This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 09-30-2025 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 15-0165 Worksheet S Peri od: From 01/01/2022 Parts I-III AND SETTLEMENT SUMMARY 12/31/2022 Date/Time Prepared: 5/29/2023 9:51 am PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 5/29/2023 9:51 am] Manually prepared cost report use only Ilf this is an amended report enter the number of times the provider resubmitted this cost report [Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no. [1] Cost Report Status
[1] As Submitted
[2] Settled without Audit
[3] Settled with Audit
[4] Date Received:
[5] To. NPR Date:
[6] 10. NPR Date:
[7] 11. Contractor's Vendor Code:
[7] 12. [8] Final Report for this Provider CCN
[9] [8] Final Report for this Provider CCN
[10] NPR Date:
[11] 12. NPR Date:
[12] 13. NPR Date:
[13] 14. NPR Date:
[14] 15. NPR Date:
[15] 15. NPR Date:
[16] 16. NPR Date:
[17] 17. NPR Date:
[18] 17. NPR Date:
[18] 18. NPR Date:
[18] 18. NPR Date:
[18] 19. NPR Da

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

(3) Settled with Audit

(4) Reopened (5) Amended

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

number of times reopened = 0-9.

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 MUNSTER (15-0165) for the cost reporting period beginning 01/01/2022 and ending 12/31/2022 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

		Title	XVIII			
	Title V	Part A	Part B	HIT	Title XIX	
	1.00	2. 00	3. 00	4. 00	5. 00	
PART III - SETTLEMENT SUMMARY						
1. 00 HOSPI TAL	0	1, 551, 233	3, 360	0	0	1. 00
2. 00 SUBPROVI DER - I PF	0	0	0		0	2. 00
3. 00 SUBPROVI DER - I RF	0	0	0		0	3. 00
5. 00 SWING BED - SNF	0	0	0		0	5. 00
6.00 SWING BED - NF	0				0	6. 00
7.00 SKILLED NURSING FACILITY	0	0	0		0	7. 00
8.00 NURSING FACILITY	0				0	8. 00
9.00 HOME HEALTH AGENCY I	0	0	0		0	9. 00
10.00 RURAL HEALTH CLINIC I	0		0		0	10. 00
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11. 00
12. 00 CMHC I	0		0		0	12. 00
200. 00 TOTAL	0	1, 551, 233	3, 360	0	0	200. 00
The above amounts represent "due to" or "due from"	the applicable	program for th	ne element of t	he above comple	ex indicated.	

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The number for this information collection is OMB 0938-0050 and the number for the Supplement to Form CMS 2552-10, Worksheet N95, is OMB 0938-1425. The time required to complete and review the information collection is estimated 675 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.

Contractor use only

								-rom 01/01/ Γο 12/31/		Date/Tir		
	1.00		2.00		3. 00				4. 00	5/29/202	23 9:5	1 am
	Hospital and Hospital Health Care Co	mplex Ad	dress:									
1. 00 2. 00	Street: 701 SUPERIOR STREET City: MUNSTER		PO Box: State: IN	Zip Cod	o. 162	21	County	y: LAKE				1. 00 2. 00
2.00	orty. WONSTER	Com	ponent Name	CCN	CBS		ovi der	Date	Payme	nt Syste	em (P,	2.00
				Number	Numb	per	Туре	Certi fi ed		0, or		
			1. 00	2.00	3. (20	4. 00	5. 00	V 6. 00	7. 00	XI X 8. 00	
	Hospital and Hospital-Based Componen	t Identi		2.00] 3. (50 -	4.00	3. 00	0.00	7.00	0.00	
3. 00			CAN HEALTH	150165	238	44	1	06/01/2007	N	P	Р	3. 00
4. 00	Subprovider - IPF	MUNSTER										4. 00
5.00	Subprovider - IRF											5. 00
6. 00 7. 00	Subprovider - (Other) Swing Beds - SNF											6. 00 7. 00
8. 00	Swing Beds - SNF											8. 00
9. 00	Hospi tal -Based SNF											9. 00
10. 00 11. 00	Hospi tal -Based NF Hospi tal -Based OLTC											10. 00 11. 00
12. 00	Hospi tal -Based HHA											12. 00
13.00	Separately Certified ASC											13.00
14. 00 15. 00	Hospi tal -Based Hospi ce Hospi tal -Based Health Clinic - RHC											14. 00 15. 00
16. 00	Hospi tal -Based Health Clinic - FQHC											16. 00
17.00	Hospi tal Based (CMHC) I											17.00
17. 10 18. 00	Hospital-Based (CORF) I Renal Dialysis											17. 10 18. 00
19. 00												19. 00
								1.00		To: 2. 0		
20. 00	.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2022 12/31/2022								20. 00			
21. 00	.00 Type of Control (see instructions)								21. 00			
						1.	00	2. 00		3. 0	0	
22.00	Inpatient PPS Information				_	,	V	N.				22.00
22. 00	Does this facility qualify and is it disproportionate share hospital adju		, ,	-			Y	N				22. 00
	§412.106? In column 1, enter "Y" fo	r yes or	"N" for no. I	s this faci	lity							
	subject to 42 CFR Section §412.106(c column 2, enter "Y" for yes or "N" f		kle amendment	hospital?)	In							
22. 01	Did this hospital receive interim UC	Ps, incl					N	N				22. 01
	this cost reporting period? Enter in											
	for the portion of the cost reportin Enter in column 2, "Y" for yes or "N											
00.00	reporting period occurring on or aft						.,					00.00
22. 02	Is this a newly merged hospital that at cost report settlement? (see inst						N	N				22. 02
	yes or "N" for no, for the portion o	f the co	st reporting p	eriod prio	r to							
	October 1. Enter in column 2, "Y" fo of the cost reporting period on or a			or the por	ti on							
22. 03	Did this hospital receive a geograph			om urban to	5		N	N		N		22. 03
	rural as a result of the OMB standar											
	adopted by CMS in FY2015? Enter in c the portion of the cost reporting pe											
	column 2, "Y" for yes or "N" for no	for the p	portion of the	cost repo								
	period occurring on or after October hospital contain at least 100 but no				in							
	accordance with 42 CFR 412.105)? Ent											
22. 04	no. Did this hospital receive a geograph	ic recla	ssification fr	om urban to	,							22. 04
22.04	rural as a result of the revised OMB											22.04
	adopted by CMS in FY 2021? Enter in for the portion of the cost reportin											
	column 2, "Y" for yes or "N" for no	U 1	•									
	period occurring on or after October	1. (see	instructions)	Does this								
	hospital contain at least 100 but no accordance with 42 CFR 412.105)? En											
	for no.			,								
23. 00	Which method is used to determine Me below? In column 1, enter 1 if date		•					3 N				23. 00
	if date of discharge. Is the method	of ident	ifying the day	s in this (
	reporting period different from the reporting period? In column 2, ente	method u	sed in the pri	or cost								
	portion. The contained 2, either		. , 65 01 14 1	o. 110.		ı		1	1		'	

in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for

58.00

58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.

yes in column 1, do not complete column 2, and complete Worksheet E-4.

Health Financial Systems FRANCISCAN HEALTH MUNSTER In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0165 Peri od: Worksheet S-2 From 01/01/2022 Part I Date/Time Prepared: 12/31/2022 5/29/2023 9:51 am 1. 00 2.00 3.00 59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I Ν 59.00 NAHE 413.85 Worksheet A Pass-Through Y/N Line # Qual i fi cati on Criterion Code 1.00 2.00 3.00 60.00 Are you claiming nursing and allied health education (NAHE) costs for any 60.00 programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2. Y/N IME Direct GME IME Direct GME 1. 00 2. 00 3. 00 4.00 5.00 61.00 Did your hospital receive FTE slots under ACA section Ν 0.00 0.00 61.00 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) 61.01 Enter the average number of unweighted primary care 61.01 FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) 61.02 Enter the current year total unweighted primary care 61.02 FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions) 61 03 Enter the base line FTE count for primary care and/or 61 03 general surgery residents, which is used for determining compliance with the 75% test. (see instructions) 61.04 Enter the number of unweighted primary care/or surgery 61.04 allopathic and/or osteopathic FTEs in the current cost reporting period (see instructions). 61.05 Enter the difference between the baseline primary 61.05 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) 61.06 Enter the amount of ACA §5503 award that is being used 61.06 for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions) Program Code Unweighted IME Unweighted Program Name FTE Count Direct GME FTE Count 2.00 1.00 3.00 4.00 61.10 Of the FTEs in line 61.05, specify each new program 0 00 0.00 61.10 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. 61. 20 Of the FTEs in line 61.05, specify each expanded 0.00 0.00 61.20 program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count 1.00 ACA Provisions Affecting the Health Resources and Services Administration (HRSA) Enter the number of FTE residents that your hospital trained in this cost reporting period for which 0.00 62.00 62.00 your hospital received HRSA PCRE funding (see instructions) Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital 62.01 0.00 62.01 during in this cost reporting period of HRSA THC program. (see instructions) Teaching Hospitals that Claim Residents in Nonprovider Settings

Has your facility trained residents in nonprovider settings during this cost reporting period? Enter

for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)

63.00

In Lieu of Form CMS-2552-10 Health Financial Systems FRANCISCAN HEALTH MUNSTER HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0165 Peri od: Worksheet S-2 From 01/01/2022 Part I Date/Time Prepared: 12/31/2022 5/29/2023 9:51 am Unwei ghted Unwei ghted Ratio (col. (col. 1 + col FTEs FTEs in Nonprovi der Hospi tal 2)) Si te 1.00 2.00 3.00 Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. 64. 00 0.00 0.00 0.000000 64.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Ratio (col. 3/ Unwei ghted Unwei ghted Program Name Program Code FTEs FTEs in (col. 3 + col.Nonprovi der Hospi tal 4)) Si te 2.00 3.00 1.00 4.00 5.00 65.00 Enter in column 1, if line 63 0.00 0.00 0.000000 65.00 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Unwei ghted Unwei ghted Ratio (col. 1/ FTES FTEs in (col. 1 + col Nonprovi der Hospi tal 2)) Si te 2.00 1.00 3.00 Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 Enter in column 1 the number of unweighted non-primary care resident FTEs 0.00 0.00 0.000000 66.00 attributable to rotations occurring in all nonprovider settings. column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Program Name Program Code Unwei ghted Unwei ghted Ratio (col. 3/ (col. 3 + col. FTEs FTEs in Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3. 00 4.00 5.00 0.000000 67.00 67.00 Enter in column 1, the program 0.00 0.00 name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)

0.00

0.00

97.00

97.00 If line 96 is "Y", enter the reduction percentage in the applicable column.

118.00

"Y" for yes or "N" for no.

118.00 s the mal practice insurance a claims-made or occurrence policy? Enter 1

if the policy is claim-made. Enter 2 if the policy is occurrence.

enter the approval date (mm/dd/yyyy) in column 2.

Health Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE COMPLE		ALTH MUNSTER Provider CC	N: 15 0165	Peri od:	worksheet S-	
IOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	Provider CC	.N. 15-0105	From 01/01/2022 To 12/31/2022	Part I Date/Time Pr	epared:
					5/29/2023 9:	51 am
					1.00	
147.00Was there a change in the statisti	cal basis? Enter "Y" for	ves or "N" for	no.		N	147.0
148.00 Was there a change in the order of					N	148. C
149.00 Was there a change to the simplifi				or no.	N	149. 0
		Part A	Part B	Title V	Title XIX	
		1.00	2. 00	3.00	4. 00	
Does this facility contain a prov						
or charges? Enter "Y" for yes or	'N" for no for each compor					
55. 00 Hospi tal		N	N	N	N	155. 0
56.00 Subprovi der - IPF		N	N	N	N	156. 0
57.00 Subprovi der - IRF		N	N	N	N	157. (
58. 00 SUBPROVI DER			l			158. (
59. 00 SNF		N	N	N	N	159. (
60. 00 HOME HEALTH AGENCY		N	N	N	N	160. (
61. 00 CMHC			N	N	N	161. (
61. 10 CORF			N N	N	N	161.
						_
M I + !					1.00	
Multicampus	mous been tal that has an		ooo in dift	Forant CDCAo2 Ent	er N	1/5 (
65.00 s this hospital part of a Multica "Y" for yes or "N" for no.	ampus nospitai that has on	ie or illore callipu	ises in airi	ferent CBSAs? Ent	er n	165. 0
1 Tol yes of N Tol Ho.	Name	County	State 2	Zi p Code CBSA	FTE/Campus	
	0	1. 00	2. 00	3. 00 4. 00	5. 00	_
66.00 If line 165 is yes, for each	Ü	1.00	2.00	3.00 4.00		00 166. 0
campus enter the name in column 0,					0. (00.0
county in column 1, state in						
column 2, zip code in column 3,						
CBSA in column 4, FTE/Campus in						
column 5 (see instructions)						
	·					
					1.00	
Health Information Technology (HI				ent Act	_	
167.00 Is this provider a meaningful use					Υ	167. 0
68.00 If this provider is a CAH (line 10			e 167 is "Y'	'), enter the		168. 0
reasonable cost incurred for the I						
68.01 If this provider is a CAH and is a						168. 0
exception under §413.70(a)(6)(ii) 169.00 f this provider is a meaningful u					0.1	99169. C
transition factor. (see instruction		I IS HUL A CAH (Title 105 Is	s N), enter the	9.	99 109. 0
transition ractor. (see mistruction	JIIS)			Begi nni ng	Endi ng	
				1. 00	2.00	_
70.00 Enter in columns 1 and 2 the EHR I	peginning date and ending	date for the re	eporting per		2.00	170. 0
respectively (mm/dd/yyyy)	beginning date and ending	date for the re	por tring per	100		170.0
prospectively (mm dan jjjj)						
				1. 00	2.00	
71.00 If line 167 is "Y", does this prov	vider have any days for in	ndi vi dual s enrol	led in sect			0 171. (
					1	
1876 Medicare cost plans reported	on WKST. S-3, PT. I, IIne	2, COL. OF EIL	er r ror	yes		
and "N" for no in column 1. If col						

Health Financial Systems FRANCISCAN HEALTH MUNSTER In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provider CCN: 15-0165 Peri od: Worksheet S-2 From 01/01/2022 Part II Date/Time Prepared: 12/31/2022 5/29/2023 9:51 am Y/N Date 1. 00 2.00 PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSEMENT QUESTIONNAIRE General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS Provider Organization and Operation 1 00 Has the provider changed ownership immediately prior to the beginning of the cost N 1.00 reporting period? If yes, enter the date of the change in column 2. (see instructions) Date V/I 1.00 2.00 3.00 Has the provider terminated participation in the Medicare Program? If yes 2.00 2.00 Ν enter in column 2 the date of termination and in column 3, "V" voluntary or "I" for involuntary. 3.00 Is the provider involved in business transactions, including management Ν 3.00 contracts, with individuals or entities (e.g., chain home offices, drug o medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions) Y/N Date Type 1.00 2.00 3.00 Financial Data and Reports
Column 1: Were the financial statements prepared by a Certified Public 4 00 05/22/2023 4 00 Α Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, o for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation. 5 00 5 00 Ν Y/N Legal Oper. 1.00 Approved Educational Activities 6.00 Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider Ν 6.00 the legal operator of the program? 7 00 Are costs claimed for Allied Health Programs? If "Y" see instructions. N 7 00 Were nursing programs and/or allied health programs approved and/or renewed during the Ν 8.00 8.00 cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved graduate medical education 9.00 Ν 9.00 program in the current cost report? If yes, see instructions.

Was an approved Intern and Resident GME program initiated or renewed in the current cost 10.00 Ν 10.00 reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Ν 11.00 Program on Worksheet A? If yes, see instructions Y/N 1.00 Bad Debts 12.00 Is the provider seeking reimbursement for bad debts? If yes, see instructions. 12.00 If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting 13.00 Ν 13.00 period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or coinsurance amounts waived? If yes, see instructions 14.00 Bed Complement Υ 15.00 Did total beds available change from the prior cost reporting period? If yes, 15.00 see instructions Part B Y/N Date Y/N Date 1.00 2.00 3.00 4.00 PS&R Data 16.00 Was the cost report prepared using the PS&R Report only? If N N 16.00 either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see instructions) Was the cost report prepared using the PS&R Report for 04/21/2023 04/21/2023 17.00 17.00 Υ totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in column's 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Ν 18.00 Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions. 19.00 If line 16 or 17 is yes, were adjustments made to PS&R N N 19.00 Report data for corrections of other PS&R Report information? If yes, see instructions.

	Financial Systems FRANCISCAN HEAL				u of Form CMS		
HOSPI I	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der CC	JN: 15-0165	Peri od: From 01/01/2022 To 12/31/2022	Worksheet S- Part II Date/Time Pr 5/29/2023 9:	epared:	
		Descri	pti on	Y/N	Y/N		
		C)	1. 00	3. 00		
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20. 00	
	Report data for other: bescribe the other adjustments.	Y/N	Date	Y/N	Date		
		1.00	2.00	3. 00	4. 00		
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21. 00	
					1. 00		
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEP	T CHILDRENS H	OSPI TALS)		1.00		
	Capital Related Cost						
	Have assets been relifed for Medicare purposes? If yes, see		ala mada dum	ing the cost	N	22. 00	
23. 00	Have changes occurred in the Medicare depreciation expense d reporting period? If yes, see instructions.	iue to apprais	ars made dur	ring the cost	N	23. 00	
24. 00	Were new leases and/or amendments to existing leases entered yes, see instructions	f N	24. 00				
25. 00	Have there been new capitalized leases entered into during tinstructions.	he cost repor	ting period?	'If yes, see	N	25. 00	
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during the	cost reporti	ng period? I	f yes, see	N	26. 00	
27. 00	instructions. Has the provider's capitalization policy changed during the	cost reportin	g period? If	yes, submit copy	. N	27. 00	
28. 00	<u>Interest Expense</u> Were new loans, mortgage agreements or letters of credit ent	ered into dur	ing the cost	reporting period	? N	28. 00	
29. 00	If yes, see instructions. 00 Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) N						
30. 00	treated as a funded depreciation account? If yes, see instru Has existing debt been replaced prior to its scheduled matur		dobt2 If you	. coo i netrueti on	s. N	30.00	
31. 00	Has debt been recalled before scheduled maturity without iss					31. 00	
	Purchased Services						
32. 00	Have changes or new agreements occurred in patient care serv arrangements with suppliers of services? If yes, see instruc		d through co	ntractual	N	32. 00	
33. 00	If line 32 is yes, were the requirements of Sec. 2135.2 appl		g to competi	tive bidding? If	N	33. 00	
	no, see instructions.			_			
	Provider-Based Physicians Were services furnished at the provider facility under an ar	rongoment wit	h providor b	acad physicians?	If Y	34.00	
34.00	ves, see instructions.	rangement wit	ii provider-L	aseu physicians?	11 1	34.00	
35. 00	If line 34 is yes, were there new agreements or amended exis		ts with the	provi der-based	N	35. 00	
	physicians during the cost reporting period? If yes, see ins	tructions.		Y/N	Date		
				1.00	2. 00		
	Home Office Costs						
	Were home office costs claimed on the cost report?	unamad by the	homo offico?	Y Y If Y		36.00	
37. 00	If line 36 is yes, has a home office cost statement been pre yes, see instructions.	epared by the	nome office?	Y		37. 00	
38. 00	If line 36 is yes , was the fiscal year end of the home offi			the N		38. 00	
20 00	provider? If yes, enter in column 2 the fiscal year end of t			. N		39. 00	
	see instructions.						
40. 00	If line 36 is yes, did the provider render services to the hinstructions.	nome office?	If yes, see	N		40. 00	
		1. (00	2.0	00		
	Cost Report Preparer Contact Information						
41. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	AMES		HALL		41. 00	
	respectively.						
42.00		DANCI CCAN UEA	TH			1 40 00	
	Enter the employer/company name of the cost report preparer	RANCI SCAN HEAI 14-565-2739	LTH	JAMES. HALL@FRAN	ICI SCANALI LANG	42.00	

Health Fina	ncial Systems	FRANCI SCAN HEAI	LTH MUNSTER		In Lieu	u of Form CMS-2	2552-10
HOSPITAL AN	ND HOSPITAL HEALTH CARE REIMBURSEMENT	QUESTI ONNAI RE	Provi der CC		Peri od:	Worksheet S-2	
						Part II Date/Time Pre 5/29/2023 9:5	pared: 1 am
		-	3.	00	_		
Cost	Report Preparer Contact Information						
	er the first name, last name and the t		REIMBURSEMENT A	ANALYST			41. 00
	the cost report preparer in columns 1,	2, and 3,					
	pecti vel y.						
	er the employer/company name of the co						42. 00
	er the telephone number and email addr						43. 00
repo	ort preparer in columns 1 and 2, respe	ectively.					

 Heal th Financial
 Systems
 FRANCIS

 HOSPITAL
 AND
 HOSPITAL
 HEALTH CARE COMPLEX
 STATISTICAL
 DATA
 Provider CCN: 15-0165

					11	0 12/31/2022	5/29/2023 9:5	
	·						I/P Days / 0/P	ı allı
							Visits / Trips	
	Component	Worksheet A	No	of Beds	Bed Days	CAH Hours	Title V	
	36pariant	Li ne No.	1101	0. 2000	Avai I abl e	57 H. 110 G. 5		
		1. 00		2. 00	3. 00	4. 00	5. 00	
	PART I - STATISTICAL DATA						0.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		69	25, 185	0.00	0	1. 00
	8 exclude Swing Bed, Observation Bed and							
	Hospice days) (see instructions for col. 2 for	-						
	the portion of LDP room available beds)							
2.00	HMO and other (see instructions)							2. 00
3.00	HMO IPF Subprovider							3. 00
4.00	HMO IRF Subprovider							4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF						0	5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						o	6. 00
7.00	Total Adults and Peds. (exclude observation			69	25, 185	0.00	l o	7. 00
	beds) (see instructions)				·			
8.00	INTENSIVE CARE UNIT	31. 00		9	3, 285	0.00	0	8. 00
9.00	CORONARY CARE UNIT	32. 00		0	. 0	0.00	0	9. 00
10.00	BURN INTENSIVE CARE UNIT	33. 00		0	0	0.00	0	10.00
11.00	SURGICAL INTENSIVE CARE UNIT	34. 00		o	0	0.00	O	11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)							12.00
13. 00	NURSERY	43. 00					0	13. 00
14. 00	Total (see instructions)			78	28, 470	0.00		14. 00
15. 00	CAH vi si ts				·		l o	15. 00
16.00	SUBPROVI DER - I PF	40. 00		o	0		0	16. 00
17.00	SUBPROVI DER - I RF	41. 00		o	0		0	17. 00
18.00	SUBPROVI DER							18. 00
19.00	SKILLED NURSING FACILITY	44. 00		o	0		0	19. 00
20.00	NURSING FACILITY	45. 00		o	0		0	20. 00
21.00	OTHER LONG TERM CARE	46. 00		o	0			21. 00
22. 00	HOME HEALTH AGENCY	101. 00					0	22. 00
23.00	AMBULATORY SURGICAL CENTER (D. P.)	115. 00						23. 00
24.00	HOSPI CE	116. 00		o	0			24. 00
24. 10	HOSPICE (non-distinct part)	30. 00						24. 10
25.00	CMHC - CMHC	99. 00					0	25. 00
25. 10	CMHC - CORF	99. 10					0	25. 10
26.00	RURAL HEALTH CLINIC	88. 00					0	26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00					0	26. 25
27.00	Total (sum of lines 14-26)			78				27. 00
28. 00	Observation Bed Days						O	28. 00
29. 00	Ambul ance Trips							29. 00
30.00	Employee discount days (see instruction)							30. 00
31. 00	Employee discount days - IRF							31. 00
32.00	Labor & delivery days (see instructions)			o	0			32. 00
32. 01	Total ancillary labor & delivery room							32. 01
	outpatient days (see instructions)							
33.00	LTCH non-covered days			j				33. 00
33. 01	LTCH site neutral days and discharges			j				33. 01
34.00	Temporary Expansion COVID-19 PHE Acute Care	30. 00		0	0		0	34.00
	· · · · · · · · · · · · · · · · · · ·			'			. '	'

Health Financial Systems FRANCIS
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-0165

In Lieu of Form CMS-2552-10

Period:	Worksheet S-3
From 01/01/2022	Part
To 12/31/2022	Date/Time Prepared:
5/79/2023 9:51 am	

						5/29/2023 9:5	1 am
		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	
	PART I - STATISTICAL DATA	2. 22					
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	4, 934	2, 224	17, 009			1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2 for	⁻					
	the portion of LDP room available beds)						
2.00	HMO and other (see instructions)	5, 649	1, 419				2. 00
3.00	HMO IPF Subprovider	0	0				3. 00
4.00	HMO IRF Subprovider	0	0				4. 00
5. 00	Hospital Adults & Peds. Swing Bed SNF	0	0	C			5. 00
6.00	Hospital Adults & Peds. Swing Bed NF		0	()		6. 00
7. 00	Total Adults and Peds. (exclude observation	4, 934	2, 224	17, 009)		7. 00
0.00	beds) (see instructions)	1 410		2.050			0.00
8. 00 9. 00	INTENSIVE CARE UNIT	1, 418 0	0	2, 058			8. 00 9. 00
10.00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT	0	0				10.00
11. 00	SURGICAL INTENSIVE CARE UNIT	0	0				11.00
12. 00	OTHER SPECIAL CARE (SPECIFY)	U	Ů,	C	'l		12.00
13. 00	NURSERY		0	(13. 00
14. 00	Total (see instructions)	6, 352	2, 224	19, 067	0.00	608. 19	14. 00
15. 00	CAH visits	0, 332	2, 22 1	17,007	0.00	000.17	15. 00
16. 00	SUBPROVIDER - I PF	o	0	C	0.00	0.00	16. 00
17. 00	SUBPROVI DER - I RF	0	0	C		0.00	17. 00
18. 00	SUBPROVI DER		1				18. 00
19. 00	SKILLED NURSING FACILITY	o	o	C	0.00	0.00	19. 00
20.00	NURSING FACILITY		o	C	0.00	0.00	20. 00
21. 00	OTHER LONG TERM CARE			C	0.00	0.00	21. 00
22. 00	HOME HEALTH AGENCY	O	o	C	0.00	0.00	22. 00
23.00	AMBULATORY SURGICAL CENTER (D. P.)				0.00	0.00	23. 00
24.00	HOSPI CE	0	0	C	0.00	0.00	24. 00
24. 10	HOSPICE (non-distinct part)			C			24. 10
25. 00	CMHC - CMHC	0	0	C	0.00	0.00	25. 00
25. 10	CMHC - CORF	0	0	C		0.00	
26. 00	RURAL HEALTH CLINIC	0	0	C		0.00	26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	C	0.00	0.00	26. 25
27. 00	Total (sum of lines 14-26)				0.00	608. 19	27. 00
28. 00	Observation Bed Days	_	725	3, 635			28. 00
29. 00	Ambul ance Tri ps	0		_			29. 00
30.00	Employee discount days (see instruction)			C)		30.00
31.00	Employee discount days - IRF			C)		31.00
32.00	Labor & delivery days (see instructions)	0	0	C)		32.00
32. 01	Total ancillary labor & delivery room			C)		32. 01
33. 00	outpatient days (see instructions) LTCH non-covered days	o					33. 00
33. 00	LTCH site neutral days and discharges	o					33. 00
	Temporary Expansion COVID-19 PHE Acute Care	o	o	C	,		34. 00
51.50	1. Simpo. a. 3. Expansion out to 17 The Moute out o	١	٩		1		31.00

Provider CCN: 15-0165

					J 12/31/2022	5/29/2023 9:5	
		Full Time Equivalents	'	Di sch	arges	, , , , , , , , , , , , , , , , , , , ,	
	Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11. 00	12. 00	13. 00	14. 00	15. 00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		0	1, 325	368	3, 715	1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)						
2. 00	HMO and other (see instructions)			902	232		2.00
3.00	HMO IPF Subprovider			702	232		3.00
4. 00	HMO IRF Subprovider				ol		4. 00
5. 00	Hospital Adults & Peds. Swing Bed SNF				Ĭ		5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation						7. 00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT						8. 00
9.00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10. 00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12. 00
13. 00	NURSERY						13. 00
14. 00	Total (see instructions)	0. 00	0	1, 325	368	3, 715	
15. 00	CAH visits		_		_	_	15. 00
16.00	SUBPROVI DER - I PF	0. 00	0	1	0	0	
17. 00	SUBPROVI DER - I RF	0. 00	0	0	0	0	17. 00
18.00	SUBPROVI DER	0.00					18.00
19. 00 20. 00	SKILLED NURSING FACILITY NURSING FACILITY	0. 00 0. 00					19. 00 20. 00
21. 00	OTHER LONG TERM CARE	0.00				0	
21.00	HOME HEALTH AGENCY	0.00				U	21.00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)	0.00					23. 00
24. 00	HOSPICE	0.00					24. 00
24. 10	HOSPICE (non-distinct part)	0.00					24. 10
25. 00	CMHC - CMHC	0. 00					25. 00
25. 10	CMHC - CORF	0. 00					25. 10
26. 00	RURAL HEALTH CLINIC	0. 00					26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0. 00					26. 25
27.00	Total (sum of lines 14-26)	0. 00					27. 00
28.00	Observation Bed Days						28. 00
29.00	Ambul ance Tri ps						29. 00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32. 00	Labor & delivery days (see instructions)						32. 00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
33. 00	LTCH non-covered days			0			33. 00
33. 01	LTCH site neutral days and discharges			0			33. 01
34. 00	Temporary Expansion COVID-19 PHE Acute Care				l		34.00

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet S-3 | From 01/01/2022 | Part II | To 12/31/2022 | Date/Time Prepared: | From 20020 | Prepared: | Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0165

					'	o 12/31/2022	Date/lime Pre 5/29/2023 9:5	
		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)		Average Hourly Wage (col. 4 ÷ col. 5)	
		1. 00	2.00	3.00	4.00	5. 00	6. 00	
	PART II - WAGE DATA							
1. 00	SALARIES Total salaries (see	200. 00	52, 907, 558	0	52, 907, 558	1, 265, 034. 74	41. 82	1.00
2. 00	instructions) Non-physician anesthetist Part		0	0	C	0.00	0. 00	2. 00
3.00	A Non-physician anesthetist Part		0	0	C	0.00	0. 00	3.00
4. 00	B Physician-Part A -		0	0	C	0.00	0. 00	4. 00
4. 01	Administrative Physicians - Part A - Teaching		0	0	C	0.00	0.00	4. 01
5.00	Physician and Non Physician-Part B		0	0	C	0.00	l .	
6. 00	Non-physician-Part B for hospital-based RHC and FQHC services		0	О	C	0.00	0.00	6. 00
7. 00	Interns & residents (in an	21. 00	0	0	С	0.00	0. 00	7. 00
7. 01	approved program) Contracted interns and residents (in an approved programs)		0	0	C	0.00	0.00	7. 01
8.00	Home office and/or related organization personnel		8, 565, 438	0	8, 565, 438	232, 938. 74	36. 77	8. 00
9. 00 10. 00	SNF Excluded area salaries (see	44. 00	0 2, 345, 694	0		0. 00 49, 831. 47	l .	
10.00	instructions)		2, 345, 694	0	2, 345, 694	49, 831. 47	47.07	10.00
11. 00	OTHER WAGES & RELATED COSTS Contract labor: Direct Patient		9, 257, 886	0	9, 257, 886	66, 756. 75	138. 68	11. 00
12. 00	Care Contract labor: Top level management and other managemen	t	0	О	C	0.00	0.00	12. 00
13. 00	and administrative services Contract Labor: Physician-Part A - Administrative		66, 133	0	66, 133	294. 15	224. 83	13. 00
14. 00	Home office and/or related organization salaries and wage-related costs		0	О	С	0.00	0.00	14. 00
14. 01	Home office salaries		10, 120, 722	l			l .	14. 01
14. 02 15. 00	Related organization salaries Home office: Physician Part A Administrative	-	0	0		0. 00 0. 00		14. 02 15. 00
16. 00	Home office and Contract Physicians Part A - Teaching		0	0	C	0.00	0. 00	16. 00
16. 01	Home office Physicians Part A	-	0	0	С	0.00	0. 00	16. 01
16. 02	Teaching Home office contract Physician Part A - Teaching	5	0	0	C	0.00	0. 00	16. 02
17. 00	WAGE-RELATED COSTS Wage-related costs (core) (see		9, 563, 859	0	9, 563, 859			17. 00
18. 00	instructions) Wage-related costs (other) (see	Э						18. 00
19. 00	instructions) Excluded areas		443, 692	i e				19. 00
	Non-physician anesthetist Part		0	0				20.00
21. 00	Non-physician anesthetist Part B	:	0	0				21.00
	Physician Part A - Administrative		0	_				22. 00
	Physician Part A - Teaching Physician Part B		0	0				22. 01 23. 00
24. 00	Wage-related costs (RHC/FQHC) Interns & residents (in an		0	0	1			24. 00 25. 00
25. 50 25. 51	approved program) Home office wage-related (core Related organization)	3, 093, 678	0				25. 50 25. 51
	wage-related (core)		0	0				
25. 52	Home office: Physician Part A Administrative - wage-related (core)	-	0					25. 52
25. 53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	C			25. 53

Provider CCN: 15-0165

| Peri od: | Worksheet S-3 | From 01/01/2022 | Part II | To 12/31/2022 | Date/Time Prepared:

					''	0 12/31/2022	5/29/2023 9:5	
		Wkst. A Line	Amount	Recl assi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from Wkst.	(col.2 ± col.	Salaries in	col . 5)	
				A-6)	3)	col. 4		
		1.00	2.00	3. 00	4. 00	5. 00	6. 00	
	OVERHEAD COSTS - DIRECT SALARIE							
26. 00	Employee Benefits Department	4. 00	47, 607	0	47, 607	3, 623. 77		
27. 00	Administrative & General	5. 00	11, 082, 324	0	11, 082, 324	70, 881. 99		
28. 00	Administrative & General under		625, 827	0	625, 827	5, 251. 25	119. 18	28. 00
	contract (see inst.)							
29. 00	Maintenance & Repairs	6. 00	855, 983	0	855, 983	·		29. 00
30. 00	Operation of Plant	7. 00	0	0	0	0. 00		
31. 00	Laundry & Linen Service	8. 00	0	0	0	0. 00		
32.00	Housekeepi ng	9. 00	1, 169, 194	0	1, 169, 194	59, 868. 24	19. 53	32.00
33. 00	Housekeeping under contract		0	0	0	0. 00	0. 00	33.00
	(see instructions)							
34.00	Di etary	10. 00	1, 052, 060	-543, 313	508, 747	22, 456. 00	22. 66	34.00
35. 00	Di etary under contract (see		0	0	0	0.00	0. 00	35.00
	instructions)							
36. 00	Cafeteri a	11. 00	0	543, 313	543, 313	23, 981. 73		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, 556, 844	0	2, 556, 844	54, 912. 44	46. 56	38.00
39. 00	Central Services and Supply	14. 00	268, 446	0	268, 446	10, 642. 36	25. 22	39.00
40.00	Pharmacy	15. 00	1, 822, 190	0	1, 822, 190	35, 049. 10	51. 99	40.00
41.00	Medical Records & Medical	16. 00	568, 411	0	568, 411	14, 266. 48	39. 84	41.00
	Records Library							
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	0.00	43.00

					''	0 12/31/2022	5/29/2023 9:5	
		Worksheet A	Amount	Recl assi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from	$(col.2 \pm col.$	Salaries in	col . 5)	
				Worksheet A-6)	3)	col. 4		
		1. 00	2. 00	3.00	4. 00	5. 00	6. 00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see instructions))	44, 967, 947	0	44, 967, 947	1, 037, 347. 25	43. 35	1.00
2.00	Excluded area salaries (see		2, 345, 694	. 0	2, 345, 694	49, 831. 47	47. 07	2.00
	instructions)							
3.00	Subtotal salaries (line 1 minus	5	42, 622, 253	0	42, 622, 253	987, 515. 78	43. 16	3.00
	line 2)							
4.00	Subtotal other wages & related		19, 444, 741	0	19, 444, 741	342, 285. 90	56. 81	4.00
	costs (see inst.)							
5. 00	Subtotal wage-related costs		12, 657, 537	0	12, 657, 537	0.00	29. 70	5. 00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		74, 724, 531	ł	74, 724, 531			6. 00
7.00	Total overhead cost (see		20, 048, 886	0	20, 048, 886	326, 065. 79	61. 49	7. 00
	instructions)							

Health Financial Systems	FRANCISCAN HEALTH MUNSTER	In Lieu of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 15-0165	Peri od: Worksheet S-3
		From 01/01/2022 Part IV
		To 12/21/2022 Data/Time Propared:

	To 12/31/20	022 Date/Time Pre 5/29/2023 9:5	
		Amount	
		Reported	
		1.00	
	PART IV - WAGE RELATED COSTS	•	
	Part A - Core List		1
	RETI REMENT COST		1
1.00	401K Employer Contributions	934, 676	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3. 00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	1, 181, 511	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal /Accounting/Management Fees-Pension Plan	0	6. 00
7.00	Employee Managed Care Program Administration Fees	0	7. 00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8. 00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8. 01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	3, 996, 012	8. 02
8.03	Health Insurance (Purchased)	0	8. 03
9.00	Prescription Drug Plan	0	9. 00
10.00	Dental, Hearing and Vision Plan	156, 172	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	12, 672	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12. 00
13.00	Disability Insurance (If employee is owner or beneficiary)	251, 406	13. 00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14. 00
15. 00	'Workers' Compensation Insurance	735, 947	15. 00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16. 00
	Noncumul ati ve porti on)		
	TAXES		
17. 00	FICA-Employers Portion Only	2, 739, 155	17. 00
18. 00	Medicare Taxes - Employers Portion Only	0	
19. 00	Unempl oyment Insurance	0	
20. 00	State or Federal Unemployment Taxes	0	20.00
	OTHER		1
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (s	see 0	21. 00
	instructions))		
22. 00	Day Care Cost and Allowances	0	
23. 00	Tuition Reimbursement	0	
24. 00	Total Wage Related cost (Sum of lines 1 -23)	10, 007, 551	24. 00
	Part B - Other than Core Related Cost		
25. 00	OTHER WAGE RELATED COSTS (SPECIFY)		25. 00

Health Financial Systems	FRANCISCAN HEALTH MUNSTER	In Lieu of Form CMS-2552-10	0
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provider CCN: 15-0165	Peri od: Worksheet S-3 From 01/01/2022 Part V To 12/31/2022 Date/Time Prepared:	_

		To 12/31/2022	Date/Time Prep 5/29/2023 9:5	
	Cost Center Description	Contract Labor		ı allı
	oost center bescriptron	1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost	11.00	2.00	
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	9, 257, 886	10, 007, 551	1. 00
2.00	Hospi tal	9, 257, 886	10, 007, 551	2.00
3.00	SUBPROVI DER - I PF	0	0	3.00
4.00	SUBPROVI DER - I RF	0	0	4.00
5.00	Subprovider - (Other)	0	0	5. 00
6.00	Swing Beds - SNF	0	0	6. 00
7.00	Swing Beds - NF	0	0	7. 00
8.00	SKILLED NURSING FACILITY	0	0	8. 00
9.00	NURSING FACILITY	0	0	9. 00
10.00	OTHER LONG TERM CARE I			10.00
11. 00	Hospi tal -Based HHA	0	0	11. 00
12.00	AMBULATORY SURGICAL CENTER (D. P.) I	0	0	12.00
13.00	Hospi tal -Based Hospi ce	0	0	13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14.00
15. 00	Hospital-Based Health Clinic FQHC	0	0	15. 00
16. 00	Hospi tal -Based-CMHC	0	0	16. 00
16. 10	Hospi tal -Based-CMHC 10	0	0	16. 10
17. 00	RENAL DIALYSIS I	0	0	17. 00
18. 00	Other	0	0	18. 00

USPI	n Financial Systems FRANCISCAN HEALTH MUI TAL UNCOMPENSATED AND INDIGENT CARE DATA Pro		N: 15-0165	Peri od:	eu of Form CMS-2 Worksheet S-1	
	THE SHOOM ENGINES THE THEFTEEN STATE STATE	, , , , , , , , , , , , , , , , , , ,		From 01/01/2022		
				To 12/31/2022	Date/Time Pre 5/29/2023 9:5	pared
					372472023 4.3	ı aiii
					1. 00	
	Uncompensated and indigent care cost computation			2)		
00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divide	ed by lir	ie 202 column	1 8)	0. 219485	1.
00	Medicaid (see instructions for each line) Net revenue from Medicaid				15 571 502	2.
00	Did you receive DSH or supplemental payments from Medicaid?				15, 571, 503 N	2. 3.
00	If line 3 is yes, does line 2 include all DSH and/or supplemental	navments	from Medica	ni d2	i iv	4.
00	If line 4 is no, then enter DSH and/or supplemental payments from				0	5.
00	Medi cai d charges				90, 978, 024	6.
00	Medicaid cost (line 1 times line 6)				19, 968, 312	7.
00	Difference between net revenue and costs for Medicaid program (lir	ne 7 minu	s sum of lir	nes 2 and 5; if	4, 396, 809	8.
	zero then enter zero)					
	Children's Health Insurance Program (CHIP) (see instructions for e	each line)			
00 . 00	Net revenue from stand-alone CHIP Stand-alone CHIP charges				0	9. 10.
. 00					0	10.
. 00	` ,	ne 11 mir	us line 9·i	f < zero then	0	12.
00	enter zero)	110 11 11111	143 11116 7, 1	1 × 2010 then		
	Other state or local government indigent care program (see instruc	ctions fo	r each line)			
. 00					0	13.
. 00		rogram (N	lot included	in lines 6 or 10	1	14.
. 00					0	15
. 00		ent care	program (lir	ne 15 minus line	0	16.
	13; if < zero then enter zero) Grants donations and total unreimbursed cost for Medicaid CHLP a	and state				
	Grants, donations and total unreimbursed cost for Medicaid, CHIP a	and state				
7. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP a instructions for each line)		/local indig			
	Grants, donations and total unreimbursed cost for Medicaid, CHIP a instructions for each line) Private grants, donations, or endowment income restricted to fundi Government grants, appropriations or transfers for support of hosp	ing chari pital ope	/local indig ty care erations	gent care progran	ms (see	17.
3. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP a instructions for each line) Private grants, donations, or endowment income restricted to fundi Government grants, appropriations or transfers for support of hosp Total unreimbursed cost for Medicaid, CHIP and state and local in	ing chari pital ope	/local indig ty care erations	gent care progran	ms (see	17. 18.
7. 00 3. 00 9. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP a instructions for each line) Private grants, donations, or endowment income restricted to fundi Government grants, appropriations or transfers for support of hosp	ing chari pital ope	/local indig ty care erations	gent care progran	0 0 0 3, 4,396,809	17. 18. 19.
3. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP a instructions for each line) Private grants, donations, or endowment income restricted to fundi Government grants, appropriations or transfers for support of hosp Total unreimbursed cost for Medicaid, CHIP and state and local in	ing chari pital ope	/local indig ty care rations are programs Uninsured patients	(sum of lines to patients	0 0 3, 4,396,809 Total (col. 1 + col. 2)	17. 18.
3. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP a instructions for each line) Private grants, donations, or endowment income restricted to fundi Government grants, appropriations or transfers for support of hosp Total unreimbursed cost for Medicaid, CHIP and state and local in 12 and 16)	ing chari pital ope	/local indic ty care erations care programs	gent care program s (sum of lines 8	0 0 0 3, 4,396,809	17. 18.
. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP a instructions for each line) Private grants, donations, or endowment income restricted to fundi Government grants, appropriations or transfers for support of hosp Total unreimbursed cost for Medicaid, CHIP and state and local ir 12 and 16) Uncompensated Care (see instructions for each line)	ing chari pital ope ndigent c	ty care rations are programs Uninsured patients 1.00	s (sum of lines a line lines a line line line line line line line line	Total (col. 1 + col. 2) 3.00	17. 18. 19.
8. 00 9. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP a instructions for each line) Private grants, donations, or endowment income restricted to fundi Government grants, appropriations or transfers for support of host Total unreimbursed cost for Medicaid, CHIP and state and local ir 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facili	ing chari pital ope ndigent c	/local indig ty care rations are programs Uninsured patients	(sum of lines to line	Total (col. 1 + col. 2) 3.00	17. 18. 19.
3. 00 9. 00 0. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP a instructions for each line) Private grants, donations, or endowment income restricted to fundi Government grants, appropriations or transfers for support of hosp Total unreimbursed cost for Medicaid, CHIP and state and local in 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facili instructions) Cost of patients approved for charity care and uninsured discounts	ing chari pital ope ndigent c	ty care rations are programs Uninsured patients 1.00	Insured patients 2.00	Total (col. 1 + col. 2) 3.00	17. 18. 19.
0.00	Grants, donations and total unreimbursed cost for Medicaid, CHIP a instructions for each line) Private grants, donations, or endowment income restricted to fundi Government grants, appropriations or transfers for support of hosp Total unreimbursed cost for Medicaid, CHIP and state and local in 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facili instructions) Cost of patients approved for charity care and uninsured discounts instructions)	ing chari pital ope ndigent c ity (see s (see	/local indigity care erations are programs Uninsured patients 1.00 9,488,82	Insured patients 2.00 21 2,379,716 2,379,716	Total (col. 1 + col. 2) 3.00	17. 18. 19. 20.
0.00	Grants, donations and total unreimbursed cost for Medicaid, CHIP a instructions for each line) Private grants, donations, or endowment income restricted to fundi Government grants, appropriations or transfers for support of hosp Total unreimbursed cost for Medicaid, CHIP and state and local in 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facili instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written off	ing chari pital ope ndigent c ity (see s (see	/local indigity care erations are programs Uninsured patients 1.00 9,488,82	Insured patients 2.00	Total (col. 1 + col. 2) 3.00	17. 18. 19. 20. 21.
0.00	Grants, donations and total unreimbursed cost for Medicaid, CHIP a instructions for each line) Private grants, donations, or endowment income restricted to fundi Government grants, appropriations or transfers for support of hosp Total unreimbursed cost for Medicaid, CHIP and state and local in 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facili instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written off charity care	ing chari pital ope ndigent c ity (see s (see	/local indigity care erations are programs Uninsured patients 1.00 9,488,82	Insured patients 2.00 21 2,379,716 0 0	Total (col. 1 + col. 2) 3. 00 11, 868, 537 4, 462, 370	17. 18. 19. 20. 21.
0. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP a instructions for each line) Private grants, donations, or endowment income restricted to fundi Government grants, appropriations or transfers for support of hosp Total unreimbursed cost for Medicaid, CHIP and state and local in 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facili instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written off charity care	ing chari pital ope ndigent c ity (see s (see	/local indig ty care trations hare programs Uninsured patients 1.00 9,488,82 2,082,65	Insured patients 2.00 21 2,379,716 0 0	Total (col. 1 + col. 2) 3.00 11,868,537 4,462,370	17. 18. 19. 20. 21.
. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP a instructions for each line) Private grants, donations, or endowment income restricted to fundi Government grants, appropriations or transfers for support of hosp Total unreimbursed cost for Medicaid, CHIP and state and local in 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facili instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written off charity care Cost of charity care (line 21 minus line 22)	ing chari pital ope ndigent c ity (see s (see f as	ty care trations are programs Uninsured patients 1.00 9,488,82 2,082,68	Insured patients 2.00 21 2,379,716 0 0 2,379,716	Total (col. 1 + col. 2) 3. 00 11, 868, 537 4, 462, 370	17. 18. 19. 20. 21. 22. 23.
. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP a instructions for each line) Private grants, donations, or endowment income restricted to fundi Government grants, appropriations or transfers for support of hosp Total unreimbursed cost for Medicaid, CHIP and state and local in 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facili instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written off charity care Cost of charity care (line 21 minus line 22)	ing chari pital ope ndigent c ity (see s (see f as	ty care trations are programs Uninsured patients 1.00 9,488,82 2,082,68	Insured patients 2.00 21 2,379,716 0 0 2,379,716	Total (col. 1 + col. 2) 3.00 11,868,537 4,462,370 0 4,462,370	17. 18. 19. 20. 21.
0.00	Grants, donations and total unreimbursed cost for Medicaid, CHIP a instructions for each line) Private grants, donations, or endowment income restricted to fundi Government grants, appropriations or transfers for support of hosp Total unreimbursed cost for Medicaid, CHIP and state and local in 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facili instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written off charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient of imposed on patients covered by Medicaid or other indigent care pro-	ing chari pital ope ndigent c ity (see s (see f as days beyou	ty care trations have programs Uninsured patients 1.00 9,488,82 2,082,65	Insured patients 2.00 21 2,379,716 0 0 2,379,716 0 0 54 2,379,716 0 0 0 54 2,379,716	Total (col. 1 + col. 2) 3. 00 11, 868, 537 4, 462, 370 0 4, 462, 370 1. 00 N	17. 18. 19. 20. 21. 22.
3. 00 2. 00 3. 00 3. 00 3. 00 5. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP a instructions for each line) Private grants, donations, or endowment income restricted to fundi Government grants, appropriations or transfers for support of hosp Total unreimbursed cost for Medicaid, CHIP and state and local in 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facili instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written off charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient care prolifine 24 is yes, enter the charges for patient days beyond the ilimit	ing chari pital ope ndigent c ity (see s (see f as days beyo ogram? indigent	ty care trations have programs Uninsured patients 1.00 9,488,82 2,082,65	Insured patients 2.00 21 2,379,716 0 0 2,379,716 0 0 54 2,379,716 0 0 0 54 2,379,716	Total (col. 1 + col. 2) 3. 00 11, 868, 537 4, 462, 370 0 4, 462, 370 1. 00 N	17. 18. 19. 20. 21. 22. 23. 24. 25.
3. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP a instructions for each line) Private grants, donations, or endowment income restricted to fundi Government grants, appropriations or transfers for support of hosp Total unreimbursed cost for Medicaid, CHIP and state and local in 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facili instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written off charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient of imposed on patients covered by Medicaid or other indigent care prolifine 24 is yes, enter the charges for patient days beyond the ilimit Total bad debt expense for the entire hospital complex (see instructions)	ing chari pital ope ndigent c ity (see s (see f as days beyo ogram? indigent uctions)	ty care erations are programs Uninsured patients 1.00 9,488,82 2,082,65 2,082,65 and a length care program	Insured patients 2.00 21 2,379,716 0 0 2,379,716 0 0 54 2,379,716 0 0 0 54 2,379,716	Total (col. 1 + col. 2) 3.00 11,868,537 4,462,370 0,4,462,370 1.00 N	17. 18. 19. 20. 21. 22. 23. 24. 25.
3. 00 3. 00 3. 00 3. 00 4. 00 5. 00 7. 00 7. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP a instructions for each line) Private grants, donations, or endowment income restricted to fundi Government grants, appropriations or transfers for support of hosp Total unreimbursed cost for Medicaid, CHIP and state and local in 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facili instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written off charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient of imposed on patients covered by Medicaid or other indigent care proceed in the composition of the charges for patient days beyond the ilimit Total bad debt expense for the entire hospital complex (see instrumedicare reimbursable bad debts for the entire hospital complex (see	ing chari pital ope ndigent c ity (see s (see f as days beyo ogram? indigent uctions) see instr	ty care trations are programs Uninsured patients 1.00 9,488,82 2,082,68 2,082,68 and a Length care program	Insured patients 2.00 21 2,379,716 0 0 2,379,716 0 0 54 2,379,716 0 0 0 54 2,379,716	Total (col. 1 + col. 2) 3.00 11,868,537 4,462,370 0,4,462,370 1.00 N	17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 27.
3. 00 3. 00 3. 00 3. 00 3. 00 4. 00 5. 00 7. 00 7. 00 7. 00 7. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP a instructions for each line) Private grants, donations, or endowment income restricted to fundi Government grants, appropriations or transfers for support of hosp Total unreimbursed cost for Medicaid, CHIP and state and local in 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facili instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written off charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient of imposed on patients covered by Medicaid or other indigent care proof of the composition of the charges for patient days beyond the ilimit Total bad debt expense for the entire hospital complex (see instrumedicare reimbursable bad debts for the entire hospital complex (see Non-Medicare bad debt expense (see instructions)	ing chari pital ope ndigent c ity (see s (see f as days beyo ogram? indigent uctions) see instr instruct	ty care trations are programs Uninsured patients 1.00 9,488,82 2,082,65 2,082,65 and a length care program	Insured patients 2.00 21 2,379,716 0 0 2,379,716 of stay limit of stay lim	Total (col. 1 + col. 2) 3.00 11, 868, 537 4, 462, 370 0 4, 462, 370 1.00 N 1, 760, 272 320, 150 492, 538 1, 267, 734	17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 27. 28.
33. 00 3. 00 3. 00 3. 00 3. 00 4. 00 5. 00 7. 01 3. 00 7. 01 3. 00	Grants, donations and total unreimbursed cost for Medicaid, CHIP a instructions for each line) Private grants, donations, or endowment income restricted to fundi Government grants, appropriations or transfers for support of hosp Total unreimbursed cost for Medicaid, CHIP and state and local in 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facili instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written off charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient of the imposed on patients covered by Medicaid or other indigent care proceed in the complex of the entire hospital complex (see instrumedicare reimbursable 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 expense	ing chari pital ope ndigent c ity (see s (see f as days beyo ogram? indigent uctions) see instr instruct	ty care trations are programs Uninsured patients 1.00 9,488,82 2,082,65 2,082,65 and a length care program	Insured patients 2.00 21 2,379,716 0 0 2,379,716 of stay limit of stay lim	Total (col. 1 + col. 2) 3.00 11,868,537 4,462,370 0,4,462,370 1.00 N 1,760,272 320,150 492,538 1,267,734 450,637	17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 27. 28. 29.
33. 00 3. 00 4. 00 5. 00 6. 00 7. 00 7. 00 8. 00 8	Grants, donations and total unreimbursed cost for Medicaid, CHIP a instructions for each line) Private grants, donations, or endowment income restricted to fundi Government grants, appropriations or transfers for support of hosp Total unreimbursed cost for Medicaid, CHIP and state and local in 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facili instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written off charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient of the imposed on patients covered by Medicaid or other indigent care proof of the charges for patient days beyond the ilimit Total bad debt expense for the entire hospital complex (see instrumedicare reimbursable 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 expense	days beyongram? indigent days beyongram? indigent uctions) see instrinstruct	ty care trations are programs Uninsured patients 1.00 9,488,82 2,082,65 2,082,65 and a length care program	Insured patients 2.00 21 2,379,716 0 0 2,379,716 of stay limit of stay lim	Total (col. 1 + col. 2) 3.00 11, 868, 537 4, 462, 370 0 4, 462, 370 1.00 N 1, 760, 272 320, 150 492, 538 1, 267, 734	20 21 22 23 24 25 26 27 27 28 29 30

