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 01/01/2023 Parts I-III AND SETTLEMENT SUMMARY 12/31/2023 Date/Time Prepared: 5/28/2024 2:16 pm PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 5/28/2024 2:16 pm] Manually prepared cost report use only Ilf this is an amended report enter the number of times the provider resubmitted this cost report [Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no. [1] Cost Report Status
[1] As Submitted
[2] Settled without Audit
[3] Settled with Audit
[4] Date Received:
[5] To. NPR Date:
[6] 10. NPR Date:
[7] 11. Contractor's Vendor Code:
[7] 12. [8] 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 Contractor use only

number of times reopened = 0-9.

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

(3) Settled with Audit

(4) Reopened (5) Amended

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by FRANCISCAN HEALTH MUNSTER (15-0165) for the cost reporting period beginning 01/01/2023 and ending 12/31/2023 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 FINA	NCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONI C	
		1	2	SI GNATURE STATEMENT	
1	Pa	nmela Ott	Y	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	Pamel a Ott			2
3	Signatory Title	CF0			3
4	Date	(Dated when report is electronica			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	904, 170	914	0	0	1.00
2.00	SUBPROVIDER - IPF	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	904, 170	914	0	0	200.00
The ab	nove amounts represent "due to" or "due from"	the applicable	nrogram for th	e element of t	he above comple	ev indicated	

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The 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.

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4 00		MUNSTER								4 00
. 00	Subprovi der - IPF									4.00
. 00	Subprovi der - IRF									5.00
. 00	Subprovi der - (Other)									6.00
. 00	Swing Beds - SNF									7.00
3. 00	Swing Beds - NF									8.00
0.00	Hospi tal -Based SNF									9.00
0. 00	Hospi tal -Based NF									10.00
11.00	Hospi tal -Based OLTC									11. 00
2.00	Hospi tal -Based HHA									12.00
	Separately Certified ASC									13.00
	Hospi tal -Based Hospi ce									14.00
	Hospital-Based Health Clinic - RHC									15. 00
	Hospital-Based Health Clinic - FQHC									16. 00
	Hospital-Based (CMHC) I									17. 00
17. 10	Hospital-Based (CORF) I									17. 10
18.00	Renal Dialysis									18.00
9.00	0ther									19.00
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21. 00	Type of Control (see instructions)					1				21. 00
	1 1 1 200 1 6 11				1. 00	2. 00		3.0	00	
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22.00	Does this facility qualify and is it	3 0.3			Y	N				22. 00
	disproportionate share hospital adju §412.106? In column 1, enter "Y" fo			·						
	facility subject to 42 CFR Section §									
	hospital?) In column 2, enter "Y" fo		muniem							
22 01	Did this hospital receive interim UC		al IICDs	for	N	N	ŀ			22. 01
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	cost reporting period occurring on o									
		arter october 1. (3cc								
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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 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/28/2024 2:16 pm XVIII XIX 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 60.00 any 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 IMF Direct GME IME Direct GME 2. 00 3. 00 4.00 5.00 1 00 61.00 Did your hospital receive FTE slots under ACA Ν 0.00 0.00 61.00 section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) 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 61 03 and/or 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 61.04 surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). Enter the difference between the baseline primary 61.05 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 61.06 used 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 "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)

63.00

icial Systems	FRANCIS	CAN HEALTH MUNSTER		In Lie	u of Form CMS-:	2552-10
				eri od:	Worksheet S-2	
					Date/Time Pre	pared: 6 pm
			Unwei ghted	Unwei ghted	Ratio (col. 1/	
			Nonprovi der	FTEs in Hospital	(col. 1 + col. 2))	
				2.00	3 00	
on 5504 of the ACA Base Yea	r FTE Residents in No	onprovider Settings-		·	•	
d that begins on or after J	uly 1, 2009 and befor	re June 30, 2010.				64 00
e base year period, the num ent FTEs attributable to ro ngs. Enter in column 2 the	ber of unweighted nor tations occurring in number of unweighted	n-primary care all nonprovider d non-primary care		3.00	0.00000	01100
	1 + column 2)). (see	instructions)				
	Program Name	Program Code	Unwei ghted		Ratio (col. 3/	
				ноѕрі таі	4))	
	1 00	2 00		4 00	5.00	
in column 1. if line 63	1.00	2.00				65. 00
ed residents in the base period, the program name iated with primary care for each primary care am in which you trained ents. Enter in column 2, rogram code. Enter in n 3, the number of ghted primary care FTE ents attributable to ions occurring in all rovider settings. Enter in n 4, the number of ghted primary care ent FTEs that trained in hospital. Enter in column e ratio of (column 3 ed by (column 3 + column (see instructions)			Unwei ghted	Unwei ghted	Ratio (col. 1/	65.00
				nospi tai	2))	
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on 5504 of the ACA Current	Year FTE Residents in	n Nonprovider Setting				
ning on or after July 1, 20	10					
attributable to rotations o	ccurring in all nonpr	rovider settings.	0.00	0.00	0. 000000	66. 00
, ,	Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col. 3/	
			FTEs	FTEs in	(col. 3 + col.	
				Hospi tal	4))	
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in column 1 the program	1.00	2.00				47.00
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	on 5504 of the ACA Base Yead that begins on or after Jin column 1, if line 63 is e base year period, the num ent FTEs attributable to rongs. Enter in column 2 the ent FTEs that trained in yoolumn 1 divided by (column 1 divided by (column 1 divided by (column 2, or your facility ed residents in the base period, the program name iated with primary care for each primary care am in which you trained ents. Enter in column 2, rogram code. Enter in n 3, the number of ghted primary care FTE ents attributable to ions occurring in all rovider settings. Enter in n 4, the number of ghted primary care ent FTEs that trained in hospital. 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(see Program Name in column 1, if line 63 s, or your facility ed residents in the base period, the program name lated with primary care for each primary care eam in which you trained ents. Enter in column 2, rogram code. Enter in n 3, the number of ghted primary care ent FTEs that trained in hospital. Enter in column eratio of (column 3 + column (see instructions) on 5504 of the ACA Current Year FTE Residents in n 4, the number of ghted primary care ent FTEs that trained in hospital. Enter in column (see instructions) on 5504 of the ACA Current Year FTE Residents in n 1 divided by (column 1 + column 2). (see instructions) on 5504 of the ACA Current Year FTE Residents in n 1 divided by (column 1 + column 2). (see instructions) on 5504 of the ACA Current Year FTE Residents in n 1 divided by (column 1 + column 2). (see instructions)	on 5504 of the ACA Base Year FTE Residents in Nonprovider Settings- d that begins on or after July 1, 2009 and before June 30, 2010. In column 1, if line 63 is yes, or your facility trained residents e base year period, the number of unweighted non-primary care ent FTEs attributable to rotations occurring in all nonprovider ngs. Enter in column 2 the number of unweighted non-primary care ent FTEs that trained in your hospital. Enter in column 3 the ratio olumn 1 divided by (column 1 + column 2)). (see instructions) Program Name Program Code 1.00 2.00 In column 1, If line 63 sor your facility ed residents in the base period, the program name lated with primary care for each primary care for each primary care for each primary care for each primary care ent FTEs that trained in hospital. Enter in column 1, the number of ghted primary care ent FTEs that trained in hospitals. Enter in column con 5504 of the ACA Current Year FTE Residents in Nonprovider Settings in column 2 the number of unweighted non-primary care resident that trained in your hospital. 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0 00

0.00

97.00

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

participation in the demonstration, if applicable.		
Miscellaneous Cost Reporting Information		
115.00 s this an all-inclusive rate provider? Enter "Y" for yes or "N" for no	N	0 115. 00
in column 1. If column 1 is yes, enter the method used (A, B, or E only)		
in column 2. If column 2 is "E", enter in column 3 either "93" percent		
for short term hospital or "98" percent for long term care (includes		
psychiatric, rehabilitation and long term hospitals providers) based on		
the definition in CMS Pub. 15-1, chapter 22, §2208.1.		
116.00 Is this facility classified as a referral center? Enter "Y" for yes or	N	116. 00
"N" for no.		
117.00 s this facility legally-required to carry malpractice insurance? Enter	Υ	117. 00
"Y" for yes or "N" for no.		
118.00 s the malpractice insurance a claims-made or occurrence policy? Enter 1	1	118. 00
if the policy is claim-made. Enter 2 if the policy is occurrence.		
MCRI F32 - 22. 2. 178. 2		

Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	Provider CC	N: 15-0165		: 1/01/2023 2/31/2023		repared:
						5/28/2024 2:	16 pm
						1.00	
147.00Was there a change in the statist	cal basis? Enter "Y" for	ves or "N" for	no.			N N	147. 00
148.00Was there a change in the order o						N	148. 00
149.00 Was there a change to the simplif				or no.		N	149.00
		Part A	Part B	Т	itle 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 compon			. (See 42			
55. 00 Hospi tal		N	N		N	N	155. 0
56.00 Subprovi der - IPF		N	N N		N	N	156. 0
57. 00 Subprovi der - I RF 58. 00 SUBPROVI DER		N	N		N	N	157. 0 158. 0
59. 00 SNF		N	N		N	N	159. 0
60.00HOME HEALTH AGENCY		N N	N N		N	N N	160. 0
161. OO CMHC		IN	N N		N	N N	161. 0
61. 10 CORF			N N		N	N N	161. 1
01. 10 00Ki							101.1
						1.00	
Multicampus							
165.00 Is this hospital part of a Multic	ampus hospital that has on	e or more campu	ses in dif	ferent CE	SSAs?	N	165. 0
Enter "Y" for yes or "N" for no.							
	Name	County		Zip Code	CBSA	FTE/Campus	
	0	1. 00	2. 00	3. 00	4. 00	5. 00	20111
166.00 If line 165 is yes, for each						0. (00 166. 0
campus enter the name in column O, 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 s this provider a meaningful use						Y	167. 0
68.00 If this provider is a CAH (line 1			e 167 is "Y	'), enter	the		168. 0
reasonable cost incurred for the					I=I=!		1/0 0
168.01 If this provider is a CAH and is exception under §413.70(a)(6)(ii)					isni þ		168. 0
169.00 f this provider is a meaningful					enter the	9	99169. 0
transition factor. (see instruction	,	13 1101 4 0/111 (11110 100 1	3 11), 0	inter the	7.	,,,,,,,,,,
[]				Ве	gi nni ng	Endi ng	
					1. 00	2.00	
170.00 Enter in columns 1 and 2 the EHR I	peginning date and ending	date for the re	porting				170. 0
period respectively (mm/dd/yyyy)							
							_
					1. 00	2. 00	
171.00 fline 167 is "Y", does this pro					N		0 171. 0
section 1876 Medicare cost plans "Y" for yes and "N" for no in col				ion			

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 01/01/2023 Part II Date/Time Prepared: 12/31/2023 5/28/2024 2:16 pm 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 2.00 2.00 Ν yes, enter in column 2 the date of termination and in column 3, "V" for 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 or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions) Y/N Date Type 1.00 2.00 3.00 Financial Data and Reports
Column 1: Were the financial statements prepared by a Certified Public 4 00 04/17/2024 4 00 Α Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions. 5 00 Are the cost report total expenses and total revenues different from 5 00 Ν those on the filed financial statements? If yes, submit reconciliation. 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 N 9.00 program in the current cost report? If yes, see instructions. Was an approved Intern and Resident GME program initiated or renewed in the current 10.00 Ν 10.00 cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I & R in an Approved Ν 11.00 Teaching Program on Worksheet A? If yes, see instructions. Y/N 1.00 Bad Debts 12.00 Is the provider seeking reimbursement for bad debts? If yes, see instructions. 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 Ν 14.00 instructions. Bed Complement 15.00 Did total beds available change from the prior cost reporting period? If yes, see instructions Υ 15.00 Part B Y/N Y/N Date 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? N Ν 16.00 If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions) 17.00 Was the cost report prepared using the PS&R Report for Υ 05/01/2024 05/01/2024 17 00 totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed Ν Ν 18.00 but are not included on the PS&R Report used to file this cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Ν Ν 19.00 Report data for corrections of other PS&R Report information? If yes, see instructions.

SPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider Co	CN: 15-0165	Peri od: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part II Date/Time Pre 5/28/2024 2:1	epared
		Descri	pti on	Y/N	Y/N	T Pill
)	1. 00	3. 00	
0. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.0
	Report data for other: bescribe the other adjustments.	Y/N	Date	Y/N	Date	
		1.00	2. 00	3. 00	4. 00	-
. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.0
					1. 00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	PT CHILDRENS H	OSPI TALS)			
2. 00	Capital Related Cost Have assets been relifed for Medicare purposes? If yes, see	instructions			N	22.
. 00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.		als made dur	ing the cost	N N	23.
. 00	Were new leases and/or amendments to existing leases entere If yes, see instructions	d into during	this cost re	porting period?	N	24.
. 00	Have there been new capitalized leases entered into during instructions.	the cost repor	ting period?	'If yes, see	N	25.
. 00	Were assets subject to Sec. 2314 of DEFRA acquired during th instructions.	e cost reporti	ng period? I	f yes, see	N	26.
'. 00	Has the provider's capitalization policy changed during the copy.	cost reportin	g period? If	yes, submit	N	27.
	<u>Interest Expense</u> Were new Loans, mortgage agreements or Letters of credit en	tered into dur	ing the cost	reporting	N	28.
. 00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or		bt Service R	eserve Fund)	N	29.
. 00	treated as a funded depreciation account? If yes, see instr Has existing debt been replaced prior to its scheduled matu		debt? If yes	s, see	N	30.
. 00	instructions. Has debt been recalled before scheduled maturity without is instructions.	suance of new	debt? If yes	s, see	N	31.
. 00	Purchased Services Have changes or new agreements occurred in patient care ser		d through co	ntractual	N	32.
3. 00	arrangements with suppliers of services? If yes, see instru If line 32 is yes, were the requirements of Sec. 2135.2 app no, see instructions.		g to competi	tive bidding? If	N	33.
	Provi der-Based Physi ci ans					
	Were services furnished at the provider facility under an a If yes, see instructions.	rrangement wit	h provider-b	ased physicians?	Y	34.
. 00	If line 34 is yes, were there new agreements or amended exi physicians during the cost reporting period? If yes, see in		ts with the	provi der-based	N	35.
	, , , , , , , , , , , , , , , , , , ,			Y/N	Date	
				1. 00	2. 00	
	Home Office Costs					
	Were home office costs claimed on the cost report?		h	Y		36.
	If line 36 is yes, has a home office cost statement been pr If yes, see instructions.					37.
. 00	If line 36 is yes, was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end	of the home o	ffi ce.			38.
	If line 36 is yes, did the provider render services to othe see instructions.	•	,			39.
. 00	If line 36 is yes, did the provider render services to the instructions.	nome office?	ir yes, see	N		40.
		1.	00	2.	00	
	Cost Report Preparer Contact Information	DAVILD				4.5
. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DAVI D		LI		41.
. 00		FRANCISCAN HEA	LTH			42.
. 00		205-222-0184		DAVI D. LI @FRANC	I SCANALLI ANCE.	43.

Health Financial Systems	FRANCI SCAN HEA	ALTH MUNSTER		In Lie	u of Form CM	IS-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE	ESTI ONNAI RE	Provider CCN: 1		Peri od:	Worksheet	S-2
				From 01/01/2023 To 12/31/2023		Proparod:
			'	12/31/2023	5/28/2024	
		3. 00				
Cost Report Preparer Contact Information						
41.00 Enter the first name, last name and the title		MANAGER REIMBURSEM	IENT			41. 00
held by the cost report preparer in columns	1, 2, and 3,					
respecti vel y.						
42.00 Enter the employer/company name of the cost	report					42. 00
preparer.						
43.00 Enter the telephone number and email address						43. 00
report preparer in columns 1 and 2, respecti	vel y.					

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 Systems
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 HOSPITAL
 AND
 HOSPITAL
 HEALTH CARE COMPLEX
 STATISTICAL
 DATA

Component Worksheet A No. of Beds Bed Days Available If P Days / O/P VITE VIT						'	0 12/31/2023	5/28/2024 2: 10	
Component									
Component Worksheet A No. of Beds Bed Bays Available No. of Beds Red Bays Available No. of Beds Red Bays Available No. of Beds Red Bays Available No. of Beds No. of B									
PART I - STATISTICAL DATA		Component	Worksheet A	No.	of Beds	Bed Days			
PART I - STAINSTICAL DATA		·	Li ne No.			Avai I abl e			
1.00			1. 00		2. 00	3.00	4. 00	5. 00	
8 exclude Swing Bed, Observation Bed and Hospice days)(See Instructions for col. 2 for the portion of LDP room available beds) 10									
Hospice days) (see instructions for col. 2	1.00		30. 00		54	19, 710	0.00	0	1. 00
For the portion of LDP room available beds) 3.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00									
2.00 HM and other (see instructions) 3.00 HM IPF Subprovider 4.00 4.00 HM IPF Subprovider 4.00 6.00 Hspit al Adult is & Peds. Swing Bed SNF 6.00 Hspit al Adult is & Peds. Swing Bed NF 7.00 Total Adult is and Peds. (exclude observation beds) (see instructions) 8.00 HTTERIS VE CARE UNIT 8.00 CORONARY CARE UNIT 9.00 COR									
3. 00 MMO IPF Subprovider		1							
4. 00 HMO I RF Subprovider 0 5.00 0 10.00									
5.00		•							
6.00 Hospital Adults & Peds. Swing Bed NF		· · · · · · · · · · · · · · · · · · ·						_	
Total Adults and Peds (exclude observation beds) (see instructions) S4 19,710 0.00 0 7.00									
Deds) (see instructions) 8.00 NTRINSIVE CARE UNIT 31.00 24 8.760 0.00 0.800 9.00 0.00 0.00 0.900 0.00									
8. 00 INTENSIVE CARE UNIT 31. 00 24 8,760 0. 00 0 8. 00 0. 00	7. 00				54	19, 710	0.00	0	7. 00
9. 00 CORONARY CARE UNIT 32. 00 0 0 0. 00 0 9, 00 10. 00 BURN I NTENSIVE CARE UNIT 33. 00 0 0 0. 00 0 11. 00 SURGI CAL INTENSIVE CARE UNIT 34. 00 0 0 0 0 12. 00 OTHER SPECIAL CARE (SPECIFY) 12. 00 13. 00 NURSERY 43. 00 13. 00 14. 00 Total (see instructions) 78 28, 470 0. 00 0 15. 10 15. 00 CAH visits 0 15. 10 16. 00 SUBPROVIDER - IPF 40. 00 0 0 0 17. 00 SUBPROVIDER - IFF 41. 00 0 0 0 18. 00 SUBPROVIDER - IRF 41. 00 0 0 0 19. 00 SALLED NURSING FACILITY 44. 00 0 0 0 21. 00 OTHER LONG TERM CARE 46. 00 0 0 22. 00 OMBURATORY SURGICAL CENTER (D.P.) 115. 00 24. 00 HOSPICE (non-distinct part) 30. 00 24. 10 25. 10 CMHC - COMP 99. 10 25. 10 26. 05 FORDRALLY OLULIFIED HEALTH CENTER 89. 00 30. 00 32. 00 Labor & delivery days (see instructions) 33. 00 170 170 170 170 170 170 170 170 170 170 33. 00 LTCH sick neutral days and discharges 33. 01 170			04.00			0.740			
10. 00 BURN INTENSIVE CARE UNIT 33.00 0 0 0.00 0 10.00									
11. 00 SURGICAL INTENSIVE CARE UNIT 34.00 0 0 0 0 0 0 11.00 12. 00 OTHER SPECIAL CARE (SPECIFY) 32.00 13.00 13.00 14. 00 Total (see instructions) 78 28,470 0.00 0 14.00 15. 00 CAH visits 0 0 0 0 0 0 15. 00 CAH visits 0 0 0 0 0 15. 10 REH hours and visits 0.00 0 15.10 16. 00 SUBPROVIDER - IPF 40.00 0 0 0 17. 00 SUBPROVIDER - IRF 41.00 0 0 0 18. 00 SUBPROVIDER - IRF 44.00 0 0 0 19. 00 SKILLED NURSING FACILITY 44.00 0 0 0 19. 00 SKILLED NURSING FACILITY 45.00 0 0 0 21. 00 OTHER LONG TERM CARE 46.00 0 0 22. 00 OHME HEALTH AGENCY 101.00 0 23. 00 AMBULATORY SURGICAL CENTER (D. P.) 115.00 24. 00 HOSPICE (non-distinct part) 30.00 24.00 25. 00 CMHC - CMHC 99.00 25.00 25. 00 CMHC - CORF 99.10 26.00 26. 05 EDEFRALLY OUALLIFIED HEALTH CENTER 89.00 78 27.00 29. 00 Anbul ance Trips 30.00 32.01 30. 00 Employee di scount days (see instructions) 31.00 32. 01 Total ancil I ary I abor & delivery room outpatient days (see instructions) 33.00 Total ancil I ary I abor & delivery room outpatient days (see instructions) 33.00 Total sincil I ary I abor & delivery room outpatient days (see instructions) 33.00 Total sincil I ary I abor & delivery room outpatient days (see instructions) 33.00 Total sincil I ary I abor & delivery room outpatient days (see instructions) 33.00 Total sincil I ary I abor & delivery room outpatient days (see instructions) 33.00 Total sincil I ary I abor & delivery room outpatient days (see instructions) 33.00 Total capter and the since the sin						-			
12. 00 O THER SPECIAL CARE (SPECIFY) 13. 00 NURSERY 14. 00 Total (see instructions) 15. 10 REH hours and visits 16. 00 SUBPROVIDER - IPF 17. 00 SUBPROVIDER - IRF 18. 00 O SUBPROVIDER - IRF 19. 00 SKILLED NURSING FACILITY 19. 00 O NURSING FACILITY 19. 00 O NURSING FACILITY 19. 00 O O O O O O O O O O O O O O O O O O		• • • • • • • • • • • • • • • • • • •			- 1	-			
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14. 00 Total (see instructions) 15. 00 CAH visits REH hours and visits 0.00 15. 10 REH hours and visits 0.00 15. 10 REH hours and visits 0.00 15. 10 16. 00 SUBPROVI DER - I PF 40. 00 0 0 17. 00 SUBPROVI DER - I RF 41. 00 0 0 0 16. 00 17. 00 SUBPROVI DER - I RF 41. 00 0 0 0 0 17. 00 SUBPROVI DER 18. 00 19. 00 SKI LLED NURSI NG FACI LITY 44. 00 0 0 0 0 0 0 0 0 0 0 0 0		` ′	40.00						
15.00 CAH visits 0.00 15.10 REH hours and visits 0.00 0 15.00 15.10 REH hours and visits 0.00 0 15.10 16.00 SUBPROVIDER - IPF 40.00 0 0 17.00 SUBPROVIDER - IRF 41.00 0 0 18.00 SUBPROVIDER - IRF 41.00 0 0 19.00 SKILLED NURSING FACILITY 44.00 0 0 20.00 NURSING FACILITY 45.00 0 0 21.00 OTHER LONG TERM CARE 46.00 0 0 22.00 HOME HEALTH AGENCY 101.00 22.00 23.00 AMBULATORY SURGICAL CENTER (D. P.) 115.00 24.00 HOSPICE (non-distinct part) 30.00 24.10 HOSPICE (non-distinct part) 30.00 24.10 HOSPICE (non-distinct part) 30.00 26.25 FEDERALLY QUALIFIED HEALTH CENTER 89.00 27.00 TOTAI (Sum of lines 14-26) 28.00 29.00 Ambulance Trips 20.00 Ambulance Trips 20.00 Cab delivery days (see instruction) 28.00 Employee discount days - IRF 20.00 Cutch of a delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 33.01 LTCH non-covered days 33.01 LTCH non-covered days 33.01			43.00		7.0	00 470			
15. 10 REH hours and visits					/8	28, 470	0.00		
16. 00 SUBPROVIDER - IPF									
17. 00 SUBPROVI DER - IRF			40.00			•			
18. 00 SUBPROVIDER						-			
19.00 SKILLED NURSING FACILITY			41.00		U	0		0	
20. 00 NURSING FACILITY		4	44.00			•			
21.00 OTHER LONG TERM CARE 22.00 HOME HEALTH AGENCY 33.00 AMBULATORY SURGICAL CENTER (D.P.) 21.00 22.00 23.00 AMBULATORY SURGICAL CENTER (D.P.) 115.00 24.10 HOSPICE 116.00 25.00 CMHC - CMHC 25.00 CMHC - CORF 26.00 RURAL HEALTH CLINIC 26.25 FEDERALLY QUALIFIED HEALTH CENTER 27.00 Total (sum of lines 14-26) 28.00 Observation Bed Days 29.00 29.00 Ambulance Trips 30.00 Employee discount days (see instruction) 31.00 Employee discount days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 33.00 LTCH non-covered days 33.00 LTCH site neutral days and discharges		- N				-			
22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGICAL CENTER (D. P.) 21. 00 HOSPICE 24. 00 HOSPICE 24. 00 HOSPICE 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 00 RURAL HEALTH CLINIC 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambul ance Trips 30. 00 29. 00 Labor & delivery days (see instruction) 31. 00 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 31. 01 LTCH non-covered days 30. 00 31. 01 LTCH non-covered days and discharges						-		U	
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24. 00 HOSPICE		•						U	
24. 10 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 25. 00 CMHC - CORF 26. 00 RURAL HEALTH CLINIC 26. 05 FEDERALLY QUALIFIED HEALTH CENTER 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambulance Trips 29. 00 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 32. 00 Labor & delivery days (see instructions) 33. 00 LTCH non-covered days 30. 00 31. 01 LTCH site neutral days and discharges		` ′				0			
25. 00 CMHC - CMHC 25. 10 CMHC - CORF 25. 10 CMHC - CORF 26. 00 RURAL HEALTH CLINIC 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambulance Trips 29. 00 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 32. 00 Labor & delivery days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH non-covered days 33. 01 LTCH site neutral days and discharges					U	U			
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29. 00 Ambulance Trips 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 32. 00 Labor & delivery days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH non-covered days 33. 01 LTCH site neutral days and discharges		1 '			/8				
30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 33.01 LTCH site neutral days and discharges		,						U	
31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 33.01 LTCH site neutral days and discharges									
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32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 33.01 LTCH site neutral days and discharges 32.01 33.01					0	0			
outpatient days (see instructions) 33.00 LTCH non-covered days 33.01 LTCH site neutral days and discharges 33.01					U	U			
33.00 LTCH non-covered days 33.01 LTCH site neutral days and discharges 33.00 LTCH site neutral days and discharges	32. UI								3∠. U I
33.01 LTCH site neutral days and discharges 33.01	22 00				ŀ				22 00
34. 00 Tolliporary Expansion 60412-17 THE Acute care 30. 00 0 0 0 0 34. 00			30 00		0	0		۸	
	54.00	Transportary Expansion Govito 17 The Acute Galle	30.00		Ч	O	I	١	54.00

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

Provider CCN: 15-0165

		1 /5 5	/ 0 /5 1/1 1 1	,		5/28/2024 2: 1	5 pm
		I/P Days	/ O/P Visits	/ Irips	Full Time E	Equi val ents	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
				Pati ents	& Residents	Payrol I	
		6. 00	7. 00	8. 00	9. 00	10. 00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	4, 383	1, 016	11, 261			1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
2 00	for the portion of LDP room available beds)	4 771	1 205				2 00
2. 00 3. 00	HMO and other (see instructions)	4, 771	1, 295				2. 00 3. 00
4. 00	HMO IPF Subprovider HMO IRF Subprovider	0	U				4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5. 00
6.00	Hospital Adults & Peds. Swing Bed NF	٩	0	0			6. 00
7. 00	Total Adults and Peds. (exclude observation	4, 383	1, 016	11, 261			7. 00
7.00	beds) (see instructions)	4, 303	1,010	11, 201			7.00
8. 00	INTENSIVE CARE UNIT	1, 701	0	5, 296			8. 00
9. 00	CORONARY CARE UNIT	0	0	0, 2, 0			9. 00
10. 00	BURN INTENSIVE CARE UNIT	o	o	0			10.00
11. 00	SURGICAL INTENSIVE CARE UNIT	o	0	0			11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		0	0			13.00
14.00	Total (see instructions)	6, 084	1, 016	16, 557	0.00	528. 53	14.00
15.00	CAH visits	0	0	0			15.00
15. 10	REH hours and visits	0	0	0			15. 10
16.00	SUBPROVI DER - I PF	0	0	0	0.00	0.00	16.00
17. 00	SUBPROVI DER - I RF	0	0	0	0.00	0.00	17.00
18. 00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY	0	0	0		0.00	19. 00
20. 00	NURSING FACILITY		0	0	0.00	0.00	20. 00
21. 00	OTHER LONG TERM CARE	_	_	0	0.00		21. 00
22. 00	HOME HEALTH AGENCY	0	0	0	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	0		0.00	24. 00
24. 10 25. 00	HOSPICE (non-distinct part) CMHC - CMHC	0	0	0		0.00	24. 10 25. 00
25. 00	CMHC - CMF	0	0	0		0.00	25. 00
26. 00	RURAL HEALTH CLINIC		0	0	0.00		26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26. 25
27. 00	Total (sum of lines 14-26)	٩	J	O	0.00	528. 53	27. 00
28. 00	Observation Bed Days		0	2, 733		320.33	28. 00
29. 00	Ambulance Trips	0	٥	2, 733			29. 00
30.00	Employee discount days (see instruction)	٩		0			30.00
31. 00	Employee discount days - IRF			0			31.00
32. 00	Labor & delivery days (see instructions)	o	o	0			32.00
32. 01	Total ancillary labor & delivery room		Ĭ	0			32. 01
	outpatient days (see instructions)			_			
33.00	LTCH non-covered days	o					33. 00
33. 01	LTCH site neutral days and discharges	O					33. 01
34.00	Temporary Expansion COVID-19 PHE Acute Care	0	O	0			34.00

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

| Peri od: | Worksheet S-3 | From 01/01/2023 | Part I | To 12/31/2023 | Date/Time Prepared:

				10) 12/31/2023	5/28/2024 2:10	parea: 6 nm
		Full Time		Di sch	arges	072072021 2. 1	Б
		Equi val ents		5. 55.	a. 900		
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
	'	Workers				Pati ents	
		11.00	12.00	13.00	14.00	15. 00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		0	1, 382	552	3, 735	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)			906	0		2. 00
3.00	HMO IPF Subprovider				0		3. 00
4.00	HMO IRF Subprovider				0		4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF						5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						6. 00
7.00	Total Adults and Peds. (exclude observation						7. 00
	beds) (see instructions)						
8. 00	I NTENSI VE CARE UNI T						8. 00
9.00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10. 00
11. 00	SURGI CAL INTENSI VE CARE UNI T						11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY			4 000	550	0 705	13. 00
14.00	Total (see instructions)	0. 00	0	1, 382	552	3, 735	
15. 00	CAH visits						15. 00
15. 10	REH hours and visits	0.00	•				15. 10
16.00	SUBPROVI DER - I PF	0.00	0		0	0	16. 00
17. 00	SUBPROVIDER - I RF	0. 00	0	0	0	0	17. 00
18.00	SUBPROVI DER	0.00					18.00
19.00	SKILLED NURSING FACILITY	0.00					19. 00
20.00	NURSING FACILITY OTHER LONG TERM CARE	0. 00 0. 00				0	20. 00 21. 00
21. 00 22. 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. 00	HOSPICE (non-distinct part)	0.00					24. 00
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	0.00					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
02.01	outpatient days (see instructions)						-2.0.
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						34. 00

Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION

In Lieu of Form CMS-2552-10
Period: Worksheet S-3
From 01/01/2023 Part II

						o 12/31/2023	Date/Time Pre	
		Wkst. A Line	Amount	Recl assi fi cati	Adj usted	Pai d Hours	5/28/2024 2: 10 Average Hourly	
		Number	Reported	on of Salaries (from Wkst.		Related to Salaries in	Wage (col. 4 ÷ col. 5)	
				A-6)	3)	col. 4	COI. 5)	
		1. 00	2. 00	3.00	4. 00	5. 00	6. 00	
	PART II - WAGE DATA SALARIES							-
1. 00	Total salaries (see	200. 00	48, 668, 616	0	48, 668, 616	1, 099, 333. 00	44. 27	1.00
	instructions)							
2.00	Non-physician anesthetist Part		C	0	C	0.00	0. 00	2.00
3. 00	A Non-physician anesthetist Part		C	0	0	0.00	0.00	3.00
	В							
4. 00	Physician-Part A - Administrative		C	0	C	0.00	0. 00	4.00
4. 01	Physicians - Part A - Teaching		C	0	l c	0.00	0.00	4. 01
5.00	Physician and Non		4, 103, 746	0	4, 103, 746			
6. 00	Physician-Part B Non-physician-Part B for		C	0	0	0.00	0. 00	6.00
6.00	hospital -based RHC and FQHC		C	0		0.00	0.00	0.00
	servi ces							
7. 00	Interns & residents (in an approved program)	21. 00	C	0	C	0.00	0. 00	7.00
7. 01	Contracted interns and		C	0	C	0.00	0.00	7. 01
	residents (in an approved							
8. 00	programs) Home office and/or related		C	0		0.00	0. 00	8.00
0.00	organi zati on personnel		C			0.00	0.00	0.00
9. 00	SNF	44. 00	C	0	0	0.00		
10. 00	Excluded area salaries (see instructions)		2, 919, 836	-199, 886	2, 719, 950	56, 454. 00	48. 18	10.00
	OTHER WAGES & RELATED COSTS							
11. 00	Contract labor: Direct Patient		6, 270, 735	0	6, 270, 735	58, 395. 00	107. 38	11. 00
12. 00	Care Contract Labor: Top Level		C	0		0.00	0.00	12.00
	management and other							
	management and administrative							
13. 00	services Contract Labor: Physician-Part		50, 315	0	50, 315	389. 00	129. 34	13.00
	A - Administrative							
14. 00	Home office and/or related organization salaries and		C	0	C	0.00	0.00	14.00
	wage-related costs							
14. 01	Home office salaries		11, 382, 154	0	11, 382, 154			14. 01
14. 02 15. 00	Related organization salaries Home office: Physician Part A		C	0		0. 00 0. 00		
13.00	- Administrative		C			0.00	0.00	13.00
16. 00	Home office and Contract		C	0	C	0.00	0. 00	16.00
16. 01	Physicians Part A - Teaching Home office Physicians Part A		C	0		0.00	0. 00	16. 01
10.01	- Teachi ng					0.00	0.00	10.01
16. 02	Home office contract		C	0	C	0.00	0. 00	16. 02
	Physicians Part A - Teaching WAGE-RELATED COSTS							1
17. 00	Wage-related costs (core) (see		11, 063, 019	33, 847	11, 096, 866			17. 00
18. 00	instructions) Wage-related costs (other)							18.00
10.00	(see instructions)							10.00
19.00	Excl uded areas		705, 127	-33, 847	671, 280			19.00
20. 00	Non-physician anesthetist Part		C	0				20.00
21. 00	Non-physician anesthetist Part		C	0	C			21.00
22. 00	B Physician Part A -							22. 00
22.00	Administrative		C					22.00
22. 01	Physician Part A - Teaching		C	0	C			22. 01
23. 00	Physician Part B		622, 088	0	622, 088			23. 00
24. 00 25. 00	Wage-related costs (RHC/FQHC) Interns & residents (in an		0	0				24. 00 25. 00
	approved program)		_					
25. 50	Home office wage-related (core)		3, 695, 629	0	3, 695, 629			25. 50
25. 51	Related organization		C	О	C			25. 51
25 52	wage-related (core)		C	_				25 50
25. 52	Home office: Physician Part A - Administrative -		C					25. 52
	, main in strative							

					T	o 12/31/2023	Date/Time Prep 5/28/2024 2:10	
		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	
25. 53	Home office: Physicians Part A		0	0	0			25. 53
	- Teaching - wage-related							
	(core)							
	OVERHEAD COSTS - DIRECT SALARII							
26. 00	Employee Benefits Department	4. 00	419, 301			,		26. 00
27. 00	Administrative & General	5. 00	2, 140, 764		2, 140, 764			27. 00
28. 00	Administrative & General under		22, 897	0	22, 897	610. 00	37. 54	28. 00
	contract (see inst.)							
29. 00	Maintenance & Repairs	6. 00	1, 179, 970	0	1, 179, 970			
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, 186, 201	0	1, 186, 201	56, 611. 00		
33. 00	Housekeeping under contract (see instructions)		0	0	0	0. 00	0. 00	33. 00
34. 00	Di etary	10. 00	1, 007, 068	-693, 095	313, 973	13, 637. 00	23. 02	34. 00
35. 00	Di etary under contract (see		0	0	0	0.00	0.00	35. 00
27 00	instructions)	11 00	0	(02.005	(02.005	20 105 00	22.02	27.00
36. 00	Cafeteria	11.00	0	693, 095	693, 095			
37. 00	Maintenance of Personnel	12.00	0 150 0/0	0	0 152 0/0	0.00		
38. 00	Nursing Administration	13. 00	2, 152, 968		2, 152, 968	,		
39. 00	Central Services and Supply	14. 00	313, 622		313, 622			
40. 00	Pharmacy	15. 00	1, 827, 843	l .	1, 827, 843			
41. 00	Medical Records & Medical Records Library	16. 00	570, 998	0	570, 998	13, 649. 00	41. 83	41. 00
42.00	Social Service	17. 00	0	0	l o	0.00	0.00	42.00
43.00	Other General Service	18. 00	0	0	0	0.00	0.00	43. 00

| Peri od: | Worksheet S-3 | From 01/01/2023 | Part III | To 12/31/2023 | Date/Time Prepared: Provider CCN: 15-0165

					11	0 12/31/2023	5/28/2024 2: 16	
		Worksheet A	Amount	Recl assi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Line Number		on of Salaries	,		Wage (col. 4 ÷	
			'	(from	(col.2 ± col.	Salaries in	col . 5)	
				Worksheet A-6)	3)	col. 4	·	
		1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		44, 587, 767	0	44, 587, 767	1, 082, 006. 00	41. 21	1.00
	instructions)							
2.00	Excluded area salaries (see		2, 919, 836	-199, 886	2, 719, 950	56, 454. 00	48. 18	2. 00
	instructions)							
3.00	Subtotal salaries (line 1		41, 667, 931	199, 886	41, 867, 817	1, 025, 552. 00	40. 82	3. 00
	minus line 2)							
4.00	Subtotal other wages & related		17, 703, 204	0	17, 703, 204	393, 868. 00	44. 95	4. 00
	costs (see inst.)							
5. 00	Subtotal wage-related costs		14, 758, 648	33, 847	14, 792, 495	0. 00	35. 33	5. 00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		74, 129, 783					
7. 00	Total overhead cost (see		10, 821, 632	199, 886	11, 021, 518	317, 221. 00	34. 74	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	Period: Worksheet S-3 From 01/01/2023 Part IV To 12/31/2023 Date/Time Prepared:

	To 12/31/2023	Date/Time Prep 5/28/2024 2:10	
		Amount	
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	1, 754, 893	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, 318, 153	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)	4, 668, 952	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	176, 544	10. 00
11. 00	Life Insurance (If employee is owner or beneficiary)	17, 277	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)	203, 011	13. 00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14. 00
15. 00	'Workers' Compensation Insurance	1, 149, 421	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)		1
	TAXES		
	FICA-Employers Portion Only	3, 101, 983	
18. 00	Medicare Taxes - Employers Portion Only	0	
19. 00	Unempl oyment Insurance	0	
20.00		0	20. 00
	OTHER		
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see	0	21. 00
	instructions))		
22. 00	Day Care Cost and Allowances	0	22. 00
23. 00	Tuition Reimbursement	0	
24. 00	Total Wage Related cost (Sum of lines 1 -23)	12, 390, 234	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
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provi der CCN: 15-0165	Peri od: From 01/01/2023 Part V To 12/31/2023 Date/Ti me Prepared:

		0 12/31/2023	Date/lime Prep 5/28/2024 2:16	
	Cost Center Description	Contract Labor		J PIII
	·	1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	6, 270, 735	12, 390, 234	1.00
2.00	Hospi tal	6, 270, 735	12, 390, 234	2.00
3.00	SUBPROVI DER - I PF	0	0	3.00
4.00	SUBPROVI DER - I RF	0	0	4.00
5.00	Subprovi der - (Other)	0	0	5.00
6. 00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	SKILLED NURSING FACILITY	0	0	8. 00
9.00	NURSING FACILITY	0	0	9. 00
10. 00	OTHER LONG TERM CARE I			10.00
11. 00	Hospi tal -Based HHA	0	0	11. 00
12. 00	AMBULATORY SURGICAL CENTER (D. P.) I	0	0	12.00
13. 00	Hospi tal -Based Hospi ce	0	0	13.00
14. 00	Hospital-Based Health Clinic RHC	0	0	14.00
15. 00	Hospital-Based Health Clinic FQHC	0	0	15.00
16. 00	Hospi tal -Based-CMHC	0	0	16.00
16. 10	Hospi tal -Based-CMHC 10	0	0	16. 10
	RENAL DIALYSIS I	0	0	17.00
18. 00	Other	0	0	18.00

OSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	rovi der CC	CN: 15-0165	Peri od: From 01/01/2023 To 12/31/2023	Worksheet S-1 Parts I & II Date/Time Pre 5/28/2024 2:1	pared:
					1. 00	
	PART I - HOSPITAL AND HOSPITAL COMPLEX DATA					
	Uncompensated and Indigent Care Cost-to-Charge Ratio					
. 00	Cost to charge ratio (see instructions)				0. 200123	1.0
	Medicaid (see instructions for each line)					
. 00	Net revenue from Medicaid				16, 570, 416	
. 00	Did you receive DSH or supplemental payments from Medicaid?					3.0
. 00	If line 3 is yes, does line 2 include all DSH and/or supplementa			ai d?		4. (
. 00	If line 4 is no, then enter DSH and/or supplemental payments fro	om Medicai	d		0	
. 00	Medicaid charges				100, 124, 338	
00	Medicaid cost (line 1 times line 6)		-4!>		20, 037, 183	1
00	Difference between net revenue and costs for Medicaid program (s Children's Health Insurance Program (CHIP) (see instructions for				3, 466, 767	8.
00	Net revenue from stand-alone CHIP	each iiii	=)		0	9.
00	Stand-alone CHIP charges				0	
. 00	Stand-alone CHIP cost (line 1 times line 10)				0	
2. 00	Difference between net revenue and costs for stand-alone CHIP (s	see instru	ctions)		0	1
00	Other state or local government indigent care program (see instr)		
. 00	Net revenue from state or local indigent care program (Not inclu				0	13.
. 00	Charges for patients covered under state or local indigent care				0	1
	10)					
6. 00	State or local indigent care program cost (line 1 times line 14)				0	15.
5. 00	Difference between net revenue and costs for state or local indi				0	16.
	Grants, donations and total unreimbursed cost for Medicaid, CHIP	and state	e/Local indiç	gent care program	ıs (see	
	instructions for each line)		• •			1
7.00	Private grants, donations, or endowment income restricted to fur	0	,		0	1
3. 00 9. 00	Government grants, appropriations or transfers for support of ho Total unreimbursed cost for Medicaid , CHIP and state and local			c (cum of lines	3, 466, 767	
. 00	8, 12 and 16)	rnargent	care programs	s (Suiii OI IIIIeS	3, 400, 707	19.
	12		Uni nsured	Insured	Total (col. 1	
			pati ents	pati ents	+ col . 2)	
			1. 00	2. 00	3. 00	
	Uncompensated care cost (see instructions for each line)					
. 00	Charity care charges and uninsured discounts (see instructions)	_	8, 319, 4		11, 002, 266	1
. 00	Cost of patients approved for charity care and uninsured discour	nts (see	1, 664, 9	16 2, 682, 800	4, 347, 716	21.
00	instructions)	ee oo		0 0	0	22
. 00	Payments received from patients for amounts previously written c charity care	orr as		0 0	0	22.
. 00	Cost of charity care (see instructions)		1, 664, 9	16 2, 682, 800	4, 347, 716	23
. 00	cost of chartty care (see thistractions)		1,004,7	2,002,000	4, 347, 710	25.
					1. 00	
. 00	Does the amount on line 20 col. 2, include charges for patient of	days beyon	d a Length of	f stay limit	N	24.
	imposed on patients covered by Medicaid or other indigent care p					
. 00	If line 24 is yes, enter the charges for patient days beyond the	indigent	care program	m's length of	0	25.
	stay limit	-		-		
. 01	Charges for insured patients' liability (see instructions)				0	
. 00	Bad debt amount (see instructions)				3, 614, 114	
. 00	· · · · · · · · · · · · · · · · · · ·				267, 769	1
7. 01	Medicare allowable bad debts (see instructions)				411, 951	
3. 00	Non-Medicare bad debt amount (see instructions) Cost of non-Medicare and non-reimbursable Medicare bad debt amou				3, 202, 163 785, 008	

29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)
30.00 Cost of uncompensated care (line 23, col. 3, plus line 29)
31.00 Total unreimbursed and uncompensated care cost (line 19 plus line 30)

785, 008 29. 00 5, 132, 724 30. 00 8, 599, 491 31. 00

HOSPI 7	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provi der CC	CN: 15-0165	Peri od:	Worksheet S-10	0
				From 01/01/2023	Parts I & II	
				To 12/31/2023	Date/Time Prep 5/28/2024 2:10	
					0, 20, 2021 211	, p
	F				1. 00	
	PART II - HOSPITAL DATA					4
1. 00	Uncompensated and Indigent Care Cost-to-Charge Ratio Cost to charge ratio (see instructions)				0. 200123	1 00
1.00	Medicaid (see instructions for each line)				0. 200123	1.00
2.00	Net revenue from Medicaid					2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?					3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplement	al payment	s from Medic	ai d?		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments fr	om Medicai	d			5.00
6.00	Medi cai d charges					6.00
7.00	Medicaid cost (line 1 times line 6)					7. 00
8.00	Difference between net revenue and costs for Medicaid program (8.00
	Children's Health Insurance Program (CHIP) (see instructions fo	r each line	e)			4
9.00	Net revenue from stand-alone CHIP					9.00
10.00	Stand-alone CHIP charges					10.00
11. 00 12. 00	Stand-alone CHIP cost (line 1 times line 10) Difference between net revenue and costs for stand-alone CHIP (coo inctru	ctions)			12.00
12.00	Other state or local government indigent care program (see inst			١		12.00
13. 00	Net revenue from state or local indigent care program (Not incl					13.00
14. 00	Charges for patients covered under state or local indigent care					14. 00
	10)	p9 (
15.00	State or local indigent care program cost (line 1 times line 14)				15.00
16.00	Difference between net revenue and costs for state or local ind	igent care	program (se	e instructions)		16. 00
	Grants, donations and total unreimbursed cost for Medicaid, CHI	P and state	e/Local indig	gent care program	ns (see	
47.00	instructions for each line)		• •			17.00
17. 00 18. 00	Private grants, donations, or endowment income restricted to fu	-	,			17. 00 18. 00
19. 00	Government grants, appropriations or transfers for support of h Total unreimbursed cost for Medicaid, CHIP and state and Local			c (sum of lines		19.00
19.00	8, 12 and 16)	That gent	care program	s (suii oi iiiles		19.00
	10, 12 and 10,		Uni nsured	Insured	Total (col. 1	
			pati ents	pati ents	+ col . 2)	
			1. 00	2. 00	3. 00	
	Uncompensated care cost (see instructions for each line)					
20.00	Charity care charges and uninsured discounts (see instructions)		8, 319, 4		11, 002, 266	
21. 00	Cost of patients approved for charity care and uninsured discou instructions)	ints (see	1, 664, 9	16 2, 682, 800	4, 347, 716	21. 00
22. 00	Payments received from patients for amounts previously written	off as		0 0	0	22. 00
22.00	charity care	011 43			O	22.00
23. 00			1, 664, 9	16 2, 682, 800	4, 347, 716	23. 00
	, , , , , , , , , , , , , , , , , , , ,		, ,		., ,	
					1. 00	
24. 00	Does the amount on line 20 col. 2, include charges for patient		d a Length o	f stay limit	N	24. 00
	imposed on patients covered by Medicaid or other indigent care					
25. 00	If line 24 is yes, enter the charges for patient days beyond th	e indigent	care progra	m's length of	0	25. 00
25 24	Stay limit					25 04
25. 01	Charges for insured patients' liability (see instructions)				2 414 114	
26. 00	Bad debt amount (see instructions) Medicare reimbursable bad debts (see instructions)				3, 614, 114 267, 769	1
27. 00	Medicare allowable bad debts (see instructions)				411, 951	1
	Non-Medicare bad debt amount (see instructions)				3, 202, 163	1
	Cost of non-Medicare and non-reimbursable Medicare bad debt amo					29 00

785, 008 29. 00 5, 132, 724 30. 00 5, 132, 724 31. 00

29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)
30.00 Cost of uncompensated care (line 23, col. 3, plus line 29)
31.00 Total unreimbursed and uncompensated care cost (line 19 plus line 30)

	Financial Systems	FRANCI SCAN HEAL		ou 15 o1/5 5		u of Form CMS-2	2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (OF EXPENSES	Provi der CC	CN: 15-0165 F	Period: From 01/01/2023	Worksheet A	
				r	o 12/31/2023	Date/Time Pre	
	Coot Conton Decemintion	Calarias	Othor	Total (asl 1	Dool agai fi agti	5/28/2024 2: 1	6 pm
	Cost Center Description	Sal ari es	0ther	+ col . 2)	Reclassifications (See A-6)	Reclassified Trial Balance	
				1 001. 2)	0113 (300 71 0)	(col . 3 +-	
						col . 4)	
		1.00	2. 00	3. 00	4. 00	5. 00	
1 00	GENERAL SERVI CE COST CENTERS		0		12 121 725	12 121 725	1 00
1. 00 2. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP		0		13, 121, 735 5, 941, 319	13, 121, 735 5, 941, 319	1. 00 2. 00
3.00	00300 OTHER CAP REL COSTS		0		0, 941, 319	5, 941, 319	3.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	419, 301	12, 198, 164	12, 617, 465	250, 242	12, 867, 707	4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	2, 140, 764	37, 325, 243	39, 466, 007	-7, 509, 625	31, 956, 382	5. 00
6.00	00600 MAINTENANCE & REPAIRS	1, 179, 970	11, 030, 156	12, 210, 126	-4, 344, 695	7, 865, 431	6. 00
7.00	00700 OPERATION OF PLANT	0	0	000 044	ή	0	7. 00
8. 00 9. 00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	0 1, 186, 201	308, 241 350, 903	308, 241 1, 537, 104		308, 241 1, 528, 998	8. 00 9. 00
10.00	01000 DI ETARY	1, 007, 068	830, 132			506, 338	10.00
11. 00	01100 CAFETERI A	0	0	1,7007,200		1, 117, 739	11. 00
12.00	01200 MAINTENANCE OF PERSONNEL	0	0	C	0	0	12. 00
13. 00	01300 NURSING ADMINISTRATION	2, 152, 968	489, 855			2, 755, 326	
14. 00	01400 CENTRAL SERVICES & SUPPLY	313, 622	832, 745			841, 364	14.00
15. 00 16. 00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	1, 827, 843 570, 998	3, 476, 243 263, 199			1, 900, 295 834, 196	
17. 00	01700 SOCIAL SERVICE	370, 448	203, 199 0	034, 177		034, 190	17. 00
18. 00	01850 OTHER GEN SERV	o	0		ol ol	0	18. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS	0	0	C	o	0	19. 00
20. 00	02000 NURSI NG PROGRAM	0	0	C	0	0	20. 00
21. 00	02100 &R SERVI CES-SALARY & FRINGES APPRVD	0	0	(0	0	21.00
22. 00 23. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD 02301 PARAMED ED PRGM	0	0			0	22. 00 23. 00
23.00	INPATIENT ROUTINE SERVICE COST CENTERS	l U	U)l Ol	0	23.00
30. 00	03000 ADULTS & PEDIATRICS	13, 148, 314	5, 193, 558	18, 341, 872	-1, 575, 685	16, 766, 187	30.00
31. 00	03100 INTENSIVE CARE UNIT	1, 977, 982	689, 142			2, 289, 416	31. 00
32. 00	03200 CORONARY CARE UNIT	0	0	C	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 PF		0			0	41.00
43. 00	04300 NURSERY		0		ol ol	0	43. 00
44.00	04400 SKILLED NURSING FACILITY	0	0	C	0	0	44. 00
45. 00	04500 NURSING FACILITY	0	0	C	0	0	45. 00
46. 00	04600 OTHER LONG TERM CARE	0	0) 0	0	46. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	4, 072, 777	15, 738, 228	19, 811, 005	-13, 297, 639	6, 513, 366	50.00
51. 00	05100 RECOVERY ROOM	727, 290	91, 552				1
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	52. 00
53. 00	05300 ANESTHESI OLOGY	37, 577	4, 560, 634			4, 396, 997	53. 00
54.00	05400 RADI OLOGY - DI AGNOSTI C	2, 058, 425	2, 768, 519				
55. 00 56. 00	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE	0	0	0		0	55. 00 56. 00
57. 00	05700 CT SCAN	539, 618	1, 142, 381	1, 681, 999	-398, 957	1, 283, 042	57.00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	951, 742	609, 546			1, 106, 766	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	1, 729, 691	2, 015, 636			1, 984, 816	59. 00
60. 00	06000 LABORATORY	0	7, 734, 379	7, 734, 379	-594, 248	7, 140, 131	1
60. 01	06001 BLOOD LABORATORY	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	61. 00 62. 00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.		0			0	63.00
64. 00	06400 I NTRAVENOUS THERAPY	o	0		ol ol	0	64. 00
65. 00	06500 RESPI RATORY THERAPY	1, 542, 937	406, 529	1, 949, 466	-244, 504	1, 704, 962	65. 00
66. 00	06600 PHYSI CAL THERAPY	376, 140	13, 510			383, 492	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	291, 330	1, 422			292, 707	67.00
68. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	109, 265	340	1		109, 605 535, 225	68.00
69. 00 70. 00	07000 ELECTROENCEPHALOGRAPHY	522, 962 365, 013	210, 840 426, 873			434, 257	69. 00 70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	771,000	9, 413, 236	9, 413, 236	71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	C	6, 607, 913	6, 607, 913	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	C	4, 475, 054	4, 475, 054	73. 00
74.00	07400 RENAL DIALYSIS	0	0	(0	0	74.00
75. 00	07500 ASC (NON-DISTINCT PART)	0	0			0	75.00
76. 00 76. 01	03950 OTHER ANCILL SRVC 03951 CARDI AC AND PULMONARY REHAB	420, 891	10, 490	431, 381	-3, 963	0 427, 418	76. 00 76. 01
76. 01	03952 WOUND CARE	120,071	10, 470	431,301	0, 703	427, 410	76. 01
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION		0		ol ol	0	77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	(0	0	78. 00
00 -:	OUTPATIENT SERVICE COST CENTERS	.1					00 5-
88. 00 89. 00	08800 RURAL HEALTH CLINIC	0	0			0	88.00
07.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	١	U	1 (^기	0	89. 00

