CENTERS					
1.00 CAP REL COSTS-BLDG & FLXT	0	0	(7, 776, 342		1. 00
2.00 CAP REL COSTS-MVBLE EQUIP	0	0		13, 301, 007		2. 00
3.00 Total (sum of lines 1-2)	0	0	JMMARY OF CAPI	21, 077, 349	0	3. 00
		50	JIVIIVIARY OF CAPI	IAL		
Cost Center Description	Interest	Insurance (see instructions)	,	Capi tal -Rel ate d Costs (see	Total (2) (sum of cols. 9 through 14)	
	11.00	12.00	12.00	instructions)	15.00	
PART III - RECONCILIATION OF CAPITAL	11.00	12. 00	13.00	14. 00	15. 00	
1.00 CAP REL COSTS-BLDG & FIXT	1, 946, 948	1, 861, 137		0	11, 584, 427	1. 00
2. 00 CAP REL COSTS-MVBLE EQUIP	1, 740, 740	1,001,137			13, 301, 007	2.00
3.00 Total (sum of lines 1-2)	1, 946, 948	1, 861, 137			24, 885, 434	

| Period: | Worksheet A-8 | From 01/01/2022 | To 12/31/2022 | Date/Time Prepared:

					o 12/31/2022		pared:
				Expense Classification on	Worksheet A	4/13/2023 4: 18	3 pm
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
1.00	Investment income - CAP REL	1.00	2.00	3.00 CAP REL COSTS-BLDG & FLXT	4. 00	5. 00 0	1. 00
1.00	COSTS-BLDG & FIXT (chapter 2)		U	CAP REL CUSTS-BLDG & FIXT	1.00	o o	1.00
2.00	Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	2. 00
3.00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other	В	0	CAP REL COSTS-BLDG & FIXT	1.00	11	3. 00
4 00	(chapter 2) Trade, quantity, and time		0		0.00	0	4 00
4. 00	di scounts (chapter 8)		0		0.00		4. 00
5.00	Refunds and rebates of expenses (chapter 8)	В	0	ADMINISTRATIVE & GENERAL	5. 00	0	5. 00
6.00	Rental of provider space by		0		0.00	0	6. 00
7. 00	suppliers (chapter 8) Telephone services (pay		0		0.00	0	7. 00
7.00	stations excluded) (chapter		O		0.00	Ŭ	7.00
8. 00	21) Television and radio service		0		0.00	0	8. 00
	(chapter 21)		, and the second				
9. 00 10. 00	Parking Lot (chapter 21) Provider-based physician	A-8-2	0 9, 821, 605-		0.00	0	9. 00 10. 00
	adj ustment						
11. 00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11. 00
12. 00	Related organization	A-8-1	-1, 567, 125			О	12.00
13. 00	transactions (chapter 10) Laundry and linen service		0		0.00	0	13. 00
14.00	Cafeteria-employees and guests		-564, 730	CAFETERI A	11. 00	0	14.00
15. 00	Rental of quarters to employee and others		0		0.00	0	15. 00
16. 00	Sale of medical and surgical		0		0. 00	О	16. 00
	supplies to other than patients						
17. 00	Sale of drugs to other than patients		0		0.00	0	17. 00
18. 00	Sale of medical records and	В	-13	ADMINISTRATIVE & GENERAL	5. 00	0	18. 00
19. 00	abstracts Nursing and allied health		0		0.00	0	19. 00
	education (tuition, fees,						
20. 00	books, etc.) Vending machines	В	-26, 546	CAFETERI A	11. 00	0	20. 00
21. 00	Income from imposition of		0		0.00	0	21. 00
	interest, finance or penalty charges (chapter 21)						
22. 00	Interest expense on Medicare overpayments and borrowings to		0		0.00	0	22. 00
	repay Medicare overpayments						
23. 00	Adjustment for respiratory therapy costs in excess of	A-8-3	0	RESPIRATORY THERAPY	65. 00		23. 00
	limitation (chapter 14)						
24. 00	Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSI CAL THERAPY	66. 00		24. 00
	limitation (chapter 14)						
25. 00	Utilization review - physicians' compensation		0	UTILIZATION REVIEW-SNF	114. 00		25. 00
000	(chapter 21)			0.5 051 00070 0100 0 5147			0.4.00
26. 00	Depreciation - CAP REL COSTS-BLDG & FLXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26. 00
27. 00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	27. 00
28. 00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19. 00		28. 00
29. 00 30. 00	Physicians' assistant Adjustment for occupational	A-8-3	0	OCCUPATI ONAL THERAPY	0. 00 67. 00	0	29. 00 30. 00
30.00	therapy costs in excess of	A-0-3	0	DOOG! ATTOMAL THERAFT	67.00		30.00
30. 99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30. 99
	instructions)						
31. 00	Adjustment for speech pathology costs in excess of	A-8-3	0	SPEECH PATHOLOGY	68. 00		31. 00
32. 00	limitation (chapter 14)		0		0.00	0	32. 00
	Depreciation and Interest		_				
33. 00	PROPERTY RENTAL	В	-16, 640	OPERATING ROOM	50.00	0	33. 00

Provider CCN: 15-0015 Peri od: Worksheet A-8 From 01/01/2022 | To 12/31/2022 | Date/Time Prepared:

				T	o 12/31/2022	Date/Time Prep	
				Expense Classification on	Workshoot A	4/13/2023 4: 18	5 piii
				To/From Which the Amount is			
				TO/FI OIII WITCH THE AMOUNT IS	to be Aujusteu		
	Coot Conton Decemention	Dagi a (Cada (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
	Cost Center Description	Basi s/Code (2) 1.00	Amount 2.00	3.00	4. 00	5. 00	
34. 00	RENTAL INCOME	B		ADMI NI STRATI VE & GENERAL			34. 00
	II		·	l e e e e e e e e e e e e e e e e e e e	5. 00 5. 00	0	
35. 00 36. 00	RETAIL SERVICES	B B		ADMINISTRATIVE & GENERAL		0	35. 00
	SHARED SAVINGS	В	·	ADMINISTRATIVE & GENERAL	5. 00		36.00
37. 00	PROPERTY RENTAL			OPERATION OF PLANT	7.00	0	37. 00
38. 00	ADVERTISING EXPENSE	A		EMPLOYEE BENEFITS DEPARTMENT	4.00	ı v	38. 00
40.00	ADVERTISING EXPENSE	A	·	ADMINISTRATIVE & GENERAL	5.00	0	40.00
41. 00	LOBBYING	A	·	ADMINISTRATIVE & GENERAL	5. 00	0	41. 00
42. 00	OTHER NON-OPERATING EXPENSE	A		ADMINISTRATIVE & GENERAL	5. 00	0	42. 00
45. 00	ADVERTI SI NG EXPENSE	A	·	OPERATION OF PLANT	7.00	0	45. 00
47. 00	ADVERTISING EXPENSE	A		ADMINISTRATIVE & GENERAL	5. 00	0	47. 00
48. 00	PROGRAM FEES	В		PHARMACY	15. 00	0	48. 00
49. 00	HAF PROVIDER TAX	A		ADMINISTRATIVE & GENERAL	5. 00	0	49. 00
49. 01	PENSI ON	A	·	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	49. 01
49. 02	ADVERTISING EXPENSE	A		EMERGENCY	91. 00	0	49. 02
49. 03	DI SCOUNTS EARNED/REBATES	В		CENTRAL SERVICES & SUPPLY	14. 00	0	49. 03
49. 04	DI SCOUNTS EARNED/REBATES	В		DI ETARY	10.00	0	49. 04
49. 05	DI SCOUNTS EARNED/REBATES	В	·	PHARMACY	15. 00	0	49. 05
49. 06	MI SCELLANEOUS - OTHER	В	-3, 298	RADI OLOGY-DI AGNOSTI C	54. 00	0	49. 06
	OPERATI NG						
49. 07	DI SCOUNTS EARNED/REBATES	В	·	RADI OLOGY-DI AGNOSTI C	54. 00	0	49. 07
49. 08	MI SCELLANEOUS - OTHER	В	-8, 108	ADULTS & PEDIATRICS	30.00	0	49. 08
	OPERATI NG	_					
49. 09	DI SCOUNTS EARNED/REBATES	В		RESPI RATORY THERAPY	65. 00	0	49. 09
49. 10	MI SCELLANEOUS - OTHER	В	-253, 826	ADMINISTRATIVE & GENERAL	5. 00	0	49. 10
	OPERATI NG						
49. 11	ADVERTISING EXPENSE	A		HOUSEKEEPI NG	9. 00	0	49. 11
49. 12	ADVERTISING EXPENSE	A		DI ETARY	10.00	0	49. 12
49. 13	MI SCELLANEOUS - OTHER	В	-44, 185	PHARMACY	15. 00	0	49. 13
	OPERATI NG	_				_	
49. 14	OMNI REVENUE	В	-921, 999	OMNI HEALTH & FITNESS	194. 11	0	49. 14
40.45	MI COEL LANGOUC OTUED		4 750	CHESTERTOWN	E4 04		40.45
49. 15	MI SCELLANEOUS - OTHER	В	-4, /50	FSED RADIOLOGY - DIAGNOSTIC	54. 01	0	49. 15
40 17	OPERATING	В	140	EMDLOVEE DENEELTS DEDADTMENT	4 00	0	40 17
49. 16	MI SCELLANEOUS - OTHER	В	- 140	EMPLOYEE BENEFITS DEPARTMENT	4.00	U	49. 16
49. 17	OPERATI NG	Δ .	1 500	DADLOLOGY THEDADELITIC	FF 00		49. 17
	ADVERTISING EXPENSE	A	·	RADI OLOGY-THERAPEUTI C	55.00	0	
49. 18 49. 19	ADVERTISING EXPENSE	A		NURSI NG ADMI NI STRATI ON	13.00	0	49. 18
	ADVERTISING EXPENSE	A		PHARMACY	15. 00	Ĭ	49. 19
49. 20	ADVERTISING EXPENSE	A	·	ADULTS & PEDIATRICS	30.00	0	49. 20
49. 21	ADVERTISING EXPENSE	A		INTENSIVE CARE UNIT	31.00	0	49. 21
49. 22	ADVERTISING EXPENSE	A		SUBPROVI DER - I PF	40.00	0	49. 22
49. 23	ADVERTISING EXPENSE	A		OPERATING ROOM	50.00	0	49. 23
49. 24	ADVERTISING EXPENSE	A		RADI OLOGY-DI AGNOSTI C	54.00	0	49. 24
49. 25	ADVERTISING EXPENSE	A		FSED RADIOLOGY - DIAGNOSTIC	54. 01	0	49. 25
50. 00	TOTAL (sum of lines 1 thru 49)		-25, 140, 393				50.00
	(Transfer to Worksheet A,						
	column 6, line 200.)						

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

⁽²⁾ Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

OFFICE COSTS

Provi der CCN: 15-0015

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

				To 12/31/2022	Date/Time Pre 4/13/2023 4:1	
	Li ne No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost	Included in	
					Wks. A, column	
					5	
	1. 00	2. 00	3. 00	4. 00	5. 00	
	A. COSTS INCURRED AND ADJUSTM	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OR	GANIZATIONS OR	CLAI MED	
	HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	I NTEREST	1, 922, 504	10, 392, 695	1. 00
2.00	1.00	CAP REL COSTS-BLDG & FIXT	ALLOWABLE NEW CAPITAL COSTS	2, 077, 517	1, 398, 396	2. 00
3.00	5. 00	ADMINISTRATIVE & GENERAL	ADMINISTRATIVE & GENERAL	32, 570, 674	28, 783, 867	3. 00
4.00	15. 00	PHARMACY	COEP / PHARMACY	316, 326	-709, 644	4.00
4.01	16. 00	MEDICAL RECORDS & LIBRARY	HI M	1, 411, 168	0	4. 01
5.00	TOTALS (sum of lines 1-4).			38, 298, 189	39, 865, 314	5.00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					
	line 12.					

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

1103 1101	been posted to worksheet A,	corullins i and/or 2, the allour	it allowable 311	ioura de marcatea m corumn 4	or this part.	
				Related Organization(s) and/	or Home Office	
	0 1 1 (1)					
	Symbol (1)	Name	Percentage of	Name	Percentage of	
			Ownershi p		Ownershi p	
	1. 00	2. 00	3. 00	4. 00	5. 00	
	B. INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HO	ME OFFICE:			
		2.00	3.00			

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.

. c. mou	TOTAL COMOTE WINDS CONTRACT						
6.00	В	100.00 0.00	6. 00				
7.00		0.00	7. 00				
8.00		0.00	8.00				
9.00		0.00	9. 00				
10.00		0.00	10.00				
100.00	G. Other (financial or		100.00				
	non-financial) specify:						

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

Heal th	Financial Syste	ems	FRANCISCAN H	EALTH MI	CHIGAN CITY		In Lie	u of Form Cl	MS-2552-10
STATEME	NT OF COSTS OF	SERVICES FROM	RELATED ORGANIZATIONS AND	HOME	Provider CCN:	: 15-0015	Peri od:	Worksheet	A-8-1
OFFICE	COSTS						From 01/01/2022 To 12/31/2022	Date/Ti me	Droparod:
							10 12/31/2022	4/13/2023	4:18 pm
	Net	Wkst. A-7 Ref.							
	Adjustments								
	(col. 4 minus								
	col. 5)*								
	6. 00	7. 00							
	A. COSTS INCUR	RED AND ADJUSTI	MENTS REQUIRED AS A RESULT	OF TRAI	NSACTIONS WITH	H RELATED O	RGANIZATIONS OR (CLAI MED	
	HOME OFFICE CO	STS:							
1.00	-8, 470, 191	11							1. 00
2.00	679, 121	9							2. 00
3.00	3, 786, 807	C							3. 00
4.00	1, 025, 970	C							4. 00

-1, 567, 125 The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part

4.01

5 00

1100 110 0	book postou to normanost //	cordinate i diagraf 27 the dimedite divender o chedita so that dated in cordinat i of this parti	
	Related Organization(s)		
	and/or Home Office		
	Type of Business		
	3.		
	6. 00		
	B. INTERRELATIONSHIP TO RELAT	FED 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	FRANCISCAN ALLI	6.00
7.00		7.00
8.00		8.00
9.00		9.00
10.00		10.00
9. 00 10. 00 100. 00		100.00

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

0

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

4.01

5.00

1, 411, 168

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 15-0015

Peri od: Worksheet A-8-2 From 01/01/2022 To 12/31/2022 Date/Time Prepared:

							4/13/2023 4: 1	8 pm
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component	
				'	•		Hours	
	1. 00	2.00	3.00	4.00	5. 00	6. 00	7. 00	
1.00	5. 00	ADMINISTRATIVE & GENERAL	146, 352	105, 027	41, 325	197, 500	34	1. 00
2.00	13. 00	NURSING ADMINISTRATION	4, 700, 248	4, 450, 501	249, 747	197, 500	2, 423	2. 00
3.00	40. 00	SUBPROVIDER - IPF	275, 438	262, 188	13, 250	181, 300	107	3.00
4.00		OPERATING ROOM	1, 248, 445	473, 001	775, 444	246, 400	5, 103	4.00
5. 00	53. 00	ANESTHESI OLOGY	3, 337, 226	3, 089, 476	247, 750	239, 400	231	5. 00
6. 00	60.00	LABORATORY	34, 205		34, 205		72	6. 00
7. 00		CLINIC	102, 386			1	0	7. 00
8. 00		EMERGENCY	534, 607		250		2	8. 00
9. 00		FREE STANDING EMERGENCY DEPT	325, 617		0		0	9. 00
10. 00	0.00		020,017	020,017	0	0	Ő	10.00
200.00	0.00		10, 704, 524	9, 342, 553	1, 361, 971	l ~	·	200. 00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physi ci an Cost	200.00
	WKSt. A LITIC #	I denti fi er	Li mi t	Unadjusted RCE			of Malpractice	
		T deliter i i ei	Li iiii t	Li mi t	Continuing	Share of col.	Insurance	
				Li iiii t	Educati on	12	Tribul dilec	
	1. 00	2.00	8, 00	9, 00	12. 00	13.00	14. 00	
1. 00		ADMINISTRATIVE & GENERAL	3, 228		0		0	1. 00
2. 00		NURSI NG ADMI NI STRATI ON	230, 069		0		0	2. 00
3. 00		SUBPROVI DER - I PF	9, 326		0		o o	3. 00
4. 00		OPERATING ROOM	604, 509		0		o o	4. 00
5. 00		ANESTHESI OLOGY	26, 587	1, 329	0	l ~	Ö	5. 00
6. 00		LABORATORY	9, 010		0	o o	Ö	6. 00
7. 00		CLI NI C	7,010	0	0	l ő	Ő	7. 00
8. 00		EMERGENCY	190		0	l ő	Ő	8. 00
9. 00		FREE STANDING EMERGENCY DEPT	170	0	0	l o	0	9. 00
10. 00	0.00		0	0	0	l o	0	10. 00
200.00	0.00		882. 919	44, 145	0	0	0	
200.00	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment	0	200.00
	WKSt. A LITIC #	I denti fi er	Component	Limit	Di sal I owance	Auj us tilicit		
		rucittifici	Share of col.		Di Sai i Owance			
			14					
	1. 00	2.00	15. 00	16. 00	17. 00	18. 00		
1. 00		ADMINISTRATIVE & GENERAL	0	3, 228	38, 097			1. 00
2. 00		NURSI NG ADMI NI STRATI ON	0		19, 678			2. 00
3. 00		SUBPROVI DER - I PF	0	9, 326	3, 924			3. 00
4. 00		OPERATI NG ROOM	l o	604, 509	170, 935			4. 00
5. 00		ANESTHESI OLOGY	0	26, 587	221, 163			5. 00
6. 00		LABORATORY		9, 010	25, 195			6. 00
7. 00		CLI NI C	0	9,010	25, 175			7. 00
8.00		EMERGENCY		190	60	· ·		7. 00 8. 00
9. 00		FREE STANDING EMERGENCY DEPT		190	0			9. 00
9. 00 10. 00	0.00				0	· ·		9. 00 10. 00
200.00	0.00		0	882, 919		l ~		200. 00
200.00	I	I	ı	002, 919	4/9,052	J 9, 021, 005		200.00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS FRANCISCAN HEALTH MICHIGAN CITY In Lieu of Form CMS-2552-10 Provider CCN: 15-0015

				To	12/31/2022	Date/Time Pre 4/13/2023 4:1	
			CAPI TAL REI	LATED COSTS		1, 10, 2020 11 1	ļ
	Cost Center Description	Net Expenses	BLDG & FLXT	MVBLE EQUIP	EMPLOYEE	Subtotal	
	COST CENTER DESCRIPTION	for Cost	DEDO & TTAT	MVDLL LQ011	BENEFITS	Subtotal	
		Allocation			DEPARTMENT		
		(from Wkst A col. 7)					
		0	1.00	2.00	4. 00	4A	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT	11, 584, 427	11, 584, 427				1.00
2. 00 4. 00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT	13, 301, 007 21, 211, 244	56, 396	13, 301, 007 248, 756	21, 516, 396		2. 00 4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL	41, 599, 580	1, 009, 070		5, 083, 424	49, 363, 884	5. 00
6.00	00600 MAINTENANCE & REPAIRS	0	0	0	0	0	6. 00
7. 00 8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	11, 933, 676 1, 478, 664	1, 916, 138 35, 197		993, 482 27, 271	16, 752, 716 1, 543, 269	1
9. 00	00900 HOUSEKEEPI NG	2, 386, 540	432, 997		450, 149	3, 415, 556	1
10. 00		960, 302	118, 314		164, 465	1, 289, 688	1
11.00		1, 256, 145	230, 317		305, 675	1, 792, 137	1
13. 00 14. 00		4, 204, 037 -119, 436	54, 640 426, 278		820, 673 64, 824	5, 154, 555 777, 021	1
15. 00		3, 964, 816	153, 638		733, 344	4, 874, 305	1
16. 00		1, 411, 366	17, 255	0	1, 786	1, 430, 407	
17. 00 18. 00		0	0	0	0	0	
19. 00		0	0	0	0	0	18. 00 19. 00
20. 00	• • • • • • • • • • • • • • • • • • •	o	Ö	Ö	0	0	20.00
21. 00		0	0	0	0	0	21. 00
22. 00 23. 00	• • • • • • • • • • • • • • • • • • •	0	0	0	0	0	22. 00 23. 00
23.00	I NPATIENT ROUTINE SERVICE COST CENTERS	ı o	0	0	U	0	23.00
30. 00	03000 ADULTS & PEDIATRICS	18, 875, 838	2, 144, 266	951, 024	4, 626, 268	26, 597, 396	30.00
31.00		3, 918, 182	341, 735	208, 560	927, 396	5, 395, 873	
32. 00 33. 00		0	0	0	0	0	
34. 00		0	0	0	0	0	34.00
40.00	04000 SUBPROVI DER - I PF	1, 911, 441	556, 604	36, 717	322, 940	2, 827, 702	40. 00
41. 00		0	105 413	0	110.747	0	
43. 00 44. 00		634, 109	105, 412 0		112, 747 0	852, 268 0	1
45. 00		Ö	0	Ö	0	0	1
46. 00		0	0	0	0	0	46. 00
50. 00	ANCI LLARY SERVI CE COST CENTERS 05000 OPERATI NG ROOM	8, 820, 674	1, 372, 844	3, 023, 967	1, 743, 021	14, 960, 506	50.00
51. 00		0, 020, 074	1, 372, 044	3, 023, 707	1, 743, 021	14, 700, 300	1
52. 00		1, 137, 038			202, 170	1, 527, 839	1
53.00		101, 125	4, 454		19, 389	197, 927	
54. 00 54. 01	• • • • • • • • • • • • • • • • • • •	4, 323, 228 1, 356, 071	506, 215 0	1, 807, 774 160, 262	1, 011, 697 339, 412	7, 648, 914 1, 855, 745	1
55.00	05500 RADI OLOGY-THERAPEUTI C	1, 205, 533	83, 092		147, 151	2, 139, 096	55. 00
	05501 WOODLAND CANCER CARE CTR	398, 598	51, 357	0	100, 559		1
56. 00 57. 00	05600	0	0	0	0	0	
58. 00		0	0	o	0	0	58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	1, 410, 746			223, 507	2, 653, 674	59. 00
60.00		11, 056, 791	212, 146	52, 213	0	11, 321, 150	
60. 01 61. 00	06001 FS ED LAB 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0		O	0	
62. 00			0	О	0	0	
63. 00	• • • • • • • • • • • • • • • • • • •	O	10, 027	0	0		63. 00
63. 01		0	0	0	0	0	
64. 00 65. 00	• • • • • • • • • • • • • • • • • • •	1, 888, 691	51, 052	150, 814	339, 794	0 2, 430, 351	
66. 00		3, 080, 759			248, 921	3, 416, 638	1
67. 00		0	0	0	0	0	
68.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	1 001 200	227 542	202 790	0 266, 851	0 1, 788, 454	
70.00		1, 091, 280	227, 543 0	202, 780 0	∠∪0, ୪၁ I N	1, 788, 454	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	10, 108, 188	Ö	o o	Ö	10, 108, 188	71.00
72.00		11, 021, 027	0	0	0	11, 021, 027	
	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	27, 170, 064	0	0	0	27, 170, 064 0	1
75. 00			0		0	0	1
76. 00	03020 CLI NI C	456, 849	0	8, 539	89, 290	554, 678	76. 00
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77. 00
88. 00	OUTPATIENT SERVICE COST CENTERS O8800 RURAL HEALTH CLINIC	0	0	0	0	0	88. 00
	· · · · · · · · · · · · · · · · · · ·	, -1		1			•

| Peri od: | Worksheet B | From 01/01/2022 | Part | | To 12/31/2022 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0015

			10	12/31/2022	Date/IIme Pre 4/13/2023 4:1	
		CAPI TAL REL	ATED COSTS		17 107 2020 1. 1	D DIII
Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Subtotal	
	for Cost			BENEFITS		
	Allocation			DEPARTMENT		
	(from Wkst A					
	col. 7) 0	1. 00	2. 00	4. 00	4A	
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89. 00
90. 00 09000 CLI NI C	o	0	0	0	0	90.00
90. 03 09003 INFUSION OP SERVICES	1, 511, 354	81, 769	41, 630	242, 369	1, 877, 122	90. 03
91. 00 09100 EMERGENCY	5, 129, 778	479, 442	235, 230	1, 148, 969	6, 993, 419	91. 00
91.01 09101 FREE STANDING EMERGENCY DEPT	2, 344, 151	544, 134	141, 150	446, 869	3, 476, 304	91. 01
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART					0	92. 00
OTHER REIMBURSABLE COST CENTERS						
94. 00 09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94. 00
95. 00 09500 AMBULANCE SERVICES	0	0	0	0	0	95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
97.00 09700 DURABLE MEDI CAL EQUI P-SOLD 98.00 09850 OTHER REI MBURSABLE COST CENTERS	0	0	0	O O	0	97. 00 98. 00
98.00 09850 OTHER REIMBURSABLE COST CENTERS 99.00 09900 CMHC	0	0	0	0	0	98.00
99. 10 09910 CORF	0	0	0	0	0	99. 10
100. 00 10000 I &R SERVI CES-NOT APPRVD PRGM	0	0	0	0	0	
101. 00 10100 HOME HEALTH AGENCY	o o	0	0	0	0	
102. 00 10200 OPI OI D TREATMENT PROGRAM	l o	0	0	0		102.00
SPECIAL PURPOSE COST CENTERS	-1		-1	-1		
105.00 10500 KIDNEY ACQUISITION	0	0	0	0	0	105. 00
106.00 10600 HEART ACQUISITION	0	0	0	0	0	
107.00 10700 LIVER ACQUISITION	0	0	0	0		107. 00
108.00 10800 LUNG ACQUISITION	0	0	0	0		108. 00
109. 00 10900 PANCREAS ACQUISITION	0	0	0	0	0	
110. 00 11000 I NTESTI NAL ACQUI SI TI ON	0	0	0	0		110.00
111. 00 11100 SLET ACQUI SITI ON	0	0	0	O	0	111.00
113. 00 11300 I NTEREST EXPENSE						113. 00 114. 00
114. 00 11400 UTILIZATION REVIEW-SNF 115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)		0			0	115.00
116. 00 11600 HOSPI CE	0	0	0	0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	234, 123, 883	11, 584, 427	13, 257, 521	21, 204, 413	233, 768, 414	
NONREI MBURSABLE COST CENTERS	201, 120, 000	11,001,127	10, 207, 021	21, 201, 110	200, 700, 111	1110.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	55, 451	0	0	0	55, 451	190. 00
191. 00 19100 RESEARCH	o	0	0	0	0	191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	-141, 647	0	0	516	-141, 131	192. 00
193.00 19300 NONPALD WORKERS	0	0	0	0	0	
194.00 07950 BEACON JOINT VENTURE	3, 482	0	0	0		194. 00
194. 01 07951 WORKI NG WELL	440, 739	0	38, 397	116, 944	596, 080	
194. 03 07953 MED WATCHER	0	0	0	0		194. 03
194. 10 07960 DUNELAND FITNESS CTR	0	0	0	0	0	
194. 11 07961 OMNI HEALTH & FITNESS CHESTERTOWN	-656	0	0	171, 277	170, 621	
194. 16 07966 PHYSICIAN PRACTICE MD WISW	59, 061	0	0	15, 121	74, 182	
194. 19 07969 HEALTH PARTNERS 194. 20 07970 CENTER OF HOPE	21 211	0	5, 089	0 125		194. 19 194. 20
200.00 Cross Foot Adjustments	31, 311	U	5, 089	8, 125		200.00
201.00 Negative Cost Centers		Ω	٥	0		200.00
202.00 TOTAL (sum lines 118 through 201)	234, 571, 624	11, 584, 427	13, 301, 007	21, 516, 396	234, 571, 624	
232. 33 1017/E (34/11 117/03 110 11/1 34g/1 201)	201, 071, 024	11,001,421	10,001,007	21,010,070	201, 071, 024	1-32. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0015 | Period: From 01/01/2

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2022 | Part I | To 12/31/2022 | Date/Time Prepared: | 4/13/2023 4:18 pm

	Cost Center Description	ADMI NI STRATI VE	MAINTENANCE &	OPERATION OF	LAUNDRY &	4/13/2023 4: 1 HOUSEKEEPI NG	
		& GENERAL	REPAI RS	PLANT	LINEN SERVICE		
	GENERAL SERVICE COST CENTERS	5.00	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 5. 00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	49, 363, 884					4. 00 5. 00
6. 00	00600 MAINTENANCE & REPAIRS	49, 303, 664	0				6. 00
7. 00	00700 OPERATION OF PLANT	4, 461, 751	0	21, 214, 467			7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	411, 019	0	86, 794		l	8. 00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	909, 665	0	1, 067, 765	0 816	5, 392, 986	9. 00 10. 00
11. 00	01100 CAFETERI A	343, 483 477, 300	0	291, 762 567, 960			11. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON	1, 372, 813	0	134, 741	0	36, 224	13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	206, 944	0	1, 051, 197	0	282, 608	14. 00
15. 00	01500 PHARMACY	1, 298, 174	0	378, 870	0	101, 857	15. 00
16. 00 17. 00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	380, 960	0	42, 550	0	11, 439	16. 00 17. 00
18. 00	01080 I NSERVI CE EDUCATI ON	O	0	o o	0	ő	18. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19. 00
20.00	02000 NURSI NG PROGRAM	0	0	0	0	0	20.00
21. 00 22. 00	02100 &R SERVICES-SALARY & FRINGES APPRV 02200 &R SERVICES-OTHER PRGM COSTS APPRV	0	0		0	0	21. 00 22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)		0	0	0	0	23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	7, 083, 684	0	-,,	959, 309		30.00
31. 00 32. 00	03100 I NTENSI VE CARE UNI T 03200 CORONARY CARE UNI T	1, 437, 083	0	842, 715	102, 053	226, 559 0	31. 00 32. 00
33. 00	03300 BURN INTENSIVE CARE UNIT		0		0	0	33. 00
34. 00	03400 SURGICAL INTENSIVE CARE UNIT	O	0	Ō	0	Ō	34.00
40. 00	04000 SUBPROVI DER - I PF	753, 102	0	1, 372, 580	306, 162	l	40. 00
41. 00 43. 00	04100 SUBPROVI DER - I RF 04300 NURSERY	0 226, 985	0	0 259, 944	0	0	41. 00 43. 00
44. 00	04400 SKILLED NURSING FACILITY	220, 965	0	259, 944	613 0	69, 884 0	44. 00
45. 00	04500 NURSING FACILITY	O	0	o o	0	Ö	45. 00
46. 00	04600 OTHER LONG TERM CARE	0	0	0	0	0	46. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	3, 984, 432	0	3, 385, 418	108, 177	910, 149	50. 00
51. 00	05100 RECOVERY ROOM	3, 904, 432	0	0, 300, 410	100, 177	910, 149	51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	406, 909	0	465, 162	0	125, 056	52. 00
53.00	05300 ANESTHESI OLOGY	52, 714	0	10, 983	0	2, 953	53. 00
54. 00	05400 RADI OLOGY - DI AGNOSTI C	2, 037, 135	0	1, 248, 320	82, 051	335, 603	
54. 01 55. 00	05401 FSED RADI OLOGY - DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	494, 241 569, 705	0	204, 905	1, 022	0 55, 087	54. 01 55. 00
55. 01	05501 WOODLAND CANCER CARE CTR	146, 618	0	126, 646	, -	34, 048	55. 01
56.00	05600 RADI OI SOTOPE	0	0	0	0	0	56. 00
57. 00	05700 CT SCAN	0	0	0	0	0	57. 00
58. 00 59. 00	05800 MRI 05900 CARDI AC CATHETERI ZATI ON	706, 753	0	334, 249	0 613	0 89, 861	58. 00 59. 00
60.00	06000 LABORATORY	3, 015, 162	0			l	
60. 01	06001 FS ED LAB	0	0	0	0	0	60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		_	_	_	_	61.00
62. 00 63. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06300 BLOOD STORING, PROCESSING & TRANS.	2,670	0	0	0	0 6, 648	62. 00 63. 00
63. 00	06301 FS ED BLOOD BANK	2,870	0	24, 727	0	0,040	63. 00
64. 00	06400 I NTRAVENOUS THERAPY	O	0	0	0	Ō	64. 00
65. 00	06500 RESPIRATORY THERAPY	647, 275	0	125, 893	0	33, 845	65. 00
66. 00	06600 PHYSI CAL THERAPY	909, 953	0	93, 509	61, 232	25, 139	66.00
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	0	0	0	0	67. 00 68. 00
69. 00	06900 ELECTROCARDI OLOGY	476, 319	0	561, 119	10, 205		69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2, 692, 114	0	0	0	0	71.00
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	2, 935, 230 7, 236, 124	0	0	0	0	72. 00 73. 00
74. 00	07400 RENAL DIALYSIS	7, 230, 124	0		0	0	74.00
75. 00	07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75. 00
76. 00	03020 CLINIC	147, 727	0	0	0	0	76. 00
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION OUTPATIENT SERVICE COST CENTERS	0	0) 0	0	0	77. 00
88. 00	08800 RURAL HEALTH CLINIC	O	0	0	0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0	o o	0	ő	89. 00
90.00	09000 CLI NI C	0	0	0	0	0	90. 00
90. 03	09003 I NFUSION OP SERVICES 09100 EMERGENCY	499, 934	0	201, 641	613	54, 210	90.03
91. 00 91. 01	O9100 EMERGENCY O9101 FREE STANDING EMERGENCY DEPT	1, 862, 557 925, 844	0	1, 182, 298 1, 341, 829		l	91. 00 91. 01
01	1	, ,,,,,,,,,		1 1,011,027	31,010	1 230, 7 10	

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0015

			'	0 12/31/2022	4/13/2023 4: 1	
Cost Center Description	ADMI NI STRATI VE I	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	, p
	& GENERAL	REPAI RS	PLANT	LINEN SERVICE		
	5.00	6. 00	7. 00	8. 00	9. 00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
OTHER REIMBURSABLE COST CENTERS	<u>. </u>		•			
94. 00 09400 HOME PROGRAM DIALYSIS	0	C		0	0	94. 00
95. 00 09500 AMBULANCE SERVICES	O	C		ol	0	95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	ol	C		ol	0	96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	o	C		o	0	97. 00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	C		o	0	98. 00
99. 00 09900 CMHC	0	Ċ			0	
99. 10 09910 CORF	0	Č			0	
100.00 10000 I &R SERVICES-NOT APPRVD PRGM		Č			0	100.00
101. 00 10100 HOME HEALTH AGENCY		Č		o o		101. 00
102. 00 10200 OPI OI D TREATMENT PROGRAM						102.00
SPECIAL PURPOSE COST CENTERS	<u> </u>		/	<u>/</u>		102.00
105. 00 10500 KI DNEY ACQUI SI TI ON	0				0	105. 00
106. 00 10600 HEART ACQUISITION						106.00
107. 00 10700 LI VER ACQUI SI TI ON						107. 00
108. 00 10800 LUNG ACQUISITION						108.00
109. 00 10900 PANCREAS ACQUISITION						109.00
110. 00 11000 NTESTI NAL ACQUI SI TI ON						110, 00
111. 00 111000 I SLET ACQUI SI TI ON						111.00
113. 00 11300 NTEREST EXPENSE	٩	C	ή) U	U	113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
+ I					0	115.00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	C				
116. 00 11600 HOSPI CE	40 112 270	C	01 014 4/	1 000 000		116.00
118. 00 SUBTOTALS (SUM OF LINES 1 through 117)	49, 112, 379		21, 214, 467	1, 939, 029	5, 392, 986	1118.00
NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	14.7(0		\	\	0	100 00
	14, 768	C				190. 00 191. 00
191. 00 19100 RESEARCH	0	C		102.052		191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 193. 00 19300 NONPALD WORKERS	0	C		102, 053		193. 00
	0	C				
194. 00 07950 BEACON JOINT VENTURE	927	C				194. 00
194. 01 07951 WORKI NG WELL	158, 754	C				194. 01
194. 03 07953 MED WATCHER	0	C		0		194. 03
194. 10 07960 DUNELAND FITNESS CTR	0	C		0		194. 10
194. 11 07961 OMNI HEALTH & FITNESS CHESTERTOWN	45, 441	C		0		194. 11
194.16 07966 PHYSICIAN PRACTICE MD WISW	19, 757	C		0		194. 16
194. 19 07969 HEALTH PARTNERS	0	C		0		194. 19
194. 20 07970 CENTER OF HOPE	11, 858	C		이	0	194. 20
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	C) (0		201. 00
202.00 TOTAL (sum lines 118 through 201)	49, 363, 884	C	21, 214, 467	2, 041, 082	5, 392, 986	202. 00

Provider CCN: 15-0015

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2022 Part I
To 12/31/2022 Date/Time Prepared:
4/13/2023 4:18 pm

) 12/31/2022	4/13/2023 4: 1	
Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	
			ADMI NI STRATI ON	SERVICES &		
	10.00	11. 00	13. 00	SUPPLY 14.00	15. 00	
GENERAL SERVICE COST CENTERS	10.00	11.00	13.00	14.00	15.00	
1. 00 00100 CAP REL COSTS-BLDG & FLXT						1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00 00500 ADMINISTRATIVE & GENERAL						5. 00
6.00 00600 MAINTENANCE & REPAIRS						6. 00
7.00 O0700 OPERATION OF PLANT						7. 00
8.00 00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00 00900 HOUSEKEEPI NG						9. 00
10. 00 01000 DI ETARY	2, 004, 187					10.00
11. 00 01100 CAFETERI A	0	2, 990, 090				11. 00
13.00 O1300 NURSING ADMINISTRATION	0	156, 871	6, 855, 204			13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY	0	22, 897	0	2, 340, 667		14. 00
15. 00 01500 PHARMACY	0	140, 843		16, 679	6, 810, 728	15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	0	390	0	0	0	16.00
17. 00 01700 SOCI AL SERVI CE	0	0	0	0	0	17.00
18. 00 01080 I NSERVI CE EDUCATI ON	0	0	0	U	0	18.00
19.00 01900 NONPHYSICIAN ANESTHETISTS 20.00 02000 NURSING PROGRAM	0	0	0	U O	0	19. 00 20. 00
21. 00 02000 NORSTING PROGRAW 21. 00 02100 I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22. 00 02200 &R SERVI CES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23. 00 02300 PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	٥		9	<u> </u>		25.00
30. 00 03000 ADULTS & PEDIATRICS	1, 605, 504	984, 389	3, 082, 176	117, 278	0	30.00
31. 00 03100 I NTENSI VE CARE UNI T	225, 893	183, 714		37, 411	0	31.00
32. 00 03200 CORONARY CARE UNIT	0	0	0	0	0	32. 00
33.00 03300 BURN INTENSIVE CARE UNIT	0	0	0	o	0	33.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	o	0	34.00
40. 00 04000 SUBPROVI DER - I PF	172, 790	82, 381	286, 391	620	0	40.00
41. 00 04100 SUBPROVI DER - I RF	0	0	О	o	0	41.00
43. 00 04300 NURSERY	0	0	0	o	0	43. 00
44.00 04400 SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00 04500 NURSING FACILITY	0	0	0	0	0	45. 00
46.00 O4600 OTHER LONG TERM CARE	0	0	0	0	0	46. 00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0	421, 504	677, 598	1, 422, 455	0	50.00
51. 00 05100 RECOVERY ROOM	0	0	0	0	0	51.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	8, 574		70 (75	0	53.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	0	245, 585		79, 675	0	54.00
54. 01 05401 FSED RADI OLOGY - DI AGNOSTI C	0	76, 292		5, 733	0	54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C 55. 01 05501 WOODLAND CANCER CARE CTR	0	32, 738 22, 897		42, 438 10, 211	0	55. 00 55. 01
56. 00 05600 RADI 01 SOTOPE	0	22, 097	73,079	10, 211	0	56.00
57. 00 05700 CT SCAN	0	0	0	0	0	57.00
58. 00 05800 MRI	0	0	0	0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	48, 182	104, 815	411, 772	0	59.00
60. 00 06000 LABORATORY	0	0,102	0	65, 380	0	60.00
60. 01 06001 FS ED LAB	o	0	Ö	0	0	60. 01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	o	0	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	О	0	0	o	0	63. 00
63. 01 06301 FS ED BLOOD BANK	0	0	0	o	0	63. 01
64. 00 06400 I NTRAVENOUS THERAPY	О	0	0	o	0	64. 00
65. 00 06500 RESPI RATORY THERAPY	О	74, 684		27, 800	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	55, 294	10, 019	2, 990	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	63, 430		4, 153	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	2, 004	0	0	70. 00
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	0	0	0	0	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 010 720	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	6, 810, 728	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	O	0	74.00
75. 00 07500 ASC (NON-DISTINCT PART)		0	20 073	0 73	0	75.00
76.00 03020 CLINIC 77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	38, 072	72	0	76. 00 77. 00
OUTPATIENT SERVICE COST CENTERS	U	0	1 0	U	0	, , ,
88. 00 08800 RURAL HEALTH CLINIC	ol	0	Λ	n	0	88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		٥	0	89.00
90. 00 09000 CLI NI C	ام	n	ا	n N	0	90.00
90. 03 09003 NFUSION OP SERVICES	o	33, 566	95, 875	12, 852	0	90. 03
91. 00 09100 EMERGENCY	o	242, 467		71, 711	0	91.00

Provider CCN: 15-0015

| Period: | Worksheet B | From 01/01/2022 | Part | To | 12/31/2022 | Date/Time Prepared:

				To	12/31/2022	Date/Time Pre 4/13/2023 4:1	
Cc	ost Center Description	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	O pili
		10.00	11. 00	13. 00	14. 00	15. 00	
91. 01 09101 FF	REE STANDING EMERGENCY DEPT	0	93, 392	495, 096	10, 344	0	91. 01
	BSERVATION BEDS (NON-DISTINCT PART						92. 00
	EIMBURSABLE COST CENTERS						
1 1	DME PROGRAM DIALYSIS	0	0	0	0	0	94. 00
	MBULANCE SERVICES	0	0	0	0	0	95. 00
	JRABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96. 00
1 1	JRABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97. 00
	THER REIMBURSABLE COST CENTERS	0	0	0	0	0	98. 00
99. 00 09900 CN		0	0	0	0	0	1 , , , , , ,
99. 10 09910 CC		0	0	0	0	0	1 //
	&R SERVICES-NOT APPRVD PRGM	0	0	0	0		100.00
1 1	DME HEALTH AGENCY	0	0	0	0		101.00
	PLOID TREATMENT PROGRAM	0	0	0	0	U	102. 00
	PURPOSE COST CENTERS DNEY ACQUISITION	0	0	0	ما	0	105 00
1 1	EART ACQUISITION	0	0	j – j	0		105. 00 106. 00
	VER ACQUISITION	O O	0	0	0		106.00
1 1	JNG ACQUISITION	o o	0	0	0		107.00
1 1	ANCREAS ACQUISITION		0	0	0		109. 00
	NTESTINAL ACQUISITION		0	0	0		110.00
	SLET ACQUISITION		0	0	0		111.00
1 1	NTEREST EXPENSE	٩	O		J	O	113. 00
	TILIZATION REVIEW-SNF						114. 00
	MBULATORY SURGICAL CENTER (D. P.)	0	0	0	0	0	115. 00
116. 00 11600 HC		o	0	0	0		116. 00
	JBTOTALS (SUM OF LINES 1 through 117)	2, 004, 187	2, 990, 090	6, 786, 612	2, 339, 574	6, 810, 728	
	BURSABLE COST CENTERS	, , , , , , , , , , , , , , , , , , , ,	, , , , , , , , , , , , , , , , , , , ,	.,,	, ,	.,	
190. 00 19000 GI	FT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
191. 00 19100 RE	ESEARCH	0	0	0	0	0	191. 00
192. 00 19200 PH	HYSICIANS' PRIVATE OFFICES	0	0	36, 223	0	0	192. 00
193.00 19300 NO	ONPALD WORKERS	0	0	0	0	0	193. 00
194. 00 07950 BE	EACON JOINT VENTURE	0	0	0	0	0	194. 00
194. 01 07951 WC	ORKING WELL	0	0	14, 643	1, 020	0	194. 01
194. 03 07953 ME		0	0	0	0		194. 03
	JNELAND FITNESS CTR	0	0	0	0		194. 10
	MNI HEALTH & FITNESS CHESTERTOWN	0	0	154	73		194. 11
	HYSICIAN PRACTICE MD WISW	0	0	4, 162	0		194. 16
194. 19 07969 HE		0	0	0	0		194. 19
194. 20 07970 CE		0	0	13, 410	0	0	194. 20
	ross Foot Adjustments	_	_	_	_	_	200. 00
1 1	egative Cost Centers	0	0	0	0		201. 00
202. 00 TO	OTAL (sum lines 118 through 201)	2, 004, 187	2, 990, 090	6, 855, 204	2, 340, 667	6, 810, 728	202.00

Health Financial Systems FRA
COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0015 Perio

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2022 | Part | | To 12/31/2022 | Date/Time Prepared: | 4/13/2023 4:18 pm

						4/13/2023 4: 1	8 pm
	Cost Center Description	MEDI CAL RECORDS & LI BRARY	SOCIAL SERVICE	OTHER GENERAL SERVI CE I NSERVI CE EDUCATI ON	NONPHYSI CI AN ANESTHETI STS	NURSI NG PROGRAM	
		16. 00	17. 00	18. 00	19. 00	20.00	
	GENERAL SERVICE COST CENTERS		Г	T	T		
1. 00 2. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY						1. 00 2. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
15. 00 16. 00 17. 00 18. 00 19. 00 20. 00	01100 CAFETERIA 01300 NURSI NG ADMINI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE 01080 I NSERVI CE EDUCATI ON 01900 NONPHYSI CI AN ANESTHETI STS 02000 NURSI NG PROGRAM 02100 I &R SERVI CES-OTHER PRGM COSTS APPRV 02200 I &R SERVI CES-OTHER PRGM COSTS APPRV 02300 PARAMED ED PRGM-(SPECI FY) I NPATI ENT ROUTI NE SERVI CE COST CENTERS	1, 865, 746 0 0 0 0 0 0 0	0 0 0 0 0 0		0	0	11. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00 22. 00 23. 00
30.00	03000 ADULTS & PEDI ATRI CS	140, 771	0	0	0	0	30. 00
31. 00	03100 INTENSIVE CARE UNIT	23, 865	О	О	0	0	31. 00
32.00	03200 CORONARY CARE UNIT	0	0	0	0	0	32.00
33. 00 34. 00	03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	33. 00 34. 00
40. 00	04000 SUBPROVI DER - I PF	8, 691		Ö	0	0	40.00
41. 00	04100 SUBPROVI DER - I RF	0	Ö	Ō	0	0	41.00
43.00	04300 NURSERY	2, 730	0	0	0	0	43. 00
44.00	04400 SKILLED NURSING FACILITY	0	0	0	_	0	44. 00
45. 00 46. 00	04500 NURSING FACILITY 04600 OTHER LONG TERM CARE	0		0	_	0	45. 00 46. 00
40.00	ANCILLARY SERVICE COST CENTERS	0	0	<u> </u>	0	0	46.00
50. 00	05000 OPERATING ROOM	265, 343	0	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	4, 896	l .	0	0	0	52. 00
53. 00	05300 ANESTHESI OLOGY	16, 545	0	0	0	0	53.00
54. 00 54. 01	05400 RADI OLOGY-DI AGNOSTI C 05401 FSED RADI OLOGY - DI AGNOSTI C	237, 901	0	0	0	0	54.00
54.01	05500 RADI OLOGY - DI AGNOSTI C	48, 848 34, 475	l	0	0	0	54. 01 55. 00
55. 01	05501 WOODLAND CANCER CARE CTR	10, 087	0	0	0	0	55. 01
56. 00	05600 RADI OI SOTOPE	0	Ö	ō	0	0	56.00
57. 00	05700 CT SCAN	0	0	0	0	0	57. 00
	05800 MRI	0	0	0	0	0	58. 00
59. 00 60. 00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	65, 217 183, 451	0	0	0	0	59. 00 60. 00
60. 01	06001 FS ED LAB	29, 527		Ö	0	0	60.00
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	•					61. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	2, 713	ł	0	0	0	63.00
63. 01 64. 00	06301 FS ED BLOOD BANK 06400 I NTRAVENOUS THERAPY	30	0	0	0	0	63. 01 64. 00
65. 00	06500 RESPIRATORY THERAPY	32, 852	ĺ	Ö	0	Ö	65. 00
66. 00	06600 PHYSI CAL THERAPY	35, 847	Ö	ō	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	54, 948	0	0	0	0	69.00
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	73, 944	0	0	0	0	70. 00 71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	54, 402	0	Ö	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	291, 214	0	0	0	0	73. 00
74.00	07400 RENAL DI ALYSI S	0	0	0	0	0	74.00
75. 00	07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76. 00 77. 00	03020 CLINIC 07700 ALLOGENEIC STEM CELL ACQUISITION	0	l	0	_	0	76. 00 77. 00
77.00	OUTPATIENT SERVICE COST CENTERS		·		0	<u> </u>	, , , . 00
88. 00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	ł				89. 00
90. 00	09000 CLI NI C	0	0	0	0	0	90. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS In Lieu of Form CMS-2552-10 Provider CCN: 15-0015

			''	0 12/31/2022	4/13/2023 4: 18	
			OTHER GENERAL			
			SERVI CE			
Cost Center Description	MEDI CAL	SOCIAL SERVICE	I NSERVI CE	NONPHYSI CI AN	NURSI NG	
	RECORDS &		EDUCATI ON	ANESTHETI STS	PROGRAM	
	LI BRARY					
	16.00	17. 00	18. 00	19. 00	20.00	
90. 03 09003 INFUSION OP SERVICES	42,006	0	0	0	0	90. 03
91. 00 09100 EMERGENCY	168, 915	0	0	0	0	91.00
91.01 09101 FREE STANDING EMERGENCY DEPT	36, 528	0	0	0	0	91. 01
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
95. 00 09500 AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	0	o	o	98.00
99. 00 09900 CMHC	0	0	0	o	ol	99.00
99. 10 09910 CORF	0	0	0	o	o	99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	o	0	100.00
101.00 10100 HOME HEALTH AGENCY	0	0	0	o	0	101. 00
102.00 10200 OPIOID TREATMENT PROGRAM	0	0	0	o	0	102. 00
SPECIAL PURPOSE COST CENTERS	•	•	•			
105. 00 10500 KIDNEY ACQUISITION	0	0	0	0	0	105. 00
106. 00 10600 HEART ACQUI SI TI ON	0	0	0	o	0	106. 00
107. 00 10700 LIVER ACQUISITION	0	0	0	o	0	107. 00
108.00 10800 LUNG ACQUISITION	0	0	0	o	0	108. 00
109. 00 10900 PANCREAS ACQUISITION	0	0	0	o		109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	o	0	110. 00
111.00 11100 I SLET ACQUISITION	0	0	0	ol	ol-	111. 00
113. 00 11300 NTEREST EXPENSE					l l	113. 00
114.00 11400 UTI LI ZATI ON REVI EW-SNF					-	114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	ol	0	115. 00
116. 00 11600 HOSPI CE	0	0	0		l l	116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	1, 865, 746	0	o	ol		118. 00
NONREI MBURSABLE COST CENTERS				-1		
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
191. 00 19100 RESEARCH	0	0	o	ol		191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0			192. 00
193. 00 19300 NONPALD WORKERS		0	o o	ol		193. 00
194. 00 07950 BEACON JOINT VENTURE		0	0	_		194. 00
194. 01 07951 WORKI NG WELL		0	0	ol		194. 01
194. 03 07953 MED WATCHER		0	j o			194. 03
194. 10 07960 DUNELAND FITNESS CTR		0	j ,	0		194. 10
194. 11 07961 OMNI HEALTH & FITNESS CHESTERTOWN		0	o o	0		194. 11
194. 16 07966 PHYSI CI AN PRACTI CE MD WI SW		0	l o	ام		194. 16
194. 19 07969 HEALTH PARTNERS		0	0	ام		194. 19
194. 20 07970 CENTER OF HOPE		0	0	ام		194. 20
200.00 Cross Foot Adjustments			1	0		200. 00
201.00 Negative Cost Centers		_	0	=		200.00
202.00 TOTAL (sum lines 118 through 201)	1, 865, 746	0		_		201.00
202.00 TOTAL (Sum Tries To through 201)	1,005,740	1		ı Y	O J2	_02.00

| Peri od: | Worksheet B | From 01/01/2022 | Part | | To | 12/31/2022 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0015

