PART II - CERTIFICATION

(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 OF 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 the Balance Sheet and Statement of Revenue and Expenses prepared by FRANCISCAN HEALTH MICHIGAN CITY (15-0015) for the cost reporting period beginning 01/01/2020 and ending 12/31/2020 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.

]I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my original signature.

(Si aned)

Officer or Administrator of Provider(s)

Time:

number of times reopened = 0-9.

7:41 pm

Δ

Title

Date

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	4, 111	-24, 321	0	0	1.00
2.00	Subprovider - IPF	0	7, 843	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
8.00	NURSING FACILITY	0				0	8.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		0		0	10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
12.00	CMHC I	0		0		0	12.00
200.00	Total	0	11, 954	-24, 321	0	0	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. lf vou 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.

	X IDENTIFICATION DATA	Provio	der CCN: 1	5-0015	Period: From 01/01/2 To 12/31/2	2020 2020	Workshe Part I Date/Ti 7/28/20	me Pre	epare
1.00	2.00		3.00		4	. 00			
Hospital and Hospital Health Care									
) Street: 3500 FRANCI SCAN WAY	PO Box:	7:	- 4/2/0	0	.				1.
O City: MICHIGAN CITY	State: IN		e: 46360	Coun		Dayma	at Curat		2.
	Component Name	CCN Number	CBSA Number	Provi der Type	- Date Certified		nt Syst 0, or		
		Number	Number	lighe		V 1,			-
	1.00	2.00	3.00	4.00	5.00	6. 00	7.00	8.00	-
Hospital and Hospital-Based Compor	1	2.00	3.00	4.00	5.00	0.00	7.00	0.00	
) Hospi tal	FRANCI SCAN HEALTH	150015	33140	1	07/01/1966	N	Р	0	3
	MI CHI GAN CI TY	130013	33140	'	0770171300	IN IN	'		
) Subprovider - IPF	FRANCI SCAN HEALTH	15S015	33140	4	01/01/1998	Ν	Р	0	4
	MI CHI GAN CI TY	100010	00110				.		'
) Subprovider - IRF									5
Subprovider - (Other)									6
Swing Beds - SNF									7
) Swing Beds - NF									8
Hospital-Based SNF									9
00 Hospital-Based NF									10
0 Hospi tal -Based OLTC									11
0 Hospital-Based HHA									12
0 Separately Certified ASC									13
0 Hospi tal -Based Hospi ce									14
0 Hospital-Based Health Clinic - RHC	:	1							15
0 Hospital-Based Health Clinic - FQH								1	16
0 Hospital-Based (CMHC) I									17
0 Hospital-Based (CORF) I									17
0 Renal Dialysis								1	18
00 Other		1							19
					From:		То	:	
					1.00		2.0		
00 Cost Reporting Period (mm/dd/yyyy)					01/01/20	020	12/31/	2020	20
00 Type of Control (see instructions)					1				21
				1.00	2.00		3.0	00	
Inpatient PPS Information									
									-
51 5				Y	N				22
disproportionate share hospital ad	ljustment, in accordance v	ıı́th 42 CFI		Y	N				22
disproportionate share hospital ac §412.106? In column 1, enter "Y"	ljustment, in accordance v for yes or "N" for no. Is	vith 42 CFI 5 this		Y	N				22
disproportionate share hospital ac §412.106? In column 1, enter "Y" facility subject to 42 CFR Sectior	ljustment, in accordance v for yes or "N" for no. Is §412.106(c)(2)(Pickle ar	vith 42 CFI 5 this		Y	N				22
disproportionate share hospital ac §412.106? In column 1, enter "Y" facility subject to 42 CFR Section hospital?) In column 2, enter "Y"	ljustment, in accordance v for yes or "N" for no. Is v§412.106(c)(2)(Pickle ar for yes or "N" for no.	vith 42 CFN this nendment	2						
disproportionate share hospital ac §412.106? In column 1, enter "Y" facility subject to 42 CFR Section hospital?) In column 2, enter "Y" 1 Did this hospital receive interim	ljustment, in accordance v for yes or "N" for no. Is § §412.106(c)(2)(Pickle ar for yes or "N" for no. uncompensated care paymer	vith 42 CFR this mendment its for thi	s	Y Y	N Y				
disproportionate share hospital ac §412.106? In column 1, enter "Y" facility subject to 42 CFR Section hospital?) In column 2, enter "Y" 1 Did this hospital receive interim cost reporting period? Enter in co	ljustment, in accordance v for yes or "N" for no. Is a §412.106(c)(2)(Pickle ar for yes or "N" for no. uncompensated care paymer olumn 1, "Y" for yes or "N	vith 42 CFF this mendment its for thi "for no t	s for						
disproportionate share hospital ac §412.106? In column 1, enter "Y" facility subject to 42 CFR Sectior hospital?) In column 2, enter "Y" 1 Did this hospital receive interim cost reporting period? Enter in cc the portion of the cost reporting	<pre>ij ustment, in accordance v for yes or "N" for no. Is 9 §412.106(c)(2)(Pickle ar for yes or "N" for no. uncompensated care paymer jumn 1, "Y" for yes or "N period occurring prior to</pre>	i th 42 CFI this hendment ts for thi "for no to October f	s for 1.						
 disproportionate share hospital ac §412.106? In column 1, enter "Y" facility subject to 42 CFR Section hospital?) In column 2, enter "Y" 1 Did this hospital receive interim cost reporting period? Enter in co the portion of the cost reporting Enter in column 2, "Y" for yes or 	<pre>ij ustment, in accordance v for yes or "N" for no. Is §412.106(c)(2)(Pickle ar for yes or "N" for no. uncompensated care paymer olumn 1, "Y" for yes or "N period occurring prior to "N" for no for the portic</pre>	ith 42 CFI this nendment its for thi "for no to October for on of the co	s for 1.						
 disproportionate share hospital ac §412.106? In column 1, enter "Y" facility subject to 42 CFR Section hospital?) In column 2, enter "Y" 10 d this hospital receive interim cost reporting period? Enter in co the portion of the cost reporting Enter in column 2, "Y" for yes or reporting period occurring on or a 	ljustment, in accordance v for yes or "N" for no. Is §412.106(c)(2)(Pickle ar for yes or "N" for no. uncompensated care paymer Jumn 1, "Y" for yes or "N period occurring prior to "N" for no for the portio fter October 1. (see inst	i th 42 CFI this nendment its for thi of for no to october on of the c ructions)	s for 1. cost	Y	Y				22
 disproportionate share hospital ac §412.106? In column 1, enter "Y" facility subject to 42 CFR Sectior hospital?) In column 2, enter "Y" 1 Did this hospital receive interim cost reporting period? Enter in cothe portion of the cost reporting Enter in column 2, "Y" for yes or reporting period occurring on or a 1s this a newly merged hospital th 	Ijustment, in accordance w for yes or "N" for no. Is 9 §412.106(c)(2)(Pickle an for yes or "N" for no. uncompensated care paymer olumn 1, "Y" for yes or "N period occurring prior to "N" for no for the portion fter October 1. (see insta nat requires final uncompe	i th 42 CFI this hendment for no thi 0 October on of the o cructions) ensated cal	s for 1. cost						22
<pre>disproportionate share hospital ac §412.106? In column 1, enter "Y" facility subject to 42 CFR Section hospital?) In column 2, enter "Y" 1 Did this hospital receive interim cost reporting period? Enter in co the portion of the cost reporting Enter in column 2, "Y" for yes or reporting period occurring on or a 2 Is this a newly merged hospital th payments to be determined at cost</pre>	ljustment, in accordance v for yes or "N" for no. Is a §412.106(c)(2)(Pickle ar for yes or "N" for no. uncompensated care paymer olumn 1, "Y" for yes or "N period occurring prior to "N" for no for the portion fter October 1. (see inst at requires final uncomper report settlement? (see i	i th 42 CFI s this mendment "for no thi 0 October on of the cructions) ensated can	s for 1. cost re ns)	Y	Y				22
 disproportionate share hospital ac §412.106? In column 1, enter "Y" facility subject to 42 CFR Sectior hospital?) In column 2, enter "Y" 1 Did this hospital receive interim cost reporting period? Enter in column 2, "Y" for yes or reporting period occurring on or a 2 Is this a newly merged hospital th payments to be determined at cost Enter in column 1, "Y" for yes or 	justment, in accordance w for yes or "N" for no. Is o §412.106(c)(2)(Pickle ar for yes or "N" for no. uncompensated care paymer olumn 1, "Y" for yes or "N period occurring prior to "N" for no for the portion at requires final uncompe report settlement? (see i "N" for no, for the porti	if th 42 CFI s this hendment its for this o October on of the o cructions) ensated can nstruction on of the	s for 1. cost re ns)	Y	Y				22
 disproportionate share hospital ac §412.106? In column 1, enter "Y" facility subject to 42 CFR Sectior hospital?) In column 2, enter "Y" 11 Did this hospital receive interim cost reporting period? Enter in column 2, "Y" for yes or reporting period occurring on or at 1s this a newly merged hospital the payments to be determined at cost Enter in column 1, "Y" for yes or cost reporting period prior to Octa 	justment, in accordance w for yes or "N" for no. Is a §412.106(c)(2)(Pickle ar for yes or "N" for no. uncompensated care paymer Jumn 1, "Y" for yes or "N period occurring prior to "N" for no for the portion fter October 1. (see inst at requires final uncompo report settlement? (see i "N" for no, for the portion ober 1. Enter in column 2	i th 42 CFI this hendment ts for this o October on of the o ructions) ensated cal nstruction on of the c, "Y" for	s for 1. cost re ns) yes	Y	Y				22
 disproportionate share hospital ac §412.106? In column 1, enter "Y" facility subject to 42 CFR Sectior hospital?) In column 2, enter "Y" 1 Did this hospital receive interim cost reporting period? Enter in column 2, "Y" for yes or reporting period occurring on or a 2 Is this a newly merged hospital th payments to be determined at cost Enter in column 1, "Y" for yes or cost reporting period prior to Octor "N" for no, for the portion of 	justment, in accordance w for yes or "N" for no. Is a §412.106(c)(2)(Pickle ar for yes or "N" for no. uncompensated care paymer Jumn 1, "Y" for yes or "N period occurring prior to "N" for no for the portion fter October 1. (see inst at requires final uncompo report settlement? (see i "N" for no, for the portion ober 1. Enter in column 2	i th 42 CFI this hendment ts for this o October on of the o ructions) ensated cal nstruction on of the c, "Y" for	s for 1. cost re ns) yes	Y	Y				22
 disproportionate share hospital ac §412.106? In column 1, enter "Y" facility subject to 42 CFR Sectior hospital?) In column 2, enter "Y" 1 Did this hospital receive interim cost reporting period? Enter in column 2, "Y" for yes or reporting period occurring on or a 2 Is this a newly merged hospital th payments to be determined at cost Enter in column 1, "Y" for yes or cost reporting period prior to Oct or "N" for no, for the portion of of the portion of of the portion of of the portion of the portion of of the portion of of the portion of the portion of the cost reporting period occurring on or a 	ij ustment, in accordance w for yes or "N" for no. Is \$412.106(c)(2)(Pickle ar for yes or "N" for no. uncompensated care paymer olumn 1, "Y" for yes or "N period occurring prior to "N" for no for the portion (fter October 1. (see inst at requires final uncomper report settlement? (see i "N" for no, for the portion ober 1. Enter in column 2 the cost reporting perior	i th 42 CFI this hendment ts for thi o October on of the or ructions) insated can nstruction on of the c, "Y" for I on or af	s for 1. cost re ns) yes ter	YN	Y		Ν		22
 disproportionate share hospital ac §412.106? In column 1, enter "Y" facility subject to 42 CFR Sectior hospital?) In column 2, enter "Y" 1 Did this hospital receive interim cost reporting period? Enter in column 2, "Y" for yes or reporting period occurring on or a? 2 Is this a newly merged hospital the payments to be determined at cost Enter in column 1, "Y" for yes or cost reporting period prior to Octoor "N" for no, for the portion of the portion of 2.3 Did this hospital receive a geogramical the portion of the cost reporting period prior to Octooter 1. 	ij ustment, in accordance w for yes or "N" for no. Is a §412.106(c)(2)(Pickle ar for yes or "N" for no. uncompensated care paymer olumn 1, "Y" for yes or "N period occurring prior to "N" for no for the portio (fter October 1. (see inst iat requires final uncomper report settlement? (see i "N" for no, for the portio ober 1. Enter in column 2 the cost reporting period	if th 42 CFI this this lendment ts for thi o October on of the o nsated can nstruction on of the c, "Y" for I on or aff m urban to	s for 1. cost re ns) yes ter	Y	Y		N		22
 disproportionate share hospital ac §412.106? In column 1, enter "Y" facility subject to 42 CFR Section hospital?) In column 2, enter "Y" 1 Did this hospital receive interim cost reporting period? Enter in column 2, "Y" for yes or reporting period occurring on or a? 2 Is this a newly merged hospital the payments to be determined at cost Enter in column 1, "Y" for yes or cost reporting period prior to 0ct or "N" for no, for the portion of the portion of the payments. 3 Did this hospital receive a geograrural as a result of the OMB stance. 	ij ustment, in accordance w for yes or "N" for no. Is §412.106(c)(2)(Pickle ar for yes or "N" for no. uncompensated care paymer olumn 1, "Y" for yes or "N period occurring prior to "N" for no for the portion fter October 1. (see inst at requires final uncompere report settlement? (see "N" for no, for the portion ober 1. Enter in column 2 the cost reporting period phic reclassification fro lards for delineating stat	if th 42 CFI s this hendment its for thi o October on of the o insated can instruction on of the 2, "Y" for I on or af- om urban to istical an	s for 1. cost re ns) yes ter peas	YN	Y		Ν		22
 disproportionate share hospital ac §412.106? In column 1, enter "Y" facility subject to 42 CFR Sectior hospital?) In column 2, enter "Y" 1 Did this hospital receive interim cost reporting period? Enter in column 2, "Y" for yes or reporting period occurring on or a? Is this a newly merged hospital the payments to be determined at cost Enter in column 1, "Y" for yes or cost reporting period prior to Octoor "N" for no, for the portion of the solution of the aceive a geograrural as a result of the OMB standard by CMS in FY2015? Enter in column 1, "Y" for the portion of the solution of the cost reporting period prior to octoor "N" for no, for the portion of the solution of the cost reporting the portion of the cost reporting the period prior to octoor "N" for no, for the portion of the portion of the cost reporting the portion of the cost reporting the period prior to octoor "N" for no, for the portion of the portion of the cost reporting the portion of the cost reporting the period prior to prior to period the portion of the portion period prior to period prior to port the portion of the portion of the portion of the portion of the portion period perio	ij ustment, in accordance w for yes or "N" for no. Is §412.106(c)(2)(Pickle ar for yes or "N" for no. uncompensated care paymer olumn 1, "Y" for yes or "N period occurring prior to "N" for no for the portion at requires final uncompe- report settlement? (see in "N" for no, for the portion ober 1. Enter in column 2 the cost reporting period phic reclassification fro lards for delineating state column 1, "Y" for yes on	if th 42 CFI s this hendment its for thi o October on of the o cructions) ensated can nstruction on of the c, "Y" for l on or af m urban to istical an "N" for i	s for 1. cost re ns) yes ter p reas	YN	Y		Ν		22
 disproportionate share hospital ac §412.106? In column 1, enter "Y" facility subject to 42 CFR Sectior hospital?) In column 2, enter "Y" 1 Did this hospital receive interim cost reporting period? Enter in column 2, "Y" for yes or reporting period occurring on or a 2 Is this a newly merged hospital th payments to be determined at cost Enter in column 1, "Y" for yes or cost reporting period prior to 0ct or "N" for no, for the portion of 0ctober 1. 3 Did this hospital receive a geograrural as a result of the OMB standadopted by CMS in FY2015? Enter in for the portion of the cost report 	justment, in accordance w for yes or "N" for no. Is §412.106(c)(2)(Pickle ar for yes or "N" for no. uncompensated care paymer Jumn 1, "Y" for yes or "N period occurring prior to "N" for no for the portio fter October 1. (see inst at requires final uncompe report settlement? (see i "N" for no, for the portio ober 1. Enter in column 2 the cost reporting period phic reclassification fro lards for delineating stat o column 1, "Y" for yes or ing period prior to Octob	if th 42 CFI this hendment ts for this o October on of the o ructions) ensated can nstruction on of the c, "Y" for I on or aff om urban to istical an c "N" for i per 1. Enter on on the or of the control o	s for 1. cost re ns) yes ter p reas	YN	Y		Ν		22
 disproportionate share hospital ac §412.106? In column 1, enter "Y" facility subject to 42 CFR Sectior hospital?) In column 2, enter "Y" 1 Did this hospital receive interim cost reporting period? Enter in column 2, "Y" for yes or reporting period occurring on or at 1s this a newly merged hospital the payments to be determined at cost Enter in column 1, "Y" for yes or cost reporting period prior to 0c1 or "N" for no, for the portion of the cost reportion of Did this hospital receive a geograrural as a result of the OMB standadopted by CMS in FY2015? Enter in for the portion of the cost reporting in column 2, "Y" for yes or "N" for the portion of the cost reporting for the portion for the portion	justment, in accordance w for yes or "N" for no. Is \$412.106(c)(2)(Pickle ar for yes or "N" for no. uncompensated care paymer olumn 1, "Y" for yes or "N period occurring prior to "N" for no for the portion for October 1. (see inst int requires final uncomper report settlement? (see i "N" for no, for the portion ober 1. Enter in column 2 the cost reporting period phic reclassification from and for delineating stat i column 1, "Y" for yes of ing period prior to Octob pro for the portion of the portion of the portion of the portion of the portion of the portion of the portion of the portion of the portion of the portion of the portion of the portion of the portion of the portion of the portion of the portion of the portion of the port	i th 42 CFI this hendment ts for this o October on of the o ructions) instruction on of the c, "Y" for I on or aff m urban to ""N" for i per 1. Ento the cost	s for 1. cost re ns) yes ter p reas	YN	Y		Ν		22
 disproportionate share hospital ac §412.106? In column 1, enter "Y" facility subject to 42 CFR Section hospital?) In column 2, enter "Y" 1 Did this hospital receive interim cost reporting period? Enter in column 2, "Y" for yes or reporting period occurring on or at 1s this a newly merged hospital the payments to be determined at cost Enter in column 1, "Y" for yes or cost reporting period prior to 0ct or "N" for no, for the portion of 0ctober 1. 3 Did this hospital receive a geogra rural as a result of the OMB standadopted by CMS in FY2015? Enter in for the portion of the cost reporting period occurring on or a port of the portion of the cost reporting the portion of 0 to the portion of the cost reporting the portion of 0 to the none in "Y" for yes or cost reporting period prior to 0 to no "N" for no, for the portion of 0 to the none in column 2, "Y" for yes or cost reporting to the cost reporting the portion of the cost reporting period prior to 0 to no "N" for no, for the portion of 0 to the portion of the cost reporting the portion of the cost reporting period prior to 0.0 to the portion of the cost reporting period occurring on or a portion period occurring on or a portion period occurring on or a period occurring on period occurring occurring occurring period occurring occurring period occurring occurring period perio	justment, in accordance w for yes or "N" for no. Is \$412.106(c)(2)(Pickle ar for yes or "N" for no. uncompensated care paymer olumn 1, "Y" for yes or "N period occurring prior to "N" for no for the portio fat requires final uncomper report settlement? (see in "N" for no, for the portio ober 1. Enter in column 2 the cost reporting period phic reclassification fro lards for delineating stat o column 1, "Y" for yes or ing period prior to Octob r no for the portion of 1 fiter October 1. (see inst	if th 42 CFI this this lendment ts for thi o October o October rructions) insated can nstruction on of the c, "Y" for I on or aff m urban to istical an c "N" for i wher 1. Ento the cost rructions)	s for 1. cost re ns) yes ter p reas no er	YN	Y		Ν		22
 disproportionate share hospital ac §412.106? In column 1, enter "Y" facility subject to 42 CFR Section hospital?) In column 2, enter "Y" Did this hospital receive interim cost reporting period? Enter in column 2, "Y" for yes or reporting period occurring on or at 15 this a newly merged hospital the payments to be determined at cost Enter in column 1, "Y" for yes or cost reporting period prior to 0ct or "N" for no, for the portion of the cost reportion of 0ctober 1. Did this hospital receive a geogra rural as a result of the 0MB standadopted by CMS in FY2015? Enter in for the portion of the cost reporting period occurring on or a 20 period period period the portion of the cost reporting period period period period by CMS in FY2015? Enter in for the portion of the cost reporting period occurring on or a 20 period period occurring on a 20 period occurring	justment, in accordance w for yes or "N" for no. Is \$412.106(c)(2)(Pickle ar for yes or "N" for no. uncompensated care paymer olumn 1, "Y" for yes or "N period occurring prior to "N" for no for the portion fter October 1. (see insti- tat requires final uncomper- report settlement? (see "N" for no, for the portion ober 1. Enter in column 2 the cost reporting period phic reclassification from lards for delineating station of the portion of the portion for the portion of the period prior to October ing period prior to October fter October 1. (see insti- t 100 but not more than 4	i th 42 CFI this this this this to for no to ctober o october o october on of the cructions) on of the the cost "N" for the cost "N" for the cost ructions) 99 beds (a	s for 1. cost re ns) yes ter preas no er	YN	Y		Ν		22
 disproportionate share hospital ac §412.106? In column 1, enter "Y" facility subject to 42 CFR Section hospital?) In column 2, enter "Y" 1 Did this hospital receive interim cost reporting period? Enter in column 2, "Y" for yes or reporting period occurring on or a? 2 Is this a newly merged hospital th payments to be determined at cost Enter in column 1, "Y" for yes or cost reporting period prior to 0ct or "N" for no, for the portion of the cost reportion of the cost reporting for the portion of the portion of the portion of the cost reporting period prior to 0ct or "N" for no, for the portion of 0ctober 1. 3 Did this hospital receive a geogra rural as a result of the OMB stand adopted by CMS in FY2015? Enter in for the portion of the cost reporting period occurring on or a 20 Does this hospital contain at leas counted in accordance with 42 CFR 	justment, in accordance w for yes or "N" for no. Is \$412.106(c)(2)(Pickle ar for yes or "N" for no. uncompensated care paymer olumn 1, "Y" for yes or "N period occurring prior to "N" for no for the portion fter October 1. (see insti- tat requires final uncomper- report settlement? (see "N" for no, for the portion ober 1. Enter in column 2 the cost reporting period phic reclassification from lards for delineating station of the portion of the portion for the portion of the period prior to October ing period prior to October fter October 1. (see insti- t 100 but not more than 4	i th 42 CFI this this this this to for no to ctober o october o october on of the cructions) on of the the cost "N" for the cost "N" for the cost ructions) 99 beds (a	s for 1. cost re ns) yes ter preas no er	YN	Y		Ν		22
 disproportionate share hospital ac §412.106? In column 1, enter "Y" facility subject to 42 CFR Sectior hospital?) In column 2, enter "Y" 1 Did this hospital receive interim cost reporting period? Enter in column 2, "Y" for yes or reporting period occurring on or at 1s this a newly merged hospital th payments to be determined at cost Enter in column 1, "Y" for yes or cost reporting period prior to 0ct or "N" for no, for the portion of the cost reportion of 0ctober 1. 3 Did this hospital receive a geogra rural as a result of the OMB standadopted by CMS in FY2015? Enter in for the portion of the cost reporting period occurring on a count 2, "Y" for yes or "N" for no, for the cost reporting count 1, "Y" for yes or "N" for the portion of the cost reporting count 2, "Y" for yes or "N" for yes or "N"	justment, in accordance w for yes or "N" for no. Is of 12.106(c)(2)(Pickle ar for yes or "N" for no. uncompensated care paymer olumn 1, "Y" for yes or "N period occurring prior to "N" for no for the portion fter October 1. (see inst at requires final uncompe- tat requires final uncompo- ter 1. Enter in column 2 the cost reporting period phic reclassification fro lards for delineating stat column 1, "Y" for yes of ing period prior to Octob r no for the portion of the fter October 1. (see inst ist 100 but not more than 4 412.105)? Enter in column	if th 42 CFI s this hendment its for this o October on of the o cructions) insated cal nstruction on of the c, "Y" for l on or aff m urban to istical an "N" for n her 1. Ento the cost cructions) .99 beds (a 0.3, "Y" for	s for 1. cost re ns) yes ter preas no er	YN	YN		Ν		22
 disproportionate share hospital ac §412.106? In column 1, enter "Y" facility subject to 42 CFR Sectior hospital?) In column 2, enter "Y" Did this hospital receive interim cost reporting period? Enter in column 2, "Y" for yes or reporting period occurring on or a 1s this a newly merged hospital th payments to be determined at cost Enter in column 1, "Y" for yes or cost reporting period prior to 0ct or "N" for no, for the portion of the cost reportion of 0ctober 1. Did this hospital receive a geogra rural as a result of the OMB stand adopted by CMS in FY2015? Enter in for the portion of the cost reporting period occurring on or a boes this hospital contain at leas counted in accordance with 42 CFR yes or "N" for no. Which method is used to determine 	justment, in accordance w for yes or "N" for no. Is \$412.106(c)(2)(Pickle ar for yes or "N" for no. uncompensated care paymer olumn 1, "Y" for yes or "N period occurring prior to "N" for no for the portion for october 1. (see inst the cost report in al uncompo- tere ort settlement? (see i "N" for no, for the portion ober 1. Enter in column 2 the cost reporting period phic reclassification fro lards for delineating stat oclumn 1, "Y" for yes of ing period prior to Octob or no for the portion of 1 for october 1. (see inst it 100 but not more than 4 412.105)? Enter in column Medicaid days on lines 24	if th 42 CFI this hendment ts for this o October on of the o ructions) ensated can nstruction on of the c, "Y" for I on or aff om urban to istical and "N" for in the cost ructions) 99 beds (a 1 and/or 25	s for 1. cost re ns) yes ter por ceas no er	YN	Y		Ν		22
 disproportionate share hospital ac §412.106? In column 1, enter "Y" facility subject to 42 CFR Section hospital?) In column 2, enter "Y" Did this hospital receive interim cost reporting period? Enter in column 2, "Y" for yes or reporting period occurring on or at 1s this a newly merged hospital the payments to be determined at cost Enter in column 1, "Y" for yes or cost reporting period prior to 0ct oor "N" for no, for the portion of the cost reportion of 0ctober 1. Did this hospital receive a geogra rural as a result of the 0MB stand adopted by CMS in FY2015? Enter in for the portion of the cost reporting period occurring on or a Does this hospital contain at leas counted in accordance with 42 CFR yes or "N" for no. Which method is used to determine 	ij ustment, in accordance v for yes or "N" for no. Is \$412.106(c)(2)(Pickle ar for yes or "N" for no. uncompensated care paymer olumn 1, "Y" for yes or "N period occurring prior to "N" for no for the portio fter October 1. (see inst iat requires final uncomper report settlement? (see i "N" for no, for the portio ober 1. Enter in column 2 the cost reporting period phic reclassification fro lards for delineating stat o column 1, "Y" for yes or ing period prior to Octob r no for the portion of 1 fter October 1. (see inst ifter October 1. (see inst to 100 but not more than 4 412.105)? Enter in column Medicaid days on lines 24 e of admission, 2 if cens	i th 42 CFI this this lendment ts for thi o October o October rructions) insated can nstruction on of the c, "Y" for I on or aff m urban to istical an "N" for i er 1. Ento he cost rructions) 199 beds (a a, "Y" for and/or 25 sus days, of the cost tructions)	s for 1. cost re ns) yes ter o reas no er as or as or 35 or 3	YN	YN		Ν		22 22 22 22 22 22 22 22
 disproportionate share hospital ac §412.106? In column 1, enter "Y" facility subject to 42 CFR Sectior hospital?) In column 2, enter "Y" 11 Did this hospital receive interim cost reporting period? Enter in column 2, "Y" for yes or reporting period occurring on or at payments to be determined at cost Enter in column 1, "Y" for yes or cost reporting period prior to 0ct or "N" for no, for the portion of the cost reportion of 0ctober 1. 13 Did this hospital receive a geogra rural as a result of the OMB standadopted by CMS in FY2015? Enter in for the portion of the cost reporting period occurring on or a Does this hospital contain at leas counted in accordance with 42 CFR yes or "N" for no. 10 Which method is used to determine 	justment, in accordance w for yes or "N" for no. Is §412.106(c)(2)(Pickle ar for yes or "N" for no. uncompensated care paymer olumn 1, "Y" for yes or "N period occurring prior to "N" for no for the portion fter October 1. (see inst report settlement? (see i "N" for no, for the portion ober 1. Enter in column 2 the cost reporting period the cost reporting period priod prior to Octobe ands for delineating stat of no for the portion of the period prior to Octobe the cost reporting period the cost reporting period ands for delineating stat of no for the portion of the fter October 1. (see inst t 100 but not more than 4 412.105)? Enter in column Medicaid days on lines 24 e of admission, 2 if cent of identifying the days	i th 42 CFI this this hendment ts for thi o October o October on of the cructions) instruction on of the cruction or aff on urban to istical and or N" for the cost ructions) 199 beds (a a, "Y" for and/or 25 us days, (a in this of in and/or 25 us days, (a) in this of in this of in this of in this of in this of in this of istical and/or 25 istical and/or 25 ist	s for 1. cost re ns) yes ter o reas no er as or as or 35 or 3	YN	YN		Ν		22

USPIT	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	ATA I	Provider CC	N: 15-0015	Period: From 01/	01/2020	Worksh Part I	eet S-2	2
					To 12/	31/2020	Date/1 7/28/2	021 7:4	
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medi cai d el i gi bl e unpai d	Medi ca HMO da	ays Me)ther di cai d days	
	1	1.00	2.00	3.00	4.00	5.00		6.00	
4.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	96	5	D 4,	0	100) 24. (
						'Rural S	-		_
6. 00	Enter your standard geographic classification (not wa	ade) status	at the beg	innina of t		. 00	2.	00	26.0
7. 00 5. 00	cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not wa reporting period. Enter in column 1, "1" for urban or enter the effective date of the geographic reclassifi If this is a sole community hospital (SCH), enter the	r rural. age) status r "2" for r ication in d	at the end ural. If ap column 2.	of the cos plicable,	t	2			27. (
5. 00	effect in the cost reporting period.					nni ng:	End	i ng:	35.
b. 00	Enter applicable beginning and ending dates of SCH st	tatus. Subs	cript line	36 for numb		. 00	2.	00	36.
. 00	of periods in excess of one and enter subsequent date If this is a Medicare dependent hospital (MDH), enter		r of period	s MDH statu	s	0			37.
7. 01	is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for th accordance with FY 2016 OPPS final rule? Enter "Y" fo instructions)								37.
8. 00	If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates.					(/h)		(81	38.
						<u>//N</u> . 00		/N 00	-
9. 00	Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet t accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii or "N" for no. (see instructions)), (İi), or the mileage ii)? Enter	(iii)? Ent requiremen in column 2	er in colum ts in "Y" for ye	in is	N		N	39.
0. 00	Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1.	per 1. Ente	r "Y" for y			N		N	40.
						V	XVIII 2.00		-
	Prospective Payment System (PPS)-Capital								
5. 00 5. 00	Does this facility qualify and receive Capital paymer with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exce pursuant to 42 CFR §412.348(f)? If yes, complete Wks1	eption for	extraordi na	ry circumst	ances	N	N	N N	45. 46.
7.00 3.00	Pt. III. Is this a new hospital under 42 CFR §412.300(b) PPS of Is the facility electing full federal capital payment					N	N N	N N	47. 48.
	Teaching Hospitals Is this a hospital involved in training residents in "N" for no in column 1. If column 1 is "Y", are you i GME payment reduction? Enter "Y" for yes or "N" for	impacted by	CR 11642 (2				56.
. 00	If line 56 is yes, is this the first cost reporting p	period duri	ng which re		lf column				57.
	GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "N	th of this Y", complet	cost report e Worksheet	ing period?					
5. 00 7. 00 3. 00	GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont	th of this Y", complete I, if applic pursement fo	cost report e Worksheet cable. or physicia	ing period? E-4. If cc	lumn 2 is				58.

			I MICHIGAN CITY			eu of Form CMS-2	
HUSPII	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	IA	Provider CO		eriod: rom 01/01/2020 o 12/31/2020	Date/Time Pre	pared:
				NAHE 413.85	Worksheet A	7/28/2021 7:4 Pass-Through	1 pm
				Y/N	Line #	Qualification Criterion Code	
				1.00	2.00	3.00	
60.00	Are you claiming nursing and allied health education any programs that meet the criteria under 42 CFR 413. instructions) Enter "Y" for yes or "N" for no in col is "Y", are you impacted by CR 11642 (or subsequent C	85? (s umn 1.	see If column 1	N			60.00
	adjustement? Enter "Y" for yes or "N" for no in colu		I ME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see						61.01
61. 02	instructions) Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of						61.02
61. 03	ACA). (see instructions) Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see						61.03
61.04	instructions) Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the						61.04
61.05	current cost reporting period. (see instructions). Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line						61.05
61.06	61.04 minus line 61.03). (see instructions) Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
		Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
(1.10			1.00	2.00	3.00	4.00	(1.10
	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Of the FTEs in line 61.05, specify each expanded				0.00		61. 10
	program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.						
						1.00	
62.00	ACA Provisions Affecting the Health Resources and Ser Enter the number of FTE residents that your hospital	trai neo			od for which		62.00
62. 01	your hospital received HRSA PCRE funding (see instruc Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC prog	Teachi Iram. (s	<u>see instructio</u>		your hospital	0.00	62.01
63.00	Teaching Hospitals that Claim Residents in Nonprovide Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, comple	ettings	during this co			N	63.00
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
	Section 5504 of the ACA Base Year FTE Residents in No			1.00 This base year	2.00 is your cost r	3.00 reporting	
64.00	period that begins on or after July 1, 2009 and befor Enter in column 1, if line 63 is yes, or your facilit in the base year period, the number of unweighted non resident FTEs attributable to rotations occurring in settings. Enter in column 2 the number of unweighted resident FTEs that trained in your hospital. Enter in of (column 1 divided by (column 1 + column 2)). (see	y trair i-primar all nor l non-pr i columr	ned residents ry care nprovider rimary care n 3 the ratio	0.00	0.00	0. 000000	64.00

	EX IDENTIFICATION DA	ATA Provi der		eriod:	Worksheet S-2	2
			F T	rom 01/01/2020 o 12/31/2020	Date/Time Pre	epared:
	Program Name	Program Code	Unweighted	Unweighted	7/28/2021 7:4 Ratio (col. 3	
	i i ogi alli Mallic		FTEs	FTEs in	(col . 3 + col .)	
			Nonprovi der	Hospi tal	(4))	
			Si te			
	1.00	2.00	3.00	4.00	5.00	
5.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3			0. 00) O. OC	0. 00000	0 65.0
divided by (column 3 + column 4)). (see instructions)			Unweighted FTEs	Unweighted FTEs in	Ratio (col. 1. (col. 1 + col	
			Nonprovi der Si te	Hospi tal	2))	
			1.00	2.00	3.00	-
Section 5504 of the ACA Current N	/ear FTF Residents i	n Nonnrovider Settir				
beginning on or after July 1, 201			.go 211001110 11	51 000t 1 0p01 ti	ng por rouo	
Enter in column 2 the number of u FTEs that trained in your hospita (column 1 divided by (column 1 +	al. Enter in column :	3 the ratio of	Unweighted FTEs Nonprovider	Unweighted FTEs in Hospital	Ratio (col. 3. (col. 3 + col 4))	
			Site			
7 00 Enter in column 1 the program	1.00	2.00	Si te 3.00	4.00	5.00	0 67 0
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	1.00	2.00			5.00	0 67. C
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	1.00	2.00	3.00	0.00	5.00	
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)	25		3.00	0.00	5.00	
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)	≥S rchiatric Facility (3.00	0.00	5.00	
<pre>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)</pre>	≥S /chiatric Facility (the facility have an fore November 15, 20 umn 2: Did this faci 2 412.424 (d)(1)(iii) ate which program ye	IPF), or does it con n approved GME teach 004? Enter "Y" for ility train resident)(D)? Enter "Y" for	3.00 0.00 Itain an IPF subp ing program in 1 yes or "N" for r s in a new teach yes or "N" for r	0.00 0.00 1.0 provi der? Y the most no. (see i ng io.	5.00	70. 0
<pre>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)</pre>	2S rchiatric Facility (the facility have an efore November 15, 20 umn 2: Did this faci 2 412.424 (d)(1)(iii) cate which program you / PPS nabilitation Facility	IPF), or does it con n approved GME teach 004? Enter "Y" for ility train resident)(D)? Enter "Y" for ear began during thi	3.00 0.00 Itain an IPF subp ing program in t yes or "N" for r s in a new teach yes or "N" for r s cost reporting	0.00 0.00 1.0 provi der? Y the most no. (see i ng io.	5.00 0.000000 0.0000000 0.0000000000000	

Health Financial Systems FRANCISCAN HEALTH HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	MICHIGAN CIT Provider C		In Lie Period:	u of Form CMS Worksheet S	
		UN. 13 0013	From 01/01/2020 To 12/31/2020	Part I Date/Time P	repared:
				1.00	41 pm
Long Term Care Hospital PPS					
 80.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes 81.00 Is this a LTCH co-located within another hospital for part of "Y" for yes and "N" for no. 			ng period? Enter	N N	80.00
TEFRA Providers85.00Is this a new hospital under 42 CFR Section §413.40(f)(1)(i)86.00Did this facility establish a new Other subprovider (excluded)				N	85.00 86.00
<pre>§413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. 87.00 Is this hospital an extended neoplastic disease care hospita 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.</pre>	al classified	under sectior	1	N	87.00
			V	XI X	
Title V and XIX Services			1.00	2.00	_
90.00 Does this facility have title V and/or XIX inpatient hospita	al services? E	nter "Y" for	N	Y	90.00
yes or "N" for no in the applicable column. 91.00 Is this hospital reimbursed for title V and/or XIX through 1			Ν	Y	91.00
92.00 full or in part? Enter "Y" for yes or "N" for no in the appl 92.00 Are title XIX NF patients occupying title XVIII SNF beds (du instructions) Enter "Y" for yes or "N" for no in the applica	ual certificat			N	92.00
93. 00 Does this facility operate an ICF/IID facility for purposes "Y" for yes or "N" for no in the applicable column.		d XIX? Enter	Ν	N	93.00
94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, applicable column.	and "N" for n	o in the	Ν	Ν	94.00
95.00 If line 94 is "Y", enter the reduction percentage in the app 96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes			0. 00 N	0. 00 N	95.00 96.00
applicable column. 97.00 If line 96 is "Y", enter the reduction percentage in the app	olicable colum	n.	0.00	0.00	97.00
98.00 Does title V or XIX follow Medicare (title XVIII) for the in stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" f			Ν	N	98.00
 column 1 for title V, and in column 2 for title XIX. 98.01 Does title V or XIX follow Medicare (title XVIII) for the reconstruction of the column 1 for title XVIII) for the reconstruction of the column 1 for title XVIII (the column 1 for title XVIII) for the column 1 for title XVIII) for the column 1 for title XVIII (the column 1 for title XVIII) for the column				Ν	98. 01
 title XIX. 98.02 Does title V or XIX follow Medicare (title XVIII) for the cabed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes of 			Ν	N	98.02
for title V, and in column 2 for title XIX. 98.03 Does title V or XIX follow Medicare (title XVIII) for a crit reimbursed 101% of inpatient services cost? Enter "Y" for ye	tical access h	ospital (CAH)		N	98.03
for title V, and in column 2 for title XIX. 98.04 Does title V or XIX follow Medicare (title XVIII) for a CAH outpatient services cost? Enter "Y" for yes or "N" for no in	reimbursed 10	1% of	N	N	98.04
in column 2 for title XIX.					
98.05 Does title V or XIX follow Medicare (title XVIII) and add ba Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in c column 2 for title XIX.				N	98.05
98.06 Does title V or XIX follow Medicare (title XVIII) when cost Pts. I through IV? Enter "Y" for yes or "N" for no in column column 2 for title XIX.			Ν	N	98.06
Rural Providers					
105.00 Does this hospital qualify as a CAH? 106.00 of this facility qualifies as a CAH, has it elected the all-	inclusive met	hod of paymer	nt N		105. 00 106. 00
for outpatient services? (see instructions) 107.00 Column 1: If line 105 is Y, is this facility eligible for co training programs? Enter "Y" for yes or "N" for no in column					107.00
Column 2: If column 1 is Y and line 70 or line 75 is Y, do approved medical education program in the CAH's excluded IF	you train I&R PF and/or IRF	s in an			
Enter "Y" for yes or "N" for no in column 2. (see instructi 108.00 Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		dul e? See 42	2 N		108.00
	Physi cal	Occupati ona		Respi ratory	/
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y"	1.00	2.00	3.00	4.00	109.00
for yes or "N" for no for each therapy.					
				1.00	
110.00 Did this hospital participate in the Rural Community Hospita Demonstration) for the current cost reporting period? Enter ' complete Worksheet E, Part A, lines 200 through 218, and Wor applicable.	'Y" for yes or	"N" for no.	lf yes,	N	110.00

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CC		Perio	od:	u of Form CMS Worksheet S-	
			From To	01/01/2020 12/31/2020	Part I Date/Time Pr 7/28/2021 7:	
				1 00		_
11.00 If this facility qualifies as a CAH, did it participate in th Health Integration Project (FCHIP) demonstration for this cos "Y" for yes or "N" for no in column 1. If the response to col integration prong of the FCHIP demo in which this CAH is part Enter all that apply: "A" for Ambulance services; "B" for add for tele-health services.	st reporting p lumn 1 is Y, e ticipating in	eriod? Enter enter the column 2.	-	1.00 N	2.00	111. (
		1.00		2.00	3.00	-
12.00 Did this hospital participate in the Pennsylvania Rural Healt demonstration for any portion of the current cost reporting p Enter "Y" for yes or "N" for no in column 1. If column 1 is in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceas participation in the demonstration, if applicable. Miscellappeus Cost Reporting Information	period? "Y", enter e	N				112. (
15.00 Is this an all-inclusive rate provider? Enter "Y" for yes or in column 1. If column 1 is yes, enter the method used (A, B, in column 2. If column 2 is "E", enter in column 3 either "93 for short term hospital or "98" percent for long term care (i psychiatric, rehabilitation and long term hospitals providers the definition in CMS Pub. 15-1, chapter 22, §2208.1.	, or E only) 3" percent includes s) based on	N				0115.0
 00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this "Y" for yes or "N" for no in column 1. If the response to integration prong of the FCHIP demo in which this CAH is pEnter all that apply: "A" for Ambulance services: "B" for for tele-health services. 00[Did this hospital participate in the Pennsylvania Rural He demostration for any portion of the current cost reportin Enter "Y" for yes or "N" for no in column 1. If column 1 in colum 2, the date the hospital began participating in demostration. In colum 3, enter the date the hospital caparticipation in the demonstration on the demonstration. If applicable, Miscellaneous Cost Reporting Information 00 Is this an all-inclusive rate provider? Enter "Y" for yes in column 1. If column 1 is yes, enter the method used (A, in colum 1. If column 1 is yes, enter the method used (A, in colum 1. If column 1 is yes, enter the method used (A, in colum 1. If column 1 is yes, enter the method used (A, in colum 1. If column 1 is yes, enter the mospitals provide the definition in CMS Pub 15-1, chapter 22, §2208.1. 00 Is this facility legally-required to carry malpractice ins "Y" for yes or "N" for no. 00 Is the laptractice premiums and paid losses: 01 List amounts of malpractice premiums and paid losses: 02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sch and ministrative and General? If yes, submit supporting sch and ministrative and General? If yes, submit supporting sch and ministrative and General? If yes or "N" for no. 00 Do NOT USE THIS LINE 00 Dost Not Se Trais LINE 00 Dost has SCH or EACH that qualifies for the Outpatient He §3121 and applicable amendments? (see instructions) Enter "N" for no. Is this a rural hospital with < 100 beds that Hoid Harmless provision in ACA §3121 and applicable amendments? enter certified liday transplant center, in colu	for yes or	Y				116. (
"N" for no. 00 s this facility legally-required to carry malpractice insurance?		Y	2			117.
		Premiums	2	Losses	Insurance	110.
8.01 List amounts of malpractice premiums and paid losses:		1.00 1,101,6	570	2.00 207,501	3.00	0118.
				1.00	2.00	-
9.00 DO NOT USE THIS LINE 20.00 Is 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 qua	ule listing co Harmless prov column 1, "Y" alifies for th	st centers rision in ACA for yes or ne Outpatient		N	N	118. 119. 120.
		ŗ		Y		121.
	ined in §1903(w)(3) of the		Ν		122.
5.00 Does this facility operate a transplant center? Enter "Y" for	r yes and "N"	for no. If		N		125.
6.00 If this is a Medicare certified kidney transplant center, ent in column 1 and termination date, if applicable, in column 2.		ication date	•			126.
7.00 If this is a Medicare certified heart transplant center, enter in column 1 and termination date, if applicable, in column 2.						127.
in column 1 and termination date, if applicable, in column 2.			n			128. 129.
column 1 and termination date, if applicable, in column 2. 0.00 f this is a Medicare certified pancreas transplant center, e	enter the cert					130.
date in column 1 and termination date, if applicable, in colu 1.00 If this is a Medicare certified intestinal transplant center,	, enter the ce	erti fi cati on				131.
2.00 If this is a Medicare certified islet transplant center, ente	er the certifi	cation date				132.
						133. 134.
	e OPO number i	n column 1				_

HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	Provider (CCN: 15-0015	Period From C	l:)1/01/2020	Worksheet S-2 Part I	2
					2/31/2020		
1.00		2.00			3.00	172072021 7.	
If this facility is part of a cha				name an	d address	of the	
home office and enter the home of 41.00Name: FRANCISCAN ALLIANCE	<u>Contractor name ar</u> Contractor's Name			tor's Nu	umber: 8001		141. (
42.00 Street: 1515 DRAGOON TRAIL	PO Box:	5. WI 5	Contrac	.101 3 11			142.0
43.00 City: MISHAWAKA	State:	IN	Zip Coo	le:	4654	6	143.0
							4
44.00 Are provider based physicians' cos	sts included in Workshe	ρet Δ?				1.00 Y	144.0
		7.4			1.00	2.00	1.15 0
 145.00 If costs for renal services are clipatient services only? Enter "Y' no, does the dialysis facility ind period? Enter "Y" for yes or "N" 146.00 Has the cost allocation methodology 	' for yes or "N" for no clude Medicare utilizat for no in column 2.	o in column 1. If tion for this cost	column 1 is t reporting		N		145.0
Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/d	n column 1. (See CMS Pu			f			
47.00Was there a change in the statisti	cal hasis? Entor "V" f	for ves or "N" for	<u> </u>			1.00 N	147. (
48.00 Was there a change in the order of						N	147.0
149.00Was there a change to the simplifi		d? Enter "Y" for y	yes or "N" fo			N	149.0
		Part A	Part B	1	<u>Fitle V</u>	Title XIX	-
Does this facility contain a provi	der that qualifies for	1.00	2.00	cation o	3.00 If the Lowe	4.00	
or charges? Enter "Y" for yes or							
55.00Hospi tal		N	N		Ν	N	155. (
56.00 Subprovider - IPF 57.00 Subprovider - IRF		N	N		N	N	156. (
57. 00 Subprovider - TRF 58. 00 SUBPROVIDER		N	N		Ν	N	157.0
159. 00 SNF		N	N		Ν	N	159.0
60.00 HOME HEALTH AGENCY		N	N		Ν	N	160. 0
161.00 CMHC 161.10 CORF			N N		N N	N	161.0
					IN	N	161.1
						1.00	
Multicampus 165.00Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	ampus hospital that has	s one or more camp	ouses in diff	Ferent Cl	BSAs?	N	165. 0
	Name	County	State Z	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)						0.00	0166.0
						1.00	
Health Information Technology (HI 67.00 Is this provider a meaningful user 68.00 If this provider is a CAH (line 10	under §1886(n)? Ente	er "Y" for yes or	"N" for no.		r tho	Y	167. 0 168. 0
reasonable cost incurred for the H	IT assets (see instruc	ctions)					
68.01 If this provider is a CAH and is r exception under §413.70(a)(6)(ii)	P Enter "Y" for yes or	"N" for no. (see	instructions	ланаг(s)	usinih		168. (
69.00 If this provider is a meaningful u transition factor. (see instruction	user (line 167 is "Y")			s "N"), (9169. (
				Be	egi nni ng 1. 00	Endi ng 2.00	-
70.00 Enter in columns 1 and 2 the EHR H period respectively (mm/dd/yyyy)	beginning date and endi	ng date for the	reporting		1.00	2.00	170. (
					1.00	2.00	_
171.00 If line 167 is "Y", does this prov section 1876 Medicare cost plans n "Y" for yes and "N" for no in colu 1876 Medicare days in column 2. (s	reported on Wkst. S-3, umn 1. If column 1 is y	Pt. I, line 2, co	ol. 6? Enter	on	Ν		0 171. (

ealth Financial Systems FRANCISCAN HEALT				u of Form CMS	
IOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-0015	Period: From 01/01/2020 To 12/31/2020	Date/Time Pr	epared:
)/ /N	7/28/2021 7:	41 pm
			Y/N 1.00	Date 2.00	
General Instruction: Enter Y for all YES responses. Enter I	N for all NO re	esponses. Ente			
mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS					_
Provider Organization and Operation					
.00 Has the provider changed ownership immediately prior to th	e beginning of	the cost	N		1.0
reporting period? If yes, enter the date of the change in	column 2. (see				_
		Y/N 1.00	Date 2.00	V/I 3.00	
2.00 Has the provider terminated participation in the Medicare	Program? If	N 1.00	2.00	5.00	2.0
yes, enter in column 2 the date of termination and in colu					
voluntary or "I" for involuntary.					
B.00 Is the provider involved in business transactions, includi contracts, with individuals or entities (e.g., chain home)	ng management	N			3.0
or medical supply companies) that are related to the provi	der or its				
officers, medical staff, management personnel, or members					
of directors through ownership, control, or family and oth	er similar				
relationships? (see instructions)		N/ /N	Trues	Data	
		Y/N 1.00	Туре 2.00	Date 3.00	
Financial Data and Reports		1.00	2.00	5.00	
1.00 Column 1: Were the financial statements prepared by a Cer	tified Public	Y	A		4.00
Accountant? Column 2: If yes, enter "A" for Audited, "C"					
or "R" for Reviewed. Submit complete copy or enter date av column 3. (see instructions) If no, see instructions.	ailable in				
5.00 Are the cost report total expenses and total revenues diff	erent from	N			5.00
those on the filed financial statements? If yes, submit re					
			Y/N	Legal Oper.	_
			1.00	2.00	
Approved Educational Activities 0.00 Column 1: Are costs claimed for nursing school? Column 2:	If yos is th	e provider is	s N		6.00
the legal operator of the program?	11 yes, 15 ti		5 11		0.00
7.00 Are costs claimed for Allied Health Programs? If "Y" see i	nstructions.		N		7.00
8.00 Were nursing school and/or allied health programs approved	and/or renewed	during the	N		8.00
cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved	araduata media	al education	Ν		9.00
program in the current cost report? If yes, see instructio			IN		9.00
0.00 Was an approved Intern and Resident GME program initiated		the current	N		10.00
cost reporting period? If yes, see instructions.					
1.00 Are GME cost directly assigned to cost centers other than Teaching Program on Worksheet A? If yes, see instructions.	I & R in an App	proved	N		11.00
Teaching Program on worksneet A? IT yes, see thistructions.				Y/N	
				1.00	
Bad Debts					
2.00 Is the provider seeking reimbursement for bad debts? If ye				Y	12.00
3.00 If line 12 is yes, did the provider's bad debt collection period? If yes, submit copy.	policy change d	auring this co	ost reporting	N	13.00
4.00 If line 12 is yes, were patient deductibles and/or co-paym	ents waived? If	yes, see ins	structions.	N	14.00
		-			
Bed Complement					
5.00 Did total beds available change from the prior cost report		2 .		Y	15.00
	Par	rt A	Par	t B	15.00
	Par Y/N	t A Date	Par Y/N	t B Date	15.00
	Par Y/N 1.00	rt A	Par	t B	15.00
5.00 Did total beds available change from the prior cost report PS&R Data 6.00 Was the cost report prepared using the PS&R Report only?	Par Y/N	t A Date	Par Y/N	t B Date	
 5.00 Did total beds available change from the prior cost report 6.00 Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through 	Par Y/N 1.00	t A Date 2.00	Par Y/N 3.00	t B Date 4.00	
 5.00 Did total beds available change from the prior cost report 6.00 Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see 	Par Y/N 1.00	t A Date 2.00	Par Y/N 3.00	t B Date 4.00	
 5.00 Did total beds available change from the prior cost report 6.00 Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through 	Par Y/N 1.00	t A Date 2.00	Par Y/N 3.00	t B Date 4.00	16.00
 5.00 Did total beds available change from the prior cost report 6.00 Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions) 7.00 Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If 	Par Y/N 1.00 Y	rt A Date 2.00 03/16/2021	Par Y/N 3.00 Y	t B Date 4.00	16.00
 5.00 Did total beds available change from the prior cost report 6.00 Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions) 7.00 Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date 	Par Y/N 1.00 Y	rt A Date 2.00 03/16/2021	Par Y/N 3.00 Y	t B Date 4.00	16.00
 5.00 Did total beds available change from the prior cost report 6.00 Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions) 7.00 Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) 	Par Y/N 1.00 Y N	rt A Date 2.00 03/16/2021	Par Y/N 3.00 Y N	t B Date 4.00	16.00
 5.00 Did total beds available change from the prior cost report 6.00 Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions) 7.00 Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date 	Par Y/N 1.00 Y	rt A Date 2.00 03/16/2021	Par Y/N 3.00 Y	t B Date 4.00	16.00
 5.00 Did total beds available change from the prior cost report 6.00 Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions) 7.00 Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) 8.00 If line 16 or 17 is yes, were adjustments made to PS&R 	Par Y/N 1.00 Y N	rt A Date 2.00 03/16/2021	Par Y/N 3.00 Y N	t B Date 4.00	16.00
 5.00 Did total beds available change from the prior cost report 6.00 Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions) 7.00 Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) 8.00 If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions. 	Par Y/N 1.00 Y N N	rt A Date 2.00 03/16/2021	Par Y/N 3.00 Y N N	t B Date 4.00	16. 00 17. 00 18. 00
 5.00 Did total beds available change from the prior cost report 6.00 Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions) 7.00 Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) 8.00 If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this 	Par Y/N 1.00 Y N	rt A Date 2.00 03/16/2021	Par Y/N 3.00 Y N	t B Date 4.00	15. 00 16. 00 17. 00 18. 00 19. 00

Health Financial Systems

FRANCISCAN HEALTH MICHIGAN CITY

In Lieu of Form CMS-2552-10

HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CC		Period: From 01/01/2020	Worksheet S-2 Part II	
				To 12/31/2020	Date/Time Pre 7/28/2021 7:4	pared: 1 pm
		Descri	ption	Y/N	Y/N	·
		()	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
21 00	Was the cost report prepared only using the provider's	1.00 N	2.00	3.00 N	4.00	21.00
21.00	records? If yes, see instructions.			IN .		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	EPT CHILDRENS H	OSPI TALS)			
22.00	Capital Related Cost				N	
	Have assets been relifed for Medicare purposes? If yes, see Have changes occurred in the Medicare depreciation expense		als made durin	ng the cost	N N	22.00 23.00
24.00	reporting period? If yes, see instructions. Were new leases and/or amendments to existing leases entered If yes, see instructions	ed into during	this cost repo	orting period?	Ν	24.00
25.00	Have there been new capitalized leases entered into during instructions.	f yes, see	Ν	25.00		
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during th instructions.	yes, see	Ν	26.00		
27.00	Has the provider's capitalization policy changed during the copy.	e cost reportin	g period? If y	yes, submit	Ν	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit en period? If yes, see instructions.	ntered into dur	ing the cost i	reporting	Ν	28.00
29.00	Did the provider have a funded depreciation account and/or treated as a funded depreciation account? If yes, see inst		bt Service Res	serve Fund)	Ν	29.00
30.00	Has existing debt been replaced prior to its scheduled matu instructions.	urity with new	debt? If yes,	see	Ν	30.00
31.00	Has debt been recalled before scheduled maturity without is instructions.	ssuance of new	debt? If yes,	see	Ν	31.00
	Purchased Services				N	
	Have changes or new agreements occurred in patient care set arrangements with suppliers of services? If yes, see instru If line 32 is yes, were the requirements of Sec. 2135.2 app	uctions.	0		Ν	32.00
33.00	no, see instructions.					33.00
34 00	Provider-Based Physicians Are services furnished at the provider facility under an a	rrangement with	nrovi der-base	ed physicians?	Y	34.00
	If yes, see instructions.					
35.00	If line 34 is yes, were there new agreements or amended exi physicians during the cost reporting period? If yes, see in		ts with the pi	Y/N	N	35.00
				1.00	Date 2.00	
	Home Office Costs			1		
	Were home office costs claimed on the cost report?	reported by the	home office?	Y		36.00
	If line 36 is yes, has a home office cost statement been pulf yes, see instructions.			Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home of the provider? If yes, enter in column 2 the fiscal year end	fice different d of the home o	from that of ffice.	N		38.00
39.00	If line 36 is yes, did the provider render services to othe see instructions.	er chain compon	ents? If yes,	Ν		39.00
40.00	If line 36 is yes, did the provider render services to the instructions.	home office?	lf yes, see	Ν		40.00
		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,	SCOTT		HOVE		41.00
42.00	respectively. Enter the employer/company name of the cost report	FRANCI SCAN ALL	I ANCE			42.00
43.00	preparer. Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	417-207-\6033		SCOTT. HOVE@FRA	NCI SCANALLI ANC	43.00
	• •				'	

Health Financial Systems FRANCISC	AN HEALTH MICHIGAN CITY	In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTION	AIRE Provider CCN: 15-0015	Period: From 01/01/2020	Worksheet S-2 Part II	
		To 12/31/2020		pared: 1 pm
	3.00			
Cost Report Preparer Contact Information				
41.00 Enter the first name, last name and the title/posi	tion FINANCIAL ANALYST - SR.			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 th	e cost			43.00
report preparer in columns 1 and 2, respectively.				

)SPI 1	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC	CN: 15-0015	Period: From 01/01/2020 To 12/31/2020	Worksheet S-3 Part I Date/Time Pre 7/28/2021 7:4	pare
			·			I/P Days / O/P	
	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	<u>Visits / Trips</u> Title V	
		1.00	2.00	3.00	4.00	5.00	
00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions)	30. 00	83	30, 37	0.00	0	1.
00 00	HMO IPF Subprovider HMO IRF Subprovider						3. 4.
00	Hospital Adults & Peds. Swing Bed SNF					0	5.
00	Hospital Adults & Peds. Swing Bed SM Hospital Adults & Peds. Swing Bed NF					0	
00	Total Adults and Peds. (exclude observation beds) (see instructions)		83	30, 37	78 0.00	0	
00	INTENSIVE CARE UNIT	31.00	16	5, 85	0.00	0	8
00	CORONARY CARE UNIT	32.00	0		0 0.00	0	9
00	BURN INTENSIVE CARE UNIT	33.00	0		0 0.00	0	10
00	SURGICAL INTENSIVE CARE UNIT	34.00	0		0 0.00	0	11
00	OTHER SPECIAL CARE (SPECIFY)						12
00	NURSERY	43.00				0	13
00	Total (see instructions)		99	36, 23	0.00	0	14
. 00	CAH visits					0	15
00	SUBPROVI DER – I PF	40.00	14	5, 12	24	0	16
00	SUBPROVIDER - IRF	41.00	0		0	0	17
00	SUBPROVI DER						18
00	SKILLED NURSING FACILITY	44.00	0		0	0	
00	NURSING FACILITY	45.00	0		0	0	20
00	OTHER LONG TERM CARE	46.00	0		0	_	21
00	HOME HEALTH AGENCY	101.00				0	1
00	AMBULATORY SURGICAL CENTER (D. P.)	115.00					23
00	HOSPICE	116. 00 30. 00	0		0		24
10 00	HOSPICE (non-distinct part) CMHC - CMHC	30.00 99.00				0	24
10	CMHC - CORF	99.00 99.10				0	25
00	RURAL HEALTH CLINIC	88.00				0	26
25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26
00	Total (sum of lines 14-26)	07.00	113			Ū	27
00	Observation Bed Days					0	28
00	Ambul ance Trips						29
00	Employee discount days (see instruction)						30
. 00	Employee discount days - IRF						31
00	Labor & delivery days (see instructions)		0		0		32
. 01	Total ancillary labor & delivery room						32
. 00	outpatient days (see instructions) LTCH non-covered days						33
	LTCH site neutral days and discharges						33

IOSPI 1	FAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC		Period: From 01/01/2020 To 12/31/2020		pared
		I/P Days	/ O/P Visits	/ Trips	Full Time E		
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
2. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions)	9, 820 4, 381	547 4, 038	21, 72			1. (2. (
3.00 1.00	HMO IPF Subprovider HMO IRF Subprovider	220 0	0				3.0
. 00	Hospital Adults & Peds. Swing Bed SNF	0	0		0		5.0
5. 00 7. 00	Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions)	9, 820	0 547	21, 72	0 27		6. (7. (
8.00 9.00	INTENSIVE CARE UNIT CORONARY CARE UNIT	1, 155 0	394 0	3, 76	0		8. 9.
0. 00 1. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT	0 0	0		0 0		10.
2.00 3.00	OTHER SPECIAL CARE (SPECIFY) NURSERY		609	84	12		12. 13.
4.00 5.00	Total (see instructions)	10, 975	1, 550		0. 00	801.85	14. 15.
6.00	CAH visits SUBPROVIDER - IPF	0 104	0 1, 653	3, 35	-	19.00	
7.00	SUBPROVI DER – I RF SUBPROVI DER	0	0		0 0.00	0.00	17.
9.00	SKILLED NURSING FACILITY NURSING FACILITY	0	0		0 0.00 0 0.00		
I. 00	OTHER LONG TERM CARE		0		0 0.00		
2.00	HOME HEALTH AGENCY	0	0		0 0.00		
3.00 4.00 4.10	AMBULATORY SURGICAL CENTER (D.P.) HOSPICE HOSPICE (non-distinct part)	0	0		0.00 0 0.00		
5. 00 5. 10	CMHC - CMHC CMHC - CORF	0	0 0		0 0.00 0 0.00		25.
o. 00 o. 25	RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER	0	0 0		0 0.00 0 0.00		
7.00 3.00	Total (sum of lines 14–26) Observation Bed Days		0	18	0.00	820. 85	27
. 00 . 00	Ambulance Trips Employee discount days (see instruction)	0			0		29 30
1.00 2.00 2.01	Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room	О	100		0 18 0		31 32 32
3. 00 3. 01	outpatient days (see instructions) LTCH non-covered days LTCH site neutral days and discharges	0					33

HOSPI -	TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA		Provider C	CN: 15-0015	Period: From 01/01/2020 To 12/31/2020	Worksheet S-3 Part I Date/Time Pre 7/28/2021 7:4	pared:
		Full Time Equivalents	Di sc		scharges		
	Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00 2.00 3.00 4.00 5.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 14.00 15.00 16.00 17.00 18.00 19.00 20.00 21.00 23.00 24.00 23.00 24.00 25.10 25.00 25.00 25.00 25.00 26.00 27.00 28.00 29.00 30.00 20.	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions) HMO IPF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed SNF Total Adults and Peds. (exclude observation beds) (see instructions) INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.) HOSPICE HOSPICE (non-distinct part) CMHC - CORF RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instruction)	11.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0	12.00 0 0 0	2, 6	08 188 82 895 0 0	15.00 5,868 551 0 0	1.00 2.00 3.00 4.00 5.00 7.00 8.00 7.00 1.00 12.00 13.00 14.00 15.00 14.00 15.00 14.00 17.00 18.00 17.00 18.00 17.00 20.00 21.00 21.00 23.00 24.00 25.00 25.00 25.00 25.00 25.00 25.00 26.00 27.00 28.00 29.00 30.00 20.0
31. 00 32. 00 32. 01	Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions)						31.00 32.00 32.01
33. 00 33. 01	LTCH non-covered days LTCH site neutral days and discharges				0 0		33.00 33.01

SPI T	AL WAGE INDEX INFORMATION			Provider C		eriod: rom 01/01/2020 p 12/31/2020		pared
		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	<u>ı pııı</u>
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA SALARIES							
00	Total salaries (see	200. 00	68, 269, 174	0	68, 269, 174	2, 077, 949. 37	32.85	1.0
00	instructions) Non-physician anesthetist Part		C	0	0	0.00	0. 00	2.0
00	A Non-physician anesthetist Part B		C	0	0	0.00	0.00	3. C
00	Physician-Part A - Administrative		C	0	0	0.00	0.00	4.0
01 00	Physicians - Part A - Teaching Physician and Non		0		0 0	0.00 0.00		
00	Physician-Part B Non-physician-Part B for hospital-based RHC and FOHC services		C	0	0	0.00	0. 00	6. (
00	Interns & residents (in an approved program)	21.00	C	0	0	0.00	0.00	7. (
01	Contracted interns and residents (in an approved programs)		C	0	Ο	0.00	0. 00	7. (
00	Home office and/or related organization personnel		10, 408, 739	0	10, 408, 739	274, 052. 12	37. 98	8. (
00 00	SNF Excluded area salaries (see instructions)	44.00	0 2, 344, 726		0 2, 344, 726	0. 00 210, 726. 30		
00	OTHER WAGES & RELATED COSTS Contract labor: Direct Patient Care		569, 656	0	569, 656	6, 533. 00	87. 20	11.
00	Contract labor: Top level management and other management and administrative services		C	0	Ο	0.00	0. 00	12. (
00	Contract Labor: Physician-Part A - Administrative		406, 896	0	406, 896	3, 255. 17	125.00	13.
00	Home office and/or related organization salaries and wage-related costs		C	0	0	0.00	0.00	14.
01	Home office salaries		13, 777, 486	0	13, 777, 486	362, 748. 00	37.98	14.
02	Related organization salaries		0	0	0	0.00		
00	Home office: Physician Part A - Administrative		l		0	0.00		
	Home office and Contract Physicians Part A - Teaching		(0	_	0.00		
01 02	Home office Physicians Part A - Teaching Home office contract		(0	0.00		
02	Physicians Part A - Teaching WAGE-RELATED COSTS				0	0.00	0.00	10.0
	Wage-related costs (core) (see instructions)		18, 048, 453	3 0	18, 048, 453			17.
00	Wage-related costs (other) (see instructions)							18.0
00 00	Èxcluded areas Non-physician anesthetist Part		843, 061 (0000	843, 061 0			19. 20.
00	A Non-physician anesthetist Part B		C	0	0			21.
00	Physician Part A - Administrative		C	0	0			22.
01	Physician Part A - Teaching		C	0	0			22.
00 00 00	Physician Part B Wage-related costs (RHC/FQHC) Interns & residents (in an		((0 0 0			23. 24. 25.
50	approved program) Home office wage-related		4, 066, 318		_			25.
51	(core) Related organization		(0	0			25.
52	wage-related (core) Home office: Physician Part A - Administrative -		(0	0			25.

ealth Financial Systems			HICHIGAN CITY		Peri od:	u of Form CMS-2 Worksheet S-3	
USPITAL WAGE INDEX INFORMATION			Provi der Co		From 01/01/2020 To 12/31/2020	Part II	pared
	Wkst. A Line		Recl assi fi cati		Paid Hours	Average Hourly	
	Number	Reported	on of Salaries			Wage (col. 4 ÷	
			(from Wkst.	(col.2 ± col	Salaries in	col. 5)	
			A-6)	3)	col. 4		
	1.00	2.00	3.00	4.00	5.00	6.00	
25.53 Home office: Physicians Part A	N	0	0		0		25.
- Teaching - wage-related							
(core)							
OVERHEAD COSTS - DIRECT SALARI							
6.00 Employee Benefits Department	4.00	2,027,604	0	2, 027, 60			
7.00 Administrative & General	5.00	17, 333, 052		17, 333, 05			
8.00 Administrative & General under		741, 171	6, 587	747, 75	6, 587. 00	113. 52	28.
contract (see inst.)							
9.00 Maintenance & Repairs	6.00	0	0		0 0.00		
0.00 Operation of Plant	7.00	2, 568, 965	0	2, 568, 96			
1.00 Laundry & Linen Service	8.00	73, 595	0	73, 59			
2.00 Housekeepi ng	9.00	1, 595, 377	0	1, 595, 37	7 103, 823. 36	15.37	
3.00 Housekeeping under contract (see instructions)		0	0		0 0.00	0.00	33.
4.00 Dietary	10.00	1, 621, 942	-1, 159, 685	462, 25	7 24, 776. 90	18.66	34.
5.00 Dietary under contract (see instructions)		0	0		0 0.00	0.00	35.
6.00 Cafeteria	11.00	0	1, 159, 685	1, 159, 68	62, 108. 80	18. 67	36.
7.00 Maintenance of Personnel	12.00	0	0		0 0.00	0.00	37.
8.00 Nursing Administration	13.00	2, 274, 101	0	2, 274, 10	55, 741. 76	40. 80	38.
9.00 Central Services and Supply	14.00	173, 003	0	173, 00	3 8, 696. 95	19.89	39.
0.00 Pharmacy	15.00	2, 365, 631	0	2, 365, 63	1 55, 965. 47	42.27	40.
1.00 Medical Records & Medical Records Library	16.00	14, 804	0	14,80	982.00	15.08	41.
2.00 Social Service	17.00	0	0		0 0.00	0.00	42.
3.00 Other General Service	18.00	0	0		0 0.00	0.00	43

Heal th	Health Financial Systems FRANCISCAN HEALTH MICHIGAN CITY In Lieu of Form CMS-2552-1							
HOSPIT	AL WAGE INDEX INFORMATION			Provider CC		Period: From 01/01/2020 To 12/31/2020		
		Worksheet A		Recl assi fi cati			Average Hourly	
		Line Number	Reported	on of Salaries			Wage (col. 4 ÷	
				(from	(col.2 ± col.		col. 5)	
				Worksheet A-6)		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		58, 601, 606	6, 587	58, 608, 19	3 1, 810, 484. 25	32.37	1.00
	instructions)							
2.00	Excluded area salaries (see instructions)		2, 344, 726	0	2, 344, 72	6 210, 726. 30	11. 13	2.00
3.00	Subtotal salaries (line 1 minus line 2)		56, 256, 880	6, 587	56, 263, 46	7 1, 599, 757. 95	35. 17	3.00
4.00	Subtotal other wages & related costs (see inst.)		14, 754, 038	0	14, 754, 03	8 372, 536. 17	39.60	4.00
5.00	Subtotal wage-related costs (see inst.)		22, 114, 771	0	22, 114, 77	1 0.00	39. 31	5.00
6.00	Total (sum of lines 3 thru 5)		93, 125, 689	6, 587	93, 132, 27	6 1, 972, 294. 12	47.22	6.00
7.00	Total overhead cost (see instructions)		30, 789, 245	6, 587	30, 795, 83	2 629, 791. 54	48.90	7.00

	Financial Systems FRANCISCAN HEALTH TAL WAGE RELATED COSTS	MICHIGAN CITY Provider CCN: 15-0015	Peri od:	u of Form CMS-2 Worksheet S-3	
			From 01/01/2020		
			To 12/31/2020		
				7/28/2021 7:4 Amount	I pm
				Reported	
				1.00	
	PART IV - WAGE RELATED COSTS			1.00	
	Part A - Core List				1
	RETIREMENT COST				1
. 00	401K Employer Contributions			1, 406, 503	1.
. 00	Tax Sheltered Annuity (TSA) Employer Contribution			0	
. 00	Nongualified Defined Benefit Plan Cost (see instructions)			0	3.
. 00	Qualified Defined Benefit Plan Cost (see instructions)			2, 537, 000	4.
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				1
. 00	401K/TSA PLan Administration fees			0	5.
. 00	Legal/Accounting/Management Fees-Pension Plan			0	6.
. 00	Employee Managed Care Program Administration Fees			0	7.
	HEALTH AND INSURANCE COST				
. 00	Health Insurance (Purchased or Self Funded)			0	8.
01	Health Insurance (Self Funded without a Third Party Adminis			0	8.
02	Health Insurance (Self Funded with a Third Party Administra	tor)		6, 103, 273	8.
03	Health Insurance (Purchased)			0	8.
. 00	Prescription Drug Plan			0	9.
0. 00	Dental, Hearing and Vision Plan			606, 886	10.
1.00	Life Insurance (If employee is owner or beneficiary)			25, 267	11.
2.00	Accident Insurance (If employee is owner or beneficiary)			0	12.
3.00	Disability Insurance (If employee is owner or beneficiary)			704, 773	13.
4.00	Long-Term Care Insurance (If employee is owner or beneficia	ry)		0	1
5.00	'Workers' Compensation Insurance			331, 782	15.
5.00	Retirement Health Care Cost (Only current year, not the ext	raordinary accrual require	ed by FASB 106.	0	16.
	Non cumulative portion)				
	TAXES				
7.00	FICA-Employers Portion Only			4, 186, 321	
8.00	Medicare Taxes - Employers Portion Only			0	
9.00	Unemployment Insurance			80, 973	
0. 00	State or Federal Unemployment Taxes			0	20.
	OTHER	<u> </u>			
1. 00	Executive Deferred Compensation (Other Than Retirement Cost	Reported on lines 1 throu	ugh 4 above. (see	0	21.
2 00	instructions)) Day Care Cost and Allowances			0	22
2.00	5			0	
3.00				15 000 770	
4.00	Total Wage Related cost (Sum of Lines 1 -23) Part B - Other than Core Related Cost			15, 982, 778	24.
	Part B - Uther than Core Related Cost				

HOSPITAL CONTRACT LABOR AND BENEFIT COST Provider CCN: 15-0015 From 01/01/2020 To 12/31/2020 Part V To 12/31/2020	
To 12/31/2020 Date/Time Prepar	
7/28/2021 7:41 p	
Cost Center Description Contract Labor Benefit Cost	
1.00 2.00	
PART V - Contract Labor and Benefit Cost	
Hospital and Hospital-Based Component Identification:	
	1.00
the second se	2.00
	3.00
	4.00
	5.00
	6.00
	7.00
	8.00
	9.00
	0.00
	1.00
	2.00
	3.00
	4.00
	5.00
	6.00
	6. 10
	7.00
18.00 0ther 0 0 1	8.00

Heal th	Health Financial Systems FRANCISCAN HEALTH MICHIGAN CITY In Lieu of Form CMS-255							
		Provider CCN:		Period:	Worksheet S-1			
				From 01/01/2020				
				To 12/31/2020		pared:		
					7/28/2021 7:4	Грш		
					1.00			
	Uncompensated and indigent care cost computation				1.00			
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 div	ided by line	202 column	8)	0. 222050	1.00		
	Medicaid (see instructions for each line)			-)				
2.00	Net revenue from Medicaid				38, 111, 294	2.00		
3.00	Did you receive DSH or supplemental payments from Medicaid?				Y	3.00		
4.00	If line 3 is yes, does line 2 include all DSH and/or supplementation	al payments [.]	from Medicai	d?	Y	4.00		
5.00	If line 4 is no, then enter DSH and/or supplemental payments from	om Medicaid			0	5.00		
6.00	Medi cai d charges				167, 490, 420	6.00		
7.00	Medicaid cost (line 1 times line 6)				37, 191, 248	7.00		
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus	sum of line	es 2 and 5; if	0	8.00		
	< zero then enter zero)							
	Children's Health Insurance Program (CHIP) (see instructions for	r each line)						
9.00	Net revenue from stand-alone CHIP				0	9.00		
10.00	Stand-al one CHIP charges				0	10.00		
11.00	Stand-alone CHIP cost (line 1 times line 10)				0	11.00		
12.00	Difference between net revenue and costs for stand-alone CHIP (line ii minus	s line 9; i	< zero then	0	12.00		
	enter zero) Other state en local gevernment indigent care program (see inst	ructions for	oach lino)					
13.00	Other state or local government indigent care program (see instructions for each line) 3.00 Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)							
14.00	Charges for patients covered under state or local indigent care				0	13.00 14.00		
		program (no			, i i i i i i i i i i i i i i i i i i i			
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 state or local ind		rogram (line	e 15 minus line	0	16.00		
	13; if < zero then enter zero)	0 1	o .					
	Grants, donations and total unreimbursed cost for Medicaid, CHII instructions for each line)	P and state/I	local indige	ent care progra	ms (see			
17.00	Private grants, donations, or endowment income restricted to fu	nding charity	v care		0	17.00		
18.00	Government grants, appropriations or transfers for support of h				0	18.00		
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local	indigent ca	re programs	(sum of lines	0	19.00		
	8, 12 and 16)							
			Uni nsured	Insured	Total (col. 1			
			patients 1.00	2.00	+ col. 2) 3.00			
	Uncompensated Care (see instructions for each line)	I	1.00	2.00	3.00			
20.00	Charity care charges and uninsured discounts for the entire fac	ility	25, 520, 91	9 4, 417, 155	29, 938, 074	20 00		
20.00	(see instructions)		20, 020, 71	, , , , , , , , , , , , , , , , , , , ,	27,700,071	20.00		
21.00	Cost of patients approved for charity care and uninsured discour	nts (see	5, 666, 92	4, 417, 155	10, 084, 075	21.00		
22.00	instructions) Payments received from patients for amounts previously written	off as			0	22.00		
22.00	chari ty care				Ŭ	22.00		
23.00	Cost of charity care (line 21 minus line 22)		5, 666, 92	4, 417, 155	10, 084, 075	23.00		
					1.00			
24 00	24.00 Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit							
24.00	imposed on patients covered by Medicaid or other indigent care program?							
25.00	00 If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of							
24 00	stay limit 00 Total bad debt expense for the entire hospital complex (see instructions) 11,							
26.00 27.00								
27.00								
27.01								
28.00	Cost of non-Medicare and non-reimbursable Medicare bad debt exp	ense (see in	structions)		10, 129, 227 2, 587, 340			
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)				12, 671, 415			
	Total unreimbursed and uncompensated care cost (line 19 plus lin	ne 30)			12, 671, 415			

	Financial Systems SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	ANCISCAN HEALTH F EXPENSES	MICHIGAN CITY Provider CO	CN: 15-0015 P	eriod:	u of Form CMS-2 Worksheet A	2552-10
				F T	rom 01/01/2020 p 12/31/2020		
	Cost Center Description	Sal ari es	Other	Total (col 1	Recl assi fi cati	7/28/2021 7:4 Recl assi fi ed	1 pm
	cost center bescription	Salaries	other	+ col. 2)	ons (See A-6)	Trial Balance	
				,	. ,	(col. 3 +-	
		1.00	2.00	3.00	4.00	<u>col. 4)</u> 5.00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	0.00	1.00	0.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT		19, 194, 402		1, 227, 824	20, 422, 226	1.00
2.00 3.00	00200 CAP REL COSTS-MVBLE EQUIP 00300 OTHER CAP REL COSTS		0	0	9, 157, 117	9, 157, 117 0	2.00 3.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	2, 027, 604	465, 894	2, 493, 498	-50, 058	2, 443, 440	4.00
5.00	00500 ADMINISTRATIVE & GENERAL	17, 333, 052	39, 196, 343		-9, 881, 815	46, 647, 580	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	2, 568, 965 73, 595	6, 610, 245 466, 274		-44, 463 -12, 034	9, 134, 747 527, 835	7.00
9.00	00900 HOUSEKEEPING	1, 595, 377	934, 743		-3, 118	2, 527, 002	9.00
10.00	01000 DI ETARY	1, 621, 942	1, 312, 810	2, 934, 752	-2, 108, 167	826, 585	
11. 00 13. 00	01100 CAFETERIA 01300 NURSING ADMINISTRATION	0 2, 274, 101	0 4, 850, 209	0 7, 124, 310	2, 098, 341 -2, 150	2, 098, 341 7, 122, 160	11.00 13.00
13.00	01400 CENTRAL SERVICES & SUPPLY	173,003	4,850,209		-188, 510	686, 278	
15.00	01500 PHARMACY	2, 365, 631	20, 180, 092	22, 545, 723	-18, 997, 443	3, 548, 280	
16.00	01600 MEDI CAL RECORDS & LI BRARY	14, 804	1, 175		0	15, 979	
17.00 18.00	01700 SOCIAL SERVICE 01080 INSERVICE EDUCATION	0	0	0	0	0	17.00 18.00
19.00	01900 NONPHYSI CI AN ANESTHETI STS	0	0	0	0	0	19.00
20.00	02000 NURSI NG SCHOOL	0	0	0	0	0	20.00
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00 23.00	02200 I & SERVI CES-OTHER PRGM COSTS APPRVD 02300 PARAMED ED PRGM-(SPECI FY)	0	0	0	0	0	22.00 23.00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS						20.00
30.00	03000 ADULTS & PEDIATRICS	13, 910, 236	5, 502, 164				
31.00 32.00	03100 I NTENSI VE CARE UNI T 03200 CORONARY CARE UNI T	2, 192, 942	1, 085, 602	3, 278, 544	-284, 176	2, 994, 368 0	31.00 32.00
33.00	03300 BURN I NTENSI VE CARE UNI T	0	0	0	0	0	33.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
40.00	04000 SUBPROVIDER - IPF	1, 198, 808	662, 851	1, 861, 659	-5, 108	1, 856, 551	40.00
41.00 43.00	04100 SUBPROVI DER – I RF 04300 NURSERY	0	0	0	0 1, 259, 920	0 1, 259, 920	41.00 43.00
44.00	04400 SKILLED NURSING FACILITY	0	0	0	1, 237, 720	1, 237, 720	44.00
45.00	04500 NURSING FACILITY	0	0	0	0	0	45.00
46.00	04600 OTHER LONG TERM CARE ANCI LLARY SERVICE COST CENTERS	0	0	0	0	0	46.00
50.00	05000 OPERATING ROOM	5, 475, 193	15, 661, 853	21, 137, 046	-12, 505, 112	8, 631, 934	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 54.00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	34, 392 3, 192, 280	2, 871, 411 1, 552, 525		-28, 183 -448, 407	2, 877, 620 4, 296, 398	1
54.01	05401 FSED RADIOLOGY - DI AGNOSTI C	1, 155, 223	1, 251, 171				
55.00	05500 RADI OLOGY-THERAPEUTI C	628, 901	880, 602		-30, 047	1, 479, 456	
55. 01 56. 00	05501 WOODLAND CANCER CARE CTR 05600 RADI 0I SOTOPE	350, 730	165, 062	515, 792	-63, 030	452, 762 0	55.01 56.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	920, 496	2, 753, 625		-2, 391, 094	1, 283, 027	59.00
60. 00 60. 01	06000 LABORATORY 06001 FS ED LAB		8, 238, 961 1, 501, 920		-16, 654 -1, 019	8, 222, 307 1, 500, 901	60.00 60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0	0	0	1, 300, 701	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00	06300 BLOOD STORI NG, PROCESSI NG & TRANS. 06400 I NTRAVENOUS THERAPY	0	0	0	0	0	63.00
64.00 65.00	06400 INTRAVENOUS THERAPY 06500 RESPIRATORY THERAPY	0 996, 561	0 622, 219	0 1, 618, 780	ں 159, 510-	0 1, 459, 270	64.00 65.00
66.00	06600 PHYSI CAL THERAPY	823, 087	2, 306, 321		-32, 600	3, 096, 808	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67.00
68.00 69.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0 897, 309	0 436, 975	0 1, 334, 284	0 -20, 523	0 1, 313, 761	68.00 69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	20, 323	1, 313, 701	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	5, 530, 289	5, 530, 289	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	11, 510, 510	11, 510, 510	
73.00 74.00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0	0	0 0	19, 087, 457 0	19, 087, 457 0	73.00
75.00	07500 ASC (NON-DISTINCT PART)	Ő	0	0	0	0	75.00
76.00	03020 CV RESOURCE CTR	0	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	0	0	0	0	0	88.00
89.00	08900 FEDERALLY QUALI FIED HEALTH CENTER	0	0	0	0	0	89.00
90. 00 90. 03	09000 CLINIC 09003 INFUSION OP SERVICES	0 361, 893	0 485, 978	0 847, 871	0 -24, 444	0 823, 427	90.00 90.03
70.03	107003 THE USE ON OF SERVICES	301,073	405, 770	047,071	-24,444	023, 427	70.03

Health Financial Systems FR	ANCISCAN HEALTH	MICHIGAN CITY	/	In Lie	eu of Form CMS-:	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O		Provider CO		Peri od:	Worksheet A	
				From 01/01/2020		
				To 12/31/2020	Date/Time Pre 7/28/2021 7:4	
Cost Center Description	Sal ari es	Other	Total (col. '	1 Reclassi ficati	Recl assi fi ed	
			+ col. 2)	ons (See A-6)	Trial Balance	
					(col. 3 +-	
					col. 4)	
	1.00	2.00	3.00	4.00	5.00	
91.00 09100 EMERGENCY	3, 604, 063	4, 824, 193	8, 428, 25	6 -334, 902	8, 093, 354	91.00
91.01 09101 FREE STANDING EMERGENCY DEPT	1, 333, 068	687, 027	2, 020, 09	5 -55, 035	1, 965, 060	91.01
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS	· ·				•	1
94.00 09400 HOME PROGRAM DI ALYSI S	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	o	0		0 0	l o	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	99.00
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	
101.00 10100 HOME HEALTH AGENCY	0	0		0 0		101.00
SPECIAL PURPOSE COST CENTERS	<u> </u>	0	<u> </u>	0 0	0	101.00
105. 00 10500 KI DNEY ACQUI SI TI ON	0	0		0 0	0	105.00
106. 00 10600 HEART ACQUI SI TI ON	0	0		0 0		106.00
107. 00 10700 LI VER ACQUI SI TI ON	0	0		0 0		107.00
108. 00 10800 LUNG ACQUISITION	0	0		0 0		107.00
109. 00 10900 PANCREAS ACQUISITION	0	0		0 0		108.00
110. 00 11000 NTESTI NAL ACQUI SI TI ON	0	0		0 0		1109.00
111. 00 11100 I SLET ACQUI SI TI ON	0	0		0 0		111.00
	U	0		0 0		
113.00 11300 I NTEREST EXPENSE		0		0 0		113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF	0	0		0 0		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)	67, 123, 256	145, 404, 432	212, 527, 68	8 159, 691	212, 687, 379	118.00
NONREI MBURSABLE COST CENTERS		17 (00	17.10		17 (00	
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	-17,609	-17, 60	9 0	-17, 609	
191. 00 19100 RESEARCH	0	0		0 0		191.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0		192.00
193.00 19300 NONPALD WORKERS	0	0		0 0		193.00
193.01 19301 NONPALD WORKERS	0	0		0 0		193. 01
194.0007950 BEACON JOINT VENTURE	0	0		0 0	0	194.00
194.0107951 WORKING WELL	1, 085, 671	875, 785	1, 961, 45	6 -159, 691	1, 801, 765	194.01
194.0307953 MED WATCHER	0	0		0 0	0	194.03
194.1007960 DUNELAND FITNESS CTR	0	0		0 0	0	194.10
194.11 07961 OMNI HEALTH & FITNESS CHESTERTOWN	0	0		0 0	0	194. 11
194.16 07966 PHYSICIAN PRACTICE MD WISW	5, 325	4, 834	10, 15	9 0	10, 159	194.16
194. 19 07969 HEALTH PARTNERS	0	-617, 177	-617, 17		-617, 177	
194.20 07970 CENTER OF HOPE	54, 922	11, 016			65, 938	194.20
200.00 TOTAL (SUM OF LINES 118 through 199)	68, 269, 174	145, 661, 281				
				1		

Health Financial Systems	FRANCI SCAN HEALTH M	ICHIGAN CITY	In Lieu	u of Form CMS-2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TH	REAL BALANCE OF EXPENSES	Provider CCN: 15-0015	Period: From 01/01/2020	Worksheet A

RECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C	IF EXPENSES	Provider CCN: 1	From 01/01/2020	Date/Time Prepared:
	Cost Center Description	Adjustments	Net Expenses		7/28/2021 7:41 pm
		(See A-8)	For Allocation		
	GENERAL SERVICE COST CENTERS	6.00	7.00		
1.00	00100 CAP REL COSTS-BLDG & FIXT	1, 959, 397	22, 381, 623		1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	0			2.00
3.00	00300 OTHER CAP REL COSTS	0			3.00
4.00 5.00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	986, 000 -12, 396, 084			4.00 5.00
6.00	00600 MAI NTENANCE & REPAI RS	0	0		6.00
7.00	00700 OPERATION OF PLANT	0	9, 134, 747		7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	527, 835		8.00
9.00	00900 HOUSEKEEPING	0	2/02//002		9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	-290 -534, 034			10.00
13.00	01300 NURSI NG ADMI NI STRATI ON	-3, 839, 883			13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0,007,000	686, 278		14.00
15.00	01500 PHARMACY	732, 935	4, 281, 215		15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	1, 311, 866			16.00
17.00	01700 SOCIAL SERVICE	0	0		17.00
18.00 19.00	01080 I NSERVI CE EDUCATI ON 01900 NONPHYSI CI AN ANESTHETI STS	0			18. 00 19. 00
	02000 NURSI NG SCHOOL	0	Ő		20.00
21.00	02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	0		21.00
22.00	02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0		22.00
23.00	02300 PARAMED ED PRGM-(SPECIFY)	0	0		23.00
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	-52, 984	17, 386, 180		30.00
31.00	03100 I NTENSI VE CARE UNI T	-3, 400			31.00
32.00	03200 CORONARY CARE UNI T	0			32.00
33.00	03300 BURN INTENSIVE CARE UNIT	0	0		33.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0	0		34.00
40.00 41.00	04000 SUBPROVIDER - IPF 04100 SUBPROVIDER - IRF	-261, 342	1, 595, 209		40.00
41.00	04300 NURSERY		1, 259, 920		41.00
44.00	04400 SKILLED NURSING FACILITY	0	0		44.00
45.00	04500 NURSING FACILITY	0			45.00
46.00	04600 OTHER LONG TERM CARE	0	0		46.00
50.00	ANCI LLARY SERVI CE COST CENTERS	-1, 684, 459	6, 947, 475		50.00
51.00	05100 RECOVERY ROOM	0			51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300 ANESTHESI OLOGY	-2, 804, 872			53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	-76, 229			54.00
54. 01 55. 00	05401 FSED RADI OLOGY - DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	-23, 895			54. 01 55. 00
55.00	05501 WOODLAND CANCER CARE CTR	-76, 556			55.01
56.00	05600 RADI OI SOTOPE	0			56.00
57.00	05700 CT SCAN	0	0		57.00
	05800 MAGNETIC RESONANCE I MAGING (MRI)	0			58.00
59.00 60.00	05900 CARDI AC CATHETERI ZATI ON	-1, 082 -209, 781			59.00 60.00
	06000 LABORATORY 06001 FS ED LAB	-209, 781			60.00
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0		61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		62.00
63.00	06300 BLOOD STORI NG, PROCESSI NG & TRANS.	0	0		63.00
64.00	06400 I NTRAVENOUS THERAPY	0	0		64.00
65.00 66.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	-329, 340 -199, 372			65. 00 66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	0		67.00
68.00	06800 SPEECH PATHOLOGY	0	0		68.00
	06900 ELECTROCARDI OLOGY	-2, 610	1, 311, 151		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	-12, 274			71.00
72.00 73.00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS		11, 510, 510 19, 087, 457		72.00 73.00
	07400 RENAL DI ALYSI S	0	0		73.00
75.00	07500 ASC (NON-DI STI NCT PART)	0	0		75.00
76.00	03020 CV RESOURCE CTR	0	-		76.00
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0		77.00
88.00	OUTPATIENT SERVICE COST CENTERS	0	0		88.00
88.00 89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00	09000 CLINIC	0	ŏ		90.00
90.03	09003 INFUSION OP SERVICES	-991			90. 03
	09100 EMERGENCY	-226, 567			91.00
91.01	09101 FREE STANDING EMERGENCY DEPT	-61, 070	1, 903, 990		91.01

Heal th	Financial Systems FR	ANCISCAN HEALTH	MICHIGAN CITY	In Lieu	u of Form CMS-2552-10
RECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider CCN: 15-0015	Peri od:	Worksheet A
				From 01/01/2020 To 12/31/2020	Date/Time Prepared: 7/28/2021 7:41 pm
	Cost Center Description	Adjustments N	Net Expenses		172072021 7. 11 pm
			or Allocation		
		6.00	7.00		
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				92.00
	OTHER REIMBURSABLE COST CENTERS				
94.00	09400 HOME PROGRAM DI ALYSI S	0	0		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	0		100.00
101.00	10100 HOME HEALTH AGENCY	0	0		101.00
	SPECIAL PURPOSE COST CENTERS		1		
105.00	10500 KIDNEY ACQUISITION	0	0		105.00
106.00	10600 HEART ACQUI SI TI ON	o	o		106.00
	10700 LIVER ACQUISITION	0	o		107.00
	10800 LUNG ACQUISITION	0	o		108.00
	10900 PANCREAS ACQUI SI TI ON	0	o		109.00
	11000 I NTESTI NAL ACQUI SI TI ON	0	o		110.00
	11100 I SLET ACQUI SI TI ON	0	0		111.00
	11300 I NTEREST EXPENSE	0	o		113.00
	11400 UTI LI ZATI ON REVI EW-SNF	0	0		114.00
	11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0		115.00
	11600 HOSPI CE	0	0		116.00
118.00		u	194, 880, 462		118.00
110.00	NONREI MBURSABLE COST CENTERS	17,000,717	174,000,402		110:00
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	-17, 609		190. 00
	19100 RESEARCH	0	0		191.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		191.00
	19300 NONPALD WORKERS	0	0		192.00
	19301 NONPALD WORKERS	0	0		193. 0
	07950 BEACON JOINT VENTURE	0	0		193.01
	07950 BEACON JOINT VENTORE	0	1, 801, 765		194. 00
	07953 MED WATCHER	0	0		194. 03
	07953 MED WATCHER 07960 DUNELAND FITNESS CTR	0	0		194. 03
		0			
	07961 OMNI HEALTH & FITNESS CHESTERTOWN	0	0		194. 1
	07966 PHYSICIAN PRACTICE MD WISW	0	10, 159		194.16
	07969 HEALTH PARTNERS	0	-617, 177		194. 19
	07970 CENTER OF HOPE	0	65, 938		194.20
200.00	TOTAL (SUM OF LINES 118 through 199)	-17, 806, 917	196, 123, 538		200.00

_ASSI F	I CATI ONS			Provider CCN: 1	5-0015	Peri od:	Worksheet A-	6
						From 01/01/2020 To 12/31/2020	Date/Time Pro	epared
		Increases				I.,	7/28/2021 7:	<u>41 pm</u>
	Cost Center	Line #	Salary	Other				
Δ	2. 00	3.00	4.00	5.00				
	P REL COSTS-MVBLE EQUI P	2.00	0	9, 157, 117				1.0
0			0	9, 157, 117				_
	- CAFETERI A FETERI A	11.00	1, 159, 685	938, 656				1.0
0			1, 159, 685	938, 656				1.0
	- IMPLANTABLE DEVICES							
	PL. DEV. CHARGED TO TIENTS	72.00	0	10, 441, 100				1. (
0		+		10, 441, 100				
	- MEDI CAL SUPPLI ES							
	DI CAL SUPPLI ES CHARGED TO TI ENTS	71.00	0	15, 971, 389				1.0
	MINISTRATIVE & GENERAL	5.00	o	75, 695				2.
		0.00	0	0				3.
		0.00	0	0				4.0
		0.00 0.00	0	0				5.0
		0.00	Ő	0				7.
		0.00	0	0				8.
		0.00 0.00	0	0				9. 10.
		0.00	0	0				11.
		0.00	0	0				12.
		0.00	0	0				13.
		0.00 0.00	0	0				14. 15.
		0.00	0	0				16.
		0.00	0	0				17.
		0.00	0	0				18.
		0.00 0.00	0	0				19. 20.
		0.00	0	0				21.
		0.00	0	0				22.
		0.00 0.00	0	0				23.
		0.00	0	0				25.
		0.00	0	0				26.
0 F	- MEDICAL SUPPLIES PACEMAKER	29	0	16, 047, 084				-
I M	PL. DEV. CHARGED TO	72.00	0	1, 069, 410				1.0
PA.	TIENTS	0.00		2				
		0.00 0.00	0	0				2. 3.
0			0	1,069,410				0.1
	- NURSERY AND L&D	40.00	740.044	500.07/				
	<u>RSERY</u>		<u>719, 9</u> 44 719, 944	<u>539, 976</u> 539, 976				1.0
	- DEPRECIATION		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	· ·				
CAI	P REL_COSTS_BLDG_&_FI_XT		0	427, 416				1.0
O H	- INTEREST		0	427, 416				-
	P REL COSTS-BLDG & FIXT		0	<u>9, 957, 5</u> 25				1.0
0	- DRUGS & PHARM		0	9, 957, 525				-
	MINI STRATI VE & GENERAL	5.00	0	15				1.
	ED RADIOLOGY - DIAGNOSTIC	54.01	0	52				2.
DRI	UGS CHARGED TO PATIENTS	73.00	0	19, 087, 457				3.
		0.00 0.00	0	0				4.
		0.00	0	0				6.
		0.00	0	0				7.
		0.00	0	0				8.
		0.00 0.00	0	0				9. 10.
		0.00	0	0				10.
		0.00	0	ŏ				12.
		0.00	0	0				13.
		0.00	0	0				14.
		0.00 0.00	0	0				15. 16.
		0.00	0	0				17.
		0. 00 0. 00	0	0				18. 19.