Hearth Frhancial Systems	FRANCI SCAN HEAD	LIH WUNSIEK		III LI e	U OT FORM CWS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider CO		eri od:	Worksheet A	
				rom 01/01/2023	D-+- /T: D	
			T	o 12/31/2023	Date/Time Pre 5/28/2024 2:1	
Cost Center Description	Sal ari es	Other	Total (col 1	Recl assi fi cati		O PIII
cost center bescriptron	Sararres	Other	+ col . 2)	ons (See A-6)		
			1 (01. 2)	0113 (3CC A 0)	(col. 3 +-	
					col . 4)	
	1.00	2. 00	3. 00	4. 00	5. 00	
90. 00 09000 CLI NI C	0	0				90. 00
90. 01 09001 CLINIC	1, 890, 838	1, 451, 551	3, 342, 389	-1, 187, 576	2, 154, 813	
90. 02 09002 CLI NI C	210, 696	252, 813				
91. 00 09100 EMERGENCY	3, 976, 557	3, 355, 077				1
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		2, 222, 211	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	.,,	-, ,	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	Ö		0	95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	o	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 o	0	١	0	0	98.00
99. 00 09900 CMHC	o o	0	0	0	0	99.00
99. 10 09910 CORF	o o	0	١	0	0	
100.00 10000 I &R SERVI CES-NOT APPRVD PRGM	o o	0	١	0	_	100.00
101. 00 10100 HOME HEALTH AGENCY	o o	0	Ö	0		101.00
102. 00 10200 OPI OI D TREATMENT PROGRAM		0	Ö	_		102.00
SPECIAL PURPOSE COST CENTERS	<u>ا</u>	J		J		102.00
105. 00 10500 KI DNEY ACQUI SI TI ON	0	0	0	0	0	105. 00
106. 00 10600 HEART ACQUI SI TI ON	o	0		_		106. 00
107. 00 10700 LI VER ACQUI SI TI ON	o	0	0	0		107. 00
108. 00 10800 LUNG ACQUISITION	o	0	0	0		108. 00
109. 00 10900 PANCREAS ACQUISITION	o	0	0	0		109. 00
110. 00 11000 NTESTI NAL ACQUI SI TI ON	o	0	0	0		110.00
111. 00 11100 SLET ACQUISITION		0	١	0		111.00
113. 00 11300 NTEREST EXPENSE		0	١	0		113.00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF		0	١	0		114. 00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)		0	١	0		115. 00
116. 00 11600 HOSPI CE		0		0		116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	45, 748, 780	113, 777, 901	159, 526, 681	384, 817		
NONREI MBURSABLE COST CENTERS	43, 740, 700	113,777,701	137, 320, 001	304, 017	137, 711, 470	1110.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	42, 971	66, 088	109, 059	0	109, 059	190 00
191. 00 19100 RESEARCH	59, 045	127			59, 172	
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	2, 092, 081	538, 382	,			
192. 01 19201 CENTER OF HOPE	89, 575	462				
192. 02 19202 OTHER FA FACILITIES NRCC	549, 994	134, 695				
193. 00 19300 NONPALD WORKERS	377, 774	134, 073				193. 00
194. 00 07950 OTHER NRCC	86, 170	113	_	-		
200.00 TOTAL (SUM OF LINES 118 through 199)	48, 668, 616	114, 517, 768				
200.00 TOTAL (SOM OF LINES THE CHIROUGH 177)	40, 000, 010	114, 517, 700	100, 100, 304	١	100, 100, 304	1200.00

Health Financial Systems	FRANCI SCAN HE	ALTH MUNSTER		In Lie	u of Form CMS	-2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE		Provi der CCN:	: 15-0165	Peri od:	Worksheet A	
				From 01/01/2023 To 12/31/2023	Date/Time Pr	epared:
					5/28/2024 2:	16 pm
Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation				
	6.00	7.00				
GENERAL SERVICE COST CENTERS						
1.00 00100 CAP REL COSTS-BLDG & FIXT 2.00 00200 CAP REL COSTS-MVBLE EQUIP	1, 058, 115 0	1				1. 00 2. 00
3.00 00300 OTHER CAP REL COSTS						3.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT	390, 682	1				4. 00
5.00 00500 ADMINISTRATIVE & GENERAL	-12, 548, 237	19, 408, 145				5. 00
6.00 00600 MAINTENANCE & REPAIRS	177					6. 00
7. 00 00700 OPERATION OF PLANT	0	1				7.00
8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG	-36					8. 00 9. 00
10. 00 01000 DI ETARY	-30	506, 338				10.00
11. 00 01100 CAFETERI A	-357, 540	1				11. 00
12.00 01200 MAINTENANCE OF PERSONNEL	0	0				12. 00
13. 00 01300 NURSI NG ADMINI STRATI ON	-96, 633	1				13. 00
14. 00 01400 CENTRAL SERVI CES & SUPPLY 15. 00 01500 PHARMACY	-813, 462					14. 00 15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	212, 707 1, 017, 359	1				16. 00
17. 00 01700 SOCI AL SERVI CE	0	0				17. 00
18.00 01850 OTHER GEN SERV	0	0				18. 00
19. 00 01900 NONPHYSICIAN ANESTHETISTS	0	0				19. 00
20. 00 02000 NURSI NG PROGRAM	0	0				20.00
21. 00 02100 I &R SERVI CES-SALARY & FRI NGES APPRVD 22. 00 02200 I &R SERVI CES-OTHER PRGM COSTS APPRVD	0					21. 00 22. 00
23. 00 02301 PARAMED ED PRGM		1				23. 00
INPATIENT ROUTINE SERVICE COST CENTERS		' '				
30. 00 03000 ADULTS & PEDIATRICS	-4, 374, 866					30. 00
31. 00 03100 INTENSIVE CARE UNIT	0					31.00
32.00 03200 CORONARY CARE UNIT 33.00 03300 BURN INTENSIVE CARE UNIT	0	0				32. 00 33. 00
34. 00 03400 SURGI CAL INTENSIVE CARE UNIT						34.00
40. 00 04000 SUBPROVI DER - 1 PF	0	o o				40. 00
41. 00 04100 SUBPROVI DER - I RF	0	0				41. 00
43. 00 04300 NURSERY	0	0				43. 00
44.00 04400 SKILLED NURSING FACILITY 45.00 04500 NURSING FACILITY	0	-1				44. 00 45. 00
46. 00 O4600 OTHER LONG TERM CARE		1				46.00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	-1, 494, 498	1				50.00
51. 00 05100 RECOVERY ROOM 52. 00 05200 DELIVERY ROOM & LABOR ROOM	0					51. 00 52. 00
53. 00 05300 ANESTHESI OLOGY	-4, 354, 643					53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	-1, 081	1				54. 00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	o				55. 00
56. 00 05600 RADI 01 SOTOPE	0	1				56. 00
57.00 05700 CT SCAN 58.00 05800 MAGNETIC RESONANCE MAGING (MRI)	-2, 337	1, 283, 042 1, 104, 429				57. 00 58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	-2, 111	1				59.00
60. 00 06000 LABORATORY	0	1				60.00
60. 01 06001 BLOOD LABORATORY	0	0				60. 01
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0				61. 00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0					62. 00 63. 00
64. 00 06400 NTRAVENOUS THERAPY						64. 00
65. 00 06500 RESPIRATORY THERAPY	-23, 692	1, 681, 270				65. 00
66. 00 06600 PHYSI CAL THERAPY	0	383, 492				66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	292, 707				67. 00
68. 00 06800 SPEECH PATHOLOGY	0	109, 605				68. 00
69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY	-14, 551					69. 00 70. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	9, 413, 236				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	6, 607, 913				72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	4, 475, 054				73. 00
74. 00 07400 RENAL DIALYSIS	0					74.00
75. 00 07500 ASC (NON-DISTINCT PART) 76. 00 03950 OTHER ANCILL SRVC						75. 00 76. 00
76. 00 03930 OTHER ANCITE SAVE	-50	-				76. 00
76. 02 03952 WOUND CARE	0					76. 02
77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	1				77. 00
78. 00 07800 CAR T-CELL IMMUNOTHERAPY	0	0				78. 00
0UTPATIENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC	0	0				88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	1				89.00
90. 00 09000 CLI NI C	0	o				90.00
90. 01 09001 CLI NI C	-955	2, 153, 858				90. 01

Peri od: Worksheet A From 01/01/2023 To 12/31/2023 Date/Time Prepared:

			5/28/2024 2:	
Cost Center Description	Adjustments	Net Expenses		
	(See A-8)	For Allocation		
	6. 00	7. 00		
90. 02 09002 CLI NI C	-309	242, 996		90. 02
91. 00 09100 EMERGENCY	-998, 026	4, 943, 164		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 SERVI CES	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	0		101. 00
102.00 10200 OPIOLD TREATMENT PROGRAM	0	0		102. 00
SPECIAL PURPOSE COST CENTERS				
105. 00 10500 KIDNEY ACQUISITION	0	0		105. 00
106. 00 10600 HEART ACQUI SI TI ON	0	0		106. 00
107. 00 10700 LIVER ACQUISITION	0	0		107. 00
108.00 10800 LUNG ACQUISITION	0	0		108. 00
109.00 10900 PANCREAS ACQUISITION	0	0		109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0		110. 00
111.00 11100 I SLET ACQUI SI TI ON	0	0		111. 00
113.00 11300 INTEREST EXPENSE	0	0		113. 00
114.00 11400 UTI LI ZATI ON REVI EW-SNF	0	0		114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0		115. 00
116. 00 11600 H0SPI CE	0	0		116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	-22, 403, 987	137, 507, 511		118. 00
NONRE MBURSABLE COST CENTERS				
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	109, 059		190. 00
191. 00 19100 RESEARCH	0	59, 172		191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	-904, 528			192. 00
192. 01 19201 CENTER OF HOPE	0	89, 626		192. 01
192. 02 19202 OTHER FA FACILITIES NRCC	-4, 350			192. 02
193. 00 19300 NONPALD WORKERS	0	0		193. 00
194. 00 07950 OTHER NRCC	0	86, 283		194. 00
200.00 TOTAL (SUM OF LINES 118 through 199)	-23, 312, 865	139, 873, 519		200. 00

Health Financial Systems RECLASSIFICATIONS In Lieu of Form CMS-2552-10
Worksheet A-6 Peri od: Worksheet A-6 From 01/01/2023 To 12/31/2023 Date/Time Prepared: Provider CCN: 15-0165

Can Control						/2024 2:16 pm
Company Comp						
A CAPTIAL INSURANCE 1 00						
1.00			3.00	4.00	5.00	
2.00	1. 00		1.00	0	278, 932	1.00
1.00 20.00		•		0	97, 658	
1.00					376, 590	
2.00 CAP REL COSTS-MARLE EQUI P 2.00 0 1,330,740 3,900 R43 3,900 R						
1.00		•				1
IGNATS		CAP REL COSTS-MVBLE EQUIP				
DRINKS	3.00	TOTALS				3.00
2.00 RURS CHARGED TO PATIENTS 73.00 0 4.475,054 2.00 3.00 4.00 4.75,054 7.00 4.0					0,702,010	
3.00 4.00 5.00 6.00 6.00 6.00 6.00 6.00 6.00 6	1.00	CENTRAL SERVICES & SUPPLY		0	,	1. 00
4.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00		DRUGS CHARGED TO PATIENTS				
5.00			l l			
6.00 7.00 8.00 9.00 9.00 9.00 9.00 9.00 9.00 9			l l			
7. 00 9. 00						
8.00 9.00 10				-		
10.00	8.00		0.00	0		8. 00
11.00				-		l l
12.00						
13.00				-		
14. 00 0. 00 0. 00 0. 00 15. 00 16.						
15.00						
16. 00						
D - MED SUPPLIES AND IMPANTS 1,00 PATTENTS 71,00 O 9,413,236 PATTENTS 2,00 PATTENTS 0,00 O O O O O PATTENTS 0,00 O O O PATTENTS 0,00 O O O O PATTENTS 0,00 O PATTENTS 0,00 O O PATTENTS 0,00 O O PATTENTS 0,00 O O PATTENTS 0,00 O						
1.00 NEDICAL SUPPLIES CHARGED TO					4, 484, 316	
PATI ENTS						
2. 00 MPL. DEV. CHARGED TO 72. 00 0 6, 607, 913 2. 00 ATTENTS 0. 00 0. 0 0. 0 ATTENTS 0. 00 0. 0 0. 0 ATTENTS 0. 00 0. 00 0. 00 ATTENTS 0. 00 0. 00 0. 00 ATTENTS 0. 00 ATTENTS 0. 00 ATTENTS 0. 00 0. 0	1.00		/1.00	0	9, 413, 236	1.00
PATIENTS	2 00		72 00	0	6 607 913	2.00
3.00 0.	2.00		72.00	O	0,007,713	2.00
S. 00	3.00		0.00	0	0	3. 00
6. 00 7. 00 8. 00 9. 00 10. 00 10. 00 11. 00 11. 00 12. 00 13. 00 14. 00 15. 00 17. 00 18. 00 19. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 11. 00			l l	0		4. 00
7. 00 8. 00 9. 00 10. 00 11. 0			l l			i i
8. 00 9. 00 0. 0						i i
9.00 0.00 0.00 0.00 0.00 10.00 11.00 11.00 12.00 13.00 13.00 14.00 15.00 15.00 15.00 15.00 16.00 17.00 16.00 17.00 18.00 19.						i i
10.00						
11.00			l l			•
13.00	11. 00		0.00	0		11. 00
14. 00						
15. 00			l l			
16. 00 17. 00 18. 00 0. 00 0. 00 0. 00 17. 00 18. 00 19. 00 0. 00 0. 00 0. 00 0. 00 0. 00 19. 00 0. 00			l l			
17. 00						
18. 00 19. 00 20. 00 0 0 0 0 0 0 0 0						
19, 00 20, 00 2				0		18. 00
1.00	19. 00			0		19. 00
TOTALS						
1.00	21. 00	TOTALS				21.00
1. 00 CAP REL COSTS-BLDG & FIXT					10,021,149	
3. 00 NURSI NG ADMI NI STRATI ON 13. 00 0 112, 505 3. 00 4. 00 5. 00 6. 00 0 0 0 0 5. 00 6. 00 7. 00 8. 00 7. 00 8. 00 9. 00 0 0 0 0 0 0 0 0 0	1.00	CAP REL COSTS-BLDG & FIXT		0	6, 809, 071	
4.00 0.00 0 0 4.00 5.00 0.00 0 0 5.00 6.00 0.00 0 0 6.00 7.00 0.00 0 0 0 8.00 0.00 0 0 0 8.00 9.00 0.00 0 0 0 9.00 10.00 0.00 0 0 0 10.00 11.00 0.00 0 0 0 11.00 12.00 0.00 0 0 0 12.00 13.00 0.00 0 0 0 12.00 14.00 0.00 0 0 0 14.00 15.00 0.00 0 0 0 15.00 16.00 0.00 0 0 0 17.00 18.00 0.00 0 0 0 19.00 20.00 0.00 0 0 0 0				0		
5. 00 0. 00 0 0 5. 00 6. 00 0. 00 0 0 6. 00 7. 00 0. 00 0 0 7. 00 8. 00 0. 00 0 0 8. 00 9. 00 0. 00 0 0 9. 00 10. 00 0. 00 0 0 10. 00 11. 00 0. 00 0 0 11. 00 12. 00 0. 00 0 0 12. 00 13. 00 0. 00 0 0 13. 00 14. 00 0. 00 0 0 14. 00 15. 00 0. 00 0 0 15. 00 16. 00 0. 00 0 0 17. 00 18. 00 0. 00 0 0 0 18. 00 19. 00 0. 00 0 0 0 19. 00 20. 00		NURSING ADMINISTRATION				1
6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 17.00 18.00 18.00 19.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 11.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 18.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00						1
7.00 0.00 0 0 7.00 8.00 0.00 0 0 8.00 9.00 0.00 0 0 9.00 10.00 0.00 0 0 10.00 11.00 0.00 0 0 11.00 12.00 0.00 0 0 12.00 13.00 0.00 0 0 13.00 14.00 0.00 0 0 14.00 15.00 0.00 0 0 15.00 16.00 0.00 0 0 16.00 17.00 0.00 0 0 17.00 18.00 0.00 0 0 0 18.00 19.00 0.00 0 0 0 19.00 20.00 0.00 0 0 0 0						1
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21.00 0.00 0 0 21.00						· ·
	21.00	1	0.00	0	0	21.00

Health Financial Systems RECLASSIFICATIONS Provider CCN: 15-0165

					10	5/28/2024 2:16 pm
		Increases			<u> </u>	 57 207 202 1 2 1 1 0 pin
	Cost Center	Li ne #	Sal ary	0ther		
	2. 00	3. 00	4. 00	5. 00		
22. 00		0.00	0	0		22. 00
23. 00		0.00	0	0		23. 00
24. 00		0.00	0	0		24. 00
25. 00		0.00	0	0		25. 00
26. 00		0.00	0	0		26.00
27. 00		0.00	0	0		27. 00
28. 00	TOTALS — — — —	0.00	0	0 11, 213, 661		28. 00
	F - CAFETERIA		<u> </u>	11, 213, 001		
1.00	CAFETERI A	11. 00	693, 095	424, 644		1.00
1.00	TOTALS		693, 095	424, 644		1.00
	G - BENEFITS		0,0,0,0	12.701.1		
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	20, 195		1. 00
2.00	ADMINISTRATIVE & GENERAL	5.00	O	1, 613		2. 00
3.00		0.00	O	0		3.00
4.00		0.00	O	0		4. 00
5.00		0.00	0	0		5. 00
6.00		0.00	0	0		6. 00
7.00		0.00	0	0		7. 00
8.00		0.00	0	0		8. 00
9.00		0.00	0	0		9. 00
10.00		0.00	0	0		10.00
11. 00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14. 00 15. 00		0. 00 0. 00	0	0		14. 00 15. 00
16. 00		0.00	ol	0		16. 00
17. 00		0.00	0	0		17. 00
18. 00		0.00	o	o		18. 00
19. 00		0.00	Ö	ő		19. 00
20. 00		0.00	o	Ö		20.00
21. 00		0.00	o	Ö		21. 00
22. 00		0.00	o	0		22.00
23.00		0.00	o	0		23. 00
24.00		0.00	O	0		24. 00
25.00		0.00	0	0		25. 00
26.00		0.00	0	0		26. 00
27. 00		0.00	0	0		27. 00
28. 00		0.00	0	0		28. 00
29. 00		0.00	0	0		29. 00
30.00		0.00	0	0		30.00
31.00		0.00	0	0		31.00
32. 00	TOTAL C — — — —	0.00	0	0		32. 00
	TOTALS H - CAPITAL LEASE		<u> </u>	21, 808		
1.00	CAP REL COSTS-BLDG & FIXT	1.00	O	1, 661, 629		1.00
2.00	CAP REL COSTS-BLDG & TTAT	2.00	0	20, 836		2. 00
3.00	WILL GOOTS WINDEL EQUIP	0.00	o	20, 830		3.00
4. 00		0.00	o	o		4. 00
5. 00		0.00	Ö	ő		5. 00
6. 00		0.00	Ö	0		6. 00
7. 00		0.00	Ö	0		7. 00
8.00		0.00	o	0		8. 00
9.00		0.00	O	0		9. 00
10.00		0.00	O	0		10.00
11. 00		0.00	0	0		11. 00
12.00		0.00	0	0		12. 00
13.00		0.00	0	0		13. 00
14.00		0.00	0_	0		14. 00
	TOTALS		0	1, 682, 465		
4.60	I - WORKING WELL		462 22:	eel		
1. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	199, 886	<u>56, 462</u>		1.00
500 00	TOTALS Grand Total: Increases		199, 886 892, 981	56, 462 40, 183, 938		500. 00
500.00	orana rotar. THEFEASES	I	072, 701	40, 103, 738		500.00

| Peri od: | Worksheet A-6 | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: 5/28/2024 2:16 pm

						5/28/2024 2:	16 pm
		Decreases					
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
	A - CAPITAL INSURANCE		-1				
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	376, 590			1.00
2. 00			•	0			2. 00
	TOTALS		0	376, 590			
1 00	B - CAPITAL INTEREST	F 00	٥	F 77/ 201	11		1 00
1.00	ADMINISTRATIVE & GENERAL	5.00	0	5, 776, 301	11		1.00
2. 00 3. 00	MAINTENANCE & REPAIRS CT SCAN	6.00	0	126, 505 37			2. 00
3.00	TOTALS	<u>57.</u> 00		5, 902, 843			3.00
	C - DRUGS		<u> </u>	3, 902, 643			
1.00	PHARMACY	15. 00	0	3, 318, 106	0		1.00
2. 00	ADULTS & PEDIATRICS	30.00	0	58, 929	1		2. 00
3.00	INTENSIVE CARE UNIT	31.00	o	20, 215	1		3. 00
4. 00	OPERATING ROOM	50.00	o	45, 668	1		4. 00
5. 00	RECOVERY ROOM	51.00	Ö	671	o		5. 00
6. 00	ANESTHESI OLOGY	53.00	o	28, 461	o		6. 00
7. 00	RADI OLOGY-DI AGNOSTI C	54.00	o	520, 732	· ·		7. 00
8.00	CT SCAN	57.00	0	1, 652	l 1		8. 00
9.00	MAGNETIC RESONANCE IMAGING	58.00	0	1, 282	o		9. 00
	(MRI)						
10.00	CARDIAC CATHETERIZATION	59.00	0	4, 861	0		10.00
11. 00	RESPI RATORY THERAPY	65. 00	0	2, 618	l 1		11. 00
12.00	ELECTROCARDI OLOGY	69. 00	0	28	l !		12. 00
13.00	CARDIAC AND PULMONARY REHAB	76. 01	0	266	0		13. 00
14. 00	CLINIC	90. 01	0	451, 615	l 1		14. 00
15. 00	CLINIC	90. 02	0	3, 166			15. 00
16. 00	EMERGENCY	91.00	•	26, 046			16. 00
	TOTALS		0	4, 484, 316			_
4 00	D - MED SUPPLIES AND IMPANTS	44.00		70.005			4 00
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	72, 025	l 1		1.00
2.00	PHARMACY ADULTS & PEDIATRICS	15. 00 30. 00	0	13, 816	l 1		2.00
3. 00 4. 00	INTENSIVE CARE UNIT	31.00	0	605, 462	· ·		3. 00 4. 00
5. 00	OPERATING ROOM	50.00	0	210, 065 11, 702, 241	0		5. 00
6. 00	RECOVERY ROOM	51. 00	0	29, 561	0		6. 00
7. 00	ANESTHESI OLOGY	53.00	0	139, 721	0		7. 00
8. 00	RADI OLOGY-DI AGNOSTI C	54.00	o	52, 083	0		8. 00
9. 00	CT SCAN	57. 00	o	166, 079			9. 00
10. 00	MAGNETIC RESONANCE I MAGING	58.00	0	262, 424	l 1		10.00
10.00	(MRI)	55. 55		202, 121			10.00
11. 00	CARDIAC CATHETERIZATION	59. 00	0	1, 415, 907	0		11.00
12.00	LABORATORY	60.00	О	512, 447	o		12. 00
13.00	RESPIRATORY THERAPY	65.00	О	162, 888	0		13. 00
14.00	PHYSI CAL THERAPY	66.00	0	29	0		14. 00
15.00	OCCUPATI ONAL THERAPY	67.00	0	45	0		15. 00
16.00	ELECTROCARDI OLOGY	69.00	0	33, 196	0		16. 00
17. 00	ELECTROENCEPHALOGRAPHY	70. 00	0	39, 887	0		17. 00
18. 00	CARDIAC AND PULMONARY REHAB	76. 01	0	913	l .		18. 00
19. 00	CLINIC	90. 01	0	21, 853			19. 00
20.00	CLINIC	90. 02	0	39, 608			20. 00
21. 00	EMERGENCY	<u>91.</u> 00	•	540, 899			21. 00
	TOTALS		0	16, 021, 149			
1 00	E - DEPRECIATION	. 00	اء	4 050			1 00
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1, 352	l 1		1.00
2. 00 3. 00	ADMINISTRATIVE & GENERAL	5. 00 6. 00	0	1, 267, 070			2. 00
3.00 4.00	MAINTENANCE & REPAIRS	6. 00 9. 00	0	3, 913, 593			4. 00
4. 00 5. 00	HOUSEKEEPI NG DI ETARY	10. 00	0	8, 105 212, 705	l 1		5. 00
6. 00	CENTRAL SERVICES & SUPPLY	14. 00	0	242, 240	1		6. 00
7. 00	PHARMACY	15. 00	0	242, 240 27, 107	1		7. 00
8. 00	ADULTS & PEDIATRICS	30.00	Ö	909, 213	1		8. 00
9. 00	INTENSIVE CARE UNIT	31.00	o	147, 425	l 1		9. 00
10. 00	OPERATING ROOM	50.00	Ö	1, 079, 692	l 1		10.00
11. 00	RECOVERY ROOM	51.00	o	17, 584	l 1		11. 00
12. 00	ANESTHESI OLOGY	53.00	Ö	33, 032	l .		12. 00
13. 00	RADI OLOGY-DI AGNOSTI C	54.00	Ö	726, 491	1		13. 00
14. 00	CT SCAN	57. 00	o	205, 707	l .		14. 00
15.00	MAGNETIC RESONANCE IMAGING	58.00	0	165, 334	l 1		15. 00
	(MRI)						
16.00	CARDÍAC CATHETERIZATION	59. 00	O	339, 741			16. 00
17. 00	LABORATORY	60.00	0	81, 801	0		17. 00
18. 00	RESPIRATORY THERAPY	65. 00	0	78, 997			18. 00
19. 00	PHYSI CAL THERAPY	66.00	0	6, 128			19. 00
20. 00	ELECTROCARDI OLOGY	69. 00	0	165, 352	0		20. 00

Health Financial Systems RECLASSIFICATIONS Period: Worksheet A-6
From 01/01/2023
To 12/31/2023 Date/Time Prepared: 5/28/2024 2:16 pm Provider CCN: 15-0165

					Ι'	0 12/31/2023	5/28/2024 2:16 pm
		Decreases		,	'		
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7.00	8. 00	9. 00	10. 00		
21. 00	ELECTROENCEPHALOGRAPHY	70. 00	0	25, 118			21.00
22. 00	CARDIAC AND PULMONARY REHAB	76. 01	0	2, 784	0		22. 00
23. 00	CLINIC	90. 01	0	714, 105			23. 00
24. 00	CLINIC	90. 02	0	9, 424	0		24. 00
25. 00	EMERGENCY	91.00	0	820, 658	0		25. 00
26. 00	PHYSICIANS' PRIVATE OFFICES	192.00	0	12, 379			26. 00
27. 00	CENTER OF HOPE	192. 01	0	411	0		27. 00
28. 00	OTHER FA FACILITIES NRCC	192.02	•	113			28. 00
	TOTALS		0	11, 213, 661			
	F - CAFETERIA	40.00	(00 005				
1. 00	DI ETARY	10.00	693, 095	424,644			1.00
	TOTALS		693, 095	424, 644			
1 00	G - BENEFITS	4 00	ما	ຳ	0		1 00
1.00	MAINTENANCE & REPAIRS	6. 00 9. 00	0	2	0		1.00
2.00	HOUSEKEEPI NG DI ETARY		0	1	0		2.00
3.00	l I	10. 00 13. 00	0	1	0		3.00
4.00	NURSING ADMINISTRATION		0	0			4.00
5. 00 6. 00	CENTRAL SERVICES & SUPPLY PHARMACY	14. 00 15. 00	0	0	0		5. 00
7. 00	MEDICAL RECORDS & LIBRARY	16. 00	0	1	0		6. 00 7. 00
8. 00	ADULTS & PEDIATRICS	30.00	0	0	0		8.00
9. 00	INTENSIVE CARE UNIT	31.00	0	7	0		9. 00
10. 00	OPERATING ROOM	50.00	0	3	0		10.00
11. 00	RECOVERY ROOM	51.00	0	7	0		11. 00
12. 00	ANESTHESI OLOGY	53.00	0	0	0		12. 00
13. 00	RADI OLOGY-DI AGNOSTI C	54.00	0	14, 683			13. 00
14. 00	CT SCAN	57. 00	0	14, 003	0		14. 00
15. 00	MAGNETIC RESONANCE I MAGING	58.00	0	1	0		15. 00
10.00	(MRI)	00.00	Ĭ		J		10.00
16. 00	CARDIAC CATHETERIZATION	59.00	o	2	0		16. 00
17. 00	RESPI RATORY THERAPY	65.00	o	_ 1	0		17. 00
18. 00	PHYSI CAL THERAPY	66.00	o	1	0		18. 00
19. 00	OCCUPATI ONAL THERAPY	67.00	o	0	0		19. 00
20. 00	SPEECH PATHOLOGY	68.00	o	0	0		20. 00
21. 00	ELECTROCARDI OLOGY	69.00	0	1	0		21. 00
22. 00	ELECTROENCEPHALOGRAPHY	70.00	0	4, 285	0		22. 00
23. 00	CARDIAC AND PULMONARY REHAB	76. 01	o	. 0	0		23. 00
24. 00	CLINIC	90. 01	o	3	0		24. 00
25. 00	CLINIC	90. 02	0	0	0		25. 00
26. 00	EMERGENCY	91.00	0	2, 801	0		26. 00
27. 00	GIFT, FLOWER, COFFEE SHOP &	190.00	0	0	0		27. 00
	CANTEEN						
28.00	RESEARCH	191. 00	0	0	0		28. 00
29.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	1	0		29. 00
30.00	CENTER OF HOPE	192. 01	0	0	0		30.00
31.00	OTHER FA FACILITIES NRCC	192. 02	0	1	0		31.00
32.00	OTHER NRCC	194. 00	0	0	0		32.00
	TOTALS		0	21, 808			
	H - CAPITAL LEASE						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	24, 949			1.00
2.00	ADMINISTRATIVE & GENERAL	5. 00	0	91, 277			2. 00
3.00	MAINTENANCE & REPAIRS	6.00	0	304, 595			3. 00
4.00	DI ETARY	10. 00	0	417	0		4. 00
5.00	PHARMACY	15. 00	0	44, 760			5. 00
6. 00	ADULTS & PEDIATRICS	30.00	0	2, 072			6. 00
7. 00	OPERATING ROOM	50.00	0	470, 034			7. 00
8.00	RADI OLOGY-DI AGNOSTI C	54.00	0	121, 450			8. 00
9.00	CT SCAN	57.00	0	25, 481	0		9. 00
10.00	MAGNETIC RESONANCE IMAGING	58. 00	0	25, 481	0		10.00
14 00	(MRI)		_	000 05-	_		
11. 00	ELECTROENCEPHALOGRAPHY	70.00	0	288, 339			11.00
12.00	CLINIC	90. 02	0	168, 006			12.00
13.00	EMERGENCY	91.00	0	40			13. 00
14. 00	PHYSICIANS' PRIVATE OFFICES	192.00		115,564			14. 00
	TOTALS		0	1, 682, 465			
1 00	I - WORKING WELL	400.00	400.001	F/ 4/2			
1. 00	PHYSICIANS' PRIVATE OFFICES	192.00	199, 886	<u>56, 462</u>			1. 00
E00 00	TOTALS Grand Total: Decreases		199, 886	56, 462 40, 183, 938			E00.00
300.00	pranu rotar: Decreases	l l	892, 981	40, 183, 938			500.00

					From 01/01/2023 To 12/31/2023	Date/Time Pre	
				Acqui si ti ons		5/28/2024 2:1	o pili
		Begi nni ng	Purchases	Donati on	Total	Disposals and	
		Bal ances	. u. onasos	5011411 011	10 (4)	Retirements	
		1.00	2.00	3.00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	F BALANCES					
1.00	Land	12, 513, 724	22, 410		22, 410	0	1. 00
2.00	Land Improvements	2, 720, 511	0		0 0	0	2. 00
3.00	Buildings and Fixtures	95, 600, 677	7, 234, 724	(7, 234, 724	0	3. 00
4.00	Building Improvements	5, 029, 669	0		0	0	4. 00
5.00	Fi xed Equipment	59, 707, 367	266, 317		266, 317	0	5. 00
6.00	Movable Equipment	63, 397, 243	5, 358, 836		5, 358, 836	0	6. 00
7. 00	HIT designated Assets	0	0		0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	238, 969, 191	12, 882, 287		12, 882, 287	0	8. 00
9.00	Reconciling Items	2, 271, 850	6, 177, 692		0 6, 177, 692	0	9. 00
10.00	Total (line 8 minus line 9)	236, 697, 341	6, 704, 595	(6, 704, 595	0	10.00
		Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
		6.00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET		_				
1.00	Land	12, 536, 134	0				1.00
2.00	Land Improvements	2, 720, 511	0				2. 00
3.00	Buildings and Fixtures	102, 835, 401	0				3. 00
4.00	Building Improvements	5, 029, 669	0				4. 00
5.00	Fi xed Equipment	59, 973, 684	0				5. 00
6.00	Movable Equipment	68, 756, 079	0				6. 00
7.00	HIT designated Assets	0	0				7. 00
8.00	Subtotal (sum of lines 1-7)	251, 851, 478	0				8. 00
9.00	Reconciling Items	8, 449, 542	0				9. 00
10. 00	Total (line 8 minus line 9)	243, 401, 936	0				10. 00

Heal th	Financial Systems	FRANCISCAN HEA	ALTH MUNSTER		In Lie	u of Form CMS-2	2552-10
RECONC	ILIATION OF CAPITAL COSTS CENTERS		Provi der Co	CN: 15-0165	Peri od:	Worksheet A-7	
					From 01/01/2023 To 12/31/2023		nared·
					10 12/01/2020	5/28/2024 2:1	6 pm
			Sl	JMMARY OF CAP	I TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see		
		0.00	40.00	44.00	instructions)		
	DART LL BESSHOLLLATION OF AMOUNTS FROM WORK	9.00	10.00	11.00	12. 00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1 a	nd 2			
1. 00	CAP REL COSTS-BLDG & FLXT	0	0		0 0	0	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		0	0	2. 00
3.00	Total (sum of lines 1-2)	0	0		0 0	0	3. 00
		SUMMARY O	F CAPITAL				
	Cost Center Description	0ther	Total (1) (sum				
		Capi tal -Relate	of cols. 9				
		d Costs (see	through 14)				
		instructions)	ů ,				
		14. 00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A. COLUM	N 2. LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FLXT	0					1. 00
2. 00	CAP REL COSTS-MVBLE EQUIP	0	0				2. 00
3. 00	Total (sum of lines 1-2)	0	0				3. 00
5.00	Trotal (Sum of Trilos 1 2)	١	0	ı			0.00

Heal th	Financial Systems	FRANCI SCAN HEA	ALTH MUNSTER		In Lie	u of Form CMS-2	2552-10
RECONG	CILIATION OF CAPITAL COSTS CENTERS		Provi der Co		Peri od: From 01/01/2023 To 12/31/2023	Worksheet A-7 Part III Date/Time Prep 5/28/2024 2:16	
		COM	PUTATION OF RAT	TIOS	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets		Insurance	
			Leases	for Ratio	instructions)		
				2)			
		1.00	2.00	3.00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE			,			
1.00	CAP REL COSTS-BLDG & FLXT	183, 095, 398	0	183, 095, 39		0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	68, 756, 080					2.00
3.00	Total (sum of lines 1-2)	251, 851, 478					3. 00
		ALLOCA'	TION OF OTHER (CAPI TAL	SUMMARY C	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	
	PART III - RECONCILIATION OF CAPITAL COSTS CE						
1.00	CAP REL COSTS-BLDG & FLXT	0	1	1	0 7, 867, 186		1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1)	0 4, 292, 085		2.00
3.00	Total (sum of lines 1-2)	0			0 12, 159, 271	1, 682, 465	3. 00
				JMMARY OF CAPI			
	Cost Center Description	Interest	Insurance (see			Total (2) (sum	
			instructions)	instructions)	Capi tal -Rel ate		
					d Costs (see	through 14)	
					instructions)		
		11. 00	12. 00	13. 00	14. 00	15. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE						
1.00	CAP REL COSTS-BLDG & FIXT	4, 372, 103		•	0	14, 179, 850	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	1, 530, 740		1	0		2. 00
3.00	Total (sum of lines 1-2)	5, 902, 843	376, 590)	0 0	20, 121, 169	3. 00

| Period: | Worksheet A-8 | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: Provider CCN: 15-0165

Suppose Classal Floation on North-Sheet A \$7,867,004 2 3 pr						o 12/31/2023		pared:
Cost Center Description Basis/Code (2)								5 PIII
1.00 Investment Income - CAP REL 1.00 2.00 3.00 4.00 5.00 7.00					To/From Which the Amount is	to be Adjusted		
1.00 Investment Income - CAP REL 1.00 2.00 3.00 4.00 5.00 7.00								
1.00 Investment Income - CAP REL 1.00 2.00 3.00 4.00 5.00 7.00								
Timusstant Income - CAP REL		Cost Center Description						
Investment income - CAP REL OCAP REL COSTS-MVBLE EQUIP 2.00 0 2.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 4.00 0 5.00 0 4.00 0 5.00 0 4.00 0 5.00 0 6.00	1.00	II	1.00					1. 00
0.00 0.00	2. 00			0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2. 00
Chapter 2) Chapter 3) Chapter 3) Chapter 4) Chapter 4) Chapter 5) Chapter 5) Chapter 6) Chapter 7) Chapte	3 00			0		0.00	0	3 00
discounts (chapter 8)		(chapter 2)		-				
Color Colo	4.00	di scounts (chapter 8)		0		0.00	0	4.00
Sentral or provi der space by Sentral or provi der space by Sentral or Sentral or Sentral Se	5. 00		В	-813, 462	CENTRAL SERVICES & SUPPLY	14. 00	0	5. 00
Telephone services (pay stations excluded) (chapter 21) Stations excluded) (chapter 22) Stations excluded) (chapter 23) Stations excluded) (chapter 24) Stations exclu	6.00	Rental of provider space by	В	-966, 924	ADMINISTRATIVE & GENERAL	5. 00	0	6. 00
8. 00 Television and radio service (Chapter 21) 0 0 0.00 0	7. 00	Tel ephone servi ces (pay		0		0.00	0	7. 00
1.00 1.00 0.00								
Parking of (chapter 21)	8.00	II		0		0.00	o	8. 00
adjustment		Parking Lot (chapter 21)		0		0. 00	0	
11.00 Saile of scrap, waste, etc. (Chapter 23) 12.00 Related organization A-8-1 -3,707,699 0 12.00 0 13.00	10. 00		A-8-2	-11, 315, 391			0	10. 00
12.00 Related organization Chapter 10 Chapter 12	11. 00	Sale of scrap, waste, etc.		0		0.00	o	11. 00
13.00 Laundry and I linen service 0 0.00 0.13.00 15.00 1	12. 00	Related organization	A-8-1	-3, 707, 699			0	12. 00
15.00 Rental of quarters to employee and others 0 0 0 15.00 0 16.00 0 16.00 0 16.00 0 16.00 0 16.00 0 17.00 0 17.00 0 18.00 0 19.00 0	13. 00			0		0. 00	0	13. 00
and others				-332, 409	CAFETERI A			
Supplies to other than		and others		0				
17. 00 Sale of drugs to other than patients 0 0.00	16.00			0		0.00	0	16.00
patients	17. 00	1.		0		0.00	0	17. 00
abstracts		pati ents	D	E1.4	DADLOLOCV DLACNOSTIC		0	19 00
education (tuition, fees, books, etc.)		abstracts						
20. 00 Vending machines Canada Vending machines Canada Vending machines Vending machines Canada Vending machines Vending machi	19. 00			0		0.00	0	19.00
21.00	20. 00		В	-25. 131	CAFETERI A	11.00	0	20. 00
Charges (chapter 21) Canal		Income from imposition of		0			0	
overpayments and borrowings to repay Medicare overpayments 23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14) 24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14) 25.00 Utilization review - physicians' compensation (chapter 21) 26.00 Depreciation - CAP REL COSTS-BLDG & FIXT COSTS-BLDG & FIXT Depreciation - CAP REL COSTS-BLDG & FIXT Depreciation - CAP REL COSTS-MVBLE EQUIP COSTS-MV		charges (chapter 21)						
Page	22. 00			0		0.00	0	22. 00
therapy costs in excess of limitation (chapter 14) 24. 00 Adjustment for physical therapy costs in excess of limitation (chapter 14) 25. 00 Utilization review - physicians' compensation (chapter 21) 26. 00 Depreciation - CAP REL COSTS-BLDG & FIXT	22 00	repay Medicare overpayments		0	DESDIDATODY THEDADY	45. OO		22 00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14) 25.00 Utilization review - physicians' compensation (chapter 21) 26.00 Depreciation - CAP REL COSTS-BLDG & FIXT	23.00	therapy costs in excess of	A-0-3	O	RESTINATORY THERAFT	03.00		23.00
limitation (chapter 14) Utilization review - physicians' compensation (chapter 21) 26.00 Depreciation - CAP REL OCAP REL COSTS-BLDG & FIXT 1.00 O 26.00 COSTS-BLDG & FIXT T.00 O 27.00 COSTS-BLDG & FIXT Depreciation - CAP REL OCAP REL COSTS-MVBLE EQUIP COSTS-MVBLE EQUIP COSTS-MVBLE EQUIP Depreciation and therapy costs in excess of limitation (chapter 14) OCAP REL COSTS-MVBLE EQUIP OCAP REL COSTS-MVBLE EQUIP Depreciation and Interest ONONPHYSICIAN ANESTHETISTS OCCUPATIONAL THERAPY	24. 00		A-8-3	0	PHYSICAL THERAPY	66.00		24. 00
25.00 Utilization review - physicians' compensation (chapter 21) 26.00 Depreciation - CAP REL COSTS-BLDG & FIXT 27.00 Depreciation - CAP REL COSTS-BLDG & FIXT 27.00 Depreciation - CAP REL COSTS-BLDG & FIXT 27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP 28.00 Non-physician Anesthetist 29.00 Physicians' assistant 29.00 Physicians' assistant 29.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14) 30.99 Hospice (non-distinct) (see instructions) 31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 32.00 CAP REL COSTS-MVBLE EQUIP 32.00 CAP REL COSTS								
(chapter 21) Depreciation - CAP REL COSTS-BLDG & FIXT 27. 00 Depreciation - CAP REL COSTS-BUDG & FIXT 27. 00 Depreciation - CAP REL COSTS-MVBLE EQUIP 28. 00 Non-physician Anesthetist ONONPHYSICIAN ANESTHETISTS ONONPHYSICIAN ANESTHETIS	25. 00	Utilization review -		0	UTILIZATION REVIEW-SNF	114. 00		25. 00
COSTS-BLDG & FIXT Depreciation - CAP REL COSTS-MVBLE EQUIP 28. 00 Non-physician Anesthetist Physicians' assistant 30. 00 Adjustment for occupational therapy costs in excess of limitation (chapter 14) 30. 99 Hospice (non-distinct) (see instructions) 31. 00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 32. 00 CAP REL COSTS-MVBLE EQUIP OCAP REL COSTS ON OCAP OCAP REL COSTS ON		(chapter 21)						
28. 00 Non-physician Anesthetist ONONPHYSICIAN ANESTHETISTS 19. 00 28. 00 29. 00 30. 00 Adjustment for occupational therapy costs in excess of limitation (chapter 14) 30. 99 Hospice (non-distinct) (see instructions) A-8-3 OSPEECH PATHOLOGY OSPEECH PATHOLOGY	26. 00			0	CAP REL COSTS-BLDG & FIXT	1.00	0	26. 00
28.00 Non-physician Anesthetist 0 NONPHYSICIAN ANESTHETISTS 19.00 29.00 30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14) 40.00 Adjustment for speech pathology costs in excess of limitation (chapter 14) A-8-3 0 OCCUPATIONAL THERAPY 67.00 30.00 30.00 30.99 instructions) A-8-3 0 OCCUPATIONAL THERAPY 67.00 30.00 30.00 30.99 instructions) A-8-3 0 OCCUPATIONAL THERAPY 67.00 30.00 3	27. 00			0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	27. 00
30. 00 Adj ustment for occupational therapy costs in excess of limitation (chapter 14) 30. 99 Hospice (non-distinct) (see instructions) 31. 00 Adj ustment for speech pathology costs in excess of limitation (chapter 14) 32. 00 CAH HIT Adj ustment for Depreciation and Interest A-8-3 OCCUPATIONAL THERAPY 67. 00 30. 00 A-8-3 OSPEECH PATHOLOGY 68. 00 31. 00 32. 00		Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS			
limitation (chapter 14) 30. 99 Hospice (non-distinct) (see instructions) 31. 00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 32. 00 CAH HIT Adjustment for Depreciation and Interest O ADULTS & PEDIATRICS 30. 00 30. 99 31. 00 31. 00 31. 00 32. 00			A-8-3	0	OCCUPATIONAL THERAPY			
30. 99 Hospice (non-distinct) (see instructions) 31. 00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 32. 00 CAH HIT Adjustment for Depreciation and Interest OADULTS & PEDIATRICS 30. 00 30. 99 31. 00 SPEECH PATHOLOGY 68. 00 31. 00 0 0 0 0 32. 00								
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 32.00 CAH HIT Adjustment for Depreciation and Interest A-8-3 OSPEECH PATHOLOGY 68.00 31.00 O O O O O O O O O O O O O O O O O O	30. 99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30. 99
I i mi tation (chapter 14) 32.00 CAH HIT Adjustment for 0 0.00 0 32.00 Depreciation and Interest	31. 00	Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68. 00		31. 00
32.00 CAH HIT Adjustment for 0 0.00 0 32.00 Depreciation and Interest								
	32. 00	CAH HIT Adjustment for		0		0.00	0	32. 00
	33. 00		В	-394, 936	ADMINISTRATIVE & GENERAL	5. 00	0	33. 00

				''	0 12/31/2023	5/28/2024 2:1	
				Expense Classification on	Worksheet A		
				To/From Which the Amount is	to be Adjusted		
					•		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
		1. 00	2. 00	3.00	4. 00	5. 00	
33. 01	MI SC REVENUE	В		HOUSEKEEPI NG	9. 00	0	33. 01
33. 02	MI SC REVENUE	В	-91, 050	NURSING ADMINISTRATION	13.00	0	33. 02
33. 03	MI SC REVENUE	В	-853	PHARMACY	15. 00	0	33. 03
33. 04	MI SC REVENUE	В	-23	ADULTS & PEDIATRICS	30.00	0	33. 04
33. 05	MI SC REVENUE	В	-27	OPERATING ROOM	50.00	0	33. 05
33.06	MI SC REVENUE	В	-516	RADI OLOGY-DI AGNOSTI C	54.00	0	33. 06
33. 07	MI SC REVENUE	В	21, 369	EMERGENCY	91.00	0	33. 07
34.00	LOBBYING FEES	A	-2, 948	ADMINISTRATIVE & GENERAL	5. 00	0	34.00
35.00	ADVERTI SI NG	A	-194	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	35. 00
35. 01	ADVERTI SI NG	A	-2, 337	ADMINISTRATIVE & GENERAL	5. 00	0	35. 01
35. 02	ADVERTI SI NG	A I	177	MAINTENANCE & REPAIRS	6. 00	0	35. 02
35. 03	ADVERTI SI NG	A	-1, 012	NURSING ADMINISTRATION	13.00	0	35. 03
35. 04	ADVERTI SI NG	A		ADULTS & PEDIATRICS	30.00	0	35. 04
35. 05	ADVERTI SI NG	A		RADI OLOGY-DI AGNOSTI C	54.00	0	35. 05
35. 06	ADVERTI SI NG	A		MAGNETIC RESONANCE I MAGING	58. 00	0	35. 06
			_, -, -, -	(MRI)		_	
35. 07	ADVERTI SI NG	l A	-111	CARDÍ AC CATHETERIZATION	59.00	0	35. 07
35. 08	ADVERTI SI NG	A	-1, 216	RESPIRATORY THERAPY	65.00	0	35. 08
35. 09	ADVERTI SI NG	A	-639	ELECTROENCEPHALOGRAPHY	70.00	0	35. 09
35. 10	ADVERTI SI NG	A		CARDIAC AND PULMONARY REHAB	76. 01	0	35. 10
35. 11	ADVERTI SI NG	l A		CLINIC	90. 01	0	35. 11
35. 12	ADVERTI SI NG	l A		CLINIC	90. 02	0	35. 12
35. 13	ADVERTISING	A		EMERGENCY	91. 00	0	35. 13
36. 00	PROVDER TAX (HIP HAF)	A		ADMINISTRATIVE & GENERAL	5. 00	0	36.00
37. 00	PENSION	A		EMPLOYEE BENEFITS DEPARTMENT	4.00	0	37. 00
38. 00	NRCC PHYSI CI ANS	A		PHYSICIANS' PRIVATE OFFICES	192. 00	0	38. 00
38. 01	NRCC PHYSI CLANS	A		OTHER FA FACILITIES NRCC	192. 02	n	38. 01
50. 00	TOTAL (sum of lines 1 thru 49)		-23, 312, 865		172.02	Ĭ	50.00
55. 56	(Transfer to Worksheet A,		20,012,000				50.00
	column 6, line 200.)						
(1) De	escription - all chapter referen	ocas in this cal	umn nertain to	n CMS Pub 15_1			

- (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.