				Τ̈́	o 12/31/2022		
		INTERNS &	RESI DENTS			4/13/2023 4: 1	8 piii
	Cost Center Description	SERVI CES-SALAR Y & FRI NGES APPRV	SERVICES-OTHER PRGM COSTS APPRV	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown	
		21.00	22. 00	23. 00	24. 00	Adjustments 25.00	
	GENERAL SERVICE COST CENTERS	21.00	22.00	23.00	24.00	25.00	
17. 00 18. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 01080 INSERVICE EDUCATION 01900 NONPHYSICIAN ANESTHETISTS 02000 NURSING PROGRAM 02100 I &R SERVICES-SALARY & FRINGES APPRV 02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0	C			1. 00 2. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 16. 00 17. 00 19. 00 20. 00 21. 00 22. 00 23. 00
30. 00 31. 00 32. 00 33. 00 34. 00 40. 00 41. 00 43. 00 44. 00 45. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF 04100 SUBPROVIDER - IRF 04300 NURSERY 04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY 04600 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS	0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0		9, 111, 608 C C C 6, 179, 429 C 1, 412, 424	0 0 0 0 0 0 0	30. 00 31. 00 32. 00 33. 00 34. 00 40. 00 41. 00 43. 00 44. 00 45. 00
56. 00 57. 00 58. 00 59. 00 60. 01 61. 00 62. 00 63. 01 64. 00 65. 00 67. 00 68. 00 69. 00 70. 00 71. 00 72. 00 74. 00 75. 00 77. 00	05000 OPERATI NG ROOM 05100 RECOVERY ROOM 05200 DELI VERY ROOM & LABOR ROOM 05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY - DI AGNOSTI C 05401 FSED RADI OLOGY - DI AGNOSTI C 05500 RADI OLOGY - THERAPEUTI C 05501 WOODLAND CANCER CARE CTR 05600 RADI OI SOTOPE 05700 CT SCAN 05800 MRI 05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY 06001 FS ED LAB 06100 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 06301 FS ED BLOOD BANK 06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY 06900 ELECTROCARDI OLOGY 07000 ELECTROCARDI OLOGY 07000 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 07200 IMPL. DEV. CHARGED TO PATI ENT 07300 DRUGS CHARGED TO PATI ENTS 07400 RENAL DI ALYSI S 07500 ASC (NON-DI STI NCT PART) 03020 CLI NI C 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON OUTPATI ENT SERVI CE COST CENTERS	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		2, 529, 862 289, 696 11, 953, 102 2, 509, 375 3, 079, 466 995, 111 0 4, 415, 136 15, 248, 940 29, 527 0 46, 785 30 30 3, 372, 700 4, 610, 621 0 3, 312, 021 2, 004 12, 874, 246 14, 010, 659 41, 508, 130 0 740, 549		77. 00
88. 00	08800 RURAL HEALTH CLINIC	0	0	C	C	0	88. 00

| Period: | Worksheet B | From 01/01/2022 | Part | To | 12/31/2022 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0015

			To	12/31/2022	Date/Time Pre 4/13/2023 4:1	
	INTERNS &	RESIDENTS			4/13/2023 4: 1	8 pili
	TIVIERNO Q	RESIDENTS				
Cost Center Description	SERVI CES-SALAR	SERVI CES-OTHER	PARAMED ED	Subtotal	Intern &	
	Y & FRINGES	PRGM COSTS	PRGM		Residents Cost	
	APPRV	APPRV			& Post	
					Stepdown	
	24.00		22.22		Adjustments	
00 00 00000 FEDERALLY OHALLELED HEALTH CENTER	21.00	22. 00	23.00	24. 00	25. 00	00.00
89. 00 08900 FEDERALLY QUALI FI ED HEALTH CENTER 90. 00 09000 CLI NI C	0	0	0	0	0	89. 00 90. 00
90. 03 09003 NFUSION OP SERVICES	0	0	0	O		90.00
91. 00 09100 EMERGENCY	0	0	0	2, 817, 819 12, 058, 802	0	91.00
91. 01 09101 FREE STANDING EMERGENCY DEPT		0	0	6, 821, 723	1	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		ĭ	o l	0,021,723	0	92.00
OTHER REIMBURSABLE COST CENTERS						72.00
94.00 09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94. 00
95. 00 09500 AMBULANCE SERVICES	0	O	0	0	0	95. 00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	О	0	0	0	96. 00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	o	0	0	0	97. 00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98. 00
99. 00 09900 CMHC	0	0	0	0	0	99. 00
99. 10 09910 CORF	0	0	0	0	0	99. 10
100.00 10000 I &R SERVI CES-NOT APPRVD PRGM	0	0	0	0	0	1.00.00
101. 00 10100 HOME HEALTH AGENCY	0	0	0	0	0	
102. 00 10200 OPI OI D TREATMENT PROGRAM	0	0	0	0	0	102. 00
SPECIAL PURPOSE COST CENTERS		٥		0	1 0	105 00
105.00 10500 KIDNEY ACQUISITION 106.00 10600 HEART ACQUISITION	0	0	0	0		105. 00 106. 00
107. 00 10700 LIVER ACQUISITION	0	0	0	0		106.00
108. 00 10800 LUNG ACQUISITION	0	0	0	0		107.00
109. 00 10900 PANCREAS ACQUI SI TI ON		0	0	0		109.00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON	o o	Ö	0	0		110.00
111. 00 11100 SLET ACQUI SI TI ON	o	o	0	0		111.00
113. 00 11300 NTEREST EXPENSE						113.00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	o	o	0	0	0	115. 00
116. 00 11600 HOSPI CE			0	0	0	116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	233, 345, 171	0	118. 00
NONREI MBURSABLE COST CENTERS					1	
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	70, 219		190. 00
191. 00 19100 RESEARCH	0	0	0	0		191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	-2, 855		192. 00
193.00 19300 NONPALD WORKERS 194.00 07950 BEACON JOINT VENTURE	0	0	0	4, 409		193. 00 194. 00
194. 01 07950 BEACON SOTNI VENTURE	0	0	0	770, 497		194. 00
194. 03 07953 MED WATCHER		0	0	770, 497 O	1	194. 01
194. 10 07960 DUNELAND FITNESS CTR	0	0	0	0		194. 10
194. 11 07961 OMNI HEALTH & FITNESS CHESTERTOWN	l ol	o	0	216, 289		194. 11
194. 16 07966 PHYSI CI AN PRACTI CE MD WI SW	o	o	O	98, 101		194. 16
194. 19 07969 HEALTH PARTNERS	o	o	0	0	0	194. 19
194.20 07970 CENTER OF HOPE	o	o	0	69, 793	0	194. 20
200.00 Cross Foot Adjustments	0	0	0	0		200. 00
201.00 Negative Cost Centers	0	0	0	0		201. 00
202.00 TOTAL (sum lines 118 through 201)	0	0	0	234, 571, 624	0	202. 00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0015

Peri od: Worksheet B From 01/01/2022 Part I To 12/31/2022 Date/Time Prepared:

4/13/2023 4:18 pm Cost Center Description Total 26. 00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5 00 6.00 00600 MAINTENANCE & REPAIRS 6.00 00700 OPERATION OF PLANT 7.00 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 00900 HOUSEKEEPI NG 9.00 9 00 10.00 01000 DI ETARY 10 00 11.00 01100 CAFETERI A 11.00 13 00 01300 NURSING ADMINISTRATION 13 00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 15.00 01500 PHARMACY 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 16.00 01700 SOCIAL SERVICE 17 00 17 00 18.00 01080 I NSERVI CE EDUCATI ON 18.00 19.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 20.00 02000 NURSING PROGRAM 20.00 21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV 21.00 22. 00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 22.00 02300 PARAMED ED PRGM-(SPECIFY) 23.00 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 47, 279, 824 30.00 03100 INTENSIVE CARE UNIT 31.00 9, 111, 608 31.00 03200 CORONARY CARE UNIT 32.00 32.00 0 33 00 03300 BURN INTENSIVE CARE UNIT 0 33 00 34.00 03400 SURGICAL INTENSIVE CARE UNIT 34.00 04000 SUBPROVIDER - IPF 40.00 6, 179, 429 40.00 04100 SUBPROVI DER - I RF 41.00 41.00 43.00 04300 NURSERY 1, 412, 424 43 00 44.00 04400 SKILLED NURSING FACILITY 44.00 45.00 04500 NURSING FACILITY 0 45.00 46.00 04600 OTHER LONG TERM CARE 0 46.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 26, 135, 582 50.00 05100 RECOVERY ROOM 51.00 51.00 05200 DELIVERY ROOM & LABOR ROOM 2, 529, 862 52.00 52.00 53.00 05300 ANESTHESI OLOGY 289, 696 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 11, 953, 102 54.00 54.01 05401 FSED RADIOLOGY - DIAGNOSTIC 2, 509, 375 54.01 05500 RADI OLOGY-THERAPEUTI C 3, 079, 466 55.00 55.00 55.01 05501 WOODLAND CANCER CARE CTR 995, 111 55.01 56.00 05600 RADI OI SOTOPE 0 56.00 57.00 05700 CT SCAN 0 57.00 05800 MRI 58.00 0 58.00 59.00 05900 CARDIAC CATHETERIZATION 4, 415, 136 59.00 60.00 06000 LABORATORY 15, 248, 940 60.00 06001 FS ED LAB 60.01 29, 527 60.01 61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 0 61.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 62.00 06300 BLOOD STORING, PROCESSING & TRANS. 63 00 46 785 63 00 06301 FS ED BLOOD BANK 63.01 30 63.01 64.00 06400 I NTRAVENOUS THERAPY 0 64.00 65.00 06500 RESPIRATORY THERAPY 3, 372, 700 65.00 66.00 06600 PHYSI CAL THERAPY 4, 610, 621 66 00 67.00 06700 OCCUPATIONAL THERAPY 67.00 0 06800 SPEECH PATHOLOGY 68.00 68.00 69.00 06900 ELECTROCARDI OLOGY 3, 312, 021 69.00 07000 ELECTROENCEPHALOGRAPHY 70 00 2.004 70 00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 12, 874, 246 71.00 14, 010, 659 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 41, 508, 130 73.00 07400 RENAL DIALYSIS 74.00 0 74 00 75.00 07500 ASC (NON-DISTINCT PART) 0 75.00 03020 CLI NI C 76.00 740, 549 76.00 07700 ALLOGENEIC STEM CELL ACQUISITION 77.00 77.00 0 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 88.00 0 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 89.00 09000 CLINIC 90.00 90.00 0 09003 INFUSION OP SERVICES 90.03 2.817.819 90.03 09100 EMERGENCY 12, 058, 802 91.00 91.00 09101 FREE STANDING EMERGENCY DEPT 91.01 91.01 6,821,723 92. 00 | 09200 | OBSERVATION BEDS (NON-DISTINCT PART 92.00

In Lieu of Form CMS-2552-10
Period: Worksheet B
From 01/01/2022 Part I
To 1/21/2022 Part I
To 1/21/2022 Part II
To

		To 12/31/2022 Date/Time 4/13/2023	Prepared: 4·18 nm
Cost Center Description	Total	17 107 2020	1. 10 piii
	26. 00		
OTHER REIMBURSABLE COST CENTERS			
94.00 09400 HOME PROGRAM DIALYSIS	0		94. 00
95. 00 09500 AMBULANCE SERVI CES	0		95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0		96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0		97. 00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0		98. 00
99. 00 09900 CMHC	0		99. 00
99. 10 09910 CORF	0		99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0		100. 00
101.00 10100 HOME HEALTH AGENCY	0		101. 00
102.00 10200 OPIOLD TREATMENT PROGRAM	0		102. 00
SPECIAL PURPOSE COST CENTERS			
105.00 10500 KIDNEY ACQUISITION	0		105. 00
106. 00 10600 HEART ACQUISITION	0		106. 00
107.00 10700 LIVER ACQUISITION	0		107. 00
108.00 10800 LUNG ACQUISITION	0		108. 00
109.00 10900 PANCREAS ACQUISITION	0		109. 00
110.00 11000 INTESTINAL ACQUISITION	0		110. 00
111.00 11100 ISLET ACQUISITION	0		111. 00
113. 00 11300 I NTEREST EXPENSE			113. 00
114.00 11400 UTILIZATION REVIEW-SNF			114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0		115. 00
116. 00 11600 HOSPI CE	0		116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	233, 345, 171		118. 00
NONREI MBURSABLE COST CENTERS			
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	70, 219		190. 00
191. 00 19100 RESEARCH	0		191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	-2, 855		192. 00
193. 00 19300 NONPALD WORKERS	0		193. 00
194.00 07950 BEACON JOINT VENTURE	4, 409		194. 00
194. 01 07951 WORKING WELL	770, 497		194. 01
194.03 07953 MED WATCHER	0		194. 03
194. 10 07960 DUNELAND FITNESS CTR	0		194. 10
194.11 07961 OMNI HEALTH & FITNESS CHESTERTOWN	216, 289		194. 11
194.16 07966 PHYSICIAN PRACTICE MD WISW	98, 101		194. 16
194. 19 07969 HEALTH PARTNERS	0		194. 19
194.20 07970 CENTER OF HOPE	69, 793		194. 20
200.00 Cross Foot Adjustments	0		200. 00
201.00 Negative Cost Centers	0		201. 00
202.00 TOTAL (sum lines 118 through 201)	234, 571, 624		202. 00

| Peri od: | Worksheet B | From 01/01/2022 | Part | I | To | 12/31/2022 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0015

			Ť	o 12/31/2022	Date/Time Pre 4/13/2023 4:1	
		CAPI TAL REI	LATED COSTS		47 137 2023 4. 1	<u>Б</u>
Cost Center Description	Di rectly	BLDG & FLXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
	Assigned New				BENEFI TS	
	Capital Related Costs				DEPARTMENT	
	0	1. 00	2.00	2A	4. 00	
GENERAL SERVICE COST CENTERS						
1. 00 00100 CAP REL COSTS-BLDG & FLXT 2. 00 00200 CAP REL COSTS-MVBLE EQUIP						1. 00 2. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	0	56, 396	248, 756	305, 152	305, 152	4.00
5.00 00500 ADMINISTRATIVE & GENERAL	0	1, 009, 070				5. 00
6. 00 00600 MAI NTENANCE & REPAI RS	0	0 1 01 (120	1 000 430	0	0	6.00
7. 00 00700 OPERATION OF PLANT 8. 00 00800 LAUNDRY & LINEN SERVICE	0	1, 916, 138 35, 197			14, 088 387	7. 00 8. 00
9. 00 00900 HOUSEKEEPI NG	0	432, 997			6, 383	9. 00
10. 00 01000 DI ETARY	0	118, 314		164, 921	2, 332	10. 00
11. 00 01100 CAFETERI A 13. 00 01300 NURSI NG ADMI NI STRATI ON	0	230, 317 54, 640		230, 317 129, 845	4, 335 11, 638	11. 00 13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY	0	426, 278			919	14.00
15. 00 01500 PHARMACY	0	153, 638		176, 145		15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	0	17, 255	0	17, 255	25	16.00
17. 00 01700 SOCIAL SERVICE 18. 00 01080 INSERVICE EDUCATION	0	0	0	0	0	17. 00 18. 00
19. 00 01900 NONPHYSICIAN ANESTHETISTS	0	0	Ö	0	Ö	19. 00
20. 00 02000 NURSI NG PROGRAM	0	0	0	0	0	20. 00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV 22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	21. 00 22. 00
23. 00 02300 PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23. 00
INPATIENT ROUTINE SERVICE COST CENTERS		-				
30. 00 03000 ADULTS & PEDI ATRI CS	0	2, 144, 266			65, 604	30.00
31. 00 03100 INTENSI VE CARE UNI T 32. 00 03200 CORONARY CARE UNI T	0	341, 735 0	208, 560	550, 295 0	13, 151 0	31. 00 32. 00
33. 00 03300 BURN INTENSIVE CARE UNIT	0	Ö	Ö	0	0	33. 00
34. 00 03400 SURGICAL INTENSIVE CARE UNIT	0	0		0	0	34. 00
40. 00 04000 SUBPROVI DER - 1 PF 41. 00 04100 SUBPROVI DER - 1 RF	0	556, 604 0	36, 717	593, 321	4, 580 0	40. 00 41. 00
43. 00 04300 NURSERY	0	105, 412		105, 412	1, 599	43.00
44.00 04400 SKILLED NURSING FACILITY	0	0	0	0	0	44. 00
45. 00 04500 NURSING FACILITY 46. 00 04600 OTHER LONG TERM CARE	0	0	0	0	0	45. 00 46. 00
ANCI LLARY SERVI CE COST CENTERS	U	0	<u> </u>	0	0	46.00
50. 00 05000 OPERATING ROOM	0	1, 372, 844	3, 023, 967	4, 396, 811	24, 717	50. 00
51.00 05100 RECOVERY ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM	0	100 (21	0	0 188, 631	0	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY	0	188, 631 4, 454	72, 959		2, 867 275	52. 00 53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	506, 215				54. 00
54. 01 05401 FSED RADI OLOGY - DI AGNOSTI C	0	0	160, 262		4, 813	1
55. 00 05500 RADI OLOGY-THERAPEUTI C 55. 01 05501 WOODLAND CANCER CARE CTR	0	83, 092 51, 357			2, 087 1, 426	55. 00 55. 01
56. 00 05600 RADI OI SOTOPE	0	0	Ö	0	0	56. 00
57. 00 05700 CT SCAN	0	0	0	0	0	57. 00
58. 00 05800 MRI 59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0 135, 544	0 883, 877	0 1, 019, 421	0 3, 170	58. 00 59. 00
60. 00 06000 LABORATORY	0	212, 146			3,170	60.00
60. 01 06001 FS ED LAB	0	0	0	0	0	60. 01
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0		0		61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	10, 027		10, 027	0	62. 00 63. 00
63. 01 06301 FS ED BLOOD BANK	0	0	Ö	0	Ö	63. 01
64. 00 06400 I NTRAVENOUS THERAPY	0	0		0	0	64. 00
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	0	51, 052 37, 920				65. 00 66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	37, 720	47,030	00, 738	0, 330	67. 00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	227, 543	202, 780	430, 323	3, 784	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	0		0	0	70. 00 71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	Ö	Ö	0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73. 00
74. 00 07400 RENAL DIALYSIS 75. 00 07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	74. 00 75. 00
76. 00 07500 ASC (NON-DISTINCT PART)		0	8, 539	8, 539	1, 266	1
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77. 00
0UTPATIENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC	0	0	0	0	0	88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	•			88.00
		·			•	

| Peri od: | Worksheet B | From 01/01/2022 | Part | I | To | 12/31/2022 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0015

			То	12/31/2022	Date/Time Pre 4/13/2023 4:1	
		CAPLTAL REI	ATED COSTS		4/ 13/ 2023 4. 10	5 PIII
		0,11 , 1,12 , 1,21	21125 00010			
Cost Center Description	Directly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
	Assigned New				BENEFITS	
	Capi tal				DEPARTMENT	
	Related Costs					
	0	1.00	2.00	2A	4. 00	
90. 00 09000 CLI NI C	0	0	1	0	0	90.00
90. 03 09003 NFUSION OP SERVICES	0	81, 769		123, 399	3, 437	90. 03
91. 00 09100 EMERGENCY	0	479, 442		714, 672	16, 293	91.00
91. 01 09101 FREE STANDING EMERGENCY DEPT	0	544, 134	141, 150	685, 284	6, 337	91. 01
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART				0		92. 00
OTHER REIMBURSABLE COST CENTERS 94. 00 09400 HOME PROGRAM DI ALYSI S	O	0	O	Ol	0	94. 00
95. 00 09500 AMBULANCE SERVI CES	0	0		0	0	94. 00 95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-RENTED	0	0		0	0	98. 00 97. 00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98. 00
99. 00 09900 CMHC	0	0	0	0	0	99. 00
99. 10 09910 CORF	0	0		0	0	99. 10
100.00 10000 I &R SERVI CES-NOT APPRVD PRGM		0				100.00
101.00 10100 HOME HEALTH AGENCY		0				101. 00
102. 00 10200 OPI OI D TREATMENT PROGRAM		0	1	0		101.00
SPECIAL PURPOSE COST CENTERS	٩		<u> </u>	<u> </u>	0	102.00
105. 00 10500 KIDNEY ACQUISITION	0	0	0	0	0	105. 00
106. 00 10600 HEART ACQUI SI TI ON	l ol	0		o	-	106. 00
107. 00 10700 LI VER ACQUI SI TI ON	o	0	0	o		107. 00
108.00 10800 LUNG ACQUISITION	o	0	0	0		108. 00
109.00 10900 PANCREAS ACQUISITION	o	0	0	0	0	109. 00
110.00 11000 INTESTINAL ACQUISITION	o	0	0	0	0	110. 00
111.00 11100 ISLET ACQUISITION	o	0	0	o	0	111. 00
113.00 11300 INTEREST EXPENSE						113. 00
114.00 11400 UTILIZATION REVIEW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	0	0	115. 00
116. 00 11600 H0SPI CE	0	0	0	0		116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	11, 584, 427	13, 257, 521	24, 841, 948	300, 729	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0		190. 00
191. 00 19100 RESEARCH	0	0	0	0		191. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0	0	0		192. 00
193. 00 19300 NONPAI D WORKERS	0	0	0	0	-	193. 00
194. 00 07950 BEACON JOINT VENTURE	0	0	20 207	20 207		194. 00
194. 01 07951 WORKI NG WELL	0	0	38, 397	38, 397		194. 01
194. 03 07953 MED WATCHER	0	0	0	O O		194. 03 194. 10
194.10 07960 DUNELAND FITNESS CTR 194.11 07961 OMNI HEALTH & FITNESS CHESTERTOWN	0	0		0	-	194. 10
194. 1107961 OMNI HEALTH & FITNESS CHESTERTOWN 194. 16 07966 PHYSICIAN PRACTICE MD WISW		0		0	· ·	194. 11 194. 16
194. 19 07969 HEALTH PARTNERS		0		0		194. 16 194. 19
194. 19 07969 HEALTH PARTNERS 194. 20 07970 CENTER OF HOPE		0	5, 089	5, 089		194. 19
200.00 Cross Foot Adjustments	١	U	3,009	3, 009 N		200. 00
201.00 Negative Cost Centers		Λ		0		200.00
202.00 TOTAL (sum lines 118 through 201)	o	11, 584, 427	13, 301, 007	24, 885, 434	305, 152	
232. 33 ₁ 1017/2 (34m 111163 116 through 201)	١	11,001,427	10,001,007	21,000,404	555, 152	

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0015

Peri od: Worksheet B From 01/01/2022 Part II To 12/31/2022 Date/Time Prepared:

In Lieu of Form CMS-2552-10

4/13/2023 4:18 pm Cost Center Description ADMINISTRATIVE MAINTENANCE & OPERATION OF LAUNDRY & HOUSEKEEPI NG & GENERAL **REPAIRS PLANT** LINEN SERVICE 9.00 5.00 6.00 7.00 8.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5 00 2, 753, 001 5 00 6.00 00600 MAINTENANCE & REPAIRS 6.00 00700 OPERATION OF PLANT 248, 828 4, 088, 474 7.00 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 22, 922 0 16, 727 77, 370 8.00 00900 HOUSEKEEPI NG 50.731 205.781 841, 762 9.00 9 00 10.00 01000 DI ETARY 19, 156 56, 229 31 12, 243 10.00 11.00 01100 CAFETERI A 26, 619 109, 458 0 23,833 11.00 01300 NURSING ADMINISTRATION 25, 968 5, 654 76.561 0 13 00 13 00 14.00 01400 CENTRAL SERVICES & SUPPLY 11,541 202, 588 44, 111 14.00 15.00 01500 PHARMACY 72, 398 73,016 0 15, 898 15.00 0 01600 MEDICAL RECORDS & LIBRARY 21, 246 1, 785 16, 00 8, 200 16,00 01700 SOCIAL SERVICE 17.00 C 0 17.00 0 18.00 01080 INSERVICE EDUCATION 0 0 0 18.00 01900 NONPHYSICIAN ANESTHETISTS 0 19 00 0 0 19.00 0 02000 NURSI NG PROGRAM 0 20.00 0 0 20.00 0 02100 I&R SERVICES-SALARY & FRINGES APPRV 0 21.00 0 0 0 Λ 21 00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 0 22.00 0 22.00 02300 PARAMED ED PRGM-(SPECIFY) 23.00 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 395,051 0 1, 019, 057 36, 365 221, 888 30.00 31.00 03100 INTENSIVE CARE UNIT 80.145 0 162, 409 3.868 35, 362 31.00 03200 CORONARY CARE UNIT 32.00 32.00 0 C03300 BURN INTENSIVE CARE UNIT 33.00 0 \cap 0 Λ 33.00 34.00 03400 SURGICAL INTENSIVE CARE UNIT 0 C C Ω 34.00 04000 SUBPROVI DER - I PF 40.00 42,000 264, 525 11,605 57, 597 40.00 04100 SUBPROVIDER - IRF 0 41.00 C0 41.00 04300 NURSERY 43.00 12,659 C 50, 097 23 10, 908 43.00 44.00 04400 SKILLED NURSING FACILITY 0 0 0 44.00 04500 NURSING FACILITY 45.00 0 0 0 0 0 45.00 46.00 04600 OTHER LONG TERM CARE Ω 0 46 00 0 0 0 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 222, 208 0 4, 101 142, 060 50.00 652, 441 51.00 05100 RECOVERY ROOM 0 51.00 C0 05200 DELIVERY ROOM & LABOR ROOM 52.00 22,693 0 89, 647 0 19, 519 52.00 53.00 05300 ANESTHESI OLOGY 2,940 0 2, 117 461 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 113, 609 240, 577 3, 110 52, 382 54.00 54 01 05401 FSED RADIOLOGY - DIAGNOSTIC Ω 27.563 54 01 0 0 |05500| RADI OLOGY-THERAPEUTI C 55.00 31,772 C 39, 489 39 8, 598 55.00 05501 WOODLAND CANCER CARE CTR 774 55.01 8.177 24, 407 5, 314 55.01 56.00 05600 RADI OI SOTOPE 0 0 56.00 0 C 0 05700 CT SCAN 57 00 Ω 0 57 00 0 0 0 58.00 05800 MRI 58.00 0 59.00 05900 CARDIAC CATHETERIZATION 39, 415 64, 417 23 14, 026 59.00 06000 LABORATORY 60.00 168, 153 100.822 21, 953 60.00 06001 FS ED LAB 0 60.01 0 C 0 0 60.01 61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 62.00 62.00 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 0 0 1,038 63.00 149 4.765 63 01 06301 FS ED BLOOD BANK 0 C0 0 63.01 06400 INTRAVENOUS THERAPY 0 64.00 0 64.00 65.00 06500 RESPI RATORY THERAPY 36, 098 24, 262 5, 283 65.00 06600 PHYSI CAL THERAPY 3, 924 66.00 66,00 50, 747 0 18,021 2, 321 06700 OCCUPATI ONAL THERAPY 67.00 Λ 67.00 06800 SPEECH PATHOLOGY 68.00 0 68.00 69.00 06900 ELECTROCARDI OLOGY 108, 140 387 23, 546 69.00 26.564 70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 150, 137 0 0 71.00 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 163, 695 0 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 403, 570 0 0 73.00 0 0 0 74.00 07400 RENAL DIALYSIS C 0 74.00 07500 ASC (NON-DISTINCT PART) 75.00 75.00 o 76.00 03020 CLI NI C 8, 239 C 0 0 76.00 07700 ALLOGENEIC STEM CELL ACQUISITION 77.00 0 0 0 0 0 77.00 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 88.00 0 88.00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 89.00 C 0 09000 CLI NI C 90 00 Ω C \cap 0 Λ 90 00 90.03 09003 INFUSION OP SERVICES 27,881 0 38, 861 23 8, 461 90.03 91.00 09100 EMERGENCY 103, 873 227, 854 7,737 49, 612 91.00 09101 FREE STANDING EMERGENCY DEPT 51, 634 258. 599 56, 306 91.01 91 01 3 095

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

ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0015 From 01/01/2022 From 01/01/2022 To 12/31/2022 From 12/31/2023 4:18 pm

				12/31/2022	4/13/2023 4: 1	
Cost Center Description	ADMI NI STRATI VE	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	, p
	& GENERAL	REPAI RS	PLANT	LINEN SERVICE		
	5. 00	6. 00	7. 00	8. 00	9. 00	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
OTHER REIMBURSABLE COST CENTERS						
94. 00 09400 HOME PROGRAM DI ALYSI S	0	0	0	0	0	94. 00
95. 00 09500 AMBULANCE SERVICES	0	0	0	o	0	95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	o	0	96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	o	0	97. 00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98. 00
99. 00 09900 CMHC	0	0	0	0	0	99. 00
99. 10 09910 CORF	0	0	0	0	0	
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101. 00 10100 HOME HEALTH AGENCY	0	0	0	0		101. 00
102. 00 10200 OPI OI D TREATMENT PROGRAM	o o	0	٥	0		102. 00
SPECIAL PURPOSE COST CENTERS				<u> </u>	<u> </u>	102.00
105. 00 10500 KIDNEY ACQUISITION	0	0	0	0	0	105. 00
106. 00 10600 HEART ACQUI SI TI ON	0	0	0	0		106. 00
107. 00 10700 LIVER ACQUISITION	0	0	0	0		107. 00
108. 00 10800 LUNG ACQUISITION	0	0	0	0		108. 00
109. 00 10900 PANCREAS ACQUISITION	0	0	0	0		109. 00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON	0	0	0	0		110.00
111. 00 11100 SLET ACQUISITION	0	0	0	0		111. 00
113. 00 11300 I NTEREST EXPENSE	-	_		-	_	113. 00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF						114. 00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	0	0	115. 00
116. 00 11600 HOSPI CE	0	0	0	0		116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	2, 738, 974	0	4, 088, 474	73, 502	841, 762	
NONREI MBURSABLE COST CENTERS		-	.,		2	
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	824	0	0	0	0	190. 00
191. 00 19100 RESEARCH	0	0	0	0	0	191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	3, 868	0	192. 00
193. 00 19300 NONPALD WORKERS	0	0	0	0	0	193. 00
194.00 07950 BEACON JOINT VENTURE	52	0	0	0	0	194. 00
194. 01 07951 WORKI NG WELL	8, 854	0	0	0	0	194. 01
194.03 07953 MED WATCHER	0	0	0	0	0	194. 03
194. 10 07960 DUNELAND FITNESS CTR	0	0	0	0	0	194. 10
194.11 07961 OMNI HEALTH & FITNESS CHESTERTOWN	2, 534	0	0	0	0	194. 11
194.16 07966 PHYSICIAN PRACTICE MD WISW	1, 102	0	0	0	0	194. 16
194. 19 07969 HEALTH PARTNERS	0	0	0	0	0	194. 19
194. 20 07970 CENTER OF HOPE	661	0	0	0	0	194. 20
200.00 Cross Foot Adjustments		_		-		200. 00
201.00 Negative Cost Centers	0	0	o	o	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	2, 753, 001	0	4, 088, 474	77, 370	841, 762	
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Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provi der CCN: 15-0015

| Peri od: | Worksheet B | From 01/01/2022 | Part | I | To 12/31/2022 | Date/Time Prepared:

				To	12/31/2022	Date/Time Prep 4/13/2023 4:18	
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	
	ASSUMED ASSUME	10.00	11. 00	13. 00	14. 00	15. 00	
	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1. 00
	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
	00500 ADMINISTRATIVE & GENERAL						5. 00
	00600 MAI NTENANCE & REPAI RS						6. 00
	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE						7. 00 8. 00
1	00900 HOUSEKEEPING						9. 00
1	01000 DI ETARY	254, 912					10.00
	01100 CAFETERI A	0	394, 562				11. 00
	01300 NURSI NG ADMI NI STRATI ON	0	20, 700	270, 366			13.00
	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	0	3, 021 18, 585	0	1, 040, 710 7, 416	373, 857	14. 00 15. 00
	01600 MEDICAL RECORDS & LIBRARY	0	10, 303	0	7,416	373, 657	16. 00
	01700 SOCI AL SERVI CE	o	0	Ö	o	Ö	17. 00
18. 00	01080 INSERVICE EDUCATION	o	0	0	o	0	18.00
	01900 NONPHYSI CI AN ANESTHETI STS	0	0	0	0	0	19. 00
	02000 NURSI NG PROGRAM	0	0	0	0	0	20.00
	02100 &R SERVICES-SALARY & FRINGES APPRV 02200 &R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	21. 00 22. 00
	02300 PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS			-1	-,	-	
	03000 ADULTS & PEDIATRICS	204, 204	129, 899	121, 559	52, 145	0	30.00
	03100 I NTENSI VE CARE UNI T	28, 731	24, 242	25, 101	16, 634	0	31. 00
	03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	32. 00 33. 00
	03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34. 00
	04000 SUBPROVI DER – I PF	21, 977	10, 871	11, 295	276	0	40. 00
	04100 SUBPROVI DER - I RF	· o	0	O	o	0	41.00
43.00	04300 NURSERY	0	0	0	О	0	43.00
	04400 SKILLED NURSING FACILITY	0	0	0	0	0	44.00
1	04500 NURSING FACILITY	0	0	0	0	0	45. 00
	04600 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS	<u> </u>	U	U U	U _I	U	46. 00
	05000 OPERATI NG ROOM	0	55, 620	26, 724	632, 452	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0	1, 131	1 405	0 35, 425	0	53.00
	05400 RADI OLOGY - DI AGNOSTI C	0	32, 407 10, 067	1, 495 1, 125	2, 549	0	54. 00 54. 01
1	05500 RADI OLOGY-THERAPEUTI C	o	4, 320	0	18, 869	0	55. 00
	05501 WOODLAND CANCER CARE CTR	0	3, 021	2, 906	4, 540	0	55. 01
	05600 RADI OI SOTOPE	0	0	0	0	0	56.00
	05700 CT SCAN	0	0	0	0	0	57. 00
	05800 MRI 05900 CARDI AC CATHETERI ZATI ON	0	6, 358	4, 134	183, 083	0	58. 00 59. 00
	06000 LABORATORY	0	0, 338	4, 134	29, 069	0	60.00
	06001 FS ED LAB	o	0	Ō	0	0	60. 01
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62. 00
	06300 BLOOD STORING, PROCESSING & TRANS. 06301 FS ED BLOOD BANK	0	0	0	0	0	63.00
	06400 INTRAVENOUS THERAPY	0	0	0	0	0	63. 01 64. 00
	06500 RESPIRATORY THERAPY	0	9, 855	0	12, 361	0	65. 00
	06600 PHYSI CAL THERAPY	0	7, 296	395	1, 329	0	66.00
	06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67. 00
	06800 SPEECH PATHOLOGY	0	0	0	0	0	68. 00
	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	0	8, 370	7, 988 79	1, 847	0	69. 00 70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	7 7	0	0	71.00
1	07200 IMPL. DEV. CHARGED TO PATIENTS	o	Ö	Ö	Ö	Ö	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	o	373, 857	73.00
	07400 RENAL DIALYSIS	0	0	0	O	0	74.00
	07500 ASC (NON-DISTINCT PART)	0	0	1 500	0	0	75. 00
	03020 CLINIC 07700 ALLOGENEIC STEM CELL ACQUISITION		0	1, 502 0	32 0	0	76. 00 77. 00
<u> </u>	OUTPATIENT SERVICE COST CENTERS	J	0	, O		U	, , . 50
	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88. 00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	o	0	89. 00
	09000 CLINIC	0	4 430	0	0	0	90.00
	09003 INFUSION OP SERVICES 09100 EMERGENCY		4, 429 31, 995		5, 714 31, 884	0	90. 03 91. 00
71. 50		<u>. </u>	51, 775	10,000	51,004	0	

In Lieu of Form CMS-2552-10
Period: Worksheet B
From 01/01/2022 Part II
To 1/21/2022 Part/Time Propagate Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0015

			To	12/31/2022	Date/Time Pre 4/13/2023 4:1	
Cost Center Description	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	S piii
	10. 00	11. 00	13. 00	14. 00	15. 00	
91.01 09101 FREE STANDING EMERGENCY DEPT	0	12, 324	19, 526	4, 599	0	91. 01
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94. 00
95. 00 09500 AMBULANCE SERVICES	0	0	0	0	0	95. 00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97. 00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98. 00
99. 00 09900 CMHC	0	0	0	0	0	
99. 10 09910 CORF	0	0	0	0	0	
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0		100. 00
101.00 10100 HOME HEALTH AGENCY	0	0	0	0		101. 00
102.00 10200 OPIOLD TREATMENT PROGRAM	0	0	0	0	0	102. 00
SPECIAL PURPOSE COST CENTERS						
105.00 10500 KIDNEY ACQUISITION	0	0	0	0		105. 00
106. 00 10600 HEART ACQUI SI TI ON	0	0	0	0		106. 00
107.00 10700 LIVER ACQUISITION	0	0	0	0		107. 00
108.00 10800 LUNG ACQUISITION	0	0	0	0		108. 00
109.00 10900 PANCREAS ACQUISITION	0	0	0	0		109. 00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON	0	0	0	0		110. 00
111. 00 11100 SLET ACQUI SITI ON	0	0	0	0	0	111. 00
113. 00 11300 I NTEREST EXPENSE						113. 00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF	_	_	_	_	_	114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	0		115. 00
116. 00 11600 HOSPI CE	0	0	0	0		116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	254, 912	394, 562	267, 660	1, 040, 224	373, 857	1118. 00
NONREI MBURSABLE COST CENTERS			1	-		
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
191. 00 19100 RESEARCH	0	0	0	0		191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	1, 429	0		1.,2.00
193. 00 19300 NONPAI D WORKERS	0	0	0	0		193. 00
194. 00 07950 BEACON JOINT VENTURE	0	0	0	0		194. 00
194. 01 07951 WORKI NG WELL	0	0	578	454		194. 01
194. 03 07953 MED WATCHER	0	0	0	0		194. 03
194. 10 07960 DUNELAND FITNESS CTR	0	0	0	0		194. 10
194. 11 07961 OMNI HEALTH & FITNESS CHESTERTOWN	0	0	0	32		194. 11
194. 16 07966 PHYSI CI AN PRACTI CE MD WI SW	0	0	164	U		194. 16
194. 19 07969 HEALTH PARTNERS		0	0	0		194. 19 194. 20
194. 20 07970 CENTER OF HOPE		0	529	U	0	
200.00 Cross Foot Adjustments		0		E2 102	^	200.00
201.00 Negative Cost Centers	254 012	204 5/2	270 24	53, 103		201. 00
202.00 TOTAL (sum lines 118 through 201)	254, 912	394, 562	270, 366	1, 093, 813	3/3,85/	J2U2. UU

| Peri od: | Worksheet B | From 01/01/2022 | Part | I | To 12/31/2022 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0015

				Т	o 12/31/2022	Date/Time Pre 4/13/2023 4:1	
				OTHER GENERAL		17 107 2020 11	, p
	Cost Contan Decemintion	MEDICAL	COCLAL CEDVICE	SERVI CE	MONDHIVELCLAN	NUDCLNC	
	Cost Center Description	MEDI CAL RECORDS &	SOCIAL SERVICE	I NSERVI CE EDUCATI ON	NONPHYSI CI AN ANESTHETI STS	NURSI NG PROGRAM	
		LI BRARY		2500/117 OIL	7.11.20111.211.010	7 110 0117 1111	
	OFNEDAL CEDILOF OCCT OFNEDO	16.00	17. 00	18. 00	19. 00	20.00	
1. 00	GENERAL SERVICE COST CENTERS O0100 CAP REL COSTS-BLDG & FIXT	I	I	I		I	1.00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						5. 00
6.00	00600 MAI NTENANCE & REPAI RS						6.00
7. 00 8. 00	OO7OO OPERATION OF PLANT OO8OO LAUNDRY & LINEN SERVICE						7. 00 8. 00
9. 00	00900 HOUSEKEEPING						9. 00
10.00	01000 DI ETARY						10. 00
11.00	01100 CAFETERI A						11. 00
13. 00 14. 00	O1300 NURSI NG ADMI NI STRATI ON O1400 CENTRAL SERVI CES & SUPPLY						13. 00 14. 00
15. 00	01500 PHARMACY						15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	48, 562					16. 00
17. 00	01700 SOCIAL SERVICE	0	0				17. 00
18.00	01080 I NSERVI CE EDUCATI ON	0	0				18. 00
19. 00 20. 00	01900 NONPHYSICIAN ANESTHETISTS 02000 NURSING PROGRAM	0	0	0			19. 00 20. 00
21. 00	02100 I &R SERVI CES-SALARY & FRINGES APPRV		0				21.00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	Ō				22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0	0	0			23. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	2 (05				ı	20.00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 NTENSIVE CARE UNIT	3, 685 625					30. 00 31. 00
32. 00	03200 CORONARY CARE UNIT	0		•			32. 00
33. 00	03300 BURN INTENSIVE CARE UNIT	0	0	1			33. 00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0	0	0			34. 00
40. 00 41. 00	04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF	227	0	0			40. 00 41. 00
43. 00	04300 NURSERY	71		Ö			43. 00
44. 00	04400 SKILLED NURSING FACILITY	0	0	0			44. 00
45. 00	04500 NURSING FACILITY	0	0				45. 00
46. 00	O4600 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS	0	0	0			46. 00
50.00	05000 OPERATING ROOM	6, 945	0	0			50.00
51. 00	05100 RECOVERY ROOM	0	_				51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	128					52. 00
53. 00 54. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	433 6, 227		0			53. 00 54. 00
54. 01	05401 FSED RADIOLOGY - DIAGNOSTIC	1, 279		Ö			54. 01
55. 00	05500 RADI OLOGY-THERAPEUTI C	902		0			55. 00
55. 01	O5501 WOODLAND CANCER CARE CTR	264	l .	0			55. 01
56. 00 57. 00	05600	0	0	0			56. 00 57. 00
	05800 MRI	0	Ö	Ö			58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	1, 707	0	0			59. 00
60.00	06000 LABORATORY	4, 802		0			60.00
60. 01 61. 00	06001 FS ED LAB 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	773	0	0			60. 01 61. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	О	0			62.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	71	0	0			63. 00
63. 01	06301 FS ED BLOOD BANK	1	0	0			63. 01
64. 00 65. 00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	860	0	0			64. 00 65. 00
66. 00	06600 PHYSI CAL THERAPY	938	l .	0			66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0	Ö	Ö			67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0	0			68. 00
69. 00	06900 ELECTROCARDI OLOGY	1, 438	0	0			69. 00
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 935	0	0			70. 00 71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	1, 424		Ö			72. 00
	07300 DRUGS CHARGED TO PATIENTS	7, 350	0	0			73. 00
	07400 RENAL DIALYSIS	0	0	0			74.00
75. 00 76. 00	07500 ASC (NON-DISTINCT PART) 03020 CLINIC		0	0			75. 00 76. 00
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION		0				77. 00
	OUTPATIENT SERVICE COST CENTERS	1	1				
	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0				88. 00 89. 00
	09000 CLINIC		0				90.00
		•	•		•		·

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2022 | Part II | To 12/31/2022 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0015

			'	0 12/31/2022	4/13/2023 4:	
			OTHER GENERAL			
			SERVI CE			
Cost Center Description	MEDI CAL	SOCI AL SERVI CE		NONPHYSI CI AN	NURSI NG	
	RECORDS &		EDUCATI ON	ANESTHETI STS	PROGRAM	
	LI BRARY	17.00	10.00	10.00	20.00	
90. 03 09003 NFUSI ON OP SERVI CES	16.00	17. 00	18.00	19. 00	20.00	90. 03
91. 00 09100 EMERGENCY	1, 100 4, 421	l control of the cont				91.00
91. 00 09100 EMERGENCY 91. 01 09101 FREE STANDI NG EMERGENCY DEPT	956	l control of the cont				91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	950	9	0			92.00
OTHER REIMBURSABLE COST CENTERS						72.00
94. 00 09400 HOME PROGRAM DIALYSIS		0				94. 00
95. 00 09500 AMBULANCE SERVICES		-				95. 00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED		1				96. 00
97. 00 09700 DURABLE MEDICAL EQUI P-SOLD						97. 00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS						98. 00
99. 00 09900 CMHC						99. 00
99. 10 09910 CORF			0			99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM			0			100.00
101. 00 10100 HOME HEALTH AGENCY			0			101.00
102.00 10200 OPIOID TREATMENT PROGRAM		0	0			102. 00
SPECIAL PURPOSE COST CENTERS			_			1.02.00
105. 00 10500 KIDNEY ACQUISITION	C	0	0			105. 00
106. 00 10600 HEART ACQUISITION	C	o	0			106.00
107.00 10700 LIVER ACQUISITION	C	o	0			107.00
108.00 10800 LUNG ACQUISITION		0	0			108. 00
109.00 10900 PANCREAS ACQUISITION	C	0	0			109. 00
110.00 11000 INTESTINAL ACQUISITION	C	0	0			110.00
111.00 11100 ISLET ACQUISITION	C	0	0			111. 00
113.00 11300 I NTEREST EXPENSE						113. 00
114.00 11400 UTILIZATION REVIEW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	C	0	0			115. 00
116. 00 11600 HOSPI CE	C	0	0			116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	48, 562	2 0	0	0	(118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	C		0			190. 00
191. 00 19100 RESEARCH	C	1	0			191. 00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	C	0	0			192. 00
193. 00 19300 NONPALD WORKERS	C	0	0			193. 00
194.00 07950 BEACON JOINT VENTURE	C	0	0			194. 00
194. 01 07951 WORKI NG WELL	C	0	0			194. 01
194. 03 07953 MED WATCHER	0	0	0			194. 03
194. 10 07960 DUNELAND FITNESS CTR		0	0			194. 10
194. 11 07961 OMNI HEALTH & FITNESS CHESTERTOWN		0	0			194. 11
194. 16 07966 PHYSI CI AN PRACTI CE MD WI SW						194. 16
194. 19 07969 HEALTH PARTNERS		0	0			194. 19
194. 20 07970 CENTER OF HOPE		0	0	_		194. 20
200.00 Cross Foot Adjustments			_	0	l .	200.00
201.00 Negative Cost Centers	40.57			0	•	201.00
202.00 TOTAL (sum lines 118 through 201)	48, 562	2 0	l 0	1 0	۱ (0 202. 00

| Peri od: | Worksheet B | From 01/01/2022 | Part | I | To 12/31/2022 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0015

				To	12/31/2022	Date/Time Pre 4/13/2023 4:1	
		INTERNS &	RESI DENTS			47 137 2023 4. 1	o piii
		050111 050 041 40	 	5.5.455 55			
	Cost Center Description	Y & FRINGES	SERVICES-OTHER PRGM COSTS	PARAMED ED PRGM	Subtotal	Intern & Residents Cost	
		APPRV	APPRV	I KOW		& Post	
						Stepdown	
		04.00	22.22	00.00	04.00	Adjustments	
	GENERAL SERVICE COST CENTERS	21. 00	22. 00	23. 00	24. 00	25.00	
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
5.00	00500 ADMI NI STRATI VE & GENERAL						5. 00
6. 00 7. 00	OO6OO MAINTENANCE & REPAIRS OO7OO OPERATION OF PLANT						6. 00 7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE						8. 00
9.00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY						10.00
11. 00 13. 00	O1100 CAFETERI A O1300 NURSI NG ADMI NI STRATI ON						11. 00 13. 00
14. 00	01400 CENTRAL SERVI CES & SUPPLY						14. 00
15. 00	01500 PHARMACY						15. 00
16.00	01600 MEDI CAL RECORDS & LI BRARY						16.00
17. 00 18. 00	01700 SOCIAL SERVICE 01080 INSERVICE EDUCATION						17. 00 18. 00
19. 00	01900 NONPHYSI CI AN ANESTHETI STS						19. 00
20. 00	02000 NURSI NG PROGRAM						20. 00
21. 00	02100 I &R SERVI CES-SALARY & FRINGES APPRV	0					21. 00
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRV		0				22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY) INPATIENT ROUTINE SERVICE COST CENTERS			0		1	23. 00
30. 00	03000 ADULTS & PEDIATRICS				5, 344, 747	0	30.00
31.00	03100 INTENSIVE CARE UNIT				940, 563	0	31. 00
32.00	03200 CORONARY CARE UNIT				(0	32.00
33. 00 34. 00	03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT				(0	33. 00 34. 00
40. 00	04000 SUBPROVI DER - I PF				1, 018, 274	1	40.00
41. 00	04100 SUBPROVI DER - I RF				(,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	o o	41. 00
43. 00	04300 NURSERY				180, 769		43. 00
44. 00	04400 SKILLED NURSING FACILITY				(1	44.00
45. 00 46. 00	04500 NURSING FACILITY 04600 OTHER LONG TERM CARE				(1	45. 00 46. 00
10. 00	ANCI LLARY SERVI CE COST CENTERS					,	10.00
50. 00	05000 OPERATING ROOM				6, 164, 079		
51. 00 52. 00	O5100 RECOVERY ROOM O5200 DELIVERY ROOM & LABOR ROOM				222 405	1	51. 00 52. 00
53. 00	05300 ANESTHESI OLOGY				323, 485 84, 770	l l	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C				2, 813, 568	l l	54.00
54. 01	05401 FSED RADIOLOGY - DIAGNOSTIC				207, 658	1	54. 01
55. 00 55. 01	O5500 RADI OLOGY-THERAPEUTI C				892, 488	1	55. 00
	05501 WOODLAND CANCER CARE CTR 05600 RADI OI SOTOPE				102, 18 <i>6</i>		55. 01 56. 00
	05700 CT SCAN				Ć	o o	57. 00
58. 00	05800 MRI				(0	58. 00
	05900 CARDI AC CATHETERI ZATI ON				1, 335, 754		59.00
60. 00 60. 01	06000 LABORATORY 06001 FS ED LAB				589, 158 773		60. 00 60. 01
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY				775	,	61. 00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL				(0	62. 00
	06300 BLOOD STORING, PROCESSING & TRANS.				16, 050	1	63. 00
63. 01	06301 FS ED BLOOD BANK				1	0	63. 01
65. 00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY				295, 404	0	64. 00 65. 00
	06600 PHYSI CAL THERAPY				175, 459	1	66. 00
	06700 OCCUPATI ONAL THERAPY				(0	67. 00
68. 00	06800 SPEECH PATHOLOGY				(40.00	0	68. 00
	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY				612, 387 79	1	69. 00 70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT				152, 072	l .	71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS				165, 119	1	1
	07300 DRUGS CHARGED TO PATIENTS				784, 777	1	73. 00
	07400 RENAL DIALYSIS				(1	1
	O7500 ASC (NON-DISTINCT PART) O3020 CLINIC				19, 578	0 0	75. 00 76. 00
	07700 ALLOGENEIC STEM CELL ACQUISITION				17, 370	1	77. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC				(0	88. 00

| Period: | Worksheet B | From 01/01/2022 | Part II | To | 12/31/2022 | Date/Time | Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0015

