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: 15-0022 Worksheet S Peri od: From 01/01/2022 Parts I-III AND SETTLEMENT SUMMARY 12/31/2022 Date/Time Prepared: 5/30/2023 4:12 pm PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 5/30/2023 4: 12 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] Initial 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 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 CRAWFORDSVILLE (15-0022) for the cost reporting period beginning 01/01/2022 and ending 12/31/2022 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINA	NCIAL OFFICER OR ADMINISTRATOR	CHECKBOX		
		1	2	SI GNATURE STATEMENT	
1				I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name				2
3	Signatory Title	CF0			3
4	Date				4

			Title	XVIII			
		Title V	Part A	Part B	HI T	Title XIX	
		1. 00	2.00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPI TAL	0	-86, 881	-51, 075	0	7, 400, 789	1.00
2.00	SUBPROVI DER - I PF	0	-819	12		8, 845	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	-87, 700	-51, 063	0	7, 409, 634	200.00
	TOTAL ove amounts represent "due to" or "due from"	the applicable		. ,			200. 00

the applicable program for 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.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0022 Peri od: Worksheet S-2 From 01/01/2022 Part I Date/Time Prepared: 12/31/2022 5/30/2023 4:12 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 1710 LAFAYETTE ROAD 1.00 PO Box: 1.00 State: IN 2.00 City: CRAWFORDSVILLE Zip Code: 47933 County 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, 0, or N) Number Number Certi fi ed Type XVIII XIX 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 Hospi tal FRANCISCAN HEALTH 150022 99915 01/01/1966 Ν Р 0 3.00 1 CRAWFORDSVI LLE 99915 Р 4.00 Subprovider - IPF FRANCISCAN HEALTH 15S022 4 01/01/1995 N 0 4 00 CRAWFORDSVILLE PSY 5.00 Subprovider - IRF 5.00 6.00 Subprovider - (Other) 6.00 Swi ng Beds - SNF Swi ng Beds - NF 7 00 7.00 8.00 8.00 9.00 Hospi tal -Based SNF 9.00 Hospi tal -Based NF 10.00 10.00 Hospi tal -Based OLTC 11.00 11.00 12.00 Hospi tal -Based HHA 12.00 Separately Certified ASC 13.00 13.00 14.00 Hospi tal -Based Hospi ce 14 00 15.00 Hospital-Based Health Clinic - RHC 15.00 16.00 Hospital-Based Health Clinic - FQHC 16.00 17.00 Hospital -Based (CMHC) I 17.00 17. 10 Hospital - Based (CORF) I 17.10 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From To: 1.00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2022 12/31/2022 20.00 21.00 Type of Control (see instructions) 21.00 1.00 2.00 3.00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for N N 22.00 disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim UCPs, including supplemental UCPs, for Ν 22.01 this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Is this a newly merged hospital that requires a final UCP to be 22.02 Ν 22.02 determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to Ν Ν Ν 22.03 rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 22.04 Did this hospital receive a geographic reclassification from urban to 22.04 rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for ves or "N" for no. 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 0 23 00 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.

25. 00	out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. If this provider is an IRF, enter the in-state 0 0 0 Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0		0		25. 00	
		Urban/Ru 1.00		Date of		1	
26. 00	Enter your standard geographic classification (not wage) status at the beginning of the	1.00	2	2. (JU	26. 00	
27. 00	cost reporting period. Enter "1" for urban or "2" for rural. Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable,		2			27. 00	
35. 00	enter the effective date of the geographic reclassification in column 2. If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.		0			35. 00	
		Begi nni 1. 00		Endi 2. (4	
36. 00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number	1.00		2. (36. 00	
37. 00	of periods in excess of one and enter subsequent dates. If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.		1			37. 00	
37. 01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)					37. 01	
38. 00	00 If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is 01/01/2022 greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.						
	onto subsequent dates.	Y/N		Y/			
39. 00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in	1. 00 Y)	2. (Y		39. 00	
40. 00	accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions) .00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" N "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for						
	no in column 2, for discharges on or after October 1. (see instructions)		l v	XVIII	XIX		
			1.00	2. 00	3.00	1	
45.00	Prospective Payment System (PPS)-Capital		T N	l N	l NI	45.00	
45.00	Does this facility qualify and receive Capital payment for disproportionate share in acc with 42 CFR Section §412.320? (see instructions)	cordance	N	N	N	45. 00	
46. 00	Is this facility eligible for additional payment exception for extraordinary circumstand pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I Pt. III.		N	N	N	46. 00	
	ls this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" folls the facility electing full federal capital payment? Enter "Y" for yes or "N" for no		N N	N N	N N	47. 00 48. 00	
56. 00	Teaching Hospitals Is this a hospital involved in training residents in approved GME programs? For cost reperiods beginning prior to December 27, 2020, enter "Y" for yes or "N" for no in column cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b)(3) the instructions. For column 2, if the response to column 1 is "Y", or if this hospital involved in training residents in approved GME programs in the prior year or penultimate and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction	1. For 2), see was e year,	N			56. 00	
57. 00	"Y" for yes; otherwise, enter "N" for no in column 2. For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, is this the first cost reporting period during which residents in approved GME programs at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", did residents start training in the first month of this cost reporting period? Enter "Y" for "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N",	is yes, trained or yes or				57. 00	
F0. 00	complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting perbeginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regard which month(s) of the cost report the residents were on duty, if the response to line 5 for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Workshee If line 56 is yes, did this facility elect cost reimbursement for physicians' services and complete was serviced.	iods less of 6 is "Y" t E-4.	N			58. 00	

	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 Se	rvices Administration (HRSA)					
62.00	62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which							
	your hospital received HRSA PCRE funding (see instructions)							
62.01 Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital						62. 01		
	during in this cost reporting period of HRSA THC proj	gram. (see instructions))					
	Teaching Hospitals that Claim Residents in Nonprovid	er Settings						
63.00	Has your facility trained residents in nonprovider se	ettings during this cost	t reporting p	eriod? Enter	N	63.00		
	"Y" for yes or "N" for no in column 1. If yes, comple	ete lines 64 through 67.	. (see instru	ctions)				

program specialty, if any, and the number of FTE residents for each expanded program. (see

Heal th	Financial Systems	FRANCI SCAN	HEALTH CRAWFORDSVILLE	Ē	In Lie	u of Form CMS-2	2552-10
	TAL AND HOSPITAL HEALTH CARE COMP	LEX IDENTIFICATION DA	TA Provider CC		riod: com 01/01/2022	Worksheet S-2 Part I	pared:
				Unwei ghted FTEs	Unweighted FTEs in	Ratio (col. 1/	
				Nonprovi der Si te	Hospi tal	2))	
				1. 00	2.00	3.00	
	Section 5504 of the ACA Base Year period that begins on or after J			This base year	is your cost r	reporting	
64. 00	Enter in column 1, if line 63 is in the base year period, the num resident FTEs attributable to rosettings. Enter in column 2 the resident FTEs that trained in you of (column 1 divided by (column	yes, or your facilit ber of unweighted nor tations occurring in number of unweighted ur hospital. Enter ir	ry trained residents n-primary care all nonprovider I non-primary care n column 3 the ratio	0.00	0. 00	0. 000000	64.00
		Program Name	Program Code	Unwei ghted FTEs	Unweighted FTEs in	Ratio (col. 3/ (col. 3 + col.	
				Nonprovi der	Hospi tal	4))	
		1.00	2.00	Si te 3. 00	4. 00	5. 00	
65. 00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			Unwei ghted FTEs Nonprovi der Si te 1.00	Unweighted FTEs in Hospital	0.000000 Ratio (col. 1/ (col. 1 + col. 2))	65. 00
	Section 5504 of the ACA Current beginning on or after July 1, 20		n Nonprovider Setting:	sEffective fo	r cost reporti	ng peri ods	
66. 00	Enter in column 1 the number of FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 +	unweighted non-primar ccurring in all nonpr unweighted non-primar al. Enter in column 3 column 2)). (see ins	ovider settings. Ty care resident The thick the ratio of structions)	0.00	0.00		66. 00
		Program Name	Program Code	Unwei ghted FTEs	Unweighted FTEs in	Ratio (col. 3/ (col. 3 + col.	
				Nonprovi der Si te	Hospi tal	4))	
		1.00	2.00	3. 00	4.00	5. 00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0. 000000	67. 00

Ν

0.00

Ν

0.00

96.00

97.00

applicable column.

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

96.00

113.00 Miscellaneous Cost Reporting Information 115.00 s this an all-inclusive rate provider? Enter "Y" for yes or "N" for no N 0115.00 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 116. 00 "N" for no. 117.00 is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no. N 117. 00 118.00|s the mal practice insurance a claims-made or occurrence policy? Enter 1 118. 00 if the policy is claim-made. Enter 2 if the policy is occurrence.

146, 00

Ν

146.00 Has the cost allocation methodology changed from the previously filed cost report?

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

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

Health Financial Systems	FRANCI SCAN HEALTH	CRAWFORDSVI LLE	<u> </u>	In Lie	eu of Form CMS	-2552-10		
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	Provi der CC	Provider CCN: 15-0022 PF		Worksheet S-Part IDate/Time Pr5/30/2023 4:	epared:		
					1.00			
147.00 Was there a change in the statisti 148.00 Was there a change in the order of	fallocation? Enter "Y" for	r yes or "N" fo	or no.		N N	147. 00 148. 00		
149.00 Was there a change to the simplifi	ed cost finding method? Er				N	149. 00		
		Part A	Part B	Title V	Title XIX			
Does this facility contain a provi								
or charges? Enter "Y" for yes or '	'N" for no for each compone							
155. 00 Hospi tal		N	N	N	N	155. 00		
156. 00 Subprovi der – IPF		N	N	N	N	156. 00		
157.00 Subprovi der - I RF 158.00 SUBPROVI DER		N	N	N	N	157. 00 158. 00		
159. 00 SNF		N	N	N	N	159. 00		
160.00 HOME HEALTH AGENCY		N	N	N	N	160. 00		
161. 00 CMHC			N	N	N	161. 00		
161. 10 CORF			N	N	N	161. 10		
					1.00			
Multicampus								
165.00 s this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? N Enter "Y" for yes or "N" for no.								
	Name	County	State 2	Zi p Code CBSA	FTE/Campus			
	0	1. 00	2. 00	3. 00 4. 00	5. 00			
166.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)					0. 0	00 166. 00		
					1.00			
Health Information Technology (HI	I) inconting in the America	on Docovory on	d Doinyoctm	ont Act	1.00			
167.00 s this provider a meaningful user				ent Act	Υ	167. 00		
168.00 If this provider is a CAH (line 10 reasonable cost incurred for the h	05 is "Y") and is a meaning	gful user (line		'), enter the	!	168. 00		
168.01 If this provider is a CAH and is r	not a meaningful user, does	s this provider	qualify fo	or a hardship		168. 01		
exception under §413.70(a)(6)(ii)(169.00) If this provider is a meaningful transition factor. (see instructions)	user (line 167 is "Y") and	is not a CAH (line 105 is	s "N"), enter the	9. 9	95 169. 00		
transition ractor. (see instruction	JIIS)			Begi nni ng	Endi ng			
				1. 00	2.00			
170.00 Enter in columns 1 and 2 the EHR liperiod respectively (mm/dd/yyyy)	peginning date and ending o	date for the re	eporti ng			170. 00		
				1. 00	2, 00			
171.00 If line 167 is "Y", does this prov	/ider have anv davs for ind	di vi dual s enrol	led in	N N		0 171. 00		
section 1876 Medicare cost plans i "Y" for yes and "N" for no in colu 1876 Medicare days in column 2. (s	reported on Wkst. S-3, Pt. umn 1. If column 1 is yes,	I, line 2, col	. 6? Enter					

Heal th	Financial Systems FRANCISCAN HEALTH	I CRAWFORDSVILL	F	In Lie	u of Form CMS-	2552-10			
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CN: 15-0022	Peri od: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part II Date/Time Pre	pared:			
				Y/N	5/30/2023 4:1 Date	2 pm			
				1. 00	2. 00				
	PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSE General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS			r all dates in 1	the				
1. 00	Provider Organization and Operation Has the provider changed ownership immediately prior to the reporting period? If yes, enter the date of the change in a			N		1.00			
			Y/N	Date	V/I				
2.00	Has the provider terminated participation in the Medicare F	Program2 If	1.00 N	2. 00	3. 00	2.00			
	yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.	mn 3, "V" for	Y						
3.00	Is the provider involved in business transactions, includir contracts, with individuals or entities (e.g., chain home or medical supply companies) that are related to the provide officers, medical staff, management personnel, or members of directors through ownership, control, or family and other relationships? (see instructions)			3.00					
			Y/N	Туре	Date				
	Financial Data and Reports		1.00	2. 00	3. 00				
4.00	Column 1: Were the financial statements prepared by a Certified Public Y A 05/ 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	those on the filed financial statements? If yes, submit rec		IN IN			5. 00			
			•	Y/N	Legal Oper.				
	Approved Educational Activities			1. 00	2. 00				
6. 00									
7. 00 8. 00									
9.00	O Are costs claimed for Interns and Residents in an approved graduate medical education N								
10. 00	program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated cost reporting period? If yes, see instructions.		he current	N		10. 00			
11. 00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	proved	N		11. 00			
					Y/N				
	Bad Debts				1. 00				
	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection μ			st reporting	Y N	12. 00 13. 00			
14. 00	period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or coinsuratinstructions.	ance amounts wa	nived? If yes,	see	N	14. 00			
15. 00	Bed Complement Did total beds available change from the prior cost reporti	,			N	15. 00			
		Y/N	t A Date	Y/N	t B Date				
		1.00	2.00	3. 00	4. 00				
4/	PS&R Data		1			4			
16. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see instructions)	N		N		16. 00			
17. 00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	04/05/2023	Y	04/05/2023	17. 00			
18. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18. 00			
19. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19. 00			

Heal th	Financial Systems FRANCISCAN HEALTH	CRAWFORDSVI LL	E	In Lie	u of Form CMS-:	2552-10
	HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CN: 15-0022	Peri od: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part II Date/Time Pre 5/30/2023 4:1	pared:
			i pti on	Y/N	Y/N	
20.00	16 1: 1/ 17 :		0	1.00	3. 00 N	20.00
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	IN	20. 00
	The part of the strict and the strict and activities	Y/N	Date	Y/N	Date	
		1.00	2.00	3. 00	4. 00	
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21. 00
					1. 00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEP	PT CHILDRENS H	IOSPI TALS)			
	Capital Related Cost					
22. 00	Have assets been relifed for Medicare purposes? If yes, see				N	22. 00
23. 00	Have changes occurred in the Medicare depreciation expense of reporting period? If yes, see instructions.	due to apprais	sais made dur	ing the cost	N	23. 00
24. 00	Were new leases and/or amendments to existing leases entered lifyes, see instructions	d into during	this cost re	porting period?	N	24. 00
25. 00	Have there been new capitalized leases entered into during instructions.	the cost repor	ting period?	If yes, see	N	25. 00
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during the instructions.	•	0 .		N	26. 00
27. 00	Has the provider's capitalization policy changed during the copy.	yes, submit	N	27. 00		
28. 00	<pre>Interest Expense Were new Loans, mortgage agreements or Letters of credit ent period? If yes, see instructions.</pre>	N	28. 00			
29. 00	Did the provider have a funded depreciation account and/or betreated as a funded depreciation account? If yes, see instru	eserve Fund)	Υ	29. 00		
30. 00	Has existing debt been replaced prior to its scheduled maturinstructions.	, see	N	30. 00		
31. 00	Has debt been recalled before scheduled maturity without issinstructions.	, see	N	31. 00		
32. 00	Purchased Services Have changes or new agreements occurred in patient care serv	ntractual	N	32. 00		
33. 00	arrangements with suppliers of services? If yes, see instruction 1f line 32 is yes, were the requirements of Sec. 2135.2 applino, see instructions.		ng to competi	tive bidding? If	N	33. 00
	Provi der-Based Physi ci ans					
34. 00	Were services furnished at the provider facility under an an	rrangement wit	h provider-b	ased physicians?	Υ	34. 00
35. 00	If yes, see instructions. If line 34 is yes, were there new agreements or amended exist physicians during the cost reporting period? If yes, see instructions.		nts with the p	provi der-based	N	35. 00
	phrysicians during the cost reporting period: 11 yes, see this	structions.		Y/N	Date	
				1. 00	2. 00	
2/ 20	Home Office Costs					2/ 00
36. 00 37. 00	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pro-	enared by the	home office?	Y		36. 00 37. 00
37.00	If yes, see instructions.	epared by the	nome office:	· ·		37.00
38. 00	If line 36 is yes, was the fiscal year end of the home offithe provider? If yes, enter in column 2 the fiscal year end			N		38. 00
39. 00	If line 36 is yes, did the provider render services to other see instructions.	r chain compor	ents? If yes	, N		39. 00
40. 00	If line 36 is yes, did the provider render services to the linstructions.	home office?	If yes, see	N		40. 00
		1	00	2.	00	
	Cost Report Preparer Contact Information	1.		2.	-	
41. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	HONG		YANG		41. 00
42. 00		FRANCISCAN HEA	LTH			42. 00
43. 00	preparer. Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	219-407-6568 X	76568	HONG. YANG@FRANG . ORG	CI SCANALLI ANCE	43. 00
					'	

Heal th	Financial Systems FRANCISCA	AN HEALTH	I CRAWFORDSVILLE	<u> </u>	In Lie	u of Form CMS-	2552-10
HOSPI 7	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONN	IAI RE	Provi der CC		Peri od:	Worksheet S-2	!
					From 01/01/2022 To 12/31/2022	Date/Time Pre 5/30/2023 4:1	pared: 2 pm
			3. (20			
			3. (JU			
	Cost Report Preparer Contact Information						
41.00	Enter the first name, last name and the title/posi	tion	ADMIN DIR GVT (COST RPT &			41.00
	held by the cost report preparer in columns 1, 2, a	and 3.	REIMB				
	respectively.						
42 00	Enter the employer/company name of the cost report						42.00
42.00							72.00
	preparer.						
43.00	Enter the telephone number and email address of the	e cost					43. 00
	report preparer in columns 1 and 2, respectively.						

 Heal th
 Financial
 Systems
 FRANCISCAN
 HEALTH
 CRAWFORDSVILLE

 HOSPITAL
 AND
 HOSPITAL
 HEALTH
 CARE
 COMPLEX
 STATISTICAL
 DATA
 Provider
 CCN
 In Lieu of Form CMS-2552-10 Provider CCN: 15-0022

						12/31/2022	5/30/2023 4: 1	
							I/P Days / O/P	
							Visits / Trips	
	Component	Worksheet A	No.	of Beds	Bed Days	CAH Hours	Title V	
	·	Li ne No.			Avai I abl e			
		1. 00		2. 00	3. 00	4. 00	5. 00	
	PART I - STATISTICAL DATA							
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		24	8, 760	0.00	0	1. 00
	8 exclude Swing Bed, Observation Bed and							
	Hospice days) (see instructions for col. 2							
	for the portion of LDP room available beds)							
2.00	HMO and other (see instructions)							2. 00
3.00	HMO IPF Subprovider							3. 00
4.00	HMO IRF Subprovider							4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF						0	5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						0	6. 00
7.00	Total Adults and Peds. (exclude observation			24	8, 760	0.00	0	7. 00
	beds) (see instructions)							
8.00	INTENSIVE CARE UNIT	31. 00		5	1, 825	0.00		8. 00
9.00	CORONARY CARE UNIT	32. 00		0	0	0.00		9. 00
10.00	BURN INTENSIVE CARE UNIT	33. 00		0	0	0.00	0	10.00
11. 00	SURGICAL INTENSIVE CARE UNIT	34. 00		0	0	0.00	0	11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)							12.00
13.00	NURSERY	43.00					0	13.00
14.00	Total (see instructions)			29	10, 585	0.00	0	14.00
15.00	CAH visits						0	15. 00
16.00	SUBPROVI DER - I PF	40. 00		11	4, 015		0	16. 00
17.00	SUBPROVI DER - I RF	41. 00		0	0		0	17. 00
18.00	SUBPROVI DER							18. 00
19.00	SKILLED NURSING FACILITY	44. 00		0	0		0	19. 00
20.00	NURSING FACILITY	45. 00		0	0		0	20.00
21.00	OTHER LONG TERM CARE	46. 00		0	0			21. 00
22.00	HOME HEALTH AGENCY	101. 00					0	22. 00
23.00	AMBULATORY SURGICAL CENTER (D. P.)	115. 00						23. 00
24.00	HOSPI CE	116. 00		O	0			24. 00
24. 10	HOSPICE (non-distinct part)	30. 00						24. 10
25.00	CMHC - CMHC	99. 00					0	25. 00
25. 10	CMHC - CORF	99. 10					0	25. 10
26.00	RURAL HEALTH CLINIC	88. 00					0	26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00					0	26. 25
27.00	Total (sum of lines 14-26)			40				27. 00
28. 00	Observation Bed Days						0	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)			o	0			32. 00
32. 01	Total ancillary labor & delivery room							32. 01
	outpatient days (see instructions)							
33.00	LTCH non-covered days							33. 00
	LTCH site neutral days and discharges							33. 01
	Temporary Expansion COVID-19 PHE Acute Care	30. 00		0	0		0	34.00
			'	- 1	-1			

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-0022

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

5/30/2023 4:12 pm Full Time Equivalents I/P Days / O/P Visits / Trips 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 2, 980 Hospital Adults & Peds. (columns 5, 6, 7 and 1.00 1, 182 80 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) 1, 152 2.00 3.00 HMO IPF Subprovider 372 3.00 4.00 HMO IRF Subprovider 0 4.00 0 Hospital Adults & Peds. Swing Bed SNF 5.00 0 0 0 5.00 6.00 Hospital Adults & Peds. Swing Bed NF 6.00 Total Adults and Peds. (exclude observation 7.00 1, 182 80 2,980 7.00 beds) (see instructions) INTENSIVE CARE UNIT 8.00 94 283 819 8.00 9.00 CORONARY CARE UNIT 0 C 0 9.00 10.00 BURN INTENSIVE CARE UNIT 0 0 10.00 11.00 SURGICAL INTENSIVE CARE UNIT 0 0 0 11.00 OTHER SPECIAL CARE (SPECIFY) 12.00 12.00 13.00 NURSERY C 13.00 Total (see instructions) 14.00 1, 465 174 3, 799 0.00 161.58 14.00 15.00 CAH visits C C 15.00 SUBPROVIDER - IPF 0 16.00 1,022 1,700 0.00 11.15 16.00 SUBPROVIDER - IRF 17.00 0 0 0 0.00 0.00 17.00 18.00 SUBPROVI DER 18.00 19 00 SKILLED NURSING FACILITY 0 Ω O 0 00 0.00 19 00 0.00 20.00 NURSING FACILITY C 0 0.00 20.00 21.00 OTHER LONG TERM CARE 0 0.00 0.00 21.00 22.00 HOME HEALTH AGENCY 0 0 0 0.00 0.00 22.00 AMBULATORY SURGICAL CENTER (D. P.) 23.00 0.00 23.00 0.0024.00 HOSPI CE 0 0 0 0.00 0.00 24.00 HOSPICE (non-distinct part) 0 24. 10 24. 10 25.00 CMHC - CMHC 0 0 0 0 0 0.00 0.00 25.00 CMHC - CORF 0 0.00 25.10 Ω 0.00 25. 10 26.00 RURAL HEALTH CLINIC 0 0 0.00 0.00 26.00 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 0 0.00 0.00 26.25 Total (sum of lines 14-26) 0.00 27.00 172.73 27.00 28 00 Observation Bed Days 180 1, 407 28 00 29. 00 Ambul ance Trips 0 29.00 30.00 Employee discount days (see instruction) 30.00 0 Employee discount days - IRF 0 31.00 31.00 32.00 Labor & delivery days (see instructions) 0 0 0 32.00 Total ancillary labor & delivery room 0 32.01 32.01 outpatient days (see instructions) 33.00 33.00 LTCH non-covered days 33.01 LTCH site neutral days and discharges 33.01 34.00 Temporary Expansion COVID-19 PHE Acute Care 0 34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-0022

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

5/30/2023 4:12 pm Full Time Di scharges Equi val ents Title XVIII Total All Component Nonpai d Title V Title XIX Workers Pati ents 14.00 15.00 12.00 13.00 11.00 PART I - STATISTICAL DATA Hospital Adults & Peds. (columns 5, 6, 7 and 1.00 443 84 946 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) 297 2.00 3.00 HMO IPF Subprovider 0 3.00 4.00 HMO IRF Subprovider ol 4.00 Hospital Adults & Peds. Swing Bed SNF 5.00 5.00 6.00 Hospital Adults & Peds. Swing Bed NF 6.00 Total Adults and Peds. (exclude observation 7.00 7.00 beds) (see instructions) INTENSIVE CARE UNIT 8.00 8.00 9.00 CORONARY CARE UNIT 9.00 10.00 BURN INTENSIVE CARE UNIT 10.00 11.00 SURGICAL INTENSIVE CARE UNIT 11.00 OTHER SPECIAL CARE (SPECIFY) 12.00 12.00 13.00 NURSERY 13.00 Total (see instructions) 946 14.00 14.00 0.00 443 84 CAH visits 15.00 15.00 SUBPROVIDER - I PF SUBPROVIDER - I RF 16.00 83 0.00 51 0 16.00 17.00 0.00 C 0 17.00 SUBPROVI DER 18.00 18.00 19 00 SKILLED NURSING FACILITY 0 00 19 00 NURSING FACILITY 20.00 0.00 20.00 21.00 OTHER LONG TERM CARE 0.00 0 21.00 HOME HEALTH AGENCY 22.00 0.00 22.00 AMBULATORY SURGICAL CENTER (D. P.) 23.00 0 00 23 00 24.00 HOSPI CE 0.00 24.00 24. 10 HOSPICE (non-distinct part) 24. 10 25. 00 CMHC - CMHC 0.00 25.00 25. 10 CMHC - CORF 25. 10 0.00 26.00 RURAL HEALTH CLINIC 0.00 26.00 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 0.00 26.25 Total (sum of lines 14-26) 0.00 27.00 27.00 28 00 Observation Bed Days 28 00 29. 00 Ambul ance Trips 29.00 30.00 Employee discount days (see instruction) 30.00 Employee discount days - IRF 31.00 31.00 32.00 Labor & delivery days (see instructions) 32.00 Total ancillary labor & delivery room 32.01 32.01 outpatient days (see instructions) 33.00 LTCH non-covered days 33.00 0 33.01 LTCH site neutral days and discharges 0 33.01 34.00 Temporary Expansion COVID-19 PHE Acute Care 34.00

| Peri od: | Worksheet S-3 | From 01/01/2022 | Part II | To 12/31/2022 | Date/Time Prepared: Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0022