	FINANCIAL SYSTEMS	FRANCI SCAN HEAL		CN. 1E 01/E		Westebeet A	2332-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der Co		Period: From 01/01/2022 Fo 12/31/2022	Worksheet A Date/Time Pre	nared:
					12/31/2022	5/29/2023 9:5	
	Cost Center Description	Sal ari es	Other		Recl assi fi cati	Recl assi fi ed	
				+ col. 2)	ons (See A-6)	Trial Balance	
						(col. 3 +-	
		1.00	2.00	2.00	4.00	col . 4)	
	GENERAL SERVICE COST CENTERS	1.00	2. 00	3. 00	4. 00	5. 00	
1.00	00100 CAP REL COSTS-BLDG & FIXT		814, 373	814, 37	5, 609, 176	6, 423, 549	1.00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP		014, 379	014, 37	0,007,170	0, 423, 347	2. 00
3. 00	00300 OTHER CAP REL COSTS		0			0	3. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	47, 607	9, 879, 525	9, 927, 13	2, 000, 163	11, 927, 295	4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	11, 082, 324	20, 719, 040	31, 801, 36	4 -7, 683, 778	24, 117, 586	5. 00
6.00	00600 MAINTENANCE & REPAIRS	855, 983	10, 782, 840	11, 638, 82	3 -38, 709	11, 600, 114	6. 00
7.00	00700 OPERATION OF PLANT	0	0		0	0	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	247, 599		1	247, 599	8. 00
9.00	00900 HOUSEKEEPI NG	1, 169, 194	293, 698			1, 461, 778	9. 00
10.00	01000 DI ETARY	1, 052, 060	754, 697	1, 806, 75		852, 675	
11.00	01100 CAFETERI A	0	0		933, 060		11.00
12. 00 13. 00	01200 MAI NTENANCE OF PERSONNEL 01300 NURSI NG ADMI NI STRATI ON	2, 556, 844	747, 190	3, 304, 03	5 4 -1, 112	0 3, 302, 922	12. 00 13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	268, 446	493, 598			711, 979	14. 00
15. 00	01500 PHARMACY	1, 822, 190	3, 842, 703			1, 936, 800	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	568, 411	49, 402		1 ' '	619, 658	16. 00
17.00	01700 SOCIAL SERVICE	0	0		o o	0	17. 00
18.00	01850 OTHER GEN SERV	0	0		o o	0	18. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS	0	0		0	0	19. 00
20. 00	02000 NURSI NG PROGRAM	0	0	(0	0	20.00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	0	0		0	0	21. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	0	0	(0	0	22. 00
23. 00	02301 PARAMED ED PRGM INPATIENT ROUTINE SERVICE COST CENTERS	0	0		0	0	23. 00
20.00	03000 ADULTS & PEDIATRICS	12, 073, 926	5, 479, 185	17, 553, 11	-721, 122	16, 831, 989	30.00
30. 00 31. 00	03100 INTENSIVE CARE UNIT	1, 923, 053	921, 333			2, 526, 781	
32. 00	03200 CORONARY CARE UNIT	1, 723, 033	721, 333 N	2,044,30	3 -317,003	2, 320, 781	32.00
33. 00	03300 BURN INTENSIVE CARE UNIT		0			0	33.00
34. 00	03400 SURGICAL INTENSIVE CARE UNIT	l ol	0			0	34.00
40.00	04000 SUBPROVI DER - I PF	O	0		o o	0	40.00
41.00	04100 SUBPROVI DER - I RF	o	0		o o	0	41. 00
43.00	04300 NURSERY	0	0	(0	0	43. 00
44. 00	04400 SKILLED NURSING FACILITY	0	0	(0	0	44. 00
45. 00	04500 NURSING FACILITY	0	0	1	0	0	45. 00
46. 00	04600 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS	0	0) ()	0	46. 00
50. 00	05000 OPERATING ROOM	4, 064, 695	14, 748, 393	18, 813, 08	-10, 444, 909	8, 368, 179	50.00
51. 00	05100 RECOVERY ROOM	788, 680	194, 379			935, 585	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	52. 00
53.00	05300 ANESTHESI OLOGY	36, 132	3, 464, 588	3, 500, 720	-182, 007	3, 318, 713	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 624, 134	1, 953, 190	3, 577, 32	-608, 580	2, 968, 744	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0		0	0	55. 00
56. 00	05600 RADI OI SOTOPE	0	0	(0	0	56. 00
57. 00	05700 CT SCAN	505, 080	598, 390			966, 042	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	882, 531	628, 619			1, 214, 696	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	1, 754, 889	3, 051, 785				1
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	0	7, 537, 150	7, 537, 150	565, 570 0	6, 971, 580 0	60. 00 60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0			0	61.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0			0	62.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.		0		ol ől	Ö	63.00
64. 00	06400 I NTRAVENOUS THERAPY	0	0		ol ol	0	64. 00
65. 00	06500 RESPI RATORY THERAPY	1, 207, 549	931, 091	2, 138, 640	-165, 216	1, 973, 424	65. 00
66. 00	06600 PHYSI CAL THERAPY	322, 195	7, 461	329, 65		330, 434	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	241, 633	40, 548		1	281, 438	1
68. 00	06800 SPEECH PATHOLOGY	115, 276	76			115, 562	68. 00
69. 00	06900 ELECTROCARDI OLOGY	529, 117	167, 451	696, 568		670, 577	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	397, 951	385, 519	783, 470		756, 829	70.00
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0]	9, 318, 006	9, 318, 006	71. 00 72. 00
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS		0		6, 270, 410 4, 542, 229	6, 270, 410 4, 542, 229	73.00
74.00	07400 RENAL DIALYSIS		0) 4, 542, 229	4, 542, 229	74.00
75. 00	07500 ASC (NON-DISTINCT PART)	ا	0			0	75. 00
76. 00	03950 OTHER ANCILL SRVC	l ől	0		ol ől	Ö	76. 00
76. 01	03951 CARDI AC AND PULMONARY REHAB	234, 130	11, 356	245, 48	-1, 053	244, 433	76. 01
76. 02	03952 WOUND CARE	0	0	(o o	0	76. 02
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	O	0	(0	0	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 CLI NI C	0	0	1	이	0	90. 00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der CC		Peri od:	Worksheet A	
				From 01/01/2022 To 12/31/2022	Date/Time Pre	nared:
				10 12/31/2022	5/29/2023 9:5	1 am
Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati		
			+ col . 2)	ons (See A-6)		
			,		(col. 3 +-	
					col. 4)	
	1.00	2. 00	3.00	4. 00	5. 00	
90. 01 09001 CLI NI C	1, 559, 628	875, 016		4 -76, 759	2, 357, 885	90. 01
90. 02 09002 CLI NI C	192, 511	240, 682				
91. 00 09100 EMERGENCY	2, 685, 695	4, 221, 540			6, 405, 184	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	_, _, _,	., == .,	2,,		,,	92.00
OTHER REIMBURSABLE COST CENTERS						72.00
94. 00 09400 HOME PROGRAM DI ALYSI S	0	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	Ö	97. 00
98. 00 09850 OTHER REI MBURSE		0			0	98. 00
99. 00 09900 CMHC		0			0	•
99. 10 09910 CORF		0			0	ı
100.00 10000 1&R SERVICES-NOT APPRVD PRGM		0			_	100.00
101. 00 10100 HOME HEALTH AGENCY		0				100.00
102. 00 10200 OPI OI D TREATMENT PROGRAM	0	0		0		101.00
SPECIAL PURPOSE COST CENTERS	UU	U	'	<u>J</u>	U	102.00
105. 00 10500 KI DNEY ACQUI SI TI ON		0		0 (0	0	105. 00
106. 00 10600 HEART ACQUISITION		0				106. 00
107. 00 10700 LI VER ACQUI SI TI ON	0	0				107. 00
108. 00 10800 LUNG ACQUISITION	0	0				107.00
109. 00 10900 PANCREAS ACQUISITION	0	0		0		109.00
110. 00 11000 PANCKEAS ACQUISITION 110. 00 11000 INTESTINAL ACQUISITION	0	0		0		1109.00
	0	0		0		l
111. 00 11100 SLET ACQUI SI TI ON	U	00.070	00.07	0 00 070		111.00
113. 00 11300 NTEREST EXPENSE		-20, 073	-20, 07	3 20, 073		113. 00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF	0	0	'	0		114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	'	0		115. 00
116. 00 11600 HOSPI CE	0	0		0		116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	50, 561, 864	94, 062, 344	144, 624, 20	8 0	144, 624, 208	J118. 00
NONREI MBURSABLE COST CENTERS	40.000	oo-		-	0, 405	
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	40, 288	55, 907	96, 19		96, 195	
191. 00 19100 RESEARCH	20, 325	0	20, 32		20, 325	
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	1, 734, 895	253, 816			1, 988, 711	
192. 01 19201 CENTER OF HOPE	2, 714	48				192. 01
192. 02 19202 OTHER FA FACILITIES NRCC	465, 690	87, 311	553, 00		553, 001	
193. 00 19300 NONPALD WORKERS	0	0		0		193. 00
194.00 07950 OTHER NRCC	81, 782	-1	81, 78		81, 781	
200.00 TOTAL (SUM OF LINES 118 through 199)	52, 907, 558	94, 459, 425	147, 366, 98	3 0	147, 366, 983	200. 00

Heal th	Financial Systems	FRANCI SCAN HE	ALTH MUNSTER		In Lieu	of Form CMS-2552-1
RECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE	OF EXPENSES	Provider CCN:	15-0165		Worksheet A
					From 01/01/2022 To 12/31/2022	Date/Time Prepared:
						5/29/2023 9:51 am
	Cost Center Description	Adjustments	Net Expenses			
		(See A-8) 6.00	For Allocation 7.00			
	GENERAL SERVICE COST CENTERS	0.00	7.00			
1.00	00100 CAP REL COSTS-BLDG & FIXT	131, 848	6, 555, 397			1. 0
2.00	00200 CAP REL COSTS-MVBLE EQUIP	0	0			2. 0
3.00	00300 OTHER CAP REL COSTS	0 00	0			3. 0
4. 00 5. 00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	691, 082 -7, 610, 621				4. 0
6. 00	00600 MAI NTENANCE & REPAI RS	-7,010,021				6. 0
7. 00	00700 OPERATION OF PLANT	0				7. 0
8.00	00800 LAUNDRY & LINEN SERVICE	0	1			8. 0
9. 00	00900 HOUSEKEEPI NG	-57				9. 0
10.00	01000 DI ETARY	-339, 609				10.0
11.00	01100 CAFETERI A	0	933, 060			11.0
12.00	01200 MAINTENANCE OF PERSONNEL 01300 NURSING ADMINISTRATION	-3, 537	3, 299, 385			12. 0
	01400 CENTRAL SERVICES & SUPPLY	-3, 537				14. 0
	01500 PHARMACY	184, 744				15. 0
16. 00	01600 MEDICAL RECORDS & LIBRARY	889, 822	1			16. 0
17. 00	01700 SOCIAL SERVICE	0	0			17. 0
	01850 OTHER GEN SERV	0	0			18. 0
19.00	01900 NONPHYSI CLAN ANESTHETI STS	0	0			19. 0
20.00	02000 NURSING PROGRAM 02100 I&R SERVICES-SALARY & FRINGES APPRVD		0			20.0
	02200 I &R SERVI CES-OTHER PRGM COSTS APPRVD		-			22. 0
	02301 PARAMED ED PRGM	Ö				23. 0
	INPATIENT ROUTINE SERVICE COST CENTERS		· · · · · · · · · · · · · · · · · · ·			
30.00	03000 ADULTS & PEDI ATRI CS	-1, 956	16, 830, 033			30. 0
31. 00	03100 INTENSIVE CARE UNIT	-8, 832	1			31. 0
32.00	03200 CORONARY CARE UNIT	0				32. 0
33. 00 34. 00	03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT	0	0			33.0
40. 00	04000 SUBPROVI DER – I PF		0			40. 0
41. 00	04100 SUBPROVI DER - I RF					41. 0
43.00	04300 NURSERY	0	0			43. 0
44. 00	04400 SKILLED NURSING FACILITY	0	O			44. 0
45. 00	04500 NURSING FACILITY	0	1			45. 0
46. 00	04600 OTHER LONG TERM CARE	0	0			46. 0
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	-1, 622, 515	6, 745, 664			50. 0
51. 00	05100 RECOVERY ROOM	-118	1			51. 0
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	1			52. 0
	05300 ANESTHESI OLOGY	0	-, ,			53. 0
54. 00	05400 RADI OLOGY-DI AGNOSTI C	-796	1			54. 0
55. 00 56. 00	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE	0	0			55. 0 56. 0
	05700 CT SCAN		966, 042			57. 0
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	-3, 914	1 ' 1			58. 0
59. 00	05900 CARDI AC CATHETERI ZATI ON	-82, 639	1			59. 0
60.00	06000 LABORATORY	-1, 510	6, 970, 070			60. 0
60. 01	06001 BLOOD LABORATORY	0	1			60. 0
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0			61. 0
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0			62. 0
63. 00 64. 00	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY					63. 0
65. 00	06500 RESPI RATORY THERAPY	-714	1, 972, 710			65. 0
	i i	, , ,				66. 0
67. 00	06700 OCCUPATI ONAL THERAPY	0	281, 438			67. 0
68. 00	06800 SPEECH PATHOLOGY	0	115, 562			68. 0
69. 00	06900 ELECTROCARDI OLOGY	-12, 499				69. 0
	07000 ELECTROENCEPHALOGRAPHY	-1, 049				70. 0
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	9, 318, 006			71. 0
	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS		6, 270, 410 4, 542, 229			72. 0 73. 0
74. 00	07400 RENAL DIALYSIS		4, 542, 229			74. 0
	07500 ASC (NON-DISTINCT PART)		l ő			75. 0
	03950 OTHER ANCILL SRVC	0	o			76. 0
	03951 CARDI AC AND PULMONARY REHAB	0				76. 0
	03952 WOUND CARE	0	1			76. 0
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0			77. 0
88. 00	OUTPATIENT SERVICE COST CENTERS	0	0			88. 0
00. 00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER					88. 0
89. 00 90. 00	1 1	Ö				
89. 00	09000 CLI NI C 09001 CLI NI C	-	O			90. 0 90. 0

 Health Financial
 Systems
 FRANCISCAN

 RECLASSIFICATION
 AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES
 FRANCISCAN HEALTH MUNSTER In Lieu of Form CMS-2552-10

Peri od: Worksheet A From 01/01/2022 Provider CCN: 15-0165

			To 12/31/2022 Date/Time Pr 5/29/2023 9:	epared:
Cost Center Description	Adjustments	Net Expenses	072772020 7.	
		For Allocation		
	6.00	7. 00		
91. 00 09100 EMERGENCY	-571, 393	5, 833, 791		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)				92. 00
OTHER REIMBURSABLE COST CENTERS				
94.00 09400 HOME PROGRAM DIALYSIS	0	0		94. 00
95. 00 09500 AMBULANCE SERVICES	0	0		95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		96. 00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0		97. 00
98. 00 09850 OTHER REI MBURSE	0	0		98. 00
99. 00 09900 CMHC	0	0		99. 00
99. 10 09910 CORF	0	0		99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0		100. 00
101.00 10100 HOME HEALTH AGENCY	0	O		101.00
102.00 10200 OPIOLD TREATMENT PROGRAM	0	o		102.00
SPECIAL PURPOSE COST CENTERS				
105.00 10500 KIDNEY ACQUISITION	0	0		105. 00
106.00 10600 HEART ACQUISITION	0	0		106. 00
107.00 10700 LIVER ACQUISITION	0	0		107. 00
108.00 10800 LUNG ACQUISITION	0	0		108. 00
109.00 10900 PANCREAS ACQUISITION	0	0		109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0		110. 00
111.00 11100 ISLET ACQUISITION	0	0		111. 00
113.00 11300 INTEREST EXPENSE	0	0		113. 00
114.00 11400 UTILIZATION REVIEW-SNF	0	0		114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0		115. 00
116. 00 11600 HOSPI CE	0	0		116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	-8, 366, 821	136, 257, 387		118. 00
NONREI MBURSABLE COST CENTERS				
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	96, 195		190. 00
191. 00 19100 RESEARCH	0	20, 325		191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	1, 988, 711		192. 00
192.01 19201 CENTER OF HOPE	0	2, 762		192. 01
192.02 19202 OTHER FA FACILITIES NRCC	0	553, 001		192. 02
193. 00 19300 NONPALD WORKERS	0	0		193. 00
194.00 07950 OTHER NRCC	0	81, 781		194. 00
200.00 TOTAL (SUM OF LINES 118 through 199)	-8, 366, 821	139, 000, 162		200. 00

Health Financial Systems RECLASSIFICATIONS Period: Worksheet A-6
From 01/01/2022
To 12/31/2022 Date/Time Prepared: 5/29/2023 9:51 am Provider CCN: 15-0165

					10 12	5/29/2023	
		Increases		0.11			
	Cost Center 2.00	Li ne # 3.00	Sal ary 4.00	0ther 5.00			
	A - I NSURANCE	3.00	4.00	3.00			
1.00	CAP REL COSTS-BLDG & FIXT	1. 00	0	66, 482			1. 00
2.00		0.00	0	0			2. 00
3. 00			0	<u>0</u> 66, 482			3. 00
	B - INTEREST EXPENSE		<u> </u>	00, 402			
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	5, 542, 694			1. 00
2.00	INTEREST EXPENSE	1 <u>13.</u> 00	•	20, 073			2. 00
	O C - DRUG EXPENSE		0	5, 562, 767			
1.00	DRUGS CHARGED TO PATIENTS	73. 00	O	4, 542, 229			1.00
2. 00		0.00	Ö	0			2. 00
3.00		0. 00	0	0			3. 00
4. 00 E. 00		0.00	0	0			4.00
5. 00 6. 00		0. 00 0. 00	0	0			5. 00 6. 00
7. 00		0.00	Ö	Ö			7. 00
8.00		0. 00	0	0			8. 00
9.00		0.00	0	0			9.00
10. 00 11. 00		0. 00 0. 00	0	0			10. 00 11. 00
12. 00		0.00	Ö	Ö			12. 00
13.00		0. 00	0	0			13. 00
14.00		0.00	0	0			14.00
15. 00 16. 00		0. 00 0. 00	0	0			15. 00 16. 00
17. 00		0.00	o	o			17. 00
18. 00		0.00	o_	0			18. 00
	0		0	4, 542, 229			
1. 00	D - MED SUPPLIES EXPENSE MEDICAL SUPPLIES CHARGED TO	71. 00	0	9, 318, 006			1.00
1.00	PATI ENTS	71.00		9, 310, 000			1.00
2.00		0.00	0	0			2. 00
3.00		0.00	0	0			3.00
4. 00 5. 00		0. 00 0. 00	0	0			4. 00 5. 00
6. 00		0.00	o	o			6. 00
7.00		0. 00	0	0			7. 00
8.00		0.00	0	0			8. 00
9. 00 10. 00		0. 00 0. 00	0	0			9. 00 10. 00
11. 00		0.00	ő	Ö			11. 00
12. 00		0.00	О	0			12. 00
13.00		0.00	0	0			13.00
14. 00 15. 00		0. 00 0. 00	0	0			14. 00 15. 00
16. 00		0.00	o	Ō			16. 00
17. 00		0.00	0	0			17. 00
18. 00 19. 00		0. 00 0. 00	0	0			18. 00 19. 00
20. 00		0.00	o	0			20.00
21. 00		0.00	O	0			21. 00
22. 00		0.00	0	0			22. 00
23. 00 24. 00		0. 00 0. 00	0	0			23. 00 24. 00
25. 00		0.00	o	0			25. 00
26. 00		0.00	О	0			26. 00
28. 00		0.00	0	0			28. 00
29. 00 30. 00		0. 00 0. 00	0	0			29. 00 30. 00
50.00				9, 318, 006			30.00
	E - IMPLANTABLE DEVICES						
1.00	I MPL. DEV. CHARGED TO	72. 00	0	6, 270, 410			1. 00
2. 00	PATI ENTS RADI OLOGY-DI AGNOSTI C	54.00	0	608			2. 00
3. 00	I S. SESSI BINGNOSTI	0.00	o	0			3. 00
4.00		0.00	ó	0			4. 00
5.00		0.00	0	0			5. 00
6. 00 7. 00		0. 00 0. 00	0	0			6. 00 7. 00
7.00				6, 271, 018			7.00
		'	-1				'

Health Financial Systems RECLASSIFICATIONS FRANCISCAN HEALTH MUNSTER In Lieu of Form CMS-2552-10 Provider CCN: 15-0165

					5/29/2023 9	:51 am
		Increases				
	Cost Center	Li ne #	Sal ary	Other		
	2. 00	3. 00	4.00	5. 00		
	F - CAFE					
1.00	CAFETERI A	1100	54 <u>3, 3</u> 13	389, 747		1. 00
	TOTALS		543, 313	389, 747		
	G - EMPLOYEE BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	2, 022, 925		1. 00
2.00	MAINTENANCE & REPAIRS	6. 00	0	1, 980		2. 00
3.00	HOUSEKEEPI NG	9. 00	0	2, 455		3. 00
4.00	NURSING ADMINISTRATION	13. 00	0	5, 649		4. 00
5.00	CENTRAL SERVICES & SUPPLY	14. 00	0	520		5. 00
6.00	PHARMACY	15. 00	0	3, 887		6. 00
7.00	MEDICAL RECORDS & LIBRARY	16. 00	0	1, 848		7. 00
8.00	ADULTS & PEDIATRICS	30.00	0	15, 051		8. 00
9.00	INTENSIVE CARE UNIT	31. 00	0	4, 021		9. 00
10.00	OPERATING ROOM	50.00	0	6, 544		10. 00
11.00	RECOVERY ROOM	51.00	0	101		11. 00
12.00	ANESTHESI OLOGY	53.00	0	103		12. 00
13.00	RADI OLOGY-DI AGNOSTI C	54.00	0	2, 649		13. 00
14.00	CT SCAN	57. 00	0	883		14.00
15.00	MAGNETIC RESONANCE IMAGING	58. 00	0	1, 134		15. 00
	(MRI)					
16. 00	CARDIAC CATHETERIZATION	59. 00	0	3, 738		16. 00
17. 00	PHYSI CAL THERAPY	66. 00	0	843		17. 00
18. 00	SPEECH PATHOLOGY	68. 00	0	264		18. 00
19.00	ELECTROCARDI OLOGY	69. 00	0	787		19. 00
20.00	CARDIAC AND PULMONARY REHAB	76. 01	0	448		20. 00
21. 00	CLINIC	90. 01	0	3, 023		21. 00
22.00	CLINIC	90. 02	0	613		22. 00
23.00	EMERGENCY	91. 00	0	1, 950		23. 00
	TOTALS			2, 081, 416		
500.00	Grand Total: Increases		543, 313	28, 231, 665		500.00

Health Financial Systems RECLASSIFICATIONS Provider CCN: 15-0165

					'	o 12/31/2022 Date/lime P 5/29/2023 9	
		Decreases		-			
	Cost Center 6.00	Li ne # 7.00	Sal ary 8.00	0ther 9.00	Wkst. A-7 Ref.		
	A - I NSURANCE	7.00	8.00	9.00	10.00		
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	15, 435	5 11		1.00
2.00	ADMINISTRATIVE & GENERAL	5. 00	0	23, 581			2. 00
3.00	ADULTS & PEDIATRICS	3000	•	27, 466			3. 00
	O B - INTEREST EXPENSE		0	66, 482	2		_
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	5, 541, 683	3 11		1.00
2. 00	MAINTENANCE & REPAIRS	6. 00	ő	21, 084			2. 00
				5, 562, 767			
	C - DRUG EXPENSE						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	283			1.00
2. 00 3. 00	ADMINISTRATIVE & GENERAL MAINTENANCE & REPAIRS	5. 00 6. 00	0	2, 47 <i>6</i> 18			2. 00 3. 00
4.00	NURSING ADMINISTRATION	13. 00	0	2, 617			4. 00
5. 00	CENTRAL SERVICES & SUPPLY	14. 00	Ö	895			5. 00
6.00	PHARMACY	15. 00	О	3, 712, 842	2 0		6. 00
7.00	ADULTS & PEDIATRICS	30.00	0	57, 360			7. 00
8.00	INTENSIVE CARE UNIT	31.00	0	34, 782			8. 00
9. 00 10. 00	OPERATING ROOM RECOVERY ROOM	50. 00 51. 00	0	38, 47 <i>6</i> 332			9. 00 10. 00
11. 00	ANESTHESI OLOGY	53.00	ő	32, 053	-1 ~1		11. 00
12.00	RADI OLOGY-DI AGNOSTI C	54.00	O	574, 158			12. 00
13.00	CT SCAN	57. 00	0	1, 152	0		13. 00
14.00	MAGNETIC RESONANCE I MAGING	58. 00	0	885	5 0		14. 00
15. 00	(MRI) CARDIAC CATHETERIZATION	59. 00		3, 600	o		15. 00
16. 00	CLINIC	90. 01	0	60, 068			16. 00
17. 00	CLINIC	90. 02	ő	1, 404	7 "		17. 00
18. 00	EMERGENCY	91.00	o_	18, 828			18. 00
	0		0	4, 542, 229	9		_
1 00	D - MED SUPPLIES EXPENSE	4 00	ما	7.04	4		1 00
1. 00 2. 00	EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL	4. 00 5. 00	0	7, 044 37, 969			1. 00 2. 00
3. 00	MAINTENANCE & REPAIRS	6. 00	0	19, 587			3. 00
4.00	HOUSEKEEPI NG	9.00	O	3, 569			4. 00
5.00	DI ETARY	10.00	0	19, 226	6 0		5. 00
6. 00	NURSING ADMINISTRATION	13. 00	0	4, 144			6. 00
7. 00 8. 00	CENTRAL SERVICES & SUPPLY PHARMACY	14.00	0	49, 690			7. 00 8. 00
9.00	MEDICAL RECORDS & LIBRARY	15. 00 16. 00	0	19, 138	3 0		9. 00
10. 00	ADULTS & PEDIATRICS	30.00	o	651, 347			10. 00
11. 00	INTENSIVE CARE UNIT	31.00	О	286, 763			11. 00
12.00	OPERATING ROOM	50.00	0	4, 708, 284			12. 00
13.00	RECOVERY ROOM	51.00	0	44, 610			13. 00
14. 00 15. 00	ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C	53. 00 54. 00	0	150, 057 37, 679			14. 00 15. 00
16. 00	CT SCAN	57. 00	0	137, 159			16. 00
	MAGNETIC RESONANCE I MAGING	58. 00	Ö	287, 382			17. 00
	(MRI)						
18.00	CARDI AC CATHETERI ZATI ON	59.00	0	1, 537, 566			18. 00
19. 00 20. 00	LABORATORY RESPIRATORY THERAPY	60. 00 65. 00	0	565, 570 165, 017			19. 00 20. 00
21. 00	PHYSICAL THERAPY	66.00	0	165, 017			21. 00
22. 00	OCCUPATI ONAL THERAPY	67. 00	o	483			22. 00
23. 00	SPEECH PATHOLOGY	68.00	О	54			23. 00
24. 00	ELECTROCARDI OLOGY	69. 00	0	26, 778			24. 00
25. 00	ELECTROENCEPHALOGRAPHY	70.00	0	25, 549			25. 00
26. 00 28. 00	CARDIAC AND PULMONARY REHAB	76. 01 90. 01	0	1, 501 19, 694			26. 00 28. 00
29. 00	CLINIC	90. 02	0	27, 124			29. 00
30. 00	EMERGENCY	91.00	o	484, 954			30.00
	0		0	9, 318, 006			\perp
4 60	E - IMPLANTABLE DEVICES	24 25	<u>-1</u>	-	.1 -1		
1. 00 2. 00	INTENSIVE CARE UNIT OPERATING ROOM	31. 00 50. 00	0	81 5, 704, 693			1. 00 2. 00
3.00	RECOVERY ROOM	51. 00	0	5, 704, 693 2, 633			3. 00
4. 00	MAGNETIC RESONANCE I MAGING	58. 00	ol	9, 321			4. 00
	(MRI)		1				
5.00	CARDI AC CATHETERI ZATI ON	59. 00	0	554, 051			5. 00
6.00	CLI NI C EMERGENCY	90. 01 91. 00	0	20 219			6. 00 7. 00
7. 00	O	91.00					7.00
	1- I	ı	ગ	5, 2. 1, 010	- I		T.

Health Financial Systems RECLASSIFICATIONS FRANCISCAN HEALTH MUNSTER Provi der CCN: 15-0165

						To 12/31/2022	Date/Time Prepared: 5/29/2023 9:51 am
		Decreases					97 2 77 2 9 2 9 7 1 9 1 9 1 1
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
	F - CAFE						
1.00	DI ETARY	1000	54 <u>3, 3</u> 13	389, 747			1. 00
	TOTALS		543, 313	389, 747			
	G - EMPLOYEE BENEFITS						
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	2, 078, 069)	1.00
2.00	DI ETARY	10.00	0	1, 796)	2. 00
3.00	RESPI RATORY THERAPY	65.00	0	199			3. 00
4.00	OCCUPATI ONAL THERAPY	67.00	0	260			4. 00
5.00	ELECTROENCEPHALOGRAPHY	70.00	0	1, 092	C		5. 00
6.00		0.00	0	0	C		6. 00
7.00		0.00	0	0	C		7. 00
8.00		0.00	0	0	C		8. 00
9.00		0.00	0	0	C		9. 00
10.00		0.00	0	0	C		10. 00
11. 00		0.00	0	0	C		11. 00
12.00		0.00	0	0	C		12. 00
13.00		0.00	0	0	C		13. 00
14. 00		0.00	0	0	C		14. 00
15.00		0.00	0	0	C		15. 00
16.00		0.00	0	0	C		16. 00
17. 00		0.00	0	0	C		17. 00
18. 00		0.00	0	0	C		18. 00
19. 00		0.00	0	0	C		19. 00
20.00		0.00	0	0	C		20. 00
21. 00		0.00	0	0	C		21. 00
22. 00		0.00	0	0	C		22. 00
23. 00		0.00	•	0	<u> </u>		23. 00
	TOTALS		0	2, 081, 416		4	
500.00	Grand Total: Decreases		543, 313	28, 231, 665			500.00

				10	12/31/2022	5/29/2023 9:5	
				Acqui si ti ons		0,2,,2020 ,.0	<u> </u>
		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, 641, 227	2, 872, 497		2, 872, 497	0	1.00
2.00	Land Improvements	2, 710, 184	10, 327		10, 327	0	2. 00
3.00	Buildings and Fixtures	98, 268, 539	349, 400	0	349, 400	259, 443	3. 00
4.00	Building Improvements	0	0	0	0	0	4. 00
5.00	Fi xed Equipment	0	0	0	0	0	5. 00
6.00	Movable Equipment	119, 232, 596	3, 872, 014	0	3, 872, 014	0	6. 00
7. 00	HIT designated Assets	0	0	0	0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	229, 852, 546	7, 104, 238		7, 104, 238	259, 443	8. 00
9.00	Reconciling Items	-1, 038, 466	-1, 233, 384		-1, 233, 384	0	9. 00
10.00	Total (line 8 minus line 9)	230, 891, 012	8, 337, 622	0	8, 337, 622	259, 443	10. 00
		Endi ng Bal ance	Fully				
			Depreciated				
			Assets				
	DART I ANALYCIC OF CHANCEC IN CARLTAL ACCE	6.00	7. 00				
1. 00	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET		0				1 00
		12, 513, 724	0				1.00
2.00	Land Improvements	2, 720, 511	2.752.000				2.00
3.00	Buildings and Fixtures	98, 358, 496	2, 753, 988				3. 00
4. 00 5. 00	Building Improvements	0	0				4. 00 5. 00
	Fixed Equipment	122 104 (10	20 001 007				
6. 00 7. 00	Movable Equipment HIT designated Assets	123, 104, 610	20, 081, 997				6. 00 7. 00
8. 00	Subtotal (sum of lines 1-7)	224 407 241	22 025 005				8. 00
9. 00	Reconciling Items	236, 697, 341 -2, 271, 850	22, 835, 985				9. 00
9. 00 10. 00	Total (line 8 minus line 9)	238, 969, 191	22, 835, 985				9. 00 10. 00
10.00	Tiotal (Title o milius Title 9)	230, 909, 191	22, 033, 903	I			10.00

Heal th	Financial Systems	FRANCI SCAN HEA	ALTH MUNSTER		In Lie	Lieu of Form CMS-2552-10		
RECONC	RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der C	CN: 15-0165	Peri od: From 01/01/2022	Worksheet A-7 Part II		
					To 12/31/2022	Date/Time Pre	pared:	
				IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII	L TAI	5/29/2023 9:5	ı am	
			51	UMMARY OF CAP	TIAL			
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)			
		0.00	10.00	11 00				
	DART II DECONOLILATION OF AMOUNTS FROM WORK	9.00	10.00	11.00	12. 00	13. 00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	CSHEET A, COLUM	N 2, LINES 1 a	and 2		_		
1. 00	CAP REL COSTS-BLDG & FLXT	0	C)	0 771, 137	0	1. 00	
2.00	CAP REL COSTS-MVBLE EQUIP	0	C		0	0	2. 00	
3.00	Total (sum of lines 1-2)	0	C		0 771, 137	0	3. 00	
		SUMMARY O	F CAPITAL					
	Cost Center Description		Total (1) (sum	וֹן				
		Capi tal -Relate	of cols. 9					
		d Costs (see	through 14)					
		instructions)						
		14. 00	15. 00					
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1 a	and 2				
1.00	CAP REL COSTS-BLDG & FLXT	43, 236					1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	0					2.00	
3. 00	Total (sum of lines 1-2)	43, 236	814, 373	3			3. 00	

Heal th	n Financial Systems	FRANCISCAN HEA	FRANCISCAN HEALTH MUNSTER			In Lieu of Form CMS-2552-10		
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der Co		Period: From 01/01/2022 To 12/31/2022	Worksheet A-7 Part III Date/Time Prep 5/29/2023 9:5		
		COM	PUTATION OF RAT	TI 0S	ALLOCATION OF	OTHER CAPITAL		
	Cost Center Description		Capi talized	Gross Assets		Insurance		
			Leases	for Ratio	instructions)			
				(col . 1 - col 2)				
		1. 00	2.00	3.00	4. 00	5. 00		
	PART III - RECONCILIATION OF CAPITAL COSTS CI					0.00		
1.00	CAP REL COSTS-BLDG & FIXT	101, 079, 006	0	101, 079, 00	6 0. 457263	0	1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	123, 104, 610	3, 131, 223	119, 973, 38	7 0. 542737	0	2.00	
3.00	Total (sum of lines 1-2)	224, 183, 616					3. 00	
		ALLOCA	TION OF OTHER (CAPI TAL	SUMMARY O	F CAPITAL		
	Cost Center Description	Taxes	Other	Total (sum of	f Depreciation	Lease		
			Capi tal -Relate					
			d Costs	through 7)				
		6.00	7. 00	8. 00	9. 00	10. 00		
4 00	PART III - RECONCILIATION OF CAPITAL COSTS CI	ENTERS			0 404 (54		1 00	
1.00	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP	0	0		0 421, 654	0	1.00	
2. 00 3. 00	Total (sum of lines 1-2)	0	0		0 421 454	0	2.00	
3.00	Total (Sull of Titles 1-2)	0	<u> </u>	<u>l</u> JMMARY OF CAPI	0 421, 654	U	3. 00	
			30	JIVIIVIART OF CAPT	TAL			
	Cost Center Description	Interest	Insurance (see	Taxes (see	0ther	Total (2) (sum		
			instructions)	instructions)	Capi tal -Rel ate			
					d Costs (see	through 14)		
					instructions)			
	DART LLL DECONOLILATION OF CARLEY COOKS	11.00	12. 00	13. 00	14. 00	15. 00		
1 00	PART III - RECONCILIATION OF CAPITAL COSTS CI		771 107	1	0 24/ 570	/ 555 207	1 00	
1.00	CAP REL COSTS-BLDG & FLXT CAP REL COSTS-MVBLE EQUIP	5, 609, 176	1	1	0 -246, 570		1.00	
2. 00 3. 00	Total (sum of lines 1-2)	_			0	0 4 EEE 207	2. 00 3. 00	
3.00	Total (Suil of Titles 1-2)	5, 609, 176	771, 137	I	0 -246, 570	6, 555, 397	3.00	

					To 12/31/2022	Date/Time Prep 5/29/2023 9:5	
				Expense Classification	on Worksheet A	372772023 7.3	ı aiii
				To/From Which the Amount i			
	Cost Center Description		Amount	Cost Center		Wkst. A-7 Ref.	
1. 00	Investment income - CAP REL	1.00	2.00	3.00 CAP REL COSTS-BLDG & FIXT	4. 00	5. 00 0	1. 00
1.00	COSTS-BLDG & FIXT (chapter 2)		0	NEE GOOTS BEBU & TTAT	1.00	Ĭ	1. 00
2.00	Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	2. 00
3. 00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other	A	-26 148	CAP REL COSTS-BLDG & FLXT	1.00	9	3. 00
0.00	(chapter 2)		20, 110	NEE GOSTO BEBG & TTXT	1.00	(0.00
4.00	Trade, quantity, and time		0		0.00	0	4. 00
5. 00	discounts (chapter 8) Refunds and rebates of expense	s B	-688 255	ADMINISTRATIVE & GENERAL	5. 00	0	5. 00
0.00	(chapter 8)		000, 200		0.00		0.00
6.00	Rental of provider space by		0		0.00	0	6. 00
7. 00	suppliers (chapter 8) Telephone services (pay		0		0.00	0	7. 00
	stations excluded) (chapter 21)	_				
8.00	Television and radio service		0		0.00	0	8. 00
9. 00	(chapter 21) Parking Lot (chapter 21)		0		0.00	0	9. 00
10.00	Provi der-based physician	A-8-2	-2, 122, 094		0.00	Ö	10. 00
44.00	adjustment				0.00		44.00
11. 00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11. 00
12. 00	Related organization	A-8-1	-304, 727			О	12.00
40.00	transactions (chapter 10)						40.00
13. 00 14. 00	Laundry and linen service Cafeteria-employees and guests	В	-307, 271	DI ETARY	0. 00 10. 00	0	13. 00 14. 00
15. 00	Rental of quarters to employee		0	DI ETAKI	0.00	ő	15. 00
	and others						
16. 00	Sale of medical and surgical supplies to other than patient		0		0.00	0	16. 00
17. 00	Sale of drugs to other than		0		0.00	0	17. 00
	pati ents						
18. 00	Sale of medical records and abstracts	В	-59	RADI OLOGY-DI AGNOSTI C	54.00	0	18. 00
19. 00	Nursing and allied health		0		0.00	О	19. 00
	education (tuition, fees,						
20. 00	books, etc.) Vending machines	В	_ 22 212	DI ETARY	10.00	0	20. 00
21. 00	Income from imposition of	В	-32, 319	DILIANI	0.00	o	
	interest, finance or penalty						
22. 00	charges (chapter 21)		0		0.00	0	22. 00
22.00	Interest expense on Medicare overpayments and borrowings to		U		0.00	١	22.00
	repay Medicare overpayments						
23. 00	Adjustment for respiratory	A-8-3	0	RESPIRATORY THERAPY	65. 00		23. 00
	therapy costs in excess of limitation (chapter 14)						
24. 00	Adjustment for physical therap	y A-8-3	0	PHYSICAL THERAPY	66.00		24. 00
	costs in excess of limitation						
25. 00	(chapter 14) Utilization review -		0	UTILIZATION REVIEW-SNF	114.00		25. 00
_5.00	physicians' compensation		0		111.00		_2. 50
24 00	(chapter 21)		^	CAD DEL COSTS DIDO 0 FLYT	1 00		24 00
26. 00	Depreciation - CAP REL COSTS-BLDG & FLXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26. 00
27. 00	Depreciation - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2.00	О	27. 00
20 00	COSTS-MVBLE EQUIP		^	MONDHVCI CLAN AMECTUETI CTC	10.00		20 00
28. 00 29. 00	Non-physician Anesthetist Physicians' assistant		0	NONPHYSICIAN ANESTHETISTS	19. 00 0. 00	0	28. 00 29. 00
30. 00	Adjustment for occupational	A-8-3	0	OCCUPATI ONAL THERAPY	67. 00	Ĭ	30.00
	therapy costs in excess of						
30. 99	limitation (chapter 14) Hospice (non-distinct) (see		Ω	ADULTS & PEDIATRICS	30.00		30. 99
	instructions)						
31. 00	Adjustment for speech patholog	y A-8-3	0	SPEECH PATHOLOGY	68. 00		31. 00
	costs in excess of limitation (chapter 14)						
32. 00	CAH HIT Adjustment for		0		0.00	О	32. 00
	Depreciation and Interest	5	e -	ADMINI CTDATIVE A SEVER :			
33. 00 33. 01	CAFETERI A CAFETERI A	B B		ADMINISTRATIVE & GENERAL NURSING ADMINISTRATION	5. 00 13. 00	0	33. 00 33. 01
	CAFETERI A	В		PHARMACY	15. 00		
-		<u>'</u>				<u>'</u>	

From 01/01/2022 To 12/31/2022 Date/Time Prepared:

					12/31/2022	Date/lime Pre 5/29/2023 9:5	
				Expense Classification on	Worksheet A	3/2//2023 7.3	ı diii
				To/From Which the Amount is			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4. 00	5. 00	
33. 03	CAFETERI A	В	-63	ADULTS & PEDIATRICS	30.00	0	33. 03
33. 04	CAFETERI A	В	-2	OPERATING ROOM	50.00	0	33. 04
33. 05	CAFETERI A	В	-37	RECOVERY ROOM	51.00	0	33. 05
33.06	CAFETERI A	В	-15	MAGNETIC RESONANCE IMAGING	58.00	0	33. 06
				(MRI)			
33. 07	RENTAL INCOME	В	•	ADMINISTRATIVE & GENERAL	5. 00	0	33. 07
33. 08	RENTAL INCOME	В	-289, 806	CAP REL COSTS-BLDG & FIXT	1.00	14	33. 08
33. 09	MI SCELLANEOUS - SERVI CES	В		ADMINISTRATIVE & GENERAL	5. 00	0	33. 09
33. 10	MI SCELLANEOUS - SERVI CES	В		RADI OLOGY-DI AGNOSTI C	54. 00	0	33. 10
33. 11	MI SCELLANEOUS - OTHER OPERATIN			ADMINISTRATIVE & GENERAL	5. 00	0	33. 11
33. 12	MI SCELLANEOUS - OTHER OPERATIN			HOUSEKEEPI NG	9. 00	0	33. 12
33. 13	MI SCELLANEOUS - OTHER OPERATIN			ADULTS & PEDIATRICS	30.00	0	33. 13
33. 14	MISCELLANEOUS - OTHER OPERATIN			ADMINISTRATIVE & GENERAL	5. 00	0	33. 14
33. 15	CONTRIBUTION OF PPE	В		ELECTROCARDI OLOGY	69. 00	0	33. 15
33. 16	DONATI ONS/CONTRI BUTI ONS	В		PHARMACY	15. 00	0	33. 16
33. 17	EMPLOYEE BADGES	В		EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33. 17
33. 18	OUTSOURCED STAFF	В	•	EMERGENCY	91. 00	0	33. 18
33. 19	UNCLAIMED PROPERTY RECEIPTS	В		ADMINISTRATIVE & GENERAL	5. 00	0	33. 19
33. 20	SHARED SAVINGS	В	•	ADMINISTRATIVE & GENERAL	5. 00	0	33. 20
33. 21	INSURANCE CLAIM PROCEEDS	В		ADMINISTRATIVE & GENERAL	5. 00	0	33. 21
33. 22	RETAIL SERVICES	В		DI ETARY	10. 00	0	33. 22
33. 23	RETAIL SERVICES	В	•	PHARMACY	15. 00	0	33. 23
33. 24	RETAIL SERVICES	В		ADULTS & PEDIATRICS	30.00	0	33. 24
33. 25	RETAIL SERVICES	В		RECOVERY ROOM	51. 00	0	33. 25
33. 26	MEDICAL STAFF DUES AND FEES	В	•	ADMINISTRATIVE & GENERAL	5. 00	0	33. 26
33. 27	HAF ASSESSMENT FEES	A		ADMINISTRATIVE & GENERAL	5. 00	0	33. 27
33. 28	PENSION	A		EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33. 28
33. 29	ADVERTI SI NG	A		EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33. 29
33. 30	ADVERTI SI NG	A	•	ADMINISTRATIVE & GENERAL	5. 00	0	33. 30
33. 31	ADVERTI SI NG	A		MAINTENANCE & REPAIRS	6. 00	0	33. 31
33. 32	ADVERTI SI NG	A	•	NURSI NG ADMI NI STRATI ON	13. 00	0	33. 32
33. 33	ADVERTI SI NG	A		ADULTS & PEDIATRICS	30.00	0	33. 33
33. 34	ADVERTI SI NG	A		RECOVERY ROOM	51.00	0	33. 34
33. 35	ADVERTI SI NG	A	-3, 899	MAGNETIC RESONANCE IMAGING	58. 00	0	33. 35
22 2/	ADVEDTI SI NC	_	120	(MRI)	EO 00	_	22.24
33. 36 33. 37	ADVERTISING	A A		CARDIAC CATHETERIZATION RESPIRATORY THERAPY	59.00	0	33. 36 33. 37
	ADVERTI SI NG			1	65. 00	Ŭ	
33. 38 33. 39	ADVERTI SI NG	A		CLINIC CLINIC	90. 01	0	33. 38
	ADVERTI SI NG	A		1	90. 02	0	33. 39
33. 40	ADVERTI SI NG	A		EMERGENCY	91.00	0	33. 40
33. 41 33. 42	LOBBYING	A	-2, 082	ADMINISTRATIVE & GENERAL	5. 00	0	33. 41 33. 42
33. 42	OTHER ADJUSTMENTS (SPECIFY) (3 OTHER ADJUSTMENTS (SPECIFY) (3	1	0		0. 00 0. 00	0	33. 42
33. 43		1	0		0.00	0	33. 43
33. 44	OTHER ADJUSTMENTS (SPECIFY) (3 OTHER ADJUSTMENTS (SPECIFY) (3	1	0		0.00	0	33. 44
33. 45	OTHER ADJUSTMENTS (SPECIFY) (3	1	0		0.00) 0	33. 45
50. 00	TOTAL (sum of lines 1 thru 49)	ľ l	-8, 366, 821		0.00		50.00
30.00	(Transfer to Worksheet A,		-0, 300, 621				30.00
	column 6, line 200.)						
	COLUMN 0, TIME 200. J					L	

⁽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.

