Health Financial Systems FRANCISCAN HEALTH MICHIGAN CITY In Lieu of Form CMS-2	552-10
This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED	
payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0	
EXPI RES 03-31-	2022
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION Provider CCN: 15-0015 Period: Worksheet S	
AND SETTLEMENT SUMMARY From 01/01/2021 Parts I-III To 12/31/2021 Date/Time Prep	ared
5/26/2022 11:2	
PART I - COST REPORT STATUS	
Provider 1. [X] Electronically prepared cost report Date: 5/26/2022 Time: 11:	23 am
use only 2. [] Manually prepared cost report	
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report	
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.	
Contractor 5. [1] Cost Report Status 6. Date Received: 10. NPR Date: Use only (1) As Submitted 7. Contractor No. 11. Contractor's Vendor Code:	4
use only (1) As Submitted 7. Contractor No. [11. Contractor's Vendor Code: (2) Settled without Audit 8. [N] Initial Report for this Provider CCN 12. [0] If line 5, column 1 is 4: Er	ter
(3) Settled with Audit 9. [N] Final Report for this Provider CCN number of times reopened = C	
(4) Reopened	
(5) Amended	
PART II - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OR PROVIDER(S)	
MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE	1
PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OF INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND	`
ADVIN 15 TRATIVE ACTION. FINES AND/OR IMPRISONMENT MAY RESULT.	
CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S)	
I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying	
electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and	
Statement of Revenue and Expenses prepared by FRANCISCAN HEALTH MICHIGAN CITY (15-0015) for the cost reporting	
period beginning 01/01/2021 and ending 12/31/2021 and to the best of my knowledge and belief, this report and	
statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations	
regarding the provision of health care services, and that the services identified in this cost report were	
regarding the provision of hearth care services, and that the services ruentified in this cost report were	

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRA	ATOR CHECKBOX		
	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	HI T	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	308, 996	-168, 057	0	0	1.00
2.00	Subprovider - IPF	0	0	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	308, 996	-168, 057	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.

	FAL AND HOSPITAL HEALTH CARE COMPLEX	IDENIFICATION DATA	Provi d	er CCN: 1	1	Period: From 01/01/ Fo 12/31/		Workshe Part I Date/Ti		
	1.00	0.00		2 00				5/26/20		
	1.00 Hospital and Hospital Health Care Co	2.00		3.00		2	. 00			
00	Street: 3500 FRANCI SCAN WAY	PO Box:								1.0
00	City: MICHIGAN CITY	State: IN Component Name	Zip Code	e: 46360 CBSA	Count Provi der	y: Date	Payme	nt Syste	em (P	2.0
			Number	Number	Туре	Certified		0, or		
		1.00	0.00	0.00	1.00	5.00	V	XVIII	XIX	
	Hospital and Hospital-Based Componer	1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
00	Hospi tal	FRANCI SCAN HEALTH	150015	33140	1	07/01/1966	Ν	Р	0	3. (
00	Subprovider - IPF	MICHIGAN CITY FRANCISCAN HEALTH	15S015	33140	4	01/01/1998	N	Р	0	4.0
		MICHIGAN CITY							-	
00 00	Subprovider - IRF Subprovider - (Other)									5. 0 6. 0
00	Swing Beds - SNF									7.0
00	Swing Beds - NF									8.0
00). 00	Hospi tal -Based SNF Hospi tal -Based NF									9.0
1.00	Hospi tal -Based OLTC									11. (
2.00	Hospital-Based HHA									12. (
. 00 . 00	Separately Certified ASC Hospital-Based Hospice									13. 14.
. 00										15.0
. 00										16.
. 00 . 10	Hospital-Based (CMHC) Hospital-Based (CORF)									17. 17.
. 00	Renal Dialysis									18.
. 00	Other									19.
						From: 1.00				-
. 00	Cost Reporting Period (mm/dd/yyyy)					01/01/20)21	12/31/		20.
. 00	Type of Control (see instructions)					1				21.0
					1.00	2.00		3. C	00	1
	Inpatient PPS Information					· ·				
. 00	Does this facility qualify and is it disproportionate share hospital adju				Y	N				22.0
	§412. 106? In column 1, enter "Y" fo									
	facility subject to 42 CFR Section §		endment							
2. 01	hospital?) In column 2, enter "Y" fo Did this hospital receive interim un		ts for thi	s	Y	Y				22.0
. 01	cost reporting period? Enter in colu				·					22. \
	the portion of the cost reporting pe									
	Enter in column 2, "Y" for yes or "N reporting period occurring on or aft			ost						
2. 02	Is this a newly merged hospital that			e	Ν	N				22.
	payments to be determined at cost re	port settlement? (see i	nstruction	s)						
	Enter in column 1, "Y" for yes or "N cost reporting period prior to Octob			ves						
	or "N" for no, for the portion of th									
0.00	October 1. Did this hospital receive a geograph	ic roclassification fra	m urban ta		Ν	N		N		22.
2.03	rural as a result of the OMB standar				IN	IN		IN		22.0
	adopted by CMS in FY2015? Enter in c	olumn 1, "Y" for yes or	"N" for n	0						
	for the portion of the cost reportin in column 2, "Y" for yes or "N" for			r						
	reporting period occurring on or aft	•								
	Does this hospital contain at least	100 but not more than 4	99 beds (a							
	counted in accordance with 42 CFR 41	2.105)? Enter in column	3, "Y" fo	r						
		ic reclassification fro	m urban to		Ν	N		Ν		22.
2. 04	yes or "N" for no. Did this hospital receive a geograph		stical are	as						
. 04	Did this hospital receive a geograph rural as a result of the revised OMB		r "N" for							
2. 04	Did this hospital receive a geograph rural as a result of the revised OME adopted by CMS in FY 2021? Enter in	column 1, "Y" for yes o	er 1 Fnt≏	· I						
2. 04	Did this hospital receive a geograph rural as a result of the revised OMB	column 1, "Y" for yes o g period prior to Octob								
2. 04	Did this hospital receive a geograph rural as a result of the revised OME adopted by CMS in FY 2021? Enter in for the portion of the cost reportin in column 2, "Y" for yes or "N" for reporting period occurring on or aft	column 1, "Y" for yes o g period prior to Octob no for the portion of t er October 1. (see inst	he cost ructions)							
. 04	Did this hospital receive a geograph rural as a result of the revised OME adopted by CMS in FY 2021? Enter in for the portion of the cost reportin in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least	column 1, "Y" for yes o g period prior to Octob no for the portion of t er October 1. (see inst 100 but not more than 4	he cost ructions) 99 beds (a	s						
2. 04	Did this hospital receive a geograph rural as a result of the revised OME adopted by CMS in FY 2021? Enter in for the portion of the cost reportin in column 2, "Y" for yes or "N" for reporting period occurring on or aft	column 1, "Y" for yes o g period prior to Octob no for the portion of t er October 1. (see inst 100 but not more than 4	he cost ructions) 99 beds (a	s						
	Did this hospital receive a geograph rural as a result of the revised OME adopted by CMS in FY 2021? Enter in for the portion of the cost reportin in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no. Which method is used to determine Me	column 1, "Y" for yes o g period prior to Octob no for the portion of t er October 1. (see inst 100 but not more than 4 2.105)? Enter in colum dicaid days on lines 24	he cost ructions) 99 beds (a n 3, "Y" f and/or 25	s òr		3 N				23. (
	Did this hospital receive a geograph rural as a result of the revised OME adopted by CMS in FY 2021? Enter in for the portion of the cost reportin in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no. Which method is used to determine Me below? In column 1, enter 1 if date	column 1, "Y" for yes o g period prior to Octob no for the portion of t er October 1. (see inst 100 but not more than 4 2.105)? Enter in colum dicaid days on lines 24 of admission, 2 if cens	he cost ructions) 99 beds (a n 3, "Y" f and/or 25 us days, o	s for r 3		3 N				23.
	Did this hospital receive a geograph rural as a result of the revised OME adopted by CMS in FY 2021? Enter in for the portion of the cost reportin in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no. Which method is used to determine Me	column 1, "Y" for yes o g period prior to Octob no for the portion of t er October 1. (see inst 100 but not more than 4 2.105)? Enter in colum dicaid days on lines 24 of admission, 2 if cens of identifying the days	he cost ructions) 99 beds (a n 3, "Y" f and/or 25 us days, o in this c	s for r 3		3 N				23.

Health Financial Systems FRANCISCAN	I HEALTH MIC	CHIGAN CITY		_	In Lie	eu of	Form CMS	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA I	Provider CC	N: 15-0015	Period: From 01/C		Part		
					1/2021	5/26	/Time Pr /2022 11	
	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medi cai d el i gi bl e unpai d	Medic HMO d		Other Medi cai d days	
	1.00	2.00	3.00	4.00	5.0		6.00	
 24.00 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. 25.00 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 eligible unpaid days in column 4, Medicaid HMO paid and eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5. 	0			61	5	, 979 0	9	3 24.0025.00
	-						of Geog	-
26.00 Enter your standard geographic classification (not wa		at the beg	jinning of t	:he	2	2	2.00	26.00
 cost reporting period. Enter "1" for urban or "2" for 27.00 Enter your standard geographic classification (not we reporting period. Enter in column 1, "1" for urban or enter the effective date of the geographic reclassifi 35.00 If this is a sole community hospital (SCH), enter the 	age) status ~ "2" for r cation in d	ural. If ap column 2.	plicable,		2	2		27.00
effect in the cost reporting period.						-		
				Begi n 1.			ndi ng: 2. 00	-
36.00 Enter applicable beginning and ending dates of SCH st of periods in excess of one and enter subsequent date					36.00			
 37.00 If this is a Medicare dependent hospital (MDH), enter is in effect in the cost reporting period. 37.01 Is this hospital a former MDH that is eligible for the construction of the second sec	ne MDH tran	sitional pa	yment in	IS	(D		37.00 37.01
 accordance with FY 2016 OPPS final rule? Enter "Y" for instructions) 38.00 If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates. 	s of MDH st	atus. Ifli	ne 37 is					38.00
				Y/			Y/N 2.00	_
39.00 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 1 accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii or "N" for no. (see instructions)), (ii), or the mileage i)? Enter	(iii)? Ent requiremer in column 2	er in colum nts in ? "Y" for ye	ime N in es			N	39.00
40.00 Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1.	per 1. Ente	r"Y" for y					Y	40.00
					V 1.0			_
Prospective Payment System (PPS)-Capital45.00Does this facility qualify and receive Capital payment	nt for disp	roporti onat	e share in	accordance	N	N	I N	45.00
 with 42 CFR Section §412.320? (see instructions) 46.00 Is this facility eligible for additional payment excerpursuant to 42 CFR §412.348(f)? If yes, complete Wks1 					N	N	I N	46.00
Pt. III. 47.00 Is this a new hospital under 42 CFR §412.300(b) PPS of 48.00 Is the facility electing full federal capital payment	•		5		N	N		47.00
Teaching Hospitals 56.00 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	approved G e to column rograms in cable CRs)	ME programs 1 is "Y", the prior y	? Enter "Y" or if this vear or penu	for yes o hospital Iltimate	r N			56.00
Enter "Y" for yes; otherwise, enter "N" for no in col 57.00 f ine 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. f column 2 is "Y "N", complete Wkst. D, Parts & V and D-2, Pt.	period durin yes or "N th of this Y", complet , if applic	" for no ir cost report e Worksheet cable.	n column 1. ing period? E-4. If co	lf column 'Enter "Y olumn 2 is				57.00
58.00 If line 56 is yes, did this facility elect cost reimb defined in CMS Pub. 15-1, chapter 21, §2148? If yes,	oursement f	or physicia	ins' service	es as	N			58.00
59.00 Are costs claimed on line 100 of Worksheet A? If yes			Pt. I.		N			59.00

	Financial Systems FRANCISCAN AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATE Description		MICHIGAN CITY Provider C	CN: 15-0015 P	Period: From 01/01/2021	eu of Form CMS-2 Worksheet S-2 Part I	
					o 12/31/2021	Date/Time Pre 5/26/2022 11:	
				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	
51.00	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 0.00	61.00
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						61. 0
61.03	ACA). (see instructions) Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see 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).						61.0
1. 05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.0
1.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.0
		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	<u>4.00</u> 0.00	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	trai nec			iod for which	0.00	62.0
2. 01	Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC prog Teaching Hospitals that Claim Residents in Nonprovide	ram. (s	see instruction		your hospital	0.00	62.0
3.00	Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, comple					N Ratio (col. 1/	63. C
				FTEs Nonprovi der Si te 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 columr	ned residents Ty care nprovider Timary care	0.00	0.00	0. 000000	64.0

	EX IDENTIFICATION DA			eriod: com 01/01/2021	Workshe Part I		orad
				12/31/2021	Date/Ti 5/26/20	me Prep 22 11:2	23 am
	Program Name	Program Code	Unweighted	Unweighted	Ratio (c	:ol. 3/	
			FTEs Nonprovider	FTEs in Hospital	(col. 3 4)		
			Si te	nosprear		,	
	1.00	2.00	3.00	4.00	5. C		
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			0.00	0. 00	J U.	000000	65.0
column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			Unwei ghted FTEs	Unweighted FTEs in	Ratio (c (col. 1	+ col .	
			Nonprovi der	Hospi tal	2))	
			Si te	2.00	2.0	0	
Section 5504 of the ACA Current	Vaar ETE Residents i	n Nonnrovider Settir	1.00	2.00 r.cost.reporti			
FTEs attributable to rotations of Enter in column 2 the number of u FTEs that trained in your hospita (column 1 divided by (column 1 +	unweighted non-prima al. Enter in column	ry care resident 3 the ratio of					
	Program Name	structions) Program Code	Unweighted FTEs Nonprovider	Unweighted FTEs in Hospital	Ratio (c (col. 3 4)	+ col .	
			FTĔs Nonprovider Site 3.00	FTES in Hospital	(col. 3 4) 5.0	+ col.)	
OO 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)	Program Name	Program Code	FTËs Nonprovider Site	FTES in Hospital	(col. 3 4) 5.0	+ col.)	67.0
00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	Program Name	Program Code	FTĔs Nonprovider Site 3.00	FTES in Hospital	(col . 3 4) 5. C 0 0.	+ col.)	67.
OO Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column	Program Name 1.00 2S	Program Code	FTĚs Nonprovi der Si te 3.00 0.00	FTES in Hospi tal 4.00 0.00 1.0	(col . 3 4) 5. c 0 0.	+ col .)0 000000	
 O0 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 3 divided by (column 3 + column 4)). (see instructions) Inpatient Psychiatric Facility PF 00 Is this facility an Inpatient Psy Enter "Y" for yes or "N" for no. 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 CFR Column 3: If column 2 is Y, indic (see instructions) 	Program Name 1.00 1.00 2S ychiatric Facility (the facility have a efore November 15, 2 umn 2: Did this fac 2 412.424 (d)(1)(iii cate which program y	Program Code 2.00 IPF), or does it con n approved GME teach 004? Enter "Y" for ility train resident)(D)? Enter "Y" for	FTĚs Nonprovi der Si te 3.00 0.00 tain an IPF subp ing program in t yes or "N" for m s in a new teach yes or "N" for m	FTES in Hospital 4.00 0.00 1.0 rovider? Y he most o. (see ing o.	(col . 3 4) 5. c 0 0.	+ col .)0 000000	70.
 O0 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 3, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Inpatient Psychiatric Facility PF 00 Is this facility an Inpatient Psysenter "Y" for yes or "N" for no. 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 CFC Column 3: If column 2 is Y, indic 	Program Name 1.00 2S ychiatric Facility (the facility have a efore November 15, 2 umn 2: Did this fac 2 412.424 (d)(1)(iii cate which program y y PPS nabilitation Facilit	Program Code 2.00 IPF), or does it con n approved GME teach 004? Enter "Y" for ility train resident)(D)? Enter "Y" for ear began during thi	FTĚs Nonprovi der Si te 3.00 0.00 intain an IPF subp sing program in t yes or "N" for m s in a new teach yes or "N" for m	FTES in Hospital 4.00 0.00 1.0 rovider? Y he most o. (see ing o.	(col . 3 4) 5. c 0 0 2. 00	+ col . 00 0000000 0000000 3.00	67. (70. (71. (75. (

		MICHIGAN CIT	ſ		u of Form CMS	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION D	ATA	Provider C	CN: 15-0015	Period: From 01/01/2021	Worksheet S Part I	-2
				To 12/31/2021	Date/Time P	repared:
					5/26/2022 1	1:23 am
					1.00	
Long Term Care Hospital PPS 80.00 Is this a long term care hospital (LTCH)? Enter "Y"	' for ves	and "N" for	no.		N	80.00
81.00 Is this a LTCH co-located within another hospital for				ng period? Enter	N	81.00
"Y" for yes and "N" for no.						_
TEFRA Providers 85.00 Is this a new hospital under 42 CFR Section §413.400	(f)(1)(i)	TEERA? Ente	r "Y" for ve	s or "N" for no	N	85.00
86.00 Did this facility establish a new Other subprovider	(excl udeo					86.00
§413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no				_	N	07.00
87.00 Is this hospital an extended neoplastic disease care 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	e nospitai	CI assi Ti ed	under sectio	n	N	87.00
				V	XI X	
Title V and XIX Services				1.00	2.00	
90.00 Does this facility have title V and/or XIX inpatient	t hospital	servi ces? E	nter "Y" for	N	Y	90.00
yes or "N" for no in the applicable column.	•					
91.00 Is this hospital reimbursed for title V and/or XIX t				N	Y	91.00
full or in part? Enter "Y" for yes or "N" for no in 92.00 Are title XIX NF patients occupying title XVIII SNF					N	92.00
instructions) Enter "Y" for yes or "N" for no in the	e applicat	ole column.				
93.00 Does this facility operate an ICF/IID facility for p "Y" for yes or "N" for no in the applicable column.	ourposes o	of title V an	d XIX? Enter	N	N	93.00
94.00 Does title V or XIX reduce capital cost? Enter "Y" 1	for yes, a	and "N" for n	o in the	Ν	N	94.00
applicable column.	-					
95.00 f line 94 is "Y", enter the reduction percentage in 96.00 Does title V or XIX reduce operating cost? Enter "Y"				0.00 N	0.00 N	95.00 96.00
applicable column.	TOT yes		o in the	IN	IN	90.00
97.00 If line 96 is "Y", enter the reduction percentage in				0.00	0.00	97.00
98.00 Does title V or XIX follow Medicare (title XVIII) for stepdown adjustments on Wkst. B, Pt. I, col. 25? End				N	N	98.00
column 1 for title V, and in column 2 for title XIX.		JI yes of N				
98.01 Does title V or XIX follow Medicare (title XVIII) fo	or the rep				N	98. 01
C, Pt. I? Enter "Y" for yes or "N" for no in column title XIX.	1 for tit	tle V, and in	column 2 fo	r		
98.02 Does title V or XIX follow Medicare (title XVIII) fo	or the cal	culation of	observati on	Ν	N	98.02
bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" 1	for yes or	~ "N" for no	in column 1			
for title V, and in column 2 for title XIX. 98.03 Does title V or XIX follow Medicare (title XVIII) fo	or a criti	cal access h	osnital (CAH) N	N	98.03
reimbursed 101% of inpatient services cost? Enter "						70.03
for title V, and in column 2 for title XIX.						
98.04 Does title V or XIX follow Medicare (title XVIII) for outpatient services cost? Enter "Y" for yes or "N" f				N	N	98.04
in column 2 for title XIX.						
98.05 Does title V or XIX follow Medicare (title XVIII) ar					N	98.05
Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for column 2 for title XIX.	no in co	DIUMN I TOP T	itle V, and	In		
98.06 Does title V or XIX follow Medicare (title XVIII) wh				Ν	N	98.06
Pts. I through IV? Enter "Y" for yes or "N" for no i	n column	1 for title	V, and in			
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 it elected for outpatient services? (see instructions)	the all-i	nclusive met	hod of payme	nt		106.00
107.00 Column 1: If line 105 is Y, is this facility eligibl	e for cos	st reimbursem	ent for I&R			107.00
training programs? Enter "Y" for yes or "N" for no i						
Column 2: If column 1 is Y and line 70 or line 75 i approved medical education program in the CAH's excl						
Enter "Y" for yes or "N" for no in column 2. (see i						
108.00 Is this a rural hospital qualifying for an exception		CRNA fee sche	dul e? See 4	2 N		108.00
CFR Section §412.113(c). Enter "Y" for yes or "N" fo		Physi cal	0ccupation	al Speech	Respi ratory	v
		1.00	2.00	3.00	4.00	
109.00 If this hospital qualifies as a CAH or a cost provide therapy services provided by outside supplier? Enter						109.00
for yes or "N" for no for each therapy.						
110.00 Did this hospital participate in the Rural Community	/ Hosnital	Demonstrati	on project (\$410A	1.00 N	110.00
Demonstration) for the current cost reporting period	? Enter "ו	/" for yes or	"N" for no.	lf yes,		
complete Worksheet E, Part A, lines 200 through 218, applicable.	and Work	ksheet E-2, I	ines 200 thr	ough 215, as		
lappi i cabi c.					I	I

AITH FINANCIAL SYSTEMS FRANCISCAN HEALTH M DSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der CC		Peri od:	eu of Form CMS Worksheet S-	
			From 01/01/202 To 12/31/202		repareo 1: <u>23</u> an
			1.00	2.00	
1.00 If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this cos "Y" for yes or "N" for no in column 1. If the response to coluintegration prong of the FCHIP demo in which this CAH is part Enter all that apply: "A" for Ambulance services; "B" for add for tele-health services.	t reporting p umn 1 is Y, e icipating in	eriod? Enter enter the column 2.	1.00 N	2.00	111.
		1.00	2.00	3.00	_
2.00 Did this hospital participate in the Pennsylvania Rural Healtl demonstration for any portion of the current cost reporting p Enter "Y" for yes or "N" for no in column 1. If column 1 is in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital cease participation in the demonstration, if applicable. Wiscoll approximate Reporting Information	eriod? "Y", enter	N			112.
Miscellaneous Cost Reporting Information 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 (in 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" for "N" for no.	or yes or	Y			116.
7.00 Is this facility legally-required to carry malpractice insurat "Y" for yes or "N" for no.	Y			117.	
8.00 Is the malpractice insurance a claims-made or occurrence poli- if the policy is claim-made. Enter 2 if the policy is occurrent		2		118.	
		Premi ums	Losses	Insurance	
		1.00	2.00	3.00	_
8.01 List amounts of malpractice premiums and paid losses:		1, 133, 3	21 93, 50	01	0 118.
			1.00	2.00	
 8. 02 Are malpractice premiums and paid losses reported in a cost of Administrative and General? If yes, submit supporting schedu and amounts contained therein. 9. 00 DO NOT USE THIS LINE 0. 00 Is this a SCH or EACH that qualifies for the Outpatient Hold I §3121 and applicable amendments? (see instructions) Enter in 0 	le listing co Harmless prov	ost centers vision in ACA	N . N	N	118. 119. 120.
"N" for no. Is this a rural hospital with < 100 beds that qua Hold Harmless provision in ACA §3121 and applicable amendment: Enter in column 2, "Y" for yes or "N" for no.	lifies for th	e Outpatient			
1.00 Did this facility incur and report costs for high cost implan patients? Enter "Y" for yes or "N" for no.	table devices	charged to	Y		121.
2.00 Does the cost report contain healthcare related taxes as defined to the cost report contain healthcare related taxes as defined to the cost of					122
Transplant Center Information 5.00 Does 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. 5.00 If this is a Medicare certified kidney transplant center, enter	er the certif	ication date			126.
in column 1 and termination date, if applicable, in column 2. 7.00 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. 3.00 If 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. 9.00 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. 30.00 f this is a Medicare certified pancreas transplant center, enter the certification					130
column 1 and termination date, if applicable, in column 2. 0.00 f this is a Medicare certified pancreas transplant center, end	date in column 1 and termination date, if applicable, in column 2. 31.00 If this is a Medicare certified intestinal transplant center, enter the certification				131.
column 1 and termination date, if applicable, in column 2. 0.00 If this is a Medicare certified pancreas transplant center, endate in column 1 and termination date, if applicable, in colum		date in column 1 and termination date, if applicable, in column 2.			
 column 1 and termination date, if applicable, in column 2. 00 If this is a Medicare certified pancreas transplant center, endate in column 1 and termination date, if applicable, in colum 1.00 If this is a Medicare certified intestinal transplant center, date in column 1 and termination date, if applicable, in colum 2.00 If this is a Medicare certified islet transplant center, endate in column 1.00 If this is a Medicare certified islet transplant center, endate in column 1.00 If this is a Medicare certified islet transplant center, entertied transplant centertied transplant center, entertied transplant center, entertied	enter the ce mn 2.				132.
 column 1 and termination date, if applicable, in column 2. 0.00 If this is a Medicare certified pancreas transplant center, end date in column 1 and termination date, if applicable, in colum 1.00 If this is a Medicare certified intestinal transplant center, date in column 1 and termination date, if applicable, in colum 2.00 If this is a Medicare certified islet transplant center, enterning this is a Medicare certified islet transplant center, enterning to column 1 and termination date, if applicable, in colum 2.00 If this is a Medicare certified islet transplant center, enterning to column 1 and termination date, if applicable, in column 2. 3.00 Removed and reserved 4.00 If this is an organ procurement organization (OPO), enter the 	enter the ce mn 2. r the certifi	cation date			132. 133. 134.
 column 1 and termination date, if applicable, in column 2. 0.00 If this is a Medicare certified pancreas transplant center, edate in column 1 and termination date, if applicable, in column 1.00 If this is a Medicare certified intestinal transplant center, date in column 1 and termination date, if applicable, in colum 2.00 If this is a Medicare certified islet transplant center, enter 	enter the ce mn 2. r the certifi	cation date			133.

alth Financial Systems SPITAL AND HOSPITAL HEALTH CARE COMPLE		ALTH MICHIGAN CITY Provider CC		Peri od:		u of Form CMS Worksheet S-	
					1/01/2021 2/31/2021		repared
						5/26/2022 11	
1.00		2.00			3.00		_
If this facility is part of a chai home office and enter the home off				e name and	address	or the	
1.00 Name: FRANCI SCAN ALLI ANCE	Contractor's Name:	: WPS	Contra	ctor's Nur	mber: 800'	1	141.
2.00 Street: 1515 DRAGOON TRAIL	PO Box:						142.
13.00 City: MISHAWAKA	State:	IN	Zip Co	de:	4654	46	143.
						1.00	-
4.00 Are provider based physicians' cos	ts included in Workshe	et A?				Y	144.
· · ·							
		74 11 1			1.00	2.00	4.45
5.00 If costs for renal services are cl inpatient services only? Enter "Y"							145.
no, does the dialysis facility inc							
period? Enter "Y" for yes or "N"			reporting				
6.00 Has the cost allocation methodolog	y changed from the prev				Ν		146.
Enter "Y" for yes or "N" for no in		b. 15-2, chapter 4	40, §4020)	lf			
yes, enter the approval date (mm/d	d/yyyy) in column 2.						_
						1.00	-
7.00Was there a change in the statisti	cal basis? Enter "Y" fo	or yes or "N" for	no.			N 1.00	147.
18.00 Was there a change in the order of						N	148.
19.00 Was there a change to the simplifi	ed cost finding method					N	149.
		Part A	Part B		tle V	Title XIX	_
		1.00	2.00		3.00	4.00	_
Does this facility contain a provi or charges? Enter "Y" for yes or "							
5. 00 Hospi tal	N TOT TIO TOT EACT COM			<u>. (3ee 42</u>	N	N	155.
6. 00 Subprovi der – IPF		N	N		N	N	156.
7.00 Subprovi der – IRF		N	N		Ν	N	157.
8. 00 SUBPROVI DER							158.
59. 00 SNF		N	N		N	N	159.
0. OOHOME HEALTH AGENCY		N	N		N	N	160.
01.00 CMHC 01.10 CORF			N N		N N	N N	161.
							101.
						1.00	
Multicampus							
5.00 Is this hospital part of a Multica	mpus hospital that has	one or more campu	uses in dif	ferent CB	SAs?	N	165.
Enter "Y" for yes or "N" for no.	Name	County	State	Zip Code	CBSA	FTE/Campus	_
	0	1. 00	2.00	3.00	4. 00	5. 00	-
6.00 If line 165 is yes, for each			21.00	0.00			00166.
campus enter the name in column							
0, county in column 1, state in							
column 2, zip code in column 3,							
CBSA in column 4, FTE/Campus in column 5 (see instructions)							
					I		
						1.00	
Health Information Technology (HIT				nent Act		1	
57.00 Is this provider a meaningful user						Y	167.
08.00 If this provider is a CAH (line 10 reasonable cost incurred for the H			e 10/ IS "Y), enter	the		168.
8.01 If this provider is a CAH and is n		,	r qualifv f	or a hard	ship		168.
					· · · P		
exception under §413.70(a)(6)(ii)?	ser (line 167 is "Y") ;	and is not a CAH ((line 105 i	s ['] "N"), e	nter the	9. 9	99169.
9.00 If this provider is a meaningful u				-			_
				Bec	gi nni ng	Endi ng	_
9.00 If this provider is a meaningful u					1 00		
9.00 If this provider is a meaningful u transition factor. (see instruction	ns)	na data far the r	oporting		1.00	2.00	1170
99.00 If this provider is a meaningful u transition factor. (see instruction 70.00 Enter in columns 1 and 2 the EHR b	ns)	ng date for the re	eporting		1.00	2.00	170.
99.00 If this provider is a meaningful u transition factor. (see instruction	ns)	ng date for the re	eporti ng		1.00	2.00	170.
99.00 If this provider is a meaningful u transition factor. (see instruction 70.00 Enter in columns 1 and 2 the EHR b	ns)	ng date for the re	eporting		1.00	2.00	170.
 00 If this provider is a meaningful u transition factor. (see instruction factor.) 00.00 Enter in columns 1 and 2 the EHR b period respectively (mm/dd/yyyy) 10.00 If line 167 is "Y", does this provider for the period respectively. 	ns) reginning date and endin rider have any days for	i ndi vi dual s enrol	lled in				170. 0 171.
9.00 If this provider is a meaningful u transition factor. (see instruction 0.00 Enter in columns 1 and 2 the EHR b period respectively (mm/dd/yyyy)	ns) reginning date and endin rider have any days for reported on Wkst. S-3, F	individuals enrol Pt. I, line 2, col	lled in 1. 6? Enter		1.00		_

ealth Financial Systems	FRANCI SCAN HEALT				u of Form CMS	
IOSPITAL AND HOSPITAL HEALTH CAR	E REIMBURSEMENT QUESTIONNAIRE	Provider C		Period: From 01/01/2021 To 12/31/2021	Worksheet S- Part II Date/Time Pre	
				Y/N	5/26/2022 11 Date	
				1.00	2.00	
General Instruction: Enter mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	r Y for all YES responses. Enter I	N for all NO re	esponses. Ente	r all dates in 1	the	_
Provider Organization and						-
00 Has the provider changed of reporting period? If yes	ownership immediately prior to the enter the date of the change in the date of the change in the cha	e beginning of	the cost	N		1.00
reperting period. IT yes,	enter the date of the change in	001 dilli1 2. (300	Y/N	Date	V/I	
	<u> </u>		1.00	2.00	3.00	
	ed participation in the Medicare e date of termination and in colu luntary.		N			2.00
contracts, with individual or medical supply companio officers, medical staff, m	s the provider involved in business transactions, including management 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? (con instructions)					3.00
relationships? (see instru					-	
			Y/N 1.00	Type 2.00	Date 3.00	
Financial Data and Reports	3		1.00	2.00	3.00	
00 Column 1: Were the finance Accountant? Column 2: If or "R" for Reviewed. Submi	for Compiled,	Y	A	05/06/2022	4.00	
00 Are the cost report total	ns) If no, see instructions. expenses and total revenues diffi ial statements? If yes, submit re		N			5.00
				Y/N	Legal Oper.	
Approved Educational Activ	vitios			1.00	2.00	
00 Column 1: Are costs clai	Approved Educational Activities Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provide is the legal operator of the program?					6. 00
	ied Health Programs? If "Y" see in /or allied health programs approve ves, see instructions		ved during the	N N		7.00 8.00
O Are costs claimed for Inte	erns and Residents in an approved st report? If yes, see instruction	0	cal education	Ν		9.00
	d Resident GME program initiated		the current	Ν		10.00
00 Are GME cost directly ass	igned to cost centers other than heet A? If yes, see instructions.	I & R in an App	proved	Ν		11.00
					Y/N 1.00	-
Bad Debts					1.00	
	eimbursement for bad debts? If ye e provider's bad debt collection			st reporting	Y N	12.00 13.00
00 If line 12 is yes, were p	py. atient deductibles and/or co-paym	ents waived? If	fyes, see ins	tructions.	Ν	14.00
. 00 Did total beds available (change from the prior cost report		1 ·	ructions.	Y	15.00
		Y/N Par	rt A Date	Y/N	t B Date	
		1.00	2.00	3.00	4. 00	
	red using the PS&R Report only? s yes, enter the paid-through	Y	03/17/2022	Y	03/17/2022	16. 00
date of the PS&R Report us instructions)	sed in columns 2 and 4 .(see	N	02/17/2022	Ν	00 (17 (2022	17.00
totals and the provider's	red using the PS&R Report for records for allocation? If es, enter the paid-through date instructions)	N	03/17/2022	N	03/17/2022	17.00
00 If line 16 or 17 is yes, w	were adjustments made to PS&R I claims that have been billed	Ν		Ν		18.00
but are not included on th	he PS&R Report used to file this					

Health Financial Systems

FRANCISCAN HEALTH MICHIGAN CITY

In Lieu of Form CMS-2552-10

Ith Financial Systems FRANCISCAN HEALT	H MICHIGAN CITY		In Lie	eu of Form CMS-	-2552
PITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CC	N: 15-0015	Period: From 01/01/2021 To 12/31/2021		
				5/26/2022 11:	
	Descri		Y/N	Y/N	
	0)	1.00	3.00	
00 If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.
Report data for other? bescribe 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		N		21.
records? If yes, see instructions.					
				1.00	+
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCI	EPT CHILDRENS HO	SPLTALS)		1.00	
Capital Related Cost					
00 Have assets been relifed for Medicare purposes? If yes, se	e instructions			N	22
00 Have changes occurred in the Medicare depreciation expense	due to appraisa	als made dur	ing the cost	N	23
reporting period? If yes, see instructions.					
00 Were new leases and/or amendments to existing leases enter	ed into during ⁻	this cost re	porting period?	N	24
<pre>If yes, see instructions 00 Have there been new capitalized leases entered into during</pre>	the cost renor	ting period?	IF VAS SAA	N	25
instructions.	the cost repor	ting period:	11 yes, see	IN IN	25
00 Were assets subject to Sec. 2314 of DEFRA acquired during t	he cost reporti	ng period? I	f yes, see	N	26
instructions.		0.1	5		
00 Has the provider's capitalization policy changed during th	e cost reporting	g period? If	yes, submit	N	27
COPY.					-
00 Were new loans, mortgage agreements or letters of credit e	ntered into duri	ing the cost	reporting	N	28
period? If yes, see instructions.		ng the cost	reporting	IN IN	20
00 Did the provider have a funded depreciation account and/or	bond funds (Del	ot Service R	eserve Fund)	N	29
treated as a funded depreciation account? If yes, see inst					
00 Has existing debt been replaced prior to its scheduled mat	urity with new o	debt? If yes	, see	N	30
instructions. 00 Has debt been recalled before scheduled maturity without is	scuence of now	dobt2 If yoc	600	N	31
instructions.	ssuance of new (Jebt: II yes	, 566	IN	31
Purchased Servi ces				1	
00 Have changes or new agreements occurred in patient care se		d through co	ntractual	N	32
arrangements with suppliers of services? If yes, see instru					
00 If line 32 is yes, were the requirements of Sec. 2135.2 ap	plied pertaining	g to competi	tive bidding? If		33
no, see instructions. Provi der-Based Physici ans					
00 Are services furnished at the provider facility under an a	rrangement with	provi der-ba	sed physicians?	Y	34
If yes, see instructions.	i angonorie in en	protraci ba	sou physionalish		
00 If line 34 is yes, were there new agreements or amended ex	isting agreemen [.]	ts with the	provi der-based	N	35
physicians during the cost reporting period? If yes, see i	nstructions.				
			Y/N	Date	_
Home Office Costs			1.00	2.00	-
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 p	repared by the I	nome office?			37
If yes, see instructions.					
00 If line 36 is yes, was the fiscal year end of the home of			N		38
the provider? If yes, enter in column 2 the fiscal year en					
00 If line 36 is yes, did the provider render services to othe see instructions.	er chain compone	ents? If yes	, N		39
00 If line 36 is yes, did the provider render services to the	home office?	lf ves see	N		40
instructions.		, <u>j</u> es, see			
	1. (00	2.	00	
Cost Report Preparer Contact Information	LIONC				
00 Enter the first name, last name and the title/position	HONG		YANG		41
held by the cost report preparer in columns 1, 2, and 3,					
l respecti vel v	1				42
respectively. 00 Enter the employer/company name of the cost report	FRANCI SCAN ALLI	ANCE			
	FRANCI SCAN ALLI	ANCE			
00 Enter the employer/company name of the cost report	FRANCI SCAN ALLI 219-407-6568	TANCE	Hong. Yang@Fran	ICI SCANALLI ANCE	

Health Financial Systems FRANCISC	AN HEALTH MICHIGAN CITY	In Lie	u of Form CMS-:	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONN	AIRE Provider CCN: 15-0015	Peri od:	Worksheet S-2	
		From 01/01/2021 To 12/31/2021	Part II Date/Time Pre 5/26/2022 11:	pared: 23 am
	3.00			
Cost Report Preparer Contact Information				
41.00 Enter the first name, last name and the title/posi	tion DIRECTOR - REIMBURSEMENT			41.00
held by the cost report preparer in columns 1, 2,	and 3,			
respecti vel y.				
42.00 Enter the employer/company name of the cost report				42.00
preparer.				
43.00 Enter the telephone number and email address of th	e cost			43.00
report preparer in columns 1 and 2, respectively.				

HOSPI T	Financial Systems FR AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC	N: 15-0015	Period: From 01/01/2021	u of Form CMS-: Worksheet S-3 Part I	
					To 12/31/2021	Date/Time Pre 5/26/2022 11:	
						I/P Days / O/P Visits / Trips	
	Component	Worksheet A Line Number	No. of Beds	Bed Days Avai I abl e	CAH Hours	Title V	
		1.00	2.00	3.00	4.00	5.00	
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)	30. 00	83	30, 29	95 0.00	0	1.00
2.00 3.00	HMO and other (see instructions) HMO IPF Subprovider						2.00 3.00
4.00 5.00	HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF					0	
5. 00 7. 00	Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions)		83	30, 29	95 0.00	0	
8.00	INTENSI VE CARE UNI T	31.00	16	5,84	10 0.00	0	8.00
9.00	CORONARY CARE UNI T	32.00	0		0 0.00	0	
0.00	BURN INTENSIVE CARE UNIT	33.00	0		0 0.00	0	10.0
1.00	SURGICAL INTENSIVE CARE UNIT	34.00	0		0 0.00	0	11.0
2.00	OTHER SPECIAL CARE (SPECIFY)						12.0
13.00	NURSERY	43.00				0	13.0
14.00	Total (see instructions)		99	36, 13	35 0.00	0	14.0
5.00	CAH visits					0	15.0
16.00	SUBPROVIDER - IPF	40.00	14	5, 11	10	0	
17.00	SUBPROVIDER - IRF	41.00	0		0	0	
18.00	SUBPROVI DER						18.0
9.00	SKILLED NURSING FACILITY	44.00	0		0	0	
20.00	NURSING FACILITY	45.00	0		0	0	
21.00	OTHER LONG TERM CARE	46.00	0		0		21.0
22.00	HOME HEALTH AGENCY	101.00				0	22.0
23.00	AMBULATORY SURGICAL CENTER (D. P.) HOSPICE	115. 00 116. 00	0		0		23.0
24.10	HOSPICE (non-distinct part)	30.00	0		0		24.0
25.00	CMHC - CMHC	99.00				0	
5. 10	CMHC - CORF	99.10				0	
6.00	RURAL HEALTH CLINIC	88.00				o o	
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	
27.00	Total (sum of lines 14-26)	0,100	113			, , , , , , , , , , , , , , , , , , ,	27.0
28.00	Observation Bed Days					0	
29.00	Ambulance Trips						29.0
30. 00	Employee discount days (see instruction)						30.0
1. 00	Employee discount days - IRF						31.0
32.00	Labor & delivery days (see instructions)		0		0		32.0
32.01	Total ancillary labor & delivery room						32.0
	outpatient days (see instructions)						
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.0

HOSPI 1	TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC	CN: 15-0015	Period: From 01/01/2021 To 12/31/2021	Worksheet S-3 Part I Date/Time Pre 5/26/2022 11:	pared:
		I/P Days	/ O/P Visits	/ Trips	Full Time E	qui 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 2.00 3.00 4.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider	9, 303 6, 532 307 0	557 5, 368 0 0	23, 28			1.00 2.00 3.00 4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0		0		5.00
5.00 7.00	Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions)	9, 303	0 557	23, 28	0 30		6.00 7.00
3.00 9.00 10.00 11.00	I NTENSI VE CARE UNI T CORONARY CARE UNI T BURN I NTENSI VE CARE UNI T SURGI CAL I NTENSI VE CARE UNI T	1,030 0 0 0	39 0 0 0	4, 51	2 0 0 0		8.00 9.00 10.00 11.00
12.00	OTHER SPECIAL CARE (SPECIFY)		FZO	92	0		12.00
13.00 14.00	NURSERY	10, 333	572	92 28, 72	-	847.43	13.00
15.00	Total (see instructions) CAH visits	10, 333	1, 168 0	20, 72	0.00	047.43	15.00
16.00	SUBPROVIDER - IPF	499	1, 956	3, 46		20.07	
17.00 18.00	SUBPROVI DER – I RF SUBPROVI DER	0	0	5, 40	0 0.00	0.00	
19.00	SKILLED NURSING FACILITY	0	0		0 0.00		
20.00	NURSING FACILITY		0		0 0.00		
21.00	OTHER LONG TERM CARE				0 0.00		
22.00	HOME HEALTH AGENCY	0	0		0 0.00		
23.00	AMBULATORY SURGICAL CENTER (D. P.)		0		0.00		
24.00 24.10	HOSPICE HOSPICE (non-distinct part)	0	0		0 0.00 0	0.00	24.0
25.00	CMHC - CMHC	0	0		0 0.00	0.00	
25.10	CMHC - CORF	0	0		0 0.00		
26.00	RURAL HEALTH CLINIC	0	0		0 0.00		
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0.00		
27.00	Total (sum of lines 14-26)				0.00	867.50	
28.00	Observation Bed Days		601	3, 68	36		28.0
29.00	Ambul ance Tri ps	0					29.0
30.00	Employee discount days (see instruction)				0		30.0
31.00	Employee discount days - IRF				0		31.0
32.00 32.01	Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions)	0	93	1, 14	17 0		32.0 32.0
33.00	LTCH non-covered days	0					33.0
33.01	LTCH site neutral days and discharges	0					33.0

HOSPIT	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provi der	CCN		Period: From 01/01/2021 To 12/31/2021	Worksheet S-3 Part I Date/Time Pre 5/26/2022 11:	pared:
		Full Time			Di so	charges		
	Component	Equi val ents Nonpai d Workers	Title V	Τ	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00		13.00	14.00	15.00	
1.00 2.00 3.00 4.00 5.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 15.00 15.00 16.00 17.00 18.00 19.00 20.00 21.00 23.00 24.00 23.00 24.00 25.10 25.00 25.00 25.00 25.00 25.00 26.00 27.00 28.00 29.00 20.	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions) HMO IPF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions) INTENSI VE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D. P.) HOSPICE HOSPICE (non-distinct part) CMHC - CMHC CMHC - CORF RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instruction)	11.00 0.000 0.00		0	2, 39 1, 15 2, 39 5	5 1, 792 5 0 0 0	15.00 7,132 7,132 560 0	1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 16.00 20.00 21.00 23.00 24.00 22.00 23.00 24.00 25.10 25.00 25.10 26.00 26.25 27.00 28.00 29.00 30.00 29.00 20.00 25.10 25.00 26.00 26.00 27.00 28.00 29.00 20.00 21.00 20.0
31. 00 32. 00 32. 01	Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions)							31. 00 32. 00 32. 01
33. 00 33. 01	LTCH non-covered days LTCH si te neutral days and discharges					0		33. 00 33. 01

Image: services Wkst. A Line Number Amount Reported (from vkst. A-6) Reclassificati (set (from vkst. A-6) Adjusted (salaries) (salaries) (salaries) Average Rel ateors (salaries) Rel ateors (salaries) Rel ateors (salaries) Rel ateors (salaries) Rel ateors (salaries) Rel ateors (salaries) Rel ateors (salaries) 0 Antil salaries (see Instructions) 1.00 2.00 77.281,224 0 77.281,224 2.129,669.00 0 Non-physician anesthetist Part Administrative 200.00 77.281,224 0 77.281,224 2.129,669.00 0.00 0 Non-physician anesthetist Part Administrative 2.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	et S-3 ne Prepa	of Form CMS-2 Worksheet S-3 Part II Date/Time Pre 5/26/2022 11:	W 1 F 1 C	Period: From 01/01/2021 To 12/31/2021	CN: 15-0015 Pe	H MICHIGAN CITY Provider CC			Financial Systems AL WAGE INDEX INFORMATION	
DART I 1 - MAGE DATA 1.00 2.00 3.00 4.00 5.00 6.00 SALARIES SALARIES 200.00 77.281.224 0 77.281.224 2.129.669.00 0.00 Non-physician anesthetist Part A 0 0 0 0.00 0.00 0.00 Physician Part A 0 0 0 0.00 0.00 0.00 Physician and Non 0 0 0 0.00 0.00 0.00 Physician Part A 0 0 0 0.00 0.00 0.00 Physician Part B 0 0 0 0.00 0.00 0.00 approved program 0 0 0 0.00 0.00 0.00 approved program 2.05.788 -622.118 1.983.870 0.00 0.00 0 Fractuad and Stratus 2.05.788 -622.118 1.983.870 0.00 0 0 0 0 0 0.00 0.00 0.00 0.00 0.0	lourly .4÷	Average Hourly Wage (col. 4 ÷ col. 5)	Av	Related to Salaries in	Sal ari es (col . 2 ± col .	on of Salaries (from Wkst.				
SALAR IS 77, 281, 224 77, 281, 224 2, 129, 669, 00 Instal salaries (see Instructions) 0	,	6.00		5.00	4.00		2.00	1.00		
0 Total salaries (see instructions) 200.00 77.281,224 0 77.281,224 2,129,669.00 0 Non-physician anesthetist Part 0 0 0 0.00 0 Mon-physician anesthetist Part 0 0 0 0.00 0 Physicians Part A 0 0 0 0 0 0 Physician and Ron 0 <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></td<>										
0 Non-physician anesthetist Part 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	36. 29	36.29	0	2, 129, 669. 00	77, 281, 224	0	77, 281, 224	200.00	Total salaries (see	0
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Addin instrative 0	0.00	0.00	0	0.00	0	0	0		Non-physician anesthetist Part	0
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0 Physician-Part B 0	0.00 0.00				-	0	0		3	
hospit fail-based RRC and FOHC services approved program output	0.00	0.00	1	0.00	0	Ŭ	0			0
services o<	0.00	0.00	0	0.00	0	0	0			00
approved program) o										
11 Contracted interns and residents (in an approved programs) 0	0. 00	0.00	0	0.00	0	0	0	21.00		00
residents (in an approved programs) Image: constraint of the program is and proved programs) Image: constraint of the proves of	0.00	0.00	0	0.00	0	0	0)1
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organization personnel OSKF At. oo O <	36.34	26 24		224 570 00	12 156 670	0	12 156 670			0
D0 Excluded area salaries (see instructions) 2,605,788 -622,118 1,983,670 81,870.00 OTHER WAGES & RELATED COSTS Ontract Labor: Direct Patient Care 184,748 0 184,748 2,163.00 Contract Labor: Top level management and other management and administrative services 0 </td <td>30. 34</td> <td>50. 54</td> <td></td> <td>334, 370. 00</td> <td>12, 150, 070</td> <td>0</td> <td>12, 150, 070</td> <td></td> <td></td> <td>0</td>	30. 34	50. 54		334, 370. 00	12, 150, 070	0	12, 150, 070			0
instructions) instructions OTHER WARES & RELATED COSTS OC Care OC Contract labor: Top level management and other management and other management and other management and other management and administrative services Contract labor: Physician-Part A - Administrative Memory Construct Ibme office and/or related O Contract labor: Physician salaries Display (additional salaries) O Memorffice and Contract Physicians salaries O O O O Contract labor: Solaries O O Related organization salaries O O O O O O Home office Physician Part A O O O O Ibme office Physicians Part A O O Ibme office Physician	0.00				0	0	0	44.00	-	
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Care Care Care Care 00 Contract labor: Top level management and other management and administrative services 0									OTHER WAGES & RELATED COSTS	
00 Contract Labor: Top Level management and administrative services 0	85. 41	85. 41	0	2, 163. 00	184, 748	0	184, 748			00
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or Services 169,005 169,005 1,323.00 00 Contract labor: Physician-Part 169,005 0 169,005 1,323.00 01 Home office and/or related 0 0 0 0.00 01 Grant aries and wage-rel ated costs 0<										
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(see instructions)793,064793,06400Excluded areas793,064000Non-physician anesthetist Part000Non-physician anesthetist Part000Non-physician anesthetist Part000Physician Part A -00Administrative00001Physician Part A - Teaching0000Physician Part B0000Wage-related costs (RHC/FQHC)0000Interns & residents (in an approved program)00										00
00Excluded areas793,0640793,06400Non-physician anesthetist Part00000Non-physician anesthetist Part00000Physician Part A -00001Physician Part A - Teaching00000Physician Part B00000Wage-related costs (RHC/FQHC)00000Interns & residents (in an approved program)000										υU
A00Non-physician anesthetist Part0000Physician Part A -0000Physician Part A -01Physician Part A - Teaching00001Physician Part B00000Wage-related costs (RHC/FOHC)000001nterns & residents (in an approved program)				ŧ.	793, 064	0	793, 064		Excluded areas	
B00Physician Part A - Administrative00001Physician Part A - Teaching00000Physician Part B00000Wage-related costs (RHC/FQHC)00000Interns & residents (in an approved program)000	1				0	0	0		Non-physician anesthetist Part	00
Administrative01Physician Part A - Teaching0000Physician Part B0000Wage-related costs (RHC/FQHC)0000Interns & residents (in an approved program)00				þ	0	О	0		Non-physician anesthetist Part	00
Administrative01Physician Part A - Teaching0000Physician Part B0000Wage-related costs (RHC/FQHC)0000Interns & residents (in an approved program)00					0	_	0		B Physician Part A -	00
00 Physician Part B 0 0 0 00 Wage-related costs (RHC/FQHC) 0 0 0 00 Interns & residents (in an approved program) 0 0 0	'				0		0		5	50
00 Wage-related costs (RHC/FQHC) 0 0 0 00 Interns & residents (in an approved program) 0 0 0					0	0	0			
00 Interns & residents (in an 0 0 0 0 approved program)					0	0	0		-	
				þ	0	0	0		Interns & residents (in an	
30 HIONE OTTEE WAYE-LETALEN 4,000,070 UL 4,000,070				2	1 600 600		1 600 600			50
(core)	'				4, 000, 098		4,000,098		Ũ	50
51 Related organization 0 0 0	1			D	0	0	0			51
wage-related (core) 52 Home office: Physician Part A 0 0					0	0	0			52
- Administrative - wage-related (core)	1				0		0		- Administrative -	

Heal th	Financial Systems	FRA	ANCISCAN HEALTH	H MICHIGAN CITY	1	In Li€	eu of Form CMS-2	2552-10
HOSPI 1	AL WAGE INDEX INFORMATION			Provider C		Period: From 01/01/2021 To 12/31/2021	Worksheet S-3 Part II Date/Time Pre 5/26/2022 11:	pared:
		Wkst. A Line Number		Reclassificati on of Salaries (from Wkst. A-6)		Related to	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0		0		25. 53
24 00	OVERHEAD COSTS - DIRECT SALARII		1 045 200	(00.110	2 5 (7 40	((7.007.00	20.12	
26.00	Employee Benefits Department	4.00						
27.00	Administrative & General	5.00	17, 914, 415	0				
28.00	Administrative & General under		986, 261	0	986, 26	1 8, 354. 00	118.06	28.00
20.00	contract (see inst.)	(00	0	0		0 0.00	0.00	29.00
29.00	Maintenance & Repairs	6.00	0 2 210 F(1	0	2 210 57			
30.00	Operation of Plant	7.00	3, 218, 561	0	3, 218, 56			
31.00	Laundry & Linen Service	8.00	260, 763	0	260, 76			
32.00	Housekeeping	9.00	1, 671, 584	0	1, 671, 58			
33.00	Housekeeping under contract (see instructions)		0	0		0 0.00		
34.00	Dietary	10.00	1, 694, 014	-1, 119, 000	575, 01			34.00
35.00	Dietary under contract (see instructions)		0	0		0 0.00	0.00	35.00
36.00	Cafeteri a	11.00	0	1, 119, 000	1, 119, 00	0 57, 380. 00	19.50	36.00
37.00	Maintenance of Personnel	12.00	0	0		0 0.00	0.00	37.00
38.00	Nursing Administration	13.00	2, 569, 182	0	2, 569, 18	2 59, 215. 00	43.39	38.00
39.00	Central Services and Supply	14.00	225, 464	0	225, 46	4 9, 506.00	23.72	39.00
40.00	Pharmacy	15.00	2, 610, 179	0	2, 610, 17	9 58, 798.00	44.39	40.00
41.00	Medi cal Records & Medi cal Records Library	16.00	0	0		0 0.00		41.00
42.00	Social Service	17.00	0	0		0 0.00	0.00	42.00
43.00	Other General Service	18.00	0	0		0 0.00		43.00

Heal th	Financial Systems	FR/	ANCISCAN HEALT	H MICHIGAN CITY	/	In Lie	eu of Form CMS-2	2552-10
HOSPI	FAL WAGE INDEX INFORMATION			Provider CC		Period: From 01/01/2021 To 12/31/2021		
		Worksheet A		Recl assi fi cati			Average Hourly	
		Line Number	Reported	on of Salaries			Wage (col. 4 ÷	
				(from	(col.2 ± col.		col. 5)	
				Worksheet A-6)	,	col. 4		
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY				_		
1.00	Net salaries (see		66, 110, 815	0	66, 110, 81	5 1, 803, 453. 00	36.66	1.00
	instructions)							
2.00	Excluded area salaries (see instructions)		2, 605, 788	-622, 118	1, 983, 67	81, 870. 00	24. 23	2.00
3.00	Subtotal salaries (line 1 minus line 2)		63, 505, 027	622, 118	64, 127, 14	5 1, 721, 583. 00	37. 25	3.00
4.00	Subtotal other wages & related costs (see inst.)		15, 744, 460	0	15, 744, 46	427, 061. 00	36.87	4.00
5.00	Subtotal wage-related costs (see inst.)		24, 939, 656	0	24, 939, 65	6 0.00	38. 89	5.00
6.00	Total (sum of lines 3 thru 5)		104, 189, 143	622, 118	104, 811, 26	1 2, 148, 644. 00	48. 78	6.00
7.00	Total overhead cost (see instructions)		33, 095, 711	622, 118	33, 717, 82	9 965, 459. 00	34. 92	7.00

	Financial Systems FRANCISCAN HEAL TAL WAGE RELATED COSTS	TH MICHIGAN CITY Provider CCN: 15-0015	Period:	u of Form CMS-2 Worksheet S-3	
105P1	AL WAGE RELATED CUSTS	Provider CCN: 15-0015	From 01/01/2021	Part IV	
			To 12/31/2021		pared
				5/26/2022 11:	<u>23 am</u>
				Amount	
				Reported	
				1.00	
	PART IV - WAGE RELATED COSTS				-
	Part A - Core List				-
1 00	RETIREMENT COST			2 0(0 220	1 1 0
1.00	401K Employer Contributions			2, 069, 228	
2.00	Tax Sheltered Annuity (TSA) Employer Contribution			0	2.0
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)			0	
4.00	Qualified Defined Benefit Plan Cost (see instructions)			3, 816, 398	4.0
- 00	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			0	
5.00	401K/TSA Plan Administration fees			0	
5.00	Legal /Accounting/Management Fees-Pension Plan			0	6.0
7.00	Employee Managed Care Program Administration Fees			0	7.0
	HEALTH AND INSURANCE COST			0	
. 00	Health Insurance (Purchased or Self Funded)			0	
. 01	Health Insurance (Self Funded without a Third Party Admini			0	
. 02	Health Insurance (Self Funded with a Third Party Administr	rator)		8, 801, 373	
3. 03	Health Insurance (Purchased)			0	
0.00	Prescription Drug Plan			0	
0.00	Dental, Hearing and Vision Plan			549, 599	
1.00	Life Insurance (If employee is owner or beneficiary)			0	
2.00	Accident Insurance (If employee is owner or beneficiary)			0	
3.00	Disability Insurance (If employee is owner or beneficiary)			0	13.0
4.00	Long-Term Care Insurance (If employee is owner or benefici	ary)		0	
5.00	'Workers' Compensation Insurance			0	1 .0.0
6.00	Retirement Health Care Cost (Only current year, not the ex	traordinary accrual require	ed by FASB 106.	0	16.0
	Non cumulative portion)				
7 00	TAXES			E 007 404	170
7.00	FICA-Employers Portion Only Medicare Taxes - Employers Portion Only			5, 807, 424	
8.00				0	
9.00	Unemployment Insurance			0	
0.00	State or Federal Unemployment Taxes OTHER			0	20.0
1 00		+ Departed on Lines 1 three	in t about (and	0	21 0
1.00	Executive Deferred Compensation (Other Than Retirement Cos instructions))	st Reported on Times I through	ign 4 above. (See	0	21.0
2.00	Day Care Cost and Allowances			0	22.0
3.00	Tuition Reimbursement			0	
23.00 24.00	Total Wage Related cost (Sum of lines 1 -23)			21, 044, 022	
-4.00	Part B - Other than Core Related Cost			21, 044, 022	24.0
	OTHER WAGE RELATED COSTS (SPECIFY)				25.0