					To	12/31/2022	Date/Time Prep 5/30/2023 4:12	
		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries		Paid Hours Related to	Average Hourly Wage (col. 4 ÷	2 (2)
			Nopol tou	(from Wkst.	(col.2 ± col.	Salaries in	col . 5)	
		1. 00	2. 00	A-6) 3.00	3) 4.00	<u>col . 4</u> 5. 00	6. 00	
	PART II - WAGE DATA							
1. 00	SALARIES Total salaries (see	200. 00	19, 370, 638	869, 889	20, 240, 527	536, 914. 00	37. 70	1. 00
	instructions)	200.00						
2. 00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2. 00
3.00	Non-physician anesthetist Part		0	0	О	0.00	0.00	3. 00
4. 00	Physician-Part A -		0	О	О	0.00	0.00	4. 00
4. 01	Administrative Physicians - Part A - Teaching		0	О	О	0.00		4. 01
5. 00	Physician and Non Physician-Part B		0	0	0	0.00	0.00	5. 00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0. 00	6. 00
7. 00	Interns & residents (in an approved program)	21. 00	0	0	0	0.00	0. 00	7. 00
7. 01	Contracted interns and residents (in an approved		0	0	0	0.00	0. 00	7. 01
8. 00	programs) Home office and/or related organization personnel		4, 792, 197	0	4, 792, 197	140, 019. 00	34. 23	8. 00
9. 00 10. 00	SNF Excluded area salaries (see	44. 00	0 3, 476, 838	0		0. 00 48, 340. 00		9. 00 10. 00
	instructions) OTHER WAGES & RELATED COSTS							
11. 00	Contract Labor: Direct Patient		3, 260, 011	0	3, 260, 011	24, 209. 00	134. 66	11. 00
12. 00	Care Contract Labor: Top Level		0	0	0	0.00	0. 00	12. 00
	management and other management and administrative services							
13. 00	Contract Labor: Physician-Part A - Administrative		3, 297, 987	0	3, 297, 987	20, 211. 00	163. 18	13. 00
14. 00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0. 00	14. 00
14. 01	Home office salaries		4, 305, 950	0	4, 305, 950	125, 839. 00		14. 01
14. 02 15. 00	Related organization salaries Home office: Physician Part A		0	0	0	0. 00 0. 00		14. 02 15. 00
	- Administrative							
16. 00	Home office and Contract Physicians Part A - Teaching		U	0	U	0.00	0.00	16. 00
16. 01	Home office Physicians Part A - Teaching		0	0	0	0.00	0. 00	16. 01
16. 02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16. 02
	WAGE-RELATED COSTS							
17. 00	Wage-related costs (core) (see instructions)		3, 071, 647	0	3, 071, 647			17. 00
18. 00	Wage-related costs (other) (see instructions)							18. 00
19. 00 20. 00	Excluded areas Non-physician anesthetist Part		663, 377 0	0	663, 377 0			19. 00 20. 00
21. 00	A Non-physician anesthetist Part		0	0	0			21. 00
22. 00	B Physician Part A -		0	0	0			22. 00
22. 01	Administrative Physician Part A - Teaching		0	o	О			22. 01
23. 00	Physician Part B		0	0	0			23. 00
24. 00 25. 00	Wage-related costs (RHC/FQHC) Interns & residents (in an		0	0	0			24. 00 25. 00
25. 50	approved program) Home office wage-related		1, 316, 233	0	1, 316, 233			25. 50
25. 51	(core) Related organization		0	0	0			25. 51
25. 52	wage-related (core) Home office: Physician Part A		0					25. 52
20.02	- Administrative - wage-related (core)		U					ZJ. JZ

Provi der CCN: 15-0022

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

Wkst. A Line Amount Reclassificati on of Salaries (from Wkst. A-6) Salaries and col. 4 Salaries (col. 2 ± col. Salaries in col. 5)	
Number Reported on of Salaries Salaries Related to Wage (col. 4 ÷ (from Wkst. (col.2 ± col. Salaries in col. 5)	
() () () () () () ()	
A-0) 3) COI. 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 SALARIES	
	26. 00
	27.00
28. 00 Administrative & General under 257, 170 0 257, 170 2, 051. 00 125. 39	28. 00
contract (see inst.)	
	29. 00
30. 00 Operation of Plant 7. 00 352, 740 0 352, 740 13, 189. 00 26. 75	30.00
31. 00 Laundry & Linen Service 8. 00 15, 607 0 15, 607 927. 00 16. 84	31. 00
32. 00 Housekeepi ng 9. 00 0 0 0. 00 0. 00	
	33.00
(see instructions)	
	34.00
35.00 Di etary under contract (see 0 0 0 0 0.00 0.00	35.00
instructions)	
	36. 00
	37.00
38. 00 Nursi ng Admi ni strati on 13. 00 155, 851 283, 248 439, 099 18, 735. 00 23. 44	38. 00
39.00 Central Services and Supply 14.00 81,174 0 81,174 2,241.00 36.22	39. 00
40.00 Pharmacy 15.00 390,658 0 390,658 8,352.00 46.77	40.00
41.00 Medical Records & Medical 16.00 0 0 0 0.00 0.00	41.00
Records Li brary	
	42.00
43.00 Other General Service 18.00 0 0 0.00 0.00	43.00

Total overhead cost (see

instructions)

7.00

32. 48

7.00

HOSPITAL WAGE INDEX INFORMATION Worksheet S-3 Part III Date/Time Prepared: Provi der CCN: 15-0022 Peri od: From 01/01/2022 To 12/31/2022 5/30/2023 4:12 pm Worksheet A Amount Recl assi fi cati Adj usted Pai d Hours Average Hourly Line Number Reported on of Salaries Sal ari es Related to Wage (col. 4 ÷ (col . 2 ± col . col. 5) (from Salaries in Works<u>heet A-6)</u> 3) col. 4 1.00 5.00 6.00 2.00 3.00 4.00 PART III - HOSPITAL WAGE INDEX SUMMARY 1.00 Net salaries (see 14, 835, 611 869, 889 15, 705, 500 398, 946. 00 39. 37 1.00 instructions) 2.00 3, 476, 838 3, 476, 838 48, 340. 00 71. 92 2.00 Excluded area salaries (see 0 instructions) 3.00 Subtotal salaries (line 1 11, 358, 773 869, 889 12, 228, 662 350, 606. 00 34.88 3.00 minus line 2) 4.00 Subtotal other wages & related 10, 863, 948 10, 863, 948 170, 259. 00 63.81 4.00 costs (see inst.) Subtotal wage-related costs 5.00 4, 387, 880 C 4, 387, 880 0.00 35. 88 5.00 (see inst.) Total (sum of lines 3 thru 5) 6.00 6.00 26, 610, 601 869, 889 27, 480, 490 520, 865. 00 52. 76

6, 786, 243

869, 889

7, 656, 132

235, 693. 00

Health Financial Systems	FRANCISCAN HEALTH CRAWFORDSVILLE	In Lie	u of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 15-0022	Peri od: From 01/01/2022	Worksheet S-3 Part IV
		To 12/31/2022	Date/Time Prepared:

	To 12/31/2022	Date/Time Prep 5/30/2023 4:1:	
		Amount	
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	471, 962	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)	680, 087	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)	1, 550, 084	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	66, 799	10.00
11. 00	Life Insurance (If employee is owner or beneficiary)	0	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)	0	13. 00
14. 00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14. 00
15. 00	'Workers' Compensation Insurance	0	15. 00
16. 00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16. 00
	Noncumulative portion)		
	TAXES		
17.00	FICA-Employers Portion Only	966, 092	17. 00
18.00	Medicare Taxes - Employers Portion Only	0	18. 00
19.00	Unempl oyment Insurance	0	19. 00
20.00	State or Federal Unemployment Taxes	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))		
	Day Care Cost and Allowances	0	22. 00
	Tuition Reimbursement	0	23. 00
24. 00	Total Wage Related cost (Sum of lines 1 -23)	3, 735, 024	24. 00
	Part B - Other than Core Related Cost		
25. 00	OTHER WAGE RELATED COSTS (SPECIFY)		25. 00

Health Financial Systems	FRANCISCAN HEALTH CRAWFORDSVILLE	In Lie	u of Form CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provi der CCN: 15-0022	Peri od:	Worksheet S-3
		From 01/01/2022	

		To 12/31/2022		
	Cook Contag Description	C	5/30/2023 4: 1	2 pm
	Cost Center Description	Contract Labor		
	DADT V. O. I. I. I. I. D. CI I. O. I.	1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost			
4 00	Hospital and Hospital -Based Component I dentification:			
1.00	Total facility's contract labor and benefit cost	0	0	1.00
2.00	Hospi tal	0	0	2. 00
3. 00	SUBPROVI DER - I PF	0	0	3. 00
4.00	SUBPROVI DER - I RF	0	0	4. 00
5. 00	Subprovider - (Other)	0	0	5. 00
6.00	Swing Beds - SNF	0	0	6. 00
7.00	Swing Beds - NF	0	0	7. 00
8.00	SKILLED NURSING FACILITY	0	0	8. 00
9.00	NURSING FACILITY	0	0	9. 00
10.00	OTHER LONG TERM CARE I			10.00
11. 00	Hospi tal -Based HHA	0	0	11. 00
12.00	AMBULATORY SURGICAL CENTER (D.P.) I	0	0	12.00
13.00	Hospi tal -Based Hospi ce	0	0	13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14. 00
15. 00	Hospital-Based Health Clinic FQHC	0	0	15. 00
16.00	Hospi tal -Based-CMHC	0	0	16. 00
	Hospi tal -Based-CMHC 10	0	0	16. 10
	RENAL DIALYSIS I	0	0	17. 00
	Other	0	0	18. 00

Heal th	Financial Systems FRANCISC	CAN HEALTH CRAWFORDSVILL	E	In Lie	u of Form CMS-2	2552-10
	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provi der Co		Peri od:	Worksheet S-10	
				From 01/01/2022	Doto/Time Dro	nonod.
				To 12/31/2022	Date/Time Prep 5/30/2023 4:1:	pareu: 2 pm
	Uncompensated and indigent care cost computation				1. 00	
1.00	Cost to charge ratio (Worksheet C, Part I line 20:	2 column 3 divided by li	ne 202 column	8)	0. 204979	1. 00
	Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid				7, 205, 618	2.00
3.00	Did you receive DSH or supplemental payments from		a from Madias	: 40	N	3.00
4. 00 5. 00	If line 3 is yes, does line 2 include all DSH and. If line 4 is no, then enter DSH and/or supplement:			ı u ?	0	4. 00 5. 00
6. 00	Medi cai d charges	ar payments from mearear	u		44, 246, 818	6.00
7. 00	Medicaid cost (line 1 times line 6)				9, 069, 669	7. 00
8.00	Difference between net revenue and costs for Medic	caid program (line 7 min	us sum of lir	es 2 and 5; if	1, 864, 051	8. 00
	< zero then enter zero)		,			
0.00	Children's Health Insurance Program (CHIP) (see in	nstructions for each lin	e)		0	0.00
9. 00 10. 00	Net revenue from stand-alone CHIP Stand-alone CHIP charges				0	9. 00 10. 00
11. 00	Stand-alone CHIP cost (line 1 times line 10)				0	
12. 00	Difference between net revenue and costs for stand	d-alone CHIP (line 11 mi	nus line 9: i	f < zero then	0	12.00
	enter zero)					
	Other state or local government indigent care pro					
13.00	Net revenue from state or local indigent care pro	5 ``		,		13.00
14. 00	Charges for patients covered under state or local 10)	indigent care program (Not included	in lines 6 or	0	14. 00
15. 00		times line 14)			0	15. 00
16. 00	Difference between net revenue and costs for state		program (lir	e 15 minus line	0	16.00
	13; if < zero then enter zero)					
	Grants, donations and total unreimbursed cost for instructions for each line)	Medicaid, CHIP and stat	e/local indig	ent care progran	ns (see	
17. 00	·	stricted to funding char	itv care		0	17. 00
18. 00	Government grants, appropriations or transfers for	· ·	,		0	18. 00
19. 00	Total unreimbursed cost for Medicaid , CHIP and s	tate and local indigent	care programs	(sum of lines	1, 864, 051	19. 00
	8, 12 and 16)		Uni nsured	Insured	Total (col. 1	
			patients	patients	+ col . 2)	
			1.00	2. 00	3. 00	
	Uncompensated Care (see instructions for each line					
20. 00	Charity care charges and uninsured discounts for	the entire facility		0 8, 000, 290	8, 000, 290	20. 00
21. 00	(see instructions) Cost of patients approved for charity care and uni	insured discounts (see		0 8, 000, 290	8, 000, 290	21 00
21.00	instructions)	riisurea arscourts (see		0,000,270	0,000,270	21.00
22. 00	Payments received from patients for amounts previous	ously written off as		0 0	0	22. 00
	charity care					
23. 00	Cost of charity care (line 21 minus line 22)			0 8, 000, 290	8, 000, 290	23. 00
					1. 00	
24. 00	Does the amount on line 20 column 2, include charge	ges for patient days bey	ond a Length	of stav limit	N N	24. 00
	imposed on patients covered by Medicaid or other	indigent care program?	-	•		25. 00
25.00	If line 24 is yes, enter the charges for patient of stay limit	aays beyond the margent	care program	i s rengtii ui		25.00
26. 00	Total bad debt expense for the entire hospital co				5, 906, 345	
27. 00	Medicare reimbursable bad debts for the entire ho				80, 724	1
27. 01	Medicare allowable bad debts for the entire hospi	tal complex (see instruc	tions)		124, 191	1
28. 00 29. 00	Non-Medicare bad debt expense (see instructions) Cost of non-Medicare and non-reimbursable Medicare	a had debt eynonso (soo	instructions)		5, 782, 154 1, 228, 687	
30. 00	Cost of uncompensated care (line 23 column 3 plus		111311 UCTI UIIS)		9, 228, 977	
	Total unreimbursed and uncompensated care cost (I	· ·			11, 093, 028	
		•			. '	

	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der Co	CN: 15-0022 F	Peri od:	Worksheet A	
					From 01/01/2022 To 12/31/2022	Date/Time Pre 5/30/2023 4:1	
	Cost Center Description	Sal ari es	Other		Recl assi fi cati	Recl assi fi ed	2 (2)
				+ col . 2)	ons (See A-6)	Trial Balance (col. 3 +-	
						col . 4)	
	CENEDAL CEDILLOS COCT CENTEDO	1.00	2. 00	3. 00	4. 00	5. 00	
1. 00	GENERAL SERVICE COST CENTERS OO100 CAP REL COSTS-BLDG & FIXT		194, 354	194, 354	1, 218, 597	1, 412, 951	1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		0	(3, 328, 405	2. 00
3.00	00300 OTHER CAP REL COSTS 00400 EMPLOYEE BENEFITS DEPARTMENT		0	2 7// 71/	<u> </u>	0	3.00
4. 00 5. 00	00500 ADMINISTRATIVE & GENERAL	0 5, 197, 054	3, 766, 714 12, 440, 408			3, 766, 956 15, 137, 823	4. 00 5. 00
6.00	00600 MAINTENANCE & REPAIRS	0	0	(0	0	6. 00
7.00	00700 OPERATION OF PLANT	352, 740	1, 872, 904				7.00
8. 00 9. 00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING	15, 607	150, 224 613, 447				8. 00 9. 00
10.00	01000 DI ETARY	335, 989	222, 736		-17, 195	541, 530	10. 00
11.00	01100 CAFETERI A	0	0	1	-, -, -, -,		11. 00
13. 00 14. 00	01300 NURSI NG ADMINI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	155, 851 81, 174	286, 369 149, 609			345, 556 176, 069	13. 00 14. 00
15. 00	01500 PHARMACY	390, 658	962, 667			420, 368	15. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	0	0	(0	0	16. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	1, 608, 260	1, 027, 183	2, 635, 443	-170, 395	2, 465, 048	30.00
31.00	03100 INTENSIVE CARE UNIT	962, 868	554, 258				31. 00
32.00	03200 CORONARY CARE UNIT	0	0	(0	0	32.00
33. 00 34. 00	03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT	0	0	(0	0	33. 00 34. 00
40. 00	04000 SUBPROVI DER - I PF	1, 155, 249	251, 667	1, 406, 916	-38, 621	1, 368, 295	40. 00
41. 00	04100 SUBPROVI DER - I RF	0	0	(0	0	41. 00
43. 00 44. 00	04300 NURSERY 04400 SKILLED NURSING FACILITY	0	0	(0	0	43. 00 44. 00
45. 00	04500 NURSING FACILITY	0	0			0	45. 00
46. 00	04600 OTHER LONG TERM CARE	0	0	(0	0	46. 00
EO 00	ANCILLARY SERVICE COST CENTERS O5000 OPERATING ROOM	1 422 014	2 249 240	2 700 254	-588, 895	2 101 441	E0 00
50. 00 51. 00	05100 RECOVERY ROOM	1, 432, 016	2, 348, 340 0	3, 780, 35 <i>6</i>) -588, 895	3, 191, 461 0	50. 00 51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0	(0	0	52. 00
53. 00 54. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	1 201 425	1 102 749	2 405 273	0	0 1, 718, 945	53. 00 54. 00
54. 00	03630 ULTRA SOUND	1, 301, 625 67, 350	1, 103, 748 7, 429			74, 779	54. 00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	(0	0	55. 00
56.00	05600 RADI OI SOTOPE 05700 CT SCAN	116, 184	113, 807	229, 991	-45, 038	184, 953 0	56.00
57. 00 58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0			0	57. 00 58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	(0	0	59. 00
60.00	06000 LABORATORY	0	3, 134, 085	3, 134, 085	-57, 777	3, 076, 308	60.00
60. 01 61. 00	06001 BLOOD LABORATORY 06100 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY		0			0	60. 01 61. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	(0	0	62. 00
63. 00 64. 00	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY	0	0	(0	0	63. 00 64. 00
65. 00	06500 RESPIRATORY THERAPY	667, 697	107, 541	775, 238	24, 089	799, 327	65.00
66. 00	06600 PHYSI CAL THERAPY	563, 423	145, 170	708, 593	-13, 719	694, 874	66. 00
67. 00 68. 00	06700 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY	0	0	(0	0	67. 00 68. 00
69. 00	06900 ELECTROCARDI OLOGY	479, 322	155, 155	634, 477	-279, 064	355, 413	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0	0	70. 00
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		840, 933 213, 538	840, 933 213, 538	71. 00 72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	695	695		1, 011, 100	73.00
74. 00	07400 RENAL DIALYSIS	0	0	(0	0	74. 00
75. 00 76. 00	07500 ASC (NON-DISTINCT PART) 03480 ONCOLOGY	0 28	0 75	103	0	0 103	75. 00 76. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	10.		0	76. 97
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0		0	0	77. 00
88. 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	l ol	0	Γ		0	88. 00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0			0	89.00
90.00	09000 CLI NI C	148, 399	27, 320			167, 676	90. 00
91. 00 91. 01	09100 EMERGENCY 04950 WOUND CARE	2, 017, 555	1, 625, 204	3, 642, 759	-599, 619	3, 043, 140 0	91. 00 91. 01
91.01	09200 OBSERVATION BEDS (NON-DISTINCT PART)		U		_	0	91.01
	OTHER REIMBURSABLE COST CENTERS						
94. 00 95. 00	09400 HOME PROGRAM DIALYSIS 09500 AMBULANCE SERVICES	0	0	(0	0	94. 00 95. 00
95. 00 96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0			0	96.00
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD	o	0		o o	0	
		·					

Health Financial Systems FRA				eu of Form CMS-:	2552-10	
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES				Peri od:	Worksheet A	
				From 01/01/2022 To 12/31/2022		nared·
					5/30/2023 4:1	
Cost Center Description	Sal ari es	0ther		Reclassificati	Recl assi fi ed	
			+ col. 2)	ons (See A-6)	Trial Balance	
					(col. 3 +-	
	1.00	2.00	3. 00	4.00	col . 4) 5.00	
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	1.00	2.00	3.00	0 0	0.00	98. 00
99. 00 09900 CMHC	l ol	o		o o	l o	
99. 10 09910 CORF	O	O		0 0	0	99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	O	o		0 0	0	100.00
101.00 10100 HOME HEALTH AGENCY	O	o		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 KI DNEY ACQUI SI TI ON	0	0		0		105. 00
106. 00 10600 HEART ACQUI SI TI ON	0	0		0		106. 00
107. 00 10700 LIVER ACQUISITION	0	0		0		107. 00
108. 00 10800 LUNG ACQUISITION	0	0		0		108. 00
109. 00 10900 PANCREAS ACQUISITION	0	0		0		109. 00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON	0	0		0		110.00
111. 00 11100 I SLET ACQUI SI TI ON	U	0		0		111.00
113.00 11300 INTEREST EXPENSE 114.00 11400 UTILIZATION REVIEW-SNF		0		0		113. 00 114. 00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0		0		115. 00
116. 00 11600 HOSPI CE		0		0		116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	17, 049, 049	31, 261, 109	48, 310, 15	8 37, 877		1
NONREI MBURSABLE COST CENTERS	1770177017	01/201/10/	10/ 010/ 10	0,70,7	10/010/000	1
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	137	13	7 0	137	190. 00
191. 00 19100 RESEARCH	O	0		0 0	0	191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	1, 839, 260	1, 978, 289	3, 817, 54	9 -29, 340	3, 788, 209	192. 00
193. 00 19300 NONPALD WORKERS	0	0		0 0		193. 00
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	0		0		194. 00
194. 01 07951 OTHER NONREIMBURSABLE COST CENTERS	231, 927	58, 836	290, 76		290, 763	1
194. 02 07952 OTHER NONREIMBURSABLE COST CENTERS	250, 402	138, 746	389, 14			
200.00 TOTAL (SUM OF LINES 118 through 199)	19, 370, 638	33, 437, 117	52, 807, 75	5 0	52, 807, 755	200. 00

		FRANCISCAN HEALTH	CRAWFORDSVILLE		In Lieu	of Form CMS-25	52-10
RECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE	OF EXPENSES	Provi der CCN:	15-0022	Peri od: From 01/01/2022	Worksheet A	
					To 12/31/2022	Date/Time Prepa	ared:
	Cost Center Description	Adjustments	Net Expenses			5/30/2023 4: 12	pm
	·	(See A-8)	For Allocation				
	GENERAL SERVICE COST CENTERS	6. 00	7. 00				
1.00	00100 CAP REL COSTS-BLDG & FLXT	506, 561	1, 919, 512				1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	0					2. 00
3.00	00300 OTHER CAP REL COSTS	0	0				3. 00
4. 00 5. 00	OO400	73, 487 -4, 520, 963	1				4. 00 5. 00
6.00	00600 MAI NTENANCE & REPAI RS	-4, 520, 703					6. 00
7. 00	00700 OPERATION OF PLANT	0					7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	-2, 700	160, 193				8.00
9.00	00900 HOUSEKEEPI NG	0	607, 674				9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	-6, 226 -142, 696	1			I	10. 00 11. 00
13.00	01300 NURSING ADMINISTRATION	312, 567	1			I	13. 00
	01400 CENTRAL SERVICES & SUPPLY	-165, 718	1			•	14. 00
15.00	01500 PHARMACY	65, 712	486, 080			1	15. 00
16.00	01600 MEDI CAL RECORDS & LI BRARY	465, 805	465, 805			1	16. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS		2.4/5.040				20.00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 NTENSIVE CARE UNIT	0				•	30. 00 31. 00
32. 00	03200 CORONARY CARE UNIT	Ö	1, 440, 510				32. 00
33.00	03300 BURN INTENSIVE CARE UNIT	0	o				33. 00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0				•	34. 00
40.00	04000 SUBPROVI DER - I PF	0	.,,				40.00
41. 00 43. 00	04100 SUBPROVI DER - I RF 04300 NURSERY	0	0			•	41. 00 43. 00
44. 00	04400 SKILLED NURSING FACILITY					•	44. 00
45. 00	04500 NURSING FACILITY	0				•	45. 00
46.00	04600 OTHER LONG TERM CARE	0	0			4	46. 00
	ANCILLARY SERVICE COST CENTERS						
50. 00 51. 00	O5000 OPERATI NG ROOM O5100 RECOVERY ROOM	0				I	50. 00 51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM						52. 00
53. 00	05300 ANESTHESI OLOGY	0	o o			I	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	-16, 598					54. 00
54. 01	03630 ULTRA SOUND	0	74, 779			I	54. 01
55.00	O5500 RADI OLOGY-THERAPEUTI C	0	104 053				55.00
56. 00 57. 00	05600		184, 953			I	56. 00 57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	o			•	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0			5	59. 00
60.00	06000 LABORATORY	0	-, -, -,				60.00
60. 01 61. 00	06001 BLOOD LABORATORY 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0			•	60.01
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		-1			•	61. 00 62. 00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	Ö	o o			•	63.00
64.00	06400 I NTRAVENOUS THERAPY	0	0			6	64. 00
65. 00	06500 RESPI RATORY THERAPY	0	1 ,]			•	65.00
66. 00 67. 00	06600 PHYSI CAL THERAPY	0	694, 874				66. 00 67. 00
68. 00	06700 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY	0				•	68. 00
	06900 ELECTROCARDI OLOGY	-10, 125	1			•	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	o			7	70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	840, 933			I	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	213, 538				72.00
	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS		1, 011, 100				73. 00 74. 00
	07500 ASC (NON-DISTINCT PART)	0					75. 00
	03480 ONCOLOGY		103			I	76. 00
76. 97	07697 CARDIAC REHABILITATION	0	0				76. 97
77. 00	07700 ALLOGENEI C STEM CELL ACQUI SI TI ON	0	0			7	77. 00
88 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC		O			c	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER		1			I	89. 00
	09000 CLI NI C	0	167, 676			•	90. 00
91. 00	09100 EMERGENCY	-595, 753	1			I	91. 00
91. 01	04950 WOUND CARE	0	0				91. 01
92. 00	O9200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS					9	92. 00
94. 00	09400 HOME PROGRAM DIALYSIS	0	0			c	94. 00
95. 00	09500 AMBULANCE SERVICES		1				95. 00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	0	o			9	96. 00
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD	0					97. 00
98. 00 99. 00	09850 OTHER REIMBURSABLE COST CENTERS 09900 CMHC	0				•	98. 00 99. 00
	10 7 700 GWI IG	1 0	ı U			۶ ا	77. UU

 Heal th Financial
 Systems
 FRANCISCAN HEALTH CRAWFORDSVILLE

 RECLASSIFICATION
 AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES
 Provider CCN
 In Lieu of Form CMS-2552-10 Provi der CCN: 15-0022

			5/30/2023 4: 1 ² pm
Cost Center Description	Adjustments	Net Expenses	
		For Allocation	
	6. 00	7. 00	
99. 10 09910 CORF	0	0	99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	100.00
101.00 10100 HOME HEALTH AGENCY	0	0	101.00
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 I NTEREST EXPENSE	0	0	113. 00
114.00 11400 UTI LI ZATI ON REVI EW-SNF	0	0	114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	115. 00
116. 00 11600 HOSPI CE	0	0	116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	-4, 036, 647	44, 311, 388	118. 00
NONREI MBURSABLE COST CENTERS			
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	137	190. 00
191. 00 19100 RESEARCH	0	0	191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	3, 788, 209	192. 00
193. 00 19300 NONPALD WORKERS	0	0	193. 00
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	194. 00
194. 01 07951 OTHER NONREI MBURSABLE COST CENTERS	0	290, 763	194. 01
194.02 07952 OTHER NONREIMBURSABLE COST CENTERS	0	380, 611	194. 02
200.00 TOTAL (SUM OF LINES 118 through 199)	-4, 036, 647	48, 771, 108	200. 00