Health Financial Systems RECLASSIFICATIONS			RANCISCAN HEALTH	MICHIGAN CIT	In Lieu of Form CMS-2552-10			
				Provider CCN: 15-0015		Period: From 01/01/2020	Worksheet A-	6
							Date/Time Pr 7/28/2021 7:	
		Increases						
	Cost Center	Line #	Salary	0ther				
	2.00	3.00	4.00	5.00				
C)		0	19, 087, 524				
500.00	Grand Total: Increases		1, 879, 629	67, 665, 808				500.00

Incrementary Incrementary<	LASSI	I FI CATI ONS		ANCI SCAN HEALTH		CCN: 15-0015	Peri od:	Worksheet A-6	2552)
Image: Contract Contract Unite 3 Statary Other ext. A.7 Rec. A = 620 TAL 50 M A FINT 1.00 9.00 9.00 10.00 B = CARTERIA 1.00 0 9.157,117 9 B = CARTERIA 0.00 1.159,568 938,664 0 1 B = CARTERIA 0.00 1.159,568 938,664 0 1 C = MENTARE EWIGES 0 0 1.4179,368 938,664 0 1 D = MENTARE EWIGES 0 0 1.441.100 0 1									
6.00 7.00 8.00 9.00 10.00 0 A - CAP 14 - </th <th></th> <th></th> <th>Decreases</th> <th></th> <th></th> <th></th> <th>I</th> <th>//28/2021 /:4</th> <th>1 pm</th>			Decreases				I	//28/2021 /:4	1 pm
N CAPTRIA CO Q C<		Cost Center	Line #	Sal ary	Other		<u>f.</u>		
0 De DELCOSTS-BLOG & FIXT 1.00 0 9.075.117 2 0 DE DELCOSTS-BLOG & FIXT 10.00 1.159.691 938.660 0 0 DE DELCOSTS-BLOG & FIXT 10.00 1.159.691 938.660 0 0 DE DELCOSTS-BLOG & FIXT 0 0 0.041.100 0 0 DE DELCOSTS-BLOG & FIXT 0 0 0.041.100 0 0 DE DELCOSTS-BLOG & FIXT 0 0 0.041.100 0 0 DE DELCOSTS-BLOG & FIXT 0 0 0.041.100 0 0 DE DELCOSTS-BLOG & FIXT 0 0 4.44.63 0 2 0 DE DEVENTOR FIXT 10.00 0 2.108.00 0 2 0 DE DEVENTOR FIXT 10.00 0 2.108.00 0 2 0 DE DEVENTOR FIXT 10.00 0 2.108.00 0 2 0 DE DEVENTOR FIXT 10.00 0 2.108.00 0 2 <td></td> <td></td> <td>7.00</td> <td>8.00</td> <td>9.00</td> <td>10.00</td> <td></td> <td></td> <td></td>			7.00	8.00	9.00	10.00			
0 0			1 00		0 457 447				
B CAPTINIA Image: Control of the second sec		CAP REL COSTS-BLDG & FIXI					9		1
D DITARY ID. 00 I.159.06 938.660 0 0 ID.159.060 33.600 0	L L			0	9, 157, 117				
D T. 199, 045 938, 065 T 0 MEDICAL SUPPLIES CHARGED TO 71, 00 0 10, 441, 100 0 0 MEDICAL SUPPLIES 0 10, 441, 100 0 1 0 MEDICAL SUPPLIES 0 10, 441, 100 0 1 0 MEDICAL SUPPLIES 0 0 44, 453 0 2 0 MEDICAL SUPPLIES 0 0 44, 453 0 2 0 MEDICAL SUPPLIES 0 0 13, 100 0 44, 453 0 2 0 MERSING SADIM STRATION 13, 00 0 2, 156 0 0 11, 100 0 MERSING SADIM STRATION 13, 00 0 276, 536 0 11 0 MERSING SADIM STRATION 13, 00 0 276, 536 0 11 0 MERSING SADIM STRATION 13, 00 0 276, 536 0 11 0 MERSING SADIM STRATION 13, 00 0			10.00	1 159 685	938 656		0		1
Description Description <thdescription< th=""> <thdescription< th=""></thdescription<></thdescription<>		<u> </u>							
PART PLATS	C	C - IMPLANTABLE DEVICES			· · · · · ·				
0 0 10 44.104 0 0 FUNDER 0 10.441.100 1 1 0 FUNDER 0 4.00 4.104 0 1 0 FUNDER 7.00 0 4.104 0 1 0 FUNDER 7.00 0 4.104 0 1 0 FUNDER 7.00 0 4.104 0 1 0 FUNDER 5.00 0 2.150 0 1 0 FUNDER 13.00 0 7.15.87 0 1 1 0 FUNDER 1.5 0.00 1.21.57.184 0 1 1 0 SUBROVIER = IFF 40.00 0 5.05.96 0 1 </td <td></td> <td></td> <td>71.00</td> <td>0</td> <td>10, 441, 100</td> <td>)</td> <td>0</td> <td></td> <td>1</td>			71.00	0	10, 441, 100)	0		1
D MEDICAL SUPPLY IS UMPLOVE DURY ITS DEPARTMENT 4.00 0 44.463 0 0 OPERATION OF PLANT 7.00 0 44.463 0 0 OPERATION OF PLANT 7.00 0 44.463 0 0 DEPARTION OF PLANT 13.00 0 2.33 0 0 DEPARTMENT SUBJECT 5.00 12.02 0 0 0 DEPARTMENT SUBJECT 5.00 12.05 0 0 0 DEPARTMENT SUBJECT 5.00 12.05 13.00 0 0 770.6939 0 0 DEPARTMENT SUBJECT 5.00 12.05 18.00 11.00 12.05 18.00 11.00 12.05 18.00 11.00 12.05 18.00 13.00 12.05 18.00 13.00 13.00 13.00 13.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00	F	PATI ENTS	+				_		
0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	(0	10, 441, 100)			
0 0 0000000000000000000000000000000000			4.00	0	4 104		0		1
0 LAUNDRY & LINER SERVICE 8.00 0 12,034 0 0 MUSENERPING 9.00 0 9.118 0 0 DIFFARY 10.00 0 9.224 0 0 DIFFARY 10.00 0 9.220 0 0 MIRSING ADJININSTRATION 13.00 0 12,152 0 0 MUSING NETHING 13.00 0 276,530 0 17 0 DURISING REALMONT 53.00 0 12,054,184 0 17 0 DERATING ROWIN 10.00 0 5,076 0 17 0 DERATING ROWIN 50.00 0 12,054,184 0 17 0 DERATING ROWIN 55.00 0 64,932 0 11 0 DERATING ROWIN 55.00 0 13,48,862 0 10 0 ADDIAC CATHETER JATION 55.00 0 13,48,862 0 22 0<									
0 0005KELEPING 9,00 0,3110 0 2,150 0 0 0,722 0 0 0 0,722 0 0 0 0,722 0 0 0 0,722 0 0 0 0,722 0 0 0 0,722 0 0 0 0,722 0 0 0 0,722 0 0 0 0,722 0 0 0 0,723 0 0 0 0,732 0 0 0 0,732 0 0 0 0,732 0 0 0 0,732 0 0 0 0,732 0 0 0 0,732 0 0 0 0,732 0 0 0 0 0,733 0 0 0 0,733 0 0 0 0,733 0 0 0 0,733 0 0 0 0,733 0 0 0 0,733 0 0 0 0,733 0 0 0 0,733 0 0 0 0 0,733 0 0 0 0 0,733 0 0 0 0 0,733 0 0 0 0 0,733 0 0 0 0 0,733 0 0 0 0 0 0 0 0 0									
0 0 0 0 9,826 0 9 9 0 0 5,757 0							-		
0 CENTRAL SERVICES & SUPPLY 14.00 167, 322 0 0 MARMACY 15.00 0 721, 587 0 0 MULTS & PEDIATRICS 30.00 0 766, 539 0 0 NITENSIVE CARE UNIT 31.00 0 276, 532 0 11 0 OPERATING ROM 50.00 0 12, 087, 088 0 11 0 OPERATING ROM 50.00 0 14, 6332 0 11 0 OPERATING ROM 50.00 0 14, 848, 862 0 11 0 RADIOLONY-DIACOSTIC 54.00 0 13, 333 0 11 0 RADIOLONY-DIACOSTIC 54.00 0 13, 348, 862 0 11 0 ADDONTORY THERDAY 65.00 0 13, 348, 862 0 22 0 LABINATINERAPY 65.00 0 13, 348, 962 0 22 0 LARDIN MORTHERAPY 90.03 24, 143					9, 826		0		
0 PARAMACY 15.00 0 121.827 0 6 0 121.827 0 6 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0	NURSING ADMINISTRATION	13.00	0	2, 150)	0		e
0 ADLTS & PEDIATICS 30.00 0 706, 939 0 5 00 NUTENSIVE CARE UNIT 31.00 0 276, 536 0 11 00 SUPPRVIDER - IPF 40.00 0 5, 098 0 11 00 PRATINE ROW 50.00 0 12, 054, 184 0 13 00 PRATINE ROW 550, 00 0 445, 832 0 13 00 RADIOLGY - HEARPUTIC 55, 00 0 14, 932 0 14 00 RADIOLGY - THEARPUTIC 55, 00 0 14, 932 0 11 00 RADIOLGY - THEARPUTIC 56, 00 0 1, 019 0 13 00 RADIOLANC FURPARTING 66, 00 0 32, 092 0 12 01 FED LAB 60, 01 0 22, 00 22 0 22 0 22 0 22 0 14, 03 0 22 0 16, 00 22				8			0		
00 INTENSIVE CARE UNIT 31:00 0 276.334 0 11 00 OPERATING ROM 50:00 0 12,054,184 0 12 00 OPERATING ROM 50:00 0 12,054,184 0 12 00 RADICLOSY-INTERAPEUTIC 55:00 0 14,932 0 14 00 RADICLOSY-INTERAPEUTIC 55:00 0 13,88,862 0 11 00 CARDIA CCARTHETRIZATION 59:00 0 1,348,862 0 11 01 LABORATORY 60:00 0 136,805 0 22 01 LABORATORY 60:00 0 32,941,433 0 22 00 INTESTORE NUMER 91:00 0 334,892 0 22 00 INTESTORE SUPPLY 14:00 0 21,64,07,084 22 00 INTESTORE SUPPLY 14:00 0 1,042,214 0 0 CENTRAL SUPPLIES PACEMARKES 0				-			0		
00 SUBPROVIDER - 1PF 40.00 0 5.098 0 01 SUBPROVIDER - 1PF 40.00 0 12.043.184 0 00 OPERATINE ROM 55.00 0 445.832 0 11 00 RADIOLOGY - DI AGNOSTI C 54.00 0 445.832 0 11 00 RADIOLOGY - THERAPEUTI C 55.00 0 14.932 0 11 00 RADIOLOGY - THERAPEUTI C 55.00 0 13.368.62 0 11 00 CABORATORY 66.00 0 17.036 0 16 01 ADRIANTORY THERAPY 66.00 0 32.092 0 22 01 NUTSION OF SERVICES 90.03 0 24.143 0 22 01 RESPIRATORY THERAPY 66.00 0 22.092 0 22 01 NORMINE WELL 0 0 15.066 0 22 01 FIASTRATORY THERAPY 60.00							0		
00 0PERATING ROM 50.00 0 12.054.184 0 01 0PERATING ROM 50.00 0 445.832 0 00 PSED RADIOLOGY - DIAGNOSTIC 54.00 0 450.832 0 00 RADIOLOGY - DIAGNOSTIC 54.00 0 450.832 0 00 RADIOLOGY - THERAPEUTIC 55.01 0 63.030 0 11 00 NODOLAND CANCER CARE CTR 55.01 0 1.348.862 0 11 00 CABDIA CARTHETRIZATION 59.00 0 1.348.862 0 12 00 CABDIA CARTHETRIZATION 66.00 0 32.092 0 22 00 CARTHACASTRAPY THERAPY 66.00 0 32.492 0 22 00 DERECENCY 91.00 0 344.890 0 22 00 FE STANDI NG ENERGENCY DEFT 91.01 0 64.977_0 0 0 24.00 27 01 DERECIATION NO ENER							0		
00 NADIOLOGY - DIAGNOSTIC 54.00 0 445.832 0 11 00 RSD.RADIOLOGY - THERAPEUTIC 55.00 0 14.932 0 11 00 RADIOLOGY - THERAPEUTIC 55.00 0 14.932 0 11 00 RADIAC CATHETERIZATION 59.00 0 1.348.862 0 11 00 ARDIAC CATHETERIZATION 59.00 0 1.348.862 0 12 00 ARDIATORY 66.00 0 32.092 0 22 00 RESPIRATORY THERAPY 66.00 0 32.092 0 22 00 RADIACRANOLOGY OF VEROPY 91.00 0 34.892 0 22 00 RESPIRATORY THERAPY 10.00 0 34.892 0 22 01 FIGURATORY 91.00 0 34.892 0 22 01 FIGURATORY 91.00 0 4.60 0 24.892 02 CATHE									
00 R5D RADIOLOGY - DIAGNOSTIC 54,01 0 50,981 0 00 RADIOLOGY - PIREAPEUTIC 55,00 0 14,932 0 00 MODOLAND CANCER CARE CTR 55,01 0 63,030 0 00 CARDIA CCATHETERIZATION 59,00 0 1,348,862 0 01 DAGRATIAC CATHETERIZATION 60,00 0 1,019 0 01 RESE TRATORY THERAPY 66,00 0 32,092 0 02 INFUSION D'SERVICES 90,03 0 24,143 0 22 01 INFUSION E MERGENCY DEPT 91,01 0 54,880 0 22 02 INFUSION E MERGENCY DEPT 91,01 0 21,060 0 22 03 ORERETING CASE SUPPLY 14,00 0 21,060 0 22 04 OPERATING ROMA 50,00 0 6,136 0 22 04 OPERATING ROMA 59,00 0 1,042,				-			0		
00 NADIOLOCY THERAPEUTIC 55.00 0 14.932 0 11 00 MODIAL CARVER CARE CTR 55.01 0 63.030 0 11 00 CARDIAC CATHETERIZATION 59.00 0 1.348.862 0 11 0 0 1.019 0 1.019 0 12 0 12 0 12 0 0 1.019 0 12 0 0 15 0 0 15 0 0 12 0 0 12 0 0 12 0 0 12 0 0 12 0 0 14 0 0 12 0 0 12 0 0 12 0 0 12 0 0 12 0 0 12 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0							0		
00 MODLAND CANCER CARE CTR 55.01 0 63.030 0 11 00 CARDIA CATHETERIZATION 59.00 0 1.348,862 0 11 00 LABORATORY 60.00 0 1.1036 0 10 01 RADIA CATHETERIZATION 59.00 0 1.348,862 0 11 00 RESE TANDING PURPY 65.00 0 12.092 0 22 00 HUSION OP SERVICES 90.03 0 24.143 0 22 00 INFUSION OF PURCENCY DEPT 91.00 0 324.892 0 22 00 INFUSION OF ENERGENCY DEPT 91.01 0 45.880 0 22 00 INFUSION OF ENERGENCY DEPT 91.01 0 24.143 0 22 00 CARDIAC, CATHETERIZATION 59.00 0 1.042.214 0 0 0 CENTRAL SERVICES & SUPPLY 14.00 0 1.049.910 1.042.214 0 0 <td></td> <td></td> <td></td> <td>0</td> <td></td> <td></td> <td>0</td> <td></td> <td></td>				0			0		
00 LABORATORY 60.00 0 11.036 0 00 FS ED LAB 60.01 0 1.019 0 00 RESPIRATORY THERAPY 65.00 0 32.092 0 00 RESPIRATORY THERAPY 66.00 0 32.092 0 00 ILECTROCARDI OLOGY 69.00 0 22.291 0 00 INFUSION OP SERVICES 90.03 0 24.143 0 22 00 INFUSIONIG EURRENCY DEPT 91.01 0 54.880 0 22 00 INFUSIONIG EURRENCY DEPT 91.01 0 72.677 0 24 00 CERTRAL SERVICES & SUPLY 14.00 21.060 0 24 00 CERTRAL SERVICES & SUPLY 14.00 1.049.410 0 24 0 CERTRAL SERVICES & SUPLY 14.00 1.049.410 0 24 0 CERTRAL SERVICES & SUPLY 14.00 1.049.410 0 27.416 0				0			0		
00 FS ED LAB 60.01 0 1,019 0 11 00 FSEP RATORY THERAPY 65.00 0 156.965 0 22 00 PHYSICAL THERAPY 66.00 0 32.992 0 22 00 PLUETORCARDIOLOCY 69.00 0 22,91 0 22 00 INTUSION OP SERVICES 90.03 0 24,143 0 22 00 EMERGENCY 91.00 0 34.892 0 22 00 MORNING WELL 0 16.047.084 0 22 24 01 16.047.084 0 16.047.084 0 24 24 0 CARNACCAL SUPPLIES PACEMAKERS 0 1.042.214 0 0 24 24 0 24 24 0 24 24 0 24 24 24 24 24 24 24 24 24 24 24 24 24 24 24	00 0	CARDI AC CATHETERI ZATI ON	59.00	0	1, 348, 862		0		
00 RESPIRATORY THERAPY 65.00 0 158.056 0 22 00 PHYSICAL THERAPY 66.00 0 32.092 0 22 00 ELECTROCARDI OLOGY 69.00 0 22.091 0 22 00 INFUSION OP SERVICES 90.03 0 24.143 0 22 00 INFUSION REL 91.01 0 54.880 0 22 0 OWDRNING RULE 194.01 0 10.047.084 2 2 0 ORTRAL SERVICES & SUPPLY 14.00 0 21.060 0 1 0 OPERATING ROM 50.00 0 6.136 0 2 0 0 0 0 1 0 <td>00 l</td> <td>LABORATORY</td> <td>60.00</td> <td>0</td> <td>11, 036</td> <td>0</td> <td>0</td> <td></td> <td>18</td>	00 l	LABORATORY	60.00	0	11, 036	0	0		18
00 PHYSICAL THERAPY 66.00 0 32.092 0 00 FLECTBOCABDIOLOCY 69.00 0.2.091 0 00 INFUSION OP SERVICES 90.03 0 24.143 0 00 DEMERGENY 91.00 0 334.892 0 22 00 FREE STANDING EMERCENCY DEPT 91.01 0 54.880 0 22 00 MORKING WELL							0		
OD ELECTROCARD DUGGY 69.00 0 20.291 0 00 INFUSION OP SERVICES 90.03 0 24.143 0 00 EMERGENCY 91.00 0 334.992 0 00 FREE STANDING EMERGENCY DEPT 91.01 0 74.677 0 0 0 79.677 0 0 22 0 0 16.047.064 0 22 0 0 16.047.064 0 22 0 0 16.047.064 0 22 0 0 1.069.410 0 23.600 0 0 1.042.214 0 24 0 0 1.069.410 0 25.000 0 0 0 1.042.214 0 0 1.042.214 0 0 0 1.069.410 1 1.069.410 1 1.069.410 1 0 0 -1.99.44 539.976 0 0<							0		
00 INFUSION OP SERVICES 90.03 0 24,143 0 EMERGENCY 91.00 0 334,892 0 22 00 FREE STANDING EMERGENCY DEPT 91.01 0 54,880 0 22 01 0 0.47,084 0 24 24 24 0 0 0.47,084 0 24 24 24 0 0 0.47,084 0 24				8			0		
OD ELERGENCY 91.00 0 33.4.892 0 00 FREE STADI NG EMERGENCY DEPT 91.01 0 54.880 0 00 OPRING. WELL 194.01 0 79.677 0 0 2 MEDICAL SUPPLIES PACEMAKERS 0 16.047.084 0 24 0 OPERATING ROW 50.00 0 6,136 0 12 0 OPERATING ROW 50.00 0 1,069,410 12 0 0 ADULTS & PEDIATRICS 30.00 719,944 539,976 0 0 1,069,410 14 0 O 719,944 539,976 0 0 247,416 9 14 179,944 539,976 0 0 9,957,525 11 16				-			0		
00 FERE STANDING EMERGENCY DEPT 91.01 0 54.880 0 00 WORKING. WELL 194.01 0 79.677 0 22 0 0 16.047.084 0 16.047.084 22 0 0 16.047.084 0 16.047.084 22 0 0 16.047.084 0 16.047.084 22 0 0 0 1.042.214 0 0 21.060 21.060 21.060 21.060 22 0 CARDIAC. CATHETERIZATION 59.00 0 1.042.214 0 0 21.060 21.0				8			0		
00 WORKING_WELL 194.01 0 79.677 0 0 16.047.084 26 E - MEDICAL SUPPLIES PACEMAKERS 0 21.060 0 16.047.084 1				-			0		
0 - 0 16,047,084 - E - MEDICAL SUPPLIES PACEMAKERS -				-			0		
0 CENTRAL SERVICES & SUPPLY 14.00 0 21.060 0 0 OPERATING ROOM 50.00 0 6.136 0 0 CARDIAC CATHETERIZIATION 59.00 0 1.042.214 0 0 CARDIAC CATHETERIZIATION 59.00 0 1.049.410 23 0 ADULTS & PEDIATRICS 30.00 719.944 539.976 0 0 0 OPERATING ROOM 0 427.416 9 0 427.416 9 0 OPERATING ROOM 0 9.957.525 11 1 1 0 ADMIN TSTRATIVE & GENERAL 5.00 0 9.957.525 11 1 1 - DRUGS & PHARM - 0 9.957.525 11 1 0 CENTRAL SERVICES & SUPPLY 14.00 0 18.875.856 0 23 0 PHARMACY 15.00 0 18.875.856 0 24 0 ANUSTS & PEDIATRICS 30.00 0 <td>Ċ</td> <td><u> </u></td> <td></td> <td></td> <td></td> <td></td> <td>1</td> <td></td> <td></td>	Ċ	<u> </u>					1		
00 DEPRATI NG ROOM 50.00 0 6.136 0 01 CARDIAC CATHETERIZATION 59.00 0 1.042,214 0 0 1.059,410 59.00 0 1.042,214 0 0 1.059,410 59.00 0 1.042,214 0 0 1.059,410 59.00 0 1.059,410 59.00 0 1.059,410 59.00 0 1.059,410 59.00 0 4.01158 59.00 0 4.27,416 9 0 0 4.27,416 9 0 4.27,416 9 0 4.27,416 9 0 9,957,525 11 0 0 9,957,525 11 0 0 9,957,525 11 0 0 1.042,954 0 128 0 128 0 128 0 128 0 1.041158 30.00 0 7.640 0 128 0 1.011160 1.011160 1.011160 1.011160 1.011160 1.011160 1.011160 1.011160	E	E - MEDICAL SUPPLIES PACEMAKE	RS						
00 CARDIAC CATHETERIZATION 59.00 0 1.042,214 0 0 0 1.069,410 0 1.069,410 0 F - NURSERY AND L&D 0 1.069,410 0 1 0 0 ADULTS & PEDIATRICS 30.00 719,944 539,976 0 1 0 OPERATING ROOM 0 427,416 9 1 1 0 OPERATING ROOM 0 427,416 9 1 1 0 ADMINISTRATIVE & GENERAL 5.00 0 9,957,525 11 1 0 ADMINISTRATIVE & GENERAL 5.00 0 9,957,525 1 1 1 - DRUGS & PHARM 9 0 2 1 2 1 00 EMPLOYEE BENEFITS DEPARTMENT 4.00 0 45,954 0 2 2 1 - DRUGS & PHARM 0 0 7,460 0 2 3 00 PHARMACY 13.00 0 7,640 0 3 3 3 3 3 3									
0				0			0		
F - NURSERY AND L&D - 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 1 <th1< th=""> <th1< th=""> 1</th1<></th1<>			<u>59.00</u>				0		3
DO ADULTS & PEDIATRICS 30.00 719.944 539.976 0 0 0 719.944 539.976 0 1 0 0 427.416 9 1 0 0 427.416 9 1 0 0 427.416 9 1 0 0 9.957.525 11 1 0 0 9.957.525 11 1 1 - DRUGS & PHARM - 0 9.957.525 1 1 - DRUGS & PHARM 4.00 0 45.954 0 1 0 CENTRAL SERVICES & SUPPLY 14.00 0 128 0 2 0 HARMACY 15.00 0 18.875.856 0 2 0 ADULTS & PEDIATRICS 30.00 0 7.640 0 5 0 SUBPROVIDER - IPF 40.00 0 17.376 0 5 0 OPERATING ROOM 50.00	L L			U	1,009,410				
O 719,944 539,976 76 0 OPERATING ROOM 0 427,416 9 0 OPERATING ROOM 0 427,416 9 0 0 427,416 9 0 0 427,416 9 0 0 9,957,525 11 0 0 9,957,525 11 1 DRUGS & PHARM 9 9 0 EMPLOYEE BENEFITS DEPARTMENT 4.00 0 45,954 0 0 CENTRAL SERVICES & SUPPLY 14.00 0 18,875,856 0 20 00 PHARMACY 15.00 0 8,875,856 0 20 00 INTENSI VE CARE UNI T 31.00 0 7,640 0 6 01 SUBPROVI DER - IPF 40.00 0 17,376 0 7 02 ANDI CACY-DI AGNOSTI C 54.00 0 2,575 0 7 03 RADI OLOGY-DI AGNOSTI C <t< td=""><td></td><td></td><td>30.00</td><td>719 944</td><td>539 976</td><td></td><td>0</td><td></td><td>1</td></t<>			30.00	719 944	539 976		0		1
G DEPRECIATION 00 DPERATING ROOM 50.00 0 427,416 9 0 ADMI NI STRATI VE & GENERAL 50.00 0 9,957,525 11 0 ADMI NI STRATI VE & GENERAL 0 9,957,525 11 0 - 0 9,957,525 11 0 - 0 9,957,525 11 0 - 0 9,957,525 11 0 - 0 9,957,525 11 0 CENTRAL SERVI CES & SUPPLY 4.00 0 428 0 0 EMPLOYEE BENEFITS DEPARTMENT 4.00 0 128 0 0 PHARMACY 15.00 0 18,875,856 0 2 0 NTENSI VE CARE UNI T 31.00 0 7,640 0 2 0 SUBPROVI DER - I PF 40.00 0 17,376 0 2 0 PADI ACGY - THERAPEUTI C 55.00 0 15,115				+					
0 - - 0 427, 416 - 0 ADMI NI STRATI VE & GENERAL 5.00 0 9, 957, 525 11 0 - - 0 9, 957, 525 11 0 - - 0 9, 957, 525 11 0 - - 0 9, 957, 525 11 0 - - 0 9, 957, 525 11 0 - - 0 9, 957, 525 11 0 - - 0 9, 957, 525 11 0 - - 0 9, 957, 525 0 0 EMPLOYEE BENEFITS DEPARTMENT 4.00 0 128 0 0 PHARMACY 15.00 0 18, 875, 856 0 2 0 ADUITS & PEDIATRICS 30.00 0 7, 640 0 2 0 OPERATING ROM 50.00 0 17, 376 0 2 0	C	G - DEPRECIATION			,,,,,		1		
H INTEREST 0 ADMI NI STRATI VE & GENERAL 5.00 0 9, 957, 525 11 0 EMPLOYEE BENEFI TS DEPARTMENT 4.00 0 45, 954 0 1 0 CENTRAL SERVICES & SUPPLY 14.00 0 128 0 2 0 PHARMACY 15.00 0 18, 875, 856 0 2 0 INTENSI VE CARE UNIT 31.00 0 7, 640 0 2 0 SUBPROVI DER - IPF 40.00 0 17, 376 0 2 0 OPERATING ROOM 50.00 0 17, 376 0 7 0 NETHESI OLOGY 53.00 0 2, 575 0 7 0 RADI OLOGY-THERAPEUTI C 55.00 0 15, 115 0 10 0 CARDI AC CATHETREIZATI ON 59, 00 0 18, 80 13 0 LABORATORY 65.00 0 14, 44 0 13 0	οŔ	DPERATING ROOM	50.00	0	427, 416		9		1
0 ADMI NI STRATI VE & GENERAL 5.00 0 9,957,525 11 0 9,957,525 0 9,957,525 11 0 EMPLOYEE BENEFI TS DEPARTMENT 4.00 0 45,954 0 0 PHARMACY 15.00 0 128 0 0 ADULTS & PEDI ATRI CS 30.00 0 6,377 0 0 SUBPROVI DER - IPF 40.00 0 17,640 0 0 OPERATING ROOM 50.00 0 17,376 0 0 ADIGY-THERAPEUTIC 53.00 0 2,575 0 0 RADI OLOGY-THERAPEUTIC 55.00 0 15,115 0 00 CARDI AC CATHETERI ZATI ON 59.00 0 18 0 17 00 CARDI AC CATHETERI ZATI ON 59.00 0 18 0 17 00 CARDI AC CATHETERI ZATI ON 59.00 0 18 0 17 00 CARDI AC CATHETERI ZATI ON 59.00 0 18 0 17 00 RESPI RATOR	C			0	427, 416				
O O O 9, 957, 525 I - DRUGS & PHARM	- E		1		0.055				
I - DRUGS & PHARM 0 EMPLOYEE BENEFITS DEPARTMENT 4.00 0 45,954 0 0 CENTRAL SERVICES & SUPPLY 14.00 0 128 0 0 PHARMACY 15.00 0 18,875,856 0 22 0 ADULTS & PEDIATRICS 30.00 0 6,377 0 24 0 INTENSIVE CARE UNIT 31.00 0 7,640 0 55 0 SUBPROVI DER - IPF 40.00 0 10 0 66 0 OPERATI NG ROOM 50.00 0 17,376 0 76 0 ANESTHESI OLOGY 53.00 0 2,575 0 76 0 RADI OLOGY-THERAPEUTI C 55.00 0 15,115 0 10 00 LABORATORY 60.00 0 5,618 0 11 00 LABORATORY 65.00 0 14,454 0 13 00 HASINGY	υļ	ADMINISIRAIIVE & GENERAL	5.00	•			14		1
0 EMPLOYEE BENEFITS DEPARTMENT 4.00 0 45,954 0 0 CENTRAL SERVICES & SUPPLY 14.00 0 128 0 0 PHARMACY 15.00 0 18,875,856 0 0 ADULTS & PEDI ATRICS 30.00 0 6,377 0 0 INTENSIVE CARE UNIT 31.00 0 7,640 0 0 SUBPROVIDER - IPF 40.00 0 10 0 0 OPERATING ROOM 50.00 0 17,376 0 0 ANESTHESI OLOGY 53.00 0 28,183 0 00 RADI OLOGY-DI AGNOSTI C 54.00 0 2,575 0 00 RADI OLOGY-THERAPEUTI C 55.00 0 18 0 11 00 LABORATORY 60.00 0 5,618 0 12 00 RADI OLOGY 65.00 0 1,454 0 12 00 RESPI RATORY THERAPY 65.00 0 14 14 14 00 INFUSI ON OP SERVICES	0			0	9,957,525				
0 CENTRAL SERVICES & SUPPLY 14.00 0 128 0 0 PHARMACY 15.00 0 18,875,856 0 3 0 ADULTS & PEDIATRICS 30.00 0 6,377 0 4 0 INTENSIVE CARE UNIT 31.00 0 7,640 0 5 0 SUBPROVIDER - IPF 40.00 0 10 0 6 0 OPERATING ROOM 50.00 0 17,376 0 6 0 RADI OLOGY-DI AGNOSTI C 54.00 0 2,575 0 16 00 CARDI AC CATHETERIZATI ON 59.00 0 15,115 0 17 00 LABORATORY 60.00 0 5,618 0 17 00 RASTIRATORY THERAPY 66.00 0 508 0 17 00 RESPI RATORY THERAPY 66.00 0 232 0 14 00 PHYSI CAL THERAPY 66.00 0 232 0 14 00 INFUSI ON OP SERVI CES 90.03			4 00	0	45 954		0		1
00 PHARMACY 15.00 0 18,875,856 0 0 0 00 ADULTS & PEDIATRICS 30.00 0 6,377 0 0 00 INTENSIVE CARE UNIT 31.00 0 7,640 0 5 00 SUBPROVIDER - IPF 40.00 0 10 0 6 00 OPERATING ROOM 50.00 0 17,376 0 6 00 RADIOLOGY - DI AGNOSTIC 53.00 0 28,183 0 6 00 RADIOLOGY-THERAPEUTIC 55.00 0 15,115 0 10 00 LABORATORY 66.00 0 5,618 0 11 00 LABORATORY 66.00 0 508 0 14 00 ELECTROCARDIOLOGY 69.00 0 232 0 14 00 INFUSION OP SERVICES 90.03 0 301 0 16 00 INFUSION OP SERVICES 90.03 0 301 0 17 00 FREE STANDING EMERGENCY DEP									
0 ADULTS & PEDIATRICS 30.00 0 6, 377 0 0 INTENSIVE CARE UNIT 31.00 0 7, 640 0 0 SUBPROVIDER - IPF 40.00 0 10 0 0 OPERATING ROOM 50.00 0 17, 376 0 6 0 OPERATING ROOM 50.00 0 28, 183 0 8 0 ANDIOLOGY - DIAGNOSTIC 54.00 0 2, 575 0 6 00 RADIOLOGY - THERAPEUTIC 55.00 0 15, 115 0 10 00 LABORATORY 60.00 0 5, 618 0 12 00 LABORATORY HERAPY 65.00 0 1, 454 0 12 00 LABORATORY HERAPY 66.00 0 232 0 14 00 INFUSION OP SERVICES 90.03 0 301 0 14 00 INFUSION OP SERVICES 90.03 0 301 0 16 00 INFUSION OP SERVICES 90.03									
0 INTENSIVE CARE UNIT 31.00 0 7,640 0 0 SUBPROVIDER - IPF 40.00 0 10 0 0 OPERATING ROM 50.00 0 17,376 0 0 ANESTHESIOLOGY 53.00 0 28,183 0 0 RADIOLOGY-DIAGNOSTIC 54.00 0 2,575 0 00 RADIOLOGY-THERAPEUTIC 55.00 0 15,115 0 10 00 CARDIAC CATHETERIZATION 59.00 0 18 0 11 00 LABORATORY 60.00 0 5,618 0 12 00 RESPIRATORY THERAPY 65.00 0 1,454 0 12 00 RESPIRATORY THERAPY 66.00 0 508 0 14 00 ELECTROCARDIOLOGY 69.00 0 232 0 15 00 INFUSION OP SERVICES 90.03 0 301 0 16 00 EMERGENCY 91.00 0 10 0 17 16				Ö			-		
0 00ERATING ROM 50.00 0 17,376 0 0 ANESTHESI OLOGY 53.00 0 28,183 0 6 0 RADI OLOGY-DI AGNOSTI C 54.00 0 2,575 0 6 00 RADI OLOGY-THERAPEUTI C 55.00 0 15,115 0 10 00 CARDI AC CATHETERI ZATI ON 59.00 0 18 0 11 00 CARDI AC CATHETERI ZATI ON 59.00 0 18 0 11 00 LABORATORY 60.00 0 5,618 0 11 00 RESPI RATORY THERAPY 65.00 0 1,454 0 11 00 PHYSI CAL THERAPY 66.00 0 508 0 14 00 ELECTROCARDI OLOGY 69.00 0 232 0 14 00 EMERGENCY 91.00 0 10 0 16 00 EMERGENCY 91.01 0 155 0 14 00 FREE STANDI NG EMERGENCY DEPT 91.01				0			0		
0 ANESTHESI OLOGY 53.00 0 28,183 0 68 0 RADI OLOGY-DI AGNOSTI C 54.00 0 2,575 0 9 00 RADI OLOGY-THERAPEUTI C 55.00 0 15,115 0 16 00 CARDI AC CATHETERI ZATI ON 59.00 0 18 0 17 00 LABORATORY 60.00 0 5,618 0 12 00 RESPI RATORY THERAPY 65.00 0 1,454 0 13 00 PHYSI CAL THERAPY 66.00 0 508 0 14 00 ELECTROCARDI OLOGY 69.00 0 232 0 15 00 INFUSI ON OP SERVICES 90.03 0 301 0 16 00 EMERGENCY 91.00 0 10 0 17 00 FREE STANDI NG EMERGENCY DEPT 91.01 0 155 0 17 00 WORKI NG WELL				8			0		
0 RADI OLOGY-DI AGNOSTI C 54.00 0 2,575 0 10 00 RADI OLOGY-THERAPEUTI C 55.00 0 15,115 0 10 00 CARDI AC CATHETERI ZATI ON 59.00 0 18 0 11 00 LABORATORY 60.00 0 5,618 0 12 00 RESPI RATORY THERAPY 65.00 0 1,454 0 13 00 RESPI RATORY THERAPY 66.00 0 508 0 14 00 ELECTROCARDI OLOGY 69.00 0 232 0 15 00 INFUSI ON OP SERVI CES 90.03 0 301 0 16 00 FREE STANDI NG EMERGENCY DEPT 91.00 0 155 0 16 00 WORKI NG WELL 194.01 0 155 0 15 15 00 WORKI NG WELL 194.01 0 155 0 15 15				-			0		
00 RADI OLOGY-THERAPEUTI C 55.00 0 15,115 0 10 00 CARDI AC CATHETERI ZATI ON 59.00 0 18 0 17 00 LABORATORY 60.00 0 5,618 0 12 00 RESPI RATORY THERAPY 65.00 0 1,454 0 13 00 PHYSI CAL THERAPY 66.00 0 508 0 14 00 ELECTROCARDI OLOGY 69.00 0 232 0 15 00 INFUSI ON OP SERVI CES 90.03 0 301 0 16 00 EMERGENCY 91.00 0 155 0 17 00 FREE STANDI NG EMERGENCY DEPT 91.01 0 155 0 18 00 WORKI NG WELL 194.01 0 155 0 18 19 0 19,087,524 0 19,087,524 19 19 19 19				-			0		
00 CARDI AC CATHETERI ZATI ON 59.00 0 18 0 11 00 LABORATORY 60.00 0 5,618 0 12 00 RESPI RATORY THERAPY 65.00 0 1,454 0 13 00 PHYSI CAL THERAPY 66.00 0 508 0 14 00 ELECTROCARDI OLOGY 69.00 0 232 0 15 00 INFUSI ON OP SERVI CES 90.03 0 301 0 16 00 EMERGENCY 91.00 0 155 0 17 00 FREE STANDI NG EMERGENCY DEPT 91.01 0 155 0 18 00 WORKI NG WELL 194.01 0 155 0 18 0 19				-			U O		
00 LABORATORY 60.00 0 5,618 0 12 00 RESPIRATORY THERAPY 65.00 0 1,454 0 13 00 PHYSI CAL THERAPY 66.00 0 508 0 14 00 ELECTROCARDI OLOGY 69.00 0 232 0 15 00 INFUSI ON OP SERVICES 90.03 0 301 0 16 00 EMERGENCY 91.00 0 10 0 16 00 FREGENCY 91.01 0 155 0 17 00 WORKI NG WELL 194.01 0 155 0 17 00 WORKI NG WELL 0 194.01 0 19,087,524 19 19				0			0		
00 RESPIRATORY THERAPY 65.00 0 1,454 0 13 00 PHYSICAL THERAPY 66.00 0 508 0 14 00 ELECTROCARDI OLOGY 69.00 0 232 0 15 00 INFUSI ON OP SERVI CES 90.03 0 301 0 16 00 EMERGENCY 91.00 0 10 0 17 00 FREE STANDI NG EMERGENCY DEPT 91.01 0 155 0 17 00 WORKI NG WELL 194.01 0 155 0 16 0 19.087, 524 0 19,087,524 19 16				0			0		
00 PHYSICAL THERAPY 66.00 0 508 0 14 00 ELECTROCARDI OLOGY 69.00 0 232 0 15 00 INFUSI ON OP SERVICES 90.03 0 301 0 16 00 EMERGENCY 91.00 0 10 0 17 00 FREE STANDI NG EMERGENCY DEPT 91.01 0 155 0 18 00 WORKI NG WELL				0			0		
00 ELECTROCARDI OLOGY 69.00 0 232 0 15 00 INFUSI ON OP SERVI CES 90.03 0 301 0 16 00 EMERGENCY 91.00 0 10 0 17 00 FREE STANDI NG EMERGENCY DEPT 91.01 0 155 0 18 00 WORKI NG WELL				0			õ		
00 INFUSION OP SERVICES 90.03 0 301 0 16 00 EMERGENCY 91.00 0 10 0 17 00 FREE STANDING EMERGENCY DEPT 91.01 0 155 0 18 00 WORKING WELL				0			0		
00 EMERGENCY 91.00 0 10 0 17 00 FREE STANDING EMERGENCY DEPT 91.01 0 155 0 18 00 WORKING WELL				o			0		
00 WORKING WELL 194.01 0 80,014 0 19 0 19,087,524 0 19,087,524 0 19 19 19				0			0		
0 19,087,524				0	155	5	0		18
	00	NORKING WELL	194.01				이		19
	6	D		0					

Heal th Financia	I S	Systems		
RECONCI LI ATI ON	0F	CAPI TAL	COSTS	CENTERS

FRANCI SCAN HEALTH MI CHI GAN CI TY Provi der CCN: 15-0015

In Lieu of Form CMS-2552-10 Period: Worksheet A-7 From 01/01/2020 Part I

					To	12/31/2020	Date/Time Pre 7/28/2021 7:4	
				Acqui si ti on	s			
		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, 516, 038	79, 511		0	79, 511		1.00
2.00	Land Improvements	4, 616, 374	1, 525, 888		0	1, 525, 888		2.00
3.00	Buildings and Fixtures	292, 850, 400	17, 322, 490		0	17, 322, 490	136, 308	3.00
4.00	Building Improvements	0	0		0	0	0	4.00
5.00	Fixed Equipment	6, 246, 041	47, 529, 639		0	47, 529, 639		5.00
6.00	Movable Equipment	136, 063, 315	6, 016, 455		0	6, 016, 455	50, 589, 871	6.00
7.00	HIT designated Assets	0	0		0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	449, 292, 168	72, 473, 983		0	72, 473, 983	50, 811, 397	8.00
9.00	Reconciling Items	7,047,515	1, 208, 158		0	1, 208, 158	0	9.00
10.00	Total (line 8 minus line 9)	442, 244, 653	71, 265, 825		0	71, 265, 825	50, 811, 397	10.00
		Endi ng Bal ance	Fully					
			Depreci ated					
			Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET							
1.00	Land	9, 595, 549	530, 084					1.00
2.00	Land Improvements	6, 134, 413	2, 669, 152	1				2.00
3.00	Buildings and Fixtures	310, 036, 582	33, 232, 035					3.00
4.00	Building Improvements	0	0					4.00
5.00	Fixed Equipment	53, 698, 311	32, 598, 957					5.00
6.00	Movable Equipment	91, 489, 899	18, 643, 542					6.00
7.00	HIT designated Assets	0	0					7.00
8.00	Subtotal (sum of lines 1-7)	470, 954, 754	87, 673, 770					8.00
9.00	Reconciling Items	8, 255, 673	0					9.00
10.00	Total (line 8 minus line 9)	462, 699, 081	87, 673, 770					10.00

Heal th	Financial Systems FR	ANCISCAN HEALTH	MICHIGAN CITY	(In Lie	u of Form CMS-2	2552-10
RECONC	CILIATION OF CAPITAL COSTS CENTERS		Provider CO	CN: 15-0015	Peri od:	Worksheet A-7	
					From 01/01/2020	Part II	norod.
					To 12/31/2020	Date/Time Pre 7/28/2021 7:4	
			SL	JMMARY OF CAP	ITAL	1120/2021 1.1	
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see	Taxes (see	
					instructions)	instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUMN	12, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	19, 194, 402	0		0 0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		0 0	0	2.00
3.00	Total (sum of lines 1-2)	19, 194, 402	0		0 0	0	3.00
		SUMMARY OF	CAPITAL				
	Cost Center Description		Fotal (1) (sum				
		Capi tal -Rel ate	of cols. 9				
		d Costs (see	through 14)				
		instructions)	15.00				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUMN					
1.00	CAP REL COSTS-BLDG & FIXT	0	19, 194, 402				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	O	19, 194, 402				3.00

	Financial Systems	FRANCI SCAN HEALTH				u of Form CMS-2	
RECONC	CILIATION OF CAPITAL COSTS CENTERS		Provider C	F	Period: From 01/01/2020 Fo 12/31/2020		bared
		COM	PUTATION OF RA	TI OS	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col. 2)		Insurance	
		1.00	2.00	3.00	4.00	5.00	
1.00 2.00 3.00	PART III - RECONCILIATION OF CAPITAL CO CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP Total (sum of lines 1-2)	379, 464, 855 91, 489, 899 470, 954, 754	0	379, 464, 855 91, 489, 899 470, 954, 754 CAPI TAL	0. 194265	0 0 0 F CAPITAL	1. (2. (3. (
	Cost Center Description	Taxes	Other Capi tal -Rel ate d Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
	1	6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL CO	STS CENTERS					
. 00 2. 00 5. 00	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP Total (sum of lines 1-2)	0			0 10, 424, 426 9, 157, 117 19, 581, 543	0 0	1. (2. (3. (
			SL	IMMARY OF CAPI			0. (
	Cost Center Description	Interest	Insurance (see instructions)		Other Capital-Relate d Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL CO		-	-	-		
1.00 2.00	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP Total (sum of lines 1-2)	11, 957, 197 0 11, 957, 197	0	0	0	22, 381, 623 9, 157, 117 31, 538, 740	1. 2. 3.

Heal th	Fi nanci a	I Systems
AD JUST	MENTS TO	EXPENSES

FRANCISCAN HEALTH MICHIGAN CITY

	Financial Systems	FRA	ANCISCAN HEALT	H MICHIGAN CITY	. In Lie	u of Form CMS-2	2552-10
ADJUST	MENTS TO EXPENSES			Provider CCN: 15-0015	Period: From 01/01/2020	Worksheet A-8	
					To 12/31/2020	Date/Time Pre	pared:
	· · · · · · · · · · · · · · · · · · ·			Expense Classification	on Worksheet A	7/28/2021 7:4	I pm
				To/From Which the Amount i			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	cost center bescription	1.00	2.00	3.00	4.00	5. 00	
1.00	Investment income - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL		O	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
	COSTS-MVBLE EQUIP (chapter 2)	_					
3.00	Investment income - other (chapter 2)	В	-29, 049	CAP REL COSTS-BLDG & FIXT	1.00	11	3.00
4.00	Trade, quantity, and time		0		0.00	0	4.00
5.00	discounts (chapter 8) Refunds and rebates of	В	-72 707	ADMI NI STRATI VE & GENERAL	5.00	0	5.00
5.00	expenses (chapter 8)	D	12,101		5.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Tel ephone servi ces (pay		0		0.00	0	7.00
	stations excluded) (chapter						
8.00	21) Television and radio service		0		0.00	0	8.00
	(chapter 21)		_				
9. 00 10. 00	Parking lot (chapter 21) Provider-based physician	A-8-2	0 -8, 265, 559		0.00	0	9.00 10.00
	adjustment						
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization	A-8-1	-1, 958, 711			0	12.00
13.00	transactions (chapter 10) Laundry and linen service		0		0.00	0	13.00
	Cafeteria-employees and guests	В	-521, 528	CAFETERI A	11.00		13.00
15.00	Rental of quarters to employee		0		0.00	0	15.00
16.00	and others Sale of medical and surgical		O		0.00	0	16.00
	supplies to other than					_	
17 00	patients Sale of drugs to other than		0		0.00	0	17.00
	patients		-				
18.00	Sale of medical records and abstracts	В	-1, 347	ADMI NI STRATI VE & GENERAL	5.00	0	18.00
19.00	Nursing and allied health		0		0.00	0	19.00
	education (tuition, fees,						
20.00	books, etc.) Vending machines	В	-12, 506	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		0		0.00	0	22.00
	overpayments and borrowings to repay Medicare overpayments						
23.00	Adjustment for respiratory	A-8-3	0	RESPI RATORY THERAPY	65.00		23.00
	therapy costs in excess of limitation (chapter 14)						
24.00	Adjustment for physical	A-8-3	0	PHYSI CAL THERAPY	66.00		24.00
	therapy costs in excess of limitation (chapter 14)						
25.00	Utilization review -		0	UTILIZATION REVIEW-SNF	114.00		25.00
	physicians' compensation						
26.00	(chapter 21) Depreciation - CAP REL		O	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
	COSTS-BLDG & FIXT						
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
	Physicians' assistant Adjustment for occupational	A-8-3	0	OCCUPATI ONAL THERAPY	0.00 67.00		29. 00 30. 00
55.00	therapy costs in excess of		0	COUNTIONAL THENALT	07.00		55.00
30. 99	limitation (chapter 14)		0		20.00		30. 99
30. 99	Hospice (non-distinct) (see instructions)		U	ADULTS & PEDIATRICS	30.00		30. 77
31.00	Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
	pathology costs in excess of limitation (chapter 14)						
32.00	CAH HIT Adjustment for		0		0.00	0	32.00
33.00	Depreciation and Interest RENTAL INCOME	В	-44.588	ADMI NI STRATI VE & GENERAL	5.00	0	33.00
		1	, 500			۰ ۱	

Heal th	Fi nanci a	al Systems
	MENTS TO	EXPENSES

FRANCISCAN HEALTH MICHIGAN CITY

In Lieu of Form CMS-2552-10

	MENTS TO EXPENSES			Provi der CCN: 15-0015	Peri od:	Worksheet A-8	
AD5 05 1	MENTS TO EXTENSES				From 01/01/2020		
					To 12/31/2020	Date/Time Pre 7/28/2021 7:4	pared: 1 pm
				Expense Classification or			
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	oust benter beschiption	1.00	2.00	3.00	4.00	5.00	
34.00	DEFERED LEASE REV	B		ADMI NI STRATI VE & GENERAL	5.00		34.00
35.00	OTHER MISC REVENUE	В		DI ETARY	10.00		
36.00	MI SC REVENUE	В	0	ADULTS & PEDIATRICS	30.00		36.00
37.00	DONATIONS EXPENSE	В	0	ADMI NI STRATI VE & GENERAL	5.00	0	37.00
38.00	ADVERTI SI NG EXPENSE	В		ADMINI STRATI VE & GENERAL	5.00	0	38.00
40.00	A&G MISC REVENUE	В		ADMI NI STRATI VE & GENERAL	5.00	0	40.00
41.00	LOBBYI NG	В		ADMINI STRATI VE & GENERAL	5.00	0	41.00
42.00	OTHER NON-OPERATING EXPENSE	А		ADMINI STRATI VE & GENERAL	5.00	0	42.00
45.00	OUTSIDE HOME HEALTH SUPPLIES	В		ADMINI STRATI VE & GENERAL	5.00		
47.00	DI SCOUNTS/REBATES	В		DI ETARY	10.00		
48.00	DI SCOUNTS/REBATES	В		DRUGS CHARGED TO PATIENTS	73.00		
49.00	HAF PROVIDER TAX	A		ADMI NI STRATI VE & GENERAL	5.00		
49.01	PENSION	A		EMPLOYEE BENEFITS DEPARTMEN			
49.02	OTHER ADJUSTMENTS (SPECIFY)		00,000		0.00		
	(3)		0		0.00	Ū	
49.03	DI SCOUNTS EARNED/REBATES	В	-141.572	OPERATING ROOM	50.00	0	49.03
49.04	DI SCOUNTS EARNED/REBATES	В		RADI OLOGY-DI AGNOSTI C	54.00		49.04
49.05	DI SCOUNTS EARNED/REBATES	В		LABORATORY	60,00		
49.06	DI SCOUNTS EARNED/REBATES	В		RESPI RATORY THERAPY	65.00		
49.07	DI SCOUNTS EARNED/REBATES	B		WOODLAND CANCER CARE CTR	55.01	0	49.07
49.08	DI SCOUNTS EARNED/REBATES	B		MEDI CAL SUPPLIES CHARGED TO	71.00	0	
		-		PATIENTS		-	
49.09	DI SCOUNTS EARNED/REBATES	В		RESPI RATORY THERAPY	65.00	0	49.09
49.10	MI SCELLANEOUS - OTHER	В		PHYSICAL THERAPY	66.00		
	OPERATI NG						
49.11	MI SCELLANEOUS - OTHER	В	-290	DI ETARY	10.00	0	49.11
	OPERATI NG						
49.12	MI SCELLANEOUS - OTHER	В	-55	NURSING ADMINISTRATION	13.00	0	49.12
	OPERATI NG						
49.13	MI SCELLANEOUS - OTHER	В	-79	PHARMACY	15.00	0	49.13
	OPERATI NG						
49.14	MI SCELLANEOUS - OTHER	В	-861, 718	OPERATING ROOM	50.00	0	49.14
	OPERATI NG						
49.15	MI SCELLANEOUS - OTHER	В	-11, 748	ADMI NI STRATI VE & GENERAL	5.00	0	49.15
	OPERATI NG						
49. 16	MI SCELLANEOUS - OTHER	В	-141	PHYSICAL THERAPY	66.00	0	49.16
	OPERATI NG						
49. 17	MI SCELLANEOUS - OTHER	В	-1, 182	ADMINISTRATIVE & GENERAL	5.00	0	49.17
	OPERATI NG						
49. 18	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	49.18
	(3)						
49. 19	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	49.19
	(3)						
50.00	TOTAL (sum of lines 1 thru 49)		-17, 806, 917	1			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.

A. costs - fricost, find during appreciate 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.

Heal th	Financial Systems	FRANCI SCAN HEAL	TH MICHIGAN CITY	In Lie	eu of Form CMS-2	2552-10
STATEME	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HOM	ME Provider CCN: 15-0015	Peri od:	Worksheet A-8	-1
OFFI CE	COSTS			From 01/01/2020 To 12/31/2020		norod.
				10 12/31/2020	7/28/2021 7:4	
	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	
		MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED O	RGANIZATIONS OR	CLAI MED	
	HOME OFFICE COSTS:		r			
1.00			INTEREST	2, 030, 172	1, 451	1.00
2.00			ALLOWABLE NEW CAPITAL COSTS	2, 724, 345	2, 764, 620	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	ADMINISTRATIVE & GENERAL	25, 871, 041	31, 865, 406	3.00
4.00	15.00	PHARMACY	COEP / PHARMACY	367, 719	-367,623	4.00
4.01	16.00	MEDICAL RECORDS & LIBRARY	HIM	1, 311, 866	0	4.01
4.02	0.00			0	0	4.02
5.00	TOTALS (sum of lines 1-4).			32, 305, 143	34, 263, 854	5.00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					
	line 12.					
4.01 4.02 5.00	16.00 0.00 TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2,	MEDICAL RECORDS & LIBRARY	HI M	1, 311, 866 0 32, 305, 143	0 0 34, 263, 854	4. 01 4. 02

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

			Related Organization(s) and/	or Home Office	
Symbol (1)	Name	Percentage of	Name	Percentage of	
	Name	Ownershi p	Name	Ownershi p	
1.00	2.00	3.00	4.00	5.00	1
B. INTERRELATIONSHIP TO RELAT	FD ORGANIZATION(S) AND/OR HO	ME_OFFLCE:			

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

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

6.00	В	100.00	0.00	6.00
7.00		0.00	0.00	7.00
8.00		0.00	0.00	8.00
9.00		0.00	0.00	9.00
10.00		0.00	0.00	0 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 organization.

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

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

Health Financial Systems	FRANCISCAN HEALTH N	II CHI GAN CI TY	In Lie	u of Form CMS-2552-10
STATEMENT OF COSTS OF SERVICES OFFICE COSTS	FROM RELATED ORGANIZATIONS AND HOME	Provider CCN: 15-0015	From 01/01/2020	Worksheet A-8-1 Date/Time Prepared: 7/28/2021 7:41 pm

							1/20/2021 7.	+ i piii
	Net	Wkst. A-7 Ref.						
	Adjustments							
	(col. 4 minus							
	col. 5)*							
	6.00	7.00						
	A. COSTS INCUR	RED AND ADJUST	IENTS REQUIRED	AS A RESULT OF	TRANSACTIONS \	WITH RELATED C	ORGANIZATIONS OR CLAIMED	
	HOME OFFICE CO	STS:						
1.00	2, 028, 721	11						1.00
2.00	-40, 275	9						2.00
3.00	-5, 994, 365	0						3.00
4.00	735, 342	0						4.00
4.01	1, 311, 866	0						4.01
4.02	0	0						4.02
5.00	-1, 958, 711							5.00

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

Related Organization(s) and/or Home Office	nus	not	been posted to morkaneet A,		
and/or Home Office			Related Organization(s)		
			and/or Home Office		
Type of Busi ness			Type of Business		
			51.0		
6.00			6.00	1	
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:		E	3. INTERRELATIONSHIP TO RELATIONSHIP	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.

1 CT IIID GI		
	FRANCI SCAN ALLI	6.00
7.00 8.00		7.00
8.00		8.00
9.00 10.00		9.00
10.00		10.00
100.00		 100.00

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

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

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

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

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

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

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

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

	Financial Syste		RANCI SCAN HEAL	TH MICHIGAN CIT		In Lie	EU OT FORM CMS-	
PROVI DE	ER BASED PHYSIC	I AN ADJUSTMENT		Provider (1	Period: From 01/01/2020 Fo 12/31/2020		epared:
	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Prov ider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	422, 035	220, 660	201, 375	197, 500	1, 611	1.00
2.00		NURSING ADMINISTRATION	3, 845, 525		7, 531	197, 500	60	2.00
3.00		PHARMACY	8, 500			197, 500		3.00
4.00		ADULTS & PEDIATRICS	80, 045			197, 500		4.00
5.00		INTENSIVE CARE UNIT	3, 400			197, 500		5.00
6.00		SUBPROVIDER - IPF	272, 167			197, 500	114	6.00
7.00 8.00		OPERATING ROOM	718, 366			246, 400 239, 400		7.00 8.00
8.00 9.00		ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C	2, 833, 761 19, 965			197, 500		8.00 9.00
9.00 10.00		FSED RADIOLOGY - DIAGNOSTIC	38, 138			197, 500		10.00
11.00		CARDI AC CATHETERI ZATI ON	4, 500			197, 500		11.00
12.00		LABORATORY	52, 655			197, 500		12.00
13.00		INFUSION OP SERVICES	4, 219		4, 219	197, 500		13.00
14.00		EMERGENCY	227, 422			197, 500	9	14.00
15.00	91.01	FREE STANDING EMERGENCY DEPT	61, 070	61, 070	0	197, 500	0	15.00
16.00	69.00	ELECTROCARDI OLOGY	6, 313	1, 500	4, 813	197, 500	39	16.00
200.00			8, 598, 081	8, 176, 995			3, 371	200.00
	Wkst. A Line #		Unadjusted RCE		Cost of		Physician Cost	
		I denti fi er	Limit	Unadjusted RCE Limit		Component	of Malpractice	
					Conti nui ng Educati on	Share of col. 12	Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00		ADMI NI STRATI VE & GENERAL	152, 968			0	0	1.00
2.00	13.00	NURSING ADMINISTRATION	5, 697	285	0	0	0	2.00
3.00		PHARMACY	6, 172	309	0	0	0	3.00
4.00		ADULTS & PEDIATRICS	27, 061	1, 353		0	0	4.00
5.00		INTENSIVE CARE UNIT	0	0	-	0	0	5.00
6.00		SUBPROVIDER - IPF	10, 825			0	0	6.00
7.00		OPERATING ROOM	37, 197			0	0	7.00
8.00 9.00		ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C	28, 889				0	8.00 9.00
9.00 10.00		FSED RADIOLOGY - DIAGNOSTIC	14, 243	-		0	0	9.00 10.00
11.00		CARDI AC CATHETERI ZATI ON	3, 418		-	0	0	11.00
12.00		LABORATORY	38, 266			0	0	12.00
13.00		INFUSION OP SERVICES	3, 228			0	0	13.00
14.00		EMERGENCY	855			0	0	14.00
15.00	91.01	FREE STANDING EMERGENCY DEPT	0	0	0	0	0	15.00
16.00	69.00	ELECTROCARDI OLOGY	3, 703	185	0	0	0	16.00
200.00			332, 522			0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component	Adjusted RCE Limit	RCE Di sal I owance	Adjustment		
			Share of col. 14					
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00		ADMINISTRATIVE & GENERAL	0	152, 968		269, 067		1.00
2.00		NURSING ADMINISTRATION	0			3, 839, 828		2.00
3.00		PHARMACY	0			2, 328		3.00
4.00		ADULTS & PEDIATRICS	0		8, 564	52, 984		4.00
5.00		I NTENSI VE CARE UNI T		10.025	0	3,400		5.00
6.00 7.00		SUBPROVIDER - IPF OPERATING ROOM				261, 342 681, 169		6.00 7.00
8.00		ANESTHESI OLOGY				2, 804, 872		8.00
9.00		RADI OLOGY-DI AGNOSTI C		20,007		19, 965		9.00
10.00		FSED RADIOLOGY - DIAGNOSTIC		-	-	23, 895		10.00
11.00		CARDI AC CATHETERI ZATI ON	c c	3, 418		1, 082		11.00
12.00		LABORATORY	0	38, 266		14, 389		12.00
13.00	90.03	INFUSION OP SERVICES	0	3, 228	991	991		13.00
14.00		EMERGENCY	0	855	270	226, 567		14.00
15.00		FREE STANDING EMERGENCY DEPT	0	0	-	61,070		15.00
16.00		ELECTROCARDI OLOGY	0					16.00
200.00	I	1	0	332, 522	88, 564	8, 265, 559		200. 00

	Financial Systems Fi LLOCATION - GENERAL SERVICE COSTS	RANCI SCAN HEALTH	Provider CC	CN: 15-0015 F	Period: From 01/01/2020 Fo 12/31/2020	u of Form CMS-2 Worksheet B Part I Date/Time Pre	pare
			CAPI TAL REL	ATED COSTS		7/28/2021 7:4	I pm
	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFI TS DEPARTMENT	Subtotal	
		<u>col. 7)</u>	1.00	2.00	4.00	4A	
	GENERAL SERVICE COST CENTERS	0	1.00	2.00	4.00	4A	
00 00 00 00 00 00 00 00 00 00 00 00 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS	22, 381, 623 9, 157, 117 3, 429, 440 34, 251, 496	102, 135	9, 157, 117 8, 260	3, 539, 835 926, 264	37, 849, 974 0	1. 2. 4. 5. 6.
00 00 00 00 0.00 1.00 3.00 4.00 5.00	00700 OPERATI ON OF PLANT 00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG 01000 DI ETARY 01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY	9, 134, 747 527, 835 2, 527, 002 826, 295 1, 564, 307 3, 282, 277 686, 278 4, 281, 215	3, 525, 578 63, 742 832, 102 179, 934 451, 448 98, 954 772, 001 278, 243	952, 822 896 53, 817 52, 118 122, 300 209, 374 9, 694	3 137, 280 5 3, 933 7 85, 254 3 24, 702 0 61, 971 9 121, 523 4 9, 245 4 126, 415	13, 750, 433 596, 406 3, 498, 175 1, 083, 049 2, 077, 726 3, 625, 063 1, 676, 898 4, 695, 567	7. 8. 9. 10. 11. 13. 14. 15.
7.00 3.00 9.00	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 SCHOOL 02100 I &R SERVI CES-SALARY & FRI NGES APPRVD 02200 I &R SERVI CES-OTHER PRGM COSTS APPRVD 02300 PARAMED ED PRGM-(SPECI FY) I NPATI ENT ROUTI NE SERVI CE COST CENTERS	1, 327, 845 0 0 0 0 0 0 0 0	31, 249 0 0 0 0 0 0 0			1, 359, 885 0 0 0 0 0 0 0	17. 18. 19. 20. 21. 22.
D. 00 1. 00	03000 ADULTS & PEDI ATRI CS 03100 I NTENSI VE CARE UNI T	17, 386, 180 2, 990, 968	3, 234, 707 618, 891	277, 869 120, 001		21, 603, 619 3, 847, 046	31.
	03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT	0	0	(0	32. 33.
	03400 SURGICAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF	0	659 621	20 592	0	0	34.
D. 00 1. 00	04000 SUBPROVIDER - TPF 04100 SUBPROVIDER - TRF	1, 595, 209 0	658, 621 0	39, 582 (2, 357, 474 0	40. 41.
3.00 4.00	04300 NURSERY 04400 SKI LLED NURSI NG FACI LI TY	1, 259, 920	341, 616	534		1, 640, 542 0	43. 44.
5.00	04500 NURSI NG FACILI TY 04600 OTHER LONG TERM CARE	0	0	(-	0	45. 46.
5.00	ANCI LLARY SERVICE COST CENTERS	0	0			0	40.
	05000 OPERATI NG ROOM	6, 947, 475	2, 486, 258	2, 068, 556	5 292, 583	11, 794, 872	50.
1.00	05100 RECOVERY ROOM	0	0	(0	51.
	05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	72, 748	256, 397 8, 066	(29, 466	-	256, 397 112, 118	
	05400 RADI OLOGY-DI AGNOSTI C	4, 220, 169					
	05401 FSED RADIOLOGY - DIAGNOSTIC	2, 331, 570		1, 276, 660	61, 733	3, 802, 010	
	05500 RADI OLOGY-THERAPEUTI C	1, 479, 456				1, 938, 095	
	05501 WOODLAND CANCER CARE CTR 05600 RADI OI SOTOPE	376, 206	492, 514	1, 881 (889, 343 0	
. 00	05700 CT SCAN	0	0	(0	
. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0	(0 0	0	
	05900 CARDI AC CATHETERI ZATI ON	1, 281, 945					
. 00	06000 LABORATORY	8, 012, 526			3 0	8, 420, 927	
. 01 . 00	06001 FS ED LAB 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	1, 500, 901	59, 916		0	1, 560, 817 0	60 61
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	(0 0	0	
	06300 BLOOD STORING, PROCESSING & TRANS.	0	18, 159	(0 0	18, 159	63
	06400 I NTRAVENOUS THERAPY	0	0	(-	0	
	06500 RESPI RATORY THERAPY	1, 129, 930					
	06600 PHYSI CAL THERAPY	2, 897, 436	68, 674				
	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0				0	
	06900 ELECTROCARDI OLOGY	1, 311, 151	412, 087	226, 045	- -	1, 997, 233	
	07000 ELECTROENCEPHALOGRAPHY	0	0	(0	0	70
. 00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	5, 518, 015		(0 0	5, 518, 015	
. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	11, 510, 510	0		0	11, 510, 510	
1.00 2.00		19, 087, 457	0			19, 087, 457	
1.00 2.00 3.00	07300 DRUGS CHARGED TO PATIENTS	^		. (ں _ا ر	0	
1.00 2.00 3.00 4.00	07400 RENAL DIALYSIS	0	0	r		∩	1 / ト
2.00 2.00 3.00 4.00 5.00	07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART)	0	0	(0	
1.00 2.00 3.00 4.00 5.00 5.00	07400 RENAL DIALYSIS	0 0 0 0	0	(0	76
1.00 2.00 3.00 4.00 5.00 5.00 7.00	07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART) 03020 CV RESOURCE CTR		0 0 0	(0 0	0	75 76 77 88

	u of Form CMS-2552-10
Peri od:	Worksheet B Part I Date (Time December 1
From 01/01/2020	Part I
T 40/04/0000	

				o 12/31/2020	Date/Time Pre	pared:
		CAPI TAL REI	ATED COSTS		7/28/2021 7:4	
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFI TS DEPARTMENT	Subtotal	
	0	1.00	2.00	4.00	4A	
90.00 09000 CLINIC 90.03 09003 INFUSION OP SERVICES 91.00 09100 EMERGENCY 91.01 09101 FREE STANDING EMERGENCY DEPT 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0 822, 436 7, 866, 787 1, 903, 990	0 148, 086 868, 282 985, 442	10, 379 145, 687	19, 339 192, 594	0 1, 000, 240 9, 073, 350 3, 283, 490 0	90.00 90.03 91.00 91.01 92.00
OTHER REIMBURSABLE COST CENTERS	1 I		I	1 1		
94. 0009400HOMEPROGRAMDI ALYSI S95. 0009500AMBULANCESERVI CES96. 0009600DURABLEMEDI CALEQUI P-RENTED97. 0009700DURABLEMEDI CALEQUI P-SOLD	0 0 0	0 0 0			0 0 0	94.00 95.00 96.00 97.00
97.00 09850 OTHER REIMBURSABLE COST CENTERS 99.00 09900 CMHC 99.10 09910 CORF	0	0			0	97.00 98.00 99.00 99.10
100.00 10000 I &R SERVICES-NOT APPRVD PRGM 101.00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	0		0	0	100. 00 101. 00
105. 00 10500 KI DNEY ACQUI SI TI ON	0	0	C	0	0	105.00
106. 00 10600 HEART ACQUI SI TI ON	0	0	C	0		106.00
107.00 10700 LI VER ACQUI SI TI ON	0	0	C	0		107.00
108.00 10800 LUNG ACQUI SI TI ON	0	0	C	0		108.00
109. 00 10900 PANCREAS ACQUI SI TI ON 110. 00 11000 I NTESTI NAL ACQUI SI TI ON	0	0		0		109. 00 110. 00
111. 00 11100 I SLET ACQUI SI TI ON	0	0		0		111.00
113. 00 11300 I NTEREST EXPENSE	0	0		0	0	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 c	0	0	115.00
116. 00 11600 HOSPI CE	0	0	c	0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	194, 880, 462	20, 741, 985	8, 901, 792	3, 478, 599	192, 924, 263	118.00
NONREI MBURSABLE COST CENTERS	1		1	1 1		
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	-17,609	45, 398	C	0	27, 789	
191. 00 19100 RESEARCH 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0		191. 00 192. 00
193. 00 19300 NONPALD WORKERS	0	0		0		192.00
193. 01 19301 NONPAI D WORKERS	0	0		0		193.00
194. 00 07950 BEACON JOINT VENTURE	0	0		0		194.00
194.01 07951 WORKING WELL	1, 801, 765	0	251, 889	58, 016	2, 111, 670	194.01
194.0307953 MED WATCHER	0	1, 384, 855	2, 671	0	1, 387, 526	194.03
194.1007960 DUNELAND FITNESS CTR	0	209, 385	C	0	209, 385	
194. 11 07961 OMNI HEALTH & FITNESS CHESTERTOWN	0	0	C	0		194.11
194.16 07966 PHYSICIAN PRACTICE MD WISW 194.19 07969 HEALTH PARTNERS	10, 159 -617, 177	0		285	10, 444 -617, 177	
194. 20 07970 CENTER OF HOPE	65, 938	0	765	, U	-617, 177 69, 638	
200.00 Cross Foot Adjustments	00,700	0	/00	2,755		200.00
201.00 Negative Cost Centers		0	c	0		201.00
202.00 TOTAL (sum lines 118 through 201)	196, 123, 538	22, 381, 623	9, 157, 117	3, 539, 835	196, 123, 538	202.00

	Financial Systems F ALLOCATION - GENERAL SERVICE COSTS	RANCI SCAN HEALTH			N: 15-0015 P F	eriod: rom 01/01/2020 o 12/31/2020	Worksheet B Part I Date/Time Pre 7/28/2021 7:4	epare
	Cost Center Description	ADMI NI STRATI VE & GENERAL	MAI NTENANCE REPAI RS	&	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5.00	6.00		7.00	8.00	9.00	
. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT			Т				1 1.
. 00	00200 CAP REL COSTS-BEDG & TTXT							2.
. 00	00400 EMPLOYEE BENEFITS DEPARTMENT							4.
. 00	00500 ADMINI STRATI VE & GENERAL	37, 849, 974						5.
. 00	00600 MAI NTENANCE & REPAI RS	0		0				6
00	00700 OPERATION OF PLANT	3, 275, 546		0	17, 025, 979			7
00	00800 LAUNDRY & LINEN SERVICE	142,072		0	64, 117			8
00	00900 HOUSEKEEPI NG	833, 314		0	836, 994		5, 168, 483	
0.00	01000 DI ETARY	257, 997		0	180, 992		58, 013	
1.00 3.00	01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON	494, 943 863, 541		0	454, 102 99, 536		145, 553 31, 904	
4.00	01400 CENTRAL SERVICES & SUPPLY	399, 461		0	776, 540		248, 903	
5.00	01500 PHARMACY	1, 118, 550		0	279, 879		89, 709	
5.00	01600 MEDI CAL RECORDS & LI BRARY	323, 944		0	31, 432		10, 075	
7.00	01700 SOCI AL SERVI CE	0		0	0	0	C	17
8.00	01080 I NSERVI CE EDUCATI ON	0		0	0	0	0	
9.00	01900 NONPHYSI CI AN ANESTHETI STS	0		0	0	0	0	
0.00	02000 NURSI NG SCHOOL 02100 I &R SERVI CES-SALARY & FRI NGES APPRVD	0		0	0	0		
2.00	02200 I &R SERVICES-SALART & PRINGES APPRVD	0		0	0	0		
3.00	02300 PARAMED ED PRGM-(SPECIFY)	0		o	0	0		
	INPATIENT ROUTINE SERVICE COST CENTERS				-			
0. 00	03000 ADULTS & PEDIATRICS	5, 146, 262		0	3, 253, 729	377, 222	1, 042, 911	30
1.00	03100 INTENSIVE CARE UNIT	916, 420		0	622, 530	40, 130		
2.00	03200 CORONARY CARE UNIT	0		0	0	0	0	
3.00	03300 BURN INTENSIVE CARE UNIT	0		0	0	0	0	
4.00 0.00	03400 SURGI CAL I NTENSI VE CARE UNI T 04000 SUBPROVI DER – I PF	561, 583		0	662, 493	120, 390	0 212, 348	
1.00	04100 SUBPROVI DER – I RF	0		0	002, 473	120, 370	212, 340	
3.00	04300 NURSERY	390, 800		0	343, 625	0	110, 142	
4.00	04400 SKILLED NURSING FACILITY	0		0	0		C	
5.00	04500 NURSING FACILITY	0		0	0	0	C	45
6. 00	04600 OTHER LONG TERM CARE	0		0	0	0	0	46
0. 00	ANCI LLARY SERVI CE COST CENTERS	2, 809, 704		0	2, 500, 877	42, 537	801, 603	50
1.00	05100 RECOVERY ROOM	2,007,704		0	2, 300, 077		001,003	
2.00	05200 DELIVERY ROOM & LABOR ROOM	61,077		Ō	257, 904	0	82,666	
3.00	05300 ANESTHESI OLOGY	26, 708		0	8, 113		2, 600	53
4.00	05400 RADI OLOGY-DI AGNOSTI C	1, 555, 334		0	922, 159	32, 264	295, 578	54
4. 01	05401 FSED RADIOLOGY - DIAGNOSTIC	905, 692		0	132, 823		42, 574	
5.00	05500 RADI OLOGY-THERAPEUTI C	461, 681		0	151, 367		48, 518	
5.01	05501 WOODLAND CANCER CARE CTR 05600 RADI 0I SOTOPE	211, 854		0	495, 409			
7.00	05700 CT SCAN	0		0	0	0) 56) 57
8.00	05800 MAGNETIC RESONANCE I MAGI NG (MRI)	0		0	0	0		
9.00	05900 CARDI AC CATHETERI ZATI ON	494, 410		0	246, 917	240		
0. 00	06000 LABORATORY	2,005,983		0	386, 462	0	123, 872	60
0. 01	06001 FS ED LAB	371, 808		0	60, 269	0	19, 318	
1.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY			_	_	_	_	61
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0		0	0	0	0	
3.00	06300 BLOOD STORI NG, PROCESSI NG & TRANS. 06400 I NTRAVENOUS THERAPY	4, 326		0	18, 266	0	5, 855 0	
5.00	06500 RESPI RATORY THERAPY	323, 769		0	92, 999	0	29,809	
6.00	06600 PHYSI CAL THERAPY	723, 119		ō	69,077		22, 141	
7.00	06700 OCCUPATI ONAL THERAPY	0		0	0	0	C	
8.00	06800 SPEECH PATHOLOGY	0		0	0	0	C	68
	06900 ELECTROCARDI OLOGY	475, 769		0	414, 510	4, 013		
	07000 ELECTROENCEPHALOGRAPHY	0		0	0	0	0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 314, 468		0	0	0		
	07200 I MPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	2, 741, 965 4, 546, 899		0	0	0		
	07300 DRUGS CHARGED TO PATTENTS	4, 340, 899 A		0	0	0		
	07500 ASC (NON-DI STINCT PART)	0		0	0	0 0		
6.00	03020 CV RESOURCE CTR	0		0	0	0		
7.00	07700 ALLOGENEIC STEM CELL ACQUISITION	0		0	0	0	0	
	OUTPATIENT SERVICE COST CENTERS							
	08800 RURAL HEALTH CLINIC	0		0	0	0	C	
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	0	
		0		0	0	0		
0. 03 1. 00	09003 I NFUSI ON OP SERVI CES	238, 271		0	148, 957 873 387			
1. UU	09100 EMERGENCY	2, 161, 399		U	873, 387			
1.01	09101 FREE STANDING EMERGENCY DEPT	782, 173		(1)	991, 236	32, 104	317, 720) 91

