Heal th Financi	al Systems FRA	NCISCAN HEALTH CR	RAWFORDSVI LLE	In Lieu	u of Form CMS-2552-10
	s required by law (42 USC 1395g; 42 CFF				FORM APPROVED
payments made	since the beginning of the cost report	ing period being	deemed overpayments (	42 USC 1395g).	OMB NO. 0938-0050
					EXPI RES 03-31-2022
	OSPITAL HEALTH CARE COMPLEX COST REPOR	RT CERTIFICATION	Provider CCN: 15-0022	Period: From 01/01/2021	Worksheet S Parts  -
AND SETTLEMEN	SUMMARY			To 12/31/2021	Date/Time Prepared:
					5/31/2022 8:56 am
PART I - COST					
Provi der	1. [ X ] Electronically prepared cost	report		Date: 5/31/20	22 Time: 8:56 am
use only	2. [ ] Manually prepared cost report				
	3. [0] If this is an amended report of 4. [F] Medicare Utilization. Enter "I			resubmitted this co	ost report
Contractor	5. [ 1 ] Cost Report Status 6. Date F			.NPR Date:	
use only	(1) As Submitted 7. Contra	actor No.	11	. Contractor's Vendo	or Code: 4
use only	(2) Settled without Audit 8. [ N ]	Initial Report fo	or this Provider CCN 12	.[0] fline 5, co	lumn 1 is 4: Enter
	(3) Settled with Audit 9. [N]	Final Report for	this Provider CCN		es reopened = 0-9.
	(4) Reopened				
	(5) Amended				
PART LL - CER	I FIFICATION BY A CHIEF FINANCIAL OFFICE	OR ADMINISTRATO	R OR PROVIDER(S)		
	TION OR FALSIFICATION OF ANY INFORMATION			PUNISHABLE BY CRIM	INAL. CIVIL AND
	ACTION, FINE AND/OR IMPRISONMENT UNDE				
PROVIDED OR PR	ROCURED THROUGH THE PAYMENT DIRECTLY OF	R INDIRECTLY OF A	KICKBACK OR WERE OTHE	RWISE ILLEGAL, CRIN	IINAL, CIVIL AND
ADMI NI STRATI VE	E ACTION, FINES AND/OR IMPRISONMENT MAY	RESULT.			
CERTI	FICATION BY CHIEF FINANCIAL OFFICER OR	ADMI NI STRATOR OF	PROVIDER(S)		
I HER	EBY CERTIFY that I have read the above	certification st	atement and that I hav	e examined the acco	ompanyi ng
el ect	ronically filed or manually submitted o	cost report and s	ubmitted cost report a	ind the Balance Shee	et and
	ment of Revenue and Expenses prepared b				
	ting period beginning 01/01/2021 and er				
	t and statement are true, correct, comp				
	dance with applicable instructions, exe				
	ations regarding the provision of healt t were provided in compliance with such			s identified in this	S COST
·		5			
	E OF CHUEF FLNANCIAL OFFICER OF ADMINI	CTRATOR QUEOK	DOV		

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

			Title	XVIII			
	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	-192, 254	-62, 211	0	0	1.00
2.00	Subprovider - IPF	0	1, 829	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	-190, 425	-62, 211	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. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

	TAL AND HOSPITAL HEALTH CARE COMPLEX I	DENTIFICATION DATA	Provid	ler CCN: 1		Period: From 01/01/	2021	Workshe Part I	eet S-2	2
						To 12/31/		Date/Ti 5/31/20		
	1.00	2.00		3.00		4	4.00			
. 00	Hospital and Hospital Health Care Co Street: 1710 LAFAYETTE ROAD	PO Box:								1.0
. 00	City: CRAWFORDSVILLE	State: IN		e: 47933	Count		-			2.0
		Component Name	CCN Number	CBSA Number	Provi der Type	Date Certified		ent Syst , 0, or		
			Number	Number	l i jpc		V	XVIII	XIX	
	Userital and Userital Decad Company	1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
. 00	Hospital and Hospital-Based Componen Hospital	FRANCI SCAN HEALTH	150022	99915	1	01/01/1966	N	P	0	3.0
		CRAWFORDSVI LLE	150000	00015						
00	Subprovider - IPF	FRANCI SCAN HEALTH CRAWFORDSVILLE PSY	15S022	99915	4	01/01/1995	N	P	0	4. (
00	Subprovider - IRF									5.0
00 00	Subprovider - (Other)									6.
00	Swing Beds - SNF Swing Beds - NF									8.
00	Hospital -Based SNF									9.0
). 00	Hospital-Based NF									10.
. 00 2. 00	Hospi tal -Based OLTC Hospi tal -Based HHA									11. 12.
3.00	Separately Certified ASC									13.
1.00	Hospi tal -Based Hospi ce									14.
5. 00 5. 00	Hospital-Based Health Clinic - RHC Hospital-Based Health Clinic - FQHC									15. 16.
. 00										17.
. 10	Hospital-Based (CORF) I									17.
00	Renal Dialysis Other									18. 19.
						From:		То		
. 00	Cost Reporting Period (mm/dd/yyyy)					1.00	021	2. (		20.
	Type of Control (see instructions)						021	12/ 51/	2021	21.
						2				21.0
					4.00				20	
					1.00	2.00		3. (	00	
	Inpatient PPS Information Does this facility qualify and is it	currently receiving pa	yments for		1.00 N			3. (	00	
	Inpatient PPS Information Does this facility qualify and is it disproportionate share hospital adju	stment, in accordance w	íth 42 CFF	-		2.00		3. (	00	
	Inpatient PPS Information Does this facility qualify and is it	stment, in accordance w r yes or "N" for no. Is	ith 42 CFF this	-		2.00		3. (	00	
2. 00	Inpatient PPS Information Does this facility qualify and is it disproportionate share hospital adju §412.106? In column 1, enter "Y" fo facility subject to 42 CFR Section § hospital?) In column 2, enter "Y" fo	stment, in accordance w r yes or "N" for no. Is 412.106(c)(2)(Pickle am r yes or "N" for no.	ith 42 CFF this endment	2	N	2.00		3. (	00	22.0
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					To		1/2021 1/2021		ı /Time /2022	Prep 8: 56	bared 5 am
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out- Stat Medica eligi unpa	e aid ole	Medica HMO da		Othe Medic day	ai d	
		1.00	2.00	3.00	4.0	)	5.00	)	6.0	0	
5. 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		0		0	24.
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5.00	Entor your standard geographic classification (at w	ano) ctotu-	at the be-	unning of t	ho	1. 0	)0		2.00		26. (
7.00	Enter your standard geographic classification (not wa 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	r rural. age) status r "2" for ru	at the end ural. If ap	l of the cos			2				20. 27.
5. 00	If this is a sole community hospital (SCH), enter the effect in the cost reporting period.			CH status ir	n		C				35.
					В	egi nr			ndi ng:	:	
. 00	Enter applicable beginning and ending dates of SCH st	tatus. Subse	cript line	36 for numb	er	1.0	0		2.00		36.
00	of periods in excess of one and enter subsequent date If this is a Medicare dependent hospital (MDH), enter	es.					1				37.
. 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.
. 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.				0	1/01/		12/	31/20	)21	38.
						<u> </u>			Y/N 2.00		
. 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 accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii or "N" for no. (see instructions) Is this hospital subject to the HAC program reduction	), (İi), or the mileage i)? Enter i	(iii)? Ent requiremen in column 2	er in colum nts in ? "Y" for ye	n S	Y			Y N		39. 40.
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. 00	no in column 2, for discharges on or after October 1.	per 1. Enter	r "Y" for y		ōr		V 1.00	XVI 0 2.0		XI X . 00	
	no in column 2, for discharges on or after October 1. Prospective Payment System (PPS)-Capital	per 1. Enter (see instr	r "Y" for y ructions)	ves or "N" f		ance	1.00	) 2.(	00 3	. 00	45.
00	no in column 2, for discharges on or after October 1.	oer 1. Enter (see instr nt for dispr eption for d	r "Y" for y ructions) roportionat extraordina	ves or "N" f	accord			_	00 3		
00	no in column 2, for discharges on or after October 1. Prospective Payment System (PPS)-Capital 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 Wkst Pt. III.	oer 1. Enter (see instr nt for disp eption for d t. L, Pt. I	r "Y" for y ructions) roportionat extraordina II and Wkst	ves or "N" f e share in ary circumst L-1, Pt.	accord ances I thro	ugh	N N	0 2.0 N	00 3	. 00 N N	46.
00 00 00	no in column 2, for discharges on or after October 1. Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital paymen 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 Wkst Pt. III. Is this a new hospital under 42 CFR §412.300(b) PPS of Is the facility electing full federal capital payment Teaching Hospitals	oer 1. Enter (see instruc- nt for dispu- eption for o t. L, Pt. I capital? En t? Enter "	r "Y" for y ructions) roportionat extraordina II and Wkst hter "Y for Y" for yes	res or "N" f e share in rry circumst L-1, Pt. yes or "N" or "N" for	accord ances I thro for n no.	ugh o.	1.00	0 2.( N	00 3	. 00 N	46. 47. 48.
00 00 00	no in column 2, for discharges on or after October 1. Prospective Payment System (PPS)-Capital 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 Wkst Pt. III. Is this a new hospital under 42 CFR §412.300(b) PPS of Is the facility electing full federal capital payment Teaching Hospitals Is this a hospital involved in training residents in "N" for no in column 1. For column 2, if the response was involved in training residents in approved GME pr year, and are you are impacted by CR 11642 (or applic	oper 1. Enter (see instru- nt for dispre- eption for of t. L, Pt. II capital? En- t? Enter "" approved G e to column rograms in " cable CRs) f	r "Y" for y ructions) roportionat extraordina II and Wkst hter "Y for Y" for yes ME programs 1 is "Y", the prior y	res or "N" f e share in ary circumst :. L-1, Pt. yes or "N" or "N" for or "N" for or if this rear or penu	accord accord I thro for n no. for y hospit I timat	ugh o. es or al e	1.00	D 2. (	00 3	. 00 N N N	46. 47. 48.
. 00 . 00 . 00 . 00	<pre>no in column 2, for discharges on or after October 1. Prospective Payment System (PPS)-Capital 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 Wkst Pt. III. Is this a new hospital under 42 CFR §412.300(b) PPS of Is the facility electing full federal capital payment Teaching Hospitals Is this a hospital involved in training residents in "N" for no in column 1. For column 2, if the response was involved in training residents in approved GME pr year, and are you are impacted by CR 11642 (or applic Enter "Y" for yes; otherwise, enter "N" for no in col If line 56 is yes, is this the first cost reporting p 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"</pre>	ber 1. Enter (see instru- eption for dispre- eption for dispre- eption for dispre- eption for dispre- eption for dispre- capital? Enter approved GG e to column cograms in for cable CRs) for umn 2. beriod durin ryes or "N" th of this of (", complete	r "Y" for y ructions) roportionat extraordina II and Wkst nter "Y for Y" for yes WE programs I is "Y", the prior y WA direct G ng which re " for no in cost report e Worksheet	res or "N" f re share in rry circumst c. L-1, Pt. ryes or "N" or "N" for r "N" for r "N" for r "f this rear or penu SME payment esidents in a column 1. ring period?	accord ances I thro for n no. for y hospit Iltimat reduct approv If col 2 Ente	ugh o. es or al e i on? ed umn 1 r "Y"	1.00	D 2. (	00 3	. 00 N N N	45. 46. 47. 48. 56. 57.
. 00 . 00 . 00 . 00 . 00	no in column 2, for discharges on or after October 1. Prospective Payment System (PPS)-Capital 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 Wkst Pt. III. Is this a new hospital under 42 CFR §412.300(b) PPS of Is the facility electing full federal capital payment Teaching Hospitals Is this a hospital involved in training residents in "N" for no in column 1. For column 2, if the response was involved in training residents in approved GME pri year, and are you are impacted by CR 11642 (or applic Enter "Y" for yes; otherwise, enter "N" for no in col If line 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont	er 1. Enter (see instru- nt for disple eption for of t. L, Pt. II capital? En- t? Enter "Y approved GG e to column rograms in cable CRs) I umn 2. beriod durin r yes or "N" cth of this of (", complet (, if applic bursement for	r "Y" for y ructions) roportionat extraordina 11 and Wkst hter "Y for Y" for yes 1 is "Y", the prior y WA direct G mg which re of for no in cost report e Worksheet cable.	res or "N" f restance in ary circumst to L-1, Pt. yes or "N" or "N" for s? Enter "Y" or if this rear or penu SME payment esidents in a column 1. ting period? E E-4. If co	accord ances I thro for n no. for y hospit iltimat reduct approv If col P Ente olumn 2	ugh o. es or al e i on? ed umn 1 r "Y"	1.00	D 2. (	00 3	. 00 N N N	46 47 48 56

IOSPI T	Financial Systems FRANCISCAN AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DAT		CRAWFORDSVILL Provider C	CN: 15-0022 F	Period: From 01/01/2021	u of Form CMS-2 Worksheet S-2 Part I	
					o 12/31/2021	Date/Time Pre 5/31/2022 8:5	
				NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
				1.00	2.00	3.00	
0. 00	Are you claiming nursing and allied health education any programs that meet the criteria under 42 CFR 413. instructions) Enter "Y" for yes or "N" for no in col is "Y", are you impacted by CR 11642 (or subsequent C adjustement? Enter "Y" for yes or "N" for no in colu	85? (s umn 1. R) NAHE	see If column 1	N			60.0
		Y/N	IME	Direct GME	IME	Direct GME	
1.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in	1.00 N	2. 00	3.00	4.00	5.00	61. C
1. 01	column 1. (see instructions) Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see						61.0
1. 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 ACA). (see instructions)						61.0
	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61. 0
	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). Enter the difference between the baseline primary						61. C
	and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions) Enter the amount of ACA §5503 award that is being						61.0
1.00	used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						01.0
		Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
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.		1.00	2.00	3.00	4.00	61. 1
1. 20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.2
						1.00	
2.00	ACA Provisions Affecting the Health Resources and Ser Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instruc Enter the number of FTE residents that rotated from a	trai nec ti ons)	in this cost	reporting per			62. C
	during in this cost reporting period of HRSA THC prog Teaching Hospitals that Claim Residents in Nonprovide	ram. (s r Setti	see instruction ngs	ns)	· ·		
3. 00	Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, comple			67. (see instri Unweighted	uctions) Unweighted	N Ratio (col. 1/	63. (
				FTEs Nonprovider Site 1.00	FTEs in Hospital	(col. 1 + col. 2)) 3.00	
	Section 5504 of the ACA Base Year FTE Residents in No period that begins on or after July 1, 2009 and befor						
4. 00	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	y trair -primar all nor non-pr	ned residents Ty care nprovider Timary care	0.00	0 0.00	0. 000000	64. (

OSPITAL AND HOSPITAL HEALTH CARE COMPL	EX IDENTIFICATION DAT	FA Provider C		eriod: rom 01/01/2021 o 12/31/2021	Worksheet S-2 Part I Date/Time Pre	
					5/31/2022 8:5	<u>6 am</u>
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2.00	3.00	4.00	5.00	1
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			0.00	0.00	0. 000000	65.0
resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			Unweighted	Unweighted	Ratio (col. 1/	,
			FTEs	FTEsin	(col. 1 + col.	
			Nonprovider Site	Hospi tal	2))	
			1.00	2.00	3.00	1
Section 5504 of the ACA Current ) beginning on or after July 1, 201		Nonprovider Setting	gsEffective fo	or cost reporti	ng periods	
5.00 Enter in column 1 the number of u FTEs attributable to rotations oc Enter in column 2 the number of u FTEs that trained in your hospita (column 1 divided by (column 1 +	curring in all nonpr nweighted non-primar I. Enter in column 3	ovider settings. y care resident the ratio of	0.00 Unweighted FTEs Nonprovider Site 3.00		0.000000 Ratio (col. 3/ (col. 3 + col. 4)) 5.00	
7.00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care fTEs that trained in your hospital. Enter in column 3 divided by (column 3 + column 4)). (see instructions)			0.00			67. C
				1.00	0 2.00 3.00	-
Inpatient Psychiatric Facility PF						70.0
0.00 Is this facility an Inpatient Psy Enter "Y" for yes or "N" for no.	Conduite Facility (I	FIJ, UL QUES IT CONT	ain an irt subp	provider? Y		70.0
1.00 If line 70 is yes: Column 1: Did recent cost report filed on or be 42 CFR 412.424(d)(1)(iii)(c)) Col program in accordance with 42 CFF Column 3: If column 2 is Y, indic (see instructions) Inpatient Rehabilitation Facility	fore November 15, 20 umn 2: Did this faci 2 412.424 (d)(1)(iii) ate which program ye	04? Enter "Y" for y lity train residents (D)? Enter "Y" for y	yes or "N" for r s in a new teach yes or "N" for r	no. (see ni ng no.	N O	71. C
5.00 Is this facility an Inpatient Ref	abilitation Facility	(IRF), or does it o	contain an IRF	N		75.0
subprovider? Enter "Y" for yes a 6.00 If line 75 is yes: Column 1: Did recent cost reporting period endi no. Column 2: Did this facility t CFR 412.424 (d)(1)(iii)(D)? Enter	the facility have an ng on or before Nove rain residents in a	mber 15, 2004? Enter new teaching program	"Y" for yes or in accordance	"N" for with 42	0	76. 0

Health Financial Systems	FRANCI SCAN HEALTH				u of Form CMS	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTI	FICATION DATA	Provider CC	CN: 15-0022	Period: From 01/01/2021	Worksheet S- Part I	2
				To 12/31/2021	Date/Time Pr 5/31/2022 8:	epared:
Long Term Care Hospital PPS					1.00	-
80.00 Is this a Long term care hospital (LTCH)? 81.00 Is this a LTCH co-located within another "Y" for yes and "N" for no.				ng period? Enter	N N	80. 00 81. 00
TEFRA Providers85.00Is this a new hospital under 42 CFR Section	$\frac{1}{2}$ 8412 40(f)(1)(i)	TEEDA2 Entor	- "V" for vo	or "N" for po	N	85.00
86.00 Did this facility establish a new Other si					IN IN	86.00
\$413.40(f)(1)(ii)? Enter "Y" for yes and 87.00 Is this hospital an extended neoplastic d	isease care hospita	al classified u	under section	า	Ν	87.00
1886(d)(1)(B)(vi)? Enter "Y" for yes or "	N" for no.			V	XIX	-
				1.00	2.00	
Title V and XIX Services	V innotiont boonits		ton "V" for	N	Y	
90.00 Does this facility have title V and/or XI yes or "N" for no in the applicable colum		al services? Er	iter i for	IN	Y	90.00
91.00 Is this hospital reimbursed for title V a	nd/or XIX through 1			N	Y	91.00
full or in part? Enter "Y" for yes or "N" 92.00 Are title XIX NF patients occupying title					N	92.00
instructions) Enter "Y" for yes or "N" fo			01): (366		IN IN	72.00
93.00 Does this facility operate an ICF/IID fac		of title V and	d XIX? Enter	Ν	N	93.00
"Y" for yes or "N" for no in the applicab 94.00 Does title V or XIX reduce capital cost?		and "N" for no	o in the	N	N	94.00
applicable column.	-					
95.00 If line 94 is "Y", enter the reduction pe 96.00 Does title V or XIX reduce operating cost				0.00 N	0.00 N	95.00 96.00
applicable column.	Enter i for yes			IN	IN IN	90.00
97.00 If line 96 is "Y", enter the reduction pe				0.00	0.00	97.00
98.00 Does title V or XIX follow Medicare (title stepdown adjustments on Wkst. B, Pt. I, c				Y	Y	98.00
column 1 for title V, and in column 2 for		5. 900 0				
98.01 Does title V or XIX follow Medicare (title					Y	98.01
C, Pt. I? Enter "Y" for yes or "N" for no title XIX.		tre v, and m	corumn 2 ro			
98.02 Does title V or XIX follow Medicare (title				Y	Y	98. 02
bed costs on Wkst. D-1, Pt. IV, line 89? for title V, and in column 2 for title XI.		or "N" for no i	n column 1			
98.03 Does title V or XIX follow Medicare (title	e XVIII) for a crit				N	98.03
reimbursed 101% of inpatient services cos for title V, and in column 2 for title XI		es or "N" for r	no in column	1		
98.04 Does title V or XIX follow Medicare (title		reimbursed 101	1% of	N	N	98.04
outpatient services cost? Enter "Y" for y	es or "N" for no ir	n column 1 for	title V, and	b		
in column 2 for title XIX. 98.05 Does title V or XIX follow Medicare (title	e XVIII) and add ba	ack the RCF dis	sallowance o	n Y	Y	98.05
Wkst. C, Pt. I, col. 4? Enter "Y" for yes						
column 2 for title XIX. 98.06 Does title V or XIX follow Medicare (title	e XVIII) when cost	reimbursed for	~ Wkst. D.	Y	Y	98.06
Pts. I through IV? Enter "Y" for yes or "						
column 2 for title XIX. Rural Providers						-
105.00 Does this hospital qualify as a CAH?				N		105.00
106.00 If this facility qualifies as a CAH, has		inclusive meth	nod of payme	nt		106.00
for outpatient services? (see instruction: 107.00Column 1: If line 105 is Y, is this facil		ost reimburseme	ent for I&R	N		107.00
training programs? Enter "Y" for yes or "						
Column 2: If column 1 is Y and line 70 o approved medical education program in the						
Enter "Y" for yes or "N" for no in column	2. (see instructi	ons)				
108.00 Is this a rural hospital qualifying for a CFR Section §412.113(c). Enter "Y" for ye		CRNA fee schee	dule? See 4	2 N		108.00
CFR Section 9412. Its(C). Enter 1 for ye	<u>S OF N TOF 110.</u>	Physi cal	Occupation	al Speech	Respi ratory	
		1.00	2.00	3.00	4.00	100.00
109.00 If this hospital qualifies as a CAH or a therapy services provided by outside supp		Ν	N	N	N	109.00
for yes or "N" for no for each therapy.						
					1.00	_
110.00 Did this hospital participate in the Rura					N 1.00	110.00
Demonstration)for the current cost report complete Worksheet E, Part A, lines 200 t						
applicable.	mouyn ∠ro, anu Wor	NSHEEL E-Z, II	nes zuu liiri	Jugii 210, dS		

alth Financial Systems FRANCISCAN HEALTH CA DSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der CCI		Period:	eu of Form CMS Worksheet S-	
			From 01/01/202 To 12/31/202		
			1.00	2.00	_
11.00 If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this cost "Y" for yes or "N" for no in column 1. If the response to colu integration prong of the FCHIP demo in which this CAH is parti Enter all that apply: "A" for Ambulance services; "B" for addi for tele-health services.	t reporting p umn 1 is Y, e icipating in d	eriod? Enter nter the column 2.	N	2.00	111. (
	-	1.00	2.00	3.00	-
12.00 Did this hospital participate in the Pennsylvania Rural Health demonstration for any portion of the current cost reporting pendemonstration 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 cease participation in the demonstration, if applicable. Miscell aneous Cost Reporting Information	eriod? 'Y", enter	Ν			112.0
5.00 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 (ir psychiatric, rehabilitation and long term hospitals providers) the definition in CMS Pub. 15-1, chapter 22, §2208.1.	or E only) ' percent ncludes ) based on	N			0115.
6.00 Is this facility classified as a referral center? Enter "Y" fo "N" for no.	5	Ν			116.
<ul> <li>7.00 Is this facility legally-required to carry malpractice insurar "Y" for yes or "N" for no.</li> <li>8.00 Is the malpractice insurance a claims-made or occurrence polic</li> </ul>		N	2		117.
if the policy is claim-made. Enter 2 if the policy is occurren	nce.	Premiums	Losses	Insurance	
8.01 List amounts of malpractice premiums and paid losses:	-	1. 00 245, 1	2.00	3.00 0	0 118.
			1.00	2.00	-
8.02 Are malpractice premiums and paid losses reported in a cost ce Administrative and General? If yes, submit supporting schedul and amounts contained therein. 9.00 D0 NOT USE THIS LINE			N		118.
0.00 Is this a SCH or EACH that qualifies for the Outpatient Hold H §3121 and applicable amendments? (see instructions) Enter in c "N" for no. Is this a rural hospital with < 100 beds that qual Hold Harmless provision in ACA §3121 and applicable amendments Enter in column 2, "Y" for yes or "N" for no.	column 1, "Y" lifies for th	for yes or e Outpatient		N	120.
1.00 Did this facility incur and report costs for high cost implant patients? Enter "Y" for yes or "N" for no.	table devices	charged to	Y		121.
2. OODoes the cost report contain healthcare related taxes as defin Act?Enter "Y" for yes or "N" for no in column 1. If column 1 i the Worksheet A line number where these taxes are included.				5.00	122.
Transplant Center Information 5.00Does this facility operate a transplant center? Enter "Y" for	yes and "N"	for no. If	N		125.
yes, enter certification date(s) (mm/dd/yyyy) below. 0.00 If this is a Medicare certified kidney transplant center, enter	-				126.
in column 1 and termination date, if applicable, in column 2. 2.00 If this is a Medicare certified heart transplant center, enter	r the certifi	cation date			127.
in column 1 and termination date, if applicable, in column 2. B.OOIF this is a Medicare certified liver transplant center, enter	r the certifi	cation date			128.
in column 1 and termination date, if applicable, in column 2. 100 If this is a Medicare certified lung transplant center, enter	the certific	ation date i	n		129.
column 1 and termination date, if applicable, in column 2. 0.00 If this is a Medicare certified pancreas transplant center, er		i fi cati on			130.
date in column 1 and termination date, if applicable, in colum .00 If this is a Medicare certified intestinal transplant center,		rti fi cati on			131.
	mn 2.				132.
date in column 1 and termination date, if applicable, in colum 0.00 If this is a Medicare certified islet transplant center, enter					133.
<ol> <li>2.00 If this is a Medicare certified islet transplant center, enter in column 1 and termination date, if applicable, in column 2.</li> <li>3.00 Removed and reserved</li> <li>4.00 If this is an organ procurement organization (0P0), enter the</li> </ol>	OPO number i	n column 1			134.
2.00 If this is a Medicare certified islet transplant center, enter	0P0 number i	n column 1			134.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA		Provi der CC	N: 15-0			: 1/01/2021 2/31/2021		epared:
1.00		2.00					3.00	0/01/2022 0.	
If this facility is part of a chai					the n	ame an	d address	of the	
home office and enter the home off			tractor numbe						
41.00 Name: FRANCISCAN ALLIANCE	Contractor's Name			Cor	ntracto	or's Nu	mber: 0810	)1	141.0
42.00 Street: 1515 W DRAGOON TRAIL 43.00 City: MISHAWAKA	PO Box: State:	1290 I N		7: .	o Code:		1451	46-1200	142. C
43. OOCITY. MISHAWARA	state.	I IN		21	o coue		4054	1200	143.0
								1.00	-
44.00 Are provider based physicians' cos	sts included in Workshe	et A?						Y	144.0
							1.00	2.00	
<ul> <li>45.00 If costs for renal services are clipatient services only? Enter "Y' no, does the dialysis facility inceperiod? Enter "Y" for yes or "N"</li> <li>46.00 Has the cost allocation methodologenter "Y" for yes or "N" for no if</li> </ul>	for yes or "N" for no clude Medicare utilizat for no in column 2. yy changed from the pre column 1. (See CMS Pu	o in co tion fo evious	olumn 1. lf c or this cost y filed cost	olumn report repor	i ng t?		N		145. (
yes, enter the approval date (mm/o	ld/yyyy) in column 2.								
								1.00	
47.00 Was there a change in the statisti	cal basis? Enter "Y" f	for yes	s or "N" for	no.				N N	147.0
48.00 Was there a change in the order of	allocation? Enter "Y"	for	yes or "N" fo	r no.				N	148. 0
49.00Was there a change to the simplifi	ed cost finding method	d? Ente						N	149.0
			Part A		rt B	T	itle V	Title XIX	_
Dood this fasility	don that much first f		1.00		. 00	tion	3.00	4.00	_
Does this facility contain a provi or charges? Enter "Y" for yes or '									
55. 00Hospi tal		iponen	N		N	(366 4.	N	N	155. 0
56.00 Subprovi der – IPF			N		N		N	N	156.0
57.00 Subprovider - IRF			N		Ν		Ν	N	157.0
58. 00 SUBPROVI DER									158.0
59. 00 SNF			Ν		N		N	N	159.0
60. 00 HOME HEALTH AGENCY			N		N		N	N	160.0
61. 00 CMHC 61. 10 CORF					N N		N N	N N	161. C
							11	IN	101.1
								1.00	-
Multicampus									
65.00 Is this hospital part of a Multica	ampus hospital that has	s one o	or more campu	ses in	di ffe	rent CE	BSAs?	N	165.0
Enter "Y" for yes or "N" for no.	Name		County	Stat	71	p Code	CBSA	FTE/Campus	
	0		1.00	2.0		<u>3.00</u>	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)					-				00 166. 0
								1.00	-
Health Information Technology (HI	) incentive in the Ame	eri can	Recovery and	Reinv	estmen	t Act			
67.00 Is this provider a meaningful user 68.00 If this provider is a CAH (line 10	05 is "Y") and is a mea	ani ngfi	ul user (line			, enter	the	Y	167. ( 168. (
reasonable cost incurred for the H 68.01 f this provider is a CAH and is r				quali	fv for	a haro	lshi n		168. (
exception under §413.70(a)(6)(ii)?							P		00.0
69.00 If this provider is a meaningful u	ıser (line 167 is "Y")						enter the	9.9	95 169. 0
transition factor. (see instruction	ons)								
						Be	gi nni ng	Endi ng	_
70 00 Enter in columns 1 and 2 the EUD k	oginning data and andi	na do	to for the re	nontin	~		1.00	2.00	170 0
70.00 Enter in columns 1 and 2 the EHR k period respectively (mm/dd/yyyy)	eginning date and endi	ng da	te for the re	ροιτιή	y				170. 0
							1.00	2.00	
171.00 If line 167 is "Y", does this prov section 1876 Medicare cost plans r "Y" for yes and "N" for no in colu 1876 Medicare days in column 2. (s	reported on Wkst. S-3, mn 1. If column 1 is y	Pt. I,	line 2, col	. 6? E	nter	n	N		0 171. (

Health Financial Systems FRANCI SCAN HEALTH CRAWFORDSVILLE In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provider CCN: 15-0022 Peri od: Worksheet S-2 From 01/01/2021 Part II Date/Time Prepared: То 12/31/2021 5/31/2022 8:56 am Y/N Date 1.00 2.00 General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS Provider Organization and Operation Has the provider changed ownership immediately prior to the beginning of the cost 1.00 Ν 1.00 reporting period? If yes, enter the date of the change in column 2. (see instructions) V/I Y/N Date 1.00 2.00 3.00 Has the provider terminated participation in the Medicare Program? If 2.00 Ν 2 00 yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary. Is the provider involved in business transactions, including management 3.00 γ 3.00 contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions) Y/N Date Туре 1.00 2.00 3.00 Financial Data and Reports Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, 4.00 Y А 05/06/2022 4.00 or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions. 5.00 Are the cost report total expenses and total revenues different from Ν 5.00 those on the filed financial statements? If yes, submit reconciliation. Y/N Legal Oper 1.00 2.00 Approved Educational Activities Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider Ν 6.00 6.00 is the legal operator of the program? Are costs claimed for Allied Health Programs? If "Y" see instructions. 7.00 Ν 7.00 8.00 Were nursing programs and/or allied health programs approved and/or renewed during the Ν 8.00 cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved graduate medical education 9 00 Ν 9.00 program in the current cost report? If yes, see instructions. Was an approved Intern and Resident GME program initiated or renewed in the current 10.00 Ν 10.00 cost reporting period? If yes, see instructions. 11.00 Are GME cost directly assigned to cost centers other than I & R in an Approved Ν 11.00 Teaching Program on Worksheet A? If yes, see instructions Y/N 1.00 Bad Debts 12.00 Is the provider seeking reimbursement for bad debts? If yes, see instructions. Y 12.00 13.00 If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting Ν 13.00 period? If yes, submit copy. 14.00 If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions. Ν 14.00 Bed Complement 15.00 Did total beds available change from the prior cost reporting period? If yes, Ν 15.00 see instructions. Part B Part A Y/N Date Y/N Date 1.00 2.00 3.00 4.00 PS&R Data Was the cost report prepared using the PS&R Report only? 16.00 Ν 16.00 Ν 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) 17.00 Was the cost report prepared using the PS&R Report for Υ 04/21/2022 γ 04/21/2022 17.00 totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) 18.00 If line 16 or 17 is yes, were adjustments made to PS&R Ν Ν 18.00 Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions. 19.00 If line 16 or 17 is yes, were adjustments made to PS&R 19.00 Ν Ν Report data for corrections of other PS&R Report information? If yes, see instructions.

Health Financial Systems

In Lieu of Form CMS-2552-10

alth Financial Systems FRANCISCAN HEALTH	CRAWFORDSVI LL	E	In Lie	u of Form CMS-	2552-1
SPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CO	F	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part II Date/Time Pre	
			12/01/2021	5/31/2022 8:5	
	Descri	ption	Y/N	Y/N	
	(	2	1.00	3.00	
0.00 If line 16 or 17 is yes, were adjustments made to PS&R			Ν	N	20.0
Report data for Other? Describe the other adjustments:					
	Y/N	Date	Y/N	Date	
	1.00	2.00	3.00	4.00	
.00 Was the cost report prepared only using the provider's	N		Ν		21.0
records? If yes, see instructions.		l			
				1.00	<u> </u>
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	PT CHILDRENS H	OSPI TALS)		1.00	
Capital Related Cost					1
2.00 Have assets been relifed for Medicare purposes? If yes, see	e instructions			N	22.0
8.00 Have changes occurred in the Medicare depreciation expense		als made durir	na the cost	Ν	23.0
reporting period? If yes, see instructions.			.g		
1.00 Were new leases and/or amendments to existing leases entere	ed into durina	this cost repo	ortina period?	Ν	24.0
If yes, see instructions					
5.00 Have there been new capitalized leases entered into during	the cost repor	ting period?	f yes, see	Ν	25.0
instructions.		51	<b>J</b> .		
6.00 Were assets subject to Sec.2314 of DEFRA acquired during th	ne cost reporti	ng period? If	yes, see	Ν	26.0
instructions.		0.1	5		
7.00 Has the provider's capitalization policy changed during the	e cost reportin	g period? If y	yes, submit	N	27.0
сору.					
Interest Expense					
3.00 Were new loans, mortgage agreements or letters of credit en	ntered into dur	ing the cost r	reporting	N	28.0
period? If yes, see instructions.					
.00 Did the provider have a funded depreciation account and/or		bt Service Res	serve Fund)	Y	29.
treated as a funded depreciation account? If yes, see instru	ructions				
.00 Has existing debt been replaced prior to its scheduled matu	irity with new	debt? If yes,	see	N	30.
instructions.	6				
1.00 Has debt been recalled before scheduled maturity without is	suance of new	debt? If yes,	see	N	31.
instructions.					-
Purchased Services	ulara Cumiaka		har a dura l	NI	1 22 4
2.00 Have changes or new agreements occurred in patient care ser arrangements with suppliers of services? If yes, see instru-		a through con	tractuar	N	32.
0.00 If line 32 is yes, were the requirements of Sec. 2135.2 app		a to compotiti	vo bidding2 lf	Ν	33.
no, see instructions.	nieu pertainin	g to competiti	ve bruurny: rr	IN	33.
Provi der-Based Physi ci ans					1
. 00 Are services furnished at the provider facility under an ar	rangement with	nrovi der base	od physicians?	Y	34.
If yes, see instructions.	rangement with	provider-base	eu physicians:	I	54.
.00 If line 34 is yes, were there new agreements or amended exis	sting agreemen	ts with the nu	rovi der-based	Ν	35.
physicians during the cost reporting period? If yes, see in:		to write the pr	ovruer based	in in	00.
			Y/N	Date	
			1.00	2.00	
Home Office Costs					
. 00 Were home office costs claimed on the cost report?			Y		36.
.00 If line 36 is yes, has a home office cost statement been pro	repared by the	home office?	Ŷ		37.
If yes, see instructions.	,				
.00 If line 36 is yes, was the fiscal year end of the home off	ice different	from that of	Ν		38.
the provider? If yes, enter in column 2 the fiscal year end					
.00  If line 36 is yes, did the provider render services to othe			Ν		39.
see instructions.	•	<b>3</b>			
.00 If line 36 is yes, did the provider render services to the	home office?	lf yes, see	Ν		40.
i nstructi ons.		- 			
	1.	00	2.	00	
					-
Cost Report Preparer Contact Information	STEVE		HOWELL		41.
.00 Enter the first name, last name and the title/position	0.2.2				
.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	0.2.2				11
.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.					
<ul> <li>.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.</li> <li>.00 Enter the employer/company name of the cost report</li> </ul>	FRANCI SCAN HEA	LTH			42.
<ul> <li>.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.</li> <li>2.00 Enter the employer/company name of the cost report preparer.</li> </ul>	FRANCI SCAN HEA	LTH			
<ul> <li>.00 Enter the first name, I ast name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.</li> <li>.00 Enter the employer/company name of the cost report preparer.</li> </ul>		LTH	STEVEN. HOWELL@ ANCE. ORG	FRANCI SCANALLI	42. 43.

Health Financial Systems	FRANCI SCAN HEALT	TH CRAWFORD	OSVI LLE	In Lieu of Form CMS-2552-				
HOSPITAL AND HOSPITAL HEALTH CARE REI	MBURSEMENT QUESTI ONNAI RE	Provi	der CCN: 15-0022	Peri		Worksheet S-2		
				To	n 01/01/2021 12/31/2021	Part II Date/Time Pre 5/31/2022 8:5	pared: 6 am	
			3.00					
Cost Report Preparer Contact I	nformation							
41.00 Enter the first name, last nam	e and the title/position	MANAGER,	COST REPORTING				41.00	
held by the cost report prepar	er in columns 1, 2, and 3,							
respecti vel y.								
42.00 Enter the employer/company nam	e of the cost report						42.00	
preparer.								
43.00 Enter the telephone number and	email address of the cost						43.00	
report preparer in columns 1 a	nd 2, respectively.							

	Financial Systems FRA AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC.	NCISCAN HEALTH	Provi der CC		Peri od:	u of Form CMS-2 Worksheet S-3	
HUSPI	AL AND HUSPITAL HEALTH CARE COMPLEX STATISTIC.	AL DATA	Provider CC	N: 15-0022	From 01/01/2021	Part I	
					To 12/31/2021	Date/Time Pre 5/31/2022 8:5	
						I/P Days / O/P Visits / Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Title V	
		Line Number		Avai I abl e			
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00	24	8, 76	0.00	0	1.00
	8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)						2.00
3.00	HMO I PF Subprovi der						3.00
1. 00	HMO I RF Subprovi der						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	
5.00	Hospital Adults & Peds. Swing Bed NF					0	
7.00	Total Adults and Peds. (exclude observation		24	8, 76	0.00	0	7.00
	beds) (see instructions)		2 '	0,70	0.00		/ /
3.00	INTENSIVE CARE UNIT	31.00	5	1, 82	0.00	0	8.00
7.00	CORONARY CARE UNIT	32.00	0	.,	0 0.00	0	9.00
0.00	BURN INTENSIVE CARE UNIT	33.00	0		0 0.00	0	10.0
1.00	SURGI CAL I NTENSI VE CARE UNI T	34.00	0		0 0.00	0	11.00
2.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		29	10, 58	0.00	0	14.00
15.00	CAH visits					0	15.00
6.00	SUBPROVIDER - IPF	40. 00	11	4, 01	5	0	16.00
7.00	SUBPROVIDER – IRF	41.00	О		0	0	17.00
8.00	SUBPROVI DER						18.00
9.00	SKILLED NURSING FACILITY	44.00	0		0	0	19.0
20.00	NURSING FACILITY	45.00	0		0	0	20.00
21.00	OTHER LONG TERM CARE	46.00	0		0		21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)	115. 00					23.0
4. 00	HOSPI CE	116. 00	0		0		24.0
4.10	HOSPICE (non-distinct part)	30. 00					24.1
5. 00	CMHC – CMHC	99.00				0	25.0
5. 10	CMHC - CORF	99. 10				0	25.10
6. 00	RURAL HEALTH CLINIC	88.00				0	26.0
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	
7.00	Total (sum of lines 14-26)		40				27.0
8.00	Observation Bed Days					0	28.0
9.00	Ambul ance Trips						29.00
0.00	Employee discount days (see instruction)						30.00
1.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0		0		32.00
32.01	Total ancillary labor & delivery room						32.0
2 00	outpatient days (see instructions)						22 00
3.00	LTCH non-covered days						33.00 33.01
J. UI	LTCH site neutral days and discharges				I	I	<u>3</u> 3.0

HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC	CN: 15-0022	Period: From 01/01/2021 To 12/31/2021		pared:
		I/P Days	/ O/P Visits	/ Trips	Full Time	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	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)	1, 442	387	3, 35	52		1.00
2.00 3.00	HMO and other (see instructions) HMO IPF Subprovider	1, 230 369	0 0				2.00 3.00
4.00 5.00	HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF	0	0 0		0		4.00
5.00 7.00	Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions)	1, 442	0 387	3, 35	0 52		6.00 7.00
B. 00 9. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT	320 0	137 0	99	91 0		8.00 9.00
10. 00	BURN INTENSIVE CARE UNIT	0	0		0		10.00
11. 00 12. 00	SURGI CAL I NTENSI VE CARE UNI T OTHER SPECI AL CARE (SPECI FY)	0	0		0		11. 00 12. 00
13.00 14.00	NURSERY Total (see instructions)	1, 762	0 524	4, 34	0 43 0.00	274.00	13.00 14.00
15.00 16.00	CAH visits SUBPROVIDER - IPF	0 1, 221	0 13	1, 63	0 31 0.00	20.00	15.00
17.00 18.00	SUBPROVI DER – I RF SUBPROVI DER	0	0		0 0.00		
19.00 20.00	SKILLED NURSING FACILITY NURSING FACILITY	0	0		0 0.00		19.00
21.00	OTHER LONG TERM CARE		-		0 0.00	0.00	21.00
22.00 23.00	HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.)	0	0		0 0.00	0.00	23.00
24.00 24.10	HOSPICE HOSPICE (non-distinct part)	0	0		0 0.00	0.00	24.00 24.10
25.00 25.10	CMHC - CMHC CMHC - CORF	0 0	0		0 0.00 0 0.00		
26.00 26.25	RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0.00		
27.00 28.00	Total (sum of lines 14-26) Observation Bed Days		180	1, 40	0.00		
29.00 30.00	Ambulance Trips Employee discount days (see instruction)	0	100	1, 40	0		29.00 30.00
31.00 32.00 32.01	Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary Labor & delivery room	О	0		0 0 0		31.00 32.00 32.01
33. 00 33. 01	outpatient days (see instructions) LTCH non-covered days LTCH site neutral days and discharges	0					33. 00 33. 01

HOSPI	FAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider (	CCN: 15-0022	Period: From 01/01/20 To 12/31/20		pared:
		Full Time		Di	scharges		
	Component	Equi val ents Nonpai d Workers	Title V	Title XVI	II 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 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 14.00 15.00 14.00 15.00 16.00 20.00 21.00 22.00 23.00 24.00 23.00 24.00 25.10 25.10 26.00 27.00 28.00 29.00 30.00 21.00 21.00 21.00 22.00 23.00 24.00 25.00 25.00 26.00 27.00 27.00 28.00 29.00 20.00 21.00 22.00 23.00 24.00 25.00 26.00 26.00 27.00 27.00 27.00 28.00 29.00 20.00 21.00 20.00 21.00 22.00 23.00 24.00 25.00 26.00 26.00 27.00 27.00 27.00 28.00 29.00 21.00 20.00 21.00 20.00 21.00 25.00 26.00 26.00 26.00 27.00 26.00 27.00 26.00 27.00 26.00 27.00 26.00 26.00 27.00 26.00 27.00 26.00 26.00 27.00 26.00 26.00 27.00 26.00 27.00 26.00 27.00 26.00 27.00 26.00 27.00 27.00 28.00 29.00 20.0	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 HMO IRF 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 SURGICAL INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IPF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.) HOSPICE HOSPICE (non-distinct part) CMHC - COMF RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF	11.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0		0	289	115.00 115 982 0 0 0 0 0 115 982 104 0 0 0 0 0 0 0 0 0 0 0 0 0	2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00 20.00
32.00 32.01 33.00	Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions) LTCH non-covered days				0		32.00 32.01 33.00

						rom 01/01/2021 o 12/31/2021	Date/Time Pre	
		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)			5/31/2022 8:50 Average Hourly Wage (col. 4 ÷ col. 5)	
Ir	PART II - WAGE DATA	1.00	2.00	3.00	4.00	5.00	6.00	-
	SALARIES							1
o [ <sup>.</sup>	Total salaries (see	200.00	19, 644, 888	869, 889	20, 514, 777	570, 768. 00	35. 94	1.
o	instructions) Non-physician anesthetist Part A		C	0	0	0.00	0. 00	2.
	n Non-physician anesthetist Part B		C	0	0	0.00	0. 00	3
	Physician-Part A - Administrative		C	0	0	0.00	0.00	4
)	Physicians - Part A - Teaching Physician and Non		C	0 0				
	Physician-Part B Non-physician-Part B for hospital-based RHC and FOHC		C	0	0	0.00	0. 00	6
	services Interns & residents (in an approved program)	21.00	C	0	0	0.00	0. 00	7
	Contracted interns and residents (in an approved programs)		C	0	0	0.00	0. 00	
)  i	Home office and/or related organization personnel		C	0	0	0.00	0. 00	6
)	SNF Excluded area salaries (see	44.00	C 3, 221, 135	0				
	instructions) DTHER WAGES & RELATED COSTS							
	Contract Labor: Direct Patient Care		1, 709, 999					
1	Contract Labor: Top Level management and other management and administrative services		C	0	0	0.00	0.00	1:
00	Contract Labor: Physician-Part A - Administrative		C	0	0	0.00	0. 00	1:
	Home office and/or related organization salaries and wage-related costs		C	0	0	0.00	0. 00	1.
D1	Home office salaries		4, 624, 272	0				
	Related organization salaries Home office: Physician Part A		C	0	0			
	- Administrative		C					
	Home office and Contract Physicians Part A - Teaching		C	0	-			
	Home office Physicians Part A - Teaching		C	0	-			
	Home office contract Physicians Part A - Teaching VAGE-RELATED COSTS			0	0	0.00	0.00	
oc 🛛	Wage-related costs (core) (see instructions)		3, 588, 885	0	3, 588, 885			1
00	Wage-related costs (other) (see instructions)							1
	Excluded areas Non-physician anesthetist Part		520, 929 C	0 0		1		1º 20
	A Non-physician anesthetist Part B		C	0	0			2
	Physician Part A - Administrative		C	0	0			2
	Physician Part A - Teaching Physician Part B		C	0	0			2
0	Wage-related costs (RHC/FQHC) Interns & residents (in an		C	0	0			2
50	approved program) Home office wage-related		1, 408, 760	0	1, 408, 760	1		2
51	(core) Related organization		C	0	0	1		2!
	wage-related (core) Home office: Physician Part A - Administrative -		C	0	0	1		2