HOSPITAL CONTRACT LABOR AND BENEFIT COST Provider CCN: 15-0015 Period: From 01/01/2021 Worksheet S-3 Part V Cost Center Description Contract Labor and Benefit Cost Contract Labor Benefit Cost 0 2.00 PART V - Contract Labor and Benefit Cost 0 0 2.00 Hospital and Hospital-Based Component Identification: 0 0 2.00 1.00 Total facility's contract labor and benefit cost 0 0 2.00 0 Ospital 0 0 0 2.00 3.00 Subprovider - IPF 0	Heal th	Financial Systems	FRANCISCAN HEALTH MICHIGAN CITY	In Lie	u of Form CMS-:	2552-10
To 12/31/2021 Date/Time Prepared: 5/26/2022 11:23 am PART V - Contract Labor and Benefit Cost Contract Labor and Benefit Cost 1.00 2.00 PART J - Contract Labor and Benefit Cost 0 0 1.00 2.00 Part J - Contract Labor and Benefit Cost 0 0 1.00 2.00 Part J - Contract Labor and Benefit Cost 0 0 1.00 2.00 1.00 To at a facility's contract labor and benefit cost 0 0 1.00 2.00 2.00 Hospital 0 0 2.00 0 1.00 2.00 3.00 Subprovider - IPF 0 0 0 2.00 3.00 3.00 Subprovider - IRF 0 0 4.00 5.00 5.00 5.00 6.00 6.00 6.00 7.00 Swing Beds - SNF 0	HOSPI T	AL CONTRACT LABOR AND BENEFIT COST	Provider CCN: 15-0015			
Cost Center Description 5/26/2022 11: 23 am PART V - Contract Labor and Benefit Cost 1.00 2.00 Hospital and Hospital-Based Component I dentification: 0 0 1.00 Total facility's contract labor and benefit cost 0 0 1.00 2.00 Hospital 0 0 1.00 2.01 Hospital 0 0 1.00 2.02 Hospital 0 0 1.00 2.00 Hospital 0 0 1.00 3.00 Subprovider - IPF 0 0 3.00 4.00 Subprovider - IRF 0 0 4.00 5.00 Subprovider - IQ 0 0 5.00 6.00 Swing Beds - SNF 0 0 6.00 7.00 Swing Beds - NF 0 0 0 8.00 9.00 Hospital -Based NF 0 0 0 1.00 10.00 Hospital -Based HAA 0 0 1.00 0 1.00						narad
PART V - Contract Labor and Benefit Cost I.00 2.00 Hospital and Hospital -Based Component Identification: 0 0 1.00 1.00 Subprovider - IPF 0 0 2.00 3.00 Subprovider - IPF 0 0 3.00 3.00 Subprovider - IRF 0 0 4.00 5.00 Subprovider - (Other) 0 0 5.00 6.00 Swing Beds - SNF 0 0 7.00 7.00 Suing Beds - NF 0 0 7.00 8.00 Hospital -Based SNF 0 0 7.00 9.00 Hospital -Based SNF 0 0 7.00 9.00 Hospital -Based SNF 0 0 7.00 9.00 Hospital -Based SNF 0 0 7.00 10.00 Hospital -Based SNF 0 0 10.00 10.00 Hospital -Based SNF 0 0 10.00 10.00 Hospital -Based NF 0 0 10.00				10 12/31/2021		
PART V - Contract Labor and Benefit Cost Hospital and Hospital-Based Component I dentification: 1.00 Total facility's contract labor and benefit cost 0 0 1.00 2.00 Hospital 0 0 1.00 2.00 3.00 Total facility's contract labor and benefit cost 0 0 1.00 3.00 Subprovider - IPF 0 0 3.00 3.00 3.00 Subprovider - IRF 0 0 4.00 4.00 5.00 Subprovider - (Other) 0 0 5.00 6.00 5.00 6.00 5.00 6.00 7.00 8.00 9.00 6.00 7.00 8.00 9.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 11.00 10.00 11.00 10.00 11.00 10.00 11.00 11.00 10.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.0		Cost Center Description		Contract Labor		
Hospi tal and Hospi tal -Based Component I denti fi cati on: 1.00 Total facility's contract labor and benefit cost 0 0 1.00 2.00 Hospi tal 0 0 2.00 3.00 Subprovi der - IPF 0 0 4.00 5.00 Subprovi der - IRF 0 0 5.00 6.00 Swing Beds - SNF 0 0 6.00 7.00 Swing Beds - SNF 0 0 8.00 7.00 Swing Beds - SNF 0 0 8.00 8.00 Hospi tal -Based SNF 0 0 8.00 9.00 Hospi tal -Based SNF 0 0 9.00 10.00 Hospi tal -Based SNF 0 0 9.00 10.00 Hospi tal -Based NF 0 0 10.00 11.00 Hospi tal -Based NF 0 0 11.00 12.00 Separatel y Certi fi ed ASC 0 0 12.00 13.00 Hospi tal -Based Heal th Clinic RHC 0 0				1.00		
1.00 Total facility's contract labor and benefit cost 0 0 1.00 2.00 Hospital 0 0 2.00 3.00 Subprovider - IPF 0 0 0 3.00 0.00 Subprovider - IPF 0 0 0 4.00 0.00 Subprovider - IRF 0 0 0 4.00 5.00 Subprovider - (Other) 0 0 5.00 0 0 6.00 6.00 Swing Beds - SNF 0 0 0 6.00 0 6.00 7.00 0	-	PART V - Contract Labor and Benefit Cost				
2.00 Hospital 0 0 2.00 3.00 Subprovider - IPF 0 0 3.00 4.00 Subprovider - IRF 0 0 4.00 5.00 Subprovider - (Other) 0 0 6.00 6.00 Swing Beds - SNF 0 0 6.00 7.00 Swing Beds - NF 0 0 7.00 8.00 Hospital -Based SNF 0 0 8.00 9.00 Hospital -Based NF 0 0 9.00 10.00 Hospital -Based HHA 0 0 10.00 12.00 Separately Certified ASC 0 0 11.00 12.00 Separately Certified ASC 0 0 13.00 14.00 Hospital -Based Heal th Clinic RHC 0 0 14.00 15.00 Hospital -Based-CMHC 0 0 15.00 16.00 Hospital -Based-CMHC 10 0 0 16.00 17.00 Renal Dialysis 0 0 17.00		Hospital and Hospital-Based Component Ide	nti fi cati on:			
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 7.00 7.00 Swing Beds - NF 0 0 7.00 8.00 Hospital - Based SNF 0 0 8.00 9.00 Hospital - Based OLTC 0 0 9.00 11.00 Hospital - Based HHA 0 0 11.00 12.00 Separatel y Certified ASC 0 0 13.00 14.00 Hospital - Based Heal th Clinic RHC 0 0 14.00 15.00 Hospital - Based -CMHC 0 0 15.00 16.00 Hospital - Based-CMHC 0 0 16.00 16.00 Hospital - Based-CMHC 0 0 16.10 17.00 Renal Dialysis 0 0 16.10		Total facility's contract labor and benef	ït cost	0	0	1.00
4.00 Subprovi der - IRF 0 0 4.00 5.00 Subprovi der - (Other) 0 0 5.00 6.00 Swing Beds - SNF 0 0 6.00 7.00 Swing Beds - NF 0 0 7.00 8.00 Hospi tal -Based SNF 0 0 9.00 9.00 Hospi tal -Based NF 0 0 9.00 10.00 Hospi tal -Based OLTC 10.00 10.00 11.00 11.00 Hospi tal -Based HHA 0 0 12.00 12.00 Separatel y Certi fi ed ASC 0 0 13.00 14.00 Hospi tal -Based Heal th Clinic RHC 0 0 13.00 15.00 Hospi tal -Based Heal th Clinic RHC 0 0 14.00 15.00 Hospi tal -Based-CMHC 0 0 15.00 16.10 Hospi tal -Based-CMHC 10 0 0 16.10 17.00 Renal Dial ysi s 0 0 17.00				0	0	
5.00 Subprovider - (0ther) 0 5.00 6.00 Swing Beds - SNF 0 0 6.00 7.00 Swing Beds - NF 0 0 7.00 8.00 Hospital - Based SNF 0 0 8.00 9.00 Hospital - Based NF 0 0 9.00 10.00 Hospital - Based OLTC 10.00 10.00 11.00 11.00 Hospital - Based HHA 0 0 12.00 12.00 Separatel y Certified ASC 0 0 13.00 14.00 Hospital - Based Heal th Clinic RHC 0 0 14.00 15.00 Hospital - Based Heal th Clinic FOHC 0 0 14.00 15.00 Hospital - Based -CMHC 0 0 15.00 16.00 Hospital - Based-CMHC 0 0 16.00 16.10 Hospital - Based-CMHC 10 0 0 16.10 17.00 Renal Dialysis 0 0 17.00				0	0	
6.00 Swing Beds - SNF 0 0 6.00 7.00 Swing Beds - NF 0 0 7.00 8.00 Hospital - Based SNF 0 0 8.00 9.00 Hospital - Based NF 0 0 9.00 10.00 Hospital - Based OLTC 10.00 10.00 10.00 11.00 Hospital - Based HHA 0 0 11.00 12.00 Separatel y Certified ASC 0 0 12.00 13.00 Hospital - Based Heal th Clinic RHC 0 0 14.00 15.00 Hospital - Based-CMHC 0 0 14.00 16.00 Hospital - Based-CMHC 0 0 15.00 16.10 Hospital - Based-CMHC 10 0 0 16.10 17.00 Renal Dialysis 0 0 16.10				0	0	
7.00 Swing Beds - NF 0 0 7.00 8.00 Hospital -Based SNF 0 0 8.00 9.00 Hospital -Based NF 0 0 9.00 10.00 Hospital -Based OLTC 10.00 10.00 11.00 Hospital -Based HHA 0 0 11.00 12.00 Separatel y Certified ASC 0 0 12.00 13.00 Hospital -Based Heal th Clinic RHC 0 0 13.00 14.00 Hospital -Based Heal th Clinic RHC 0 0 14.00 15.00 Hospital -Based-CMHC 0 0 15.00 16.00 Hospital -Based-CMHC 10 0 0 16.10 17.00 Renal Dialysis 0 0 17.00				0	0	
8.00 Hospital -Based SNF 0 0 8.00 9.00 Hospital -Based NF 0 0 9.00 10.00 Hospital -Based OLTC 10.00 10.00 11.00 Hospital -Based HHA 0 0 11.00 12.00 Separately Certified ASC 0 0 12.00 13.00 Hospital -Based Hospice 0 0 13.00 14.00 Hospital -Based Heal th Clinic RHC 0 0 14.00 15.00 Hospital -Based Heal th Clinic FOHC 0 0 15.00 16.00 Hospital -Based-CMHC 0 0 16.00 16.10 Hospital -Based-CMHC 10 0 0 16.10 17.00 Renal Dialysis 0 0 17.00				0	0	
9.00 Hospital -Based NF 0 9.00 10.00 Hospital -Based OLTC 10.00 11.00 Hospital -Based HHA 0 0 12.00 Separately Certified ASC 0 0 12.00 13.00 Hospital -Based Hospice 0 0 13.00 14.00 Hospital -Based Health Clinic RHC 0 0 14.00 15.00 Hospital -Based Health Clinic FOHC 0 0 15.00 16.00 Hospital -Based-CMHC 0 0 16.00 17.00 Renal Dialysis 0 0 17.00				0	0	
10.00 Hospital -Based OLTC 10.00 11.00 Hospital -Based HHA 0 0 11.00 12.00 Separately Certified ASC 0 0 12.00 13.00 Hospital -Based Hospice 0 0 13.00 14.00 Hospital -Based Health Clinic RHC 0 0 14.00 15.00 Hospital -Based Health Clinic FOHC 0 0 15.00 16.00 Hospital -Based-CMHC 0 0 16.00 17.00 Renal Dialysis 0 0 17.00				0	0	1
11.00 Hospital -Based HHA 0 0 11.00 12.00 Separatel y Certified ASC 0 0 12.00 13.00 Hospital -Based Hospice 0 0 13.00 14.00 Hospital -Based Heal th Clinic RHC 0 0 14.00 15.00 Hospital -Based Heal th Clinic FOHC 0 0 15.00 16.00 Hospital -Based-CMHC 0 0 16.00 16.10 Hospital -Based-CMHC 10 0 0 16.10 17.00 Renal Dialysis 0 0 17.00				0	0	
12.00 Separately Certified ASC 0 12.00 13.00 Hospital -Based Hospice 0 0 13.00 14.00 Hospital -Based Health Clinic RHC 0 0 14.00 15.00 Hospital -Based Health Clinic FOHC 0 0 15.00 16.00 Hospital -Based-CMHC 0 0 16.00 16.10 Hospital -Based-CMHC 10 0 0 16.10 17.00 Renal Dialysis 0 0 17.00					l	
13. 00 Hospi tal -Based Hospi ce 0 0 13. 00 14. 00 Hospi tal -Based Heal th Clinic RHC 0 0 14. 00 15. 00 Hospi tal -Based Heal th Clinic FOHC 0 0 15. 00 16. 00 Hospi tal -Based-CMHC 0 0 16. 00 16. 10 Hospi tal -Based-CMHC 10 0 0 16. 10 17. 00 Renal Dial ysi s 0 0 17. 00				0	0	
14.00 Hospital -Based Health Clinic RHC 0 0 14.00 15.00 Hospital -Based Health Clinic FOHC 0 0 15.00 16.00 Hospital -Based-CMHC 0 0 16.00 16.10 Hospital -Based-CMHC 10 0 0 16.10 17.00 Renal Dialysis 0 0 17.00				0	0	
15.00 Hospital -Based Health Clinic FOHC 0 0 15.00 16.00 Hospital -Based -CMHC 0 0 16.00 16.10 Hospital -Based -CMHC 10 0 0 16.10 17.00 Renal Dialysis 0 0 17.00	13.00			0	0	•
16.00 Hospital -Based-CMHC 0 0 16.00 16.10 Hospital -Based-CMHC 10 0 0 16.10 17.00 Renal Dialysis 0 0 17.00	14.00			0	0	
16. 10 Hospital -Based-CMHC 10 0 0 16. 10 17. 00 Renal Dialysis 0 0 17. 00	15.00			0	0	
17.00 Renal Dialysis 0 0 17.00	16.00			0	0	16.00
5				0	0	
18.00 0ther 0 0 18.00				0	0	
	18.00	Other		0	0	18.00

Heal th	Financial Systems FRANCISCAN HEALTH MICH	IGAN CITY	In Lie	eu of Form CMS-2	2552-10
		ovider CCN: 15-0015	Peri od:	Worksheet S-1	
			From 01/01/2021		
			To 12/31/2021	Date/Time Pre 5/26/2022 11:	
				572072022 11.	2.5 am
				1.00	
	Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divid	ded by line 202 colu	mn 8)	0. 199915	1.00
	Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid			45, 902, 872	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?			Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental		cai d?	N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from	n Medicaid		7, 838, 970	5.00
6.00	Medi cai d charges			205, 623, 144	6.00
7.00	Medicaid cost (line 1 times line 6)			41, 107, 151	7.00
8.00	Difference between net revenue and costs for Medicaid program (li	ne 7 minus sum of I	ines 2 and 5; if	0	8.00
	< zero then enter zero)				
	Children's Health Insurance Program (CHIP) (see instructions for	each line)		-	
9.00	Net revenue from stand-al one CHIP			0	9.00
10.00	Stand-al one CHIP charges			0	
11.00	Stand-alone CHIP cost (line 1 times line 10)			0	
12.00	Difference between net revenue and costs for stand-alone CHIP (li	ne II minus Iine 9;	IT < Zero then	0	12.00
	enter zero) Other state or local government indigent care program (see instru	ictions for each lin	0)		
13.00	Net revenue from state or local indigent care program (Net includ			0	13.00
13.00	Charges for patients covered under state or local indigent care p			0	14.00
14.00	10)			0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)			0	15.00
16.00	Difference between net revenue and costs for state or local indic	nent care program (ine 15 minus line	-	
10.00	13; if < zero then enter zero)			, o	10.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP	and state/local ind	igent care progra	ns (see	
	instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to fund	5		0	
18.00	Government grants, appropriations or transfers for support of hos			0	
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local i	ndigent care progra	ms (sum of lines	0	19.00
	8, 12 and 16)	Uni nsure	d Insured	Total (col. 1	
		patients		+ col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facil	ity 15, 926,	975 2, 475, 052	18, 402, 027	20.00
	(see instructions)	<u> </u>			
21.00	Cost of patients approved for charity care and uninsured discount	ts (see 3, 184,	041 2, 475, 052	5, 659, 093	21.00
	instructions)				
22.00	Payments received from patients for amounts previously written of	f as	0 0	0	22.00
	charity care				
23.00	Cost of charity care (line 21 minus line 22)	3, 184,	041 2, 475, 052	5, 659, 093	23.00
0.4.00				1.00	0.1.00
24.00	Does the amount on line 20 column 2, include charges for patient		n of stay limit	N	24.00
25.00	imposed on patients covered by Medicaid or other indigent care pr If line 24 is yes, enter the charges for patient days beyond the		om's longth of	0	25.00
25.00		That gent care progr	all S rength of	0	25.00
	lstav limit				
26.00	stay limit	ructions)		13 325 838	26 00
26.00 27.00	Total bad debt expense for the entire hospital complex (see instr			13, 325, 838 416_111	
27.00	Total bad debt expense for the entire hospital complex (see instr Medicare reimbursable bad debts for the entire hospital complex ((see instructions)		416, 111	27.00
27. 00 27. 01	Total bad debt expense for the entire hospital complex (see instr Medicare reimbursable bad debts for the entire hospital complex (Medicare allowable bad debts for the entire hospital complex (see	(see instructions)		416, 111 640, 171	27. 00 27. 01
27.00	Total bad debt expense for the entire hospital complex (see instr Medicare reimbursable bad debts for the entire hospital complex (Medicare allowable bad debts for the entire hospital complex (see Non-Medicare bad debt expense (see instructions)	(see instructions) e instructions)	s)	416, 111 640, 171 12, 685, 667	27.00 27.01 28.00
27. 00 27. 01 28. 00	Total bad debt expense for the entire hospital complex (see instr Medicare reimbursable bad debts for the entire hospital complex (Medicare allowable bad debts for the entire hospital complex (see	(see instructions) e instructions)	s)	416, 111 640, 171	27.00 27.01 28.00 29.00
27.00 27.01 28.00 29.00	Total bad debt expense for the entire hospital complex (see instr Medicare reimbursable bad debts for the entire hospital complex (see Medicare allowable bad debts for the entire hospital complex (see Non-Medicare bad debt expense (see instructions) Cost of non-Medicare and non-reimbursable Medicare bad debt exper Cost of uncompensated care (line 23 column 3 plus line 29)	(see instructions) e instructions) nse (see instruction	s)	416, 111 640, 171 12, 685, 667 2, 760, 115	27.00 27.01 28.00 29.00 30.00

	Financial Systems FR SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	ANCI SCAN HEALTH F EXPENSES	MICHIGAN CITY Provider CO	CN: 15-0015 P	eriod:	u of Form CMS-2 Worksheet A	2552-10
					rom 01/01/2021 o 12/31/2021	Date/Time Prep 5/26/2022 11:2	
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT		1, 769, 638	1, 769, 638	16, 475, 957	18, 245, 595	1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		1, 707, 030	0	13, 449, 768	13, 449, 768	2.00
3.00 4.00	00300 OTHER CAP REL COSTS 00400 EMPLOYEE BENEFITS DEPARTMENT	1, 945, 288	0 950, 627	0 2, 895, 915	-	0 3, 804, 392	3.00 4.00
5.00	00500 ADMINI STRATI VE & GENERAL	17, 914, 415	38, 254, 263	56, 168, 678		41, 836, 647	5.00
6.00 7.00	00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT	0 3, 218, 561	0 17, 232, 152	0 20, 450, 713	0 -8, 960, 149	0 11, 490, 564	6.00 7.00
8.00	00800 LAUNDRY & LINEN SERVICE	260, 763	663, 159			919, 369	8.00
9.00	00900 HOUSEKEEPI NG	1, 671, 584	1, 482, 807			3, 082, 755	9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	1, 694, 014 0	2, 060, 943 0	3, 754, 957 0		1, 235, 849 2, 480, 380	10. 00 11. 00
13.00	01300 NURSING ADMINISTRATION	2, 569, 182	5, 180, 271	7, 749, 453	-168, 612	7, 580, 841	13.00
14.00 15.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	225, 464 2, 610, 179	1, 121, 529 19, 381, 977			584, 935 3, 444, 032	14.00 15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	2,010,179	-9, 826	-9, 826		-9, 826	16.00
17.00	01700 SOCIAL SERVICE	0	0	0	0	0	17.00
18.00 19.00	01080 I NSERVI CE EDUCATI ON 01900 NONPHYSI CI AN ANESTHETI STS	0	0	0	0	0	18.00 19.00
20.00	02000 NURSI NG PROGRAM	0	0	0	0	0	20.00
21. 00 22. 00	02100 I & R SERVI CES-SALARY & FRI NGES APPRV 02200 I & R SERVI CES-OTHER PRGM COSTS APPRV	0	0	0	0	0	21.00 22.00
22.00	02300 PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	22.00
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	14 001 010	(1(0 001	00 740 400	0 (40 . 001	10,000,011	
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	16, 281, 818 3, 289, 809	6, 460, 284 1, 395, 030			19, 093, 211 4, 168, 493	30. 00 31. 00
32.00	03200 CORONARY CARE UNI T	0	0	0		0	32.00
33.00 34.00	03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	33.00 34.00
40.00	04000 SUBPROVIDER - IPF	1, 369, 151	813, 932	2, 183, 083	-41, 489	2, 141, 594	40.00
41.00	04100 SUBPROVI DER - I RF	0	0	0	0	0	41.00
43.00 44.00	04300 NURSERY 04400 SKI LLED NURSI NG FACI LI TY	0	0		751, 867 0	751, 867 0	43.00 44.00
45.00	04500 NURSING FACILITY	0	0	0	0	0	45.00
46.00	04600 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS	0	0	0	0	0	46.00
	05000 OPERATING ROOM	6, 695, 422	20, 370, 616	27, 066, 038	-16, 964, 378	10, 101, 660	50.00
51.00 52.00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0 1, 348, 195	0 1, 348, 195	51.00 52.00
52.00 53.00	05300 ANESTHESI OLOGY	38, 756	2, 706, 798	-		2, 679, 094	52.00 53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	3, 528, 193	2, 905, 106			4, 661, 284	
	05401 FSED RADI OLOGY - DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	1, 263, 483 614, 321	978, 157 1, 182, 066			1, 939, 746 1, 199, 477	
55.01	05501 WOODLAND CANCER CARE CTR	349, 699	127, 684			416, 266	55.01
56.00 57.00	05600 RADI OI SOTOPE 05700 CT SCAN	0	0	0	0	0	56.00 57.00
58.00	05800 MRI	0	0	0	0	0	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	988, 111	4, 375, 179			1, 478, 413	59.00
60. 00 60. 01	06000 LABORATORY 06001 FS ED LAB	4, 590 0	8, 991, 760 1, 600, 236			8, 240, 912 1, 599, 216	60. 00 60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0	0	0	0	61.00
62.00 63.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06300 BLOOD STORING, PROCESSING & TRANS.	0	0 41, 510	0 41, 510	0 -41, 510	0	62.00 63.00
63.01	06301 FS ED BLOOD BANK	0	0	0	0	0	63.01
64.00 65.00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	0 1, 203, 578	0 769, 585	0 1, 973, 163	0 -276, 099	0 1, 697, 064	64.00 65.00
66. 00	06600 PHYSI CAL THERAPY	919, 603	2, 754, 868			3, 467, 709	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67.00
68.00 69.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	1, 010, 031	0 561, 841	0 1, 571, 872	0 - 178, 340	0 1, 393, 532	68.00 69.00
	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	0	0	0	6, 984, 595	6, 984, 595	71.00
72.00 73.00	07200 I MPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS	0	0	0	16, 628, 068 18, 855, 515	16, 628, 068 18, 855, 515	
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
75.00 76.00	07500 ASC (NON-DISTINCT PART) 03020 CLINIC	0 306, 948	0 252, 585	0 559, 533	0	0 559, 533	75.00 76.00
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0		0	77.00
88.00	OUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	88.00
88.00 89.00	08800 FEDERALLY QUALIFIED HEALTH CENTER	0	0			0	88.00 89.00
90.00	09000 CLI NI C	0	0	0	0	0	90.00

Health Financial Systems FR	ANCISCAN HEALTH	MICHIGAN CITY	/	In Lie	u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF		Provider CC		Peri od:	Worksheet A	
				From 01/01/2021		
				To 12/31/2021	Date/Time Pre 5/26/2022 11:	
Cost Center Description	Sal ari es	Other	Total (col.	Reclassi fi cati	Recl assi fi ed	
			+ col. 2)	ons (See A-6)	Trial Balance	
					(col. 3 +-	
					col. 4)	
	1.00	2.00	3.00	4.00	5.00	
90.03 09003 INFUSION OP SERVICES	440, 669	669, 158	1, 109, 82	7 -102,097	1, 007, 730	90.03
91.00 09100 EMERGENCY	4, 230, 056	2, 336, 105	6, 566, 16	1 -741, 615	5, 824, 546	91.00
91.01 09101 FREE STANDING EMERGENCY DEPT	1,400,899	1, 953, 793				1
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	.,,	.,,	-,,		_, _ , _ , _ , ,	92.00
OTHER REIMBURSABLE COST CENTERS						/2:00
94. 00 09400 HOME PROGRAM DI ALYSI S	0	0		0 0	0	94.00
95. 00 09500 AMBULANCE SERVICES	Ö	0		0 0	0	95.00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0	0		0 0	0	96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0		0 0	0	
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0	0		0 0	0	98.00
99. 00 09900 CMHC	0	0		0 0	0	
99. 10 09900 CMRC	0	0		0 0	0	
	0	0		0 0	-	
100.00 10000 I &R SERVI CES-NOT APPRVD PRGM	0	0		0 0		100.00
101.00 10100 HOME HEALTH AGENCY	0	0		0 0	0	101.00
SPECIAL PURPOSE COST CENTERS		0				105 00
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 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		111.00
113.00 11300 INTEREST EXPENSE		0		0 0		113.00
114.00 11400 UTILIZATION REVIEW-SNF	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)	76, 044, 587	149, 333, 833	225, 378, 42	0 1, 551, 469	226, 929, 889	118.00
NONREI MBURSABLE COST CENTERS				1		
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	43, 519	43, 51	9 0	43, 519	
191. 00 19100 RESEARCH	0	0		0 0		191.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	94, 492	218, 229	312, 72	1 -157, 960	154, 761	
193.00 19300 NONPALD WORKERS	0	0		0 0	0	193.00
194.0007950 BEACON JOINT VENTURE	0	0		0 0	0	194.00
194.01 07951 WORKING WELL	1, 036, 863	1, 012, 524	2, 049, 38	7 -1, 392, 382	657, 005	194.01
194.03 07953 MED WATCHER	0	0		0 0	0	194.03
194.10 07960 DUNELAND FITNESS CTR	0	0		0 0	0	194. 10
194.11 07961 OMNI HEALTH & FITNESS CHESTERTOWN	0	0		o o	0	194.11
194.16 07966 PHYSICIAN PRACTICE MD WISW	54, 269	10, 573	64, 84	2 0	64, 842	194.16
194. 19 07969 HEALTH PARTNERS	0	0		0 0		194.19
194. 20 07970 CENTER OF HOPE	51,013	-7,470	43, 54	-1, 127		194.20
200.00 TOTAL (SUM OF LINES 118 through 199)	77, 281, 224	150, 611, 208				
			,	-		

	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE		Provider CCN: 15-	From 01/01/2021 To 12/31/2021 Date/Time	e Prepare
	Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation	5/26/2022	2 11:23 a
	· · · · · · · · · · · · · · · · · · ·	6.00	7.00		
00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT	1, 781, 427	20, 027, 022		1.
00	00200 CAP REL COSTS-BLDG & FIXT	1, 781, 427			2.
00	00300 OTHER CAP REL COSTS				3.
00	00400 EMPLOYEE BENEFITS DEPARTMENT	785, 858	-		4.
00	00500 ADMINI STRATI VE & GENERAL	-17, 130, 111			5.
00	00600 MAI NTENANCE & REPAI RS	C			6.
00	00700 OPERATION OF PLANT	C	11, 490, 564		7.
00	00800 LAUNDRY & LINEN SERVICE	-114, 855			8.
00	00900 HOUSEKEEPI NG	-40			9.
. 00	01000 DI ETARY	-13, 386			10.
. 00	01100 CAFETERIA 01300 NURSING ADMINISTRATION	-518, 695 -3, 734, 011			11.
. 00		-3, 734, 011			14.
. 00		1, 029, 334			15
. 00		1, 602, 297			16
. 00	01700 SOCIAL SERVICE	C	0		17
. 00		C	0		18
. 00		C	0		19
. 00		C	0		20
. 00		C	0		21
. 00			-		22
. 00	02300 PARAMED ED PRGM-(SPECIFY) INPATIENT ROUTINE SERVICE COST CENTERS		0		23
. 00		-7,643	19, 085, 568		30
. 00		-120			31
. 00		C			32
. 00	03300 BURN INTENSIVE CARE UNIT	C	o		33
. 00		C	0		34
. 00		-260, 103			40
. 00		C	, s		41
. 00		C	/ / / / / /		43
. 00 . 00					44
. 00					45
. 00	ANCI LLARY SERVICE COST CENTERS				
. 00		-1, 549, 488	8, 552, 172		50
. 00	05100 RECOVERY ROOM	C	0		51
. 00		C	.,		52
. 00		-2, 586, 956			53
. 00	05400 RADI OLOGY-DI AGNOSTI C 05401 FSED RADI OLOGY - DI AGNOSTI C	-1,004			54
. 01 . 00		-19, 419			54 55
. 00					55
. 00			0		56
	05700 CT SCAN	C	0		57
. 00	05800 MRI	C	0		58
. 00	05900 CARDI AC CATHETERI ZATI ON	C	., ., ., ., .,		59
	06000 LABORATORY	-1, 990			60
	06001 FS ED LAB	C	1, 599, 216		60
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL				61
	06300 BLOOD STORING, PROCESSING & TRANS.				63
	06301 FS ED BLOOD BANK				63
	06400 I NTRAVENOUS THERAPY		o o		64
	06500 RESPI RATORY THERAPY	C	1, 697, 064		65
. 00	06600 PHYSI CAL THERAPY	C	3, 467, 709		66
	06700 OCCUPATI ONAL THERAPY	C	0		67
	06800 SPEECH PATHOLOGY	C	-		68
		-511	1, 393, 021		69
00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	-981, 592	6,003,003		70
	07200 IMPL. DEV. CHARGED TO PATIENTS	- 701, 392	16, 628, 068		72
	07300 DRUGS CHARGED TO PATIENTS		18, 855, 515		73
	07400 RENAL DI ALYSI S		0		74
	07500 ASC (NON-DI STINCT PART)	C	0		75
	03020 CLINIC	C			76
. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	C	0		77
~~	OUTPATIENT SERVICE COST CENTERS	-			
	08800 RURAL HEALTH CLINIC	0	-		88
	08900 FEDERALLY QUALIFIED HEALTH CENTER				89
	09000 CLINIC 09003 INFUSION OP SERVICES		1,007,730		90 90
(1<	STORE THE OF ON OF SERVICES		1,001,100		170

ECLASSI FI (CATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider C	CN: 15-0015	Period: From 01/01/2021 To 12/31/2021	Worksheet A Date/Time Prepar 5/26/2022 11:23
	Cost Center Description	Adjustments	Net Expenses		· · ·	
		(See A-8) 6.00	For Allocation 7.00	1		
1.01 0910	1 FREE STANDING EMERGENCY DEPT	-337, 702				9
	O OBSERVATION BEDS (NON-DISTINCT PART	-337,702	2,207,100			9
	R REIMBURSABLE COST CENTERS		1			,
	O HOME PROGRAM DI ALYSI S	0	C			9
	O AMBULANCE SERVICES	0				9
	O DURABLE MEDICAL EQUIP-RENTED	0	c c			9
	O DURABLE MEDICAL EQUIP-SOLD	0	C			9
	O OTHER REIMBURSABLE COST CENTERS	0	C			9
9.00 0990	о смнс	0	C			9
9.10 0991	0 CORF	0	C			9
00. 00 1000	0 I&R SERVICES-NOT APPRVD PRGM	0	C			10
01.00 1010	O HOME HEALTH AGENCY	0	C			10
SPEC	I AL PURPOSE COST CENTERS	_	_			
05.00 1050	O KIDNEY ACQUISITION	0				10
	O HEART ACQUISITION	0	C	p		10
	O LIVER ACQUISITION	0	C	p		10
	O LUNG ACQUISITION	0	C	p		10
	O PANCREAS ACQUISITION	0	C			10
1	O INTESTINAL ACQUISITION	0	C			11
	OISLET ACQUISITION	0	C	D		11
	O I NTEREST EXPENSE	0	C	D		11
	O UTI LI ZATI ON REVI EW-SNF	0	C	D		11
	O AMBULATORY SURGICAL CENTER (D. P.)	0	C			11
16.001160		0		0		11
18.00	SUBTOTALS (SUM OF LINES 1 through 117)	-22, 503, 196	204, 426, 693	3		11
	EIMBURSABLE COST CENTERS	0	42 510			10
	O GIFT, FLOWER, COFFEE SHOP & CANTEEN O RESEARCH	0		1		19 19
	0 PHYSI CLANS' PRI VATE OFFI CES	-155, 154				19
	O NONPAID WORKERS	-155, 154		1		19
	O BEACON JOINT VENTURE	0				19
	1 WORKING WELL		657,005			19
	3 MED WATCHER		057,005			19
	O DUNELAND FI TNESS CTR					19
	1 OMNI HEALTH & FITNESS CHESTERTOWN					19
	6 PHYSICIAN PRACTICE MD WISW		64, 842			19
	9 HEALTH PARTNERS		04,042			19
	O CENTER OF HOPE		42, 416			19
	TOTAL (SUM OF LINES 118 through 199)		1 72, 410	1		17

	Financial Systems SIFICATIONS	FRA	NCISCAN HEALTH	MICHIGAN CITY Provider CCN: 15-00		eu of Form CMS-2552-10 Worksheet A-6
					From 01/01/2021 To 12/31/2021	Date/Time Prepared:
		Increases				5/26/2022 11:23 am
	Cost Center 2.00	Li ne # 3.00	Salary 4.00	0ther 5.00		
1.00	A - CAPITAL CAP REL COSTS-MVBLE EQUIP	2.00	0	13, 449, 768		1.00
1.00	0		0	13, 449, 768		1.00
1.00	B – CAFETERI A CAFETERI A	11.00	1, 119, 000	1, 361, 380		1.00
	O		1, 119, 000	1, 361, 380		
1.00	IMPL. DEV. CHARGED TO	72.00	0	16, 628, 068		1.00
	PATI ENTS	+		<u> </u>		
1.00	D - MEDICAL SUPPLIES MEDICAL SUPPLIES CHARGED TO	71.00	0	23, 612, 663		1.00
	PATI ENT					
2.00 3.00		0.00 0.00	0 0	0		2.00 3.00
4.00 5.00		0.00 0.00	0	0		4.00 5.00
6.00		0.00	0	0		6. 00
7.00 8.00		0.00 0.00	0	0		7.00 8.00
9.00		0.00	О	0		9.00
10. 00 11. 00		0.00 0.00	0	0		10.00
12.00		0.00	0	0		12.00
13.00 14.00		0.00 0.00	0 0	0		13.00 14.00
15.00		0.00	0	0		15.00
16. 00 17. 00		0. 00 0. 00	0 0	0 0		16.00 17.00
18. 00 19. 00		0.00 0.00	0	0		18.00 19.00
20.00		0.00	0	0		20.00
21.00 22.00		0.00 0.00	0	0		21.00 22.00
23.00		0.00	0	0		23.00
24.00 25.00		0.00 0.00	0 0	0		24.00 25.00
26.00		0.00	0 0	0		26.00
27.00 28.00		0. 00 0. 00	0	0		27.00 28.00
29.00			<u>0</u>	0000000		29.00
	E - NURSERY AND L&D		· · ·	÷		
1.00 2.00	NURSERY DELIVERY ROOM & LABOR ROOM	43.00 52.00	426, 678 765, 089	325, 189 583, 106		1.00 2.00
	0		1, 191, 767	908, 295		
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	20, 019, 989		1.00
2.00 3.00		0.00 0.00	0 0	0		2.00 3.00
4.00		0.00	О	0		4.00
5.00 6.00		0. 00 0. 00	0 0	0		5.00 6.00
7.00		0.00	0	0		7.00
8.00 9.00		0.00 0.00	0	0		8. 00 9. 00
10.00		0.00	0	0		10.00
11. 00 12. 00		0. 00 0. 00	0 0	0		11. 00 12. 00
13.00 14.00		0.00 0.00	0 0	0		13.00 14.00
15.00		0.00	О	0		15.00
16. 00 17. 00		0.00 0.00	0 0	0		16.00 17.00
18.00		0.00	О	0		18.00
19. 00 20. 00		0.00 0.00	0 0	0		19.00 20.00
21.00		0.00	О	0		21.00
22.00 23.00		0.00 0.00	0 0	0		22. 00 23. 00
24.00		0.00	О	0		24.00
25.00 26.00		0. 00 0. 00	0 0	0 0		25.00 26.00
27.00		0.00	0	0		27.00

Heal th	Financial Systems	FR	ANCISCAN HEALTH	MICHIGAN CIT	Y	In Lie	u of Form CMS	-2552-10
RECLASS	SEFECATIONS			Provider C	CCN: 15-0015	Period: From 01/01/2021 To 12/31/2021	Worksheet A- Date/Time Pr 5/26/2022 11	epared:
		Increases						
	Cost Center	Line #	Salary	Other				
	2.00	3.00	4.00	5.00				
28.00		0.00	0	0				28.00
29.00		0.00	0	0				29.00
	0	T		20, 019, 989				1
	G - INTEREST							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	9, 905, 736				1.00
	0	T	<u>0</u>	9, 905, 736				
	H - DRUGS & PHARM	<u>.</u>	·					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	18, 855, 515				1.00
2.00		0.00	0	0				2.00
3.00		0.00	0	0				3.00
4.00		0.00	0	0				4.00
5.00		0.00	0	0				5.00
6.00		0.00	0	0				6.00
7.00		0.00	0	0				7.00
8.00		0.00	0	0				8.00
9.00		0.00	0	0				9.00
10.00		0.00	0	0				10.00
11.00		0.00	0	0				11.00
12.00		0.00	0	0				12.00
13.00		0.00	0	0				13.00
14.00		0.00	0	0				14.00
15.00		0.00	0	0				15.00
16.00		0.00	0	0				16.00
17.00		0.00	0	0				17.00
18.00		0.00	0	0				18.00
19.00		0.00	0	0				19.00
20.00		0.00	0	0				20.00
21.00		0.00	0	0				21.00
22.00		0.00	0	0				22.00
23.00		0.00	0	0				23.00
				18, 855, 515				
	I - WORKING WELL	I		-,				-
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	622, 118	607, 514				1.00
	TOTALS		622, 118	607, 514				
500.00	Grand Total: Increases		2, 932, 885	105, 348, 928				500.00
		I						

RECLASS	Financial Systems SIFICATIONS			Provider (CCN: 15-0015	Period: From 01/01/2021	Worksheet A-6	
						To 12/31/2021	Date/Time Prepa 5/26/2022 11:23	
		Decreases					372072022 11.23	<u>) an</u>
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref			
	6. 00	7.00	8.00	9.00	10.00			
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	13, 449, 768	3	9		1.00
	0		o	13, 449, 768	3	1		
1.00	B – CAFETERIA DI ETARY	10.00	1, 119, 000	1, 361, 380		0		1.00
1.00			1, 119, 000	1, 361, 380				1.00
	C - IMPLANTABLE DEVICES		· · ·		F			
1.00	MEDICAL SUPPLIES CHARGED TO	71.00	0	16, 628, 068	3	0		1.00
	PATI ENT	+		16, 628, 068	3	-		
	D - MEDI CAL SUPPLI ES		-		-			
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	82, 456		0		1.00
2.00 3.00	ADMINISTRATIVE & GENERAL OPERATION OF PLANT	5.00 7.00	0	14, 081 51, 793		0		2.00
4.00	LAUNDRY & LINEN SERVICE	8.00	0	3, 375		0		4.00
	HOUSEKEEPING	9.00	0	4, 032		0		5.00
	DIETARY	10.00	0	1, 803		0		6.00
7.00 8.00	NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY	13.00 14.00	0	103, 606 526, 108				7.00 8.00
	PHARMACY	15.00	0	130, 822		o		9.00
	ADULTS & PEDIATRICS	30.00	0	1, 068, 679		0		10.00
	I NTENSI VE CARE UNI T SUBPROVI DER – I PF	31.00 40.00	0	370, 272		0		11.00 12.00
	OPERATING ROOM	40.00 50.00	0	8, 366 15, 138, 172		ol		12.00
	RADI OLOGY-DI AGNOSTI C	54.00	0	708, 940		0		14.00
	FSED RADIOLOGY - DIAGNOSTIC	54.01	о	60, 436		o		15.00
		55.00	0	371, 078		0		16.00
	WOODLAND CANCER CARE CTR CARDIAC CATHETERIZATION	55.01 59.00	0	55, 511 3, 398, 979				17.00 18.00
	LABORATORY	60.00	0	452, 630		0		19.00
	FS ED LAB	60. 01	о	713		0		20.00
21.00	BLOOD STORING, PROCESSING &	63.00	0	41, 510		0	2	21.00
22.00	TRANS. RESPI RATORY THERAPY	65.00	o	197, 953	3	o	2	22.00
	PHYSICAL THERAPY	66.00	0	34, 940		0		23.00
	ELECTROCARDI OLOGY	69.00	0	40, 171		0		24.00
	INFUSION OP SERVICES EMERGENCY	90.03 91.00	0	55, 061 589, 886				25.00 26.00
	FREE STANDING EMERGENCY DEPT	91.01	0	91, 335		0		27.00
	PHYSICIANS' PRIVATE OFFICES	192.00	О	3, 219		o		28.00
29.00	WORKING WELL	<u>194.01</u>	0	<u> </u>		0	2	29.00
	E – NURSERY AND L&D		U	23, 612, 663	5			
1.00	ADULTS & PEDIATRICS	30.00	1, 191, 767	908, 295	5	0		1.00
2.00	$\sqsubseteq _ _ _ _ _ _ _ _$	0.00	0	<u>c</u>		o		2.00
	O F - DEPRECIATION		1, 191, 767	908, 295				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	154, 323	3	9		1.00
2.00	ADMI NI STRATI VE & GENERAL	5.00	0	4, 412, 214		0		2.00
3.00	OPERATION OF PLANT	7.00	0	8, 908, 231		0		3.00
4.00 5.00	LAUNDRY & LINEN SERVICE HOUSEKEEPING	8.00 9.00	0	1, 178 67, 604				4.00 5.00
	DI ETARY	10.00	0	36, 925		ŏ		6.00
7.00	NURSING ADMINISTRATION	13.00	О	63, 617		o		7.00
8.00	CENTRAL SERVICES & SUPPLY	14.00	0	234, 793		0		8.00
9.00 10.00	PHARMACY ADULTS & PEDIATRICS	15.00 30.00	0	13, 817 406, 579		0		9.00 10.00
	I NTENSI VE CARE UNI T	31.00	0	109, 793		0		11.00
12.00	SUBPROVIDER - IPF	40.00	О	33, 123	3	o	1	12.00
	OPERATING ROOM	50.00	0	1, 754, 885		0		13.00
	ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C	53.00 54.00	0	35, 421 1, 046, 720		0		14.00 15.00
	FSED RADIOLOGY - DIAGNOSTIC	54.00	0	239, 123		0		16. 0
17.00	RADI OLOGY-THERAPEUTI C	55.00	0	201, 733	3	o	1	17.0
	CARDIAC CATHETERIZATION	59.00	0	480, 684		0		18.0
	LABORATORY FS ED LAB	60. 00 60. 01	0	296, 556 307				19.0 20.0
	RESPIRATORY THERAPY	65.00	o	76, 139		ŏ		20.0
22.00	PHYSI CAL THERAPY	66.00	О	171, 380		o	2	22. 0
	ELECTROCARDI OLOGY	69.00	0	137, 902		0		23.0
	INFUSION OP SERVICES EMERGENCY	90.03 91.00	0	22, 156 124, 040		0		24.0 25.0
	FREE STANDING EMERGENCY DEPT		0	711, 862		0		26.00
26.00	FREE STANDING EMERGENCE DEPT	91.01	U	/11,002	-	0	2	∠U. U

FCL AS	SEFECATIONS			Provider (CCN: 15-0015	Peri od:	Worksheet A-6
					. 10 0010	From 01/01/2021	
						To 12/31/2021	Date/Time Prepared: 5/26/2022 11:23 am
		Decreases			_		
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref	·	
	6.00	7.00	8.00	9.00	10.00		
3.00	WORKING WELL	194.01	0	123, 547		0	28.00
9.00	CENTER OF HOPE	<u> </u>	º	<u> </u>		ol	29.00
			0	20, 019, 989			
~~	G - INTEREST	5 00		0.005.73/	1	4	1.00
. 00	ADMI NI STRATI VE & GENERAL	5.00	0	<u>9, 905, 7</u> 36 9, 905, 736		4	1.00
	H - DRUGS & PHARM		U	9,905,730	1		
00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	84, 376	1	0	1.00
00	OPERATION OF PLANT	7.00	0	125		0	2.00
00	NURSING ADMINISTRATION	13.00	0	1, 389		0	3. 00
00	CENTRAL SERVICES & SUPPLY	14.00	0	1, 307		0	4. 00
00	PHARMACY	15.00	0	18, 403, 485		0	5.00
00	ADULTS & PEDIATRICS	30.00	0	73, 571		0	6. 00
00	INTENSIVE CARE UNIT	31.00	0	36, 281		0	7.00
00	OPERATING ROOM	50.00	0	71, 321		0	8.00
00	ANESTHESI OLOGY	53.00	0	31, 039		0	9.00
0.00	RADI OLOGY-DI AGNOSTI C	54.00	o	16, 355		0	10.00
1.00	FSED RADIOLOGY - DIAGNOSTIC	54.01	0	2, 335		0	11.00
2.00	RADI OLOGY-THERAPEUTI C	55.00	0	24,099		0	12.00
3.00	WOODLAND CANCER CARE CTR	55.01	0	5,606		0	13.00
1.00	CARDIAC CATHETERIZATION	59.00	0	5, 214		0	14.00
5.00	LABORATORY	60.00	0	6, 252		0	15.00
5.00	RESPI RATORY THERAPY	65.00	0	2,007	,	0	16.00
7.00	PHYSICAL THERAPY	66.00	0	442		0	17.00
3.00	ELECTROCARDI OLOGY	69.00	0	267		0	18.00
9.00	INFUSION OP SERVICES	90. 03	0	24, 880		0	19.00
0. 00	EMERGENCY	91.00	0	27, 689		0	20.00
I. 00	FREE STANDING EMERGENCY DEPT	91.01	0	4, 627		0	21.00
2.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	531		0	22.00
8.00	WORKING WELL	194.01	0	32, 467		o	23.00
	0		0	18, 855, 515			
	I - WORKING WELL						
00	WORKING WELL	1 <u>94.</u> 01	<u>622, 1</u> 18	<u>607, 5</u> 14		Q	1.00
	TOTALS		622, 118	607, 514			

Heal th	Financial Systems FR	ANCISCAN HEALTH	I MICHIGAN CITY	,		In Lie	u of Form CMS-2	2552-10
RECONC	ILIATION OF CAPITAL COSTS CENTERS		Provider CC	CN: 15-0015		iod: m 01/01/2021 12/31/2021	Worksheet A-7 Part I Date/Time Pre 5/26/2022 11:	pared:
				Acqui si ti on	s			
		Begi nni ng	Purchases	Donati on		Total	Di sposal s and	
		Bal ances					Retirements	
		1.00	2.00	3.00		4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET							
1.00	Land	9, 595, 549	141, 729		0	141, 729	0	1.00
2.00	Land Improvements	6, 134, 413	852, 693		0	852, 693	1, 514, 350	2.00
3.00	Buildings and Fixtures	310, 036, 582	18, 273, 266		0	18, 273, 266	10, 589, 245	3.00
4.00	Building Improvements	0	0		0	0	0	4.00
5.00	Fixed Equipment	53, 698, 311	291, 866		0	291, 866	0	5.00
6.00	Movable Equipment	91, 489, 899	3, 466, 745		0	3, 466, 745	7, 302, 595	6.00
7.00	HIT designated Assets	0	0		0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	470, 954, 754	23, 026, 299		0	23, 026, 299	19, 406, 190	8.00
9.00	Reconciling Items	-8, 255, 673	-1, 079, 978		0	-1, 079, 978	0	9.00
10.00	Total (line 8 minus line 9)	479, 210, 427	24, 106, 277		0	24, 106, 277	19, 406, 190	10.00
	· · · ·	Endi ng Bal ance	Fully					
		Ŭ	Depreci ated					
			Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	BALANCES						
1.00	Land	9, 737, 278	0					1.00
2.00	Land Improvements	5, 472, 756	2, 673, 049					2.00
3.00	Buildings and Fixtures	317, 720, 603	33, 743, 016					3.00
4.00	Building Improvements	0	0					4.00
5.00	Fixed Equipment	53, 990, 177	33, 182, 031					5.00
6.00	Movable Equipment	87, 654, 049	21, 755, 661					6.00
7.00	HIT designated Assets	0	0					7.00
8.00	Subtotal (sum of lines 1-7)	474, 574, 863	91, 353, 757					8.00
9.00	Reconciling Items	-9, 335, 651	o					9.00
10.00	Total (line 8 minus line 9)	483, 910, 514	91, 353, 757					10.00

Heal th	Financial Systems FR	RANCISCAN HEALTH	I MICHIGAN CITY	ſ	In Lie	u of Form CMS-2	2552-10
RECONC	CILIATION OF CAPITAL COSTS CENTERS		Provider C		Period: From 01/01/2021 To 12/31/2021	Worksheet A-7 Part II Date/Time Pre 5/26/2022 11:2	pared:
			SL	JMMARY OF CAPI	TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)		
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUMI	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	5, 801	0	-115, 96	0 1, 879, 797	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0)	0 0	0	2.00
3.00	Total (sum of lines 1-2)	5, 801	0	-115, 96	0 1, 879, 797	0	3.00
		SUMMARY OF	F CAPITAL				
	Cost Center Description	0ther	Total (1) (sum				
	·	Capi tal -Rel ate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	N 2, LINES 1 a	ind 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	1, 769, 638				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0)			2.00
3.00	Total (sum of lines 1-2)	0	1, 769, 638				3.00

Health Financ		FRANCI SCAN HEALT				u of Form CMS-2	
RECONCI LI ATI (ON OF CAPITAL COSTS CENTERS		Provider CO		Period: From 01/01/2021 To 12/31/2021	Worksheet A-7 Part III Date/Time Prep 5/26/2022 11:2	pared:
		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)	instructions)	Insurance	
DADT	II - RECONCILIATION OF CAPITAL COSTS	1.00	2.00	3.00	4.00	5.00	
1.00 CAP RE 2.00 CAP RE	L COSTS-BLDG & FLXT L COSTS-MVBLE EQUIP (sum of lines 1-2)	000000000000000000000000000000000000000	O O O TION OF OTHER (CAPI TAL	0 1.000000 0 0.000000 0 1.000000 SUMMARY 0	0	1.00 2.00 3.00
(Cost Center Description	Taxes	Other Capital-Relate d Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	II - RECONCILIATION OF CAPITAL COSTS						1.0
. 00 CAP RE	L COSTS-BLDG & FIXT L COSTS-MVBLE EQUIP (sum of lines 1-2)	0			0 6, 516, 555 0 13, 449, 768 0 19, 966, 323		1.0 2.0 3.0
			SL	JMMARY OF CAPI			0.00
(Cost Center Description	Interest	Insurance (see instructions)		Other Capital-Relate d Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	II - RECONCILIATION OF CAPITAL COSTS L COSTS-BLDG & FIXT	<u>5 CENTERS</u> 11, 630, 670	1, 879, 797		0 0	20, 027, 022	1.00
2.00 CAP RE	L COSTS-BLOG & TTXT L COSTS-MVBLE EQUIP (sum of lines 1-2)	11, 630, 670	0			13, 449, 768 33, 476, 790	2.00

Heal th	Fi nanc	i al	Systems
AD JUST	MENTS 1	0 F	XPENSES

FRANCISCAN HEALTH MICHIGAN CITY

Heal th	Financial Systems	FRA	NCI SCAN HEALTI	H MICHIGAN CITY	In Lie	u of Form CMS-2	552-10
ADJUST	MENTS TO EXPENSES			Provider CCN: 15-0015	Period:	Worksheet A-8	
					From 01/01/2021 To 12/31/2021	Date/Time Prep	
	· · · · · ·			Expense Classification c	n Worksheet A	5/26/2022 11:2	<u>3 am</u>
				To/From Which the Amount is			
	Cost Center Description	Basi s/Code (2) 1.00	Amount 2.00	Cost Center 3.00	Li ne # 4. 00	Wkst. A-7 Ref. 5.00	
1.00	Investment income - CAP REL	1.00		CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
0.00	COSTS-BLDG & FIXT (chapter 2)		0				0.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other	В	0	CAP REL COSTS-BLDG & FIXT	1.00	11	3.00
4.00	(chapter 2) Trade, quantity, and time		0		0.00	0	4, 00
4.00	di scounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of	В	-133, 572	ADMINISTRATIVE & GENERAL	5.00	0	5.00
6.00	expenses (chapter 8) Rental of provider space by		0		0.00	0	6.00
0.00	suppliers (chapter 8)		0		0.00	Ű	0.00
7.00	Tel ephone servi ces (pay		0		0.00	0	7.00
	stations excluded) (chapter 21)						
8.00	Television and radio service		0		0.00	0	8.00
9.00	(chapter 21) Parking lot (chapter 21)		<u>^</u>		0.00	0	9.00
9.00 10.00	Provi der-based physici an	A-8-2	-8, 820, 514		0.00	0	9.00 10.00
	adjustment						
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization	A-8-1	-2, 112, 436			0	12.00
10.00	transactions (chapter 10)		0				40.00
13.00 14.00	Laundry and linen service Cafeteria-employees and guests	В	-510.257	CAFETERI A	0.00 11.00		13.00 14.00
15.00	Rental of quarters to employee		0		0.00		15.00
16.00	and others Sale of medical and surgical		0		0.00	0	16.00
10.00	supplies to other than		0		0.00	0	10.00
	patients						
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and	В	-1, 716	ADMI NI STRATI VE & GENERAL	5.00	0	18.00
10.00	abstracts		0				10.00
19.00	Nursing and allied health education (tuition, fees,		0		0.00	0	19.00
	books, etc.)						
20.00 21.00	Vending machines Income from imposition of	В	-8, 438	CAFETERI A	11.00 0.00	0	20. 00 21. 00
21.00	interest, finance or penalty		0		0.00	0	21.00
~~ ~~	charges (chapter 21)						~~ ~~
22.00	Interest expense on Medicare overpayments and borrowings to		0		0.00	0	22.00
	repay Medicare overpayments						
23.00	Adjustment for respiratory	A-8-3	0	RESPI RATORY THERAPY	65.00		23.00
	therapy costs in excess of limitation (chapter 14)						
24.00	Adjustment for physical	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
	therapy costs in excess of limitation (chapter 14)						
25.00	Utilization review -		0	UTILIZATION REVIEW-SNF	114.00		25.00
	physicians' compensation						
26.00	(chapter 21) Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
20.00	COSTS-BLDG & FIXT		0		1.00	Ŭ	20.00
27.00	Depreciation - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	COSTS-MVBLE EQUIP Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of	A-8-3	0	OCCUPATI ONAL THERAPY	67.00		30.00
	limitation (chapter 14)						
30. 99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30. 99
31.00	instructions) Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
J I. UU	pathology costs in excess of	A-0-3	0		00.00		51.00
22.00	limitation (chapter 14)		-		0.00		22.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	PROPERTY RENTAL	В	-21, 490	OPERATING ROOM	50.00	0	33.00

	Financial Systems	FR/	ANCISCAN HEALTH			eu of Form CMS-2	
ADJUSIM	ENTS TO EXPENSES				Period: From 01/01/2021	Worksheet A-8	
					To 12/31/2021	Date/Time Pre 5/26/2022 11:	pared: 23 am
				Expense Classification or			
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	cost center bescription	1.00	2.00	3.00	4.00	5.00	
34.00 F	RENTAL INCOME	B		ADMI NI STRATI VE & GENERAL	5.00		34.00
	RETALL SERVICES	B		ADMI NI STRATI VE & GENERAL	5.00		
	SHARED SAVINGS	B		ADMI NI STRATI VE & GENERAL	5.00		
	PROPERTY RENTAL	B		FSED RADIOLOGY - DIAGNOSTIC	54.01		•
	ADVERTISING EXPENSE	Ā		EMPLOYEE BENEFITS DEPARTMEN			
	ADVERTISING EXPENSE	A		ADULTS & PEDIATRICS	30.00		
	_OBBYI NG	A		ADMI NI STRATI VE & GENERAL	5.00		
	OTHER NON-OPERATING EXPENSE	A		ADMI NI STRATI VE & GENERAL	5.00		
	ADVERTI SI NG EXPENSE	Â		PHARMACY	15.00		
	PROGRAM FEES	B		ADMI NI STRATI VE & GENERAL	5.00		
	PROGRAM FEES	B		PHARMACY	15.00		1
	HAF PROVIDER TAX	A		ADMI NI STRATI VE & GENERAL	5.00		
	PENSION	A		EMPLOYEE BENEFITS DEPARTMEN			
	CONVERSION ADJUSTMENT	A		PHYSICIANS' PRIVATE OFFICES			
		B					
49.03	DI SCOUNTS EARNED/REBATES	В		MEDI CAL SUPPLIES CHARGED TO PATIENT	71.00	0	49.0
49.04	DI SCOUNTS EARNED/REBATES	В		DIETARY	10.00	0	49.0
	DI SCOUNTS EARNED/REBATES	B		PHARMACY	15.00		
	MISCELLANEOUS - OTHER	В		RADI OLOGY-DI AGNOSTI C			•
	DPERATING	В	- 998	RADI ULUGI - DI AGNUSTI C	54.00	0	49.0
	DI SCOUNTS EARNED/REBATES	В	۷.	RADI OLOGY-DI AGNOSTI C	54.00	0	49.0
	AI SCELLANEOUS - OTHER	В		ADULTS & PEDIATRICS	30.00		
	DPERATING	В	- 303/	ADULIS & PEDIATRICS	30.00	0	49.0
	ADVERTISING EXPENSE	А	101	NURSING ADMINISTRATION	13.00	0	49.0
	MISCELLANEOUS - OTHER	B		ADMINI STRATI VE & GENERAL	5.00		
	DPERATING	D	-33, 018	ADMINISTRATIVE & GENERAL	5.00	0	47.1
	ADVERTI SI NG EXPENSE	А	-3 572	DI ETARY	10.00	0	49.1
	MISCELLANEOUS - OTHER	В		NURSING ADMINISTRATION	13.00		
	OPERATI NG	D D	23,0001		13.00		
	MISCELLANEOUS - OTHER	В	-126, 932	PHARMACY	15.00	0	49.1
	OPERATI NG		120, 702		10.00		
	MISCELLANEOUS - OTHER	В	-961 194	OPERATING ROOM	50.00	0	49.1
	OPERATI NG	_				-	
	MISCELLANEOUS - OTHER	В	-9, 920	FSED RADIOLOGY - DIAGNOSTIC	54.01	0	49.1
	OPERATING	_	.,			-	
	MI SCELLANEOUS - OTHER	В	-106, 484	EMPLOYEE BENEFITS DEPARTMEN	T 4.00	0	49.10
	OPERATI NG						
	MISCELLANEOUS - OTHER	В	-114, 855	LAUNDRY & LINEN SERVICE	8.00	0	49.1 [°]
	OPERATI NG		.,			- -	
49.18 A	ADVERTISING EXPENSE	A	-790	ADMINISTRATIVE & GENERAL	5.00	0	49.18
	ADVERTISING EXPENSE	A		HOUSEKEEPING	9.00		•
	TOTAL (sum of lines 1 thru 49)		-22, 658, 350				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 HEAL	In Lieu of Form CMS-2552-10					
STATEM	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HOM	ME Provider CCN: 15-0015	Peri od:	Worksheet A-8	3-1		
OFFICE	COSTS			From 01/01/2021 To 12/31/2021	Date/Time Pre	pared.		
	5.							
	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 ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED							
	HOME OFFICE COSTS:							
1.00	1.00	CAP REL COSTS-BLDG & FIXT	INTEREST	1, 840, 894	0	1.00		
2.00	1.00	CAP REL COSTS-BLDG & FIXT	ALLOWABLE NEW CAPITAL COSTS	2, 257, 423	2, 316, 890	2.00		
3.00	5.00	ADMINISTRATIVE & GENERAL	ADMINISTRATIVE & GENERAL	28, 792, 842	35, 469, 438	3.00		
4.00	15.00	PHARMACY	COEP / PHARMACY	325, 556	-854, 880	4.00		
4.01	16.00	MEDICAL RECORDS & LIBRARY	нім	1, 602, 297	0	4.01		
5.00	TOTALS (sum of lines 1-4).			34, 819, 012	36, 931, 448	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.