Heal th	Fi nanci al	Systems	

Health Financial Systems Fk	ANCISCAN HEALI	H MICHIGAN CITY	(In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider C		eriod:	Worksheet B	
			F	rom 01/01/2020	Part I	
			T		Date/Time Pre	pared:
					7/28/2021 7:4	
Cost Center Description	ADMI NI STRATI VE	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
	& GENERAL	REPAI RS	PLANT	LINEN SERVICE	HOUSEREEFING	
					0.00	
	5.00	6.00	7.00	8.00	9.00	
OTHER REI MBURSABLE COST CENTERS	1					
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 MEDI CAL EQUI P-RENTED	0	0	0	0	0	96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0		0	0	0	1
	0	0	0	0	-	
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	99.10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00 10100 HOME HEALTH AGENCY	0	0	0	0		101.00
SPECIAL PURPOSE COST CENTERS	0	0	0	V	0	101.00
						1.05 00
105.00 10500 KIDNEY ACQUISITION	0	0	0	0		105.00
106. 00 10600 HEART ACQUI SI TI ON	0	0	0	0	0	106.00
107.00 10700 LIVER ACQUISITION	0	0	0	0	0	107.00
108.00 10800 LUNG ACQUISITION	0	0	0	0	0	108.00
109.00 10900 PANCREAS ACQUISITION	0		0	0		109.00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON	0		0	0		110.00
	0	0	0	0		
111.00 11100 I SLET ACQUI SI TI ON	0	0	0	0	0	111.00
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	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)	36, 940, 842	0	-	762, 465	4, 639, 841	
NONREI MBURSABLE COST CENTERS	30, 940, 042	0	15, 370, 701	702,403	4, 037, 041	110.00
						1.00.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	6, 620	0	45, 665	0		190.00
191. 00 19100 RESEARCH	0	0	0	0	0	191.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193. 00 19300 NONPALD WORKERS	0	0	0	0	0	193.00
193. 01 19301 NONPALD WORKERS	0	0	0	0		193.01
194. 00 07950 BEACON JOINT VENTURE	0		0	0		194.00
	500.000	0	0	0		
194. 01 07951 WORKING WELL	503, 029	0	0	0		194.01
194.0307953 MED WATCHER	330, 528	0	1, 392, 997	40, 130	446, 496	194.03
194.1007960 DUNELAND FITNESS CTR	49, 878	0	210, 616	0	67, 509	194.10
194.1107961 OMNI HEALTH & FITNESS CHESTERTOWN	0	0	0	0	0	194.11
194. 16 07966 PHYSI CLAN PRACTICE MD WISW	2,488		0	0		194.16
194. 19 07969 HEALTH PARTNERS	2,400			0		194.10
	14 500			0		
194.20 07970 CENTER OF HOPE	16, 589	0	0	0	0	194. 20
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	37, 849, 974	0	17, 025, 979	802, 595	5, 168, 483	202.00
					· ·	

	Cost Center Description		1 I I I I I I I I I I I I I I I I I I I			7/20/2024 7 *	1
		DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	7/28/2021 7:4 PHARMACY	<u>1 pm</u>
		10.00	11.00	13.00	14.00	15.00	
	GENERAL SERVICE COST CENTERS	[]		1			1 00
$\begin{array}{c} 2,00\\ 4,00\\ 5,00\\ 6,00\\ 7,00\\ 8,00\\ 9,00\\ 10,00\\ 11,00\\ 13,00\\ 14,00\\ 15,00\\ 15,00\\ 15,00\\ 15,00\\ 15,00\\ 10,00\\ 20,00\\ 21,00\\ 22,00\\ \end{array}$	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUI P 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMI NI STRATI VE & GENERAL 00600 MAI NTENANCE & REPAI RS 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVI CE 00900 HOUSEKEEPI NG 01000 DI ETARY 01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE 01080 I NSERVI CE 01080 I NSERVI CE 01080 INSERVI CE EDUCATI ON 01900 NONPHYSI CI AN ANESTHETI STS 02000 NURSI NG SCHOOL 02100 I &R SERVI CES-SALARY & FRI NGES APPRVD 02200 I &R SERVI CES-OTHER PRGM COSTS APPRVD	1, 580, 372 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	3, 172, 324 137, 186 21, 397 137, 749 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	4, 757, 230 0 0 0 0 0 0 0 0 0 0 0 0 0 0	3, 123, 199 22, 158 0 0 0 0 0 0 0 0 0 0 0 0 0 0	6, 343, 612 0 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 4.\ 00\\ 5.\ 00\\ 7.\ 00\\ 8.\ 00\\ 7.\ 00\\ 10.\ 00\\ 11.\ 00\\ 13.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 20.\ 00\\ 21.\ 00\\ 20.\ 00\\ 21.\ 00\\ 22.\ 00\\ 22.\ 00\\ 23.\ 00\ 00\\ 23.\ 00\ 00\\ 23.\ 00\ 00\ 00\ 00\ 00\ 00\ 00\ 00\ 00\ 0$
23.00	02300 PARAMED ED PRGM-(SPECIFY) INPATIENT ROUTINE SERVICE COST CENTERS	0	0	0	0	0	23.00
31. 00 32. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT	1, 192, 271 205, 109 0 0	733, 996 152, 287 0 0		115, 427 43, 286 0 0	0 0 0 0	30. 00 31. 00 32. 00 33. 00
40. 00 41. 00 43. 00	03400 SURGI CAL I NTENSI VE CARE UNI T 04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF 04300 NURSERY	0 182, 992 0 0	0 97, 105 0 23, 444	0	0 869 0 1	0 0 0 0	34.00 40.00 41.00 43.00
	04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY	0	0	0	0	0	44.00 45.00
	04600 OTHER LONG TERM CARE	0	0	0	0	0	46.00
F0.00	ANCI LLARY SERVICE COST CENTERS	0	407 0/1	712 470	2 202 044		F0 00
	05000 OPERATING ROOM 05100 RECOVERY ROOM	0	407, 361 0	713, 478	2, 393, 044 0	0	50.00 51.00
	05200 DELIVERY ROOM & LABOR ROOM	0	41, 975		О	0	52.00
	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0	4, 812 244, 427		0 82, 718	0	53.00 54.00
	05401 FSED RADIOLOGY - DIAGNOSTI C	0	79, 189		10, 558	0	54.00
	05500 RADI OLOGY-THERAPEUTI C	0	37, 163		3, 938	0	55.00
	05501 WOODLAND CANCER CARE CTR 05600 RADI 0I SOTOPE	0	22, 267	72, 359	13, 085	0	55. 01 56. 00
	05700 CT SCAN	0	0	0	0	0	57.00
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0	53, 902 0	90, 271	243, 224 81, 329	0	59.00 60.00
60. 01	06001 FS ED LAB	0	0	0	40	0	60. 01
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	61.00 62.00
	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400 I NTRAVENOUS THERAPY	0	0	0	0	0	64.00
		0	76, 937		23, 921	0	65.00
	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0	55, 130 0	0	6, 921 0	0	66.00 67.00
	06800 SPEECH PATHOLOGY	0	0	0	Ő	0	68.00
		0	64, 651	81, 226	4, 774	0	69.00
	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	70.00 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	Ő	0	Ő	Ö	0	72.00
	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0	0	0	0	6, 343, 612 0	73.00 74.00
	07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	74.00
76.00 77.00	03020 CV RESOURCE CTR 07700 ALLOGENEIC STEM CELL ACQUISITION OUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	76.00 77.00
	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
00 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
	09000 CLINIC		\cap			01	90 00
90.00	09000 CLINIC 09003 INFUSION OP SERVICES	0	0 25, 338	0 74, 132	0 3, 553	0 0	90. 00 90. 03

Health Financial Systems FR	ANCISCAN HEALTH	MI CHI GAN CI TY	ſ	In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider C	CN: 15-0015	Period: From 01/01/2020 To 12/31/2020	Worksheet B Part I	oared:
Cost Center Description	DI ETARY	CAFETERI A	NURSING ADMINISTRATIO	SUPPLY	PHARMACY	
	10.00	11.00	13.00	14.00	15.00	
92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS	-	-	1		-	
94.00 09400 HOME PROGRAM DI ALYSI S	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	/// 00
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	0	101. 00
SPECIAL PURPOSE COST CENTERS			1			
105.00 10500 KI DNEY ACQUI SI TI ON	0	0		0 0		105.00
106. 00 10600 HEART ACQUI SI TI ON	0	0		0 0		106.00
107.00 10700 LI VER ACQUI SI TI ON	0	0		0 0		107.00
108.00 10800 LUNG ACQUI SI TI ON	0	0		0 0		108.00
109.00 10900 PANCREAS ACQUI SI TI ON	0	0		0 0		109.00
110.00 11000 INTESTINAL ACQUISITION	0	0		0 0		110. 00
111.00 11100 I SLET ACQUI SI TI ON	0	0		0 0		111.00
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0		0 0		115.00
116.00 11600 HOSPI CE	0	0		0 0		116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	1, 580, 372	2, 750, 835	4, 498, 29	3, 118, 233	6, 343, 612	118.00
NONREI MBURSABLE COST CENTERS	a		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		0 0		192.00
193. 00 19300 NONPALD WORKERS	0	0		0 0		193.00
193. 01 19301 NONPALD WORKERS	0	0		0 0		193.01
194.00 07950 BEACON JOINT VENTURE	0	0	057.00	0 0		194.00
194. 01 07951 WORKI NG WELL	0	419, 083	257, 33	4, 966		194.01
194. 03 07953 MED WATCHER	0	0		0 0		194.03
194. 10 07960 DUNELAND FI TNESS CTR	0	0		0 0		194.10
194. 11 07961 OMNI HEALTH & FITNESS CHESTERTOWN	0	0		0		194.11
194. 16 07966 PHYSI CLAN PRACTICE MD WISW	0	0		0 0		194.16
194. 19 07969 HEALTH PARTNERS	0	0		0 0		194.19
194. 20 07970 CENTER OF HOPE	0	2, 406	1, 59	0		194.20
200.00 Cross Foot Adjustments		-				200.00
201.00 Negative Cost Centers	1 500 070	0	4 757 0			201.00
202.00 TOTAL (sum lines 118 through 201)	1, 580, 372	3, 172, 324	4, 757, 23	3, 123, 199	6, 343, 612	202.00

Image: Transmission of the second prior of	COST AL	LOCATION - GENERAL SERVICE COSTS		Provider C	CN: 15-0015	Period: From 01/01/2020	Worksheet B Part I	
Lost Center Description MEDICAL SCIAL SERVICE (1990) CCIAL SERVICE (1990) OTHER (1990) MESSING SCIOL (1990) MESSIN							Date/Time Pre	
Cast Center Description MEDICAL BECORES SOCIAL SLEVICE EDUCATION 18:00 INDERVICE EDUCATION 19:00 INDERVICE EDUCATION 19:00 <thindervice 19:00 INDERVICE 19:00</thindervice 						L	//28/2021 /.4	
CENERAL SERVICE COST CENTERS 16.00 17.00 18.00 19.00 20.00 10 DIDIO LAP HEL COST CENTERS 10.00 19.00 19.00 20.00 10 DIDIO LAP HEL COST CENTERS 10.00 19.00 19.00 19.00 19.00 10 DIDIO LAP HEL COST CENTERS 10.00 10.00 19.00 19.00 19.00 19.00 10 DIDIO LAP HEL COST CENTERS 10.00		Cost Center Description	RECORDS &	SOCI AL SERVI CE	I NSERVI CE		NURSING SCHOOL	
1.00 CODO CAP, REL, COSTS-PUED, G, FIXT 0.00 CODO CAP, REL, COST, PUED, G, FIXT 0.00 CODO CAP, REL, COST, PUED, G, FIXT 0.00 CODO CAP, REL, COST, PUED, G, FIXT 1.00 CODO CAP, REL, COST, PUED, G, FIXT 1.00 CODO CAP, REL, COST, PUED, REW COST, CAPROD C 1.00 CODO CAP, REL, COST, CAPROD C C 1.00 CODO CAP, REL, CAPRON, COST, SAPROD C C 1.00 CODO CAP, REN, REV, COST, SAPROD C C C 1.00 CODO CAP, REV, REV, COST, SAPROD C C C 1.00 CODO CAP, REV, REV, COST, SAPROD C C C 1.00 CODO CAP, REV, REV, COST, SAPROD C				17.00	18.00	19.00	20.00	
2.00 DOUD CAP REL COSTS-WRUE EQUIP								1.0
11:00 D2100 LAR SERVICES-SALARY & FRINCES APPRVD 0 0 0 23:00 D2200 PARAMED DE PREAM: (SPECIFY) 0 0 0 INMATI ENT ROUTINE SERVICE COST CENTERS 124.678 0 0 0 0 10:00 03000 ADULTS & PEDIATRICS 124.678 0 0 0 0 10:00 03000 NERSIEV 0	2.00 0 4.00 0 5.00 0 6.00 0 7.00 0 8.00 0 11.00 0 13.00 0 14.00 0 15.00 0 17.00 0 18.00 0 19.00 0	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMI NI STRATI VE & GENERAL 00600 MAI NTENANCE & REPAI RS 00700 OPERATI ON OF PLANT 00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG 01000 DI ETARY 01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY 01500 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE 01080 I INSERVI CE EDUCATI ON 01900 NONPHYSI CI AN ANESTHETI STS	1, 725, 336 0 0 0	0		0 0		2.0 4.0 5.0 6.0 7.0 8.0 9.0 10.0 11.0 13.0 14.0 15.0 16.0 17.0 18.0 19.0
00.00 02000 AUULTS & PEDIATRICS 124.678 0 0 0 0 00 03200 (DRIVENSIVE CARE UNIT 26.576 0	21.00 22.00 23.00	02100 I &R SERVI CES-SALARY & FRI NGES APPRVD 02200 I &R SERVI CES-OTHER PRGM COSTS APPRVD 02300 PARAMED ED PRGM-(SPECI FY)	-	0		0 0	0	20.0 21.0 22.0 23.0
11.00 03100 INTERSIVE CARE UNIT 26.576 0 0 0 0 32.00 03200 DEWN INTERSIVE CARE UNIT 0 <td></td> <td></td> <td>124, 678</td> <td>0</td> <td>1</td> <td>0 0</td> <td>) 0</td> <td>30.0</td>			124, 678	0	1	0 0) 0	30.0
33 00 03300 BURN INTENSIVE CARE UNIT 0	31.00	03100 I NTENSI VE CARE UNI T	26, 576	0		0 0	-	31.0
34.00 00 00 0 0 0 0 0 04.00 04000 SUBPROVIDER - I FF 15,661 0			-	-			-	
11 00 04100 SUBPROVIDER - I RF 0 </td <td></td> <td></td> <td>U U</td> <td>-</td> <td></td> <td>-</td> <td>-</td> <td></td>			U U	-		-	-	
43.00 04300 NURSERY 3.5.42 0 0 0 0 44.00 04400 SKILLED NURSING FACILITY 0 <			15, 661	-			-	
44.00 04400 SKILLED NURSING FACILITY 0			3, 542	-		-	-	
0 0 0 0 0 0 0 ANCILLARY SERVICE COST CENTERS			0	-			-	
ANCILLARY SERVICE COST CENTERS 257.83 0			-	-	1		-	
51:00 05100 RECOVERY ROM 0 0 0 0 0 0 52:00 05200 DELIVERY ROM & LABOR ROM 6, 352 0				0	1	<u> </u>	,	40.0
52.00 052.00 DEL IVERY ROM & LABOR ROM 6.352 0 0 0 0 53.00 05300 ANESTHESI OLOGY 16.135 0 0 0 0 54.01 05400 RADIOLOGY - DIAGNOSTIC 212.436 0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>-</td> <td></td>							-	
33.00 05300 ANESTHESI OLOGY 16, 135 0 0 0 54.00 05400 RADI OLOGY - DI AGNOSTI C 212, 436 0 0 0 64.01 05401 FSED RADI OLOGY - THERAPEUTI C 32, 044 0 0 0 0 55.01 05501 MODI OLOGY - THERAPEUTI C 32, 044 0			0	-			-	
54.01 05401 FSED RADIOLOGY - DIAGNOSTIC 44,268 0 0 0 55.01 05501 RUDOLOGY-THERAPEUTIC 32,044 0 0 0 55.01 05501 WOODLAND CANCER CARE CTR 9,384 0 0 0 0 56.00 05600 RADIOISOTOPE 0				0		0 0	-	
55:00 05500 RADI 0LOGY-THERAPEUTI C 32,044 0 0 0 05501 WODLAND CANCER CARE CTR 9,384 0 0 0 0 0501 WODLAND CANCER CARE CTR 9,384 0						0 0	-	
55. 01 00501 WODDLAND CANCER CARE CTR 9, 384 0 0 0 0 66. 00 05600 RADI OI STOPE 0				0				
57.00 057.00 CT SCAN 0				0		0 0	-	
18:00 058:00 MAGNETIC RESONANCE IMAGING (MRI) 0			0	0		0 0	0	
59.00 CARDI AC CATHETERI ZATI ON 59, 370 0 0 0 0 50.00 06000 LABORATORY 168, 800 0			0) 57.0 58.0
50.01 06001 FS ED LAB 23,879 0			59, 370	0		0 0		
51.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 0 0 0 0 52.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 0 0 53.00 06300 BLOOD STORING, PROCESSING & TRANS. 2,770 0 0 0 0 0 53.00 06400 INTRAVENOUS THERAPY 0				0		0 0	-	
52.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 <td>1</td> <td></td> <td>23, 879</td> <td>0</td> <td></td> <td>0 0</td> <td>0</td> <td>60. 0 61. 0</td>	1		23, 879	0		0 0	0	60. 0 61. 0
54.00 06400 INTRAVENOUS THERAPY 0<	1		0	0		0 0	0	
55.00 06500 RESPI RATORY THERAPY 35, 507 0 0 0 0 56.00 06600 PHYSI CAL THERAPY 35, 253 0 0 0 0 57.00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 0 58.00 06800 SPEECH PATHOLOGY 0			2, 770	0		0 0	-	
56.00 06600 PHYSI CAL THERAPY 35, 253 0 <t< td=""><td>1</td><td></td><td>35 507</td><td></td><td></td><td></td><td></td><td></td></t<>	1		35 507					
57.00 06700 0CCUPATI ONAL THERAPY 0				0		0 0	-	
99.00 06900 ELECTROCARDI OLOGY 55, 119 0 <	7.00	06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	
70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 70.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 59, 624 0 <td>1</td> <td></td> <td>0</td> <td>0</td> <td></td> <td>0 0</td> <td></td> <td></td>	1		0	0		0 0		
V1.00 O7100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 59,624 0 0 0 0 V2.00 07200 IMPL. DEV. CHARGED TO PATIENTS 55,815 0 0 0 0 0 V3.00 07300 DRUGS CHARGED TO PATIENTS 55,815 0			55, 119				-	
V3.00 O7300 DRUGS CHARGED TO PATIENTS 277,560 0 0 0 0 0 V4.00 07400 RENAL DI ALYSI S 0 <td></td> <td></td> <td>59, 624</td> <td>0</td> <td></td> <td>0 0</td> <td>-</td> <td></td>			59, 624	0		0 0	-	
74.00 07400 RENAL DIALYSIS 0				0		0 0	-	
v75.00 07500 ASC (NON-DISTINCT PART) 0 <			277,560					
76.00 03020 CV RESOURCE CTR 0			0			0 0	-	
OUTPATI ENT SERVICE COST CENTERS 38. 00 08800 RURAL HEALTH CLINIC 0	76.00		0	0		0 0		76.0
38.00 08800 RURAL HEALTH CLINIC 0	-		0	0		0 0	0	77. C
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0						0		00 0
			0	, s			-	
90. 03 09000 CLINIC 0 0 0 0 0	90.00	09000 CLI NI C	0	0		0 0	0	90. 0

	ANCISCAN HEALTH				u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CO		Period: From 01/01/2020 To 12/31/2020		
Cost Center Description	RECORDS & LI BRARY	SOCI AL SERVI CE	EDUCATI ON	NONPHYSI CI AN ANESTHETI STS	NURSI NG SCHOOL	
	16.00	17.00	18.00	19.00	20.00	
91. 00 09100 EMERGENCY	159, 352	0		0 0		
91.01 09101 FREE STANDING EMERGENCY DEPT	35, 162	0		0 0	0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS	-1		1	-	-	
94.00 09400 HOME PROGRAM DI ALYSI S	0	0		0 0	-	
95. 00 09500 AMBULANCE SERVI CES	0	0		0 0	-	
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0 0	-	
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0		0 0	0	
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0		0 0	0	
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	0	101.00
SPECIAL PURPOSE COST CENTERS	1					
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 ACQUI SI TI ON	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 I SLET ACQUI SI TI ON	0	0		0 0	0	111.00
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF		0				114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0		0 0	-	115.00
116.00 11600 HOSPICE 118.00 SUBTOTALS (SUM OF LINES 1 through 117)	1 725 224	0		0 0		116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	1, 725, 336	0		0 0	0	118.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	1	0 0	0	190. 00
191. 00 19100 RESEARCH	0	0		0 0		191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0		192.00
193. 00 19300 NONPALD WORKERS	0	0		0 0		193.00
193. 01 19301 NONPALD WORKERS	0	0		0 0		193.0
194. 00 07950 BEACON JOINT VENTURE	0	0		0 0		194.00
194. 01 07951 WORKING WELL	0	0		0 0		194.01
194. 03 07953 MED WATCHER	0 0	0		0 0		194. 03
194. 10 07960 DUNELAND FI TNESS CTR	0	0		0 0		194.10
194.11 07961 OMNI HEALTH & FITNESS CHESTERTOWN	o	0		0 0		194.11
194.16 07966 PHYSICIAN PRACTICE MD WISW	0	0		0 0		194.16
194. 19 07969 HEALTH PARTNERS	0	0		0 0		194.19
194. 20 07970 CENTER OF HOPE	0	0		0 0		194.20
200.00 Cross Foot Adjustments				0		200.00
201.00 Negative Cost Centers	0	0		0 0	-	201.00
202.00 TOTAL (sum lines 118 through 201)	1, 725, 336	0		0 0		202.00
	,	0	1			

Tom DUDY 1200 PPULT 1		ALLOCATION - GENERAL SERVICE COSTS		Provider C		Period:	Worksheet B	2002 10
Initiation Initiation Provide the construction of						From 01/01/2020		nared
Cost Center Description SERVICES-SALAPECRICES-OTHER Y & HINRCS PARADE (NOIL CISIS) Subtotal PROB From test Subtotal Prob From test Subtotal Prob 1:00 Cost Center Description 21.00 22.00 23.00 24.00 20.00 1:00 Cost Center Description 21.00 23.00 24.00 20.00 20.00 1:00 Cost Center Description 21.00 23.00 24.00 20.00 20.00 0:000 Cost Center Description 0 0.00 0.00 20.0						10 12/31/2020		
V A FRINCTS PROM Residents - Dool Adjustments - Adjustments - Dool Adjustments - Adjustments - Adjusthththththththththththththt			INTERNS &	RESI DENTS				
V A FRINCTS PROM Residents - Dool Adjustments - Adjustments - Dool Adjustments - Adjustments - Adjusthththththththththththththt		Cost Coston Description				Culture		
Image: state		Cost center Description				Subtotal		
Image: Stand of Cost Carteries 21 00 22.00 23.00 24.00 25.00 1.00 DOTOOLAR LL COST - WALL CALL PUT 1.00 2.00 23.00 24.00 25.00 2.00 DOTOOLAR LL COST - WALL CALL PUT 1.00 2.00 <td></td> <td></td> <td>I & I KINGES</td> <td>11000 00010</td> <td>I ROW</td> <td></td> <td></td> <td></td>			I & I KINGES	11000 00010	I ROW			
CHERAL SERVIC DOT CHITRS 21.00 22.00 24.00 25.00 24.00 25.00 2.00 00000 CAP REL.005T_WRSE FOURP 4.00								
HARMA SERVICE COST CARLESS I.00 0 COROOL CAR EL COST SAMPLE FOULPATT 1.00 0 COROOL CARLESS AND LE FOULPATT 1.00 0 COROOL CARLESS AND THE FOULPATT 1.00 0 DISOL CARLESS AND THANK 1.00 1 DISOL CARL								
1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 0.00 00100 CAP REL COSTS-BLDG & FIXT 2.00 0.00 00100 CAP REL COSTS-BLDG & FIXT 4.00 0.00 00100 CAP REL COSTS-BLDG & FIXT 7.00 0.00 00100 CAP REL COSTS-BLDG & FIXT 8.00 0.00 00100 CAP FIXT 8.00 0.00 00100 CAP FIXT 8.00 0.00 00100 CAP FIXT 8.00 1.00 011000 CAP FIXT 8.00 1.00 011000 CAP FIXT 8.00 1.00 011000 CAP FIXT 10.00 1.00 011000 CAP FIXT 10.00 1.00 011000 CAP FIXT 10.00 1.00 01100 CAP FIXT 10.00 1.00 01000 CAP FIXT 10.00 1.00 01000 CAP FIXT 1			21.00	22.00	23.00	24.00	25.00	
2.00 00200 (ZP REL COSTS-WRELE EDILP 2.00 5.00 00200 (ZP REL COSTS-WRELE EDILP) 4.00 5.00 00200 (ZM IN STRATIVE & GLEBAL 5.00 5.00 00200 (ZM IN STRATIVE & GLEBAL 7.00 5.00 00200 (ZM INSTRATIVE & GLEBAL 8.00 5.00 00200 (ZM INSTRATIVE & GLEBAL 8.00 5.00 00200 (ZM INSTRATIVE & GLEBAL 8.00 5.00 00200 (ZM INSTRATIVE & GLEBAL 18.00 5.00 01200 (ZM INSTRATIVE & GLEBAL 18.00 5.00 012	1 00						1	1 1 00
4.00 00000 EVPLOYEE BEREFITS DEPARTMENT 4.00 5.00 005000 MINI TIRATURE & GENERAL 5.00 6.00 DECORD MINI TIRATURE & GENERAL 5.00 6.00 DECORD MINI TIRATURE & GENERAL 5.00 6.00 DECORD MINI TIRATURE & MERNICE 7.00 7.00								
5.00 DODOD ADMINI INTERVICE & GENERAL 5.00 BODOD ADMINI STRATUTE & GENERAL 5.00 7.00 DODOD OFERATION OF PLANT 6.00 7.00 0.00 7.00 0.00 7.00 0.00 7.00 0.00 7.00 0.00 7.00 0.00 7.00 0.00 7.00 0.00 7.00 0.00 7.00 0.00 7.00 0.00 7.00 0.00 7.00 0.00 7.00 0.00 7.00								•
6.00 000000 000000 FARMER LINE OF SERVICE 6.00 7.00 8.00 00000 LAMREY & LINES SERVICE 6.00 8.00 8.00 00000 LAMREY & LINES SERVICE 6.00 8.00 8.00 00000 LAMREY & LINES SERVICE 6.00 8.00 8.00 00000 LAMREY & LINES SERVICE & SUPELY 10.00 11.00 11.00 011000 CAETERIA 11.00 11.00 11.00 011000 SERVICE & SUPELY 11.00 11.00 11.00 011000 MARAEY 11.00 11.00 11.00 11.00 011000 MARAEY 11.00 11.00 11.00 11.00 011000 MARAEY AT INKAS AVARUD 11.00 11.00 11.00 11.00 011000 MARAEY AT INKAS AVARUD 0 0 0 0.00 11.00 11.00 011000 MARAEY AFRE AVARUE CONST CENTER 20.00 21.00 21.00 21.00 21.00 21.00 21.00 21.00								•
8.00 00000 LAUNDRY S LI JEN SERVICE 8.00 0000 10.00 01000 DITADD 110.00 1000 110.00 1000 110.00 1000 1000 110.00 1000 110.00 1000 1000 1000 110.00 1000 110.00 <								•
9.00 00000 POLISEREP ING 9.00 00000 POLISEREP ING 11.00 01100 CAFETENIA 11.00 0100 CAFETENI	7.00	00700 OPERATION OF PLANT						7.00
10. 00 01000 DE FLARY 10. 00 01000 DE FLARY 10. 00 01000 DE FLARY 13. 00 01000 DEFTARA SERVICES SUPPLY 11. 00 011000 DEFTARA SERVICES SUPPLY 11. 00 011000 DEFTARA SERVICES 14. 00 01000 DEFTARA SERVICES SUPPLY 11. 00 011000 DEFTARA SERVICES 11. 00 011000 DEFTARA SERVICES 16. 00 010400 DEFTARA SERVICES SUPPLY 11. 00 011000 DEFTARA SERVICES SUPPLY 11. 00 011000 DEFTARA SERVICES 18. 00 010400 DEFTARA SERVICES SUPPLY 11. 00 011000 DEFTARA SERVICES SUPPLY 11. 00 01100 DEFTARA SERVICES SUPPLY 18. 00 010400 DEFTARA SERVICES SUPPLY 0 0 12. 00 0200 DEFTARA SERVICES SUPPLY 0 10. 00 01000 DEFTARA SERVICES SUPPLY 0 0 0. 00 000 DEFTARA SERVICES SUPPLY 0 20. 00 2200 DEFTARA SERVICES SUPPLY 0 10. 00 01000 DEFTARA SERVICES SUPPLY 0 0 0. 00 000 DEFTARA SERVICES SUPPLY 0 0 0. 00 00 00 DEFTARA SERVICES SUPPLY 0 0 0. 00 00 DEFTARA SERVICES SUPPLY								•
11.00 01100 CAFETERIA 11.00 13.00 01300 INES NG ADMIN STRATION 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 15.00 01300 INESPICE FUNCTION 15.00 17.00 01700 SCIAL SERVICE 15.00 17.00 01700 SCIAL SERVICE SENARY & FUNCTION 17.00 18.00 01300 INESPICE FUNCTION 18.00 19.00 01500 INESPICE FUNCTION SITURE SERVICES 19.00 20.01 01200 IAR SERVICE COSTALARY & FIN NESS APPRVD 0 22.00 20.01 02100 IAR SERVICE COSTALARY & FIN NESS APPRVD 0 0 35.318.565 30.00 31.00 03200 INTEN NESSIGA LINTER NERVICE COST CENTERS 0 0 0 32.00 32.00 33200 G3200 INTENSIVE CARE UNIT 0 0 0 32.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>•</td></t<>								•
13.00 01300 UNESN BS ADM IN STRATT ON 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 15.00 01500 PHARMACY 15.00 15.00 01500 PHARMACY 15.00 16.00 01500 PHARMACY 17.00 17.00 01500 PHARMACY 17.00 17.00 01500 PHARMACY 17.00 17.00 01500 PHARMACY 17.00 17.00 00 17.00 17.00 00 01500 PHARMACY 0 0 18.00 02200 IRA SERVICE-S-SHARY & FRINCES APPRVD 0 21.00 20.00 02200 IRA SERVICE-SONT CENTERS 0 0 35.318, 566 10.00 02200 IRA SERVICE-SONT CENTERS 0 0 0 32.00 21.00 2200 D2200 IRA SERVICE-CARE UNIT 0 0 0 33.00 21.00 230.00 230.00 230.00 230.00								•
14.00 01400 CENTRAL SERVICES & SUBPLY 14.00 15.00 01500 MECOMPANACY 15.00 16.00 01600 MECOMPANACY 16.00 17.00 01700 SERVICE 16.00 18.00 010801 MESERVICE 16.00 18.00 010801 MESERVICE 16.00 18.00 010001 MESERVICE 16.00 19.00 01001 MESERVICE 16.00 10.00 02300 PARAMET 16.00 16.00 10.00 03000 ADMER SERVICE 0 0 22.00 10.00 03000 ADMER SERVICE 0 0 35.316.56 30.00 31.00 03000 ADMER SERVICE ADE NTR 0 0 6.67.05 31.00 32.00 03200 CARAMER MERT 0 0 0 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>•</td>								•
15. 00 01500 IHABINACY 15. 00								•
17.00 01700 SOCIAL SERVICE 17.00								•
18. 00 010001 (NSERVICE EDUCATION 110. 00 19. 00 190. 00 190. 00 190. 00 20. 00 190. 00 20. 00 12000 (MRSING SCHOL 20. 00 20.								
19:00 01900 MOMPHYSICAS CLARA ANESTHETISTS 19:00 10:00								•
20.00 20200 NURSI NS SCHOL 20.00								•
21.00 2200 LAR SERVICES-SALARY & FRINCES APPRVD 0 21.00 22.00 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>•</td>								•
22.00 02200 [LAR SERVICES-OTHER PROM_COSTS APPRVD 0 22.00 INPATIENT SOUTH & SERVICE COST CENTERS 0 0 33.00 0 33.00 0 33.00 0 33.00 0 33.00 0 33.00 0 0 0 0 0 0 33.00 0 33.00 0 33.00 0 33.00 0 33.00 0 33.00 0 33.00 0 33.00 0 33.00 0 33.00 0 33.00 0 34.00 44.00 0 0 0 0 33.00 0 34.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 44.00 46.00 46.00 46.00 46.00 46.00 46.00 46.00 46.00 46.00 46.00 46.00 46.00 46.00 46.00 46.00 46.00 46.00<			0					•
23.00 23.00 23.00 23.00 INVATURE NUMERABLE DE PROL-CREVERS			0	0				•
INPATI ENT ROUTI NE SERVICE COST CENTERS Impati enter control of the service of the se				0		0		•
31.00 03100 INTENSIVE CARE UNIT 0 0 6,566,705 0 32.00 33.00 03300 BURN INTENSIVE CARE UNIT 0 0 0 0 33.00 04.00 03400 SURGICAL INTENSIVE CARE UNIT 0 0 0 0 33.00 04.00 04000 SURGICAL INTENSIVE CARE UNIT 0 0 0 43.00 04000 SURGICAL INTENSIVE CARE UNIT 0 0 0 43.00 04000 SURGICAL INTENSIVE CARE UNIT 0 0 0 44.00 04000 SURGICAL INTENSIVE CARE UNIT 0 0 0 45.00 04000 SURGICAL INTENSIVE CARE UNIT 0 0 0 45.00 04000 SURGICAL INTENSIVE CARE 0 0 0 0 45.00 04500 ONRESING FACILITY 0 0 0 0 45.00 000 OPERATING ROOM 0 0 0 0 50.00 50.00 000 ODELLARY SENVICE COST CENTERS			1		1	-1	1	
32. 00 03200 COROMARY CARE UNIT 0 0 0 0 23. 00 33. 00 03300 SURGI CAL INTENSIVE CARE UNIT 0 0 0 33. 00 34. 00 03400 SURGI CAL INTENSIVE CARE UNIT 0 0 0 34. 00 04. 00 04000 SURGI CAL INTENSIVE CARE UNIT 0 0 0 44. 00 04. 00 04000 SURGI CAL INTENSIVE CARE UNIT 0 0 0 44. 00 0. 0100 SURGRWO IER - IFF 1FF 0 0 0 2. 672. 128 43. 00 0. 04400 SKILLED NURSING FACULITY 0 0 0 0 46. 00 0. 04600 ONESING FACULITY 0 0 0 0 0 0 50. 00 0. 05000 OPEATING REOW 0 0 0 0 0 50. 00 0. 05200 DELIVERY ROM 0 0 0 0 70. 63. 71 55. 00 51. 00 05300 RADI LOGY - DI ACNOSTI C 0 0 70. 63. 73 55. 01 52. 00 <t< td=""><td>30.00</td><td>03000 ADULTS & PEDIATRICS</td><td>0</td><td>0</td><td></td><td>0 35, 318, 565</td><td>0</td><td>30.00</td></t<>	30.00	03000 ADULTS & PEDIATRICS	0	0		0 35, 318, 565	0	30.00
33.00 03300 BURR INTERSIVE CARE UNIT 0 0 0 0 33.00 40.00 63400 SURGICAL INTERSIVE CARE UNIT 0 0 0 43.00 40.00 SURGICAL INTERSIVE CARE UNIT 0 0 0 43.00 41.00 41000 SURGICAL INTERSIVE CARE 0 0 0 43.00 43.00 G4300 NURSIRE FAL INTERSIVE CARE 0 0 0 0 45.00 44.00 G4400 SVILLEN NURSING FACILITY 0 0 0 0 45.00 44.00 G4500 NURSING FACILITY 0 0 0 0 65.00 64.00 05000 NURSING FACILITY 0 0 0 0 65.00 50.00 05000 OFHER LONG TERM CARE 0 0 0 0 65.00 51.00 05000 OFERATING ROOM 0 0 0 0 65.00 56.00 52.00 05000 ALSTHESI LOGY 0 0 0 0 770.486 53.00 53.00 05300 ALSTHESI LOGY 0 0			0	0		0 6, 566, 705	0	•
34.00 03400 SUBJECAL INTENSIVE CARE UNIT 0 0 0 0 4.00 0 4.00 0 4.37,870 0 4.00 41.00 SUBPROV DER - IPF 0 0 0 .37,870 0 40.00 41.00 OVATOD SUBPROV DER - IPF 0 0 0 .272,128 0 43.00 43.00 OVATOD SUBPROV DER - INF 0 0 0 0 0 44.00 50.00 OVATOD SUBPROV DER - INF 0 0 0 0 0 0 44.00 64.00 OVESOND OPERATING ROOM 0			0	0		0 0		•
40. 00 04.000 SUBJECT PF 0 0 4.3.67, 870 0 40.00 41. 00 04.300 SUBPECT 0 0 0 0 41.00 43. 00 OUSDO SUBPECT 0 0 0 0 44.00 44. 00 OUSDO SUBLEST 0 0 0 0 0 44.00 44. 00 OUSDO STERI LOR TREIL CARE 0 0 0 45.00 0 50.00 0 0 51.00 50.00 0 51.00 50.00 0 0 0 0 0 51.00 52.00 0 0 0 0 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 55.01 55.01 0 54.01 55.01 0 54.01 55.01 55.01 0 55.01 55.01 0 56.01 55.01 55.01 0 56.01 55.01 55.01			0	0		0 0	-	•
41.00 04100 Support 0 0 0 0 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 1 0 0 0 0 1 0 1 0 0 0 0 1 0 1 0 0 0 0 0 0 0 1 0			0	0				•
43. 00 04300 NURSERY 0 0 2, 672, 128 0 43. 00 44. 00 04400 SKILLED NURSING FACILITY 0 0 0 0 44. 00 66.00 04600 SKILLED NURSING FACILITY 0			0	0		4, 307, 870		•
44.00 04400 SKILLED NURSING FACILITY 0 <th< td=""><td></td><td></td><td>0</td><td>0</td><td></td><td>0 2 672 128</td><td></td><td>•</td></th<>			0	0		0 2 672 128		•
45.00 04500 NURSTING FACILITY 0 <td></td> <td></td> <td>0</td> <td>0</td> <td></td> <td>0 2, 0, 2, 120</td> <td></td> <td>•</td>			0	0		0 2, 0, 2, 120		•
ANCI LLARY SERVICE COST CENTERS 000 00000 (PERATING ROOM 0 0 21, 721, 312 0 50.00 51.00 05100 (RECOVERY ROOM 0 0 0 0 51.00 51.00 51.00 51.00 51.00 52.00 52.00 52.00 52.00 53.00 0 0 0 0 0 0 51.00 51.00 51.00 0 0 0 0 0 51.00 52.00 53.00 53.00 53.00 0 0 0 0 0 0 0 0 0 0 0 0 0 54.00 54.00 0		04500 NURSING FACILITY	0	0		0 0	0	•
50.00 05000 0FEATING ROOM 0 0 21,721,312 0 50.00 51.00 05100 RECOVERY ROOM 0 0 0 0 51.00 52.00 DELIVERY ROOM & LABOR ROOM 0 0 0 706,371 0 52.00 53.00 DESTHESI LOGY 0 0 0 0 706,371 0 52.00 54.01 DS400 RADICLOGY - DIAGNOSTIC 0 0 0 2,2,658 0 54.00 55.00 DS500 RADICLOGY - THERAPEUTIC 0 0 0 2,73,207 0 55.00 55.00 DS501 WODDLAND CANCER CARE CTR 0 0 0 0 0 55.00 56.00 DS600 RADICISTOPE 0 0 0 0 0 57.00 55.00 58.00 DS600 RADICISTOPE 0 0 0 0 0 57.00 58.00 0 0 0 58.00 59.00 59.00 59.00 <t< td=""><td>46.00</td><td>04600 OTHER LONG TERM CARE</td><td>0</td><td>0</td><td></td><td>0 0</td><td>0</td><td>46.00</td></t<>	46.00	04600 OTHER LONG TERM CARE	0	0		0 0	0	46.00
51.00 OS100 RECOVERY ROM O O O O O S1.00 52.00 05200 DELIVERY ROM & LABOR ROM O O 706,371 G 52.00 53.00 05300 ANESTHESI OLDGY O O 0 9,922,658 54.00 54.01 OS401 FSDE RADIOLOGY - DI AGNOSTI C O O 2,673,207 55.00 55.01 OS500 RADI OLOGY - THERAPEUTI C O O 2,673,207 55.00 55.01 WOOLAND CAWCER CARE CTR O O 0 0 56.00 56.00 05400 RADI OLSOTPE O O O 0 57.00 57.00 DS7000 CT SCAN O O O 0 57.00 58.00 DS6000 MARDETI C RESONANCE IMAGI NG (MRI) O O 0 0 57.00 59.00 OS900 CABDI AC CATHETERI ZATI ON O O 0 1.187,373 0 60.01 60.01 60.014 SE D LAB O			1		1		T	-
52.00 OS200 DELIVERY ROM & LABOR ROM 0 0 706.371 0 52.00 53.00 05300 ANESTHESI OLOGY 0 0 0 170.486 53.00 54.00 05400 RADI OLOGY - DI AGNOSTI C 0 0 9.922.658 54.01 55.00 05500 RADI OLOGY - THEARPEUTI C 0 0 2.673.207 0 55.01 55.01 05501 WODLAND CANCER CARE CTR 0 0 0 2.673.207 0 55.01 56.00 05007 CT SCAN 0 0 0 0 55.01 56.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 57.00 58.00 0 0 0 0 58.00 58.00 58.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 59.00 50.00 60.00 <td< td=""><td></td><td></td><td>0</td><td>0</td><td></td><td>0 21, 721, 312</td><td></td><td></td></td<>			0	0		0 21, 721, 312		
53 00 NESTHESI OLOGY 0 0 170.486 53.00 54.00 05400 RADIOLOGY -DIAGNOSTI C 0 0 9.922.658 0 54.00 55.00 05500 RADIOLOGY -DIAGNOSTI C 0 0 5.67,836 0 54.01 55.00 05500 RADIOLOGY -THERAPEUTI C 0 0 0 2.673.207 0 55.01 56.00 05600 RADIOLOGY -THERAPEUTI C 0 0 0 0 55.01 56.00 05600 RADIOLOGY -THERAPEUTI C 0 0 0 0 55.01 57.00 05700 CTSCAN 0 0 0 0 56.00 59.00 OS900 CARDIAC CATHETERI ZATION 0 0 0 58.00 59.00 50.00 59.00 50.00 60.00			0	0		0 704 271		•
54.00 Colored RADIOLOGY-DIAGNOSTIC O O 9, 922, 658 0 54.01 54.01 05401 FSED RADIOLOGY - DIAGNOSTIC O O 5, 067, 836 O 54.01 55.00 05501 RADIOLOGY - THERAPEUTIC O O 2, 673, 207 O 55.00 55.01 05501 NODLAND CANCER CARE CTR O O 0 0 55.00 60.00 0500 RADIOLOGY - THERAPEUTIC O O 0 0 55.00 57.00 05700 CT SCAN O O O 0 57.00 58.00 05900 MAGNETIC RESONANCE IMAGING (MRI) O O 0 0 58.00 60.01 06001 LS0RATORY O O 0 0 58.00 61.00 64001 INTRAVENDUS THERAPY O O 0 0 62.00 64.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 0 O 0 0 0			0	0				
54.01 05401 FSED RADI OLOGY - THERAPEUTI C 0 0 2, 673, 207 0 55.00 55.01 05501 WODLAND CARCE CARE 0 0 0 2, 673, 207 0 55.00 56.00 05501 WODLAND CARCE CARE 0 0 0 0 0 55.01 56.00 05501 NOTOLAND CARE CARE 0 0 0 0 55.01 56.00 05501 NOTOLAND CARE CARE 0 0 0 55.01 56.00 05600 MAGNETIC RESONANCE IMAGING (MRI) 0 0 0 57.00 58.00 59.00 05900 CARDI AC CATHETERIZATI ON 0 0 0 11.1187,373 0 60.00 60.01 06001 FS ED LAB 0 0 0 2,036,131 0 60.01 61.00 0 0 0 0 0 0 0 64.00 62.00 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 0 65.00			0	0				•
55.00 OS500 RADI OLGY-THERAPEUTI C O O C, 673, 207 O 55.00 55.01 OS500 RADI OLGY-THERAPEUTI C O O O 0 55.01 55.01 OS500 RADI OLGY-THERAPEUTI C O O O 0 55.01 56.00 OS500 RADI OLGY-THERAPEUTI C O O O 0 55.01 56.00 OS500 RADI TC RESONANCE I MAGI NG (MRI) O O 0 57.00 58.00 OS500 CARDI AC CATHETERI ZATI ON O O 0 58.00 60.01 OG001 FS ED LAB C O O 2, 036, 131 O 60.00 61.00 OF300 BHODL & BLODB & PACKED RED MOLLY O O 0 61.00 63.00 O6300 BLODD & PACKED RED BLODD CELLS O O 0 63.00 64.00 O6300 BLODD & PACKED RED RED MASS. O O 0 64.00 65.00 OS600<			0	0				
56.00 05600 RADIOISOTOPE 0			0	0				
57.00 05700 CT SCAN 0 0 0 0 57.00 58.00 05800 05900 00 0 0 0 0 0 0 0 0 58.00 60.00 06000 LABORATORY 0 0 0 11,187,373 0 60.01 61.00 06100 PSE CLINICAL LAB SERVICES-PRGM ONLY 0 0 0 2,036,131 0 60.01 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 62.00 64.00 64.00 63.00 64.00 64.00 64.00 65.00 66.00 65.00 66.00 65.00 66.00 65.00 66.00 65.00 66.00 65.00 66.00 65.00 66.00 65.00 66.00 65.00 66.00 66.00 65.00 66.00 65.00 66.00 65.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.0			0	0		0 1, 880, 520	0	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 0 0 3,342,964 0 59.00 59.00 CARDIAC CATHETERIZATION 0 0 0 3,342,964 0 59.00 60.00 CABONACATORY 0 0 0 11,187,373 0 60.01 61.00 06001 LABORATORY 0 0 2,036,131 0 60.01 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 62.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 63.00 64.00 64.00 64.00 64.00 64.00 64.00 66.00 0 0 66.00 0 0 66.00			0	0		0 0		
59.00 05900 CARDI AC CATHETERI ZATI ON 0 0 3, 342, 964 0 59.00 60.00 06000 LABORATORY 0 0 0 11, 187, 373 0 60.00 61.00 06010 FS ED LAB 0 0 0 2, 036, 131 0 61.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 41.00 62.00 63.00 06400 INTRAVENOUS THERAPY 0 0 0 63.00 66.00 63.00 650.00 65.00 65.00 65.00 65.00 65.00 66.00 6			0	0		0 0		
60.00 06000 LABORATORY 0 0 11, 187, 373 0 60.00 60.01 06001 FS ED LAB 0 0 2, 036, 131 0 60.01 61.00 06001 FS ED LAB 0 0 2, 036, 131 0 60.01 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 62.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 49, 376 0 63.00 64.00 0400 INTRAVENOUS THERAPY 0 0 0 1, 942, 095 0 64.00 65.00 06500 RESPI RATORY THERAPY 0 0 0 0 64.00 66.00 06600 PHYSI CAL THERAPY 0 0 0 0 65.00 65.00 06600 PECH PATHOLOGY 0 0 0 0 66.00 69.00 06900 ELECTROCARDI OLOGY 0 0 0 0 69.00 70.00 07000 ELECTROCARDI OLOGY 0 0			0	0		0 2 242 064		
60.01 660.01 FS ED LAB 0 0 2,036,131 0 60.01 61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 0 0 61.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 62.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 49.376 0 63.00 64.00 06400 INTRAVENOUS THERAPY 0 0 0 1.942,095 65.00 65.00 65.00 06500 RESPI RATORY THERAPY 0 0 0 0 64.00 65.00 06500 RESPI RATORY THERAPY 0 0 0 65.00 65.00 66.00 06500 RESPI RATORY THERAPY 0 0 0 67.00 71.00 71.00 71.00			0	0				
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 0 0 0 61.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 62.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 49.376 0 63.00 64.00 06400 INTRAVENOUS THERAPY 0 0 0 1942.095 65.00 65.00 06500 RESPI RATORY THERAPY 0 0 0 1942.095 65.00 66.00 06600 PHYSI CAL THERAPY 0 0 0 0 67.00 67.00 06700 0CUPATI ONAL THERAPY 0 0 0 67.00 68.00 SPEECH PATHOLOGY 0 0 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0 0 0 70.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 71.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 72.00			0	0				
63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 49,376 0 63.00 64.00 06400 INTRAVENOUS THERAPY 0 0 0 0 64.00 65.00 06500 RESPIRATORY THERAPY 0 0 0 1,942,095 0 65.00 66.00 06600 PHYSICAL THERAPY 0 0 0 3,971,304 0 66.00 67.00 06700 0CUPATIONAL THERAPY 0 0 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0 0 0 0 70.00 70.00 07000 ELECTROCARDI OLOGY 0 0 0 70.00 70.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 74.00 75.00 75.00 </td <td></td> <td></td> <td></td> <td>-</td> <td></td> <td>C</td> <td></td> <td></td>				-		C		
64.00 06400 INTRAVENOUS THERAPY 0 0 0 0 64.00 65.00 06500 RESPI RATORY THERAPY 0 0 0 1, 942, 095 0 65.00 66.00 06600 PHYSI CAL THERAPY 0 0 0 3, 971, 304 0 66.00 67.00 0CCUPATI ONAL THERAPY 0 0 0 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 0 0 68.00 69.00 0 0 69.00 69.00 69.00 69.00 69.00 69.00 69.00 69.00 69.00 69.00 69.00 0 0 69.00 69.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 71.00 71.00 72.00 72.00 72.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 74.00 0 0 0 0 75.00 75.00 75.00 75.00 76.00 0	62.00		0	0		0 0	0	62.00
65.00 06500 RESPI RATORY THERAPY 0 0 1,942,095 0 65.00 66.00 06600 PHYSI CAL THERAPY 0 0 0 3,971,304 0 66.00 67.00 0CCUPATI ONAL THERAPY 0 0 0 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0 0 0 0 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 70.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 71.00 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 14,308,290 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 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-DI	63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 49, 376	0	63.00
66.00 06600 PHYSI CAL THERAPY 0 0 3, 971, 304 0 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0 0 0 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0 0 0 3, 230, 157 0 69.00 70.00 07000 ELECTROCENEADI ALOGRAPHY 0 0 0 0 70.00 70.00 71.00 70.00 70.00 71.00 71.00 71.00 71.00 71.00 71.00 71.00 72.00 0 0 0 0 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 74.00 74.00 74.00 75.00 75.00 75.00 75.00 75.00 76.00 0 0 0 76.00 76.00 76.00			0	0		0 0		
67.00 06700 0CCUPATIONAL THERAPY 0 0 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 0 0 0 68.00 69.00 06900 ELECTROCARDIOLOGY 0 0 0 3,230,157 0 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 70.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 68.92,107 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 30,255,528 0 73.00 73.00 07400 RENAL DI ALYSI S 0 0 0 0 0 74.00 75.00 07500 ASC (NON-DI STINCT PART) 0 0 0 0 75.00 76.00 30202 CV RESOURCE CTR 0 0 0 0 76.00 77.00 77.00 77.00 07004 LLOGENEIC STEM CELL ACOUISITION 0 0 0 0			0	0				•
68.00 06800 SPEECH PATHOLOGY 0 0 0 0 68.00 69.00 06900 ELECTROCARDIOLOGY 0 0 0 3,230,157 0 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 70.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 6,892,107 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 14,308,290 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 74.00 74.00 74.00 74.00 74.00 74.00 75.00 0 0 0 0 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 76.00 75.00 76.00 76.00 76.00 76.00 77.00 77.00 77.00 77.00 77.00 77.00 77.00 77.00 77.00 77.00 77.00 77.00 77.00 77.00			0	0		0 3, 971, 304		
69.00 06900 ELECTROCARDIOLOGY 0 0 3,230,157 0 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 70.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 6,892,107 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 14,308,290 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 30,255,528 0 73.00 74.00 07400 RENAL DI ALYSI S 0 0 0 0 75.00 75.00 0 0 0 75.00 75.00 76.00 0 0 0 75.00 76.00 76.00 76.00 76.00 76.00 77.00 77.00 77.00 77.00 77.00 77.00 77.00 77.00 77.00 76.00 76.00 76.00 76.00 76.00 76.00 77.00 77.00 77.00 77.00 77.00 77.00 77.00 77.00			0	0				
70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 6, 892, 107 0 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 14, 308, 290 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 30, 255, 528 0 73. 00 74. 00 07400 RENAL DI ALYSI S 0 0 0 0 75. 00 75. 00 75. 00 0 0 0 75. 00 75. 00 76. 00 0 0 0 75. 00 76. 00 76. 00 76. 00 76. 00 76. 00 76. 00 77. 00 <td< td=""><td></td><td></td><td>0</td><td>0 0</td><td></td><td>0 3.230 157</td><td></td><td></td></td<>			0	0 0		0 3.230 157		
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 6,892,107 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 14,308,290 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 30,255,528 0 73.00 74.00 07400 RENAL DI ALYSIS 0 0 0 0 74.00 75.00 07500 ASC (NON-DI STINCT PART) 0 0 0 0 75.00 76.00 76.00 76.00 76.00 76.00 76.00 77.00 88.00			0	0		0 0		•
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 14, 308, 290 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 30, 255, 528 0 73.00 74.00 07400 RENAL DI ALYSI S 0 0 0 0 74.00 75.00 07500 ASC (NON-DI STINCT PART) 0 0 0 0 75.00 76.00 03020 CV RESOURCE CTR 0 0 0 0 76.00 76.00 76.00 76.00 76.00 76.00 76.00 77.00 77.00 77.00 0 0 0 0 70.00 77.00 07700 ALLOGENEI C STEM CELL ACQUISITION 0 0 0 0 0 70.00 0UTPATIENT SERVICE COST CENTERS 0 0 0 0 0 0 0 88.00			0	0		0 6, 892, 107		•
74.00 07400 RENAL DI ALYSI S 0 0 0 0 74.00 75.00 07500 ASC (NON-DI STINCT PART) 0 0 0 0 75.00 76.00 03020 CV RESOURCE CTR 0 0 0 0 76.00 77.00 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON 0 0 0 0 77.00 00 07700 RURAL HEALTH CLINIC 0 0 0 0 88.00		07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				
75.00 07500 ASC (NON-DI STINCT PART) 0 0 0 0 75.00 76.00 03020 CV RESOURCE CTR 0 0 0 0 76.00 77.00 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON 0 0 0 0 0 77.00 0UTPATI ENT SERVICE COST CENTERS 0 0 0 0 0 88.00 0 0 0 0 88.00			0	0		0 30, 255, 528		
76. 00 03020 CV RESOURCE CTR 0 0 0 0 0 76. 00 76. 00 77. 00 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON 0 0 0 0 0 0 77. 00 0 0 0 0 0 0 0 0 77. 00 77. 00 0			0	0		0 0		•
77. 00 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON 0 88. 00 0 0 0 0 0 0 0 0 0 0 88. 00			0	0		0 0		
OUTPATI ENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 0 0 88.00			0	0				
88.00 08800 RURAL HEALTH CLINIC 0 0 0 0 0 88.00	77.00		0	0	1		<u> </u>	, , . 00
	88.00		0	0		0 0	0	88.00
			1					•

	ANGI SCAN REALIF					2552-10
COST ALLOCATI ON - GENERAL SERVI CE COSTS		Provider C	F	Period: From 01/01/2020 Fo 12/31/2020	Date/Time Pre	pared:
					7/28/2021 7:4	1 pm
	INTERNS &	RESIDENTS				
Cost Center Description	SERVI CES-SALAR			Subtotal	Intern &	
	Y & FRINGES	PRGM COSTS	PRGM		Residents Cost	
					& Post	
					Stepdown	
					Adjustments	
	21.00	22.00	23.00	24.00	25.00	
90. 00 09000 CLINIC	0	0	0	0 0	0	90.00
90.03 09003 INFUSION OP SERVICES	0	0	(1, 546, 689	0	90.03
91.00 09100 EMERGENCY	0	0	0	13, 502, 200	0	91.00
91.01 09101 FREE STANDING EMERGENCY DEPT	0	0	(5, 779, 823		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		-			0	
OTHER REIMBURSABLE COST CENTERS						12.00
94. 00 09400 HOME PROGRAM DI ALYSI S	0	0		0 0	0	94.00
95. 00 09500 AMBULANCE SERVICES	0	0				95.00
	0	0	-	-	-	•
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0	U U	
97.00 09700 DURABLE MEDI CAL EQUI P-SOLD	0	0		0	0	
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	(0	0	98.00
99.00 09900 CMHC	0	0	(0 0	0	
99. 10 09910 CORF	0	0	0	0 0	0	
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	0	0	(0 0		100.00
101.0010100 HOME HEALTH AGENCY	0	0	(0 0	0	101.00
SPECIAL PURPOSE COST CENTERS						
105.00 10500 KIDNEY ACQUISITION	0	0	(0 0	0	105.00
106.00 10600 HEART ACQUI SI TI ON	0	0	(0 0	0	106.00
107.00 10700 LIVER ACQUISITION	0	0	(0 0	0	107.00
108.00 10800 LUNG ACQUISITION	0	0	0	0 0	0	108.00
109.00 10900 PANCREAS ACQUISITION	0	0		0		109.00
110.00 11000 INTESTINAL ACQUISITION	0	0	(0		110.00
111. 00 11100 I SLET ACQUI SI TI ON	0	0		0		111.00
113. 00 11300 I NTEREST EXPENSE	Ŭ	0				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				116.00
	0	0	-	-		
	0	0	<u> </u>	189, 111, 695	0	118.00
	0	0		04 711	0	190.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	-					
191.00 19100 RESEARCH	0	0		-		191.00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0		0		192.00
193.00 19300 NONPALD WORKERS	0	0	(0		193.00
193. 01 19301 NONPALD WORKERS	0	0	(0 0		193. 01
194.0007950 BEACON JOINT VENTURE	0	0	0	0 0		194.00
194.01 07951 WORKING WELL	0	0	(3, 296, 083	0	194.01
194.0307953 MED WATCHER	0	0	(3, 597, 677	0	194.03
194. 10 07960 DUNELAND FI TNESS CTR	0	0	0	537, 388	0	194. 10
194.1107961 OMNI HEALTH & FITNESS CHESTERTOWN	0	0	0	0 0	0	194. 11
194.16 07966 PHYSICIAN PRACTICE MD WISW	0	0	(12, 932		194.16
194. 19 07969 HEALTH PARTNERS	0	0	(-617, 177		194.19
194. 20 07970 CENTER OF HOPE	0	0				194.20
200.00 Cross Foot Adjustments		0	-) ,0,227		200.00
201.00 Negative Cost Centers		0		, e		201.00
202.00 TOTAL (sum lines 118 through 201)	0	0		-		201.00
	i O	0	I C	1 170, 120, 000	1 0	202.00

Heal th	Fi nanci al	S	ystems	
COST A	LLOCATI ON	-	GENERAL	SE

	Financial Systems FR	ANCI SCAN HEALTH	MI CHI GAN CI TY Provi der CCN: 15-0015	In Lieu Period: From 01/01/2020 To 12/31/2020	of Form CMS-2552-10 Worksheet B Part I Date/Time Prepared:
	Cost Center Description	Total 26.00			7/28/2021 7:41 pm
	GENERAL SERVICE COST CENTERS	20.00			
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 ADMINI STRATI VE & GENERAL				4.00 5.00
6.00	00600 MAINTENANCE & REPAIRS				6.00
7.00	00700 OPERATION OF PLANT				7.00
8.00	00800 LAUNDRY & LINEN SERVICE				8.00
9.00	00900 HOUSEKEEPI NG				9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A				10.00 11.00
13.00	01300 NURSI NG ADMI NI STRATI ON				13.00
14.00	01400 CENTRAL SERVICES & SUPPLY				14.00
15.00					15.00
16. 00 17. 00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE				16.00 17.00
17.00					18.00
	01900 NONPHYSI CI AN ANESTHETI STS				19.00
20.00					20.00
21.00					21.00
22.00 23.00					22.00 23.00
23.00	INPATIENT ROUTINE SERVICE COST CENTERS	I I			23.00
30.00	03000 ADULTS & PEDI ATRI CS	35, 318, 565			30.00
31.00		6, 566, 705			31.00
32.00 33.00		0			32.00 33.00
33.00		0			34.00
40.00	04000 SUBPROVIDER - IPF	4, 367, 870			40.00
41.00		0			41.00
43.00		2, 672, 128			43.00
44.00 45.00	04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY	0			44.00 45.00
46.00		0			46.00
	ANCI LLARY SERVICE COST CENTERS	·			
50.00 51.00		21, 721, 312			50.00 51.00
52.00		706, 371			52.00
53.00	05300 ANESTHESI OLOGY	170, 486			53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	9, 922, 658			54.00
	05401 FSED RADIOLOGY - DIAGNOSTIC	5,067,836			54.01 55.00
55.00	05500 RADIOLOGY-THERAPEUTIC 05501 WOODLAND CANCER CARE CTR	2, 673, 207 1, 880, 520			55.00
56.00		0			56.00
57.00	05700 CT SCAN	0			57.00
58.00		0			58.00
59.00 60.00		3, 342, 964 11, 187, 373			59.00 60.00
60.01	06001 FS ED LAB	2,036,131			60.01
61.00		0			61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0			62.00
63.00 64.00		49, 376			63.00 64.00
65.00		1, 942, 095			65.00
66.00		3, 971, 304			66.00
67.00		0			67.00
68.00		0			68.00
69.00 70.00		3, 230, 157			69.00 70.00
70.00		6, 892, 107			70.00
72.00		14, 308, 290			72.00
73.00		30, 255, 528			73.00
74.00 75.00		0			74.00 75.00
15.00	UTSUCIASE (NUN-DISTINCT FART)	U U			75.00

75.00	07500 ASC (NON-DI STINCT PART)	0		75.00
76.00	03020 CV RESOURCE CTR	0	-	76.00
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION	0		77.00
	OUTPATIENT SERVICE COST CENTERS			
88.00	08800 RURAL HEALTH CLINIC	0	8	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	8	89.00
90.00	09000 CLI NI C	0		90.00
90.03	09003 INFUSION OP SERVICES	1, 546, 689		90. 03
91.00	09100 EMERGENCY	13, 502, 200		91.00
91.01	09101 FREE STANDING EMERGENCY DEPT	5, 779, 823		91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)			92.00

Health Financial Syste

FRANCI SCAN	HEALTH	MI CHI GAN	CITY	

Health Financial Systems	FRANCI SCAN HEALTH	MICHIGAN CITY	In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 15-0015	Period: From 01/01/2020 To 12/31/2020	Worksheet B Part I Date/Time Pre 7/28/2021 7:4	pared: 1 pm
Cost Center Description	Total 26.00		· ·	-	
OTHER REIMBURSABLE COST CENTERS					
94.00 09400 HOME PROGRAM DI ALYSI S	0				94.00
95. 00 09500 AMBULANCE SERVICES	0				95.00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0				96.00
97. 00 09700 DURABLE MEDICAL EQUI P-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
SPECIAL PURPOSE COST CENTERS					
105.00 10500 KIDNEY ACQUISITION	0				105.00
106.00 10600 HEART ACQUI SI TI ON	0				106.00
107.00 10700 LIVER ACQUISITION	0				107.00
108.00 10800 LUNG ACQUISITION	0				108.00
109.00 10900 PANCREAS ACQUI SI TI ON	0				109.00
110.00 11000 INTESTINAL ACQUISITION	0				110.00
111.00 11100 I SLET ACQUI SI TI ON	0				111.00
113.00 11300 INTEREST EXPENSE					113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF					114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0				115.00
116. 00 11600 HOSPI CE	0				116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) 189, 111, 695				118.00
NONREI MBURSABLE COST CENTERS					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	94, 711				190.00
191. 00 19100 RESEARCH	0				191.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0				192.00
193.00 19300 NONPALD WORKERS	0				193.00
193. 01 19301 NONPALD WORKERS	0				193.01
194.00 07950 BEACON JOINT VENTURE	0				194.00
194.01 07951 WORKING WELL	3, 296, 083				194.01
194. 03 07953 MED WATCHER	3, 597, 677				194.03
194. 10 07960 DUNELAND FI TNESS CTR	537, 388				194.10
194. 11 07961 OMNI HEALTH & FITNESS CHESTERTOWN	0				194.11
194. 16 07966 PHYSICIAN PRACTICE MD WISW	12, 932				194.16
194. 19 07969 HEALTH PARTNERS	-617, 177				194.19
194. 20 07970 CENTER OF HOPE	90, 229				194.20
200.00 Cross Foot Adjustments	0				200.00
201.00 Negative Cost Centers					201.00
202.00 TOTAL (sum lines 118 through 201)	196, 123, 538				202.00

	Financial Systems Fi ATION OF CAPITAL RELATED COSTS	RANCI SCAN HEALTH	MICHIGAN CITY Provider C	CN: 15-0015 P	eriod:	u of Form CMS-: Worksheet B	2552-10
				F	rom 01/01/2020 o 12/31/2020	Part II Date/Time Pre 7/28/2021 7:4	
			CAPI TAL REI	LATED COSTS			
	Cost Center Description	Directly Assigned New Capital	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFI TS DEPARTMENT	
		Related Costs 0	1.00	2.00	2A	4.00	
-	GENERAL SERVICE COST CENTERS			1			
1.00 2.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1.00
2.00 4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	102, 135	8, 260	110, 395	110, 395	1
5.00	00500 ADMI NI STRATI VE & GENERAL	0	1, 827, 453		2, 672, 214	28, 865	1
6.00	00600 MAINTENANCE & REPAIRS	0	0	0	0	0	
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	0	3, 525, 578			4, 282	
8.00 9.00	00900 HOUSEKEEPING	0	63, 742 832, 102			123 2, 659	1
10.00	01000 DI ETARY	0	179, 934			771	
11.00	01100 CAFETERI A	0	451, 448		451, 448	1, 933	
13.00 14.00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	0	98, 954 772, 001		221, 263 981, 375	3, 791	1
15.00	01500 PHARMACY	0	278, 243		287, 937	288 3, 944	
16.00	01600 MEDI CAL RECORDS & LI BRARY	0	31, 249		31, 249	25	
17.00	01700 SOCIAL SERVICE	0	0	0	0	0	
18.00 19.00	01080 I NSERVI CE EDUCATI ON 01900 NONPHYSI CLAN ANESTHETI STS	0	0	0	0	0	
20.00	02000 NURSI NG SCHOOL	0	0	0	0	0	1
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	
22.00	02200 I & R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	
23.00	02300 PARAMED ED PRGM-(SPECIFY) INPATIENT ROUTINE SERVICE COST CENTERS	0	0	0	0	0	23.00
30.00	03000 ADULTS & PEDI ATRI CS	0	3, 234, 707	277, 869	3, 512, 576	21, 988	30.00
31.00	03100 I NTENSI VE CARE UNI T	0	618, 891		738, 892	3, 656	
32.00	03200 CORONARY CARE UNIT	0	0	0	0	0	
33.00 34.00	03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	
40.00	04000 SUBPROVIDER - IPF	0	658, 621	39, 582	698, 203	1, 998	1
41.00	04100 SUBPROVI DER – I RF	0	0	0	0	0	
43.00	04300 NURSERY	0	341, 616	534	342, 150	1, 200	
44.00 45.00	04400 SKI LLED NURSI NG FACI LI TY 04500 NURSI NG FACI LI TY	0	0	0	0	0	
46.00	04600 OTHER LONG TERM CARE	0	0	0	Ű	0	1
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	2, 486, 258			9, 127	
51.00 52.00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	0	0 256, 397	0	0 256, 397	0	
53.00	05300 ANESTHESI OLOGY	0	8, 066			57	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	916, 768				54.00
54.01	05401 FSED RADI OLOGY - DI AGNOSTI C	0	132, 047			1, 926	
55.00 55.01	05500 RADIOLOGY-THERAPEUTIC 05501 WOODLAND CANCER CARE CTR	0	150, 483 492, 514		425, 032 494, 395	1, 048 585	
56.00	05600 RADI OI SOTOPE	0	0	0	0	0	1
57.00	05700 CT SCAN	0	0	0	0	0	
58.00 59.00	05800 MAGNETIC RESONANCE I MAGING (MRI) 05900 CARDIAC CATHETERIZATION	0	0 245, 473	0 498, 879	0 744, 352	0 1, 534	
60.00	06000 LABORATORY	0	384, 203			1, 334	
60. 01	06001 FS ED LAB	0	59, 916		59, 916	0	60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY				0	0	61.00
62.00 63.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06300 BLOOD STORING, PROCESSING & TRANS.	0	0 18, 159	0	0 18, 159	0	
64.00	06400 I NTRAVENOUS THERAPY	0	10, 139	0	10, 137	0	
65.00	06500 RESPI RATORY THERAPY	0	92, 456	83, 513	175, 969	1, 661	65.00
66.00	06600 PHYSI CAL THERAPY	0	68, 674	25, 492	94, 166	1, 372	
67.00 68.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	0	0	0	0	
69.00	06900 ELECTROCARDI OLOGY	0	412, 087	226, 045	638, 132	1, 496	
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	
72.00 73.00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	
75.00	07500 ASC (NON-DI STI NCT PART)	0	0	0	0	0	75.00
76.00	03020 CV RESOURCE CTR	0	0	0	0	0	
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION OUTPATIENT SERVICE COST CENTERS	0	0	<u> </u>	0	0	77.00
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0			0	1
	09000 CLI NI C	0	0	0	0	0	90.00

Health Financial Systems ALLOCATION OF CAPITAL RELATED COSTS	FRANCI SCAN HEALTH	Provi der C		Peri od:	u of Form CMS-2 Worksheet B	2002 1
ALLUCATION OF CAPITAL RELATED COSTS		Provider Co	UN: 15-0015	From 01/01/2020 To 12/31/2020	Part II	pared: 1 pm
		CAPI TAL REL	LATED COSTS			
Cost Center Description	Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFI TS DEPARTMENT	
	0	1.00	2.00	2A	4.00	
90. 03 09003 INFUSION OP SERVICES	0	148, 086	10, 37	9 158, 465	603	90.03
91.00 09100 EMERGENCY	0	868, 282			6, 008	
91.01 09101 FREE STANDING EMERGENCY DEPT	0	985, 442	322, 82		2, 222	
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT	PART)			0		92.00
OTHER REIMBURSABLE COST CENTERS			1		-	
94. 00 09400 HOME PROGRAM DI ALYSI S	0	0		0 0	-	94.00
95. 00 09500 AMBULANCE SERVICES	0	0		0 0	0	95.00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0	0		0 0	0	96.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD 98.00 09850 OTHER REIMBURSABLE COST CENTERS	. 0	0		0 0	-	97.00 98.00
78.00 09850 0THER REIMBURSABLE COST CENTERS 79.00 09900 CMHC	, U	0			0	98.00
99. 10 09900 CMRC	0	0		0 0	0	99.00
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. 0
SPECIAL PURPOSE COST CENTERS	0	0		0 0	0	101.00
105. 00 10500 KI DNEY ACQUI SI TI ON	0	0		0 0	0	105.00
106. 00 10600 HEART ACQUI SI TI ON	o	0		0 0		106.00
107. 00 10700 LIVER ACQUISITION	o	0		0 0		107.00
108.00 10800 LUNG ACQUISITION	0	0		0 0	0	108.00
109.00 10900 PANCREAS ACQUISITION	0	0		0 0	0	109.00
110.00 11000 INTESTINAL ACQUISITION	0	0		0 0	0	110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0		0 0	0	111.00
13.00 11300 INTEREST EXPENSE						113.00
14.00 11400 UTILIZATION REVIEW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.F	P.) 0	0		0 0		115.00
16. 00 11600 HOSPI CE	0	0		0 0		116. 00
I18.00 SUBTOTALS (SUM OF LINES 1 throu	ıgh 117) 0	20, 741, 985	8, 901, 79	2 29, 643, 777	108, 484	118.00
NONREI MBURSABLE COST CENTERS			1	<u>a</u>		
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CAN		45, 398		0 45, 398		190.00
	0	0		0 0		191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0		192.0
193. 00 19300 NONPALD WORKERS 193. 01 19301 NONPALD WORKERS	0	0		0 0		193. 0 193. 0
194. 00 07950 BEACON JOINT VENTURE	0	0		0 0		193.0
194. 01 07951 WORKI NG WELL	0	0		9 251, 889		194. 0
194. 03 07953 MED WATCHER	0	1, 384, 855				194.0
194. 10 07960 DUNELAND FI TNESS CTR	0	209, 385		0 209, 385		194. 10
194. 11 07961 OMNI HEALTH & FITNESS CHESTERTO	WN O	207,000		0 207, 303		194.1
194. 16 07966 PHYSI CI AN PRACTICE MD WI SW	0	0		0 0		194.1
194. 19 07969 HEALTH PARTNERS	0	0		0 0		194.1
194. 20 07970 CENTER OF HOPE	0	0	76	5 765		194.20
200.00 Cross Foot Adjustments				0		200.00
201.00 Negative Cost Centers		0		0 0	0	201.00
202.00 TOTAL (sum lines 118 through 20	01) ol	22, 381, 623	9, 157, 11	7 31, 538, 740	110, 395	202 0

ALLOCA	ATION OF CAPITAL RELATED COSTS		Provider CCI		eriod: rom 01/01/2020 o 12/31/2020	Worksheet B Part II Date/Time Pre 7/28/2021 7:4	
	Cost Center Description	ADMI NI STRATI VE <u>& GENERAL</u> 5. 00	MAI NTENANCE & REPAI RS 6.00	OPERATI ON OF PLANT 7.00	LAUNDRY & LINEN SERVICE 8.00	HOUSEKEEPI NG 9.00	
	GENERAL SERVICE COST CENTERS	5.00	0.00	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	2, 701, 079					4.00
6.00	00600 MAINTENANCE & REPAIRS	2, 701, 079	0				6.00
7.00	00700 OPERATION OF PLANT	233, 757	0	4, 716, 445			7.00
8.00	00800 LAUNDRY & LINEN SERVICE	10, 139	0	17, 761	92, 661		8.00
9.00	00900 HOUSEKEEPI NG	59, 469	0	231, 860	0	1, 179, 907	
10.00 11.00	01000 DI ETARY 01100 CAFETERI A	18, 412 35, 321	0	50, 137	37 0	13, 244	
13.00	01300 NURSI NG ADMI NI STRATI ON	61, 626	0	125, 793 27, 573	0	33, 228 7, 283	
14.00	01400 CENTRAL SERVICES & SUPPLY	28, 507	0	215, 113	0	56, 822	
15.00	01500 PHARMACY	79, 825	0	77, 531	0	20, 480	
16.00	01600 MEDICAL RECORDS & LIBRARY	23, 118	0	8, 707	0	2, 300	1
17.00	01700 SOCIAL SERVICE	0	0	0	0	0	
18.00 19.00	01080 I NSERVI CE EDUCATI ON 01900 NONPHYSI CI AN ANESTHETI STS	0	0	0	0	0	
20.00	02000 NURSI NG SCHOOL	0	0	0	0	0	
21.00	02100 I & R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	
22.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	0	О	0	0	0	22.00
23.00	02300 PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	367, 196	0	901, 331	43, 551	238, 083	30. 00
31.00	03100 I NTENSI VE CARE UNI T	65, 400	o	172, 450	43, 551 4, 633	45, 552	
32.00	03200 CORONARY CARE UNI T	00,100	0	0	0	0	
33.00	03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	
40.00	04000 SUBPROVIDER - IPF	40, 077	0	183, 520	13, 899	48, 477	
41.00 43.00	04100 SUBPROVI DER – I RF 04300 NURSERY	0 27, 889	0	0 95, 189	0 28	0 25, 144	
43.00	04400 SKILLED NURSING FACILITY	27,009	0	95, 169 0	20	25, 144	
45.00	04500 NURSING FACILITY	0	0	0	0	0	
46.00	04600 OTHER LONG TERM CARE	0	0	0	0	0	46.00
	ANCI LLARY SERVICE COST CENTERS						
50.00 51.00	05000 OPERATING ROOM 05100 RECOVERY ROOM	200, 513	0	692, 779	4, 911	182, 997	
51.00	05200 DELIVERY ROOM & LABOR ROOM	4,359	0	0 71, 443	0	0 18, 872	
53.00	05300 ANESTHESI OLOGY	1, 906	0	2, 247	0	594	
54.00	05400 RADI OLOGY-DI AGNOSTI C	110, 996	0	255, 451	3, 725	67, 477	54.00
54.01	05401 FSED RADIOLOGY - DIAGNOSTIC	64, 634	0	36, 794	0	9, 719	
55.00	05500 RADI OLOGY-THERAPEUTI C	32, 948	0	41, 931	46	11,076	
55.01 56.00	05501 WOODLAND CANCER CARE CTR 05600 RADI 0I SOTOPE	15, 119	0	137, 236	927	36, 251 0	
57.00	05700 CT SCAN	0	0	0	0	0	
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0	0	0	0	
59.00	05900 CARDI AC CATHETERI ZATI ON	35, 283	0	68, 400	28	18, 068	
	06000 LABORATORY	143, 156	0	107, 056	0	28, 279	1
60. 01 61. 00	06001 FS ED LAB 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	26, 534	0	16, 695	0	4, 410	60. 01 61. 00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	Ο	0	0	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	309	0	5, 060	0	1, 337	
64.00	06400 I NTRAVENOUS THERAPY	0	О	0	0	0	64.00
65.00		23, 106	0	25, 762	0	6, 805	
66.00 67.00	06600 PHYSI CAL THERAPY	51, 605	0	19, 135	2, 780	5, 055	
67.00 68.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	0	0	0	0	
	06900 ELECTROCARDI OLOGY	33, 953	0	114, 825	463	30, 331	
	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	93, 806	О	0	0	0	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	195, 679	0	0	0	0	
73.00 74.00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	324, 487	0	0	0	0	
	07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	
76.00	03020 CV RESOURCE CTR	0	0	0	0	0	
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	
90.00 90.03	09000 CLINIC 09003 INFUSION OP SERVICES	0 17, 004	0	0 41, 263	0 28	0 10, 900	
90.03	09100 EMERGENCY	154, 247	0	41, 203 241, 941	28 9, 266	63, 909	
91.01	09101 FREE STANDING EMERGENCY DEPT	55, 819	0	274, 587	3, 706		
	09200 OBSERVATION BEDS (NON-DISTINCT PART)		-		-, -=		92.00

Heal th	Fi nanci	al Syste	ems
	TI 011 05	OADL TAL	DEL ATED

Health Financial Systems FR	ANCI SCAN HEALT	H MICHIGAN CIT	ř.	In Lie	U OI FOIM CMS	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider C	CN: 15-0015	Period:	Worksheet B	
				From 01/01/2020	Part II	
				To 12/31/2020	Date/Time Pre 7/28/2021 7:4	pared:
Cost Conton Deparintian	ADMI NI STRATI VE		OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	T pm
Cost Center Description	& GENERAL			LINEN SERVICE	HUUSEKEEPING	
		REPAI RS 6, 00	PLANT 7.00		9.00	
OTHER REIMBURSABLE COST CENTERS	5.00	0.00	7.00	8.00	9.00	
			1		0	
		0		0 0	0	
95. 00 09500 AMBULANCE SERVICES	0			0 0	0	
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0)	0 0	0	
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD	0	0)	0 0	0	
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0 0)	0 0	0	
99. 00 09900 CMHC	0	0)	0 0	0	1 / / / 00
99. 10 09910 CORF	0	0)	0 0	0	99.10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0)	0 0	0	100.00
101.00 10100 HOME HEALTH AGENCY	0	0)	0 0	0	101.00
SPECIAL PURPOSE COST CENTERS						1
105.00 10500 KIDNEY ACQUISITION	0	0)	0 0	0	105.00
106.00 10600 HEART ACQUI SI TI ON	0	o c		0 0	0	106.00
107.00 10700 LIVER ACQUISITION	0	o c		o o	0	107.00
108.00 10800 LUNG ACQUI SI TI ON	0			0 0		108.00
109. 00 10900 PANCREAS ACQUI SI TI ON	0			0 0		109.00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON	0			0 0		110.00
111. 00 11100 I SLET ACQUI SI TI ON	0					111.00
113. 00 11300 I NTEREST EXPENSE				0	0	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	115.00
116. 00 11600 HOSPI CE	0			0 0		116.00
	2, 636, 199		4, 259, 57	0 88, 028	1, 059, 225	
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	2, 030, 199	0	4, 259, 57	0 88,028	1, 059, 225	118.00
	472		12 (5		2 241	100.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	4/2	0	12, 65			190.00
	0)	0 0		191.00
192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0)	0 0		192.00
193.00 19300 NONPALD WORKERS	0	0)	0 0		193.00
193. 01 19301 NONPALD WORKERS	0	0)	0 0		193. 01
194.0007950 BEACON JOINT VENTURE	0	0 0)	0 0		194.00
194.0107951 WORKING WELL	35, 898)	0 0		194.01
194.0307953 MED WATCHER	23, 588	0	385, 88		101, 930	
194.1007960DUNELAND FITNESS CTR	3, 560	0	58, 34	4 0	15, 411	194.10
194.1107961OMNI HEALTH & FITNESS CHESTERTOWN	0	0)	0 0	0	194.11
194.16 07966 PHYSICIAN PRACTICE MD WISW	178	0		0 0	0	194.16
194.1907969 HEALTH PARTNERS	0	0)	0 0	0	194.19
194. 20 07970 CENTER OF HOPE	1, 184	. 0		o o	0	194.20
200.00 Cross Foot Adjustments	1				-	200.00
201.00 Negative Cost Centers	0	0		0 0	0	201.00
202.00 TOTAL (sum Lines 118 through 201)	2, 701, 079		4, 716, 44	5 92, 661		
	2,101,017	1		,2,001	1, 1, 7, 707	1-02.00

ALLOCA	Financial Systems FI TION OF CAPITAL RELATED COSTS		Provider C		eriod: rom 01/01/2020	u of Form CMS-2 Worksheet B Part II Date/Time Prep 7/28/2021 7:4	pared:
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
1.00 2.00 4.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						1.00 2.00 4.00
5.00 6.00 7.00 8.00 9.00 11.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00 20.00 21.00 22.00	00500 ADMI NI STRATI VE & GENERAL 00600 MAI NTENANCE & REPAI RS 00700 OPERATI ON OF PLANT 00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG 01000 DI ETARY 01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE 01080 I NSERVI CE EDUCATI ON 01900 NONPHYSI CI AN ANESTHETI STS 02000 NURSI NG SCHOOL 02100 I &R SERVI CES-SALARY & FRI NGES APPRVD 02200 I &R SERVI CES-OTHER PRGM COSTS APPRVD	314, 653 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	647, 723 28, 011 4, 369 28, 126 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	349, 547 0 0 0 0 0 0 0 0 0 0 0 0	1, 286, 474 9, 127 0 0 0 0 0 0 0 0 0 0 0 0 0	506, 970 0 0 0 0 0 0 0 0 0	5.00 6.00 7.00 8.00 9.00 11.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00 20.00 21.00 22.00
23.00	02300 PARAMED ED PRGM- (SPECI FY)	0	0	0	0	0	23.00
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	237, 382	149, 866	127,001	47, 546	0	30.00
	03100 I NTENSI VE CARE UNI T	40, 837	31, 094		17, 830	0	31.00
	03200 CORONARY CARE UNI T	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
	04000 SUBPROVIDER - IPF	36, 434	19, 827	11, 533	358	0	40.00
41.00	04100 SUBPROVI DER – I RF	0	0	0	0	0	41.00
	04300 NURSERY	0	4, 787	11, 741	0	0	43.00
	04400 SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00 46.00	04500 NURSING FACILITY 04600 OTHER LONG TERM CARE	0	0	0	0	0	45.00 46.00
	ANCI LLARY SERVI CE COST CENTERS				-1		
	05000 OPERATING ROOM	0	83, 175	52, 424	985, 716	0	50.00
	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	0	0 8, 570	0	0	0	51.00 52.00
	05300 ANESTHESI OLOGY	0	982		0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	49, 907		34, 072	0	54.00
54.01	05401 FSED RADI OLOGY - DI AGNOSTI C	0	16, 169		4, 349	0	54.01
55.00 55.01	05500 RADIOLOGY-THERAPEUTIC 05501 WOODLAND CANCER CARE CTR	0	7, 588 4, 546		1, 622 5, 390	0	55.00 55.01
	05600 RADI OI SOTOPE	0	4, 540	0,317	5, 340	0	56.00
	05700 CT SCAN	0	0	0	0	0	57.00
	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0	0	0	0	58.00
	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0	11, 006 0	6, 633	100, 186 33, 500	0	59.00 60.00
	06001 FS ED LAB	0	0	0 0	16	0	60.01
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		_				61.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	62.00 63.00
	06400 I NTRAVENOUS THERAPY	0	0	0	0	0	64.00
	06500 RESPI RATORY THERAPY	0	15, 709	0	9, 853	0	65.00
	06600 PHYSI CAL THERAPY	0	11, 256	0	2, 851	0	66.00
		0	0	0	0	0	67.00
	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0	13, 200	5, 968	1, 966	0	68.00 69.00
	07000 ELECTROENCEPHALOGRAPHY	0	13, 200	0, 200	1, 300	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	
	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0	0	0	0	506, 970 0	
	07500 ASC (NON-DI STI NCT PART)	0	0	0	0	0	
	03020 CV RESOURCE CTR	0	0	0	Ō	0	76.00
75. 00 76. 00			0	0	0	0	77.00
75. 00 76. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	U					
75.00 76.00 77.00	07700 ALLOGENEIC STEM CELL ACQUISITION OUTPATIENT SERVICE COST CENTERS		0			0	88 00
75.00 76.00 77.00 88.00	07700 ALLOGENEIC STEM CELL ACQUISITION		0	0	0 0	0	88. 00 89. 00
75.00 76.00 77.00 88.00 89.00 90.00	07700 ALLOGENEI C STEM CELL ACQUI SI TI ON OUTPATI ENT SERVI CE COST CENTERS 08800 RURAL HEALTH CLI NI C 08900 FEDERALLY QUALI FI ED HEALTH CENTER 09000 CLI NI C		0 0 0	0 0 0	0 0 0	-	89. 00 90. 00
75.00 76.00 77.00 88.00 89.00 90.00 90.03	07700 ALLOGENEIC STEM CELL ACQUISITION OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER		0 0 0 5, 174 51, 997		0 0 0 1, 464 24, 986	0	89. 00 90. 00 90. 03