Heal th	Financial Systems	FRA	NCISCAN HEALTH	CRAWFORDSVI LL	E	In Lie	u of Form CMS-2	2552-10
HOSPI T	AL WAGE INDEX INFORMATION			Provider CO		Period: From 01/01/2021 To 12/31/2021	Worksheet S-3 Part II Date/Time Pre 5/31/2022 8:50	pared:
		Wkst. A Line		Recl assi fi cati	Adj usted		Average Hourly	
		Number	Reported	on of Salaries			Wage (col. 4 ÷	
				(from Wkst.	(col.2 ± col.		col. 5)	
				A-6)	3)	col. 4		
	1	1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A		0	0		C		25.53
	- Teaching - wage-related							
	(core)							
	OVERHEAD COSTS - DIRECT SALARIE							
26.00	Employee Benefits Department	4.00	-3,085	59, 044				26.00
27.00	Administrative & General	5.00	4, 698, 543	527, 597				27.00
28.00	Administrative & General under		263, 682	0	263, 68	2 2, 548. 00	103. 49	28.00
	contract (see inst.)							
29.00	Maintenance & Repairs	6.00	0	0		0.00		29.00
30.00	Operation of Plant	7.00	296, 698	0	296, 69			30.00
31.00	Laundry & Linen Service	8.00	14, 627	0	14, 62			31.00
32.00	Housekeepi ng	9.00	516	0	51	6 50.00	10. 32	32.00
33.00	Housekeeping under contract (see instructions)		0	0		0.00	0.00	33.00
34.00	Dietary	10. 00	346, 861	-135, 427	211, 43	4 10, 971. 00	19. 27	34.00
35.00	Dietary under contract (see instructions)		0	0		0.00	0.00	35.00
36.00	Cafeteri a	11.00	0	135, 427	135, 42	7 27, 556. 00	4. 91	36.00
37.00	Maintenance of Personnel	12.00	0	0		0.00	0.00	37.00
38.00	Nursing Administration	13.00	254, 500	283, 248	537, 74	B 5, 665. 00	94. 92	38.00
39.00	Central Services and Supply	14.00	82, 228	0	82, 22	3, 298. 00	24.93	39.00
40.00	Pharmacy	15.00	382, 026	0	382, 02	6 13, 408. 00	28.49	40.00
41.00	Medical Records & Medical	16.00	0	0		0.00		41.00
	Records Library		-					
42.00	Soci al Servi ce	17.00	0	0		0.00	0.00	42.00
43.00	Other General Service	18.00	0	0		0.00	0.00	43.00

Heal th	n Financial Systems	FRA	NCISCAN HEALTH	CRAWFORDSVI LL	E	In Lie	eu of Form CMS-2	2552-10
HOSPI	TAL WAGE INDEX INFORMATION			Provider CC		Period: From 01/01/2021 To 12/31/2021		pared:
						5	5/31/2022 8: 5	
		Worksheet A		Recl assi fi cati	5		Average Hourly	
		Line Number	Reported	on of Salaries			Wage (col. 4 ÷	
				(from	(col.2 ± col.	Salaries in	col. 5)	
				Worksheet A-6)	3)	col. 4		
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		19, 908, 570	869, 889	20, 778, 45	9 573, 316.00	36. 24	1.00
	instructions)							
2.00	Excluded area salaries (see instructions)		3, 221, 135	0	3, 221, 13	5 67, 983.00	47.38	2.00
3.00	Subtotal salaries (line 1		16, 687, 435	869, 889	17, 557, 32	4 505, 333.00	34. 74	3.00
	minus line 2)							
4.00	Subtotal other wages & related costs (see inst.)		6, 334, 271	0	6, 334, 27	1 149, 646. 50	42.33	4.00
5.00	Subtotal wage-related costs (see inst.)		4, 997, 645	0	4, 997, 64	5 0.00	28. 46	5.00
6.00	Total (sum of lines 3 thru 5)		28, 019, 351	869, 889	28, 889, 24	0 654, 979. 50	44, 11	6,00
7.00	Total overhead cost (see		6, 336, 596					7.00
7.00	instructions)		0, 330, 390	007,009	7,200,40	131, 402.00	54. 62	7.00

)SPI T <i>i</i>	AL WAGE RELATED COSTS	Provider CCN: 15-0022	Period: From 01/01/2021 To 12/31/2021		pare
				Amount	
				Reported	
				1.00	
	PART IV - WAGE RELATED COSTS				
	Part A - Core List				
	RETIREMENT COST				
	401K Employer Contributions			0	
00	Tax Sheltered Annuity (TSA) Employer Contribution			0	2.
	Nonqualified Defined Benefit Plan Cost (see instructions)			0	3.
	Qualified Defined Benefit Plan Cost (see instructions)			918, 461	4.
0	PLAN ADMINISTRATIVE COSTS (Paid to External Organization) 401K/TSA Plan Administration fees			0	5
-	Legal /Accounting/Management Fees-Pension Plan			0	6
	Employee Managed Care Program Administration Fees			0	0
	HEALTH AND INSURANCE COST			0	
	Health Insurance (Purchased or Self Funded)			0	8
1	Health Insurance (Self Funded without a Third Party Administr	rator)		0	-
	Health Insurance (Self Funded with a Third Party Administrate			1, 680, 462	-
	Heal th Insurance (Purchased)	)		1, 000, 402	
	Prescription Drug Plan			0	
	Dental, Hearing and Vision Plan			68, 227	
	Life Insurance (If employee is owner or beneficiary)			6, 209	
	Accident Insurance (If employee is owner or beneficiary)				12
	Disability Insurance (If employee is owner or beneficiary)			97, 086	
	Long-Term Care Insurance (If employee is owner or beneficiary	<i>(</i> )		0	
00	'Workers' Compensation Insurance	,,		67, 511	
	Retirement Health Care Cost (Only current year, not the extra	aordinary accrual require	ed by FASB 106.	0	
	Non cumulative portion)	5	j		
Ì	TAXES				1
	FICA-Employers Portion Only			750, 929	17
00	Medicare Taxes - Employers Portion Only			0	18
	Unemployment Insurance			0	19
	State or Federal Unemployment Taxes			0	20
	OTHER				
	Executive Deferred Compensation (Other Than Retirement Cost Finstructions))	Reported on lines 1 throu	ugh 4 above. (see	0	21
00	Day Care Cost and Allowances			0	22
	Tuition Reimbursement			0	
	Total Wage Related cost (Sum of lines 1 -23)			3, 588, 885	24
Ī	Part B - Other than Core Related Cost				

Heal th	Financial Systems	FRANCI SCAN HEALTH CRAWFORDS	VILLE	In Lie	u of Form CMS-2	2552-10
HOSPI T	AL CONTRACT LABOR AND BENEFIT COST	Provide	er CCN: 15-0022	Peri od:	Worksheet S-3	
				From 01/01/2021	Part V	
				To 12/31/2021	Date/Time Pre 5/31/2022 8:5	
	Cost Center Description			Contract Labor		
				1.00	2.00	
	PART V - Contract Labor and Benefit Cos	t in the second s				
	Hospital and Hospital-Based Component I	denti fi cati on:				
1.00	Total facility's contract labor and ben	efit cost		1, 709, 999	3, 588, 885	1.00
2.00	Hospi tal			1, 709, 999	3, 588, 885	2.00
3.00	Subprovider - IPF			0	0	3.00
4.00	Subprovider - IRF			0	0	4.00
5.00	Subprovider - (Other)			0	0	5.00
6.00	Swing Beds - SNF			0	0	6.00
7.00	Swing Beds - NF			0	0	
8.00	Hospital-Based SNF			0	0	0.00
9.00	Hospital-Based NF			0	0	1100
10.00	Hospi tal -Based OLTC					10.00
11.00	Hospital-Based HHA			0	0	11.00
12.00	Separately Certified ASC			0	0	
13.00	Hospi tal -Based Hospi ce			0	0	
14.00	Hospital-Based Health Clinic RHC			0	0	
15.00	Hospital-Based Health Clinic FQHC			0	0	
16.00	Hospital-Based-CMHC			0	0	
16. 10	Hospital-Based-CMHC 10			0	0	
17.00	Renal Dialysis			0	0	
18.00	Other			0	0	18.00

Heal th	Financial Systems FRANCISCAN HEALTH CF	RAWFORDSVI LLE	-	In Lie	eu of Form CMS-2	2552-10
	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provi der CC		Peri od:	Worksheet S-1	
				From 01/01/2021		
				To 12/31/2021		
					5/31/2022 8:5	6 am
					1.00	
	Uncompensated and indigent care cost computation				1.00	
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 d	ivided by lir	ne 202 column	8)	0. 194798	1.00
	Medicaid (see instructions for each line)			,		
2.00	Net revenue from Medicaid				444, 459	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?				N	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplement	ntal payments	s from Medica	i d?		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments	from Medicai	b		0	5.00
6.00	Medi cai d charges				2, 206, 951	6.00
7.00	Medicaid cost (line 1 times line 6)				429, 910	7.00
8.00	Difference between net revenue and costs for Medicaid program	(line 7 minu	us sum of lin	es 2 and 5; if	0	8.00
	< zero then enter zero)					
	Children's Health Insurance Program (CHIP) (see instructions t	for each line	e)		-	
9.00	Net revenue from stand-al one CHIP				0	9.00
10.00	Stand-alone CHIP charges				0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	(line 11 min		f . Toro then	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP enter zero)	(IINE II MI	nus line 9; i	r < zero then	0	12.00
	Other state or local government indigent care program (see ins	structions fo	or each line)			
13.00	Net revenue from state or local indigent care program (Not in			)	0	13.00
14.00	Charges for patients covered under state or local indigent ca				0	14.00
	10)					
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 in	ndigent care	program (lin	e 15 minus line	0	16.00
	13; if < zero then enter zero)	-				
	Grants, donations and total unreimbursed cost for Medicaid, Cl	HP and state	e/local indig	ent care progra	ms (see	
47 00	instructions for each line)	<u> </u>				47.00
17.00	Private grants, donations, or endowment income restricted to				0	17.00
18. 00 19. 00	Government grants, appropriations or transfers for support of			(our of lines	0	18.00 19.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and loca 8, 12 and 16)	ai inuigent o	Lare programs	(Sull OF TITLES	0	19.00
			Uni nsured	Insured	Total (col. 1	
			patients	patients	+ col. 2)	
			1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				1	
20.00	Charity care charges and uninsured discounts for the entire fa	acility	3, 973, 27	7 4, 108, 610	8, 081, 887	20.00
	(see instructions)					
21.00	Cost of patients approved for charity care and uninsured disc	ounts (see	773, 98	6 4, 108, 610	4, 882, 596	21.00
22.00	instructions)	a off oc		o c	0	22.00
22.00	Payments received from patients for amounts previously written charity care	I UII dS			0	22.00
23.00	Cost of charity care (line 21 minus line 22)		773, 98	6 4, 108, 610	4, 882, 596	23.00
23.00		1	775,70	4,100,010	4,002,370	23.00
					1.00	
24.00	Does the amount on line 20 column 2, include charges for patie	ent days beyo	ond a length	of stay limit	N	24.00
	imposed on patients covered by Medicaid or other indigent card	e program?	0	5		
25.00	If line 24 is yes, enter the charges for patient days beyond	the indigent	care program	's length of	0	25.00
	stay limit					
26.00	Total bad debt expense for the entire hospital complex (see in				1, 018, 693	
27.00	Medicare reimbursable bad debts for the entire hospital comple				107, 619	
27.01	Medicare allowable bad debts for the entire hospital complex	(see instruct	tions)		165, 568	
28.00	Non-Medicare bad debt expense (see instructions)				853, 125	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt e.	xpense (see i	instructions)		224, 136	
30. 00 31. 00	Cost of uncompensated care (line 23 column 3 plus line 29) Total unreimbursed and uncompensated care cost (line 19 plus	Lino 20)			5, 106, 732 5, 106, 732	
31.00	Trotal uniternibul seu and uncompensated care cost (Trne 19 plus	iiile 30)			J 5, 100, 732	31.00

EULAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C	OF EXPENSES	Provider CC	F	eriod: rom 01/01/2021 o 12/31/2021	Worksheet A Date/Time Pre	
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	5/31/2022 8:50 Reclassified Trial Balance (col. 3 +- col. 4)	<u>6 am</u>
		1.00	2.00	3.00	4.00	5.00	
. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT		4, 030, 883	4, 030, 883	1, 182, 272	5, 213, 155	1.0
. 00	00200 CAP REL COSTS-BEDG & TTXT		4,030,883	4, 030, 883		47, 128	2.0
. 00	00300 OTHER CAP REL COSTS		0	0		0	3.0
. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	-3, 085	5, 169, 568			5, 166, 725	4.0
. 00	00500 ADMI NI STRATI VE & GENERAL	4, 698, 543	10, 456, 990	15, 155, 533	-1, 208, 990	13, 946, 543	5.0
. 00 . 00	00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT	0 296, 698	0 1, 106, 557	0 1, 403, 255	0 -3, 185	0 1, 400, 070	6.0 7.0
. 00	00800 LAUNDRY & LINEN SERVICE	14, 627	146, 029	160, 656		160, 227	8.0
. 00	00900 HOUSEKEEPI NG	516	567, 494	568, 010		559, 651	9.0
0. 00	01000 DI ETARY	346, 861	208, 025	554, 886		274, 689	
1.00		0	0	0		276, 591	11.0
3.00 4.00	01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY	254, 500 82, 228	225, 944 190, 415	480, 444 272, 643		474, 336 251, 153	
4.00 5.00	01500 PHARMACY	382, 026	9, 079, 301	9, 461, 327	-10, 646, 430	-1, 185, 103	
6.00	01600 MEDI CAL RECORDS & LI BRARY	0	0	0		0	
	INPATIENT ROUTINE SERVICE COST CENTERS			-	1		
0.00	03000 ADULTS & PEDIATRICS	1, 675, 764	783, 198			2, 455, 416	
1.00 2.00	03100 I NTENSI VE CARE UNI T 03200 CORONARY CARE UNI T	862, 229	125, 994	988, 223 0		988, 223 0	31.0 32.0
3.00	03300 BURN INTENSIVE CARE UNIT	0	0		0	0	33.0
4.00	03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.0
0. 00	04000 SUBPROVI DER – I PF	1, 126, 377	83, 312	1, 209, 689	-1, 401	1, 208, 288	40.0
1.00	04100 SUBPROVI DER – I RF	0	0	0	0	0	41.0
3.00		0	0	0	0	0	43.0
4.00 5.00	04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY	0	0		0	0	44.0 45.0
6.00	04600 OTHER LONG TERM CARE	0	0		0	0	45.0
	ANCI LLARY SERVICE COST CENTERS		-		-	-	1
0. 00	05000 OPERATI NG ROOM	1, 694, 857	2,091,370	3, 786, 227	1, 793	3, 788, 020	
1.00	05100 RECOVERY ROOM	0	0	0	0	0	51.0
2.00 3.00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	0	0		0	0	52.0 53.0
4.00	05400 RADI OLOGY-DI AGNOSTI C	1, 328, 988	215, 869	1, 544, 857	-3, 284	1, 541, 573	
4.01	03630 ULTRA SOUND	37, 357	78, 538	115, 895		114, 698	
5.00	05500 RADI OLOGY-THERAPEUTI C	791, 299	530, 909			1, 322, 208	
6.00	05600 RADI OI SOTOPE	95, 022	3, 543	98, 565	0	98, 565	
7.00 8.00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	57.0 58.0
9.00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59.0
0. 00	06000 LABORATORY	0	3, 018, 654	3, 018, 654	-439	3, 018, 215	60.0
0. 01	06001 BLOOD LABORATORY	0	0	0	0	0	
1.00 2.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	61.0 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	0	64. C
5.00	06500 RESPI RATORY THERAPY	616, 789	111, 711	728, 500	88, 868	817, 368	65. C
6.00	06600 PHYSI CAL THERAPY	619, 287	62, 373	681, 660	- 326	681, 334	66.0
7.00 8.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	0		0	0	67.0 68.0
8.00 9.00	06900 ELECTROCARDI OLOGY	480, 754	96, 292	577, 046	-186, 005	391, 041	69.0
0.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.0
1.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	899	899	1, 765, 301	1, 766, 200	1
2.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	12, 614	12, 614	72.0
3.00 4.00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0	0		9, 005, 445	9, 005, 445 0	73.0 74.0
4.00 5.00	07500 ASC (NON-DISTINCT PART)	0	0		0	0	75.0
6.00	03480 ONCOLOGY	571	0	571	0	571	76.0
6. 97	07697 CARDI AC REHABI LI TATI ON	0	0	0	0	0	76.9
7.00		0	0	0	0	0	77. C
8. 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC		0	0	0	0	88. C
9.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.0
0.00	09000 CLINIC	153, 587	26, 223	179, 810	0	179, 810	
1. 00	09100 EMERGENCY	1, 994, 335	1, 160, 922	3, 155, 257	-602	3, 154, 655	91. C
1.01	04950 WOUND CARE	0	0	0	0	0	91.0
2.00	09200 OBSERVATI ON BEDS (NON-DI STINCT PART) OTHER REIMBURSABLE COST CENTERS						92. C
4.00	09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94.0
5.00	09500 AMBULANCE SERVICES	0	0	0	0	0	95.0
6.00	09600 DURABLE MEDI CAL EQUI P-RENTED	0	0	0	0	0	96.0
7.00	09700 DURABLE MEDICAL EQUIP-SOLD		0		0	0	97. (

Health Financial Systems FR	ANCISCAN HEALTH C	RAWFORDSVI LLI	E	In Lie	u of Form CMS-:	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C	F EXPENSES	Provider CC		Peri od:	Worksheet A	
				From 01/01/2021 To 12/31/2021	Date/Time Pre	narod
				10 12/31/2021	5/31/2022 8:5	
Cost Center Description	Sal ari es	Other		Recl assi fi cati	Recl assi fi ed	
			+ col. 2)	ons (See A-6)	Trial Balance	
					(col. 3 +-	
	1.00			6.00	col . 4)	
	1.00	2.00	3.00	4.00	5.00	00.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS 99.00 09900 CMHC	0	0		0	0	
99. 00 109900 CMHC 99. 10 109910 CORF	0	0			0	
100.001000001&R SERVICES-NOT APPRVD PRGM	0	0			°	100.00
101.00/10100 HOME HEALTH AGENCY	0	0		0		100.00
SPECIAL PURPOSE COST CENTERS	U U	0		<u> </u>	0	101.00
105. 00 10500 KI DNEY ACQUI SI TI ON	0	0			0	105.00
106. 00 10600 HEART ACQUISITION	0	0				106.00
107. 00 10700 LI VER ACQUI SI TI ON	0	0				107.00
108. 00 10800 LUNG ACQUISITION	0	0		0		108.00
109. 00 10900 PANCREAS ACQUISITION	0	0		0 0		109.00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON	0	0		0 0		110.00
111. 00 11100 I SLET ACQUI SI TI ON	0	0		0 0		111.00
113.0011300 INTEREST EXPENSE		0		0 0		113.00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF	0	0		0 0	0	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)	17, 550, 130	39, 571, 698	57, 121, 82	8 7, 581	57, 129, 409	118.00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	34	4, 367	4, 40	1 -180	4, 221	190. 00
191. 00 19100 RESEARCH	0	0		0 0	0	191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	1, 604, 981	1, 846, 842	3, 451, 82	3 -4, 669	3, 447, 154	192.00
193.00 19300 NONPALD WORKERS	0	0		0 0	0	193.00
194.0007950 OTHER NONREIMBURSABLE COST CENTERS	0	0		0 0		194.00
194.0107951 OTHER NONREIMBURSABLE COST CENTERS	248, 273	120, 293				
194.0207952 OTHER NONREI MBURSABLE COST CENTERS	241, 470	103, 763			345, 233	
200.00 TOTAL (SUM OF LINES 118 through 199)	19, 644, 888	41, 646, 963	61, 291, 85	1 0	61, 291, 851	200.00

LASSI	FICATION AND ADJUSTMENTS OF TRIAL BALANCE (	JF EXPENSES	Provider CCN: 1	From 01/		Worksheet A	
		_		To 12/	31/2021	Date/Time Pr 5/31/2022 8:	
	Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation				
		6.00	7.00				
	ENERAL SERVICE COST CENTERS						
	0100 CAP REL COSTS-BLDG & FIXT	228, 194					1
	0200 CAP REL COSTS-MVBLE EQUIP 0300 OTHER CAP REL COSTS						2
	0400 EMPLOYEE BENEFITS DEPARTMENT	134, 539	-				3
	0500 ADMI NI STRATI VE & GENERAL	-3, 372, 672					5
	0600 MAI NTENANCE & REPAI RS	C					6
	0700 OPERATION OF PLANT	0	.,,				7
	0800 LAUNDRY & LI NEN SERVI CE 0900 HOUSEKEEPI NG	-2,700					8
	1000 DI ETARY	-5, 682					10
	1100 CAFETERI A	-124, 936					11
	1300 NURSING ADMINISTRATION	210, 531					13
	1400 CENTRAL SERVICES & SUPPLY	-144, 612					14
	1500 PHARMACY 1600 MEDI CAL RECORDS & LI BRARY	39, 747 580, 343					15
	NPATIENT ROUTINE SERVICE COST CENTERS						
. 00 0	3000 ADULTS & PEDIATRICS	-354					30
	3100 I NTENSI VE CARE UNI T	C					31
	3200 CORONARY CARE UNIT 3300 BURN INTENSIVE CARE UNIT		-				32
	3400 SURGI CAL I NTENSI VE CARE UNI T	0					34
	4000 SUBPROVIDER - IPF	C					40
	4100 SUBPROVIDER - IRF	C	0				41
	4300 NURSERY 4400 SKILLED NURSING FACILITY						43
	4500 NURSING FACILITY	C					45
	4600 OTHER LONG TERM CARE	C	0				46
	NCI LLARY SERVICE COST CENTERS	24.405					
	5000 OPERATING ROOM 5100 RECOVERY ROOM	-26, 695					50
	5200 DELIVERY ROOM & LABOR ROOM						52
	5300 ANESTHESI OLOGY	C	0				53
	5400 RADI OLOGY-DI AGNOSTI C	-23, 259					54
	3630 ULTRA SOUND 5500 RADI OLOGY-THERAPEUTI C	0	) 114, 698 ) 1, 322, 208				54
	5600 RADI OLOGI - MERALEUTI C	-380, 234					56
	5700 CT SCAN	C	0				57
	5800 MAGNETIC RESONANCE IMAGING (MRI)	C					58
	5900 CARDI AC CATHETERI ZATI ON 6000 LABORATORY	-4, 840					59 60
	6001 BLOOD LABORATORY	-4, 040					60
. 00 0	6100 PBP CLINICAL LAB SERVICES-PRGM ONLY	C	0				61
	6200 WHOLE BLOOD & PACKED RED BLOOD CELLS	C	0				62
	6300 BLOOD STORI NG, PROCESSI NG & TRANS. 6400 I NTRAVENOUS THERAPY						63
	6500 RESPI RATORY THERAPY		817, 368				65
	6600 PHYSI CAL THERAPY		681, 334				66
	6700 OCCUPATIONAL THERAPY	C	0				67
	6800 SPEECH PATHOLOGY 6900 ELECTROCARDI OLOGY	-28, 050	0 362, 991				68
	7000 ELECTROENCEPHALOGRAPHY	-28, 050	) 302, 991				69
	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS		1, 766, 200				71
. 00  0	7200 IMPL. DEV. CHARGED TO PATIENTS	C	12, 614				72
	7300 DRUGS CHARGED TO PATIENTS		9,005,445				73
	7400 RENAL DI ALYSI S 7500 ASC (NON-DI STINCT PART)						74
	3480 ONCOLOGY		571				76
	7697 CARDI AC REHABI LI TATI ON	C	0				76
	7700 ALLOGENEIC STEM CELL ACQUISITION	C	0				77
	UTPATIENT SERVICE COST CENTERS 8800 RURAL HEALTH CLINIC	(	0				88
	8900 FEDERALLY QUALIFIED HEALTH CENTER		o o				89
00 0	9000 CLI NI C	C	179, 810				90
1		-605, 549	2, 549, 106				91
	4950 WOUND CARE 9200 OBSERVATION BEDS (NON-DISTINCT PART)	C	0				91
	THER REIMBURSABLE COST CENTERS						- 72
. 00 0	9400 HOME PROGRAM DI ALYSI S	C	0				94
	9500 AMBULANCE SERVICES	C	0				95
	9600 DURABLE MEDICAL EQUIP-RENTED 9700 DURABLE MEDICAL EQUIP-SOLD						96
	9850 OTHER REIMBURSABLE COST CENTERS						97
	9900 CMHC						99

Health Financial Systems FR/	ANCISCAN HEALTH (	CRAWFORDSVI LLE		In Lie	u of Form CMS-	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider CCN:	15-0022	Peri od:	Worksheet A	
				From 01/01/2021		
				To 12/31/2021	Date/Time Pre 5/31/2022 8:5	
Cost Center Description	Adjustments N	Net Expenses			0/01/2022 0.3	
		or Allocation				
	6.00	7.00				
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						
105.00 10500 KIDNEY ACQUISITION	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 ACQUISITION	0	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	0	0				113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF	0	0				114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0				115.00
116.00 11600 HOSPI CE	0	0				116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	-3, 526, 229	53, 603, 180				118.00
NONREI MBURSABLE COST CENTERS		4 001				190.00
190. 00 19000 GLFT, FLOWER, COFFEE SHOP & CANTEEN 191. 00 19100 RESEARCH	0	4, 221				190.00
191. 00 19100 RESEARCH 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	3, 447, 154				191.00
193. 0019300 NONPALD WORKERS	0	5,447,154				192.00
194. 00 07950 OTHER NONRELMBURSABLE COST CENTERS	0	0				193.00
194. 0107951 OTHER NONREI MBURSABLE COST CENTERS	0	365, 834				194.00
194. 02 07952 OTHER NONREI MBURSABLE COST CENTERS	0	345, 233				194.02
200.00 TOTAL (SUM OF LINES 118 through 199)	-3, 526, 229	57, 765, 622				200.00
······································	-,,,					

Heal th	Fi nanci al	Systems
DECLAS	SIFICATION	21

## FRANCI SCAN HEALTH CRAWFORDSVILLE

In Lieu of Form CMS-2552-10

					From 01/01/202 To 12/31/202	1 Date/Time	Prepar
		Incroscoc				5/31/2022	<u>8:56 a</u>
	Cost Center	Li ne #	Salary	Other			
	2.00	3.00	4.00	5.00			
/	A - DEFAULT						
	CAP REL COSTS-MVBLE EQUIP	2.00	0	46, 443			1
)		0.00	0	0			2
		0.00	0	0			3
		0.00	0	0			4
		0.00	0	0			5
		0.00	0	0			6
		0.00 0.00	0	0			8
	TOTALS	0.00		46, 443			
	B - INTEREST		9	40, 443			
	CAP REL COSTS-BLDG & FIXT	1.00	0	1, 182, 272			
	TOTALS			1, 182, 272			
	C - DIETARY						
) (	CAFETERI A	11.00	135, 427	141, 164			1
-	TOTALS		135, 427	141, 164			
	D – CHARGEABLE SUPPLIES						
	MEDICAL SUPPLIES CHARGED TO	71.00	0	1, 765, 301			
	PATIENTS						
	OPERATING ROOM	50.00	0	1, 793			
	EMPLOYEE BENEFITS DEPARTMENT	4.00 0.00	0	242 0			
)			0	0			
		0.00 0.00	0	0			
		0.00	0	0			
		0.00	0	0			
		0.00	0	0			
0		0.00	o	Ő			1
0		0.00	0	0			1
0		0.00	0	0			1
0		0.00	0	0			1
00		0.00	0	0			1
0		0.00	0	0			1
00		0.00	0	0			1
00		0.00	0	0			1
00		0.00	0	0			1
00		0.00	0	0			1
00		0.00	<u>0</u>	$- \frac{0}{17(7.22)}$			2
	TOTALS E - DRUGS CHARGED TO PATIENTS		0	1, 767, 336			
	DRUGS CHARGED TO PATIENTS	73.00	0	9,005,445			
Ś	DRUGS CHARGED TO TATTENTS	0.00	0	0,000,440			
Ś		0.00	0	0			
		0.00	0	Ō			
)		0.00	0	0			
)		0.00	0	0			
		0.00	0	0			
		0.00	0	0			
		0.00	0	0			
			0	9,005,445			_
	F - PROSTHESIS & IMPLANTS	72.00	a	10 (1)			
	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	12, 614			
	TOTALS	+	— —  _  _	12, 614			
	G - SHARED SERVICES		0	12,014			
	EMPLOYEE BENEFITS DEPARTMENT	4.00	59, 044	0			
	ADMI NI STRATI VE & GENERAL	5.00	527, 597	0			
	NURSI NG ADMI NI STRATI ON	13.00	283, 248	õ			
	TOTALS		869, 889				1
	H - RESPIRATORY THERAPY ADMIN			- 1			
	RESPIRATORY_THERAPY	65.00	184, 457	0			
	TOTALS		184, 457				1

Heal th	Fi nanci al	Systems
RECLAS	SIFICATION	IS

CLASSI FI	CATIONS			Provider (	CCN: 15-0022	Period: From 01/01/2021	Worksheet A-6	
						To 12/31/2021	Date/Time Prepa 5/31/2022 8:56	
		Decreases					0,01,2022 0.00	Gilli
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref	·		
•	6.00	7.00	8.00	9.00	10.00			
	· DEFAULT II NI STRATI VE & GENERAL	5.00	0	15, 120	1	9		1. (
	RATION OF PLANT	7.00	0	3, 064		9		2. (
	TARY	10.00	0	535		0		3. (
OO NUR	RSING ADMINI STRATION	13.00	0	350		0		4. (
OO CEN	ITRAL SERVICES & SUPPLY	14.00	0	38		0		5.
	ARMACY	15.00	0	26, 107		0		6.
	SPI RATORY THERAPY	65.00	0	568		0		7.
	SICIANS' PRIVATE OFFICES	192.00	0	661		Ō		8.
	ALS		0	46, 443				
	INTEREST	5.00	0	1, 182, 272	1	1		1.
	ALS		0	1, 182, 272				1.
	· DI ETARY	I	0	1, 102, 272				
	TARY	10.00	135, 427	141, 164		0		1.
	ALS		135, 427	141, 164		1		
	CHARGEABLE SUPPLIES							
	MINISTRATIVE & GENERAL	5.00	0	11, 596		0		1.
	RATION OF PLANT	7.00	0	121		0		2.
	JNDRY & LINEN SERVICE	8.00	0	429		0		3.
	JSEKEEPI NG	9.00	0	8, 359		0		4.
		10.00	0	3, 064		0		5.
	RSING ADMINISTRATION	13.00 14.00	0	1, 828 8, 764		0		6. 7.
	ARMACY	15.00	0	1, 619, 094		0		8.
	JLTS & PEDIATRICS	30.00	0	3, 465		0		9.
	BPROVIDER - IPF	40.00	0	1, 393		0		10.
	DI OLOGY-DI AGNOSTI C	54.00	0	3, 284		0		11.
00 ULT	RA SOUND	54.01	0	1, 197		0		12.
00 LAB	BORATORY	60.00	0	439		0		13.
	SPIRATORY THERAPY	65.00	0	95, 021		0		14.
	SICAL THERAPY	66.00	0	326		0	-	15.
	CTROCARDI OLOGY	69.00	0	1, 548		0		16.
	RGENCY	91.00	0	501		0		17.
	T, FLOWER, COFFEE SHOP &	190.00	0	180		0		18.
	ITEEN 'SICIANS' PRIVATE OFFICES	192.00	0	3, 995		0		19.
	IER NONREI MBURSABLE COST	192.00	0	2, 732		0		20.
	ITERS	174.01	0	2,752				20.
	ALS		0	1, 767, 336				
E -	DRUGS CHARGED TO PATIENTS							
	MINISTRATIVE & GENERAL	5.00	0	2		0		1
		10.00	0	7		0		2.
	RSING ADMINISTRATION	13.00	0	3, 930		0		3.
	ITRAL SERVICES & SUPPLY	14.00 15.00	0	74 9, 001, 229		0		4 5
	JLTS & PEDIATRICS	30.00	0	9,001,229		0		6
	BPROVIDER - IPF	40.00	0	8		0		7.
	ERGENCY	91.00	0	101		0		8.
	SICIANS' PRIVATE OFFICES	192.00	0	13		0		9.
	ALS	T		9,005,445				
	PROSTHESIS & IMPLANTS							
	ITRAL_SERVICES_&_SUPPLY		0	1 <u>2, 6</u> 14		Q		1.
	ALS		0	12, 614				
	SHARED SERVICES	!	-1					
	PLOYEE BENEFITS DEPARTMENT	4.00	0	59, 044		0		1
	MINISTRATIVE & GENERAL	5.00	0	527, 597		0		2
	RSING ADMINISTRATION	<u>13.</u> 00	<u>v</u>	<u>283, 2</u> 48 869, 889		Q		3.
	RESPIRATORY THERAPY ADMIN		U	007, 089	I			
	CTROCARDI OLOGY	69.00	184, 457	C		0		1.
	ALS		184, 457	0	<u> </u>	7		
	and Total: Decreases		319, 884	13, 025, 163			5	500.

Heal th	Financial Systems FR.	ANCI SCAN HEALTH	CRAWFORDSVI LL	E	In Li	eu of Form CMS-:	2552-10
	ILIATION OF CAPITAL COSTS CENTERS	,	Provider CC		Period: From 01/01/202 To 12/31/202		pared:
				Acqui si ti on			
		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 ASSE						
1.00	Land	970, 120			0	0 0	1.00
2.00	Land Improvements	3, 753, 111	0		0	0 0	2.00
3.00	Buildings and Fixtures	37, 590, 704	137, 571		0 137, 57	1 0	3.00
4.00	Building Improvements	7, 885, 784	0		0	0 0	4.00
5.00	Fixed Equipment	0	0		0	0 0	5.00
6.00	Movable Equipment	22, 113, 408	3, 035, 574		0 3, 035, 57	4 501, 293	6.00
7.00	HIT designated Assets	0	0		0	o o	7.00
8.00	Subtotal (sum of lines 1-7)	72, 313, 127	3, 173, 145		0 3, 173, 14	5 501, 293	8.00
9.00	Reconciling Items	0	0		0	0 0	9.00
10.00	Total (line 8 minus line 9)	72, 313, 127	3, 173, 145		0 3, 173, 14	5 501, 293	10.00
		Ending Balance				· · · · ·	
		5	Depreciated				
			Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	T BALANCES					
1.00	Land	970, 120	0				1.00
2.00	Land Improvements	3, 753, 111	721, 150	1			2.00
3.00	Buildings and Fixtures	37, 728, 275	1, 897, 445	1			3.00
4.00	Building Improvements	7, 885, 784					4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	24, 647, 689	10, 126, 145				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	74, 984, 979	13, 130, 615				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	74, 984, 979	13, 130, 615				10.00

Heal th	Financial Systems FRA	ANCI SCAN HEALTH	I CRAWFORDSVI LL	E	In Lie	u of Form CMS-2	2552-10
RECONC	ILIATION OF CAPITAL COSTS CENTERS		Provider C	CN: 15-0022	Peri od:	Worksheet A-7	
					From 01/01/2021	Part II	
					To 12/31/2021	Date/Time Pre 5/31/2022 8:5	
				UMMARY OF CAP		0/31/2022 0.5	
		JOININALL OF OATTAL					
	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, COLUM	IN 2, LINES 1 a	and 2			
1.00	CAP REL COSTS-BLDG & FIXT	4, 030, 883	C		0 0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	685	C		0 0	0	2.00
3.00	Total (sum of lines 1-2)	4, 031, 568	C		0 0	0	3.00
		SUMMARY O	F CAPITAL				
				_			
	Cost Center Description		Total (1) (sum	ו			
		Capi tal -Rel ate					
		d Costs (see	through 14)				
		instructions)	15.00	-			
	DADT LL DECONCLULATION OF ANOUNTS FROM WORK	14.00	15.00				
1 00	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, CULUM					1 1 00
1.00	CAP REL COSTS-BLDG & FIXT	0	4, 030, 883				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	685				2.00
3.00	Total (sum of lines 1-2)	0	4, 031, 568	3			3.00

Heal th	n Financial Systems FR	ANCISCAN HEALTH	I CRAWFORDSVI LL	E	In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provider C		Period: From 01/01/2021 Fo 12/31/2021		pared: 5 am
		COM	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPI TAL	
	Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col. 2)		Insurance	
	PART III - RECONCILIATION OF CAPITAL COSTS C	1.00	2.00	3.00	4.00	5.00	
1.00 2.00 3.00	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP Total (sum of lines 1-2)	45, 414, 996 23, 966, 395 69, 381, 391	0	45, 414, 990 23, 966, 399 69, 381, 39 CAPI TAL	5 0. 345430 1 1. 000000	0	1.00 2.00 3.00
	Cost Center Description	Taxes	Other Capi tal -Rel ate d Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS				1/1.000	
1.00 2.00 3.00	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP Total (sum of lines 1-2)	0			0 4, 097, 678 0 47, 128 0 4, 144, 806	0	1.00 2.00 3.00
3.00			SL	JMMARY OF CAPI		101, 377	3.00
	Cost Center Description		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	
1.00	PART III - RECONCILIATION OF CAPITAL COSTS C CAP REL COSTS-BLDG & FIXT	ENTERS 1, 182, 272	0	(	0 0	5, 441, 349	1. 00
2.00 3.00	CAP REL COSTS-MVBLE EQUIP Total (sum of lines 1-2)	0 1, 182, 272	0		0 0 0	47, 128 5, 488, 477	2.00 3.00

	Financial Systems MENTS TO EXPENSES	E KAN	UT JUAN HEALIF	CRAWFORDSVILLE Provider CCN: 15-0022	Peri od:	u of Form CMS-2 Worksheet A-8	
					From 01/01/2021 To 12/31/2021	Date/Time Pre	pared:
				Expense Classification o To/From Which the Amount is		5/31/2022 8:5	6 am
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	· · ·	1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		C	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		C	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other	В	-325	ADMI NI STRATI VE & GENERAL	5.00	0	3.00
4.00	(chapter 2) Trade, quantity, and time		C		0.00	0	4.00
5.00	discounts (chapter 8) Refunds and rebates of	В	-31,264	PHARMACY	15.00	0	5.00
6.00	expenses (chapter 8) Rental of provider space by		C		0.00	0	6.00
	suppliers (chapter 8)					-	
7.00	Telephone services (pay stations excluded) (chapter 21)		C		0.00	0	7.00
8.00	Television and radio service		C		0.00	0	8. 00
9.00	(chapter 21) Parking lot (chapter 21)		C		0.00	0	
10.00	Provider-based physician adjustment	A-8-2	-1, 108, 629			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		C		0.00	0	11.00
12.00	Related organization	A-8-1	2, 564, 013			0	12.00
13.00	transactions (chapter 10) Laundry and linen service	В	-2, 700	LAUNDRY & LINEN SERVICE	8.00	0	13.00
14.00 15.00	Cafeteria-employees and guests Rental of quarters to employee			CAFETERI A ADMI NI STRATI VE & GENERAL	11.00 5.00	0	
	and others		11, 100				
16.00	Sale of medical and surgical supplies to other than		Ĺ		0.00	0	16.00
17.00	patients Sale of drugs to other than		C		0.00	0	17.00
18.00	patients Sale of medical records and	В	-325	ADMI NI STRATI VE & GENERAL	5.00	0	18.00
19.00	abstracts Nursing and allied health		C		0.00	0	19.00
	education (tuition, fees,		-			-	
	books, etc.) Vending machines	В	-5, 682	DI ETARY	10.00	0	
21.00	Income from imposition of interest, finance or penalty		C		0.00	0	21.00
22.00	charges (chapter 21) Interest expense on Medicare		C		0.00	0	22.00
22.00	overpayments and borrowings to		C		0.00	0	22.00
23.00	repay Medicare overpayments Adjustment for respiratory	A-8-3	C	RESPI RATORY THERAPY	65.00		23.00
	therapy costs in excess of limitation (chapter 14)						
24.00	Adjustment for physical therapy costs in excess of	A-8-3	C	PHYSI CAL THERAPY	66.00		24.00
	limitation (chapter 14)						
25.00	Utilization review - physicians' compensation		C	UTILIZATION REVIEW-SNF	114.00		25.00
26.00	(chapter 21) Depreciation - CAP REL		C	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
	COSTS-BLDG & FIXT						
	Depreciation - CAP REL COSTS-MVBLE EQUIP			CAP REL COSTS-MVBLE EQUIP	2.00	0	
28.00 29.00	Non-physician Anesthetist Physicians'assistant		C	*** Cost Center Deleted ***	19.00 0.00	0	28.00 29.00
30.00	Adjustment for occupational therapy costs in excess of	A-8-3	C	OCCUPATI ONAL THERAPY	67.00		30.00
30. 99	limitation (chapter 14) Hospice (non-distinct) (see		C	ADULTS & PEDIATRICS	30.00		30.99
	instructions) Adjustment for speech	A-8-3		SPEECH PATHOLOGY	68.00		31.00
	pathology costs in excess of limitation (chapter 14)	A-0-3	C	SILLOIT FATIOLOGI			
32.00	CAH HIT Adjustment for Depreciation and Interest		C		0.00	0	32.00
33.00	MI SC I NCOME	В	-91,835	ADMI NI STRATI VE & GENERAL	5.00	0	33.00

Heal t	h Financial Systems	FRA	NCISCAN HEALTH	I CRAWFORDSVILLE	In Lie	u of Form CMS-2	2552-10
ADJUS	STMENTS TO EXPENSES			Provider CCN: 15-0022	Peri od:	Worksheet A-8	
					From 01/01/2021 To 12/31/2021	Date/Time Pre 5/31/2022 8:5	
				Expense Classification o	n Worksheet A		
				To/From Which the Amount is	s to be Adjusted		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.0	I DI SCOUNTS EARNED/REBATES	В	-144, 612	CENTRAL SERVICES & SUPPLY	14.00	0	33.01
33.02	2 DI SCOUNTS EARNED/REBATES	В	-1, 897	PHARMACY	15.00	0	33.02
33.03	B DI SCOUNTS EARNED/REBATES	В	-86	OPERATING ROOM	50.00	0	33.03
33.04	4 HAF ASSESSMENT	A	-4, 249, 635	ADMI NI STRATI VE & GENERAL	5.00	0	33.04
33.05	5 PENSION ADJUSTMENT	A	-313, 557	ADMI NI STRATI VE & GENERAL	5.00	0	33.05
33.06	5 EMPATH (LAF DEPT)	A	-335	ADULTS & PEDIATRICS	30.00	0	33.06
33.07	7 LABOR & DELIVERY (LAF DEPT)	A	-19	ADULTS & PEDIATRICS	30.00	0	33.07
50.00	) TOTAL (sum of lines 1 thru 49)		-3, 526, 229				50.00
	(Transfer to Worksheet A,						
	column 6. line 200.)						

 column 6, line 200.)

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

 (2) Basis for adjustment (see instructions).

A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

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

Heal th	Financial Systems	FRANCI SCAN HEALT	H CRAWFORDSVILLE	In Lie	eu of Form CMS-	2552-10
	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HOM	ME Provider CCN: 15-0022	Peri od:	Worksheet A-8	-1
OFFICE				From 01/01/2021 To 12/31/2021		
	Line No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost		
					Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTN HOME OFFICE COSTS:	IENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED	ORGANI ZATI ONS OR	CLAI MED	
1.00	1.00	CAP REL COSTS-BLDG & FIXT		1, 332, 857	1, 171, 458	1.00
2.00	1.00	CAP REL COSTS-BLDG & FIXT		614, 190	547, 395	2.00
3.00		ADMINISTRATIVE & GENERAL		8, 160, 253		3.00
4.00		PHARMACY		72, 908		4.00
4.01		MEDICAL RECORDS & LIBRARY		580, 343	0	4.01
4.02	4.00	EMPLOYEE BENEFITS DEPARTMENT		134, 712	0	4.02
4.03		ADMINISTRATIVE & GENERAL		1, 047, 548	0	4.03
4.04	13.00	NURSING ADMINISTRATION		390, 531	180, 000	4.04
5.00	TOTALS (sum of lines 1-4).			12, 333, 342	9, 769, 329	5.00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					
	line 12.					

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

has not been posted to not kalleet A, cordinas i and/or z, the amount arrowable should be indicated in cordinar 4 or this part.							
				Related Organization(s) and/	or Home Office		
				je i tra ci je i t			
		•.		••		<u> </u>	
	Symbol (1)	Name	Percentage of	Name	Percentage of		
			Ownership		Ownership		
	1.00	2.00		1.00			
	1.00	2.00	3.00	4.00	5.00		
	B. INTERRELATIONSHIP TO RELAT	ED ORGANIZATION(S) AND/OR HO	ME 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 Of Inio al					
6.00	В	HOME OFFICE	100.00	0.00	6.00
7.00	G	SISTER FACILITY	100.00	0.00	7.00
8.00			0.00	0.00	8.00
9.00			0.00	0.00	9.00
10.00			0.00	0.00	10.00
100.00	G. Other (financial or	FINANCIAL			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.

Heal th	Financial Syste	ems	FR	ANCISCAN HEALTH C	RAWFORDSVI LLE	In Lie	eu of Form CMS-	2552-10
		SERVICES FROM	RELATED ORGANIZ	ATIONS AND HOME	Provider CCN: 15-00		Worksheet A-8	3-1
OFFICE	COSTS					From 01/01/2021 To 12/31/2021	Date/Time Pro 5/31/2022 8:	epared: 56 am
	Net	Wkst. A-7 Ref.						
	Adjustments							
	(col. 4 minus							
	col. 5)*							
	6.00	7.00						
	A. COSTS INCUR	RED AND ADJUST	MENTS REQUIRED A	AS A RESULT OF TR	ANSACTIONS WITH RELAT	FED ORGANIZATIONS OR	CLAI MED	
	HOME OFFICE CO	STS:						
1.00	161, 399	10						1.00
2.00	66, 795	9						2.00
3.00	289, 777	0						3.00
4.00	72, 908	0						4.00
4.01	580, 343	0						4.01
4.02	134, 712	0						4. 02
4.03	1,047,548	0						4.03
4.04	210, 531	0						4.04

5.00 2, 564, 013 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 houl d

5 00

nas not	been posted to worksheet A,	corumns r and/or 2, the amount arrowable should be indicated in corumn 4 of this part.	
	Related Organization(s)		
	and/or Home Office		
	Type of Business		1
	5.		
	6.00	1	
	B. INTERRELATIONSHIP TO RELA	TED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

6.00 7.00	6.00
7.00	7.00
8.00 9.00	8.00
9.00	9.00
10. 00 100. 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.

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

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

organi zati on.