Provi der CCN: 15-0022

In Lieu of Form CMS-2552-10
Worksheet A-6

Peri od: From 01/01/2022 To 12/31/2022 Date/Time Prepared: 5/30/2023 4:12 pm

		Increases			5/30/2023 4:	TZ pili
	Cost Center	Li ne #	Sal ary	Other		
	2.00	3. 00	4. 00	5. 00		
	A - CAPITAL			2. 22		
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	3, 328, 405		1.00
2.00		0.00	o	0		2. 00
3.00		0.00	o	0		3. 00
4.00		0.00	o	0		4. 00
5.00		0.00	o	0		5. 00
6.00		0.00	0	0		6. 00
7.00		0.00	0	0		7. 00
8.00		0.00	0	0		8. 00
9.00		0.00	0	0		9. 00
10.00		0.00	0	0		10.00
11. 00		0.00	0	0		11. 00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15. 00		0.00	0	0		15. 00
16.00		0.00	0	0		16.00
17. 00 18. 00		0. 00 0. 00	0	0		17. 00 18. 00
19. 00		0.00	0	0		19. 00
19.00			— — — ö	3, 328, 405		17.00
	B - INTEREST		<u> </u>	5, 520, 405		1
1.00	CAP REL COSTS-BLDG & FIXT	1. 00	0	_1, 218, 597		1.00
55	0	— — +	— — ŏ	1, 218, 597		
	C - DI ETARY		٥,	, = . = , = , ,]		1
1.00	CAFETERI A	11. 00	4, 727	618		1.00
	0		4, 727	618		
	D - CHARGEABLE SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	840, 933		1. 00
	PATI ENTS					
	OPERATING ROOM	50.00	0	1, 793		2. 00
	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	242		3. 00
4.00		0.00	0	0		4. 00
5.00		0.00	0	0		5. 00
6.00		0.00	0	0		6. 00
7.00		0.00	0	0		7. 00
8.00		0.00	0	0		8. 00
9. 00 10. 00		0. 00 0. 00	0	0		9. 00 10. 00
11. 00		0.00	0	0		11.00
13. 00		0.00	0	0		13.00
14. 00		0.00	0	0		14. 00
15. 00		0.00	o	0		15. 00
16. 00		0.00	o	0		16. 00
17. 00		0.00	o	0		17. 00
19. 00		0.00	o	0		19. 00
21. 00		0.00	Ö	0		21. 00
22.00		0.00	o	0		22. 00
23.00		0. 00	o	0		23. 00
	0			842, 968		
	E - DRUGS CHARGED TO PATIENTS					4
	DRUGS CHARGED TO PATIENTS	73. 00	0	1, 010, 405		1. 00
	NURSING ADMINISTRATION	13. 00	0	3, 524		2. 00
3.00		0.00	0	0		3. 00
4.00		0.00	0	0		4. 00
5.00		0.00	0	0		5. 00
6.00		0.00	0	0		6. 00
7. 00 8. 00		0. 00 0. 00	0	0		7. 00 8. 00
9. 00		0.00	0	0		9. 00
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
15. 00		0.00	0	0		15. 00
16. 00		0.00	Ö	0		16. 00
. 5. 50	<u> </u>	<u> </u>	— — — ŏ	1, 013, 929		. 5. 55
	F - PROSTHESIS & IMPLANTS		- 1			1
1.00	IMPL. DEV. CHARGED TO	72.00	0	213, 538		1. 00
	PATI ENTS					
2.00	EMERGENCY	91.00	0	12		2. 00
	0		0	213, 550		

Heal th	Financial Systems	FR	ANCI SCAN HEALTI	H CRAWFORDSVIL	LE	In Lie	u of Form CMS	-2552-10
RECLAS	SIFICATIONS			Provi der (CCN: 15-0022	Peri od: From 01/01/2022	Worksheet A-	6
						To 12/31/2022	Date/Time Pr 5/30/2023 4:	
		Increases						
	Cost Center	Li ne #	Sal ary	0ther				
	2. 00	3. 00	4. 00	5. 00				
	G - SHARED SERVICES							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	59, 044	0				1. 00
2.00	ADMINISTRATIVE & GENERAL	5. 00	527, 597	0				2. 00
3.00	NURSING ADMINISTRATION	13. 00	283, 248	0				3. 00
	0		869, 889	0				
	H - RESPIRATORY THERAPY ADMIN							
1.00	RESPIRATORY THERAPY	65. 00	126, 513	0				1. 00
	0		126, 513					
500.00	Grand Total: Increases		1, 001, 129	6, 618, 067]			500.00

Health Financial Systems
RECLASSIFICATIONS In Lieu of Form CMS-2552-10 Peri od: Worksheet A-6
From 01/01/2022
To 12/31/2022 Date/Time Prepared: 5/20/2023 4:12 pm Provider CCN: 15-0022

						5/30/2023 4:	
		Decreases				1	
	Cost Center 6.00	Li ne # 7.00	Sal ary	0ther 9.00	Wkst. A-7 Ref. 10.00		
	A - CAPITAL	7.00	8. 00	9.00	10.00		
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1, 265, 497	9		1.00
2.00	OPERATION OF PLANT	7. 00	0	436, 408		1	2. 00
3.00	DI ETARY	10.00	0	8, 246			3. 00
4. 00 5. 00	NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY	13. 00 14. 00	0 0	100, 183 31, 353	_		4. 00 5. 00
6. 00	PHARMACY	15. 00	0	58, 375			6. 00
7.00	RESPIRATORY THERAPY	65.00	0	25, 911	0		7. 00
8.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	24, 497	0		8. 00
9. 00	OTHER NONREI MBURSABLE COST CENTERS	194. 02	0	8, 537	0		9. 00
10. 00	LAUNDRY & LINEN SERVICE	8.00	0	2, 535	0		10.00
11. 00	ADULTS & PEDIATRICS	30.00	0	85, 329	0		11. 00
12.00	INTENSIVE CARE UNIT	31.00	0	16, 044			12. 00
13. 00 14. 00	SUBPROVIDER - IPF OPERATING ROOM	40. 00 50. 00	0	28, 481	0		13.00
15. 00	RADI OLOGY-DI AGNOSTI C	54.00	0	369, 961 404, 367	0		15. 00
16. 00	RADI OI SOTOPE	56.00	0	31, 688	_		16. 00
17. 00	PHYSI CAL THERAPY	66.00	0	9, 035			17. 00
18.00	ELECTROCARDI OLOGY	69.00	0	69, 611	0	1	18.00
19. 00	EMERGENCY	91.00	<u>0</u>				19. 00
	B - INTEREST		0	3, 320, 403		<u> </u>	
1.00	ADMI NI STRATI VE & GENERAL	5.00	0		11		1. 00
	0		0	1, 218, 597			_
1. 00	C - DI ETARY DI ETARY	10.00	4, 727	618	0		1.00
1.00	0		$\frac{4,727}{4,727}$	618			1.00
	D - CHARGEABLE SUPPLIES						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	14, 885			1.00
2. 00 3. 00	OPERATION OF PLANT LAUNDRY & LINEN SERVICE	7. 00 8. 00	0	969 403			2. 00 3. 00
4. 00	HOUSEKEEPI NG	9.00	0	5, 773	-		4. 00
5.00	DI ETARY	10.00	0	3, 598			5. 00
6.00	NURSING ADMINISTRATION	13. 00	0		0		6. 00
7. 00 8. 00	CENTRAL SERVICES & SUPPLY PHARMACY	14. 00 15. 00	0	23, 249			7. 00 8. 00
9. 00	ADULTS & PEDIATRICS	30.00	0	44, 818 84, 030			9. 00
10. 00	SUBPROVI DER - I PF	40.00	0	10, 125			10.00
11. 00	RADI OLOGY-DI AGNOSTI C	54.00	0	122, 974			11. 00
13.00	LABORATORY THERADY	60.00	0	57, 777	0		13.00
14. 00 15. 00	RESPIRATORY THERAPY PHYSICAL THERAPY	65. 00 66. 00	0	76, 513 4, 609			14. 00 15. 00
16. 00	ELECTROCARDI OLOGY	69.00	0	82, 896			16. 00
17.00	EMERGENCY	91.00	0	245, 074			17. 00
19. 00	PHYSICIANS' PRIVATE OFFICES	192.00	0	4, 593			19.00
21. 00	INTENSIVE CARE UNIT	31. 00 56. 00	0	52, 445 189			21. 00 22. 00
22. 00 23. 00	CLINIC	90.00	_		_		23. 00
	0 = = = =		<u> </u>				
	E - DRUGS CHARGED TO PATIENTS				T		
1. 00 2. 00	ADMINISTRATIVE & GENERAL DIETARY	5. 00 10. 00	0				1.00
3.00	NURSING ADMINISTRATION	10.00	0	_	0	•	3. 00
4. 00	CENTRAL SERVICES & SUPPLY	14.00	Ö	112			4. 00
5.00	PHARMACY	15. 00	0	829, 764			5. 00
6.00	ADULTS & PEDIATRICS	30.00	0	1, 036			6. 00
7. 00 8. 00	SUBPROVI DER - I PF EMERGENCY	40. 00 91. 00	0	15 2, 210			7. 00 8. 00
9. 00	PHYSICIANS' PRIVATE OFFICES	192.00	0	250			9. 00
10.00	OPERATION OF PLANT	7.00	0	5			10.00
11. 00	INTENSIVE CARE UNIT	31.00	0	327	0		11. 00
12.00	OPERATING ROOM	50.00	0	7, 177	0		12.00
13. 00 14. 00	RADI OLOGY-DI AGNOSTI C RADI OI SOTOPE	54. 00 56. 00) 0	159, 087 13, 161	0		13. 00 14. 00
15. 00	PHYSI CAL THERAPY	66.00	Ö	75	_		15. 00
16. 00	ELECTROCARDI OLOGY	69.00		44			16. 00
	DDOSTHESIS & LMDLANTS		0	1, 013, 929			-
1. 00	F - PROSTHESIS & IMPLANTS OPERATING ROOM	50.00	0	213, 550	0		1.00
2. 00		0.00		c	0		2. 00
	0 = = = = =			213, 550			

Heal th	Financial Systems	FR	ANCISCAN HEALTH	H CRAWFORDSVIL	LE	In Lie	u of Form CMS	S-2552-10
RECLAS	SI FI CATI ONS			Provi der	CCN: 15-0022	Period: From 01/01/2022	Worksheet A	-6
						To 12/31/2022		
		Decreases						
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref			
	6. 00	7. 00	8. 00	9. 00	10. 00			
	G - SHARED SERVICES							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	59, 044		0		1. 00
2.00	ADMINISTRATIVE & GENERAL	5. 00	0	527, 597	,	o		2. 00
3.00	NURSING ADMINISTRATION	13. 00	0	283, 248	3	0		3. 00
	0		0	869, 889				
	H - RESPIRATORY THERAPY ADMIN							
1.00	ELECTROCARDI OLOGY	69. 00	126, 513	()	0		1. 00
	0		126, 513					
500.00	Grand Total: Decreases		131, 240	7, 487, 956				500.00

Subtotal (sum of lines 1-7)

Reconciling Items

10.00 Total (line 8 minus line 9)

8.00

9.00

8.00

9.00

10.00

RECONCILIATION OF CAPITAL COSTS CENTERS Provider CCN: 15-0022 Peri od: Worksheet A-7 From 01/01/2022 Part I 12/31/2022 Date/Time Prepared: 5/30/2023 4:12 pm Acqui si ti ons Begi nni ng Purchases Donati on Total Di sposal s and Bal ances Retirements 2.00 3.00 4. 00 1 00 5 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 970, 120 0 1.00 3, 753, 111 0 2.00 Land Improvements 0 2.00 37, 728, 275 0 3.00 1,003,310 1, 003, 310 3.00 Buildings and Fixtures 233.038 0 4.00 Building Improvements 7, 885, 784 35, 927 35, 927 0 4.00 5.00 Fixed Equipment 0 5.00 0 6.00 Movable Equipment 24, 647, 689 591, 178 591, 178 1, 787, 103 6.00 0 7.00 HIT designated Assets 0 7.00 0 8.00 Subtotal (sum of lines 1-7) 74, 984, 979 1, 630, 415 1, 630, 415 2, 020, 141 8.00 9.00 Reconciling Items 0 9.00 Total (line 8 minus line 9) 74, 984, 979 2, 020, 141 10.00 1, 630, 415 0 1, 630, 415 10.00 Endi ng Bal ance Fully Depreci ated Assets 6.00 7.00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 970, 120 1.00 2.00 Land Improvements 3, 753, 111 757, 350 2.00 2, 512, 303 3.00 Buildings and Fixtures 38, 498, 547 3.00 4.00 Building Improvements 7, 921, 711 4.00 5.00 Fi xed Equipment 5.00 Movable Equipment 6.00 23, 451, 764 9, 413, 253 6.00 7. 00 7.00 HIT designated Assets

74, 595, 253

74, 595, 253

12, 682, 906

12, 682, 906

Heal th	Financial Systems FR.	ANCISCAN HEALTH	CRAWEORDSVIII	F	In lie	eu of Form CMS-2	2552-10
	CILIATION OF CAPITAL COSTS CENTERS	WOT SOM TIEMETH	Provi der Co		Period: From 01/01/2022 To 12/31/2022	Worksheet A-7 Part II	pared:
			SU	JMMARY OF CAP	PITAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)		
		9. 00	10.00	11. 00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	194, 354	0		0 0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		0 0	0	2.00
3.00	Total (sum of lines 1-2)	194, 354	0		0 0	0	3. 00
		SUMMARY O	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum				
	·	Capi tal -Relate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	194, 354			ļ	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0			ļ	2. 00
	1 - 1 - (404 054	I .			

0 0 0

194, 354

1. 00 2. 00 3. 00

1.00 CAP REL COSTS-BLDG & FLX1
2.00 CAP REL COSTS-MVBLE EQUIP
3.00 Total (sum of lines 1-2)

Heal th	n Financial Systems FRA	ANCISCAN HEALTH	I CRAWFORDSVILL	E	In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der Co		Period: From 01/01/2022 To 12/31/2022	Worksheet A-7 Part III Date/Time Pre 5/30/2023 4:1:	pared:
		COM	PUTATION OF RAT	TI 0S	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets		Insurance	
			Leases	for Ratio (col. 1 - col 2)	instructions)		
		1.00	2.00	3. 00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS					
1.00	CAP REL COSTS-BLDG & FLXT	0	0		0 1.000000		
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		0.000000		
3.00	Total (sum of lines 1-2)	0	0	DADI TAL	0 1.000000		3. 00
		ALLUCA	TION OF OTHER (CAPITAL	SUMMARY U	F CAPITAL	
	Cost Center Description	Taxes	Other	Total (sum o	f Depreciation	Lease	
			Capi tal -Relate				
			d Costs	through 7)			
	DART LLL DESCRIPTION OF CARLEY COOTS OF	6.00	7. 00	8. 00	9. 00	10. 00	
1 00	PART III - RECONCILIATION OF CAPITAL COSTS CI			1	0 24/ 550	454.254	1 00
1.00	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP	0	0		0 246, 559	·	1.00
2. 00 3. 00	Total (sum of lines 1-2)	0	0		0 3, 328, 405		2. 00 3. 00
3.00	Total (Sull of Titles 1-2)	0	<u> </u>	<u>l</u> JMMARY OF CAPI	0 3, 574, 964	454, 350	3.00
				JIVIIVIART OF CAPI			
	Cost Center Description	Interest	Insurance (see	,		Total (2) (sum	
			instructions)	i nstructi ons) Capi tal -Rel ate		
					d Costs (see	through 14)	
		11 00	12.00	12.00	instructions)	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CI	11. 00	12.00	13. 00	14.00	15. 00	
1. 00	CAP REL COSTS-BLDG & FIXT	1, 218, 597	0		0 0	1, 919, 512	1. 00
2.00	CAP REL COSTS-BLDG & FIXT	1,210,397				3, 328, 405	
3.00	Total (sum of lines 1-2)	1, 218, 597			0 0	5, 247, 917	
3.00	Total (Sum of Titles 1-2)	1,210,377	1	1	0	5, 247, 717	J 3.00

					To 12/31/2022	Date/Time Prep 5/30/2023 4:12	
				Expense Classification or	n Worksheet A	37 307 2023 4. 12	z piii
				To/From Which the Amount is	to be Adjusted		
					1		
	Cost Center Description	Basi s/Code (2) 1.00	Amount 2.00	Cost Center 3.00	Li ne # 4. 00	Wkst. A-7 Ref. 5.00	
1.00	Investment income - CAP REL	1.00		CAP REL COSTS-BLDG & FIXT	1.00		1. 00
	COSTS-BLDG & FLXT (chapter 2)						
2.00	Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	2. 00
3. 00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other	В	0	ADMINISTRATIVE & GENERAL	5. 00	0	3. 00
3.00	(chapter 2)		O	ADMINISTRATIVE & GENERAL	3.00	Ĭ	3.00
4.00	Trade, quantity, and time		0		0.00	0	4. 00
5. 00	discounts (chapter 8) Refunds and rebates of	В	71	PHARMACY	15. 00	0	5. 00
5.00	expenses (chapter 8)	В	-/1	FTIARWACT	15.00		3.00
6.00	Rental of provider space by		0		0.00	О	6. 00
7 00	suppliers (chapter 8)		0		0.00		7 00
7. 00	Tel ephone servi ces (pay stations excluded) (chapter		Ü		0.00	0	7. 00
	21)						
8.00	Television and radio service		0		0.00	0	8. 00
9. 00	(chapter 21) Parking Lot (chapter 21)		0		0.00		9. 00
10.00	Provi der-based physician	A-8-2	-678, 984		0.00	0	10.00
	adjustment	-					
11. 00	Sale of scrap, waste, etc.		0		0.00	0	11. 00
12. 00	(chapter 23) Related organization	A-8-1	1, 213, 338			0	12. 00
12.00	transactions (chapter 10)	7. 0 1	1,210,000			Ĭ	12.00
13. 00	Laundry and linen service	В		LAUNDRY & LINEN SERVICE	8. 00		13. 00
14. 00 15. 00	Cafeteria-employees and guests Rental of quarters to employee			CAFETERIA ADMINISTRATIVE & GENERAL	11. 00 5. 00		14. 00 15. 00
13.00	and others	D	U	ADMINISTRATIVE & GENERAL	5.00	U	13.00
16. 00	Sale of medical and surgical		0		0.00	0	16. 00
	supplies to other than						
17. 00	patients Sale of drugs to other than		0		0.00	0	17. 00
17.00	patients		0		0.00	Ĭ	17.00
18. 00	Sale of medical records and	В	0	ADMINISTRATIVE & GENERAL	5. 00	0	18. 00
19. 00	abstracts Nursing and allied health		0		0.00	0	19. 00
17.00	education (tuition, fees,		0		0.00		19.00
	books, etc.)						
20.00	Vending machines	В	-6, 226	DI ETARY	10.00		20.00
21. 00	Income from imposition of interest, finance or penalty		Ü		0.00	0	21. 00
	charges (chapter 21)						
22. 00	Interest expense on Medicare		0		0.00	0	22. 00
	overpayments and borrowings to repay Medicare overpayments						
23. 00	Adjustment for respiratory	A-8-3	0	RESPI RATORY THERAPY	65. 00		23. 00
	therapy costs in excess of						
24 00	limitation (chapter 14)	A-8-3	^	PHYSI CAL THERAPY	66.00		24. 00
∠4. UU	Adjustment for physical therapy costs in excess of	H-0-3	Ü	FILISICAL INEKAPY	00.00		24. UU
	limitation (chapter 14)						
25. 00	Utilization review -		0	UTILIZATION REVIEW-SNF	114. 00		25. 00
	physicians' compensation (chapter 21)						
26. 00	Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1.00	o	26. 00
	COSTS-BLDG & FLXT						
27. 00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27. 00
28. 00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28. 00
29. 00	Physicians' assistant		0		0.00		29. 00
30. 00	Adjustment for occupational	A-8-3	0	OCCUPATI ONAL THERAPY	67. 00		30. 00
	therapy costs in excess of limitation (chapter 14)						
30. 99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30. 99
	instructions)						
31. 00	Adjustment for speech pathology costs in excess of	A-8-3	0	SPEECH PATHOLOGY	68. 00		31. 00
	limitation (chapter 14)						
32. 00	CAH HIT Adjustment for		0		0.00	o	32. 00
22.00	Depreciation and Interest MISC INCOME	В	100 740	ADMINISTRATIVE & GENERAL	5. 00		33. 00
	LIVIT JO I INCUINE	ן ט ן	- 103, 748	INDINI NI SIRMII VË & GENEKAL	5.00	ı U	JJ. UU

Health Financial Systems	FRANCISCAN HEALTH CRAWFORDSVILLE	In Lieu of Form CMS-2552-10
ADJUSTMENTS TO EXPENSES		Period: Worksheet A-8 From 01/01/2022
		To 12/31/2022 Date/Time Prepared: 5/30/2023 4:12 pm
	Expense Classification on	Worksheet A
	To/From Which the Amount is	to be Adjusted

				Expense Classification on To/From Which the Amount is			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4. 00	5. 00	
33. 01	DI SCOUNTS EARNED/REBATES	В	-165, 718	CENTRAL SERVICES & SUPPLY	14.00	0	33. 01
33. 02	DI SCOUNTS EARNED/REBATES	В	-2, 166	PHARMACY	15.00	0	33. 02
33. 03	DI SCOUNTS EARNED/REBATES	В	0	OPERATING ROOM	50.00	0	33. 03
33.04	HAF ASSESSMENT	Α	-4, 076, 416	ADMINISTRATIVE & GENERAL	5.00	0	33. 04
33. 05	PENSION ADJUSTMENT	A	-71, 260	ADMINISTRATIVE & GENERAL	5. 00	0	33. 05
33.06	EMPATH (LAF DEPT)	Α	0	ADULTS & PEDIATRICS	30.00	0	33. 06
33. 07	LABOR & DELIVERY (LAF DEPT)	Α	0	ADULTS & PEDIATRICS	30.00	0	33. 07
50.00	TOTAL (sum of lines 1 thru 49)		-4, 036, 647				50.00
	(Transfer to Worksheet A,						
	column 6, line 200.)						
(4) D				ONC D.I. 4E 4			

- (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.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider CCN: 15-0022

Worksheet A-8-1 From 01/01/2022

12/31/2022 Date/Time Prepared: 5/30/2023 4:12 pm Li ne No. Cost Center Expense I tems Amount of Amount Allowable Cost Included in Wks. A, column 1.00 3.00 4.00 5.00 2.00 COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS 1.00 CAP REL COSTS-BLDG & FIXT 1.00 415, 843 363, 638 1.00 1. 00 CAP REL COSTS-BLDG & FIXT 1, 672, 953 2.00 1, 218, 597 2.00 5. 00 ADMINISTRATIVE & GENERAL 3.00 8, 760, 963 7, 136, 733 3.00 4.00 15. 00 PHARMACY 67, 949 0 4.00 4.01 16.00 MEDICAL RECORDS & LIBRARY 465, 805 0 4.01 4. 00 EMPLOYEE BENEFITS DEPARTMENT 77, 287 0 4 02 4 02 5. 00 ADMINISTRATIVE & GENERAL 0 4.03 1, 407, 399 4.03 4.04 13.00 NURSING ADMINISTRATION 312, 567 4.04 TOTALS (sum of lines 1-4) 10. 343. 198 5.00 5 00 11, 556, 536 Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.

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

			Related Organization(s) and/	or Home Office	
Symbol (1)	Name	Percentage of	Name	Percentage of	
		Ownershi p		Ownershi p	
1. 00	2. 00	3.00	4. 00	5. 00	
B. INTERRELATIONSHIP TO RELAT	ED ORGANIZATION(S) AND/OR HO	ME OFFICE:			

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

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

6. 00	В	HOME OFFICE	100.00	0. 00	6. 00
7.00	G	SISTER FACILITY	100.00	0. 00	7. 00
8.00			0.00	0. 00	8. 00
9.00			0.00	0. 00	9. 00
10.00			0.00	0. 00	10.00
100.00	G. Other (financial or	FI NANCI AL			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.
- 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 provi der

Heal th	Financial Syste	ems	FRA	ANCISCAN HEALTH CR	AWFORDSVI LLE	In Lie	u of Form Cl	MS-2552-10
		SERVICES FRO	M RELATED ORGANIZ	ATIONS AND HOME	Provi der CCN: 15-0022	Peri od:	Worksheet	A-8-1
OFFICE	COSTS					From 01/01/2022 To 12/31/2022	Date/Time	Prepared:
						12,01,2022	5/30/2023	
	Net	Wkst. A-7 Ref	`.					
	Adjustments							
	(col. 4 minus							
	col. 5)*							
	6. 00	7. 00						
	A. COSTS INCUR	RED AND ADJUS	TMENTS REQUIRED A	S A RESULT OF TRA	NSACTIONS WITH RELATED	ORGANIZATIONS OR (CLAI MED	
	HOME OFFICE CO	STS:						
1.00	52, 205		9					1. 00
2.00	454, 356	1	0					2. 00
3.00	-1, 624, 230		0					3. 00
4.00	67, 949		0					4. 00
4. 01	465, 805		0					4. 01
4.02	77, 287		0					4. 02

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

4.03

4.04

5 00

nas not	been posted to worksheet A,	cordinas i and/or 2, the amount arrowable should be mareated in cordinar 4 or 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 7. 00 8. 00	6.00
7. 00	7.00
8. 00	8.00
9. 00	9.00
9. 00 10. 00 100. 00	10.00
100.00	100.00

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

0

4.03

4.04

5.00

1, 407, 399

1, 213, 338

312, 567

- 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.

| Period: | Worksheet A-8-2 | From 01/01/2022 | To 12/31/2022 | Date/Time Prepared: Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Provi der CCN: 15-0022

						To 12/31/2022	Date/Time Pre 5/30/2023 4:	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	Dill
		l 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		EMPLOYEE BENEFITS DEPARTMENT	3, 800			1		
2.00		ADMINISTRATIVE & GENERAL	52, 708			0	0	
3.00	54. 00	RADI OLOGY-DI AGNOSTI C	16, 598			0	0	3. 00
4.00		ELECTROCARDI OLOGY	10, 125			0	0	4. 00
5.00	91. 00	EMERGENCY	595, 753	595, 753	3 0	0	0	5. 00
6.00	0.00		0	C) c	0	0	6. 00
7.00	0.00		0	C) c	0	0	7. 00
8.00	0.00		0	C) c	0	0	8. 00
9.00	0.00		0	C) c	0	0	9. 00
10.00	0.00		0	C) c	0	0	10.00
200.00			678, 984		1 0		0	200.00
	Wkst. A Line #		Unadjusted RCE		Cost of		Physician Cost	
		ldenti fi er	Limit		Memberships &		of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1. 00	2.00	8.00	9. 00	12. 00	13. 00	14. 00	
1.00		EMPLOYEE BENEFITS DEPARTMENT	0	-	1	1	1	
2.00		ADMINISTRATIVE & GENERAL	0	1	1	0	1	2.00
3.00		RADI OLOGY-DI AGNOSTI C	0	C			0	
4.00		ELECTROCARDI OLOGY	0				0	4. 00
5.00		EMERGENCY	0				0	
6.00	0.00		0				0	
7.00	0.00		0				0	
8.00	0.00		0				0	
9.00	0.00		0				0	
10.00	0. 00		0				0	10.00
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	Auj us tillent		
		rdentiffer	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	l c		52, 708		2. 00
3.00	54. 00	RADI OLOGY-DI AGNOSTI C	0			16, 598		3. 00
4.00	69. 00	ELECTROCARDI OLOGY	0			10, 125		4. 00
5. 00		EMERGENCY	0			595, 753		5. 00
6.00	0. 00		0	d		0	1	6. 00
7.00	0.00		0	C) c	0		7. 00
8. 00	0.00		0	C) c	0		8. 00
9. 00	0.00		0	C) c	0		9. 00
10.00	0.00		0	C) c) 0)	10. 00
200.00			0	C	o c	678, 984	.	200. 00

| Peri od: | Worksheet B | From 01/01/2022 | Part | | To | 12/31/2022 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0022