Health Financial Systems FR	ANCISCAN HEALTH	MICHIGAN CITY	/	Inlie	u of Form CMS-:	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CC	CN: 15-0015 P F T	eriod: rom 01/01/2020 o 12/31/2020	Worksheet B Part II	pared:
Cost Center Description	DI ETARY		NURSI NG ADMI NI STRATI ON	SUPPLY	PHARMACY	
	10.00	11.00	13.00	14.00	15.00	
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	
95. 00 09500 AMBULANCE SERVI CES	0	0	0	0	0	
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	99.00
99. 10 09910 CORF	0	0	0	0	0	99.10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
105.00 10500 KIDNEY ACQUISITION	0	0	0	0	0	105.00
106.00 10600 HEART ACQUI SI TI ON	0	0	0	0	0	106.00
107. 00 10700 LI VER ACQUI SI TI ON	0	0	0	0	0	107.00
108.00 10800 LUNG ACQUISITION	0	0	0	0	0	108.00
109.00 10900 PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0	0	0	0	111.00
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	0	0	115.00
116.00 11600 HOSPI CE	0	0	0	0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	314, 653	561, 664	330, 522	1, 284, 428	506, 970	118.00
NONREI MBURSABLE COST CENTERS	· · ·					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191. 00 19100 RESEARCH	0	0	0	0	0	191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0	0	192.00
193.00 19300 NONPALD WORKERS	0	0	0	0	0	193.00
193. 01 19301 NONPALD WORKERS	0	0	0	0	0	193.01
194.0007950 BEACON JOINT VENTURE	0	0	0	0	0	194.00
194.01 07951 WORKING WELL	0	85, 568	18, 908	2, 046	0	194.01
194.03 07953 MED WATCHER	0	0	0	0	0	194.03
194.1007960 DUNELAND FITNESS CTR	0	0	0	0	0	194.10
194.1107961 OMNI HEALTH & FITNESS CHESTERTOWN	0	0	0	0	0	194.11
194.16 07966 PHYSICIAN PRACTICE MD WISW	0	0	0	0	0	194.16
194.1907969 HEALTH PARTNERS	0	0	0	0	0	194.19
194.2007970 CENTER OF HOPE	o	491	117	0	0	194.20
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	314, 653	647, 723	349, 547	1, 286, 474	506, 970	202.00

					From 01/01/2020 To 12/31/2020		
							1 nm
				OTHER GENERAL		172072021 7.1	
	Cost Center Description	MEDI CAL	SOCI AL SERVI CE	SERVI CE	NONPHYSI CI AN	NURSING SCHOOL	
	·	RECORDS &		EDUCATI ON	ANESTHETI STS		
		LI BRARY 16.00	17.00	18.00	19.00	20.00	
	GENERAL SERVICE COST CENTERS	T	I	1	1	1	
	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1.00 2.00
	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
	00500 ADMINI STRATI VE & GENERAL						5.00
	00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT						6.00 7.00
	00800 LAUNDRY & LINEN SERVICE						8.00
	00900 HOUSEKEEPI NG						9.00
	01000 DI ETARY 01100 CAFETERI A						10.00 11.00
13.00	01300 NURSI NG ADMI NI STRATI ON						13.00
	01400 CENTRAL SERVICES & SUPPLY						14.00
	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	65, 399					15.00 16.00
17.00	01700 SOCIAL SERVICE	0	0				17.00
	01080 I NSERVI CE EDUCATI ON 01900 NONPHYSI CI AN ANESTHETI STS	0					18.00 19.00
	02000 NURSING SCHOOL	0	-			0	20.00
	02100 I &R SERVICES-SALARY & FRINGES APPRVD	0	-		D		21.00
	02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 02300 PARAMED ED PRGM-(SPECIFY)	0					22.00 23.00
	INPATIENT ROUTINE SERVICE COST CENTERS			<u>/</u>			23.00
	03000 ADULTS & PEDI ATRI CS	4, 739			D		30.00
	03100 I NTENSI VE CARE UNI T 03200 CORONARY CARE UNI T	1,010					31.00 32.00
	03300 BURN INTENSIVE CARE UNIT	0					32.00
	03400 SURGI CAL I NTENSI VE CARE UNI T	0	-		C		34.00
	04000 SUBPROVI DER – I PF 04100 SUBPROVI DER – I RF	595 0					40.00
	04300 NURSERY	135					43.00
	04400 SKI LLED NURSI NG FACI LI TY	0			2 2		44.00
	04500 NURSING FACILITY 04600 OTHER LONG TERM CARE	0					45.00 46.00
	ANCI LLARY SERVI CE COST CENTERS	-	1		-		
	05000 OPERATING ROOM 05100 RECOVERY ROOM	9, 799					50.00 51.00
	05200 DELIVERY ROOM & LABOR ROOM	241					52.00
	05300 ANESTHESI OLOGY	613	0		D		53.00
	05400 RADI OLOGY-DI AGNOSTI C 05401 FSED RADI OLOGY - DI AGNOSTI C	8, 074 1, 682					54.00 54.01
	05500 RADI OLOGY - THERAPEUTI C	1, 218		1			55.00
	05501 WOODLAND CANCER CARE CTR	357	C) (C		55.01
	05600 RADI OI SOTOPE 05700 CT SCAN	0					56.00 57.00
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0					58.00
	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	2,256					59.00 60.00
	06000 LABORATORY 06001 FS ED LAB	6, 415 908					60.00
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY				-		61.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06300 BLOOD STORING, PROCESSING & TRANS.	0 105	0				62.00 63.00
	06400 INTRAVENOUS THERAPY	0					64.00
65.00	06500 RESPI RATORY THERAPY	1, 349					65.00
	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	1, 340					66.00 67.00
	06800 SPEECH PATHOLOGY	0		1			68.00
69.00	06900 ELECTROCARDI OLOGY	2,095			5		69.00
	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0 2, 266					70.00 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	2, 200			Ď		72.00
	07300 DRUGS CHARGED TO PATIENTS	10, 377	0				73.00
	07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART)	0					74.00 75.00
	03020 CV RESOURCE CTR	0					76.00
1	07700 ALLOGENEIC STEM CELL ACQUISITION	0	C		כ		77.00
							1
	OUTPATIENT SERVICE COST CENTERS	0	0				88 00
88.00	001PATTENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	-))		88.00 89.00

		ANCISCAN HEALTH				eu of Form CMS-2	2552-10
ALLOCATION (OF CAPITAL RELATED COSTS		Provider CO		Period: From 01/01/2020 To 12/31/2020		
	Cost Center Description	RECORDS & LI BRARY	SOCIAL SERVICE	EDUCATI ON	NONPHYSI CI AN ANESTHETI STS	NURSING SCHOOL	
	1	16.00	17.00	18.00	19.00	20.00	
	EMERGENCY	6, 056	0		0		91.00
	FREE STANDING EMERGENCY DEPT	1, 336	0		0		91.01
	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	REIMBURSABLE COST CENTERS	I		1		1	
	HOME PROGRAM DI ALYSI S	0	0		0		94.00
	AMBULANCE SERVICES	0	0		0		95.00
	DURABLE MEDICAL EQUIP-RENTED	0	0		0		96.00
	DURABLE MEDICAL EQUIP-SOLD	0	0		0		97.00
	OTHER REIMBURSABLE COST CENTERS	0	0		0		98.00
99.00 09900		0	0		0		99.00
99.10 09910		0	0		0		99.10
	I&R SERVICES-NOT APPRVD PRGM	0	0		0		100.00
	HOME HEALTH AGENCY	0	0		0		101.00
	AL PURPOSE COST CENTERS						_
	KIDNEY ACQUISITION	0	0		0		105.00
	HEART ACQUI SI TI ON	0	0		0		106.00
	LIVER ACQUISITION	0	0		0		107.00
	LUNG ACQUISITION	0	0		0		108.00
	PANCREAS ACQUISITION	0	0		0		109.00
	INTESTINAL ACQUISITION	0	0		0		110.00
	I SLET ACQUI SI TI ON	0	0		0		111.00
	INTEREST EXPENSE						113.00
	UTILIZATION REVIEW-SNF						114.00
	AMBULATORY SURGICAL CENTER (D. P.)	0	0		0		115.00
116.0011600		0	0		0		116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	65, 399	0		0 0	0	118.00
	I MBURSABLE COST CENTERS					1	
	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0		190.00
191.0019100		0	0		0		191.00
	PHYSICIANS' PRIVATE OFFICES	0	0		0		192.00
	NONPALD WORKERS	0	0		0		193.00
	NONPAI D WORKERS	0	0		0		193.01
	BEACON JOINT VENTURE	0	0		0		194.00
	WORKING WELL	0	0		0		194.01
	MED WATCHER	0	0		0		194.03
	DUNELAND FITNESS CTR	0	0		0		194.10
	OMNI HEALTH & FITNESS CHESTERTOWN	0	0		-		194.11
	PHYSICIAN PRACTICE MD WISW HEALTH PARTNERS	0	0		0		194.16 194.19
		0	0		0		194. 19
		I ()	()	1	U	1	1194.20
194. 20 07970		0	0				000 00
194. 20 07970 200. 00	Cross Foot Adjustments		0		C	0	
194. 20 07970		0 65, 399	0			0	200. 00 201. 00 202. 00

FRANCI SCAN HEALTH MI CHI GAN CI TY Provi der CCN: 15-0015 Peri od:

In Lieu of Form CMS-2552-10 -iod: Worksheet B om 01/01/2020 Part II

ALLUCA	TION OF CAPITAL RELATED COSTS		Provider CC	:N: 15-0015	Period: From 01/01/2020 To 12/31/2020	Date/Time Prep	
		INTERNS & F	RESIDENTS			7/28/2021 7:4	
	Cost Center Description	SERVI CES-SALARS Y & FRI NGES	ERVICES-OTHER PRGM COSTS	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		21.00	22.00	23.00	24.00	25.00	
	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
	00900 HOUSEKEEPING						9.00
	01000 DI ETARY						10.00
11.00	01100 CAFETERI A						11.00
	01300 NURSI NG ADMI NI STRATI ON						13.00
	01400 CENTRAL SERVICES & SUPPLY						14.00 15.00
	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY						16.00
	01700 SOCIAL SERVICE						17.00
18.00	01080 INSERVICE EDUCATION						18.00
	01900 NONPHYSI CI AN ANESTHETI STS						19.00
	02000 NURSI NG SCHOOL						20.00
	02100 I & R SERVI CES-SALARY & FRI NGES APPRVD 02200 I & R SERVI CES-OTHER PRGM COSTS APPRVD	0	0				21.00 22.00
	02300 PARAMED ED PRGM-(SPECIFY)		0		0		23.00
	INPATIENT ROUTINE SERVICE COST CENTERS		1				
	03000 ADULTS & PEDIATRICS				5, 651, 259		30.00
	03100 I NTENSI VE CARE UNI T				1, 159, 105		31.00
	03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT				0	0	32.00 33.00
	03400 SURGI CAL I NTENSI VE CARE UNI T				0	0	34.00
	04000 SUBPROVI DER – I PF				1, 054, 921	0	40.00
	04100 SUBPROVI DER – I RF				0	0	41.00
	04300 NURSERY				508, 263		43.00
	04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY				0		44.00 45.00
	04600 OTHER LONG TERM CARE				0		46.00
	ANCI LLARY SERVI CE COST CENTERS		1				
	05000 OPERATING ROOM				6, 776, 255	1	50.00
	05100 RECOVERY ROOM				0	-	51.00
	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY				359, 882 43, 931	1	52.00 53.00
	05400 RADI OLOGY-DI AGNOSTI C				2, 676, 985	1	54.00
	05401 FSED RADIOLOGY - DIAGNOSTIC				1, 547, 707		54.01
	05500 RADI OLOGY-THERAPEUTI C				522, 509	1	55.00
	05501 WOODLAND CANCER CARE CTR				700, 123		55.01
	05600 RADI OI SOTOPE 05700 CT SCAN				0	0	56.00 57.00
	05800 MAGNETIC RESONANCE IMAGING (MRI)				0	0	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON				987, 746		59.00
	06000 LABORATORY				726, 807		60.00
	06001 FS ED LAB				108, 479	0	60.01
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS				0	0	61.00 62.00
	06300 BLOOD STORING, PROCESSING & TRANS.				24, 970		63.00
	06400 I NTRAVENOUS THERAPY				0	0	64.00
65.00	06500 RESPI RATORY THERAPY				260, 214		65.00
	06600 PHYSI CAL THERAPY				189, 560	1	66.00
	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY				0	0	67.00 68.00
	06900 ELECTROCARDI OLOGY				842, 429		68.00 69.00
	07000 ELECTROENCEPHALOGRAPHY				0	0	70.00
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS				96, 072		71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS				197, 800	1	72.00
	07300 DRUGS CHARGED TO PATIENTS				841, 834	1	73.00
	07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART)				0	-	74.00 75.00
75 00	03020 CV RESOURCE CTR				0		76.00
	USUZUCV RESUURCE CIR						
76.00	07700 ALLOGENEIC STEM CELL ACQUISITION				0	0	77.00
76. 00 77. 00					0	-	77.00 88.00

In Lieu of Form CMS-2552-10 d: Worksheet B

ALLOCATION OF CAPITAL RELATED COSTS		Provider CC	CN: 15-0015	Period: From 01/01/2020 To 12/31/2020	Worksheet B Part II Date/Time Prep 7/28/2021 7:4	
	INTERNS & R	ESI DENTS				
Cost Center Description	SERVI CES-SALAR SI Y & FRI NGES	ERVICES-OTHER PRGM COSTS	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown	
	21.00	22.00	22.00	24.00	Adjustments	
90. 00 09000 CLINIC	21.00	22.00	23.00	24.00	25.00 0	90.00
90. 03 09003 I NFUSI ON OP SERVI CES				240, 660	0	90.00
91. 00 09100 EMERGENCY				1, 613, 466	0	91.00
91. 01 09101 FREE STANDING EMERGENCY DEPT				1, 756, 689	0	91.01
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)				1,700,007	0	92.00
OTHER REIMBURSABLE COST CENTERS	I					
94.00 09400 HOME PROGRAM DI ALYSI S				0	0	94.00
95. 00 09500 AMBULANCE SERVICES				0	0	95.00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED				0	0	96.00
97.00 09700 DURABLE 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
100.00100001&R SERVICES-NOT APPRVD PRGM 101.0010100000000000000000000000000000				0		100. 00 101. 00
SPECIAL PURPOSE COST CENTERS				0	0	101.00
105. 00 10500 KI DNEY ACQUI SI TI ON				0	0	105.00
106. 00 10600 HEART ACQUI SI TI ON				0		106.00
107. 00 10700 LI VER ACQUI SI TI ON				0		107.00
108.00 10800 LUNG ACQUI SI TI ON				0		108.00
109.00 10900 PANCREAS ACQUISITION				0	0	109.00
110.00 11000 INTESTINAL ACQUISITION				0	0	110. 00
111.00 11100 I SLET ACQUI SI TI ON				0	0	111.00
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)				0		115.00
116.00 11600 HOSPICE 118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	0		0		116. 00 118. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	0	0		0 28, 887, 666	0	118.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN				61, 861	0	190.00
191. 00 19100 RESEARCH				01,001		191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES				0		192.00
193.00 19300 NONPALD WORKERS				0	0	193.00
193.01 19301 NONPALD WORKERS				0	0	193. 01
194.0007950 BEACON JOINT VENTURE				0	0	194.00
194.01 07951 WORKING WELL				396, 119	0	194.01
194.0307953 MED WATCHER				1, 903, 558		194. 03
194.1007960 DUNELAND FITNESS CTR				286, 700		194.10
194. 11 07961 OMNI HEALTH & FITNESS CHESTERTOWN				0		194.11
194. 16 07966 PHYSI CLAN PRACTI CE MD WI SW				187		194.16
194. 19 07969 HEALTH PARTNERS 194. 20 07970 CENTER OF HOPE				0		194. 19 194. 20
200.00 Cross Foot Adjustments		0		2,649		194. 20 200. 00
201.00 Negative Cost Centers	0	0		0 0		200.00
202.00 TOTAL (sum lines 118 through 201)	0	0		0 31, 538, 740		201.00
	-1	-1			- 1	

Health Fina	nci al	Syste	ms	
ALLOCATI ON	OF CA	PI TAL	RELATED	COSTS

TH N	AICHIGAN CITY	In Lie	u of Form CMS-2	2552-10
	Provider CCN: 15-0015	Period: From 01/01/2020 To 12/31/2020	Worksheet B Part II Date/Time Pre 7/28/2021 7:4	
				1.00 2.00
				4.00
				5.00 6.00

			7/28/2021 7:41	1 pm
	Cost Center Description	Total		
	GENERAL SERVICE COST CENTERS	26.00		
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 ADMINI STRATI VE & GENERAL			5.00
6.00	00600 MAINTENANCE & REPAIRS			6.00
7.00	00700 OPERATION OF PLANT			7.00
8.00	00800 LAUNDRY & LINEN SERVICE			8.00
9.00	00900 HOUSEKEEPI NG			9.00
10.00	01000 DI ETARY			10.00
11.00				11.00
13.00	01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY			13.00
14.00 15.00	01500 PHARMACY			14.00 15.00
16.00	01600 MEDICAL RECORDS & LIBRARY			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 SCHOOL			20.00
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRVD			21.00
22.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD			22.00
23.00	02300 PARAMED ED PRGM-(SPECIFY)			23.00
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000 ADULTS & PEDIATRICS	5, 651, 259		30.00
31.00	03100 I NTENSI VE CARE UNI T	1, 159, 105		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 SUBPROVIDER - IPF	1, 054, 921		40.00
40.00	04100 SUBPROVIDER - IRF	1,034,721		40.00
43.00	04300 NURSERY	508, 263		43.00
44.00	04400 SKI LLED NURSI NG FACI LI TY	0		44.00
45.00	04500 NURSING FACILITY	0		45.00
46.00	04600 OTHER LONG TERM CARE	0		46.00
	ANCI LLARY SERVI CE COST CENTERS			
50.00	05000 OPERATING ROOM	6, 776, 255		50.00
51.00	05100 RECOVERY ROOM	0		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	359, 882		52.00
53.00		43,931		53.00
54.00 54.01	05400 RADI OLOGY-DI AGNOSTI C 05401 FSED RADI OLOGY - DI AGNOSTI C	2, 676, 985 1, 547, 707		54.00 54.01
55.00	05500 RADI OLOGY-THERAPEUTI C	522, 509		55.00
55.01	05501 WOODLAND CANCER CARE CTR	700, 123		55.01
56.00	05600 RADI OI SOTOPE	0		56.00
57.00	05700 CT SCAN	0		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0		58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	987, 746		59.00
60.00	06000 LABORATORY	726, 807		60.00
60. 01	06001 FS ED LAB	108, 479		60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY			61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0		62.00
63.00 64.00	06300 BLOOD STORI NG, PROCESSI NG & TRANS. 06400 I NTRAVENOUS THERAPY	24, 970		63.00 64.00
64.00 65.00	06500 RESPIRATORY THERAPY	260, 214		64.00 65.00
66. 00	06600 PHYSI CAL THERAPY	189, 560		66.00
67.00	06700 OCCUPATI ONAL THERAPY	0, 500		67.00
68.00	06800 SPEECH PATHOLOGY	0		68.00
69.00	06900 ELECTROCARDI OLOGY	842, 429		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	96, 072		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	197, 800		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	841, 834		73.00
74.00	07400 RENAL DI ALYSI S	0		74.00
75.00	07500 ASC (NON-DI STINCT PART)	0		75.00
76.00	03020 CV RESOURCE CTR	0		76.00
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION	0		77.00
88.00	OUTPATIENT SERVICE COST CENTERS	0		88.00
88.00 89.00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0		88.00 89.00
89.00 90.00	09000 CLINIC	0		90.00
	09003 I NFUSI ON OP SERVI CES	240, 660		90.00
		1, 613, 466		91.00
91.00 91.01	09100 EMERGENCY 09101 FREE STANDING EMERGENCY DEPT	1, 756, 689		91.01

Health Financial Systems FR ALLOCATION OF CAPITAL RELATED COSTS		MICHIGAN CITY Provider CCN: 15-0015	Peri od:	u of Form CMS-2552- Worksheet B
ALLUCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0015	From 01/01/2020 To 12/31/2020	Part II Date/Time Prepared 7/28/2021 7:41 pm
Cost Center Description	Total 26.00			
OTHER REIMBURSABLE COST CENTERS	20100			
94. 00 09400 HOME PROGRAM DI ALYSI S	0			94.0
95. 00 09500 AMBULANCE SERVICES	0			95.0
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0			96.0
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0			97.0
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0			98.0
79. 00 1099001 CMHC	0			99.0
99. 10 09910 CORF	0			
				99.1
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	0			100.0
101.00 10100 HOME HEALTH AGENCY	0			101. C
SPECIAL PURPOSE COST CENTERS				105.0
105. 00 10500 KI DNEY ACQUI SI TI ON	0			105. C
106. 00 10600 HEART ACQUI SI TI ON	0			106.0
107.00 10700 LIVER ACQUISITION	0			107. C
108.00 10800 LUNG ACQUISITION	0			108. C
109.00 10900 PANCREAS ACQUISITION	0			109.0
110.00 11000 INTESTINAL ACQUISITION	0			110.0
111.00 11100 I SLET ACQUI SI TI ON	0			111.0
113.00 11300 INTEREST EXPENSE				113. 0
114.00 11400 UTILIZATION REVIEW-SNF				114. C
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0			115.0
116. 00 11600 HOSPI CE	0			116.0
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	28, 887, 666			118.0
NONREI MBURSABLE COST CENTERS	· · · · ·			
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	61,861			190. 0
191. 00 19100 RESEARCH	0			191.0
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0			192.0
193. 00 19300 NONPALD WORKERS	0			193. 0
193. 01 19301 NONPALD WORKERS	0			193.0
194. 00 07950 BEACON JOINT VENTURE	0			194. 0
194. 01 07951 WORKI NG WELL	396, 119			194.0
194. 03 07953 MED WATCHER	1, 903, 558			194.0
194. 10/07960 DUNELAND FI TNESS CTR	286, 700			194. 0
194.11 07961 OMNI HEALTH & FITNESS CHESTERTOWN	0			194. 1
194.16 07966 PHYSICIAN PRACTICE MD WISW	187			194. 1
194. 19 07969 HEALTH PARTNERS	0			194. 1
194. 20 07970 CENTER OF HOPE	2,649			194. 2
200.00 Cross Foot Adjustments	0			200. C
201.00 Negative Cost Centers	0			201. C
202.00 TOTAL (sum lines 118 through 201)	31, 538, 740			202.0

Heal th	n Financial Systems	FR	ANCISCAN HEALT	H MICHIGAN CITY	,
COST	ALLOCATION - STATISTICAL BASIS			Provider CO	CN: 15-0015
			CAPI TAL REI	LATED COSTS	
	Cost Center Description		BLDG & FIXT	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFI TS
			(SQUARE FEET)	(DOLLAR VALUE)	DEPARTMEN
					(GROSS SALARI ES)
			1.00	2.00	4.00
	GENERAL SERVICE COST CENTERS				
1.00	00100 CAP REL COSTS-BLDG & FIXT		485, 611		
2.00	00200 CAP REL COSTS-MVBLE EQUIP			6, 294, 838	
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT		2, 216	5, 678	66, 241, 5
5 00	00500 ADMINISTRATIVE & GENERAL		39 650	580 710	17 222 (

	Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUI P (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMI NI STRATI VE & GENERAL (ACCUM. COST)	
		1.00	2.00	4.00	5A	5.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT	485, 611				[1.00
2.00	00200 CAP REL COSTS-BEDG & TTXT	405,011	6, 294, 838				2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	2, 216	5, 678				4.00
5.00	00500 ADMINI STRATI VE & GENERAL	39, 650		17, 333, 052	-37, 849, 974		5.00
6.00 7.00	00600 MAI NTENANCE & REPAI RS 00700 OPERATI ON OF PLANT	C 76, 494		2, 568, 965		0 13, 750, 433	6.00 7.00
8.00	00800 LAUNDRY & LINEN SERVICE	1, 383					8.00
9.00	00900 HOUSEKEEPI NG	18, 054					9.00
10.00		3,904		462, 257		.,	
11.00 13.00		9, 795		1, 159, 685 2, 274, 101	0	2, 077, 726 3, 625, 063	11. 00 13. 00
14.00		16, 750			0	1, 676, 898	
15.00		6, 037					15.00
16.00		678		14, 804		.,	
17.00 18.00		0	0		0	-	17.00 18.00
19.00			0		0	0	19.00
20.00		C	0	C	0	0	20. 00
21.00		C	0	C	0	0	21.00
22.00 23.00		0	0			-	22.00 23.00
23.00	INPATIENT ROUTINE SERVICE COST CENTERS		<u>ı</u> 0		y 0	0	23.00
30.00		70, 183	191, 014	13, 190, 292	0	21, 603, 619	30.00
31.00		13, 428		2, 192, 942			31.00
32.00		C	0	0	0	-	32.00
33.00 34.00						0	33.00 34.00
40.00		14, 290	27, 210	1, 198, 808	0	2, 357, 474	40.00
41.00	04100 SUBPROVIDER - IRF	C	0	C	0	0	41.00
43.00		7, 412	1	719, 944		1, 640, 542	43.00
44.00 45.00			-		0	0	44.00 45.00
46.00		0	-	C	-		46.00
	ANCI LLARY SERVI CE COST CENTERS				1		
50.00 51.00		53, 944		5, 475, 193	0	11, 794, 872 0	50.00 51.00
52.00		5, 563	-	c c	0	256, 397	52.00
53.00		175		34, 392	0	112, 118	53.00
54.00		19, 891				6, 529, 148	
54.01 55.00		2,865					54.01 55.00
55.00		10, 686					55.00
56.00	05600 RADI OI SOTOPE	C		C	0	0	56.00
57.00		C	0	C	0	-	57.00
58.00 59.00		5, 326	342, 942	920, 496			
60.00		8, 336			0		60.00
60. 01	06001 FS ED LAB	1, 300		C	0	1, 560, 817	60. 01
61.00					0		61.00
62.00 63.00		C 394				0 18, 159	62.00 63.00
64.00		0,11		C	0	0	64.00
65.00	06500 RESPI RATORY THERAPY	2,006	57, 409	996, 561	0	1, 359, 153	65.00
66.00		1, 490			0	3, 035, 586	66.00
67.00 68.00		0	0			0	67.00 68.00
69.00		8, 941	155, 389	897, 309	0	1, 997, 233	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	C	0	C	0		70.00
71.00		C	0	C	0	5, 518, 015	
72.00 73.00			0		0	11, 510, 510 19, 087, 457	72.00 73.00
74.00			0		0	19,087,457	
75.00	07500 ASC (NON-DISTINCT PART)	C	0	C	0	0	75.00
76.00		C	0	C	-		76.00
77.00	07700 ALLOGENEI C STEM CELL ACQUI SI TI ON OUTPATI ENT SERVI CE COST CENTERS	C	0	C	0	0	77.00
88.00		C	0	C	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	C					89.00

In Lieu of Form CMS-2552-10 Worksheet B-1

Date/Time Prepared: 7/28/2021 7:41 pm

Period: From 01/01/2020 To 12/31/2020

	RANCISCAN HEALI				eu of Form CMS-	
COST ALLOCATION - STATISTICAL BASIS		Provider C		Period:	Worksheet B-1	
				rom 01/01/2020		
			1	o 12/31/2020		
	0401 TAL 05				7/28/2021 7:4	i pm
	CAPITAL REI	LATED COSTS				
Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Reconciliation	ADMI NI STRATI VE	
	(SOUARE FEET)	(DOLLAR VALUE)	BENEFITS		& GENERAL	
	(()	DEPARTMENT		(ACCUM. COST)	
					(ACCON. COST)	
			(GROSS		1	
			SALARI ES)			
	1.00	2.00	4.00	5A	5.00	
90. 00 09000 CLINIC	0	0	C	0	0	90.00
90. 03 09003 I NEUSI ON OP SERVI CES	3, 213	7, 135	361, 893	0	1, 000, 240	90.03
	18, 839				.,	
91.01 09101 FREE STANDING EMERGENCY DEPT	21, 381	221, 916	1, 333, 068	8 0	3, 283, 490	91.01
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)					1	92.00
OTHER REIMBURSABLE COST CENTERS						1
94. 00 09400 HOME PROGRAM DI ALYSI S	0	0	c c	0	0	94.00
	-	-		-	-	
95. 00 09500 AMBULANCE SERVICES	0	-		-	-	
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	C C	0 0	0	96.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	C	0	0	97.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0			0	
99. 00 09900 CMHC				-	0	
	0	0	-	-	-	•
99. 10 09910 CORF	0	0	-	-	0	
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	C	0	0	100.00
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
	0	0	C	0	0	105 00
105. 00 10500 KI DNEY ACQUI SI TI ON	-	-		-	-	105.00
106.00 10600 HEART ACQUI SI TI ON	0	0	C C	0 0		106.00
107.00 10700 LIVER ACQUISITION	0	0	C	0	0	107.00
108.00 10800 LUNG ACQUISITION	0	0		0	0	108.00
109. 00 10900 PANCREAS ACQUI SI TI ON	0			-		109.00
	0	0	-	-		
110.00 11000 I NTESTI NAL ACQUI SI TI ON	0	0	C	0		110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0	C	0 0	0	111.00
113.00 11300 INTEREST EXPENSE					1	113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF					Í	114.00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	c c	0	1 0	115.00
	-	-				
116. 00 11600 HOSPI CE	0		C	-		116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	450, 036	6, 119, 321	65, 095, 652	-37, 849, 974	155, 074, 289	118.00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	985	0	C) 0	27 789	190.00
191. 00 19100 RESEARCH	0	0				191.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	C	0		192.00
193.00 19300 NONPALD WORKERS	0	0	C	0	0	193.00
193. 01 19301 NONPALD WORKERS	0	0	c c	0	0	193.01
194. 00 07950 BEACON JOINT VENTURE	1 0	0				194.00
	0	-		-		
194. 01 07951 WORKING WELL	-				_, ,	
194.0307953 MED WATCHER	30, 047		C	0 0	1, 387, 526	
194.1007960 DUNELAND FITNESS CTR	4, 543	0	C	0	209, 385	194.10
194.1107961 OMNI HEALTH & FITNESS CHESTERTOWN	0		0	0	0	194.11
194. 16 07966 PHYSI CI AN PRACTI CE MD WI SW	0			-		194.16
194.1907969 HEALTH PARTNERS	0					194.19
194.2007970 CENTER OF HOPE	0	526	54, 922	0	69, 638	194.20
200.00 Cross Foot Adjustments					1	200.00
201.00 Negative Cost Centers					1	201.00
	22 201 (22	0 157 117	2 520 025		27 040 074	
202.00 Cost to be allocated (per Wkst. B,	22, 381, 623	9, 157, 117	3, 539, 835		37, 849, 974	202.00
Part I)					1	
203.00 Unit cost multiplier (Wkst. B, Part I)	46. 089613	1.454703	0. 053438	3	0. 238214	203.00
204.00 Cost to be allocated (per Wkst. B,			110, 395		2, 701, 079	
Part II)						
			0.001//-		0.047000	005 00
205.00 Unit cost multiplier (Wkst. B, Part			0. 001667		0. 017000	205.00
					1	
206.00 NAHE adjustment amount to be allocated					1	206.00
(per Wkst. B-2)					1	
207.00 NAHE unit cost multiplier (Wkst. D,					1	207.00
Parts III and IV)					1	
Faits III and IV)	I	I	1	1	l	I

COST A	Financial Systems Financial Systems Financial Systems Financial Systems Financial BASIS	KANCI SCAN HEALT	Provider C	CN: 15-0015 P	rom 01/01/2020	u of Form CMS-2 Worksheet B-1	
					o 12/31/2020	Date/Time Pre 7/28/2021 7:4	
	Cost Center Description	MAI NTENANCE & REPAI RS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPI NG (SQUARE FEET)	DI ETARY	
		6.00	7.00	8.00	9.00	10.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1.00
$\begin{array}{c} 2.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 10.\ 00\\ 11.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ \end{array}$	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 DI ETARY 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 SCHOOL	443, 745 76, 494 1, 383 18, 054 3, 904 9, 795 2, 147 16, 750 6, 037 678 0 0 0	367, 251 1, 383 18, 054 3, 904 9, 795 2, 147 16, 750 6, 037	0 282 0 0 0 0 0 0 0 0	347, 814 3, 904 9, 795 2, 147 16, 750 6, 037 678	116, 970 0 0 0 0 0 0 0 0 0 0	2.00 4.00 5.00 6.00 7.00 8.00 10.00 11.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00
20.00 21.00	02000 NURSING SCHOOL 02100 I &R SERVICES-SALARY & FRINGES APPRVD	0			0	0	20.00
22.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	0	0	c c	0	0	22.00
23.00	02300 PARAMED ED PRGM-(SPECIFY) I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	0	C	0	0	23.00
30.00	03000 ADULTS & PEDI ATRI CS	70, 183	70, 183	331, 106	70, 183	88, 245	30.00
31.00 32.00	03100 I NTENSI VE CARE UNI T 03200 CORONARY CARE UNI T	13, 428	13, 428	35, 224	13, 428	15, 181 0	31.00 32.00
32.00	03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34.00	03400 SURGI CAL I NTENSI VE CARE UNI T	0	0	C	0	0	34.00
40.00 41.00	04000 SUBPROVI DER – I PF 04100 SUBPROVI DER – I RF	14, 290	14, 290	105, 672	14, 290 0	13, 544 0	40.00
43.00	04300 NURSERY	7, 412	7, 412	211	7, 412	0	43.00
44.00 45.00	04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY	0	0		0	0	44.00 45.00
46.00	04600 OTHER LONG TERM CARE	0	0	, s	0	0	
50.00	ANCI LLARY SERVI CE COST CENTERS	53,944	53, 944	37, 337	53, 944	0	50.00
51.00	05100 RECOVERY ROOM	0	0	C	0	0	51.00
52.00 53.00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	5, 563	5, 563 175		5, 563 5, 563	0	52.00 53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	19, 891	19, 891	28, 320	19, 891	0	54.00
54.01	05401 FSED RADI OLOGY - DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	2, 865 3, 265			=1 = = =	0	
55.00 55.01	05501 WOODLAND CANCER CARE CTR	10, 686				0	
56.00		0	0	C	0	0	56.00
57.00 58.00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	0				0	57.00 58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	5, 326	5, 326	211	5, 326		59.00
60. 00 60. 01	06000 LABORATORY 06001 FS ED LAB	8, 336 1, 300			8, 336 1, 300		60.00 60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	1, 300	1, 300		1, 300	0	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	-	C	0	0	62.00
63.00 64.00	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY	394	394 0		394 0	0	63.00 64.00
65.00	06500 RESPI RATORY THERAPY	2,006			2, 006	0	65.00
66.00 67.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	1,490	1, 490	21, 134	1, 490	0	66.00 67.00
68.00	06800 SPEECH PATHOLOGY	0	0	c c	0	0	68.00
	06900 ELECTROCARDI OLOGY	8, 941	8, 941	3, 522	8, 941	0	69.00
70.00 71.00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS					0	70.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	c c	0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0	0		0	0	73.00 74.00
	07500 ASC (NON-DI STINCT PART)	0	0		0	0	75.00
76.00	03020 CV RESOURCE CTR	0	0	C C	0	0	
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION OUTPATIENT SERVICE COST CENTERS	0	0	C	0	0	77.00
	08800 RURAL HEALTH CLINIC	0	0	C	0	0	
89.00 90.00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC	0	0		0	0	89.00 90.00
90.00 90.03	09003 I NFUSI ON OP SERVI CES	3, 213	3, 213	211	3, 213	0	90.00
	09100 EMERGENCY	18, 839	18, 839	70, 448	18, 839	0	91.00

ST ALLOCATION ·	- STATISTICAL BASIS		Provider C		eriod:	Worksheet B-1	
					rom 01/01/2020 o 12/31/2020	Date/Time Pre	par
						7/28/2021 7:4	
Cost	Center Description	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG		
		REPAI RS (SQUARE FEET)	PLANT (SQUARE FEET)	LINEN SERVICE (POUNDS OF	(SQUARE FEET)	(MEALS SERVED)	
		(SQUARE ILLI)	(SQUARE ILLI)	LAUNDRY)			
		6.00	7.00	8.00	9.00	10.00	1
. 01 09101 FREE	STANDING EMERGENCY DEPT	21, 381	21, 381	28, 179	21, 381	0) 9
	RVATION BEDS (NON-DISTINCT PART)						9
	BURSABLE COST CENTERS	1			1		
	PROGRAM DI ALYSI S	0	0	0	0	0	
	LANCE SERVICES	0	0	0	0	0	
	BLE MEDICAL EQUIP-RENTED	0	0	0	0	0	
	BLE MEDICAL EQUIP-SOLD	0			0	0	
00 09900 CMHC	R REIMBURSABLE COST CENTERS	0	0		0	0	
10 09910 CORF					0	0	
	SERVICES-NOT APPRVD PRGM	0		0	0	-	10
	HEALTH AGENCY	0	Ö	0 0	0		10
	RPOSE COST CENTERS		1			1	1
5. 00 10500 KI DN	EY ACQUISITION	0	0	0	0	0	10
5. 00 10600 HEAR	F ACQUISITION	0	0	0	0	0	10
7. 00 10700 LI VE		0	0	0	0		10
3. 00 10800 LUNG		0	0	0	0		10
	REAS ACQUISITION	0	0	0	0	-	10
	STINAL ACQUISITION	0	0	0	0		11
I. 00 11100 SLE		0	0	0	0	0	11
3. 00 11300 NTE							11
	ZATION REVIEW-SNF _ATORY SURGICAL CENTER (D.P.)	0		0	0	0	
6.0011600 HOSP			0		0	-	011
	DTALS (SUM OF LINES 1 through 117)	408, 170	331, 676	669, 254	312, 239		
	SABLE COST CENTERS	100,170	001,070	007,201	012,207	110, 770	1
	FLOWER, COFFEE SHOP & CANTEEN	985	985	0	985	0	19
. 00 19100 RESE	ARCH	0	0	0	0	0	19
2. 00 19200 PHYS	CLANS' PRIVATE OFFICES	0	0	0	0	0) 19
3. 00 19300 NONP		0	0	0	0) 19
3. 01 19301 NONP		0	0	0	0		19
	ON JOINT VENTURE	0	0	0	0		19
4. 01 07951 WORK		0	0 047	0	0		19
4. 03 07953 MED		30, 047		35, 224			19
	_AND FITNESS CTR HEALTH & FITNESS CHESTERTOWN	4, 543	4, 543		4, 543) 19) 19
	CIAN PRACTICE MD WISW				0		19
1. 19 07969 HEAL		0		0	0		19
1. 20 07970 CENT		0	0	0	0		19
	s Foot Adjustments		ĺ				20
	tive Cost Centers						20
	to be allocated (per Wkst. B,	0	17, 025, 979	802, 595	5, 168, 483	1, 580, 372	20
Part							
	cost multiplier (Wkst. B, Part I)	0. 000000					
	to be allocated (per Wkst. B,	0	4, 716, 445	92, 661	1, 179, 907	314, 653	20
5.00 Part Unit	II) cost multiplier (Wkst. B, Part	0. 000000	12. 842565	0. 131531	3. 392351	2. 690032	20
11)		0.00000	2. 072303	0.101001	0.072001	2.070032	
	adjustment amount to be allocated Wkst. B-2)						20
	unit cost multiplier (Wkst. D,						20
Part	s III and IV)						1

	Financial Systems FR	ANCISCAN HEALT	H MICHIGAN CITY Provider CO		In Lie Period:	u of Form CMS-: Worksheet B-1	
C031 P	LLUCATION - STATISTICAL DASIS		FIOVIDEI CC		From 01/01/2020 To 12/31/2020	Date/Time Pre 7/28/2021 7:4	pared:
	Cost Center Description	CAFETERI A (FTE' S)	NURSI NG ADMI NI STRATI ON (DI RECT NURS.	CENTRAL SERVI CES & SUPPLY (COSTED	PHARMACY (COSTED REQUIS.)	MEDI CAL RECORDS & LI BRARY (GROSS	
		11.00	HRS.) 13. 00	REQUIS.) 14.00	15.00	<u>CHARGES</u>) 16.00	
	GENERAL SERVICE COST CENTERS	1	10.00				
20.00	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 DI ETARY 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 SCHOOL 02100 I & SERVICES-SALARY & FRINGES APPRVD 02200 I & SERVICES-OTHER PRGM COSTS APPRVD 02300 PARAMED ED PRGM-(SPECIFY) INPATIENT ROUTINE SERVICE COST CENTERS	61, 973 2, 680 418 2, 691 C C C C C C C C C C C C C C C C C C C	26, 824 0	15, 829, 07 112, 30		851, 661, 161 0 0 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 1. \ 00\\ 2. \ 00\\ 4. \ 00\\ 5. \ 00\\ 6. \ 00\\ 7. \ 00\\ 8. \ 00\\ 9. \ 00\\ 10. \ 00\\ 10. \ 00\\ 11. \ 00\\ 13. \ 00\\ 14. \ 00\\ 15. \ 00\\ 16. \ 00\\ 17. \ 00\\ 18. \ 00\\ 17. \ 00\\ 18. \ 00\\ 20. \ 00\\ 21. \ 00\\ 22. \ 00\\ 23. \ 00\\ \end{array}$
30.00	03000 ADULTS & PEDI ATRI CS	14, 339				61, 538, 972	•
31.00 32.00	03100 I NTENSI VE CARE UNI T 03200 CORONARY CARE UNI T	2, 975 C		219, 38	4 0 0 0	13, 117, 265 0	31.00 32.00
33.00 34.00	03300 BURN INTENSIVE CARE UNIT	C	0			0	33.00 34.00
40. 00	03400 SURGI CAL INTENSI VE CARE UNI T 04000 SUBPROVI DER - I PF	1, 897	885	4, 40	0	7, 730, 099	•
41.00 43.00	04100 SUBPROVI DER – I RF 04300 NURSERY	458	, i i i i i i i i i i i i i i i i i i i		0 0	0 1, 748, 468	41.00 43.00
43.00	04400 SKI LLED NURSI NG FACI LI TY	438			0 0	1, 748, 408	43.00
45.00	04500 NURSING FACILITY		-		0 0 0 0	0	45.00
46.00	04600 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS		<u>i</u> 0		0 0	0	46.00
50.00	05000 OPERATING ROOM	7,958				127, 263, 350	
51.00 52.00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	820	-		0 0 0 0	0 3, 135, 225	
53.00	05300 ANESTHESI OLOGY	94	. 0		0 0	7, 964, 181	53.00
54.00 54.01	05400 RADI OLOGY-DI AGNOSTI C 05401 FSED RADI OLOGY - DI AGNOSTI C	4, 775 1, 547		419, 23 53, 50		104, 854, 845 21, 850, 178	
	05500 RADI OLOGY - THERAPEUTI C	726				15, 816, 256	
		435				4, 631, 648	•
	05600 RADI 0I SOTOPE 05700 CT SCAN		0		0 0 0 0	0	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	C	0		0 0	0	
	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	1,053	509 0	1, 232, 71 412, 19		29, 303, 802 83, 317, 092	•
60.01	06001 FS ED LAB	C	0	20		11, 786, 107	60. 01
61.00 62.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0		0 0	0	61.00 62.00
	06300 BLOOD STORING, PROCESSING & TRANS.	C C	0		0 0	1, 367, 218	•
		1 503	0	101 00	0 0	17 525 720	
	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	1, 503		121, 23 35, 07		17, 525, 728 17, 400, 286	•
67.00	06700 OCCUPATI ONAL THERAPY	C	0		0 0	0	67.00
		1, 263	0 458	24, 19	0 0	0 27, 206, 021	68.00 69.00
	07000 ELECTROENCEPHALOGRAPHY	C	0	27,17	0 0	0	
	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	C	0		0 0	29, 429, 594	•
	07200 I MPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS		0		0 0 0 100	27, 549, 477 137, 062, 698	•
74.00	07400 RENAL DI ALYSI S	C	0		0 0	0	74.00
75.00 76.00	07500 ASC (NON-DISTINCT PART) 03020 CV RESOURCE CTR					0	75.00 76.00
	07700 ALLOGENEIC STEM CELL ACQUISITION	C	0		0 0	0	
00 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC		0		0 0	0	00 00
	08800 FEDERALLY QUALIFIED HEALTH CENTER		0		0 0	0	
	09000 CLINIC	0	0	10.00	0 0	0	
90.03	09003 I NFUSI ON OP SERVI CES	495	418	18, 00	9 0	4, 053, 800	1 40. 03

	anci al Systems FR. ATLON - STATI STI CAL BASI S		Provider CC		Period: From 01/01/2020	Worksheet B-1	
					To 12/31/2020	Date/Time Pre 7/28/2021 7:4	
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		(FTE'S)	ADMI NI STRATI ON	SERVICES & SUPPLY	(COSTED REQUIS.)	RECORDS & LI BRARY	
			(DIRECT NURS.	(COSTED	RE2013.)	(GROSS	
			HRS.)	REQUIS.)		CHARGES)	
		11.00	13.00	14.00	15.00	16.00	0.1.00
	0 EMERGENCY 1 FREE STANDING EMERGENCY DEPT	4, 975 1, 560		307, 42 44, 24		78, 653, 715 17, 355, 136	
	0 OBSERVATION BEDS (NON-DISTINCT PART)	1, 300	1,400	44, 24	0 0	17, 555, 150	91.01
	R REIMBURSABLE COST CENTERS		11				1 /2/ 00
	O HOME PROGRAM DI ALYSI S	C	0 0		0 0	0	94.00
	O AMBULANCE SERVI CES	C	0 0		0 0	0	
	O DURABLE MEDICAL EQUIP-RENTED	C	0		0 0	0	
	O DURABLE MEDICAL EQUIP-SOLD		0		0 0	0	
	0 OTHER REIMBURSABLE COST CENTERS 0 CMHC				0 0	0	
99.10 0991					0 0	0	
	0 I &R SERVICES-NOT APPRVD PRGM	C	o o		0 0	-	100.00
101.00 1010	O HOME HEALTH AGENCY	C	0		0 0	0	101.00
	I AL PURPOSE COST CENTERS		-		1		
	O KIDNEY ACQUISITION	C	-		0 0		105.00
	O HEART ACQUISITION	C	0		0 0		106.00
	O LIVER ACQUISITION O LUNG ACQUISITION				0 0		107.00
	0 PANCREAS ACQUISITION				0 0		109.00
	0 INTESTINAL ACQUISITION	C	o o		0 0		110.00
111.0011110	O I SLET ACQUI SI TI ON	C	0 0		0 0	0	111.00
	O INTEREST EXPENSE						113.00
	OUTILIZATION REVIEW-SNF					0	114.00
115.001150 116.00 1160	O AMBULATORY SURGICAL CENTER (D. P.)						115.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	53, 739	, i	15, 803, 90	7 100	851, 661, 161	
	EI MBURSABLE COST CENTERS		20,001	10,000,70	, 100	001,001,101	
	O GIFT, FLOWER, COFFEE SHOP & CANTEEN	C	0 0		0 0	0	190. 00
191. 00 1910		C	0 0		0 0		191.00
	O PHYSI CI ANS' PRI VATE OFFI CES	C	0		0 0		192.00
	0 NONPALD WORKERS 11 NONPALD WORKERS				0 0		193.00 193.01
	O BEACON JOINT VENTURE						193.01
	1 WORKING WELL	8, 187	1, 451	25, 17	1 0		194.00
	3 MED WATCHER	C	0 0		0 0		194.03
	O DUNELAND FITNESS CTR	C	0 0		0 0		194.10
	1 OMNI HEALTH & FITNESS CHESTERTOWN	C	0 0		0 0		194.11
	6 PHYSICIAN PRACTICE MD WISW	C	0		0 0		194.16
	9 HEALTH PARTNERS 0 CENTER OF HOPE	47					194.19 194.20
200.00	Cross Foot Adjustments	47	7		0	0	200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	3, 172, 324	4, 757, 230	3, 123, 19	9 6, 343, 612	1, 725, 336	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	51. 188808	177. 349761	0. 19730	8 63, 436. 120000	0. 002026	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	647, 723		1, 286, 47		65, 399	
205.00	Unit cost multiplier (Wkst. B, Part	10. 451697	13. 031129	0. 08127	3 5, 069. 700000	0. 000077	205. 00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

SIA	Financial Systems F LLOCATION - STATISTICAL BASIS		H MICHIGAN CIT	CN: 15-0015 F	Period: From 01/01/2020	Worksheet B-1	
				٦	Го 12/31/2020	Date/Time Pre 7/28/2021 7:4	
			OTHER GENERAL			INTERNS &	
	Cost Center Description		SERVI CE			RESIDENTS	<u> </u>
	cost center bescription	SOCIAL SERVICE	E I NSERVI CE EDUCATI ON	ANESTHETI STS	NURSING SCHOOL	Y & FRINGES	
		(TIME SPENT)	(TIME SPENT)	(ASSI GNED	(ASSI GNED	(ASSI GNED	
				TIME)	TIME)	TIME)	
	GENERAL SERVICE COST CENTERS	17.00	18.00	19.00	20.00	21.00	-
00	00100 CAP REL COSTS-BLDG & FIXT						1 1
00	00200 CAP REL COSTS-MVBLE EQUIP						2
00	00400 EMPLOYEE BENEFITS DEPARTMENT						4
00	00500 ADMINISTRATIVE & GENERAL						5
00	00600 MAINTENANCE & REPAIRS						6
00	00700 OPERATION OF PLANT						7
00 00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING						8
. 00	01000 DI ETARY						9
. 00	01100 CAFETERI A						11
. 00	01300 NURSING ADMINISTRATION						13
. 00	01400 CENTRAL SERVICES & SUPPLY						14
	01500 PHARMACY						15
. 00	01600 MEDICAL RECORDS & LIBRARY						16
	01700 SOCIAL SERVICE 01080 INSERVICE EDUCATION						17
	01900 NONPHYSI CI AN ANESTHETI STS						19
	02000 NURSI NG SCHOOL	(0		20
	02100 I &R SERVICES-SALARY & FRINGES APPRVD	(_	0	
. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	() C				22
. 00	02300 PARAMED ED PRGM-(SPECIFY)	() C				23
00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS					0	1 20
. 00 . 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	(0	
	03200 CORONARY CARE UNIT	(0	
	03300 BURN INTENSIVE CARE UNIT				-	0	
	03400 SURGICAL INTENSIVE CARE UNIT	(c c	(o o	0	34
. 00	04000 SUBPROVI DER – I PF	(C	(0 0	0	
	04100 SUBPROVIDER - IRF	(C	(-	0	
. 00 . 00	04300 NURSERY				°	0	
. 00	04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY				-	0	
. 00	04600 OTHER LONG TERM CARE	(-	0	
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATI NG ROOM	(0	
	05100 RECOVERY ROOM	(0	
. 00 . 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY				-	0	
	05400 RADI OLOGY-DI AGNOSTI C					0	
. 01	05401 FSED RADIOLOGY - DIAGNOSTIC				0 0	0	
. 00	05500 RADI OLOGY-THERAPEUTI C	0) C	(0 0	0	55
	05501 WOODLAND CANCER CARE CTR	() C	(0 0	0	
	05600 RADI OI SOTOPE	() C	(0	0	
	05700 CT SCAN					0	
. 00	05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION					0	
. 00	06000 LABORATORY				0 0	0	
. 01	06001 FS ED LAB	0	C	0	0 0	0	60
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	(C	(0 0	0	
	06300 BLOOD STORING, PROCESSING & TRANS.	(0	0	
	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY					0	
	06600 PHYSI CAL THERAPY					0	
	06700 OCCUPATI ONAL THERAPY					0	
	06800 SPEECH PATHOLOGY	0		0	0 0	0	
	06900 ELECTROCARDI OLOGY	0) C	0	0 0	0	69
	07000 ELECTROENCEPHALOGRAPHY	0) C	0	0	0	
	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS				0	0	
	07200 IMPL. DEV. CHARGED TO PATIENTS					0	
	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS					0	
	07500 ASC (NON-DI STI NCT PART)	(0	
. 00	03020 CV RESOURCE CTR					0	
	07700 ALLOGENEIC STEM CELL ACQUISITION	() C	(0 0	0	
<i>c</i> .	OUTPATIENT SERVICE COST CENTERS						
. 00	08800 RURAL HEALTH CLINIC				-	0	
. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER						

,	ANCI SCAN TILALTI					
COST ALLOCATION - STATISTICAL BASIS		Provider C		Period:	Worksheet B-1	
				rom 01/01/2020		
			T	o 12/31/2020		
					7/28/2021 7:4	<u>1 pm</u>
		OTHER GENERAL			INTERNS &	
		SERVI CE			RESI DENTS	
Cost Center Description	SOCIAL SERVICE		NONPHYSI CI AN	NURSING SCHOOL		
COST CONTON DESCRIPTION	SOUTHE SERVICE			NORSTING SCHOOL		
		EDUCATI ON	ANESTHETI STS	(10010155	Y & FRINGES	
	(TIME SPENT)	(TIME SPENT)	(ASSI GNED	(ASSI GNED	(ASSI GNED	
			TIME)	TIME)	TIME)	
	17.00	18.00	19.00	20.00	21.00	
90.03 09003 INFUSION OP SERVICES	0	0	C	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	1
	0	0		0	0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DIALYSIS	0	0	C	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		0	0	1
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0 0	[C	0	0	97.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	C	0	0	98.00
99. 00 09900 CMHC	0	0		0	0	99.00
	0					
99. 10 09910 CORF	0	/ U		0	0	
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0 0	0	0 0	0	100.00
101.0010100 HOME HEALTH AGENCY	0	0	C	0 0	0	101.00
SPECIAL PURPOSE COST CENTERS	·		•		•	
105. 00 10500 KI DNEY ACQUI SI TI ON	0	0	C	0	0	105.00
106. 00 10600 HEART ACQUI SI TI ON	0					106.00
	0	0		0		
107.00 10700 LIVER ACQUISITION	0	0 0	0	0	0	107.00
108.00 10800 LUNG ACQUI SI TI ON	0	0	C	0	0	108.00
109.00 10900 PANCREAS ACQUISITION	0	0		0	0	109.00
	0					110.00
110.00 11000 INTESTINAL ACQUISITION	0	0		0		1
111.00 11100 I SLET ACQUI SI TI ON	0	0	0	0	0	111.00
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTILIZATION REVIEW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0					115.00
	0	0		0	0	1
116. 00 11600 HOSPI CE	0	0		0		116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	0	C	0 0	0	118.00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	C	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		192.00
	0	0		0		
193.00 19300 NONPALD WORKERS	0	0		0		193.00
193. 01 19301 NONPALD WORKERS	0	0	0	0	0	193.01
194.0007950 BEACON JOINT VENTURE	0	0	0	0	0	194.00
194. 01 07951 WORKI NG WELL	0			0		194.01
	0	0		0		
194. 03 07953 MED WATCHER	0	ין 0	C	0		194.03
194.1007960 DUNELAND FITNESS CTR	0	0	0	0 0	0	194.10
194.1107961 OMNI HEALTH & FITNESS CHESTERTOWN	0	0	0	0	0	194.11
194. 16 07966 PHYSI CLAN PRACTICE MD WI SW	0	- -				194.16
194. 19 07969 HEALTH PARTNERS	0	ין 0	C	0		194.19
194.20 07970 CENTER OF HOPE	0	0 0	0	0 0	0	194.20
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	1					201.00
5	_					201.00
202.00 Cost to be allocated (per Wkst. B,	0	0 0	C	0 0	0	202.00
Part I)						
203.00 Unit cost multiplier (Wkst. B, Part I)	0. 000000	0. 000000	0.000000	0. 000000	0.000000	203.00
204.00 Cost to be allocated (per Wkst. B,	0	0	l c	0	0	204.00
Part II)				- -		
205.00 Unit cost multiplier (Wkst. B, Part	0. 000000	0. 000000	0. 000000	0. 000000	0.000000	205 00
	0.00000	0.00000		0.00000	0.00000	200.00
				-		001 00
206.00 NAHE adjustment amount to be allocated				0		206.00
(per Wkst. B-2)						
207.00 NAHE unit cost multiplier (Wkst. D,				0.000000		207.00
Parts III and IV)						
		•				•

	LLOCATION - STATISTICAL BASIS		MICHIGAN CITY Provider CC		Period: From 01/01/2020	
					To 12/31/2020	Date/Time Prepared: 7/28/2021 7:41 pm
	Cost Center Description	I NTERNS & RESI DENTS SERVI CES-OTHER PRGM COSTS (ASSI GNED TIME) 22.00	PARAMED ED PRGM (ASSI GNED TI ME) 23.00			
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT					1.00
$\begin{array}{c} 2.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ \end{array}$	00200 CAP REL COSTS-MVBLE EQUI P 00400 EMPLOYEE BENEFI TS DEPARTMENT 00500 ADMI NI STRATI VE & GENERAL 00600 MAI NTENANCE & REPAI RS 00700 OPERATI ON OF PLANT 00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG 01000 DI ETARY 01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE					2.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 13.00 14.00 15.00 16.00 17.00
19.00 20.00 21.00 22.00	01080 I NSERVI CE EDUCATI ON 01900 NONPHYSI CI AN ANESTHETI STS 02000 NURSI NG SCHOOL 02100 I &R SERVI CES-SALARY & FRI NGES APPRVD 02200 I &R SERVI CES-OTHER PRGM COSTS APPRVD 02300 PARAMED ED PRGM-(SPECI FY) I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	0			18. 00 19. 00 20. 00 21. 00 22. 00 23. 00
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			30.00 31.00 32.00 33.00
	03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT	0	0			34.00
	04000 SUBPROVIDER - IPF	0	0			40.00
	04100 SUBPROVIDER - IRF	0	0			41.00
	04300 NURSERY 04400 SKILLED NURSING FACILITY	0	0			43. 00 44. 00
	04500 NURSING FACILITY	0	0			45.00
	04600 OTHER LONG TERM CARE	0	0			46.00
50.00	ANCI LLARY SERVICE COST CENTERS		0			
	05000 OPERATING ROOM 05100 RECOVERY ROOM	0	0			50. 00 51. 00
	05200 DELIVERY ROOM & LABOR ROOM	0	0			52.00
	05300 ANESTHESI OLOGY	0	0			53.00
	05400 RADI OLOGY-DI AGNOSTI C	0	0			54.00
	05401 FSED RADI OLOGY - DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	0	0			54. 01 55. 00
	05501 WOODLAND CANCER CARE CTR	0	0			55. 01
	05600 RADI OI SOTOPE	0	0			56.00
	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0			57.00 58.00
	05900 CARDI AC CATHETERI ZATI ON	0	0			59.00
	06000 LABORATORY	0	0			60.00
	06001 FS ED LAB	0	0			60.01
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0			61.00 62.00
	06300 BLOOD STORING, PROCESSING & TRANS.	0	0			63.00
	06400 I NTRAVENOUS THERAPY	0	0			64.00
	06500 RESPIRATORY THERAPY	0	0			65.00
	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0	0			66. 00 67. 00
	06800 SPEECH PATHOLOGY	0	0			68.00
	06900 ELECTROCARDI OLOGY	0	0			69. OC
	07000 ELECTROENCEPHALOGRAPHY	0	0			70.00 71.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0			71.00
	07300 DRUGS CHARGED TO PATIENTS	0	0			73.00
	07400 RENAL DI ALYSI S	0	0			74.00
	07500 ASC (NON-DI STI NCT PART)	0	0			75.00
16 00	03020 CV RESOURCE CTR 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON	0	0			76.00 77.00
	OUTPATIENT SERVICE COST CENTERS			1		//. 00
77. 00 88. 00		0	0	1		88. 00 89. 00

Health Financial Systems F	RANCI SCAN HEALTH	I MICHIGAN CITY		In Lie	u of Form C	CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider CCN	: 15-0015	Peri od:	Worksheet	B-1
				From 01/01/2020	D . (T)	
				To 12/31/2020	Date/Time 7/28/2021	
	INTERNS &				172872021	7:41 pm
	RESIDENTS					
Cost Center Description	SERVI CES-OTHER	PARAMED ED				
cost center bescription	PRGM COSTS	PRGM				
	(ASSI GNED	(ASSI GNED				
	TIME)	TI ME)				
	22.00	23.00				
90. 03 09003 INFUSION OP SERVICES	0	0				90.03
91. 00 09100 EMERGENCY	0	0				91.00
91. 01 09101 FREE STANDING EMERGENCY DEPT	0	0				91.01
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
94. 00 09400 HOME PROGRAM DI ALYSI S	0	0				94.00
95. 00 09500 AMBULANCE SERVICES	0	0				95.00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	o				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	0				100.00
101.00 10100 HOME HEALTH AGENCY	0	0				101.00
	0	U				101.00
SPECIAL PURPOSE COST CENTERS		a				105.00
105.00 10500 KI DNEY ACQUI SI TI ON	0	0				105.00
106.00 10600 HEART ACQUI SI TI ON	0	0				106.00
107.00 10700 LIVER ACQUISITION	0	0				107.00
108.00 10800 LUNG ACQUI SI TI ON	0	0				108.00
109.00 10900 PANCREAS ACQUI SI TI ON	0	0				109.00
110.00 11000 INTESTINAL ACQUISITION	0	0				110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0				111.00
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0				115.00
116. 00 11600 HOSPI CE		o				116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	0				118.00
NONREI MBURSABLE COST CENTERS	, <u> </u>	0				110.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0				190.00
191. 00 19100 RESEARCH	0	0				190.00
	0	0				
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0				192.00
193. 00 19300 NONPALD WORKERS	0	0				193.00
193.01 19301 NONPALD WORKERS	0	0				193.01
194.0007950 BEACON JOINT VENTURE	0	0				194.00
194.01 07951 WORKING WELL	0	0				194.01
194.0307953 MED WATCHER	0	0				194.03
194.1007960 DUNELAND FITNESS CTR	0	0				194.10
194.11 07961 OMNI HEALTH & FITNESS CHESTERTOWN	0	0				194.11
194.1607966 PHYSICIAN PRACTICE MD WISW	0	ol				194.16
194.1907969 HEALTH PARTNERS	0	o				194.19
194. 20 07970 CENTER OF HOPE	0	0				194.20
200.00 Cross Foot Adjustments		J.				200.00
201.00 Negative Cost Centers						201.00
5	0	0				
202.00 Cost to be allocated (per Wkst. B,	0	0				202.00
Part I)	0 000000	0 000000				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				204.00
Part II)						0.5
205.00 Unit cost multiplier (Wkst. B, Part	0. 000000	0. 000000				205.00
206.00 NAHE adjustment amount to be allocated	t	0				206.00
(per Wkst. B-2)						
207.00 NAHE unit cost multiplier (Wkst. D,		0. 000000				207.00
Parts III and IV)						

Heal th	Fi nar	ici a	I Syst	ems			
COMPLIE		OF	DATIO	OF	COSTS	ΤO	0

International and the second			RANCI SCAN HEALTI				u of Form CMS-	2552-10
To 1911 (2000) Dirac Trans Prepared in the part of the pa	COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-0015 F	rom 01/01/2020	Worksheet C Part I	
Tritin XVIII Inspiration Tritin XVIII Inspiration PS Cost Control Description Total Onst (Cros Mast. A, 20. Total Onst (Part I, col) Total Onst (P						0 12/31/2020	Date/Time Pre	pared:
Cost Center Description Total Costs (Fram Resc) Integra (Fram Resc) <thintegra (Fram Resc) Integra (Fram Resc</thintegra 				Title	× XVIII	Hospi tal		i piii
International and another international and another international and another international another internatinteric interinteric international another international another in								
Part I. J. col Part I. J. col Part I. J. col J. col <thj. col<="" th=""> J. col <thj. col<="" t<="" td=""><td></td><td>Cost Center Description</td><td></td><td>1.5</td><td>Total Costs</td><td></td><td>Total Costs</td><td></td></thj.></thj.>		Cost Center Description		1.5	Total Costs		Total Costs	
20/ 2.00 3.00 4.00 5.00 10 00 00000 AULUS & FUEN AUR OS 29, 318, bod 39, 327, 237, 320 00, 656, 700 00, 656, 700 00, 656, 700 00, 656, 700 00, 656, 700 00, 656, 700 00, 656, 700 00, 656, 700 00, 656, 700 00, 832, 66, 700 00, 832, 66, 700 00, 832, 66, 700 00, 832, 66, 700 00, 832, 66, 700 00, 832, 66, 700 00, 832, 66, 700 00, 832, 66, 700 00, 832, 66, 700 00, 832, 66, 700 00, 832, 66, 700 00, 832, 66, 700 00, 832, 66, 700 00, 832, 66, 700 00, 832, 723, 733, 82, 64, 737, 733, 720 00, 700, 710, 700, 771 00, 700, 711, 700, 771 00, 700, 771 00, 700, 771 00, 700, 771 00, 700, 771 00, 700, 771 00, 700, 771 00, 771, 700, 771 00, 700, 771 00, 700, 771 00, 771 00, 700, 771 00, 770, 771 00, 770, 771 00, 770, 771 00, 770, 771 00, 770, 771 00, 770, 771 00, 770, 771 00, 770, 771 00, 770, 771 00, 770, 771 00, 770, 771 00, 770, 771 00, 770, 771 00, 770, 771 <				Adj.		DI Sal Lowance		
IDENT LEAT NOUTH & SUMMECL COST CENTERS JS. 311, Se								
30. DD DOXODD ADULLIS # FIER ATHICS 95, 315, 586 95, 315, 586 95, 315, 586 95, 315, 586 95, 315, 586 95, 315, 586 95, 315, 586 95, 315, 586 95, 315, 586 95, 315, 586 95, 315, 586 95, 315, 586 95, 315, 586 95, 327, 527 33, 30 34, 317, 323 40 <th< td=""><td></td><td></td><td>1.00</td><td>2.00</td><td>3.00</td><td>4.00</td><td>5.00</td><td></td></th<>			1.00	2.00	3.00	4.00	5.00	
31.00 03100 103100 103100 103100 1000000000000000000000000000000000000	30 00		35 318 565	1	35 318 565	8 564	35 327 129	30.00
32. D0 DOCKNOMENT CASE: LINE TO CONTENT TO								
34.00 D3400 SURCICAL INTENSIVE CARE UNIT 0		03200 CORONARY CARE UNI T	0		c	0		
40. 00 (abdod SuberRov) DER - I FF 4, 307, 870 4, 307, 870 6, 37, 970 70, 35, 36, 37, 77, 381 5, 50, 67, 313 6, 50, 50, 50, 50, 50, 50, 50, 50, 50, 50			0			0		
11.00 0.01100 SUBPROVIDER - I RF 0 0 0 0 </td <td></td> <td></td> <td>4 367 870</td> <td></td> <td>4 367 870</td> <td>3 363</td> <td></td> <td></td>			4 367 870		4 367 870	3 363		
44. 00 04400 SKI LLED NURSING FACI LITY 0			0		C	0 0		1
45. 00 04500 04500 04500 04500 0								
46. 00 0.0400 0.0400 0.0 <t< td=""><td></td><td></td><td>-</td><td></td><td></td><td></td><td></td><td>•</td></t<>			-					•
NCILLARY SERVICE COST CENTERS 21, 721, 312						-		
51.00 DOI TOD DECOVERY ROOM LABOR ROOM TOD S1.00 DECOVERY ROOM LABOR ROOM <thlabor room<="" th=""> LABOR ROOM LABOR ROOM</thlabor>			-		-			
52. 00 65200 DE1/UREY ROM & LABR ROM 706. 371 706. 371 0 706. 371 52. C 53. 00 05200 DE1/UREY ROM & LABR ROM 702. 486 9. 922. 658 0 9. 222. 658 0 9. 222. 658 0 9. 222. 658 0 9. 222. 658 0 9. 222. 658 0 9. 222. 658 0 9. 222. 658 0 0 2. 673. 207 0 2. 673. 207 0 2. 673. 207 0 2. 673. 207 0 2. 673. 207 0								
53. 00 03300 AMESTHESS OLOCY 170. 486 170. 486 24. 424 172. 910 53. 52 54. 01 05401 FSED. RAN OLOCY - DI ALMOSTI C 5, 667. 836 5, 673. 207 0 5, 673. 207 0 5, 673. 207 0 2, 673. 207 0 2, 673. 207 0 2, 673. 207 0 2, 673. 207 0 2, 673. 207 0 2, 673. 207 0 2, 673. 207 0 2, 673. 207 0 2, 673. 207 0 2, 673. 207 0 2, 673. 207 0			-		-	-		
54. 00 64.00 65.00 65.00 9.922, 688 9.923, 693 9.922, 685 9.923, 693 9.922, 685 9.923, 693 9.922, 685 9.923, 693 9.923, 693 9.923, 693 9.923, 693 9.923, 693 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></t<>								
55. 00 05501 RADICIONCY-THERAPEUTIC 2, 673, 207 2, 673, 207 0 2, 673, 207 0 2, 673, 207 0 1, 880, 520 0 </td <td>54.00</td> <td>05400 RADI OLOGY-DI AGNOSTI C</td> <td></td> <td></td> <td>9, 922, 658</td> <td></td> <td>9, 922, 658</td> <td>54.00</td>	54.00	05400 RADI OLOGY-DI AGNOSTI C			9, 922, 658		9, 922, 658	54.00
55. 01 05501 WOODLAND CANCER CARE CTR 1,880,520 1,880,520 0 1,880,520 55. 00 0 0 0 55. 00 0 0 0 55. 00 0 0 0 55. 00 0 0 0 55. 00 0 0 0 55. 00 0 0 0 0 55. 00 0 0 0 0 0 55. 00 0								
56.00 05600 (RADIOISOTOPE 0								
58. 00 05800 MAGNETIC RESONANCE LIMIGING (MRT) 0 0 58. 00 0 0 0 58. 00 0 0 0 58. 00 0						-		
59.00 06900 CARDIAC CATHETERIZATION 3.342,964 3.342,964 1.082 3.344,046 59.0 60.00 06000 LABORTORY 11.187,373 12.072 11.197,9445 60.0 60.00 06000 PS CLINICAL LAB SERVICES-PREM ONLY 0 0 0 61.0 61.00 06100 PB CLINICAL LAB SERVICES-PREM ONLY 0 0 0 62.0 63.00 06300 WHOLE BLOOD A PACKED RED BLOOD CELLS 0 0 0 0 62.0 65.00 06500 CERSIP RATERY THERAPY 1.942.095 0 1.942.095 0 1.942.095 0 <t< td=""><td></td><td></td><td>0</td><td></td><td> c</td><td>0</td><td></td><td></td></t<>			0		c	0		
60.00 06000 LABORATORY 11.197.373 11.197.373 12.072 11.199.445 60.0 60.01 06017 FS ED LAB SERVICES-PRGM ONLY 0			0		0	0		
60.01 06001 FS ED LAB 2,036,131 0 2,036,131 0								
62.00 06200 WHOLE BLODD & PACKED RED BLODD CELLS 0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>								
63.00 D63200 BLOOD STORING, PROCESSING & TRANS. 49.376 49.376 0 0 0 0 64.00 64.00 64.00 64.00 64.00 64.00 64.00 64.00 64.00 64.00 66.00 0 0 0 0 64.00 66.00 66.00 0 0 0 0 64.00 66.00 66.00 0 0 0 0 0 0 64.00 66.00 67.00 77.00 77.00 77.00 77.00 77.00 77.00 77.00 77.00 77.00 77.00			0		C	0		
64.00 Dodd00 INTRAVENUES THERAPY 0 0 0 64.00 65.00 D6500 DESPIR ATORY THERAPY 1, 942, 095 0 1, 942, 095 0 1, 942, 095 0 1, 942, 095 0 1, 942, 095 0 1, 942, 095 0 <td></td> <td></td> <td>0</td> <td></td> <td>C 40.274</td> <td>0</td> <td></td> <td></td>			0		C 40.274	0		
65.00 06500 PESPI RATORY 1,942,095 0 1,942,095 65.0 66.00 06000 PHYSIGAL HERAPY 3,971,304 0 3,971,304 67.00 68.00 06000 PHYSIGAL HERAPY 3,971,304 0 0 67.00 68.00 06800 PEECH PATHOLOGY 0 0 0 67.00 68.00 06800 PEECTROENCEPHALOGRAPHY 0			49, 376		49,376			
67. 00 0 <td></td> <td></td> <td>1, 942, 095</td> <td>o</td> <td></td> <td>0</td> <td></td> <td></td>			1, 942, 095	o		0		
68 00 0 b6800 SPECH PATHOLOGY 0 0 0 0 68 00 69 00 0 OGPO ELECTROACRID (LOGY 3, 230, 157 3, 230, 157 1, 110 3, 231, 267 69.0 71.00 0 TOOD ELECTROACRID (LAL, SUPPLIES CHARGED TO PATIENTS 6, 892, 107 6, 892, 107 0 6, 892, 107 0 6, 892, 107 0 6, 892, 107 71.00 73.00 70.00 73.00 70.00 14, 308, 290 14, 308, 290 14, 308, 290 14, 308, 290 14, 308, 290 14, 308, 290 14, 308, 290 14, 308, 290 16, 14, 308, 290 16, 14, 308, 290 16, 14, 308, 290 16, 14, 308, 290 16, 14, 308, 290 16, 14, 308, 290 16, 14, 308, 290 17, 00 17, 00 0 0 0 0 17, 00 0 0 0 0 16, 14, 308, 290 16, 14, 308, 290 17, 00 16, 00 0 0 0 0 0 0 0 0 0 16, 00 16, 00 0 16, 00 16, 00 16, 00 16, 00 16, 00 16, 00 0								
69:00 0x9000 ELECTROCARDI OLOGY 3, 230, 157 1, 110 3, 232, 27 60.0 70.0 70:00 07000 ELECTROCARDI OLOGY 3, 230, 157 0 0 0 70.0 0 0 0 0 70.0			0	0		, s		
70. 00 00000 ClCCTROENCEPHALOGRAPHY 0 <t< td=""><td></td><td></td><td>3, 230, 157</td><td></td><td>3, 230, 157</td><td>-</td><td></td><td></td></t<>			3, 230, 157		3, 230, 157	-		
72.00 IPL. DEV. CHARGED TO PATIENTS 14, 308, 290 14, 308, 290 72.00 73.00 07300 RUKS CHARGED TO PATIENTS 30, 255, 528 30, 255, 528 0 30, 255, 528 73.00 74.00 07400 RENAL DI ALYSI S 0 0 0 0 73.00 75.00 07500 ASC (NON-DI STINCT PART) 0 0 0 0 0 75.00 0 07700 ALLOGENEI C STEM CELL ACOUISITION 0 0 0 0 76.00 0 0700 RULAGENEI C STEM CELL ACOUISITION 0 0 0 0 0 77.00 0 0800 RURAL HEALTH CLINIC 0	70.00	07000 ELECTROENCEPHALOGRAPHY	0		c	0 0	0	70.00
73:00 DRUGS CHARGED TO PATIENTS 30, 255, 528 30, 255, 528 0 30, 255, 528 73.00 74:00 O7400 RENAL DI ALYSIS 0 0 0 74.00 76:00 O7500 ASC (NON-DI STI NCT PART) 0 0 0 0 0 0 75.00 76:00 O7500 ALSC (NON-DI STI NCT PART) 0								
74:00 OT400 RENAL DI ALYSI S 0 0 0 0 74:00 75:00 O7500 ASC (NON-DI STINCT PART) 0 0 0 0 76:00 0 0 0 0 0 0 0 76:00 0								
76.00 03020 CV RESOURCE CTR 0								
77.00 0700 ALLOGENEIC STEM CELL ACQUISITION 0 0 77.00 0UTPATIENT SERVICE COST CENTERS			-					
OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 0 0 88.00 90.00 09000 CLINIC 0								
88.00 08800 RURAL HEALTH CLINIC 0 0 0 0 88.00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0	//.00		0			0	0	//.00
90.00 09000 CLINIC 0			0		C	0	0	
90.03 09003 INFUSION OP SERVICES 1,546,689 1,546,689 991 1,547,680 90.0 91.00 09100 EMERGENCY 13,502,200 13,502,200 270 13,502,470 91.0 91.01 OP101 FREE STANDING EMERGENCY DEPT 5,779,823 5,779,823 0 5,779,823 92.0 92.00 OBSERVATION BEDS (NON-DISTINCT PART) 304,655 304,655 304,655 304,655 92.0 01HER REIMBURSABLE COST CENTERS 0 0 0 94.00 9400 HME PROGRAM DI ALYSIS 0 0 0 94.00 9400 9400 0 0 94.00 9400 9400 9400 94.00 9400 94.00 </td <td></td> <td></td> <td>-</td> <td></td> <td></td> <td></td> <td></td> <td></td>			-					
91.00 09100 EMERGENCY 13, 502, 200 13, 502, 200 270 13, 502, 470 91.0 91.01 09101 FREE STANDING EMERGENCY DEPT 5, 779, 823 0 5, 779, 823 0 5, 779, 823 91.0 92.00 0BSERVATION BEDS (NON-DI STINCT PART) 304, 655 305, 65 305, 65 305, 6			-		-	-		
92.00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 304,655 304,655 304,655 92.0 0THER REIMBURSABLE COST CENTERS 0 0 0 94.0 0 9400 HOME PROGRAM DI ALYSI S 0 0 0 94.0 0 0 0 94.0 0 94.0 0 0 94.0 0 0 94.0 0 0 0 94.0 0 0 0 94.0 0 0 0 94.0 0 0 0 94.0 94.0 0 0 0 94.0								
OTHER REI MBURSABLE COST CENTERS 94. 00 09400 HOME PROGRAM DI ALYSI S 0 0 0 0 94. 0 95. 00 09500 AMBULANCE SERVI CES 0 0 0 0 95. 0 96. 00 09600 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 0 97. 0 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 97. 0 09700 0 0 0 97. 0 0 0 0 97. 0 0 0 0 97. 0 0 0 0 97. 0 0 0 0 98. 0 0 0 0 0 98. 0 99. 0 99. 0 0 99. 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0								
94.00 09400 HOME PROGRAM DI ALYSI S 0 0 0 0 94.00 95.00 09500 AMBULANCE SERVI CES 0 0 0 0 0 95.00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 <	92.00		304, 655		304, 655		304, 655	92.00
95.00 09500 AMBULANCE SERVICES 0 0 0 95.00 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 0 0 0 96.00 97.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 0 0 97.00 98.00 09800 OTHER REIMBURSABLE COST CENTERS 0 0 0 98.00 99.00 09900 CMHC 0 0 0 98.00 99.10 09910 CORF 0 0 0 99.10 100.00 1600 IAR SERVICES-NOT APPRVD PRGM 0 0 0 0 101.00 10100 HOME HEALTH AGENCY 0 0 0 0 101.00 101.00 10100 HARA CQUI SI TI ON 0 0 0 0 105.00 105.00 10500 KI DNEY ACQUI SI TI ON 0 0 0 0 105.00 106.00 10600 LING ACQUI SI TI ON 0 0 0 0 106.00 107.00 10700 LIVER ACQUI	94.00		0		0) ()	0	94.00
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 98.00 99.00 09900 CMHC 0 0 0 99.00 99.10 09910 CORF 0 0 0 99.10 100.00 10000 I& & SERVI CES-NOT APPRVD PRGM 0 0 0 0 101.00 10100 HOME HEALTH AGENCY 0 0 0 0 101.00 105.00 10500 KI DNEY ACQUI SI TI ON 0 0 0 0 105.00 105.00 10500 KI DNEY ACQUI SI TI ON 0 0 0 105.00 105.00 10500 LIVER 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 LIVER ACQUI SI TI ON 0 0 0 107.00 108.00 10800 LIVER ACQUI SI TI ON 0 0		09500 AMBULANCE SERVI CES	0					
98.00 09850 OTHER REIMBURSABLE COST CENTERS 0 0 0 98.00 99900 CMHC 0 0 0 99.00 09900 CMHC 0 0 0 99.00 09910 CORF 0 0 0 0 99.10 09910 CORF 0 0 0 0 0 99.10 0 100.00 18.8 SERVI CES-NOT APPRVD PRGM 0 0 0 100.00 101.00 101.00 101.00 0 0 0 101.00 0<			0		0	0		
99.00 09900 CMHC 0 0 0 99.0 0 99.0 0 99.0 0 99.0 0 99.0 0 99.0 0 99.0 0 99.0 0 0 0 0 99.0 0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>-</td> <td></td>							-	
100.00 10000 I&R SERVICES-NOT APPRVD PRGM 0 0 0 100.00 101.00 10100 HOME HEALTH AGENCY 0 0 0 0 101.00 SPECIAL PURPOSE COST CENTERS SPECIAL PURPOSE COST CENTERS 0 0 0 105.00 105.00 HDART ACQUISITION 0 0 0 105.00 106.00 106.00 106.00 106.00 106.00 0 0 105.00 0 0 105.00 105.00 105.00 105.00 106.00 0 0 105.00 0 0 105.00 106.00 106.00 106.00 0 106.00 0 106.00 106.00 0 0 106.00 106.00 106.00 106.00 0 107.00 107.00 107.00 107.00 0 0 0 107.00 107.00 107.00 107.00 0 0 107.00 107.00 107.00 107.00 0 0 107.00 107.00 107.00 0 0 <td></td> <td></td> <td>0</td> <td></td> <td></td> <td>)</td> <td>-</td> <td></td>			0)	-	
101.00 10100 HOME HEALTH AGENCY 0 0 101.00 SPECIAL PURPOSE COST CENTERS 0 0 105.00 105.00 105.00 105.00 106.00 106.00 106.00 106.00 106.00 0 0 0 106.00 106.00 106.00 106.00 0 0 106.00 106.00 106.00 106.00 0 0 106.00 106.00 106.00 0 106.00 106.00 0 106.00 0 0 106.00 106.00 106.00 106.00 0 0 106.00 106.00 106.00 106.00 106.00 106.00 106.00 107.00 107.00 107.00 107.00 107.00 107.00 107.00 107.00 107.00 107.00 0 0 0 108.00 108.00 108.00 108.00 109.00 109.00 0 0 0 109.00 109.00 109.00 0 0 0	99.10	09910 CORF	0		c		0	99.10
SPECIAL PURPOSE COST CENTERS 105.00 10500 KIDNEY ACQUISITION 0 0 0 0 105.00 106.00 10600 HEART ACQUISITION 0 0 0 0 106.00 107.00 10700 LIVER ACQUISITION 0 0 0 0 107.00 108.00 LONG ACQUISITION 0 0 0 0 108.00 10800 LUNG ACQUISITION 0 0 109.00 109.00 0 0 109.00 0 0 0 109.00 1000 INTESTINAL ACQUISITION 0 0 0 110.00 100.00 0 0 0 0 100.00 0 100.00 0 0 0 0 0 110.00 0 0 0 0 0 100.00 0 100.00 0 0 0 0 0 110.00 0 0 0 0 0 0 0 0 100.00 0 0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>100.00</td>								100.00
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 0 107.00 108.00 10800 LUNG ACQUI SI TI ON 0 0 0 0 108.00 109.00 10900 PANCREAS ACQUI SI TI ON 0 0 0 0 109.00 110.00 11000 INTESTI NAL ACQUI SI TI ON 0 0 0 110.00	101.00		0	1	L C	<u>)</u>	0	
106.00 HEART ACQUI SI TI ON 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 0 108.00 109.00 10900 PANCREAS ACQUI SI TI ON 0 0 0 109.00 110.00 11000 INTESTI NAL ACQUI SI TI ON 0 0 0 100.00	105.00		0		C		0	105.00
108.00 LUNG ACQUISITION 0 0 108.00 109.00 10900 PANCREAS ACQUISITION 0 0 0 109.00 110.00 11000 INTESTINAL ACQUISITION 0 0 0 110.00	106.00	10600 HEART ACQUI SI TI ON	0				0	106.00
109.00 PANCREAS ACQUISITION 0 0 0 0 109.00 110.00 11000 INTESTINAL ACQUISITION 0 0 0 110.00			0					107.00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON 0 0 110. C								
			0					110.00
			0		C			111.00

Health Financial Systems FR	ANCI SCAN HEALT	H MICHIGAN CITY	(In Lie	u of Form CMS-:	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2020 To 12/31/2020		
		Title	XVIII	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
113.00 11300 INTEREST EXPENSE 114.00 11400 UTILIZATION REVIEW-SNF 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 116.00 11600 HOSPICE 200.00 Subtotal (see instructions) 201.00 Less Observation Beds	0 0 189, 416, 350 304, 655		189, 416, 35 304, 65		0	1
201.00 Total (see instructions)	189, 111, 695		189, 111, 69			

	inancial Systems FF	ANCI SCAN HEALTH		CN: 15-0015	Peri od:	u of Form CMS- Worksheet C	2002-1
					From 01/01/2020 To 12/31/2020	Part I Date/Time Pre	epared:
			Title	e XVIII	Hospi tal	7/28/2021 7:4 PPS	i pm
			Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA I npati ent Rati o	
		6.00	7.00	8.00	9.00	10.00	
	NPATIENT ROUTINE SERVICE COST CENTERS						
	3000 ADULTS & PEDIATRICS	53, 935, 968		53, 935, 96			30.0
	3100 I NTENSI VE CARE UNI T 3200 CORONARY CARE UNI T	13, 117, 265		13, 117, 26	5		31.0
	3300 BURN INTENSIVE CARE UNIT	0			0		33.0
	3400 SURGICAL INTENSIVE CARE UNIT	0			0		34.0
0. 00 0	4000 SUBPROVIDER - IPF	7, 730, 099		7, 730, 09	9		40.0
	4100 SUBPROVIDER - IRF	0			0		41.0
		1, 748, 468		1, 748, 46	8		43.0
	4400 SKILLED NURSING FACILITY 4500 NURSING FACILITY	0					44.0
	4600 OTHER LONG TERM CARE	0			0		46.0
	NCILLARY SERVICE COST CENTERS	Ч					
	5000 OPERATING ROOM	30, 951, 220	96, 312, 130				
	5100 RECOVERY ROOM	0	222.455		0 0.000000	0.00000	
	5200 DELIVERY ROOM & LABOR ROOM 5300 ANESTHESIOLOGY	2, 902, 770 2, 463, 212	232, 455 5, 500, 969			0.000000	
	5400 RADI OLOGY-DI AGNOSTI C	30, 271, 207	74, 583, 638			0. 000000	
	5401 FSED RADIOLOGY - DIAGNOSTIC	1, 601, 987	20, 248, 191			0.00000	
	5500 RADI OLOGY-THERAPEUTI C	3, 938, 013	11, 878, 243			0. 000000	
	5501 WOODLAND CANCER CARE CTR	341, 694	4, 289, 954			0.00000	
	5600 RADI OI SOTOPE 5700 CT SCAN	0			0 0. 000000 0 0. 000000	0. 000000 0. 000000	
	5700 CT SCAN 5800 MAGNETIC RESONANCE IMAGING (MRI)	0			0.000000	0. 000000	
	5900 CARDI AC CATHETERI ZATI ON	15, 819, 545	13, 484, 257	29, 303, 80		0. 000000	
	6000 LABORATORY	38, 973, 617	44, 343, 475			0. 000000	60.0
	6001 FS ED LAB	97, 531	11, 688, 576	11, 786, 10		0.00000	
	6100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	C		0 0.00000	0.00000	
	6200 WHOLE BLOOD & PACKED RED BLOOD CELLS 6300 BLOOD STORING, PROCESSING & TRANS.	0 897, 707	469, 511	1, 367, 21	0 0. 000000 8 0. 036114	0. 000000 0. 000000	
	6400 INTRAVENOUS THERAPY	097,707	409, 311		0.000000	0. 000000	
	6500 RESPI RATORY THERAPY	15, 175, 593	2, 350, 135	17, 525, 72		0. 000000	
6.00 0	6600 PHYSI CAL THERAPY	4, 585, 798	12, 814, 488	17, 400, 28	6 0. 228232	0. 000000	66. 0
	6700 OCCUPATI ONAL THERAPY	0	C		0 0. 000000	0.00000	
		11 022 210	14 170 711	27, 206, 02	0 0.000000	0.00000	
	6900 ELECTROCARDI OLOGY 7000 ELECTROENCEPHALOGRAPHY	11, 033, 310	16, 172, 711	27, 200, 02	1 0. 118729 0 0. 000000	0. 000000 0. 000000	
	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	13, 882, 164	15, 547, 430	29, 429, 59		0. 000000	
	7200 IMPL. DEV. CHARGED TO PATIENTS	12, 779, 841	14, 769, 636	27, 549, 47	7 0. 519367	0. 000000	
	7300 DRUGS CHARGED TO PATIENTS	27, 353, 770	109, 708, 928	137, 062, 69		0.00000	
	7400 RENAL DI ALYSI S	0	C		0 0. 000000 0 0. 000000	0. 000000 0. 000000	
	7500 ASC (NON-DISTINCT PART) 3020 CV RESOURCE CTR	0	C C		0 0. 000000 0 0. 000000		
	7700 ALLOGENEIC STEM CELL ACQUISITION	0	C		0.000000	0. 000000	
0	UTPATIENT SERVICE COST CENTERS						
	8800 RURAL HEALTH CLINIC	0	C		0		88.0
	8900 FEDERALLY QUALIFIED HEALTH CENTER 9000 CLINIC	0	C			0. 000000	89.0 90.0
	9003 I NFUSI ON OP SERVI CES	26, 910	4, 026, 890	4, 053, 80	0 0. 000000 0 0. 381541	0. 000000	
	9100 EMERGENCY	23, 796, 404	54, 857, 311			0. 000000	
	9101 FREE STANDING EMERGENCY DEPT	2, 444, 711	14, 910, 425			0.000000	
	9200 OBSERVATION BEDS (NON-DISTINCT PART)	600, 000	7,003,004	7, 603, 00	4 0. 040070	0.00000	92.0
	THER REIMBURSABLE COST CENTERS					0.000000	1
	9400 HOME PROGRAM DI ALYSI S 9500 AMBULANCE SERVI CES	0	C		0 0. 000000 0 0. 000000	0. 000000 0. 000000	
	9600 DURABLE MEDICAL EQUIP-RENTED	0	C C		0.000000	0.000000	
	9700 DURABLE MEDICAL EQUIP-SOLD	0	C		0.000000	0. 000000	
3. 00 0	9850 OTHER REIMBURSABLE COST CENTERS	0	C		0.000000	0. 000000	98.
	9900 CMHC	0	C		0		99.
	9910 CORF	0	C		0		99.
	0000 I &R SERVICES-NOT APPRVD PRGM 0100 HOME HEALTH AGENCY	0			0		100. 101.
	PECIAL PURPOSE COST CENTERS	<u> </u>		1	<u> </u>		
	0500 KIDNEY ACQUISITION	0	C		0		105.
06. 00 1	0600 HEART ACQUI SI TI ON	0	C		0		106.
	0700 LIVER ACQUISITION	0	C		0		107.
	0800 LUNG ACQUISITION	0	C		0		108.
	0900 PANCREAS ACQUISITION 1000 INTESTINAL ACQUISITION	0	C		0		109.
	1100 I SLET ACQUISITION	0	C C		0		111.
	1300 I NTEREST EXPENSE		C	l '	-		113.