			T	12/31/2022		
	INTERNS &	RESI DENTS			4/13/2023 4: 1	8 pm
	1111211110 0	NEO I DEN I O				
Cost Center Description		SERVI CES-OTHER	PARAMED ED	Subtotal	Intern &	
	Y & FRINGES	PRGM COSTS	PRGM		Residents Cost	
	APPRV	APPRV			& Post	
					Stepdown Adjustments	
	21. 00	22. 00	23. 00	24. 00	25. 00	
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER				0	0	89. 00
90. 00 09000 CLI NI C				0	0	90.00
90.03 09003 INFUSION OP SERVICES				217, 086	0	90. 03
91. 00 09100 EMERGENCY				1, 228, 391	0	91. 00
91. 01 09101 FREE STANDING EMERGENCY DEPT				1, 098, 660	l	91. 01
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART					0	92. 00
94.00 OTHER REIMBURSABLE COST CENTERS 94.00 O9400 HOME PROGRAM DIALYSIS				0	0	94. 00
95. 00 09500 AMBULANCE SERVI CES				0	1	95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED				0	1	96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD				0	Ö	97. 00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS				0	0	98. 00
99. 00 09900 CMHC				0	0	99. 00
99. 10 09910 CORF				0	0	99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM				0	0	
101. 00 10100 HOME HEALTH AGENCY				0	l e	101.00
102. 00 10200 OPI OI D TREATMENT PROGRAM				0	0	102. 00
SPECIAL PURPOSE COST CENTERS 105.00 10500 KI DNEY ACQUISITION	1			0		1 105. 00
106. 00 10600 REART ACQUISITION				0		106. 00
107. 00 10700 LI VER ACQUI SI TI ON				0		107. 00
108. 00 10800 LUNG ACQUISITION				0		108.00
109.00 10900 PANCREAS ACQUISITION				0	0	109. 00
110.00 11000 INTESTINAL ACQUISITION				0	l	110. 00
111. 00 11100 I SLET ACQUI SI TI ON				0	0	111. 00
113. 00 11300 I NTEREST EXPENSE						113. 00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF				0		114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 116.00 11600 HOSPICE				0		115. 00 116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	o	0	24, 763, 335	l	118. 00
NONREI MBURSABLE COST CENTERS		<u> </u>	J	21,700,000		1110.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN				824	0	190. 00
191. 00 19100 RESEARCH				0	0	191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES				5, 304	l e	192. 00
193. 00 19300 NONPALD WORKERS				0		193. 00
194. 00 07950 BEACON JOINT VENTURE				52		194. 00
194. 01 07951 WORKI NG WELL				49, 941 0		194. 01 194. 03
194. 03 07953 MED WATCHER 194. 10 07960 DUNELAND FITNESS CTR				0		194. 03
194. 11 07961 OMNI HEALTH & FITNESS CHESTERTOWN				5, 001		194. 10
194. 16 07966 PHYSICIAN PRACTICE MD WISW				1, 480	1	194. 16
194. 19 07969 HEALTH PARTNERS				0	l	194. 19
194.20 07970 CENTER OF HOPE				6, 394		194. 20
200.00 Cross Foot Adjustments	0		0	0	•	200. 00
201.00 Negative Cost Centers	0		0	53, 103	•	201. 00
202.00 TOTAL (sum lines 118 through 201)	0	0	0	24, 885, 434	1 0	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0015

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2022 Part II
To 12/31/2022 Date/Time Prepared:
4/13/2023 4:18 pm

			4/13/2023 4:	
	Cost Center Description	Total		
	CENEDAL SERVICE COST CENTERS	26. 00		
1. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT			1.00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP			2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT			4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL			5. 00
6.00	00600 MAINTENANCE & REPAIRS			6.00
7. 00 8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE			7. 00 8. 00
9. 00	00900 HOUSEKEEPING			9. 00
10.00	01000 DI ETARY			10.00
11. 00	01100 CAFETERI A			11. 00
13.00	01300 NURSING ADMINISTRATION			13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY			14. 00
15. 00 16. 00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY			15. 00 16. 00
17. 00	01700 SOCIAL SERVICE			17. 00
18. 00	01080 I NSERVI CE EDUCATI ON			18. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS			19. 00
20. 00	02000 NURSI NG PROGRAM			20. 00
21. 00	02100 I &R SERVI CES-SALARY & FRINGES APPRV			21. 00
22. 00 23. 00	02200 1&R SERVICES-OTHER PRGM COSTS APPRV 02300 PARAMED ED PRGM-(SPECIFY)			22. 00
23.00	I NPATIENT ROUTINE SERVICE COST CENTERS			25.00
30. 00	03000 ADULTS & PEDI ATRI CS	5, 344, 747		30.00
31.00	03100 INTENSIVE CARE UNIT	940, 563		31. 00
32.00	03200 CORONARY CARE UNIT	0		32. 00
33. 00	03300 BURN INTENSIVE CARE UNIT	0		33. 00
34. 00 40. 00	03400 SURGICAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF	1, 018, 274		34. 00 40. 00
41. 00	04100 SUBPROVI DER - I RF	1,018,274		41.00
43. 00	04300 NURSERY	180, 769		43. 00
44.00	04400 SKILLED NURSING FACILITY	0		44. 00
45. 00	04500 NURSING FACILITY	0		45. 00
46. 00	04600 OTHER LONG TERM CARE	0		46. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	6, 164, 079		50.00
51. 00	05100 RECOVERY ROOM	0, 104, 079		51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	323, 485		52. 00
53.00	05300 ANESTHESI OLOGY	84, 770		53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	2, 813, 568		54. 00
54. 01 55. 00	05401 FSED RADI OLOGY - DI AGNOSTI C	207, 658 892, 488		54. 01 55. 00
55. 00	O5500 RADI OLOGY-THERAPEUTI C O5501 WOODLAND CANCER CARE CTR	102, 186		55. 00
56. 00	05600 RADI OI SOTOPE	0		56. 00
57. 00	05700 CT SCAN	0		57. 00
58. 00	05800 MRI	0		58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	1, 335, 754		59. 00
	06000 LABORATORY 06001 FS ED LAB	589, 158		60.00
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	773		60. 01 61. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	O		62. 00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	16, 050		63. 00
63. 01	06301 FS ED BLOOD BANK	1		63. 01
64.00	06400 I NTRAVENOUS THERAPY	0		64.00
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	295, 404 175, 459		65. 00 66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	175, 459		67.00
68. 00	06800 SPEECH PATHOLOGY			68. 00
69. 00	06900 ELECTROCARDI OLOGY	612, 387		69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	79		70. 00
71.00	1	152, 072		71. 00
72. 00 73. 00		165, 119 784, 777		72. 00 73. 00
74.00		784,777		74.00
75. 00				75. 00
76. 00		19, 578		76. 00
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0		77. 00
00.05	OUTPATIENT SERVICE COST CENTERS			00.00
	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0		88. 00 89. 00
90.00				90.00
90.03		217, 086		90. 03
91. 00	09100 EMERGENCY	1, 228, 391		91. 00
91. 01	09101 FREE STANDING EMERGENCY DEPT	1, 098, 660		91. 01
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART			92. 00

In Lieu of Form CMS-2552-10
Period: Worksheet B
From 01/01/2022 Part II
To 1/21/2022 Part/Time Propagate Provider CCN: 15-0015

		To 12/31/2022 Date/Time P 4/13/2023 4	repared:
Cost Center Description	Total	17 107 2020	. 10 piii
	26. 00		
OTHER REIMBURSABLE COST CENTERS			
94.00 09400 HOME PROGRAM DIALYSIS	0		94. 00
95. 00 09500 AMBULANCE SERVICES	0		95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0		96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0		97. 00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0		98. 00
99. 00 09900 CMHC	0		99. 00
99. 10 09910 CORF	0		99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0		100. 00
101.00 10100 HOME HEALTH AGENCY	0		101. 00
102.00 10200 OPIOLD TREATMENT PROGRAM	0		102. 00
SPECIAL PURPOSE COST CENTERS			
105.00 10500 KIDNEY ACQUISITION	0		105. 00
106. 00 10600 HEART ACQUISITION	0		106. 00
107.00 10700 LIVER ACQUISITION	0		107. 00
108.00 10800 LUNG ACQUISITION	0		108. 00
109.00 10900 PANCREAS ACQUISITION	0		109. 00
110.00 11000 INTESTINAL ACQUISITION	0		110. 00
111.00 11100 ISLET ACQUISITION	0		111. 00
113.00 11300 I NTEREST EXPENSE			113. 00
114.00 11400 UTILIZATION REVIEW-SNF			114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0		115. 00
116. 00 11600 HOSPI CE	0		116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	24, 763, 335		118. 00
NONREI MBURSABLE COST CENTERS			
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	824		190. 00
191. 00 19100 RESEARCH	0		191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	5, 304		192. 00
193. 00 19300 NONPALD WORKERS	0		193. 00
194.00 07950 BEACON JOINT VENTURE	52		194. 00
194. 01 07951 WORKING WELL	49, 941		194. 01
194.03 07953 MED WATCHER	0		194. 03
194.10 07960 DUNELAND FITNESS CTR	0		194. 10
194.11 07961 OMNI HEALTH & FITNESS CHESTERTOWN	5, 001		194. 11
194.16 07966 PHYSICIAN PRACTICE MD WISW	1, 480		194. 16
194. 19 07969 HEALTH PARTNERS	0		194. 19
194.20 07970 CENTER OF HOPE	6, 394		194. 20
200.00 Cross Foot Adjustments	0		200. 00
201.00 Negative Cost Centers	53, 103		201. 00
202.00 TOTAL (sum lines 118 through 201)	24, 885, 434		202. 00

		TION - STATISTICAL BASIS	ANCI SCAN TILALTI		CN: 15-0015 F	Peri od:	Worksheet B-1	
						From 01/01/2022 To 12/31/2022	Date/Time Pre	nared:
						12/31/2022	4/13/2023 4: 1	8 pm
			CAPITAL REI	LATED COSTS				
		Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Reconciliation	ADMINISTRATIVE	
		Cost Center Description	(SQUARE FEET)	(DOLLAR VALUE)		Reconciliation	& GENERAL	
				,	DEPARTMENT		(ACCUM. COST)	
					(GROSS			
			1.00	2.00	SALARI ES) 4. 00	5A	5. 00	
	GENER	AL SERVICE COST CENTERS	1.00	2.00	4.00	J.A.	3.00	
1.00		CAP REL COSTS-BLDG & FIXT	455, 194					1.00
2.00		CAP REL COSTS-MVBLE EQUIP		7, 332, 083	1			2.00
4. 00 E. 00	1	EMPLOYEE BENEFITS DEPARTMENT	2, 216				105 240 071	4.00
5. 00 6. 00		ADMINISTRATIVE & GENERAL MAINTENANCE & REPAIRS	39, 650		19, 588, 964	-49, 363, 884	185, 348, 871 0	
7. 00		OPERATION OF PLANT	75, 292		3, 828, 360	o o	16, 752, 716	
8.00		LAUNDRY & LINEN SERVICE	1, 383				1, 543, 269	
9.00		HOUSEKEEPI NG	17, 014				3, 415, 556	
10. 00 11. 00		DI ETARY CAFETERI A	4, 649 9, 050				1, 289, 688 1, 792, 137	
13. 00		NURSING ADMINISTRATION	2, 147		1			1
14. 00		CENTRAL SERVICES & SUPPLY	16, 750		1	0	777, 021	
15.00		PHARMACY	6, 037		1		.,	
16. 00 17. 00		MEDICAL RECORDS & LIBRARY SOCIAL SERVICE	678		6, 881		1, 430, 407 0	1
18. 00	1	I NSERVI CE EDUCATI ON					0	1
19. 00	01900	NONPHYSICIAN ANESTHETISTS	0	o		0	0	19. 00
20. 00		NURSI NG PROGRAM	0	0		0	0	
21. 00	1	I &R SERVICES-SALARY & FRINGES APPRV	0	0		0	0	21.00
22. 00 23. 00		I&R SERVICES-OTHER PRGM COSTS APPRV PARAMED ED PRGM-(SPECIFY)					•	
23.00		TENT ROUTINE SERVICE COST CENTERS			/	<u>, </u>		25.00
30.00	03000	ADULTS & PEDIATRICS	84, 256	524, 245	17, 827, 210	0		
31.00		INTENSIVE CARE UNIT	13, 428	114, 967	3, 573, 698		5, 395, 873	
32. 00 33. 00		CORONARY CARE UNIT BURN INTENSIVE CARE UNIT	0			0 0	0	
34. 00		SURGICAL INTENSIVE CARE UNIT					0	1
40. 00		SUBPROVIDER - I PF	21, 871	20, 240	1, 244, 441		2, 827, 702	1
41.00		SUBPROVI DER - I RF	0	O		0	0	
43.00	1	NURSERY	4, 142	0	434, 468		852, 268	
44. 00 45. 00		SKILLED NURSING FACILITY NURSING FACILITY	0			0 0	0	
46. 00		OTHER LONG TERM CARE					1	1
	ANCI L	LARY SERVICE COST CENTERS		1				
		OPERATING ROOM	53, 944	1, 666, 940	6, 716, 688			1
51. 00 52. 00		RECOVERY ROOM DELIVERY ROOM & LABOR ROOM	7, 412		779, 056	0 0	0 1, 527, 839	
53. 00		ANESTHESI OLOGY	175		1			1
	05400	RADI OLOGY-DI AGNOSTI C	19, 891	996, 522	3, 898, 550	0	7, 648, 914	54.00
		FSED RADI OLOGY - DI AGNOSTI C	0	88, 343			1, 855, 745	
55. 00 55. 01	1	RADIOLOGY-THERAPEUTIC WOODLAND CANCER CARE CTR	3, 265 2, 018		567, 041 387, 502		2, 139, 096 550, 514	
56. 00		RADI OI SOTOPE	2,010) 367, 302		0 550, 514	1
57. 00		CT SCAN	0	Ö		o o	Ö	1
58. 00	05800		0	O		0	0	
59.00		CARDI AC CATHETERI ZATI ON	5, 326				2, 653, 674	•
60. 00 60. 01		LABORATORY FS ED LAB	8, 336	28, 782		0	11, 321, 150 0	1
61. 00		PBP CLINICAL LAB SERVICES-PRGM ONLY			1	ĺ		61.00
62. 00		WHOLE BLOOD & PACKED RED BLOOD CELL	0	o		0	0	1
63. 00		BLOOD STORING, PROCESSING & TRANS.	394	0		0	10, 027	1
63. 01		FS ED BLOOD BANK	0	0		0	0	
64. 00 65. 00		I NTRAVENOUS THERAPY RESPI RATORY THERAPY	2,006	83, 135	1, 309, 389	9 0	0 2, 430, 351	
66. 00	1	PHYSI CAL THERAPY	1, 490		1		3, 416, 638	1
67. 00		OCCUPATI ONAL THERAPY	0	O) (0	0	1
68. 00		SPEECH PATHOLOGY	0	0	(0	0	1
69. 00 70. 00		ELECTROCARDI OLOGY ELECTROENCEPHALOGRAPHY	8, 941	111, 781	1, 028, 305	0	1, 788, 454 0	1
		MEDICAL SUPPLIES CHARGED TO PATIENT					10, 108, 188	1
72.00	1	IMPL. DEV. CHARGED TO PATIENTS	0	O		0	11, 021, 027	1
		DRUGS CHARGED TO PATIENTS	0	0		0	27, 170, 064	1
		RENAL DIALYSIS ASC (NON-DISTINCT PART)				0	0	
		CLINIC		4, 707	344, 076	5 0	1	
77. 00	07700	ALLOGENEIC STEM CELL ACQUISITION	o			o o		1
	OUTPA	TIENT SERVICE COST CENTERS						1
88. 00	08800	RURAL HEALTH CLINIC	0	0) (0	0	88. 00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0015

				T	o 12/31/2022	Date/Time Pre 4/13/2023 4:1	
		CAPLTAL REL	LATED COSTS			47 137 2023 4. 1	o piii
		07.11.71.2 11.22	27.725 000.0				
	Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Reconciliation	ADMI NI STRATI VE	
		(SQUARE FEET)	(DOLLAR VALUE)	BENEFITS		& GENERAL	
				DEPARTMENT		(ACCUM. COST)	
				(GROSS			
				SALARI ES)			
00.00.0000	EEDEDALLY QUALLELED HEALTH OFNIED	1.00	2.00	4. 00	5A	5. 00	00.00
	FEDERALLY QUALIFIED HEALTH CENTER	0	1				89. 00
	CLINIC	2 212	0	· -	0	0	90.00
	INFUSION OP SERVICES EMERGENCY	3, 213 18, 839			0	1, 877, 122	90. 03
	FREE STANDING EMERGENCY DEPT	21, 381	129, 669 77, 808		ū	6, 993, 419 3, 476, 304	91. 00 91. 01
1	OBSERVATION BEDS (NON-DISTINCT PART	21, 301	77,000	1, 721, 777	0	3, 470, 304	92. 00
	REIMBURSABLE COST CENTERS						72.00
	HOME PROGRAM DI ALYSI S	0	0	0	0	0	94. 00
	AMBULANCE SERVICES	0	0				95. 00
	DURABLE MEDICAL EQUIP-RENTED	0	Ö	Ö	0	Ö	96. 00
	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97. 00
	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98. 00
99. 00 09900	CMHC	0	0	0	0	0	99. 00
99. 10 09910	CORF	0	0	0	0	0	99. 10
100.00 10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100. 00
	HOME HEALTH AGENCY	0	0	0	0	l	101. 00
	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102. 00
	AL PURPOSE COST CENTERS	T	T				
	KIDNEY ACQUISITION	0	0			•	105. 00
	HEART ACQUISITION	0	0	· ·	0	•	106. 00
	LIVER ACQUISITION	0	0	0	0	l	107. 00
	LUNG ACQUISITION	0	0	0	0	l	108. 00
	PANCREAS ACQUISITION	0	0	0	0		109. 00
	INTESTINAL ACQUISITION	0	0	0	0		110. 00 111. 00
	ISLET ACQUISITION INTEREST EXPENSE	0	0	U	0	0	113. 00
	UTILIZATION REVIEW-SNF						114. 00
	AMBULATORY SURGICAL CENTER (D. P.)	0	_	_	0	0	115. 00
116. 00 11600		0	0	0	0	l	116. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	455, 194	7, 308, 112	81, 710, 799	-49, 363, 884	l e	
	I MBURSABLE COST CENTERS	100, 171	7,000,112	01,710,777	17,000,001	101, 101, 000	1110.00
	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	55, 451	190. 00
191. 00 19100		0	0	0	0	l	191. 00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	1, 988	141, 131	0	192. 00
193.00 19300	NONPALD WORKERS	0	0	0	0	0	193. 00
194. 00 07950	BEACON JOINT VENTURE	0	0	0	0	3, 482	194. 00
194. 01 07951	WORKING WELL	0	21, 166	450, 639	0	596, 080	194. 01
	MED WATCHER	0	0	0	0	ł	194. 03
	DUNELAND FITNESS CTR	0	0	0	0	l e	194. 10
	OMNI HEALTH & FITNESS CHESTERTOWN	0	0	660, 013	0	170, 621	
	PHYSICIAN PRACTICE MD WISW	0	0	58, 269	0	74, 182	
	HEALTH PARTNERS	0	0	0	0		194. 19
	CENTER OF HOPE	0	2, 805	31, 311	0	44, 525	
200.00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers	11 504 407	12 201 007	21 517 207		l	201. 00
202. 00	Cost to be allocated (per Wkst. B,	11, 584, 427	13, 301, 007	21, 516, 396		49, 363, 884	202.00
203. 00	Part I) Unit cost multiplier (Wkst. B, Part I)	25. 449428	1. 814083	0. 259506		0. 266330	303 00
204. 00	Cost to be allocated (per Wkst. B,	25. 447420	1.014003	305, 152		2, 753, 001	•
204.00	Part II)			303, 132		2, 755, 001	204.00
205. 00	Unit cost multiplier (Wkst. B, Part			0. 003680		0. 014853	205. 00
206. 00	NAHE adjustment amount to be allocated						206. 00
	(per Wkst. B-2)						
207. 00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)						

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0015

Peri od: Worksheet B-1 From 01/01/2022 To 12/31/2022 Date/Ti me Prepared:

4/13/2023 4:18 pm Cost Center Description MAINTENANCE & OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY REPAIRS PLANT LINEN SERVICE (SQUARE FEET) (MEALS SERVED) (SQUARE FEET) (SQUARE FEET) (POUNDS OF LAUNDRY) 7.00 6.00 9.00 10.00 8.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4 00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00600 MAINTENANCE & REPAIRS 6.00 413, 328 6.00 00700 OPERATION OF PLANT 7.00 75, 292 338, 036 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 1, 383 1, 383 795, 207 8.00 9.00 00900 HOUSEKEEPI NG 17,014 17,014 319, 639 9.00 01000 DI ETARY 4,649 4, 649 318 4,649 133, 226 10.00 10.00 9, 050 01100 CAFETERI A 9.050 9,050 11 00 \cap Λ 11.00 01300 NURSING ADMINISTRATION 13.00 2, 147 2, 147 0 2, 147 0 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 16, 750 16, 750 16, 750 14.00 01500 PHARMACY 6,037 6, 037 0 6,037 15.00 15.00 0 01600 MEDICAL RECORDS & LIBRARY 16.00 678 678 0 678 0 16.00 17.00 01700 SOCIAL SERVICE 0 17.00 01080 INSERVICE EDUCATION 0 0 18.00 0 0 0 18.00 0 0 01900 NONPHYSICIAN ANESTHETISTS 0 19 00 C 0 19 00 20.00 02000 NURSING PROGRAM C 0 0 0 20.00 02100 I &R SERVICES-SALARY & FRINGES APPRV 0 0 0 0 21.00 21.00 C 22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 0 22.00 0 02300 PARAMED ED PRGM-(SPECIFY) O 23 00 23.00 0 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 84, 256 84, 256 373, 747 84, 256 106, 724 30.00 31 00 03100 INTENSIVE CARE UNIT 13 428 13, 428 13, 428 15, 016 31 00 39, 760 03200 CORONARY CARE UNIT 32.00 0 C 32.00 0 0 03300 BURN INTENSIVE CARE UNIT 0 0 0 33.00 33.00 0 34.00 03400 SURGICAL INTENSIVE CARE UNIT 34.00 C 0 04000 SUBPROVI DER - I PF 40 00 21, 871 21, 871 119, 281 21, 871 11, 486 40 00 04100 SUBPROVIDER - IRF 41.00 0 41.00 04300 NURSERY 239 43.00 43.00 4.142 4.142 4.142 0 44.00 04400 SKILLED NURSING FACILITY C 0 44.00 0 O 04500 NURSING FACILITY 45 00 45 00 0 C 0 0 04600 OTHER LONG TERM CARE 0 0 46.00 46.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 53.944 53, 944 42. 146 53. 944 0 50.00 05100 RECOVERY ROOM 51.00 C 0 51.00 7, 412 52.00 05200 DELIVERY ROOM & LABOR ROOM 7, 412 7, 412 0 52.00 53 00 05300 ANESTHESI OLOGY 175 175 175 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 19,891 31, 967 19, 891 54.00 54.00 19, 891 0 05401 FSED RADIOLOGY - DIAGNOSTIC 54.01 0 54.01 55.00 05500 RADI OLOGY-THERAPEUTI C 3, 265 3, 265 398 3, 265 0 55.00 05501 WOODLAND CANCER CARE CTR 2,018 2,018 7, 952 2,018 55.01 55.01 05600 RADI OI SOTOPE 56.00 0 C 0 0 0 56.00 57.00 05700 CT SCAN 0 C 0 0 0 57.00 58.00 05800 MRI C 58.00 59.00 05900 CARDIAC CATHETERIZATION 5, 326 5, 326 239 5, 326 59.00 0 60.00 06000 LABORATORY 8.336 8, 336 C 8.336 0 60.00 06001 FS ED LAB 60.01 0 60.01 61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 62.00 0 0 0 0 62.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 394 394 0 394 0 63.00 63.01 06301 FS ED BLOOD BANK 0 0 0 0 63.01 06400 I NTRAVENOUS THERAPY 64.00 64.00 0 0 06500 RESPIRATORY THERAPY 2, 006 65.00 2.006 2,006 0 65.00 66.00 06600 PHYSI CAL THERAPY 1,490 1, 490 23, 856 1, 490 0 66.00 06700 OCCUPATIONAL THERAPY 67.00 0 67.00 06800 SPEECH PATHOLOGY 68.00 0 0 68.00 06900 ELECTROCARDI OLOGY 69.00 8,941 8, 941 3, 976 8,941 0 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 0 0 0 0 71.00 72 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 72 00 C 07300 DRUGS CHARGED TO PATIENTS 0 73.00 0 0 0 73.00 07400 RENAL DIALYSIS 0 0 0 0 74.00 74.00 0 0 75.00 07500 ASC (NON-DISTINCT PART) 0 0 0 75.00 76.00 03020 CLI NI C 0 0 0 C 0 76.00 77.00 07700 ALLOGENEIC STEM CELL ACQUISITION C 0 0 77.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 n C 0 0 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 89 00 0 C 0 0 89.00 90.00 09000 CLI NI C 0 0 90.00 90.03 09003 INFUSION OP SERVICES 3.213 3, 213 239 3.213 0 90.03 Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0015 Peri od: Worksheet B-1 From 01/01/2022 To 12/31/2022 Date/Time Prepared:

				T	o 12/31/2022		
Cost	Center Description	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	4/13/2023 4: 1 DI ETARY	8 piii
0001	conton boson per on	REPAI RS	PLANT	LINEN SERVICE	(SQUARE FEET)	(MEALS SERVED)	
		(SQUARE FEET)	(SQUARE FEET)	(POUNDS OF	, ,	ĺ	
				LAUNDRY)			
		6. 00	7. 00	8. 00	9. 00	10. 00	
91. 00 09100 EMERG		18, 839		1	18, 839	0	
1 1	STANDING EMERGENCY DEPT	21, 381	21, 381	31, 808	21, 381	0	
	RVATION BEDS (NON-DISTINCT PART BURSABLE COST CENTERS						92.00
	PROGRAM DIALYSIS	0	0	0	0	0	94. 00
	ANCE SERVICES	0	1	1	_	0	
1 1	BLE MEDICAL EQUIP-RENTED	Ö			0	Ö	1
	BLE MEDICAL EQUIP-SOLD	0	i c	Ó	0	0	1
98. 00 09850 OTHER	REIMBURSABLE COST CENTERS	0	0	0	0	0	98. 00
99.00 09900 CMHC		0	0	0	0	0	
99. 10 09910 CORF		0	0	0	0	0	
	SERVICES-NOT APPRVD PRGM	0	-	0	0	0	100.00
101. 00 10100 HOME		0		· ·	0		101.00
	D TREATMENT PROGRAM	0	0	0	0	0	102. 00
105. 00 10500 KI DNE	RPOSE COST CENTERS	0		0	0		105. 00
106. 00 10600 HEART			l e	_	_		106. 00
107. 00 10700 LI VER		0	-	1			107. 00
108. 00 10800 LUNG		0	1	_	0	-	108. 00
109. 00 10900 PANCR		0	Ö	Ō	0	-	109. 00
110. 00 11000 I NTES		0	C	Ö	0	0	110.00
111. 00 11100 I SLET	ACQUI SI TI ON	0	O	0	0	0	111. 00
113. 00 11300 I NTER	REST EXPENSE						113. 00
114. 00 11400 UTI LI							114. 00
	ATORY SURGICAL CENTER (D. P.)	0	0	0	0	-	115. 00
116. 00 11600 HOSPI		0	0	0	0		116. 00
	OTALS (SUM OF LINES 1 through 117) SABLE COST CENTERS	413, 328	338, 036	755, 447	319, 639	133, 226]118. 00]
	FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
191. 00 19100 RESEA		0					191. 00
	CLANS' PRIVATE OFFICES	0			_		192. 00
193. 00 19300 NONPA		0	-	0	0		193. 00
194. 00 07950 BEAC0	N JOINT VENTURE	0	0	0	0	0	194. 00
194. 01 07951 WORKI	NG WELL	0	0	0	0		194. 01
194.03 07953 MED W		0		0	0		194. 03
194. 10 07960 DUNEL		0	1	0	0		194. 10
	HEALTH & FITNESS CHESTERTOWN	0	0	0	0		194. 11
194. 16 07966 PHYST	CLAN PRACTICE MD WISW	0		0	0		194. 16 194. 19
194. 19 07969 REALT		0			0		194. 19
1 1	Foot Adjustments	0			0		200. 00
	ive Cost Centers						201. 00
	to be allocated (per Wkst. B,	0	21, 214, 467	2, 041, 082	5, 392, 986	2, 004, 187	1
Part			, , , , ,	, ,		,	
203. 00 Uni t	cost multiplier (Wkst. B, Part I)	0. 000000	62. 758011	2. 566730	16. 872115	15. 043513	203. 00
	to be allocated (per Wkst. B,	0	4, 088, 474	77, 370	841, 762	254, 912	204. 00
Part							
	cost multiplier (Wkst. B, Part	0. 000000	12. 094789	0. 097295	2. 633477	1. 913380	205. 00
204 00 NAUE	adjustment amount to be allegated						204 00
	adjustment amount to be allocated Wkst. B-2)						206. 00
1 1 7	unit cost multiplier (Wkst. D,						207. 00
	III and IV)						
	•			•	•	•	•

	ALLOCATION - STATISTICAL BASIS	INNOTSOAN TIERET	Provi der CC	N: 15-0015 P	eri od:	Worksheet B-1	
				F To	rom 01/01/2022 o 12/31/2022	Date/Time Pre	pared:
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	4/13/2023 4: 1 MEDI CAL	8 pm
	Cost Center Description	(FTE'S)	ADMI NI STRATI ON	SERVICES &	(COSTED	RECORDS &	
		(,		SUPPLY	REQUIS.)	LI BRARY	
			(DIRECT NRSING	(COSTED		(GROSS CHAR	
		11.00	HRS)	REQUIS.)	15.00	GES)	
	GENERAL SERVICE COST CENTERS	11.00	13. 00	14. 00	15. 00	16. 00	
1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00 6. 00	00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS						5. 00 6. 00
7. 00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
9.00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY						10. 00
11.00	01100 CAFETERI A	61, 376	1				11.00
13. 00 14. 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	3, 220 470		21, 054, 315			13. 00 14. 00
15. 00	01500 PHARMACY	2, 891	1	150, 030			15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	8	o o	0	0	1, 110, 182, 135	16. 00
17. 00	01700 SOCIAL SERVICE	C	0	0	0	0	
	01080 I NSERVI CE EDUCATI ON			0	0	0	
20. 00	01900 NONPHYSICIAN ANESTHETISTS 02000 NURSING PROGRAM			0	0	0	19. 00 20. 00
21. 00			ol ol	0	0	0	
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	C	o	0	0	0	22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)		0	0	0	0	23. 00
20 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	20, 206	19, 996	1, 054, 918	0	83, 742, 675	30.00
31.00		3, 771	1	336, 513		14, 196, 770	
32. 00		0,777	1	0	Ö	0	
33. 00	03300 BURN INTENSIVE CARE UNIT	C	0	0	0	0	
34.00	03400 SURGICAL INTENSIVE CARE UNIT	1 (01	0	0	0	0	
40. 00 41. 00	04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF	1, 691	1, 858	5, 581	0	5, 169, 917 0	40.00
			ol ol	0	0	1, 624, 297	
44.00	04400 SKILLED NURSING FACILITY	C	o	0	0	0	1
45. 00	04500 NURSING FACILITY	C	0	0	0	0	
46. 00	04600 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS)	0	0	0	46. 00
50. 00		8, 652	4, 396	12, 795, 002	0	157, 848, 558	50.00
51.00	05100 RECOVERY ROOM	C	o	0	0	0	
	05200 DELIVERY ROOM & LABOR ROOM	(0	0	2, 912, 572	
53. 00 54. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	17 <i>6</i> 5, 041	1	716, 679	0	9, 842, 518 141, 523, 535	
54. 00	05401 FSED RADIOLOGY - DIAGNOSTIC	1, 566	1	51, 564	0	29, 059, 002	
55.00	05500 RADI OLOGY-THERAPEUTI C	672	el o	381, 726	0	20, 508, 758	
	05501 WOODLAND CANCER CARE CTR	470	1	91, 851	0	6, 000, 798	1
56.00	05600 RADI 0I SOTOPE 05700 CT SCAN		1	0	0	0	
57. 00 58. 00	05800 MRI			0	0	0	57. 00 58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	989	680	3, 703, 886	0	38, 796, 753	
60.00	06000 LABORATORY	C	o	588, 093	0	109, 131, 773	
60. 01	06001 FS ED LAB	C	이	0	0	17, 565, 031	
61. 00 62. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL			0	0	0	61. 00 62. 00
63.00	1			0	0	1, 614, 175	
63. 01	06301 FS ED BLOOD BANK	d	o	0	0	17, 819	
64. 00		C	o	0	0	0	
65. 00	06500 RESPI RATORY THERAPY	1, 533		250, 063	0	19, 543, 256	
67.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	1, 135	1	26, 895 0	0	21, 325, 045 0	1
	06800 SPEECH PATHOLOGY		ol ol	0	0	0	
69. 00		1, 302	1, 314	37, 356	0	32, 687, 872	1
70. 00		C	13	0	0	0	
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS			0	0	43, 988, 239 32, 363, 108	1
	07300 DRUGS CHARGED TO PATIENTS			0	100	173, 516, 410	1
74.00	07400 RENAL DIALYSIS	d	o o	0	0	0	1
75. 00	07500 ASC (NON-DISTINCT PART)	C	o	0	0	0	75. 00
76.00			247	645		0	
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION OUTPATIENT SERVICE COST CENTERS	C	0	0	0	0	77. 00
88. 00			o	0	0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	C	1	0	0	0	89. 00
90. 00	09000 CLI NI C	C	0	0	0	0	90.00

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0015 Peri od: Worksheet B-1 From 01/01/2022 12/31/2022 Date/Time Prepared: 4/13/2023 4:18 pm Cost Center Description CAFETERI A NURSI NG CENTRAL **PHARMACY** MEDI CAL ADMI NI STRATI ON SERVICES & (COSTED RECORDS & (FTE'S) **SUPPLY** REQUIS.) LI BRARY (DIRECT NRSING (COSTED (GROSS CHAR REQUIS.) HRS) GES) 15.00 11.00 13.00 14.00 16.00 24, 988, 730 90. 03 09003 INFUSION OP SERVICES 115, 600 689 622 90.03 09100 EMERGENCY 91.00 4,977 6, 588 645, 038 0 100, 484, 593 91.00 91.01 09101 FREE STANDING EMERGENCY DEPT 1,917 93, 042 0 21, 729, 931 91.01 3, 212 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0 0 0 94.00 0 0 09500 AMBULANCE SERVICES 0 0 0 0 0 95.00 95.00 0 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0000 0 0 0 96.00 97.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 97.00 09850 OTHER REIMBURSABLE COST CENTERS 0 0 98.00 98 00 0 09900 CMHC 0 99.00 99.00 0 0 99. 10 09910 CORF 0 0 99. 10 100.00 10000 I &R SERVICES-NOT APPRVD PRGM 0 0 0 100.00 0 0 101.00 10100 HOME HEALTH AGENCY 0 0 101 00 Ω 0 102.00 10200 OPIOID TREATMENT PROGRAM 0 0 102.00 SPECIAL PURPOSE COST CENTERS 0 105. 00 10500 KIDNEY ACQUISITION 0 0 105, 00 Ω 0 0 106.00 10600 HEART ACQUISITION 0 0 106. 00 107. 00 10700 LIVER ACQUISITION 0 0 0 0 107. 00 0000 0 108.00 10800 LUNG ACQUISITION 0 0 108. 00 109.00 10900 PANCREAS ACQUISITION 0 0 109.00 Ω 110.00 11000 INTESTINAL ACQUISITION 0 0 0 0 110.00 111.00 11100 I SLET ACQUISITION 0 0 0 111.00 113.00 11300 INTEREST EXPENSE 113. 00 114.00 11400 UTILIZATION REVIEW-SNF 114.00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 0 0 0 115.00 116. 00 11600 HOSPI CE 0 116.00 SUBTOTALS (SUM OF LINES 1 through 117)
NONREI MBURSABLE COST CENTERS 61, 376 44, 029 21, 044, 482 100 1, 110, 182, 135 118. 00 118.00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 190. 00 191. 00 19100 RESEARCH 0 0 191. 00 0 0 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 00000 235 0 0 192.00 193.00 19300 NONPALD WORKERS 0 0 193 00 r o 194.00 07950 BEACON JOINT VENTURE 0 194.00 194. 01 07951 WORKING WELL 0 194. 01 95 9, 177 0 194. 03 07953 MED WATCHER 0 194. 03 C 0 194. 10 07960 DUNELAND FITNESS CTR 0 194. 10 C 0 0 0 194. 11 07961 OMNI HEALTH & FITNESS CHESTERTOWN 656 0 194. 11 194. 16 07966 PHYSICIAN PRACTICE MD WISW 27 0 194. 16 C 0 0 0 194. 19 194. 19 07969 HEALTH PARTNERS 0 194. 20 07970 CENTER OF HOPE 87 0 0 194. 20 200.00 Cross Foot Adjustments 200.00 Negative Cost Centers 201.00 201.00 2, 990, 090 202.00 Cost to be allocated (per Wkst. B, 6, 855, 204 2, 340, 667 6, 810, 728 1, 865, 746 202. 00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 48. 717577 154. 139587 0. 111173 68, 107. 280000 0.001681 203.00 204.00 Cost to be allocated (per Wkst. B, 394.562 270, 366 1, 093, 813 373.857 48, 562 204. 00 Part II) Unit cost multiplier (Wkst. B, Part 205.00 6. 428604 6 079192 0.049430 3, 738. 570000 0.000044 205.00 II) 206.00 NAHE adjustment amount to be allocated 206.00

207. 00

207.00

(per Wkst. B-2)

Parts III and IV)

NAHE unit cost multiplier (Wkst. D,

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0015 Peri od: Worksheet B-1 From 01/01/2022 12/31/2022 Date/Time Prepared: 4/13/2023 4:18 pm OTHER GENERAL INTERNS & SERVI CE **RESI DENTS** Cost Center Description SOCIAL SERVICE I NSERVI CE NONPHYSI CI AN NURSI NG SERVI CES-SALAR Y & FRINGES **FDUCATION ANESTHETI STS PROGRAM** (ASSI GNED (ASSI GNED (TIME SPENT) (TIME SPENT) **APPRV** TIME) TIME) (ASSI GNED TIME) 17.00 18. 00 19.00 20.00 21.00 GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 5 00 5 00 6.00 00600 MAINTENANCE & REPAIRS 6.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 00900 HOUSEKEEPI NG 9 00 9 00 10.00 01000 DI ETARY 10.00 01100 CAFETERI A 11.00 11.00 01300 NURSING ADMINISTRATION 13.00 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 15.00 01500 PHARMACY 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16.00 01700 SOCIAL SERVICE 17.00 17.00 00000 18 00 01080 INSERVICE EDUCATION 18 00 19.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 0 20.00 02000 NURSING PROGRAM 20.00 0 02100 I &R SERVICES-SALARY & FRINGES APPRV 21.00 0 0 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 22.00 Ω 22.00 02300 PARAMED ED PRGM-(SPECIFY) 0 23.00 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 03000 ADULTS & PEDIATRICS 30.00 0 0 0 0 0 0 0 31.00 03100 INTENSIVE CARE UNIT C 0 31.00 03200 CORONARY CARE UNIT 32.00 000000 0 0 0 0 0 0 32.00 33.00 03300 BURN INTENSIVE CARE UNIT 0 0 33.00 0 0 34.00 03400 SURGICAL INTENSIVE CARE UNIT C 0 34.00 04000 SUBPROVIDER - IPF 40.00 40.00 0 41.00 04100 SUBPROVIDER - IRF 0 0 0 41.00 04300 NURSERY 0 43 00 C 0 43 00 0 44.00 04400 SKILLED NURSING FACILITY 0 0 44.00 04500 NURSING FACILITY 0 0 0 45.00 0 0 45.00 04600 OTHER LONG TERM CARE 0 0 46.00 46.00 0 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 0 0 0 0 50.00 51.00 05100 RECOVERY ROOM 000000000000 0 0 0 0 0 0 0 0 0 0 0 0 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 0 52 00 0 0 52 00 0 53.00 05300 ANESTHESI OLOGY 0 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 54.00 0 54.01 05401 FSED RADIOLOGY - DIAGNOSTIC 0 0 54.01 05500 RADI OLOGY-THERAPEUTI C 0 55 00 Ω 55 00 0 55.01 05501 WOODLAND CANCER CARE CTR 0 0 0 55.01 05600 RADI OI SOTOPE 0 56.00 0 56.00 57.00 05700 CT SCAN 0 0 0 57.00 0 05800 MRI 58.00 Ω 0 58 00 59.00 05900 CARDIAC CATHETERIZATION 0 0 0 59.00 06000 LABORATORY 60.00 60.00 0 06001 FS ED LAB 0 60.01 0 0 60.01 |06100| PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 61.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 0 62.00 0 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 00000000000000 0 0 0 0 0 0 0 0 0 0 0 0 0 0 63.00 63.01 06301 FS ED BLOOD BANK 0 Ω 0 63.01 64.00 06400 I NTRAVENOUS THERAPY 0 64.00 06500 RESPI RATORY THERAPY 0 65.00 65.00 06600 PHYSI CAL THERAPY 66.00 0 0 0 66,00 06700 OCCUPATIONAL THERAPY 0 67.00 0 0 67.00 06800 SPEECH PATHOLOGY 0 68.00 68.00 0 06900 ELECTROCARDI OLOGY 69 00 69.00 07000 ELECTROENCEPHALOGRAPHY 0 70.00 0 70.00 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71.00 C 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 0 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 0 0 0 73.00 07400 RENAL DIALYSIS 0 74.00 0 0 74.00 75.00 07500 ASC (NON-DISTINCT PART) 0 0 75.00 76.00 03020 CLI NI C 0 0 0 0 76.00 07700 ALLOGENEIC STEM CELL ACQUISITION 77.00 77.00 0 0 OUTPATIENT SERVICE COST CENTERS 0 88.00 08800 RURAL HEALTH CLINIC 0 0 0 0 88.00 Health Financial Systems FRANCISCAN HEALTH MICHIGAN CITY In Lieu of Form CMS-2552-10 COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0015 Peri od: Worksheet B-1 From 01/01/2022 12/31/2022 Date/Time Prepared: 4/13/2023 4:18 pm OTHER GENERAL INTERNS & SERVI CE **RESI DENTS** Cost Center Description SOCIAL SERVICE I NSERVI CE NONPHYSI CI AN NURSI NG SERVI CES-SALAR Y & FRINGES **FDUCATION ANESTHETISTS PROGRAM** (ASSI GNED (TIME SPENT) (TIME SPENT) (ASSI GNED **APPRV** (ASSI GNED TIME) TIME) TIME) 17. 00 18. 00 19.00 20.00 21.00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 89. 00 0 0 0 0 o 09000 CLI NI C 90 00 90 00 0 90.03 09003 INFUSION OP SERVICES 0 0 0 0 90.03 91.00 09100 EMERGENCY 0 0 0 91.00 09101 FREE STANDING EMERGENCY DEPT 0 0 ol 91. 01 91 01 0 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0 0 0 0 94.00 00000000 0 09500 AMBULANCE SERVICES 0 95 00 95 00 Ω 0 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 0 Ω 96.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 97.00 97.00 0 09850 OTHER REIMBURSABLE COST CENTERS 98.00 98.00 0 0 99. 00 09900 CMHC 99. 00 0 Ω 0 0 99. 10 09910 CORF 0 0 0 99. 10 100.00 10000 I &R SERVICES-NOT APPRVD PRGM 0 100.00 0 0 101.00 10100 HOME HEALTH AGENCY 0 0 101.00 0 102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 0 102.00 SPECIAL PURPOSE COST CENTERS 105. 00 10500 KIDNEY ACQUISITION 0 0 0 0 105. 00 0 106.00 10600 HEART ACQUISITION 0000 0 0 0 0 106, 00 107.00 10700 LIVER ACQUISITION Ω 0 107, 00 108.00 10800 LUNG ACQUISITION 0 0 108.00 0 109. 00 10900 PANCREAS ACQUISITION 0 0 109.00 110.00 11000 INTESTINAL ACQUISITION 0 0 110.00 111.00 11100 | SLET ACQUISITION 0 0 0 0 111.00 113.00 11300 INTEREST EXPENSE 113.00 114.00 11400 UTILIZATION REVIEW-SNF 114. 00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 0 0 0 0 115. 00 116. 00 11600 HOSPI CE 0 116. 00 SUBTOTALS (SUM OF LINES 1 through 117)
NONREI MBURSABLE COST CENTERS 118.00 0 0 118.00 0 190. 00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 191. 00 19100 RESEARCH 0 0 0 191.00 00000000 0 0 0 0 0 0 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 192. 00 0 193. 00 19300 NONPALD WORKERS 0 0 193. 00 0 194. 00 07950 BEACON JOINT VENTURE 0 0 0 194. 00 194. 01 07951 WORKING WELL 0 194. 01 194. 03 07953 MED WATCHER 0 0 194.03 0 194. 10 194. 10 07960 DUNELAND FITNESS CTR 0 194. 11 07961 OMNI HEALTH & FITNESS CHESTERTOWN 0 194. 11 194. 16 07966 PHYSICIAN PRACTICE MD WISW 0 0 0 194. 16 0 194. 19 07969 HEALTH PARTNERS 0 194, 19 O

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206.00

207.00

0.000000 203.00

0.000000 205.00

200.00

201. 00 0 202. 00

194. 20 07970 CENTER OF HOPE

Part I)

Part II)

(per Wkst. B-2)

Parts III and IV)

II)

MCRI F32 - 18. 1. 175. 5

Cross Foot Adjustments

Cost to be allocated (per Wkst. B,

Cost to be allocated (per Wkst. B,

Unit cost multiplier (Wkst. B, Part

NAHE unit cost multiplier (Wkst. D,

Unit cost multiplier (Wkst. B, Part I)

NAHE adjustment amount to be allocated

Negative Cost Centers

200.00

201.00

202.00

203.00

204.00

205 00

206.00

207.00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS In Lieu of Form CMS-2552-10
Worksheet B-1 FRANCISCAN HEALTH MICHIGAN CITY Provider CCN: 15-0015

					To 12/31/20	D22 Date/Time Pre 4/13/2023 4:1	
		INTERNS &				17 107 2020 1. 1) piii
		RESI DENTS					
	Cost Center Description	SERVI CES-OTHER	PARAMED ED				
		PRGM COSTS	PRGM				
		APPRV	(ASSI GNED				
		(ASSIGNED TIME)	TIME)				
		22.00	23. 00				
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS						5. 00
6. 00 7. 00	00700 OPERATION OF PLANT						6. 00 7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY						10.00
11.00	01100 CAFETERI A						11. 00
13.00	01300 NURSI NG ADMI NI STRATI ON						13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY						14. 00
	01500 PHARMACY						15. 00
16. 00 17. 00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE						16. 00 17. 00
17.00	01080 I NSERVI CE EDUCATI ON						18.00
	01900 NONPHYSI CI AN ANESTHETI STS						19. 00
	02000 NURSI NG PROGRAM						20.00
	02100 I&R SERVICES-SALARY & FRINGES APPRV						21. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0					22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)		0				23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	1					
30.00	03000 ADULTS & PEDIATRICS	0	0				30.00
31. 00 32. 00	03100 I NTENSI VE CARE UNI T 03200 CORONARY CARE UNI T	0	0				31. 00 32. 00
	1 1	0	0				33. 00
34. 00	03400 SURGICAL INTENSIVE CARE UNIT	l o	0				34. 00
40. 00	04000 SUBPROVI DER - I PF	o	0				40.00
41.00	04100 SUBPROVI DER - I RF	o	0				41. 00
43.00	04300 NURSERY	0	0				43.00
44. 00	04400 SKILLED NURSING FACILITY	0	0				44. 00
45. 00	04500 NURSING FACILITY	0	0				45. 00
46. 00	04600 OTHER LONG TERM CARE ANCI LLARY SERVICE COST CENTERS	0	0				46. 00
50. 00		l	0				50.00
51. 00	05100 RECOVERY ROOM	o	0				51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	o	0				52. 00
53.00	05300 ANESTHESI OLOGY	0	0				53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	0				54. 00
54. 01	05401 FSED RADI OLOGY - DI AGNOSTI C	0	0				54. 01
55. 00 55. 01	05500 RADI OLOGY-THERAPEUTI C 05501 WOODLAND CANCER CARE CTR	0	0				55.00
	05600 RADI OI SOTOPE	0	0				55. 01 56. 00
	05700 CT SCAN	l ő	0	1			57. 00
	05800 MRI	o	0				58. 00
	05900 CARDI AC CATHETERI ZATI ON	o	0				59. 00
	06000 LABORATORY	0	0				60.00
	06001 FS ED LAB	0	0				60. 01
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		Ō				61.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0				62.00
	06300 BLOOD STORING, PROCESSING & TRANS. 06301 FS ED BLOOD BANK		0				63. 00 63. 01
	06400 I NTRAVENOUS THERAPY		0				64. 00
	06500 RESPIRATORY THERAPY		0				65. 00
	06600 PHYSI CAL THERAPY		0				66. 00
	06700 OCCUPATI ONAL THERAPY	0	0				67. 00
	06800 SPEECH PATHOLOGY	0	0				68. 00
	06900 ELECTROCARDI OLOGY	0	0				69. 00
	07000 ELECTROENCEPHALOGRAPHY	0	0				70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS		0				71. 00 72. 00
	07300 DRUGS CHARGED TO PATIENTS		0				73.00
	07400 RENAL DIALYSIS		0				74.00
	07500 ASC (NON-DISTINCT PART)		0				75. 00
76.00	03020 CLI NI C	0	0				76. 00
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0				77. 00
	OUTPATIENT SERVICE COST CENTERS						00.55
88. 00	08800 RURAL HEALTH CLINIC	0	0	l			88. 00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0015