Li ne No.	Cost Center	Expense Items	Amount of	Amount	
			Allowable Cost	Included in	
				Wks. A, column	
				5	
1. 00	2. 00	3. 00	4. 00	5. 00	
A. COSTS INCURRED AND ADJUST!	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OR	GANIZATIONS OR	CLAI MED	
HOME OFFICE COSTS:					
1.00	CAP REL COSTS-BLDG & FIXT	ALLOWABLE NEW CAPITAL COSTS	1, 058, 115	0	1. 00
5. 00	ADMINISTRATIVE & GENERAL	ADMINISTRATIVE & GENERAL	20, 199, 973	22, 184, 172	2. 00
16. 00	MEDICAL RECORDS & LIBRARY	HI M	1, 017, 359	0	3. 00
15. 00	PHARMACY	COEP / PHARMACY	213, 560	0	4. 00
5. 00	ADMINISTRATIVE & GENERAL	I NTEREST	1, 804, 012	5, 816, 546	4. 01
TOTALS (sum of lines 1-4).			24, 293, 019	28, 000, 718	5. 00
Transfer column 6, line 5 to					
Worksheet A-8, column 2,					1
line 12.					1
	1.00 A. COSTS INCURRED AND ADJUSTMHOME OFFICE COSTS: 1.00 5.00 16.00 15.00 5.00 TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2,	1.00 2.00 A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF HOME OFFICE COSTS: 1.00 CAP REL COSTS-BLDG & FIXT 5.00 ADMINISTRATIVE & GENERAL 16.00 MEDICAL RECORDS & LIBRARY 15.00 PHARMACY 5.00 ADMINISTRATIVE & GENERAL TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2,	1.00 2.00 3.00 A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED OR HOME OFFICE COSTS: 1.00 CAP REL COSTS-BLDG & FIXT 5.00 ADMINISTRATIVE & GENERAL 16.00 MEDICAL RECORDS & LIBRARY 15.00 PHARMACY 15.00 ADMINISTRATIVE & GENERAL 11 M COEP / PHARMACY INTEREST TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2,	Allowable Cost 1.00 2.00 3.00 4.00 A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR HOME OFFICE COSTS: 1.00 CAP REL COSTS-BLDG & FIXT 5.00 ADMINISTRATIVE & GENERAL 16.00 MEDICAL RECORDS & LIBRARY 15.00 PHARMACY 15.00 PHARMACY 15.00 ADMINISTRATIVE & GENERAL TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2,	Allowable Cost Included in Wks. A, column 5 1.00

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

			Related Organization(s) and/	or Home Office			
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

i ci ilibai	Schieffe dilact title XVIII.					
6.00	В	FRANCISCAN ALLI	100.00	FRANCISCAN ALLI	100. 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

Heal th	Financial Syste	ems		FRANCISCAN HEAL	TH MUNSTER	In Lie	u of Form CMS-	2552-10
STATEME OFFI CE		SERVICES FROM	RELATED ORGA	NIZATIONS AND HOME	Provider CCN: 15-016	Period: From 01/01/2023 To 12/31/2023	Worksheet A-8	epared:
	Adjustments (col. 4 minus col. 5)*						5/28/2024 2:1	16 pm
	6.00 A COSTS INCUR	7.00 RED AND ADJUSTI	 MENTS REQUIRE	D AS A RESULT OF TE	RANSACTIONS WITH RELATE	D ORGANIZATIONS OR	CLAIMED	
	HOME OFFICE CO		MENTO REGOTRE	D NO N NEGOET OF TH	WINDHOTT ONS WITH RELATE	D ONOMINI ZATITONO ON	OLIVI MED	
1.00	1, 058, 115	9						1. 00
2.00	-1, 984, 199	C						2. 00
3.00	1, 017, 359	C						3. 00
4.00	213, 560	C						4. 00
4. 01	-4, 012, 534							4. 01

* 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

5.00

1103 1101	been posted to worksheet A,	cordinate and or 2, the amount arrowable should be that cated the cordinate of this part.	
	Related Organization(s)		
	and/or Home Office		
	Type of Business		
	3.		
	6. 00		
	B. INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

6. 00	HOME OFFICE	6.00
7.00		7.00
8.00		8.00
9.00		9.00
10.00		10.00
9. 00 10. 00 100. 00		100.00

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

5.00

-3, 707, 699

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT

						10 12/31/2023	3 Date/IIme Pre 5/28/2024 2:1	
	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	4. 00	EMPLOYEE BENEFITS DEPARTMENT	9, 904	9, 904	(211, 500	0	1. 00
2.00		ADMINISTRATIVE & GENERAL	20, 244		(211, 500	0	2. 00
3.00		NURSING ADMINISTRATION	4, 571	4, 571	(,		
4.00		ADULTS & PEDIATRICS	4, 374, 024			,		
5. 00		OPERATING ROOM	1, 494, 471	1, 494, 471	(
6.00		ANESTHESI OLOGY	4, 354, 643					
7. 00		CARDI AC CATHETERI ZATI ON	2, 000					
8.00		LABORATORY	0	0	(0.00
9.00		RESPIRATORY THERAPY	22, 476			,		
10.00		ELECTROENCEPHALOGRAPHY	13, 912			,		
11. 00		CLI NI C	0	1		2,000	•	
12. 00	91.00	EMERGENCY	1, 019, 146		(,	0	
200.00	Wkst. A Line #	Cost Center/Physician	11, 315, 391 Unadi usted RCE	11, 315, 391	Cost of	Provi der	Physician Cost	
	WKSt. A LITTE #	I denti fi er	Limit	Unadjusted RCE			of Malpractice	
		racittifici		Li mi t	Continuing	Share of col.	Insurance	
				27 (Education	12	Trisur unce	
	1. 00	2.00	8. 00	9. 00	12. 00	13. 00	14. 00	
1.00	4. 00	EMPLOYEE BENEFITS DEPARTMENT	0	0	(0	0	1. 00
2.00	5. 00	ADMINISTRATIVE & GENERAL	0	0	(0	0	2. 00
3.00	13. 00	NURSING ADMINISTRATION	0	0	(0	0	3. 00
4.00	30. 00	ADULTS & PEDIATRICS	0	0	(0	0	4. 00
5.00		OPERATING ROOM	0	0	(0	0	5. 00
6.00		ANESTHESI OLOGY	0	0	(1	0	
7. 00		CARDIAC CATHETERIZATION	0	0	(0	0	
8. 00		LABORATORY	0	0	(0	0	0.00
9. 00		RESPI RATORY THERAPY	0	0	(1	0	
10.00		ELECTROENCEPHALOGRAPHY	0	0	(1	0	
11. 00		CLI NI C	0	0	(ή	0	1
12.00	91.00	EMERGENCY	0	0	(
200.00	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment	0	200. 00
	wkst. A line #	I denti fi er	Component	Limit	Di sal I owance	Adjustment		
		ruenti i i ei	Share of col.	LIIIII	Di Sai i Owance			
			14					
	1. 00	2.00	15. 00	16, 00	17. 00	18. 00		
1. 00		EMPLOYEE BENEFITS DEPARTMENT	0		(1. 00
2.00		ADMINISTRATIVE & GENERAL	0	0	(20, 244		2. 00
3.00	13. 00	NURSING ADMINISTRATION	0	0	(4, 571		3. 00
4.00	30. 00	ADULTS & PEDIATRICS	0	0	(4, 374, 024		4. 00
5.00	50. 00	OPERATING ROOM	0	0	(1, 494, 471		5. 00
6.00	53. 00	ANESTHESI OLOGY	0	0	(4, 354, 643		6. 00
7.00		CARDIAC CATHETERIZATION	0	1	(2, 000		7. 00
8. 00		LABORATORY	0	ı	(1		8. 00
9. 00		RESPI RATORY THERAPY	0		(9. 00
10.00		ELECTROENCEPHALOGRAPHY	0		(1	10.00
11. 00		CLI NI C	0					11.00
12.00	91. 00	EMERGENCY	0		(, , , , , , , , , , , , , , , , , , , ,		12.00
200. 00			0	0		11, 315, 391	I	200. 00

COST	n Financial Systems ALLOCATION - GENERAL SERVICE COSTS	FRANCISCAN HEA	Provi der Co		eriod: rom 01/01/2023	wof Form CMS-: Worksheet B Part I	
			OARL TALL REL	To			pared: 6 pm
	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FLXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		0	1.00	2.00	4. 00	4A	
4 00	GENERAL SERVICE COST CENTERS	44 470 050	44 470 050	1			4 00
1. 00 2. 00 4. 00 5. 00 6. 00 7. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT	14, 179, 850 5, 941, 319 13, 258, 389 19, 408, 145 7, 865, 608	317, 432 2, 264, 558	5, 941, 319 133, 003	13, 708, 824	23, 232, 322 8, 202, 262 0	6. 00
8. 00 9. 00 10. 00 11. 00 12. 00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG 01000 DI ETARY 01100 CAFETERI A	308, 241 1, 528, 962 506, 338 760, 199	0 0 0 698, 137 0	0 0 0 292, 517 0	338, 431 89, 579 197, 745	308, 241 1, 867, 393 1, 586, 571 957, 944	8. 00 9. 00 10. 00 11. 00
13. 00 14. 00 15. 00 16. 00 17. 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE	2, 658, 693 27, 902 2, 113, 002 1, 851, 555	0 0 0 271, 173 12, 761 0		614, 257 89, 479 521, 496 162, 910	3, 272, 950 117, 381 3, 019, 292 2, 032, 573 0	13. 00 14. 00 15. 00 16. 00 17. 00
18. 00 19. 00 20. 00 21. 00 22. 00 23. 00	01900 NONPHYSICIAN ANESTHETISTS 02000 NURSING PROGRAM 02100 I&R SERVICES-SALARY & FRINGES APPRVD 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	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 0 0	20. 00 21. 00 22. 00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS						20.00
30. 00 31. 00 32. 00 33. 00 34. 00 40. 00 41. 00 43. 00	03100 I NTENSI VE CARE UNI T 03200 CORONARY CARE UNI T 03300 BURN I NTENSI VE CARE UNI T 03400 SURGI CAL I NTENSI VE CARE UNI T 04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF	12, 391, 321 2, 289, 416 0 0 0 0	3, 401, 798 819, 721 0 0 0 0 0		3, 751, 291 564, 332 0 0 0 0	20, 969, 756 4, 016, 930 0 0 0 0	31. 00 32. 00 33. 00
44. 00 45. 00 46. 00	04500 NURSING FACILITY	0 0	0 0 0	0 0 0	0 0 0	0 0 0	45. 00
51. 00 52. 00	05000 OPERATING ROOM 05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	5, 018, 868 771, 024 0	677, 311 0	283, 792 0	207, 501 0	1, 939, 628 0	51. 00 52. 00
54. 00 55. 00 56. 00	05600 RADI OI SOTOPE	42, 354 3, 390, 424 0 0	717, 810 0 0	0 300, 760 0 0	587, 283 0 0	4, 996, 277 0 0	55. 00 56. 00
57. 00 58. 00 59. 00 60. 00	05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION 06000 LABORATORY	1, 283, 042 1, 104, 429 1, 982, 705 7, 140, 131	0 0 1, 458, 218 250, 613			1, 436, 999 1, 375, 968 4, 545, 405 7, 495, 750	58. 00 59. 00 60. 00
60. 01 61. 00 62. 00 63. 00 64. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06300 BLOOD STORING, PROCESSING & TRANS.	0 0	0 0	0 0	0 0	0 0 0 0	61. 00 62. 00
65. 00 66. 00 67. 00 68. 00 69. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	1, 681, 270 383, 492 292, 707 109, 605 535, 225	124, 864 0 0 0 0	0 0 0 0	107, 315 83, 118 31, 174 149, 205	2, 298, 662 490, 807 375, 825 140, 779 684, 430	66. 00 67. 00 68. 00 69. 00
70. 00 71. 00 72. 00 73. 00 74. 00 75. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	419, 706 9, 413, 236 6, 607, 913 4, 475, 054 0	637, 256 0 0 0 0 0	267, 008 0 0 0 0	104, 141 0 0 0 0 0	1, 428, 111 9, 413, 236 6, 607, 913 4, 475, 054 0	71. 00 72. 00 73. 00 74. 00
76. 00 76. 01 76. 02 77. 00	03950 OTHER ANCILL SRVC 03951 CARDIAC AND PULMONARY REHAB	427, 368 0 0 0 0	0 0 0 0	0 0	0	547, 451 0 0	76. 00 76. 01 76. 02

COST ALLOCATION - GENERAL SERVICE COSTS		Provider Co	F	rom 01/01/2023 o 12/31/2023	Part I Date/Time Pre 5/28/2024 2:1	pared: 6 pm
		CAPI TAL REI	LATED COSTS			
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
	0	1.00	2.00	4. 00	4A	
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	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, 153, 858	0	0	539, 469	2, 693, 327	90. 01
90. 02 09002 CLI NI C	242, 996	106, 963	44, 817	60, 113	454, 889	90. 02
91. 00 09100 EMERGENCY	4, 943, 164	877, 323	367, 596	1, 134, 540	7, 322, 623	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	0	_	0	96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	_	0	97. 00
98. 00 09850 OTHER REI MBURSE	0	0	0	_	0	98. 00
99. 00 09900 CMHC	0	0	0	_	0	99. 00
99. 10 09910 CORF	0	0	0	_	0	99. 10
100. 00 10000 I &R SERVI CES-NOT APPRVD PRGM	0	0	0			100.00
101. 00 10100 HOME HEALTH AGENCY	0	0	0	-		101.00
102. 00 10200 OPI OI D TREATMENT PROGRAM	0	0	0	0	0	102. 00
SPECIAL PURPOSE COST CENTERS 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 LIVER ACQUISITION		0	1	-		100.00
108. 00 10800 LUNG ACQUISITION		0				107.00
109. 00 10900 PANCREAS ACQUISITION		0	0			109.00
110. 00 11000 NTESTI NAL ACQUI SI TI ON		0	0	0		110.00
111. 00 11100 SLET ACQUI SI TI ON	0	0	0	0		111. 00
113. 00 11300 NTEREST EXPENSE		Ü			Ŭ	113. 00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF						114. 00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	0	0	115. 00
116. 00 11600 HOSPI CE	0	0	0	0		116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	137, 507, 511	14, 179, 850	5, 941, 319	12, 932, 804	136, 731, 491	1
NONREI MBURSABLE COST CENTERS		, , , , , , , , , , , , , , , , , , , ,				
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	109, 059	0	0	12, 260	121, 319	190. 00
191. 00 19100 RESEARCH	59, 172	0	0	16, 846	76, 018	191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	1, 341, 643	0	0	539, 856	1, 881, 499	192. 00
192. 01 19201 CENTER OF HOPE	89, 626	0	0	25, 556	115, 182	192. 01
192.02 19202 OTHER FA FACILITIES NRCC	680, 225	0	0	156, 917	837, 142	192. 02
193. 00 19300 NONPALD WORKERS	0	0	0	0	0	193. 00
194.00 07950 OTHER NRCC	86, 283	0	0	24, 585	110, 868	194. 00
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers		0	0	0		201. 00
202.00 TOTAL (sum lines 118 through 201)	139, 873, 519	14, 179, 850	5, 941, 319	13, 708, 824	139, 873, 519	202. 00

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2023 Part I
To 12/31/2023 Date/Time Prepared: 5/28/2024 2:16 pm

BURBOL SERVICE COST CINTEES 8 OW 8 OW 7 OW 8 OW 9 OW 1 OW						12/31/2023	5/28/2024 2:1	
		Cost Center Description			OPERATION OF		HOUSEKEEPI NG	
DESCRIPTION SERVICE DOST CENTERS DAY							9. 00	
2.00		GENERAL SERVICE COST CENTERS	0.00	0.00	7.00	0.00	7. 00	
4 00 00000 PURP OVER PRIFFETS OF PRATURETS 1, 647, 236 V, 849, 490 0 0 0 0.0000 PURP OVER PRIFFETS OF PRATURES 1, 647, 236 V, 849, 490 0 0 0 370, 144 0 0.0000 PURP OVER PRIFFETS OF PRIFFTS OF PRIFFT								1
DOC DOCK ANN INSTRUCT AS CHEINNI 22, 323, 322								1
0.000 0.0000 MINTENANCE & REPAIRS			22 222 222					1
2.00 CONTROL OPERATION OF PLANT 0				9 849 498				1
B. DO DOUBLO LAURDIN'S ALTINITY SERVICE 1,1,903 0 0 379,144 0 0 0 1,24,746 0 0 0 1,000 1,000 1,14,875 0 0 0 0 0 0 0 0 0			0	0	0			1
10.00 0000 DETARY			61, 903	0	0	370, 144		1
11-00 0 1000 CAFETERIA 0 0 0 0 0 11-00 0 12-00 13-00 1				0	0	0	1	
12.00 10.00 MAINTENANCE OF PERSONNEL 0			1		0	0		
13.00 01300 NURSING ADMINISTRATION			0	0	0	0		ı
14 00 0 1400 CENTRAL SERVICES & SUPPLY			657 207	0	0	0	1	
15.00 0 1500 [PARAMACY] 16.00 1600 [PARAMACY] 17.00 0 1500 [PARAMACY] 18.00 0 100 0 100 0 2.447 16.00 18.00 100 0 100 0 2.47 16.00 18.00 100 0 100 0 0 0 0 0 0 10.00 18.00 100 0 100 0 0 0 0 0 0 0 10.00 18.00 100 0 100 0 0 0 0 0 0 0 0 0 0 0 0 0		1	1	0	Ö	0	Ö	1
17.00 01700 SOCIAL SERVICE 0 0 0 0 0 17.00 19.00 01900 NORPHYSICI ANI AMESTHETISTS 0 0 0 0 0 0 19.00 19.00 01900 NORPHYSICI ANI AMESTHETISTS 0 0 0 0 0 0 0 21.00 02000 NORPHYSICI ANI AMESTHETISTS 0 0 0 0 0 0 0 21.00 02000 NORPHYSICI ANI AMESTHETISTS 0 0 0 0 0 0 0 21.00 02000 NORPHYSICI ANI AMESTHETISTS 0 0 0 0 0 0 0 21.00 02000 NORPHYSICI ANI AMESTHETISTS 0 0 0 0 0 0 0 21.00 02000 NORPHYSICI ANI AMESTHETISTS 0 0 0 0 0 0 0 21.00 02000 NORPHYSICI ANI AMESTHETISTS 0 0 0 0 0 0 0 22.00 02000 NORPHYSICI ANI AMESTHETISTS 0 0 0 0 0 0 0 0 23.00 02000 NORPHYSICI ANI AMESTHETISTS 0 0 0 0 0 0 0 0 24.00 02000 NORPHYSICI ANI AMESTHETISTS 0 0 0 0 0 0 0 0 25.00 02000 NORPHYSICI ANI AMESTHETISTS 0 0 0 0 0 0 0 0 0 26.00 03000 NORPHYSICI ANI AMESTHETISTS 0 0 0 0 0 0 0 0 0				230, 294	0	0	52, 431	1
18 OO 01800 ONE ON DEPTING TO AN AMESTHETISTS O O O O O O O O O			408, 196	10, 837	0	0	2, 467	1
19.00 01900 MORPHYSIC IAN ANESTHEID IS 0 0 0 0 0 0 19.00		1	0	0	0	0	1	1
20.00 02000 NURSIN PROGRAM 0 0 0 0 0 0 0 20.00			0	0	0	0	1	1
21.00		1		0	0	0	1	1
22.00 02200 RAT SERVICES-OTHER PROM COST APPRVD 0 0 0 0 0 23.00 0230 PRAMADE DE I PROM COST CENTERS 0 0 0 0 23.00 0230 PRAMADE DE I PROM COST CENTERS 0 0 0 0 0 23.00 0230 PRAMADE DE I PROM COST CENTERS 0 0 0 0 0 0 23.00 0230 PRAMADE DE I PROM COST CENTERS 0 0 0 0 0 0 0 0 0			l ő	0	Ö	0	1	1
INPATI ENT ROUTINE SERVICE COST CENTERS 4, 211, 295 2, 888, 933 0 251, 788 657, 729 30, 00 30 00 300 500 500 600 60 118, 396 158, 491 31, 00 32, 00 320, 00			o	0	0	0	0	1
30.00 030000 ADULTS & PEDI ATRICS 4,211,295 2,888,983 0 251,748 667,729 30.00 31.00 03100 INTENSIVE CARE UNIT 0 0 0 0 0 0 0 0 32.00 33.00 33.00 33.00 03300 DAVING VECARE UNIT 0 0 0 0 0 0 0 0 33.00 33.00 33.00 03300 BURN INTENSIVE CARE UNIT 0 0 0 0 0 0 0 0 33.00 33.00 03300 SURFORVIDER - IPF 0 0 0 0 0 0 0 0 0	23. 00		0	0	0	0	0	23. 00
31 00 03100 INTENSIVE CARE UNIT				0.000.000	1	054 740		
32, 00 03200 COROMARY CARE UNIT		1	1 1			·	1	1
33. 00 03300 03300 03400 0340 0350 03			1		0	118, 390 N	l	1
34. 00 03400 SUBRICAL INTENSIVE CARE UNIT 0 0 0 0 0 0 0 0 0				0	o o	0		1
41.00 04100 SUBPROVI DER - I RF			o	0	0	0	Ō	
43. 00 04300 NURSERY 0 0 0 0 0 0 43. 00 45. 00 46. 00 045.			0	0	0	0	0	40. 00
44. 00 04400 SKILLED NURSING FACILITY			0	0	0	0	0	1
45.00 04500 OURS NOIS TEMP CARE			0	0	0	0	0	1
46. 00 04000 04000 0 0 0 0 0			0	0	0	0	1	1
ANCILLARY SERVICE COST CENTERS 50.00 50.			l ő	0	0	0	-	1
51.00 05100 RECOVERY ROOM 389, 530 575, 208 0 0 130, 956 51.00 52.								
52.00 05200 05200 05200 05200 05200 05200 05200 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 053000 053						_	,	1
53.00 05.300 ANESTHESI OLOGY				575, 208	0	0	l	1
54.00 05400 RADI OLOCY-DI AGNOSTI C 1,003,387 609,601 0 0 138,787 54.00 055.00 05500 RADI OLOCY-THERAPEUTI C 0 0 0 0 0 0 0 0 0				0	0	0	1	1
55. 00 05500 RADI 0.0 OY—THERAPEUTI C			1	609 601	0	0		1
56. 00 05600 RABIO I SOTOPE 0 0 0 0 0 0 0 0 56. 00			0	007,001	Ö	0		1
58. 00 05800 MACNETI C RESONANCE I MAGI NG (MRI) 276, 332 0 0 0 0 0 58. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 912, 840 1, 238, 393 0 0 281, 943 59. 00 60. 01 06000 LABORATORY 1, 505, 349 212, 834 0 0 0 48, 455 60. 00 06000 LABORATORY 1, 505, 349 212, 834 0 0 0 0 48, 455 60. 01 06001 BLOOD LABORATORY 0 0 0 0 0 0 61. 00 06100 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY 0 0 0 0 0 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 0 0 0 63. 00 06300 BLOOD STORI NO, PROCESSI NG & TRANS. 0 0 0 0 0 0 64. 00 06400 INTRAVENOUS THERAPY 0 0 0 0 0 0 65. 00 06500 RESPI RATORY THERAPY 461, 633 106, 040 0 0 24, 142 65. 00 66. 00 06600 PHYSI CAL THERAPY 75, 476 0 0 0 0 0 67. 00 06700 OCCUPATI ONAL THERAPY 75, 476 0 0 0 0 0 68. 00 06800 SPECCH PATHOLOGY 28, 272 0 0 0 0 0 69. 00 06900 ELECTROCARDI OLOGY 137, 452 0 0 0 0 69. 00 06900 ELECTROCARDI OLOGY 137, 452 0 0 0 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 1, 890, 432 0 0 0 0 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 1, 890, 432 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATI ENTS 1, 897, 474 0 0 0 0 0 74. 00 07400 REMALD I ALLYSIS 0 0 0 0 0 75. 00 07500 ASC (NON-DI STINCT PART) 0 0 0 0 0 76. 01 03950 OTHER ANCI LL SRVC 0 0 0 0 0 76. 01 03950 OTHER ANCI LL SRVC 0 0 0 0 0 76. 01 03950 OTHER ANCI LL SRVC 0 0 0 0 76. 01 07500 CLINI C 0 0 0 0 0 76. 00 07600 OTHER ANCI LL SRVC 0 0 0 0 77. 00 07700 ALLOGARDI TO CARDI TION 0 0 0 0 77. 00 07700 OTHER ANCI LL SRVC 0 0 0 0 78. 00 07800 CART T-CELL I MUNIOTHERAPY 0 0 0 0 77. 00 07700 OTHER ANCI LL SRVC 0 0 0 0 78. 00 07800 CART T-CELL I MUNIOTHERA			o	0	0	0	1	1
59,00 05900 CARDI AC CATHETERI ZATI ON 912, 840 1, 238, 393 0 0 281, 943 59, 00	57.00		288, 588	0	0	0	0	57. 00
60. 00 06000 LABORATORY 1,505,349 212,834 0 0 48,455 60. 00 60. 01 06001 BLOOD LABORATORY 0 0 0 0 0 61. 00 06100 PBP CLINI CAL LAB SERVI CES-PRGM ONLY 0 0 0 0 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 0 0 0 63. 00 06300 SLOOD STORI NG, PROCESSI NG & TRANS. 0 0 0 0 0 0 64. 00 06400 INTRAVENOUS THERAPY 0 0 0 0 0 0 65. 00 06500 RESPI RATORY THERAPY 461,633 106,040 0 0 0 0 0 66. 00 06600 PHST CAL THERAPY 98,567 0 0 0 0 0 67. 00 06700 0CCUPATI ONAL THERAPY 75,476 0 0 0 0 0 68. 00 06800 SPEECH PATHOLOGY 28,272 0 0 0 0 0 69. 00 06900 ELECTROCARDI OLOGY 137,452 0 0 0 0 70. 00 07000 ELECTROENCEPHALOGRAPHY 286,803 541,190 0 0 123,212 70.00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 1,327,047 0 0 0 0 0 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 1,327,047 0 0 0 0 0 74. 00 07400 RENAL DI ALSYSTES 0 0 0 0 0 75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 76. 01 03951 CARDI JACKSTES 0 0 0 0 0 77. 00 07500 DIFFI CANDI LILES 0 0 0 0 0 78. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 78. 00 07500 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 79. 00 09000 CLINI C 0 0 0 0 79. 00 09000 CLINI C 0 0 0 0 79. 00 09000 CLINI C 0 0 0 0 79. 00 09000 CLINI C 0 0 0 79. 00 09000 CLINI C 0 0			1	0	0	0	-	1
60.01 66.01 BLOOD LABORATORY 0 0 0 0 60.01 61.00 06100 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY 0 0 0 0 0 61.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 0 0 0 0 63.00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 0 0 0 0 0 0 0 64.00 06400 INTRAVENOUS THERAPY 0 0 0 0 0 0 65.00 06500 RESPI RATORY THERAPY 461, 633 106, 040 0 0 24, 142 65.00 66.00 06600 PHYSI CAL THERAPY 98, 567 0 0 0 0 0 66.00 67.00 06600 PHYSI CAL THERAPY 75, 476 0 0 0 0 0 67.00 68.00 06600 PHYSI CAL THERAPY 75, 476 0 0 0 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 28, 272 0 0 0 0 0 69.00 69.00 06900 ELECTROCARDI OLOGY 137, 452 0 0 0 0 0 0 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 1, 890, 432 0 0 0 0 123, 212 70.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 1, 890, 432 0 0 0 0 72.00 73.00 07300 DRUES CHARGED TO PATIENTS 1, 327, 047 0 0 0 0 73.00 74.00 07400 RENAL DI ALYSIS 0 0 0 0 0 74.00 75.00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 75.00 76.01 03951 CARDI AC AND PULMONARY REHAB 109, 943 0 0 0 0 0 76.00 76.01 03952 CARDI AC AND PULMONARY REHAB 109, 943 0 0 0 0 0 0 76.00 76.02 03952 WOUND CARE 0 0 0 0 0 0 78.00 76.00 03950 OTHER ANCI LL SRVC 0 0 0 0 0 0 78.00 77.00 07900 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 0 0 78.00 07900 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 0 79.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 0 79.00 09000 CLINI C 540,893 0 0 0 0 0 0 79.01 09001 CLINI C 540,893 0 0 0 0 0 79.01 09001 CLINI C 0 0 0 0 0 79.01 09001 CLINI C 0 0 0 0 0 79.01 09001 CLINI C 0 0 0 0 0 79.01 09001 CLINI C 0 0 0			1			0		1
61. 00						0		1
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 0 0 0 62. 00 63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 0 0 0 0 64. 00 06400 INTRAVENOUS THERAPY 0 0 0 0 0 0 65. 00 06500 RESPI RATORY THERAPY 461, 633 106, 040 0 0 24, 142 65. 00 66. 00 06600 PHYSI CAL THERAPY 98, 567 0 0 0 0 67. 00 67. 00 06700 OCCUPATI ONAL THERAPY 75, 476 0 0 0 0 0 67. 00 68. 00 06800 SPECH PATHOLOGY 28, 272 0 0 0 0 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 137, 452 0 0 0 0 0 69. 00 70. 00 07000 ELECTROCARDI OLOGY 137, 452 0 0 0 123, 212 70. 00 71. 00 07000 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 1, 890, 432 0 0 0 0 123, 212 70. 00 72. 00 07300 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 1, 327, 047 0 0 0 0 73. 00 74. 00 07300 MRUS CHARGED TO PATI ENTS 1, 327, 047 0 0 0 0 73. 00 75. 00 07300 DRUGS CHARGED TO PATI ENTS 898, 712 0 0 0 0 0 74. 00 76. 00 03950 OTHER ANCI LL SRVC 0 0 0 0 0 76. 00 76. 01 03951 CARDI AC AND PULMONARY REHAB 109, 943 0 0 0 0 0 76. 00 77. 00 07500 ASC (NON-DI STINCT PART) 0 0 0 0 0 0 77. 00 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 0 77. 00 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 0 0 79. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 0 0 90. 00 09000 CLINIC S40,893 0 0 0 0 0 0 90. 01 09000 CLINIC S40,893 0 0 0 0 0 90. 01 09000 CLINIC S40,893 0 0 0 0 0 90. 01 09000 CLINIC 0 0 0 0 0 90. 01 09000 CLINIC 0 0 0 0 0 90. 01 09000 CLINIC 0 0 0 0 0 90. 01 09000 CLINIC 0 0 0 0 0 90. 01 09000 CLINIC 0 0 0 0 0 90. 01 09000 CLINIC 0 0 0 0 0 90. 01 09000 CLINIC 0 0 0 0 90. 01 09				0	0	0		ı
64. 00 06400 INTRAVENOUS THERAPY			o	0	0	0	0	1
65. 00 06500 RESPIRATORY THERAPY 461, 633 106, 040 0 0 24, 142 65. 00 66. 00 06600 PHYSI CAL THERAPY 98, 567 0 0 0 0 0 0 66. 00 66. 00 66. 00 66. 00 0 0 0	63.00	06300 BLOOD STORING, PROCESSING & TRANS.	O	0	0	0	0	63. 00
66. 00			0	0	0	0	1	1
67. 00 06700 OCCUPATIONAL THERAPY 75, 476 0 0 0 0 0 0 67. 00 68. 00 06800 SPEECH PATHOLOGY 28, 272 0 0 0 0 0 0 68. 00 69. 00 06900 ELECTROCARDIOLOGY 137, 452 0 0 0 0 0 0 68. 00 07. 00 07000 ELECTROCARDIOLOGY 137, 452 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				106, 040	0	0	i .	1
68. 00				0	0	0		1
69. 00				0	0	0	1	1
70. 00 07000 ELECTROENCEPHALOGRAPHY 286, 803 541, 190 0 0 123, 212 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 1, 890, 432 0 0 0 0 0 71. 00 072.00 MPL. DEV. CHARGED TO PATI ENTS 1, 327, 047 0 0 0 0 0 72. 00 07300 DRUGS CHARGED TO PATI ENTS 898, 712 0 0 0 0 0 0 73. 00 07400 RENAL DI ALYSIS 0 0 0 0 0 0 0 0 0				0	Ö	0	o o	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 1,327,047 0 0 0 72.00 73. 00 07300 DRUGS CHARGED TO PATIENTS 898,712 0 0 0 0 73.00 74. 00 07400 RENAL DIALYSIS 0 0 0 0 0 74.00 75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 0 75.00 76. 01 03950 OTHER ANCILL SRVC 0 0 0 0 0 0 0 75.00 76. 01 03951 CARDI AC AND PULMONARY REHAB 109,943 0 0 0 0 0 0 76.01 76. 02 03952 WOUND CARE 0 0 0 0 0 0 0 76.02 77. 00 07700 ALLOGENEI C STEM CELL ACQUISITION 0 0 0 0 0 0 0 0 77.00 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 0 <td>70.00</td> <td>07000 ELECTROENCEPHALOGRAPHY</td> <td></td> <td>541, 190</td> <td>0</td> <td>0</td> <td>123, 212</td> <td>70. 00</td>	70.00	07000 ELECTROENCEPHALOGRAPHY		541, 190	0	0	123, 212	70. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS 898, 712 0 0 0 0 0 73. 00 74. 00 74. 00 74. 00 75. 00 0 0 0 0 0 0 0 0 74. 00 75. 00 0 0 0 0 0 0 0 0 0				0	0	0		1
74. 00 07400 RENAL DI ALYSI S 0 0 0 0 0 0 74. 00 75. 00 07500 ASC (NON-DI STI NCT PART) 0 0 0 0 0 0 75. 00 76. 00 03950 OTHER ANCI LL SRVC 0 0 0 0 0 0 0 0 76. 00 76. 01 03951 CARDI AC AND PULMONARY REHAB 109, 943 0 0 0 0 0 0 76. 01 76. 02 03952 WOUND CARE 0 0 0 0 0 0 0 76. 02 77. 00 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON 0 0 0 0 0 0 77. 00 78. 00 07800 CAR T-CELL I MMUNOTHERAPY 0 0 0 0 0 0 78. 00 0UTPATI ENT SERVI CE COST CENTERS 88. 00 08800 RURAL HEALTH CLI NI C 0 0 0 0 0 88. 00 89. 00 08900 FEDERALLY QUALI FI ED HEALTH CENTER 0 0 0 0 0 0 90. 00 90. 01 09001 CLI NI C 540, 893 0 0 0 0 0 0 0 0 90. 01				0	0	0		
75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 0 75. 00 76. 00 0 0 0 0 0 75. 00 0 0 0 0 0 0 0 0 0			898, /12	0	0	0		
76. 00 03950 OTHER ANCILL SRVC 0 0 0 0 0 0 0 76. 00 76. 00 76. 01 03951 CARDI AC AND PULMONARY REHAB 109, 943 0 0 0 0 0 76. 01 76. 02 03952 WOUND CARE 0 0 0 0 0 0 0 76. 02 77. 00 0700 ALLOGENEI C STEM CELL ACQUISITION 0 0 0 0 0 0 0 77. 00 078. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	0	0	0	1	
76. 01 03951 CARDI AC AND PULMONARY REHAB 109, 943 0 0 0 0 0 76. 01 76. 02 03952 WOUND CARE 0 0 0 0 0 0 76. 02 77. 00 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON 0 0 0 0 0 0 77. 00 78. 00 07800 CAR T - CELL IMMUNOTHERAPY 0 0 0 0 0 0 78. 00 OUTPATI ENT SERVI CE COST CENTERS 88. 00 08800 RURAL HEALTH CLI NI C 0 0 0 0 0 88. 00 89. 00 08900 FEDERALLY QUALI FI ED HEALTH CENTER 0 0 0 0 0 89. 00 90. 00 09000 CLI NI C 0 0 0 0 0 0 90. 00 90. 01 09001 CLI NI C 540, 893 0 0 0 0 0 0 0 90. 01				0	0	0	1	1
77. 00 07700 ALLOGENEI C STEM CELL ACQUI SITION 0 0 0 0 0 77. 00 0 0 0 0 0 78. 00 0 0 0 0 0 0 0 78. 00 0 0 0 0 0 0 0 0 0			109, 943	0	0	0	0	1
78. 00 07800 CAR T - CELL I MMUNOTHERAPY 0 0 0 0 0 78. 00			0	0	0	0	0	1
SERVICE COST CENTERS				0	0	0	1	1
88. 00 08800 RURAL HEALTH CLINIC 0 0 0 0 0 88. 00 89. 00 89. 00 6DERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 0 0 89. 00 90. 00 90. 01 09001 CLINIC 0 0 0 0 0 0 0 0 0 0 0 90. 01 09001 CLINIC 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	/8. 00		0	0	1 0	0	0	J 78.00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 89. 00 90. 00 90. 01 09001 CLI NI C 0 0 0 0 0 90. 01 09001 CLI NI C 540, 893 0 0 0 0 90. 01	88 00			0	0	n	n	88 00
90. 00 09000 CLI NI C 0 0 0 0 90. 00 90. 01 09001 CLI NI C 540, 893 0 0 0 0 90. 01		1		0	ا	0	1	
		1		0	Ö	0	1	1
90. 02 09002 CLINIC 91, 354 90, 838 0 0 20, 681 90. 02				0	0	0	0	1
	90. 02	09002 CLI NI C	91, 354	90, 838] 0	0	20, 681	90.02

| Peri od: | Worksheet B | From 01/01/2023 | Part | | To | 12/31/2023 | Date/Time Prepared:

			To	o 12/31/2023	Date/Time Pre 5/28/2024 2:1	pared:
Cost Center Description	ADMI NI STRATI VE	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	O piii
	& GENERAL	REPAI RS	PLANT	LINEN SERVICE		
	5. 00	6. 00	7. 00	8. 00	9. 00	
91. 00 09100 EMERGENCY	1, 470, 580	745, 068	0	0	169, 628	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
OTHER REIMBURSABLE COST CENTERS						1
94.00 09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94. 00
95. 00 09500 AMBULANCE SERVICES	0	0	0	0	0	95.00
96. 00 09600 DURABLE 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	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	0	105. 00
106. 00 10600 HEART ACQUI SI TI ON	0	0	0	0	0	106. 00
107.00 10700 LIVER ACQUISITION	0	0	0	0	0	107. 00
108.00 10800 LUNG ACQUISITION	0	0	0	0	0	108. 00
109.00 10900 PANCREAS ACQUISITION	0	0	0	0	0	109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0	0	110. 00
111.00 11100 ISLET 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	0	115. 00
116. 00 11600 HOSPI CE	0	0	0	0	0	116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	22, 601, 318	9, 849, 498	0	370, 144	2, 242, 416	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	24, 364	0	0	0		190. 00
191. 00 19100 RESEARCH	15, 266	0	0	0	0	191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	377, 856	0	0	0		192. 00
192.01 19201 CENTER OF HOPE	23, 132	0	0	0	0	192. 01
192.02 19202 OTHER FA FACILITIES NRCC	168, 121	0	0	0	0	192. 02
193. 00 19300 NONPALD WORKERS	0	0	0	0	0	193. 00
194.00 07950 OTHER NRCC	22, 265	0	0	0	0	194. 00
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	0	0	0	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	23, 232, 322	9, 849, 498	0	370, 144	2, 242, 416	202. 00

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2023 Part I
To 12/31/2023 Date/Time Prepared: 5/28/2024 2:16 pm

					0 12/31/2023	5/28/2024 2:1	
	Cost Center Description	DI ETARY	CAFETERI A	MAINTENANCE OF PERSONNEL	NURSI NG ADMI NI STRATI ON	CENTRAL SERVICES &	
						SUPPLY	
	GENERAL SERVICE COST CENTERS	10.00	11. 00	12.00	13. 00	14. 00	
1.00	00100 CAP REL COSTS-BLDG & FIXT			T			1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						5. 00
6.00	00600 MAI NTENANCE & REPAI RS						6.00
7. 00 8. 00	OO7OO OPERATION OF PLANT OO8OO LAUNDRY & LINEN SERVICE						7. 00 8. 00
9. 00	00900 HOUSEKEEPI NG						9.00
10.00	01000 DI ETARY	2, 633, 074					10.00
11.00	01100 CAFETERI A	0	957, 94	4			11. 00
12. 00	01200 MAI NTENANCE OF PERSONNEL	0	(1)		12. 00
13.00	O1300 NURSI NG ADMI NI STRATI ON O1400 CENTRAL SERVI CES & SUPPLY	0	(-,	140 417	13.00
14. 00 15. 00	01500 PHARMACY		(2, 463	143, 417 287	1
16. 00	01600 MEDICAL RECORDS & LIBRARY		(498	1	16.00
17. 00	01700 SOCIAL SERVICE	o	(0	0	1
18. 00	01850 OTHER GEN SERV	0	(0	0	18. 00
19. 00	01900 NONPHYSI CI AN ANESTHETI STS	0	(0	0	
20.00	02000 NURSI NG PROGRAM	0	(0	0	20.00
21. 00 22. 00	O2100 I &R SERVICES-SALARY & FRINGES APPRVD O2200 I &R SERVICES-OTHER PRGM COSTS APPRVD	0	(0	21. 00 22. 00
23. 00	02301 PARAMED ED PRGM		(0	1
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>		71	,		20.00
30.00	03000 ADULTS & PEDI ATRI CS	1, 790, 844	651, 532	2 (1, 545, 734	437	30. 00
31. 00	03100 I NTENSI VE CARE UNI T	842, 230	306, 412			81	1
32.00	03200 CORONARY CARE UNIT	0	(1	0	0	
33. 00 34. 00	03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT	0	(0	0	33. 00 34. 00
40. 00	04000 SUBPROVI DER – I PF		(0	40.00
41. 00	04100 SUBPROVI DER - I RF	O	Č		o o	0	41. 00
43.00	04300 NURSERY	0	(0	0	1
44.00	04400 SKILLED NURSING FACILITY	0	(0	0	44. 00
45. 00	04500 NURSING FACILITY	0			0	0	
46. 00	O4600 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS	0	(0	0	46. 00
50.00	05000 OPERATING ROOM	O	(592, 290	2, 267	50.00
51.00	05100 RECOVERY ROOM	0	(36	1
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	(0	0	52.00
53. 00	05300 ANESTHESI OLOGY	0	(0	2	53. 00
54.00	O5400 RADI OLOGY - DI AGNOSTI C	0	(115	203	1
55. 00 56. 00	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE		(0	0	
57. 00	05700 CT SCAN		(868	4	57.00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	o	(0	163	1
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	(251, 886	46	59. 00
60.00	06000 LABORATORY	0	(0	0	
60. 01	06001 BLOOD LABORATORY	0	(0	0	
61. 00 62. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		(0	61.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.		(0	1
64. 00	06400 I NTRAVENOUS THERAPY	Ö	(O	0	1
65.00	06500 RESPI RATORY THERAPY	0	(0	59	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	(0	0	66. 00
67. 00	06700 OCCUPATIONAL THERAPY	0	(0	1	67. 00
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0	(0) 255	0 55	68. 00 69. 00
70. 00	07000 ELECTROCARDI OLOGI 07000 ELECTROENCEPHALOGRAPHY		() 255	97	1
	1 1	o	Č		o o	81, 920	1
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	O	(0	57, 509	
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	(0	0	
74.00	07400 RENAL DIALYSIS	0	(0	0	
75. 00 76. 00	O7500 ASC (NON-DISTINCT PART) O3950 OTHER ANCILL SRVC		(0	75. 00 76. 00
76. 00 76. 01	03951 CARDI AC AND PULMONARY REHAB		(32, 046	٥	76.00
	03952 WOUND CARE		() 32, 046	0	1
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	Ö	(o o	0	1
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	(0	0	1
	OUTPATIENT SERVICE COST CENTERS			-			
88. 00	08800 RURAL HEALTH CLINIC	0	(0	
89. 00 90. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC		(0	
90. 00	09001 CLI NI C		(ol d	136, 606	52	
	ı I	, -1				·	

					Fo 12/31/2023	Date/Time Pre 5/28/2024 2:1	
	Cost Center Description	DI ETARY	CAFETERI A	MAINTENANCE OF	NURSI NG	CENTRAL	O PIII
	oost odired bescription	DI E ITIKI	ON ETENIA	PERSONNEL	ADMI NI STRATI ON		
						SUPPLY	
		10.00	11. 00	12.00	13.00	14. 00	
90. 02 09002	CLINIC	0	0	(40, 316	101	90. 02
91. 00 09100	EMERGENCY	0	0		521, 562	87	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	94.00
	AMBULANCE SERVICES	0	0		0	0	95. 00
	DURABLE MEDICAL EQUIP-RENTED	0	0		0	0	96. 00
	DURABLE MEDICAL EQUIP-SOLD	0	0		0	0	97. 00
	OTHER REIMBURSE	0	0		0	0	98. 00
99. 00 09900		0	0		0	0	99. 00
99. 10 09910		0	0		0	0	99. 10
	I&R SERVICES-NOT APPRVD PRGM	0	0		0		100. 00
	HOME HEALTH AGENCY	0	0		0		101. 00
	OPIOID TREATMENT PROGRAM	0	0	(0	0	102. 00
	AL PURPOSE COST CENTERS						
	KIDNEY ACQUISITION	0	0		0		105. 00
	HEART ACQUISITION	0	0	(0		106. 00
	LIVER ACQUISITION	0	0	(0		107. 00
	LUNG ACQUISITION	0	0	(0		108. 00
	PANCREAS ACQUISITION	0	0	(0		109. 00
	INTESTINAL ACQUISITION	0	0	(0		110. 00
	ISLET ACQUISITION	0	0	(0	0	111. 00
	I NTEREST EXPENSE						113. 00
	UTI LI ZATI ON REVI EW-SNF	_	_		_		114. 00
	AMBULATORY SURGICAL CENTER (D. P.)	0	0	(0		115. 00
116. 00 11600		0	0		0		116. 00
	SUBTOTALS (SUM OF LINES 1 through 117)	2, 633, 074	957, 944		3, 753, 377	143, 417	118.00
	MBURSABLE COST CENTERS						100.00
	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0		190. 00
191. 00 19100		0	0		0		191. 00
	PHYSI CLANS' PRI VATE OFFI CES	0	0		62, 394		192. 00
	CENTER OF HOPE	U	0		498		192. 01
	OTHER FA FACILITIES NRCC	U	0		113, 978		192. 02
193.00 19300	NONPALD WORKERS	0	0		0		193. 00 194. 00
1 1		U	Ü		0		200. 00
	Cross Foot Adjustments Negative Cost Centers		^				200.00
	TOTAL (sum lines 118 through 201)	2, 633, 074	957, 944		3, 930, 247		
202.00	TOTAL (Suill TITIES TTO THE OUGH 201)	2,033,074	907, 944	I '	J 3, 930, 247	143, 417	1202.00

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2023 Part I
To 12/31/2023 Date/Time Prepared: 5/28/2024 2:16 pm Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0165

							5/28/2024 2:1	
						OTHER GENERAL		
		Cost Center Description	PHARMACY	MEDI CAL	 SOCIAL SERVICE	SERVI CE OTHER GEN SERV	NONPHYSI CI AN	
		·		RECORDS &			ANESTHETI STS	
			15. 00	16. 00	17. 00	18. 00	19. 00	
	GENER	AL SERVICE COST CENTERS	13.00	10.00	17.00	10.00	17.00	
1.00	1	CAP REL COSTS-BLDG & FIXT						1. 00
2.00	1	CAP REL COSTS-MVBLE EQUIP						2.00
4. 00 5. 00		EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL						4. 00 5. 00
6.00	1	MAINTENANCE & REPAIRS						6. 00
7.00		OPERATION OF PLANT						7. 00
8. 00 9. 00	1	LAUNDRY & LINEN SERVICE HOUSEKEEPING						8. 00 9. 00
10.00	1	DI ETARY						10.00
11. 00	1	CAFETERI A						11. 00
12.00	1	MAINTENANCE OF PERSONNEL						12.00
13. 00 14. 00	1	NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY						13. 00 14. 00
15. 00	1	PHARMACY	3, 908, 659					15. 00
16. 00	01600	MEDICAL RECORDS & LIBRARY	0	2, 454, 572				16. 00
17. 00	1	SOCIAL SERVICE	0	0	0			17. 00
18. 00 19. 00		OTHER GEN SERV NONPHYSICIAN ANESTHETISTS	0	0	l o	0	0	18. 00 19. 00
20. 00	1	NURSI NG PROGRAM	Ö	0	C	0	· ·	20.00
21. 00		I&R SERVICES-SALARY & FRINGES APPRVD	0	0	C	0		21. 00
22. 00 23. 00	1	I&R SERVICES-OTHER PRGM COSTS APPRVD PARAMED ED PRGM	0	0				22. 00 23. 00
23.00		I ENT ROUTINE SERVICE COST CENTERS	UU	0		0		23.00
30.00	03000	ADULTS & PEDIATRICS	0	122, 590			0	30. 00
31.00	1	INTENSIVE CARE UNIT	0	61, 544	0	0	0	31.00
32. 00 33. 00	1	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT	0	0	l o	0	0	32. 00 33. 00
34. 00	1	SURGICAL INTENSIVE CARE UNIT	Ö	0	C	0	0	34.00
40. 00	1	SUBPROVI DER - I PF	0	0	C	0	0	40. 00
41. 00 43. 00	1	SUBPROVI DER - I RF NURSERY	0	0		0	0	41. 00 43. 00
44. 00	1	SKILLED NURSING FACILITY	0	0		0	0	44. 00
45.00	04500	NURSING FACILITY	О	0			0	45. 00
46. 00		OTHER LONG TERM CARE LARY SERVICE COST CENTERS	0	0	C	0	0	46. 00
50. 00		OPERATING ROOM	ol	393, 975	С	O	0	50.00
51.00	05100	RECOVERY ROOM	O	51, 629			0	51. 00
52.00	1	DELIVERY ROOM & LABOR ROOM	0	0 054	1	0	0	52.00
53. 00 54. 00	1	ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C	0	86, 954 197, 361	C		0	53. 00 54. 00
55. 00	1	RADI OLOGY-THERAPEUTI C	Ö	0	· ·	0	0	55. 00
56. 00		RADI OI SOTOPE	0	0	C	0	0	56. 00
57. 00 58. 00		CT SCAN MAGNETIC RESONANCE IMAGING (MRI)	0	219, 901 66, 979			0	57. 00 58. 00
59.00		CARDIAC CATHETERIZATION	0	63, 280		0	0	
60.00	1	LABORATORY	O	282, 430		0	0	60.00
60. 01		BLOOD LABORATORY	0	0	C	0	0	60. 01
61. 00 62. 00	1	PBP CLINICAL LAB SERVICES-PRGM ONLY WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	l o	0	0	61. 00 62. 00
63. 00		BLOOD STORING, PROCESSING & TRANS.	Ö	0	C	0	0	63. 00
64.00	1	I NTRAVENOUS THERAPY	0	0	C	0	0	64.00
65. 00 66. 00		RESPI RATORY THERAPY PHYSI CAL THERAPY	0	31, 843 11, 619		0	0	65. 00 66. 00
67. 00	1	OCCUPATIONAL THERAPY	o	10, 713		0	0	67. 00
68. 00	1	SPEECH PATHOLOGY	О	4, 271	C	0	0	68. 00
69. 00 70. 00		ELECTROCARDI OLOGY ELECTROENCEPHALOGRAPHY	0	84, 111	0	0	0	69. 00 70. 00
71.00		MEDICAL SUPPLIES CHARGED TO PATIENTS	0	18, 632 148, 432		0	0	71.00
72. 00		IMPL. DEV. CHARGED TO PATIENTS	O	111, 780		0	0	72. 00
73.00		DRUGS CHARGED TO PATIENTS	3, 908, 659	125, 503		0	0	73.00
74. 00 75. 00	1	RENAL DIALYSIS ASC (NON-DISTINCT PART)	0	0		0	0	74. 00 75. 00
76. 00		OTHER ANCILL SRVC	o o	0		o	0	1
76. 01		CARDI AC AND PULMONARY REHAB	0	4, 882	1	0	0	l
76. 02 77. 00		WOUND CARE ALLOGENEIC STEM CELL ACQUISITION	0	0		0	0	76. 02 77. 00
78.00	1	CAR T-CELL IMMUNOTHERAPY	o	0			0	78.00
	OUTPA	TIENT SERVICE COST CENTERS	-					
88. 00 89. 00		RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER	0	0			0	•
	100 700	TERENTEL CONCLUENCE TENETH CENTER	<u>ا</u>	0	1	ı V	0	1 07.00

			'	0 12/31/2023	5/28/2024 2: 1	
		<u> </u>		OTHER GENERAL		
				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. 00 09000 CLI NI C	0	0	0	0	0	90. 00
90. 01 09001 CLI NI C	0	122, 717	0	0	0	90. 01
90. 02 09002 CLI NI C	0	15, 718	0	0	0	90. 02
91. 00 09100 EMERGENCY	0	217, 708	0	0	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 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	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 OPIOLD TREATMENT PROGRAM	0	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 ACQUI SI TI ON	0	0	0	0	0	106. 00
107.00 10700 LIVER ACQUISITION	0	0	0	0	0	107. 00
108.00 10800 LUNG ACQUISITION	0	0	0	0	0	108. 00
109.00 10900 PANCREAS ACQUISITION	0	0	0	0	0	109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0	0	0	0	111. 00
113.00 11300 INTEREST EXPENSE						113. 00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	0	0	115. 00
116. 00 11600 HOSPI CE	0	0	0	0		116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	3, 908, 659	2, 454, 572	0	0	0	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	O	0	0	0		191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	O	0	0	0		192. 00
192. 01 19201 CENTER OF HOPE	0	0	Ō	0		192. 01
192. 02 19202 OTHER FA FACILITIES NRCC	0	0	Ō	0		192. 02
193. 00 19300 NONPALD WORKERS	0	0	o o	0		193. 00
194. 00 07950 OTHER NRCC	0	0	o o	0		194. 00
200.00 Cross Foot Adjustments	١	· ·				200. 00
201.00 Negative Cost Centers	0	0	0	0		201. 00
202.00 TOTAL (sum lines 118 through 201)	3, 908, 659	2, 454, 572	Ö	0		202. 00
1 (22 23 23		,,	'	١	, and the second	

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2023 | Part | | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | Date/Tim Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0165

				10	5 12/31/2023	Date/lime Pre 5/28/2024 2:1	
			INTERNS &	RESI DENTS			
	Cost Center Description	NURSI NG	SERVICES_SALAR	SERVI CES-OTHER	PARAMED ED	Subtotal	
	cost center bescription	PROGRAM	Y & FRINGES	PRGM COSTS	PRGM	Subtotal	
		20. 00	21. 00	22. 00	23. 00	24. 00	
1. 00	GENERAL SERVICE COST CENTERS O0100 CAP REL COSTS-BLDG & FIXT						1.00
2. 00	00200 CAP REL COSTS-BEDG & TTXT						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						5. 00
6.00	00600 MAI NTENANCE & REPAI RS						6.00
7. 00 8. 00	OO7OO OPERATION OF PLANT OO8OO LAUNDRY & LINEN SERVICE						7. 00 8. 00
9. 00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY						10.00
11. 00	01100 CAFETERI A						11. 00
12.00	01200 MAI NTENANCE OF PERSONNEL						12.00
13. 00 14. 00	O1300 NURSI NG ADMI NI STRATI ON O1400 CENTRAL SERVI CES & SUPPLY						13. 00 14. 00
15. 00	01500 PHARMACY						15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY						16. 00
17. 00	01700 SOCIAL SERVICE						17. 00
18. 00 19. 00	O1850 OTHER GEN SERV O1900 NONPHYSI CI AN ANESTHETI STS						18. 00 19. 00
20. 00	02000 NURSI NG PROGRAM	0					20.00
21. 00	02100 I &R SERVI CES-SALARY & FRI NGES APPRVD		0				21. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD			0			22. 00
23. 00	02301 PARAMED ED PRGM				0		23. 00
30. 00	O3000 ADULTS & PEDIATRICS		0	0	0	33, 090, 648	30. 00
31. 00	03100 INTENSIVE CARE UNIT	0		1	0	7, 482, 138	1
32. 00	03200 CORONARY CARE UNIT	0	Ö	Ö	0	0	1
33.00	03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	33. 00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	
40. 00 41. 00	04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF	0	0	0	0	0	
43. 00	04300 NURSERY	0	0	o	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	
46. 00	04600 OTHER LONG TERM CARE	0	0	0	0	0	46. 00
50. 00	ANCILLARY SERVICE COST CENTERS O5000 OPERATING ROOM	0	0	0	0	12, 651, 136	50.00
51. 00	05100 RECOVERY ROOM	0	Ö	1	0	3, 240, 528	1
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52. 00
53. 00	05300 ANESTHESI OLOGY	0	0	0	0	150, 690	1
54. 00 55. 00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	6, 945, 731 0	1
56. 00	05600 RADI OI SOTOPE	0	Ö	Ö	0	0	1
57.00	05700 CT SCAN	0	0	0	0	1, 946, 360	
	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0	0	0	1, 719, 442	
60.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0	0	0	0	7, 293, 793 9, 544, 818	
60. 01	06001 BLOOD LABORATORY	0	0	0	0	9, 344, 616	1
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY				J	0	1
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	
64. 00 65. 00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	0	0	0	0	0 2, 922, 379	
66. 00	06600 PHYSI CAL THERAPY	0	Ö	Ö	0	600, 993	
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	0	0	462, 015	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0	0	0	173, 322	1
69. 00 70. 00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	906, 303 2, 398, 045	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	11, 534, 020	1
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	O	0	8, 104, 249	
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	9, 407, 928	1
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	
75. 00 76. 00	O7500 ASC (NON-DISTINCT PART) O3950 OTHER ANCILL SRVC	0	0	0	0	0	1
76. 00 76. 01	03951 CARDI AC AND PULMONARY REHAB	0	n	ا	0	694, 331	1
76. 02	03952 WOUND CARE	0	0	0	Ō	0	1
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	1
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	1 0	0	0	0	0	78. 00
88. 00	OUTPATIENT SERVICE COST CENTERS O8800 RURAL HEALTH CLINIC	0	0	0	0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	Ö	-	0	0	
	09000 CLI NI C	0	0		0		
				<u> </u>			

			To	12/31/2023	Date/Time Pre 5/28/2024 2:1	
		INTERNS &	RESI DENTS		372072024 2. 1	J DIII
Cost Center Description			SERVI CES-OTHER	PARAMED ED	Subtotal	
	PROGRAM	Y & FRINGES	PRGM COSTS	PRGM	24.00	
90. 01 09001 CLI NI C	20.00	21.00	22. 00	23. 00	24. 00 3, 493, 595	90, 01
90. 01 09001 CLI NI C	0	0	0	ol Ol	3, 493, 595 713, 897	1
91. 00 09100 EMERGENCY	0	0	0	0	10, 447, 256	1
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		O	J	o _l	10, 447, 230	92.00
OTHER REIMBURSABLE COST CENTERS						72.00
94. 00 09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94. 00
95. 00 09500 AMBULANCE SERVICES	0	0	0	O	0	95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	О	0	0	96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	o	o	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	
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	0	0	0	0		100. 00
101.00 10100 HOME HEALTH AGENCY	0	0	0	0		101. 00
102. 00 10200 OPI OI D TREATMENT PROGRAM	0	0	0	0	0	102. 00
SPECIAL PURPOSE COST CENTERS	0	0		ما	0	105 00
105. 00 10500 KI DNEY ACQUI SI TI ON 106. 00 10600 HEART ACQUI SI TI ON	O O	0	0	0		105. 00 106. 00
107. 00 10700 LI VER ACQUI SI TI ON	0	0	0	0		107. 00
108.00 10800 LUNG ACQUISITION	0	0	0	0		107.00
109. 00 10900 PANCREAS ACQUISITION	0	0	0	0		109.00
110. 00 11000 NTESTI NAL ACQUI SI TI ON	0	0	0	0		110. 00
111. 00 11100 SLET ACQUISITION	0	0	Ö	0		111. 00
113. 00 11300 I NTEREST EXPENSE	1	_	_]	_	113. 00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	О	0	0	115. 00
116. 00 11600 H0SPI CE	0			O	0	116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	0	135, 923, 617	118. 00
NONREI MBURSABLE COST CENTERS	<u> </u>					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	145, 683	
191. 00 19100 RESEARCH	0	0	0	0		191. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0	0	0	2, 321, 749	
192. 01 19201 CENTER OF HOPE	0	0	0	0	138, 812	
192. 02 19202 OTHER FA FACILITIES NRCC	0	0	0	0	1, 119, 241	
193. 00 19300 NONPALD WORKERS 194. 00 07950 OTHER NRCC	O	0		0	0 133, 133	193. 00
200.00 Cross Foot Adjustments	0	0	0	0		200. 00
201.00 Negative Cost Centers	0	0	0	0		200.00
202.00 TOTAL (sum lines 118 through 201)	0	0	0	o	139, 873, 519	
252.55 101/12 (3411 111165 116 till 6491 201)	બ	O ₁	١	٩	.07, 070, 017	1202.00

Heal th FinancialSystemsFRANCISCAN HEALTH MUNSTERIn Lieu of Form CMS-2552-10COST ALLOCATION- GENERAL SERVICE COSTSProvider CCN: 15-0165Period:Worksheet B

From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/28/2024 2:16 pm Cost Center Description Intern & Total Residents Cost & Post Stepdown Adjustments 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 HOUSEKEEPING 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 33 090 648 30.00 31.00 03100 INTENSIVE CARE UNIT 7, 482, 138 31.00 0000000 03200 CORONARY CARE UNIT 32.00 0 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 12, 651, 136 50.00 51.00 05100 RECOVERY ROOM 0 3, 240, 528 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 53.00 05300 ANESTHESI OLOGY 150, 690 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 00000000 6, 945, 731 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 55.00 05600 RADI OI SOTOPE 56.00 56.00 57.00 05700 CT SCAN 1, 946, 360 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 1, 719, 442 58.00 05900 CARDI AC CATHETERI ZATI ON 59.00 7, 293, 793 59.00 06000 LABORATORY 9, 544, 818 60 00 60.00 60.01 06001 BLOOD LABORATORY 0 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 0 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 62.00 00000000000000000 0 62.00 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 Λ 63.00 64.00 06400 I NTRAVENOUS THERAPY 64.00 06500 RESPIRATORY THERAPY 65.00 2, 922, 379 65.00 66 00 06600 PHYSI CAL THERAPY 600, 993 66 00 06700 OCCUPATIONAL THERAPY 67.00 462, 015 67.00 06800 SPEECH PATHOLOGY 173, 322 68.00 68.00 69.00 06900 ELECTROCARDI OLOGY 906, 303 69.00 70 00 07000 FLECTROENCEPHALOGRAPHY 2, 398, 045 70 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 11, 534, 020 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 8, 104, 249 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 9, 407, 928 73.00 74.00 07400 RENAL DIALYSIS 0 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 694, 331 76.01 76.02 03952 WOUND CARE 0 C 76.02 07700 ALLOGENEIC STEM CELL ACQUISITION 0 77.00 77.00 78.00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 78.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 88.00 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0165