Health Financial Systems	FRANCI SCAN HEALTH	I MICHIGAN CITY	<i>,</i>	In Lie	u of Form CMS	-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CO		Period: From 01/01/2020 To 12/31/2020		
		Title	XVIII	Hospi tal	PPS	
		Charges				
Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
			+ col. 7)	Ratio	Inpati ent	
					Rati o	
	6.00	7.00	8.00	9.00	10.00	
114.00 11400 UTILIZATION REVIEW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0	(C		115.00
116.00 11600 HOSPI CE	0	0	(D		116.00
200.00 Subtotal (see instructions)	316, 468, 804	535, 192, 357	851, 661, 16	1		200.00
201.00 Less Observation Beds					l .	201.00
202.00 Total (see instructions)	316, 468, 804	535, 192, 357	851, 661, 16	1	l .	202.00

COMPUTATION OF PARTO OF COSTS TO CRAMES Provide:	<u>Heal t</u> h	Financial Systems	FRANCI SCAN HEALTH	MI CHI GAN CI TY	In Lie	u of Form CMS-25	<u>52-10</u>
Less Cast Caster Description PPS Input etc. Ittle XVIII Respit tal PPS 10 Display Caster Description PPS Input etc. PPS Input etc.					Period: From 01/01/2020	Worksheet C Part I Date/Time Prepa	ired:
Cost Center Description PPS Inpati ent Bation 10.00 PPS Inpati ent Bation 10.00 1000000000000000000000000000000000000				Title XVIII	Hospi tal		pili
HWATLENT ROUTINE SERVICE QST CARLENS 30 00 000000000000000000000000000000000000		Cost Center Description	Ratio		· · · · · · · · · · · · · · · · · · ·		
1:00 Distol (NESS) V. CARE UNIT 31:00 3:00 Distol (NESS) V. CARE UNIT 32:00 3:00 Distol (NESS) V. CARE UNIT 32:00 3:00 Distol (NESS) V. CARE UNIT 40:00 4:00 Distol (NESS) V. CRAE 40:00 4:00 Distol (NESS) V. CRAE 41:00 4:00 Distol (NESS) V. CRAE 42:00 5:00 DISTOL (NESS) V. CRAE 40:00 5:00 DISTOL (NESS) V. CRAE 40:00 5:00 DISTOL (NESS) V. CRAE 40:00 5:00 DISTOL (NESS) V. CRAE <td></td> <td>INPATIENT ROUTINE SERVICE COST CENTERS</td> <td></td> <td></td> <td></td> <td></td> <td></td>		INPATIENT ROUTINE SERVICE COST CENTERS					
32.00 DSD00 DSD00 <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td></td<>							
33.00 33.00 Signer Larrescience CARE UNIT 34.00 40.00 Colorado Subergovi Dec Ale UNIT 34.00 40.00 Subergovi Dec Ale UNIT 35.00 40.00 Subergovi Dec Ale UNIT 35.00 50.00 Subergovi Dec Ale UNIT 0.00000 51.00 51.00 Subergovi Dec Ale UNIT 0.00000 51.00 51.00 Subergovi Dec Ale UNIT 0.00000 52.00 51.00 Subergovi Dec Ale UNIT 0.00000 55.00 51.00 Subergovi Dec Ale UNIT 0.000000 55.00 51.00 Subergovi Dec Ale UNIT 0.000000 55.00 51.00 <							
34.00 SADO SUBCICAL, ITRUSSIVE CARE, UNIT 44.00 35.00 DEMONSTREET, INC. 45.00 36.00 DEMONSTREET, INC. 46.00 36.00 DEMONSTREET, INC. 0.07000 37.00 DEMONSTREET, INC. 0.0743.02 36.00 DEMONSTREET, INC. 0.0443.02 36.00 DEMONSTREET, INC. 0.0443.02 36.00 DEMONSTREET, INC. 0.0443.02 36.00 DEMONSTREET, INC. 0.04000 37.00 DEMONSTREET, INC. 0.04001 37.00 DEMONSTREET, INC. 0.04001 37.00 DEMONSTREET, INC. 0.04001 37.00 DEMONSTREET, INC. 0.04001 37.00 DEMONSTREET, INC. 0.04001 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
0.000 DOUDOS SUBPROVIDER - IFF 40.00 0.0010 SUBPROVIDER - IFF 41.00 0.0010 SUBPROVIDER - IFF 41.00 0.0010 SUBPROVIDER - IFF 41.00 0.0010 SUBPROVIDER - IFF 45.00 0.0010 SUBPROVIDER - IFF 55.00 0.00000 SUBPROVIDER - IFF 55.00 0.00000 SUBPROVIDER - IFF 55.00 0.00000 SUBPROVIDER - IFF 55.00							
41 00 42 00 43 00 43 00 43 00 43 00 44 00 44 00 44 00 44 00 44 00 44 00 44 00 44 00 44 00 44 00 44 00 44 00 44 00 44 00 44 00 44 00 44 00 45 00 60 00 <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td></td<>							
44.00 04400 SKILLED NURSING FACILITY 44.00 45.00 04500 MURET LOR NURSING FACILITY 45.00 46.00 DECOMENTO FACILITY 45.00 47.00 DECOMENTO FACILITY 45.00 47.00 DECOMENTO FACILITY 45.00 47.00 DECOMENTO FACILITY 45.00 47.00 DECOMENTO FACILITY 55.00 47.00 DECOMENTO FACILITY 55.00 57.00 DESCOMENTO FACILITY 55.00 57.00 DESCOMENTO CARCELINGUESTIC 0.0443.31 57.00 DESCOMENTO CARCE FACILITY 0.140401 58.00 DESCOMENTO CARCE FACILITY 0.140401 59.00 DESCOMENTO CARCE FACILITY 0.140401 50.00 DESCOMENTO FACILITY 0.140401 50.00 DESCOMENTO FACILITY <t< td=""><td>41.00</td><td></td><td></td><td></td><td></td><td>4</td><td>41.00</td></t<>	41.00					4	41.00
45.00 0.00000		04300 NURSERY				4	43.00
40, 00 04000 THER LOOK TERM CARE 40.00 AMCLL ARY NEWICE COSE UNITES 60.00							
MARILLARY SERVICE COST CENTERS 0.1709% 0.0000 51.00 51.00 DSIGO PECOVERY NOOM 0.20000 51.00 51.00 DSIGO PECOVERY NOOM 0.22302 52.00 51.00 DSIGO PECOVERY NOOM 0.22302 52.00 51.00 DSIGO PECOVERY NOOM 0.22302 54.00 51.00 DSIGO PECOVERY NOOM 0.22302 54.00 51.00 DSIGO PECOVERY NOOM 0.204512 54.00 51.00 DSIGO PECANTERS NOOM 0.400015 55.00 51.00 DSIGO PECANTERS NOOM 0.400015 55.00 51.00 DSIGO PECANTERS NOOM 0.000000 56.00 51.00 DSIGO PECANTERS NOOM 0.111116 59.00 51.00 DSIGO PECANTERS NOOM 0.11116 59.00 51.00 DSIGO PECANTERS NOOM 0.11116 59.00 51.00 DSIGO PECANTERS NOOM 0.111176 59.00 51.00 DSIGO PECANTERS NOOM 0.111176 50.00 51.00 DSIGO PECANTERS NOOM 0.1102777 50.							
50.00 65000 (DF RATINE ROUL 0.770694 50.00 52.00 65200 (DE LIVERY NOCM & LABOR ROUL 0.225302 52.00 52.00 65200 (DE LIVERY NOCM & LABOR ROUL 0.225302 52.00 54.00 55200 (DE LIVERY NOCM & LABOR ROUL 0.221711 53.00 54.00 5500 (DE LIVERY NOCM & LABOR ROUL 0.221711 53.00 55.00 5500 (DS CONTRATING ON CONTROLL 0.221711 55.00 55.01 5500 (DS CONTRATING ON CONTROLL 0.231712 55.00 55.01 5500 (DS CONTRATING ON CONTROLL 0.000000 57.00 57.00 5500 (DS CONTRATING ON CONTROLL 0.000000 57.00 57.00 5500 (DS CONTRATIC RESONANCE INACING (MRI) 0.000000 57.00 57.00 5500 (DS CONTRATIC RESONANCE INACING (CIRI) 0.000000 67.00 57.00 5500 (DS CONTRATING PORTICIC CLISS 0.000000 67.00 50.00 5500 (DS CONTRATING PORTICIC CLISS 0.000000 67.00 61.00 6000 (DN CHINE FILL STATING PORTICIC CLISS 0.000000 67.00 61.00 <td< td=""><td>46.00</td><td></td><td></td><td></td><td></td><td>4</td><td>46.00</td></td<>	46.00					4	46.00
51.00 60100 RECOVERY NOOM & LABOR ROOM 0.000000 51.00 52.00 05200 RESTHESI OLGOY 0.021711 53.00 53.00 05000 RESTHESI OLGOY 0.021711 53.00 50.00 05000 RESTHESI OLGOY 0.021711 53.00 50.00 05000 REDIOLEVY - HEARPEUTIC 0.040010 55.00 50.00 05000 REDIOLEVY - HEARPEUTIC 0.0400010 55.00 50.00 05000 REDIOLEVY - HEARPEUTIC 0.0400000 55.00 50.00 05000 REDIOLEVY - HEARPEUTIC 0.0400000 55.00 50.00 05000 REDIOLEVY - HEARPEUTIC 0.0400000 55.00 50.00 05000 RESCOLARY - HEARPEUTIC 0.000000 56.00 50.00 05000 RESCOLARY - HEARPEUTIC 0.072757 66.01 60.00 06000 FERD LARY - RESTHER ANDY 0.000000 64.00 60.00 06000 SERD ROTHY - THEARPY 0.000000 64.00 60.00 060000	50 00		0 170696			F	50 00
32.00 DS300 AMESTHESI OLGOY 0.021711 S3.00 32.00 DS400 READ ILGOX-01 ACMOSTIC 0.232142 S4.01 32.00 DS400 READ ILGOX-01 ACMOSTIC 0.232142 S4.01 35.00 DS500 MAD ILGOX-01 ACMOSTIC 0.232142 S5.01 35.00 DS500 MAD ILGOX-01 ACMOSTIC 0.200000 S5.01 35.00 DS500 MADIANA CANCER CAR CTR 0.400010 S5.01 35.00 DS500 MAGINI CARCEL TARGINS (NRI) 0.000000 S5.00 36.00 DS400 MARCET CRESONANCE I MAGINS (NRI) 0.000000 S6.00 37.00 DS400 MAGINI CALLAR SERVICES-PREM ONLY 0.000000 S6.00 37.00 DS400 MACON RESTRICES AND CALLAR SERVICES-PREM ONLY 0.000000 S6.00 38.00 DS400 MACON RESTRICES AND CALLAR SERVICES-PREM ONLY 0.000000 S6.00 38.00 DS400 MACON RESTRICES AND CALLAR SERVICES-PREM ONLY 0.000000 S6.00 38.00 DS400 MACON RESTRICES AND ARCETRER BE RUCOL CALARE							
94.00 05400 FADU DLOCY - DLARMOSTIC 0.944522 54.00 55.00 DSSOR FADU DLOCY - THERAPEUTIC 0.1404016 55.00 55.00 DSSOR FADU DLOCY - THERAPEUTIC 0.440415 55.00 50.00 DSSOR MADU DLOCY - THERAPEUTIC 0.440415 55.00 50.00 DSSOR MADU STOPE 0.400415 55.00 50.00 DSSOR MADU STOPE 0.000000 57.00 50.00 DSSOR MADU STOPE 0.000000 57.00 50.00 DSSOR MADU LAS CARRETERIZATION 0.000000 65.00 60.00 DSSOR MADU LAS STEVICES- PREM ONLY 0.000000 61.00 60.00 DSSOR MADU STEVICES- PREM ONLY 0.000000 63.00 61.00 DSSOR SPI CLIN THERAPY 0.000000 63.00 61.00 DSSOR SPI RATOR THERAPY 0.000000 63.00 61.00 DSSOR SPI RATOR THERAPY 0.2002322 66.00 61.00 DSSOR SPI RATOR THERAPY 0.200000 67.00 61.00 DSSOR SPI RATOR THERAPY 0.200000 71.00	52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 225302			5	52.00
54.01 DS401 FSFD RAD 00,00Y - DIAGNOSTIC 0.232142 54.01 55.00 DS500 RUDGOX - HEARPEUTIC 0.169016 DS5.01 55.01 DS500 RUDGOX - HEARPEUTIC 0.000000 DS5.01 57.00 DS500 RUDGOX - HEARPEUTIC 0.000000 DS5.01 57.00 DS500 RUDGOX - HEARPEUTIC 0.000000 DS5.00 57.00 DS500 RUDGOX - THEARPEUTIC 0.114116 S5.00 57.00 DS500 RUDGOX - THEARPEUTIC 0.000000 CD CD 57.00 DS500 RUDGOX - THEARPEUTIC 0.000000 CD CD 57.00 DS500 RUDGOX - THEARPEUTIC 0.000000 CD CD 50.01 DS500 RUDGOX - THEARPEUTIC 0.000000 CD CD 50.01 DS500 RUDGOX STORE NE RUDGES RUDGES RUDGOX HUDGOX 0.000000 CD CD CD <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td></td<>							
51.00 05:00 <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td></td<>							
5.01 DISCOI WODLAND CANCER CARE CTR 0. A00015 55.0 55.00 56.00 5							
56.00 05600 RADIO 3070FE 0.000000 56.00 57.00 05700 75700 57700 57700 58.00 05800 MACNETIC RESONANCE IMAGING (MEI) 0.0000000 57.00 50.00 05800 ACRADIA CC ATHERET ZATION 0.114116 59.00 60.00 60001 F5 FD LAB ASENDACE ENDIA 60.01 61.00 66001 F5 FD LAB ASENDACE ENDIA 60.01 61.00 66000 F5 FD LAB ASENDACE ENDIA 63.00 61.00 66000 FFECH FRANCES 0.000000 62.00 61.00 66000 FFECH FRANCES 0.000000 62.00 61.00 66000 FFECH FRANCE 0.000000 67.00 61.00 06800 FFECH FRANCE 0.000000 67.00 61.00 06800 FFECH FRANCE 0.000000 67.00 60.00 06800 FFECH FRANCE DIOCEY 0.0113770 68.00 70.00 07000 DECTRETROCADED IOCEY 0.113770 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td></t<>							
57.00 05700 CT SCAM 0.000000 57.00 57.00 05500 CARDIAC CATHETERI ZATION 0.114116 59.00 59.00 05500 CARDIAC CATHETERI ZATION 0.114110 59.00 60.01 06000 DEGODAL CATHETERI ZATION 0.114420 60.00 60.01 06000 PP CLINICAL LAB SERVICES-PRGN ONLY 0.000000 61.00 61.00 06100 DEGOD STORIN, R. PROCESSING TARAS. 0.03114 63.00 61.00 06100 DEGOD STORIN, R. PROCESSING TARAS. 0.03114 65.00 61.00 DEGOD STORIN, R. PROCESSING TARAS. 0.040000 67.00 66.00 60.00 DEGOD STORIN, R. PROCESSING TARAS. 0.0111770 63.00 66.00 60.00 DEGOD STORIN, R. THERAPY 0.020000 67.00 66.00 66.00 60.00 DEGOD STORING, THERAPY 0.020000 67.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 <							
58.00 05800 MAGNETIC RESONANCE INAGUNA (MRI) 0.000000 58.00 059000 059000 059000							
60.00 00000 ABORATORY 0.134420 60.00 60.00 00100 FS ED LAB SERVICES-PRGN (0)LY 0.000000 61.00 61.00 00400 PP CLINICAL LAB SERVICES-PRGN (0)LY 0.000000 62.00 63.00 00400 PP CLINICAL LAB SERVICES-PRGN (0)LY 0.000000 63.00 63.00 00400 PP CLINICAL LAB SERVICES-PRGN (0)LY 0.000000 63.00 64.00 046.00 017787/2000 0.030114 63.00 65.00 06500 PESICAL THERAPY 0.000000 65.00 66.00 064000 PESICAL THERAPY 0.000000 67.00 60.00 064000 PESICAL THERAPY 0.000000 67.00 60.00 064000 PESICAL THERAPY 0.0000000 67.00 70.00 07200 ILECTROACHARGE TO PATIENTS 0.234190 71.00 70.00 07200 ILECTROACHARGE TO PATIENTS 0.220742 73.00 70.00 07200 ILECTROACHARGE TO PATIENTS 0.220742 73.00	58.00						
60.01 06001 [FS ED LAB 0.172757 60.01 61.00 06100 [STOLPPP CLINICAL LAB SERVICES-PRAN ONLY 0.000000 61.00 62.00 06200 [WHOLE BLOOD X PACKED RED BLOOD CELLS 0.000000 63.00 63.00 06400 [INTRAVENUIS THERAPY 0.000000 64.00 64.00 06400 [NTRAVENUIS THERAPY 0.100314 65.00 65.00 06500 [CUPATIONAL THERAPY 0.228232 66.00 66.00 06600 [SEECH PATHOLOGY 0.118770 69.00 70.00 07000 [LECTROCAPHALOGRAPHY 0.000000 69.00 70.00 07000 [LECTROCAPTIOLES CHARGED TO PATIENTS 0.234190 71.00 71.00 07100 [NUES CHARGED TO PATIENTS 0.22742 73.00 73.00 07300 [AULGORNEC TO PATIENTS 0.22742 73.00 74.00 07400 [RALL LORLY LES CHARGED TO PATIENTS 0.22742 73.00 70.00 07000 [LICS CHARCED TO PATIENTS 0.220742 73.00 70.00 07000 [RALL LORLY LES CHARGED TO PATIENTS 0.22742 73.00 70.00 07000 [CUNC SCHARGED TO PATIENTS <td>59.00</td> <td>05900 CARDI AC CATHETERI ZATI ON</td> <td>0. 114116</td> <td></td> <td></td> <td>5</td> <td>59.00</td>	59.00	05900 CARDI AC CATHETERI ZATI ON	0. 114116			5	59.00
61.00 0ot000 PRP CLINICAL LAB SERVICES-PRG NULY 0.000000 62.00 62.00 0c200 NULE BLOOD PACED BLOOD CELLS 0.000000 62.00 63.00 0c300 BLOOD STORING, PROCESSING & TRANS. 0.036114 63.00 64.00 0c400 NTRAVENOS 0.03600 64.00 66.00 0c600 NTRAVENOS 0.00000 65.00 66.00 0c600 NTRAVENOS 0.000000 67.00 66.00 0c600 SECEN PATIONAL THERAPY 0.000000 68.00 60.00 0c600 SECEN PATIONAL THERAPY 0.000000 69.00 60.00 0c600 SECEN PATIONAL THERAPY 0.000000 70.00 70.00 0r000 ELECTROECCEPTRALOGRAPHY 0.000000 70.00 70.00 0r000 INPL DEV. CHARGED TO PATIENTS 0.234190 71.00 70.00 0r300 IRVAL DIALYSIS 0.000000 75.00 70.00 0r300 RUAL DIALYSIS 0.000000 76.00 70.00 0r300 RUAL DIALYSIS 0.000000 76.00 70.00							
62.00 06200 WHOLE BLOOD STORME, PROCESSINE & TRANS. 0.000000 63.00 63.00 63.00 63.00 63.00 63.00 63.00 63.00 63.00 63.00 63.00 63.00 63.00 63.00 65.00 70.00 71.00 71.00 71.00 71.00 71.00 72.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
63.00 0.6300 BLOD.STORING, PROCESSING & TRANS. 0.036114 64.00 64.00 0.6400 INTRAVENDUS THERAPY 0.000000 64.00 65.00 0.6500 RESPI RATORY THERAPY 0.200000 65.00 66.00 0.6600 PHYSICAL THERAPY 0.228232 66.00 66.00 0.6600 PHYSICAL THERAPY 0.228232 66.00 66.00 0.6600 PHYSICAL THERAPY 0.200000 67.00 66.00 0.6600 ELECTRONCHADILOGY 0.118770 68.00 67.00 0.7000 PHYSICAL THERAPY 0.000000 77.00 71.00 0.7000 IMPL. DEV. CHARGED TO PATI ENTS 0.2319307 72.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.200000 74.00 70.00 07300 PRUS CHARGET TO PATI ENTS 0.220742 73.00 70.00 07300 PRUS CHARGET TO PATI ENTS 0.200000 74.00 70.00 07300 PRUS CHARGET TO PATI ENTS 0.200000 74.00 70.00 07300 PRUS CHARGET TO PATI ENTS 0.200000							
64.00 06400 INTRAVENUUS THERAPY 0.00000 64.00 65.00 06500 RESPIRATORY THERAPY 0.10814 65.00 66.00 06600 PHYSICAL THERAPY 0.228232 66.00 67.00 06700 06700 67.00 67.00 68.00 06800 SPECIP ATHOLOGY 0.118770 68.00 00 06900 ILECTROCARPHALIGRAPHY 0.000000 69.00 70.00 0700 ELECTROCARPHALIGRAPHY 0.000000 71.00 71.00 0720.00 ILECTROCARPHALIGRAPHY 0.000000 72.00 71.00 0720.01 INFL.DEV. CHARGED TO PATIENTS 0.519367 72.00 73.00 07300 IRAL DI ALYSIS 0.000000 74.00 76.00 07500 ASC (NON-DISTINCT PART) 0.000000 75.00 077.00 00 0700 ALLOGENEL'S CHARGED TO PATIENTS 0.000000 75.00 00 077.00 VESTINTENT SERVICE COST CENTRES 88.00 00 08000 RURAL HEALTHALINE LINIC ENERGENCY							
65:00 06500 RESPI RATORY THERAPY 0.110814 65:00 66:00 06600 PHYSICAL THERAPY 0.28232 66:00 67:00 06070 DCUPATIONAL THERAPY 0.200000 68:00 68:00 06600 ELECTROCARDIOLOGY 0.000000 68:00 69:00 06070 ELECTROCARDIOLOGY 0.118770 69:00 70:00 07000 ELECTROCARDIOLOGY 0.118770 70:00 71:00 0700 IMEDICAL SUPPLIES CHARGED TO PATLENTS 0.231930 71:00 71:00 0700 IRPL. DEV. CHARGED TO PATLENTS 0.220742 73:00 71:00 07500 IRPL. DEV. CHARGED TO PATLENTS 0.220742 73:00 71:00 07500 ASC (WN-DISTINCT PART) 0.000000 74:00 71:00 07500 ASC (WN-DISTINCT PART) 0.000000 75:00 00 07700 ALLOGENEL C CSTL CENTER 89:00 89:00 80:00 08900 RURAL HATATY CLINIC 0.387302 91:00 91:01 0710 ALLOGENAV 0.38775 0.000000 90:00 90:00 09000 CLINIC SERVICES 0.38775							
67:00 06700 00000 67:00 67:00 67:00 67:00 67:00 67:00 68:00 68:00 68:00 68:00 68:00 68:00 68:00 68:00 67:00 67:00 67:00 67:00 67:00 67:00 67:00 67:00 67:00 67:00 67:00 67:00 67:00 67:00 67:00 67:00 67:00 67:00 77:00 <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td></td<>							
68:00 66800 SPEECH PATHOLOGY 0.000000 69:00 69:00 6600 LECTROCARCEPHALOGRAPHY 0.000000 70.00 71:00 07000 ELECTROCARCEPHALOGRAPHY 0.000000 71.00 71:00 07000 HEDI CALL SUPPLIES CHARGED TO PATIENTS 0.234190 71.00 72:00 07200 PATIENTS 0.220742 73.00 73:00 07300 REAL DI ALYSIS 0.000000 74.00 74:00 07300 CV RESOURCE CTR 0.000000 75.00 70:00 07700 ALLOCENET COST CENTERS 0.000000 76.00 80:00 08900 PEDERALLY OLLF COST CENTERS 99.00 80:00 09000 FEDERALLY OLLF OLST COST CENTERS 99.03 90:00 09000 FEDERALLY OLLF OLST COST CENTERS 99.03 91:01 91:01 FEDERALLY OLLF OLST CENT CENTERS 99.03 91:00 92:00 09200 AMBULANCE SERVICES 0.331785 90.040 90:00 09000 FEDERALLY OLLSIST 0.000000 95.00 <	66.00	06600 PHYSI CAL THERAPY	0. 228232			6	66.00
69:00 69:00 LECTRPCARDIOLOGY 0.118770 69:00 71:00 07000 LECTRPCARDIPHALOGRAPHY 0.000000 71:00 72:00 07200 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.234190 72:00 72:00 07200 IMPL DEV. CHARGED TO PATIENTS 0.220742 73:00 74:00 07400 REMAL DIALYSIS 0.000000 74:00 70:00 0700 ACC (NN-DISTINCT PART) 0.000000 75:00 70:00 0700 ALLOGENEC STEM CELL ACQUISITION 0.000000 76:00 70:00 0700 ALLOGENEC STEM CELL ACQUISITION 0.000000 77:00 00 08000 FEDERALLY OUALIFIED HEALTH CENTER 88:00 00 08900 FEDERALLY OUALIFIED HEALTH CENTER 90:03 00 09003 INFUSION OF SERVICES 0.381785 90:03 91:00 99000 INBEDS (NON-DISTINCT PART) 0.400070 91:00 91:00 99000 INSEDS (NON-DISTINCT PART) 0.400070 91:00 92:00 09400 INMER HEALTH CLINIC PART) 0.400070 91:00 92:00 095400 INSEDS (NON-DIS							
70.00 07000 LECTROENCEPHALOGRAPHY 0.000000 71.00 70.00 07000 MEDICAL SUPPLISS CHARGED TO PATIENTS 0.234190 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.220142 73.00 74.00 07400 REAL DI ALYSIS 0.000000 74.00 74.00 07400 REAL DI ALYSIS 0.000000 75.00 75.00 07500 ASC (NON-DI STINCT PART) 0.000000 75.00 76.00 07700 ALLOGENEIC CSTEM CELL ACOUISITION 0.000000 76.00 00 07701 ALLOGENEIC COST CENTERS 88.00 88.00 88.00 08900 RURAL HEALTH CLINIC 89.00 99.00 90.00 99000 INFUSION OP SERVICES 0.381785 90.03 90.00 99000 INFUSION OP SERVICES 0.3403032 91.01 91.01 91.01 FREE STANDING EMERGENCY DEPT 0.333032 91.01 91.00 97000 OBSERVATION BEDS (NON-DISTINCT PART) 0.400070 92.00 92.00 09200 CILINE COST CENTERS 0.0000000 95.00 <tr< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr<>							
71.00 07100 MCDICAL SUPPLIES CHARGED TO PATIENTS 0.231190 71.00 72.00 07200 IMPLO EVC, CHARGED TO PATIENTS 0.20742 72.00 73.00 07400 RENAL DI ALYSIS 0.000000 74.00 74.00 07400 RENAL DI ALYSIS 0.000000 74.00 70.00 07700 RENAL DI ALYSIS 0.000000 75.00 70.00 07700 ALCOGENET STEM CELL ACQUISITION 0.000000 76.00 001700 ALLOGENET STEM CELL ACQUISITION 0.000000 77.00 001700 REALLY QUALIFIED HEALTH CENTER 0.000000 88.00 80.00 08000 REAL HALTH CLINIC 0.000000 90.00 00 09000 CINIC 0.000000 90.00 90.00 00 09000 CINIC 0.000000 90.00							
72.00 IMPL. DEV. CHARGED TO PATIENTS 0.519367 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.220742 73.00 74.00 07400 RENAL DI ALYSI S 0.000000 74.00 75.00 07500 ASC (NON-DI STINCT PART) 0.000000 75.00 70.00 0700 ALLOGENEI C STEM CELL ACOUIS ITI ON 0.000000 76.00 00770.01 ALLOGENEI C STEM CELL ACOUIS ITI ON 0.000000 77.00 77.00 00 07000 CENTERS 88.00 08000 RERAL HEALTH CLINIC 88.00 89.00 08000 CLIRAL HEALTH CLINIC 0.000000 99.00 90.00 09000 CLINIC C STRING 91.00 91.00 09100 CHERGENCY 0.171670 91.00 91.00 09100 DISEDS (INO-DI STINCT PART) 0.333032 91.01 92.00 095600 ALLORAL MERCENT CENTERS 0.000000 95.00 91.00 09400 DABEDS (MON-DI STINCT PART) 0.333032 91.01 92.00 09400 DABEL MEDI							
73.00 O7300 DRUSS CHARGED TO PATIENTS 0.220742 73.00 74.00 O7400 REALD LALVSIS 0.000000 74.00 75.00 D7500 ASC (NON-DISTINCT PART) 0.000000 76.00 70.00 D7700 (ALLOGENEL C STEM CELL ACOUISITION 0.000000 77.00 00 D01700 (ALLOGENEL C STEM CELL ACOUISITION 0.000000 77.00 00 000 (RDAL HEALTH C STEM CELL ACOUISITION 0.000000 88.00 80.00 08000 (RDAL HEALTH CLINIC 88.00 80.00 08000 CLINIC SERVICE COST CENTERS 90.03 91.00 09003 INFUSION OP SERVICES 0.381785 90.03 91.00 09003 INFUSION OP SERVICES 0.330322 91.01 92.00 09200 (DSERVATION BEDS (NON-DISTINCT PART) 0.440070 91.01 92.00 09200 (MBULAUCE SERVICES 0.000000 95.00 96.00 09400 (HOME PROGRAM DIALYSIS 0.000000 95.00 96.00 09400 (MBULAUCE SERVICES 0.000000 96.00 97.00 09700 DURABLE MEDICAL EQUI P-RENTED 0.000000 97.00 98.00 09900 (MHC							
74.00 07400 RENAL DIALYSIS 0.000000 74.00 75.00 07500 ACCONDASC (NON-DISTINCT PART) 0.000000 75.00 77.00 07700 ALLOGENEI C STEM CELL ACQUISITION 0.000000 76.00 00770.01 ALLOGENEI C STEM CELL ACQUISITION 0.000000 77.00 00700 FEDERALLY QUALIFIED TEAT 0.000000 88.00 88.00 08000 RUROAL HEALTH CLINIC 89.00 89.00 90.00 09000 FEDERALLY QUALIFIED HEALTH CENTER 0.000000 90.03 90.00 09000 FEDERALLION BEDS (NON-DISTINCT PART) 0.333322 91.01 91.00 09100 OE LEWREGENCY 0.117670 91.00 91.01 09101 FEDERALTION BEDS (NON-DISTINCT PART) 0.40070 92.00 92.00 09200 OESENVATION BEDS (NON-DISTINCT PART) 0.40000 94.00 95.00 09500 AMBULANCE SERVICES 0.000000 95.00 96.00 99600 OURABLE MEDICAL EQUIP-RENTED 0.000000 95.00 97.00 09700 OURABLE MEDICAL EQUIP-RENTED 0.000000 95.00 99.00 09900 CMHC 90.00 99.00 99.00 <							
76.00 03302 CV RESOURCE CTR 0.00000 76.00 077.00 077.00 0.0000 77.00							
77. 00 07700 ALLOGENEL C STEM CELL ACQUISITION 0.00000 77. 00 0UTPATIENT SERVICE COST CENTERS 000000 00000 00000 00000 00000 00000 000000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 000000 000000 000000 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
OUTPATI ENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 88.00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 88.00 90.00 09000 CLINIC 0.000000 90.01 09000 CLINIC 0.000000 91.00 09100 EMERGENCY 0.171670 90.03 91.00 09100 EMERGENCY 0.171670 91.00 91.01 09101 FIEE STANDI NG EMERGENCY DEPT 0.333032 91.00 01.01 09101 FIEE STANDI NG EMERGENCY DEPT 0.330332 92.00 071HER REIMBURSABLE COST CENTERS 0.000000 92.00 07100 OP400 HOME PROGRAM DI ALYSI S 0.000000 94.00 08000 DURABLE MEDI CAL EQUI P-RENTED 0.000000 95.00 97.00 09700 DURABLE MEDI CAL EQUI P-SOLD 0.000000 97.00 99.00 0MHC SERVI CES 0.000000 97.00 99.00 09850 OTHER REI MBURSABLE COST CENTERS 0.000000 99.00 99.00 CMHC 99.00 99.00 99.00 99.10 09910 CMHC RESEVICES-NOT APP							
88.00 08800 RURAL HEALTH CLINIC 88.00 88.00 88.00 88.00 88.00 89.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 90.03 14.01 0.00000 0.000 90.03 90.03 90.03 90.03 90.03 90.03 90.03 90.03 90.03 91.01 91.01 91.01 91.01 91.01 91.01 91.01 92.00 05058FNATION BEDS (NON-DISTINCT PART) 0.040070 92.00 01HER REIMBURSABLE COST CENTERS 0.000000 95.00 09500 AMBULANCE SERVICES 0.000000 95.00 95.00 09500 DURABLE MEDICAL EQUIP-RENTED 0.000000 97.00 97.00 97.00 99.00	77.00		0. 000000			7	77.00
89:00 09000 CLINIC 0.00000 99:00 99:00 09:00 00:00 91:00 91:00 91:00 91:00 91:00 91:00 91:00 91:00 92:00 082:00 085:00 10:00 92:00 080:00 94:00 92:00 080:00 94:00 92:00 080:00 94:00 92:00 080:00 94:00 92:00 080:00 94:00 95:00 95:00 95:00 94:00 95:00 95:00 94:00 95:00 96:00 09:00 00:00:00 96:00 96:00 96:00 96:00 96:00 96:00 96:00 96:00 96:00 96:00 99:00 99:00 <td>88 00</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>88 00</td>	88 00						88 00
90.00 CLINIC 0.000000 90.03 90.00 91.01 91.00 92.00 90.00 95.00 0.000000 95.00 95.00 95.00 95.00 95.00 92.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00							
91.00 09100 EMERGENCY 0.171670 91.00 91.01 09101 FREE STANDI NG EMERGENCY DEPT 0.33032 91.01 92.00 005200 005200 005200 005200 005200 07HER REI MBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DI ALYS IS 0.000000 94.00 95.00 09500 AMBULANCE SERVI CES 0.000000 96.00 96.00 97.00 9700 DURABLE MEDI CAL EQUI P-RENTED 0.000000 96.00 97.00 99700 DURABLE MEDI CAL EQUI P-SOLD 0.000000 97.00 99.00 09900 CMHC 99.00 09900 CMHC 99.00 99.10 09910 CORF 99.10 9910 CORF 99.10 9910 CORF 99.10 101.00 10100 1000 KI DNEY ACQUI SI TI ON 101.00 101.00 101.00 100.00 106.00 168.00 107.00 106.00 107.00 106.00 106.00 107.00 107.00 107.00 107.00 107.00 107.00 107.00 107.00 107.00 107.00 107.00 107.00 107.00 107.00 107.00 107.00			0. 000000				
91.01 09101 FREE STANDING EMERGENCY DEPT 0.333032 91.01 92.00 09507 (MSRABLE COST CENTERS 0.040070 92.00 07400 HOME PROGRAM DI ALYSI S 0.000000 94.00 94.00 09400 HOME PROGRAM DI ALYSI S 0.000000 95.00 95.00 09500 AMBULANCE SERVI CES 0.000000 95.00 96.00 09600 DURABLE MEDI CAL EQUI P-RENTED 0.000000 97.00 97.00 09700 DURABLE MEDI CAL EQUI P-SOLD 0.000000 97.00 98.00 09850 OTHER REI MBURSABLE COST CENTERS 0.000000 98.00 99.00 09900 CMHC 99.00 99.00 99.10 09900 CMHC 99.10 101.00 101.00 10000 I AK SERVI CES-NOT APPRVD PRGM 100.00 101.00 101.00 10100 HEAT ACQUI SI TI ON 105.00 105.00 105.00 105.00 105.00 105.00 105.00 106.00 107.00 107.00 107.00 107.00 107.00 107.00 107.00 107.00 107.00 107.00 <t< td=""><td>90.03</td><td>09003 INFUSION OP SERVICES</td><td>0. 381785</td><td></td><td></td><td>ç</td><td>90. 03</td></t<>	90.03	09003 INFUSION OP SERVICES	0. 381785			ç	90. 03
92.00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 0.040070 92.00 0THER REIMBURSABLE COST CENTERS 0 04.00 95.00 96.00 95.00 95.00 95.00 95.00 95.00 95.00 95.00 96.00 09400 HUANCE SERVI CES 0.000000 95.00 96.00 97.00 DURABLE MEDI CAL EQUI P-RENTED 0.000000 96.00 97.00 97.00 DURABLE MEDI CAL EQUI P-SOLD 0.000000 97.00 99.00 100.00 100.00 100.00 100.00 100.00 100.00 100.00 100.00 100.00 100.00 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td></t<>							
OTHER REI MBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DI ALYSI S 0.000000 95.00 95.00 95.00 09500 AMBULANCE SERVI CES 0.000000 95.00 95.00 95.00 95.00 09600 DURABLE MEDI CAL EQUI P-RENTED 0.000000 96.00 97.00 97.00 09700 DURABLE MEDI CAL EQUI P-SOLD 0.000000 97.00 97.00 97.00 09700 DURABLE MEDI CAL EQUI P-SOLD 0.000000 97.00 97.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.10 00910 CORF 99.10 000F 99.10 000F 99.10 100.00 100.00 100.00 100.00 100.00 100.00 100.00 100.00 100.00 100.00 100.00 100.00 100.00 100.00 100.00 106.00 106.00 106.00 106.00 106.00 106.00 106.00 107.00 108.00 108.00							
94.00 09400 HOME PROGRAM DI ALYSI S 0.000000 94.00 95.00 09500 AMBULANCE SERVI CES 0.000000 96.00 96.00 09600 DURABLE MEDI CAL EQUI P-RENTED 0.000000 96.00 97.00 09700 DURABLE MEDI CAL EQUI P-SOLD 0.000000 97.00 98.00 09850 OTHER REI MBURSABLE COST CENTERS 0.000000 98.00 99.00 09900 CMHC 99.00 99.10 100.00 168 SERVI CES-NOT APPRVD PRGM 100.00 100.00 101.00 10100 HAME HEALTH AGENCY 101.00 SPECI AL PURPOSE COST CENTERS 105.00 10500 KI DNEY ACQUI SI TI ON 105.00 106.00 10500 KI DNEY ACQUI SI TI ON 107.00 108.00 10800 LING ACQUI SI TI ON 107.00 108.00 10900 PANCREAS ACQUI SI TI ON 109.00 109.00 INFERTION 108.00 1090 1090 PANCREAS ACQUI SI TI ON 110.00 11000 INFERST EXPENSE 113.00 111.00 1111.00 11100 ISLET ACQU	92.00		0. 040070			ç	92.00
95.00 09500 AMBULANCE SERVICES 0.000000 95.00 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0.000000 96.00 97.00 DURABLE MEDICAL EQUIP-SOLD 0.000000 97.00 98.00 09805 OTHER REI MBURSABLE COST CENTERS 0.000000 98.00 99.00 0990 CMHC 99.00 99.00 99.10 0910 CORF 99.00 99.00 100.00 10000 1 & SERVICES-NOT APPRVD PRGM 99.00 101.00 10000 HME HEALTH AGENCY 101.00 105.00 10500 KIDNEY ACQUISITION 105.00 105.00 10500 LIVER ACQUISITION 105.00 108.00 LUNG ACQUISITION 106.00 106.00 108.00 LING ACQUISITION 105.00 106.00 108.00 LING ACQUISITION 108.00 109.00 109.00 110.00 10000 INFESTINAL ACQUISITION 108.00 109.00 109.00 111.00 11000 INFESTINAL ACQUISITION 110.00 110.00 1100.00 1100.00 1100.00 <td>94 00</td> <td></td> <td>0,00000</td> <td></td> <td></td> <td> c</td> <td>94 00</td>	94 00		0,00000			c	94 00
96.00 09600 DURABLE MEDI CAL EQUI P-RENTED 0.000000 96.00 97.00 09700 DURABLE MEDI CAL EQUI P-SOLD 0.000000 97.00 98.00 09850 OTHER REI MBURSABLE COST CENTERS 0.000000 98.00 99.10 099710 CORF 99.10 99110 0001 18R SERVI CES-NOT APPRVD PRGM 100.00 101.00 10100 HOME HEALTH AGENCY 101.00 1010.00 10500 KI DNEY ACQUI SI TI ON 105.00 105.00 10500 KI DNEY ACQUI SI TI ON 105.00 107.00 107.00 107.00 107.00 107.00 107.00 107.00 107.00 107.00 107.00 107.00 107.00 107.00 107.00 107.00 107.00 107.00 107.00 107.00 108.00							
97.00 09700 DURABLE MEDI CAL EQUI P-SOLD 0.000000 97.00 98.00 09850 OTHER REIMBURSABLE COST CENTERS 0.000000 98.00 99.00 09900 CMHC 99.00 99.10 09910 CORF 99.00 100.00 10000 I & SERVI CES-NOT APPRVD PRGM 100.00 101.00 HOME HEALTH AGENCY 101.00 105.00 10500 KI DNEY ACQUI SI TI ON 105.00 105.00 10500 LIVER ACQUI SI TI ON 106.00 108.00 10800 LIVER ACQUI SI TI ON 106.00 108.00 10800 LIVER ACQUI SI TI ON 107.00 108.00 10800 LIVER ACQUI SI TI ON 108.00 109.00 INGESTI INAL ACQUI SI TI ON 108.00 109.00 109.00 INGO INTESTI NAL ACQUI SI TI ON 109.00 111.00 INTERST EXPENSE 111.00 110.00 113.00 11300 INTEREST EXPENSE 113.00 114.00 114.00 UT IL IZATI ON REVI EW-SNF 114.00							
99.00 09900 CMHC 99.00 09900 CMHC 99.00 99.10 09910 CORF 99.10 1000.00 10000 1&& SEVI CES-NOT APPRVD PRGM 100.00 101.00 HOME HEALTH AGENCY 101.00 10100 HOME HEALTH AGENCY 101.00 105.00 10500 K IDNEY ACQUI SITI ON 105.00 105.00 10500 10600 107.00 10600 107.00 10600 107.00 108.00 109.00 10900 10900 PANCREAS ACQUI SI TI ON 108.00 109.00 109.00 10900 10900 INTERST INAL ACQUI SI TI ON 110.00 110.00 110.00 110.00 111.00 111.00 111.00 111.00 111.00 111.00 111.00 111.00 111.00 111.00 111.00 111.00 114.00			0. 000000			ç	97.00
99.10 09910 CORF 99.10 100.00 1&& SERVICES-NOT APPRVD PRGM 100.00 101.00 10100 HOME HEALTH AGENCY 101.00 SPECIAL PURPOSE COST CENTERS 105.00 105.00 105.00 10500 KIDNEY ACQUISITION 105.00 106.00 10400 HART ACQUISITION 105.00 107.00 10700 LIVER ACQUISITION 106.00 108.00 10800 LUNG ACQUISITION 108.00 109.00 PANCREAS ACQUISITION 108.00 101.00 INTESTINAL ACQUISITION 100.00 111.00 INTERST EXPENSE 111.00 113.00 11300 INTEREST EXPENSE 113.00 114.00 114.00 UTILIZATION REVIEW-SNF 114.00			0. 000000				
100.00 1000 I & R SERVI CES-NOT APPRVD PRGM 100.00 101.00 10100 HOME HEALTH AGENCY 101.00 SPECI AL PURPOSE COST CENTERS 105.00 105.00 106.00 10600 HEART ACQUI SI TI ON 105.00 107.00 10700 LI VER ACQUI SI TI ON 106.00 108.00 10800 LUNG ACQUI SI TI ON 106.00 109.00 10800 LUNG ACQUI SI TI ON 107.00 109.00 PANCREAS ACQUI SI TI ON 108.00 109.00 INTESTI NAL ACQUI SI TI ON 108.00 101.00 INTERST INAL ACQUI SI TI ON 110.00 111.00 ISLET ACQUI SI TI ON 110.00 111.00 ISLET ACQUI SI TI ON 111.00 111.00 INTEREST EXPENSE 113.00 114.00 UTI LIZATI ON REVIEW-SNF 114.00							
101.00 1010 HOME HEALTH AGENCY 101.00 SPECIAL PURPOSE COST CENTERS 105.00 10500 KI DNEY ACQUI SI TI ON 105.00 106.00 10600 HEART ACQUI SI TI ON 106.00 106.00 107.00 10700 LI VER ACQUI SI TI ON 106.00 106.00 10800 LIVER ACQUI SI TI ON 107.00 107.00 10700 108.00 108.00 109.00 10900 PANCREAS ACQUI SI TI ON 100.00 110.00 110.00 110.00 111.00 111.00 111.00 111.00 111.00 111.00 111.00 111.00 113.00 114.00 114.00 114.00 114.00 114.00 114.00 114.00 114.00 114.00							
SPECIAL PURPOSE COST CENTERS 105.00 105.00 10500 KI DNEY ACQUI SI TI ON 105.00 106.00 10600 HEART ACQUI SI TI ON 106.00 107.00 10700 LI VER ACQUI SI TI ON 106.00 10800 LUNG ACQUI SI TI ON 107.00 107.00 10900 PANCREAS ACQUI SI TI ON 108.00 10900 PANCREAS ACQUI SI TI ON 109.00 110.00 INTESTI NAL ACQUI SI TI ON 110.00 111.00 INTERST EXPENSE 113.00 114.00 UTI LI ZATI ON REVIEW-SNF 114.00							
105. 00 10500 KI DNEY ACQUI SI TI ON 105. 00 106. 00 10600 HEART ACQUI SI TI ON 106. 00 107. 00 10700 LI VER ACQUI SI TI ON 107. 00 108. 00 10800 LUNG ACQUI SI TI ON 108. 00 109. 00 10900 PANCREAS ACQUI SI TI ON 108. 00 100. 01 INTESTI NAL ACQUI SI TI ON 109. 00 110. 00 INTESTI NAL ACQUI SI TI ON 110. 00 111. 00 INTEREST EXPENSE 113. 00 114. 00 UTI LI ZATI ON REVIEW-SNF 114. 00	101.00						51.00
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 108.00 101.00 INTESTINAL ACQUISITION 109.00 111.00 INTERST EXPENSE 110.00 114.00 UTILIZATION REVIEW-SNF 114.00	105.00					10	05.00
107.00 10700 LI VER ACQUI SI TI ON 107.00 108.00 10800 LUNG ACQUI SI TI ON 108.00 109.00 10900 PANCREAS ACQUI SI TI ON 109.00 110.00 INTESTI NAL ACQUI SI TI ON 110.00 111.00 INTEREST EXPENSE 111.00 114.00 11400 UTI LI ZATI ON REVIEW-SNF 114.00							
109.00 10900 PANCREAS ACQUISITION 109.00 110.00 11000 INTESTINAL ACQUISITION 110.00 111.00 11100 ISLET ACQUISITION 111.00 113.00 11300 INTEREST EXPENSE 113.00 114.00 114.00 114.00 114.00						10	07.00
110. 00 11000 INTESTINAL ACQUISITION 110. 00 111. 00 11100 ISLET ACQUISITION 111. 00 113. 00 11300 INTEREST EXPENSE 113. 00 114. 00 11400 UTILIZATION REVIEW-SNF 114. 00							
111. 00 11100 I SLET ACQUI SI TI ON 111. 00 113. 00 11300 INTEREST EXPENSE 113. 00 114. 00 114.00 UTI LI ZATI ON REVIEW-SNF 114. 00							
113. 00 11300 INTEREST EXPENSE 113. 00 114. 00 11400 UTI LI ZATI ON REVIEW-SNF 114. 00							
114. 00 11400 UTI LI ZATI ON REVIEW-SNF 114. 00							

Health Financial Systems	F	RANCI SCAN HEALTH	I MICHIGAN CITY	In Lieu of Form CMS-2552-10			
COMPUTATION OF RATIO OF COSTS	TO CHARGES		Provider CCN: 15-0015	Peri od:	Worksheet C		
				From 01/01/2020 To 12/31/2020		pared:	
					7/28/2021 7:4	1 pm	
			Title XVIII	Hospi tal	PPS		
Cost Center Descri	ption	PPS Inpatient					
		Ratio					
		11.00					
116.00 11600 H0SPI CE						116.00	
200.00 Subtotal (see inst	ructions)					200.00	
201.00 Less Observation E	Beds					201.00	
202.00 Total (see instruc	ctions)					202.00	

Heal th	th Financial Systems						
COMPLIT		OF	DATIO	OF	COSTS	ΤO	(

FRANCISCAN HEALTH MICHIGAN CITY

In Lieu of Form CMS-2552-10

Frem B/10/12020 Bprt 1.1 Titla XIX Hospital Cost Locat Center Description Titla XIX Hospital Cost Cost 1000 2.00 3.00 4.00 5.00 Cost Cost 1000 2.00 3.00 4.00 5.00 Cost Cost <td< th=""><th></th><th></th><th>RANCI SCAN HEALTH</th><th></th><th></th><th></th><th>u of Form CMS-</th><th>2552-10</th></td<>			RANCI SCAN HEALTH				u of Form CMS-	2552-10
Intervent Intervent <t< td=""><td>COMPU</td><td>TATION OF RATIO OF COSTS TO CHARGES</td><td></td><td>Provider C</td><td>F</td><td>rom 01/01/2020</td><td></td><td></td></t<>	COMPU	TATION OF RATIO OF COSTS TO CHARGES		Provider C	F	rom 01/01/2020		
Cost Emitter Bescription Total Cost (Pmill et et al. 200) Total Cost (Pmill et et al. 200					1	0 12/31/2020	Date/lime Pre 7/28/2021 7:4	epared: 1 pm
Cent Center Description Triat Cent (run West, et al.) Triat Cent All Triat Cent All Triat Cent All Triat Cent All MMAILERT ROUTE COST CENTERS 36, 318, 566 30, 316, 566 30,				Titl	e XIX		Cost	
From Next a A A A D		Cast Capton Decerintian	Tatal Cost	Thereasy Limit	Tatal Casta		Tatal Casta	
Part Int Burn Bart Int Strev IC CONT CENTERS 1.00 2.00 3.00 4.00 5.00 00 03000 INTERS VELOTIONS 33, 314, 565 35, 314, 565 0 3 0 3 0<		Cost center Description			Total Costs		Total Costs	
200 2.00 3.00 4.00 5.00 10001 AULTS & PULATINGS 9.311.5e0 9.311.5e0 0				naj .		Di Sal i Owaliee		
INPATE DUT. REVENT ROLE ON CONTROL CONTROL OF SUPERS 0								
01000 DADION FARLETS & FUNCTIONS 35.718.19.665 35.718.19.66 0			1.00	2.00	3.00	4.00	5.00	
11:00 D3100 INTENSIVE CONFERENCE 6, 566, 705 0				I	1	1		
22 00 02200 CORDMARY CARE UNIT 0 <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></td<>								
33.00 0.3300 0.3300 0.3300 0.3300 0.3300 0.3300 0.3300 0.3300 0.3300 0.3300 0.3300 0.3300 0.3300 0.3400 </td <td></td> <td></td> <td></td> <td></td> <td>6, 566, 705</td> <td>-</td> <td></td> <td></td>					6, 566, 705	-		
41.00 0.80000 0.8000 0.8000<			0					
00 00 0000 SUBPROVIDER - IFF 4, 367, 870 4, 367, 870 0 <td></td> <td></td> <td>0</td> <td></td> <td></td> <td>0</td> <td></td> <td>1</td>			0			0		1
41.00 0 4400 MRSERY 2. 672, 128 2. 672, 128 0	40.00		4, 367, 870		4, 367, 870	0 0	C	40.00
44.00 Deadod Skiller D. MIRSIN GFACILITY 0	41.00		0		C	0 0	C	41.00
45.00 O HSSOD INER NO. FARCH LITY 0 <t< td=""><td></td><td></td><td>1</td><td></td><td></td><td></td><td></td><td></td></t<>			1					
4.000 Delected DYHER LOUGY TERM CARE 0			-			-		
MARCILLARY SERVICE COST DENTERS 21,721,372 0								1
50.00 G5000 DFEARTING ROM 21, 721, 312 0 <	46.00		0			0		46.00
51:00 DESTOR PECOVERY ROOM 0 <td>50 00</td> <td></td> <td>21 721 312</td> <td></td> <td>21 721 312</td> <td>0</td> <td>0</td> <td>50.00</td>	50 00		21 721 312		21 721 312	0	0	50.00
52.00 05200 DELUVERY ROUE & LABOR ROOM 706, 371 706, 371 707, 486 0 52.0 532.00 552.00								
54.00 05400 RADIOLOGY-DIAGNOSTIC 9.922, 658 9.922, 658 0 05400 50.00 55.00 05500 RADIOLOGY-THERAPEUTIC 2,673, 207 2,673, 207 0 0 0 0 55.00 05500 RADIOLOGY-THERAPEUTIC 2,673, 207 2,673, 207 0 0 0 0 55.00 0			706, 371		706, 371			1
54.01 05401 ESED RADIOLOCY - DIARNESTIC 5.07, 836 0 05501 005501 0001AND CANCER CARE (TR 1.880, 570 0 </td <td></td> <td>05300 ANESTHESI OLOGY</td> <td>170, 486</td> <td></td> <td>170, 486</td> <td>0</td> <td></td> <td></td>		05300 ANESTHESI OLOGY	170, 486		170, 486	0		
55.00 00500 PADIOLORY-THERAPFUTIC 2,673,207 2,673,207 0 0 55.00 55.01 05500 00500 PADIOLAND CARCER CARE CTR 1,880,520 0 55.00 0 55.00 0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>								
55. 01 05501 WOOLAND CANCER CARE CTR 1,880,520 0 05.00 05.00 00 00 0 <t< td=""><td></td><td></td><td></td><td></td><td></td><td>-</td><td></td><td></td></t<>						-		
56. 00 056.00 056.00 056.00 056.00 0 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>								
57.0 00 0700 0<			1, 880, 520		1, 880, 520	-	-	
58. 00 05800 (MACHETT C RESONANCE I MAGENG (MRI.) 0			0			-		
59. 00 05900 CARDIAC CATHETERIZATION 3. 342, 964 3. 342, 964 0 59. 0 60. 00 06000 LABORATORY 11, 187, 373 11, 187, 373 0 <td></td> <td></td> <td>0</td> <td></td> <td></td> <td></td> <td></td> <td>1</td>			0					1
60.00 06000 LABORATORY 11, 187, 373 1 1, 187, 373 0 0 0, 00 61.00 0610 FS ED LAB SERVICES-PROM ONLY 0			3, 342, 964		3, 342, 964	-		
61:00 61:00 65:00 PRP CLINICAL LAB SERVICES-PRGMONLY 0 0 0 61:00 0 <t< td=""><td>60.00</td><td>06000 LABORATORY</td><td>11, 187, 373</td><td></td><td>11, 187, 373</td><td>0</td><td>C</td><td>60.00</td></t<>	60.00	06000 LABORATORY	11, 187, 373		11, 187, 373	0	C	60.00
62:00 63:00 63:00 63:00 63:00 63:00 63:00 63:00 63:00 63:00 63:00 63:00 63:00 63:00 63:00 63:00 63:00 64:00 <th< td=""><td>60. 01</td><td></td><td>2, 036, 131</td><td></td><td>2, 036, 131</td><td></td><td></td><td>60. 01</td></th<>	60. 01		2, 036, 131		2, 036, 131			60. 01
63:00 b6300 ELODD STORI NG, PROCESSI NG & TRANS. 49,376 49,376 0 0 64:00 64:00 64:00 0 0 0 0 0 0 64:00 64:00 66:00 0			0		C			
64.00 locado INTRAVENDUS THERAPY 0			0					
65:00 06500 PKSTCRATTORY THERAPY 1,942,095 0 1,942,095 0 0 65:00 66:00 06600 PKSTCRATTRAPRAPY 0			49, 376		49, 376			
66.00 06600 PHYSICAL THERAPY 3, 971, 304 0 3, 971, 304 0 0 66.00 67.00 06700 CCUMATIONAL THERAPY 0 0 0 0 67.00 67.00 67.00 67.00 67.00 68.00 68.00 68.00 68.00 68.00 68.00 68.00 68.00 68.00 68.00 67.00 67.00 67.00 0 0 0 68.00 67.00 67.00 0 0 0 67.00 67.00 0 0 0 70.00 0 0 0 70.00 70.00 14.308.290 0 0 71.00 73.00 <td< td=""><td></td><td></td><td>1 942 005</td><td>0</td><td>1 042 005</td><td>-</td><td></td><td>1</td></td<>			1 942 005	0	1 042 005	-		1
67:00 067:00 0CUPATIONAL THERAPY 0 0 0 0 67:00 <								1
68:00 068:00 SPEECH PATHOLOGY 0 0 0 0 69:00 06:00 06:00 06:00 06:00 06:00 00				-				1
70. 00 070.00 00.00	68.00		0	0	C	0 0	C	68.00
71.00 VO100 MEDICAL SUPPLIES CHARGED TO PATIENTS 6,892,107 6,892,107 0 71.00 72.00	69.00	06900 ELECTROCARDI OLOGY	3, 230, 157		3, 230, 157	0	C	69.00
72.00 07200 IMPL DEV. CHARGED TO PATIENTS 14, 308, 290 0 72.00 07300 DT300 DT300 </td <td></td> <td></td> <td>0</td> <td></td> <td>C</td> <td></td> <td></td> <td></td>			0		C			
73.00 ORJOCS CHARGED TO PATLENTS 30,255,528 30,255,528 0 0 73.00 74.00 07400 RENAL DIALYSIS 0 0 0 0 0 0 0 0 0 0 74.00 73.00 0 0 0 0 0 0 0 0 0 0 0 0 0 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 0								
74.00 07400 PENAL DI ALYSIS 0 0 0 74.00 75.00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 76.00 70.00 03202 CV RESOURCE CTR 0 0 0 0 0 76.00 0 0 0 0 76.00 0 0 0 0 76.00 0 0 0 0 76.00 0 0 0 0 76.00 76.00 76.00 0 0 0 76.00 76.00 76.00 0 0 0 76.00						-		1
75.00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 0 75.00 76.00 03200 CV RESOURCE CTR 0<								
76.00 03202 CV RESOURCE CTR 0								
OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 0 88.00 0 89.00 89.00 89.00 90.00 0 0 0 0 0 0 0 0 0 0 90.00 90.00 0			-					
88.00 08800 RURAL HEALTH CLINIC 0<	77.00	07700 ALLOGENEIC STEM CELL ACQUISITION	0		c	0 0	C	77.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0			1					
90.00 09000 CLINIC 0			-					
90.03 09003 INFUSION OP SERVICES 1,546,689 1,546,689 0 90.0 91.0 91.0 91.0 91.0 91.0 91.0 91.0 91.0 91.0 91.0 91.0 91.0 91.0 91.0 91.0 91.0 91.0 91.0 91.0 92.0			0			0		
91.00 09100 EMERGENCY 13, 502, 200 13, 502, 200 0 91.00 91.01 09101 FREE STANDING EMERGENCY DEPT 5, 779, 823 0 0 91.00 92.00 09200 00SERVATI ON BEDS (NON-DI STI NCT PART) 0 0 0 92.00 0 00 0 0 0 0 0 0 92.00 0 0 0 0 0 0 0 0 92.00 0 0 0 0 0 0 0 92.00 0 0 0 0 0 0 92.00 0 0 0 0 0 0 0 92.00 0 94.00 09400 HOME PROGRAM DI ALYSI S 0 0 0 94.00 95.00 09500 MABULANCE SERVI CES 0 0 0 0 95.00 96.00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 99.00 99010 CMF 0 0 99.00 99.00 <td< td=""><td></td><td></td><td>1 5/6 600</td><td></td><td>1 5/6 600</td><td></td><td></td><td></td></td<>			1 5/6 600		1 5/6 600			
91.01 09101 FREE STANDING EMERGENCY DEPT 5,779,823 5,779,823 0 0 91.0 92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0 0 0 92.0 0THER REI MBURSABLE COST CENTERS 0 0 0 94.00 94.00 0 0 0 94.00 94.00 0400 HOME PROGRAM DI ALYSI S 0 0 0 0 95.00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 95.00 96.00 97.00 97.00 0 0 0 97.00 9700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 97.00 9700 DURABLE MEDI CAL EQUI P-SOLD 0 0 98.00 98.00 99.00 09900 CMF 0 0 0 99.00 99.00 99.00 99.00 0 99.01 09910 CORF 0 0 0 99.01 0 99.01 0 101.0 0 101.0 0 0 101.0 0 101.0 0 101.0 0 101.0 0 101.0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>								
92.00 OP200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 92.00 OTHER REIMBURSABLE COST CENTERS 0 0 0 0 94.00 0 94.00 0 94.00 0 94.00 95.00 95.00 95.00 95.00 95.00 95.00 96.00 96.00 96.00 97.00 97.00 97.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>								
94.00 09400 HOME PROGRAM DI ALYSI S 0 0 0 0 94.00 95.00 95.00 09500 AMBULANCE SERVI CES 0 0 0 0 0 0 95.00 96.00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 0 0 95.00 96.00 96.00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 0 0 96.00 97.00							C	
95.00 09500 AMBULANCE SERVICES 0 0 0 95.00 95.00 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 0 0 96.00 97.00 97.00 97.00 97.00 DURABLE MEDICAL EQUIP-SOLD 0 0 0 0 97.00 98.00 98.00 98.00 98.00 98.00 98.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00								
96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 0 0 96.00 97.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 0 0 97.00 98.00 09850 OTHER REIMBURSABLE COST CENTERS 0 0 0 97.00 99.00 09900 CMHC 0 0 0 98.00 99.00 99.00 09910 CORF 0 0 99.00 99.10 09910 CORF 0 0 0 99.10 09910 CAR SERVICES-NOT APPRVD PRGM 0 0 0 100.00 1 & & & & & & & & & & & & & & & & & & &			-					
97.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 0 97.00 97.00 98.00 09850 OTHER REIMBURSABLE COST CENTERS 0 0 0 98.00 99.00 99.00 09900 CMHC 0 0 99.00 99.00 99.00 09910 CORF 0 0 0 99.00 <t< td=""><td></td><td></td><td>0</td><td></td><td>C</td><td>0</td><td></td><td></td></t<>			0		C	0		
98.00 09850 OTHER REIMBURSABLE COST CENTERS 0 0 0 98.00 99.00 09900 CMHC 0 0 99.00 99.00 09900 CMHC 0 0 0 99.00 </td <td></td> <td></td> <td>0</td> <td></td> <td></td> <td>0</td> <td></td> <td></td>			0			0		
99.00 09900 CMHC 0 0 99.00 90.00 90.00 <td></td> <td></td> <td>0</td> <td></td> <td></td> <td>0</td> <td></td> <td>1</td>			0			0		1
99.10 09910 CORF 0 0 99.10 100.00 1&R SERVICES-NOT APPRVD PRGM 0 0 0 100.00 101.00 10100 HOME HEALTH AGENCY 0 0 0 101.00 SPECIAL PURPOSE COST CENTERS SPECIAL PURPOSE COST CENTERS 0 0 105.00 106.00 10600 HEART ACQUISITION 0 0 105.00 106.00 10700 LIVER ACQUISITION 0 0 106.00 107.00 10700 LIVER ACQUISITION 0 0 106.00 107.00 LIVER ACQUISITION 0 0 0 106.00 107.00 LIVER ACQUISITION 0 0 0 106.00 108.00 LUNG ACQUISITION 0 0 0 0 108.00 109.00 10900 PANCREAS ACQUISITION 0 0 0 109.00 100.00 INTESTINAL ACQUISITION 0 0 0 109.00 110.00			0			0	-	
100.00 10000 I & R SERVI CES-NOT APPRVD PRGM 0 0 0 100.00 101.00 10100 HOME HEALTH AGENCY 0 0 0 101.00 SPECIAL PURPOSE COST CENTERS 5 5 0 0 0 105.00			0					1
101.00 10100 HOME HEALTH AGENCY 0 0 101.00 SPECIAL PURPOSE COST CENTERS			0					
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 0 108.00 109.00 10900 PANCREAS ACQUI SI TI ON 0 0 0 109.00 100.01 INTESTI NAL ACQUI SI TI ON 0 0 0 100.00			-					
106.00 10600 HEART ACQUISITION 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 INTESTINAL ACQUISITION 0 0 0 110.00			1					
107.00 107.00 LI VER ACQUI SI TI ON 0 0 107.00 107.00 107.00 107.00 107.00 107.00 107.00 108.00 0 0 0 108.00 108.00 108.00 108.00 0 0 108.00 108.00 108.00 108.00 0 108.00 108.00 108.00 108.00 108.00 108.00 108.00 108.00 108.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 0 0 0 109.00 109.00 109.00 100.00 100.00 0 0 0 0 100.00 110.00 109.00 100.00 0 0 0 0 0 0 100.00			-					
108.00 10800 LUNG ACQUISITION 0 0 108.00 109.00 10900 PANCREAS ACQUISITION 0 0 0 109.00 110.00 11000 INTESTINAL ACQUISITION 0 0 0 110.00			0					
109.00 10900 PANCREAS ACQUISITION 0 0 109.00 110.00 11000 INTESTINAL ACQUISITION 0 0 110.00			0					
110.00 11000 I NTESTI NAL ACQUISITI ON 0 0 110.00			0					
			0					
		11100 I SLET ACQUI SI TI ON	0					111.00

Health Financial Systems	FRANCI SCAN HEALTH	H MICHIGAN CITY	(In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2020 To 12/31/2020	Worksheet C Part I Date/Time Pre 7/28/2021 7:4	
		Titl	e XIX	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
113.0011300INTEREST EXPENSE114.0011400UTILIZATION REVIEW-SNF115.0011500AMBULATORY SURGICAL CENTER (D. P.)116.0011600HOSPICE200.00Subtotal (see instructions)201.00Less Observation Beds202.00Total (see instructions)	0 0 189, 111, 695 0 189, 111, 695		189, 111, 69	0	0 0 0	113.00 114.00 115.00 116.00 200.00 201.00 202.00

Health Financial Systems FF COMPUTATION OF RATIO OF COSTS TO CHARGES FF	RANCISCAN HEALTH		Y CN: 15-0015	Peri od:	u of Form CMS- Worksheet C	2552-10
				From 01/01/2020 To 12/31/2020	Part I Date/Time Pre 7/28/2021 7:4	
			e XIX	Hospi tal	Cost	
Cost Center Description	I npati ent	<u>Charges</u> Outpatient	Total (col. + col. 7)	6 Cost or Other Ratio	TEFRA I npati ent	
	6.00	7.00	8.00	9.00	Rati o 10.00	
INPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS 31. 00 03100 INTENSI VE CARE UNI T 32. 00 03200 CORONARY CARE UNI T 33. 00 03300 BURN INTENSI VE CARE UNI T 34. 00 03300 BURN INTENSI VE CARE UNI T	0 0 0 0			0 0 0 0		30.00 31.00 32.00 33.00
34. 00 03400 SURGI CAL I NTENSI VE CARE UNI T 40. 00 04000 SUBPROVI DER - I PF 41. 00 04100 SUBPROVI DER - I RF 43. 00 04300 NURSERY 44. 00 04400 SKI LLED NURSI NG FACI LI TY				0 0 0 0		34.00 40.00 41.00 43.00 44.00
45.00 04500 NURSING FACILITY 46.00 04600 OTHER LONG TERM CARE	0			0		45.00 46.00
ANCI LLARY SERVI CE COST CENTERS			1			
50. 00 05000 OPERATI NG ROOM 51. 00 05100 RECOVERY ROOM 52. 00 05200 DELI VERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY - DI AGNOSTI C 54. 01 05401 FSED RADI OLOGY - DI AGNOSTI C				0 0.000000 0 0.000000 0 0.000000 0 0.000000 0 0.000000 0 0.000000 0 0.000000 0 0.000000 0 0.000000	0.00000 0.00000 0.00000 0.00000 0.00000 0.000000	51.00 52.00 53.00 54.00
55.00 05500 RADI OLOGY-THERAPEUTI C 55.01 05501 WOODLAND CANCER CARE CTR 56.00 05600 RADI OLOGY-THERAPEUTI C 57.00 05700 CT SCAN 58.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI)	0 0 0 0			0 0.00000 0 0.000000 0 0.000000 0 0.000000 0 0.000000 0 0.000000	0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000	55.00 55.01 56.00 57.00
59.00 05900 CARDIAC CATHETERIZATION 60.00 06000 LABORATORY 60.01 06001 FS ED LAB 61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0 0 0 0 0		D D D D	0 0.000000 0 0.000000 0 0.000000 0 0.000000 0 0.000000 0 0.000000 0 0.000000	0. 000000 0. 000000 0. 000000 0. 000000 0. 000000	60.00 60.01 61.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 64. 00 06400 INTRAVENOUS THERAPY 65. 00 06500 RESPIRATORY THERAPY 66. 00 06600 PHYSICAL THERAPY 67. 00 06700 OCUPATIONAL THERAPY 60. 00 06500 RESPIRATORY	0 0 0 0			0 0.000000 0 0.000000 0 0.000000 0 0.000000 0 0.000000 0 0.000000 0 0.000000	0.000000 0.000000 0.000000 0.000000 0.000000	64.00 65.00 66.00 67.00
 68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 73. 00 07300 DRUGS CHARGED TO PATI ENTS 74. 00 07400 DENAL DEVALUELS 				0 0.000000 0 0.000000 0 0.000000 0 0.000000 0 0.000000 0 0.000000 0 0.000000 0 0.000000 0 0.000000 0 0.000000	0.000000 0.000000 0.000000 0.000000 0.000000	69.00 70.00 71.00 72.00 73.00
74.00 07400 RENAL DI ALYSI S 75.00 07500 ASC (NON-DI STI NCT PART) 76.00 03020 CV RESOURCE CTR 77.00 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON 0UTPATI ENT SERVI CE COST CENTERS	0 0 0	(0 0.00000 0 0.000000 0 0.000000 0 0.000000	0. 000000 0. 000000 0. 000000 0. 000000	75.00 76.00
88. 00 08800 RURAL HEALTH CLINIC 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 90. 00 09000 CLINIC	0 0 0	((()))	0 0.00000 0 0.000000 0 0.000000	0. 000000 0. 000000 0. 000000	89.00
90. 03 09003 I NFUSI ON OP SERVICES 91. 00 09100 EMERGENCY 91. 01 09101 FREE STANDING EMERGENCY DEPT 92. 00 095ERVATI ON BEDS (NON-DI STINCT PART) 0THER REIMBURSABLE COST CENTERS	0 0 0 0		D D D	0 0.00000 0 0.000000 0 0.000000 0 0.000000	0. 000000 0. 000000 0. 000000 0. 000000	91.00 91.01
94.00 09400 HOME PROGRAM DI ALYSI S 95.00 09500 AMBULANCE SERVI CES 96.00 09600 DURABLE MEDI CAL EQUI P-RENTED 97.00 09700 DURABLE MEDI CAL EQUI P-SOLD	0 0 0 0	((((D D D	0 0.000000 0 0.000000 0 0.000000 0 0.000000	0. 000000 0. 000000 0. 000000 0. 000000	95.00 96.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS 99.00 09900 CMHC 99.10 09910 CORF 100.00 10000 I & SERVI CES-NOT APPRVD PRGM 101.00 10100 HME	0 0 0 0))))	0 0.000000 0 0 0 0	0. 000000	98.00 99.00 99.10 100.00 101.00
SPECIAL PURPOSE COST CENTERS 105.00 10500 KI DNEY ACQUI SI TI ON 106.00 10600 HEART ACQUI SI TI ON 107.00 10700 LI VER ACQUI SI TI ON 108.00 10800 LUNG ACQUI SI TI ON 109.00 D0900 PANCREAS ACQUI SI TI ON	0 0 0 0 0		D D D D	0 0 0 0		105.00 106.00 107.00 108.00 109.00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON 111. 00 11100 I SLET ACQUI SI TI ON 113. 00 11300 I NTEREST EXPENSE	000	(D D	0 0		110. 00 111. 00 113. 00

Health Financial Systems FF	In Lie	eu of Form CMS-	2552-10			
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2020	Worksheet C Part I	
			To 12/31/2020	Date/Time Pre 7/28/2021 7:4	epared: 11 pm	
	Title XIX			Hospi tal	Cost	
	Charges					
Cost Center Description	I npati ent	Outpati ent	Total (col.	6 Cost or Other	TEFRA	
			+ col. 7)	Ratio	Inpati ent	
					Ratio	
	6.00	7.00	8.00	9.00	10.00	
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)	0	0		0		200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	0	0		0	l	202.00

leal th	Financial Systems	RANCI SCAN HEALTH	MICHIGAN CITY	In Lie	u of Form CMS	-2552-10
	ATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0015	Peri od: From 01/01/2020 To 12/31/2020	Worksheet C Part I Date/Time Pro 7/28/2021 7:4	epared:
		1	Title XIX	Hospi tal	Cost	
	Cost Center Description	PPS Inpatient Ratio 11.00				
	INPATIENT ROUTINE SERVICE COST CENTERS	11.00				
	03000 ADULTS & PEDI ATRI CS					30.00
	03100 INTENSIVE CARE UNIT					31.00
	03200 CORONARY CARE UNIT					32.00
	03300 BURN INTENSIVE CARE UNIT					33.00
	03400 SURGI CAL I NTENSI VE CARE UNI T					34.00
0.00	04000 SUBPROVIDER - IPF					40.00
1.00 3.00	04100 SUBPROVI DER – I RF 04300 NURSERY					41.00
	04400 SKI LLED NURSI NG FACI LI TY					43.00
5.00	04500 NURSI NG FACILI TY					45.00
6.00	04600 OTHER LONG TERM CARE					46.00
	ANCI LLARY SERVICE COST CENTERS					
0. 00	05000 OPERATI NG ROOM	0.000000				50.00
1.00	05100 RECOVERY ROOM	0.000000				51.00
2.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000				52.00
	05300 ANESTHESI OLOGY	0. 000000				53.00
4.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.0
4.01	05401 FSED RADIOLOGY - DIAGNOSTIC	0.000000				54.0
5.00	05500 RADI OLOGY-THERAPEUTI C	0. 000000				55.0
	05501 WOODLAND CANCER CARE CTR	0. 000000				55.0
6.00	05600 RADI OI SOTOPE	0. 000000				56.0
7.00 8.00	05700 CT SCAN	0. 000000				57.0 58.0
8.00 9.00	05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION	0. 000000 0. 000000				59.0
0.00	06000 LABORATORY	0. 000000				60.0
0.00	06001 FS ED LAB	0. 000000				60.0
1.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000				61.0
2.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000				62.0
3.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000				63.0
4.00	06400 I NTRAVENOUS THERAPY	0. 000000				64.0
5.00	06500 RESPI RATORY THERAPY	0.000000				65.0
6.00	06600 PHYSI CAL THERAPY	0. 000000				66.00
7.00	06700 OCCUPATI ONAL THERAPY	0. 000000				67.0
8.00	06800 SPEECH PATHOLOGY	0.000000				68.0
9.00	06900 ELECTROCARDI OLOGY	0. 000000				69.0
	07000 ELECTROENCEPHALOGRAPHY	0. 000000				70.0
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000 0. 000000				71.0
	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000				73.0
	07400 RENAL DIALYSIS	0. 000000				74.0
	07500 ASC (NON-DI STINCT PART)	0. 000000				75.0
	03020 CV RESOURCE CTR	0.000000				76.0
	07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000				77.0
	OUTPATIENT SERVICE COST CENTERS					
	08800 RURAL HEALTH CLINIC	0. 000000				88.00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000				89.0
		0.00000				90.0
	09003 INFUSION OP SERVICES 09100 EMERGENCY	0.00000				90.0
	09100 EMERGENCY 09101 FREE STANDING EMERGENCY DEPT	0. 000000				91.0
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000 0. 000000				91.0
2.00	OTHER REIMBURSABLE COST CENTERS	0.00000				- 72.0
4.00	09400 HOME PROGRAM DI ALYSI S	0.000000				94.0
	09500 AMBULANCE SERVICES	0. 000000				95.0
	09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000				96.0
	09700 DURABLE MEDICAL EQUIP-SOLD	0. 000000				97.0
	09850 OTHER REIMBURSABLE COST CENTERS	0. 000000				98.0
	09900 СМНС					99.0
	09910 CORF					99.1
	10000 I &R SERVICES-NOT APPRVD PRGM					100. 0
01.00	10100 HOME HEALTH AGENCY					101.00
05 05	SPECIAL PURPOSE COST CENTERS					105 -
	10500 KIDNEY ACQUISITION					105.0
	10600 HEART ACQUI SI TI ON					106.0
	10700 LIVER ACQUISITION					107.0
	10800 LUNG ACQUI SI TI ON					108.0
	10900 PANCREAS ACQUISITION 11000 INTESTINAL ACQUISITION					109. 0 110. 0
	TTOOOTINIESTINAL ACCUISTICN					111.0
10.00	11100 ISLET ACOULSTION	1				
10.00 11.00	11100 I SLET ACQUI SI TI ON 11300 I NTEREST EXPENSE					
10.00 11.00 13.00	11100 I SLET ACQUI SI TI ON 11300 I NTEREST EXPENSE 11400 UTI LI ZATI ON REVI EW-SNF					113. 0 114. 0

Health Finan	cial Systems	FRANCI SCAN HEALTH	MICHIGAN CITY	In Lieu of Form CMS-2552-10			
COMPUTATI ON	OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0015	Peri od:	Worksheet C		
				From 01/01/2020 To 12/31/2020		pared:	
					7/28/2021 7:4	1 pm	
			Title XIX	Hospi tal	Cost		
	Cost Center Description	PPS Inpatient					
		Ratio					
		11.00					
116.00 11600	HOSPI CE					116.00	
200.00	Subtotal (see instructions)					200.00	
201.00	Less Observation Beds					201.00	
202.00	Total (see instructions)					202.00	

Health Financial Systems	RANCI SCAN HEALTH	H MICHIGAN CIT	Y	In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	_ COSTS	Provider C		Period: From 01/01/2020 To 12/31/2020	Date/Time Pre 7/28/2021 7:4	
		Titl€	e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,	-	Related Cost	t l		
	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, 651, 259	C	5, 651, 2	59 21, 916	257.86	30.00
31.00 INTENSIVE CARE UNIT	1, 159, 105		1, 159, 10	3, 764	307.95	31.00
32. 00 CORONARY CARE UNIT	0			0 0	0.00	
33. 00 BURN INTENSIVE CARE UNIT	0			0 0	0.00	
34. 00 SURGI CAL I NTENSI VE CARE UNI T	0			0 0	0.00	•
40. 00 SUBPROVIDER - IPF	1, 054, 921	C	1, 054, 92	3, 358		•
41. 00 SUBPROVIDER - IRF	1,004,721		1,004,72	0 0,000	0.00	
43. 00 NURSERY	508, 263	C C	508, 20	53 842	603.64	
44. 00 SKILLED NURSING FACILITY	500, 205		500, 20	0 042	0.00	
45. 00 NURSING FACILITY	0			0 0		44.00
	0 272 540		0 272 5			45.00 200.00
200.00 Total (lines 30 through 199) Cost Center Description	8, 373, 548 I npati ent		8, 373, 54	18 29, 880		200.00
Cost center Description		Inpati ent				
	Program days	Program Capital Cost				
		(col. 5 x col.				
		(COL 5 X COL 6)				
	6.00	7.00	4			
INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00				
30. 00 ADULTS & PEDIATRICS	9, 820	2, 532, 185	:			30.00
31. 00 INTENSIVE CARE UNIT	1, 155		•			31.00
32.00 CORONARY CARE UNIT	1, 100	300,002	-			31.00
	0					
33. 00 BURN INTENSIVE CARE UNIT	0	L L				33.00
34. 00 SURGI CAL I NTENSI VE CARE UNI T	0					34.00
40.00 SUBPROVIDER - IPF	104	32, 672				40.00
41.00 SUBPROVIDER - IRF	0	C				41.00
43. 00 NURSERY	0	C				43.00
44.00 SKILLED NURSING FACILITY	0	C				44.00
45.00 NURSING FACILITY	0	C				45.00
200.00 Total (lines 30 through 199)	11, 079	2, 920, 539	2			200.00

	I FINANCIAL SYSTEMS FF TIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	RANCISCAN HEALT	Provider C		Period:	u of Form CMS-2 Worksheet D	
					From 01/01/2020 To 12/31/2020	Date/Time Pre	pared:
						7/28/2021 7:4	1 pm
	Cost Center Description	Capi tal	Total Charges	XVIII	Hospital t Inpatient	PPS Capital Costs	
	cost center bescription		(from Wkst. C,	to Charges	Program	(column 3 x	
		(from Wkst. B,	Part I, col.	$(col. 1 \div col$		column 4)	
		Part II, col.	8)	2)	i ondrigeo		
		26)		, í			
		1.00	2.00	3.00	4.00	5.00	
	ANCI LLARY SERVICE COST CENTERS	1	1	-			
50.00	05000 OPERATI NG ROOM	6, 776, 255	127, 263, 350			413, 261	50.00
51.00	05100 RECOVERY ROOM	0	, °	0.0000		0	
52.00	05200 DELIVERY ROOM & LABOR ROOM	359, 882				0	
53.00	05300 ANESTHESI OLOGY	43, 931				3, 429	
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 676, 985				137, 418	
54.01	05401 FSED RADIOLOGY - DIAGNOSTIC	1, 547, 707				0	
55.00	05500 RADI OLOGY-THERAPEUTI C	522, 509				64, 662	
55.01	05501 WOODLAND CANCER CARE CTR	700, 123				15, 969	
56.00	05600 RADI OI SOTOPE	0	-	0.0000		0	
57.00	05700 CT SCAN	0	-			0	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	-			0	
59.00	05900 CARDI AC CATHETERI ZATI ON	987, 746				63, 904	
60.00	06000 LABORATORY	726, 807				73, 188	•
60. 01	06001 FS ED LAB	108, 479	11, 786, 107	0.00920	04 0	0	
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0.0000		0	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	24, 970	1, 367, 218			0	
64.00	06400 I NTRAVENOUS THERAPY	0	0	0.0000		0	
65.00	06500 RESPI RATORY THERAPY	260, 214				21, 455	
66.00	06600 PHYSI CAL THERAPY	189, 560	17, 400, 286			5, 146	
67.00	06700 OCCUPATI ONAL THERAPY	0	0			0	
68.00	06800 SPEECH PATHOLOGY	0	0			0	
69.00	06900 ELECTROCARDI OLOGY	842, 429	27, 206, 021			96, 780	•
70.00	07000 ELECTROENCEPHALOGRAPHY	0	, s	0.0000		0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	96, 072				6, 636	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	197, 800				15, 630	•
73.00	07300 DRUGS CHARGED TO PATIENTS	841, 834	137, 062, 698			34, 381	•
74.00	07400 RENAL DI ALYSI S	0	-	0.0000		0	
75.00	07500 ASC (NON-DISTINCT PART)	0	-			0	75.00
76.00	03020 CV RESOURCE CTR	0	-			0	
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0.0000	0 00	0	77.00
	OUTPATIENT SERVICE COST CENTERS	-					
88.00	08800 RURAL HEALTH CLINIC	0	-			0	
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	-			0	
90.00	09000 CLI NI C	0	-			0	
90. 03	09003 INFUSION OP SERVICES	240, 660				0	
91.00	09100 EMERGENCY	1, 613, 466				72, 083	
91.01	09101 FREE STANDING EMERGENCY DEPT	1, 756, 689				0	91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	48, 735	7, 603, 004	0.0064	10 175, 347	1, 124	92.00
	OTHER REIMBURSABLE COST CENTERS	1	1	1	- 1		
94.00	09400 HOME PROGRAM DI ALYSI S	0	0	0.0000	0 00	0	
95.00	09500 AMBULANCE SERVICES						95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	-			0	
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0	-			0	
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0	, v	0.0000		0	
200.00) Total (lines 50 through 199)	20, 562, 853	775, 129, 361		44, 654, 501	1, 025, 066	1200.00

Health Financial Systems	FRANCI SCAN HEALTH	H MICHIGAN CIT	(In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER	PASS THROUGH COS	TS Provider C	F	eriod: rom 01/01/2020 o 12/31/2020		pared: 1 pm
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School	Nursing School	Allied Health	Allied Health	All Other	
	Post-Stepdown	-	Post-Stepdown	Cost	Medi cal	
	Adjustments		Adjustments		Education Cost	
	1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	C	C	0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	l a		0	0	31.00
32.00 03200 CORONARY CARE UNI T	0		0	0	0	
33. 00 03300 BURN INTENSIVE CARE UNIT	0			-	0	
34. 00 03400 SURGI CAL I NTENSI VE CARE UNI T	0			0	0	
40. 00 04000 SUBPROVIDER - IPF	0			0	0	
	0			Ŭ	-	
41. 00 04100 SUBPROVIDER - IRF	0	0	C	Ŭ	0	
43. 00 04300 NURSERY	0	0	C	0	0	
44.00 04400 SKILLED NURSING FACILITY	0	0	C	0		44.00
45.00 04500 NURSING FACILITY	0	0	C	0		45.00
200.00 Total (lines 30 through 199)	0	0	C	0	0	200.00
Cost Center Description	Swing-Bed	Total Costs	Total Patient	Per Diem (col.	Inpati ent	
· · · · · · · · · · · · · · · · · · ·	Adjustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,				
	instructions)	minus col. 4)				
	4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	0.00	0.00	7.00	0.00	
30. 00 03000 ADULTS & PEDIATRICS	0	C	21, 916	0.00	9, 820	30.00
	0					
31. 00 03100 I NTENSI VE CARE UNI T		0	-,			•
32. 00 03200 CORONARY CARE UNI T		0	C			
33.00 03300 BURN INTENSIVE CARE UNIT		0	C			
34.00 03400 SURGICAL INTENSIVE CARE UNIT		0	C	0.00	0	34.00
40. 00 04000 SUBPROVI DER - I PF	0	0	3, 358	0.00	104	40.00
41.00 04100 SUBPROVIDER - IRF	0	0	C	0.00	0	41.00
43.00 04300 NURSERY		l a	842	0.00	0	43.00
44. 00 04400 SKILLED NURSING FACILITY			0			•
45. 00 04500 NURSING FACILITY						
200.00 Total (lines 30 through 199)						200.00
	I npati ent	0	29,000		11,079	200.00
Cost Center Description						
	Program					
	Pass-Through					
	Cost (col. 7 x					
	col. 8)					
	9.00					
INPATIENT ROUTINE SERVICE COST CENTERS		1				
30. 00 03000 ADULTS & PEDIATRICS	0					30.00
31.00 03100 INTENSIVE CARE UNIT	0					31.00
32.00 03200 CORONARY CARE UNIT	0					32.00
33.00 03300 BURN INTENSIVE CARE UNIT	0					33.00
34. 00 03400 SURGI CAL I NTENSI VE CARE UNI T	0					34.00
40. 00 04000 SUBPROVIDER - IPF	0					40.00
40.00 04000 SUBPROVIDER - TFT 41.00 04100 SUBPROVIDER - TRF	0					40.00
	0					•
43. 00 04300 NURSERY	0					43.00
44.00 04400 SKILLED NURSING FACILITY	0					44.00
45.00 04500 NURSING FACILITY	0					45.00
200.00 Total (lines 30 through 199)	0					200.00
						•

PPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE HROUGH COSTS	RVICE OTHER PAS	S Provider C	CN: 15-0015	Period: From 01/01/2020	Worksheet D Part IV	
				To 12/31/2020	Date/Time Pre 7/28/2021 7:4	pared: 1 pm
			XVIII	Hospi tal	PPS	
Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing Scho	ol Allied Health Post-Stepdown Adjustments	Allied Health	
	1.00	2A	2.00	3A	3.00	
ANCI LLARY SERVI CE COST CENTERS		1				
D. 00 05000 OPERATI NG ROOM	0	0		0 0	0	50.0
1.00 05100 RECOVERY ROOM	0	0		0 0	0	51.0
2.00 05200 DELIVERY ROOM & LABOR ROOM	0	-		0 0	0	52.0
3. 00 05300 ANESTHESI OLOGY	0	-		0 0	0	53.0
4. 00 05400 RADI OLOGY-DI AGNOSTI C	0	-		0 0	0	54.0
4. 01 05401 FSED RADIOLOGY - DIAGNOSTIC	0	-		0 0	0	54.0
5. 00 05500 RADI OLOGY - THERAPEUTI C	0	0		0 0	0	55.0
5.01 05501 WOODLAND CANCER CARE CTR	0	0		0 0	0	55.0
5. 00 05600 RADI 0I SOTOPE	0	0		0 0	0	56.0
7.00 05700 CT SCAN	0	0		0 0	0	57.0
B. OO 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0	0	58.0
9. 00 05900 CARDIAC CATHETERIZATION	0	0		0 0	0	59.0
D. 00 06000 LABORATORY	0	0		0 0	0	60.0
D. 01 06001 FS ED LAB	0	0		0 0	0	60.0
1.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.0
2.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	-		0 0	0	62.0
3.00 06300 BLOOD STORING, PROCESSING & TRANS.	0			0 0	0	63.0
4. 00 06400 I NTRAVENOUS THERAPY	0	-		0 0	0	64.0
5. 00 06500 RESPI RATORY THERAPY	0	0		0 0	0	65.0
5. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66.0
7.00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67.0
3. 00 06800 SPEECH PATHOLOGY	0	0		0 0	0	68.0
9. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	
D. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	-		0 0	0	71. (
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	-		0 0	0	72. (
3. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.
4. 00 07400 RENAL DIALYSIS	0	0		0 0	0	
5.00 07500 ASC (NON-DISTINCT PART)	0	0		0 0	0	75.0
5. 00 03020 CV RESOURCE CTR	0	-		0 0	0	
7. 00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0		0 0	0	77. (
	0	0	1			
B. 00 08800 RURAL HEALTH CLINIC	0			0 0	0	88.0
9. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0			0 0	0	89.0
	0	-		0 0	0	90.0
D. 03 09003 I NFUSI ON OP SERVI CES	0	-		0 0	0	90.0
	0	-		0 0	0	91.0
1. 01 09101 FREE STANDING EMERGENCY DEPT	0	-		0 0	0	91.0
2. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) OTHER REI MBURSABLE COST CENTERS	0	<u> </u>	I	0	0	92.0
4. 00 09400 HOME PROGRAM DI ALYSI S	0	0		0 0	0	94. (
5. 00 09500 AMBULANCE SERVICES						95. (
5. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0 0	0	96.0
7. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0		0 0	0	97.
3. 00 09850 OTHER REIMBURSABLE COST CENTERS	0	0		0 0	0	
DO.00 Total (lines 50 through 199)	0			0 0		200.