210, 531

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

Heal th Fi	nanci a	I Systems	
	DACED	DUVELCIAN	AD ILICTMENT

## FRANCI SCAN HEALTH CRAWFORDSVILLE

In Lieu of Form CMS-2552-10

PROVI DE	R BASED PHYSIC	I AN ADJUSTMENT		Provider C		Period:	Worksheet A-8	3-2
						From 01/01/2021 To 12/31/2021	Date/Time Pre	narod
						10 12/31/2021	5/31/2022 8:5	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		Identifier	Remunerati on	Component	Component		ider Component	
							Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00		EMPLOYEE BENEFITS DEPARTMENT	173	173	0		-	1.00
2.00		ADMINISTRATIVE & GENERAL	39, 915				0	2.00
3.00		OPERATING ROOM	26, 609	26, 609			0	3.00
4.00		RADI OLOGY-DI AGNOSTI C	23, 259			0	0	4.00
5.00		RADI OI SOTOPE	380, 234	380, 234	0	0	0	5.00
6.00		LABORATORY	4, 840	4, 840	0	0	0	6.00
7.00		ELECTROCARDI OLOGY	28, 050	28, 050	0	0	0	7.00
8.00		EMERGENCY	605, 549	605, 549	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1, 108, 629				0	200.00
	Wkst. A Line #		Unadjusted RCE		Cost of		Physician Cost	
		I denti fi er	Limit	Unadjusted RCE			of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
1.00	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00		EMPLOYEE BENEFITS DEPARTMENT	0	0	0	-	0	1.00
2.00		ADMI NI STRATI VE & GENERAL	0	0	-		0	2.00
3.00		OPERATING ROOM	0	0	-	-	0	3.00
4.00		RADI OLOGY-DI AGNOSTI C	0	0	0	0	0	4.00
5.00		RADI OI SOTOPE	0	0	0	0	0	5.00
6.00			0	0	0	0	0	6.00
7.00		ELECTROCARDI OLOGY EMERGENCY	0	0	0	0	0	7.00
8.00 9.00	91.00 0.00		0	0		0	0	8.00 9.00
9.00 10.00	0.00		0	0	0	0	0	9.00 10.00
	0.00		0	0		0	0	
200.00	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment	0	200.00
	WKSL A LINE #	I denti fi er	Component	Limit	Di sal l owance	Adjustment		
		Identifier	Share of col.		DISALIOWANCE			
			14					
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00		EMPLOYEE BENEFITS DEPARTMENT	0	0		173		1.00
2.00		ADMI NI STRATI VE & GENERAL	0	0	-			2.00
3.00		OPERATING ROOM	0	0	0			3.00
4.00		RADI OLOGY-DI AGNOSTI C	0	0	0			4.00
5.00		RADI OI SOTOPE	0	0	0			5.00
6.00		LABORATORY	0	0	-			6.00
7.00		ELECTROCARDI OLOGY	0	0	0	.,		7.00
8.00		EMERGENCY	0	0	-			8.00
9.00	0.00		n 0	0	-			9.00
10.00	0.00		n 0	0	-	-		10.00
200.00	0.00		0 0	0				200.00
		1				.,, 02,	· ·	

COST A	ILLOCATION - GENERAL SERVICE COSTS		Provider CC		Period: From 01/01/2021 To 12/31/2021	Worksheet B Part I Date/Time Pre 5/31/2022 8:5	pared: 6 am
			CAPI TAL REL	ATED COSTS			
	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	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT	5, 441, 349	5, 441, 349				1.0
2.00	00200 CAP REL COSTS-MVBLE EQUIP	47, 128		47, 12	28		2.0
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	5, 301, 264	113, 851	98	5, 416, 101		4.0
5.00	00500 ADMINISTRATIVE & GENERAL	10, 573, 871	508, 937	4,40	08 154, 080	11, 241, 296	5.0
6.00	00600 MAINTENANCE & REPAIRS	0	0		0 0	0	6.0
7.00	00700 OPERATION OF PLANT	1, 400, 070	650, 940	5,64	112, 613	2, 169, 263	7.0
3.00	00800 LAUNDRY & LINEN SERVICE	157, 527	5, 751	5	50 5, 594	168, 922	8.0
9.00	00900 HOUSEKEEPI NG	559, 651	57, 293	49	96 196	617, 636	9.0
10.00	01000 DI ETARY	269, 007	152, 379	1, 32	924	423, 630	10.0
11.00	01100 CAFETERIA	151, 655	94, 134	81	5 131, 008	377, 612	11.0
13.00	01300 NURSI NG ADMI NI STRATI ON	684, 867	0		0 99, 096	783, 963	13.0
14.00	01400 CENTRAL SERVICES & SUPPLY	106, 541	360, 710	3, 12	30, 609	500, 984	14.0
15.00	01500 PHARMACY	-1, 145, 356	51, 196	44	142, 377	-951, 340	15. C
16.00	01600 MEDICAL RECORDS & LIBRARY	580, 343	36, 754	31	8 0	617, 415	16. C
	INPATIENT ROUTINE SERVICE COST CENTERS	· · · ·					1
30.00	03000 ADULTS & PEDIATRICS	2, 455, 062	398, 588	3, 45	631, 281	3, 488, 383	1 30. C
	03100 I NTENSI VE CARE UNI T	988, 223	113, 116	98		1, 428, 390	
	03200 CORONARY CARE UNI T	0	0		0 0	0	
	03300 BURN INTENSIVE CARE UNIT	0	0		0 0	0	
	03400 SURGI CAL I NTENSI VE CARE UNI T	0	0		0 0	0	
10.00	04000 SUBPROVIDER - IPF	1, 208, 288	193, 284	1, 67	369, 741	1, 772, 987	
	04100 SUBPROVIDER - IRF	0	0		0 0	0	41. C
	04300 NURSERY	0	0		0 0	0	
	04400 SKILLED NURSING FACILITY	0	0		0 0	0	
5.00	04500 NURSING FACILITY	0	0		0 0	0	
	04600 OTHER LONG TERM CARE	0	0		0 0	0	
	ANCI LLARY SERVICE COST CENTERS		-			-	
50.00	05000 OPERATING ROOM	3, 761, 325	645, 793	5, 59	641, 802	5, 054, 513	50.0
	05100 RECOVERY ROOM	0	0	-,	0 0	0	1
2.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	52.0
	05300 ANESTHESI OLOGY	0	0		0 0	0	53.0
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 518, 314	477, 458	4, 13	730, 412	2, 730, 319	
	03630 ULTRA SOUND	114, 698	22, 744	19		153, 225	
55.00	05500 RADI OLOGY-THERAPEUTI C	1, 322, 208	85, 399	74		1, 408, 347	
56.00	05600 RADI OI SOTOPE	-281,669	53, 834	46		-227, 369	
	05700 CT SCAN	201,007	00,001		0 0	0	1
	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		0 0	0	
	05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0	
	06000 LABORATORY	3, 013, 375	153, 676	1, 33	1 0	3, 168, 382	
	06001 BLOOD LABORATORY	3, 013, 373	133, 070	1, 50		0, 100, 302	1
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0		0	0	
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0			0	1
	06300 BLOOD STORING, PROCESSING & TRANS.		0			0	
	06400 I NTRAVENOUS THERAPY	0	0			0	
	06500 RESPIRATORY THERAPY	817, 368	0		0 233, 499	1, 050, 867	
	06600 PHYSI CAL THERAPY		101, 528	87			
	06700 OCCUPATI ONAL THERAPY	681, 334	101, 528	87	<sup>79</sup> 236, 138	1, 019, 879	
		0	0			0	
		242 001	150 100	1 00	0 0	0 404 EE2	
		362, 991	150, 130	1, 30	0 182, 132	696, 553	70.0
0 00	07000 ELECTROENCEPHALOGRAPHY	1 01	0		0	0	1 70

71.00

72.00

73.00

74.00 75.00

76.00

76.97

90.00 91.00

0 77.00

0 88.00

0 89.00

0 91.01

0 92.00 94.00 0 0 95.00

09.00		JUZ, 771	150, 150	1, 500	102, 132	070, 555
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 766, 200	0	0	0	1, 766, 200
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	12, 614	0	0	0	12, 614
73.00	07300 DRUGS CHARGED TO PATIENTS	9,005,445	0	0	0	9, 005, 445
74.00	07400 RENAL DI ALYSI S	0	0	0	0	0
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0	0	0
76.00	03480 ONCOLOGY	571	0	0	0	571
76.97	07697 CARDI AC REHABI LI TATI ON	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	09000 CLINIC	179, 810	94, 523	819	175, 460	450, 612
91.00	09100 EMERGENCY	2, 549, 106	506, 905	4, 390	751, 198	3, 811, 599
91.01	04950 WOUND CARE	0	0	0	0	0
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)					0
	OTHER REIMBURSABLE COST CENTERS					
94.00	09400 HOME PROGRAM DI ALYSI S	0	0	0	0	0
95.00	09500 AMBULANCE SERVICES	0	0	0	0	0

Health Financial Systems F	RANCI SCAN HEALTH	CRAWFORDSVI LL	E	In Lie	eu of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC	-	Period: From 01/01/2021 To 12/31/2021	Worksheet B Part I Date/Time Pre 5/31/2022 8:50	pared: 6 am
		CAPI TAL REL	LATED COSTS			
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
	0	1.00	2.00	4.00	4A	
96. 00         09600         DURABLE         MEDI CAL         EQUI P-RENTED           97. 00         09700         DURABLE         MEDI CAL         EQUI P-SOLD           98. 00         09850         OTHER         REI MBURSABLE         COST         CENTERS           99. 00         09900         CMHC <td< td=""><td></td><td>0 0 0 0 0 0</td><td></td><td>0 0 0 0 0 0 0 0 0 0 0 0</td><td>0 0 0 0 0 0</td><td>97.00 98.00 99.00 99.10 100.00</td></td<>		0 0 0 0 0 0		0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0	97.00 98.00 99.00 99.10 100.00
101.00 10100 HOME HEALTH AGENCY	0	0	(	0 0	0	101.00
SPECIAL PURPOSE COST CENTERS 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	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 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 UTILIZATION REVIEW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0	(	0 0		115.00
116.00 11600 HOSPI CE	0	0		0 0		116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117 NONREI MBURSABLE COST CENTERS	53, 603, 180	5, 028, 923	43, 55	6 4, 969, 817	52, 740, 898	118.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	4, 221	15, 394	13	3 13	19, 761	190.00
191. 00 19100 RESEARCH	0	0		0 0		191.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	3, 447, 154	397, 032	3, 43	260, 669		
193. 00 19300 NONPALD WORKERS	0	0		0 0		193.00
194.0007950 OTHER NONREIMBURSABLE COST CENTERS	0	0	(	0 0	0	194.00
194.01 07951 OTHER NONREIMBURSABLE COST CENTERS	365, 834	0	(	94, 309	460, 143	194.01
194.0207952 OTHER NONREIMBURSABLE COST CENTERS	345, 233	0	(	91, 293	436, 526	194.02
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)	57, 765, 622	5, 441, 349	47, 12	B 5, 416, 101	57, 765, 622	202.00

	ALLOCATION - GENERAL SERVICE COSTS	ANCI SCAN HEALTH	Provider CC	CN: 15-0022 P	eriod: rom 01/01/2021 o 12/31/2021	Worksheet B Part I Date/Time Pre 5/31/2022 8:5	pared:
	Cost Center Description	ADMI NI STRATI VE & GENERAL	REPAI RS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	
	GENERAL SERVICE COST CENTERS	5.00	6.00	7.00	8.00	9.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	11 241 204					4.00
5.00 6.00	00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS	11, 241, 296	0				5.00 6.00
7.00	00700 OPERATION OF PLANT	511, 191	0	2, 680, 454			7.00
3.00	00800 LAUNDRY & LINEN SERVICE	39, 807	0	3, 699	212, 428		8.00
9.00	00900 HOUSEKEEPI NG	145, 547	0	36, 849	23, 551	823, 583	9.00
0.00	01000 DI ETARY	99, 829	0	98, 004	1, 428		10.00
1.00 3.00	01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON	88, 985 184, 742	0	60, 543 0	0	18, 888 0	11.00 13.00
4.00	01400 CENTRAL SERVICES & SUPPLY	118, 058	0	231, 995	784	72, 376	
5.00	01500 PHARMACY	0	0	32, 928	0		
6.00	01600 MEDICAL RECORDS & LIBRARY	145, 495	0	23, 639	0		
	INPATIENT ROUTINE SERVICE COST CENTERS	1					
30.00	03000 ADULTS & PEDIATRICS	822,044	0	256, 357	64, 419		30.00
31.00 32.00	03100 I NTENSI VE CARE UNI T 03200 CORONARY CARE UNI T	336, 603	0	72, 752 0	6, 041 0	22, 697 0	31.00 32.00
33.00	03300 BURN INTENSIVE CARE UNIT	0	0	0	0	-	33.00
34.00	03400 SURGI CAL I NTENSI VE CARE UNI T	0	0	0	0	0	34.0
40.00	04000 SUBPROVI DER – I PF	417, 808	0	124, 313	19, 816	38, 782	40.00
1.00	04100 SUBPROVIDER - IRF	0	0	0	0	0	
13.00	04300 NURSERY 04400 SKILLED NURSING FACILITY	0	0	0	0	-	43.00
14.00 15.00	04500 NURSING FACILITY	0	0	0	0	0	44.0
6.00	04600 OTHER LONG TERM CARE	0	0	0	0		46.00
	ANCI LLARY SERVICE COST CENTERS						
0.00	05000 OPERATING ROOM	1, 191, 106	0	415, 347	28, 380		50.0
1.00	05100 RECOVERY ROOM	0	0	0	0		51.0
2.00 3.00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	0	0	0	0	0	52.0 53.0
4.00	05400 RADI OLOGY-DI AGNOSTI C	643, 405	0	307, 083	7, 897	95, 802	54.0
4. 01	03630 ULTRA SOUND	36, 108	0	14, 628	0		
5. 00	05500 RADI OLOGY-THERAPEUTI C	331, 880	0	54, 926	0		
6.00	05600 RADI OI SOTOPE	0	0	34, 624	0	10, 802	
57.00 58.00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	57.00 58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	0		59.00
50.00	06000 LABORATORY	746, 636	0	98, 838	0	-	
60.01	06001 BLOOD LABORATORY	0	0	0	0	0	
51.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
52.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0		62.0
53.00 54.00	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY	0	0	0	0	0	63.00 64.00
5.00	06500 RESPI RATORY THERAPY	247, 639	0	0	1, 093		65.00
6. 00	06600 PHYSI CAL THERAPY	240, 337	0	65, 299	5, 519	20, 372	66.0
7.00	06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67.0
8.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.0
9.00 0.00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	164, 144	0	96, 558 0	0	30, 124	69.0 70.0
1.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	416, 209	0	0	0	0	71.0
2.00	07200 I MPL. DEV. CHARGED TO PATIENTS	2, 973	0	0	0	0	72.0
3.00	07300 DRUGS CHARGED TO PATIENTS	2, 122, 129	0	0	0	0	73.0
4.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.0
5.00	07500 ASC (NON-DISTINCT PART) 03480 ONCOLOGY	0 135	0	0	0	0	75.0 76.0
6.97	07697 CARDI AC REHABI LI TATI ON	0	0	0	0	0	76.9
7.00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.0
	OUTPATIENT SERVICE COST CENTERS						
8.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	
9.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0		89.0
0.00		106, 188	0	60, 794 326, 022	E3 E00	18, 966	
1.00 1.01	09100 EMERGENCY 04950 WOUND CARE	898, 211	0	326, 022 0	53, 500 0	101, 710 0	
2.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0	0	0	0	92.0
	OTHER REIMBURSABLE COST CENTERS						
4.00	09400 HOME PROGRAM DI ALYSI S	0	0	0	0	0	94.0
5.00	09500 AMBULANCE SERVICES	0	0	0	0	0	95.0
6.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.0
7.00	09700 DURABLE MEDICAL EQUIP-SOLD 09850 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	97.0 98.0
9.00	09900 CMHC	0	0	0	0	-	
	09910 CORF	0	0	0		-	

Health Financial Systems FR.	ANCI SCAN HEALTH	CRAWFORDSVI LL	E	In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider C	CN: 15-0022	Peri od:	Worksheet B	
				From 01/01/2021	Part I	
				To 12/31/2021	Date/Time Pre 5/31/2022 8:5	epared:
Cost Center Description	ADMI NI STRATI VE	MAINTENANCE &	OPERATION C	F LAUNDRY &	HOUSEKEEPI NG	
Cost Conton Description	& GENERAL	REPAI RS	PLANT	LINEN SERVICE	HOUSEREEFING	
	5.00	6.00	7.00	8.00	9.00	
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	101.00
SPECIAL PURPOSE COST CENTERS			_			
105.00 10500 KI DNEY ACQUI SI TI ON	0	(	D	0 0		105.00
106.00 10600 HEART ACQUI SI TI ON	0	(	D	0 0		106. 00
107.00 10700 LI VER ACQUI SI TI ON	0	(	D	0 0		107.00
108.00 10800 LUNG ACQUISITION	0	(	D	0 0		108.00
109.00 10900 PANCREAS ACQUISITION	0	(	D	0 0		109.00
110.00 11000 INTESTINAL ACQUISITION	0	(	D	0 0		110.00
111.00 11100 I SLET ACQUI SI TI ON	0	(	D	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	(	D	0 0		115.00
116. 00 11600 HOSPI CE	0	(	D	0 0		116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	10, 057, 209	(	2, 415, 1	98 212, 428	740, 830	118.00
NONREI MBURSABLE COST CENTERS	,		1			
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	4, 657	(	9,9	01 0		190. 00
191. 00 19100 RESEARCH	0	(	D	0 0	-	191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	968, 128	(	255, 3	55 0		192.00
193. 00 19300 NONPAI D WORKERS	0	(	D .	0 0		193.00
194.00 07950 OTHER NONREI MBURSABLE COST CENTERS	0	(	)	0 0		194.00
194.0107951 OTHER NONREI MBURSABLE COST CENTERS	108, 434	(	)	0 0		194.01
194.02 07952 OTHER NONREI MBURSABLE COST CENTERS	102, 868	(		0 0	0	194.02
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	(				201.00
202.00   TOTAL (sum lines 118 through 201)	11, 241, 296	(	2, 680, 4	54 212, 428	823, 583	J202.00

COST A	Financial Systems FR/ LLOCATION - GENERAL SERVICE COSTS	ANCI SCAN HEALTH		CN: 15-0022 Pe	riod: om 01/01/2021 12/31/2021	Worksheet B Part I Date/Time Pre 5/31/2022 8:5	2552-10 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 5.00 6.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS						1.00 2.00 4.00 5.00 6.00
7.00 8.00 9.00 10.00 11.00	00700 OPERATI ON OF PLANT 00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG 01000 DI ETARY 01100 CAFETERI A	653, 466 0	546, 028				7.00 8.00 9.00 10.00 11.00
15.00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY INPATI ENT ROUTI NE SERVI CE COST CENTERS	0 0 0	2, 956 3, 475 14, 147 C	72	927, 744 0 0	-893, 992 0	1
30.00	03000 ADULTS & PEDIATRICS	366, 655	90, 354	247, 513	0	0	30.00
31. 00 32. 00 33. 00	03100 I NTENSI VE CARE UNI T 03200 CORONARY CARE UNI T 03300 BURN I NTENSI VE CARE UNI T	108, 403 0	37, 693 C		0 0 0	0 0 0	31.00 32.00 33.00
34.00 40.00 41.00 43.00	03400 SURGI CAL INTENSI VE CARE UNI T 04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF 04300 NURSERY	0 178, 408 0 0	46, 143 C C	0 117, 272 0 0	0 0 0	0 0 0 0	40.00
44.00 45.00 46.00	04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY 04600 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS	0 0 0	C C C	0 0 0	0 0 0	0 0 0	44.00 45.00 46.00
50.00	05000 OPERATING ROOM	0	71, 962	165, 904	0	0	50.00
51.00 52.00 53.00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	0 0	C C C	0 0 0	0 0 0	0 0 0	51.00 52.00 53.00
54.00 54.01 55.00 56.00	05400 RADI OLOGY-DI AGNOSTI C 03630 ULTRA SOUND 05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE	0 0 0	76, 381 2, 122 C		0 0 0	0 0 0	54.00 54.01 55.00 56.00
57.00 58.00 59.00 60.00	05700 CT SCAN 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0 0 0			0 0 0 0	0 0 0 0	57.00 58.00 59.00
	06001 BLOOD LABORATORY 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06300 BLOOD STORING, PROCESSING & TRANS.	0 0 0	C C		0 0 0	0 0 0	61.00 62.00
64.00 65.00 66.00 67.00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0 0 0	0 32, 247 17, 223 0		0 0 0	0 0 0 0	65. 00 66. 00
68.00 69.00 70.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	0 0 0	C 14, 189 C	0 5, 907 0	0 0 0	0 0 0	68.00 69.00 70.00
72.00 73.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0 0 0	C C C		677, 253 250, 491 0 0	0 0 0 0	72. 00 73. 00
76. 00 76. 97	07500 ASC (NON-DISTINCT PART) 03480 ONCOLOGY 07697 CARDIAC REHABILITATION 07700 ALLOGENEIC STEM CELL ACQUISITION	0 0 0	C C C C	0 0 2, 354	0 0 0	0 0 0 0	76. 00 76. 97
	OUTPATIENT SERVICE COST CENTERS	· · · · ·					
	08800 RURAL HEALTH CLINIC	0	C	0	0	0	
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	C 13, 959	0	0	0	
	09100 EMERGENCY	0	96, 199		0	0	
91. 01 92. 00	04950 WOUND CARE 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) OTHER REI MBURSABLE COST CENTERS	0	C	17, 311	0	0	91.01 92.00
	09400 HOME PROGRAM DI ALYSI S	0	C	0	0	0	
	09500 AMBULANCE SERVICES 09600 DURABLE MEDICAL EQUIP-RENTED	0	C.		0	0 0	
	09700 DURABLE MEDICAL EQUIP-SOLD	0	C	o o	0	0	1
97.00 98.00	09850 OTHER REI MBURSABLE COST CENTERS	1		1	1	0	1

Health Financial Systems FRA	NCI SCAN HEALTH	CRAWFORDSVI LL	E	In Lie	u of Form CMS-2	552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider C		Period:	Worksheet B	
				From 01/01/2021 To 12/31/2021	Part I Date/Time Prep	ared
				10 12/31/2021	5/31/2022 8:56	aneu. am
Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	
			ADMI NI STRATI O	N SERVICES &		
				SUPPLY		
	10.00	11.00	13.00	14.00	15.00	
99. 10 09910 CORF	0	0		0 0		99. 10
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 1	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 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		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	074 57	0 0		116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	653, 466	519, 050	971, 57	7 927, 744	01	118.00
NONREI MBURSABLE COST CENTERS			1			
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2		0 0		190.00
	0	6, 907		0 0		191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	8	4 0		192.00 193.00
193. 00 19300 NONPALD WORKERS	0	0		0 0		
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS 194.01 07951 OTHER NONREIMBURSABLE COST CENTERS	0	11 407		0 0		194.00
194.01079510THER NONREIMBURSABLE COST CENTERS	0	11, 407				194. 01 194. 02
	0	8, 662		4		200.00
200.00Cross Foot Adjustments201.00Negative Cost Centers	0	0		0 0	-893, 992 2	
201.00 Negative cost centers 202.00 TOTAL (sum lines 118 through 201)	653, 466	546, 028	971, 66	0		
202.00 TOTAL (Sum TIMES TIS INFOUGH 201)	053, 400	346, 028	971,00	927,744	- 693, 992  2	202.00

ST ALLOCATION - GENERAL SERVICE COSTS		Provider C		Period:	Worksheet B	
				From 01/01/2021 To 12/31/2021	Part I Date/Time Pre	
Cost Center Description	MEDI CAL RECORDS & LI BRARY	Subtotal	Intern & Residents Cos & Post Stepdown Adjustments	Total t	5/31/2022 8:5	<u>6 am</u>
	16.00	24.00	25.00	26.00		
GENERAL SERVICE COST CENTERS						
00 00100 CAP REL COSTS-BLDG & FLXT 00 00200 CAP REL COSTS-MVBLE EQUI P						1.
00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.
00 00500 ADMI NI STRATI VE & GENERAL						5.
00 00600 MAI NTENANCE & REPAI RS						6.
00 00700 OPERATION OF PLANT						7.
00 00800 LAUNDRY & LINEN SERVICE 00 00900 HOUSEKEEPING						8.
. 00 01000 DI ETARY						9. 10.
. 00 01100 CAFETERI A						111.
. 00 01300 NURSI NG ADMI NI STRATI ON						13.
. 00 01400 CENTRAL SERVICES & SUPPLY						14.
	702 024					15.
00 01600 MEDI CAL RECORDS & LI BRARY I NPATI ENT ROUTI NE SERVI CE COST CENTERS	793, 924					16
00 03000 ADULTS & PEDI ATRI CS	31, 504	5, 447, 206		5, 447, 206		30
. 00 03100 I NTENSI VE CARE UNI T	13, 917	2, 161, 812	1	2, 161, 812		31
. 00 03200 CORONARY CARE UNI T	0	0		o c		32
. 00 03300 BURN INTENSIVE CARE UNIT	0	0		0 0		33
00 03400 SURGI CAL INTENSI VE CARE UNIT	11 70(	0		0 0 0 2,727,235		34
00 04000 SUBPROVI DER - I PF 00 04100 SUBPROVI DER - I RF	11, 706	2, 727, 235 0		2, 727, 235		40
00 04300 NURSERY	0	0		0 0		43
00 04400 SKILLED NURSING FACILITY	0	0		0 0		44
00 04500 NURSING FACILITY	0	0		0 0		45
00 04600 OTHER LONG TERM CARE	0	0		0 0		46
ANCI LLARY SERVICE COST CENTERS	80, 349	7, 137, 138		7, 137, 138		50
. 00 05100 RECOVERY ROOM	00, 349	7, 137, 138	1	0 7,137,138		51
. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0		52
. 00 05300 ANESTHESI OLOGY	0	0		o o		53
. 00 05400 RADI OLOGY-DI AGNOSTI C	120, 261	3, 989, 417		3, 989, 417		54
01  03630 ULTRA_SOUND 00  05500 RADI 0L0GY-THERAPEUTI C	16, 497	227, 144		0 227, 144 0 1, 844, 751		54
. 00 05600 RADI OLOGI - THERAPEUTI C	32, 463 9, 173	1, 844, 751 -172, 770		0 1, 844, 751 0 -172, 770		56
. 00 05700 CT SCAN	0	0		0 0		57
.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0		58
00 05900 CARDIAC CATHETERIZATION	0	0		0 0		59
	77, 866	4, 122, 557		0 4, 122, 557		60
01 06001 BLOOD LABORATORY 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0		0		60
. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		o o		62
. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	)	o o		63
. 00 06400 I NTRAVENOUS THERAPY	0	16, 630		0 16, 630		64
. 00 06500 RESPIRATORY THERAPY	9, 412	1, 341, 258		0 1, 341, 258		65
00 06600 PHYSI CAL THERAPY 00 06700 OCCUPATI ONAL THERAPY	16, 251	1, 384, 880		0 1, 384, 880		66
00 06800 SPEECH PATHOLOGY	0	0		0 0		68
00 06900 ELECTROCARDI OLOGY	26, 677	1, 034, 152	1	0 1, 034, 152		69
00 07000 ELECTROENCEPHALOGRAPHY	0	0		o o		70
00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	47, 749	2,907,411		2, 907, 411		71
00 07200 IMPL. DEV. CHARGED TO PATIENTS 00 07300 DRUGS CHARGED TO PATIENTS	13, 130 144, 831	279, 208 11, 272, 405	1	279, 208 11, 272, 405		72
00 07400 RENAL DIALYSIS	144, 031	11, 272, 405 N		0 11, 272, 405		74
00 07500 ASC (NON-DI STINCT PART)	0	0		o o		75
00 03480 ONCOLOGY	54	760		760		76
97 07697 CARDI AC REHABI LI TATI ON	0	2, 354		2, 354		76
00 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON	0	0	1	0 0		77
OUTPATIENT SERVICE COST CENTERS           00         08800         RURAL HEALTH CLINIC	0	0		0 0		88
00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		o o		89
00 09000 CLINIC	3, 660	654, 179		654, 179		90
. 00 09100 EMERGENCY	138, 424	5, 680, 694		5, 680, 694		91
01 04950 WOUND CARE	0	17, 311		0 17, 311		91
00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)				0		92
OTHER REIMBURSABLE COST CENTERS	0			0 0		94
. 00 09500 AMBULANCE SERVICES	0	0				94.
. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0	0		0 0		96.
	1			1		97

Health Financial Systems FR	ANCISCAN HEALTH (	CRAWFORDSVI LLE		In Lie	u of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN		Period: From 01/01/2021 To 12/31/2021	Worksheet B Part I Date/Time Prepared: 5/31/2022 8:56 am
Cost Center Description	MEDI CAL RECORDS & LI BRARY	Subtotal R	Intern & Residents Cos & Post Stepdown Adjustments	Total t	
	16.00	24.00	25.00	26.00	
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0		0 0	98.00
99.00 09900 CMHC	0	0		0 0	99.00
99. 10 09910 CORF	0	0		0 0	99.10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0		0 0	100.00
101.00 10100 HOME HEALTH AGENCY	0	0		0 0	101.00
SPECIAL PURPOSE COST CENTERS					
105.00 10500 KIDNEY ACQUISITION	0	0		0 0	105.00
106.00 10600 HEART ACQUI SI TI ON	0	0		0 0	106.00
107.00 10700 LIVER ACQUISITION	0	0		0 0	107.00
108.00 10800 LUNG ACQUI SI TI ON	0	0		0 0	108.00
109.00 10900 PANCREAS ACQUISITION	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)	793, 924	52, 075, 732		0 52, 075, 732	118.00
NONREI MBURSABLE COST CENTERS					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	37, 410		0 37, 410	
191. 00 19100 RESEARCH	0	6, 907		0 6, 907	191.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	5, 411, 525		0 5, 411, 525	192.00
193. 00 19300 NONPAI D WORKERS	0	0		0 0	193.00
194.00079500THER NONREIMBURSABLE COST CENTERS	0	0		0 0	194.00
194.0107951OTHER NONREIMBURSABLE COST CENTERS	0	579, 984		0 579, 984	194. 01
194.0207952OTHER NONREIMBURSABLE COST CENTERS	0	548, 056		0 548, 056	194. 02
200.00 Cross Foot Adjustments		0		0 0	200.00
201.00 Negative Cost Centers	0	-893, 992		0 -893, 992	201.00
202.00 TOTAL (sum lines 118 through 201)	793, 924	57, 765, 622		0 57, 765, 622	202.00

ealth Financial Systems ALLOCATION OF CAPITAL RELATED COSTS		INCI SCAN HEALTH	CRAWFORDSVILL Provider CO	CN: 15-0022 Pe	In Lie riod: om 01/01/2021 12/31/2021	Worksheet B Part II Date/Time Prepared 5/31/2022 8:56 am	
			CAPI TAL REL	ATED COSTS		575172022 8.5	
	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						
00 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1.00 2.00
00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	113, 851	986	114, 837	114, 837	4.00
00	00500 ADMI NI STRATI VE & GENERAL	0	508, 937	4, 408	513, 345	3, 267	5.00
00	00600 MAI NTENANCE & REPAI RS	0	0	0	0	0	6.00
00	00700 OPERATION OF PLANT	0	650, 940	5, 640	656, 580	2, 388	7.00
00	00800 LAUNDRY & LINEN SERVICE	0	5, 751	50	5, 801	119	8.00
00	00900 HOUSEKEEPI NG 01000 DI ETARY	0	57, 293 152, 379	496 1, 320	57, 789 153, 699	4 20	9.00 10.00
. 00	01100 CAFETERI A	0	94, 134	815	94, 949	2, 778	11.00
. 00	01300 NURSI NG ADMI NI STRATI ON	0	0	0.0	0	2, 101	13.00
. 00	01400 CENTRAL SERVICES & SUPPLY	0	360, 710	3, 124	363, 834	649	14.00
. 00	01500 PHARMACY	0	51, 196	443	51, 639	3, 019	15.00
. 00	01600 MEDI CAL RECORDS & LI BRARY	0	36, 754	318	37, 072	0	16.00
. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	0	398, 588	3, 452	402, 040	13, 385	30.00
. 00	03100 I NTENSI VE CARE UNI T	0	113, 116	3, 452 980	114, 096	6, 914	31.00
. 00	03200 CORONARY CARE UNI T	0	0	0	0	0, , 11	32.00
. 00	03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
. 00	03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
. 00	04000 SUBPROVIDER - IPF	0	193, 284	1, 674	194, 958	7, 839	40.00
. 00	04100 SUBPROVI DER – I RF 04300 NURSERY	0	0	0	0	0	41.00
. 00	04400 SKI LLED NURSI NG FACI LI TY		0	0	0	0	43.00 44.00
. 00	04500 NURSI NG FACI LI TY	0	0	0	0	0	45.00
. 00	04600 OTHER LONG TERM CARE	0	0	0	0	0	46.00
	ANCILLARY SERVICE COST CENTERS						
. 00	05000 OPERATING ROOM	0	645, 793	5, 593	651, 386	13, 608	50.00
. 00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
. 00	05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	0	0	0	0	0	52.00
. 00	05400 RADI OLOGY-DI AGNOSTI C	0	477, 458	4, 135	481, 593	15, 487	53.00 54.00
. 01	03630 ULTRA SOUND	0	22, 744	197	22, 941	330	54.00
. 00	05500 RADI OLOGY-THERAPEUTI C	0	85, 399	740	86, 139	0	55.00
. 00	05600 RADI OI SOTOPE	0	53, 834	466	54, 300	0	56.00
. 00	05700 CT SCAN	0	0	0	0	0	57.00
. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0	0	0	0	58.00
0. 00 0. 00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0	0 153, 676	1, 331	155, 007	0	59.00 60.00
0.01	06001 BLOOD LABORATORY	0	133, 070	1, 331	133, 007	0	
. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	_		_	0	-	61.00
. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
. 00	06400 I NTRAVENOUS THERAPY	0	0	0	0	0	64.00
. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0	0 101, 528	879	0 102, 407	4, 951 5, 007	65.00 66.00
. 00	06700 OCCUPATI ONAL THERAPY	0	101, 520	0/7	102, 407	3,007	67.00
. 00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
. 00	06900 ELECTROCARDI OLOGY	0	150, 130	1, 300	151, 430	3, 862	69.00
. 00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
. 00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0	0	0	0	71.00
. 00 . 00	07200 I MPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	72.00 73.00
. 00	07300 DRUGS CHARGED TO PATTENTS		0	0	0	0	74.00
. 00	07500 ASC (NON-DI STI NCT PART)	0	0	0	0	0	75.00
. 00	03480 ONCOLOGY	0	0	0	0	0	76.00
. 97	07697 CARDI AC REHABI LI TATI ON	0	0	0	0	0	76.97
. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	0	0		0	0	
. 00 . 00	08800 FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	0	88.00 89.00
0.00	09000 CLINIC	0	94, 523	819	95, 342	3, 720	90.00
. 00	09100 EMERGENCY	0	506, 905	4, 390	511, 295	15, 926	91.00
. 01	04950 WOUND CARE	0	0	0	0	0	91. 0 <sup>-</sup>
. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
00	OTHER REIMBURSABLE COST CENTERS						
. 00	09400 HOME PROGRAM DI ALYSI S	0	0	0	0	0	94.00
. 00	09500 AMBULANCE SERVICES	∩			OI		95.00

Health Financial Systems FR/	ANCI SCAN HEALTH		F	Inlie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS	ANGI SCAN TILALITI	Provi der CO		Peri od:	Worksheet B	2332-10
ALLOCATION OF CALLTAL RELATED COSTS				From 01/01/2021	Part II	
				To 12/31/2021	Date/Time Pre	pared:
					5/31/2022 8:5	<u>6 am</u>
		CAPI TAL REL	LATED COSTS			
Cost Center Description	Directly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
	Assigned New				BENEFI TS	
	Capi tal				DEPARTMENT	
	Related Costs					
	0	1.00	2.00	2A	4.00	
97. 00 09700 DURABLE MEDI CAL EQUI P-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	
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						
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 ACQUI SI TI ON	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)	0	5, 028, 923	43, 55	6 5, 072, 479	105, 374	118.00
NONREI MBURSABLE COST CENTERS						1
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	15, 394	13	3 15, 527	0	190.00
191. 00 19100 RESEARCH	0	0		0 0	0	191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	397, 032	3, 43	9 400, 471	5, 527	192.00
193. 00 19300 NONPALD WORKERS	0	0		0 0	0	193.00
194.0007950 OTHER NONREIMBURSABLE COST CENTERS	0	0		0 0		194.00
194.0107951 OTHER NONREIMBURSABLE COST CENTERS	0	0		0 0	2,000	194.01
194.0207952 OTHER NONREI MBURSABLE COST CENTERS	0	0		0 0		194.02
200.00 Cross Foot Adjustments				0		200.00
201.00 Negative Cost Centers		0		0 0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	0	5, 441, 349	47, 12	8 5, 488, 477	114, 837	202.00
				1		

	TION OF CAPITAL RELATED COSTS	ANCI SCAN HEALTH	Provi der	· CC	N: 15-0022	F	Period: From 01/01/2021 To 12/31/2021	u of Form CMS- Worksheet B Part II Date/Time Pre 5/31/2022 8:5	pared:
	Cost Center Description	ADMI NI STRATI VE & GENERAL	REPAI RS	. &	OPERATI ON PLANT	OF	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	
	GENERAL SERVICE COST CENTERS	5.00	6.00		7.00		8.00	9.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT								1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP								2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT								4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	516, 612							5.00
6.00 7.00	00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT	0 23, 493		0	682,	161			6.00 7.00
8.00	00800 LAUNDRY & LINEN SERVICE	1, 829		0		942			8.00
9.00	00900 HOUSEKEEPING	6, 689		0		382		74, 828	
10.00	01000 DI ETARY	4, 588		0	24,	952	58	2, 778	10.00
11.00	01100 CAFETERI A	4, 090		0	15,	415	0	1, 716	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	8, 490		0		0	-	0	
14.00	01400 CENTRAL SERVICES & SUPPLY	5, 426		0		067		6, 576	
15.00 16.00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	0 6, 687		0		384 019		933 670	
10.00	INPATIENT ROUTINE SERVICE COST CENTERS	0,007		<u> </u>	0,	019	0	070	10.00
30.00	03000 ADULTS & PEDIATRICS	37, 779		0	65,	270	2, 635	7, 266	30.00
31.00	03100 I NTENSI VE CARE UNI T	15, 469		0		523		2,062	1
32.00	03200 CORONARY CARE UNI T	0		0		0	0 0	0	32.00
33.00	03300 BURN INTENSIVE CARE UNIT	0		0		0	-	0	
34.00	03400 SURGI CAL I NTENSI VE CARE UNI T	0		0	0.4	0	-	0	
40.00 41.00	04000 SUBPROVIDER - IPF 04100 SUBPROVIDER - IRF	19, 201		0	31,	651	811	3, 524	1
41.00	04300 NURSERY	0		0		0		0	1
44.00	04400 SKILLED NURSING FACILITY	0		0		0	0	0	
45.00	04500 NURSING FACILITY	0		0		0	0	0	1
46.00	04600 OTHER LONG TERM CARE	0		0		0	0 0	0	46.00
	ANCILLARY SERVICE COST CENTERS						1		
50.00	05000 OPERATING ROOM	54, 740		0	105,			11, 773	
51.00 52.00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	0		0		0		0	
52.00 53.00	05300 ANESTHESI OLOGY	0		0		0	0	0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	29, 569		0	78.	185	-	8, 704	
54.01	03630 ULTRA SOUND	1, 659		0		724		415	
55.00	05500 RADI OLOGY-THERAPEUTI C	15, 252		0	13,	984	0	1, 557	55.00
56.00	05600 RADI OI SOTOPE	0		0	8,	815		981	56.00
57.00	05700 CT SCAN	0		0		0		0	
58.00 59.00	05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION	0		0		0	, s	0	
60.00	06000 LABORATORY	34, 314		0	25	165	-	2, 802	
60.01	06001 BLOOD LABORATORY	01,011		o	20,	0	0	2,002	1
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY								61.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0		0		0	0	0	
	06300 BLOOD STORING, PROCESSING & TRANS.	0		0		0	0	0	
		11 201		0		0	0	0	
65.00 66.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	11, 381 11, 045		0	16	626	45 226	0 1, 851	
67.00	06700 OCCUPATI ONAL THERAPY	11,045		0	10,	020	0	1, 851	1
68.00	06800 SPEECH PATHOLOGY	0		0		0	0	0	
69.00	06900 ELECTROCARDI OLOGY	7, 544		0	24,	584	0	2, 737	69.00
	07000 ELECTROENCEPHALOGRAPHY	0		0		0	0	0	
	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	19, 128		0		0	0	0	
	07200 IMPL. DEV. CHARGED TO PATIENTS	137		0		0	0	0	
	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DI ALYSI S	97, 518		0		0	0	0	
	07500 ASC (NON-DISTINCT PART)	0		0		0		0	1
76.00	03480 ONCOLOGY	6		0		0		0	1
	07697 CARDI AC REHABI LI TATI ON	0		0		0	) Ö	0	1
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION	0		0		0	0	0	77.00
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800 RURAL HEALTH CLINIC	0		0		0		0	1
	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC	0 4, 880		0	15,	0 478	-	0 1, 723	
90.00 91.00	09100 EMERGENCY	4, 880		0	83,			9, 241	1
91.00 91.01	04950 WOUND CARE	41,280		0	03,	0	) 2,109	9, 241	1
	09200 OBSERVATION BEDS (NON-DISTINCT PART)								92.00
	OTHER REIMBURSABLE COST CENTERS								
	09400 HOME PROGRAM DI ALYSI S	0		0		0	0	0	
	09500 AMBULANCE SERVICES	0		0		0	0	0	
	09600 DURABLE MEDICAL EQUIP-RENTED	0		0		0	0	0	
97.00 98.00	09700 DURABLE MEDICAL EQUIP-SOLD 09850 OTHER REIMBURSABLE COST CENTERS	0		0		0		0	
		0				0			
99.00	09900 CMHC	()		0			) ()	0	99.00

Health Financial Systems FR	ANCISCAN HEALTH	CRAWFORDSVIL	LLE		In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der	CCN:		eriod:	Worksheet B	
					rom 01/01/2021 0 12/31/2021	Part II	narod
				1	J 12/31/2021	Date/Time Pre 5/31/2022 8:5	6 am
Cost Center Description	ADMI NI STRATI VE	MAI NTENANCE	& 0	PERATION OF	LAUNDRY &	HOUSEKEEPI NG	
	& GENERAL	REPAI RS		PLANT	LINEN SERVICE		
	5.00	6.00		7.00	8.00	9.00	
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		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		108.00
109.00 10900 PANCREAS ACQUISITION	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	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)	462, 194		0	614, 925	8, 691	67, 309	118.00
NONREI MBURSABLE COST CENTERS		1					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	214		0	2, 521	0		190.00
191. 00 19100 RESEARCH	0		0	0	0		191.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	44, 493		0	65, 015	0		192.00
193.00 19300 NONPALD WORKERS	0		0	0	0		193.00
194.00079500THER NONREIMBURSABLE COST CENTERS	0		0	0	0		194.00
194.01079510THER NONREIMBURSABLE COST CENTERS	4, 983		0	0	0		194.01
194.02079520THER NONREIMBURSABLE COST CENTERS	4, 728		0	0	0	0	194. 02
200.00 Cross Foot Adjustments							200.00
201.00 Negative Cost Centers	0		0	0	0		201.00
202.00  TOTAL (sum lines 118 through 201)	516, 612		0	682, 461	8, 691	74, 828	202.00

	Financial Systems FRA	ANCI SCAN HEALTH	Provider C	CN: 15-0022 Pe	eriod: com 01/01/2021	u of Form CMS-: Worksheet B Part II Date/Time Pre	pared:
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	5/31/2022 8:5 PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
1.00 2.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00	GENERAL SERVICE COST CENTERS OD100 CAP REL COSTS-BLDG & FIXT OD200 CAP REL COSTS-MVBLE EQUIP O0400 EMPLOYEE BENEFITS DEPARTMENT OD500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS O0700 OPERATION OF PLANT O0800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA	186, 095 0	118, 948				1.00 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	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY	0 0 0	644 757 3, 082 0	1	436, 342 0 0	67, 057 0	13.00 14.00 15.00 16.00
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	104, 417	19, 683	2, 862	0	0	30.00
31.00 32.00 33.00	03100 I NTENSI VE CARE UNI T 03200 CORONARY CARE UNI T 03300 BURN I NTENSI VE CARE UNI T	30, 871 0	8, 211 0 0	1, 565	0 0 0	0 0 0	31.00 32.00 33.00
34.00 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 50, 807 0 0	0 10, 052 0 0	0 1, 356 0 0	0 0 0 0	0 0 0 0	34.00 40.00 41.00 43.00
44. 00 45. 00 46. 00	04400 SKI LLED NURSI NG FACI LI TY 04500 NURSI NG FACI LI TY 04600 OTHER LONG TERM CARE	0 0 0	0 0	0 0 0	0 0 0	0 0 0	44.00 45.00 46.00
50.00	ANCI LLARY SERVI CE COST CENTERS 05000 OPERATI NG ROOM	0	15, 676	1, 918	0	0	50.00
51.00 52.00 53.00 54.00 54.01 55.00 56.00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 03630 ULTRA SOUND 05500 RADI OLOGY-THERAPEUTI C 05600 RADI OLOGY-THERAPEUTI C		0 0 16, 639 462 0	0			51.00 52.00 53.00 54.00 54.01 55.00 56.00
57.00 58.00 59.00 60.00 60.01	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION 06000 LABORATORY 06001 BLOOD LABORATORY	0 0 0 0		0 0 0 0	0 0 0 0 0	0 0 0 0 0 0	57.00 58.00 59.00 60.00 60.01
61.00 62.00 63.00 64.00 65.00 66.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY 06500 RESPIRATORY THERAPY 06600 PHYSICAL THERAPY	0 0 0 0	0 0 0 7, 025 3, 752		0 0 0 0	0 0 0 0	61.00 62.00 63.00 64.00 65.00 66.00
67.00 68.00 69.00 70.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	000000000000000000000000000000000000000	0 0 3, 091 0	0 0 68 0	0 0 0 318, 530	0 0 0 0 0	67.00 68.00 69.00 70.00 71.00
72.00 73.00 74.00	07200 IMPL. DEV. CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART)	0 0 0 0		0 0 0 0	117, 812 0 0 0	0 0 0 0 0	72.00 73.00 74.00 75.00
76. 97 77. 00	07697 CARDI AC REHABI LI TATI ON 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON OUTPATI ENT SERVI CE COST CENTERS	0000	000000000000000000000000000000000000000	0 27 0	0 0 0	000000	76.00 76.97 77.00
89. 00 90. 00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC 09100 EMERGENCY 04950 WOUND CARE 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0 0 3, 041 20, 956 0	0 0 2, 949 200		0 0 0 0	88.00 89.00 90.00 91.00 91.01 92.00
95.00 96.00		000000000000000000000000000000000000000	000000000000000000000000000000000000000	0 0 0	000000000000000000000000000000000000000	0 0 0 0	94.00 95.00 96.00 97.00
97.00 98.00 99.00	09900 DURABLE MEDICAL EQUIP-SOLD 09850 OTHER REIMBURSABLE COST CENTERS 09900 CMHC	0	0	0	0 0 0	0	97.00 98.00 99.00