				To 12/31/2023 Date/Time P	
	Cost Center Description	Intern &	Total	372072024 2	. 10 piii
		Residents Cost			
		& Post			
		Stepdown Adjustments			
		25. 00	26. 00		
90.00 0	9000 CLI NI C	23.00	20.00		90.00
	9001 CLI NI C		3, 493, 595	l .	90. 01
	9002 CLI NI C	0	713, 897	•	90. 02
1	9100 EMERGENCY	0	10, 447, 256	•	91. 00
92.00 0	9200 OBSERVATION BEDS (NON-DISTINCT PART)	o			92. 00
0	THER REIMBURSABLE COST CENTERS	<u> </u>			
94.00 0	9400 HOME PROGRAM DIALYSIS	0	0		94. 00
95. 00 0	9500 AMBULANCE SERVICES	0	0		95. 00
	9600 DURABLE MEDICAL EQUIP-RENTED	0	0		96. 00
	9700 DURABLE MEDICAL EQUIP-SOLD	0	0		97. 00
	9850 OTHER REIMBURSE	0	0	1	98. 00
	9900 CMHC	0	0		99. 00
	9910 CORF	0	0	l .	99. 10
	0000 I &R SERVICES-NOT APPRVD PRGM	0	0	1	100.00
	0100 HOME HEALTH AGENCY	0	0	1	101.00
	0200 OPIOLD TREATMENT PROGRAM PECLAL PURPOSE COST CENTERS	0	0		102. 00
_	0500 KIDNEY ACQUISITION	0	0		105. 00
1	0600 HEART ACQUISITION		0	•	106.00
1	0700 LIVER ACQUISITION		0	•	107. 00
	0800 LUNG ACQUISITION	0	0		108. 00
	0900 PANCREAS ACQUISITION	0	0		109. 00
	1000 INTESTINAL ACQUISITION	0	0		110.00
111.001	1100 ISLET ACQUISITION	0	0		111. 00
113.001	1300 INTEREST EXPENSE				113. 00
1	1400 UTILIZATION REVIEW-SNF				114. 00
	1500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	I	115. 00
1	1600 HOSPI CE	0	0	1	116. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	0	135, 923, 617		118. 00
	ONREI MBURSABLE COST CENTERS		445 (00	I	
	9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	145, 683		190.00
	9100 RESEARCH 9200 PHYSI CI ANS' PRI VATE OFFI CES	0	91, 284		191. 00 192. 00
	9200 PHYSICIANS PRIVATE OFFICES 9201 CENTER OF HOPE		2, 321, 749 138, 812	•	192. 00
	9201 CENTER OF HOPE 9202 OTHER FA FACILITIES NRCC		1, 119, 241	•	192. 01
	9300 NONPALD WORKERS		1, 117, 241	1	193. 00
	7950 OTHER NRCC		133, 133	l .	194. 00
200.00	Cross Foot Adjustments	0	0	•	200. 00
201.00	Negative Cost Centers	0	0	l .	201. 00
202.00	TOTAL (sum lines 118 through 201)	0	139, 873, 519		202. 00
				•	•

	Financial Systems	FRANCI SCAN HEA		N 45 0415		u of Form CMS-	2552-10
ALLOCA	ATION OF CAPITAL RELATED COSTS	_	Provider CO		Period: From 01/01/2023 To 12/31/2023	Worksheet B Part II Date/Time Pre 5/28/2024 2:1	pared: 6 pm
			CAPI TAL REI	ATED COSTS			
	Cost Center Description	Directly Assigned New Capital	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		Related Costs 0	1. 00	2. 00	2A	4. 00	
1 00	GENERAL SERVICE COST CENTERS						1.00
1. 00 2. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1. 00 2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	317, 432	133, 00	450, 435	450, 435	
5.00	00500 ADMINISTRATIVE & GENERAL	0	2, 264, 558	948, 84	3, 213, 402	20, 068	1
6. 00 7. 00	00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT	0	0		0 0	11, 061 0	1
8.00	00800 LAUNDRY & LINEN SERVICE	0	0		0 0	0	
9.00	00900 HOUSEKEEPI NG	0	0	000 54	0 0	11, 119	
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	0	698, 137 0	292, 51	7 990, 654 0 0	2, 943 6, 497	
12. 00	01200 MAINTENANCE OF PERSONNEL	Ö	0		0 0	0, 177	
13.00	01300 NURSI NG ADMI NI STRATI ON	0	0		0	20, 182	
14. 00 15. 00	01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY	0	0 271, 173	113. 62	384, 794	2, 940 17, 134	
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	12, 761	5, 34		5, 353	
17.00	01700 SOCIAL SERVICE	0	0		0	0	1
18. 00 19. 00	01850 OTHER GEN SERV 01900 NONPHYSICIAN ANESTHETISTS	0	0		0 0	0	
20. 00	02000 NURSI NG PROGRAM	0	0		0 0	0	1
21. 00	02100 I &R SERVI CES-SALARY & FRI NGES APPRVD	0	0		0	0	21.00
22. 00 23. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD 02301 PARAMED ED PRGM	0	0		0 0	0	
	INPATIENT ROUTINE SERVICE COST CENTERS						1
30.00	03000 ADULTS & PEDIATRICS	0	3, 401, 798	1, 425, 34		123, 272	
31. 00 32. 00	03100 I NTENSI VE CARE UNI T 03200 CORONARY CARE UNI T	0	819, 721 0	343, 46	1, 163, 182 0 0	18, 542 0	1
33. 00	03300 BURN INTENSIVE CARE UNIT	0	0		0 0	0	1
34. 00 40. 00	03400 SURGI CAL INTENSI VE CARE UNIT	0	0		0	0	
41. 00	04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF	0	0		0 0	0	
43. 00	04300 NURSERY	0	0		0 0	0	10.00
44. 00 45. 00	04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY	0	0		0 0	0	
46. 00	04600 OTHER LONG TERM CARE	0	0		0 0	0	1
	ANCILLARY SERVICE COST CENTERS	_					ļ
50.00	05000 OPERATING ROOM 05100 RECOVERY ROOM	0	., ,	646, 89 283, 79		38, 178 6, 818	1
52. 00		0		203, 75	0 0		
53.00	05300 ANESTHESI OLOGY	0	0		0 0	352	53.00
54. 00 55. 00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	0	717, 810 0	300, 76	1, 018, 570	19, 296 0	1
56. 00	05600 RADI OI SOTOPE	0	0		0 0	0	1
57. 00	05700 CT SCAN	0	0		0 0	5, 058	
58. 00 59. 00	05800 MAGNETI C RESONANCE MAGING (MRI) 05900 CARDI AC CATHETERI ZATI ON	0	1, 458, 218	610, 98	0 39 2, 069, 207	8, 922 16, 214	1
60.00	06000 LABORATORY	0	250, 613			0	1
60. 01	06001 BLOOD LABORATORY	0	0		0	0	
61. 00 62. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	n		0 0	0	61. 00 62. 00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 0	0	1
64.00	06400 I NTRAVENOUS THERAPY	0	124.044	F2 21	0 0	14.463	
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0	124, 864 0	52, 31	7 177, 181 0 0	14, 463 3, 526	1
67. 00	06700 OCCUPATIONAL THERAPY	0	0		0 0	2, 731	67. 00
68. 00		0	0		0	1, 024	
69. 00 70. 00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	0	637, 256	267, 00	904, 264	4, 902 3, 422	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	71.00
72. 00 73. 00		0	0		0	0	
74.00	07400 RENAL DIALYSIS		0		o o	0	1
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	0 3, 945	
76. 01 76. 02			0		o o	3, 945 0	1
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0		0	0	77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY OUTPATIENT SERVICE COST CENTERS	0	0		0 0	0	78.00

| Period: | Worksheet B | From 01/01/2023 | Part II | To | 12/31/2023 | Date/Time Prepared: Provider CCN: 15-0165

			То	12/31/2023	Date/Time Pre 5/28/2024 2:1	
		CAPI TAL REI	ATED COSTS		372072024 2. 1	о ріп
Cost Center Description	Directly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
· ·	Assigned New				BENEFI TS	
	Capi tal				DEPARTMENT	
	Related Costs					
OO OO OOOOO EEDEDALLY OUALLELED HEALTH OFNITED	0	1.00	2.00	2A	4. 00	00.00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89. 00
90. 00 09000 CLI NI C 90. 01 09001 CLI NI C	0	0	0	0	17 725	90. 00 90. 01
90. 01 09001 CLI NI C	0	106, 963	44, 817	151, 780	17, 725 1, 975	
91. 00 09100 EMERGENCY	0	877, 323	367, 596	1, 244, 919	37, 276	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		077, 323	307, 370	1, 244, 717	37,270	92.00
OTHER REIMBURSABLE COST CENTERS				<u> </u>		72.00
94. 00 09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
95. 00 09500 AMBULANCE SERVICES	0	0	o	0	0	95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	o	Ö	0	96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	O	O	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		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				_1		
105. 00 10500 KI DNEY ACQUI SI TI ON	0	0	- 1	0		105. 00
106. 00 10600 HEART ACQUI SI TI ON	0	0	0	0		106. 00
107. 00 10700 LIVER ACQUI SI TI ON	0	0	0	0		107. 00
108.00 10800 LUNG ACQUISITION 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		1109.00
111. 00 11100 ISLET ACQUISITION	0	0		0		111.00
113. 00 11300 NTEREST EXPENSE		O	0	J	U	113. 00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF						114. 00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	0	0	115. 00
116. 00 11600 H0SPI CE	0	0	o	0		116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	14, 179, 850	5, 941, 319	20, 121, 169	424, 938	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	403	190. 00
191. 00 19100 RESEARCH	0	0	0	0	553	191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	17, 737	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	808	194. 00
200.00 Cross Foot Adjustments		-		0	_	200. 00
201.00 Negative Cost Centers		14 170 050	0	0 101 110		201. 00
202.00 TOTAL (sum lines 118 through 201)	0	14, 179, 850	5, 941, 319	20, 121, 169	450, 435	ZUZ. UU

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2023 Part II
To 12/31/2023 Date/Time Prepared: 5/28/2024 2:16 pm

		1		'		5/28/2024 2: 1	
	Cost Center Description	ADMI NI STRATI VE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	
	January 2007	5.00	6.00	7. 00	8. 00	9. 00	
1. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT			I			1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMI NI STRATI VE & GENERAL	3, 233, 470	0.40.000				5. 00
6. 00 7. 00	00600 MAI NTENANCE & REPAIRS 00700 OPERATION OF PLANT	229, 261	240, 322	2			6. 00 7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	8, 616			8, 616		8.00
9. 00	00900 HOUSEKEEPI NG	52, 196	Č	o o	0,010	63, 315	9. 00
10.00	01000 DI ETARY	44, 346	14, 466	0	0	3, 811	1
11. 00	01100 CAFETERI A	0	C	0	0	0	11. 00
12. 00 13. 00	01200 MAI NTENANCE OF PERSONNEL 01300 NURSI NG ADMI NI STRATI ON	91, 482	C	0	0	0	12. 00 13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	3, 281			0	0	14. 00
15. 00	01500 PHARMACY	84, 392	5, 619	o	0	1, 480	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	56, 812	264	· 0	0	70	16. 00
17. 00	01700 SOCIAL SERVICE	0	C	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		C		0	0	20.00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	O	Ċ	o o	0	0	21. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	0	C	0	0	0	22. 00
23. 00	02301 PARAMED ED PRGM	0	C) 0	0	0	23. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	586, 131	70, 490) 0	5, 860	18, 570	30.00
31. 00	03100 I NTENSI VE CARE UNI T	112, 277	16, 986	•	2, 756		31.00
32.00	03200 CORONARY CARE UNIT	o	C	0	0	0	32. 00
33. 00	03300 BURN INTENSIVE CARE UNIT	0	C	0	0	0	33. 00
34. 00	03400 SURGICAL INTENSIVE CARE UNIT	0	C	0	0	0	34.00
40. 00 41. 00	04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF				0	0	40. 00 41. 00
43. 00	04300 NURSERY		C		0	0	43. 00
44.00	04400 SKILLED NURSING FACILITY	0	C	0	0	0	44. 00
45. 00	04500 NURSING FACILITY	0	С	0	0	0	45. 00
46. 00	04600 OTHER LONG TERM CARE ANCI LLARY SERVICE COST CENTERS	0	C) 0	0	0	46. 00
50. 00	05000 OPERATING ROOM	233, 996	31, 992	2 0	0	8, 429	50.00
51.00	05100 RECOVERY ROOM	54, 215	14, 035		0		•
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	C	0	0	0	52. 00
53.00	05300 ANESTHESI OLOGY	1, 483	14.074	0	0	0	53.00
54. 00 55. 00	05400 RADI OLOGY - DI AGNOSTI C 05500 RADI OLOGY - THERAPEUTI C	139, 651	14, 874		0	3, 919 0	54. 00 55. 00
56. 00	05600 RADI OI SOTOPE	Ö	C	ol o	0	Ö	56. 00
57. 00	05700 CT SCAN	40, 166	C	0	0	0	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	38, 460	C	0	0	0	58. 00
59. 00 60. 00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	127, 049 209, 514	30, 216 5, 193	•	0	7, 961 1, 368	59. 00 60. 00
60. 00	1 1	209, 314	5, 193 C	1	0	0	1
61. 00							61.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	C	0	0	0	62. 00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	C	0	0	0	63.00
64. 00 65. 00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	64, 250	2, 587	7	0	0 682	64. 00 65. 00
66. 00	06600 PHYSI CAL THERAPY	13, 719	2, 307	o o	0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	10, 505	C	0	0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	3, 935	C	0	0	0	68. 00
69. 00 70. 00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	19, 131	13, 205	0	0	0 3, 479	69. 00 70. 00
70.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	39, 917 263, 109	13, 200		0	3, 479	70.00
72. 00	1	184, 698	Ċ	o o	0	Ö	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	125, 082	C	0	0	0	73. 00
74.00	07400 RENAL DIALYSIS	0	C	0	0	0	74.00
75. 00 76. 00	07500 ASC (NON-DISTINCT PART) 03950 OTHER ANCILL SRVC	0	C		0	0	75. 00 76. 00
76. 00 76. 01	03951 CARDIAC AND PULMONARY REHAB	15, 302) 0	0	0	76.00
76. 02	03952 WOUND CARE	0	C	o	0	Ö	76. 02
	07700 ALLOGENEIC STEM CELL ACQUISITION	0	C	0	0	0	77. 00
78. 00		0	C) 0	0	0	78. 00
88. 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	O	() 0	0	0	88. 00
89. 00	1 1		C	o o	0	0	89. 00
90.00	09000 CLI NI C	0	C	0	0	0	90. 00
90. 01	09001 CLI NI C	75, 281	0	0	0	0	90. 01
90. 02	09002 CLI NI C	12, 715	2, 216	<u>ا</u> ر	1 0	584	90. 02

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0165

Peri od: Worksheet B From 01/01/2023 Part II 12/31/2023 Date/Time Prepared:

5/28/2024 2:16 pm ADMINISTRATIVE MAINTENANCE & Cost Center Description OPERATION OF LAUNDRY & HOUSEKEEPI NG & GENERAL **REPAI RS** LINEN SERVICE **PLANT** 5.00 6.00 7.00 8.00 9.00 91. 00 09100 EMERGENCY 91. 00 204, 675 18 179 4, 789 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DIALYSIS 94.00 00000000 0 94.00 0 95 00 09500 AMBULANCE SERVICES Ω 0 0 0 0 0 0 95.00 0 09600 DURABLE MEDICAL EQUIP-RENTED 96.00 0 0 96.00 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 97.00 09850 OTHER REIMBURSE 0 98.00 0 0 98.00 09900 CMHC 0 99.00 99 00 0 0 99. 10 09910 CORF 0 0 0 99. 10 100.00 10000 I &R SERVICES-NOT APPRVD PRGM 0 0 0 100.00 101.00 10100 HOME HEALTH AGENCY 0 0 0 101.00 Ω 102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 102. 00 SPECIAL PURPOSE COST CENTERS 105. 00 10500 KI DNEY ACQUI SI TI ON 0 0 0 0 105. 00 0 106. 00 10600 HEART ACQUISITION 0 106.00 0 107. 00 10700 LIVER ACQUISITION 0 0 0 0 0 0 0 0 0 107. 00 108.00 10800 LUNG ACQUISITION 0 0 108. 00 109. 00 10900 PANCREAS ACQUISITION 110. 00 11000 INTESTINAL ACQUISITION 0 0 109. 00 0 0 0 0 110.00 111.00 11100 | SLET ACQUISITION 0 0 0 0 111. 00 113. 00 11300 | NTEREST EXPENSE 113. 00 114.00 11400 UTI LI ZATI ON REVI EW-SNF 114.00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 C 0 0 0 115. 00 116. 00 11600 HOSPI CE 0 0 116.00 SUBTOTALS (SUM OF LINES 1 through 117) 8, 616 63, 315 118. 00 118.00 3, 145, 647 240, 322 0 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190. 00 3, 391 0 0 0 191. 00 19100 RESEARCH 2, 125 0 0 191.00 0 0 0 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 0 192, 00 52, 590 0 0 192. 01 19201 CENTER OF HOPE 3, 219 0 0 192, 01 0 192.02 19202 OTHER FA FACILITIES NRCC 23, 399 0 0 192. 02 193. 00 19300 NONPALD WORKERS 0 0 0 193.00 0 o 194.00 07950 OTHER NRCC 3 099 0 0 194.00 200.00 200.00 Cross Foot Adjustments 201.00 Negative Cost Centers 0 0 201. 00 202.00 TOTAL (sum lines 118 through 201) 3. 233. 470 240, 322 0 8.616 63, 315 202. 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2023 | Part II | To 12/31/2023 | Date/Time Prepared: | 5/28/2024 2:16 pm

	Cost Center Description	DI ETARY	CAFETERI A	MAI NTENANCE OF PERSONNEL	NURSI NG ADMI NI STRATI ON	5/28/2024 2: 1 CENTRAL SERVI CES & SUPPLY	
		10.00	11. 00	12.00	13.00	14.00	
1. 00	GENERAL SERVICE COST CENTERS O0100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-BLDG & FTXT						2.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						5. 00
6.00	00600 MAINTENANCE & REPAIRS						6. 00
7.00	00700 OPERATION OF PLANT						7. 00
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	1, 056, 220					9. 00 10. 00
11. 00	01100 CAFETERI A	1,030,220	6, 497	,			11.00
12. 00	01200 MAINTENANCE OF PERSONNEL	l o	(12.00
13.00	01300 NURSING ADMINISTRATION	o	() c	111, 664		13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	() c	70	6, 291	14. 00
15.00	01500 PHARMACY	0	(0	13	15.00
16. 00 17. 00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	0	(14	0	16. 00 17. 00
18. 00	01850 OTHER GEN SERV		(0	18.00
19. 00	01900 NONPHYSICIAN ANESTHETISTS		(ól ől	0	19.00
20. 00	02000 NURSI NG PROGRAM	o	Ć	o c	o	0	20.00
21.00	02100 I&R SERVICES-SALARY & FRINGES APPRVD	o	() c	o	0	21. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	0	() c	0	0	22. 00
23. 00	O2301 PARAMED ED PRGM	0	() <u> </u>	0	0	23. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	718, 372	4, 419	el c	43, 919	19	30.00
31. 00	03100 I NTENSI VE CARE UNI T	337, 848	2, 078			4	31.00
32. 00	03200 CORONARY CARE UNIT	0	2,070			0	32. 00
33. 00	03300 BURN INTENSIVE CARE UNIT	o	Ċ		o	0	33. 00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	o	(o c	o	0	34.00
40.00	04000 SUBPROVI DER - I PF	O	(o c	o	0	40. 00
41. 00	04100 SUBPROVI DER - I RF	0	() c	0	0	41. 00
43. 00	04300 NURSERY	0	(0	0	43.00
44. 00	04400 SKI LLED NURSI NG FACILITY	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	<u> </u>		7	η		40.00
50.00	05000 OPERATING ROOM	0	(0	16, 828	100	50.00
51.00	05100 RECOVERY ROOM	0	() c	4, 362	2	51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	() C	0	0	52. 00
53.00	05300 ANESTHESI OLOGY	0	(0	0	53.00
54. 00 55. 00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	0	(3	9	54. 00 55. 00
56. 00	05600 RADI OI SOTOPE		(0	56. 00
57. 00	05700 CT SCAN	l o	(25	0	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	o	(o c	o	7	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	o	() c	7, 156	2	59. 00
60.00	06000 LABORATORY	0	() C	0	0	60.00
60. 01	06001 BLOOD LABORATORY	0	(O	0	0	60. 01
61. 00 62. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS					0	61. 00 62. 00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.		(0	63.00
64. 00	06400 I NTRAVENOUS THERAPY		(ól ől	0	64. 00
65.00	06500 RESPI RATORY THERAPY	o	Ć	o c	o	3	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	() c	o	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	() c	0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	() C	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	0	(2	69.00
70. 00 71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	(4 3, 592	70. 00 71. 00
71.00	07200 IMPL. DEV. CHARGED TO PATIENTS		(2, 524	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS		(ol ol	0	73. 00
74.00	07400 RENAL DIALYSIS	o	Ć		ol ol	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	0	0	76. 00
76. 01	03951 CARDI AC AND PULMONARY REHAB	0	(C	910	0	76. 01
76. 02	03952 WOUND CARE	0	(0	76. 02
77. 00 78. 00	O7700 ALLOGENEIC STEM CELL ACQUISITION O7800 CAR T-CELL IMMUNOTHERAPY	0	(0	77. 00 78. 00
70. UU	OUTPATIENT SERVICE COST CENTERS	<u> </u>	(<i>γ</i> ι	, U	U	, 70.00
88. 00	08800 RURAL HEALTH CLINIC	0	(C	ol	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	O	() c	o o	0	89. 00
90.00	09000 CLI NI C	0	(0	0	90.00
90. 01	09001 CLI NI C	0	(η C	3, 881	2	90. 01

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0165

			T	o 12/31/2023	Date/Time Prep 5/28/2024 2:10	
Cost Center Description	DI ETARY	CAFETERI A	MAINTENANCE OF	NURSI NG	CENTRAL	o piii
· ·			PERSONNEL	ADMI NI STRATI ON	SERVICES &	
					SUPPLY	
00.00.000000000000000000000000000000000	10.00	11.00	12.00	13.00	14. 00	00.00
90. 02 09002 CLINIC	0	0	1	, , , , ,	4	90. 02
91. 00 09100 EMERGENCY	0	0	0	14, 818	4	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS						92. 00
94. 00 O9400 HOME PROGRAM DI ALYSI S	ام		0	ol	0	94. 00
95. 00 09500 AMBULANCE SERVI CES	0	0	0	_	0	94. 00 95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0	0	96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD		0			0	97. 00
98. 00 09850 OTHER REIMBURSE		0	0	٥	0	98. 00
99. 00 09900 CMHC		0	0	٥	0	99. 00
99. 10 09910 CORF		0	0	٥	0	99. 10
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	0	0	0	ol ol		100.00
101. 00 10100 HOME HEALTH AGENCY		0	0	o	-	101. 00
102.00 10200 OPI OI D TREATMENT PROGRAM	o	0	Ö	ol		102. 00
SPECIAL PURPOSE COST CENTERS	-1	-	-	-1	-	
105.00 10500 KIDNEY ACQUISITION	0	0	0	0	0	105.00
106.00 10600 HEART ACQUISITION	o	0	0	o	0	106. 00
107.00 10700 LIVER ACQUISITION	o	0	0	o	0	107. 00
108.00 10800 LUNG ACQUISITION	0	0	0	0	0	108.00
109.00 10900 PANCREAS ACQUISITION	0	0	0	0	0	109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0		110. 00
111.00 11100 I SLET ACQUI SI TI ON	0	0	0	0	0	111. 00
113.00 11300 I NTEREST EXPENSE						113. 00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	0		115. 00
116. 00 11600 HOSPI CE	0	0	0	_		116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	1, 056, 220	6, 497	0	106, 639	6, 291	118. 00
NONREI MBURSABLE COST CENTERS			1	ام	0	100.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190. 00
191. 00 19100 RESEARCH	0	0	0	1 772		191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES 192.01 19201 CENTER OF HOPE	0	0	0	1, 773 14		192. 00 192. 01
192. 01 19201 CENTER OF HOPE 192. 02 19202 OTHER FA FACILITIES NRCC	0	0	0	3, 238		192. 01
193. 00 19300 NONPALD WORKERS	0	0		3, 230		192. 02
194. 00 07950 OTHER NRCC		0				193.00
200.00 Cross Foot Adjustments		0				200. 00
201.00 Negative Cost Centers	٥	0	0	٥		200. 00
202.00 TOTAL (sum lines 118 through 201)	1, 056, 220	6, 497	Ö	111, 664		201.00
((.,	=, .,,	'	, 00 .	=, =,	

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2023 Part II
To 12/31/2023 Date/Time Prepared: 5/28/2024 2:16 pm Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0165

							5/28/2024 2:1	
						OTHER GENERAL		
		Cost Center Description	PHARMACY	MEDI CAL	SOCIAL SERVICE	SERVI CE OTHER GEN SERV	NONPHYSI CI AN	
		·		RECORDS &			ANESTHETI STS	
			15. 00	16. 00	17. 00	18. 00	19. 00	
	GENER	AL SERVICE COST CENTERS	10.00	10. 00	17.00	10.00	17.00	
1.00	1	CAP REL COSTS-BLDG & FIXT						1. 00
2. 00 4. 00	1	CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT						2. 00 4. 00
5.00		ADMINISTRATIVE & GENERAL						5. 00
6.00	1	MAINTENANCE & REPAIRS						6. 00
7.00	1	OPERATION OF PLANT						7. 00
8. 00 9. 00	1	LAUNDRY & LINEN SERVICE HOUSEKEEPING						8. 00 9. 00
10.00	1	DI ETARY						10.00
11. 00	1	CAFETERI A						11. 00
12.00	1	MAINTENANCE OF PERSONNEL						12.00
13. 00 14. 00	1	NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY						13. 00 14. 00
15. 00	1	PHARMACY	493, 432					15. 00
16. 00	1	MEDICAL RECORDS & LIBRARY	0	80, 621				16. 00
17. 00 18. 00	1	SOCIAL SERVICE OTHER GEN SERV	0	0	1			17. 00 18. 00
19. 00		NONPHYSICIAN ANESTHETISTS	0	0		0	0	19. 00
20. 00	1	NURSI NG PROGRAM	O	0	C	0		20. 00
21. 00	1	I &R SERVICES-SALARY & FRINGES APPRVD	0	0	C	0		21. 00
22. 00 23. 00	1	I&R SERVICES-OTHER PRGM COSTS APPRVD PARAMED ED PRGM	0	0				22. 00 23. 00
23.00		IENT ROUTINE SERVICE COST CENTERS	5			<u> </u>		25.00
30.00		ADULTS & PEDIATRICS	0	4, 037	C			30. 00
31. 00 32. 00		INTENSIVE CARE UNIT CORONARY CARE UNIT	0	2, 026 0		0		31. 00 32. 00
33. 00	1	BURN INTENSIVE CARE UNIT	0	0	i c	0		33.00
34. 00	1	SURGICAL INTENSIVE CARE UNIT	O	0	C	0		34. 00
40.00	1	SUBPROVI DER - I PF	0	0	C	0		40.00
41. 00 43. 00	1	SUBPROVI DER - I RF NURSERY	0	0		0		41. 00 43. 00
44. 00	1	SKILLED NURSING FACILITY	0	0	Ö	0		44. 00
45.00	1	NURSING FACILITY	0	0				45. 00
46. 00		OTHER LONG TERM CARE LARY SERVICE COST CENTERS	0	0	C	0		46. 00
50. 00		OPERATING ROOM	0	12, 766	С	0		50. 00
51.00	05100	RECOVERY ROOM	0	1, 700		0		51. 00
52.00	1	DELIVERY ROOM & LABOR ROOM	0	2 943	1	0		52.00
53. 00 54. 00	1	ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C	0	2, 863 6, 499		0		53. 00 54. 00
55. 00		RADI OLOGY-THERAPEUTI C	Ö	0		0		55. 00
56. 00	1	RADI OI SOTOPE	0	0	C	0		56. 00
57. 00 58. 00	1	CT SCAN MAGNETIC RESONANCE IMAGING (MRI)	0	7, 241 2, 205				57. 00 58. 00
59.00		CARDI AC CATHETERI ZATI ON	0	2, 084		0		59.00
60.00	06000	LABORATORY	0	9, 300		0		60. 00
60. 01	1	BLOOD LABORATORY	0	0	C	0		60. 01
61. 00 62. 00		PBP CLINICAL LAB SERVICES-PRGM ONLY WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	l o	0		61. 00 62. 00
63. 00	1	BLOOD STORING, PROCESSING & TRANS.	o	0	C	0		63. 00
64. 00	1	I NTRAVENOUS THERAPY	0	0		0		64. 00
65. 00 66. 00	1	RESPI RATORY THERAPY PHYSI CAL THERAPY	0	1, 049 383		0		65. 00 66. 00
67. 00		OCCUPATI ONAL THERAPY	0	353		0		67. 00
68. 00	1	SPEECH PATHOLOGY	0	141	C	0		68. 00
69. 00 70. 00	1	ELECTROCARDI OLOGY ELECTROENCEPHALOGRAPHY	0	2, 770 613		0		69. 00 70. 00
71.00	1	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4, 888		0		70.00
72. 00		IMPL. DEV. CHARGED TO PATIENTS	0	3, 681		0		72. 00
73.00	1	DRUGS CHARGED TO PATIENTS	493, 432	4, 133		0		73.00
74. 00 75. 00	1	RENAL DIALYSIS ASC (NON-DISTINCT PART)	0	0		0		74. 00 75. 00
76. 00		OTHER ANCILL SRVC	0	0		o		76. 00
76. 01	1	CARDIAC AND PULMONARY REHAB	0	161	C	0		76. 01
76. 02 77. 00	1	WOUND CARE ALLOGENEIC STEM CELL ACQUISITION	0	0		0		76. 02 77. 00
78.00	1	CAR T-CELL IMMUNOTHERAPY	0	0				78.00
	OUTPA	TIENT SERVICE COST CENTERS						
88. 00 89. 00		RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER	0	0				88. 00
09.00	100400	I EDENALLI QUALIFIED HEALIH CENTER	l 이	0	[C	ı U		89. 00

| Peri od: | Worksheet B | From 01/01/2023 | Part | I | To | 12/31/2023 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0165

			Т	o 12/31/2023	Date/Time Pre 5/28/2024 2:1	
				OTHER GENERAL	072072021 2. 1	J piii
				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. 00 09000 CLI NI C	0	0	1	0		90.00
90. 01 09001 CLI NI C	0	4, 041	C	0		90. 01
90. 02 09002 CLI NI C	0	518		0		90. 02
91. 00 09100 EMERGENCY	0	7, 169	r C	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) C	0		94. 00
95. 00 09500 AMBULANCE SERVICES	0	0) C	0		95. 00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0) C	0		96. 00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0) C	0		97. 00
98. 00 09850 OTHER REI MBURSE	0	0	C	0		98. 00
99. 00 09900 CMHC	0	0	C	0		99. 00
99. 10 09910 CORF	0	0) C	0		99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	(0		100. 00
101.00 10100 HOME HEALTH AGENCY	0	0	(0		101. 00
102.00 10200 OPIOLD TREATMENT PROGRAM	0	0	<u>C</u>	0		102. 00
SPECIAL PURPOSE COST CENTERS			1			4
105. 00 10500 KIDNEY ACQUISITION	0	0	1			105. 00
106. 00 10600 HEART ACQUISITION	0	0		0		106. 00
107. 00 10700 LI VER ACQUI SI TI ON	0	0		0		107. 00
108. 00 10800 LUNG ACQUISITION	0	0		0		108. 00
109. 00 10900 PANCREAS ACQUISITION	0	0		0		109. 00
110. 00 11000 NTESTI NAL ACQUI SI TI ON	0	0		0		110.00
111. 00 11100 SLET ACQUI SI TI ON	0	0	1) O		111.00
113. 00 11300 INTEREST EXPENSE						113.00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF		•				114.00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0		0		115. 00
116.00 11600 HOSPICE 118.00 SUBTOTALS (SUM OF LINES 1 through 117)	493, 432	80, 621			_	116. 00 118. 00
118. 00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	493, 432	80, 621) 0	0	1118.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	1) 0		190. 00
191. 00 19100 RESEARCH		0		,		191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES		0				192. 00
192. 01 19201 CENTER OF HOPE		0				192. 00
192. 02 19202 OTHER FA FACILITIES NRCC		0				192. 01
193. 00 19300 NONPALD WORKERS		0				193. 00
194. 00 07950 OTHER NRCC		0				194. 00
200.00 Cross Foot Adjustments		0	1	ή	_	200. 00
201.00 Negative Cost Centers	0	0				201.00
202.00 TOTAL (sum lines 118 through 201)	493, 432	80, 621				202.00
	1,0,102	00, 021	,	٠, ١	'	1-02.00

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2023 | Part II | To 12/31/2023 | Date/Time Prepared: | Part | Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0165

				11	0 12/31/2023	Date/lime Pre 5/28/2024 2:1	
			INTERNS &	RESI DENTS			
	Cost Center Description	NURSI NG	SERVICES_SALAR	SERVI CES-OTHER	PARAMED ED	Subtotal	
	cost center bescription	PROGRAM	Y & FRINGES	PRGM COSTS	PRGM	Subtotal	
	OFFICE OFFICE OFFICE	20. 00	21. 00	22. 00	23. 00	24. 00	
1. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT		I				1.00
2.00	00200 CAP REL COSTS-BUBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						5. 00
6. 00 7. 00	00600 MAI NTENANCE & REPAI RS						6.00
7. 00 8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE						7. 00 8. 00
9. 00	00900 HOUSEKEEPING						9. 00
10.00	01000 DI ETARY						10. 00
11. 00	01100 CAFETERI A						11.00
12. 00 13. 00	01200 MAINTENANCE OF PERSONNEL 01300 NURSING ADMINISTRATION						12. 00 13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY						14. 00
15. 00	01500 PHARMACY						15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY						16. 00
17.00	01700 SOCIAL SERVICE						17. 00
18. 00 19. 00	O1850 OTHER GEN SERV O1900 NONPHYSICIAN ANESTHETISTS						18. 00 19. 00
20. 00	02000 NURSI NG PROGRAM	0		•			20.00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRVD		0				21. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD			0			22. 00
23. 00	02301 PARAMED ED PRGM NPATIENT ROUTINE SERVICE COST CENTERS				0		23. 00
30. 00	03000 ADULTS & PEDIATRICS					6, 402, 233	30.00
31. 00	03100 NTENSIVE CARE UNIT					1, 673, 675	31.00
32. 00	03200 CORONARY CARE UNIT					0	32. 00
33.00	03300 BURN INTENSIVE CARE UNIT					0	33.00
34. 00 40. 00	03400 SURGICAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF					0 0	34. 00 40. 00
41. 00	04100 SUBPROVI DER - I RF			•		0	41. 00
43.00	04300 NURSERY					0	43. 00
44. 00	04400 SKILLED NURSING FACILITY					0	44. 00
45. 00 46. 00	04500 NURSING FACILITY 04600 OTHER LONG TERM CARE					0 0	45. 00 46. 00
40.00	ANCI LLARY SERVI CE COST CENTERS						1 40.00
50.00	05000 OPERATING ROOM					2, 533, 096	1
51.00	05100 RECOVERY ROOM					1, 045, 933	1
52. 00 53. 00	05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY					0 4, 698	52. 00 53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C					1, 202, 821	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C					0	55. 00
56. 00	05600 RADI OI SOTOPE					0	56.00
57. 00 58. 00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)					52, 490 49, 594	1
	05900 CARDI AC CATHETERI ZATI ON					2, 259, 889	
60.00	06000 LABORATORY					580, 994	60.00
60. 01	06001 BLOOD LABORATORY					0	60. 01
61. 00 62. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS					0	61. 00 62. 00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.					0	63.00
64. 00	06400 I NTRAVENOUS THERAPY					0	64.00
65. 00	06500 RESPI RATORY THERAPY					260, 215	1
66.00	06600 PHYSI CAL THERAPY					17, 628	1
67. 00 68. 00	06700 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY					13, 589 5, 100	1
69. 00	06900 ELECTROCARDI OLOGY					26, 812	1
70. 00	07000 ELECTROENCEPHALOGRAPHY					964, 904	1
71. 00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS					271, 589	1
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS					190, 903 622, 647	1
74. 00	07400 RENAL DIALYSIS					022, 047	1
75. 00	07500 ASC (NON-DISTINCT PART)					0	75. 00
76.00	03950 OTHER ANCILL SRVC					0	76. 00
76. 01 76. 02	03951 CARDI AC AND PULMONARY REHAB 03952 WOUND CARE					20, 318 0	76. 01 76. 02
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION					0	1
	07800 CAR T-CELL IMMUNOTHERAPY					0	1
00	OUTPATIENT SERVICE COST CENTERS						00.00
88. 00 89. 00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER					0	
	09000 CLINIC					0	
			•			-	·

In Lieu of Form CMS-2552-10
Period: Worksheet B
From 01/01/2023 Part II Provider CCN: 15-0165

			Ť	0 12/31/2023	Date/Time Pre 5/28/2024 2:1	pared:
		INTERNS &	RESI DENTS		7 07 207 202 1 21 1	<u>Б</u>
Cost Center Description	NURSI NG		SERVI CES-OTHER		Subtotal	
	PROGRAM	Y & FRINGES	PRGM COSTS	PRGM		
	20. 00	21.00	22. 00	23. 00	24. 00	
90. 01 09001 CLI NI C					100, 930	
90. 02 09002 CLI NI C					170, 937	90. 02
91. 00 09100 EMERGENCY					1, 531, 829	91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART)						92. 00
OTHER REIMBURSABLE COST CENTERS	I					04.00
94. 00 09400 HOME PROGRAM DI ALYSI S					0	94. 00
95. 00 09500 AMBULANCE SERVICES					0	95. 00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED					0	96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD					0	97. 00
98. 00 09850 OTHER REI MBURSE 99. 00 09900 CMHC					0	98. 00
					0	99. 00
99. 10 09910 CORF					0	99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM						100.00
101. 00 10100 HOME HEALTH AGENCY						101. 00 102. 00
102.00 10200 OPLOID TREATMENT PROGRAM SPECIAL PURPOSE COST CENTERS		<u> </u>			U	102.00
105. 00 10500 KI DNEY ACQUI SI TI ON			I		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						107. 00
109. 00 10900 PANCREAS ACQUISITION						109. 00
110. 00 11000 NTESTINAL ACQUISITION						110.00
111. 00 11100 SLET ACQUI SI TI ON						111. 00
113. 00 11300 NTEREST EXPENSE					U	113. 00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF						114. 00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)						115. 00
116. 00 11600 HOSPI CE						116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)		0	0	o	20, 002, 824	
NONREI MBURSABLE COST CENTERS		, 0	0	<u> </u>	20, 002, 024	110.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN					3 794	190. 00
191. 00 19100 RESEARCH					· ·	191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES					72, 100	
192. 01 19201 CENTER OF HOPE					· ·	192. 01
192. 02 19202 OTHER FA FACILITIES NRCC					31, 793	
193. 00 19300 NONPALD WORKERS						193. 00
194. 00 07950 OTHER NRCC						194. 00
200.00 Cross Foot Adjustments	0	0	0	o		200. 00
201.00 Negative Cost Centers		ا ا	ا م	Ö		201. 00
202.00 TOTAL (sum lines 118 through 201)	l d	Ö	Ö		20, 121, 169	
, , , , , , , , , , , , , , , , , , ,		1		-1		

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

From 01/01/2023 Part II Date/Time Prepared: 12/31/2023 5/28/2024 2:16 pm Cost Center Description Intern & Total Residents Cost & Post Stepdown Adjustments 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 HOUSEKEEPING 9.00 01000 DI ETARY 10 00 10 00 01100 CAFETERI A 11.00 11.00 12. 00 01200 MAINTENANCE OF PERSONNEL 12.00 01300 NURSING ADMINISTRATION 13.00 13.00 01400 CENTRAL SERVICES & SUPPLY 14 00 14 00 15. 00 01500 PHARMACY 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16.00 01700 SOCIAL SERVICE 17 00 17 00 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 6, 402, 233 30.00 31.00 03100 INTENSIVE CARE UNIT 1, 673, 675 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 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 0 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 50.00 05000 OPERATING ROOM 0 2, 533, 096 51.00 05100 RECOVERY ROOM 0 1,045,933 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 53.00 05300 ANESTHESI OLOGY 4, 698 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 00000000 1, 202, 821 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 55.00 56.00 05600 RADI OI SOTOPE 56.00 57.00 05700 CT SCAN 52, 490 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 49, 594 58.00 05900 CARDI AC CATHETERI ZATI ON 59.00 2, 259, 889 59.00 06000 LABORATORY 60 00 60.00 580, 994 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 65.00 260, 215 65.00 66 00 06600 PHYSI CAL THERAPY 17, 628 66 00 06700 OCCUPATIONAL THERAPY 67.00 13, 589 67.00 06800 SPEECH PATHOLOGY 5, 100 68.00 68.00 69.00 06900 ELECTROCARDI OLOGY 26, 812 69.00 70 00 07000 ELECTROENCEPHALOGRAPHY 964.904 70 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 271, 589 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 190, 903 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 622, 647 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 20, 318 76.01 76.02 03952 WOUND CARE 0 C 76.02 07700 ALLOGENEIC STEM CELL ACQUISITION 0 77.00 77.00 78.00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 78.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 88.00 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00

ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0165 Peri od: Worksheet B From 01/01/2023 Part II Date/Time Prepared: 12/31/2023 5/28/2024 2:16 pm Cost Center Description Intern & Total Residents Cost & Post Stepdown Adjustments 25.00 26.00 90. 00 09000 CLINIC 90.00 09001 CLI NI C 0 90. 01 100, 930 90.01 0 09002 CLINIC 90.02 170, 937 90.02 09100 EMERGENCY 91.00 1,531,829 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DIALYSIS 94.00 94.00 0 0 0 0 0 0 0 09500 AMBULANCE SERVICES 95.00 0 95.00 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED 0 96.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 97.00 97.00 09850 OTHER REIMBURSE 0 98.00 98.00 99. 00 09900 CMHC 0 99.00 99. 10 09910 CORF 0 99. 10 100.00 10000 I &R SERVICES-NOT APPRVD PRGM 100.00 0 101.00 10100 HOME HEALTH AGENCY 0 101.00 102.00 10200 OPI OI D TREATMENT PROGRAM 0 102. 00 SPECIAL PURPOSE COST CENTERS 105. 00 10500 KI DNEY ACQUI SI TI ON 0 105.00 00000 106.00 10600 HEART ACQUISITION 0 106.00 107. 00 10700 LIVER ACQUISITION 0 107. 00 108.00 10800 LUNG ACQUISITION 0 108. 00 109. 00 10900 PANCREAS ACQUISITION 0 109.00 110.00 11000 INTESTINAL ACQUISITION 0 110. 00 111.00 11100 I SLET ACQUISITION 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 0 115. 00 0 116. 00 11600 HOSPI CE 116. 00 SUBTOTALS (SUM OF LINES 1 through 117)
NONREI MBURSABLE COST CENTERS 118.00 20, 002, 824 118. 00 3, 794 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190.00 191. 00 19100 RESEARCH 000000000 2, 678 191. 00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 72, 100 192. 00 192. 01 19201 CENTER OF HOPE 4,073 192. 01 192.02 19202 OTHER FA FACILITIES NRCC 192. 02 31, 793 193. 00 19300 NONPALD WORKERS 193. 00 C 194.00 07950 OTHER NRCC 194. 00 3, 907

0

20, 121, 169

200.00

201. 00

202.00

200.00

201.00

202.00

Cross Foot Adjustments

TOTAL (sum lines 118 through 201)

Negative Cost Centers

				From 01/01/2023 To 12/31/2023	Date/Ti me Pre 5/28/2024 2:1	
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) 4. 00	5A	5. 00	
GENERAL SERVICE COST CENTERS	1/0 010					1 00
1. 00 00100 CAP REL COSTS-BLDG & FLXT 2. 00 00200 CAP REL COSTS-MVBLE EQUIP	160, 010	160, 010				1. 00 2. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.00 00500 ADMINISTRATIVE & GENERAL 6.00 00600 MAINTENANCE & REPAIRS 7.00 00700 OPERATION OF PLANT	3, 582 25, 554 0 0	3, 582	48, 049, 42 2, 140, 76 1, 179, 97	4 -23, 232, 322	115, 683, 253 8, 202, 262 0	4. 00 5. 00 6. 00 7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE 9. 00 00900 HOUSEKEEPING 10. 00 01000 DIETARY 11. 00 01100 CAFETERIA	0 0 7,878 0	0 0 7, 878 0	1, 186, 20 313, 97 693, 09	3 0	308, 241 1, 867, 393 1, 586, 571	11. 00
12. 00 01200 MAI NTENANCE OF PERSONNEL 13. 00 01300 NURSI NG ADMI NI STRATI ON 14. 00 01400 CENTRAL SERVI CES & SUPPLY 15. 00 01500 PHARMACY 16. 00 01600 MEDI CAL RECORDS & LI BRARY	0 0 0 3, 060 144	0 0 0 3, 060 144	2, 152, 96 313, 62 1, 827, 84 570, 99	2 0	0 3, 272, 950 117, 381 3, 019, 292	12. 00 13. 00 14. 00 15. 00 16. 00
18. 00 01700 NORTH RECORDS & LIBRARY 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	0 0	0	370, 99		2, 032, 573 0 0 0 0	17. 00 18. 00 19. 00 20. 00
21.00 02100 I &R SERVI CES-SALARY & FRINGES APPRVD 22.00 02200 I &R SERVI CES-OTHER PRGM COSTS APPRVD 23.00 02301 PARAMED ED PRGM I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0 0	0 0		0 0 0 0 0 0	0 0	21. 00 22. 00 23. 00
30. 00 03000 ADULTS & PEDIATRICS	38, 387		13, 148, 31		,,	30. 00
31. 00 03100 INTENSIVE CARE UNIT 32. 00 03200 CORONARY CARE UNIT	9, 250	9, 250	1, 977, 98	2 0	4, 016, 930 0	31.00
32. 00 03200 CORONARY CARE UNIT 33. 00 03300 BURN INTENSIVE CARE UNIT		0		0 0	0	32. 00 33. 00
34. 00 03400 SURGI CAL INTENSIVE CARE UNIT	0	o		0 0	0	34. 00
40. 00 04000 SUBPROVI DER - 1 PF	0	0		0 0	0	40. 00
41. 00 04100 SUBPROVI DER - RF	0	0		0 0	0	41.00
43. 00 04300 NURSERY 44. 00 04400 SKI LLED NURSI NG FACI LI TY	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	o o	Ö		0 0	0	46. 00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	17, 422				-,,	50.00
51. 00 05100 RECOVERY ROOM 52. 00 05200 DELIVERY ROOM & LABOR ROOM	7, 643	7, 643	727, 29	0 0	1, 939, 628 0	51. 00 52. 00
53. 00 05200 DELIVERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY	0	0	37, 57	0	53, 075	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	8, 100	8, 100			4, 996, 277	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0 0	0	
56. 00 05600 RADI OI SOTOPE	0	0		0	0	56. 00
57.00 05700 CT SCAN 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0	539, 61 951, 74		1, 436, 999 1, 375, 968	57. 00 58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	16, 455	1			4, 545, 405	
60. 00 06000 LABORATORY	2, 828	2, 828		0 0	7, 495, 750	60.00
60. 01 06001 BLOOD LABORATORY	0	0		0	0	60. 01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS				0	0	61. 00 62. 00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0		0 0	0	63.00
64. 00 06400 I NTRAVENOUS THERAPY	Ö	Ö		0 0	0	64. 00
65. 00 06500 RESPI RATORY THERAPY	1, 409	1, 409			2, 298, 662	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0	376, 14		490, 807	66.00
67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	0	0	291, 33 109, 26		375, 825 140, 779	
69. 00 06900 ELECTROCARDI OLOGY	0	Ö	522, 96		684, 430	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	7, 191	7, 191	365, 01		1, 428, 111	•
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	9, 413, 236	71.00
72.00 07200 DDLCS CHARGED TO PATLENTS	0	0		0	6, 607, 913	1
73. 00 07300 DRUGS CHARGED TO PATIENTS 74. 00 07400 RENAL DIALYSIS				o o	4, 475, 054 0	73. 00 74. 00
75. 00 07500 ASC (NON-DISTINCT PART)	0			o o	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	420, 89	1 0	547, 451	1
76.02 03952 WOUND CARE 77.00 07700 ALLOGENEIC STEM CELL ACQUISITION				0 0	0	76. 02 77. 00
78. 00 07800 CAR T-CELL IMMUNOTHERAPY	0	l ől		o o		1
	•	·	-	•	-	

				Ţ	o 12/31/2023	Date/Time Pre 5/28/2024 2:1	
		CAPITAL REL	ATED COSTS			372072024 2. 1	Dill Dill
	Cost Center Description	BLDG & FLXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMI NI STRATI VE & GENERAL (ACCUM. COST)	
		1.00	2.00	4. 00	5A	5. 00	
OUTPA	TIENT SERVICE COST CENTERS						
	RURAL HEALTH CLINIC	0	_	_		0	
	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89. 00
	CLINIC CLINIC	0	0	0 1, 890, 838	0	0 2, 693, 327	90. 00 90. 01
	CLINIC	1, 207			0	454, 889	1
	EMERGENCY	9, 900			0	7, 322, 623	1
92. 00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	·					92. 00
	REIMBURSABLE COST CENTERS						
	HOME PROGRAM DI ALYSI S	0	0			0	94. 00
	AMBULANCE SERVICES	0	0	_	0	0	95.00
	DURABLE MEDICAL EQUIP-RENTED DURABLE MEDICAL EQUIP-SOLD	0	0	0 0	0	0	96. 00 97. 00
	OTHER REIMBURSE	0	0	0	0	0	98.00
99. 00 09900		0	Ö	ő	O	0	99. 00
99. 10 09910	CORF	0	0	0	О	0	99. 10
	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0		100. 00
	HOME HEALTH AGENCY	0	0	_			101. 00
	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102. 00
	AL PURPOSE COST CENTERS KIDNEY ACQUISITION	0	0	0	ol	0	105. 00
	HEART ACQUISITION	0	Ö				106.00
	LIVER ACQUISITION	0	Ō	Ō	Ō		107. 00
	LUNG ACQUISITION	0	0	0	0		108. 00
	PANCREAS ACQUISITION	0	0	0	0		109. 00
	INTESTINAL ACQUISITION	0	0	0	0		110.00
	ISLET ACQUISITION INTEREST EXPENSE	0	U	0	U	U	111. 00 113. 00
	UTILIZATION REVIEW-SNF						114. 00
	AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	0	0	115. 00
116. 00 11600		0	0	0	O	0	116. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	160, 010	160, 010	45, 329, 479	-24, 190, 266	112, 541, 225	118. 00
	I MBURSABLE COST CENTERS	0		42.071	ما	101 010	100 00
191. 00 19100	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0	121, 319 76, 018	1
	PHYSICIANS' PRIVATE OFFICES	0	0	1, 892, 195		1, 881, 499	
	CENTER OF HOPE	0	Ō	89, 575		115, 182	
192. 02 19202	OTHER FA FACILITIES NRCC	0	0	549, 994	0	837, 142	192. 02
	NONPAI D WORKERS	0	0	0	0		193. 00
194. 00 07950		0	0	86, 170	0	110, 868	1
200. 00 201. 00	Cross Foot Adjustments Negative Cost Centers						200. 00 201. 00
202.00	Cost to be allocated (per Wkst. B,	14, 179, 850	5, 941, 319	13, 708, 824		23, 232, 322	1
202.00	Part I)	11,177,000	0,,,,,	10, 700, 02 1		20, 202, 022	202.00
203. 00	Unit cost multiplier (Wkst. B, Part I)	88. 618524	37. 130923	0. 285307		0. 200827	203. 00
204. 00	Cost to be allocated (per Wkst. B,			450, 435		3, 233, 470	204. 00
205 00	Part II)			0.000274		0 027051	205 00
205. 00	Unit cost multiplier (Wkst. B, Part			0. 009374		0. 027951	205.00
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207. 00	NAHE unit cost multiplier (Wkst. D,						207. 00
1	Parts III and IV)						

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

				11	0 12/31/2023	Date/lime Pre 5/28/2024 2:1	
	Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF	HOUSEKEEPING (SQUARE FEET)	DI ETARY (MEALS SERVED)	<u> Бііі</u>
		6.00	7. 00	LAUNDRY) 8. 00	9. 00	10.00	
	GENERAL SERVICE COST CENTERS	0.00	7.00	8.00	7.00	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	130, 874					5. 00 6. 00
7. 00	00700 OPERATION OF PLANT	130, 674	130, 874				7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	0	336, 248			8. 00
9.00	00900 HOUSEKEEPI NG	0	0	0	130, 874	ł	9. 00
10.00	01000 DI ETARY	7, 878		0	7, 878	1	10.00
11. 00 12. 00	O1100 CAFETERI A O1200 MAI NTENANCE OF PERSONNEL	0	0	0	0	0 0	11. 00 12. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON	0	Ö	0	0	Ö	13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14. 00
15. 00	01500 PHARMACY	3, 060	1		3, 060	l e	15. 00
16.00	01600 MEDI CAL RECORDS & LI BRARY	144	144	0	144	0	16.00
17. 00 18. 00	O1700 SOCIAL SERVICE O1850 OTHER GEN SERV	0		0	0	0	17. 00 18. 00
19. 00	01900 NONPHYSI CI AN ANESTHETI STS	0	Ö	0	0	Ö	19. 00
20.00	02000 NURSI NG PROGRAM	0	0	0	0	0	20. 00
21. 00	02100 I &R SERVI CES-SALARY & FRI NGES APPRVD	0	0	0	0	0	21.00
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22. 00
23. 00	O2301 PARAMED ED PRGM INPATIENT ROUTINE SERVICE COST CENTERS	0		0	U	0	23. 00
30.00	03000 ADULTS & PEDI ATRI CS	38, 387	38, 387	228, 694	38, 387	59, 305	30. 00
31.00	03100 INTENSIVE CARE UNIT	9, 250	9, 250	107, 554	9, 250	27, 891	31.00
32.00	03200 CORONARY CARE UNIT	0	0	0	0	0	32.00
33. 00 34. 00	03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0 0	33. 00 34. 00
40. 00	04000 SUBPROVI DER - I PF	0	0	0	0		40.00
41. 00	04100 SUBPROVI DER - I RF	0	Ö	0	0	Ō	41. 00
43.00	04300 NURSERY	0	0	0	0	0	43. 00
44. 00	04400 SKILLED NURSING FACILITY	0	0	0	0	0	44. 00
45. 00 46. 00	04500 NURSING FACILITY 04600 OTHER LONG TERM CARE	0		0	0	0 0	45. 00 46. 00
40.00	ANCI LLARY SERVI CE COST CENTERS				0		1 40.00
50.00	05000 OPERATING ROOM	17, 422	17, 422	0	17, 422	0	50. 00
51.00	05100 RECOVERY ROOM	7, 643	1			0	51.00
52. 00 53. 00	05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	0	0	0	0	0	52. 00 53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	8, 100	8, 100	0	8, 100		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 0	57. 00 58. 00
58. 00 59. 00	05800 MAGNETIC RESONANCE I MAGING (MRI) 05900 CARDIAC CATHETERIZATION	16, 455	16, 455		16, 455		59.00
60.00	06000 LABORATORY	2, 828			2, 828	Ö	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 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		0	0	0	64.00
65. 00	06500 RESPIRATORY THERAPY	1, 409	1, 409	0	1, 409	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 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0	0	0	0	0 1	68. 00 69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	7, 191	7, 191	0	7, 191		70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72. 00
73. 00 74. 00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0	0	0	0	0 0	73. 00 74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0		0	0		75.00
76. 00	03950 OTHER ANCILL SRVC	0	Ö	Ö	0	Ö	76.00
76. 01	03951 CARDI AC AND PULMONARY REHAB	0	0	0	0	0	76. 01
76. 02	03952 WOUND CARE	0	0	0	0	0	76. 02
77. 00	O7700 ALLOGENEIC STEM CELL ACQUISITION O7800 CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	77. 00 78. 00
70.00	OUTPATIENT SERVICE COST CENTERS	0	<u> </u>	1 0	0	<u> </u>	70.00
88. 00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0				89. 00
90. 00	09000 CLI NI C	0	0	0	0	0	90. 00