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

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

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

6.00	В	100.00	0.00	0 6.00
7.00		0.00	0.00	7.00
8.00		0.00	0.00	8.00
9.00		0.00	0.00	9.00
10.00		0.00	0.00	10.00
100.00	G. Other (financial or			100.00
	non-financial) specify:			

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

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

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

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

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

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

Health Financial Systems	FRANCISCAN HEALTH M	In Lieu of Form CMS-2552-10			
STATEMENT OF COSTS OF SERVICES F OFFICE COSTS	FROM RELATED ORGANIZATIONS AND HOME	Provider CCN: 15-0015	From 01/01/2021	Worksheet A-8-1 Date/Time Prepared: 5/26/2022 11:23 am	

	Net	Wkst. A-7 Ref.		
	Adjustments			
	(col. 4 minus			
	col. 5)*			
	6.00	7.00		
	A. COSTS INCUR	RED AND ADJUSTN	IENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED	
	HOME OFFICE CO	STS:		
1.00	1, 840, 894	11		1.00
2.00	-59, 467	9		2.00
3.00	-6, 676, 596	0		3.00
4.00	1, 180, 436	0		4.00
4.01	1, 602, 297	0		4.01
5.00	-2, 112, 436			5.00

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

nas not	been posted to worksheet A,		Ζ, Ι	The aniount	arrowabre	Shourd be	Thui cateu	this part.	
	Related Organization(s)								
	and/or Home Office								
	Type of Business								
	6. 00								
	B INTERRELATIONSHIP TO RELA	TED ORGANIZATION	(S) AN	ID/OR HOME	OFFLCE.				

B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:

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

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

6.00 FRANCI SCAN ALLI	6.00
7.00	7.00
8.00	8.00
9.00 10.00	9.00
10.00	10.00
100.00	100.00

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

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

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

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

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

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

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

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

	Financial Syste		RANCI SCAN HEAL				eu or Form CMS-	
PROVI DE	ER BASED PHYSIC	I AN ADJUSTMENT		Provi der		Period:	Worksheet A-8	3-2
						From 01/01/2021		
						To 12/31/2021		
							5/26/2022 11:	23 am
	Wkst. A Line #		Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component	
							Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	3, 570	3, 570	0	197, 500	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	905, 984	899, 984	6,000	197, 500	48	2.00
3.00		NURSING ADMINISTRATION	3, 715, 846					3.00
4.00		PHARMACY	2, 250					4.00
5.00		ADULTS & PEDIATRICS	28, 588					5.00
6.00		INTENSIVE CARE UNIT	500					6.00
7.00		SUBPROVIDER - IPF	270, 563					7.00
8.00		OPERATING ROOM	575, 096					8.00
9.00	53.00	ANESTHESI OLOGY	2, 618, 377	2, 584, 252	2 34, 125	239, 400	273	9.00
10.00	54.01	FSED RADIOLOGY - DIAGNOSTIC	1, 875	0	1,875	197, 500	13	10.00
11.00	60.00	LABORATORY	28, 521	0	28, 521	260, 300	212	11.00
12.00		ELECTROCARDI OLOGY	2, 125					12.00
13.00		EMERGENCY	467, 749					13.00
14.00		FREE STANDING EMERGENCY DEPT	337, 702					14.00
	91.01	FREE STANDING EMERGENCE DEPT						
200.00			8, 958, 746					200.00
	Wkst. A Line #		Unadjusted RCE		Cost of	Provi der	Physician Cost	
		I denti fi er	Limit		Memberships &		of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	0	() C	0	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	4, 558	228	3 C	0	0	2.00
3.00		NURSI NG ADMI NI STRATI ON	7, 026				0	3.00
4.00		PHARMACY	1, 709		-		0	4.00
		ADULTS & PEDIATRICS					0	
5.00			21, 744	1, 087	-		0	5.00
6.00		INTENSIVE CARE UNIT	380				0	6.00
7.00		SUBPROVIDER - IPF	10, 460				0	7.00
8.00	50.00	OPERATING ROOM	8, 292	415	5 C	0	0	8.00
9.00	53.00	ANESTHESI OLOGY	31, 421	1, 571	C	0	0	9.00
10.00	54.01	FSED RADIOLOGY - DIAGNOSTIC	1, 234	62	2 0	0	0	10.00
11.00	60.00	LABORATORY	26, 531	1, 327	/ C	0	0	11.00
12.00		ELECTROCARDI OLOGY	1, 614			0	0	12.00
13.00		EMERGENCY	23, 263			0	0	13.00
			23, 203	1, 103		0	0	
14.00	91.01	FREE STANDING EMERGENCY DEPT	0				-	14.00
200.00			138, 232			°	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		I denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
			14					
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	0	() C	3, 570		1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	l o	4, 558	1, 442	901, 426		2.00
3.00		NURSING ADMINISTRATION	0					3.00
4.00		PHARMACY	0					4.00
5.00		ADULTS & PEDIATRICS						5.00
			0					
6.00		INTENSIVE CARE UNIT	0					6.00
7.00		SUBPROVIDER - IPF	0					7.00
8.00		OPERATING ROOM	0					8.00
9.00	53.00	ANESTHESI OLOGY	0	31, 421	2, 704	2, 586, 956		9.00
10.00	54.01	FSED RADIOLOGY - DIAGNOSTIC	0	1, 234	641	641		10.00
11.00	60.00	LABORATORY	0					11.00
12.00		ELECTROCARDI OLOGY	0					12.00
13.00		EMERGENCY	0					13.00
14.00		FREE STANDING EMERGENCY DEPT	0					14.00
	71.01	CALL STANDING ENERGENCE DEPT						
200.00	I	I	0	138, 232	30, 773	8, 820, 514		200.00

	LLOCATION - GENERAL SERVICE COSTS		Provider C	F	Period: From 01/01/2021 Fo 12/31/2021	Worksheet B Part I Date/Time Pre	
			CAPI TAL REL	ATED COSTS		5/26/2022 11:	23 an
	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFI TS DEPARTMENT	Subtotal	
		<u>col.7)</u> 0	1.00	2.00	4.00	4A	
	GENERAL SERVICE COST CENTERS	0	1.00	2.00	4.00	47	
00 00 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	20, 027, 022 13, 449, 768 4, 590, 250 24, 706, 536		13, 449, 768 282, 983	4, 975, 740 1, 193, 071	29, 680, 672	
. 00 . 00 . 00 0. 00	00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA	0 11, 490, 564 804, 514 3, 082, 715 1, 222, 463 1, 961, 685	3, 482, 847 63, 975 787, 031 215, 053 418, 634	2, 213 127, 000 69, 363	3 17, 366 D 111, 322 7 38, 294	0 17, 037, 212 888, 068 4, 108, 068 1, 545, 177 2, 454, 841	7. 8. 9. 10.
3.00 4.00 5.00 6.00	01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	3, 846, 830 584, 935 4, 473, 366 1, 592, 471	99, 316 974, 819 279, 259 31, 363	119, 51(440, 332 22, 472	2 171, 100 2 15, 015	4, 236, 756 1, 815, 101 4, 948, 927 1, 623, 834	13. 14. 15. 16.
8.00 9.00 0.00 1.00 2.00	01080 I NSERVI CE EDUCATI ON 01900 NONPHYSI CI AN ANESTHETI STS 02000 NURSI NG PROGRAM 02100 I &R SERVI CES-SALARY & FRI NGES APPRV 02200 I &R SERVI CES-OTHER PRGM COSTS APPRV				0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0	18. 19. 20. 21.
	02300 PARAMED ED PRGM-(SPECIFY)	0	0	(0 0	0	23.
D. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS 03100 I NTENSI VE CARE UNI T	19, 085, 568 4, 168, 373	3, 218, 900 621, 151	724, 182 198, 96		24, 033, 602 5, 207, 582	
3.00	03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT	0	0			0 0 0	33.
0.00 1.00	04000 SUBPROVI DER – I PF 04100 SUBPROVI DER – I RF	1, 881, 491 0	661, 025 0	(2 91, 181 0 0	2, 695, 929 0	40. 41.
1.00	04300 NURSERY 04400 SKI LLED NURSI NG FACI LI TY 04500 NURSI NG FACI LI TY	751, 867 0 0	191, 600 0 0		28, 415 0 0 0 0	971, 882 0 0	44.
	04600 OTHER LONG TERM CARE	0	0	(0 0	0	
	ANCI LLARY SERVICE COST CENTERS	0 550 170	2 405 225	2 042 10	445.005	14 425 (01	
. 00	05000 OPERATING ROOM 05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	8, 552, 172 0 1, 348, 195	2, 495, 335 0 342, 863		9 445, 895 0 0 50, 953	14, 435, 601 0 1, 742, 011	51
. 00 . 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	92, 138 4, 660, 280	8, 095 920, 115	66, 542 1, 965, 553	2 2, 581 3 234, 967	169, 356 7, 780, 915	53 54
. 00 . 01 . 00	05401 FSED RADI OLOGY - DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C 05501 WOODLAND CANCER CARE CTR 05600 RADI OI SOTOPE 05700 CT SCAN	1, 920, 327 1, 199, 477 416, 266 0	0 151, 032 93, 348 0 0			2, 289, 536 1, 770, 395 532, 903 0 0	55 55 56
. 00 . 00 . 00 . 01	05800 MRI 05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY 06001 FS ED LAB	0 1, 478, 413 8, 238, 922 1, 599, 216	0 246, 369 385, 606 0		0 1 65, 805 1 306	0 2, 693, 318 8, 680, 145 1, 599, 216	58 59 60 60
. 00 . 00 . 01	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06300 BLOOD STORING, PROCESSING & TRANS. 06301 FS ED BLOOD BANK		0 18, 226 0	(0 0 18, 226 0	62 63 63
. 00 . 00 . 00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0 1, 697, 064 3, 467, 709 0	0 92, 793 68, 924 0		6 61, 243 0 0	0 2, 007, 232 3, 635, 942 0	65 66 67
00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	1, 393, 021 0 6, 003, 003	413, 592 0	259, 06 ⁻	0 1 67, 265 0 0	0 2, 132, 939 0 6, 003, 003	69 70
. 00 . 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	6, 003, 003 16, 628, 068 18, 855, 515 0				6, 003, 003 16, 628, 068 18, 855, 515 0	72 73
. 00 . 00	07500 ASC (NON-DISTINCT PART) 03020 CLINIC 07700 ALLOGENEIC STEM CELL ACQUISITION	0 559, 533 0	0		0 0 0 20, 442 0 0	0 0 579, 975 0	75 76
	OUTPATIENT SERVICE COST CENTERS			````		0	1 . (

	In Lie	u of Form CMS-2552-10
15	Peri od:	Worksheet B Part I Date/Time Prepared:
	From 01/01/2021	Part I
	To 12/31/2021	Date/Time Prepared:
	1	E /2/ /2022 11. 22 cm

				J 12/31/2021	5/26/2022 11:	
		CAPI TAL REL	ATED COSTS			
Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Subtotal	
	for Cost			BENEFI TS		
	Allocation			DEPARTMENT		
	(from Wkst A					
	col. 7)					
	0	1.00	2.00	4.00	4A	
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	-	0	0	89.00
90. 00 09000 CLINIC	0	0	Ű	0	0	90.00
90. 03 09003 I NFUSI ON OP SERVI CES	1, 007, 730	148, 627		29, 347	1, 226, 635	90. 03
91. 00 09100 EMERGENCY	5, 380, 060	871, 452		281, 709	6, 764, 384	91.00
91.01 09101 FREE STANDING EMERGENCY DEPT	2, 209, 166	989, 040	253, 685	93, 296	3, 545, 187	91.01
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
OTHER REIMBURSABLE COST CENTERS			· · · · · · · · · · · · · · · · · · ·			
94.00 09400 HOME PROGRAM DI ALYSI S	0	0	-	0	0	94.00
95. 00 09500 AMBULANCE SERVICES	0	0		0	0	95.00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0	0	96.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
99. 00 09900 CMHC	0	0	Ű	0	0	99.00
99. 10 09910 CORF	0	0	0	0	0	99.10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0		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		105.00
106. 00 10600 HEART ACQUI SI TI ON	0	0		0		106.00
107. 00 10700 LI VER ACQUI SI TI ON 108. 00 10800 LUNG ACQUI SI TI ON	0	0	-	0		107.00 108.00
109. 00 10900 PANCREAS ACQUISITION	0	0	0	0		
110. 00 110900 PANCREAS ACQUISTITION 110. 00 11000 I NTESTI NAL ACQUI SI TI ON	0	0	0	0		109. 00 110. 00
111. 00 11100 I SLET ACQUI SI TI ON	0	0	0	0		111.00
113. 00 11300 INTEREST EXPENSE	0	0	0	0	0	113.00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
115. 00/11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	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)	204, 426, 693	20, 027, 022	-	4, 934, 815	204, 338, 153	
NONREI MBURSABLE COST CENTERS	204, 420, 075	20,027,022	13,402,133	4, 754, 015	204, 330, 133	110.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	43, 519	0	0	0	43, 519	190 00
191. 00 19100 RESEARCH	10, 017	0		0		191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	-393	0		6, 293		192.00
193. 00 19300 NONPALD WORKERS	0,0	0	0	0,2,0		193.00
194.00 07950 BEACON JOINT VENTURE	0	0	0	0		194.00
194. 01 07951 WORKI NG WELL	657,005	0	45, 498	27, 621	730, 124	
194. 03 07953 MED WATCHER	001,000	0	0	0		194.03
194. 10 07960 DUNELAND FI TNESS CTR	0	0	0	0		194, 10
194.11 07961 OMNI HEALTH & FITNESS CHESTERTOWN	0	0	0	0	0	194.11
194.16 07966 PHYSICIAN PRACTICE MD WISW	64, 842	0	0	3, 614	68, 456	
194. 19 07969 HEALTH PARTNERS	0	0	0	0	0	194.19
194.2007970 CENTER OF HOPE	42, 416	0	2, 117	3, 397	47, 930	194. 20
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)	205, 234, 082	20, 027, 022	13, 449, 768	4, 975, 740	205, 234, 082	202.00
	·		·	·		

IST A	Financial Systems I ALLOCATION - GENERAL SERVICE COSTS	FRANCI SCAN HEALTH	Provi der CC	CN: 15-0015 P F	eriod: rom 01/01/2021 o 12/31/2021	Worksheet B Part I Date/Time Pre 5/26/2022 11:	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	
00	00100 CAP REL COSTS-BLDG & FIXT						1.0
00	00200 CAP REL COSTS-MVBLE EQUIP						2.0
00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.0
00	00500 ADMINISTRATIVE & GENERAL	29, 680, 672					5.0
00	00600 MAINTENANCE & REPAIRS	0	0				6.0
00	00700 OPERATION OF PLANT	2,880,464	0				7.0
00	00800 LAUNDRY & LINEN SERVICE	150, 145	0	87, 231	1, 125, 444		8.0
00	00900 HOUSEKEEPI NG 01000 DI ETARY	694, 547	0	1, 073, 133 293, 229		5, 875, 748	
. 00	01100 CAFETERI A	261, 242 415, 038	0	293, 229 570, 815		91, 854 178, 809	
. 00	01300 NURSI NG ADMI NI STRATI ON	716, 304	0			42, 420	
. 00	01400 CENTRAL SERVICES & SUPPLY	306, 877	0	1, 056, 482		330, 944	
. 00	01500 PHARMACY	836, 710	0	380, 775		119, 278	
. 00	01600 MEDI CAL RECORDS & LI BRARY	274, 540	0	42, 764		13, 396	
. 00	01700 SOCIAL SERVICE	0	0	0		0	
. 00	01080 I NSERVI CE EDUCATI ON	0	0	0	0	0	18.
. 00	01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.
	02000 NURSI NG PROGRAM	0	0	0	0	0	20.
	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	
. 00	02200 I & SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	
. 00	02300 PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.
00	INPATIENT ROUTINE SERVICE COST CENTERS	4 0/2 2/7	~	4 200 024	EE(000	1 074 074	200
0.00	03000 ADULTS & PEDIATRICS	4,063,367	0			1, 374, 871	
. 00	03100 I NTENSI VE CARE UNI T 03200 CORONARY CARE UNI T	880, 441	0	846, 951 0	59, 234 0	265, 308 0	
	03200 CORONARY CARE UNIT	0	0	0	0	0	
. 00	03400 SURGI CAL I NTENSI VE CARE UNI T	0	0	0	0	0	
. 00	04000 SUBPROVI DER – I PF	455, 798	0	901, 321	177, 701	282, 340	
. 00	04100 SUBPROVI DER – I RF	400,770	0	/01, 321	0	0	
. 00	04300 NURSERY	164, 315	0	261, 251	355	81, 837	
. 00	04400 SKILLED NURSING FACILITY	0	0	201,201	0	0 0	
. 00	04500 NURSING FACILITY	0	0	0	0	0	
. 00	04600 OTHER LONG TERM CARE	0	0	0	0	0	
	ANCILLARY SERVICE COST CENTERS						
. 00	05000 OPERATING ROOM	2, 440, 613	0	3, 402, 439	62, 787	1, 065, 818	50.
. 00	05100 RECOVERY ROOM	0	0	-	0	0	
. 00	05200 DELIVERY ROOM & LABOR ROOM	294, 520	0	467, 501	0	146, 445	
. 00	05300 ANESTHESI OLOGY	28, 633	0			3, 458	
. 00	05400 RADI OLOGY-DI AGNOSTI C	1, 315, 512	0	1, 254, 596	47, 624	393, 003	
. 01	05401 FSED RADIOLOGY - DIAGNOSTIC	387,090	0	0	0	0	
. 00	05500 RADI OLOGY-THERAPEUTI C	299, 319	0	205, 935		64, 509	
. 01	05501 WOODLAND CANCER CARE CTR	90, 097	0	127, 282	11, 847		
. 00	05600 RADI OI SOTOPE	0	0	0	0	0	
. 00 . 00	05700 CT SCAN 05800 MRI	0	0	0	0	0	
. 00	05900 CARDI AC CATHETERI ZATI ON	455, 357	0	335, 930	-	105, 230	
. 00	06000 LABORATORY	1, 467, 543	0	525, 781	0	164, 701	
. 00	06001 FS ED LAB	270, 378	0	525, 761	-	0	
. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	210, 370	0	0	0	0	61.
. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	n	n	0	
	06300 BLOOD STORING, PROCESSING & TRANS.	3, 081	0	24, 851	0	7, 785	
. 01	06301 FS ED BLOOD BANK	0	0	0	0	0	
. 00	06400 I NTRAVENOUS THERAPY	0	0	0	0	0	
. 00	06500 RESPI RATORY THERAPY	339, 361	0	126, 526	0	39, 634	
. 00	06600 PHYSI CAL THERAPY	614, 725	0	93, 980		29, 439	66.
. 00	06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	
. 00	06800 SPEECH PATHOLOGY	0	0	0	0	0	
	06900 ELECTROCARDI OLOGY	360, 614	0	563, 940	5, 923	176, 655	
	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	
	07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	1,014,922	0	0	0	0	
. 00	07200 I MPL. DEV. CHARGED TO PATI ENTS	2,811,291	0	0	0	0	
. 00	07300 DRUGS CHARGED TO PATIENTS	3, 187, 883	0	0	0	0	
. 00	07400 RENAL DI ALYSI S	0	0	0	0	0	
. 00	07500 ASC (NON-DI STINCT PART)	0	0	0	0	0	
. 00		98, 056	0	0	0	0	
. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.
00			-	-			1
	08800 RURAL HEALTH CLINIC	0	0		-	0	
. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	
00	09000 CLI NI C	0	0	0	0	0	
. 00			0	202, 655	355	63, 482	90.
. 00 . 03 . 00	09003 I NFUSI ON OP SERVI CES 09100 EMERGENCY	207, 386 1, 143, 648	0	1, 188, 242			

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FRANCISCAN HEALTH MICHIGAN CITY

In Lieu of Form CMS-2552-10

learth Financial Systems FR	ANCI SCAN REALTH	MICHIGAN CIT		III LIE	U OI FOIII CM3-2	2002-1
COST ALLOCATI ON - GENERAL SERVI CE COSTS		Provider CO	CN: 15-0015 P F T	eriod: rom 01/01/2021 o 12/31/2021	Worksheet B Part I Date/Time Pre 5/26/2022 11:2	pared: 23 am
Cost Center Description	ADMI NI STRATI VE	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	25 am
	& GENERAL	REPAI RS	PLANT	LINEN SERVICE	HOUSEREEFING	
	5.00	6.00	7.00	8.00	9.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS	II.					1 / 2 / 0 /
24. 00 09400 HOME PROGRAM DI ALYSI S	0	0	0	0	0	94.00
25. 00 09500 AMBULANCE SERVICES	0	0	0	0	0	
26.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	
07. 00 097000 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	
28.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	
	0	0	0	0	-	
29.00 09900 CMHC	0	0	0	0	0	1 / / . 0
99. 10 09910 CORF	0	0	0	0	0	
00.00 10000 I &R SERVICES-NOT APPRVD PRGM	0	0	0	0		100. 00
01.00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
05.00 10500 KI DNEY ACQUI SI TI ON	0	0	0	0	0	105.00
06.00 10600 HEART ACQUI SI TI ON	0	0	0	0	0	106.00
07.00 10700 LIVER ACQUISITION	0	0	0	0	0	107.0
08.00 10800 LUNG ACQUISITION	0	0	0	0	0	108.00
09.00 10900 PANCREAS ACQUISITION	0	0	0	0	0	109.00
10.00 11000 INTESTINAL ACQUISITION	o	0	0	0	0	110.00
11. 00 11100 I SLET ACQUI SI TI ON	0	0	0	0		111.00
13.00 11300 INTEREST EXPENSE			-	-	-	113.00
14. 00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
15. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	0		115.00
16. 00 11600 H0SPI CE	0	0	0	0		116.00
18.00 SUBTOTALS (SUM OF LINES 1 through 117)	29, 529, 198	0	19, 917, 676	1, 125, 444		
NONREI MBURSABLE COST CENTERS	27, 327, 170	0	17, 717, 070	1, 125, 444	5, 875, 748	1110.00
90. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	7, 358	0	0	0	0	190. 00
91. 00 19100 RESEARCH	7,356	0	0	0		190.00
	-	0	0	0		
92. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	998	0	0	0		192.0
93. 00 19300 NONPALD WORKERS	0	0	0	0		193.0
94.00 07950 BEACON JOINT VENTURE	0	0	0	0		194. 0
94.01 07951 WORKING WELL	123, 441	0	0	0		194. 0
94. 03 07953 MED WATCHER	0	0	0	0	0	194.0
94.1007960 DUNELAND FITNESS CTR	0	0	0	0	0	194.10
94.11079610MNI HEALTH & FITNESS CHESTERTOWN	0	0	0	0	0	194. 1 ⁻
94.1607966 PHYSICIAN PRACTICE MD WISW	11, 574	0	0	0	0	194.1
94. 19 07969 HEALTH PARTNERS	0	0	0	0	0	194.1
94. 20 07970 CENTER OF HOPE	8, 103	0	0	0	0	194. 2
200.00 Cross Foot Adjustments			_	-		200. 0
201.00 Negative Cost Centers	0	0	0	0	0	201.0
		0	U			
202.00 TOTAL (sum lines 118 through 201)	29, 680, 672	0	19, 917, 676	1, 125, 444	5, 875, 748	1202 0

	Financial Systems FR	ANCI SCAN HEALTH		CN: 15-0015 Pe	eri od:	u of Form CMS-2 Worksheet B	2552-10
				Fr Tc	com 01/01/2021 0 12/31/2021	Part I Date/Time Pre	pared:
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	5/26/2022 11: PHARMACY	23 am
		10.00	11.00	13.00	14.00	15.00	
1 00	GENERAL SERVICE COST CENTERS	1					1 00
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ 20.\ 00\\ 21.\ 00\\ 22.\ 00\\ 23.\ 00\\ \end{array}$	00100CAP REL COSTS-BLDG & FIXT00200CAP REL COSTS-MVBLE EQUI P00400EMPLOYEE BENEFITS DEPARTMENT00500ADMI NI STRATI VE & GENERAL00600MAI NTENANCE & REPAI RS00700OPERATI ON OF PLANT00800LAUNDRY & LI NEN SERVI CE00900HOUSEKEEPI NG01000DI ETARY01100CAFETERI A01300NURSI NG ADMI NI STRATI ON01400CENTRAL SERVI CES & SUPPLY01500PHARMACY01600MEDI CAL RECORDS & LI BRARY01700SOCI AL SERVI CE01080I NSERVI CE EDUCATI ON01900NONPHYSI CI AN ANESTHETI STS02000NURSI NG PROGRAM02100I &R SERVI CES-SALARY & FRI NGES APPRV02300PARAMED ED PRGM- (SPECI FY)	2, 191, 976 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	3, 619, 503 170, 118 27, 307 168, 923 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	5, 301, 017 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	3, 536, 711 20, 270 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	6, 474, 883 0 0 0 0 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 15.\ 00\\ 15.\ 00\\ 15.\ 00\\ 15.\ 00\\ 15.\ 00\\ 15.\ 00\\ 15.\ 00\\ 25.\ 00\\ 21.\ 00\\ 22.\ 00\\ 23.\ 00\\ 23.\ 00\\ \end{array}$
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	1 641 901	1 047 220	2 149 422	145 500	0	20.00
30. 00 31. 00 32. 00 33. 00 34. 00 40. 00 41. 00 43. 00 44. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT 03400 SUBGICAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF 04100 SUBPROVIDER - IRF 04300 NURSERY 04400 SKILLED NURSING FACILITY	1, 641, 891 311, 571 0 0 238, 514 0 0	1, 047, 239 232, 082 C C 119, 925 C 33, 820 C	2 724, 868 0 0 0 0 6 307, 565 0 0 105, 632 0 0	165, 588 57, 372 0 0 1, 296 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 46.00	04500 NURSING FACILITY 04600 OTHER LONG TERM CARE	0	C	-	0	0	45.00 46.00
40.00	ANCILLARY SERVICE COST CENTERS	0			Q	0	40.00
50.00 51.00 52.00 53.00 54.00 54.01	05000 OPERATI NG ROOM 05100 RECOVERY ROOM 05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05401 FSED RADI OLOGY - DI AGNOSTI C		555, 707 C 60, 47C 6, 035 295, 062 97, 279	0 0 188, 869 5 0 2 0	2, 345, 607 0 0 109, 847 9, 364	0 0 0 0 0 0	50.00 51.00 52.00 53.00 54.00 54.01
55.00 55.01 56.00 57.00	05500 RADI OLOGY-THERAPEUTI C 05501 WOODLAND CANCER CARE CTR 05600 RADI OI SOTOPE 05700 CT SCAN		39, 915 25, 335 C	5 O	57, 497 8, 601 0	0 0 0 0	55.00 55.01 56.00 57.00
58.00 59.00 60.00 60.01 61.00 62.00	05800 MRI 05900 CARDIAC CATHETERIZATION 06000 LABORATORY 06001 FS ED LAB 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL		59, 036 C C C		0 526, 658 70, 133 110 0	0 0 0 0	58.00 59.00 60.00 60.01 61.00 62.00
63.00 63.01 64.00 65.00 66.00	06300 BLOOD STORI NG, PROCESSI NG & TRANS. 06301 FS ED BLOOD BANK 06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY		C C 94, 590 66, 506		6, 432 0 30, 672 5, 414	0 0 0 0 0	63.00 63.01 64.00 65.00 66.00
67.00 68.00 69.00 70.00 71.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT		C C 81, 444 C C C	0	0 0 6, 224 0 0	0 0 0 0 0	67.00 68.00 69.00 70.00 71.00
74.00	07200 MPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART) 03020 CLINIC 07700 ALLOGENEIC STEM CELL ACQUISITION	0 0 0 0 0			0 0 0 0 0 0	0 6, 474, 883 0 0 0 0	72.00 73.00 74.00 75.00 76.00 77.00
	OUTPATI ENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	C C C		0	0	88.00 89.00
90.00 90.03 91.00	09000 CLINIC 09003 INFUSION OP SERVICES 09100 EMERGENCY	0 0 0	0 33, 044 314, 841		0 8, 531 91, 400	0 0 0	90.00 90.03 91.00

Health Financial Systems FRA	ANCISCAN HEALTH	MICHIGAN CITY	Y	In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider C	Fi Ti		Worksheet B Part I Date/Time Pre 5/26/2022 11:	
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	
91.01 09101 FREE STANDING EMERGENCY DEPT	0	90, 825	283, 676	14, 152	0	
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART						92.00
OTHER REIMBURSABLE COST CENTERS						1
94.00 09400 HOME PROGRAM DI ALYSI S	0	0	0	0	0	
95. 00 09500 AMBULANCE SERVI CES	0	0	0	0	0	95.00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0	0	0 0	0	0	96.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	1 /0.00
99. 00 09900 CMHC	0	0	0 0	0	0	
99. 10 09910 CORF	0	0	0 0	0	0	1 / / / / 0
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	0	0	0	0		100.00
101.00 10100 HOME HEALTH AGENCY	0	0	00	0	0	101.00
SPECIAL PURPOSE COST CENTERS	-		-			
105.00 10500 KI DNEY ACQUI SI TI ON	0	0		0		105.00
106.00 10600 HEART ACQUI SI TI ON	0	0	0	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	0	111.00
113.00 11300 INTEREST EXPENSE						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	0	0		115.00
116.00 11600 HOSPI CE						116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	2, 191, 976	3, 619, 503	5, 194, 825	3, 535, 168	6, 474, 883	118.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0		190.00
191. 00 19100 RESEARCH 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	499		191.00
193. 00 19300 NONPALD WORKERS	0	0	0	499		192.00
194. 00 07950 BEACON JOINT VENTURE	0	0	0	0		193.00
194. 01 07951 BEACON SOLAT VENTORE	0	0	106, 192	1, 044		194.00
194. 03 07953 MED WATCHER	0	0	100, 192	1, 044		194.01
194. 10 07960 DUNELAND FI TNESS CTR	0	0	0	0		194.03
194. 11 07961 OMNI HEALTH & FITNESS CHESTERTOWN	0	0		0		194.10
194. 16 07966 PHYSI CI AN PRACTI CE MD WI SW	0	0		0		194.11
194. 19 07969 HEALTH PARTNERS	0	0		0		194.10
194. 20 07970 CENTER OF HOPE	0	0		0		194. 19
200.00 Cross Foot Adjustments	0	0	, U	0	0	200.00
201.00 Negative Cost Centers	0	0	0	0	Ο	200.00
202.00 TOTAL (sum lines 118 through 201)	2, 191, 976	3, 619, 503	5, 301, 017	3, 536, 711	6, 474, 883	
	2, 171, 770	5,017,005	J 5, 501, 017	5, 550, 711	0, 474, 003	202.00

	Financial Systems LOCATION - GENERAL SERVICE COSTS	FRANCI SCAN HEALT	H MICHIGAN CITY Provider Ci	CN: 15-0015 F	Period: From 01/01/2021	u of Form CMS- Worksheet B Part I	
	Cost Center Description	RECORDS & LI BRARY	SOCI AL SERVI CE	OTHER GENERAL SERVI CE I NSERVI CE EDUCATI ON	NONPHYSI CI AN ANESTHETI STS	Date/Time Pre 5/26/2022 11: NURSI NG PROGRAM	23 am
0	GENERAL SERVICE COST CENTERS	16.00	17.00	18.00	19.00	20.00	
1.00 0 2.00 0 4.00 0 5.00 0 6.00 0 7.00 0 8.00 0 9.00 0 10.00 0 11.00 0 13.00 0 15.00 0 16.00 0 17.00 0 18.00 0 20.00 0 21.00 0 23.00 0	DUNUAL SERVICE COSTS CLINIERS D0100 CAP REL COSTS BLDG & FIXT D0200 CAP REL COSTS MVBLE EQUIP D0400 EMPLOYEE BENEFITS DEPARTMENT D0500 ADMI NI STRATI VE & GENERAL D0500 OPERATION OF PLANT D0800 LAUNDRY & LINEN SERVICE D0900 HOUSEKEEPING D1400 CAFETERIA D1400 CENTRAL SERVICES & SUPPLY D1600 MEDICAL RECORDS & LIBRARY D1600 MEDICAL RECORDS & LIBRARY D1600 NURSING ADMINISTRATION D1400 CENTRAL SERVICE D1600 MEDICAL RECORDS & LIBRARY D1600 NONPHYSICIAN ANESTHETISTS D2000 NONPHYSICIAN ANESTHETISTS D2000 NURSING PROGRAM D2100 I&R SERVICES-SALARY & FRINGES APPRV D2200 I&R SERVICES-OTHER PROG COSTS APPRV D2200 I&R SERVICES-OTHER PROG COST APPRV D2300 PARAMED ED PROM-(SPECIFY) NPATI ENT ROUTINE SERVICE COST CENTERS	1, 954, 534 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				C	$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ 20.\ 00\\ 21.\ 00\\ 22.\ 00\\ 23.\ 00\\ \end{array}$
30.00 0 31.00 0 32.00 0 33.00 0 40.00 0 41.00 0 43.00 0 44.00 0 45.00 0 46.00 0	D3000 ADULTS & PEDIATRICS D3100 INTENSIVE CARE UNIT D3200 CORONARY CARE UNIT D3200 BURN INTENSIVE CARE UNIT D3400 SURGICAL INTENSIVE CARE UNIT D4000 SUBPROVIDER - IPF D4100 SUBPROVIDER - IRF D4300 NURSERY D4400 SKILLED NURSING FACILITY D4400 SKILLED NURSING FACILITY D4400 SKILLED NURSING FACILITY	143, 922 31, 662 0 0 0 11, 969 0 3, 936 0 0 0 0 0 0					31.00 32.00 33.00 34.00 40.00 41.00 43.00 44.00 45.00
50.00 (51.00) 51.00 (52.00) 52.00 (53.00) 54.01 (55.00) 55.01 (55.00) 55.01 (55.00) 56.00 (55.00) 57.00 (59.00) 60.00 (60.00) 60.01 (61.00) 61.00 (63.00) 63.00 (63.00) 63.00 (63.00) 64.00 (65.00) 65.00 (66.00) 67.00 (67.00) 68.00 (67.00) 67.00 (71.00) 71.00 (71.00) 71.00 (71.00) 75.00 (77.00) 77.00 (77.00) 77.0	ANCILLARY SERVICE COST CENTERS D5000 OPERATING ROOM D5100 RECOVERY ROOM D5200 DELIVERY ROOM & LABOR ROOM D5300 ANESTHESIOLOGY D5400 RADIOLOGY-DIAGNOSTIC D5401 FSED RADIOLOGY - DIAGNOSTIC D5501 FSED RADIOLOGY - DIAGNOSTIC D5501 WODLAND CANCER CARE CTR D5500 RADIOLOGY-THERAPEUTIC D5501 WODLAND CANCER CARE CTR D5500 CARDIOLOGY-THERAPEUTIC D5500 CARDIOLOGY-THERAPEUTIC D5500 CARDIOLOGY D5600 RADIOLOGY-THERAPEUTIC D5600 RADIOLOGY-THERAPEUTIC D5600 CARDIAC CATHETERIZATION D6000 LABORATORY D6001 FS ED LAB D6100 PBP CLINICAL LAB SERVICES-PRGM ONLY D6200 WHOLE BLOOD & PACKED RED BLOOD CELL D6300 BLOOD STORING, PROCESSING & TRANS. D6400 INTRAVENOUS THERAPY D6400 INTRAVENOUS THERAPY D6400 PHYSICAL THERAPY D6400 SPEECH PATHOLOGY D6400 SPEECH PATHOLOGY D6400 SPEECH PATHOLOGY D6400 ELECTROCARDIOLOGY D6400 ELECTROCARDIOLOGY D7000 ELECTROCARDIOLOGY D7000 ELECTROCARDIOLOGY D7100 MEDICAL SUPPLIES CHARGED TO PATIENT D7200 IMPL. DEV. CHARGED TO PATIENTS D7300 DRUGS CHARGED TO PATIENTS D7300 ASC (NON-DISTINCT PART) D3020 CLINIC D7700 ALLOGENEIC STEM CELL ACOUISITION	311, 180 0 7, 058 19, 855 246, 312 54, 402 36, 996 8, 305 0 0 68, 951 191, 739 28, 529 0 3, 018 43 0 39, 342 40, 709 0 63, 196 73, 006 72, 860 266, 956 0 0 0					51.00 52.00 53.00 54.01 55.00 55.01 55.01 55.00 57.00 57.00 58.00 59.00 60.01 61.00 62.00 63.01 64.00 65.00 67.00 68.00 67.00 67.00 67.00 70.00 71.00 72.00 73.00 74.00 75.00
88.00 89.00	DUTPATIENT SERVICE COST CENTERS D8800 RURAL HEALTH CLINIC D8900 FEDERALLY QUALIFIED HEALTH CENTER D9000 CLINIC		000000000000000000000000000000000000000			0 0 0	89.00

91.00 09100 EMERGENCY 181, 411 0 0 91.01 09101 FREE STANDING EMERGENCY DEPT 39, 230 0 0 0 92.00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART 39, 230 0 0 0 0THER REI MBURSABLE COST CENTERS 0 0 0 0 0 94.00 09400 HOME PROGRAM DI ALYSI S 0 0 0 0 95.00 09500 AMBULANCE SERVI CES 0 0 0 0 96.00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 97.00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 0 98.00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 99.00 09900 CMHC 0 0 0 0 0 99.10 09910 CORF 0 0 0 0 0 0 100.00 1 AR SERVI CES-NOT APPRVD PRGM 0 0 0 0	
Cost Center Description MEDICAL RECORDS & LIBRARY SOCIAL SERVICE NONPHYSICIAN ANESTHETISTS NURSING PROGRAM 90.03 09003 INFUSION OP SERVICES 9,947 0 0 0 0 91.00 09100 EMERGENCY 181,411 0 0 0 0 0 92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART 181,411 0 0 0 0 0 94.00 O9400 HOME PROGRAM DIALYSIS 0 0 0 0 0 0 95.00 09500 AMBULANCE SERVICES 0 0 0 0 0 0 96.00 09500 DIRABLE MEDICAL EQUIP-RENTED 0 0 0 0 0 0 97.00 09500 MBULANCE SERVICES 0	
90.03 09003 INFUSION OP SERVICES 9,947 0 0 0 91.00 09100 EMERGENCY 181,411 0 0 0 91.01 09101 FREE STANDING EMERGENCY DEPT 39,230 0 0 0 92.00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART 39,230 0 0 0 0THER REIMBURSABLE COST CENTERS 0 0 0 0 0 94.00 09400 HOME PROGRAM DI ALYSI S 0 0 0 0 0 95.00 09500 AMBULANCE SERVI CES 0 0 0 0 0 96.00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 0 97.00 09700 DURABLE MEDI CAL EQUI P-SOLD 0	
91.00 09100 EMERGENCY 181, 411 0 0 0 91.01 09101 FREE STANDING EMERGENCY DEPT 39, 230 0 0 0 92.00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART 39, 230 0 0 0 0THER REI MBURSABLE COST CENTERS 0 0 0 0 0 94.00 09400 HOME PROGRAM DI ALYSI S 0 0 0 0 95.00 09500 AMBULANCE SERVI CES 0 0 0 0 96.00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 0 97.00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 0 0 98.00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 0 99.10 09910 CORF 0 0 0 0 0 99.10 09910 CORF 0 0 0 0 0 0 100.00 10000 I & K SERVI CES-NOT APPRVD PRGM 0 </td <td></td>	
91.01 09101 FREE STANDING EMERGENCY DEPT 39, 230 0 0 0 92.00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART 39, 230 0 0 0 0THER REI MBURSABLE COST CENTERS 0 0 0 0 94.00 09400 HOME PROGRAM DI ALYSI S 0 0 0 0 95.00 09500 AMBULANCE SERVI CES 0 0 0 0 96.00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 97.00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 0 98.00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 99.00 09900 CMHC 0 0 0 0 0 99.10 09910 COFF 0 0 0 0 0 0 100.00 10000 I&& SERVI CES-NOT APPRVD PRGM 0 0 0 0 0 0 1010.01 HOME HEALTH AGENCY 0	90.03
92.00 O9200 OBSERVATI ON BEDS (NON-DI STINCT PART O O OTHER REI MBURSABLE COST CENTERS 0 <	91.00
OTHER REI MBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DI ALYSI S O	91.01
94. 00 09400 HOME PROGRAM DI ALYSI S 0 0 0 95. 00 09500 AMBULANCE SERVI CES 0 0 0 0 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 0 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 0 98. 00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 99. 00 09900 CMHC 0 0 0 0 0 99. 10 09910 CORF 0 0 0 0 0 100.0 10000 I & R SERVI CES-NOT APPRVD PRGM 0 0 0 0 0 101.00 HOME HEALTH AGENCY 0 0 0 0 0 0 101.00 HOME HEALTH AGENCY 0 0 0 0 0 0 105.00 10500 KI DNEY ACQUI SI TI ON 0 0	92.00
95.00 09500 AMBULANCE SERVICES 0 </td <td></td>	
96.00 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 97.00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 0 98.00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 99.00 09900 CMHC 0 0 0 0 99.10 09910 CORF 0 0 0 0 100.00 10000 I & SERVI CES-NOT APPRVD PRGM 0 0 0 0 101.00 HEALTH AGENCY 0 0 0 0 0 105.00 10500 K I DNEY ACQUI SI TI ON 0 0 0 0	94.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD 0	95.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS 0	96.00
99.00 09900 CMHC 0 0 0 0 99.10 09910 CORF 0 0 0 0 0 100.00 10000 I &R SERVICES-NOT APPRVD PRGM 0 0 0 0 0 101.00 10100 HOME HEALTH AGENCY 0	97.00
99.10 09910 CORF 0 0 0 0 100.00 1 & R SERVICES-NOT APPRVD PRGM 0<	98.00
100.00 1 & R SERVICES-NOT APPRVD PRGM 0 0 0 0 0 101.00 10100 HOME HEALTH AGENCY 0	99.00
101.00 HOME HEALTH AGENCY 0	100.00
SPECIAL PURPOSE COST CENTERS 105.00 10500 KI DNEY ACQUI SI TI ON 0 0 0 0	100.00
105. 00 10500 KI DNEY ACQUI SI TI ON 0 0 0	
	105.00
	105.00
107.00 10700 LIVER ACQUISITION 0 0 0	107.00
	108.00
	109.00
	110.00
	111.00
113.00 11300 I NTEREST EXPENSE	113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF	114.00
	115.00
	116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) 1,954,534 0 0 0	118.00
NONREI MBURSABLE COST CENTERS	
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0	190.00
	191.00
	192.00
	193.00
	194.00
	194.01
	194.03
	194.10
	194.11
	194.16
	194.19
	194.20
	200.00
	1201 00
202.00 TOTAL (sum lines 118 through 201) 1,954,534 0 0 0	201.00

	n Financial Systems Fi ALLOCATION - GENERAL SERVICE COSTS		Provider C	MICHIGAN CITY Provider CCN: 15-0015		eu of Form CMS-2552- Worksheet B Part I	
					From 01/01/2021 To 12/31/2021	Date/Time Pre 5/26/2022 11:	
		INTERNS &	RESI DENTS			1 37 207 2022 11.	
	Cost Center Description	SERVI CES-SALAR Y & FRI NGES APPRV	SERVI CES-OTHER PRGM COSTS APPRV	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
	GENERAL SERVICE COST CENTERS	21.00	22.00	23.00	24.00	25.00	
1.00 2.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 13.00 14.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUI P 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINI STRATI VE & GENERAL 00600 MAI NTENANCE & REPAI RS 00700 OPERATI ON OF PLANT 00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG 01000 DI ETARY 01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON						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 17.00 18.00 20.00 21.00 22.00 23.00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 01080 INSERVICE EDUCATION 01900 NONPHYSICIAN ANESTHETISTS 02000 NURSING PROGRAM 02100 I&R SERVICES-SALARY & FRINGES APPRV 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 02300 PARAMED ED PRGM-(SPECIFY) INPATIENT ROUTINE SERVICE COST CENTERS	0	0		0		15.00 16.00 17.00 18.00 20.00 21.00 22.00 23.00
30. 00 31. 00 32. 00 33. 00 34. 00 40. 00 41. 00 43. 00 44. 00 45. 00 46. 00	03100 INTENSIVE CARE UNIT 03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT 03400 SUBGI CAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF 04100 SUBPROVIDER - IRF 04300 NURSERY 04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY 04600 OTHER LONG TERM CARE				0 39, 584, 948 0 8, 617, 071 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 5, 192, 358 0 1, 623, 028 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0	31.00 32.00 33.00 34.00 40.00 41.00 43.00 44.00 45.00
53. 00 54. 01 55. 01 55. 01 55. 01 55. 00 57. 00 58. 00 59. 00 60. 01 61. 00 62. 00 63. 01 64. 00 65. 00 66. 00 66. 00 66. 00 67. 00 68. 00 71. 00 72. 00 73. 00 74. 00 75. 00 77. 00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05401 FSED RADI OLOGY - DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C 05501 WOODLAND CANCER CARE CTR 05600 RADI OI SOTOPE 05700 CT SCAN 05800 MRI 05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY 06001 FS ED LAB 06100 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06600 PHYSI CAL THERAPY 06600 SPEECH PATHOLOGY 06600 SPEECH PATHOLOGY 06600 SPEECH PATHOLOGY 06600 SPEECH PATHOLOGY 07000 ELECTROCARDI OLOGY 07000 ELECTROCARDI OLOGY 07000 ELECTROCARDI OLOGY 07000 ELECTROCARDI OLOGY 07000 ELECTROCARDI OLOGY 07000 ELECTROCARDI OLOGY 07000 RENAL DI ALYSI S 07500 ASC (NON-DI STI NCT PART) 03020 CLI NI C				0 24, 869, 649 0 0 0 2, 906, 874 0 238, 375 0 11, 442, 871 0 2, 837, 671 0 2, 475, 158 0 923, 372 0 0 0 2, 475, 158 0 923, 372 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 4, 244, 835 0 11, 100, 042 0 1, 898, 233 0 0 0 63, 393 0 0 0 63, 393 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 <		$\begin{array}{c} 51.\ 00\\ 52.\ 00\\ 53.\ 00\\ 54.\ 01\\ 55.\ 01\\ 55.\ 01\\ 55.\ 01\\ 55.\ 01\\ 55.\ 01\\ 55.\ 01\\ 55.\ 01\\ 56.\ 02\\ 59.\ 00\\ 60.\ 01\\ 61.\ 00\\ 62.\ 00\\ 60.\ 01\\ 61.\ 00\\ 62.\ 00\\ 63.\ 01\\ 64.\ 00\\ 65.\ 00\\ 65.\ 00\\ 66.\ 00\\ 67.\ 00\\ 67.\ 00\\ 71.\ 00\\ 72.\ 00\\ 71.\ 00\\ 73.\ 00\\ 74.\ 00\\ 74.\ 00\\ 76.\ $

FRANCISCAN HEALTH MICHIGAN CITY

 AI CHIGAN CITY
 In Lieu of Form CMS-2552-10

 Provider CCN: 15-0015
 Period: From 01/01/2021
 Worksheet B

				From 01/01/2021 To 12/31/2021	Part I Date/Time Pre 5/26/2022 11:	
	INTERNS & R	ESI DENTS			0,20,2022 111	
Cost Center Description	SERVI CES-SALAR SE	ERVI CES-OTHER	PARAMED ED	Subtotal	Intern &	
	Y & FRINGES	PRGM COSTS	PRGM		Residents Cost	
	APPRV	APPRV			& Post	
					Stepdown	
					Adjustments	
	21.00	22.00	23.00	24.00	25.00	
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0	-	89.00
90. 00 09000 CLINIC	0	0		0 0	-	90.00
90. 03 09003 I NFUSI ON OP SERVI CES	0	0		0 1, 855, 241	0	90.03
91. 00 09100 EMERGENCY	0	0		0 11, 157, 961	0	91.00
91.01 09101 FREE STANDING EMERGENCY DEPT	0	0		0 6, 390, 856		91.01
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART					0	92.00
OTHER REIMBURSABLE COST CENTERS						04.00
94. 00 09400 HOME PROGRAM DI ALYSI S	0	0		0 0		94.00
95. 00 09500 AMBULANCE SERVICES	0	0		0 0	-	95.00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0	0		0 0	-	96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0		0 0	0	97.00
98. 00 09850 OTHER REI MBURSABLE COST CENTERS	0	0		0 0	0	98.00
99.00 09900 CMHC	0	0		0 0	0	99.00
99.10 09910 CORF	0	0		0 0	0	99.10
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	0	0		0 0		100.00
101. 00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	0		0 0	0	101.00
105. 00 10500 KIDNEY ACQUISITION	0	0		0 0	0	105.00
106. 00 10600 HEART ACQUISITION	0	0		0 0		105.00
107. 00 10700 LI VER ACQUI SI TI ON	0	0		0 0	-	107.00
108. 00 10800 LUNG ACQUISITION	0	0		0 0		107.00
109. 00 10900 PANCREAS ACQUISITION	0	0		0 0	-	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 I NTEREST EXPENSE	Ŭ	Ŭ		0	Ŭ	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		116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	0		0 204, 078, 944		118.00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 50, 877	0	190.00
191. 00 19100 RESEARCH	0	0		0 0	0	191.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 7, 397	0	192.00
193. 00 19300 NONPALD WORKERS	0	0		0 0	0	193.00
194.0007950 BEACON JOINT VENTURE	0	0		0 0	0	194.00
194.0107951WORKING WELL	0	0		0 960, 801	0	194.01
194.0307953 MED WATCHER	0	0		0 0	0	194.03
194. 10 07960 DUNELAND FI TNESS CTR	0	0		0 0		194.10
194.1107961 OMNI HEALTH & FITNESS CHESTERTOWN	0	0		0 0		194. 11
194.1607966 PHYSICIAN PRACTICE MD WISW	0	0		0 80, 030		194. 16
194.1907969 HEALTH PARTNERS	0	0		0 0		194. 19
194. 20 07970 CENTER OF HOPE	0	0		0 56, 033		194.20
200.00 Cross Foot Adjustments	0	0		0 0		200.00
201.00 Negative Cost Centers	0	0		0 0		201.00
202.00 TOTAL (sum lines 118 through 201)	0	0		0 205, 234, 082	0	202.00

Heal th Financial	Systems		
COST ALLOCATION	- GENERAL	SERVI CE	COSTS

In Lieu of Form CMS-2552-10 Period: Worksheet B From 01/01/2021 Part I To 12/31/2021 Date/Time Prepared:

		-	To 12/31/2021 Date/Time Pr 5/26/2022 11	
	Cost Center Description	Total 26.00		
	GENERAL SERVICE COST CENTERS	20.00		
1.00	00100 CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP			2.00
4.00 5.00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL			4.0
6.00	00600 MAINTENANCE & REPAIRS			6.0
7.00	00700 OPERATION OF PLANT			7.0
8.00	00800 LAUNDRY & LINEN SERVICE			8.00
9.00	00900 HOUSEKEEPI NG			9.00
10.00 11.00				10.00
13.00				13.0
				14.0
15.00	01500 PHARMACY			15.0
				16.0
17.00				17.0
18.00 19.00				18.0
20.00				20.0
21.00				21.0
22.00				22.0
23.00				23.0
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	20 504 040		- 20.0
		39, 584, 948 8, 617, 071		30.0
		0,017,071		32.0
		0		33.0
34.00		0		34.0
		5, 192, 358		40.0
41.00 43.00		1 422 029		41.0
43.00		1, 623, 028		43.0
		0		45.0
46.00		0		46.0
	ANCI LLARY SERVI CE COST CENTERS			
		24, 869, 649		50.00
51.00 52.00		0 2, 906, 874		51.0
53.00		2, 900, 874		53.00
		11, 442, 871		54.0
54.01	05401 FSED RADIOLOGY - DIAGNOSTIC	2, 837, 671		54.0
55.00		2, 475, 158		55.0
55.01 56.00		923, 372		55.0 56.0
		0		57.0
58.00		0		58.0
59.00	05900 CARDI AC CATHETERI ZATI ON	4, 244, 835		59.0
		11, 100, 042		60.0
	06001 FS ED LAB	1, 898, 233		60.0
		0		61.0
		63, 393		63.0
63.01		43		63.0
64.00	06400 I NTRAVENOUS THERAPY	0		64.0
65.00		2, 677, 357		65.0
		4, 522, 255		66.0
67.00 68.00		0		67.0 68.0
		3, 390, 935		69.0
		0		70.0
71.00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	7, 090, 931		71.0
		19, 512, 219		72.0
	07300 DRUGS CHARGED TO PATIENTS	28, 785, 237		73.0
		0		74.0
		678, 031		76.0
		0/0,031		77.0
	OUTPATI ENT SERVICE COST CENTERS			
88.00	08800 RURAL HEALTH CLINIC	0		88. 0
		0		89.0
00 5-	09000 CLINIC	0		90.0
		1 055 3/1		00 0
90.03	09003 INFUSION OP SERVICES	1, 855, 241 11 157 961		
90. 03 91. 00	09003 INFUSION OP SERVICES	1, 855, 241 11, 157, 961 6, 390, 856		90. 03 91. 00 91. 0

DST ALLOCATI ON - GENERAL SERVI CE COSTS		Provider CCN: 15-0015	Peri od: From 01/01/2021 To 12/31/2021	Worksheet B Part I Date/Time Prepart 5/26/2022 11:23
Cost Center Description	Total			
	26.00			
OTHER REIMBURSABLE COST CENTERS				
4. 00 09400 HOME PROGRAM DI ALYSI S	0			94
5. 00 09500 AMBULANCE SERVICES	0			95
5. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0			96
7.00 09700 DURABLE MEDICAL EQUIP-SOLD	0			97
B. 00 09850 OTHER REIMBURSABLE COST CENTERS	0			98
9. 00 09900 CMHC	0			99
9. 10 09910 CORF	o			99
DO. 00 10000 I &R SERVICES-NOT APPRVD PRGM	0			100
D1. 00 10100 HOME HEALTH AGENCY	0			101
SPECIAL PURPOSE COST CENTERS				
D5. 00 10500 KI DNEY ACQUI SI TI ON	0			105
06. 00 10600 HEART ACQUI SI TI ON	0			106
07. 00 10700 LI VER ACQUI SI TI ON	0			107
08. 0010800 LUNG ACQUISITION	0			108
09. 00 10900 PANCREAS ACQUISITION	0			109
	0			
10. 00 11000 INTESTINAL ACQUISITION	0			110
11. 00 11100 I SLET ACQUI SI TI ON	0			111
13. 00 11300 INTEREST EXPENSE				113
14.00 11400 UTI LI ZATI ON REVI EW-SNF	_			114
15.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0			115
16. 00 11600 HOSPI CE	0			116
18.00 SUBTOTALS (SUM OF LINES 1 through 117)	204, 078, 944			118
NONREI MBURSABLE COST CENTERS				
90.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	50, 877			190
91. 00 19100 RESEARCH	0			191
92. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	7, 397			192
93. 00 19300 NONPAI D WORKERS	0			193
94. 00 07950 BEACON JOINT VENTURE	0			194
94. 01 07951 WORKING WELL	960, 801			194
94.0307953 MED WATCHER	0			194
94. 10 07960 DUNELAND FITNESS CTR	o			194
94. 11 07961 OMNI HEALTH & FITNESS CHESTERTOWN	0			194
94. 16 07966 PHYSI CI AN PRACTI CE MD WI SW	80, 030			194
94. 19 07969 HEALTH PARTNERS	0			194
94. 20 07970 CENTER OF HOPE	56,033			194
00.00 Cross Foot Adjustments	0			200
01.00 Negative Cost Centers	0			200
Inegative cost centers	0			201

	Financial Systems F ATION OF CAPITAL RELATED COSTS	RANCI SCAN HEALTH	HICHIGAN CITY Provider C	CN: 15-0015 P	eriod:	u of Form CMS-2 Worksheet B	2552-10
				F	rom 01/01/2021 o 12/31/2021	Part II Date/Time Pre 5/26/2022 11:	
			CAPI TAL REL	ATED COSTS		372072022 11.	
	Cost Center Description	Directly Assigned New Capital	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		Related Costs	1.00	2.00	2A	4.00	
	GENERAL SERVICE COST CENTERS			2.00			
1.00 2.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	102, 507	282, 983	385, 490	385, 490	•
5.00	00500 ADMI NI STRATI VE & GENERAL	0	1, 834, 125	1, 946, 940	3, 781, 065	92, 404	
5.00 7.00	00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT	0	0 3, 482, 847	0 1, 849, 454	0 5, 332, 301	0 16, 608	
3.00	00800 LAUNDRY & LINEN SERVICE	0	63, 975		66, 188	1, 346	•
9.00	00900 HOUSEKEEPI NG	0	787, 031	127, 000		8, 625	
10.00	01000 DI ETARY 01100 CAFETERI A	0	215, 053 418, 634	69, 367 0	284, 420 418, 634	2, 967 5, 774	
13.00	01300 NURSI NG ADMI NI STRATI ON	0	99, 316	-		13, 257	
14.00	01400 CENTRAL SERVICES & SUPPLY	0	774, 819		1, 215, 151	1, 163	•
15.00 16.00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	0	279, 259 31, 363	22, 472	301, 731 31, 363	13, 469 0	1
17.00	01700 SOCIAL SERVICE	0	0	0	0	0	•
18.00	01080 I NSERVI CE EDUCATI ON	0	0	0	0	0	
19.00 20.00	01900 NONPHYSI CI AN ANESTHETI STS 02000 NURSI NG PROGRAM	0	0	0	0	0	
20.00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	•
22.00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	
23.00	02300 PARAMED ED PRGM-(SPECIFY) I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	0	0	0	0	23.00
30. 00	03000 ADULTS & PEDIATRICS	0	3, 218, 900	724, 182	3, 943, 082	77, 865	30.00
31.00	03100 I NTENSI VE CARE UNI T	0	621, 151	198, 967	820, 118	16, 975	31.00
32.00	03200 CORONARY CARE UNIT	0		0	0	0	
33.00 34.00	03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	
40.00	04000 SUBPROVIDER - IPF	0	661, 025	62, 232	723, 257	7,065	
41.00	04100 SUBPROVIDER - IRF	0	0	0	0	0	
43.00 44.00	04300 NURSERY 04400 SKI LLED NURSI NG FACI LI TY	0	191, 600	0	191, 600 0	2, 202 0	
45.00	04500 NURSI NG FACI LI TY	0	Ű	0	0	0	•
46.00	04600 OTHER LONG TERM CARE	0	0	0	0	0	46.00
50.00	ANCI LLARY SERVI CE COST CENTERS	0	2, 495, 335	2, 942, 199	5, 437, 534	34, 548	50.00
51.00	05100 RECOVERY ROOM	0			0	0	1
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	342, 863	0	342, 863	3, 948	•
53.00 54.00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0	8, 095 920, 115			200 18, 205	
54.01	05401 FSED RADIOLOGY - DIAGNOSTIC	0	0	285, 065		6, 520	
55.00	05500 RADI OLOGY-THERAPEUTI C	0	151, 032	378, 974	530, 006	3, 170	
55.01 56.00	05501 WOODLAND CANCER CARE CTR 05600 RADI 0I SOTOPE	0	93, 348	0	93, 348	1, 804 0	1
57.00	05700 CT SCAN	0	0	0	0	0	1
58.00	05800 MRI	0	0	0	0	0	
59.00 60.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0	246, 369 385, 606		1, 149, 100 440, 917	5, 099 24	1
60.01	06001 FS ED LAB	0	0	0	0	0	•
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY				0		61.00
62.00 63.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06300 BLOOD STORING, PROCESSING & TRANS.	0	0 18, 226	0	0 18, 226	0	
63. 01	06301 FS ED BLOOD BANK	0	0	0	0	0	
64.00	06400 I NTRAVENOUS THERAPY	0	0	0	0	0	
65.00 66.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0	92, 793 68, 924	137, 220 38, 066		6, 210 4, 745	
50.00 67.00	06700 OCCUPATI ONAL THERAPY	0	00, 924	0	100, 990	4,745	
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDI OLOGY	0	413, 592	259, 061	672, 653	5, 212	1
70.00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0			0	0	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	•
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	
74.00	07400 RENAL DI ALYSI S 07500 ASC (NON-DI STI NCT PART)				0	0	
76.00	03020 CLINIC	0	0	0	0	1, 584	1
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	1
	OUTPATIENT SERVICE COST CENTERS			0			
38. 00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00