				10 12/	31/2022	4/13/2023	
		INTERNS &		'			
		RESI DENTS					
	Cost Center Description	SERVI CES-OTHER	PARAMED ED				
		PRGM COSTS APPRV	PRGM				
		(ASSI GNED	(ASSIGNED TIME)				
		TIME)	11 WL)				
		22. 00	23.00				
	FEDERALLY QUALIFIED HEALTH CENTER	0	0				89. 00
	CLINIC	0	0				90. 00
	I NFUSION OP SERVICES	0	0				90. 03
	EMERGENCY	0	0				91.00
	FREE STANDING EMERGENCY DEPT OBSERVATION BEDS (NON-DISTINCT PART	٥	U				91. 01 92. 00
	REIMBURSABLE COST CENTERS						72.00
	HOME PROGRAM DIALYSIS	0	0				94. 00
95. 00 09500	AMBULANCE SERVICES	O	o				95. 00
	DURABLE MEDICAL EQUIP-RENTED	0	0				96. 00
	DURABLE MEDI CAL EQUI P-SOLD	0	0				97. 00
	OTHER REIMBURSABLE COST CENTERS	0	0				98.00
99. 00 09900 99. 10 09910		0	0				99. 00 99. 10
	I &R SERVICES-NOT APPRVD PRGM	0	0				100.00
	HOME HEALTH AGENCY	o	o				101.00
	OPIOID TREATMENT PROGRAM	O	O				102.00
	AL PURPOSE COST CENTERS						
	KIDNEY ACQUISITION	0	0				105. 00
	HEART ACQUISITION	0	0				106. 00
	LIVER ACQUISITION LUNG ACQUISITION	0	0				107. 00 108. 00
	PANCREAS ACQUISITION	0	0				108.00
	INTESTINAL ACQUISITION	o o	0				110.00
	I SLET ACQUISITION	o	O				111. 00
113.00 11300	INTEREST EXPENSE						113. 00
	UTILIZATION REVIEW-SNF						114. 00
	AMBULATORY SURGICAL CENTER (D. P.)	0	0				115. 00
116. 00 11600	•		0				116.00
118. 00 NONDE	SUBTOTALS (SUM OF LINES 1 through 117) IMBURSABLE COST CENTERS	0	0				118. 00
	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0				190. 00
191. 00 19100		o	O				191. 00
192. 00 19200	PHYSICIANS' PRIVATE OFFICES	O	o				192. 00
	NONPALD WORKERS	0	0				193. 00
	BEACON JOINT VENTURE	0	0				194. 00
	WORKING WELL	0	0				194. 01 194. 03
	MED WATCHER DUNELAND FITNESS CTR	0	0				194. 03
	OMNI HEALTH & FITNESS CHESTERTOWN	0	0				194. 11
	PHYSICIAN PRACTICE MD WISW	o	o				194. 16
	HEALTH PARTNERS	0	o				194. 19
	CENTER OF HOPE	0	0				194. 20
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)	0	0				202. 00
203. 00	Unit cost multiplier (Wkst. B, Part I)	0. 000000	0. 000000				203. 00
204.00	Cost to be allocated (per Wkst. B,	0	0. 000000				204. 00
-	Part II)]	آ				
205. 00	Unit cost multiplier (Wkst. B, Part	0. 000000	0. 000000				205. 00
20/ 62	NAME of the state						201 22
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)		0				206. 00
207. 00	NAHE unit cost multiplier (Wkst. D,		0. 000000				207. 00
	Parts III and IV)		2. 222200				
•	•		'				•

| In Lieu of Form CMS-2552-10 | Period: | Worksheet C | From 01/01/2022 | Part | To 12/31/2022 | Date/Time Prepared: | 4/13/2023 4:18 pm Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0015

Total Coult								4/13/2023 4:1	8 pm
Cost Center Description					Title	XVIII	Hospi tal	PPS	
Pint 1						T			
No No No No No No			Cost Center Description			lotal Costs		Total Costs	
260					Aaj .		DI Sai i owance		
1.03 2.00 3.00 4.00 5.00									
MAYLER MOUTH SERVING COST CENTERS					2 00	3 00	4 00	5.00	
30.00 30.000 AURLIS & PERI ATRICS		I NPAT	LENT ROUTINE SERVICE COST CENTERS	1.00	2.00	0.00	1. 00	0.00	
31.00 GISTOOL RITLEST VECASE URIT 9,111,608 9,111,608 0 9,111,608 31.00 32.00 33.00	30. 00			47, 279, 824		47, 279, 824	0	47, 279, 824	30.00
32 00 032000 CORROMARY CARE UNIT 0 0 0 0 0 32.00 0 33.00 33.00 33.00 03300 SURG CAL INTENSIVE CARE UNIT 0 0 0 0 0 0 33.0				1		9, 111, 608	0		1
3-4.00 03-000 SIRRICAL INTIMENU F CARF UNIT 0 0 0 0 0 0 0 0 0	32.00	03200	CORONARY CARE UNIT	0		0	0		
40, DO GOODD SUBPROVIDER - 1 FF 0, 179, 429 0, 179, 429 0, 179, 429 0, 183, 333 40 00 14 100 04 100 04 100 04 100 04 100 04 100 04 100 04 100 100 04 04	33.00	03300	BURN INTENSIVE CARE UNIT	0		0	0	0	33. 00
41.00 04100 MURSERY 1.412, 424				0		0	0	0	34. 00
43.00 04-000 MURSERY 1, 412, 424 1, 412, 424 0 1, 412, 424 43.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 64.				6, 179, 429		6, 179, 429	3, 924	6, 183, 353	
44.00 0.400 SKILLED NIKSH NG FACILITY				0		0	0	_	•
45.00 05-6		04300	NURSERY	1, 412, 424		1, 412, 424	0		
46.00 0.6400 OTHER LORN TERM CARE O O O 0.400				0		0	0	_	ł
MACILLARY SERVICE COST CENTERS 2,6,135,582 170,935 26,306,517 50.00 05.00				0		0	0	_	
50.00 05000 0FERATING ROOM 26, 135, 582 26, 135, 582 170, 935 26, 306, 517 50, 00 51.00 051.	46. 00			0] 0	U	0	46.00
51.00 05100 DECOMPEY ROBIN 0 0 0 0 51.00 55.00 05200 01.1787 ROBIN 2,579,862 2,579,862 2,579,862 0,259,862 53.00 05300 MISTINESI DLORY 289,969 289,969 289,969 221,603 510,859 53.00 53.00 54.00 05000 MISTINESI DLORY 1993,102 11.993,10	50 00			26 135 592		26 135 592	170 035	26 306 517	50 00
52.00 63200 DELLYPEY ROOM & LABOR ROOM 2,559, 862 2,599, 862 20, 29, 660 221, 163 510, 859 53.00 53.00 03500 ARSTHESLOGAY 11, 993, 102 11, 993,					l				1
53.00					l				
54.00 05400 FRADIOLOVY-DIAGNOSTIC 11, 993, 102 11, 993, 102 51, 00 55, 00 05500 FRADIOLOVY-DIAGNOSTIC 2, 509, 375 52, 509, 375 54, 01 55, 00 05500 FRADIOLOVY-THERAPEUTIC 3, 079, 466 3, 079, 466 0, 30, 079, 466 0,				The state of the s	l				
54.01 0.5401 FSED RADIOLOGY - DIARNOSTIC 2,509, 375 2,509, 375 0 2,509, 375 54.01		1	l .				0		1
55.01 550 MOOLAND CANCER CARE CTR 995.111 0 995.111 50.01 550.00 560.00 560.00 570.00	54.01	05401	FSED RADIOLOGY - DIAGNOSTIC	2, 509, 375		2, 509, 375	0	2, 509, 375	54. 01
56.00 05600 RADIOISTOPE 0 0 0 0 0 55.00 57.00 570.00 570.00 570.00 570.00 570.00 570.00 570.00 570.00 570.00 570.00 570.00 580.00	55.00	05500	RADI OLOGY-THERAPEUTI C	3, 079, 466		3, 079, 466	0	3, 079, 466	55. 00
57. 00 05700 CT SCAN	55. 01	05501	WOODLAND CANCER CARE CTR	995, 111		995, 111	0	995, 111	55. 01
58. 00 05800 MRI				0		0	0	0	56. 00
59.00 05000 CARDIAC CATHETERIZATION				0		0	0	_	
60.00				0		0	_	_	1
60.00 6000 FSE DLAB 29,527 29,527 0.0 29,527 0.0									
6-1.00 66100 PBP CLINI CAL LAB SERVI (CES-PERG NOLY 0 0 0 0 0 0 0 0 0							25, 195		
62.00				29, 527			0		1
63.00 06300 06400 STORI NG, PROCESSING & TRANS. 46,785 30 0 30 30 30 0 30 30				0		0	0	_	
63.01 06301 FS ED BLOOD BANK 30				16 785		16 785	0	_	1
64. 00 06400 INTRAVENOUS THERAPY 0 0 0 0 6.4. 00							0		
65.00 06500 RESPIRATORY THERAPY 3., 372, 700 0 3., 372, 700 0 3., 372, 700 0 65.00 66.00 06.00 PMYSICAL HERAPY 4.610, 621 0 4.610, 621 0 4.610, 621 0 6.7.00 0.00 0 0 0 0 0 0 0					ł		0		1
66.00 06600 PhYSI CAL THERAPY				3, 372, 700	0	3, 372, 700	0	_	
67.00 06700 06700 06700 06700 06700 06700 0680				1	0		0		
69 00 06900 CLECTROCARDIOLOGY 3,312,021 0, 3,312,021 0, 2,004 0 2,004 0 2,004 0 2,004 0 2,004 0 2,004 0 2,004 0 2,004 0 2,004 0 2,004 0 2,004 0 0,000	67.00	06700	OCCUPATIONAL THERAPY	0	0		0	0	67. 00
70. 00 070	68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68. 00
17. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 12, 874, 246 12, 874, 246 0 12, 874, 246 71. 00 72. 00 72.00 IMPL. DEV. CHARGED TO PATIENTS 14, 010, 659 14, 010, 659 0 14, 010, 659 73. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 41, 508, 130 41, 508, 130 0 41, 508, 130 0 0 0 0 74. 00 0 0 0 0 0 0 0 0 0				3, 312, 021		3, 312, 021	0	3, 312, 021	69. 00
14, 010, 659 14, 010, 659 14, 010, 659 72, 00 73, 00 07300 DRUGS CHARGED TO PATIENTS 41, 508, 130 41, 508, 130 0 41, 508, 130 0 73, 00 07300 DRUGS CHARGED TO PATIENTS 41, 508, 130 0 41, 508, 130 0 0 0 0 0 74, 00 0 0 0 0 0 0 0 0 0							_		
17.3 00 07.300 DRUGS CHARGED TO PATIENTS		1	l .						
74-00 07400 07400 07400 0 0 0 0 0 0 0 0 0							0		
75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 75. 00 76. 00 03020 CLINIC 740,549 740,549 740,549 0 740,549 770.00 77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION 0 0 0 0 0 0 0 00000000				41, 508, 130		41, 508, 130	0		
76.00 03020 CLI NIC 740, 549 740, 549 0 740, 549 76.00 77.00 0770 ALLOGENEIC STEM CELL ACQUISITION 0 0 0 0 0 77.00 0 0 0 0 0 0 77.00 0 0 0 0 0 0 0 0 0				0		0	0		1
77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION 0 0 0 0 0 77. 00				740 549		740 549	0		1
OUTPATIENT SERVICE COST CENTERS SR. 00 OSBOOR BURAL HEALTH CLINIC O O O O O O O O O		1			l				•
88. 00 08800 RURAL HEALTH CLINI C 0 0 0 0 88. 00 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 89. 00 09000 CLINI C 0 0 0 0 0 90. 00 09000 CLINI C 0 0 0 0 0 90. 01 09000 CLINI C 0 0 0 0 0 90. 02 09000 CLINI C 0 0 0 0 90. 03 09003 INFUSI ON OP SERVI CES 2, 817, 819 2, 817, 819 0 2, 817, 819 90. 03 91. 00 09100 EMERGENCY 12, 058, 802 12, 058, 802 60 12, 058, 862 91. 00 91. 01 09101 FREE STANDING EMERGENCY DEPT 6, 821, 723 6, 821, 723 0, 6, 821, 723 91. 01 92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART 6, 806, 513 6, 806, 513 6, 806, 513 6, 806, 513 94. 00 09400 HOME PROGRAM DI ALYSI S 0 0 0 0 0 95. 00 09500 AMBULANCE SERVI CES 0 0 0 0 95. 00 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 96. 00 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 99. 00 99. 00 09900 CMHC 0 0 0 0 0 99. 00 09900 CMHC 0 0 0 0 99. 10 09910 CORF 0 0 0 0 100. 00 10000 I RESERVATI ON PROGRAM 0 0 0 0 101. 00 10100 HOME HEALTH AGENCY 0 0 0 0 101. 00 10100 HOME HEALTH AGENCY 0 0 0 0 101. 00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 0 101. 00 10700 I LIVER ACQUI SI TI ON 0 0 0 106. 00 10600 HEART ACQUI SI TI ON 0 0 105. 00 107. 00 10700 I LIVER ACQUI SI TI ON 0 0 0 106. 00 108. 00 10800 LUNG ACQUI SI TI ON 0 0 108. 00 108. 00 10800 LUNG ACQUI SI TI ON 0 0 108. 00 101. 00 10800 LUNG ACQUI SI TI ON 0 0 108. 00 101. 00 10800 LUNG ACQUI SI TI ON 0 0 108. 00 101. 00 10800 LUNG ACQUI SI TI ON 0 0 108. 00 102. 00 10800 LUNG ACQUI SI TI ON 0 0 108. 00 103. 00 10800 LUNG ACQUI SI TI ON 0 0 108. 00 104. 00 10800 LUNG ACQUI SI TI ON 0 108. 00 107. 00 10800 LUNG ACQUI SI TI ON 0 108. 00 108. 00 10800 LUNG ACQUI SI TI ON 0 108. 00 109. 00 10800						_			
89.00 8900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 0 0 0 0	88. 00			0		0	0	0	88. 00
90. 03 09003 INFUSION OP SERVICES 2, 817, 819 2, 817, 819 0 2, 817, 819 90. 03 91. 00 09100 EMERGENCY 12, 058, 802 12, 058, 802 60 12, 058, 862 91. 00 92. 00 09200 09SERVATI ON BEDS (NON-DISTINCT PART 6, 806, 513 6, 806, 513 6, 806, 513 6, 806, 513 92. 00 09400 HOME PROGRAM DI ALYSI S 0 0 0 0 0 95. 00 09500 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 0 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 0 97. 00 98. 00 09900 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 98. 00 99. 10 09900 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 99. 00 99. 10 09900 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 99. 00 99. 10 09900 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 99. 00 99. 10 09900 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 99. 00 99. 10 09900 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 99. 00 99. 10 09910 CORF 0 0 0 0 0 101. 00 10000 I&R SERVI CES-NOT APPRVD PRGM 0 0 0 0 100. 00 101. 00 10100 HOME HEALTH AGENCY 0 0 0 0 100. 00 102. 00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 0 100. 00 105. 00 10500 KI DNEY ACQUI SI TI ON 0 0 0 105. 00 106. 00 10600 HEART ACQUI SI TI ON 0 0 0 107. 00 107. 00 10700 LI VER ACQUI SI TI ON 0 0 0 107. 00 108. 00 10800 LUNG ACQUI SI TI ON 0 0 0 108. 00 108. 00 10800 LUNG ACQUI SI TI ON 0 0 0 108. 00 108. 00 10800 LUNG ACQUI SI TI ON 0 0 108. 00 108. 00 10800 LUNG ACQUI SI TI ON 0 0 108. 00 108. 00 10800 LUNG ACQUI SI TI ON 0 0 108. 00 109. 00 10800 LUNG ACQUI SI TI ON 0 0 108. 00 109. 00 10800 LUNG ACQUI SI TI ON 0 0 108. 00 109. 00 10800 LUNG ACQUI SI TI ON 0 0 108. 00 109. 00 10800 LUNG ACQUI SI TI ON 0 0 108. 00 109. 00 10800 LUNG ACQUI SI TI ON 0 108. 00 109. 00 10800 10800 10800 10800	89. 00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	
91. 00 09100 EMERGENCY 12, 058, 802 12, 058, 802 60 12, 058, 862 91. 00 91. 01 09101 FREE STANDI NG EMERGENCY DEPT 6, 821, 723 6, 821, 723 0 6, 821, 723 91. 01 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART 6, 806, 513 6, 806, 513 6, 806, 513 92. 00 0THER REI MBURSABLE COST CENTERS 94. 00 09500 HOME PROGRAM DI ALYSI S 0 0 0 0 94. 00 95. 00 09500 AMBULANCE SERVI CES 0 0 0 0 95. 00 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 97. 00 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 97. 00 98. 00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 99. 00 99. 10 09900 CMHC 0 0 0 0 99. 00 99. 10 09900 CMF 0 0 0 0 99. 10 100. 00 10000 L&R SERVI CES-NOT APPRVD PRGM 0 0 0 101. 00 101. 00 10100 HOME HEALTH AGENCY 0 0 0 101. 00 102. 00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 102. 00 SPECIAL PURPOSE COST CENTERS 105. 00 10500 KI DNEY ACQUI SI TI ON 0 0 0 106. 00 107. 00 10700 LIVER ACQUI SI TI ON 0 0 0 108. 00 108. 00 10800 LUNG ACQUI SI TI ON 0 0 0 108. 00 108. 00 10800 LUNG ACQUI SI TI ON 0 0 0 108. 00 109. 00 108. 00 10800 LUNG ACQUI SI TI ON 0 0 108. 00 109. 00 108. 00 10800 LUNG ACQUI SI TI ON 0 0 108. 00 109. 00 108. 00 10800 LUNG ACQUI SI TI ON 0 0 108. 00 100. 00 108. 00 108. 00 108. 00 100. 00 108. 00 108. 00 108. 00 100. 00 108. 00 108. 00 100. 00 100. 00 100. 00 100. 00 100. 00 100. 00 100. 00 100. 00 100. 00 100. 00 100. 00 100. 00 100. 00 100. 00 100. 00 100. 00 100. 00 100. 00 100. 00 100. 00 100. 00 100. 00 100. 00 100. 00 100. 00 100. 00 100. 00 100. 00 100. 00 100. 00 100. 00 100. 00 100. 00 100. 00 100. 00 100. 00 100. 00 100. 00 100. 00 100. 00 100. 00 100. 00 100. 00 100. 00 100. 00				0		0	0	_	1
91. 01				1	ł		0		1
92. 00				1	ł		60		•
OTHER REIMBURSABLE COST CENTERS O O9400 HOME PROGRAM DI ALYSI S O O O O O O O O O		1	l .	1	ł		0		1
94. 00	92.00		•	6, 806, 513		6, 806, 513		6, 806, 513	92.00
95. 00	94 00			1		0	0	0	04 00
96. 00				0			, and the second	_	1
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 0 97. 00 98. 00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 98. 00 99. 00 09900 CMHC 0 0 0 0 0 99. 00 99. 10 09910 CORF 0 0 0 0 0 99. 10 100. 00 10000 1				0		0	0	_	•
98. 00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 98. 00 99. 00 09900 CMHC 0 0 0 99. 00 99. 10 09910 CORF 0 0 0 0 99. 10 100. 00 10000 1&R SERVI CES-NOT APPRVD PRGM 0 0 0 100. 00 101. 00 10100 HEALTH AGENCY 0 0 0 101. 00 102. 00 10200 OPI 0I D TREATMENT PROGRAM 0 0 0 102. 00 SPECIAL PURPOSE COST CENTERS 105. 00 10500 KI DNEY ACQUI SI TI ON 0 0 0 105. 00 106. 00 10600 HEART ACQUI SI TI ON 0 0 0 106. 00 107. 00 10700 LI VER ACQUI SI TI ON 0 0 107. 00 108. 00 10800 LUNG ACQUI SI TI ON 0 0 108. 00 108. 00 10800 LUNG ACQUI SI TI ON 0 0 108. 00 108. 00 10800 LUNG ACQUI SI TI ON 0 0 108. 00 109. 00 0 0 0 0 0 0 100. 00 108. 00 10800 LUNG ACQUI SI TI ON 0 0 0 100. 00 108. 00 10800 LUNG ACQUI SI TI ON 0 0 0 100. 00 108. 00 10800 LUNG ACQUI SI TI ON 0 0 0 100. 00 108. 00 10800 10800 10800 10800 108. 00 100. 00 108. 00 10800 1		1	l .	0		o o	o O	-	1
99. 00 09900 CMHC 0 0 0 99. 00 99. 10 09910 CORF 0 0 0 99. 10 100. 00 10000 1&R SERVI CES-NOT APPRVD PRGM 0 0 0 100. 00 101. 00 10100 HOME HEALTH AGENCY 0 0 0 101. 00 102. 00 10200 OPI 0I D TREATMENT PROGRAM 0 0 0 102. 00 SPECIAL PURPOSE COST CENTERS 0 0 0 105. 00 105. 00 10500 KI DNEY ACQUI SI TI ON 0 0 0 106. 00 107. 00 10700 LI VER ACQUI SI TI ON 0 0 0 107. 00 108. 00 10800 LUNG ACQUI SI TI ON 0 0 0 108. 00 108. 00 10800 LUNG ACQUI SI TI ON 0 0 0 108. 00 108. 00 10800 LUNG ACQUI SI TI ON 0 0 0 108. 00 109. 00 099. 00 0 0 0 0 0 100. 00 0 0 0 0 0 100. 00 0 0 0 0 100. 00 0 0 0 0 100. 00 0 0 0 100. 00 0 0 0 100. 00 0 0 100. 00 0 0 100. 00 0 0 100. 00 0 0 100. 00 0 0 100. 00 0 100. 00 0 100. 00 0 100. 00 0 100. 00 0 100. 00 100.				0		0	0		
100. 00 10000 L&R SERVI CES-NOT APPRVD PRGM	99.00	09900	CMHC	0		0		0	99. 00
101. 00 10100 HOME HEALTH AGENCY	99. 10	09910	CORF	0		0		0	99. 10
102. 00		1	l e e e e e e e e e e e e e e e e e e e	0		0			1
SPECIAL PURPOSE COST CENTERS 105.00 10500 KI DNEY ACQUI SI TI ON O O 105.00 106.00 106.00 106.00 106.00 106.00 107.00 107.00 107.00 107.00 107.00 108.00 1				0					1
105. 00 10500 KI DNEY ACQUI SI TI ON 0 0 105. 00 106. 00 10600 HEART ACQUI SI TI ON 0 0 0 106. 00 107. 00 10700 LI VER ACQUI SI TI ON 0 0 0 107. 00 108. 00 10800 LUNG ACQUI SI TI ON 0 0 0 108. 00	102.00			0		0		0	102. 00
106. 00 10600 HEART ACQUISITION	105.00								105 00
107. 00 10700 LI VER ACQUI SI TI ON 0 0 107. 00 108. 00 108. 00 108. 00 108. 00 108. 00 0 0 108. 00									
108. 00 10800 LUNG ACQUISITION 0 0 0 108. 00									
						0			
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		1.2700	1		1	1 9	1	<u> </u>	1

Health Financial Systems	FRANCISCAN HEALTH MICHIGAN CITY	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0015	From 01/01/2022	Worksheet C Part I Date/Time Prepared: 4/13/2023 4:18 pm

		Title	XVIII	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst. B,	Adj .		Di sal I owance		
	Part I, col.					
	26)					
	1.00	2. 00	3. 00	4. 00	5. 00	
110.00 11000 INTESTINAL ACQUISITION	0		0		0	110. 00
111.00 11100 ISLET ACQUISITION	0		0		0	111. 00
113.00 11300 INTEREST EXPENSE						113. 00
114.00 11400 UTILIZATION REVIEW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0		0		0	115. 00
116. 00 11600 HOSPI CE	0		0		0	116. 00
200.00 Subtotal (see instructions)	240, 151, 684	0	240, 151, 684	421, 277	240, 572, 961	200.00
201.00 Less Observation Beds	6, 806, 513		6, 806, 513		6, 806, 513	201.00
202.00 Total (see instructions)	233, 345, 171	0	233, 345, 171	421, 277	233, 766, 448	202. 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet C | From 01/01/2022 | Part I | To 12/31/2022 | Date/Time Prepared: | 4/13/2023 4:18 pm Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0015

						0 12/31/2022	4/13/2023 4: 1	
					XVIII	Hospi tal	PPS	
		Cost Center Description	Inpatient	Charges Outpatient	Total (col. 6	Cost or Other	TEFRA	
		, , , , , , , , , , , , , , , , , , ,			+ col. 7)	Ratio	I npati ent	
			/ 00	7.00	0.00	0.00	Ratio	
	INDAT	LENT ROUTINE SERVICE COST CENTERS	6. 00	7. 00	8. 00	9. 00	10. 00	
30. 00		ADULTS & PEDIATRICS	73, 044, 597		73, 044, 597			30. 00
31.00	1	INTENSIVE CARE UNIT	14, 196, 770		14, 196, 770			31.00
32. 00		CORONARY CARE UNIT	o		0			32. 00
33.00		BURN INTENSIVE CARE UNIT	0		0			33. 00
34. 00 40. 00		SURGICAL INTENSIVE CARE UNIT SUBPROVIDER - IPF	5, 169, 917		5, 169, 917			34. 00 40. 00
41. 00	1	SUBPROVIDER - I RF	3, 109, 917		3, 109, 917			41. 00
43. 00		NURSERY	1, 624, 297		1, 624, 297			43. 00
44.00	1	SKILLED NURSING FACILITY	o		0			44. 00
45. 00		NURSING FACILITY	0		0			45. 00
46. 00		OTHER LONG TERM CARE LARY SERVICE COST CENTERS	<u> </u>		0			46. 00
50. 00		OPERATING ROOM	36, 464, 963	121, 383, 595	157, 848, 558	0. 165574	0. 000000	50.00
51. 00		RECOVERY ROOM	0	0	1	0. 000000	0. 000000	
52.00		DELIVERY ROOM & LABOR ROOM	2, 583, 129	329, 443			0. 000000	
53.00		ANESTHESI OLOGY	2, 995, 156	6, 847, 362			0.000000	
54. 00 54. 01	1	RADI OLOGY-DI AGNOSTI C FSED RADI OLOGY - DI AGNOSTI C	39, 093, 003 2, 043, 343	102, 430, 532 27, 015, 659			0. 000000 0. 000000	
55. 00		RADI OLOGY - BY AGNOSTIC	2, 699, 895	17, 808, 863			0. 000000	
55. 01		WOODLAND CANCER CARE CTR	44, 283	5, 956, 515			0. 000000	
56. 00		RADI OI SOTOPE	o	0	0	0. 000000	0. 000000	
57. 00		CT SCAN	0	0	0	0.000000	0.000000	
58. 00 59. 00	05800	MRI CARDI AC CATHETERI ZATI ON	20, 722, 507	0 18, 074, 246	38, 796, 753	0. 000000 0. 113802	0. 000000 0. 000000	
60.00		LABORATORY	47, 272, 757	61, 859, 016			0. 000000	
60. 01		FS ED LAB	178, 458	17, 386, 573		0. 001681	0. 000000	
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	o	0	0	0. 000000	0. 000000	61. 00
62. 00		WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	1	0. 000000	0. 000000	
63.00		BLOOD STORING, PROCESSING & TRANS.	1, 066, 627	547, 548			0.000000	
63. 01 64. 00		FS ED BLOOD BANK INTRAVENOUS THERAPY	1, 014	16, 805 0	1	0. 001684 0. 000000	0. 000000 0. 000000	
65. 00		RESPI RATORY THERAPY	17, 510, 401	2, 032, 855	1		0. 000000	
66. 00		PHYSI CAL THERAPY	5, 900, 631	15, 424, 414			0. 000000	66. 00
67. 00		OCCUPATIONAL THERAPY	0	0	0	0. 000000	0. 000000	
68. 00 69. 00		SPEECH PATHOLOGY ELECTROCARDI OLOGY	12 400 400	0 107 272	0 20 407 070	0. 000000 0. 101323	0. 000000 0. 000000	
70.00		ELECTROCARDI OLOGI ELECTROENCEPHALOGRAPHY	12, 490, 499 0	20, 197, 373 0	32, 687, 872	0. 000000	0. 000000	
71. 00		MEDICAL SUPPLIES CHARGED TO PATIENT	15, 724, 263	28, 263, 976	43, 988, 239		0. 000000	
72. 00		IMPL. DEV. CHARGED TO PATIENTS	10, 490, 563	21, 872, 545			0. 000000	
73.00		DRUGS CHARGED TO PATIENTS	29, 946, 919	143, 569, 491	173, 516, 410		0.000000	
74. 00 75. 00		RENAL DIALYSIS ASC (NON-DISTINCT PART)	0	0	0	0. 000000 0. 000000	0. 000000 0. 000000	
76.00		CLINIC		0		0. 000000	0. 000000	
		ALLOGENEIC STEM CELL ACQUISITION	ō	0	Ö		0. 000000	
		TIENT SERVICE COST CENTERS			,			
88. 00		RURAL HEALTH CLINIC	0	0				88. 00
89. 00 90. 00		FEDERALLY QUALIFIED HEALTH CENTER	٥	0	0	0. 000000	0. 000000	89. 00 90. 00
90. 03		INFUSION OP SERVICES	44, 826	24, 943, 904	24, 988, 730		0. 000000	1
91.00	1	EMERGENCY	28, 408, 246	72, 076, 347			0. 000000	
91. 01		FREE STANDING EMERGENCY DEPT	2, 753, 771	18, 976, 160			0. 000000	1
92. 00		OBSERVATION BEDS (NON-DISTINCT PART	0	10, 698, 078	10, 698, 078	0. 636237	0. 000000	92.00
94. 00		REIMBURSABLE COST CENTERS HOME PROGRAM DI ALYSI S	O	0	0	0. 000000	0. 000000	94. 00
95. 00	1	AMBULANCE SERVICES		Ö			0. 000000	
96.00		DURABLE MEDICAL EQUIP-RENTED	o	0	0	0. 000000	0. 000000	
97. 00	1	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0. 000000	0. 000000	1
98. 00		OTHER REIMBURSABLE COST CENTERS	0	0	0	0. 000000	0. 000000	
99. 00 99. 10	09900 09910	•		0				99. 00 99. 10
	1	I&R SERVICES-NOT APPRVD PRGM	o	0	Ö			100.00
	1	HOME HEALTH AGENCY	o	0	•			101. 00
102.00		OPIOID TREATMENT PROGRAM	0	0	0			102. 00
105.00		AL PURPOSE COST CENTERS KIDNEY ACQUISITION	ما	0	0			105. 00
		HEART ACQUISITION		0				106. 00
	1	LIVER ACQUISITION	0	0	0			107. 00
		LUNG ACQUISITION	0	0				108. 00
	1	PANCREAS ACQUISITION INTESTINAL ACQUISITION	0	0				109. 00 110. 00
110.00	111000	TINIESTINAL ACQUISITION	<u>၊ </u>	0	1 0		1	1110.00

Health Financial Systems	FRANCISCAN HEALTH MICHIGAN CITY	In Lie	eu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-001	From 01/01/2022	Worksheet C Part I Date/Time Prepared: 4/13/2023 4:18 pm

		Title	XVIII	Hospi tal	PPS	
		Charges				
Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
			+ col. 7)	Ratio	I npati ent	
					Ratio	
	6.00	7. 00	8. 00	9. 00	10.00	
111. 00 11100 SLET ACQUI SI TI ON	0	0	C)		111. 00
113. 00 11300 I NTEREST EXPENSE						113. 00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114. 00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	C			115. 00
116. 00 11600 HOSPI CE	0	0	C			116. 00
200.00 Subtotal (see instructions)	372, 470, 835	737, 711, 300	1, 110, 182, 135	5		200.00
201.00 Less Observation Beds						201. 00
202.00 Total (see instructions)	372, 470, 835	737, 711, 300	1, 110, 182, 135	5		202. 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet C | From 01/01/2022 | Part | | Date/Time Prepared: | 4/13/2023 4:18 pm | PPS | P

		Title XVIII	Hospi tal	PPS
Cost Center Description	PPS Inpatient			
	Ratio			
I NPATI ENT ROUTI NE SERVI CE COST CENTE	11.00			
30. 00 03000 ADULTS & PEDIATRICS	LIKS			30.00
31.00 03100 INTENSIVE CARE UNIT				31. 00
32.00 03200 CORONARY CARE UNIT				32. 00
33.00 03300 BURN INTENSIVE CARE UNIT				33. 00
34.00 O3400 SURGICAL INTENSIVE CARE UNIT				34.00
40. 00 04000 SUBPROVI DER - I PF				40.00
41. 00 04100 SUBPROVI DER - I RF 43. 00 04300 NURSERY				41.00
43.00 04300 NURSERY 44.00 04400 SKILLED NURSING FACILITY				43. 00 44. 00
45. 00 04500 NURSI NG FACILITY				45. 00
46. 00 04600 OTHER LONG TERM CARE				46. 00
ANCI LLARY SERVI CE COST CENTERS				10.00
50. 00 05000 OPERATING ROOM	0. 166657			50.00
51.00 05100 RECOVERY ROOM	0. 000000			51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 868601			52. 00
53. 00 05300 ANESTHESI OLOGY	0. 051903			53.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	0. 084460			54.00
54. 01 05401 FSED RADI OLOGY - DI AGNOSTI C 55. 00 05500 RADI OLOGY - THERAPEUTI C	0. 086354 0. 150154			54. 01 55. 00
55. 01 05501 WOODLAND CANCER CARE CTR	0. 165830			55. 01
56. 00 05600 RADI OI SOTOPE	0. 000000			56. 00
57. 00 05700 CT SCAN	0. 000000			57.00
58. 00 05800 MRI	0. 000000			58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 113802			59. 00
60. 00 06000 LABORATORY	0. 139960			60. 00
60. 01 06001 FS ED LAB	0. 001681			60. 01
61. 00 06100 PBP CLI NI CAL LAB SERVI CES-PRGN	1			61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD 63.00 06300 BLOOD STORING, PROCESSING & TR				62.00
63. 00 06300 BLOOD STORING, PROCESSING & TR 63. 01 06301 FS ED BLOOD BANK	ANS. 0. 028984 0. 001684			63. 00 63. 01
64. 00 06400 I NTRAVENOUS THERAPY	0. 000000			64. 00
65. 00 06500 RESPIRATORY THERAPY	0. 172576			65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 216207			66. 00
67. 00 06700 OCCUPATIONAL THERAPY	0. 000000			67. 00
68.00 06800 SPEECH PATHOLOGY	0. 000000			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 101323			69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000			70.00
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PA	1			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS	0. 432921 0. 239217			72. 00 73. 00
74. 00 07400 RENAL DI ALYSI S	0. 237217			74. 00
75. 00 07500 ASC (NON-DISTINCT PART)	0. 000000			75. 00
76. 00 03020 CLI NI C	0. 000000			76. 00
77.00 07700 ALLOGENEIC STEM CELL ACQUISITI	1			77. 00
OUTPATIENT SERVICE COST CENTERS				
88.00 08800 RURAL HEALTH CLINIC				88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CEN	1			89.00
90. 00 09000 CLI NI C	0.000000			90.00
90. 03 09003 INFUSION OP SERVICES 91. 00 09100 EMERGENCY	0. 112764			90. 03
91. 01 09100 EMERGENCY 91. 01 09101 FREE STANDI NG EMERGENCY DEPT	0. 120007 0. 313932			91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT	1			92. 00
OTHER REIMBURSABLE COST CENTERS	3. 3. 3. 3. 3. 3. 3. 3. 3. 3. 3. 3.			72.00
94. 00 09400 HOME PROGRAM DIALYSIS	0. 000000			94. 00
95. 00 09500 AMBULANCE SERVICES	0. 000000			95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000			96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0. 000000			97. 00
98. 00 09850 OTHER REIMBURSABLE COST CENTER	S 0.000000			98.00
99. 00 09900 CMHC				99.00
99. 10 09910 CORF 100. 00 10000 L&R SERVI CES-NOT APPRVD PRGM				99. 10 100. 00
101. 00 10100 HOME HEALTH AGENCY				101. 00
102.00 10200 OPLOLD TREATMENT PROGRAM				101.00
SPECIAL PURPOSE COST CENTERS				102.00
105. 00 10500 KIDNEY ACQUISITION				105. 00
106.00 10600 HEART ACQUISITION				106. 00
107.00 10700 LIVER ACQUISITION				107. 00
108.00 10800 LUNG ACQUISITION				108. 00
109. 00 10900 PANCREAS ACQUISITION				109.00
110.00 11000 INTESTINAL ACQUISITION				110.00
111.00 11100 ISLET ACQUISITION 113.00 11300 INTEREST EXPENSE				111. 00 113. 00
110. 00 11000 1111LINEST EAFENSE	<u> </u>			[113.00

Health Financial Systems	FRANCISCAN HEALTH	MICHIGAN CITY	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0015	Peri od: From 01/01/2022 To 12/31/2022	Worksheet C Part I Date/Time Prepared:
				4/13/2023 4:18 pm
		Title XVIII	Hospi tal	PPS
Cost Center Description	PPS Inpatient			
	Ratio			
	11.00			
114.00 11400 UTI LI ZATI ON REVI EW-SNF				114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)				115. 00
116. 00 11600 HOSPI CE				116. 00
200.00 Subtotal (see instructions)				200.00
201.00 Less Observation Beds				201. 00
202. 00 Total (see instructions)				202. 00

Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0015

						4/13/2023 4:1	8 pm
			Ti tl	e XIX	Hospi tal	Cost	
	Cost Center Description	Total Cost (from Wkst. B, Part I, col.	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
		26)					
		1.00	2.00	3.00	4. 00	5. 00	
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	47 270 024	Γ	47 270 024		0	20.00
		47, 279, 824		47, 279, 824		_	
	03100 I NTENSI VE CARE UNI T	9, 111, 608		9, 111, 608		0	
	03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT	0				0	
	03400 SURGICAL INTENSIVE CARE UNIT	0					1
40. 00	04000 SUBPROVI DER - I PF	6, 179, 429		6, 179, 429		Ö	1
41. 00	04100 SUBPROVI DER - I RF	0,1,7,127		0, 1, 7, 1, 2,		ő	1
43. 00	04300 NURSERY	1, 412, 424		1, 412, 424		ő	43. 00
44.00	04400 SKILLED NURSING FACILITY	0		l c	0	0	1
45.00	04500 NURSING FACILITY	0		C	0	0	45. 00
46.00	04600 OTHER LONG TERM CARE	0		C	0	0	46. 00
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	26, 135, 582		26, 135, 582			
	05100 RECOVERY ROOM	0		0	_		
	05200 DELIVERY ROOM & LABOR ROOM	2, 529, 862		2, 529, 862		_	
	05300 ANESTHESI OLOGY	289, 696		289, 696		0	
54. 00 54. 01	05400 RADI OLOGY - DI AGNOSTI C	11, 953, 102		11, 953, 102			54.00
55. 00	05401 FSED RADI OLOGY - DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	2, 509, 375		2, 509, 375		0	54. 01 55. 00
	05501 WOODLAND CANCER CARE CTR	3, 079, 466 995, 111		3, 079, 466 995, 111		0	1
56. 00	05600 RADI OI SOTOPE	773, 111		773, 111			56.00
	05700 CT SCAN	0					1
58. 00	05800 MRI	0		Ö		ő	1
59. 00	05900 CARDI AC CATHETERI ZATI ON	4, 415, 136		4, 415, 136	Ö	o o	
60.00	06000 LABORATORY	15, 248, 940		15, 248, 940		ő	60.00
60. 01	06001 FS ED LAB	29, 527		29, 527		0	60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0		C	0	0	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0		C	0	0	62. 00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	46, 785		46, 785	0	0	63. 00
63. 01	06301 FS ED BLOOD BANK	30		30	0	0	63. 01
64. 00	06400 I NTRAVENOUS THERAPY	0	l .	0	_	0	
65. 00	06500 RESPI RATORY THERAPY	3, 372, 700	0		0	0	
66. 00	06600 PHYSI CAL THERAPY	4, 610, 621	0	4, 610, 621	0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0	0 040 004	0	0	68. 00
	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	3, 312, 021		3, 312, 021		0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2, 004 12, 874, 246		2, 004 12, 874, 246		0	
	07200 IMPL. DEV. CHARGED TO PATIENTS	14, 010, 659		14, 010, 659			1
	07300 DRUGS CHARGED TO PATIENTS	41, 508, 130		41, 508, 130			1
	07400 RENAL DIALYSIS	0		11, 000, 100		ő	1
75. 00	07500 ASC (NON-DISTINCT PART)	0			Ö	o o	75. 00
76. 00	03020 CLI NI C	740, 549		740, 549	0	0	1
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION	0		C	0	0	77. 00
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0		C	0	0	88. 00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	
	09000 CLINIC	0		0	0	0	
	09003 I NFUSI ON OP SERVI CES	2, 817, 819		2, 817, 819		0	
	09100 EMERGENCY	12, 058, 802		12, 058, 802		0	91.00
	09101 FREE STANDING EMERGENCY DEPT 09200 OBSERVATION BEDS (NON-DISTINCT PART	6, 821, 723 0		6, 821, 723		0	91. 01 92. 00
72.00	OTHER REIMBURSABLE COST CENTERS	0					72.00
94. 00	09400 HOME PROGRAM DI ALYSI S	0) 0	0	94. 00
	09500 AMBULANCE SERVICES	0					
	09600 DURABLE MEDICAL EQUIP-RENTED	0		Ö		ő	1
	09700 DURABLE MEDICAL EQUIP-SOLD	0		i c	Ó	ő	
	09850 OTHER REIMBURSABLE COST CENTERS	0		l d	0	o o	1
	09900 CMHC	0		C)	0	1
99. 10	09910 CORF	0		C)	0	99. 10
100.00	10000 I&R SERVICES-NOT APPRVD PRGM	0		C)	0	100. 00
	10100 HOME HEALTH AGENCY	0		C		•	101. 00
102.00	10200 OPIOLD TREATMENT PROGRAM	0		C		0	102. 00
	SPECIAL PURPOSE COST CENTERS						1
	10500 KI DNEY ACQUI SI TI ON	0		C		1	105.00
	10600 HEART ACQUISITION	0		0		1	106.00
	10700 LIVER ACQUISITION					1	107.00
	10800 LUNG ACQUISITION 10900 PANCREAS ACQUISITION	0					108. 00 109. 00
109.00	TO TO TO THE TOTAL	1 0	I	1 0	1	1 0	1107.00

Health Financial Systems	FRANCISCAN HEALTH MICHIGAN CITY	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0015	From 01/01/2022	Worksheet C Part I Date/Time Prepared:

		Ti tl	e XIX	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst. B,	Adj .		Di sal I owance		
	Part I, col.					
	26)					
	1. 00	2.00	3.00	4. 00	5. 00	
110.00 11000 INTESTINAL ACQUISITION	0		[C)	0	110. 00
111.00 11100 ISLET ACQUISITION	0				0	111. 00
113. 00 11300 I NTEREST EXPENSE						113. 00
114.00 11400 UTILIZATION REVIEW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0				0	115. 00
116. 00 11600 HOSPI CE	0				0	116. 00
200.00 Subtotal (see instructions)	233, 345, 171	0	233, 345, 171	0	0	200.00
201.00 Less Observation Beds	O		[c		0	201. 00
202.00 Total (see instructions)	233, 345, 171	0	233, 345, 171	0	0	202. 00

Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0015

		Ti tl	e XIX	Hospi tal	4/13/2023 4: 1 Cost	8 pm
Cost Center Description	I npati ent	Charges Outpatient		6 Cost or Other Ratio	ļ.	
	6.00	7. 00	8. 00	9. 00	10.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	0			O		30.00
31. 00 03100 NTENSI VE CARE UNIT	0			0		31.00
32. 00 03200 CORONARY CARE UNIT	0			0		32. 00
33. 00 03300 BURN INTENSIVE CARE UNIT	0			0		33. 00
34. 00 03400 SURGICAL INTENSIVE CARE UNIT 40. 00 04000 SUBPROVIDER - IPF	0			0		34. 00 40. 00
41. 00 04100 SUBPROVI DER -	O			Ö		41. 00
43. 00 04300 NURSERY	0			0		43. 00
44.00 04400 SKILLED NURSING FACILITY 45.00 04500 NURSING FACILITY	0			0		44. 00 45. 00
46. 00 04600 OTHER LONG TERM CARE	0			0		46. 00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM 51. 00 05100 RECOVERY ROOM	0	0	1	0 0.00000 0 0.00000	•	1
52. 00 05200 DELI VERY ROOM & LABOR ROOM		0		0.00000		1
53. 00 05300 ANESTHESI OLOGY	0	0		0.00000		1
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0.00000	1	1
54. 01 05401 FSED RADI OLOGY - DI AGNOSTI C 55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0 0.00000 0 0.00000		1
55. 01 05501 WOODLAND CANCER CARE CTR	l ő	0	6	0.00000	•	
56. 00 05600 RADI OI SOTOPE	0	0		0. 00000		1
57. 00 05700 CT SCAN 58. 00 05800 MRI	0	0		0 0.00000 0 0.00000		1
59. 00 05900 CARDI AC CATHETERI ZATI ON		0		0 0.00000 0 0.00000		
60. 00 06000 LABORATORY	o	0		0.00000	•	
60. 01 06001 FS ED LAB	0	0		0.00000	1	1
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0 0.00000 0 0.00000		
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0		0.00000	1	1
63. 01 06301 FS ED BLOOD BANK	0	0		0. 00000	0. 000000	1
64. 00 06400 I NTRAVENOUS THERAPY	0	0		0.00000		1
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY		0		0 0.00000 0 0.00000		1
67. 00 06700 OCCUPATI ONAL THERAPY	O	0	6	0.00000	•	1
68.00 06800 SPEECH PATHOLOGY	o	0		0.00000	•	1
69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 0.00000 0 0.00000		
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0.00000	•	1
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0. 00000	0. 000000	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		0.00000		1
74. 00 07400 RENAL DIALYSIS 75. 00 07500 ASC (NON-DISTINCT PART)		0		0 0.00000 0 0.00000		
76. 00 03020 CLI NI C	O	0		0.00000	1	1
77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0		0.00000	0.000000	77. 00
0UTPATIENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC	0	0		0.00000	0.000000	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0. 00000	0. 000000	1
90. 00 09000 CLI NI C	0	0		0.00000	1	1
90. 03 09003 NFUSI ON OP SERVI CES 91. 00 09100 EMERGENCY	0	0		0 0.00000 0 0.00000	1	
91. 01 09101 FREE STANDING EMERGENCY DEPT	o	0		0.00000	1	1
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0)	0.00000	0.000000	92. 00
94. 00 O9400 HOME PROGRAM DI ALYSI S	O	0)	0.00000	0.000000	94. 00
95. 00 09500 AMBULANCE SERVICES	0	0	1	0.00000	•	1
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0.00000	•	1
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD 98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0	0		0 0.00000 0 0.00000	1	
99. 00 09900 CMHC	O	0	6	0	0.00000	99. 00
99. 10 09910 CORF	0	0		0		99. 10
100.00 10000 1&R SERVICES-NOT APPRVD PRGM 101.00 10100 HOME HEALTH AGENCY	0	0		0		100. 00 101. 00
102.00 10200 OPI OI D TREATMENT PROGRAM	0	0	1	0		102.00
SPECIAL PURPOSE COST CENTERS			J			
105. 00 10500 KI DNEY ACQUI SI TI ON 106. 00 10600 HEART ACQUI SI TI ON		0	1	0		105. 00 106. 00
107. 00 10700 LI VER ACQUI SI TI ON		0	o	Ö		107. 00
108. 00 10800 LUNG ACQUISITION	0	0	1	0		108. 00
109.00 10900 PANCREAS ACQUISITION 110.00 11000 INTESTINAL ACQUISITION	0	0	1	0		109. 00 110. 00
	<u>, </u>		1	-1	1	1 3. 30

Health Financial Systems	FRANCISCAN HEALTH MICHIGAN CITY	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0015	Peri od: From 01/01/2022 To 12/31/2022	Worksheet C Part I Date/Time Prepared: 4/13/2023 4:18 pm
	T1.11 V1.V		<u> </u>

		Ti tl	e XIX	Hospi tal	Cost	
		Charges				
Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
			+ col . 7)	Ratio	I npati ent	
					Ratio	
	6. 00	7. 00	8. 00	9. 00	10.00	
111.00 11100 I SLET ACQUI SI TI ON	0	C)	O		111. 00
113. 00 11300 I NTEREST EXPENSE						113. 00
114.00 11400 UTILIZATION REVIEW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	C				115.00
116. 00 11600 HOSPI CE	0	(116.00
200.00 Subtotal (see instructions)	0	(200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	1 0	1 0				202.00

Title XIX

			Title XIX	Hospi tal	Cost
	Cost Center Description	PPS Inpatient			
		Ratio			
		11.00			
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS				30.00
31. 00	03100 INTENSIVE CARE UNIT				31.00
32. 00	03200 CORONARY CARE UNIT				32. 00
33.00	03300 BURN INTENSIVE CARE UNIT				33. 00
34. 00	03400 SURGICAL INTENSIVE CARE UNIT				34.00
40. 00	04000 SUBPROVI DER - I PF				40. 00
41. 00	04100 SUBPROVI DER – I RF				41. 00
43.00	04300 NURSERY				43. 00
44. 00	04400 SKILLED NURSING FACILITY				44.00
45. 00	04500 NURSING FACILITY				45. 00
46. 00	04600 OTHER LONG TERM CARE				46. 00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0. 000000			50.00
51.00	05100 RECOVERY ROOM	0. 000000			51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000			52. 00
53.00	05300 ANESTHESI OLOGY	0. 000000			53. 00
54.00	05400 RADI OLOGY - DI AGNOSTI C	0.000000			54. 00
54. 01	05401 FSED RADI OLOGY - DI AGNOSTI C	0.000000			54. 01
55. 00	05500 RADI OLOGY-THERAPEUTI C	0.000000			55. 00
55. 01	05501 WOODLAND CANCER CARE CTR	0.000000			55. 01
56.00	05600 RADI OI SOTOPE	0.000000			56.00
57. 00	05700 CT SCAN	0.000000			57. 00
58. 00	05800 MRI	0.000000			58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0.000000			59.00
60.00	06000 LABORATORY	0.000000			60.00
60. 01	06001 FS ED LAB	0.000000			60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000			61. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000			62. 00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000			63. 00
63. 01	06301 FS ED BLOOD BANK	0.000000			63. 01
64. 00	06400 I NTRAVENOUS THERAPY	0.000000			64. 00
65. 00	06500 RESPI RATORY THERAPY	0.000000			65. 00
66.00	06600 PHYSI CAL THERAPY	0.000000			66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 000000			67. 00
68. 00	06800 SPEECH PATHOLOGY	0. 000000			68. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 000000			69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0. 000000			70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000			71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000			72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 000000			73. 00
74. 00	1 · · · · · · · · · · · · · · · · · · ·	0. 000000			74.00
75. 00	07500 ASC (NON-DISTINCT PART)	0.000000			75. 00
76. 00	03020 CLINIC	0. 000000			76.00
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000			77. 00
00.00	OUTPATIENT SERVICE COST CENTERS	0.000000			00.00
88. 00	08800 RURAL HEALTH CLINIC	0.000000			88. 00
89. 00		0.000000			89.00
	09000 CLINIC	0.000000			90.00
90. 03 91. 00	09003 NFUSION OP SERVICES 09100 EMERGENCY	0.000000			90. 03
91.00		0.000000			
91.01	O9101 FREE STANDING EMERGENCY DEPT O9200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000 0. 000000			91. 01 92. 00
7Z. UU	OTHER REIMBURSABLE COST CENTERS	0.000000			92.00
94. 00	09400 HOME PROGRAM DIALYSIS	0. 000000			94. 00
94. 00 95. 00	09500 AMBULANCE SERVICES	0. 000000			95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000			96.00
96.00	09700 DURABLE MEDICAL EQUIP-SOLD	0. 000000			97.00
98. 00	09850 OTHER REIMBURSABLE COST CENTERS	0. 000000			98. 00
	09900 CMHC	0.000000			99.00
	09910 CORF				99. 10
	10000 I&R SERVICES-NOT APPRVD PRGM				100.00
	10000 T&R SERVICES-NOT APPROD PROM				101. 00
	10100 HOME HEALTH AGENCY 10200 OPIOID TREATMENT PROGRAM				102.00
102.00	SPECIAL PURPOSE COST CENTERS				102.00
105.00	10500 KIDNEY ACQUISITION	1			105. 00
	1 1				106. 00
	10600 HEART ACQUISITION				
	10700 LIVER ACQUISITION 10800 LUNG ACQUISITION				107. 00 108. 00
	10800 LUNG ACQUISITION 10900 PANCREAS ACQUISITION				109. 00
	10900 PANCREAS ACQUISITION 11000 INTESTINAL ACQUISITION				110.00
	TIOOO TNIESTINAL ACQUISITION 11100 ISLET ACQUISITION				111.00
	11100 15LET ACQUISTITON 11300 INTEREST EXPENSE				113. 00
113.00	7. 1999 I WIERCOT EXILENSE	<u> </u>			1113.00