Health Financial Systems FRANCISCAN HEALTH MUNSTER In Lieu of Form CMS-2552-10 COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0165 Peri od: Worksheet B-1 From 01/01/2023 12/31/2023 Date/Time Prepared: 5/28/2024 2:16 pm Cost Center Description MAINTENANCE & OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY LINEN SERVICE (SQUARE FEET) (MEALS SERVED) **REPAIRS** PLANT (SQUARE FEET) (SQUARE FEET) (POUNDS OF LAUNDRY) 6.00 10.00 7.00 9.00 8.00 90. 01 09001 CLINIC 0 0 90.01 09002 CLI NI C 1, 207 0 1, 207 90.02 90. 02 1, 207 91.00 09100 EMERGENCY 9, 900 9, 900 0 9, 900 91.00 0 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0 94.00 09500 AMBULANCE SERVICES 0 0 0 95.00 95.00 C 0 09600 DURABLE MEDICAL EQUIP-RENTED 96.00 0 0 96.00 97.00 09700 DURABLE MEDICAL EQUIP-SOLD 00000 0 0 0 97.00 98. 00 09850 OTHER REIMBURSE 0 98.00 99.00 99 00 09900 CMHC 0 0 Ω 0 99. 10 09910 CORF C 0 0 99. 10 100.00 10000 I&R SERVICES-NOT APPRVD PRGM 0 0 100.00 o 101.00 10100 HOME HEALTH AGENCY 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 0 0 0 106. 00 10600 HEART ACQUISITION 0000 0 0 106, 00 Ω 0 107. 00 10700 LIVER ACQUISITION 0 0 107, 00 108.00 10800 LUNG ACQUISITION 0 0 0 108. 00 109.00 10900 PANCREAS ACQUISITION 0 0 0 109. 00 110.00 11000 INTESTINAL ACQUISITION 0 0 0 110.00 Ω 111.00 11100 | SLET ACQUISITION 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 0 116.00 SUBTOTALS (SUM OF LINES 1 through 117) 118.00 130,874 130, 874 336, 248 130, 874 87, 196 118. 00 NONREI MBURSABLE COST CENTERS 0 190. 00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 191. 00 19100 RESEARCH 0 0 0 0 191. 00 0 0 0 192. 00 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 0 192. 01 19201 CENTER OF HOPE 0 0 192. 01 0 0 192.02 19202 OTHER FA FACILITIES NRCC 0 0 0 0 192. 02 193. 00 19300 NONPALD WORKERS 0 0 0 193.00 0 194.00 07950 OTHER NRCC 0 C 0 ol 0 194. 00 200. 00 200.00 Cross Foot Adjustments 201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, 9,849,498 370, 144 2, 242, 416 2, 633, 074 202. 00 Part I) 17. 134160 203.00 Unit cost multiplier (Wkst. B, Part I) 75. 259395 0.000000 1 100807 30. 197188 203. 00 204.00 Cost to be allocated (per Wkst. B, 240, 322 8,616 63, 315 1, 056, 220 204. 00

1.836285

0.000000

0.025624

0.483786

12. 113170 205. 00

206.00

207.00

Part II)

(per Wkst. B-2)

Parts III and IV)

II)

Unit cost multiplier (Wkst. B, Part

NAHE unit cost multiplier (Wkst. D,

NAHE adjustment amount to be allocated

205.00

206.00

207.00

Heal th	Financial Systems	FRANCI SCAN HEA	ALTH MUNSTER		In Lie	u of Form CMS-	2552-10
	ALLOCATION - STATISTICAL BASIS		Provi der (Peri od:	Worksheet B-1	
					From 01/01/2023 To 12/31/2023		pared:
	Cost Center Description	CAFETERI A	MAINTENANCE O	F NURSI NG	CENTRAL	5/28/2024 2: 1 PHARMACY	6 pm
	Cost Center Description	(MEALS SERVED)	PERSONNEL	ADMI NI STRATI O		(COSTED	
			(NUMBER		SUPPLY	REQUIS.)	
			HOUSED)	(DI RECT NURS.	(COSTED		
		11. 00	12. 00	HRS.) 13. 00	REQUIS.) 14.00	15. 00	
	GENERAL SERVICE COST CENTERS	111.00	12.00	10.00	111.00	10.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
2. 00 4. 00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2. 00 4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						5. 00
6. 00	00600 MAINTENANCE & REPAIRS						6. 00
7. 00	00700 OPERATION OF PLANT						7. 00
8. 00 9. 00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING						8. 00 9. 00
10.00	01000 DI ETARY						10.00
11. 00	01100 CAFETERI A	192, 485					11. 00
12.00	01200 MAI NTENANCE OF PERSONNEL	0	1	0			12.00
13. 00 14. 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	0		0 307, 96 0 19			13. 00 14. 00
15. 00	01500 PHARMACY	0			0 33,000	100	1
16. 00	01600 MEDICAL RECORDS & LIBRARY	0		0 3		0	1
17. 00		0		o	0	0	17. 00
18.00	01850 OTHER GEN SERV 01900 NONPHYSICIAN ANESTHETISTS	0		0	0	0	18. 00 19. 00
20. 00	02000 NURSING PROGRAM	0		ol	0 0	0	20.00
	02100 I &R SERVICES-SALARY & FRINGES APPRVD	0		ō	0 0	0	1
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	0		o	0	0	
23. 00	O2301 PARAMED ED PRGM I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0		0	0 0	0	23. 00
30. 00		130, 916	(0 121, 11	9 50, 185	0	30.00
	03100 INTENSIVE CARE UNIT	61, 569		0 37, 23		0	1
32. 00	03200 CORONARY CARE UNIT	0		-	0	0	
33.00	03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT	0		0	0	0	
40. 00	04000 SUBPROVIDER - IPF	0		ol .	0 0	0	1
41. 00	04100 SUBPROVI DER - I RF	0	(o	0 0	0	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	
46. 00		0		o o	0 0	0	1
	ANCILLARY SERVICE COST CENTERS			<u> </u>			
	05000 OPERATING ROOM	0		0 46, 41		0	
51. 00 52. 00	O5100 RECOVERY ROOM O5200 DELIVERY ROOM & LABOR ROOM	0		0 12, 03 0	1 4, 151 0 0	0	
53. 00	05300 ANESTHESI OLOGY	Ö		o	0 264	0	
54.00		0	(o	9 23, 313	0	
	05500 RADI OLOGY-THERAPEUTI C	0		0	0	0	1
	05600	0		0 6	0 8 449	0	
58. 00		0		ol o	0 18, 683	0	1
	05900 CARDI AC CATHETERI ZATI ON	0	(0 19, 73	7 5, 275	0	
60.00	06000 LABORATORY	0		0	0	0	
60. 01 61. 00	06001 BLOOD LABORATORY 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		'	U _I	U	0	60. 01 61. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	(o	0 0	0	1
	06300 BLOOD STORING, PROCESSING & TRANS.	0	(o	0 0	0	
64.00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	0		0	0 0	0	64.00
66. 00	1	0		ol	0 6, 770 0 36	0	
67. 00	· ·	O		o o	0 142	0	67. 00
68. 00		0		0	0 0	0	
69.00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	0		0 2		0	69. 00 70. 00
71.00		0		ol	0 11, 106 0 9, 413, 237	0	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0		o	0 6, 607, 913	0	1
	07300 DRUGS CHARGED TO PATIENTS	0	!	0	0	100	1
74. 00 75. 00	07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART)	0		0	0	0	
76. 00				ŏ	o o	0	76.00
76. 01	03951 CARDI AC AND PULMONARY REHAB	0		0 2, 51	1 998	0	1
76. 02	03952 WOUND CARE	0		0	0	0	
	07700 ALLOGENEIC STEM CELL ACQUISITION 07800 CAR T-CELL IMMUNOTHERAPY	0			0 0	0	
, 0. 00	OUTPATIENT SERVICE COST CENTERS	<u> </u>		~1	<u> </u>	0	75.00
	08800 RURAL HEALTH CLINIC	0			0 0	0	
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	<u> </u>	ol	0 0	0	89. 00

Health Financial Systems FRANCISCAN HEALTH MUNSTER In Lieu of Form CMS-2552-10 COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0165 Peri od: Worksheet B-1 From 01/01/2023 12/31/2023 Date/Time Prepared: 5/28/2024 2:16 pm Cost Center Description CAFETERI A MAINTENANCE OF NURSI NG CENTRAL **PHARMACY** (MEALS SERVED) PERSONNEL ADMI NI STRATI ON SERVICES & (COSTED (NUMBER **SUPPLY** REQUIS.) (DIRECT NURS HOUSED) (COSTED REQUIS.) HRS.) 11.00 12.00 15.00 13.00 14.00 90. 00 09000 CLINIC 90.00 0 0 09001 CLI NI C 0 90. 01 10, 704 5, 990 90.01 0 09002 CLINIC 3. 159 11,654 90.02 90.02 C 0 91.00 09100 EMERGENCY 40, 868 10, 045 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DIALYSIS 94.00 94.00 0 0 0 95.00 09500 AMBULANCE SERVICES 00000000 0 0 95.00 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 0 0 0 96.00 0 97.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 97.00 0 09850 OTHER REIMBURSE 0 98.00 98.00 0 0 99. 00 09900 CMHC 0 99.00 99. 10 09910 CORF 99. 10 0 0 0 0 100. 00 10000 I &R SERVICES-NOT APPRVD PRGM 0 100.00 0 Ω 0 101.00 10100 HOME HEALTH AGENCY 0 0 101.00 102.00 10200 OPI OI D TREATMENT PROGRAM 0 102.00 0 SPECIAL PURPOSE COST CENTERS 105.00 10500 KIDNEY ACQUISITION 0 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 0 0 107. 00 108.00 10800 LUNG ACQUISITION 0 0 108.00 Ω 109.00 10900 PANCREAS ACQUISITION 0 0 0 109.00 110.00 11000 INTESTINAL ACQUISITION 0 0 110.00 0 ol 111.00 11100 | SLET ACQUISITION 0 0 111.00 113. 00 11300 INTEREST EXPENSE 113. 00 114.00 11400 UTILIZATION REVIEW-SNF 114. 00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 115.00 0 116. 00 11600 HOSPI CE 0 116.00 0 SUBTOTALS (SUM OF LINES 1 through 117) 118.00 16, 479, 364 192, 485 294, 103 100 118.00 0 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190. 00 191. 00 19100 RESEARCH 0 0 0 191.00 0 C 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 192. 00 0 4,889 0 192. 01 19201 CENTER OF HOPE 39 0 0 192. 01 192.02 19202 OTHER FA FACILITIES NRCC 0 0 0 192. 02 8, 931 193. 00 19300 NONPALD WORKERS 0 0 193. 00 0 C 0 194. 00 194.00 07950 OTHER NRCC 0 0 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201. 00 3, 908, 659 202. 00 Cost to be allocated (per Wkst. B, 957.944 3, 930, 247 143.417 202.00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 4. 976720 0.000000 12.762117 0.008703 39,086.590000 203.00

6, 497

0.000000

0.033753

6, 291

0.000382

111,664

0.362590

493, 432 204. 00

206.00

207.00

4, 934. 320000 205. 00

204.00

205.00

206.00

207.00

Cost to be allocated (per Wkst. B,

Unit cost multiplier (Wkst. B, Part

NAHE unit cost multiplier (Wkst. D.

NAHE adjustment amount to be allocated

Part II)

(per Wkst. B-2)

Parts III and IV)

II)

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0165 Peri od: Worksheet B-1 From 01/01/2023 12/31/2023 Date/Time Prepared: 5/28/2024 2:16 pm OTHER GENERAL SERVI CE MEDI CAL SOCIAL SERVICE OTHER GEN SERV NONPHYSI CI AN NURSI NG Cost Center Description RECORDS & **ANESTHETISTS PROGRAM** (TIME SPENT) (TIME SPENT) (ASSI GNED LI BRARY (ASSI GNED (GROSS TIME) TIME) CHARGES) 17. 00 18.00 19.00 20.00 16.00 GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 5 00 5 00 6.00 00600 MAINTENANCE & REPAIRS 6.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 00900 HOUSEKEEPI NG 9 00 9 00 10.00 01000 DI ETARY 10.00 01100 CAFETERI A 11.00 11.00 01200 MAINTENANCE OF PERSONNEL 12.00 12.00 01300 NURSING ADMINISTRATION 13.00 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 01500 PHARMACY 15.00 15.00 01600 MEDICAL RECORDS & LIBRARY 679, 200, 199 16,00 16,00 17 00 01700 SOCIAL SERVICE 17 00 18.00 01850 OTHER GEN SERV 18.00 0 19 00 01900 NONPHYSICIAN ANESTHETISTS 0 0 19.00 0 02000 NURSI NG PROGRAM 0 20.00 0 0 0 20.00 0 21.00 02100 I &R SERVICES-SALARY & FRINGES APPRVD Ω 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 0 0 22.00 22.00 02301 PARAMED ED PRGM 0 23.00 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 33, 920, 884 0 0 0 30.00 03100 INTENSIVE CARE UNIT 0 31.00 17, 029, 244 0 0 0 0 0 0 31.00 0 32.00 03200 CORONARY CARE UNIT 0 0 32.00 03300 BURN INTENSIVE CARE UNIT 0 33.00 0 C 0 33.00 03400 SURGICAL INTENSIVE CARE UNIT 0 34.00 0 34.00 04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF 40.00 0 0 0 0 0 40.00 0 41 00 C 0 41 00 04300 NURSERY 0 43.00 0 0 43.00 0 04400 SKILLED NURSING FACILITY 0 0 44.00 0 0 44.00 04500 NURSING FACILITY 0 45.00 45.00 0 0 04600 OTHER LONG TERM CARE 0 46.00 0 46.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 109, 029, 068 0 50.00 0 0 0 0 0 0 0 0 0 0 0 0 05100 RECOVERY ROOM 14, 285, 949 0 51 00 0 51 00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 0 0 52.00 53.00 05300 ANESTHESI OLOGY 24, 060, 437 0 0 0 53.00 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 54, 610, 117 0 0 54.00 0 05500 RADI OLOGY-THERAPEUTI C 55 00 0 55 00 0 56.00 05600 RADI OI SOTOPE 0 0 56.00 05700 CT SCAN 60, 847, 115 0 0 57.00 57.00 0 05800 MAGNETIC RESONANCE I MAGING (MRI) 58.00 18, 533, 135 0 0 0 58.00 0 05900 CARDIAC CATHETERIZATION 17 509 717 59 00 0 0 59 00 60.00 06000 LABORATORY 78, 148, 864 0 0 0 60.00 06001 BLOOD LABORATORY 60.01 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 62.00 0 0 62.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 63.00 06400 I NTRAVENOUS THERAPY 0 64.00 0 64.00 06500 RESPIRATORY THERAPY 8, 811, 065 Ω 0 65.00 0 65.00 0 66.00 06600 PHYSI CAL THERAPY 3, 215, 008 0 66.00 06700 OCCUPATIONAL THERAPY 0 67.00 2, 964, 287 0 67.00 06800 SPEECH PATHOLOGY 1, 181, 906 0 68.00 0 0 68.00 06900 ELECTROCARDI OLOGY 0 69.00 23, 273, 645 0 0 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 5, 155, 371 0 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 41, 071, 439 71 00 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 30, 929, 812 0 72.00 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 34, 727, 023 C 0 73.00 07400 RENAL DIALYSIS 74.00 74.00 0 07500 ASC (NON-DISTINCT PART) 75.00 0 0 0 O 75.00 0 03950 OTHER ANCILL SRVC 76.00 0 0 76.00 76.01 03951 CARDIAC AND PULMONARY REHAB 1, 350, 939 0 0 76.01 0 03952 WOUND CARE 0 0 0 0 76.02 07700 ALLOGENEIC STEM CELL ACQUISITION 0 0 0 77.00 77 00 0 78.00 |07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 78.00

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

Cost Center Description				T	o 12/31/2023	Date/Time Pre 5/28/2024 2:1	
DUTPATT ENT SERVICE COST CENTERS 0	Cost Center Description	RECORDS & LI BRARY (GROSS		SERVICE OTHER GEN SERV	ANESTHETI STS (ASSI GNED	NURSI NG PROGRAM (ASSI GNED	<u>У</u> рііі
OUTPATIENT SERVICE COST CENTERS			17 00	18 00	19 00	20.00	
0.0000 0.00000 0.000000 0.000000 0.000000 0.00000000	OUTPATIENT SERVICE COST CENTERS	10.00	17.00	10.00	17.00	20.00	
90.00 99000 CLINIC 0 0 0 0 0 0 0 0 0		C	0	0	0	0	88. 00
90.01 99001 CLINIC 33,955,902 0 0 0 0 0 0 0 0 0	1 I	C	0	0	0	0	89. 00
90.00 99000 DERGENTY EDS (NON-DISTINCT PART) 60,240,145 0 0 0 0 0 0 0 0 0		C	0	0	0		•
91.00 09100 DERERGENCY 0 0 0 0 0 0 0 0 0			ł .	0	0		1
92.00	· · · · · · · · · · · · · · · · · · ·			0	0		•
OTHER REIMBURSABLE COST CENTERS		00, 240, 140			J	O	ı
95.00 09500 MABULANCE SERVICES 0 0 0 0 0 95.00 97.00 09700 DURABLE MEDICAL EQUIP P-RINTED 0 0 0 0 0 0 0 97.00 09700 DURABLE MEDICAL EQUIP P-SOLD 0 0 0 0 0 0 97.00 09700 DURABLE MEDICAL EQUIP P-SOLD 0 0 0 0 0 0 97.00 09900 CMPC 0 0 0 0 0 0 0 0 97.00 09900 CMPC 0 0 0 0 0 0 0 0 97.00 09900 CMPC 0 0 0 0 0 0 0 0 97.00 09900 CMPC 0 0 0 0 0 0 0 0 97.00 100.00 100.00 128 ESRVICES-NOT APPRVD PRGM 0 0 0 0 0 0 101.00 102.00 10200 0P101 TREATMENT PROGRAM 0 0 0 0 0 101.00 102.00 10200 0P101 TREATMENT PROGRAM 0 0 0 0 0 101.00 103.00 10500 KIDNEY ACQUISITION 0 0 0 0 105.00 107.00 10700 LIVER ACQUISITION 0 0 0 0 105.00 107.00 10700 LIVER ACQUISITION 0 0 0 0 107.00 108.00 10800 UING ACQUISITION 0 0 0 0 0 107.00 109.00 10900 PANGREAS ACQUISITION 0 0 0 0 0 108.00 109.00 10900 NESTINAL ACQUISITION 0 0 0 0 0 109.00 1011.00 11000 INTESTINAL ACQUISITION 0 0 0 0 0 111.00 111.00 11100 INTESTINAL ACQUISITION 0 0 0 0 0 0 111.00 111.00 11100 INTESTINAL ACQUISITION 0 0 0 0 0 0 111.00 111.00 11100 INTESTINAL ACQUISITION 0 0 0 0 0 0 111.00 111.00 1100 INTESTINAL SUM OF LINES STATES 0 0 0 0 0 0 0 0 111.00 1100 HORE PROFRES STATES 0 0 0 0 0 0 0 0 0							
96.00 09600 09400 DURABLE WEDI CAL EQUI P-SQLD 0 0 0 0 0 0 0 0 0	94.00 09400 HOME PROGRAM DIALYSIS	C	0	0	0	0	94. 00
97.00 09700 09700 09700 09700 09700 09700 09700 099000 0990000 0990000 0990000 0990000 0990000000 09900000000		C	0		0		•
98. 00 OSBSO OTHER REIMBURSE		C	0		0		1
99.00 09900 CMHC 0 0 0 0 0 0 0 0 99.00 99.10 09910 CORF 0 0 0 0 0 0 0 0 0	• • • • • • • • • • • • • • • • • • •				0		•
99.10 00910 CORF 0 0 0 0 0 0 0 0 0					0	-	1
100.00 100.00 100.00 100.00 100.00 0 0 0 0 0 0 0 0				Ö	Ö		
102.00 102.00 10.7 TREATMENT PROGRAM		C	o	0	0	0	100.00
SPECIAL PURPOSE COST CENTERS	101.00 10100 HOME HEALTH AGENCY	C	0	0	0	0	101. 00
105.00 10500 IDNEY ACQUISITION		C	0	0	0	0	102. 00
106.00 106.00 106.00 106.00 107.00 1					٥	0	105 00
107.00 10700 LUVER ACQUISITION			_				1
108. 00 10800 LUNG ACQUISITION				_			
110. 00 11000 INTESTI NAL ACQUISITION		C	O	0	0		1
111.00 11100 SLET ACQUISITION 0 0 0 0 0 111.00 11300 INTEREST EXPENSE 114.00 114100 UTILIZATI ON REVIEW-SNF 114.00 114100 UTILIZATI ON REVIEW-SNF 114.00 115.00 11500 AMBULATORY SURGICAL CENTER (D.P.) 0 0 0 0 0 0 0 115.00 116.00 11600 HOSPICE		C	0	0	0		•
113.00 11300 INTEREST EXPENSE 113.00 11440 UTI LI ZATI ON REVIEW-SNF 115.00 11500 AMBILATORY SURGICAL CENTER (D.P.) 0 0 0 0 0 0 0 115.00 0 0 0 0 0 0 0 0 0		C	0	0	0		•
114.00 11400 UTILIZATION REVIEW-SNF		C		0	O	0	•
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)							•
116. 00 11600 HOSPICE 0 0 0 0 0 0 0 0 0 116. 00		C		0	0	0	1
NONNEI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 190.00 191.00 19100 RESEARCH 0 0 0 0 0 0 192.00 19200 PHYSI CI ANS' PRI VATE OFFICES 0 0 0 0 0 192.01 19201 CENTER OF HOPE 0 0 0 0 0 192.02 19202 OTHER FA FACILITIES NRCC 0 0 0 0 0 193.00 19300 NONPAID WORKERS 0 0 0 0 0 194.00 07950 OTHER NRCC 0 0 0 0 194.00 07950 OTHER NRCC 0 0 0 0 201.00 Negative Cost Centers 200.00 202.00 Cost to be allocated (per Wkst. B, 2, 454, 572 0 0 0 0 203.00 Unit cost multiplier (Wkst. B, Part I) 0.003614 0.000000 0.000000 0.000000 0.000000 204.00 Cost to be allocated (per Wkst. B, 80, 621 0 0 0 205.00 Unit cost multiplier (Wkst. B, Part I) 0.000119 0.000000 0.000000 0.000000 0.000000 0.000000 206.00 NAHE unit cost multiplier (Wkst. D, 0.000119 0.000000		C	O		-		1
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191.00 19100 RESEARCH 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 0 0 0 0 192.00 192.01 19201 CENTER OF HOPE 0 0 0 0 0 0 0 192.00 192.02 19202 OTHER FA FACILITIES NRCC 0 0 0 0 0 0 0 192.02 193.00 19300 NONPAID WORKERS 0 0 0 0 0 0 0 193.00 194.00 07950 OTHER NRCC 200.00 Cross Foot Adjustments 201.00 Negative Cost Centers 202.00 Cost to be allocated (per Wkst. B, Part I) 203.00 Unit cost multiplier (Wkst. B, Part II) 204.00 Cost to be allocated (per Wkst. B, Part II) 205.00 Unit cost multiplier (Wkst. B, Part II) 205.00 NAHE adjustment amount to be allocated (per Wkst. D, NAHE unit cost multiplier (Wkst. D, NO00000 207.00				_	ام		
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Part II) Unit cost multiplier (Wkst. B, Part 0.000119 0.000000 0.000000 0.000000 0.000000 0.000000		0. 003614	0. 000000	0. 000000	0. 000000	0. 000000	203. 00
205.00 Unit cost multiplier (Wkst. B, Part 0.000119 0.000000 0.000000 0.000000 0.000000 205.00 11) 206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, 0.000000 0.000000 0.000000 0.000000 0.000000		80, 621	0	0	0	0	204. 00
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206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) 0 206.00 207.00 NAHE unit cost multiplier (Wkst. D, 0.000000 207.00		0.000119	0.000000	0.00000	0. 000000	0. 000000	205.00
207.00 NAHE unit cost multiplier (Wkst. D, 0.000000 207.00	206.00 NAHE adjustment amount to be allocated					0	206. 00
	207.00 NAHE unit cost multiplier (Wkst. D,					0. 000000	207. 00

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

					To 12/31/2023 Date/Time Pro 5/28/2024 2:	
		INTERNS &	RESI DENTS		372072024 2.	TO pill
Cost Center De	escription	SERVI CES-SALAR Y & FRI NGES (ASSI GNED	SERVICES-OTHER PRGM COSTS (ASSIGNED	PARAMED ED PRGM (ASSI GNED		
		TIME)	TIME)	TIME)		
GENERAL SERVICE COST	CENTERS	21.00	22. 00	23. 00		
1. 00 00100 CAP REL COSTS-						1.00
2.00 00200 CAP REL COSTS- 4.00 00400 EMPLOYEE BENEF						2. 00 4. 00
5. 00 00500 ADMI NI STRATI VE						5. 00
6. 00 00600 MAI NTENANCE &						6.00
7.00 00700 0PERATION OF F 8.00 00800 LAUNDRY & LINE						7. 00 8. 00
9. 00 00900 HOUSEKEEPING	NV SERVI SE					9. 00
10. 00 01000 DI ETARY						10.00
11. 00 01100 CAFETERI A 12. 00 01200 MAI NTENANCE OF	PERSONNEL					11. 00 12. 00
13.00 01300 NURSING ADMINI	STRATI ON					13. 00
14. 00 01400 CENTRAL SERVI (ES & SUPPLY					14. 00
15. 00 01500 PHARMACY 16. 00 01600 MEDI CAL RECORD	S & LIBRARY					15. 00 16. 00
17. 00 01700 SOCIAL SERVICE						17. 00
18. 00 01850 0THER GEN SERV 19. 00 01900 NONPHYSI CLAN A						18. 00 19. 00
20. 00 02000 NURSI NG PROGRA						20.00
1 1	ALARY & FRINGES APPRVD	0	_			21. 00
22. 00 02200 1 &R SERVI CES-0 23. 00 02301 PARAMED ED PRO	THER PRGM COSTS APPRVD		0	i	0	22. 00 23. 00
I NPATI ENT ROUTI NE SE					<u> </u>	20.00
30. 00 03000 ADULTS & PEDIA		0	0	1	0	30.00
31. 00 03100 I NTENSI VE CARE 32. 00 03200 CORONARY CARE		0	0	1	0	31. 00 32. 00
33.00 03300 BURN INTENSIVE	CARE UNIT	0	0		0	33. 00
34. 00 03400 SURGI CAL I NTEN 40. 00 04000 SUBPROVI DER -		0	0		0	34. 00 40. 00
41. 00 04100 SUBPROVI DER -		0	0		0	41. 00
43. 00 04300 NURSERY		0	0		O	43. 00
44. 00 04400 SKI LLED NURSI N 45. 00 04500 NURSI NG FACI LI		0	0 0		0	44. 00 45. 00
46. 00 04600 OTHER LONG TER		0		1	0	46. 00
ANCILLARY SERVICE CO			0	1	ol	F0.00
50.00 05000 OPERATING ROOM 51.00 05100 RECOVERY ROOM	l	0	0		0	50. 00 51. 00
52.00 05200 DELIVERY ROOM		0	0		O	52. 00
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AG		0	0		0	53. 00 54. 00
55. 00 05500 RADI OLOGY-THER		0	0		0	55. 00
56. 00 05600 RADI 0I SOTOPE		0	0		0	56.00
57. 00 05700 CT SCAN 58. 00 05800 MAGNETI C RESON	IANCE IMAGING (MRI)	0	0		0	57. 00 58. 00
59. 00 05900 CARDI AC CATHET		0	Ö		o o	59. 00
60. 00 06000 LABORATORY	NDV	0	0		0	60.00
60. 01 06001 BLOOD LABORATO 61. 00 06100 PBP CLINI CAL L	AB SERVICES-PRGM ONLY	0	U		0	60. 01 61. 00
62.00 06200 WHOLE BLOOD &	PACKED RED BLOOD CELLS	0	0		0	62. 00
63. 00 06300 BLOOD STORING, 64. 00 06400 INTRAVENOUS TH	PROCESSING & TRANS.	0	0		0	63. 00 64. 00
65. 00 06500 RESPI RATORY TH		0	0		0	65.00
66.00 06600 PHYSI CAL THERA	.PY	0	0		0	66. 00
67. 00 06700 0CCUPATI ONAL T		0	0		0	67. 00 68. 00
69. 00 06900 ELECTROCARDI OL		0	0		0	69.00
70. 00 07000 ELECTROENCEPHA		0	0		0	70. 00
71. 00 07100 MEDI CAL SUPPLI 72. 00 07200 I MPL. DEV. CHA	ES CHARGED TO PATIENTS	0	0		0	71. 00 72. 00
73. 00 07300 DRUGS CHARGED		0	0		ŏ	73. 00
74. 00 07400 RENAL DIALYSIS		0	0		0	74.00
75. 00 07500 ASC (NON-DISTI 76. 00 03950 OTHER ANCILL S		0	0 0		0	75. 00 76. 00
76. 01 03951 CARDI AC AND PL		0	Ö		ō	76. 01
76. 02 03952 WOUND CARE	M OFFI ACOUNCETION	0	0	1	0	76. 02
77. 00 07700 ALLOGENEI C STE 78. 00 07800 CAR T-CELL IMM		0	0 0	1	0	77. 00 78. 00
OUTPATIENT SERVICE (COST CENTERS					
88. 00 08800 RURAL HEALTH 0	CLINIC	0	0		0	88. 00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0165

Peri od: Worksheet B-1 From 01/01/2023

Date/Time Prepared:

12/31/2023

5/28/2024 2:16 pm 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 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 89. 00 90. 00 09000 CLINIC 0 90.00 C 0 09001 CLI NI C 0 90.01 90.01 90.02 09002 CLI NI C 0 0 0 90.02 91.00 09100 EMERGENCY 0 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0 0 94.00 95.00 09500 AMBULANCE SERVICES 000000 0 0 95.00 0 09600 DURABLE MEDICAL EQUIP-RENTED 96.00 0 96.00 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD 0 97.00 09850 OTHER REIMBURSE 0 98.00 0 98.00 0 99. 00 09900 CMHC 99 00 Ω 99. 10 09910 CORF 0 99.10 100.00 10000 I&R SERVICES-NOT APPRVD PRGM 0 0 100.00 0 101.00 10100 HOME HEALTH AGENCY 0 0 101.00 102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 102.00 SPECIAL PURPOSE COST CENTERS 105.00 10500 KIDNEY ACQUISITION 0 0 105.00 0 106. 00 10600 HEART ACQUISITION 0 0 106.00 00000 107. 00 10700 LIVER ACQUISITION 0 107 00 0 108.00 10800 LUNG ACQUISITION 0 108.00 109. 00 10900 PANCREAS ACQUISITION 0 109.00 110.00 11000 INTESTINAL ACQUISITION 0 0 110.00 111.00 11100 I SLET ACQUISITION O 111. 00 113.00 11300 INTEREST EXPENSE 113.00 114.00 11400 UTILIZATION REVIEW-SNF 114. 00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 0 0 115.00 0 116. 00 11600 HOSPI CE 116. 00 SUBTOTALS (SUM OF LINES 1 through 117) 0 118.00 118.00 NONREI MBURSABLE COST CENTERS 0 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190.00 0 0 191. 00 19100 RESEARCH C 191. 00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 192. 00 0 0 0 192. 01 19201 CENTER OF HOPE 0 192, 01 0 192.02 19202 OTHER FA FACILITIES NRCC 0 192. 02 193.00 19300 NONPALD WORKERS 0 0 193.00 194.00 07950 OTHER NRCC 0 194.00 200. 00 200.00 Cross Foot Adjustments 201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, 202.00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 0.000000 0.000000 203.00 0.000000 204.00 Cost to be allocated (per Wkst. B, 204.00 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 0.000000 0.000000 0.000000 205.00 H) NAHE adjustment amount to be allocated 206. 00 206.00 0 (per Wkst. B-2) NAHE unit cost multiplier (Wkst. D, 207. 00 207.00 0.000000 Parts III and IV)

Total Cost Cost Center Description	COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provi der Co		Period: From 01/01/2023 To 12/31/2023		pared·
Total Cost Center Description				Title			5/28/2024 2:1	
IMPATIENT ROUTINE SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00		Cost Center Description	Total Cost			Costs		
INPATIENT ROUTINE SERVICE COST CENTERS			(from Wkst. B,					
IMPATI FINT BOUTINE SERVICE COST CENTERS 33,090,648 0 33,090,648 0 33,090,648 0 30.00 31.00 3000 DAULTS & PEDIATRICS 33,090,648 0 30.00 31			26)	2.00	2.00	4.00	5.00	
31. DO 03100 (NTENSIVE CARE UNIT 7, 482, 138 7, 482, 138 0, 7, 482, 138 31. OO 3320 (DO 3320 CORROMAY CARE UNIT 0 0 0 0 33. OO 3320 SURN INTENSIVE CARE UNIT 0 0 0 0 0 33. OO 3320 SURN INTENSIVE CARE UNIT 0 0 0 0 0 33. OO 34. OO 340. OO 34								
32.00 03200 CORDMARY CARE UNIT		1		ł				
34 00 03400 SURPRICU DET - 1PF	32.00	03200 CORONARY CARE UNIT	0		7, 102, 10		0	32. 00
40,00 04000 SUBPROVIDER - I PF		1 I	0			0 0	l .	1
13. 00 04300 MURSERY 0 0 0 0 0 0 0 0 0			0			0 0		
44. 00 04400 SKILLED NURSING FACILITY			0			0 0		1
46. 00 OdeOO OTHER LONG TERM CARE		1	0			0 0		1
ANCI LLARY SERVICE COST CENTERS 50.00 50.00 OPERATIN ROOM 12, 651, 136 50.00 51.00 OSTOO OPERATINE ROOM 3, 240, 528 3, 240, 528 0, 3, 240, 528 51.00 052.00 OSTOO OELIVERY ROOM & LABOR ROOM 0 0 0 0 52.00 OSTOO OELIVERY ROOM & LABOR ROOM 0 0 0 0 0 52.00 OSTOO OELIVERY ROOM & LABOR ROOM 0 0 0 0 0 52.00 OSTOO OELIVERY ROOM & LABOR ROOM 0 0 0 0 0 52.00 OSTOO OELIVERY ROOM & LABOR ROOM 0 0 0 0 0 0 0 0 0		1	0			0 0	•	
51-00 05100 RECOVERY ROOM 0 3, 240, 528 51-00 0 0 0 0 0 52-00 52-00 52-00 05200 DELIVERY ROOM 2 150, 690 150, 690 150, 690 150, 690 32-00 52-00 52-00 62-00	46.00		0		l	<u>0</u>	0	46.00
S2.00 05.200 05.200 05.200 05.00 0 0 0 0 0 0 0 0 0								1
150.0 05300 ANESTHESI OLOGY 150.690 150.690 0 150.690 0 150.690 33.00					3, 240, 52			
55.00 05500 RADIOLOGY-THERAPEUTI C		05300 ANESTHESI OLOGY						1
55.00 05500 CADO					6, 945, 73	1 0		
58.00 05800 MAGNETIC RESONANCE I MAGI NG (MRI)	56.00	05600 RADI OI SOTOPE	0			o o	l .	56. 00
59.00 05900 CARDIAC CATHETER ZATION 7, 293, 793 7, 293, 793 0, 7, 293, 793 0, 0, 293, 793 0, 0, 293, 793 0, 0, 293, 793 0, 0, 293, 793 0, 0, 293, 793 0, 0, 293, 793 0, 0, 293, 793 0, 0, 293, 793 0, 0, 293, 793 0, 0, 293, 793 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 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, 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,			1	l .				1
60.01 06001 BLOOD LABORATORY 0 0 0 0 0 0 0 0 0								
61.00 06100 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY 0 0 0 0 0 62.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 0 0 0 63.00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 0 0 0 0 0 0 64.00 06400 INTRAVENOUS THERAPY 0 0 0 0 0 0 65.00 06500 RESPIRATORY THERAPY 2, 922, 379 0 2, 922, 379 2, 922, 379 2, 922, 379 2, 922, 379 2, 922, 379 2, 922, 379 2, 922, 379 2, 922, 379 2, 922,			9, 544, 818		9, 544, 81	8 0	1	
63.00 06300 BLODD STORI NG, PROCESSING & TRANS. 0 0 0 0 63.00 64.00 06400 INTRAVENOUS THERAPY 0 0 0 0 0 64.00 65.00 06500 RESPI RATORY THERAPY 2,922,379 0 2,922,379 0 2,922,379 0 2,922,379 0 66.00 06600 PHYSI CAL THERAPY 600,993 0 600,993 0 600,993 0 600,093 0 66.00 06600 PHYSI CAL THERAPY 600,993 0 600,993 0 600,093 0 66.00 06600 DHYSI CAL THERAPY 600,993 0 600,993 0 600,093 0 67.00 06700 0CUPATI IONAL THERAPY 462,015 0 462,015 0 462,015 0 68.00 06800 SPEECH PATHOLOGY 173,322 0 173,322 0 173,322 0 173,322 68.00 69.00 06900 ELECTROCARDI OLOGY 906,303 906,303 906,303 0 9		1	0			0 0		1
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67. 00 06700 OCCUPATIONAL THERAPY 462, 015 0 462, 015 0 462, 015 67. 00 68. 00 06800 SPECCH PATHOLOGY 173, 322 0 173, 322 0 69. 00 06900 ELECTROCARDI OLOGY 906, 303 906, 303 0 70. 00 07000 ELECTROENCEPHALOGRAPHY 2, 398, 045 2, 398, 045 0 71. 00 07000 ELECTROENCEPHALOGRAPHY 2, 398, 045 2, 398, 045 0 72. 00 07200 MEDI CAL SUPPLIES CHARGED TO PATIENTS 11, 534, 020 11, 534, 020 0 73. 00 07200 IMPL DEV. CHARGED TO PATIENTS 8, 104, 249 8, 104, 249 0 74. 00 07200 IMPL DEV. CHARGED TO PATIENTS 9, 407, 928 9, 407, 928 0 75. 00 07300 DRUGS CHARGED TO PATIENTS 9, 407, 928 9, 407, 928 0 76. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 76. 00 03950 OTHER ANCILL SRVC 0 0 0 0 76. 01 03951 CARDI AC AND PULMONARY REHAB 694, 331 694, 331 0 694, 331 0 694, 331 76. 02 03952 WOUND CARE 0 0 0 0 0 77. 00 07700 ALLOGENEI C STEM CELL ACQUISITION 0 0 0 0 0 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 78. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 78. 00 08900 CLINIC 0 0 0 0 79. 01 09000 CLINIC 0 0 0 79. 02 09002 CLINIC 713, 897 713, 897 0 79. 00 09000 CLINIC 713, 897 713, 897 0 79. 00 09000 CLINIC 0 0 0 79. 00 09000 CLINIC 0 0 79. 00 09000 CLINIC 0 0 0 79. 00 09000 CLINIC 0 0 79. 00 09000 CLINIC 0 0 0 79. 00 09000 CLINIC 0 0 79. 00 09000 CLINIC 0 0 0 79. 00 09000 CLINIC 0 0 0 79. 00 09000 CLINIC 0 0 79. 00 09000 CLINIC 0 0 0 79. 00	65.00	06500 RESPI RATORY THERAPY		О			2, 922, 379	65. 00
68. 00 06800 SPEECH PATHOLOGY 173, 322 0 173, 322 0 906, 303 906, 303 906, 303 906, 303 906, 303 906, 303 906, 303 906, 303 90007000 ELECTROENCEPHALOGRAPHY 2,398, 045 2,398, 045 0 2,398, 045 70.00 07100 MeDI CAL SUPPLIES CHARGED TO PATI ENTS 11,534, 020 11,534, 020 0 17,500 0 10,700 0 1			1	0				
70.00 07000 ELECTROENCEPHALOGRAPHY 2, 398, 045 2, 398, 045 0 2, 398, 045 70.00 71.00 MEDI CAL SUPPLIES CHARGED TO PATIENTS 11, 534, 020 11, 534, 020 0 11, 534, 020 71.00 72.00 772.00 772.00 1MPL. DEV. CHARGED TO PATIENTS 8, 104, 249 8, 104, 249 0 8, 104, 249 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 9, 407, 928 9, 407, 928 0 9, 407, 928 73.00 074.00 074.00 074.00 074.00 075.				ő				
71. 00		1		l e			1	
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SERVICE COST CENTERS				l .		-	l .	
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92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) 6, 462, 534 6, 462, 534 6, 462, 534 92. 00 OTHER REI MBURSABLE COST CENTERS								1
	92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	6, 462, 534		6, 462, 53	4	6, 462, 534	92. 00
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102. 00 10200 OPI 0I D TREATMENT PROGRAM O O 102. 00 SPECIAL PURPOSE COST CENTERS	102.00			<u> </u>		<u> </u>	<u> </u>	1102.00
105. 00 10500 KIDNEY ACQUISITION 0 0 105. 00		10500 KIDNEY ACQUISITION	0			0		
106. 00 10600 HEART ACQUISITION 0 0 0 106. 00 107. 00 10700 LI VER ACQUISITION 0 0 0 107. 00						0		
108. 00 10800 LUNG ACQUISITION 0 0 108. 00	108.00	10800 LUNG ACQUISITION		l		0	0	108. 00
109. 00 10900 PANCREAS ACQUISITION 0 0 109. 00	109.00	IOAOO SAUCKER2 ACOOL 21 II ON	1 0	<u> </u>		U	<u> </u>	1109.00

Health Financial Systems	FRANCI SCAN HE	ALTH MUNSTER		In Lie	u of Form CMS-:	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider Co		Period: From 01/01/2023 To 12/31/2023		
	_	Title	XVIII	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	1.00	2.00	3.00	4. 00	5. 00	
110. 00 11000 NTESTINAL ACQUISITION 111. 00 11100 SLET ACQUISITION 113. 00 11300 NTEREST EXPENSE 114. 00 11400 UTILIZATION REVIEW-SNF	0			0	0	110. 00 111. 00 113. 00 114. 00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.) 116. 00 11600 HOSPI CE	142 204 151		142 207 15	0	0	115. 00

142, 386, 151

6, 462, 534 135, 923, 617

142, 386, 151 200. 00 6, 462, 534 201. 00 135, 923, 617 202. 00

142, 386, 151

6, 462, 534 135, 923, 617

200.00

201.00 202.00 Subtotal (see instructions)

Less Observation Beds Total (see instructions)

| In Lieu of Form CMS-2552-10 | Period: | Worksheet C | From 01/01/2023 | Part | To 12/31/2023 | Date/Time Prepared: | 5/28/2024 2:16 pm Health Financial Systems

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

Cost Center Description			Title	xVIII	Hospi tal	5/28/2024 2: 1 PPS	6 pm
DENTIFIED ROUTH RESIDENCE COST CENTERS 22,255,081 17,929,244 30,000	Cost Center Description	I npati ent	Charges	Total (col. 6	Cost or Other	TEFRA	
WAT I FERT FROUTINES SERVICE COST CERTIFIES 20,255,081 33.00 330		/ 00	7.00	,		Ratio	
30. 00 30000 ADAUL 15 A PLEIJAHINES 22, 255, 081 77, 095 78 78 78 78 78 78 78 7	INPATIENT ROUTINE SERVICE COST CENTERS	6.00	7.00	8.00	9.00	10.00	
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51.00 05100 RECOVERY ROM 1,201,746 14,255,946 0,226833 0,000000 51.00 05300		22, 019, 525	87, 009, 543	109, 029, 068	0. 116035	0.000000	50.00
53.00 0.0000 0.8000 ARESTHESI OLOGY 3, 833, 279 20, 227, 158 24, 000, 437 0.006263 0.000000 54, 00 0.000000 55, 00 0.000000 56, 00 0.0000000 56, 00 0.0000000 56, 00 0.0000000 56, 00 0.	51.00 05100 RECOVERY ROOM	1			0. 226833	0. 000000	51. 00
54.00 0.0400 RAD ILLOY-DIADNOSTIC 8, 047, 632 46, 562, 485 54, 610, 117 0.127188 0.000000 55, 00 55.00 0.5000 6300 0.000000 55, 00 0.000000 55, 00 0.000000 55, 00 0.000000 55, 00 0.000000 55, 00 0.000000 55, 00 0.000000 55, 00 0.000000 55, 00 0.000000 55, 00 0.000000 55, 00 0.000000 55, 00 0.000000 55, 00 0.000000 55, 00 0.000000 55, 00 0.000000 55, 00 0.000000 55, 00 0.000000 55, 00 0.000000 57, 00 0.000000 55, 00 0.000000 57, 00 0.000000 57, 00 0.000000 57, 00 0.000000 57, 00 0.000000 57, 00 0.000000 57, 00 0.000000 57, 00 0.000000 58, 00 0.000000 57, 00 0.000000 58, 00 0.0000000 58, 00 0.0000000 58, 00 0.00		0	-				
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57.00 05700 CT SCAN 14.135, 645 46, 711, 470 66, 887, 715 0.031988 0.000000 57.00 59.00 05900		1		1			1
58.00 0.6800 MAGNETIC RESONANCE I MAGING (URI) 3,255,420 15,277,715 18,533,315 0.992777 0.000000 59.00 69.00 0.6800 CARDI ACCRITERERIZATION 25,409,572 52,739,292 78,148,864 0.122136 0.000000 59.00 0.00000		o	-				
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68. 00 06800 SPECCH PATHOLOGY 1, 017, 077 164, 829 1, 181, 906 0, 146646 0, 000000 68. 00 69. 00 06900 ELECTROCRACEPHALOGRAPHY 314, 121 4, 841, 250 5, 155, 371 0, 465155 0, 000000 67. 00 70. 00 07000 ELECTROCRACEPHALOGRAPHY 314, 121 4, 841, 250 5, 155, 371 0, 465155 0, 000000 70. 00 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 13, 789, 991 27, 281, 448 1, 071, 439 0, 280828 0, 000000 71. 00 72. 00 07200 IMPL DEV. CHARGED TO PATIENTS 6, 981, 439 23, 948, 373 30, 929, 812 0, 262021 0, 000000 72. 00 74. 00 07400 DRIBLIS CHARGED TO PATIENTS 19, 104, 718 15, 622, 305 34, 727, 023 0, 2709011 0, 000000 73, 00 75. 00 07400 REMAL DIALYSIS 0 0 0 0 0 0 0 0 0, 000000 0, 000000 74, 00 75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 0 0, 000000 0, 000000 76, 01 76. 01 03951 CARDAIA CAND PULIMONARY REHAB 85, 983 1, 264, 956 1, 350, 939 0, 513962 0, 000000 76, 01 76. 01 03951 CARDAIA CAND PULIMONARY REHAB 85, 983 1, 264, 956 1, 350, 939 0, 513962 0, 000000 76, 01 77. 00 07700 ALLOGENET C STEM ECELL ACQUISTITON 0 0 0 0 0 0 0, 000000 0, 000000 77, 00 78. 00 07500 CART -CELL IMMUNOTHERAPY 0 0 0 0 0 0 0, 000000 0, 000000 78, 00 79. 00 08900 REDERRALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 0 0, 000000 0, 000000 79, 00 79. 00 09000 CLINIC 0, 43,49, 127 0, 164147 0, 000000 90, 01 79. 00 09000 OSERVANTION BEDS (NON-DISTINCT PART) 2, 684, 887 5, 980, 916 8, 665, 803 0, 745571 0, 000000 90, 00 79. 00 09000 OSERVANTION BEDS (NON-DISTINCT PART) 2, 684, 887 5, 980, 916 0, 000000							
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H	Health Financial Systems FRANCISCAN HEALTH				In Lie	u of Form CMS-2552-10	
(COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der C	CN: 15-0165	Peri od: From 01/01/2023		
					To 12/31/2023	Date/Time Pre 5/28/2024 2:1	
				e XVIII	Hospi tal	PPS	
			Charges				
	C+ C+ D	I nnoti ont	Outpotiont	Total (aal	/ Coot on Othon	TEEDA	

		litie	XVIII	ноѕрі таі	PPS	
		Charges				
Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
			+ col. 7)	Ratio	I npati ent	
					Ratio	
	6. 00	7. 00	8. 00	9. 00	10.00	
111. 00 11100 SLET ACQUISITION	0	0	C)		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	C			115.00
116. 00 11600 HOSPI CE	0	0	C			116.00
200.00 Subtotal (see instructions)	207, 401, 605	471, 798, 594	679, 200, 199			200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	207, 401, 605	471, 798, 594	679, 200, 199			202. 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet C | From 01/01/2023 | Part | To 12/31/2023 | Date/Time Prepared: | 5/28/2024 2:16 pm

-			Title XVIII	Hospi tal	5/28/2024 2:16 pm PPS
	Cost Center Description	PPS Inpatient	THE XVIII	поэрг саг	
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	T	11. 00			
00.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS				
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT				30. 00 31. 00
32. 00	03200 CORONARY CARE UNIT				32. 00
33. 00	03300 BURN INTENSIVE CARE UNIT				33. 00
34. 00	03400 SURGICAL INTENSIVE CARE UNIT				34. 00
40. 00	04000 SUBPROVI DER - I PF				40.00
41.00	04100 SUBPROVI DER - I RF				41. 00
43.00	04300 NURSERY				43.00
44.00	04400 SKILLED NURSING FACILITY				44. 00
45.00	04500 NURSING FACILITY				45. 00
46. 00	04600 OTHER LONG TERM CARE				46. 00
F0 00	ANCILLARY SERVICE COST CENTERS	0.44/005			
50.00	05000 OPERATING ROOM	0. 116035			50.00
51. 00 52. 00	O5100 RECOVERY ROOM O5200 DELIVERY ROOM & LABOR ROOM	0. 226833 0. 000000			51. 00 52. 00
53. 00	05300 ANESTHESI OLOGY	0. 006263			53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0. 127188			54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0. 000000			55. 00
56. 00	05600 RADI OI SOTOPE	0. 000000			56. 00
57. 00	05700 CT SCAN	0. 031988			57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 092777			58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 416557			59. 00
60.00	06000 LABORATORY	0. 122136			60. 00
60. 01	06001 BLOOD LABORATORY	0. 000000			60. 0
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 I NTRAVENOUS THERAPY	0. 000000			64. 00
65. 00	06500 RESPI RATORY THERAPY	0. 331671			65. 00
66.00	06600 PHYSI CAL THERAPY	0. 186934			66. 00
67. 00	06700 OCCUPATIONAL THERAPY	0. 155860			67. 00
68. 00 69. 00	06800 SPEECH PATHOLOGY	0. 146646			68. 00
70. 00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	0. 038941 0. 465155			69. 00 70. 00
70.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 463133			71. 00
71.00	07200 I MPL. DEV. CHARGED TO PATTENTS	0. 262021			72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 270911			73. 00
74. 00	07400 RENAL DIALYSIS	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 CARDI AC AND PULMONARY REHAB	0. 513962			76. 0°
76. 02	03952 WOUND CARE	0. 000000			76. 02
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000			77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0. 000000			78. 00
	OUTPATIENT SERVICE COST CENTERS				
88. 00	08800 RURAL HEALTH CLINIC				88. 00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000			89. 00
90.00	09000 CLI NI C 09001 CLI NI C	0. 000000 0. 102886			90.00
90.01	l l	0. 164147			90.0
	09100 EMERGENCY	0. 104147			91. 0
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 745751			92. 00
20	OTHER REIMBURSABLE COST CENTERS				.2100
94.00	09400 HOME PROGRAM DIALYSIS	0. 000000			94. 00
95.00	09500 AMBULANCE SERVICES	0. 000000			95. 00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000			96. 00
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD	0. 000000			97. 00
	09850 OTHER REI MBURSE	0. 000000			98. 00
	09900 CMHC				99. 00
	09910 CORF				99. 10
	10000 I &R SERVI CES-NOT APPRVD PRGM				100. 00
	10100 HOME HEALTH AGENCY				101. 00
102.00	10200 OPI OI D TREATMENT PROGRAM				102. 00
105 00	SPECIAL PURPOSE COST CENTERS				105.00
	10500 KIDNEY ACQUISITION				105. 00
	10600 HEART ACQUISITION				106. 00
	10700 LIVER ACQUISITION 10800 LUNG ACQUISITION				107. 00 108. 00
	10800 PANCREAS ACQUISITION				109. 00
	11000 NTESTINAL ACQUISITION				110.00
	11100 I SLET ACQUISITION				111. 00
	11300 INTEREST EXPENSE				113. 00
	1	<u> </u>			1 5:5:

Health Financial Systems	FRANCISCAN HEALT	H MUNSTER	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0165	Period: From 01/01/2023	Worksheet C Part I	
			To 12/31/2023	Date/Time Pre	
				5/28/2024 2:1	6 pm
		Title XVIII	Hospi tal	PPS	
Cost Center Description	PPS Inpatient				
	Ratio				
	11. 00				
114.00 11400 UTILIZATION REVIEW-SNF					114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)					115. 00
116. 00 11600 HOSPI CE					116. 00
200.00 Subtotal (see instructions)					200. 00
201.00 Less Observation Beds					201. 00
202.00 Total (see instructions)					202. 00