	RANCI SCAN HEALTH				eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE THROUGH COSTS	RVICE OTHER PAS	S Provider C	CN: 15-0015	Period: From 01/01/2020 To 12/31/2020		pared:
					7/28/2021 7:4	1 pm
Cost Conton Description	ALL Other		XVIII	Hospital	PPS	
Cost Center Description	All Other Medical	Total Cost (sum of cols.	Total Outpatient		Ratio of Cost to Charges	
	Education Cost	•	Cost (sum o		(col. 5 ÷ col.	
		4)	col s. 2, 3,		7)	
		.,	and 4)	0)	(see	
					instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVI CE COST CENTERS		•	•			
50. 00 05000 OPERATI NG ROOM	0	0		0 127, 263, 350	0.000000	50.00
51.00 05100 RECOVERY ROOM	0	0		0 0	0.000000	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 3, 135, 225	0.000000	52.00
53. 00 05300 ANESTHESI OLOGY	0	0		0 7, 964, 181	0.000000	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 104, 854, 845	0.000000	54.00
54. 01 05401 FSED RADI OLOGY - DI AGNOSTI C	0	0		0 21, 850, 178	0.000000	54.01
55. 00 05500 RADI OLOGY - THERAPEUTI C	0	0		0 15, 816, 256	0.000000	55.00
55.01 05501 WOODLAND CANCER CARE CTR	0	0		0 4, 631, 648	0.000000	55.01
56. 00 05600 RADI OI SOTOPE	0	0		0 0	0.000000	56.00
57.00 05700 CT SCAN	0	0		0 0	0.000000	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0	0.000000	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 29, 303, 802	0.000000	59.00
60. 00 06000 LABORATORY	0	0		0 83, 317, 092	0.000000	60.00
60. 01 06001 FS ED LAB	0	0		0 11, 786, 107	0.000000	60. 01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0 0	0.000000	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 1, 367, 218	0. 000000	63.00
64.00 06400 INTRAVENOUS THERAPY	0	0		0 0	0. 000000	64.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 17, 525, 728	0. 000000	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 17, 400, 286	0. 000000	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 0		
68.00 06800 SPEECH PATHOLOGY	0	0		0 0	0.000000	
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 27, 206, 021	0.000000	
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0.000000	1
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 29, 429, 594		
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 27, 549, 477		
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 137, 062, 698		
74.00 07400 RENAL DI ALYSI S	0	0		0 0	0.000000	
75.00 07500 ASC (NON-DI STINCT PART)	0	0		0 0		
76.00 03020 CV RESOURCE CTR	0			0 0		
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0		0 0	0.000000	77.00
OUTPATIENT SERVICE COST CENTERS					0.000000	
88.00 08800 RURAL HEALTH CLINIC	0	0		0 0		
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0		
90. 00 09000 CLINIC	0	0		0 0		
90. 03 09003 INFUSION OP SERVICES 91. 00 09100 EMERGENCY	0			0 4, 053, 800		
	0			0 78, 653, 715 0 17 355 136		
91. 01 09101 FREE STANDING EMERGENCY DEPT	0	0		0 1770007100		
92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) OTHER REI MBURSABLE COST CENTERS	0	0	1	0 7,603,004	0.000000	92.00
94. 00 09400 HOME PROGRAM DI ALYSI S	0	0		0	0.000000	94.00
95. 00 09500 AMBULANCE SERVICES				0	0.00000	94.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	n –		0	0. 000000	1
97. 00 09700 DURABLE MEDICAL EQUIP-RENTED				0 0		
98. 00 09850 OTHER REI MBURSABLE COST CENTERS	0	0		0 0		
200.00 Total (lines 50 through 199)	0			0 775, 129, 361		200.00
200.00 [10tal (11163 30 through 177)	1 0	1 0	I	0 113, 127, 301	I	200.00

APPORT	Financial Systems Fi TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEE		Provider C		Peri od:	eu of Form CMS-2 Worksheet D	2002 10
	COSTS	WHEE OTHER TROO		. 10 0010	From 01/01/2020	Part IV	
					To 12/31/2020	Date/Time Pre 7/28/2021 7:4	pared:
			Title	XVIII	Hospi tal	PPS	
	Cost Center Description	Outpatient	Inpati ent	I npati ent	Outpati ent	Outpati ent	
	•	Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Throug	h Charges	Pass-Through	
		(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
		7)		x col. 10)		x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
F0 00	ANCI LLARY SERVICE COST CENTERS	0.000000	7 7/1 051		0 00 0/5 554	0	
50.00	05000 OPERATING ROOM	0.000000	7, 761, 351		0 22, 865, 554		50.00
51.00	05100 RECOVERY ROOM	0.000000	0		0 0	-	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0		0 0	-	52.00
53.00	05300 ANESTHESI OLOGY	0.000000	621, 697		0 1, 944, 384		53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0.000000	5, 382, 620		0 24, 096, 122		54.00
54.01	05401 FSED RADI OLOGY - DI AGNOSTI C	0.000000	0		0 0	-	54.01
55.00	05500 RADI OLOGY-THERAPEUTI C	0.000000	1, 957, 322		0 5, 257, 490		55.00
55.01	05501 WOODLAND CANCER CARE CTR	0.000000	105, 645		0 0	-	55.01
56.00	05600 RADI OI SOTOPE	0. 000000	0		0 0	-	56.00
57.00	05700 CT SCAN	0. 000000	0		0 0	-	57.00
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0.000000	0		0 0	-	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	1, 895, 858		0 2, 967, 399		59.00
60.00	06000 LABORATORY	0. 000000	8, 390, 274		0 2, 136, 559		60.00
60. 01	06001 FS ED LAB	0. 000000	0		0 0	0	60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	0		0 0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0		0 0	-	63.00
64.00	06400 I NTRAVENOUS THERAPY	0.000000	0		0 0	, v	64.00
65.00	06500 RESPI RATORY THERAPY	0.000000	1, 445, 007		0 232, 366		65.00
66.00	06600 PHYSI CAL THERAPY	0.000000	472, 346		0 63, 880		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000	0		0 0		67.00
68.00		0.000000	0		0 0	, v	68.00
69.00	06900 ELECTROCARDI OLOGY	0.000000	3, 125, 468		0 11, 158, 070		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0		0 0	0	70.00
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0.000000	2,033,099		0 3, 428, 668		71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0.000000	2, 176, 882		0 3, 926, 276		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	5, 597, 757		0 43, 467, 714		73.00
74.00	07400 RENAL DIALYSIS	0.000000	0		0 0	-	74.00
75.00	07500 ASC (NON-DI STINCT PART)	0.000000	0		0 0		75.00
76.00 77.00	03020 CV RESOURCE CTR 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON	0.000000	0		0 0		76.00
//.00	OUTPATIENT SERVICE COST CENTERS	0.000000	0		0 0	0	//.00
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	-	90.00
90.03	09003 I NFUSI ON OP SERVI CES	0.000000	0		0 0		90.03
91.00	09100 EMERGENCY	0.000000	3, 513, 828		0 9, 511, 654	-	91.00
91.00	09101 FREE STANDING EMERGENCY DEPT	0.000000	3, 513, 626		0 9, 511, 054	0	91.00
91.01	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	175, 347		0 1, 290, 785		91.01
7Z. UU	OTHER REIMBURSABLE COST CENTERS	0.000000	170, 347		0 1,290,785	0	72.00
94.00	09400 HOME PROGRAM DI ALYSI S	0.000000	0		0 0	0	94.00
94.00 95.00	09500 AMBULANCE SERVICES	0.000000	0				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		97.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0.000000	0		0 0		98.00
98 00							

	Financial Systems Ff IONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	RANCISCAN HEALTI VACCINE COST	Provi der C		Peri od: From 01/01/2020 To 12/31/2020	u of Form CMS-: Worksheet D Part V Date/Time Pre 7/28/2021 7:4	pared:
		1	Title	XVIII	Hospi tal	PPS	
				Charges		Costs	
	Cost Center Description		PPS Reimbursed		Cost	PPS Services	
		Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins			
		1.00	2.00	(see inst.) 3.00	(see inst.) 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	0. 170680	22, 865, 554		0 0	3, 902, 693	50.00
51.00	05100 RECOVERY ROOM	0. 000000			0 0	3, 702, 073	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 225302			0 0	0	52.00
53.00	05300 ANESTHESI OLOGY	0. 021407			0 0	41, 623	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 094632			0 0	2, 280, 264	54.00
54.00	05401 FSED RADIOLOGY - DIAGNOSTIC	0. 231936			0 0	2, 200, 204	54.00
55.00	05500 RADI OLOGY - THERAPEUTI C	0. 231930			0 0	888, 600	
55.00	05501 WOODLAND CANCER CARE CTR	0. 406015			0 0	000	
56.00	05600 RADI OI SOTOPE	0. 408013			0 0	0	56.00
57.00	05700 CT SCAN	0. 000000			0 0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000			0 0	0	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 114080	-		0 0	338, 521	59.00
60.00	06000 LABORATORY	0. 134275			0 0	286, 886	60.00
60.00	06001 FS ED LAB	0. 172757			0 0	200, 000	60.00
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000			0 0	0	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000			0 0	0	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 036114			0 0	0	63.00
64.00	06400 I NTRAVENOUS THERAPY	0. 000000			0 0	0	64.00
65.00	06500 RESPI RATORY THERAPY	0. 110814	232, 366		0 0	25, 749	
66.00	06600 PHYSI CAL THERAPY	0. 228232			0 0	14, 579	
67.00	06700 OCCUPATI ONAL THERAPY	0. 220232			0 0	0	
68.00	06800 SPEECH PATHOLOGY	0. 000000			0 0	0	
69.00	06900 ELECTROCARDI OLOGY	0. 118729			0 0	1, 324, 786	1
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000			0 0	0	70.00
	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0. 234190			0 0	802, 960	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 519367			0 0	2, 039, 178	
	07300 DRUGS CHARGED TO PATIENTS	0. 220742			0 1, 883	9, 595, 150	
74.00	07400 RENAL DI ALYSI S	0. 000000			0 0	0	74.00
	07500 ASC (NON-DISTINCT PART)	0. 000000			0 0	0	
76.00	03020 CV RESOURCE CTR	0.000000			0 0	0	76.00
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION	0.000000			0 0	0	77.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC						88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER						89.00
90.00	09000 CLI NI C	0. 000000	0		0 0	0	90.00
	09003 INFUSION OP SERVICES	0. 381541			0 0	0	
91.00	09100 EMERGENCY	0. 171666	9, 511, 654		0 0	1, 632, 828	91.00
	09101 FREE STANDING EMERGENCY DEPT	0. 333032	0		0 0	0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 040070	1, 290, 785		0 0	51, 722	92.00
	OTHER REIMBURSABLE COST CENTERS			•			
94.00	09400 HOME PROGRAM DI ALYSI S	0. 000000			0 0		94.00
95.00	09500 AMBULANCE SERVICES	0. 000000			0		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	
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0. 000000	0		0 0	0	98.00
200.00			132, 346, 921		0 1, 883	23, 225, 539	
201.00					0 0		201.00
	Only Charges						
202.00	Net Charges (line 200 - line 201)	1	132, 346, 921	1	0 1,883	23, 225, 539	000

Cost Center Description Cost Sect Environment Survices Cost Sect Environment Survices Ittle XVIII Hospital PPS Cost Center Description Environment Survices En	Health Financial Systems Fi	RANCISCAN HEALTH N	MICHIGAN CITY	In Lie	u of Form CMS-2552-10
Unite VIII Hospital PPS Cost Cost <t< td=""><td>APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES ANI</td><td>D VACCINE COST</td><td>Provider CCN: 15-0015</td><td>From 01/01/2020</td><td>Part V Date/Time Prepared:</td></t<>	APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES ANI	D VACCINE COST	Provider CCN: 15-0015	From 01/01/2020	Part V Date/Time Prepared:
Cost Center Description Cost Reinbursed Services Cost Reinbursed Reinbursed Cost Reinbursed Reinbursed Cost Reinbursed MACILLARY SERVICE COST CENTERS Ded & Coins: Cost Center Description 50:00 DECOMPT ROOM 0 0 0 Description Descrint			Title XVIII	Hospi tal	
Reinbursed Subject To Dect. & Corns. (see inst.) Reinbursed Subject To Subject To Dect. & Corns. (see inst.) Reinbursed Subject To Subject To Dect. & Corns. (see inst.) Reinbursed Subject To Dect. & Corns. (see inst.) 50.00 05000 0FEAN ING ROOM 0 0 50.00 50.00 05000 0FEAN ING ROOM 0 0 50.00 50.00 05200 DFEAN ING ROOM 0 0 50.00 50.00 05200 DFEAN ING ROOM 0 0 50.00 51.00 D5400 RADI OLOCY - DI AMOSTIC 0 0 55.00 51.00 D5500 RADI OLOCY - DI AMOSTIC 0 0 55.00 55.00 D5500 RADI OLOCY - HERAPEUTIC 0 0 55.00 55.00 D5500 RADI OLOCY - HERAPEUTIC 0 0 55.00 55.00 D5500 RADI OLOCY - HERAPEUTIC 0 0 55.00 56.00 D5500 RADI OLOCY - HERAPEUTIC 0 0 0 56.00 D5500 RADI OLOCY - HERAPEUTIC 0 0 0 56.00 D5500 RADI OLOCY - HE		Costs			
Services Services Services Services Services 8.00 A Coin ns. Coin ns. Coin ns. Coin ns. Coin ns. 8.00 OSTOR (ECONST CENTERS 7.00 7.00 5.0	Cost Center Description	Cost	Cost		
Bub ject To Subject To Subject To 0 00000 (PFRPT ING R00M 0 0 0.00 00000 (PFRPT ING R00M 0 0 0 0.00 00000 (PFRPT ING R00M 0 0 0 0.00 00000 (PFRPT ING R00M 0 0 0 0.00 000000 (PFRPT ING R00M 0 0 0 0.00 000000000000000000000000000000000000					
Ded. & Coins. Ded. & Coins. 0.00 0.00 7.00 0.01 0.00 7.00 0.02 0.00 0.00 0.03000 0.00 0 0.01 0.00 0 0.02001 0.00 0 0.02001 0.00 0 0.02001 0.00 0 0.02001 0.00 0 0.02001 0.00 0 0.02001 0.00 0 0.02001 0.00 0 0.02001 0.00 0 0.02001 0.00 0 0.02001 0.00 0 0.02001 0.00 0 0.02001 0.00 0 0.02001 0.00 0 0.02001 0.00 0.00 0.00 0.02001 0.00 0.00 0.00 0.02001 0.00 0.00 0.00 0.02001 0.00 0.00 0.00 </td <td></td> <td></td> <td></td> <td></td> <td></td>					
(see inst.) (see inst.) (see inst.) 50.00 OBDOD OPERATING COST CENTERES 0 0 51.00 OBTOD (ECOVERY MOOM 0 0 0 51.00 OBTOD (ECOVERY MOOM 0 0 0 0 51.00 OBTOD (ECOVERY MOOM 0					
International and a service cost centres 6.00 7.00 50.00 05000 (PERATING ROM 0 0 50.00 0 50.00 0 50.00 0 50.00 55.00 50.00 55.00 50.00 50.00 55.00 <td< td=""><td></td><td></td><td></td><td></td><td></td></td<>					
ARCILLARY SERVICE COST CENTERS 0.0 05000 (PERATIN ROM 0 <td< td=""><td></td><td></td><td></td><td></td><td></td></td<>					
50. 00 5000 () PERATING ROOM 0 0 50. 00 51.00 55.00	ANCILLARY SERVICE COST CENTERS	0.00	7.00		
51.00 05100 RECOVERY ROOM 0 51.00 52.00 55.00		0	0		50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 53.00 55.00 <t< td=""><td></td><td>0</td><td></td><td></td><td>51.00</td></t<>		0			51.00
54.00 654.01 654.01 654.01 654.01 554.01 54.01 05500 RADI OLGOY - DI AGNOSTI C 0 0 556.01 55.01 05501 RADI OLGOY - THERAPUTI C 0 0 0 55.01 05501 RADI OLGOY - THERAPUTI C 0 0 0 56.01 05501 05501 05501 05501 05501 0 556.01 0 556.01 0 0 0 556.01 0 0 0 556.01 0 0 0 556.01 0 0 0 0 556.01 0 0 0 0 556.01 0 0 0 0 0 0 556.01 0		0	o		52.00
54 01 05401 (FSED RADIOLOGY - DIAGNOSTIC 0 0 55 0 55 00 05500 (MOLOLOGY - THERAPEUTIC 0 0 55 0 55 00 05501 (WODLAND CANCER CARE CTR 0 0 55 0 56 00 05600 (RADIOLSCARE CARE CTR 0 0 55 0 57 00 05700 (CT SCAN 0 0 55 0 58 00 05800 (ARDIOLAC CATHETERLIZATION 0 0 60 0 60 00 06001 (ARDIAC CATHETERLIZATION 0 0 60 0 60 00 06001 (ARDIAC CATHETERLIZATION 0 0 60 0 60 00 06001 (ARDIAC CATHETERLIZATION 0 0 60 0 60 00 06001 (ARDIAC CATHETERLIZATION 0 0 60 0 61 00 06001 (MTRALENDIS THERAPY 0 0 60 0 62 00 06200 (WHOLE BLOOD STORINT THERAPY 0 0 64 0 63 00 06200 (PHYSI LAL THERAPY 0 0 65 0 64 00 06200 SPEICH PATHOLOGY 0 0 65 0 65 00 06200 SPEICH PATHOLOGY 0 0	53. 00 05300 ANESTHESI OLOGY	0	0		53.00
55:00 05500 RADIOLOGY-THERAPEUTIC 0 0 55:0 55:01 05501 WOOLAND CARCE CARE CTR 0 0 55:0 50:00 05000 RADIO SOTOPE 0 0 55:0 50:00 05000 CT SCAN 0 0 55:0 50:00 05000 AGDETIC RESONANCE WAREING (MR1) 0 0 55:0 50:00 05000 CARDIA CARDHETERIZATION 0 0 60:0 0 60:00 06000 LABORATORY 0 0 60:0 <td< td=""><td>54. 00 05400 RADI OLOGY-DI AGNOSTI C</td><td>0</td><td>0</td><td></td><td>54.00</td></td<>	54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		54.00
55.01 05501 WOODLAND CANCER CARE CTR 0 0 55.01 55.00 56.00 66.00	54. 01 05401 FSED RADIOLOGY - DIAGNOSTIC	0	0		54.01
56.00 05600 RADIO ISOTOPE 0 56.00 57.00	55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		55.00
57.00 05700 C T SCAN 0 57.00	55.01 05501 WOODLAND CANCER CARE CTR	0	0		55. 01
58:00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 58:0 59:00 60:00		0	0		56.00
59:00 05900 CARDIAC CATHETERIZATION 0 0 59:00 66:00		0	-		57.00
60.00 66000 LABORATORY 0 0 60.0 60.01 66001 FS ED LAB 0 0 60.0 61.00 06101 FS ED LAB 0 0 66.0 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 63.0 63.00 06300 RENDR TORING, PROCESSING & TRANS. 0 0 63.0 63.00 06400 INTRAVENOUS THERAPY 0 0 64.0 66.00 06600 PRSYLCAL THERAPY 0 0 66.0 67.00 06700 00 0 67.0 67.0 67.00 06700 0 0 67.0 67.0 67.00 06700 0 0 67.0 67.0 70.00 07200 INPL DEV. CHARGED TO PATI ENTS 0 0 70.0 71.00 07200 INPL DEV. CHARGED TO PATI ENTS 0 0 73.0 73.00 07300 ASC (NON-DI STI NOT PART) 0 0		0			58.00
60.01 FS ED LAB 0 <		0	-		59.00
61.00 06100 PEP CLINICAL LAB SERVICES-PREM ONLY 0 61.0 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 63.0 64.00 06400 INTRAVENOUS THERAPY 0 0 64.0 65.00 06500 RESPI RATONAL THERAPY 0 0 65.0 66.00 06600 PRESPI RATONAL THERAPY 0 0 66.0 66.00 06600 SPEECH PATHOLOGY 0 0 66.0 67.00 06700 DELECTROCARDIOLOGY 0 0 66.0 71.00 0700 MELCAT SCHARGED TO PATIENTS 0 0 71.0 72.00 720.01 720.01 720.01 720.01 720.0 72.0 73.00 07300 RENA THERAPY 0 0 74.0 74.0 74.00 07400 RENALDIALYSIS 0 0 74.0 74.0 74.0 74.0		0	-		60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 62.00 63.00 66.00 67.00 70.00		0	0		60.01
63:00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 63:00 64:00 65:0 75:0 73:0 73:0 <t< td=""><td></td><td>0</td><td></td><td></td><td>61.00</td></t<>		0			61.00
64.00 0c400 INTRAVENOUS THERAPY 0 0 64.0 65.00 0c500 RESPIRATORY THERAPY 0 0 65.0 66.00 0c6000 PHYSI CAL THERAPY 0 0 66.0 66.00 0c6000 SPECEH PATHOLOGY 0 0 67.0 68.00 0c6000 SPECEH PATHOLOGY 0 0 68.0 68.00 0c6000 SPECEH PATHOLOGY 0 0 69.0 70.00 07000 ELECTROECHALOGRAPHY 0 0 71.0 71.00 071000 MELDCARGED TO PATIENTS 0 0 73.0 73.00 07300 DRAGE CHARGED TO PATIENTS 0 0 74.0 74.00 07400 RENAL DIALYSIS 0 0 75.0 75.0 75.00 07300 CNOCONCRE CTR 0 0 76.0 76.0 76.00 0020 (V RESQURCE CTR 0 0 0 76.0 76.0 76.00 0		0	-		
65:00 06500 PESPI RATORY THERAPY 0 0 65:00 66:00 06000 PHYSI CAL THERAPY 0 0 66:00 66:00 0 66:00 0 66:00 0 66:00 0 66:00 0 66:00 70:00 70:00 71:00 71:00 0 71:00 73:00 73:00 73:00 73:00 73:00 73:00 73:00 73:00 73:00 73:00 73:00 73:00 73:00 73:00 73:00 73:00		0	-		
66.00 06600 PHSICAL THERAPY 0 0 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0 0 67.00 67.00 06800 SPEECH PATHOLOGY 0 0 68.0 68.00 06800 SPEECH PATHOLOGY 0 0 68.0 69.00 06800 SPEECH PATHOLOGY 0 0 69.0 70.00 07000 ELECTROCARDI OLOGY 0 0 70.0 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 71.0 72.00 072000 IMPL DEV. CHARGED TO PATIENTS 0 0 72.0 73.00 073000 DATICARRED TO PATIENTS 0 0 74.0 74.0 74.00 07400 REAL DI ALYSIS 0 0 0 74.0 75.00 07000 ALCOGENEI C STEM CELL ACQUISITION 0 0 75.0 76.0 70.00 07100 ALLOGENEI C STEM CELL ACQUISITION 0 0 90.0 90.0 </td <td></td> <td>0</td> <td>-</td> <td></td> <td></td>		0	-		
67.00 06700 0CCUPATI ONAL THERAPY 0 0 68.00 06800 SPECH PATHOLOGY 0 0 68.00 0 6900 68.00 0 0 0 0 68.00 0 6900 68.00 0 0 0 0 0 68.00 70.00 70.00 70.00 70.00 0 0 71.00 0 0 71.00 70.00		0	-		
68.00 06800 SPEECH PATHOLOGY 0 0 68.0 69.0 70.0 70.0 70.0 70.0 70.0 70.0 70.0 70.0 71.0 0 0 71.0 <		0	-		67.00
69:00 06900 ELECTROCARDIOLOGY 0 0 0 0 0 0 0 70:00 70:00 70:00 70:00 70:00 70:00 70:00 70:00 70:00 70:00 70:00 70:00 70:00 71:00		0	-		68.00
70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 72.00 7020 IMPLO CAL SUPPLIES CHARGED TO PATIENTS 0 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 74.00 77400 RENAL DI ALYSIS 0 0 75.00 7500 ASC (NON-DI STINCT PART) 0 0 76.00 75.00 7500 ALGC (NON-DI STINCT PART) 0 0 76.00 76.00 03020 CV RESOURCE CTR 0 0 76.00 77.00 04LOGENEIC STEM CELL ACQUI SI TI ON 0 0 76.00 70.01 04LOGENEIC STEM CELL ACQUI SI TI ON 0 0 90.00 70.02 ALLOGENEIC STEM CELL ACQUI SI TI ON 0 0 90.00 70.03 OVADAL HEALTH CLINIC 88.00 0 0000 9000 1.01 O 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00		0	o		69.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 73.00 DRUGS CHARGED TO PATIENTS 0 416 73.0 74.00 74.00 74.00 74.00 74.00 74.00 75.00 07500 ASC (NON-DISTINCT PART) 0 0 75.0 76.00 07500 ASC (NON-DISTINCT PART) 0 0 76.0 70.00 ALLOGENEIC STEM CELL ACQUISITION 0 0 77.0 00700 ALLOGENEIC CST CENTERS 0 0 0 88.00 08800 RURAL HEALTH CLINIC 88.0 88.0 90.00 09000 EDERRALLY QUALIFIED HEALTH CENTER 88.0 90.0 90.00 09000 CLINIC 0 0 90.0 91.01 09101 FREE STANDING EMERGENCY DEPT 0 0 90.0 91.00 9200 0BSERVATION BEDS (NON-DISTINCT PART) 0 91.0 92.00 09500 AMBURANCE SERVICES 0 0 92.00 95.00 95.00 95.00 95.00 95.00 95.00 95.00 95.00 96.00		0	O		70.00
73.00 07300 DRUGS CHARGED TO PATIENTS 0 416 73.0 74.00 07400 RENAL DIALYSIS 0 0 74.0 75.00 0500 ASC (NON-DISTINCT PART) 0 0 75.00 70.00 03020 CV RESOURCE CTR 0 0 0 75.00 007700 ALLOGENEI C STEM CELL ACQUISTION 0 0 77.00 07700 ALLOGENEI C STEM CELL ACQUISTION 0 0 77.00 07700 ALLOGENEI C STEM CELL ACQUISTION 0 0 77.00 07700 ALLOGENEI C STEM CELL ACQUISTION 0 0 77.00 07700 ALLOGENEI C STEM CELL ACQUISTION 0 0 77.00 0700 ALLOGENEI C STEM CELL ACQUISTION 0 0 77.00 08900 FEDRALLY QUALIFIED HEALTH CENTER 88.00 88.00 88.00 89.00 89.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 <td< td=""><td>71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS</td><td>0</td><td>o</td><td></td><td>71.00</td></td<>	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	o		71.00
74.00 07400 RENAL DI ALYSI S 0 0 74.00 75.00 07500 ASC (NON-DI STINCT PART) 0 0 75.0 76.00 03020 CV RESOURCE CTR 0 0 76.00 70.00 ALLOGENEI C STEM CELL ACOUISITION 0 0 77.00 0UTPATI ENT SERVICE COST CENTERS 88.00 88.00 88.00 88.00 89.00 08000 RURAL HEALTH CLINIC 88.0 89.00 90.00 90000 1.01 C 0 0 90.00 90.00 09000 CLINIC 0 0 0 90.00	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
75.00 07500 ASC (NON-DI STINCT PART) 0 0 75.00 76.00 03020 (V RESOURCE CTR 0 0 76.00 76.00 077.00 ALLOGENEI C STEM CELL AQUI SI TI ON 0 0 76.00 76.00 0UTPATIENT SERVICE COST CENTERS 0 0 76.00 76.00 76.00 88.00 08900 RURAL HEALTH CLINIC 88.00 89.00 89.00 89.00 90.00 09000 FEDERALLY QUALI FIED HEALTH CENTER 89.00 90.00	73.00 07300 DRUGS CHARGED TO PATIENTS	0	416		73.00
76.00 03020 CV RESOURCE CTR 0 0 76.00 77.00 07700 ALLOGENEIC STEM CELL ACQUISITION 0 0 77.00 0UTPATI ENT SERVICE COST CENTERS 0 0 0 77.00 0000 0800 RURAL HEALTH CLINIC 88.00 88.00 89.00 00 08900 FDERALLY QUALIFIED HEALTH CENTER 89.00 90.00 09000 CLINIC 0 0 90.00 91.01 90.00 91.	74.00 07400 RENAL DIALYSIS	0	0		74.00
77.00 OT700 ALLOGENEIC STEM CELL ACQUISITION 0 0 77.00 0UTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 88.00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 0 90.00 09000 CLINIC 0 0 90.00 90.01 09000 EDERALLY QUALIFIED HEALTH CENTER 89.00 90.00 90.03 09000 INFUSION OP SERVICES 0 0 90.00 91.00 09100 EMERGENCY 0 0 91.00 91.01 OP101 FREE STANDING EMERGENCY DEPT 0 0 91.00 92.00 092500 BSERVATION BEDS (NON-DISTINCT PART) 0 0 91.00 0 0 0 0 92.00 95.00 95.00 95.00 0 0 0 0 0 95.00 94.00 95.00 95.00 95.00 95.00 95.00 95.00 95.00 95.00 95.00 95.00 95.00 98.00 98.00 97.00 97.00 97.00	75.00 07500 ASC (NON-DISTINCT PART)	0	0		75.00
OUTPATI ENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 88.0 90.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.0 90.00 09000 CLINIC 0 0 90.03 09003 INFUSION OP SERVICES 0 0 90.0 91.00 09100 EMERGENCY 0 0 90.0 91.01 09101 FREE STANDING EMERGENCY DEPT 0 0 91.0 92.00 09200 DSSERVATION BEDS (NON-DISTINCT PART) 0 0 91.0 92.00 09200 DBSERVATION BEDS (NON-DISTINCT PART) 0 0 91.0 92.00 09200 DBSERVATION BEDS (NON-DISTINCT PART) 0 0 92.0 07100 DHER REIMBURSABLE COST CENTERS 0 0 95.00 09500 AMBULANCE SERVICES 95.00 96.00 96.00 97.0 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 98.00 98.00 98.00 98.00 </td <td></td> <td></td> <td></td> <td></td> <td>76.00</td>					76.00
88.00 08800 RURAL HEALTH CLINIC 88.0 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.0 90.00 09000 CLINIC 0 0 90.01 09000 CLINIC 0 0 90.02 09003 INFUSION OP SERVICES 0 0 91.00 09100 EMERGENCY 0 0 91.01 OP101 FREE STANDING EMERGENCY DEPT 0 0 91.0 92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0 0 91.0 92.00 09400 HOME PROGRAM DIALYSIS 0 0 92.0 95.00 09500 AMBULANCE SERVICES 0 0 95.0 94.00 09400 HOME PROGRAM DIALYSIS 0 0 95.0 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 0 95.0 96.00 09600 DURABLE MEDICAL EQUIP-SOLD 0 0 97.0 97.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 98.0 0 98.00 09850 <td></td> <td>0</td> <td>0</td> <td></td> <td>77.00</td>		0	0		77.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.0 90.00 09000 CLINIC 0 0 90.03 09003 INFUSION OP SERVICES 0 0 91.00 09100 EMERGENCY 0 0 90.0 91.01 09101 FREE STANDING EMERGENCY DEPT 0 0 91.0 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 91.0 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 92.0 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 92.0 92.0 09200 DOSORAM DI ALYSIS 0 0 92.0 92.00 92.00 95.00 09400 HOME PROGRAM DI ALYSIS 0 0 94.00 95.00 96.00 09400 DURABLE MEDI CAL EQUI P-RENTED 0 0 95.00 96.00 97.00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 98.00 0<			I		
90.00 09000 CLINIC 0 0 90.00 90.03 09003 INFUSION OP SERVICES 0 0 90.00 91.00 09100 EMERGENCY 0 0 91.00 91.01 09101 FREE STANDING EMERGENCY DEPT 0 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 92.00 92.00 09400 HOME PROGRAM DIALYSIS 0 0 92.00 92.00 95.00 09500 AMBULANCE SERVICES 0 95.00 95.00 95.00 96.00 DURABLE MEDICAL EQUIP-RENTED 0 0 95.00 96.00 97.00 97.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 97.00 98.00 9850 98.00 98.00 98.00 98.00 98.00 98.00 98.00 98.00 98.00 98.00 98.00 98.00 98.00 98.00 98.00 98.00 98.00 98.00 98.00					88.00
90.03 09003 INFUSION OP SERVICES 0 0 90.03 91.00 09100 EMERGENCY 0 0 0 91.00 91.01 09101 FREE STANDING EMERGENCY DEPT 0 0 0 91.00 91.00 92.00 09200 OBSERVATION BEDS (NON-DI STINCT PART) 0 0 91.00					
91.00 09100 EMERGENCY 0 0 91.01 91.01 09101 FREE STANDING EMERGENCY DEPT 0 0 91.01 92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0 0 92.0 09400 HOME PROGRAM DIALYSIS 0 0 94.00 95.00 09400 HOME PROGRAM DIALYSIS 0 0 95.00 95.00 96.00 97.00 97.00 97.00 97.00 97.00 0 0 95.00 96.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 98.00 <td></td> <td>0</td> <td></td> <td></td> <td></td>		0			
91.01 09101 FREE STANDING EMERGENCY DEPT 0 0 91.01 92.00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART) 0 0 92.00 0THER REI MBURSABLE COST CENTERS 0 0 94.00 09400 HOME PROGRAM DI ALYSIS 0 0 94.00 95.00 09500 AMBULANCE SERVICES 0 95.00 95.00 96.00 00 95.00 96.00 96.00 97.00 90700 DURABLE MEDI CAL EQUI P-RENTED 0 0 96.00 96.00 97.00 90700 DURABLE MEDI CAL EQUI P-SOLD 0 0 97.00 97.00 97.00 90850 0THER REI MBURSABLE COST CENTERS 0 0 97.00 97.00 90850 0THER REI MBURSABLE COST CENTERS 0 0 98.00 90850 0 98.00 98.00 98.00 98.00 90.00 98.00 90.00 98.00 90.00 98.00 90.00 98.00 90.00 98.00 90.00 98.00 90.00 98.00 90.00 98.00 90.00 98.00 90.00 98.00 90.00 90.00 90.00		-			
92.00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART) 0 0 92.00 0THER REI MBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DI ALYSI S 0 0 94.00 95.00 09500 AMBULANCE SERVICES 0 95.00 96.00 00400 DURABLE MEDI CAL EQUI P-RENTED 0 0 95.00 96.00 97.00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 97.00 97.00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 97.00 97.00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 97.00 98.00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 98.00 09850 0 98.00		Ű	-		
OTHER REI MBURSABLE COST CENTERS 94. 00 09400 HOME PROGRAM DI ALYSI S 0 0 95. 00 09500 AMBULANCE SERVI CES 0 95. 0 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 98. 00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 200. 00 Subtotal (see instructions) 0 416 200. 0 201. 00 Less PBP Clinic Lab. Services-Program 0 201. 0 201. 0					
94.00 09400 HOME PROGRAM DI ALYSI S 0 0 94.00 95.00 09500 AMBULANCE SERVI CES 0 95.00 96.00 96.00 96.00 96.00 96.00 96.00 96.00 97.00		ч Ч	0		72.00
95.00 09500 AMBULANCE SERVICES 0 95.00 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 0 97.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 98.00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 200.00 Subtotal (see instructions) 0 416 200.00 201.00 Less PBP Clinic Lab. Services-Program Only Charges 0 201.00 201.00		0	0		94.00
96.0009600DURABLE MEDICAL EQUIP-RENTED0097.0009700DURABLE MEDICAL EQUIP-SOLD0098.0009850OTHER REI MBURSABLE COST CENTERS00200.00Subtotal (see instructions)0416201.00Less PBP Clinic Lab. Services-Program Only Charges0201.00			-		95.00
97.0009700DURABLE MEDICAL EQUIP-SOLD097.0098.00098500THER REI MBURSABLE COST CENTERS00200.00Subtotal (see instructions)0416201.00Less PBP Clinic Lab. Services-Program Only Charges0201.00		0	o		96.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS 0 0 98.00 200.00 Subtotal (see instructions) 0 416 200.00 201.00 Less PBP Clinic Lab. Services-Program Only Charges 0 201.00 0		0			97.00
201.00 Less PBP Clinic Lab. Services-Program 0 201.0 Only Charges 0 0		0	o		98.00
Only Charges	200.00 Subtotal (see instructions)	0	416		200.00
		0			201.00
202.00 Net Charges (line 200 - line 201) 0 416 202.0	3 8				
	202.00 Net Charges (line 200 - line 201)	0	416		202.00

PPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT	AL COSTS	Provider C	CN: 15-0015	Peri od:	Worksheet D	
			CCN: 15-S015	From 01/01/2020 To 12/31/2020	Part II Date/Time Pre 7/28/2021 7:4	pared: 1 pm
		Title	e XVIII	Subprovider - IPF	PPS	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,			(column 3 x	
	(from Wkst. B,			I. Charges	column 4)	
	Part II, col.	8)	2)			
	26)	2.00	2.00	4.00	F 00	
ANCILLADY SEDVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	6, 776, 255	107 040 050	0.0532	46 149	8	50.00
			1		0	
	0					
2. 00 05200 DELIVERY ROOM & LABOR ROOM	359, 882				0	
3. 00 05300 ANESTHESI OLOGY	43, 931				0	
4. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 676, 985				669	
4. 01 05401 FSED RADI OLOGY - DI AGNOSTI C	1, 547, 707				0	
5. 00 05500 RADI OLOGY - THERAPEUTI C	522, 509				490	
5.01 05501 WOODLAND CANCER CARE CTR	700, 123				0	
6. 00 05600 RADI 0I SOTOPE	0				0	
7.00 05700 CT SCAN	0				0	
B. OO 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	-			0	58.00
9. 00 05900 CARDIAC CATHETERIZATION	987, 746				0	59.00
D. 00 06000 LABORATORY	726, 807	83, 317, 092	0.0087	23 158, 382	1, 382	60.00
D. 01 06001 FS ED LAB	108, 479	11, 786, 107	0.0092	04 0	0	60.01
1.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
2.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0.0000	00 0	0	62.00
3.00 06300 BLOOD STORING, PROCESSING & TRANS.	24, 970	1, 367, 218	0. 0182	63 0	0	63.00
4. 00 06400 I NTRAVENOUS THERAPY	0	0	0.0000	00 0	0	64.00
5. 00 06500 RESPI RATORY THERAPY	260, 214	17, 525, 728	0.0148	48 2, 332	35	65.00
6. 00 06600 PHYSI CAL THERAPY	189, 560	17, 400, 286	0. 0108	94 5, 705	62	66.00
7.00 06700 OCCUPATIONAL THERAPY	0	C	0.0000	00 0	0	67.00
8.00 06800 SPEECH PATHOLOGY	0	l a	1		0	68.00
9. 00 06900 ELECTROCARDI OLOGY	842, 429	27, 206, 021			301	69.00
D. 00 07000 ELECTROENCEPHALOGRAPHY	0				0	
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	96,072	29, 429, 594			27	71.00
2.00 07200 I MPL. DEV. CHARGED TO PATIENTS	197, 800				0	•
3. 00 07300 DRUGS CHARGED TO PATIENTS	841, 834				494	
4. 00 07400 RENAL DIALYSIS	041,034				0	
5. 00 07500 ASC (NON-DISTINCT PART)	0				0	
6. 00 03020 CV RESOURCE CTR	0		1		0	
7. 00 07700 ALLOGENEIC STEM CELL ACQUISITION	0				0	
OUTPATIENT SERVICE COST CENTERS	0		0.0000	00 0	0	1 / /. 00
B. 00 08800 RURAL HEALTH CLINIC	0	C	0.0000	00 0	0	88. 00
9. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0. 00 09000 CLINIC	0				0	
	-	-			0	
D. 03 09003 I NFUSI ON OP SERVI CES	240, 660				0	90.03
1.00 09100 EMERGENCY	1, 613, 466				2, 907	
1. 01 09101 FREE STANDING EMERGENCY DEPT	1, 756, 689					
2. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	0	7, 603, 004	0.0000	00 0	0	92.00
OTHER REIMBURSABLE COST CENTERS	-	-		-	-	
4. 00 09400 HOME PROGRAM DI ALYSI S	0	C	0.0000	00 0	0	
5. 00 09500 AMBULANCE SERVICES						95.00
6.00 09600 DURABLE MEDICAL EQUIP-RENTED	0				0	
7.00 09700 DURABLE MEDICAL EQUIP-SOLD	0				0	
B. 00 09850 OTHER REIMBURSABLE COST CENTERS	0				0	
DO.00 Total (lines 50 through 199)	20, 514, 118	775, 129, 361	1	447, 574	6, 375	1200 00

Heal th	Financial Systems FR	ANCISCAN HEALTH	I MICHIGAN CIT	Y	In Lie	u of Form CMS-	2552-10
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PASS	Provider C	CN: 15-0015	Peri od:	Worksheet D	
THROUG	COSTS		Component	CCN: 15-S015	From 01/01/2020 To 12/31/2020	Part IV Date/Time Pre	narod
			component	CON. 15-3015	10 12/31/2020	7/28/2021 7:4	1 pm
			Title	e XVIII	Subprovider - IPF	PPS	
	Cost Center Description	Non Physician	Nursing School	Nursing Scho	ol Allied Health	Allied Health	
	· · · · · · · · · · · · · · · · · · ·		Post-Stepdown		Post-Stepdown		
		Cost	Adjustments		Adjustments		
		1.00	2A	2.00	3A	3.00	
	ANCI LLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0		0 0		
51.00 52.00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	0	C		0 0 0 0	-	
52.00 53.00	05300 ANESTHESI OLOGY	0			0 0	-	
54.00	05400 RADI OLOGY - DI AGNOSTI C	0			0 0		
54.00	05401 FSED RADIOLOGY - DIAGNOSTIC	0	(0 0	0	
55.00	05500 RADI OLOGY - THERAPEUTI C	0	(0 0	0	
55.01	05501 WOODLAND CANCER CARE CTR	0	C		0 0		
56.00	05600 RADI OI SOTOPE	0	C		0 0	0	1
57.00	05700 CT SCAN	0	C		0 0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	C		0 0	0	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	C		0 0	0	59.00
60.00	06000 LABORATORY	0	C	D	0 0	0	60.00
60. 01	06001 FS ED LAB	0	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 CELLS	0	C		0 0	0	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	C	D	0 0	0	
64.00	06400 I NTRAVENOUS THERAPY	0	0	2	0 0	0	1
65.00		0	(0 0	0	
66.00	06600 PHYSI CAL THERAPY	0			0 0	0	
67.00 68.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	(0 0 0 0	0	1
69.00	06900 ELECTROCARDI OLOGY	0	(0 0		1
70.00	07000 ELECTROENCEPHALOGRAPHY	0			0 0	0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	(0 0		1
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	(0 0	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	C		0 0	0	1
74.00	07400 RENAL DIALYSIS	0	C		0 0	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	C		0 0	0	75.00
76.00	03020 CV RESOURCE CTR	0	C	D	0 0	0	76.00
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION	0			0 0	0	77.00
	OUTPATIENT SERVICE COST CENTERS				-	-	
88.00	08800 RURAL HEALTH CLINIC	0	C		0 0		1
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0		1
90.00 90.03		0	0		0 0	0	
90.03 91.00	09003 I NFUSI ON OP SERVI CES 09100 EMERGENCY	0			0 0	0	
91.00 91.01	09101 FREE STANDING EMERGENCY DEPT	0			0 0	0	1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	C		0	0	1
00	OTHER REIMBURSABLE COST CENTERS	<u> </u>		1	-	0	1
94.00	09400 HOME PROGRAM DI ALYSI S	0	(0 0	0	94.00
95.00	09500 AMBULANCE SERVICES			1		_	95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	C		0 0	0	96.00
97.00	09700 DURABLE MEDI CAL EQUI P-SOLD	0	C		0 0	0	
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0	C		0 0		
200.00	Total (lines 50 through 199)	0	C	P	0 0	0	200.00

Instrume Component CCN: 15-S015 To 12/31/2020 Description Total cost Title XVIII Subprovider - IPF Cost Center Description All Other Addition Formula Subprovider - IPF Cost Content on the Cost Control on the Cost Cost Control on the Cost Cost Cost Control on the Cost Cost Cost Cost Cost Cost Cost Cost		DNMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI	RVICE OTHER PASS	S Provider C	CN: 15-0015	Peri od:	Worksheet D	
Cost Center Description Ail Other Medical Education Cost Total Cost (sum of Cost) (sum of Cost) (su	IROUGH	COSTS		Component	CCN: 15-S015	From 01/01/2020 To 12/31/2020		
Cost Center Description All Other Medical Education Cost Total (sum of cost (sum of cost) (sum of c				Title	e XVIII		PPS	•
Education Cost 1, 2, 3, and (1, 2, 3, and 4) Cost (sum of (st, s), and 4) Part I, col. (st, s), and 4) Col. 5, and 4) 0.00 05000 OPERATING ROOM 0		Cost Center Description	All Other	Total Cost	Total	Total Charges		
AICLILARY SERVICE COST CENTERS 4.00 5.00 6.00 7.00 8.0 00 05000 OPERATI ING ROM 0 0 0 0.00 0 0.00 0 0.00 0								
Anci LLARY SERVICE COST CENTERS 6.00 7.00 8.1 0.00 05000 OPERATING ROOM 0 0 127, 263, 350 0 0.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 127, 263, 350 0 <td></td> <td></td> <td>Education Cost</td> <td></td> <td></td> <td></td> <td></td> <td></td>			Education Cost					
ACCULTARY SERVICE COST CENTERS Instruct 00 5.00 6.00 7.00 8.0 100 05000 PERATINE ROM 0 0 0.00				4)		8)	7)	
ALCLLARY SERVICE COST CENTERS 0 0.00 0.0					and 4)		(see	
ANCILLARY SERVICE COST CENTERS Image: Center Cost Centers 00 00000 PERATING ROOM 0				5.00	(7.00	instructions)	
00.00 05000 OPECATI NG. ROOM 0 0 127, 233, 350 0 10.00 05000 DECOVERY ROOM 0		NOLLLARY SERVICE COST CENTERS	4.00	5.00	6.00	7.00	8.00	
1 00 0 0100 RECOVERY ROOM 0			0			0 127 263 350	0,000000	50.00
22 00 05200 DELUTERY ROMA & LABOR ROM 0 0 3, 135, 225 0 30 05300 RADIOLOGY 0 0 7, 964, 181 0 44.00 05400 RADIOLOGY DI AGNOSTI C 0 0 21, 850, 178 0 55.01 05500 RADIOLOCANT HERAPEUTI C 0 0 15, 816, 256 0 0 0 4, 631, 648 0				-			0.000000	
3.00 05300 AMESTHESI OLOGY 0 0 7, 964, 181 0. 4.00 05400 RADI OLOGY-OLAGNOSTI C 0 0 21, 850, 178 0. 4.00 05500 RADI OLOGY-THERAPEUTI C 0 0 15, 816, 256 0. 5.00 05500 RADI OLOGY-THERAPEUTI C 0 0 14, 631, 648 0. 6.00 05600 RADI OLOGY-THERAPEUTI C 0 0 0 0. 0. 0.0 <td></td> <td></td> <td></td> <td>-</td> <td></td> <td></td> <td></td> <td></td>				-				
44 00 05400 RADIOLOGY-DIAGNOSTIC 0 0 104, 854, 845 0. 50 05500 RADIOLOGY - THERAPEUTIC 0 0 0 21, 850, 178 0. 5.00 05501 WODLAND CANCER CARE CTR 0 0 0 4, 631, 648 0. 6.00 05600 RADIOISOTPE 0			0	-	1			
4.01 05401 FSED RADIOLOGY - DIAGNOSTIC 0 0 21, 850, 178 0. 5.00 05500 RADIOLOGY - THERAPEUTIC 0 0 15, 816, 256 0. 5.01 05501 RODLAND CANCER CARE CTR 0 0 4, 631, 648 0. 7.00 05700 CT SCAN 0			0	-	1			
5:00 05500 RADI OLOGY-THERAPEUTI C 0 0 15.81 (3501) 0501) 0501 05501 05501 05501 05501 05501 05501 05501 05501 0500 0 </td <td></td> <td></td> <td>0</td> <td>-</td> <td>1</td> <td></td> <td></td> <td></td>			0	-	1			
5.01 05501 WODLAND CANCER CARE CTR 0 0 4,631,648 0.0 6.00 05600 RADI 01 SOTOPE 0			0	-				
6.00 05600 RADIOLSTOPE 0			0	-				
7.00 05700 CT SCAN 0			0	-	1			
8.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0			0	-			0.000000	
99. 00 05900 CARDIAC CATHETERIZATION 0 <			0	-		-		
0.00 06000 LABORATORY 0 0 0 83,317,092 0.0 0.01 06001 FS ED LAB 0 0 11,786,107 0.1 1.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 0 0 11,786,107 0.1 2.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 1,367,218 0.0 3.00 06300 BLOOD STORING, PROCESSI NG & TRANS. 0 0 0 1,367,218 0.0 6.00 06600 PHYSICAL THERAPY 0 0 0 17,400,286 0.0 0 0.0 0 0.0 <t< td=""><td></td><td></td><td>0</td><td>-</td><td></td><td></td><td>0.00000</td><td></td></t<>			0	-			0.00000	
0.01 66001 FS ED LAB 0 0 11,786,107 0. 1.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 0			0	C)			
1.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 2.00 06200 WHOLE BLOOD A O			0	C				
2:00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0			0	C		0 11, 786, 107	0. 000000	60.01
3.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 1,367,218 0, 4.00 06400 INTRAVENOUS THERAPY 0	1.00 0	6100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
44.00 06400 INTRAVENOUS THERAPY 0	2.00 0	6200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	C)	0 0	0. 000000	62.00
55.00 06500 RESPI RATORY THERAPY 0 0 17, 525, 728 0, 66.00 06600 PHYSI CAL THERAPY 0 0 0 17, 400, 286 0, 70.00 06700 OCCUPATI ONAL THERAPY 0 0 0 0 0, 88.00 06800 SPEECH PATHOLOGY 0 0 0 0 0, 90.00 04900 ELECTROCARDIOLOGY 0 0 0 0, <td>3.00 0</td> <td>6300 BLOOD STORING, PROCESSING & TRANS.</td> <td>0</td> <td>C</td> <td>)</td> <td>0 1, 367, 218</td> <td>0. 000000</td> <td>63.00</td>	3.00 0	6300 BLOOD STORING, PROCESSING & TRANS.	0	C)	0 1, 367, 218	0. 000000	63.00
66.00 06600 PHYSI CAL THERAPY 0 0 17,400,286 0. 77.00 06700 0CCUPATI ONAL THERAPY 0 0 0 0.0 88.00 06800 SPEECH PATHOLOGY 0 0 0.0 0.0 90.00 06900 ELECTROCARDI OLOGY 0 0 0 0.0 90.00 06900 ELECTROENCEPHALOGRAPHY 0 0 0 0.0 11.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 27,249,2594 0.0 22.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 137,062,698 0.0 3.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0.0 3.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0.0 5.00 07500 ASC (NON-DI STI NCT PART) 0 0 0 0.0 6.00 03020 CV RESOURCE CTR 0 0 0 0 0.0 0.0 7.00 DUTPATI ENT SERVICE COST CENTERS 0 0 <t< td=""><td>4.00 0</td><td>6400 INTRAVENOUS THERAPY</td><td>0</td><td>C</td><td>)</td><td>0 0</td><td>0. 000000</td><td>64.00</td></t<>	4.00 0	6400 INTRAVENOUS THERAPY	0	C)	0 0	0. 000000	64.00
77.00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 0 88.00 06800 SPEECH PATHOLOGY 0	5.00 0	6500 RESPI RATORY THERAPY	0	C		0 17, 525, 728	0. 000000	65.00
b8.00 06800 SPEECH PATHOLOGY 0	5.00 0	6600 PHYSI CAL THERAPY	0	C		0 17, 400, 286	0.00000	66.00
99.00 06900 ELECTROCARDIOLOGY 0 0 0 27, 206, 021 0. 10.00 07000 ELECTROENCEPHALOGRAPHY 0	7.00 0	6700 OCCUPATI ONAL THERAPY	0	C		0 0	0. 000000	67.00
0.000 07000 ELECTROENCEPHALOGRAPHY 0 <th< td=""><td>3.00 0</td><td>6800 SPEECH PATHOLOGY</td><td>0</td><td>C</td><td></td><td>0 0</td><td>0. 000000</td><td>68.00</td></th<>	3.00 0	6800 SPEECH PATHOLOGY	0	C		0 0	0. 000000	68.00
0.00 07000 ELECTROENCEPHALOGRAPHY 0	9.00 0	6900 ELECTROCARDI OLOGY	0	c c		0 27, 206, 021	0.000000	69.00
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 27, 549, 477 0. 3.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 137, 062, 698 0. 4.00 07400 RENAL DIALYSIS 0	0. 00 0 [.]	7000 ELECTROENCEPHALOGRAPHY	0	c c				70.00
12.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 27, 549, 477 0. 13.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 137, 062, 698 0. 14.00 07400 RENAL DIALYSIS 0 0 0 0 0 0 0 15.00 07500 ASC (NON-DISTINCT PART) 0	1. 00 0 [.]	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	c c		0 29, 429, 594	0. 000000	71.00
3.00 07300 DRUGS CHARGED TO PATIENTS 0 0 137,062,698 0. 4.00 07400 RENAL DI ALYSIS 0 0 0 0 0. 5.00 07500 ASC (NON-DI STINCT PART) 0			0	l c				
4.00 07400 RENAL DI ALYSI S 0 <td></td> <td></td> <td>0</td> <td>l c</td> <td></td> <td></td> <td></td> <td></td>			0	l c				
15.00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 16.00 03020 CV RESOURCE CTR 0			0				0.000000	
76.00 03020 CV RESOURCE CTR 0 <td></td> <td></td> <td>0</td> <td>0</td> <td></td> <td>0 0</td> <td></td> <td></td>			0	0		0 0		
7.00 07700 ALLOGENEIC STEM CELL ACQUISITION 0			0					
OUTPATI ENT SERVICE COST CENTERS 18.00 08800 RURAL HEALTH CLINIC 0								
88.00 08800 RURAL HEALTH CLINIC 0 0 0 0 0 99.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0						0	01000000	1
19:00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0			0	0)	0 0	0.000000	88.00
0.00 09000 CLINIC 0 <								
00.03 09003 I NFUSI ON OP SERVICES 0 0 4,053,800 0.0 01.00 09100 EMERGENCY 0 0 0 78,653,715 0.0 01.00 09101 FREE STANDING EMERGENCY DEPT 0 0 0 17,355,136 0.0 02.00 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 7,603,004 0.0 07400 OBSERVATION DIALS CENTERS 0 0 0 0.0 0			0				0.000000	
11.00 09100 EMERGENCY 0 0 78, 653, 715 0. 11.01 09101 FREE STANDING EMERGENCY DEPT 0 0 0 17, 355, 136 0. 12.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 7, 603, 004 0. 07HER REI MBURSABLE COST CENTERS 0 0 0 0. 14.00 09400 HOME PROGRAM DI ALYSIS 0 0 0. 0. 15.00 09500 AMBULANCE SERVICES 0 0 0 0. 0.			0	-		-		
1. 01 09101 FREE STANDING EMERGENCY DEPT 0 0 17, 355, 136 0. 2. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 7, 603, 004 0. 0 THER REI MBURSABLE COST CENTERS 0 0 0 0 0. 5. 00 09500 AMBULANCE SERVICES 0 0 0 0. 0.			0	-				
2. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 7,603,004 0. OTHER REI MBURSABLE COST CENTERS 0			-	-				
OTHER REI MBURSABLE COST CENTERS 4. 00 09400 HOME PROGRAM DI ALYSI S 0								
44.00 09400 HOME PROGRAM DI ALYSI S 0<			0		<u> </u>	7,003,004	0.00000	72.00
5. 00 09500 AMBULANCE SERVICES			0			0	0.00000	94.0
			0		<u></u>			94.0
		9600 DURABLE MEDICAL EQUIP-RENTED	0			0 0	0. 000000	
			0	-			0.000000	
			-	-			0.000000	
18.00 09850 OTHER REIMBURSABLE COST CENTERS 0								98.00 200.00

PPORTI	ONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEP	RVICE OTHER PASS	Provider C	CN: 15-0015	Per	ri od:	Worksheet D	2552-10
	I COSTS			CCN: 15-S015		om 01/01/2020	Part IV Date/Time Pre 7/28/2021 7:4	
			Title	e XVIII	Su	ubprovider - IPF	PPS	
	Cost Center Description	Outpatient	Inpatient	Inpati ent		Outpatient	Outpati ent	
		Ratio of Cost	Program	Program		Program	Program	
		to Charges	Charges	Pass-Throug		Charges	Pass-Through	
		(col. 6 ÷ col.		Costs (col.			Costs (col. 9	
		7) 9.00	10.00	x col. 10) 11.00	_	12.00	x col . 12) 13.00	
[ANCI LLARY SERVI CE COST CENTERS	9.00	10.00	11.00		12.00	13.00	
	05000 OPERATING ROOM	0. 000000	149		0	0	0	50. 00
	05100 RECOVERY ROOM	0. 000000	0		0	0	0	51.00
	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0		0	0	0	52.00
	05300 ANESTHESI OLOGY	0. 000000	0		0	0	0	53.00
	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	26, 201		0	0	0	54.00
	05401 FSED RADIOLOGY - DIAGNOSTIC	0. 000000	0		0	o	0	54.01
	05500 RADI OLOGY-THERAPEUTI C	0. 000000	14, 846		0	0	0	55.00
	05501 WOODLAND CANCER CARE CTR	0. 000000	0		Ő	o	0	55.0
	05600 RADI OI SOTOPE	0. 000000	0		0	0	0	56.00
	05700 CT SCAN	0. 000000	0		0	0	0	57.00
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	0		Ö	0	0	58.00
1	05900 CARDI AC CATHETERI ZATI ON	0. 000000	0		0	0	0	59.0
	06000 LABORATORY	0. 000000	158, 382		Ö	0	0	60.0
	06001 FS ED LAB	0. 000000	130, 302		Ö	0	0	60.0
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	0		Ŭ	0	0	61.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	0		0	0	0	62.0
	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0		0	0	0	63.00
	06400 I NTRAVENOUS THERAPY	0. 000000	0		0	0	0	64.00
	06500 RESPIRATORY THERAPY	0. 000000	2, 332		0	0	0	65.00
	06600 PHYSI CAL THERAPY	0. 000000	5, 705		0	0	0	66.00
	06700 OCCUPATI ONAL THERAPY	0. 000000	5,705		0	0	0	67.0
	06800 SPEECH PATHOLOGY	0. 000000	0		0	0	0	68.0
	06900 ELECTROCARDI OLOGY	0. 000000	9, 736		0	0	0	69.0
	07000 ELECTROENCEPHALOGRAPHY	0. 000000	7, 730		0	0	0	70.0
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	8, 131		0	0	0	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0, 131		0	0	0	72.0
	07300 DRUGS CHARGED TO PATIENTS	0. 000000	80, 380		0	0	0	73.0
	07400 RENAL DI ALYSI S	1 1	80, 380 0		0	0	-	74.0
	07400 RENAL DIALISIS 07500 ASC (NON-DISTINCT PART)	0. 000000 0. 000000	0		0	0	0	75.00
	03020 CV RESOURCE CTR	0. 000000	0		0	0	0	76.00
1	07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000	0		0	0	0	77.00
+	OUTPATIENT SERVICE COST CENTERS	0.000000	0		0	0	0	1 / /. 00
	08800 RURAL HEALTH CLINIC	0. 000000	0		0	0	0	88. 00
1	08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000	0		0	0	0	89.00
	09000 CLINIC	0. 000000	0		0	0	0	90.00
	09003 INFUSION OP SERVICES	0. 000000	0		0	0	0	90.0
	09003 THEOSTON OF SERVICES	0. 000000	141, 712		0	0	0	90.0
	09101 FREE STANDING EMERGENCY DEPT	0. 000000	141, 712		0	0	0	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0		0	0	0	
	OTHER REIMBURSABLE COST CENTERS	0.000000	0	1	9	U	0	72.0
	09400 HOME PROGRAM DI ALYSI S	0. 000000	0		0	0	0	94.00
	09500 AMBULANCE SERVICES	0.000000	0		J	0	0	95.0
	09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000	0		0	0	0	
	09700 DURABLE MEDICAL EQUIP-RENTED	0. 000000	0		0	0	0	
,			0					
8.00	09850 OTHER REIMBURSABLE COST CENTERS	0. 000000	n		0	0	0	

31. 00 INTENSIVE CARE UNIT 1, 159, 105 1, 159, 105 3, 764 307. 95 31. 00	Health Financial Systems F	RANCI SCAN HEALTH	I MICHIGAN CIT	Y	In Lie	u of Form CMS-:	2552-10
Cost Center Description Capital Related Cost (from Wkst. B, Part II, col. Swing Bed Adjustment Reduced Capital Related Cost (col. 1 - col. 2) Total Patient Related Cost (col. 4) Per Diem (col. 3 / col. 4) 1NPATIENT ROUTINE SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 1NPATIENT ROUTINE SERVICE COST CENTERS 5.651.259 0 5.651.259 21.916 257.86 30.00 30.00 ADULTS & PEDIATRICS 5.651.259 0 5.651.259 0 5.651.259 0.00 3.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 3.00 0.00 30.00	APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider C	CN: 15-0015	From 01/01/2020	Part I Date/Time Pre	
Related Cost (Part II, col. 26) Adjustment (26) Capital Related Cost (col. 1 - col. 2) Days 3 / col. 4) 1NPATIENT ROUTINE SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 30.00 ADULTS & PEDIATRICS 5, 651, 259 0 5, 651, 259 21, 916 257.86 30.00 31.00 INPATIENT ROUTINE SERVICE CAST CENTERS 5, 651, 259 0 5, 651, 259 21, 916 257.86 30.00 32.00 CORNARY CARE UNIT 0 0 0 0.00 32.00 34.00 34.00 34.00 34.00 34.00 34.00 34.00 34.00 32.00 33.00 33.00 0 0 0.00 32.00 34.00 34.00 34.00 34.00 34.00 34.00 34.00 34.00 34.00 34.00 34.00 34.00 34.00 34.00 34.00 34.00 36.00 36.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 36.00 36.00			Ti tl	e XIX	Hospi tal		
Related Cost (Part II, col. 26) Adjustment (26) Capital Related Cost (col. 1 - col. 2) Days 3 / col. 4) 1NPATIENT ROUTINE SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 30.00 ADULTS & PEDIATRICS 5, 651, 259 0 5, 651, 259 21, 916 257.86 30.00 31.00 INPATIENT ROUTINE SERVICE CAST CENTERS 5, 651, 259 0 5, 651, 259 21, 916 257.86 30.00 32.00 CORNARY CARE UNIT 0 0 0 0.00 32.00 34.00 34.00 34.00 34.00 34.00 34.00 34.00 34.00 32.00 33.00 33.00 0 0 0.00 32.00 34.00 34.00 34.00 34.00 34.00 34.00 34.00 34.00 34.00 34.00 34.00 34.00 34.00 34.00 34.00 34.00 36.00 36.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 36.00 36.00	Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem (col.	
Impart end Ref ared Cost (col. 1 - col. 26) Ref ared Cost (col. 1 - col. 26) Ref ared Cost (col. 1 - col. 26) Ref ared Cost (col. 1 - col. 20) Ref ared Cost (col. 20) Ref ared Co		Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
26) 2)		(from Wkst. B,	·	Related Cos	t		
Image: Instant Routine Stervice COST CENTERS Image: I		Part II, col.		(col. 1 - col			
Image: Instant Routine Stervice COST CENTERS Image: I		26)		2)			
30.00 ADULTS & PEDIATRICS 5, 651, 259 0 5, 651, 259 21, 916 257. 86 30.00 31.00 INTENSI VE CARE UNIT 1, 159, 105 3, 764 307. 95 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 33.00 34.00 SURGROWIDER - IPF 1, 054, 921 0 1, 054, 921 3, 358 314.15 40.00 41.00 SVIBROVIDER - IRF 0 0 0 0 0.00 41.00 42.00 SKILLED NURSING FACILITY 508, 263 508, 263 842 603.64 43.00 43.00 NURSING FACILITY 0 0 0 0.00 0.00 200.00 200.00 0 0.00 44.00 54.00 29, 880 200.00 200.00 200.00 200.00 200.00			2.00		4.00	5.00	
31.00 INTENSIVE CARE UNIT 1, 159, 105 1, 159, 105 3, 764 307, 95 31, 00 32.00 CORONARY CARE UNIT 0 0 0 0, 00 32, 00 33.00 SURG CAL INTENSIVE CARE UNIT 0 0 0 0, 00 32, 00 34.00 SURG ICAL INTENSIVE CARE UNIT 0 0 0 0, 00 33, 00 40.00 SUBPROVIDER - IPF 1, 054, 921 0 1, 054, 921 3, 358 314, 15 40, 00 41.00 SUBPROVIDER - IRF 0 0 0 0 0, 00 0 0, 00 43, 00 44.00 NURSING FACILITY 0 0 0 0 0, 00 0, 00 43, 00 44.00 SULLED NURSING FACILITY 0 0 0 0, 00 0, 00 43, 00 41.00 SUBPROVIDER - IRF Inpatient Inpatient Inpatient Program 20, 00 0 0, 00 0, 00 0 0, 00 0 0 0 0 0 0 0 0 0 0 0 0 <td>INPATIENT ROUTINE SERVICE COST CENTERS</td> <td>-1</td> <td></td> <td></td> <td></td> <td></td> <td></td>	INPATIENT ROUTINE SERVICE COST CENTERS	-1					
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 40.00 SUBPROVIDER - IPF 1,054,921 0 0 0 0.00 34.00 41.00 SUBPROVIDER - IPF 1,054,921 0 1,054,921 3,358 314.15 40.00 43.00 SUBPROVIDER - IFF 0 <td>30. 00 ADULTS & PEDIATRICS</td> <td>5, 651, 259</td> <td>C</td> <td>5, 651, 2</td> <td>59 21, 916</td> <td>257.86</td> <td>30.00</td>	30. 00 ADULTS & PEDIATRICS	5, 651, 259	C	5, 651, 2	59 21, 916	257.86	30.00
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 43.00 SURGICAL INTENSIVE CARE UNIT 0 0 0 0.00 33.00 40.00 SUBPROVIDER - IPF 1,054,921 0 1,054,921 3,358 314.15 40.00 41.00 SUBPROVIDER - IFF 0<	31.00 INTENSIVE CARE UNIT	1, 159, 105		1, 159, 10	3, 764	307.95	31.00
33.00 BURN INTENSIVE CARE UNIT 0 0 0 0.00 33.00 34.00 SURGICAL INTENSIVE CARE UNIT 0 0 0 0 0.00 34.00 40.00 SUBPROVIDER - IPF 1,054,921 0 0 0 0 0.00 34.00 41.00 SUBPROVIDER - IRF 0	32.00 CORONARY CARE UNIT	0			0 0	0.00	32.00
34.00 SURGI CAL INTENSIVE CARE UNIT 0 0 0 0.00 34.00 40.00 SUBPROVIDER - IPF 1,054,921 0 1,054,921 3,358 314.15 40.00 41.00 SUBPROVIDER - IRF 0 0 0 0.00 41.00 43.00 NURSERY 508,263 508,263 842 603.64 43.00 44.00 SKILLED NURSING FACILITY 0 0 0 0.00 43.00 45.00 NURSING FACILITY 0 0 0 0.00 45.00 200.00 Total (lines 30 through 199) 8,373,548 8,373,548 29,880 200.00 200.00 Total (lines 30 through 199) 8,373,548 8,373,548 29,880 200.00 30.00 ADULTS & PEDIATRICS 547 141,049 31.00 31.00 31.00 31.00 INTENSIVE CARE UNIT 0 0 0 32.00 31.00 32.00 CORNARY CARE UNIT 0 0 32.00 31.00 32.00 32.00 33.00 SURGI CAL INTENSIVE CARE UNIT <td< td=""><td>33.00 BURN INTENSIVE CARE UNIT</td><td>0</td><td></td><td></td><td>0 0</td><td>0.00</td><td>33.00</td></td<>	33.00 BURN INTENSIVE CARE UNIT	0			0 0	0.00	33.00
40.00 SUBPROVIDER - IPF 1,054,921 0 1,054,921 3,358 314.15 40.00 41.00 SUBPROVIDER - IRF 0 0 0 0 0.00 41.00 43.00 NURSERY 508,263 842 603.64 43.00 44.00 SKILLED NURSING FACILITY 0 0 0 0.00 44.00 44.00 NURSING FACILITY 0 0 0 0.00 44.00 44.00 NURSING FACILITY 0 0 0 0.00 44.00 45.00 NURSING FACILITY 0 0 0 0.00 45.00 200.00 Total (Lines 30 through 199) 8,373,548 8,373,548 29,880 200.00 200.10 Cost Center Description Inpatient Program days Inpatient Capital Cost (col. 5 x col. 6) 8,373,548 29,880 200.00 31.00 ADULTS & PEDIATRICS 547 141,049 30.00 30.00 31.00 INTENSIVE CARE UNIT 0 0 32.00 32.00 32.00 CONNARY CARE UNIT 0 0 <		0			0 0		
41.00 SUBPROVIDER - IRF 0 0 0 0.00 41.00 43.00 NURSERY 508,263 508,263 842 603.64 43.00 44.00 SKILLED NURSING FACILITY 0 0 0 0.00 44.00 500 NURSING FACILITY 0 0 0 0.00 44.00 200.00 Total (lines 30 through 199) 8,373,548 8,373,548 29,880 200.00 Cost Center Description Inpatient Program Capital Cost (col. 5 x col. 6) 0 <td< td=""><td></td><td>1 054 921</td><td>C</td><td>1 054 9</td><td>21 3 358</td><td></td><td></td></td<>		1 054 921	C	1 054 9	21 3 358		
43.00 NURSERY 508,263 508,263 842 603.64 43.00 44.00 SKILLED NURSING FACILITY 0 0 0 0.00 44.00 45.00 NURSING FACILITY 0 0 0 0.00 44.00 45.00 NURSING FACILITY 0 0 0 0.00 45.00 0 Train (lines 30 through 199) 8,373,548 8,373,548 29,880 20.00 Cost Center Description Inpatient Program days Program Capital Cost (col. 5 x col. 6) 8,373,548 29,880 20.00 1 Number of the service cost centers 60 7.00 7.00 7.00 1 Number of the service cost centers 547 141,049 31.00 30.00 31.00 INTENSI VE CARE UNIT 394 121,332 31.00 32.00 33.00 34.00 Subprovi DER - IPF 1,653 519,290 40.00 43.00 41.00 Subprovi DER - IRF 0 0 43.00 44.00 43.00 NURSING FACILITY 0 0 41.00 44.0		1,001,721	(1,001, 2	0 0,000		
44.00 SKILLED NURSING FACILITY 0 0 0 0.00 44.00 45.00 NURSING FACILITY 0 0 0 0 0.00 45.00 200.00 Total (lines 30 through 199) 8,373,548 8,373,548 29,880 200.00 Cost Center Description Inpatient Program days Inpatient Capital Cost (col. 5 x col. 6) 200.00 7.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 ADULTS & PEDIATRICS 547 141,049 30.00 31.00 INTENSI VE CARE UNIT 394 121,332 31.00 32.00 CORNARY CARE UNIT 0 0 34.00 34.00 SUBPROVIDER - IPF 1,653 519,290 41.00 41.00 SUBPROVIDER - IRF 0 0 41.00 43.00 NURSING FACILITY 0 0 41.00 44.00 SKILLED NURSING FACILITY 0 0 43.00 44.00 SUBPROVIDER - IFF 1,653 519,290 41.00		508 263	C	508.2	53 842		
45.00 200.00 NURSI NG FACI LI TY O tatal (lines 30 through 199) 0 8,373,548 0 8,373,548 0 8,373,548 0 29,880 0 200.00 200.00		500, 205		500, 20	0 042		
200.00 Total (lines 30 through 199) 8, 373, 548 8, 373, 548 29, 880 200.00 Cost Center Description Inpatient Program days Inpatient Program Capital Cost (col. 5 x col. 6) Inpatient Program 200.00		0			0 0		
Cost Center Description Inpatient Program days Inpatient Program Capital Cost (col. 5 x col. 6) 1NPATIENT ROUTINE SERVICE COST CENTERS 60 7.00 30.00 ADULTS & PEDIATRICS 547 141,049 30.00 31.00 INTENSIVE CARE UNIT 394 121,332 31.00 32.00 32.00 CORONARY CARE UNIT 0 0 33.00 32.00 33.00 34.00 34.00 34.00 SURGICAL INTENSIVE CARE UNIT 0 0 34.00 44.00 44.00 44.00 44.00 44.00 45.00 0 0 0 45.00 45.00 45.00 0 0 0 0 0 45.00 45.00 0 0 0 0 0 45.0		0 272 540		0 272 5	10 20.000		
Instruction Program days Program Capital Cost (col. 5 x col. 6) Copital Cost (col. 5 x col. 6)			Innationt	0, 373, 5	+0 27,000		200.00
INPATI ENT ROUTI NE SERVI CE COST CENTERS 6.00 7.00 30.00 ADULTS & PEDI ATRI CS 547 141,049 30.00	cost center bescription						
INPATI ENT ROUTI NE SERVI CE COST CENTERS 6.00 7.00 30.00 ADULTS & PEDI ATRI CS 547 141,049 30.00 31.00 INTENSI VE CARE UNI T 394 121,332 31.00 32.00 CORONARY CARE UNI T 0 0 32.00 33.00 BURN INTENSI VE CARE UNI T 0 0 33.00 34.00 SURGI CAL INTENSI VE CARE UNI T 0 0 34.00 40.00 SUBPROVI DER - I PF 1,653 519,290 40.00 41.00 SUBPROVI DER - I RF 0 0 41.00 43.00 NURSERY 609 367,617 43.00 45.00 NURSI NG FACI LI TY 0 0 44.00		Program uays					
6) 6) 6.00 7.00 30.00 ADULTS & PEDIATRICS 547 31.00 INTENSI VE CARE UNIT 394 32.00 CORONARY CARE UNIT 0 32.00 SURN INTENSI VE CARE UNIT 0 33.00 BURN INTENSI VE CARE UNIT 0 34.00 SURGI CAL INTENSI VE CARE UNIT 0 0 0 0 41.00 SUBPROVI DER - I PF 1, 653 519, 290 40.00 43.00 NURSERY 609 367, 617 44.00 5KI LLED NURSI NG FACI LI TY 0 0 45.00 NURSI NG FACI LI TY							
6.00 7.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 ADULTS & PEDIATRICS 547 141,049 30.00 31.00 INTENSIVE CARE UNIT 394 121,332 31.00 32.00 CORONARY CARE UNIT 0 0 32.00 33.00 BURN INTENSIVE CARE UNIT 0 0 33.00 34.00 SURGI CAL INTENSIVE CARE UNIT 0 0 34.00 40.00 SUBPROVIDER - IPF 1,653 519,290 40.00 41.00 SUBPROVIDER - IRF 0 0 41.00 43.00 NURSERY 609 367,617 43.00 45.00 NURSING FACILITY 0 0 44.00							
INPATI ENT_ROUTI NE_SERVICE_COST_CENTERS 30.00 ADULTS & PEDI ATRI CS 547 141,049 30.00 31.00 INTENSI VE_CARE_UNI T 394 121,332 31.00 32.00 CORONARY_CARE_UNI T 0 0 32.00 33.00 BURN_INTENSI VE_CARE_UNI T 0 0 33.00 34.00 SURGI CAL_INTENSI VE_CARE_UNI T 0 0 33.00 34.00 SUBPROVI DER - I PF 1,653 519,290 40.00 41.00 SUBPROVI DER - I RF 0 0 41.00 43.00 NURSERY 609 367,617 43.00 44.00 SKI LLED NURSI NG FACILI TY 0 0 44.00 45.00 NURSI NG FACILI TY 0 0 45.00		6.00		-			
30.00 ADULTS & PEDIATRICS 547 141,049 30.00 31.00 INTENSIVE CARE UNIT 394 121,332 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 SUBPROVIDER - IPF 1,653 519,290 40.00 41.00 SUBPROVIDER - IRF 0 0 41.00 43.00 NURSERY 609 367,617 43.00 44.00 SKILLED NURSING FACILITY 0 0 44.00 45.00 NURSING FACILITY 0 0 44.00	INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00	1			
31.00 INTENSIVE CARE UNIT 394 121,332 31.00 32.00 CORONARY CARE UNIT 0 0 32.00 33.00 BURN INTENSIVE CARE UNIT 0 0 33.00 34.00 SUBGICAL INTENSIVE CARE UNIT 0 0 34.00 40.00 SUBPROVIDER - IPF 1,653 519,290 40.00 41.00 SUBPROVIDER - IRF 0 0 41.00 43.00 NURSERY 609 367,617 43.00 44.00 SKILLED NURSING FACILITY 0 0 44.00 45.00 NURSING FACILITY 0 0 45.00		547	141 049				30.00
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 SUBPROVIDER - IPF 1,653 519,290 40.00 41.00 SUBPROVIDER - IRF 0 0 41.00 43.00 NURSERY 609 367,617 43.00 44.00 SKILLED NURSING FACILITY 0 0 44.00 45.00 NURSING FACILITY 0 0 45.00				•			
33.00 BURN INTENSIVE CARE UNIT 0 0 33.00 34.00 SURGICAL INTENSIVE CARE UNIT 0 0 34.00 40.00 SUBPROVIDER - IPF 1,653 519,290 40.00 41.00 SUBPROVIDER - IRF 0 0 41.00 43.00 NURSERY 609 367,617 43.00 44.00 SKILLED NURSING FACILITY 0 0 44.00 45.00 NURSING FACILITY 0 0 45.00		0,14	121, 332				
34.00 SURGI CAL INTENSIVE CARE UNIT 0 0 34.00 40.00 SUBPROVIDER - IPF 1,653 519,290 40.00 41.00 SUBPROVIDER - IRF 0 0 41.00 43.00 NURSERY 609 367,617 43.00 44.00 SKILLED NURSING FACILITY 0 0 44.00 45.00 NURSING FACILITY 0 0 45.00		0					
40.00 SUBPROVIDER - IPF 1,653 519,290 40.00 41.00 SUBPROVIDER - IRF 0 0 41.00 43.00 NURSERY 609 367,617 43.00 44.00 SKILLED NURSING FACILITY 0 0 44.00 45.00 NURSING FACILITY 0 0 45.00		0					
41.00 SUBPROVIDER - IRF 0 0 41.00 43.00 NURSERY 609 367,617 43.00 44.00 SKILLED NURSING FACILITY 0 0 44.00 45.00 NURSING FACILITY 0 0 45.00		1 4 5 2	E10 200				
43.00 NURSERY 609 367,617 43.00 44.00 SKILLED NURSING FACILITY 0 0 44.00 45.00 NURSING FACILITY 0 0 45.00		1,003	019, 29U				
44.00 SKILLED NURSING FACILITY 0 0 44.00 45.00 NURSING FACILITY 0 0 45.00		400	247 /17				
45.00 NURSING FACILITY 0 0 0 45.00		609	307,017				
		0					
		2 202	1 140 200				
	ZUU. UUTIOTAI (TENES 30 ENFOUGN 199)	3, 203	1, 149, 288	P			200.00