Health Financial Systems FRA	NCI SCAN HEALTH	CRAWFORDSVI LL	.E	In Lie	u of Form CMS-25	52-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider C		Period: From 01/01/2021 To 12/31/2021	Worksheet B Part II Date/Time Prepa 5/31/2022 8:56	
Cost Center Description	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI C	CENTRAL N SERVI CES & SUPPLY	PHARMACY	
	10.00	11.00	13.00	14.00	15.00	
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 1	00.00
101.00 10100 HOME HEALTH AGENCY	0	0	)	0 0	0 1	01.00
SPECIAL PURPOSE COST CENTERS						
105.00 10500 KIDNEY ACQUISITION	0	0	)	0 0	0 1	05.00
106. 00 10600 HEART ACQUI SI TI ON	0	0	)	0 0	0 1	06.00
107.00 10700 LIVER ACQUISITION	0	0	)	0 0	0 1	07.00
108.00 10800 LUNG ACQUISITION	0	0	)	0 0	0 1	08.00
109.00 10900 PANCREAS ACQUISITION	0	0	)	0 0	0 1	09.00
110.00 11000 INTESTINAL ACQUISITION	0	0	)	0 0	0 1	10.00
111.00 11100 I SLET ACQUI SI TI ON	0	0	)	0 0	0 1	11.00
113.00 11300 INTEREST EXPENSE					1	13.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF					1	14.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	)	0 0	0 1	15.00
116. 00 11600 HOSPI CE	0	0	)	0 0	0 1	16.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	186, 095	113, 071	11, 23	436, 342	0 1	18.00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0		90.00
191. 00 19100 RESEARCH	0	1, 505		0 0		91.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		1 0		92.00
193.00 19300 NONPALD WORKERS	0	0		0 0		93.00
194.00079500THER NONREIMBURSABLE COST CENTERS	0	0		0 0		94.00
194.0107951OTHER NONREIMBURSABLE COST CENTERS	0	2, 485		0 0		94.01
194.0207952 OTHER NONREIMBURSABLE COST CENTERS	0	1, 887	1	0 0		94.02
200.00 Cross Foot Adjustments						00.00
201.00 Negative Cost Centers	0	0		0 0	67, 057 2	
202.00   TOTAL (sum lines 118 through 201)	186, 095	118, 948	11, 23	436, 342	67, 057 2	02.00

	Financial Systems FR. ATION OF CAPITAL RELATED COSTS	ANCI SCAN HEALTH		CN: 15-0022 P	eriod: rom 01/01/2021	u of Form CMS- Worksheet B Part II	-2002-11
				T		Date/Time Pre	epared:
	Cost Center Description	MEDI CAL RECORDS & LI BRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	5/31/2022 8:5	
		16.00	24.00	25.00	26.00		
	GENERAL SERVICE COST CENTERS	1		1			
1.00 2.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMI NI STRATI VE & GENERAL						5.00
6.00	00600 MAI NTENANCE & REPAI RS						6.00
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00 10.00	00900 HOUSEKEEPI NG 01000 DI ETARY						9.00
11.00	01100 CAFETERI A						11.00
13.00	01300 NURSI NG ADMI NI STRATI ON						13.00
14.00	01400 CENTRAL SERVICES & SUPPLY						14.00
	01500 PHARMACY						15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	50, 448					16.00
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	2,001	657, 338	0	657, 338		30. 00
31.00	03100 I NTENSI VE CARE UNI T	884	198, 842		198, 842		31.00
32.00	03200 CORONARY CARE UNI T	0	C		0		32.00
33.00	03300 BURN INTENSIVE CARE UNIT	0	C	-	0		33.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0	C	0	0		34.00
40.00	04000 SUBPROVIDER - IPF	743	320, 942		320, 942		40.00
41.00 43.00	04100 SUBPROVIDER – IRF 04300 NURSERY	0	C	l i	0		41.00
44.00	04400 SKILLED NURSING FACILITY	0	C		0		44.00
45.00	04500 NURSING FACILITY	0	C	0	0		45. OC
46.00	04600 OTHER LONG TERM CARE	0	C	0 0	0		46.00
	ANCI LLARY SERVICE COST CENTERS	5 400			0/4.447		-
50.00 51.00	05000 OPERATING ROOM 05100 RECOVERY ROOM	5, 103 0	861, 117 C		861, 117 0		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	C		0		52.00
53.00	05300 ANESTHESI OLOGY	0	C	0	0		53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	7,638	638, 234		638, 234		54.00
54.01	03630 ULTRA SOUND	1,048	30, 579		30, 579		54.01
55.00 56.00	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE	2, 062 583	118, 994 64, 679		118, 994 64, 679		55.00
57.00	05700 CT SCAN	0	04,079	0	04,077		57.00
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	C	0	0		58. OC
59.00	05900 CARDI AC CATHETERI ZATI ON	0	C	0	0		59.00
	06000 LABORATORY	4, 946	222, 234		222, 234		60.00
	06001 BLOOD LABORATORY	0	C	0	0		60.01
62.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	C	0	0		61.00 62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	C	0 0	0		63.00
64.00	06400 I NTRAVENOUS THERAPY	0	192		192		64.00
65.00		598	24,000		24, 000		65.00
66.00	06600 PHYSI CAL THERAPY	1,032	141, 946	0	141, 946		66.00
67.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0			0		67.00 68.00
	06900 ELECTROCARDI OLOGY	1, 694	195, 010	-	195, 010		69.00
	07000 ELECTROENCEPHALOGRAPHY	0	C	0	0		70.00
		3, 033	340, 691		340, 691		71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS	834	118, 783		118, 783		72.00
	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	9, 222	106, 740	0	106, 740		73.00
		0	ſ	0 0	0		75.00
	03480 ONCOLOGY	3	9	0	9		76.00
76.97	07697 CARDI AC REHABI LI TATI ON	0	27		27		76.97
77.00		0	C	0 0	0		77.00
00 00	OUTPATIENT SERVICE COST CENTERS		-	0			00 00
	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	C C		0		88.00 89.00
		232	124, 416	0	124, 416		90.00
91.00	09100 EMERGENCY	8, 792	695, 635		695, 635		91.00
91.01	04950 WOUND CARE	0	200		200		91.01
92.00	09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)			0			92.00
01 00	OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DI ALYSI S	0		0	0		94.00
	09500 AMBULANCE SERVICES	0	C C		0		94.00
	10,000 Million Delivinoed			0	0		
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	0	C	0	0		96.00

Health Financial Systems FR/	ANCISCAN HEALTH (	CRAWFORDSVI LLE		In Lie	u of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15	F	eriod: rom 01/01/2021 o 12/31/2021	Worksheet B Part II Date/Time Prepared: 5/31/2022 8:56 am
Cost Center Description	MEDI CAL RECORDS & LI BRARY	Resid & St	itern & lents Cost Post epdown ustments	Total	
	16.00	24.00	25.00	26.00	
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	C	0	98.00
99. 00 09900 CMHC	0	0	C	0	99.00
99. 10 09910 CORF	0	0	C	0	99.10
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	0	0	C	0	100.00
101.00 10100 HOME HEALTH AGENCY	0	0	C	0	101.00
SPECIAL PURPOSE COST CENTERS					
105.00 10500 KIDNEY ACQUISITION	0	0	C	0	105.00
106.00 10600 HEART ACQUI SI TI ON	0	0	C	0	106.00
107.00 10700 LIVER ACQUISITION	0	0	C	0	107.00
108.00 10800 LUNG ACQUISITION	0	0	C	0	108.00
109.00 10900 PANCREAS ACQUI SI TI ON	0	0	C	0	109.00
110.00 11000 INTESTINAL ACQUISITION	0	0	C	0	110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0	C	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	C	0	115.00
116. 00 11600 HOSPI CE	0	0	C	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	50, 448	4, 860, 608	C	4, 860, 608	118.00
NONREI MBURSABLE COST CENTERS					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	18, 543	C		
191. 00 19100 RESEARCH	0	1, 505	C	1, 505	191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	522, 745	C	522, 745	192.00
193.00 19300 NONPALD WORKERS	0	0	C	0	193.00
194.00079500THER NONREIMBURSABLE COST CENTERS	0	0	C	0	194.00
194.0107951 OTHER NONREI MBURSABLE COST CENTERS	0	9, 468	C	9, 468	194. 01
194.0207952 OTHER NONREI MBURSABLE COST CENTERS	0	8, 551	C	8, 551	194. 02
200.00 Cross Foot Adjustments		0	C	0	200.00
201.00 Negative Cost Centers	0	67, 057	C	67, 057	201.00
202.00 TOTAL (sum lines 118 through 201)	50, 448	5, 488, 477	C	5, 488, 477	202.00

 FRANCI SCAN HEALTH CRAWFORDSVILLE
 In Lieu of Form CMS-2552-10

 Provider CCN: 15-0022
 Period: From 01/01/2021
 Worksheet B-1

	ALLUCATION - STATISTICAL BASIS	1		F	From 01/01/2021 0 12/31/2021	Date/Time Pre 5/31/2022 8:50	
	Cost Center Description	CAPI TAL REL BLDG & FI XT (SQUARE FEET)	ATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		1.00	2.00	4.00	5A	5.00	
	GENERAL SERVICE COST CENTERS			-			
1.00	00100 CAP REL COSTS-BLDG & FIXT	125, 840	105 0.10				1.00
2.00 4.00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT	2,633	125, 840 2, 633	14, 256, 354	1		2.00 4.00
4.00 5.00	00500 ADMI NI STRATI VE & GENERAL	11,770	2, 033	405, 573		47, 703, 035	5.00
6.00	00600 MAINTENANCE & REPAIRS	0	0	400, 07	0	0	6.00
7.00	00700 OPERATION OF PLANT	15, 054	15, 054	296, 422	2 0	2, 169, 263	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	133	133	14, 725	5 0	168, 922	8.00
9.00	00900 HOUSEKEEPI NG	1, 325	1, 325	516		617, 636	9.00
10.00	01000 DI ETARY 01100 CAFETERI A	3, 524	3, 524	2, 433		423, 630	10.00
11.00 13.00	01300 NURSI NG ADMI NI STRATI ON	2, 177	2, 177 0	344, 842 260, 841		377, 612 783, 963	11.00 13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	8, 342	8, 342	80, 570		500, 984	14.00
15.00	01500 PHARMACY	1, 184	1, 184	374, 76		0	15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	850	850	(	00	617, 415	16.00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	0.010	0.010	1 //1 ///		2 400 202	20.00
30.00 31.00	03100 INTENSIVE CARE UNIT	9, 218 2, 616	9, 218 2, 616	1, 661, 668 858, 290		3, 488, 383 1, 428, 390	30.00 31.00
32.00	03200 CORONARY CARE UNIT	2,010	2,010	030, 270		1, 420, 370	32.00
33.00	03300 BURN INTENSIVE CARE UNIT	0	0	(	-	0	33.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0	0	(	0 0	0	34.00
40.00	04000 SUBPROVI DER - I PF	4, 470	4, 470	973, 239	9 0	1, 772, 987	40.00
41.00 43.00	04100 SUBPROVIDER - IRF	0	0		0	0	41.00 43.00
43.00	04300 NURSERY 04400 SKI LLED NURSI NG FACI LI TY	0	0			0	43.00
45.00	04500 NURSING FACILITY	0	0	(	0 0	0	45.00
46.00	04600 OTHER LONG TERM CARE	0	0	(	0 0	0	46.00
	ANCI LLARY SERVI CE COST CENTERS	· · · · · · · · · · · · · · · · · · ·			-		
50.00	05000 OPERATING ROOM 05100 RECOVERY ROOM	14, 935	14, 935	1, 689, 362			50.00
51.00 52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0			0	51.00 52.00
53.00	05300 ANESTHESI OLOGY	0	0	(	0 0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	11,042	11, 042	1, 922, 603	3 0	2, 730, 319	54.00
54.01	03630 ULTRA SOUND	526	526	41, 025		153, 225	54.01
55.00 56.00	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE	1, 975 1, 245	1, 975 1, 245		-	1, 408, 347 0	55.00 56.00
57.00	05700 CT SCAN	1, 243	1, 245	(	0 227, 307	0	57.00
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0	(	0	0	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	(	0 0	0	59.00
60.00		3, 554	3, 554	(	-	3, 168, 382	60.00
60. 01 61. 00	06001 BLOOD LABORATORY 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	(	0	0	60. 01 61. 00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	(	0 0	0	62.00
63.00	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
65.00 66.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0	0	614, 62		1, 050, 867	65.00 66.00
	06700 OCCUPATI ONAL THERAPY	2, 348	2, 348	621, 565		1, 019, 879 0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	(	0 0	0	68.00
	06900 ELECTROCARDI OLOGY	3, 472	3, 472	479, 41 <sup>-</sup>	0	696, 553	69.00
	07000 ELECTROENCEPHALOGRAPHY	0	0	(	0 0	0	70.00
	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0	(	0	1, 766, 200	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0			12, 614 9, 005, 445	72.00 73.00
	07400 RENAL DIALYSIS	0	0	(	0 0	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	(	0 0	0	75.00
	03480 ONCOLOGY	0	0	(	0 0	571	76.00
76.97	07697 CARDIAC REHABILITATION	0	0		-	0	76.97
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION OUTPATIENT SERVICE COST CENTERS	0	0		<u>ں</u> 0	0	77.00
88.00	08800 RURAL HEALTH CLINIC	0	0	(	0 0	0	88.00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	(	, v	0	89.00
		2, 186	2, 186			450, 612	90.00
91.00 91.01	09100 EMERGENCY 04950 WOUND CARE	11, 723	11, 723	1, 977, 319		3, 811, 599 0	91.00 91.01
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0			0	91.01
	OTHER REIMBURSABLE COST CENTERS	· 1					
	09400 HOME PROGRAM DI ALYSI S	0	0	(			94.00
95.00	09500 AMBULANCE SERVICES	0	0	(	0 0	0	95.00

ST ALLOCATION - STATISTICAL BASIS		Provider CC		Period: From 01/01/2021	Worksheet B-1	
				To 12/31/2021	Date/Time Pre 5/31/2022 8:5	
	CAPI TAL REI	LATED COSTS	I		0/01/2022 0.0	
Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Reconciliation	ADMI NI STRATI VE	
cost center bescription	(SQUARE FEET)	(SQUARE FEET)	BENEFITS	Reconciliation	& GENERAL	
	(000)	(000,000,000,000,000,000,000,000,000,00	DEPARTMENT		(ACCUM. COST)	
			(GROSS			
			SALARI ES)			
	1.00	2.00	4.00	5A	5.00	
. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0 0	0	
. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	-		0 0	0	1
. 00 09850 OTHER REIMBURSABLE COST CENTERS	0	0		0 0	0	
. 00 09900 CMHC	0	0		0 0	0	1
. 10  09910 CORF 0. 00 10000 I&R_SERVICES-NOT_APPRVD_PRGM	0	0		0 0	0	99 100
1.00 10100 HOME HEALTH AGENCY	0	0		0 0		100
SPECIAL PURPOSE COST CENTERS	0	0		0 0	0	
5. 00 10500 KI DNEY ACQUI SI TI ON	0	0		0 0	0	105
6. 00 10600 HEART ACQUI SI TI ON	0	0		0 0		106
7. 00 10700 LIVER ACQUISITION	0	0		0 0		107
8. 00 10800 LUNG ACQUI SI TI ON	0	0		0 0		108
9. 00 10900 PANCREAS ACQUI SI TI ON	0	0		0 0		109
0.00 11000 INTESTINAL ACQUISITION	0	0		0 0	0	110
1.00 11100 I SLET ACQUI SI TI ON	0	0		0 0	0	111
3.00 11300 INTEREST EXPENSE						113
4.00 11400 UTI LI ZATI ON REVI EW-SNF						114
5.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0		0 0		115
6. 00 11600 HOSPI CE	0	0		0 0		116
8.00 SUBTOTALS (SUM OF LINES 1 through 117)	116, 302	116, 302	13, 081, 64	0 -10, 062, 587	42, 678, 311	118
NONREI MBURSABLE COST CENTERS	05/	05/			10 7/1	1400
0.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	356	356		3 0		
1. 00 19100 RESEARCH 2. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	9, 182	Ŭ	686, 13	0 0	4, 108, 294	191
3. 00 19300 NONPALD WORKERS	9, 182	9, 182		0 0		192
4. 00 07950 OTHER NONREI MBURSABLE COST CENTERS	0	0		0 0		194
4. 01 07951 OTHER NONREI MBURSABLE COST CENTERS	0	0	248, 24	0	460, 143	
4. 02 07952 OTHER NONREI MBURSABLE COST CENTERS	0	0	240, 30		436, 526	
0.00 Cross Foot Adjustments		Ū	210,00		100, 020	200
1.00 Negative Cost Centers						201
2.00 Cost to be allocated (per Wkst. B,	5, 441, 349	47, 128	5, 416, 10	1	11, 241, 296	202
Part I)						
3.00 Unit cost multiplier (Wkst. B, Part I)	43. 240218	0. 374507	0.37990		0. 235652	
4.00 Cost to be allocated (per Wkst. B, Part II)			114, 83	7	516, 612	204
5.00 Unit cost multiplier (Wkst. B, Part			0. 00805	5	0. 010830	205
6.00 NAHE adjustment amount to be allocated						206
(per Wkst. B-2) 7.00 NAHE unit cost multiplier (Wkst. D,						207
Parts III and IV)						201

	Financial Systems FR. ALLOCATION - STATISTICAL BASIS	ANCI SCAN HEALTH	CRAWFORDSVILL	CN: 15-0022 P	eriod:	u of Form CMS-2 Worksheet B-1	
					rom 01/01/2021 o 12/31/2021	Date/Time Pre 5/31/2022 8:5	
	Cost Center Description	MAI NTENANCE & REPAI RS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY)	HOUSEKEEPI NG (SQUARE FEET)	DI ETARY (MEALS SERVED)	
		6.00	7.00	8.00	9.00	10.00	
4 00	GENERAL SERVICE COST CENTERS		1		1		1 4 00
1.00 2.00 4.00 5.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL						1.00 2.00 4.00 5.00
6.00 7.00 8.00 9.00	00600 MAI NTENANCE & REPAI RS 00700 OPERATI ON OF PLANT 00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	111, 437 15, 054 133 1, 325	1, 325	230, 625 25, 568	94, 925		6.00 7.00 8.00 9.00
10. 00 11. 00 13. 00	01000 DI ETARY 01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON	3, 524 2, 177 0	3, 524 2, 177 0	1, 550 C		31, 280 0 0	11.00
14. 00 15. 00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	8, 342 1, 184	8, 342 1, 184		1, 184	0	14.00 15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	850	850	C	850	0	16.00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 I NTENSI VE CARE UNI T	9, 218 2, 616				17, 551 5, 189	•
32.00 33.00	03200 CORONARY CARE UNI T 03300 BURN I NTENSI VE CARE UNI T	0	0	C	0	0	32.00
34.00 40.00	03400 SURGI CAL INTENSI VE CARE UNI T 04000 SUBPROVI DER - I PF	0 4, 470	0 4, 470	C 21, 513	0 4, 470	0 8, 540	34.00
41.00 43.00	04100 SUBPROVIDER - IRF 04300 NURSERY	0	0	C	0	0	41.00
44.00 45.00	04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY	0	0		0	0	44.00
46.00	04600 OTHER LONG TERM CARE ANCI LLARY SERVICE COST CENTERS	0	0	C	0	0	46.00
50. 00 51. 00	05000 OPERATING ROOM 05100 RECOVERY ROOM	14, 935 0	14, 935 0	30, 811 C	14, 935 0	0	50.00 51.00
52.00 53.00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	0	0		0	0	
54. 00 54. 01	05400 RADI OLOGY-DI AGNOSTI C 03630 ULTRA SOUND	11, 042 526	11, 042 526	8, 573 C		0	
55.00 56.00	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE	1, 975 1, 245	1, 975 1, 245		1, 975 1, 245	0	
57.00 58.00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	C C	0 0	0	57.00 58.00
59. 00 60. 00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0 3, 554	0 3, 554	C C	0 3, 554	0	59.00 60.00
	06001 BLOOD LABORATORY 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	C	0	0	61.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	C C	0	0	63.00
64.00 65.00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	0	0	C 1, 187		0	64.00 65.00
66. 00 67. 00	06600 PHYSICAL THERAPY 06700 OCCUPATIONAL THERAPY	2, 348 0	2, 348 0	5, 992 C	2, 348 0	0	66.00 67.00
68.00 69.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0 3, 472	0 3, 472		0 3, 472	0	
71.00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	71.00
73.00	07200 I MPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	73.00
75.00	07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART)				0	0	75.00
76.97	03480 ONCOLOGY 07697 CARDIAC REHABILITATION	0	0		0	0	76.97
	07700 ALLOGENEIC STEM CELL ACQUISITION OUTPATIENT SERVICE COST CENTERS	0	0	<u> </u>	0	0	
	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	C C	0 0	0	89.00
91.00	09000 CLINIC 09100 EMERGENCY	2, 186 11, 723			2, 186 11, 723	0 0	91.00
91. 01 92. 00	04950 WOUND CARE 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	C	0	0	91.01 92.00
	OTHER REIMBURSABLE COST CENTERS	0	0	C	0	0	
96.00	09500 AMBULANCE SERVICES 09600 DURABLE MEDICAL EQUIP-RENTED				0	0	96.00
97.00 98.00	09700 DURABLE MEDICAL EQUIP-SOLD 09850 OTHER REIMBURSABLE COST CENTERS	0	0		0	0	

	ANOI JOAN HEALIN	CRAWFORDSVI LL	E	In Lie	eu of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider C	CN: 15-0022	Peri od:	Worksheet B-1	
				From 01/01/2021 To 12/31/2021	Date/Time Pre	nared
				10 12/31/2021	5/31/2022 8:5	
Cost Center Description	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	REPAI RS	PLANT	LINEN SERVIC	E (SQUARE FEET)	(MEALS SERVED)	
	(SQUARE FEET)	(SQUARE FEET)	(POUNDS OF			
	( 00	7.00	LAUNDRY)	0.00	10.00	
99.00 09900 CMHC	6.00	7.00	8.00	9.00	10.00	99.00
99. 10 09900 CMRC	0	0		0 0	-	
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	0	0		0 0		100.00
101.00 10100 HOME HEALTH AGENCY	0	0		0 0		101.00
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	0	0		0 0		106.00
107.00 10700 LIVER ACQUISITION	0	0		0 0		107.00
108.00 10800 LUNG ACQUI SI TI ON	0	0		0 0		108.00
109. 00 10900 PANCREAS ACQUISITION	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	0	115.00
116.00 11600 HOSPI CE	0	0		0 0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	101, 899	86, 845	230, 62	85, 387	31, 280	118.00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	356	356		0 356		190.00
191. 00 19100  RESEARCH	0	0		0 0		191.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	9, 182	9, 182		0 9, 182		192.00
193.00 19300 NONPALD WORKERS	0	0		0 0		193.00
194.00079500THER NONREIMBURSABLE COST CENTERS	0	0		0 0		194.00
194.0107951OTHER NONREIMBURSABLE COST CENTERS	0	0		0 0		194.01
194.0207952OTHER NONREIMBURSABLE COST CENTERS	0	0		0 0	0	194. 02
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	-					201.00
202.00 Cost to be allocated (per Wkst. B,	0	2, 680, 454	212, 42	823, 583	653, 466	202.00
Part I) 203.00 Unit cost multiplier (Wkst. B, Part I)	0. 000000	27. 810444	0. 92109	8. 676144	20. 890857	202 00
203.00 Cost to be allocated (per Wkst. B,	0.000000	682, 461	8, 69			
Part II)		002,401	0,05	/4,020	100, 095	204.00
205.00 Unit cost multiplier (Wkst. B, Part	0, 000000	7.080720	0. 03768	0. 788285	5.949329	205 00
	0.000000	7.000720	0.00700	0.700200	0.717027	200.00
206.00 NAHE adjustment amount to be allocated	ł					206.00
(per Wkst. B-2)						
207.00 NAHE unit cost multiplier (Wkst. D,	1					207.00
Parts III and IV)			1		1	

	Financial Systems FRA LLOCATION - STATISTICAL BASIS	ANCI SCAN HEALTH	Provider CC	N: 15-0022 P	eriod:	u of Form CMS-2 Worksheet B-1	
					rom 01/01/2021 o 12/31/2021	Date/Time Pre 5/31/2022 8:5	
	Cost Center Description	CAFETERI A (HOURS OF SERVI CE)	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY (COSTED REQUIS.)	MEDI CAL RECORDS & LI BRARY	
		,	(DI RECT NURS.	(COSTED	,	(GROSS	
		11.00	HRS.) 13.00	REQUIS.) 14.00	15.00	CHARGES) 16.00	
1 00	GENERAL SERVICE COST CENTERS		1				1 1 00
1.00 2.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00 6.00	00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS						5.00
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00 10.00	00900 HOUSEKEEPI NG 01000 DI ETARY						9.00
11.00	01100 CAFETERIA	507, 659					11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	2,748		100			13.00
14. 00 15. 00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	3, 231 13, 153		100 0			14.00
	01600 MEDICAL RECORDS & LIBRARY	0		0		268, 219, 262	
00.00	INPATIENT ROUTINE SERVICE COST CENTERS					40.442.253	00.0-
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	84,005 35,044		0 0		10, 643, 321 4, 701, 783	
32.00	03200 CORONARY CARE UNIT	0	0	0		4,701,703	
33.00	03300 BURN I NTENSI VE CARE UNI T	0	0	0	0	0	
34.00 40.00	03400 SURGI CAL INTENSI VE CARE UNI T 04000 SUBPROVI DER - I PF	42, 901	0 29, 441	0	0	0 3, 954, 720	
41.00	04100 SUBPROVI DER – I RF	42, 701	0	0	0	0,734,720	1
43.00	04300 NURSERY	0	0	0	0	0	
44.00 45.00	04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY	0	0	0	0	0	
46.00	04600 OTHER LONG TERM CARE	0	0	0	0	0	1
	ANCI LLARY SERVICE COST CENTERS		· · · ·				1
50. 00 51. 00	05000 OPERATING ROOM 05100 RECOVERY ROOM	66, 905	41, 650 0	0		27, 144, 966 0	1
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0		0	1
53.00	05300 ANESTHESI OLOGY	0	0	0	0	0	
54.00 54.01	05400 RADI OLOGY-DI AGNOSTI C 03630 ULTRA SOUND	71,014		0	0	40, 628, 605 5, 573, 184	
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	10, 967, 062	
56.00 57.00	05600 RADI OI SOTOPE	0	0	0	0	3, 099, 132	
57.00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)		0	0	0	0	
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59.00
60.00	06000 LABORATORY 06001 BLOOD LABORATORY	0	0	0	0	26, 305, 928	
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0	U	0	0	60.01 61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63.00 64.00	06300 BLOOD STORI NG, PROCESSI NG & TRANS. 06400 I NTRAVENOUS THERAPY	0	0 4, 175	0	0	0	63.00 64.00
65.00	06500 RESPIRATORY THERAPY	29, 981		0	0	3, 179, 571	
66.00	06600 PHYSI CAL THERAPY	16, 013	0	0	0	5, 490, 035	1
67.00 68.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	0	0	0	0	
	06900 ELECTROCARDI OLOGY	13, 192	1, 483	0	0	9, 012, 613	
	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	73 27		16, 131, 464 4, 435, 778	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	27	100	48, 931, 516	
	07400 RENAL DI ALYSI S	0	0	0	0	0	74.00
	07500 ASC (NON-DI STI NCT PART) 03480 ONCOLOGY	0	0	0	0	0 18, 261	
	07697 CARDI AC REHABI LI TATI ON	0	591	0	0	0	
	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	1
88.00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	0		0	0	0	88.00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	
90.00	09000 CLINIC	12, 978		0	0	1, 236, 575	
91.00 91.01	09100 EMERGENCY 04950 WOUND CARE	89, 439	64, 025 4, 346	0	0	46, 764, 748 0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		4, 340				92.00
	OTHER REIMBURSABLE COST CENTERS		· · · · ·		· · · · · ·		
	09400 HOME PROGRAM DI ALYSI S	0	0	0	0	0	
				∩		∩	95 00
	09500 AMBULANCE SERVICES 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0 0	0	0 0	

Health Financial Systems	FRA	NCISCAN HEALTH	I CRAWFORDSVILLE	-	In Lie	u of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL	BASI S		Provider CC	N: 15-0022	Peri od:	Worksheet B-1	
					From 01/01/2021	Data /Tima Dra	nored.
					To 12/31/2021	Date/Time Pre 5/31/2022 8:5	
Cost Center Descr	iption	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
			ADMI NI STRATI ON	SERVICES &	(COSTED	RECORDS &	
		SERVI CE)		SUPPLY	REQUIS.)	LI BRARY	
			(DI RECT NURS.	(COSTED		(GROSS	
			HRS.)	REQUIS.)		CHARGES)	
		11.00	13.00	14.00	15.00	16.00	
98.00 09850 OTHER REI MBURSABL	E 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	1
100.00 10000 I &R SERVICES-NOT		0	0		0 0		100. 00
101.00 10100 HOME HEALTH AGENC		0	0		0 0	0	101.00
SPECIAL PURPOSE COST CE			I				
105.00 10500 KIDNEY ACQUISITIC		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		108.00
109.00 10900 PANCREAS ACQUISIT		0	0		0 0		109.00
110.00 11000 I NTESTI NAL ACQUIS		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 I NTEREST EXPENSE							113.00
114.00 11400 UTI LI ZATI ON REVIE					_	_	114.00
115.00 11500 AMBULATORY SURGIO	AL 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 NONREI MBURSABLE COST CE	LINES 1 through 117)	482, 577	243, 914	10	00 100	268, 219, 262	118.00
190.00 19000 GIFT, FLOWER, COF			0		0 0	0	190.00
190.00 19000 GFFT, FLOWER, COF 191.00 19100 RESEARCH	FEE SHUP & CANTEEN	6, 422	-		0 0		190.00
191. 00 19100 RESEARCH 192. 00 19200 PHYSI CLANS' PRI VA		0, 422			0 0		191.00
193. 00 19300 NONPAID WORKERS	TE UFFICES	0	0		0 0		192.00
193. 00 19300 NONPATE WORKERS 194. 00 07950 OTHER NONREI MBURS	ARLE COST CENTERS	0	0				193.00
194. 01 07951 OTHER NORRET MBURS		10, 605	0				194.00
194. 02 07952 OTHER NONRET MBURS		8, 053			0 0		194.01
200.00 Cross Foot Adjust		0,000	0		0 0	0	200.00
201.00 Negative Cost Cer							200.00
201.00 Regative cost cer 202.00 Cost to be alloca		546, 028	971, 661	927, 74	-893, 992	793, 924	
Part I)	teu (pei wkst. b,	540, 028	971,001	727,74	-073, 772	773, 724	202.00
	ier (Wkst. B, Part I)	1. 075580	3. 983278	9, 277. 44000	0. 000000	0.002960	203 00
204.00 Cost to be alloca		118, 948		436, 34			204.00
Part II)		110, 740	11,200	100, 04	.2 07,007	00, 440	
	ier (Wkst. B, Part	0. 234307	0. 046057	4, 363. 42000	670. 570000	0. 000188	205.00
206.00 NAHE adjustment a	mount to be allocated						206.00
(per Wkst. B-2)							
207.00 NAHE unit cost mu	ltiplier (Wkst. D,						207.00
Parts III and IV)							1

Heal th	Fi nar	ici a	I Syst	ems			
COMPLIE	ATLON	OE	DATIO	0E	COSTS	TO	CL

Health Financial Systems FR	ANCI SCAN HEALTH	CRAWFORDSVI LL	E	In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2021 To 12/31/2021	Worksheet C Part I Date/Time Pre 5/31/2022 8:5	pared:
		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	
INPATIENT ROUTINE SERVICE COST CENTERS	-					
30. 00 03000 ADULTS & PEDIATRICS	5, 447, 206		5, 447, 20		5, 447, 206	
31.00 03100 INTENSIVE CARE UNIT	2, 161, 812		2, 161, 81	2 0	2, 161, 812	
32.00 03200 CORONARY CARE UNI T	0			0 0	0	1
33.00 03300 BURN INTENSIVE CARE UNIT	0			0 0	0	
34.00 03400 SURGI CAL INTENSI VE CARE UNI T	0			0 0	0	
40. 00 04000 SUBPROVIDER - IPF	2, 727, 235		2, 727, 23	5 0	2, 727, 235	
41.00 04100 SUBPROVIDER – IRF	0			0 0	0	1
43. 00 04300 NURSERY	0			0 0	0	43.00
44.00 04400 SKILLED NURSING FACILITY	0			0 0	0	
45.00 04500 NURSING FACILITY	0			0 0	0	
46.00 04600 OTHER LONG TERM CARE	0			0 0	0	46.00
ANCI LLARY SERVI CE COST CENTERS						
50.00 O5000 OPERATING ROOM	7, 137, 138		7, 137, 13		7, 137, 138	
51.00 O5100 RECOVERY ROOM	0			0 0	0	
52.00 O5200 DELIVERY ROOM & LABOR ROOM	0			0	0	
53. 00 05300 ANESTHESI OLOGY	0		0.077	0	0	1
54. 00 05400 RADI OLOGY-DI AGNOSTI C	3, 989, 417		3, 989, 41		3, 989, 417	
54. 01 03630 ULTRA SOUND	227, 144		227, 14		227, 144	
55. 00 05500 RADI OLOGY-THERAPEUTI C	1, 844, 751		1, 844, 75	1 0	1, 844, 751	1
56. 00 05600 RADI 0I SOTOPE	0			0 0	0	
57.00 05700 CT SCAN	0			0 0	0	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0			0 0	0	
59.00 05900 CARDI AC CATHETERI ZATI ON	0			0 0	0	
60. 00 06000 LABORATORY	4, 122, 557		4, 122, 55	7 0	4, 122, 557	
60. 01 06001 BLOOD LABORATORY	0			0 0	0	
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0			0 0	0	
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 INTRAVENOUS THERAPY	16, 630		16, 63	0 0	16, 630	64.00
65. 00 06500 RESPI RATORY THERAPY	1, 341, 258	0	1, 341, 25	8 0	1, 341, 258	65.00
66. 00 06600 PHYSI CAL THERAPY	1, 384, 880	0	1, 384, 88	0 0	1, 384, 880	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 0	0	1
69.00 06900 ELECTROCARDI OLOGY	1, 034, 152		1, 034, 15	2 0	1, 034, 152	1
70.00 07000 ELECTROENCEPHALOGRAPHY	0			0 0	0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 907, 411		2, 907, 41		2, 907, 411	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	279, 208		279, 20		279, 208	
73.00 07300 DRUGS CHARGED TO PATIENTS	11, 272, 405		11, 272, 40	5 0	11, 272, 405	
74.00 07400 RENAL DIALYSIS	0			0 0	0	
75.00 07500 ASC (NON-DISTINCT PART)	0			0 0		75.00
76.00 03480 ONCOLOGY	760		76		760	
76. 97 07697 CARDI AC REHABI LI TATI ON	2, 354		2, 35		2, 354	
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0			0 0	0	77.00
OUTPATIENT SERVICE COST CENTERS			1			
88.00 08800 RURAL HEALTH CLINIC	0			0 0	0	
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0		<i>,</i> =	0	0	
90. 00 09000 CLINIC	654, 179		654, 17		654, 179	1
91.00 09100 EMERGENCY	5, 680, 694		5, 680, 69		5, 680, 694	
91.01 04950 WOUND CARE	17, 311		17, 31		17, 311	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 610, 466		1, 610, 46	6	1, 610, 466	92.00
OTHER REIMBURSABLE COST CENTERS	-		1	-		
94. 00 09400 HOME PROGRAM DI ALYSI S	0			0	0	
95. 00 09500 AMBULANCE SERVICES	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	
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0			0 0	0	
99.00 09900 CMHC	0			U	0	
99. 10 09910 CORF	0			U	0	
100.00 10000 I &R SERVI CES-NOT APPRVD PRGM	0			U		100.00
101.00 HOME HEALTH AGENCY	0			U	0	101.00
SPECIAL PURPOSE COST CENTERS						1.05
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 LI VER ACQUI SI TI ON	0			U		107.00
108.00 10800 LUNG ACQUISITION	0			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	0	111.00
113.00 11300 INTEREST EXPENSE						113.00

Health Financial Systems FF	RANCI SCAN HEALTH	CRAWFORDSVI LL	E	In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CO	F	Period: From 01/01/2021 To 12/31/2021		epared:
		Title	XVIII	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst. B,	Adj.		Di sal I owance		
	Part I, col.					
	26)					
	1.00	2.00	3.00	4.00	5.00	
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	0		(	)	0	116.00
200.00 Subtotal (see instructions)	53, 858, 968	0	53, 858, 968	3 0	53, 858, 968	200.00
201.00 Less Observation Beds	1, 610, 466		1, 610, 466	5	1, 610, 466	201.00
202.00 Total (see instructions)	52, 248, 502	0	52, 248, 502	2 0	52, 248, 502	202.00

	Financial Systems FR ATION OF RATIO OF COSTS TO CHARGES	RANCI SCAN HEALTH	Provider C	CN: 15-0022	In Lie Period: From 01/01/2021 To 12/31/2021 Hospital	wof Form CMS- Worksheet C Part I Date/Time Pre 5/31/2022 8:5 PPS	epared:
	Cost Center Description	I npati ent	<u>Charges</u> Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA I npati ent	
		6.00	7.00	8.00	9.00	Rati o 10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS	7, 165, 992		7, 165, 99	า		30.00
	03100 I NTENSI VE CARE UNI T	4, 701, 783		4, 701, 78			31.00
32.00	03200 CORONARY CARE UNI T	0			0		32.00
	03300 BURN INTENSIVE CARE UNIT	0			0		33.00
	03400 SURGI CAL I NTENSI VE CARE UNI T 04000 SUBPROVI DER – I PF	0 3, 954, 720		3, 954, 72	0		34.00 40.00
	04100 SUBPROVIDER - IRF	0		3, 734, 72	0		41.00
	04300 NURSERY	0			0		43.00
	04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY	0			0		44.00
	04600 OTHER LONG TERM CARE	0			0		45.00
	ANCI LLARY SERVICE COST CENTERS				5		101.00
	05000 OPERATI NG ROOM	4, 369, 695	22, 775, 271	27, 144, 96		0.00000	
	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0. 000000 0 0. 000000		
	05300 ANESTHESI OLOGY	0	C		0. 000000	0.000000	
54.00	05400 RADI OLOGY-DI AGNOSTI C	5, 157, 675	35, 470, 930	40, 628, 60		0. 000000	
	03630 ULTRA SOUND	658, 607	4, 914, 577			0.00000	
	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE	9, 203 118, 231	10, 957, 859 2, 980, 901			0.000000	
	05700 CT SCAN	0	2, 980, 901	)	0. 000000	0. 000000	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	C		0 0. 000000	0.000000	
	05900 CARDI AC CATHETERI ZATI ON	0	0		0 0.00000		
	06000 LABORATORY 06001 BLOOD LABORATORY	5, 802, 963	20, 502, 965	26, 305, 92	8 0. 156716 0 0. 000000	0.000000	
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	C		0. 000000	0. 000000	
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	C		0.00000	0.000000	
	06300 BLOOD STORING, PROCESSING & TRANS.	0	C		0 0. 000000	0.00000	
	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	0 2, 153, 042	0 1, 026, 529	3, 179, 57	0 0. 000000 1 0. 421836	0. 000000	
	06600 PHYSI CAL THERAPY	1, 124, 107	4, 365, 928			0. 000000	
	06700 OCCUPATI ONAL THERAPY	0	C		0.000000		
	06800 SPEECH PATHOLOGY	0	C		0 0.00000	0.000000	
	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	1, 163, 378	7, 849, 235	9, 012, 61	3 0. 114745 0 0. 000000	0.000000	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	4, 712, 971	11, 418, 493	16, 131, 46		0. 000000	
	07200 IMPL. DEV. CHARGED TO PATIENTS	1, 522, 853	2, 912, 925				
	07300 DRUGS CHARGED TO PATIENTS	4, 044, 809	44, 886, 707	48, 931, 51		0.000000	
	07400 RENAL DI ALYSI S 07500 ASC (NON-DI STI NCT PART)	0			0 0. 000000 0 0. 000000		
	03480 ONCOLOGY	0	18, 261				
	07697 CARDI AC REHABI LI TATI ON	0	C		0 0. 000000		
	07700 ALLOGENEIC STEM CELL ACQUISITION OUTPATIENT SERVICE COST CENTERS	0	C		0 0.000000	0.000000	77.00
	08800 RURAL HEALTH CLINIC	0	C		0		88.00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	C		0		89.00
		0	1, 236, 575				
	09100 EMERGENCY 04950 WOUND CARE	4, 905, 947	41, 858, 801 C	46, 764, 74	8 0. 121474 0 0. 000000		
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	602, 355	2, 874, 974	3, 477, 32			
	OTHER REIMBURSABLE COST CENTERS	1					
	09400 HOME PROGRAM DIALYSIS 09500 AMBULANCE SERVICES	0	C		0 0. 000000 0 0. 000000	0.000000	
	09500 AMBULANCE SERVICES 09600 DURABLE MEDICAL EQUIP-RENTED	0		Ď	0.000000	0. 000000	
	09700 DURABLE MEDI CAL EQUI P-SOLD	0	C		0 0. 000000		
	09850 OTHER REIMBURSABLE COST CENTERS	0	C	0	0 0. 000000	0.000000	
	09900 CMHC 09910 CORF	0			0		99.00 99.10
	10000 I &R SERVICES-NOT APPRVD PRGM	0	C		0		100.00
101.00	10100 HOME HEALTH AGENCY	0	C		0		101.00
	SPECIAL PURPOSE COST CENTERS		-		ol	1	105 00
	10500 KIDNEY ACQUISITION 10600 HEART ACQUISITION	0	C		0		105.00 106.00
	10700 LI VER ACQUI SI TI ON	0	C	þ	0		107.00
	10800 LUNG ACQUISITION	0	C		0		108.00
	10900 PANCREAS ACQUISITION 11000 INTESTINAL ACQUISITION	0	C				109.00 110.00
	11100 I SLET ACQUI SI TI ON	0		Ď	õ		111.00
113.00	11300 INTEREST EXPENSE		-				113.00
	11400 UTILIZATION REVIEW-SNF				1		114.00

Health Financial Systems F	RANCI SCAN HEALTH	CRAWFORDSVI LL	E	In Lie	u of Form CMS	-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-0022	Period: From 01/01/2021 To 12/31/2021	Worksheet C Part I Date/Time Pr 5/31/2022 8:	
		Titl∈	e XVIII	Hospi tal	PPS	
Cost Center Description	I npati ent	Charges Outpati ent	Total (col. + col. 7)	6 Cost or Other Ratio	TEFRA I npati ent Rati o	
	6.00	7.00	8.00	9.00	10.00	
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P. ) 116. 00 11600 HOSPICE	0	0		0		115. 00 116. 00
200.00Subtotal (see instructions)201.00Less Observation Beds202.00Total (see instructions)	52, 168, 331 52, 168, 331					200. 00 201. 00 202. 00

MPUT	ATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0022	Peri od:	Worksheet C
				From 01/01/2021 To 12/31/2021	Part I Date/Time Prepare 5/31/2022 8:56 am
			Title XVIII	Hospi tal	PPS
	Cost Center Description	PPS Inpatient			
		Ratio			
		11.00			
00	INPATIENT ROUTINE SERVICE COST CENTERS				30
	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT				31
	03200 CORONARY CARE UNIT				32
	03300 BURN I NTENSI VE CARE UNI T				33
	03400 SURGI CAL I NTENSI VE CARE UNI T				34
). 00	04000 SUBPROVIDER - IPF				40
	04100 SUBPROVI DER – I RF				41
	04300 NURSERY				43
	04400 SKILLED NURSING FACILITY				44
5.00	04500 NURSING FACILITY				45
	04600 OTHER LONG TERM CARE				46
	ANCI LLARY SERVICE COST CENTERS				
. 00	05000 OPERATI NG ROOM	0. 262927			50
. 00	05100 RECOVERY ROOM	0. 000000			51
. 00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52
. 00	05300 ANESTHESI OLOGY	0. 000000			53
	05400 RADI OLOGY-DI AGNOSTI C	0. 098192			54
	03630 ULTRA SOUND	0. 040757			54
	05500 RADI OLOGY-THERAPEUTI C	0. 168208			55.
	05600 RADI OI SOTOPE	0. 000000			56
	05700 CT SCAN	0. 000000			57
00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000			58
. 00	05900 CARDI AC CATHETERI ZATI ON	0. 000000			59
00	06000 LABORATORY	0. 156716			60
	06001 BLOOD LABORATORY	0. 000000			60
00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000			61
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000			62
	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000			63
	06400 I NTRAVENOUS THERAPY	0. 000000			64
. 00	06500 RESPI RATORY THERAPY	0. 421836			65
. 00	06600 PHYSI CAL THERAPY	0. 252253			66
. 00	06700 OCCUPATIONAL THERAPY	0. 000000			67.
	06800 SPEECH PATHOLOGY	0. 000000			68
		0. 114745			69
	07000 ELECTROENCEPHALOGRAPHY	0.000000			70
	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0. 180232			71
	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0. 062945 0. 230371			72
	07400 RENAL DIALYSIS	0. 000000			74
	07500 ASC (NON-DI STINCT PART)	0. 000000			75
	03480 ONCOLOGY	0. 041619			76
	07697 CARDI AC REHABI LI TATI ON	0.000000			76
	07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000			77
	OUTPATIENT SERVICE COST CENTERS	01000000			
. 00	08800 RURAL HEALTH CLINIC				88
	08900 FEDERALLY QUALIFIED HEALTH CENTER				89
	09000 CLI NI C	0. 529025			90
00	09100 EMERGENCY	0. 121474			91.
01	04950 WOUND CARE	0. 000000			91
00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 463133			92
	OTHER REIMBURSABLE COST CENTERS	'			
	09400 HOME PROGRAM DI ALYSI S	0. 000000			94
	09500 AMBULANCE SERVICES	0.00000			95.
	09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000			96
	09700 DURABLE MEDICAL EQUIP-SOLD	0.00000			97
	09850 OTHER REIMBURSABLE COST CENTERS	0. 000000			98
	09900 CMHC				99
	09910 CORF				99
	10000 I &R SERVICES-NOT APPRVD PRGM				100
1.00	10100 HOME HEALTH AGENCY				101
5 00	SPECIAL PURPOSE COST CENTERS 10500 KIDNEY ACQUISITION				105
	10600 HEART ACQUISITION				105
	10700 LIVER ACQUISITION				106
	10800 LUNG ACQUISITION				108
	10900 PANCREAS ACQUISITION				109
$\sim \sim$	11000 INTESTINAL ACQUISITION 11100 ISLET ACQUISITION				110
		1			111.
1.00		1			140
1.00 3.00	11300 INTEREST EXPENSE				113
1.00 3.00 4.00					113 114 115