Health Financial Systems	FRANCISCAN HEALTH	MICHIGAN CITY	In Lieu of Form CMS-2552-10		
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0015	Peri od: From 01/01/2022 To 12/31/2022	Worksheet C Part I Date/Time Prepared: 4/13/2023 4:18 pm	
		Title XIX	Hospi tal	Cost	
Cost Center Description 114.00 11400 UTILIZATION REVIEW-SNF 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	PPS Inpatient Ratio 11.00			114. 00 115. 00	
116.00 11600 HOSPICE 200.00 Subtotal (see instructions) 201.00 Less Observation Beds 202.00 Total (see instructions)				116. 00 200. 00 201. 00 202. 00	

Health Financial Systems FRA	ANCISCAN HEALTI	H MICHIGAN CIT	Y	In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL (Provi der C	CN: 15-0015	Peri od: From 01/01/2022 To 12/31/2022	Worksheet D Part I	pared:
		Title	e XVIII	Hospi tal	PPS	
	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col 2)		Per Diem (col. 3 / col. 4)	
	1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS 31.00 INTENSIVE CARE UNIT 32.00 CORONARY CARE UNIT 33.00 BURN INTENSIVE CARE UNIT 34.00 SURGICAL INTENSIVE CARE UNIT 40.00 SUBPROVIDER - IPF 41.00 SUBPROVIDER - IRF 43.00 NURSERY 44.00 SKILLED NURSING FACILITY 45.00 NURSING FACILITY 200.00 Total (lines 30 through 199) Cost Center Description	5, 344, 747 940, 563 0 0 1, 018, 274 180, 769 0 7, 484, 353 Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col.	5, 344, 74 940, 56 1, 018, 27 180, 76 7, 484, 38	33 3, 531 0 0 0 0 0 0 74 2, 701 0 0 59 760 0 0	266. 37 0. 00 0. 00 0. 00 377. 00 0. 00 237. 85 0. 00	31. 00 32. 00 33. 00 34. 00 40. 00 41. 00 43. 00
LAUDATI ENT. DOUTLAGE OFFILIAGE COOT OFFITEDO	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS 30.00 ADULTS & PEDIATRICS 31.00 INTENSIVE CARE UNIT 32.00 CORONARY CARE UNIT 34.00 SURGICAL INTENSIVE CARE UNIT 40.00 SUBPROVIDER - IPF 41.00 SUBPROVIDER - IRF 43.00 NURSERY 44.00 SKILLED NURSING FACILITY 45.00 NURSING FACILITY 200.00 Total (lines 30 through 199)	9, 483 903 0 0 0 364 0 0 0 0	240, 532 0 0 0 137, 228 0 0 0				30. 00 31. 00 32. 00 33. 00 34. 00 40. 00 41. 00 43. 00 44. 00 45. 00 200. 00

	RANCISCAN HEALTH	H MICHIGAN CITY	<i>(</i>		eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT.	AL COSTS	Provi der CO	CN: 15-0015	Peri od:	Worksheet D	
				From 01/01/2022 To 12/31/2022		pared.
					4/13/2023 4: 1	8 pm
	_		XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
	Related Cost	(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,		(col . 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26) 1.00	2.00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	1.00	2.00	0.00	1. 00	0.00	
50. 00 05000 OPERATING ROOM	6, 164, 079	157, 848, 558	0. 03905	11, 541, 597	450, 711	50.00
51.00 05100 RECOVERY ROOM	0	0	0. 00000	00	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	323, 485	2, 912, 572	0. 11106	5 11, 638	1, 293	52. 00
53. 00 05300 ANESTHESI OLOGY	84, 770	9, 842, 518	0. 00861	3 1, 176, 511		
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 813, 568	141, 523, 535	0. 01988	14, 013, 859	278, 610	54.00
54. 01 05401 FSED RADIOLOGY - DIAGNOSTIC	207, 658	29, 059, 002	0. 00714	6 0	0	54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C	892, 488	20, 508, 758	0. 04351	7 1, 215, 904	52, 912	55. 00
55. 01 05501 WOODLAND CANCER CARE CTR	102, 186	6, 000, 798	0. 01702	.9 0	0	55. 01
56. 00 05600 RADI 0I SOTOPE	0	0	0.00000	0 0	0	56. 00
57. 00 05700 CT SCAN	0	0	0. 00000	00	0	57. 00
58. 00 05800 MRI	0	0	0.00000	0 0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	1, 335, 754	38, 796, 753	0. 03443	4, 213, 059	145, 056	59. 00
60. 00 06000 LABORATORY	589, 158	109, 131, 773	0. 00539	17, 156, 688	92, 629	60.00
60. 01 06001 FS ED LAB	773	17, 565, 031	0. 00004	4 0	0	60. 01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61. 00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0. 00000		0	62. 00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	16, 050				0	
63. 01 06301 FS ED BLOOD BANK	1	17, 819			0	63. 01
64. 00 06400 I NTRAVENOUS THERAPY	0	0	0. 00000		0	64. 00
65. 00 06500 RESPI RATORY THERAPY	295, 404	19, 543, 256				
66. 00 06600 PHYSI CAL THERAPY	175, 459	21, 325, 045			l	•
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0. 00000		0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0	0. 00000		0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	612, 387	32, 687, 872			l	
70. 00 07000 ELECTROENCEPHALOGRAPHY	79	0	0. 00000		0	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	152, 072					
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	165, 119					•
73. 00 07300 DRUGS CHARGED TO PATIENTS	784, 777	173, 516, 410			l	•
74. 00 07400 RENAL DI ALYSI S	0	0	0.00000		0	74.00
75. 00 07500 ASC (NON-DISTINCT PART)	10.570	0	0.00000		0	75. 00
76.00 03020 CLINIC 77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	19, 578	0				76.00
77. 00 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON OUTPATI ENT SERVI CE COST CENTERS	0	0	0.00000	0	0	77. 00
88. 00 08800 RURAL HEALTH CLINIC	0	0	0.00000	00 0	0	88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0				89. 00
90. 00 09000 CLINI C	0	0	0.00000			90.00
90. 03 09003 NFUSION OP SERVICES	217, 086	24, 988, 730			0	90. 03
91. 00 09100 EMERGENCY	1, 228, 391					
91. 01 09101 FREE STANDI NG EMERGENCY DEPT	1, 098, 660					
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	769, 442					
OTHER REI MBURSABLE COST CENTERS	107, 442	10,070,070	0.07172	.5 0		72.00
94. 00 09400 HOME PROGRAM DI ALYSI S	0	0	0.00000	00 0	0	94. 00
95. 00 09500 AMBULANCE SERVICES			0.00000		ĺ	95. 00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0	0	0. 00000	00	0	•
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	1 0	Ö			Ö	
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0	l ő	0. 00000		Ö	98. 00
200.00 Total (lines 50 through 199)	18, 048, 424	1, 016, 146, 554		96, 833, 579		
, , , , , , , , , , , , , , , , , , , ,			•			

Health Financial Systems FF	RANCISCAN HEALII	H MICHIGAN CITY	Υ	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COS	TS Provider C	F	eriod: rom 01/01/2022 o 12/31/2022		pared:
		Ti tl c	xVIII	Hospi tal	PPS	о рііі
Cost Center Description	Nursi ng	Nursi ng		Allied Health	All Other	
cost center bescription	Program	Program	Post-Stepdown	Cost	Medi cal	
	Post-Stepdown	Frogram	Adjustments		Education Cost	
			Aujustillerits		Education Cost	
	Adj ustments	1.00	24	2.00	2.00	
LAIDATI FAIT DOUTLAIF CERVILOE COCT OFATERS	1A	1.00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	_	_	_	_	_	
30. 00 03000 ADULTS & PEDI ATRI CS	0	0		0		30. 00
31.00 03100 INTENSIVE CARE UNIT	0	0		0		31. 00
32. 00 03200 CORONARY CARE UNIT	0	0	0	0	0	32.00
33.00 03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
40. 00 04000 SUBPROVI DER - 1 PF	0	l 0	0	0	0	40.00
41. 00 04100 SUBPROVI DER - I RF	0	1 0	0	0	0	41.00
43. 00 04300 NURSERY	0	0	0	0	0	43. 00
44.00 04400 SKILLED NURSING FACILITY	0	١		0		44. 00
45. 00 04500 NURSI NG FACILITY				0		45. 00
	0			0	_	
200.00 Total (lines 30 through 199)	0 0	T 1 1 0 1	T 1 1 D 11 1	0		200. 00
Cost Center Description	Swi ng-Bed	Total Costs		Per Diem (col.	Inpatient	
	Adjustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,				
	instructions)	minus col. 4)				
	4. 00	5. 00	6. 00	7. 00	8. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		1		T .		
30. 00 03000 ADULTS & PEDIATRICS	0	-	,	0.00		
31.00 03100 INTENSIVE CARE UNIT		0	3, 531	0.00	903	31. 00
32. 00 03200 CORONARY CARE UNIT		0	0	0.00	0	32.00
33.00 03300 BURN INTENSIVE CARE UNIT		0	0	0.00	0	33.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT		0	0	0.00	0	34.00
40. 00 04000 SUBPROVI DER - I PF	0	0	2, 701	0.00	364	40. 00
41. 00 04100 SUBPROVI DER - I RF	0	1 0	. 0	0.00	0	41.00
43. 00 04300 NURSERY	_	0	760	0.00	0	43. 00
44.00 04400 SKILLED NURSING FACILITY		1	1	0.00	0	44. 00
45. 00 04500 NURSI NG FACILITY		Ö	1	0.00	·	45. 00
200.00 Total (lines 30 through 199)				0.00		200. 00
<u> </u>	Inpatient	0	33, 271		10, 730	200.00
Cost Center Description	Program					
	Pass-Through					
	Cost (col. 7 x					
	col . 8)					
LAIDATI ENT. DOUTLAIE CEDIALOE COCT. CENTEDO	9. 00					
INPATIENT ROUTINE SERVICE COST CENTERS		I				
30. 00 03000 ADULTS & PEDI ATRI CS	0	l .				30. 00
31.00 03100 INTENSIVE CARE UNIT	0					31. 00
32. 00 03200 CORONARY CARE UNIT	0					32. 00
33.00 03300 BURN INTENSIVE CARE UNIT	0					33. 00
34.00 03400 SURGI CAL INTENSIVE CARE UNIT	0					34. 00
40. 00 04000 SUBPROVI DER - 1 PF	0					40.00
41. 00 04100 SUBPROVI DER - I RF	0					41. 00
43. 00 04300 NURSERY	0					43. 00
44.00 04400 SKILLED NURSING FACILITY	0					44. 00
45. 00 04500 NURSI NG FACILITY	Ö					45. 00
200.00 Total (lines 30 through 199)						200. 00
200.00 10tal (11163 30 till ough 177)	1	I				₁ 200.00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet D | From 01/01/2022 | Part IV | To 12/31/2022 | Date/Time Prepared: | 4/13/2023 4:18 pm
 Heal th Financial
 Systems
 FRANCISCAN HEALTH MICHIGAN CITY

 APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY
 SERVICE OTHER PASS
 Provider CCN: 15-0015
 THROUGH COSTS

						4/13/2023 4:1	8 pm
			Titl∈	XVIII	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
		Anestheti st	Program	Program	Post-Stepdown		
		Cost	Post-Stepdown		Adjustments		
			Adjustments				
		1.00	2A	2.00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
50. 00	O5000 OPERATI NG ROOM	0		II.	0	0	50. 00
	05100 RECOVERY ROOM	0	0)	0	0	51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0)	0	0	52.00
53.00	05300 ANESTHESI OLOGY	0	0)	0 0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0)	0 0	0	54.00
54. 01	05401 FSED RADIOLOGY - DIAGNOSTIC	0	0		0	0	54. 01
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0		0	0	55. 00
55. 01	05501 WOODLAND CANCER CARE CTR	0	0		0	0	55. 01
56.00	05600 RADI OI SOTOPE	0	0		0	0	56. 00
57.00	05700 CT SCAN	0	0		0	0	57. 00
58. 00	05800 MRI	0	0		0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		0	0	59. 00
60.00	06000 LABORATORY	0	0		0	0	60.00
60. 01	06001 FS ED LAB	0	o c		0 0	0	60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0 0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 0	0	63. 00
63. 01	06301 FS ED BLOOD BANK	0			0	o	63. 01
64. 00	06400 I NTRAVENOUS THERAPY	0			0	o	64. 00
65. 00	06500 RESPI RATORY THERAPY	0			0	o	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	0		0	0	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0	i o		0	Ō	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	i o		0	Ō	68. 00
69. 00	06900 ELECTROCARDI OLOGY		0		0	Ō	69. 00
	07000 ELECTROENCEPHALOGRAPHY		0		0	Ō	70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	i o		0	Ō	71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS		0		0	Ō	72. 00
	07300 DRUGS CHARGED TO PATIENTS	0				o o	73. 00
	07400 RENAL DIALYSIS	0				ő	74. 00
	07500 ASC (NON-DISTINCT PART)	0				o o	1
	03020 CLI NI C	0	_			_	1
	07700 ALLOGENEIC STEM CELL ACQUISITION	0		1		_	77. 00
00	OUTPATIENT SERVICE COST CENTERS			1	<u> </u>	·	1 55
88. 00	08800 RURAL HEALTH CLINIC	0	0		0 0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0		•		o o	89. 00
90. 00	09000 CLINIC					o o	90.00
90. 03	09003 INFUSION OP SERVICES					ő	1
91. 00	09100 EMERGENCY					o o	91.00
	09101 FREE STANDING EMERGENCY DEPT					0	1
	09200 OBSERVATION BEDS (NON-DISTINCT PART			1			
72.00	OTHER REIMBURSABLE COST CENTERS				<u> </u>		72.00
94.00	09400 HOME PROGRAM DIALYSIS		0	1	0 0	0	94. 00
	09500 AMBULANCE SERVICES			1			95. 00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0	0	1
	09700 DURABLE MEDICAL EQUIP-SOLD					0	
98. 00	09850 OTHER REIMBURSABLE COST CENTERS						98. 00
200.00					0 0		200. 00
200.00	1.0tal (11105 50 till bugil 177)	1	,	1	- ₁	, 0	1200.00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet D | From 01/01/2022 | Part IV | To 12/31/2022 | Part IV | Date/Time Prepared: 4/13/2023 4:18 pm | Hospital | PPS
 Heal th Financial APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY
 FRANCISCAN HEALTH MI CHIGAN CITY

 APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY
 SERVICE OTHER PASS
 Provider CCM
 Provider CCN: 15-0015 THROUGH COSTS Title XVIII

			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		Cost (sum of		(col. 5 ÷ col.	
			4)	col s. 2, 3,	8)	7)	
			,,	and 4)	-,	(see	
				und 1)		instructions)	
		4.00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS	4.00	3.00	0.00	7.00	0.00	
50. 00	05000 OPERATING ROOM	1 0	О	О	157, 848, 558	0. 000000	50. 00
51. 00	05100 RECOVERY ROOM				137, 646, 336	0.000000	51. 00
		_	1	1	0 010 570		
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	1	·	_,,	0. 000000	52. 00
53.00	05300 ANESTHESI OLOGY		0			0. 000000	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	0	0	,	0. 000000	54. 00
54. 01	05401 FSED RADIOLOGY - DIAGNOSTIC	0	0	0	29, 059, 002	0. 000000	54. 01
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	0	20, 508, 758	0.000000	55.00
55. 01	05501 WOODLAND CANCER CARE CTR	0	0	0	6, 000, 798	0.000000	55. 01
56.00	05600 RADI OI SOTOPE	0	l 0	l 0	0	0. 000000	56.00
57.00	05700 CT SCAN		0	0	0	0. 000000	57.00
58. 00	05800 MRI		0	0	0	0. 000000	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON		١	١	38, 796, 753	0. 000000	59. 00
60. 00	06000 LABORATORY		0			0. 000000	60.00
				0			
60. 01	06001 FS ED LAB		0	0	17, 565, 031	0. 000000	60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	_	_	_	_		61. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	·		0. 000000	62. 00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	1, 614, 175	0. 000000	63. 00
63. 01	06301 FS ED BLOOD BANK	0	0	0	17, 819	0. 000000	63. 01
64.00	06400 I NTRAVENOUS THERAPY	0	0	0	0	0.000000	64. 00
65.00	06500 RESPI RATORY THERAPY	0	0	0	19, 543, 256	0.000000	65. 00
66.00	06600 PHYSI CAL THERAPY	0	0	l 0	21, 325, 045	0. 000000	66. 00
67.00	06700 OCCUPATI ONAL THERAPY		0	0	0	0. 000000	67. 00
68. 00	06800 SPEECH PATHOLOGY		0	0	0	0. 000000	68. 00
	06900 ELECTROCARDI OLOGY		1	١	32, 687, 872	0. 000000	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY		0	١	02,007,072	0. 000000	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT				43, 988, 239	0. 000000	71.00
				0			
	07200 I MPL. DEV. CHARGED TO PATIENTS		0	0	32, 363, 108	0. 000000	
	07300 DRUGS CHARGED TO PATIENTS		0	0	173, 516, 410	0. 000000	73. 00
	07400 RENAL DI ALYSI S	0	0	0	0	0. 000000	74. 00
	07500 ASC (NON-DISTINCT PART)	0	0	0	0	0. 000000	75. 00
76. 00	03020 CLI NI C	0	0	0	0	0. 000000	76. 00
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0.000000	77. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0	0	0	0	0.000000	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0.000000	89. 00
90.00	09000 CLI NI C	0	l 0	l 0	0	0. 000000	90.00
90. 03	09003 INFUSION OP SERVICES	0	0	0	24, 988, 730	0. 000000	90. 03
91. 00	09100 EMERGENCY		0	0	100, 484, 593	0. 000000	91.00
91. 01	09101 FREE STANDING EMERGENCY DEPT		0	l ~		0. 000000	91. 01
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART					0. 000000	92. 00
92.00	OTHER REIMBURSABLE COST CENTERS				10, 090, 070	0.000000	72.00
94. 00	09400 HOME PROGRAM DIALYSIS	1 0	0	0	0	0.000000	94. 00
94. 00 95. 00			0	l o	U	0. 000000	
	09500 AMBULANCE SERVICES	_	_	_		0.000000	95. 00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0. 000000	96. 00
97. 00	09700 DURABLE MEDI CAL EQUI P-SOLD	0	0	0	0	0. 000000	97. 00
98. 00	09850 OTHER REIMBURSABLE COST CENTERS	0	1	0	0	0. 000000	
200.00	Total (lines 50 through 199)	0	0	0	1, 016, 146, 554	j l	200. 00

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 Fi nancial
 Systems
 FRANCISCAN HEALTH M

 APPORTI ONMENT
 OF
 I NPATI ENT/OUTPATI ENT ANCILLARY
 SERVI CE
 OTHER PASS
 Peri od: Worksheet D From 01/01/2022 Part IV To 12/31/2022 Date/Time Prepared: 4/13/2023 4:18 pm Provider CCN: 15-0015 THROUGH COSTS

						4/13/2023 4: 1	8 pm
			Title	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	Charges	Pass-Through	
		(col. 6 ÷ col.	Ŭ	Costs (col. 8	ŭ	Costs (col. 9	
		7)		x col. 10)		x col. 12)	
		9. 00	10.00	11.00	12.00	13. 00	
Α	NCILLARY SERVICE COST CENTERS	<u>'</u>					
50.00	05000 OPERATING ROOM	0. 000000	11, 541, 597	0	25, 644, 674	0	50.00
51.00 0	05100 RECOVERY ROOM	0. 000000	0	o	0	0	51.00
	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	11, 638	l o	0	0	52.00
	05300 ANESTHESI OLOGY	0. 000000	1, 176, 511	l o	2, 052, 586	0	53.00
1	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	14, 013, 859	l o	28, 389, 163	0	54.00
	05401 FSED RADIOLOGY - DIAGNOSTIC	0. 000000	0	0	0	0	54. 01
	05500 RADI OLOGY-THERAPEUTI C	0. 000000	1, 215, 904	l o	5, 334, 372	0	55. 00
	05501 WOODLAND CANCER CARE CTR	0. 000000	., 2.0, ,0.	0	0,001,072	0	55. 01
	05600 RADI OI SOTOPE	0. 000000	0	0	0	0	56. 00
	05700 CT SCAN	0. 000000	0		0	0	57. 00
	05800 MRI	0. 000000	0		0	0	58. 00
	05900 CARDI AC CATHETERI ZATI ON	0. 000000	4, 213, 059		2, 678, 843	0	59. 00
	16000 LABORATORY	0. 000000	17, 156, 688		4, 102, 826	0	60.00
		1	17, 130, 000		4, 102, 620	0	1
	06001 FS ED LAB	0. 000000	Ü	٥	U	U	60. 01
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	0		0	0	61.00
1	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000	0	0	0	0	62.00
	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0	0	0	0	63.00
	06301 FS ED BLOOD BANK	0. 000000	0	0	0	0	63. 01
	06400 I NTRAVENOUS THERAPY	0. 000000	0	0	0	0	64.00
4	06500 RESPI RATORY THERAPY	0. 000000	4, 345, 023	0	182, 335	0	65. 00
	06600 PHYSI CAL THERAPY	0. 000000	2, 658, 604	0	79, 441	0	66. 00
4	06700 OCCUPATI ONAL THERAPY	0. 000000	0	0	0	0	67. 00
	06800 SPEECH PATHOLOGY	0. 000000	0	0	0	0	68. 00
	06900 ELECTROCARDI OLOGY	0. 000000	10, 006, 096	0	12, 601, 097	0	69. 00
	07000 ELECTROENCEPHALOGRAPHY	0. 000000	0	0	0	0	70. 00
	77100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	4, 524, 795		4, 040, 511	0	71. 00
	7200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	4, 100, 045	0	6, 258, 068	0	72. 00
	7300 DRUGS CHARGED TO PATIENTS	0. 000000	10, 481, 893	0	49, 763, 241	0	73. 00
74.00 0	7400 RENAL DIALYSIS	0. 000000	0	0	0	0	74. 00
	07500 ASC (NON-DISTINCT PART)	0. 000000	0	0	0	0	75. 00
76. 00 0	03020 CLI NI C	0. 000000	0	0	0	0	76. 00
77.00 0	07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000	0	0	0	0	77. 00
	UTPATIENT SERVICE COST CENTERS						
88. 00 0	08800 RURAL HEALTH CLINIC	0. 000000	0	0	0	0	88. 00
	8900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000	0	0	0	0	89. 00
	99000 CLI NI C	0. 000000	0	0	0	0	90.00
90. 03 0	99003 INFUSION OP SERVICES	0. 000000	0	0	0	0	90. 03
91.00 0	9100 EMERGENCY	0. 000000	11, 387, 867	0	10, 789, 842	0	91.00
91. 01 0	9101 FREE STANDING EMERGENCY DEPT	0. 000000	0	О	0	0	91. 01
92.00 0	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0	О	1, 049, 957	0	92.00
O	THER REIMBURSABLE COST CENTERS	<u> </u>					
94.00 0	9400 HOME PROGRAM DIALYSIS	0. 000000	0	0	0	0	94. 00
95. 00 0	9500 AMBULANCE SERVICES						95. 00
96.00 0	9600 DURABLE MEDICAL EQUIP-RENTED	0. 000000	0	0	0	0	96. 00
1	9700 DURABLE MEDICAL EQUIP-SOLD	0. 000000	0	0	0	0	97. 00
	9850 OTHER REIMBURSABLE COST CENTERS	0. 000000	0	o	0	0	98. 00
200.00	Total (lines 50 through 199)		96, 833, 579	0	152, 966, 956	0	200. 00
		•					

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0015 Peri od: Worksheet D From 01/01/2022 Part V Date/Time Prepared: 12/31/2022 4/13/2023 4:18 pm Title XVIII Hospi tal Charges Costs Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Ratio From Services (see Rei mbursed Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Part I, col. 9 Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 1. 00 5. 00 2.00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 165574 25, 644, 674 4, 246, 091 50.00 51.00 05100 RECOVERY ROOM 0.000000 0 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 52 00 0.868601 52 00 0 0 0 53.00 05300 ANESTHESI OLOGY 0.029433 2, 052, 586 60, 414 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.084460 28, 389, 163 0 2, 397, 749 54.00 54.01 05401 FSED RADIOLOGY - DIAGNOSTIC 0.086354 0 0 54 01 0 05500 RADI OLOGY-THERAPEUTI C 0 55.00 0.150154 5, 334, 372 800, 977 55.00 55.01 05501 WOODLAND CANCER CARE CTR 0.165830 0 55.01 0 56.00 05600 RADI OI SOTOPE 0.000000 0 0 56.00 0 05700 CT SCAN 0 0.000000 57 00 57 00 Ω 0 0 58.00 05800 MRI 0.000000 0 58.00 05900 CARDIAC CATHETERIZATION 0.113802 2, 678, 843 0 304, 858 59.00 59.00 0 0 0 06000 LABORATORY 0.139730 4, 102, 826 0 573, 288 60.00 60.00 0 06001 FS FD LAB 60.01 0.001681 0 60.01 61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 0.000000 0 61.00 0 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0.000000 62.00 62.00 06300 BLOOD STORING, PROCESSING & TRANS. 0.028984 0 63.00 0 0 0 63.00 06301 FS ED BLOOD BANK 0 63.01 0.001684 C 0 63.01 64.00 06400 INTRAVENOUS THERAPY 0.000000 0 64.00 06500 RESPI RATORY THERAPY 0 65.00 0.172576 182, 335 0 31, 467 65.00 06600 PHYSI CAL THERAPY 0 66.00 0.216207 79, 441 17, 176 66,00 οĺ 06700 OCCUPATIONAL THERAPY 67.00 0.000000 C 0 67 00 06800 SPEECH PATHOLOGY 0.000000 0 0 68.00 0 68.00 0 06900 ELECTROCARDI OLOGY 69 00 0.101323 12, 601, 097 1, 276, 781 69.00 07000 ELECTROENCEPHALOGRAPHY 0 70.00 0.000000 70.00 0 0 1, 182, 557 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0. 292675 4, 040, 511 0 71.00 07200 I MPL. DEV. CHARGED TO PATIENTS 0.432921 6, 258, 068 0 2, 709, 249 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 0. 239217 49, 763, 241 0 1, 858 11, 904, 213 73.00 07400 RENAL DIALYSIS 0 74 00 74 00 0.000000 0 Ω 75.00 07500 ASC (NON-DISTINCT PART) 0.000000 C 0 0 0 75.00 03020 CLI NI C o 76.00 0.000000 C 0 O 76.00 07700 ALLOGENEIC STEM CELL ACQUISITION 77.00 0.000000 0 77.00 0 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 88.00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 90 00 09000 CLINIC 0.000000 90 00 0 0 Λ 09003 INFUSION OP SERVICES 90.03 0.112764 0 0 0 90.03 91.00 09100 EMERGENCY 0.120006 10, 789, 842 0 0 1, 294, 846 91.00 o 91.01 09101 FREE STANDING EMERGENCY DEPT 0. 313932 0 91.01 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 0.636237 1,049,957 0 0 668, 021 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0.000000 0 0 94.00 09500 AMBULANCE SERVICES 0.000000 0 95 00 95 00 0 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0.000000 0 Λ 96.00 97.00 09700 DURABLE MEDICAL EQUIP-SOLD 0.000000 0 0 97.00 0 98.00 09850 OTHER REIMBURSABLE COST CENTERS 0.000000 0 98.00 0 152, 966, 956 0 27, 467, 687 1, 858 200 00 200 00 Subtotal (see instructions) 201.00 Less PBP Clinic Lab. Services-Program 0 201.00 Only Charges

0

1 858

152, 966, 956

27, 467, 687 202. 00

202.00

Net Charges (line 200 - line 201)

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

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0015 From 01/01/2022 To 12/31/2022 Worksheet D Part V Date/Time Prepared: 4/13/2023 4:18 pm

Title XVIII Hospital PPS

		T: 41 -	- \(\alpha\)	11: +-1	4/13/2023 4:1	8 pm
			XVIII	Hospi tal	PPS	
		sts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00				
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0	0				50.00
51.00 05100 RECOVERY ROOM	0					51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	1				52.00
53. 00 05300 ANESTHESI OLOGY		íl ő				53.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C						54.00
54. 01 05401 FSED RADI OLOGY - DI AGNOSTI C						
						54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0		2			55. 00
55. 01 05501 WOODLAND CANCER CARE CTR	0)			55. 01
56. 00 05600 RADI 0I SOTOPE	0	0				56. 00
57. 00 05700 CT SCAN	0) 0)			57. 00
58. 00 05800 MRI	0	0)			58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0				59. 00
60. 00 06000 LABORATORY	0	0				60.00
60. 01 06001 FS ED LAB	0	ol o	ol			60. 01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0					61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL		ol o				62.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.						63.00
63. 01 06301 FS ED BLOOD BANK						63. 01
64. 00 06400 I NTRAVENOUS THERAPY						64. 00
65. 00 06500 RESPIRATORY THERAPY	0		2			65. 00
66. 00 06600 PHYSI CAL THERAPY	0)			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0) 0)			67. 00
68. 00 06800 SPEECH PATHOLOGY	0) 0)			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0) 0)			69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0)			70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0				71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	444	.			73. 00
74. 00 07400 RENAL DIALYSIS	0					74. 00
75.00 07500 ASC (NON-DISTINCT PART)	0					75. 00
76. 00 03020 CLINIC	0					76. 00
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION		1	1			77. 00
OUTPATIENT SERVICE COST CENTERS		,	<u>'</u>			77.00
						88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	_	,	,			89.00
90. 00 09000 CLI NI C	0	0	()			90.00
90. 03 09003 NFUSI ON OP SERVI CES	0		2			90. 03
91. 00 09100 EMERGENCY	0	0)			91.00
91.01 09101 FREE STANDING EMERGENCY DEPT	0	-	1			91. 01
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0) 0)			92.00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DIALYSIS	0	0				94. 00
95. 00 09500 AMBULANCE SERVICES	0)				95. 00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0					96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	1	1			97. 00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS		-	1			98.00
200.00 Subtotal (see instructions)		444	1			200.00
201.00 Less PBP Clinic Lab. Services-Program						201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)	0	444	ı			202. 00
232. 33 ₁	1	, I	1			1202.00

lealth Financial Systems F APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT	RANCISCAN HEALTI TAL COSTS		CN: 15-0015	Peri od:	u of Form CMS-2 Worksheet D	
		Component		From 01/01/2022 To 12/31/2022	Part II Date/Time Pre 4/13/2023 4:1	pared:
		Ti tl e	× XVIII	Subprovider -	PPS	о рііі
Cost Center Description	Capi tal	Total Charges		t Inpatient	Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B, Part II, col.		(col . 1 ÷ col	. Charges	column 4)	
	26)	8)	2)			
	1.00	2.00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 O5000 OPERATING ROOM	6, 164, 079		•		0	
51. 00 05100 RECOVERY ROOM	0	C			0	
52. 00 05200 DELI VERY ROOM & LABOR ROOM	323, 485	2, 912, 572			0	52.00
53. 00 05300 ANESTHESI OLOGY	84, 770		1		0	53.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C 54. 01 05401 FSED RADI OLOGY - DI AGNOSTI C	2, 813, 568 207, 658	1			218 0	54. 00 54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C	892, 488		1		309	
55. 01 05501 WOODLAND CANCER CARE CTR	102, 186	l			0	55. 01
56. 00 05600 RADI OI SOTOPE	0	0,000,770	1		0	56. 00
57.00 05700 CT SCAN	0	l c	0.00000		0	57.00
58. 00 05800 MRI	0	C	0. 00000	0 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	1, 335, 754	38, 796, 753	1		0	59.00
50. 00 06000 LABORATORY	589, 158	l	1		674	60.00
50. 01 06001 FS ED LAB	773	17, 565, 031	0.00004	4 0	0	60.01
51. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		_	0.00000	0	0	61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 63.00 06300 BLOOD STORING, PROCESSING & TRANS.	16, 050	1 414 175			0	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS. 63.01 06301 FS ED BLOOD BANK	10, 050	1, 614, 175 17, 819			0	63. 00
54. 00 06400 I NTRAVENOUS THERAPY	,	17,017	0.00000		0	64. 00
55. 00 06500 RESPIRATORY THERAPY	295, 404	19, 543, 256	l		0	65. 00
66. 00 06600 PHYSI CAL THERAPY	175, 459	1			0	66.00
57. 00 06700 OCCUPATI ONAL THERAPY	0	C	0.00000	0 0	0	67.00
58.00 06800 SPEECH PATHOLOGY	0	C	0.00000	0 0	0	68. 00
59. 00 06900 ELECTROCARDI OLOGY	612, 387	32, 687, 872			24	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	79	C	0.0000		0	70.00
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	152, 072	43, 988, 239	•		44	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	165, 119	32, 363, 108			0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS 74.00 07400 RENAL DIALYSIS	784, 777	173, 516, 410	1		186 0	73.00
75. 00 07500 ASC (NON-DISTINCT PART)			1		0	75.00
76. 00 03020 CLINIC	19, 578		1		0	76.00
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0				0	
OUTPATIENT SERVICE COST CENTERS						Ī
38.00 08800 RURAL HEALTH CLINIC	0	C	0.00000	0 0	0	88. 00
39.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	C			0	89.00
90. 00 09000 CLI NI C	0	C			0	
90. 03 09003 I NFUSI ON OP SERVI CES	217, 086		1		0	
91. 00 09100 EMERGENCY	1, 228, 391 1, 098, 660	100, 484, 593	1			91.00
P1. 01 09101 FREE STANDING EMERGENCY DEPT P2. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 098, 660	21, 729, 931 10, 698, 078			0	
OTHER REIMBURSABLE COST CENTERS		10, 070, 076	, J. 00000		0	1 /2.00
94. 00 09400 HOME PROGRAM DIALYSIS	0	C	0.00000	0 0	0	94.00
95. 00 09500 AMBULANCE SERVICES					Ü	95. 00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	C	0.00000	0 0	0	l l
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	(0. 00000		0	97.00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0	(0.00000		0	98.00
200.00 Total (lines 50 through 199)	1 17 270 002	1, 016, 146, 554	1	271, 110	2 250	200.00

Health Financial Systems	FRANCISCAN HEALTH M	In Lieu of Form CMS-2552-1		
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0015 Component CCN: 15-S015		Worksheet D Part IV Date/Time Prepared: 4/13/2023 4:18 pm

-		Ti tl e	Title XVIII		PPS	о рііі	
		I			IPF		
	Cost Center Description	Non Physician	Nursi ng	Nursi ng		Allied Health	
		Anesthetist	Program	Program	Post-Stepdown		
		Cost	Post-Stepdown Adjustments		Adjustments		
		1.00	2A	2.00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS	1.00		2.00	0.1	0.00	
50.00	05000 OPERATI NG ROOM	0	C	1	0 0	0	50.00
51.00	05100 RECOVERY ROOM	0	0)	0 0	0	51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0)	0 0	0	52.00
53. 00	05300 ANESTHESI OLOGY	0	0	1	0 0	0	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	0)	0 0		54. 00
54. 01	05401 FSED RADIOLOGY - DIAGNOSTIC	0	0	1	0 0		54. 01
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0	1	0 0	_	55. 00
55. 01	05501 WOODLAND CANCER CARE CTR	0	0	1	0 0		55. 01
56.00	05600 RADI OI SOTOPE	0	0		0 0	_	56. 00
57. 00	05700 CT SCAN	0			0 0		57. 00
58. 00 59. 00	05800 MRI	0	0		0 0	_	58. 00
60.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0					59. 00 60. 00
60. 00	06001 FS ED LAB	0					60. 00
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY			1			61. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0 0	0	62. 00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	Ŏ	Ö		o c		63. 00
63. 01	06301 FS ED BLOOD BANK	0	Ö		0		63. 01
64. 00	06400 I NTRAVENOUS THERAPY	0	O	,	0	Ö	64. 00
65.00	06500 RESPI RATORY THERAPY	0	O)	0 0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0	0	1	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	1	0	0	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0)	0 0		70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0)	0 0		71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	1	0 0	1	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	1	0 0	_	73. 00
74.00	07400 RENAL DIALYSIS	0	0		0 0	_	74. 00
75. 00 76. 00	07500 ASC (NON-DISTINCT PART) 03020 CLINIC	0				_	75. 00
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	1	0 0		76. 00 77. 00
77.00	OUTPATIENT SERVICE COST CENTERS	0		1	0	0	77.00
88. 00	08800 RURAL HEALTH CLINIC	0	0		0 0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	o o	Ö	1	o c		89. 00
90. 00	09000 CLI NI C	o o	Ö	,	o c	_	90.00
90. 03	09003 INFUSION OP SERVICES	0	O)	0 0	0	90. 03
91.00	09100 EMERGENCY	0	o	,	0 0	0	91.00
91. 01	09101 FREE STANDING EMERGENCY DEPT	0	0	1	0 0	0	91. 01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
94.00	09400 HOME PROGRAM DIALYSIS	0	0		0 0	0	94. 00
95. 00	09500 AMBULANCE SERVICES						95. 00
96. 00	09600 DURABLE MEDI CAL EQUI P-RENTED	0	0	1	0 0		96. 00
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0		0 0	0	97. 00
98. 00	09850 OTHER REIMBURSABLE COST CENTERS	0]	0 0		98. 00
200.00	Total (lines 50 through 199)	0	0	1	0 0	ıj 0	200. 00

	TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI	RVICE OTHER PAS	S Provider Co	CN: 15-0015	Peri od:	Worksheet D	
THROUG	COSTS		Component		From 01/01/2022 To 12/31/2022		pared:
			Title	· XVIII	Subprovi der - I PF	PPS	<u>о р</u>
	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		Cost (sum of		(col. 5 ÷ col.	
			4)	col s. 2, 3,	8)	7)	
				and 4)		(see instructions)	
		4.00	5.00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS	4.00	3.00	0.00	7.00	0.00	
50. 00	05000 OPERATING ROOM	0	0		0 157, 848, 558	0. 000000	50.00
51. 00	05100 RECOVERY ROOM	0	Ö		0 0	0. 000000	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	Ö	•	0 2, 912, 572		
53. 00	05300 ANESTHESI OLOGY	0	Ö		9, 842, 518		
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	Ō		0 141, 523, 535		
54. 01	05401 FSED RADIOLOGY - DIAGNOSTIC	0	Ō		0 29, 059, 002		
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0		0 20, 508, 758		
55. 01	05501 WOODLAND CANCER CARE CTR	0	0		6, 000, 798		
56. 00	05600 RADI OI SOTOPE	0	0		0 0	0.000000	
57. 00	05700 CT SCAN	0	0		0 0	0.000000	
58. 00	05800 MRI	0	0		0 0	0.000000	58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0		0 38, 796, 753	0.000000	59.00
60.00	06000 LABORATORY	0	0		0 109, 131, 773	0.000000	60.00
50. 01	06001 FS ED LAB	0	0		0 17, 565, 031	0.000000	60. 0°
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0	0. 000000	
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 1, 614, 175		
63. 01	06301 FS ED BLOOD BANK	0	0		0 17, 819	0. 000000	
64. 00	06400 I NTRAVENOUS THERAPY	0	0		0	0. 000000	
55.00	06500 RESPI RATORY THERAPY	0	0		0 19, 543, 256		
66.00	06600 PHYSI CAL THERAPY	0	0		0 21, 325, 045		
57. 00	06700 OCCUPATI ONAL THERAPY	0	0		0	0. 000000	
58. 00	06800 SPEECH PATHOLOGY	0	0		0 0	0.000000	
59. 00	06900 ELECTROCARDI OLOGY	0	0		0 32, 687, 872		
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0.000000	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 43, 988, 239 0 32, 363, 108		
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0		0 32, 363, 108 0 173, 516, 410		
74.00	07400 RENAL DIALYSIS	0	0		0 1/3, 516, 410	0.00000	
75. 00	07500 ASC (NON-DISTINCT PART)	0	0		0 0		
76. 00	03020 CLINIC	0	0		0 0		
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION				0 0		
77.00	OUTPATIENT SERVICE COST CENTERS		· · · · · ·	·	0 0	0.000000	1 / / . 00
88. 00	08800 RURAL HEALTH CLINIC	1 0	0		0 0	0.000000	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	Ö	•	o o	0. 000000	
90.00	09000 CLINIC	0	Ö	•	0 0	0. 000000	
90. 03	09003 INFUSION OP SERVICES		l o	•	0 24, 988, 730		
91. 00	09100 EMERGENCY		Ö		0 100, 484, 593		
91. 01	09101 FREE STANDING EMERGENCY DEPT	0	Ö		0 21, 729, 931	0. 000000	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0 10, 698, 078		
	OTHER REIMBURSABLE COST CENTERS						1
94. 00	09400 HOME PROGRAM DIALYSIS	0	0		0 0	0.000000	94.00
} 5. 00	09500 AMBULANCE SERVICES						95.00
	09600 DURABLE MEDICAL FOLL P-RENTED	0	0	1	n n	0 000000	96 00

0.000000 0.000000

0.000000

0 0 0 0 0 0 0 1, 016, 146, 554

96. 00

97.00

98.00

200.00

200.00

96. 00 09600 DURABLE MEDICAL EQUIP-RENTED 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD

98. 00 09850 OTHER REIMBURSABLE COST CENTERS

Total (lines 50 through 199)

	FIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE GH COSTS	RVICE OTHER PASS	Provider Component	CN: 15-0015 CCN: 15-S015	Peri od: From 01/01/2022 To 12/31/2022		pared: 8 pm
			Title	· XVIII	Subprovider -	PPS	
	Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges (col. 6 ÷ col.	Charges	Pass-Through Costs (col.		Pass-Through Costs (col. 9	
		7)		x col . 10)		x col . 12)	
		9. 00	10. 00	11.00	12.00	13.00	
	ANCILLARY SERVICE COST CENTERS						
50. 00	05000 OPERATI NG ROOM	0. 000000	0		0 0		
51.00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	0.000000	0		0 0		
52. 00 53. 00	05300 ANESTHESI OLOGY	0. 000000 0. 000000	0		0 0		
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	10, 984			0	54.00
54. 01	05401 FSED RADIOLOGY - DIAGNOSTIC	0. 000000	0		o c	Ö	54. 01
55. 00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	7, 101		0 0	0	55.00
55. 01	05501 WOODLAND CANCER CARE CTR	0. 000000	0		0 0	0	55. 01
56. 00	05600 RADI 0I SOTOPE	0. 000000	0		0 0	0	56. 00
57. 00	05700 CT SCAN	0. 000000	0		0 0	0	57. 00
58. 00	05800 MRI	0.000000	0		0 0		58. 00
59. 00 60. 00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0. 000000 0. 000000	0 124, 747		0 0	0	59. 00 60. 00
60. 01	06001 FS ED LAB	0. 000000	124, 747				60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0.00000	· ·				61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000	0		0 0	0	1
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0		0 0		63. 00
63. 01	06301 FS ED BLOOD BANK	0. 000000	0		0 0		63. 01
64.00	06400 I NTRAVENOUS THERAPY	0.000000	0		0 0		64. 00
65. 00 66. 00	06500 RESPIRATORY THERAPY	0. 000000 0. 000000	0		0 0	0	65. 00 66. 00
67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0. 000000	0		0 0	0	67.00
68. 00	06800 SPEECH PATHOLOGY	0. 000000	0				68. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 000000	1, 287		o c	ő	1
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0 0	0	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	12, 688		0 0	0	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0 0		72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	41, 081		0	0	
74. 00 75. 00	07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART)	0. 000000 0. 000000	0		0 0	0	74. 00 75. 00
76. 00	03020 CLINIC	0. 000000	0		0 0		
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000	0				
	OUTPATIENT SERVICE COST CENTERS					_	1
88. 00	08800 RURAL HEALTH CLINIC	0. 000000	0		0 0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000	0		0 0		89. 00
90.00	09000 CLINIC	0.000000	0		0 0	0	90.00
90. 03 91. 00	09003 INFUSION OP SERVICES 09100 EMERGENCY	0.000000	72 222		0 0		90. 03
91.00	O9100 EMERGENCY O9101 FREE STANDING EMERGENCY DEPT	0. 000000 0. 000000	73, 222 0	•	0 0	0	
91.01	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0	1	0 0		
, 2. 00	OTHER REIMBURSABLE COST CENTERS	3. 333000			-1		1 /2: 33
94.00	09400 HOME PROGRAM DIALYSIS	0. 000000	0		0 0	0	94. 00
95. 00							95. 00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000	0		0	0	96.00

0. 000000 0. 000000

0.000000

271, 110

96. 00 97. 00

0 200.00

0

0 98.00

0 0 0

0 0 0

96.00 O9600 DURABLE MEDICAL EQUIP-RENTED
97.00 O9700 DURABLE MEDICAL EQUIP-SOLD
98.00 O9850 OTHER REIMBURSABLE COST CENTERS
200.00 Total (lines 50 through 199)

Health Financial Customs	ANCI CCAN LIFALTI	I MICHICAN CLT	v	الحا	u of Form CMC	2552 10
Health Financial Systems FR APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	ANCISCAN HEALTI COSTS		CN: 15-0015	Period: From 01/01/2022 To 12/31/2022	wof Form CMS-: Worksheet D Part I Date/Time Pre 4/13/2023 4:1	pared:
					Cost	•
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	t		
	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	5, 344, 747	0	5, 344, 74	17 28, 299	188. 87	30.00
31.00 INTENSIVE CARE UNIT	940, 563		940, 56	3, 531	266. 37	31. 00
32. 00 CORONARY CARE UNIT	0			0 0	0.00	32. 00
33.00 BURN INTENSIVE CARE UNIT	0			0 0	0.00	33. 00
34.00 SURGICAL INTENSIVE CARE UNIT	0			0 0	0.00	34.00
40. 00 SUBPROVI DER - I PF	1, 018, 274		1, 018, 27	74 2, 701	377.00	40.00
41. 00 SUBPROVI DER - I RF	0	l		0 0	0.00	41.00
43. 00 NURSERY	180, 769		180, 76	760	237. 85	43.00
44.00 SKILLED NURSING FACILITY	0			0 0	0.00	
45.00 NURSING FACILITY	0			0 0	0.00	45. 00
200.00 Total (lines 30 through 199)	7, 484, 353		7, 484, 35	35, 291		200. 00
Cost Center Description	Inpatient	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 & PEDI ATRI CS	4, 862		<u> </u>			30.00
31.00 INTENSIVE CARE UNIT	910	242, 397	7			31.00
32. 00 CORONARY CARE UNIT	0	0				32. 00
33.00 BURN INTENSIVE CARE UNIT	0	0				33. 00
34.00 SURGICAL INTENSIVE CARE UNIT	0	0				34.00
40. 00 SUBPROVI DER - I PF	1, 439	542, 503	3			40.00
41. 00 SUBPROVI DER - I RF	0	0				41. 00
43. 00 NURSERY	469	111, 552	2			43.00
44.00 SKILLED NURSING FACILITY	0	0				44. 00
45.00 NURSING FACILITY	0	0				45. 00
200.00 Total (lines 30 through 199)	7, 680	1, 814, 738	3			200. 00

Heal th	Financial Systems FF	RANCISCAN HEALII	H MICH	IGAN CITY	Y	In Lie	u of Form CMS-	2552-10
APPORT	TIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Pr	ovider C	CN: 15-0015	Peri od: From 01/01/2022 To 12/31/2022	Date/Time Pre	pared:
							4/13/2023 4: 1	8 pm
		1 0 111	-		e XIX	Hospi tal	Cost	
	Cost Center Description	Capi tal			Ratio of Cos		Capital Costs	
		Related Cost		Wkst. C,	to Charges	Program	(column 3 x	
		(from Wkst. B, Part II, col.	Part	I, col. 8)	(col . 1 ÷ col	. Charges	column 4)	
		26)		0)	2)			
		1.00		2. 00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS	1.00	1	2.00	3.00	4.00	3.00	
50.00	05000 OPERATI NG ROOM	6, 164, 079		0	0.00000	9, 355, 439	0	50.00
51.00	05100 RECOVERY ROOM	0		0	0. 00000		0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	323, 485		0	0.00000	00 0	0	52. 00
53.00	05300 ANESTHESI OLOGY	84, 770		0	0.00000	00 612, 626	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 813, 568		0	0.00000	7, 556, 885	0	54.00
54. 01	05401 FSED RADIOLOGY - DIAGNOSTIC	207, 658		0	0.00000	250, 884	0	54. 01
55.00	05500 RADI OLOGY-THERAPEUTI C	892, 488		0	0.00000	00 468, 260	0	55. 00
55. 01	05501 WOODLAND CANCER CARE CTR	102, 186		0	0.00000	2, 603	0	55. 01
56.00	05600 RADI OI SOTOPE	0		0	0.00000	00	0	56. 00
57.00	05700 CT SCAN	0		0	0.00000	00	0	57. 00
58.00	05800 MRI	0		0	0.00000	00	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	1, 335, 754		0	0. 00000	3, 575, 664	0	59. 00
60.00	06000 LABORATORY	589, 158		0	0. 00000	9, 637, 036	0	60.00
60. 01	06001 FS ED LAB	773		0	0.00000	20, 450	0	60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY							61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	ĺ	0	0. 00000	00	0	62. 00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	16, 050	İ	0	0.00000	00 444, 109	0	63.00
63. 01	06301 FS ED BLOOD BANK	1	İ	0	0.00000	00 676	0	63. 01
64.00	06400 I NTRAVENOUS THERAPY	0	İ	0	0.00000	00	0	64. 00
65.00	06500 RESPIRATORY THERAPY	295, 404	ĺ	0	0. 00000	3, 217, 655	0	65. 00
66.00	06600 PHYSI CAL THERAPY	175, 459		0	0.00000	765, 250	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0		0	0. 00000	00	0	67. 00
68.00	06800 SPEECH PATHOLOGY	0		0	0.00000	00	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	612, 387		0	0.00000	1, 985, 250	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	79		0	0.00000	00	0	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	152, 072		0	0.00000	13, 394	0	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	165, 119		0	0.00000	00	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	784, 777		0	0.00000	5, 913, 813	0	73. 00
74.00	07400 RENAL DI ALYSI S	0		0			0	74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0		0			0	75. 00
76. 00	03020 CLI NI C	19, 578		0			0	76. 00
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0		0	0.0000	00 0	0	77. 00
	OUTPATIENT SERVICE COST CENTERS	_			I			
88. 00	08800 RURAL HEALTH CLINIC	0		0			-	
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0	0.0000		0	89. 00
90. 00	09000 CLI NI C	0		0	1 0.0000		0	90.00
90. 03	09003 I NFUSI ON OP SERVI CES	217, 086		0			0	90. 03
91. 00	09100 EMERGENCY	1, 228, 391		0			0	91.00
91. 01	09101 FREE STANDING EMERGENCY DEPT	1, 098, 660		0			0	91. 01
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0		0	0.0000	00 0	0	92.00
04.00	OTHER REIMBURSABLE COST CENTERS					20		04.00
94.00	09400 HOME PROGRAM DIALYSIS	0		0	0. 00000	0	0	94.00
95. 00 96. 00	09500 AMBULANCE SERVI CES 09600 DURABLE MEDI CAL EQUI P-RENTED	0		^	0.0000	0	0	95. 00 96. 00
96.00	09700 DURABLE MEDICAL EQUIP-RENTED			0			0	96.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS			0	1		0	98.00
200.00		17, 278, 982		0	1	49, 881, 506		200.00
∠00. UU	Trotal (Titles 50 tillough 199)	11,210,982	I	U	7	47, 001, 300	ı	1200.00