Health Financial Systems FR	ANCISCAN HEALTH	I MICHIGAN CITY	(In Lie	u of Form CMS-:	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CC		Period: From 01/01/2021 To 12/31/2021	Worksheet B Part II Date/Time Pre 5/26/2022 11:	
		CAPI TAL REL	LATED COSTS			
Cost Center Description	Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
	0	1.00	2.00	2A	4.00	
90.00 09000 CLINIC 90.03 09003 INFUSION OP SERVICES 91.00 09100 EMERGENCY 91.01 09101 FREE STANDING EMERGENCY DEPT 92.00 0BSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS	0 0 0	0 148, 627 871, 452 989, 040	40, 93 231, 16	3 1, 102, 615	0 2, 274 21, 827 7, 229	90.00 90.03 91.00 91.01 92.00
94. 00 09400 HOME PROGRAM DI ALYSI S	0	0		0 0	0	94.00
95. 00 09500 AMBULANCE SERVICES 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0 0 0	0 0 0		0 0 0 0 0 0	0 0 0	95.00 96.00 97.00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS 99. 00 09900 CMHC 99. 10 09910 CORF 100. 00 10000 I &R SERVI CES-NOT APPRVD PRGM	0 0 0	0 0 0			0 0 0 0	99.10
101. 00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	0		0 0		101.00
105. 00 10500 KI DNEY ACQUI SI TI ON 106. 00 10600 HEART ACQUI SI TI ON 107. 00 10700 LI VER ACQUI SI TI ON	0 0 0	0 0 0		0 0 0 0 0 0		105. 00 106. 00 107. 00
108.00 10800 LUNG ACQUISITION 109.00 10900 PANCREAS ACQUISITION 110.00 11000 INTESTINAL ACQUISITION	0	0 0 0		0 0 0 0 0 0		108.00 109.00 110.00
111. 00 11100 I SLET ACQUI SI TI ON 113. 00 11300 I NTEREST EXPENSE 114. 00 11400 UTI LI ZATI ON REVI EW-SNF	0	0		0 0	0	111. 00 113. 00 114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 116.00 11600 HOSPICE 118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0 0 0	0 0 20, 027, 022	13, 402, 15	0 0 0 0 3 33, 429, 175		115. 00 116. 00 118. 00
NONREI MBURSABLE COST CENTERS	0	0				100.00
190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 191. 00 19100 RESEARCH 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0 0 0		0 0 0 0 0 0	0	190. 00 191. 00 192. 00
193. 00 19300 NONPALD WORKERS 194. 00 07950 BEACON JOINT VENTURE	0	0 0		0 0 0 0		193. 00 194. 00
194. 01 07951 WORKING WELL 194. 03 07953 MED WATCHER 194. 10 07960 DUNELAND FITNESS CTR	0 0 0	0 0 0	45, 49	8 45, 498 0 0 0 0	0	194. 01 194. 03 194. 10
194.11 07961 OMNI HEALTH & FITNESS CHESTERTOWN 194.16 07966 PHYSICIAN PRACTICE MD WISW 194.19 07969 HEALTH PARTNERS	0 0 0	0 0 0		0 0 0 0 0 0	280	194. 11 194. 16 194. 19
194. 2007970CENTER OF HOPE200. 00Cross Foot Adjustments201. 00Negative Cost Centers	0	0	2, 11	7 2, 117 0 0 0		194. 20 200. 00 201. 00
202.00 TOTAL (sum lines 118 through 201)	0	20, 027, 022	13, 449, 76	8 33, 476, 790	385, 490	202.00

ALLOC	ATION OF CAPITAL RELATED COSTS		Provider CCN		eriod: rom 01/01/2021 o 12/31/2021	Worksheet B Part II Date/Time Pre 5/26/2022 11:	pared:
	Cost Center Description	ADMI NI STRATI VE & GENERAL 5. 00	MAI NTENANCE & REPAI RS 6.00	OPERATION OF PLANT 7.00	LAUNDRY & LINEN SERVICE 8.00	9.00	
	GENERAL SERVICE COST CENTERS	5.00	0.00	7.00	8.00	9.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 5.00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	3, 873, 469					4.00
6.00	00600 MAINTENANCE & REPAIRS	3, 073, 407	0				6.00
7.00	00700 OPERATION OF PLANT	375, 909	0	5, 724, 818			7.00
8.00	00800 LAUNDRY & LINEN SERVICE	19, 594	0	25, 072			8.00
9.00 10.00	00900 HOUSEKEEPI NG 01000 DI ETARY	90, 640	0	308, 444	0	1, 321, 740	
11.00	01100 CAFETERIA	34, 093 54, 164	0	84, 281 164, 066	47	20, 662 40, 223	
13.00	01300 NURSI NG ADMI NI STRATI ON	93, 480	0	38, 923		9, 542	
14.00	01400 CENTRAL SERVICES & SUPPLY	40, 048	0	303, 658	0	74, 445	
15.00	01500 PHARMACY	109, 193	0	109, 444	0	26, 831	
16.00 17.00	01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE	35, 828 0	0	12, 291 0	0	3, 013 0	
18.00	01080 I NSERVI CE EDUCATI ON	0	0	0	0	0	
19.00	01900 NONPHYSICIAN ANESTHETISTS	0	О	0	0	0	19.00
20.00	02000 NURSI NG PROGRAM	0	0	0	0	0	
21.00 22.00	02100 I &R SERVICES-SALARY & FRINGES APPRV 02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	
22.00		0	0	0	-	0	
201.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS						20100
30.00	03000 ADULTS & PEDIATRICS	530, 338	0	1, 261, 514		309, 277	
31.00	03100 I NTENSI VE CARE UNI T	114, 900	0	243, 434	5, 905	59, 681	
32.00 33.00	03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	
40.00	04000 SUBPROVI DER – I PF	59, 483	0	259, 061	17, 716	63, 512	40.00
41.00	04100 SUBPROVIDER - IRF	0	0	0	0	0	
43.00 44.00	04300 NURSERY 04400 SKI LLED NURSI NG FACI LI TY	21, 444	0	75, 090 0		18, 409 0	
45.00	04500 NURSING FACILITY	0	0	0	-	0	
46.00	04600 OTHER LONG TERM CARE	0	0	0	0	0	
	ANCI LLARY SERVICE COST CENTERS	210 507		077.042	()(0	220 754	
50.00 51.00	05000 OPERATING ROOM 05100 RECOVERY ROOM	318, 507 0	0	977, 943 0	6, 260 0	239, 754 0	
52.00	05200 DELIVERY ROOM & LABOR ROOM	38, 436	0	134, 371	0	32, 943	
53.00	05300 ANESTHESI OLOGY	3, 737	0	3, 173		778	
54.00	05400 RADI OLOGY-DI AGNOSTI C	171, 678	0	360, 601	4, 748	88, 405	
54.01 55.00	05401 FSED RADI OLOGY - DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	50, 516 39, 062	0	0 59, 191	0 59	0 14, 511	
55.01	05501 WOODLAND CANCER CARE CTR	11, 758	0	36, 584	1, 181	8, 969	
56.00		0	О	0	0	0	
57.00		0	0	0	0	0	
58.00 59.00	05800 MRI 05900 CARDI AC CATHETERI ZATI ON	59, 425	0	0 96, 554	0 35	0 23, 671	
60.00		191, 519	0	151, 122		37,049	
60. 01	06001 FS ED LAB	35, 285	О	0	0	0	
61.00				0		0	61.00
62.00 63.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06300 BLOOD STORING, PROCESSING & TRANS.	0 402	0	7, 143	0	0 1, 751	
63.01	06301 FS ED BLOOD BANK	0	0	0	0	0	
64.00	06400 I NTRAVENOUS THERAPY	0	0	0	0	0	
65.00		44, 288	0	36, 366		8, 916	
66.00 67.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	80, 223 0	0	27, 012 0		6, 622 0	
68.00		0	0	0	0	0	
69.00	06900 ELECTROCARDI OLOGY	47, 061	0	162, 090	590	39, 738	69.00
70.00		0	0	0	0	0	
71.00 72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	132, 450 366, 882	0	0	0	0	
72.00	07200 TMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	416, 028	0	0	0	0	
74.00		0	0	0	0	0	
75.00	07500 ASC (NON-DI STINCT PART)	0	О	0	0	0	
76.00		12, 797	0	0	-	0	
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	Ó	0	0	0	89.00
90.00		0	0	0	0	0	
90.03 91.00	09003 I NFUSI ON OP SERVI CES 09100 EMERGENCY	27, 064 149, 249	0	58, 248 341, 529		14, 280 83, 730	
					11,011	00,100	1 / 1. 00

LLOCATION OF CAPITAL RELATED COSTS		Provi der	CCN	F	Period: From 01/01/2021 Fo 12/31/2021	Worksheet B Part II Date/Time Pre 5/26/2022 11:	pared: 23 am
Cost Center Description	ADMI NI STRATI VE		&	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
	& GENERAL	REPAI RS		PLANT	LINEN SERVICE	0.00	
	5.00	6.00	_	7.00	8.00	9.00	00.0
2. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART							92.0
0THER 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	
5. 00 09500 AMBOLANCE SERVICES 5. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0			(0	
7. 00 09700 DURABLE MEDICAL EQUIP-RENTED	0			(0	
3. 00 09850 OTHER REIMBURSABLE COST CENTERS	0			(0	
2. 00 09900 CMHC	0		0	(0	0	
7. 10 09910 CORF	0		0	(0	1
00.00 10000 I &R SERVICES-NOT APPRVD PRGM	0		0	(100.0
D1. 00 10100 HOME HEALTH AGENCY	0		0				100.0
SPECIAL PURPOSE COST CENTERS	<u> </u>		<u> </u>			0	101.0
D5. 00 10500 KI DNEY ACQUI SI TI ON	0		0	(0 0	0	105. C
D6. 00 10600 HEART ACQUISITION	0		0				106.0
07. 00 10700 LIVER ACQUISITION	0		0	(107.0
08. 00 10800 LUNG ACQUISITION	0		0	(108.0
09. 00 10900 PANCREAS ACQUISITION	0		0	(109.0
10. 00 11000 I NTESTI NAL ACQUI SI TI ON	0		0	(1110. 0
11. 00 11100 I SLET ACQUI SI TI ON	0		0	(1111. 0
13. 00 11300 I NTEREST EXPENSE	Ŭ		Ĭ			Ű	113.0
14. 00 11400 UTI LI ZATI ON REVIEW-SNF							114. (
15. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0		0	(0	0	115. (
16. 00 11600 HOSPI CE	0		0	(0		116. (
18.00 SUBTOTALS (SUM OF LINES 1 through 117)	3, 853, 702		0	5, 724, 818	112, 200		
NONREI MBURSABLE COST CENTERS						., -= .,	1
90.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	960		0	(0 0	0	190. (
91. 00 19100 RESEARCH	0		0	(0 0	0	191. (
92. 00 19200 PHYSICIANS' PRIVATE OFFICES	130		0	(0 0	0	192. (
93. 00 19300 NONPALD WORKERS	0		0	(0 0	0	193. (
94.0007950 BEACON JOINT VENTURE	0		0	(0 0	0	194. (
94.0107951 WORKING WELL	16, 109		0	(0 0	0	194. (
94.0307953 MED WATCHER	0		0	(0 0	0	194. (
94.1007960 DUNELAND FITNESS CTR	0		0	(0 0	0	194.1
94.1107961 OMNI HEALTH & FITNESS CHESTERTOWN	0		0	(0 0	0	194.1
94.1607966 PHYSICIAN PRACTICE MD WISW	1, 510		0	(0 0	0	194.1
94. 19 07969 HEALTH PARTNERS	0		0	(0	0	194.1
94.2007970 CENTER OF HOPE	1, 058		0	(0 0	0	194.2
00.00 Cross Foot Adjustments							200. (
01.00 Negative Cost Centers	0		0	(0 0	0	201. (
D2.00 TOTAL (sum lines 118 through 201)	3, 873, 469		0	5, 724, 818	3 112, 200	1, 321, 740	202.0

ALLOCA	TION OF CAPITAL RELATED COSTS		Provider C		eriod: rom 01/01/2021 o 12/31/2021	Worksheet B Part II Date/Time Prep	
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	5/26/2022 11:2 PHARMACY	<u>13 ann</u>
		10.00	11.00	13.00	14.00	15.00	
15. 00 16. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	426, 470 0 0 0 0 0	682, 861 32, 095 5, 152 31, 869 0	406, 123 0	1, 639, 617 9, 397 0	601, 934 0 0	$\begin{array}{c} 1. \ 0.0\\ 2. \ 0.0\\ 4. \ 0.0\\ 5. \ 0.0\\ 6. \ 0.0\\ 7. \ 0.0\\ 8. \ 0.0\\ 10. \ 0.0\\ 11. \ 0.0\\ 13. \ 0.0\\ 14. \ 0.0\\ 15. \ 0.0\\ 15. \ 0.0\\ 17. \ 0.0\\ \end{array}$
18.00	01080 JOSTAL SERVICE 01080 INSERVICE EDUCATION 01900 NONPHYSICIAN ANESTHETISTS 02000 NURSING PROGRAM 02100 I&R SERVICES-SALARY & FRINGES APPRV 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 02300 PARAMED ED PRGM-(SPECIFY) INPATIENT ROUTINE SERVICE COST CENTERS				0 0 0 0 0		17.00 18.00 19.00 20.00 21.00 22.00 23.00
30.00	03000 ADULTS & PEDIATRICS	319, 446	197, 575	166, 143	76, 766	0	30.00
 31.00 32.00 33.00 34.00 40.00 	03100 I NTENSI VE CARE UNI T 03200 CORONARY CARE UNI T 03300 BURN I NTENSI VE CARE UNI T 03400 SURGI CAL I NTENSI VE CARE UNI T 04000 SUBPROVI DER - I PF	60, 619 0 0 46, 405	43, 785 0 0 22, 625	0 0 0	26, 598 0 0 0 601		31.00 32.00 33.00 34.00 40.00
40.00	04100 SUBPROVIDER - IRF	40, 405	22, 025	23, 503	0	0	40.00
43.00 44.00 45.00 46.00	04300 NURSERY 04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY 04600 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS	0 0 0	6, 381 0 0	8, 093 0 0	0 0 0	0 0 0 0	43.00 44.00 45.00 46.00
50. 00 51. 00 52. 00	05000 OPERATI NG ROOM 05100 RECOVERY ROOM 05200 DELI VERY ROOM & LABOR ROOM	000000000000000000000000000000000000000	104, 840 0 11, 408	0	1, 087, 419 0 0	0 0	50.00 51.00 52.00
53.00 54.00 54.01 55.00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05401 FSED RADI OLOGY - DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	0 0 0	1, 139 55, 667 18, 353 7, 530	0 0 0	0 50, 925 4, 341 26, 656	0 0 0 0	53.00 54.00 54.01 55.00
55. 01 56. 00 57. 00	05501 WOODLAND CANCER CARE CTR 05600 RADI OI SOTOPE 05700 CT SCAN	0 0 0	4, 780 4, 780 0	6, 062 0 0	3, 988 0	0 0 0	55.0 [°] 56.00 57.00
59. 00 60. 00	05800 MRI 05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY 06001 FS ED LAB	0 0 0	0 11, 138 0 0		0 244, 159 32, 514 51	0 0 0 0	58.00 59.00 60.00 60.0
62.00 63.00 63.01 64.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06300 BLOOD STORING, PROCESSING & TRANS. 06301 FS ED BLOOD BANK 06400 INTRAVENOUS THERAPY 06500 RESPIRATORY THERAPY	0 0 0 0 0	0 0 0 0 17, 845		0 2, 982 0 0 14, 220	0 0 0 0	61.00 62.00 63.00 63.01 64.00 65.00
66.00 67.00 68.00 69.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0 0 0	12, 547 0 0 15, 365	0 0 0	2, 510 0 2, 886	0 0 0	66.00 67.00 68.00 69.00
71.00 72.00 73.00 74.00 75.00 76.00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART) 03020 CLINIC		0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0	0 0 0 0 0 0	0 0	74. 0 75. 0 76. 0
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION OUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	77.00
89.00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC	0 0 0	0 0 0	0 0 0	0 0 0	0 0 0	88.00 89.00 90.00
	09003 I NFUSI ON OP SERVI CES 09100 EMERGENCY	0 0	6, 234 59, 398		3, 955 42, 373	0 0	90. 0 91. 0

Health Financial Systems F	RANCI SCAN HEALTH	MICHIGAN CITY	(In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider C	F	eriod: rom 01/01/2021 o 12/31/2021	Worksheet B Part II Date/Time Pre 5/26/2022 11:	pared:
Cost Center Description	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI ON	SUPPLY	PHARMACY	
	10.00	11.00	13.00	14.00	15.00	
91. 01 09101 FREE STANDING EMERGENCY DEPT	0	17, 135	21, 733	6, 561	0	1
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS						1
94.00 09400 HOME PROGRAM DI ALYSI S	0	0	0	0	0	
95. 00 09500 AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	
99. 00 09900 CMHC	0	0	0	0	0	
99. 10 09910 CORF	0	0	0	0	0	1 / /
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	0	0	0	0		100.00
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						1.05 00
105.00 10500 KI DNEY ACQUI SI TI ON	0	0		-		105.00
106.00 10600 HEART ACQUI SI TI ON	0	0	0	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 ACQUI SI TI ON	0	0	0	0		109.00
110.00 11000 I NTESTI NAL ACQUI SI TI ON	0	0	0	0		110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0	0	0	0	111.00
113.00 11300 I NTEREST EXPENSE						113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	0		115.00
116.00 11600 HOSPI CE	0	0	0	0		116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)) 426, 470	682, 861	397, 987	1, 638, 902	601, 934	118.00
NONREI MBURSABLE COST CENTERS						100.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	-		190.00
	0	0	0	0		191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	231		192.00
193.00 19300 NONPALD WORKERS	0	0	0	0		193.00
194. 00 07950 BEACON JOINT VENTURE	0	0	0	0		194.00
194. 01 07951 WORKI NG WELL	0	0	8, 136	484		194.01
194. 03 07953 MED WATCHER	0	0	0	0		194.03
194. 10 07960 DUNELAND FI TNESS CTR	0	0	0	0		194.10
194. 11 07961 OMNI HEALTH & FITNESS CHESTERTOWN	0	0	0	0		194.11
194. 16 07966 PHYSI CLAN PRACTICE MD WI SW	0	0	0	0		194.16
194. 19 07969 HEALTH PARTNERS	0	0		0		194.19
194. 20 07970 CENTER OF HOPE	0	0	0	0	0	194.20
200.00 Cross Foot Adjustments		~	_		~	200.00
201.00 Negative Cost Centers	426 470	(02.0(1	404 100			201.00
202.00 TOTAL (sum lines 118 through 201)	426, 470	682, 861	406, 123	1, 639, 617	601, 934	1202. UU

Health Financial Systems ALLOCATION OF CAPITAL RELATED COSTS	FRANCI SCAN HEALT	H MICHIGAN CIT Provider C	CN: 15-0015	In Lie Period: From 01/01/2021	eu of Form CMS- Worksheet B Part II	-2552-1
				To 12/31/2021		epared:
			OTHER GENERAL	-	572072022 11	
Cost Center Description	MEDI CAL	SOCIAL SERVICE	SERVI CE	NONPHYSI CI AN	NURSI NG	
cost center bescription	RECORDS &	SUCIAL SERVICE	EDUCATION	ANESTHETI STS	PROGRAM	
	LI BRARY 16.00	17.00	18.00	19.00	20.00	_
GENERAL SERVICE COST CENTERS	10.00	17.00	18.00	19.00	20.00	
1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						2.00
5. 00 00500 ADMINI 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 9. 00 00900 HOUSEKEEPING						8. 00 9. 00
10. 00 01000 DI ETARY						10.0
11.00 01100 CAFETERI A						11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON 14. 00 01400 CENTRAL SERVI CES & SUPPLY						13.0
15. 00 01500 PHARMACY						15.00
16. 00 01600 MEDICAL RECORDS & LIBRARY	82, 495					16.00
17.00 01700 SOCIAL SERVICE	0	0				17.00
18. 00 01080 I NSERVI CE EDUCATI ON 19. 00 01900 NONPHYSI CI AN ANESTHETI STS				0 0		18.00
20. 00 02000 NURSI NG PROGRAM	0	0		0		20.00
21.00 02100 I &R SERVICES-SALARY & FRINGES APPRV	C	C		0		21.00
22. 00 02200 I &R SERVICES-OTHER PRGM COSTS APPRV		0		0		22.00
23. 00 02300 PARAMED ED PRGM-(SPECIFY) INPATIENT ROUTINE SERVICE COST CENTERS	(C	1	0		23.00
30. 00 03000 ADULTS & PEDI ATRI CS	6, 088	C		0		30.00
31. 00 03100 I NTENSI VE CARE UNI T	1, 339		1	0		31.00
32. 00 03200 CORONARY CARE UNI T 33. 00 03300 BURN INTENSIVE CARE UNI T				0		32.00
34. 00 03400 SURGI CAL I NTENSI VE CARE UNI T		-		0		34.00
40. 00 04000 SUBPROVIDER - IPF	506			0		40.00
41.00 04100 SUBPROVIDER - IRF	0	-		0		41.00
43.00 04300 NURSERY 44.00 04400 SKILLED_NURSING_FACILITY	166			0		43.00
45. 00 04500 NURSING FACILITY	C	-		0		45.00
46. 00 O4600 OTHER LONG TERM CARE	0	C		0		46.00
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM	12, 985	C		0		50.00
51. 00 05100 RECOVERY ROOM	(2,)00	0		0		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	299			0		52.00
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C	840			0		53.00
54. 01 05400 RADIOLOGY - DIAGNOSTIC	10, 418			0		54.00 54.0
55. 00 05500 RADI OLOGY-THERAPEUTI C	1, 565	0		0		55.00
55. 01 05501 WOODLAND CANCER CARE CTR	351	0		0		55.0
56. 00 05600 RADI 0I SOTOPE 57. 00 05700 CT SCAN				0		56.00 57.00
58. 00 05800 MRI	0	0		0		58.0
59. 00 05900 CARDI AC CATHETERI ZATI ON	2, 916			0		59.0
60. 00 06000 LABORATORY 60. 01 06001 FS_ED_LAB	8, 110 1, 207			0		60. 0 60. 0
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	1,207			0		61.0
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	C	C		0		62.0
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	128	0		0		63.0
63. 01 06301 FS ED BLOOD BANK 64. 00 06400 NTRAVENOUS THERAPY	2			0		63.0 ⁻ 64.0
65. 00 06500 RESPI RATORY THERAPY	1, 664	0		ŏ		65.00
66. 00 06600 PHYSI CAL THERAPY	1, 722			о		66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0		0		67.0
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	2,673			0		68.00 69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	2,0/0	d d		0		70.00
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT	3, 088			0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS	3, 082 11, 292			0		72.00
73.00 07300 DRUGS CHARGED TO PATTENTS 74.00 07400 RENAL DIALYSIS	11, 292			0		73.00
75. 00 07500 ASC (NON-DI STINCT PART)	0	0		о		75.00
76.00 03020 CLINIC	C	C		0		76.00
77. 00 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON OUTPATI ENT SERVI CE COST CENTERS	C	0	2	0		77.00
88.00 08800 RURAL HEALTH CLINIC	0	C		0		88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0		89.00
90. 00 09000 CLINIC		0	NI	0	1	90.00

Health Financial Systems FR.	ANCISCAN HEALTI	H MICHIGAN CIT	Y	In Lie	eu of Form CMS-	-2552-10
ALLOCATION OF CAPITAL RELATED COSTS	1	Provider C		Period: From 01/01/2021 To 12/31/2021		
Cost Center Description	RECORDS & LI BRARY	SOCI AL SERVI CE	EDUCATI ON	NONPHYSI CI AN ANESTHETI STS	NURSI NG PROGRAM	
	16.00	17.00	18.00	19.00	20.00	
90. 03 09003 I NFUSI ON OP SERVI CES	421	0		0		90.03
91.00 09100 EMERGENCY	7, 673)	0		91.00
91.01 09101 FREE STANDING EMERGENCY DEPT	1, 659	0		0		91.01
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DI ALYSI S	0	C)	0		94.00
95. 00 09500 AMBULANCE SERVICES	0	l a		0		95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0			0		96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0			0		97.00
98. 00 09850 OTHER REI MBURSABLE COST CENTERS	0			0		98.00
99. 00 09900 CMHC	0			0		99.00
99. 10 09910 CORF	0			0		99.10
	0			0		
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	0			0		100.00
101.00 10100 HOME HEALTH AGENCY	0	0		0		101.00
SPECIAL PURPOSE COST CENTERS			1		1	_
105.00 10500 KIDNEY ACQUISITION	0			0		105.00
106.00 10600 HEART ACQUI SI TI ON	0	0)	0		106.00
107.00 10700 LIVER ACQUISITION	0	0		0		107.00
108.00 10800 LUNG ACQUISITION	0	0)	0		108.00
109.00 10900 PANCREAS ACQUISITION	0	C)	0		109.00
110.00 11000 INTESTINAL ACQUISITION	0	0		0		110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0		0		111.00
113.00 11300 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		115.00
116. 00 11600 HOSPI CE	0			0		116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	82, 495	-		0 0		118.00
NONREI MBURSABLE COST CENTERS	02,170	<u> </u>	1		1	
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0)	0		190.00
191. 00 19100 RESEARCH	0	-		0		191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	-		0		192.00
193. 00 19300 NONPALD WORKERS	0			0		193.00
194. 00 07950 BEACON JOINT VENTURE	0			0		194.00
194. 01 07951 WORKI NG WELL	0			0		194.00
	0			0		
194. 03 07953 MED WATCHER	0	0		0		194.03
194. 10 07960 DUNELAND FITNESS CTR	0	0)	0		194.10
194.11 07961 OMNI HEALTH & FITNESS CHESTERTOWN	0	C		0		194. 11
194. 16 07966 PHYSICIAN PRACTICE MD WISW	0	C		U		194.16
194. 19 07969 HEALTH PARTNERS	0	0		0		194. 19
194.2007970 CENTER OF HOPE	0	0		0		194.20
200.00 Cross Foot Adjustments				C) (200.00
201.00 Negative Cost Centers	0	0		0 0) (201.00
202.00 TOTAL (sum lines 118 through 201)	82, 495	0		0 0) (202.00

OCATION OF CAPITAL RELATED COSTS		Provider CC		Period: From 01/01/2021	Worksheet B Part II	
				To 12/31/2021	Date/Time Pre	
	I NTERNS &	RESI DENTS			5/26/2022 11:	23 8
Cost Center Description	SEDVICES SALAD	SERVI CES-OTHER	PARAMED ED	Subtotal	Intern &	
cost center bescription	Y & FRI NGES	PRGM COSTS	PARAMEDED	Subtotal	Residents Cost	
	APPRV	APPRV			& Post	
					Stepdown Adjustments	
	21.00	22.00	23.00	24.00	25.00	
GENERAL SERVICE COST CENTERS	-					
0 00100 CAP REL COSTS-BLDG & FIXT 0 00200 CAP REL COSTS-MVBLE EQUIP						1
0 00400 EMPLOYEE BENEFITS DEPARTMENT						
0 00500 ADMINISTRATIVE & GENERAL						5
0 00600 MAI NTENANCE & REPAI RS						6
0 00700 OPERATION OF PLANT 0 00800 LAUNDRY & LINEN SERVICE						7
0 00900 HOUSEKEEPING						9
00 01000 DI ETARY						10
						11
00 01300 NURSI NG ADMI NI STRATI ON 00 01400 CENTRAL SERVI CES & SUPPLY						13
00 01500 PHARMACY						15
00 01600 MEDICAL RECORDS & LIBRARY						16
00 01700 SOCIAL SERVICE 00 01080 INSERVICE EDUCATION						17 18
00 01900 NONPHYSICIAN ANESTHETISTS						19
00 02000 NURSI NG PROGRAM						20
00 02100 I &R SERVICES-SALARY & FRINGES APPRV	0	_				21
00 02200 I &R SERVICES-OTHER PRGM COSTS APPRV 00 02300 PARAMED ED PRGM-(SPECIFY)		0		0		22
INPATIENT ROUTINE SERVICE COST CENTERS						
00 03000 ADULTS & PEDI ATRI CS				6, 943, 605		
00 03100 INTENSIVE CARE UNIT 00 03200 CORONARY CARE UNIT				1, 448, 888	0	
00 03300 BURN INTENSIVE CARE UNIT				0	0	
00 03400 SURGICAL INTENSIVE CARE UNIT				0	0	
00 04000 SUBPROVIDER - IPF				1, 223, 794	0	
00 04100 SUBPROVI DER – I RF 00 04300 NURSERY				0 323, 420	0	
00 04400 SKILLED NURSING FACILITY				525, 420	0	
00 04500 NURSING FACILITY				0	0	
00 04600 OTHER LONG TERM CARE				0	0	46
ANCI LLARY SERVI CE COST CENTERS 00 05000 OPERATI NG ROOM				8, 238, 935	0	50
00 05100 RECOVERY ROOM				0	-	
00 05200 DELIVERY ROOM & LABOR ROOM				578, 738		
00 05300 ANESTHESI OLOGY 00 05400 RADI OLOGY-DI AGNOSTI C				84, 504 3, 646, 315	0	
01 05401 FSED RADIOLOGY - DIAGNOSTIC				367, 096		
00 05500 RADI OLOGY-THERAPEUTI C				681, 750		
01 05501 WOODLAND CANCER CARE CTR				168, 825		
00 05600 RADI 0I SOTOPE 00 05700 CT SCAN				0	0	
00 05800 MRI				0	0	58
00 05900 CARDI AC CATHETERI ZATI ON				1, 592, 097		
00 06000 LABORATORY 01 06001 FS ED LAB				861, 255 36, 543		
00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY				30, 343	0	61
00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL				0	0	62
00 06300 BLOOD STORING, PROCESSING & TRANS.				30, 632	0	
01 06301 FS ED BLOOD BANK 00 06400 I NTRAVENOUS THERAPY				2	0	
00 06500 RESPIRATORY THERAPY				359, 522	0	
00 06600 PHYSI CAL THERAPY				245, 914	0	66
00 06700 OCCUPATI ONAL THERAPY				0	0	
00 06800 SPEECH PATHOLOGY 00 06900 ELECTROCARDI OLOGY				0 948, 268	0	
00 07000 ELECTROENCEPHALOGRAPHY				940, 200	0	
00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT				135, 538		71
00 07200 IMPL. DEV. CHARGED TO PATIENTS				369, 964	0	
00 07300 DRUGS CHARGED TO PATIENTS 00 07400 RENAL DIALYSIS				1, 029, 254	0	
00 07400 RENAL DIALYSIS 00 07500 ASC (NON-DISTINCT PART)				0	0	
00 03020 CLINIC				14, 381	0	
00 07700 ALLOGENEIC STEM CELL ACQUISITION				0	0	
OUTPATIENT SERVICE COST CENTERS 00 08800 RURAL HEALTH CLINIC				0	0	

Health Financial Systems FRA	ANCISCAN HEALTH	MICHIGAN CITY	(In Lie	u of Form CMS-:	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CC		Period: From 01/01/2021 To 12/31/2021	Worksheet B Part II Date/Time Pre 5/26/2022 11:	pared:
	INTERNS &	RESIDENTS			572072022 11.	2.5 8111
Cost Center Description	SERVI CES-SALARS Y & FRI NGES APPRV		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
	21.00	22.00	23.00	24.00	25.00	
89.0008900FEDERALLY QUALI FI ED HEALTH CENTER90.0009000CLI NI C90.0309003I NFUSI ON OP SERVI CES91.0009100EMERGENCY91.0109101FREE STANDI NG EMERGENCY DEPT92.00095ERVATI ON BEDS (NON-DI STI NCT PARTOTHER REI MBURSABLE COST CENTERS				0 0 309, 976 1, 895, 542 1, 862, 628	0 0 0 0 0 0	90. 00 90. 03 91. 00 91. 01
94. 00 09400 95. 00 09500 09600 09600 09600 09700 09700 09700 09700 09700 09700 09700 09700 00700						97.00 98.00 99.00
105.00 10500 KI DNEY ACQUI SI TI ON 106.00 10600 HEART ACQUI SI TI ON 107.00 10700 LI VER ACQUI SI TI ON 108.00 10800 LUVE ACQUI SI TI ON 109.00 10900 PANCREAS ACQUI SI TI ON 100.00 INTESTI NAL ACQUI SI TI ON 110.00 INTESTI NAL ACQUI SI TI ON 111.00 ISLET ACQUI SI TI ON 113.00 INTEREST EXPENSE 114.00 ITI LI ZATI ON REVI EW-SNF 115.00 AMBULATORY SURGI CAL CENTER (D. P.) 116.00 11600 10500 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	0	0		0 0 0 0 0 0 33, 397, 386	0 0 0 0 0 0 0 0 0 0	105.00 106.00 107.00 108.00 109.00 110.00 111.00 113.00 114.00 115.00 116.00 118.00
190.00 GFT, FLOWER, COFFE SHOP & CANTEEN 191.00 19000 GFT, FLOWER, COFFE SHOP & CANTEEN 191.00 19200 PHYSI CLANS' PRI VATE OFFICES 193.00 19300 NONPAI D WORKERS 194.00 07950 BEACON JOI NT VENTURE 194.01 07951 WORKI NG WELL 194.03 07953 MED WATCHER 194.10 07960 DUNELAND FI TNESS CTR 194.10 O7960 DUNELAND FI TNESS CTR 194.10 07964 PHYSI CLAN PRACTICE MD WISW 194.10 07969 HEALTH PARTNERS 194.20 07970 CENTER OF HOPE 200.00 Cross Foot Adj ustments 201.00 Negative Cost Centers 202.00 TOTAL (sum Lines 118 through 201)	0 0 0	0 0 0		960 0 849 0 72, 367 0 0 0 1, 790 0 3, 438 0 0 0 33, 476, 790	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	190. 00 191. 00 192. 00 193. 00 194. 00 194. 01 194. 03 194. 10 194. 10 194. 11 194. 16 194. 19 194. 20 200. 00 201. 00 202. 00

Hea	l th	Fi na	inci al	Syste	ems	

88.00

89.00

90.00

90.03

91.00

91.01

92.00

Heal th	Financial Systems F	RANCI SCAN HEALTH	MICHIGAN CITY	In Lieu of Form CMS-	2552-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provider CCN: 15-0015	Period: Worksheet B From 01/01/2021 Part II	
				To 12/31/2021 Date/Time Pre 5/26/2022 11:	
	Cost Center Description	Total		572072022 11.	23 am
	GENERAL SERVICE COST CENTERS	26.00			
1.00	00100 CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00 6.00	00500 ADMI NI STRATI VE & GENERAL 00600 MAI NTENANCE & REPAI RS				5.00 6.00
7.00	00700 OPERATION OF PLANT				7.00
8.00	00800 LAUNDRY & LINEN SERVICE				8.00
9.00	00900 HOUSEKEEPI NG				9.00
10.00					10.00
11. 00 13. 00	01100 CAFETERIA 01300 NURSI NG ADMI NI STRATI ON				11.00 13.00
14.00	01400 CENTRAL SERVICES & SUPPLY				14.00
15.00	01500 PHARMACY				15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY				16.00
17.00 18.00	01700 SOCIAL SERVICE 01080 INSERVICE EDUCATION				17.00 18.00
19.00	01900 NONPHYSICIAN ANESTHETISTS				19.00
20.00	02000 NURSI NG PROGRAM				20.00
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRV				21.00
22.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV				22.00
23.00	02300 PARAMED ED PRGM-(SPECIFY) I NPATI ENT ROUTI NE SERVI CE COST CENTERS				23.00
30.00	03000 ADULTS & PEDIATRICS	6, 943, 605			30.00
31.00	03100 I NTENSI VE CARE UNI T	1, 448, 888			31.00
32.00	03200 CORONARY CARE UNI T	0			32.00
33.00	03300 BURN I NTENSI VE CARE UNI T	0			33.00
34.00 40.00	03400 SURGI CAL I NTENSI VE CARE UNI T 04000 SUBPROVI DER – I PF	1, 223, 794			34.00 40.00
40.00	04100 SUBPROVI DER – I RF	1, 223, 794			41.00
43.00	04300 NURSERY	323, 420			43.00
44.00	04400 SKILLED NURSING FACILITY	0			44.00
45.00	04500 NURSING FACILITY	0			45.00
46.00	04600 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS	0			46.00
50.00	05000 OPERATI NG ROOM	8, 238, 935			50.00
51.00	05100 RECOVERY ROOM	0			51.00
52.00 53.00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	578, 738 84, 504			52.00 53.00
53.00	05400 RADI OLOGY – DI AGNOSTI C	3, 646, 315			54.00
54.01	05401 FSED RADIOLOGY - DIAGNOSTIC	367, 096			54.01
55.00	05500 RADI OLOGY-THERAPEUTI C	681, 750			55.00
55.01	05501 WOODLAND CANCER CARE CTR	168, 825			55.01
56.00 57.00	05600 RADI OI SOTOPE 05700 CT SCAN	0			56.00 57.00
58.00	05800 MRI	0			58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	1, 592, 097			59.00
60.00	06000 LABORATORY	861, 255			60.00
60. 01 61. 00	06001 FS ED LAB 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	36, 543			60. 01 61. 00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0			62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	30, 632			63.00
63.01	06301 FS ED BLOOD BANK	2			63.01
64.00	06400 I NTRAVENOUS THERAPY	0			64.00
65.00 66.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	359, 522 245, 914			65.00 66.00
67.00	06700 OCCUPATI ONAL THERAPY	0			67.00
68.00	06800 SPEECH PATHOLOGY	0			68.00
69.00		948, 268			69.00
70.00 71.00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0 135, 538			70.00
		369, 964			71.00
	07300 DRUGS CHARGED TO PATIENTS	1, 029, 254			73.00
	07400 RENAL DI ALYSI S	0			74.00
	07500 ASC (NON-DI STINCT PART)	0			75.00
76.00 77.00	03020 CLINIC 07700 ALLOGENEIC STEM CELL ACQUISITION	14, 381			76.00 77.00
	OUTPATI ENT SERVICE COST CENTERS				

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0015	Peri od: From 01/01/2021 To 12/31/2021	Worksheet B Part II Date/Time Prepared 5/26/2022 11:23 am
Cost Center Description	Total			
	26.00			
OTHER REIMBURSABLE COST CENTERS				
94. 00 09400 HOME PROGRAM DI ALYSI S	0			94. C
95. 00 09500 AMBULANCE SERVICES	0			95. C
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0			96. C
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD	0			97. C
98.00 09850 OTHER REIMBURSABLE COST CENTE				98. C
99. 00 09900 CMHC	0			99. C
99. 10 09910 CORF	0			99. 1
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	0			100. C
101.00 10100 HOME HEALTH AGENCY	0			101. C
SPECIAL PURPOSE COST CENTERS				
105. 00 10500 KI DNEY ACQUI SI TI ON	0			105. C
106.00 10600 HEART ACQUI SI TI ON	0			106. C
107.00 10700 LIVER ACQUISITION	0			107.0
108.00 10800 LUNG ACQUI SI TI ON	0			108. C
109.00 10900 PANCREAS ACQUI SI TI ON	0			109. C
110.00 11000 INTESTINAL ACQUISITION	0			110. C
111.00 11100 1SLET_ACQUISITION 113.00 11300 1NTEREST_EXPENSE	0			111. C 113. C
113.001130011NTEREST EXPENSE 114.0011400 UTILIZATION REVIEW-SNF				113. C
114.00 11400 011 ELZATION REVIEW-SNF 115.00 11500 AMBULATORY SURGICAL CENTER (E	(P.) 0			114. 0
115.00 11500 AMBULATORT SURGICAL CENTER (L 116.00 11600 HOSPI CE	(P.) 0			115.0
I18.00 SUBTOTALS (SUM OF LINES 1 thr	°			118.0
NONREI MBURSABLE COST CENTERS	ough (17) 35, 377, 300			
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & C	ANTEEN 960			190. 0
191. 00 19100 RESEARCH	0			191.0
192. 00 19200 PHYSI CLANS' PRI VATE OFFICES	849			192.0
193. 00 19300 NONPALD WORKERS	0			193. 0
194. 00 07950 BEACON JOINT VENTURE	0			194.0
194. 01 07951 WORKING WELL	72, 367			194.0
194. 03 07953 MED WATCHER	0			194.0
194. 1007960 DUNELAND FITNESS CTR	0			194. 1
194. 11 07961 OMNI HEALTH & FITNESS CHESTER	TOWN			194. 1
194. 16 07966 PHYSI CI AN PRACTICE MD WI SW	1, 790			194. 1
194. 19 07969 HEALTH PARTNERS	0			194. 1
194. 20 07970 CENTER OF HOPE	3, 438			194. 2
200.00 Cross Foot Adjustments	0			200. C
201.00 Negative Cost Centers	0			201.0
TOTAL (sum lines 118 through	201) 33, 476, 790			202. 0

IST A	LLOCATION - STATISTICAL BASIS		Provider C		eriod: rom 01/01/2021	Worksheet B-1	
				Т	o 12/31/2021	Date/Time Pre 5/26/2022 11:	
		CAPI TAL RE	LATED COSTS				
	Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Reconciliation	ADMI NI STRATI VE	
			(DOLLAR VALUE)	BENEFITS		& GENERAL	
				DEPARTMENT		(ACCUM. COST)	
				(GROSS			
		1.00	2.00	SALARIES) 4.00	5A	5.00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	1.00	0/1	0.00	
00	00100 CAP REL COSTS-BLDG & FIXT	432, 943	6] '
00	00200 CAP REL COSTS-MVBLE EQUIP		7, 159, 497				2
00	00400 EMPLOYEE BENEFITS DEPARTMENT	2, 216				175 552 410	
00 00	00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS	39, 650	1, 036, 383	17, 914, 415	-29, 680, 672	175, 553, 410 0	
00 00	00700 OPERATION OF PLANT	75, 292	984, 490	3, 218, 561		-	
00	00800 LAUNDRY & LINEN SERVICE	1, 383				888, 068	
00	00900 HOUSEKEEPI NG	17, 014				4, 108, 068	
. 00	01000 DI ETARY	4, 649	36, 925	575, 014	0	1, 545, 177	10
. 00	01100 CAFETERI A	9, 050		., ,		2, 454, 841	11
. 00	01300 NURSI NG ADMI NI STRATI ON	2, 147				4, 236, 756	
. 00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	16, 750 6, 037				1, 815, 101 4, 948, 927	14
	01600 MEDICAL RECORDS & LIBRARY	678		2,010,1/5		1, 623, 834	
	01700 SOCI AL SERVI CE	0			0	0	17
. 00	01080 INSERVICE EDUCATION	0	0	(c	0	0	
	01900 NONPHYSI CI AN ANESTHETI STS	0	0	(C	0	0	19
	02000 NURSI NG PROGRAM	0	0		0	0	20
. 00 . 00	02100 I & SERVI CES-SALARY & FRI NGES APPRV 02200 I & SERVI CES-OTHER PRGM COSTS APPRV	0				0	21
	02300 PARAMED ED PRGM-(SPECIFY)					0	23
. 00	INPATIENT ROUTINE SERVICE COST CENTERS		<u> </u>			<u> </u>	
. 00	03000 ADULTS & PEDIATRICS	69, 586	385, 492	15, 090, 051	0	24, 033, 602	30
	03100 INTENSIVE CARE UNIT	13, 428	105, 913	3, 289, 809	0	5, 207, 582	31
	03200 CORONARY CARE UNI T	0		C	0	0	32
	03300 BURN INTENSIVE CARE UNIT	0	0	C	0	0	
. 00	03400 SURGI CAL I NTENSI VE CARE UNI T 04000 SUBPROVI DER – I PF	14 200	0 22 122	1 240 151		0 2, 695, 929	34
. 00 . 00	04000 SUBPROVIDER - TPF 04100 SUBPROVIDER - TRF	14, 290	33, 127	1, 369, 151		2, 695, 929	40
	04300 NURSERY	4, 142	0	426, 678		971, 882	
. 00	04400 SKILLED NURSING FACILITY	0	0	C	0	0	44
. 00	04500 NURSING FACILITY	0		C	0	0	45
. 00	04600 OTHER LONG TERM CARE	0	0	C	0	0	46
00	ANCI LLARY SERVI CE COST CENTERS	E2 044	1, 566, 173	((OF 40)		14 425 (01	
. 00 . 00	05100 RECOVERY ROOM	53, 944		6, 695, 422			50 51
	05200 DELIVERY ROOM & LABOR ROOM	7, 412	-	765, 089	-		
	05300 ANESTHESI OLOGY	175					
. 00	05400 RADI OLOGY-DI AGNOSTI C	19, 891			C	7, 780, 915	54
. 01	05401 FSED RADIOLOGY - DIAGNOSTIC	0	151, 744			2, 289, 536	
	05500 RADI OLOGY-THERAPEUTI C	3, 265				1, 770, 395	
	05501 WOODLAND CANCER CARE CTR	2,018		349, 699	0	532, 903	
. 00	05600 RADI OI SOTOPE 05700 CT SCAN					0	56
. 00	05800 MRI					0	58
	05900 CARDI AC CATHETERI ZATI ON	5, 326	480, 536	988, 111	0	2, 693, 318	
. 00	06000 LABORATORY	8, 336				8, 680, 145	60
	06001 FS ED LAB	0	0	C	0	1, 599, 216	
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY				0		61
. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0			0	19 224	
. 00 . 01	06300 BLOOD STORING, PROCESSING & TRANS. 06301 FS ED BLOOD BANK	394				18, 226 0	63
	06400 I NTRAVENOUS THERAPY					0	
. 00	06500 RESPI RATORY THERAPY	2,006	73, 044	1, 203, 578	0	2,007,232	65
	06600 PHYSI CAL THERAPY	1, 490				3, 635, 942	
00	06700 OCCUPATI ONAL THERAPY	0	0	c c	0	0	67
	06800 SPEECH PATHOLOGY	0	0	C	0	0	
		8, 941	137, 902	1, 010, 031	0	2, 132, 939	
	07000 ELECTROENCEPHALOGRAPHY	0	0		0	6 002 002	70
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	0			0	6, 003, 003 16, 628, 068	
	07200 TMPL. DEV. CHARGED TO PATIENTS					18, 855, 515	
	07400 RENAL DIALYSIS					18, 855, 515	
	07500 ASC (NON-DI STI NCT PART)		o o		0	0	
	03020 CLI NI C	0	0	306, 948	0	579, 975	
. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	C	0	0	77
. 00	OUTPATIENT SERVICE COST CENTERS						

ST ALLOCA	TION - STATISTICAL BASIS		Provider CC		Period: From 01/01/2021	Worksheet B-1	
					o 12/31/2021	Date/Time Pre 5/26/2022 11:	
		CAPI TAL RELA	ATED COSTS			372072022 11.	
	Cost Center Description	BLDG & FIXT (SQUARE FEET) (MVBLE EQUIP DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS	Reconci I i ati on	ADMI NI STRATI VE & GENERAL (ACCUM. COST)	
				SALARI ES)			
		1.00	2.00	4.00	5A	5.00	
	FEDERALLY QUALIFIED HEALTH CENTER	0	0	C		0	
	OCLINIC SINFUSION OP SERVICES	3, 213	0 21, 788	C 440, 669	-	0 1, 226, 635	
	EMERGENCY	18, 839	123, 051	4, 230, 056		6, 764, 384	
	FREE STANDING EMERGENCY DEPT	21, 381	135, 040	1, 400, 899		3, 545, 187	
	OBSERVATION BEDS (NON-DISTINCT PART	21,001	155, 040	1, 400, 077		5, 545, 167	92
	REIMBURSABLE COST CENTERS	<u> </u>			1		1 12
	HOME PROGRAM DI ALYSI S	0	0	C	0 0	0	94
. 00 09500	AMBULANCE SERVICES	0	0	C	0 0	0	95
. 00 09600	DURABLE MEDICAL EQUIP-RENTED	0	0	C	0 0	0	96
	DURABLE MEDICAL EQUIP-SOLD	0	0	C	0 0	0	
	OTHER REIMBURSABLE COST CENTERS	0	0	C	0 0	0	
00 09900		0	0	C	0 0	0	
. 10 09910		0	0	C	0 0	0	
	I&R SERVICES-NOT APPRVD PRGM	0	0	C	0		100
	HOME HEALTH AGENCY	0	0	C	0 0	0	101
	AL PURPOSE COST CENTERS	0	0	C		0	1105
	HEART ACQUISITION	0	0				105. 106.
	LIVER ACQUISITION	0	0				107
	LUNG ACQUISITION	0	0			-	108
	PANCREAS ACQUISITION	0	0	c c			109
	INTESTINAL ACQUISITION	0	0	C	0		110
	I SLET ACQUI SI TI ON	0	0	C	0		111
	INTEREST EXPENSE						113
4.00 11400	UTILIZATION REVIEW-SNF						114
5.00 11500	AMBULATORY SURGICAL CENTER (D. P.)	0	0	C	0 0	0	115
6.0011600	HOSPICE	0	0	C			116
8. 00	SUBTOTALS (SUM OF LINES 1 through 117)	432, 943	7, 134, 151	74, 099, 299	-29, 680, 672	174, 657, 481	118
	I MBURSABLE COST CENTERS	-	-	-	.I		
	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	C		43, 519	
	RESEARCH	0	0	04 402	, u		191
) PHYSICIANS' PRIVATE OFFICES NONPAID WORKERS	0	0	94, 492		5, 900	192
	BEACON JOINT VENTURE	0	0				193
	WORKING WELL	0	24, 219	414, 745		730, 124	
	MED WATCHER	0	24,219	414, 740 C			194
	DUNELAND FITNESS CTR	0	0	C			194
	OMNI HEALTH & FITNESS CHESTERTOWN	0	0	c.	0		194
	PHYSICIAN PRACTICE MD WISW	o	0	54, 269	o o	68, 456	
	HEALTH PARTNERS	0	0	C	0		194
	CENTER OF HOPE	0	1, 127	51, 013	0	47, 930	194
D. 00	Cross Foot Adjustments						200
1.00	Negative Cost Centers						201
2.00	Cost to be allocated (per Wkst. B, Part I)	20, 027, 022	13, 449, 768	4, 975, 740		29, 680, 672	202
3.00	Unit cost multiplier (Wkst. B, Part I)	46. 257872	1. 878591	0.066597		0. 169069	
4.00	Cost to be allocated (per Wkst. B, Part II)			385, 490		3, 873, 469	
	Unit cost multiplier (Wkst. B, Part			0. 005160		0. 022064	205
5.00	11)						
5. 00 6. 00 7. 00	NAHE adjustment amount to be allocated (per Wkst. B-2) NAHE unit cost multiplier (Wkst. D,						206 207

	Financial Systems FI LLOCATION - STATISTICAL BASIS	RANCI SCAN HEALTI	H MICHIGAN CITY Provider C		In Lie eriod:	u of Form CMS-2 Worksheet B-1	2552-10
				F	rom 01/01/2021 o 12/31/2021	Date/Time Pre	
	Cost Center Description	MAI NTENANCE & REPAI RS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LI NEN SERVICE (POUNDS OF	HOUSEKEEPI NG (SQUARE FEET)	5/26/2022 11: DI ETARY (MEALS SERVED)	23 am
		. ,		LAUNDRY)		10.00	
	GENERAL SERVICE COST CENTERS	6.00	7.00	8.00	9.00	10.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
$\begin{array}{c} 2.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ \end{array}$	00200 CAP REL COSTS-MVBLE EQUI P 00400 EMPLOYEE BENEFI TS DEPARTMENT 00500 ADMI NI STRATI VE & GENERAL 00600 MAI NTENANCE & REPAI RS 00700 OPERATI ON OF PLANT 00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG 01000 DI ETARY 01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE 01080 I NSERVI CE EDUCATI ON	391, 077 75, 292 1, 383 17, 014 4, 649 9, 050 2, 147 16, 750 6, 037 678 0 0	315, 785 1, 383 17, 014 4, 649 9, 050 2, 147 16, 750 6, 037 678 0 0	669, 257 0 282 0 0 0 0 0 0 0 0	4, 649	168, 501 0 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 2.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ \end{array}$
	01900 NONPHYSICIAN ANESTHETISTS 02000 NURSING PROGRAM 02100 I &R SERVICES-SALARY & FRINGES APPRV 02200 I &R SERVICES-OTHER PRGM COSTS APPRV 02300 PARAMED ED PRGM-(SPECIFY)					0 0 0 0	19.00 20.00 21.00 22.00 23.00
23.00	INPATIENT ROUTINE SERVICE COST CENTERS				0		23.00
30. 00 31. 00 32. 00	03000 ADULTS & PEDI ATRI CS 03100 I NTENSI VE CARE UNI T 03200 CORONARY CARE UNI T	69, 586 13, 428 0	69, 586 13, 428 0	35, 224		126, 215 23, 951 0	30. 00 31. 00 32. 00
33.00 34.00	03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	33.00 34.00
40.00	04000 SUBPROVI DER – I PF	14, 290	14, 290	105, 672	14, 290	18, 335	40.00
41.00 43.00	04100 SUBPROVIDER - IRF 04300 NURSERY	0 4, 142	0 4, 142	0	0 4, 142	0	41.00 43.00
44.00	04400 SKI LLED NURSI NG FACI LI TY	4, 142		0	4, 142	0	44.00
45.00	04500 NURSING FACILITY	0	0	0	0	0	45.00
46.00	04600 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS	0	0	0	0	0	46.00
50.00	05000 OPERATI NG ROOM	53, 944	53, 944	37, 337	53, 944	0	50.00
51.00 52.00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	0 7, 412	0 7, 412	-	0 7, 412	0	51.00 52.00
53.00	05300 ANESTHESI OLOGY	175	175		175	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	19, 891	19, 891	28, 320	19, 891	0	54.00
54. 01 55. 00	05401 FSED RADI OLOGY - DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	3, 265	3, 265	352	0 3, 265	0	54.01 55.00
	05501 WOODLAND CANCER CARE CTR	2,018				0	55.01
56.00	05600 RADI OI SOTOPE	0	0	0	0	0	56.00
	05700 CT SCAN 05800 MRI	0		0	0	0	57.00 58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	5, 326			5, 326	0	59.00
60. 00 60. 01	06000 LABORATORY 06001 FS ED LAB	8, 336	8, 336	0	8, 336	0	60. 00 60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY				0	0	61.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
	06300 BLOOD STORING, PROCESSING & TRANS. 06301 FS ED BLOOD BANK	394	394	0	394	0	63.00 63.01
	06400 I NTRAVENOUS THERAPY	0	0	0	0	0	64.00
	06500 RESPI RATORY THERAPY	2,006			2, 006	0	65.00
66.00 67.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	1,490	1, 490	21, 134	1, 490	0	66.00 67.00
	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
	06900 ELECTROCARDI OLOGY	8, 941	8, 941	3, 522	8, 941	0	69.00
	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	70.00 71.00
	07200 I MPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
	07400 RENAL DI ALYSI S	0	0	0	0	0	74.00
75.00 76.00	07500 ASC (NON-DISTINCT PART) 03020 CLINIC			0	0	0	75.00 76.00
	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	
<u>go nn</u>	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 CLI NI C	0	0	0	0	0	90.00
90. 03	09003 I NFUSI ON OP SERVI CES	3, 213	3, 213	211	3, 213	0	90.03

OST ALLOC	ancial Systems FR ATION - STATISTICAL BASIS	ANCI SCAN HEALTI	Provider C	CN: 15-0015	Period:	Worksheet B-1	2552- I
				1	rom 01/01/2021		
					To 12/31/2021	Date/Time Pre 5/26/2022 11:	
	Cost Center Description	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DIETARY	
		REPAI RS	PLANT	LINEN SERVICE	(SQUARE FEET)	(MEALS SERVED)	
		(SQUARE FEET)	(SQUARE FEET)	(POUNDS OF			
		6.00	7.00	LAUNDRY) 8.00	9.00	10.00	
1.00 0910	DO EMERGENCY	18, 839				0	91.
1.01 0910	1 FREE STANDING EMERGENCY DEPT	21, 381	21, 381	28, 17	21, 381	0	91.
	OO OBSERVATION BEDS (NON-DISTINCT PART						92.
	R REIMBURSABLE COST CENTERS	-	-		-	-	4
	00 HOME PROGRAM DI ALYSI S	0	-		0	0	
	00 AMBULANCE SERVICES 00 DURABLE MEDICAL EQUIP-RENTED	0	0			0	
	00 DURABLE MEDICAL EQUIP-RENTED	0				0	
	O OTHER REIMBURSABLE COST CENTERS	0	0		0 0	0	
	о синс	0	0		0 0	0	
9. 10 0991	0 CORF	0	0		0 0	0	99.
	00 I&R SERVICES-NOT APPRVD PRGM	0	0		0 0	0	
	DO HOME HEALTH AGENCY	0	0) (0 0	0	101
	TAL PURPOSE COST CENTERS						
	00 KIDNEY ACQUISITION 00 HEART ACQUISITION	0	-				105
	00 LIVER ACQUISITION	0					106
	DO LUNG ACQUISITION	0					108
	DO PANCREAS ACQUI SI TI ON	0	0		0 0		109
	00 INTESTINAL ACQUISITION	0	0		0 0		110
1.00 1110	0 ISLET ACQUISITION	0	0		0 0	0	111
	00 INTEREST EXPENSE						113
	00 UTILIZATION REVIEW-SNF						114
	00 AMBULATORY SURGICAL CENTER (D. P.)	0	0		0		115
8.00	00 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117)	391,077	315, 785	669, 25	7 297, 388		116
	EIMBURSABLE COST CENTERS	391,077	515,765	007,23	277, 300	100, 501	1110
	O GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	0	190
	00 RESEARCH	0	0		0 0		191
2.00 1920	00 PHYSICIANS' PRIVATE OFFICES	0	0		0 0	0	192
1	OO NONPAID WORKERS	0	0		0 0		193
	60 BEACON JOINT VENTURE	0	0		0 0		194
	1 WORKING WELL	0	0		0		194
	3 MED WATCHER 00 DUNELAND FI TNESS CTR	0	0) 194) 194
	1 OMNI HEALTH & FITNESS CHESTERTOWN						194
	66 PHYSI CI AN PRACTI CE MD WI SW	0	0		0 0		194
	9 HEALTH PARTNERS	0	0		0 0		194
4. 20 0797	O CENTER OF HOPE	0	0		0 0	0	194
0.00	Cross Foot Adjustments						200
1.00	Negative Cost Centers						201
2.00	Cost to be allocated (per Wkst. B,	0	19, 917, 676	1, 125, 44	4 5, 875, 748	2, 191, 976	202
3.00	Part I)	0. 000000	63. 073534	1. 68163	2 19. 757852	13.008682	200
03.00 04.00	Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B,	0.00000	5, 724, 818				
	Part II)		5,724,010	112,20	1, 521, 740	420,470	204
05.00	Unit cost multiplier (Wkst. B, Part	0. 000000	18. 128847	0. 16764	4. 444497	2. 530964	205
6.00	NAHE adjustment amount to be allocated						206
07.00	(per Wkst. B-2) NAHE unit cost multiplier (Wkst. D,						207
	Parts III and IV)						[]