Health Fina	ancial Systems	FRANCI SCAN HEALTH C	CRAWFORDSVI LLE	In Lieu of Form CMS-2552-10			
COMPUTATI O	N OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0022	Peri od:	Worksheet C		
				From 01/01/2021			
				To 12/31/2021	Date/Time Pre 5/31/2022 8:5		
			Title XVIII	Hospi tal	PPS		
	Cost Center Description	PPS Inpatient					
		Ratio					
		11.00					
200.00	Subtotal (see instructions)					200.00	
201.00	Less Observation Beds					201.00	
202.00	Total (see instructions)					202.00	

Heal th	Fi nar	ici a	I Syst	ems			
COMPLIE		OF	PATIO	OF	27200	ΤO	CI

In Lieu of Form CMS-2552-10

Health Financial Systems         FR           COMPUTATION OF RATIO OF COSTS TO CHARGES         FR	ANCISCAN HEALTH	Provider C		In Lie Period:	u of Form CMS- Worksheet C	2552-10
			F	rom 01/01/2021 o 12/31/2021	Part I Date/Time Pre	pared:
		Titl	e XIX	Hospi tal	5/31/2022 8:5 Cost	6 am
				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	
INPATIENT ROUTINE SERVICE COST CENTERS	1	r	1	1		
30. 00 03000 ADULTS & PEDI ATRI CS	5, 447, 206		5, 447, 206			
31.00 03100 INTENSIVE CARE UNIT	2, 161, 812		2, 161, 812		2, 161, 812	1
32. 00 03200 CORONARY CARE UNIT	0			-	0	1
33. 00 03300 BURN INTENSIVE CARE UNIT 34. 00 03400 SURGICAL INTENSIVE CARE UNIT	0			0	0	
40. 00 04000 SUBPROVIDER - IPF	2, 727, 235		2, 727, 235	0	2, 727, 235	1
41. 00 04100 SUBPROVIDER - IRF	0		2,727,200	0	2, 727, 200	
43. 00 04300 NURSERY	0		c c	0	0	1
44.00 04400 SKILLED NURSING FACILITY	0		c c	0	0	44.00
45.00 04500 NURSING FACILITY	0		C	0	0	45.00
46.00 04600 OTHER LONG TERM CARE	0		C	0	0	46.00
ANCI LLARY SERVICE COST CENTERS				-		
50. 00 05000 OPERATING ROOM	7, 137, 138		7, 137, 138			
51.00 05100 RECOVERY ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM	0			0	0	1
53. 00 05300 ANESTHESI OLOGY	0			0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	3, 989, 417		3, 989, 417	0		1
54. 01 03630 ULTRA SOUND	227, 144		227, 144		227, 144	
55. 00 05500 RADI OLOGY-THERAPEUTI C	1, 844, 751		1, 844, 751		1, 844, 751	
56. 00 05600 RADI OI SOTOPE	0		c	0	0	56.00
57.00 05700 CT SCAN	0		C	0	0	
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0		C	0	0	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0			-	0	
60. 00 06000 LABORATORY	4, 122, 557		4, 122, 557	0	4, 122, 557	
60. 01 06001 BLOOD LABORATORY 61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0			0 0	0	1
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0			0	0	
63. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS.	0			0	0	
64.00 06400 INTRAVENOUS THERAPY	16, 630		16, 630	0	16, 630	1
65. 00 06500 RESPI RATORY THERAPY	1, 341, 258	0	1, 341, 258	0	1, 341, 258	
66. 00 06600 PHYSI CAL THERAPY	1, 384, 880	0	1, 384, 880	0	1, 384, 880	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0	C	-	0	1
68.00 06800 SPEECH PATHOLOGY	1 024 152	0		0	0	1
69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY	1, 034, 152		1, 034, 152	0	1, 034, 152 0	1
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 907, 411		2, 907, 411	-	2, 907, 411	1
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	279, 208		279, 208		279, 208	
73.00 07300 DRUGS CHARGED TO PATIENTS	11, 272, 405		11, 272, 405		11, 272, 405	
74.00 07400 RENAL DI ALYSI S	0		c		0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0		C	-	0	1
76.00 03480 ONCOLOGY	760		760			
76. 97 07697 CARDIAC REHABILITATION	2, 354		2, 354			
77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION OUTPATIENT SERVICE COST CENTERS	0		C	0	0	77.00
88. 00 08800 RURAL HEALTH CLINIC	0		c	0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0				0	
90. 00 09000 CLINIC	654, 179		654, 179	-	654, 179	
91.00 09100 EMERGENCY	5, 680, 694		5, 680, 694		5, 680, 694	
91.01 04950 WOUND CARE	17, 311		17, 311	0	17, 311	91.01
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	1, 610, 466		1, 610, 466	)	1, 610, 466	92.00
OTHER REIMBURSABLE COST CENTERS		[			0	04.00
94. 00 09400 HOME PROGRAM DI ALYSI S 95. 00 09500 AMBULANCE SERVI CES	0					
95.00 09500 AMBULANCE SERVICES 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	0	1
99. 00 09900 CMHC	0		c		0	99.00
99. 10 09910 CORF	0		C		0	
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0		C			100.00
101.00 10100 HOME HEALTH AGENCY	0		C		0	101.00
SPECIAL PURPOSE COST CENTERS					0	105 00
105. 00 10500 KI DNEY ACQUI SI TI ON 106. 00 10600 HEART ACQUI SI TI ON	0					105.00 106.00
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 ACQUI SI TI ON	0			)		109.00
110.00 11000 INTESTINAL ACQUISITION	0		C	)		110.00
111.00 11100 I SLET ACQUI SI TI ON	0		C		0	111.00
113.00 11300 INTEREST EXPENSE						113.00

Health Financial Systems F	RANCI SCAN HEALTH	CRAWFORDSVI LL	E	In Lie	eu of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CO		Period: From 01/01/2021 To 12/31/2021	Worksheet C Part I Date/Time Pre 5/31/2022 8:5	pared: 6 am
		Ti tl	e XIX	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst. B,	Adj.		Di sal I owance		
	Part I, col.					
	26)					
	1.00	2.00	3.00	4.00	5.00	
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
200.00 Subtotal (see instructions)	53, 858, 968	0	53, 858, 96	0 8	53, 858, 968	200.00
201.00 Less Observation Beds	1, 610, 466		1, 610, 46	6	1, 610, 466	201.00
202.00 Total (see instructions)	52, 248, 502	0	52, 248, 50	02 0	52, 248, 502	202.00

ealth Financial Systems OMPUTATION OF RATIO OF COSTS TO CHARGES	FRANCI SCAN HEALTH	CRAWFORDSVILL Provider C	CN: 15-0022 P F	In Lie Period: irom 01/01/2021 io 12/31/2021	u of Form CMS- Worksheet C Part I Date/Time Pre	epared:
		Ti tl	e XIX	Hospi tal	5/31/2022 8:5 Cost	6 am
Cost Center Description	I npati ent	Charges Outpati ent	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA I npati ent Rati o	
	6.00	7.00	8.00	9.00	10.00	
0.00 03000 ADULTS & PEDIATRICS	7, 165, 992		7, 165, 992			30.0
1. 00 03100 I NTENSI VE CARE UNI T	4, 701, 783		4, 701, 783			31.0
2.00 03200 CORONARY CARE UNI T	0		C			32.0
3. 00 03300 BURN INTENSIVE CARE UNIT	0		0			33.0
4. 00 03400 SURGICAL INTENSIVE CARE UNIT 0. 00 04000 SUBPROVIDER - IPF	0 3, 954, 720		3, 954, 720			34.0
1. 00 04100 SUBPROVIDER - IRF	0		0, 754, 720			41.0
3. 00 04300 NURSERY	0		C			43.0
4. 00 04400 SKI LLED NURSI NG FACI LI TY	0		0			44.0
5. 00 04500 NURSING FACILITY 6. 00 04600 OTHER LONG TERM CARE	0					45.0
ANCI LLARY SERVICE COST CENTERS	0					40.0
0. 00 05000 OPERATI NG ROOM	4, 369, 695	22, 775, 271	27, 144, 966	0. 262927	0. 000000	50.0
1.00 05100 RECOVERY ROOM	0	C	C	0. 000000	0.00000	
2.00 05200 DELIVERY ROOM & LABOR ROOM	0	C	0	0.000000	0.00000	
3. 00 05300 ANESTHESI OLOGY 4. 00 05400 RADI OLOGY-DI AGNOSTI C	5, 157, 675	35, 470, 930	40, 628, 605	0. 000000 0. 098192	0. 000000 0. 000000	
4. 01 03630 ULTRA SOUND	658, 607	4, 914, 577			0. 000000	
5. 00 05500 RADI OLOGY-THERAPEUTI C	9, 203	10, 957, 859			0.00000	
6. 00 05600 RADI 0I SOTOPE	118, 231	2, 980, 901	3, 099, 132		0.00000	
7.00 05700 CT SCAN 8.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0. 000000 0. 000000	0. 000000 0. 000000	
9. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0. 000000	0. 000000	
0. 00 06000 LABORATORY	5, 802, 963	20, 502, 965	26, 305, 928		0. 000000	
0. 01 06001 BLOOD LABORATORY	0	C	C	0. 000000	0.00000	
1.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	C	C	0. 000000	0. 000000	
2. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 3. 00 06300 BLOOD STORING, PROCESSING & TRANS.	S 0			0. 000000 0. 000000	0. 000000 0. 000000	
4. 00 06400 I NTRAVENOUS THERAPY	0	C	c c	0. 000000	0. 000000	
5. 00 06500 RESPI RATORY THERAPY	2, 153, 042	1, 026, 529	3, 179, 571		0.00000	
6. 00 06600 PHYSI CAL THERAPY	1, 124, 107	4, 365, 928			0.00000	
7. 00 06700 OCCUPATI ONAL THERAPY 8. 00 06800 SPEECH PATHOLOGY	0	C		0. 000000 0. 000000	0. 000000 0. 000000	
9. 00 06900 ELECTROCARDI OLOGY	1, 163, 378	7, 849, 235	9, 012, 613		0. 000000	
0. 00 07000 ELECTROENCEPHALOGRAPHY	0	C	C	0. 000000	0. 000000	
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		11, 418, 493			0.00000	
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS 3.00 07300 DRUGS CHARGED TO PATIENTS	1, 522, 853	2, 912, 925			0.00000	
3. 00 07300 DRUGS CHARGED TO PATIENTS 4. 00 07400 RENAL DIALYSIS	4, 044, 809 0	44, 886, 707 C			0. 000000 0. 000000	
5. 00 07500 ASC (NON-DISTINCT PART)	0	C			0. 000000	
6. 00 03480 ONCOLOGY	0	18, 261	18, 261		0.00000	
6. 97 07697 CARDI AC REHABI LI TATI ON	0	C			0.00000	
7. 00 07700 ALLOGENEIC STEM CELL ACQUISITION OUTPATIENT SERVICE COST CENTERS	0	C	C	0.000000	0. 000000	77.0
8. 00 08800 RURAL HEALTH CLINIC	0	C	C	0. 000000	0. 000000	88. 0
9.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	C	-	0. 000000	0. 000000	
0. 00 09000 CLI NI C	0	1, 236, 575			0.00000	
1. 00 09100 EMERGENCY	4, 905, 947	41, 858, 801			0.00000	
1.01  04950 WOUND CARE 2.00  09200 OBSERVATION BEDS (NON-DISTINCT PART)	) 602, 355	C 2, 874, 974			0.000000	
OTHER REIMBURSABLE COST CENTERS	, 002, 333	2,014,714	5,477,527	0.403133	0.000000	/ /2.0
4. 00 09400 HOME PROGRAM DI ALYSI S	0	C	C	0. 000000	0. 000000	
5. 00 09500 AMBULANCE SERVICES	0	C		0.000000	0.00000	
6.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	C		0.000000	0.00000	
7.00 09700 DURABLE MEDICAL EQUIP-SOLD 8.00 09850 OTHER REIMBURSABLE COST CENTERS	0			0. 000000 0. 000000	0. 000000 0. 000000	
9. 00 09900 CMHC	0	C		0.000000	0.000000	99.0
9. 10 09910 CORF	0	C				99.1
00.00 10000 I &R SERVICES-NOT APPRVD PRGM	0	C				100.0
01. 00 10100 HOME HEALTH AGENCY	0	C	C			101.0
SPECIAL PURPOSE COST CENTERS 05. 00 10500 KI DNEY ACQUI SI TI ON	0	C	C			105. 0
06. 00 10600 HEART ACQUISITION	0	C				106.0
07. 00 10700 LI VER ACQUI SI TI ON	0	C	c			107.0
08.00 10800 LUNG ACQUISITION	0	C	C			108.0
09.00 10900 PANCREAS ACQUISITION	0	C				109.0
10. 00 11000 I NTESTI NAL ACQUI SI TI ON 11. 00 11100 I SLET ACQUI SI TI ON	0	C				110. C
13. 00 11300 INTEREST EXPENSE		C	ĺ			113. C
14. 00 11400 UTI LI ZATI ON REVI EW-SNF						114.0

Health Financial Systems Fi	RANCI SCAN HEALTH	CRAWFORDSVI LL	E	In Lie	u of Form CMS	-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-0022	Period: From 01/01/2021 To 12/31/2021	Worksheet C Part I Date/Time Pro 5/31/2022 8:	
		Titl	e XIX	Hospi tal	Cost	
Cost Center Description	I npati ent	Charges Outpati ent	Total (col. + col. 7)	6 Cost or Other Ratio	TEFRA I npati ent Rati o	
	6.00	7.00	8.00	9.00	10.00	
115. 00 11500 AMBULATORY SURGI CAL CENTER (D. P. ) 116. 00 11600 HOSPI CE	0	0 0		0 0		115.00 116.00
200.00Subtotal (see instructions)201.00Less Observation Beds202.00Total (see instructions)	52, 168, 331 52, 168, 331	216, 050, 931 216, 050, 931				200. 00 201. 00 202. 00

					Worksheet C Part I	
				From 01/01/2021 To 12/31/2021	Date/Time Prepar 5/31/2022 8:56 a	
			Title XIX	Hospi tal	Cost	
	Cost Center Description	PPS Inpatient				
		Ratio				
T		11.00				
	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS				30	
	03100 INTENSIVE CARE UNIT				31	
	03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT				32	
					33	
	03400 SURGI CAL INTENSI VE CARE UNI T				34	
	04000 SUBPROVI DER – I PF				40	
	04100 SUBPROVIDER - IRF				41	
	04300 NURSERY				43	
	04400 SKI LLED NURSI NG FACI LI TY				44	
	04500 NURSING FACILITY				45	
	04600 OTHER LONG TERM CARE				46	
	ANCI LLARY SERVICE COST CENTERS	0,000000				
	05000 OPERATI NG ROOM	0.00000			50	
	05100 RECOVERY ROOM	0.00000			51	
	05200 DELIVERY ROOM & LABOR ROOM	0.00000			52	
	05300 ANESTHESI OLOGY	0. 000000			53	
	05400 RADI OLOGY-DI AGNOSTI C	0.00000			54	
-	03630 ULTRA SOUND	0.00000			54	
	05500 RADI OLOGY-THERAPEUTI C	0.00000			55	
	05600 RADI OI SOTOPE	0.00000			56	
	05700 CT SCAN	0. 000000			57	
	05800 MAGNETIC RESONANCE I MAGING (MRI)	0.00000			58	
	05900 CARDI AC CATHETERI ZATI ON	0.00000			59	
		0.000000			60	
1	06001 BLOOD LABORATORY	0. 000000			60	
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000			61	
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000			62	
	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000			63	
	06400 I NTRAVENOUS THERAPY	0.000000			64	
	06500 RESPI RATORY THERAPY	0.000000			65	
	06600 PHYSI CAL THERAPY	0.000000			66	
	06700 OCCUPATI ONAL THERAPY	0.000000			67	
	06800 SPEECH PATHOLOGY	0.000000			68	
	06900 ELECTROCARDI OLOGY	0. 000000			69	
	07000 ELECTROENCEPHALOGRAPHY	0.000000			70	
	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0.000000			71	
	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			72	
	07300 DRUGS CHARGED TO PATIENTS	0.000000			73	
	07400 RENAL DI ALYSI S	0. 000000			74	
	07500 ASC (NON-DI STI NCT PART)	0.00000			75	
		0. 000000			76	
	07697 CARDI AC REHABI LI TATI ON	0. 000000			76	
	07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000			77	
	OUTPATIENT SERVICE COST CENTERS	0,000000				
	08800 RURAL HEALTH CLINIC	0.000000			88	
	08900 FEDERALLY QUALI FI ED HEALTH CENTER 09000 CLI NI C	0.000000				
	09000 CLINIC 09100 EMERGENCY	0.000000			90	
	04950 WOUND CARE	0.000000			91	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92	
	OTHER REIMBURSABLE COST CENTERS	0.00000			92	
	09400 HOME PROGRAM DI ALYSI S	0.000000			94	
	09500 AMBULANCE SERVICES	0.000000			95	
	09600 DURABLE MEDI CAL EQUI P-RENTED	0.000000			96	
	09700 DURABLE MEDICAL EQUIP-RENTED	0.000000			97	
	09850 OTHER REIMBURSABLE COST CENTERS	0.000000			98	
	09900 CMHC	0.00000			99	
	09910 CORF				99	
	10000 I &R SERVICES-NOT APPRVD PRGM				100	
	10100 HOME HEALTH AGENCY				101	
	SPECIAL PURPOSE COST CENTERS				101	
	10500 KIDNEY ACQUISITION				105	
	10600 HEART ACQUISITION				106	
	10700 LIVER ACQUISITION				107	
1	10800 LUNG ACQUISITION				108	
1	10900 PANCREAS ACQUISITION				109	
1						
	11000 INTESTINAL ACQUISITION				110	
	11100 I SLET ACQUI SI TI ON				111	
	11300 I NTEREST EXPENSE				113	
	11400 UTI LI ZATI ON REVI EW-SNF				114	
	11500 AMBULATORY SURGICAL CENTER (D. P. ) 11600 HOSPICE				115	

Health Fina	ancial Systems	FRANCI SCAN HEALTH	CRAWFORDSVI LLE	In Lieu of Form CMS-2552-10			
COMPUTATI O	N OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0022	Period: From 01/01/2021 To 12/31/2021	Worksheet C Part I Date/Time Pre 5/31/2022 8:5		
			Title XIX	Hospi tal	Cost		
	Cost Center Description	PPS Inpatient					
		Ratio					
		11.00					
200.00	Subtotal (see instructions)					200.00	
201.00	Less Observation Beds					201.00	
202.00	Total (see instructions)					202.00	

Health Financial Systems F	RANCI SCAN HEALTH	CRAWFORDSVI LL	.E	In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	. COSTS	Provider C		Period: From 01/01/2021 To 12/31/2021	5/31/2022 8:5	
			e XVIII	Hospi tal	PPS	
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cos <sup>-</sup> (col. 1 - col 2)	Days	Per Diem (col. 3 / col. 4)	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS					•	
30.00 ADULTS & PEDIATRICS 31.00 INTENSIVE CARE UNIT 32.00 CORONARY CARE UNIT 33.00 BURN INTENSIVE CARE UNIT 34.00 SUBROVIDER - IPF 41.00 SUBPROVIDER - IPF 43.00 NURSERY 44.00 SKILLED NURSING FACILITY 45.00 NURSING FACILITY 200.00 Total (lines 30 through 199) Cost Center Description	657, 338 198, 842 0 0 320, 942 0 0 0 0 1, 177, 122 Inpatient Program days 6, 00	Inpatient Program Capital Cost (col. 5 x col. 6) 7.00	657, 3: 198, 84 320, 94 1, 177, 12	12         991           0         0           0         0           0         0           1, 631         0           0         0           0         0           0         0           0         0           0         0           0         0           0         0           0         0	200. 65 0. 00 0. 00 196. 78 0. 00 0. 00 0. 00	31.00 32.00 33.00 34.00 40.00
INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00				
30. 00       ADULTS & PEDI ATRI CS         31. 00       INTENSI VE CARE UNI T         32. 00       CORONARY CARE UNI T         33. 00       BURN INTENSI VE CARE UNI T         34. 00       SURGI CAL INTENSI VE CARE UNI T         34. 00       SUBPROVI DER - IPF         41. 00       SUBPROVI DER - IPF         43. 00       NURSERY         44. 00       SKI LLED NURSI NG FACI LI TY         45. 00       NURSI NG FACI LI TY         200. 00       Total (lines 30 through 199)	1, 442 320 0 0 1, 221 0 0 0 0 0 0 0 0 0 2, 983	199, 183 64, 208 0 240, 268 0 240, 268 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				30.00 31.00 32.00 33.00 34.00 40.00 41.00 43.00 44.00 45.00 200.00

PPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT	AL COSTS	Provider C	CN: 15-0022	Peri od:	Worksheet D	
				From 01/01/2021 To 12/31/2021	Part II Date/Time Pre	pared
				11	5/31/2022 8:5	6 am
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,		$(col \cdot 1 \div col$		column 4)	
	Part II, col.	8)	2)	. ondriges		
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	-	<u> </u>			•	
D. 00 05000 OPERATING ROOM	861, 117	27, 144, 966	0.03172	1, 742, 570	55, 280	50.0
1.00 05100 RECOVERY ROOM	0	0	0.0000	0 00	0	51.0
2.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0.0000	0 00	0	52.0
3. 00 05300 ANESTHESI OLOGY	0	0	0.0000	0 00	0	53.0
4. 00 05400 RADI OLOGY-DI AGNOSTI C	638, 234	40, 628, 605	0.01570	2, 226, 337	34, 974	54.0
4. 01 03630 ULTRA SOUND	30, 579	5, 573, 184	0.00548	37 281, 404	1, 544	54.0
5. 00 05500 RADI OLOGY-THERAPEUTI C	118, 994	10, 967, 062	0. 0108	50 1, 349	15	55.0
6. 00 05600 RADI OI SOTOPE	0	C	0.0000		0	56. C
7. 00 05700 CT SCAN	0	l d	0.0000		0	
B. OO 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	l d	0.0000		0	
9. 00 05900 CARDI AC CATHETERI ZATI ON	0	l d	0.0000		0	59. C
0. 00 06000 LABORATORY	222, 234	26, 305, 928			19, 238	
D. 01 06001 BLOOD LABORATORY	0	0	0.0000		0	
1.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	-			-	-	61.0
2. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0. 00000	0 0	0	
3. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0		0.00000		0	
4. 00 06400 I NTRAVENOUS THERAPY	192		0.00000		0	1
5. 00 06500 RESPIRATORY THERAPY	24,000	3, 179, 571	0.00754		6, 092	1
6. 00 06600 PHYSI CAL THERAPY	141, 946	5, 490, 035			13, 137	
7. 00 06700 OCCUPATI ONAL THERAPY	0	0, 170, 000	0.00000		0	
B. 00 06800 SPEECH PATHOLOGY	0		0.00000		0	
9. 00 06900 ELECTROCARDI OLOGY	195,010	9, 012, 613			10, 992	
D. 00 07000 ELECTROENCEPHALOGRAPHY	0	, 012, 013	0.0000		0	70.0
1. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	340, 691	16, 131, 464			33, 587	
2. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	118, 783	4, 435, 778			17, 191	
3. 00 07300 DRUGS CHARGED TO PATIENTS	106, 740				3, 332	
4. 00 07400 RENAL DIALYSIS	00,740	40, 751, 510	0.0000		0	
5. 00 07500 ASC (NON-DISTINCT PART)	0		0.00000		0	
5. 00 03480 0NCOLOGY	9	18, 261	0.0004		0	
5. 97 07697 CARDI AC REHABI LI TATI ON	27	10, 201			0	
7. 00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	-				
OUTPATIENT SERVICE COST CENTERS	0		0.0000		0	1 / / . (
B. 00 08800 RURAL HEALTH CLINIC	0	C	0.0000	0 00	0	88. 0
9.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0.00000		0	
0.00 09000 CLINIC	124, 416				0	
1. 00 09100 EMERGENCY	695, 635				-	
1. 01 04950 WOUND CARE	200		0.0000		30, 487 0	
2. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	194, 341	3, 477, 329	0. 05588	38 510, 212	28, 515	92. (
OTHER REIMBURSABLE COST CENTERS	-		0.0000			
4. 00 09400 HOME PROGRAM DI ALYSI S	0	C	0.0000	0 00	0	
5. 00 09500 AMBULANCE SERVICES	-	-		-	-	95.0
6. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	, s	0.00000		0	
7. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0		0.00000		0	
8. 00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	0.0000		0	
00.00 Total (lines 50 through 199)	3, 813, 148	249, 297, 635		14, 671, 693	254, 384	200.

Health Financial Systems F APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER	RANCI SCAN HEALTH			Period:	eu of Form CMS-: Worksheet D	2552-10
			F	From 01/01/2021 To 12/31/2021	Part III	
		Title	e XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng	Nursi ng	Allied Health	Allied Health	All Other	
	Program	Program	Post-Stepdown	Cost	Medi cal	
	Post-Stepdown		Adj ustments		Education Cost	
	Adjustments					
	1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		0		0 0	0	20.00
30. 00 03000 ADULTS & PEDI ATRI CS 31. 00 03100 I NTENSI VE CARE UNI T	0	0			-	
32. 00 03200 CORONARY CARE UNIT	0	0		-		
33. 00 03300 BURN INTENSIVE CARE UNIT	0	0		-	0	
34. 00 03400 SURGICAL INTENSIVE CARE UNIT	0	0		-	0	
40. 00 04000 SUBPROVIDER - IPF	0	0				
40.00 04000 SUBPROVIDER - TPF 41.00 04100 SUBPROVIDER - TRF	0	0		0		
43. 00 04300 NURSERY	0	0				
43. 00 04400 SKI LLED NURSING FACILITY	0	0			0	43.00
44. 00 04400 SKILLED NORSING FACILITY 45. 00 04500 NURSING FACILITY	0	0		0		44.00
200.00 Total (lines 30 through 199)	0	0			0	200.00
Cost Center Description	Swing-Bed	Total Costs	Total Pationt	Per Diem (col.	Inpati ent	200.00
Cost Center Description	Adjustment	(sum of cols.	Days	$5 \div \text{col}$ . 6)	Program Days	
	Amount (see	1 through 3,	Days	5 . 601. 0)		
	i nstructi ons)					
	4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS	<b>_</b>					
30. 00 03000 ADULTS & PEDIATRICS	0	C	4, 759	9 0.00	1, 442	1 30. OC
31.00 03100 INTENSIVE CARE UNIT		C	99	0.00	320	31.00
32.00 03200 CORONARY CARE UNI T		0		0.00	0	32.00
33.00 03300 BURN INTENSIVE CARE UNIT		0		0.00	0	33.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT		0		0.00	0	34.00
40. 00 04000 SUBPROVIDER - IPF	0	0	1, 63	0.00	1, 221	40.00
41.00 04100 SUBPROVIDER - IRF	0	C		0.00	0	41.00
43. 00 04300 NURSERY		0		0.00	0	43.00
44.00 04400 SKILLED NURSING FACILITY		0	) (	0.00	0	44.00
45.00 04500 NURSING FACILITY		0		0.00	0	45.00
200.00 Total (lines 30 through 199)		0	7, 38	1	2, 983	200.00
Cost Center Description	I npati ent					
	Program					
	Pass-Through					
	Cost (col. 7 x					
	<u>col. 8)</u>					
UNDATIONT DOUTING CEDVICE COST CENTERS	9.00					
I NPATI ENT ROUTI NE SERVI CE COST CENTERS           30. 00         03000 ADULTS & PEDI ATRI CS	0					30.00
31. 00 03100 INTENSIVE CARE UNIT	0					30.00
32. 00 03200 CORONARY CARE UNIT	0					32.00
33. 00 03200 CORONARY CARE UNIT 33. 00 03300 BURN INTENSIVE CARE UNIT	0					32.00
33. OU JUSSOU DURIN THITENSIVE CARE UNIT	0					33.00
34 00 03400 SUPCICAL INTENSIVE CAPE UNIT	0					40.00
34. 00 03400 SURGI CAL I NTENSI VE CARE UNI T						
40. 00 04000 SUBPROVI DER - I PF	0					1 11 00
40. 00 04000 SUBPROVI DER - I PF 41. 00 04100 SUBPROVI DER - I RF	0					41.00
40. 00 04000 SUBPROVI DER - I PF 41. 00 04100 SUBPROVI DER - I RF 43. 00 04300 NURSERY	0					43.00
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	000000000000000000000000000000000000000					43.00 44.00
40. 00 04000 SUBPROVI DER - I PF 41. 00 04100 SUBPROVI DER - I RF 43. 00 04300 NURSERY	0					43.00

	2	ANCI SCAN HEALTH			Peri od:	u of Form CMS-2 Worksheet D	2552-10
	APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE FHROUGH COSTS		Provider CCN: 15-0022		From 01/01/2021 To 12/31/2021	Part IV Date/Time Pre 5/31/2022 8:5	pared: 6 am
			Title	XVIII	Hospi tal	PPS	<u> </u>
	Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program		Allied Health	
		1.00	2A	2.00	3A	3.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0		0 0	0	50.00
51.00	05100 RECOVERY ROOM	0	0		0 0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	52.00
53.00	05300 ANESTHESI OLOGY	0	0		0 0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
54.01	03630 ULTRA SOUND	0	0		0 0	0	54.01
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0		0 0	0	55.00
56.00	05600 RADI OI SOTOPE	0	0		0 0	0	56.00
57.00	05700 CT SCAN	0	0		0 0	0	57.00
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		0 0	0	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0	59.00
60.00	06000 LABORATORY	0	0		0 0	0	60.00
60.01	06001 BLOOD LABORATORY	0	0		0 0	0	60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	Ŭ		0	Ū	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0 0	0	62.00
63.00	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
65.00	06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
69.00	06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	70.00
70.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	
		0	0				71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0			0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0			0	73.00
74.00	07400 RENAL DIALYSIS	0	0		0	0	74.00
75.00	07500 ASC (NON-DI STINCT PART)	0			0 0	0	75.00
76.00	03480 ONCOLOGY	0	0		0 0	0	76.00
76.97	07697 CARDI AC REHABI LI TATI ON	0	0		0 0	0	76.97
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0		0 0	0	77.00
~ ~ ~	OUTPATIENT SERVICE COST CENTERS					0	
88.00	08800 RURAL HEALTH CLINIC	0	0		0 0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0	0	89.00
90.00	09000 CLINIC	0	0		0 0	0	90.00
91.00	09100 EMERGENCY	0	0		0 0	0	91.00
91.01	04950 WOUND CARE	0	0		0 0	0	91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	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						95.00
96.00	09600 DURABLE MEDI CAL EQUI P-RENTED	0	0		0 0	0	96.00
97.00	09700 DURABLE MEDI CAL EQUI P-SOLD	0	0		0 0	0	97.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0	0		0 0	0	98.00
200.00	Total (lines 50 through 199)	0	0		0 0	0	200.00

	ONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF						
	I COSTS	RVICE OTHER PASS	S Provider C	CN: 15-0022	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part IV Date/Time Pre	pared:
						5/31/2022 8:5	6 am
	Cast Castan Danasi sti as			XVIII	Hospital	PPS	
	Cost Center Description	All Other Medical	Total Cost (sum of cols.	Total Outpatient	Total Charges (from Wkst. C,	to Charges	
		Education Cost	•	Cost (sum of		(col. 5 ÷ col.	
			4)	col s. 2, 3,		7)	
				and 4)	0)	(see	
						instructions)	
		4.00	5.00	6.00	7.00	8.00	
4	ANCILLARY SERVICE COST CENTERS	·					
50.00	05000 OPERATING ROOM	0	0	I	0 27, 144, 966	0.00000	50.00
51.00 0	05100 RECOVERY ROOM	0	0		0 0	0. 000000	51.00
52.00 0	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0. 000000	52.00
53.00 0	05300 ANESTHESI OLOGY	0	0		0 0	0. 000000	53.00
54.00 0	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 40, 628, 605	0. 000000	54.00
54.01 0	03630 ULTRA SOUND	0	0		0 5, 573, 184	0.000000	54.01
55.00 0	05500 RADI OLOGY-THERAPEUTI C	0	0		0 10, 967, 062	0. 000000	55.00
56.00 0	05600 RADI OI SOTOPE	0	0		0 3, 099, 132	0.000000	56.00
57.00 0	05700 CT SCAN	0	0		0 0	0.000000	57.00
58.00 0	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0	0.000000	58.00
59.00 0	05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0.000000	59.00
60.00	06000 LABORATORY	0	0		0 26, 305, 928	0.000000	60.00
	06001 BLOOD LABORATORY	0	0		0 0	0.000000	60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0 0	0.000000	62.00
	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 0	0. 000000	
	06400 INTRAVENOUS THERAPY	0	0		0 0	0. 000000	
	06500 RESPI RATORY THERAPY	0	0		0 3, 179, 571	0. 000000	
	06600 PHYSI CAL THERAPY	0	0		0 5, 490, 035		
	06700 OCCUPATI ONAL THERAPY	0	0		0 0	0. 000000	
	06800 SPEECH PATHOLOGY	0	0		0 0	0. 000000	
	06900 ELECTROCARDI OLOGY	0	0		0 9, 012, 613	0. 000000	
	07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0.000000	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 16, 131, 464		
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 4, 435, 778		
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 48, 931, 516		
	07400 RENAL DIALYSIS	0	0		0 0	0.000000	
	07500 ASC (NON-DI STI NCT PART)	0	0		0 0	0.000000	
	03480 ONCOLOGY	0	0		0 18, 261	0.000000	
	07697 CARDI AC REHABI LI TATI ON	0	0		0 0	0.000000	
	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0		0 0	0.000000	77.00
	OUTPATIENT SERVICE COST CENTERS			1	0	0.000000	00.00
	08800 RURAL HEALTH CLINIC	0			0 0		
	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC	0			0 0 0	0.000000	
		-			0 1, 236, 575		
		0	0		0 46, 764, 748 0 0	0.000000	
	04950 WOUND CARE 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0				0.000000	
	OTHER REIMBURSABLE COST CENTERS	0	0	1	0 3, 477, 329	0.000000	92.00
	09400 HOME PROGRAM DIALYSIS	0	0	1	0 0	0. 000000	94.00
	09400 HOME PROGRAM DIALISIS 09500 AMBULANCE SERVICES				0	0.00000	94.00
	09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0 0	0. 000000	
	09700 DURABLE MEDICAL EQUIP-RENTED	0			0 0	0.000000	
	09850 OTHER REIMBURSABLE COST CENTERS	0	0		0 0	0.000000	
	Total (lines 50 through 199)	0			0 252, 396, 767		200.00
200.00							

Health Financial Systems APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY S	FRANCI SCAN HEALTH C	Provi der CO		Peri od:	eu of Form CMS-: Worksheet D	2002-10
THROUGH COSTS	SERVICE OTHER TASS		SN. 15 0022	From 01/01/2021 To 12/31/2021	Part IV Date/Time Pre	
				lloonital	5/31/2022 8:5	6 am
Cost Center Description	Outpati ent	Inpatient	XVIII Inpatient	Hospital Outpatient	PPS Outpatient	
Cost center Description	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Throug		Pass-Through	
		charges	Costs (col.		Costs (col. 9	
	(col. 6 ÷ col.		x  col. 10)	0	x col. 12)	
	7) 9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVI CE COST CENTERS	9.00	10.00	11.00	12.00	13.00	
50. 00 05000 OPERATI NG ROOM	0.000000	1, 742, 570		0 5, 156, 451	0	50.00
51. 00 05100 RECOVERY ROOM	0. 000000	0		0 0		
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 0		
53. 00 05300 ANESTHESI OLOGY	0.000000	0		0 0	0	
		0		-	-	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0.00000	2, 226, 337		0 8, 368, 398		
54. 01 03630 ULTRA SOUND	0. 000000	281, 404		0 1, 174, 475		
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	1, 349		0 3, 774, 027	0	
56. 00 05600 RADI OI SOTOPE	0. 000000	75, 555		0 932, 970		
57.00 05700 CT SCAN	0. 000000	0		0 0	-	
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 000000	0		0 0		
59. 00 05900 CARDIAC CATHETERIZATION	0. 000000	0		0 0	0	59.00
60. 00 06000 LABORATORY	0. 000000	2, 277, 195		0 4, 389, 333	0	60.00
60. 01 06001 BLOOD LABORATORY	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 INTRAVENOUS THERAPY	0.000000	0		0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	807, 073		0 241, 356		
66. 00 06600 PHYSI CAL THERAPY	0. 000000	508, 115		0 1, 415, 772		
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	000, 110		0 0		
68. 00 06800 SPEECH PATHOLOGY	0. 000000	0		0 0	o o	
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	508, 010		0 2, 267, 063		1
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	300, 010		0 2,207,003	0	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	1, 590, 288		0 2,004,710		
	0.000000					
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS		641, 989			0	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0.00000	1, 527, 602			-	
74. 00 07400 RENAL DI ALYSI S	0.00000	0		0 0	0	
75. 00 07500 ASC (NON-DI STINCT PART)	0. 000000	0		0 0	0	
76.00 03480 ONCOLOGY	0. 000000	0		0 0	0	
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000	0		0 0	0	
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		
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000	0		0 0	0	
90. 00 09000 CLINIC	0. 000000	0		0 366, 828	0	
91.00 09100 EMERGENCY	0. 000000	2,049,549		0 6, 183, 109	0	
91.01 04950 WOUND CARE	0. 000000	0		0 0	0	91.01
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	510, 212		0 658, 795	0	92.00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DI ALYSI S	0. 000000	0		0 0	0	94.00
95.00 09500 AMBULANCE SERVICES						95.00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000	0		0 0	0	96.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0. 000000	0		0 0	0	97.00
98. 00 09850 OTHER REI MBURSABLE COST CENTERS	0. 000000	0		0 0	0	98.00

PPORTI ONMENT	al Systems FR OF MEDICAL, OTHER HEALTH SERVICES AND		CRAWFORDSVILL Provider C	CN: 15-0022	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part V Date/Time Pre 5/31/2022 8:5	pared:
			Title	e XVIII	Hospi tal	PPS	_
				Charges		Costs	
Co	ost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins	Cost Reimbursed Services Not Subject To Ded. & Coins.	PPS Services (see inst.)	
				(see inst.)	(see inst.)		
		1.00	2.00	3.00	4.00	5.00	
	RY SERVICE COST CENTERS	0.0(0007		1	-	4 955 339	
	PERATING ROOM	0. 262927			0 0	1, 355, 770	
	ECOVERY ROOM	0. 000000			0 0	0	
	ELIVERY ROOM & LABOR ROOM	0. 000000			0 0	0	
	NESTHESI OLOGY	0. 000000			0 0	0	
	ADI OLOGY-DI AGNOSTI C	0. 098192			0 0	821, 710	54.00
4.01 03630 UL	LTRA SOUND	0. 040757	1, 174, 475		0 0	47, 868	54.01
5.00 05500 RA	ADI OLOGY-THERAPEUTI C	0. 168208	3, 774, 027		0 0	634, 822	55.00
6.00 05600 RA	ADI OI SOTOPE	0. 000000	932, 970		0 0	0	56.00
7.00 05700 CT		0. 000000	0		0 0	0	57.00
8.00 05800 MA	AGNETIC RESONANCE IMAGING (MRI)	0. 000000	0		0 0	0	58.00
	ARDI AC CATHETERI ZATI ON	0. 000000	0		0 0	0	59.00
0. 00  06000  LA	ABORATORY	0. 156716	4, 389, 333		0 0	687, 879	60.00
0. 01 06001 BL	LOOD LABORATORY	0. 000000	0		0 0	0	60. 0 <sup>-</sup>
1.00 06100 PE	BP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000			0 0		61.00
	HOLE BLOOD & PACKED RED BLOOD CELLS	0.00000			0 0	0	62.00
	LOOD STORING, PROCESSING & TRANS.	0.00000			0 0	0	
	NTRAVENOUS THERAPY	0.00000			0 0	0	64.00
	ESPI RATORY THERAPY	0. 421836			0 0	101, 813	
1 1	HYSI CAL THERAPY	0. 252253			0 0	357, 133	
	CCUPATIONAL THERAPY	0. 000000			0 0	0	
	PEECH PATHOLOGY	0. 000000			0 0	0	
	LECTROCARDI OLOGY	0. 114745			0 0	260, 134	
	LECTROENCEPHALOGRAPHY	0. 000000			0 0	0	1
	EDICAL SUPPLIES CHARGED TO PATIENTS	0. 180232			0 0	361, 313	
	MPL. DEV. CHARGED TO PATIENTS	0. 062945			0 0	53, 267	
	RUGS CHARGED TO PATIENTS	0. 230371			0 0	4, 073, 498	
	ENAL DIALYSIS	0. 230371			0 0	4, 073, 498	
	SC (NON-DISTINCT PART)	0. 000000			0 0	0	
					0 0		
		0. 041619			-	0	
	ARDI AC REHABI LI TATI ON	0. 000000			0 0	0	
	LLOGENEIC STEM CELL ACQUISITION	0. 000000	0		0 0	0	77.0
	ENT SERVICE COST CENTERS JRAL HEALTH CLINIC			1			00 00
							88.00
	EDERALLY QUALIFIED HEALTH CENTER	0 500005	0// 000			104.0/1	89.0
0.00 09000 CL		0. 529025			0 0		
	MERGENCY	0. 121474			0 0	751, 087	
	OUND CARE	0. 000000			0 0	-	
	BSERVATION BEDS (NON-DISTINCT PART)	0. 463133	658, 795		0 0	305, 110	92.00
	EI MBURSABLE COST CENTERS		1	1			
	OME PROGRAM DI ALYSI S	0. 000000			0 0		94.00
	MBULANCE SERVICES	0. 000000			0		95.00
	JRABLE MEDICAL EQUIP-RENTED	0. 000000			0 0	0	
	JRABLE MEDICAL EQUIP-SOLD	0. 000000			0 0	0	
	THER REIMBURSABLE COST CENTERS	0. 000000			0 0	0	
	ubtotal (see instructions)		55, 461, 868		0 0	10, 005, 465	200. 0
01.00 Le	ess PBP Clinic Lab. Services-Program				0 0		201.0
Or	nly Charges						1
	et Charges (line 200 - line 201)						

leal th Financial Systems FR APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND		CRAWFORDSVILL Provider CO		Peri od:	eu of Form CMS- Worksheet D	2002 1
				From 01/01/2021 To 12/31/2021	Part V Date/Time Pre	epared:
		Title	XVIII	Hospi tal	5/31/2022 8:5 PPS	oo am
	Cos	sts				
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.					
	(see inst.) 6.00	(see inst.) 7.00				
ANCI LLARY SERVI CE COST CENTERS	0.00	7.00	I			
50. 00 05000 OPERATI NG ROOM	0	0				50.0
51.00 05100 RECOVERY ROOM	0	0				51.0
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0				52.0
53. 00 05300 ANESTHESI OLOGY	0	0				53.0
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0				54.0
54.01 03630 ULTRA SOUND	0	0				54.0
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0				55.0
56. 00 05600 RADI OI SOTOPE	0	0				56.0
57.00 05700 CT SCAN	0	0				57.0
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0				58.0
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0				59.0
50. 00 06000 LABORATORY	0	0				60.0
50. 01 06001 BLOOD LABORATORY	0	0				60.0
1.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0					61.0
2.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0				62.0
3.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0				63.0
64.00 06400 INTRAVENOUS THERAPY	0	0				64.0
55. 00 06500 RESPI RATORY THERAPY	0	0				65.0
66. 00 06600 PHYSI CAL THERAPY	0	0				66.0
57.00 06700 OCCUPATI ONAL THERAPY	0	0				67.0
58.00 06800 SPEECH PATHOLOGY	0	0				68.0
	0	0				69.0
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0				70.0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				71.0
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS	0					73.0
74.00 07400 RENAL DIALYSIS	0					74.0
75. 00 07500 ASC (NON-DI STINCT PART)	0	0				75.0
76. 00 03480 ONCOLOGY	0	0				76.0
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0				76.9
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0				77.0
OUTPATIENT SERVICE COST CENTERS		<u> </u>				- //.0
38. 00 08800 RURAL HEALTH CLINIC						88. 0
39.00 08900 FEDERALLY QUALIFIED HEALTH CENTER						89.0
90. 00 09000 CLINIC	0	0				90.0
91.00 09100 EMERGENCY	0	0				91.0
91.01 04950 WOUND CARE	0	0				91.0
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0				92.0
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DI ALYSI S	0	0				94.0
25. 00 09500 AMBULANCE SERVI CES	0					95.0
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0					96.0
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0				97.0
28.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0				98.0
200.00 Subtotal (see instructions)	0	0				200. 0
201.00 Less PBP Clinic Lab. Services-Program	0					201.0
Only Charges	_	_				
202.00 Net Charges (line 200 - line 201)	0	0				202.0

ORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT	AL COSTS		CN: 15-0022	Period: From 01/01/2021	Worksheet D Part II Date (Time Dre	norce
		Component	CCN: 15-S022	To 12/31/2021	Date/Time Pre 5/31/2022 8:5	
		Title	e XVIII	Subprovider - IPF	PPS	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,			L. Charges	column 4)	
	Part II, col. 26)	8)	2)			
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	1.00	2.00	0.00	1.00	0.00	
00 05000 OPERATI NG ROOM	861, 117	27, 144, 966	0. 0317	23 0	0	50.0
00 05100 RECOVERY ROOM	0				0	
00 05200 DELIVERY ROOM & LABOR ROOM	0				0	
00 05300 ANESTHESI OLOGY	0				0	
00 05400 RADI OLOGY-DI AGNOSTI C	638, 234	40, 628, 605			986	54.
01 03630 ULTRA SOUND	30, 579				57	54.
00 05500 RADI OLOGY-THERAPEUTI C	118, 994	10, 967, 062	0. 0108	50 0	0	55.
00 05600 RADI OI SOTOPE	0	C			0	56.
00 05700 CT SCAN	0	c c	0.0000	0 00	0	57.
00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	c c	0. 0000	0 00	0	58.
00 05900 CARDI AC CATHETERI ZATI ON	0	c c	0. 0000	0 00	0	59.
00 06000 LABORATORY	222, 234	26, 305, 928	0. 0084	48 195, 775	1, 654	60.
01 06001 BLOOD LABORATORY	0	c c	0. 0000	0 00	0	60.
00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.
00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	C	0.0000	0 00	0	62.
00 06300 BLOOD STORING, PROCESSING & TRANS.	0	C	0.0000	0 00	0	63.
00 06400 I NTRAVENOUS THERAPY	192	C	0.0000	0 00	0	64.
00 06500 RESPI RATORY THERAPY	24,000	3, 179, 571			18	65.
00 06600 PHYSI CAL THERAPY	141, 946	5, 490, 035	0. 0258	55 62, 459	1, 615	66.
00 06700 OCCUPATI ONAL THERAPY	0	C			0	67.
00 06800 SPEECH PATHOLOGY	0	-			0	
00 06900 ELECTROCARDI OLOGY	195, 010	9, 012, 613			716	
00 07000 ELECTROENCEPHALOGRAPHY	0	C	0.0000		0	70.
00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	340, 691	16, 131, 464			1, 303	71.
00 07200 IMPL. DEV. CHARGED TO PATIENTS	118, 783				0	
00 07300 DRUGS CHARGED TO PATIENTS	106, 740	48, 931, 516			159	
00 07400 RENAL DIALYSIS	0	-			0	
00 07500 ASC (NON-DISTINCT PART)	0	-			0	
00 03480 ONCOLOGY	9	18, 261			0	
97 07697 CARDI AC REHABI LI TATI ON	27	C			0	
00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	C	0.0000	0 00	0	77.
OUTPATIENT SERVICE COST CENTERS	-	-			-	1
00 08800 RURAL HEALTH CLINIC	0				0	
00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	-			0	
00 09000 CLINIC	124, 416				0	
00 09100 EMERGENCY	695, 635				1, 430	
01 04950 WOUND CARE	200		0.0000		0	
00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	0	3, 477, 329	0.0000	0 00	0	92.
OTHER REIMBURSABLE COST CENTERS	2		0.0000			1
00 09400 HOME PROGRAM DI ALYSI S	0	C	0.0000	0 00	0	1
	_		0.0000	20	_	95.
00 09600 DURABLE MEDICAL EQUIP-RENTED	0				0	
00 09700 DURABLE MEDICAL EQUIP-SOLD	0				0	
00 09850 OTHER REIMBURSABLE COST CENTERS	0	C	0.0000	0 00	0	98.