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)	
6, 547	1.00
32, 527	2.00
9, 276	3.00
0	4.00
0	4.01
8, 350	5.00
51 53	516, 547 532, 527 199, 276 0 0 348, 350

* 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

1101 001	not been posted to worksheet A, cordinas i and or 2, the amount arrowable should be indicated in cordina 4 or this part.										
				Related Organization(s) and/or Home Office							
	Symbol (1)	Name	Percentage of	Name	Percentage of						
			Ownershi p		Ownershi p						
	1. 00	2. 00	3.00	4. 00	5. 00						
	B. 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

11 11 0 7					
6.00	В	FRANCISCAN ALLI	100.00	0. 00	6. 00
7.00			0.00	0.00	7. 00
8.00			0.00	0.00	8. 00
9.00			0.00	0.00	9. 00
10.00			0.00	0.00	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

Health Financial Systems				FRANCISCAN HEALT	H MUNSTER		In Lieu of Form CMS-2552-10		
STATEME	NT OF COSTS OF	SERVICES FROM	RELATED ORGANI	ZATIONS AND HOME	Provider CCN:	15-0165	Peri od:	Worksheet A-8	3-1
OFFICE	COSTS						From 01/01/2022		
							To 12/31/2022		
								5/29/2023 9:5	1 am
	Net	Wkst. A-7 Ref							
	Adjustments								
	(col. 4 minus								
	col. 5)*								
	6. 00	7. 00							
	A. COSTS INCUR	RED AND ADJUST	MENTS REQUIRED .	AS A RESULT OF TRA	NSACTIONS WITH	RELATED 0	RGANI ZATI ONS OR	CLAI MED	
	HOME OFFICE CO:	STS:							
1.00	-3, 684, 787	1	1						1. 00
2.00	447, 802		9						2. 00
3.00	1, 854, 085		O						3. 00
4.00	188, 351		0						4. 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

4.01

5 00

110 0	in posted to worksheet A, cord	mins 1 and 01 2, the amount arrowable should be find eated in cordini 4 of this part.	
	Related Organization(s)		
	and/or Home Office		
	Type of Business		
	6. 00		
	B. INTERRELATIONSHIP TO RELAT	FED ORGANIZATION(S) AND/OR HOME OFFICE:	1

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	6. 00
7. 00	7. 00
8. 00	8. 00 9. 00
9. 00	9. 00
10. 00	10.00
6. 00 7. 00 8. 00 9. 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.

4.01

5.00

889, 822

-304, 727

						10 12/31/2022	5/29/2023 9:5	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component	
							Hours	
	1. 00	2. 00	3.00	4.00	5. 00	6. 00	7. 00	
1. 00	5. 00	ADMINISTRATIVE & GENERAL	64, 510	64, 510	0	0	0	1. 00
2.00	13. 00	NURSING ADMINISTRATION	235	235	0	0	0	2. 00
3.00	30.00	ADULTS & PEDIATRICS	1, 446	1, 446	0	0	0	3. 00
4.00	31.00	INTENSIVE CARE UNIT	8, 832	8, 832	0	0	0	4. 00
5.00	50.00	OPERATING ROOM	1, 629, 384	1, 594, 284	35, 100	246, 400	58	5. 00
6.00	59.00	CARDIAC CATHETERIZATION	82, 500	82, 500	0	0	0	6. 00
7.00	60.00	LABORATORY	21, 283		21, 283	260, 300	158	7. 00
8.00	70.00	ELECTROENCEPHALOGRAPHY	5, 625				45	8. 00
9.00	90. 02	CLINIC	4, 902	777	4, 125	179, 000	33	9. 00
10.00	91.00	EMERGENCY	337, 437		0	1	1	10.00
200.00			2, 156, 154	2, 090, 021	66, 133		294	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 Percent of	Cost of	Provi der	Physician Cost	
		I denti fi er	Limit	Unadjusted RCE	Memberships &	Component	of Mal practice	
				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		ADMINISTRATIVE & GENERAL	0		_	1		
2.00	•	NURSING ADMINISTRATION	0		1	0	_	
3.00		ADULTS & PEDIATRICS	0	· · · · · ·	1	0	0	
4.00		INTENSIVE CARE UNIT	0	_	1	0	0	1
5.00		OPERATING ROOM	6, 871	1		0	0	0.00
6.00		CARDIAC CATHETERIZATION	0	C		0	0	0.00
7.00		LABORATORY	19, 773			0	0	,
8.00		ELECTROENCEPHALOGRAPHY	4, 576			0	0	0.00
9.00		CLINIC	2, 840	•		0	0	7.00
10.00	91.00	EMERGENCY	0	1	1	0	0	1
200.00		0 1 0 1 (8)	34, 060			0	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		l denti fi er	Component Share of col.	Limit	Di sal I owance			
			14					
	1. 00	2.00	15. 00	16. 00	17. 00	18. 00		
1. 00		ADMI NI STRATI VE & GENERAL	13.00					1.00
2. 00		NURSI NG ADMI NI STRATI ON		1	_	235		2. 00
3. 00		ADULTS & PEDIATRICS	1 0		0	1, 446	1	3. 00
4. 00		INTENSIVE CARE UNIT			1			4. 00
5. 00		OPERATING ROOM	1 0	6, 871				5. 00
6. 00		CARDI AC CATHETERI ZATI ON				82, 500		6.00
7. 00		LABORATORY	1 0		,			7. 00
8. 00		ELECTROENCEPHALOGRAPHY	0	, , , , ,				8.00
9. 00		CLI NI C	0					9. 00
10. 00		EMERGENCY		_, -,		l	1	10.00
200.00	,1.00				1	l	1	200.00
_00.00	1	I	1	1 2.,000	32,070	2, .22, 071	ı	1 =00.00

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0165 Peri od: Worksheet B From 01/01/2022 Part I Date/Time Prepared: 12/31/2022 5/29/2023 9:51 am CAPITAL RELATED COSTS Net Expenses BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Subtotal Cost Center Description for Cost **BENEFITS** DEPARTMENT Allocation (from Wkst A col. 7) 1.00 2.00 4. 00 4A GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 6, 555, 397 1 00 6, 555, 397 2.00 00200 CAP REL COSTS-MVBLE EQUIP 0 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 12, 618, 377 83, 718 0 12, 702, 095 4.00 00500 ADMINISTRATIVE & GENERAL 0 19, 974, 643 5 00 16 506 965 2 663 049 5 00 804.629 6.00 00600 MAINTENANCE & REPAIRS 11, 599, 728 0 205, 690 11, 805, 418 6.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 247, 599 0 247, 599 8.00 8.00 0 00900 HOUSEKEEPI NG 0 280, 954 1, 742, 675 9 00 1, 461, 721 9 00 10.00 01000 DI ETARY 513,066 289, 142 122, 250 924, 458 10.00 01100 CAFETERI A C 11.00 933, 060 130, 556 1,063,616 11.00 01200 MAINTENANCE OF PERSONNEL 0 12.00 12.00 01300 NURSING ADMINISTRATION 3, 299, 385 0 614, 402 13.00 Ω 3, 913, 787 13 00 14.00 01400 CENTRAL SERVICES & SUPPLY 711, 979 64, 507 776, 486 14.00 01500 PHARMACY 15.00 2, 121, 544 112, 310 437, 867 2, 671, 721 15.00 01600 MEDICAL RECORDS & LIBRARY 136, 587 1, 651, 352 1,509,480 0 16,00 5. 285 16,00 17 00 01700 SOCIAL SERVICE 17 00 01850 OTHER GEN SERV 18.00 18.00 19 00 01900 NONPHYSICIAN ANESTHETISTS 0 C 0 0 O 19.00 02000 NURSI NG PROGRAM 20.00 0 0 0 20.00 C 0 0 21.00 02100 I &R SERVICES-SALARY & FRINGES APPRVD 0 0 0 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 0 0 22.00 0 22.00 02301 PARAMED ED PRGM 23.00 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 21, 140, 269 30.00 03000 ADULTS & PEDIATRICS 16, 830, 033 1, 408, 898 0 2, 901, 338 30.00 03100 INTENSIVE CARE UNIT 31.00 2, 517, 949 339, 498 462, 104 3, 319, 551 31.00 32.00 03200 CORONARY CARE UNIT 0 0 0 32.00 0 03300 BURN INTENSIVE CARE UNIT 33.00 0 C 0 0 0 33.00 03400 SURGICAL INTENSIVE CARE UNIT 0 0 34.00 34.00 04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF 0 0 40.00 0 0 0 40.00 0 0 41 00 C Λ 41 00 0 0 43.00 04300 NURSERY 0 0 43.00 04400 SKILLED NURSING FACILITY 0 0 0 44.00 0 44.00 04500 NURSING FACILITY 0 45.00 45.00 0 04600 OTHER LONG TERM CARE 0 46.00 0 46.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 6, 745, 664 639, 431 976, 734 8, 361, 829 50.00 05100 RECOVERY ROOM 0 51 00 935 467 280 517 189 517 1, 405, 501 51 00 05200 DELIVERY ROOM & LABOR ROOM 52.00 0 52.00 53.00 05300 ANESTHESI OLOGY 3, 318, 713 8, 682 3, 327, 395 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 2, 967, 948 297, 290 0 390, 275 3, 655, 513 54.00 05500 RADI OLOGY-THERAPEUTI C O 55 00 55 00 0 56.00 05600 RADI OI SOTOPE C Λ 56.00 05700 CT SCAN 966, 042 121, 369 1, 087, 411 57.00 57.00 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 1, 210, 782 212, 070 1, 422, 852 58.00 603, 940 05900 CARDIAC CATHETERIZATION O 3, 658, 191 59 00 2 632 556 421, 695 59 00 60.00 06000 LABORATORY 6, 970, 070 103, 795 0 7, 073, 865 60.00 06001 BLOOD LABORATORY 60.01 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 61.00 0 0 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 62 00 0 0 0 62 00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 63.00 0 06400 I NTRAVENOUS THERAPY 64.00 64.00 06500 RESPIRATORY THERAPY 1, 972, 710 290, 170 2, 314, 594 65.00 51, 714 65 00 66.00 06600 PHYSI CAL THERAPY 330, 434 77, 422 407, 856 66.00 06700 OCCUPATIONAL THERAPY 339, 502 67.00 281, 438 58.064 67.00 06800 SPEECH PATHOLOGY 143, 262 68.00 115, 562 27.700 68.00 06900 ELECTROCARDI OLOGY 69.00 658.078 127, 145 785, 223 69 00 70.00 07000 ELECTROENCEPHALOGRAPHY 755, 780 263, 928 95, 626 1, 115, 334 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71 00 9, 318, 006 9, 318, 006 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 6, 270, 410 0 6, 270, 410 72.00 72.00 0 07300 DRUGS CHARGED TO PATIENTS 0 73.00 4, 542, 229 C 0 4, 542, 229 73.00 07400 RENAL DIALYSIS 0 74.00 74.00 07500 ASC (NON-DISTINCT PART) 75.00 0 0 0 75.00 03950 OTHER ANCILL SRVC 76.00 C 0 0 76.00 0 76.01 03951 CARDIAC AND PULMONARY REHAB 244, 433 56, 261 300, 694 76.01 76.02 03952 WOUND CARE 0 0 0 76.02 07700 ALLOGENEIC STEM CELL ACQUISITION 77.00 77.00 0 0 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 0 0 0 88.00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2022 | Part I | To 12/31/2022 | Date/Time Prepared: | 5/29/2023 9:51 am Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS FRANCISCAN HEALTH MUNSTER Provider CCN: 15-0165

					5/29/2023 9:5	<u>1 am</u>
		CAPI TAL REI	LATED COSTS			
Cost Center Description	Net Expenses	BLDG & FLXT	MVBLE EQUIP	EMPLOYEE	Subtotal	
cost center bescription	for Cost	DLDG & FIXI	WIVELE EQUIP	BENEFITS	Subtotal	
	Allocation			DEPARTMENT		
	(from Wkst A			<i>52.7.</i>		
	col. 7)					
	0	1. 00	2. 00	4. 00	4A	
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89. 00
90. 00 09000 CLI NI C	0	0	0	0	0	90. 00
90. 01 09001 CLI NI C	2, 358, 054	0	0	374, 774	2, 732, 828	90. 01
90. 02 09002 CLI NI C	402, 937	44, 300		46, 260	493, 497	90. 02
91. 00 09100 EMERGENCY	5, 833, 791	363, 355	0	645, 364	6, 842, 510	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS					0	92. 00
94. 00 O9400 HOME PROGRAM DIALYSIS		0	0	0	0	94. 00
95. 00 09500 AMBULANCE SERVI CES	0	0	0	0	0	95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	Ö	0	0	96. 00
97. 00 09700 DURABLE MEDICAL EQUI P-SOLD	0	0	Ö	0	0	97. 00
98. 00 09850 OTHER REIMBURSE	i o	Ö	Ö	0	0	98. 00
99. 00 09900 CMHC	0	0	0	0	0	99. 00
99. 10 09910 CORF	0	0	О	0	0	99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00
102.00 10200 OPI OI D TREATMENT PROGRAM	0	0	0	0	0	102. 00
SPECIAL PURPOSE COST CENTERS						
105. 00 10500 KIDNEY ACQUISITION	0	_		0		105. 00
106. 00 10600 HEART ACQUISITION	0	0	_	0		106. 00
107.00 10700 LIVER ACQUISITION 108.00 10800 LUNG ACQUISITION	0	0	0	0		107. 00
109.00 10900 PANCREAS ACQUISITION	0	0	0	0		108. 00 109. 00
110. 00 11000 NTESTI NAL ACQUI SI TI ON	0	0	0	0		1109.00
111. 00 11100 I SLET ACQUI SI TI ON	0	0	0	0		111. 00
113. 00 11300 NTEREST EXPENSE			Ĭ	O	O	113. 00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	o	0	0	115. 00
116. 00 11600 HOSPI CE	0	0	0	0		116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	136, 257, 387	5, 691, 750	О	12, 138, 432	134, 830, 077	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	96, 195	0	0	9, 681	105, 876	190. 00
191. 00 19100 RESEARCH	20, 325		0	4, 884	-	
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	1, 988, 711	863, 647	0	416, 890		
192.01 19201 CENTER OF HOPE	2, 762	0	0	652		192. 01
192. 02 19202 OTHER FA FACILITIES NRCC	553, 001	0	0	111, 904	664, 905	
193. 00 19300 NONPALD WORKERS	01 701	0	0	10 (50		193. 00
194.00 07950 OTHER NRCC 200.00 Cross Foot Adjustments	81, 781	0	0	19, 652	101, 433	
200.00 Cross Foot Adjustments 201.00 Negative Cost Centers		_		0		200. 00 201. 00
202.00 Regative Cost Centers 202.00 TOTAL (sum lines 118 through 201)	139, 000, 162	6, 555, 397	0	12, 702, 095		
202.00 TOTAL (Suill TITIES TTO LITEOUGH 201)	139,000,102	0, 555, 397	ı Y	12, 102, 095	139,000,162	1202.00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2022 | Part I | To 12/31/2022 | Date/Time Prepared: | 5/29/2023 9:51 am

		Cost Contor Doscription	ADMI NI STRATI VE	MAINTENANCE &	ODEDATION OF	1 AUNIDDV 8.	5/29/2023 9:5 HOUSEKEEPI NG	
		Cost Center Description	& GENERAL	REPAI RS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
	OENED	AL CERVICE COST OFFITERS	5. 00	6. 00	7. 00	8. 00	9. 00	
1. 00		AL SERVICE COST CENTERS CAP REL COSTS-BLDG & FIXT					Π	1. 00
2.00		CAP REL COSTS-MVBLE EQUIP						2. 00
4.00		EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	1	ADMINISTRATIVE & GENERAL	19, 974, 643	12 004 441				5. 00
6. 00 7. 00		MAINTENANCE & REPAIRS OPERATION OF PLANT	1, 999, 023	13, 804, 441 0				6. 00 7. 00
8. 00		LAUNDRY & LINEN SERVICE	41, 926	0	1	289, 525		8.00
9.00		HOUSEKEEPI NG	295, 089	0	0	0	2, 037, 764	9. 00
10. 00		DI ETARY	156, 539	704, 326	0	0	103, 970	1
11. 00		CAFETERI A	0	0	0	0	0	11.00
12. 00 13. 00		MAI NTENANCE OF PERSONNEL NURSI NG ADMI NI STRATI ON	662, 725	0	0	0	0	12. 00 13. 00
14. 00	1	CENTRAL SERVICES & SUPPLY	131, 483	0	0	o	0	14. 00
15.00		PHARMACY	452, 405	273, 577	0	0	40, 384	•
16. 00		MEDICAL RECORDS & LIBRARY	279, 625	12, 874	1	0	1, 900	1
17. 00		SOCIAL SERVICE	0	0		0	0	
18. 00 19. 00		OTHER GEN SERV NONPHYSICIAN ANESTHETISTS		0	0	0	0	18. 00 19. 00
20. 00		NURSI NG PROGRAM		0	Ö	o	Ö	20.00
21. 00		I&R SERVICES-SALARY & FRINGES APPRVD	o	0	0	0	0	21. 00
22. 00		I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	
23. 00		PARAMED ED PRGM	0	0	0	0	0	23. 00
30. 00		I ENT ROUTINE SERVICE COST CENTERS ADULTS & PEDIATRICS	3, 579, 739	3, 431, 954	0	258, 275	506, 615	30. 00
31. 00	1	INTENSIVE CARE UNIT	562, 103	826, 988		31, 250		31. 00
32.00		CORONARY CARE UNIT	0	0	1	0	0	32. 00
33.00		BURN INTENSIVE CARE UNIT	0	0	0	0	0	33. 00
34.00	1	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
40. 00 41. 00		SUBPROVIDER - IPF SUBPROVIDER - IRF		0	0	0	0	40. 00 41. 00
43. 00		NURSERY		0	Ö	o	Ö	•
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44. 00
45.00		NURSING FACILITY	0	0		0	0	45. 00
46. 00		OTHER LONG TERM CARE LARY SERVICE COST CENTERS] 0	0	0	0	0	46. 00
50. 00		OPERATING ROOM	1, 415, 917	1, 557, 598	0	0	229, 927	50.00
51. 00	1	RECOVERY ROOM	237, 995	683, 316		Ö	100, 869	•
52.00		DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52. 00
53. 00		ANESTHESI OLOGY	563, 431	0		0	0	
54. 00 55. 00		RADI OLOGY-DI AGNOSTI C RADI OLOGY-THERAPEUTI C	618, 992	724, 173 0		0	106, 900 0	1
56. 00		RADI OI SOTOPE		0	0	0	0	1
57. 00		CT SCAN	184, 132	0	0	O	0	57. 00
58. 00	1	MAGNETIC RESONANCE IMAGING (MRI)	240, 933	0	1	0	0	58. 00
59. 00		CARDI AC CATHETERI ZATI ON	619, 445	1, 471, 145		0	217, 165	•
60. 00 60. 01	1	LABORATORY BLOOD LABORATORY	1, 197, 825 0	252, 835 0	•	0	37, 323 0	1
61. 00		PBP CLINICAL LAB SERVICES-PRGM ONLY		O			Ĭ	61.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	1
63. 00	1	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64. 00 65. 00		I NTRAVENOUS THERAPY RESPI RATORY THERAPY	391, 933	0 125, 970	0	0	0 18, 595	64. 00 65. 00
66. 00	1	PHYSI CAL THERAPY	69, 063	123, 970	0	0	18, 343	66.00
67. 00	1	OCCUPATIONAL THERAPY	57, 488	0	Ö	Ö	Ö	67. 00
68. 00	1	SPEECH PATHOLOGY	24, 259	0	0	0	0	68. 00
69. 00		ELECTROCARDI OLOGY	132, 963	(42.005	_	0	0	
70. 00 71. 00		ELECTROENCEPHALOGRAPHY MEDICAL SUPPLIES CHARGED TO PATIENTS	188, 861 1, 577, 827	642, 905 0	_	0	94, 903 0	1
72.00		IMPL. DEV. CHARGED TO PATIENTS	1, 061, 775	0		o	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	769, 140	0	0	0	0	73. 00
74. 00		RENAL DIALYSIS	0	0	0	0	0	74. 00
75. 00	1	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76. 00 76. 01	1	OTHER ANCILL SRVC CARDIAC AND PULMONARY REHAB	50, 917	0	0	0	0	76. 00 76. 01
76. 02	1	WOUND CARE	0	0	ő	0	0	•
77. 00	1	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77. 00
00.05		TIENT SERVICE COST CENTERS			-		_	00.00
88. 00 89. 00		RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	88. 00 89. 00
90.00		CLINIC		0			0	90.00
90. 01		CLI NI C	462, 752	0	Ö	0	0	90. 01
90. 02		CLINIC	83, 564	107, 911		0	15, 929	1
91. 00	09100	EMERGENCY	1, 158, 649	885, 101	0	0	130, 656	91. 00

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

			Т	o 12/31/2022	Date/Time Pre 5/29/2023 9:5	
Cost Center Description	ADMI NI STRATI VE	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	T dill
oust deliter beschiptron	& GENERAL	REPAI RS	PLANT	LI NEN SERVI CE	HOUSEKEELLING	
	5. 00	6. 00	7. 00	8. 00	9. 00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
OTHER REIMBURSABLE COST CENTERS		•				
94.00 09400 HOME PROGRAM DIALYSIS	0	0	C	0	0	94. 00
95. 00 09500 AMBULANCE SERVICES	0	o	C	o	0	95.00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	o	C	o	0	96.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	o	C	o	0	97. 00
98. 00 09850 OTHER REIMBURSE	0	o	C	o	0	98. 00
99. 00 09900 CMHC	0	o	C	o	0	99. 00
99. 10 09910 CORF	0	o	Ö	o	0	99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	o	Ö	o	0	100.00
101.00 10100 HOME HEALTH AGENCY	0	o	Ö	o	0	101. 00
102.00 10200 OPIOID TREATMENT PROGRAM	O	О	C	o	0	102.00
SPECIAL PURPOSE COST CENTERS						
105.00 10500 KIDNEY ACQUISITION	0	0	C	0	0	105. 00
106. 00 10600 HEART ACQUISITION	0	o	C	o	0	106. 00
107.00 10700 LIVER ACQUISITION	0	o	C	o	0	107. 00
108.00 10800 LUNG ACQUISITION	0	o	C	o	0	108. 00
109.00 10900 PANCREAS ACQUISITION	0	o	C	o	0	109. 00
110.00 11000 INTESTINAL ACQUISITION	O	o	C	o	0	110. 00
111.00 11100 ISLET ACQUISITION	O	o	C	o	0	111. 00
113. 00 11300 INTEREST EXPENSE						113. 00
114.00 11400 UTILIZATION REVIEW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	o	C	o	0	115. 00
116. 00 11600 HOSPI CE	0	o	C	o	0	116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	19, 268, 518	11, 700, 673	C	289, 525	1, 727, 213	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	17, 928	0	C	0	0	190. 00
191. 00 19100 RESEARCH	4, 269	0	C	0	0	191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	553, 585	2, 103, 768	C	0	310, 551	192. 00
192. 01 19201 CENTER OF HOPE	578	0	C	0	0	192. 01
192.02 19202 OTHER FA FACILITIES NRCC	112, 589	0	C	0	0	192. 02
193. 00 19300 NONPALD WORKERS	0	0	C	o	0	193. 00
194.00 07950 OTHER NRCC	17, 176	o	C	o	0	194. 00
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	o	C	o	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	19, 974, 643	13, 804, 441	C	289, 525	2, 037, 764	202. 00

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2022 Part I
To 12/31/2022 Date/Time Prepared: 5/29/2023 9:51 am

				10 12/31/2022	5/29/2023 9:5	
Cost Center Description	DI ETARY	CAFETERI A	MAINTENANCE OF		CENTRAL	
			PERSONNEL	ADMI NI STRATI ON	SERVI CES & SUPPLY	
	10.00	11. 00	12.00	13.00	14. 00	
GENERAL SERVICE COST CENTERS						
1.00 00100 CAP REL COSTS-BLDG & FIXT						1. 00
2. 00 00200 CAP REL COSTS-MVBLE EQUI P						2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 00 00500 ADMINISTRATIVE & GENERAL						4. 00 5. 00
6.00 00600 MAINTENANCE & REPAIRS						6.00
7. 00 00700 0PERATION OF PLANT						7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00 00900 HOUSEKEEPI NG						9. 00
10. 00 01000 DI ETARY	1, 889, 293					10.00
11. 00 01100 CAFETERI A	0	1, 063, 616	5			11. 00
12.00 01200 MAINTENANCE OF PERSONNEL	0	C) (12. 00
13. 00 01300 NURSI NG ADMINI STRATI ON	0	C) (.,		13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY	0	C		152	908, 121	14.00
15. 00 01500 PHARMACY	0	C			0	15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY 17. 00 01700 SOCI AL SERVI CE		C			0	16. 00 17. 00
18. 00 01850 OTHER GEN SERV					0	18. 00
19. 00 01900 NONPHYSI CLAN ANESTHETI STS	o	C		ol ol	0	19. 00
20. 00 02000 NURSI NG PROGRAM	0	C		o	0	20.00
21.00 02100 1&R SERVICES-SALARY & FRINGES APPRVD	0	C		o	0	21. 00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	C		o	0	22. 00
23. 00 02301 PARAMED ED PRGM	0	C		0	0	23. 00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	1, 685, 374	948, 814	1		0	30.00
31. 00 03100 I NTENSI VE CARE UNI T 32. 00 03200 CORONARY CARE UNI T	203, 919	114, 802			0	31. 00 32. 00
33. 00 03200 CORONARY CARE UNIT		C			0	32.00
34. 00 03400 SURGI CAL INTENSI VE CARE UNI T					0	34. 00
40. 00 04000 SUBPROVI DER - 1 PF	0	Ċ			0	40. 00
41. 00 04100 SUBPROVI DER - I RF	o	C		o	0	41. 00
43. 00 04300 NURSERY	0	C		o	0	43.00
44.00 04400 SKILLED NURSING FACILITY	0	C		o	0	44. 00
45.00 04500 NURSING FACILITY	0	C		이	0	45. 00
46. 00 O4600 OTHER LONG TERM CARE	0	C		0	0	46. 00
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 0PERATI NG ROOM	O	C		811, 822	0	50.00
51. 00 05100 RECOVERY ROOM					0	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM				243, 021	0	52. 00
53. 00 05300 ANESTHESI OLOGY	o	C		ol ol	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	C		236	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	C		o	0	55. 00
56. 00 05600 RADI 0I SOTOPE	0	C) (0	0	56. 00
57.00 05700 CT SCAN	0	C		1, 096	0	57. 00
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	C		0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON		C		349, 420	0	59.00
60. 00 06000 LABORATORY 60. 01 06001 BLOOD LABORATORY		C			0	60. 00 60. 01
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		C		1	U	61. 00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	o	C		ol ol	0	62. 00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	C		o	0	63.00
64. 00 06400 I NTRAVENOUS THERAPY	0	C		o	0	64. 00
65. 00 06500 RESPI RATORY THERAPY	0	C		0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	C		0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	C		0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	C		0 0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY	0			961	0	69. 00 70. 00
71. 00 07100 ELECTROENCEPHALOGRAPHY 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS					544, 873	70.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		C		ol ol	363, 248	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	o	C		ol ol	0	73. 00
74. 00 07400 RENAL DIALYSIS	o	C		o	0	74. 00
75.00 07500 ASC (NON-DISTINCT PART)	0	C		ol ol	0	75. 00
76.00 03950 OTHER ANCILL SRVC	0	C		o	0	76. 00
76. 01 03951 CARDI AC AND PULMONARY REHAB	0	C		3, 052	0	76. 01
76. 02 03952 WOUND CARE	0	C		이	0	76. 02
77. 00 07700 ALLOGENEI C STEM CELL ACQUI SITI ON	0	C		0	0	77. 00
0UTPATIENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC	l ol				0	00 00
88. 00 08800 RURAL HEALTH CLINIC 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER		(0	88. 00 89. 00
90. 00 09000 CLI NI C		(0	90.00
90. 01 09001 CLI NI C		C		76, 328	0	90. 01
90. 02 09002 CLI NI C		C		45, 996	0	90. 02
·				· · · · · · · · · · · · · · · · · · ·		·

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

			To	12/31/2022	Date/Time Pre 5/29/2023 9:5	pared:
Cost Center Description	DI ETARY	CAFETERIA N	MAINTENANCE OF	NURSI NG	CENTRAL	i dili
5551 551151 B5551 p11511	512171111	5,11 2 1 2 11 11 11		ADMI NI STRATI ON	SERVICES &	
					SUPPLY	
	10.00	11. 00	12.00	13.00	14. 00	
91. 00 09100 EMERGENCY	0	0	0	320, 183	0	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94. 00
95. 00 09500 AMBULANCE SERVICES	0	0	0	0	0	95. 00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96. 00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97. 00
98. 00 09850 OTHER REI MBURSE	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	o	0	0	0	100.00
101.00 10100 HOME HEALTH AGENCY	0	o	0	0	0	101. 00
102.00 10200 OPIOID TREATMENT PROGRAM	0	O	0	0	0	102. 00
SPECIAL PURPOSE COST CENTERS						
105.00 10500 KIDNEY ACQUISITION	0	0	0	0	0	105. 00
106. 00 10600 HEART ACQUI SI TI ON	0	0	0	0	0	106. 00
107.00 10700 LIVER ACQUISITION	0	0	0	0	0	107. 00
108.00 10800 LUNG ACQUISITION	0	0	0	0		108. 00
109.00 10900 PANCREAS ACQUISITION	0	0	0	0	0	109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0	0	110. 00
111.00 11100 I SLET ACQUISITION	0	0	0	0	0	111. 00
113.00 11300 INTEREST EXPENSE						113. 00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	0		115. 00
116. 00 11600 HOSPI CE	0	0	0	0	0	116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	1, 889, 293	1, 063, 616	0	4, 367, 356	908, 121	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
191. 00 19100 RESEARCH	0	0	0	0		191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	60, 580		192. 00
192. 01 19201 CENTER OF HOPE	0	0	0	573		192. 01
192.02 19202 OTHER FA FACILITIES NRCC	0	0	0	148, 003		192. 02
193. 00 19300 NONPALD WORKERS	0	0	0	0		193. 00
194. 00 07950 OTHER NRCC	0	0	0	0	0	194. 00
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)	1, 889, 293	1, 063, 616	0	4, 576, 512	908, 121	202. 00

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2022 | Part | To 12/31/2022 | Date/Time Prepared: | To 12/31/2022 | Date/Time Prepared: | To 12/31/2022 | Prepared: | To 12/31/2022 | To 12/31/2022 | Prepared: | To 12/31/2022 | Prepared Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0165

				'	o 12/31/2022	Date/lime Pre 5/29/2023 9:5	
					OTHER GENERAL		
	Cost Contor Doscription	PHARMACY	MEDI CAL	SOCIAL SERVICE	SERVI CE OTHER GEN SERV	NONDHAST CT VN	
	Cost Center Description	PHARMACY	RECORDS &	SUCTAL SERVICE	UTHER GEN SERV	NONPHYSI CI AN ANESTHETI STS	
			LI BRARY				
	CENEDAL CEDALOE COCT CENTEDO	15. 00	16. 00	17. 00	18. 00	19. 00	
1. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP					•	2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						5.00
6. 00 7. 00	00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT						6. 00 7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE			•			8. 00
9.00	00900 HOUSEKEEPI NG						9. 00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A						10. 00 11. 00
12. 00	01200 MAI NTENANCE OF PERSONNEL						12.00
13.00	01300 NURSING ADMINISTRATION						13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	2 420 007					14. 00
15. 00 16. 00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	3, 438, 087	1, 945, 751				15. 00 16. 00
17. 00	01700 SOCIAL SERVICE		1, 743, 731	o)		17. 00
18. 00	01850 OTHER GEN SERV	0	0	0	0		18. 00
19.00	01900 NONPHYSI CI AN ANESTHETI STS	0	0	0		0	19.00
20. 00 21. 00	02000 NURSING PROGRAM 02100 I&R SERVICES-SALARY & FRINGES APPRVD		0	0	_		20. 00 21. 00
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRVD	o	0	Ö			22. 00
23. 00	02301 PARAMED ED PRGM	o	0	0	0		23. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS		178, 898	0	0	0	30. 00
31.00	03100 INTENSIVE CARE UNIT		27, 879	1			31.00
32.00	03200 CORONARY CARE UNIT	O	0	i		0	32. 00
33.00	03300 BURN INTENSIVE CARE UNIT	0	0	0		0	33.00
34. 00 40. 00	03400 SURGICAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF	0	0	0		0	34. 00 40. 00
41. 00	04100 SUBPROVI DER - I RF	o	Ö	Ö		Ö	41. 00
43.00	04300 NURSERY	0	0	0	· ·	0	43. 00
44. 00 45. 00	04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY	0	0	0		0	44. 00 45. 00
46. 00	04600 OTHER LONG TERM CARE		0			-	46.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	278, 706	1			50.00
51. 00 52. 00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM		32, 728 0	1		0	51. 00 52. 00
53. 00	05300 ANESTHESI OLOGY	o	69, 550			Ö	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	103, 888	1	0	0	54. 00
55. 00 56. 00	05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0 0	55.00
57. 00	05600		154, 825	0	0	Ŭ	56. 00 57. 00
	05800 MAGNETIC RESONANCE IMAGING (MRI)	O	87, 751			0	58. 00
	05900 CARDI AC CATHETERI ZATI ON	0	80, 535		0	0	59.00
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	0	221, 795	0	0	0	60. 00 60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY					Ŭ	61.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62. 00
63. 00 64. 00	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY	0	0	0	0	0	63. 00 64. 00
65.00	06500 RESPIRATORY THERAPY		28, 684		0	0	65.00
66.00	06600 PHYSI CAL THERAPY	O	8, 845	l .	0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	8, 451	l .	0	0	67.00
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY		4, 160 66, 710	l .	0	0	68. 00 69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	o	13, 579		Ö	Ö	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	94, 259		0	0	71. 00
72.00	07200 DRUCS CHARGED TO PATIENTS	2 429 097	98, 695	l .	0	0	72.00
73. 00 74. 00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	3, 438, 087	100, 294 0	n	0	0	73. 00 74. 00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	o	Ö	0	75. 00
	03950 OTHER ANCILL SRVC	0	0	0	0	0	76.00
76. 01 76. 02	03951 CARDI AC AND PULMONARY REHAB 03952 WOUND CARE	0	1, 519 0	1	0	0	76. 01 76. 02
	07700 ALLOGENEIC STEM CELL ACQUISITION		0				77.00
	OUTPATIENT SERVICE COST CENTERS		-				
88. 00 89. 00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0				
	09000 CLINIC		0				
		. "!					

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

				0 12/31/2022	5/29/2023 9:5	
				OTHER GENERAL	10,27,2020 7.0	
				SERVI CE		
Cost Center Description	PHARMACY	MEDI CAL	SOCIAL SERVICE	OTHER GEN SERV	NONPHYSI CI AN	
		RECORDS &			ANESTHETI STS	
		LI BRARY				
	15. 00	16. 00	17. 00	18. 00	19. 00	
90. 01 09001 CLI NI C	0	88, 365	1	0	0	90. 01
90. 02 09002 CLI NI C	0	11, 284	0	0	0	
91. 00 09100 EMERGENCY	0	184, 351	0	0	0	91.00
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
95. 00 09500 AMBULANCE SERVICES	0	0	C	0	0	95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	O.	0	0	96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	C	0	0	97. 00
98. 00 09850 OTHER REI MBURSE	0	0	C	0	0	98. 00
99. 00 09900 CMHC	O	0	ol c	o	0	99. 00
99. 10 09910 CORF	0	0	ol c	o	0	99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	O	0	l c	o	0	100.00
101.00 10100 HOME HEALTH AGENCY	o	0		o	0	101.00
102.00 10200 OPIOID TREATMENT PROGRAM	o	0		o	0	102.00
SPECIAL PURPOSE COST CENTERS	-			- 1		
105. 00 10500 KIDNEY ACQUISITION	0	0	C	0	0	105. 00
106. 00 10600 HEART ACQUISITION	o	0	l c	o	0	106. 00
107. 00 10700 LIVER ACQUISITION	ol	0		ol	0	107. 00
108.00 10800 LUNG ACQUISITION	0	0		0		108. 00
109. 00 10900 PANCREAS ACQUISITION	o	0	i d	o		109. 00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON	o	0	i d	o		110.00
111. 00 11100 SLET ACQUI SITION	o	0		أم		111. 00
113. 00 11300 NTEREST EXPENSE		· ·			ı	113. 00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF					I	114.00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)		0		ا	0	115. 00
116. 00 11600 HOSPI CE		0]		ı	116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	3, 438, 087	1, 945, 751			0	118. 00
NONREI MBURSABLE COST CENTERS	3, 430, 007	1, 743, 731		<u> </u>	0	1110.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		O	0	190. 00
191. 00 19100 RESEARCH	o	0		o		191. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	o o	0				192. 00
192. 01 19201 CENTER OF HOPE	ا	0				192. 01
192. 02 19202 OTHER FA FACILITIES NRCC	ا	0				192. 02
193. 00 19300 NONPALD WORKERS		0]	0		193. 00
194. 00 07950 OTHER NRCC		0				194. 00
200.00 Cross Foot Adjustments	١	0	1	i Y		200. 00
201.00 Negative Cost Centers		0				200.00
202.00 TOTAL (sum lines 118 through 201)	3, 438, 087	1, 945, 751				201.00
202. 00 TOTAL (Suill TITIES TTO LITEOUGH 201)	3, 430, 087	1, 940, 751	1	ı Y	. 0	1202.00

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2022 Part I
To 12/31/2022 Date/Time Prepared: 5/29/2023 9:51 am

NIPSHINES A RESIDENTS SALUTION PROMISE TO PROMISE					1) 12/31/2022	5/29/2023 9:5	
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In Lieu of Form CMS-2552-10
Period: Worksheet B
From 01/01/2022 Part I Provider CCN: 15-0165

			To	12/31/2022	Date/Time Pre 5/29/2023 9:5	pared: 1 am
		INTERNS &	RESI DENTS		, -, -, -, -, -, -, -, -, -, -, -, -, -,	
Cost Center Description	NURSI NG		SERVI CES-OTHER	PARAMED ED	Subtotal	
	PROGRAM	Y & FRINGES	PRGM COSTS	PRGM	24.00	
90. 02 09002 CLI NI C	20. 00	21.00	22. 00	23.00	24. 00 758, 181	90. 02
91. 00 09100 EMERGENCY	0		· -	0	9, 521, 450	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	O	0	U	٥	9, 521, 450	92.00
OTHER REIMBURSABLE COST CENTERS						72.00
94. 00 09400 HOME PROGRAM DI ALYSI S	0	0	0	0	0	94.00
95. 00 09500 AMBULANCE SERVICES	0	Ö	o	ol	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	o	0	97. 00
98. 00 09850 OTHER REIMBURSE	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	o	0	99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100. 00
101.00 10100 HOME HEALTH AGENCY	0	0	0	0		101. 00
102.00 10200 OPI OI D TREATMENT PROGRAM	0	0	0	0	0	102. 00
SPECIAL PURPOSE COST CENTERS						
105.00 10500 KIDNEY ACQUISITION	0	0	0	0		105. 00
106. 00 10600 HEART ACQUI SI TI ON	0	0	0	0		106. 00
107. 00 10700 LIVER ACQUISITION	0	0	0	0		107. 00
108. 00 10800 LUNG ACQUISITION	0	0	0	0		108. 00
109. 00 10900 PANCREAS ACQUISITION	0	0	0	0		109. 00
110. 00 11000 NTESTI NAL ACQUI SI TI ON	0	0	0	0		110.00
111. 00 11100 SLET ACQUI SI TI ON	Ü	0	0	U	0	111.00
113. 00 11300 I NTEREST EXPENSE						113.00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF	0			0	0	114.00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.) 116. 00 11600 HOSPICE	0	0	U	U O		115. 00 116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0		0	0	131, 500, 477	1
NONREI MBURSABLE COST CENTERS	U		l o	<u> </u>	131, 300, 477	1110.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	123, 804	190 00
191. 00 19100 RESEARCH	0	0	Ö	o o		191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	Ö	0	6, 297, 732	
192. 01 19201 CENTER OF HOPE	0	0	0	0		192. 01
192.02 19202 OTHER FA FACILITIES NRCC	0	0	0	o	925, 497	
193. 00 19300 NONPALD WORKERS	0	0	0	o	0	193. 00
194. 00 07950 OTHER NRCC	0	0	0	O	118, 609	194. 00
200.00 Cross Foot Adjustments	0	0	o	0	0	200. 00
201.00 Negative Cost Centers	0	0	0	0	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	0	0	0	0	139, 000, 162	202. 00

Health Financial Systems FRANCISCAN HEALTH MUNSTER In Lieu of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0165 Period: Worksheet B

From 01/01/2022 Part I Date/Time Prepared: 12/31/2022 5/29/2023 9:51 am Cost Center Description Intern & Total Residents Cost & Post Stepdown Adj ustments 25.00 26.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 00600 MAINTENANCE & REPAIRS 6.00 6.00 00700 OPERATION OF PLANT 7.00 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10 00 10 00 01100 CAFETERI A 11.00 11.00 12. 00 01200 MAINTENANCE OF PERSONNEL 12.00 13.00 01300 NURSING ADMINISTRATION 13.00 01400 CENTRAL SERVICES & SUPPLY 14 00 14 00 15.00 01500 PHARMACY 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16.00 01700 SOCIAL SERVICE 17 00 17 00 01850 OTHER GEN SERV 18.00 18.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 19.00 02000 NURSING PROGRAM 20.00 20.00 02100 I &R SERVICES-SALARY & FRINGES APPRVD 21 00 21 00 22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 22.00 02301 PARAMED ED PRGM 23.00 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 33, 647, 597 30.00 31.00 03100 INTENSIVE CARE UNIT 5, 805, 199 31.00 0000000 03200 CORONARY CARE UNIT 32.00 32.00 03300 BURN INTENSIVE CARE UNIT 33.00 0 33.00 03400 SURGICAL INTENSIVE CARE UNIT 34.00 0 34 00 40.00 04000 SUBPROVIDER - IPF 0 40.00 04100 SUBPROVI DER - I RF 41.00 0 41.00 43.00 04300 NURSERY 0 43.00 04400 SKILLED NURSING FACILITY 44.00 Ω 44 00 04500 NURSING FACILITY 0 45.00 45.00 04600 OTHER LONG TERM CARE 0 46.00 46.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 12, 655, 799 50.00 51.00 05100 RECOVERY ROOM 0 2, 704, 230 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 53.00 05300 ANESTHESI OLOGY 3, 960, 376 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 00000000 5, 209, 702 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 55.00 56.00 05600 RADI OI SOTOPE 56.00 57.00 05700 CT SCAN 1, 427, 464 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 1, 751, 536 58.00 05900 CARDI AC CATHETERI ZATI ON 59.00 6, 395, 901 59.00 06000 LABORATORY 60.00 8, 783, 643 60 00 60.01 06001 BLOOD LABORATORY C 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 0 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 62.00 0000000000000000 62.00 0 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 63.00 64.00 06400 I NTRAVENOUS THERAPY 64.00 06500 RESPIRATORY THERAPY 65.00 2, 879, 776 65.00 485, 764 66 00 06600 PHYSI CAL THERAPY 66 00 06700 OCCUPATIONAL THERAPY 67.00 405, 441 67.00 06800 SPEECH PATHOLOGY 171, 681 68.00 68.00 69.00 06900 ELECTROCARDI OLOGY 985, 857 69.00 70 00 07000 ELECTROENCEPHALOGRAPHY 2, 055, 582 70 00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 11, 534, 965 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 7, 794, 128 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 8, 849, 750 73.00 74.00 07400 RENAL DIALYSIS Ω 74.00 75.00 07500 ASC (NON-DISTINCT PART) 0 75.00 03950 OTHER ANCILL SRVC 76.00 76.00 0 76.01 03951 CARDIAC AND PULMONARY REHAB 356, 182 76.01 76.02 03952 WOUND CARE 0 C 76.02 07700 ALLOGENEIC STEM CELL ACQUISITION 77.00 0 77.00 OUTPATIENT SERVICE COST CENTERS 88 00 0 88.00 108800 RURAL HEALTH CLINIC 0 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 89.00 90. 00 09000 CLINIC 90.00

| Period: | Worksheet B | From 01/01/2022 | Part | I | To | 13/21/2023 | Part | To | 13/21/2023 Provider CCN: 15-0165

			From 01/01/2022 Part To 12/31/2022 Date/Time Pr	epared:
			5/29/2023 9:	
Cost Center Description	Intern &	Total		
	Residents Cost			
	& Post			
	Stepdown			
	Adjustments			
	25. 00	26. 00		
90. 01 09001 CLI NI C	0	3, 360, 273		90. 01
90. 02 09002 CLI NI C	0	758, 181		90. 02
91. 00 09100 EMERGENCY	0	9, 521, 450		91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			92. 00
OTHER REIMBURSABLE COST CENTERS				
94.00 09400 HOME PROGRAM DIALYSIS	0	0		94.00
95. 00 09500 AMBULANCE SERVICES	0	0		95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0		97. 00
98. 00 09850 OTHER REI MBURSE	0	0		98. 00
99. 00 09900 CMHC	o	0		99. 00
99. 10 09910 CORF	o	0		99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	o	0		100.00
101.00 10100 HOME HEALTH AGENCY	0	0		101. 00
102.00 10200 OPIOID TREATMENT PROGRAM	0	0		102. 00
SPECIAL PURPOSE COST CENTERS	' '	<u>'</u>		
105. 00 10500 KI DNEY ACQUI SI TI ON	0	0		105. 00
106. 00 10600 HEART ACQUISITION	o	0		106. 00
107. 00 10700 LIVER ACQUISITION	0	0		107. 00
108. 00 10800 LUNG ACQUISITION	0	0		108. 00
109. 00 10900 PANCREAS ACQUISITION	0	0		109. 00
110. 00 11000 NTESTINAL ACQUISITION	0	0		110.00
111. 00 11100 SLET ACQUISITION	0	0		111.00
113. 00 11300 NTEREST EXPENSE		J		113. 00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF				114. 00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)	ا	0		115. 00
116. 00 11600 HOSPI CE		0		116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)		131, 500, 477		118. 00
NONREI MBURSABLE COST CENTERS	ı o	131, 300, 477		110.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		123, 804		190. 00
191. 00 19100 RESEARCH		29, 478		191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES		6, 297, 732		191.00
192. 00 19200 PHYSICIANS PRIVATE OFFICES 192. 01 19201 CENTER OF HOPE		4, 565		192. 00
192. 01 19201 CENTER OF HOPE 192. 02 19202 OTHER FA FACILITIES NRCC		925, 497		192. 01
193. 00 19300 NONPALD WORKERS		920, 497		192. 02
193. 00 19300 NONPALD WORKERS 194. 00 07950 OTHER NRCC		110 (00		194. 00
		118, 609		
200.00 Cross Foot Adjustments		0		200. 00
201.00 Negative Cost Centers	0	120,000,110		201. 00
202.00 TOTAL (sum lines 118 through 201)	0	139, 000, 162		202. 00

| Peri od: | Worksheet B | From 01/01/2022 | Part | I | To 12/31/2022 | Date/Time Prepared: | Part | Part | Prepared: | Part | Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0165