	Financial Systems LOCATION - STATISTICAL BASIS	FRANCI SCAN HEALT	H MICHIGAN CITY Provider CC	CN: 15-0015 Pe	eri od:	u of Form CMS-2 Worksheet B-1	2552-10
				Fr Tc	om 01/01/2021 12/31/2021	Date/Time Pre	
	Cost Center Description	CAFETERI A (FTE' S)	NURSI NG ADMI NI STRATI ON	CENTRAL SERVICES &	PHARMACY (COSTED	5/26/2022 11: MEDI CAL RECORDS &	23 am
			(DIRECT NRSING	SUPPLY (COSTED	REQUIS.)	LI BRARY (GROSS CHAR	
		11.00	HRS) 13.00	REQUIS.) 14.00	15.00	GES) 16.00	
(GENERAL SERVICE COST CENTERS	11.00	13.00	14.00	15.00	18.00	
$\begin{array}{cccccccccccccccccccccccccccccccccccc$	D0100 CAP REL COSTS-BLDG & FIXT D0200 CAP REL COSTS-MVBLE EQUIP D0400 EMPLOYEE BENEFITS DEPARTMENT D0500 ADMINISTRATIVE & GENERAL D0500 MAINTENANCE & REPAIRS D0700 OPERATION OF PLANT D0800 LAUNDRY & LINEN SERVICE D0900 HOUSEKEEPING D1000 DIETARY D1100 CAFETERIA D1300 NURSING ADMINISTRATION D1400 CENTRAL SERVICES & SUPPLY D1500 PHARMACY D1500 MEDICAL RECORDS & LIBRARY D1700 SOCIAL SERVICE D1080 INSERVICE EDUCATION D1900 NONPHYSICIAN ANESTHETISTS D2000 NURSING PROGRAM D2100 I & SERVICES-SALARY & FRINGES APPRV D2200 PARMED ED PRGM-(SPECIFY)	60, 574 2, 847 457 2, 827 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	28, 404 0	22, 825, 410 130, 822 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	100 0 0 0 0 0 0 0 0 0 0 0 0 0	1, 020, 828, 970 0 0 0 0 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 1. \ 00\\ 2. \ 00\\ 4. \ 00\\ 5. \ 00\\ 6. \ 00\\ 7. \ 00\\ 8. \ 00\\ 9. \ 00\\ 10. \ 00\\ 11. \ 00\\ 13. \ 00\\ 14. \ 00\\ 15. \ 00\\ 16. \ 00\\ 17. \ 00\\ 18. \ 00\\ 19. \ 00\\ 20. \ 00\\ 21. \ 00\\ 22. \ 00\\ 23. \ 00\\ \end{array}$
	NPATIENT ROUTINE SERVICE COST CENTERS D3000 ADULTS & PEDIATRICS	17, 526	11, 620	1, 068, 679	0	75, 154, 895	30.00
	D3100 I NTENSI VE CARE UNI T D3200 CORONARY CARE UNI T	3, 884	3, 884	370, 272 0	0	16, 533, 543 0	31.00 32.00
1	D3300 BURN I NTENSI VE CARE UNI T	0	0	0	0	0	33.00
	03400 SURGICAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF	0 2,007	0 1, 648	0 8, 366	0	0 6, 250, 035	34.00 40.00
	04100 SUBPROVI DER – I RF	2,007	0,040	0, 300	0	0, 200, 000	41.00
	04300 NURSERY	566	566	0	0	2, 055, 349	43.00
	04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY		0	0	0	0	44.00 45.00
46.00	04600 OTHER LONG TERM CARE	0	0	0	0	0	
	ANCI LLARY SERVICE COST CENTERS	9, 300	1, 339	15, 138, 173	0	162, 681, 971	50.00
	D5100 RECOVERY ROOM	9, 300	1, 339	13, 138, 173	0	02,001,971	51.00
	D5200 DELIVERY ROOM & LABOR ROOM	1,012		0	0	3, 685, 504	
	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	101 4, 938		0 708, 940	0	10, 368, 372 128, 622, 350	
	05400 RADIOLOGI - DI AGNOSTI C 05401 FSED RADIOLOGY - DI AGNOSTI C	1, 628		60, 436	0	28, 408, 336	1
55.00 (05500 RADI OLOGY-THERAPEUTI C	668	0	371, 078	0	19, 318, 818	
	05501 WOODLAND CANCER CARE CTR	424	424	55, 511	0	4, 336, 926	
	05600 RADI 0I SOTOPE 05700 CT_SCAN		0	0	0	0	
	05800 MRI	0	0	0	0	0	
	05900 CARDI AC CATHETERI ZATI ON	988	0	3, 398, 979	0	36,005,555	
	D6000 LABORATORY D6001 FS ED LAB		0	452, 630 713	0	100, 124, 636 14, 897, 414	1
	D6100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0	/13	0	14,077,414	61.00
1	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	О	0	
	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	41, 510	0	1, 575, 822	
	06301 FS ED BLOOD BANK 06400 I NTRAVENOUS THERAPY		0	0	0	22, 542 0	
	06500 RESPIRATORY THERAPY	1, 583	0	197, 953	Ő	20, 544, 305	
	D6600 PHYSI CAL THERAPY	1, 113	0	34, 940	0	21, 257, 798	
		0	0	0	0	0	
	D6800 SPEECH PATHOLOGY D6900 ELECTROCARDI OLOGY	1, 363	0	40, 171	0	0 33, 000, 490	
	D7000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	1
	07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	38, 123, 036	1
	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0 100	38, 047, 166 139, 402, 749	1
	07400 RENAL DIALYSIS		0	0	0	139, 402, 749	
	07500 ASC (NON-DI STINCT PART)	0	0	0	Ö	0	
	D3020 CLINIC	0	0	0	0	0	
	D7700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77.00
	DIPATIENT SERVICE COST CENTERS	0	0	0	0	0	88.00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
	09000 CLI NI C			0	0		90.00

Health Financial Systems FRA	ANCISCAN HEALT	H MICHIGAN CITY	,	In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider CC		Period:	Worksheet B-1	
				rom 01/01/2021 o 12/31/2021	Date/Time Pre	pared [.]
					5/26/2022 11:	
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
	(FTE'S)	ADMI NI STRATI ON	SERVICES &	(COSTED	RECORDS &	
		(DIRECT NRSING	SUPPLY (COSTED	REQUIS.)	LI BRARY (GROSS CHAR	
		HRS)	REQUIS.)		GES)	
	11.00	13.00	14.00	15.00	16.00	
90. 03 09003 I NFUSI ON OP SERVI CES	553	553	55, 061	0	5, 194, 075	90.03
91.00 09100 EMERGENCY	5, 269		589, 886		94, 731, 669	
91. 01 09101 FREE STANDING EMERGENCY DEPT	1, 520	1, 520	91, 335	6 0	20, 485, 614	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92.00
94. 00 09400 HOME PROGRAM DI ALYSI S	C	0	(0	0	94.00
95. 00 09500 AMBULANCE SERVICES	C	-	(0	95.00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	C	0	C	0	0	96.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	C	0	C	0 0	0	97.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	C	0	C	0 0	0	98.00
99.00 09900 CMHC	C	0	C	0 0	0	99.00
99.10 09910 CORF	C	0	0	0	0	99.10
100.00 10000 I & SERVI CES-NOT APPRVD PRGM 101.00 10100 HOME HEALTH AGENCY			(100.00 101.00
SPECIAL PURPOSE COST CENTERS	U				0	101.00
105. 00 10500 KI DNEY ACQUI SI TI ON	C	0	(0	0	105.00
106. 00 10600 HEART ACQUI SI TI ON	C	0	C			106.00
107.00 10700 LI VER ACQUI SI TI ON	C	0	C	0 0	0	107.00
108.00 10800 LUNG ACQUISITION	C	0	C	0 0	0	108.00
109.00 10900 PANCREAS ACQUI SI TI ON	C	0	C	0 0		109.00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON	C	0	0	0		110.00
111.00 11100 I SLET ACQUI SI TI ON	C	0	(0	0	111.00
113. 00 11300 I NTEREST EXPENSE 114. 00 11400 UTI LI ZATI ON REVI EW-SNF						113.00 114.00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)	C	0	C	0	0	115.00
116. 00 11600 HOSPI CE	C	0	(o o		116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	60, 574	27, 835	22, 815, 455	5 100	1, 020, 828, 970	118.00
NONREI MBURSABLE COST CENTERS		1 1		1		
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	C		0			190.00
191. 00 19100 RESEARCH	C	0	2 210	-		191.00 192.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 193. 00 19300 NONPALD WORKERS		0	3, 219			192.00
194. 00 07950 BEACON JOINT VENTURE		0	(194.00
194. 01 07951 WORKI NG WELL	C	569	6, 736	0		194.01
194.03 07953 MED WATCHER	C	0	C	0	0	194.03
194.1007960 DUNELAND FITNESS CTR	C	0	C	0 0	0	194. 10
194.11 07961 OMNI HEALTH & FITNESS CHESTERTOWN	C	0	C	0 0		194. 11
194.16 07966 PHYSICIAN PRACTICE MD WISW	C	0	0	0		194.16
194. 19 07969 HEALTH PARTNERS	C	0	(0		194.19
194.20 07970 CENTER OF HOPE 200.00 Cross Foot Adjustments	U	0	Ĺ	0	0	194. 20 200. 00
200.00Cross Foot Adjustments201.00Negative Cost Centers						200.00
202.00 Cost to be allocated (per Wkst. B,	3, 619, 503	5, 301, 017	3, 536, 711	6, 474, 883	1, 954, 534	
Part I)	0,017,000	0,001,017	0,000,711	0, 11 1, 000	17 /0 17 00 1	202:00
203.00 Unit cost multiplier (Wkst. B, Part I)	59. 753409		0. 154946		0. 001915	
204.00 Cost to be allocated (per Wkst. B,	682, 861	406, 123	1, 639, 617	601, 934	82, 495	204.00
Part II)	11 070470	14 200000	0 074000	4 010 040000	0.000001	205 00
205.00 Unit cost multiplier (Wkst. B, Part	11. 273170	14. 298092	0.071833	6, 019. 340000	0.000081	205.00
206.00 NAHE adjustment amount to be allocated						206. 00
(per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D,						207.00
Parts III and IV)						207.00
						-

	LLOCATION - STATISTICAL BASIS	RANCI SCAN HEALTI	Provi der C	CN: 15-0015 F	Period: From 01/01/2021	u of Form CMS-25 Worksheet B-1
					o 12/31/2021	Date/Time Prepa
			OTHER GENERAL			5/26/2022 11:23
			SERVI CE			RESI DENTS
	Cost Center Description	SOCI AL SERVI CE	I NSERVI CE EDUCATI ON	NONPHYSI CI AN ANESTHETI STS	NURSI NG PROGRAM	SERVICES-SALAR Y&FRINGES
		(TIME SPENT)	(TIME SPENT)	(ASSI GNED	(ASSI GNED	APPRV
				TIME)	TIME)	(ASSI GNED
		17.00	18.00	19.00	20.00	TIME) 21.00
	GENERAL SERVICE COST CENTERS				20100	21100
	00100 CAP REL COSTS-BLDG & FIXT					
	00200 CAP REL COSTS-MVBLE EQUIP					
	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL					
	00600 MAI NTENANCE & REPAI RS					
00	00700 OPERATION OF PLANT					
	00800 LAUNDRY & LINEN SERVICE					
	00900 HOUSEKEEPI NG 01000 DI ETARY					
	01100 CAFETERIA					
	01300 NURSI NG ADMI NI STRATI ON					
	01400 CENTRAL SERVICES & SUPPLY					
	01500 PHARMACY					
	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	_				
	01080 I NSERVI CE EDUCATI ON	0	0			
	01900 NONPHYSICIAN ANESTHETISTS	0	0	c		
	02000 NURSI NG PROGRAM	0	0		0	
	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0			0
	02200 I & R SERVICES-OTHER PRGM COSTS APPRV 02300 PARAMED ED PRGM-(SPECIFY)	0	0			
. 00	INPATIENT ROUTINE SERVICE COST CENTERS	0				· · · · · · · · · · · · · · · · · · ·
. 00	03000 ADULTS & PEDIATRICS	0	0	C	0 0	0
	03100 I NTENSI VE CARE UNI T	0	0			0 3
	03200 CORONARY CARE UNIT	0	0	C	-	0
-	03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT	0			-	0
-	04000 SUBPROVIDER - IPF	0	0		-	0
	04100 SUBPROVI DER – I RF	0	0	C C	-	0
	04300 NURSERY	0	0	C	, s	0
	04400 SKI LLED NURSI NG FACI LI TY	0	0	C	-	0 4
	04500 NURSING FACILITY 04600 OTHER LONG TERM CARE		0			
	ANCI LLARY SERVICE COST CENTERS				, <u> </u>	
	05000 OPERATING ROOM	0	0			0
	05100 RECOVERY ROOM	0	0			0
	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	0				0
	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0
	05401 FSED RADIOLOGY - DIAGNOSTIC	0	0	C	0 0	0
	05500 RADI OLOGY-THERAPEUTI C	0	0	C	0	0
	05501 WOODLAND CANCER CARE CTR 05600 RADI 0I SOTOPE	0			0	0
		0				
					, v	
. 00	05700 CT SCAN 05800 MRI	0	0	C	0 0	0 5
. 00 . 00 . 00	05800 MRI 05900 CARDI AC CATHETERI ZATI ON	0	0		0 0 0	0 5
. 00 . 00 . 00 . 00	05800 MRI 05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0				0
. 00 . 00 . 00 . 00 . 01	05800 MRI 05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY 06001 FS ED LAB					0 2 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
. 00 . 00 . 00 . 00 . 01 . 00	05800 MRI 05900 CARDIAC CATHETERIZATION 06000 LABORATORY 06001 FS ED LAB 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY				-	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
. 00 . 00 . 00 . 00 . 01 . 00 . 00	05800 MRI 05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY 06001 FS ED LAB				-	0 0 0 0
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	05800 MRI 05900 CARDIAC CATHETERIZATION 06000 LABORATORY 06001 FS ED LAB 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06300 BLOOD STORING, PROCESSING & TRANS. 06301 FS ED BLOOD BANK				-	
. 00 . 00 . 00 . 00 . 01 . 00 . 00 . 01 . 00	05800 MRI 05900 CARDIAC CATHETERIZATION 06000 LABORATORY 06001 FS ED LAB 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06300 BLOOD STORING, PROCESSING & TRANS. 06301 FS ED BLOOD BANK 06400 INTRAVENOUS THERAPY				-	
. 00 . 00 . 00 . 00 . 01 . 00 . 00 . 00	05800 MRI 05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY 06001 FS ED LAB 06100 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 06301 FS ED BLOOD BANK 06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY				-	
. 00 . 00 . 00 . 01 . 00 . 00 . 00 . 00	05800 MRI 05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY 06001 FS ED LAB 06100 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 06301 FS ED BLOOD BANK 06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY				-	
. 00 . 00 . 00 . 01 . 00 . 00 . 00 . 00	05800 MRI 05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY 06001 FS ED LAB 06100 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 06301 FS ED BLOOD BANK 06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY				-	
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	05800 MRI 05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY 06001 FS ED LAB 06100 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 06301 FS ED BLOOD BANK 06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY				-	
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	05800 MRI 05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY 06001 FS ED LAB 06100 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 06301 FS ED BLOOD BANK 06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06600 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07000 ELECTROCARDI OLOGY				-	
. 00 . 00 . 00 . 01 . 00 . 00 . 00 . 00	05800 MRI 05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY 06001 FS ED LAB 06100 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 06301 FS ED BLOOD BANK 06400 INTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07000 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT				-	
. 00 . 00 . 00 . 00 . 01 . 00 . 00 . 00	05800 MRI 05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY 06001 FS ED LAB 06100 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 06301 FS ED BLOOD BANK 06400 INTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY 06500 PHYSI CAL THERAPY 06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 07200 IMPL. DEV. CHARGED TO PATI ENTS				-	
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Cost Center Description SCI AL SERVICE SIGNATION (TIME SPENT) NOMENSICIAL SIGNATION (TIME SPENT) NOMENSICIAL SIGNATION (TIME SPENT) NOMENSICIAL SIGNATION (SSI GRED TIME) 80 00 09000 FEDERALY QUALIFIED HEALTH CENTER 00 09000 CLINIC 17.00 18.00 19.00 20.00 91 00 09000 FEDERALY QUALIFIED HEALTH CENTER 00 09000 CLINIC 0 0 0 0 0 91 00 09000 FEDERALY QUALIFIED HEALTH CENTER 00 09000 CLINIC 0 0 0 0 0 0 91 00 09000 FEDERALY QUALIFIED HEALTH CENTER 00 09000 CLINIC 0 <	-1	u of Form CMS-: Worksheet B-1	eriod: com 01/01/2021	N: 15-0015 P	H MICHIGAN CITY Provider C		Health Financial Systems FR COST ALLOCATION - STATISTICAL BASIS
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	LLOCATION - STATISTICAL BASIS		Provider CC	N: 15-0015	Period: From 01/01/2021	Worksheet B-1
					To 12/31/2021	Date/Time Prepar
	Cost Center Description	I NTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)	PARAMED ED PRGM (ASSIGNED TIME)			5/26/2022 11: 23
		22.00	23.00			
	GENERAL SERVICE COST CENTERS					
-	00100 CAP REL COSTS-BLDG & FIXT					
-	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT					
	00500 ADMINISTRATIVE & GENERAL					
	00600 MAI NTENANCE & REPAI RS					
	00700 OPERATION OF PLANT					
	00800 LAUNDRY & LINEN SERVICE					
	00900 HOUSEKEEPI NG					
	01000 DI ETARY					1
00	01100 CAFETERI A					1
00	01300 NURSING ADMINISTRATION					1
	01400 CENTRAL SERVICES & SUPPLY					1
	01500 PHARMACY					1
	01600 MEDICAL RECORDS & LIBRARY					1
	01700 SOCIAL SERVICE 01080 INSERVICE EDUCATION					1
	01900 NONPHYSI CLAN ANESTHETI STS					1
	02000 NURSI NG PROGRAM					2
	02100 I & R SERVICES-SALARY & FRINGES APPRV					2
	02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0				2
00	02300 PARAMED ED PRGM-(SPECIFY)		0			2
	INPATIENT ROUTINE SERVICE COST CENTERS					
	03000 ADULTS & PEDI ATRI CS	0	0			3
	03100 I NTENSI VE CARE UNI T	0	0			3
	03200 CORONARY CARE UNIT	0	0			3.
	03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT	0	0			3
	04000 SUBPROVIDER - IPF	0	0			4
	04100 SUBPROVI DER – I RF	0	0			4
	04300 NURSERY	0	0			4
	04400 SKILLED NURSING FACILITY	0	0			4
	04500 NURSING FACILITY	0	0			4
	04600 OTHER LONG TERM CARE	0	0			4
	ANCI LLARY SERVICE COST CENTERS		0			
	05000 OPERATING ROOM 05100 RECOVERY ROOM	0	0			5
	05200 DELIVERY ROOM & LABOR ROOM	0	0			5
	05300 ANESTHESI OLOGY	0	0			5
	05400 RADI OLOGY-DI AGNOSTI C	0	0			5
01	05401 FSED RADIOLOGY - DIAGNOSTIC	0	0			5
	05500 RADI OLOGY - THERAPEUTI C	0	0			5
	05501 WOODLAND CANCER CARE CTR	0	0			5
	05600 RADI OI SOTOPE	0	0			5
	05700 CT SCAN 05800 MRI	0	0			5
	05900 CARDI AC CATHETERI ZATI ON	0	0			5
	06000 LABORATORY	0	0			6
	06001 FS ED LAB	0	0			6
00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY					6
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0			6
	06300 BLOOD STORING, PROCESSING & TRANS.	0	0			6
-	06301 FS ED BLOOD BANK	0	0			6
	06400 I NTRAVENOUS THERAPY	0	0			6
	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0	0			6
	06700 OCCUPATIONAL THERAPY	0	0			6
	06800 SPEECH PATHOLOGY	0	0			6
	06900 ELECTROCARDI OLOGY	0	Ő			6
	07000 ELECTROENCEPHALOGRAPHY	0	0			7
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0			7
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0			7.
	07300 DRUGS CHARGED TO PATIENTS	0	0			7
	07400 RENAL DIALYSIS	0	0			7
00	ATEOD ACC (NON DICTINCT DADT)					
00 00	07500 ASC (NON-DISTINCT PART)	0	0			
00 00 00	07500 ASC (NON-DISTINCT PART) 03020 CLINIC 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0			7

OST ALLOCATION - STATISTICAL BASIS		Provider CCN: 15	-0015	Peri od:	Worksheet	B-1
				From 01/01/2021 To 12/31/2021	Date/Time	
Cost Center Description	I NTERNS & RESI DENTS SERVI CES-OTHER PRGM COSTS APPRV (ASSI GNED TI ME)	PARAMED ED PRGM (ASSI GNED TI ME)		L	5/26/2022	<u>11: 23 a</u>
	22.00	23.00				
 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 00 09000 CLINIC 03 09003 INFUSION OP SERVICES 00 09100 EMERGENCY 01 09101 FREE STANDING EMERGENCY DEPT 		0 0 0 0 0				89 90 90 91 91
. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART						92
OTHER REIMBURSABLE COST CENTERS 4. 00 09400 HOME PROGRAM DI ALYSI S 5. 00 09500 AMBULANCE SERVI CES 5. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 7. 00 09700 DURABLE MEDI CAL EQUI P. SOLD	000000000000000000000000000000000000000	0 0 0				94 95 96
7. 00 09700 DURABLE MEDICAL EQUIP-SOLD 8. 00 09850 OTHER REIMBURSABLE COST CENTERS 9. 00 09900 CMHC 9. 10 09910 CORF 9. 00 10000 LEP SERVICES NOT ADDRVD DRCM	000000000000000000000000000000000000000	0 0 0				97 98 99 99
DO. 00 10000 I &R SERVICES-NOT APPRVD PRGM D1. 00 10100 HOME HEALTH AGENCY	0	0 0				100 101
SPECIAL PURPOSE COST CENTERS		a				
D5. 00 10500 KIDNEY ACQUISITION 26. 00 10600 HEART ACQUISITION 27. 00 10700 LIVER ACQUISITION 28. 00 10800 LIVER ACQUISITION 29. 00 10900 PANCREAS ACQUISITION 10. 00 11000 INTESTINAL ACQUISITION						105 106 107 108 109 110
11. 00 11100 I SLET ACQUI SI TI ON 13. 00 11300 I NTEREST EXPENSE 14. 00 11400 UTI LI ZATI ON REVI EW-SNF 15. 00 11500 AMBULATORY SURGI CAL CENTER (D. P.)	0	0				111 113 114 115
16.00 11600 HOSPICE 18.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	0				116 118
NONREI MBURSABLE COST CENTERS						
90. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 91. 00 19100 RESEARCH 92. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 93. 00 19300 NONPAI D WORKERS 94. 00 07950 BEACON JOI NT VENTURE 94. 01 07951 WORKI NG WELL	0 0 0 0 0	0 0 0 0 0				190 191 192 193 194 194
94.0307953 MED WATCHER 94.1007960 DUNELAND FITNESS CTR 94.1107961 OMNI HEALTH & FITNESS CHESTERTOWN 94.1607966 PHYSICIAN PRACTICE MD WISW	000000000000000000000000000000000000000	0 0 0				194 194 194 194
19 07969 HEALTH PARTNERS 14.20 07970 CENTER OF HOPE 10.00 Cross Foot Adjustments 11.00 Negative Cost Centers	0	0 0				194 194 200 201
 12.00 Cost to be allocated (per Wkst. B, Part I) 13.00 Unit cost multiplier (Wkst. B, Part I) 14.00 Cost to be allocated (per Wkst. B, Part II) 	0 0. 000000 0	0 0. 000000 0				202 203 204
05.00 Unit cost multiplier (Wkst. B, Part	0. 000000	0. 000000				205
D6.00 NAHE adjustment amount to be allocated (per Wkst. B-2)		0				206
07.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)		0. 000000				207

Heal th Financial				I Syst	ems			
	COMPLIE		OF	DATIO	OF	COSTS	ΤO	(

FRANCISCAN HEALTH MICHIGAN CITY

In Lieu of Form CMS-2552-10

31.00 0.03100 INTERSIVE CARE_UNIT 8, 617, 071 120 8, 617, 071 613 <th< th=""><th>Health Financial Systems F</th><th>RANCI SCAN HEALT</th><th><u>H MICHIGAN CIT</u></th><th>ſ</th><th>In Lie</th><th>eu of Form CMS-</th><th>2552-10</th></th<>	Health Financial Systems F	RANCI SCAN HEALT	<u>H MICHIGAN CIT</u>	ſ	In Lie	eu of Form CMS-	2552-10
Cost Center Description Total Cost Perty 1, col Terry Hint Ag Total Cost Perty 1, col Total Cost Ag Total Cost Perty 1, col Total Cost Ag Total Cost Perty 1, col Total Cost Ag Total Cost Perty 1, col Total Cost Perty 1, col <thtotal cost<br="">Perty 1, col <thtotal cost<br="">Pert</thtotal></thtotal>			Provider C	F	rom 01/01/2021	Part I	pared: 23 am
Cost Center Description Total Cost (Prom Mist e), Prof 20, 201 Total Cost (Prof 20, 201 Total Cost (Prof 20, 201 Total Cost (Prof 20, 201 Total Cost (Prof 20, 201 50.00 00000 (Prof 20, Prof 20, 201 200 3.00 4.00 5.00 50.00 00000 (Prof 20, Prof 20, 201 201 201 2.00 3.00 4.00 5.00 50.00 00000 (Prof 20, Prof 20, 201 201 201 2.00 3.00 4.00 5.00 50.00 00000 (Prof 20, Prof 20, 201 201 201 2.00 3.00 4.00 5.00 50.00 00000 (Prof 20, Prof 20, 201 2.00 3.00 2.00 3.00 2.00 3.00 2.00 3.00 2.00 3.00 2.00<			Title	e XVIII	Hospi tal	PPS	20 0111
Image: state of the s							
INPART FAT ROUTHE SHEWICE COST CENTERS 39:564 940 30:00 4.00 5.00 10:00 COSON ADDITS, A PRIATRICS 39:564 940 30:514 946 30:514 946 30:500 50:500 70:500 <td< td=""><td>Cost Center Description</td><td>(from Wkst. B, Part I, col.</td><td></td><td>Total Costs</td><td></td><td>Total Costs</td><td></td></td<>	Cost Center Description	(from Wkst. B, Part I, col.		Total Costs		Total Costs	
30.00 DORDO ADMULTS & FID ATRICS 39, 564, 448 39, 564, 448 39, 564, 448 39, 564, 448 39, 564, 749 30, 56, 617, 579 30, 510, 510, 510, 510, 510, 510, 510, 51			2.00	3.00	4.00	5.00	
31.00 03100 INTERSIVE CARE UNIT 8, 617, 071 120 8, 617, 071 120 8, 617, 071 320 32.00 03300 BURN INTERSIVE CARE UNIT 0							
22.00 03200 CORONARY CARE UNIT 0 </td <td></td> <td>39, 584, 948</td> <td></td> <td>39, 584, 948</td> <td>6, 844</td> <td></td> <td></td>		39, 584, 948		39, 584, 948	6, 844		
33.00 B3300 BURRI INTERSIVE CARE UNIT 0 <	31.00 03100 INTENSIVE CARE UNIT	8, 617, 071		8, 617, 071	1 120	8, 617, 191	31.00
34 00 03400 SURG (CAL, INTERSIVE CARE UNIT 0	32.00 03200 CORONARY CARE UNI T	0		0	0 0	0	32.00
40.00 OMODO SUBPROVIDER - I PF 5, 192, 358 5, 192, 358 4, 560 5, 192, 358 0 1, 623, 028 0 1, 623, 028 0 1, 623, 028 0 1, 623, 028 0 1, 623, 028 0 1, 623, 028 0 1, 623, 028 0 1, 623, 028 0 1, 623, 028 0 1, 623, 028 0 1, 623, 028 0	33.00 03300 BURN INTENSIVE CARE UNIT	0		0	0 0	0	33.00
11.00 0.01100 SUBPROVIDER - I.BF 0.0 0.00		0		0	0 0	0	34.00
12.00 04300 NURSERY 1, 623, 028 1, 623, 028 0		5, 192, 358		5, 192, 358	3 4, 540	5, 196, 898	40.00
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44.00 0 <td>44.00 04400 SKILLED NURSING FACILITY</td> <td>0</td> <td></td> <td></td> <td>0 0</td> <td>0</td> <td>44.00</td>	44.00 04400 SKILLED NURSING FACILITY	0			0 0	0	44.00
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54.00 05400 RADI CLORY-DI AGNOSTIC 11, 442, 871 11, 442, 871 0 11, 442, 871 0 12, 483, 671 641 2, 833, 671 641 2, 833, 871 55 00 0500 RADI CLORY-THERAPEUTIC 2, 437, 671 641 2, 833, 671 641 2, 833, 871 55 00 0500 RADI CLORY-THERAPEUTIC 2, 437, 671 641 2, 833, 871 56 00 00 0 0 923, 372 50 9500 RADI CLORY-THERAPEUTIC 2, 437, 873 2, 243, 835 0 4, 244, 835 0 923, 372 50 00 500 00 0 <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td></td<>							
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55. 01 05501 WODEAND CARCER CARE CTR 923, 372 923, 372 923, 372 923, 372 923, 372 923, 372 923, 372 923, 372 923, 372 923, 372 923, 372 923, 372 923, 372 923, 372 923, 372 923, 372 923, 372 933 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
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58. 00 05800 MRI 0 0 0 51. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 4. 244. 835 4. 244. 835 0 1. 100. 042 1. 100. 042 1. 990. 233 0 1. 898. 233 0 1. 898. 233 0 1. 898. 233 0 1. 898. 233 0 0 0 0 6 60. 00 0000 WHOLE BLOOD BANCORY 0		-					
59. 00 05900 CARDIACC CATHETERIZATION 4.244.835 4.244.835 0 4.244.835 0 4.244.835 0 4.244.835 0 4.244.835 0 4.244.835 0 1.990 11.102.032 6 60.00 06001 PEP CLINICAL LAB SERVICES-PROM ONLEL 0 0 0 6 0 63.01 63.937 6 6.3.933 6 6 6 0 64.00 6 6 0 6 6 0 66.00 6 6 6 0 6 6 6 6 6 0 6 6 6 0 6		0		0	-		
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61:00 06:100 PRP CLINICAL LAB SERVICES-PROM ONLY 0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
62:00 06:200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
63:00 06300 BLODD STORI NG, PROCESSI NG & TRANS. 63.393 63.521 63.521 63.521 63.521 63.521 63.521 63.521 63.521 73.500 63.600 66.00 67.73 73.730 63.521 73.900 73.700 70.000 70.73		0			-		
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OTHER REI MBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DI ALYSI S 0 0 0 0 9 95.00 09500 AMBULANCE SERVI CES 0 0 0 0 0 9 96.00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 9 97.00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 0 9 98.00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 9 9 0 0 0 9 9 0 0 0 9 9 0 0 0 0 9 9 0 0 0 9 9 0 0 0 0 9 9 0 0 0 9 0 0 0 0 10 0 10							
94.00 09400 HOME PROGRAM DIALYSIS 0 0 0 0 9 95.00 09500 AMBULANCE SERVICES 0 0 0 0 0 9 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 0 0 0 9 97.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 0 0 9 98.00 09850 OTHER REIMBURSABLE COST CENTERS 0 0 0 9 9 99.00 09900 CMHC 0 0 0 9 9 9 9 0 0 9 9 9 0 0 9 9 9 0 99.00 0 0 0 9 9 9 0 0 0 9 9 9 0 0 0 9 9 0 9 9 0 0 9 9 0 0 0 9 0 9 0 9 0 9 0 0 9 0 0 0	· · · · · · · · · · · · · · · · · · ·						
95.00 09500 AMBULANCE SERVICES 0 0 0 99 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 0 0 0 99 97.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 0 0 99 98.00 09850 OTHER REIMBURSABLE COST CENTERS 0 0 0 99 99.00 09900 CMHC 0 0 0 99 99.10 09900 CMF 0 0 0 99 100.00 148 SERVICES-NOT APPRVD PRGM 0 0 0 0 100 101.00 HOME HEALTH AGENCY 0 0 0 0 0 100 99.10 0500 KI DNEY ACQUI SI TI ON 0 0 0 0 100 105.00 10500 KI DNEY ACQUI SI TI ON 0 0 0 0 100 106.00 10600 HEART ACQUI SI TI ON 0 0 0 0 100 107.00 10800 LIVER ACQUI SI TI ON 0 0 0 <td></td> <td>0</td> <td></td> <td>(</td> <td>0 0</td> <td>0</td> <td>94.00</td>		0		(0 0	0	94.00
96.00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 99 97.00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 0 99 98.00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 99 99.00 09900 CMHC 0 0 0 99 99.10 09910 CORF 0 0 0 99 0 09910 CORF 0 0 0 100 99 100.00 1 & & & & & & & & & & & & & & & & & & &		0		(0 0	0	95.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS 0 0 0 99 0 09900 CMHC 0 0 0 99 0 09900 CMHC 0 0 0 0 99 0 09900 CMHC 0 0 0 0 99 0 09900 CMHC 0 0 0 0 99 0 09910 CORF 0 0 0 0 99 0	96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0		(0 0	0	96.00
99.00 09900 CMHC 0 0 94 99.10 09910 CORF 0 0 0 94 100.00 1 & R SERVI CES-NOT APPRVD PRGM 0	97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0		0	0 0	0	97.00
99.10 09910 CORF 0 0 94 100.00 I&R SERVICES-NOT APPRVD PRGM 0 0 0 0 0 100 101.00 10100 HOME HEALTH AGENCY 0 0 0 0 0 0 100 SPECI AL PURPOSE COST CENTERS 5 0 0 0 0 0 100 105.00 10500 KI DNEY ACQUISITION 0 0 0 0 100 106.00 10600 HEART ACQUISITION 0 0 0 0 0 0 100 107.00 10700 LIVER ACQUISITION 0 0 0 0 0 100 108.00 10800 LUNG ACQUISITION 0	98.00 09850 OTHER REIMBURSABLE COST CENTERS	0		0	0 0	0	98.00
100.00 10000 I &R SERVICES-NOT APPRVD PRGM 0 0 0 1000 101.00 HOME HEALTH AGENCY 0 <td></td> <td>0</td> <td></td> <td> (</td> <td>ס</td> <td>0</td> <td></td>		0		(ס	0	
101.00 10100 HOME HEALTH AGENCY 0 0 0 100 SPECIAL PURPOSE COST CENTERS 0 0 0 105 00 105 00 105 00 105 00 105 00 105 00 105 00 105 00 105 00 105 00 105 00 105 00 105 00 105 00 106 00 105 00 106 00 106 00 106 00 106 00 106 00 107	99. 10 09910 CORF	0		0	2		
SPECIAL PURPOSE COST CENTERS 105.00 10500 KI DNEY ACQUI SI TI ON 0 0 0 105 106.00 10600 HEART ACQUI SI TI ON 0 0 0 0 0 0 106 107.00 10700 LI VER ACQUI SI TI ON 0 0 0 0 0 107 108.00 10800 LUNG ACQUI SI TI ON 0	100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0		0	2		100.00
105.00 10500 KI DNEY ACQUI SI TI ON 0 0 0 105 106.00 10600 HEART ACQUI SI TI ON 0	101.0010100 HOME HEALTH AGENCY	0)	0	101.00
106.00 10600 HEART ACQUISITION 0 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
107.00 10700 LIVER ACQUISITION 0 <td></td> <td>0</td> <td></td> <td>(</td> <td>)</td> <td></td> <td>105.00</td>		0		()		105.00
108.00 10800 LUNG ACQUISITION 0 0 0 108	106.00 10600 HEART ACQUI SI TI ON	0		(כ	0	106.00
		0		(2		107.00
109.00/10900/PANCREAS ACQUISITION 0 0 0 0 0		0		(ס		108.00
		0					109.00
110. 00 11000 INTESTINAL ACQUISITION 0 0 110	110.00 11000 INTESTINAL ACQUISITION	0	1	(וכ	0	110.00

Health Financial Systems	FRANCI SCAN HEALTH	H MICHIGAN CITY	(In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CC		Period: From 01/01/2021 To 12/31/2021	Worksheet C Part I Date/Time Pre 5/26/2022 11:	epared: 23 am
		Title	e XVIII Hospital		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	
111.00 11100 ISLET ACQUISITION 113.00 11300 INTEREST EXPENSE 114.00 11400 UTILIZATION REVIEW-SNF 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 116.00 11600 HOSPICE 200.00 Subtotal (see instructions) 201.00 Less Observation Beds 202.00 Total (see instructions)	0 0 209, 490, 766 5, 411, 822 204, 078, 944		209, 490, 76 5, 411, 82 204, 078, 94	22	0 0 209, 516, 326 5, 411, 822	201.00

Health Financial Systems	F
COMPUTATION OF RATIO OF COSTS TO CHARGES	

NCI SCAN HEALTH MI CHI GAN CI TY

In Lieu of Form CMS-2552-10

	ATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-0015	Period: From 01/01/2021 To 12/31/2021	Worksheet C Part I Date/Time Pre 5/26/2022 11:	pared:
				e XVIII	Hospi tal	PPS	
	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	
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS			(5.0(0.05)			1 20 00
	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	65, 968, 958 16, 533, 543		65, 968, 95 16, 533, 54			30.00
	03200 CORONARY CARE UNIT	10, 555, 545		10, 555, 54	5		32.00
	03300 BURN INTENSIVE CARE UNIT	0			Ő		33.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0			C		34.00
40.00	04000 SUBPROVI DER – I PF	6, 250, 035		6, 250, 03	5		40.00
41.00	04100 SUBPROVIDER - IRF	0		0.055.04	0		41.00
43.00 44.00	04300 NURSERY 04400 SKI LLED NURSI NG FACI LI TY	2,055,349		2, 055, 34	7		43.00
45.00	04500 NURSING FACILITY	0					45.00
	04600 OTHER LONG TERM CARE	0					46.00
	ANCI LLARY SERVI CE COST CENTERS	1				I	
	05000 OPERATING ROOM	37, 324, 043	125, 357, 928	162, 681, 97		0. 000000	
	05100 RECOVERY ROOM	0	C		0.00000	0.000000	
52.00 53.00	05200 DELIVERY ROOM & LABOR ROOM	3, 328, 214	357, 290			0.000000	
53.00 54.00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	3, 053, 402 35, 663, 511	7, 314, 970 92, 958, 839			0.000000	
	05401 FSED RADIOLOGY - DIAGNOSTIC	1, 886, 619	26, 521, 717			0. 000000	
55.00	05500 RADI OLOGY-THERAPEUTI C	2, 389, 904	16, 928, 914			0. 000000	
	05501 WOODLAND CANCER CARE CTR	39, 256	4, 297, 670			0. 000000	
	05600 RADI OI SOTOPE	0	0		0. 000000	0. 000000	
	05700 CT SCAN	0	0		0. 00000	0.00000	
		19 542 009	17 442 EEZ	24 OOF FE	0.00000	0.00000	
59.00 60.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	18, 562, 998 45, 138, 631	17, 442, 557 54, 986, 005			0.000000	
60.00	06001 FS ED LAB	180, 972	14, 716, 442			0. 000000	
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	11,077,11	0. 000000	0. 000000	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	C		0. 000000	0.000000	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	1, 065, 366	510, 456	1, 575, 82		0. 000000	
63.01	06301 FS ED BLOOD BANK	1, 272	21, 270	22, 54		0.000000	
64.00	06400 I NTRAVENOUS THERAPY	0	0	00 544 00	0.00000	0.000000	
65.00 66.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	17, 704, 600 5, 582, 986	2, 839, 705 15, 674, 812			0.000000	
67.00	06700 OCCUPATI ONAL THERAPY	5, 562, 960	15, 074, 812	21,237,79	0. 000000	0. 000000	
68.00	06800 SPEECH PATHOLOGY	0	Ő		0. 000000	0. 000000	
	06900 ELECTROCARDI OLOGY	12, 577, 254	20, 423, 236	33, 000, 49		0. 000000	
	07000 ELECTROENCEPHALOGRAPHY	0	C		0. 000000	0. 000000	
	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	16, 030, 631	22,092,405			0.000000	
72.00 73.00	07200 I MPL. DEV. CHARGED TO PATIENTS	14, 610, 699	23, 436, 467			0.00000	
	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	31, 038, 040	108, 364, 709	139, 402, 74	9 0. 206490 0. 000000	0.000000	
	07500 ASC (NON-DI STI NCT PART)	0	C		0. 000000		
	03020 CLI NI C	0	C		0. 000000		1
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0		0.00000	0.00000	77.00
~~ ~~	OUTPATIENT SERVICE COST CENTERS						
	08800 RURAL HEALTH CLINIC	0	0				88.00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0			0. 000000	0. 000000	89.00 90.00
	09003 INFUSION OP SERVICES	13, 184	5, 180, 891	5, 194, 07			
	09100 EMERGENCY	29, 908, 046	64, 823, 623			0. 000000	
91.01	09101 FREE STANDING EMERGENCY DEPT	2, 794, 189	17, 691, 425	20, 485, 61	4 0. 311968	0. 000000	91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	9, 185, 937	9, 185, 93	7 0. 589142	0.00000	92.00
04.00	OTHER REIMBURSABLE COST CENTERS			1	0.000000	0.000000	04.00
	09400 HOME PROGRAM DI ALYSI S 09500 AMBULANCE SERVI CES	0	0		0. 000000 0. 000000	0.000000	
	09500 AMBULANCE SERVICES 09600 DURABLE MEDICAL EQUIP-RENTED	0			0.000000	0. 000000	
	09700 DURABLE MEDICAL EQUIP-RENTED	0	0		0. 000000	0. 000000	
	09850 OTHER REIMBURSABLE COST CENTERS	0	0		0. 000000	0. 000000	
99.00	09900 СМНС	0	C		C		99.00
	09910 CORF	0	C		C		99.10
	10000 I &R SERVICES-NOT APPRVD PRGM	0	0				100.00
101.00	10100 HOME HEALTH AGENCY	0	0	1	0		101.00
105 00	SPECIAL PURPOSE COST CENTERS 10500 KIDNEY ACQUISITION		0				105.00
	10600 HEART ACQUISITION	0	0				106.00
	10700 LIVER ACQUISITION	0	C		С		107.00
108.00	10800 LUNG ACQUISITION	0	C		C		108.00
	10900 PANCREAS ACQUI SI TI ON	0	C		C		109.00
	11000 INTESTINAL ACQUISITION	0	0	1	U		110.00
	11100 I SLET ACQUI SI TI ON	0	0				111.00

Health Financial Systems FF	/	In Lie	u of Form CMS-	2552-10		
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C			Peri od: Worksheet C From 01/01/2021 Part I To 12/31/2021 Date/Time Prej 5/26/2022	
		Title	XVIII	Hospi tal	PPS	
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	
113.00 11300 I NTEREST EXPENSE 114.00 11400 UTI LI ZATI ON REVI EW-SNF 115.00 11500 AMBULATORY SURGI CAL CENTER (D. P.) 116.00 11600 HOSPI CE	0	0		0		113.00 114.00 115.00 116.00
200.00Subtotal (see instructions)201.00Less Observation Beds202.00Total (see instructions)	369, 701, 702 369, 701, 702		1, 020, 828, 97 1, 020, 828, 97			200. 00 201. 00 202. 00

OMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0015	Peri od: From 01/01/2021 To 12/31/2021	Worksheet C Part I Date/Time Prep 5/26/2022 11:2	oared: 23 am
			Title XVIII	Hospi tal	PPS	
	Cost Center Description	PPS Inpatient Ratio 11.00				
	INPATIENT ROUTINE SERVICE COST CENTERS					
0.00	03000 ADULTS & PEDIATRICS					30.00
1.00	03100 INTENSIVE CARE UNIT					31.00
2.00	03200 CORONARY CARE UNIT					32.0
3.00	03300 BURN INTENSIVE CARE UNIT					33.0
4.00	03400 SURGI CAL I NTENSI VE CARE UNI T					34.0
0.00	04000 SUBPROVI DER – I PF 04100 SUBPROVI DER – I RF					40.0 41.0
3.00	04300 NURSERY					41. C
4.00	04400 SKI LLED NURSI NG FACI LI TY					44. C
5.00	04500 NURSING FACILITY					45. C
6.00	04600 OTHER LONG TERM CARE					46. C
	ANCI LLARY SERVICE COST CENTERS					
0. 00	05000 OPERATING ROOM	0. 152878				50. C
1.00	05100 RECOVERY ROOM	0. 000000				51.C
2.00	05200 DELIVERY ROOM & LABOR ROOM	0. 788732				52. C
3.00	05300 ANESTHESI OLOGY	0. 023251				53.C
1. 00	05400 RADI OLOGY-DI AGNOSTI C	0. 088965				54.0
4.01	05401 FSED RADI OLOGY - DI AGNOSTI C	0. 099911				54.0
5.00	05500 RADI OLOGY-THERAPEUTI C	0. 128122				55.0
5.01	05501 WOODLAND CANCER CARE CTR	0. 212909				55.0
5.00	05600 RADI OI SOTOPE	0. 000000				56.0
7.00	05700 CT SCAN 05800 MRI	0. 000000 0. 000000				57. (58. (
9.00	05900 CARDI AC CATHETERI ZATI ON	0. 117894				59.0
). 00	06000 LABORATORY	0. 11/894				60.0
0.00 0.01	06001 FS ED LAB	0. 127420				60.0
1.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000				61. (
2.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000				62.0
3.00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 040229				63. (
3. 01	06301 FS ED BLOOD BANK	0. 001908				63.0
4.00	06400 I NTRAVENOUS THERAPY	0. 000000				64.0
5.00	06500 RESPI RATORY THERAPY	0. 130321				65.0
6. 00	06600 PHYSI CAL THERAPY	0. 212734				66. 0
7.00	06700 OCCUPATI ONAL THERAPY	0. 000000				67.0
8.00	06800 SPEECH PATHOLOGY	0. 000000				68. (
9.00	06900 ELECTROCARDI OLOGY	0. 102770				69. (
0.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000				70. (
1.00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0. 186001				71.(
2.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 512843				72.(
3.00	07300 DRUGS CHARGED TO PATIENTS	0. 206490				73.0
4.00	07400 RENAL DIALYSIS	0. 000000				74.0
	07500 ASC (NON-DI STINCT PART)	0. 000000				75.0
7 00	03020 CLINIC 07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000				76. (77. (
7.00	OUTPATIENT SERVICE COST CENTERS	0.000000				77.0
8.00	08800 RURAL HEALTH CLINIC					88. (
9.00	08900 FEDERALLY QUALIFIED HEALTH CENTER					89. (
0.00		0. 000000				90.0
0. 03	09003 INFUSION OP SERVICES	0. 357184				90. (
1.00	09100 EMERGENCY	0. 117863				91. (
1. 01	09101 FREE STANDING EMERGENCY DEPT	0. 311968				91.0
2. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 589142				92. (
	OTHER REIMBURSABLE COST CENTERS					
4.00	09400 HOME PROGRAM DI ALYSI S	0. 000000				94. (
5.00		0. 000000				95.0
b. 00	09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000				96. (
	09700 DURABLE MEDICAL EQUIP-SOLD	0. 000000				97.0
	09850 OTHER REIMBURSABLE COST CENTERS	0. 000000				98.0
	09900 CMHC					99. (
						99. [•]
)10000 I&R SERVICES-NOT APPRVD PRGM)10100 HOME HEALTH AGENCY					100. (101. (
	SPECIAL PURPOSE COST CENTERS					101.0
5 00	DID500 KIDNEY ACQUISITION					105. 0
	10500 HEART ACQUISITION					105. (
	10000 HEART ACQUISTITION					100.0
	10700 LIVER ACCUISITION					107.0
	10800 PANCREAS ACQUISITION					108.0
	11000 I NTESTI NAL ACQUI SI TI ON					109. (
	11100 I SLET ACQUI SI TI ON					111. (
	11300 I NTEREST EXPENSE					113. (
13.0	11400 UTI LI ZATI ON REVIEW-SNF	1				114. (

Health Financial Systems	FRANCI SCAN HEALTH	MICHIGAN CITY	In Lieu of Form CMS-2552-10			
COMPUTATION OF RATIO OF COSTS TO CHARGES	PUTATION OF RATIO OF COSTS TO CHARGES			Worksheet C		
			From 01/01/2021 To 12/31/2021	Part I Date/Time Prep	o road.	
			10 12/31/2021	5/26/2022 11: 2	23 am	
		Title XVIII	Hospi tal	PPS		
Cost Center Description	PPS Inpatient					
	Ratio					
	11.00					
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)				·	115.00	
116.00 11600 HOSPI CE				·	116. 00	
200.00 Subtotal (see instructions)					200. 00	
201.00 Less Observation Beds					201.00	
202.00 Total (see instructions)					202.00	
	1					

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

FRANCISCAN HEALTH MICHIGAN CITY

In Lieu of Form CMS-2552-10

		RANCI SCAN HEALT				eu of Form CMS-	2552-10
COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2021 To 12/31/2021	Worksheet C Part I Date/Time Pre 5/26/2022 11:	epared: 23 am
		-	Titl	e XIX	Hospi tal	Cost	
					Costs		
	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS		2100	0.00		0100	
30.00	03000 ADULTS & PEDI ATRI CS	39, 584, 948		39, 584, 94	8 0	0	30.00
	03100 INTENSIVE CARE UNIT	8, 617, 071		8, 617, 07	1 0	0	
	03200 CORONARY CARE UNI T	0			0 0	0	
	03300 BURN INTENSIVE CARE UNIT	0			0 0	0	
	03400 SURGICAL INTENSIVE CARE UNIT	0			0 0	0	
	04000 SUBPROVIDER - IPF	5, 192, 358		5, 192, 35	8 0	0	
	04100 SUBPROVIDER - IRF	0		1 (00.00	0 0	0	
	04300 NURSERY	1, 623, 028		1, 623, 02	8 0	0	
	04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY	0				0	
	04600 OTHER LONG TERM CARE				0 0 0 0		
40.00	ANCI LLARY SERVICE COST CENTERS	0			0 0	0	40.00
50.00	05000 OPERATING ROOM	24, 869, 649		24, 869, 64	9 0	0	50.00
	05100 RECOVERY ROOM	21,007,017		21,007,01	0 0		
	05200 DELIVERY ROOM & LABOR ROOM	2, 906, 874		2, 906, 87		-	
	05300 ANESTHESI OLOGY	238, 375		238, 37		0	
	05400 RADI OLOGY-DI AGNOSTI C	11, 442, 871		11, 442, 87		0	54.00
54.01	05401 FSED RADIOLOGY - DIAGNOSTIC	2, 837, 671		2, 837, 67	1 0	0	54.01
	05500 RADI OLOGY-THERAPEUTI C	2, 475, 158		2, 475, 15	8 0	0	55.00
	05501 WOODLAND CANCER CARE CTR	923, 372		923, 37	2 0	0	55.01
	05600 RADI OI SOTOPE	0			0 0	0	
	05700 CT SCAN	0			0 0	0	
	05800 MRI	0			0 0	0	
	05900 CARDI AC CATHETERI ZATI ON	4, 244, 835		4, 244, 83		0	
	06000 LABORATORY	11, 100, 042		11, 100, 04		0	
	06001 FS ED LAB	1, 898, 233		1, 898, 23		0	
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0			0 0	0	
	06300 BLOOD STORING, PROCESSING & TRANS.	63, 393		63, 39	2 0	0	
	06301 FS ED BLOOD BANK	43		4		0	
	06400 I NTRAVENOUS THERAPY			-		0	
	06500 RESPI RATORY THERAPY	2, 677, 357	0	2, 677, 35	7 0	0	
	06600 PHYSI CAL THERAPY	4, 522, 255		4, 522, 25		o o	
	06700 OCCUPATI ONAL THERAPY	0			0 0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
69.00	06900 ELECTROCARDI OLOGY	3, 390, 935		3, 390, 93	5 0	0	69.00
	07000 ELECTROENCEPHALOGRAPHY	0			0 0	0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	7, 090, 931		7, 090, 93		0	
	07200 IMPL. DEV. CHARGED TO PATIENTS	19, 512, 219		19, 512, 21		0	
	07300 DRUGS CHARGED TO PATIENTS	28, 785, 237		28, 785, 23		-	
	07400 RENAL DIALYSIS	0			0 0	0	
	07500 ASC (NON-DI STINCT PART) 03020 CLINIC	678, 031		678, 03	0	0	
	07700 ALLOGENEIC STEM CELL ACQUISITION	078,031			0 0	-	
//.00	OUTPATIENT SERVICE COST CENTERS	0			0 0	0	///.00
88.00	08800 RURAL HEALTH CLINIC	0			0 0	0	88.00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0			0 0	0	
	09000 CLINIC	0			0 0	0	
	09003 I NEUSI ON OP SERVI CES	1, 855, 241		1, 855, 24	1 0	0	1
91.00	09100 EMERGENCY	11, 157, 961		11, 157, 96	1 0	0	
	09101 FREE STANDING EMERGENCY DEPT	6, 390, 856		6, 390, 85	6 0	0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0	0	92.00
	OTHER REIMBURSABLE COST CENTERS		1	1	_1	1	4
	09400 HOME PROGRAM DI ALYSI S	0			0 0		
	09500 AMBULANCE SERVICES	0			0 0	0	
	09600 DURABLE MEDICAL EQUIP-RENTED	0			u 0	0	
	09700 DURABLE MEDICAL EQUIP-SOLD					0	
	09850 OTHER REIMBURSABLE COST CENTERS 09900 CMHC					0	
77. UU	09900 CMHC 09910 CORF						
00 10		0					100.00
	10000 L&P SERVICES NOT ADDRVD DOCM		1	1			
100.00	10000 I&R SERVICES-NOT APPRVD PRGM	0			()	1 11	
100.00	10100 HOME HEALTH AGENCY	0			0	0	101.00
100. 00 101. 00	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	1	1		1	
100. 00 101. 00 105. 00	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS 10500 KIDNEY ACQUISITION	0	1	1	0	0	105.00
100. 00 101. 00 105. 00 106. 00	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS 10500 KI DNEY ACQUI SI TI ON 10600 HEART ACQUI SI TI ON	0	1	1		0	105.00 106.00
100.00 101.00 105.00 106.00 107.00	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS 10500 KIDNEY ACQUISITION	0	1	1		0 0 0	105.00 106.00 107.00
100.00 101.00 105.00 106.00 107.00 108.00	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS 10500 KI DNEY ACQUI SI TI ON 10600 HEART ACQUI SI TI ON 10700 LI VER ACQUI SI TI ON	0	1	1		0 0 0 0	105.00 106.00

Health Financial Systems FR/	ANCISCAN HEALTH	H MICHIGAN CITY	,	In Lie	u of Form CMS-:	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CC	CN: 15-0015	Period: From 01/01/2021 To 12/31/2021	Worksheet C Part I Date/Time Pre 5/26/2022 11:	
		Ti tl	e XIX	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
111.00 113.00 113.00 11300 11400 11400 11400 11500 11500 11500 11500 11600 11600 11600 11600 11600 11600 11700	0			0	0	111.00 113.00 114.00 115.00 116.00
200.00Subtotal (see instructions)201.00Less Observation Beds202.00Total (see instructions)	204, 078, 944 0 204, 078, 944	0	204, 078, 94 204, 078, 94	0	0	200.00 201.00 202.00