Heal th	Financial Systems FR	ANCISCAN HEALTH	CRAWFORDSVI LL	E	In Li	eu of Form CMS-	2552-10
	TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER CH COSTS	RVICE OTHER PASS			Period: From 01/01/202		
			Component	CCN: 15-S022	To 12/31/202	1 Date/Time Pre 5/31/2022 8:5	
			Title	XVIII	Subprovider -		
	Cost Center Description	Non Physician	Nursi ng	Nursi ng		h Allied Health	
		Anestheti st	Program	Program	Post-Stepdow	n	
		Cost	Post-Stepdown Adjustments		Adj ustments		
		1.00	2A	2.00	3A	3.00	
	ANCI LLARY SERVI CE COST CENTERS	1.00	20	2.00	0/1	0.00	
50.00	05000 OPERATI NG ROOM	0	0		0	0 0	50.00
51.00	05100 RECOVERY ROOM	0	0		0	0 0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0 0	52.00
53.00	05300 ANESTHESI OLOGY	0	0		0	0 0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0 0	
54.01	03630 ULTRA SOUND	0	0		0	0 0	1
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0		0	0 0	1
56.00	05600 RADI OI SOTOPE	0	0		0	0 0	
57.00	05700 CT SCAN	0	0		0	0 0	
58.00 59.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		0	0 0	
59.00 60.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0	0		0	0 0	1
60. 00 60. 01	06001 BLOOD LABORATORY	0	0		0	0 0	
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0		0	0	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0	0 0	1
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0	0 0	
64.00	06400 I NTRAVENOUS THERAPY	0	0		0	0 0	1
65.00	06500 RESPI RATORY THERAPY	0	0		0	0 0	65.00
66.00	06600 PHYSI CAL THERAPY	0	0	1	0	0 0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0	0 0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0		0	0 0	68.00
69.00	06900 ELECTROCARDI OLOGY	0	0		0	0 0	
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0	0 0	
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0 0	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0	0 0	
73.00 74.00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0	0		0	0 0 0 0	
75.00	07500 ASC (NON-DI STI NCT PART)	0	0		0	0 0	1
76.00	03480 ONCOLOGY	0	0		0	0 0	1
76.97	07697 CARDI AC REHABI LI TATI ON	0	0		0	0 0	
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0		0	0 0	1
	OUTPATIENT SERVICE COST CENTERS			I			
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	09000 CLINIC	0	0		0	0 0	90.00
91.00	09100 EMERGENCY	0	0		0	0 0	91.00
91.01	04950 WOUND CARE	0	0		0	0 0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
94.00	09400 HOME PROGRAM DI ALYSI S	0	0		0	0 0	
95.00	09500 AMBULANCE SERVICES		~				95.00
96.00 97.00	09600 DURABLE MEDICAL EQUIP-RENTED 09700 DURABLE MEDICAL EQUIP-SOLD	0	0		0	0 0	1
97.00 98.00	09850 OTHER REIMBURSABLE COST CENTERS	0	0		0	0 0	
200.00		0	0		0		200.00
200.00		. 0	0	I	-1	-1 0	1-00.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLA	DV CEDVICE OTHED DAG	CRAWFORDSVI LL		Peri od:	eu of Form CMS-: Worksheet D	2002 10
THROUGH COSTS	INT SERVICE UTHER PAS.		CCN: 15-0022	From 01/01/2021 To 12/31/2021	Part IV	
		Title	e XVIII	Subprovider - IPF	PPS	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent			
	Education Cost		Cost (sum o		(col. 5 ÷ col.	
		4)	cols. 2, 3, and 4)	8)	7)	
			and 4)		(see instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVI CE COST CENTERS		0.00	0100	1100	0.00	
50. 00 05000 OPERATI NG ROOM	0	C	)	0 27, 144, 966	0.000000	50.00
51.00 05100 RECOVERY ROOM	0	C	)	0 0	0.00000	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	C	)	0 0	0.000000	52.00
53. 00 05300 ANESTHESI OLOGY	0	C		0 0	0.000000	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 40, 628, 605	0. 000000	54.00
54.01 03630 ULTRA SOUND	0	C		0 5, 573, 184		
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	C	1	0 10, 967, 062		
56. 00 05600 RADI OI SOTOPE	0	0		0 3, 099, 132		
57.00 05700 CT SCAN	0	0	1	0 0	01000000	
58. 00 05800 MAGNETIC RESONANCE I MAGI NG (MRI)	0	0		0 0	01000000	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 0 0	0.000000	
60. 00 06000 LABORATORY 60. 01 06001 BLOOD LABORATORY	0		1	0 26, 305, 928	0. 000000 0. 000000	1
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM 01				0	0.000000	61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CI		C		0 0	0. 000000	
63. 00 06300 BLOOD STORING, PROCESSING & TRANS				0 0		
64. 00 06400 I NTRAVENOUS THERAPY	,. 0 0	0		0 0	0.000000	
65. 00 06500 RESPIRATORY THERAPY	0	C C		0 3, 179, 571		
66. 00 06600 PHYSI CAL THERAPY	0	0		0 5, 490, 035		
67.00 06700 OCCUPATI ONAL THERAPY	0	C		0 0		
68.00 06800 SPEECH PATHOLOGY	0	C		0 0	0.000000	
69.00 06900 ELECTROCARDI OLOGY	0	C	)	0 9, 012, 613		
70.00 07000 ELECTROENCEPHALOGRAPHY	0	C	)	0 0	0. 000000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIE	ENTS 0	C		0 16, 131, 464	0. 000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	C		0 4, 435, 778	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 48, 931, 516		
74.00 07400 RENAL DI ALYSI S	0	C		0 0		
75.00 07500 ASC (NON-DISTINCT PART)	0	0		0 0	0.000000	
76.00 03480 ONCOLOGY	0	0		0 18, 261	0.000000	
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0 0		
77. 00 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON OUTPATI ENT SERVI CE COST CENTERS	0	0	1	0 0	0.000000	77.00
88. 00 08800 RURAL HEALTH CLINIC	0	C		0 0	0.000000	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER			1	0 0		
90. 00 09000 CLINIC			1	0 1, 236, 575		
91. 00 09100 EMERGENCY	0	0		0 46, 764, 748		
91.01 04950 WOUND CARE	0	0		0 0		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT P/	ART) O			0 3, 477, 329		1
OTHER REIMBURSABLE COST CENTERS						
94. 00 09400 HOME PROGRAM DI ALYSI S	0	C		0 0	0. 000000	
95.00 09500 AMBULANCE SERVICES						95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	C		0 0	0. 000000	
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD	0	0		0 0	0.000000	
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	1	0 0	0.00000	98.00
200.00 Total (lines 50 through 199)	0	C		0 252, 396, 767		200.00

	ANCISCAN HEALTH C	RAWFORDSVILL	E		eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE THROUGH COSTS	RVICE OTHER PASS	Provider C	CN: 15-0022	Period: From 01/01/202	Worksheet D 1 Part IV	
		Component (	CCN: 15-S022	To 12/31/202		
		Title	e XVIII	Subprovider -		
Cost Center Description	Outpatient	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Throug		Pass-Through Costs (col. 9	
	(col. 6 ÷ col. 7)		Costs (col. x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVI CE COST CENTERS	7.00	10.00	11.00	12.00	13.00	
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	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0	0 0	
53.00 05300 ANESTHESI OLOGY	0. 000000	0		0	0 0	
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	62, 781		0	0 0	
54.01 03630 ULTRA SOUND	0. 000000	10, 451		0	0 0	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	0		0	0 0	55.00
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 IMAGING (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. 000000	195, 775		0	0 0	60.00
60.01 06001 BLOOD LABORATORY	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 INTRAVENOUS THERAPY	0. 000000	0		0	0 0	64.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	2, 401		0	0 0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	62, 459		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	
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	33, 078		0	0 0	
70.00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0	0 0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	61, 676		0	0 0	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0	0 0	
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	72, 938		0	0 0	
74.00 07400 RENAL DIALYSIS	0. 000000	0		0	0 0	
75.00 07500 ASC (NON-DI STINCT PART)	0. 000000	0		0	0 0	
76.00 03480 0NC0L0GY	0. 000000	0		0	0 0	
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000	0		0	0 0	
77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000	0		0	0 0	77.00
	0.000000		1	0		00.00
88.00 08800 RURAL HEALTH CLINIC 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000	0		0	0 0 0 0	
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 90. 00 09000 CLINIC	0. 000000	0		0		
91. 00 09100 EMERGENCY	0. 000000 0. 000000			0	0 0 0 0	
91. 01 04950 WOUND CARE	0. 000000	96, 104 0		0		
91. 01 04950 WOUND CARE 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0		0		
0THER REIMBURSABLE COST CENTERS	0.000000	0	1	0	<u>vi</u> 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		0	۰ ۱	94.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000	0		0	0 0	
97. 00 09700 DURABLE MEDICAL EQUITERENTED	0. 000000	0		0	0 0	
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0. 000000	0		0	0 0	
200.00 Total (lines 50 through 199)	0.000000	597,663		0		200.00
	I I	077,000	I	-1	-1 0	

APPORTI ONME	INCI AL SYSTEMS FR	ANCISCAN HEALTH VACCINE COST	Provider C	CN: 15-0022	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part V Date/Time Pre 5/31/2022 8:5	pared:
			Titl	e XIX	Hospi tal	Cost	
				Charges		Costs	
	Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	PPS Reimbursed Services (see inst.)	Reimbursed Services Subject To Ded. & Coins		PPS Services (see inst.)	
		1.00	2.00	(see inst.) 3.00	4.00	5.00	
ANCI	LLARY SERVICE COST CENTERS		2100	0.00		0100	
	O OPERATING ROOM	0. 262927	3, 730, 652		0 0	980, 889	50. 00
51.00 0510	O RECOVERY ROOM	0. 000000	0		0 0	0	51.00
52.00 0520	O DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 0	0	52.00
53.00 0530	0 ANESTHESI OLOGY	0. 000000	0		0 0	0	53.00
54.00 0540	0 RADI OLOGY-DI AGNOSTI C	0. 098192	6, 781, 980	)	0 0	665, 936	54.00
54.01 0363	O ULTRA SOUND	0. 040757	907, 320	)	0 0	36, 980	54.01
55.00 0550	0 RADI OLOGY-THERAPEUTI C	0. 168208	1, 092, 697		0 0	183, 800	55.00
6. 00 0560	0 RADI 0I SOTOPE	0. 000000	322, 557		0 0	0	56.00
57.00 0570	O CT SCAN	0. 000000	0		0 0	0	57.00
58.00 0580	O MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	0	)	0 0	0	58.00
59.00 0590	O CARDI AC CATHETERI ZATI ON	0. 000000	0	)	0 0	0	59. OC
60.00 0600	0 LABORATORY	0. 156716	5, 069, 922		0 0	794, 538	60. OC
50.01 0600	1 BLOOD LABORATORY	0. 000000	0	)	0 0	0	60.01
1.00 0610	O PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000			0 0		61.00
62.00 0620	O WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	0	)	0 0	0	62.00
53.00 0630	O BLOOD STORING, PROCESSING & TRANS.	0. 000000	0	)	0 0	0	63.00
64.00 0640	O I NTRAVENOUS THERAPY	0. 000000	0	)	0 0	0	64.00
5.00 0650	0 RESPI RATORY THERAPY	0. 421836	161, 621		0 0	68, 178	65. OC
6. 00 0660	0 PHYSI CAL THERAPY	0. 252253	530, 913		0 0	133, 924	66.00
7.00 0670	O OCCUPATI ONAL THERAPY	0. 000000	0	)	0 0	0	67.00
8.00 0680	O SPEECH PATHOLOGY	0. 000000	0	)	0 0	0	68.00
69.00 0690	0 ELECTROCARDI OLOGY	0. 114745	1, 093, 027		0 0	125, 419	69.00
0.00 0700	0 ELECTROENCEPHALOGRAPHY	0. 000000	0	)	0 0	0	70.00
1.00 0710	O MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 180232	1, 461, 931		0 0	263, 487	71.00
2.00 0720	O IMPL. DEV. CHARGED TO PATIENTS	0. 062945	443, 470	)	0 0	27, 914	72.00
3.00 0730	O DRUGS CHARGED TO PATIENTS	0. 230371	4, 908, 228		0 0	1, 130, 713	73.00
74.00 0740	0 RENAL DIALYSIS	0. 000000	0		0 0	0	74.00
5.00 0750	O ASC (NON-DISTINCT PART)	0. 000000	0		0 0	0	75.00
6.00 0348	O ONCOLOGY	0. 041619	0		0 0	0	76.00
6.97 0769	7 CARDIAC REHABILITATION	0. 000000	0		0 0	0	76.9
7.00 0770	O ALLOGENEIC STEM CELL ACQUISITION	0. 000000	C		0 0	0	77.00
	ATIENT SERVICE COST CENTERS	-1					
	ORURAL HEALTH CLINIC						88.00
	O FEDERALLY QUALIFIED HEALTH CENTER						89.00
90.00 0900		0. 529025	130, 854		0 0	69, 225	90.00
	O EMERGENCY	0. 121474	14, 134, 907		0 0	1, 717, 024	91.00
91.01 0495	O WOUND CARE	0. 000000			0 0	-	91.01
	O OBSERVATION BEDS (NON-DISTINCT PART)	0. 463133	578, 813		0 0	268, 067	92.00
	R REIMBURSABLE COST CENTERS	i.	I	1	1		
	O HOME PROGRAM DI ALYSI S	0. 000000			0 0		94.00
	O AMBULANCE SERVI CES	0. 000000			0		95.00
	O DURABLE MEDICAL EQUIP-RENTED	0. 000000			0 0	0	
	O DURABLE MEDICAL EQUIP-SOLD	0. 000000			0 0	0	97.00
	O OTHER REIMBURSABLE COST CENTERS	0. 000000			0 0	0	98.00
200.00	Subtotal (see instructions)		41, 348, 892		0 0	6, 466, 094	
201.00	Less PBP Clinic Lab. Services-Program				0 0		201.00
202.00	Only Charges Net Charges (line 200 - line 201)		44 0 40 5		-		000 01
	(1) = 1 (1) $= 200$ (1) $= 201$ )	1	41, 348, 892	1	0 0	6, 466, 094	1000 0

PORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN		CRAWFORDSVILL Provider C		Peri od: From 01/01/2021	eu of Form CMS-2 Worksheet D Part V	
				To 12/31/2021	Date/Time Prep 5/31/2022 8:50	
			e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Cost				
cost center bescription	Reimbursed	Reimbursed				
	Servi ces	Servi ces Not				
	Subject To	Subject To				
	Ded. & Coi ns.					
	(see inst.)	(see inst.)				
	6.00	7.00				
ANCI LLARY SERVI CE COST CENTERS			1			
00 05000 OPERATING ROOM	0	0				50.
00 05100 RECOVERY ROOM	0	0				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.
01 03630 ULTRA SOUND	0	0				54.
00 05500 RADI OLOGY-THERAPEUTI C	0	0				55.
00 05600 RADI 0I SOTOPE	0	0				56.
00 05700 CT SCAN	0	0				57.
00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0				58.
00 05900 CARDI AC CATHETERI ZATI ON	0	0				59.
00 06000 LABORATORY	0	0				60.
01 06001 BLOOD LABORATORY	0	0				60.
00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0					61.
00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0				62.
00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0				63.
00 06400 INTRAVENOUS THERAPY	0	0				64.
00 06500 RESPI RATORY THERAPY	0	0				65.
00 06600 PHYSI CAL THERAPY	0	0				66.
00 06700 OCCUPATI ONAL THERAPY	0	0				67.
00 06800 SPEECH PATHOLOGY	0	0				68.
00 06900 ELECTROCARDI OLOGY	0	0				69.
00 07000 ELECTROENCEPHALOGRAPHY	0	0				70.
00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71.
00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72.
00 07300 DRUGS CHARGED TO PATIENTS	0	0				73.
00 07400 RENAL DI ALYSI S	0	0				74.
00 07500 ASC (NON-DISTINCT PART)	0	0				75.
00 03480 ONCOLOGY	0	0				76.
97 07697 CARDI AC REHABI LI TATI ON	0	0				76.
00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0				77.
OUTPATIENT SERVICE COST CENTERS						
00 08800 RURAL HEALTH CLINIC						88.
00 08900 FEDERALLY QUALIFIED HEALTH CENTER						89.
00 09000 CLINIC	0	0				90.
00 09100 EMERGENCY	0	0				91.
01 04950 WOUND CARE	0	0				91.
00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0				92.
OTHER REIMBURSABLE COST CENTERS						
00 09400 HOME PROGRAM DI ALYSI S	0	0				94.
00 09500 AMBULANCE SERVICES	0					95.
00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0				96.
00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0				97.
00 09850 OTHER REIMBURSABLE COST CENTERS	0	0				98.
0.00 Subtotal (see instructions)	0	0				200.
.00 Less PBP Clinic Lab. Services-Program	0	-				201.
Only Charges						
Net Charges (line 200 - line 201)	0	0				202.

FRANCI SCAN	HEALTH	CRAWFORDSVI LLE	

In Lieu of Form CMS-2552-10

Heal th	Financial Systems FRANCI SCAN HEALTH CF	RAWFORDSVI LLE	In Lie	eu of Form CMS-2	2552-10
	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0022	Peri od:	Worksheet D-1	
			From 01/01/2021 To 12/31/2021		
		Title XVIII	Hospi tal	5/31/2022 8: 5 PPS	<u>6 am</u>
	Cost Center Description	II LIE XVIII			
				1.00	
	PART I – ALL PROVIDER COMPONENTS INPATIENT DAYS				-
1.00	Inpatient days (including private room days and swing-bed days			4, 759	•
2.00 3.00	Inpatient days (including private room days, excluding swing- Private room days (excluding swing-bed and observation bed day do not complete this line.		ivate room days,	4, 759 0	
4.00 5.00	Semi-private room days (excluding swing-bed and observation be Total swing-bed SNF type inpatient days (including private roo		er 31 of the cost	3, 352 0	4.00 5.00
6.00	reporting period Total swing-bed SNF type inpatient days (including private row reporting period (if calendar year, enter 0 on this line)	om days) after December	31 of the cost	0	6. 00
7.00	Total swing-bed NF type inpatient days (including private room reporting period	m days) through December	31 of the cost	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	n days) after December 3	31 of the cost	0	8.00
9.00	Total inpatient days including private room days applicable to newborn days) (see instructions)	0		1, 442	9.00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII of through December 31 of the cost reporting period (see instruction)	tions)			10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII on December 31 of the cost reporting period (if calendar year, en	nter 0 on this line)	5	0	
	Swing-bed NF type inpatient days applicable to titles V or XI through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XI	3 · · · · · · · ·	5,	0	
13.00 14.00	after December 31 of the cost reporting period (if calendar y Medically necessary private room days applicable to the Progr	ear, enter O on this lir	ne)	0	
15.00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)	and (excluding swing-bed	uays)	0	15.00
10.00	SWING BED ADJUSTMENT				10.00
	Medicare rate for swing-bed SNF services applicable to service reporting period	C			17.00
18.00	Medicare rate for swing-bed SNF services applicable to service reporting period				18.00
	Medicaid rate for swing-bed NF services applicable to services reporting period	5			19.00
	Medicaid rate for swing-bed NF services applicable to services reporting period		the cost		20.00
	Total general inpatient routine service cost (see instruction: Swing-bed cost applicable to SNF type services through December $5 \times 1$ ine 17)		ing period (line	5, 447, 206 0	1
23. 00	swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reportir	ng period (line 6	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 7 x line 19)	r 31 of the cost reporti	ng period (line	0	24.00
25. 00	Swing-bed cost applicable to NF type services after December 3 x line 20)	31 of the cost reporting	period (line 8	0	25.00
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		0 5, 447, 206	26.00 27.00
28.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-be	h and observation had ch	ardes)	0	28.00
	Private room charges (excluding swing-bed charges)		lai ges)	0	
30.00	Semi -private room charges (excluding swing-bed charges)			0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0. 000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	•
	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
34.00	Average per diem private room charge differential (line 32 mil		ctions)	0.00	
	Average per diem private room cost differential (line 34 x lin	ne 31)		0.00	•
	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	0 5, 447, 206	36.00 37.00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY			I	1
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	JSTMENTS			1
	Adjusted general inpatient routine service cost per diem (see	instructions)		1, 144. 61	
	Program general inpatient routine service cost (line 9 x line			1, 650, 528	1
40. 00 41. 00	Medically necessary private room cost applicable to the Progra Total Program general inpatient routine service cost (line 39			0 1, 650, 528	

	ATION OF INPATIENT OPERATING COST		FIOVICEI	CCN: 15-0022	Period: From 01/01/2021	Worksheet D-1	1
					To 12/31/2021		
				e XVIII	Hospi tal	PPS	
	Cost Center Description	Total Inpatient Cost	Total Inpatient Day			(col. 3 x col.	
		1.00	2.00	col. 2) 3.00	4.00	4) 5.00	
. 00	NURSERY (title V & XIX only)	0		0.00			) 42
	Intensive Care Type Inpatient Hospital Units			-			
	INTENSIVE CARE UNIT	2, 161, 812					
	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT	0		0. 0 0.			
	SURGICAL INTENSIVE CARE UNIT	0		0.			
	OTHER SPECIAL CARE (SPECIFY)	0		0.			47
	Cost Center Description			•			
	Dragnam inpatient angillary convice cost (W/s	+ D 2 and 2	Line 200)			1.00	1 40
	Program inpatient ancillary service cost (Wks Total Program inpatient costs (sum of lines 4			ons)		2, 736, 473 5, 085, 065	
. 00	PASS THROUGH COST ADJUSTMENTS		see matructr	01137			J 47
. 00	Pass through costs applicable to Program inpa	tient routine	services (fro	m Wkst. D, su	m of Parts I and	263, 391	1 50
. 00	Pass through costs applicable to Program inpa	tient ancillar	y services (f	rom Wkst. D,	sum of Parts II	254, 384	4 51
. 00	and IV) Total Program excludable cost (sum of lines 5	0 and 51)				517, 775	5 52
. 00	Total Program inpatient operating cost exclud		lated, non-ph	ysician anest	hetist, and	4, 567, 290	
	medical education costs (line 49 minus line 5	2)		-			
00	TARGET AMOUNT AND LIMIT COMPUTATION						
	Program discharges Target amount per discharge					0.00	) 54 ) 55
	Target amount (line 54 x line 55)					0.00	
	Difference between adjusted inpatient operati	ng cost and ta	rget amount (	line 56 minus	line 53)	0	
. 00	Bonus payment (see instructions)	-	-			( C	
. 00	Lesser of lines 53/54 or 55 from the cost rep	orting period	endi ng 1996,	updated and c	ompounded by the	0.00	59
. 00	market basket Lesser of lines 53/54 or 55 from prior year c	oct roport up	dated by the	markat backat		0.00	0 60
	If line 53/54 is less than the lower of lines					0.00	
	which operating costs (line 53) are less than						
	amount (line 56), otherwise enter zero (see i	nstructions)					
	Relief payment (see instructions)	nt (and instru	ati ana)				
. 00	Allowable Inpatient cost plus incentive payme PROGRAM INPATIENT ROUTINE SWING BED COST		ictions)			<u> </u>	) 63
. 00	Medicare swing-bed SNF inpatient routine cost	s through Dece	mber 31 of th	e cost report	ing period (See	(	5 64
	instructions)(title XVIII only)	-					
. 00	Medicare swing-bed SNF inpatient routine cost	s after Decemb	er 31 of the	cost reportin	g period (See	C	) 65
. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routin	e costs (line	64 nlus line	65)(title XVI	ll only) For		0 66
. 00	CAH (see instructions)			00)((1110 XV)	ri oniy). Toi		
. 00	Title V or XIX swing-bed NF inpatient routine	costs through	December 31	of the cost r	eporting period	( C	67
	(line 12 x line 19)						
. 00	Title V or XIX swing-bed NF inpatient routine	costs after D	ecember 31 of	the cost rep	orting period		) 68
. 00	(line 13 x line 20)  Total title V or XIX swing-bed NF inpatient r	outine costs (	line 67 + lin	e 68)		(	0 69
	PART III - SKILLED NURSING FACILITY, OTHER NU			,			
	Skilled nursing facility/other nursing facili				)		70
	Adjusted general inpatient routine service co		ine 70 ÷ line	2)			71
	Program routine service cost (line 9 x line 7 Medically necessary private room cost applica		(line 1/ v l	ine 35)			72
. 00	Total Program general inpatient routine servi						74
	Capital -related cost allocated to inpatient r				Part II, column		75
_	26, line 45)						
	Per diem capital-related costs (line 75 ÷ lin						76
	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minus						77
	Aggregate charges to beneficiaries for excess		rovi der recor	ds)			79
00	Total Program routine service costs for compa	<b>`</b>			nus line 79)		80
	Inpatient routine service cost per diem limit						81
	Inpatient routine service cost limitation (li						82
. 00 . 00	Reasonable inpatient routine service costs (s Program inpatient ancillary services (see ins		5)				83
	Utilization review - physician compensation (		ns)				85
	Total Program inpatient operating costs (sum						86
	PART IV - COMPUTATION OF OBSERVATION BED PASS	THROUGH COST					
	Total observation bed days (see instructions)					1, 407	
. 00 . 00	Adjusted general inpatient routine cost per d	1 am (11 am	1			1, 144. 61	1 88

Health Financial Systems FR/	ANCISCAN HEALTH	CRAWFORDSVI LLI	E	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period: From 01/01/2021	Worksheet D-1	
				To 12/31/2021	Date/Time Prep 5/31/2022 8:50	pared: 6 am
		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	657, 338	5, 447, 206	0. 12067	4 1, 610, 466	194, 341	90.00
91.00 Nursing Program cost	0	5, 447, 206	0.00000	0 1, 610, 466	0	91.00
92.00 Allied health cost	0	5, 447, 206	0.00000	0 1, 610, 466	0	92.00
93.00 All other Medical Education	0	5, 447, 206	0.00000	1, 610, 466	0	93.00

MPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0022 Component CCN: 15-S022	Peri od: From 01/01/2021 To 12/31/2021	Worksheet D-1 Date/Time Pre 5/31/2022 8:50	par
		Title XVIII	Subprovider -	PPS	
	Cost Center Description		-	1.00	
	PART I - ALL PROVIDER COMPONENTS				
00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days	s. excluding newborn)		1, 631	1 1
00 00	Inpatient days (including private room days, excluding swing- Private room days (excluding swing-bed and observation bed day do not complete this line.	bed and newborn days)	ivate room days,	1, 631 0	2
00 00	Semi-private room days (excluding swing-bed and observation be Total swing-bed SNF type inpatient days (including private roo		er 31 of the cost	1, 631 0	2
00	reporting period Total swing-bed SNF type inpatient days (including private roo reporting period (if calendar year, enter 0 on this line)	om days) after December	31 of the cost	0	6
00	Total swing-bed NF type inpatient days (including private roor reporting period	m days) through December	31 of the cost	0	7
00	Total swing-bed NF type inpatient days (including private roor reporting period (if calendar year, enter 0 on this line)	5		0	8
00	Total inpatient days including private room days applicable to newborn days) (see instructions)	5 . 5	5	1, 221	
. 00	Swing-bed SNF type inpatient days applicable to title XVIII on through December 31 of the cost reporting period (see instruct Swing-bed SNF type inpatient days applicable to title XVIII on	tions)	3 /	0	
00	December 31 of the cost reporting period (if calendar year, er Swing-bed NF type inpatient days applicable to titles V or XI)	nter 0 on this line)			12
00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XI:			0	13
. 00	after December 31 of the cost reporting period (if calendar ye Medically necessary private room days applicable to the Progra Total nursery days (title V or XIX only)			0	
	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			-	16
00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through December 31 c	of the cost	0.00	17
. 00	Medicare rate for swing-bed SNF services applicable to service reporting period			0.00	
00	Medicaid rate for swing-bed NF services applicable to services reporting period	5		0.00	
. 00	Medicaid rate for swing-bed NF services applicable to services reporting period Total general inpatient routine service cost (see instructions		ne cost	0. 00 2, 727, 235	
00	Swing-bed cost applicable to SNF type services through December 5 x line 17)	er 31 of the cost report		0	22
00	Swing-bed cost applicable to SNF type services after December x line 18) Swing-bed cost applicable to NF type services through December			0	
00	7 x line 19) Swing-bed cost applicable to NF type services after December 3		51 (	0	
. 00	Total swing-bed cost (see instructions)			0	
	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)		2, 727, 235	
	General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges)	d and observation bed ch	arges)	0	
00	Semi-private room charges (excluding swing-bed charges)			0	30
	General inpatient routine service cost/charge ratio (line 27 -	÷line 28)		0.000000	
	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	
	Average per diem private room charge differential (line 32 min	nus line 33)(see instruc	tions)	0.00	
	Average per diem private room cost differential (line 34 x lin			0.00	
00 00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost a		fferential (line)	0 2, 727, 235	36
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY			_, , _ 1, _ 33	
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU				1
	Adjusted general inpatient routine service cost per diem (see			1, 672. 12	
	Program general inpatient routine service cost (line 9 x line	38)		2, 041, 659	39
	Medically necessary private room cost applicable to the Progra	/iii	1	0	40

	Financial         Systems         FR/           ATION OF INPATIENT OPERATING COST	ANCISCAN HEALTH (	Provider C		Period:	eu of Form CMS- Worksheet D-1	
			Component	CCN: 15-S022	From 01/01/2021 To 12/31/2021	Date/Time Pre	
			Title	XVIII	Subprovider -	5/31/2022 8:5 PPS	56 am
	Cost Center Description	Total	Total	Average Per	IPF Program Days	Program Cost	
		Inpatient Costli	npatient Days	Diem (col. 1 col. 2)	÷	(col. 3 x col. 4)	
2.00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00 00 0	5.00 0	) 42.0
	Intensive Care Type Inpatient Hospital Units			1		1	
3.00	I NTENSI VE CARE UNI T CORONARY CARE UNI T	0	0	0.1		-	
5.00	BURN INTENSIVE CARE UNIT	0	0	0.		-	
6.00	SURGI CAL I NTENSI VE CARE UNI T	0	0	0.	00 C	C	
7.00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47.
8.00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3,	line 200)			1.00	9 48.
9. 00	Total Program inpatient costs (sum of lines - PASS THROUGH COST ADJUSTMENTS			ns)		2, 139, 088	3 49.
0. 00	Pass through costs applicable to Program inpa	atient routine s	ervices (from	Wkst. D, sur	n of Parts I and	240, 268	3 50.
1. 00	III) Pass through costs applicable to Program inpa	atient ancillary	services (fr	om Wkst. D, s	sum of Parts II	7, 938	51.
2.00	and IV) Total Program excludable cost (sum of lines !	50 and 51)				248, 206	52.
53.00	Total Program inpatient operating cost exclu medical education costs (line 49 minus line 1 TARGET AMOUNT AND LIMIT COMPUTATION	ding capital rel	ated, non-phy	sician anestl	netist, and	1, 890, 882	
4.00	Program discharges					0	
5.00 6.00	Target amount per discharge Target amount (line 54 x line 55)					0.00	
7.00	Difference between adjusted inpatient operat	ing cost and tar	pet amount (I	ine 56 minus	line 53)		
8.00	Bonus payment (see instructions)	5				0	
9.00	Lesser of lines 53/54 or 55 from the cost re	porting period e	nding 1996, u	pdated and co	ompounded by the	0.00	59.
0. 00	market basket Lesser of lines 53/54 or 55 from prior year o	cost report upd	ated by the m	arket basket		0.00	60.
1.00	If line 53/54 is less than the lower of line				the amount by	0.00	
	which operating costs (line 53) are less than		(lines 54 x	60), or 1% or	f the target		
2.00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	instructions)				c	62.
	PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instruc	tions)			0	
4.00	Medicare swing-bed SNF inpatient routine cos	ts through Decem	per 31 of the	cost reporti	ng period (See	C	64.
5.00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after Decembe	- 31 of the c	ost reporting	g period (See	C	65.
6. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	ne costs (line 6	1 nlus line 6	5)(title XVI)	lonly) For	, o	66.
	CAH (see instructions)			, ,	5.		
	Title V or XIX swing-bed NF inpatient routine (line 12 x line 19)	-					
8. 00	Title V or XIX swing-bed NF inpatient routine (line 13 x line 20)	e costs after De	cember 31 of	the cost repo	orting period	C	68.0
9. 00	Total title V or XIX swing-bed NF inpatient   PART III - SKILLED NURSING FACILITY, OTHER NU					C	69.0
0.00	Skilled nursing facility/other nursing facil				)		70.
1.00	Adjusted general inpatient routine service of		ne 70 ÷ line	2)			71.
2.00 3.00	Program routine service cost (line 9 x line Medically necessary private room cost applic		(line 14 x li	ne 35)			72.
4.00	Total Program general inpatient routine serv	0	•				74.
5.00	Capital-related cost allocated to inpatient 26, line 45)	routine service	costs (from W	orksheet B, I	Part II, column		75.
6.00	Per diem capital-related costs (line 75 ÷ li						76.
7.00 8.00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu:						77.
9.00	Aggregate charges to beneficiaries for excess		ovider record	s)			79.
0.00	Total Program routine service costs for compa		st limitation	(line 78 min	nus line 79)		80.
1.00 2.00	Inpatient routine service cost per diem limi						81.
2.00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (		)				82.
3. 00 84. 00	Program inpatient ancillary services (see in	structions)					84.
5.00	Utilization review - physician compensation	(see instruction					85.
6. 00	Total Program inpatient operating costs (sum		bugh 85)				86.
7.00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions					C	87.
38. 00	Adjusted general inpatient routine cost per	diem (line 27 ÷	ine 2)			0.00	88.
9 00	Observation bed cost (line 87 x line 88) (see	e instructions)				0	89.

Health Financial Systems FR.	ANCISCAN HEALTH	CRAWFORDSVI LL	E	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period: From 01/01/2021	Worksheet D-1	
		Component (		To 12/31/2021	Date/Time Prep 5/31/2022 8:50	
		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	320, 942	2, 727, 235	0. 11768	0 0	0	90.00
91.00 Nursing Program cost	0	2, 727, 235	0.00000	0 0	0	91.00
92.00 Allied health cost	0	2, 727, 235	0.00000	0 0	0	92.00
93.00 All other Medical Education	0	2, 727, 235	0. 00000	0 0	0	93.00

PATIEN	IT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 15-0		Period: From 01/01/2021	Worksheet D-3	
				To 12/31/2021	Date/Time Pre 5/31/2022 8:5	
		Title XVIII		Hospi tal	PPS	_
	Cost Center Description		of Cost		Inpatient	
			narges	Program	Program Costs (col. 1 x col.	
				Charges	2)	
		1.	. 00	2.00	3.00	-
11	NPATIENT ROUTINE SERVICE COST CENTERS					
	3000 ADULTS & PEDI ATRI CS			2, 608, 544		30
	3100 I NTENSI VE CARE UNI T			1, 587, 121		31
	3200 CORONARY CARE UNI T			0		32
	3300 BURN INTENSIVE CARE UNIT			0		33
	3400 SURGI CAL I NTENSI VE CARE UNI T			0		34
	4000 SUBPROVIDER - IPF			0		40
	4100 SUBPROVIDER - IRF			0		41
	4300 NURSERY NCILLARY SERVICE COST CENTERS					43
	5000 OPERATING ROOM		0. 26292	7 1, 742, 570	458, 169	50
	5100 RECOVERY ROOM		). 20292 ). 00000		438, 109	
	5200 DELIVERY ROOM & LABOR ROOM		D. 00000		0	
	5300 ANESTHESI OLOGY		D. 00000		0	
	5400 RADI OLOGY-DI AGNOSTI C		0. 09819		218, 608	
01 03	3630 ULTRA SOUND	(	0. 04075	7 281, 404	11, 469	54
00 05	5500 RADI OLOGY-THERAPEUTI C	(	0. 16820	8 1, 349	227	55
00 05	5600 RADI OI SOTOPE	(	0.0000	0 75, 555	0	56
	5700 CT SCAN	(	0.0000	0 0	0	57
	5800 MAGNETIC RESONANCE IMAGING (MRI)	(	0.0000	0 0	0	
	5900 CARDI AC CATHETERI ZATI ON	(	0.0000		0	
	6000 LABORATORY		0. 15671			
	6001 BLOOD LABORATORY		0.0000		0	
1	6100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0.0000		0	
	6200 WHOLE BLOOD & PACKED RED BLOOD CELLS		00000		0	
	6300 BLOOD STORING, PROCESSING & TRANS. 6400 I NTRAVENOUS THERAPY		D. 00000 D. 00000		0	63
	6500 RESPI RATORY THERAPY		). 42183			
	6600 PHYSI CAL THERAPY		). 25225		128, 174	
	6700 OCCUPATI ONAL THERAPY		D. 00000		0	
	6800 SPEECH PATHOLOGY		0.0000		0	
00 00	6900 ELECTROCARDI OLOGY	(	D. 11474	5 508, 010	58, 292	69
	7000 ELECTROENCEPHALOGRAPHY	(	0.0000	0 0	0	70
	7100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS		0. 18023		286, 621	
	7200 I MPL. DEV. CHARGED TO PATIENTS		0. 06294		40, 410	
	7300 DRUGS CHARGED TO PATIENTS		0. 23037		351, 915	
	7400 RENAL DIALYSIS		00000		0	
	7500 ASC (NON-DI STINCT PART) 3480 ONCOLOGY		D. 00000		0	
	7697 CARDIAC REHABILITATION		D. 04161 D. 00000			
	7700 ALLOGENEI C STEM CELL ACQUI SI TI ON		). 00000 ). 00000			
	JTPATIENT SERVICE COST CENTERS		0.00000	<u> </u>		1 ' '
	B800 RURAL HEALTH CLINIC		D. 00000	0	0	88
	8900 FEDERALLY QUALI FI ED HEALTH CENTER		0.0000		0	
00 09	9000 CLINIC	(	D. 52902	5 0	0	90
	9100 EMERGENCY	(	D. 12147	4 2, 049, 549	248, 967	91
	4950 WOUND CARE		0.0000		0	
	9200 OBSERVATION BEDS (NON-DISTINCT PART)	(	D. 46313	3 510, 212	236, 296	92
	THER REIMBURSABLE COST CENTERS	1				١.
	9400 HOME PROGRAM DI ALYSI S		0.0000	0 0	0	
	9500 AMBULANCE SERVICES				_	95
	9600 DURABLE MEDICAL EQUIP-RENTED		00000 C		0	
	9700 DURABLE MEDICAL EQUIP-SOLD				0	
00 09	9850 OTHER REIMBURSABLE COST CENTERS Total (sum of lines 50 through 94 and 96 through 98)		00000	14, 747, 248		
1.00	Less PBP Clinic Laboratory Services-Program only charges	(line 61)		14, 747, 248	2, 130, 413	200
	Less i bi office caboratory bervices-riogram only charges			0		1201

VPATI ENT	ANCILLARY SERVICE COST APPORTIONMENT P	rovider C	CN: 15-0022	Period:	Worksheet D-3	
	c	omponent	CCN: 15-S022	From 01/01/2021 To 12/31/2021	Date/Time Pre 5/31/2022 8:5	
		Titl€	e XVIII	Subprovider - IPF	PPS	<u>u a</u>
	Cost Center Description		Ratio of Cos		Inpati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
			1.00	2.00	2)	-
	TIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
	0 ADULTS & PEDIATRICS					30
	O I NTENSI VE CARE UNI T					3
	O CORONARY CARE UNI T					32
	O BURN I NTENSI VE CARE UNI T					33
	O SURGICAL INTENSIVE CARE UNIT					34
0.00 0400	0 SUBPROVIDER - IPF			2, 963, 919		40
1.00 0410	0 SUBPROVIDER - IRF					41
3.00 0430	0 NURSERY					43
	LLARY SERVICE COST CENTERS					
	O OPERATING ROOM		0. 26292		0	
	O RECOVERY ROOM		0.0000		0	
	O DELIVERY ROOM & LABOR ROOM		0.0000		0	
	O ANESTHESI OLOGY		0.0000		0	5
	0 RADI OLOGY-DI AGNOSTI C 0 ULTRA SOUND		0.0981		6, 165	
			0.0407		426	
	0 RADI 0L0GY-THERAPEUTI C 0 RADI 0I SOTOPE		0. 16820		0	
	O CT SCAN		0.0000		0	
	O MAGNETIC RESONANCE I MAGI NG (MRI)		0.0000		0	
	O CARDI AC CATHETERI ZATI ON		0.0000		0	59
	0 LABORATORY		0. 1567		30, 681	
	1 BLOOD LABORATORY		0.0000		0	60
	O PBP CLINICAL LAB SERVICES-PRGM ONLY		0.0000		0	6
2.00 0620	O WHOLE BLOOD & PACKED RED BLOOD CELLS		0.0000	0 00	0	62
	0 BLOOD STORING, PROCESSING & TRANS.		0.0000	0 00	0	63
	O I NTRAVENOUS THERAPY		0.0000		0	
	0 RESPI RATORY THERAPY		0. 4218		1, 013	
	0 PHYSI CAL THERAPY		0. 2522		15, 755	
	O OCCUPATI ONAL THERAPY		0.0000		0	
	O SPEECH PATHOLOGY		0.0000		0	
	0 ELECTROCARDI OLOGY 0 ELECTROENCEPHALOGRAPHY		0. 1147		3, 796 0	
	0 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 1802		11, 116	
	O IMPL. DEV. CHARGED TO PATIENTS		0. 0629		0	
	O DRUGS CHARGED TO PATIENTS		0. 2303		16, 803	
	O RENAL DI ALYSI S		0.0000		0	
	O ASC (NON-DI STI NCT PART)		0.0000		0	
	O ONCOLOGY		0.0416		0	
6. 97 0769	7 CARDI AC REHABI LI TATI ON		0.0000	0 00	0	76
7.00 0770	O ALLOGENEIC STEM CELL ACQUISITION		0.0000	0 00	0	7
	ATIENT SERVICE COST CENTERS					
	O RURAL HEALTH CLINIC		0.0000		0	
	0 FEDERALLY QUALIFIED HEALTH CENTER		0.0000		0	
			0. 52902		0	
			0. 1214		11, 674	
	O WOUND CARE		0.0000		0	
2.00 0920	O OBSERVATION BEDS (NON-DISTINCT PART) R REIMBURSABLE COST CENTERS		0. 4631	33 0	0	92
	O HOME PROGRAM DI ALYSI S		0.0000	0 00	0	94
	0 AMBULANCE SERVICES		0.0000	0	0	92
	O DURABLE MEDICAL EQUIP-RENTED		0.0000	0	0	
	O DURABLE MEDICAL EQUIP-SOLD		0.0000		0	
	O OTHER REIMBURSABLE COST CENTERS		0.0000		0	
0.00	Total (sum of lines 50 through 94 and 96 through 98)			597, 663	97, 429	
01.00	Less PBP Clinic Laboratory Services-Program only charges (	line 61)		0	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	201
02.00	Net charges (line 200 minus line 201)		1	597, 663		202

PATIEN	IT ANCILLARY SERVICE COST APPORTIONMENT	rovider CCN: 15-002	F	Period: From 01/01/2021 Fo 12/31/2021	Worksheet D-3 Date/Time Pre 5/31/2022 8:5	par
	Cost Center Description	Title XIX Ratio of To Char		Hospital Inpatient Program Charges	Cost Inpatient Program Costs (col. 1 x col. 2)	
		1.00	)	2.00	3.00	
	NPATIENT ROUTINE SERVICE COST CENTERS			1		
1	3000 ADULTS & PEDI ATRI CS			694, 344		30
	3100 I NTENSI VE CARE UNI T			581, 743		3
	3200 CORONARY CARE UNIT			0		32
	3300 BURN INTENSIVE CARE UNIT			0		33
	3400  SURGI CAL I NTENSI VE CARE UNI T 4000  SUBPROVI DER – I PF			0		34
	4000 SUBPROVIDER - IPF 4100 SUBPROVIDER - IRF			0		40
	4300 NURSERY			0		43
	NCI LLARY SERVI CE COST CENTERS	I		0		1 75
	5000 OPERATING ROOM	0.2	262927	7 539, 600	141, 875	50
	5100 RECOVERY ROOM		000000		0	
	5200 DELIVERY ROOM & LABOR ROOM		000000		0	
00 05	5300 ANESTHESI OLOGY	0.0	00000	0 0	0	53
	5400 RADI OLOGY-DI AGNOSTI C	0.0	098192	2 514, 203	50, 491	54
	3630 ULTRA SOUND		040757		2, 989	
	5500 RADI OLOGY-THERAPEUTI C		168208		0	
	5600 RADI OI SOTOPE		00000		0	
	5700 CT SCAN		00000		0	
	5800 MAGNETIC RESONANCE I MAGING (MRI)		00000		0	
	5900 CARDI AC CATHETERI ZATI ON		00000		0	
	6000 LABORATORY 6001 BLOOD LABORATORY		156716		104, 317	
1	6100 PBP CLINICAL LAB SERVICES-PRGM ONLY		00000		0	
	6200 WHOLE BLOOD & PACKED RED BLOOD CELLS		000000		0	
	6300 BLOOD STORING, PROCESSING & TRANS.		000000		0	
	6400 I NTRAVENOUS THERAPY		000000		0	
1	6500 RESPI RATORY THERAPY		421836		97, 910	6
00 06	6600 PHYSI CAL THERAPY	0.2	252253	3 57, 212	14, 432	60
00 06	6700 OCCUPATI ONAL THERAPY	0.0	00000	0 0	0	6
	6800 SPEECH PATHOLOGY		00000		0	
	6900 ELECTROCARDI OLOGY		114745		11, 312	
1	7000 ELECTROENCEPHALOGRAPHY		00000		0	
	7100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS		180232		99, 179	
	7200 IMPL. DEV. CHARGED TO PATIENTS 7300 DRUGS CHARGED TO PATIENTS		062945 230371		9, 373 110, 358	
	7400 RENAL DIALYSIS		230371		0	
	7500 ASC (NON-DI STINCT PART)		000000		0	
	3480 ONCOLOGY		041619		0	
97 07	7697 CARDI AC REHABI LI TATI ON		000000		0	
	7700 ALLOGENEIC STEM CELL ACQUISITION		000000			
	JTPATIENT SERVICE COST CENTERS					
	8800 RURAL HEALTH CLINIC		000000		0	
	8900 FEDERALLY QUALI FI ED HEALTH CENTER		00000		0	
			529025		0	
	9100 EMERGENCY		121474		73, 051	
	4950 WOUND CARE		00000		0	
	9200 OBSERVATI ON BEDS (NON-DI STINCT PART) THER REIMBURSABLE COST CENTERS	0.4	463133	3 92, 143	42, 674	92
	9400 HOME PROGRAM DI ALYSI S	0.0	000000	0 0	0	94
	9500 AMBULANCE SERVICES	0.0			0	92
	9600 DURABLE MEDICAL EQUIP-RENTED	0.0	000000	0	0	
1	9700 DURABLE MEDICAL EQUIP-SOLD		000000		0	
	9850 OTHER REIMBURSABLE COST CENTERS		000000		0	
0.00	Total (sum of lines 50 through 94 and 96 through 98)			4, 054, 201	757, 961	
1.00	Less PBP Clinic Laboratory Services-Program only charges (	line 61)		0		201
2.00	Net charges (line 200 minus line 201)			4, 054, 201		202