APPOR	Financial Systems FF	RANCI SCAN HEALTH			CN: 15-0015	Peri od:	eu of Form CMS-: Worksheet D	2002 10
ALLON	TOWNERT OF THEATPENT ANOTEEART SERVICE GATTA	12 00010			CN. 13 0013	From 01/01/2020	Part II	
						To 12/31/2020	Date/Time Pre 7/28/2021 7:4	pared:
				Ti tl	e XIX	Hospi tal	Cost	i pili
	Cost Center Description	Capi tal	Tota		Ratio of Cos		Capital Costs	
	•	Related Cost	(fron	Wkst. C,	to Charges	Program	(column 3 x	
		(from Wkst. B,	Part		(col. 1 ÷ co	I. Charges	column 4)	
		Part II, col.		8)	2)			
		26)		2 00	2.00	4.00	F 00	
	ANCI LLARY SERVI CE COST CENTERS	1.00		2.00	3.00	4.00	5.00	
50.00	05000 OPERATING ROOM	6, 776, 255		C	0.0000	00 7, 761, 351	0	50.00
51.00	05100 RECOVERY ROOM	0, 770, 233		0				
52.00	05200 DELIVERY ROOM & LABOR ROOM	359, 882		C				
53.00	05300 ANESTHESI OLOGY	43, 931		C				
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 676, 985		Ő				
54.01	05401 FSED RADIOLOGY - DIAGNOSTIC	1, 547, 707		Ő				
55.00	05500 RADI OLOGY-THERAPEUTI C	522, 509		Ő				
55.01	05501 WOODLAND CANCER CARE CTR	700, 123		Ő				
56.00	05600 RADI OI SOTOPE	0		0				
57.00	05700 CT SCAN	0		0				
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0		0				
59.00	05900 CARDI AC CATHETERI ZATI ON	987, 746		0				
60.00	06000 LABORATORY	726, 807		0				
60.01	06001 FS ED LAB	108, 479		C				1
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	100, 177		0	0.0000		, I	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0		0	0.0000	00 0	o	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	24, 970		Ő				
64.00	06400 I NTRAVENOUS THERAPY	0		C				
65.00	06500 RESPI RATORY THERAPY	260, 214		Ő			-	
66.00	06600 PHYSI CAL THERAPY	189, 560		0				
67.00	06700 OCCUPATI ONAL THERAPY	0		0				
68.00	06800 SPEECH PATHOLOGY	0		0				
69.00	06900 ELECTROCARDI OLOGY	842, 429		0				
70.00	07000 ELECTROENCEPHALOGRAPHY	0		0			0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	96,072		0				
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	197, 800		0				
73.00	07300 DRUGS CHARGED TO PATIENTS	841, 834		0				
74.00	07400 RENAL DI ALYSI S	0		0				
75.00	07500 ASC (NON-DISTINCT PART)	0		0				
76.00	03020 CV RESOURCE CTR	0		0				
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION	0		0				
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0		0	0.0000	00 (0 0	88. 00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0				
90.00	09000 CLINIC	0		C			o o	90.00
90.03	09003 INFUSION OP SERVICES	240,660		0				
91.00	09100 EMERGENCY	1, 613, 466		C			3 0	91.00
91.01	09101 FREE STANDING EMERGENCY DEPT	1, 756, 689		0			0	91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0		C	0.0000	00 175, 347	0	92.00
	OTHER REIMBURSABLE COST CENTERS							
94.00	09400 HOME PROGRAM DI ALYSI S	0		C	0.0000	00 (0 0	94.00
95.00	09500 AMBULANCE SERVICES							95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0		0	0.0000	00 0	0 0	96.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0		0			0 0	97.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0		0			0 0	98.00
200.00	Total (lines 50 through 199)	20, 514, 118	1	C		45, 390, 173		200.00

Health Financial Systems	FRANCI SCAN HEALTH	H MICHIGAN CIT	(In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER	PASS THROUGH COS	TS Provider C	F	eriod: rom 01/01/2020 o 12/31/2020		pared: 1 pm
			e XIX	Hospi tal	Cost	
Cost Center Description		Nursing School		Allied Health	All Other	
	Post-Stepdown		Post-Stepdown	Cost	Medi cal	
	Adjustments		Adjustments		Education Cost	
	1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS	· · ·					
30. 00 03000 ADULTS & PEDIATRICS	0	C	C	0	0	30.00
31.00 03100 I NTENSI VE CARE UNI T	0			-	0	
32. 00 03200 CORONARY CARE UNIT	0			-	0	
	0		-	-	-	
33.00 03300 BURN INTENSIVE CARE UNIT	0		C	0	0	
34.00 03400 SURGICAL INTENSIVE CARE UNIT	0	0	C	0	0	
40. 00 04000 SUBPROVI DER – I PF	0	0	C	0	0	
41. 00 04100 SUBPROVIDER - IRF	0	0	C	0	0	41.00
43.00 04300 NURSERY	0	l o	C	0	0	43.00
44.00 04400 SKILLED NURSING FACILITY	0			0		44.00
45. 00 04500 NURSI NG FACILITY	0			0		45.00
200.00 Total (lines 30 through 199)	0			0	0	200.00
	Curi a a Da d	Tatal Casta				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	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0	21, 916	0.00	547	30.00
31. 00 03100 I NTENSI VE CARE UNI T		l a	3, 764	0.00	394	31.00
32.00 03200 CORONARY CARE UNI T					0	32.00
33. 00 03300 BURN INTENSIVE CARE UNIT					0	•
34. 00 03400 SURGI CAL I NTENSI VE CARE UNI T					0	
					-	
	0		3, 358		1, 653	•
41.00 04100 SUBPROVIDER - IRF	0	0	C		0	
43. 00 04300 NURSERY		0	842	0.00	609	43.00
44.00 04400 SKILLED NURSING FACILITY		0	C	0.00	0	44.00
45.00 04500 NURSING FACILITY		0	C	0.00	0	45.00
200.00 Total (lines 30 through 199)		0	29, 880		3, 203	200.00
Cost Center Description	I npati ent					
	Program					
	Pass-Through					
	Cost (col. 7 x					
	<u>col. 8)</u>					
	9.00					
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	-					00.05
30. 00 03000 ADULTS & PEDI ATRI CS	0					30.00
31.00 03100 INTENSIVE CARE UNIT	0					31.00
32.00 03200 CORONARY CARE UNIT	0					32.00
33.00 03300 BURN INTENSIVE CARE UNIT	0					33.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	0					34.00
40. 00 04000 SUBPROVIDER - IPF	0					40.00
41. 00 04100 SUBPROVIDER - IRF						40.00
	0					•
43. 00 04300 NURSERY	0					43.00
44.00 04400 SKILLED NURSING FACILITY	0					44.00
45.00 04500 NURSING FACILITY	0					45.00
200.00 Total (lines 30 through 199)	0					200.00
						•

PPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PAS	S Provider C		In Lie Period:	Worksheet D	
HROUGH COSTS				From 01/01/2020 To 12/31/2020		
		Titl	e XIX	Hospi tal	Cost	трш
Cost Center Description	Non Physician			Allied Health		
	Anestheti st	Post-Stepdown		Post-Stepdown		
	Cost	Adjustments		Adjustments		
	1.00	2A	2.00	3A	3.00	
ANCI LLARY SERVI CE COST CENTERS					0	
D. OO O5000 OPERATING ROOM 1. OO O5100 RECOVERY ROOM	0			0 0 0 0	0	
	0			0 0	0	
2. 00 05200 DELIVERY ROOM & LABOR ROOM 3. 00 05300 ANESTHESIOLOGY	0				0	1
4. 00 05300 ANESTHESTOLOGY 4. 00 05400 RADI OLOGY-DI AGNOSTI C	0				0	
4. 01 05400 RADIOLOGY - DIAGNOSTIC 4. 01 05401 FSED RADIOLOGY - DIAGNOSTIC	0				0	
5. 00 05500 RADI OLOGY - DIAGNOSTIC	0				0	
5. 01 05501 WOODLAND CANCER CARE CTR	0				0	
6. 00 05600 RADI OI SOTOPE	0				0	
7. 00 05700 CT SCAN	0			0 0	0	
3. 00 05500 MAGNETIC RESONANCE IMAGING (MRI)	0				0	
9. 00 05900 CARDI AC CATHETERI ZATI ON	0				0	
0. 00 06000 LABORATORY					0	
D. 01 06001 FS ED LAB					0	
1.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY				0	0	61.0
2.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0			0 0	0	
3. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0				0	
4. 00 06400 I NTRAVENOUS THERAPY					0	
5. 00 06500 RESPI RATORY THERAPY					0	
6. 00 06600 PHYSI CAL THERAPY	0				0	
7. 00 06700 OCCUPATI ONAL THERAPY	0				0	
B. 00 06800 SPEECH PATHOLOGY	0			0 0	0	
9. 00 06900 ELECTROCARDI OLOGY	0			0 0	0	
0.00 07000 ELECTROENCEPHALOGRAPHY	0			0 0	0	
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	
2.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0			0 0	0	
3. 00 07300 DRUGS CHARGED TO PATIENTS	0	C		0 0	0	73.0
4. 00 07400 RENAL DIALYSIS	0	c c		0 0	0	74.0
5.00 07500 ASC (NON-DISTINCT PART)	0	C		0 0	0	75.0
6.00 03020 CV RESOURCE CTR	0	C		0 0	0	76.0
7.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	C		0 0	0	77. (
OUTPATIENT SERVICE COST CENTERS						
3. 00 08800 RURAL HEALTH CLINIC	0	0)	0 0	0	88. 0
9.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0) (0 0	0	89.0
D. 00 09000 CLINIC	0	0) (0 0	0	90.0
D. 03 09003 INFUSION OP SERVICES	0	0) (0 0	0	90.0
1.00 09100 EMERGENCY	0	0) (0 0	0	91.0
1. 01 09101 FREE STANDING EMERGENCY DEPT	0	0) (0 0	0	91.0
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0		(0	0	92.0
OTHER REIMBURSABLE COST CENTERS						
4. 00 09400 HOME PROGRAM DI ALYSI S	0	C		0 0	0	
5. 00 09500 AMBULANCE SERVICES						95. (
5. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0) (0 0	0	96. (
7.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0) (0 0	0	97. (
B. 00 09850 OTHER REIMBURSABLE COST CENTERS	0	0) (0 0	0	98. (
DO.00 Total (lines 50 through 199)	0	0) (0 0	0	200. (

			H MI CHI GAN CI TY			eu of Form CMS-2	2552-10
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI H COSTS	RVICE OTHER PASS	6 Provider C	JN: 15-0015	Period: From 01/01/2020	Worksheet D Part IV	
TIKOUG	11 00313				To 12/31/2020	Date/Time Pre	
					11	7/28/2021 7:4	1 pm
	Cost Center Description	All Other	Total Cost	e XIX Total	Hospital	Cost Ratio of Cost	
	Cost center bescription	Medi cal	(sum of cols.	Outpatient	(from Wkst. C,		
		Educati on Cost		Cost (sum of		$(col. 5 \div col.$	
			4)	col s. 2, 3,		7)	
			· ·	and 4)	,	(see	
						instructions)	
		4.00	5.00	6.00	7.00	8.00	
	ANCI LLARY SERVI CE COST CENTERS						
	05000 OPERATING ROOM	0	0		0 0		
	05100 RECOVERY ROOM	0	0		0 0	0.000000	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0.000000	
	05300 ANESTHESI OLOGY	0	0		0 0	0.000000	
54.00 54.01	05400 RADI OLOGY-DI AGNOSTI C 05401 FSED RADI OLOGY - DI AGNOSTI C	0	0		0 0	0.000000	
54.01 55.00	05500 RADIOLOGY - DIAGNOSTIC	0	0			0.000000	
55.00 55.01	05501 WOODLAND CANCER CARE CTR	0				0.000000	
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 MAGNETIC RESONANCE IMAGING (MRI)	0			0 0	0.000000	
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0.000000	
60.00	06000 LABORATORY	0	0		0 0	0. 000000	
60.01	06001 FS ED LAB	0	0		0 0	0. 000000	
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		-		-		61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0 0	0.000000	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 0	0. 000000	63.00
64.00	06400 I NTRAVENOUS THERAPY	0	0		0 0	0. 000000	64.00
65.00	06500 RESPI RATORY THERAPY	0	0		0 0	0. 000000	65.00
66.00	06600 PHYSI CAL THERAPY	0	0		0 0	0.000000	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0 0	0. 000000	67.00
68.00	06800 SPEECH PATHOLOGY	0	0		0 0	0. 000000	
69.00	06900 ELECTROCARDI OLOGY	0	0		0 0	0.000000	
	07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0.000000	1
	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0		0 0	0.00000	
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0.000000	
	07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0.000000	
	07400 RENAL DI ALYSI S	0	0		0 0	0.000000	
	07500 ASC (NON-DISTINCT PART) 03020 CV RESOURCE CTR	0	0		0 0	0.000000	
	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0		0 0	0.000000	
77.00	OUTPATIENT SERVICE COST CENTERS	0	0		0 0	0.000000	//.00
88.00	08800 RURAL HEALTH CLINIC	0	0		0 0	0.000000	88.00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0	0.000000	
90.00	09000 CLINIC	0	0		0 0	0. 000000	
	09003 I NFUSI ON OP SERVI CES	0	0		0 0	0. 000000	
	09100 EMERGENCY	0	0		0 0		
	09101 FREE STANDING EMERGENCY DEPT	0	0		0 0		
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 0		
	OTHER REIMBURSABLE COST CENTERS						
94.00	09400 HOME PROGRAM DI ALYSI S	0	0		0 0	0.000000	94.00
	09500 AMBULANCE SERVI CES						95.00
	09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0 0	0.000000	
	09700 DURABLE MEDICAL EQUIP-SOLD	0	0		0 0	0.000000	97 00
					-		
	09850 OTHER REIMBURSABLE COST CENTERS	0	0			0.000000	

		RANCISCAN HEALTH				In Lie	u of Form CMS-2	2552-10
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF H COSTS	RVICE OTHER PASS	Provider CO	CN: 15-0015	Period: From 01/C To 12/3	01/2020 1/2020	Worksheet D Part IV Date/Time Pre 7/28/2021 7:4	
			Ti tl	e XIX	Hospi	tal	Cost	
	Cost Center Description	Outpatient	Inpati ent	Inpati ent	Outpat		Outpati ent	
	•	Ratio of Cost	Program	Program	Prog		Program	
		to Charges	Charges	Pass-Throug	h Char	ges	Pass-Through	
		(col. 6 ÷ col.	U	Costs (col.	8	0	Costs (col. 9	
		7)		x col. 10)			x col. 12)	
		9.00	10.00	11.00	12.	00	13.00	
	ANCI LLARY SERVI CE COST CENTERS	1 1		1				
50.00	05000 OPERATI NG ROOM	0. 000000	7, 761, 351		0	0	0	50.00
51.00	05100 RECOVERY ROOM	0. 000000	0		0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	735, 672		0	0	0	52.00
53.00	05300 ANESTHESI OLOGY	0. 000000	621, 697		0	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	5, 382, 620		0	0	0	54.00
54.01	05401 FSED RADIOLOGY - DIAGNOSTIC	0. 000000	0		0	0	0	54.01
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	1, 957, 322		0	0	0	55.00
55.01	05501 WOODLAND CANCER CARE CTR	0. 000000	105, 645		0	0	0	55.01
56.00	05600 RADI OI 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 MAGNETIC RESONANCE I MAGING (MRI)	0. 000000	0		0	0	0	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	1, 895, 858		0	0	0	59.00
60.00	06000 LABORATORY	0. 000000	8, 390, 274		0	0	0	60.00
60. 01	06001 FS ED LAB	0. 000000	0		0	0	0	60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY							61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	0		0	0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0		0	0	0	63.00
64.00	06400 I NTRAVENOUS THERAPY	0. 000000	0		0	0	0	64.00
65.00	06500 RESPI RATORY THERAPY	0. 000000	1, 445, 007		0	0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0. 000000	472, 346		0	0	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	3, 125, 468		0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	2,033,099		0	0	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATI ENTS	0. 000000	2, 176, 882		0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	5, 597, 757		0	0	0	73.00
74.00	07400 RENAL DI ALYSI S	0. 000000	0		0	0	0	74.00
75.00	07500 ASC (NON-DI STI NCT PART)	0. 000000	0		0	0	0	75.00
76.00	03020 CV RESOURCE CTR	0. 000000	0		0	0	0	76.00
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000	0		0	0	0	77.00
88.00	OUTPATIENT SERVICE COST CENTERS	0. 000000	0		0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000	0		0	0	0	89.00
90.00	09000 CLINIC	0. 000000	0		0	0	0	90.00
90.00 90.03	09003 I NFUSI ON OP SERVI CES	0. 000000	0		0	0	0	90.00
90. 03 91. 00	09100 EMERGENCY	0. 000000	3, 513, 828		0	0	0	90.03
91.00 91.01	09101 FREE STANDING EMERGENCY DEPT	0. 000000	3, 313, 626		0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	175, 347		0	0	0	92.00
72.00	OTHER REIMBURSABLE COST CENTERS	0.000000	170, 347	1	0	0	0	72.00
94.00	09400 HOME PROGRAM DI ALYSI S	0. 000000	0		0	0	0	94.00
95.00	09500 AMBULANCE SERVICES	0.000000	0		5	0	0	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 REI MBURSABLE COST CENTERS	0. 000000	0		0	0	0	98.00
200.00			45, 390, 173		0	0		200.00
	· · · · · · · · · · · · · · · · · · ·	1 I	,,	1	<u>1</u>	0	Ű	

61.00 06100 PBP CLINICAL LAB SERVICES-PROM ONLY 0.00000 0 0 61.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.000000 0 0 0 62.00 0 0 0 0 62.00 0 0 0 0 62.00 0 0 0 0 0 62.00 0 0 0 0 62.00 0 0 0 0 62.00 0 0 0 0 62.00 0 0 0 0 0 0 0 0 0 0 63.00 65.00 65.00 65.00 66.00 RESPI RATORY HERAPY 0.000000 0 0 0 0 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 67.00 0 0 0 67.00 0 60.00 67.00 0 0 67.00 0 0 0 0 70.00 70.00 70.00 <t< th=""><th>Health Financial Systems Fi</th><th>RANCI SCAN HEALTH</th><th>I MICHIGAN CITY</th><th>1</th><th>In Lie</th><th>u of Form CMS-</th><th>2552-10</th></t<>	Health Financial Systems Fi	RANCI SCAN HEALTH	I MICHIGAN CITY	1	In Lie	u of Form CMS-	2552-10
Cost Center Description Cost Solution Title XIX Hoggital Cost Cost Center Description 20st to from Services (see high mbursed binness) Cost Center Description Post Services (see high mbursed binness) Relitorse (see high mbursed binness) Solo of the Services (see high mbursed binness) Relitorse (see high mbursed binness) Solo of the Services (see high mbursed binness) Solo of the Serv	APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	O VACCINE COST	Provider C		From 01/01/2020	Part V Date/Time Pre	pared:
Cast Center Description Dast to Charges Ratio From Worksheet C, Part I, col. Charges Services (See Inst.) (See Inst.) Casts (See Inst.) (See Inst.) Costs (See Inst.) (See Inst.) MACILLARY SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 00.00 05030 (PENATINK ROOM 0.00 01000 (See Inst.) 0.000000 0 19,856,208 0 0.00 0.00 05030 (PENATINK ROOM 0.000000 0 19,856,208 0 0 0 0.00 05030 (PENATINK ROOM 0.000000 0 0 19,856,208 0 0 0 0.00 05030 (PENATINK ROOM 0.000000 0 0 19,856,208 0 </td <td></td> <td></td> <td>Ti +1</td> <td></td> <td>Hocni tal</td> <td></td> <td>I pm</td>			Ti +1		Hocni tal		I pm
Cost Center Description Cost to ChargePPS ReinBursed Worksheet (, col., 9 err) (cos (see) (set inst.) Cost Services Not Ded. & Coins. Cost Services Not Subject To Ded. & Coins. PPS Services Services Not Subject To Ded. & Coins. MACILLARY SERVICE COST CENTERS 1.00 2.00 3.00 6.00 5.00			1111		позрітаі		
Barti G From Part 1, col. 9 Services inst.) Beinbursed Subject 10 bd. 6 Coins. (see inst.) Services Subject 10 bd. 6 Coins. (see inst.) Services Subject 10 bd. 6 Coins. (see inst.) 1.00 2.00 3.00 4.00 0.00 5000 (PEATINE ROOM 0.000000 0 19, 852,000 5.00 0.00 0.000000 0 19, 852,000 0 0 0.00 0.000000 0 19, 852,000 0 0 51,00 0.00 0.000000 0 19, 852,000 0 0 51,00 0.00 0.000000 0 19, 852,000 0 0 53,00 0.000000 0 19, 863,38 0 0 54,00 0.000000 0 10, 863,38 0 0 55,00 0.000000 0 10, 863,38 0 0 55,00 0.000000 0 0 0 0 0 0 0 55,00 0.000000 0 0 0 0 0 0	Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost		
Worksheet C, Part I, col., 9 Inst.) Services Not Ded. & Corns. Services Not Subject To Ded. & Corns. 00 1.00 2.00 3.00 4.00 5.00 00 05000 (Cornst.) 0.00000 0 1.00 5.00 00 05000 (Cornst.) 0.00000 0 1.9, E62.288 0 0 5.00 00 05000 (Cornst.) 0.00000 0 1.9, E62.288 0 5.00 00 05000 (Cornst.) 0.00000 0 1.81.395 0 53.00 00 0.000000 0 1.81.395 0 55.00							
Part I. col. 9 Subject To Subject To Subject To 50 00 60000 002400 1.00 2.00 3.00 4.00 5.00 50 00 60000 002400 1.00 2.00 1.00 5.00 0 0 0 5.00 50 00 60000 002400 0						()	
Image: state in the s			,	Subject To	Subject To		
Inclutary SERVICE COST CENTERS 0.00 3.00 4.00 5.00 0.00 05000 0FERATING ROM 0.000000 0 19.85, 208 0 0 50.00 0.00 05000 0EEVERY ROMA 0.000000 0 0 0 51.00 52.00 05200 DELIVERY ROMA & LABOR ROM 0.000000 0 1, 801.99 0 53.00 54.00 06400 RADIOLOCY - DIAGNOSTIC 0.000000 0 0 0 55.00 55.00 05500 RADIOLAND CARCECARE CARE 0.000000 0 0 0 55.00 55.00 05500 RADIOLAND CARCECARE CARE 0.000000 0 0 0 0 55.00 50.00 05600 0 0 0 0 0 0 0 0 0 0 0 55.00 50.00 05600 0 0 0 0 0 0 0 0 0 0 0 0				Ded. & Coins.	Ded. & Coins.		
MACLLARY SERVICE COST CENTERS 000000 0 19.856.208 0 05000 51.00 05100 RECOVERN ROM 0.000000 0 19.856.208 0 0 0 0 0 0 0 0 0 0 0 0 51.00 0 0 0 0 0 0 52.00 0 0 0 0 52.00 0 0 0 0 0 0 52.00 0 0 0 0 0 0 52.00 0 0 0 0 0 0 0 52.00 0 <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td></td<>							
00.00 DEGODO JOPERATI NO. ROOM 0.000000 0 19.865, 208 0 0 0 0 51.00 52.00 DESCON EXCURSEN ROOM & LABOR ROOM 0.000000 0 5.707 0 0 53.00 52.00 DESCON DELLIVERY ROOM & LABORSTIC 0.000000 0 1.801.395 0 0 53.00 53.00 DESCON ADLOLOGY - DI AGNOSTIC 0.000000 0 0 0 54.00 55.00 DESCON ADLOLOGY - THEAPEUTIC 0.000000 0 0 0 55.01 0 0 0 55.01 0 0 0 0 55.01 0		1.00	2.00	3.00	4.00	5.00	
51:00 00:51:00 RECOVERY ROOM 0.000000 0 57:00 00:50:00 00:00:00:00 00:00:00:00 00:00:00:00:00:00:00:00:00:00:00:00:00:				10.05/.00			
52 00 05200 DELI VERY ROOM & LABOR ROOM 0.000000 0 5.707 0 0 52.00 53 00 05300 MASTHESI LOCAY 0.000000 0 1.801.395 0 0 53.00 0 53.00 0 54.00 0 0.000000 0 0.6000 0 54.00 0.54.01 0.000000 0 0.54.01 0.55.01 0.00 0.55.00 0.55.00 0.55.00 0.55.00 0.00 0.00 0.55.00 0.00 0.00 0.55.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00							•
33 00 05300 AMESTHESI OLCOY 0.000000 0 15.00 55.00 055.00 ANDIOLOCY-10KANOSTI C 0.000000 0 0 0 54.00 054.00 0 0 0 55.00 0 055.00 0 0 0 0 0 55.00 0 055.00 0							•
64 00 06400 RAD10LORY-DIAGNOSTIC 0.000000 0 19, 680, 338 0 0 54, 00 65 00 05500 RAD10LORY-THERAPEUTIC 0.000000 0 0 55, 00 05500 0 0 0 0 55, 00 0 0 0 0 0 0 0 0 55, 00 0 0 0 0 0 0 55, 00 0 0 0 0 0 0 55, 00 0			-				•
64.01 05401 FSED RADIOLOGY - DIAGNOSTIC 0.000000 55.01 0 0500 0 0 0 0 0 0 0 0 0 0 0 0 0 55.01 0			-				
55.00 05500 RADI OLOXY - THERAPEUT C 0.000000 0 6.009, 199 0 0 55.00 55.00 05500 RADI OLOXAND CANCER CARE CTR 0.000000 0 0 55.00 56.00 05000 RADI OLSTOPE 0.000000 0 0 0 55.00 57.00 057.00 057.00 0 0 0 0 57.00 58.00 05800 MARCHT C, RESONANCE THARING (MRI) 0.000000 0 76.00 76.00 60.00							
55.01 0501 WOODLAND CARCER CARE CTR 0.000000 0 0 55.01 055.00 0500 CTS 0.00000 0 0 0 55.00 0 55.00 0.00000 0 0 0 55.00 0 55.00 0.00000 0 0 0 55.00 0 0.00000 0 0 0 55.00 0 0.00000 0 0 0 55.00 0 0.00000 0			-		-		•
64.00 05600 RAD ID SOTOPE 000000 0 0 0 57.00 57.00 057.00 057.00 057.00 057.00 057.00 0 0 0 57.00 057.00 057.00 0 0 0 57.00 0 59.00 0 0 0 0 0 57.00 0 0 0 0 57.00 0 0 0 0 0 0 59.00 0							•
57:00 05700 0 0 0 0 0 0 0 57:00 05700 0			-	_/ • · • / · ·			•
B3:00 05800 MAGNETIC RESONANCE IMAGINE 0 <td< td=""><td></td><td></td><td>-</td><td></td><td>-</td><td></td><td>•</td></td<>			-		-		•
59:00 05900 CARDIAC CATHETERIZATION 0.000000 768,071 0 59:00 60:00 060001 DABORATORY 0.000000 0 12,586,639 0 0 60:01 60:01 06001 PBP CLINICAL LAB SERVICES-PRGM ONLY 0.000000 0 0 0 0 61:00 0 0 0 0 64:00 0			-		-		•
60.00 LABDRATORY 0.000000 0 12,586,639 0 0 60.01 60.01 FS ED LAB 0.000000 0							•
60.01 60.01 FS ED LAB 0.000000 0 0 0 60.01 61.00 61.00 61.00 61.00 61.00 61.00 62.00 66.00 67.00 67.00 67.00 67.00 70.00 71.00 71.00 71.0			-		-		•
61:00 PBP CLI NI CAL LAB SERVICES-PROM ONLY 0.00000 0 61:00 62:00 72:00 72:00				,,			
62:00 062:00 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.000000 0 0 62:00 66:00 66:00 66:00 0 0 0 63:00 66:00 0 0 0 0 0 0 63:00 66:00 0 0 0 64:00 0 0 0 0 64:00 0 0 0 0 64:00 0 0 0 0 64:00 0 0 0 0 64:00 0 0 0 0 0 0 64:00 0 0 0 0 0 0 0 64:00 0 0 0 0 0 0 66:00 0		0.000000			0 0		61.00
64.00 INTRAVENOUS THERAPY 0.000000 0 0 0 64.00 65.00 06500 RESPI RATORY THERAPY 0.000000 0 231,452 0 0 65.00 66.00 06600 PHYSI CAL THERAPY 0.000000 0 2,404,063 0 0 66.00 66.00 06000 SPECE THATOLOGY 0.000000 0 0 0 67.00 66.00 MEGO ELECTROCARDIOLOGY 0.000000 0 0 0 68.00 68.00 070.00 IECETROENCEPHALOGRAPHY 0.000000 0 2,185,745 0 71.00 770.00 71.00 07100 DIMEDI CAL SUPPLIES CHARGED TO PATIENTS 0.000000 11,690,264 0 73.00 73.00 07300 DRUSC STARGED TO PATIENTS 0.000000 0 0 0 74.00 74.00 07400 RENAL DI ALYSIS 0.000000 0 0 0 75.00 75.00 0750 ASC (NON-DI STINCT PART) 0.000000 <td></td> <td></td> <td>0</td> <td></td> <td>0 0</td> <td>0</td> <td>62.00</td>			0		0 0	0	62.00
65.00 06500 RESPIRATORY THERAPY 0.000000 231,452 0 0 65.00 65.00 06600 PHYSICAL THERAPY 0.000000 0 2,404,063 0 0 66.00 0 66.00 0 0 0 0 67.00 67.00 67.00 0 0 0 0 67.00 68.00 0 0 0 0 0 68.00 0 0 0 0 0 68.00 0 0 0 0 68.00 0 0 0 0 0 0 68.00 0 0 0 0 69.00 0 0 0 69.00 0	63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0		0 0	0	63.00
66.00 06600 PHYSICAL THERAPY 0.000000 0 2,404,063 0 0 66.00 67.00 06700 00 0	64.00 06400 INTRAVENOUS THERAPY	0. 000000	0		0 0	0	64.00
67.00 06700 0CCUPATIONAL THERAPY 0.000000 0 0 0 67.00 0	65. 00 06500 RESPI RATORY THERAPY	0. 000000	0	231, 45	2 0	0	65.00
68:00 06800 SPECH PATHOLOGY 0.000000 0 0 0 68:00 69:00 06900 ELECTROCARDIOLOGY 0.000000 0 3,899,325 0 0 69:00 70:00 07000 ELECTROCARDIOLOGY 0.000000 0 0 0 71:00 71:00 07000 ELECTROCARDIOLOGY 0.000000 0 2,870,591 0 71:00 72:00 07200 INPL DEV. CHARGED TO PATIENTS 0.000000 0 11,690,264 0 73:00 73:00 73:00 73:00 74:00 72:00 0 0 0 73:00 73:00 0 0 0 73:00 73:00 0 0 0 73:00 0 0 73:00 73:00 0 0 0 73:00 0 0 0 73:00 73:00 0 0 0 0 0 0 0 73:00 0 0 0 0 0 0 0 </td <td>66. 00 06600 PHYSI CAL THERAPY</td> <td>0. 000000</td> <td>0</td> <td>2, 404, 06</td> <td>3 0</td> <td>0</td> <td>66.00</td>	66. 00 06600 PHYSI CAL THERAPY	0. 000000	0	2, 404, 06	3 0	0	66.00
69:00 0.6900 LECTROCARDIOLOGY 0.000000 0 3, 899, 325 0 0 69:00 70:00 07000 ELECTROENCEPHALOGRAPHY 0.000000 0 0 0 70:00 71:00 07100 MPL. ESUPALIES CHARGED TO PATIENTS 0.000000 0 2, 185, 745 0 0 73:00 073:00 07400 RENAL DIALYSIS 0.000000 0 11, 690, 264 0 73:00 073:00 073:00 0.000000 0 0 0 74:00 07400 RENAL DIALYSIS 0.000000 0 0 0 73:00 07700 ACMONTOR ENAL DIALYSIS 0.000000 0 0 0 0 74:00 74:00 0 0 0 0 0 0 75:00 75:00 75:00 0 <td></td> <td></td> <td>0</td> <td></td> <td>0 0</td> <td>0</td> <td>67.00</td>			0		0 0	0	67.00
70.00 070.00 ELECTROENCEPHALOGRAPHY 0.000000 0			-		-		68.00
71.00 071.00 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0.000000 2,185,745 0 0 71.00 72.00 072001 IMPL. DEV. CHARGED TO PATIENTS 0.000000 0 2,670,591 0 0 72.00 73.00 07300 RENAL DI ALYSI S 0.000000 0				3, 899, 32			•
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 0 2,670,591 0 0 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 0 11,690,264 0 0 73.00 74.00 07400 RENAL DIALYSIS 0.000000 0 0 0 0 74.00 0 0 0 0 74.00 75.00 0 0 0 0 0 0 0 0 0 0 0 75.00 0 0 0 0 0 0 0 0 0 0 75.00 0 0 0 0 0 0 75.00 0 0 0 0 0 0 0 0 0 0 75.00 0			0		-		•
73.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 0 11,690,264 0 0 73.00 74.00 07400 RENAL DI ALYSIS 0.000000 0 0 0 0 73.00 75.00 050 ASC (NON-DI STINCT PART) 0.000000 0 0 0 0 75.00 76.00 03020 CV RESOURCE CTR 0.000000 0 0 0 77.00 07700 ALLOGENEI C STEM CELL ACQUISITION 0.000000 0 0 0 77.00 0017PATIENT SERVICE COST CENTERS 0.000000 0 0 0 0 0 0 77.00 00.00000 FEDERALLY QUALIFIED HEALTH CENTER 0.000000 0							•
74.00 07400 RENAL DIALYSIS 0.000000 0 0 0 74.00 75.00 07500 ASC (NON-DI STI NCT PART) 0.000000 0 0 0 75.00 76.00 03020 CV RESOURCE CTR 0.000000 0 0 0 76.00 77.00 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON 0.000000 0 0 0 0 0UTPATI ENT SERVICE COST CENTERS 0.000000 0			-				•
75.00 07500 ASC (NON-DISTINCT PART) 0.000000 0 0 0 75.00 75.00 000000 0 0 0 75.00 75.00 000000 0 0 0 75.00 0 0 0 0 0 0 0 75.00 0 0 0 0 0 0 0 75.00 0 0 0 0 0 0 0 0 0 0 0 0 75.00 0							•
76.00 03020 CV RESOURCE CTR 0.000000 0 0 0 76.00 077.00 ALLOGENEL C STEM CELL ACQUISITION 0.000000 0 0 0 0 77.00 0UTPATIENT SERVICE COST CENTERS 0.000000 0 0 0 0 0 0 77.00 08800 RURAL HEALTH CLINIC 88.00 88.00 88.00 0.00000 0 0 0 90.00 <td></td> <td></td> <td>0</td> <td></td> <td></td> <td></td> <td>•</td>			0				•
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION 0.00000 0 0 0 0 77.00 0UTPATI ENT SERVICE COST CENTERS 0.00000 0 <td< td=""><td></td><td></td><td>-</td><td></td><td></td><td></td><td></td></td<>			-				
OUTPATI ENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 88.00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 88.00 90.00 09000 CLINIC 0.000000 0 0 0 90.00 90.01 09000 CLINIC 0.000000 0 0 0 90.00 90.03 INFUSION OP SERVICES 0.000000 0 0 0 90.03 91.00 09101 EREGENCY 0.000000 0 0 91.00 91.01 09101 FREE STANDING EMERGENCY DEPT 0.000000 0 0 91.01 92.00 092200 0BSERVATI ON BEDS (NON-DI STINCT PART) 0.000000 0 0 92.00 071HER REI MBURSABLE COST CENTERS 0.000000 0 0 94.00 95.00 09500 AMBULANCE SERVI CES 0.000000 0 95.00 95.00 96.00 96.00 96.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00							•
88.00 08800 RURAL HEALTH CLINIC 88.00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 88.00 90.00 09000 CLINIC 0.000000 0 0 90.00 90.00 09000 CLINIC 0.000000 0 0 0 90.00 90.00 09000 CLINIC 0.000000 0 0 0 90.00 90.00 09000 EMERGENCY 0.000000 0 0 0 90.00 91.00 09101 FREE STANDI NG EMERGENCY DEPT 0.000000 0 0 0 91.01 92.00 0BSERVATI ON BEDS (NON-DI STINCT PART) 0.000000 0 2,000,467 0 92.00 92.00 OBSERVATI ON BEDS (NON-DI STINCT PART) 0.000000 0 0 92.00 92.00 94.00 09400 HOME PROGRAM DI ALYSIS 0.000000 0 0 92.00 95.00 09500 AMBULANCE SERVICES 0.000000 0 0 95.00 <td></td> <td>0.00000</td> <td>0</td> <td></td> <td>5 0</td> <td>0</td> <td>//.00</td>		0.00000	0		5 0	0	//.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 90.00 09000 CLINIC 0.000000 0 0 0 90.00 90.03 09003 INFUSION OP SERVICES 0.000000 0 0 0 90.03 91.00 09100 EMERGENCY 0.000000 0 18,839,566 0 0 91.01 91.01 OP101 FREE STANDING EMERGENCY DEPT 0.000000 0 0 0 91.01 92.00 OBSERVATION BEDS (NON-DISTINCT PART) 0.000000 0 2,000,467 0 0 92.00 92.00 OP300 HOME PROGRAM DIALYSIS 0.000000 0 2,000,467 92.00 92.00 94.00 09400 HOME PROGRAM DIALYSIS 0.000000 0 0 92.00 95.00 95.00 09500 AMBULANCE SERVICES 0.000000 0 0 95.00 96.00 09600 DURABLE MEDICAL EQUI P-RENTED 0.000000 0 0 0 96.00 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>88 00</td>							88 00
90.00 09000 CLINIC 0.000000 0 0 0 90.00 90.00 90.03 09003 INFUSION OP SERVICES 0.000000 0 0 0 0 90.03 91.00 09100 EMERGENCY 0.000000 0 18,839,566 0 0 91.00 91.01 09101 FREE STANDING EMERGENCY DEPT 0.000000 0 0 0 91.00 92.00 085ERVATION BEDS (NON-DISTINCT PART) 0.000000 0 2,000,467 0 92.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.000000 0 2,000,467 0 92.00 94.00 09400 HOME PROGRAM DIALYSIS 0.000000 0 0 92.00 92.00 95.00 09500 AMBULANCE SERVICES 0.000000 0 0 95.00 96.00 96.00 96.00 96.00 97.00 97.00 97.00 97.00 97.00 97.00 98.00 98.00 98.00 98.00 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>•</td>							•
90.03 09003 INFUSION OP SERVICES 0.000000 0 0 0 90.03 91.00 09100 EMERGENCY 0.000000 0 18,839,566 0 0 91.00 91.01 09101 FRE STANDING EMERGENCY DEPT 0.000000 0 0 0 91.01 92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0.000000 0 2,000,467 0 0 92.00 94.00 09400 HOME PROGRAM DIALYSIS 0.000000 0 2,000,467 0 92.00 92.00 95.00 09400 HOME PROGRAM DIALYSIS 0.000000 0 0 94.00 95.00 96.00 09500 AMBULANCE SERVICES 0.000000 0 0 95.00 96.00 97.00 09700 DURABLE MEDICAL EQUIP-RENTED 0.000000 0 0 0 97.00 98.00 09850 OTHER REI MBURSABLE COST CENTERS 0.000000 0 0 0 98.00 920.00 Subtotal (see instructions) 0 0 0 0 200.00 201		0, 000000	0		0 0	0	•
91.00 09100 EMERGENCY 0.000000 0 18,839,566 0 0 91.00 91.00 91.01 09101 FREE STANDING EMERGENCY DEPT 0.000000 0 0 0 0 0 91.01 92.00 09200 (DBSERVATION BEDS (NON-DISTINCT PART) 0.000000 0 2,000,467 0 0 92.00 0THER REIMBURSABLE COST CENTERS 0 0.000000 0 0 94.00 94.00 94.00 94.00 94.00 94.00 94.00 95.00 09500 AMBULANCE SERVICES 94.00 0 95.00 95.00 96.00 96.00 96.00 96.00 96.00 96.00 96.00 96.00 96.00 96.00 96.00 96.00 96.00 96.00 96.00 96.00 96.00 96.00 96.00 97.00 97.00 97.00 97.00 98.00 98.00 98.00 98.00 98.00 98.00 98.00 98.00 98.00 98.00 92.00.00 200.00			0				•
91.01 O9101 FREE STANDING EMERGENCY DEPT 0.000000 0 0 0 91.01 92.00 OBSERVATION BEDS (NON-DISTINCT PART) 0.000000 0 2,000,467 0 0 92.00 07HER REI MBURSABLE COST CENTERS 0 0 0 94.00 94.00 09400 HOME PROGRAM DI ALYSIS 0.000000 0 94.00 94.00 95.00 09500 AMBULANCE SERVICES 0.000000 0 0 95.00 9500 0 96.00 97.00 97.00 97.00 97.00 97.00 97.00 98.00 98.00 98.00 98.00 98.00 98.00 98.00 98.00 98.00 98.00 92.00.00 200.00 200.00 200.00 200.0	91. 00 09100 EMERGENCY						•
92.00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 0.000000 0 2,000,467 0 0 92.00 0THER REIMBURSABLE COST CENTERS 0.000000 0 0 94.00 94.00 95.00 09500 AMBULANCE SERVICES 0.000000 0 0 95.00 96.00 00600 0 0 95.00 96.00 0 0 0 95.00 97.00 00600 0 0 0 95.00 96.00 00600 0 0 0 96.00 97.00 00700 DURABLE MEDI CAL EQUI P-SOLD 0.000000 0 0 0 97.00 97.00 9850 OTHER REI MBURSABLE COST CENTERS 0.000000 0 0 98.00 9850 0 98.00 98.00 0 0 98.00 98.00 200.00 200.00 200.00 200.00 200.00 200.00 200.00 200.00 201.00 201.00 201.00 201.00 201.00 <t< td=""><td></td><td></td><td>0</td><td></td><td></td><td>0</td><td></td></t<>			0			0	
OTHER REI MBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DI ALYSI S 0.000000 0 94.00 95.00 09500 AMBULANCE SERVI CES 0.000000 0 95.00 96.00 09600 DURABLE MEDI CAL EQUI P-RENTED 0.000000 0 0 0 96.00 97.00 09700 DURABLE MEDI CAL EQUI P-SOLD 0.000000 0 0 0 97.00 97.00 0 98.00 0 98.00 0 0 0 97.00 0 0 0 97.00 97.00 0 0 0 97.00 97.00 0 0 97.00 97.00 0 0 97.00 97.00 0 98.00 9850 0 0 98.00 98.00 0 98.00 0 98.00 98.00 200.00 200.00 200.00 200.00 201.00 201.00 201.00 201.00 201.00	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						
95.00 09500 AMBULANCE SERVICES 0.000000 0 0 95.00 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0.000000 0 0 0 96.00 97.00 09700 DURABLE MEDICAL EQUIP-SOLD 0.000000 0 0 0 97.00 98.00 09850 OTHER REIMBURSABLE COST CENTERS 0.000000 0 0 0 98.00 200.00 Subtotal (see instructions) 0 106,646,028 0 0 200.00 201.00 Less PBP Clinic Lab. Services-Program 0 0 0 201.00	OTHER REIMBURSABLE COST CENTERS						
96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0.000000 0 0 0 96.00 96.00 97.00 09700 DURABLE MEDICAL EQUIP-SOLD 0.000000 0 0 0 97.00 97.00 09800 0 0 0 97.00 97.00 09800 0 0 0 97.00 97.00 98.00 0 0 0 0 97.00 98.00 0 0 0 0 97.00 98.00 0 0 0 98.00 0 0 0 0 98.00 0 0 0 0 98.00 0 0 0 0 98.00 0 200.00 200.00 200.00 200.00 200.00 201.00							94.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD 0.000000 0 0 0 97.00 98.00 09850 OTHER REIMBURSABLE COST CENTERS 0.000000 0 0 0 98.00 200.00 Subtotal (see instructions) 0 106,646,028 0 0 200.00 201.00 Less PBP Clinic Lab. Services-Program 0 0 0 201.00			0		C		95.00
98.00 09850 OTHER RELIMBURSABLE COST CENTERS 0.000000 0 0 0 98.00 200.00 Subtotal (see instructions) 0 106,646,028 0 0 200.00 201.00 Less PBP Clinic Lab. Services-Program 0 0 0 201.00			0		0 0		•
200.00 Subtotal (see instructions) 0 106,646,028 0 0 200.00 201.00 Less PBP Clinic Lab. Services-Program 0 0 0 201.00 0nly Charges 0 0 0 201.00 0 0 201.00			0		0 0		97.00
201.00 Less PBP Clinic Lab. Services-Program 0 0 201.00 Only Charges		0. 000000	0		0 0		
Only Charges			0	106, 646, 02	8 0	0	
Only charges 202.00 Net Charges (Line 200 - Line 201) 0 106, 646, 028 0 0 202.00	5				0 0		201.00
ער איז	202.00 Not Charges (Line 200 Line 201)		_	106 444 00		_	202 00
		I	0	100, 040, 02		0	1202.00

52.00 05200 DELLIVERY ROOM & LABOR ROOM 0 0 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 55.00 56.00 56.00 56.00 56.00 56.00 56.00 58.00 58.00 58.00 58.00 59.00 50.00 50.00 50.00 <th>Health Financial Systems FF</th> <th>RANCISCAN HEALTH</th> <th>MICHIGAN CITY</th> <th>In Lie</th> <th>u of Form CMS-2552-10</th>	Health Financial Systems FF	RANCISCAN HEALTH	MICHIGAN CITY	In Lie	u of Form CMS-2552-10
Cost Cost <th< td=""><td>APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND</td><td>VACCINE COST</td><td>Provider CCN: 15-0</td><td>From 01/01/2020</td><td>Part V Date/Time Prepared:</td></th<>	APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider CCN: 15-0	From 01/01/2020	Part V Date/Time Prepared:
Cost Center Description Cost Cest Reinbursed Services 0 (act) Cest Reinbursed (act) Cest Reinbursed (act) <thcest Reinbursed (act) <thcest Reinbursed (a</thcest </thcest 			Title XIX	Hospi tal	
Reinbursed Subject To Ded & Corns. (see inst.) Reinbursed Subject To Subject To Ded & Corns. (see inst.) Reinbursed Subject To Subject To Ded & Corns. (see inst.) 50.00 65000 65000 50.00 50.00 50.00 65000 0 51.00 50.00 50.00 65000 0 51.00 50.00 51.00 50.00 65000 0 0 53.00 53.00 50.00 65000 0 0 0 53.00 50.00 65000 RADIOLOGY PLANDON'SIC 0 0 0 54.00 50.00 65000 RADIOLOGY - HERAPLUIC 0 0 0 55.00 50.00 65000 RADIOLAD CARCE CARE CAR 0 0 0 55.00 50.00 05000 CARDIA CARCE CARE CAR 0		Cost		nooprear	
Services Services Services Services NUCLU ARY SERVICE COST CENTERS 6.00 7.00 0 05000 0PENALTING ROW 0 0 5.00 05100 RECOVERY ROM 0 0 0 5.00 05100 RECOVERY ROM 0 0 0 0 5.00 05300 ARESTHESI OLOGY 0 0 0 53.00 5.00 05300 ARESTHESI OLOGY 0 0 0 54.00 5.00 05400 IDGOV-INANOSTIC 0 0 0 54.00 5.00 05600 MARESTHESI OLOGY 0 0 0 55.00 5.00 05600 MARETIC RESONANCE I MARI NG (WRI) 0 0 0 55.00 5.00 05600 MARETIC RESONANCE I MARI NG (WRI) 0 0 0 66.00 5.00 05600 MARETIC RESONANCE I MARI NG (WRI) 0 0 0 66.00 5.00 05600 MARETIC RESONANCE I MARI NG (WRI) 0 0 0 66.00 5.00 05600 MARETIC	Cost Center Description				
Ded. % Col ns. (see Inst.) Ded. % Col ns. (see Inst.) See Inst.) 0.00 0 <td></td> <td></td> <td></td> <td></td> <td></td>					
(see inst.) 6.00 7.00 50.00 05000(PECATING ROM 0 51.00 6500(PECATING ROM 0 0 51.00 6500(PECATING ROM 0 0 51.00 0500(PECATING ROM 0 0 51.00 05100(PECATING ROM 0 0 51.00 0500(PECATING ROM 0 0 51.00 0500(PECATING ROM 0 0 51.00 0500(PARESTHESIOLOCY 0 0 51.01 0500(PARESTHESIOLOCY 0 0 54.01 51.01 05400(PARESTHESIOLOCY 0 0 55.00 52.00 05500(PARESTHESIONE					
Instrument 6.00 7.00 ANDELLARY SERVICE COST CENTERS 0 0 50.00 50.00 05000 DPERATING ROM 0 0 50.00 52.00 05200 DELIVERY ROOM & LABOR ROM 0 0 53.00 52.00 05300 ANDESTHESI LOGY 0 0 53.00 54.00 05400 RADIOLOGY - DLAGNOSTIC 0 0 54.00 55.00 DESCONCY - DLAGNOSTIC 0 0 55.00 55.00 DESCONCHARC - CAREETR CR 0 0 56.00 56.00 DESCONCHARC - CAREETR ZATION 0 0 56.00 56.00 DESCONCHARC - CAREETR ZATION 0 0 66.00 56.00 DESCONCHARC - CAREETR ZATION 0 0 66.00 56.00 DESCONCHARC - CAREETR ZATION					
MACILLARY SERVICE COST CENTERS Image: Cost Centers 0.0 05000 (PERATI NG ROM 0 51.00 05100 (PECOVERY ROM 0 52.00 05200 (PECOVERY ROM 0 53.00 05300 (MESTHESI OLGEY 0 53.00 05300 (MESTHESI OLGEY 0 53.00 05300 (MESTHESI OLGEY 0 54.01 0.0401 [SSD RADIOLOCY - DI AGNOSTI C 0 50.01 0.0500 (MALSTHESI OLGEY 0 55.01 0.05501 (MOLAND CANCER CARE CIR 0 55.01 0.05501 (MOLAND CANCER CARE CIR 0 50.01 05000 (ALSOMARC INACIN (MRI) 0 0 50.01 05000 (LSOMARD CANCER CARE CIR 0 0 50.01 05000 (LSOMARD CANCER CARE CIR 0 0 50.00 05000 (ALSOMARD CANCER CARE CIR 0 0 50.00 000000 (ALSOMARD CANCER CARE CIR 0 0 51.00 000000 (ALSOMARDORY 0 0 0 50.00 000000 (ALSOMARDORY 0 0 0 <td></td> <td></td> <td></td> <td></td> <td></td>					
51.00 05100 RECOVERY ROM 0 51.00 05200 52.00 52.00 52.00 52.00 52.00 52.00 52.00 52.00 52.00 52.00 52.00 52.00 52.00 52.00 52.00 52.00 52.00 52.00 52.00 55.01 55.00 55.01 55.00 55.01 55.00 55.01 55.00 55.01 55.00	ANCI LLARY SERVI CE COST CENTERS	0.00	7.00		
52.00 05200 DELLIVERY ROOM & LABOR ROOM 0 0 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 55.00 56.00 56.00 56.00 56.00 56.00 56.00 58.00 58.00 58.00 58.00 59.00 50.00 50.00 <td></td> <td>0</td> <td>0</td> <td></td> <td>50.00</td>		0	0		50.00
51.00 05300 AMESTHESIOLOGY 0 0 53.00 54.00 05400 ARADIOLOGY - DI AGNOSTI C 0 0 54.01 55.00 05500 MODIOLOGY - HRAPPLUTI C 0 0 55.01 55.00 05500 MODIOLOGY - HRAPPLUTI C 0 0 55.01 56.01 05501 MODIOLOGY - HRAPPLUTI C 0 0 55.01 56.00 05600 MARDIT C ESDNANCE I MAGING (MRI) 0 0 55.01 57.00 05700 (CT SCAN 0 0 0 58.00 58.00 06800 MARCTT C ESDNANCE I MAGING (MRI) 0 0 60.01 60.01 60.01 60.01 60.01 60.01 60.01 60.01 60.01 60.01 60.01 60.01 61.00 62.00 63.00 63.00 63.00 63.00 63.00 63.00 63.00 63.00 63.00 63.00 63.00 63.00 63.00 63.00 63.00 63.00 63.00 63.00 63.00					51.00
54.00 05400 RADI CLORY - DI AGNOSTI C 0 0 54.00 05500 RADI CLORY - THERAPEUTI C 0 0 55.00 05500 RADI CLORY - THERAPEUTI C 0 0 55.00 05500 RADI CLORY - THERAPEUTI C 0 0 56.00 05600 RADI CLORY - THERAPEUTI C 0 0 57.00 05700 CSTOR 0 0 58.00 05600 RADI CLORY - THERAPEUTI C 0 0 58.00 05600 CSROR (ARDI CATHETERI ZATION 0 0 60.00 06000 LABORATORY 0 0 60.00 60.01 06010 FS ED LAB 0 0 60.00 60.00 61.00 06100 PROCESSING & TRANS. 0 0 62.00 62.00 62.00 62.00 62.00 62.00 62.00 63.00 64.00 64.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.0		0			52.00
54.01 05401 (FSED RADIOLOGY - DIAGNOSTIC 0 0 55.01 05500 0500 05000		0	-		
55. 00 05500 RADIOLOCY-THERAPEUTIC 0 0 55. 00 55. 01 05501 WOOLAND CARCE CARE CTR 0 0 55. 00 56. 00 05600 RADIO ISOTOPE 0 0 57. 00 57. 00 05700 CT SCAN 0 0 58. 00 58. 00 58. 00 58. 00 58. 00 59. 00 59. 00 59. 00 59. 00 59. 00 59. 00 59. 00 59. 00 59. 00 59. 00 59. 00 59. 00 59. 00 59. 00 60. 01 <td< td=""><td></td><td>0</td><td>-</td><td></td><td></td></td<>		0	-		
55. 01 05501 WOODLAND CANCER CARE CTR 0 0 55. 01 05.00 55. 00 60. 01 60. 01 60. 01 60. 01 60. 01 60. 01 60. 01 60. 01 60. 01 60. 01 62. 00 62. 00 62. 00 62. 00 62. 00 62. 00 64. 00 64. 00 64. 00 64. 00 65. 00		0	-		
56.00 05600 RADIO 1SOTOPE 56.00 57.00 57.00 57.00 05700 CT SCAN 0 0 57.00 58.00 05800 MAGNETI C RESONANCE I MAGING (MRI) 0 0 58.00 59.00 50.00 59.00 50.00 59.00 50.00		0			
57.00 65700 CT SCAN 0 57.00		0	-		
58:00 05800 MACRETIC RESONANCE IMAGING (MRI) 0 0 58:00 59:00 59:00 59:00 60:00 70:00 70:00 70:00 70:00 70:00 70:00 70:00 70:00 70:00 70:00 70:00 70:		-			57.00
0.000 CABORATORY 0		0	o		58.00
60.01 FS ED LAB 0 0 60.01 FS ED LAB 60.01 61.00 61.00 61.00 62.00 <td< td=""><td>59. 00 05900 CARDI AC CATHETERI ZATI ON</td><td>0</td><td>o</td><td></td><td>59.00</td></td<>	59. 00 05900 CARDI AC CATHETERI ZATI ON	0	o		59.00
61.00 06100 PEP CLINICAL LAB SERVICES-PRCM ONLY 0 61.00 62.00		0	-		60.00
62:00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 62:00 62:00 62:00 62:00 62:00 63:00 63:00 63:00 63:00 63:00 63:00 63:00 63:00 63:00 64:00 64:00 64:00 64:00 64:00 64:00 64:00 64:00 64:00 64:00 66:00 67:00 70:00 70:00 70:00 70:00 70:00 70:00 70:00 70:00 70:00 71:00 72:00 73:00 73:00 73:00 73:00 <td< td=""><td></td><td>0</td><td>0</td><td></td><td></td></td<>		0	0		
63.00 06300 Decodo Storn NG, PROCESSI NG & TRANS. 0 0 64.00 06400 INTRAVENOUS THERAPY 0 0 64.00 64.00 64.00 64.00 64.00 64.00 66.00 67.00 67.00 67.00 67.00 67.00 67.00 70.00 70.00 71.00 71.00 71.00 72.00 72.00 72.00 72.00 73.00 73.00 73.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00		0			
64.00 06400 INTRAVENOUS THERAPY 0 0 64.00 65.00 06500 RESPIRATORY THERAPY 0 0 65.00 66.00 06600 PHYSI CAL THERAPY 0 0 66.00 66.00 06600 PHYSI CAL THERAPY 0 0 67.00 68.00 06600 SPECE THATORY THERAPY 0 0 68.00 68.00 06600 SPECE THATOLOGY 0 0 68.00 69.00 OC70.00 ELECTROEXCEPHALOGRAPHY 0 0 71.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 73.00 73.00 07300 DRUG CAL SUPPLIES CHARGED TO PATI ENTS 0 0 74.00 74.00 OT400 RENAL DI ALYSIS 0 0 73.00 73.00 75.00 07500 ASC (NON-DI STINCT PART) 0 0 0 75.00 76.00 020 CV RESOURCE CTR 0 0 0 76.00 70.00 <td></td> <td>-</td> <td>-</td> <td></td> <td></td>		-	-		
65:00 0c500 RESPIRATORY THERAPY 0 0 65:00 66:00 0 66:00 0 66:00 0 66:00 0 66:00 0 66:00 0 66:00 0 66:00 0 66:00 0 66:00 0 66:00 67:00 66:00 67:00 66:00 70:00 70:00 70:00 70:00 71:00 71:00 71:00 71:00 71:00 71:00 71:00 71:00 71:00 71:00 71:00		-			
66.00 06600 PHSICAL THERAPY 0 0 66.00 67.00 06700 0CCUPATIONAL THERAPY 0 0 67.00 77.00		0			
67.00 06700 CCUPATIONAL THERAPY 0 0 67.00 68.00 06800 SPECH PATHOLOGY 0 0 68.00 69.00 70.00 70.00 70.00 70.00 70.00 70.00 71.00 70.00 71.00 71.00 71.00 71.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 73.00 00 73.00 00 74.00 74.00 74.00 74.00 75.00 75.00 75.00 75.00 75.00 77.00 70.00 77.00 70.00 77.00 70.00 77.00 70.00 70.00 70.00 70.00 70.00 70.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00		0	-		
69:00 06900 ELECTROCARDIOLOGY 0 <td></td> <td>0</td> <td>0</td> <td></td> <td>67.00</td>		0	0		67.00
70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 70.00 70.00 71.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 72.00 73.00 73.00 73.00 73.00 73.00 73.00 74.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 76.00 75.00 76.00 75.00 76.00 77.00 <td>68.00 06800 SPEECH PATHOLOGY</td> <td>0</td> <td>o</td> <td></td> <td>68.00</td>	68.00 06800 SPEECH PATHOLOGY	0	o		68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 73.00 07300 DRUGO CHARGED TO PATIENTS 0 0 74.00 07400 RENAL DI ALYSIS 0 0 75.00 07500 ASC (NON-DI STINCT PART) 0 0 77.00 00700 ALLOGENEIC STEM CELL ACQUISITION 0 0 77.00 07700 ALLOGENEIC STEM CELL ACQUISITION 0 0 77.00 07700 ALLOGENEIC STEM CELL ACQUISITION 0 0 77.00 00700 ALLOGENEIC STEM CELL ACQUISITION 0 0 77.00 00700 ALLOGENEIC STEM CELL ACQUISITION 0 0 77.00 00700 ALLOGENEIC STEM CELL ACQUISITION 0 0 70.01 00700 FEDERALLY QUALIFIED HEALTH CENTER 88.00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 90.00 90.03 09000 ELINIC 0 0 91.00 91001 FREE STANDI NG EMERGENCY DEPT 0		0			69.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 73.00 74.00 7400 RENAL DI ALYSI S 0 0 74.00 75.00 07500 ASC (NON-DI STINCT PART) 0 0 75.00 70.00 07500 ALGCENE CTR 0 0 75.00 77.00 0700 ALLOGENEI C STEM CELL ACQUISITION 0 0 76.00 00 07500 ASC (NON-DI STINCT PART) 0 0 77.00 00 0700 ALLOGENEI C STEM CELL ACQUISITION 0 0 77.00 00 0700 ALLOGENEI C COST CENTERS 88.00 88.00 88.00 88.00 88.00 89.00 6900 FEDERALLY QUALIFIED HEALTH CENTER 88.00 90.00 9000 CLI NI C 89.00 90.03 9003 I NFUSI ON OP SERVI CES 0 0 90.03 9003 I NFUSI ON OP SERVI CES 0 0 90.03 90.03 90.03 90.03 90.03 90.03 90.03 90.03 90.01 91.01 92.00 92.00 92.00 92.00 92.00 92.00 92.00 9		0	-		
73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 73.00 74.00 07400 RENAL DI ALYSI S 0 0 74.00 75.00 07500 ASC (NON-DI STINCT PART) 0 0 75.00 76.00 03020 CV RESOURCE CTR 0 0 76.00 0 77.00 07700 ALLOGENEI C STEM CELL ACQUISITION 0 0 77.00 00TPATIENT SERVICE COST CENTERS 88.00 08900 RURAL HEALTH CLINIC 88.00 80.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 99.00 99.00 90.00 90.00 90.00 09000 CLINIC 0 0 0 90.03 90.03 91.00 09100 EMERGENCY 0 0 91.00 90.03 90.03 91.00 09101 FREE STANDING EMERGENCY DEPT 0 0 91.01 91.01 92.00 09500 AMBULANCE SERVICES 0 0 94.00 94.00 94.00 94.00 94.00 94.00 95.00 95.00 95.00 95.00 95.00 95.00 95.00 95.00 95.00 95.00 9		-			
74.00 07400 RENAL DI ALYSI S 0 0 74.00 75.00 07500 ASC (NON-DI STINCT PART) 0 0 75.00 76.00 03020 CV RESOURCE CTR 0 0 76.00 00 07700 ALLOGENEI C STEM CELL ACOUI SI TI ON 0 0 76.00 00 0 0 0 0 0 77.00 00 0 0 0 0 0 77.00 00 0 0 0 0 0 77.00 00 0 0 0 0 0 77.00 00 0 0 0 0 0 88.00 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 88.00 90.00 90.00 90.00 09000 LINIC 0 0 0 90.00 90.00 91.00 DEREGENCY 0 0 0 90.00 90.00 91.01 FREE STANDING EMERGENCY DEPT 0 0 91.00 91.00 92.00 00 <		0	-		
75.00 07500 ASC (NON-DI STINCT PART) 0 0 75.00 75.00 76.00 03020 (V RESOURCE CTR 0 0 76.00 76.00 007700 ALLOGENEI C STEM CELL ACQUI SI TI ON 0 0 76.00 0UTPATIENT SERVICE COST CENTERS 0 0 70.00 88.00 88.00 08900 FEDERALLY QUALI FIED HEALTH CENTER 88.00 89.00 90.00 09000 CLINI C 0 0 90.00 90.01 09000 CLINI C 0 0 90.00 90.02 09000 CLINI C 0 0 90.00 90.03 19003 INFUSI ON OP SERVI CES 0 0 90.00 91.00 09101 ERGENCY DEPT 0 0 91.00 91.01 09101 INER ESTANDI NG EMERGENCY DEPT 0 0 91.00 92.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 0 0 94.00 94.00 09400 HOME PROGRAM DI ALYSI S 0 0 94.00 95.00		0	-		
76.00 03020 CV RESOURCE CTR 0 0 76.00 77.00 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON 0 0 77.00 0UTPATI ENT SERVICE COST CENTERS 0 0 0 77.00 0000 0800 RURAL HEALTH CLINIC 88.00 88.00 89.00 90.00 09000 CLINIC 0 0 90.00 90.00 09000 CLINIC 0 0 90.00 91.00 09100 EMERGENCY 0 0 90.03 91.01 09101 FREE STANDING EMERGENCY DEPT 0 0 91.00 92.00 09200 DSERVATION BEDS (NON-DI STINCT PART) 0 0 92.00 0 0 0 94.00 94.00 95.00 9400 95.00 95.00 09400 HOMABLE MEDI CAL EQUI P-RENTED 0 0 95.00 95.00 97.00 09400 HOMABLE MEDI CAL EQUI P-RENTED 0 0 95.00 96.00 96.00 97.00 98.00 098500 OTHER REI MBURSABLE COST CENTERS </td <td></td> <td>0</td> <td>-</td> <td></td> <td></td>		0	-		
OUTPATI ENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 88.00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 88.00 90.00 09000 CLINIC 0 0 90.01 09000 CLINIC 0 0 90.02 09000 CLINIC 0 0 91.00 09100 EMERGENCY 0 0 91.01 09101 FREE STANDING EMERGENCY DEPT 0 0 91.01 09200 DBSERVATI ON BEDS (NON-DI STINCT PART) 0 0 92.00 09200 DBSERVATI ON BEDS (NON-DI STINCT PART) 0 0 92.00 09500 AMBULANCE SERVICES 0 94.00 94.00 09400 HORGRAM DI ALYSI S 0 0 94.00 95.00 09500 AMBULANCE SERVICES 0 95.00 95.00 95.00 09500 DURABLE MEDI CAL EQUI P-RENTED 0 0 94.00 97.00 09700 DURABLE MEDI CAL EQUI		0	0		76.00
88.00 08800 RURAL HEALTH CLINIC 88.00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 90.00 09000 CLINIC 0 0 90.01 09000 CLINIC 0 0 90.02 09000 CLINIC 0 0 91.00 09100 EMERGENCY 0 0 91.01 OP101 FREE STANDING EMERGENCY DEPT 0 0 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 92.00 09200 BOST CENTERS 0 0 91.01 94.00 09400 HOME PROGRAM DIALYSIS 0 0 92.00 95.00 09500 AMBULANCE SERVICES 0 94.00 94.00 09400 HOME PROGRAM DIALYSIS 0 0 95.00 95.00 09500 AMBULANCE SERVICES 0 95.00 95.00 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 0 97.00 98.00 09850 OTHER REI MBURSABLE COST CENTERS 0 0	77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0		77.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 90.00 09000 CLINIC 0 0 90.03 09003 INFUSION OP SERVICES 0 0 91.00 09100 EMERGENCY 0 0 91.01 09101 FREE STANDING EMERGENCY DEPT 0 0 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 92.00 09200 DSERVATION BEDS (NON-DISTINCT PART) 0 0 94.00 09400 HOME PROGRAM DIALYSIS 0 0 94.00 09400 HOME PROGRAM DIALYSIS 0 0 95.00 09500 AMBULANCE SERVICES 0 9 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 0 97.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 98.00 09850 OTHER REIMBURSABLE COST CENTERS 0 0 98.00 09850 OTHER REIMBURSABLE COST CENTERS 0 0 90.00 Subtotal (see instructions) 0 0 200.00					
90.00 09000 CLINIC 0 0 90.00 90.03 09003 INFUSION OP SERVICES 0 0 90.03 91.00 09100 EMERGENCY 0 0 91.00 91.01 09101 FREE STANDING EMERGENCY DEPT 0 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 92.00 07HER REIMBURSABLE COST CENTERS 0 0 92.00 92.00 94.00 09400 HOME PROGRAM DI ALYSI S 0 0 94.00 95.00 09500 AMBULANCE SERVICES 0 95.00 95.00 96.00 DURABLE MEDI CAL EQUI P-RENTED 0 0 96.00 97.00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 97.00 98.00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 98.00 200.00 Subtotal (see instructions) 0 0 200.00 200.00 201.00 Only Charges 0 0 0 201.00					
90.03 09003 INFUSION OP SERVICES 0 0 90.03 91.00 09100 EMERGENCY 0 0 0 91.01 09101 FREE STANDING EMERGENCY DEPT 0 0 91.01 92.00 092000 DSERVATION BEDS (NON-DI STINCT PART) 0 0 91.01 92.00 09200 DSERVATION BEDS (NON-DI STINCT PART) 0 0 92.00 94.00 09400 HOME PROGRAM DI ALYSIS 0 0 94.00 95.00 09500 AMBULANCE SERVICES 0 95.00 95.00 96.00 09700 DURABLE MEDI CAL EQUI P-RENTED 0 0 96.00 97.00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 97.00 98.00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 98.00 200.00 Subtotal (see instructions) 0 0 200.00 200.00 201.00 Only Charges 0 0 0 201.00					
91.00 09100 EMERGENCY 0 0 91.00 91.00 91.01 09101 FREE STANDING EMERGENCY DEPT 0 0 91.01 91.01 92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0 0 92.00 0THER REI MBURSABLE COST CENTERS 0 0 94.00 9400 HOME PROGRAM DIALYSIS 94.00 95.00 09500 AMBULANCE SERVICES 0 0 95.00 96.00 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 0 96.00 97.00 97.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 97.00 98.00 98.00 200.00 Subtotal (see instructions) 0 0 0 200.00 200.00 201.00 Less PBP Clinic Lab. Services-Program 0 0 201.00 201.00		-	-		
91.01 09101 FREE STANDING EMERGENCY DEPT 0 0 91.01 92.00 0BSERVATION BEDS (NON-DISTINCT PART) 0 0 92.00 0THER REIMBURSABLE COST CENTERS 0 0 0 94.00 94.00 09400 HOME PROGRAM DIALYSIS 0 0 94.00 95.00 09500 AMBULANCE SERVICES 0 95.00 96.00 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 0 95.00 97.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 97.00 98.00 09850 OTHER REIMBURSABLE COST CENTERS 0 0 98.00 200.00 Subtotal (see instructions) 0 0 200.00 201.00 201.00 Unly Charges 0 0 0 201.00		-	-		
92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0 0 92.00 0THER REIMBURSABLE COST CENTERS 0 0 0 94.00 94.00 94.00 94.00 94.00 94.00 95.00 0 94.00 95.00 95.00 00600 DURABLE MEDICAL EQUIP-RENTED 0 0 95.00 96.00 97.00 97000 DURABLE MEDICAL EQUIP-SOLD 0 0 96.00 97.00 98.00 08850 0 97.00 98.00 200.00 200.00 200.00 200.00 200.00 201.00 0 0 200.00 201.00		-	-		
OTHER REI MBURSABLE COST CENTERS94. 0009400HOME PROGRAM DI ALYSI S0094. 0095. 0009500AMBULANCE SERVI CES095. 0095. 0096. 0009600DURABLE MEDI CAL EQUI P-RENTED0096. 0097. 0009700DURABLE MEDI CAL EQUI P-SOLD0097. 0098. 0009850OTHER REI MBURSABLE COST CENTERS0098. 00200. 00Subtotal (see instructions)00200. 00201. 00Less PBP Clinic Lab. Services-Program0201. 00					
95.00 09500 AMBULANCE SERVICES 0 95.00 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 0 97.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 98.00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 200.00 Subtotal (see instructions) 0 0 200.00 201.00 Only Charges Only Charges 0 201.00		1 1	-1		
96.00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 96.00 97.00 97.00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 97.00 98.00 90.00 98.00 98.00 98.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00			0		94.00
97.00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 97.00 98.00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 98.00 200.00 Subtotal (see instructions) 0 0 200.00 201.00 Less PBP Clinic Lab. Services-Program Only Charges 0 201.00					95.00
98.00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 98.00 200.00 Subtotal (see instructions) 0 0 200.00 201.00 Less PBP Clinic Lab. Services-Program 0 0 201.00 0nly Charges 0 0 0 0					
200.00Subtotal (see instructions)00200.00201.00Less PBP Clinic Lab. Services-Program0201.00201.00Only Charges0000		0			
201.00 Less PBP Clinic Lab. Services-Program 0 201.00 Only Charges 0 0		0	U		
Only Charges		0	U		
					201.00
	3 0	0	o		202.00

	RANCI SCAN HEALTH	H MICHIGAN CIT	ſ		u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT	AL COSTS	Provider C Component	CN: 15-0015 CCN: 15-S015	Period: From 01/01/2020 To 12/31/2020	Worksheet D Part II Date/Time Prep	
		Titl	e XIX	Subprovi der –	7/28/2021 7:4 Cost	1 pm
Cost Center Description	Capi tal	Total Charges	Datio of Cor	I PF st Inpatient	Capital Costs	
cost center bescription		(from Wkst. C,			(column 3 x	
	(from Wkst. B,		(col. 1 ÷ co	U U	column 4)	
	Part II, col.	8)	2)	5	ŕ	
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	(77(055					
50. 00 05000 OPERATI NG ROOM	6, 776, 255				0	50.00
51.00 05100 RECOVERY ROOM	0	-			0	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	359, 882				0	52.00
53. 00 05300 ANESTHESI OLOGY	43, 931	0			0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 676, 985				0	54.00
54. 01 05401 FSED RADI OLOGY - DI AGNOSTI C	1, 547, 707	0			0	54.01
55. 00 05500 RADI OLOGY-THERAPEUTI C	522, 509		0.0000		0	55.00
55. 01 05501 WOODLAND CANCER CARE CTR	700, 123				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 MAGNETIC RESONANCE I MAGING (MRI)	0				0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	987, 746				0	59.00
60. 00 06000 LABORATORY	726, 807	0			0	60.00
60. 01 06001 FS ED LAB	108, 479	C	0.0000	0 00	0	60.01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY			0.0000			61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0				0	62.00
63. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS.	24, 970				0	63.00
64.00 06400 INTRAVENOUS THERAPY	0		0.0000		0	64.00
65. 00 06500 RESPI RATORY THERAPY	260, 214	0			0	65.00
66. 00 06600 PHYSI CAL THERAPY	189, 560	0			0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0				0	67.00
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	-				0	68.00 69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	842, 429				0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	96, 072				0	70.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	197, 800				0	72.00
73.00 07200 DRUGS CHARGED TO PATIENTS	841, 834	0	1		0	73.00
74. 00 07400 RENAL DIALYSIS	041, 034		1		0	74.00
75. 00 07500 ASC (NON-DI STI NCT PART)	0	-	1		0	75.00
76. 00 03020 CV RESOURCE CTR	0				0	76.00
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0				0	77.00
OUTPATIENT SERVICE COST CENTERS			0.0000	0	0	11.00
B8. 00 08800 RURAL HEALTH CLINIC	0	C	0.0000	0 00	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0				0	89.00
90. 00 09000 CLINIC	0				0	90.00
90. 03 09003 INFUSION OP SERVICES	240, 660	0			0	90.03
91.00 09100 EMERGENCY	1, 613, 466	0			0	91.00
91. 01 09101 FREE STANDING EMERGENCY DEPT	1, 756, 689				0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0				0	92.00
OTHER REIMBURSABLE COST CENTERS						
94. 00 09400 HOME PROGRAM DI ALYSI S	0	C	0.0000	0 00	0	94.00
	1					95.00
95. 00 09500 AMBULANCE SERVICES						
95. 00 09500 AMBULANCE SERVICES 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	C	0.0000	0 00	0	96.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0		0.0000	0 00	0 0	97.00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED		C C	0.0000	0 00	0	97.00

Heal th	Financial Systems FR	ANCISCAN HEALTH	I MICHIGAN CIT	Y	In Lie	u of Form CMS-	2552-10
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PASS	6 Provider C	CN: 15-0015	Peri od:	Worksheet D	
THROUG	COSTS		Component	CCN: 15-S015	From 01/01/2020 To 12/31/2020		narod
			component	CON. 15-3015	10 12/31/2020	7/28/2021 7:4	1 pm
			Ti tl	e XIX	Subprovider - IPF	Cost	
	Cost Center Description	Non Physician	Nursing School	Nursing Scho	ol Allied Health	Allied Health	
			Post-Stepdown		Post-Stepdown		
		Cost	Adjustments		Adjustments		
		1.00	2A	2.00	3A	3.00	
	ANCI LLARY SERVICE COST CENTERS	-		.1	-	-	
50.00	05000 OPERATING ROOM	0	(0 0		
51.00	05100 RECOVERY ROOM	0	(0 0	-	
52.00 53.00	05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	0	(0 0	-	
53.00 54.00	05400 RADI OLOGY-DI AGNOSTI C	0	(0 0		
54.00	05401 FSED RADIOLOGY - DIAGNOSTIC	0	(0 0	0	
55.00	05500 RADI OLOGY-THERAPEUTI C	0	(0 0	0	
55.01	05501 WOODLAND CANCER CARE CTR	0	(0 0		
56.00	05600 RADI OI SOTOPE	0	(0 0	0	1
57.00	05700 CT SCAN	0	(0 0		1
58.00	05800 MAGNETIC RESONANCE IMAGING (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	(D	0 0	0	60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	(0 0	0	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	(0 0	0	
64.00	06400 I NTRAVENOUS THERAPY	0	(D	0 0	0	1
65.00	06500 RESPI RATORY THERAPY	0	(0	0 0	0	
66.00	06600 PHYSI CAL THERAPY	0	(0 0	0	
67.00	06700 OCCUPATIONAL THERAPY	0	(0 0		1
68.00 69.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0	(0 0	0	1
70.00	07000 ELECTROENCEPHALOGRAPHY	0	(0 0	0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	(0 0		1
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	(0 0	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	(0 0	0	1
74.00	07400 RENAL DIALYSIS	0	C		0 0	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	(0 0	0	75.00
76.00	03020 CV RESOURCE CTR	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		1
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	(0 0		1
90.00	09000 CLINIC	0	(0 0		
90. 03 91. 00	09003 I NFUSI ON OP SERVI CES 09100 EMERGENCY	0	(0 0	0	
91.00 91.01	09101 FREE STANDING EMERGENCY DEPT	0	(0 0	0	1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	(0	0	1
72.00	OTHER REIMBURSABLE COST CENTERS	<u> </u>			0	0	72.00
94.00	09400 HOME PROGRAM DI ALYSI S	0	(0 0	0	94.00
95.00	09500 AMBULANCE SERVICES	Ű		1			95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	(0 0	0	1
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0	(0 0	0	97.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0	(0 0		
200.00	Total (lines 50 through 199)	0	(기	0 0	0	200. 00

PORT	Financial Systems F ONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	6 Provider C	CN: 15-0015	In Lie Period:	Worksheet D	
IROUGI	1 COSTS		Component	CCN: 15-S015	From 01/01/2020 To 12/31/2020		pared: 1 pm
			Titl	e XIX	Subprovider -	Cost	
	Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
		Medi cal	(sum of cols.	Outpati ent			
		Education Cost		Cost (sum of		(col. 5 ÷ col.	
			4)	col s. 2, 3,	8)	7)	
				and 4)		(see	
		4.00	5.00	6.00	7.00	instructions) 8.00	
	ANCILLARY SERVICE COST CENTERS	4.00	5.00	0.00	7.00	0.00	
	05000 OPERATI NG ROOM	0	C		0 0	0.000000	50.0
	05100 RECOVERY ROOM	0			0 0	0.000000	
	05200 DELIVERY ROOM & LABOR ROOM	0			0 0	0. 000000	
	05300 ANESTHESI OLOGY	0	c c		0 0	0. 000000	
	05400 RADI OLOGY-DI AGNOSTI C	0	c c		0 0	0.000000	
	05401 FSED RADI OLOGY - DI AGNOSTI C	0	c c		0 0	0.000000	
	05500 RADI OLOGY-THERAPEUTI C	0			0 0	0.000000	
	05501 WOODLAND CANCER CARE CTR					0.000000	
	05600 RADI OI SOTOPE	0			0 0	0.000000	
	05700 CT SCAN	0			0 0	0.000000	
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0			0 0	0.000000	
	05900 CARDI AC CATHETERI ZATI ON	0			0 0	0. 000000	
	06000 LABORATORY	0			0 0	0.000000	
	06001 FS ED LAB	0			0 0	0.000000	
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0			0	0.000000	61.0
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	C		0 0	0. 000000	
	06300 BLOOD STORING, PROCESSING & TRANS.	0	c c		0 0	0.000000	
	06400 I NTRAVENOUS THERAPY	0			0 0	0. 000000	
	06500 RESPI RATORY THERAPY	0	c c		0 0	0. 000000	
	06600 PHYSI CAL THERAPY	0			0 0	0. 000000	
	06700 OCCUPATI ONAL THERAPY	0			0 0	0.000000	
	06800 SPEECH PATHOLOGY	0			0 0	0.000000	
	06900 ELECTROCARDI OLOGY	0			0 0	0.000000	
	07000 ELECTROENCEPHALOGRAPHY	0	c c		0 0	0. 000000	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C		0 0	0.000000	
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	C		0 0	0.000000	
	07300 DRUGS CHARGED TO PATIENTS	0	C		0 0	0.000000	
	07400 RENAL DI ALYSI S	0	Ċ		0 0	0.000000	
	07500 ASC (NON-DISTINCT PART)	0	C		0 0	0.000000	75.0
	03020 CV RESOURCE CTR	0	C		0 0	0.000000	
-	07700 ALLOGENEIC STEM CELL ACQUISITION	0	C		0 0		
	OUTPATIENT SERVICE COST CENTERS						
3. 00	08800 RURAL HEALTH CLINIC	0	C)	0 0	0.000000	88.0
9.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	C		0 0	0. 000000	89.0
0. 00	09000 CLINIC	0	C		0 0	0. 000000	90.0
). 03	09003 INFUSION OP SERVICES	0	C		0 0	0. 000000	90.0
. 00	09100 EMERGENCY	0	C		0 0	0.000000	91. (
I. 01	09101 FREE STANDING EMERGENCY DEPT	0			0 0	0. 000000	91. (
2.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	C		0 0	0.000000	92.0
	OTHER REIMBURSABLE COST CENTERS						
	09400 HOME PROGRAM DI ALYSI S	0	C)	0 0	0.00000	
	09500 AMBULANCE SERVI CES						95. (
	09600 DURABLE MEDICAL EQUIP-RENTED	0	C		0 0	0.000000	
	09700 DURABLE MEDICAL EQUIP-SOLD	0	C		0 0	0.000000	97. (
3. 00	09850 OTHER REIMBURSABLE COST CENTERS	0	C		0 0	0.000000	98. (
0. 00	Total (lines 50 through 199)	0	C		0 0		200.