COMPUT	ATI ON	OF RATIO OF COSTS TO CHARGES		Provi der C		Period: From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Pre	pared:
				Ti †I	e XIX	Hospi tal	5/28/2024 2: 1 PPS	6 pm
				71 (1		Costs	113	
		Cost Center Description	Total Cost (from Wkst. B, Part I, col.	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
			26) 1. 00	2.00	3.00	4. 00	5. 00	
	I NPAT	IENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3. 00	
30.00		ADULTS & PEDI ATRI CS	33, 090, 648		33, 090, 64		33, 090, 648	1
31. 00 32. 00		INTENSIVE CARE UNIT CORONARY CARE UNIT	7, 482, 138		7, 482, 13	8 0	7, 482, 138 0	1
		BURN INTENSIVE CARE UNIT	0		•	0 0	0	
34. 00		SURGICAL INTENSIVE CARE UNIT	0		1	0 0	0	
40. 00 41. 00		SUBPROVI DER	0		1	0 0	0	
43. 00		NURSERY	0			0 0	0	1
44.00		SKILLED NURSING FACILITY	0		•	0	0	
45. 00 46. 00	1	NURSING FACILITY OTHER LONG TERM CARE	0			0 0	0	
	ANCI L	LARY SERVICE COST CENTERS						1
50. 00 51. 00	1	OPERATING ROOM RECOVERY ROOM	12, 651, 136 3, 240, 528		12, 651, 13 3, 240, 52		12, 651, 136 3, 240, 528	1
51.00		DELIVERY ROOM & LABOR ROOM	3, 240, 526			0 0	3, 240, 526	1
53.00	05300	ANESTHESI OLOGY	150, 690		150, 69		150, 690	•
54. 00 55. 00	1	RADI OLOGY-DI AGNOSTI C RADI OLOGY-THERAPEUTI C	6, 945, 731		6, 945, 73	1 0 0 0	6, 945, 731 0	1
56. 00		RADI OLOGI - THERAPEUTI C	0			0 0	0	1
57. 00	05700	CT SCAN	1, 946, 360		1, 946, 36		1, 946, 360	57. 00
58. 00		MAGNETIC RESONANCE IMAGING (MRI)	1, 719, 442		1, 719, 44		1, 719, 442 7, 293, 793	
59. 00 60. 00		CARDI AC CATHETERI ZATI ON LABORATORY	7, 293, 793 9, 544, 818		7, 293, 79 9, 544, 81		7, 293, 793 9, 544, 818	1
60. 01	06001	BLOOD LABORATORY	0			0 0	0	60. 01
61.00	1	PBP CLINICAL LAB SERVICES-PRGM ONLY	0			0	0	
62. 00 63. 00	1	WHOLE BLOOD & PACKED RED BLOOD CELLS BLOOD STORING, PROCESSING & TRANS.	0			0 0	0	02.00
64. 00	06400	INTRAVENOUS THERAPY	0			0 0	0	1
65. 00		RESPIRATORY THERAPY	2, 922, 379	0			2, 922, 379	1
66. 00 67. 00		PHYSI CAL THERAPY OCCUPATI ONAL THERAPY	600, 993 462, 015		600, 99 462, 01		600, 993 462, 015	1
68. 00	06800	SPEECH PATHOLOGY	173, 322	O	173, 32	2 0	173, 322	68. 00
69. 00 70. 00	1	ELECTROCARDI OLOGY	906, 303		906, 30		906, 303	1
	1	ELECTROENCEPHALOGRAPHY MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 398, 045 11, 534, 020		2, 398, 04 11, 534, 02		2, 398, 045 11, 534, 020	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8, 104, 249		8, 104, 24	9 0	8, 104, 249	72. 00
		DRUGS CHARGED TO PATIENTS RENAL DIALYSIS	9, 407, 928		9, 407, 92	8 0 0 0	9, 407, 928 0	1
74. 00 75. 00		ASC (NON-DISTINCT PART)	0			0 0	0	1
	03950	OTHER ANCILL SRVC	0			0 0	0	
		CARDIAC AND PULMONARY REHAB	694, 331		694, 33	0 0	694, 331 0	1
77.00	07700	ALLOGENEIC STEM CELL ACQUISITION	0			0 0	0	1
78. 00		CAR T-CELL IMMUNOTHERAPY	0			0 0	0	78. 00
88. 00		TIENT SERVICE COST CENTERS RURAL HEALTH CLINIC	0			0 0	0	88. 00
		FEDERALLY QUALIFIED HEALTH CENTER	0			0 0	0	
		CLINIC CLINIC	3, 493, 595		3, 493, 59	0 5	0 3, 493, 595	
90. 02		CLI NI C	713, 897		713, 89		713, 897	1
	1	EMERGENCY	10, 447, 256		10, 447, 25		10, 447, 256	1
92. 00		OBSERVATION BEDS (NON-DISTINCT PART) REIMBURSABLE COST CENTERS	6, 462, 534		6, 462, 53	4	6, 462, 534	92.00
	09400	HOME PROGRAM DIALYSIS	0		•	0 0	0	
		AMBULANCE SERVICES DURABLE MEDICAL EQUIP-RENTED	0		•	0 0	0	
		DURABLE MEDICAL EQUIP-SOLD	0			0 0	0	1
98. 00	09850	OTHER REIMBURSE	0			0 0	0	98. 00
99. 00 99. 10	09900		0			0	0	
	1	I&R SERVICES-NOT APPRVD PRGM	0			0	_	100.00
		HOME HEALTH AGENCY	0		1	0		101. 00
102. 00		OPIOID TREATMENT PROGRAM AL PURPOSE COST CENTERS	0			0	0	102. 00
	10500	KIDNEY ACQUISITION	0			0		105. 00
		HEART ACQUISITION	0		1	0		106.00
		LIVER ACQUISITION LUNG ACQUISITION	0			0		107. 00 108. 00
		PANCREAS ACQUISITION	0			0		109. 00

Health Financial Systems	FRANCI SCAN HEA	ALTH MUNSTER		In Lie	u of Form CMS-:	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der C		Period: From 01/01/2023		
				To 12/31/2023	Date/Time Pre 5/28/2024 2:1	pared: 6 pm
		Titl	e XIX	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst. B,	Adj .		Di sal I owance		
	Part I, col.					
	26)					
	1.00	2.00	3.00	4. 00	5. 00	
110. 00 11000 I NTESTI NAL ACQUI SI TI ON	0			0	0	110. 00
111.00 11100 I SLET ACQUISITION	0			0	0	111. 00
113.00 11300 INTEREST EXPENSE						113. 00

142, 386, 151

6, 462, 534 135, 923, 617

114. 00

114.00 0 115.00 116.00 142,386,151 200.00 6,462,534 201.00 135,923,617 202.00

0

142, 386, 151

6, 462, 534 135, 923, 617

114. 00 11400 UTI LI ZATI ON REVI EW-SNF 115. 00 11500 AMBULATORY SURGI CAL CENTER (D. P.) 116. 00 11600 HOSPI CE

Subtotal (see instructions)

Less Observation Beds Total (see instructions)

200. 00 201. 00

202.00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet C | From 01/01/2023 | Part | To 12/31/2023 | Date/Time Prepared: | 5/28/2024 2:16 pm Health Financial Systems

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

Cost Center Description				Ti tl	e XIX	Hospi tal	5/28/2024 2: 1 PPS	6 pm
New 1.00 1		Cost Genter Description	Inpatient		Total (col. 6	Cost or Other	TFFRA	
DEPART THE REDUTTHE SHAVILE COST CENTERS							I npati ent	
30.00 30.00 ADULTS & PEDIATRIC S 25, 255, 081 25, 255, 081 30, 00 30.00 ADULTS & PEDIATRIC S 25, 255, 081 17, 029, 244 17, 029, 244 17, 029, 244 31, 00 320, 0			6.00	7. 00	8. 00	9. 00		
31 0.0 03100 INTENSIVE CARE UNIT 17, 029, 244 17, 039, 240 0 33. 00 330 0 3300 BURN INTENSIVE CARE UNIT 0 0 0 33. 00 330 0 3300 BURN INTENSIVE CARE UNIT 0 0 0 0 33. 00 330 0 3300 0300 BURN INTENSIVE CARE UNIT 0 0 0 0 0 0 0 0 0	20.00		25 255 004		25 255 00			20.00
32 00 303200 CORROMARY CARE UNIT 0 0 0 33.00 33.00 33300 33300 833		1			1			1
33.00 03000 BURN INTENSIVE CARE UNIT 0 0 33.00 40.00 04000 SUBPREVIOUR - 1PT 0 0 0 40.00 41.00 04000 SUBPREVIOUR - 1PT 0 0 0 41.00 44.00 04000 SUBPREVIOUR - 1PT 0 0 0 44.00 44.00 04400 SWILLED MURSING FACILITY 0 0 0 44.00 46.00 04400 SWILLED MURSING FACILITY 0 0 0 0 45.00 46.00 04400 SWILLED MURSING FACILITY 0 0 0 0 45.00 46.00 04400 SWILLED MURSING FACILITY 0 0 0 0 45.00 46.00 04400 SWILLED MURSING FACILITY 0 0 0 0 0 0 46.00 04400 SWILLED MURSING FACILITY 0 0 0 0 0 0 46.00 04400 SWILLED MURSING FACILITY 0 0 0 0 0 0 46.00 04400 SWILLED MURSING FACILITY 0 0 0 0 0 0 46.00 04400 SWILLED MURSING FACILITY 0 0 0 0 0 0 46.00 04400 SWILLED MURSING FACILITY 0 0 0 0 0 0 46.00 04400 SWILLED MURSING FACILITY 0 0 0 0 0 0 0 46.00 04400 SWILLED MURSING FACILITY 0 0 0 0 0 0 0 0 46.00 04400 SWILLED MURSING FACILITY 0 0 0 0 0 0 0 0 0 46.00 04400 SWILLED MURSING FACILITY 0 0 0 0 0 0 0 0 0			0		17,027,24			
40,00 0.00000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.			o					1
11 00 0100 SURPROVIDER - I RF			0					
43.00 04300 BURSERY 0 0 0 0 43.00			0					
44.00 0450			0)		
46.00			o					1
MICHELARY SERVICE COST CENTERS			0					1
50.00 65000 PERATING ROOM 22,011,9528 87,009,543 109,029,668 0.116035 0.000000 51.00 52.00 0.5000	46. 00		0)		46.00
51.00 05100 ECOVERY ROM 2.071, 205 12.214, 744 14, 285, 949 0.226933 0.000000 51.00 53.00 05200 05200 05200 05200 05200 05200 0.000000 52.00 0.00000 52.00 0.00000 52.00 0.00000 52.00 0.00000 52.00 0.00000 52.00 0.00000 52.00 0.00000 52.00 0.00000 52.00 0.00000 52.00 0.00000 52.00 0.00000 52.00 0.00000 0.00000 52.00 0.00000 52.00 0.00000 0.00000 52.00 0.00000 52.00 0.000000 0.000000 0.00000 0.000000	50. 00		22, 019, 525	87, 009, 543	109, 029, 068	0. 116035	0. 000000	50.00
53.00 05300 ANESTHESIOLOGY 3,833,279 20,227,158 24,060,437 0.066263 0.000005 53.00			1					
54.00 05400 RADIOLOSY-DIAGNOSTIC 8.047.632 46.562.485 54.610.117 0.027188 0.00000 54.00 55.00 05500 RADIOLOSY-THERAPPUTIC 0 0.000000 0.000000 56.00 56.00 56.00 56.00 56.00 56.00 56.00 57.00 57.00 57.00 0.000000 0.000000 56.00 57.00 57.00 57.00 0.000000 56.00 58.00 58.00 58.00 58.00 MAGNETIC RESONANCE IMAGING (MRI) 3.255.420 15.277.715 18.533, 135 0.092777 0.000000 58.00 59.00 59.00 69.00 CARDIAC CARTHETERI ZATION 9.279 77.0 8, 230.247 75.097, 717 0.416557 0.000000 58.00 59.00 59.00 69.00 CARDIAC CARTHETERI ZATION 9.279 77.0 8, 230.247 75.097, 717 0.416557 0.000000 59.00 59.00 69.00 LABORATORY 25.409.572 52.739.292 78.148, 864 0.122136 0.0000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0			0	-	1			
55.00 05500 RADIOLOGY-THERAPCHIC 0 0 0 0 0 0.000000 55.00		1						
56.00 05600 RADIO ISOTOPE 0 0 0.000000 0.000000 5.0 0.00000 0.00000 5.0 0.000000 0.00000 0.00000 0.00000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000			1		1			1
58.00 05800 MAGNETIC RESONANCE IMAGN MG (MRI) 3, 255, 420 15, 277, 715 18, 533, 135 0, 092777 0, 0000000 59, 00 60.00 CARDIAC CATHETER IZATI ON 9, 279, 470 8, 230, 247 17, 509, 717 0, 416557 0, 000000 69, 00 0, 000000 0, 000000 60, 01 0001 1000 12000 LABORATORY 0 0 0 0 0, 0000000 0, 0000000 0, 000000 0, 000000 0, 000000 0, 0000000 0, 000000 0, 000000 0, 000000	56.00	05600 RADI OI SOTOPE	O	0		0. 000000	0. 000000	56. 00
59.00 05900 CARDIA CA CATHETERI ZATION 9, 279, 470 8, 230, 247 17, 509, 717 0. 416557 0. 000000 60. 00								
60.00 06000 LABORATORY 25, 409, 572 52, 739, 292 78, 148, 864 0.12136 0.000000 60. 01 60.01 10.00 10.000000 10.000000 60. 01 60.01 10.000000 10.000000 60. 01 60.01 60.01 10.000000 10.000000 60. 01 60.01 6								
60. 01 06001 BLOOD LABORATORY 0 0 0 0 0 0 0 0 0				52, 739, 292	78, 148, 864			
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 0 0 0 0 0 0			0	0				
63.00 06300 BLOOD STORINC, PROCESSING & TRANS. 0 0 0 0 0.000000 0.000000 63.00			0	0				1
64.00 06400 INTRAVENDUS THERAPY 7, 845, 133 965, 922 8, 811, 065 0. 331671 0. 000000 65.00 66.00 06600 RESPIRATORY THERAPY 7, 845, 133 965, 922 8, 811, 065 0. 331671 0. 000000 65.00 66.00 06600 086000 0860000 0860000 0860000 0860000 0860000 0860000 0860000 0860000 0860000 0860000 08600000 08600000 086000000 08600000 0860000000 0860000000 08600000000 08600000000 086000000000 0860000000000			0	0			l .	1
65.00 0.6500 RESPI RATORY THERAPY 7, 845, 133 965, 932 8, 811, 0.65 0. 331671 0. 0.00000 65. 0.0			0	0				
67.00 06700 06700 06700 06700 06700 06700 06700 06700 06700 06700 06700 06800 06800 06800 06800 06800 06800 06800 06800 06800 06900 06800 06900 06900 06800 069000 06900 06900 0690000 069000 069000 069000 069000 069000 069000 0690000 0690000 0690000 069000 069000 06900			7, 845, 133	965, 932	8, 811, 06!			
68.00 06800 DEECR PATHOLOGY 1, 017, 077 164, 829 1, 181, 906 0. 146646 0. 000000 68.00								
69.00 06900 06900 06900 06900 070000 070000 070000 070000 070000 070000 070000 070000 070000 070000 070000 070000 070000 070000 070000 0700000 0700000 0700000 0700000 0700000 0700000 0700000 07000000 0700000 0700000 07000000 07000000 07000000 070000000 07000000 070000000 070000000 0700000000								
70. 00 07000 ELECTROENCEPHALOGRAPHY 314, 121 4, 841, 250 5, 155, 371 0. 465155 0. 000000 70. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 13, 789, 991 27, 281, 448 41, 071, 439 0. 280828 0. 000000 71. 00 72. 00 73. 00 07200 MPL. DEV. CHARGED TO PATIENTS 6, 981, 439 23, 948, 373 30, 929, 812 0. 262021 0. 000000 72. 00 73. 00 74. 00 74. 00 74. 00 74. 00 74. 00 74. 00 75. 00 75. 00 75. 00 07400 RSNAL DIALYSIS 0. 0 0. 000000 0. 000000 75. 00 75. 00 07500 ASC (NON-DISTINCT PART) 0. 0 0. 0 0. 000000 0. 000000 75. 00 76. 00 0. 000000 0. 000000 76. 00 76. 00 0. 000000 76. 00 0. 000000 76. 00 0. 000000 76. 00 0. 000000 76. 00 0. 000000 76. 00 76. 00 0. 000000 76. 00 76. 00 0. 000000 76. 00 76. 00 0. 000000 76. 00 76. 00 76. 00 0. 000000 76. 00 76.								
72. 00 07200 IMPL DEV. CHARGED TO PATIENTS 6, 981, 439 23, 948, 373 30, 929, 812 0. 262021 0. 000000 72. 00 73. 00 73. 00 73. 00 74.00 RENAL DIALYSIS 0 0 0 0 0. 000000 0. 000000 73. 00 74.00 75. 00 7							l e	1
73. 00 07300 DRUGS CHARGED TO PATIENTS 19, 104, 718 15, 622, 305 34, 727, 023 0. 270911 0. 0000000 73. 00 74. 00 74. 00 74. 00 74. 00 75. 00 0. 0000000 0. 0000000 74. 00 75. 00 0. 0000000 0. 0000000 75. 00 0. 0000000 0. 0000000 75. 00 76. 00 0. 0000000 0. 0000000 75. 00 76. 00 0. 0000000 0. 0000000 76. 00 0. 0000000 0. 0000000 76. 00 0. 000000 0. 0000000 76. 00 0. 0000000 0. 0000000 76. 00 0. 000000 76. 00 0. 0000000 0. 0000000 76. 00 0. 0000000 76. 00 0. 0000000 76. 00 0. 0000000 76. 00 0. 0000000 76. 00 0. 0000000 76. 00 0. 0000000 76. 00 0. 0000000 76. 00 0. 0000000 76. 00 0. 0000000 76. 00 0. 0000000 76. 00 0. 0000000 76. 00 78. 00 0. 0000000 76. 00 0. 0000000 76. 00 0. 0000000 76. 00 0. 0000000 76. 00 0. 0000000 76. 00 0. 0000000 76. 00 0. 0000000 76. 00 0. 0000000 76. 00 0. 0000000 76. 00 0. 0000000 76. 00 0. 0000000 76. 00 0. 0000000 76. 00 0. 0000000 76. 00 0. 0000000 76. 00 0. 0000000 76. 00 0. 0000000 76. 00 0. 0000000 76. 00 77. 00 78. 00 0. 0000000 78. 00 0. 0000000 78. 00 0. 0000000 78. 00 0. 0000000 78. 00 0. 0000000 78. 00 0. 0000000 78. 00 0. 0000000 78. 00 0. 0000000 78. 00 0. 0000000 78. 00 0. 0000000 78. 00 0. 0000000 0. 0000000 78. 00 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 000000 0. 0000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 0000000 0. 0000							l e	1
74. 00								
75.00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0.000000 0.000000 76.00 76.00 76.00 0.000000 0.000000 76.00 76.00 0.000000 0.000000 76.00 76.01 0.000000 0.000000 76.00 76.01 0.000000 76.01 0.000000 76.01 0.000000 76.01 0.000000 76.01 0.000000 76.01 0.000000 76.01 0.000000 76.01 0.000000 76.02 77.00 0.000000 0.000000 76.02 77.00 0.000000 0.000000 0.000000 76.02 77.00 0.000000 0.000000 0.000000 76.02 77.00 0.000000 0.000000 0.000000 0.000000 78.00 0.000000 0.000000 0.000000 78.00 0.000000 0.000000 0.000000 78.00 0.0000000 0.0000000 0.00000000			19, 104, 718	15, 022, 303	1			
76. 01 03951 CARDI AC AND PULMONARY REHAB 85, 983 1, 264, 956 1, 350, 939 0. 513962 0. 000000 76. 01 76. 02 03952 WOUND CARE 0 0 0 0 0 0. 000000 76. 02 77. 00 0. 0700 ALLOGENEI C STEM CELL ACQUI SI TI ON 0 0 0 0 0. 000000 0. 000000 77. 00 78. 00 07800 CAR T - CELL I MMUNOTHERAPY 0 0 0 0 0 0. 000000 0. 000000 78. 00 000000 0. 0000000 0. 0000000			O	0				
76. 02			0	0.44.054	4 252 224			
77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION 0 0 0 0 0 0 0 0 0			85, 983	1, 264, 956	1			
78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0.000000 78. 00			l o	Ö			l	1
88. 00	78. 00		0	0		0.00000	0. 000000	78. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 0 0 0 0	00 00				J	0.00000	0.000000	1 00 00
90. 00			0		1			
90. 02			o	0	1			
91. 00			1, 454, 273					
92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 2,684,887 5,980,916 8,665,803 0.745751 0.000000 92. 00			12 510 251				1	1
94. 00		1	1		1		l .	
95. 00	72.00		27 00 17 00 7	57 7557 715	7 07 0007 000	31710701	0.00000	72.00
96. 00			0		1			
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 0 0 0 0 0 0			0					
98. 00 09850 OTHER REI MBURSE 0 0 0.000000 0.000000 98. 00 99. 00 99. 00 99. 10 09910 CORF 0 0 0 0 0 0 0 0 0			0	0	1			
99. 10 09910 CORF 0 0 0 99. 10 100. 00 1 00. 00.			O	0			l e	
100. 00 10000 I &R SERVI CES-NOT APPRVD PRGM 0 0 100. 00			0	0	1			
		1	0	0	1			1
				0				101.00
102. 00 102.00 OPI OI D TREATMENT PROGRAM 0 0 0 102. 00		1	0		1			
SPECIAL PURPOSE COST CENTERS								
105. 00 10500 KI DNEY ACQUI SI TI ON 0 0 0 0. 000000 0. 000000 105. 00 106. 00 106. 00 10600 HEART ACQUI SI TI ON 0 0 0 0. 000000 0. 000000 106. 00			0		1		l e	
107. 00 10700 LI VER ACQUI SI TI ON 0 0 0 0. 000000 0. 000000 107. 00				_	1		l e	
108.00 10800 LUNG ACQUISITION 0 0 0.000000 0.000000 108.00	108.00	10800 LUNG ACQUISITION		-	1	0. 000000	0. 000000	108. 00
109. 00 10900 PANCREAS ACQUISITION 0 0 0.000000 0.000000 109. 00		1	0		l .		•	
110. 00 11000 1 NTESTI NAL ACQUI SI TI ON 0 0 0. 000000 0. 000000 110. 00	110.00	TITOOOTINIESTINAL ACQUISTITON	<u> </u> 0	C	'l (0. 0000000 _ا ر	J U. UUUU00	1110.00

Health Financial Systems	FRANCISCAN HEA	LTH MUNSTER			In Lieu of Form CMS-2552		
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der C	Provi der CCN: 15-0165		eriod: rom 01/01/2023 o 12/31/2023	Worksheet C Part I Date/Time Prep 5/28/2024 2:10	
		Ti ti	le XIX		Hospi tal	PPS	
		Charges	Charges				
Coot Contor Doporintian	Innotiont	Outpotiont	Total (on	1 /	Coot on Othor	TEEDA	

			Titl	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	
111.00 11100	ISLET ACQUISITION	0	0	(0.000000	0.000000	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	0	(116. 00
200.00	Subtotal (see instructions)	207, 401, 605	471, 798, 594	679, 200, 199			200. 00
201.00	Less Observation Beds						201. 00
202.00	Total (see instructions)	207, 401, 605	471, 798, 594	679, 200, 199			202.00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet C | From 01/01/2023 | Part | To 12/31/2023 | Date/Time Prepared: | 5/28/2024 2:16 pm

			Title XIX	Hospi tal	5/28/2024 2: 16 PPS	o pm
	Cost Center Description	PPS Inpatient	THE XIX	поэрг саг	113	
	, , , , , , , , , , , , , , , , , , ,	Ratio				
	T	11.00				
00.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS					00.00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT					30. 00 31. 00
32. 00	03200 CORONARY CARE UNIT					32. 00
33. 00	03300 BURN INTENSIVE CARE UNIT					33. 00
34. 00	03400 SURGICAL INTENSIVE CARE UNIT					34. 00
40. 00	04000 SUBPROVI DER - I PF					40. 00
41.00	04100 SUBPROVI DER - I RF					41.00
43.00	04300 NURSERY					43.00
44. 00	04400 SKILLED NURSING FACILITY					44. 00
45. 00	04500 NURSING FACILITY					45. 00
46. 00	04600 OTHER LONG TERM CARE					46. 00
FO 00	ANCI LLARY SERVI CE COST CENTERS	0.11/025				FO 00
50. 00 51. 00	05000 OPERATING ROOM 05100 RECOVERY ROOM	0. 116035 0. 226833				50. 00 51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0. 220033				51.00
53. 00	05300 ANESTHESI OLOGY	0. 006263				53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0. 127188				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. 031988				57.00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 092777				58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 416557				59. 00
60.00	06000 LABORATORY	0. 122136				60.00
60. 01	06001 BLOOD LABORATORY	0.000000				60. 01
61. 00 62. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000				61. 00 62. 00
63. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000 0. 000000				63. 00
64. 00	06400 I NTRAVENOUS THERAPY	0. 000000				64. 00
65. 00	06500 RESPI RATORY THERAPY	0. 331671				65. 00
66. 00	06600 PHYSI CAL THERAPY	0. 186934				66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 155860				67. 00
68. 00	06800 SPEECH PATHOLOGY	0. 146646				68. 00
69.00	06900 ELECTROCARDI OLOGY	0. 038941				69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 465155				70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 280828				71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 262021				72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 270911				73. 00
74. 00	07400 RENAL DIALYSIS	0.000000				74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0.000000				75. 00
76. 00 76. 01	03950 OTHER ANCILL SRVC 03951 CARDI AC AND PULMONARY REHAB	0.000000				76. 00
	03952 WOUND CARE	0. 513962 0. 000000				76. 01 76. 02
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000				77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0. 000000				78. 00
	OUTPATIENT SERVICE COST CENTERS	2.222229				
88. 00	08800 RURAL HEALTH CLINIC	0. 000000				88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000				89. 00
90.00		0. 000000				90.00
90. 01		0. 102886				90. 01
90. 02		0. 164147				90. 02
	09100 EMERGENCY	0. 173427				91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 745751				92. 00
94. 00	OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DI ALYSI S	0.00000				04 00
94. 00 95. 00	09500 AMBULANCE SERVICES	0. 000000 0. 000000				94. 00 95. 00
96.00		0. 000000				96. 00
97.00	09700 DURABLE MEDICAL EQUIP-RENTED	0. 000000				97.00
	09850 OTHER REIMBURSE	0. 000000				98. 00
	09900 CMHC					99. 00
	09910 CORF					99. 10
100.00	10000 I&R SERVICES-NOT APPRVD PRGM				1	100. 00
101.00	10100 HOME HEALTH AGENCY				1	101. 00
102.00	10200 OPI OI D TREATMENT PROGRAM				1	102. 00
	SPECIAL PURPOSE COST CENTERS					
	10500 KIDNEY ACQUISITION	0.000000			•	105.00
	10600 HEART ACQUISITION	0.000000				106.00
	10700 LIVER ACQUISITION	0.000000				107. 00
	10800 LUNG ACQUISITION 10900 PANCREAS ACQUISITION	0. 000000				108. 00 109. 00
	10900 PANCREAS ACQUISITION 11000 INTESTINAL ACQUISITION	0. 000000 0. 000000				109. 00 110. 00
	TIOOO INTESTINAL ACQUISITION 11100 ISLET ACQUISITION	0. 000000				110.00
	11300 I NTEREST EXPENSE	3. 000000				113. 00
	1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	1			I'	

Health Financial Systems	FRANCISCAN HEALT	TH MUNSTER	In Lieu of Form CMS-2552-10			
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CCN: 15-0165	Peri od: From 01/01/2023 To 12/31/2023			
				5/28/2024 2:1	6 pm	
		Title XIX	Hospi tal	PPS		
Cost Center Description	PPS Inpatient					
	Ratio					
	11. 00					
114.00 11400 UTILIZATION REVIEW-SNF		·			114. 00	
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)					115. 00	
116. 00 11600 HOSPI CE					116. 00	
200.00 Subtotal (see instructions)					200. 00	
201.00 Less Observation Beds					201. 00	
202.00 Total (see instructions)					202. 00	

| In Lieu of Form CMS-2552-10 | Period: | Worksheet C | From 01/01/2023 | Part II | To 12/31/2023 | Date/Time Prepared: | 5/28/2024 2:16 pm Heal th FinancialSystemsFRANCISCAN HEALTH MUNSTERCALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OFProvider Provider CCN: 15-0165 REDUCTIONS FOR MEDICALD ONLY

					5/28/2024 2:1	6 pm
			e XIX	Hospi tal	PPS	
Cost Center Description	Total Cost	Capital Cost	Operating Cost	Capi tal	Operating Cost	
			Net of Capital	Reduction	Reduction	
	I, col. 26)	II col. 26)	Cost (col. 1 -		Amount	
	1.00	0.00	col . 2)	4.00	F 00	
ANCILL ADV. SEDVI CE. COST. CENTEDS	1.00	2. 00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS 50.00 OPERATING ROOM	12, 651, 136	2, 533, 096	10, 118, 040		0	50. 00
51. 00 05100 RECOVERY ROOM	3, 240, 528	l		0	1	51. 00
· · · · · · · · · · · · · · · · · · ·	3, 240, 326	1,045,955		0		52. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM 53.00 05300 ANESTHESI OLOGY	150, 690	٧	7	0	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	6, 945, 731	1, 202, 821		0		54. 00
55. 00 05500 RADI OLOGY - DI AGNOSTI C	0, 945, 751	1, 202, 621	5, 742, 910	0		55. 00
56. 00 05600 RADI 01 SOTOPE	0			0	0	56. 00
	1 04/ 2/0	F2 400	1 002 070	0		
	1, 946, 360	l		0	0	57. 00 58. 00
58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 59. 00 05900 CARDI AC CATHETERI ZATI ON	1, 719, 442		1 ' '	0		58. 00 59. 00
	7, 293, 793	l '		0		
60. 00 06000 LABORATORY	9, 544, 818	580, 994	8, 963, 824	0	0	60.00
60. 01 06001 BLOOD LABORATORY	0			0		60. 01
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0			0	0	61.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0			0		62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS. 64.00 06400 INTRAVENOUS THERAPY	0			0	0	63. 00 64. 00
	2 022 270	2/0 215	2 (/2 1/4	0		
	2, 922, 379	1		0		65. 00
66. 00 06600 PHYSI CAL THERAPY	600, 993			0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	462, 015			0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	173, 322			0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	906, 303			0	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	2, 398, 045	1		0	0	70.00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	11, 534, 020	l		0	0	71. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	8, 104, 249	l		0	0	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	9, 407, 928	622, 647	8, 785, 281	0	0	73. 00
74. 00 07400 RENAL DI ALYSI S	0	0	0	0	0	74.00
75. 00 07500 ASC (NON-DISTINCT PART)	0	C	0	0	0	75. 00
76. 00 03950 OTHER ANCILL SRVC	0	C	0	0	0	76. 00
76. 01 03951 CARDI AC AND PULMONARY REHAB	694, 331	20, 318	674, 013	0	0	76. 01
76. 02 03952 WOUND CARE	0	C	0	0	0	76. 02
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	C	0	0	0	77. 00
78. 00 07800 CAR T-CELL IMMUNOTHERAPY	0	<u> </u>	0	0	0	78. 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	0 400 505	100 000	0 200 ((5	0	0	90.00
90. 01 09001 CLI NI C	3, 493, 595			0	0	90. 01
90. 02 09002 CLI NI C	713, 897			0	0	90. 02
91. 00 09100 EMERGENCY	10, 447, 256	1		0	0	91.00
92. 00 O9200 OBSERVATION BEDS (NON-DISTINCT PART)	6, 462, 534	1, 250, 345	5, 212, 189	0	0	92. 00
OTHER REIMBURSABLE COST CENTERS						04.00
94. 00 09400 HOME PROGRAM DI ALYSI S	0			0	0	94. 00
95. 00 09500 AMBULANCE SERVICES	0			0	0	95. 00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0			0	0	96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0			0	0	
98. 00 09850 OTHER REI MBURSE	0			0	0	98. 00
99. 00 09900 CMHC	0			0	0	99. 00
99. 10 09910 CORF	0			0	0	99. 10
100.00 10000 I &R SERVI CES-NOT APPRVD PRGM	0			0	l e	100.00
101. 00 10100 HOME HEALTH AGENCY	0			0		101.00
102. 00 10200 OPI OI D TREATMENT PROGRAM	0		0	0	0	102. 00
SPECIAL PURPOSE COST CENTERS						105 00
105. 00 10500 KI DNEY ACQUI SI TI ON	0			0	l e	105. 00
106. 00 10600 HEART ACQUISITION 107. 00 10700 LIVER ACQUISITION	0			0		106. 00
107.00 10700 LIVER ACQUISITION 108.00 10800 LUNG ACQUISITION	0			0		107. 00 108. 00
	0			0		
109.00 10900 PANCREAS ACQUISITION	0			0		109. 00 110. 00
110. 00 11000 INTESTINAL ACQUISITION	0			0		
111.00 11100 SLET ACQUI SI TI ON	0		ή	0	"	111.00
113. 00 11300 INTEREST EXPENSE	-					113.00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF		,		^	_	114.00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0			0		115.00
116. 00 11600 HOSPI CE	101 012 275	12 177 2/4	0 434 104	0		116.00
200.00 Subtotal (sum of lines 50 thru 199)	101, 813, 365			0		200. 00 201. 00
201.00 Less Observation Beds 202.00 Total (line 200 minus line 201)	6, 462, 534 95, 350, 831	1		0		201.00
202.00 Total (True 200 IIII lius True 201)	75, 350, 631	11,720,710	ار (۵۵, ۹۷۵, ۱۱۵	U	ı	202.00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet C | From 01/01/2023 | Part II | To 12/31/2023 | Date/Time Prepared: | 5/28/2024 2:16 pm

-		T: ±1	- VIV	11	5/28/2024 2: 1	о рт
	10 1 11 6		e XIX	Hospi tal	PPS	
Cost Center Description	Cost Net of	Total Charges				
	Capital and	(Worksheet C,	Cost to Charge			
			Ratio (col. 6			
	Reduction	8)	/ col . 7)			
	6. 00	7. 00	8. 00			
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	12, 651, 136	109, 029, 068	0. 116035			50.00
51.00 05100 RECOVERY ROOM	3, 240, 528	14, 285, 949	0. 226833			51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	l c	0.000000			52. 00
53. 00 05300 ANESTHESI OLOGY	150, 690	24, 060, 437				53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	6, 945, 731	l				54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0		i			55. 00
56. 00 05600 RADI OI SOTOPE	0	1	0. 000000			56.00
57. 00 05700 CT SCAN	1, 946, 360	1				57. 00
· · · · · · · · · · · · · · · · · · ·						
1 1	1, 719, 442	l '				58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	7, 293, 793					59. 00
60. 00 06000 LABORATORY	9, 544, 818	1				60.00
60. 01 06001 BLOOD LABORATORY	0	C	0. 000000			60. 01
61.00 O6100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	C	0. 000000			61. 00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	[C	0.000000			62. 00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	C	0.000000			63. 00
64.00 06400 I NTRAVENOUS THERAPY	0	C	0.000000			64. 00
65. 00 06500 RESPIRATORY THERAPY	2, 922, 379	8, 811, 065	0. 331671			65.00
66. 00 06600 PHYSI CAL THERAPY	600, 993	3, 215, 008	0. 186934			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	462, 015	1				67.00
68. 00 06800 SPEECH PATHOLOGY	173, 322					68. 00
69. 00 06900 ELECTROCARDI OLOGY	906, 303					69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	2, 398, 045					70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	11, 534, 020					71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	8, 104, 249					72.00
73. 00 07300 DRUGS CHARGED TO PATTENTS		1				73.00
· · · · · · · · · · · · · · · · · · ·	9, 407, 928	34, 727, 023				
	0		0.000000			74.00
75. 00 07500 ASC (NON-DISTINCT PART)	0		0.000000			75. 00
76. 00 03950 OTHER ANCILL SRVC	0		0.00000			76. 00
76. 01 03951 CARDI AC AND PULMONARY REHAB	694, 331	1, 350, 939				76. 01
76. 02 03952 WOUND CARE	0	C	0. 000000			76. 02
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0					77. 00
78.00 O7800 CAR T-CELL IMMUNOTHERAPY	0	C	0.000000			78. 00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	C	0.000000			88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	[C	0.000000			89. 00
90. 00 09000 CLI NI C	0	C	0.000000			90.00
90. 01 09001 CLI NI C	3, 493, 595	33, 955, 902	0. 102886			90. 01
90. 02 09002 CLI NI C	713, 897	4, 349, 127	0. 164147			90. 02
91.00 09100 EMERGENCY	10, 447, 256	60, 240, 145	0. 173427			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	6, 462, 534	8, 665, 803	0. 745751			92.00
OTHER REIMBURSABLE COST CENTERS						
94. 00 09400 HOME PROGRAM DIALYSIS	0	C	0.000000			94. 00
95. 00 09500 AMBULANCE SERVICES	0	l	0.000000			95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	l c	1			96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0		0. 000000			97. 00
98. 00 09850 OTHER REI MBURSE	0					98. 00
99. 00 09900 CMHC	0	l e	0. 000000			99. 00
99. 10 09910 CORF		· -	0.000000			99. 10
100. 00 10000 I &R SERVI CES-NOT APPRVD PRGM			0.000000			100.00
101. 00 10100 HOME HEALTH AGENCY	0		1			101.00
102.00 10200 OPI OI D TREATMENT PROGRAM	0	l e				102.00
	1 0		0.000000			102.00
SPECIAL PURPOSE COST CENTERS	1 0		0.000000			105 00
105. 00 10500 KI DNEY ACQUI SI TI ON	0	l	0.000000			105. 00
106. 00 10600 HEART ACQUISITION	0		0.000000			106.00
107. 00 10700 LI VER ACQUI SI TI ON	0		0.000000			107. 00
108. 00 10800 LUNG ACQUISITION	0		0. 000000			108. 00
109. 00 10900 PANCREAS ACQUISITION	0	C	0.000000			109. 00
110.00 11000 INTESTINAL ACQUISITION	0	C	0. 000000			110. 00
111.00 11100 I SLET ACQUI SI TI ON	0	[C	0. 000000			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	[C	0. 000000			115. 00
116. 00 11600 H0SPI CE	0		0. 000000			116. 00
200.00 Subtotal (sum of lines 50 thru 199)	101, 813, 365	636, 915, 874	Į.			200. 00
201.00 Less Observation Beds	6, 462, 534					201. 00
202.00 Total (line 200 minus line 201)	95, 350, 831	636, 915, 874				202. 00
			· ·			

Health Financial Systems	FRANCI SCAN HEA				u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITA	_ COSTS	Provi der C	CN: 15-0165	Peri od: From 01/01/2023 To 12/31/2023	Worksheet D Part I Date/Time Pre 5/28/2024 2:1	pared: 6 pm
		Ti tl e	XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swi ng Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cos			
	Part II, col.		(col . 1 - col	l .		
	26)		2)			
	1.00	2. 00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	6, 402, 233	C	6, 402, 2	33 13, 994	457. 50	30.00
31.00 INTENSIVE CARE UNIT	1, 673, 675		1, 673, 6	75 5, 296	316. 03	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	0.00	34.00
40. 00 SUBPROVI DER - I PF	0	C		0	0.00	40.00
41. 00 SUBPROVI DER - I RF	0	C		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)	8, 075, 908		8, 075, 90	19, 290		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				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDI ATRI CS	4, 383	2, 005, 223	3			30.00
31.00 INTENSIVE CARE UNIT	1, 701	537, 567	'			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	C)			45. 00
200.00 Total (lines 30 through 199)	6, 084	2, 542, 790				200.00

Health Financial Systems FRANCISCAN HEALTH MUNSTER In Lieu						u of Form CMS-	2552-10
APP0R1	TIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der C	CN: 15-0165	Peri od:	Worksheet D	
					From 01/01/2023	Part II	
					To 12/31/2023	Date/Time Pre	pared:
			T: +1 a	S VVIIII	Hooni tal	5/28/2024 2:1	ь рш
	Cook Cook on Donais at the cook	0: +-1		XVIII	Hospi tal	PPS	
	Cost Center Description	Capi tal	Total Charges			Capital Costs	
		Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
		(from Wkst. B,	Part I, col.	(col . 1 ÷ col	. Charges	column 4)	
		Part II, col.	8)	2)			
		26)	2.00	2.00	4.00	F 00	
	ANCILLARY SERVICE COST CENTERS	1. 00	2.00	3. 00	4. 00	5. 00	
50. 00	05000 OPERATING ROOM	2, 533, 096	109, 029, 068	0. 02323	7, 777, 863	180, 703	50.00
51. 00	05100 RECOVERY ROOM	1, 045, 933		•		53, 739	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	1,045,755	14, 203, 949	1		0 33, 737	1
53. 00	05300 ANESTHESI OLOGY	4, 698	١ -	•			
54. 00	05400 RADI OLOGY-DI AGNOSTI C	1, 202, 821		•		63, 675	
		1, 202, 821	54, 610, 117			'	
55. 00	05500 RADI OLOGY-THERAPEUTI C		C			0	
56. 00	05600 RADI OI SOTOPE	0	C	0.0000		0	
57. 00	05700 CT SCAN	52, 490				4, 423	
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	49, 594	18, 533, 135			3, 321	
59. 00	05900 CARDI AC CATHETERI ZATI ON	2, 259, 889				356, 079	
60.00	06000 LABORATORY	580, 994	78, 148, 864			67, 999	
60. 01	06001 BLOOD LABORATORY	0	C	0. 00000	00	0	60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	l c	0. 00000	00	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0		0. 00000	00	0	63. 00
64.00	06400 I NTRAVENOUS THERAPY	0		0.00000		0	64.00
65. 00	06500 RESPIRATORY THERAPY	260, 215	8, 811, 065	•		91, 289	
66. 00	06600 PHYSI CAL THERAPY	17, 628				5, 782	
67. 00	06700 OCCUPATI ONAL THERAPY	13, 589		•		4, 698	
68. 00	06800 SPEECH PATHOLOGY	5, 100		•		1, 880	
69. 00	06900 ELECTROCARDI OLOGY			•			
		26, 812		•			
70.00	07000 ELECTROENCEPHALOGRAPHY	964, 904	5, 155, 371	0. 18716		23, 076	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	271, 589					
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	190, 903					
73.00	07300 DRUGS CHARGED TO PATIENTS	622, 647	34, 727, 023			120, 977	
74.00	07400 RENAL DIALYSIS	0	(0.00000		0	
75. 00	07500 ASC (NON-DISTINCT PART)	0	[C	0.0000		0	
76.00	03950 OTHER ANCILL SRVC	0	C	0.00000	00	0	76. 00
76. 01	03951 CARDIAC AND PULMONARY REHAB	20, 318	1, 350, 939	0. 01504	10 29, 112	438	76. 01
76. 02	03952 WOUND CARE	0	C	0. 00000	00	0	76. 02
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	l c	0. 00000	00	0	77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0		0. 00000	00	0	78. 00
	OUTPATIENT SERVICE COST CENTERS	•	•				1
88. 00	08800 RURAL HEALTH CLINIC	0	C	0.00000	00	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0		l		0	1
90.00	09000 CLI NI C	0		0.00000		0	
90. 01	09001 CLINI C	100, 930	33, 955, 902			1, 744	
90. 02	09002 CLINIC	170, 937	4, 349, 127	1		1, 744	90. 02
91. 00	09100 EMERGENCY			l		122 202	
91.00		1, 531, 829				122, 392	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 250, 345	8, 665, 803	0. 14428	35 1, 114, 993	160, 877	92.00
04.00	OTHER REIMBURSABLE COST CENTERS	_	_	0.0000	20	^	04.00
94.00	09400 HOME PROGRAM DI ALYSI S	0		0.00000	00	0	
95.00	09500 AMBULANCE SERVI CES	_	_		-	_	95.00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	0		0.00000		0	
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD	0	l c	0.00000		0	
98. 00	09850 OTHER REIMBURSE	0	C C	0.00000		0	
200.00	Total (lines 50 through 199)	13, 177, 261	636, 915, 874	·	60, 168, 522	1, 315, 286	J200. 00

Health Financial Systems	FRANCISCAN HEA	LTH MUNSTER		In Li€	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER P	ASS THROUGH COST	S Provider C		Period: From 01/01/2023 To 12/31/2023	Worksheet D Part III Date/Time Pre 5/28/2024 2:10	pared: 6 pm
		Ti tl e	e XVIII	Hospi tal	PPS	
Cost Center Description	Nursing Program Post-Stepdown Adjustments	Nursi ng Program	Allied Healt Post-Stepdow Adjustments		All Other Medical Education Cost	
	1A	1. 00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						

		Title	e XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng	Nursi ng	Allied Health	Allied Health	All Other	
	Program	Program	Post-Stepdown	Cost	Medi cal	
	Post-Stepdown		Adjustments		Education Cost	
	Adjustments		,			
	1A	1.00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		11.00		2.00	0.00	
30. 00 03000 ADULTS & PEDIATRICS	0	0	0	0	0	30. 00
31. 00 03100 NTENSI VE CARE UNI T	0	Ö	Ö	0	0	31. 00
32. 00 03200 CORONARY CARE UNIT	0				-	32. 00
1	0	1	· -	0		
33. 00 03300 BURN INTENSIVE CARE UNIT	0	0	0	Ü	0	33.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34. 00
40. 00 04000 SUBPROVI DER - 1 PF	0	0	0	0	0	40. 00
41. 00 04100 SUBPROVI DER - I RF	0	0	0	0	0	41.00
43. 00 04300 NURSERY	0	0	0	0	0	43.00
44.00 04400 SKILLED NURSING FACILITY	0	0	0	0		44.00
45. 00 04500 NURSING FACILITY	0	0	1 0	0		45. 00
200.00 Total (lines 30 through 199)	0	0	0	0	0	200. 00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patient	Per Diem (col.	Inpati ent	200.00
	Adjustment	(sum of cols.	Days	5 ÷ col . 6)	Program Days	
	Amount (see	1 through 3,		0 . 00 0)	l og. a bayo	
	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	13, 994	0.00	4, 383	30. 00
31. 00 03100 NTENSI VE CARE UNI T		0				31. 00
						32.00
		1	-			
33. 00 03300 BURN INTENSIVE CARE UNIT		0		0.00		33. 00
34.00 03400 SURGICAL INTENSIVE CARE UNIT		0	0	0.00		34. 00
40. 00 04000 SUBPROVI DER - I PF	0	0	0	0.00		40. 00
41. 00 04100 SUBPROVI DER - I RF	0	0	0	0.00	0	41. 00
43. 00 04300 NURSERY		0	0	0.00	0	43.00
44.00 04400 SKILLED NURSING FACILITY		0	0	0.00	0	44.00
45.00 04500 NURSING FACILITY		0	1 0	0.00	0	45. 00
200.00 Total (lines 30 through 199)		0	19, 290			200. 00
Cost Center Description	Inpatient	_	, =		-, -, -, -,	
5551 551161 55551 Pt 1511	Program					
	Pass-Through					
	Cost (col. 7 x					
	cost (cor. 7 x					
	9.00					
INPATIENT ROUTINE SERVICE COST CENTERS	7.00					
30. 00 03000 ADULTS & PEDIATRICS	1 0					30. 00
31. 00 03100 NTENSI VE CARE UNI T						31. 00
		•				
32. 00 03200 CORONARY CARE UNIT	0					32.00
33. 00 03300 BURN INTENSIVE CARE UNIT	0					33.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	0					34. 00
40. 00 04000 SUBPROVI DER - 1 PF	0					40. 00
41. 00 04100 SUBPROVI DER - I RF	0					41. 00
43. 00 04300 NURSERY	0					43.00
44.00 04400 SKILLED NURSING FACILITY	0					44. 00
45. 00 04500 NURSING FACILITY	0	•				45. 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet D | From 01/01/2023 | Part IV | To 12/31/2023 | Date/Time Prepared: 5/28/2024 2:16 pm THROUGH COSTS

							5/28/2024 2: 10	6 pm
			Ti tl e	e XVIII	Hos	spi tal	PPS	
	Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allie	ed Health	Allied Health	
		Anesthetist	Program	Program	Post-	-Stepdown		
		Cost	Post-Stepdown		Adj ı	ustments		
			Adjustments					
		1.00	2A	2. 00		3A	3. 00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATI NG ROOM	0	(0	0	0	50.00
51.00	05100 RECOVERY ROOM	0	(0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	(0	0	0	52.00
53.00	05300 ANESTHESI OLOGY	0	(0	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	(0	0	0	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	0	(0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	(0	0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	(0	0	0	59. 00
60.00	06000 LABORATORY	0	(0	0	0	60.00
60. 01	06001 BLOOD LABORATORY	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		ol	0	0	0	62. 00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0			0	0	0	63. 00
64. 00	06400 I NTRAVENOUS THERAPY	0			0	0	0	64.00
65. 00	06500 RESPIRATORY THERAPY	0			0	0	0	65.00
66, 00	06600 PHYSI CAL THERAPY	0			0	0	0	66, 00
67. 00	06700 OCCUPATI ONAL THERAPY	0			0	0	o	67. 00
68. 00	06800 SPEECH PATHOLOGY	0			0	0		68. 00
69. 00	06900 ELECTROCARDI OLOGY	0			0	0	0	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0			Ö	0	Ö	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0			Ö	0		71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0		1	0	0		72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0			0	0	0	73. 00
74. 00	07400 RENAL DIALYSIS	0		1	0	0		74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0			0	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			0	0	0	76. 01
76. 02	03952 WOUND CARE	0		á	0	0	0	76. 02
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0			0	0		77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0		1	0	0		78. 00
70.00	OUTPATIENT SERVICE COST CENTERS		`	4			Ü	70.00
88. 00	08800 RURAL HEALTH CLINIC	0			0	0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0		1	0	0		89. 00
90. 00	09000 CLINIC	0	1	á	0	0	Ö	90. 00
90. 01	09001 CLI NI C	0			0	0	Ö	90. 01
90. 02	09002 CLI NI C	0			0	0	0	90. 02
91. 00	09100 EMERGENCY				0	0		91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	,	Ί	0	U	0	92.00
72. UU	OTHER REIMBURSABLE COST CENTERS				J _I		U	72. UU
94. 00	09400 HOME PROGRAM DIALYSIS	0		1	O	0	0	94. 00
95.00	09500 AMBULANCE SERVICES			Ί	J	U	ا	94. 00 95. 00
95. 00 96. 00		_		1	0	0	o	95. 00 96. 00
96.00	O9600 DURABLE MEDI CAL EQUI P-RENTED O9700 DURABLE MEDI CAL EQUI P-SOLD)	(0	0	0	96. 00 97. 00
98.00	09850 OTHER REIMBURSE)	(0	0	0	
	1			J	-	_		98. 00
200.00	Total (lines 50 through 199)	1 0	l ()	0	0	ا	200. 00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 15-0165 Peri od: Worksheet D From 01/01/2023 THROUGH COSTS Part IV 12/31/2023 Date/Time Prepared: 5/28/2024 2:16 pm 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. (col. 5 ÷ col 4) 8) 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 109, 029, 068 0.000000 50.00 000000000000 05100 RECOVERY ROOM 0 0 14, 285, 949 0.000000 51.00 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0.000000 52.00 05300 ANESTHESI OLOGY 0 0 24 060 437 0.000000 53 00 53 00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 54, 610, 117 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 60, 847, 115 57.00 05700 CT SCAN 0 0.000000 57.00 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 18, 533, 135 0.000000 58.00 05900 CARDIAC CATHETERIZATION 59.00 0 17, 509, 717 0.000000 59.00 06000 LABORATORY 78, 148, 864 0.000000 60 00 60 00 60.01 06001 BLOOD LABORATORY 0 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 0000000000000000000 0 62.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0.000000 0 0 63 00 64.00 06400 I NTRAVENOUS THERAPY 0 0 0.000000 64.00 06500 RESPIRATORY THERAPY 8, 811, 065 0.000000 65.00 65.00 06600 PHYSI CAL THERAPY 0 0 3, 215, 008 0.000000 66.00 66, 00 06700 OCCUPATIONAL THERAPY 0 2, 964, 287 67.00 0 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 1, 181, 906 0.000000 68.00 06900 ELECTROCARDI OLOGY 0.000000 69.00 23, 273, 645 69.00 07000 ELECTROENCEPHALOGRAPHY 70.00 5, 155, 371 0.000000 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0.000000 71.00 41, 071, 439 71 00 07200 IMPL. DEV. CHARGED TO PATIENTS 30, 929, 812 0.000000 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 34, 727, 023 0.000000 73.00 0 07400 RENAL DIALYSIS 0.000000 74.00 0 74.00 0 07500 ASC (NON-DISTINCT PART) 75.00 0 0 0.000000 75.00 03950 OTHER ANCILL SRVC 0.000000 76.00 76.00 0 76. 01 03951 CARDIAC AND PULMONARY REHAB 0 1, 350, 939 0.000000 76.01 03952 WOUND CARE 0 0 76.02 0.000000 76.02 07700 ALLOGENEIC STEM CELL ACQUISITION 0 77.00 0 0.000000 77.00 07800 CAR T-CELL IMMUNOTHERAPY 0 78.00 0 0 0 0.000000 78.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 0 0 0.000000 88 00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 0 0.000000 89.00 90.00 09000 CLI NI C 0 0 0.000000 90.00 33, 955, 902 90 01 09001 CLI NI C 0 0 0.000000 90 01 90.02 09002 CLI NI C 0 0 4, 349, 127 0.000000 90.02 91.00 09100 EMERGENCY 0 0 60, 240, 145 0.000000 91.00

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636, 915, 874

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95.00

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97.00

98.00

200.00

92.00

94.00

95.00

98. 00

200.00

09200 OBSERVATION BEDS (NON-DISTINCT PART)

Total (lines 50 through 199)

OTHER REIMBURSABLE COST CENTERS

09400 HOME PROGRAM DIALYSIS

96. 00 09600 DURABLE MEDICAL EQUIP-RENTED

97. 00 09700 DURABLE MEDICAL EQUIP-SOLD

09850 OTHER REIMBURSE

09500 AMBULANCE SERVICES

| Peri od: | Worksheet D | From 01/01/2023 | Part IV | To 12/31/2023 | Date/Time Prepared: | Part IV | Par Provider CCN: 15-0165 THROUGH COSTS