Health Financial Systems F	RANCISCAN HEALII	H MICHIGAN CIIY	<i>(</i>	In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER P.	ASS THROUGH COS	TS Provider C	F	eriod: rom 01/01/2022 o 12/31/2022		pared:
		Ti †I	e XIX	Hospi tal	Cost	
Cost Center Description	Nursi ng	Nursi ng		Allied Health	All Other	
cost center bescription	Program			Cost	Medi cal	
		Program	Post-Stepdown			
	Post-Stepdown		Adjustments		Education Cost	
	Adjustments					
	1A	1. 00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	•					
30. 00 03000 ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31. 00 03100 INTENSIVE CARE UNIT	0		•			31. 00
32. 00 03200 CORONARY CARE UNIT	0	0	0	0		32. 00
33.00 03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	33. 00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
40. 00 04000 SUBPROVI DER - 1 PF	0	1	0	0	0	40.00
41. 00 04100 SUBPROVI DER - I RF	0	-	0	0	Ö	41.00
	_	1		U		
43. 00 04300 NURSERY	0	0	0	0	0	43. 00
44.00 04400 SKILLED NURSING FACILITY	0	0	0	0		44. 00
45.00 04500 NURSING FACILITY	0	0	0	0		45. 00
200.00 Total (lines 30 through 199)	0	1	0	0	0	200. 00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patient	Dor Diom (col	Inpati ent	200.00
cost center bescription				•		
	Adjustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,				
	instructions)	minus col. 4)				
	4.00	5. 00	6. 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	28, 299	0.00	4, 862	30.00
31. 00 03100 INTENSIVE CARE UNIT		1 0	3, 531	0.00	910	31.00
32. 00 03200 CORONARY CARE UNIT		Ö			0	32. 00
33. 00 03300 BURN INTENSIVE CARE UNIT			0			33.00
		0	1			
34.00 03400 SURGICAL INTENSIVE CARE UNIT		0	0	0.00	0	34. 00
40. 00 04000 SUBPROVI DER - 1 PF	0	0	2, 701	0.00	1, 439	40. 00
41. 00 04100 SUBPROVI DER - I RF	0	0	0	0.00	0	41.00
43. 00 04300 NURSERY		1 0	760	0.00	469	43.00
44.00 04400 SKILLED NURSING FACILITY		0		0.00	0	44. 00
45. 00 04500 NURSI NG FACILITY		ا	1	0.00		45. 00
4 I				0.00		
200.00 Total (lines 30 through 199)		0	35, 291		/, 680	200. 00
Cost Center Description	I npati ent					
	Program					
	Pass-Through					
	Cost (col. 7 x					
	col . 8)					
	9. 00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0					30.00
31. 00 03100 NTENSI VE CARE UNI T	Ö	l .			l	31.00
		l .			l	
32.00 03200 CORONARY CARE UNIT	0				l	32. 00
33.00 03300 BURN INTENSIVE CARE UNIT	0				ļ	33. 00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	0				ļ	34.00
40. 00 04000 SUBPROVI DER - PF	0				ļ	40.00
41. 00 04100 SUBPROVI DER - RF	Ö	l .			ļ	41.00
					ļ	
43. 00 04300 NURSERY	0				ļ	43. 00
44.00 04400 SKILLED NURSING FACILITY	0				ļ	44. 00
45.00 04500 NURSING FACILITY	0				ļ	45. 00
200.00 Total (lines 30 through 199)	0				ļ	200. 00
, , ,	•				'	•

| In Lieu of Form CMS-2552-10 | Period: | Worksheet D | From 01/01/2022 | Part IV | To 12/31/2022 | Date/Time Prepared: | 4/13/2023 4:18 pm
 Heal th Financial
 Systems
 FRANCISCAN HEALTH MICHIGAN CITY

 APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY
 SERVICE OTHER PASS
 Provider CCN: 15-0015
 THROUGH COSTS

						4/13/2023 4:1	8 pm
			Titl	e XIX	Hospi tal	Cost	
	Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
		Anesthetist	Program	Program	Post-Stepdown		
		Cost	Post-Stepdown		Adjustments		
			Adjustments				
		1.00	2A	2. 00	3A	3.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0		1	0		50. 00
51.00	05100 RECOVERY ROOM	0	()	0	0	51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	(0	0	52.00
53.00	05300 ANESTHESI OLOGY	0	(0 (0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	(0	0	54.00
54.01	05401 FSED RADIOLOGY - DIAGNOSTIC	0	(0	0	54. 01
55.00	05500 RADI OLOGY-THERAPEUTI C	0	(0	0	55. 00
55. 01	05501 WOODLAND CANCER CARE CTR	0			0	o l	55. 01
56.00	05600 RADI OI SOTOPE	0			0	0	56. 00
57.00	05700 CT SCAN	0	1 (0	0	57. 00
58. 00	05800 MRI	0			0	1	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0			o d		59. 00
60.00	06000 LABORATORY	0			o o	1	60. 00
60. 01	06001 FS ED LAB						60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY			1		ĺ	61. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0			0	0	62.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0		1	0 (63. 00
63. 00	06301 FS ED BLOOD BANK	0		1	0 0	1	
		0			0 (63. 01
64. 00	06400 I NTRAVENOUS THERAPY	0			-	1	64. 00
65. 00	06500 RESPIRATORY THERAPY	0	(1	0 (65. 00
66. 00	06600 PHYSI CAL THERAPY	0	(0 (1	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	(1	0		67. 00
68. 00	06800 SPEECH PATHOLOGY	0	(1	0		68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	(1	0	1	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	(0	0	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	()	0	0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	()	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	()	0	0	73. 00
74.00	07400 RENAL DIALYSIS	0	()	0	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	(0	0	75. 00
76.00	03020 CLI NI C	0	(0 (0	76. 00
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	(0	0	77. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0	()	0 (0	88. 00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	(0 (0	89. 00
90.00	09000 CLI NI C	0	(0	0	90. 00
90. 03	09003 INFUSION OP SERVICES	0	(0	0	90. 03
91.00	09100 EMERGENCY	0			0	o l	91. 00
91. 01	09101 FREE STANDING EMERGENCY DEPT	0			0	0	91. 01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
94.00	09400 HOME PROGRAM DIALYSIS	0			0 (0	94. 00
95. 00	09500 AMBULANCE SERVICES	1					95. 00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	0		ol	0	0	96. 00
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD	0					97. 00
98. 00	09850 OTHER REIMBURSABLE COST CENTERS				0		98. 00
200.00					0		200.00
200.00	1. Trace (Trace 30 through 177)	1	1	1	٥,	1	

In Lieu of Form CMS-2552-10

Period:	Worksheet D	
From 01/01/2022	Part IV	
To 12/31/2022	Date/Time Prepared:	4/13/2023 4:18 pm
 Heal th Financial
 Systems
 FRANCISCAN HEALTH MICHIGAN CITY

 APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY
 SERVICE OTHER PASS
 Provider CCN: 15-0015
 THROUGH COSTS

					10 12/01/2022	4/13/2023 4: 1	8 pm
			Ti tl	e XIX	Hospi tal	Cost	
	Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	2001 30mtol 20001 pt on	Medi cal	(sum of cols.	Outpatient	(from Wkst. C,	to Charges	
		Education Cost	`	Cost (sum of		(col . 5 ÷ col .	
		Ludcati on cost	4)	col s. 2, 3,	8)	7)	
			4)		0)		
				and 4)		(see	
		4.00	Г 00	/ 00	7.00	instructions)	
	ANOLILIADY CERVILOE COCT OFNITERS	4. 00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS	T _					
50. 00	05000 OPERATING ROOM	0	C		0		50. 00
51. 00	05100 RECOVERY ROOM	0	C	l .	0		51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	C)	0	0.000000	52. 00
53.00	05300 ANESTHESI OLOGY	0	C)	0	0.000000	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	C		0 0	0.000000	54.00
54.01	05401 FSED RADIOLOGY - DIAGNOSTIC	0	C		0 0	0.000000	54. 01
55.00	05500 RADI OLOGY-THERAPEUTI C	0	C	ol	0 0	0.000000	55. 00
55. 01	05501 WOODLAND CANCER CARE CTR	0	Ċ		0 0		55. 01
56. 00	05600 RADI OI SOTOPE	0	Č	1	0 0		56.00
57. 00	05700 CT SCAN			1	0 0		57.00
		0	_	1			1
58. 00	05800 MRI	0	C	1			58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	C	1	0		59. 00
60. 00	06000 LABORATORY	0	C	•	0		60. 00
60. 01	06001 FS ED LAB	0	C)	0	0.000000	60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61. 00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	C)	0 0	0.000000	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	C		0 0	0.000000	63.00
63. 01	06301 FS ED BLOOD BANK	0		ol	0 0	0.000000	63. 01
64.00	06400 I NTRAVENOUS THERAPY	0	C		0 0		64.00
65. 00	06500 RESPI RATORY THERAPY	0	Ċ	1	0 0		65. 00
66. 00	06600 PHYSI CAL THERAPY	i o	Ċ	1	0 0		66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0		1	0 0		
68. 00		0	C	1	0 0		68. 00
	06800 SPEECH PATHOLOGY	0					1
69. 00	06900 ELECTROCARDI OLOGY	0	C	•	0 0		69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	C	1	0		1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	C	1	0		l .
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	C)	0	0.00000	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	C)	0		73. 00
74.00	07400 RENAL DI ALYSI S	0	C)	0	0.000000	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	C		0 0	0.000000	75. 00
76.00	03020 CLI NI C	0	C		0 0	0.000000	76. 00
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	C	ol	0 0	0.000000	77. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0	C		0 0	0.000000	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0		1	0 0		
90.00	09000 CLINIC	0		1	0 0		90.00
		0		(•
90. 03	09003 NFUSION OP SERVICES	0		<u>'</u>	0		90. 03
91. 00	09100 EMERGENCY	0	C	1	0		•
91. 01	09101 FREE STANDING EMERGENCY DEPT	0	C	1	0		91. 01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	C)	0 0	0.000000	92. 00
	OTHER REIMBURSABLE COST CENTERS						
94.00	09400 HOME PROGRAM DIALYSIS	0	C		0 0	0.000000	94.00
95.00	09500 AMBULANCE SERVICES						95. 00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	C		0 0	0.000000	96. 00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0	C		0 0		97. 00
98. 00	09850 OTHER REIMBURSABLE COST CENTERS	l n	Ċ	1	0 0		
200.00	1 I	1 0	Ċ		0 0		200. 00
_55.50	1 1.0ta. (1.1.00 00 till odgil 177)	1		1	-1	I	,_00.00

 Heal th Financial
 Systems
 FRANCISCAN HEALTH MICHIGAN CITY

 APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY
 SERVICE OTHER PASS
 Provider CCN: 15-0015
 THROUGH COSTS

				10) 12/31/2022	4/13/2023 4: 1	
			Titl	e XIX	Hospi tal	Cost	
	Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through	Charges	Pass-Through	
		(col. 6 ÷ col.		Costs (col. 8		Costs (col. 9	
		7)		x col. 10)		x col. 12)	
	ANOULLABLY OFFICE COOT, OFFITTED	9. 00	10. 00	11. 00	12. 00	13. 00	
FO 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	0.000000	0.255.420	ı o	20 022 502	0	FO 00
50. 00 51. 00	05100 RECOVERY ROOM	0. 000000 0. 000000	9, 355, 439 0	1	28, 823, 582 0	0	50. 00 51. 00
51.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0	1	0	0	51.00
53. 00	05300 ANESTHESI OLOGY	0. 000000	612, 626		1, 294, 861	0	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	7, 556, 885		23, 943, 147	0	54. 00
54. 01	05401 FSED RADIOLOGY - DIAGNOSTIC	0. 000000	250, 884	1	4, 478, 487	0	54. 01
55. 00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	468, 260	1	2, 471, 919	0	55. 00
55. 01	05501 WOODLAND CANCER CARE CTR	0. 000000	2, 603		1, 187, 442	Ö	55. 01
56. 00	05600 RADI OI SOTOPE	0. 000000	2, 000	1	0, 107, 112	0	56. 00
57. 00	05700 CT SCAN	0. 000000	0		0	0	57. 00
58. 00	05800 MRI	0. 000000	0		0	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	3, 575, 664	l	2, 476, 295	0	59. 00
60.00	06000 LABORATORY	0. 000000	9, 637, 036		16, 381, 957	0	60. 00
60. 01	06001 FS ED LAB	0. 000000	20, 450	1	2, 957, 066	0	60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61. 00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000	0	О	0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	444, 109	o	230, 832	0	63.00
63. 01	06301 FS ED BLOOD BANK	0. 000000	676	o	4, 508	0	63. 01
64.00	06400 I NTRAVENOUS THERAPY	0. 000000	0	0	0	0	64.00
65.00	06500 RESPI RATORY THERAPY	0. 000000	3, 217, 655	0	366, 498	0	65.00
66. 00	06600 PHYSI CAL THERAPY	0. 000000	765, 250	0	2, 512, 322	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 000000	0	0	0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0. 000000	0	0	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 000000	1, 985, 250	1	3, 313, 070	0	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	0	1	0	0	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	13, 394	1	714	0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000	0	1	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	5, 913, 813	1	18, 074, 532	0	73. 00
74. 00	07400 RENAL DIALYSIS	0.000000	0		0	0	74. 00
75. 00	07500 ASC (NON-DISTINCT PART) 03020 CLINIC	0.000000	0		0	0	75. 00
76. 00 77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000 0. 000000	0		0	0	76. 00 77. 00
77.00	OUTPATIENT SERVICE COST CENTERS	0.000000		ıj U	U	U	77.00
88. 00	08800 RURAL HEALTH CLINIC	0. 000000	0	o	0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000	0		0	0	89. 00
90.00	09000 CLINIC	0. 000000	0		0	0	90. 00
90. 03	09003 I NFUSI ON OP SERVI CES	0. 000000	0		677, 492	0	90. 03
91.00	09100 EMERGENCY	0. 000000	5, 731, 322		27, 757, 524	0	91. 00
91. 01	09101 FREE STANDING EMERGENCY DEPT	0. 000000	330, 190		4, 235, 457	0	91. 01
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0		1, 672, 746	0	92. 00
	OTHER REIMBURSABLE COST CENTERS			'	,		
94.00	09400 HOME PROGRAM DIALYSIS	0. 000000	0	0	0	0	94. 00
95.00	09500 AMBULANCE SERVICES						95. 00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000	0	0	0	0	96. 00
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD	0. 000000	0	0	0	0	97. 00
98. 00	09850 OTHER REIMBURSABLE COST CENTERS	0. 000000	0		0	0	98. 00
200.00	Total (lines 50 through 199)		49, 881, 506	0	142, 860, 451	0	200. 00

Health Financial Systems FRANCISCAN HEALTH MICHIGAN CITY In Lieu of Form CMS-2552-10 APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0015 Peri od: Worksheet D From 01/01/2022 Part V Date/Time Prepared: 12/31/2022 4/13/2023 4:18 pm Title XIX Hospi tal Cost Charges Costs Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Ratio From Services (see Rei mbursed Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Part I, col. 9 Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 1. 00 2.00 5. 00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0.000000 28, 823, 582 0 50.00 51.00 05100 RECOVERY ROOM 0.000000 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 0 52 00 52 00 0 05300 ANESTHESI OLOGY 0 53.00 0.000000 1, 294, 861 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 23, 943, 147 0 54.00 54.01 05401 FSED RADIOLOGY - DIAGNOSTIC 0.000000 4, 478, 487 0 54.01 0 |05500| RADI OLOGY-THERAPEUTI C 0 55.00 0.000000 2, 471, 919 0 55.00 55.01 05501 WOODLAND CANCER CARE CTR 0.000000 1, 187, 442 0 55.01 0 56.00 05600 RADI OI SOTOPE 0.000000 0 0 56.00 05700 CT SCAN 0.000000 0 57 00 57 00 0 Ω 58.00 05800 MRI 0.000000 0 58.00 59.00 05900 CARDIAC CATHETERIZATION 0.000000 2, 476, 295 0 0 59.00 06000 LABORATORY 0.000000 16, 381, 957 0 60.00 60.00 0 06001 FS ED LAB 0 60.01 2, 957, 066 0.000000 0 60.01 61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 0.000000 0 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0.000000 62.00 62.00 06300 BLOOD STORING, PROCESSING & TRANS. 0.000000 230, 832 0 63.00 0 63.00 0 06301 FS ED BLOOD BANK 0.000000 63.01 4,508 0 63.01 64.00 06400 INTRAVENOUS THERAPY 0.000000 0 64.00 06500 RESPI RATORY THERAPY 0 65.00 0.000000 366, 498 0 65.00 0 06600 PHYSI CAL THERAPY 66.00 0.000000 2, 512, 322 0 66,00 06700 OCCUPATIONAL THERAPY 67.00 0.000000 0 67 00 06800 SPEECH PATHOLOGY 0.000000 0 0 68.00 68.00 06900 ELECTROCARDI OLOGY 69 00 0.000000 3, 313, 070 69.00 07000 ELECTROENCEPHALOGRAPHY 0 70.00 0.000000 0 70.00 C 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 0.000000 714 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 72.00 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 0.000000 18, 074, 532 0 73.00 07400 RENAL DIALYSIS 74 00 0.000000 0 74 00 Ω 0 75.00 07500 ASC (NON-DISTINCT PART) 0.000000 0 75.00 03020 CLI NI C 0 o 76.00 0.000000 C 0 76.00 07700 ALLOGENEIC STEM CELL ACQUISITION 77.00 0.000000 0 77.00 0 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 88.00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 90 00 09000 CLI NI C 0.000000 90 00 0 0 Λ 09003 INFUSION OP SERVICES 90.03 0.000000 677, 492 0 0 0 90.03 91.00 09100 EMERGENCY 0.000000 27, 757, 524 0 0 0 91.00 0 o 91.01 09101 FREE STANDING EMERGENCY DEPT 0.000000 4, 235, 457 0 91.01

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1, 672, 746

142, 860, 451

142, 860, 451

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0 98.00

201.00

0 200.00

0 202. 00

92.00

94.00

95 00

96.00

97.00

98.00

200 00

201.00

202.00

09200 OBSERVATION BEDS (NON-DISTINCT PART

OTHER REIMBURSABLE COST CENTERS

09600 DURABLE MEDICAL EQUIP-RENTED

09850 OTHER REIMBURSABLE COST CENTERS

Subtotal (see instructions)

Less PBP Clinic Lab. Services-Program

Net Charges (line 200 - line 201)

09700 DURABLE MEDICAL EQUIP-SOLD

09400 HOME PROGRAM DIALYSIS

09500 AMBULANCE SERVICES

Only Charges

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0015 Peri od: Worksheet D From 01/01/2022 Part V Date/Time Prepared: 12/31/2022 4/13/2023 4:18 pm Title XIX Hospi tal Cost Costs Cost Center Description Cost Cost Rei mbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 6.00 7.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 50.00 51.00 05100 RECOVERY ROOM 0 51.00 52. 00 05200 DELIVERY ROOM & LABOR ROOM 0 52 00 05300 ANESTHESI OLOGY 53.00 0 53.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 54. 01 05401 FSED RADIOLOGY - DIAGNOSTIC 0 54.01 05500 RADI OLOGY-THERAPEUTI C 0 55.00 55.00 55. 01 05501 WOODLAND CANCER CARE CTR 0 55.01 05600 RADI OI SOTOPE 56.00 0 56.00 05700 CT SCAN 0 57 00 57 00 58.00 05800 MRI 0 58.00 59.00 05900 CARDIAC CATHETERIZATION 0 59.00 06000 LABORATORY 60.00 0 60.00 06001 FS ED LAB 60.01 0 60.01 61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 62.00 62.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 63.00 63.00 06301 FS ED BLOOD BANK 0 63.01 63.01 64.00 06400 I NTRAVENOUS THERAPY 0 64.00 06500 RESPIRATORY THERAPY 0 65.00 65.00 06600 PHYSI CAL THERAPY 0 66.00 66.00 06700 OCCUPATIONAL THERAPY 0 67.00 67 00 68.00 06800 SPEECH PATHOLOGY 0 68.00 06900 ELECTROCARDI OLOGY 69.00 69.00 Ol 07000 ELECTROENCEPHALOGRAPHY 70.00 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71.00 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 73.00 07400 RENAL DIALYSIS 74 00 0 74 00 75.00 07500 ASC (NON-DISTINCT PART) 0 75.00 03020 CLI NI C 0 76.00 0 76.00 07700 ALLOGENEIC STEM CELL ACQUISITION 77.00 77.00 0 OUTPAȚI ENT SERVI CE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 88.00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 90 00 09000 CLI NI C 0 90 00 0 09003 INFUSION OP SERVICES 90.03 0 0 0 90.03 91.00 09100 EMERGENCY 0 91.00 91.01 09101 FREE STANDING EMERGENCY DEPT 0 91.01 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 92.00 0 92.00 OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DIALYSIS 94.00 0 94.00 000000 95 00 09500 AMBULANCE SERVICES 95 00 09600 DURABLE MEDICAL EQUIP-RENTED 96.00 0 96.00 97.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 97.00 98.00 09850 OTHER REIMBURSABLE COST CENTERS 98.00 0

0

200 00

201.00

202.00

200.00

201.00

202.00

Subtotal (see instructions)

Only Charges

Less PBP Clinic Lab. Services-Program

Net Charges (line 200 - line 201)

APPOR ⁻	FIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider Component (CN: 15-0015 CCN: 15-S015	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part II Date/Time Pre	pared:
			·			4/13/2023 4:1	8 pm
			Ti tl	e XIX	Subprovi der - I PF	Cost	
	Cost Center Description	Capi tal	Total Charges		t Inpatient	Capital Costs	
		Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
		(from Wkst. B,		(col . 1 ÷ col	. Charges	column 4)	
		Part II, col.	8)	2)			
		26) 1. 00	2.00	3.00	4. 00	5. 00	
	ANCI LLARY SERVI CE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
50. 00	05000 OPERATING ROOM	6, 164, 079	0	0.00000	9, 274	0	50.00
51. 00	05100 RECOVERY ROOM	0, 104, 077	0			0	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	323, 485	-			0	52.00
53. 00	05300 ANESTHESI OLOGY	84, 770				0	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	2, 813, 568	0			0	54.00
54. 00	05401 FSED RADIOLOGY - DIAGNOSTIC	2, 613, 568	0			0	54. 00
55. 00	05500 RADI OLOGY - BIAGNOSTI C	892, 488				0	55.00
55. 00	05501 WOODLAND CANCER CARE CTR	102, 186	0	•		0	55. 00
56. 00	05600 RADI OI SOTOPE	102, 180				0	56.00
57. 00	05700 CT SCAN	0	0	0.00000		0	57.00
58. 00	05800 MRI	0	0			0	58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	1, 335, 754	0	1		0	59.00
60.00	06000 LABORATORY	589, 158		1		0	60.00
60. 00	06001 FS ED LAB	773	0	1		0	60.00
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	//3	0	0.00000	14,004	O	61.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0. 00000	0	0	62.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	16, 050		0. 00000		0	63.00
63. 01	06301 FS ED BLOOD BANK	10,030	0			0	63. 01
64. 00	06400 I NTRAVENOUS THERAPY	0	ĺ	•		0	64. 00
65. 00	06500 RESPI RATORY THERAPY	295, 404	0			0	65.00
66. 00	06600 PHYSI CAL THERAPY	175, 459	0	0. 00000		0	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	173, 437	ĺ			0	67.00
68. 00	06800 SPEECH PATHOLOGY	0	0			0	68.00
69. 00	06900 ELECTROCARDI OLOGY	612, 387	l ő			0	69.00
70. 00	07000 ELECTROENCEPHALOGRAPHY	79	0			0	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	152, 072	0	•		0	71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	165, 119	0			0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	784, 777	0			0	73.00
74. 00	07400 RENAL DIALYSIS	0	0	1		0	74.00
75. 00	07500 ASC (NON-DISTINCT PART)	0	0	1		0	75. 00
76. 00	03020 CLINIC	19, 578	Ö			0	76.00
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0				0	77. 00
77.00	OUTPATIENT SERVICE COST CENTERS			0.0000	,0 0		77.00
88. 00	08800 RURAL HEALTH CLINIC	0	0	0.00000	0 0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0			0	89.00
90. 00	09000 CLINIC	0	0			0	90.00
90. 03	09003 INFUSION OP SERVICES	217, 086	0	0. 00000		0	90. 03
91. 00	09100 EMERGENCY	1, 228, 391	0	1		0	91.00
91. 01	09101 FREE STANDING EMERGENCY DEPT	1, 098, 660	Ö			0	91. 01
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	1	l .		0	
20	OTHER REIMBURSABLE COST CENTERS	<u> </u>					1
94. 00	09400 HOME PROGRAM DIALYSIS	0	0	0.00000	0 0	0	94. 00
	09500 AMBULANCE SERVICES	1]				95 00

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17, 278, 982

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96. 00 97. 00

0 200.00

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0 98.00

0

1, 540, 902

95. 00 09500 AMBULANCE SERVICES

96.00 O9600 DURABLE MEDICAL EQUIP-RENTED
97.00 O9700 DURABLE MEDICAL EQUIP-SOLD
98.00 O9850 OTHER REIMBURSABLE COST CENTERS
200.00 Total (lines 50 through 199)

Health Financial Systems	FRANCISCAN HEALTH N	IICHIGAN CITY	In Lieu of Form CMS-25		
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0015 Component CCN: 15-S015	Peri od: From 01/01/2022 To 12/31/2022	Worksheet D Part IV Date/Time Prepared: 4/13/2023 4:18 pm	

						4/13/2023 4: 1	8 pm
			Ti tl	e XIX	Subprovi der -	Cost	
		I.,			IPF		
	Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health		
		Anesthetist	Program	Program	Post-Stepdown		
		Cost	Post-Stepdown		Adjustments		
		1.00	Adjustments 2A	2.00	3A	3.00	
	ANCILLARY SERVICE COST CENTERS	1.00	ZA	2.00	JA JA	3.00	
50.00	05000 OPERATING ROOM	0	0)	0 (0	50.00
51. 00	05100 RECOVERY ROOM	0	0	l .	0		
	05200 DELIVERY ROOM & LABOR ROOM	0	0	•	0	1	
	05300 ANESTHESI OLOGY	0	0		0	ol o	
	05400 RADI OLOGY-DI AGNOSTI C	0	0		0		54. 00
	05401 FSED RADI OLOGY - DI AGNOSTI C	0	0		0		1
	05500 RADI OLOGY-THERAPEUTI C	0	0		0	ol o	
	05501 WOODLAND CANCER CARE CTR	0	0		0		55. 01
56. 00	05600 RADI OI SOTOPE	0	0		0		56. 00
57. 00	05700 CT SCAN	0	0		0		57. 00
	05800 MRI	0	0		0		58. 00
	05900 CARDI AC CATHETERI ZATI ON	0	0		0	ol o	59. 00
60. 00	06000 LABORATORY	0	0		0		60.00
60. 01	06001 FS ED LAB	0	0		0		60. 01
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		_				61. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0	ol o	
	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0		1
	06301 FS ED BLOOD BANK	0	0		0	ol o	1
64. 00	06400 I NTRAVENOUS THERAPY	0	0		0	ol o	
	06500 RESPI RATORY THERAPY	0	0		0	ol o	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	0		0	o o	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0		0	o o	1
	06800 SPEECH PATHOLOGY	0	0		0	o o	1
	06900 ELECTROCARDI OLOGY	0	0		0	o o	69. 00
	07000 ELECTROENCEPHALOGRAPHY	0	0		0 (ol o	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 (ol o	71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	o o	72. 00
	07300 DRUGS CHARGED TO PATIENTS	0	0		0	o o	73. 00
74.00	07400 RENAL DIALYSIS	0	0		0	o o	74. 00
75.00	07500 ASC (NON-DISTINCT PART)	0	0		0	o o	75. 00
76.00	03020 CLI NI C	0	0		0	0	76. 00
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0		0	0	77. 00
	OUTPATIENT SERVICE COST CENTERS						1
88. 00	08800 RURAL HEALTH CLINIC	0	0)	0 (0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0	89. 00
90.00	09000 CLI NI C	0	0		0	0	90.00
90. 03	09003 INFUSION OP SERVICES	0	0		0	0	90. 03
91.00	09100 EMERGENCY	0	0		0 (0	91.00
91. 01	09101 FREE STANDING EMERGENCY DEPT	0	0		0 (0	91. 01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
94.00	09400 HOME PROGRAM DIALYSIS	0	0)	0	0	94. 00
95. 00	09500 AMBULANCE SERVICES						95. 00
	09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0	0	
	09700 DURABLE MEDICAL EQUIP-SOLD	0	0)	0	0	
	09850 OTHER REIMBURSABLE COST CENTERS	0	0)	0	0	98. 00
200.00	Total (lines 50 through 199)	0	0)	0) 0	200. 00

APPORT	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RANCISCAN HEALTI RVICE OTHER PAS		CN: 15-0015 I	Peri od:	u of Form CMS-2 Worksheet D	0
THROUG	H COSTS		Component		From 01/01/2022 To 12/31/2022	Part IV Date/Time Pre 4/13/2023 4:1	
			Ti tl	e XIX	Subprovi der -	Cost	о рііі
	Cost Center Description	All Other	Total Cost	Total	Total Charges		
		Medi cal	(sum of cols.	Outpatient	(from Wkst. C,	to Charges	
		Education Cost	1, 2, 3, and 4)	Cost (sum of cols. 2, 3,	Part I, col. 8)	(col. 5 ÷ col. 7)	
			4)	and 4)	0)	(see	
				and 4)		instructions)	
		4.00	5.00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0			0	0. 000000	
51.00	05100 RECOVERY ROOM	0	0		0	0. 000000	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0. 000000	
53.00	05300 ANESTHESI OLOGY	0	0		0	0. 000000	
54.00	05400 RADI OLOGY - DI AGNOSTI C	0	0		0	0.000000	1
54. 01 55. 00	05401 FSED RADI OLOGY - DI AGNOSTI C	0	0		0 0	0.000000	1
55. 00	05500 RADI OLOGY-THERAPEUTI C 05501 WOODLAND CANCER CARE CTR		0		0	0. 000000 0. 000000	
56. 00	05600 RADI OI SOTOPE		0		0	0. 000000	1
57. 00	05700 CT SCAN	0	0		0	0. 000000	
58. 00	05800 MRI	0	Ö		0	0. 000000	1
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	Ö		0	0. 000000	1
60.00	06000 LABORATORY	0	0		0 0	0.000000	
60. 01	06001 FS ED LAB	0	0		0 0	0. 000000	60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0	0. 000000	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0	0. 000000	
63. 01	06301 FS ED BLOOD BANK	0	0		0	0. 000000	
64.00	06400 I NTRAVENOUS THERAPY	0	0		0	0. 000000	1
65.00	06500 RESPIRATORY THERAPY	0	0		0	0.000000	
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0. 000000 0. 000000	1
68. 00	06800 SPEECH PATHOLOGY		0		0	0. 000000	1
69.00	06900 ELECTROCARDI OLOGY		0		0	0. 000000	1
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0	0. 000000	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	Ö		0	0. 000000	1
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(0	0.000000	1
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0. 000000	73. 00
74.00	07400 RENAL DIALYSIS	0	0	(0 0	0. 000000	74. 00
75.00	07500 ASC (NON-DISTINCT PART)	0	0		0	0. 000000	
76. 00	03020 CLI NI C	0	0		0 0	0. 000000	
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0		0	0. 000000	77. 00
00.00	OUTPATIENT SERVICE COST CENTERS	1				0.00000	00.00
88. 00 89. 00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0	0. 000000 0. 000000	
90.00	09000 CLINIC	0	0		0	0. 000000	
90.00	09003 INFUSION OP SERVICES				0	0. 000000	
91.00	09100 EMERGENCY	0	0		0	0. 000000	
91. 01	09101 FREE STANDING EMERGENCY DEPT	o o	Ö		0	0. 000000	1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	Ö		0	0. 000000	
	OTHER REIMBURSABLE COST CENTERS]
	09400 HOME PROGRAM DIALYSIS	0	0		0 C	0. 000000	
95 00	109500 AMBULANCE SERVICES	1	1				95 00

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97.00

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95. 00 09500 AMBULANCE SERVICES

200.00

96. 00 09600 DURABLE MEDICAL EQUIP-RENTED 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD

98.00 09850 OTHER REIMBURSABLE COST CENTERS

Total (lines 50 through 199)

Heal th	Financial Systems FF	RANCISCAN HEALTH	MICHIGAN CITY	/	In lie	eu of Form CMS-2	2552-10
	TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER				Peri od:	Worksheet D	2002 10
	THROUGH COSTS				From 01/01/2022 To 12/31/2022	Part IV	
			Ti tl	e XIX	Subprovi der -	Cost	о рііі
	Cost Center Description	Outpati ent	Inpatient	Inpati ent	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through		Pass-Through	
		(col. 6 ÷ col.		Costs (col.	3	Costs (col. 9	
		7)	10.00	x col. 10)	10.00	x col . 12)	
	ANOLUL ADV. CEDVI OF COCT. CENTEDO	9. 00	10. 00	11. 00	12.00	13. 00	
EO 00	ANCI LLARY SERVI CE COST CENTERS	0.000000	0.074	1	0 0	0	F0 00
50.00	05000 OPERATI NG ROOM	0. 000000	9, 274	1	-1	1	
51.00	05100 RECOVERY ROOM	0.000000	0	1	0 0	0	
52.00	05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	0. 000000 0. 000000	0	1	0 0	0	
53. 00 54. 00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	-		0 0		
54. 00	05400 RADI OLOGY - DI AGNOSTI C	0. 000000	119, 924 2, 620	1	0 0	0	
55. 00	05500 RADI OLOGY - THERAPEUTI C	0. 000000	2, 020	1	0 0		
55. 00	05501 WOODLAND CANCER CARE CTR	0. 000000	0	1	0 0		
56. 00	05600 RADI OI SOTOPE	0. 000000	0	1	0 0	0	1
57. 00	05700 CT SCAN	0. 000000	0	1	0 0	o o	1
58. 00	05800 MRI	0. 000000	0		0 0	1	
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	0	1	0 0	0	
60. 00	06000 LABORATORY	0. 000000	706, 659		0 0	0	1
60. 01	06001 FS ED LAB	0. 000000	14, 604	1	0 0	0	
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		,			1	61. 00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000	0	,	0 0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0)	0 0	0	63. 00
63. 01	06301 FS ED BLOOD BANK	0. 000000	0)	0 0	0	63. 01
64.00	06400 I NTRAVENOUS THERAPY	0. 000000	0)	0 0	0	64. 00
65. 00	06500 RESPI RATORY THERAPY	0. 000000	4, 044		0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0. 000000	1, 617	1	0	0	
67. 00	06700 OCCUPATI ONAL THERAPY	0. 000000	0		0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0. 000000	0		0	0	
69. 00	06900 ELECTROCARDI OLOGY	0. 000000	23, 668	1	0 0	0	
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	0	1	0 0	0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	0	1	0 0	0	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000	141 105	1	٦	0	
73.00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0. 000000	141, 185		0 0	0	
74. 00 75. 00	07500 ASC (NON-DISTINCT PART)	0. 000000 0. 000000	0	1	0 0	0	
76. 00	03020 CLINIC	0. 000000	0	1	0 0	0	1
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000	0	1	0 0		
, , . 00	OUTPATIENT SERVICE COST CENTERS	0.000000	0	1	0	0	1 , , . 00
88. 00	08800 RURAL HEALTH CLINIC	0. 000000	0	1	0 0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000	0	l .	0 0		
90. 00	09000 CLINIC	0. 000000	0	l .	0 0	Ö	
90. 03	09003 INFUSION OP SERVICES	0. 000000	0		0 0	0	1
91.00	09100 EMERGENCY	0. 000000	488, 791		0 0	0	1
91. 01	09101 FREE STANDING EMERGENCY DEPT	0. 000000	28, 516		0 0	0	91. 01
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0		0 0	0	92. 00
	OTHER RELIMBURGARIE COST CENTERS						

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0 98.00

96.00 O9600 DURABLE MEDICAL EQUIP-RENTED
97.00 O9700 DURABLE MEDICAL EQUIP-SOLD
98.00 O9850 OTHER REIMBURSABLE COST CENTERS
200.00 Total (lines 50 through 199)

94.00 09400 HOME PROGRAM DIALYSIS

95. 00 09500 AMBULANCE SERVICES

09200 OBSERVATION BEDS (NON-DISTINCT PART
OTHER REIMBURSABLE COST CENTERS

Health Financial Systems	FRANCISCAN HEALTH M	FRANCISCAN HEALTH MICHIGAN CITY		In Lieu of Form CMS-255		
COMPUTATION OF INPATIENT OPERATING COST		Provi der CCN: 15-0015	Peri od: From 01/01/2022	Worksheet D-1		
			To 12/31/2022	Date/Time Pre 4/13/2023 4:1		
		Title XVIII	Hospi tal	PPS		
Cost Center Description						
				1. 00		
PART I - ALL PROVIDER COMPONENTS						
I NPATI ENT DAYS						
1.00 Inpatient days (including private roo	Inpatient days (including private room days and swing-bed days, excluding newborn)			28, 299	1. 00	
2.00 Inpatient days (including private roo	Inpatient days (including private room days, excluding swing-bed and newborn days) 28,299				2. 00	
3.00 Private room days (excluding swing-be	ed and observation bed day	ys). If you have only pr	ivate room days,	0	3. 00	

	Cost Center Description		
	NOT I NU DOUGLE AND AND AND AND AND AND AND AND AND AND	1. 00	
	PART I - ALL PROVIDER COMPONENTS		
1 00	INPATIENT DAYS	20, 200	1 00
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	28, 299	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	28, 299	2.00
3. 00	Private room days (excluding swing-bed and observation bed days). If you have only private room days,	0	3. 00
4. 00	do not complete this line.	24 225	4. 00
5. 00	Semi-private room days (excluding swing-bed and observation bed days) Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	24, 225 0	5. 00
5.00		۷	5.00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6. 00
6.00	reporting period (if calendar year, enter 0 on this line)	۷	6.00
7. 00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	0	7. 00
7.00	reporting period	۷	7.00
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	٥	0.00
9. 00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	9, 483	9. 00
7. 00	newborn days) (see instructions)	7, 403	7. 00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10. 00
	through December 31 of the cost reporting period (see instructions)	ĭ	
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11. 00
	December 31 of the cost reporting period (if calendar year, enter 0 on this line)	ĭ	
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12. 00
	through December 31 of the cost reporting period	-	
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13.00
	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15. 00
16.00	Nursery days (title V or XIX only)	0	16. 00
	SWING BED ADJUSTMENT		
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0.00	17. 00
	reporting period		
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0.00	18. 00
	reporting period		
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	0.00	19. 00
	reporting period		
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	0.00	20.00
	reporting period		
21.00	Total general inpatient routine service cost (see instructions)	47, 279, 824	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	0	22. 00
	5 x line 17)		
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	0	23. 00
	x line 18)		
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24.00
	7 x line 19)		
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25. 00
	x line 20)		
26. 00	Total swing-bed cost (see instructions)	0	
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	47, 279, 824	27. 00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28. 00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28. 00
	Private room charges (excluding swing-bed charges)	0	
30. 00	Semi-private room charges (excluding swing-bed charges)	0	
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)		32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33. 00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35. 00	Average per diem private room cost differential (line 34 x line 31)	0. 00	35. 00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	47, 279, 824	37. 00
	27 minus line 36)		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38. 00	Adjusted general inpatient routine service cost per diem (see instructions)	1, 670. 72	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line 38)	15, 843, 438	39. 00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40. 00
41. 00	Total Program general inpatient routine service cost (line 39 + line 40)	15, 843, 438	41.00

19.00	medical difface for swring-bed NF services applicable to services through becember 31 of the cost	0.00	19.00
	reporting period		
20. 00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	0.00	20.00
	reporting period		
21. 00	Total general inpatient routine service cost (see instructions)	47, 279, 824	
22. 00		0	22. 00
	5 x line 17)		
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	0	23. 00
	x line 18)		
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24.00
	7 x line 19)		
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25.00
	x line 20)		
26.00	Total swing-bed cost (see instructions)	0	26. 00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	47, 279, 824	27. 00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28. 00
29.00	Pri vate room charges (excluding swing-bed charges)	0	29. 00
30.00	Semi - pri vate room charges (excluding swing-bed charges)	ol	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33. 00
	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	
	Average per diem private room cost differential (line 34 x line 31)	0.00	
		0.00	36. 00
37. 00		47, 279, 824	37. 00
37.00	27 minus line 36)	47, 277, 024	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38. 00	Adjusted general inpatient routine service cost per diem (see instructions)	1, 670. 72	38. 00
	Program general inpatient routine service cost (line 9 x line 38)	15, 843, 438	
	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	
	Total Program general inpatient routine service cost (line 39 + line 40)	15, 843, 438	
11.00	Total Trogram general impatient routine service cost (The 67 Time 16)	10, 010, 100	11.00

		RANCISCAN HEALTH				eu of Form CMS-2	
COMPUI	ATION OF INPATIENT OPERATING COST		Provider CCN: 15	From	01/01/2022	Worksheet D-1	
				То	12/31/2022	Date/Time Pre 4/13/2023 4:1	
	Cost Center Description	Total	Title XVII Total Ave		Hospital Togram Days	PPS Program Cost	
	cost center bescription		npatient Days Diem	(col . 1 ÷	ogi alli bays	(col. 3 x col.	
		1.00	2.00	ol . 2) 3.00	4. 00	4) 5. 00	
42. 00	NURSERY (title V & XIX only)	0	0	0.00	0		42. 00
43. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	9, 111, 608	3, 531	2, 580. 46	903	2, 330, 155	43.00
44. 00	CORONARY CARE UNIT	0	0	0.00	0	2, 330, 133	1
45. 00 46. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT	0	o o	0. 00 0. 00	0	0	45. 00 46. 00
	OTHER SPECIAL CARE (SPECIFY)	O O	O,	0.00	U	U	47. 00
	Cost Center Description					1. 00	
48. 00	Program inpatient ancillary service cost (W	kst. D-3, col. 3,	line 200)			15, 553, 415	48. 00
48. 01 49. 00	Program inpatient cellular therapy acquisit Total Program inpatient costs (sum of lines				umn 1)	0 33, 727, 008	
49.00	PASS THROUGH COST ADJUSTMENTS	41 through 48.01)	(See This tructions	s)		33, 727, 008	49.00
50. 00	Pass through costs applicable to Program in	patient routine se	ervices (from Wks	t. D, sum of	Parts I and	2, 031, 586	50. 00
51. 00	<pre>III) Pass through costs applicable to Program in and IV)</pre>	patient ancillary	services (from W	kst. D, sum o	f Parts II	1, 529, 535	51.00
52. 00	Total Program excludable cost (sum of lines					3, 561, 121	52. 00
53. 00	Total Program inpatient operating cost excluded ical education costs (line 49 minus line		ated, non-physicia	an anesthetis	t, and	30, 165, 887	53. 00
54. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54. 00
55. 00	Target amount per discharge					0.00	55. 00
55. 01 55. 02	Permanent adjustment amount per discharge Adjustment amount per discharge (contractor	uso only)				l e	55. 01 55. 02
56. 00	Target amount (line 54 x sum of lines 55, 5					0.00	1
57. 00	Difference between adjusted inpatient opera	ting cost and targ	get amount (line 5	56 minus line	53)	0	
58. 00 59. 00	Bonus payment (see instructions) Trended costs (lesser of line 53 ÷ line 54,	or line 55 from 1	the cost renorting	n neriod endi	na 1996	0 00	58. 00 59. 00
	updated and compounded by the market basket)					
60. 00	Expected costs (lesser of line 53 ÷ line 54 market basket)	, or line 55 from	prior year cost i	report, updat	ed by the	0.00	60. 00
61. 00	Continuous improvement bonus payment (if li 55.01, or line 59, or line 60, enter the le 53) are less than expected costs (lines 54)	sser of 50% of the	e amount by which	operating co	sts (line	0	61.00
(2.00	enter zero. (see instructions)						42.00
62. 00 63. 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive pay PROGRAM INPATIENT ROUTINE SWING BED COST	ment (see instruct	tions)			•	62. 00 63. 00
64. 00		sts through Decemb	per 31 of the cost	reporting p	eriod (See	0	64. 00
65. 00	Medicare swing-bed SNF inpatient routine co instructions)(title XVIII only)	sts after December	31 of the cost i	reporting per	iod (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient rout CAH, see instructions	ine costs (line 64	1 plus line 65)(ti	tle XVIII on	ly); for	0	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routil (line 12 x line 19)	ne costs through [December 31 of the	e cost report	ing period	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routing (line 13 x line 20)	ne costs after Dec	cember 31 of the d	cost reportin	g period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER I					0	69. 00
70.00	Skilled nursing facility/other nursing faci	lity/ICF/IID routi	ne service cost	(line 37)			70.00
71. 00 72. 00	Adjusted general inpatient routine service Program routine service cost (line 9 x line	•	ne /U ÷ line 2)				71. 00 72. 00
73.00	Medically necessary private room cost appli	cable to Program (•	5)			73. 00
74. 00 75. 00	Total Program general inpatient routine ser Capital-related cost allocated to inpatient			neet B, Part	II, column		74. 00 75. 00
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ l	ine 2)					76. 00
77. 00	Program capital-related costs (line 9 x line	e 76)					77. 00
78. 00 79. 00	Inpatient routine service cost (line 74 min Aggregate charges to beneficiaries for exce		ovi der records)				78. 00 79. 00
80.00	Total Program routine service costs for com	parison to the cos	· · · · · · · · · · · · · · · · · · ·	ne 78 minus I	i ne 79)		80. 00
81. 00 82. 00	Inpatient routine service cost per diem lim Inpatient routine service cost limitation (81. 00 82. 00
83. 00	Reasonable inpatient routine service costs	(see instructions))				83. 00
84. 00 85. 00	Program inpatient ancillary services (see in Utilization review - physician compensation		s)				84. 00 85. 00
86. 00	Total Program inpatient operating costs (su						86.00
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PAST Total observation bed days (see instruction:					4, 074	87. 00
88. 00	Adjusted general inpatient routine cost per	•	ine 2)			1, 670. 72	ł
89. 00	Observation bed cost (line 87 x line 88) (s	ee instructions)				6, 806, 513	89. 00

Health Financial Systems FR	ANCISCAN HEALTH	H MICHIGAN CITY	,	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Period: From 01/01/2022	Worksheet D-1	
				To 12/31/2022	Date/Time Prep 4/13/2023 4:18	
		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	5, 344, 747	47, 279, 824	0. 11304	5 6, 806, 513	769, 442	90.00
91.00 Nursing Program cost	0	47, 279, 824	0.00000	0 6, 806, 513	0	91.00
92.00 Allied health cost	0	47, 279, 824	0. 00000	0 6, 806, 513	0	92.00
93.00 All other Medical Education	0	47, 279, 824	0. 00000	6, 806, 513	0	93. 00

Health Financial Systems	FRANCISCAN HEALTH MICHIGAN CITY	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0015	Peri od: From 01/01/2022	Worksheet D-1
	Component CCN: 15-S015		
	Title XVIII	Subprovi der -	PPS