			MICHIGAN CITY				u of Form CMS-2	2002-10
THRUUG	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF H COSTS	RVICE OTHER PASS	Provider C			01/01/2020	Worksheet D Part IV	
			Component (CCN: 15-S015	То	12/31/2020	Date/Time Prep 7/28/2021 7:4	
			Ti tl	e XIX	Sub	provider - IPF	Cost	•
	Cost Center Description	Outpatient	Inpati ent	Inpati ent	(Dutpati ent	Outpati ent	
		Ratio of Cost	Program	Program		Program	Program	
		to Charges	Charges	Pass-Throug Costs (col.		Charges	Pass-Through Costs (col. 9	
		(col. 6 ÷ col. 7)		x col. 10)			x col. 12)	
		9.00	10.00	11.00		12.00	13.00	
	ANCI LLARY SERVI CE COST CENTERS							
50.00	05000 OPERATI NG ROOM	0. 000000	0		0	0	0	50.00
51.00	05100 RECOVERY ROOM	0. 000000	0		0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0	0	0	52.00
53.00	05300 ANESTHESI OLOGY	0. 000000	0		0	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	0		0	0	0	54.00
54.01	05401 FSED RADIOLOGY - DIAGNOSTIC	0. 000000	0		0	0	0	54.01
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	0		0	0	0	55.00
55.01	05501 WOODLAND CANCER CARE CTR	0. 000000	0		0	0	0	55.01
56.00	05600 RADI OI 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 MAGNETIC RESONANCE I MAGING (MRI)	0. 000000	0		0	0	0	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	0		0	0	0	59.00
60.00	06000 LABORATORY	0.00000	0		0	0	0	60.00
60.01	06001 FS ED LAB	0. 000000	0		0	0	0	60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	0		~			61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0		0	0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0		0	0	0	63.00
64.00 65.00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	0. 000000	0		0 0	0	0	64.00 65.00
66. 00	06600 PHYSI CAL THERAPY	0. 000000 0. 000000	0		0	0	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	0		0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	0		0	0	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	0		0	0	0	73.00
74.00	07400 RENAL DI ALYSI S	0. 000000	0		0	0	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0. 000000	0		0	0	0	75.00
	03020 CV RESOURCE CTR	0. 000000	0		0	0	0	76.00
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000	0		0	0	0	77.00
	OUTPATIENT SERVICE COST CENTERS							
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	0	89.00
90.00	09000 CLI NI C	0. 000000	0		0	0	0	90.00
90. 03	09003 INFUSION OP SERVICES	0. 000000	0		0	0	0	90.03
	09100 EMERGENCY	0.00000	0		0	0	0	91.00
	09101 FREE STANDING EMERGENCY DEPT	0.000000	0		0	0	0	91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0		0	0	0	92.00
04 00	OTHER REIMBURSABLE COST CENTERS	0.000000		1	0			04 00
	09400 HOME PROGRAM DI ALYSI S	0. 000000	0		0	0	0	
	09500 AMBULANCE SERVICES 09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000	0		0	0	0	95.00 96.00
		0.000000	0	1	V	U	0	
96.00			Λ		0			97 00
96. 00 97. 00	09700 DURABLE MEDICAL EQUI P-SOLD 09850 OTHER REI MBURSABLE COST CENTERS	0. 000000 0. 000000	0 0		0 0	0	0	

FRANCI SCAN	HEALTH	MI C	CHI GA	N I	СІТ	Y	
		-					

In Lieu of Form CMS-2552-10

Heal th	Financial Systems FRANCISCAN HEALTH M	AICHIGAN CITY	In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0015	Peri od:	Worksheet D-1	
			From 01/01/2020 To 12/31/2020	Date/Time Pre	pared:
				7/28/2021 7:4	
		Title XVIII	Hospi tal	PPS	
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	I NPATI ENT DAYS				1
. 00	Inpatient days (including private room days and swing-bed day			21, 916	1.00
. 00	Inpatient days (including private room days, excluding swing-			21, 916	2.00
. 00	Private room days (excluding swing-bed and observation bed day	iys). If you have only pr	rivate room days,	0	3.00
00	do not complete this line.	ad dave)		21 727	4.00
. 00	Semi-private room days (excluding swing-bed and observation b Total swing-bed SNF type inpatient days (including private ro		or 31 of the cost	21, 727 0	
. 00	reporting period	in days) through becchibe		0	0.00
5.00	Total swing-bed SNF type inpatient days (including private ro	om days) after December	31 of the cost	0	6.00
	reporting period (if calendar year, enter 0 on this line)				
7.00	Total swing-bed NF type inpatient days (including private roo	m days) through December	- 31 of the cost	0	7.00
	reporting period			0	
3. 00	Total swing-bed NF type inpatient days (including private roo reporting period (if calendar year, enter 0 on this line)	m days) after December 3	al of the cost	0	8.00
9.00	Total inpatient days including private room days applicable t	o the Program (excluding	n swing-bed and	9, 820	9.00
	newborn days) (see instructions)		g on ng sou ana	7,020	
0.00	Swing-bed SNF type inpatient days applicable to title XVIII o		room days)	0	10.00
	through December 31 of the cost reporting period (see instruc				
1.00	Swing-bed SNF type inpatient days applicable to title XVIII o		room days) after	0	11.00
12.00	December 31 of the cost reporting period (if calendar year, e Swing-bed NF type inpatient days applicable to titles V or XI		to room dave)	0	12.00
2.00	through December 31 of the cost reporting period	x only (merualing privat	le room uays)	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XI.	X only (including privat	te room days)	0	13.00
	after December 31 of the cost reporting period (if calendar y				
	Medically necessary private room days applicable to the Progra	am (excluding swing-bed	days)	0	14.00
	Total nursery days (title V or XIX only)			0	
16.00	Nursery days (title V or XIX only)			0	16.00
17 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to servic	os through December 21 (of the cost	0.00	17.00
17.00	reporting period	es through becember 31 c		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to servic	es after December 31 of	the cost	0.00	18.00
	reporting period				
19.00	Medicaid rate for swing-bed NF services applicable to service	es through December 31 of	f the cost	0.00	19.00
00.00	reporting period	a often December 21 of t	the east	0.00	20.00
20. 00	Medicaid rate for swing-bed NF services applicable to service reporting period	is after December 31 01 1	the cost	0.00	20.00
21.00	Total general inpatient routine service cost (see instruction	s)		35, 327, 129	21.00
	Swing-bed cost applicable to SNF type services through Decemb		ting period (line	0	
	5 x line 17)				
23.00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	ng period (line 6	0	23.00
1 00	x line 18)	- 01 -6		0	24.00
24.00	Swing-bed cost applicable to NF type services through Decembe 7×10^{-1} x line 19)	ar 31 01 the cost report	ng period (inne	0	24.00
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)		, point and (in the p	-	
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)		35, 327, 129	27.00
	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT		<u>\</u>		
8.00	General inpatient routine service charges (excluding swing-be	a and observation bed cr	narges)	0	28.0 29.0
29.00 30.00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	30.0
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)	20)		0.00	
3. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
4.00	Average per diem private room charge differential (line 32 mi		ctions)	0.00	34.0
35.00	Average per diem private room cost differential (line 34 x li	ne 31)		0.00	
36.00	Private room cost differential adjustment (line 3 x line 35)	and and the first of the second se	Second 1 (1)	0	36.0
37.00	General inpatient routine service cost net of swing-bed cost	and private room cost di	tterential (line	35, 327, 129	37.0
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				-
		USTMENTS			1
	IPROGRAM INPATIENT OPERATING COST REFORE PASS THROUGH COST AD H	OOT MENTO			
8.00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ Adjusted general inpatient routine service cost per diem (see			1,611,93	38.00
38.00 39.00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line	instructions)		1, 611. 93 15, 829, 153	
89.00 10.00	Adjusted general inpatient routine service cost per diem (see	e instructions) e 38) am (line 14 x line 35)			39.00 40.00

	ATION OF INPATIENT OPERATING COST		Provider C		eriod: rom 01/01/2020	Worksheet D-1	1		
				To		Date/Time Prepa 7/28/2021 7:41			
				XVIII	Hospi tal	PPS			
	Cost Center Description	Total Inpatient Cost	Total npatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)			
		1.00	2.00	3.00	4.00	5.00	-		
00	NURSERY (title V & XIX only)	0	0) 42.		
	Intensive Care Type Inpatient Hospital Units			1		1			
00	INTENSIVE CARE UNIT	6, 566, 705	3, 764						
00	CORONARY CARE UNIT	0	0			-			
00 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT	0	0						
00		0	0	0.00	0		40		
00	Cost Center Description								
	·					1.00			
00	Program inpatient ancillary service cost (Wks					7, 657, 359			
00	Total Program inpatient costs (sum of lines 4	11 through 48)(s	see instructio	ns)		25, 501, 537	49		
00	PASS THROUGH COST ADJUSTMENTS	tiont moutine a	and and (from	Wkat D oum	of Donto L and	2 007 0(7			
00	Pass through costs applicable to Program inpa	attent routine s	services (Iron	WKSL. D, SUM	or Parts r and	2, 887, 867	/ 50		
00	Pass through costs applicable to Program inpa	atient ancillary	v services (fr	om Wkst. D. su	m of Parts II	1, 025, 066	5 51		
	and IV)								
00	Total Program excludable cost (sum of lines 5					3, 912, 933			
00	Total Program inpatient operating cost exclud		ated, non-phy	sician anesthe	tist, and	21, 588, 604	1 53		
	medical education costs (line 49 minus line 5 TARGET AMOUNT AND LIMIT COMPUTATION)					-		
00	Program discharges					0	54		
00	Target amount per discharge								
00	Target amount (line 54 x line 55)					0.00			
00	Difference between adjusted inpatient operati	ng cost and tar	-get amount (I	ine 56 minus l	ine 53)	C	57		
00	Bonus payment (see instructions)		C						
00	Lesser of lines 53/54 or 55 from the cost rep	porting period e	ending 1996, u	pdated and com	pounded by the	0.00) 59		
00	market basket Lesser of lines 53/54 or 55 from prior year of	act conart un	hatad by the m	arkat backat		0.00	60		
00	If line 53/54 is less than the lower of lines				he amount by	0.00			
00	which operating costs (line 53) are less than						101		
	amount (line 56), otherwise enter zero (see i				the target				
00	Relief payment (see instructions)					C) 62		
00	Allowable Inpatient cost plus incentive payme	ent (see instruc	ctions)			0) 63		
00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cost	to through Dooon	where 21 of the	anat reportin	a popilad (Soo	C	64		
00	instructions) (title XVIII only)	is through becen		cost reportin	y period (see		1 04		
00	Medicare swing-bed SNF inpatient routine cost	ts after Decembe	er 31 of the c	ost reportina	period (See	0	65		
	instructions)(title XVIII only)								
00	Total Medicare swing-bed SNF inpatient routir	C) 66						
~ ~	CAH (see instructions)								
00	Title V or XIX swing-bed NF inpatient routine (line 12 x line 19)	e costs through	December 31 d	f the cost rep	orting period	C	67		
00	Title V or XIX swing-bed NF inpatient routine	ting period		68					
00	(line 13 x line 20)	ting period							
00	Total title V or XIX swing-bed NF inpatient r	routine costs (I	ine 67 + line	68)		0) 69		
	PART III - SKILLED NURSING FACILITY, OTHER NU					1			
00	Skilled nursing facility/other nursing facili						70		
00	Adjusted general inpatient routine service co Program routine service cost (line 9 x line 7		ne /0 ÷ iine	2)			71		
00	Medically necessary private room cost applica		73						
00	Total Program general inpatient routine servi		74						
00	Capital-related cost allocated to inpatient r				rt II, column		75		
	26, line 45)								
00	Per diem capital-related costs (line 75 ÷ lir						76		
00	Program capital -related costs (line 9 x line		77						
00	Inpatient routine service cost (line 74 minus Aggregate charges to beneficiaries for excess		ovider record	s)			78		
00	Total Program routine service costs for compa	· · ·		· .	s line 79)		80		
00	Inpatient routine service cost per diem limit			(81		
00	Inpatient routine service cost limitation (li)				82		
00	Reasonable inpatient routine service costs (s						83		
00	Program inpatient ancillary services (see ins						84		
00	Utilization review - physician compensation (85		
00	Total Program inpatient operating costs (sum		rough 85)				86		
	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions)					189	87		
$\cap \cap$	Total observation bed days (see this dult offs)	,							
00	Adjusted general inpatient routine cost per o	diem (line 27 ∸	line 2)			1, 611. 93	31 88		

Health Financial Systems FR	RANCISCAN HEALTH	H MICHIGAN CITY	,	In Lieu of Form CMS-2552-10				
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0015		Period: Workshee From 01/01/2020				
				To 12/31/2020				
		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, 651, 259	35, 327, 129	0. 15996	9 304, 655	48, 735	90.00		
91.00 Nursing School cost	0	35, 327, 129	0.00000	0 304, 655	0	91.00		
92.00 Allied health cost	0	35, 327, 129	0.00000	0 304, 655	0	92.00		
93.00 All other Medical Education	0	35, 327, 129	0. 00000	0 304, 655	0	93.00		

MPUTA	TION OF INPATIENT OPERATING COST	Provider CCN: 15-0015 Component CCN: 15-S015	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Pre 7/28/2021 7:4	
		Title XVIII	Subprovider -	PPS	
	Cost Center Description		-	1.00	
	PART I - ALL PROVIDER COMPONENTS				
	INPATIENT DAYS Inpatient days (including private room days and swing-bed day	(s excluding newborn)		3, 358	1.
	Inpatient days (including private room days and swing bed day Inpatient days (including private room days, excluding swing-			3, 358	2
00	Private room days (excluding swing-bed and observation bed da		ivate room days,	0	3
	do not complete this line.			0.050	
	Semi-private room days (excluding swing-bed and observation b Total swing-bed SNF type inpatient days (including private ro		r 31 of the cost	3, 358 0	45
50	reporting period	the ought become	i of the cost	0	
	Total swing-bed SNF type inpatient days (including private ro	oom days) after December	31 of the cost	0	6
	reporting period (if calendar year, enter 0 on this line)		01 6 11 1	0	
	Total swing-bed NF type inpatient days (including private roc reporting period	om days) through December	31 of the cost	0	7
	Total swing-bed NF type inpatient days (including private roc	om days) after December 3	1 of the cost	0	8
	reporting period (if calendar year, enter 0 on this line)				
	Total inpatient days including private room days applicable t	to the Program (excluding	swing-bed and	104	9
	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII c	only (including private r	oom days)	0	10
	through December 31 of the cost reporting period (see instruc	ctions)	<i>,</i>	Ũ	
	Swing-bed SNF type inpatient days applicable to title XVIII o		oom days) after	0	11
	December 31 of the cost reporting period (if calendar year, e Swing-bed NF type inpatient days applicable to titles V or XI		e room dave)	0	12
	through December 31 of the cost reporting period	x only (meruaring privat	e room days)	0	12
. 00	Swing-bed NF type inpatient days applicable to titles V or XI			0	13
	after December 31 of the cost reporting period (if calendar y			0	1.4
	Medically necessary private room days applicable to the Progr Total nursery days (title V or XIX only)	"am (excluding swing-bed	days)	0	14 15
	Nursery days (title V or XIX only)			0	16
	SWING BED ADJUSTMENT				
. 00	Medicare rate for swing-bed SNF services applicable to servic	ces through December 31 o	f the cost	0.00	17
. 00	reporting period Medicare rate for swing-bed SNF services applicable to servic	ces after December 31 of	the cost	0.00	18
	reporting period				
	Medicaid rate for swing-bed NF services applicable to service	es through December 31 of	the cost	0.00	19
	reporting period Medicaid rate for swing-bed NF services applicable to service	s after December 31 of t	he cost	0.00	20
	reporting period			0.00	
	Total general inpatient routine service cost (see instruction	·		4, 371, 233	
	Swing-bed cost applicable to SNF type services through Decemb	per 31 of the cost report	ing period (line	0	22
	5 x line 17) Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	a period (line 6	0	23
	x line 18)		g per loa (i i i e e	0	
. 00	Swing-bed cost applicable to NF type services through Decembe	er 31 of the cost reporti	ng period (line	0	24
. 00	7 x line 19) Swing-bed cost applicable to NF type services after December	31 of the cost reporting	period (line 8	0	25
. 00	x line 20)	ST OF the cost reporting	period (inne o	0	25
	Total swing-bed cost (see instructions)			0	26
- E	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		4, 371, 233	27
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-be	and observation bed ch	arges)	0	28
	Private room charges (excluding swing-bed charges)		ai gooy	0	29
. 00	Semi-private room charges (excluding swing-bed charges)			0	30
	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0.00000	31
	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0.00 0.00	32
	Average per diem private room charge differential (line 32 mi	nus line 33)(see instruc	tions)	0.00	34
. 00	Average per diem private room cost differential (line 34 x li			0.00	35
	Private room cost differential adjustment (line 3 x line 35)		Committee (1)	0	36
	General inpatient routine service cost net of swing-bed cost 27 minus line 36)	and private room cost di	TTERENTIAL (LINE	4, 371, 233	37
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
[PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ				1
	Adjusted general inpatient routine service cost per diem (see			1, 301. 74	
	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Progr			135, 381 0	39 40
. 00	Total Program general inpatient routine service cost (line 39			135, 381	

OMPUT	Financial Systems FR ATION OF INPATIENT OPERATING COST	ANCISCAN HEALTH				Peri od:	u of Form CMS- Worksheet D-1	
			Compone	nt C		From 01/01/2020 To 12/31/2020		
			Ti	tle	XVIII	Subprovider -	7/28/2021 7:4 PPS	11 pm
	Cost Center Description	Total	Total		Average Per	IPF Program Days	Program Cost	
		Inpatient Cost		ays	Diem (col. 1 col. 2)	÷	(col. 3 x col. 4)	
		1.00	2.00	_	3.00	4.00	5.00	
. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0		0	0.0	0 0	0	42
. 00	INTENSIVE CARE UNIT	0		0	0.0	0 0	C	43
. 00	CORONARY CARE UNI T	0		0	0.0		C	
. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT	0		0	0.0		0	
. 00	OTHER SPECIAL CARE (SPECIFY)	0		0	0.0	0 0	U	46
	Cost Center Description					1	1.00	
. 00	Program inpatient ancillary service cost (Wks	st. D-3. col. 3	. line 200)	,			1.00	48
	Total Program inpatient costs (sum of lines 4				ıs)		208, 375	
. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inpa	atient routine	services (f	rom	Wkst. D. sum	of Parts L and	32, 672	2 50
. 00	Pass through costs applicable to Program inpa and IV)	atıent ancillar	y services	(fro	om Wkst. D, s	um of Parts II	6, 375	51
. 00	Total Program excludable cost (sum of lines !						39, 047	
. 00	Total Program inpatient operating cost exclude medical education costs (line 49 minus line 5		lated, non-	phys	sician anesth	etist, and	169, 328	3 53
	TARGET AMOUNT AND LIMIT COMPUTATION	J2)						
	Program di scharges						0	
	Target amount per discharge						0.00	
. 00 . 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operati	ing cost and ta	rget amount	- (1)	ne 56 minus	line 53)	0	
. 00	Bonus payment (see instructions)	ing obser and ea	got anount	. (0	
. 00	Lesser of lines 53/54 or 55 from the cost rep	porting period	endi ng 1996	i, up	dated and co	mpounded by the	0.00	59
. 00	market basket Lesser of lines 53/54 or 55 from prior year of	cost roport up	dated by th		rkat backat		0.00	60
. 00	If line 53/54 is less than the lower of line					the amount by	0.00	
	which operating costs (line 53) are less than	n expected cost						
00	amount (line 56), otherwise enter zero (see i	instructions)						
. 00 . 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive payme	ent (see instru	ictions)				0	
. 00	PROGRAM INPATIENT ROUTINE SWING BED COST							
. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts through Dece	mber 31 of	the	cost reporti	ng period (See	C	64
. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of th	ne co	ost reporting	period (See	C	65
00	instructions)(title XVIII only)	na agata (lina		No. 45	· · · · · · · · · · · · · · · · · · ·		C	
. 00	Total Medicare swing-bed SNF inpatient routin CAH (see instructions)	ne costs (inne	o4 prus rrr	ie oc		i oniy). For	U	66
. 00	Title V or XIX swing-bed NF inpatient routine	e costs through	December 3	31 of	f the cost re	porting period	C	67
. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routing	e costs after D	ecember 31	of t	he cost repo	rting period	C	68
	(line 13 x line 20)							
. 00	Total title V or XIX swing-bed NF inpatient N PART III - SKILLED NURSING FACILITY, OTHER NU						C) 69
. 00	Skilled nursing facility/other nursing facili							70
. 00	Adjusted general inpatient routine service co		ine 70 ÷ li	ne 2	2)			71
. 00 . 00	Program routine service cost (line 9 x line Medically necessary private room cost applica	,	(line 14 x	(lir	ue 35)			72
. 00	Total Program general inpatient routine servi	0	•					74
. 00	Capital-related cost allocated to inpatient (26, line 45)				orksheet B, P	art II, column		75
. 00	Per diem capital-related costs (line 75 ÷ lin							76
00	Program capital -related costs (line 9 x line							77
00 00	Inpatient routine service cost (line 74 minus Aggregate charges to beneficiaries for excess		rovi der .roc	orde	5)			78
00	Total Program routine service costs for compa					us line 79)		80
00	Inpatient routine service cost per diem limi	tati on			-	<i>,</i>		81
. 00	Inpatient routine service cost limitation (li							82
. 00 . 00	Reasonable inpatient routine service costs (see in		s)					83
. 00	Program inpatient ancillary services (see ins Utilization review - physician compensation		ns)					84
. 00	Total Program inpatient operating costs (sum							86
	PART IV - COMPUTATION OF OBSERVATION BED PASS							
. 00	Total observation bed days (see instructions)						0. 00	
	Adjusted general inpatient routine cost per o	diem (line)/ ÷	LINE //					

Health Financial Systems FF	RANCISCAN HEALTH	H MICHIGAN CITY	,	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period: From 01/01/2020	Worksheet D-1	
		Component (To 12/31/2020		
		Title	XVIII	Subprovider - IPF	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	1, 054, 921	4, 371, 233	0. 24133	3 0	0	90.00
91.00 Nursing School cost	0	4, 371, 233	0.00000	0 0	0	91.00
92.00 Allied health cost	0	4, 371, 233	0.00000	0 0	0	92.00
93.00 All other Medical Education	0	4, 371, 233	0.00000	0 0	0	93.00

	Financial Systems FRANCISCAN HEAL ENT ANCILLARY SERVICE COST APPORTIONMENT	<u>TH MICHIGAN CIT</u> Provider C	CN: 15-0015	Peri od:	u of Form CMS- Worksheet D-3	
				From 01/01/2020		
				To 12/31/2020	Date/Time Pre 7/28/2021 7:4	
		Title	e XVIII	Hospi tal	PPS	
	Cost Center Description		Ratio of Cos		Inpati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col. 2)	
			1.00	2.00	3.00	-
1	INPATIENT ROUTINE SERVICE COST CENTERS					
. 00 🛛	03000 ADULTS & PEDI ATRI CS			8, 827, 438		30
	03100 I NTENSI VE CARE UNI T			2, 334, 365		3
	03200 CORONARY CARE UNIT			0		32
	03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT			0		3
	04000 SUBPROVIDER - IPF			2, 977, 274		34
	04100 SUBPROVI DER – I RF			2, 777, 274		4
	04300 NURSERY					4
/	ANCILLARY SERVICE COST CENTERS					
	05000 OPERATING ROOM		0. 17069		1, 324, 832	
	05100 RECOVERY ROOM		0.00000		0	
	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY		0. 22530		0 13, 498	
	05300 ANESTHESTOLOGY 05400 RADI OLOGY-DI AGNOSTI C		0. 02171		509, 368	
	05401 FSED RADI OLOGY - DI AGNOSTI C		0. 23214		0	
	05500 RADI OLOGY-THERAPEUTI C		0. 16901		330, 819	
5. 01	05501 WOODLAND CANCER CARE CTR		0. 40601	5 105, 645	42, 893	5
	05600 RADI OI SOTOPE		0.00000		0	
	05700 CT SCAN		0.00000		0	
	05800 MAGNETIC RESONANCE IMAGING (MRI)		0.00000		0	
	05900 CARDI AC CATHETERI ZATI ON		0. 11411			
	06000 LABORATORY 06001 FS ED LAB		0. 13442		1, 127, 821 0	
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0. 00000		0	
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0.00000		0	
3.00	06300 BLOOD STORING, PROCESSING & TRANS.		0. 03611	4 0	0	6
	06400 INTRAVENOUS THERAPY		0.00000	0 0	0	
	06500 RESPI RATORY THERAPY		0. 11081		160, 127	
	06600 PHYSI CAL THERAPY		0. 22823		107, 804	
	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY		0.00000		0	
	06900 ELECTROCARDI OLOGY		0. 11877		371, 212	
	07000 ELECTROENCEPHALOGRAPHY		0.00000		0,1,2.2	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 23419		476, 131	7
	07200 IMPL. DEV. CHARGED TO PATIENTS		0. 51936		1, 130, 601	
	07300 DRUGS CHARGED TO PATIENTS		0. 22074		1, 235, 660	
	07400 RENAL DI ALYSI S		0.00000		0	
	07500 ASC (NON-DISTINCT PART) 03020 CV RESOURCE CTR		0.00000		0	
	07700 ALLOGENEIC STEM CELL ACQUISITION		0.00000			7
	OUTPATIENT SERVICE COST CENTERS			-		
	08800 RURAL HEALTH CLINIC		0.00000	0	0	8
	08900 FEDERALLY QUALIFIED HEALTH CENTER		0.00000		0	
	09000 CLINIC		0.00000		0	
	09003 INFUSION OP SERVICES		0. 38178		0	
	09100 EMERGENCY 09101 FREE STANDING EMERGENCY DEPT		0. 17167		603, 219 0	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 33303		7, 026	
	OTHER REIMBURSABLE COST CENTERS		0.04007	175,547	7, 020	1 ^
	09400 HOME PROGRAM DI ALYSI S		0.00000	0 0	0	9
	09500 AMBULANCE SERVICES				_	9
	09600 DURABLE MEDI CAL EQUI P-RENTED		0. 00000		0	
	09700 DURABLE MEDI CAL EQUI P-SOLD		0.00000		0	
	09850 OTHER REIMBURSABLE COST CENTERS	, ,	0.00000		0	
0.00	Total (sum of lines 50 through 94 and 96 through 98) Less PBP Clinic Laboratory Services-Program only cha			44, 654, 501	7, 657, 359	
01.00	Net charges (line 200 minus line 201)	arges (inne of)		44, 654, 501		20

NPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0015	Peri od:	Worksheet D-3	
		CCN: 15-S015	From 01/01/2020 To 12/31/2020	Date/Time Pre	pare
	Title	e XVIII	Subprovider -	7/28/2021 7:4 PPS	1 pm
Cast Canton Decerintian		Datio of Cor	I PF	Inpati ent	
Cost Center Description		Ratio of Cos To Charges		Program Costs	
		10 charges	Charges	$(col \cdot 1 \times col \cdot$	
			ondrigeo	2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1			
0. 00 03000 ADULTS & PEDI ATRI CS			0		30
			0		31
. 00 03200 CORONARY CARE UNI T . 00 03300 BURN I NTENSI VE CARE UNI T			0		32
. 00 03400 SURGI CAL I NTENSI VE CARE UNI T			0		34
0. 00 04000 SUBPROVIDER - IPF			908, 338		40
. 00 04100 SUBPROVI DER – I RF			,00, 330		41
B. 00 04300 NURSERY					43
ANCI LLARY SERVI CE COST CENTERS					1
0. 00 05000 OPERATI NG ROOM		0. 1706	96 149	25	50
.00 05100 RECOVERY ROOM		0.0000	00 0	0	51
2. OO 05200 DELIVERY ROOM & LABOR ROOM		0. 2253		0	
0 05300 ANESTHESI OLOGY		0. 0217		0	
. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 0946		2, 479	
I. 01 05401 FSED RADI OLOGY - DI AGNOSTI C		0. 2321		0	
0.00 05500 RADI OLOGY-THERAPEUTI C		0. 1690		2, 509	
5. 01 05501 WOODLAND CANCER CARE CTR 5. 00 05600 RADI 0I SOTOPE		0.4060		0	
o. 00 05600 RADI 0I SOTOPE 7. 00 05700 CT_SCAN		0.0000		0	
3. OO OSTOO ET SEAN 3. OO OSSOO MAGNETIC RESONANCE IMAGING (MRI)		0.0000		0	
0. 00 05900 CARDI AC CATHETERI ZATI ON		0. 1141		0	
0. 00 06000 LABORATORY		0. 1344		21, 290	
0. 01 06001 FS ED LAB		0. 1727		0	
. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0.0000		0	61
2.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0.0000	00 0	0	62
. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 0361	14 0	0	63
I. 00 06400 I NTRAVENOUS THERAPY		0.0000	00 0	0	64
5. 00 06500 RESPI RATORY THERAPY		0. 1108			
0. 00 06600 PHYSI CAL THERAPY		0. 2282		1, 302	
7. 00 06700 OCCUPATIONAL THERAPY		0.0000		0	
		0.0000		0	
OO 06900 ELECTROCARDI OLOGY OO 07000 ELECTROENCEPHALOGRAPHY		0. 1187		1, 156 0	
1. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 0000		1, 904	
2. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 5193		0	
. 00 07300 DRUGS CHARGED TO PATIENTS		0. 2207		17, 743	
00 07400 RENAL DIALYSIS		0.0000		0	
00 07500 ASC (NON-DISTINCT PART)		0.0000		0	
5. 00 03020 CV RESOURCE CTR		0.0000		0	
2. 00 07700 ALLOGENEIC STEM CELL ACQUISITION		0.0000	00 0	0	
OUTPATIENT SERVICE COST CENTERS		1			
8. 00 08800 RURAL HEALTH CLINIC		0.0000		0	
0. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0.0000		0	
		0.0000		0	
. 03 09003 I NFUSI ON OP SERVI CES . 00 09100 EMERGENCY		0. 3817		0	
. 00 09100 EMERGENCY . 01 09101 FREE STANDING EMERGENCY DEPT		0. 1716		24, 328 0	
2. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 3330		0	
OTHER REIMBURSABLE COST CENTERS		0.0400	<u>, oj</u> 0	0	174
. 00 09400 HOME PROGRAM DI ALYSI S		0.0000	00 0	0	94
5. 00 09500 AMBULANCE SERVICES					95
0. 00 09600 DURABLE MEDI CAL EQUI P-RENTED		0.0000	00 0	0	
. 00 09700 DURABLE MEDI CAL EQUI P-SOLD		0.0000		0	97
3. 00 09850 OTHER REIMBURSABLE COST CENTERS		0.0000		0	
DO.00 Total (sum of lines 50 through 94 and 96 through 98)			447, 574	72, 994	1200

96. UU U	7000 DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	90.00
97.00 0	9700 DURABLE MEDICAL EQUIP-SOLD	0.000000	0	0	97.00
98.00 09	2850 OTHER REIMBURSABLE COST CENTERS	0.00000	0	0	98.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		447, 574	72, 994	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net charges (line 200 minus line 201)		447, 574		202.00

eal th Financial	RY SERVICE COST APPORTIONMENT	EALTH MICHIGAN CIT	r CN: 15-0015	Peri od:	u of Form CMS-: Worksheet D-3	
NFATLENT ANGLEF	RT SERVICE COST AFFORTIONWENT	FIOVICEI C	CN. 15-0015	From 01/01/2020	WOLKSHEEL D-3	
				To 12/31/2020		
		T: +1	e XIX	Hocpi tol	7/28/2021 7:4	1 pm
Cost	Center Description		Ratio of Cos	Hospital t Inpatient	Cost Inpati ent	
0031			To Charges	Program	Program Costs	
			J	Charges	(col. 1 x col.	
					2)	
			1.00	2.00	3.00	
	ROUTINE SERVICE COST CENTERS		1	0 007 400		
	S & PEDIATRICS ISIVE CARE UNIT			8, 827, 438 2, 334, 365		30.0
	ARY CARE UNIT			2, 334, 303		32. (
1 1	INTENSIVE CARE UNIT			0		33. (
1 1	CAL INTENSIVE CARE UNIT			0		34. (
0. 00 04000 SUBPF	OVIDER - IPF			2, 977, 274		40.0
	OVIDER – IRF			0		41. (
3.00 04300 NURSE				666, 049		43. (
	SERVICE COST CENTERS		0.0000			
0.00 05000 0PERA			0.0000		0	
1 1	ERY ROOM & LABOR ROOM		0.0000		0	
3. 00 05300 ANEST			0.0000		0	
	ILOGY-DI AGNOSTI C		0.0000		0	1
4.01 05401 FSED	RADI OLOGY - DI AGNOSTI C		0.0000	0 00	0	54.
	LOGY-THERAPEUTI C		0.0000		0	
	AND CANCER CARE CTR		0.0000		0	
6.00 05600 RADI (0.0000		0	
7.00 05700 CT SC			0.0000		0	
	TIC RESONANCE IMAGING (MRI)		0.0000		0	
0. 00 06000 LABOR	AC CATHETERI ZATI ON		0.0000		0	
0. 01 06001 FS EL			0.0000		0	1
	LINICAL LAB SERVICES-PRGM ONLY		0.0000		0	
	BLOOD & PACKED RED BLOOD CELLS		0.0000		0	62.
	STORING, PROCESSING & TRANS.		0.0000	0 00	0	63.
	VENOUS THERAPY		0.0000		0	
	RATORY THERAPY		0.0000		0	
	CAL THERAPY ATIONAL THERAPY		0.0000		0	
	H PATHOLOGY		0.0000		0	
1 1	ROCARDI OLOGY		0.0000		-	
1 1	ROENCEPHALOGRAPHY		0.0000		0	
1.00 07100 MEDI (AL SUPPLIES CHARGED TO PATIENTS		0.0000	2, 033, 099	0	71. (
	DEV. CHARGED TO PATIENTS		0.0000		0	
	CHARGED TO PATIENTS		0.0000		0	
4.00 07400 RENAL			0.0000		0	
5. 00 07500 ASC (6. 00 03020 CV RE	NON-DI STI NCT PART)		0.0000		0	
	ENELC STEM CELL ACQUISITION		0.0000			77. (
	SERVICE COST CENTERS		0.0000	50 0	0	1 / /
	HEALTH CLINIC		0.0000	0 00	0	88. (
	ALLY QUALIFIED HEALTH CENTER		0.0000	0 00	0	
0. 00 09000 CLI NI			0.0000			
	I ON OP SERVICES		0.0000		0	
1.00 09100 EMER			0.0000			1
	STANDING EMERGENCY DEPT		0.0000		-	
	VATION BEDS (NON-DISTINCT PART) BURSABLE COST CENTERS		0.0000	00 175, 347	0	72. '
	PROGRAM DI ALYSI S		0,0000	0 00	0	94.
	ANCE SERVICES				0	95.
	LE MEDICAL EQUIP-RENTED		0.0000	0 00	0	
	LE MEDICAL EQUIP-SOLD		0.0000		0	1
	REIMBURSABLE COST CENTERS		0.0000		0	
	(sum of lines 50 through 94 and 96 through			45, 390, 173	0	200.
01.00 Less	PBP Clinic Laboratory Services-Program only harges (line 200 minus line 201)	cnarges (line 61)	1	0		201. (202. (

	Financial Systems FRANCISCAN HEALTH N ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0015	Peri od: From 01/01/2020 To 12/31/2020	u of Form CMS-2 Worksheet E Part A Date/Time Pre 7/28/2021 7:4	pared:
		Title XVIII	Hospi tal	PPS	
				1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS			1.00	
1. 00 1. 01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurr	ing prior to October 1	(see	0 17, 459, 180	1. 00 1. 01
1. 02	instructions) DRG amounts other than outlier payments for discharges occurr	ing on or after October	1 (see	7, 070, 067	1. 02
1. 03	instructions) DRG for federal specific operating payment for Model 4 BPCI f 1 (see instructions)	or discharges occurring	prior to October	0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI f October 1 (see instructions)	or discharges occurring	on or after	0	1.04
2.00	Outlier payments for discharges. (see instructions)			-	2.00
2.01 2.02	Outlier reconciliation amount Outlier payment for discharges for Model 4 BPCI (see instruct	i ops)		0	2.01
2.02	Outlier payments for discharges occurring prior to October 1	-		176, 388	
2.04	Outlier payments for discharges occurring on or after October			168, 064	
3.00	Managed Care Simulated Payments			0	
4.00	Bed days available divided by number of days in the cost repo	rting period (see instru	uctions)	98.48	4.00
5.00	Indirect Medical Education Adjustment FTE count for allopathic and osteopathic programs for the mos or before 12/31/1996. (see instructions)	t recent cost reporting	period ending on	0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet t new programs in accordance with 42 CFR 413.79(e)	he criteria for an add-o	on to the cap for	0.00	6. 00
7.00 7.01	MMA Section 422 reduction amount to the IME cap as specified ACA § 5503 reduction amount to the IME cap as specified under			0. 00 0. 00	•
8.00	cost report straddles July 1, 2011 then see instructions. Adjustment (increase or decrease) to the FTE count for allopa	thic and ostoonathic pro	arams for	0.00	8.00
8.00	affiliated programs in accordance with 42 CFR 413.75(b), 413. 1998), and 67 FR 50069 (August 1, 2002).		9	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap sl report straddles July 1, 2011, see instructions.	ots under § 5503 of the	ACA. If the cost	0.00	8. 01
8.02	The amount of increase if the hospital was awarded FTE cap sl under § 5506 of ACA. (see instructions)	ots from a closed teachi	ng hospital	0.00	8. 02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lin instructions)	es (8, 8,01 and 8,02)	(see	0.00	9.00
10.00 11.00	FTE count for allopathic and osteopathic programs in the curr FTE count for residents in dental and podiatric programs.	ent year from your recom	rds	0.00 0.00	
12.00	Current year allowable FTE (see instructions)			0.00	
13.00	Total allowable FTE count for the prior year.			0.00	
14.00	Total allowable FTE count for the penultimate year if that ye otherwise enter zero.	ar ended on or after Sep	otember 30, 1997,	0.00	•
15.00	Sum of lines 12 through 14 divided by 3.			0.00	15.00
16.00	Adjustment for residents in initial years of the program				16.00
17.00	Adjustment for residents displaced by program or hospital clo	sure		0.00	•
18.00 19.00	Adjusted rolling average FTE count Current year resident to bed ratio (line 18 divided by line 4	`		0.00 0.000000	
	Prior year resident to bed ratio (see instructions)).		0.000000	
21.00	Enter the lesser of lines 19 or 20 (see instructions)			0.000000	
22.00	IME payment adjustment (see instructions)			0	22.00
22. 01	IME payment adjustment - Managed Care (see instructions) Indirect Medical Education Adjustment for the Add-on for § 42.	2 of the MMA		0	22.01
23. 00	Number of additional allopathic and osteopathic IME FTE resid (f)(1)(iv)(C).		CFR 412.105	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)			0.00	24.00
25.00	If the amount on line 24 is greater than -O-, then enter the instructions)	lower of line 23 or line	e 24 (see	0.00	
26.00	Resident to bed ratio (divide line 25 by line 4)			0. 000000	
27.00	IME payments adjustment factor. (see instructions)			0.000000	
28.00	IME add-on adjustment amount (see instructions)	<u>۱</u>		0	
28. 01 29. 00	IME add-on adjustment amount - Managed Care (see instructions Total IME payment (sum of lines 22 and 28))		0	
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.0 Disproportionate Share Adjustment	1)		0	
30. 00	Percentage of SSI recipient patient days to Medicare Part A p	atient days (see instruc	ctions)	4.84	30.00
31.00	Percentage of Medicaid patient days (see instructions)			21.48	31.00
32.00	Sum of lines 30 and 31	、 、			32.00
33.00	Allowable disproportionate share percentage (see instructions)			33.00
34.UU	Disproportionate share adjustment (see instructions)			670, 262	J 34. U

ALCUL	Financial Systems FRANCISCAN HEAL ATION OF REIMBURSEMENT SETTLEMENT	TH MICHIGAN CITY Provider CCN: 15-0015	Peri od:	u of Form CMS-2 Worksheet E	_002
			From 01/01/2020 To 12/31/2020	Part A Date/Time Pre	pare
		Title XVIII	Hospi tal	7/28/2021 7:4 PPS	I pr
			Prior to 10/1		
			1.00	2.00	
	Uncompensated Care Adjustment		0.050.500.00/	0.000.014.504	
. 00 . 01	Total uncompensated care amount (see instructions) Factor 3 (see instructions)		8, 350, 599, 096	8, 290, 014, 521 0. 000295331	
. 01	Hospital uncompensated care payment (If line 34 is zero,	enter zero on this line) (se		2, 448, 301	
. 02	instructions)		1, 110, 007	2, 110, 001	
. 03	Pro rata share of the hospital uncompensated care payment	amount (see instructions)	3, 324, 338	617, 107	35
00	Total uncompensated care (sum of columns 1 and 2 on line		3, 941, 445		36
00	Additional payment for high percentage of ESRD beneficiar Total Medicare discharges, excluding MS-DRGs 652, 682, 68	y discharges (lines 40 through)	gh 46)		1 40
. 00	instructions)	3, 684 and 685. (See	0		40
. 00	Total ESRD Medicare discharges excluding MS-DRGs 652, 68	2, 683, 684 an 685, (see	0		41
	instructions)				
. 01	Total ESRD Medicare covered and paid discharges excluding	MS-DRGs 652, 682, 683, 684	0		41
00	an 685. (see instructions)	ualify for adjustment)	0.00		
. 00 . 00	Divide line 41 by line 40 (if less than 10%, you do not q Total Medicare ESRD inpatient days excluding MS-DRGs 652		0.00		42
. 00	instructions)	, 332, 333, 334 an 333. (See			'`
. 00	Ratio of average length of stay to one week (line 43 divi	ded by line 41 divided by 7	0. 000000		44
	days)				
. 00	Average weekly cost for dialysis treatments (see instruct		0.00		45
. 00	Total additional payment (line 45 times line 44 times lin Subtotal (see instructions)	ie 41.01)	29, 485, 406		46
. 00	Hospital specific payments (to be completed by SCH and MD	H. small rural hospitals	27,403,400		48
	only. (see instructions)				``
				Amount	
00		: \		1.00	
. 00 . 00	Total payment for inpatient operating costs (see instruct Payment for inpatient program capital (from Wkst. L, Pt.	-		29, 485, 406 2, 049, 117	
. 00	Exception payment for inpatient program capital (Wkst. L,			2, 047, 117	
. 00	Direct graduate medical education payment (from Wkst. E-4			0	
. 00	Nursing and Allied Health Managed Care payment			0	
. 00	Special add-on payments for new technologies			121, 944	
. 01	Islet isolation add-on payment	no (0)		0	
. 00 . 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, li Cost of physicians' services in a teaching hospital (see			0	
. 00	Routine service other pass through costs (from Wkst. D, P	-	nrough 35).	0	
. 00	Ancillary service other pass through costs from Wkst. D,			0	
. 00	Total (sum of amounts on lines 49 through 58)			31, 656, 467	5
. 00	Primary payer payments			22, 040	
. 00	Total amount payable for program beneficiaries (line 59 m	inus line 60)		31, 634, 427	
. 00 . 00	Deductibles billed to program beneficiaries			2, 526, 216 71, 456	
. 00	Coinsurance billed to program beneficiaries Allowable bad debts (see instructions)			71, 456 348, 779	
. 00	Adjusted reimbursable bad debts (see instructions)			226, 706	
. 00	Allowable bad debts for dual eligible beneficiaries (see	instructions)		96, 290	
. 00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			29, 263, 461	6
. 00	Credits received from manufacturers for replaced devices			0	
. 00	Outlier payments reconciliation (sum of lines 93, 95 and	96). (For SCH see instruction:	5)	0	
. 00 . 50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Dem	onstration) adjustment (see	nstructions)	0	
. 87	Demonstration payment adjustment amount before sequestrat	· •		0	
. 88	SCH or MDH volume decrease adjustment (contractor use onl			0	
. 89	Pioneer ACO demonstration payment adjustment amount (see	instructions)			70
. 90	HSP bonus payment HVBP adjustment amount (see instruction			0	70
	HSP bonus payment HRR adjustment amount (see instructions)		0	
. 91				0	70
). 91). 92	Bundled Model 1 discount amount (see instructions)			-	
), 91), 92), 93), 94	Bundled Model 1 discount amount (see instructions) HVBP payment adjustment amount (see instructions) HRR adjustment amount (see instructions)			-33, 929 -103, 128	70

	TION OF REIMBURSEMENT SETTLEMENT	Provi der CC	 - 	Period: From 01/01/2020 Fo 12/31/2020	Date/Time Prep 7/28/2021 7:47	pared: 1 pm
		Title		<u>Hospital</u>	PPS Amount	
		t the second sec		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter	in column O		0	0	70.9
70. 97	the corresponding federal year for the period prior to 10/1) Low volume adjustment for federal fiscal year (yyyy) (Enter the corresponding federal year for the period ending on or a	in column O		0	0	70. 9
70. 98	Low Volume Payment-3 HAC adjustment amount (see instructions)				0	70.9
	Amount due provider (line 67 minus lines 68 plus/minus lines	s 69 & 70)			29, 126, 404	
	Sequestration adjustment (see instructions)				192, 234	
	Demonstration payment adjustment amount after sequestration Sequestration adjustment-PARHM pass-throughs				0	71.0
1	Interim payments				28, 930, 059	
	Interim payments-PARHM				,,	72.0
	Tentative settlement (for contractor use only)				0	
	Tentative settlement-PARHM (for contractor use only)	00 70 and			4 111	73.0
	Balance due provider/program (line 71 minus lines 71.01, 71. 73)	02, 72, and			4, 111	74.0
	Balance due provider/program-PARHM (see instructions)					74.0
75.00 I	Protested amounts (nonallowable cost report items) in accord CMS Pub. 15-2, chapter 1, §115.2	dance with			2, 007, 022	75.0
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96) Operating outlier amount from Wkst. E, Pt. A, line 2, or sum	of 2.02			0	90. 0
	plus 2.04 (see instructions)	1 01 2.03			0	70.0
	Capital outlier from Wkst. L, Pt. I, line 2				0	91.0
	Operating outlier reconciliation adjustment amount (see inst				0	
	Capital outlier reconciliation adjustment amount (see instru				0 0.00	
	The rate used to calculate the time value of money (see inst Time value of money for operating expenses (see instructions				0.00	
	Time value of money for capital related expenses (see instru				0	1
				Prior to 10/1		
L	ISP Bonus Payment Amount			1.00	2.00	
	HSP bonus amount (see instructions)			0	0	100. C
	IVBP Adjustment for HSP Bonus Payment					
	HVBP adjustment factor (see instructions)			0. 000000000	0.000000000	
02 001	HVBP adjustment amount for HSP bonus payment (see instructio	ons)		0	0	102. (
	IDD Additionate from UCD Density Deciment					1
F	HRR Adjustment for HSP Bonus Payment			0,0000	0,0000	103 0
03. 00 I	HRR adjustment factor (see instructions)			0.0000	0. 0000	
03.00 04.00		ns)	stment			
03.00 04.00 60.00	HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructior Rural Community Hospital Demonstration Project (§410A Demons Is this the first year of the current 5-year demonstration p	ns) stration) Adjus			0	104. (
03. 00 04. 00 200. 00	HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructior Rural Community Hospital Demonstration Project (§410A Demons Is this the first year of the current 5-year demonstration p Century Cures Act? Enter "Y" for yes or "N" for no.	ns) stration) Adjus			0	104. 0
03. 00 04. 00 00. 00 00. 00 00. 00 00	HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructior Rural Community Hospital Demonstration Project (§410A Demons Is this the first year of the current 5-year demonstration p Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement	ns) stration) Adjus period under th			0	104. (200. (
03.001 04.001 00.00 00.00	HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructior Rural Community Hospital Demonstration Project (§410A Demons Is this the first year of the current 5-year demonstration p Century Cures Act? Enter "Y" for yes or "N" for no.	ns) stration) Adjus period under th			0	104. (200. (201. (
03. 00 04. 00 00. 00 00. 00 00. 00 02. 00 03. 00	HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demons Is this the first year of the current 5-year demonstration p Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Ii Medicare discharges (see instructions) Case-mix adjustment factor (see instructions)	ns) stration) Adjus period under th ne 49)	ne 21st	0	0	104. (200. (201. (202. (
03. 00 1 04. 00 1 00. 00 0 001. 00 1 02. 00 1 03. 00 0	HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demons Is this the first year of the current 5-year demonstration p Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Ii Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A i	ns) stration) Adjus period under th ne 49)	ne 21st	0	0	104. (200. (201. (202. (
03.00 04.00 00.00 01.00 02.00 03.00 03.00 03.00	HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demons Is this the first year of the current 5-year demonstration p Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Ii Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A i period)	ns) stration) Adjus period under th ne 49)	ne 21st	0	0	104. (200. (201. (202. (203. (
03.001 04.001 800.001 801.001 802.001 803.001 803.001 803.001 803.001 803.001 803.001 803.001 803.001 803.001 803.001 803.001 803.001	HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demons Is this the first year of the current 5-year demonstration p Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Ii Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A i period) Medicare target amount	ns) stration) Adjus period under th ne 49)	ne 21st	0	0	104. (200. (201. (202. (203. (203. (
H H 03.001 H 04.001 H 200.001 H 201.001 H 202.001 H 203.000 H 203.000 H 204.001 H 205.000 H 204.001 H 205.000 H	HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demons Is this the first year of the current 5-year demonstration p Century Cures Act? Enter "Y" for yes or "N" for no. Dost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Ii Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A i Deriod) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205	ns) stration) Adjus period under th ne 49) n first year c	ne 21st	0	0	103. 0 104. 0 200. 0 201. 0 202. 0 203. 0 203. 0 204. 0 205. 0 206. 0
F 03. 00 1 04. 00 1 700. 00 0 01. 00 1 02. 00 1 03. 00 0 00 0 00 0 00 0 00 0 00 0 00 0	HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demons Is this the first year of the current 5-year demonstration p Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Ii Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A i beeriod) 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	ns) stration) Adjus period under th ne 49) n first year c	ne 21st	0	0 	104. c 200. c 201. c 202. c 203. c 204. c 205. c 206. c
F 03.00 04.00 F 200.00 201.00 202.00 203.00 203.00 204.00 205.00 206.00 207.00 207.00	HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demons Is this the first year of the current 5-year demonstration p Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Ii Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A i 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 ins	ns) stration) Adjus period under th ne 49) n first year of structions)	ne 21st	0	0 Tration	104. 0 200. 0 201. 0 202. 0 203. 0 204. 0 205. 0 206. 0 207. 0
03.00 0 04.00 1 800.00 6 201.00 1 202.00 1 203.00 1 204.00 1 205.00 1 206.00 1 207.00 1 208.00 1 209.00 1 200.00 1 200.00 1 200.00 1 200.00 1 200.00 1 200.00 1 200.00 1 200.00 1 200.00 1 200.00 1 200.00 1 200.00 1 200.00 1	HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demons Is this the first year of the current 5-year demonstration p Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Wedicare inpatient service costs (from Wkst. D-1, Pt. II, Ii Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A i 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 ins Medicare Part A inpatient service costs (from Wkst. E, Pt. A	ns) stration) Adjus period under th ne 49) n first year of structions)	ne 21st	0	0	104. 0 200. 0 201. 0 202. 0 203. 0 204. 0 205. 0 206. 0 206. 0 207. 0 208. 0
03.001 04.001 00.001	HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demons Is this the first year of the current 5-year demonstration p Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Ii Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A i 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 ins	ns) stration) Adjus period under th ne 49) n first year of structions)	ne 21st	0	0	104. (200. (201. (202. (203. (203. (205. (206. (206. (207. (208. (209. (
03. 00 04. 00 00. 00 01. 00 01. 00 03. 00 03. 00 04. 00 05. 00 06. 00 07. 00	HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demons Is this the first year of the current 5-year demonstration p Century Cures Act? Enter "Y" for yes or "N" for no. Dost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, li Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A i Deriod) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205 Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see ins Medicare Part A inpatient service costs (from Wkst. E, Pt. A Adjustment to Medicare IPPS payments (see instructions)	ns) stration) Adjus period under th ne 49) n first year c 5) structions) A, line 59)	ne 21st	0	0	104. (200. (202. (203. (203. (205. (206. (206. (206. (207. (208. (209. (209. (209. (209. (
H H 03.00 H 04.00 H 00.00 H 01.00 H 02.00 H 03.00 H 03.00 H 03.00 H 03.00 H 03.00 H 04.00 H 05.00 H 07.00 H 08.00 H 09.00 H 10.00 H 11.00 H	HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demons Is this the first year of the current 5-year demonstration p Century Cures Act? Enter "Y" for yes or "N" for no. Dost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Ii Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Case-mix adjustment factor (see instructions) Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 204) Medicare inpatient onder the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions)	ns) stration) Adjus period under th ne 49) n first year c s) structions) A, line 59)	ne 21st	0	0 ration	104. (200. (201. (202. (203. (203. (204. (205. (206. (207. (207. (207. (208. (207. (209. (209. (210. (
03. 00 04. 00 00. 00 01. 00 02. 00 03. 00 04. 00 05. 00 06. 00 07. 00 08. 00 10. 00 11. 00 11. 00 12. 00 13. 00 14. 00 15. 00	HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demons Is this the first year of the current 5-year demonstration p Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Ii Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Case-mix adjustment factor (see instructions) Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 204) Medicare part A inpatient service costs (from Wkst. E, Pt. A Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Comparision of PPS versus Cost Reimbursement Total adjustment to Medicare Part A IPPS payments (from line Comparision of PPS versus Cost Reimbursement Total adjustment to Medicare Part A IPPS payments (from line Comparision of PPS versus Cost Reimbursement Total adjustment to Medicare Part A IPPS payments (from line Comparision of PPS versus Cost Reimbursement	ns) stration) Adjus period under th ne 49) n first year c s) structions) A, line 59)	ne 21st	0	0 Cration	104. (200. (201. (202. (203. (203. (205. (207. (208. (209. (209. (211. (211. (212. (
H H 03.00 H 04.00 H 00.00 H 01.00 H 02.00 H 03.00 H 04.00 H 05.00 H 05.00 H 07.00 H 07.00 H 09.00 H 11.00 H 12.00 H 13.00 H	HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demons Is this the first year of the current 5-year demonstration p Century Cures Act? Enter "Y" for yes or "N" for no. Dost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Ii Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Case-mix adjustment factor (see instructions) Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 204) Medicare inpatient onder the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions)	ns) stration) Adjus period under th ne 49) n first year of 5) structions) A, line 59) 5)	of the current	0	0	104. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 209. 201.

	Financial Systems FRANCISCAN HEALTH M ATION OF REIMBURSEMENT SETTLEMENT	IICHIGAN CITY Provider CCN: 15-0015	In Lie Period: From 01/01/2020 To 12/31/2020		pared:
		Title XVIII	Hospi tal	PPS	- p
				1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
1.00 2.00 3.00	Medical and other services (see instructions) Medical and other services reimbursed under OPPS (see instruc OPPS payments	ti ons)		416 23, 225, 539 19, 498, 014	
4.00 4.01 5.00	Outlier payment (see instructions) Outlier reconciliation amount (see instructions) Enter the hospital specific payment to cost ratio (see instru-	ctions)		105, 699 0 0. 000	4.00 4.01 5.00
6.00 7.00 8.00	Line 2 times line 5 Sum of lines 3, 4, and 4.01, divided by line 6 Transitional corridor payment (see instructions)			0 0. 00 0	7.00
9.00 10.00 11.00	Ancillary service other pass through costs from Wkst. D, Pt. Organ acquisitions Total cost (sum of lines 1 and 10) (see instructions)	IV, col. 13, line 200		0 0 416	10.00
	COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges				-
12.00	Ancillary service charges			1, 883	12.00
13.00 14.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, I Total reasonable charges (sum of lines 12 and 13) Customary charges	ine 69)		0 1, 883	13.00
15.00 16.00	Aggregate amount actually collected from patients liable for Amounts that would have been realized from patients liable fo had such payment been made in accordance with 42 CFR §413.13(r payment for services o		0 0	15. 00 16. 00
17.00 18.00 19.00	Ratio of line 15 to line 16 (not to exceed 1.000000) Total customary charges (see instructions) Excess of customary charges over reasonable cost (complete on		ne 11) (see	0. 000000 1, 883 1, 467	18.00
20.00	instructions) Excess of reasonable cost over customary charges (complete on instructions)	5		0	
21.00 22.00 23.00	Lesser of cost or charges (see instructions) Interns and residents (see instructions) Cost of physicians' services in a teaching hospital (see inst	ructions)		416 0 0	
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) COMPUTATION OF REIMBURSEMENT SETTLEMENT	·		19, 603, 713	24.00
25. 00 26. 00 27. 00	Deductibles and coinsurance amounts (for CAH, see instruction Deductibles and Coinsurance amounts relating to amount on lin Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) instructions)	e 24 (for CAH, see instr		0 3, 587, 474 16, 016, 655	26.00
28.00 29.00 30.00	Direct graduate medical education payments (from Wkst. E-4, I ESRD direct medical education costs (from Wkst. E-4, line 36) Subtotal (sum of lines 27 through 29)	ine 50)		0 0 16, 016, 655	29.00
31.00 32.00	Primary payer payments Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVIO	CES)		2, 203 16, 014, 452	
33.00 34.00 35.00	Composite rate ESRD (from Wkst. I-5, line 11) Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			0 604, 329 392, 814	
36. 00 37. 00	Allowable bad debts for dual eligible beneficiaries (see inst Subtotal (see instructions)	ructions)		297, 228 16, 407, 266	36.00
38.00 39.00 39.50	MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instruction	5)		-85 0	38.00 39.00 39.50
39. 97 39. 98	Demonstration payment adjustment amount before sequestration Partial or full credits received from manufacturers for repla		tions)	0 0 0	39. 97 39. 98
39.99 40.00 40.01	RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions) Sequestration adjustment (see instructions)			16, 407, 351 108, 289	
40. 02 40. 03 41. 00	Demonstration payment adjustment amount after sequestration Sequestration adjustment-PARHM pass-throughs Interim payments			0 16, 323, 383	40. 03
41. 01 42. 00 42. 01	Interim payments-PARHM Tentative settlement (for contractors use only) Tentative settlement-PARHM (for contractor use only)			0	41.01 42.00 42.01
43. 00 43. 01	Balance due provider/program (see instructions) Balance due provider/program-PARHM (see instructions)	nco with CMS Dub 15 3	chantor 1	-24, 321 0	43.00 43.01
44.00	Protested amounts (nonallowable cost report items) in accorda §115.2 TO BE COMPLETED BY CONTRACTOR				
90.00 91.00 92.00	Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money			0 0 0.00	91.00
93.00 94.00	Time Value of Money (see instructions) Total (sum of lines 91 and 93)			0 0	93.00 94.00

ANALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC	:N: 15-0015	Period: From 01/01/2020 To 12/31/2020	Worksheet E-1 Part I Date/Time Prep 7/28/2021 7:41	pared:
		Title	XVIII	Hospi tal	PPS	
		I npati en	t Part A	Par	tВ	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00 2.00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		28, 930, 05	0 0	16, 323, 383 0	1.00 2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3.00
3.01	ADJUSTMENTS TO PROVIDER			0	0	3.01
3.02				0	0	3. 02
3.03				0	0	3. 0
3.04				0	0	3.04
3.05	Provider to Program			0	0	3.05
3.50	ADJUSTMENTS TO PROGRAM			0	0	3.50
3.51				0	Ő	3.5
3.52				0	0	3.5
3.53				0	0	3.5
3.54				0	0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0	0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		28, 930, 05	59	16, 323, 383	4.00
5.00	TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after					5.00
5.00	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					5.00
5.01	TENTATI VE TO PROVIDER			0	0	5.01
5.02				0	0	5.02
5.03				0	0	5.03
	Provider to Program				-	
5.50 5.51	TENTATI VE TO PROGRAM			0	0	5.50 5.5
5.51				0	0	5.5
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5.9
	5. 50-5. 98)				J	
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6. 01	SETTLEMENT TO PROVIDER		4, 11	11	0	6.0
6. 02	SETTLEMENT TO PROGRAM			0	24, 321	6. 0
7.00	Total Medicare program liability (see instructions)		28, 934, 17		16, 299, 062	7.0
				Contractor Number	NPR Date (Mo/Day/Yr)	
		C		1.00	2.00	

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider CO	CN: 15-0015 CCN: 15-S015	Peri From To	od: 01/01/2020 12/31/2020	Worksheet Part I Date/Time 7/28/2021	Prep	
		Title	e XVIII	Sub	provider - IPF	PP	S	
		Inpatien	t Part A			t B		
		mm/dd/yyyy	Amount	r	nm/dd/yyyy	Amount		
00	Tatal interim assuments with the survivier	1.00	2.00	11	3.00	4.00		1 (
00 00 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each		401, 9	0			0	1. (2. (3. (
	payment. If none, write "NONE" or enter a zero. (1) Program to Provider							
01	ADJUSTMENTS TO PROVIDER			0			0	3.
02				0			0	3.
03				0			0	3.
04 05				0 0			0	3. 3.
00	Provider to Program		<u> </u>					0.
50	ADJUSTMENTS TO PROGRAM			0			0	3.
51				0			0	3.
52				0			0	3
53 54				0 0			0	3. 3.
99	Subtotal (sum of lines 3.01–3.49 minus sum of lines			0			0	3.
	3. 50-3. 98)						_	
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		401, 9	16			0	4
	TO BE COMPLETED BY CONTRACTOR							
00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)							5
	Program to Provider							
01	TENTATI VE TO PROVIDER			0			0	5
)2)3				0 0			0	5 5
5	Provider to Program			0				5
50	TENTATI VE TO PROGRAM			0			0	5
51				0			0	5
52 99				0			0	5 5
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0			0	
00	Determined net settlement amount (balance due) based on the cost report. (1)							6
)1)2	SETTLEMENT TO PROVIDER		7,8	343			0	6
02 00	SETTLEMENT TO PROGRAM Total Medicare program liability (see instructions)		409, 7	0 '59			0	6 7
.0			409,7		Contractor	NPR Date		/
				Ì	Number	(Mo/Day/Yi		
		(C		1.00	2.00		

Heal th	Financial Systems FRANCISCAN HEALTH N	II CHI GAN CI TY	In Lie	u of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0015	Peri od:	Worksheet E-1	
			From 01/01/2020 To 12/31/2020		nared
			10 12/01/2020	7/28/2021 7:4	
		Title XVIII	Hospi tal	PPS	
	TO BE CONDUCTED DV CONTRACTOR FOR NONCTANDARD COST REPORTS			1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				-
1.00	Total hospital discharges as defined in AARA §4102 from Wkst.		14		1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8				2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8	-12			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 l				6.00
7.00	CAH only - The reasonable cost incurred for the purchase of c	ertified HIT technology	Wkst. S-2, Pt. I		7.00
0.00	line 168				0.00
	Calculation of the HIT incentive payment (see instructions)				8.00
9.00 10.00	Sequestration adjustment amount (see instructions)	(ass. i patruati ang)			9.00
10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)			10.00
30 00	Initial/interim HIT payment adjustment (see instructions)				30,00
	Other Adjustment (specify)				31.00
	Balance due provider (line 8 (or line 10) minus line 30 and l	ine 31) (see instruction	s)		32.00
					•

	Financial Systems FRANCISCAN HEA ATION OF REIMBURSEMENT SETTLEMENT	ALTH MICHIGAN CITY Provider CCN: 15-0015	Peri od:	u of Form CMS-2 Worksheet E-3	
ALCUL	ATTON OF REIMBORSEMENT SETTLEMENT		From 01/01/2020		
		Component CCN: 15-S015	To 12/31/2020	Date/Time Pre 7/28/2021 7:4	
		Title XVIII	Subprovider -	PPS	трп
				1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS			1.00	
00	Net Federal IPF PPS Payments (excluding outlier, ECT, an	d medical education payments)	456, 734	
00	Net IPF PPS Outlier Payments			1, 447	2
00	Net IPF PPS ECT Payments			0	
00	Unweighted intern and resident FTE count in the most rec 15, 2004. (see instructions)	ent cost report filed on or	betore November	0.00	4
01	Cap increases for the unweighted intern and resident FTE	count for residents that we	re displaced by	0.00	4
	program or hospital closure, that would not be counted w	ithout a temporary cap adjus	tment under 42		
	CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)				
00	New Teaching program adjustment. (see instructions)			0.00	
00	Current year's unweighted FTE count of I&R excluding FTE	s in the new program growth	period of a "new	0.00	6
. 00	teaching program" (see instuctions) Current year's unweighted I&R FTE count for residents wi	thin the new program growth	period of a "new	0.00	7
00	teaching program" (see instuctions)	thin the new program growth		0.00	'
00	Intern and resident count for IPF PPS medical education	adjustment (see instructions)	0.00	8
00	Average Daily Census (see instructions)	5	, ,	9. 174863	(
0. 00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raise	d to the power of .5150 -1}.		0. 000000	10
. 00	Teaching Adjustment (line 1 multiplied by line 10).			0	1
. 00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and	11)		458, 181	1:
	Nursing and Allied Health Managed Care payment (see inst	ruction)		0	1:
	Organ acquisition (DO NOT USE THIS LINE)				14
	Cost of physicians' services in a teaching hospital (see	instructions)		0	
	Subtotal (see instructions)			458, 181	10
	Primary payer payments			450, 101	1
	Subtotal (line 16 less line 17). Deductibles			458, 181 52, 052	
	Subtotal (line 18 minus line 19)			406, 129	
	Coinsurance			2, 112	
	Subtotal (line 20 minus line 21)			404, 017	
	Allowable bad debts (exclude bad debts for professional	services) (see instructions)		13, 021	2
	Adjusted reimbursable bad debts (see instructions)	····, (······,		8, 464	
. 00	Allowable bad debts for dual eligible beneficiaries (see	instructions)		2, 109	2
b. 00	Subtotal (sum of lines 22 and 24)			412, 481	20
7.00	Direct graduate medical education payments (see instruct	i ons)		0	27
	Other pass through costs (see instructions)			0	28
	Outlier payments reconciliation			0	29
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	30
	Pioneer ACO demonstration payment adjustment (see instru			0	30
	Demonstration payment adjustment amount before sequestra	tion		412 491	
	Total amount payable to the provider (see instructions) Sequestration adjustment (see instructions)			412, 481 2, 722	
	Demonstration payment adjustment amount after sequestrat	ion		2,722	
	Interim payments			401, 916	
	Tentative settlement (for contractor use only)			0	
	Balance due provider/program (line 31 minus lines 31.01,	31.02, 32 and 33)		7, 843	
	Protested amounts (nonallowable cost report items) in ac		chapter 1,	0	
	\$115.2 TO BE COMPLETED BY CONTRACTOR				
D. 00	Original outlier amount from Worksheet E-3, Part II, lin	e 2		1, 447	50
1.00	Outlier reconciliation adjustment amount (see instructio	ns)		0	51
1.00					

	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0015	Peri od:	Worksheet E-3	2552 1
.2002			From 01/01/2020	Part VII	
			To 12/31/2020	Date/Time Prep 7/28/2021 7:4	
		Title XIX	Hospi tal	Cost	<u> </u>
		· · ·	I npati ent	Outpati ent	
			1.00	2.00	_
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH	SERVICES FOR TITLES V OR X	(IX SERVICES		4
00	COMPUTATION OF NET COST OF COVERED SERVICES Inpatient hospital/SNF/NF services		0		1 1
00	Medical and other services		0	0	
00	Organ acquisition (certified transplant centers only)		0		
00	Subtotal (sum of lines 1, 2 and 3)		0	0	4
00	Inpatient primary payer payments		0		1
00	Outpatient primary payer payments			0	
00	Subtotal (line 4 less sum of lines 5 and 6)		0	0	
	COMPUTATION OF LESSER OF COST OR CHARGES Reasonable Charges				1
00	Routi ne servi ce charges		0		1 8
00	Ancillary service charges		45, 390, 173	106, 646, 028	
. 00	Organ acquisition charges, net of revenue		0		1 1
	Incentive from target amount computation		0		1
. 00	Total reasonable charges (sum of lines 8 through 11)		45, 390, 173	106, 646, 028	1:
00	CUSTOMARY CHARGES	for convious on a charge	0	0	1 1
. 00	Amount actually collected from patients liable for payment basis	for services on a charge	0	0	1:
. 00	Amounts that would have been realized from patients liable	for payment for services (on O	0	14
	a charge basis had such payment been made in accordance wi				
	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.00000		
	Total customary charges (see instructions)		45, 390, 173		
. 00	Excess of customary charges over reasonable cost (complete	only if line 16 exceeds	45, 390, 173	106, 646, 028	1
. 00	line 4) (see instructions) Excess of reasonable cost over customary charges (complete	only if line 4 exceeds li	ne 0	0	1
. 00	16) (see instructions)				''
. 00	Interns and Residents (see instructions)		0	0	10
	Cost of physicians' services in a teaching hospital (see in		0	0	
. 00	Cost of covered services (enter the lesser of line 4 or lin		0	0	2'
00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only	be completed for PPS provi			
	Other than outlier payments Outlier payments		0	0	
	Program capital payments		0		2
	Capital exception payments (see instructions)		0		2
. 00	Routine and Ancillary service other pass through costs		0	0	2
	Subtotal (sum of lines 22 through 26)		0	0	
	Customary charges (title V or XIX PPS covered services only	у)	0	0	
. 00	Titles V or XIX (sum of lines 21 and 27)		0	0	2
00	COMPUTATION OF REIMBURSEMENT SETTLEMENT Excess of reasonable cost (from line 18)		0	0	30
	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and	d 6)	0	-	
	Deducti bl es		0		
. 00	Coinsurance		0	0	3
	Allowable bad debts (see instructions)		0	0	
	Utilization review		0		3
	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32	and 33)	0	0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	
	Subtotal (line 36 \pm line 37) Direct graduate medical education payments (from Wkst. E-4))	0	-	30
	Total amount payable to the provider (sum of lines 38 and 3		0	0	
	Interim payments		0	0	
			0	Ő	
	Balance due provider/program (line 40 minus line 41)		0	0.	

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0015	Peri od:	Worksheet E-3	
		Component CCN: 15-S015	From 01/01/2020 To 12/31/2020	Part VII Date/Time Pre 7/28/2021 7:4	
		Title XIX	Subprovider - IPF	Cost	
			Inpatient 1.00	Outpatient 2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SE	ERVICES FOR TITLES V OR X		2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES				1
00	Inpatient hospital/SNF/NF services		0		1 1
00	Medical and other services			0	2
00	Organ acquisition (certified transplant centers only)		0		3
00	Subtotal (sum of lines 1, 2 and 3)		0	0	4
00	Inpatient primary payer payments		0		5
00	Outpatient primary payer payments			0	6
00	Subtotal (line 4 less sum of lines 5 and 6)		0	0	7
	COMPUTATION OF LESSER OF COST OR CHARGES				
~ ~	Reasonable Charges				
00	Routi ne servi ce charges		0	2	8
00	Ancillary service charges Organ acquisition charges, net of revenue		0	0	
. 00	Incentive from target amount computation		0		10
. 00	Total reasonable charges (sum of lines 8 through 11)		0	0	
. 00	CUSTOMARY CHARGES		0	0	1 12
. 00	Amount actually collected from patients liable for payment for	or services on a charge	0	0	13
	basi s	er eer reee en a enarge			
. 00	Amounts that would have been realized from patients liable for	or payment for services o	n 0	0	14
	a charge basis had such payment been made in accordance with	42 CFR §413.13(e)			
. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.00000	
. 00	Total customary charges (see instructions)		0	0	
. 00	Excess of customary charges over reasonable cost (complete or	nly if line 16 exceeds	0	0	17
	line 4) (see instructions)				
. 00	Excess of reasonable cost over customary charges (complete of	nly if line 4 exceeds lin	e 0	0	18
. 00	16) (see instructions) Interns and Residents (see instructions)		0	0	19
. 00	Cost of physicians' services in a teaching hospital (see ins	tructions)	0	0	20
. 00	Cost of covered services (enter the lesser of line 4 or line		0	0	
. 00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be				- ²
. 00	Other than outlier payments		0	0	22
. 00	Outlier payments		0	0	
. 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	26
. 00	Subtotal (sum of lines 22 through 26)		0	0	27
. 00	Customary charges (title V or XIX PPS covered services only)		0	0	28
. 00	Titles V or XIX (sum of lines 21 and 27)		0	0	29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		- 1 1		
	Excess of reasonable cost (from line 18)		0	0	
	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6	6)	0	0	
	Deductibles		0	0	
. 00	Coinsurance		0	0	
. 00 . 00	Allowable bad debts (see instructions) Utilization review		0	0	34
. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 a	nd 33)	0	0	
. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	
. 00	Subtotal (line 36 \pm line 37)		0	0	
. 00	Direct graduate medical education payments (from Wkst. E-4)		0	0	39
. 00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	
. 00	Interim payments	-	0	0	
2.00	Balance due provider/program (line 40 minus line 41)		0	0	
00					43

ALANCE	inancial Systems FRANCISCAN HEALTH SHEET (If you are nonproprietary and do not maintain be accounting records, complete the General Fund column	Provi der C	CN: 15-0015	Period: From 01/01/2020	u of Form CMS-: Worksheet G	
ina-typ il y)	e accounting records, complete the General Fund column			To 12/31/2020	Date/Time Pre 7/28/2021 7:4	pare
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
CI	JRRENT ASSETS	1.00	2.00	3.00	4.00	
	ash on hand in banks	0	(o l	0	1 1
	emporary investments	29, 038, 354		0	0	
	otes receivable	0		o o	0	3
00 Ad	ccounts receivable	39, 856, 684		o o	0	4
00 0	ther receivable	0		0 0	0	5
00 AI	llowances for uncollectible notes and accounts receivable	-7, 288, 661		0 0	0	6
1 00	nventory	4, 200, 072		0 0	0	7
	repaid expenses	0	(0 0	0	8
00 0	ther current assets	10, 332, 449		0 0	0	9
. 00 Di	ue from other funds	0	(0 0	0	10
	otal current assets (sum of lines 1-10)	76, 138, 898	(0 0	0	11
	XED ASSETS			· · · · · · ·		
	and	9, 595, 549		0 0	0	
	and improvements	6, 134, 414		0 0	0	
	ccumulated depreciation	-3, 773, 804		0 0	0	
	ui I di ngs	310, 036, 581		0	0	
	ccumulated depreciation	-124, 215, 213		u u u u u u u u u u u u u u u u u u u	0	16
	easehold improvements	0	(-	0	17
	ccumulated depreciation	0			0	18
	ixed equipment	0		-	0	19
	ccumulated depreciation	0			0	20
	utomobiles and trucks ccumulated depreciation	0		-	0	21
		153, 443, 883		-	0	22
1	ajor movable equipment ccumulated depreciation	-34, 936, 523		-	0	23
	i nor equi pment depreci abl e	-34, 930, 523		-	0	24
	ccumul ated depreciation	0			0	26
	IT designated Assets	0		-	0	27
	ccumul ated depreciation			-	0	28
	i nor equi pment-nondepreci abl e				0	
	otal fixed assets (sum of lines 12-29)	316, 284, 887			0	
	THER ASSETS	010,201,007	· · · · · ·		0	
	nvestments	0	(0 0	0	31
	eposits on leases	0			0	32
	ue from owners/officers	0		0 0	0	33
. 00 0	ther assets	13, 366, 518		0 0	0	34
5. 00 To	otal other assets (sum of lines 31-34)	13, 366, 518		o o	0	35
5. 00 To	otal assets (sum of lines 11, 30, and 35)	405, 790, 303	(o o	0	36
CL	JRRENT LI ABI LI TI ES					1
7.00 Ac	ccounts payable	0	(0 0	0	37
3. 00 Sa	al ari es, wages, and fees payable	0		0 0	0	38
0. 00 Pa	ayroll taxes payable	19, 336, 123	0	0 0	0	39
). OO No	otes and loans payable (short term)	8, 303, 496	(0 0	0	40
I. 00 De	eferred income	0	(0 0	0	41
2.00 A	ccelerated payments	0				42
3.00 Di	ue to other funds	0	(0 0	0	43
	ther current liabilities	0		0 0	0	
	otal current liabilities (sum of lines 37 thru 44)	27, 639, 619	(0 0	0	45
	DNG TERM LIABILITIES		1	1		
	ortgage payable	56, 813, 300		0 0	0	
	otes payable	0	0	0 0	0	
	nsecured loans	0			0	
	ther long term liabilities			0	0	
	otal long term liabilities (sum of lines 46 thru 49)	56, 813, 300			0	
	otal liabilities (sum of lines 45 and 50)	84, 452, 919	(0 0	0	51
	APITAL ACCOUNTS eneral fund balance	321, 337, 384		1		F ~
	pecific purpose fund	JZ1, JJ/, J84				52 53
	onor created - endowment fund balance - restricted			0		54
	onor created - endowment fund balance - restricted			0		54
	overning body created - endowment fund balance			0		56
	lant fund balance - invested in plant			0	0	
1	lant fund balance - reserve for plant improvement,				0	
	eplacement, and expansion				0	1 30
	otal fund balances (sum of lines 52 thru 58)	321, 337, 384	(0 0	0	59
	otal liabilities and fund balances (sum of lines 51 and	405, 790, 303			0	
		,,,			0	

			From 01/01/202 To 12/31/202		
General	Fund	Speci al	Purpose Fund	Endowment Fund	
1.00	2.00	3.00	4.00	5.00	
69, 588, 523 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	531, 046, 166 -189, 587, 068 341, 459, 098 69, 588, 523 411, 047, 621 0 411, 047, 621				6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00
Endowment Fund	PI ant	Fund			
6.00	7.00	8.00			
0	0 0 0 0 0 0		0		1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
0	0 0 0 0 0 0		0		10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00
	1.00 69,588,523 0 0 0 0 0 0 0 0 0 0 0 0 0	531, 046, 166 -189, 587, 068 341, 459, 098 69, 588, 523 0 <td< td=""><td>Image: constraint of the second state of th</td><td>Image: constraint of the second state of th</td><td>General Fund Special Purpose Fund Endowment Fund 1.00 2.00 3.00 4.00 5.00 531,046,166 0 0 0 0 0 -189,587,068 0</td></td<>	Image: constraint of the second state of th	Image: constraint of the second state of th	General Fund Special Purpose Fund Endowment Fund 1.00 2.00 3.00 4.00 5.00 531,046,166 0 0 0 0 0 -189,587,068 0

Heal th	Financial Systems FRANCISCAN HEALTH M	I CHI GAN CI TY		In Lie	u of Form CMS-2	2552-10
STATEM	IENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider CC	N: 15-0015	Period: From 01/01/2020 To 12/31/2020	Worksheet G-2 Parts I & II Date/Time Pre 7/28/2021 7:4	pared:
	Cost Center Description		Inpati ent	Outpati ent	Total	
	PART I - PATIENT REVENUES		1.00	2.00	3.00	
	General Inpatient Routine Services					1
1.00	Hospi tal		57, 699, 43	36	57, 699, 436	1.00
2.00	SUBPROVIDER - IPF		5, 715, 09	99	5, 715, 099	2.00
3.00	SUBPROVIDER - IRF			0	0	
4.00	SUBPROVIDER				_	4.00
5.00	Swing bed - SNF			0	0	
6.00 7.00	Swing bed - NF SKILLED NURSING FACILITY			0	0	
7.00 8.00	NURSING FACILITY			0	0	
9.00	OTHER LONG TERM CARE			0	0	
10.00	Total general inpatient care services (sum of lines 1-9)		63, 414, 53	35	63, 414, 535	
	Intensive Care Type Inpatient Hospital Services					
11.00	I NTENSI VE CARE UNI T		13, 117, 26		13, 117, 265	
12.00	CORONARY CARE UNIT			0	0	
13.00	BURN INTENSIVE CARE UNIT			0	0	
14.00 15.00	SURGI CAL INTENSI VE CARE UNI T			0	0	14.00 15.00
16.00	OTHER SPECIAL CARE (SPECIFY) Total intensive care type inpatient hospital services (sum of	lines	13, 117, 26	5	13, 117, 265	
10.00	11-15)	TTHES	13, 117, 20	15	13, 117, 203	10.00
17.00	Total inpatient routine care services (sum of lines 10 and 16))	76, 531, 80	00	76, 531, 800	17.00
18.00	Ancillary services	, I	212, 208, 97	79 455, 254, 727	667, 463, 706	18.00
19.00	Outpatient services		26, 268, 02	81, 397, 630	107, 665, 655	19.00
20.00	RURAL HEALTH CLINIC			0 0	0	
21.00	FEDERALLY QUALIFIED HEALTH CENTER			0 0	0	
22.00 23.00	HOME HEALTH AGENCY			0	0	
23.00	AMBULANCE SERVICES CMHC			0 0	0	
24.00	CORF			0 0	0	
25.00	AMBULATORY SURGICAL CENTER (D. P.)			0 0	0	
26.00	HOSPI CE			0 0	0	26.00
27.00	PROFESSI ONAL FEES			0 16, 485, 729	16, 485, 729	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3	to Wkst.	315, 008, 80	04 553, 138, 086	868, 146, 890	28.00
	G-3, line 1)					-
29.00	PART II - OPERATING EXPENSES Operating expenses (per Wkst. A, column 3, line 200)			213, 930, 455		29.00
30.00	ADD (SPECIFY)			213, 930, 433		30.00
31.00				0		31.00
32.00				0		32.00
33.00				0		33.00
34.00				0		34.00
35.00				0		35.00
36.00	Total additions (sum of lines 30-35)			0		36.00
37.00 38.00	DEDUCT (SPECIFY)			0		37.00 38.00
38.00 39.00				0		38.00
40.00				0		40.00
40.00				0		40.00
42.00	Total deductions (sum of lines 37-41)			0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 4	2)(transfer		213, 930, 455		43.00
	to Wkst. G-3, line 4)					

STATEM	ENT OF REVENUES AND EXPENSES	Provider CCN: 15-0015	Peri od:	Worksheet G-3	
STATEN	ENT OF REVENUES AND EXFENSES	FIOVIDEI CCN. 15-0015	From 01/01/2020	WULKSHEEL G-3	
			To 12/31/2020		
				7/28/2021 7:4	1 pm
			-	1.00	
1 00	Tetel actions and from West C. 2. Dest L. selvers 2. Liv	20)		1.00	1 00
1.00 2.00	Total patient revenues (from Wkst. G-2, Part I, column 3, lin			868, 146, 890	1.00 2.00
	Less contractual allowances and discounts on patients' accounts and the second	nts		632, 741, 776	-
3.00	Net patient revenues (line 1 minus line 2)	42)		235, 405, 114	3.00 4.00
4.00 5.00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		213, 930, 455	
5.00	Net income from service to patients (line 3 minus line 4) OTHER INCOME			21, 474, 659	5.00
6.00	Contributions, donations, bequests, etc			0	6.00
7.00	Income from investments			-226, 326, 071	7.00
7.00 8.00	Revenues from telephone and other miscellaneous communication	n sorvi cos		-220, 320, 071	8.0
8.00 9.00	Revenue from television and radio service	IT SELVICES		0	9.0
9.00 10.00	Purchase di scounts			0	9.0 10.0
10.00	Rebates and refunds of expenses			0	11.0
12.00	Parking lot receipts			0	12.0
13.00	Revenue from Laundry and Linen service			0	12.0
14.00	Revenue from meals sold to employees and guests			0	14.0
	Revenue from rental of living quarters			0	15.0
	Revenue from sale of medical and surgical supplies to other	than natients		0	16.0
17.00	Revenue from sale of drugs to other than patients	than patronts		0	17.0
18.00	Revenue from sale of medical records and abstracts			0	18.0
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)			Ő	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen			Ő	20.00
21.00	Rental of vending machines			Ő	21.0
22.00	Rental of hospital space			0	22.0
23.00	Governmental appropriations			0	23.0
	MI SC I NCOME			2, 709, 021	
24.50	COVI D-19 PHE Funding			12, 555, 323	
25.00	Total other income (sum of lines 6-24)			-211, 061, 727	25.0
26.00	Total (line 5 plus line 25)			-189, 587, 068	
	OTHER EXPENSES (SPECIFY)			0	27.0
28.00	Total other expenses (sum of line 27 and subscripts)			Ő	28.0
29.00	Net income (or loss) for the period (line 26 minus line 28)			-189, 587, 068	

ALCUL	ATION OF CAPITAL PAYMENT	Provider CCN: 15-0015	Peri od:	Worksheet L	
			From 01/01/2020 To 12/31/2020		
		Title XVIII	Hospi tal	7/28/2021 7:4 PPS	1 pm
	PART I - FULLY PROSPECTIVE METHOD			1.00	
	CAPITAL FEDERAL AMOUNT				1
00	Capital DRG other than outlier			1, 912, 649	1.
01	Model 4 BPCI Capital DRG other than outlier			0	1.
00	Capital DRG outlier payments			136, 468	2.
01	Model 4 BPCI Capital DRG outlier payments			0	2.
00	Total inpatient days divided by number of days in the cost	reporting period (see inst	ructions)	70.05	3.
00	Number of interns & residents (see instructions)			0.00	4.
00	Indirect medical education percentage (see instructions)			0.00	5.
00	Indirect medical education adjustment (multiply line 5 by t	he sum of lines 1 and 1.01	, columns 1 and	0	6.
	1.01) (see instructions)				
00	Percentage of SSI recipient patient days to Medicare Part A 30) (see instructions)	patient days (Worksheet E	, part A line	0.00	7.
00	Percentage of Medicaid patient days to total days (see inst	ructions)		0.00	8.
00	Sum of lines 7 and 8			0.00	
. 00	Allowable disproportionate share percentage (see instructio	ins)		0.00	10.
. 00	Disproportionate share adjustment (see instructions)			0	
. 00	Total prospective capital payments (see instructions)			2, 049, 117	12.
				1.00	
	PART II - PAYMENT UNDER REASONABLE COST				
00	Program inpatient routine capital cost (see instructions)			0	
00	Program inpatient ancillary capital cost (see instructions)			0	
00	Total inpatient program capital cost (line 1 plus line 2)			0	3.
00	Capital cost payment factor (see instructions)			0	
00	Total inpatient program capital cost (line 3 x line 4)			0	5.
				1.00	
~~	PART III - COMPUTATION OF EXCEPTION PAYMENTS			0	1 1
00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumsta			0	
00 00	5 1 1	inces (see instructions)		0	
00	Net program inpatient capital costs (line 1 minus line 2)			0.00	
	Applicable exception percentage (see instructions)				
00 00	Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see	instructions)		0 0. 00	
00			lino 6)	0.00	
00	Adjustment to capital minimum payment level for extraordina Capital minimum payment level (line 5 plus line 7)	ny cricumstances (rine 2 x		0	
00	Current year capital payments (from Part I, line 12, as app			0	
. 00	Current year comparison of capital minimum payment level to		Less line 0)	0	
. 00	Carryover of accumulated capital minimum payment level over	1 1 3 1		0	
00	Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital	navments (line 10 plus lin	0 11)	0	12.
	Current year exception payment (if line 12 is positive, ent			0	
	Carryover of accumulated capital minimum payment level over			0	
	(if line 12 is negative, enter the amount on this line)	capital payment for the r	orrowing period	-	
5. 00	Current year allowable operating and capital payment (see i			0	
5. 00 5. 00				0	