					0 12/31/2023	5/28/2024 2:1	
			Title	: XVIII	Hospi tal	PPS	
	Cost Center Description	Outpati ent	I npati 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)	
	T	9. 00	10. 00	11. 00	12. 00	13. 00	
F0 00	ANCI LLARY SERVI CE COST CENTERS	0.000000	7 777 0/0		00 047 004		F0 00
50.00	05000 OPERATI NG ROOM	0.000000	7, 777, 863	•	22, 047, 901	0	50.00
51.00	O5100 RECOVERY ROOM O5200 DELIVERY ROOM & LABOR ROOM	0.000000	733, 993 0	•	3, 002, 739	0	51.00
52. 00 53. 00	05300 ANESTHESI OLOGY	0. 000000 0. 000000	1, 313, 599		-	0	52. 00 53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	2, 890, 924			0	54.00
55. 00	05500 RADI OLOGY - THERAPEUTI C	0. 000000	2, 690, 924	1		0	55.00
56. 00	05600 RADI OLOGI - ITIERAF LUTT C	0. 000000	0	1	·	0	56.00
57. 00	05700 CT SCAN	0. 000000	5, 125, 092		-	0	57.00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 000000	1, 240, 890	•		0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	2, 758, 914	•		0	59.00
60.00	06000 LABORATORY	0. 000000	9, 146, 978			0	60.00
60. 01	06001 BLOOD LABORATORY	0. 000000	7, 140, 770			Ö	60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0.00000	O	`		· ·	61. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	0		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	3, 091, 084		1	Ö	65. 00
66. 00	06600 PHYSI CAL THERAPY	0. 000000	1, 054, 444	•	1	Ö	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 000000	1, 024, 808			Ö	67. 00
68. 00	06800 SPEECH PATHOLOGY	0. 000000	435, 793			0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 000000	2, 544, 728	•		0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	123, 294			0	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	4, 550, 269			0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	3, 064, 630		7, 824, 336	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	6, 747, 177		3, 953, 157	0	73. 00
74.00	07400 RENAL DIALYSIS	0. 000000	0		0	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0. 000000	0	(0	0	75. 00
76.00	03950 OTHER ANCILL SRVC	0. 000000	0	(0	0	76. 00
76. 01	03951 CARDI AC AND PULMONARY REHAB	0. 000000	29, 112		380, 599	0	76. 01
76. 02	03952 WOUND CARE	0. 000000	0			0	76. 02
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000	0			0	77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0. 000000	0	(0	0	78. 00
	OUTPATIENT SERVICE COST CENTERS			T			
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 CLINIC	0.000000	0			0	90.00
90. 01	09001 CLINIC	0. 000000	586, 866			0	90. 01
90. 02	09002 CLINIC	0.000000	0			0	90. 02
91.00	09100 EMERGENCY	0.000000	4, 813, 071			0	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	0. 000000	1, 114, 993		742, 286	0	92. 00
94. 00	09400 HOME PROGRAM DI ALYSI S	0. 000000	0		0	0	94. 00
95. 00	09500 AMBULANCE SERVICES	0.000000	0	1)	U	95.00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000	0		0	0	96.00
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD	0. 000000	0		-	0	97. 00
98. 00	09850 OTHER REI MBURSE	0. 000000	0	1	-	Ö	98. 00
200.00	i i	1.000000	60, 168, 522		98, 670, 322		200.00
	1	1	,,	'		'	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACO		VACCINE COST	Provider C	F		Period: Worksheet D rom 01/01/2023 Part V o 12/31/2023 Date/Time Pre	
-						5/28/2024 2:1	
			litle	XVIII	Hospi tal	PPS	
	Cost Center Description	Cost to Charge	DDS Doimburged	Charges Cost	Cost	Costs PPS Services	
	cost center bescriptron		Services (see	Rei mbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not	(300 11131.)	
		Part I, col. 9	11.561)	Subject To	Subject To		
		, , , , ,		Ded. & Coins	,		
				(see inst.)	(see inst.)		
		1.00	2. 00	3. 00	4. 00	5. 00	
EO 00	ANCILLARY SERVICE COST CENTERS	0.11/025	22 047 001	I	0 0	2 550 220	F0 00
50. 00 51. 00	05000 OPERATING ROOM 05100 RECOVERY ROOM	0. 116035 0. 226833	22, 047, 901 3, 002, 739	l .	0 0	2, 558, 328	1
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0. 226633	3,002,739 0			681, 120 0	1
53. 00	05300 ANESTHESI OLOGY	0. 006263	4, 498, 752		0 0	28, 176	1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0. 127188	9, 143, 962			1, 163, 002	
55. 00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	0		0 0	0	1
56. 00	05600 RADI OI SOTOPE	0. 000000	Ö		0 0	0	1
57.00	05700 CT SCAN	0. 031988	9, 244, 367		0 0	295, 709	1
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 092777	2, 799, 710		0 0	259, 749	1
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 416557	2, 805, 720		0 0	1, 168, 742	59. 00
60.00	06000 LABORATORY	0. 122136	3, 130, 796		0 0	382, 383	60.00
60. 01	06001 BLOOD LABORATORY	0. 000000	0		0	0	60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000			0		61.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	0		0	0	
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0		0 0	0	63. 00
64.00	06400 I NTRAVENOUS THERAPY	0.000000	0		0 0	0	
65. 00	06500 RESPIRATORY THERAPY	0. 331671	282, 705		0 0	93, 765	1
66.00	06600 PHYSI CAL THERAPY	0. 186934	121, 884		0 0	22, 784	1
67. 00 68. 00	06700 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY	0. 155860 0. 146646	71, 071 15, 082			11, 077 2, 212	1
69. 00	06900 ELECTROCARDI OLOGY	0. 038941	4, 764, 849	1	0 0	185, 548	1
70. 00	07000 ELECTROENCEPHALOGRAPHY	0. 465155	774, 675	1	0 0	360, 344	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 280828	5, 551, 313	1	0 0	1, 558, 964	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 262021	7, 824, 336	1	0 0	2, 050, 140	
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 270911	3, 953, 157		0 3, 743	1, 070, 954	73.00
74.00	07400 RENAL DIALYSIS	0. 000000	0		0 0	0	74. 00
75.00	07500 ASC (NON-DISTINCT PART)	0. 000000	0		0	0	
76. 00	03950 OTHER ANCILL SRVC	0. 000000	0		0	0	
76. 01	03951 CARDI AC AND PULMONARY REHAB	0. 513962	380, 599		0 0	195, 613	•
76. 02	03952 WOUND CARE	0. 000000	0		0 0	0	1
77. 00 78. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000 0. 000000	0 0		0 0	0	
76.00	OUTPATIENT SERVICE COST CENTERS	0.000000	0		0 0	0	78.00
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. 102886	9, 868, 961		0	1, 015, 378	90. 01
90. 02	09002 CLI NI C	0. 164147	1, 142, 254	1	0	187, 498	1
	09100 EMERGENCY	0. 173427	6, 503, 203	1	0 0		
92.00	O9200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 745751	742, 286		0 0	553, 561	92.00
94. 00	09400 HOME PROGRAM DIALYSIS	0. 000000		1	0 0		94. 00
95. 00	09500 AMBULANCE SERVICES	0. 000000			o		95.00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000	0		0 0	0	1
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD	0. 000000	Ö		0 0	0	
98. 00	09850 OTHER REIMBURSE	0. 000000	0		0 0	0	1
200.00			98, 670, 322		0 3, 743	14, 972, 878	
201.00					0 0		201. 00
202.00	Only Charges (Line 200 Line 201)		00 (70 222		0 2.742	14 072 070	202.00
202.00	Net Charges (line 200 - line 201)	1	98, 670, 322	I	0 3, 743	14, 972, 878	1202.00

Peri od: Worksheet D From 01/01/2023 Part V To 12/31/2023 Date/Time Prepared: 5/28/2024 2:16 pm Provider CCN: 15-0165

					5/28/2024 2: 1	6 pm
		Title	: XVIII	Hospi tal	PPS	
	Co	sts				
Cost Center Description	Cost	Cost				
COST CENTER DESCRIPTION						
	Rei mbursed	Rei mbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00	-			
ANOLILIABY OFRICAS COOT OFFITEDO	0.00	7.00				
ANCILLARY SERVICE COST CENTERS						1
50. 00 05000 OPERATING ROOM	C) 0				50. 00
51.00 05100 RECOVERY ROOM		ol o				51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		م ا				52. 00
		1				
53. 00 05300 ANESTHESI OLOGY) U	1			53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	C) 0	1			54. 00
55. 00 05500 RADI OLOGY-THERAPEUTI C	C	0				55. 00
56. 00 05600 RADI 0I SOTOPE		n n				56. 00
		j ,				
			1			57. 00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI))	1			58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	C	0				59. 00
60. 00 06000 LABORATORY	C	0				60.00
60. 01 06001 BL00D LABORATORY		0				60. 01
		J	1			
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61. 00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS) 0	1			62. 00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	C	0				63. 00
64.00 06400 INTRAVENOUS THERAPY		ol o				64. 00
65. 00 06500 RESPIRATORY THERAPY		م م				65.00
			1			
66. 00 06600 PHYSI CAL THERAPY	C) U	1			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	C) 0)			67. 00
68. 00 06800 SPEECH PATHOLOGY	C	0				68. 00
69. 00 06900 ELECTROCARDI OLOGY		n n				69. 00
		j ,				
			'			70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS)	1			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	C	0				72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS		1, 014				73. 00
74. 00 07400 RENAL DI ALYSI S		1 .,				74. 00
		1				1
75. 00 07500 ASC (NON-DI STINCT PART)		1	'			75. 00
76. 00 03950 OTHER ANCILL SRVC) 0	1			76. 00
76.01 03951 CARDIAC AND PULMONARY REHAB	C	0				76. 01
76. 02 03952 WOUND CARE	C	0 ا				76. 02
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION		0				77. 00
			1			
78. 00 O780O CAR T-CELL IMMUNOTHERAPY	C) 0	1			78. 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		ol o				90.00
90. 01 09001 CLI NI C		j ,				90. 01
			'			1
90. 02 09002 CLI NI C) 0	1			90. 02
91. 00 09100 EMERGENCY	C	0				91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0				92.00
OTHER REIMBURSABLE COST CENTERS	•	•	•			1
			1			04.00
		(Ί			94.00
95. 00 09500 AMBULANCE SERVICES	C	1				95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	C	0	1			96. 00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0)			97. 00
98. 00 09850 OTHER REI MBURSE		ol o	1			98. 00
200.00 Subtotal (see instructions)		1, 014	1			200.00
201.00 Less PBP Clinic Lab. Services-Program	C	ין				201. 00
Only Charges	1		1			1
202.00 Net Charges (line 200 - line 201)	C	1, 014				202. 00
	•	•	•			•

Health Financial Systems	FRANCISCAN HEA	AI TH MUNSTER		In lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL (CN: 15-0165	Peri od: From 01/01/2023 To 12/31/2023	Worksheet D Part I Date/Time Pre 5/28/2024 2:1	pared:
		Ti tl	e XIX	Hospi tal	PPS	•
	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capi tal Rel ated Cos (col . 1 - col 2)		Per Diem (col. 3 / col. 4)	
	1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	0.00	1.00	0.00	
30.00 ADULTS & PEDIATRICS 31.00 INTENSIVE CARE UNIT 32.00 CORONARY CARE UNIT 33.00 BURN INTENSIVE CARE UNIT 34.00 SUBPROVIDER - IPF 41.00 SUBPROVIDER - IRF 43.00 NURSERY 44.00 SKILLED NURSING FACILITY 45.00 NURSING FACILITY 200.00 Total (lines 30 through 199) Cost Center Description	6, 402, 233 1, 673, 675 0 0 0 0 0 0 0 8, 075, 908 Inpatient Program days	C	8, 075, 90	75 5, 296 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	316. 03 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00	31. 00 32. 00 33. 00 34. 00 40. 00 41. 00 43. 00
INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00				
30. 00 ADULTS & PEDIATRICS 31. 00 INTENSIVE CARE UNIT 32. 00 CORONARY CARE UNIT 33. 00 BURN INTENSIVE CARE UNIT 34. 00 SURGICAL INTENSIVE CARE UNIT 40. 00 SUBPROVIDER - IPF 41. 00 SUBPROVIDER - IRF 43. 00 NURSERY 44. 00 SKILLED NURSING FACILITY 45. 00 NURSING FACILITY 200. 00 Total (lines 30 through 199)	1, 016 0 0 0 0 0 0 0 0 0 0					30. 00 31. 00 32. 00 33. 00 34. 00 40. 00 41. 00 43. 00 44. 00 45. 00 200. 00

Heal th	Financial Systems	FRANCI SCAN HEA	ALTH MUNSTER		In Lie	u of Form CMS-	2552-10
APP0R1	TIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der C	CN: 15-0165	Peri od:	Worksheet D	
					From 01/01/2023	Part II	
					To 12/31/2023	Date/Time Pre	pared:
			T: +1	a VIV	Hooni tal	5/28/2024 2:1	ь рш
	Cook Cooks Decomination	0: +-1		e XIX	Hospi tal	PPS	
	Cost Center Description	Capi tal	Total Charges			Capital Costs	
		Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
		(from Wkst. B,	Part I, col.	(col . 1 ÷ col	. Charges	column 4)	
		Part II, col.	8)	2)			
		26)	2.00	2.00	4.00	Г 00	
	ANCILLARY SERVICE COST CENTERS	1. 00	2.00	3. 00	4. 00	5. 00	
50. 00	05000 OPERATING ROOM	2, 533, 096	109, 029, 068	0. 02323	33 2, 444, 753	56, 799	50.00
51. 00	05100 RECOVERY ROOM	1, 045, 933		•		17, 733	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	1,043,733	14, 203, 949	1		0	
53. 00	05300 ANESTHESI OLOGY	4, 698	١ -	•		79	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	1, 202, 821		•		23, 289	
		1, 202, 821	54, 610, 117			'	
55. 00	05500 RADI OLOGY-THERAPEUTI C		C			0	55.00
56. 00	05600 RADI OI SOTOPE	0	C	0.0000		0	
57. 00	05700 CT SCAN	52, 490				1, 715	
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	49, 594	18, 533, 135		· ·	1, 025	
59. 00	05900 CARDI AC CATHETERI ZATI ON	2, 259, 889				112, 899	
60.00	06000 LABORATORY	580, 994	78, 148, 864			28, 008	
60. 01	06001 BLOOD LABORATORY	0	C	0. 00000	00	0	60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	l c	0. 00000	00	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0		0. 00000	00	0	63.00
64.00	06400 I NTRAVENOUS THERAPY	0		1		0	64.00
65. 00	06500 RESPIRATORY THERAPY	260, 215	8, 811, 065	•		29, 785	
66. 00	06600 PHYSI CAL THERAPY	17, 628				819	
67. 00	06700 OCCUPATI ONAL THERAPY	13, 589		•		684	
68. 00	06800 SPEECH PATHOLOGY	5, 100		•		346	
69. 00	06900 ELECTROCARDI OLOGY			•		988	
		26, 812		•			
70.00	07000 ELECTROENCEPHALOGRAPHY	964, 904	5, 155, 371	0. 18716		7, 161	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	271, 589				12, 836	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	190, 903				1, 609	
73. 00	07300 DRUGS CHARGED TO PATIENTS	622, 647	34, 727, 023				
74.00	07400 RENAL DIALYSIS	0	(0.00000		0	74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0	[C	0.0000		0	
76.00	03950 OTHER ANCILL SRVC	0	C	0.00000	00	0	76. 00
76. 01	03951 CARDIAC AND PULMONARY REHAB	20, 318	1, 350, 939	0. 01504	11, 783	177	76. 01
76. 02	03952 WOUND CARE	0	C	0. 00000	00	0	76. 02
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	l c	0. 00000	00	0	77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0		0. 00000	00	0	78. 00
	OUTPATIENT SERVICE COST CENTERS	<u>'</u>	•				1
88. 00	08800 RURAL HEALTH CLINIC	0	C	0.00000	00	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0		l		0	
90.00	09000 CLI NI C	0		0.00000		0	
90. 01	09001 CLINI C	100, 930	33, 955, 902			593	
90. 02	09002 CLINIC	170, 937	4, 349, 127	1		0	90. 02
91. 00	09100 EMERGENCY	1, 531, 829		l		-	ı
91.00							
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 250, 345	8, 665, 803	0. 14428	35 298, 192	43, 025	92.00
04.00	OTHER REIMBURSABLE COST CENTERS			0.0000	20	0	04.00
94.00	09400 HOME PROGRAM DI ALYSI S	0		0.00000	00	0	
95.00	09500 AMBULANCE SERVI CES	_	_		-	_	95.00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	0		0.00000		0	
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD	0	l c	0.00000		0	
98. 00	09850 OTHER REIMBURSE	0	0	0.00000		0	
200.00	Total (lines 50 through 199)	13, 177, 261	636, 915, 874	·	20, 748, 549	435, 452	J200. 00

					5/28/2024 2: 1	6 pm
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Nursi ng	Nursi ng	Allied Health	Allied Health	All Other	
	Program	Program	Post-Stepdown	Cost	Medi cal	
	Post-Stepdown		Adjustments		Education Cost	
	Adjustments					
	1A	1. 00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					0.00	
30. 00 03000 ADULTS & PEDIATRICS	0	0) C	0	0	30. 00
31. 00 03100 NTENSI VE CARE UNI T		0				31.00
32. 00 03200 CORONARY CARE UNIT		0				32.00
	٥	-			_	
33. 00 03300 BURN INTENSIVE CARE UNIT	0	0	1		-	33. 00
34. 00 03400 SURGI CAL INTENSI VE CARE UNIT	0	0	1		-	34. 00
40. 00 04000 SUBPROVI DER - 1 PF	0	0	1		0	40. 00
41. 00 04100 SUBPROVI DER - I RF	0	0) C	0	0	41.00
43. 00 04300 NURSERY	0	0) C	0	0	43. 00
44.00 04400 SKILLED NURSING FACILITY	0	0	0	0		44.00
45.00 04500 NURSING FACILITY	0	0) C	0		45. 00
200.00 Total (lines 30 through 199)	l ol	0	ol c	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,		0 . 00 0)	og. a bajo	
		minus col. 4)				
	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	O	0	13, 994	0.00	1, 016	30. 00
31. 00 03100 NTENSI VE CARE UNIT	١	0				31.00
		-	1 -,			
32. 00 03200 CORONARY CARE UNIT		0	Ί -			32.00
33. 00 03300 BURN INTENSIVE CARE UNIT		Ü	0			33. 00
34.00 03400 SURGICAL INTENSIVE CARE UNIT		0	0		0	34. 00
40. 00 04000 SUBPROVI DER - I PF	0	0) C	0.00	0	40. 00
41. 00 04100 SUBPROVI DER - I RF	0	0	0	0.00	0	41.00
43. 00 04300 NURSERY		0	0	0.00	0	43.00
44.00 04400 SKILLED NURSING FACILITY		0) C	0.00	0	44.00
45.00 04500 NURSING FACILITY		0		0.00	0	45. 00
200.00 Total (lines 30 through 199)		0	19, 290		1. 016	200. 00
Cost Center Description	I npati ent	-	, =		.,	
	Program					
	Pass-Through					
	Cost (col. 7 x					
	col. 8)					
	9.00					
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	7.00					
30. 00 03000 ADULTS & PEDIATRICS	O					30. 00
31. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT						30.00
32. 00 03200 CORONARY CARE UNIT	0					32. 00
33. 00 03300 BURN INTENSIVE CARE UNIT	0					33. 00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	0					34. 00
40. 00 04000 SUBPROVI DER - 1 PF	0					40. 00
41. 00 04100 SUBPROVI DER - I RF	0					41.00
43. 00 04300 NURSERY	l ol					43.00
44.00 04400 SKILLED NURSING FACILITY	0					44.00
45. 00 04500 NURSING FACILITY	ا					45. 00
200.00 Total (lines 30 through 199)	ا					200. 00
200.00 10tal (11100 00 till ough 177)	١					

| In Lieu of Form CMS-2552-10 | Period: | Worksheet D | From 01/01/2023 | Part IV | To 12/31/2023 | Date/Time Prepared: | 5/28/2024 2:16 pm THROUGH COSTS

						5/28/2024 2: 10	ь рш
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
		Anesthetist	Program	Program	Post-Stepdown		
		Cost	Post-Stepdown		Adjustments		
			Adjustments				
		1.00	2A	2.00	3A	3.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	C		0 0	0	50. 00
51. 00	05100 RECOVERY ROOM	0	ĺ	1	o c		51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM			1			52. 00
53. 00	05300 ANESTHESI OLOGY					1	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C					1 "	54. 00
55. 00	I I					1	55.00
	05500 RADI OLOGY-THERAPEUTI C	0			-	1	
56. 00	05600 RADI OI SOTOPE	0			0 0		56. 00
57. 00	05700 CT SCAN	0			0 0	1	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0			0 0	1	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	C	7	0 0		59. 00
60.00	06000 LABORATORY	0	C		0 0	1	60. 00
60. 01	06001 BLOOD LABORATORY	0	C		0 0	0	60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61. 00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	C		0 0	0	62. 00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	C		0 0	0	63.00
64.00	06400 I NTRAVENOUS THERAPY	0	C		0 0	0	64. 00
65.00	06500 RESPI RATORY THERAPY	0		ol	0 0	ol	65. 00
66.00	06600 PHYSI CAL THERAPY	0		ol	0 0	ol ol	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0			o c		67. 00
68. 00	06800 SPEECH PATHOLOGY	0			o c		68. 00
69. 00	06900 ELECTROCARDI OLOGY				0 0	1 "	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY				0 0	1	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS						71.00
71.00	07200 IMPL. DEV. CHARGED TO PATIENTS				0 0	1	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0			0 0		
	I I	0				ή "	73. 00
74.00	07400 RENAL DIALYSIS	0	C		0 0	1	74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0			0 0	1 "	75. 00
76. 00	03950 OTHER ANCILL SRVC	0		2	0 0	/I ~ I	76. 00
76. 01	03951 CARDI AC AND PULMONARY REHAB	0	C)	0 0	1	76. 01
76. 02	03952 WOUND CARE	0	C		0 0	1	76. 02
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	C	1	0 0		77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	C)	0 0	0	78. 00
	OUTPATIENT SERVICE COST CENTERS	_	,				
88. 00	08800 RURAL HEALTH CLINIC	0	1	1	0 0		88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	[C		0 0	0	89. 00
90.00	09000 CLI NI C	0	C		0	0	90. 00
90. 01	09001 CLI NI C	0	C		0 0	0	90. 01
90. 02	09002 CLI NI C	0	C		0 0	0	90. 02
91.00	09100 EMERGENCY	0		ol	0 0	ol	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 ALYSI S	0	C		0 0	0	94. 00
95. 00	09500 AMBULANCE SERVI CES	1]			1	95. 00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	0		ol	o c	ol	96. 00
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD	0	1		o c	1	97. 00
98. 00	09850 OTHER REI MBURSE	0				1	98. 00
200.00	I I			á	0 0		200.00
200.00	1 Total (Tries so till bugil 199)	1 0	1	1	ο ₁	1 01	200.00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet D | From 01/01/2023 | Part IV | To 12/31/2023 | Date/Time Prepared: | 5/28/2024 2:16 pm |
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 Systems
 FRANCISCAN HEALT

 APPORTIONMENT
 OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
 Provider CCN: 15-0165 THROUGH COSTS

						5/28/2024 2: 10	6 pm
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	, , , , , , , , , , , , , , , , , , ,	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
		Education Cost		Cost (sum of	Part I, col.	(col . 5 ÷ col .	
		Ludouti on oost	4)	col s. 2, 3,	8)	7)	
			4)		0)		
				and 4)		(see	
		4.00	5.00		7.00	instructions)	
		4. 00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	(109, 029, 068	0.000000	50.00
51.00	05100 RECOVERY ROOM	0	0	(14, 285, 949	0.000000	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	l o		0	0.000000	52. 00
53.00	05300 ANESTHESI OLOGY	0	0		24, 060, 437	0.000000	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C		1			0. 000000	54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C						55. 00
		0	l		1		
56. 00	05600 RADI OI SOTOPE	0	0	-		0. 000000	56. 00
57. 00	05700 CT SCAN	0	0				57. 00
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0	(18, 533, 135	0.000000	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	(17, 509, 717	0. 000000	59. 00
60.00	06000 LABORATORY	0	0	(78, 148, 864	0.000000	60.00
60. 01	06001 BLOOD LABORATORY	0	1 0		0	0.000000	60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	_	-				61. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0	0. 000000	62. 00
63. 00					-		63. 00
	06300 BLOOD STORING, PROCESSING & TRANS.	0	1	1	1		
64.00	06400 I NTRAVENOUS THERAPY	0	0		-	0. 000000	64. 00
65. 00	06500 RESPI RATORY THERAPY	0	0				65. 00
66. 00	06600 PHYSI CAL THERAPY	0	0	(0. 000000	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	(2, 964, 287	0. 000000	67. 00
68.00	06800 SPEECH PATHOLOGY	0	0	(1, 181, 906	0.000000	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	0	(23, 273, 645	0.000000	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	l o			0.000000	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	i e			71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	ĺ			0. 000000	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS						73. 00
74. 00	07400 RENAL DIALYSIS						74.00
		0	0	`		0.000000	
75. 00	07500 ASC (NON-DISTINCT PART)	0	0	(-		75. 00
76. 00	03950 OTHER ANCILL SRVC	0	0			0. 000000	76. 00
76. 01	03951 CARDI AC AND PULMONARY REHAB	0	0	(1, 350, 939		76. 01
76. 02	03952 WOUND CARE	0	0	(0	0.000000	76. 02
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	(0	0.000000	77. 00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0	l o		0	0.000000	78. 00
	OUTPATIENT SERVICE COST CENTERS			•			
88. 00	08800 RURAL HEALTH CLINIC	0	0		0	0. 000000	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	ĺ		-		89. 00
90.00	09000 CLINIC				-	0. 000000	90.00
		0	1				
90. 01	09001 CLI NI C	0	0				90. 01
90. 02	09002 CLI NI C	0	0			0. 000000	90. 02
91. 00	09100 EMERGENCY	0	0	(60, 240, 145		91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	(8, 665, 803	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS						
94.00	09400 HOME PROGRAM DIALYSIS	0	0	(0	0.000000	94. 00
95.00	09500 AMBULANCE SERVICES						95. 00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0	0. 000000	96. 00
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD		0		-		97. 00
98. 00	09850 OTHER REIMBURSE			1			
200.00							200.00
200.00	Trotal (Tries 50 till bugil 177)	1	1	1	7 030, 713, 074	l l	200.00

In Lieu of Form CMS-2552-10

| Period: | Worksheet D |
| From 01/01/2023 | Part IV |
| To 12/31/2023 | Date/Time Prepared: | 5/28/2024 2:16 pm | Provider CCN: 15-0165 THROUGH COSTS

					12/01/2020	5/28/2024 2: 1	6 pm
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	Outpati ent	Inpati ent	Inpatient	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through	Charges	Pass-Through	
		(col. 6 ÷ col.		Costs (col.	3	Costs (col. 9	
		7)		x col. 10)		x col. 12)	
		9. 00	10.00	11. 00	12.00	13.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0. 000000	2, 444, 753		0	0	50.00
51.00	05100 RECOVERY ROOM	0. 000000	242, 201		0 0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 0	0	52.00
53.00	05300 ANESTHESI OLOGY	0. 000000	402, 629		0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	1, 057, 349		0	0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	0		0	0	55. 00
56.00	05600 RADI OI SOTOPE	0. 000000	0		0 0	0	56. 00
57.00	05700 CT SCAN	0. 000000	1, 987, 802		0 0	0	57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	383, 202		0 0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	874, 745		0 0	0	59. 00
60.00	06000 LABORATORY	0. 000000	3, 767, 594		0 0	0	60.00
60. 01	06001 BLOOD LABORATORY	0. 000000	0		0 0	0	60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	0		0	0	62.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0		o o	ő	63.00
64. 00	06400 I NTRAVENOUS THERAPY	0. 000000	0		o o	ő	64. 00
65. 00	06500 RESPIRATORY THERAPY	0. 000000	1, 008, 532		0 0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0. 000000	149, 339		0 0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 000000	149, 339		0 0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0. 000000	80, 071		0 0	0	68.00
69. 00	06900 ELECTROCARDI OLOGY	0. 000000	857, 215		0 0	0	69.00
70.00	07000 ELECTROCARDI GLOGI	0. 000000	38, 260		0 0	0	70.00
	1 1	1	1, 940, 970		0 0	0	
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000		•	0 0	0	71. 00 72. 00
	1 1	0.000000	260, 662				
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	2, 793, 989	1	٥	0	73. 00
74. 00	07400 RENAL DIALYSIS	0.000000	0		٥	0	74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0.000000	0	•	0	0	75. 00
76.00	03950 OTHER ANCILL SRVC	0.000000	0		0	0	76.00
76. 01	03951 CARDI AC AND PULMONARY REHAB	0. 000000	11, 783	1	0	0	76. 01
76. 02	03952 WOUND CARE	0. 000000	0		0	0	76. 02
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000	0		0	0	77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0. 000000	0		0 0	0	78. 00
	OUTPATIENT SERVICE COST CENTERS			T		1	
88. 00	08800 RURAL HEALTH CLINIC	0. 000000	0		0		88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000	0		0	0	89. 00
90.00	09000 CLI NI C	0. 000000	0	l .	0	0	90. 00
90. 01	09001 CLI NI C	0. 000000	199, 446		0	0	90. 01
90. 02	09002 CLI NI C	0. 000000	0		0	0	90. 02
91. 00	09100 EMERGENCY	0. 000000	1, 800, 550		0	0	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	298, 192		0 0	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
94. 00	09400 HOME PROGRAM DIALYSIS	0. 000000	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 MEDI CAL EQUI P-SOLD	0. 000000	0		0	0	97. 00
98. 00	09850 OTHER REI MBURSE	0. 000000	0	•	0		98. 00
200.00	Total (lines 50 through 199)		20, 748, 549	1	0 0	0	200. 00

APPORT	TONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der C		Period: From 01/01/2023 To 12/31/2023		pared:
			Ti tl	e XIX	Hospi tal	PPS	о рііі
				Charges		Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed		Cost	PPS Services	
		Ratio From	Services (see		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 OPERATI NG ROOM	0. 116035					1
51. 00	05100 RECOVERY ROOM	0. 226833				_	1
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000			0		
53. 00	05300 ANESTHESI OLOGY	0. 006263					
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0. 127188		1 ,, ,		_	
55. 00	05500 RADI OLOGY-THERAPEUTI C	0. 000000			0	_	
56. 00	05600 RADI OI SOTOPE	0. 000000			0	_	
57. 00	05700 CT SCAN	0. 031988		1 // 0/ 1/ /2		_	
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 092777		2, .00, 00			
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 416557	l .				
60.00	06000 LABORATORY	0. 122136		1 .0,0.0,2.		_	
60. 01	06001 BLOOD LABORATORY	0. 000000	l .)	0		
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	l .	2	0		
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	l .)	0	_	63.00
64.00	06400 I NTRAVENOUS THERAPY	0. 000000)	0	_	
65.00	06500 RESPI RATORY THERAPY	0. 331671		1,			
66.00	06600 PHYSI CAL THERAPY	0. 186934	l .	54, 99			
67. 00	06700 OCCUPATI ONAL THERAPY	0. 155860					
68. 00	06800 SPEECH PATHOLOGY	0. 146646		1		_	
69. 00	06900 ELECTROCARDI OLOGY	0. 038941	l .				
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 465155		1 0, 1, , ,		_	1
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 280828		7 0,00,,20		_	71. 00 72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 262021 0. 270911	1			_	1
74.00	07400 RENAL DIALYSIS	0. 270911			0 0		1
75. 00	07500 ASC (NON-DISTINCT PART)	0. 000000		1	0 0		1
76. 00	03950 OTHER ANCILL SRVC	0. 000000			0 0	_	1
76. 01	03951 CARDI AC AND PULMONARY REHAB	0. 513962		75, 38	-	_	1
76. 01	03952 WOUND CARE	0. 000000			0	_	1
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000			0 0	_	1
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0. 000000			o o		
70.00	OUTPATIENT SERVICE COST CENTERS	0.00000		1	<u> </u>		70.00
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	1
90. 01	09001 CLI NI C	0. 102886	l .	3, 192, 41	9 0	Ō	1
90. 02	09002 CLI NI C	0. 164147	l .				1
	09100 EMERGENCY	0. 173427		1			1
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 745751	l .	1		0	92.00
	OTHER REIMBURSABLE COST CENTERS	1					
94.00	09400 HOME PROGRAM DIALYSIS	0. 000000			0 0		94. 00
	09500 AMBULANCE SERVICES	0. 000000			0		95. 00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000	C		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	C)	0 0	0	98. 00
200.00			c	73, 952, 72	1 0	0	200. 00
201.00					0 0		201. 00
	Only Charges						
202.00	Net Charges (line 200 - line 201)		0	73, 952, 72	1 0	0	202. 00

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 FRANCISCAN HE

 APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST
 Peri od: Worksheet D From 01/01/2023 Part V To 12/31/2023 Date/Time Prepared: 5/28/2024 2:16 pm Provider CCN: 15-0165

						5/28/2024 2: 1	6 pm
			Ti tl	e XIX	Hospi tal	PPS	
		Cos	sts		· · · · · · · · · · · · · · · · · · ·		
Cost C	Center Description	Cost	Cost				
COST	benter bescription						
		Rei mbursed	Rei mbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
		Ded. & Coins.	Ded. & Coins.				
		(see inst.)	(see inst.)				
				-			
		6. 00	7. 00				
ANCI LLARY SE	ERVICE COST CENTERS						
50. 00 05000 OPERAT	ING ROOM	924, 607	C				50.00
51. 00 05100 RECOVE	RY ROOM	280, 537	1 0				51.00
I I		0		1			1
	RY ROOM & LABOR ROOM			1			52. 00
53. 00 05300 ANESTH		12, 464	0)			53. 00
54. 00 05400 RADI OL	LOGY-DI AGNOSTI C	908, 760	0)			54.00
55. 00 05500 RADI OL	LOGY-THERAPEUTI C	0	l o				55. 00
56. 00 05600 RADI 0I		0	-	1			56. 00
			-	1			1
57. 00 05700 CT SCA		299, 789		1			57. 00
58. 00 05800 MAGNET	TIC RESONANCE IMAGING (MRI)	198, 408	0)			58. 00
59. 00 05900 CARDI A	AC CATHETERIZATION	271, 891	0)			59.00
60. 00 06000 LABORA		1, 222, 978	l o				60.00
60. 01 06001 BL00D				1			1
		0	1	'			60. 01
	INICAL LAB SERVICES-PRGM ONLY	0					61. 00
62. 00 06200 WHOLE	BLOOD & PACKED RED BLOOD CELLS	0	0)			62.00
63. 00 06300 BL00D	STORING, PROCESSING & TRANS.	0	l o	ol			63.00
	/ENOUS THERAPY	0	1				64. 00
		-					1
	RATORY THERAPY	59, 028		1			65. 00
66. 00 06600 PHYSI 0	CAL THERAPY	10, 281	0)			66. 00
67. 00 06700 OCCUPA	ATIONAL THERAPY	6, 045	1 0				67.00
68. 00 06800 SPEECH		2, 639		\			68. 00
							1
69. 00 06900 ELECTR		81, 913		'			69. 00
70. 00 07000 ELECTR	ROENCEPHALOGRAPHY	312, 572	0				70. 00
71. 00 07100 MEDI CA	AL SUPPLIES CHARGED TO PATIENTS	1, 420, 228	0)			71.00
	DEV. CHARGED TO PATIENTS	383, 860	1 0				72. 00
	CHARGED TO PATIENTS			1			73. 00
		550, 380		1			
74. 00 07400 RENAL		0	0)			74. 00
75.00 07500 ASC (N	ION-DISTINCT PART)	0	0)			75. 00
76. 00 03950 OTHER		0	1				76. 00
	AC AND PULMONARY REHAB	38, 743					76. 01
							1
76. 02 03952 WOUND		0		1			76. 02
77. 00 07700 ALLOGE	ENEIC STEM CELL ACQUISITION	0	0)			77. 00
78.00 07800 CAR T-	CELL IMMUNOTHERAPY	0	0				78. 00
	SERVICE COST CENTERS						1
	HEALTH CLINIC						88. 00
							1
	ALLY QUALIFIED HEALTH CENTER						89. 00
90. 00 09000 CLI NI C		0	0)			90.00
90. 01 09001 CLI NI C		328, 455	1 0				90. 01
90. 02 09002 CLINIC		71, 637					90. 02
1 1				1			1
		2, 928, 291	0	1			91. 00
92. 00 09200 OBSERV	/ATION BEDS (NON-DISTINCT PART)	915, 634	0)			92. 00
	JRSABLE COST CENTERS						
	PROGRAM DIALYSIS	0	0				94. 00
	NCE SERVICES	0	Ĭ				95. 00
		1					
	LE MEDICAL EQUIP-RENTED	0	-	i			96. 00
97. 00 09700 DURABL	LE MEDICAL EQUIP-SOLD	0	0)			97.00
98. 00 09850 OTHER	REIMBURSE	0	0)			98. 00
	tal (see instructions)	11, 229, 140		ol .			200.00
	PBP Clinic Lab. Services-Program	11,227,140	١				201.00
	9						201.00
	Charges						
202.00 Net Ch	narges (line 200 - line 201)	11, 229, 140	0)			202. 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 01/01/2023	Worksheet D-1	
			Date/Time Pre 5/28/2024 2:1	
	Title XVIII	Hospi tal	PPS	
Cost Center Description	_			

		Ti +1 o V/////	Haani tal	5/28/2024 2:1	6 pm		
	Cost Center Description	Title XVIII	Hospi tal	PPS			
	<u> </u>			1. 00			
	PART I - ALL PROVIDER COMPONENTS						
1. 00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days	s excluding newborn)		13, 994	1. 00		
2. 00	Inpatient days (including private room days, excluding swing-l			13, 994	2. 00		
3.00	Private room days (excluding swing-bed and observation bed day	ys). If you have only pri	vate room days,	0	3. 00		
4. 00	do not complete this line. Semi-private room days (excluding swing-bed and observation be	ad days)		11 241	4. 00		
5.00	Total swing-bed SNF type inpatient days (including private roo		31 of the cost	11, 261 0	5. 00		
0.00	reporting period	siii days) trii dagii beceiiibei	01 01 110 0031	Ŭ	0.00		
6.00	Total swing-bed SNF type inpatient days (including private roo	om days) after December 3	31 of the cost	0	6. 00		
7. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private roor	m days) through Docombor	21 of the cost	0	7. 00		
7.00	reporting period	ii days) tiii ougii beceiibei	31 Of the Cost	U	7.00		
8.00	Total swing-bed NF type inpatient days (including private roor	n days) after December 3°	1 of the cost	0	8. 00		
	reporting period (if calendar year, enter 0 on this line)	5					
9. 00	Total inpatient days including private room days applicable to newborn days) (see instructions)	the Program (excluding	swing-bed and	4, 383	9. 00		
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or	nly (including private ro	oom days)	0	10. 00		
	through December 31 of the cost reporting period (see instruc						
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or December 31 of the cost reporting period (if calendar year, en		oom days) after	0	11. 00		
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI)		e room days)	0	12. 00		
	through December 31 of the cost reporting period	3 .	,				
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI)			0	13. 00		
14. 00	after December 31 of the cost reporting period (if calendar ye Medically necessary private room days applicable to the Progra			0	14. 00		
15. 00	Total nursery days (title V or XIX only)	0	15. 00				
16. 00	Nursery days (title V or XIX only)			0	16. 00		
	SWING BED ADJUSTMENT						
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through December 31 o	f 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	0.00	18. 00		
	reporting period						
19. 00	Medicaid rate for swing-bed NF services applicable to services	0. 00	19. 00				
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	0.00	20. 00				
20.00	reporting period	3 d. te. Becomber e. e. e.		0.00	20.00		
21. 00	Total general inpatient routine service cost (see instructions			33, 090, 648			
22. 00	Swing-bed cost applicable to SNF type services through December 5×1 ine 17)	er 31 of the cost reporti	ng period (line	0	22. 00		
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	period (line 6	0	23. 00		
	x line 18)						
24. 00	Swing-bed cost applicable to NF type services through December 7×1 ine 19)	1 31 of the cost reportion	ng period (line	0	24. 00		
25. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25. 00		
	x line 20)	3					
26. 00	Total swing-bed cost (see instructions)	(1: 04 : 1: 04)		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, 090, 648	27. 00		
28. 00	General inpatient routine service charges (excluding swing-bed	d and observation bed cha	arges)	0	28. 00		
29. 00	Private room charges (excluding swing-bed charges)		3 /	0	29. 00		
30.00	Semi -pri vate room charges (excluding swing-bed charges)	00)		0	30.00		
31. 00 32. 00	General inpatient routine service cost/charge ratio (line 27 - Average private room per diem charge (line 29 ÷ line 3)	Fine 28)		0. 000000 0. 00			
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00			
34. 00	Average per diem private room charge differential (line 32 min	nus line 33)(see instruc	tions)	0.00			
35. 00	Average per diem private room cost differential (line 34 x lin		0.00				
36. 00 37. 00	Private room cost differential adjustment (line 3 x line 35)	0 33, 090, 648	36. 00 37. 00				
37.00	00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)						
	PART II - HOSPITAL AND SUBPROVIDERS ONLY						
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU						
38. 00 39. 00	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line	*		2, 364. 63 10, 364, 173			
40. 00	Medically necessary private room cost applicable to the Progra	-		10, 364, 173	40.00		
	Total Program general inpatient routine service cost (line 39	,		10, 364, 173			

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	Financial Systems	FRANCI SCAN HEA		ON 45 00:5		eu of Form CMS-2		
COMPUT	ATION OF INPATIENT OPERATING COST			CCN: 15-0165	Period: From 01/01/2023 To 12/31/2023	5/28/2024 2: 1	pared:	
	Cost Center Description	Total Inpatient Cost	Total	Average Per Diem (col. 1 col. 2)		PPS Program Cost (col. 3 x col. 4)		
42.00	MUDCEDY (+:+Lo V 0 VIV only)	1.00	2.00	3.00	4.00	5. 00	42.00	
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0		0.	00 0	0	42.00	
43. 00	INTENSIVE CARE UNIT	7, 482, 138	5, 290	1, 412.	79 1, 701	2, 403, 156	43.00	
44.00	CORONARY CARE UNIT	0	(0.	00 0	0	44. 00	
45. 00	BURN INTENSIVE CARE UNIT	0		0.		l e		
46.00	SURGICAL INTENSIVE CARE UNIT	0	(0.	00 0	0		
47.00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47. 00	
						1. 00		
48. 00	Program inpatient ancillary service cost (W					11, 243, 105		
48. 01	Program inpatient cellular therapy acquisit				, column 1)	0	48. 01	
49. 00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48.0	i)(see instru	ctions)		24, 010, 434] 49.00	
50. 00	Pass through costs applicable to Program in	patient routine	servi ces (fro	m Wkst. D, su	m of Parts I and	2, 542, 790	50.00	
			•					
51. 00	Pass through costs applicable to Program in	patient ancillar	y services (f	rom Wkst. D,	sum of Parts II	1, 315, 286	51.00	
52. 00	and IV) Total Program excludable cost (sum of lines	50 and 51)				3, 858, 076	52 00	
53. 00	Total Program inpatient operating cost exclu		ated, non-ph	ysician anest	hetist, and	20, 152, 358		
	medical education costs (line 49 minus line				· 			
E4 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges						54. 00	
54. 00 55. 00	Target amount per discharge						55.00	
55. 01	Permanent adjustment amount per discharge					l e	55. 01	
55. 02	Adjustment amount per discharge (contractor	use only)				0.00	55. 02	
56.00	Target amount (line 54 x sum of lines 55, 5					0		
57. 00	Difference between adjusted inpatient opera	ting cost and ta	rget amount (line 56 minus	line 53)	0		
58. 00 59. 00	Bonus payment (see instructions) Trended costs (lesser of line 53 ÷ line 54,	or line 55 from	the cost ren	orting period	endina 1996	0 00	58. 00 59. 00	
37.00	updated and compounded by the market basket	0.00	37.00					
60.00	Expected costs (lesser of line 53 ÷ line 54	0.00	60.00					
61. 00	market basket) Continuous improvement bonus payment (if li 55.01, or line 59, or line 60, enter the le 53) are less than expected costs (lines 54:	sser of 50% of t	ne amount by v	which operati	ng costs (line	0	61. 00	
	enter zero. (see instructions)	x 00), 01 1 % 01	the target a	illount (Title 5	b), Otherwise			
62.00	Relief payment (see instructions)					0		
63. 00	Allowable Inpatient cost plus incentive pays PROGRAM INPATIENT ROUTINE SWING BED COST	ment (see instru	ctions)			0	63.00	
64. 00	Medicare swing-bed SNF inpatient routine co:	sts through Dece	mber 31 of the	e cost report	ing period (See	0	64. 00	
	instructions) (title XVIII only)	· ·		·				
65. 00	Medicare swing-bed SNF inpatient routine con	sts after Decemb	er 31 of the (cost reportin	g period (See	0	65. 00	
66. 00	Instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient rout	ine costs (line	64 plus line (65)(title XVI	II only); for	0	66. 00	
67. 00	CAH, see instructions Title V or XIX swing-bed NF inpatient routing	ne costs through	December 31	of the cost r	eporting period	0	67. 00	
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient roution	ne costs after D	ecember 31 of	the cost rep	orting period	0	68. 00	
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient					0	69. 00	
70.00	PART III - SKILLED NURSING FACILITY, OTHER N)		70 00	
70. 00 71. 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service	,		•)		70.00	
72. 00	Program routine service cost (line 9 x line			7			72.00	
73.00	Medically necessary private room cost appli						73.00	
74.00	Total Program general inpatient routine services to program general inpatient routine services to program general inpatient	•		•	Dort II oction		74.00	
75. 00	Capital-related cost allocated to inpatient 26, line 45)	Toutine Service	cusis (from)	wurksneet B,	rarı II, COLUMN		75. 00	
76. 00	Per diem capital-related costs (line 75 ÷ 1)	ine 2)					76. 00	
77. 00	Program capital -related costs (line 9 x line						77. 00	
78.00	Inpatient routine service cost (line 74 min		78. 00 79. 00					
79. 00 80. 00								
81. 00								
82. 00	Inpatient routine service cost limitation (line 9 x line 81					82. 00	
83.00	Reasonable inpatient routine service costs	•	s)				83. 00 84. 00	
84. 00 85. 00								
86. 00	Total Program inpatient operating costs (su	,	•				85. 00 86. 00	
	PART IV - COMPUTATION OF OBSERVATION BED PAS	SS THROUGH COST						
07 00	Total observation bed days (see instructions	s)				2, 733	87.00	
87. 00 88. 00	Adjusted general inpatient routine cost per	*	line 2)			2, 364. 63		

Health Financial Systems	FRANCISCAN HEALTH MUNSTER			In Lieu of Form CMS-2552-10		
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2023 To 12/31/2023		
		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	6, 402, 233	33, 090, 648	0. 19347	6 6, 462, 534	1, 250, 345	90.00
91.00 Nursing Program cost	0	33, 090, 648	0.00000	0 6, 462, 534	0	91.00
92.00 Allied health cost	0	33, 090, 648	0.00000	0 6, 462, 534	0	92.00
93.00 All other Medical Education	0	33, 090, 648	0.00000	0 6, 462, 534	0	93. 00

Health Financial Systems	FRANCISCAN HEALTH MUNSTER	In Lieu of Form CMS-2552-10			
COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0165 Period: From 01/01/2023		Worksheet D-1		
			Date/Time Pre 5/28/2024 2:1		
	Title XIX	Hospi tal	PPS		
Cost Center Description					
			1. 00		
				I	

		Title XIX	Hospi tal	PPS	<u> </u>
	Cost Center Description			1. 00	
	PART I - ALL PROVIDER COMPONENTS				
1. 00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days	s excluding newborn)		13, 994	1.00
2. 00	Inpatient days (including private room days, excluding swing-bed and newborn days)				2. 00
3.00	Private room days (excluding swing-bed and observation bed day	ys). If you have only pri	vate room days,	0	3. 00
4. 00	do not complete this line. Semi-private room days (excluding swing-bed and observation be	ed days)		11, 261	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private room		31 of the cost	0	5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private roo	om days) after December (31 of the cost	0	6. 00
7. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost				
8.00	reporting period Total swing-bed NF type inpatient days (including private room	m days) after December 3°	l 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	o the Program (excluding	swing-bed and	1, 016	9. 00
10. 00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII on		oom days)	0	10. 00
11. 00	through December 31 of the cost reporting period (see instruc Swing-bed SNF type inpatient days applicable to title XVIII or	nly (including private ro	oom days) after	0	11. 00
12. 00	December 31 of the cost reporting period (if calendar year, en Swing-bed NF type inpatient days applicable to titles V or XI)		e room days)	0	12. 00
13. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XIX after December 31 of the cost reporting period (if calendar vo			0	13. 00
14. 00 15. 00	Medically necessary private room days applicable to the Progra Total nursery days (title V or XIX only)	•	′	0	14. 00 15. 00
	Nursery days (title V or XIX only)			0	
17. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to service	es through December 31 of	the cost	0.00	17. 00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to service	Ü			18. 00
19. 00	medicald rate for swing-bed SM services applicable to service Medicald rate for swing-bed NF services applicable to services				19. 00
	reporting period	G			
20. 00	Medicaid rate for swing-bed NF services applicable to services reporting period		ie cost	0.00	
21. 00 22. 00	Total general inpatient routine service cost (see instructions $Swing$ -bed cost applicable to SNF type services through December 5×1 ine 17)		ng period (line	33, 090, 648 0	21. 00 22. 00
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reporting	g period (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December $ 7 \times 1 $ ine 19)	31 of the cost reportin	ng period (line	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December : x line 20)	31 of the cost reporting	period (line 8	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, 090, 648	27. 00
	General inpatient routine service charges (excluding swing-bed	d and observation bed cha	arges)	0	
29. 00 30. 00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	
31. 00	General inpatient routine service cost/charge ratio (line 27	: line 28)		0. 000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)	,		0.00	ı
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33. 00
34.00	Average per diem private room charge differential (line 32 min	nus line 33)(see instruct	tions)	0.00	34. 00
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	and private room cost di	ferential (line	33, 090, 648	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	JSTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see			2, 364. 63	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line			2, 402, 464	
	Medically necessary private room cost applicable to the Progra Total Program general inpatient routine service cost (line 39			0 2, 402, 464	
41.00	Trotal Trogram general Impatrent routine service cost (ITHE 39	11116 40)		2, 402, 404	1 41.00

COMPUT	Financial Systems ATION OF INPATIENT OPERATING COST	FRANCI SCAN HEAL	Provi der C	CN: 15-0165	Peri od:	worksheet D-1	
001111 01	WHOM OF THE THE STEEL ST		Trovider of	014. 10 0100	From 01/01/2023 To 12/31/2023	Date/Time Pre	pared:
			Ti tl	e XIX	Hospi tal	5/28/2024 2: 1 PPS	6 pm
	Cost Center Description	Total Inpatient Cost	Total npatient Days	Average Pe Diem (col. 1 col. 2)	r Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2. 00	3. 00	4. 00	5. 00	
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	0	0.	00 0	0	42. 00
43. 00	INTENSIVE CARE UNIT	7, 482, 138	5, 296	1, 412.	79 C	0	43. 00
44.00	CORONARY CARE UNIT	O	0		00 0		
45. 00 46. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT	0	0		00 0		
	OTHER SPECIAL CARE (SPECIFY)			0.			47. 00
	Cost Center Description					1.00	
48. 00	Program inpatient ancillary service cost (Wk:	st. D-3. col. 3.	line 200)			1. 00 3, 779, 417	48. 00
48. 01	Program inpatient cellular therapy acquisition	on cost (Workshe	et D-6, Part		, column 1)	0	48. 01
49. 00	Total Program inpatient costs (sum of lines a PASS THROUGH COST ADJUSTMENTS	41 through 48.01	(see instruc	ti ons)		6, 181, 881	49. 00
50. 00	Pass through costs applicable to Program inpa	atient routine s	ervices (from	ı Wkst. D, su	m of Parts I and	464, 820	50.00
E4 00					6.5	405 450	F4 00
51. 00	Pass through costs applicable to Program inpa and IV)	atrent ancillary	services (fr	υπ WKST. D,	sum or Parts II	435, 452	51.00
52. 00	Total Program excludable cost (sum of lines!					900, 272	
53. 00	Total Program inpatient operating cost exclude medical education costs (line 49 minus line !		ated, non-phy	sician anest	hetist, and	5, 281, 609	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION	32)					
	Program di scharges					1	54.00
	Target amount per discharge Permanent adjustment amount per discharge					0.00	55. 00 55. 01
55. 02	Adjustment amount per discharge (contractor	use only)				1	55. 02
56.00	0 Target amount (line 54 x sum of lines 55, 55.01, and 55.02)						56.00
57. 00 58. 00							57. 00 58. 00
59. 00	70 Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996,						59. 00
60. 00	updated and compounded by the market basket) 00 Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the						60.00
00.00	market basket)	of Title 33 Troil	piroi yeai c	ost report,	apaarea by the	0.00	00.00
61. 00	Continuous improvement bonus payment (if line 55.01, or line 59, or line 60, enter the less					0	61. 00
	53) are less than expected costs (lines 54×10^{-2} enter zero. (see instructions)	60), or 1 % of	the target am	ount (line 5	6), otherwise		
62. 00							62. 00
63. 00							63. 00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST 4.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See						64. 00
	instructions)(title XVIII only)						
65. 00						0	65. 00
66. 00	instructions)(title XVIII only) O Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for					0	66. 00
67. 00	CAH, see instructions					0	67. 00
07.00	Ol Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						07.00
68. 00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68. 00
69. 00	00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facili)	I	70.00
71. 00	Adjusted general inpatient routine service of	•		•	,		71.00
	Program routine service cost (line 9 x line		(III - 14 II	25)			72.00
73. 00 74. 00	Medically necessary private room cost application Total Program general inpatient routine services.		•				73.00
75. 00	Capital -related cost allocated to inpatient				Part II, column		75. 00
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	20. 2)					76. 00
	Program capital -related costs (line 9 x line						77.00
78. 00	Inpatient routine service cost (line 74 minus line 77)						78. 00
79. 00 80. 00	95 9 , , , , , , , , , , , , , , , , , ,						79. 00 80. 00
81. 00							81.00
82.00	0 Inpatient routine service cost limitation (line 9 x line 81)						82.00
83. 00 84. 00							83.00
85. 00	Utilization review - physician compensation	(see instruction					85. 00
86. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		ough 85)				86. 00
87. 00	Total observation bed days (see instructions)					2, 733	87. 00
67.00							88. 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 01/01/2023 To 12/31/2023		
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	6, 402, 233	33, 090, 648	0. 19347	6, 462, 534	1, 250, 345	90.00
91.00 Nursing Program cost	0	33, 090, 648	0. 00000	6, 462, 534	0	91.00
92.00 Allied health cost	0	33, 090, 648	0.00000	6, 462, 534	0	92.00
93.00 All other Medical Education	0	33, 090, 648	0. 00000			93. 00

Health Financial Systems	FRANCISCAN HEALTH MUNSTER	₹	In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi de	r CCN: 15-0165	Peri od:	Worksheet D-3	
			From 01/01/2023	Doto/Timo Dro	paradi
			To 12/31/2023	Date/Time Pre 5/28/2024 2:1	
	Ti	tle XVIII	Hospi tal	PPS	<u>o p</u>
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2. 00	3. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS			8, 980, 278		30.00
31. 00 03100 INTENSIVE CARE UNIT			5, 935, 164		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 UNIT			0		34.00
40. 00 04000 SUBPROVI DER - PF 41. 00 04100 SUBPROVI DER - RF			0		40. 00 41. 00
43. 00 04300 NURSERY			0		43.00
ANCI LLARY SERVI CE COST CENTERS					43.00
50. 00 05000 OPERATI NG ROOM		0. 1160	35 7, 777, 863	902, 504	50.00
51. 00 05100 RECOVERY ROOM		0. 2268			1
52. 00 05200 DELIVERY ROOM & LABOR ROOM		0.0000	•	0	1
53. 00 05300 ANESTHESI OLOGY		0. 0062			1
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1271		367, 691	1
55. 00 05500 RADI OLOGY-THERAPEUTI C		0. 0000		0	1
56. 00 05600 RADI 01 SOTOPE		0. 0000		0	1
57. 00 05700 CT SCAN		0. 0319		163, 941	
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)		0. 0927		115, 126	1
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 4165		1, 149, 245	1
60. 00 06000 LABORATORY		0. 1221		1, 117, 175	
60. 01 06001 BLOOD LABORATORY		0.0000		0	1
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0.0000		0	1
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0.0000		0	1
63.00 06300 BLOOD STORING, PROCESSING & TRANS.		0.0000		0	1
64.00 06400 INTRAVENOUS THERAPY		0.0000	00 0	0	64. 00
65. 00 06500 RESPIRATORY THERAPY		0. 3316	71 3, 091, 084	1, 025, 223	65. 00
66. 00 06600 PHYSI CAL THERAPY		0. 1869	34 1, 054, 444	197, 111	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 1558	60 1, 024, 808	159, 727	67. 00
68.00 06800 SPEECH PATHOLOGY		0. 1466	46 435, 793	63, 907	68. 00
69. 00 06900 ELECTROCARDI OLOGY		0. 0389	41 2, 544, 728	99, 094	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 4651	55 123, 294	57, 351	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 2808			1
72.00 O7200 MPL. DEV. CHARGED TO PATIENTS		0. 2620			1
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 2709		1, 827, 884	1
74. 00 07400 RENAL DI ALYSI S		0.0000		0	
75. 00 07500 ASC (NON-DISTINCT PART)		0.0000		0	
76. 00 03950 OTHER ANCILL SRVC		0.0000		0	
76. 01 03951 CARDI AC AND PULMONARY REHAB		0. 5139		14, 962	1
76. 02 03952 WOUND CARE		0.0000		0	1
77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION		0.0000		0	
78.00 07800 CAR T-CELL IMMUNOTHERAPY OUTPATIENT SERVICE COST CENTERS		0.0000	00 0	0	78. 00
88. 00 08800 RURAL HEALTH CLINIC		0.0000	00	0	88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0.0000		Ö	1
90. 00 09000 CLI NI C		0.0000		Ö	1
90. 01 09001 CLI NI C		0. 1028			1
90. 02 09002 CLI NI C		0. 1641		0	1
91. 00 09100 EMERGENCY		0. 1734		834, 716	1
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 7457		831, 507	1
OTHER REIMBURSABLE COST CENTERS		<u>'</u>			1
94.00 09400 HOME PROGRAM DIALYSIS		0.0000	00 0	0	94. 00
95. 00 09500 AMBULANCE SERVICES					95.00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED		0.0000		0	
97.00 09700 DURABLE MEDICAL EQUIP-SOLD		0.0000		0	
98. 00 09850 OTHER REI MBURSE		0.0000	00 0	0	98. 00
200.00 Total (sum of lines 50 through 94 and 9			60, 168, 522	11, 243, 105	
201.00 Less PBP Clinic Laboratory Services-Pro	ogram only charges (line 6	1)	0		201. 00
202.00 Net charges (line 200 minus line 201)		I	60, 168, 522		202. 00