Health Financial Systems FR COMPUTATION OF RATIO OF COSTS TO CHARGES	RANCI SCAN HEALTH	Provider C	Y CN: 15-0015 Le XIX	In Lie Period: From 01/01/2021 To 12/31/2021 Hospital	wof Form CMS- Worksheet C Part I Date/Time Pre 5/26/2022 11: Cost	epared:
Cost Center Description	I npati ent	Charges Outpatient	Total (col. + col. 7)	6 Cost or Other Ratio	TEFRA I npati ent	
	6.00	7.00	8.00	9.00	Rati o 10. 00	
INPATIENT ROUTINE SERVICE COST CENTERS			1			
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 32. 00 03200 CORONARY CARE UNIT 33. 00 03200 BURN INTENSIVE CARE UNIT 34. 00 03400 SURGICAL INTENSIVE CARE UNIT 40. 00 04000 SUBPROVIDER - IPF 41. 00 04100 SUBPROVIDER - IRF 43. 00 04300 NURSERY 44. 00 04400 SKILLED NURSING FACILITY 45. 00 04500 NURSING FACILITY 46. 00 04600 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS ANCILLARY				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 46.00
50.00 05000 OPERATI NG ROOM 51.00 05100 RECOVERY ROOM 52.00 05200 DELI VERY ROOM & LABOR ROOM 53.00 05300 ANESTHESI OLOGY 54.00 05400 RADI OLOGY - DI AGNOSTI C 54.01 05401 FSED RADI OLOGY - DI AGNOSTI C 55.00 05500 RADI OLOGY - THERAPEUTI C 55.01 05501 WODLAND CANCER CARE CTR 56.00 05600 RADI OLOGY - THERAPEUTI C 57.00 05700 CT SCAN 58.00 05800 MRI 59.00 05900 CARDI AC CATHETERI ZATI ON 60.01 06000 LABORATORY 60.01 06100 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY 61.00 06100 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 63.00 BLOOD STORI NG, PROCESSI NG & TRANS. 63.01 06301 FS ED BLOOD BANK 64.00 06400 INTRAVENOUS THERAPY 65.00 06500 RESPI RATORY THERAPY 65.00 06500 RESPI RA				0 0.000000 0 0.000000 </td <td>0. 000000 0. 000000 0. 000000</td> <td>51.00 52.00 53.00 54.00 54.01 55.01 56.00 57.00 59.00 60.01 61.00 62.00 63.01 64.00 65.00 65.00 66.00 67.00 68.00 67.00 70.00 71.00 72.00 73.00 74.00 75.00 76.00</td>	0. 000000 0. 000000 0. 000000	51.00 52.00 53.00 54.00 54.01 55.01 56.00 57.00 59.00 60.01 61.00 62.00 63.01 64.00 65.00 65.00 66.00 67.00 68.00 67.00 70.00 71.00 72.00 73.00 74.00 75.00 76.00
77.00 O7700 ALLOGENEI C STEM CELL ACQUI SI TI ON OUTPATI ENT SERVI CE COST CENTERS 0000 0000 CONTROL 00000 CONTROL CONTROL			D D D D D	0 0.000000 0 0.000000 0 0.000000 0 0.000000 0 0.000000 0 0.000000 0 0.000000 0 0.000000 0 0.000000 0 0.000000 0 0.000000 0 0.000000	0.000000 0.000000 0.000000 0.000000 0.000000	88.00 89.00 90.00 90.03 91.00 91.01
OTHER REI MBURSABLE COST CENTERS 94.00 O9400 HOME PROGRAM DI ALYSI S 95.00 O9500 AMBULANCE SERVI CES 96.00 O9600 DURABLE MEDI CAL EQUI P-RENTED 97.00 O9700 DURABLE MEDI CAL EQUI P-SOLD 98.00 O9850 OTHER REI MBURSABLE COST CENTERS 99.00 O9900 CMHC O9910 CORF O0000 10000 I & SERVI CES-NOT APPRVD PRGM 101.00 10000 I & SERVI CES-NOT APPRVD PRGM 101.00 DUDDOC CONF CONTERS CONT				0 0.000000 0 0.000000 0 0.000000 0 0.000000 0 0.000000 0 0 0	0.000000 0.000000 0.000000 0.000000 0.000000	95.00 96.00 97.00
SPECIAL PURPOSE COST CENTERS 105.00 IDSOO KIDNEY ACQUISITION 106.00 HEART ACQUISITION 107.00 10700 LIVER ACQUISITION 108.00 10800 LUNG ACQUISITION 109.00 PANCREAS ACQUISITION 110.00 INTESTINAL ACQUISITION 111.00 ISLET ACQUISITION			D D D D D D D	0 0 0 0 0 0 0 0		105.00 106.00 107.00 108.00 109.00 110.00 111.00

Health Financial Systems	FRANCI SCAN HEALTH MI CHI GAN CI TY				eu of Form CMS-2552-10		
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	Provider CCN: 15-0015		Worksheet C Part I Date/Time Prepared: 5/26/2022 11:23 am		
		Titl	e XIX	Hospi tal	Cost		
Cost Center Description	Inpati 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		
113.0011300INTEREST EXPENSE114.0011400UTI LI ZATI ON REVIEW-SNF115.0011500AMBULATORY SURGICAL CENTER (D. P.)116.0011600HOSPICE200.00Subtotal (see instructions)201.00Less Observation Beds202.00Total (see instructions)	000000000000000000000000000000000000000			0 0 0		113.00 114.00 115.00 116.00 200.00 201.00 202.00	

UNIPUI	ATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0015	Peri od: From 01/01/2021 To 12/31/2021	Worksheet C Part I Date/Time Prep 5/26/2022 11:2	
			Title XIX	Hospi tal	Cost	
	Cost Center Description	PPS Inpatient Ratio 11.00				
	INPATIENT ROUTINE SERVICE COST CENTERS	11.00				
0. 00	03000 ADULTS & PEDIATRICS					30. 0
1.00	03100 I NTENSI VE CARE UNI T					31.0
2.00	03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT					32.0
3.00 4.00	03400 SURGICAL INTENSIVE CARE UNIT					33.0 34.0
0.00	04000 SUBPROVIDER - IPF					40.0
1.00	04100 SUBPROVIDER - IRF					41.0
3.00	04300 NURSERY					43. C
4.00	04400 SKILLED NURSING FACILITY					44.C
5.00	04500 NURSING FACILITY					45.0
6.00	04600 OTHER LONG TERM CARE					46.0
0.00	ANCI LLARY SERVICE COST CENTERS	0.000000				50. 0
1.00	05100 RECOVERY ROOM	0. 000000				51.0
2.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000				52.0
3. 00	05300 ANESTHESI OLOGY	0. 000000				53.0
4.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.0
4.01	05401 FSED RADI OLOGY - DI AGNOSTI C	0.000000				54.C
5.00 5.01	05500 RADI OLOGY-THERAPEUTI C	0.000000				55.0
5. 01 6. 00	05501 WOODLAND CANCER CARE CTR 05600 RADI OI SOTOPE	0. 000000 0. 000000				55. 0 56. 0
7.00	05700 CT SCAN	0.000000				57.0
8.00	05800 MRI	0. 000000				58. C
9.00	05900 CARDI AC CATHETERI ZATI ON	0. 000000				59.0
0.00	06000 LABORATORY	0. 000000				60.0
0. 01	06001 FS ED LAB	0. 000000				60.0
1.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000				61.0
2.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000				62.0
3. 00 3. 01	06300 BLOOD STORING, PROCESSING & TRANS. 06301 FS ED BLOOD BANK	0.000000				63. 0 63. 0
4.00	06400 I NTRAVENOUS THERAPY	0. 000000				64.0
5.00	06500 RESPI RATORY THERAPY	0. 000000				65.0
6. 00	06600 PHYSI CAL THERAPY	0. 000000				66. C
7.00	06700 OCCUPATI ONAL THERAPY	0. 000000				67.C
8. 00	06800 SPEECH PATHOLOGY	0. 000000				68. C
9.00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	0.000000				69. C
0.00 1.00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000 0. 000000				70. C 71. C
2.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000				72.0
3.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000				73.0
4.00	07400 RENAL DIALYSIS	0. 000000				74. C
5.00	07500 ASC (NON-DISTINCT PART)	0. 000000				75. C
6.00		0.000000				76.0
7.00	07700 ALLOGENEIC STEM CELL ACQUISITION OUTPATIENT SERVICE COST CENTERS	0.000000				77. C
8. 00	08800 RURAL HEALTH CLINIC	0.000000				88. 0
9.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000				89. C
0.00	09000 CLINIC	0. 000000				90.0
0. 03	09003 INFUSION OP SERVICES	0. 000000				90. C
1.00	09100 EMERGENCY	0.00000				91.0
1.01	09101 FREE STANDING EMERGENCY DEPT	0.000000				91. C
2.00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS	0.000000				92. C
4.00	09400 HOME PROGRAM DI ALYSI S	0.000000				94.0
5.00	09500 AMBULANCE SERVICES	0. 000000				95. C
6.00	09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000				96. C
7.00	09700 DURABLE MEDICAL EQUIP-SOLD	0. 000000				97. C
8.00	09850 OTHER REIMBURSABLE COST CENTERS	0. 000000				98.0
	09900 CMHC					99. (
	09910 CORF 10000 I &R SERVICES-NOT APPRVD PRGM					99. 1 100. 0
	10000 T&R SERVICES-NOT APPROD PRGM					100. C
51.00	SPECIAL PURPOSE COST CENTERS					101.0
05.00	DI0500 KIDNEY ACQUISITION					105. C
	10600 HEART ACQUI SI TI ON				1	106. 0
	10700 LIVER ACQUISITION					107. (
	10800 LUNG ACQUISITION					108.0
	10900 PANCREAS ACQUISITION					109.0
) 11000 INTESTINAL ACQUISITION) 11100 ISLET ACQUISITION					110. C 111. C
	11300 INTEREST EXPENSE				1	113. C

Health Financial Systems	FRANCI SCAN HEALTH	MICHIGAN CITY	In Lieu of Form CMS-2552-10			
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0015	Peri od:	Worksheet C	_	
			From 01/01/2021 To 12/31/2021	Part I		
			To 12/31/2021	Date/Time Prepared: 5/26/2022 11:23 am		
		Title XIX	Hospi tal	Cost	-	
		II LIE AIA	позрі саї	0031	_	
Cost Center Description	PPS Inpatient					
	Ratio					
	11.00					
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)				115.00	วิ	
116.00 11600 HOSPI CE				116.00	D	
200.00 Subtotal (see instructions)				200.00	D	
201.00 Less Observation Beds				201.00	0	
202.00 Total (see instructions)				202.00	0	

Health Financial Systems	FRANCISCAN HEALTH	I MICHIGAN CIT	Y	In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITA	L COSTS		CN: 15-0015	Period: From 01/01/2021 To 12/31/2021	5/26/2022 11:	
		Title	e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,	·	Related Cost	t		
	Part II, col.		(col. 1 - col			
	26)		2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	6, 943, 605	C	6, 943, 60	26, 966	257.49	30.00
31.00 INTENSIVE CARE UNIT	1, 448, 888		1, 448, 88	38 4, 512	321.12	31.00
32.00 CORONARY CARE UNIT	0			0 0	0.00	32.00
33.00 BURN INTENSIVE CARE UNIT	0			0 0	0.00	33.00
34.00 SURGICAL INTENSIVE CARE UNIT	0			0 0	0.00	
40. 00 SUBPROVIDER - IPF	1, 223, 794	(1, 223, 79	3, 466		
41. 00 SUBPROVIDER - IRF	0	()	0 0	0.00	
43. 00 NURSERY	323, 420		323, 42	20 928		
44.00 SKILLED NURSING FACILITY	020, 120		020, 12	0 0	0.00	
45. 00 NURSING FACILITY	0					45.00
200.00 Total (lines 30 through 199)	9, 939, 707		9, 939, 70	35, 872		200.00
Cost Center Description	Inpati ent	Inpati ent	7, 737, 10	55, 072		200.00
cost center bescription	Program days	Program				
	riogram days	Capital Cost				
		(col. 5 x col.				
		6)				
	6,00	7.00	-			
INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00				
30, 00 ADULTS & PEDIATRICS	9, 303	2, 395, 429				30.00
31. 00 INTENSIVE CARE UNIT	1,030	330, 754				31.00
32. 00 CORONARY CARE UNIT	1,030	330,734				32.00
33. 00 BURN INTENSIVE CARE UNIT	0					33.00
34. 00 SURGI CAL I NTENSI VE CARE UNI T	0					34.00
40. 00 SUBPROVIDER - IPF	499	176, 192				40.00
40.00 SUBPROVIDER - TPF 41.00 SUBPROVIDER - TRF	499	170, 192				40.00
41.00 SUBPROVIDER - TRF 43.00 NURSERY	0					41.00
	0					
44.00 SKILLED NURSING FACILITY	0	(44.00
45.00 NURSING FACILITY	0))			45.00
200.00 Total (lines 30 through 199)	10, 832	2, 902, 375	9			200. 00

	Financial Systems FF		Provider C		Peri od:	u of Form CMS-2 Worksheet D	2002 10
				un. 15 0015	From 01/01/2021 To 12/31/2021	Part II Date/Time Pre	
			Ti tl c	e XVIII	Hospi tal	5/26/2022 11: PPS	23 am
	Cost Center Description	Capi tal	Total Charges			Capital Costs	
	best benter beschiption	Related Cost	(from Wkst. C,		Program	(column 3 x	
		(from Wkst. B,	Part I, col.	$(col \cdot 1 \div col$		column 4)	
		Part II, col.	8)	2)	J		
		26)	,	,			
	1	1.00	2.00	3.00	4.00	5.00	
	ANCI LLARY SERVI CE COST CENTERS						
50.00	05000 OPERATING ROOM	8, 238, 935					
51.00	05100 RECOVERY ROOM	0	-	0.0000			
52.00	05200 DELIVERY ROOM & LABOR ROOM	578, 738					•
53.00	05300 ANESTHESI OLOGY	84, 504					•
54.00	05400 RADI OLOGY-DI AGNOSTI C	3, 646, 315					•
54.01	05401 FSED RADI OLOGY - DI AGNOSTI C	367,096				0	
55.00	05500 RADI OLOGY-THERAPEUTI C	681, 750					
55.01	05501 WOODLAND CANCER CARE CTR	168, 825	4, 336, 926			0	
56.00	05600 RADI OI SOTOPE	0	0	0.0000		-	
57.00	05700 CT SCAN	0	0				
58.00	05800 MRI	0	-	0.0000		0	
59.00	05900 CARDI AC CATHETERI ZATI ON	1, 592, 097				160, 914	59.00
60.00	06000 LABORATORY	861, 255			02 16, 576, 397	142, 590	60.00
60. 01	06001 FS ED LAB	36, 543	14, 897, 414	0.0024	53 0	0	60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0.0000	0 00	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	30, 632	1, 575, 822	0. 01943	39 0	0	63.00
63. 01	06301 FS ED BLOOD BANK	2	22, 542			0	63.01
64.00	06400 INTRAVENOUS THERAPY	0	0	0.0000	0 00	0	64.00
65.00	06500 RESPI RATORY THERAPY	359, 522	20, 544, 305			74, 469	65.00
66.00	06600 PHYSI CAL THERAPY	245, 914					•
67.00	06700 OCCUPATI ONAL THERAPY	0					
68.00	06800 SPEECH PATHOLOGY	0	-	1		0	•
69.00	06900 ELECTROCARDI OLOGY	948, 268	33, 000, 490				
70.00	07000 ELECTROENCEPHALOGRAPHY	0	00,000,170	0.0000		0	1
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	135, 538	38, 123, 036				•
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	369, 964					
73.00	07300 DRUGS CHARGED TO PATIENTS	1, 029, 254		1			
74.00	07400 RENAL DI ALYSI S	1, 027, 234					1
75.00	07500 ASC (NON-DI STI NCT PART)	0	-				•
76.00	03020 CLINIC	14, 381	-				
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION	0					•
77.00	OUTPATIENT SERVICE COST CENTERS	0	0	0.0000	0	0	1 / /. 00
88.00	08800 RURAL HEALTH CLINIC	0	0	0.0000	0 00	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	-				
90.00	09000 CLINIC	0	-	0.0000		-	
90.00	09000 CLINIC 09003 INFUSION OP SERVICES	309, 976	-			0	
	09100 EMERGENCY						
		1, 895, 542					
	09101 FREE STANDING EMERGENCY DEPT	1, 862, 628					91.01
92.00	09200 OBSERVATI ON BEDS (NON-DI STI NCT PART	949, 125	9, 185, 937	0. 10332	24 0	0	92.00
04 00	OTHER REIMBURSABLE COST CENTERS	-		0,0000	20 2		01 00
	09400 HOME PROGRAM DI ALYSI S	0	0	0.0000	0 00	0	
	09500 AMBULANCE SERVICES	-	_	0.0000	-	_	95.00
	09600 DURABLE MEDICAL EQUIP-RENTED	0	-	0.0000		0	
	09700 DURABLE MEDI CAL EQUI P-SOLD	0	-			0	•
	09850 OTHER REIMBURSABLE COST CENTERS	0	-			0	
200.00) Total (lines 50 through 199)	24, 406, 804	930, 021, 085		97, 807, 705	2, 147, 931	1200.00

	RANCI SCAN HEALTH				eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER F	ASS THROUGH COST	rs Provider C		Period: From 01/01/2021 To 12/31/2021		pared: 23 am
		Title	e XVIII	Hospi tal	PPS	20 0111
Cost Center Description	Nursi ng	Nursi ng		Allied Health	All Other	
	Program	Program	Post-Stepdow	n Cost	Medi cal	
	Post-Stepdown		Adj ustments		Education Cost	
	Adjustments					
	1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		-	.1	-	-	
30. 00 03000 ADULTS & PEDI ATRI CS	0	0		0 0		•
31. 00 03100 I NTENSI VE CARE UNI T	0	0		0 0		•
32.00 03200 CORONARY CARE UNI T	0	0		0 0	-	
33.00 03300 BURN INTENSIVE CARE UNIT	0	C		0 0		
34.00 03400 SURGICAL INTENSIVE CARE UNIT	0	C		0 0	-	
40. 00 04000 SUBPROVIDER - IPF	0	C		0 0	0	
41. 00 04100 SUBPROVIDER - IRF	0	0		0 0	0	
43. 00 04300 NURSERY	0	C		0 0	0	
44.00 04400 SKILLED NURSING FACILITY	0	0	D	0 0		44.00
45.00 04500 NURSING FACILITY	0	0		0 0		45.00
200.00 Total (lines 30 through 199)	0	0	-	0 0		200.00
Cost Center Description	Swi ng-Bed	Total Costs		t Per Diem (col.	Inpati ent	
	Adjustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,				
	instructions)					
	4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS		-				
30. 00 03000 ADULTS & PEDI ATRI CS	0	-				
31.00 03100 INTENSIVE CARE UNIT		C				
32.00 03200 CORONARY CARE UNIT		C		0 0.00		
33.00 03300 BURN INTENSIVE CARE UNIT		C		0 0.00		
34.00 03400 SURGICAL INTENSIVE CARE UNIT		0	D	0 0.00		
40. 00 04000 SUBPROVI DER - I PF	0	C	3, 46	6 0.00	499	40.00
41.00 04100 SUBPROVIDER - IRF	0	C		0.00	0	41.00
43.00 04300 NURSERY		0	92	8 0.00	0	43.00
44.00 04400 SKILLED NURSING FACILITY		0		0 0.00	0	44.00
45.00 04500 NURSING FACILITY		C		0 0.00	0	45.00
200.00 Total (lines 30 through 199)		C	35, 87	2	10, 832	200.00
Cost Center Description	Inpatient					
· · · · · · · · · · · · · · · · · · ·	Program					
	Pass-Through					
	Cost (col. 7 x					
	col. 8)					
	9.00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0					30.00
31.00 03100 INTENSIVE CARE UNIT	0					31.00
32.00 03200 CORONARY CARE UNIT	0					32.00
33.00 03300 BURN INTENSIVE CARE UNIT	0					33.00
	0					34.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT						40.00
	0					
40. 00 04000 SUBPROVIDER - IPF	-					41.00
40. 00 04000 SUBPROVIDER - IPF 41. 00 04100 SUBPROVIDER - IRF	0					41.00
40. 00 04000 SUBPROVIDER - IPF 41. 00 04100 SUBPROVIDER - IRF 43. 00 04300 NURSERY	0					43.00
40. 00 04000 SUBPROVIDER - IPF 41. 00 04100 SUBPROVIDER - IRF 43. 00 04300 NURSERY 44. 00 04400 SKILLED NURSING FACILITY	0 0 0					43.00 44.00
40. 00 04000 SUBPROVIDER - IPF 41. 00 04100 SUBPROVIDER - IRF 43. 00 04300 NURSERY	0					43.00

HROUG		RVICE OTHER PASS	1.1.01.001.00	CN: 15-0015	Peri od:		Worksheet D	
	H COSTS				From 01 To 12	1/01/2021 2/31/2021	Part IV Date/Time Pre	pared:
				XVIII	Hos	pi tal	5/26/2022 11: PPS	23 am
	Cost Center Description	Non Physician	Nursing	Nursing			Allied Health	
		Anestheti st	Program	Program		Stepdown	All rou nour en	
		Cost	Post-Stepdown			stments		
			Adjustments					
		1.00	2A	2.00		3A	3.00	
	ANCI LLARY SERVICE COST CENTERS			1		0	0	
50.00 51.00	05000 OPERATING ROOM 05100 RECOVERY ROOM	0	0		0	0	0	50.00 51.00
	05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	0	52.00
	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
54.00	05401 FSED RADIOLOGY - DIAGNOSTIC	0	0		0	0	0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0		0	0	0	55.00
	05501 WOODLAND CANCER CARE CTR	0	0		0	0	0	55.01
56.00	05600 RADI OI SOTOPE	0	0		0	0	0	56.00
57.00	05700 CT SCAN	0	0		0	0	0	57.00
58.00	05800 MRI	0	0		0	0	0	58.00
	05900 CARDI AC CATHETERI ZATI ON	0	0		0	0	0	59.00
	06000 LABORATORY	0	0		0	0	0	60.00
	06001 FS ED LAB	0	0		0	0	0	60.01
51.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY							61.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0	0	0	62.00
	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0	0	0	63.00
53. 01	06301 FS ED BLOOD BANK	0	0		0	0	0	63.01
54.00	06400 INTRAVENOUS THERAPY	0	0		0	0	0	64.00
55.00	06500 RESPI RATORY THERAPY	0	0		0	0	0	65.00
56.00	06600 PHYSI CAL THERAPY	0	0		0	0	0	66.00
57.00	06700 OCCUPATI ONAL THERAPY	0	0		0	0	0	67.00
58.00	06800 SPEECH PATHOLOGY	0	0		0	0	0	68.00
59.00	06900 ELECTROCARDI OLOGY	0	0		0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0	0	0	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	0	73.00
	07400 RENAL DIALYSIS	0	0		0	0	0	74.00
	07500 ASC (NON-DISTINCT PART)	0	0		0	0	0	75.00
	03020 CLI NI C	0	0		0	0	0	76.00
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0		0	0	0	77.00
	OUTPATIENT SERVICE COST CENTERS			1				
	08800 RURAL HEALTH CLINIC	0	0		0	0	0	88.00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0	0	89.00
	09000 CLI NI C	0	0		0	0	0	90.00
	09003 I NFUSI ON OP SERVI CES	0	0		0	0	0	90.03
	09100 EMERGENCY	0	0		0	0	0	91.00
	09101 FREE STANDING EMERGENCY DEPT	0	0		0	0	0	91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0		I	0		0	92.00
14 00				1	0		0	04.00
	09400 HOME PROGRAM DI ALYSI S	0	0		0	0	0	94.00
	09500 AMBULANCE SERVICES		0		~	~	0	95.00
	09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0	0	0	
	09700 DURABLE MEDICAL EQUIP-SOLD	0	0		0	0	0	97.00
	09850 OTHER REIMBURSABLE COST CENTERS	0	0	1	0	0	0	98.00

	RANCI SCAN HEALT				u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE THROUGH COSTS	RVICE OTHER PAS	S Provider C		Period: From 01/01/2021 To 12/31/2021	Worksheet D Part IV Date/Time Pre 5/26/2022 11:	
		Title	× XVIII	Hospi tal	PPS	23 ан
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
	Education Cost		Cost (sum of		(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	
		, í	and 4)		(see	
					instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0	0		0 162, 681, 971	0.000000	50.00
51.00 05100 RECOVERY ROOM	0	0		0 0	0.000000	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 3, 685, 504		1
53. 00 05300 ANESTHESI OLOGY	0			0 10, 368, 372	0. 000000	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0			0 128, 622, 350		
54. 01 05401 FSED RADIOLOGY - DIAGNOSTIC	0			0 28, 408, 336		
55. 00 05500 RADIOLOGY - THERAPEUTIC	0					
	0			, ,		
55. 01 05501 WOODLAND CANCER CARE CTR	0	0		0 4, 336, 926		
56. 00 05600 RADI 0I SOTOPE	0	0		0 0	0.000000	
57.00 05700 CT SCAN	0	0		0 0		
58.00 05800 MRI	0	0		0 0	0.000000	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 36, 005, 555		
60. 00 06000 LABORATORY	0	0		0 100, 124, 636	0. 000000	60.00
60. 01 06001 FS ED LAB	0	0		0 14, 897, 414	0.000000	60.01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0 0	0.000000	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 1, 575, 822	0.000000	63.00
63.01 06301 FS ED BLOOD BANK	0	0		0 22, 542	0.000000	63.01
64.00 06400 INTRAVENOUS THERAPY	0	l o		0 0	0.000000	
65. 00 06500 RESPI RATORY THERAPY	0	0		0 20, 544, 305	0.000000	
66. 00 06600 PHYSI CAL THERAPY	0	0		0 21, 257, 798		
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0. 000000	
68. 00 06800 SPEECH PATHOLOGY	0			0 0	0. 000000	
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 33, 000, 490		1
70. 00 07000 ELECTROENCEPHALOGRAPHY	0			0 33,000,470	0.000000	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0			0 38, 123, 036		
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0			0 38, 047, 166		
73. 00 07300 DRUGS CHARGED TO PATIENTS	0			0 139, 402, 749		1
74. 00 07400 RENAL DIALYSIS	0			0 137,402,749		
	0				0.000000	
	0			0	0.000000	
	0	0		0 0	0.000000	
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0		0 0	0.000000	77.00
OUTPATIENT SERVICE COST CENTERS	1		1		0	
88.00 08800 RURAL HEALTH CLINIC	0	0		0 0		
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0		
90. 00 09000 CLINIC	0	0		0 0	0.000000	
90. 03 09003 INFUSION OP SERVICES	0	0		0 5, 194, 075		
91. 00 09100 EMERGENCY	0	0		0 94, 731, 669	0.000000	91.00
91.01 09101 FREE STANDING EMERGENCY DEPT	0	0		0 20, 485, 614	0.000000	91.01
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0 9, 185, 937	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DI ALYSI S	0	0		0 0	0.000000	94.00
95. 00 09500 AMBULANCE SERVICES						95.00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0 0	0. 000000	
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0		0 0	0. 000000	
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0		0 0	0. 000000	
200.00 Total (lines 50 through 199)	0			0 930, 021, 085		200.00
	1 0	ı 0	I	·····	I	

	FRANCI SCAN HEALTH			In Lieu of Form CMS-2552 Period: Worksheet D				
PPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY S HROUGH COSTS	ERVICE OTHER PASS	Provider C	CN: 15-0015	From O	1/01/2021 2/31/2021	Worksheet D Part IV Date/Time Pre 5/26/2022 11:3	pared: 23 am	
		Title	XVIII	Hos	pi tal	PPS	25 am	
Cost Center Description	Outpati ent	Inpati ent	I npati ent		patient	Outpati ent		
	Ratio of Cost	Program	Program		ogram	Program		
	to Charges	Charges	Pass-Throug		narges	Pass-Through		
	(col. 6 ÷ col.	5	Costs (col.		5	Costs (col. 9		
	7)		x col. 10)			x col. 12)		
	9.00	10.00	11.00	1	2.00	13.00		
ANCI LLARY SERVI CE COST CENTERS						-		
0.00 05000 OPERATING ROOM	0. 000000	12, 353, 043			6, 530, 295			
1.00 05100 RECOVERY ROOM	0. 000000	0		0	0			
2.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	6, 816		0	0	0	52.00	
3. 00 05300 ANESTHESI OLOGY	0. 000000	1, 213, 154		0	2, 461, 802	0	53.00	
4. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	14, 769, 804		0 2	9, 402, 411	0	54.00	
4. 01 05401 FSED RADIOLOGY - DIAGNOSTIC	0. 000000	0		0	0	0	54.01	
5. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	170, 059		0	5, 301, 650	0	55.00	
5.01 05501 WOODLAND CANCER CARE CTR	0.000000	0		0	0	0	55.01	
6. 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	
i8. 00 05800 MRI	0. 000000	0		0	0	0	58.00	
9. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	3, 639, 096		0	3, 455, 433	0	59.00	
0. 00 06000 LABORATORY	0.000000	16, 576, 397		0	2, 803, 757	0	60.00	
0. 01 06001 FS ED LAB	0.000000	0		0	0		60.01	
1.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY							61.00	
2.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	0		0	0	0	62.00	
3.00 06300 BLOOD STORING, PROCESSING & TRANS.	0.000000	0		0	0	0	63.00	
3. 01 06301 FS ED BLOOD BANK	0, 000000	0		0	0	0	63.01	
4. 00 06400 I NTRAVENOUS THERAPY	0.000000	0		0	0	0		
5. 00 06500 RESPI RATORY THERAPY	0.000000	4, 255, 399		0	201,064	0		
6. 00 06600 PHYSI CAL THERAPY	0.000000	2, 510, 482		0	109, 474			
7.00 06700 OCCUPATI ONAL THERAPY	0.000000	0		0	0			
8.00 06800 SPEECH PATHOLOGY	0.000000	0		0	0		68.00	
9.00 06900 ELECTROCARDI OLOGY	0.000000	10, 259, 110			3, 733, 904	0		
0.00 07000 ELECTROENCEPHALOGRAPHY	0.000000	0		0	0	0		
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	4, 417, 099		0	4, 286, 209			
2.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0.000000	4, 720, 699			5, 646, 692			
3.00 07300 DRUGS CHARGED TO PATIENTS	0.000000	10, 716, 816			2, 325, 615			
4.00 07400 RENAL DIALYSIS	0.000000	0		0	0			
75.00 07500 ASC (NON-DI STINCT PART)	0. 000000	0		0	0			
76. 00 03020 CLINIC	0. 000000	0		0	0	-		
7.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000	0		0	0			
OUTPATIENT SERVICE COST CENTERS	0.000000	0			0		//.00	
88. 00 08800 RURAL HEALTH CLINIC	0.000000	0		0	0	0	88. 00	
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000	0		0	0			
0. 00 09000 CLINIC	0. 000000	0		0	0			
0. 03 09003 INFUSION OP SERVICES	0.000000	0		0	0	0		
1. 00 09100 EMERGENCY	0. 000000	12, 199, 731		0 1	0, 777, 750			
1. 01 09101 FREE STANDING EMERGENCY DEPT	0. 000000	12, 199, 731		0	0, 777, 750		1	
22.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0		Ŭ	0 1, 283, 132		92.00	
OTHER REIMBURSABLE COST CENTERS	0.000000	0		9	1, 203, 132	0	72.00	
04.00 09400 HOME PROGRAM DI ALYSI S	0, 000000	0		0	0	0	94.00	
12. 00 09400 HOME PROGRAM DIALISIS 15. 00 09500 AMBULANCE SERVICES	0.000000	0		0	0	0	94.00	
6.00 09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000	^		0	0	0		
	0.000000	0		0	0			
77.00 09700 DURABLE MEDICAL EQUIP-SOLD 98.00 09850 OTHER REIMBURSABLE COST CENTERS	0.000000	0		0	0		97.00	
	0.000000			0 14	-			
200.00 Total (lines 50 through 199)		97, 807, 705		0 14	8, 319, 188	0	200.00	

	RANCI SCAN HEALT				u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	ID VACCINE COST	Provider C	CN: 15-0015	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part V Date/Time Pre 5/26/2022 11:	
	1	Title	XVIII	Hospi tal	PPS	
			Charges		Costs	
Cost Center Description		PPS Reimbursed		Cost	PPS Services	
	Ratio From Worksheet C,	Services (see inst.)	Reimbursed Services	Reimbursed Services Not	(see inst.)	
	Part I, col. 9	· · · ·	Subject To	Subject To		
			Ded. & Coi ns			
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0. 152873			0 0	4, 055, 766	•
51.00 05100 RECOVERY ROOM	0. 000000			0 0	0	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 788732			0 0	0	52.00
53.00 05300 ANESTHESI OLOGY	0. 022991			0 0	56, 599	•
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 088965			0 0		•
54. 01 05401 FSED RADIOLOGY - DIAGNOSTIC	0. 099889			0 0	0	54.01
55. 00 05500 RADI OLOGY-THERAPEUTI C 55. 01 05501 WOODLAND CANCER CARE CTR	0. 128122			0 0	679, 258 0	55.00 55.01
56. 00 05600 RADI OI SOTOPE	0. 212909			0 0	0	56.00
57. 00 05700 CT_SCAN	0.000000			0 0		57.00
58. 00 05800 MRI	0. 000000			0 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 117894			0 0	407, 375	
60. 00 06000 LABORATORY	0. 110862			0 0	310, 830	•
60. 01 06001 FS ED LAB	0. 127420		1	0 0	0	60.01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000			0 0		61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000	c		0 0	0	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 040229	0)	0 0	0	63.00
63.01 06301 FS ED BLOOD BANK	0. 001908	0)	0 0	0	63.01
64. 00 06400 I NTRAVENOUS THERAPY	0. 000000	C		0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0. 130321	201, 064		0 0	26, 203	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 212734		1	0 0	23, 289	
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000			0 0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0.00000			0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 102754			0 0		•
70. 00 07000 ELECTROENCEPHALOGRAPHY	0.00000			0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 186001 0. 512843			0 0	797, 239 2, 895, 866	
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 206490			0 8,969	8, 739, 816	•
74. 00 07400 RENAL DIALYSIS	0. 200470			0 0	0, 737, 010	74.00
75. 00 07500 ASC (NON-DI STINCT PART)	0. 000000			0 0	0	
76. 00 03020 CLINIC	0. 000000			0 0	0	76.00
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000			0 0		77.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC						88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER						89.00
90. 00 09000 CLINIC	0. 000000			0 0		90.00
90. 03 09003 I NFUSI ON OP SERVI CES	0. 357184			0 0	-	
91.00 09100 EMERGENCY	0. 117785			0 0		•
91.01 09101 FREE STANDING EMERGENCY DEPT	0. 311968			0 0		
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART	0. 589142	1, 283, 132		0 0	755, 947	92.00
94. 00 09400 HOME PROGRAM DI ALYSI S	0. 000000	1	1	0 0		04 00
95. 00 09500 AMBULANCE SERVICES	0. 000000			0		94.00 95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000			0 0	0	96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0.000000				0	•
98.00 09850 OTHER REI MBURSABLE COST CENTERS	0. 000000			0 0	0	98.00
200.00 Subtotal (see instructions)		148, 319, 188		0 8, 969	-	•
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)		148, 319, 188		0 8, 969	24, 044, 644	202.00

PPORTI ONME	ncial Systems FR NT OF MEDICAL, OTHER HEALTH SERVICES AND		H MICHIGAN CITY Provider CC		Period: From 01/01/2021 To 12/31/2021	Worksheet D Part V Date/Time Pre 5/26/2022 11:	
			Title	XVIII	Hospi tal	PPS	20 4
		Cos	sts				
	Cost Center Description	Cost	Cost				
		Reimbursed	Reimbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
		Ded. & Coins.					
		(see inst.)	(see inst.)				
ANGLI		6.00	7.00				-
	LARY SERVICE COST CENTERS	0	0				50.00
	RECOVERY ROOM	0	0				51.00
	DELIVERY ROOM & LABOR ROOM	0	0				51.00
	ANESTHESI OLOGY	0	0				53.00
	RADI OLOGY-DI AGNOSTI C	0	0				53.00
		0	0				
	FSED RADI OLOGY – DI AGNOSTI C RADI OLOGY-THERAPEUTI C	0	0				54.01
	WOODLAND CANCER CARE CTR	0	0				55.00
	RADI OI SOTOPE	0	0				
	CT SCAN	0	0				56.00
8.00 05800		0	0				58.00
	CARDIAC CATHETERIZATION	0	0				59.00
	LABORATORY	0	0				60.00
		0	0				
	FS ED LAB PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0				60.0
	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0				61.00
		0	-				62.00
	BLOOD STORING, PROCESSING & TRANS. FS ED BLOOD BANK	0	0				63.00
	INTRAVENOUS THERAPY	0	0				63.01
		0	0				64.00
		0	0				65.00 66.00
	PHYSI CAL THERAPY OCCUPATI ONAL THERAPY	0	0				67.00
	SPEECH PATHOLOGY	0	0				68.00
	ELECTROCARDI OLOGY	0	0				69.00
	ELECTROENCEPHALOGRAPHY	0	0				70.00
	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0				71.00
	IMPL. DEV. CHARGED TO PATIENTS	0	0				72.00
	DRUGS CHARGED TO PATIENTS	0	1, 852				73.0
	RENAL DI ALYSI S	0	0				74.0
	ASC (NON-DI STI NCT PART)	0	0				75.0
		0	0				76.00
	ALLOGENEIC STEM CELL ACQUISITION	0	0				77.00
	TIENT SERVICE COST CENTERS		U 0				_ //.0
	RURAL HEALTH CLINIC						88.00
	FEDERALLY QUALIFIED HEALTH CENTER						89.00
	CLINIC	0	0				90.0
	INFUSION OP SERVICES	0	0				90.0
	EMERGENCY	0	0				91.0
	FREE STANDING EMERGENCY DEPT	0	0				91.0
	OBSERVATION BEDS (NON-DISTINCT PART	0	0				92.0
	REIMBURSABLE COST CENTERS	· · · · · ·	<u> </u>				1 2.0
	HOME PROGRAM DI ALYSI S	0	0				94.00
	AMBULANCE SERVICES	0					95.0
	DURABLE MEDICAL EQUIP-RENTED	0	0				96.0
	DURABLE MEDICAL EQUIP-SOLD	0	0				97.0
	OTHER REIMBURSABLE COST CENTERS	0	0				98.0
00.00	Subtotal (see instructions)	0	1, 852				200. 0
01.00	Less PBP Clinic Lab. Services-Program	0	1,002				201.0
	5	- V					
	Only Charges						

APPORTI C	DNMENT OF INPATIENT ANCILLARY SERVICE CAPIT.	AL COSTS	Provider C	CN: 15-0015	Peri od:	Worksheet D	2552-10
				CCN: 15-S015	From 01/01/2021 To 12/31/2021	Part II Date/Time Pre 5/26/2022 11:	pared: 23 am
			Title	e XVIII	Subprovider - IPF	PPS	
	Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
		Related Cost	(from Wkst. C,		Program	(column 3 x	
		(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
		Part II, col.	8)	2)			
		26)					
		1.00	2.00	3.00	4.00	5.00	
	NCI LLARY SERVICE COST CENTERS	1				-	
	5000 OPERATING ROOM	8, 238, 935				0	
	5100 RECOVERY ROOM	0		0.00000			
	5200 DELIVERY ROOM & LABOR ROOM	578, 738	3, 685, 504	0. 15703	31 0	0	52.00
53.00 0	5300 ANESTHESI OLOGY	84, 504	10, 368, 372	0. 00815	50 0	0	53.00
	5400 RADI OLOGY-DI AGNOSTI C	3, 646, 315			49 17, 787	504	54.00
54.01 0	5401 FSED RADIOLOGY - DIAGNOSTIC	367,096	28, 408, 336	0. 01292	22 0	0	54.01
55.00 0	5500 RADI OLOGY-THERAPEUTI C	681, 750	19, 318, 818	0. 03528	39 16, 694	589	55.00
55.01 0	5501 WOODLAND CANCER CARE CTR	168, 825	4, 336, 926	0. 03892	27 0	0	55.01
56.00 0	5600 RADI OI SOTOPE	0	C	0. 00000	0 00	0	56.00
57.00 0	5700 CT SCAN	0	C	0. 00000	0 00	0	57.00
58.00 0	5800 MRI	0	c c	0. 00000	0 00	0	58.00
59.00 0	5900 CARDI AC CATHETERI ZATI ON	1, 592, 097	36, 005, 555	0.0442	18 0	0	59.00
	6000 LABORATORY	861, 255				1, 383	
	6001 FS ED LAB	36, 543					
	6100 PBP CLINICAL LAB SERVICES-PRGM ONLY	00,010		0100210		Ŭ	61.00
	6200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0. 00000	0 0	0	
	6300 BLOOD STORING, PROCESSING & TRANS.	30, 632				0	
	6301 FS ED BLOOD BANK	30,032	22, 542			0	
	6400 I NTRAVENOUS THERAPY	0		0.00000		0	
	6500 RESPI RATORY THERAPY	359, 522					
	6600 PHYSI CAL THERAPY	245, 914					
	6700 OCCUPATIONAL THERAPY	245, 914				0	
				0.0000			
		0	-	0.0000		0	
	6900 ELECTROCARDI OLOGY	948, 268				340	
	7000 ELECTROENCEPHALOGRAPHY	0		0.0000		0	
	7100 MEDI CAL SUPPLIES CHARGED TO PATIENT	135, 538					
	7200 IMPL. DEV. CHARGED TO PATIENTS	369, 964				0	
	7300 DRUGS CHARGED TO PATIENTS	1, 029, 254				601	
	7400 RENAL DIALYSIS	0		0.0000		0	
	7500 ASC (NON-DISTINCT PART)	0	-	0.0000		0	
	3020 CLI NI C	14, 381				0	
	7700 ALLOGENEIC STEM CELL ACQUISITION	0	C	0.0000	0 00	0	77. OC
	UTPATIENT SERVICE COST CENTERS		·				
88.00 0	8800 RURAL HEALTH CLINIC	0	C	0. 00000	0 00	0	88.00
89.00 0	8900 FEDERALLY QUALIFIED HEALTH CENTER	0	C	0.0000	0 00	0	89.00
90.00 0	9000 CLI NI C	0	C	0.0000	0 00	0	90.00
90.03 0	9003 INFUSION OP SERVICES	309, 976	5, 194, 075	0. 0596	79 0	0	90.03
91.00 0	9100 EMERGENCY	1, 895, 542	94, 731, 669	0. 02001	10 123, 105	2, 463	91.00
	9101 FREE STANDING EMERGENCY DEPT	1, 862, 628					
	9200 OBSERVATION BEDS (NON-DISTINCT PART	0					
	THER REIMBURSABLE COST CENTERS						1
	9400 HOME PROGRAM DI ALYSI S	0	C	0.0000	0 00	0	94.00
	9500 AMBULANCE SERVICES					, U	95.00
	9600 DURABLE MEDICAL EQUIP-RENTED	0		0. 00000	0 00	0	
	9700 DURABLE MEDICAL EQUIP-SOLD	0		0.00000		0	
98.00 0	9850 OTHER REIMBURSABLE COST CENTERS	0		0. 00000	0 00	0	1 98 11

PORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY ROUGH COSTS	SERVICE OTHER PASS	Provider Concernent (CN: 15-0015 CCN: 15-S015	Peri od: From 01/01/2021 To 12/31/2021		pared 23 am
		Title	XVIII	Subprovider -	PPS	
Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program		Allied Health	
	1.00	2A	2.00	3A	3.00	
ANCI LLARY SERVI CE COST CENTERS						
00 05000 OPERATING ROOM 00 05100 RECOVERY ROOM	0	0 0				50. C
00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0		52.0
00 05300 ANESTHESI OLOGY	0	0		0 0	-	53. C
00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	-	54. C
01 05401 FSED RADIOLOGY - DIAGNOSTIC	0	0		0 0	0	54. C
00 05500 RADI OLOGY-THERAPEUTI C	0	0		0 0	0	55. C
01 05501 WOODLAND CANCER CARE CTR	0	0		0 0	0 0	55. C
00 05600 RADI OI SOTOPE	0	0		0 0	0 0	56. C
00 05700 CT SCAN	0	0		0 0	0	57. C
00 05800 MRI	0	0		0 0	0	58. C
00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0	59. C
00 06000 LABORATORY	0	0		0 0	0 0	60. C
01 06001 FS ED LAB	0	0		0 0	0	60.0
00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.0
00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0 0	-	62. (
00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 0	-	63.0
01 06301 FS ED BLOOD BANK	0	0		0 0	, i i i i i i i i i i i i i i i i i i i	63.0
00 06400 I NTRAVENOUS THERAPY	0	0		0 0	, i i i i i i i i i i i i i i i i i i i	64.0
00 06500 RESPI RATORY THERAPY 00 06600 PHYSI CAL THERAPY	0	0			-	65.0 66.0
00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	-	67.0
00 06800 SPEECH PATHOLOGY	0	0		0 0	-	68.0
00 06900 ELECTROCARDI OLOGY	0	0				69.0
00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 0		70.0
00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 0	-	71. (
00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72.
00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0 0	73.
00 07400 RENAL DIALYSIS	0	0		0 0	0	74.
00 07500 ASC (NON-DISTINCT PART)	0	0		0 0	0	75.
00 03020 CLINIC	0	0		0 0	0 0	76.
00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0		0 0	0 0	77.0
OUTPATIENT SERVICE COST CENTERS						
00 08800 RURAL HEALTH CLINIC	0	0		0 0		88.
00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0		89.1
00 09000 CLINIC	0	0		0 0	0	90.0
03 09003 I NFUSI ON OP SERVI CES	0	0		0 0	0	90.0
00 09100 EMERGENCY	0	0				91. (91. (
01 09101 FREE STANDING EMERGENCY DEPT 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0		
OTHER REIMBURSABLE COST CENTERS	U		1	0	. 0	72.0
00 09400 HOME PROGRAM DI ALYSI S	0	0		0 0	0	94. (
00 09500 AMBULANCE SERVICES		0				95.0
00 09600 DURABLE MEDICAL EQUIP-RENTED	0	Ω		0 0	0	
00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0		0 0		
00 09850 OTHER REI MBURSABLE COST CENTERS	0	0		0 0		
D. 00 Total (lines 50 through 199)	0	0		0 0		200.

	Financial Systems F ONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE		H MICHIGAN CIT S Provider C		Peri od:	Worksheet D	2552-10
THROUGH		RVICE UTHER PAS		CCN: 15-0015	From 01/01/2021 To 12/31/2021	Part IV Date/Time Pre	pared:
						5/26/2022 11:	23 am
			Title	e XVIII	Subprovider - IPF	PPS	
	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
		Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
		Education Cost		Cost (sum of		(col. 5 ÷ col.	
			4)	col s. 2, 3,	8)	7)	
				and 4)		(see	
		1.00	5.00	(7.00	instructions)	
	ANCI LLARY SERVI CE COST CENTERS	4.00	5.00	6.00	7.00	8.00	
	05000 OPERATI NG ROOM	0	C		0 162, 681, 971	0. 000000	50.00
	05100 RECOVERY ROOM	0	-		0 0	0.000000	
	05200 DELIVERY ROOM & LABOR ROOM	0	-		0 3, 685, 504	0.000000	1
	05300 ANESTHESI OLOGY	0			0 10, 368, 372	0.000000	
	05400 RADI OLOGY-DI AGNOSTI C	0			0 128, 622, 350	0.000000	1
	05401 FSED RADIOLOGY - DIAGNOSTIC	0			0 28, 408, 336	0.000000	
	05500 RADI OLOGY-THERAPEUTI C	0	-		0 19, 318, 818		
	05501 WOODLAND CANCER CARE CTR	0			0 4, 336, 926	0.000000	
	05600 RADI OI SOTOPE	0			0 4, 330, 720	0.000000	
	05700 CT SCAN	0			0 0	0.000000	
	05800 MRI	0			0 0	0.000000	
	05900 CARDI AC CATHETERI ZATI ON	0			0 36,005,555	0.000000	1
	06000 LABORATORY	0			0 100, 124, 636	0.000000	
	06001 FS ED LAB	0			0 14, 897, 414	0.000000	1
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0			0 14,077,414	0.000000	61.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	c c		0 0	0. 000000	1
	06300 BLOOD STORING, PROCESSING & TRANS.	0			0 1, 575, 822	0.000000	1
	06300 FS ED BLOOD BANK	0			0 1, 575, 822	0.000000	
	06400 I NTRAVENOUS THERAPY	0			0 22, 342	0.000000	
	06500 RESPI RATORY THERAPY	0			0 20, 544, 305	0.000000	
	06600 PHYSI CAL THERAPY	0			0 21, 257, 798	0.000000	1
	06700 OCCUPATIONAL THERAPY	0			0 21, 237, 748	0.000000	
	06800 SPEECH PATHOLOGY	0			0 0	0.000000	1
	06900 ELECTROCARDI OLOGY	0			0 33, 000, 490		
	07000 ELECTROENCEPHALOGRAPHY	0	-		0 33,000,490	0.000000	1
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0			0 38, 123, 036	0.000000	
	07200 IMPL. DEV. CHARGED TO PATIENTS	0			0 38, 047, 166	0.000000	
	07300 DRUGS CHARGED TO PATIENTS	0			0 139, 402, 749	0.000000	
	07400 RENAL DI ALYSI S	0			0 137, 402, 747	0.000000	1
	07500 ASC (NON-DI STINCT PART)	0			0 0	0.000000	
	03020 CLINIC	0	-		0 0	0.000000	
	07700 ALLOGENEIC STEM CELL ACQUISITION	0			0 0	0.000000	
	OUTPATIENT SERVICE COST CENTERS	0		1	0 0	0.000000	//.00
	08800 RURAL HEALTH CLINIC	0	C		0 0	0.00000	88.00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0			0 0	0.000000	
	09000 CLINIC	0	l d		0 0	0.000000	
	09003 INFUSION OP SERVICES	0			0 5, 194, 075		
	09100 EMERGENCY	0	-		0 94, 731, 669		
	09101 FREE STANDING EMERGENCY DEPT	0			0 20, 485, 614	0.000000	
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0 9, 185, 937	0.000000	
	OTHER REIMBURSABLE COST CENTERS				,, ,, ,,		1
	09400 HOME PROGRAM DI ALYSI S	0	C		0 0	0.00000	94.00
	09500 AMBULANCE SERVI CES						95.00
	09600 DURABLE MEDICAL EQUIP-RENTED	0	C		0 0	0.000000	1
	09700 DURABLE MEDICAL EQUIP-SOLD	0			0 0	0. 000000	1
		1	-		-		
	09850 OTHER REIMBURSABLE COST CENTERS	0	0		0 0	0.000000	98.00

Health Financial Systems APPORTIONMENT OF INPATIENT/OUTP		RANCISCAN HEALTH	Provider C		Per	ri od:	u of Form CMS-2 Worksheet D	2352 10
THROUGH COSTS				CCN: 15-S015		om 01/01/2021	Part IV Date/Time Pre 5/26/2022 11:	
			Title	XVIII	S	ubprovider - IPF	PPS	
Cost Center Descrip	tion	Outpatient	Inpatient	Inpati ent		Outpatient	Outpati ent	
		Ratio of Cost	Program	Program		Program	Program	
		to Charges	Charges	Pass-Throug		Charges	Pass-Through	
		(col. 6 ÷ col.		Costs (col.			Costs (col. 9	
		7) 9.00	10.00	x col. 10) 11.00)	12.00	x col. 12) 13.00	
ANCI LLARY SERVICE COST CE	INTERS	9.00	10.00	11.00		12.00	13.00	
50. 00 05000 OPERATI NG ROOM	INTERS	0. 000000	0		0	0	0	50.00
51.00 05100 RECOVERY ROOM		0. 000000	0		0	0	0	
52.00 05200 DELIVERY ROOM & LAB	OR ROOM	0. 000000	0		0	0	0	
53. 00 05300 ANESTHESI OLOGY		0. 000000	0		0	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI	С	0. 000000	17, 787		0	0	0	54.00
54. 01 05401 FSED RADI OLOGY - DI		0. 000000	0		0	o	0	54.01
55. 00 05500 RADI OLOGY - THERAPEUT		0. 000000	16, 694		0	0	0	55.00
55. 01 05501 WOODLAND CANCER CAR		0. 000000	10,071		0	0	0	55.01
56. 00 05600 RADI OI SOTOPE		0. 000000	0		0	0	0	56.00
57. 00 05700 CT SCAN		0.000000	0		0	0	0	
58. 00 05800 MRI		0. 000000	0		0	0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZA	TLON	0. 000000	0		0	0	0	59.00
60. 00 06000 LABORATORY		0. 000000	160, 725		0	0	0	60.00
60. 01 06001 FS ED LAB		0. 000000	00,720		0	0	0	60.01
61.00 06100 PBP CLINICAL LAB SE	RVICES-PRGM ONLY	0.000000	0		Ŭ	Ű	0	61.00
62.00 06200 WHOLE BLOOD & PACKE		0. 000000	0		0	0	0	
63. 00 06300 BLOOD STORING, PROC		0. 000000	0		0	0	0	
63. 01 06301 FS ED BLOOD BANK		0.000000	0		0	0	0	63.01
64. 00 06400 I NTRAVENOUS THERAPY		0. 000000	0		0	0	0	64.00
65. 00 06500 RESPIRATORY THERAPY		0. 000000	5, 356		0	0	0	65.00
66.00 06600 PHYSI CAL THERAPY		0. 000000	2, 089		0	0	0	66.00
67. 00 06700 OCCUPATIONAL THERAP	Y	0. 000000	2,007		0	Ő	0	67.00
68.00 06800 SPEECH PATHOLOGY		0. 000000	0		0	0	0	68.00
69.00 06900 ELECTROCARDI OLOGY		0. 000000	11, 842		0	o	0	69.00
70.00 07000 ELECTROENCEPHALOGRA	PHY	0. 000000	0		0	o	0	
71.00 07100 MEDICAL SUPPLIES CH		0. 000000	6, 123		0	o	0	
72.00 07200 I MPL. DEV. CHARGED		0.000000	0		0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PA		0. 000000	81, 357		0	0	0	1
74.00 07400 RENAL DIALYSIS		0.000000	0		0	0	0	74.00
75.00 07500 ASC (NON-DISTINCT P	ART)	0. 000000	0		0	0	0	75.00
76.00 03020 CLINIC	,	0. 000000	0		0	0	0	76.00
77.00 07700 ALLOGENEIC STEM CEL	L ACQUESTION	0. 000000	0		0	0	0	77.00
OUTPATIENT SERVICE COST C	ENTERS							1
88.00 08800 RURAL HEALTH CLINIC	:	0. 000000	0		0	0	0	88.00
89.00 08900 FEDERALLY QUALIFIED	HEALTH CENTER	0. 000000	0		0	0	0	89.00
90. 00 09000 CLINIC		0. 000000	0		0	0	0	90.00
90.03 09003 INFUSION OP SERVICE	S	0. 000000	0		0	0	0	
91.00 09100 EMERGENCY		0. 000000	123, 105		0	0	0	91.00
91.01 09101 FREE STANDING EMERG	ENCY DEPT	0. 000000	0		0	0	0	
92.00 09200 OBSERVATION BEDS (N	ON-DISTINCT PART	0. 000000	0		0	0	0	92.00
OTHER REIMBURSABLE COST C	ENTERS							
94.00 09400 HOME PROGRAM DIALYS	IS	0. 000000	0		0	0	0	
95.00 09500 AMBULANCE SERVICES								95.00
96.00 09600 DURABLE MEDICAL EQU		0. 000000	0		0	0	0	
97.00 09700 DURABLE MEDICAL EQU		0. 000000	0		0	0	0	
	COST CENTERS	0. 000000 0. 000000	0 0 425, 078		0 0 0	0 0 0	0	

Health Financial Systems F	RANCISCAN HEALTH	H MICHIGAN CIT	Y	In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider C	CN: 15-0015	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part I Date/Time Pre 5/26/2022 11:	pared: 23 am
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description	Capi tal	Swing Bed	Reduced		Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,	-	Related Cos	t		
	Part II, col.		(col. 1 - col			
	26)		2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS	· · ·		•		•	
30. 00 ADULTS & PEDIATRICS	6, 943, 605	C	6, 943, 60	26, 966	257.49	30.00
31.00 INTENSIVE CARE UNIT	1, 448, 888		1, 448, 8	38 4, 512	321.12	31.00
32.00 CORONARY CARE UNIT	0			0 0	0.00	32.00
33.00 BURN INTENSIVE CARE UNIT	0			0 0	0.00	33.00
34.00 SURGICAL INTENSIVE CARE UNIT	0			0 0	0.00	34.00
40. 00 SUBPROVIDER - IPF	1, 223, 794	C	1, 223, 7	3, 466	353.09	40.00
41.00 SUBPROVIDER - IRF	0	C	b	0 0	0.00	41.00
43.00 NURSERY	323, 420		323, 42	20 928	348.51	43.00
44.00 SKILLED NURSING FACILITY	0			0 0	0.00	44.00
45.00 NURSING FACILITY	0			0 0	0.00	45.00
200.00 Total (lines 30 through 199)	9, 939, 707		9, 939, 70	35, 872		200.00
Cost Center Description	I npati ent	Inpati ent			I	
'	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6.00	7.00	1			
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	557	143, 422	2			30.00
31.00 INTENSIVE CARE UNIT	39	12, 524	1			31.00
32.00 CORONARY CARE UNIT	0	C				32.00
33.00 BURN INTENSIVE CARE UNIT	0	C				33.00
34.00 SURGICAL INTENSIVE CARE UNIT	0	C				34.00
40. 00 SUBPROVIDER - IPF	1, 956	690, 644	1			40.00
41.00 SUBPROVIDER - IRF	0	C	b			41.00
43.00 NURSERY	572	199, 348	3			43.00
44.00 SKILLED NURSING FACILITY	0	C	b			44.00
45.00 NURSING FACILITY	0	C	b			45.00
200.00 Total (lines 30 through 199)	3, 124	1, 045, 938	3			200.00

		RANCI SCAN HEALTH				u of Form CMS-2	2552-1
APPOR I I ONMEI	NT OF INPATIENT ANCILLARY SERVICE CAPIT.	AL COSTS	Provider C	CN: 15-0015	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part II Date/Time Pre 5/26/2022 11:	pared: 23 am
				e XIX	Hospi tal	Cost	
	Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
		Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
		(from Wkst. B,	Part I, col.	(col. 1 + col	L. Charges	column 4)	
		Part II, col.	8)	2)	Ŭ	· · ·	
		26)	ŕ				
		1.00	2.00	3.00	4.00	5.00	
ANCI L	LARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	8, 238, 935	(0.0000	00 7, 455, 276	0	50.00
51.00 05100	RECOVERY ROOM	0	(0. 0000	0 00	0	51.00
2.00 05200	DELIVERY ROOM & LABOR ROOM	578, 738	C	0.0000	0 00	0	52.00
	ANESTHESI OLOGY	84, 504	C			0	
	RADI OLOGY-DI AGNOSTI C	3, 646, 315	(
	FSED RADIOLOGY - DIAGNOSTIC	367,096	(
	RADI OLOGY-THERAPEUTI C	681, 750	(
	WOODLAND CANCER CARE CTR		(
		168, 825	-				
	RADI OI SOTOPE	0	(
	CT SCAN	0	(0.0000		-	
58.00 05800		0	(0	
	CARDI AC CATHETERI ZATI ON	1, 592, 097	0	0.0000			
0.00 06000	LABORATORY	861, 255	(0.0000	0 9, 743, 184	0	60.0
0. 01 06001	FS ED LAB	36, 543	(0.0000	21, 432	0	60.0
51.00 06100	PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
2.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	(0. 0000	0 00	0	62.0
3.00 06300	BLOOD STORING, PROCESSING & TRANS.	30, 632	C	0. 0000	260, 604	0	63.00
	FS ED BLOOD BANK	2	C			0	
	INTRAVENOUS THERAPY	0	(0	
	RESPI RATORY THERAPY	359, 522	(0	
	PHYSI CAL THERAPY	245, 914	(0	
	OCCUPATIONAL THERAPY	243, 914	(
		0	(
	SPEECH PATHOLOGY	-		0.0000		-	68.0 69.0
		948, 268		0.0000			
		0	(0	
	MEDICAL SUPPLIES CHARGED TO PATIENT	135, 538	(0	
	IMPL. DEV. CHARGED TO PATIENTS	369, 964	0			0	
	DRUGS CHARGED TO PATIENTS	1, 029, 254	0	0.0000		0	
	RENAL DIALYSIS	0	(0	
75.00 07500	ASC (NON-DISTINCT PART)	0	0	0.0000	0 00	0	75.00
76.00 03020		14, 381	(0.0000	0 00	0	76.0
77.00 07700	ALLOGENEIC STEM CELL ACQUISITION	0	(0.0000	0 00	0	77.00
OUTPA	TIENT SERVICE COST CENTERS						
38.00 08800	RURAL HEALTH CLINIC	0	(0.0000	0 00	0	88. 0
	FEDERALLY QUALIFIED HEALTH CENTER	0	0			0	89.0
	CLINIC	0	C			0	
	INFUSION OP SERVICES	309, 976	C				
	EMERGENCY	1, 895, 542	(
	FREE STANDING EMERGENCY DEPT	1, 862, 628					•
	OBSERVATION BEDS (NON-DISTINCT PART	1, 802, 028		0.0000			
	REIMBURSABLE COST CENTERS	0	L C	<u>1 0.0000</u>	0	0	72.0
	HOME PROGRAM DI ALYSI S			0.0000		0	
		0	0	0.0000	0 00	0	
	AMBULANCE SERVICES				-	_	95.0
	DURABLE MEDICAL EQUIP-RENTED	0	(0	
	DURABLE MEDICAL EQUIP-SOLD	0	C			0	
	OTHER REIMBURSABLE COST CENTERS	0	0			-	
200.00	Total (lines 50 through 199)	23, 457, 679	()	52, 898, 488	0	200.00