					To	12/31/2022	Date/Time Prep 5/30/2023 4:1:	
				CAPI TAL REI	_ATED COSTS		37 307 2023 4. 1.	z piii
		Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Subtotal	
		oost center bescription	for Cost	DEDO & TTAT	WVDEE EQUIT	BENEFITS	Subtotal	
			Allocation			DEPARTMENT		
			(from Wkst A col. 7)					
	loeves.	AL 05504 05 000T 050T500	0	1. 00	2.00	4. 00	4A	
1.00		AL SERVICE COST CENTERS CAP REL COSTS-BLDG & FIXT	1, 919, 512	1, 919, 512				1. 00
2. 00		CAP REL COSTS-MVBLE EQUIP	3, 328, 405	1,,1,,012	3, 328, 405			2. 00
4.00		EMPLOYEE BENEFITS DEPARTMENT	3, 840, 443			4, 118, 451	44 007 070	4. 00
5. 00 6. 00	1	ADMINISTRATIVE & GENERAL MAINTENANCE & REPAIRS	10, 616, 860	205, 581 0	356, 474 0	117, 164 0	11, 296, 079 0	5. 00 6. 00
7. 00		OPERATION OF PLANT	1, 788, 262	235, 544	· · · · · · · · · · · · · · · · · · ·	85, 632	2, 517, 865	7. 00
8.00	1	LAUNDRY & LINEN SERVICE	160, 193	2, 127		4, 254	170, 263	8. 00
9. 00 10. 00		HOUSEKEEPI NG DI ETARY	607, 674 535, 304	22, 806 91, 143		149 703	670, 175 785, 191	9. 00 10. 00
11. 00		CAFETERI A	-137, 351	29, 500		99, 620	42, 922	11. 00
13.00		NURSING ADMINISTRATION	658, 123	0	I -	75, 353	733, 476	13.00
14. 00 15. 00		CENTRAL SERVICES & SUPPLY PHARMACY	10, 351 486, 080	98, 447 18, 931		23, 275 108, 265	302, 779 646, 101	14. 00 15. 00
16. 00	01600	MEDICAL RECORDS & LIBRARY	465, 805			0	497, 295	16. 00
20.00		I ENT ROUTINE SERVICE COST CENTERS ADULTS & PEDIATRICS	2 445 040	147, 705	257 110	480, 031	2 240 002	20.00
30. 00 31. 00		INTENSIVE CARE UNIT	2, 465, 048 1, 448, 310			247, 947	3, 348, 902 1, 821, 405	30. 00 31. 00
32.00	03200	CORONARY CARE UNIT	0	0		0	0	32.00
33. 00 34. 00		BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	33. 00 34. 00
40.00	1	SUBPROVIDER - IPF	1, 368, 295	71, 617	124, 182	281, 154	1, 845, 248	
41.00	04100	SUBPROVI DER - I RF	0	0	0	0	0	41. 00
43. 00 44. 00	1	NURSERY SKILLED NURSING FACILITY	0	0	0	0	0	43. 00 44. 00
45.00		NURSING FACILITY	0	0	0	0	0	45. 00
46. 00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46. 00
50. 00		LARY SERVICE COST CENTERS OPERATING ROOM	3, 191, 461	235, 040	407, 556	488, 031	4, 322, 088	50. 00
51.00	1	RECOVERY ROOM	3, 191, 401	233, 040	407, 550	488, 031	4, 322, 088	51. 00
52.00		DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52. 00
53. 00 54. 00		ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C	0 1, 702, 347	0 137, 948	0 239, 200	0 555, 411	0 2, 634, 906	53. 00 54. 00
54. 01		ULTRA SOUND	74, 779			11, 852	106, 118	
55. 00		RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55. 00
56. 00 57. 00		RADI OI SOTOPE CT SCAN	184, 953	19, 906 0	34, 517	0	239, 376 0	56. 00 57. 00
58. 00		MAGNETIC RESONANCE IMAGING (MRI)	0	0	Ö	0	0	58. 00
59.00		CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59. 00
60. 00 60. 01		LABORATORY BLOOD LABORATORY	3, 076, 308	56, 819 0	98, 523 0	0	3, 231, 650 0	60. 00 60. 01
61. 00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0			J	0	61. 00
62.00		WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63. 00 64. 00		BLOOD STORING, PROCESSING & TRANS. INTRAVENOUS THERAPY	0) 0	0	0	0	63. 00 64. 00
65.00		RESPI RATORY THERAPY	799, 327	0	0	177, 555	976, 882	65. 00
66.00	1	PHYSI CAL THERAPY	694, 874	37, 536	65, 087	179, 561	977, 058	
67. 00 68. 00		OCCUPATIONAL THERAPY SPEECH PATHOLOGY	0	0	0	0	0	67. 00 68. 00
69. 00	06900	ELECTROCARDI OLOGY	345, 288	59, 136	102, 541	138, 495	645, 460	
70.00		ELECTROENCEPHALOGRAPHY	0	0	0	0	040.033	70.00
71. 00 72. 00	1	MEDICAL SUPPLIES CHARGED TO PATIENTS IMPL. DEV. CHARGED TO PATIENTS	840, 933 213, 538	0	0	0	840, 933 213, 538	
73. 00	07300	DRUGS CHARGED TO PATIENTS	1, 011, 100		0	0	1, 011, 100	
74. 00		RENAL DIALYSIS	0	0	0	0	0	74. 00
75. 00 76. 00	1	ASC (NON-DISTINCT PART) ONCOLOGY	103	0	0	0	0 103	75. 00 76. 00
76. 97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76. 97
77. 00		ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77. 00
88. 00		TIENT SERVICE COST CENTERS 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 91. 00		CLINIC EMERGENCY	167, 676 2, 447, 387	38, 254 148, 409		133, 421 571, 221	405, 683 3, 424, 357	90. 00 91. 00
91. 00	1	WOUND CARE	2, 447, 387	148, 409	1	0	3, 424, 337	91. 00
92. 00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92. 00
94. 00		REIMBURSABLE COST CENTERS HOME PROGRAM DIALYSIS	0	0	O	0	0	94. 00
		AMBULANCE SERVICES	o o			0		95. 00
			<u> </u>		<u> </u>	<u> </u>		

Health Financial Systems FRANCISCAN HEALTH CRAWFORDSVILLE In Lieu of Form CMS-2552-10 COST ALLOCATION - GENERAL SERVICE COSTS Provi der CCN: 15-0022 Peri od: Worksheet B From 01/01/2022 Part I 12/31/2022 Date/Time Prepared: 5/30/2023 4:12 pm CAPITAL RELATED COSTS **EMPLOYEE** Cost Center Description Net Expenses BLDG & FIXT MVBLE EQUIP Subtotal for Cost **BENEFITS** DEPARTMENT Allocation (from Wkst A col. 7) 1.00 2.00 4. 00 4A 0 0 0 96.00 0 97. 00 0 09850 OTHER REIMBURSABLE COST CENTERS 0 0 0 98.00 0000 09900 CMHC 0 0 99.00 0 99. 10 Ω 0 0 100.00 0 0 0 0 0 101.00 0 102. 00 0 SPECIAL PURPOSE COST CENTERS 0 0 0 0 105. 00 0 0 0 0 106.00 0 0 0 107. 00 0 0 0 0 0 108. 00 0 0 0 0 109. 00 0 110.00 0 0 0 111.00 0 113. 00 114. 00 0 0 0 115.00 0 0 116, 00

96. 00 09600 DURABLE MEDICAL EQUIP-RENTED 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD 98.00 99. 00 99. 10 09910 CORF 100.00 10000 I &R SERVICES-NOT APPRVD PRGM 101.00 10100 HOME HEALTH AGENCY 102.00 10200 OPI OI D TREATMENT PROGRAM 105.00 10500 KIDNEY ACQUISITION 106.00 10600 HEART ACQUISITION 107. 00 10700 LIVER ACQUISITION 108.00 10800 LUNG ACQUISITION 109. 00 10900 PANCREAS ACQUISITION 110.00 11000 INTESTINAL ACQUISITION 111.00 11100 I SLET ACQUISITION 113. 00 11300 INTEREST EXPENSE 114.00 11400 UTILIZATION REVIEW-SNF 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 116. 00 11600 HOSPI CE SUBTOTALS (SUM OF LINES 1 through 117) 1, 822, 556 3, 160, 283 3, 779, 094 43, 706, 953 118. 00 118.00 44, 311, 388 NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 15, 707 190. 00 137 5, 691 9, 869 10 0 191.00 191. 00 19100 RESEARCH 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 4, 235, 941 192. 00 3, 788, 209 91, 265 158, 253 198, 214 193. 00 19300 NONPALD WORKERS 0 193.00 194. 00 07950 OTHER NONREIMBURSABLE COST CENTERS C 0 0 194. 00 194. 01 07951 OTHER NONREI MBURSABLE COST CENTERS 290, 763 C 0 71, 713 362, 476 194. 01 194. 02 07952 OTHER NONREIMBURSABLE COST CENTERS 380, 611 0 69, 420 450, 031 194. 02 0 200. 00 200.00 Cross Foot Adjustments 0 201, 00 201.00 Negative Cost Centers 202.00 TOTAL (sum lines 118 through 201) 48, 771, 108 1, 919, 512 3, 328, 405 4, 118, 451 48, 771, 108 202. 00

| Period: | Worksheet B | From 01/01/2022 | Part | | Date/Time Prepared: | 5/30/2023 4:12 pm

	Cost Center Description	ADMI NI STRATI VE	MAINTENANCE &	OPERATION OF	LAUNDRY &	5/30/2023 4: 1 HOUSEKEEPI NG	
		& GENERAL	REPAI RS	PLANT	LINEN SERVICE		
	GENERAL SERVICE COST CENTERS	5.00	6. 00	7. 00	8. 00	9. 00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00 6. 00	00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS	11, 296, 079	0				5. 00 6. 00
7. 00	00700 OPERATION OF PLANT	758, 958	0				7.00
8. 00	00800 LAUNDRY & LINEN SERVICE	51, 322	0	5, 064	226, 649		8. 00
9.00	00900 HOUSEKEEPI NG	202, 010	0	54, 283	25, 127	951, 595	9. 00
10.00	01000 DI ETARY	236, 679	0	216, 939	1, 523		10.00
11.00	01100 CAFETERI A	12, 938	0	70, 216	0		11.00
13. 00 14. 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	221, 091 91, 266	0	0 234, 324	0 836	0 69, 303	13. 00 14. 00
15. 00	01500 PHARMACY	194, 754	0		030		1
16. 00	01600 MEDICAL RECORDS & LIBRARY	149, 899	0	1	0		1
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	1, 009, 456	0		68, 732		30.00
31. 00 32. 00	03100 I NTENSI VE CARE UNI T 03200 CORONARY CARE UNI T	549, 024	0	108, 953	6, 446 0	32, 224 0	31. 00 32. 00
33. 00	03300 BURN INTENSIVE CARE UNIT	l ő	0	Ö	0	0	33.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
40. 00	04000 SUBPROVI DER - I PF	556, 211	0	170, 461	21, 142		1
41. 00	04100 SUBPROVI DER - I RF 04300 NURSERY	0	0	0	0	0	41.00
43. 00 44. 00	04400 SKI LLED NURSING FACILITY	0	0))	0	0 0	43. 00 44. 00
45. 00	04500 NURSING FACILITY		0	0	0	0	45. 00
46. 00	04600 OTHER LONG TERM CARE	0	0	0	0	0	46. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	1, 302, 820	0		30, 280		
51. 00 52. 00	O5100 RECOVERY ROOM O5200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	51. 00 52. 00
53. 00	05300 ANESTHESI OLOGY		0	0	0	0	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	794, 237	0	328, 344	8, 425		1
54. 01	03630 ULTRA SOUND	31, 987	0	16, 965	0		1
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55. 00
56. 00 57. 00	05600 RADI 0I SOTOPE 05700 CT SCAN	72, 155	0	47, 381 0	0	14, 013 0	56. 00 57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)		0	0	0	0	58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	o	0	Ö	0	Ö	59. 00
60.00	06000 LABORATORY	974, 113	0	135, 240	0	39, 998	60.00
60. 01	06001 BLOOD LABORATORY	0	0	0	0	0	60. 01
61. 00 62. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0	0	0	0	61. 00 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	0	64. 00
65. 00	06500 RESPI RATORY THERAPY	294, 461	0	0	1, 167	0	65. 00
66.00	06600 PHYSI CAL THERAPY	294, 514	0	89, 343	5, 889		1
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	0	1	0	-	
69. 00	06900 ELECTROCARDI OLOGY	194, 560	0	140, 756	0	41, 630	
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	253, 482	0	0	0	0	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	64, 367	0	0	0	0	72.00
73. 00 74. 00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	304, 775	0	0	0	0	73. 00 74. 00
75. 00	07500 ASC (NON-DISTINCT PART)		0	0	0	0	75. 00
76. 00	03480 ONCOLOGY	31	0	Ō	0	0	76. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	0	0	0	76. 97
77. 00	07700 ALLOGENEI C STEM CELL ACQUI SI TI ON	0	0	0	0	0	77. 00
88. 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC		0	0	0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	0	89. 00
90. 00	09000 CLINIC	122, 285	0	91, 052	0	26, 930	
91. 00	09100 EMERGENCY	1, 032, 201	0	353, 243	57, 082	104, 475	91. 00
91. 01	04950 WOUND CARE	0	0	0	0	0	91. 01
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
94. 00	OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DI ALYSI S		0	0	0	0	94. 00
95. 00	09500 AMBULANCE SERVICES		0	0	0	0	95. 00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96. 00
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97. 00
98. 00 99. 00	09850 OTHER REIMBURSABLE COST CENTERS 09900 CMHC	0	0	0	0	0 0	98. 00 99. 00
	09910 CORF		0	0	0	0	
- 7. 10	122 50	<u>, </u>			0		1 77.10

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

			10	0 12/31/2022	Date/IIme Pre 5/30/2023 4:1	
Cost Center Description	ADMI NI STRATI VE	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
	& GENERAL	REPAI RS	PLANT	LINEN SERVICE		
	5. 00	6. 00	7. 00	8. 00	9. 00	
100.00 10000 I &R SERVI CES-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		105. 00
106. 00 10600 HEART ACQUISITION	0	0	0	0		106. 00
107.00 10700 LIVER ACQUISITION	0	0	0	0		107. 00
108.00 10800 LUNG ACQUISITION	0	0	0	0		108. 00
109.00 10900 PANCREAS ACQUISITION	0	0	0	0		109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0		110. 00
111.00 11100 I SLET ACQUI SI TI ON	0	0	0	0	0	111. 00
113.00 11300 INTEREST EXPENSE						113. 00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	0		115. 00
116. 00 11600 HOSPI CE	0	0	0	0		116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	9, 769, 596	0	3, 046, 047	226, 649	883, 341	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	4, 735	0	13, 547	0		190. 00
191. 00 19100 RESEARCH	0	0	0	0		191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	1, 276, 835	0	217, 229	0		192. 00
193. 00 19300 NONPALD WORKERS	0	0	0	0		193. 00
194. 00 07950 OTHER NONREI MBURSABLE COST CENTERS	0	0	0	0		194. 00
194. 01 07951 OTHER NONREI MBURSABLE COST CENTERS	109, 261	0	0	0		194. 01
194. 02 07952 OTHER NONREIMBURSABLE COST CENTERS	135, 652	0	0	0	0	194. 02
200.00 Cross Foot Adjustments		-			_	200. 00
201.00 Negative Cost Centers	0	0	0 07/ 000	0 (40		201. 00
202.00 TOTAL (sum lines 118 through 201)	11, 296, 079	O	3, 276, 823	226, 649	951, 595	J202. 00

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2022 | Part | | To 12/31/2022 | Date/Time Prepared: | To 12/31/2022 | Date/Time Prepared: | To 12/31/2022 | To 12/31/2022

				10	12/31/2022	Date/lime Pre 5/30/2023 4:1	
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES &	PHARMACY	2 piii
		10.00	11 00	12.00	SUPPLY	15. 00	
	GENERAL SERVICE COST CENTERS	10.00	11. 00	13.00	14. 00	15.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMI NI STRATI VE & GENERAL						5. 00
6. 00	00600 MAI NTENANCE & REPAI RS						6. 00
7.00	00700 OPERATION OF PLANT						7. 00
8. 00 9. 00	O0800 LAUNDRY & LINEN SERVICE O0900 HOUSEKEEPING						8. 00 9. 00
10. 00	01000 DI ETARY	1, 304, 493					10.00
11. 00	01100 CAFETERI A	0	146, 843				11. 00
13. 00	01300 NURSING ADMINISTRATION	o	795				13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	935	67	699, 510		14. 00
15. 00	01500 PHARMACY	0	3, 805		0	903, 045	1
16. 00	01600 MEDI CAL RECORDS & LI BRARY	0	0	0	0	0	16. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	731, 942	24, 299	243, 365	ol	0	30.00
31. 00	03100 INTENSIVE CARE UNIT	216, 401	10, 137		0	0	31. 00
32. 00	03200 CORONARY CARE UNIT	0	0	0	o	0	32. 00
33. 00	03300 BURN INTENSIVE CARE UNIT	o	0	0	0	0	33. 00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34. 00
40. 00	04000 SUBPROVI DER - I PF	356, 150	12, 409	115, 306	0	0	40. 00
41. 00	04100 SUBPROVI DER – I RF	0	0	0	0	0	41.00
43. 00 44. 00	04300 NURSERY	0	0		O O	0	43. 00 44. 00
45. 00	04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY		0		0	0	45. 00
46. 00	04600 OTHER LONG TERM CARE	o	0		Ö	0	46. 00
	ANCILLARY SERVICE COST CENTERS	-1	-	-	-,		
50.00	05000 OPERATING ROOM	0	19, 353	163, 123	0	0	50.00
51. 00	05100 RECOVERY ROOM	0	0	0	0	0	51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52. 00
53. 00	05300 ANESTHESI OLOGY	0	00.544	0	0	0	53.00
54. 00 54. 01	05400 RADI OLOGY-DI AGNOSTI C 03630 ULTRA SOUND	0	20, 541		0	0	54. 00 54. 01
55. 00	05500 RADI OLOGY-THERAPEUTI C		571		0	0	55. 00
56. 00	05600 RADI OI SOTOPE	o	0	ol ol	Ö	0	56. 00
57. 00	05700 CT SCAN	o	0	Ö	Ö	0	57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	o	0	0	0	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59. 00
60. 00	06000 LABORATORY	0	0	0	0	0	60.00
60. 01	06001 BLOOD LABORATORY	0	0	0	O	0	60. 01
61. 00 62. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0		0	0	61. 00 62. 00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.		0		0	0	63.00
64. 00	06400 NTRAVENOUS THERAPY	o	0	o	o	0	64. 00
65. 00	06500 RESPI RATORY THERAPY	o	8, 672	2 0	0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	4, 632	0	0	0	66. 00
	06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0	0 115	0	0	68. 00
	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	0	3, 816	8, 115	O O	0	69. 00 70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		510, 642	0	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		188, 868	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	o	0	Ö	0	903, 045	1
74.00	07400 RENAL DIALYSIS	o	0	0	0	0	74. 00
	07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75. 00
	03480 ONCOLOGY	0	0	0	0	0	76. 00
	07697 CARDI AC REHABI LI TATI ON	0	0	0	0	0	76. 97
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION	l O	0) 0	U _I	0	77. 00
88. 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	n n	0		οl	0	88. 00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	o o	0		o o	0	89. 00
	09000 CLI NI C	o	3, 754	16, 351	0	0	90.00
91.00	09100 EMERGENCY	o	25, 868	267, 774	0	0	91. 00
	04950 WOUND CARE	0	0	0	0	0	91. 01
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
04.00	OTHER REIMBURSABLE COST CENTERS		^		ام	^	04.00
94. 00 95. 00	09400 HOME PROGRAM DIALYSIS 09500 AMBULANCE SERVICES		0		0	0	94. 00 95. 00
	09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0	0	96.00
	09700 DURABLE MEDICAL EQUIP-SOLD	0	0		o o	0	97. 00
	09850 OTHER REIMBURSABLE COST CENTERS	o	0	o	ō	0	1
99. 00	09900 CMHC	0	0	o		0	99. 00
		·					

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

			To	12/31/2022	Date/Time Pre 5/30/2023 4:1	
Cost Center Description	DIETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	Z piii
5551 551151 B5551 p11511	512171111		ADMI NI STRATI ON	SERVICES &		
				SUPPLY		
	10.00	11. 00	13.00	14. 00	15. 00	
99. 10 09910 CORF	0	0	0	0	0	, , ,
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		105. 00
106. 00 10600 HEART ACQUI SI TI ON	0	0	0	0		106. 00
107. 00 10700 LI VER ACQUI SI TI ON	0	0	0	0		107. 00
108.00 10800 LUNG ACQUISITION	0	0	0	0		108. 00
109.00 10900 PANCREAS ACQUISITION	0	0	0	0		109. 00
110.00 11000 I NTESTI NAL ACQUI SI TI ON	0	0	0	0		110. 00
111.00 11100 I SLET ACQUI SI TI ON	0	0	0	0	0	111. 00
113. 00 11300 I NTEREST EXPENSE						113. 00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	0		115. 00
116. 00 11600 HOSPI CE	0	0	0	0		116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	1, 304, 493	139, 587	955, 280	699, 510	903, 045	1118. 00
NONREI MBURSABLE COST CENTERS	ما		1	ما		
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1	0	0		190. 00
191. 00 19100 RESEARCH	0	4 050	0	0		191. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0	1, 858	82	0		192. 00
193.00 19300 NONPALD WORKERS 194.00 07950 OTHER NONRELMBURSABLE COST CENTERS	0	0		0		193. 00
194.00 07950 0THER NONREIMBURSABLE COST CENTERS	0	2.040		0		194. 00 194. 01
194. 02 07952 OTHER NONREIMBURSABLE COST CENTERS	0	3, 068 2, 329		0		194. 01
200.00 Cross Foot Adjustments	ď	2, 329	١	٩	U	200.00
201.00 Negative Cost Centers		0		0	0	200.00
202.00 TOTAL (sum lines 118 through 201)	1, 304, 493	146, 843	955, 362	699, 510	903, 045	
202. 00 TOTAL (Suiii TTHES TTO LTH OUGH 201)	1, 304, 493	140, 043	900, 302	099, 310	903, 043	1202.00

In Lieu of Form CMS-2552-10 Health Financial Systems FRANCISCAN HEALTH CRAWFORDSVILLE COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0022 Peri od: Worksheet B From 01/01/2022 Part I Date/Time Prepared: 12/31/2022 5/30/2023 4:12 pm Cost Center Description MEDI CAL Total Subtotal Intern & RECORDS & Residents Cost LI BRARY & Post Stepdown Adjustments 16.00 24.00 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 9.00 00900 HOUSEKEEPI NG 01000 DI ETARY 10 00 10 00 01100 CAFETERI A 11.00 11.00 13.00 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 14.00 01500 PHARMACY 15 00 15 00 16.00 01600 MEDICAL RECORDS & LIBRARY 682, 718 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 5, 915, 642 5, 915, 642 33 401 30.00 0 31.00 03100 INTENSIVE CARE UNIT 14, 306 2, 891, 944 2, 891, 944 31.00 32.00 03200 CORONARY CARE UNIT 0 0 03300 BURN INTENSIVE CARE UNIT 33.00 0 0 0 03400 SURGICAL INTENSIVE CARE UNIT 0 34 00 0 40.00 04000 SUBPROVI DER - I PF 13,653 3, 140, 995 0 3, 140, 995 40.00 04100 SUBPROVIDER - IRF 41.00 41.00 43.00 04300 NURSERY 0 0 0 0 0 04400 SKILLED NURSING FACILITY 0 44.00 Ω 0 0 45.00 04500 NURSING FACILITY 0 C 0 04600 OTHER LONG TERM CARE 46.00 46.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 69.645 6, 632, 211 0 6, 632, 211 51.00 05100 RECOVERY ROOM 0 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 0 0 53.00 05300 ANESTHESI OLOGY 0 53.00 0 05400 RADI OLOGY-DI AGNOSTI C 0 3, 934, 052 54 00 42.358 3, 934, 052 54 00 03630 ULTRA SOUND 54.01 17,067 177, 726 177, 726 54.01 05500 RADI OLOGY-THERAPEUTI C 55.00 0 0 05600 RADI 0I SOTOPE 383, 129 56,00 10.204 383, 129 56,00 57.00 05700 CT SCAN 65, 959 65, 959 65, 959 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 11, 512 11, 512 11, 512 58.00 05900 CARDIAC CATHETERIZATION 59.00 06000 LABORATORY 83.083 4, 464, 084 0 60.00 60.00 4, 464, 084 60.01 06001 BLOOD LABORATORY 0 0 60.01 61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 0 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 62.00 C 0 62.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 674 674 0 674 63.00 64.00 06400 INTRAVENOUS THERAPY 64.00 06500 RESPIRATORY THERAPY 9,764 1, 290, 946 0 1, 290, 946 65.00 06600 PHYSI CAL THERAPY 0 1, 414, 924 66.00 17,064 1, 414, 924 66,00 67.00 06700 OCCUPATIONAL THERAPY 67.00 06800 SPEECH PATHOLOGY 68.00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0022

			To	12/31/2022	Date/Time Prepared: 5/30/2023 4:12 pm
Cost Center Description	MEDI CAL RECORDS & LI BRARY	Subtotal	Intern & Residents Cost & Post Stepdown	Total	373072023 4. 12 piii
			Adjustments		
OO OO OOOFO OTHER RELABILISCARI E COCT OFHITERS	16. 00	24. 00	25. 00	26. 00	00.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS 99.00 09900 CMHC	0	0	0	0	98. 00 99. 00
99. 10 09910 CORF	0	0	0	0	99.00
100.00 10000 1&R SERVICES-NOT APPRVD PRGM	0	0	0	0	100.00
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	100.00
102.00 10200 OPI OI D TREATMENT PROGRAM	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS	<u> </u>	<u> </u>	O _I	O _I	102.00
105. 00 10500 KI DNEY ACQUI SI TI ON	O	0	0	0	105. 00
106. 00 10600 HEART ACQUISITION	o	o	0	0	106. 00
107. 00 10700 LIVER ACQUISITION	o	o	0	o	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 INTESTINAL ACQUISITION	O	O	0	0	110.00
111.00 11100 ISLET ACQUISITION	0	0	0	0	111. 00
113.00 11300 I NTEREST EXPENSE					113. 00
114.00 11400 UTILIZATION REVIEW-SNF					114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	0	115. 00
116. 00 11600 H0SPI CE	0	0	0	0	116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	682, 718	41, 874, 102	0	41, 874, 102	118. 00
NONREI MBURSABLE COST CENTERS					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	37, 997	0	37, 997	190. 00
191. 00 19100 RESEARCH	0	0	0	0	191. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0	5, 796, 192	0	5, 796, 192	192. 00
193. 00 19300 NONPALD WORKERS	0	0	0	0	193. 00
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS 194.01 07951 OTHER NONREIMBURSABLE COST CENTERS		474 005	0	474 005	194. 00 194. 01
194. 02 07952 OTHER NONREIMBURSABLE COST CENTERS	0	474, 805 588, 012	0	474, 805 588, 012	194. 01
200.00 Cross Foot Adjustments	٩	300, 012	0	300, 012	200. 00
201.00 Negative Cost Centers		0	0	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	682, 718	48, 771, 108	0	48, 771, 108	202. 00
1 ((٦		1==21 00

| Peri od: | Worksheet B | From 01/01/2022 | Part | I | To | 12/31/2022 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0022