Description 1.000 Description 1.000			II the Aviii	I PF	FF3	
PART - ALL PROVIDER COMPONENTS		Cost Center Description				
INPATIENT DAYS		DART I - ALL PROVINER COMPONENTS			1. 00	
Inpatient days (including private room days, excluding saing-bed and newborn days) 1 you have only private room days. 2,701 2,00 3,00 2,00 2,00 2,00 3,00 2,00 2,00 3,00 2,00 3,00 2,00 3,00 2,00 3,00 2,00 3,00 2,00 3,00 3,00 2,00 3,0						
2.70 2.70 2.70 3.00					•	
do not complete this line. 4.00 Selephivate room days (excluding swing-bed and observation bed days) 5.00 Ioral swing-bed SW type inpatient days. (Including private room days) after December 31 of the cost cost reporting period (if callendar year, enter 0 on this line) 7.00 Total swing-bed W type inpatient days (including private room days) after December 31 of the cost reporting period (if callendar year, enter 0 on this line) 7.00 Total swing-bed W type inpatient days (including private room days) after December 31 of the cost reporting period (if callendar year, enter 0 on this line) 7.00 Total swing-bed W type inpatient days (including private room days) after December 31 of the cost reporting period of reporting period (if callendar year, enter 0 on this line) 7.00 Total swing-bed SW type inpatient days (including private room days) after December 31 of the cost reporting period (if callendar year, enter 0 on this line) 7.00 Swing-bed SW type inpatient days applicable to the Program (excluding swing-bed and newbork days) (see instructions) 8.00 Total inpatient days applicable to title XVIII only (including private room days) the object of the cost reporting period (see instruction to this line) 8.00 Swing-bed SW type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if callendar year, enter 0 on this line) 8.00 Swing-bed M type inpatient days applicable to title XVIII only (including private room days) 8.00 Swing-bed M type inpatient days applicable to title XVIII only (including private room days) 8.00 Swing-bed M type inpatient days applicable to services applicable to service with such as a swing-bed days of the cost reporting period (if callendar year, enter 0 on this line) 9.00 Swing-bed M type inpatient days applicable to services through December 31 of the cost reporting period (if callendar year, enter 0 on this line) 9.01 Swing-bed W type inpatient days applicable to services applicable to service safter December 31 of the c						
5.00 Total swing-bed SF type inpatient days (netuding private room days) after December 31 of the cost reporting period (reporting period (reporting period) (reporti	3.00		(S). IT you have only pri	vate room days,	U	3.00
reporting period (if callendar year, enter 0 on this line) 7.00	4.00		ed days)		2, 701	4. 00
1 Total swing-bed SNF type inpatient days (including private room days) after becember 31 of the cost reporting period (if calendar year, enter 0 on this line) 7.00	5.00		om days) through December	31 of the cost	0	5. 00
reporting period (if calendar year, enter 0 on this line) 7.00 Total swing-bed MF type inpatient days (including private room days) through December 31 of the cost 8.00 Total swing-bed MF type inpatient days (including private room days) after December 31 of the cost 9.00 Total swing-bed MF type inpatient days (including private room days) after December 31 of the cost 10.00 Swing-bed SWF type inpatient days applicable to the Program (excluding swing-bed and newborn days) (see instructions) 10.00 Swing-bed SWF type inpatient days applicable to trile XVIII only (including private room days) after 10.00 Swing-bed SWF type inpatient days applicable to trile XVIII only (including private room days) 11.00 Swing-bed SWF type inpatient days applicable to trile XVIII only (including private room days) 11.00 Swing-bed WF type inpatient days applicable to trile XVIII only (including private room days) 12.00 Swing-bed WF type inpatient days applicable to triles V or XIX only (including private room days) 13.00 Swing-bed WF type inpatient days applicable to the Program (excluding swing-bed days) 14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 15.00 Total nursery days (title V or XIX and y) 16.00 Nursery days (title V or XIX and y) 17.00 Medicare rate for swing-bed SWF services applicable to services through December 31 of the cost 18.00 Medicare rate for swing-bed SWF services applicable to services after December 31 of the cost 18.00 Medicare rate for swing-bed SWF services applicable to services after December 31 of the cost 18.00 Medicare rate for swing-bed SWF services applicable to services after December 31 of the cost 18.00 Swing-bed cost applicable to SWF type services through December 31 of the cost reporting period (line 6 x x line 13) 18.00 Medical rate for swing-bed SWF services after December 31 of the cost reporting period (line 6 x x line 13) 18.00 Swing-bed cost applicable to SWF type services through December 31 of the cost reporting period (line 6 x x line	6 00		om days) after December 3	11 of the cost	0	6.00
reporting period No Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 10. ON Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions) 10. ON Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 11. ON Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) 12. ON Swing-bed SNF type inpatient days applicable to titles Vor XIX only (including private room days) after December 31 of the cost reporting period (including private room days) 13. ON Swing-bed SNF type inpatient days applicable to titles Vor XIX only (including private room days) 14. ON Swing-bed SNF type inpatient days applicable to titles Vor XIX only (including private room days) 15. ON Total nursery days (title Vor XIX only) 16. ON Indicar nursery days (title Vor XIX only) 17. ON December 31 of the cost reporting period (if calendar year, enter 0 on this time) 18. ON Medically necessary private room days applicable to the Program (excluding swing-bed days) 18. ON Medical rursery days (title Vor XIX only) 18. ON Medical rursery days (title Vor XIX only) 18. ON Medical rursery days (with Vor XIX only) 18. ON Medical rare for for swing-bed SNF services applicable to services through December 31 of the cost reporting period (including private room days applicable to SNF type services after December 31 of the cost reporting period (line 8 x I including x I including x I including x I including x I including x I including x I including x I including x I including x I including x I including x I including x I including x I including x I including x I inclu	0.00		om days) arter becember a	or the cost	O	0.00
Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if Calendary seep. netre 0 on this line) 10.00 Swing-bed SNF type inpatient days applicable to the Program (excluding swing-bed and newborn days) (see instructions) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after some days applicable to title XVIII only (including private room days) after some days applicable to title XVIII only (including private room days) after some days) after some days applicable to title XVIII only (including private room days) after some days) after some days applicable to title XVIII only (including private room days) after some days) after some days applicable to title XVIII only (including private room days) after some days) after some days applicable to title XVIII only (including private room days) after some days) after seember 31 of the cost reporting period some days applicable to title XVIII only (including private room days) after seember 31 of the cost reporting period seember 31 of the cost reporting days applicable to the Program (excluding swing-bed days) site seems after see	7. 00		n days) through December	31 of the cost	0	7. 00
reporting period (if calendar year, enter 0 on this line) 0.0 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions) 10.0 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after through becember 31 of the cost reporting period (see instructions) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only on this line) 12.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after on the only of through becember 31 of the cost reporting period (see instructions) 13.00 Swing-bed NF type inpatient days applicable to title XVII only (including private room days) after 50 single becember 31 of the cost reporting period (including private room days) after 50 single becember 31 of the cost reporting period (including private room days) after 50 single becember 31 of the cost reporting period (including private room days) after 50 single bed 50 single bed 50 single 50 sing	8 00		n days) after December 31	of the cost	0	8 00
newborn days) (see Instructions) 0 10.00 00 10.00 00 10.00 00	0.00		days) arter becember 31	or the cost	O	0.00
10.00 Swing-bed SMF type Inpatient days applicable to title XVIII only (Including private room days) 10.00	9.00		the Program (excluding	swing-bed and	364	9. 00
through December 31 of the cost reporting period (see instructions) 1.00 Swing-bed SNF type inpatient days applicable to title XVII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 14.00 Medical Iv necessary private room days applicable to titles V or XIX only (including private room days) 15.00 Total nursery days (title V or XIX only) 16.00 No Mursery days (title V or XIX only) 17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (including swing-bed days) 18.00 Nedicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (including private room days applicable to services after December 31 of the cost reporting period (including swing-bed SNF services applicable to services after December 31 of the cost (including swing-bed SNF services applicable to services after December 31 of the cost (including swing-bed SNF services applicable to services after December 31 of the cost (including swing-bed SNF services applicable to services after December 31 of the cost (including swing-bed SNF services applicable to services after December 31 of the cost (including swing-bed SNF services applicable to services after December 31 of the cost (including swing-bed SNF services applicable to services after December 31 of the cost (including swing-bed SNF services applicable to services after December 31 of the cost (including swing-bed SNF services applicable to services after December 31 of the cost reporting period (including swing-bed synchronic synchronic synchronic synchronic synchronic synchronic synchronic synchronic synchronic synchronic synchronic synchronic synchronic synchronic synchronic synchronic synchronic sync	10 00		alv (i neludi na privato re	nom daye)	0	10 00
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14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 0 14.00 0 15.00	13.00	Swing-bed NF type inpatient days applicable to titles V or XIX			0	13. 00
15.00	14 00	1 31 1	· · · · · · · · · · · · · · · · · · ·	,	0	14 00
16.00 Nursery days (title V or XIX only) 0 16.00			dii (excluding swing-bed o	iays)	-	
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		,	•			
	41. 00	Total Program general inpatient routine service cost (line 39	+ line 40)		833, 298	41. 00

	Financial Systems FR ATION OF INPATIENT OPERATING COST		Component	CCN: 15-0015 CCN: 15-S015 e XVIII	Peri od: From 01/01/2022 To 12/31/2022 Subprovi der - IPF		pared:
	Cost Center Description	Total Inpatient Cost		col . 2)	÷	Program Cost (col. 3 x col. 4) 5.00	
42. 00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4. 00 00 0		42. 00
	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	l ol		0 0.	00 0	0	43. 00
	CORONARY CARE UNIT	0		0. 0.			
	BURN INTENSIVE CARE UNIT	O		0.			
	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)	0	•	0.	00 0	0	46. 00 47. 00
17.00	Cost Center Description						17.00
48. 00	Program inpatient ancillary service cost (Wk	st D-3 col 3	line 200)			1. 00 41, 911	48. 00
	Program inpatient cellular therapy acquisition			III, line 10	, column 1)	41, 911	1
49. 00	Total Program inpatient costs (sum of lines	41 through 48.0°)(see instru	ctions)	, , , , , , , , , , , , , , , , , , ,	875, 209	49. 00
50. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp.	atient routine s	ervices (fro	m Wket D su	m of Parts I and	137, 228	50.00
30. 00	III)	atrent routine .	services (110	iii wkst. <i>D</i> , sui	ii or rarts r and	137, 220	30.00
51. 00	Pass through costs applicable to Program inpand IV)	atient ancillary	services (f	rom Wkst. D,	sum of Parts II	2, 350	51.00
52. 00	Total Program excludable cost (sum of lines	50 and 51)				139, 578	52. 00
53. 00	Total Program inpatient operating cost exclu		ated, non-ph	ysician anestl	hetist, and	735, 631	53. 00
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					
	Program di scharges					0	
	Target amount per discharge Permanent adjustment amount per discharge					0.00	
	Adjustment amount per discharge (contractor	use only)				0.00	
	Target amount (line 54 x sum of lines 55, 55				50)	0	
57. 00 58. 00					0 0		
59. 00	.00 Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996,				0.00	59. 00	
60. 00						0.00	60.00
61. 00	55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise				0	61. 00	
62. 00	enter zero. (see instructions) 2.00 Relief payment (see instructions)				0	62. 00	
	Allowable Inpatient cost plus incentive paym	ent (see instru	ctions)			0	
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Decer	nber 31 of th	e cost report	ing period (See	0	64. 00
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos</pre>					0	65. 00
03.00	instructions)(title XVIII only)						05.00
66. 00	Total Medicare swing-bed SNF inpatient routi CAH, see instructions	ne costs (line d	64 plus line	65)(title XVI	II only); for	0	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routing (line 12×1 line 19)	e costs through	December 31	of the cost r	eporting period	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	e costs after De	ecember 31 of	the cost rep	orting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N					0	69. 00
	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service c	,)		70.00
72. 00	Program routine service cost (line 9 x line	71)		ŕ			72. 00
	Medically necessary private room cost applic	•	•				73. 00 74. 00
74. 00 75. 00							75.00
7 / 00	26, line 45)		•				7, 00
	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line						76. 00 77. 00
	Inpatient routine service cost (line 74 minu						78. 00
						79. 00 80. 00	
	Inpatient routine service costs for comp.		iriii tati U	(1116 70 1111	11110 17)		81. 00
	Inpatient routine service cost limitation (I						82. 00
	Reasonable inpatient routine service costs (Program inpatient ancillary services (see in		5)				83.00
85. 00	Utilization review - physician compensation	(see instruction					85. 00
86. 00	Total Program inpatient operating costs (sum		ough 85)				86. 00
	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions					0	87. 00
87. 00	Total observation bed days (see Instructions						

Health Financial Systems FR	ANCISCAN HEALTH	H MICHIGAN CITY	•	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0015 Period:			Worksheet D-1	
		Component (CCN: 15-S015	From 01/01/2022 To 12/31/2022		
		Title	XVIII	Subprovi der -	PPS	
				I PF		
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	1, 018, 274	6, 183, 353	0. 16468	0 0	0	90.00
91.00 Nursing Program cost	0	6, 183, 353	0.00000	0 0	0	91.00
92.00 Allied health cost	0	6, 183, 353	0.00000	0 0	0	92.00
93.00 All other Medical Education	0	6, 183, 353	0.00000	0 0	0	93. 00

Health Financial Systems	FRANCISCAN HEALTH MICHIGAN CITY		l n	Lieu of Form CMS-2552-10
INDATIENT ANGLILADY SERVICE COST ADDODTIONMENT	Dravi dan CCN.	1E 001E	Doni od.	Waskahaat D 2

Health Financial Systems FRANCISCAN HEALTH N	MICHIGAN CITY		In Lie	u of Form CMS-2	2552-10
I NPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 1		Period: From 01/01/2022 To 12/31/2022	Worksheet D-3 Date/Time Pre 4/13/2023 4:1	pared:
	Title XVI	11	Hospi tal	PPS	Орш
Cost Center Description		io of Cost	<u> </u>	Inpati ent	
p		Charges	Program	Program Costs	
		g	Charges	(col. 1 x col.	
			onal goo	2)	
		1. 00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS				2.22	
30. 00 03000 ADULTS & PEDIATRICS			24, 796, 968		30.00
31. 00 03100 NTENSI VE CARE UNI T			3, 770, 241		31. 00
32. 00 03200 CORONARY CARE UNIT			3, 770, 241		32.00
33. 00 03200 BURN INTENSIVE CARE UNIT			0		33.00
			0		
34. 00 03400 SURGI CAL INTENSI VE CARE UNI T 40. 00 04000 SUBPROVI DER - IPF			0		34.00
			0		40.00
41. 00 04100 SUBPROVI DER - I RF			0		41.00
43. 00 04300 NURSERY					43. 00
ANCI LLARY SERVI CE COST CENTERS					
50. 00 05000 OPERATI NG ROOM		0. 16665		1, 923, 488	
51. 00 05100 RECOVERY ROOM		0. 000000		0	51. 00
52.00 O5200 DELIVERY ROOM & LABOR ROOM		0.86860	1 11, 638	10, 109	
53. 00 05300 ANESTHESI OLOGY		0. 05190	1, 176, 511	61, 064	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0.084460	14, 013, 859	1, 183, 611	54.00
54. 01 05401 FSED RADI OLOGY - DI AGNOSTI C		0. 08635	4 0	0	54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C		0. 15015	4 1, 215, 904	182, 573	55. 00
55. 01 05501 WOODLAND CANCER CARE CTR		0. 165830		0	55. 01
56. 00 05600 RADI 0I SOTOPE		0.00000		0	56. 00
57. 00 05700 CT SCAN		0. 000000		Ö	57. 00
58. 00 05800 MRI		0. 000000		Ö	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 11380			
		0. 139960			1
60. 01 06001 FS ED LAB		0. 00168		0	60. 01
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0.00000		0	61.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0. 000000		0	62. 00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 02898		0	63. 00
63. 01 06301 FS ED BLOOD BANK		0. 00168		0	63. 01
64. 00 06400 I NTRAVENOUS THERAPY		0. 000000	0	0	64. 00
65. 00 06500 RESPI RATORY THERAPY		0. 17257	6 4, 345, 023	749, 847	65. 00
66. 00 06600 PHYSI CAL THERAPY		0. 21620	7 2, 658, 604	574, 809	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY		0.00000	0 0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY		0.00000	0 0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY		0. 10132	10, 006, 096	1, 013, 848	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY		0.00000	0	0	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 29267	5 4, 524, 795	1, 324, 294	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 43292		1, 774, 996	
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 23921		2, 507, 447	73. 00
74. 00 07400 RENAL DI ALYSI S		0. 000000		0	74. 00
75. 00 07500 ASC (NON-DISTINCT PART)		0. 000000		Ö	75. 00
76. 00 03020 CLI NI C		0. 000000		Ö	76.00
77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION		0. 000000			
OUTPATIENT SERVICE COST CENTERS		0.00000	J ₁ U	<u> </u>	, ,
88. 00 08800 RURAL HEALTH CLINIC		0. 00000		0	88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0. 000000		0	
90. 00 09000 CLI NI C		0.00000		0	1
90. 03 09003 NFUSION OP SERVICES		0. 11276		0	90. 03
91. 00 09100 EMERGENCY		0. 12000		1, 366, 624	
91.01 09101 FREE STANDING EMERGENCY DEPT		0. 31393		0	91. 01
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 63623	7 0	0	92.00
OTHER REIMBURSABLE COST CENTERS			_		1
94. 00 09400 HOME PROGRAM DIALYSIS		0.00000	0	0	94. 00
95. 00 09500 AMBULANCE SERVICES					95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED		0.00000	0	0	96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD		0.00000		0	
98. 00 09850 OTHER REIMBURSABLE COST CENTERS		0.00000		0	98. 00
200.00 Total (sum of lines 50 through 94 and 96 through 98)			96, 833, 579		
201. 00 Less PBP Clinic Laboratory Services-Program only charges	s (line 61)		0	12,000,110	201. 00
202.00 Net charges (line 200 minus line 201)	((((((((((((((((((((96, 833, 579		202. 00
	ı			ı	, 00

NPATIENT ANCILLARY SERVICE COST APPORTIONMENT		CCN: 15-0015 CCN: 15-S015	Peri od: From 01/01/2022 To 12/31/2022		epare
	Ti tl d	e XVIII	Subprovider -	4/13/2023 4: 1 PPS	<u>8 pr</u>
Cost Center Description		Ratio of Cos To Charges		Inpatient Program Costs (col. 1 x col.	
		1.00	2. 00	2) 3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					Γ.
0. 00 03000 ADULTS & PEDIATRICS 1. 00 03100 INTENSIVE CARE UNIT 2. 00 03200 CORONARY CARE UNIT 3. 00 03300 BURN INTENSIVE CARE UNIT 4. 00 03400 SURGICAL INTENSIVE CARE UNIT 5. 00 04000 SUBPROVIDER - IPF 6. 00 04100 SUBPROVIDER - IRF 6. 00 04300 NURSERY			694, 320		30 31 32 33 34 40 41 43
ANCILLARY SERVICE COST CENTERS					
0.00		0. 16665 0. 00000 0. 86860 0. 05190 0. 08444 0. 08635 0. 15015 0. 16583 0. 00000 0. 00000 0. 11380 0. 13996 0. 00166 0. 00000 0. 02898 0. 00166 0. 00000 0. 17257 0. 21620 0. 00000 0. 00000 0. 00000 0. 10132 0. 00000 0. 29266	00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 928 0 1,066 0 0 17,460 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	510 510 510 510 510 510 510 510 510 510
07100 MEDICAL SUFFETES CHARGED TO PATIENTS		0. 43292 0. 23921 0. 00000 0. 00000 0. 00000	0.1 0 0.7 41,081 0.0 0 0.0 0 0.0 0	0 9, 827 0 0 0	72 73 74 75 76
3. 00 08800 RURAL HEALTH CLINIC 9. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 9. 00 09000 CLINIC 9. 03 09003 INFUSION OP SERVICES 1. 00 09100 EMERGENCY 1. 01 09101 FREE STANDING EMERGENCY DEPT 9. 00 09200 08SERVATION BEDS (NON-DISTINCT PART		0. 00000 0. 00000 0. 00000 0. 11276 0. 12000 0. 31393 0. 63623	00 00 04 07 73, 222 32	0 0 0 0 8, 787 0 0	90 90 91 91 91
OTHER REIMBURSABLE COST CENTERS OO O9400 HOME PROGRAM DIALYSIS		0.00000	00 0	0	9.
5. 00 09500 AMBULANCE SERVI CES 5. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 7. 00 09700 DURABLE MEDI CAL EQUI P-SOLD		0. 00000	00 0	0	95

0 98.00 41, 911 200.00 201.00 202.00

200. 00 201. 00

202.00

98. 00 09850 OTHER REIMBURSABLE COST CENTERS

Net charges (line 200 minus line 201)

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

Health Financial Systems FRANCISCAN HEALTH N	MICHIGAN CITY	<u> </u>	In Lie	eu of Form CMS-2	<u> 2552-10</u>
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der Co		Period: From 01/01/2022 To 12/31/2022	Worksheet D-3 Date/Time Pre 4/13/2023 4:1	pared:
	Ti tl	e XIX	Hospi tal	Cost	Орш
Cost Center Description		Ratio of Cost		Inpatient	
p		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS			16, 556, 661		30.00
31.00 03100 INTENSIVE CARE UNIT			3, 438, 765		31. 00
32. 00 03200 CORONARY CARE UNIT			0		32. 00
33.00 03300 BURN INTENSIVE CARE UNIT			0		33. 00
34.00 03400 SURGICAL INTENSIVE CARE UNIT			0		34. 00
40. 00 04000 SUBPROVI DER - 1 PF			0		40. 00
41. 00 04100 SUBPROVI DER - RF			0		41. 00
43. 00 04300 NURSERY			0		43. 00
ANCILLARY SERVICE COST CENTERS		•			1
50. 00 05000 OPERATING ROOM		0.00000	9, 355, 439	0	50.00
51.00 05100 RECOVERY ROOM		0. 000000	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 000000	0	0	52. 00
53. 00 05300 ANESTHESI OLOGY		0.00000	612, 626	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0.00000	7, 556, 885	0	54. 00
54. 01 05401 FSED RADI OLOGY - DI AGNOSTI C		0.00000	250, 884	0	54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C		0.00000		0	55. 00
55. 01 05501 WOODLAND CANCER CARE CTR		0.00000		0	55. 01
56. 00 05600 RADI OI SOTOPE		0. 00000		0	56.00
57. 00 05700 CT SCAN		0.00000		0	57. 00
58. 00 05800 MRI		0.00000		0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 00000		0	59. 00
60. 00 06000 LABORATORY		0. 00000		Ō	60.00
60. 01 06001 FS ED LAB		0. 00000		o o	60. 01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0. 00000		Ō	61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0.00000		0	62. 00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.		0.00000		0	63.00
63. 01 06301 FS ED BLOOD BANK		0.00000		l	63. 01
64.00 06400 INTRAVENOUS THERAPY		0.00000		0	64.00
65. 00 06500 RESPIRATORY THERAPY		0.00000		0	65.00
66. 00 06600 PHYSI CAL THERAPY		0.00000		0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY		0.00000		0	67.00
68. 00 06800 SPEECH PATHOLOGY		0.00000		0	68. 00
69. 00 06900 ELECTROCARDI OLOGY		0.00000	1, 985, 250	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 000000	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 000000	13, 394	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 000000	0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS		0.00000	5, 913, 813	0	73. 00
74.00 07400 RENAL DI ALYSI S		0.00000	0	0	74.00
75. 00 07500 ASC (NON-DISTINCT PART)		0.00000	0	0	75. 00
76. 00 03020 CLI NI C		0.00000	0	0	76. 00
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION		0.00000	0	0	77. 00
OUTPATIENT SERVICE COST CENTERS					
88. 00 08800 RURAL HEALTH CLINIC		0. 000000	0	0	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0.00000	0	0	89. 00
90. 00 09000 CLI NI C		0.00000	0	0	90. 00
90. 03 09003 I NFUSI ON OP SERVI CES		0.00000	0	0	90. 03
91. 00 09100 EMERGENCY		0.00000	5, 731, 322	0	91. 00
91.01 09101 FREE STANDING EMERGENCY DEPT		0. 000000	330, 190	0	91. 01
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 00000	0	0	92. 00
OTHER REIMBURSABLE COST CENTERS					
94.00 09400 HOME PROGRAM DIALYSIS		0. 000000	0	0	
95. 00 09500 AMBULANCE SERVICES					95. 00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED		0. 000000		0	
97.00 09700 DURABLE MEDICAL EQUIP-SOLD		0. 000000		0	
98. 00 09850 OTHER REIMBURSABLE COST CENTERS		0. 000000		0	
200.00 Total (sum of lines 50 through 94 and 96 through 98)			49, 881, 506	0	200. 00
201.00 Less PBP Clinic Laboratory Services-Program only charges	s (line 61)		0		201. 00
202.00 Net charges (line 200 minus line 201)			49, 881, 506		202. 00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der CCN: 15-0015	Peri od: From 01/01/2022		
	Component CCN: 15-S015	To 12/31/2022	4/13/2023 4:1	pared: 8 pm
	Title XIX	Subprovi der - I PF	Cost	
Cost Center Description	Ratio of Co To Charges		Inpatient Program Costs (col. 1 x col.	
	1.00	2. 00	2) 3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS			T	
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT				30.0
32. 00 03200 CORONARY CARE UNIT				32. 0
33.00 03300 BURN INTENSIVE CARE UNIT				33. 0
34.00 03400 SURGICAL INTENSIVE CARE UNIT				34.0
40. 00 04000 SUBPROVI DER - I PF		2, 847, 827		40.0
41. 00 04100 SUBPROVI DER - RF				41.0
43. 00 04300 NURSERY				43. 0
ANCILLARY SERVICE COST CENTERS 50. 00 05000 OPERATING ROOM	0.0000	9, 274	0	50.0
51. 00 05100 RECOVERY ROOM	0.0000			51.0
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.0000		0	1
53. 00 05300 ANESTHESI OLOGY	0.0000	000	0	53.0
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0.0000		l .	
54. 01 05401 FSED RADI OLOGY - DI AGNOSTI C	0.0000		l .	
55. 00 05500 RADI OLOGY-THERAPEUTI C 55. 01 05501 WOODLAND CANCER CARE CTR	0. 0000 0. 0000		0	
56. 00 05600 RADI 0I SOTOPE	0.0000		0	56.0
57. 00 05700 CT SCAN	0.0000		Ö	
58. 00 05800 MRI	0.0000			58. 0
59. 00 05900 CARDI AC CATHETERI ZATI ON	0.0000	000	0	59.0
50. 00 06000 LABORATORY	0.0000		l .	60.0
60. 01 06001 FS ED LAB	0.0000		l	
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 0000 0. 0000		0	61. C
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0.0000		0	63.0
53. 01 06301 FS ED BLOOD BANK	0.0000		Ö	63.0
64. 00 06400 I NTRAVENOUS THERAPY	0.0000		0	64.0
65. 00 06500 RESPIRATORY THERAPY	0.0000		0	65. 0
66. 00 06600 PHYSI CAL THERAPY	0.0000	· ·		
57. 00 06700 OCCUPATI ONAL THERAPY	0.0000		_	
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	0. 0000 0. 0000		0	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0.0000		0	1
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.0000		Ō	71. C
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.0000	000	0	72.0
73.00 07300 DRUGS CHARGED TO PATIENTS	0.0000			
74. 00 07400 RENAL DIALYSIS	0.0000		-	
75. 00 07500 ASC (NON-DISTINCT PART)	0.0000		0	
76.00 03020 CLINIC 77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0. 0000 0. 0000		0	
OUTPATIENT SERVICE COST CENTERS	1 0.0000	,00 ₁ C	0	1 , , , ,
38. 00 08800 RURAL HEALTH CLINIC	0.0000	000 0	0	88. 0
9.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0.0000		0	
0. 00 09000 CLI NI C	0.0000		0	
0. 03 09003 NFUSI ON OP SERVI CES	0.0000		0	
P1.00 09100 EMERGENCY P1.01 09101 FREE STANDING EMERGENCY DEPT	0.0000		0	
21. 01 09101 FREE STANDING EMERGENCY DEPT 22. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 0000 0. 0000		l	
OTHER REIMBURSABLE COST CENTERS		,00 ₁ C	0	72.0
94. 00 09400 HOME PROGRAM DI ALYSI S	0.0000	000	0	94.0
95. 00 09500 AMBULANCE SERVICES				95. C
P6. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0.0000			
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0.0000	0001 0	0	97.0

0. 000000 0. 000000

0.000000

1, 540, 902

97.00

98.00

0 200. 00 201. 00

202. 00

200. 00 201. 00

202.00

97. 00 09700 DURABLE MEDICAL EQUIP-SOLD

98. 00 09850 OTHER REIMBURSABLE COST CENTERS

Net charges (line 200 minus line 201)

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

Health Financial Systems	FRANCISCAN HEALTH MICHIGAN CITY	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0015	Peri od: From 01/01/2022 To 12/31/2022	Worksheet E Part A Date/Time Prepared: 4/13/2023 4:18 pm

PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS 1.00 PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS 1.00 DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions) 1.02 DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions) 1.03 DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions) 1.04 DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions) 2.00 Outlier payments for discharges. (see instructions) 2.01 Outlier payments for discharges occurring prior to October 1 (see instructions) 2.02 Outlier payment for discharges occurring prior to October 1 (see instructions) 2.03 Outlier payments for discharges occurring on or after October 1 (see instructions) 2.04 Outlier payments for discharges occurring on or after October 1 (see instructions) 3.00 Managed Care Simulated Payments 4.00 Bed days available divided by number of days in the cost reporting period (see instructions) 5.00 FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions) 5.01 FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e) 6.26 Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS 1.00 DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions) 1.02 DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions) 1.03 DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions) 1.04 DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions) 2.00 Outlier payments for discharges. (see instructions) 2.01 Outlier payments for discharges for Model 4 BPCI (see instructions) 2.02 Outlier payment for discharges occurring prior to October 1 (see instructions) 2.03 Outlier payments for discharges occurring prior to October 1 (see instructions) 2.04 Outlier payments for discharges occurring on or after October 1 (see instructions) 3.00 Managed Care Simulated Payments 4.00 Bed days available divided by number of days in the cost reporting period (see instructions) 5.00 FTE count for all opathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions) 5.01 FTE cap adjustment for qualifing hospitals under §131 of the CAA 2021 (see instructions) 6.00 FTE count for all opathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)
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DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after 0 October 1 (see instructions) 2.00 Outlier payments for discharges. (see instructions) 2.01 Outlier payment for discharges for Model 4 BPCI (see instructions) 2.02 Outlier payment for discharges occurring prior to October 1 (see instructions) 2.03 Outlier payments for discharges occurring prior to October 1 (see instructions) 2.04 Outlier payments for discharges occurring on or after October 1 (see instructions) 3.00 Managed Care Simulated Payments 4.00 Bed days available divided by number of days in the cost reporting period (see instructions) 5.00 If E count for all opathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions) 5.01 FTE count for all opathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)
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2.02 Outlier payment for discharges for Model 4 BPCI (see instructions) 2.03 Outlier payments for discharges occurring prior to October 1 (see instructions) 3.04 Outlier payments for discharges occurring on or after October 1 (see instructions) 4.05 Managed Care Simulated Payments 4.06 Bed days available divided by number of days in the cost reporting period (see instructions) 5.00 FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions) 5.01 FTE cap adjustment for qualifing hospitals under §131 of the CAA 2021 (see instructions) 6.00 FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)
2.03 Outlier payments for discharges occurring prior to October 1 (see instructions) 1,887,748 2.04 Outlier payments for discharges occurring on or after October 1 (see instructions) 4.00 Managed Care Simulated Payments Bed days available divided by number of days in the cost reporting period (see instructions) 5.00 FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions) 5.01 FTE cap adjustment for qualifing hospitals under §131 of the CAA 2021 (see instructions) 6.00 FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)
3.00 Managed Care Simulated Payments 4.00 Bed days available divided by number of days in the cost reporting period (see instructions) 5.00 Indirect Medical Education Adjustment 5.00 FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions) 5.01 FTE cap adjustment for qualifing hospitals under §131 of the CAA 2021 (see instructions) 6.00 FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)
4.00 Bed days available divided by number of days in the cost reporting period (see instructions) 107.84 Indirect Medical Education Adjustment 5.00 FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions) 5.01 FTE cap adjustment for qualifing hospitals under §131 of the CAA 2021 (see instructions) 6.00 FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)
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new programs in accordance with 42 CFR 413.79(e)
the CAA 2021 (see instructions)
7.00 MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)
7.01 ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the 0.00 cost report straddles July 1, 2011 then see instructions.
7.02 Adjustment (increase or decrease) to the hospital's rural track program FTE limitation(s) for rural track programs with a rural track for Medicare GME affiliated programs in accordance with 413.75(b)
and 87 FR 49075 (August 10, 2022) (see instructions) 8.00 Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for 0.00
affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12,
1998), and 67 FR 50069 (August 1, 2002). 8.01 The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost 0.00 8
report straddles July 1, 2011, see instructions. 8.02 The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital 0.00 8
under § 5506 of ACA. (see instructions) 8.21 The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see 0.00 8
instructions) 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 0.00
minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions) 10.00 FTE count for allopathic and osteopathic programs in the current year from your records 0.00 10
11.00 FTE count for residents in dental and podiatric programs. 0.00 1
12.00 Current year allowable FTE (see instructions) 0.00 13.00 Total allowable FTE count for the prior year. 0.00 13.0
14.00 Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, 0.00 14
otherwise enter zero.
15. 00 Sum of lines 12 through 14 divided by 3.
16.00 Adjustment for residents in initial years of the program (see instructions) 17.00 Adjustment for residents displaced by program or hospital closure 0.00 10
18.00 Adjusted rolling average FTE count 0.00 11
19.00 Current year resident to bed ratio (line 18 divided by line 4).
20.00 Prior year resident to bed ratio (see instructions) 0.000000 20
21.00 Enter the lesser of lines 19 or 20 (see instructions) 0.000000 2
22.00 IME payment adjustment (see instructions) 0 22.01 IME payment adjustment - Managed Care (see instructions) 0 22.01 IME payment adjustment - Managed Care (see instructions) 0 23.01 IME payment adjustment - Managed Care (see instructions) 0 23.01 IME payment adjustment - Managed Care (see instructions) 0 23.01 IME payment adjustment - Managed Care (see instructions) 0 23.01 IME payment adjustment - Managed Care (see instructions) 0 24.01 IME payment adjustment - Managed Care (see instructions) 0 25.01 IME payment adjustment - Managed Care (see instructions) 0 25.01 IME payment adjustment - Managed Care (see instructions) 0 25.01 IME payment adjustment - Managed Care (see instructions) 0 25.01 IME payment adjustment - Managed Care (see instructions) 0 25.01 IME payment adjustment - Managed Care (see instructions) 0 25.01 IME payment adjustment - Managed Care (see instructions) 0 25.01 IME payment adjustment - Managed Care (see instructions) 25.01 IME payment adjustment - Managed Care (see instructions) 25.01 IME payment adjustment - Managed Care (see instructions) 25.01 IME payment adjustment - Managed Care (see instructions) 25.01 IME payment adjustment - Managed Care (see instructions) 25.01 IME payment - Managed Ca
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA
23.00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 0.00 2: (f)(1)(iv)(C).
24.00 IME FTE Resident Count Over Cap (see instructions) 0.00 24
instructions)
26.00 Resident to bed ratio (divide line 25 by line 4) 27.00 IME payments adjustment factor. (see instructions) 0.000000 26
27.00 IME payments adjustment factor. (see instructions) 0.000000 2.000
28.01 IME add-on adjustment amount - Managed Care (see instructions) 0 2
29.00 Total IME payment (sum of lines 22 and 28) 0 2
29. 01 Total IME payment - Managed Care (sum of lines 22. 01 and 28. 01) 0
Disproportionate Share Adjustment 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 3.50 30
31.00 Percentage of Medicaid patient days (see instructions) 3.50 31.00 Percentage of Medicaid patient days (see instructions)
32.00 Sum of Lines 30 and 31 26.38 33
33.00 Allowable disproportionate share percentage (see instructions) 10.98 3
34.00 Disproportionate share adjustment (see instructions) 609, 471 34

CLII		MI CHI GAN CI TY		u of Form CMS-2	2552
CUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0015	Peri od: From 01/01/2022	Worksheet E Part A	
			To 12/31/2022	Date/Time Pre	
		Title XVIII	Hospi tal	4/13/2023 4: 1 PPS	8 p
		THE AVIII	Prior to 10/1		
			1.00	2. 00	
	Uncompensated Care Payment Adjustment				
00	Total uncompensated care amount (see instructions)			6, 874, 403, 459	
01	Factor 3 (see instructions)		0. 000445324	0. 000413255	
02	Hospital UCP, including supplemental UCP (If line 34 is zero (see instructions)	, enter zero on this line	3, 202, 774	2, 840, 883	35
03	Pro rata share of the hospital UCP, including supplemental U	ICP (see instructions)	2, 395, 499	716, 059	35
	Total UCP adjustment (sum of columns 1 and 2 on line 35.03)	(3, 111, 558		36
	Additional payment for high percentage of ESRD beneficiary d	ischarges (lines 40 throu	gh 46)		
00	Total Medicare discharges (see instructions)		0		40
00	Total ESRD Medicare discharges (see instructions)		0		41
01	Total ESRD Medicare covered and paid discharges (see instruc		0		4
00	Divide line 41 by line 40 (if less than 10%, you do not qual Total Medicare ESRD inpatient days (see instructions)	iry for adjustment)	0.00		4:
00	Ratio of average length of stay to one week (line 43 divided	Lby Line 41 divided by 7	0. 000000		4.
00	days)	by Time 41 divided by 7	0.00000		
00	Average weekly cost for dialysis treatments (see instruction	is)	0.00		4
00	Total additional payment (line 45 times line 44 times line 4	1. 01)	0		4
00	Subtotal (see instructions)		27, 954, 780		4
00	Hospital specific payments (to be completed by SCH and MDH,	small rural hospitals	0		48
	only. (see instructions)			Amount	
				1. 00	
00	Total payment for inpatient operating costs (see instruction	is)		27, 954, 780	40
00	Payment for inpatient program capital (from Wkst. L, Pt. I a	nd Pt. II, as applicable)		2, 393, 031	50
00	Exception payment for inpatient program capital (Wkst. L, Pt			0	
00	Direct graduate medical education payment (from Wkst. E-4, I	ine 49 see instructions).		0	5.
00	Nursing and Allied Health Managed Care payment			0 490, 989	
01	Special add-on payments for new technologies Islet isolation add-on payment			490, 969	1
00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line	69)		0	
01	Cellular therapy acquisition cost (see instructions)	,		0	5
00	Cost of physicians' services in a teaching hospital (see int	ructions)		0	5
00	Routine service other pass through costs (from Wkst. D, Pt.		hrough 35).	0	5
00	Ancillary service other pass through costs from Wkst. D, Pt.	IV, col. 11 line 200)		0	
00	Total (sum of amounts on lines 49 through 58)			30, 838, 800	
00	Primary payer payments Total amount payable for program beneficiaries (line 59 minu	s line 60)		7, 046 30, 831, 754	
00	Deductibles billed to program beneficiaries	13 TTHE 00)		2, 641, 906	
00	Coinsurance billed to program beneficiaries			45, 902	
00	Allowable bad debts (see instructions)			234, 601	
00	Adjusted reimbursable bad debts (see instructions)			152, 491	
00	Allowable bad debts for dual eligible beneficiaries (see ins	tructions)		77, 598	
00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			28, 296, 437	
00	Credits received from manufacturers for replaced devices for			0	
00	Outlier payments reconciliation (sum of lines 93, 95 and 96) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	. (FOR SUB-SEE INSTRUCTION	15)	0	1
50	Rural Community Hospital Demonstration Project (§410A Demons	tration) adjustment (see	instructions)	0	
87	Demonstration payment adjustment amount before sequestration	, ,		0	ł
88	SCH or MDH volume decrease adjustment (contractor use only)			0	7
89	Pioneer ACO demonstration payment adjustment amount (see ins	tructions)			7
90	HSP bonus payment HVBP adjustment amount (see instructions)			0	
91	HSP bonus payment HRR adjustment amount (see instructions)			0	
	Bundled Model 1 discount amount (see instructions)			0	
92	lunger in the second se				
	HVBP payment adjustment amount (see instructions) HRR adjustment amount (see instructions)			0 -131, 434	

Health Financial Systems	FRANCISCAN HEALTH MICHIGAN CI	ΓΥ	In Lie	u of Form CMS-	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der	CCN: 15-0015	Peri od: From 01/01/2022 To 12/31/2022	Worksheet E Part A Date/Time Pre 4/13/2023 4:1	
	Ti tl	e XVIII	Hospi tal	PPS	
		FFY	(yyyy)	Amount	
			0	1. 00	
70.96 Low volume adjustment for federal fis the corresponding federal year for th			0	0	70. 96
70.97 Low volume adjustment for federal fis the corresponding federal year for the			0	0	70. 97

		(VIII	HOSPI Tai		
		FFY (Amount	
		0		1. 00	
0. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0	0)	0	70. 96
	the corresponding federal year for the period prior to 10/1)				
0. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0	0)	0	70. 97
	the corresponding federal year for the period ending on or after 10/1)				
0. 98	Low Volume Payment-3			0	70. 98
0. 99	HAC adjustment amount (see instructions)			68, 886	
1. 00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)			28, 096, 117	71.00
1. 01	Sequestration adjustment (see instructions)			354, 011	71.0
1. 02	Demonstration payment adjustment amount after sequestration			0	71. 0
1. 03	Sequestration adjustment-PARHM or CHART pass-throughs			· ·	71. 0
				07.40/.05/	
2. 00	Interim payments			27, 136, 356	•
2. 01	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
				/OF 750	
4. 00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and			605, 750	14.0
	[73]				
4. 01	Balance due provider/program-PARHM or CHART (see instructions)				74.0
5. 00	Protested amounts (nonallowable cost report items) in accordance with			847, 219	75.0
	CMS Pub. 15-2, chapter 1, §115.2				
					1
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				٠
0.00	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. L, Pt. I, line 2			0	91.0
2. 00	Operating outlier reconciliation adjustment amount (see instructions)			0	
	, ,				1
3. 00	Capital outlier reconciliation adjustment amount (see instructions)			0	
4. 00	The rate used to calculate the time value of money (see instructions)			0. 00	94.0
5. 00	Time value of money for operating expenses (see instructions)			0	95. C
6 00	Time value of money for capital related expenses (see instructions)			0	96. C
0. 00	Time varie of money for each tar ferated expenses (see first detrois)		Prior to 10/1		70.0
		_			
			1.00	2. 00	
	HSP Bonus Payment Amount		1. 00	2. 00	
00. 00	HSP Bonus Payment Amount HSP bonus amount (see instructions)			2. 00	100. 0
00.00	HSP bonus amount (see instructions)		1. 00	2. 00	100. 0
	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment		1.00	2.00	
01. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions)		1.00 0 0.0000000000	2.00 0 0.0000000000	101. 0
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)		1.00	2.00 0 0.0000000000	101. 0
01. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions)		1.00 0 0.0000000000	2.00 0 0.0000000000 0	101. 0 102. 0
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)		1.00 0 0.0000000000	2.00 0 0.0000000000	101. C
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 0 0. 0000000000 0	2.00 0 0.0000000000 0	101. C
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) HRR adjustment amount for HSP bonus payment (see instructions)		1.00 0.0000000000 0.000000000000	2.00 0 0.0000000000 0	101. 0 102. 0
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 factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjust	ment	1.00 0.0000000000 0.000000000000	2.00 0.0000000000 0.0000 0.0000 0	101. 0 102. 0 103. 0 104. 0
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 factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjust Is this the first year of the current 5-year demonstration period under the	ment	1.00 0.0000000000 0.000000000000	2.00 0.0000000000 0.0000 0.0000 0	101. (102. (103. (104. (
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 factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjust	ment	1.00 0.0000000000 0.000000000000	2.00 0.0000000000 0.0000 0.0000 0	101. 0 102. 0 103. 0 104. 0
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 Demonstration) Adjust Is this the first year of the current 5-year demonstration period under the Century Cures Act? Enter "Y" for yes or "N" for no.	ment	1.00 0.0000000000 0.000000000000	2.00 0.0000000000 0.0000 0.0000 0	101. (102. (103. (104. (
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 Demonstration) Adjust Is this the first year of the current 5-year demonstration period under the Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement	ment	1.00 0.0000000000 0.000000000000	2.00 0.0000000000 0.0000 0.0000 0	101. (102. (103. (104. (200. (
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201. 00 202. 00 203. 00 203. 00 204. 00 204. 00 205. 00 205. 00 206. 00 206. 00 207. 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) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjust Is this the first year of the current 5-year demonstration period under the Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of 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)	ment	1.00 0.0000000000 0.0000 0.0000	2.00 0.0000000000 0.0000 0.0000	101. (102. (103. (104. (
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01. 00 02. 00 03. 00 04. 00 00. 00 01. 00 02. 00 03. 00 04. 00 05. 00 06. 00 07. 00 08. 00 09. 00 110. 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 factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjust Is this the first year of the current 5-year demonstration period under the Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of 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) Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59) Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions)	ment	1.00 0.0000000000 0.0000 0.0000	2.00 0.000000000000 0.0000 0.ration	101. 0 102. 0 103. 0 104. 0 200. 0 201. 0 203. 0 204. 0 205. 0 206. 0 207. 0 208. 0 209. 0 210. 0
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01. 00 02. 00 03. 00 04. 00 00. 00 01. 00 02. 00 02. 00 04. 00 06. 00 06. 00 09. 00 09. 00 09. 00 11. 00 01. r>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 factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjust Is this the first year of the current 5-year demonstration period under the Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of 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) Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59) Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare Part A IPPS payments (from line 211)	the current	1.00 0.0000000000 0.0000 0.0000	2.00 0.0000000000000 0.0000 0.rati on	101. C

| In Lieu of Form CMS-2552-10 | Period: | Worksheet E | From 01/01/2022 | Part A Exhibit 4 | Date/Time Prepared: 4/13/2023 4:18 pm Health Financial Systems

LOW VOLUME CALCULATION EXHIBIT 4 Provider CCN: 15-0015

						0 12/31/2022	4/13/2023 4: 18	
					XVIII	Hospi tal	PPS	
			Amounts (from	Pre/Post	Period Prior	Peri od	Total (Col 2	
		line	E, Part A)	Entitlement		On/After 10/01	through 4)	
1.00	DRG amounts other than outlier	1.00	1.00	2.00	3.00	4. 00	5. 00 0	1. 00
1.00	payments	1.00	٩	U	0	U	U	1.00
1. 01	DRG amounts other than outlier	1. 01	16, 780, 987	0	16, 780, 987		16, 780, 987	1. 01
	payments for discharges				,,		, ,	
	occurring prior to October 1							
1.02	DRG amounts other than outlier	1. 02	5, 421, 967	0		5, 421, 967	5, 421, 967	1. 02
	payments for discharges							
	occurring on or after October							
1 00		1 00		0	0			1 00
1. 03	DRG for Federal specific	1. 03	۷	Ü	0		0	1. 03
	operating payment for Model 4 BPCI occurring prior to							
	October 1							
1.04	DRG for Federal specific	1. 04	ol	0		0	0	1. 04
	operating payment for Model 4							
	BPCI occurring on or after							
	October 1							
2.00	Outlier payments for	2. 00						2. 00
2 01	discharges (see instructions)	2.02		0				2 01
2. 01	Outlier payments for	2. 02	۷	Ü	0	U	U	2. 01
2. 02	discharges for Model 4 BPCI Outlier payments for	2. 03	1, 887, 748	0	1, 887, 748		1, 887, 748	2. 02
2.02	discharges occurring prior to	2.03	1,007,740	0	1,007,740		1,007,740	2.02
	October 1 (see instructions)							
2.03	Outlier payments for	2. 04	143, 049	0		143, 049	143, 049	2. 03
	discharges occurring on or							
	after October 1 (see							
	instructions)		_	_	_	_	_	
3.00	Operating outlier	2. 01	0	0	0	O	0	3. 00
4. 00	reconciliation Managed care simulated	3. 00		0	0	0	0	4. 00
4.00	payments	3.00	١	0	0	U	U	4.00
	Indirect Medical Education Adj	ustment						
5.00	Amount from Worksheet E, Part	21.00	0. 000000	0. 000000	0.000000	0.000000		5. 00
	A, line 21 (see instructions)							
6.00	IME payment adjustment (see	22. 00	0	0	0	0	0	6. 00
. 01	instructions)	00.04		Ō				. 01
6. 01	IME payment adjustment for managed care (see	22. 01	U	0	0	U	0	6. 01
	instructions)							
	Indirect Medical Education Adj	ustment for the	Add-on for Se	ction 422 of t	he MMA			
7.00	IME payment adjustment factor	27. 00	0. 000000	0.000000		0.000000		7. 00
	(see instructions)							
8.00	IME adjustment (see	28.00	0	0	0	0	0	8. 00
	instructions)							
8. 01	IME payment adjustment add on	28. 01	0	0	0	0	0	8. 01
	for managed care (see							
9. 00	instructions) Total IME payment (sum of	29. 00		0	0	0	0	0 00
7.00	lines 6 and 8)	29.00	١	0	0	U	U	9. 00
9. 01	Total IME payment for managed	29. 01	o	0	0	o	0	9. 01
	care (sum of lines 6.01 and			3				
	8. 01)							
	Disproportionate Share Adjustm							
10. 00	Allowable disproportionate	33.00	0. 1098	0. 1098	0. 1098	0. 1098		10. 00
	share percentage (see instructions)							
11 00	Di sproporti onate share	34.00	609, 471	0	140 420	140 022	609, 471	11 00
11. 00	adjustment (see instructions)	34.00	009, 471	U	460, 638	148, 833	009, 471	11.00
11. 01	Uncompensated care payments	36.00	3, 111, 558	0	2, 395, 499	716, 059	3, 111, 558	11. 01
	Additional payment for high pe				_, _, ,,,,		57	
12.00	Total ESRD additional payment	46.00	ol	0	0	0	0	12. 00
	(see instructions)							
13.00	Subtotal (see instructions)	47. 00	27, 954, 780	0	21, 524, 872	6, 429, 908	27, 954, 780	
14. 00	Hospital specific payments	48. 00	0	0	0	0	0	14. 00
	(completed by SCH and MDH,							
	small rural hospitals only.)							
15. 00	(see instructions) Total payment for inpatient	49. 00	27, 954, 780	0	21 524 072	6, 429, 908	27, 954, 780	15 00
15.00	operating costs (see	47.00	21, 904, 180	U	21, 524, 872	0, 427, 708	21, 704, 180	15.00
	instructions)							
16. 00	Payment for inpatient program	50.00	2, 393, 031	0	1, 939, 660	453, 371	2, 393, 031	16. 00
	capital (from Wkst. L, Pt. I,					·		
	if applicable)							

	20112 0112002111 011 2111 011 1				Т	rom 01/01/2022 o 12/31/2022	Part A Exhibi Date/Time Pre 4/13/2023 4:1	pared:
					XVIII	Hospi tal	PPS	
		W/S E, Part A	Amounts (from	Pre/Post	Period Prior	Peri od	Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	On/After 10/01	through 4)	
		0	1.00	2.00	3.00	4. 00	5. 00	
17. 00	Special add-on payments for	54.00	490, 989	0	461, 161	29, 828	490, 989	17. 00
	new technologies							
17. 01	Net organ aquisition cost							17. 01
17. 02	Credits received from	68. 00	0	0	C	0	0	17. 02
	manufacturers for replaced							
	devices for applicable MS-DRGs							
18.00	Capital outlier reconciliation	93.00	0	0	C	0	0	18. 00
	adjustment amount (see							
	instructions)							
19. 00	SUBTOTAL			0	23, 925, 693	6, 913, 107	30, 838, 800	19. 00
		W/S L, line	(Amounts from					
			L)					
		0	1.00	2. 00	3. 00	4. 00	5. 00	
20. 00	Capital DRG other than outlier	1. 00	1, 671, 466	0	.,	404, 475	1, 671, 466	
20. 01	Model 4 BPCI Capital DRG other	1. 01	0	0	C	0	0	20. 01
	than outlier							
21. 00	Capital DRG outlier payments	2. 00	721, 565	0	672, 669	48, 896	721, 565	
21. 01	Model 4 BPCI Capital DRG	2. 01	0	0	0	0	0	21. 01
	outlier payments							
22. 00	Indirect medical education	5. 00	0. 0000	0. 0000	0.0000	0.0000		22. 00
	percentage (see instructions)							
23. 00	Indirect medical education	6. 00	0	0	C	0	0	23. 00
0.4.00	adjustment (see instructions)	10.00	0.0000	0.0000	0 0000	0.0000		04.00
24. 00	Allowable disproportionate	10. 00	0. 0000	0. 0000	0.0000	0.0000		24. 00
	share percentage (see							
25 00	instructions)	11 00	0	0			_	25 00
25. 00	Disproportionate share adjustment (see instructions)	11. 00	U	U		U	0	25. 00
26. 00	Total prospective capital	12.00	2, 393, 031	0	1, 939, 660	453, 371	2, 393, 031	26. 00
20.00	payments (see instructions)	12.00	2, 393, 031	U	1, 939, 000	433, 371	2, 393, 031	20.00
	payments (see thistructions)	W/S E, Part A	(Amounts to F					
		line	Part A)					
		0	1.00	2.00	3.00	4. 00	5. 00	
27. 00	Low volume adjustment factor	U	1.00	2.00	0.000000	1 1 1	3.00	27. 00
28. 00	Low volume adjustment	70. 96			0.000000		0	
20.00	(transfer amount to Wkst. E,	70. 70						20.00
	Pt. A, line)							
29. 00	Low volume adjustment	70. 97				0	0	29. 00
27.00	(transfer amount to Wkst. E,	70. 77						27.00
	Pt. A, line)							
100.00	Transfer low volume		Υ					100. 00
	adiustments to Wkst F Dt A		1 ' 1			1	1	1

adjustments to Wkst. E, Pt. A.