Health Financial Systems APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHE	FRANCISCAN HEALTH			Period:	worksheet D	2552-10
ALLONTION WENT OF THEATENE ROOTINE SERVICE OTHE			F	From 01/01/2021 o 12/31/2021	Part III	pared: 23 am
		Titl	e XIX	Hospi tal	Cost	20 4
Cost Center Description	Nursi ng	Nursi ng	Allied Health	Allied Health	All Other	
	Program	Program	Post-Stepdown	Cost	Medi cal	
	Post-Stepdown		Adjustments		Education Cost	
	Adjustments					
	1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	C) (0 0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0		0 0	0	31.00
32.00 03200 CORONARY CARE UNIT	0	0		0 0	0	32.00
33.00 03300 BURN INTENSIVE CARE UNIT	0	C		0 0	0	33.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	0	C		0	0	34.00
40. 00 04000 SUBPROVIDER - IPF	0	0		0	0	40.00
41. 00 04100 SUBPROVIDER - IRF	0	n n) 0	0	
43. 00 04300 NURSERY	0	0		0	0	
44. 00 04400 SKILLED NURSING FACILITY	0	0			0	44.00
45. 00 04500 NURSING FACILITY	0	0				45.00
200.00 Total (lines 30 through 199)	0	0				200.00
Cost Center Description	Swing-Bed	Total Costs	Total Dationt	Per Diem (col.	Inpati ent	200.00
COST Center Description	Adjustment	(sum of cols.		$5 \div col.$ 6)	Program Days	
	Amount (see	1 through 3,	Days	5 ÷ COL. 6)	Program Days	
	instructions)					
	4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS	4.00	5.00	0.00	7.00	0.00	
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	26, 966	0.00	557	30.00
31. 00 03100 INTENSIVE CARE UNIT	0	0	20,700			
		0				
		U				
33. 00 03300 BURN INTENSIVE CARE UNIT		U				
34. 00 03400 SURGICAL INTENSIVE CARE UNIT		U		0.00		
40. 00 04000 SUBPROVIDER - IPF	0	C	3, 466			
41.00 04100 SUBPROVIDER – IRF	0	C		0.00		
43. 00 04300 NURSERY		C	928			
44.00 04400 SKILLED NURSING FACILITY		C				1
45.00 04500 NURSING FACILITY		0				1
200.00 Total (lines 30 through 199)		0	35, 872	2	3, 124	200.00
Cost Center Description	I npati ent					
	Program					
	Pass-Through					
	Cost (col. 7 x					
	col . 8)					
	9.00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0					30.00
31.00 03100 INTENSIVE CARE UNIT	0					31.00
32.00 03200 CORONARY CARE UNIT	0					32.00
33.00 03300 BURN INTENSIVE CARE UNIT	0					33.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	0					34.00
10. 00 04000 SUBPROVIDER - IPF	0					40.00
1.00 04100 SUBPROVIDER - IRF	0					41.00
43. 00 04300 NURSERY	0					43.00
44. 00 04400 SKILLED NURSING FACILITY	0					44.00
	-					45.00
						200.00
44.00 04400 SKILLED NURSING FACILITY 45.00 04500 NURSING FACILITY 200.00 Total (lines 30 through 199)	0 0 0					

	Financial Systems Fi TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	Provider CO	CN: 15-0015	Period:	/01/2021	Worksheet D Part IV	2552-10
THROUG	GH COSTS				To 12	/31/2021	Date/Time Pre 5/26/2022 11:	pared: 23 am
			Titl	e XIX	Hosp	oi tal	Cost	20 411
	Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Post-S	d Health Stepdown stments	Allied Health	
		1.00	2A	2.00		3A	3.00	
	ANCILLARY SERVICE COST CENTERS							
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	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	0	54.00
54.01	05401 FSED RADIOLOGY - DIAGNOSTIC	0	0		0	0	0	54.01
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0		0	0	0	55.00
55.01	05501 WOODLAND CANCER CARE CTR	0	0		0	0	0	55.01
56.00	05600 RADI OI SOTOPE	0	0		0	0	0	56.00
57.00	05700 CT SCAN	0	0		0	0	0	57.00
58.00	05800 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 FS ED LAB	0	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 CELL	0	0		0	0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0	0	0	63.00
63.01	06301 FS ED BLOOD BANK	0	0		0	0	0	63.01
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
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	0	0		0	0	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0		0	0	0	74.00
75.00	07500 ASC (NON-DI STINCT PART)	0	0		0	0	0	75.00
76.00 77.00		0	0		0 0	0	0	
77.00	07700 ALLOGENEI C STEM CELL ACQUI SI TI ON OUTPATI ENT SERVI CE COST CENTERS	U	0		0	0	0	77.00
88. 00	08800 RURAL HEALTH CLINIC	0	0	[0	0	0	88. 00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0	0	89.00
90.00	09000 CLINIC	0	0		0	0	0	90.00
90.00	09003 I NFUSI ON OP SERVI CES	0	0		0	0	0	90.00
90.03	09100 EMERGENCY	0	0		0	0	0	90.03
91.00	09101 FREE STANDING EMERGENCY DEPT	0	0		0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0	0	0	92.00
.2.00	OTHER REIMBURSABLE COST CENTERS	<u> </u>		I	<u> </u>		0	1 2.00
94.00	09400 HOME PROGRAM DI ALYSI S	0	0		0	0	0	94.00
95.00	09500 AMBULANCE SERVICES		0		Ŭ.	0	0	95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0	0	0	•
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0		0	0	0	97.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0	0		0	0	0	98.00
98 00								

			Draw delate of	CNL 1E 001E	Dani ad.	Waskab+ P	2552-10
	ONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE UTHER PAS	6 Provider C		Period: From 01/01/2021	Worksheet D Part IV	
				-	To 12/31/2021	Date/Time Pre 5/26/2022 11:	
			Titl	e XIX	Hospi tal	Cost	20 411
	Cost Center Description	All Other	Total Cost	Total	Total Charges		
		Medical	(sum of cols.	Outpatient	(from Wkst. C,	to Charges	
		Education Cost	1, 2, 3, and 4)	Cost (sum of cols. 2, 3,	Part I, col. 8)	(col. 5 ÷ col. 7)	
			4)	and 4)	0)	(see	
						instructions)	
		4.00	5.00	6.00	7.00	8.00	
	ANCI LLARY SERVI CE COST CENTERS	1	-	1	1		
	05000 OPERATING ROOM	0	0		0 0	0.00000	
	05100 RECOVERY ROOM	0	0		0 0	0.000000	
	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	0	0			0.000000	
	05400 RADI OLOGY-DI AGNOSTI C	0	0			0.00000 0.000000	
	05400 FSED_RADI OLOGY - DI AGNOSTI C	0				0.000000	
	05500 RADI OLOGY-THERAPEUTI C	0	0		0 0	0.000000	
	05501 WOODLAND CANCER CARE CTR	0	0		0 0	0.000000	
	05600 RADI OI SOTOPE	0	0		0 0	0. 000000	
	05700 CT SCAN	0	0		0 0	0. 000000	
	05800 MRI	0	0		o o	0.00000	
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0. 000000	59.00
	06000 LABORATORY	0	0	(0 0	0.00000	60.00
	06001 FS ED LAB	0	0		0 0	0. 000000	
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0 0	0.00000	
	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 0	0.000000	
	06301 FS ED BLOOD BANK	0	0		0 0	0.000000	1
	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	0	0			0.000000 0.000000	
	06600 PHYSI CAL THERAPY	0	0		0 0	0.000000	1
	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 0	0. 000000	
	07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0.000000	1
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 0	0. 000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(0 0	0.00000	72.00
	07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0. 000000	1
	07400 RENAL DI ALYSI S	0	0		0 0	0.00000	
	07500 ASC (NON-DI STI NCT PART)	0	0		0 0	0.000000	
	03020 CLINIC	0	0		0 0	0.000000	
	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	1	0 0	0. 000000	77.00
	08800 RURAL HEALTH CLINIC	0	0		0 0	0. 000000	88.00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0	0.000000	
	09000 CLINIC	0	0		- 0 0	0.000000	
	09003 INFUSION OP SERVICES	0	0		0 0	0. 000000	
	09100 EMERGENCY	0	0		0 0	0.000000	
91.01	09101 FREE STANDING EMERGENCY DEPT	0	0	(0 0	0. 000000	91.01
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0 0	0.00000	92.00
	OTHER REIMBURSABLE COST CENTERS			1		_	
	09400 HOME PROGRAM DI ALYSI S	0	0	(0 0	0.000000	1
95.00	09500 AMBULANCE SERVICES	-	_			0 000000	95.00
		1 ()	ı ()	y (JI 0	0.000000	96.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0				0 000000	07 00
96. 00 97. 00	09000 DURABLE MEDICAL EQUIP-RENTED 09700 DURABLE MEDICAL EQUIP-SOLD 09850 OTHER REIMBURSABLE COST CENTERS	0	0		o o o o	0. 000000 0. 000000	

Z	RANCI SCAN HEALTH				eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE THROUGH COSTS	RVICE OTHER PASS	Provider CO	CN: 15-0015	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part IV Date/Time Pre 5/26/2022 11:	pared: 23 am
		Ti tl	e XIX	Hospi tal	Cost	25 411
Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Throug	h Charges	Pass-Through	
	(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVI CE COST CENTERS	1		1		1	-
50. 00 O5000 OPERATING ROOM	0. 000000	7, 455, 276		0 23, 649, 872		
51.00 O5100 RECOVERY ROOM	0. 000000	0		0 0		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 0	-	52.00
53. 00 05300 ANESTHESI OLOGY	0. 000000	628, 332		0 1, 577, 824		53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	6, 762, 620		0 21, 235, 516		54.00
54. 01 05401 FSED RADI OLOGY - DI AGNOSTI C	0. 000000	288, 169		0 4, 232, 897		54.01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	400, 010		0 1, 868, 762		55.00
55.01 05501 WOODLAND CANCER CARE CTR	0. 000000	1, 002		0 659, 858		55.01
56. 00 05600 RADI OI SOTOPE	0. 000000	0		0 0		56.00
57.00 05700 CT SCAN	0. 000000	0		0 0		57.00
58. 00 05800 MRI	0. 000000	0		0 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	2, 341, 825		0 2, 094, 739		59.00
60. 00 06000 LABORATORY	0. 000000	9, 743, 184		0 14, 169, 970	0	60.00
60. 01 06001 FS ED LAB	0. 000000	21, 432		0 2, 403, 264	0	60.01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000	0		0 0	0	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	260, 604		0 155, 074	0	63.00
63.01 06301 FS ED BLOOD BANK	0. 000000	0		0 0	0	63.01
64.00 06400 INTRAVENOUS THERAPY	0. 000000	0		0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	3, 188, 934		0 504, 676	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	724, 897		0 2, 670, 302	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	0		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	2, 165, 940		0 3, 504, 511	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	2, 965, 617		0 3, 568, 408	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	3, 010, 416		0 4, 334, 830	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	6, 219, 024		0 11, 794, 496	0	73.00
74.00 07400 RENAL DIALYSIS	0. 000000	0		0 0	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0. 000000	0		0 0	0	75.00
76. 00 03020 CLINIC	0. 000000	0		0 0	0	76.00
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000	0		0 0	0	77.00
OUTPATIENT SERVICE COST CENTERS				-		
88.00 08800 RURAL HEALTH CLINIC	0. 000000	0		0 0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000	0		0 C		89.00
90. 00 09000 CLINIC	0. 000000	0		0 0	0	90.00
90. 03 09003 INFUSION OP SERVICES	0. 000000	5, 475		0 782, 258	0	90.03
91.00 09100 EMERGENCY	0. 000000	6, 327, 530		0 24, 810, 476	0	91.00
91.01 09101 FREE STANDING EMERGENCY DEPT	0. 000000	388, 201		0 3, 685, 966		
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0		0 1, 699, 707	0	92.00
94.00 09400 HOME PROGRAM DI ALYSI S	0. 000000	0		0 0	0	94.00
95. 00 09500 AMBULANCE SERVICES	0.000000	0				94.00
	0. 000000	0			0	
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0.000000	0			-	
		0				97.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS 200.00 Total (lines 50 through 199)	0. 000000	0 52, 898, 488		0 0 129, 403, 406		200.00
200.00 Thotal (Thes so through 199)	I I	JZ, 070, 488	I	U 129, 403, 400	u U	I∠00. 00

	RANCISCAN HEALTH				u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	O VACCINE COST	Provider C	CN: 15-0015	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part V Date/Time Pre 5/26/2022 11:	
		Titl	e XIX	Hospi tal	Cost	
			Charges		Costs	
Cost Center Description	Cost to Charge			Cost	PPS Services	
	Ratio From Worksheet C,	Services (see inst.)	Reimbursed Services	Reimbursed Services Not	(see inst.)	
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins			
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0. 000000			0 0	0	50.00
51.00 05100 RECOVERY ROOM	0. 000000			0 0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000			0 0	0	52.00
53.00 05300 ANESTHESI OLOGY	0. 000000			0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			0 0	0	54.00
54. 01 05401 FSED RADI OLOGY - DI AGNOSTI C	0. 000000			0 0	0	54.01
55. 00 05500 RADI OLOGY-THERAPEUTI C 55. 01 05501 WOODLAND CANCER CARE CTR	0. 000000			0 0	0	55.00
55. 01 05501 WOODLAND CANCER CARE CTR 56. 00 05600 RADI 0I SOTOPE	0.000000			0 0	0	55.01 56.00
57. 00 05700 CT SCAN	0.000000				0	57.00
58. 00 05800 MRI	0. 000000			0 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000			0 0	0	59.00
60. 00 06000 LABORATORY	0. 000000			0 0	0	60.00
60. 01 06001 FS ED LAB	0. 000000			0 0	0	60.01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000			0 0		61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000	0		0 0	0	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	155, 074		0 0	0	63.00
63.01 06301 FS ED BLOOD BANK	0. 000000	0		0 0	0	63.01
64.00 06400 INTRAVENOUS THERAPY	0. 000000	0		0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	504, 676		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000			0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000			0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000			0 0	0	68.00
69.00 06900 ELECTROCARDI OLOGY	0. 000000			0 0	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000			0 0	0	70.00
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	0. 000000			0 0	0	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS 73. 00 07300 DRUGS CHARGED TO PATIENTS	0.000000				0	72.00
74. 00 07400 RENAL DIALYSIS	0.000000			0 0	0	74.00
75. 00 07500 ASC (NON-DI STINCT PART)	0. 000000			0 0	0	75.00
76. 00 03020 CLINIC	0. 000000			0 0	0	76.00
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000			0 0	0	77.00
OUTPATIENT SERVICE COST CENTERS					i	
88.00 08800 RURAL HEALTH CLINIC						88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER						89.00
90. 00 09000 CLINIC	0. 000000			0 0	0	90.00
90. 03 09003 INFUSION OP SERVICES	0. 000000			0 0	0	90.03
91.00 09100 EMERGENCY	0. 000000			0 0	0	91.00
91.01 09101 FREE STANDING EMERGENCY DEPT	0. 000000			0 0	0	•
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	1, 699, 707		0 0	0	92.00
OTHER REIMBURSABLE COST CENTERS	0,000000	[1	0		
94. 00 09400 HOME PROGRAM DI ALYSI S 95. 00 09500 AMBULANCE SERVI CES	0. 000000			0 0		94.00
95. 00 09500 AMBULANCE SERVICES 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0.000000			0 0	0	95.00 96.00
97. 00 09700 DURABLE MEDICAL EQUIP-RENTED	0.000000				0	98.00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0.000000			0 0	0	1
200.00 Subtotal (see instructions)	3. 000000	129, 403, 406		0 0	-	200.00
201.00 Less PBP Clinic Lab. Services-Program		, 100, 100		0 0	0	201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)		129, 403, 406		0 0	0	202.00
	•		•	•	•	•

Health Financial Systems FF	ANCISCAN HEALTH	MICHIGAN CITY		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider CC	CN: 15-0015	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part V Date/Time Pre 5/26/2022 11:	epared: 23 am
		Titl	e XIX	Hospi tal	Cost	20 011
	Cost					
Cost Center Description	Subject To Ded. & Coins. [Cost Reimbursed Services Not Subject To Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00				-
ANCI LLARY SERVI CE COST CENTERS	0	0				50.00
51. 00 05100 RECOVERY ROOM	0	0				51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0				52.00
53. 00 05300 ANESTHESI OLOGY	0	0				53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
	0	0				1
54. 01 05401 FSED RADI OLOGY - DI AGNOSTI C	0	0				54.01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0				55.00
55. 01 05501 WOODLAND CANCER CARE CTR	0	0				55.01
56. 00 05600 RADI OI SOTOPE	0	0				56.00
57. 00 05700 CT SCAN	0	0				57.00
	0	0				58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY	0	•				59.00
	0	0				60.00
	0	0				60.01
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0				61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0				62.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0				63.00
63. 01 06301 FS ED BLOOD BANK	0	0				63.01
64.00 06400 INTRAVENOUS THERAPY	0	0				64.00
65. 00 06500 RESPI RATORY THERAPY	0	0				65.00
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	0	0				66.00 67.00
67.00 06700 OCCUPATI ONAL THERAPY 68.00 06800 SPEECH PATHOLOGY	0	0				
69. 00 06900 ELECTROCARDI OLOGY	0	0				68.00 69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0				70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0				73.00
74. 00 07400 RENAL DI ALYSI S	0	0				74.00
75. 00 07500 ASC (NON-DI STINCT PART)	0	0				75.00
76. 00 03020 CLINIC	0	0				76.00
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0				77.00
OUTPATIENT SERVICE COST CENTERS						//.00
88.00 08800 RURAL HEALTH CLINIC						88.00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER						89.00
90. 00 09000 CLINIC	0	0				90.00
90. 03 09003 I NFUSI ON OP SERVI CES	0	0				90.03
91. 00 09100 EMERGENCY	0	0				91.00
91. 01 09101 FREE STANDING EMERGENCY DEPT	0	0				91.01
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0				92.00
OTHER REIMBURSABLE COST CENTERS	-	-				
94. 00 09400 HOME PROGRAM DI ALYSI S	0	0				94.00
95. 00 09500 AMBULANCE SERVICES	0					95.00
96. 00 09600 DURABLE MEDICAL EQUI P-RENTED	0	0				96.00
97. 00 09700 DURABLE MEDICAL EQUI P-SOLD	0	0				97.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0				98.00
200.00 Subtotal (see instructions)	0	0				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)	0	0				202.00

Health Financial Systems APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPI		H MICHIGAN CIT		Peri od:	u of Form CMS-: Worksheet D	2002-1
APPORTIONMENT OF INPATIENT ANGILLARY SERVICE CAPI	TAL CUSTS	Provider C Component	CCN: 15-0015 CCN: 15-S015	From 01/01/2021 To 12/31/2021	Part II Date/Time Pre 5/26/2022 11:	
		Titl	e XIX	Subprovider - IPF	Cost	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos		Capital Costs	
		(from Wkst. C,			(column 3 x	
	(from Wkst. B,		(col. 1 ÷ co	I. Charges	column 4)	
	Part II, col.	8)	2)			
	26)	2.00	2.00	4.00	F 00	
ANCI LLARY SERVI CE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
50. 00 05000 OPERATING ROOM	8, 238, 935	C	0.0000	00 0	0	50.00
51.00 05100 RECOVERY ROOM	0, 200, 700	-				51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	578, 738					52.00
53. 00 05300 ANESTHESI OLOGY	84, 504				0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	3, 646, 315				0	54.00
54. 01 05401 FSED RADI OLOGY - DI AGNOSTI C	367, 096				0	54.0
55. 00 05500 RADI OLOGY-THERAPEUTI C	681, 750				0	55.00
55.01 05501 WOODLAND CANCER CARE CTR	168, 825		0.0000	00 0	0	55.0
56. 00 05600 RADI 0I SOTOPE	0	0	0.0000	00 0	0	56.00
57.00 05700 CT SCAN	0	0	0. 0000	00 0	0	57.00
58. 00 05800 MRI	0	0	0. 0000	00 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	1, 592, 097	0	0.0000	00 0	0	59.00
50. 00 06000 LABORATORY	861, 255	0	0.0000	00 0	0	60.0
50. 01 06001 FS ED LAB	36, 543	0	0.0000	00 0	0	60.0
51.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.0
52.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	-			-	62.0
53.00 06300 BLOOD STORING, PROCESSING & TRANS.	30, 632				0	63.00
53.01 06301 FS ED BLOOD BANK	2	0	0.0000		0	63.0
54.00 06400 I NTRAVENOUS THERAPY	0	-			0	64.00
55. 00 06500 RESPI RATORY THERAPY	359, 522				0	65.0
56. 00 06600 PHYSI CAL THERAPY	245, 914				0	66.0
57.00 06700 OCCUPATI ONAL THERAPY	0	-			-	67.0
58.00 06800 SPEECH PATHOLOGY	0	-	0.0000		0	68.0
9.00 06900 ELECTROCARDI OLOGY	948, 268					69.0
70.00 07000 ELECTROENCEPHALOGRAPHY	105 500	-			0	70.0
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	135, 538		0.0000		0	71.0
22.00 07200 IMPL. DEV. CHARGED TO PATIENTS	369, 964		0.0000		0	72.0
23. 00 07300 DRUGS CHARGED TO PATIENTS 24. 00 07400 RENAL DIALYSIS	1, 029, 254	, s	0.0000		0	74.0
75.00 07500 ASC (NON-DI STINCT PART)	0	-	1		0	75.0
76. 00 03020 CLINIC	14, 381				0	76.0
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0					
OUTPATIENT SERVICE COST CENTERS			0.0000	00 0	<u> </u>	1 / / . 0.
38. 00 08800 RURAL HEALTH CLINIC	0	C	0.0000	00 0	0	88. 00
39. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0				0	89.00
90. 00 09000 CLINIC	0	-	1		0	90.00
PO. 03 09003 INFUSION OP SERVICES	309, 976	c c			0	90.03
91. 00 09100 EMERGENCY	1, 895, 542	c c	0.0000	00 0	0	91.00
91. 01 09101 FREE STANDING EMERGENCY DEPT	1, 862, 628		0.0000	00 0	0	91.0
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0					•
OTHER REI MBURSABLE COST CENTERS]
94. 00 09400 HOME PROGRAM DI ALYSI S	0	C	0.0000	00 0	0	94.00
95. 00 09500 AMBULANCE SERVI CES						95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0.0000		0	
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0.0000		0	
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0				98.00 200.00
200.00 Total (lines 50 through 199)	23, 457, 679	0		0		

THROUGH COSTS Component CCN: 15-S015 From 01/01/2021 To 12/31/2021 Part Date/ 5/26/ Title XIX Subprovider - IPF Cost Center Description Non Physician Anesthetist Cost Nursing Program Post-Stepdown Adjustments Allied Health Post-Stepdown Adjustments	Time Prepa 2022 11:23 Cost	
Title XIX Subprovider - IPF Cost Center Description Non Physician Anesthetist Nursing Program Cost Nursing Program Adjustments Allied Health Program Adjustments	Cost	<u> </u>
Cost Center DescriptionNon PhysicianNursingNursingAllied HealthAlliedAnesthetistProgramProgramProgramPost-StepdownCostPost-StepdownAdjustmentsAdjustments	Heal th	
Cost Post-Stepdown Adjustments Adjustments Adjustments		
Adjustments		
	. 00	
ANCI LLARY SERVI CE COST CENTERS	. 00	
50. 00 05000 0PERATING ROOM 0 0 0 0	0 5	50.00
51.00 05100 RECOVERY ROOM 0 0 0	0 5	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0	0 5	52.00
53.00 05300 ANESTHESI OLOGY 0 0 0		53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0		54.00
54. 01 05401 FSED RADIOLOGY - DIAGNOSTIC 0 0 0 0		54.01
55. 00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 0		55.00
55.01 05501 WOODLAND CANCER CARE CTR 0 0 0 0		55.01
56.00 05600 RADI 0I SOTOPE 0		56.00
57.00 05700 CT SCAN 0 0 0 58.00 05800 MRI 0 0 0 0		57.00 58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 0		59.00
60.00 CABORATORY 0 0 0 0		60.00
0. 01 06001 FS ED LAB		60.01
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 0 0 0	0 6	62.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 0	0 6	63.00
63.01 06301 FS ED BLOOD BANK 0 0 0 0	0 6	63.01
64.00 06400 I NTRAVENOUS THERAPY 0 0 0 0		64.00
65. 00 06500 RESPIRATORY THERAPY 0 0 0 0		65.00
66.00 06600 PHYSI CAL THERAPY 0 0 0 0		66.00
67.00 06700 0CCUPATI 0NAL THERAPY 0 0 0 0 68.00 06800 SPEECH PATHOLOGY 0 0 0		67.00
68.00 06800 SPEECH PATHOLOGY 0 0 0 0 69.00 06900 ELECTROCARDI OLOGY 0		68.00 69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 0 0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0		72.00
73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0		73.00
74.00 07400 RENAL DIALYSIS 0 0 0 0	0 7	74.00
75.00 07500 ASC (NON-DISTINCT PART) 0 0 0 0	0 7	75.00
76.00 03020 CLINIC 0 0 0		76.00
77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION 0 0 0	0 7	77.00
OUTPATIENT SERVICE COST CENTERS		~~ ~~
88.00 08800 RURAL HEALTH CLINIC 0 0 0 0		88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0		89.00
90. 00 09000 CLINIC 0 0 0 90. 03 09003 INFUSION OP SERVICES 0 0 0 0		90.00 90.03
91. 00 09100 EMERGENCY 0 0 0 0		90.03
91. 01 09101 FREE STANDING EMERGENCY DEPT 0 0 0 0		91.00
2.00 09200 OBSERVATION BEDS (NON-DI STINCT PART 0 0		92.00
OTHER REIMBURSABLE COST CENTERS		2. 50
94.00 09400 HOME PROGRAM DI ALYSI S 0 0 0 0	0 9	94.00
95. 00 09500 AMBULANCE SERVICES	9	95.00
96.00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0		96.00
97.00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0		97.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS 0 0 0 0		98.00
200.00 Total (lines 50 through 199) 0 0 0 0	0 20	200.00

			H MICHIGAN CIT			u of Form CMS-2	2552-10
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE SH COSTS	RVICE UTHER PAS:	6 Provider C	UN: 15-0015	Period: From 01/01/2021	Worksheet D Part IV	
mixooc			Component	CCN: 15-S015	To 12/31/2021		pared: 23 am
			Titl	e XIX	Subprovider - IPF	Cost	
	Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
		Medi cal	(sum of cols.	Outpatient			
		Education Cost		Cost (sum o		(col. 5 ÷ col.	
			4)	cols. 2, 3, and 4)	8)	7) (see	
						instructions)	
		4.00	5.00	6.00	7.00	8.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	C		0 0	0. 000000	50.00
51.00	05100 RECOVERY ROOM	0			0 0	0.00000	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0. 000000	52.00
53.00	05300 ANESTHESI OLOGY	0	C		0 0	0.00000	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	C		0 0	0.00000	
54.01	05401 FSED RADI OLOGY - DI AGNOSTI C	0	0		0 0	0.00000	
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0		0 0	0.000000	1
55.01	05501 WOODLAND CANCER CARE CTR	0	0		0 0	0.000000	
56.00	05600 RADI OI SOTOPE	0	0		0 0	0.000000	
57.00 58.00	05700 CT SCAN 05800 MRI	0			0 0	0. 000000 0. 000000	
59.00	05900 CARDI AC CATHETERI ZATI ON	0			0 0	0.000000	
60.00	06000 LABORATORY	0			0 0	0.000000	
60.01	06001 FS ED LAB	0			0 0	0.000000	
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0			0	0.000000	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0 0	0.000000	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 0	0. 000000	1
63.01	06301 FS ED BLOOD BANK	0	0		0 0	0. 000000	
64.00	06400 INTRAVENOUS THERAPY	0	C		0 0	0.000000	64.00
65.00	06500 RESPI RATORY THERAPY	0	C		0 0	0.000000	65.00
66.00	06600 PHYSI CAL THERAPY	0	C		0 0	0.000000	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	C		0 0	0.00000	67.00
68.00	06800 SPEECH PATHOLOGY	0	C		0 0	0. 000000	68.00
69.00	06900 ELECTROCARDI OLOGY	0	C		0 0	0.00000	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0.00000	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 0	0. 000000	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	C		0 0	0.00000	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	C		0 0	0.00000	
74.00	07400 RENAL DI ALYSI S	0	0		0 0	0.000000	
75.00	07500 ASC (NON-DI STI NCT PART)	0			0 0	0.000000	
76.00		0			0 0	0.000000	
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION OUTPATIENT SERVICE COST CENTERS	0	0		0 0	0. 000000	77.00
88.00	08800 RURAL HEALTH CLINIC	0	C	1	0 0	0. 000000	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0			0 0	0.000000	89.00
90.00	09000 CLINIC	0			0 0	0.000000	
	09003 I NFUSI ON OP SERVI CES	0			0 0		1
91.00	09100 EMERGENCY	0	-		0 0		1
91.01	09101 FREE STANDING EMERGENCY DEPT	0			0 0		
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0 0		
	OTHER REIMBURSABLE COST CENTERS						1
94.00	09400 HOME PROGRAM DI ALYSI S	0	C		0 0	0. 000000	94.00
95.00	09500 AMBULANCE SERVICES						95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0 0	0. 000000	96.00
	09700 DURABLE MEDICAL EQUIP-SOLD	0	0		0 0	0. 000000	
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0			0 0	0. 000000	
200.00	Total (lines 50 through 199)	0	0	1	0 0		200.00

		RANCI SCAN HEALTH			Daust		u of Form CMS-2	2552-10
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE H COSTS	RVICE UTHER PASS	Provider Concernent (CCN: 15-0015	Peri From To	01/01/2021 12/31/2021	Worksheet D Part IV Date/Time Pre 5/26/2022 11:	pared: 23 am
			Ti tl	e XIX	Sub	provider - IPF	Cost	25 am
	Cost Center Description	Outpati ent	Inpati ent	I npati ent	0	outpatient	Outpati ent	
		Ratio of Cost	Program	Program		Program	Program	
		to Charges	Charges	Pass-Throug		Charges	Pass-Through	
		(col. 6 ÷ col.		Costs (col.			Costs (col. 9	
		7) 9.00	10.00	x col. 10) 11.00		12.00	x col. 12) 13.00	
	ANCI LLARY SERVICE COST CENTERS	9.00	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	1
53.00	05300 ANESTHESI OLOGY	0. 000000	0		0	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	0		0	0	0	54.00
54.01	05401 FSED RADIOLOGY - DIAGNOSTIC	0. 000000	0		0	0	0	54.01
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	0		0	0	0	55.00
55.01	05501 WOODLAND CANCER CARE CTR	0. 000000	0		0	0	0	55.01
56.00	05600 RADI OI SOTOPE	0. 000000	0		0	0	0	
57.00	05700 CT SCAN	0. 000000	0		0	0	0	
58.00	05800 MRI	0. 000000	0		0	0	0	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0.00000	0		0	0	0	59.00
60.00	06000 LABORATORY	0.000000	0		0	0	0	60.00
60.01	06001 FS ED LAB	0. 000000	0		0	0	0	60.01
61.00 62.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0,00000	0		0	0	0	61.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000 0. 000000	0		0	0	0	
63.00	06301 FS ED BLOOD BANK	0. 000000	0		0	0	0	63.00
64.00	06400 I NTRAVENOUS THERAPY	0. 000000	0		0	0	0	1
65.00	06500 RESPI RATORY THERAPY	0. 000000	0		0	0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0. 000000	0		0	0	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000	0		0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0. 000000	0		0	0	0	68.00
69.00	06900 ELECTROCARDI OLOGY	0. 000000	0		0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	0		0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	0		0	0	0	
74.00	07400 RENAL DI ALYSI S	0. 000000	0		0	0	0	74.00
75.00	07500 ASC (NON-DI STINCT PART)	0.00000	0		0	0	0	75.00
76.00	03020 CLINIC	0. 000000	0		0	0	0	76.00
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION OUTPATIENT SERVICE COST CENTERS	0. 000000	0		0	0	0	77.00
88.00	08800 RURAL HEALTH CLINIC	0. 000000	0	1	0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000	0		0	0	0	
90.00	09000 CLINIC	0. 000000	0		0	0	0	90.00
90.03	09003 I NFUSI ON OP SERVI CES	0. 000000	0		0	0	0	1
	09100 EMERGENCY	0. 000000	0		0	0	0	
	09101 FREE STANDING EMERGENCY DEPT	0. 000000	0		0	0	0	
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0		0	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS	-						
94.00	09400 HOME PROGRAM DI ALYSI S	0. 000000	0		0	0	0	
95.00	09500 AMBULANCE SERVI CES							95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000	0		0	0	0	
97.00	09700 DURABLE MEDI CAL EQUI P-SOLD	0. 000000	0		0	0	0	
	09850 OTHER REIMBURSABLE COST CENTERS	0. 000000	0		0	0	0	
200.00	Total (lines 50 through 199)		0	1	0	0	0	200.00

Health Financial Systems

FRANCI SCAN	HEALTH	MI	CHI GA	N	CITY	
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In Lieu of Form CMS-2552-10

	Financial Systems FRANCISCAN HEALTH M	ICHIGAN CITY	In Lie	u of Form CMS-2	2552-1
	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0015	Peri od:	Worksheet D-1	
			From 01/01/2021 To 12/31/2021	Date/Time Pre	pared
				5/26/2022 11:	
	Control Description	Title XVIII	Hospi tal	PPS	
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	INPATIENT DAYS				1
1.00	Inpatient days (including private room days and swing-bed days			26, 966	
2.00	Inpatient days (including private room days, excluding swing-			26, 966	
3.00	Private room days (excluding swing-bed and observation bed day	ys). If you have only pr	rivate room days,	0	3.0
4.00	do not complete this line. Semi-private room days (excluding swing-bed and observation be	(ave)		23, 280	4.0
5.00	Total swing-bed SNF type inpatient days (including private roo		er 31 of the cost	23, 200	
	reporting period			Ū	
5.00	Total swing-bed SNF type inpatient days (including private roo	om days) after December	31 of the cost	0	6. C
	reporting period (if calendar year, enter 0 on this line)				
7.00	Total swing-bed NF type inpatient days (including private room	m days) through December	- 31 of the cost	0	7.0
3. 00	reporting period	m davc) after December (1 of the cost	0	8.0
5.00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	in days) at ter becember 3	SI UI LINE CUST	0	0.0
9.00	Total inpatient days including private room days applicable to	o the Program (excluding	swing-bed and	9, 303	9.0
	newborn days) (see instructions)		, j - j		
10.00	Swing-bed SNF type inpatient days applicable to title XVIII on		room days)	0	10.0
	through December 31 of the cost reporting period (see instruction				
11.00	Swing-bed SNF type inpatient days applicable to title XVIII on December 31 of the cost reporting period (if calendar year, en		room days) after	0	11.0
12.00	Swing-bed NF type inpatient days applicable to titles V or XI		te room days)	0	12.0
12.00	through December 31 of the cost reporting period	chier daring privat	te room days)	0	12.0
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX	X only (including privat	te room days)	0	13. C
	after December 31 of the cost reporting period (if calendar ye				
	Medically necessary private room days applicable to the Progra	am (excluding swing-bed	days)	0	
	Total nursery days (title V or XIX only)			0	
16.00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0	16.0
17.00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 d	of the cost	0.00	17.0
	reporting period			0.00	
18.00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0.00	18.0
	reporting period				
19.00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	f the cost	0.00	19.0
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	s after December 31 of 1	the cost	0.00	20.0
20.00	reporting period			0.00	20.0
21.00	Total general inpatient routine service cost (see instructions	s)		39, 591, 792	21.0
22.00	Swing-bed cost applicable to SNF type services through December	er 31 of the cost report	ting period (line	0	22.0
	5 x line 17)			_	
23.00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reportin	ng period (line 6	0	23.0
24.00	Swing-bed cost applicable to NF type services through December	r 31 of the cost reporti	na period (line	0	24.0
24.00	7 x line 19)		ng period (rine	0	24.0
25.00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	g period (line 8	0	25.0
	x line 20)				
	Total swing-bed cost (see instructions)			0	
27.00	General inpatient routine service cost net of swing-bed cost	(The 21 minus Tine 26)		39, 591, 792	27.0
28.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed	d and observation bed ch	arges)	0	28.0
	Private room charges (excluding swing-bed charges)		lai ges)	0	
30.00	Semi-private room charges (excluding swing-bed charges)			0	
31.00	General inpatient routine service cost/charge ratio (line 27 -	÷line 28)		0. 000000	31.0
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	
3.00	Average semi-private room per diem charge (line 30 ÷ line 4)	nuo lino 22) (' '	+:	0.00	
34.00 35.00	Average per diem private room charge differential (line 32 min Average per diem private room cost differential (line 34 x lin	, ,		0.00	
35.00 36.00	Private room cost differential adjustment (line 3 x line 35)			0.00	35.0
37.00	General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	39, 591, 792	
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				1
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU				
	Adjusted general inpatient routine service cost per diem (see			1, 468. 21	
	Program general inpatient routine service cost (line 9 x line			13, 658, 758	
	Medically necessary private room cost applicable to the Progra	am (TITHE 14 X TITHE 35)		0	40.0
	Total Program general inpatient routine service cost (line 39	+ line 40)		13, 658, 758	41 0

	ATION OF INPATIENT OPERATING COST		Provider C	CN: 15-0015	Period: From 01/01/2021	Worksheet D-	1
					To 12/31/2021	Date/Time Pre	
			Title	e XVIII	Hospi tal	5/26/2022 11: PPS	: 23 8
	Cost Center Description	Total Inpatient Costl	Total	Average Per Diem (col. 1	Program Days	Program Cost (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) 42
	Intensive Care Type Inpatient Hospital Units						
00	INTENSIVE CARE UNIT	8, 617, 191	4, 512				
00 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT	0	0				
	SURGI CAL I NTENSI VE CARE UNI T	0	0				2 46
	OTHER SPECIAL CARE (SPECIFY)		-				47
	Cost Center Description					1.00	_
00	Program inpatient ancillary service cost (Wk	st. D-3. col. 3.	line 200)			1.00 14,561,264	4 48
00	Total Program inpatient costs (sum of lines			ons)		30, 187, 157	
	PASS THROUGH COST ADJUSTMENTS	<u> </u>					
00	Pass through costs applicable to Program inp	atient routine s	ervices (from	n Wkst. D, sun	n of Parts I and	2, 726, 183	3 50
00	<pre>III) Pass through costs applicable to Program inpa</pre>	atient ancillary	services (fr	om Wkst D s	um of Parts II	2, 147, 93	1 51
20	and IV)						
00	Total Program excludable cost (sum of lines	,				4, 874, 114	
00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line 4		ated, non-phy	/si ci an anesth	netist, and	25, 313, 043	3 53
	TARGET AMOUNT AND LIMIT COMPUTATION	52)				1	
	Program di scharges						54
00	Target amount per discharge					0.00	
00 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operat	ing cost and tar	act amount (1	ino E4 minuc	Lino E2)		
00	Bonus payment (see instructions)	ing cost and tai	get anount (i	The so minus	TTHE 53)		
00	Lesser of lines 53/54 or 55 from the cost re	porting period e	nding 1996, u	updated and co	mpounded by the		
	market basket		0		. ,		
00 00	Lesser of lines 53/54 or 55 from prior year of line 53/54 is less than the lower of line				the amount by	0.00	
. 00	which operating costs (line 53) are less than						
	amount (line 56), otherwise enter zero (see				the target		
52.00 Relief payment (see instructions)) 62	
. 00	Allowable Inpatient cost plus incentive payme PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instruc	tions)			(0 63
00	Medicare swing-bed SNF inpatient routine cos	ts through Decem	ber 31 of the	e cost reporti	ng period (See		5 64
	instructions)(title XVIII only)	0			0.1		
. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decembe	r 31 of the c	cost reporting) period (See	0) 65
. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routin	ne costs (line 6	4 plus line 6	5)(title XVII	lonly) For		0 66
	CAH (see instructions)				· · · · · · · · · · · · · · · · · · ·		
. 00	Title V or XIX swing-bed NF inpatient routine	e costs through	December 31 c	of the cost re	porting period	0) 67
. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routing	e costs after De	cember 31 of	the cost rend	orting period		68 (
. 00	(line 13 x line 20)			the cost repe	n tring period		
. 00	Total title V or XIX swing-bed NF inpatient			,		() 69
00	PART III - SKILLED NURSING FACILITY, OTHER NU					1	
. 00 . 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service of						70
	Program routine service cost (line 9 x line			_)			72
00 Medically necessary private room cost applicable to Program (line 14 x line 35)					73		
00	Total Program general inpatient routine serv	•			ant II'		74
. 00	Capital-related cost allocated to inpatient 26, line 45)	ioutine service	COSTS (TROM W	WORKSNEET B, H	art II, Column		75
. 00	Per diem capital-related costs (line 75 ÷ li	ne 2)					76
.00 Program capital-related costs (line 9 x line 76)					77		
	Inpatient routine service cost (line 74 minu:	,		1->			78
00 00	Aggregate charges to beneficiaries for excess Total Program routine service costs for compa			· ·	us line 70)		80
00	Inpatient routine service cost per diem limi		st rimitati U		143 IIIC / 7)		81
00	Inpatient routine service cost limitation (I						82
00	Reasonable inpatient routine service costs ()				83
00	Program inpatient ancillary services (see in:						84
	Utilization review - physician compensation Total Program inpatient operating costs (sum						85
. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS					1	
. 00	Total observation bed days (see instructions					3, 686	5 87
. 00	Adjusted general inpatient routine cost per		line 2)			1, 468. 21	
	Observation bed cost (line 87 x line 88) (see	- 1				5, 411, 822	

Health Financial Systems FF	RANCI SCAN HEALTH	H MICHIGAN CITY	,	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 Pre 5/26/2022 11:	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	6, 943, 605	39, 591, 792	0. 17538	0 5, 411, 822	949, 125	90.00
91.00 Nursing Program cost	0	39, 591, 792	0.00000	0 5, 411, 822	0	91.00
92.00 Allied health cost	0	39, 591, 792	0.00000	0 5, 411, 822	0	92.00
93.00 All other Medical Education	0	39, 591, 792	0. 00000			93.00

JMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0015 Component CCN: 15-S015	Period: From 01/01/2021 To 12/31/2021	Worksheet D-1 Date/Time Pre 5/26/2022 11:	pare		
		Title XVIII	Subprovider - IPF	PPS			
	Cost Center Description			1.00			
	PART I - ALL PROVIDER COMPONENTS				-		
	INPATIENT DAYS Inpatient days (including private room days and swing-bed day	vs excluding newborn)		3, 466	1 1		
00	Inpatient days (including private room days, excluding swing-			3, 466			
00	Private room days (excluding swing-bed and observation bed da do not complete this line.	5, 5, 5, 5,	ivate room days,	0 3, 466	3		
00 00	Semi-private room days (excluding swing-bed and observation bed days) Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period						
00	Total swing-bed SNF type inpatient days (including private ro reporting period (if calendar year, enter 0 on this line)	oom days) after December	31 of the cost	0	6		
00	Total swing-bed NF type inpatient days (including private roc reporting period			0			
00	Total swing-bed NF type inpatient days (including private roc reporting period (if calendar year, enter 0 on this line)	om days) after December 3	1 of the cost	0	8		
00	Total inpatient days including private room days applicable t newborn days) (see instructions)	to the Program (excluding	swing-bed and	499	9		
. 00	Swing-bed SNF type inpatient days applicable to title XVIII of through December 31 of the cost reporting period (see instruction)	ctions)	3 /	0			
	Swing-bed SNF type inpatient days applicable to title XVIII of December 31 of the cost reporting period (if calendar year, e Swing-bed NF type inpatient days applicable to titles V or XI	enter 0 on this line)	•	0			
	Swing-bed NF type inpatient days applicable to titles V or XI	3 . 0 .	3 /	0			
	after December 31 of the cost reporting period (if calendar) Medically necessary private room days applicable to the Progr			0			
	Total nursery days (title V or XIX only) Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0 0	15 16		
. 00	Medicare rate for swing-bed SNF services applicable to servic reporting period	ces through December 31 c	f the cost	0.00	17		
. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	ces after December 31 of	the cost	0.00	18		
	Medicaid rate for swing-bed NF services applicable to service reporting period	C C		0.00			
	Medicaid rate for swing-bed NF services applicable to service reporting period Total general inpatient routine service cost (see instruction		he cost	0. 00 5, 196, 898			
	Swing-bed cost applicable to SNF type services through Decemb 5×1 ine 17)	·	ing period (line	3, 190, 898 0			
. 00	Swing-bed cost applicable to SNF type services after December x line 18)	r 31 of the cost reportin	g period (line 6	0			
	Swing-bed cost applicable to NF type services through December 7 x line 19)			0			
. 00	Swing-bed cost applicable to NF type services after December x line 20) Total swing-bed cost (see instructions)	31 OF THE COST REPORTING	period (line 8	0	25		
	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)		5, 196, 898			
	General inpatient routine service charges (excluding swing-be	ed and observation bed ch	arges)	0			
	Private room charges (excluding swing-bed charges)			0			
	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0 0. 000000	30		
	Average private room per diem charge (line 29 ÷ line 3)	20)		0.000000			
	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00			
	Average per diem private room charge differential (line 32 mi		tions)	0.00			
	Average per diem private room cost differential (line 34 x li	ine 31)		0.00			
	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost 27 minus line 36)	and private room cost di	fferential (line	0 5, 196, 898			
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	JUSTMENTS					
	Adjusted general inpatient routine service cost per diem (see			1, 499. 39	38		
. 00	···· J · · · · J · · · · · · · · ·						
0. 00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Progr			748, 196 0			

OMPUT	Financial Systems FR. ATION OF INPATIENT OPERATING COST		MICHIGAN CIT Provider C	CN: 15-0015	Peri od:	eu of Form CMS- Worksheet D-1	
			Component	CCN: 15-S015	From 01/01/2021 To 12/31/2021		
			Title	e XVIII	Subprovider -	5/26/2022 11: PPS	<u>23 ar</u>
	Cost Center Description	Total	Total	Average Per	IPF Program Days	Program Cost	
		Inpatient Costl		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 C) 42.
	Intensive Care Type Inpatient Hospital Units			1		1	
3.00	INTENSIVE CARE UNIT	0	(
4.00 5.00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT	0	(00 0 00 0	-	
b. 00	SURGICAL INTENSIVE CARE UNIT	0	(
	OTHER SPECIAL CARE (SPECIFY)						47.
	Cost Center Description					1.00	-
	Program inpatient ancillary service cost (Wks					56, 350	
. 00	Total Program inpatient costs (sum of lines 4 PASS THROUGH COST ADJUSTMENTS	1 through 48)(see instructio	ons)		804, 546	5 49
. 00	Pass through costs applicable to Program inpa	atient routine :	services (from	n Wkst. D, su	m of Parts I and	176, 192	2 50
. 00	<pre>III) Pass through costs applicable to Program inpa</pre>	atient ancillar	y services (fi	rom Wkst. D,	sum of Parts II	6, 020	51
	and IV)						
2.00 3.00	Total Program excludable cost (sum of lines 5 Total Program inpatient operating cost exclud		ated non-ph	vsician anest	hetist and	182, 212	
. 00	medical education costs (line 49 minus line 5					022, 334	
. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					l c	54
	Target amount per discharge					0.00	
. 00	Target amount (line 54 x line 55)					C	56
. 00	Difference between adjusted inpatient operati	ng cost and ta	rget amount (I	ine 56 minus	line 53)	C	
. 00	Bonus payment (see instructions)					0.00	
. 00	Lesser of lines 53/54 or 55 from the cost rep market basket	orting period (ending 1996, i	updated and c	ompounded by the	0.00) 59
0. 00	Lesser of lines 53/54 or 55 from prior year of	cost report, up	dated by the r	market basket		0.00	60
. 00	If line 53/54 is less than the lower of lines					c c	61
	which operating costs (line 53) are less than		s (lines 54 x	60), or 1% o	f the target		
	amount (line 56), otherwise enter zero (see i	nstructions)					
2.00 3.00	Relief payment (see instructions) Allowable Inpatient cost plus incentive payme	nt (see instru	ctions)				
. 00	PROGRAM INPATIENT ROUTINE SWING BED COST						
. 00	Medicare swing-bed SNF inpatient routine cost instructions)(title XVIII only)	s through Dece	mber 31 of the	e cost report	ing period (See	C	64
5.00	Medicare swing-bed SNF inpatient routine cost	s after Decemb	er 31 of the d	cost reportin	g period (See	c	65
00	instructions) (title XVIII only)	a aasta (lina					
5.00	Total Medicare swing-bed SNF inpatient routir CAH (see instructions)	ie costs (Tine)	54 plus line d	55)(title XVI	TI ONLY). FOR	C	66
7.00	Title V or XIX swing-bed NF inpatient routine	e costs through	December 31 d	of the cost r	eporting period	C	67
3. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routine	e costs after De	ecember 31 of	the cost rep	ortina period		68
	(line 13 x line 20)						
9.00	Total title V or XIX swing-bed NF inpatient r PART III - SKILLED NURSING FACILITY, OTHER NU					C) 69
0. 00	Skilled nursing facility/other nursing facili)		70
. 00	Adjusted general inpatient routine service co		ne 70 ÷ line	2)			71
. 00	Program routine service cost (line 9 x line 7	,	(1. 44 1.	25)			72
8.00 .00	Medically necessary private room cost applica Total Program general inpatient routine servi						73
5. 00	Capital-related cost allocated to inpatient r	•			Part II, column		75
. 00	26, line 45) Per diem capital-related costs (line 75 ÷ lin	ne 2)					76
. 00	Program capital-related costs (line 9 x line	76)					77
	Inpatient routine service cost (line 74 minus			-1 - 2			78
. 00 . 00	Aggregate charges to beneficiaries for excess Total Program routine service costs for compa				nus lino 70)		79 80
. 00	Inpatient routine service costs for compa				nus i i ne 79)		80
	Inpatient routine service cost per drem rimit)				82
3.00	Reasonable inpatient routine service costs (s						83
1.00	Program inpatient ancillary services (see ins						84
. 00	Utilization review - physician compensation (85
. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		ougn 85)				86
7.00	Total observation bed days (see instructions)					C	87
	Adjusted general inpatient routine cost per o		line 2)			0.00	
00	Observation bed cost (line 87 x line 88) (see	instructions)					89 (

Health Financial Systems FF	RANCISCAN HEALTH	H MICHIGAN CITY	,	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 5/26/2022 11:2	
		Title	XVIII	Subprovider - IPF	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	1, 223, 794	5, 196, 898	0. 23548	5 0	0	90.00
91.00 Nursing Program cost	0	5, 196, 898	0.00000	0 0	0	91.00
92.00 Allied health cost	0	5, 196, 898	0.00000	0 0	0	92.00
93.00 All other Medical Education	0	5, 196, 898	0.00000	0 0	0	93.00

IPATI E	NT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0015	Period: From 01/01/2021	Worksheet D-3	
				To 12/31/2021	Date/Time Pre 5/26/2022 11:	
		Titl€	e XVIII	Hospi tal	PPS	
	Cost Center Description		Ratio of Cos To Charges	t Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	-
I	NPATIENT ROUTINE SERVICE COST CENTERS					
	D3000 ADULTS & PEDI ATRI CS			23, 786, 691		30
	D3100 I NTENSI VE CARE UNI T			4, 065, 006		3
	D3200 CORONARY CARE UNI T D3300 BURN INTENSIVE CARE UNI T			0		3
	D3400 SURGI CAL I NTENSI VE CARE UNI T			0		3
	D4000 SUBPROVIDER - IPF			0		4
. 00 0	04100 SUBPROVI DER – I RF			0		4
	D4300 NURSERY					4
	ANCI LLARY SERVICE COST CENTERS		0 1520	10 252 042	1 000 500	1 6.
	D5100 RECOVERY ROOM		0. 15287		1, 888, 509 0	
	D5200 DELIVERY ROOM & LABOR ROOM		0. 78873		5, 376	
. 00 0	D5300 ANESTHESI OLOGY		0. 02325	51 1, 213, 154	28, 207	5
	D5400 RADI OLOGY-DI AGNOSTI C		0. 08896		1, 313, 996	
	D5401 FSED RADI OLOGY - DI AGNOSTI C		0.09991		0	
	D5500 RADIOLOGY-THERAPEUTIC D5501 WOODLAND CANCER CARE CTR		0. 12812		21, 788 0	
	D5600 RADI OI SOTOPE		0. 00000		0	
	D5700 CT SCAN		0.00000		0	
	D5800 MRI		0.00000	0 00	0	5
	D5900 CARDI AC CATHETERI ZATI ON		0. 11789		429, 028	
	D6000 LABORATORY		0. 11088		1, 838, 024	
	06001 FS ED LAB 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0. 12742		0	
	D6200 WHOLE BLOOD & PACKED RED BLOOD CELL		0.00000		0	
	D6300 BLOOD STORING, PROCESSING & TRANS.		0. 04022		0	6
	D6301 FS ED BLOOD BANK		0.00190		0	
	06400 I NTRAVENOUS THERAPY		0.00000		0	
	D6500 RESPI RATORY THERAPY D6600 PHYSI CAL THERAPY		0. 13032		554, 568 534, 065	
	D6700 OCCUPATI ONAL THERAPY		0. 00000		0 0 0 0	
	D6800 SPEECH PATHOLOGY		0. 00000		0	
	D6900 ELECTROCARDI OLOGY		0. 1027		1, 054, 329	6
			0.00000		0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 18600		821, 585 2, 420, 977	
	D7300 DRUGS CHARGED TO PATIENTS		0. 20649		2, 212, 915	
	D7400 RENAL DIALYSIS		0.00000		0	
	D7500 ASC (NON-DISTINCT PART)		0.00000	0 00	0	7
			0.00000			
	D7700 ALLOGENEIC STEM CELL ACQUISITION DUTPATIENT SERVICE COST CENTERS		0.00000	00 0	0	7
	DIRATIENT SERVICE COST CENTERS		0.0000	00	0	8
	08900 FEDERALLY QUALIFIED HEALTH CENTER		0. 00000		0	
. 00 0	09000 CLINIC		0.00000		0	1 .
	D9003 I NFUSI ON OP SERVI CES		0.35718		0	
	D9100 EMERGENCY D9101 FREE STANDING EMERGENCY DEPT		0. 11786		1, 437, 897 0	
	D9200 OBSERVATION BEDS (NON-DISTINCT PART		0. 58914		0	
	THER REIMBURSABLE COST CENTERS		0.0071	0	0	1 ^
-	09400 HOME PROGRAM DI ALYSI S		0.0000	0 00	0	9
	09500 AMBULANCE SERVI CES					9
	09600 DURABLE MEDICAL EQUIP-RENTED		0.00000		0	
	09700 DURABLE MEDICAL EQUIP-SOLD		0.0000		0	
0.00	09850 OTHER REIMBURSABLE COST CENTERS Total (sum of lines 50 through 94 and 96 through 98)		0.00000	97, 807, 705	0 14, 561, 264	
1.00	Less PBP Clinic Laboratory Services-Program only charges	(line 61)		0	11, 301, 204	20
2.00	Net charges (line 200 minus line 201)		1	97, 807, 705		20

ealth Financial Systems FRANC NPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0015	Peri od:	Worksheet D-3	
	Component	CCN: 15-S015	From 01/01/2021 To 12/31/2021	Date/Time Pre 5/26/2022 11:	
	Ti tl e	e XVIII	Subprovider -	PPS	
Cost Center Description		Ratio of Cos To Charges	Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
UNDATIONT DOUTINE CEDVICE COST CENTERS		1.00	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS					30
1. 00 03100 INTENSIVE CARE UNIT					31
22. 00 03200 CORONARY CARE UNIT					32
3. 00 03300 BURN INTENSIVE CARE UNIT					33
44.00 03400 SURGICAL INTENSIVE CARE UNIT					34
0. 00 04000 SUBPROVIDER - IPF			902, 529		40
1. 00 04100 SUBPROVI DER – I RF			,02,02,		41
3. 00 04300 NURSERY					43
ANCI LLARY SERVI CE COST CENTERS					1
0. 00 05000 OPERATI NG ROOM		0. 1528	78 0	0	1 50
1.00 05100 RECOVERY ROOM		0.0000	00 00	0	51
2.00 05200 DELIVERY ROOM & LABOR ROOM		0. 7887		0	52
3. 00 05300 ANESTHESI OLOGY		0. 0232		0	5
4. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 0889	65 17, 787	1, 582	54
4. 01 05401 FSED RADIOLOGY - DIAGNOSTIC		0. 0999		0	54
5. 00 05500 RADI OLOGY-THERAPEUTI C		0. 1281	22 16, 694	2, 139	5!
5.01 05501 WOODLAND CANCER CARE CTR		0. 2129	09 0	0	55
6. 00 05600 RADI 0I SOTOPE		0.0000	00 0	0	56
7.00 05700 CT SCAN		0.0000	00 0	0	5
8. 00 05800 MRI		0.0000	00 0	0	58
9. 00 05900 CARDI AC CATHETERI ZATI ON		0. 1178		0	59
0. 00 06000 LABORATORY		0. 1108		17, 822	
0. 01 06001 FS ED LAB		0. 1274		0	60
1.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0.0000		0	6
2.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0.0000		0	62
3. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0.0402		0	63
3. 01 06301 FS ED BLOOD BANK		0.0019		0	63
4. 00 06400 I NTRAVENOUS THERAPY		0.0000		0	64
5. 00 06500 RESPIRATORY THERAPY		0. 1303		698	
6. 00 06600 PHYSI CAL THERAPY 7. 00 06700 0CCUPATI ONAL THERAPY		0. 2127		444 0	6
8. 00 06800 SPEECH PATHOLOGY				0	68
9. 00 06900 ELECTROCARDI OLOGY		0. 0000		1, 217	6
0. 00 07000 ELECTROCARDI OLOGY		0.1027		1,217	70
1. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 1860		1, 139	
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 5128		0	7
3. 00 07200 TMPL: DEV. CHARGED TO PATIENTS		0. 2064		16, 799	
4. 00 07400 RENAL DIALYSIS		0.0000		0,799	7
5. 00 07500 ASC (NON-DISTINCT PART)		0.0000		0	
76. 00 03020 CLINIC		0.0000		0	7
7.00 07700 ALLOGENEIC STEM CELL ACQUISITION		0.0000		0	
OUTPATIENT SERVICE COST CENTERS		0.0000	001		+ '