Care Center Description Care Center Description Care Center Description Care Center Center Description Care Center						o 12/31/2022	Date/Time Pre 5/30/2023 4:1	
Assignment New Copi Table Co				CAPI TAL REI	_ATED COSTS		37 307 2023 4. 1.	Z piii
Assignment Name Copy Text Copy Cop		Cost Center Description	Directly	BLDG & FLXT	MVBLE FOULP	Subtotal	EMPLOYEE	
SPENDLOC DOTS CRIMINES 0 1.00 2.00 2A 4.00		cost center bescription		DEDG & TTAT	MVBLL LQOIT	Subtotal		
STATEMENT STRONG CHIST CHATTEST 1.00 1.00 2.00							DEPARTMENT	
1.00				1.00	2.00	2A	4. 00	
2.00	1 00		1					1 00
DOCAD DISCOUNT SERVICE OF SER								1
DOMESTION OF PLANT CONTROLL OF STREAM ISS 0 0 0 0 0 0 0 0 0			0	101, 686	176, 322	278, 008	278, 008	1
0.00 00700 00700 00FRATION OF PLANT 0 225 544 408, 427 463, 977 8.00 9.00 00500			0	205, 581	356, 474			•
0.000 0.0000 LANIDRY & LINEN SERVICE 0 2,127 3,669 62,352 10 0.00 0.0000 0.0000 0.11 1.000 1.000 0.000			0	235 544	0 408 427	١		•
0.00 0.00000 0.00000 0.00000 0.00000 0.000000 0.00000000								1
11.10.0 0 11000 (CAFFTERIA			0					1
13.00 01300 NINES INC. ADMINISTRATION 0 0 0 0 5.087 13.00			0					•
14. 00 01400 CENTRAL SERVICES & SUPPLY 0 98, 447 170, 706 269, 153 1.571 14. 00 16. 00 1000 MEDICAL RECORDS & LI BRARY 0 18, 931 32, 825 11, 756 7.08 15. 00 16. 00			0					•
15.00 O O O O PARAMACY O 18, 931 32, 25 51,756 7,308 15.00 O O O O O O O				Ŭ	l ~	-		1
INPATI ENT BOUTINE SERVICE COST CENTERS 1403, 823 32, 404 30 00 00 310 00 00 310 00	15. 00	01500 PHARMACY	0					•
30.00	16. 00		0	11, 518	19, 972	31, 490	0	16. 00
31.00 03100 NTENSI VE CARE UNIT 0 45,775 79,373 125,148 16,738 31.00 32.00 03200 CRORMARY CARE UNIT 0 0 0 0 0 32.00 33.00 3300 SURRI LINTENSI VE CARE UNIT 0 0 0 0 0 33.00 33.00 34.	30 00			147 705	256 119	403 833	32 404	30 00
32.00 03200 CORDMARY CARE UNIT			1					1
34.00 03400 SURGICAL INTENSIVE CARE UNIT 0 0 71,617 124,182 195,799 18,979 40,00	32.00	l I	0		C	0		1
00 04000 SUBPROVI DER - I PF			0	0	0	0	-	1
141 0.0 04100 SUPROVI DER - I FIF 0 0 0 0 0 0 0 0 0			0	U 71 617	124 182	195 799	-	1
43. 00 04300 NURSERY 0		l		71,017	124, 102	173, 777		1
45.00 O4500 OHURS ING FACILITY	43.00	04300 NURSERY	O	0	C	0	0	43. 00
40, 0 04600 O1400 O1 O O O O O O O O			0	0	C	0		1
AILCLILARY SERVICE COST CENTERS			1	_		0		1
51.00 05100 RECOVERY ROOM ALBOR ROOM 0 0 0 0 0 0 52 00 520 00 0	40.00		١	0		ı o	0	40.00
S2. 00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 0 0 0 52. 00	50.00	05000 OPERATING ROOM	0	235, 040	407, 556	642, 596	32, 944	1
S3. 00 05300 AMESTHESI DLOGY 0 0 0 0 0 0 0 0 0			0	0	C	0	0	•
S4. 00 05400 RADIO LOGY-DI AGNOSTIC 0 137, 948 239, 200 377, 148 37, 493 54, 00 54, 01 55, 00 05500 RADIO LOGY-THERAPEUTIC 0 0 7, 128 12, 359 19, 487 800 54, 01 55, 00 05500 RADIO LOGY-THERAPEUTIC 0 0 0 0 0 0 0 0 0			0	0		0	-	•
55. 00 05500 RADIOLOGY-THERAPEUTI C			l o	137, 948	239, 200	377, 148		1
56.00 05600 RABIO I SOTOPE 0 19,906 34,517 54,423 0 56.00	54. 01	03630 ULTRA SOUND	O	7, 128	12, 359	19, 487	800	54. 01
57.00 05700 CT SCAN 0 0 0 0 0 0 0 0 0			0	·	0.4 54.7	0		•
58. 00 05800 MAGNETIC RESONANCE I MAGIN G (MRI)			0	19, 906	34, 517	54, 423	-	•
60. 00 06000 LABORATORY 0 56, 819 98, 523 155, 342 0 60. 00			0	0		0	0	1
60.01 06001 BLOOD LABORATORY 0 0 0 0 0 0 0 60.01	59. 00		o	0	C	0	0	59. 00
61.00 06100 BPD CLI NI CAL LAB SERVI CES-PROM ONLY 0 0 0 0 0 0 0 0 0 0 62.00 62.00 06200 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 0 0 0 0 0 0 0 62.00 63.00 06300 BLOOD & STORI NG, PROCESSI NG & TRANS. 0 0 0 0 0 0 0 0 0 0 0 0 0 64.00 06400 INTRAVENOUS THERAPY 0 0 0 0 0 0 0 0 11,986 65.00 06500 RESPI RATORY THERAPY 0 0 0 0 0 0 0 11,986 65.00 06600 PHYSI CAL THERAPY 0 0 37,536 65,087 102,623 12,121 66.00 06600 PHYSI CAL THERAPY 0 0 0 0 0 0 0 0 0 0 0 0 67.00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 0 0 0 0 0 0 0 0 68.00 06600 PHYSI CAL THERAPY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 69.00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 69.00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1 I	0	56, 819	98, 523	155, 342	0	1
62.00 06200 MHOLE 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 0 65.00 06500 RESPI RATORY THERAPY 0 0 0 0 0 0 11, 986 65.00 06500 RESPI RATORY THERAPY 0 0 37, 536 65, 087 102,623 12, 121 66,000 67.00 06700 OCCUPATIONAL THERAPY 0 0 0 0 0 0 0 68.00 06800 SPEECH PATHOLOGY 0 0 0 0 0 0 0 69.00 06900 ELECTROCARDIOLOGY 0 59, 136 102,541 161,677 9, 349 69,000 70.00 07000 ELECTROCARDIOLOGY 0 59, 136 102,541 161,677 9, 349 69,000 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 74.00 07400 RENALD IALYSIS 0 0 0 0 0 0 75.00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 0 76.97 07697 CARDI AC REHABI LITATION 0 0 0 0 0 77.00 076097 CARDI AC REHABI LITATION 0 0 0 0 0 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 91.00 09900 EMERGENCY 0 148,409 257,340 405,749 38,555 91.00 91.01 04950 WOUND CARE 0 0 0 0 0 91.01 09400 HOME PROGRAM DIALYSIS 0 0 0 0 0 91.00 09500 AMBULANCE SERVICES 0 0 0 0 0 95.00 09500 AMBULANCE SERVICES 0 0 0 0 0 95.00 09500 AMBULANCE SERVICES 0 0 0 0 0 96.00 09500 AMBULANCE SERVICES 0 0 0 0 0 97.00 09500 AMBULANCE SERVICES 0 0 0 0 97.00 09500 AMBULANCE SERVICES 0 0 0 0 97.00 09500 AMBULANCE SERVICES 0 0 0 0 0 97.00 09500 AMBULANCE SERVICES 0 0 0 0 0 97.00 09500 09500 AMBULANCE SERVICES 0 0 0 0 0 97.00 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500 09500		1	0	0	C	0	0	1
63.00 66300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 0 0 0 63.00 64.00 06400 INTRAVENOUS THERAPY 0 0 0 0 0 0 0 65.00 06500 RESPIRATORY THERAPY 0 0 0 0 0 0 66.00 06600 PHYSI CAL THERAPY 0 0 0 0 0 0 67.00 06600 PHYSI CAL THERAPY 0 0 37,536 65,087 102,623 12,121 66.00 67.00 06600 PHYSI CAL THERAPY 0 0 0 0 0 0 68.00 06800 SPEECH PATHOLOGY 0 0 0 0 0 0 69.00 06900 ELECTROCARDIOLOGY 0 59,136 102,541 161,677 9,349 69.00 69.00 06900 ELECTROCARDIOLOGY 0 59,136 102,541 161,677 9,349 69.00 69.00 07000 ELECTROCARDIOLOGY 0 0 0 0 0 0 67.00 07000 ELECTROCARDIOLOGY 0 59,136 102,541 161,677 9,349 69.00 69.00 07000 ELECTROCARDIOLOGY 0 0 0 0 0 0 67.00 07000 ELECTROCARDIOLOGY 0 0 0 0 0 67.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 67.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 67.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 67.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 67.00 07380 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 67.00 07380 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 67.00 07380 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 67.00 07400 RENAL DIALYSIS 0 0 0 0 0 0 67.00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 67.00 07400 RENAL DIALYSIS 0 0 0 0 0 67.00 07700 ALLOGENEIC STEM CELL ACQUISITION 0 0 0 0 0 67.00 07600 CLINIT SERVICE COST CENTERS 68.00 08800 RURAL HEALTH CLINIC 0 0 38,254 66,332 104,586 9,006 90.00 69.00 09900 CLINIC CENTERS 0 0 0 0 0 69.00 09900 DREGERALLY OMALIFIED HEALTH CENTER 0 0 0 0 69.00 09900 OSERVATION BEDS (NON-DISTINCT PART) 0 0 0 0 0 69.00 09900 OSERVATION BEDS (NON-DISTINCT PART) 0 0 0 0 0 69.00 0990			0	0	C	0	0	1
65.00 06500 RESPI RATORY THERAPY 0 0 0 0 11, 986 65.00	63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	o	0	C	0	0	1
66. 00 06600 PHYSI CAL THERAPY 0 37, 536 65, 087 102, 623 12, 121 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 0 0 0 0 0 0 0 0 67. 00 68. 00 06800 SPEECH PATHOLOGY 0 0 0 0 0 0 0 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 59, 136 102, 541 161, 677 9, 349 69. 00 0 0 0 0 0 0 0 0 0			0	0	C	0		1
67. 00 06700 OCCUPATIONAL THERAPY 0 0 0 0 0 0 0 0 67. 00 68. 00 06800 SPEECH PATHOLOGY 0 0 0 0 0 0 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 59, 136 102, 541 161, 677 9, 349 69. 00 70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 0 0 70. 00 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 0 71. 00 72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 73. 00 74. 00 07400 RENAL DIALYSIS 0 0 0 0 0 0 0 0 73. 00 75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 0 0 75. 00 76. 00 03480 ONCOLOGY 0 0 0 0 0 0 0 75. 00 76. 07 07607 CARDIAC REHABILITATION 0 0 0 0 0 0 0 76. 00 0777. 00 07700 ALLOGENEIC STEM CELL ACQUISITION 0 0 0 0 0 0 0 0 0 0 0 0 88. 00 89. 00 08800 RURAL HEALTH CLINIC 0 0 38, 254 66, 332 104, 586 9, 006 91. 00 09900 CLINIC 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	0 37 536	65 087	102 623		1
68. 00 06800 SPEECH PATHOLOGY 0 0 0 0 0 0 0 0 68. 00 69. 00 69. 00 69. 00 LECTROCARDI OLOGY 0 59, 136 102, 541 161, 677 9, 349 69. 00 70. 00 70. 00 70. 00 0 0 0 0 0 0 0				0	05,007	102, 023		1
70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 0 0 0 0		1	O	0	C	0	0	68. 00
71. 00			0	59, 136	102, 541	161, 677	9, 349	1
72. 00			0	0		0	0	1
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 73. 00 74. 00 07400 RENAL DI ALYSI S 0 0 0 0 0 0 0 74. 00 75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 0 74. 00 75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 0 0 76. 00 76. 00 03480 ONCOLOGY 0 0 0 0 0 0 0 0 76. 00 76. 00 07697 CARDIAC REHABILITATION 0 0 0 0 0 0 0 76. 97 77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION 0 0 0 0 0 0 0 77. 00 OUTPATIENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC 0 0 0 0 0 0 89. 00 99. 00 09000 CLINIC 0 0 38, 254 66, 332 104, 586 9, 006 90. 00 91. 00 09100 EMERGENCY 0 148, 409 257, 340 405, 749 38, 555 91. 00 91. 01 04950 WOUND CARE 0 0 0 0 0 0 0 0 91. 01 92. 00 09400 HOME PROGRAM DIALYSIS 0 0 0 0 0 0 94. 00 95. 00 09500 AMBULANCE SERVICES 0 0 0 0 0 0 0 0 95. 00				0		0		1
75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 0 0 75. 00 76. 00 03480 ONCOLOGY 0 0 0 0 0 0 0 0 76. 00 76. 97 07697 CARDIAC REHABILITATION 0 0 0 0 0 0 0 76. 97 77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION 0 0 0 0 0 0 0 0 0 77. 00 OUTPATIENT SERVICE COST CENTERS 88. 00 08900 RURAL HEALTH CLINIC 0 0 0 0 0 0 88. 00 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 0 89. 00 90. 00 09000 CLINIC 0 0 38, 254 66, 332 104, 586 9, 006 90. 00 91. 00 09100 EMERGENCY 0 148, 409 257, 340 405, 749 38, 555 91. 00 91. 01 04950 WOUND CARE 0 0 0 0 0 0 0 0 0 91. 01 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	C	0	0	73. 00
76. 00 03480 ONCOLOGY 0 0 0 0 0 0 0 76. 00 76. 97 07697 CARDI AC REHABI LI TATI ON 0 0 0 0 0 0 0 76. 97 77. 00 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON 0 0 0 0 0 0 0 0 0 77. 00 OUTPATI ENT SERVI CE COST CENTERS 88. 00 08800 RURAL HEALTH CLI NI C 0 0 0 0 0 0 0 88. 00 89. 00 08900 FEDERALLY QUALI FI ED HEALTH CENTER 0 0 0 0 0 0 89. 00 90. 00 09000 CLI NI C 0 38, 254 66, 332 104, 586 9, 006 91. 00 09100 EMERGENCY 0 148, 409 257, 340 405, 749 38, 555 91. 00 91. 01 04950 WOUND CARE 0 0 0 0 0 0 0 0 91. 01 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 09400 HOME PROGRAM DI ALYSI S 0 0 0 0 0 0 0 94. 00 95. 00 09500 AMBULANCE SERVI CES 0 0 0 0 0 0 0 0 95. 00			0	0	C	0	0	•
76. 97 07697 CARDI AC REHABI LI TATI ON 0 0 0 0 0 0 0 76. 97 77. 00 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON 0 0 0 0 0 0 0 OUTPATI ENT SERVI CE COST CENTERS 88. 00 08800 RURAL HEALTH CLINI C 0 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 38, 254 66, 332 104, 586 9, 006 91. 00 09100 EMERGENCY 0 148, 409 257, 340 405, 749 38, 555 91. 01 04950 WOUND CARE 0 0 0 0 0 91. 01 92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 0 0 0 0 OTHER REI MBURSABLE COST CENTERS 94. 00 09400 HOME PROGRAM DI ALYSI S 0 0 0 0 0 95. 00 95. 00 09500 AMBULANCE SERVI CES 0 0 0 0 0 95. 00 96. 00 09500 AMBULANCE SERVI CES			0	0		0	0	1
77. 00 07700 ALLOGENEI C STEM CELL ACQUISITION 0 0 0 0 0 0 0 0 0			0	0		0	-	1
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 09900 CLINIC 0 38, 254 66, 332 104, 586 9, 006 90. 00 91. 00 09100 EMERGENCY 0 148, 409 257, 340 405, 749 38, 555 91. 00 91. 01 04950 WOUND CARE 0 0 0 0 0 0 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 92. 00 00 00 00 0 0 0 00 00 00 00 00 94. 00 09500 AMBULANCE SERVICES 0 0 0 0 0 95. 00 09500 AMBULANCE SERVICES 0 0 0 0 00 0 0 0 0 00 0	77. 00		0	0	C	0	0	77. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 0 0 0 89. 00 90. 00 09000 CLINIC 0 38, 254 66, 332 104, 586 9, 006 90. 00 91. 00 09100 EMERGENCY 0 148, 409 257, 340 405, 749 38, 555 91. 00 91. 01 04950 WOUND CARE 0 0 0 0 0 0 91. 01 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 0 0 92. 00 OTHER REIMBURSABLE COST CENTERS 94. 00 09500 AMBULANCE SERVICES 0 0 0 0 0 0 0 95. 00	00.00			=	-			00.00
90. 00 09000 CLINIC 0 38, 254 66, 332 104, 586 9, 006 90. 00 91. 00 09100 EMERGENCY 0 148, 409 257, 340 405, 749 38, 555 91. 00 91. 01 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 0 0 0 0 0 0				0		0		
91. 00			0	38. 254	66. 332	104. 586	-	•
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 92. 00		09100 EMERGENCY						1
OTHER REI MBURSABLE COST CENTERS 94. 00 09400 HOME PROGRAM DI ALYSI S 0 0 0 0 94. 00 95. 00 09500 AMBULANCE SERVI CES 0 0 0 0 0 95. 00		1	0	0	C	0	0	1
94. 00 09400 HOME PROGRAM DI ALYSI S 0 0 0 0 94. 00 95. 00 09500 AMBULANCE SERVI CES 0 0 0 0 95. 00 0 0 0 0 0 0 0 0 0	92. 00					0		92.00
95. 00 09500 AMBULANCE SERVI CES 0 0 0 95. 00	94. 00		O	0	C	O	0	94. 00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 96. 00	95. 00	09500 AMBULANCE SERVICES		0	0	o	0	95. 00
	96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	[C	0	0	96. 00

In Lieu of Form CMS-2552-10
Period: Worksheet B
From 01/01/2022 Part II Provi der CCN: 15-0022

			To	12/31/2022	Date/Time Pre 5/30/2023 4:1	pared:
		CAPI TAL REL	ATED COSTS		3/30/2023 4. 1	Z piii
		CALLIAL KLI	LATED COSTS			
Cost Center Description	Directly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
	Assigned New				BENEFI TS	
	Capi tal				DEPARTMENT	
	Related Costs					
	0	1. 00	2. 00	2A	4. 00	
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97. 00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98. 00
99. 00 09900 CMHC	0	0	0	0	0	99. 00
99. 10 09910 CORF	0	0	0	0	0	99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100. 00
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00
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 ACQUISITION	0	0	0	0	0	106. 00
107.00 10700 LIVER ACQUISITION	0	0	0	0	0	107. 00
108.00 10800 LUNG ACQUISITION	0	0	0	0	0	108. 00
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 I NTEREST EXPENSE						113. 00
114.00 11400 UTILIZATION REVIEW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115. 00
116. 00 11600 HOSPI CE	0	0	0	0	0	116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	1, 822, 556	3, 160, 283	4, 982, 839	255, 100	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	5, 691	9, 869	15, 560		190. 00
191. 00 19100 RESEARCH	0	0	0	0		191. 00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	91, 265	158, 253	249, 518		192. 00
193. 00 19300 NONPALD WORKERS	0	0	0	0		193. 00
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0		194. 00
194.01 07951 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0		194. 01
194.02 07952 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	4, 686	194. 02
200.00 Cross Foot Adjustments				0		200. 00
201.00 Negative Cost Centers		0	0	0		201. 00
202.00 TOTAL (sum lines 118 through 201)	0	1, 919, 512	3, 328, 405	5, 247, 917	278, 008	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provi der CCN: 15-0022

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2022 | Part II | To 12/31/2022 | Date/Time Prepared: | 5/30/2023 4:12 pm

	Cost Center Description	ADMI NI STRATI VE	MAINTENANCE &	OPERATION OF	LAUNDRY &	5/30/2023 4: 1. HOUSEKEEPI NG	
		& GENERAL	REPAI RS	PLANT	LI NEN SERVI CE	0.00	
	GENERAL SERVICE COST CENTERS	5.00	6. 00	7. 00	8. 00	9. 00	
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	5,00,0					4. 00
5. 00 6. 00	00500 ADMI NI STRATI VE & GENERAL	569, 964	0				5. 00 6. 00
7. 00	OO6OO MAINTENANCE & REPAIRS OO7OO OPERATION OF PLANT	38, 294	0	688, 046			7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	2, 590	0	1, 063	9. 756		8. 00
9.00	00900 HOUSEKEEPI NG	10, 193	0	11, 398	1, 082	85, 035	9. 00
10. 00	01000 DI ETARY	11, 942	0	45, 551	66	5, 733	
11. 00	01100 CAFETERI A	653	0	14, 744	0	.,	
13.00	01300 NURSI NG ADMI NI STRATI ON	11, 155	0	0	0	0	13. 00
14. 00 15. 00	01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY	4, 605 9, 827	0	49, 202 9, 461	36 0		14. 00 15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	7, 563	0	5, 757	0	.,	16. 00
10.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	7,7000	<u> </u>	3,737	<u>_</u>		10.00
30.00	03000 ADULTS & PEDIATRICS	50, 933	0	73, 820	2, 959	9, 292	30. 00
31. 00	03100 INTENSIVE CARE UNIT	27, 702	0	22, 877	277	2, 880	31. 00
32.00	03200 CORONARY CARE UNIT	0	0	0	0	·	32. 00
33.00	03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34. 00 40. 00	03400 SURGICAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF	28, 064	0	35, 792	910	0 4, 505	34. 00 40. 00
41. 00	04100 SUBPROVI DER - I RF	20,004	0	0 0	0	0	41. 00
43. 00	04300 NURSERY	o	0	0	0	0	43.00
44.00	04400 SKILLED NURSING FACILITY	o	0	0	0	0	44. 00
45. 00	04500 NURSING FACILITY	0	0	0	0	0	45. 00
46. 00	04600 OTHER LONG TERM CARE	0	0	0	0	0	46. 00
FO 00	ANCILLARY SERVICE COST CENTERS O5000 OPERATING ROOM	/F 740	٥	117 4/0	1 202	14 70/	FO 00
50. 00 51. 00	05100 RECOVERY ROOM	65, 740 0	0	117, 468	1, 303	14, 786 0	50. 00 51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM		0	0	0	0	52. 00
53. 00	05300 ANESTHESI OLOGY		Ö	0	0	Ö	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	40, 074	0	68, 943	363	8, 678	
54.01	03630 ULTRA SOUND	1, 614	0	3, 562	0	448	54. 01
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55. 00
56. 00	05600 RADI OI SOTOPE	3, 641	0	9, 949	0	1, 252	
57. 00	05700 CT SCAN	0	0	0	0	0	57. 00
58. 00	O5800 MAGNETIC RESONANCE MAGING (MRI)	0	0	0	0	0	58. 00
59. 00 60. 00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	49, 150	0	28, 397	0	0 3,574	59. 00 60. 00
60. 01	06001 BLOOD LABORATORY	47, 130	0	20, 377	0	0,374	60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		Ŭ	J	J	l	61. 00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	o	0	0	0	0	62. 00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63. 00
64. 00	06400 I NTRAVENOUS THERAPY	0	0	0	0	0	64. 00
65. 00	06500 RESPI RATORY THERAPY	14, 857	0	0	50	ł	65. 00
66. 00 67. 00	O6600 PHYSI CAL THERAPY O6700 OCCUPATI ONAL THERAPY	14, 860	0	18, 760	253 0	1	
68. 00	06800 SPEECH PATHOLOGY		0	0	0		68. 00
69. 00	06900 ELECTROCARDI OLOGY	9, 817	0	29, 555	0	3, 720	69. 00
	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	12, 790	0	0	0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	3, 248	0	0	0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	15, 378	0	0	0	0	73. 00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74. 00
76. 00	07500 ASC (NON-DISTINCT PART) 03480 ONCOLOGY	0	0	0	0	0	75. 00 76. 00
	07697 CARDI AC REHABI LI TATI ON	0	0	0	0	0	76. 97
	07700 ALLOGENEIC STEM CELL ACQUISITION	o	0	0	0	Ö	77. 00
	OUTPATIENT SERVICE COST CENTERS	-1	-				
88. 00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89. 00
90.00	09000 CLINIC	6, 170	0	19, 119	0	2, 406	90.00
91.00	09100 EMERGENCY	52, 081	0	74, 172	2, 457	1	91.00
91. 01 92. 00	04950 WOUND CARE 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	U	0	U	0	91. 01 92. 00
92.00	OTHER REIMBURSABLE COST CENTERS						92.00
94. 00	09400 HOME PROGRAM DIALYSIS	n	n	n	n	0	94. 00
95. 00	09500 AMBULANCE SERVICES		Ö	Ō	0	Ö	95. 00
	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96. 00
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD		0	0	0	0	97. 00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98. 00
99. 00	09900 CMHC	0	0	0	0	0	99. 00
99. 10	09910 CORF	l 0	U	0	Ü	0	99. 10

200.00

0 201. 00

85, 035 202. 00

9, 756

688, 046

ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0022 Peri od: Worksheet B From 01/01/2022 Part II 12/31/2022 Date/Time Prepared: 5/30/2023 4:12 pm ADMINISTRATIVE MAINTENANCE & Cost Center Description OPERATION OF LAUNDRY & HOUSEKEEPI NG & GENERAL **REPAIRS** PLANT LINEN SERVICE 5.00 6.00 7.00 8.00 9.00 100, 00 10000 I &R SERVICES-NOT APPRVD PRGM 0 100, 00 0 0 0 101.00 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 0 105.00 0 0 0 0 0 0 0 106.00 10600 HEART ACQUISITION 0 0 0 0 0 0 106.00 107. 00 10700 LIVER ACQUISITION 0 0 107. 00 108.00 10800 LUNG ACQUISITION 0 0 108.00 0 109. 00 10900 PANCREAS ACQUISITION 0 0 109.00 0 110.00 11000 INTESTINAL ACQUISITION 0 0 110.00 111.00 11100 | SLET ACQUISITION 0 0 0 0 111. 00 113.00 11300 INTEREST EXPENSE 113. 00 114.00 11400 UTI LI ZATI ON REVIEW-SNF 114. 00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 0 0 0 0 115. 00 116. 00 11600 HOSPI CE 0 116.00 0 0 0 0 SUBTOTALS (SUM OF LINES 1 through 117)
NONREI MBURSABLE COST CENTERS 9, 756 7<u>8, 936</u> 118. 00 118.00 492, 943 639, 590 0 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 358 190. 00 239 2,844 0 0 191. 00 5, 741 192. 00 191. 00 19100 RESEARCH 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 64.424 45, 612 193. 00 19300 NONPALD WORKERS 0 0 193. 00 194. 00 07950 OTHER NONREIMBURSABLE COST CENTERS 0 0 0 194.00 0 0 194. 01 194. 01 07951 OTHER NONREI MBURSABLE COST CENTERS 5, 513 0 0 194. 02 07952 OTHER NONREIMBURSABLE COST CENTERS 0 194. 02 6,845 C 0 0

569, 964

200.00

201.00

202.00

Cross Foot Adjustments

TOTAL (sum lines 118 through 201)

Negative Cost Centers

In Lieu of Form CMS-2552-10

Period:	Worksheet B
From 01/01/2022	Part II
To 12/31/2022	Date/Time Prepared:
5/30/2023 4:12 pm	