PATIENT ANCILLARY SERVICE COST APPORTIONMENT	ovider CCN: 15-0022	Period:	Worksheet D-3	
с	omponent CCN: 15-SO22	From 01/01/2021 To 12/31/2021	Date/Time Pre 5/31/2022 8:5	
	Title XIX	Subprovider -	Cost	<u>5 a</u>
Cost Center Description	Ratio of Co		Inpati ent	
	To Charges	0	Program Costs	
		Charges	(col. 1 x col.	
	1.00	2.00	2) 3.00	-
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	0.00	
00 03000 ADULTS & PEDIATRICS				30
00 03100 INTENSIVE CARE UNIT				31
00 03200 CORONARY CARE UNIT				32
00  03300  BURN INTENSIVE CARE UNIT 00  03400  SURGICAL INTENSIVE CARE UNIT				33
00 04000 SUBPROVI DER - I PF		31, 659		40
00 04100 SUBPROVI DER - I RF		51,057		41
00 04300 NURSERY				43
ANCI LLARY SERVI CE COST CENTERS		!		
00 05000 OPERATING ROOM	0. 2629		0	
00 05100 RECOVERY ROOM	0.0000		0	
00 05200 DELIVERY ROOM & LABOR ROOM	0.0000		0	
00 05300 ANESTHESI OLOGY 00 05400 RADI OLOGY-DI AGNOSTI C	0.0000		0	
01 03630 ULTRA SOUND	0. 0981		96	
00 05500 RADI OLOGY-THERAPEUTI C	0. 1682		0	
00 05600 RADI 0I SOTOPE	0.0000		0	
00 05700 CT SCAN	0.0000	00 0	0	5
00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0.0000	00 0	0	58
00 05900 CARDI AC CATHETERI ZATI ON	0.0000		0	-
00 06000 LABORATORY	0. 1567		349	
01 06001 BLOOD LABORATORY	0.0000		0	
00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.0000		0	
00 06300 BLOOD STORING, PROCESSING & TRANS.	0.0000		0	
00 06400 I NTRAVENOUS THERAPY	0.0000		0	
00 06500 RESPI RATORY THERAPY	0. 4218		0	6!
00 06600 PHYSI CAL THERAPY	0. 2522		349	
00 06700 OCCUPATI ONAL THERAPY	0.0000		0	
00 06800 SPEECH PATHOLOGY	0.0000		0	
00  06900  ELECTROCARDI OLOGY 00  07000  ELECTROENCEPHALOGRAPHY	0. 1147		0	
00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 1802		164	1
00 07200 I MPL. DEV. CHARGED TO PATI ENTS	0. 0629		0	
00 07300 DRUGS CHARGED TO PATIENTS	0. 2303		-202	
00 07400 RENAL DI ALYSI S	0.0000	00 0	0	74
00 07500 ASC (NON-DISTINCT PART)	0.0000		0	
00 03480 0NC0L0GY	0.0416		0	1 .
97 07697 CARDIAC REHABILITATION	0.0000		0	
00 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON OUTPATI ENT SERVI CE COST CENTERS	0.0000	00 0	0	7
00 08800 RURAL HEALTH CLINIC	0.0000	00 0	0	88
00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0.0000		0	
00 09000 CLINIC	0. 5290		0	
00 09100 EMERGENCY	0. 1214	74 0	0	
01 04950 WOUND CARE	0.0000		0	
00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 4631	33 0	0	92
OTHER REIMBURSABLE COST CENTERS	0.0000	00 0	0	94
00 09500 AMBULANCE SERVICES	0.0000	00	0	92
00 09500 AMBDEANDE SERVICES 00 09600 DURABLE MEDICAL EQUIP-RENTED	0.0000	00 0	0	
00 09700 DURABLE MEDICAL EQUIP-SOLD	0. 0000		0	
00 09850 OTHER REIMBURSABLE COST CENTERS	0. 0000		0	
0.00 Total (sum of lines 50 through 94 and 96 through 98)		6, 001	756	
.00 Less PBP Clinic Laboratory Services-Program only charges (	ine 61)	0		201
2.00 Net charges (line 200 minus line 201)		6, 001		202

ALCUL	Financial Systems FRANCISCAN HEALTH C ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0022	Peri od: From 01/01/2021 To 12/31/2021	u of Form CMS-2 Worksheet E Part A Date/Time Pre	pared
		Title XVIII	Hospi tal	5/31/2022 8:5 PPS	6 am
				1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS			1.00	
00 01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurr	ring prior to October 1 (	see	0 2, 974, 479	
02	instructions) DRG amounts other than outlier payments for discharges occurr	ring on or after October	1 (see	1, 194, 866	1. (
03	instructions) DRG for federal specific operating payment for Model 4 BPCI 1 1 (see instructions)	for discharges occurring	prior to October	0	1. (
04	DRG for federal specific operating payment for Model 4 BPCI 1 October 1 (see instructions)	for discharges occurring	on or after	0	1. (
00	Outlier payments for discharges. (see instructions)				2.0
01 02	Outlier reconciliation amount Outlier payment for discharges for Model 4 BPCI (see instruct	tions)		0	2.0
02	Outlier payments for discharges occurring prior to October 1	-		131, 703	
03	Outlier payments for discharges occurring on or after October			131,703	1
00	Managed Care Simulated Payments			0	
00	Bed days available divided by number of days in the cost repo	orting period (see instru	uctions)	25.15	4.
00	Indirect Medical Education Adjustment FTE count for allopathic and osteopathic programs for the mos	st recent cost reporting	period ending on	0.00	5.
00	or before 12/31/1996. (see instructions) FTE count for allopathic and osteopathic programs that meet 1 new programs in accordance with 42 CFR 413.79(e)	the criteria for an add-o	on to the cap for	0.00	6.
00	MMA Section 422 reduction amount to the IME cap as specified	under 42 CFR §412.105(f)	(1)(iv)(B)(1)	0.00	7.
01	ACA § 5503 reduction amount to the IME cap as specified under cost report straddles July 1, 2011 then see instructions.	,		0.00	
00	Adjustment (increase or decrease) to the FTE count for allopa affiliated programs in accordance with 42 CFR 413.75(b), 413. 1998), and 67 FR 50069 (August 1, 2002).			0.00	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.
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 hospi tal	0.00	8.
00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines tructions)			0.00	
). 00  . 00	FTE count for allopathic and osteopathic programs in the curr FTE count for residents in dental and podiatric programs.	rent year from your recor	as	0.00 0.00	
2.00	Current year allowable FTE (see instructions)			0.00	
3.00	Total allowable FTE count for the prior year.			0.00	
. 00	Total allowable FTE count for the penultimate year if that ye otherwise enter zero.	ear ended on or after Sep	otember 30, 1997,	0.00	
5.00	Sum of lines 12 through 14 divided by 3.			0.00	15.
	Adjustment for residents in initial years of the program			0.00	
. 00	Adjustment for residents displaced by program or hospital clo	osure		0.00	
. 00	Adjusted rolling average FTE count			0.00	
. 00	Current year resident to bed ratio (line 18 divided by line 4	4).		0.000000	
	Prior year resident to bed ratio (see instructions) Enter the lesser of lines 19 or 20 (see instructions)			0. 000000 0. 000000	
	IME payment adjustment (see instructions)			0.000000	
. 01	IME payment adjustment - Managed Care (see instructions)			0	
. 00	Indirect Medical Education Adjustment for the Add-on for § 42 Number of additional allopathic and osteopathic IME FTE resid		CFR 412.105	0.00	
. 00	(f)(1)(iv)(C).			0.00	24.
. 00	IME FTE Resident Count Over Cap (see instructions) 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 0. 00	
. 00	Resident to bed ratio (divide line 25 by line 4)			0. 000000	26.
	IME payments adjustment factor. (see instructions)			0. 000000	27.
	IME add-on adjustment amount (see instructions)			0	28.
. 01	IME add-on adjustment amount - Managed Care (see instructions	5)		0	
. 00 . 01	Total IME payment ( sum of lines 22 and 28) Total IME payment - Managed Care (sum of lines 22.01 and 28.0 Dispropertional Share Adjustment	01)		0	
0. 00	Disproportionate Share Adjustment Percentage of SSI recipient patient days to Medicare Part A p	natient days (see instruc	tions)	2.46	30.
. 00	Percentage of Medicaid patient days (see instructions)			12.36	
2.00	Sum of Lines 30 and 31			14.82	
3.00	Allowable disproportionate share percentage (see instructions	5)		0.00	
	Disproportionate share adjustment (see instructions)				34

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0022	Period: From 01/01/2021	Worksheet E Part A	
			To 12/31/2021	Date/Time Pre 5/31/2022 8:50	pare 6 am
		Title XVIII	Hospi tal	PPS	
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
- 00	Uncompensated Care Adjustment				0.5
5.00	Total uncompensated care amount (see instructions)		0	0	35.
5.01	Factor 3 (see instructions)	onton zono on this line) (so	0. 00000000	0. 000000000	35.
5. 02	Hospital uncompensated care payment (If line 34 is zero, e instructions)	enter zero on this line) (see	9 0	0	35.
5. 03	Pro rata share of the hospital uncompensated care payment	amount (see instructions)	0	0	35.
6.00	Total uncompensated care (sum of columns 1 and 2 on line 3		0	0	36.
0.00	Additional payment for high percentage of ESRD beneficiary				00.
0. OO	Total Medicare discharges (see instructions)		508		40.
1.00	Total ESRD Medicare discharges (see instructions)		0		41.
1. 01	Total ESRD Medicare covered and paid discharges (see instr	ructions)	0		41.
2.00	Divide line 41 by line 40 (if less than 10%, you do not qu	ualify for adjustment)	0.00		42.
3.00	Total Medicare ESRD inpatient days (see instructions)		0		43.
4.00	Ratio of average length of stay to one week (line 43 divid	ded by line 41 divided by 7	0. 000000		44
	days)	<b>`</b>			
5.00	Average weekly cost for dialysis treatments (see instructi	-	0.00		45
6.00	Total additional payment (line 45 times line 44 times line	e 41.01)	4 201 049		46
7.00 8.00	Subtotal (see instructions) Hospital specific payments (to be completed by SCH and MDH	I small sural baspitals	4, 301, 048 3, 692, 198		47 48
5.00	only. (see instructions)	n, sillari rurai nospitars	3, 092, 190		40
				Amount	
				1.00	
9.00	Total payment for inpatient operating costs (see instructi	ons)		4, 301, 048	49
0. 00	Payment for inpatient program capital (from Wkst. L, Pt. I	and Pt. II, as applicable)		351, 837	50
1.00	Exception payment for inpatient program capital (Wkst. L,			0	51
2.00	Direct graduate medical education payment (from Wkst. E-4,	line 49 see instructions).		0	52
3.00	Nursing and Allied Health Managed Care payment			0	53
4.00	Special add-on payments for new technologies			50, 344	
4.01	Islet isolation add-on payment			0	54
5.00 6.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, lir Cost of physicians' services in a teaching hospital (see i	-		0	55 56
7.00	Routine service other pass through costs (from Wkst. D, Pt		rough 35)	0	57
B. 00	Ancillary service other pass through costs from Wkst. D, F		li ougii oo).	0	58
9.00	Total (sum of amounts on lines 49 through 58)			4, 703, 229	
0. 00	Primary payer payments			8, 799	
1.00	Total amount payable for program beneficiaries (line 59 mi	nus line 60)		4, 694, 430	61
2.00	Deductibles billed to program beneficiaries			575, 260	62
3.00	Coinsurance billed to program beneficiaries			0	63
4.00	Allowable bad debts (see instructions)			57, 600	64
5.00	Adjusted reimbursable bad debts (see instructions)			37, 440	
6.00	Allowable bad debts for dual eligible beneficiaries (see i	nstructions)		25, 830	
7.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			4, 156, 610	
3.00	Credits received from manufacturers for replaced devices f			0	68
9.00	Outlier payments reconciliation (sum of lines 93, 95 and 9 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	FOIL (FOR SCH SEE INSTRUCTIONS	s)	0	
). 00 ). 50	Rural Community Hospital Demonstration Project (§410A Demo	onstration) adjustment (cos	nstructions)	0	70 70
). 50 ). 87	Demonstration payment adjustment amount before sequestrati	, , ,	nati ucti UNS)	0	70
). 87 ). 88	SCH or MDH volume decrease adjustment (contractor use only			0	70
D. 89	Pioneer ACO demonstration payment adjustment amount (see i			0	70
D. 90	HSP bonus payment HVBP adjustment amount (see instructions			0	70
D. 91	HSP bonus payment HRR adjustment amount (see instructions)			0	70
0. 92	Bundled Model 1 discount amount (see instructions)			0	70
D. 93	HVBP payment adjustment amount (see instructions)			13, 481	70
	HRR adjustment amount (see instructions)			0	
D. 94					

		N: 15-0022	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part A Date/Time Prep 5/31/2022 8:50	
	Title		Hospi tal	PPS	
	-	FFY	(уууу)	Amount	
	-		0	1.00	
.96 Low volume adjustment for federal fiscal year (yyyy) (Enter in col	umn 0		2021	758, 334	70.9
the corresponding federal year for the period prior to 10/1) .97 Low volume adjustment for federal fiscal year (yyyy) (Enter in col			2021	290, 627	70. 9
the corresponding federal year for the period ending on or after 1			2021	290, 027	70. 9
. 98 Low Volume Payment-3	0/1)			0	70.9
.99 HAC adjustment amount (see instructions)				Ő	70.9
.00 Amount due provider (line 67 minus lines 68 plus/minus lines 69 &	70)			5, 219, 052	71.0
01 Sequestration adjustment (see instructions)				0	71.0
02 Demonstration payment adjustment amount after sequestration				0	71.0
.03 Sequestration adjustment-PARHM pass-throughs					71.0
.00 Interim payments				5, 411, 306	
.01 Interim payments-PARHM					72.0
.00 Tentative settlement (for contractor use only)				0	73.0
.01 Tentative settlement-PARHM (for contractor use only)	.			100.054	73.0
.00 Balance due provider/program (line 71 minus lines 71.01, 71.02, 72	, and			-192, 254	74.0
73) .01 Balance due provider/program-PARHM (see instructions)					74.0
.00 Protested amounts (nonallowable cost report items) in accordance w	i th			104, 059	75.0
CMS Pub. 15-2, chapter 1, §115.2				104, 039	75.0
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)	1				
.00 Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.	03			0	90.0
plus 2.04 (see instructions)					
.00 Capital outlier from Wkst. L, Pt. I, line 2				0	91.0
.00 Operating outlier reconciliation adjustment amount (see instructio				0	92.0
.00 Capital outlier reconciliation adjustment amount (see instructions				0	93.0
.00 The rate used to calculate the time value of money (see instructio	ns)				
.00 Time value of money for operating expenses (see instructions)	、			0	95.0
.00 Time value of money for capital related expenses (see instructions	)		Prior to 10/1	0	96.0
			1.00	2.00	
HSP Bonus Payment Amount			1.00	2.00	
D. 00 HSP bonus amount (see instructions)			0	0	100. 0
HVBP Adjustment for HSP Bonus Payment					
1.00 HVBP adjustment factor (see instructions)			1.0044853822	1.000000000	101.0
			1.0044853822		
1.00 HVBP adjustment factor (see instructions) 2.00 HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment			0	0	102. 0
<ol> <li>00 HVBP adjustment factor (see instructions)</li> <li>00 HVBP adjustment amount for HSP bonus payment (see instructions)</li> <li>HRR Adjustment for HSP Bonus Payment</li> <li>00 HRR adjustment factor (see instructions)</li> </ol>			0	0	102. 0 103. 0
<ol> <li>1. 00 HVBP adjustment factor (see instructions)</li> <li>2. 00 HVBP adjustment amount for HSP bonus payment (see instructions)</li> <li>HRR Adjustment for HSP Bonus Payment</li> <li>3. 00 HRR adjustment factor (see instructions)</li> <li>4. 00 HRR adjustment amount for HSP bonus payment (see instructions)</li> </ol>			0	0	102. 0 103. 0
<ol> <li>1. 00 HVBP adjustment factor (see instructions)</li> <li>2. 00 HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment</li> <li>3. 00 HRR adjustment factor (see instructions)</li> <li>4. 00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration)</li> </ol>			0	0 1.0000 0	102. 0 103. 0 104. 0
<ol> <li>1.00 HVBP adjustment factor (see instructions)</li> <li>2.00 HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment</li> <li>3.00 HRR adjustment factor (see instructions)</li> <li>4.00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration 0.00 Is this the first year of the current 5-year demonstration period</li> </ol>			0	0 1.0000 0	102. 0 103. 0 104. 0
<ol> <li>1.00 HVBP adjustment factor (see instructions)</li> <li>2.00 HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment</li> <li>3.00 HRR adjustment factor (see instructions)</li> <li>4.00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration 0.00 Is this the first year of the current 5-year demonstration period Century Cures Act? Enter "Y" for yes or "N" for no.</li> </ol>			0	0 1.0000 0	102. 0 103. 0 104. 0
<ol> <li>1.00 HVBP adjustment factor (see instructions)</li> <li>2.00 HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment</li> <li>3.00 HRR adjustment factor (see instructions)</li> <li>4.00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration 0.00 Is this the first year of the current 5-year demonstration period Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement</li> </ol>			0	0 1.0000 0	102. 00 103. 00 104. 00 200. 00
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<ol> <li>1.00 HVBP adjustment factor (see instructions)</li> <li>2.00 HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment</li> <li>3.00 HRR adjustment factor (see instructions)</li> <li>4.00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration Is this the first year of the current 5-year demonstration period Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement</li> <li>1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)</li> <li>2.00 Medicare discharges (see instructions)</li> </ol>			0	0 1.0000 0	102. 0 103. 0 104. 0 200. 0 201. 0 202. 0
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<ol> <li>1.00 HVBP adjustment factor (see instructions)</li> <li>2.00 HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment</li> <li>3.00 HRR adjustment factor (see instructions)</li> <li>4.00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration Is this the first year of the current 5-year demonstration period Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement</li> <li>1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)</li> <li>2.00 Medicare discharges (see instructions)</li> </ol>	under th	ne 21st	0 1.0000 0	0 1.0000 0	102. 0 103. 0 104. 0 200. 0 201. 0 202. 0
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<ol> <li>1.00 HVBP adjustment factor (see instructions)</li> <li>2.00 HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment</li> <li>3.00 HRR adjustment factor (see instructions)</li> <li>4.00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement</li> <li>0.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)</li> <li>0.00 Medicare discharges (see instructions)</li> <li>0.00 Medicare target amount</li> <li>0.00 Medicare target</li> <li>0.00 Medicare target</li> <li>0.00 Medicar</li></ol>	t year o	ne 21st	0 1.0000 0	0 1.0000 0 ration	102. 0 103. 0 104. 0 200. 0 201. 0 202. 0 203. 0 204. 0 205. 0 206. 0 207. 0
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<ol> <li>1.00 HVBP adjustment factor (see instructions)</li> <li>2.00 HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment</li> <li>3.00 HRR adjustment factor (see instructions)</li> <li>4.00 HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration Century Cures Act? Enter "Y" for yes or "N" for no.</li> <li>Cost Reimbursement</li> <li>0.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)</li> <li>2.00 Medicare discharges (see instructions)</li> <li>3.00 Case-mix adjustment factor (see instructions)</li> <li>Computation of Demonstration Target Amount Limitation (N/A in first period)</li> <li>4.00 Medicare target amount</li> <li>Computation of Demonstration Target Amount Limitation (N/A in first period)</li> <li>4.00 Medicare target amount</li> <li>Computation of Demonstration Target Amount Limitation (N/A in first period)</li> <li>A.00 Medicare target amount</li> <li>Computation of Demonstration cost cap (line 202 times line 204)</li> <li>Adjustment to Medicare Part A Inpatient Reimbursement</li> <li>7.00 Program reimbursement under the §410A Demonstration (see instructions)</li> <li>Adjustment to Medicare IPPS payments (see instructions)</li> </ol>	t year o	ne 21st	0 1.0000 0	0 1.0000 0 ration	102. 0 103. 0 104. 0 200. 0 201. 0 202. 0 203. 0 204. 0 205. 0 206. 0 207. 0 207. 0 208. 0 209. 0
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<ol> <li>1.00 HVBP adjustment factor (see instructions)</li> <li>2.00 HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment</li> <li>3.00 HRR adjustment factor (see instructions)</li> <li>4.00 HRR adjustment factor (see instructions)</li> <li>7.00 Rural Community Hospital Demonstration Project (§410A Demonstration Century Cures Act? Enter "Y" for yes or "N" for no.</li> <li>7.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)</li> <li>7.00 Medicare discharges (see instructions)</li> <li>7.00 Medicare target amount</li> <li>7.00 Medicare target amount</li> <li>7.00 Medicare Part A Inpatient Reimbursement</li> <li>7.00 Medicare Part A Inpatient Reimbursement</li> <li>7.00 Medicare Part A Inpatient service costs (from Wkst. E, Pt. A, line</li> <li>8.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line</li> <li>7.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line</li> <li>7.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line</li> <li>7.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line</li> <li>7.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line</li> <li>7.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line</li> <li>7.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line</li> <li>7.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line</li> <li>7.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line</li> <li>7.00 Medicare Part A Medicare IPPS payments (see instructions)</li> <li>7.00 Medicare Part A Medicare IPPS payments (see instructions)</li> <li>7.00 Medicare Part A Medicare IPPS payments (see instructions)</li> </ol>	t year o	ne 21st	0 1.0000 0	0 1.0000 0 ration	102. 0 103. 0 104. 0 200. 0 201. 0 202. 0 202. 0 203. 0 204. 0 205. 0 206. 0 207. 0 208. 0 209. 0 201. 0 211. 0
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N VC	LUME CALCULATION EXHIBIT 4			Provider C	F	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part A Exhibi Date/Time Prep 5/31/2022 8:50	pare
		W/S F Part A	Amounts (from	Title Pre/Post	XVIII Period Prior	Hospi tal Peri od	PPS Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	On/After 10/01	through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
00	DRG amounts other than outlier	1.00	0	0	(	0 0	0	1
D1	payments DRG amounts other than outlier payments for discharges	1. 01	2, 974, 479	0	2, 974, 479		2, 974, 479	1.
2	occurring prior to October 1 DRG amounts other than outlier payments for discharges occurring on or after October	1. 02	1, 194, 866	0		1, 194, 866	1, 194, 866	1
3	T DRG for Federal specific operating payment for Model 4 BPCI occurring prior to	1.03	0	0	C		0	1
4	October 1 DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1
0	Outlier payments for	2.00						2
1	discharges (see instructions) Outlier payments for	2.02	0	0	(	0 0	0	2
12	discharges for Model 4 BPCI Outlier payments for discharges occurring prior to	2. 03	131, 703	0	131, 703	3	131, 703	2
3	October 1 (see instructions) Outlier payments for discharges occurring on or after October 1 (see	2.04	0	0		0	0	2
	instructions)							
0	Operating outlier reconciliation	2.01	0	0	0	0 0	0	3
0	Managed care simulated payments	3.00	0	0	C	0 0	0	4
~	Indirect Medical Education Adju		0,000000	0,000000	0,00000			
0	Amount from Worksheet E, Part A, line 21 (see instructions) IME payment adjustment (see	21.00 22.00	0. 000000	0. 000000	0.00000	0.000000	0	5 6
1	instructions) IME payment adjustment for managed care (see	22.01	0	0	(	0 0	0	é
	instructions)							
~	Indirect Medical Education Adju		e Add-on for Sec 0.000000					-
0	IME payment adjustment factor (see instructions) IME adjustment (see	27.00 28.00	0.000000	0. 000000			0	8
1	instructions) IME payment adjustment add on	28.01	0	0	(	0	0	
~	for managed care (see instructions) Tatal LME normant (sum of	20,00	0	0				
0	Total IME payment (sum of lines 6 and 8) Total IME payment for managed	29. 00 29. 01	0	0			0	ç
	care (sum of lines 6.01 and 8.01)	27.01	Ŭ	Ū			0	
0.2	Disproportionate Share Adjustme			0				
00	Allowable disproportionate share percentage (see instructions)	33.00	0. 0000	0.0000	0.0000	0.0000		10
00	Disproportionate share adjustment (see instructions)	34.00	0	0	C	0 0	0	11
01	Uncompensated care payments	36.00	0	0		0 0	0	11
00	Additional payment for high per Total ESRD additional payment	46.00	0 beneficiary	di scharges 0	(	0 0	0	12
00 00	(see instructions) Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.)	47.00 48.00	4, 301, 048 0	0 0	3, 106, 182 (	2 1, 194, 866 0 0	4, 301, 048 0	13 14
00	(see instructions) Total payment for inpatient operating costs (see	49.00	4, 301, 048	0	3, 106, 182	2 1, 194, 866	4, 301, 048	15
00	instructions) Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	351, 837	0	262, 851	88, 986	351, 837	16

	Financial Systems	FRA	ANCISCAN HEALTH				u of Form CMS-2	2552-1
LOW VO	LUME CALCULATION EXHIBIT 4			Provider CO		Period: From 01/01/2021 To 12/31/2021	Worksheet E Part A Exhibi Date/Time Pre 5/31/2022 8:5	pared:
				Title	XVIII	Hospi tal	PPS	
		W/S E, Part A	Amounts (from	Pre/Post	Period Prior	Period	Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	0n/After 10/01	through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
17.00	Special add-on payments for new technologies	54.00	50, 344	0	31, 11	1 19, 233	50, 344	17.0
17.01	Net organ aquisition cost							17.0
17.02	Credits received from	68.00	0	0		0 0	0	17.0
	manufacturers for replaced							
	devices for applicable MS-DRGs							
18.00	Capital outlier reconciliation	93.00	0	0		0 0	0	18.0
	adjustment amount (see							
	instructions)							
19.00	SUBTOTAL			0	3, 400, 14	4 1, 303, 085	4, 703, 229	19.0
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier		313, 904	0	226, 08		313, 904	
20. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	0	0		0 0	0	20.0
21.00	Capital DRG outlier payments	2.00	37, 933	0	36, 76	3 1, 170	37, 933	21.0
21.01	Model 4 BPCI Capital DRG outlier payments	2. 01	0	0		0 0	0	21.0
22.00	Indirect medical education percentage (see instructions)	5.00	0. 0000	0.0000				22.0
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0		0 0	-	20.0
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0. 0000	0. 0000	0.000	0.0000		24.0
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0		0 0	0	25.0
26.00	Total prospective capital payments (see instructions)	12.00	351, 837	0	262, 85	1 88, 986	351, 837	26. 0
		W/S E, Part A	(Amounts to E,					
		line	Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0. 22303	0. 223030		27.0
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			758, 33	4	758, 334	28.0
29. 00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 97				290, 627	290, 627	29.0
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Υ					100. 0

SPI 1	Financial Systems FRA FAL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5			Period: From 01/01/2021 To 12/31/2021	u of Form CMS-2 Worksheet E Part A Exhibi Date/Time Prep 5/31/2022 8:50	t 5 pared:
		Wkst. E, Pt. A, line	Title       Amt. from       Wkst. E, Pt.	Period to 10/01	Hospital Period on after 10/01	PPS Total (cols. 2 and 3)	
		0	A) 1.00	2.00	3.00	4.00	
00	DRG amounts other than outlier payments	1.00	1.00	2.00	0.00	1.00	1.0
01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	2, 974, 479	2, 974, 47	9	2, 974, 479	1.0
02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	1, 194, 866		1, 194, 866	1, 194, 866	1. C
03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October	1.03	0		0	0	1. C
04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after	1.04	0		0	0	1. C
00	October 1 Outlier payments for discharges (see instructions)	2.00					2. C
01	Outlier payments for discharges for Model 4 BPCI	2.02	0		0 0	0	2. C
02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	131, 703	131, 70	3	131, 703	2. C
03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	0		0	0	2. C
00	Operating outlier reconciliation	2.01	0		0 0	0	3.0
00	Managed care simulated payments	3.00	0		0 0	0	4.0
	Indirect Medical Education Adjustment						-
00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0. 000000	0.00000	0 0. 000000		5.
00 01	IME payment adjustment (see instructions) IME payment adjustment for managed care (see instructions)	22.00 22.01	0		0 0 0 0	0	6. 6.
	Indirect Medical Education Adjustment for the	Add-on for Se	ection 422 of th	e MMA			
00	IME payment adjustment factor (see instructions)	27.00	0. 000000	0. 00000	0 0. 000000		7.
00	IME adjustment (see instructions)	28.00	0		0 0	0	8.
01	IME payment adjustment add on for managed care (see instructions)	28.01	0		0 0	0	8.
00 01	Total IME payment (sum of lines 6 and 8) Total IME payment for managed care (sum of	29. 00 29. 01	0 0		0 0 0 0	0 0	9. 9.
	lines 6.01 and 8.01) Disproportionate Share Adjustment						
. 00		33.00	0.0000	0.000	0 0.0000		10.
	(see instructions)						
. 00	Disproportionate share adjustment (see instructions)	34.00	0		0 0	0	11.
. 01		36.00	di sebargas		00	0	11.
. 00	Additional payment for high percentage of ESR Total ESRD additional payment (see instructions)	46. 00	0		0 0	0	12.
. 00	Subtotal (see instructions)	47.00	4, 301, 048	3, 106, 18	2 1, 194, 866	4, 301, 048	13.
00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see	48.00	0		0 0	0	14.
00	instructions) Total payment for inpatient operating costs (see instructions)	49.00	4, 301, 048	3, 106, 18	2 1, 194, 866	4, 301, 048	15.
. 00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	351, 837	262, 85	1 88, 986	351, 837	16.
. 00 . 01	Special add-on payments for new technologies Net organ acquisition cost	54.00	50, 344	31, 11	1 19, 233	50, 344	17. 17.
. 02		68.00	0		0 0	0	
. 00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0		0 0	0	18.
	SUBTOTAL		1	3, 400, 14	4 1, 303, 085	4, 703, 229	1

HOSPI TAL ACC	UIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5	Provider CO		Period: From 01/01/2021 To 12/31/2021	Worksheet E Part A Exhibi Date/Time Pre 5/31/2022 8:5	pared:
			Title	XVIII	Hospi tal	PPS	_
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00 Capi t	al DRG other than outlier	1.00	313, 904	226, 08	8 87, 816	313, 904	20.00
20.01 Model	4 BPCI Capital DRG other than outlier	1.01	0		0 0	0	20.01
21. 00 Capi t	al DRG outlier payments	2.00	37, 933	36, 76	3 1, 170	37, 933	21.00
21.01 Model	4 BPCI Capital DRG outlier payments	2.01	0		0 0	0	21.01
instr	ect medical education percentage (see uctions)	5.00	0.0000	0.000	0.0000		22.00
23.00 Indir instr	ect medical education adjustment (see uctions)	6.00	0		0 0	0	23.00
	able disproportionate share percentage instructions)	10.00	0.0000	0.000	0.0000		24.00
	oportionate share adjustment (see uctions)	11.00	0		0 0	0	25.00
	prospective capital payments (see uctions)	12.00	351, 837	262, 85	88, 986	351, 837	26.00
		Wkst. E, Pt.	(Amt. from				
		A, line	Wkst. E, Pt.				
			A)	2.00	2.00	4.00	
27.00		0	1.00	2.00	3.00	4.00	27.00
	aluma adjustment pries to Ostabos 1	70, 96	750 224	750.00	4	758, 334	
	olume adjustment prior to October 1 olume adjustment on or after October 1	70.98	758, 334 290, 627	758, 33	290, 627	290, 627	•
	payment adjustment (see instructions)	70.97	13, 481	13, 48		13, 481	
	payment adjustment for HSP bonus	70.93	13, 401	13,40	0	13,401	
	nt (see instructions)	70.90	0		0 0	0	30.01
31.00 HRR a	djustment (see instructions)	70. 94	0		0 0	0	31.00
	djustment for HSP bonus payment (see uctions)	70. 91	0		0 0	0	31.01
						(Amt. to Wkst.	
			1.00			E, Pt. A)	
		0	1.00	2.00	3.00	4.00	00.00
instr	eduction Program adjustment (see uctions)	70. 99			0 0	0	02.00
100.00 Irans	fer HAC Reduction Program adjustment to		Y				100.00

1.00			lleor: t-l	5/31/2022 8:5	pared: 6 am
		Title XVIII	Hospi tal	PPS	
				1.00	
1.00	PART B - MEDICAL AND OTHER HEALTH SERVICES			0	1.00
2.00	Medical and other services (see instructions) Medical and other services reimbursed under OPPS (see instruc	tions)		10, 005, 465	
3.00	OPPS payments			6, 924, 265	
4.00	Outlier payment (see instructions)			84, 951	4.00
4.01 5.00	Outlier reconciliation amount (see instructions)	ctions)		0 0. 000	
5.00 6.00	Enter the hospital specific payment to cost ratio (see instru Line 2 times line 5			0.000	1
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	
8.00	Transitional corridor payment (see instructions)			0	
9.00 10.00	Ancillary service other pass through costs from Wkst. D, Pt.	IV, col. 13, line 200		0	9.00 10.00
10.00	Organ acquisitions Total cost (sum of lines 1 and 10) (see instructions)			0	
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e charges				
	Ancillary service charges	ing (0)			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)	The 69)		0	
11.00	Customary charges			0	11.00
	Aggregate amount actually collected from patients liable for		0	0	
16.00	Amounts that would have been realized from patients liable fo		on a chargebasis	0	16.00
17.00	had such payment been made in accordance with 42 CFR §413.13( Ratio of line 15 to line 16 (not to exceed 1.000000)	e)		0. 000000	17 00
18.00	Total customary charges (see instructions)			0.000000	
19.00	Excess of customary charges over reasonable cost (complete on	ly if line 18 exceeds li	ne 11) (see	0	19.00
20,00	instructions)		10) (		20.00
20.00	Excess of reasonable cost over customary charges (complete on instructions)	ity if the it exceeds it	ne 18) (see	0	20.00
21.00	Lesser of cost or charges (see instructions)			0	21.00
22.00	Interns and residents (see instructions)			0	
23.00	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) COMPUTATION OF REIMBURSEMENT SETTLEMENT			7, 009, 216	24.00
25.00	Deductibles and coinsurance amounts (for CAH, see instruction	s)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on lin	•	,	1, 297, 874	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26)	plus the sum of lines 2	2 and 23] (see	5, 711, 342	27.00
28.00	instructions) Direct graduate medical education payments (from Wkst. E-4, I	ine 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	1
30.00	Subtotal (sum of lines 27 through 29)			5, 711, 342	
	Primary payer payments Subtotal (line 30 minus line 31)			0 5, 711, 342	31.00 32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVIO	CES)		5,711,542	52.00
	Composite rate ESRD (from Wkst. I-5, line 11)	,			33.00
	Allowable bad debts (see instructions)			105, 152	
35.00 36.00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		68, 349 68, 349	
	Subtotal (see instructions)			5, 779, 691	
	MSP-LCC reconciliation amount from PS&R			1, 197	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	- >		0	39.00
39. 50 39. 97	Pioneer ACO demonstration payment adjustment (see instruction Demonstration payment adjustment amount before sequestration	5)		0	39.50 39.97
39.97 39.98	Partial or full credits received from manufacturers for repla	ced devices (see instru	ctions)	0	1
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0	39.99
40.00	Subtotal (see instructions)			5, 778, 494	
40. 01 40. 02	Sequestration adjustment (see instructions)			0	40.01
40. 02 40. 03	Demonstration payment adjustment amount after sequestration Sequestration adjustment-PARHM pass-throughs			0	40.02
	Interim payments			5, 840, 705	
	Interim payments-PARHM				41.01
42. 00 42. 01	Tentative settlement (for contractors use only)			0	42.00 42.01
42.01 43.00	Tentative settlement-PARHM (for contractor use only) Balance due provider/program (see instructions)			-62, 211	
43.01	Balance due provider/program-PARHM (see instructions)			02,211	43.01
	Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub. 15-2,	chapter 1,	0	
	§115.2				1
	TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions)			0	90.00
	Outlier reconciliation adjustment amount (see instructions)			0	
92.00	The rate used to calculate the Time Value of Money			0.00	
	Time Value of Money (see instructions) Total (sum of lines 91 and 93)			0	

VALYS	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC	CN: 15-0022	Period: From 01/01/2021 To 12/31/2021		pared
		Title	XVIII	Hospi tal	PPS	_
		I npati en	t Part A	Pai	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
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		5, 411, 3	06 0	5, 840, 705 0	1.0
00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3. (
01	ADJUSTMENTS TO PROVIDER			0	0	3.0
02				0	0	3.0
03				0	0	3.
04 05				0	0	3. 3.
05	Provider to Program			0	0	3.
50	ADJUSTMENTS TO PROGRAM			0	0	3.
51				0	0	
52				0	0	3.
53				0	0	3.
54				0	0	3.
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0	0	3.
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as		5, 411, 3	06	5, 840, 705	4.
	appropriate) TO BE COMPLETED BY CONTRACTOR					
00	List separately each tentative settlement payment after					5.
50	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					0.
01	TENTATI VE TO PROVIDER			0	0	5.
02				0	0	5.
)3				0	0	5.
	Provider to Program	1				_
50 1	TENTATI VE TO PROGRAM			0	0	5.
51 52				0	0	5. 5.
92 99	Subtotal (sum of lines 5.01–5.49 minus sum of lines			0	0	5
0	5.50-5.98) Determined net settlement amount (balance due) based on the cost report. (1)					6
D1	SETTLEMENT TO PROVIDER			0	0	6.
)2	SETTLEMENT TO PROGRAM		192, 2	0	62, 211	6.
00	Total Medicare program liability (see instructions)		5, 219, 0		5, 778, 494	
				Contractor Number	NPR Date (Mo/Day/Yr)	
	Name of Contractor	C	)	1.00	2.00	8.

IALYS	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CO	CN: 15-0022 CCN: 15-S022	Period: From 01/01/202 To 12/31/202		pared
		Title	XVIII	Subprovider -		<u>o un</u>
		Inpatien	t Part A		art B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
00		1.00	2.00	3.00	4.00	
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		1, 299, 9	0	0	2.
00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3.
01	ADJUSTMENTS TO PROVIDER			0	0	3.
02				0	0	3.
03				0	0	3.
04				0	0	3
)5	Drouidan to Drogram			0	0	3
50	Provider to Program ADJUSTMENTS TO PROGRAM			0	0	3
51				0	0	3
52				0	0	
53				0	0	3
54				0	0	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)		1, 299, 9	58	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					
)1	TENTATI VE TO PROVIDER			0	0	
)2				0	0	5
)3	Descriders to Description			0	0	5
50	Provider to Program TENTATIVE TO PROGRAM			0	0	5
51				0	0	5
52				0	0	
9	Subtotal (sum of lines 5.01–5.49 minus sum of lines 5.50–5.98)			0	0	5
00	Determined net settlement amount (balance due) based on the cost report. (1)					6
)1	SETTLEMENT TO PROVIDER		1, 8	29	0	
)2	SETTLEMENT TO PROGRAM			0	0	
00	Total Medicare program liability (see instructions)		1, 301, 7		0 NPR Date	7
				Contractor Number	(Mo/Day/Yr)	
			)	1.00	2.00	

Heal th	Financial Systems FRANCISCAN HEALTH CF	RAWFORDSVI LLE	In Lie	u of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0022	Peri od:	Worksheet E-1	
			From 01/01/2021 To 12/31/2021	Part     Date/Time Pre	nared
			10 12/31/2021	5/31/2022 8:5	
		Title XVIII	Hospi tal	PPS	
				1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				-
1 00	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		14		1 1 00
1.00	Total hospital discharges as defined in AARA §4102 from Wkst.				1.00
2.00	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, and 8 reporting periods beginning on or after 10/01/2013, line 32)	s through 12, and plus r	or cost		2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. Line 2				3, 00
4.00	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines )	1 and 8 through 12 and	nlus for cost		4.00
1.00	reporting periods beginning on or after 10/01/2013, line 32)				1.00
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 li	ine 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of co		Wkst. S-2, Pt. I		7.00
	line 168				
8.00	Calculation of the HIT incentive payment (see instructions)				8.00
9.00	Sequestration adjustment amount (see instructions)				9.00
10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
	Initial/interim HIT payment adjustment (see instructions)				30.00
	Other Adjustment (specify)				31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and li	ine 31) (see instruction	s)		32.00

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0022	Period: From 01/01/2021	Worksheet E-3 Part II	
		Component CCN: 15-S022	To 12/31/2021	Date/Time Pre 5/31/2022 8:5	pare 6 am
		Title XVIII	Subprovider - IPF	PPS	
				1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS				
	Net Federal IPF PPS Payments (excluding outlier, ECT, and me	edical education payments)		1, 280, 186	1.
00	Net IPF PPS Outlier Payments			123, 204	2
00	Net IPF PPS ECT Payments			0	3
00	Unweighted intern and resident FTE count in the most recent	cost report filed on or b	efore November	0.00	4
01	15, 2004. (see instructions) Cap increases for the unweighted intern and resident FTE cou	int for rocidonts that wor	a displaced by	0.00	4
01	program or hospital closure, that would not be counted with			0.00	4
	CFR		lient under 42		
00	New Teaching program adjustment. (see instructions)			0.00	5
00	Current year's unweighted FTE count of I&R excluding FTEs in	the new program growth p	eriod of a "new	0.00	6
	teaching program" (see instuctions)				
00	Current year's unweighted I&R FTE count for residents within	n the new program growth p	eriod of a "new	0.00	7
	teaching program" (see instuctions)				
00	Intern and resident count for IPF PPS medical education adju	ustment (see instructions)		0.00	
00	Average Daily Census (see instructions)			4.468493	
. 00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to	o the power of .5150 -1}.		0.000000	
. 00	Teaching Adjustment (line 1 multiplied by line 10).			0	11
	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)			1, 403, 390	
	Nursing and Allied Health Managed Care payment (see instruct	LI ON)		0	13
	Organ acquisition (DO NOT USE THIS LINE) Cost of physicians' services in a teaching hospital (see ins	structions)		0	14   15
	Subtotal (see instructions)	structions)		1, 403, 390	
	Primary payer payments			1, 403, 390	
	Subtotal (line 16 less line 17).			1, 403, 390	
	Deducti bl es			72, 640	
	Subtotal (line 18 minus line 19)			1, 330, 750	
	Coinsurance			30, 793	
. 00	Subtotal (line 20 minus line 21)			1, 299, 957	22
3. 00	Allowable bad debts (exclude bad debts for professional serv	/ices) (see instructions)		2, 816	23
l. 00	Adjusted reimbursable bad debts (see instructions)			1, 830	24
5.00	Allowable bad debts for dual eligible beneficiaries (see ins	structions)		0	25
. 00	Subtotal (sum of lines 22 and 24)			1, 301, 787	26
	Direct graduate medical education payments (see instructions	5)		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 instruction Recovery of accelerated depreciation.	ons)		0	30
	Demonstration payment adjustment amount before sequestration			0	30
	Total amount payable to the provider (see instructions)	1		1, 301, 787	31
	Sequestration adjustment (see instructions)			1, 301, 787	31
. 02	Demonstration payment adjustment amount after sequestration			0	
	Interim payments			1, 299, 958	
. 00	Tentative settlement (for contractor use only)			0	33
. 00	Balance due provider/program (line 31 minus lines 31.01, 31.	02, 32 and 33)		1, 829	34
. 00	Protested amounts (nonallowable cost report items) in accord	dance with CMS Pub. 15-2,	chapter 1,	0	35
00	TO BE COMPLETED BY CONTRACTOR			400.001	-
	Original outlier amount from Worksheet E-3, Part II, line 2			123, 204	50
	Outlier reconciliation adjustment amount (see instructions)			0	51
2.00 3.00	The rate used to calculate the Time Value of Money			0. 00 0	52 53
. 00	Time Value of Money (see instructions) FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AN	ID REGINNING REFORE THE EN			1 03
. 00	Teaching Adjustment Factor for the cost reporting period imm			0.000000	99
	Calculated Teaching Adjustment Factor for the current year.		, _, _020.	0.000000	