				То	12/31/2022	Date/Time Pre 5/29/2023 9:5	
			CAPI TAL REI	LATED COSTS		1 0, 2, 7, 2020 7. 0	
	Cost Center Description	Directly	BLDG & FLXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
	cost center bescription	Assigned New	BLDG & TIXI	WVDLL LQUIF	Subtotal	BENEFITS	
		Capi tal				DEPARTMENT	
		Related Costs 0	1.00	2.00	2A	4. 00	
	GENERAL SERVICE COST CENTERS	0	1.00	2.00	ZA	4.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUI P		00.740		00.740	00.740	2.00
4. 00 5. 00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	0	83, 718 804, 629		83, 718 804, 629	83, 718 17, 554	4. 00 5. 00
6. 00	00600 MAINTENANCE & REPAIRS	0	004, 029		004, 029	1, 356	6.00
7. 00	00700 OPERATION OF PLANT	0	0	0	0	0	7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	0	0	0	0	0	8. 00
9.00	00900 HOUSEKEEPI NG	0	0	0	0	1, 852	9. 00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	0	289, 142	0	289, 142	806 861	10. 00 11. 00
12. 00	01200 MAI NTENANCE OF PERSONNEL	0	0		0	0	12.00
13.00	01300 NURSING ADMINISTRATION	0	0	0	0	4, 050	13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	0	0	0	425	14. 00
15. 00	01500 PHARMACY	0	112, 310		112, 310	2, 886	15.00
16. 00 17. 00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	0	5, 285 0	0	5, 285 0	900	16. 00 17. 00
18. 00	01850 OTHER GEN SERV	Ö	Ö	Ö	0	0	18. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19. 00
20. 00	02000 NURSI NG PROGRAM	0	0	0	0	0	20.00
21. 00 22. 00	02100 &R SERVI CES-SALARY & FRINGES APPRVD 02200 &R SERVI CES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	21. 00 22. 00
23. 00	02301 PARAMED ED PRGM	0	0	0	0	0	23. 00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>		<u> </u>			20.00
30. 00	03000 ADULTS & PEDIATRICS	0	1, 408, 898		1, 408, 898	19, 114	30. 00
31.00	03100 NTENSIVE CARE UNIT	0	339, 498		339, 498		31.00
32. 00 33. 00	03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	32. 00 33. 00
34. 00	03400 SURGICAL INTENSIVE CARE UNIT	0	0		0	0	34. 00
40.00	04000 SUBPROVI DER - I PF	0	0	0	0	0	40. 00
41. 00	04100 SUBPROVI DER - I RF	0	0	0	0	0	41.00
43. 00 44. 00	04300 NURSERY 04400 SKILLED NURSING FACILITY	0	0	0	0	0	43. 00 44. 00
45. 00	04500 NURSING FACILITY	0	0	0	0	0	45. 00
46. 00	04600 OTHER LONG TERM CARE	Ö	0	Ö	0	0	46. 00
	ANCILLARY SERVICE COST CENTERS						
50. 00 51. 00	05000 OPERATI NG ROOM 05100 RECOVERY ROOM	0	639, 431 280, 517	0	639, 431	6, 438	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	200, 517		280, 517 0	1, 249 0	51. 00 52. 00
53. 00	05300 ANESTHESI OLOGY	O	O	Ö	0	57	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	297, 290	0	297, 290	2, 573	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55. 00
56. 00 57. 00	05600	0	0	0	0	0 800	56. 00 57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0	0	0	1, 398	58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	603, 940	ō	603, 940	2, 780	59. 00
60.00	06000 LABORATORY	0	103, 795	0	103, 795	0	60. 00
60. 01	06001 BLOOD LABORATORY	0	0	0	0	0	60. 01
61. 00 62. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	61. 00 62. 00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	Ö	Ö	Ö	0	0	63. 00
64.00	06400 I NTRAVENOUS THERAPY	0	0	0	0	0	64. 00
65. 00	06500 RESPI RATORY THERAPY	0	51, 714	0	51, 714	1, 913	65. 00
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0	0	0	0	510	66. 00 67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0	0	0	383 183	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0	Ö	0	838	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	263, 928	0	263, 928	630	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71. 00
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	72. 00 73. 00
	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
75. 00	07500 ASC (NON-DISTINCT PART)	0	Ö	0	0	0	75. 00
76. 00	03950 OTHER ANCILL SRVC	0	0	0	0	0	76. 00
76. 01	03951 CARDI AC AND PULMONARY REHAB	0	0	0	0	371	76. 01
76. 02 77. 00	03952 WOUND CARE 07700 ALLOGENEI C STEM CELL ACQUISITION	0	0	0	0	0	76. 02 77. 00
, , . 00	OUTPATIENT SERVICE COST CENTERS	·	0	. 0	U	0	, , ,
	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

COST Center Description				To	12/31/2022	Date/Time Prepared: 5/29/2023 9:51 am	
Assigned New Capital Related Costs 1,00 2,00 2A 4,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00			CAPI TAL REI	ATED COSTS		372772023 7. 31 4111	
Assigned New Capital Related Costs 1,00 2,00 2A 4,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00 0,00							
Capital Related Costs Capital Related Rela	Cost Center Description		BLDG & FIXT	MVBLE EQUIP	Subtotal		
Page							
90. 00 09000 CLI NI C						DEPARTMENT	
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114.00	111.00 11100 ISLET ACQUISITION	0	0	0	0	0 111. 00	0
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 0 0 0 0 0 115. 00 116. 00 116. 00 116. 00 116. 00 116. 00 0 0 0 0 0 0 0 116. 00 116. 00 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 0 5, 691, 750 0 5, 691, 750 80, 002 118. 00 118. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 11						113. 00	0
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118.00 SUBTOTALS (SUM OF LINES 1 through 117) 0 5,691,750 0 5,691,750 80,002 118.00		0	0		0		
NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 64 190. 00 191. 00 19100 RESEARCH 0 0 0 0 32 191. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 863, 647 0 863, 647 2, 748 192. 00 192. 01 19201 CENTER OF HOPE 0 0 0 0 0 4 192. 01 192. 02 19202 OTHER FA FACI LI TI ES NRCC 0 0 0 0 0 738 192. 02 193. 00 19300 NONPAI D WORKERS 0 0 0 0 0 193. 00 194. 00 07950 OTHER NRCC 0 0 0 0 0 130 194. 00 200. 00 Cross Foot Adjustments 0 0 0 0 0 201. 00 193. 00 19300 Negati ve Cost Centers 0 0 0 0 0 0 190. 00 0 0 0 0 0 0 190. 00 0 0 0 0 0 0 190. 00 0 0 0 0 0 0 190. 00 0 0 0 0 190. 00 0 0 0 0 190. 00 0 0 0 0 190. 00 0 0 0 0 190. 00 0 0 0 0 190. 00 0 0 0 0 190. 00 0 0 0 0 190. 00 0 0 0 0 190. 00 0 0 0 0 190. 00 0 0 0 0 190. 00 0 0 0 0 190. 00 0 0 0 0 190. 00 0 0 0 0 190. 00 0 0 0 0 190. 00 0 0 0 0 190. 00 0 0 0 0 190. 00 0 0 0 190. 00 0 0 0 190. 00 0 0 0 190. 00 0 0 0 0 190. 00 0 0 0 190. 00 0 0 0 190. 00 0 0 0 190. 00 0 0 0 190. 00 0 0 0 190. 00 0 0 0 190. 00 0 0 0 190. 00 0 0 0 190. 00 0 0 0 190. 00 0 0 0 190. 00 0 0 0 190. 00 0 0 0 190. 00 0 0 0 190. 00 0 0 0 190. 00 0 0 0 190. 00 0 0 0 190. 00 0 0 0 190. 00 0 0 0 190. 00 0 0 0 190. 00 0 0 0 190. 00 0 0 0 190. 00 0 0 0 190. 00 0 0 0 190. 00 0 0 0 190. 00 0 0 0 190. 00 0 0 0 190. 00 0 0 0 190. 00 0 0 0		0	0	- 1	0		
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 64 190. 00 191. 00 19100 RESEARCH 0 0 0 0 32 191. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFICES 0 863, 647 0 863, 647 2, 748 192. 00 192. 01 19201 CENTER OF HOPE 0 0 0 0 4 192. 01 192. 02 19202 OTHER FA FACILITIES NRCC 0 0 0 0 738 192. 02 193. 00 19300 NONPAID WORKERS 0 0 0 0 0 193.00 194. 00 07950 OTHER NRCC 0 0 0 0 0 130 194. 00 200. 00 0 Cross Foot Adjustments 0 0 0 0 0 201. 00 Negative Cost Centers 0 0 0 0 0 0	118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	5, 691, 750	0	5, 691, 750	80, 002 118. 00	J
191. 00 19100 RESEARCH			0		٥١	64 100 00	^
192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 863,647 0 863,647 2,748 192.00 192.01 19201 CENTER OF HOPE 0 0 0 0 4 192.01 192.02 19202 OTHER FA FACILITIES NRCC 0 0 0 0 0 738 192.02 193.00 19300 NORALD WORKERS 0 0 0 0 0 0 193.00 194.00 07950 OTHER NRCC 0 0 0 0 0 130 194.00 200.00 Cross Foot Adjustments 0 Negative Cost Centers 0 0 0 0 0 0 0 0 0 0 201.00		0	0		0		
192. 01 19201 CENTER OF HOPE 0 0 0 0 0 4 192. 01 192. 02 19202 OTHER FA FACILITIES NRCC 0 0 0 0 738 192. 02 193. 00 19300 NONPAI D WORKERS 0 0 0 0 0 0 193. 00 194. 00 07950 OTHER NRCC 0 0 0 0 0 130 194. 00 200. 00 Cross Foot Adjustments 0 Negative Cost Centers 0 0 0 0 0 0 0 0 201. 00			963 647	0	863 647		
192. 02 19202 OTHER FA FACILITIES NRCC 0 0 0 738 192. 02 193. 00 19300 NONPAI D WORKERS 0 0 0 0 0 193. 00 194. 00 07950 OTHER NRCC 0 0 0 0 0 130 194. 00 200. 00 Cross Foot Adjustments 0 Negative Cost Centers 0 0 0 0 0 0 0 0 201. 00			003, 047	0	003, 047		
193.00 19300 NONPAI D WORKERS 0 0 0 0 0 193.00 194.00 194.00 07950 OTHER NRCC 0 0 0 0 130 194.00 200.00 Cross Foot Adjustments 0 0 0 0 0 0 201.00			0		0		
194.00 07950 OTHER NRCC 0 0 0 130 194.00 200.00 Cross Foot Adjustments 0 0 0 0 0 200.00 201.00 Negative Cost Centers 0 0 0 0 0 0 201.00			0	o o	ol		
200.00 Cross Foot Adjustments 0 200.00 201.00 Negative Cost Centers 0 0 0 0 0 0 201.00			0	o	ol		
201.00 Negative Cost Centers 0 0 0 201.00			J		ol		
			0	o	o		
202.00 101AL (sum lines 118 through 201) 0 6,555,397 0 6,555,397 83,718 202.00	202.00 TOTAL (sum lines 118 through 201)	o	6, 555, 397	О	6, 555, 397	83, 718 202. 00	Э

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0165

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

5/29/2023 9:51 am Cost Center Description ADMINISTRATIVE MAINTENANCE & OPERATION OF LAUNDRY & HOUSEKEEPI NG & GENERAL **REPAIRS PLANT** LINEN SERVICE 9.00 5.00 6.00 8.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 5 00 822, 183 5 00 6.00 00600 MAINTENANCE & REPAIRS 82, 284 83, 640 6.00 00700 OPERATION OF PLANT 7.00 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 1.726 0 1, 726 8.00 13, 998 00900 HOUSEKEEPI NG 0 9.00 12, 146 9 00 10.00 01000 DI ETARY 6,443 714 10.00 4, 267 11.00 01100 CAFETERI A 0 0 0 Ω 11.00 0 01200 MAINTENANCE OF PERSONNEL 0 12.00 12 00 0 C 0 0 13.00 01300 NURSING ADMINISTRATION 27, 279 0 0 13.00 C 14.00 01400 CENTRAL SERVICES & SUPPLY 5, 412 0 0 0 0 0 0 14.00 01500 PHARMACY 0 15.00 277 18.622 1.658 15.00 01600 MEDICAL RECORDS & LIBRARY 0 16.00 11, 510 78 13 16.00 17.00 01700 SOCIAL SERVICE C 0 0 17.00 01850 OTHER GEN SERV 18 00 0 0 18.00 01900 NONPHYSICIAN ANESTHETISTS 0 0 19.00 0 0 19.00 02000 NURSING PROGRAM 0 20 00 0 C Λ 20.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD 0 0 21.00 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 22.00 0 0 0 O 22.00 02301 PARAMED ED PRGM 23.00 0 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 147. 335 20, 793 0 1. 540 3. 481 30.00 31.00 03100 INTENSIVE CARE UNIT 23, 137 5, 011 0 839 31.00 186 03200 CORONARY CARE UNIT 0 32.00 Λ 32.00 33.00 03300 BURN INTENSIVE CARE UNIT 0 C 0 0 0 33.00 03400 SURGICAL INTENSIVE CARE UNIT 0 34.00 0 0 0 0 34.00 04000 SUBPROVI DER - I PF 0 0 40.00 0 0 40.00 0 04100 SUBPROVIDER - IRF 0 41.00 C 0 41.00 0 43.00 04300 NURSERY 0 0 0 0 43.00 0 04400 SKILLED NURSING FACILITY 0 0 44.00 0 0 44.00 04500 NURSING FACILITY 0 45 00 0 45 00 C 0 0 04600 OTHER LONG TERM CARE 46.00 0 46.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 58, 282 9.437 0 0 1, 579 50.00 0 05100 RECOVERY ROOM 51.00 9,796 4, 140 693 51.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 0 0 0 52.00 53.00 05300 ANESTHESI OLOGY 23, 192 0 0 0 0 0 53.00 54 00 05400 RADI OLOGY-DI AGNOSTI C 25 479 4, 388 0 734 54 00 05500 RADI OLOGY-THERAPEUTI C 0 55.00 0 55.00 C 05600 RADI OI SOTOPE 56.00 0 56.00 57.00 05700 CT SCAN 7,579 0 0 57.00 C 0 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 9, 917 58 00 0 58 00 59.00 05900 CARDIAC CATHETERIZATION 25, 498 8, 914 0 1, 492 59.00 60.00 06000 LABORATORY 49, 305 1, 532 0 0 256 60.00 06001 BLOOD LABORATORY 0 0 60.01 60.01 0 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 61.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 C 0 0 0 62.00 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 0 0 0 0 0 0 0 0 0 0 0 63.00 06400 I NTRAVENOUS THERAPY 0 64.00 0 64.00 06500 RESPIRATORY THERAPY 0 65 00 16.133 763 128 65.00 06600 PHYSI CAL THERAPY 2,843 66.00 66.00 67.00 06700 OCCUPATIONAL THERAPY 2, 366 Ω 0 Ω 67.00 06800 SPEECH PATHOLOGY 999 0 68.00 C 0 68.00 0 69.00 06900 ELECTROCARDI OLOGY 5.473 Λ 69.00 07000 ELECTROENCEPHALOGRAPHY 70.00 70.00 7,774 3, 895 652 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 64, 947 71.00 71.00 43, 705 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS C 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 31,659 C 0 0 73.00 74.00 07400 RENAL DIALYSIS 0 0 74.00 0 07500 ASC (NON-DISTINCT PART) 75.00 0 0 0 75.00 0 03950 OTHER ANCILL SRVC 0 76.00 0 C Ω 76.00 03951 CARDI AC AND PULMONARY REHAB 0 76.01 2,096 76.01 o 03952 WOUND CARE C 0 0 76.02 76.02 0 07700 ALLOGENEIC STEM CELL ACQUISITION 0 77.00 0 0 0 0 77.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 С 0 0 88.00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 C 0 0 89.00 0 0 09000 CLI NI C 0 90.00 90 00 C 0 90.01 09001 CLI NI C 19,048 0 0 0 90.01 C 09002 CLI NI C 654 0 90. 02 3, 440 0 109 90.02 09100 EMERGENCY 0 898 91.00 91 00 47 692 5 363

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

			To	12/31/2022	Date/Time Pre 5/29/2023 9:5	
Cost Center Description	ADMI NI STRATI VE N	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	T GIII
oost conten boschiptron	& GENERAL	REPAI RS	PLANT	LINEN SERVICE	HOUSEREEFFING	
	5. 00	6. 00	7. 00	8. 00	9. 00	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS				•		
94. 00 09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94. 00
95. 00 09500 AMBULANCE SERVICES	o	0	0	0	0	95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	o	0	0	0	0	96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	o	0	0	0	0	97. 00
98. 00 09850 OTHER REIMBURSE	o	0	0	0	0	98. 00
99. 00 09900 CMHC	o	0	0	0	0	99. 00
99. 10 09910 CORF	o	0	0	0	0	99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	o	0	0	0	0	100.00
101.00 10100 HOME HEALTH AGENCY	o	0	0	0	0	101. 00
102.00 10200 OPIOID TREATMENT PROGRAM	o	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS						
105. 00 10500 KIDNEY ACQUISITION	0	0	0	0	0	105. 00
106.00 10600 HEART ACQUISITION	o	0	0	0	0	106. 00
107.00 10700 LIVER ACQUISITION	0	0	0	O	0	107. 00
108.00 10800 LUNG ACQUISITION	o	0	0	0	0	108. 00
109.00 10900 PANCREAS ACQUISITION	o	0	0	0	0	109. 00
110.00 11000 INTESTINAL ACQUISITION	o	0	0	0	0	110.00
111.00 11100 ISLET ACQUISITION	o	O	0	0	0	111. 00
113.00 11300 INTEREST EXPENSE						113. 00
114.00 11400 UTILIZATION REVIEW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	O	0	o	0	115. 00
116. 00 11600 HOSPI CE	o	O	0	0	0	116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 1	17) 793, 117	70, 893	0	1, 726	11, 865	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	738	0	0	0	0	190. 00
191. 00 19100 RESEARCH	176	0	0	0	0	191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	22, 787	12, 747	0	0	2, 133	192. 00
192.01 19201 CENTER OF HOPE	24	0	0	0	0	192. 01
192.02 19202 OTHER FA FACILITIES NRCC	4, 634	0	0	0	0	192. 02
193.00 19300 NONPALD WORKERS	0	0	0	0		193. 00
194.00 07950 OTHER NRCC	707	O	0	o	0	194. 00
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	O	0	o	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	822, 183	83, 640	0	1, 726	13, 998	202. 00

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2022 Part II
To 12/31/2022 Date/Time Prepared: 5/29/2023 9:51 am

					0 12/31/2022	5/29/2023 9:5	
	Cost Center Description	DI ETARY	CAFETERI A	MAINTENANCE OF PERSONNEL	NURSI NG ADMI NI STRATI ON	CENTRAL	
				PERSUNNEL	ADMINISTRATION	SERVICES & SUPPLY	
		10.00	11. 00	12.00	13. 00	14. 00	
1 00	GENERAL SERVICE COST CENTERS						1 00
1. 00 2. 00	OO100 CAP REL COSTS-BLDG & FIXT OO200 CAP REL COSTS-MVBLE EQUIP						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00	00500 ADMINISTRATIVE & GENERAL						5. 00
6.00	00600 MAI NTENANCE & REPAI RS						6.00
7.00	00700 OPERATION OF PLANT						7. 00
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
9.00	00900 HOUSEKEEPI NG						9. 00
10. 00	01000 DI ETARY	301, 372					10. 00
11. 00	01100 CAFETERI A	0	861	1			11. 00
12.00	01200 MAI NTENANCE OF PERSONNEL	0	(0	24 220		12.00
13. 00 14. 00	01300 NURSI NG ADMI NI STRATI ON		(31, 329	E 020	13.00
15. 00	O1400 CENTRAL SERVI CES & SUPPLY O1500 PHARMACY		(1	5, 838 0	1
16. 00	01600 MEDICAL RECORDS & LIBRARY		(0	0	1
17. 00	01700 SOCIAL SERVICE		(0	0	1
	01850 OTHER GEN SERV	0	(0	0	1
19. 00	01900 NONPHYSICIAN ANESTHETISTS	0	Ć	o o	0	0	1
20.00	02000 NURSI NG PROGRAM	0	(0	0	0	20. 00
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	0	(0	0	0	21. 00
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRVD	0	(0	0	0	22. 00
23. 00	02301 PARAMED ED PRGM	0	(0	0	0	23. 00
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS		=		10.10/		
30.00	03000 ADULTS & PEDI ATRI CS	268, 844	768	1		0	
31.00	03100 INTENSIVE CARE UNIT	32, 528	93	•	4, 084	0	
32. 00 33. 00	03300 BURN INTENSIVE CARE UNIT	0	(1	0	0	
34. 00	03400 SURGICAL INTENSIVE CARE UNIT		(0	0	34.00
40. 00	04000 SUBPROVI DER - I PF	0	(0	0	40.00
41. 00	04100 SUBPROVI DER - I RF	0	(0	0	41. 00
43. 00	04300 NURSERY	o	(0	0	1
44.00	04400 SKILLED NURSING FACILITY	o	(0	0	0	44. 00
45.00	04500 NURSING FACILITY	0	(0	0	0	45. 00
46.00	04600 OTHER LONG TERM CARE	0	(0	0	0	46. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0	(0	
51.00	05100 RECOVERY ROOM	0	(0	1, 669	0	51.00
52. 00 53. 00	05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY		(0	0	52. 00 53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C		(2	0	1
55. 00	05500 RADI OLOGY-THERAPEUTI C		(0	0	1
56. 00	05600 RADI OI SOTOPE	0	(0	0	1
57. 00	05700 CT SCAN	0	Ć	o o	8	0	1
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	(0	0	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	(0	2, 392	0	59. 00
60.00	06000 LABORATORY	0	(0	0	0	60. 00
60. 01	06001 BLOOD LABORATORY	0	(0	0	0	
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		_				61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	(0	0	
63. 00 64. 00	06300 BLOOD STORING, PROCESSING & TRANS.		(0	0	
65. 00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY		(0	0	1
66. 00	06600 PHYSI CAL THERAPY		(0	0	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0	(0	0	1
68. 00	06800 SPEECH PATHOLOGY	0	(0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	(7	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	o	(0	0	0	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	(0	0	3, 503	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	(0	0	2, 335	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	(0	0	0	73. 00
74. 00	07400 RENAL DI ALYSI S	0	(0	0	0	
75. 00	07500 ASC (NON-DISTINCT PART)	0	(0	0	0	75. 00
76. 00	03950 OTHER ANCILL SRVC	0	(<u>0</u>	0	0	76.00
76. 01	03951 CARDI AC AND PULMONARY REHAB	0	(21	0	
	03952 WOUND CARE	0	(0	0	
77. 00	O7700 ALLOGENEI C STEM CELL ACQUISITION OUTPATIENT SERVICE COST CENTERS	0	(0	0	0	77. 00
88. 00	08800 RURAL HEALTH CLINIC	0	(0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER		(n	0	1
90. 00	09000 CLINIC		(ol o	Ö	0	1
90. 01	09001 CLI NI C		Ć	0	523	0	1
90. 02	09002 CLI NI C	0	() 0	315	0	1
	•	'-			'		

In Lieu of Form CMS-2552-10
Period: Worksheet B
From 01/01/2022 Part II Provider CCN: 15-0165

			T	12/31/2022		pared:
Cost Center Description	DIETARY	CAFETERI A	MAINTENANCE OF	NURSI NG	CENTRAL	alli
				ADMI NI STRATI ON		
					SUPPLY	
	10.00	11. 00	12. 00	13. 00	14.00	
91. 00 09100 EMERGENCY	0	0	0	2, 192	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
95. 00 09500 AMBULANCE SERVICES	0	0	0	0	0	95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
98. 00 09850 OTHER REI MBURSE	0	0	0	0	0	98. 00
99. 00 09900 CMHC	0	0	0	0	0	99. 00
99. 10 09910 CORF	0	0	0	0	0	99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100. 00
101.00 10100 HOME HEALTH AGENCY	0	0	0	0		101. 00
102.00 10200 OPIOID TREATMENT PROGRAM	0	0	0	0	0	102. 00
SPECIAL PURPOSE COST CENTERS						
105.00 10500 KIDNEY ACQUISITION	0	0	0	0		105. 00
106. 00 10600 HEART ACQUI SI TI ON	0	0	0	0	•	106. 00
107.00 10700 LIVER ACQUISITION	0	0	0	0		107. 00
108.00 10800 LUNG ACQUISITION	0	0	0	0		108. 00
109.00 10900 PANCREAS ACQUISITION	0	0	0	0		109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0		110. 00
111.00 11100 I SLET ACQUI SI TI ON	0	0	0	0		111. 00
113.00 11300 INTEREST EXPENSE						113. 00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	0		115. 00
116. 00 11600 H0SPI CE	0	0	0	0		116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	301, 372	861	0	29, 897	5, 838	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190. 00
191. 00 19100 RESEARCH	0	0	0	0		191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	415		192. 00
192.01 19201 CENTER OF HOPE	0	0	0	4		192. 01
192.02 19202 OTHER FA FACILITIES NRCC	0	0	0	1, 013		192. 02
193. 00 19300 NONPALD WORKERS	0	0	0	0		193. 00
194.00 07950 OTHER NRCC	0	0	0	0		194. 00
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)	301, 372	861	0	31, 329	5, 838	202. 00

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2022 Part II
To 12/31/2022 Date/Time Prepared: 5/29/2023 9:51 am Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0165

					0 12/31/2022	5/29/2023 9:5	
					OTHER GENERAL		
	Cost Center Description	PHARMACY	MEDI CAL	SOCIAL SERVICE	SERVI CE OTHER GEN SERV	NONPHYSI CI AN	
	cost center bescription	FIARWACT	RECORDS &	SOCIAL SERVICE	OTTICK GEN SERV	ANESTHETISTS	
			LI BRARY				
	I	15. 00	16. 00	17. 00	18. 00	19. 00	
1. 00	GENERAL SERVICE COST CENTERS O0100 CAP REL COSTS-BLDG & FIXT			I			1.00
2. 00	00200 CAP REL COSTS-BLDG & TTXT						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						5. 00
6.00	00600 MAI NTENANCE & REPAIRS						6.00
7. 00 8. 00	OO7OO OPERATION OF PLANT OO8OO LAUNDRY & LINEN SERVICE						7. 00 8. 00
9. 00	00900 HOUSEKEEPING						9. 00
10.00	01000 DI ETARY						10. 00
11. 00	01100 CAFETERI A						11.00
12. 00 13. 00	01200 MAI NTENANCE OF PERSONNEL						12.00
14. 00	01300 NURSI NG ADMINI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY						13. 00 14. 00
15. 00	01500 PHARMACY	135, 753					15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	O	17, 786				16. 00
17. 00	01700 SOCIAL SERVICE	0	0				17. 00
18. 00 19. 00	O1850 OTHER GEN SERV O1900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	18. 00 19. 00
20. 00	02000 NURSI NG PROGRAM		0	0	0	0	20.00
21. 00	02100 I&R SERVICES-SALARY & FRINGES APPRVD	o	0	Ö	0		21. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	0	0				22. 00
23. 00	02301 PARAMED ED PRGM	0	0	0	0		23. 00
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	0	1, 652	0	0		30.00
31. 00	03100 NTENSI VE CARE UNI T	o	257	•			31.00
32.00	03200 CORONARY CARE UNIT	o	0	0	0		32. 00
33. 00	03300 BURN INTENSIVE CARE UNIT	0	0	0	0		33. 00
34. 00 40. 00	03400 SURGICAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF	0	0	0			34. 00 40. 00
41. 00	04100 SUBPROVI DER - I RF		0	0	_		41.00
43.00	04300 NURSERY	O	0	0	0		43.00
44. 00	04400 SKILLED NURSING FACILITY	0	0	0			44. 00
45. 00 46. 00	04500 NURSING FACILITY 04600 OTHER LONG TERM CARE	0	0				45. 00 46. 00
40.00	ANCI LLARY SERVI CE COST CENTERS	J	0				40.00
50.00	05000 OPERATING ROOM	0	2, 389	0	0		50. 00
51. 00	05100 RECOVERY ROOM	0	302				51.00
52. 00 53. 00	05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	0	0 642		_		52. 00 53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	o	960				54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	O	0		0		55. 00
56.00	05600 RADI OI SOTOPE	0	0	0	_		56. 00
57. 00 58. 00	05700 CT SCAN 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	1, 430 811				57. 00 58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON		744		_		59.00
60.00	06000 LABORATORY	o	2, 049				60.00
60. 01	06001 BLOOD LABORATORY	0	0	0	0		60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0		0		61.00
62. 00 63. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06300 BLOOD STORING, PROCESSING & TRANS.		0	0			62. 00 63. 00
64. 00	06400 I NTRAVENOUS THERAPY	o	0	1	0		64. 00
65. 00	06500 RESPI RATORY THERAPY	0	265		0		65. 00
66.00	06600 PHYSI CAL THERAPY	0	82 78				66.00
67. 00 68. 00	O6700 OCCUPATIONAL THERAPY O6800 SPEECH PATHOLOGY		38	•	_		67. 00 68. 00
69. 00	06900 ELECTROCARDI OLOGY	o	616	•	_		69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	o	125	0	0		70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	871		-		71.00
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	135, 753	912 926		_		72. 00 73. 00
74.00	07400 RENAL DIALYSIS	133, 733	926		0		74.00
75. 00	07500 ASC (NON-DISTINCT PART)	o	0		0		75. 00
76. 00	03950 OTHER ANCILL SRVC	0	0	0	0		76. 00
76. 01	03951 CARDI AC AND PULMONARY REHAB	0	14				76. 01
76. 02 77. 00	03952 WOUND CARE 07700 ALLOGENEIC STEM CELL ACQUISITION		0		-		76. 02 77. 00
. , . 00	OUTPATIENT SERVICE COST CENTERS	<u> </u>					1
	08800 RURAL HEALTH CLINIC	0	0				88. 00
89. 00 90. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0				89. 00 90. 00
70.00	10,000 00111110	<u> </u>	0	1	ı	İ.	1 70.00

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

			1	o 12/31/2022	Date/Time Pre 5/29/2023 9:5	
				OTHER GENERAL	3/27/2023 7.3	i dili
				SERVI CE		
Cost Center Description	PHARMACY	MEDI CAL	SOCIAL SERVICE	OTHER GEN SERV	NONPHYSI CI AN	
cost center bescription	THANWACT	RECORDS &	SOCIAL SERVICE	OTTIER GEN SERV	ANESTHETI STS	
		LI BRARY			ANESTHETISTS	
	15. 00	16. 00	17. 00	18. 00	19. 00	
90. 01 09001 CLI NI C	0	816		0		90. 01
90. 02 09002 CLI NI C	o	104		ol		90. 02
91. 00 09100 EMERGENCY		1, 703		أم		91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	١	., , , ,	Ĭ	Ĭ		92.00
OTHER REIMBURSABLE COST CENTERS			I .			72.00
94. 00 09400 HOME PROGRAM DIALYSIS	0	0	0	0		94. 00
95. 00 09500 AMBULANCE SERVICES		0	0	أم		95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED		0	0	o		96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD		0	0	0		97. 00
98. 00 09850 OTHER REI MBURSE		0	0			98. 00
99. 00 09900 CMHC		0				99.00
99. 10 09910 CORF		0		0		99. 10
100.00 10000 I &R SERVI CES-NOT APPRVD PRGM		0		0		100.00
101. 00 10100 HOME HEALTH AGENCY		0				101.00
102. OO 10200 OPI OI D TREATMENT PROGRAM		0		0		101.00
SPECIAL PURPOSE COST CENTERS	<u> </u>		10	<u> </u>		102.00
105. 00 10500 KI DNEY ACQUISITION	ol	0	0	O		105. 00
106. 00 10600 HEART ACQUISITION		0	0	_		106.00
107. 00 10700 LIVER ACQUISITION		0		0		107. 00
107. 00 10700 ETVER ACQUISITION 108. 00 10800 LUNG ACQUISITION		0		0		107.00
109. 00 10900 PANCREAS ACQUISITION	0	0		0		109.00
	0	0	0	U		
110. 00 11000 NTESTI NAL ACQUI SI TI ON	0	0	0	U		110.00
111. 00 11100 SLET ACQUI SI TI ON	U	Ü	0	U		111.00
113. 00 11300 INTEREST EXPENSE						113. 00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF		•				114.00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	0		115. 00
116. 00 11600 HOSPI CE	0	0	0	0		116. 00
118. 00 SUBTOTALS (SUM OF LINES 1 through 117)	135, 753	17, 786	0	0	0	118. 00
NONREI MBURSABLE COST CENTERS			1 0			100 00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190. 00
191. 00 19100 RESEARCH	0	0	0	0		191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0		192. 00
192. 01 19201 CENTER OF HOPE	0	0	0	0		192. 01
192.02 19202 OTHER FA FACILITIES NRCC	0	0	0	0		192. 02
193. 00 19300 NONPALD WORKERS	0	0	0	0		193. 00
194. 00 07950 OTHER NRCC	0	0	0	0		194. 00
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)	135, 753	17, 786	0	0	0	202. 00

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2022 | Part II | To 12/31/2022 | Date/Time Prepared: | To 12/31/2022 | Date/Time Prepared: | To 12/31/2022 | Date/Time Prepared: | To 12/31/2022 | To 12/31/202 | To 12/31/2022 | To 12/31/202 | To 12/31/ Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0165

Section Property					10	5 12/31/2022	Date/lime Pre 5/29/2023 9:5	
PROSECUTE PROCESS PROJECT PROCESS PROJECT				INTERNS &	RESI DENTS			
PROSECUTE PROCESS PROJECT PROCESS PROJECT		Cost Center Description	NURSLING	SERVICES_SALAR	SERVI CES_OTHER	PARAMEN EN	Subtotal	
BERBERL SERVICE COST CERT LENS 1 0 00000 CAR PEL COSTS - MIRE FORMERS 1 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		cost center bescription					Subtotal	
1.00 00000 CORP REL COSTS-BUELD & FIX 2.00 00000 CORP REL COSTS-BUELD & 1.00 2.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.			20. 00	21. 00	22. 00	23. 00	24. 00	
2.00 DOZOO CAN PILL COSTS-MYBLE EQUIP 2.00 DOZOO CAN PILL COSTS-MYBLE EQUIP 4.00 DOZOO CAN PILL COSTS-MYBLE EQUIP 4.00 DOZOO CAN PILL COSTS-MYBLE EQUIP 4.00 DOZOO CAN PILL COSTS MYBLE EQUIP 4.00 D	1 00							1 00
4.00 DOSCO HANDENDE SERVICE S CERTISAN C. 00 CONTROL								1
0.00 00.000 NA MTEMANCE & REPAIRS								1
7.00 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 000000		1						1
8.00 0000000000000000000000000000000000								1
9.00 00000 MUSIEREEPI NG		1						1
10.00 1000 DETARY		1						1
12.00 1700 MAINTENINKE: OF PERSONNEL 12.00 1400 CENTRAL SERVICES & SUPPLY 15.00 1400 CENTRAL SERVICES & SUPPLY 16.00 CENTRAL SERVIC		1						1
13.00 01300 MIRSING ALMIN INSTRATION 13.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00		1						1
14.00 101-00 104-00 104-00 104-00 104-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 105-00 10								1
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In Lieu of Form CMS-2552-10
Period: Worksheet B
From 01/01/2022 Part II Provider CCN: 15-0165

			Ť	0 12/31/2022	Date/Time Pre 5/29/2023 9:5	pared:
		INTERNS &	RESI DENTS		1072772020 7.0	T CIII
			T			
Cost Center Description	NURSI NG	SERVI CES-SALAR			Subtotal	
	PROGRAM	Y & FRINGES	PRGM COSTS	PRGM	04.00	
00. 03. 00003 CLINIC	20. 00	21.00	22.00	23. 00	24. 00	00.00
90. 02 09002 CLINI C					49, 227	90. 02
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)					425, 457	91. 00 92. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS						92.00
94. 00 09400 HOME PROGRAM DIALYSIS					0	94. 00
95. 00 09500 AMBULANCE SERVICES					0	95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED					0	96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD					0	97.00
98. 00 09850 OTHER REI MBURSE			•		0	98.00
99. 00 09900 CMHC			•		0	99.00
99. 10 09910 CORF			•		0	99. 10
100.00 10000 I &R SERVI CES-NOT APPRVD PRGM						100.00
101. 00 10100 HOME HEALTH AGENCY						101.00
102.00 10200 OPI OI D TREATMENT PROGRAM						102.00
SPECIAL PURPOSE COST CENTERS						102.00
105. 00 10500 KI DNEY ACQUI SI TI ON					0	105. 00
106. 00 10600 HEART ACQUISITION						106. 00
107. 00 10700 LI VER ACQUI SI TI ON						107. 00
108.00 10800 LUNG ACQUISITION					0	108. 00
109. 00 10900 PANCREAS ACQUISITION						109. 00
110.00 11000 INTESTINAL ACQUISITION					0	110.00
111.00 11100 I SLET ACQUI SI TI ON					0	111. 00
113. 00 11300 I NTEREST EXPENSE						113. 00
114.00 11400 UTILIZATION REVIEW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)					0	115. 00
116. 00 11600 HOSPI CE					0	116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	C	0	0	o	5, 642, 656	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN					802	190. 00
191. 00 19100 RESEARCH					208	191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES					904, 477	192. 00
192.01 19201 CENTER OF HOPE						192. 01
192.02 19202 OTHER FA FACILITIES NRCC						192. 02
193. 00 19300 NONPALD WORKERS						193. 00
194.00 07950 OTHER NRCC						194. 00
200.00 Cross Foot Adjustments	(0	0	0		200. 00
201.00 Negative Cost Centers	C	l control of the cont	0	0		201. 00
202.00 TOTAL (sum lines 118 through 201)	C) o	0	0	6, 555, 397	202. 00

Health FinancialSystemsFRANCISCAN HEALTH MUNSTERIn Lieu of Form CMS-2552-10ALLOCATION OF CAPITALRELATED COSTSProvider CCN: 15-0165Period:Worksheet B

From 01/01/2022 Part II Date/Time Prepared: 12/31/2022 5/29/2023 9:51 am Cost Center Description Intern & Total Residents Cost & Post Stepdown Adj ustments 25.00 26.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 00600 MAINTENANCE & REPAIRS 6.00 6.00 00700 OPERATION OF PLANT 7.00 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10 00 10 00 01100 CAFETERI A 11.00 11.00 12. 00 01200 MAINTENANCE OF PERSONNEL 12.00 13.00 01300 NURSING ADMINISTRATION 13.00 01400 CENTRAL SERVICES & SUPPLY 14 00 14 00 15.00 01500 PHARMACY 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16.00 01700 SOCIAL SERVICE 17 00 17 00 18.00 01850 OTHER GEN SERV 18.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 19.00 02000 NURSING PROGRAM 20.00 20.00 02100 I &R SERVICES-SALARY & FRINGES APPRVD 21 00 21 00 22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 22.00 02301 PARAMED ED PRGM 23.00 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 1, 885, 551 30.00 31.00 03100 INTENSIVE CARE UNIT 0 408, 679 31.00 03200 CORONARY CARE UNIT 000000 32.00 32.00 03300 BURN INTENSIVE CARE UNIT 33.00 0 33.00 03400 SURGICAL INTENSIVE CARE UNIT 34.00 0 34 00 40.00 04000 SUBPROVI DER - I PF 0 40.00 04100 SUBPROVI DER - I RF 41.00 0 41.00 43.00 04300 NURSERY 0 43.00 04400 SKILLED NURSING FACILITY 44.00 Ω 44 00 0 04500 NURSING FACILITY 45.00 45.00 04600 OTHER LONG TERM CARE 0 46.00 46.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 723, 113 50.00 51.00 05100 RECOVERY ROOM 0 298, 366 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 53.00 05300 ANESTHESI OLOGY 23.891 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 00000000 331, 426 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 55.00 56.00 05600 RADI OI SOTOPE 56.00 9, 817 57.00 05700 CT SCAN 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 12, 126 58.00 05900 CARDI AC CATHETERI ZATI ON 59.00 645, 760 59.00 06000 LABORATORY 60.00 156, 937 60 00 60.01 06001 BLOOD LABORATORY Ω 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 62.00 00000000000000000 0 62.00 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 0 63.00 64.00 06400 I NTRAVENOUS THERAPY 64.00 06500 RESPIRATORY THERAPY 65.00 70, 916 65.00 66 00 06600 PHYSI CAL THERAPY 3 435 66 00 06700 OCCUPATIONAL THERAPY 67.00 2, 827 67.00 1, 220 06800 SPEECH PATHOLOGY 68.00 68.00 69.00 06900 ELECTROCARDI OLOGY 6, 934 69.00 277, 004 70 00 07000 ELECTROENCEPHALOGRAPHY 70 00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 69, 321 71.00 46, 952 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 168.338 73.00 74.00 07400 RENAL DIALYSIS Ω 74.00 75.00 07500 ASC (NON-DISTINCT PART) 0 75.00 03950 OTHER ANCILL SRVC 76.00 76.00 76.01 03951 CARDIAC AND PULMONARY REHAB 2,502 76.01 76.02 03952 WOUND CARE 0 C 76.02 07700 ALLOGENEIC STEM CELL ACQUISITION 77.00 0 77.00 OUTPATIENT SERVICE COST CENTERS 88 00 0 88.00 08800 RURAL HEALTH CLINIC Ω 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 89.00 90. 00 09000 CLINIC 90.00

ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0165 Peri od: Worksheet B From 01/01/2022 Part II Date/Time Prepared: 12/31/2022 5/29/2023 9:51 am Cost Center Description Intern & Total Residents Cost & Post Stepdown Adjustments 26.00 25.00 90. 01 09001 CLINIC 22, 857 90.01 09002 CLI NI C 0 90. 02 49, 227 90.02 91.00 91.00 09100 EMERGENCY 0 425, 457 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 94.00 0 0 0 0 0 0 0 0 0 09500 AMBULANCE SERVICES 95.00 95.00 0 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 96.00 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD 0 97.00 98. 00 | 09850 OTHER REIMBURSE 0 98.00 09900 CMHC 99.00 0 99.00 99. 10 09910 CORF 0 99. 10 100.00 10000 I &R SERVICES-NOT APPRVD PRGM 0 100.00 101.00 10100 HOME HEALTH AGENCY 101. 00 0 102.00 10200 OPI OI D TREATMENT PROGRAM 0 102.00 SPECIAL PURPOSE COST CENTERS 105. 00 10500 KI DNEY ACQUISITION 105.00 000000 0 106.00 10600 HEART ACQUISITION 106. 00 0 107. 00 10700 LIVER ACQUISITION 0 107.00 108.00 10800 LUNG ACQUISITION 0 108. 00 109.00 10900 PANCREAS ACQUISITION 110.00 11000 INTESTINAL ACQUISITION 0 109. 00 0 110. 00 111.00 11100 I SLET ACQUISITION 0 111. 00 113.00 11300 INTEREST EXPENSE 113. 00 114.00 11400 UTI LI ZATI ON REVIEW-SNF 114. 00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 0 115. 00 116. 00 11600 HOSPI CE 0 116.00 SUBTOTALS (SUM OF LINES 1 through 117)
NONREI MBURSABLE COST CENTERS 0 5, 642, 656 118. 00 118.00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 802 190.00 191. 00 19100 RESEARCH 191. 00 0 0 0 0 0 0 0 0 208 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 904, 477 192. 00 192. 01 19201 CENTER OF HOPE 192. 01 32 192.02 19202 OTHER FA FACILITIES NRCC 6, 385 192. 02 193. 00 19300 NONPALD WORKERS 193. 00 0 194.00 07950 OTHER NRCC 194. 00

837

6, 555, 397

C

200. 00

201.00

202. 00

200.00

201.00

202.00

Cross Foot Adjustments

Negative Cost Centers

TOTAL (sum lines 118 through 201)

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0165 Peri od: Worksheet B-1 From 01/01/2022 12/31/2022 Date/Time Prepared: 5/29/2023 9:51 am CAPITAL RELATED COSTS BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Reconciliation ADMINISTRATIVE Cost Center Description (SQUARE FEET) (SQUARE FEET) BENEFITS & GENERAL (ACCUM. COST) DEPARTMENT (GROSS SALARI ES) 1.00 2.00 5. 00 4.00 5A GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 178 609 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 2, 281 52, 859, 951 4.00 00500 ADMINISTRATIVE & GENERAL 21, 923 -19, 974, 643 5 00 11 082 324 117 961 903 5 00 6.00 6.00 00600 MAINTENANCE & REPAIRS 0 0 855, 983 11, 805, 418 7.00 00700 OPERATION OF PLANT 0 7.00 00800 LAUNDRY & LINEN SERVICE 0 247, 599 8.00 8.00 C 0 00900 HOUSEKEEPI NG 1, 169, 194 1, 742, 675 9 00 0 0 9 00 10.00 01000 DI ETARY 7,878 508, 747 924, 458 10.00 01100 CAFETERI A 11.00 0 543, 313 -1, 063, 616 11.00 01200 MAINTENANCE OF PERSONNEL 12.00 12.00 0 n 01300 NURSING ADMINISTRATION 2.556,844 3, 913, 787 13.00 0 Ω 0 13 00 14.00 01400 CENTRAL SERVICES & SUPPLY 0 268, 446 0 776, 486 14.00 01500 PHARMACY 0 15.00 3.060 1, 822, 190 2, 671, 721 15.00 0 01600 MEDICAL RECORDS & LIBRARY 568, 411 1, 651, 352 16,00 144 16,00 17 00 01700 SOCIAL SERVICE 0 C 17 00 01850 OTHER GEN SERV 0 0 0 18.00 18.00 0 19 00 01900 NONPHYSICIAN ANESTHETISTS 0 0 O 19.00 0 02000 NURSI NG PROGRAM 20.00 0 20.00 C 0 0 0 0 21.00 02100 I &R SERVICES-SALARY & FRINGES APPRVD C 0 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 0 22.00 0 0 22.00 02301 PARAMED ED PRGM 23.00 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 38. 387 0 12, 073, 926 0 21, 140, 269 30.00 03100 INTENSIVE CARE UNIT 0 31.00 9.250 1, 923, 053 3, 319, 551 31.00 o 32.00 03200 CORONARY CARE UNIT 0 0 0 32.00 0 03300 BURN INTENSIVE CARE UNIT 0 33.00 0 C 0 Ω 33.00 03400 SURGICAL INTENSIVE CARE UNIT 0 0 34.00 34.00 04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF 0 40.00 0 0 0 Ω 40.00 0 0 41 00 C Λ 41 00 0 43.00 04300 NURSERY C 0 0 43.00 04400 SKILLED NURSING FACILITY 0 0 44.00 0 0 0 44.00 04500 NURSING FACILITY 45.00 45.00 0 0 04600 OTHER LONG TERM CARE 46.00 0 46.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 17, 422 4, 064, 695 8, 361, 829 50.00 o 05100 RECOVERY ROOM 788, 680 1, 405, 501 51 00 7 643 Ω 51 00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 0 C 52.00 53.00 05300 ANESTHESI OLOGY 36, 132 0 3, 327, 395 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 8, 100 0 1, 624, 134 0 3, 655, 513 54.00 05500 RADI OLOGY-THERAPEUTI C 55 00 Ω 55 00 0 C0 56.00 05600 RADI OI SOTOPE 0 Ω 56.00 05700 CT SCAN 0 505, 080 1, 087, 411 57.00 0 57.00 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 882, 531 1, 422, 852 58.00 0 05900 CARDIAC CATHETERIZATION 1, 754, 889 3, 658, 191 59 00 16, 455 59 00 0 60.00 06000 LABORATORY 2,828 7, 073, 865 60.00 C 06001 BLOOD LABORATORY 60.01 0 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 0 61.00 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 62 00 0 0 0 62.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 63.00 0 06400 I NTRAVENOUS THERAPY 0 64.00 0 64.00 0 06500 RESPIRATORY THERAPY 1, 207, 549 2, 314, 594 65 00 1, 409 Ω 65 00 66.00 06600 PHYSI CAL THERAPY 322, 195 407, 856 66.00 06700 OCCUPATIONAL THERAPY 0 339, 502 67.00 0 241, 633 67.00 0 06800 SPEECH PATHOLOGY 143, 262 68.00 0 115, 276 68.00 06900 ELECTROCARDI OLOGY 69.00 0 529, 117 785, 223 69 00 07000 ELECTROENCEPHALOGRAPHY 397, 951 0 0 0 1, 115, 334 70.00 70.00 7, 191 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71 00 0 9, 318, 006 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 6, 270, 410 72.00 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 C 0 4, 542, 229 73.00 07400 RENAL DIALYSIS 0 74.00 74.00 07500 ASC (NON-DISTINCT PART) 0 75.00 0 0 0 0 75.00 03950 OTHER ANCILL SRVC 76.00 C 0 0 0 76.00 76.01 03951 CARDIAC AND PULMONARY REHAB 0 234, 130 0 300, 694 76.01 76.02 03952 WOUND CARE 0 C 0 0 76.02 07700 ALLOGENEIC STEM CELL ACQUISITION 77.00 77.00 0 0 OUTPATIENT SERVICE COST CENTERS 0 88.00 08800 RURAL HEALTH CLINIC 0 0 0 0 88.00