) 12/31/2022	5/30/2023 4:1	
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	
				ADMI NI STRATI ON	SERVI CES & SUPPLY		
		10.00	11. 00	13. 00	14. 00	15. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4. 00 5. 00	00400 EMPLOYEE BENEFITS DEPARTMENT			•			4. 00 5. 00
6.00	OO5OO ADMINISTRATIVE & GENERAL OO6OO MAINTENANCE & REPAIRS			•			6. 00
7. 00	00700 OPERATION OF PLANT						7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE						8. 00
9.00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY	312, 523					10. 00
11. 00	01100 CAFETERI A	0	54, 063	1			11. 00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	293		221 105		13.00
14. 00 15. 00	O1400 CENTRAL SERVI CES & SUPPLY O1500 PHARMACY	0	344 1, 401		331, 105 0	80, 944	14. 00 15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY		1, 401	1	0	00, 744	16. 00
10.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	<u> </u>		<u> </u>			10.00
30.00	03000 ADULTS & PEDI ATRI CS	175, 355	8, 946	4, 212	0	0	30. 00
31.00	03100 INTENSIVE CARE UNIT	51, 844	3, 732	2, 303	0	0	31. 00
32. 00	03200 CORONARY CARE UNIT	0	0	0	0	0	32.00
33.00	03300 BURN INTENSIVE CARE UNIT	0	0		0	0	33. 00 34. 00
34. 00 40. 00	03400 SURGICAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF	85, 324	4, 569	1, 996	0	0	40.00
41. 00	04100 SUBPROVI DER - I RF	05, 524	4, 307	1, 770	0	0	41. 00
43. 00	04300 NURSERY	l ol	0	Ö	Ö	0	43. 00
44.00	04400 SKILLED NURSING FACILITY	o	0	0	0	0	44. 00
45.00	04500 NURSING FACILITY	O	0	0	0	0	45. 00
46. 00	04600 OTHER LONG TERM CARE	0	0	0	0	0	46. 00
EO 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	0	7 125	2, 823	O	0	E0 00
50. 00 51. 00	05100 RECOVERY ROOM	0	7, 125 0		0	0	50. 00 51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM		0		0	0	52.00
53. 00	05300 ANESTHESI OLOGY	l ol	0	Ö	Ö	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	o	7, 563	141	0	0	54.00
54. 01	03630 ULTRA SOUND	O	210	0	0	0	54. 01
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55. 00
56. 00	05600 RADI OI SOTOPE	0	0	0	0	0	56. 00
57. 00	05700 CT SCAN	0	0	0	0	0	57. 00
58. 00 59. 00	05800 MAGNETIC RESONANCE I MAGING (MRI) 05900 CARDIAC CATHETERIZATION	0	0	0	0	0	58. 00 59. 00
60. 00	06000 LABORATORY		0		0	0	60.00
60. 01	06001 BLOOD LABORATORY	l ol	0	Ö	o	0	60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61. 00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63. 00
64. 00	06400 I NTRAVENOUS THERAPY	0	0	0	0	0	64.00
65. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0	3, 193	1	0	0	65. 00
66. 00 67. 00	06700 OCCUPATIONAL THERAPY		1, 705		0	0	
68. 00	06800 SPEECH PATHOLOGY		0	Ö	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	o	1, 405	140	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	o	0	0	0	0	70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	241, 707	0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	89, 398	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	80, 944	73.00
74. 00 75. 00	07400 RENAL DI ALYSI S 07500 ASC (NON-DI STI NCT PART)	0	0	0	0	0	74. 00 75. 00
76. 00	03480 ONCOLOGY		0		0	0	76.00
76. 97	07697 CARDI AC REHABI LI TATI ON		0	Ö	Ö	0	76. 97
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	Ö	0	O	0	0	1
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	
90.00	09000 CLINIC	0	1, 382		0	0	90.00
91. 00 91. 01	O9100 EMERGENCY O4950 WOUND CARE	0	9, 524	4, 635	0	0	91. 00 91. 01
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	٩	O		U	O	92.00
,2.00	OTHER REIMBURSABLE COST CENTERS						,2.00
94. 00	09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94. 00
95. 00	09500 AMBULANCE SERVICES	0	0	0	0	0	
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96. 00
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0		0	0	97.00
98. 00 99. 00	O9850 OTHER REIMBURSABLE COST CENTERS O9900 CMHC		0		O O	0	98. 00 99. 00
77.00	0.755 Omito	<u>, </u>	0	١	- υ	0	1 / / . 00

| Period: | Worksheet B | From 01/01/2022 | Part II | To | 12/31/2022 | Date/Time | Prepared: Provider CCN: 15-0022

			To	12/31/2022	Date/Time Pre 5/30/2023 4:1:	
Cost Center Description	DIETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	z piii
5051 5011tol. 55551 F11 511	512171111		ADMI NI STRATI ON	SERVICES &		
				SUPPLY		
	10.00	11. 00	13. 00	14. 00	15. 00	
99. 10 09910 CORF	0	0	0	0	0	99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	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		105. 00
106. 00 10600 HEART ACQUISITION	0	0	0	0		106. 00
107. 00 10700 LIVER ACQUISITION	0	0	0	0		107. 00
108.00 10800 LUNG ACQUISITION	0	0	0	0		108. 00
109.00 10900 PANCREAS ACQUISITION	0	0	0	0		109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0		110. 00
111.00 11100 I SLET ACQUI SI TI ON	0	0	0	0	0	111. 00
113. 00 11300 I NTEREST EXPENSE						113. 00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	0		115. 00
116. 00 11600 HOSPI CE	0	0	0	0		116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	312, 523	51, 392	16, 534	331, 105	80, 944	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190. 00
191. 00 19100 RESEARCH	0	0	0	0		191. 00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	684	1	0		192. 00
193.00 19300 NONPALD WORKERS	0	0	0	0		193. 00
194. 00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0		194. 00
194. 01 07951 OTHER NONREI MBURSABLE COST CENTERS	0	1, 129	0	0		194. 01
194. 02 07952 OTHER NONREIMBURSABLE COST CENTERS	0	858	0	0	0	194. 02
200.00 Cross Foot Adjustments		50 5/0				200. 00
201.00 Negative Cost Centers	0	50, 568		0		201. 00
202.00 TOTAL (sum lines 118 through 201)	312, 523	104, 631	16, 535	331, 105	80, 944	202.00

		KANCISCAN HEALTH				u of form CMS	2552-10
ALLOCA	NTION OF CAPITAL RELATED COSTS		Provi der CC		eriod: rom 01/01/2022 o 12/31/2022	Worksheet B Part II Date/Time Pre 5/30/2023 4:1	pared: 2 pm
	Cost Center Description	MEDI CAL RECORDS & LI BRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		16.00	24.00	25. 00	26. 00		
	GENERAL SERVICE COST CENTERS						
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 MAI NTENANCE & REPAI RS						6.00
7.00	00700 OPERATION OF PLANT						7. 00
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
9.00	00900 HOUSEKEEPI NG						9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A						10.00
13. 00	01300 NURSI NG ADMINI STRATI ON						13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY						14. 00
15. 00	01500 PHARMACY						15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	45, 535					16. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	2, 229	763, 973	0	763, 973		30.00
31. 00	03100 NTENSI VE CARE UNI T	955	254, 456				31.00
32.00	03200 CORONARY CARE UNIT	0	0	0	0		32. 00
33.00	03300 BURN INTENSIVE CARE UNIT	0	0	0	0		33.00
34. 00 40. 00	03400 SURGICAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF	911	0 376, 849	0	0 376, 849		34. 00 40. 00
41. 00	04100 SUBPROVI DER – TPF	911	370, 649 0	0	370, 649		41.00
43. 00	04300 NURSERY	o	0	Ö	Ö		43. 00
44.00	04400 SKILLED NURSING FACILITY	0	0	0	0		44. 00
45. 00	04500 NURSING FACILITY	0	0	0	0		45. 00
46.00	04600 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS	0	0	0	0		46. 00
50.00	05000 OPERATI NG ROOM	4, 647	889, 432	0	889, 432		50.00
51. 00	05100 RECOVERY ROOM	0	0	0			51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0		52. 00
53. 00 54. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	2, 826	0 543, 229	0	0 543, 229		53. 00 54. 00
54. 01	03630 ULTRA SOUND	1, 139	27, 260		27, 260		54. 01
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0	0	0		55. 00
56.00	05600 RADI OI SOTOPE	681	69, 946		69, 946		56. 00
57. 00 58. 00	05700 CT SCAN	4, 401 768	4, 401 768	0	4, 401 768		57. 00 58. 00
59. 00	05800 MAGNETIC RESONANCE MAGING (MRI) 05900 CARDIAC CATHETERIZATION	700	700	0	0		59.00
60.00	06000 LABORATORY	5, 544	242, 007	Ö	242, 007		60.00
60. 01	06001 BLOOD LABORATORY	0	0	0	0		60. 01
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06300 BLOOD STORING, PROCESSING & TRANS.	45	45	0	0 45		62.00
64. 00	06400 I NTRAVENOUS THERAPY	0	0	Ö	0		64. 00
65.00	06500 RESPI RATORY THERAPY	652	30, 738	0	30, 738		65. 00
66.00	06600 PHYSI CAL THERAPY	1, 139	153, 822	0	153, 822		66. 00
67. 00 68. 00	06700 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY	0	0	0	0		67. 00 68. 00
69. 00	06900 ELECTROCARDI OLOGY	1, 806	217, 469		217, 469		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	O	0	0	0		70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 695	257, 192	0	257, 192		71.00
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	434 1, 759	93, 080 98, 081	0	93, 080 98, 081		72. 00
74. 00	07400 RENAL DIALYSIS	1, 737	70,001	0	90, 001		74.00
75. 00	l i	0	0	0	0		75. 00
76. 00	03480 ONCOLOGY	2	4	0	4		76. 00
76. 97	07697 CARDIAC REHABILITATION 07700 ALLOGENEIC STEM CELL ACQUISITION	201	201 0	0	201 0		76. 97 77. 00
77.00	OUTPATIENT SERVICE COST CENTERS	1 0	0	0	O ₁		77.00
88. 00		0	0	0	0		88. 00
89. 00		0	0	0	0		89. 00
90.00	09000 CLINIC	227	143, 179		143, 179		90.00
91. 00 91. 01	09100 EMERGENCY 04950 WOUND CARE	12, 474	608, 983 0	0	608, 983 0		91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)			0	-		92.00
	OTHER REIMBURSABLE COST CENTERS	_					
94.00		0	0	0	-		94.00
95. 00 96. 00	09500 AMBULANCE SERVI CES 09600 DURABLE MEDI CAL EQUI P-RENTED		0	0	0		95. 00 96. 00
	09700 DURABLE MEDICAL EQUIP-SOLD		0	0			97. 00
	· · · · · · · · · · · · · · · · · · ·	1					•

Health Financial Systems FRANCISCAN HEALTH CRAWFORDSVILLE In Lieu of Form CMS-2552-10 ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0022 Peri od: Worksheet B From 01/01/2022 Part II Date/Time Prepared: 12/31/2022 5/30/2023 4:12 pm Cost Center Description MEDI CAL Subtotal Intern & Total RECORDS & Residents Cost LI BRARY & Post Stepdown Adjustments 16.00 24.00 26.00 25.00 98. 00 09850 OTHER REIMBURSABLE COST CENTERS 98.00 0 99. 00 09900 CMHC 0 0 0 0 99.00 0 99. 10 09910 CORE 0 99. 10 0 100.00 10000 I&R SERVICES-NOT APPRVD PRGM 0 100.00 0 101.00 10100 HOME HEALTH AGENCY 0 0 0 101. 00 102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 102.00 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 0 0 0 0 106. 00 107. 00 10700 LI VER ACQUI SI TI ON 0 0 107.00 108.00 10800 LUNG ACQUISITION 0 0 108.00 109.00 10900 PANCREAS ACQUISITION 109. 00 110.00 11000 INTESTINAL ACQUISITION 0 0 110.00 0 111.00 11100 | SLET ACQUISITION 0 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 0 115. 00 O 116. 00 11600 HOSPI CE 0 116. 00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 45, 535 4, 775, 115 0 4, 775, 115 118.00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 191. 00 19100 RESEARCH 0 190. 00 0 19,002 19,002 0 0 191.00 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 379, 360 379, 360 192. 00 0 193. 00 19300 NONPALD WORKERS 0 0 0 193.00 0 194. 00 07950 OTHER NONREI MBURSABLE COST CENTERS 194 00 C 0 194. 01 07951 OTHER NONREIMBURSABLE COST CENTERS 194. 01 0 11, 483 11, 483 194. 02 07952 OTHER NONREIMBURSABLE COST CENTERS 0 12, 389 0 12, 389 194. 02 200.00 Cross Foot Adjustments 0 200. 00

45, 535

0

0

50, 568

5, 247, 917

201.00

202. 00

50, 568

5, 247, 917

201.00

202.00

Negative Cost Centers

TOTAL (sum lines 118 through 201)

Health Financial Systems FRANCISCAN HEALTH CRAWFORDSVILLE In Lieu of Form CMS-2552-10 COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0022 Peri od: Worksheet B-1 From 01/01/2022 12/31/2022 Date/Time Prepared: 5/30/2023 4:12 pm CAPITAL RELATED COSTS Cost Center Description BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Reconciliation ADMINISTRATIVE (SQUARE FEET) (SQUARE FEET) BENEFITS & GENERAL (ACCUM. COST) DEPARTMENT (GROSS SALARI ES) 1.00 2.00 5. 00 4.00 5A GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 141 652 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 141, 652 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 7.504 7, 504 14, 256, 353 4.00 00500 ADMINISTRATIVE & GENERAL 15, 171 5 00 15, 171 405, 573 -11, 296, 079 37, 475, 029 5 00 6.00 00600 MAINTENANCE & REPAIRS 6.00 7.00 00700 OPERATION OF PLANT 17, 382 17, 382 296, 422 2, 517, 865 7.00 00800 LAUNDRY & LINEN SERVICE 157 157 0 170, 263 8.00 8.00 14.725 Ó 00900 HOUSEKEEPI NG 670, 175 9 00 1.683 1, 683 516 9 00 10.00 01000 DI ETARY 6,726 6,726 2, 433 0 785, 191 10.00 01100 CAFETERI A o 42, 922 11.00 2, 177 2, 177 344, 842 11.00 0 01300 NURSING ADMINISTRATION 733, 476 13.00 260, 841 13.00 01400 CENTRAL SERVICES & SUPPLY 80, 570 14.00 7 265 7.265 302, 779 14 00 15.00 01500 PHARMACY 1, 397 1, 397 374, 767 0 646, 101 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 850 850 0 497, 295 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 10 900 10, 900 1, 661, 668 0 3, 348, 902 30.00 03100 INTENSIVE CARE UNIT 3, 378 3, 378 858, 290 1, 821, 405 31.00 31.00 32.00 03200 CORONARY CARE UNIT 0 0 0 32.00 0 33.00 03300 BURN INTENSIVE CARE UNIT 0 0 0 33.00 0 34.00 03400 SURGICAL INTENSIVE CARE UNIT Λ Λ 34 00 04000 SUBPROVIDER - IPF 0 1, 845, 248 40.00 5, 285 5, 285 973, 238 40.00 0 04100 SUBPROVI DER - I RF 41.00 41.00 C 0 43.00 04300 NURSERY 0 0 0 0 43.00 44.00 04400 SKILLED NURSING FACILITY 0 C 0 0 0 44.00 04500 NURSING FACILITY 0 45.00 0 0 45.00 04600 OTHER LONG TERM CARE 46.00 0 46.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 4, 322, 088 50.00 17.345 17.345 1, 689, 362 50.00 0 51.00 05100 RECOVERY ROOM 0 51.00 0 0 05200 DELIVERY ROOM & LABOR ROOM 52 00 0 0 Λ 52 00 53.00 05300 ANESTHESI OLOGY 0 0 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 10, 180 10, 180 1, 922, 603 0 2, 634, 906 54.00 03630 ULTRA SOUND 41, 025 106, 118 54.01 54.01 526 526 05500 RADI OLOGY-THERAPEUTI C 55.00 0 Ω 55.00 56.00 05600 RADI OI SOTOPE 1,469 1.469 0 0 239, 376 56.00 57.00 05700 CT SCAN 0 0 0 0 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0 58 00 0 C 0 58 00 05900 CARDIAC CATHETERIZATION 59.00 Ω C 0 0 59.00 60.00 06000 LABORATORY 4.193 4, 193 0 3, 231, 650 60.00 60.01 06001 BLOOD LABORATORY 0 0 60.01 0 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61 00 61 00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 62.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 63.00 0 63.00 64.00 06400 I NTRAVENOUS THERAPY 0 0 64.00 0 06500 RESPI RATORY THERAPY 976, 882 65.00 0 614, 621 65 00 66.00 06600 PHYSI CAL THERAPY 2,770 2,770 621, 565 977, 058 66.00 06700 OCCUPATIONAL THERAPY 67.00 67.00 0 06800 SPEECH PATHOLOGY 68.00 68.00 0 0 06900 ELECTROCARDI OLOGY 479, 411 645, 460 69 00 4.364 4.364 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 0 0 0 840, 933 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 213, 538 72 00 C 72 00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 1, 011, 100 73.00 07400 RENAL DIALYSIS 0 0 74.00 0 0 74.00 0 0 07500 ASC (NON-DISTINCT PART) 75.00 0 75.00 0 0 03480 ONCOLOGY 76.00 Ω 103 76.00 76. 97 07697 CARDIAC REHABILITATION 0 0 0 76.97 0 07700 ALLOGENEIC STEM CELL ACQUISITION 77.00 0 77.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 0 0 88 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 89.00 0 90.00 09000 CLI NI C 2,823 2, 823 461, 848 405, 683 90.00 09100 EMERGENCY 91.00 10.952 10, 952 1, 977, 319 0 3, 424, 357 91.00 91.01 04950 WOUND CARE 0 0 0 91.01 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DIALYSIS 94 00 94 00 0 Ω

0

0 95.00

09500 AMBULANCE SERVICES

95.00

| Peri od: | Worksheet B-1 | From 01/01/2022 | To 12/31/2022 | Date/Time Prepared: Provi der CCN: 15-0022

				T-	12/31/2022	Date/Time Pre 5/30/2023 4:1	
		CAPITAL REL	ATED COSTS			1 0, 00, 2020 11 1	_ p
Cost Center Des	cription	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconci I i ati on	ADMI NI STRATI VE & GENERAL (ACCUM. COST)	
		1.00	2. 00	4. 00	5A	5. 00	
96.00 09600 DURABLE MEDICAL		0	0	0	- 1	0	96. 00
97. 00 09700 DURABLE MEDI CAL		0	0	0	0	0	97. 00
98. 00 09850 OTHER REI MBURSA	ABLE COST CENTERS	0	0	0	0	0	98. 00
99. 00 09900 CMHC		0	0	0	0	0	99. 00
99. 10 09910 CORF	T 400010 0001	0	0	0	0	0	99. 10
100.00 10000 I &R SERVI CES-NO		0	0	0	0		100.00
101. 00 10100 HOME HEALTH AGE		0	0	0	-		101. 00
102.00 10200 OPI OI D TREATMEN SPECIAL PURPOSE COST		U U	0	0	0	U	102. 00
105. 00 10500 KI DNEY ACQUI SI T		0	0	0	0	0	105. 00
106. 00 10600 HEART ACQUISITI			0	0			106. 00
107. 00 10700 LI VER ACQUI SI TI		o o	0	0	0		107. 00
108. 00 10800 LUNG ACQUISITIO		0	0	0	0		108. 00
109. 00 10900 PANCREAS ACQUIS		o	0	0	0		109. 00
110.00 11000 INTESTINAL ACQU		o	0	0	0		110. 00
111.00 11100 SLET ACQUISITI		o	0	0	0		111. 00
113.00 11300 INTEREST EXPENS	Ε						113. 00
114.00 11400 UTILIZATION REV	'I EW-SNF						114. 00
115.00 11500 AMBULATORY SURG	GICAL CENTER (D.P.)	O	0	0	0	0	115. 00
116. 00 11600 HOSPI CE		0	0	0	0		116. 00
	OF LINES 1 through 117)	134, 497	134, 497	13, 081, 639	-11, 296, 079	32, 410, 874	118. 00
NONREI MBURSABLE COST							
190. 00 19000 GIFT, FLOWER, C	OFFEE SHOP & CANTEEN	420	420	33			
191. 00 19100 RESEARCH		0	0	0	۰		191. 00
192. 00 19200 PHYSI CI ANS' PRI		6, 735	6, 735	686, 136	0	4, 235, 941	
193. 00 19300 NONPALD WORKERS		0	0	0	0	_	193. 00
194. 00 07950 OTHER NONREI MBL		0	0	0	0		194. 00
194. 01 07951 OTHER NONREI MBL		0	0	248, 241	0	362, 476	
194. 02 07952 OTHER NONREIMBU 200. 00 Cross Foot Adiu		O O	U	240, 304	U	450, 031	200. 00
200.00 Cross Foot Adju 201.00 Negative Cost C							200.00
1 1 3	cated (per Wkst. B,	1, 919, 512	3, 328, 405	4, 118, 451		11, 296, 079	
Part I)	cated (per wkst. b,	1, 717, 312	3, 320, 403	4, 110, 451		11, 290, 079	202.00
	plier (Wkst. B, Part I)	13. 550899	23, 497056	0. 288885		0. 301429	203. 00
	cated (per Wkst. B,			278, 008		569, 964	
Part II)	Q.						
205.00 Unit cost multi	plier (Wkst. B, Part			0. 019501		0. 015209	205. 00
	amount to be allocated						206. 00
	multiplier (Wkst. D,						207. 00

| Period: | Worksheet B-1 | From 01/01/2022 | To 12/31/2022 | Date/Time Prepared: 5/30/2023 4:12 pm

						5/30/2023 4: 1	2 pm
	Cost Center Description	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		REPAIRS (SQUARE FEET)	PLANT (SQUARE FEET)	(POUNDS OF	(SQUARE FEET)	(MEALS SERVED)	
		(SQUARL TELT)	(SQUARE TELT)	LAUNDRY)			
		6. 00	7. 00	8.00	9. 00	10.00	
	GENERAL SERVICE COST CENTERS						
	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
5. 00 6. 00	OO5OO ADMINISTRATIVE & GENERAL OO6OO MAINTENANCE & REPAIRS	118, 977					5. 00 6. 00
	00700 OPERATION OF PLANT	17, 382	101, 595				7. 00
	00800 LAUNDRY & LINEN SERVICE	157	157	230, 625			8. 00
	00900 HOUSEKEEPI NG	1, 683	1, 683		99, 755		9. 00
10. 00	01000 DI ETARY	6, 726	1			31, 280	10. 00
11. 00	01100 CAFETERI A	2, 177	2, 177	0	2, 177	0	11. 00
	01300 NURSING ADMINISTRATION	0	0	0	0	0	
	01400 CENTRAL SERVI CES & SUPPLY	7, 265	7, 265		7, 265	0	14.00
	01500 PHARMACY	1, 397	1, 397	0	1, 397	0	15.00
16. 00	01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS	850	850	0	850	0	16. 00
30. 00	03000 ADULTS & PEDIATRICS	10, 900	10, 900	69, 938	10, 900	17, 551	30.00
	03100 NTENSI VE CARE UNI T	3, 378	3, 378			5, 189	1
32. 00	03200 CORONARY CARE UNIT	0	0	0	0	0	32. 00
33. 00	03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	33. 00
	03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34. 00
	04000 SUBPROVI DER - I PF	5, 285	5, 285	21, 513	5, 285	8, 540	1
	04100 SUBPROVI DER - I RF	0	0	0	0	0	41.00
	04300 NURSERY	0	0	0	0	0	43.00
	04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY	0	0	0	0	0	44. 00 45. 00
	04600 OTHER LONG TERM CARE	0		0	0	0	1
40.00	ANCI LLARY SERVI CE COST CENTERS						1 40.00
50. 00	05000 OPERATING ROOM	17, 345	17, 345	30, 811	17, 345	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52. 00
	05300 ANESTHESI OLOGY	0	0	0	0	0	53. 00
	05400 RADI OLOGY-DI AGNOSTI C	10, 180	1	8, 573		0	54.00
	03630 ULTRA SOUND	526	526	0	526	0	54. 01
	05500 RADI OLOGY-THERAPEUTI C	1 440	1 440	0	1 440	0	55.00
	05600	1, 469	1, 469	0	1, 469	0	56. 00 57. 00
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58. 00
	05900 CARDI AC CATHETERI ZATI ON	0	Ö	Ō	0	Ō	59. 00
	06000 LABORATORY	4, 193	4, 193	0	4, 193	0	60.00
60. 01	06001 BLOOD LABORATORY	0	0	0	0	0	60. 01
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61. 00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
	06400 NTRAVENOUS THERAPY 06500 RESPIRATORY THERAPY			1, 187	0	0	64. 00 65. 00
	06600 PHYSI CAL THERAPY	2,770		, .			
	06700 OCCUPATI ONAL THERAPY	0	2,,,,	0, 7,2	0	0	67. 00
	06800 SPEECH PATHOLOGY	0	0	Ō	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	4, 364	4, 364	0	4, 364	0	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
	07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	74. 00 75. 00
	03480 ONCOLOGY					0	76.00
	07697 CARDI AC REHABI LI TATI ON		ĺ	Ö	0	Ö	76. 97
	07700 ALLOGENEIC STEM CELL ACQUISITION		0		0	0	ı
	OUTPATIENT SERVICE COST CENTERS						
	08800 RURAL HEALTH CLINIC	0	0	0	0	0	
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	
	09000 CLI NI C	2, 823			2, 823	0	90.00
	09100 EMERGENCY 04950 WOUND CARE	10, 952	10, 952	58, 083	10, 952	0	91. 00 91. 01
	09200 OBSERVATION BEDS (NON-DISTINCT PART)		١				91.01
	OTHER REIMBURSABLE COST CENTERS	1					1
	09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94. 00
	09500 AMBULANCE SERVICES	0	0	0	0	0	95. 00
	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	
	09700 DURABLE MEDICAL EQUIP-SOLD		0	l ő	0	0	
98. 00	09850 OTHER REIMBURSABLE COST CENTERS	1 0	l 0	1 0	0	0	98. 00

Peri od: From 01/01/2022 Provider CCN: 15-0022

			Ť	0 12/31/2022	Date/Time Pre 5/30/2023 4:1	pared: 2 pm
Cost Center Description	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	REPAI RS	PLANT	LINEN SERVICE	(SQUARE FEET)	(MEALS SERVED)	
	(SQUARE FEET)	(SQUARE FEET)	(POUNDS OF			
			LAUNDRY)			
	6. 00	7. 00	8. 00	9. 00	10. 00	
99. 00 09900 CMHC	0	0	0	0	0	
99. 10 09910 CORF	0	0	0	0	0	
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0		100.00
101.00 10100 HOME HEALTH AGENCY	0	0	0	0		101. 00
102.00 10200 OPIOLD TREATMENT PROGRAM SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	102. 00
105. 00 10500 KI DNEY ACQUI SI TI ON		0	0	0	0	105. 00
106. 00 10600 HEART ACQUISITION	0	0	ľ	0		106. 00
107. 00 10700 LI VER ACQUI SI TI ON	0	0	0	0		107. 00
108. 00 10800 LUNG ACQUI SI TI ON	j o	0	0	0		108. 00
109. 00 10900 PANCREAS ACQUISITION	0	0	0	0		109. 00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON	0	0	l o	0		110. 00
111.00 11100 I SLET ACQUI SITION	0	0	0	0		111. 00
113. 00 11300 I NTEREST EXPENSE						113. 00
114.00 11400 UTILIZATION REVIEW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	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)	111, 822	94, 440	230, 625	92, 600	31, 280	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	420	420		420		190. 00
191. 00 19100 RESEARCH	0	0		0		191. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	6, 735	6, 735	0	6, 735		192. 00
193. 00 19300 NONPALD WORKERS	0	0	0	0		193. 00
194. 00 07950 OTHER NONREI MBURSABLE COST CENTERS	0	0	0	0		194. 00
194. 01 07951 OTHER NONREIMBURSABLE COST CENTERS 194. 02 07952 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0		194. 01 194. 02
200.00 Cross Foot Adjustments	U	U	U	0	U	200. 00
201.00 Negative Cost Centers						200.00
202.00 Cost to be allocated (per Wkst. B,	0	3, 276, 823	226, 649	951, 595	1, 304, 493	
Part I)		3, 270, 023	220, 047	751, 575	1, 304, 473	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	0. 000000	32. 253782	0. 982760	9. 539321	41. 703740	203. 00
204.00 Cost to be allocated (per Wkst. B,	0	688, 046	9, 756	85, 035	312, 523	204. 00
Part II)						
205.00 Unit cost multiplier (Wkst. B, Part	0. 000000	6. 772440	0. 042302	0. 852438	9. 991145	205. 00
11)						
206.00 NAHE adjustment amount to be allocated						206. 00
(per Wkst. B-2)						207.00
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00
raits iii allu iv)	1		I	l		l