Health Financial Systems	FRANCISCAN HEALTH MUNSTER		In Lie	eu of Form CMS-2	<u> 2552-10</u>
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0165	Peri od:	Worksheet D-3	
			From 01/01/2023		
			To 12/31/2023	Date/Time Pre	pared:
				5/28/2024 2:1	6 pm
	Ti tI	e XIX	Hospi tal	PPS	
Cost Center Description		Ratio of Cost	Inpatient	Inpati ent	
		To Charges	Program	Program Costs	
		10 onar ges	Charges	(col. 1 x col.	
			Charges		
		1.00	0.00	2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS			3, 212, 204		30.00
31.00 03100 INTENSIVE CARE UNIT			2, 388, 254		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					34.00
40. 00 04000 SUBPROVI DER - PF			0		40.00
41. 00 04100 SUBPROVI DER - I RF			0		41. 00
43. 00 04300 NURSERY			0		43. 00
ANCILLARY SERVICE COST CENTERS					
50. 00 05000 OPERATING ROOM		0. 11603	5 2, 444, 753	283, 677	50.00
51. 00 05100 RECOVERY ROOM		0. 22683	3 242, 201	54, 939	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM		0. 00000		0 1, 707	1
		1			
53. 00 05300 ANESTHESI OLOGY		0.00626			
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 12718			1
55. 00 05500 RADI OLOGY-THERAPEUTI C		0.00000	0	0	55. 00
56. 00 05600 RADI 0I SOTOPE		0.00000	0	0	56.00
57. 00 05700 CT SCAN		0. 03198	8 1, 987, 802	63, 586	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 09277			
59. 00 05900 CARDI AC CATHETERI ZATI ON		1			
		0. 41655			
60. 00 06000 LABORATORY		0. 12213			1
60. 01 06001 BLOOD LABORATORY		0.00000	0	0	60. 01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0.00000	0	0	61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0.00000	ol o	0	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.		0.00000		0	1
64. 00 06400 I NTRAVENOUS THERAPY		0. 00000		Ö	
		1			
65. 00 06500 RESPI RATORY THERAPY		0. 33167			
66. 00 06600 PHYSI CAL THERAPY		0. 18693			
67. 00 06700 OCCUPATI ONAL THERAPY		0. 15586	0 149, 265	23, 264	67. 00
68. 00 06800 SPEECH PATHOLOGY		0. 14664	6 80, 071	11, 742	68. 00
69. 00 06900 ELECTROCARDI OLOGY		0. 03894	1 857, 215	33, 381	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 46515			
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 28082			
1 I		1			
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 26202			
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 27091			
74. 00 07400 RENAL DI ALYSI S		0.00000		0	
75.00 07500 ASC (NON-DISTINCT PART)		0.00000	0	0	75. 00
76. 00 03950 OTHER ANCILL SRVC		0.00000	0 0	0	76. 00
76. 01 03951 CARDIAC AND PULMONARY REHAB		0. 51396	2 11, 783	6, 056	76. 01
76. 02 03952 WOUND CARE		0.00000		0	
77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION		0.00000		1	
		1			
78. 00 07800 CAR T-CELL IMMUNOTHERAPY		0.00000	0 0	0	78. 00
OUTPATIENT SERVICE COST CENTERS			ol -	-	00.05
88. 00 08800 RURAL HEALTH CLINIC		0.00000		0	
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0.00000		0	
90. 00 09000 CLI NI C		0.00000	0	0	90.00
90. 01 09001 CLI NI C		0. 10288	6 199, 446	20, 520	90. 01
90. 02 09002 CLI NI C		0. 16414	·	0	
91. 00 09100 EMERGENCY		0. 17342			
		1			
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)		0. 74575	1 298, 192	222, 377	92. 00
OTHER REIMBURSABLE COST CENTERS					
94.00 09400 HOME PROGRAM DIALYSIS		0.00000	0	0	
95. 00 09500 AMBULANCE SERVICES					95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED		0.00000	0 0	0	96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD		0.00000		0	
98. 00 09850 OTHER REI MBURSE		0. 00000		Ö	
200.00 Total (sum of lines 50 through 94 and	06 through 00)	3.00000		-	
			20, 748, 549	3, 119, 417	
201.00 Less PBP Clinic Laboratory Services-Pro	ugram only charges (line 61)		0 7:		201. 00
202.00 Net charges (line 200 minus line 201)		1	20, 748, 549	I	202. 00

	Title XVIII Hospital	PPS	<u>о рііі</u>		
		4 00			
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS	1. 00			
1. 00	DRG Amounts Other than Outlier Payments	0	1. 00		
1. 01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	10, 472, 257	1. 01		
1. 02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)				
1. 03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)				
1. 04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	0	1. 04		
2.00	Outlier payments for discharges. (see instructions)	_	2. 00		
2. 01 2. 02	Outlier reconciliation amount Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2. 01 2. 02		
2. 03	Outlier payments for discharges occurring prior to October 1 (see instructions)	366, 296	2. 03		
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)	66, 871	2. 04		
3.00	Managed Care Simulated Payments	70.51	3. 00		
4. 00	Bed days available divided by number of days in the cost reporting period (see instructions) Indirect Medical Education Adjustment	70. 51	4. 00		
5. 00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)	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	0.00	6. 26		
	the CAA 2021 (see instructions)				
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		
7.01	cost report straddles July 1, 2011 then see instructions.	0.00	7.01		
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)	0.00	7. 02		
	and 87 FR 49075 (August 10, 2022) (see instructions)				
8. 00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12,	0.00	8. 00		
	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 report straddles July 1, 2011, see instructions.	0.00	8. 01		
8. 02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital	0.00	8. 02		
8. 21	under § 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		
9. 00	instructions) Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or	0.00	9. 00		
10. 00	minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions) FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10. 00		
11. 00	FTE count for residents in dental and podiatric programs.		11. 00		
12. 00	Current year allowable FTE (see instructions)	0.00	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, otherwise enter zero.	0.00	14. 00		
15.00			15. 00		
16. 00			16. 00		
17. 00	Adjustment for residents displaced by program or hospital closure		17.00		
18. 00 19. 00	Adjusted rolling average FTE count Current year resident to bed ratio (line 18 divided by line 4).	0. 00 0. 000000	18. 00 19. 00		
20. 00	Prior year resident to bed ratio (see instructions)	0. 000000	20.00		
21. 00	Enter the lesser of lines 19 or 20 (see instructions)	0. 000000			
22. 00	IME payment adjustment (see instructions)	0	22. 00		
22. 01	IME payment adjustment - Managed Care (see instructions) Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA	0	22. 01		
23. 00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105	0.00	23. 00		
24. 00	(f)(1)(iv)(C). IME FTE Resident Count Over Cap (see instructions)	0.00	24. 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			
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)	0	29. 01		
30. 00	Disproportionate Share Adjustment Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	5. 67	30.00		
31.00	Percentage of Medicaid patient days (see instructions)	13. 96			
32. 00	Sum of lines 30 and 31	19. 63			
33.00	Allowable disproportionate share percentage (see instructions) Disproportionate share adjustment (see instructions)	5. 51 195, 681			
J4. 00	pri spri upor tri oriate i strare auglustimenti (see i nistracti oris)	170,001	34.00		

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0165	Peri od: From 01/01/2023 To 12/31/2023	Worksheet E Part A Date/Time Pre 5/28/2024 2:1	
		Title XVIII	Hospi tal	PPS	
			Prior to 10/1 1.00	2.00	
	Uncompensated Care Payment Adjustment		1.00	2.00	
5. 00	Total uncompensated care amount (see instructions)		6, 874, 403, 459	5, 938, 006, 757	35. (
5. 01	Factor 3 (see instructions)		0. 000197956	0. 000204672	35. (
5. 02	Hospital UCP, including supplemental UCP (see instructions)		1, 360, 829	1, 215, 344	35.
5. 03	Pro rata share of the hospital UCP, including supplemental UCF	(see instructions)	1, 017, 825	305, 496	•
5. 00	Total UCP adjustment (sum of columns 1 and 2 on line 35.03)		1, 323, 321		36.
	Additional payment for high percentage of ESRD beneficiary dis	scharges (Tines 40 throu	ign 46)		40
0. 00 1. 00	Total Medicare discharges (see instructions) Total ESRD Medicare discharges (see instructions)		0		40. 41.
1. 01	Total ESRD Medicare covered and paid discharges (see instructi	ons)	0		41.
2. 00	Divide line 41 by line 40 (if less than 10%, you do not qualif		0.00		42.
3. 00	Total Medicare ESRD inpatient days (see instructions)	y . o. aay ao (o)	0		43.
1. 00	Ratio of average length of stay to one week (line 43 divided by	by line 41 divided by 7	0. 000000		44.
	days)	3			
5. 00	Average weekly cost for dialysis treatments (see instructions)		0.00		45.
5. 00	Total additional payment (line 45 times line 44 times line 41.	01)	0		46.
7. 00	Subtotal (see instructions)	all susal boositalo	16, 157, 732		47.
3. 00	Hospital specific payments (to be completed by SCH and MDH, sm only. (see instructions)	iari rurai nospitars	0		48.
	15th y. (366 + 115th dott 6113)			Amount	
				1. 00	
9. 00	Total payment for inpatient operating costs (see instructions)			16, 157, 732	
0.00	Payment for inpatient program capital (from Wkst. L, Pt. I and			1, 105, 967	50.
1.00	Exception payment for inpatient program capital (Wkst. L, Pt.			0	51.
2. 00	Direct graduate medical education payment (from Wkst. E-4, lir Nursing and Allied Health Managed Care payment	ie 49 see mstructions).		0	52. 53.
4. 00	Special add-on payments for new technologies			95, 034	•
4. 01	Islet isolation add-on payment			0	54.
5. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69	9)		0	55.
5. 01	Cellular therapy acquisition cost (see instructions)			0	55.
5. 00	Cost of physicians' services in a teaching hospital (see intru			0	56.
7. 00	Routine service other pass through costs (from Wkst. D, Pt. II		hrough 35).	0	57.
3. 00	Ancillary service other pass through costs from Wkst. D, Pt. I	V, col. 11 line 200)		0	58.
9. 00	Total (sum of amounts on lines 49 through 58)			17, 358, 733	1
0.00	Primary payer payments	line (O)		5, 582	60.
1. 00 2. 00	Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries	Trie 60)		17, 353, 151 1, 490, 408	•
3. 00	Coinsurance billed to program beneficiaries			69, 589	•
1. 00	Allowable bad debts (see instructions)			238, 087	•
5. 00	Adjusted reimbursable bad debts (see instructions)			154, 757	•
5. 00	Allowable bad debts for dual eligible beneficiaries (see instr	ructions)		144, 589	66.
	Subtotal (line 61 plus line 65 minus lines 62 and 63)			15, 947, 911	67.
	Credits received from manufacturers for replaced devices for a				68.
9. 00	Outlier payments reconciliation (sum of lines 93, 95 and 96).	For SCH see instruction	ns)	0	
0.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	antion) adjusts t	notmunt!>	0	
). 50). 75	Rural Community Hospital Demonstration Project (§410A Demonstr N95 respirator payment adjustment amount (see instructions)	ation, adjustment (see	1 113 L1 UC L1 UHS)	0	70. 70.
). 75). 87	Demonstration payment adjustment amount (see Instructions)			0	70. 70.
). 88	SCH or MDH volume decrease adjustment (contractor use only)			0	
). 89	Pioneer ACO demonstration payment adjustment amount (see instr	ructions)		· ·	70.
). 90	HSP bonus payment HVBP adjustment amount (see instructions)	,		0	
). 91	HSP bonus payment HRR adjustment amount (see instructions)			0	1
). 92	Bundled Model 1 discount amount (see instructions)			0	
). 93	HVBP payment adjustment amount (see instructions)			-20, 634	70.
	HRR adjustment amount (see instructions)			-53, 412	

Weelth Financial Systems	EDANGI CCAN, HEALTI	I MUNCTED		la lia	u of Form CMC (DEED 10
Health Financial Systems CALCULATION OF REIMBURSEMENT SETTLEMENT	FRANCI SCAN HEALTH	Provider CO	CN: 15-0165	Peri od: From 01/01/2023 To 12/31/2023		pared:
		Title	xVIII	Hospi tal	PPS	
·			FFY	(уууу)	Amount	
				0	1. 00	
70.96 Low volume adjustment for federal fit the corresponding federal year for t		column 0		0	0	70. 96
	0.97 Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)			0	0	70. 97
70.98 Low Volume Payment-3		,		0	0	70. 98
70.99 HAC adjustment amount (see instruction	ons)				44, 117	70. 99
71.00 Amount due provider (line 67 minus l	ines 68 plus/minus lines 6	9 & 70)			15, 829, 748	71.00
74 04 0			1		04/ 505	l

316, 595

904, 170

14, 608, 983

71. 01

71.02

71.03

72.00

72.01

73.00

73.01

74.00

74. 01

74. 01	Balance due provider/program-PARHM (see instructions)			74. 01
75.00	Protested amounts (nonallowable cost report items) in accordance with		352, 959	75. 00
	CMS Pub. 15-2, chapter 1, §115.2			
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03		0	90.00
	plus 2.04 (see instructions)			
91.00			0	91.00
92. 00	· ·		0	1
93. 00			0	1
94. 00			0.00	
	Time value of money for operating expenses (see instructions)		0.00	1
	Time value of money for capital related expenses (see instructions)		0	
90.00	Trille varue of illoney for capital related expenses (see fristructions)	Drior to 10/1	On/After 10/1	90.00
		1.00		
	USD Daying Daymant Angust	1.00	2. 00	
100.0	HSP Bonus Payment Amount		1 0	100.00
100.0	OHSP bonus amount (see instructions)	() 0	100. 00
404.0	HVBP Adjustment for HSP Bonus Payment	0.00000000	1 0 00000000	101 00
	O HVBP adjustment factor (see instructions)	0. 0000000000		
102.0	O HVBP adjustment amount for HSP bonus payment (see instructions)	(<u>)</u> 0	102. 00
	HRR Adjustment for HSP Bonus Payment			
	OHRR adjustment factor (see instructions)	0.0000		
104. 0	O HRR adjustment amount for HSP bonus payment (see instructions)	() 0	104. 00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200. 0	Ols this the first year of the current 5-year demonstration period under the 21st			200. 00
	Century Cures Act? Enter "Y" for yes or "N" for no.			
	Cost Reimbursement		_	ļ
	O Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201. 00
	0 Medicare discharges (see instructions)			202. 00
203. 0	O Case-mix adjustment factor (see instructions)			203. 00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the cu	rrent 5-year demons	tration	
	peri od)			
	0 Medicare target amount		l e	204. 00
	O Case-mix adjusted target amount (line 203 times line 204)			205. 00
206. 0	O Medicare inpatient routine cost cap (line 202 times line 205)			206. 00
	Adjustment to Medicare Part A Inpatient Reimbursement			
207. 0	O Program reimbursement under the §410A Demonstration (see instructions)			207. 00
208.0	O Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208. 00
209.0	O Adjustment to Medicare IPPS payments (see instructions)			209. 00
210.0	0 Reserved for future use			210. 00
211. 0	O Total adjustment to Medicare IPPS payments (see instructions)			211. 00
	Comparision of PPS versus Cost Reimbursement	·		
212. 0	Total adjustment to Medicare Part A IPPS payments (from line 211)			212. 00
	O Low-volume adjustment (see instructions)			213.00
	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement)		218. 00
	(line 212 minus line 213) (see instructions)			
		· ·	•	

71. 01

71.02 71. 03

72.00

73.00

73.01

74.00

74. 01

73)

Interim payments

72.01 | Interim payments-PARHM

Sequestration adjustment (see instructions)

Sequestration adjustment-PARHM pass-throughs

Tentative settlement (for contractor use only)

Tentative settlement-PARHM (for contractor use only)

Balance due provider/program-PARHM (see instructions)

 $\label{thm:constration} \mbox{Demonstration payment adjustment amount after sequestration}$

Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and

| In Lieu of Form CMS-2552-10 | Period: | Worksheet E | From 01/01/2023 | Part A Exhibit 4 | To 12/31/2023 | Date/Time Prepared: | 5/28/2024 2:16 pm Health Financial Systems

LOW VOLUME CALCULATION EXHIBIT 4 Provider CCN: 15-0165

NS E, Part A Anounts (From Period Prior) Period Prior Period On/After 10/Ot Through							12/31/2023	5/28/2024 2:1	
1.00 BRG amounts other than outlier 1.00 0 0 0 0 0 0 5.00								PPS	
1.00 DRG mounts other than outilier 0.0 1.00 2.00 3.00 4.00 5.00								Total (Col 2	
1.00 DRG amounts other than outlier 1.00 0 0 0 0 0 0 0 0 0									
Description	1 00	DRG amounts other than outlier						0.00	1.00
Description			1. 00	١	Ĭ	·	1		
1.02 DRG amounts other than outlier 1.02 3,733,306 0 3,733,306 3,733 3	1. 01	DRG amounts other than outlier payments for discharges	1. 01	10, 472, 257	0	10, 472, 257	7	10, 472, 257	1. 01
1.03	1. 02	DRG amounts other than outlier	1. 02	3, 733, 306	O		3, 733, 306	3, 733, 306	1. 02
Operating payment for Model 4 BPCI occurring prior to October 1 Octobe									
Operating payment for Model 4 BPCI occurring on or after Cotober 1 Cot		operating payment for Model 4 BPCI occurring prior to	1. 03	0	0	() 	0	1. 03
2.00		operating payment for Model 4 BPCI occurring on or after	1. 04	0	O		0	0	1. 04
2.01 Outlier payments for discharges for Model 4 BPCI 2.02 0 0 0 0 0 366,296 366 366 discharges for Model 4 BPCI 2.03 366,296 0 366,296 366 discharges occurring prior to October 1 (see Instructions) 2.03 Outlier payments for discharges occurring on or after October 1 (see Instructions) 6.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2.00	Outlier payments for	2. 00						2. 00
2.02 Outlier payments for discharges occurring prior to October 1 (see instructions) 2.04 66,871 0 66,871 66	2. 01	Outlier payments for	2. 02	0	0	(0	0	2. 01
2.03 Outfler payments for discharges occurring on or after October 1 (see Instructions) 3.00 Operating outlier 2.01 O O O O O O O O O	2. 02	Outlier payments for discharges occurring prior to	2. 03	366, 296	0	366, 296	5	366, 296	2. 02
3.00 Operating outlier 2.01 0 0 0 0 0 0 0 0 0	2. 03	Outlier payments for discharges occurring on or after October 1 (see	2. 04	66, 871	0		66, 871	66, 871	2. 03
A.00	3. 00	Operating outlier	2. 01	0	0	(0	0	3. 00
Indirect Medical Education Adjustment	4.00	Managed care simulated	3. 00	0	0	(0	0	4. 00
A, I ine 21 (see instructions) IME payment adjustment (see			ustment						
6.00 IME payment adjustment (see 22.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 1 1 1 1			21. 00	0. 000000	0. 000000	0. 000000	0. 000000		5. 00
IME payment adjustment for managed care (see instructions)	6. 00	IME payment adjustment (see	22. 00	0	0	(0	0	6. 00
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA	6. 01	IME payment adjustment for	22. 01	0	0	(0	0	6. 01
7. 00 (see instructions) 27. 00 0.0000000 0.000000 0.000000 0.0000000 0.0000000 0.0000000 0.00000000000 0.00000000000 0.00000000000 0.0000000000000 0.00000000000000000 0.000000000000000000000 0.000000000000000000000000 0.000000000000000000000000000000000 0.00000000000000000000000000000000000									
See instructions See instructions See Se							0 000000		7 00
8.00 IME adjustment (see 28.00 0 0 0 0 0 0 0 0 0			27.00	0.000000	0.000000	0.000000	0.000000		7. 00
for managed care (see instructions) 9.00 Total IME payment (sum of 29.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	8. 00	ÎME adjustment (see	28. 00	0	0	(0	0	8. 00
9.00 Total IME payment (sum of lines 6 and 8) 9.01 Total IME payment for managed 29.01 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		for managed care (see	28. 01	0	O	(0	0	8. 01
9.01 Total IME payment for managed care (sum of lines 6.01 and 8.01) Disproportionate Share Adjustment 10.00 Allowable disproportionate share percentage (see instructions) 11.00 Disproportionate share adjustment 33.00 0.0551 0.0551 0.0551 0.0551 11.01 Uncompensated care payments 36.00 1,323,321 0 1,017,825 305,496 1,323 Additional payment for high percentage of ESRD beneficiary discharges 12.00 Total ESRD additional payment (see instructions) 47.00 16,157,732 0 12,000,633 4,157,099 16,157	9. 00	Total IME payment (sum of	29. 00	0	0	(0	0	9. 00
Disproportionate Share Adjustment 33.00 0.0551 0.0551 0.0551 0.0551 0.0551 share percentage (see instructions) 11.00 Disproportionate share adjustment (see instructions) 11.01 Uncompensated care payments 36.00 1,323,321 0 1,017,825 305,496 1,323 Additional payment for high percentage of ESRD beneficiary discharges 12.00 Total ESRD additional payment 46.00 0 0 0 0 (see instructions) 13.00 Subtotal (see instructions) 47.00 16,157,732 0 12,000,633 4,157,099 16,157	9. 01	Total IME payment for managed	29. 01	0	0	(0	0	9. 01
10. 00			L						
Share percentage (see				0.0554	0.0554	0.055	0.0551		10.00
11.00 Disproportionate share adjustment (see instructions) 11.01 Uncompensated care payments 36.00 1,323,321 0 1,017,825 51,426 195 Additional payment for high percentage of ESRD beneficiary discharges 12.00 Total ESRD additional payment (see instructions) 46.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		share percentage (see	33.00	0.0551	0.0551	0.055	0.0551		10.00
11. 01 Uncompensated care payments 36.00 1,323,321 0 1,017,825 305,496 1,323 Additional payment for high percentage of ESRD beneficiary discharges 12. 00 Total ESRD additional payment 46.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	11. 00	Disproportionate share	34.00	195, 681	0	144, 255	51, 426	195, 681	11. 00
12.00 Total ESRD additional payment 46.00 0 0 0 0 0 (see instructions) 47.00 16,157,732 0 12,000,633 4,157,099 16,157	11. 01	Uncompensated care payments				1, 017, 825	305, 496	1, 323, 321	11. 01
(see instructions) 13.00 Subtotal (see instructions) 47.00 16,157,732 0 12,000,633 4,157,099 16,157				ol		(0	0	12.00
					Ĭ	Ì			
(completed by SCH and MDH, small rural hospitals only.)	14. 00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.)	47.00 48.00	16, 157, 732 0	O O	12, 000, 633 (4, 157, 099 0 0	16, 157, 732 0	13. 00 14. 00
operating costs (see	15. 00	Total payment for inpatient operating costs (see	49. 00	16, 157, 732	0	12, 000, 633	4, 157, 099	16, 157, 732	15. 00
instructions) 16.00 Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable) 50.00 1,105,967 0 814,260 291,707 1,105	16. 00	Payment for inpatient program capital (from Wkst. L, Pt. I,	50.00	1, 105, 967	0	814, 260	291, 707	1, 105, 967	16. 00

12/31/2023 Date/Time Prepared: 5/28/2024 2:16 pm Title XVIII Hospi tal W/S E, Part A Amounts (from Pre/Post Period Prior Total (Col 2 Peri od On/After 10/01 E, Part A) to 10/01 line Entitlement through 4) 4 00 0 1 00 2 00 3 00 5 00 17.00 Special add-on payments for 54.00 95,034 95,034 95, 034 17.00 new technologies 17.01 Net organ aquisition cost 17.01 17.02 Credits received from 68.00 17.02 0 0 0 manufacturers for replaced devices for applicable MS-DRGs 18.00 Capital outlier reconciliation 93.00 0 0 18.00 adjustment amount (see instructions) 19.00 SUBTOTAL 12, 909, 927 4, 448, 806 17, 358, 733 19.00 W/S L, line (Amounts from 0 1.00 2.00 3.00 4. 00 5. 00 Capital DRG other than outlier 20.00 1.00 1, 082, 026 792, 527 289, 499 1, 082, 026 20.00 Model 4 BPCI Capital DRG other 20.01 1 01 20 01 than outlier 21.00 Capital DRG outlier payments 2.00 23, 941 21, 733 2, 208 23, 941 21.00 Model 4 BPCI Capital DRG 21.01 2.01 21.01 outlier payments Indirect medical education 22.00 5.00 0.0000 0.0000 0.0000 0.0000 22.00 percentage (see instructions) 23.00 Indirect medical education 6.00 0 23.00 adjustment (see instructions) 24.00 Allowable disproportionate 10.00 0.0000 0.0000 0.0000 0.0000 24.00 share percentage (see instructions) 25.00 Di sproporti onate share 11.00 0 0 25.00 C 0 adjustment (see instructions) 26.00 Total prospective capital 12.00 1, 105, 967 814, 260 291, 707 1, 105, 967 26.00 payments (see instructions) W/S E, Part A (Amounts to E, line Part A) 5. 00 1.00 2.00 3.00 4.00 0 27.00 Low volume adjustment factor 0.000000 0.000000 27.00 28.00 Low volume adjustment 70.96 28.00 (transfer amount to Wkst. E, Pt. A. line) 29.00 Low volume adjustment 29.00 70.97 0 (transfer amount to Wkst. E, Pt. A, line) 100.00 Transfer low volume 100.00 adjustments to Wkst. E, Pt. A.

HUSPII	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	IION EXHIBIT 5	Provider C		From 01/01/2023 To 12/31/2023		pared:
			Ti tl e	e 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 1. 01	DRG amounts other than outlier payments DRG amounts other than outlier payments for discharges occurring prior to October 1	1. 00 1. 01	10, 472, 257	10, 472, 25	7	10, 472, 257	1. 00 1. 01
1. 02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1. 02	3, 733, 306))	3, 733, 306	3, 733, 306	1. 02
1. 03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1. 03	C		0	0	1. 03
1. 04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1. 04	C		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	C		0	0	2. 01
2. 02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2. 03	366, 296	366, 296	5	366, 296	2. 02
2. 03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2. 04	66, 871		66, 871	66, 871	2. 03
3. 00 4. 00	Operating outlier reconciliation Managed care simulated payments	2. 01 3. 00		1	0 0	0	3. 00 4. 00
5. 00	Indirect Medical Education Adjustment Amount from Worksheet E, Part A, line 21	21. 00	0. 000000	0.00000	0.000000		5. 00
6. 00	(see instructions) IME payment adjustment (see instructions)	22. 00			0	0	6. 00
6. 01	IME payment adjustment for managed care (see instructions)	22. 01	C)	0	ō	
	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 8. 01	IME adjustment (see instructions) IME payment adjustment add on for managed care (see instructions)	28. 00 28. 01	(0	0	8. 00 8. 01
9.00	Total IME payment (sum of lines 6 and 8)	29. 00	(0	0	9.00
9. 01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29. 01)	0	0	9. 01
	Disproportionate Share Adjustment		1				
10. 00	Allowable disproportionate share percentage (see instructions)	33. 00	0. 0551	0.055	0. 0551		10. 00
11. 00	Disproportionate share adjustment (see instructions)	34.00	195, 681	144, 25!	5 51, 426	195, 681	11. 00
11. 01	Uncompensated care payments Additional payment for high percentage of ESR	36.00	1, 323, 321	1, 017, 82	305, 496	1, 323, 321	11. 01
12. 00	Total ESRD additional payment (see	46. 00	C. Sorial ges		0	0	12. 00
13. 00	instructions) Subtotal (see instructions)	47. 00	16, 157, 732	12, 000, 63	4, 157, 099	16, 157, 732	13. 00
14. 00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48. 00	C		0	0	1
15. 00	Total payment for inpatient operating costs (see instructions)	49. 00	16, 157, 732	12, 000, 63	4, 157, 099	16, 157, 732	15. 00
16. 00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50. 00	1, 105, 967	814, 260	291, 707	1, 105, 967	16. 00
17. 00 17. 01	Special add-on payments for new technologies Net organ acquisition cost	54. 00	95, 034	95, 034	4 O	95, 034	17. 00 17. 01
17. 02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68. 00	C		0	0	ı
18. 00	Capital outlier reconciliation adjustment amount (see instructions)	93. 00	C		0	0	18. 00
19. 00	SUBTOTAL			12, 909, 92	4, 448, 806	17, 358, 733	19. 00

leal th	Financial Systems	FRANCI SCAN HEA	LTH MUNSTER		In Lie	u of Form CMS-2	2552-10
HOSPI T	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5	Provi der CC		Period: From 01/01/2023 To 12/31/2023		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, 082, 026	792, 52	7 289, 499	1, 082, 026	20. 00
0. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	0		0	0	20. 01
1.00	Capital DRG outlier payments	2.00	23, 941	21, 73	2, 208	23, 941	21. 00
1. 01	Model 4 BPCI Capital DRG outlier payments	2. 01	0		0	0	21. 01
22. 00	Indirect medical education percentage (see instructions)	5. 00	0. 0000	0.000	0.0000		22. 00
3. 00	Indirect medical education adjustment (see instructions)	6. 00	0	1	0	0	23. 00
1. 00	Allowable disproportionate share percentage (see instructions)	10. 00	0. 0000	0.000	0.0000		24. 00
5. 00	Disproportionate share adjustment (see instructions)	11. 00	0	1	0	0	25. 00
4 00	Total processitive conital payments (con	12.00	1 105 047	01/ 24	201 707	1 105 047	1 2/ 20

26. 00	Total prospective capital payments (see instructions)	12.00	1, 105, 967	814, 260	291, 707	1, 105, 967	26. 00
	THIST do thous	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	-20, 634	0	-20, 634	-20, 634	30. 00
30. 01	HVBP payment adjustment for HSP bonus	70. 90	0	0	0	0	30. 01
	payment (see instructions)						
31.00	HRR adjustment (see instructions)	70. 94	-53, 412	-36, 985	-16, 427	-53, 412	31. 00
31. 01	HRR adjustment for HSP bonus payment (see instructions)	70. 91	0	0	0	0	31. 01
						(Amt. to Wkst.	
						E, Pt. A)	
		0	1.00	2.00	3. 00	4. 00	
32. 00	HAC Reduction Program adjustment (see instructions)	70. 99		0	44, 117	44, 117	32. 00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100. 00

Health Financial Systems	FRANCISCAN HEALTH MUNSTER	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0165	Peri od: Worksheet E From 01/01/2023 Part B Date/Time Prepared: 5/28/2024 2:16 pm

		Title XVIII	Hospi tal	5/28/2024 2: 10 PPS	o piii	
				1. 00		
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00		
1.00	Medical and other services (see instructions)			1, 014 14, 972, 878	1. 00 2. 00	
2. 00 3. 00	· · · · · · · · · · · · · · · · · · ·					
4.00	Outlier payment (see instructions)			13, 579, 012 22, 478	3. 00 4. 00	
4. 01	Outlier reconciliation amount (see instructions)			0	4. 01	
5.00						
6. 00 7. 00	Line 2 times line 5			0 0. 00	6. 00 7. 00	
8. 00	Sum of lines 3, 4, and 4.01, divided by line 6 Transitional corridor payment (see instructions)			0.00	8.00	
9.00	Ancillary service other pass through costs including REH direc	t graduate medical educa	ition costs from	0	9. 00	
40.00	Wkst. D, Pt. IV, col. 13, line 200				40.00	
10. 00 11. 00	Organ acquisitions Total cost (sum of lines 1 and 10) (see instructions)			0 1, 014	10. 00 11. 00	
11.00	COMPUTATION OF LESSER OF COST OR CHARGES			1,011	11.00	
	Reasonable charges					
12.00	Ancillary service charges	no (0)			12.00	
13. 00 14. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, li Total reasonable charges (sum of lines 12 and 13)	ne 69)		0 3, 743	13. 00 14. 00	
00	Customary charges			5, 7.15		
15. 00	Aggregate amount actually collected from patients liable for p			0	15. 00	
16. 00	Amounts that would have been realized from patients liable for had such payment been made in accordance with 42 CFR §413.13(e		a chargebasis	0	16. 00	
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	17. 00	
18. 00	Total customary charges (see instructions)			3, 743		
19. 00	Excess of customary charges over reasonable cost (complete onl	y if line 18 exceeds lir	ne 11) (see	2, 729	19. 00	
20. 00	<pre>instructions) Excess of reasonable cost over customary charges (complete onl</pre>	y if line 11 exceeds lir	ne 18) (see	0	20. 00	
	instructions)		, ,			
21. 00	Lesser of cost or charges (see instructions)			1, 014		
22. 00 23. 00	Interns and residents (see instructions) Cost of physicians' services in a teaching hospital (see instr	ructions)		0	22. 00 23. 00	
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	401.0		13, 601, 490		
	COMPUTATION OF REIMBURSEMENT SETTLEMENT	,				
25. 00 26. 00	Deductibles and coinsurance amounts (for CAH, see instructions Deductibles and Coinsurance amounts relating to amount on line	•	ictions)	0 2, 438, 538	25. 00 26. 00	
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) p			11, 163, 966		
	instructions)					
28. 00	Direct graduate medical education payments (from Wkst. E-4, li	ne 50)		0	28. 00	
28. 50 29. 00	REH facility payment amount (see instructions) ESRD direct medical education costs (from Wkst. E-4, line 36)			0	28. 50 29. 00	
30.00	Subtotal (sum of lines 27, 28, 28.50 and 29)			11, 163, 966		
31. 00	Primary payer payments			5, 394		
32. 00	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVIC	FC)		11, 158, 572	32. 00	
33. 00	Composite rate ESRD (from Wkst. I-5, line 11)	L3)		0	33. 00	
34.00	Allowable bad debts (see instructions)			173, 864		
35. 00	Adjusted reimbursable bad debts (see instructions)			113, 012		
36. 00 37. 00	Allowable bad debts for dual eligible beneficiaries (see instr Subtotal (see instructions)	uctions)		136, 213 11, 271, 584		
38. 00	MSP-LCC reconciliation amount from PS&R			-8	38.00	
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39. 00	
39. 50 39. 75	Pioneer ACO demonstration payment adjustment (see instructions	.)		0	39. 50 39. 75	
39. 73	N95 respirator payment adjustment amount (see instructions) Demonstration payment adjustment amount before sequestration			0	39. 73	
39. 98	Partial or full credits received from manufacturers for replac	ed devices (see instruct	i ons)	0	39. 98	
39. 99	RECOVERY OF ACCELERATED DEPRECIATION			0	39. 99	
40. 00 40. 01	Subtotal (see instructions) Sequestration adjustment (see instructions)			11, 271, 592 225, 432	40. 00 40. 01	
40. 01	Demonstration adjustment (see First detroils) Demonstration payment adjustment amount after sequestration			223, 432	40. 01	
40. 03	Sequestration adjustment-PARHM pass-throughs				40. 03	
41.00	Interim payments			11, 045, 246	•	
41. 01 42. 00	Interim payments-PARHM Tentative settlement (for contractors use only)			0	41. 01 42. 00	
42. 01	Tentative settlement-PARHM (for contractor use only)				42. 01	
43.00	Balance due provider/program (see instructions)			914	43. 00	
43. 01	Balance due provider/program-PARHM (see instructions)	on with CMC Dut 45 C	shantar 1	5	43. 01	
44. 00	Protested amounts (nonallowable cost report items) in accordan §115.2	ice with CMS Pub. 15-2, C	партег (,	0	44. 00	
	TO BE COMPLETED BY CONTRACTOR					
90.00	Original outlier amount (see instructions)			0	90.00	
91. 00 92. 00	Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money			0 0. 00	91. 00 92. 00	
	Time Value of Money (see instructions)				93. 00	
			<u> </u>		·	

Health Financial Systems	FRANCI SCAN HEALTI	H MUNSTER	In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0165	Peri od: From 01/01/2023	Worksheet E Part B	
			To 12/31/2023		
		Title XVIII	Hospi tal	PPS	
				1. 00	
94.00 Total (sum of lines 91 and 93)				0	94. 00
				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 | Peri od: | Worksheet E-1 | From 01/01/2023 | Part | To 12/31/2023 | Date/Time Prepared: Provider CCN: 15-0165

			'	0 12/31/2023	5/28/2024 2: 16	
		Title	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, 546, 383		11, 045, 246	1. 00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		C		0	2. 00
3. 00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3. 00
3. 01	ADJUSTMENTS TO PROVIDER	09/13/2023	62, 600		0	3. 01
3.02			l		ol	3. 02
3. 03)	0	3. 03
3.04)	ol	3. 04
3. 05)	ol	3. 05
	Provider to Program			•		
3.50	ADJUSTMENTS TO PROGRAM		C)	0	3.50
3. 51			l c)	o	3. 51
3.52			[c)	0	3. 52
3.53			l c)	ol	3. 53
3.54			l c)	ol	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		62, 600)	0	3. 99
4. 00	3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99)		14, 608, 983		11, 045, 246	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		. ,, 555, 155		, ,	
	TO BE COMPLETED BY CONTRACTOR		L	l		
5. 00	List separately each tentative settlement payment after					5. 00
0.00	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					0.00
	Program to Provider			"		
5. 01	TENTATI VE TO PROVI DER		C		0	5. 01
5.02)	o	5. 02
5.03			[c)	0	5.03
	Provider to Program					
5.50	TENTATI VE TO PROGRAM		C		0	5. 50
5. 51			C)	0	5. 51
5.52			0		0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		C		0	5. 99
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER		904, 170	,	914	6. 01
6. 02	SETTLEMENT TO PROGRAM		704, 170		1 7 7	6. 02
7. 00	Total Medicare program liability (see instructions)		15, 513, 153		11, 046, 160	7. 00
7.00	Total medicale program frability (see Histractions)		10, 515, 155	Contractor	NPR Date	7.00
				Number	(Mo/Day/Yr)	
		()	1. 00	2.00	
8. 00	Name of Contractor					8. 00
	· ·	•		•	'	

Heal th	Financial Systems FRA	NCISCAN HEALTH MUNSTER	In Lie	u of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provi der CCN: 15-0165	Peri od: From 01/01/2023	Worksheet E-1 Part II	
			To 12/31/2023	Date/Time Pre	pared:
				5/28/2024 2:1	6 pm
		Title XVIII	Hospi tal	PPS	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COS				-
4 00	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND		4.4		4 00
1.00	Total hospital discharges as defined in AARA §410	02 from WKSt. S-3, Pt. I col. IS line	14		1.00
2.00 Medicare days (see instructions)				2.00	
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6.	Tine 2			3.00
4. 00 5. 00	Total inpatient days (see instructions)	0 Line 200			4. 00 5. 00
6.00	Total hospital charges from Wkst C, Pt. I, col. (Total hospital charity care charges from Wkst. S				6.00
7. 00	CAH only - The reasonable cost incurred for the	· ·	Micot C 2 Dt I		7.00
7.00	line 168	purchase or certified hir technology	WKSL. 3-2, PL. I		7.00
8. 00	Calculation of the HIT incentive payment (see in:	structions)			8.00
9. 00	Sequestration adjustment amount (see instructions	· ·			9.00
10.00	, ,				10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH	,	'		1
30.00	Initial/interim HIT payment adjustment (see inst	ructions)			30. 00
31.00	Other Adjustment (specify)				31.00
32. 00	Balance due provider (line 8 (or line 10) minus	line 30 and line 31) (see instructions	s)		32. 00

Health Fina	ancial Systems I	FRANCISCAN HEALT	H MUNSTER	In Lie	u of Form CMS-2	552-10
OUTLI ER REC	CONCILIATION AT TENTATIVE SETTLEMENT		Provider CCN: 15-0165	Peri od:	Worksheet E-5	
				From 01/01/2023 To 12/31/2023	Date/Time Prep	pared:
					5/28/2024 2: 16	
			Title XVIII		PPS	
					1. 00	
ТО В	BE COMPLETED BY CONTRACTOR					
1.00 Oper	rating outlier amount from Wkst. E, Pt. A,	line 2, or sum of	of 2.03 plus 2.04 (see i	nstructions)	0	1.00
2. 00 Capi	ital outlier from Wkst. L, Pt. I, line 2				0	2.00
3.00 Oper	rating outlier reconciliation adjustment am	mount (see instru	ucti ons)		0	3.00
4. 00 Capi	ital outlier reconciliation adjustment amou	unt (see instruct	ti ons)		0	4.00
5.00 The	rate used to calculate the time value of m	money (see instru	uctions)		0.00	5.00
6.00 Ti me	e value of money for operating expenses (se	ee instructions)			0	6.00
7.00 Ti me	e value of money for capital related expens	ses (see instruct	ti ons)		0	7.00

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

Provi der CCN: 15-0165

Peri od: Worksheet G From 01/01/2023 To 12/31/2023 Date/Time Prepared:

onl y)			'	0 12/31/2023	5/28/2024 2:1	
		General Fund	Speci fi c	Endowment Fund		
		1. 00	Purpose Fund 2.00	3. 00	4. 00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	8, 860, 708	1	-	0	1.00
2. 00 3. 00	Temporary investments Notes receivable		0	-	0	2. 00 3. 00
4.00	Accounts receivable	89, 917, 981	1	0	0	4.00
5. 00	Other recei vabl e	405, 781		Ö	0	5. 00
6.00	Allowances for uncollectible notes and accounts receivable	-71, 735, 735	5 0	0	0	6. 00
7.00	Inventory	3, 027, 112	2 0	0	0	7. 00
8.00	Prepai d expenses	750, 401		0	0	8. 00
9.00	Other current assets	435, 271	1	0	0	9.00
10. 00 11. 00	Due from other funds	31, 661, 519	0		0	10. 00 11. 00
11.00	Total current assets (sum of lines 1-10) FIXED ASSETS	31,001,319	, 0	U U	0] 11.00
12. 00	Land	12, 536, 134	1 0	0	0	12. 00
13.00	Land improvements	2, 720, 511	1	0	0	13.00
14.00	Accumulated depreciation	-542, 775	5 O	0	0	14. 00
15. 00	Bui I di ngs	94, 385, 859	1	0	0	15. 00
16.00	Accumulated depreciation	-9, 287, 284	1	-	0	16.00
17. 00 18. 00	Leasehold improvements	13, 570, 656	1	-	0	17.00
19. 00	Accumulated depreciation Fixed equipment	-5, 643, 480 59, 973, 684	1		0	18. 00 19. 00
20. 00	Accumulated depreciation	-9, 580, 528	1	-	0	20.00
21. 00	Automobiles and trucks	0		0	0	21. 00
22. 00	Accumul ated depreciation	O	0	0	0	22. 00
23. 00	Major movable equipment	68, 756, 080	0	0	0	23. 00
24. 00	Accumulated depreciation	-67, 584, 704		0	0	24. 00
25. 00	Minor equipment depreciable	0	0	-	0	25. 00
26. 00	Accumulated depreciation HIT designated Assets		0	-	0	26. 00 27. 00
27. 00 28. 00	Accumul ated depreciation			0	0	28.00
29. 00	Mi nor equi pment-nondepreci abl e			0	0	29.00
30. 00	Total fixed assets (sum of lines 12-29)	159, 304, 153	8 0	0	0	30.00
	OTHER ASSETS					
31. 00	Investments	6, 995, 419	1		0	31.00
32. 00	Deposits on Leases	3, 803, 554		-	0	32.00
33. 00 34. 00	Due from owners/officers Other assets	5, 314, 915	0		0	33. 00 34. 00
35. 00	Total other assets (sum of lines 31-34)	16, 113, 888	1	-	0	35.00
36. 00	Total assets (sum of lines 11, 30, and 35)	207, 079, 560			0	36.00
	CURRENT LI ABILITIES					
37. 00	Accounts payable	9, 287, 703	0	0	0	37. 00
38. 00	Salaries, wages, and fees payable	4, 239, 395	1	0	0	38. 00
39. 00	Payroll taxes payable	665, 158	0	0	0	39.00
40. 00 41. 00	Notes and Loans payable (short term) Deferred income			0	0	40. 00 41. 00
41.00	Accel erated payments	0		U	0	42.00
43. 00	Due to other funds		ól o	0	0	43. 00
44.00	Other current liabilities	7, 985, 099	o	0	0	
45.00	Total current liabilities (sum of lines 37 thru 44)	22, 177, 355	0	0	0	45. 00
	LONG TERM LIABILITIES					
46. 00	Mortgage payable	0	0	-	0	46.00
47. 00 48. 00	Notes payable Unsecured Loans	932, 167	0		0	47. 00 48. 00
49. 00	Other long term liabilities	1, 719, 425	1	-	0	49.00
50. 00	Total long term liabilities (sum of lines 46 thru 49)	2, 651, 592			0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	24, 828, 947		0	0	51.00
	CAPI TAL ACCOUNTS					
52.00	General fund balance	182, 250, 613	1			52. 00
53. 00	Specific purpose fund		0			53.00
54. 00 55. 00	Donor created - endowment fund balance - restricted Donor created - endowment fund balance - unrestricted			0		54. 00 55. 00
56. 00	Governing body created - endowment fund balance			0		56.00
57. 00	Plant fund balance - invested in plant				0	57. 00
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
	repl acement, and expansi on					
59. 00	Total fund balances (sum of lines 52 thru 58)	182, 250, 613	1	0	0	59. 00
60. 00	Total liabilities and fund balances (sum of lines 51 and	207, 079, 560	0	0	0	60.00
	[59]	I	I			l

Provider CCN: 15-0165

Peri od: Worksheet G-1 From 01/01/2023 To 12/31/2023 Date/Time Prepared:

					То	12/31/2023	Date/Time Prep 5/28/2024 2:10	
		General	Fund	Speci al	Purp	oose Fund	Endowment Fund	
		1.00	2.00	3. 00		4. 00	5. 00	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) ROUNDING Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	1.00 14 0 0 0 0 0 0	2.00 188, 902, 071 -6, 651, 472 182, 250, 599 14 182, 250, 613		000000000000	0 0	0 0 0 0 0 0	1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00
17. 00 18. 00 19. 00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0	0 182, 250, 613		0	0	0	17. 00 18. 00 19. 00
		Endowment Fund	PI ant	Fund				
		6.00	7. 00	8. 00				
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) ROUNDING	0	0 0 0 0		0			1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0	0 0 0 0 0		0 0			10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00

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

		To	12/31/2023	Date/Time Pre 5/28/2024 2:1	
	Cost Center Description	Inpati ent	Outpati ent	Total	
	'	1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospi tal	25, 255, 081		25, 255, 081	1. 00
2.00	SUBPROVI DER - I PF	0		0	2. 00
3.00	SUBPROVI DER - I RF	0		0	3. 00
4.00	SUBPROVI DER				4. 00
5.00	Swing bed - SNF	0		0	5. 00
6.00	Swing bed - NF	0		0	6. 00
7.00	SKILLED NURSING FACILITY	0		0	7. 00
8.00	NURSING FACILITY	0		0	8. 00
9.00	OTHER LONG TERM CARE	0		0	9. 00
10.00	Total general inpatient care services (sum of lines 1-9)	25, 255, 081		25, 255, 081	10. 00
	Intensive Care Type Inpatient Hospital Services		<u>.</u>		
11.00	INTENSIVE CARE UNIT	17, 029, 244		17, 029, 244	11. 00
12.00	CORONARY CARE UNIT	0		0	12.00
13.00	BURN INTENSIVE CARE UNIT	0		0	13.00
14.00	SURGI CAL INTENSIVE CARE UNIT	0		0	14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15. 00
16.00	Total intensive care type inpatient hospital services (sum of lines	17, 029, 244		17, 029, 244	16. 00
	11-15)				
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	42, 284, 325		42, 284, 325	17. 00
18. 00	Ancillary services	148, 458, 869	381, 246, 029	529, 704, 898	18. 00
19. 00	Outpati ent servi ces	16, 658, 411	90, 552, 566	107, 210, 977	19. 00
20.00	RURAL HEALTH CLINIC	0	0	0	20. 00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21. 00
22. 00	HOME HEALTH AGENCY		0	0	22. 00
23.00	AMBULANCE SERVICES	0	0	0	23. 00
24.00	CMHC		0	0	24. 00
24. 10	CORF	0	0	0	24. 10
25. 00	AMBULATORY SURGI CAL CENTER (D. P.)	0	0	0	25. 00
26. 00	HOSPI CE	0	0	0	26. 00
27. 00	PROFESSI ONAL FEES	0	7, 808, 230	7, 808, 230	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.	207, 401, 605	479, 606, 825	687, 008, 430	28. 00
	G-3, line 1)				
	PART II - OPERATING EXPENSES	T			
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		163, 186, 384		29. 00
30.00	ADD (SPECIFY)	0			30.00
31. 00		0			31.00
32.00		0			32. 00
33. 00		0			33.00
34. 00		0			34. 00
35. 00	T	0			35. 00
36.00	Total additions (sum of lines 30-35)		0		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	Total deductions (cum of Lines 27 41)				41.00
42. 00 43. 00	Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer		163, 186, 384		42. 00 43. 00
43.00	to Wkst. G-3, line 4)		103, 180, 384		43.00
	10 mx3t. 0 0, 11110 4)	1	ı		ı

Heal th	Financial Systems FRANCISCAN HEALT	TH MUNSTER	In lie	u of Form CMS-2	2552-10
	ENT OF REVENUES AND EXPENSES	Provider CCN: 15-0165	Peri od:	Worksheet G-3	1002 10
			From 01/01/2023 To 12/31/2023	Date/Time Pre 5/28/2024 2:1	
				1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, lin			687, 008, 430	
2.00	Less contractual allowances and discounts on patients' accoun	ts		533, 588, 971	
3.00	Net patient revenues (line 1 minus line 2)			153, 419, 459	
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		163, 186, 384	
5.00	Net income from service to patients (line 3 minus line 4)			-9, 766, 925	5. 00
	OTHER I NCOME				
6.00	Contributions, donations, bequests, etc			20, 863	
7. 00	Income from investments			0	
8.00	Revenues from telephone and other miscellaneous communication	servi ces		0	
9.00	Revenue from television and radio service			0	7.00
10.00	Purchase di scounts			0	10.00
11. 00	Rebates and refunds of expenses			813, 462	
12. 00	Parking lot receipts			0	
13. 00	Revenue from Laundry and Linen service			0	13.00
	Revenue from meals sold to employees and guests			332, 409	
	Revenue from rental of living quarters			0	15. 00
	Revenue from sale of medical and surgical supplies to other t	han patients		0	16. 00
	Revenue from sale of drugs to other than patients			374	17. 00
18.00	Revenue from sale of medical records and abstracts			514	18. 00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen			72, 913	20.00
21.00	Rental of vending machines			25, 131	21. 00
22. 00	Rental of hospital space			966, 924	22. 00
23. 00	Governmental appropriations			0	23. 00
24.00	OTHER OPERATING REVENUE			882, 863	24. 00
24. 50	COVI D-19 PHE Funding			0	24. 50
25.00	Total other income (sum of lines 6-24)			3, 115, 453	25. 00
26.00	Total (line 5 plus line 25)			-6, 651, 472	26. 00
	OTHER EXPENSES (SPECIFY)			0	27. 00
	Total other expenses (sum of line 27 and subscripts)			0	28. 00
	Net income (or loss) for the period (line 26 minus line 28)			-6, 651, 472	29. 00
			·	'	

Heal th	Financial Systems FRANCISCAN HEA	LTH MUNSTER	In Lie	u of Form CMS-2	2552-10
	ATION OF CAPITAL PAYMENT	Provi der CCN: 15-0165	Peri od: From 01/01/2023 To 12/31/2023	Worksheet L Parts I-III Date/Time Pre 5/28/2024 2:1	pared:
		Title XVIII	Hospi tal	PPS	
	PART I - FULLY PROSPECTIVE METHOD			1. 00	
	CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier			1, 082, 026	1.00
1. 01	Model 4 BPCI Capital DRG other than outlier			0 1,002,020	1.01
2.00	Capital DRG outlier payments			23, 941	2.00
2.01	Model 4 BPCI Capital DRG outlier payments			0	2. 01
3.00	Total inpatient days divided by number of days in the cost	reporting period (see inst	ructions)	45. 36	3. 00
4.00	Number of interns & residents (see instructions)			0.00	
5.00	Indirect medical education percentage (see instructions)			0.00	
6. 00	Indirect medical education adjustment (multiply line 5 by to 1.01) (see instructions)	ne sum of lines I and 1.01	, columns I and	0	6. 00
7.00	Percentage of SSI recipient patient days to Medicare Part A	patient days (Worksheet E	E, part A line	0. 00	7. 00
8. 00	30) (see instructions) Percentage of Medicaid patient days to total days (see inst	ruetions)		0.00	8. 00
9. 00	Sum of lines 7 and 8	ructions)		0.00	
10. 00	Allowable disproportionate share percentage (see instruction	ns)		0.00	
11. 00					11.00
12.00	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1				12.00
				1. 00	
4 00	PART II - PAYMENT UNDER REASONABLE COST				1 4 00
1. 00 2. 00	Program inpatient routine capital cost (see instructions) Program inpatient ancillary capital cost (see instructions)			0	1. 00 2. 00
3. 00	Total inpatient program capital cost (see instructions)			0	3.00
4. 00	Capital cost payment factor (see instructions)			0	4.00
5. 00	Total inpatient program capital cost (line 3 x line 4)			0	
				1. 00	
1 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS			0	1 00
1. 00 2. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstal	ncas (saa instructions)		0	1. 00 2. 00
3.00	Net program inpatient capital costs (line 1 minus line 2)	nices (see mistractions)		0	3.00
4.00	Applicable exception percentage (see instructions)			0.00	
5.00	Capital cost for comparison to payments (line 3 x line 4)			0	5. 00
6.00	Percentage adjustment for extraordinary circumstances (see	instructions)		0.00	6. 00
7.00	Adjustment to capital minimum payment level for extraordina	ry circumstances (line 2 >	(line 6)	0	
8.00	Capital minimum payment level (line 5 plus line 7)			0	8. 00
9.00	Current year capital payments (from Part I, line 12, as app			0	9.00
10.00	Current year comparison of capital minimum payment level to	1 1 3 1	,	0	10.00
11. 00	Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14)	capital payment (from pri	oi yeai	0	11. 00
12. 00	Net comparison of capital minimum payment level to capital	payments (line 10 plus lir	ne 11)	0	12. 00
13.00	Current year exception payment (if line 12 is positive, ent			0	13. 00
14.00	Carryover of accumulated capital minimum payment level over	capital payment for the f	following period	0	14. 00
4= 0-	(if line 12 is negative, enter the amount on this line)			_	45.00
15.00		nstructions)		0	15.00
	Current year operating and capital costs (see instructions) Current year exception offset amount (see instructions)			0	16. 00 17. 00
17.00	Tourient year exception oriset amount (see instructions)		'	O	17.00