				Т	o 12/31/2022	Date/Time Pre 5/29/2023 9:5	
		CAPITAL REI	_ATED COSTS			3/24/2023 4.3	I alli
	Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS	Reconciliation	ADMI NI STRATI VE & GENERAL (ACCUM. COST)	
		1.00	2.00	SALARI ES)	ГА	F 00	
89. 00 08900	FEDERALLY QUALIFIED HEALTH CENTER	1.00	2.00	4. 00	5A 0	5. 00 0	89. 00
	CLINIC	0				0	90.00
	CLINIC	0			_	2, 732, 828	90.00
	CLINIC	1, 207		.,,		2, 732, 626 493, 497	90.01
	EMERGENCY	9, 900				6, 842, 510	
	OBSERVATION BEDS (NON-DISTINCT PART)	7, 700	٥	2,003,073	0	0, 042, 310	92.00
07200 0THER	REI MBURSABLE COST CENTERS						72.00
	HOME PROGRAM DIALYSIS	0	0	C	0	0	94. 00
	AMBULANCE SERVICES	0	Ö			0	95. 00
	DURABLE MEDICAL EQUIP-RENTED	0	O	C	0	0	96.00
	DURABLE MEDICAL EQUIP-SOLD	0	O	C	0	0	97. 00
	OTHER REIMBURSE	0	0	l c	0	0	98. 00
99. 00 09900	СМНС	0	0	C	0	0	99. 00
99. 10 09910	CORF	0	0	C	0	0	99. 10
100.00 10000	I&R SERVICES-NOT APPRVD PRGM	0	0	C	0	0	100.00
	HOME HEALTH AGENCY	0	0	_		0	101. 00
	OPIOID TREATMENT PROGRAM	0	0	C	0	0	102. 00
	AL PURPOSE COST CENTERS						
	KIDNEY ACQUISITION	0	1				105. 00
	HEART ACQUISITION	0	0				106. 00
	LIVER ACQUISITION	0	0				107. 00
	LUNG ACQUISITION	0	0		_		108.00
	PANCREAS ACQUISITION	0	0	1	_		109. 00 110. 00
	INTESTINAL ACQUISITION ISLET ACQUISITION	0	0	0	0		111.00
	INTEREST EXPENSE	0	0		0	U	113.00
	UTI LI ZATI ON REVI EW-SNF						114. 00
	AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	0	0	115. 00
116. 00 11600		0	0	1	0		116.00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	155, 078	1	1	-21, 038, 259	_	
NONRE	IMBURSABLE COST CENTERS						
190. 00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	40, 288	0	105, 876	190. 00
191. 00 19100	RESEARCH	0	0	20, 325	0	25, 209	191. 00
	PHYSICIANS' PRIVATE OFFICES	23, 531	0	1, 734, 895	0	3, 269, 248	
	CENTER OF HOPE	0	0	2, 714	0	3, 414	192. 01
	OTHER FA FACILITIES NRCC	0	0	465, 690		664, 905	1
	NONPALD WORKERS	0	0	C			193. 00
194. 00 07950		0	0	81, 782	0	101, 433	1
200. 00	Cross Foot Adjustments						200. 00
201. 00	Negative Cost Centers	, , , , , , , , , , , , , , , , , , , ,		40 700 005		40.074.440	201. 00
202.00	Cost to be allocated (per Wkst. B, Part	6, 555, 397	0	12, 702, 095		19, 974, 643	202.00
203. 00	Unit cost multiplier (Wkst. B, Part I)	36. 702501	0. 000000	0. 240297		0. 169331	203. 00
204.00	Cost to be allocated (per Wkst. B, Part			83, 718	1	822, 183	
	II						
205. 00	Unit cost multiplier (Wkst. B, Part II)			0. 001584		0. 006970	1
206. 00	NAHE adjustment amount to be allocated						206. 00
	(per Wkst. B-2)						
207. 00	NAHE unit cost multiplier (Wkst. D,						207. 00
I	Parts III and IV)	l	I	I	1		I

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0165

				11	0 12/31/2022	Date/lime Pre 5/29/2023 9:5	
	Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF	HOUSEKEEPING (SQUARE FEET)	DI ETARY (MEALS SERVED)	T Cam
		/ 00	7.00	LAUNDRY)	0.00	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
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00 6. 00	OO5OO ADMINISTRATIVE & GENERAL OO6OO MAINTENANCE & REPAIRS	154, 405					5. 00 6. 00
7. 00	00700 OPERATION OF PLANT	154, 405	0				7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	0	0	311, 110			8. 00
9. 00	00900 HOUSEKEEPI NG	0	0	0	154, 405	l .	9. 00
10.00	01000 DI ETARY	7, 878	0	0	7, 878	l '	10.00
11. 00 12. 00	O1100 CAFETERI A O1200 MAI NTENANCE OF PERSONNEL	0	0	0	0	0	11. 00 12. 00
13. 00	01300 NURSING ADMINISTRATION	0	0	0	0	0	13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	0	ő	0	Ö	14. 00
15. 00	01500 PHARMACY	3, 060	0	0	3, 060	0	15. 00
16.00	01600 MEDI CAL RECORDS & LI BRARY	144	0	0	144	0	16.00
17. 00 18. 00	O1700 SOCIAL SERVICE O1850 OTHER GEN SERV	0	0	0	0	0	17. 00 18. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19. 00
20. 00	02000 NURSI NG PROGRAM	0	0	ő	0	o o	20. 00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22. 00
23. 00	O2301 PARAMED ED PRGM INPATIENT ROUTINE SERVICE COST CENTERS	0	0	0	0	0	23. 00
30. 00	03000 ADULTS & PEDIATRICS	38, 387	0	277, 530	38, 387	192, 531	30.00
31. 00	03100 NTENSI VE CARE UNI T	9, 250	Ö		·	1	31.00
32.00	03200 CORONARY CARE UNIT	0	0	0	0	0	32. 00
33. 00	03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34. 00 40. 00	03400 SURGICAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF	0	0	0	0	0	34. 00 40. 00
41. 00	04100 SUBPROVI DER – TFI	0	0	0	0	0	41.00
43. 00	04300 NURSERY	0	0	Ō	0	0	43. 00
44. 00	04400 SKILLED NURSING FACILITY	0	0	0	0	0	44. 00
45. 00	04500 NURSING FACILITY	0	0	0	0	0	45. 00
46. 00	O4600 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	46. 00
50. 00	05000 OPERATING ROOM	17, 422	0	0	17, 422	0	50.00
51. 00	05100 RECOVERY ROOM	7, 643	0	0	7, 643	0	51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53. 00 54. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	8, 100	0	0	0 8, 100	0	53. 00 54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	8, 100	0	0	8, 100		55. 00
56. 00	05600 RADI OI SOTOPE	0	0	ő	0	ő	56. 00
57. 00	05700 CT SCAN	0	0	0	0	0	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0	0	0	0	58. 00
	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	16, 455 2, 828	0	0	16, 455 2, 828	0	59. 00 60. 00
60. 01	06001 BLOOD LABORATORY	2,020	0	0	2, 020	0	60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY				G		61.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62. 00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63. 00
64. 00 65. 00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	1, 409	0	0	0 1, 409	0	64. 00 65. 00
66. 00	06600 PHYSI CAL THERAPY	0	0	0	1, 409	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	7 101	0	0	7 101	0	69.00
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	7, 191	0	0	7, 191 0	0	70. 00 71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	Ö	ő	0	Ö	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
	07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76. 00 76. 01	03950 OTHER ANCI LL SRVC 03951 CARDI AC AND PULMONARY REHAB	0	0	0	0	0	76. 00 76. 01
76. 02	03952 WOUND CARE	0	Ö	ő	o	Ö	76. 02
	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	Ō	0		77. 00
0-	OUTPATIENT SERVICE COST CENTERS						
88. 00 89. 00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		-	0	88. 00 89. 00
90.00	09000 CLINIC	0	0	0	-		90.00
	09001 CLI NI C	0	Ö	ő	-		90. 01
	· · · · · · · · · · · · · · · · · · ·						

				T	o 12/31/2022	Date/Time Pre 5/29/2023 9:5	pared:
	Cost Center Description	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	i aiii
	, , , , , , , , , , , , , , , , , , ,	REPAI RS	PLANT	LINEN SERVICE	(SQUARE FEET)	(MEALS SERVED)	
		(SQUARE FEET)	(SQUARE FEET)	(POUNDS OF			
				LAUNDRY)			
	II	6.00	7.00	8. 00	9. 00	10.00	
90. 02	09002 CLINIC	1, 207		_	1, 207	0	
91.00	09100 EMERGENCY	9, 900	0	0	9, 900	0	7 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS						92.00
94. 00	09400 HOME PROGRAM DIALYSIS	1 0	0	0	0	0	94. 00
95. 00	09500 AMBULANCE SERVICES		_		0	1	
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED				0	0	1
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD	0	_	_	0	0	
98. 00	09850 OTHER REIMBURSE				0	0	1
99. 00	09900 CMHC	0		j o	0	o o	
	09910 CORF	0		j o	0	l o	
	10000 I &R SERVICES-NOT APPRVD PRGM	0		o o	0	0	100.00
	10100 HOME HEALTH AGENCY	0	l o	Ō	0	Ō	
	10200 OPI OI D TREATMENT PROGRAM	0	o c	o	0	0	102.00
	SPECIAL PURPOSE COST CENTERS	•		•		•	1
105.00	10500 KIDNEY ACQUISITION	0	C	0	0	0	105. 00
106.00	10600 HEART ACQUISITION	0	0	0	0	0	106. 00
107.00	10700 LIVER ACQUISITION	0	0	0	0	0	107. 00
108.00	10800 LUNG ACQUISITION	0	0	0	0	0	108. 00
	10900 PANCREAS ACQUISITION	0	0	0	0		109. 00
	11000 INTESTINAL ACQUISITION	0	0	0	0		110. 00
	11100 I SLET ACQUI SI TI ON	0	0	0	0	0	111. 00
	11300 INTEREST EXPENSE						113. 00
	11400 UTILIZATION REVIEW-SNF						114. 00
	11500 AMBULATORY SURGICAL CENTER (D. P.)	0	_		0		115. 00
	11600 HOSPI CE	100.074	0	_	0		116. 00
118. 00		130, 874	0	311, 110	130, 874	215, 826	1118.00
100.00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	_	190. 00
	19100 RESEARCH		_		0	l	191. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	23, 531			23, 531		192. 00
	19201 CENTER OF HOPE	25, 551	_		23, 331		192. 01
	19202 OTHER FA FACILITIES NRCC	0	_	j o	0		192. 02
	19300 NONPALD WORKERS	0		o o	0		193. 00
	07950 OTHER NRCC	0	l o	Ō	0		194. 00
200.00	1						200.00
201.00							201.00
202.00	Cost to be allocated (per Wkst. B, Part	13, 804, 441	0	289, 525	2, 037, 764	1, 889, 293	202. 00
203.00	Unit cost multiplier (Wkst. B, Part I)	89. 404106	0.000000	0. 930619	13. 197526	8. 753779	203. 00
204.00	Cost to be allocated (per Wkst. B, Part	83, 640	0	1, 726	13, 998	301, 372	204. 00
205.00	,	0. 541692	0. 000000	0. 005548	0. 090658	1. 396366	1
206.00	, ,						206. 00
207.00	(per Wkst. B-2)						207.00
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00
		1	I	I		I	I

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS In Lieu of Form CMS-2552-10 FRANCISCAN HEALTH MUNSTER Provider CCN: 15-0165 Peri od: From 01/01/2022 To 12/31/2022 Worksheet B-1 Date/Time Prepared: 5/29/2023 9:51 am PHARMACY CAFETERI A MAINTENANCE OF NURSING CENTRAL (MEALS SERVED) PERSONNEL ADMINISTRATION SERVICES & Cost Center Description (COSTED

		(MEALS SERVED)	(NUMBER HOUSED)	(DI RECT NURS. HRS.)	SERVICES & SUPPLY (COSTED REQUIS.)	REQUIS.)	
	OFNEDAL CEDIUSE COCT OFNEDO	11.00	12. 00	13. 00	14.00	15. 00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2. 00
4. 00 5. 00	00500 ADMINISTRATIVE & GENERAL						4. 00 5. 00
6.00	00600 MAI NTENANCE & REPAI RS						6. 00
7. 00	00700 OPERATION OF PLANT						7. 00
8. 00 9. 00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG						8. 00 9. 00
10.00	01000 DI ETARY						10.00
11. 00	01100 CAFETERI A	230, 490					11. 00
12.00	01200 MAI NTENANCE OF PERSONNEL	0	0	074 400			12.00
13. 00 14. 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	0	0	271, 432	100		13. 00 14. 00
15. 00	01500 PHARMACY		0	ó	0	100	•
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16. 00
17. 00	01700 SOCIAL SERVICE	0	0	0	0	0	17. 00
18. 00 19. 00	01850 OTHER GEN SERV 01900 NONPHYSICIAN ANESTHETISTS		0	0	0	0	18. 00 19. 00
20. 00	02000 NURSI NG PROGRAM	0	0	Ö	Ö	0	20.00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	0	0	0	o	0	21. 00
22. 00	02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 02301 PARAMED ED PRGM	0	0	0	0	0	22. 00
23. 00	INPATIENT ROUTINE SERVICE COST CENTERS	l O	0	0	0	0	23. 00
30. 00	03000 ADULTS & PEDIATRICS	205, 612	0	113, 736	0	0	30. 00
31.00	03100 NTENSI VE CARE UNI T	24, 878	0		0	0	31.00
32. 00 33. 00	03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	32. 00 33. 00
34. 00	03400 SURGICAL INTENSIVE CARE UNIT		0	o	o	0	34. 00
40.00	04000 SUBPROVI DER - I PF	0	0	0	0	0	40. 00
41. 00	04100 SUBPROVI DER - I RF	0	0	0	0	0	41.00
43. 00 44. 00	04300 NURSERY 04400 SKILLED NURSING FACILITY		0	0	0	0	43. 00 44. 00
45. 00	04500 NURSING FACILITY	O	0	Ö	Ö	0	45. 00
46. 00	04600 OTHER LONG TERM CARE	0	0	0	0	0	46. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM		0	48, 149	ol	0	50. 00
51. 00	05100 RECOVERY ROOM		0	14, 461	o	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 55. 00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C		0	14	0	0	54. 00 55. 00
56. 00	05600 RADI OI SOTOPE	0	0	o	o	0	56. 00
57. 00	05700 CT SCAN	0	0	65	O	0	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0	20. 724	0	0	58.00
59. 00 60. 00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY		0	20, 724 0	0	0	59. 00 60. 00
	06001 BLOOD LABORATORY	o	0	Ō	Ō	0	1
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62. 00 63. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	62. 00 63. 00
64. 00	06400 I NTRAVENOUS THERAPY		0	o	o	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 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY		0	0	0	0	67. 00 68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0	57	Ö	0	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	o	0	70. 00
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	60 40	0	71. 00 72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS		0	0	0	100	73.00
74. 00		o o	0	Ö	Ö	0	74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75. 00
76. 00 76. 01	03950 OTHER ANCILL SRVC 03951 CARDI AC AND PULMONARY REHAB	0	0	0 181	0	0	76. 00 76. 01
76. 01			0	0	0	0	76. 01
	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0		Ö	0	77. 00
00.00	OUTPATIENT SERVICE COST CENTERS					^	00.00
88. 00 89. 00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	88. 00 89. 00
	09000 CLINIC		0	Ö	o	0	
					<u> </u>		

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0165 Peri od: Worksheet B-1 From 01/01/2022 12/31/2022 Date/Time Prepared: 5/29/2023 9:51 am Cost Center Description CAFETERI A MAINTENANCE OF NURSI NG CENTRAL **PHARMACY** (MEALS SERVED) PERSONNEL ADMI NI STRATI ON SERVICES & (COSTED (NUMBER (DIRECT NURS. **SUPPLY** REQUIS.) (COSTED HOUSED) HRS.) REQUIS.) 13.00 15.00 11.00 12.00 14.00 90. 01 09001 CLI NI C 90.01 0 4, 527 90. 02 09002 CLI NI C 0 2,728 0 90.02 0 18, 990 0 09100 EMERGENCY 91.00 91.00 0 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0 0 94.00 0 0 0 09500 AMBULANCE SERVICES 00000 95.00 95.00 0 0 0 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 0 0 96.00 97.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 0 97.00 98.00 09850 OTHER REIMBURSE 0 0 98.00 0 09900 CMHC 0 99.00 99.00 C 0 99. 10 09910 CORF 0 0 99. 10 0 100.00 10000 I &R SERVICES-NOT APPRVD PRGM 0 0 100.00 0 0 101.00 10100 HOME HEALTH AGENCY 0 0 101 00 Ω 0 102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 102.00 SPECIAL PURPOSE COST CENTERS 0 0 105. 00 10500 KIDNEY ACQUISITION 0 105, 00 Ω 0 0 106.00 10600 HEART ACQUISITION 0 0 106. 00 107. 00 10700 LIVER ACQUISITION 0 0 0 107. 00 0000 0 108.00 10800 LUNG ACQUISITION 0 0 108. 00 109.00 10900 PANCREAS ACQUISITION 0 0 109.00 Ω 110.00 11000 INTESTINAL ACQUISITION 0 C 0 0 110.00 0 111.00 11100 I SLET ACQUISITION 0 0 0 111.00 113.00 11300 INTEREST EXPENSE 113. 00 114.00 11400 UTILIZATION REVIEW-SNF 114.00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 0 0 0 0 115.00 116. 00 11600 HOSPI CE 0 0 116.00 SUBTOTALS (SUM OF LINES 1 through 117) 230, 490 259, 027 100 100 118.00 118.00 0 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 190. 00 0 191. 00 19100 RESEARCH 0 0 191. 00 0 0 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 3, 593 0 192.00 192. 01 19201 CENTER OF HOPE 0 34 0 192, 01 192.02 19202 OTHER FA FACILITIES NRCC 0 0 0 192. 02 8,778 193. 00 19300 NONPALD WORKERS 0 o 0 193.00 0 194.00 07950 OTHER NRCC 0 194, 00 0 0 0 200.00 Cross Foot Adjustments 200. 00 201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, Part 1,063,616 4, 576, 512 908, 121 3, 438, 087 202. 00 9, 081. 210000 34, 380. 870000 203. 00 Unit cost multiplier (Wkst. B, Part I) 4.614586 203.00 0.000000 16.860621 204.00 Cost to be allocated (per Wkst. B, Part 861 31, 329 5, 838 135, 753 204. 00 II) 205.00 Unit cost multiplier (Wkst. B, Part II) 0.000000 58. 380000 1, 357. 530000 205. 00 0.003736 0.115421

206.00

207. 00

206.00

207.00

NAHE adjustment amount to be allocated

NAHE unit cost multiplier (Wkst. D,

(per Wkst. B-2)

Parts III and IV)

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS In Lieu of Form CMS-2552-10
Worksheet B-1 Provider CCN: 15-0165 Peri od: Worksheet B-1 From 01/01/2022 To 12/31/2022 Date/Time Prepared:

COST Center Description	COST. Center Description				'	0 12/31/2022	5/29/2023 9:5	
CHERNIA SINVICE COST CENT INST 1.00 GROUD CAP SEL COSTS MARIE FOULT	Control Cont	Cost Center Description	RECORDS & LI BRARY (GROSS CHARGES)	(TIME SPENT)	SERVICE OTHER GEN SERV (TIME SPENT)	ANESTHETI STS (ASSI GNED TI ME)	NURSI NG PROGRAM (ASSI GNED TI ME)	
1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00	0.00 0.00 CAP REL COSTS-HUBG & TIXT	OFNEDAL CEDIL OF COCT OFNITEDO	16.00	17. 00	18.00	19. 00	20.00	
10. 00 01000 MEDICAL RECORDS & LIBRARY 599, 132, 456 0 0 0 17. 00 170. 01 170. 00 170. 00 170. 00 181. 00 1850 01850 0716 CER SERV 0 0 0 0 0 19. 00 190. 00 190. 00 190. 00 0 0 0 0 0 0 0 19. 00 190. 00 190. 00 0 0 0 0 0 0 0 0	10.00 10.00 MEDICAL RECORDS & LIBRARY 599, 132, 456 0 0 17.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00 170.00	1. 00						2.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00
30.00 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 03000 0300	30. 00 03000 ADULTS & PEDI ATRIC CS 55, 079, 531 0 0 0 0 0 33. 00 31. 00 03200 INTENSIVE CARE UNIT	17. 00 01700 SOCI AL SERVI CE 18. 00 01850 OTHER GEN SERV 19. 00 01900 NONPHYSI CI AN ANESTHETI STS 20. 00 02000 NURSI NG PROGRAM 21. 00 02100 L&R SERVI CES-SALARY & FRI NGES APPRVD 22. 00 02200 L&R SERVI CES-OTHER PRGM COSTS APPRVD 23. 00 02301 PARAMED ED PRGM	0 0 0 0	_	1		0	17. 00 18. 00 19. 00 20. 00 21. 00 22. 00
50. 00 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 050	50.00 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 0500	30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 32. 00 03200 CORONARY CARE UNIT 33. 00 03300 BURN INTENSIVE CARE UNIT 34. 00 03400 SUBPROVIDER - I PF 41. 00 04400 SUBPROVIDER - I RF 43. 00 04100 SUBPROVIDER - I RF 43. 00 04400 NURSERY 44. 00 04400 SKILLED NURSING FACILITY 45. 00 04500 NURSING FACILITY	8, 583, 291 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0	0 0 0 0 0 0 0	0 0 0 0 0 0 0	0 0 0 0 0 0 0	31. 00 32. 00 33. 00 34. 00 40. 00 41. 00 43. 00 44. 00 45. 00
88. 00 08800 RURAL HEALTH CLINIC 0 0 0 0 0 88. 00		ANCILLARY SERVICE COST CENTERS 50. 00 05000 OPERATING ROOM 51. 00 05100 RECOVERY ROOM 52. 00 05200 DELIVERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTIC 55. 00 05500 RADI OLOGY-THERAPEUTI C 56. 00 05500 RADI OLOGY-THERAPEUTI C 57. 00 05700 CT SCAN 58. 00 05800 MAGNETI C RESONANCE IMAGING (MRI) 59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY 60. 01 06001 BLOOD LABORATORY 61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 63. 00 06300 BLOOD STORING PROCESSING & TRANS 64. 00 06400 NTRAVENOUS THERAPY 65. 00 06500 RESPIRATORY THERAPY 66. 00 06600 PHYSICAL THERAPY 67. 00 06700 OCCUPATIONAL THERAPY 68. 00 06800 SPECH PATHOLOGY 69. 00 06900 ELECTROCARDIOLOGY 70. 00 07000 CLECTROENCEPHALOGRAPHY 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 72. 00 07200 IMPL DEV CHARGED TO PATIENTS 73. 00 07300 DRUGS CHARGED TO PATIENTS 74. 00 07400 RENAL DI ALYSI S 75. 00 07500 ASC (NON-DI STINCT PART) 76. 01 03951 CARDI AC AND PULMONARY REHAB 76. 02 03952 WOUND CARE 77. 00 OT7000 ALLOGENEIC STEM CELL ACQUI SI TI ON OUTPATIENT SERVICE COST CENTERS	85, 880, 444 10, 076, 248 0 21, 413, 069 31, 985, 210 0 47, 667, 734 27, 016, 856 24, 795, 118 68, 286, 496 0 0 8, 831, 360 2, 723, 324 2, 602, 019 1, 280, 840 20, 538, 642 4, 180, 649 29, 020, 719 30, 386, 374 30, 878, 581 0 0 467, 595 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	000000000000000000000000000000000000000	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	50. 00 51. 00 52. 00 53. 00 54. 00 55. 00 56. 00 57. 00 58. 00 60. 01 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 74. 00 75. 00 76. 01 76. 01 76. 02 77. 00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0165

			10) 12/31/2022	5/29/2023 9:51 a	
			OTHER GENERAL		0,2,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
			SERVI CE			
Cost Center Description	MEDI CAL	SOCIAL SERVICE	OTHER GEN SERV	NONPHYSI CI AN	NURSI NG	
•	RECORDS &	(TIME SPENT)	(TIME SPENT)	ANESTHETI STS	PROGRAM	
	LI BRARY			(ASSI GNED	(ASSI GNED	
	(GROSS			TIME)	TIME)	
	CHARGES)			/		
	16.00	17. 00	18. 00	19. 00	20.00	
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0			0		9. 00
90. 00 09000 CLI NI C	0			0		0.00
90. 01 09001 CLINI C	27, 205, 836	l .		0		0. 01
90. 02 09002 CLI NI C	3, 474, 085		ő	0		0. 02
91. 00 09100 EMERGENCY	56, 758, 435			0		1.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	30, 736, 433			U		2. 00
OTHER REIMBURSABLE COST CENTERS					9	2.00
94. 00 09400 HOME PROGRAM DI ALYSI S	0	0	0	0	0 9	4. 00
		_		0		74. 00 95. 00
	0	_		-		
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0	0		0		6. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0		0		7. 00
98. 00 09850 OTHER REI MBURSE	0	0	_	0		8. 00
99. 00 09900 CMHC	0	0	0	0		9. 00
99. 10 09910 CORF	0	0	0	0	0 9	9. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0 10	0.00
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0 10	1. 00
102.00 10200 OPIOLD TREATMENT PROGRAM	0	l c	0	0	0 10	2. 00
SPECIAL PURPOSE COST CENTERS						
105. 00 10500 KIDNEY ACQUISITION	0	C	0	0	0 10	5. 00
106. 00 10600 HEART ACQUISITION	0	0	0	0	0 10	6. 00
107. 00 10700 LIVER ACQUISITION	0	0	0	0	0 10	7. 00
108.00 10800 LUNG ACQUISITION	0		0	0	0 10	8. 00
109. 00 10900 PANCREAS ACQUISITION	0	i o		0		9. 00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON	0		_	0		0. 00
111. 00 11100 SLET ACQUISITION			٥	0		1. 00
113. 00 11300 NTEREST EXPENSE				0		3. 00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF						4. 00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)				0	l l	5. 00
	0	0		U		
116. 00 11600 HOSPI CE	F00 122 4F4	0		0		6. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	599, 132, 456	0	0	0	0 11	8. 00
NONREI MBURSABLE COST CENTERS				0	0 10	
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	_		0		0.00
191. 00 19100 RESEARCH	0	0		0		1.00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0		0		2. 00
192.01 19201 CENTER OF HOPE	0	0		0		2. 01
192.02 19202 OTHER FA FACILITIES NRCC	0	0	0	0		2. 02
193.00 19300 NONPALD WORKERS	0	0	0	0		3.00
194. 00 07950 OTHER NRCC	0	0	0	0	0 19	4. 00
200.00 Cross Foot Adjustments					20	0.00
201.00 Negative Cost Centers					20	1. 00
202.00 Cost to be allocated (per Wkst. B, Par	t 1, 945, 751	0	0	0	0 20	2. 00
1)						
203.00 Unit cost multiplier (Wkst. B, Part I)	0. 003248	0. 000000	0.000000	0.000000	0.000000 20	3. 00
204.00 Cost to be allocated (per Wkst. B, Par			_	0		4. 00
205.00 Unit cost multiplier (Wkst. B, Part II	0. 000030	0. 000000	0.000000	0.000000	0. 000000 20	5. 00
206.00 NAHE adjustment amount to be allocated						6. 00
(per Wkst. B-2)						
207.00 NAHE unit cost multiplier (Wkst. D,					0. 000000 20	7. 00
Parts III and IV)						
					· ·	

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0165

					To 12/31/2022 Date/Time Pro 5/29/2023 9:	
		INTERNS &	RESI DENTS		372772023 7.	J dill
С	ost Center Description	SERVI CES-SALAR	SERVI CES-OTHER	PARAMED ED		
	·	Y & FRINGES	PRGM COSTS (ASSIGNED	PRGM		
		(ASSI GNED TIME)	TIME)	(ASSIGNED TIME)		
GENERAL	. SERVICE COST CENTERS	21. 00	22. 00	23. 00		
1.00 00100 C	AP REL COSTS-BLDG & FIXT					1.00
	AP REL COSTS-MVBLE EQUIP MPLOYEE BENEFITS DEPARTMENT					2. 00 4. 00
1 1	DMINISTRATIVE & GENERAL					5. 00
	AINTENANCE & REPAIRS					6. 00
1 1	PERATION OF PLANT AUNDRY & LINEN SERVICE					7. 00 8. 00
9. 00 00900 H	OUSEKEEPI NG					9. 00
10. 00 01000 D 11. 00 01100 C	I ETARY AFETERI A					10.00
	ALINTENANCE OF PERSONNEL					12. 00
	URSING ADMINISTRATION ENTRAL SERVICES & SUPPLY					13. 00 14. 00
1 1	HARMACY					15. 00
1 1	EDICAL RECORDS & LIBRARY					16.00
1 1	OCIAL SERVICE THER GEN SERV					17. 00 18. 00
19. 00 01900 N	ONPHYSICIAN ANESTHETISTS					19. 00
	URSING PROGRAM &R SERVICES-SALARY & FRINGES APPRVD	0				20. 00
	&R SERVICES-OTHER PRGM COSTS APPRVD		0			22. 00
	ARAMED ED PRGM				0	23. 00
	INT ROUTINE SERVICE COST CENTERS DULTS & PEDIATRICS	0	0		0	30.00
1 1	NTENSI VE CARE UNIT	0	0	1	0	31. 00
	ORONARY CARE UNIT URN INTENSIVE CARE UNIT	0	0		0	32. 00 33. 00
34. 00 03400 S	URGICAL INTENSIVE CARE UNIT	0	0		0	34. 00
1 1	UBPROVI DER - I PF UBPROVI DER - I RF	0	0		0	40. 00 41. 00
43. 00 04100 S		0	0		0	43. 00
1 1	KILLED NURSING FACILITY	0	0		0	44. 00
	URSING FACILITY THER LONG TERM CARE	0	0	•	0	45. 00 46. 00
	ARY SERVICE COST CENTERS					
	PERATING ROOM ECOVERY ROOM	0	0		0	50. 00 51. 00
1 1	ELIVERY ROOM & LABOR ROOM	0	0		0	52. 00
1 1	NESTHESI OLOGY ADI OLOGY-DI AGNOSTI C	0	0		0	53. 00 54. 00
55. 00 05500 R	ADI OLOGY-THERAPEUTI C	0	0		0	55. 00
56. 00 05600 R 57. 00 05700 C	ADI OI SOTOPE	0	0		0	56. 00 57. 00
1 1	AGNETIC RESONANCE IMAGING (MRI)	0	0		0	58. 00
	ARDI AC CATHETERI ZATI ON	0	0		0	59.00
	ABORATORY LOOD LABORATORY	0	0		0	60. 00 60. 01
61. 00 06100 P	BP CLINICAL LAB SERVICES-PRGM ONLY					61. 00
1 1	HOLE BLOOD & PACKED RED BLOOD CELLS LOOD STORING, PROCESSING & TRANS.	0	0		0	62. 00 63. 00
64. 00 06400 I	NTRAVENOUS THERAPY	0	0		0	64. 00
1 1	ESPIRATORY THERAPY HYSICAL THERAPY	0	0		0	65. 00 66. 00
1 1	CCUPATIONAL THERAPY	0	0		0	67. 00
	PEECH PATHOLOGY	0	0		0	68. 00
1 1	LECTROCARDI OLOGY LECTROENCEPHALOGRAPHY	0	0		0	69. 00 70. 00
71.00 07100 M	EDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	71. 00
	MPL. DEV. CHARGED TO PATIENTS RUGS CHARGED TO PATIENTS	0	0		0	72.00
	ENAL DIALYSIS		0		0	73. 00 74. 00
75. 00 07500 A	SC (NON-DISTINCT PART)	0	0		0	75. 00
1 1	THER ANCILL SRVC ARDIAC AND PULMONARY REHAB	0	0 0		0	76. 00 76. 01
76. 02 03952 W	OUND CARE	Ö	Ö		0	76. 02
	LLOGENEIC STEM CELL ACQUISITION ENT SERVICE COST CENTERS	0	0		0	77. 00
88. 00 08800 R	URAL HEALTH CLINIC	0	0	1	0	88. 00
89. 00 08900 F	EDERALLY QUALIFIED HEALTH CENTER	0	0		0	89. 00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0165

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

5/29/2023 9:51 am INTERNS & RESIDENTS SERVI CES-SALAR SERVI CES-OTHER PARAMED ED Cost Center Description Y & FRINGES PRGM COSTS PRGM (ASSI GNED (ASSI GNED (ASSI GNED TIME) TIME) TIME) 21.00 22.00 23.00 90. 00 09000 CLINIC 90. 00 0 90. 01 09001 CLINIC 0 90.01 0 09002 CLI NI C 0 90.02 90.02 91.00 09100 EMERGENCY 0 C 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0 94.00 95. 00 09500 AMBULANCE SERVICES 0 0 95.00 0 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 00000 0 96.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 97.00 0 97.00 98. 00 09850 OTHER REIMBURSE 0 98.00 09900 CMHC 0 99. 00 0 99.00 0 99. 10 09910 CORF 99 10 Ω 100.00 10000 I &R SERVICES-NOT APPRVD PRGM 0 100.00 101.00 10100 HOME HEALTH AGENCY 0 0 0 101.00 102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 102.00 0 SPECIAL PURPOSE COST CENTERS 105.00 10500 KIDNEY ACQUISITION 0 0 0 105.00 106.00 10600 HEART ACQUISITION 0 0 106.00 107. 00 10700 LIVER ACQUISITION 0 0 107. 00 0 0 108.00 10800 LUNG ACQUISITION 0 108. 00 Ω 109.00 10900 PANCREAS ACQUISITION 0 109. 00 110.00 11000 INTESTINAL ACQUISITION 0 0 110.00 0 111.00 11100 | SLET ACQUISITION 0 111.00 113.00 11300 INTEREST EXPENSE 113.00 114.00 11400 UTILIZATION REVIEW-SNF 114.00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 0 115. 00 116. 00 11600 HOSPI CE 0 116.00 SUBTOTALS (SUM OF LINES 1 through 117) 118.00 0 0 118.00 NONREIMBURSABLE COST CENTERS 0 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 190. 00 0 191. 00 19100 RESEARCH 0 0 191 00 C 192.00 19200 PHYSICIANS' PRIVATE OFFICES 192. 00 192. 01 19201 CENTER OF HOPE 0 192. 01 0 0 192. 02 19202 OTHER FA FACILITIES NRCC 192.02 0 193. 00 19300 NONPALD WORKERS 0 193. 00 194.00 07950 OTHER NRCC 0 0 194.00 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, Part 0 202. 00 203.00 Unit cost multiplier (Wkst. B, Part I) 0.000000 0.000000 0.000000 203. 00 Cost to be allocated (per Wkst. B, Part 204.00 204.00 Π 205.00 Unit cost multiplier (Wkst. B, Part II) 0.000000 0.000000 0.000000 205.00 NAHE adjustment amount to be allocated 206.00 206. 00 (per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, 0.000000 207.00 Parts III and IV)

COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provi der Co		Period: From 01/01/2022 To 12/31/2022	Worksheet C Part I Date/Time Prepared: 5/29/2023 9:51 am	
			Title	XVIII	Hospi tal	PPS	
				T 1 1 0 1	Costs	T	
	Cost Center Description	Total Cost (from Wkst. B,	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
		Part I, col.	Auj .		Di Sai i Owance		
		26)					
		1.00	2. 00	3. 00	4. 00	5. 00	
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	22 (47 507		22 (47 50	7	22 (47 507	20.00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	33, 647, 597 5, 805, 199		33, 647, 59 5, 805, 19		33, 647, 597 5, 805, 199	30. 00 31. 00
32. 00	03200 CORONARY CARE UNIT	3, 803, 177		3, 003, 17	0	3, 803, 177	32. 00
33. 00	03300 BURN INTENSIVE CARE UNIT	o			0	0	33. 00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0			0 0	0	34. 00
40.00	04000 SUBPROVI DER - I PF	0			0	0	40.00
41. 00 43. 00	04100 SUBPROVI DER - I RF 04300 NURSERY	0			0	0	41. 00 43. 00
44. 00	04400 SKILLED NURSING FACILITY				0	0	44. 00
45. 00	04500 NURSING FACILITY	o			0	0	45. 00
46.00	04600 OTHER LONG TERM CARE	O			0	0	46. 00
	ANCILLARY SERVICE COST CENTERS	10 (55 700)		10 (55 70		10 (04 000	
50. 00 51. 00	05000 OPERATING ROOM 05100 RECOVERY ROOM	12, 655, 799 2, 704, 230		12, 655, 79 2, 704, 23		12, 684, 028 2, 704, 230	50. 00 51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	2, 704, 230		2, 704, 23	0	2, 704, 230	52.00
53.00	05300 ANESTHESI OLOGY	3, 960, 376		3, 960, 37	6 0	3, 960, 376	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	5, 209, 702		5, 209, 70	2 0	5, 209, 702	54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0			0	0	55. 00
56.00	05600	1 427 464			0	1 427 444	56. 00
57. 00 58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	1, 427, 464 1, 751, 536		1, 427, 46 1, 751, 53		1, 427, 464 1, 751, 536	57. 00 58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	6, 395, 901		6, 395, 90		6, 395, 901	59. 00
60.00	06000 LABORATORY	8, 783, 643		8, 783, 64	1, 510	8, 785, 153	60. 00
60. 01	06001 BLOOD LABORATORY	0			0	0	60. 01
61. 00 62. 00	O6100 PBP CLINICAL LAB SERVICES-PRGM ONLY O6200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0			0	0	61. 00 62. 00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.				0	Ö	63. 00
64. 00	06400 I NTRAVENOUS THERAPY	o			0	0	64. 00
65. 00	06500 RESPI RATORY THERAPY	2, 879, 776	0			2, 879, 776	65. 00
66.00	06600 PHYSI CAL THERAPY	485, 764	0	485, 76		485, 764	66.00
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	405, 441 171, 681	0	405, 44 171, 68		405, 441 171, 681	67. 00 68. 00
69. 00	06900 ELECTROCARDI OLOGY	985, 857	0	985, 85		985, 857	69. 00
	07000 ELECTROENCEPHALOGRAPHY	2, 055, 582		2, 055, 58			70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	11, 534, 965		11, 534, 96		11, 534, 965	
	07200 I MPL. DEV. CHARGED TO PATIENTS	7, 794, 128		7, 794, 12		7, 794, 128	
	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	8, 849, 750		8, 849, 75	0	8, 849, 750 0	73. 00 74. 00
	07500 ASC (NON-DISTINCT PART)	o			0	Ö	75. 00
	03950 OTHER ANCILL SRVC	0			0 0	0	76. 00
	03951 CARDIAC AND PULMONARY REHAB 03952 WOUND CARE	356, 182 0		356, 18		356, 182 0	1
	07700 ALLOGENEIC STEM CELL ACQUISITION				0 0	0	
	OUTPATIENT SERVICE COST CENTERS	-1					
	08800 RURAL HEALTH CLINIC	0			0 0	0	88. 00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0				0	89. 00 90. 00
	09001 CLI NI C	3, 360, 273		3, 360, 27	3 0	3, 360, 273	90.00
90. 02		758, 181		758, 18		759, 466	90. 02
	09100 EMERGENCY	9, 521, 450		9, 521, 45		9, 521, 450	•
92.00	O9200 OBSERVATION BEDS (NON-DISTINCT PART)	5, 924, 687		5, 924, 68	7	5, 924, 687	92. 00
94.00	09400 HOME PROGRAM DIALYSIS	0			0 (0	94. 00
	09500 AMBULANCE SERVICES	o			0	0	95. 00
	09600 DURABLE MEDICAL EQUIP-RENTED	0			0	0	96. 00
	09700 DURABLE MEDICAL EQUIP-SOLD	0			0	0	97. 00
	O9850 OTHER REIMBURSE				J 0	0	98. 00 99. 00
	09910 CORF				o l	0	99. 10
	10000 I&R SERVICES-NOT APPRVD PRGM	0			C		100. 00
	10100 HOME HEALTH AGENCY	0			0		101.00
102.00	10200 OPIOID TREATMENT PROGRAM SPECIAL PURPOSE COST CENTERS	0			0	0	102. 00
105.00	10500 KIDNEY ACQUISITION	O			O O	0	105. 00
106.00	10600 HEART ACQUISITION	0			0	0	106. 00
	10700 LIVER ACQUISITION	0			ם		107. 00
	10800 LUNG ACQUISITION 10900 PANCREAS ACQUISITION						108. 00 109. 00
	11000 INTESTINAL ACQUISITION				0		110.00
-	·	,			'	'	

Health Financial Systems	FRANCI SCAN HE	ALIH MUNSIER		In Lie	u of Form CMS-	<u>2552-10</u>
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider Co	CN: 15-0165	Peri od:	Worksheet C	
				From 01/01/2022		
				To 12/31/2022	Date/Time Pre	pared:
					5/29/2023 9:5	<u>1 am</u>
		Title	XVIII	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
·	(from Wkst. B,	Adj.		Di sal I owance		
	Part I, col.					
	26)					
	1.00	2.00	3.00	4. 00	5. 00	
111. 00 11100 I SLET ACQUI SI TI ON	C)		0	0	111. 00
113.00 11300 INTEREST EXPENSE						113.00
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115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)
116.00 11600 HOSPICE
200.00 Subtotal (see instructions)

Less Observation Beds

Total (see instructions)

201.00

202.00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet C | From 01/01/2022 | Part | To 12/31/2022 | Date/Time Prepared: | 5/29/2023 9:51 am Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0165

Control Test Control			Ti tl e	e XVIII	Hospi tal	5/29/2023 9: 5 PPS	1 am
NAME SULTIMES SERVICE DOST CERTERS	Cost Center Description	Inpatient	Charges			TEFRA	
DEATLEM REQUIRES SERVICE COST CENTERS 42.067.362 42.067.362 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30		·		+ col . 7)	Ratio		
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108. 00 10800 LUNG ACQUISITION 0 0 0 108. 00 109. 00 10900 PANCREAS ACQUISITION 0 0 0 109. 00 110. 00 11000 INTESTINAL ACQUISITION 0 0 0 110. 00		0	0	1			
109. 00 10900 PANCREAS ACQUISITION 0 0 0 109. 00 110. 00 110. 00 1 100. 0 0 0 110. 00 110. 00 1 110. 00 1 100. 00 0 0 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 00 1 100. 0		0	0				
110. 00 11000 I NTESTI NAL ACQUI SI TI ON 0 0 0 1110. 00			0				
111. 00 11100 I SLET ACQUI SI TI ON 0 0 1111. 00	110.00 11000 INTESTINAL ACQUISITION	0	0	l .			110. 00
	111. 00 11100 I SLET ACQUI SI TI ON	0	0	1 (O		111. 00

Health Financial Systems	FRANCISCAN HEALTH MUNSTER	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		From 01/01/2022	Worksheet C Part I Date/Time Prepared:
			5/29/2023 9:51 am
	Title XVIII	Hospi tal	PPS

		Title	XVIII	Hospi tal	PPS	
		Charges				
Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
			+ col. 7)	Ratio	I npati ent	
					Rati o	
	6.00	7. 00	8. 00	9. 00	10.00	
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.)	o	0	(115. 00
116. 00 11600 HOSPI CE	0	0	C			116. 00
200.00 Subtotal (see instructions)	205, 223, 737	393, 908, 719	599, 132, 456			200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	205, 223, 737	393, 908, 719	599, 132, 456			202. 00

Title XVIII

		Title XVIII	Hospi tal	PPS	
Cost Center Description	PPS Inpatient				
	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS					30.00
31.00 03100 INTENSIVE CARE UNIT					31.00
32. 00 03200 CORONARY CARE UNIT					32. 00
33.00 03300 BURN INTENSIVE CARE UNIT					33. 00
34.00 03400 SURGICAL INTENSIVE CARE UNIT					34.00
40. 00 04000 SUBPROVI DER - PF					40. 00
41. 00 04100 SUBPROVI DER - I RF					41. 00
43. 00 04300 NURSERY					43. 00
44. 00 04400 SKI LLED NURSI NG FACI LI TY					44. 00
45. 00 04500 NURSI NG FACILITY					45. 00
46. 00 O4600 OTHER LONG TERM CARE					46. 00
ANCILLARY SERVICE COST CENTERS	0.447/04				F0 00
50. 00 05000 OPERATING ROOM	0. 147694				50.00
51. 00 05100 RECOVERY ROOM	0. 268377				51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000				52. 00
53. 00 05300 ANESTHESI OLOGY	0. 184951				53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 162878				54. 00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000				55. 00
56. 00 05600 RADI 0I SOTOPE	0. 000000				56. 00
57.00 05700 CT SCAN	0. 029946				57. 00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 064831				58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 257950				59. 00
60. 00 06000 LABORATORY	0. 128651				60.00
60. 01 06001 BLOOD LABORATORY	0. 000000				60. 01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000				61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000				62. 00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000				63.00
64. 00 06400 NTRAVENOUS THERAPY	0. 000000				64. 00
65. 00 06500 RESPIRATORY THERAPY	0. 326085				65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 178372				66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 155818				67.00
68. 00 06800 SPEECH PATHOLOGY	0. 134038				68.00
69. 00 06900 ELECTROCARDI OLOGY	1				69.00
	0. 048000				1
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 491941				70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 397473				71.00
72. 00 O7200 I MPL. DEV. CHARGED TO PATIENTS	0. 256501				72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 286598				73. 00
74. 00 07400 RENAL DI ALYSI S	0. 000000				74. 00
75.00 07500 ASC (NON-DISTINCT PART)	0. 000000				75. 00
76. 00 03950 OTHER ANCILL SRVC	0. 000000				76. 00
76.01 03951 CARDIAC AND PULMONARY REHAB	0. 761732				76. 01
76. 02 03952 WOUND CARE	0. 000000				76. 02
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000				77. 00
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC					88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER					89. 00
90. 00 09000 CLI NI C	0. 000000				90.00
90. 01 09001 CLI NI C	0. 123513				90. 01
90. 02 09002 CLI NI C	0. 218609				90. 02
91. 00 09100 EMERGENCY	0. 167754				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 455319				92.00
OTHER REIMBURSABLE COST CENTERS	0				
94. 00 09400 HOME PROGRAM DI ALYSI S	0. 000000				94. 00
95. 00 09500 AMBULANCE SERVICES	0. 000000				95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000				96.00
97. 00 097000 DURABLE MEDICAL EQUIP-RENTED	0. 000000				97.00
98. 00 09850 OTHER REI MBURSE	0. 000000				98.00
	0.000000				99.00
99. 00 09900 CMHC					
99. 10 09910 CORF					99. 10
100.00 10000 I &R SERVI CES-NOT APPRVD PRGM					100.00
101.00 10100 HOME HEALTH AGENCY					101. 00
102. 00 10200 OPI OI D TREATMENT PROGRAM					102. 00
SPECIAL PURPOSE COST CENTERS					1
105. 00 10500 KI DNEY ACQUI SI TI ON					105. 00
106. 00 10600 HEART ACQUI SI TI ON					106. 00
107.00 10700 LIVER ACQUISITION					107. 00
108.00 10800 LUNG ACQUISITION					108. 00
109.00 10900 PANCREAS ACQUISITION					109. 00
110. 00 11000 INTESTINAL ACQUISITION					110.00
111. 00 11100 SLET ACQUI SI TI ON					111. 00
113. 00 11300 NTEREST EXPENSE					113. 00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF					114. 00
	<u> </u>				

Heal th Finan	ncial Systems	FRANCI SCAN HEAI	LTH MUNSTER	In Lie	u of Form CMS-2	2552-10
COMPUTATI ON	OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0165	Peri od: From 01/01/2022 To 12/31/2022	Worksheet C Part I	anad.
				To 12/31/2022	Date/Time Prep 5/29/2023 9:51	
			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