Provider CCN: 15-0015

Peri od:

From 01/01/2022

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Part A Exhibit 5

Date/Time Prepared: 4/13/2023 4:18 pm 12/31/2022 Hospi tal Title XVIII Period to Total (cols. 2 Wkst. E, Pt. Amt. from Peri od on 10/01 A. line Wkst. E, Pt. after 10/01 and 3) A) 2.00 3. 00 0 4.00 1.00 1.00 DRG amounts other than outlier payments 1. 00 1. 00 DRG amounts other than outlier payments for 1.01 1.01 16, 780, 987 16, 780, 987 16, 780, 987 1.01 discharges occurring prior to October 1 1.02 DRG amounts other than outlier payments for 1.02 5, 421, 967 5. 421. 967 5, 421, 967 1.02 discharges occurring on or after October 1 1.03 DRG for Federal specific operating payment 1.03 0 1.03 for Model 4 BPCI occurring prior to October DRG for Federal specific operating payment 1.04 1.04 0 1.04 for Model 4 BPCI occurring on or after October 1 2.00 Outlier payments for discharges (see 2.00 2.00 instructions) 2.01 Outlier payments for discharges for Model 4 2.02 2.01 **BPCI** 2 02 Outlier payments for discharges occurring 2 03 1, 887, 748 1, 887, 748 1, 887, 748 2 02 prior to October 1 (see instructions) Outlier payments for discharges occurring on 2.03 2.04 143, 049 143, 049 143, 049 2.03 or after October 1 (see instructions) 3.00 Operating outlier reconciliation 2.01 0 3.00 Managed care simulated payments 4.00 3.00 0 4.00 Indirect Medical Education Adjustment 5.00 Amount from Worksheet E, Part A, line 21 21.00 0.000000 0.000000 0.000000 5.00 (see instructions) IME payment adjustment (see instructions) 6.00 22.00 0 0 0 6.00 IME payment adjustment for managed care (see 0 6.01 22.01 0 0 6.01 instructions) Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 7.00 IME payment adjustment factor (see 27. 00 0.000000 0.000000 0.000000 7.00 instructions) 8 00 IME adjustment (see instructions) 28 00 8 00 0 0 0 0 8.01 IME payment adjustment add on for managed 28.01 0 0 8.01 care (see instructions) Total IME payment (sum of lines 6 and 8) 29.00 9.00 0 0 9.00 Total IME payment for managed care (sum of 9.01 29.01 C 0 9.01 lines 6.01 and 8.01) Disproportionate Share Adjustment 10.00 Allowable disproportionate share percentage 33.00 0.1098 0.1098 0.1098 10.00 (see instructions) 11.00 Disproportionate share adjustment (see 34.00 609.471 460, 638 148.833 609.471 11.00 instructions) 11.01 2, 395, 499 716, 059 Uncompensated care payments 36, 00 3, 111, 558 3, 111, 558 11.01 Additional payment for high percentage of ESRD beneficiary discharges 12.00 Total ESRD additional payment (see 46. 00 12.00 instructions) 47.00 27, 954, 780 13 00 21, 524, 872 6, 429, 908 27, 954, 780 Subtotal (see instructions) 13 00 14.00 Hospital specific payments (completed by SCH 48.00 14.00 and MDH, small rural hospitals only.) (see instructions) Total payment for inpatient operating costs 49.00 27, 954, 780 21, 524, 872 6, 429, 908 27, 954, 780 15.00 15.00 (see instructions) 1, 939, 660 16.00 Payment for inpatient program capital (from 50 00 2, 393, 031 453.371 2, 393, 031 16.00 Wkst. L, Pt. I, if applicable) 17.00 Special add-on payments for new technologies 54.00 490, 989 461, 161 29, 828 490, 989 17.00 17.01 Net organ acquisition cost 17.01 Credits received from manufacturers for 68.00 0 17.02 17.02 0 0 replaced devices for applicable MS-DRGs 18.00 Capital outlier reconciliation adjustment 93.00 C 18.00 0 amount (see instructions) 19.00 SUBTOTAL 23, 925, 693 6, 913, 107 30, 838, 800 19. 00

Health Financial Systems FR	RANCISCAN HEALTI	H MICHIGAN CITY	1	In Lie	u of Form CMS-2	2552-10
HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	ATION EXHIBIT 5			Period: From 01/01/2022 To 12/31/2022	Date/Time Pre 4/13/2023 4:1	pared:
		Title	XVIII	Hospi tal	PPS	
	Wkst. L, line	(Amt. from				
		Wkst. L)				
	0	1. 00	2.00	3. 00	4. 00	
20.00 Capital DRG other than outlier	1.00	1, 671, 466	1, 266, 99	1 404, 475	1, 671, 466	20. 00
20.01 Model 4 BPCI Capital DRG other than outlier	1. 01	0		0	0	20. 01
21.00 Capital DRG outlier payments	2.00	721, 565	672, 66	9 48, 896	721, 565	21.00
21.01 Model 4 BPCI Capital DRG outlier payments	2. 01	0		0 0	0	21. 01
22.00 Indirect medical education percentage (see	5. 00	0.0000	0.000	0.0000		22.00
instructions)						
23.00 Indirect medical education adjustment (see instructions)	6. 00	0		0 0	0	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	11. 00	0		0 0	0	25. 00
26.00 Total prospective capital payments (see instructions)	12.00	2, 393, 031	1, 939, 66	0 453, 371	2, 393, 031	26. 00
Thisti deti onsy	Wkst. E. Pt.	(Amt. from				
	A, line	Wkst. E, Pt.				
	A, TITIC	A)				
	0	1, 00	2.00	3. 00	4. 00	
27. 00		1.00	2.00	0.00	1. 00	27. 00
28.00 Low volume adjustment prior to October 1	70. 96	0		0	0	28.00
29.00 Low volume adjustment on or after October 1	70. 97	0		0	0	29.00
30.00 HVBP payment adjustment (see instructions)	70. 93			0	0	30.00
30. 01 HVBP payment adjustment for HSP bonus	70. 90			0	0	30.00
payment (see instructions)	70. 90	0		0	U	30.01
31.00 HRR adjustment (see instructions)	70. 94	121 424	107.00	1 24 522	121 424	31. 00
, ,	70. 94	-131, 434	-106, 90	1 -24, 533	-131, 434 0	31.00
31.01 HRR adjustment for HSP bonus payment (see instructions)	70. 91	0		0		31.01
					(Amt. to Wkst. E, Pt. A)	
	0	1. 00	2. 00	3. 00	4. 00	
32.00 HAC Reduction Program adjustment (see	70. 99			0 68, 886	68, 886	32. 00
instructions)						
100.00 Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100. 00

Health Financial Systems	FRANCISCAN HEALTH MICH	HIGAN CITY		In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Pr	rovider CCN:	15-0015	Peri od: From 01/01/2022 To 12/31/2022	Worksheet E Part B Date/Time Prepared: 4/13/2023 4:18 pm

		Title XVIII	Hospi tal	4/13/2023 4: 1 PPS	8 pm
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1. 00	
1. 00	Medical and other services (see instructions)			444	1. 00
2.00	Medical and other services reimbursed under OPPS (see instructions	s)		27, 467, 687	2. 00
3.00	OPPS payments			21, 095, 107	3. 00
4.00	Outlier payment (see instructions)			13, 507	4. 00
4. 01	Outlier reconciliation amount (see instructions)	nc)		0 000	4. 01
5. 00 6. 00	Enter the hospital specific payment to cost ratio (see instruction Line 2 times line 5	15)		0. 000 0	5. 00 6. 00
7. 00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	7. 00
8.00	Transitional corridor payment (see instructions)			0	8. 00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV,	col. 13, line 200		0	9. 00
10.00	Organ acquisitions			0	10.00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			444	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges				
12. 00	Ancillary service charges			1. 858	12. 00
13. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line	69)		0	13. 00
14.00	Total reasonable charges (sum of lines 12 and 13)	·		1, 858	14. 00
	Customary charges				
15. 00	Aggregate amount actually collected from patients liable for payments			0	15.00
16. 00	Amounts that would have been realized from patients liable for payhad such payment been made in accordance with 42 CFR §413.13(e)	yment for services or	n a cnargebasis	0	16. 00
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	17. 00
18. 00	Total customary charges (see instructions)			1, 858	18. 00
19. 00	Excess of customary charges over reasonable cost (complete only in	f line 18 exceeds lir	ne 11) (see	1, 414	
	instructions)				
20. 00	Excess of reasonable cost over customary charges (complete only in	f line 11 exceeds lir	ne 18) (see	0	20. 00
21. 00	instructions) Lesser of cost or charges (see instructions)			444	21. 00
22. 00	Interns and residents (see instructions)			0	22. 00
23. 00	Cost of physicians' services in a teaching hospital (see instructi	i ons)		0	23. 00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	<u> </u>		21, 108, 614	24. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25. 00	Deductibles and coinsurance amounts (for CAH, see instructions)	(6 CAIL !+	+!>	0	25. 00
26. 00 27. 00	Deductibles and Coinsurance amounts relating to amount on line 24 Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus			3, 816, 371 17, 292, 687	26. 00 27. 00
27.00	instructions)	the sum of filles 22	ana 25] (3cc	17, 272, 007	27.00
28. 00	Direct graduate medical education payments (from Wkst. E-4, line !	50)		0	28. 00
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	29. 00
30.00	Subtotal (sum of lines 27 through 29)			17, 292, 687	30.00
31. 00 32. 00	Primary payer payments Subtotal (line 30 minus line 31)			11, 766 17, 280, 921	31. 00 32. 00
32.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)			17, 200, 921	32.00
33. 00	Composite rate ESRD (from Wkst. I-5, line 11)			0	33. 00
34.00	Allowable bad debts (see instructions)			216, 233	34.00
35. 00	Adjusted reimbursable bad debts (see instructions)			140, 551	
36.00	Allowable bad debts for dual eligible beneficiaries (see instructi	ions)		111, 859	
37. 00 38. 00	Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R			17, 421, 472 -244	
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			-244	39. 00
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)				39. 50
39. 97	Demonstration payment adjustment amount before sequestration			0	39. 97
39. 98	Partial or full credits received from manufacturers for replaced of	devices (see instruct	i ons)	0	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION			0	39. 99
40. 00 40. 01	Subtotal (see instructions) Sequestration adjustment (see instructions)			17, 421, 716 219, 513	40. 00 40. 01
40. 01	Demonstration payment adjustment amount after sequestration			219, 513	40. 01
40. 03	Sequestration adjustment-PARHM or CHART pass-throughs			Ü	40. 03
41.00	Interim payments			17, 344, 140	41.00
41. 01	Interim payments-PARHM or CHART				41. 01
42.00	Tentative settlement (for contractors use only)			0	42.00
42. 01 43. 00	Tentative settlement-PARHM or CHART (for contractor use only) Balance due provider/program (see instructions)			-141, 937	42. 01 43. 00
43. 00	Balance due provider/program-PARHM (see instructions)			-141, 737	43. 00
44. 00	Protested amounts (nonallowable cost report items) in accordance v	with CMS Pub. 15-2. c	chapter 1.	0	44. 00
	§115. 2		· '		
	TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0	90.00
91. 00 92. 00	Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money			0 0. 00	91. 00 92. 00
93. 00	Time Value of Money (see instructions)			0.00	92.00
	Total (sum of lines 91 and 93)			0	94. 00

alth Financial Systems FRANCISCAN HEALTH MICHIGAN CITY In Lieu			u of Form CMS-	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0015	Peri od: From 01/01/2022 To 12/31/2022	Worksheet E Part B Date/Time Pre 4/13/2023 4:1	
	Title XVIII	Hospi tal	PPS	
			1. 00	
MEDICARE PART B ANCILLARY COSTS				
200.00 Part B Combined Billed Days			0	200. 00

 Heal th
 Financial
 Systems
 FRANCIS

 ANALYSIS
 OF
 PAYMENTS
 TO
 PROVIDERS
 FOR
 SERVICES
 RENDERED
 Provider CCN: 15-0015

					4/13/2023 4: 18	B pm
		Title	XVIII	Hospi tal	PPS	
		I npati en	t Part A	Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4. 00	
1.00	Total interim payments paid to provider		27, 136, 356		17, 344, 140	1. 00
2.00	Interim payments payable on individual bills, either		0		0	2. 00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
3. 00	write "NONE" or enter a zero List separately each retroactive lump sum adjustment					3. 00
3.00	amount based on subsequent revision of the interim rate					3.00
	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. 01
3.02			0		0	3. 02
3.03			0		0	3. 03
3.04			0		0	3. 04
3.05			0		0	3. 05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3. 50
3.51			0		0	3. 51
3. 52			0		0	3. 52
3. 53 3. 54			0			3. 53 3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		0			3. 99
3. 77	3. 50-3. 98)		0		0	3. 77
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		27, 136, 356		17, 344, 140	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1) Program to Provider					
5. 01	TENTATI VE TO PROVI DER		0		0	5. 01
5. 02	TENTATI VE TO TROVIDER		l ő		0	5. 02
5. 03			0		0	5. 03
	Provider to Program					
5.50	TENTATI VE TO PROGRAM		0		0	5. 50
5. 51			0		0	5. 51
5. 52			0		0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		0		0	5. 99
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6. 00
4 01	the cost report. (1) SETTLEMENT TO PROVIDER		405 750		0	6. 01
6. 01 6. 02	SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM		605, 750 0		141, 937	6. 01
6. 02 7. 00	Total Medicare program liability (see instructions)		27, 742, 106		17, 202, 203	7. 00
7.00	Total medicale program Habitity (see Histructions)		21, 142, 100	Contractor	NPR Date	7.00
				Number	(Mo/Day/Yr)	
		()	1. 00	2.00	
8.00	Name of Contractor					8. 00

Component CCN: 15-S015

Title XVIII

provi der	-		PPS	
I PF				
	Par	t B		

				IPF		
		I npati en	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2.00	3. 00	4.00	
1.00	Total interim payments paid to provider		274, 689		0	1. 00
2.00	Interim payments payable on individual bills, either		0		0	2. 00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
0.01	Program to Provider		0			0.01
3. 01	ADJUSTMENTS TO PROVIDER		0		0	3. 01
3. 02			0		0	3. 02
3. 03			0		0	3. 03
3.04			0		0	3. 04
3. 05	Dravi dan ta Dragnam		0		0	3. 05
3. 50	Provider to Program ADJUSTMENTS TO PROGRAM		0		0	3. 50
3.50	ADJUSTNIENTS TO PROGRAM		0		0	3. 50
3. 52			0		0	3. 52
3. 52			0		0	3. 52
3. 54			0		0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		0		0	3. 99
3. 77	3. 50-3. 98)		0		U	3. 77
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		274, 689		0	4. 00
1. 00	(transfer to Wkst. E or Wkst. E-3, line and column as		271,007		Ŭ	1. 00
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR			l		
5.00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		0		0	5. 01
5. 02			0		0	5. 02
5. 03			0		0	5. 03
	Provider to Program					
5. 50	TENTATI VE TO PROGRAM		0		0	5. 50
5. 51			0		0	5. 51
5. 52	Cultural (0		0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5. 99
6. 00	Determined net settlement amount (balance due) based on					6. 00
0.00	the cost report. (1)					0.00
6. 01	SETTLEMENT TO PROVIDER		180		0	6. 01
6. 02	SETTLEMENT TO PROGRAM		0		0	6. 02
7. 00	Total Medicare program liability (see instructions)		274, 869		0	7. 00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
		()	1. 00	2. 00	
8. 00	Name of Contractor					8. 00

Heal th	Financial Systems FRANCISCAN HEALTH N	MICHIGAN CITY	In Lie	u of Form CMS-	-2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0015	Peri od:	Worksheet E-	I
			From 01/01/2022 To 12/31/2022		enared:
			10 12/31/2022	4/13/2023 4:	
		Title XVIII	Hospi tal	PPS	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				4
1 00	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		14		1 00
1.00	Total hospital discharges as defined in AARA §4102 from Wkst.	5-3, Pt. 1 Col. 15 Tine	14		1. 00 2. 00
3.00	2.00 Medicare days (see instructions) 3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3.00
4. 00	Total inpatient days (see instructions)				4.00
5. 00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5.00
6. 00	Total hospital charity care charges from Wkst. S-10, col. 3 I	ine 20			6. 00
7. 00	CAH only - The reasonable cost incurred for the purchase of c		Wkst. S-2, Pt. I		7. 00
	line 168	03			
8.00	Calculation of the HIT incentive payment (see instructions)				8. 00
9.00	Sequestration adjustment amount (see instructions)				9. 00
10. 00	Calculation of the HIT incentive payment after sequestration	(see instructions)			10. 00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				4
	Initial/interim HIT payment adjustment (see instructions)				30.00
31.00	1 3/	! 21)	-)		31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and l	ine 31) (see Instruction	(S)		32.00

Health Financial Systems	FRANCISCAN HEALTH MICHIGAN CITY	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0015	Peri od:	Worksheet E-3
	Component CCN: 15-S015	From 01/01/2022 To 12/31/2022	Date/Time Prepared:
			4/13/2023 4:18 pm
	Title XVIII	Subprovi der -	PPS
		I PF	

NAPT 11 - MEDICABE DART A SERVICES - 19F 99S			. I PF		
Net Federal IPF PPS Outlier PS Payments (excluding cutlier, ECT, and medical education payments)			_	1. 00	
Net IPF PPS CIT Payments 0 2.00		PART II - MEDICARE PART A SERVICES - IPF PPS			
Not IPF PPS CET Payments 0.0 3.00 15. 2004. (See Instructions) 15. 2004. (See Instructions) 16. 2004. (See Instructions) 17. 2004. (See Instructions) 18. 2004. (See Instructions) 18. 2004. (See Instructions) 18. 2004. (See Instructions) 18. 2004. (See Instructions) 18. 2004. (See Instructions) 18. 2004. (See Instructions) 18. 2004. (See Instructions) 18. 2004. (See Instructions) 18. 2004. (See Instructions) 18. 2004. (See Instructions) 20. 2004. (See Instr	1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)		313, 315	1. 00
Unwelghted Intern and resident FTE count in the most recent cost report filed on or before November 15,2004, (see instructions) 15,2004, (see instruct				- 1	
15. 2004. (see Instructions) 4. 01 Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CTR \$412.424(d)(1)(1)(1)(f)(1) or (2) (see Instructions) 5.00 New Teaching program adjustment. (see instructions) 6.00 Current year's unweighted FTE count of IAR excluding FTEs in the new program growth period of a "new teaching program" (see Instructions) 7.00 Leaching program" (see Instructions) 8.00 Intern and resident count for IPF PPS medical education adjustment (see instructions) 8.00 Intern and resident count for IPF PPS medical education adjustment (see instructions) 9.04 Average bally Census (see Instructions) 9.05 Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11) 9.06 Ocat Internal adjustment (ine 1 multiplied by line 10). 9.07 Teaching Adjustment (line 1 multiplied by line 10). 9.08 Organ acquisition (DO NOT USE THIS LINE) 9.09 Cognizing and Allied Health Managed Care payment (see instructions) 9.00 Cognizing and Allied Health Managed Care payment (see instructions) 9.01 Cognizing and Allied Health Managed Care payment (see instructions) 9.01 Cognizing and Allied Health Managed Care payment (see instructions) 9.02 Cognizing and Allied Health Managed Care payment (see instructions) 9.03 Cognizing and Allied Health Managed Care payment (see instructions) 9.04 Cognizing and Allied Health Managed Care payment (see instructions) 9.05 Cognizing and Allied Health Managed Care payment (see instructions) 9.06 Cognizing and Allied Health Managed Care payment (see instructions) 9.07 Cognizing and Allied Health Managed Care payment (see instructions) 9.08 Cognizing and Allied Health Managed Care payment (see instructions) 9.09 Cognizing and Allied Health Managed Care payment (see instructions) 9.00 Cognizing and Allied Health Managed Care payment (see instructions) 9.00 Cognizing and Allied Health Managed Care payment (see instructions) 9.01 Cognizing and Allied Health Ma				- 1	
Cap Increases for the unweighted Intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 crispans or hospital closure, that would not be counted without a temporary cap adjustment under 42 crispans or hospital closure, that would not be counted without a temporary cap adjustment under 42 crispans or hospital closure, that would not be counted without a temporary cap adjustment under 42 crispans or hospital closure for the counter of 18R excluding FTEs in the new program growth period of a "new teaching program" (see instructions) current year's unweighted 18R FTE count of 18R excluding FTEs in the new program growth period of a "new teaching program" (see instructions) current year's unweighted 18R FTE count for residents within the new program growth period of a "new teaching program" (see instructions) current year's unweighted 18R FTE count for residents within the new program growth period of a "new teaching program" (see instructions) current year's unweighted 18R FTE count for residents within the new program growth period of a "new teaching program" (see instructions) current year's unweighted 18R FTE count for residents within the new program growth period of a "new teaching program" (see instructions) current year's unweighted 18R FTE count for residents within the new program growth period of a "new teaching program" (see instructions) current year's unweighted 18R FTE count for large deutation adjustment (see instructions) current year's unweighted 18R FTE count for large 48 ftes instructions) current year's unweighted 18R FTE count for large 48 ftes instructions) current year's unweighted 18R FTE count for large 48 ftes instructions) current year's unweighted 18R FTE count for large 48 ftes instructions) current year's unweighted 18R FTE count for large 48 ftes instructions) current year's unweighted 18R FTE count for large 48 ftes instructions) current year's unweighted 18R FTE count for	4.00	9	fore November	0. 00	4. 00
program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CR 5412.424(0)(1)(1)(1)(1)(1)(1)(0) (0) (2) (see instructions) 0.00 5.00 6.00 0.00 6.	4 04			0.00	4 04
CFR \$412. 424(b)(1)(iii)(F)(1) or (2) (see instructions)	4.01			0.00	4.01
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Courrent year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions) 0.00 0.00	5 00			0.00	5 00
teaching program" (see instructions) 7. 00 Current year's unnew jathed IABR FIE count for residents within the new program growth period of a "new teaching program" (see instructions) 8. 00 Intern and resident count for IPF PPS medical education adjustment (see instructions) 9. 00 Average Dail y Census (see instructions) 10. 00 Teaching Adjustment Factor (((1 + (line 8/line 9)) raised to the power of .5150 -1). 10. 01 Teaching Adjustment Factor (((1 + (line 8/line 9)) raised to the power of .5150 -1). 10. 01 Teaching Adjustment (line 1 multiplied by line 10). 10. 01 Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11) 10. 01. 03. 03. 03. 13. 03. 13. 03. 13. 03. 13. 03. 13. 03. 13. 03. 03. 03. 03. 03. 03. 03. 03. 03. 0		,	riod of a "new		
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9.00 Average Dall Ly Census (see instructions) 7.400000 9.00 10.00 Teaching Adjustment Factor (f(1+ (line 8/line 9)) raised to the power of .5150 -1). 0.0000000 10.00		teaching program" (see instuctions)			
10.00 Teaching Adjustment Factor (((1 + (liné 8/line 9)) raised to the power of .5150 -1). 0.000000 10.00 10					
11.00					
12.00 Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11) 313, 315 12.00 13.00 Nursing and Alliel delact that Managed Care payment (see instructions) 14.00 15.00					
13.00 Nursing and Allied Health Managed Care payment (see instruction)				-	
14. 00					
15.00 Cost of physicians' services in a teaching hospital (see instructions) 0 15.00 Subtotal (see instructions) 313, 315 16.00 17.00 Primary payer payments 313, 315 18.00 18.00 Subtotal (line 16 less line 17). 313, 315 18.00 19.00 Obdectibles 31, 048 19.00 20.00 Subtotal (line 18 minus line 19) 222, 267 20.00 20.00 Subtotal (line 20 minus line 21) 278, 377 22.00 22.00 Subtotal (line 20 minus line 21) 278, 377 22.00 23.00 Allowable bad debts (exclude bad debts for professional services) (see instructions) 0 24.00 24.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 0 27.00 25.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 0 27.00 27.00 Direct graduate medical education payments (see instructions) 0 27.00 28.00 Other pass through costs (see instructions) 0 28.00 29.00 Outlier payments reconciliation 0 28.00 07.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 30.50 08.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS				0	
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17. 00 Primary payer payments 0 17. 00 Subtotal (line 16 less line 17). 313, 315 18. 00 19. 00 Deductibles 310, 418 19. 00 20. 00 Subtotal (line 18 minus line 19) 282, 267 20. 00 20. 00 Subtotal (line 20 minus line 21) 278, 377 22. 00 278, 377 22. 00 278, 377 22. 00 278, 377 22. 00 278, 377 22. 00 278, 377 22. 00 278, 377 22. 00 278, 377 22. 00 28				- 1	
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22. 00					
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25. 00	23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		0	23. 00
26. 00 Subtotal (sum of lines 22 and 24) 27. 00 Direct graduate medical education payments (see instructions) 27. 00 Direct graduate medical education payments (see instructions) 27. 00 Other pass through costs (see instructions) 28. 00 Other pass through costs (see instructions) 29. 00 Outlier payments reconciliation 29. 00 Other ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 29. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 29. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) 29. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) 30. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) 30. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) 30. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) 30. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) 30. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) 30. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) 30. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) 30. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) 30. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) 30. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) 30. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) 30. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) 30. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) 30. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) 30. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) 30. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) 30. 00 OTHER ADJUSTMENT	24.00	Adjusted reimbursable bad debts (see instructions)		0	24. 00
27. 00	25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	25. 00
28.00 Other pass through costs (see instructions) 0 28.00 29.00 Outlier payments reconciliation 0 29.00 30.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 30.00 30.50 Pioneer ACO demonstration payment adjustment (see instructions) 0 30.50 30.98 Recovery of accelerated depreciation. 0 30.99 30.99 Demonstration payment adjustment amount before sequestration 0 30.99 31.01 Sequestration adjustment (see instructions) 278, 377 31.00 31.01 Sequestration adjustment (see instructions) 3, 508 31.01 31.02 Demonstration payment adjustment amount after sequestration 0 31.02 31.01 Tentative settlement (for contractor use only) 0 31.02 32.00 Tentative settlement (for contractor use only) 0 33.00 34.00 Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33) 180 34.00 35.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 35.00 50.00 Outlier reconciliation adjustment amount (see instructions) 0	26.00	Subtotal (sum of lines 22 and 24)		278, 377	26. 00
29. 00 Outlier payments reconciliation 0 29. 00 30. 00	27. 00	Direct graduate medical education payments (see instructions)		0	27. 00
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32.00 Interim payments 274,689 32.00 33.00 Tentative settlement (for contractor use only) 0 33.00 34.00 Bal ance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33) 180 34.00 35.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 35.00 S115.2 To BE COMPLETED BY CONTRACTOR 0 50.00 Original outlier amount from Worksheet E-3, Part II, line 2 0 50.00 Outlier reconciliation adjustment amount (see instructions) 0 51.00 52.00 The rate used to calculate the Time Value of Money 0.00 52.00 Time Value of Money (see instructions) 0 53.00 FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING BEFORE THE END OF THE COVID-19 PHE 99.00 Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020. 0.000000 99.00 10 10 10 10 10 10 10					
33.00 Tentative settlement (for contractor use only) 34.00 Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33) 55.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 protested amounts (nonallowable cost report ing period immediately preceding February 29, 2020. 0.000000 protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 protested amounts (nonallowable cost report items) protested amounts (nonallowable cost report items) protested amounts (nonallowable cost report items) protested amounts (nonallowable cost report items) protested amounts (nonallowable cost report items) protested amounts (nonallowable cost report items) protested amounts (nonallowable cost report items) protested amounts (nonallowable cost report items) protested amounts (nonallowable cost report items) protested amounts (nonallowable cost report items) protested amounts (nonallowable cost report items) protested amounts (nonallowable cost report items) protested amount (nonallowable cost report items) protested amount (nonallowable cost report items) protested amount (nonallowable cost report items) protested amount (nonallowable cost report items) protest				-	
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\$\frac{\text{\$\sqrt{115.2}}{\text{TO BE COMPLETED BY CONTRACTOR}}}{50.00} \text{Original outlier amount from Worksheet E-3, Part II, line 2} \text{0 50.00} \\ 51.00 \\ 51.00 \\ 52.00 \\ 71 \text{me rate used to calculate the Time Value of Money}} \text{0.00} \\ 52.00 \\ 71 \text{me Value of Money (see instructions)}} \text{0.00} \\ 75.00 \\ 75		1 3 1	nanter 1		
TO BE COMPLETED BY CONTRACTOR 50.00 Original outlier amount from Worksheet E-3, Part II, line 2 0 50.00 51.00 Outlier reconciliation adjustment amount (see instructions) 0 51.00 52.00 The rate used to calculate the Time Value of Money 0.00 52.00 Time Value of Money (see instructions) 0 53.00 FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING BEFORE THE END OF THE COVID-19 PHE 99.00 Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020. 0.000000 99.00	00.00		apro,	· ·	00.00
51.00 Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money Time Value of Money (see instructions) FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING BEFORE THE END OF THE COVID-19 PHE 99.00 Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020. 0.000000 99.00		TO BE COMPLETED BY CONTRACTOR			
52.00 The rate used to calculate the Time Value of Money 52.00 Time Value of Money (see instructions) FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING BEFORE THE END OF THE COVID-19 PHE 99.00 Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020. 0.000000 99.00	50.00			0	50.00
53.00 Time Value of Money (see instructions) 0 53.00 FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING BEFORE THE END OF THE COVID-19 PHE 99.00 Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020. 0.000000 99.00	51.00	Outlier reconciliation adjustment amount (see instructions)		0	51.00
FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING BEFORE THE END OF THE COVID-19 PHE 99.00 Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020. 0.000000 99.00		,			
99.00 Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020. 0.000000 99.00	53. 00				53. 00
99.01 Calculated leaching Adjustment Factor for the current year. (see instructions) 0.000000 99.01			y 29, 2020.		
	99.01	practical reaching Adjustment Factor for the current year. (see instructions)		0.000000	99.01

Health Financial Systems	FRANCISCAN HEALTH MICHIGAN CITY	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0015	Peri od: From 01/01/2022 To 12/31/2022	Worksheet E-3 Part VII Date/Time Prepared: 4/13/2023 4:18 pm
	T1.11 V1.V		<u> </u>

			10 12/31/2022	4/13/2023 4:1	
		Title XIX	Hospi tal	Cost	-
			Inpati ent	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SER	RVICES FOR TITLES V OR XIX	SERVI CES		
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		0		1.00
2.00	Medical and other services			0	2. 00
3.00	Organ acquisition (certified transplant programs only)		0		3. 00
4.00	Subtotal (sum of lines 1, 2 and 3)		0	0	4. 00
5.00	Inpatient primary payer payments		0		5. 00
6.00	Outpatient primary payer payments			0	6. 00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		0	0	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e Charges				
8.00	Routine service charges		0		8. 00
9.00	Ancillary service charges		49, 881, 506	142, 860, 451	
10. 00	Organ acquisition charges, net of revenue		0		10. 00
11. 00	Incentive from target amount computation		0		11. 00
12. 00	Total reasonable charges (sum of lines 8 through 11)		49, 881, 506	142, 860, 451	12. 00
40.00	CUSTOMARY CHARGES		1		
13. 00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13. 00
14. 00	basis	normant for compless on	0	0	14 00
14.00	Amounts that would have been realized from patients liable for a charge basis had such payment been made in accordance with		٩	0	14. 00
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)	12 CFR 9413. 13(e)	0. 000000	0. 000000	15. 00
16. 00	Total customary charges (see instructions)		49, 881, 506	142, 860, 451	1
17. 00	Excess of customary charges over reasonable cost (complete onl	v if line 16 exceeds	49, 881, 506	142, 860, 451	1
17.00	line 4) (see instructions)	y 11 1111e 10 execeds	17,001,000	112,000,101	17.00
18. 00	Excess of reasonable cost over customary charges (complete onl	vifline 4 exceeds line	o	0	18. 00
	16) (see instructions)				
19.00	Interns and Residents (see instructions)		0	0	19. 00
20.00	Cost of physicians' services in a teaching hospital (see instr	ructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 1	16)	0	0	21. 00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be	completed for PPS provide	ers.		
22. 00	Other than outlier payments		0	0	22. 00
	Outlier payments		0	0	
24. 00	Program capital payments		0		24. 00
	Capital exception payments (see instructions)		0		25. 00
	Routine and Ancillary service other pass through costs		0	0	
	Subtotal (sum of lines 22 through 26)		0	0	
28. 00	Customary charges (title V or XIX PPS covered services only)		0	0	
29.00	Titles V or XIX (sum of lines 21 and 27)		0	0	29. 00
20.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT				20.00
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	1	0	0	
33. 00	Coinsurance			0	
				0	
35. 00	Allowable bad debts (see instructions)			Ü	35. 00
36. 00			0	0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	, 33)		0	
	Subtotal (line 36 ± line 37)			0	
	Direct graduate medical education payments (from Wkst. E-4)			O	39. 00
	Total amount payable to the provider (sum of lines 38 and 39)			0	1
41. 00	Interim payments		o	0	1
42. 00	Balance due provider/program (line 40 minus line 41)		o	0	
43. 00	Protested amounts (nonallowable cost report items) in accordar	nce with CMS Pub 15-2.	o	0	1
	chapter 1, §115.2	•			
			•		

Health Financial Systems	FRANCISCAN HEALTH MICHIGAN CITY	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0015		Worksheet E-3
	Component CCN: 15-S015	From 01/01/2022 To 12/31/2022	
	Title XIX	Subprovi der - I PF	Cost

		THE XIX	IPF	0031	
			Inpatient	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES	S FOR TITLES V OR XIX	SERVI CES		
	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	Organ acquisition (certified transplant programs only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		0	0	4. 00
5.00	Inpatient primary payer payments		0		5. 00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		0	0	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e Charges				
8.00	Routine service charges		0		8. 00
9.00	Ancillary service charges		1, 540, 902	0	9. 00
10.00	Organ acquisition charges, net of revenue		0		10. 00
11.00	Incentive from target amount computation		0		11. 00
12.00	Total reasonable charges (sum of lines 8 through 11)		1, 540, 902	0	12. 00
	CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for serv	vices on a charge	0	0	13. 00
	basis				
14. 00	Amounts that would have been realized from patients liable for paym		0	0	14. 00
	a charge basis had such payment been made in accordance with 42 CFF	R §413. 13(e)			
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0. 000000	1
16. 00	Total customary charges (see instructions)		1, 540, 902	0	
17. 00	Excess of customary charges over reasonable cost (complete only if	line 16 exceeds	1, 540, 902	0	17. 00
40.00	line 4) (see instructions)				40.00
18. 00	Excess of reasonable cost over customary charges (complete only if	line 4 exceeds line	0	0	18. 00
10.00	16) (see instructions)			0	19. 00
19.00	Interns and Residents (see instructions)	ana)	0	0	
20. 00 21. 00	Cost of physicians' services in a teaching hospital (see instruction	ons)	0	0	
21.00	Cost of covered services (enter the lesser of line 4 or line 16) PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be compl	ated for DDS provide		U	21.00
22. 00	Other than outlier payments	eted for PP3 provide	0	0	22. 00
23. 00	Outlier payments			0	23.00
24. 00	Program capital payments			U	24.00
	Capital exception payments (see instructions)				25. 00
26. 00	Routine and Ancillary service other pass through costs			0	
27. 00	Subtotal (sum of lines 22 through 26)			0	
28. 00	Customary charges (title V or XIX PPS covered services only)		0	0	
29. 00	Titles V or XIX (sum of lines 21 and 27)		o	0	
27.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT		<u>ا</u>		27.00
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	0	
32. 00	Deducti bl es		0	0	
33. 00	Coinsurance		o	0	•
34. 00	Allowable bad debts (see instructions)		o	0	34. 00
	Utilization review		O		35. 00
36. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		O	0	36.00
37. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		O	0	
38.00	Subtotal (line 36 ± line 37)		0	0	38. 00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39. 00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	40.00
41.00	Interim payments		0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance wi	ith CMS Pub 15-2,	0	0	43.00
	chapter 1, §115.2				

Health Financial Systems FRANCISCAN HEALTH MICHIGAN CITY In Lieu			u of Form CMS-2	2552-10	
OUTLI ER	RECONCILIATION AT TENTATIVE SETTLEMENT	Provider CCN: 15-0015	Peri od:	Worksheet E-5	
			From 01/01/2022 To 12/31/2022	Date/Time Pre	pared:
				4/13/2023 4: 18	3 pm
		Title XVIII		PPS	
				1. 00	
Т	TO BE COMPLETED BY CONTRACTOR				
1.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or s	um of 2.03 plus 2.04 (see i	nstructions)	0	1.00
2.00	Capital outlier from Wkst. L, Pt. I, line 2			0	2.00
3.00	Operating outlier reconciliation adjustment amount (see ir	structions)		0	3.00
4.00 Capital outlier reconciliation adjustment amount (see instructions)				0	4.00
5.00 The rate used to calculate the time value of money (see instructions)			0.00	5.00	
6.00	Time value of money for operating expenses (see instruction	ns)		0	6.00
7.00	Time value of money for capital related expenses (see inst	ructions)		0	7.00

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

Provider CCN: 15-0015

Peri od: Worksheet G From 01/01/2022 To 12/31/2022 Date/Time Prepared:

onl y)			'	0 12/31/2022	4/13/2023 4:1	
		General Fund	Speci fi c	Endowment Fund		
		1. 00	Purpose Fund 2.00	3. 00	4. 00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	67, 855, 829		0	0	1.00
2. 00 3. 00	Temporary investments Notes receivable	0		-	0	2. 00 3. 00
4. 00	Accounts receivable	34, 028, 975	1	0	0	4.00
5. 00	Other recei vabl e	01,020,770		Ö	0	5. 00
6.00	Allowances for uncollectible notes and accounts receivable	0) c	0	0	6. 00
7.00	Inventory	5, 100, 000) c	0	0	7. 00
8.00	Prepai d expenses	0		0	0	8. 00
9. 00 10. 00	Other current assets Due from other funds	6, 837, 303) C	0	0	9. 00 10. 00
11. 00	Total current assets (sum of lines 1-10)	113, 822, 107			0	11.00
11.00	FIXED ASSETS	110,022,107		<u> </u>		11.00
12.00	Land	9, 491, 736	C	0	0	12. 00
13. 00	Land improvements	6, 201, 855	1	-	0	13. 00
14. 00	Accumulated depreciation	000 101 010		0	0	14.00
15. 00 16. 00	Buildings Accumulated depreciation	322, 104, 842 -194, 421, 450	1	0	0	15. 00 16. 00
17. 00	Leasehold improvements	-194, 421, 430		0	0	17. 00
18. 00	Accumulated depreciation	O		0	0	18. 00
19. 00	Fi xed equipment	0) c	0	0	19. 00
20. 00	Accumulated depreciation	0) c	0	0	20. 00
21. 00	Automobiles and trucks	0	0	0	0	21.00
22. 00 23. 00	Accumulated depreciation Major movable equipment	153, 016, 114) (0	0	22. 00 23. 00
24. 00	Accumul ated depreciation	155, 016, 114		0	0	24.00
25. 00	Mi nor equipment depreciable	Ö		Ö	Ö	25. 00
26.00	Accumulated depreciation	O) c	0	0	26. 00
27. 00	HIT designated Assets	0) c	0	0	27. 00
28. 00	Accumulated depreciation	0	0	0	0	28. 00
29. 00 30. 00	Minor equipment-nondepreciable Total fixed assets (sum of lines 12-29)	296, 393, 097) C	-	0	29. 00 30. 00
30.00	OTHER ASSETS	290, 393, 097	1	U U	U	30.00
31. 00	Investments	7, 103, 662	2 C	0	0	31.00
32.00	Deposits on Leases	0) c	0	0	32. 00
33. 00	Due from owners/officers	0) c	0	0	33. 00
34. 00	Other assets	6, 355, 126	1	-	0	34.00
35. 00 36. 00	Total other assets (sum of lines 31-34) Total assets (sum of lines 11, 30, and 35)	13, 458, 788 423, 673, 992			0	35. 00 36. 00
30.00	CURRENT LIABILITIES	423, 073, 772		ı o	0	30.00
37.00	Accounts payable	13, 441, 118	3 0	0	0	37. 00
38. 00	Salaries, wages, and fees payable	6, 264, 766	o c	0	0	38. 00
39. 00	Payroll taxes payable	0) C	0	0	39. 00
40. 00 41. 00	Notes and Loans payable (short term) Deferred income	0		0	0	40. 00 41. 00
41.00	Accel erated payments	0		U	0	42.00
43. 00	Due to other funds	311, 430	ol c	0	0	43. 00
44.00	Other current liabilities	1, 237, 667		0	0	
45. 00	Total current liabilities (sum of lines 37 thru 44)	21, 254, 981	C	0	0	45. 00
47.00	LONG TERM LIABILITIES		\			1 47 00
46. 00 47. 00	Mortgage payable Notes payable	0		-	0	46. 00 47. 00
48. 00	Unsecured Loans	0			0	48.00
49. 00	Other long term liabilities	-11, 727, 887	1	-	0	49. 00
50.00	Total long term liabilities (sum of lines 46 thru 49)	-11, 727, 887	r c	0	0	50. 00
51. 00	Total liabilities (sum of lines 45 and 50)	9, 527, 094	l c	0	0	51.00
F0 00	CAPI TAL ACCOUNTS	44.4.4.4.000	<u></u>	T		
52. 00 53. 00	General fund balance Specific purpose fund	414, 146, 898	3			52. 00 53. 00
54. 00	Donor created - endowment fund balance - restricted			0		54.00
55. 00	Donor created - endowment fund balance - unrestricted			0		55. 00
56.00	Governing body created - endowment fund balance			0		56. 00
57. 00	Plant fund balance - invested in plant				0	57. 00
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
59. 00	replacement, and expansion Total fund balances (sum of lines 52 thru 58)	414, 146, 898	3	0	0	59. 00
60.00	Total liabilities and fund balances (sum of lines 51 and	423, 673, 992		ol	0	60.00
	59)					

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

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-0015
Period:
From 01/01/2022
To 12/31/2022
Date/Time Prepared:
4/13/2023 4: 18 pm

General Fund Special Purpose Fund Endowment Fund

					10 12/31/2022	4/13/2023 4:1	
		General	Fund	Speci al	Purpose Fund	Endowment Fund	
		1.00	2. 00	3.00	4. 00	5. 00	
1.00	Fund balances at beginning of period		391, 508, 157		(1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)		22, 620, 751				2. 00
3.00	Total (sum of line 1 and line 2)		414, 128, 908		(3. 00
4.00	FUND BALANCE ADJUSTMENT	17, 990			0	0	4. 00
5.00		0			0	0	5. 00
6.00		0			0	0	6. 00
7.00		o			0	0	7. 00
8.00		o			0	0	8. 00
9.00		o			0	0	9. 00
10.00	Total additions (sum of line 4-9)		17, 990		(10. 00
11.00	Subtotal (line 3 plus line 10)		414, 146, 898				11. 00
12.00	Deductions (debit adjustments) (specify)	o			0	0	12.00
13.00	, , , , , , , , , , , , , , , , , , ,	o			0	0	13.00
14. 00		o			0	0	
15. 00		o			0	0	
16. 00		o			0	0	16.00
17. 00		l ol			0	0	
18. 00	Total deductions (sum of lines 12-17)		0				18. 00
19. 00	Fund balance at end of period per balance		414, 146, 898				19. 00
	sheet (line 11 minus line 18)		,,				
		Endowment Fund	PI ant	Fund		•	
		6.00	7. 00	8. 00			
1.00	Fund balances at beginning of period	0			0		1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2. 00
3.00	Total (sum of line 1 and line 2)	0			0		3. 00
4.00	FUND BALANCE ADJUSTMENT		0				4. 00
5.00			0				5. 00
6.00			0				6. 00
7.00			0				7. 00
8.00			0				8. 00
9.00			0				9. 00
10.00	Total additions (sum of line 4-9)	0			0		10. 00
11. 00	Subtotal (line 3 plus line 10)	0			0		11. 00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15. 00			0				15. 00
16. 00			0				16. 00
17.00			0				17. 00
18.00	Total deductions (sum of lines 12-17)	0			0		18. 00
19.00	Fund balance at end of period per balance	0			0		19. 00
	chect (line 11 minus line 10)	1					
	sheet (line 11 minus line 18)						

Health Financial Systems FRAN STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provi der CCN: 15-0015

		10	0 12/31/2022	Date/Time Pre 4/13/2023 4:1	
	Cost Center Description	I npati ent	Outpati ent	Total	J
		1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospi tal	74, 668, 894		74, 668, 894	1.00
2.00	SUBPROVI DER - I PF	5, 169, 917		5, 169, 917	2.00
3.00	SUBPROVI DER - I RF	0		0	3. 00
4.00	SUBPROVI DER				4. 00
5.00	Swing bed - SNF	0		0	5. 00
6.00	Swing bed - NF	0		0	6. 00
7.00	SKILLED NURSING FACILITY	0		0	7. 00
8.00	NURSING FACILITY	0		0	8. 00
9.00	OTHER LONG TERM CARE	0		0	9. 00
10.00	Total general inpatient care services (sum of lines 1-9)	79, 838, 811		79, 838, 811	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	14, 196, 770		14, 196, 770	11. 00
12.00	CORONARY CARE UNIT	0		0	12. 00
13.00	BURN INTENSIVE CARE UNIT	0		0	13. 00
14.00	SURGI CAL INTENSIVE CARE UNIT	0		0	14. 00
15.00	OTHER SPECIAL CARE (SPECIFY)				15. 00
16.00	Total intensive care type inpatient hospital services (sum of lines	14, 196, 770		14, 196, 770	16. 00
	11-15)				
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	94, 035, 581		94, 035, 581	17. 00
18. 00	Ancillary services	239, 986, 177	629, 157, 374	869, 143, 551	18. 00
19. 00	Outpatient services	31, 206, 843	126, 694, 489	157, 901, 332	19. 00
	RURAL HEALTH CLINIC	0	0	0	
21. 00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	1	21. 00
22. 00	HOME HEALTH AGENCY		0	0	22. 00
23. 00		0	0	0	
24. 00	CMHC		0	0	24. 00
24. 10	CORF	0	0	0	
25. 00	AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	25. 00
26. 00	HOSPI CE	0	0	0	26. 00
27. 00	OTHER (SPECIFY)	0	0	0	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.	365, 228, 601	755, 851, 863	1, 121, 080, 464	28. 00
	G-3, line 1)				
00.00	PART II - OPERATING EXPENSES		050 740 047	ı	00.00
29. 00	Operating expenses (per Wkst. A, column 3, line 200)	E4 070	259, 712, 017		29. 00
30.00	BEACON JOINT VENTURE	51, 370			30.00
31.00		0			31.00
32. 00		0			32.00
33. 00		0			33.00
34. 00		0			34.00
35. 00	T-+-1	0	F1 070		35. 00
36.00	Total additions (sum of lines 30-35)		51, 370		36.00
37. 00 38. 00	DEDUCT (SPECIFY)	0			37. 00
		0			38. 00
39. 00					39.00
40.00		0			40.00
41. 00	Total deductions (our of Lines 27 44)	ا	^		41.00
42.00	Total deductions (sum of lines 37-41)	r	OEO 742 207		42.00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)	'	259, 763, 387		43. 00
	10 WKSt. 0-3, 11116 4)	l l		I	I

Heal th	Financial Systems FRAN	ICISCAN HEALTH MICHIGAN CITY	In lie	u of Form CMS-2	2552_10
	IENT OF REVENUES AND EXPENSES	Provi der CCN: 15-0015	Peri od: From 01/01/2022 To 12/31/2022	Worksheet G-3	
				4/13/2023 4:1	
			,	1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)			1, 121, 080, 464	
2.00	Less contractual allowances and discounts on patients' accounts			844, 355, 987 276, 724, 477	2. 00
3.00					
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)			259, 763, 387	
5.00	Net income from service to patients (line 3 mi		16, 961, 090	5. 00	
	OTHER I NCOME				
6.00	O Contributions, donations, bequests, etc				6. 00
7.00	Income from investments			-1, 556, 053	
8.00	Revenues from telephone and other miscellaneous communication services				8. 00
9.00					9. 00
10.00	00 Purchase discounts				10. 00
11. 00					11. 00
12.00	0 Parking lot receipts			0	1
13. 00	00 Revenue from laundry and linen service			0	1
14.00	00 Revenue from meals sold to employees and guests				14. 00
15. 00				0	
16. 00				0	1
17.00	Revenue from sale of drugs to other than patients			0	17. 00
18. 00	Revenue from sale of medical records and abstracts			0	18. 00
19. 00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19. 00
20.00				0	
21. 00	Rental of vending machines			0	21. 00
22. 00	Rental of hospital space			0	22. 00
23. 00	Governmental appropriations			0	23. 00
24.00	OTHER OPERATING REVENUE			5, 396, 493	24. 00
0.4 = 0				_	1

0 24.50

3, 840, 440 25. 00 20, 801, 530 26. 00

-1, 819, 221 27. 00 -1, 819, 221 28. 00 22, 620, 751 29. 00

24.50 COVID-19 PHE Funding
25.00 Total other income (sum of lines 6-24)
26.00 Total (line 5 plus line 25)
27.00 NON OPERATING REVENUE

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

Hool +h	Financial Cystems	MI CHI CANI CLTV	la li o	u of Form CMC (DEE2 10	
Health Financial Systems FRANCISCAN HEALTH M CALCULATION OF CAPITAL PAYMENT		Provider CCN: 15-0015	Peri od: From 01/01/2022 To 12/31/2022			
	Title XVIII Hospital				4/13/2023 4: 18 pm PPS	
	113					
				1.00		
	PART I - FULLY PROSPECTIVE METHOD					
	CAPI TAL FEDERAL AMOUNT					
1.00	Capital DRG other than outlier			1, 671, 466	1. 00	
1. 01	Model 4 BPCI Capital DRG other than outlier			0 721, 565	1. 01	
2.00	Capital DRG outlier payments				2.00	
2. 01 3. 00	Model 4 BPCI Capital DRG outlier payments Total inpatient days divided by number of days in the cost reporting period (see instructions)				2. 01 3. 00	
4. 00	Number of interns & residents (see instructions)	78. 43 0. 00				
5. 00	Indirect medical education percentage (see instructions)				5.00	
6. 00	Indirect medical education percentage (see instructions)				6. 00	
	1.01) (see instructions)		,			
7.00	Percentage of SSI recipient patient days to Medicare Part A p	0. 00	7. 00			
0.00	30) (see instructions)				8. 00	
8. 00 9. 00	Percentage of Medicaid patient days to total days (see instructions)					
10. 00	Sum of lines 7 and 8 Allowable disproportionate share percentage (see instructions)			0. 00 0. 00		
11. 00					11. 00	
12. 00					12. 00	
	The second of th			=, 0.10, 00.1		
				1. 00		
	PART II - PAYMENT UNDER REASONABLE COST	0				
1. 00	Program inpatient routine capital cost (see instructions)					
2.00	Program inpatient ancillary capital cost (see instructions)			0		
3.00	Total inpatient program capital cost (line 1 plus line 2)			0	3.00	
4. 00 5. 00	Capital cost payment factor (see instructions) Total inpatient program capital cost (line 3 x line 4)			0	4. 00 5. 00	
3.00	Total impatrent program capital cost (fine 3 x fine 4)			0	3.00	
				1. 00		
	PART III - COMPUTATION OF EXCEPTION PAYMENTS					
1.00	Program inpatient capital costs (see instructions)			0	1.00	
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)			0	2.00	
3. 00 4. 00	Net program inpatient capital costs (line 1 minus line 2)		0 0. 00	3. 00 4. 00		
5. 00	Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4)			0.00	5.00	
6. 00	Percentage adjustment for extraordinary circumstances (see instructions)			0.00		
7. 00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)			0.00		
8.00	Capital minimum payment level (line 5 plus line 7)			o	8. 00	
9.00	Current year capital payments (from Part I, line 12, as applicable)			0	9. 00	
10.00				0	10. 00	
11. 00					11. 00	
10.00	Worksheet L, Part III, line 14)			_ ا	10.00	
12.00				0	12.00	
13. 00 14. 00				0	13. 00 14. 00	
14.00	(if line 12 is negative, enter the amount on this line)				14.00	
15. 00				0	15. 00	
	Current year operating and capital costs (see instructions)			0	16. 00	
	Current year exception offset amount (see instructions)			0	17. 00	