70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 186001	6, 123	1, 139	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 512843	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 206490	81, 357	16, 799	73.00
74.00	07400 RENAL DI ALYSI S	0.00000	0	0	74.00
75.00	07500 ASC (NON-DI STI NCT PART)	0.00000	0	0	75.00
76.00	03020 CLI NI C	0.000000	0	0	76.00
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION	0.000000	0	0	77.00
	OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000		0	89.00
90.00	09000 CLI NI C	0. 000000	0	0	90.00
90.03		0. 357184	0	0	90.03
91.00	09100 EMERGENCY	0. 117863	123, 105	14, 510	91.00
91.01	09101 FREE STANDING EMERGENCY DEPT	0. 311968	0	0	91.01
92.00		0. 589142	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS	.			
94.00	09400 HOME PROGRAM DI ALYSI S	0.000000	0	0	94.00
95.00					95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	96.00
97.00	09700 DURABLE MEDI CAL EQUI P-SOLD	0.000000	0	0	97.00
98.00		0.000000	0	0	98.00
200.0			425, 078	56, 350	
201.0			0		201.00
202.0	D Net charges (line 200 minus line 201)		425, 078		202.00

	Financial Systems FRANCISCAN HEALTH N NT ANCILLARY SERVICE COST APPORTIONMENT	Provider C		Period: From 01/01/2021	Worksheet D-3	3
				To 12/31/2021	Date/Time Pre 5/26/2022 11:	
		Titl	e XIX	Hospi tal	Cost	20
	Cost Center Description	·	Ratio of Cos		I npati ent	
			To Charges	Program Charges	Program Costs (col. 1 x col.	
					2)	
ī	NPATI ENT ROUTI NE SERVI CE COST CENTERS		1.00	2.00	3.00	
	D3000 ADULTS & PEDIATRICS			15, 159, 005		30
	D3100 I NTENSI VE CARE UNI T			3, 873, 107		3
	D3200 CORONARY CARE UNIT			0		32
	D3300 BURN INTENSIVE CARE UNIT			0		3
	03400 SURGI CAL I NTENSI VE CARE UNI T 04000 SUBPROVI DER – I PF			3, 238, 398		3
	D4100 SUBPROVIDER - IRF			0		4
	D4300 NURSERY			659, 486		4
	ANCI LLARY SERVI CE COST CENTERS		0.0000			
	D5000 OPERATING ROOM D5100 RECOVERY ROOM		0.00000			
	D5200 DELIVERY ROOM & LABOR ROOM		0.00000		0	
	D5300 ANESTHESI OLOGY		0. 00000		0	
00 0	D5400 RADI OLOGY-DI AGNOSTI C		0.0000	6, 762, 620	0	5
	D5401 FSED RADIOLOGY - DIAGNOSTIC		0.0000			
	05500 RADI OLOGY-THERAPEUTI C		0.0000			
	D5501 WOODLAND CANCER CARE CTR D5600 RADI OI SOTOPE		0.00000			
	55000 RADIOTSOTOPE 55700 CT SCAN		0.00000		0	
	D5800 MRI		0.00000		0	
	D5900 CARDI AC CATHETERI ZATI ON		0.00000		0	
	D6000 LABORATORY		0.00000	9, 743, 184	0	6
	D6001 FS ED LAB		0.0000			
			0.0000		0	-
	D6200 WHOLE BLOOD & PACKED RED BLOOD CELL D6300 BLOOD STORING, PROCESSING & TRANS.		0.00000			
	D6301 FS ED BLOOD BANK		0.00000			
	D6400 I NTRAVENOUS THERAPY		0. 00000		0	6
	D6500 RESPI RATORY THERAPY		0.0000		0	
	D6600 PHYSI CAL THERAPY		0.0000		0	
	D6700 OCCUPATI ONAL THERAPY D6800 SPEECH PATHOLOGY		0.00000		0	-
	D6900 ELECTROCARDI OLOGY		0.00000			
	D7000 ELECTROENCEPHALOGRAPHY		0.00000		0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 00000		0	7
	D7200 IMPL. DEV. CHARGED TO PATIENTS		0.0000			
	07300 DRUGS CHARGED TO PATIENTS		0.0000			
	D7400 RENAL_DIALYSIS D7500 ASC_(NON-DISTINCT_PART)		0.00000			
	03020 CLINIC		0.00000			
	D7700 ALLOGENEIC STEM CELL ACQUISITION		0. 00000			
	DUTPATIENT SERVICE COST CENTERS		1		1	
	28800 RURAL HEALTH CLINIC		0.0000			
	08900 FEDERALLY QUALI FI ED HEALTH CENTER 09000 CLI NI C		0.00000			
	D9000 LINIC		0.00000		-	
	D9100 EMERGENCY		0.00000			
01 0	D9101 FREE STANDING EMERGENCY DEPT		0.0000			9
00 0	09200 OBSERVATION BEDS (NON-DISTINCT PART		0.00000	00 00	0	9
	DTHER REIMBURSABLE COST CENTERS		0.0000	00 0	0	9
	D9500 AMBULANCE SERVICES		0.0000	0		9
	D9600 DURABLE MEDI CAL EQUI P-RENTED		0. 00000	0 0	0	
00 0	D9700 DURABLE MEDI CAL EQUI P-SOLD		0.0000			9
	09850 OTHER REIMBURSABLE COST CENTERS		0.0000		0	
0.00 1.00	Total (sum of lines 50 through 94 and 96 through 98)			52, 898, 488	0	20
	Less PBP Clinic Laboratory Services-Program only charges	; (LINA 61)	1	0	1	20

CALCUL	Financial Systems FRANCISCAN HEALTH N ATION OF REIMBURSEMENT SETTLEMENT	ILCHIGAN CITY Provider CCN: 15-0015	Peri od: From 01/01/2021 To 12/31/2021	u of Form CMS-2 Worksheet E Part A Date/Time Pre 5/26/2022 11:	pared:
		Title XVIII	Hospi tal	PPS	1
				1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS			1.00	
1. 00 1. 01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurr	ing prior to October 1 ((see	0 17, 632, 004	1.00 1.01
1. 02	instructions) DRG amounts other than outlier payments for discharges occurr	ing on or after October	1 (see	5, 948, 946	1. 02
1.03	instructions) DRG for federal specific operating payment for Model 4 BPCI f 1 (see instructions)	or discharges occurring	prior to October	0	1.03
1. 04	DRG for federal specific operating payment for Model 4 BPCI f October 1 (see instructions)	or discharges occurring	on or after	0	1.04
2.00	Outlier payments for discharges. (see instructions)				2.00
2.01	Outlier reconciliation amount	iana)		0	2.01
2.02 2.03	Outlier payment for discharges for Model 4 BPCI (see instruct Outlier payments for discharges occurring prior to October 1	-		336, 131	2.02
2.03	Outlier payments for discharges occurring on or after October			237, 060	•
3.00	Managed Care Simulated Payments			207,000	
4.00	Bed days available divided by number of days in the cost repo Indirect Medical Education Adjustment	rting period (see instru	uctions)	88.90	
5.00	FTE count for allopathic and osteopathic programs for the mos or before 12/31/1996. (see instructions)			0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet t new programs in accordance with 42 CFR 413.79(e)			0.00	
7.00 7.01	MMA Section 422 reduction amount to the IME cap as specified ACA § 5503 reduction amount to the IME cap as specified under cost report straddles July 1, 2011 then see instructions.			0.00 0.00	
8.00	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	8.00
8. 01	The amount of increase if the hospital was awarded FTE cap sl report straddles July 1, 2011, see instructions.	ots under § 5503 of the	ACA. If the cost	0.00	8. 01
8.02	The amount of increase if the hospital was awarded FTE cap sl under \S 5506 of ACA. (see instructions)		o .	0.00	
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lin instructions)			0.00	
10.00 11.00	FTE count for allopathic and osteopathic programs in the curr FTE count for residents in dental and podiatric programs.	ent year from your recor	us	0.00 0.00	
12.00	Current year allowable FTE (see instructions)			0.00	
13.00	Total allowable FTE count for the prior year.			0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that ye otherwise enter zero.	ar ended on or after Sep	otember 30, 1997,	0.00	
15.00	Sum of lines 12 through 14 divided by 3.				15.00
	Adjustment for residents in initial years of the program				16.00
17.00 18.00	Adjustment for residents displaced by program or hospital clo Adjusted rolling average FTE count	sure		0.00	•
	Current year resident to bed ratio (line 18 divided by line 4)		0. 000000	
	Prior year resident to bed ratio (see instructions)	,		0.000000	
21.00	Enter the lesser of lines 19 or 20 (see instructions)			0.000000	21.00
22.00	IME payment adjustment (see instructions)			0	
22. 01	IME payment adjustment - Managed Care (see instructions) Indirect Medical Education Adjustment for the Add-on for § 42			0	1
23.00	Number of additional allopathic and osteopathic IME FTE resid $(f)(1)(iv)(C)$.	ent cap slots under 42 (JFR 412.105	0.00	
24. 00 25. 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	
26.00	Resident to bed ratio (divide line 25 by line 4)			0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)			0.000000	•
28.00	IME add-on adjustment amount (see instructions)			0	1
28. 01	IME add-on adjustment amount - Managed Care (see instructions)		0	
29. 00 29. 01	Total IME payment (sum of lines 22 and 28) Total IME payment - Managed Care (sum of lines 22.01 and 28.0 Dispropriate Share Adjustment	1)		0	
30.00	Disproportionate Share Adjustment Percentage of SSI recipient patient days to Medicare Part A p	atient days (see instru	tions)	4. 23	30.00
30.00	Percentage of Medicaid patient days (see instructions)	action days (see institut		4.23	1
32.00	Sum of lines 30 and 31				32.00
	Allowable disproportionate share percentage (see instructions)			33.00
~ . ~ ~	Disproportionate share adjustment (see instructions)			649, 656	134 00

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0015	Period: From 01/01/2021	Worksheet E Part A	
			To 12/31/2021	Date/Time Prep 5/26/2022 11:2	
		Title XVIII	Hospi tal	PPS	20 am
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
	Uncompensated Care Adjustment				
5.00	Total uncompensated care amount (see instructions)		8, 290, 014, 521		
5.01	Factor 3 (see instructions)		0. 000295331	0.000445324	35. C
5. 02	Hospital uncompensated care payment (If line 34 is zero, ent	ter zero on this line) (se	e 2, 448, 301	3, 202, 774	35. C
5. 03	instructions) Pro rata share of the hospital uncompensated care payment ar	mount (see instructions)	1, 831, 194	807, 275	35. C
6.00	Total uncompensated care (sum of columns 1 and 2 on line 35.	. ,	2, 638, 469		36. C
0.00	Additional payment for high percentage of ESRD beneficiary of				50.0
0. 00	Total Medicare discharges (see instructions)		0		40. C
1.00	Total ESRD Medicare discharges (see instructions)		0		41. C
1.01	Total ESRD Medicare covered and paid discharges (see instruc	ctions)	0		41. C
2.00	Divide line 41 by line 40 (if less than 10%, you do not qual		0.00		42.0
3.00	Total Medicare ESRD inpatient days (see instructions)	3	0		43.0
4.00	Ratio of average length of stay to one week (line 43 divided	d by line 41 divided by 7	0.000000		44.0
	days)				
5.00	Average weekly cost for dialysis treatments (see instruction		0.00		45. C
6.00	Total additional payment (line 45 times line 44 times line 4	41.01)	0		46.0
7.00	Subtotal (see instructions)		27, 442, 266		47.0
8.00	Hospital specific payments (to be completed by SCH and MDH, only. (see instructions)	small rural nospitals	0		48. C
				Amount	
				1.00	
9.00	Total payment for inpatient operating costs (see instruction	ns)		27, 442, 266	49.0
0. 00	Payment for inpatient program capital (from Wkst. L, Pt. I a	and Pt. II, as applicable)		1, 925, 391	50.0
1. 00	Exception payment for inpatient program capital (Wkst. L, Pt	t. III, see instructions)		0	51.0
2.00	Direct graduate medical education payment (from Wkst. E-4, I	line 49 see instructions).		0	52.0
3.00	Nursing and Allied Health Managed Care payment			0	53.0
4.00	Special add-on payments for new technologies			315, 913	
4.01	Islet isolation add-on payment	(0)		0	54.0
5.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line			0	55.0
6.00 7.00	Cost of physicians' services in a teaching hospital (see inf Routine service other pass through costs (from Wkst. D, Pt.		brough 2E)	0	56. (57. (
8.00	Ancillary service other pass through costs from Wkst. D, Pt.		ni ougir 55).	0	58.0
9.00	Total (sum of amounts on lines 49 through 58)	. 10, col. 11 1111c 200)		29, 683, 570	59.0
0.00	Primary payer payments			6, 395	
1.00	Total amount payable for program beneficiaries (line 59 minu	us line 60)		29, 677, 175	61. (
2.00	Deductibles billed to program beneficiaries	,		2, 554, 576	
3.00	Coinsurance billed to program beneficiaries			43, 036	63.
4.00	Allowable bad debts (see instructions)			269, 798	64. (
5.00	Adjusted reimbursable bad debts (see instructions)			175, 369	65. (
6. 00	Allowable bad debts for dual eligible beneficiaries (see ins	structions)		38, 215	66.
7.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			27, 254, 932	67.
8.00	Credits received from manufacturers for replaced devices for			0	68.
9.00	Outlier payments reconciliation (sum of lines 93, 95 and 96)).(For SCH see instruction	s)	0	
0.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	70.
0.50	Rural Community Hospital Demonstration Project (§410A Demons	, ,	instructions)	0	70.
	Demonstration payment adjustment amount before sequestration	n		0	70.
0. 87	3 1 3,	structions)		0	70.
0. 87 0. 88		STINCTIONS)		0	70.
0. 87 0. 88 0. 89	Pioneer ACO demonstration payment adjustment amount (see ins			0	70.
0.87 0.88 0.89 0.90	HSP bonus payment HVBP adjustment amount (see instructions)			0	70
0.87 0.88 0.89 0.90 0.91	HSP bonus payment HVBP adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions)			0	
0.87 0.88 0.89 0.90 0.91 0.92	HSP bonus payment HVBP adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions) Bundled Model 1 discount amount (see instructions)			0	70. 70. 70.
0.87 0.88 0.89 0.90 0.91	HSP bonus payment HVBP adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions)			-	70. 70.

	TION OF REIMBURSEMENT SETTLEMENT	Provi der CC	F	Period: rom 01/01/2021 o 12/31/2021	Worksheet E Part A Date/Time Prep 5/26/2022 11:2	
	· · · · · · · · · · · · · · · · · · ·	Title		Hospi tal (yyyy)	PPS Amount	
		-		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter	in column O		0	0	70.96
70. 97	the corresponding federal year for the period prior to 10/1) Low volume adjustment for federal fiscal year (yyyy) (Enter the corresponding federal year for the period ending on or a) in column O		0	0	70. 97
70. 98 70. 99 71. 00 71. 01	Low Volume Payment-3 HAC adjustment amount (see instructions) Amount due provider (line 67 minus lines 68 plus/minus lines Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration	s 69 & 70)			0 77, 005 26, 998, 523 0 0	70. 9 71. 0 71. 0
71.03 72.00	Sequestration adjustment-PARHM pass-throughs Interim payments				26, 689, 527	71.0 72.0
1	Interim payments-PARHM				_	72.0
	Tentative settlement (for contractor use only) Tentative settlement-PARHM (for contractor use only)				0	73.00 73.0
74.00	Balance due provider/program (line 71 minus lines 71.01, 71. 73)	02, 72, and			308, 996	
75.00	Balance due provider/program-PARHM (see instructions) Protested amounts (nonallowable cost report items) in accord CMS Pub. 15-2, chapter 1, §115.2	dance with			472, 464	74.0 [°] 75.00
90.00	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96) Operating outlier amount from Wkst. E, Pt. A, line 2, or sum plus 2.04 (see instructions)	n of 2.03			0	90.00
	Capital outlier from Wkst. L, Pt. I, line 2				0	91.0
	Operating outlier reconciliation adjustment amount (see inst	tructions)			0	92.0
1	Capital outlier reconciliation adjustment amount (see instru				0	
1	The rate used to calculate the time value of money (see inst				0.00	
	Time value of money for operating expenses (see instructions				0	95.0
96.00	Time value of money for capital related expenses (see instru	uctions)		Prior to 10/1	0 0n/After 10/1	96.0
				1.00	2.00	
ŀ	HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)			0	0]100. 0
	HVBP Adjustment for HSP Bonus Payment					
	HVBP adjustment factor (see instructions)			0.000000000	0.000000000	
	HVBP adjustment amount for HSP bonus payment (see instruction	ons)		0	0	102.0
		,				
	HRR Adjustment for HSP Bonus Payment	,		0,0000	0.0000	
103.00	HRR adjustment factor (see instructions)			0.0000		103. 0
103.00 104.00	HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructior	ns)	tment	0.0000		103. 0
103.00 104.00 <u>F</u> 200.00	HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demons Is this the first year of the current 5-year demonstration p Century Cures Act? Enter "Y" for yes or "N" for no.	ns) stration) Adjus			0	103. 0 104. 0
103.00 104.00 200.00	HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructior Rural Community Hospital Demonstration Project (§410A Demons Is this the first year of the current 5-year demonstration p Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement	ns) stration) Adjus period under th			0	103. 0 104. 0 200. 0
103.00 104.00 200.00 201.00	HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demons Is this the first year of the current 5-year demonstration p Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Ii	ns) stration) Adjus period under th			0	103. 0 104. 0 200. 0 201. 0
103.00 104.00 200.00 201.00 201.00	HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demons Is this the first year of the current 5-year demonstration p Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Ii Medicare discharges (see instructions)	ns) stration) Adjus period under th			0	103. 0 104. 0 200. 0 201. 0 202. 0
103.00 104.00 200.00 201.00 202.00 203.00	HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demons Is this the first year of the current 5-year demonstration p Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Ii	ns) stration) Adjus period under th ne 49)	ne 21st	0	0	103. 0 104. 0 200. 0 201. 0 202. 0
103.00 104.00 200.00 201.00 202.00 203.00 203.00 203.00 203.00	HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demons Is this the first year of the current 5-year demonstration p Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, li Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A i period) Medicare target amount	ns) stration) Adjus period under th ne 49)	ne 21st	0	0	103. 0 104. 0 200. 0 201. 0 202. 0 203. 0 203. 0
103.00 104.00 F 200.00 201.00 202.00 203.00 203.00 203.00 203.00 203.00 203.00 203.00 200	HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demons Is this the first year of the current 5-year demonstration p Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, li Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A i period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204)	ns) stration) Adjus beriod under th ne 49) n first year c	ne 21st	0	0	103. 0 104. 0 200. 0 201. 0 202. 0 203. 0 203. 0 204. 0 205. 0
03.00 04.00 100.00 101.00 102.00 103.00 103.00 105.00 105.00 106.00	HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demons Is this the first year of the current 5-year demonstration p Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, li Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A i Deeriod) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205	ns) stration) Adjus beriod under th ne 49) n first year c	ne 21st	0	0	103. 0 104. 0 200. 0 201. 0 202. 0 203. 0 203. 0
03.00 04.00 F 00.000	HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demons Is this the first year of the current 5-year demonstration p Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Ii Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A i beeriod) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205 Adjustment to Medicare Part A Inpatient Reimbursement	ns) stration) Adjus beriod under th ne 49) n first year o	ne 21st	0	0 tration	103. 0 104. 0 200. 0 201. 0 202. 0 203. 0 203. 0 205. 0 206. 0
03.00 04.00 00	HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demons Is this the first year of the current 5-year demonstration p Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Ii Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A i beriod) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205 Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see ins	ns) stration) Adjus period under th ne 49) n first year o 5) structions)	ne 21st	0	0 tration	103. 0 104. 0 200. 0 201. 0 202. 0 203. 0 203. 0 205. 0 206. 0 206. 0
103.00 104.00 200.00 201.00 202.00 203.00 203.00 205.00 206.00 206.00 206.00 206.00 206.00 208.00	HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demons Is this the first year of the current 5-year demonstration p Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Ii Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A i period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205 Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see ins Medicare Part A inpatient service costs (from Wkst. E, Pt. 4	ns) stration) Adjus period under th ne 49) n first year o 5) structions)	ne 21st	0	0 trati on	103. 0 104. 0 200. 0 201. 0 202. 0 203. 0 205. 0 206. 0 206. 0 207. 0 208. 0
103.00 104.00 200.00 201.00 202.00 203.00 203.00 205.00 205.00 205.00 206.00 205.00 206.00 207.00 208.00 209.00 209.00 209.00 209.00 209.00 200.00	HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demons Is this the first year of the current 5-year demonstration p Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Ii Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A i period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205 Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see ins Medicare Part A inpatient service costs (from Wkst. E, Pt. Adjustment to Medicare IPPS payments (see instructions)	ns) stration) Adjus period under th ne 49) n first year o 5) structions)	ne 21st	0	0 trati on	103. 0 104. 0 200. 0 201. 0 202. 0 203. 0 205. 0 206. 0 206. 0 207. 0 208. 0 209. 0
103.00 104.00 200.00 201.00 202.00 203.00 203.00 203.00 205.00 205.00 206.00 205.00 206.00 206.00 206.00 200.00	HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demons Is this the first year of the current 5-year demonstration p Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, li Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A i period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205 Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see ins Medicare Part A inpatient service costs (from Wkst. E, Pt. A Adjustment to Medicare IPPS payments (see instructions) Reserved for future use	ns) stration) Adjus period under th ne 49) n first year c 5) structions) A, line 59)	ne 21st	0	0 tration	103. C 104. C 200. C 201. C 202. C 203. C 203. C 205. C 206. C 207. C 208. C 208. C 209. C 209. C
103.00 104.00 200.00 201.00 202.00 203.00 203.00 205.00 205.00 206.00 207.00 208.00 209.00 209.00 210.00	HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demons Is this the first year of the current 5-year demonstration p Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Ii Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A i beriod) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 204) Medicare part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A Adjustment to Medicare IPPS payments (see instructions)	ns) stration) Adjus period under th ne 49) n first year c 5) structions) A, line 59)	ne 21st	0	0 tration	103. 0 104. 0 200. 0 201. 0 202. 0 203. 0 203. 0 205. 0 206. 0 207. 0 208. 0 209. 0 209. 0 210. 0
103.00 104.00 200.00 201.00 202.00 203.00 203.00 205.00 205.00 206.00 207.00 208.00 209.00 209.00 211.00 211.00	HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demons Is this the first year of the current 5-year demonstration p Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Ii Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A i beriod) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 204) Medicare part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see ins Medicare Part A inpatient service costs (from Wkst. E, Pt. A Adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement	ns) stration) Adjus period under th ne 49) n first year c 5) structions) A, line 59) s)	ne 21st	0	tration	103. 0 104. 0 200. 0 201. 0 202. 0 203. 0 205. 0 206. 0 207. 0 207. 0 209. 0 209. 0 209. 0 210. 0
103.00 104.00 200.00 201.00 202.00 203.00 203.00 203.00 205.00 205.00 206.00 207.00 208.00 209.00 201.00 211.00 211.00	HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demons Is this the first year of the current 5-year demonstration p Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Ii Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A i beeriod) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 204) Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see ins Medicare Part A inpatient service costs (from Wkst. E, Pt. A Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare Part A IPS payments (see instructions)	ns) stration) Adjus period under th ne 49) n first year c 5) structions) A, line 59) s)	ne 21st	0	0 tration	103. 0 104. 0 200. 0 201. 0 202. 0 203. 0 203. 0 205. 0 206. 0 207. 0 208. 0 209. 0 210. 0
03.00 04.00 F 00.00 01.00 02.00 03.00 03.00 04.00 05.00 06.00 07.00 08.00 09.00 11.00 11.00 11.00 11.00 13.00	HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demons Is this the first year of the current 5-year demonstration p Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Ii Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A i beriod) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 204) Medicare part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see ins Medicare Part A inpatient service costs (from Wkst. E, Pt. A Adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement	ns) stration) Adjus period under th ne 49) n first year of 5) structions) A, line 59) S) e 211)	of the current	0	0 tration	103. (104. (200. (202. (203. (203. (204. (205. (206. (206. (207. (208. (209. (209. (211. (211. (211. (

SPI T	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5			Period: From 01/01/2021 To 12/31/2021	Worksheet E Part A Exhibit Date/Time Prep 5/26/2022 11:2	bared
		Wkot Dt	Title		Hospital	PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
00	DRG amounts other than outlier payments	1.00					1.0
01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	17, 632, 004	17, 632, 00)4	17, 632, 004	1. C
02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	5, 948, 946		5, 948, 946	5, 948, 946	1. (
03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October	1.03	0		0	0	1. (
04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1. (
00	Outlier payments for discharges (see instructions)	2.00					2. (
01	Outlier payments for discharges for Model 4 BPCI	2.02	0		0 0	0	2. (
02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	336, 131	336, 13	1	336, 131	2.
03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	237, 060		237, 060	237, 060	2.
00	Operating outlier reconciliation	2.01	0		0 0	0	3.
00	Managed care simulated payments	3.00	0		0 0	0	4.
	Indirect Medical Education Adjustment						
00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0. 000000	0.00000	0.00000		5.
00 01	IME payment adjustment (see instructions) IME payment adjustment for managed care (see	22.00 22.01	0		0 0 0 0	0 0	6. 6.
	instructions)			- 1414.4			
00	Indirect Medical Education Adjustment for the IME payment adjustment factor (see	27.00	0.00000	0.00000	0. 000000		7.
0	instructions)	27.00	0.000000	0.00000	0.000000		7.
00	IME adjustment (see instructions)	28.00	0		0 0	0	8.
)1	IME payment adjustment add on for managed care (see instructions)	28.01	0		0 0	0	8.
00	Total IME payment (sum of lines 6 and 8)	29.00	0		0 0	0	9.
01	Total IME payment for managed care (sum of	29.01	0		0 0	0	9.
	lines 6.01 and 8.01)						
	Disproportionate Share Adjustment						
00	Allowable disproportionate share percentage (see instructions)	33.00	0. 1102	0. 110	0. 1102		10
00	Di sproporti onate share adj ustment (see i nstructi ons)	34.00	649, 656	485, 76	163, 894	649, 656	11.
01	Uncompensated care payments Additional payment for high percentage of ESR	36.00	2, 638, 469	1, 831, 19	807, 275	2, 638, 469	11.
00		46.00	0		0 0	0	12.
00 00	Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see	47.00 48.00	27, 442, 266 0	20, 285, 09	01 7, 157, 175 0 0	27, 442, 266 0	13 14
00	instructions) Total payment for inpatient operating costs (see instructions)	49.00	27, 442, 266	20, 285, 09	7, 157, 175	27, 442, 266	15
00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1, 925, 391	1, 423, 61	6 501, 775	1, 925, 391	16.
00 01	Special add-on payments for new technologies Net organ acquisition cost	54.00	315, 913	236, 28	6 79, 627	315, 913	17. 17.
02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0		0 0	0	17.
00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0		0 0	0	18.
	SUBTOTAL		1 1	21, 944, 99	7, 738, 577	29, 683, 570	

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5	Provider CO	CN: 15-0015	Period: From 01/01/2021 To 12/31/2021		pared:
		Title	XVIII	Hospi tal	PPS	
	Wkst. L, line	(Amt. from Wkst. L)				
	0	1.00	2.00	3.00	4.00	
20.00 Capital DRG other than outlier	1.00	1, 805, 754	1, 360, 51	445, 240	1, 805, 754	20.00
20.01 Model 4 BPCI Capital DRG other than outlier	1.01	0		0 0	0	20.01
21.00 Capital DRG outlier payments	2.00	119, 637	63, 10	56, 535	119, 637	21.00
21.01 Model 4 BPCI Capital DRG outlier payments	2.01	0		0 0	0	21.01
22.00 Indirect medical education percentage (see instructions)	5.00	0.0000	0.000	0.0000		22.00
23.00 Indirect medical education adjustment (see instructions)	6.00	0		0 0	0	23.00
24.00 Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.000	0.0000		24.00
25.00 Disproportionate share adjustment (see instructions)	11.00	0		0 0	0	25.00
26.00 Total prospective capital payments (see instructions)	12.00	1, 925, 391	1, 423, 61	16 501, 775	1, 925, 391	26.00
	Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
	0	1.00	2.00	3.00	4.00	
27.00						27.00
28.00 Low volume adjustment prior to October 1	70.96	0		0	0	28.00
29.00 Low volume adjustment on or after October 1	70. 97	0		0	0	29.00
30.00 HVBP payment adjustment (see instructions)	70. 93	-41, 911	-41, 91	0 0	-41, 911	30.00
30.01 HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0		0 0	0	30. 01
31.00 HRR adjustment (see instructions)	70.94	-137, 493	-99, 45	-38, 036	-137, 493	31.00
31.01 HRR adjustment for HSP bonus payment (see instructions)	70. 91	0		0 0	0	31.01
					(Amt. to Wkst. E, Pt. A)	
	0	1.00	2.00	3.00	4.00	
32.00 HAC Reduction Program adjustment (see instructions)	70. 99			0 77,005	77, 005	
100.00 Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

	Financial Systems FRANCI SCAN HEALTH MIC		In Lie Period:	eu of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0015	From 01/01/2021 To 12/31/2021	Worksheet E Part B Date/Time Pre	
		Title XVIII	Hospi tal	5/26/2022 11: PPS	<u>23 am</u>
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
1.00	Medical and other services (see instructions)			1, 852	1.00
2.00	Medical and other services reimbursed under OPPS (see instruction	ons)		24, 044, 644	
3.00 4.00	OPPS payments Outlier payment (see instructions)			20, 358, 476 37, 751	3.00 4.00
4.01	Outlier reconciliation amount (see instructions)			0	
5.00	Enter the hospital specific payment to cost ratio (see instruction	i ons)		0.000	•
6.00 7.00	Line 2 times line 5 Sum of lines 3, 4, and 4.01, divided by line 6			0.00	
8.00	Transitional corridor payment (see instructions)			0	
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV,	, col. 13, line 200		0	
10. 00 11. 00	Organ acquisitions Total cost (sum of lines 1 and 10) (see instructions)			0 1, 852	10.00
	COMPUTATION OF LESSER OF COST OR CHARGES			.,	
12.00	Reasonable charges Ancillary service charges			9.040	12.00
12.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line	e 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			8, 969	14.00
15.00	Customary charges Aggregate amount actually collected from patients liable for pay	vment for services on	a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for p			0	16.00
17 00	had such payment been made in accordance with 42 CFR §413.13(e)			0,000000	17 00
17.00 18.00	Ratio of line 15 to line 16 (not to exceed 1.000000) Total customary charges (see instructions)			0.000000 8,969	
19.00	Excess of customary charges over reasonable cost (complete only	if line 18 exceeds li	ne 11) (see	7, 117	•
20.00	instructions) Excess of reasonable cost over customary charges (complete only	ifline 11 exceeds li	ne 18) (see	0	20.00
	instructions)				
21.00 22.00	Lesser of cost or charges (see instructions) Interns and residents (see instructions)			1, 852 0	
23.00	Cost of physicians' services in a teaching hospital (see instruc	ctions)		0	
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			20, 396, 227	24.00
25.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT Deductibles and coinsurance amounts (for CAH, see instructions)			0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 2			3, 736, 220	
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) pluinstructions)	us the sum of lines 22	and 23] (see	16, 661, 859	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line	e 50)		0	28.00
29.00 30.00	ESRD direct medical education costs (from Wkst. E-4, line 36) Subtotal (sum of lines 27 through 29)			0	
30.00	Primary payer payments			16, 661, 859 6, 669	
32.00	Subtotal (line 30 minus line 31)			16, 655, 190	32.00
33 00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES Composite rate ESRD (from Wkst. 1-5, line 11)	5)		0	33.00
34.00	Allowable bad debts (see instructions)			370, 373	
35.00	Adjusted reimbursable bad debts (see instructions)	-+:>		240, 742	
36.00 37.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	ctrons)		199, 239 16, 895, 932	
38.00	MSP-LCC reconciliation amount from PS&R			0	38.00
39.00 20.50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39.00
39. 50 39. 97	Pioneer ACO demonstration payment adjustment (see instructions) Demonstration payment adjustment amount before sequestration			0	39.50 39.97
39.98	Partial or full credits received from manufacturers for replaced	d devices (see instruc	tions)	0	
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0	
40. 00 40. 01	Subtotal (see instructions) Sequestration adjustment (see instructions)			16, 895, 932 0	40.00
40. 02	Demonstration payment adjustment amount after sequestration			0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs			17 0/2 000	40.03
41.00 41.01	Interim payments Interim payments-PARHM			17, 063, 989	41.00 41.01
42.00	Tentative settlement (for contractors use only)			0	
42. 01 43. 00	Tentative settlement-PARHM (for contractor use only) Balance due provider/program (see instructions)			-168,057	42.01 43.00
43.00 43.01	Balance due provider/program-PARHM (see instructions)			- 108, 057	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance \$115.2	e with CMS Pub. 15-2,	chapter 1,	0	
90 00	TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions)			0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0	91.00
92.00	The rate used to calculate the Time Value of Money			0.00	
93.00 94.00	Time Value of Money (see instructions) Total (sum of lines 91 and 93)			0	93.00 94.00

ANALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC	CN: 15-0015	Period: From 01/01/2021 To 12/31/2021	Worksheet E-1 Part I Date/Time Prep 5/26/2022 11:2	
		Title	XVIII	Hospi tal	PPS	
		I npati en	t Part A	Par	тв	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00 2.00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		26, 689, 52	27 0	17, 063, 989 0	1.00 2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3.00
3.01	ADJUSTMENTS TO PROVIDER			0	0	3. 01
3.02				0	0	3. 02
3.03				0	0	3.03
3.04 3.05				0	0	3.04 3.05
3.05	Provider to Program			0	0	3.00
3.50	ADJUSTMENTS TO PROGRAM			0	0	3.50
3.51				0	0	3.5
3.52				0	0	3.52
3.53 3.54				0	0	3.53 3.54
3.99	Subtotal (sum of lines 3.01–3.49 minus sum of lines 3.50–3.98)			0	0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		26, 689, 52	27	17, 063, 989	4.00
5.00	TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after					5.00
5.00	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					5. 00
5.01	TENTATI VE TO PROVIDER			0	0	5. 01
5.02				0	0	5. 02
5.03				0	0	5.03
E EO	Provider to Program			0		E
5.50 5.51	TENTATI VE TO PROGRAM			0	0	5.50 5.51
5.52				0	0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		308, 99		0	6.01
6.02 7.00	SETTLEMENT TO PROGRAM Total Medicare program liability (see instructions)		26, 998, 52	0	168, 057 16, 895, 932	6.02 7.00
7.00			20, 770, 32	Contractor	NPR Date	7.00
				Number	(Mo/Day/Yr)	
)	1.00	2.00	

IALYS	IS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CO	CN: 15-0015 CCN: 15-S015	Period: From 01/01/20 To 12/31/20		repa	
		Title	XVIII	Subprovi der I PF	- PPS		
		I npati en	t Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy			
00	Tatal interim nerments wild to merciden	1.00	2.00	3.00	4.00		1
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		349, 5	0		0	1. 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.
)3				0		0	3
)4)5				0		0	3
5	Provider to Program			0		0	3
0	ADJUSTMENTS TO PROGRAM			0		0	3
51				0		0	3
52				0		0	3
53				0		0	3
54 99	Subtotal (sum of lines 3.01–3.49 minus sum of lines 3.50–3.98)			0		0 0	3 3
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		349, 5	72		0	4
	TO BE COMPLETED BY CONTRACTOR				1		
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
1	Program to Provider TENTATIVE TO PROVIDER					_	-
)1)2	IENTATIVE TO PROVIDER			0		0	5 5
)3				0		0	5
	Provider to Program		1				
50	TENTATI VE TO PROGRAM			0		0	5
51 52				0		0	5 5
99 19	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			0		0	6
02	SETTLEMENT TO PROGRAM		349, 5	0		0	6 7
00	Total Medicare program liability (see instructions)		349, 5	Contractor	NPR Date	0	
				Number	(Mo/Day/Yr)		
		()	1.00	2.00		

Heal th	Financial Systems FRANCISCAN HEALTH N	II CHI GAN CI TY	In Lie	u of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0015	Period: From 01/01/2021	Worksheet E-1 Part II	
			To 12/31/2021	Date/Time Pre	
		Title XVIII	Hospi tal	5/26/2022 11: PPS	23 am
			HOSPITAI	PP5	
				1,00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS			1.00	
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst.		14		1 1.00
2.00					2.00
	reporting periods beginning on or after 10/01/2013, line 32)				
3.00					3.00
4.00	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines	1, and 8 through 12, and	plus for cost		4.00
	reporting periods beginning on or after 10/01/2013, line 32)				
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3				6.00
7.00	CAH only - The reasonable cost incurred for the purchase of c line 168	ertified HIT technology	Wkst. S-2, Pt. I		7.00
8.00	Calculation of the HIT incentive payment (see instructions)				8.00
9.00	Sequestration adjustment amount (see instructions)				9.00
10.00	Calculation of the HIT incentive payment after sequestration	(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 l	ine 31) (see instruction	s)		32.00

ALCUL	TION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0015	Period: From 01/01/2021	Worksheet E-3 Part II	
		Component CCN: 15-S015	To 12/31/2021	Date/Time Pre 5/26/2022 11:	
		Title XVIII	Subprovider - IPF	PPS	
				1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS				
00	Net Federal IPF PPS Payments (excluding outlier, ECT, and me	edical education payments)		433, 912] 1.
00	Net IPF PPS Outlier Payments			22, 857	2
	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
~ 1	15, 2004. (see instructions)			0.00	
01	Cap increases for the unweighted intern and resident FTE cou			0.00	4
	program or hospital closure, that would not be counted with CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	but a temporary cap aujust	ment 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 n	eriod of a "new	0.00	
00	teaching program" (see instuctions)	r the new program growth p		0.00	0
00	Current year's unweighted I&R FTE count for residents within	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	8
00	Average Daily Census (see instructions)			9. 495890	9
. 00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to	o the power of .5150 -1}.		0.000000	10
. 00	Teaching Adjustment (line 1 multiplied by line 10).			0	11
. 00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11))		456, 769	12
. 00	Nursing and Allied Health Managed Care payment (see instruct	ti on)		0	13
. 00	Organ acquisition (DO NOT USE THIS LINE)				14
. 00	Cost of physicians' services in a teaching hospital (see ins	structions)		0	15
. 00	Subtotal (see instructions)			456, 769	16
. 00	Primary payer payments			2, 783	17
. 00	Subtotal (line 16 less line 17).			453, 986	18
	Deducti bl es			51, 712	
	Subtotal (line 18 minus line 19)			402, 274	
	Coinsurance			52, 702	
	Subtotal (line 20 minus line 21)			349, 572	
	Allowable bad debts (exclude bad debts for professional serv	/ices) (see instructions)		0	23
	Adjusted reimbursable bad debts (see instructions)			0	
	Allowable bad debts for dual eligible beneficiaries (see ins	structions)		0	
	Subtotal (sum of lines 22 and 24)	、 、		349, 572	
	Direct graduate medical education payments (see instructions	5)		0	
	Other pass through costs (see instructions)			0	28
	Outlier payments reconciliation OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	30
	Pioneer ACO demonstration payment adjustment (see instruction	anc)		0	30
	Recovery of accel erated depreciation.			0	30
	Demonstration payment adjustment amount before sequestration			0	
	Total amount payable to the provider (see instructions)			349, 572	
. 01	Sequestration adjustment (see instructions)			017,072	
	Demonstration payment adjustment amount after sequestration			0	
1	Interim payments			349, 572	
	Tentative settlement (for contractor use only)			0	
	Balance due provider/program (line 31 minus lines 31.01, 31.	02, 32 and 33)		0	34
. 00	Protested amounts (nonallowable cost report items) in accord	dance with CMS Pub. 15-2,	chapter 1,	0	35
	§115. 2		·		1
	TO BE COMPLETED BY CONTRACTOR		1		-
	Original outlier amount from Worksheet E-3, Part II, line 2			22, 857	50
	Outlier reconciliation adjustment amount (see instructions)			0	
	The rate used to calculate the Time Value of Money			0.00	
	Time Value of Money (see instructions)			0	53
	FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AN Teaching Adjustment Factor for the cost reporting period imm			0. 000000	
	TEACHING ACTUSTILENT FACTOR FOR THE COST FEDOLETING DEFLOG IMP	neuratery preceding rebrua	iy 27, 2020.	0.000000	99

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0015	Peri od:	Worksheet E-3	
			From 01/01/2021 To 12/31/2021	Part VII Date/Time Pre	
		Title XIX	Hospi tal	5/26/2022 11: Cost	<u>23 d</u>
		Пасили	I npati ent	Outpati ent	
			1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SE	RVICES FOR TITLES V OR >	(IX SERVICES		
	COMPUTATION OF NET COST OF COVERED SERVICES				
00	Inpatient hospital/SNF/NF services		0		1.
00	Medical and other services			0	
00	Organ acquisition (certified transplant centers only)		0		3.
00	Subtotal (sum of lines 1, 2 and 3)		0	0	
00 00	Inpatient primary payer payments Outpatient primary payer payments		0	0	5.
00	Subtotal (line 4 less sum of lines 5 and 6)		0	0	
00	COMPUTATION OF LESSER OF COST OR CHARGES		0	0	1 1
	Reasonable Charges				1
00	Routine service charges		0		8
00	Ancillary service charges		52, 898, 488	129, 403, 406	9
. 00	Organ acquisition charges, net of revenue		0		10
. 00	Incentive from target amount computation		0		11
. 00	Total reasonable charges (sum of lines 8 through 11)		52, 898, 488	129, 403, 406	12
	CUSTOMARY CHARGES				Ι.
. 00	Amount actually collected from patients liable for payment for basis	or services on a charge	0	0	13
00	Amounts that would have been realized from patients liable for		on O	0	14
. 00	a charge basis had such payment been made in accordance with Ratio of line 13 to line 14 (not to exceed 1.000000)	42 CFR 9413.13(e)	0.00000	0. 000000	15
	Total customary charges (see instructions)		52, 898, 488		
. 00	Excess of customary charges over reasonable cost (complete or	lvifline 16 exceeds	52, 898, 488		
. 00	line 4) (see instructions)		02,070,100	127, 100, 100	''
8. 00	Excess of reasonable cost over customary charges (complete or	nly if line 4 exceeds lin	ne O	0	18
00	16) (see instructions)		0	0	10
	Interns and Residents (see instructions) Cost of physicians' services in a teaching hospital (see inst	tructions)	0	0	
	Cost of covered services (enter the lesser of line 4 or line	-	0	0	
. 00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be			0	1 2 1
. 00	Other than outlier payments		0	0	22
	Outlier payments		0	0	
. 00	Program capital payments		0		24
. 00	Capital exception payments (see instructions)		0		25
6. 00	Routine and Ancillary service other pass through costs		0	0	26
7.00	Subtotal (sum of lines 22 through 26)		0	0	27
. 00	Customary charges (title V or XIX PPS covered services only)		0	0	
0. 00	Titles V or XIX (sum of lines 21 and 27)		0	0	29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
	Excess of reasonable cost (from line 18)		0	0	
. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6	b)	0	0	
. 00	Deducti bl es Coi nsurance		0	0	
. 00	Allowable bad debts (see instructions)		0	0	
	Utilization review		0	0	35
. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 ar	nd 33)	0	0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	
	Subtotal (line 36 \pm line 37)		0	0	
	Direct graduate medical education payments (from Wkst. E-4)		0	0	39
	Total amount payable to the provider (sum of lines 38 and 39)		0	0	
	Interim payments		0	0	
	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	
	chapter 1, §115.2	1	-	-	1

LCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0015	Period:	Worksheet E-3	
		Component CCN: 15-S015	From 01/01/2021 To 12/31/2021	Part VII Date/Time Pre 5/26/2022 11:	
		Title XIX	Subprovider -	Cost	20
			I npati ent	Outpati ent	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SEI	RVICES FOR TITLES V OR X	1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES	WICES TOK TITLES V OK A	IN SERVICES		1
00	Inpatient hospital/SNF/NF services		0		1 1
00	Medical and other services		, i i i i i i i i i i i i i i i i i i i	0	
00	Organ acquisition (certified transplant centers only)		0	-	
00	Subtotal (sum of lines 1, 2 and 3)		0	0	4
00	Inpatient primary payer payments		0		5
00	Outpatient primary payer payments			0	6
00	Subtotal (line 4 less sum of lines 5 and 6)		0	0	7
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable Charges				
00	Routine service charges		0		8
00	Ancillary service charges		0	0	
0.00	Organ acquisition charges, net of revenue		0		10
. 00	Incentive from target amount computation		0	0	1
. 00	Total reasonable charges (sum of lines 8 through 11)		0	0	12
. 00	CUSTOMARY CHARGES Amount actually collected from patients liable for payment fo	r sorvi cos on a chargo	0	0	13
. 00	basis	i services on a charge	0	0	'`
. 00	Amounts that would have been realized from patients liable fo	r pavment for services o	n O	0	14
	a charge basis had such payment been made in accordance with			-	
. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0.000000	15
. 00	Total customary charges (see instructions)		0	0	10
. 00	Excess of customary charges over reasonable cost (complete on	ly if line 16 exceeds	0	0	1
	line 4) (see instructions)				
. 00	Excess of reasonable cost over customary charges (complete on	ly if line 4 exceeds lin	e 0	0	18
~~	16) (see instructions)			0	
. 00	Interns and Residents (see instructions)		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 PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be			0	2
. 00	Other than outlier payments	compreted for FFS provi-	0	0	2:
. 00	Outlier payments		0	0	
. 00	Program capital payments		0	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	2
. 00	Customary charges (title V or XIX PPS covered services only)		0	0	28
. 00	Titles V or XIX (sum of lines 21 and 27)		0	0	29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
. 00			0	0	
. 00)	0	0	
	Deducti bl es		0	0	
. 00	Coinsurance		0	0	
00	Allowable bad debts (see instructions)		0	0	
. 00	Utilization review Subtotal (sum of lines 21, 24 and 25 minus sum of lines 22 an	4 22)	0	0	3!
. 00 . 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 an OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	u 33)	0	0	
. 00	Subtotal (line 36 ± 1 line 37)		0	0	
. 00	Direct graduate medical education payments (from Wkst. E-4)		0	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 accorda	nce with CMS Pub 15-2,	0	0	
	chapter 1, §115.2			-	

	E SHEET (If you are nonproprietary and do not maintain ype accounting records, complete the General Fund column	Provider C	CN: 15-0015	Period: From 01/01/2021	Worksheet G	
nd-i nly)	ype accounting records, comprete the General Fund corumn			To 12/31/2021	Date/Time Pre 5/26/2022 11:	
		General Fund	Specific Purpose Func	Endowment Fund		
	CURRENT ASSETS	1.00	2.00	3.00	4.00	
00	Cash on hand in banks	58, 001, 286		0 0	0	1.
00	Temporary investments	00,001,200		0 0	0	
00	Notes recei vabl e	34, 652, 215		0 0	0	3
00	Accounts receivable	0		0 0	0	4
00	Other receivable	0		0 0	0	5
00	Allowances for uncollectible notes and accounts receivable	0		0 0	0	
00	Inventory	4, 284, 715		0 0	0	
00	Prepai d expenses	0		0 0	0	
00	Other current assets	5, 928, 020		0 0	0	
. 00	Due from other funds	102 044 224		0 0	0	
. 00	Total current assets (sum of lines 1-10) FIXED ASSETS	102, 866, 236		0 0	0	11
. 00	Land	9, 737, 278		0 0	0	12
. 00	Land improvements	5, 472, 756		0 0	0	
. 00	Accumulated depreciation	0		0 0	0	
. 00	Buildings	317, 720, 603		0 0	0	15
. 00	Accumulated depreciation	-175, 520, 851		0 0	0	16
. 00	Leasehold improvements	0		0 0	0	17
	Accumulated depreciation	0		0 0	0	
	Fixed equipment	0		0 0	0	
	Accumulated depreciation	0		0 0	0	
	Automobiles and trucks	0		0 0	0	
	Accumulated depreciation	150 070 077		0 0	0	
	Major movable equipment Accumulated depreciation	150, 979, 877		0 0	0	
. 00	Minor equipment depreciable	0		0 0	0	
	Accumulated depreciation	0		0 0	0	
	HIT designated Assets	0		0 0	0	
	Accumulated depreciation	0		0 0	0	
	Mi nor equi pment-nondepreci abl e	0		0 0	0	
	Total fixed assets (sum of lines 12-29)	308, 389, 663		0 0	0	
	OTHER ASSETS	· · · ·			-	
. 00	Investments	8, 659, 715		0 0	0	31
. 00	Deposits on Leases	0		0 0	0	32
. 00	Due from owners/officers	0		0 0	0	
	Other assets	5, 952, 538		0 0	0	
. 00	Total other assets (sum of lines 31-34)	14, 612, 253		0 0	0	
. 00	Total assets (sum of lines 11, 30, and 35)	425, 868, 152		0 0	0	36
	CURRENT LI ABI LI TI ES	11 0/0 447	1	0	0	1
	Accounts payable	11, 069, 447 7, 686, 555		0 0	0	
. 00 . 00	Salaries, wages, and fees payable Payroll taxes payable	7,080,000		0 0	0	
. 00	Notes and Loans payable (short term)	0		0 0	0	
	Deferred income	0		0 0	0	
2.00	Accelerated payments	0		0 0	0	42
	Due to other funds	23, 821, 795		0 0	0	
	Other current liabilities	789, 367		0 0	0	
	Total current liabilities (sum of lines 37 thru 44)	43, 367, 164		0 0	0	
	LONG TERM LIABILITIES					
. 00	Mortgage payable	0		0 0	0	46
. 00	Notes payable	0		0 0	0	47
. 00	Unsecured Loans	0		0 0	0	48
. 00	Other long term liabilities	-6, 432, 169		0 0	0	
	Total long term liabilities (sum of lines 46 thru 49)	-6, 432, 169		0 0	0	
. 00	Total liabilities (sum of lines 45 and 50)	36, 934, 995		0 0	0	51
	CAPI TAL ACCOUNTS	000 000 157	1			1 - /
. 00	General fund balance	388, 933, 157		0		52
. 00	Specific purpose fund			0		53
. 00	Donor created - endowment fund balance - restricted Donor created - endowment fund balance - unrestricted			0		54
. 00	Governing body created - endowment fund balance - unrestricted			0		56
7.00	Plant fund balance - invested in plant			0	0	
3.00	Plant fund balance - reserve for plant improvement,				0	
	replacement, and expansion					
				1		1
. 00	Total fund balances (sum of lines 52 thru 58)	388, 933, 157		0 0	0	59

General 1.00 25,820,912 0 0 0 0 0 0 0 0 0	Fund 2. 00 344, 943, 699 55, 103, 541 400, 047, 240	Speci al	Purpose Fund 4.00 0 0 0 0		1. 00 2. 00 3. 00
25, 820, 912 0	344, 943, 699 55, 103, 541	3.00	0 0 0	0	2.00 3.00
25, 820, 912 0	55, 103, 541		0	0	2.00 3.00
0 0 0 0 0	25, 820, 912 425, 868, 152 0 425, 868, 152				4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00
Endowment Fund					
	7.00	8.00	0		1.00
	0 0 0 0 0 0		0		1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
0 0	0 0 0 0 0 0		0 0		10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00
	Endowment Fund 6.00 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 425, 868, 152 Endowment Fund PI ant 6.00 7.00 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 425, 868, 152 9 9 1 1 1 0 <	0 0	0 0

Heal th	Financial Systems FRANCI SCAN HEALTH M	II CHI GAN CI TY		In Lie	eu of Form CMS-2	2552-10
	ENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provi der CC		Period: From 01/01/2021 To 12/31/2021	Worksheet G-2 Parts I & II	pared:
	Cost Center Description		Inpati ent	Outpati ent	Total	
	PART I - PATIENT REVENUES		1.00	2.00	3.00	
	General Inpatient Routine Services					
1.00	Hospi tal		68, 024, 30	07	68, 024, 307	1.00
2.00	SUBPROVIDER - IPF		6, 250, 0		6, 250, 035	2.00
3.00	SUBPROVIDER - IRF			0	0	3.00
4.00	SUBPROVIDER					4.00
5.00	Swing bed - SNF			0	0	5.00
6.00 7.00	Swing bed - NF SKILLED NURSING FACILITY			0	0	6.00 7.00
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)		74, 274, 34		74, 274, 342	
	Intensive Care Type Inpatient Hospital Services					
11.00	I NTENSI VE CARE UNI T		16, 533, 5		16, 533, 543	
12.00	CORONARY CARE UNIT			0	0	12.00
13.00	BURN INTENSIVE CARE UNIT			0	0	13.00
14.00	SURGI CAL I NTENSI VE CARE UNI T			0	0	14.00
15.00 16.00	OTHER SPECIAL CARE (SPECIFY) Total intensive care type inpatient hospital services (sum of	Linos	16, 533, 54	12	16, 533, 543	15.00
10.00	11-15)	TTHES	10, 000, 04	43	10, 555, 545	10.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	90, 807, 8	85	90, 807, 885	17.00
18.00	Ancillary services	,	239, 523, 0			18.00
19.00	Outpatient services		32, 715, 4	19 96, 881, 876	129, 597, 295	19.00
20.00	RURAL HEALTH CLINIC			0 (20.00
	FEDERALLY QUALIFIED HEALTH CENTER			0 0		21.00
22.00	HOME HEALTH AGENCY			(°	22.00
23.00	AMBULANCE SERVICES			0 0	°	23.00
24.00 24.10	CMHC CORF			0	°	24.00 24.10
24.10	AMBULATORY SURGICAL CENTER (D. P.)			0 0	-	25.00
26.00	HOSPICE			0 0		26.00
27.00	OTHER (SPECIFY)			0 0	-	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3	to Wkst.	363, 046, 39	98 667, 836, 588	1, 030, 882, 986	28.00
	G-3, line 1)					
	PART II - OPERATING EXPENSES			0.07 0.00 1.01		
29.00 30.00	Operating expenses (per Wkst. A, column 3, line 200)			227, 892, 432	2	29.00
30.00 31.00	ADD (SPECI FY)			0		30.00 31.00
31.00				0		32.00
33.00				0		33.00
34.00				0		34.00
35.00				0		35.00
36.00	Total additions (sum of lines 30-35)			(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
41.00 42.00	Total deductions (sum of lines 37-41)			0		41.00
42.00	Total operating expenses (sum of lines 29 and 36 minus line 4:	2)(transfer		227, 892, 432		42.00
.5.00	to Wkst. G-3, line 4)			22.,072,402		
		1				•

	Financial Systems	FRANCI SCAN HEALTH I	MICHIGAN CITY		u of Form CMS-2	2552-10
STATEM	ENT OF REVENUES AND EXPENSES		Provider CCN: 15-0015	Peri od:	Worksheet G-3	
				From 01/01/2021 To 12/31/2021	Date/Time Pre	nared
				10 12/31/2021	5/26/2022 11:	
	1				1.00	
1.00	Total patient revenues (from Wkst				1, 030, 882, 986	1.00
2.00	Less contractual allowances and d		nts		749, 809, 258	2.00
3.00	Net patient revenues (line 1 minu:				281, 073, 728	3.00
4.00	Less total operating expenses (fro		43)		227, 892, 432	4.00
5.00	Net income from service to patien	ts (line 3 minus line 4)			53, 181, 296	5.00
	OTHER INCOME					
6.00	Contributions, donations, bequest	s, etc			0	6.00
7.00	Income from investments				-2, 022, 947	7.00
8.00	Revenues from telephone and other		n servi ces		0	8.00
9.00	Revenue from television and radio	servi ce			0	
	Purchase di scounts				0	10.00
	Rebates and refunds of expenses				0	11.00
	Parking lot receipts				0	12.00
	Revenue from laundry and linen se				0	13.00
	Revenue from meals sold to employ				0	14.00
	Revenue from rental of living qua				0	15.00
	Revenue from sale of medical and		han patients		0	16.00
	Revenue from sale of drugs to othe				0	17.00
	Revenue from sale of medical reco				0	18.00
	Tuition (fees, sale of textbooks,				0	19.00
	Revenue from gifts, flowers, coff	ee shops, and canteen			0	20.00
	Rental of vending machines				0	
	Rental of hospital space				0	22.00
23.00	Governmental appropriations				0	23.00
24.00	MISC INCOME				6, 198, 225	24.00
24.50	COVID-19 PHE Funding				-2, 253, 033	24.50
25.00	Total other income (sum of lines	5-24)			1, 922, 245	25.00
	Total (line 5 plus line 25)				55, 103, 541	26.00
27.00	OTHER EXPENSES (SPECIFY)				0	27.00
28.00	Total other expenses (sum of line	27 and subscripts)			0	28.00
29 00	Net income (or loss) for the peri	d (line 26 minus line 28)			55, 103, 541	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 15-0015	Period: From 01/01/2021 To 12/31/2021	Date/Time Prepared	
				5/26/2022 11:	23 am
		Title XVIII	Hospi tal	PPS	
				1.00	
	PART I - FULLY PROSPECTIVE METHOD			1.00	
	CAPITAL FEDERAL AMOUNT				1
	Capital DRG other than outlier			1, 805, 754	1.0
	Model 4 BPCI Capital DRG other than outlier			0	1.0
	Capital DRG outlier payments			119, 637	2.0
	Model 4 BPCI Capital DRG outlier payments			0	2.0
	Total inpatient days divided by number of days in the	cost reporting period (see inst	ructions)	79.28	3.0
	Number of interns & residents (see instructions)		, ,	0.00	4.0
	Indirect medical education percentage (see instruction	s)		0.00	5.0
	Indirect medical education adjustment (multiply line 5		, columns 1 and	0	6.0
	1.01) (see instructions)	5			
7.00	Percentage of SSI recipient patient days to Medicare P	art A patient days (Worksheet E	, part A line	0.00	7.0
	30) (see instructions)				
3.00	Percentage of Medicaid patient days to total days (see	instructions)		0.00	8.0
9.00	Sum of lines 7 and 8			0.00	9.0
	Allowable disproportionate share percentage (see instr	uctions)		0.00	•
	Disproportionate share adjustment (see instructions)			0	
12.00	Total prospective capital payments (see instructions)			1, 925, 391	12.0
			·	1.00	
	PART II – PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instruction	ns)		0	1.0
2.00	Program inpatient ancillary capital cost (see instruct	i ons)		0	2.0
	Total inpatient program capital cost (line 1 plus line	2)		0	3.0
4.00	Capital cost payment factor (see instructions)			0	4.0
5.00	Total inpatient program capital cost (line 3 x line 4)			0	5.0
				1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS				
. 00	Program inpatient capital costs (see instructions)			0	1.0
2.00	Program inpatient capital costs for extraordinary circ	umstances (see instructions)		0	2.0
. 00	Net program inpatient capital costs (line 1 minus line	2)		0	3.0
	Applicable exception percentage (see instructions)			0.00	4.0
	Capital cost for comparison to payments (line 3 x line			0	5. C
. 00	Percentage adjustment for extraordinary circumstances	(see instructions)		0.00	6.0
. 00	Adjustment to capital minimum payment level for extrac	rdinary circumstances (line 2 x	line 6)	0	7.0
. 00	Capital minimum payment level (line 5 plus line 7)			0	8.0
	Current year capital payments (from Part I, line 12, a			0	9.0
0.00	Current year comparison of capital minimum payment lev	el to capital payments (line 8	less line 9)	0	10.0
1.00	Carryover of accumulated capital minimum payment level	over canital navment (from pri	or year	0	11.0
		over capital payment (110m pri	Joan	•	-
	Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to cap		5	0	

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 12.00 0 0 13.00 14.00 0 (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) 0 15.00 0 16.00 0 17.00

17.00 Current year exception offset amount (see instructions)