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CC		Period: From 01/01/2022 Fo 12/31/2022	Worksheet C Part I Date/Time Pre 5/29/2023 9:5	pared: 1 am
		Ti tl	e XIX	Hospi tal	PPS	
			- · · · ·	Costs	T	
Cost Center Description	Total Cost 1 (from Wkst. B,	Therapy Limit	Total Costs	RCE Di sal I owance	Total Costs	
	Part I, col.	Adj .		DI Sai i Owalice		
	26)					
	1.00	2. 00	3. 00	4. 00	5. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	T			_1		
30. 00 03000 ADULTS & PEDI ATRI CS 31. 00 03100 I NTENSI VE CARE UNI T	33, 647, 597 5, 805, 199		33, 647, 59° 5, 805, 19°		33, 647, 597 5, 805, 199	30. 00 31. 00
32. 00 03200 CORONARY CARE UNIT	3, 803, 144		3, 603, 14	0	5, 805, 144	32. 00
33. 00 03300 BURN INTENSIVE CARE UNIT	o			0	0	33. 00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	o			0	0	34. 00
40. 00 04000 SUBPROVI DER - 1 PF	0		(0	0	40. 00
41. 00 04100 SUBPROVI DER - RF 43. 00 04300 NURSERY	0			0	0	41. 00 43. 00
44. 00 04400 SKI LLED NURSI NG FACI LI TY	0				0	44. 00
45. 00 04500 NURSI NG FACILITY	o			0	0	45. 00
46.00 O4600 OTHER LONG TERM CARE	0			0	0	46. 00
ANCILLARY SERVICE COST CENTERS	40 (55 700		40 (55 70)	20.000	40 (04 000	F0 00
50. 00 05000 0PERATI NG ROOM 51. 00 05100 RECOVERY ROOM	12, 655, 799 2, 704, 230		12, 655, 79 ^o 2, 704, 23 ^o		12, 684, 028 2, 704, 230	50. 00 51. 00
52. 00 05200 DELI VERY ROOM & LABOR ROOM	2, 704, 230		2, 704, 23	0	2, 704, 230	52. 00
53. 00 05300 ANESTHESI OLOGY	3, 960, 376		3, 960, 37	6 0	3, 960, 376	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	5, 209, 702		5, 209, 70	2 0	5, 209, 702	54. 00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0			0	0	55. 00
56. 00 05600 RADI 0I SOTOPE 57. 00 05700 CT SCAN	1, 427, 464		1, 427, 46	0	0 1, 427, 464	56. 00 57. 00
58. 00 05800 MAGNETIC RESONANCE MAGING (MRI)	1, 751, 536		1, 751, 53		1, 751, 536	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	6, 395, 901		6, 395, 90		6, 395, 901	59. 00
60. 00 06000 LABORATORY	8, 783, 643		8, 783, 64	1, 510	8, 785, 153	60.00
60. 01 06001 BLOOD LABORATORY 61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0				0	60. 01 61. 00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0				0	62. 00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	O			0	0	63. 00
64. 00 06400 I NTRAVENOUS THERAPY	0		(0	0	64. 00
65. 00 06500 RESPI RATORY THERAPY	2, 879, 776	0			2, 879, 776	65. 00
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	485, 764 405, 441	0	485, 76, 405, 44		485, 764 405, 441	66. 00 67. 00
68. 00 06800 SPEECH PATHOLOGY	171, 681	0	171, 68		171, 681	68. 00
69. 00 06900 ELECTROCARDI OLOGY	985, 857		985, 85		985, 857	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	2, 055, 582		2, 055, 58:			70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	11, 534, 965 7, 794, 128		11, 534, 96 7, 794, 12		11, 534, 965 7, 794, 128	71. 00 72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	8, 849, 750		8, 849, 750		8, 849, 750	73. 00
74.00 07400 RENAL DIALYSIS	0			0	0	74. 00
75. 00 07500 ASC (NON-DISTINCT PART)	0			0	0	75. 00
76.00 03950 OTHER ANCILL SRVC 76.01 03951 CARDIAC AND PULMONARY REHAB	356, 182		356, 18	0	0 356, 182	76. 00 76. 01
76. 02 03952 WOUND CARE	0					
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0			0	0	77. 00
OUTPATIENT SERVICE COST CENTERS			1		0	00.00
88.00 08800 RURAL HEALTH CLINIC 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER					0	88. 00 89. 00
90. 00 09000 CLI NI C				o o	Ö	90. 00
90. 01 09001 CLI NI C	3, 360, 273		3, 360, 27		3, 360, 273	90. 01
90. 02 09002 CLI NI C	758, 181		758, 18		759, 466	90. 02
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	9, 521, 450 5, 924, 687		9, 521, 450 5, 924, 68		9, 521, 450 5, 924, 687	91. 00 92. 00
OTHER REIMBURSABLE COST CENTERS	0,721,007		0, 721, 00	·	0, 721, 007	72.00
94. 00 09400 HOME PROGRAM DIALYSIS	0		(0	0	94. 00
95. 00 09500 AMBULANCE SERVICES	0			0	0	95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0				0	96. 00 97. 00
98. 00 09850 OTHER REI MBURSE					0	98. 00
99. 00 09900 CMHC	0				0	99. 00
99. 10 09910 CORF	0		(0	99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM 101.00 10100 HOME HEALTH AGENCY	0					100. 00 101. 00
102. 00 10200 OPI OI D TREATMENT PROGRAM						101. 00
SPECIAL PURPOSE COST CENTERS						
105. 00 10500 KI DNEY ACQUI SI TI ON	0			0		105. 00
106.00 10600 HEART ACQUISITION 107.00 10700 LIVER ACQUISITION			'			106. 00 107. 00
108. 00 10800 LUNG ACQUISITION				o l		107. 00
109.00 10900 PANCREAS ACQUISITION	0				0	109. 00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON	0		(0	0	110. 00

Health Financial Systems	FRANCI SCAN HE	ALTH MUNSTER		In Li€	eu of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der	CCN: 15-0165	Period: From 01/01/2022 To 12/31/2022	Worksheet C Part I Date/Time Pre 5/29/2023 9:5	epared: 51 am
		Ti	tle XIX	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limi Adj.	t Total Costs	RCE Di sal I owance	Total Costs	
	1.00	2. 00	3. 00	4. 00	5. 00	
111. 00 11100 SLET ACQUI SI TI ON 113. 00 11300 INTEREST EXPENSE 114. 00 11400 UTI LI ZATI ON REVI EW-SNF	C			0		111. 00 113. 00 114. 00

137, 425, 164

5, 924, 687 131, 500, 477

137, 425, 164

5, 924, 687 131, 500, 477

114. 00 0 115. 00 0 116. 00 137, 457, 237 200. 00 5, 924, 687 201. 00 131, 532, 550 202. 00

32, 073

32, 073

115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)
116.00 11600 HOSPICE
200.00 Subtotal (see instructions)

Less Observation Beds

Total (see instructions)

201.00

202.00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet C | From 01/01/2022 | Part | Date/Time Prepared: | 5/29/2023 9:51 am | PPS Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES FRANCISCAN HEALTH MUNSTER Provider CCN: 15-0165

Cost Center Description				Ti tl	e XIX	Hospi tal	PPS	ı diii
REWITTEN BUTTINE SERVICE COST CENTERS								
New York Properties Service Cost Centeres 4.0 of 36.2 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00		Cost Center Description	I npati ent	Outpati ent	Total (col. 6			
WATER TRUTHE SQUITE COST CENTERS					+ col. 7)	Rati o		
INVITED SOUTH SERVICE COST CERTERS 42,067,362 3.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0			4 00	7.00	0.00	0.00		
30 00 30000 [ANUTS & PEPILATRICS 42, 007, 362] 42, 007, 362] 30, 00 3000 [ANUTS & PEPILATRICS 42, 007, 362] 30, 00 3000 [ANUTS & PEPILATRICS 42, 007, 362] 30, 00 3000 [ANUTS & PEPILATRICS 43, 00 00 00 00 00 00 00 00 00 00 00 00 00		INDATIENT DOUTINE CEDVICE COST CENTEDS	6.00	7.00	8.00	9.00	10.00	
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Health Financial Systems	FRANCISCAN HEALTH MUNSTER	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0165	Peri od: From 01/01/2022 To 12/31/2022	Worksheet C Part I Date/Time Prepared: 5/29/2023 9:51 am
	Ti +I o VI V	Hospi tal	DDC

		Ti tl	e XIX	Hospi tal	PPS	
		Charges				
Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
			+ col. 7)	Ratio	I npati ent	
					Ratio	
	6.00	7. 00	8. 00	9. 00	10.00	
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.)	o	0	(115. 00
116. 00 11600 HOSPI CE	0	0	(116. 00
200.00 Subtotal (see instructions)	205, 223, 737	393, 908, 719	599, 132, 456			200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	205, 223, 737	393, 908, 719	599, 132, 456	5		202. 00

Desir Centre Description						5/29/2023 9:51 am
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109.00 10900 PANCREAS ACQUISITION						
110. 00 11000 INTESTI NAL ACQUI SI TI ON 0. 000000 111. 00 11100 ISLET ACQUI SI TI ON 0. 000000 111. 00 113.00 INTEREST EXPENSE 113. 00			1 1			
111. 00 11100 I SLET ACQUI SI TI ON 0. 000000 111. 00 113.00 I NTEREST EXPENSE 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 11		1 1	1 1			•
	111.00	11100 ISLET ACQUISITION				111. 00
114. 00 11400 UII LI ZATI ON REVI EW-SNF 114. 00						
	114.00	0 11400 UTILIZATION REVIEW-SNF				114. 00

Heal th Finar	ncial Systems	FRANCI SCAN HEAI	_TH MUNSTER	In Lieu of Form CMS-2552-		
COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 15-0165	Peri od:	Worksheet C	
				From 01/01/2022 To 12/31/2022	Part Date/Time Pre	parad.
				10 12/31/2022	5/29/2023 9:5	
			Title XIX	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

 Heal th Financial Systems
 FRANCISCAN HEALTH MUNSTER

 CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICALD ONLY
 Provider
 In Lieu of Form CMS-2552-10

Period: Worksheet C
From 01/01/2022 Part II
To 12/31/2022 Date/Time Prepared: 5/29/2023 9:51 am Provider CCN: 15-0165

				12/31/2022	5/29/2023 9:5	
			e XIX	Hospi tal	PPS	
Cost Center Description	Total Cost		Operating Cost	Capi tal	Operating Cost	
	(WKST. B, Part		Net of Capital Cost (col. 1 -	Reduction	Reduction Amount	
	1, (01. 20)	11 (01. 20)	cost (cor. 1 -		Alliourt	
	1.00	2.00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	12, 655, 799			0	0	50.00
51. 00 05100 RECOVERY ROOM	2, 704, 230	298, 366	2, 405, 864	0	0	51.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY	3, 960, 376	23, 891	3, 936, 485	0	0	52. 00 53. 00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	5, 209, 702			0	Ö	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55. 00
56. 00 05600 RADI 0I SOTOPE	0	o	0	0	0	56. 00
57. 00 05700 CT SCAN	1, 427, 464	9, 817		0	0	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 59.00 05900 CARDIAC CATHETERIZATION	1, 751, 536			0	0	58. 00 59. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY	6, 395, 901 8, 783, 643	645, 760 156, 937		0		60.00
60. 01 06001 BLOOD LABORATORY	0,700,010	0	0, 020, 700	0	Ö	60. 01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62. 00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64. 00 06400 I NTRAVENOUS THERAPY 65. 00 06500 RESPI RATORY THERAPY	2, 879, 776	70, 916	2, 808, 860	0	0	64. 00 65. 00
66. 00 06600 PHYSI CAL THERAPY	485, 764			0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	405, 441	2, 827		0	o o	67. 00
68.00 06800 SPEECH PATHOLOGY	171, 681	1, 220	170, 461	0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	985, 857			0	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	2, 055, 582			0	0	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	11, 534, 965 7, 794, 128			0	0	71. 00 72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	8, 849, 750			0	0	73.00
74. 00 07400 RENAL DI ALYSI S	0	0	0	0	Ö	74. 00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75. 00
76. 00 03950 OTHER ANCILL SRVC	0	0	0	0	0	76. 00
76. 01 03951 CARDI AC AND PULMONARY REHAB	356, 182	2, 502	353, 680	0	0	76. 01
76. 02 03952 WOUND CARE 77. 00 07700 ALLOGENEI C STEM CELL ACQUISITION	0			0	0	76. 02 77. 00
OUTPATIENT SERVICE COST CENTERS			, <u></u>			77.00
88. 00 08800 RURAL HEALTH CLINIC	0	C	0	0	0	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89. 00
90. 00 09000 CLI NI C	2 240 272	0 00 00 7	0	0	0	90.00
90. 01 09001 CLI NI C 90. 02 09002 CLI NI C	3, 360, 273 758, 181	1		0		90. 01 90. 02
91. 00 09100 EMERGENCY	9, 521, 450			0	Ö	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	5, 924, 687			0	0	92. 00
OTHER REIMBURSABLE COST CENTERS						
94. 00 09400 HOME PROGRAM DI ALYSI S 95. 00 09500 AMBULANCE SERVI CES	0	0	0	0	0	94. 00 95. 00
95. 00 09500 AMBULANCE SERVI CES 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0			0		96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	ĺ	o o	0	Ö	97. 00
98. 00 09850 OTHER REIMBURSE	0	O	0	0	0	1
99. 00 09900 CMHC	0	0	0	0	0	99. 00
99. 10 09910 CORF	0	0	0	0	0	99. 10
100.00 10000 1&R SERVICES-NOT APPRVD PRGM 101.00 10100 HOME HEALTH AGENCY	0			0	l e	100. 00 101. 00
102.00 10200 OPI OI D TREATMENT PROGRAM		1		0		101.00
SPECIAL PURPOSE COST CENTERS			,			102.00
105.00 10500 KIDNEY ACQUISITION	0	C	0	0		105. 00
106. 00 10600 HEART ACQUISITION	0	0	0	0		106. 00
107. 00 10700 LIVER ACQUISITION	0	0	0	0	l e	107.00
108.00 10800 LUNG ACQUISITION 109.00 10900 PANCREAS ACQUISITION	0			0		108. 00 109. 00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON	0	ĺ		0		110. 00
111.00 11100 I SLET ACQUISITION	0	O	O	0		111.00
113.00 11300 INTEREST EXPENSE			1			113. 00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF]			114.00
115.00 11500 AMBULATORY SURGI CAL CENTER (D. P.)		0		0	•	115. 00 116. 00
116.00 11600 HOSPICE 200.00 Subtotal (sum of lines 50 thru 199)	97, 972, 368	3, 680, 434	94, 291, 934	0		200.00
201.00 Less Observation Beds	5, 924, 687			0		201.00
202.00 Total (line 200 minus line 201)	92, 047, 681	1		0		202. 00

			'		5/29/2023 9:5	1 am
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost Net of	Total Charges	Outpati ent			
	Capital and	(Worksheet C,	Cost to Charge			
	Operating Cost	Part I, column	Ratio (col. 6			
	Reduction	8)	/ col. 7)			
	6. 00	7. 00	8.00			
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	12, 655, 799	85, 880, 444	0. 147365			50.00
51. 00 05100 RECOVERY ROOM	2, 704, 230					51. 00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	2,704,230					52.00
53. 00 05300 ANESTHESI OLOGY	3, 960, 376					53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C						54.00
	5, 209, 702	31, 985, 210				
55. 00 05500 RADI OLOGY-THERAPEUTI C	0		0.000000			55. 00
56. 00 05600 RADI 01 SOTOPE	0	1	0.000000			56. 00
57. 00 05700 CT SCAN	1, 427, 464					57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	1, 751, 536					58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	6, 395, 901					59. 00
60. 00 06000 LAB0RAT0RY	8, 783, 643	68, 286, 496				60.00
60. 01 06001 BL00D LABORATORY	0	0	0.000000			60. 01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0.000000			61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0.000000			62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0. 000000			63.00
64.00 06400 INTRAVENOUS THERAPY	0		0. 000000			64. 00
65. 00 06500 RESPIRATORY THERAPY	2, 879, 776	8, 831, 360				65.00
66. 00 06600 PHYSI CAL THERAPY	485, 764					66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	405, 441	2, 602, 019				67. 00
68. 00 06800 SPEECH PATHOLOGY	171, 681	1, 280, 840				68. 00
69. 00 06900 ELECTROCARDI OLOGY	985, 857					69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	2, 055, 582					70.00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	11, 534, 965					71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	7, 794, 128					72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	8, 849, 750	1				73. 00
74. 00 07400 RENAL DI ALYSI S	0	1	0. 000000			74. 00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0.000000			75. 00
76. 00 03950 0THER ANCILL SRVC	0	0	0. 000000			76. 00
76.01 03951 CARDIAC AND PULMONARY REHAB	356, 182	467, 595				76. 01
76. 02 03952 WOUND CARE	0	0				76. 02
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0.000000			77. 00
OUTPATIENT SERVICE COST CENTERS	1	,				
88. 00 08800 RURAL HEALTH CLINIC	0	0	0.000000			88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0. 000000			89. 00
90. 00 09000 CLI NI C	0	0	0.000000			90.00
90. 01 09001 CLI NI C	3, 360, 273	27, 205, 836	0. 123513			90. 01
90. 02 09002 CLI NI C	758, 181	3, 474, 085	0. 218239			90. 02
91. 00 09100 EMERGENCY	9, 521, 450	56, 758, 435	0. 167754			91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	5, 924, 687	13, 012, 169	0. 455319			92. 00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DIALYSIS	0	C	0.000000			94. 00
95. 00 09500 AMBULANCE SERVICES	0	0	0.000000			95.00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0.000000			96.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0		0. 000000			97. 00
98. 00 09850 OTHER REI MBURSE	0		0.000000			98. 00
99. 00 09900 CMHC	0	1 0				99. 00
99. 10 09910 CORF	0	-	0. 000000			99. 10
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	Ö	1	1			100.00
101. 00 10100 HOME HEALTH AGENCY	0	-				101.00
102. 00 10200 OPI OI D TREATMENT PROGRAM	0					102.00
SPECIAL PURPOSE COST CENTERS			0.000000			102.00
105. 00 10500 KI DNEY ACQUISITION	0	0	0. 000000			105. 00
106. 00 10600 HEART ACQUISITION	0	ł .				106.00
107. 00 10700 LIVER ACQUISITION		ł .	0.000000			107. 00
107.00 10700 LIVER ACQUISITION 108.00 10800 LUNG ACQUISITION	0		•			
· · · · · · · · · · · · · · · · · · ·	0		0.000000			108.00
109. 00 10900 PANCREAS ACQUISITION	0		0.000000			109.00
110. 00 11000 INTESTINAL ACQUISITION	0	0	0.000000			110.00
111. 00 11100 I SLET ACQUI SI TI ON	0	0	0.000000			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	0.000000			115. 00
116. 00 11600 H0SPI CE	0	0	0. 000000			116. 00
200.00 Subtotal (sum of lines 50 thru 199)	97, 972, 368					200. 00
201.00 Less Observation Beds	5, 924, 687					201. 00
202.00 Total (line 200 minus line 201)	92, 047, 681	548, 481, 803				202. 00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL		ALTH MUNSTER Provider C	CN: 15-0165	Peri od: From 01/01/2022 To 12/31/2022	wof Form CMS-: Worksheet D Part I Date/Time Pre 5/29/2023 9:5	pared:
		Ti tl 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 Cos	t		
	Part II, col.		(col. 1 - co	l .		
	26)		2)			
	1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	1, 885, 551					
31.00 INTENSIVE CARE UNIT	408, 679		408, 6	79 2, 058	198. 58	31.00
32. 00 CORONARY CARE UNIT	0			0 0	0.00	32. 00
33.00 BURN INTENSIVE CARE UNIT	0			0 0	0.00	33. 00
34.00 SURGICAL INTENSIVE CARE UNIT	0			0 0	0.00	34. 00
40. 00 SUBPROVI DER - I PF	0	0)	0 0	0.00	40.00
41. 00 SUBPROVI DER - I RF	0	0		0 0	0.00	41.00
43. 00 NURSERY	0			0 0	0.00	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)	2, 294, 230		2, 294, 2	30 22, 702		200. 00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6. 00	7. 00				
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	1					
30. 00 ADULTS & PEDI ATRI CS	4, 934					30.00
31. 00 INTENSIVE CARE UNIT	1, 418		1			31.00
32. 00 CORONARY CARE UNIT	0	0)			32. 00
33. 00 BURN INTENSIVE CARE UNIT	0	0)			33.00
34.00 SURGICAL INTENSIVE CARE UNIT	0	0)			34.00
40. 00 SUBPROVI DER - I PF	0	0)			40.00
41. 00 SUBPROVI DER – I RF	0	0)			41.00
43. 00 NURSERY	0	0)			43.00
44. 00 SKILLED NURSING FACILITY	0	0	1			44.00
45.00 NURSING FACILITY	0	700 050	1			45. 00
200.00 Total (lines 30 through 199)	6, 352	732, 258	5			200.00

Health Financial Systems	FRANCI SCAN HEA	ALTH MUNSTER		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der C		Peri od:	Worksheet D	
				rom 01/01/2022	Part II	
				Γο 12/31/2022	Date/Time Pre 5/29/2023 9:5	pared:
		Ti +Lo	e XVIII	Hospi tal	PPS	ı allı
Cost Center Description	Capi tal		Ratio of Cost		Capital Costs	
cost center bescription	Related Cost	(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,				column 4)	
	Part II, col.	8)	2)	Charges	corumir 4)	
	26)	0)				
	1.00	2. 00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	1.00	2.00	0.00	00	0.00	
50. 00 05000 OPERATING ROOM	723, 113	85, 880, 444	0.008420	6, 175, 633	51, 999	50. 00
51. 00 05100 RECOVERY ROOM	298, 366	10, 076, 248	1		19, 795	51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0. 00000		0	52. 00
53. 00 05300 ANESTHESI OLOGY	23, 891	21, 413, 069	1		1, 197	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	331, 426	31, 985, 210			30, 154	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	0. 00000		0	55. 00
56. 00 05600 RADI 0I SOTOPE	0	0	0. 00000		0	56. 00
57. 00 05700 CT SCAN	9, 817	47, 667, 734			803	57. 00
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)	12, 126	27, 016, 856			378	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	645, 760	24, 795, 118			0	59. 00
60. 00 06000 LABORATORY	156, 937	68, 286, 496			25, 372	60. 00
60. 01 06001 BLOOD LABORATORY	0	0	0.00000		0	60. 01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61. 00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0. 00000	0	0	62. 00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	Ö	0. 00000		0	63. 00
64. 00 06400 NTRAVENOUS THERAPY	0	Ö	0. 00000		0	64. 00
65. 00 06500 RESPIRATORY THERAPY	70, 916	8, 831, 360	•		21, 342	65. 00
66. 00 06600 PHYSI CAL THERAPY	3, 435	2, 723, 324	•		917	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	2, 827	2, 602, 019	•	· ·	800	67. 00
68. 00 06800 SPEECH PATHOLOGY	1, 220	1, 280, 840			405	68. 00
69. 00 06900 ELECTROCARDI OLOGY	6, 934	20, 538, 642	1		1, 572	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	277, 004	4, 180, 649			4, 394	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	69, 321	29, 020, 719			6, 071	71. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	46, 952	30, 386, 374			3, 413	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	168, 338	30, 878, 581			33, 220	73. 00
74. 00 07400 RENAL DI ALYSI S	0	00,0,0,00	1		0	74. 00
75. 00 07500 ASC (NON-DISTINCT PART)	0	Ö	1		0	75.00
76. 00 03950 OTHER ANCILL SRVC	0	Ö	0.00000		0	76. 00
76. 01 03951 CARDI AC AND PULMONARY REHAB	2, 502	467, 595	•		0	76. 01
76. 02 03952 WOUND CARE	2,302	107, 070	1		0	76. 02
77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	Ö	1			77. 00
OUTPATIENT SERVICE COST CENTERS	J		0.00000	<u> </u>		77.00
88. 00 08800 RURAL HEALTH CLINIC	0	C	0.00000	0	0	88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	Ö		-	0	89. 00
90. 00 09000 CLI NI C	o o	Ö	0. 00000		0	90. 00
90. 01 09001 CLI NI C	22, 857	27, 205, 836			0	90. 01
90. 02 09002 CLI NI C	49, 227	3, 474, 085			0	90. 02
91. 00 09100 EMERGENCY	425, 457	56, 758, 435			25, 976	91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	332, 008	13, 012, 169	III		31, 654	92.00
OTHER REIMBURSABLE COST CENTERS	332,000	13,012,109	0.02551	1, 240, 003	31,034	72.00
94. 00 09400 HOME PROGRAM DI ALYSI S	0	0	0.00000	0	0	94. 00
95. 00 09500 AMBULANCE SERVICES			, 0.00000		U	94. 00 95. 00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0	O	0. 00000		0	96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-RENTED	0	0	0.00000		0	97.00
98. 00 09850 OTHER REI MBURSE			0.00000		0	98.00
200.00 Total (lines 50 through 199)	3, 680, 434	548, 481, 803	1	51, 421, 224		
250.55 Total (Tries 50 through 177)	3, 000, 434	340, 401, 003	1	01,721,224	257, 402	200.00

APPORTI ONMEN	T OF INPATIENT ROUTINE SERVICE OTHER P	ASS THROUGH COST		F	Period: From 01/01/2022 To 12/31/2022		pared:
			Title	XVIII	Hospi tal	PPS	
	Cost Center Description	Nursi ng Program Post-Stepdown Adj ustments	Nursi ng Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
		1A	1. 00	2A	2. 00	3. 00	
I NPATI	ENT ROUTINE SERVICE COST CENTERS						
31. 00 03100 32. 00 03200 33. 00 03300 34. 00 03400 40. 00 04000 41. 00 04100 43. 00 04300	ADULTS & PEDIATRICS INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT SUBPROVIDER - IPF SUBPROVIDER - IRF NURSERY SKILLED NURSING FACILITY	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	31. 00 32. 00 33. 00 34. 00 40. 00 41. 00
	NURSING FACILITY	0					45. 00
	Total (lines 30 through 199)	0	0			0	200.00
	Cost Center Description	Swi ng-Bed	Total Costs	Total Patient	Per Diem (col.	Inpati ent	200.00
	oost center bescription	Adjustment Amount (see	(sum of cols. 1 through 3, minus col. 4)	Days	5 ÷ col . 6)	Program Days	
		4.00	5. 00	6. 00	7. 00	8. 00	
INPATI	ENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 31. 00 03100 32. 00 03200 33. 00 03300 40. 00 04000 41. 00 04100 43. 00 04300 44. 00 04400 45. 00 04500 200. 00	ADULTS & PEDIATRICS INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT SUBPROVIDER - IPF SUBPROVIDER - IRF NURSERY SKILLED NURSING FACILITY NURSING FACILITY Total (lines 30 through 199) Cost Center Description	0 0 0	0 0 0 0	2, 058	8 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0	1, 418 0 0 0 0 0 0 0	31. 00 32. 00 33. 00 34. 00 40. 00 41. 00 43. 00 44. 00
LANDATI	ENT POUTING CEDIUSE AGGT SENTEDS	Program Pass-Through Cost (col. 7 x col. 8) 9.00					
	ENT ROUTINE SERVICE COST CENTERS	1 ^					20.00
31. 00 03100 32. 00 03200 33. 00 03300 34. 00 03400 40. 00 04000 41. 00 04100 43. 00 04300 44. 00 04400 45. 00 04500	INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT SUBPROVIDER - IPF SUBPROVIDER - IRF NURSERY SKILLED NURSING FACILITY NURSING FACILITY	0 0 0 0 0 0 0					30. 00 31. 00 32. 00 33. 00 34. 00 40. 00 41. 00 43. 00 44. 00 45. 00 200. 00
30. 00 03000 31. 00 03100 32. 00 03200 33. 00 03300 34. 00 04400 40. 00 04000 41. 00 04400 43. 00 04400 45. 00 04500	ADULTS & PEDIATRICS INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT SUBPROVIDER - IPF SUBPROVIDER - IRF NURSERY SKILLED NURSING FACILITY	0 0 0 0 0					

In Lieu of Form CMS-2552-10

Period:	Worksheet D
From 01/01/2022	Part IV
To 12/31/2022	Date/Time Prepared:
5/29/2023 9:51 am	THROUGH COSTS

					127 017 2022	5/29/2023 9:5	1 am	
			Ti tl	e XVIII		Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursi ng	Nursi ng	Al	llied Health	Allied Health	
		Anesthetist	Program	Program	Po	ost-Stepdown		
		Cost	Post-Stepdowr	1	1	Adjustments		
			Adjustments					
		1.00	2A	2.00		3A	3. 00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0		0	0	0	0	50.00
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
55.00	05500 RADI OLOGY-THERAPEUTI C	0		0	0	0	0	55.00
56.00	05600 RADI OI SOTOPE	0		0	0	0	0	56.00
57.00	05700 CT SCAN	0		0	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	0	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0		0	0	0	0	59.00
60.00	06000 LABORATORY	0		0	0	0	0	60.00
60. 01	06001 BLOOD LABORATORY	0		o	0	o	0	60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY							61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0		o	0	o	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0		ol	0	o	0	63.00
64.00	06400 I NTRAVENOUS THERAPY	0		ol	0	o	0	64.00
65.00	06500 RESPI RATORY THERAPY	0		o	0	o	0	65.00
66.00	06600 PHYSI CAL THERAPY	0		o	0	o	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0		o	0	o	0	67.00
68. 00	06800 SPEECH PATHOLOGY	0		ol	0	o	0	68.00
69. 00	06900 ELECTROCARDI OLOGY	0		ol	0	ol	o	69.00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0		ol	0	ol	0	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		ol	0	ol	0	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0		ol	0	ol	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0		ol	0	o	0	73.00
74.00	07400 RENAL DIALYSIS	0		ol	0	o	0	74.00
75. 00	07500 ASC (NON-DISTINCT PART)	0		ol	0	ol	0	75. 00
76. 00	03950 OTHER ANCILL SRVC	0		ol	0	o	0	76.00
76. 01	03951 CARDI AC AND PULMONARY REHAB	0		ol	0	ol	0	76. 01
76. 02	03952 WOUND CARE	0		ol	0	ol	0	76. 02
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0		ol	0	ol	0	77.00
	OUTPATIENT SERVICE COST CENTERS			•	-			
88. 00	08800 RURAL HEALTH CLINIC	0		0	0	0	0	88. 00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0		ol	0	o	0	89.00
90.00	09000 CLI NI C	0		ol	0	o	0	90.00
90. 01	09001 CLI NI C	0		ol	0	o	0	90. 01
90. 02	09002 CLI NI C	0		ol	0	o	0	90. 02
91.00	09100 EMERGENCY	0		ol	0	o	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0		0	92.00
	OTHER REIMBURSABLE COST CENTERS							
94.00	09400 HOME PROGRAM DIALYSIS	0		0	0	0	0	94.00
95.00	09500 AMBULANCE SERVI CES							95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0		0	0	o	0	96.00
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD	0		o	0	o	0	97.00
98. 00	09850 OTHER REIMBURSE	0		0	0	o	0	98.00
200.00	Total (lines 50 through 199)	0		0	0	o	0	200. 00
	<u> </u>							

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 15-0165 Peri od: Worksheet D From 01/01/2022 THROUGH COSTS Part IV 12/31/2022 Date/Time Prepared: 5/29/2023 9:51 am Title XVIII Hospi tal Cost Center Description All Other Total Cost Total Total Charges Ratio of Cost to Charges Medi cal (from Wkst. C, (sum of cols. Outpati ent Education Cost 1, 2, 3, and Cost (sum of Part I, col. l(col. 5 ÷ col 8) 4) col s. 2. 3. 7) and 4) (see instructions) 4.00 5.00 6.00 7. 00 8.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 85, 880, 444 0.000000 50.00 05100 RECOVERY ROOM 0 0 10, 076, 248 0.000000 51.00 51.00 000000000000 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0.000000 52.00 05300 ANESTHESI OLOGY 0 0 21 413 069 0.000000 53 00 53 00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 31, 985, 210 0.000000 54.00 05500 RADI OLOGY-THERAPEUTI C 0.000000 55.00 05600 RADI OI SOTOPE 0 0 0.000000 56 00 56 00 0 57.00 05700 CT SCAN 0 47, 667, 734 0.000000 57.00 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 27, 016, 856 0.000000 58.00 05900 CARDIAC CATHETERIZATION 59.00 0 24, 795, 118 0.000000 59.00 06000 LABORATORY 68, 286, 496 60 00 0.000000 60 00 06001 BLOOD LABORATORY 60.01 0.000000 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.000000 62.00 000000000000000000 0 62.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 63.00 0 0 0.000000 63 00 64.00 06400 I NTRAVENOUS THERAPY 0 0 0.000000 64.00 8, 831, 360 06500 RESPIRATORY THERAPY 0.000000 65.00 65.00 06600 PHYSI CAL THERAPY 0 0 0.000000 66.00 2, 723, 324 66, 00 06700 OCCUPATIONAL THERAPY 0 67.00 0 2, 602, 019 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 1, 280, 840 0.000000 68.00 06900 ELECTROCARDI OLOGY 69.00 20, 538, 642 0.000000 69.00 07000 ELECTROENCEPHALOGRAPHY 70.00 4. 180. 649 0.000000 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0.000000 71.00 29, 020, 719 71 00 07200 IMPL. DEV. CHARGED TO PATIENTS 30, 386, 374 0.000000 72.00 07300 DRUGS CHARGED TO PATIENTS 73 00 30, 878, 581 0.000000 73.00 07400 RENAL DIALYSIS 0 0.000000 74.00 0 74.00 0 07500 ASC (NON-DISTINCT PART) 0 75.00 C 0 0.000000 75.00 03950 OTHER ANCILL SRVC 0.000000 76.00 76.00 76.01 03951 CARDIAC AND PULMONARY REHAB 0 0 467, 595 0.000000 76.01 03952 WOUND CARE 0 76.02 Ω 0.000000 76.02 07700 ALLOGENEIC STEM CELL ACQUISITION 77.00 0.00000077.00 OUTPATIENT SERVICE COST CENTERS 0 88.00 08800 RURAL HEALTH CLINIC 0 0.000000 88.00 0 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 0 0 0.00000089.00 90.00 09000 CLI NI C 0 0 0 0 0.000000 90.00 09001 CLI NI C 0 0 27, 205, 836 0.000000 90.01 90.01 09002 CLI NI C 0 0 3, 474, 085 0.000000 90 02 90.02

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200.00

09100 EMERGENCY

95. 00 09500 AMBULANCE SERVICES

98. 00 09850 OTHER REIMBURSE

09200 OBSERVATION BEDS (NON-DISTINCT PART)

OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DIALYSIS

09600 DURABLE MEDICAL EQUIP-RENTED

Total (lines 50 through 199)

97. 00 09700 DURABLE MEDICAL EQUIP-SOLD

| Peri od: | Worksheet D | From 01/01/2022 | Part IV | To 12/31/2022 | Date/Time Prepared: | Part IV | Par Health Financial Systems FRANCISCAN HEALT APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 15-0165 THROUGH COSTS

				11	5 12/31/2022	5/29/2023 9:5	
			Title	· XVIII	Hospi tal	PPS	
	Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through	Charges	Pass-Through	
		(col. 6 ÷ col.		Costs (col. 8		Costs (col. 9	
		7)		x col. 10)		x col. 12)	
		9.00	10. 00	11. 00	12. 00	13. 00	
	ANCILLARY SERVICE COST CENTERS			1	00 //4 500		
50.00	05000 OPERATI NG ROOM	0. 000000	6, 175, 633		20, 661, 532	0	50.00
51.00	05100 RECOVERY ROOM	0. 000000	668, 514		2, 643, 841	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	1 072 1/7	_	0	0	52.00
53.00	05300 ANESTHESI OLOGY	0.000000	1, 072, 167		4, 004, 872	0	53.00
54.00	05400 RADI OLOGY - DI AGNOSTI C	0.000000	2, 910, 036		16, 295, 999	_	54.00
55.00	O5500 RADI OLOGY - THERAPEUTI C	0.000000	0		0	0	55. 00
56. 00	05600 RADI 0I SOTOPE 05700 CT SCAN	0. 000000	0	0	O	0	56. 00 57. 00
57. 00		0.000000	3, 899, 801	_	8, 208, 224	_	
58. 00 59. 00	05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION	0. 000000 0. 000000	840, 954 0		2, 707, 488 0	0	58. 00 59. 00
	06000 LABORATORY	1	O	_	O	0	
60. 00 60. 01	06001 BLOOD LABORATORY	0. 000000 0. 000000	11, 040, 819 0		4, 394, 853 0	0	60. 00 60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	U	0	U	J 0 1	61. 00
		0.000000	0	0	0		
62. 00 63. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000 0. 000000	0	_	0	0	62. 00 63. 00
	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY	1	0		0	0	
64. 00 65. 00	06500 RESPIRATORY THERAPY	0. 000000 0. 000000	2, 657, 762	_	207, 335	0	64. 00 65. 00
66. 00	06600 PHYSI CAL THERAPY	0. 000000	726, 890		207, 335 245, 799	0	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 000000	726, 890		53, 881	0	67.00
68. 00	06800 SPEECH PATHOLOGY	0. 000000	425, 322		16, 835	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 000000	4, 650, 762		4, 553, 592	0	69.00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	66, 310		534, 334	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	2, 541, 355		3, 340, 954	0	71.00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000	2, 209, 188		7, 005, 345	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	6, 093, 218		3, 573, 124	0	73. 00
74. 00	07400 RENAL DI ALYSI S	0. 000000	0,070,210		0,070,121	0	74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0. 000000	0	l o	0	Ö	75. 00
76. 00	03950 OTHER ANCILL SRVC	0. 000000	0		0	Ö	76. 00
76. 01	03951 CARDI AC AND PULMONARY REHAB	0. 000000	0	0	21	0	76. 01
76. 02	03952 WOUND CARE	0. 000000	0	0	0	0	76. 02
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000	0	0	0	0	77. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0. 000000	0	0	0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000	0	0	0	0	89. 00
90.00	09000 CLI NI C	0. 000000	0	0	0	0	90. 00
90. 01	09001 CLI NI C	0. 000000	275	0	71, 878	0	90. 01
90. 02	09002 CLI NI C	0. 000000	0	0	0	0	90. 02
91.00	09100 EMERGENCY	0. 000000	3, 465, 297	0	5, 350, 618	0	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	1, 240, 603	0	1, 019, 667	0	92. 00
	OTHER REIMBURSABLE COST CENTERS						
94. 00	09400 HOME PROGRAM DIALYSIS	0. 000000	0	0	0	0	94. 00
95. 00	09500 AMBULANCE SERVICES						95. 00
96. 00	09600 DURABLE MEDI CAL EQUI P-RENTED	0. 000000	0	_	0	0	96. 00
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD	0. 000000	0		0	0	97. 00
98. 00	09850 OTHER REIMBURSE	0. 000000	0		0	0	98. 00
200.00	Total (lines 50 through 199)	1	51, 421, 224	0	84, 890, 192	. 01	200. 00

APPOR I	TONMENT OF MEDICAL, OTHER HEALTH SERVICES AND) VACCINE COST	Provider C	CN: 15-0165	Period: From 01/01/2022	Worksheet D Part V	
					To 12/31/2022	Date/Time Pre 5/29/2023 9:5	pared: 1 am
			Title	XVIII	Hospi tal	PPS	
				Charges		Costs	
	Cost Center Description	Cost to Charge			Cost	PPS Services	
			Services (see	Rei mbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To Ded. & Coins	Subject To Ded. & Coins.		
				(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. 147365	20, 661, 532		0 0	3, 044, 787	50.00
51.00	05100 RECOVERY ROOM	0. 268377	2, 643, 841		0	709, 546	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0)	0	0	
53. 00	05300 ANESTHESI OLOGY	0. 184951	4, 004, 872		0	740, 705	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0. 162878	16, 295, 999	1	0	2, 654, 260	1
55. 00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	0	1	0	0	
56. 00	05600 RADI OI SOTOPE	0.000000	0 200 224		0	0	
57. 00	05700 CT SCAN	0. 029946	8, 208, 224	1	0 0	245, 803	•
58. 00 59. 00	05800 MAGNETI C RESONANCE MAGING (MRI) 05900 CARDIAC CATHETERIZATION	0. 064831 0. 257950	2, 707, 488		0 0	175, 529 0	1
60.00	06000 LABORATORY	0. 237930	4, 394, 853		0 0	565, 306	•
60. 01	06001 BLOOD LABORATORY	0. 000000	4, 374, 033 N		0 0	0 303, 300	1
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000	O		0 0	O	61. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	0	,	0 0	0	1
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0	,	o o	0	63. 00
64.00	06400 I NTRAVENOUS THERAPY	0. 000000	0	,	0 0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0. 326085	207, 335		0 0	67, 609	65.00
66.00	06600 PHYSI CAL THERAPY	0. 178372	245, 799		0 0	43, 844	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0. 155818	53, 881		0	8, 396	67. 00
68. 00	06800 SPEECH PATHOLOGY	0. 134038	16, 835		0 0	2, 257	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 048000	4, 553, 592	1	0	218, 572	
70. 00	07000 ELECTROENCEPHALOGRAPHY	0. 491690	534, 334	1	0	262, 727	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 397473	3, 340, 954	1	0	1, 327, 939	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 256501	7, 005, 345	1	0 0	1, 796, 878	
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 286598	3, 573, 124		0 5, 156	1, 024, 050	
74. 00 75. 00	07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART)	0.000000	0		0 0	0	
76. 00	03950 OTHER ANCILL SRVC	0. 000000 0. 000000	0		0 0	0	75. 00 76. 00
76. 00	03951 CARDI AC AND PULMONARY REHAB	0. 761732	21		0 0	16	•
76. 02	03952 WOUND CARE	0. 000000	0	1	0 0	0	
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000	0		0 0	0	
,,,,,,	OUTPATIENT SERVICE COST CENTERS	0.00000			<u> </u>		77.00
88. 00	08800 RURAL HEALTH CLINIC						88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER						89. 00
90.00	09000 CLI NI C	0. 000000	0)	0 0	0	90.00
90. 01	09001 CLI NI C	0. 123513	71, 878		0	8, 878	90. 01
90. 02	09002 CLI NI C	0. 218239	0)	0	0	
91.00	09100 EMERGENCY	0. 167754	5, 350, 618	1	0	897, 588	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 455319	1, 019, 667		0 0	464, 274	92.00
94. 00	OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DIALYSIS	0. 000000		I	0 0		94. 00
95.00	09500 AMBULANCE SERVICES	0. 000000			0 0		95.00
	09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000	0		0 0	0	ı
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD	0. 000000	0	1	0 0	0	1
98. 00	09850 OTHER REIMBURSE	0. 000000	0		0 0	Ö	1
200.00			84, 890, 192		0 5, 156	14, 258, 964	
201.00			•		0 0		201. 00
	Only Charges						
202.00	Net Charges (line 200 - line 201)		84, 890, 192	1	0 5, 156	14, 258, 964	202. 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet D | From 01/01/2022 | Part V | To 12/31/2022 | Date/Time Prepared: | 5/29/2023 9:51 am Provider CCN: 15-0165

Cost Center Description						5/29/2023 9:5	1 am
Cost Center Description			Ti tl e	XVIII	Hospi tal	PPS	
Cost Center Description		Cos					
Rel indursed Servi cos Subject To Ded 4 Coins Cost	Cost Contor Doscription			1			
Services Subject To Ded. 8 coins. Cose Inst. Ded. 8 coins. Cose Inst. Ded. 8 coins. Cose Inst. Ded. 8 coins. Ded. 8 coin	cost center bescription						
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Health Financial Systems APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	FRANCI SCAN HEA		CN: 15-0165	Peri od:	u of Form CMS- Worksheet D	2332-10
AFFORTIONWENT OF INFATTENT ROUTINE SERVICE CAFTIAL	00313	Frovider C	CN. 15-0105	From 01/01/2022	Part I	
				To 12/31/2022	Date/Time Pre	
					5/29/2023 9:5	1 am
	1 2 11 1		e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Pati ent		
	Related Cost	Adjustment	Capi tal	Days	3 / col . 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		1,	1.		
	26) 1. 00	2.00	2) 3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
30. 00 ADULTS & PEDIATRICS	1, 885, 551		1, 885, 5	51 20, 644	91. 34	30.00
31. 00 INTENSIVE CARE UNIT	408, 679		408, 6	· ·	198. 58	
32. 00 CORONARY CARE UNIT	400,077		400, 0	0 2,030	0.00	
33. 00 BURN INTENSIVE CARE UNIT	0				0.00	
34. 00 SURGICAL INTENSIVE CARE UNIT					0.00	
40. 00 SUBPROVI DER – I PF					0.00	
41. 00 SUBPROVI DER – TFI					0.00	
43. 00 NURSERY			1		0.00	
44.00 SKILLED NURSING FACILITY					0.00	
45. 00 NURSING FACILITY	0					45. 00
200. 00 Total (lines 30 through 199)	2, 294, 230		2, 294, 2	30 22, 702	0.00	200.00
Cost Center Description	Inpati ent	Inpati ent	2,274,2	22, 102		200.00
oost conten beschiptron	Program days	Program				
	11 ogram days	Capital Cost				
		(col. 5 x col.				
		6)				
	6. 00	7. 00	1			
INPATIENT ROUTINE SERVICE COST CENTERS	<u>'</u>		•			
30. 00 ADULTS & PEDIATRICS	2, 224	203, 140)			30.00
31.00 INTENSIVE CARE UNIT	0	C				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 SUBPROVI DER - I PF	0	C				40.00
41. 00 SUBPROVI DER - I RF	0	C)			41. 00
43. 00 NURSERY	0	C)			43.00
44.00 SKILLED NURSING FACILITY	0	C)			44. 00
45. 00 NURSING FACILITY	0)			45.00
200.00 Total (lines 30 through 199)	_		1			

Heal th	Financial Systems	FRANCISCAN HEA	ALTH MUNSTER		In Lie	u of Form CMS-	2552-10
	TIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der C		Peri od:	Worksheet D	
					rom 01/01/2022	Part II	
					Γο 12/31/2022	Date/Time Pre 5/29/2023 9:5	pared:
			Ti +1	e XIX	Hospi tal	PPS	ı allı
	Cost Center Description	Capi tal		Ratio of Cost		Capital Costs	
	cost center bescription	Related Cost	(from Wkst. C,		Program	(column 3 x	
		(from Wkst. B,	Part I, col.	(col. 1 ÷ col.		column 4)	
		Part II, col.	8)	2)	Charges	COT GIIIIT 4)	
		26)	0)	2)			
		1.00	2.00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS	1.00	2.00	0.00	1.00	0.00	
50.00	05000 OPERATI NG ROOM	723, 113	85, 880, 444	0.008420	3, 222, 631	27, 135	50.00
51. 00	05100 RECOVERY ROOM	298, 366				7, 041	ł
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0.00000		0	52.00
53. 00	05300 ANESTHESI OLOGY	23, 891	21, 413, 069	1		682	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	331, 426	31, 985, 210			9, 580	
55. 00	05500 RADI OLOGY-THERAPEUTI C	001, 120	01, 700, 210			0	55.00
56. 00	05600 RADI OI SOTOPE	0		0.00000		0	56.00
57. 00	05700 CT SCAN	9, 817	47, 667, 734	1		326	ı
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	12, 126	27, 016, 856			207	58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	645, 760		1	1	75, 647	
60.00	06000 LABORATORY				1		60.00
	1 1	156, 937	68, 286, 496			9, 877	
60. 01	06001 BLOOD LABORATORY	0	0	0. 00000	ا ا	0	60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	7 0.00000		0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	7 0.00000		0	63.00
64. 00	06400 I NTRAVENOUS THERAPY	0	0	0.00000		0	64. 00
65. 00	06500 RESPI RATORY THERAPY	70, 916		1	1	10, 847	65. 00
66. 00	06600 PHYSI CAL THERAPY	3, 435	2, 723, 324			253	
67. 00	06700 OCCUPATI ONAL THERAPY	2, 827	2, 602, 019			218	
68. 00	06800 SPEECH PATHOLOGY	1, 220	1, 280, 840	1		130	
69. 00	06900 ELECTROCARDI OLOGY	6, 934	20, 538, 642			306	
70.00	07000 ELECTROENCEPHALOGRAPHY	277, 004	4, 180, 649	1	1	2, 382	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	69, 321	29, 020, 719			0	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	46, 952	30, 386, 374			0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	168, 338	30, 878, 581	0. 00545	2 3, 356, 806	18, 301	73. 00
74.00	07400 RENAL DI ALYSI S	0	0	0. 00000	0	0	74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0	0	0. 00000	0	0	75. 00
76. 00	03950 OTHER ANCILL SRVC	0	0	0. 000000	0	0	76. 00
76. 01	03951 CARDI AC AND PULMONARY REHAB	2, 502	467, 595	0. 00535	1 4, 344	23	76. 01
76. 02	03952 WOUND CARE	0	0	0. 00000	0	0	76. 02
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0. 00000	0	0	77. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0	0			0	
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0. 00000	0	0	89. 00
90.00	09000 CLI NI C	0	0	0. 00000	0	0	90.00
90. 01	09001 CLI NI C	22, 857	27, 205, 836	0. 000840	74, 000	62	90. 01
90.02	09002 CLI NI C	49, 227	3, 474, 085	0. 014170	0	0	90. 02
91.00	09100 EMERGENCY	425, 457	56, 758, 435	0. 00749	2, 058, 760	15, 432	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	332, 008	13, 012, 169	0. 02551	5 0	0	92.00
	OTHER REIMBURSABLE COST CENTERS	_					
94.00	09400 HOME PROGRAM DIALYSIS	0	0	0. 00000	0	0	94.00
95.00	09500 AMBULANCE SERVICES						95. 00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0. 00000	0	0	96. 00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0. 00000	0	0	97. 00
98.00	09850 OTHER REIMBURSE	0	0	0. 00000	0	0	98. 00
200.00		3, 680, 434	548, 481, 803	B	22, 567, 793	178, 449	200. 00

nearth Financial Systems	FRANCI SCAN HE	ALIT WUNSTER		III LI E	u or Form CMS	2332-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	ASS THROUGH COS	TS Provider Co	F	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part III Date/Time Pre 5/29/2023 9:5	pared:
		Ti +I	e XIX	Hospi tal	PPS	i diii
Cost Center Description	Nursi ng	Nursi ng		Allied Health	All Other	
cost center bescription	Program	Program	Post-Stepdown	Cost	Medi cal	
		Frogram			Education Cost	
	Post-Stepdown		Adjustments		Education Cost	
	Adjustments	1.00		0.00	0.00	
	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	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0		0	0	31. 00
32. 00 03200 CORONARY CARE UNIT	0	0	1	0	0	32. 00
33. 00 03300 BURN INTENSIVE CARE UNIT	0	0				33. 00
34. 00 03400 SURGI CAL INTENSI VE CARE UNI T		0		_	Ö	34. 00
	0					40.00
	0	0			0	
41. 00 04100 SUBPROVI DER - I RF	0	0	C	_	0	41. 00
43. 00 04300 NURSERY	0	0	(0	43. 00
44.00 04400 SKILLED NURSING FACILITY	0	0	(0		44.00
45.00 04500 NURSING FACILITY	0	0		0		45. 00
200.00 Total (lines 30 through 199)	0	0	1	0	0	200. 00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patient	Per Diem (col.	Inpati ent	
	Adjustment	(sum of cols.	Days	5 ÷ col . 6)	Program Days	
	Amount (see	1 through 3,	Jajo	0 . 00 0)	l og. a bajo	
	instructions)					
	4. 00	5.00	6. 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	4.00	3.00	0.00	7.00	0.00	
30. 00 03000 ADULTS & PEDIATRICS	0	0	20, 644	0.00	2, 224	30. 00
	0					
31. 00 03100 INTENSIVE CARE UNIT		0	,			31. 00
32. 00 03200 CORONARY CARE UNIT		0	C		0	32. 00
33.00 03300 BURN INTENSIVE CARE UNIT		0	(
34.00 03400 SURGICAL INTENSIVE CARE UNIT		0	(0.00	0	34.00
40. 00 04000 SUBPROVI DER - 1 PF	0	0		0.00	0	40.00
41. 00 04100 SUBPROVI DER - RF	0	0	1 0	0.00	0	41. 00
43. 00 04300 NURSERY		0	1		l	43.00
44.00 04400 SKILLED NURSING FACILITY		0			l	44. 00
45. 00 04500 NURSING FACILITY					l e	45. 00
l l					l e	
200.00 Total (lines 30 through 199)		0	22, 702		2, 224	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 & PEDI ATRI CS	0					30. 00
31.00 03100 INTENSIVE CARE UNIT	0					31. 00
32. 00 03200 CORONARY CARE UNIT	0					32.00
33.00 03300 BURN INTENSIVE CARE UNIT	0					33. 00
34. 00 03400 SURGI CAL INTENSI VE CARE UNI T	j					34. 00
40. 00 04000 SUBPROVI DER - PF						40. 00
						1
41. 00 04100 SUBPROVI DER - RF						41.00
43. 00 04300 NURSERY	0	1				43. 00
44.00 O4400 SKILLED NURSING FACILITY	0					44. 00
45.00 O4500 NURSING FACILITY	0					45. 00
200.00 Total (lines 30 through 199)	0					200. 00