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0022	Period: From 01/01/2021 To 12/31/2021	Worksheet E-3 Part VII Date/Time Pre 5/31/2022 8:5	pare
		Title XIX	Hospi tal	Cost	
			Inpatient	Outpatient	<u> </u>
			1.00	2.00	-
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SE	RVICES FOR TITLES V OR X	IX SERVICES		-
00	COMPUTATION OF NET COST OF COVERED SERVICES		0		1.
00	Medical and other services		0	0	
00	Organ acquisition (certified transplant centers only)		0	0	3
00	Subtotal (sum of lines 1, 2 and 3)		0	0	
00	Inpatient primary payer payments		0	0	5
00	Outpatient primary payer payments		Ŭ	0	6
00	Subtotal (line 4 less sum of lines 5 and 6)		0	0	
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e Charges				1
00	Routine service charges		0		8 [
00	Ancillary service charges		4, 054, 201	41, 348, 892	9
). 00	Organ acquisition charges, net of revenue		0		10
1.00	Incentive from target amount computation		0		11
2.00	Total reasonable charges (sum of lines 8 through 11)		4, 054, 201	41, 348, 892	12
	CUSTOMARY CHARGES				ł.,
3. 00	Amount actually collected from patients liable for payment for basis	C C	0	0	
. 00	Amounts that would have been realized from patients liable for a charge basis had such payment been made in accordance with		in O	0	14
5.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.00000	15
o. 00	Total customary charges (see instructions)		4, 054, 201	41, 348, 892	16
7.00	Excess of customary charges over reasonable cost (complete or	nly if line 16 exceeds	4, 054, 201	41, 348, 892	17
3. 00	line 4) (see instructions) Excess of reasonable cost over customary charges (complete only if line 4 exceeds line			0	18
	16) (see instructions)				
9.00	Interns and Residents (see instructions)		0	0	
0.00	Cost of physicians' services in a teaching hospital (see inst		0	0	
. 00	Cost of covered services (enter the lesser of line 4 or line		0	0	21
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be	e completed for PPS provi			
2.00	Other than outlier payments		0	0	
3.00	Outlier payments Program capital payments		0	0	23
1.00 5.00	Capital exception payments (see instructions)		0		24
5.00	Routine and Ancillary service other pass through costs		0	0	
7.00	Subtotal (sum of lines 22 through 26)		0	0	
3.00	Customary charges (title V or XIX PPS covered services only)		0	0	
9.00	Titles V or XIX (sum of lines 21 and 27)		0	0	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		-	-	1 - '
0. 00	Excess of reasonable cost (from line 18)		0	0	30
. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6	6)	0	0	31
2.00	Deducti bl es		0	0	32
3.00	Coinsurance		0	0	33
l. 00	Allowable bad debts (see instructions)		0	0	34
5.00	Utilization review		0		35
o. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 ar	nd 33)	0	0	
7.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	
3.00	Subtotal (line 36 ± line 37)		0	0	
9.00	Direct graduate medical education payments (from Wkst. E-4)		0		39
0.00	Total amount payable to the provider (sum of lines 38 and 39)	)	0	0	
1.00	Interim payments		0	0	41
2.00	Balance due provider/program (line 40 minus line 41)		0	0	
3.00	Protested amounts (nonallowable cost report items) in accorda	ance with CMS Pub 15-2,	0	0	43

LCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0022 Component CCN: 15-S022	Period: From 01/01/2021 To 12/31/2021	Worksheet E-3 Part VII Date/Time Pre	
				5/31/2022 8:5	
		Title XIX	Subprovider - IPF	Cost	
			Inpatient 1.00	Outpatient	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SER	RVICES FOR TITLES V OR X		2.00	-
	COMPUTATION OF NET COST OF COVERED SERVICES				1
00	Inpatient hospital/SNF/NF services		0		] 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	
00	Inpatient primary payer payments		0		5
00	Outpatient primary payer payments			0	
00	Subtotal (line 4 less sum of lines 5 and 6)		0	0	7
	COMPUTATION OF LESSER OF COST OR CHARGES				-
00	Reasonable Charges		0		1 8
00 00	Routine service charges Ancillary service charges		6, 001	0	
. 00	Organ acquisition charges, net of revenue		0,001	0	10
. 00	Incentive from target amount computation		0		1
. 00	Total reasonable charges (sum of lines 8 through 11)		6, 001	0	
	CUSTOMARY CHARGES			-	1
. 00	Amount actually collected from patients liable for payment for	r services on a charge	0	0	11:
	basi s	C			
. 00	Amounts that would have been realized from patients liable for	r payment for services c	n 0	0	14
	a charge basis had such payment been made in accordance with 4	42 CFR §413.13(e)			
. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0.000000	
. 00	Total customary charges (see instructions)		6, 001	0	
. 00	Excess of customary charges over reasonable cost (complete onl	y if line 16 exceeds	6, 001	0	1
~~	line 4) (see instructions)			0	1
. 00	Excess of reasonable cost over customary charges (complete onl 16) (see instructions)	y II IIne 4 exceeds IIn	ie 0	0	18
. 00	Interns and Residents (see instructions)		0	0	10
. 00	Cost of physicians' services in a teaching hospital (see instr	ructions)	0	0	1
. 00	Cost of covered services (enter the lesser of line 4 or line 1		0	0	
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be				
. 00	Other than outlier payments		0	0	22
. 00	Outlier payments		0	0	23
. 00	Program capital payments		0		24
. 00	Capital exception payments (see instructions)		0		2!
. 00	Routine and Ancillary service other pass through costs		0	0	
. 00	Subtotal (sum of lines 22 through 26)		0	0	
. 00	Customary charges (title V or XIX PPS covered services only)		0	0	
. 00	Titles V or XIX (sum of lines 21 and 27)		0	0	20
. 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT Excess of reasonable cost (from line 18)		0	0	1.20
. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	0	
	Deductibles	,	0	0	
. 00	Coinsurance		0	0	1 -
. 00	Allowable bad debts (see instructions)		0	0	
. 00	Utilization review		0	0	3
. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	33)	0	0	
. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	
. 00	Subtotal (line 36 ± line 37)		0	0	
. 00	Direct graduate medical education payments (from Wkst. E-4)		0		3
. 00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	
. 00	Interim payments		0	0	
. 00	Balance due provider/program (line 40 minus line 41)		0	0	
. 00	Protested amounts (nonallowable cost report items) in accordar	nce with CMS Pub 15-2,	0	0	43

	inancial Systems FRANCISCAN HEALTH SHEET (If you are nonproprietary and do not maintain a accounting records, complete the Constal Fund column	Provider C	CN: 15-0022	Period: From 01/01/2021	Worksheet G	
una-typ nly)	e accounting records, complete the General Fund column			To 12/31/2021	Date/Time Pre 5/31/2022 8:5	
		General Fund	Specific Purpose Fund		Plant Fund	
CI	JRRENT ASSETS	1.00	2.00	3.00	4.00	-
	ash on hand in banks	23, 063, 750		0 0	0	1
00 Т	emporary investments	0		0 0	0	2
00 N	otes receivable	0		0 0	0	3
00 A	ccounts receivable	11, 986, 304		0 0	0	4
00 0.	ther receivable	485, 873		0 0	0	5
00 A	llowances for uncollectible notes and accounts receivable	-3, 062, 719		0 0	0	6
	nventory	1, 489, 282		0 0	0	7
	repaid expenses	278, 989		0 0	0	
	ther current assets	0		0 0	0	
	ue from other funds	0		0 0	0	
	otal current assets (sum of lines 1-10)	34, 241, 479		0 0	0	11
	XED ASSETS	070.400		0		1 40
1	and	970, 120		0 0	0	
	and improvements	3, 753, 111		0 0	0	
	ccumulated depreciation	44 000 400		0 0	0	
	uildings ccumulated depreciation	44, 909, 400		0 0	0	
	easehold improvements	505, 596		0 0	0	
	ccumulated depreciation	505, 570			0	
	i xed equipment			0 0	0	
	ccumul ated depreciation	0		0 0	0	
	utomobiles and trucks	0		0 0	0	
1	ccumul ated depreciation	0		0 0	0	
	ajor movable equipment	25, 080, 250		0 0	0	
	ccumulated depreciation	-40, 186, 913		0 0	0	24
5. OO Mi	inor equipment depreciable	0		0 0	0	25
. 00 A	ccumulated depreciation	0	1	0 0	0	26
7. 00 H	IT designated Assets	0		0 0	0	27
3. 00 A	ccumulated depreciation	0		0 0	0	28
9.00 Mi	i nor equi pment-nondepreci abl e	0		0 0	0	29
	otal fixed assets (sum of lines 12–29)	35, 031, 564		0 0	0	30
	THER ASSETS	-	1	-	-	
	nvestments	0		0 0	0	
	eposits on leases	0		0 0	0	
	ue from owners/officers	0		0 0	0	
	ther assets	1, 656, 917		0 0	0	
	otal other assets (sum of lines 31-34)	1, 656, 917		0 0 0 0	0	
	otal assets (sum of lines 11, 30, and 35)JRRENT LIABILITIES	70, 929, 960		0 0	0	36
	ccounts payable	4, 040, 586		0 0	0	37
	alaries, wages, and fees payable	1, 383, 687		0 0	0	
	ayroll taxes payable	1, 303, 007		0 0	0	
	otes and loans payable (short term)	0		0 0	0	
	eferred income	0		0 0	0	
1	ccelerated payments	0		-	-	42
1	ue to other funds	5, 982, 827		0 0	0	43
1. 00 0 <sup>.</sup>	ther current liabilities	355, 664		0 0	0	44
5. 00 To	otal current liabilities (sum of lines 37 thru 44)	11, 762, 764		0 0	0	45
LC	DNG TERM LIABILITIES		-			
	ortgage payable	0		0 0	0	
	otes payable	0		0 0	0	
	nsecured Loans	0		0 0	0	
	ther long term liabilities	-2,067,056		0 0	0	
	otal long term liabilities (sum of lines 46 thru 49)	-2,067,056		0 0	0	
	otal liabilities (sum of lines 45 and 50)	9, 695, 708		0 0	0	51
	APITAL ACCOUNTS eneral fund balance	61 004 050				6
	pecific purpose fund	61, 234, 252		0		52
	onor created - endowment fund balance - restricted			~ ^		54
	onor created - endowment fund balance - restricted			0		54
	overning body created - endowment fund balance			0		56
1	lant fund balance - invested in plant				0	
	lant fund balance - reserve for plant improvement,				0	
	eplacement, and expansion					
	otal fund balances (sum of lines 52 thru 58)	61, 234, 252		0 0	0	59
	otal liabilities and fund balances (sum of lines 51 and	70, 929, 960		0 0	0	

	Provider CC	N. 15-0022		i od:	Worksheet G-	1
			Froi To	m 01/01/2021 12/31/2021	Date/Time Pr 5/31/2022 8:	epared:
General	Fund	Speci al	Purp	ose Fund	Endowment Fun	t
1.00	2.00	3.00		4.00	5.00	
	47, 086, 360 14, 147, 890 61, 234, 250 0 61, 234, 250 0		000000000000000000000000000000000000000	0 0 0 0 0		$ \begin{array}{c} 1.00\\ 2.00\\ 3.00\\ 0\\ 4.00\\ 0\\ 5.00\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ $
	61, 234, 250			0		19.00
Endowment Fund	Pl ant	Fund				
6.00	7.00	8.00				
0	0 0 0 0 0	0.00	0			1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
000	0 0 0 0 0 0		0 0			10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00
	1.00           0	1.00         2.00           47,086,360         14,147,890           14,147,890         61,234,250           0         0 <tr< td=""><td>Image: constraint of the second state of th</td><td>Image: constraint of the constrated of the constraint of the constraint of the constraint of the</td><td>Image: Construction         Image: Construction           1.00         2.00         3.00         4.00           47,086,360         0         0         0           14,147,890         0         0         0           61,234,250         0         0         0           0         0         0         0         0           0         0         0         0         0         0           0         0         0         0         0         0         0           0</td><td>I00         2.00         3.00         4.00         5.00           47,086,360         0<!--</td--></td></tr<>	Image: constraint of the second state of th	Image: constraint of the constrated of the constraint of the constraint of the constraint of the	Image: Construction         Image: Construction           1.00         2.00         3.00         4.00           47,086,360         0         0         0           14,147,890         0         0         0           61,234,250         0         0         0           0         0         0         0         0           0         0         0         0         0         0           0         0         0         0         0         0         0           0	I00         2.00         3.00         4.00         5.00           47,086,360         0 </td

	Financial Systems FRANCI SCAN HEALTH C					u of Form CMS-2	2552-10
STATEM	IENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider CC	:N: 15-0022		iod: m 01/01/2021 12/31/2021	Worksheet G-2 Parts I & II Date/Time Pre 5/31/2022 8:50	
	Cost Center Description		Inpati ent		Outpatient	Total	
			1.00		2.00	3.00	
	PART I - PATIENT REVENUES						
1.00	General Inpatient Routine Services Hospital		7, 165, 9	02	I	7, 165, 992	1.00
2.00	SUBPROVIDER - IPF		4,007,6			4, 007, 631	2.00
3.00	SUBPROVIDER - IRF		4,007,0	0		4,007,031	3.00
4.00	SUBPROVIDER			Ŭ		0	4.00
5.00	Swing bed - SNF			0		0	5.00
6.00	Swing bed - NF			0		0	6.00
7.00	SKILLED NURSING FACILITY			0		0	7.00
8.00	NURSING FACILITY			0		0	8.00
9.00	OTHER LONG TERM CARE			0		0	9.00
10.00	Total general inpatient care services (sum of lines 1-9)		11, 173, 6	23		11, 173, 623	10.00
	Intensive Care Type Inpatient Hospital Services					1 704 700	
11.00			4, 701, 7			4, 701, 783	
12.00 13.00	CORONARY CARE UNI T BURN INTENSI VE CARE UNI T			0 0		0	12.00 13.00
13.00	SURGICAL INTENSIVE CARE UNIT			0		0	14.00
14.00	OTHER SPECIAL CARE (SPECIFY)			U		0	15.00
16.00	Total intensive care type inpatient hospital services (sum of	lines	4, 701, 7	83		4, 701, 783	
10100	11-15)		.,	00		1, 701, 700	10100
17.00	Total inpatient routine care services (sum of lines 10 and 16	)	15, 875, 4	06		15, 875, 406	17.00
18.00	Ancillary services		30, 837, 5	34	170, 080, 581	200, 918, 115	18.00
19.00	Outpatient services		4, 905, 9	47	46, 572, 705	51, 478, 652	19.00
20.00	RURAL HEALTH CLINIC			0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER			0	0	0	21.00
22.00	HOME HEALTH AGENCY			~	0	0	22.00
23.00 24.00	AMBULANCE SERVICES CMHC			0	0	0	23.00 24.00
24.00	CORF			0	0	0	24.00
25.00	AMBULATORY SURGICAL CENTER (D. P. )			0	0	0	25.00
26.00	HOSPICE			Ö	0	0	26.00
27.00	NON-REIMBURSABLE PHYS OFFICES			0	3, 368, 443	3, 368, 443	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3	to Wkst.	51, 618, 8	87	220, 021, 729	271, 640, 616	28.00
	G-3, line 1)						
	PART II - OPERATING EXPENSES						
29.00	Operating expenses (per Wkst. A, column 3, line 200)			~	61, 291, 851		29.00
30. 00 31. 00	ADD (SPECIFY)			0 0			30. 00 31. 00
31.00				0			31.00
32.00				0			32.00
34.00				0			34.00
35.00				0			35.00
36.00	Total additions (sum of lines 30-35)				0		36.00
37.00	DEDUCT (SPECI FY)			0			37.00
38.00				0			38.00
39.00				0			39.00
40.00				0			40.00
41.00				0			41.00
42.00	Total deductions (sum of lines 37-41)	2) (transfor			41 201 0F1		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 4 to Wkst. G-3, line 4)	z) (transrer			61, 291, 851		43.00
	$10 \text{ wkst. } 0^{-3}, 1110 \text{ 4}$	I		1	I		I

STATEMENT OF REVENUES AND EXPENSES         Provider CON: 15-0022         Period: From 01/01/2021         Worksheet G-3 Date/Time Prepared: 5/31/2022           1.00         Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)         1.00         Date/Time Prepared: 5/31/2022         Date/Time Prepared: 5/31/2022           1.00         Total patient revenues (line 1 minus line 2)         1.00         271, 640, 616         1.00           3.00         Net patient revenues (line 1 minus line 2)         74, 024, 914         3.00           4.00         Less total operating expenses (from Wkst. G-2, Part II, line 43)         74, 024, 914         3.00           5.00         Net income from service to patients (line 3 minus line 4)         12, 733, 063         5.00           0.00         Revenues from telephone and other miscel aneous communication services         0         6.00           9.00         Revenue from telephone and radio service         0         10.00           10.00         Purchase di scounts         110.01         10.00           11.00         Rebates and refunds of expenses         2, 250         13.00           11.00         Revenue from neals sold to employees and guests         2, 250         13.00           11.00         Revenue from sell of medical and surgical supplies to other than patients         0         15.00	Health Financial Systems FRANCISCA	N HEALTH CRAWFORDSVILLE	In Lie	u of Form CMS-2	2552-10
To         12/31/2021         Date/Time Prepared: 5/31/2022           1.00         Total patient revenues (from Wkst. 6-2, Part I, column 3, Line 28)         1.00           0.00         Total patient revenues (from Wkst. 6-2, Part I, column 3, Line 28)         271,640,616         1.00           0.00         Net patient revenues (line 1 minus line 2)         174,024,914         3.00           0.00         Less total operating expenses (from Wkst. 6-2, Part II, line 43)         12,733,663         5.00           0.01         Income from service to patients (line 3 minus line 4)         12,733,663         5.00           0.01         Income from investments         0         6.00           0.00         Net netlephone and other miscellaneous communication services         0         8.00           0.00         Revenue from teleybone and parters         0         9.00           0.00         Revenue from teleybone and parters         0         9.00           0.00         Revenue from teleybone and guests         11.00         11.00           0.01         Revenue from laundry and linen service         0         9.00           0.00         Revenue from rental of living quarters         0         11.00           0.01         Revenue from rental of living quarters         0         15.00	STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 15-0022		Worksheet G-3	
1.00         Total patient revenues (from Wkst. 6-2, Part I, column 3, line 28)         1.00           2.00         Less contractual allowances and discounts on patients' accounts         1.76,40,616,10,00           3.00         Net patient revenues (line 1 minus line 2)         271,640,616,10,00           4.00         Less total operating expenses (from Wkst. 6-2, Part II, line 43)         61,291,851,40,00           5.00         Net income from service to patients (line 3 minus line 4)         12,733,063           0.01         Contributions, donations, bequests, etc         0           0.00         Revenues from telephone and other miscellaneous communication services         0           0.00         Revenues from telephone and radio service         0           0.00         Revenue from television and radio service         0           0.00         Revenue from television and radio service         0           0.00         Revenue from television and radio service         0           0.00         Revenue from neals sold to employees and guests         12,00           0.10.00         Revenue from meals sold to employees and guests         12,4785,114,00           0.10.00         Revenue from sale of medical and surgical supplies to other than patients         8,865 17,00           0.10.00         Revenue from sale of medical and surgical supplies to other than patients				Date/Time Pre	pared:
1 00         Total patient revenues (from Wkst G-2, Part I, column 3, Line 28)         271, 640, 616         1.00           2 00         Less contractual allowances and discounts on patients' accounts         197, 615, 702         2.00           3 00         Net patient revenues (line 1 minus line 2)         74, 024, 914         3.00           4 00         Less total operating expenses (from Wkst. G-2, Part II, line 43)         61, 291, 851         4.00           0 Net income from service to patients (line 3 minus line 4)         012, 733, 063         5.00           0 Other investments         325         7.00           8.00         Revenue from telephone and other miscel laneous communication services         0         6.00           9.00         Revenue from television and radio service         0         9.00         8.00           10.00         Purchase discounts         11.00         12.00         9.00         11.00           10.00         Revenue from television and radio service         0         11.00         12.00           10.00         Revenue from meals sold to employees and guests         124, 785         14.00           11.00         Revenue from sale of drugs to other than patients         0         15.00           10.00         Revenue from sale of drugs to other than patients         0         15.00					
1 00         Total patient revenues (from Wkst G-2, Part I, column 3, Line 28)         271, 640, 616         1.00           2 00         Less contractual allowances and discounts on patients' accounts         197, 615, 702         2.00           3 00         Net patient revenues (line 1 minus line 2)         74, 024, 914         3.00           4 00         Less total operating expenses (from Wkst. G-2, Part II, line 43)         61, 291, 851         4.00           0 Net income from service to patients (line 3 minus line 4)         012, 733, 063         5.00           0 Other investments         325         7.00           8.00         Revenue from telephone and other miscel laneous communication services         0         6.00           9.00         Revenue from television and radio service         0         9.00         8.00           10.00         Purchase discounts         11.00         12.00         9.00         11.00           10.00         Revenue from television and radio service         0         11.00         12.00           10.00         Revenue from meals sold to employees and guests         124, 785         14.00           11.00         Revenue from sale of drugs to other than patients         0         15.00           10.00         Revenue from sale of drugs to other than patients         0         15.00					
2 00Less contractual al lowances and discounts on patients' accounts197, 615, 7022.003.00Net patient revenues (lin 1 minus line 2)74, 024, 9143.004.00Less total operating expenses (from Wkst. G-2, Part II, line 43)61, 291, 8514.005.00Net income from service to patients (line 3 minus line 4)12, 733, 0635.000Other R INCOME06.000Income from investments3257.008.00Revenues from tel explone and other miscel laneous communication services08.009.00Revenue from tel explone and other miscel laneous communication services08.009.00Revenue from tel explone and other miscel laneous communication services08.009.00Revenue from tel explone and guests11.0011.0010.00Parchase di scounts12.0012.0011.00Revenue from meals sold to employees and guests12.4718.1412.00Revenue from sale of medical and surgical supplies to other than patients015.0013.00Revenue from sale of medical encords and abstracts019.0013.00Revenue from sale of medical cords and abstracts019.0010.00Revenue from sale of textbooks, uniforms, etc.)019.0010.00Revenue from sale of medical necords and abstracts011.0013.00Revenue from sale of textbooks, uniforms, etc.)012.0010.00Revenue from sale of medical necords and abstracts012.00 <td></td> <td></td> <td></td> <td></td> <td></td>					
3.00       Net patient revenues (line 1 minus line 2)       74,024,914       3.00         4.00       Less total operating expenses (from Wkst. G-2, Part II, line 43)       61,291,851       4.00         0.01       Net income from service to patients (line 3 minus line 4)       12,73,063       5.00         0.01       Contributions, donations, bequests, etc       0       6.00       6.00         0.00       Income from investments       325       7.00         8.00       Revenues from television and radio service       0       9.00         9.00       Revenues from television and radio service       0       9.00         10.00       Purchase discounts       1177,772       10.00         11.00       Rebates and refunds of expenses       0       11.00         12.00       Parking lot receipts       0       12.00         13.00       Revenue from meals sold to employees and guests       12.4,785       14.00         15.00       Revenue from sale of medical and surgical supplies to other than patients       0       15.00         10.00       Revenue from sale of medical records and abstracts       325       18.00         10.00       Revenue from sale of medical records and abstracts       325       18.00         10.00       Revenue from sale of medical					
4.00       Less total operating expenses (from Wkst. G-2, Part II, line 43)       61,291,851       4.00         5.00       Net income from service to patients (line 3 minus line 4)       12,733,063       5.00         6.00       Contributions, donations, bequests, etc       0       6.00         7.00       Income from investments       325       7.00         8.00       Revenue from telephone and other miscellaneous communication services       0       8.00         9.00       Revenue from telephone and radio service       0       9.00         10.00       Revenue from telephone and radio service       0       9.00         11.00       Rebates and refunds of expenses       0       11.00         11.00       Revenue from laundry and linen service       2,250       11.00         12.00       Revenue from sale of medical and surgical supplies to other than patients       0       16.00         12.00       Revenue from sale of drugs to other than patients       0       16.00         13.00       Revenue from sale of medical and surgical supplies to other than patients       0       16.00         14.00       Revenue from sale of medical records and abstracts       8,865       17.00         19.00       Tuition (fees, sale of textbooks, uniforms, etc.)       0       19.00		nts' accounts			
5.00Net income from service to patients (line 3 minus line 4)12,733,0635.00OTHER INCOMEOTHER INCOME06.000.01Contributions, donations, bequests, etc06.000.01Income from investments3257.008.00Revenues from television and radio service08.009.00Revenue from television and radio service09.0010.00Purchase discounts177,77210.0011.00Rebates and refunds of expenses012.0012.00Parking lot receipts012.0012.00Revenue from meals sold to employees and guests2,25013.0014.00Revenue from sale of medical and surgical supplies to other than patients015.0016.00Revenue from sale of drugs to other than patients015.0018.00Revenue from sale of textbooks, uniforms, etc.)019.0010.00Revenue from sale of textbooks, uniforms, etc.)019.0020.00Revenue from gifts, flowers, coffee shops, and canteen81120.0021.00Retal of vending machines021.0021.0022.00Rental of vending machines021.0021.0022.00Revenue from gifts, flowers, coffee shops, and canteen81120.0022.00Retal of vending machines016.0221.0022.00Retal of vending machines021.0023.0023.00Governmental appropriations22.0123.00					
OTHER INCOME06.00Contributions, donations, bequests, etc07.00Income from investments3258.00Revenue from tel ephone and other miscel laneous communication services09.00Revenue from tel ephone and radio service09.00Revenue from tel ephone and radio service09.00Revenue from tel evision and radio service010.00Purchase discounts177, 77210.00Revanue from laundry and linen service012.00Parking lot receipts013.00Revenue from rental of living quarters015.00Revenue from sale of medical and surgical supplies to other than patients016.00Revenue from sale of medical and surgical supplies to other than patients016.00Revenue from sale of textbooks, uniforms, etc.)017.00Revenue from gilts, flowers, coffee shops, and canteen81117.00Revenue from gilts, flowers, coffee shops, and canteen011.00Covernmental appropriations022.00Rental of hospital space21.0023.00Governmental appropriations024.00THER INGREVENUE025.00Total other income (sum of lines 6-24)1,414,42725.00Total other expenses (sum of line 27 and subscripts)027.00Revenue from sels (sum of line 27 and subscripts)0					
6.00       Contributions, donations, bequests, etc       0       6.00         7.00       Income from investments       325       7.00         8.00       Revenues from telephone and other miscellaneous communication services       0       8.00         9.00       Revenues from telephone and other miscellaneous communication services       0       9.00         10.00       Purchase discounts       1177.772       10.00         11.00       Rebates and refunds of expenses       0       12.00         12.00       Parking lot receipts       0       12.00         13.00       Revenue from meal sold to employees and guests       124.785       14.00         14.00       Revenue from sale of medical and surgical supplies to other than patients       0       16.00         16.00       Revenue from sale of medical records and abstracts       325       18.00         19.00       Revenue from gifts, flowers, coffee shops, and canteen       6.326       21.00         10.00       Revenue from gifts, flowers, coffee shops, and canteen       0       19.00       19.00         10.00       Revenue from gifts, flowers, coffee shops, and canteen       6.326       21.00       23.00         23.00       Governmental appropriations       0       12.00       23.00       23.00 <td></td> <td>ine 4)</td> <td></td> <td>12, 733, 063</td> <td>5.00</td>		ine 4)		12, 733, 063	5.00
7.00       Income from investments       325       7.00         8.00       Revenues from telephone and other miscellaneous communication services       0       8.00         9.00       Revenue from telephone and radio service       0       9.00         10.00       Purchase discounts       177,772       10.00         11.00       Rebates and refunds of expenses       0       11.00         2.00       Parking lot receipts       0       12.00         13.00       Revenue from laundry and linen service       2.250       13.00         14.00       Revenue from rental of living quarters       0       15.00         15.00       Revenue from sale of medical and surgical supplies to other than patients       0       16.00         17.00       Revenue from sale of medical necords and abstracts       325       18.00         19.00       Tuition (fees, sale of textbooks, uniforms, etc.)       0       19.00         20.00       Rental of hospital space       0       216,150       22.00         21.00       Retal of hospital space       0       23.00       23.00       23.00         24.00       OTHER OPERATI NG REVENUE       623.838       24.00       23.25       24.01         25.00       Total other income (sum of lines 6-24					
8.00       Revenues from telephone and other miscellaneous communication services       0       9.00         9.00       Revenue from television and radio service       0       9.00         10.00       Purchase discounts       177,772       10.00         11.00       Rebates and refunds of expenses       11.00       11.00         12.00       Parking lot receipts       0       12.00         13.00       Revenue from meals sold to employees and guests       124.785       14.00         15.00       Revenue from sale of medical and surgical supplies to other than patients       0       15.00         16.00       Revenue from sale of medical records and abstracts       325       18.00         19.00       Tuition (fees, sale of textbooks, uniforms, etc.)       0       12.00         21.00       Revalue from gifts, flowers, coffee shops, and canteen       6,326       21.00         21.00       Revalue from gifts, flowers, coffee shops, and canteen       0       22.00       0         22.00       Rental of hospital space       22.00       23.00       23.03       60vernmental appropriations       0       23.03         23.00       Governmental appropriations       125.00       124.1827       25.00       24.01         24.00       ThER OPERATING REVENUE<					
9.00         Revenue from television and radio service         0         9.00           10.00         Purchase discounts         177,772         10.00           11.00         Rebates and refunds of expenses         0         12.00           12.00         Parking lot receipts         0         12.00           13.00         Revenue from laundry and linen service         2,250         13.00           14.00         Revenue from real of living quarters         0         12.00           15.00         Revenue from sale of medical and surgical supplies to other than patients         0         15.00           16.00         Revenue from sale of medical records and abstracts         8.865         17.00           19.00         Revenue from gifts, flowers, coffee shops, and canteen         0         19.00           20.00         Revenue from gifts, flowers, coffee shops, and canteen         0         12.00           21.00         Rental of hospital space         21.00         23.00           22.00         Rental of pospital space         21.00         23.00           22.00         Rental of hospital space         21.00         23.00           23.00         Governmental appropriations         0         12.00           24.01         NET ASSETS RELEASED FROM OPERATION					
10.00       Purchase di scounts       177, 772       10.00         11.00       Rebates and refunds of expenses       0       11.00         12.00       Parki ng l ot recei pts       0       12.00         13.00       Revenue from laundry and linen service       2,250       13.00         14.00       Revenue from meals sold to employees and guests       124,785       14.00         15.00       Revenue from rental of living quarters       0       15.00         16.00       Revenue from sale of medical and surgical supplies to other than patients       0       16.00         17.00       Revenue from sale of medical records and abstracts       8,865       17.00         19.00       Tui ti on (fees, sal e of textbooks, uni forms, etc.)       0       19.00         20.00       Revenue from gifts, flowers, coffee shops, and canteen       811       20.00         21.00       Rental of vending machines       6,326       21.00         23.00       Governmental appropriations       0       23.00         24.00       OTHER OPERATING REVENUE       623,838       24.00         24.00       OTHER OPERATING REVENUE       623,838       24.00         25.00       Total other income (sum of lines 6-24)       1,414,827       25.00		nmunication services		-	
11.00       Rebates and refunds of expenses       0       11.00         12.00       Parking lot receipts       0       12.00         13.00       Revenue from laundry and linen service       2,250       13.00         14.00       Revenue from meals sold to employees and guests       124,785       14.00         15.00       Revenue from rental of living quarters       0       15.00         16.00       Revenue from sale of medical and surgical supplies to other than patients       0       15.00         17.00       Revenue from sale of furgs to other than patients       0       15.00         18.00       Revenue from sale of medical records and abstracts       325       18.00         19.00       Tuition (fees, sale of textbooks, uniforms, etc.)       0       19.00         20.00       Rental of hospital space       216,150       22.00         21.00       Rental of hospital space       216,150       22.00         22.00       Rental of hospital space       23.00       23.00         24.01       NET ASSETS RELEASED FROM OPERATIONG       23.00       23.00         24.01       NET ASSETS RELEASED FROM OPERATIONG       253,255       24.50         25.00       Total other income (sum of lines 6-24)       1,414,827       25.00				Ű	
12.00       Parking lot receipts       0       12.00         13.00       Revenue from laundry and linen service       2,250       13.00         14.00       Revenue from meals sold to employees and guests       124,785       124,785         15.00       Revenue from rental of living quarters       0       15.00         16.00       Revenue from sale of medical and surgical supplies to other than patients       0       16.00         17.00       Revenue from sale of medical records and abstracts       8,865       17.00         18.00       Revenue from sale of textbooks, uniforms, etc.)       0       0       19.00         20.00       Revent from grant of hospital space       0       12.00         21.00       Revent of hospital space       0       19.00         22.00       Rental of hospital space       216,150       22.00         23.00       Governmental appropriations       0       23.00         24.00       OTHER OPERATING REVENUE       623,838       24.00         24.50       Total other income (sum of lines 6-24)       12.414,827       25.00         25.00       Total (line 5 plus line 25)       14,147,800       27.00         26.00       Total (line 5 plus line 25)       14,147,800       27.00				177, 772	
13.00       Revenue from laundry and linen service       2,250       13.00         14.00       Revenue from meals sold to employees and guests       124,785       14.00         15.00       Revenue from rental of living quarters       0       15.00         16.00       Revenue from sale of medical and surgical supplies to other than patients       0       16.00         17.00       Revenue from sale of medical records and abstracts       8,865       17.00         18.00       Revenue from sale of textbooks, uniforms, etc.)       0       19.00         10.00       Revtaul of vending machines       811       20.00         22.00       Rental of vending machines       6,326       21.00         22.00       Rental of hospital space       216,150       22.00         23.00       Governmental appropriations       0       23.00         24.00       OTHER OPERATING REVENUE       253,255       24.01         24.50       Total other income (sum of lines 6-24)       14,147,890       25.00         27.00       Total (line 5 plus line 25)       14,147,890       26.00       27.00         28.00       Total other expenses (sum of line 27 and subscripts)       0       27.00					
14.00       Revenue from meals sold to employees and guests       124,785       14.00         15.00       Revenue from rental of living quarters       0       15.00         16.00       Revenue from sale of medical and surgical supplies to other than patients       0       16.00         17.00       Revenue from sale of medical records and abstracts       8,865       17.00         18.00       Revenue from gifts, flowers, coffee shops, and canteen       325       18.00         19.00       Tuition (fees, sale of textbooks, uniforms, etc.)       0       19.00         20.00       Revenue from gifts, flowers, coffee shops, and canteen       811       20.00         21.00       Rental of vending machines       6,326       21.00         23.00       Governmental appropriations       0       23.00         24.00       THE OPERATING REVENUE       623,838       24.00         24.00       NET ASSETS RELEASED FROM OPERATIONG       125       24.01         24.50       COVID-19 PHE Funding       253,255       24.50         25.00       Total other income (sum of lines 6-24)       14,147,890       25.00         26.00       Total other expenses (SPECIFY)       0       27.00         28.00       Total other expenses (sum of line 27 and subscripts)       0					
15.00       Revenue from rental of living quarters       0       15.00         16.00       Revenue from sale of medical and surgical supplies to other than patients       0       16.00         17.00       Revenue from sale of drugs to other than patients       0       16.00         18.00       Revenue from sale of drugs to other than patients       8,865       17.00         19.00       Tuit ion (fees, sale of textbooks, uniforms, etc.)       0       19.00         20.00       Revenue from gifts, flowers, coffee shops, and canteen       811       20.00         21.00       Rental of vending machines       6,326       21.00         23.00       Governmental appropriations       0       23.00         24.00       OTHER OPERATING REVENUE       623,838       24.00         24.01       NET ASSETS RELEASED FROM OPERATIONG       125       24.01         24.00       Total other income (sum of lines 6-24)       1,414,827       25.00         25.00       Total other income (sum of lines 6-24)       1,414,827       25.00         27.00       OTHER EXPENSES (SPECIFY)       0       27.00         28.00       Total other expenses (sum of line 27 and subscripts)       0       27.00					
16.00       Revenue from sale of medical and surgical supplies to other than patients       0       16.00         17.00       Revenue from sale of drugs to other than patients       8,865       17.00         18.00       Revenue from sale of medical records and abstracts       325       18.00         19.00       Tuition (fees, sale of textbooks, uniforms, etc.)       0       19.00         20.00       Revenue from gifts, flowers, coffee shops, and canteen       811       20.00         21.00       Rental of vending machines       216,150       22.00         23.00       Governmental appropriations       0       23.00         24.00       OTHER OPERATING REVENUE       623,838       24.00         24.01       NET ASSETS RELEASED FROM OPERATIONG       125       24.01         24.50       COVID-19 PHE Funding       253,255       24.50         25.00       Total other income (sum of lines 6-24)       14,147,890       26.00         26.00       Total other expenses (sum of line 27 and subscripts)       0       27.00         28.00       Total other expenses (sum of line 27 and subscripts)       0       28.00				124, 785	
17.00       Revenue from sale of drugs to other than patients       8,865       17.00         18.00       Revenue from sale of medical records and abstracts       325       18.00         19.00       Tuition (fees, sale of textbooks, uniforms, etc.)       0       19.00         20.00       Revenue from gifts, flowers, coffee shops, and canteen       811       20.00         21.00       Rental of vending machines       6,326       21.00         22.00       Rental of hospital space       216,150       22.00         23.00       Governmental appropriations       0       23.00         24.00       OTHER OPERATING REVENUE       623,838       24.00         24.01       NET ASSETS RELEASED FROM OPERATIONG       125       24.01         24.50       COVID-19 PHE Funding       253,255       24.50         25.00       Total other income (sum of lines 6-24)       14,147,890       26.00         26.00       Total other expenses (SPECIFY)       0       27.00       27.00       28.00         28.00       Total other expenses (sum of line 27 and subscripts)       0       28.00				0	
18.00       Revenue from sale of medical records and abstracts       325       18.00         19.00       Tuition (fees, sale of textbooks, uniforms, etc.)       0       19.00         20.00       Revenue from gifts, flowers, coffee shops, and canteen       811       20.00         21.00       Rental of vending machines       6,326       21.00         22.00       Rental of hospital space       216,150       22.00         23.00       Governmental appropriations       0       23.00         24.00       OTHER OPERATING REVENUE       623,838       24.00         24.01       NET ASSETS RELEASED FROM OPERATIONG       125       24.01         24.50       COVI D-19 PHE Funding       253,255       24.50         25.00       Total other income (sum of lines 6-24)       14,147,890       26.00         26.00       Total (line 5 plus line 25)       14,147,890       26.00         27.00       OTHER EXPENSES (SPECI FY)       0       27.00         28.00       Total other expenses (sum of line 27 and subscripts)       0       28.00		to other than patients		-	
19.00       Tuition (fees, sale of textbooks, uniforms, etc.)       0       19.00         20.00       Revenue from gifts, flowers, coffee shops, and canteen       811       20.00         21.00       Rental of vending machines       6,326       21.00         22.00       Rental of hospital space       216,150       22.00         23.00       Governmental appropriations       0       23.00         24.00       OTHER OPERATING REVENUE       623,838       24.00         24.01       NET ASSETS RELEASED FROM OPERATIONG       253,255       24.01         24.50       COVID-19 PHE Funding       253,255       24.50         25.00       Total other income (sum of lines 6-24)       1,414,827       25.00         26.00       Total (line 5 plus line 25)       14,147,890       26.00         27.00       OTHER EXPENSES (SPECIFY)       0       27.00         28.00       Total other expenses (sum of line 27 and subscripts)       0       28.00					
20.00       Revenue from gifts, flowers, coffee shops, and canteen       811       20.00         21.00       Rental of vending machines       6,326       21.00         22.00       Rental of hospital space       216,150       22.00         23.00       Governmental appropriations       0       23.00         24.00       OTHER OPERATING REVENUE       623,838       24.00         24.01       NET ASSETS RELEASED FROM OPERATIONG       253,255       24.01         24.50       COVID-19 PHE Funding       253,255       24.50         25.00       Total other income (sum of lines 6-24)       1,414,827       25.00         26.00       Total (line 5 plus line 25)       14,147,890       26.00         27.00       OTHER EXPENSES (SPECIFY)       0       27.00         28.00       Total other expenses (sum of line 27 and subscripts)       0       28.00				325	
21.00       Rental of vending machines       6,326       21.00         22.00       Rental of hospital space       216,150       22.00         23.00       Governmental appropriations       0       23.00         24.00       OTHER OPERATING REVENUE       623,838       24.00         24.01       NET ASSETS RELEASED FROM OPERATIONG       125       24.01         24.50       COVID-19 PHE Funding       253,255       24.50         25.00       Total other income (sum of lines 6-24)       1,414,827       25.00         26.00       Total (line 5 plus line 25)       14,147,890       26.00         27.00       OTHER EXPENSES (SPECIFY)       0       27.00         28.00       Total other expenses (sum of line 27 and subscripts)       0       28.00				-	
22.00       Rental of hospital space       216,150       22.00         23.00       Governmental appropriations       0       23.00         24.00       OTHER OPERATING REVENUE       623,838       24.00         24.01       NET ASSETS RELEASED FROM OPERATIONG       125       24.01         24.50       COVID-19 PHE Funding       253,255       24.50         25.00       Total other income (sum of lines 6-24)       14,147,890       26.00         26.00       Total other expenses (SPECIFY)       0       27.00         28.00       Total other expenses (sum of line 27 and subscripts)       0       28.00	5	een			
23.00       Governmental appropriations       0       23.00         24.00       OTHER OPERATING REVENUE       623,838       24.00         24.01       NET ASSETS RELEASED FROM OPERATIONG       125       24.01         24.50       COVID-19 PHE Funding       253,255       24.50         25.00       Total other income (sum of lines 6-24)       1,414,827       25.00         26.00       Total (line 5 plus line 25)       14,147,890       26.00         27.00       OTHER EXPENSES (SPECIFY)       0       27.00         28.00       Total other expenses (sum of line 27 and subscripts)       0       28.00					
24.00       OTHER OPERATING REVENUE       623,838       24.00         24.01       NET ASSETS RELEASED FROM OPERATIONG       125       24.01         24.50       COVID-19 PHE Funding       253,255       24.50         25.00       Total other income (sum of lines 6-24)       1,414,827       25.00         26.00       Total (line 5 plus line 25)       14,147,890       26.00         27.00       OTHER EXPENSES (SPECIFY)       0       27.00         28.00       Total other expenses (sum of line 27 and subscripts)       0       28.00				216, 150	
24. 01       NET ASSETS RELEASED FROM OPERATIONG       125       24. 01         24. 50       COVI D-19 PHE Funding       253, 255       24. 50         25. 00       Total other income (sum of lines 6-24)       1, 414, 827       25. 00         26. 00       Total (line 5 plus line 25)       14, 147, 890       26. 00         27. 00       OTHER EXPENSES (SPECIFY)       0       27. 00         28. 00       Total other expenses (sum of line 27 and subscripts)       0       28. 00	23.00 Governmental appropriations			0	23.00
24. 50COVI D-19 PHE Funding253, 25524. 5025. 00Total other income (sum of lines 6-24)1, 414, 82725. 0026. 00Total (line 5 plus line 25)14, 147, 89026. 0027. 00OTHER EXPENSES (SPECIFY)027. 0028. 00Total other expenses (sum of line 27 and subscripts)028. 00	24.00 OTHER OPERATING REVENUE			623, 838	24.00
25.00       Total other income (sum of lines 6-24)       1,414,827       25.00         26.00       Total (line 5 plus line 25)       14,147,890       26.00         27.00       OTHER EXPENSES (SPECIFY)       0       27.00         28.00       Total other expenses (sum of line 27 and subscripts)       0       28.00	24.01 NET ASSETS RELEASED FROM OPERATIONG			125	24.01
26.00       Total (line 5 plus line 25)       14, 147, 890       26.00         27.00       0THER EXPENSES (SPECIFY)       0       27.00         28.00       Total other expenses (sum of line 27 and subscripts)       0       28.00	24. 50 COVI D-19 PHE Fundi ng			253, 255	24.50
27.00         0THER EXPENSES (SPECIFY)         0         27.00           28.00         Total other expenses (sum of line 27 and subscripts)         0         28.00	25.00 Total other income (sum of lines 6-24)			1, 414, 827	25.00
28.00Total other expenses (sum of line 27 and subscripts)028.00				14, 147, 890	26.00
				0	27.00
29.00 Net income (or loss) for the period (line 26 minus line 28) 14,147,890 29.00	28.00 Total other expenses (sum of line 27 and subscripts	5)			
	29.00 Net income (or loss) for the period (line 26 minus	line 28)		14, 147, 890	29.00

CALCUL	ATION OF CAPITAL PAYMENT	Provider CCN: 15-0022	In Lie Period:	Worksheet L	
			From 01/01/2021	Parts I-III	nor'
			To 12/31/2021	Date/Time Pre 5/31/2022 8:5	
		Title XVIII	Hospi tal	PPS	U ani
				1.00	
	PART I - FULLY PROSPECTIVE METHOD CAPITAL FEDERAL AMOUNT				-
. 00	Capital DRG other than outlier			313, 904	1.0
. 01	Model 4 BPCI Capital DRG other than outlier			0	
. 00	Capital DRG outlier payments			37.933	
. 01	Model 4 BPCI Capital DRG outlier payments			0,,,00	
. 00	Total inpatient days divided by number of days in the cos	t reporting period (see inst	ructions)	11.90	
. 00	Number of interns & residents (see instructions)	5 F ( )		0.00	
. 00	Indirect medical education percentage (see instructions)			0.00	5.0
00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and			0	6.0
00	1.01)(see instructions) Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line			0.00	7.
00	30) (see instructions) Percentage of Medicaid patient days to total days (see in	ctructions)		0.00	8.
00	Sum of lines 7 and 8	structrons)		0.00	
	Allowable disproportionate share percentage (see instruct	ions)		0.00	
1.00	Disproportionate share adjustment (see instructions)			0.00	
	Total prospective capital payments (see instructions)			351, 837	
2.00				001/007	
				1.00	
. 00	PART II - PAYMENT UNDER REASONABLE COST Program inpatient routine capital cost (see instructions)			0	1 1.
00	Program inpatient ancillary capital cost (see instructions)	c)		0	
00	Total inpatient program capital cost (line 1 plus line 2)	5)		0	3.
00	Capital cost payment factor (see instructions)			0	4.
. 00	Total inpatient program capital cost (line 3 x line 4)			0	
00				0	0.
				1.00	
~~	PART III - COMPUTATION OF EXCEPTION PAYMENTS			0	1 1
00 00	Program inpatient capital costs (see instructions)	tancas (soo instructions)		0	1. 2.
00	Program inpatient capital costs for extraordinary circums Net program inpatient capital costs (line 1 minus line 2)	tances (see instructions)		0	
00	Applicable exception percentage (see instructions)			0.00	
00	Capital cost for comparison to payments (line 3 x line 4)			0.00	
00	Percentage adjustment for extraordinary circumstances (se			0.00	
00	Adjustment to capital minimum payment level for extraordi	,	line 6)	0.00	
00	Capital minimum payment level (line 5 plus line 7)			0	
00	Current year capital payments (from Part I, line 12, as a	pplicable)		0	
), 00	Current year comparison of capital minimum payment level		less line 9)	0	
. 00	Carryover of accumulated capital minimum payment level ov Worksheet L, Part III, line 14)			0	
2.00	Net comparison of capital minimum payment level to capita	l payments (line 10 plus lin	e 11)	0	12.
3.00	Current year exception payment (if line 12 is positive, e				13.
4 00	Carryover of accumulated capital minimum payment level ov				14

12.00 Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)
13.00 Current year exception payment (if line 12 is positive, enter the amount on this line)
14.00 Carryover of accumulated capital minimum payment level over capital payment for the following period

0 14.00 (if line 12 is negative, enter the amount on this line) 15.00 Current year allowable operating and capital payment (see instructions)
16.00 Current year operating and capital costs (see instructions)
17.00 Current year exception offset amount (see instructions) 0 15.00 0 16.00 0 17.00