In Lieu of Form CMS-2552-10

Period:	Worksheet D
From 01/01/2022	Part IV
To 12/31/2022	Date/Time Prepared:
5/29/2023 9:51 am	THROUGH COSTS

						' '	12/01/2022	5/29/2023 9:5	1 am
				Titl	e XIX		Hospi tal	PPS	
	Cost Center Description	Non Physician	N	lursi ng	Nursi ng		Allied Health	Allied Health	
	·	Anesthetist	P	Program	Program		Post-Stepdown		
		Cost	Post	t-Stepdown			Adjustments		
			Adj	ustments					
		1.00		2A	2. 00		3A	3. 00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000 OPERATING ROOM	0		0		0	0	0	50.00
51.00	05100 RECOVERY ROOM	0		0		0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0)	0		0	0	0	52.00
53.00	05300 ANESTHESI OLOGY	0		0		0	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0		0		0	0	0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0)	0		0	0	0	55.00
56.00	05600 RADI OI SOTOPE	0)	0		0	0	0	56.00
57.00	05700 CT SCAN	0)	0		0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	o	0		0	0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0)	0		0	0	0	59.00
60.00	06000 LABORATORY	0)	0		0	0	0	60.00
60. 01	06001 BLOOD LABORATORY	0		0		0	0	0	60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY								61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0		0		0	0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0		0		0	0	0	63.00
64.00	06400 I NTRAVENOUS THERAPY	0		0		0	0	0	64.00
65.00	06500 RESPI RATORY THERAPY	0		0		0	0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0		0		0	0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0		0		0	0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0		0		0	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0		0		0	0	o	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0		0		0	0	o	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0		0	0	o	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0		0		0	0	o	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	ol	0		0	0	0	73. 00
74.00	07400 RENAL DIALYSIS	0	ol	0		0	0	0	74.00
75. 00	07500 ASC (NON-DISTINCT PART)	0		0		0	0	o	75. 00
76. 00	03950 OTHER ANCILL SRVC	0	ol	0		0	0	0	76. 00
76. 01	03951 CARDI AC AND PULMONARY REHAB	0		0		0	0	o	76. 01
76. 02	03952 WOUND CARE	0	ol	0		0	0	0	76. 02
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	ol	0		0	0	0	77. 00
	OUTPATIENT SERVICE COST CENTERS	<u>'</u>							
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 CLI NI C	0		0		0	0	0	90.00
90. 01	09001 CLI NI C	0		0		0	0	0	90. 01
90. 02	09002 CLI NI C	0		0		0	0	0	90. 02
91.00	09100 EMERGENCY	0		0		0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0				0		0	92.00
	OTHER REIMBURSABLE COST CENTERS								
94.00	09400 HOME PROGRAM DI ALYSIS	0		0		0	0	0	94.00
95. 00	09500 AMBULANCE SERVI CES			_			_		95. 00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	0		0		0	0	0	96. 00
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD	0)	0		0	0	0	97.00
98. 00	09850 OTHER REIMBURSE	0)	0		0	0	0	98. 00
200.00	1 1	0)	0		0	0	o	200. 00
		•	•		•				

Provider CCN: 15-0165 From 01/01/2022 THROUGH COSTS Part IV 12/31/2022 Date/Time Prepared: 5/29/2023 9:51 am Title XIX Hospi tal Cost Center Description All Other Total Cost Total Total Charges Ratio of Cost to Charges Medi cal (from Wkst. C, (sum of cols. Outpati ent Education Cost 1, 2, 3, and Cost (sum of Part I, col. l(col. 5 ÷ col 8) 4) col s. 2, 3, 7) and 4) (see instructions) 4.00 5.00 6.00 7. 00 8.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 85, 880, 444 0.000000 50.00 05100 RECOVERY ROOM 0 0 10, 076, 248 0.000000 51.00 51.00 000000000000 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0.000000 52.00 05300 ANESTHESI OLOGY 0 0 21 413 069 0.000000 53 00 53 00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 31, 985, 210 0.000000 54.00 05500 RADI OLOGY-THERAPEUTI C 0.000000 55.00 05600 RADI OI SOTOPE 0 0 0.000000 56 00 56 00 0 57.00 05700 CT SCAN 0 47, 667, 734 0.000000 57.00 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 27, 016, 856 0.000000 58.00 05900 CARDIAC CATHETERIZATION 59.00 0 24, 795, 118 0.000000 59.00 06000 LABORATORY 68, 286, 496 60 00 0.000000 60 00 06001 BLOOD LABORATORY 60.01 0.000000 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.000000 62.00 000000000000000000 0 62.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 63.00 0 0 0.000000 63 00 64.00 06400 I NTRAVENOUS THERAPY 0 0 0.000000 64.00 8, 831, 360 06500 RESPIRATORY THERAPY 0.000000 65.00 65.00 06600 PHYSI CAL THERAPY 0 0 0.000000 66.00 2, 723, 324 66, 00 06700 OCCUPATIONAL THERAPY 0 67.00 0 2, 602, 019 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 1, 280, 840 0.000000 68.00 06900 ELECTROCARDI OLOGY 69.00 20, 538, 642 0.000000 69.00 07000 ELECTROENCEPHALOGRAPHY 70.00 4. 180. 649 0.000000 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0.000000 71.00 29, 020, 719 71 00 07200 IMPL. DEV. CHARGED TO PATIENTS 30, 386, 374 0.000000 72.00 07300 DRUGS CHARGED TO PATIENTS 73 00 30, 878, 581 0.000000 73.00 07400 RENAL DIALYSIS 0 0.000000 74.00 0 74.00 0 07500 ASC (NON-DISTINCT PART) 0 75.00 C 0 0.000000 75.00 03950 OTHER ANCILL SRVC 0.000000 76.00 76.00 76.01 03951 CARDIAC AND PULMONARY REHAB 0 0 467, 595 0.000000 76.01 03952 WOUND CARE 0 76.02 Ω 0.000000 76.02 07700 ALLOGENEIC STEM CELL ACQUISITION 77.00 0.00000077.00 OUTPATIENT SERVICE COST CENTERS 0 88.00 08800 RURAL HEALTH CLINIC 0 0.000000 88.00 0 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 0 0 0.00000089.00 90.00 09000 CLI NI C 0 0 0 0 0.000000 90.00 09001 CLI NI C 0 0 27, 205, 836 0.000000 90.01 90.01 09002 CLI NI C 0 0 3, 474, 085 0.000000 90 02 90.02 91.00 09100 EMERGENCY 0 C 0 56, 758, 435 0.000000 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 13, 012, 169 0.000000 92.00 OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DIALYSIS 94.00 0 0 0.000000 94.00 95. 00 09500 AMBULANCE SERVICES 95.00

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548, 481, 803

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0.000000

0.000000

96.00

97.00

98.00

200.00

96.00

200.00

09600 DURABLE MEDICAL EQUIP-RENTED

Total (lines 50 through 199)

97. 00 09700 DURABLE MEDICAL EQUIP-SOLD

98. 00 09850 OTHER REIMBURSE

| Peri od: | Worksheet D | From 01/01/2022 | Part IV | To 12/31/2022 | Date/Time Prepared: | Part IV | Par Provider CCN: 15-0165 THROUGH COSTS

					0 12/31/2022	5/29/2023 9:5	
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	Outpati ent	Inpati ent	I npati ent	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through	Charges	Pass-Through	
		(col. 6 ÷ col.		Costs (col. 8		Costs (col. 9	
		7)		x col. 10)		x col. 12)	
	ANOLLI ADV CEDVICE COCT CENTEDO	9. 00	10. 00	11. 00	12.00	13. 00	
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	0. 000000	3, 222, 631		0	0	50.00
51.00	05100 RECOVERY ROOM	0. 000000	237, 781			0	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	237, 761			0	52.00
53. 00	05300 ANESTHESI OLOGY	0. 000000	611, 529			0	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0.000000	924, 565			0	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	724, 303		_	0	55.00
56. 00	05600 RADI OI SOTOPE	0. 000000	0			0	56.00
57. 00	05700 CT SCAN	0. 000000	1, 583, 388			0	57.00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 000000	461, 034			Ö	58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	2, 904, 592			0	59.00
60.00	06000 LABORATORY	0. 000000	4, 297, 999			Ö	60.00
60. 01	06001 BLOOD LABORATORY	0. 000000	4, 277, 777			Ö	60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0.00000	0	۲	0		61.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	0	C	0	0	62.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0			Ö	63.00
64. 00	06400 I NTRAVENOUS THERAPY	0. 000000	0			Ö	64. 00
65. 00	06500 RESPI RATORY THERAPY	0. 000000	1, 350, 861			Ö	65.00
66. 00	06600 PHYSI CAL THERAPY	0. 000000	200, 302			Ö	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 000000	200, 581			Ö	67. 00
68. 00	06800 SPEECH PATHOLOGY	0. 000000	136, 146			Ö	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 000000	906, 520			Ö	69.00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	35, 954	ĺ		ő	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	00,701			0	71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0	1	_	Ö	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	3, 356, 806			0	73. 00
74. 00	07400 RENAL DIALYSIS	0. 000000	0			0	74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0. 000000	0	l d	0	0	75. 00
76. 00	03950 OTHER ANCILL SRVC	0. 000000	0	C	0	0	76. 00
76. 01	03951 CARDI AC AND PULMONARY REHAB	0. 000000	4, 344	C	0	0	76. 01
76. 02	03952 WOUND CARE	0. 000000	0	l c	0	0	76. 02
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000	0	C	0	0	77. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0. 000000	0			0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000	0			0	89. 00
90. 00	09000 CLI NI C	0. 000000	0	1	_	0	90. 00
90. 01	09001 CLI NI C	0. 000000	74, 000		0	0	90. 01
90. 02	09002 CLI NI C	0. 000000	0	C	_	0	90. 02
91. 00	09100 EMERGENCY	0. 000000	2, 058, 760			0	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0	C	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS			_	_		
94. 00	09400 HOME PROGRAM DI ALYSI S	0. 000000	0	C	0	0	94. 00
95.00	09500 AMBULANCE SERVICES	0 000000	_		_	_	95. 00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0.000000	0	1		0	96.00
97. 00	09700 DURABLE MEDI CAL EQUI P-SOLD	0.000000	0			0	97. 00
98. 00 200. 00	O9850 OTHER REIMBURSE Total (lines 50 through 199)	0. 000000	22 567 702			0	98. 00 200. 00
200.00	Tiotal (Titles 50 tillough 199)	1 1	22, 567, 793	1	1	0	200.00

	TONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST		CN: 15-0165	Period: From 01/01/2022 To 12/31/2022		pared:
			Ti tl	e XIX	Hospi tal	PPS	
				Charges		Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
		Ratio From	Services (see	Rei mbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins	. Ded. & Coins.		
				(see inst.)	(see inst.)		
		1.00	2. 00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0. 147365	C	12, 492, 20	0	0	50. 00
51.00	05100 RECOVERY ROOM	0. 268377	C	1, 040, 59	95 0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	C		0 0	0	52.00
53.00	05300 ANESTHESI OLOGY	0. 184951	C	2, 117, 04	14 0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 162878	C	4, 452, 7		0	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	C		0 0	0	55. 00
56. 00	05600 RADI OI SOTOPE	0. 000000	Ċ		0 0	0	56.00
57. 00	05700 CT SCAN	0. 029946	Č	6, 282, 63	-	0	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 064831		3, 124, 8		Ö	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 257950	Č			Ö	59. 00
60.00	06000 LABORATORY	0. 128629				0	60.00
60. 00	06001 BLOOD LABORATORY	0. 128029	C	1 ., ,	0	0	60.00
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000		Ί	0	U	61. 00
			_	,	0	_	1
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000		()	0	0	62.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	C	<u>'</u>	0	0	63.00
64.00	06400 I NTRAVENOUS THERAPY	0. 000000	C	, , , , , , , , , , , , , , , , , , , ,	0 0	0	64.00
65. 00	06500 RESPI RATORY THERAPY	0. 326085	C			0	65.00
66. 00	06600 PHYSI CAL THERAPY	0. 178372	C	65, 09		0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 155818	C			0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0. 134038	C			0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 048000	C			0	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0. 491690	C			0	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 397473	C	•	0	0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 256501	C	•	0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 286598	C	1, 415, 19	99 0	0	73. 00
74. 00	07400 RENAL DIALYSIS	0. 000000	C)	0	0	74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0. 000000	C)	0	0	75. 00
76.00	03950 OTHER ANCILL SRVC	0. 000000	C		0	0	76. 00
76. 01	03951 CARDI AC AND PULMONARY REHAB	0. 761732	C	28	0	0	76. 01
76. 02	03952 WOUND CARE	0. 000000	C		0	0	76. 02
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000	C		0 0	0	77. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC						88. 00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER						89. 00
90.00	09000 CLI NI C	0. 000000	C		0	0	90.00
90. 01	09001 CLI NI C	0. 123513	C	2, 825, 62	27 0	0	90. 01
90. 02	09002 CLI NI C	0. 218239	C	261, 64	19 0	0	90. 02
91.00	09100 EMERGENCY	0. 167754	C	12, 383, 5	79 0	0	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 455319	C	i	0 0	0	92. 00
	OTHER REIMBURSABLE COST CENTERS		_	1			
94.00	09400 HOME PROGRAM DI ALYSIS	0. 000000			0 0		94.00
95. 00	09500 AMBULANCE SERVI CES	0. 000000	C		0		95. 00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000	Ċ	d	0	0	96.00
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD	0. 000000	r		o o	ő	97. 00
98. 00	09850 OTHER REIMBURSE	0. 000000			0 0	Ö	1
200.00		2. 223000	Č	57, 164, 28	30 0		200.00
201.00				3., 101, 20	0 0		201.00
	Only Charges						

57, 164, 280

0 202. 00

202.00

Subtotal (see instructions)
Less PBP Clinic Lab. Services-Program
Only Charges
Net Charges (line 200 - line 201)

| Period: | Worksheet D | From 01/01/2022 | Part V | Date/Time Prepared: | 5/29/2023 9:51 am
 Heal th Financial
 Systems
 FRANCISCAN HE

 APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST
 Provider CCN: 15-0165

				5/29/2023 9:51 am
		Title XIX	Hospi tal	PPS
	Cos	sts		
Cost Center Description	Cost	Cost		
, , , , , , , , , , , , , , , , , , ,	Rei mbursed	Rei mbursed		
	Servi ces	Servi ces Not		
	Subject To	Subject To		
	Ded. & Coins.	Ded. & Coins.		
	(see inst.)	(see inst.)		
	6.00	7.00		
ANCILL ADV. CEDVI CE. COCT. CENTEDO	0.00	7.00		
ANCILLARY SERVICE COST CENTERS	1 040 044			F0.00
50. 00 05000 OPERATI NG ROOM	1, 840, 914	0		50.00
51. 00 05100 RECOVERY ROOM	279, 272	0		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53. 00 05300 ANESTHESI OLOGY	391, 549	0		53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	725, 260	0		54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	O		55.00
56. 00 05600 RADI OI SOTOPE	0	o		56.00
57. 00 05700 CT SCAN	188, 140	l ol		57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	202, 585	,		58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	233, 140			59.00
60. 00 06000 LABORATORY	940, 516	l ol		60.00
60. 01 06001 BLOOD LABORATORY	940, 310	1		60.00
	1	١		
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0			61. 00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	1		62. 00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		63. 00
64.00 06400 INTRAVENOUS THERAPY	0	0		64. 00
65. 00 06500 RESPI RATORY THERAPY	50, 748	0		65.00
66. 00 06600 PHYSI CAL THERAPY	11, 611	O		66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	9, 911	l ol		67.00
68. 00 06800 SPEECH PATHOLOGY	4, 892	l ol		68. 00
69. 00 06900 ELECTROCARDI OLOGY	81, 306	l ol		69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	264, 280	1		70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	O		71.00
	0			72.00
		1		
73. 00 07300 DRUGS CHARGED TO PATIENTS	405, 593	0		73. 00
74. 00 07400 RENAL DI ALYSI S	0	0		74. 00
75.00 07500 ASC (NON-DISTINCT PART)	0			75. 00
76.00 03950 OTHER ANCILL SRVC	0	0		76. 00
76.01 03951 CARDIAC AND PULMONARY REHAB	219	0		76. 01
76. 02 03952 WOUND CARE	0	0		76. 02
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	o		77. 00
OUTPATIENT SERVICE COST CENTERS				
88. 00 08800 RURAL HEALTH CLINIC				88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER				89. 00
90. 00 09000 CLI NI C	0	o		90.00
90. 01 09001 CLI NI C	349, 002			90. 01
		1		90. 02
	57, 102			
91. 00 09100 EMERGENCY	2, 077, 395			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92. 00
OTHER REIMBURSABLE COST CENTERS	1			
94.00 09400 HOME PROGRAM DIALYSIS	0	0		94.00
95. 00 09500 AMBULANCE SERVICES	0			95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		96. 00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	o		97. 00
98.00 09850 OTHER REIMBURSE	0	o		98. 00
200.00 Subtotal (see instructions)	8, 113, 435	ol		200. 00
201.00 Less PBP Clinic Lab. Services-Program	0			201.00
Only Charges				[20.1.00
202.00 Net Charges (line 200 - line 201)	8, 113, 435	o		202. 00
	3, 110, 100	· ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~		1202.00

Health Financial Systems	FRANCISCAN HEALTH MUNSTER	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0165	Peri od: From 01/01/2022 To 12/31/2022	Worksheet D-1 Date/Time Pre 5/29/2023 9:5	
	Title XVIII	Hospi tal	PPS	
Cost Center Description				
			1. 00	

		Title XVIII	Hospi tal	5/29/2023 9: 5 PPS	1 am	
	Cost Center Description					
	PART I - ALL PROVIDER COMPONENTS			1. 00		
	I NPATI ENT DAYS					
1.00	Inpatient days (including private room days and swing-bed days			20, 644	1.00	
2. 00 3. 00	Inpatient days (including private room days, excluding swing-l Private room days (excluding swing-bed and observation bed day		vato room days	20, 644 do 0	2. 00 3. 00	
3.00	not complete this line.	ys). If you have only pri	vate room days,	uo o	3.00	
4.00	Semi-private room days (excluding swing-bed and observation be	ed days)		17, 009	4. 00	
5.00	Total swing-bed SNF type inpatient days (including private roo	om days) through December	r 31 of the cost	0	5. 00	
	reporting period	d) - -	24 -6	0	6. 00	
6. 00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost 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. 00	
	reporting period	3 .				
8. 00	Total swing-bed NF type inpatient days (including private room	m days) after December 3°	1 of the cost	0	8. 00	
9. 00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to	the Program (eycluding	swing-bed and	4, 934	9. 00	
7. 00	newborn days) (see instructions)	The Frogram (exertaining	Swifing bed and	7, 757	7.00	
10.00	Swing-bed SNF type inpatient days applicable to title XVIII or	nly (including private ro	oom days) through	0	10.00	
44.00	December 31 of the cost reporting period (see instructions)				44 00	
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII on December 31 of the cost reporting period (if calendar year, en		oom days) arter	0	11. 00	
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX		e room days)	0	12. 00	
	through December 31 of the cost reporting period		,			
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI		e room days) afte	er 0	13. 00	
14. 00	December 31 of the cost reporting period (if calendar year, en Medically necessary private room days applicable to the Progra	am (excludina swina-bed a	davs)	0	14. 00	
15. 00	Total nursery days (title V or XIX only)	am (exertaining eming zea)	aayo,	0	15. 00	
16.00	Nursery days (title V or XIX only)			0	16. 00	
47.00	SWING BED ADJUSTMENT		6 11	0.00	17.00	
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through December 31 of	r the cost	0.00	17. 00	
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost reportir	ng 0.00	18. 00	
40.00	peri od			-	40.00	
19. 00	Medicaid rate for swing-bed NF services applicable to services period	s through December 31 of	the cost reporti	ng 0.00	19. 00	
20. 00	Medicald rate for swing-bed NF services applicable to services period	s after December 31 of th	ne cost reporting	0.00	20. 00	
21. 00	Total general inpatient routine service cost (see instructions	5)		33, 647, 597	21. 00	
22. 00	Swing-bed cost applicable to SNF type services through December		ng period (line		22. 00	
	x line 17)			_		
23. 00	Swing-bed cost applicable to SNF type services after December line 18)	31 of the cost reporting	g period (line 6	x 0	23. 00	
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reporti	ng period (line 7	' x 0	24. 00	
25 00	line 19)	01 of the east reporting	pariod (line 0)	0	25. 00	
25. 00	Swing-bed cost applicable to NF type services after December 3 line 20)	or the cost reporting	period (iine 8 x	. 0	25.00	
26. 00	Total swing-bed cost (see instructions)			0	26. 00	
27. 00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)		33, 647, 597	27. 00	
28 00	General inpatient routine service charges (excluding swing-bed	d and observation bed cha	arges)	0	28. 00	
29. 00	Pri vate room charges (excluding swing-bed charges)		a. goo)	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	1	
32. 00 33. 00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00 0. 00	1	
34. 00	Average per diem private room charge differential (line 32 mi)	nus line 33)(see instruc	tions)	0.00	1	
35.00	Average per diem private room cost differential (line 34 x li			0.00	35. 00	
36.00	Private room cost differential adjustment (line 3 x line 35)			0	36.00	
37. 00	General inpatient routine service cost net of swing-bed cost a minus line 36)	and private room cost di	rrerential (line	27 33, 647, 597	37. 00	
	PART II - HOSPITAL AND SUBPROVIDERS ONLY					
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU					
38. 00	Adjusted general inpatient routine service cost per diem (see			1, 629. 90		
39. 00 40. 00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Program			8, 041, 927 0	39. 00 40. 00	
	Total Program general inpatient routine service cost (line 39	,		8, 041, 927	•	

	PART II - HOSPITAL AND SUBPROVIDERS ONLY		1
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		1
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1, 629. 90	38.0
39.00	Program general inpatient routine service cost (line 9 x line 38)	8, 041, 927	39. C
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40. C
41. 00	Total Program general inpatient routine service cost (line 39 + line 40)	8, 041, 927	41. C

	Financial Systems	FRANCI SCAN HEAL		15 01/5		u of Form CMS	
COMPUT	ATION OF INPATIENT OPERATING COST		Provider CCN:		Period: From 01/01/2022 To 12/31/2022	Worksheet D- Date/Time Pr 5/29/2023 9:	epared:
	Cost Contan Decemintion	Total	Title X	VIII Average Per	Hospi tal	PPS Program Cost	
	Cost Center Description	Total Inpatient Costlr	patient Days Di	em (col. 1 col. 2)		Program Cost (col. 3 x col 4)	
42. 00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5. 00	0 42.00
42.00	Intensive Care Type Inpatient Hospital Units		<u> Ч</u>	0. 0	0		42.00
43. 00	INTENSIVE CARE UNIT	5, 805, 199	2, 058	2, 820. 8	1, 418	3, 999, 89	43.00
44. 00	CORONARY CARE UNIT	0	O	0. 0			0 44.00
45. 00 46. 00	BURN INTENSIVE CARE UNIT	0	0	0. C 0. C			0 45.00 0 46.00
	OTHER SPECIAL CARE (SPECIFY)	J	٩	0. 0	0		47. 00
	Cost Center Description	1					
48. 00	Program inpatient ancillary service cost (Wk	est D 2 col 2	Lino 200)			1. 00 9, 248, 72	8 48.00
48. 01	Program inpatient cellular therapy acquisiti			I. line 10.	column 1)		0 48.00
49. 00	Total Program inpatient costs (sum of lines				.,	21, 290, 54	
	PASS THROUGH COST ADJUSTMENTS						
50. 00	Pass through costs applicable to Program inp	oatient routine se	ervices (from Wi	kst. D, sum	of Parts I and	732, 25	8 50.00
51. 00	Pass through costs applicable to Program inp IV)	atient ancillary	services (from	Wkst. D, s	um of Parts II a	and 259, 46	2 51.00
52. 00 53. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu	,	ated, non-physic	cian anesth	etist, and medic		0 52.00 9 53.00
	education costs (line 49 minus line 52) TARGET AMOUNT AND LIMIT COMPUTATION						
54. 00	Program discharges						0 54.00
55. 00	Target amount per discharge						0 55.00
55. 01	Permanent adjustment amount per discharge						0 55. 01
55. 02 56. 00	Adjustment amount per discharge (contractor Target amount (line 54 x sum of lines 55, 55						0 55. 02 0 56. 00
57. 00	Difference between adjusted inpatient operat		et amount (line	e 56 minus	line 53)		0 57.00
58. 00	Bonus payment (see instructions)	y	,		,		0 58.00
59. 00	Trended costs (lesser of line 53 ÷ line 54,		he cost reporti	ing period	endi ng 1996,	0. 0	0 59. 00
60. 00	updated and compounded by the market basket) Description Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)						0 60.00
61. 00	Continuous improvement bonus payment (if lir 55.01 , or line 59 , or line 60 , enter the les are less than expected costs (lines 54×60)	ser of 50% of the	amount by which	ch operatin	g costs (line 53		0 61.00
62. 00	zero. (see instructions) Relief payment (see instructions)						0 62.00
63. 00	Allowable Inpatient cost plus incentive paym	ent (see instruct	i ons)				0 63.00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Decemb	per 31 of the co	nst renorti	ng period (See		0 64.00
	instructions) (title XVIII only)	3					
65. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	its after December	31 of the cos	t reporting	period (See		0 65.00
66. 00	Total Medicare swing-bed SNF inpatient routi see instructions	ne costs (line 64	l plus line 65)	(title XVII	I only); for CAH	l,	0 66.00
67. 00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	e costs through [ecember 31 of	the cost re	porting period		0 67. 00
68. 00	Title V or XIX swing-bed NF inpatient routin 13 x line 20)	e costs after Dec	cember 31 of the	e cost repo	rting period (li	ne	0 68. 00
69. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N						0 69.00
70.00	Skilled nursing facility/other nursing facil	•		t (line 37)			70.00
71. 00 72. 00	Adjusted general inpatient routine service of Program routine service cost (line 9 x line		ne /U ÷ line 2)				71. 00 72. 00
73. 00	Medically necessary private room cost applic	•	(line 14 x line	35)			73. 00
74. 00	Total Program general inpatient routine serv	rice costs (line l	72 + line 73)	•			74. 00
75. 00	Capital-related cost allocated to inpatient	routine service o	costs (from Worl	ksheet B, P	art II, column 2	26,	75. 00
76. 00	line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 00
77. 00	Program capital related costs (line 9 x line						77. 00
78. 00	Inpatient routine service cost (line 74 minu						78. 00
79. 00 80. 00	Aggregate charges to beneficiaries for exces Total Program routine service costs for comp			line 70 min	us line 70\		79. 00 80. 00
81. 00	Inpatient routine service costs for comp		st iimitation (/O IIII II	143 TTHE /7)		81.00
82. 00	Inpatient routine service cost limitation (I	ine 9 x line 81)					82. 00
83. 00	Reasonable inpatient routine service costs (83. 00
84. 00 85. 00	Program inpatient ancillary services (see in		:)				84. 00 85. 00
	Utilization review - physician compensation Total Program inpatient operating costs (sum						86.00
86.00	PART IV - COMPUTATION OF OBSERVATION BED PAS		· · /				
							_
87. 00 88. 00	Total observation bed days (see instructions Adjusted general inpatient routine cost per	5)	ino 2)			3, 63	5 87.00 0 88.00

Health Financial Systems	FRANCI SCAN HEA	ALTH MUNSTER		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2022 To 12/31/2022	Date/Time Prep 5/29/2023 9:5	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(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, 885, 551	33, 647, 597	0. 05603	5, 924, 687	332, 008	90.00
91.00 Nursing Program cost	0	33, 647, 597	0.00000	5, 924, 687	0	91.00
92.00 Allied health cost	0	33, 647, 597	0.00000	5, 924, 687	0	92.00
93.00 All other Medical Education	0	33, 647, 597	0. 00000	5, 924, 687	0	93. 00

Health Financial Systems	FRANCISCAN HEALTH MUNSTER	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0165	Peri od: From 01/01/2022	Worksheet D-1	
		To 12/31/2022	Date/Time Pre 5/29/2023 9:5	
	Title XIX	Hospi tal	PPS	
Cost Center Description				
			1. 00	
PART I - ALL PROVIDER COMPONENTS				

PART 1 - ALL PROVIDED COMPONENTS			Title XIX	Hospi tal	PPS	
PART 1 - ALL PROVIDER CORPORENTS		Cost Center Description		-	1 00	
Inpattient days (Including private room days and seing-bed days, excluding releasors) 20,644 2.00		PART I - ALL PROVIDER COMPONENTS			1.00	
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28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29. 00 Private room charges (excluding swing-bed charges) 30. 00 Semi-private room charges (excluding swing-bed charges) 30. 00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 30. 00 Average private room per diem charge (line 29 ÷ line 3) 30. 00 Average semi-private room per diem charge (line 30 ÷ line 4) 30. 00 Average per diem private room cost differential (line 32 minus line 33) (see instructions) 30. 00 Average per diem private room cost differential (line 34 x line 31) 30. 00 Average per diem private room cost differential (line 34 x line 31) 30. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 33, 647, 597 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS Adjusted general inpatient routine service cost (line 9 x line 38) 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 28. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00	27. 00		(line 21 minus line 26)		33, 647, 597	27. 00
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30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 33, 647, 597 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 A0.00 30.00 30.00 0.00 32.00 0.00 33.00 0.00 33.00 0.00 33.00 0.00 35.00 0.00 35.00 0.00 35.00 0.00 35.00 0.00 35.00 0.00 35.00 0.00 36.00 0.00 35.00 0.00 0.00 0.00 0.00 0.00			and observation bed cha	irges)		
31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Average per diem private room cost differential (line 34 x line 31) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 33, 647, 597 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0.00 000 32.00 0.00 32.00 37.00 000 33.00 0.00 34.00 37.00 000 34.00 37.00 000 32.00 38.00 000 33.00 0.00 34.00 37.00 000 34.00 38.00 000 000 000 000 000 000 000 000 000						
33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 33, 647, 597) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			- line 28)			
34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 33, 647, 597 and 57.00 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32. 00
35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 33, 647, 597 and 37.00 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0						
36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 33, 647, 597 37.00 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 36.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00		, , ,		i ons)		
37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 33,647,597 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 37.00 Adjusted general inpatient routine service cost per diem (see instructions) 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)		,	le 31)			
minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00						
PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 38.00 38.00 40.00		minus line 36)				
38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,629.90 38.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 1,629.90 38.00 3,624,898 39.00 40.00		PART II - HOSPITAL AND SUBPROVIDERS ONLY				
39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 3,624,898 39.00 40.00	00.05			1	4 (00 ==	00.00
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00		, , , , , , , , , , , , , , , , , , , ,	*		·	
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Heal th	Financial Systems	FRANCISCAN HEALT	TH MUNSTER	In Lie	eu of Form CMS-	2552-10
	ATION OF INPATIENT OPERATING COST		Provider CCN: 15-0165	Peri od: From 01/01/2022 To 12/31/2022	Worksheet D-1	pared:
			Title XIX	Hospi tal	PPS	
	Cost Center Description	Total Inpatient CostIn	Total Average Per patient Days Diem (col. 1 col. 2)		Program Cost (col. 3 x col. 4)	
42. 00	NURSERY (title V & XIX only)	1.00	2.00 3.00	4. 00 00 0	5. 00	42. 00
42.00	Intensive Care Type Inpatient Hospital Units	<u> </u>	<u> </u>	00 0	0	42.00
43.00	INTENSIVE CARE UNIT	5, 805, 199	2, 058 2, 820.			
44. 00	CORONARY CARE UNIT	0		00 0	0	
45. 00 46. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT	0	0 0 0.		0	
47. 00	OTHER SPECIAL CARE (SPECIFY)		0.	0		47. 00
	Cost Center Description				1. 00	
48. 00	Program inpatient ancillary service cost (Wk:	st. D-3, col. 3,	line 200)		4, 089, 754	48. 00
48. 01	Program inpatient cellular therapy acquisition			, column 1)	0	1
49. 00	Total Program inpatient costs (sum of lines	41 through 48.01)	(see instructions)		7, 714, 652	49. 00
50. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inpa	atient routine se	ervices (from Wkst. D. su	m of Parts I and	203, 140	50.00
			•			
51. 00	Pass through costs applicable to Program inpa	atient ancillary	services (from Wkst. D,	sum of Parts II a	nd 178, 449	51.00
52. 00	Total Program excludable cost (sum of lines!	50 and 51)			381, 589	52. 00
53.00	Total Program inpatient operating cost exclu	ding capital rela	ited, non-physician anest	hetist, and medic	al 7, 333, 063	53. 00
	education costs (line 49 minus line 52) TARGET AMOUNT AND LIMIT COMPUTATION					-
54. 00	Program di scharges				0	54.00
55.00	Target amount per discharge				l	55. 00
55. 01	Permanent adjustment amount per discharge Adjustment amount per discharge (contractor	una ambu)			l	55. 01 55. 02
55. 02 56. 00	Target amount (line 54 x sum of lines 55, 55				I 0.00	
57. 00	Difference between adjusted inpatient operati		get amount (line 56 minus	line 53)	0	
58.00	Bonus payment (see instructions)	0				
59. 00	Trended costs (lesser of line 53 ÷ line 54, updated and compounded by the market basket)	0.00	59. 00			
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the					60.00
61. 00	55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 5					61. 00
	are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)					
62. 00	Relief payment (see instructions)				0	
63. 00	Allowable Inpatient cost plus incentive payment (see instructions) PROGRAM INPATIENT ROUTINE SWING BED COST				0	63. 00
64. 00					0	64. 00
<i>(</i> = 00	instructions)(title XVIII only)					/= 00
65. 00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)				0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CA				l, 0	66. 00
67. 00	see instructions Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period					67. 00
07.00	(line 12 x line 19)	costs through b	recember 31 of the cost f	eportring perrod		07.00
68. 00	Title V or XIX swing-bed NF inpatient routing	e costs after Dec	cember 31 of the cost rep	orting period (li	ne 0	68. 00
69. 00	13 x line 20) Total title V or XIX swing-bed NF inpatient	routine costs (li	ne 67 + line 68)		0	69. 00
70	PART III - SKILLED NURSING FACILITY, OTHER NU	JRSING FACILITY,	AND ICF/IID ONLY		Γ	
70. 00 71. 00	Skilled nursing facility/other nursing facili Adjusted general inpatient routine service o	,	`)		70.00
72. 00	Program routine service cost (line 9 x line					72. 00
	Medically necessary private room cost application					73. 00
74. 00 75. 00	Total Program general inpatient routine servicapital-related cost allocated to inpatient	•		Part II column 1	6	74. 00 75. 00
73.00	line 45)	outine service e	Joses (11 om worksheet b,	rait II, corumii 2	,	73.00
76.00	Per diem capital related costs (line 75 ÷ lin					76.00
77. 00 78. 00	Program capital-related costs (line 9 x line 76) Inpatient routine service cost (line 74 minus line 77)					77. 00 78. 00
79. 00						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81. 00 82. 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I					81. 00 82. 00
83. 00	Reasonable inpatient routine service costs (83. 00
84. 00	Program inpatient ancillary services (see instructions)					84. 00
85. 00 86. 00	Utilization review - physician compensation					85. 00 86. 00
00. UU	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		rugii oo <i>j</i>		<u> </u>	1 66.00
87. 00	Total observation bed days (see instructions))			3, 635	1
88. 00 89. 00	Adjusted general inpatient routine cost per of Observation bed cost (line 87 x line 88) (see	•	ine 2)		1, 629. 90 5, 924, 687	1
07.00	Tonservation bed cost (Time of X Time 88) (Set	= ilisti ucti Ulis)			5, 924, 087	1 07.00

Health Financial Systems	FRANCI SCAN HEA	ALTH MUNSTER		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2022 To 12/31/2022		
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(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, 885, 551	33, 647, 597	0. 05603	5, 924, 687	332, 008	90.00
91.00 Nursing Program cost	0	33, 647, 597	0.00000	5, 924, 687	0	91.00
92.00 Allied health cost	0	33, 647, 597	0.00000	5, 924, 687	0	92.00
93.00 All other Medical Education	0	33, 647, 597	0.00000	5, 924, 687	0	93. 00

Health Financial Systems	FRANCISCAN HEALTH MUNSTER	In Lieu of Form CMS-2552-10		
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 15-0165	Peri od: Worksheet D-3		

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT Provider CCN: 15-0165 Period: Work		
From 01/01/2022 To 12/31/2022 Date	ksheet D-3 e/Time Prepa	
	9/2023 9:51	am
Title XVIII Hospital	PPS	
	pati ent	
	ram Costs	
Charges (col.	1 x col.	
1.00	2)	
	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS 30. 00 03000 ADULTS & PEDIATRICS 13, 284, 543	——— <i>.</i>	30. 00
31. 00 03100 I NTENSI VE CARE UNI T 2, 050, 666		31. 00
32. 00 03200 CORONARY CARE UNIT		32. 00
33. 00 03300 BURN INTENSIVE CARE UNIT		33.00
34. 00 03400 SURGI CAL INTENSI VE CARE UNI T 0 0 04000 CURREDOVA PER LIPE		34. 00
40. 00 04000 SUBPROVI DER - PF		40.00
41. 00 04100 SUBPROVI DER - I RF		41.00
43. 00 O4300 NURSERY		43. 00
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 0PERATI NG ROOM 0. 147694 6, 175, 633	012 104 [EO 00
		50.00
51. 00 05100 RECOVERY ROOM		51.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM		52.00
53. 00 05300 ANESTHESI OLOGY		53. 00
54. 00 05400 RADI 0LOGY - DI AGNOSTI C		54.00
55. 00 05500 RADI 0 LOGY-THERAPEUTI C 0. 000000 0		55. 00
56. 00 05600 RDI 01 SOTOPE 0. 000000 0		56. 00
57. 00 05700 CT SCAN 0. 029946 3, 899, 801		57. 00
58. 00 05800 MAGNETIC RESONANCE MAGING (MRI) 0. 064831 840, 954		58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON 0. 257950 0		59. 00
		60. 00
60. 01 06001 BLOOD LABORATORY 0. 000000 0	0 6	60. 01
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 0. 000000 0		61. 00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0. 000000 0		62. 00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 0. 000000 0	0 6	63. 00
64. 00 06400 I NTRAVENOUS THERAPY 0. 000000 0	0 6	64. 00
65. 00 06500 RESPI RATORY THERAPY 0. 326085 2, 657, 762	866, 656	65. 00
66. 00 06600 PHYSI CAL THERAPY 0. 178372 726, 890	129, 657	66. 00
67. 00 06700 0CCUPATI ONAL THERAPY 0. 155818 736, 318	114, 732	67. 00
68. 00 06800 SPEECH PATHOLOGY 0. 134038 425, 322	57, 009	68. 00
69. 00 06900 ELECTROCARDI OLOGY 0. 048000 4, 650, 762	223, 237	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY 0. 491941 66, 310	32, 621	70. 00
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0. 397473 2, 541, 355	1, 010, 120	71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 256501 2, 209, 188	566, 659	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 286598 6, 093, 218	1, 746, 304	73. 00
74. 00 07400 RENAL DI ALYSI S 0. 000000 0	0 7	74. 00
75. 00 07500 ASC (NON-DISTINCT PART) 0.000000 0	0 7	75. 00
76. 00 03950 0THER ANCILL SRVC 0. 000000 0	0 7	76. 00
76. 01 03951 CARDI AC AND PULMONARY REHAB 0. 761732 0	0 7	76. 01
76. 02 03952 WOUND CARE 0. 000000 0	0 7	76. 02
77. 00 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON 0.000000 0	0 7	77. 00
OUTPATIENT SERVICE COST CENTERS		
88. 00 08800 RURAL HEALTH CLINIC 0. 000000	0 8	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0.000000		89. 00
90. 00 09000 CLI NI C 0. 000000 0	0 9	90. 00
90. 01 09001 CLI NI C 0. 123513 275	34 9	90. 01
90. 02 09002 CLI NI C 0. 218609 0	0 9	90. 02
91. 00 09100 EMERGENCY 0. 167754 3, 465, 297	581, 317	91. 00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0. 455319 1, 240, 603	564, 870	92. 00
OTHER REIMBURSABLE COST CENTERS		
94. 00 09400 HOME PROGRAM DI ALYSI S 0. 000000 0		94. 00
95. 00 09500 AMBULANCE SERVI CES		95. 00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0. 000000 0		96. 00
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0. 000000 0		97. 00
98. 00 09850 OTHER REI MBURSE 0. 000000 0		98. 00
	9, 248, 728 20	
201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0		01. 00
202.00 Net charges (line 200 minus line 201) 51,421,224	20	02. 00

Health Financial Systems FRANCISCAN HEAL	TH MUNSTER	In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		eri od:	Worksheet D-3	
		rom 01/01/2022	5	
		o 12/31/2022	Date/Time Pre	
	Title XIX	Hospi tal	5/29/2023 9: 5 PPS	ı allı
Cost Center Description	Ratio of Cost	Inpati ent	Inpatient	
cost center bescription	To Charges	Program	Program Costs	
	To charges	Charges	(col. 1 x col.	
		Charges	2)	
	1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDIATRICS		6, 420, 212		30.00
31. 00 03100 NTENSI VE CARE UNI T		1, 981, 156		31.00
32. 00 03200 CORONARY CARE UNIT		1, 701, 130		32.00
33. 00 03200 CORONART CARE UNIT		0		33.00
34. 00 03400 SURGI CAL INTENSI VE CARE UNI T		0		34.00
40. 00 04000 SUBPROVI DER - PF		0		40.00
		0		41.00
		0		1
43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS		U U		43. 00
50. 00 05000 OPERATING ROOM	0. 147694	3, 222, 631	475, 963	50.00
51. 00 05100 RECOVERY ROOM	0. 147034		63, 815	51.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM	0. 000000	237, 781	03, 813	52.00
53. 00 05300 ANESTHESI OLOGY			113, 103	53.00
	0. 184951			1
54. 00 05400 RADI OLOGY-DI AGNOSTI C 55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 162878		150, 591	54. 00 55. 00
	0.000000		0	
56. 00 05600 RADI OI SOTOPE	0.000000		0	56.00
57. 00 05700 CT SCAN	0. 029946		47, 416	57. 00
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 064831	461, 034	29, 889	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 257950		749, 240	59.00
60. 00 06000 LABORATORY	0. 128651		552, 942	60.00
60. 01 06001 BLOOD LABORATORY	0.000000		0	60. 01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000		0	61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000		0	62. 00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0.000000		0	63. 00
64. 00 06400 I NTRAVENOUS THERAPY	0.000000		0	64. 00
65. 00 06500 RESPI RATORY THERAPY	0. 326085		440, 496	65. 00
66. 00 O6600 PHYSI CAL THERAPY	0. 178372		35, 728	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 155818		31, 254	67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 134038		18, 249	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0.048000		43, 513	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 491941		17, 687	70. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 397473		0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 256501		0	72. 00
73.00 O7300 DRUGS CHARGED TO PATIENTS	0. 286598		962, 054	73. 00
74. 00 07400 RENAL DI ALYSI S	0.000000		0	74. 00
75. 00 07500 ASC (NON-DISTINCT PART)	0.000000		0	75. 00
76. 00 03950 OTHER ANCILL SRVC	0.000000		0	76. 00
76. 01 03951 CARDI AC AND PULMONARY REHAB	0. 761732		3, 309	
76. 02 03952 WOUND CARE	0.000000		0	76. 02
77. 00 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON	0.000000	0	0	77. 00
OUTPATIENT SERVICE COST CENTERS				
88. 00 08800 RURAL HEALTH CLINIC	0.000000		0	
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89. 00
90. 00 09000 CLI NI C	0.000000		0	90.00
90. 01 09001 CLI NI C	0. 123513		9, 140	90. 01
90. 02 09002 CLI NI C	0. 218609		0	90. 02
91. 00 09100 EMERGENCY	0. 167754	2, 058, 760	345, 365	91.00
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 455319	0	0	92.00
OTHER REIMBURSABLE COST CENTERS				
94.00 09400 HOME PROGRAM DIALYSIS	0. 000000	0	0	94. 00
95. 00 09500 AMBULANCE SERVICES				95. 00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000		0	96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0. 000000		0	97. 00
98. 00 09850 OTHER REI MBURSE	0. 000000		0	98. 00
200.00 Total (sum of lines 50 through 94 and 96 through 98)		22, 567, 793	4, 089, 754	
201.00 Less PBP Clinic Laboratory Services-Program only charge	es (line 61)	0		201. 00
202.00 Net charges (line 200 minus line 201)		22, 567, 793		202. 00

	Title XVIII Hospital	PPS	ı aiii			
		1. 00				
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS	1.00				
1.00	DRG Amounts Other than Outlier Payments	0	1. 00			
1. 01 1. 02	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions) DRG amounts other than outlier payments for discharges occurring on or after October 1 (see	10, 184, 065 3, 713, 589	1. 01 1. 02			
1. 03	instructions) 3 DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1					
1. 04	(see instructions) DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October	er O	1. 04			
2. 00	1 (see instructions) Outlier payments for discharges. (see instructions)		2. 00			
2. 01	Outlier reconciliation amount	0	2. 01			
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2. 02			
2. 03 2. 04	Outlier payments for discharges occurring prior to October 1 (see instructions) Outlier payments for discharges occurring on or after October 1 (see instructions)	495, 770 65, 822	2. 03 2. 04			
3. 00	Managed Care Simulated Payments	10, 370, 326	3. 00			
4. 00	Bed days available divided by number of days in the cost reporting period (see instructions)	68. 04	4. 00			
F 00	Indirect Medical Education Adjustment	0.00	F 00			
5. 00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on before 12/31/1996. (see instructions)	or 0.00	5. 00			
5. 01	FTE cap adjustment for qualifing hospitals under §131 of the CAA 2021 (see instructions)	0. 00	5. 01			
6. 00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0. 00	6. 00			
6. 26	Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of the	ne 0.00	6. 26			
7.00	CAA 2021 (see instructions)		7.00			
7. 00 7. 01	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1) ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the	0. 00 0. 00	7. 00 7. 01			
	cost report straddles July 1, 2011 then see instructions.	0.00	7. 0.			
7. 02	Adjustment (increase or decrease) to the hospital's rural track program FTE limitation(s) for rural track programs with a rural track for Medicare GME affiliated programs in accordance with 413.75(b) and	0.00	7. 02			
	87 FR 49075 (August 10, 2022) (see instructions)	•				
8. 00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for	0. 00	8. 00			
	affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).					
8. 01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost	0. 00	8. 01			
8. 02	report straddles July 1, 2011, see instructions. The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under	§ 0.00	8. 02			
8. 21	5506 of ACA. (see instructions) The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see	0. 00	8. 21			
	instructions)					
9. 00	Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions)	0. 00	9. 00			
10. 00 11. 00	FTE count for allopathic and osteopathic programs in the current year from your records		10. 00 11. 00			
12. 00	FTE count for residents in dental and podiatric programs. Current year allowable FTE (see instructions)		12. 00			
13. 00	Total allowable FTE count for the prior year.		13. 00			
14. 00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997,	0. 00	14. 00			
15. 00	otherwise enter zero. Sum of lines 12 through 14 divided by 3.	0.00	15. 00			
16. 00	Adjustment for residents in initial years of the program (see instructions)		16. 00			
17. 00			17. 00			
18. 00	Adjusted rolling average FTE count		18. 00			
19. 00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000				
20. 00 21. 00	Prior year resident to bed ratio (see instructions) Enter the lesser of lines 19 or 20 (see instructions)	0. 000000 0. 000000	20. 00 21. 00			
22. 00	IME payment adjustment (see instructions)	0.000000	22. 00			
	IME payment adjustment - Managed Care (see instructions)	0	22. 01			
23. 00	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105	0.00	23. 00			
23.00	(f)(1)(iv)(C).	0.00	23.00			
24. 00	IME FTE Resident Count Over Cap (see instructions)	0.00				
25. 00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0. 00	25. 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	27. 00			
28. 00 28. 01	IME add-on adjustment amount (see instructions) IME add-on adjustment amount - Managed Care (see instructions)	0	28. 00 28. 01			
29. 00	Total IME payment (sum of lines 22 and 28)	0	29. 00			
29. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	Ö	29. 01			
	Di sproporti onate Share Adjustment					
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	2. 88	30.00			
31.00	Percentage of Medicaid patient days (see instructions)	19. 11				
32. 00 33. 00	Sum of lines 30 and 31 Allowable disproportionate share percentage (see instructions)	21. 99 7. 36				
	Disproportionate share adjustment (see instructions)	255, 717				

CUL	Financial Systems FRANCISCAN HEAL ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0165	Peri od:	u of Form CMS-2 Worksheet E	
			From 01/01/2022 To 12/31/2022	Part A Date/Time Prep 5/29/2023 9:5	
		Title XVIII	Hospi tal	PPS	i diii
			Prior to 10/1 1.00	0n/After 10/1 2.00	
	Uncompensated Care Payment Adjustment		1.00	2.00	
00	Total uncompensated care amount (see instructions)			6, 874, 403, 459	
01 02	Factor 3 (see instructions) Hospital UCP, including supplemental UCP (If line 34 is zero, (see instructions)	, enter zero on this line	0. 000171650 1, 234, 508	0. 000197956 1, 360, 829	
03 00	Pro rata share of the hospital UCP, including supplemental U Total UCP adjustment (sum of columns 1 and 2 on line 35.03)	· ·	923, 344 1, 266, 348	343, 004	35. 0 36. 0
00	Additional payment for high percentage of ESRD beneficiary di	ischarges (lines 40 throu			1 40 0
00	Total Medicare discharges (see instructions) Total ESRD Medicare discharges (see instructions)		0		40. 0 41. 0
01	Total ESRD Medicare covered and paid discharges (see instruc	tions)	0		41.0
00	Divide line 41 by line 40 (if less than 10%, you do not qual	ify for adjustment)	0.00		42.0
00	Total Medicare ESRD inpatient days (see instructions) Ratio of average length of stay to one week (line 43 divided days)	by line 41 divided by 7	0. 000000		43. 0 44. 0
00	Average weekly cost for dialysis treatments (see instructions	s)	0.00		45. C
00	Total additional payment (line 45 times line 44 times line 4	1. 01)	15 001 311		46.0
00	Subtotal (see instructions) Hospital specific payments (to be completed by SCH and MDH, enly, (see instructions)	small rural hospitals	15, 981, 311 0		47. C 48. C
	join y. (See Tristi de trons)			Amount 1.00	
00	Total payment for inpatient operating costs (see instructions	s)		15, 981, 311	49. (
00	Payment for inpatient program capital (from Wkst. L, Pt. I a			1, 141, 991	50.0
00	Exception payment for inpatient program capital (Wkst. L, Pt. Direct graduate medical education payment (from Wkst. E-4, I)			0	51. (52. (
00	Nursing and Allied Health Managed Care payment	The 47 see That detroils).		0	53. (
00	Special add-on payments for new technologies			97, 964	54. (
01 00	Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line o	(0)		0	54. (55. (
01	Cellular therapy acquisition cost (see instructions)	07)		0	55.
00	Cost of physicians' services in a teaching hospital (see int	*		0	56.
00	Routine service other pass through costs (from Wkst. D, Pt. Ancillary service other pass through costs from Wkst. D, Pt.		hrough 35).	0	57. 58.
00	Total (sum of amounts on lines 49 through 58)	TV, Cot. 11 Title 200)		17, 221, 266	
00	Primary payer payments			6, 180	1
00	Total amount payable for program beneficiaries (line 59 minus	s line 60)		17, 215, 086	
00	Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries			1, 383, 328 70, 798	
00	Allowable bad debts (see instructions)			311, 121	64.
00	Adjusted reimbursable bad debts (see instructions)			202, 229	
00	,	tructions)		230, 138 15, 963, 189	
00	Credits received from manufacturers for replaced devices for	applicable to MS-DRGs (s	ee instructions)	15, 903, 189	68.
00	Outlier payments reconciliation (sum of lines 93, 95 and 96).			0	69.
00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	70.
50 75	Rural Community Hospital Demonstration Project (§410A Demons N95 respirator payment adjustment amount (see instructions)	tration) adjustment (see	Instructions)	0	70. 70.
87	Demonstration payment adjustment amount before sequestration			0	70.
88	SCH or MDH volume decrease adjustment (contractor use only)			0	70.
89 90	Pioneer ACO demonstration payment adjustment amount (see ins HSP bonus payment HVBP adjustment amount (see instructions)	tructions)		0	70. 70.
91	HSP bonus payment HRR adjustment amount (see instructions)			0	70.
92	Bundled Model 1 discount amount (see instructions)			0	70.
	HVBP payment adjustment amount (see instructions)			0	70.
93 94	HRR adjustment amount (see instructions)			-67, 434	70.

Heal th	Financial Systems FRANCISCAN HEA	ALTH MUNSTER		In Lie	u of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der C	F	Period: From 01/01/2022 To 12/31/2022		
		Title	XVIII	Hospi tal	PPS	
		<u> </u>		(уууу)	Amount	
				0	1. 00	
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter the corresponding federal year for the period prior to 10/1			0	0	70. 96
70. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter the corresponding federal year for the period ending on or	in column 0		0	0	70. 97
70. 98	Low Volume Payment-3	arter 10/1)			0	70. 98
70. 99	HAC adjustment amount (see instructions)				126, 613	
71.00	Amount due provider (line 67 minus lines 68 plus/minus line	s 69 & 70)			15, 769, 142	
71. 00	Sequestration adjustment (see instructions)	3 07 & 70)			198, 691	1
	Demonstration adjustment (see First detrois) Demonstration payment adjustment amount after sequestration				0	
71. 02	Sequestration adjustment-PARHM or CHART pass-throughs					71. 02
72.00	Interim payments				14, 019, 218	
	Interim payments-PARHM or CHART				1.70.772.0	72. 01
73. 00	Tentative settlement (for contractor use only)				0	
73. 01	Tentative settlement-PARHM or CHART (for contractor use on	ly)				73. 01
74. 00	Balance due provider/program (line 71 minus lines 71.01, 71 73)				1, 551, 233	74. 00
74. 01	Balance due provider/program-PARHM or CHART (see instructio	ns)				74. 01
75. 00	Protested amounts (nonallowable cost report items) in accor Pub. 15-2, chapter 1, §115.2	dance with CMS			1, 057, 318	75. 00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90. 00	Operating outlier amount from Wkst. E, Pt. A, line 2, or su 2.04 (see instructions)	m of 2.03 plus	5		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2				0	91.00
92.00	Operating outlier reconciliation adjustment amount (see ins	tructions)			0	92.00
	Capital outlier reconciliation adjustment amount (see instr				0	
	The rate used to calculate the time value of money (see ins				0.00	
95.00	Time value of money for operating expenses (see instruction				0	
96. 00	Time value of money for capital related expenses (see instr	uctions)			0	96. 00
				Prior to 10/1		
	LION D. D. L. A. L.			1. 00	2. 00	
400 00	HSP Bonus Payment Amount			1		100.00
100.00	HSP bonus amount (see instructions)			0	0	100. 00
101 00	HVBP Adjustment for HSP Bonus Payment			0.000000000	0. 0000000000	101 00
	HVBP adjustment factor (see instructions)	ana)		0.000000000		101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructi HRR Adjustment for HSP Bonus Payment	ONS)		0	0	102.00
102 00	HRR adjustment factor (see instructions)			0.0000	0.0000	103. 00
	HRR adjustment amount for HSP bonus payment (see instruction	nc)		0.0000		104.00
104.00	Rural Community Hospital Demonstration Project (§410A Demon		etmont		0	1104.00
200.00	Is this the first year of the current 5-year demonstration Cures Act? Enter "Y" for yes or "N" for no.			У		200. 00
	Cost Reimbursement			1		1
201 00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, I	ine 49)				201. 00
	Medicare discharges (see instructions)					202.00
	Case-mix adjustment factor (see instructions)					203. 00
	Computation of Demonstration Target Amount Limitation (N/A			1		4

Computation of Demonstration larget Amount Limitation (N/A in first year of the current 5-year demonstration peri od)
204.00 Medi care target amount 204. 00 205.00 Case-mix adjusted target amount (line 203 times line 204) 205.00 206. 00 206.00 Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement 207.00 Program reimbursement under the §410A Demonstration (see instructions) 207. 00 208.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59) 208. 00 209.00 Adjustment to Medicare IPPS payments (see instructions) 209. 00 210.00 Reserved for future use 210. 00 211.00 Total adjustment to Medicare IPPS payments (see instructions) 211. 00 Comparision of PPS versus Cost Reimbursement
212.00 Total adjustment to Medicare Part A IPPS payments (from line 211) 212. 00 213. 00 218. 00 213.00 Low-volume adjustment (see instructions) 218.00 Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)

| In Lieu of Form CMS-2552-10 | Period: | Worksheet E | From 01/01/2022 | Part A Exhibit 4 | Date/Time Prepared: | 5/29/2023 9:51 am Provider CCN: 15-0165

				Ti +l o	XVIII	Hospi tal	5/29/2023 9: 5° PPS	1 am
		W/S F. Part A	Amounts (from	Pre/Post	Period Prior	Peri od	Total (Col 2	
		line	E, Part A)	Entitlement		On/After 10/01	through 4)	
	To a control of the c	0	1.00	2.00	3. 00	4. 00	5. 00	
1. 00	DRG amounts other than outlier payments	1. 00	0	0	0	0	0	1. 00
1. 01	DRG amounts other than outlier payments for discharges	1. 01	10, 184, 065	0	10, 184, 065		10, 184, 065	1. 01
1. 02	occurring prior to October 1 DRG amounts other than outlier payments for discharges	1. 02	3, 713, 589	0		3, 713, 589	3, 713, 589	1. 02
1. 03	occurring on or after October DRG for Federal specific operating payment for Model 4 BPCI occurring prior to Octobe	1.03	0	0	0		0	1. 03
1. 04	1 DRG for Federal specific operating payment for Model 4 BPCI occurring on or after	1. 04	0	0		0	0	1. 04
2. 00	October 1 Outlier payments for discharge: (see instructions)	s 2.00						2. 00
2. 01	Outlier payments for discharges for Model 4 BPCI	s 2.02	0	0	0	0	0	2. 01
2. 02	Outlier payments for discharge occurring prior to October 1 (see instructions)	5 2.03	495, 770	0	495, 770		495, 770	2. 02
2. 03	Outlier payments for discharge occurring on or after October	s 2. 04 1	65, 822	0		65, 822	65, 822	2. 03
3. 00	(see instructions) Operating outlier reconciliation	2. 01	0	0	0	0	0	3. 00
4. 00	Managed care simulated payments Indirect Medical Education Adju		10, 370, 326	0	10, 370, 326	0	10, 370, 326	4. 00
5.00	Amount from Worksheet E, Part	21. 00	0. 000000	0. 000000	0. 000000	0. 000000		5. 00
6. 00	A, line 21 (see instructions) IME payment adjustment (see instructions)	22. 00	0	0	0	0	0	6. 00
6. 01	IME payment adjustment for managed care (see instructions)	22. 01	0	0	0	0	0	6. 01
	Indirect Medical Education Adju							
7. 00	IME payment adjustment factor	27. 00	0. 000000	0. 000000	0. 000000	0. 000000		7. 00
8. 00	(see instructions) IME adjustment (see instructions)	28. 00	0	0	0	0	0	8. 00
8. 01	IME payment adjustment add on for managed care (see	28. 01	0	0	0	0	0	8. 01
9. 00	<pre>instructions) Total IME payment (sum of line: 6 and 8)</pre>	s 29.00	0	0	0	0	0	9. 00
9. 01	Total IME payment for managed care (sum of lines 6.01 and	29. 01	0	0	0	0	0	9. 01
	8.01) Disproportionate Share Adjustme	nt.						
10. 00	Allowable disproportionate share percentage (see	33. 00	0. 0736	0. 0736	0. 0736	0. 0736		10. 00
11. 00	instructions) Disproportionate share adjustment (see instructions)	34. 00	255, 717	0	187, 387	68, 330	255, 717	11. 00
11. 01	Uncompensated care payments	36.00	1, 266, 348	0	923, 344	343, 004	1, 266, 348	11. 01
12. 00	Additional payment for high per Total ESRD additional payment	centage of ESF 46.00	RD beneficiary 0		0	0	0	12. 00
13. 00	(see instructions) Subtotal (see instructions)	47. 00	15 001 211	0	11, 790, 566	4, 190, 745	15, 981, 311	13. 00
14. 00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.)	48. 00	15, 981, 311 0	0	11, 790, 366	4, 190, 743	15, 961, 311	14. 00
15. 00	Total payment for inpatient operating costs (see instructions)	49. 00	15, 981, 311	0	11, 790, 566	4, 190, 745	15, 981, 311	15. 00
16. 00	Payment for inpatient program capital (from Wkst. L, Pt. I,	50. 00	1, 141, 991	0	859, 149	282, 842	1, 141, 991	16. 00
17. 00	if applicable) Special add-on payments for new technologies	v 54.00	97, 964	0	65, 899	32, 065	97, 964	17. 00
17. 01	Net organ aquisition cost							17. 01

Heal th	Financial Systems		FRANCI SCAN HEA	ALTH MUNSTER		In Lie	u of Form CMS-2	2552-10
	LUME CALCULATION EXHIBIT 4			Provi der 0		Period: From 01/01/2022 To 12/31/2022		pared:
				Ti tl e	e XVIII	Hospi tal	PPS	
		W/S E, Part A	Amounts (from	Pre/Post	Period Prior	Peri od	Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	On/After 10/01	through 4)	
		0	1.00	2.00	3.00	4. 00	5. 00	
	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68. 00	0	(0 0	0	17. 02
	Capital outlier reconciliation adjustment amount (see instructions)	93. 00	O	(0 0	0	18. 00
19.00	SUBTOTAL			(12, 715, 61	4 4, 505, 652	17, 221, 266	19. 00
		W/S L, line	(Amounts from					

				II tie	AVIII	поѕрі гаі	PP3	
		W/S E, Part A	Amounts (from	Pre/Post	Period Prior	Peri od	Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	On/After 10/01	through 4)	
		0	1.00	2. 00	3. 00	4. 00	5. 00	
17. 02	Credits received from	68.00	0	0	0	0	0	17. 02
	manufacturers for replaced							
	devices for applicable MS-DRGs							
18.00	Capital outlier reconciliation		o	0	l o	0	0	18.00
	adjustment amount (see							
	instructions)							
19 00	SUBTOTAL			0	12, 715, 614	4, 505, 652	17, 221, 266	19 00
17100	1000.0.11.2	W/S L, line	(Amounts from	J	12/7/0/01/	1,000,002	1772217200	171.00
		117 5 E, 11110	L)					
		0	1.00	2.00	3.00	4. 00	5. 00	
20. 00	Capital DRG other than outlier		1, 053, 135	0	774, 197	278, 938		20. 00
	Model 4 BPCI Capital DRG other		0	0	,,,,,,	2,0,,00	0	1
20.01	than outlier	1.01	Ĭ	J	Ĭ	J	Ĭ	20.01
21. 00	Capital DRG outlier payments	2. 00	88, 856	0	84, 952	3, 904	99 956	21. 00
21. 00	Model 4 BPCI Capital DRG	2. 01	00, 030	0	04, 752	3, 704	00,000	21.00
21.01	outlier payments	2.01	U	0		U	0	21.01
22. 00	Indirect medical education	5. 00	0. 0000	0. 0000	0. 0000	0. 0000		22. 00
22.00		3.00	0.0000	0.0000	0.0000	0.0000		22.00
23. 00	percentage (see instructions) Indirect medical education	6. 00	0	0	,	0	0	23. 00
23.00		0.00	U	U	٥	U	0	23.00
24.00	adjustment (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24 00
24. 00	Allowable disproportionate	10.00	0. 0000	0. 0000	0.0000	0. 0000		24. 00
	share percentage (see							
25 00	instructions)	11. 00	0	0		0	_	25 00
25. 00	Di sproporti onate share	11.00	U	0	0	U	0	25. 00
0/ 00	adjustment (see instructions)	40.00	4 444 004		050 440	000 040	4 4 4 4 004	0, 00
26. 00	Total prospective capital	12. 00	1, 141, 991	0	859, 149	282, 842	1, 141, 991	26. 00
	payments (see instructions)	W/C F D I A	(1)					
		W/S E, Part A						
		line	Part A) 1.00	2.00	3.00	4. 00	5. 00	
27.00		0	1.00	2. 00			5.00	27.00
27. 00	Low volume adjustment factor	70.0/			0. 000000	0. 000000		27. 00
28. 00	Low volume adjustment (transfe				0		0	28. 00
	amount to Wkst. E, Pt. A, line					_	_	
29. 00	Low volume adjustment (transfe					0	0	29. 00
400	amount to Wkst. E, Pt. A, line							
100.00	Transfer low volume adjustment	\$	Υ					100. 00
	to Wkst. E, Pt. A.							

	AL ACCURACY CONDITION (TIME) REDUCTION CALCOLLY	TTON EXITED T	Trovider ex		om 01/01/2022 o 12/31/2022	Part A Exhibitate/Time Prep 5/29/2023 9:5	oared:
			Title	XVIII	Hospi tal	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	
1.00	DRG amounts other than outlier payments	1. 00					1. 00
1. 01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1. 01	10, 184, 065	10, 184, 065		10, 184, 065	1. 01
1. 02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1. 02	3, 713, 589		3, 713, 589	3, 713, 589	1. 02
1. 03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October	1. 03	0	0		0	1. 03
1. 04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1. 04	O		0	0	1. 04
2. 00	Outlier payments for discharges (see instructions)	2. 00					2. 00
2. 01	Outlier payments for discharges for Model 4 BPCI	2. 02	0	0	0	0	2. 01
2. 02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2. 03	495, 770	495, 770		495, 770	2. 02
2. 03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2. 04	65, 822		65, 822	65, 822	2. 03
3.00	Operating outlier reconciliation	2. 01	o	0	0	0	3. 00
4.00	Managed care simulated payments	3. 00	10, 370, 326	7, 413, 323	2, 957, 003	10, 370, 326	4.00
F 00	Indirect Medical Education Adjustment	21.00	0. 000000	0. 000000	0. 000000		F 00
5. 00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.00000	0.000000	0.000000		5. 00
6.00	IME payment adjustment (see instructions)	22. 00	0	0	0	0	6. 00
6. 01	IME payment adjustment for managed care (see instructions)	22. 01	0	0	0	0	6. 01
	Indirect Medical Education Adjustment for the						
7. 00	IME payment adjustment factor (see instructions)	27. 00	0. 000000	0. 000000	0. 000000		7. 00
8. 00	IME adjustment (see instructions)	28. 00	0	0	0	0	8. 00
8. 01	IME payment adjustment add on for managed care (see instructions)	28. 01	0	0	0	0	8. 01
9.00	Total IME payment (sum of lines 6 and 8)	29. 00	0	0	0	0	9. 00
9. 01	Total IME payment for managed care (sum of	29. 01	0	0	0	0	9. 01
	lines 6.01 and 8.01)						
	Disproportionate Share Adjustment		I				
10. 00	Allowable disproportionate share percentage (see instructions)	33. 00	0. 0736	0. 0736	0. 0736		10. 00
11. 00	Disproportionate share adjustment (see instructions)	34.00	255, 717	187, 387	68, 330	255, 717	11. 00
11. 01	Uncompensated care payments	36.00	1, 266, 348	923, 344	343, 004	1, 266, 348	11. 01
	Additional payment for high percentage of ESF	RD beneficiary	di scharges				
12. 00	Total ESRD additional payment (see	46. 00	0	0	0	0	12. 00
13. 00	instructions) Subtotal (see instructions)	47. 00	15, 981, 311	11, 790, 566	4, 190, 745	15, 981, 311	12 00
14. 00	Hospital specific payments (completed by SCH	48. 00	15, 961, 311	11, 790, 300	4, 190, 745 N	15, 961, 311	14. 00
00	and MDH, small rural hospitals only.) (see	10.00			J	S	00
15. 00	<pre>instructions) Total payment for inpatient operating costs (see instructions)</pre>	49. 00	15, 981, 311	11, 790, 566	4, 190, 745	15, 981, 311	15. 00
16. 00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50. 00	1, 141, 991	859, 149	282, 842	1, 141, 991	16. 00
17. 00	Special add-on payments for new technologies	54.00	97, 964	65, 899	32, 065	97, 964	17. 00
17. 01	Net organ acquisition cost						17. 01
17. 02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68. 00	0	0	0	0	17. 02
18. 00	Capital outlier reconciliation adjustment amount (see instructions)	93. 00	0	0	0	0	18. 00
19. 00	SUBTOTAL			12, 715, 614	4, 505, 652	17, 221, 266	19. 00

Health Financial Systems	FRANCISCAN HEALTH MUNSTER			In Lieu of Form CMS-2552-10			
HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5	Provider CC		Period: From 01/01/2022 To 12/31/2022	Worksheet E Part A Exhibi Date/Time Pre 5/29/2023 9:5	pared:	
		Title	XVIII	Hospi tal	PPS		
	Wkst. L, line	(Amt. from					
		Wkst. L)					
	0	1.00	2.00	3. 00	4. 00		
20.00 Capital DRG other than outlier	1.00	1, 053, 135	774, 19 ⁻	7 278, 938	1, 053, 135	20.00	
20.01 Model 4 BPCI Capital DRG other than outlier	1. 01	0		0	0	20. 01	
21.00 Capital DRG outlier payments	2.00	88, 856	84, 95	3, 904	88, 856	21.00	

			11 11 0	AVIII	nospi tai	113	
		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, 053, 135	774, 197	278, 938	1, 053, 135	20.00
20. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	0	o	0	0	20. 01
21.00	Capital DRG outlier payments	2. 00	88, 856	84, 952	3, 904	88, 856	21. 00
21. 01	Model 4 BPCI Capital DRG outlier payments	2. 01	0	O	0	0	21. 01
22.00	Indirect medical education percentage (see	5. 00	0.0000	0.0000	0.0000		22. 00
	instructions)						
23.00	Indirect medical education adjustment (see	6. 00	0	o	0	0	23. 00
	instructions)						
24.00	Allowable disproportionate share percentage	10.00	0.0000	0.0000	0.0000		24. 00
	(see instructions)						
25.00	Di sproporti onate share adjustment (see	11. 00	0	o	0	0	25. 00
	instructions)						
26.00	Total prospective capital payments (see	12.00	1, 141, 991	859, 149	282, 842	1, 141, 991	26. 00
	instructions)						
		Wkst. E, Pt.	(Amt. from				
		A, line	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	0	0	0	0	30.00
30. 01	HVBP payment adjustment for HSP bonus paymen	70. 90	0	o	0	0	30. 01
	(see instructions)						
31.00	HRR adjustment (see instructions)	70. 94	-67, 434	-54, 324	-13, 110	-67, 434	31.00
31. 01	HRR adjustment for HSP bonus payment (see	70. 91	0	O	0	0	31. 01
	instructions)						
	•					(Amt. to Wkst.	
						E, Pt. A)	
		0	1. 00	2.00	3. 00	4. 00	
32. 00	HAC Reduction Program adjustment (see	70. 99		126, 613	0	126, 613	32. 00
	instructions)						
100.00	Transfer HAC Reduction Program adjustment to		Y				100. 00
	Wkst. E, Pt. A.						

Health Financial Systems	FRANCISCAN HEALTH MUNSTER	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0165	Peri od: From 01/01/2022 To 12/31/2022	Worksheet E Part B Date/Time Prepared: 5/29/2023 9:51 am

		Title XVIII	Hospi tal	5/29/2023 9: 5 PPS	<u>1 am</u>
			<u> </u>	1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
1.00	Medical and other services (see instructions)			1, 478	1.00
2.00	Medical and other services reimbursed under OPPS (see instructi	ons)		14, 258, 964	2. 00
3.00	OPPS payments			11, 853, 811	3.00
4.00	Outlier payment (see instructions)			132, 421	1
4. 01 5. 00	Outlier reconciliation amount (see instructions) Enter the hospital specific payment to cost ratio (see instruct	ions)		0. 000	
6. 00	Line 2 times line 5	11 0113)		0.000	1
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	1
8.00	Transitional corridor payment (see instructions)			0	
9. 00	Ancillary service other pass through costs from Wkst. D, Pt. I	/, col. 13, line 200		0	9. 00
10.00	Organ acqui si ti ons			0	
11. 00	Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES			1, 478	11. 00
	Reasonable charges				
12.00	Ancillary service charges			5, 156	12. 00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, Iir	ne 69)		0	13. 00
14. 00	Total reasonable charges (sum of lines 12 and 13)			5, 156	14. 00
45.00	Customary charges				1 45 00
15. 00 16. 00	Aggregate amount actually collected from patients liable for pathograms that would have been realized from patients liable for			0 nad 0	
10.00	such payment been made in accordance with 42 CFR §413.13(e)	payment for services or	i a ciiai gebasi s i	iau 0	10.00
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	17. 00
18.00	Total customary charges (see instructions)			5, 156	18. 00
19. 00	Excess of customary charges over reasonable cost (complete only	/if line 18 exceeds lin	ne 11) (see	3, 678	19. 00
20.00	instructions)	. if lime 11 evenede lik	20 10) (222	0	20.00
20. 00	Excess of reasonable cost over customary charges (complete only instructions)	/ IT TIME IT exceeds ITI	ie 18) (See	0	20. 00
21. 00	Lesser of cost or charges (see instructions)			1, 478	21. 00
22.00	Interns and residents (see instructions)			0	22. 00
23. 00	Cost of physicians' services in a teaching hospital (see instru	ıcti ons)		0	
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			11, 986, 232	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		uctions)	2, 163, 068	•
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) pl			9, 824, 642	
	instructions)				
28. 00	Direct graduate medical education payments (from Wkst. E-4, lir	ne 50)		0	28. 00
	ESRD direct medical education costs (from Wkst. E-4, line 36) Subtotal (sum of lines 27 through 29)			9, 824, 642	29. 00 30. 00
31. 00	Primary payer payments			9, 624, 642 3, 567	ı
32. 00	Subtotal (line 30 minus line 31)			9, 821, 075	1
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE	S)			
	Composite rate ESRD (from Wkst. I-5, line 11)			0	
	Allowable bad debts (see instructions)			181, 417	
	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instru	ictions)		117, 921 103, 789	
37. 00	Subtotal (see instructions)	10113)		9, 938, 996	
	MSP-LCC reconciliation amount from PS&R			0	
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)	1		_	39. 50
39. 75 39. 97	N95 respirator payment adjustment amount (see instructions) Demonstration payment adjustment amount before sequestration			0	39. 75 39. 97
39. 97 39. 98	Partial or full credits received from manufacturers for replace	ed devices (see instruct	tions)	0	1
39. 99	RECOVERY OF ACCELERATED DEPRECIATION	devices (see institue	11 0113)	0	39. 99
40.00	Subtotal (see instructions)			9, 938, 996	
40. 01	Sequestration adjustment (see instructions)			125, 231	
40. 02	, , , ,			0	1
40. 03	Sequestration adjustment-PARHM or CHART pass-throughs Interim payments			9, 810, 405	40.03
41.00	Interim payments Interim payments-PARHM or CHART			9, 610, 405	41. 00 41. 01
42. 00	Tentative settlement (for contractors use only)			0	42. 00
42. 01	Tentative settlement-PARHM or CHART (for contractor use only)				42. 01
43.00	Balance due provider/program (see instructions)			3, 360	1
	Balance due provider/program-PARHM (see instructions)		4 0445 3	_	43. 01
44. 00	Protested amounts (nonallowable cost report items) in accordance	ce writh CMS Pub. 15-2, o	cnapter 1, §115.2	2 0	44. 00
90 00	TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions)			0	90.00
	Outlier reconciliation adjustment amount (see instructions)			0	
	The rate used to calculate the Time Value of Money			0.00	
93. 00	Time Value of Money (see instructions)			0	
94. 00	Total (sum of lines 91 and 93)			0	94. 00

Health Financial Systems	FRANCISCAN HEALTH MUNSTER	In Lie	u of Form CMS	-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Peri od:	Worksheet E	
		From 01/01/2022		
		To 12/31/2022	Date/Time Pr	epared:
			5/29/2023 9:	51 am
	Title XVIII	Hospi tal	PPS	
			1. 00	
MEDICARE PART B ANCILLARY COSTS				
200.00 Part B Combined Billed Days			(0 200. 00

Health Financial Systems FRAN ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 15-0165

					5/29/2023 9:51	1 am
			XVIII	Hospi tal	PPS	
		Inpatien	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4.00	
1.00	Total interim payments paid to provider		14, 019, 21	8	9, 810, 405	1. 00
2.00	Interim payments payable on individual bills, either			0	o	2. 00
	submitted or to be submitted to the contractor for services					
	rendered in the cost reporting period. If none, write					
	"NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment amount					3.00
	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. 01
3. 02				0	0	3. 02
3.03				0	0	3. 03
3.04				0	0	3. 04
3.05				0	0	3. 05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM			0	0	3. 50
3. 51				0	0	3. 51
3. 52				0	0	3. 52
3.53				0	0	3. 53
3.54				0	0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		14, 019, 21	8	9, 810, 405	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR		ı			
5.00	List separately each tentative settlement payment after desk					5. 00
	review. Also show date of each payment. If none, write					
	"NONE" or enter a zero. (1)					
F 01	Program to Provider TENTATIVE TO PROVIDER		I	0	0	E 01
5. 01	TENTATIVE TO PROVIDER			-		5. 01 5. 02
5. 02 5. 03				0	0	5. 02
5.03	Dravi dan ta Dragnam		l	U	0	5. 03
5. 50	Provider to Program TENTATIVE TO PROGRAM		I	0	0	5. 50
5. 50	TENTATIVE TO PROGRAM			0	0	5. 50
5. 52				0		5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0		5. 99
J. 77	5. 50-5. 98)			0		J. 77
6.00	Determined net settlement amount (balance due) based on the					6. 00
0.00	cost report. (1)					0.00
6. 01	SETTLEMENT TO PROVIDER		1, 551, 23	13	3, 360	6. 01
6. 02	SETTLEMENT TO PROGRAM			0	0, 300	6. 02
7. 00	Total Medicare program liability (see instructions)		15, 570, 45	-	9, 813, 765	7. 00
7.00	Total mode ode o program reductivity (occ restractivity)		10,0,0,40	Contractor	NPR Date	,. 50
				Number	(Mo/Day/Yr)	
		()	1. 00	2.00	
8. 00	Name of Contractor					8. 00
	1			1		

Heal th	Financial Systems FRANCISCAN HEA	ALTH MUNSTER	In Lie	u of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provi der CCN: 15-0165	Peri od: From 01/01/2022		
			To 12/31/2022	Date/Time Pre 5/29/2023 9:5	
	·	Title XVIII	Hospi tal	PPS	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				4
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATI				
1.00	Total hospital discharges as defined in AARA §4102 from Wks	st. S-3, Pt. I col. 15 line	e 14		1. 00
2.00	Medicare days (see instructions)				2. 00
3. 00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3. 00
4. 00	Total inpatient days (see instructions)				4. 00
5. 00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5. 00
6. 00	Total hospital charity care charges from Wkst. S-10, col. 3				6. 00
7. 00	CAH only - The reasonable cost incurred for the purchase of	certified HIT technology	Wkst. S-2, Pt. I		7. 00
	line 168				
8. 00	Calculation of the HIT incentive payment (see instructions)				8. 00
9. 00	Sequestration adjustment amount (see instructions)				9. 00
10. 00	Calculation of the HIT incentive payment after sequestration	n (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	line 31) (see instruction	ıs)		32. 00

Heal th	Financial Systems FRANCISCA	AN HEALTH MUNSTER	In Lie	u of Form CMS-2	552-10
OUTLI E	R RECONCILIATION AT TENTATIVE SETTLEMENT	Provider CCN: 15-0165	Peri od:	Worksheet E-5	
			From 01/01/2022 To 12/31/2022	Date/Time Prep 5/29/2023 9:51	
		Title XVIII		PPS	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR				
1.00	Operating outlier amount from Wkst. E, Pt. A, line 2,	or sum of 2.03 plus 2.04 (see i	nstructions)	0	1.00
2.00	Capital outlier from Wkst. L, Pt. I, line 2			0	2.00
3.00	Operating outlier reconciliation adjustment amount (se	e instructions)		0	3.00
4.00	Capital outlier reconciliation adjustment amount (see	instructions)		0	4.00
5.00	The rate used to calculate the time value of money (se	e instructions)		0.00	5.00
6.00	Time value of money for operating expenses (see instru	ctions)		0	6.00
7.00	Time value of money for capital related expenses (see	instructions)		0	7.00

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

Provider CCN: 15-0165

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

			'	0 12/31/2022	5/29/2023 9:5	
		General Fund	Speci fi c	Endowment Fund		
			Purpose Fund			
	CHIDDENT ACCETS	1. 00	2.00	3. 00	4. 00	
1. 00	CURRENT ASSETS Cash on hand in banks	15, 189, 654	·I	٥	0	1.00
2. 00	Temporary investments	13, 107, 034		-	0	
3.00	Notes recei vabl e	0		0	0	
4.00	Accounts receivable	16, 639, 932	.l c	0	0	4. 00
5.00	Other recei vable	369, 852	1	0	0	
6.00	Allowances for uncollectible notes and accounts receivable	-391	1	0	0	
7.00	Inventory Prepai d expenses	2, 206, 208		0	0	
8. 00 9. 00	Other current assets	632, 188 62, 983		0	0	
10. 00	Due from other funds	02, 703		0	0	
11. 00	Total current assets (sum of lines 1-10)	35, 100, 426			0	
	FIXED ASSETS					
12. 00	Land	12, 513, 724	1	-	0	
13.00	Land improvements	2, 720, 511	1		0	1
14.00	Accumulated depreciation	02 220 027		0	0	
15. 00 16. 00	Buildings Accumulated depreciation	93, 328, 827		0	0	
17. 00	Leasehold improvements	5, 029, 669	1	0	0	
18. 00	Accumul ated depreciation	0,027,007		0	0	
19. 00	Fi xed equipment	0) c	0	0	19. 00
20.00	Accumulated depreciation	0) c	0	0	
21. 00	Automobiles and trucks	0	0	0	0	
22. 00	Accumulated depreciation	122 104 (10		0	0	
23. 00 24. 00	Major movable equipment Accumulated depreciation	123, 104, 610 -82, 241, 821		0	0	
25. 00	Mi nor equi pment depreciable	-02, 241, 021		0	0	
26. 00	Accumul ated depreciation	0		-	0	
27. 00	HIT designated Assets	O) c	0	0	27. 00
28. 00	Accumulated depreciation	0) c	0	0	
29. 00	Mi nor equi pment-nondepreci abl e	2, 271, 850	1		0	1
30. 00	Total fixed assets (sum of lines 12-29)	156, 727, 370) <u> </u>	0	0	30.00
31. 00	OTHER ASSETS Investments	8, 666, 516	, C	O	0	31.00
32. 00	Deposits on Leases	3, 803, 554			0	
33. 00	Due from owners/officers	0, 000, 001		-	0	
34.00	Other assets	5, 387, 783	d	0	0	
35.00	Total other assets (sum of lines 31-34)	17, 857, 853	c c	0	0	35. 00
36. 00	Total assets (sum of lines 11, 30, and 35)	209, 685, 649) <u> </u>	0	0	36. 00
07.00	CURRENT LIABILITIES	7 400 400			0	07.00
37. 00 38. 00	Accounts payable Salaries, wages, and fees payable	7, 123, 132 3, 803, 060	1	0	0	
39. 00	Payroll taxes payable	576, 411	1	0	0	
40. 00	Notes and Loans payable (short term)	0,0,111		O	0	
41.00	Deferred income	O) c	0	0	41.00
42.00	Accel erated payments	0)			42. 00
43.00	Due to other funds	0) C	0	0	1
44. 00	Other current liabilities	68, 342			0	
45. 00	Total current liabilities (sum of lines 37 thru 44) LONG TERM LIABILITIES	11, 570, 945	<u> </u>	0	0	45. 00
46. 00	Mortgage payable	928, 320) (O	0	46. 00
47. 00	Notes payable	720, 320		-	0	
48. 00	Unsecured Loans	600, 156			0	
49.00	Other long term liabilities	7, 684, 156	o	0	0	49. 00
50.00	Total long term liabilities (sum of lines 46 thru 49)	9, 212, 632			0	
51. 00	Total liabilities (sum of lines 45 and 50)	20, 783, 577	' <u> </u> C	0	0	51. 00
F2 00	CAPITAL ACCOUNTS	100 000 070				F2 00
52. 00 53. 00	General fund balance Specific purpose fund	188, 902, 072	1			52. 00 53. 00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55. 00	Donor created - endowment fund balance - unrestricted			0		55. 00
56. 00	Governing body created - endowment fund balance			0		56. 00
57. 00	Plant fund balance - invested in plant				0	
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
FO 00	replacement, and expansion	100 000 070			_	F0.00
59. 00 60. 00	Total fund balances (sum of lines 52 thru 58) Total liabilities and fund balances (sum of lines 51 and 59	188, 902, 072) 209, 685, 649			0	
00.00	Tiorai Trabilities and Tund baldices (sum of Tines 51 and 54)	, 207, 000, 049	.1	ı o	0	1 00.00

Provider CCN: 15-0165

					То	12/31/2022	Date/Time Prep 5/29/2023 9:5	
		General	Fund	Speci al	Purp	oose Fund	Endowment Fund	
		1.00	2.00	3.00		4. 00	5. 00	
1.00	Fund balances at beginning of period		193, 220, 699			0		1.00
2. 00 3. 00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2)		-4, 318, 627 188, 902, 072			0		2. 00 3. 00
4.00	Additions (credit adjustments) (specify)	0	100, 702, 072		0	0	0	4. 00
5. 00	(apart)	Ö			0		Ö	5. 00
6.00		0			0		0	6. 00
7.00		0			0		0	7. 00
8. 00 9. 00		0			0		0	8. 00 9. 00
10. 00	Total additions (sum of line 4-9)		0		U	0	U	10.00
11. 00	Subtotal (line 3 plus line 10)		188, 902, 072			0		11. 00
12.00	Deductions (debit adjustments) (specify)	O			0		0	12.00
13.00		0			0		0	13.00
14.00		0			0		0	14. 00 15. 00
15. 00 16. 00					0			16. 00
17. 00					0			17. 00
18. 00	Total deductions (sum of lines 12-17)		0			0		18. 00
19. 00	Fund balance at end of period per balance		188, 902, 072			0		19. 00
	sheet (line 11 minus line 18)	Endowment Fund	PI ant	Fund				
		Endowner Turid	Trant	T dila				
		6. 00	7. 00	8. 00				
1.00	Fund balances at beginning of period	0			0			1.00
2. 00 3. 00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2)				0			2. 00 3. 00
4.00	Additions (credit adjustments) (specify)		0					4. 00
5.00	,		0					5. 00
6.00			0					6. 00
7.00			0					7. 00
8. 00 9. 00			0					8. 00 9. 00
10. 00	Total additions (sum of line 4-9)	o	Ŭ.		0			10. 00
11. 00	Subtotal (line 3 plus line 10)	O			0			11. 00
12.00	Deductions (debit adjustments) (specify)		0					12.00
13. 00 14. 00			0					13. 00 14. 00
15. 00			0					15. 00
16. 00			Ö					16. 00
17. 00			o					17. 00
18. 00	Total deductions (sum of lines 12-17)	0			0			18. 00
19. 00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0			0			19. 00
	Islieer (Title II IIIIIIus IIIle 10)	ı l	ļ	I	- 1		ļ	

Health Financial Systems FATTEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-0165

		T	o 12/31/2022	Date/Time Pre 5/29/2023 9:5	
	Cost Center Description	Inpati ent	Outpati ent	Total	i dili
		1. 00	2. 00	3. 00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospi tal	59, 576, 396		59, 576, 396	1.00
2.00	SUBPROVI DER - I PF	0		0	2. 00
3.00	SUBPROVI DER - I RF	0		0	1
4.00	SUBPROVI DER	1			4. 00
5. 00	Swing bed - SNF	0		0	5. 00
6.00	Swing bed - NF	0		0	6.00
7. 00	SKILLED NURSING FACILITY	l ő		0	
8.00	NURSING FACILITY	l ő		0	
9. 00	OTHER LONG TERM CARE	i o		0	9. 00
10. 00	Total general inpatient care services (sum of lines 1-9)	59, 576, 396		59, 576, 396	1
10.00	Intensive Care Type Inpatient Hospital Services	37, 370, 370		37, 370, 370	10.00
11. 00	INTENSIVE CARE UNIT	8, 665, 129	T	8, 665, 129	11. 00
12. 00	CORONARY CARE UNIT	0,000,127		0,000,127	1
13. 00	BURN INTENSIVE CARE UNIT	0		0	13. 00
14. 00	SURGICAL INTENSIVE CARE UNIT	0		0	14. 00
15. 00	OTHER SPECIAL CARE (SPECIFY)	٥		O	15. 00
16. 00	Total intensive care type inpatient hospital services (sum of lines 11-15	8, 665, 129		8, 665, 129	1
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	68, 241, 525		68, 241, 525	1
18. 00	Ancillary services	135, 059, 793	311, 544, 663	446, 604, 456	
19. 00	Outpatient services	16, 855, 634	72, 254, 082	89, 109, 716	•
20. 00	RURAL HEALTH CLINIC	10, 655, 654	72, 234, 062	09, 109, 710	20.00
		0	0	0	
21. 00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	-	21.00
22. 00	HOME HEALTH AGENCY		U O	0	22. 00
23. 00	AMBULANCE SERVI CES	0	U O	0	23. 00
24. 00	CMHC		U O	0	24. 00
24. 10	CORF	0	U _I	0	24. 10
25. 00	AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	25. 00
26. 00	HOSPI CE	0	0 044 004	0	26. 00
27. 00	OTHER REVENUE	6, 727	2, 046, 306	2, 053, 033	•
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.	220, 163, 679	385, 845, 051	606, 008, 730	28. 00
	G-3, line 1) PART II - OPERATING EXPENSES				
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		147, 366, 983		29. 00
30. 00	ADD (SPECIFY)	0	147, 300, 703		30.00
31. 00	ADD (SECTIT)	0			31.00
32. 00					32.00
33. 00		0			33. 00
34. 00		0			34.00
		0			
35. 00	T-+-1	0	0		35. 00
36.00	Total additions (sum of lines 30-35)		٩		36.00
37. 00	DEDUCT (SPECIFY)	0			37. 00
38. 00		0			38. 00
39. 00		0			39. 00
40.00		0			40.00
41. 00	T-t-1 d-disting (1: 27 41)				41.00
42. 00	Total deductions (sum of lines 37-41)		147 2// 222		42.00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer		147, 366, 983		43. 00
	to Wkst. G-3, line 4)	I	I		I

	FINANCI SCA	AN HEALTH MUNSTER Provider CCN: 15-0165	Peri od:	u of Form CMS-2 Worksheet G-3	
IAIEW	HENT OF REVENUES AND EXPENSES	Provider CCN: 15-0165	From 01/01/2022	worksneet G-3	
			To 12/31/2022	Date/Time Prep 5/29/2023 9:5	pared
				072772020 7.0	- u
				1. 00	
00	Total patient revenues (from Wkst. G-2, Part I, column	3, line 28)		606, 008, 730	1.
00	Less contractual allowances and discounts on patients'	accounts		466, 188, 678	2.
00	Net patient revenues (line 1 minus line 2)			139, 820, 052	3.
00	Less total operating expenses (from Wkst. G-2, Part II			147, 366, 983	4.
00	Net income from service to patients (line 3 minus line	e 4)		-7, 546, 931	5.
	OTHER I NCOME				
00	Contributions, donations, bequests, etc			0	
00	Income from investments			0	
00	Revenues from telephone and other miscellaneous commun	ication services		0	
00	Revenue from television and radio service			0	1 1
. 00	Purchase di scounts			0	
	Rebates and refunds of expenses			688, 255	
2. 00	Parking Lot receipts			0	1
	Revenue from Laundry and Linen service			0	
	Revenue from meals sold to employees and guests			0	
	Revenue from rental of living quarters			0	
	Revenue from sale of medical and surgical supplies to	other than patients		0	
	Revenue from sale of drugs to other than patients			0	
	Revenue from sale of medical records and abstracts			59	
	Tuition (fees, sale of textbooks, uniforms, etc.)			0	
	Revenue from gifts, flowers, coffee shops, and canteen	l		62, 267	
	Rental of vending machines			32, 313	
	Rental of hospital space			863, 203	
. 00	Governmental appropriations			0	
	OTHER OPERATING REVENUE			1, 158, 310	
	CAPI TATI ON AND PREMI UM REVENUE			423, 797	
	INSURANCE CLAIM PROCEEDS			100	
	COVI D-19 PHE Fundi ng			0	
	Total other income (sum of lines 6-24)			3, 228, 304	
	Total (line 5 plus line 25)			-4, 318, 627	
	OTHER EXPENSES (SPECIFY)			0	
3. 00	Total other expenses (sum of line 27 and subscripts)			0	28
∂. 00	Net income (or loss) for the period (line 26 minus lin	ne 28)		-4, 318, 627	29

CALCUL	ATION OF CAPITAL PAYMENT	Provi der CCN: 15-0165	Period: From 01/01/2022 To 12/31/2022	Worksheet L Parts I-III Date/Time Pre 5/29/2023 9:5	
		Title XVIII	Hospi tal	PPS	ı dılı
				1. 00	
	PART I - FULLY PROSPECTIVE METHOD				
00	CAPITAL FEDERAL AMOUNT Capital DRG other than outlier			1, 053, 135	1.
00	Model 4 BPCI Capital DRG other than outlier			1, 053, 135	1
. 00	Capital DRG outlier payments			88, 856	
. 01	Model 4 BPCI Capital DRG outlier payments			0	2.
. 00	Total inpatient days divided by number of days in the cost	reporting period (see inst	tructions)	52. 24	3.
. 00	Number of interns & residents (see instructions)			0.00	4.
00	Indirect medical education percentage (see instructions)			0.00	
00	Indirect medical education adjustment (multiply line 5 by t	the sum of lines 1 and 1.01	1, columns 1 and	0	6.
00	1.01) (see instructions)		+ 1 1: 20)	0.00	_
00	Percentage of SSI recipient patient days to Medicare Part A (see instructions)	n patient days (worksheet i	e, part a line 30)	0. 00	7.
00	Percentage of Medicaid patient days to total days (see inst	ructions)		0.00	8.
00	Sum of lines 7 and 8	1 40 11 0113)		0.00	1
0.00	Allowable disproportionate share percentage (see instruction	ons)		0.00	1
. 00	Di sproporti onate share adjustment (see i nstructi ons)	-,		0	11.
2. 00	Total prospective capital payments (see instructions)			1, 141, 991	12.
				1. 00	
	PART II - PAYMENT UNDER REASONABLE COST				
00	Program inpatient routine capital cost (see instructions)			0	1
00	Program inpatient ancillary capital cost (see instructions)			0	1
00	Total inpatient program capital cost (line 1 plus line 2)			0	
00	Capital cost payment factor (see instructions)			0	
00	Total inpatient program capital cost (line 3 x line 4)			0	5.
				1. 00	
00	PART III - COMPUTATION OF EXCEPTION PAYMENTS				1
00 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumsta	ances (see instructions)		0	1
00	Net program inpatient capital costs for extraordinary circumstal Net program inpatient capital costs (line 1 minus line 2)	inces (see mistructions)		0	
00	Applicable exception percentage (see instructions)			0.00	
00	Capital cost for comparison to payments (line 3 x line 4)			0	
00	Percentage adjustment for extraordinary circumstances (see	instructions)		0.00	6.
00	Adjustment to capital minimum payment level for extraordina	ary circumstances (line 2)	k line 6)	0	
00	Capital minimum payment level (line 5 plus line 7)			0	
00	Current year capital payments (from Part I, line 12, as app			0	
0.00	Current year comparison of capital minimum payment level to			0	
. 00	Carryover of accumulated capital minimum payment level over L, Part III, line 14)		,	0	
2. 00	Net comparison of capital minimum payment level to capital			0	
			- \	^	1 1 2
3. 00	Current year exception payment (if line 12 is positive, ent			0	
	Current year exception payment (if line 12 is positive, ent Carryover of accumulated capital minimum payment level over line 12 is negative, enter the amount on this line)				

0 15.00 0 16.00 0 17.00

15.00 Current year allowable operating and capital payment (see instructions)
16.00 Current year operating and capital costs (see instructions)
17.00 Current year exception offset amount (see instructions)