In Lieu of Form CMS-2552-10 Health Financial Systems FRANCISCAN HEALTH CRAWFORDSVILLE COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0022 Peri od: Worksheet B-1 From 01/01/2022 12/31/2022 Date/Time Prepared: 5/30/2023 4:12 pm Cost Center Description CAFETERI A NURSI NG CENTRAL **PHARMACY** MEDI CAL SERVICES & (HOURS OF ADMI NI STRATI ON (COSTED RECORDS & SERVICE) **SUPPLY** REQUIS.) LI BRARY (DIRECT NURS (COSTED (GROSS REQUIS.) CHARGES) HRS.) 11.00 13.00 14.00 15.00 16.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 00600 MAINTENANCE & REPAIRS 6.00 6.00 00700 OPERATION OF PLANT 7.00 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10 00 10 00 11.00 01100 CAFETERI A 507,659 11.00 13.00 01300 NURSING ADMINISTRATION 2,748 243, 931 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 3, 231 100 14.00 17 01500 PHARMACY 100 15 00 15 00 13, 153 C 0 16.00 01600 MEDICAL RECORDS & LIBRARY 0 0 204, 285, 326 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 30.00 84 005 62, 138 0 9, 994, 234 30.00 31.00 03100 INTENSIVE CARE UNIT 35,044 33, 971 0 0 4, 280, 744 31.00 03200 CORONARY CARE UNIT 0 0 32.00 32.00 0 0 33.00 03300 BURN INTENSIVE CARE UNIT 0 33.00 0 0 03400 SURGICAL INTENSIVE CARE UNIT 0 34 00 0 34 00 0 40.00 04000 SUBPROVI DER - I PF 42, 901 29, 441 0 4, 085, 188 40.00 04100 SUBPROVIDER - IRF o 41.00 41.00 0 43.00 04300 NURSERY 0 0 0 43.00 0 0 04400 SKILLED NURSING FACILITY 0 44.00 Ω 0 44 00 0 45.00 04500 NURSING FACILITY 0 0 0 45.00 04600 OTHER LONG TERM CARE 46.00 0 46.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 20, 839, 197 50 00 66, 905 41, 650 0 0 05100 RECOVERY ROOM 0 0 0 51.00 51.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 52.00 0 52 00 53.00 05300 ANESTHESI OLOGY 0 0 0 0 0 0 53.00 0 0 0 54 00 05400 RADI OLOGY-DI AGNOSTI C 71.014 2.076 12, 674, 475 54 00 03630 ULTRA SOUND 5, 106, 820 54.01 1,973 54.01 05500 RADI OLOGY-THERAPEUTI C 0 55.00 0 Ω 55.00 3, 053, 273 05600 RADI 0I SOTOPE 0 56,00 56, 00 0 C 0 57.00 05700 CT SCAN 0 19, 736, 280 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 0 0 3, 444, 706 58.00 05900 CARDIAC CATHETERIZATION 59.00 59.00 0 24, 860, 248 06000 LABORATORY 0 60.00 60.00 60.01 06001 BLOOD LABORATORY 0 0 60.01 61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 62.00 0 0 0 0 62.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 201, 716 63.00 64.00 06400 INTRAVENOUS THERAPY 64.00 0 0 0 06500 RESPI RATORY THERAPY 29, 981 0 0 2, 921, 541 65.00 65.00 06600 PHYSI CAL THERAPY 0 66.00 16,013 C 5, 105, 930 66.00 67.00 06700 OCCUPATIONAL THERAPY C 0 67.00 0 06800 SPEECH PATHOLOGY 0 68.00 0 68.00 8, 096, 949 06900 ELECTROCARDI OLOGY 0 69.00 13.192 2.072 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 C 73 0 12, 084, 657 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 72.00 27 1, 944, 532 72.00 0 73 00 07300 DRUGS CHARGED TO PATIENTS 100 7, 889, 580 73 00 Ω 0 74.00 07400 RENAL DIALYSIS C 0 0 74.00 0 0 07500 ASC (NON-DISTINCT PART) 0 75.00 75.00 0 0 0 76.00 03480 ONCOLOGY 0 0 10, 179 76.00 o 07697 CARDIAC REHABILITATION 0 76 97 899, 170 76.97 Ω 77.00 07700 ALLOGENEIC STEM CELL ACQUISITION 0 0 0 77.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 C 0 0 88.00 0 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 89 00 90.00 09000 CLI NI C 12, 978 4, 175 0 0 1, 019, 757 90.00 09100 EMERGENCY 0 91.00 89, 439 68, 370 56, 036, 150 91.00 91.01 04950 WOUND CARE 0 91.01 0 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 0 0 09500 AMBULANCE SERVICES 0 0 95.00 0 0 95.00

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ol

0 96.00

0 97.00

09600 DURABLE MEDICAL EQUIP-RENTED

09700 DURABLE MEDICAL EQUIP-SOLD

96.00

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0022 Peri od: Worksheet B-1 From 01/01/2022 12/31/2022 Date/Time Prepared: 5/30/2023 4:12 pm Cost Center Description CAFETERI A NURSI NG CENTRAL PHARMACY MEDI CAL (HOURS OF ADMI NI STRATI ON SERVICES & (COSTED RECORDS & LI BRARY SERVICE) **SUPPLY** REQUIS.) (DIRECT NURS (COSTED (GROSS REQUIS.) CHARGES) HRS.) 11.00 15.00 13.00 14.00 16.00 98. 00 09850 OTHER REIMBURSABLE COST CENTERS 98.00 99. 00 09900 CMHC 0 99.00 0 0 0 0 99. 10 99. 10 09910 CORF 0 0 100.00 10000 I&R SERVICES-NOT APPRVD PRGM 0 0 100.00 0 101.00 10100 HOME HEALTH AGENCY 0 0 101. 00 0 102.00 10200 OPI OID TREATMENT PROGRAM 0 o 0 102.00 SPECIAL PURPOSE COST CENTERS 105.00 10500 KIDNEY ACQUISITION 0 0 0 0 0 105. 00 106. 00 10600 HEART ACQUISITION 0 0 0 0 0 0 0 0 106.00 0 107. 00 10700 LIVER ACQUISITION 0 0 107.00 108.00 10800 LUNG ACQUISITION 0 C 0 108.00 109. 00 10900 PANCREAS ACQUISITION 0 109.00 110.00 11000 INTESTINAL ACQUISITION 0 0 0 110.00 0 0 111.00 11100 I SLET ACQUISITION O 0 111 00 113.00 11300 INTEREST EXPENSE 113. 00 114.00 11400 UTILIZATION REVIEW-SNF 114. 00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 115.00 0 O 116. 00 11600 HOSPI CE 0 0 0 116.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 482, 577 243, 910 100 100 204, 285, 326 118. 00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190, 00 n O 0 191. 00 19100 RESEARCH 0 0 0 0 0 191.00 6, 422 192.00 19200 PHYSICIANS' PRIVATE OFFICES 21 0 192.00 0 193. 00 19300 NONPALD WORKERS 0 0 0 193. 00 0 194. 00 07950 OTHER NONREI MBURSABLE COST CENTERS 0 0 194 00 0 Ω 194. 01 07951 OTHER NONREIMBURSABLE COST CENTERS 0 0 194. 01 10,605 0 0 194. 02 07952 OTHER NONREIMBURSABLE COST CENTERS 8,053 0 194. 02 200.00 Cross Foot Adjustments 200. 00 201.00 Negative Cost Centers 201. 00 202.00 Cost to be allocated (per Wkst. B, 146, 843 955, 362 699, 510 903, 045 682, 718 202. 00 0.003342 203.00 203.00 Unit cost multiplier (Wkst. B, Part I) 0. 289255 3. 916526 6, 995. 100000 9, 030. 450000 Cost to be allocated (per Wkst. B, 45, 535 204. 00 204.00 104, 631 16, 535 331, 105 80, 944 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 0. 106495 0.067786 3, 311. 050000 809. 440000 0.000223 205.00 206.00 NAHE adjustment amount to be allocated 206.00 (per Wkst. B-2)

207. 00

207.00

NAHE unit cost multiplier (Wkst. D,

Parts III and IV)

| In Lieu of Form CMS-2552-10 | Period: | Worksheet C | From 01/01/2022 | Part | To 12/31/2022 | Date/Time Prepared: | 5/30/2023 4:12 pm Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0022

						5/30/2023 4:1	2 pm
			Title	XVIII	Hospi tal	PPS	
	Cost Contor Doscription	Total Cost	Thorany Limit	Total Costs	Costs RCE	Total Costs	
	Cost Center Description	Total Cost (from Wkst. B,	Therapy Limit Adj.	Total Costs	Di sal Lowance	Total Costs	
		Part I, col.	Auj .		Disarrowance		
		26)					
		1. 00	2.00	3.00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	5, 915, 642		5, 915, 642		5, 915, 642	
31. 00	03100 I NTENSI VE CARE UNI T	2, 891, 944		2, 891, 944		2, 891, 944	
32.00	03200 CORONARY CARE UNIT	0		0	0	0	1
33. 00 34. 00	03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT	0		0	0	0	
40. 00	04000 SUBPROVIDER - I PF	3, 140, 995		3, 140, 995	0	1	
41. 00	04100 SUBPROVI DER - I RF	3, 140, 773		3, 140, 773	0	0, 140, 773	
43. 00	04300 NURSERY	0		ĺ	0	Ö	1
44. 00	04400 SKILLED NURSING FACILITY	0		0	Ō	Ō	44. 00
45.00	04500 NURSING FACILITY	0		0	0	0	45. 00
46.00	04600 OTHER LONG TERM CARE	0		0	0	0	46. 00
	ANCILLARY SERVICE COST CENTERS				<u> </u>		
50.00	05000 OPERATI NG ROOM	6, 632, 211		6, 632, 211			50.00
51.00	05100 RECOVERY ROOM	0		0			1
52. 00 53. 00	O5200 DELIVERY ROOM & LABOR ROOM O5300 ANESTHESI OLOGY	0		0	0	0	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	3, 934, 052		3, 934, 052	_		1
54. 01	03630 ULTRA SOUND	177, 726		177, 726		177, 726	1
55. 00	05500 RADI OLOGY-THERAPEUTI C	0		0		0	1
56.00	05600 RADI OI SOTOPE	383, 129		383, 129	0	383, 129	1
57.00	05700 CT SCAN	65, 959		65, 959	0	65, 959	57.00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	11, 512		11, 512	0	11, 512	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0		0	_		
60.00	06000 LABORATORY	4, 464, 084		4, 464, 084	0	4, 464, 084	
60. 01	06001 BLOOD LABORATORY	0		0	0	0	60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0		0	0	0	61.00
62. 00 63. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06300 BLOOD STORING, PROCESSING & TRANS.	674		674	0	0 674	1
64. 00	06400 I NTRAVENOUS THERAPY	074		0/4		074	1
65. 00	06500 RESPIRATORY THERAPY	1, 290, 946	0	· -	_		
66. 00	06600 PHYSI CAL THERAPY	1, 414, 924		1, 414, 924		1, 414, 924	1
67. 00	06700 OCCUPATI ONAL THERAPY	0	Ö	0		0	1
68. 00	06800 SPEECH PATHOLOGY	0	0	0	0	0	1
69. 00	06900 ELECTROCARDI OLOGY	1, 061, 397		1, 061, 397	0	1, 061, 397	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0		0	0	0	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 645, 444		1, 645, 444		1, 645, 444	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	473, 272		473, 272			1
73.00	07300 DRUGS CHARGED TO PATIENTS	2, 245, 287		2, 245, 287		2, 245, 287	
74. 00 75. 00	07400 RENAL DI ALYSI S 07500 ASC (NON-DI STI NCT PART)	0		0	_	0	1
76. 00	03480 ONCOLOGY	168		168	_	168	1
76. 97	07697 CARDI AC REHABI LI TATI ON	3, 005		3, 005		3, 005	
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0		0,000			1
	OUTPATIENT SERVICE COST CENTERS			-			1
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	669, 463		669, 463		669, 463	1
91. 00	09100 EMERGENCY	5, 452, 268		5, 452, 268		5, 452, 268	
91. 01	04950 WOUND CARE	0		0	_	0	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 897, 269		1, 897, 269		1, 897, 269	92.00
94. 00	OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DI ALYSI S			1 0	0	0	94. 00
95.00	09500 AMBULANCE SERVICES	0		0		l	1
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0				0	1
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD	0			_	Ö	1
98. 00	09850 OTHER REIMBURSABLE COST CENTERS	0		ĺ	o o	Ö	1
	09900 CMHC	0		0		0	99. 00
99. 10	09910 CORF	0		0		0	99. 10
	10000 I&R SERVICES-NOT APPRVD PRGM	0		0		•	100. 00
	10100 HOME HEALTH AGENCY	0		0		•	101. 00
102.00	10200 OPI OI D TREATMENT PROGRAM	0		0		0	102. 00
105 00	SPECIAL PURPOSE COST CENTERS					_	105 00
	10500 KIDNEY ACQUISITION 10600 HEART ACQUISITION			0			105. 00 106. 00
	10000 HEART ACQUISITION						106.00
	10800 LUNG ACQUISITION	0					107.00
	10900 PANCREAS ACQUISITION						109. 00
	11000 INTESTINAL ACQUISITION	0		Ö			110. 00
111.00	11100 SLET ACQUISITION	0		0			111. 00

Health Financial Systems	FRANCISCAN HEALTH CRAWFORDS	SVI LLE	In Lieu of Form CMS-2552-1			
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi c	der CCN: 15-0022	From 01/01/2022 To 12/31/2022	Worksheet C Part I Date/Time Prepared: 5/30/2023 4:12 pm		
		T: +1 a V/////	Heeni tel	DDC		

		Title	XVIII	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst. B,	Adj .		Di sal I owance		
	Part I, col.	•				
	26)					
	1.00	2. 00	3. 00	4. 00	5. 00	
113. 00 11300 I NTEREST EXPENSE						113. 00
114.00 11400 UTILIZATION REVIEW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0		0		0	115. 00
116. 00 11600 H0SPI CE	o		0		0	116. 00
200.00 Subtotal (see instructions)	43, 771, 371	O	43, 771, 371	0	43, 771, 371	200. 00
201.00 Less Observation Beds	1, 897, 269		1, 897, 269		1, 897, 269	201. 00
202.00 Total (see instructions)	41, 874, 102	0	41, 874, 102	0	41, 874, 102	202. 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet C | From 01/01/2022 | Part | To 12/31/2022 | Date/Time Prepared: | 5/30/2023 4:12 pm Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0022

					5/30/2023 4:1	2 pm
			XVIII	Hospi tal	PPS	
Cost Center Description	Inpati ent	Charges Outpatient	Total (col. 6	Cost or Other	TEFRA	
cost center bescription	Пранен	outpatrent	+ col . 7)	Ratio	Inpatient	
			1 001. 7)	Ratio	Ratio	
	6. 00	7. 00	8. 00	9. 00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS			•			
30. 00 03000 ADULTS & PEDIATRICS	6, 994, 307		6, 994, 307	'		30. 00
31. 00 03100 I NTENSI VE CARE UNI T	4, 280, 744		4, 280, 744			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	0)		34.00
40. 00 04000 SUBPROVI DER - PF	4, 085, 188		4, 085, 188	3		40.00
41. 00 04100 SUBPROVI DER - RF	0		()		41.00
43. 00 04300 NURSERY	0)		43. 00
44. 00 04400 SKI LLED NURSI NG FACI LI TY 45. 00 04500 NURSI NG FACI LI TY	0					44. 00 45. 00
46. 00 04600 OTHER LONG TERM CARE						46.00
ANCILLARY SERVICE COST CENTERS	l ol			,		40.00
50. 00 05000 OPERATI NG ROOM	1, 161, 416	19, 677, 781	20, 839, 197	0. 318257	0. 000000	50.00
51. 00 05100 RECOVERY ROOM	0	0	20,007,177	0. 000000	0. 000000	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	o	0	d	0. 000000	0. 000000	52.00
53. 00 05300 ANESTHESI OLOGY	o	0		0. 000000	0.000000	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 061, 714	11, 612, 761	12, 674, 475	0. 310392	0.000000	54.00
54.01 03630 ULTRA SOUND	478, 306	4, 628, 514	5, 106, 820	0. 034802	0. 000000	54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	C	0. 000000	0. 000000	55. 00
56. 00 05600 RADI 0I SOTOPE	86, 393	2, 966, 880			0. 000000	56. 00
57.00 05700 CT SCAN	2, 277, 886	17, 458, 394			0. 000000	57. 00
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	339, 949	3, 104, 757			0. 000000	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0	0.00000	0. 000000	59.00
60. 00 06000 LABORATORY	4, 567, 113	20, 293, 135	24, 860, 248		0.000000	60.00
60. 01 06001 BLOOD LABORATORY	0	0		0.000000	0.000000	60. 01
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0		0.000000	0.000000	61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 63.00 06300 BLOOD STORING, PROCESSING & TRANS.	78, 444	123, 272	201, 716	0. 000000 0. 003341	0. 000000 0. 000000	62. 00 63. 00
64. 00 06400 NTRAVENOUS THERAPY	70, 444	123, 272	201, /10	0.000000	0. 000000	64. 00
65. 00 06500 RESPI RATORY THERAPY	1, 879, 326	1, 042, 215	2, 921, 541		0. 000000	65.00
66. 00 06600 PHYSI CAL THERAPY	1, 088, 546	4, 017, 384			0. 000000	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	1,017,001	0, 100, 700		0. 000000	67.00
68. 00 06800 SPEECH PATHOLOGY	l o	0		0. 000000	0. 000000	68. 00
69. 00 06900 ELECTROCARDI OLOGY	1, 152, 276	6, 944, 673	8, 096, 949		0. 000000	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0. 000000	0.000000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 333, 528	9, 751, 129	12, 084, 657	0. 136160	0. 000000	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	486, 500	1, 458, 032	1, 944, 532	0. 243386	0. 000000	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	2, 750, 490	5, 139, 090	7, 889, 580		0. 000000	73. 00
74. 00 07400 RENAL DI ALYSI S	0	0	C		0. 000000	74. 00
75. 00 07500 ASC (NON-DISTINCT PART)	0	0	(0.000000	0. 000000	75. 00
76. 00 03480 0NCOLOGY	2, 458	7, 721			0.000000	76.00
76. 97 07697 CARDI AC REHABI LITATION	0	899, 170			0.000000	76. 97
77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION OUTPATIENT SERVICE COST CENTERS	J U	U	(0.000000	0. 000000	77. 00
88. 00 08800 RURAL HEALTH CLINIC		0)		88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	l o	0				89. 00
90. 00 09000 CLINI C	l o	1, 019, 757	1, 019, 757	0. 656493	0. 000000	90.00
91. 00 09100 EMERGENCY	4, 866, 729	51, 169, 421			0. 000000	91.00
91. 01 04950 WOUND CARE	0	0	C	0. 000000	0. 000000	91. 01
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	444, 290	2, 555, 637	2, 999, 927	0. 632438	0. 000000	92. 00
OTHER REIMBURSABLE COST CENTERS						
94. 00 09400 HOME PROGRAM DIALYSIS	0	0	0	0. 000000	0. 000000	94. 00
95. 00 09500 AMBULANCE SERVI CES	0	0	(0.000000	0. 000000	95. 00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0	0		0.00000	0.000000	96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0		0.000000	0.000000	97. 00
98. 00 09850 OTHER REI MBURSABLE COST CENTERS	0	0		0. 000000	0. 000000	98.00
99. 00 09900 CMHC 99. 10 09910 CORF	0	0				99. 00 99. 10
100.00 10000 1&R SERVICES-NOT APPRVD PRGM		0				100.00
101. 00 10100 HOME HEALTH AGENCY		0				100.00
102. 00 10200 OPI OI D TREATMENT PROGRAM		0	1			102.00
SPECIAL PURPOSE COST CENTERS	<u>, </u>	0				1 30
105. 00 10500 KI DNEY ACQUI SI TI ON	0	0	C)		105. 00
106. 00 10600 HEART ACQUI SI TI ON	o	0	C			106. 00
107.00 10700 LIVER ACQUISITION	0	0	C			107. 00
108.00 10800 LUNG ACQUISITION	0	0	(108. 00
109. 00 10900 PANCREAS ACQUISITION	0	0	(109. 00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON	0	0	1			110.00
111. 00 11100 I SLET ACQUI SI TI ON	0	0	1)		111.00
113. 00 11300 INTEREST EXPENSE			l	<u> </u>		113. 00

Health Financial Systems	FRANCISCAN HEALTH CRAWFORDSVILLE	In Lieu	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0022	Peri od: From 01/01/2022 To 12/31/2022	Worksheet C Part I Date/Time Prepared: 5/30/2023 4:12 pm

			Title	xVIII	Hospi tal	PPS	
		Charges					
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
				+ col . 7)	Rati o	I npati ent	
						Ratio	
		6.00	7. 00	8. 00	9. 00	10.00	
114. 00 11400	UTILIZATION REVIEW-SNF						114. 00
115. 00 11500	AMBULATORY SURGICAL CENTER (D. P.)	0	0		0		115.00
116. 00 11600	HOSPI CE	0	0		0		116. 00
200. 00	Subtotal (see instructions)	40, 415, 603	163, 869, 723	204, 285, 326	6		200.00
201. 00	Less Observation Beds						201.00
202. 00	Total (see instructions)	40, 415, 603	163, 869, 723	204, 285, 326	6		202. 00

Title XVIII

			Title XVIII	Hospi tal	PPS	
	Cost Center Description	PPS Inpatient				
		Ratio				
		11.00				
	INPATIENT ROUTINE SERVICE COST CENTERS	· ·				
30.00	03000 ADULTS & PEDIATRICS					30.00
31. 00	03100 INTENSIVE CARE UNIT					31.00
32. 00	03200 CORONARY CARE UNIT					32. 00
33. 00	03300 BURN INTENSIVE CARE UNIT					33. 00
34. 00	03400 SURGICAL INTENSIVE CARE UNIT					34.00
40. 00						1
	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
	ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0. 318257				50.00
51.00	05100 RECOVERY ROOM	0. 000000				51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000				52. 00
53.00	05300 ANESTHESI OLOGY	0. 000000				53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 310392				54.00
54. 01	03630 ULTRA SOUND	0. 034802				54. 01
55. 00	05500 RADI OLOGY-THERAPEUTI C	0. 000000				55. 00
56. 00	05600 RADI OI SOTOPE	0. 125481				56.00
57. 00	05700 CT SCAN	0. 003342				57.00
	05800 MAGNETIC RESONANCE I MAGING (MRI)	1 1				
58. 00 59. 00		0. 003342 0. 000000				58.00
	05900 CARDI AC CATHETERI ZATI ON	1				59.00
60.00	06000 LABORATORY	0. 179567				60.00
60. 01	06001 BLOOD LABORATORY	0. 000000				60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000				61. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000				62. 00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 003341				63.00
64.00	06400 I NTRAVENOUS THERAPY	0.000000				64.00
65.00	06500 RESPIRATORY THERAPY	0. 441872				65. 00
66.00	06600 PHYSI CAL THERAPY	0. 277114				66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 000000				67.00
68. 00	06800 SPEECH PATHOLOGY	0. 000000				68. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 131086				69.00
70. 00		1				70.00
	07000 ELECTROENCEPHALOGRAPHY	0.000000				1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 136160				71.00
72. 00		0. 243386				72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 284589				73. 00
74. 00	1	0. 000000				74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0. 000000				75. 00
76. 00	03480 ONCOLOGY	0. 016505				76. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0. 003342				76. 97
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0.000000				77. 00
	OUTPATIENT SERVICE COST CENTERS	· ·				Ī
88. 00	08800 RURAL HEALTH CLINIC					88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER					89. 00
90.00	1	0, 656493				90.00
	09100 EMERGENCY	0. 097299				91.00
91. 01	1	0. 000000				91. 01
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 632438				92. 00
72.00	OTHER REIMBURSABLE COST CENTERS	0.032430				72.00
04.00		0.000000				104.00
94. 00	09400 HOME PROGRAM DI ALYSI S	0.000000				94.00
	09500 AMBULANCE SERVI CES	0. 000000				95.00
96.00		0. 000000				96.00
97. 00		0. 000000				97. 00
98. 00		0. 000000				98. 00
99. 00	09900 CMHC					99. 00
99. 10	09910 CORF					99. 10
100.00	10000 I&R SERVICES-NOT APPRVD PRGM					100.00
101.00	10100 HOME HEALTH AGENCY					101.00
	10200 OPIOID TREATMENT PROGRAM					102.00
. 32. 00	SPECIAL PURPOSE COST CENTERS					1
105 00	10500 KIDNEY ACQUISITION					105. 00
	10600 HEART ACQUISITION					106.00
	10700 LIVER ACQUISITION					107. 00
	10800 LUNG ACQUISITION					108.00
	10900 PANCREAS ACQUISITION					109. 00
	0 11000 INTESTINAL ACQUISITION					110. 00
111.00	11100 SLET ACQUISITION					111. 00
113.00	11300 INTEREST EXPENSE					113. 00
114.00	11400 UTILIZATION REVIEW-SNF					114. 00
	11500 AMBULATORY SURGICAL CENTER (D. P.)					115. 00
-						·

Heal th Finar	ncial Systems	FRANCISCAN HEALTH C	RAWFORDSVI LLE	In Lie	u of Form CMS-	2552-10
COMPUTATI ON	OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0022	Peri od:	Worksheet C	
				From 01/01/2022 To 12/31/2022		
			Title XVIII	Hospi tal	PPS	
	Cost Center Description	PPS Inpatient				
		Ratio				
		11. 00				
116.00 11600	HOSPI CE					116. 00
200. 00	Subtotal (see instructions)					200. 00
201. 00	Less Observation Beds					201. 00
202.00	Total (see instructions)					202. 00

Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0022

						0 12/31/2022	5/30/2023 4: 1	
				Titl	e XIX	Hospi tal	Cost	
		Cost Center Description	Total Cost (from Wkst. B, Part I, col.	Therapy Limit Adj.	Total Costs	Costs RCE Di sal I owance	Total Costs	
			26)		0.00	4 00	5.00	
	LNDAT	LENT DOUTINE CEDVICE COST CENTERS	1.00	2.00	3.00	4. 00	5. 00	
30. 00		I ENT ROUTI NE SERVI CE COST CENTERS ADULTS & PEDI ATRI CS	5, 915, 642		5, 915, 642	1	5, 915, 642	30.00
31. 00	1	INTENSIVE CARE UNIT	2, 891, 944	ł	2, 891, 944		2, 891, 944	
32. 00		CORONARY CARE UNIT	2,071,744		2,071,744	0	2,071,744	1
33. 00		BURN INTENSIVE CARE UNIT	0		0	0	0	1
34. 00		SURGICAL INTENSIVE CARE UNIT	0		0	0	Ö	34. 00
40. 00		SUBPROVI DER - I PF	3, 140, 995		3, 140, 995	0	3, 140, 995	
41. 00		SUBPROVI DER - I RF	0		0	0	0	1
43.00		NURSERY	0		0	0	0	1
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44. 00
45.00	04500	NURSING FACILITY	0		0	0	0	45. 00
46.00	04600	OTHER LONG TERM CARE	0		0	0	0	46. 00
	ANCI L	LARY SERVICE COST CENTERS				T		
50.00		OPERATI NG ROOM	6, 632, 211		6, 632, 211	0	6, 632, 211	
51.00		RECOVERY ROOM	0		0	0	0	
52.00		DELIVERY ROOM & LABOR ROOM	0		0	0	0	
53. 00 54. 00		ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C	3, 934, 052		3, 934, 052	0	0 3, 934, 052	
54. 00		ULTRA SOUND	177, 726		177, 726		177, 726	
55. 00		RADI OLOGY-THERAPEUTI C	177,720		177,720	0	0	1
56. 00	1	RADI OI SOTOPE	383, 129		383, 129	0	383, 129	1
57. 00		CT SCAN	65, 959	l	65, 959		65, 959	1
58. 00		MAGNETIC RESONANCE IMAGING (MRI)	11, 512	l	11, 512		11, 512	1
59.00	05900	CARDI AC CATHETERI ZATI ON	0		0	0	0	1
60.00	06000	LABORATORY	4, 464, 084		4, 464, 084	0	4, 464, 084	60.00
60. 01		BLOOD LABORATORY	0		0	0	0	60. 01
61. 00		PBP CLINICAL LAB SERVICES-PRGM ONLY	0		0	0	0	
62. 00		WHOLE BLOOD & PACKED RED BLOOD CELLS	0		0	0	0	1
63. 00		BLOOD STORING, PROCESSING & TRANS.	674		674	0	674	
64.00		I NTRAVENOUS THERAPY	1 200 046	_	1 200 046	0	1 200 046	
65. 00 66. 00		RESPI RATORY THERAPY PHYSI CAL THERAPY	1, 290, 946 1, 414, 924	0	1, 290, 946 1, 414, 924		1, 290, 946 1, 414, 924	
67. 00	1	OCCUPATIONAL THERAPY	1,414,724	0	1, 414, 724	0	1, 414, 924	1
68. 00		SPEECH PATHOLOGY	0	0	0	0	0	ı
69. 00		ELECTROCARDI OLOGY	1, 061, 397	-	1, 061, 397	0	1, 061, 397	
70.00		ELECTROENCEPHALOGRAPHY	0		0	0	0	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 645, 444		1, 645, 444	0	1, 645, 444	71. 00
72.00		IMPL. DEV. CHARGED TO PATIENTS	473, 272		473, 272		473, 272	
73. 00	1	DRUGS CHARGED TO PATIENTS	2, 245, 287		2, 245, 287	0	2, 245, 287	
74.00		RENAL DIALYSIS	0		0	0	0	1
75. 00		ASC (NON-DISTINCT PART)	1/0		1/0	0	0	
76. 00 76. 97		ONCOLOGY CARDIAC REHABILITATION	168 3, 005		168 3, 005		168 3, 005	
		ALLOGENEIC STEM CELL ACQUISITION	0,009	l .	0,009		0,000	
,,,,,,		TIENT SERVICE COST CENTERS						,,,,,,,
88. 00		RURAL HEALTH CLINIC	0		0	0	0	88. 00
89. 00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89. 00
90.00		CLINIC	669, 463	l e	669, 463		669, 463	1
91.00		EMERGENCY	5, 452, 268		5, 452, 268		5, 452, 268	
91. 01	1	WOUND CARE	0		0	0	0	
92. 00		OBSERVATION BEDS (NON-DISTINCT PART) REIMBURSABLE COST CENTERS	1, 897, 269		1, 897, 269		1, 897, 269	92.00
94. 00		HOME PROGRAM DIALYSIS	0		0	0	0	94. 00
95. 00		AMBULANCE SERVICES	0		0		0	1
96. 00		DURABLE MEDICAL EQUIP-RENTED	0		0	0	Ö	1
97. 00		DURABLE MEDICAL EQUIP-SOLD	0		o o	0	ő	97. 00
98.00		OTHER REIMBURSABLE COST CENTERS	0		0	0	0	98. 00
99. 00	09900	СМНС	0		0		0	99. 00
99. 10	1	•	0		0		0	
		I&R SERVICES-NOT APPRVD PRGM	0		0			100. 00
		HOME HEALTH AGENCY	0		0			101.00
102.00		OPIOID TREATMENT PROGRAM	0		0		0	102. 00
105 00		AL PURPOSE COST CENTERS KIDNEY ACQUISITION			0		^	105. 00
		HEART ACQUISITION			0			106. 00
		LIVER ACQUISITION	0		l 0			107. 00
	1	LUNG ACQUISITION			l ő			108. 00
		PANCREAS ACQUISITION	0		0			109. 00
		INTESTINAL ACQUISITION	0		0			110. 00
111.00	11100	ISLET ACQUISITION	0	<u> </u>	0	<u> </u>	0	111. 00
		· · · · · · · · · · · · · · · · · · ·						

Health Financial Systems	FRANCISCAN HEALTH CRAWFO	FORDSVI LLE		In Lieu	of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Pro	ovider CCN:		From 01/01/2022 To 12/31/2022	Worksheet C Part I Date/Time Prepared: 5/30/2023 4:12 pm
		T: +1 a V	LV	Heeni tel	Coot

		Ti tl	e XIX	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst. B,	Adj .		Di sal I owance		
	Part I, col.					
	26)					
	1.00	2. 00	3. 00	4. 00	5. 00	
113. 00 11300 I NTEREST EXPENSE						113. 00
114.00 11400 UTILIZATION REVIEW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0		0)	0	115. 00
116. 00 11600 HOSPI CE	0		0)	0	116. 00
200.00 Subtotal (see instructions)	43, 771, 371	0	43, 771, 371	0	43, 771, 371	200.00
201.00 Less Observation Beds	1, 897, 269		1, 897, 269		1, 897, 269	201. 00
202.00 Total (see instructions)	41, 874, 102	0	41, 874, 102	. 0	41, 874, 102	202. 00
		-		1		1

In Lieu of Form CMS-2552-10

Period: Worksheet C
From 01/01/2022 Part I
To 12/31/2022 Date/Time Prepared: 5/30/2023 4:12 pm Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0022

					0 12/31/2022	5/30/2023 4:1	
			Charges	e XIX	Hospi tal	Cost	
	Cost Center Description	Inpati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
	occi conton pocci pri on	patront	output ont	+ col . 7)	Ratio	Inpati ent	
			7.00	0.00	0.00	Ratio	
	INPATIENT ROUTINE SERVICE COST CENTERS	6. 00	7. 00	8. 00	9. 00	10. 00	
30. 00	03000 ADULTS & PEDI ATRI CS	6, 994, 307		6, 994, 307			30.00
31.00	03100 INTENSIVE CARE UNIT	4, 280, 744		4, 280, 744			31. 00
32.00	03200 CORONARY CARE UNIT	0		0			32. 00
	03300 BURN INTENSIVE CARE UNIT	0		0			33.00
34. 00 40. 00	03400 SURGICAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF	4, 085, 188		4, 085, 188			34. 00 40. 00
41. 00	04100 SUBPROVI DER - I RF	0		4, 003, 100			41.00
43.00	04300 NURSERY	o		0			43. 00
	04400 SKILLED NURSING FACILITY	0		0			44.00
	04500 NURSING FACILITY 04600 OTHER LONG TERM CARE	0					45. 00 46. 00
40.00	ANCILLARY SERVICE COST CENTERS						40.00
50.00	05000 OPERATING ROOM	1, 161, 416	19, 677, 781	20, 839, 197	0. 318257	0. 000000	50. 00
51. 00	05100 RECOVERY ROOM	0	0	1		0. 000000	
52. 00 53. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	0	0	0	0. 000000 0. 000000	0. 000000 0. 000000	
	05400 RADI OLOGY-DI AGNOSTI C	1, 061, 714	11, 612, 761	12, 674, 475		0. 000000	
54. 01	03630 ULTRA SOUND	478, 306	4, 628, 514	1		0. 000000	
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0	0	0. 000000	0. 000000	
	05600 RADI OI SOTOPE	86, 393	2, 966, 880			0.000000	1
57. 00 58. 00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	2, 277, 886 339, 949	17, 458, 394 3, 104, 757			0. 000000 0. 000000	1
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	3, 104, 737	3, 444, 700		0. 000000	
60.00	06000 LABORATORY	4, 567, 113	20, 293, 135	24, 860, 248	0. 179567	0. 000000	
	06001 BLOOD LABORATORY	0	0	0		0. 000000	1
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0		0.000000	1
62. 00 63. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06300 BLOOD STORING, PROCESSING & TRANS.	78, 444	123, 272	201, 716	0. 000000 0. 003341	0. 000000 0. 000000	62. 00 63. 00
64. 00	06400 I NTRAVENOUS THERAPY	0	123, 272	201, 710	0. 000000	0. 000000	
65.00	06500 RESPI RATORY THERAPY	1, 879, 326	1, 042, 215	2, 921, 541		0. 000000	
66.00	06600 PHYSI CAL THERAPY	1, 088, 546	4, 017, 384	1		0.000000	
67. 00 68. 00	06700 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY	0	0	0		0. 000000 0. 000000	
69. 00	06900 ELECTROCARDI OLOGY	1, 152, 276	6, 944, 673	_		0. 000000	
70.00	07000 ELECTROENCEPHALOGRAPHY	o	0	0	0. 000000	0. 000000	1
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 333, 528	9, 751, 129	1		0. 000000	
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	486, 500 2, 750, 490	1, 458, 032 5, 139, 090	1		0. 000000 0. 000000	
74.00	07400 RENAL DIALYSIS	2, 750, 490	5, 139, 090	7, 869, 360		0.00000	
75. 00	07500 ASC (NON-DISTINCT PART)	Ö	0	Ō		0. 000000	
76. 00	03480 ONCOLOGY	2, 458	7, 721				
76. 97 77. 00	07697 CARDI AC REHABI LI TATI ON	0	899, 170 0	1		0.000000	1
	07700 ALLOGENEIC STEM CELL ACQUISITION OUTPATIENT SERVICE COST CENTERS	<u> </u>		0	0. 000000	0. 000000	77. 00
	08800 RURAL HEALTH CLINIC	0	0	0	0. 000000	0. 000000	88. 00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			
	09000 CLI NI C 09100 EMERGENCY	0	1, 019, 757				
	04950 WOUND CARE	4, 866, 729 0	51, 169, 421 0	1			
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	444, 290	2, 555, 637				
	OTHER REIMBURSABLE COST CENTERS						
	09400 HOME PROGRAM DI ALYSI S	0	0				
	09500 AMBULANCE SERVICES 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0		0. 000000 0. 000000	
	09700 DURABLE MEDICAL EQUIP-SOLD		0	Ö			
	09850 OTHER REIMBURSABLE COST CENTERS	o	0	0			1
	09900 CMHC	0	0	0			99. 00
	09910 CORF 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0			99. 10 100. 00
	10100 HOME HEALTH AGENCY		0	0			100.00
	10200 OPI OI D TREATMENT PROGRAM		0				102.00
	SPECIAL PURPOSE COST CENTERS						
	10500 KIDNEY ACQUISITION	0	0				
	10600 HEART ACQUISITION 10700 LIVER ACQUISITION		0	0			
	10800 LUNG ACQUISITION		0	Ö		0. 000000	
109.00	10900 PANCREAS ACQUISITION	0	O	0	0. 000000	0. 000000	
	111000 I NTESTI NAL ACQUI SI TI ON	0	0	0			
	11100 SLET ACQUISITION 11300 NTEREST EXPENSE		O	0	0. 000000	0. 000000	111.00
	1	l l		1	l .	1	1

Health Financial Systems	FRANCISCAN HEALTH CRAWFORDSVILLE	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 1	From 01/01/2022	Worksheet C Part I Date/Time Prepared: 5/30/2023 4:12 pm

		Ti tl	e XIX	Hospi tal	Cost	
		Charges		·		
Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
	·	·	+ col. 7)	Ratio	I npati ent	
			·		Rati o	
	6.00	7. 00	8. 00	9. 00	10.00	
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	O	0	(115. 00
116. 00 11600 HOSPI CE	o	0	(116. 00
200.00 Subtotal (see instructions)	40, 415, 603	163, 869, 723	204, 285, 326	6		200.00
201.00 Less Observation Beds						201. 00
202.00 Total (see instructions)	40, 415, 603	163, 869, 723	204, 285, 326	6		202. 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet C | From 01/01/2022 | Part I | To 12/31/2022 | Date/Time Prepared: 5/30/2023 4:12 pm | Hospital | Cost Title XIX

Martiner souths service of cost centres 1.00			Title XIX	Hospi tal	Cost	
MIRATERY ROUTING SERVICE COST CRIVERS 11.00	Cost Center Description	PPS Inpatient				
	'					
INVALIGN ROUTHS SERVICE DOSI CERTERS 30.00 30.00 G00000 ANT 75.8 PEPT ARTS (SES 31.00 31						
30.00 30.00	INPATIENT ROUTINE SERVICE COST CENTERS					
31.00 30300 MIRESS VEC CAME UNIT						30 00
32 00 33000 GROOM RIN HINTENSIVE CARE UNIT 33 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0						1
33.00						
34.00 0 09-000 SURRICULAL INTERSINE CARE UNIT 41.00 0 09-000 SURRICULAL INTERSINE CARE UNIT 41.00 0 09-000 SURRICULAL INTERSINE CARE UNIT 41.00 0 09-000 SURRICULAL INTERSINE CARE UNIT 42.00 09-000 SURRICULAL INTERSINE CARE UNIT 44.00 SURRICULAR UNIT						
40.00 09000 SURRROVIDER - I PEF		1				
41.00 04000 SIMPROVINE - 187 44.00 44.						•
43.00 04500 MIRSENY 44.00 04600 05500 MIRSENY 45.00 MIRS						
0.400 0.400 SKILLED NIRS IN FACILITY						
45.00 04500 MIRSH NO FACILITY 45.00						
40.00						
MICHILARY SERVICE COST CENTERS	45.00 04500 NURSING FACILITY					45. 00
50.00 00000 00000 00000 000000 50.	46.00 O4600 OTHER LONG TERM CARE					46. 00
51.00 05.00 05	ANCILLARY SERVICE COST CENTERS					
52.00 05200 05200 05400 RASTRESTICATION 0.000000 53.00 0530 05300	50. 00 05000 OPERATING ROOM	0. 000000				50.00
52.00 05200 05200 05400 RASTRESTICATION 0.000000 53.00 0530 05300	51.00 05100 RECOVERY ROOM	0. 000000				51.00
53.00 53.00 AMESTHESI OLDGY 0.000000 54.01 59.00		1				52.00
54.00 6400 RADI OLIOY-DI AGNOSTI C 0.000000 54.00		1				•
54.01 36.50 (ILITEA SQUIND 0.000000 55.00						1
55.00 05500 RADIOLOGY - THERAPEUTIC 0.000000 55.00		1				1
56.00 5600 RADIOISTOPE 0.000000 55.0	1 1					1
57. 00 5700 (CT SCAN 0.000000 55. 00 58. 00 58.00 68.00		1				1
Section Sect		1				1
59.00 05900 CARDIAC CATHETERIZATION 0.000000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.0000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.00000000		1				1
0.000 0.0000 0.0000 0.000000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.00000 0.0000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000						
60. 01 06001 BLOOD LABORATORY 0.000000 61.00 61.00 61.00 61.00 61.00 62.00						1
1.00 06100 PBP CLI NI CAL LAB SERVI CES-PREM ONLY 0.000000 62.00 63.00 6						1
62.00	60. 01 06001 BL00D LABORATORY					60. 01
63.00 06.300 06.000 STORI NG, PROCESSING & TRANS. 0.000000 64.00 06.00 06.00 INTRAVENDIST THERAPY 0.000000 06.00 06.00 06.00 08.00 PRIST RATORY THERAPY 0.000000 06.00 06.00 08.00 PRIST RATORY THERAPY 0.000000 06.70 00 06.70 00 06.70 00 06.70 00 07.00	61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000				61. 00
64.00 06.400 INTRAVENOUS THERAPY 0.000000 0.65.00 0.66	62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000				62.00
65. 00 06.500 RESPIRATORY THERAPY 0.000000 06.50 06.50 06.50 06.500 PHSTICAL THERAPY 0.000000 06.50 06.500 07.50	63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000				63.00
65. 00 06500 RESPIRATORY THERAPY 0.000000 06.00 06.00 06500 PHYSICAL THERAPY 0.000000 06.00 06.00 06500 OFCODO PHYSICAL THERAPY 0.000000 06.00 06.00 06500 OSCODO PHYSICAL THERAPY 0.000000 06.00 06.00 06500 SPECH PATHOLOGY 0.000000 06.00 06.00 06500 SPECH PATHOLOGY 0.000000 0.000000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.0000000 0.000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000	64. 00 06400 I NTRAVENOUS THERAPY	0. 000000				64.00
66.00 O6-600 PHYSI CAL THERAPY 0.000000 0.70000 0.70000 0.70000 0.70000 0.70000 0.70000 0.70000 0.70000 0.700000 0.7000						
67. 00 06700 05700 05700 05700 05700 05700 05700 0580		1				•
88. 00 06800 SPECCH PATHOLOGY 0.000000 0.9000		1				
69. 00 0.0900 0.0900 0.0000 0.000000 0.0000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000						
70. 00 07000 ELECTROENGEPHALOGRAPHY 0. 000000 71. 00 7		1				•
17. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 72.00 07200 IMPL DEV CHARGED TO PATIENTS 0.000000 72.00 07200 MPL DEV CHARGED TO PATIENTS 0.000000 73.00 074.00 07400 RENAL DIALYSIS 0.000000 75.00 07500 07500 ASC (NON-DISTINCT PART) 0.000000 75.00 07500 ASC (NON-DISTINCT PART) 0.000000 76.00 07500 ASC (NON-DISTINCT PART) 0.000000 76.00 076.97 07697 CARDIA C REHABILITATION 0.000000 76.97 07697 CARDIA C REHABILITATION 0.000000 76.97 07697 CARDIA C REHABILITATION 0.000000 76.97 07700 ALLOGENEIC STEM CELL ACQUISITION 0.000000 76.97 07900 ALLOGENEIC STEM CELL ACQUISITION 0.000000 89.00 08900 RUBAL HEALTH CLINIC 0.000000 89.00 08900 EDEPARLAY OUALIFIED HEALTH CENTER 0.000000 89.00 08900 EDEPARLAY OUALIFIED HEALTH CENTER 0.000000 89.00 09100 CLINIC 0.000000 91.00 09100 EMERGENCY 0.000000 91.00 09100 09100 EMERGENCY 0.000000 92.00 09200 09						
12.00 07200 IMPL DEV. CHARGED TO PATIENTS 0.000000 73.00 7		1				•
73.00 07300 DRIGS CHARGED TO PATIENTS 0.000000 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 75.00 75.00 75.00 75.00 75.00 75.00 76.00 75.00 76.00 75.00 76.00		1				•
74. 00		1				•
75. 00 07500 ASC (NON-DISTINCT PART) 0. 000000 75. 00 76. 00 03480 ONCOLOGY 0. 000000 76. 00 07697 CARDI AC REHABILITATION 0. 0000000 76. 07 07700 ALLOGENEIC STEM CELL ACQUISITION 0. 0000000 07700		0. 000000				73. 00
76. 00 03480 ONCOLOGY 0.000000 76. 07 76. 97 O7697 CARDI AC REHABILITATION 0.000000 77. 07 77. 00 O7700 ALLOGENEIC STEM CELL ACQUISITION 0.000000 77. 07 88. 00 O8800 RURAL HEALTH CLINIC 0.000000 88. 00 89. 00 08900 EDEFRALLY QUALIFIED HEALTH CENTER 0.000000 89. 00 90. 00 09000 CLINIC 0.000000 99. 00 91. 00 09100 EMERGENCY 0.000000 91. 00 91. 01 04950 WOUND CARE 0.000000 91. 00 92. 00 O9200 OSERVATION BEDS (NON-DISTINCT PART) 0.000000 92. 00 95. 00 09500 MBUBLANCE SERVI (EES 0.000000 95. 00 96. 00 09600 DURABLE MEDI CAL EQUIP - SOLD 0.000000 97. 00 97. 00 09700 DURABLE MEDI CAL EQUIP - SOLD 0.000000 99. 00 99. 10 09950 OTHER REIMBURSABLE COST CENTERS 0.000000 99. 00 99. 10 09990 COMBRE MEDI CAL EQUIP - SOLD 0.000000 99. 00 99. 10 09910 COMBRE MEDI CAL EQUIP - SOLD 0.000000 99. 00 99. 10 09910 COMBRE MEDI CAL EQUIP - SOLD 0.000000 99. 00 99. 10 09910 COMBRE MEDI CAL EQUIP - SOLD 0.000000 99. 00 99. 10 09910 COMBRE MEDI CAL EQUIP - SOLD 0.000000 99. 00 99. 10 09910 COMBRE MEDI CAL EQUIP - SOLD 0.000000 99. 00 99. 10 09910 COMBRE MEDI CAL EQUIP - SOLD 0.000000 99. 00 99. 10 09910 COMBRE MEDI CAL EQUIP - SOLD 0.000000 99. 00 99. 10 09910 COMBRE MEDI CAL EQUIP - SOLD 0.000000 99. 00 99. 10 09910 COMBRE MEDI CAL EQUIP - SOLD 0.000000 99. 00 99. 10 09910 COMBRE MEDI CAL EQUIP - SOLD 0.000000 99. 00 99. 10 09910 COMBRE MEDI CAL EQUIP - SOLD 0.000000 99. 00 99. 10 09910 COMBRE MEDI CAL EQUIP - SOLD 0.000000 99. 00 99. 10 09910 COMBRE MEDI CAL EQUIP - SOLD 0.000000 99. 00 99. 10 09910 COMBRE MEDI CAL EQUIP - SOLD 0.000000 99. 00 99. 10 09910 COMBRE MEDI CAL EQUIP - SOLD 0.000000 99. 00 99. 10 09910 0000 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000 1000	74.00 07400 RENAL DIALYSIS	0. 000000				74. 00
76. 97 07507 07507 07700 ALLOGENEIC STEM CELL ACQUISITION 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000	75.00 07500 ASC (NON-DISTINCT PART)	0. 000000				75. 00
76. 97 076-97 CARDI AC REHABILLITATI ON 0.0000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.00000000	76. 00 03480 ONCOLOGY	0. 000000				76. 00
77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION 0.0000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.0000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000	76. 97 07697 CARDI AC REHABI LI TATI ON					76. 97
Name		1				1
88. 00 08800 RUPAL HEALTH CLINIC 0.000000 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0.000000 90. 00 09000 CLINIC 0.000000 97. 00 09000 P7. 00 09100 EMERGENCY 0.000000 97. 00 09200 085ERVATION BEDS (NON-DISTINCT PART) 0.000000 97. 00 09200 085ERVATION 0.000000 97		0.00000				77.00
89, 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0,000000 0,00000 0,00000 0,00000 0,00000 0,0000000 0,0000000 0,0000000 0,0000000 0,0000000 0,0000000 0,0000000 0,0000000 0,0000000 0,0000000 0,000000 0,000000 0,000000 0,000000 0,000000 0,000000 0,000000 0,000000 0,000000 0,000000 0,000000 0,0000000 0,0000000 0,0000000 0,0000000 0,0000000 0,0000000 0,0000000 0,0000000 0,0000000 0,0000000 0,0000000 0,0000000 0,0000000 0,00000000		0.00000				88 00
90. 00 09000 CLINIC 0.000000 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0.000000 92. 00 09400 HOME PROGRAM DI ALYSIS 0.000000 94. 00 95. 00 96. 00 96. 00 96. 00 96. 00 96. 00 96. 00 97. 00						1
91. 00 09100 EMERGENCY 0. 000000 91. 01 04950 WOUND CARE 0. 000000 92. 00 09200 095ERVATI ON BEDS (NON-DI STI NCT PART) 0. 000000 92. 00 09200 095ERVATI ON BEDS (NON-DI STI NCT PART) 0. 000000 97. 00 09400 HOME PROGRAM DI ALYSI S 0. 000000 95. 00 09500 AMBULANCE SERVI CES 0. 000000 95. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0. 000000 97. 00 9700 DURABLE MEDI CAL EQUI P-RENTED 0. 000000 97. 00 99. 00 09900 CMHC 99. 00 09900 CMHC 99. 00 99. 00 09900 CMHC 99. 00 99. 00 09900 CMHC 99. 00 09900 CMHC 99. 00 09900 CMHC 99. 00 01000 18x SERVI CES-NOT APPRVD PRGM 100. 00 100. 00 10000 18x SERVI CES-NOT APPRVD PRGM 101. 00 101. 00 10100 HOME HEALTH AGENCY 101. 00 01000 100000 100000 100000 100000 100000 100000 100000 10000000 1000000 1000000 1000000 10000000 10000000 10000000 10000000 10000000 10000000 100000000						
91. 01		1				1
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 0.000000 0THER REI MBURSABLE COST CENTERS 94. 00 09400 HOME PROCRAM DIALYSI S 0.000000 95. 00 09500 AMBULANCE SERVI CES 0.000000 95. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0.000000 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0.000000 97. 00 09900 CMHC 99. 00 09900 CMHC 99. 00 09900 CMHC 99. 00 09900 CMHC 99. 10 00000 18 R SERVI CES-NOT APPRVD PRGM 100. 00 100. 00 10000 18 R SERVI CES-NOT APPRVD PRGM 101. 00 10100 HOME HEALTH AGENCY 101. 00 10200 0PI OI D TREATMENT PROGRAM 102. 00 10200 OPI OI D TREATMENT PROGRAM 102. 00 10500 KI DNEY ACQUI SI TI ON 0.000000 105. 00 106. 00 10700 LI VER ACQUI SI TI ON 0.000000 10700 LI VER ACQUI SI TI ON 0.000000 109. 00 10900 LIVER ACQUI SI TI ON 0.000000 109. 00 109. 00 10900 LIVER ACQUI SI TI ON 0.000000 109. 0						
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95. 00 09500 AMBULANCE SERVI CES 0. 000000 95. 00 96. 00 9700 09600 DURABLE MEDI CAL EQUI P-RENTED 0. 000000 97. 00 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0. 000000 97. 00 99. 00 09900 CMHC 99. 00 09900 CMHC 99. 00 99. 00 09910 CORF 99. 10 10000 18R SERVI CES-NOT APPRVD PRGM 100. 00 10100 HOME HEALTH AGENCY 101. 00 10200 0P1 01 D TREATMENT PROGRAM 102. 00 10200 0P1 01 D TREATMENT PROGRAM 105. 00 105. 00 HOME ACQUI SI TI ON 0. 000000 106. 00 10600 HEART ACQUI SI TI ON 0. 000000 107. 00 10700 LI VER ACQUI SI TI ON 0. 000000 108. 00 10800 LUNG ACQUI SI TI ON 0. 000000 109. 00 109. 00 10900 PANCREAS ACQUI SI TI ON 0. 000000 109. 00 109. 00 100. 00 INTESTI NAL ACQUI SI TI ON 0. 000000 109. 00 101. 00 INTESTI NAL ACQUI SI TI ON 0. 000000 109. 00 101. 00 INTESTI NAL ACQUI SI TI ON 0. 000000 109. 00 109. 00 109. 00 109. 00 INTESTI NAL ACQUI SI TI ON 0. 000000 109. 00 109. 00 109. 00 INTESTI NAL ACQUI SI TI ON 0. 000000 109. 00 109. 00 109. 00 INTESTI NAL ACQUI SI TI ON 0. 000000 110. 00 111. 00 INTESTI NAL ACQUI SI TI ON 0. 000000 110. 00 110. 00 INTESTI NAL ACQUI SI TI ON 0. 000000 110. 00 111. 00 INTESTI NAL ACQUI SI TI ON 0. 000000 111. 00 111. 00 INTERST EXPENSE 113. 00 114. 00		0.05				0
96. 00		1				1
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0.000000 97. 00 98. 00 09800 OTHER REI MBURSABLE COST CENTERS 0.000000 99. 00 99. 00 99. 00 09900 CMHC 99. 10 09910 CORF 99. 10 100. 00 10000 I&R SERVI CES-NOT APPRVD PRGM 100. 00 10100 HOME HEALTH AGENCY 101. 00 10200 0910 ID TREATMENT PROGRAM 102. 00 09500 NI DNEY ACQUI SI TI ON 0.000000 105. 00 10500 HEART ACQUI SI TI ON 0.000000 107. 00 10700 LIVER ACQUI SI TI ON 0.000000 107. 00 10700 LIVER ACQUI SI TI ON 0.000000 108. 00 109. 00 10900 PANCREAS ACQUI SI TI ON 0.000000 109. 00 10900 PANCREAS ACQUI SI TI ON 0.000000 109. 00 10900 PANCREAS ACQUI SI TI ON 0.000000 110. 00 110. 00 1100 INTESTI NAL ACQUI SI TI ON 0.000000 110. 00 111. 00 11100 INTESTI NAL ACQUI SI TI ON 0.000000 111. 00 113. 00 11300 INTEREST EXPENSE 114. 00 11400 UTI LI ZATI ON REVI EW-SNF						•
98. 00						
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99. 10 100. 00 100. 00 101. 00 101. 00 101. 00 101. 00 101. 00 102. 00 102. 00 102. 00 10500 KI DNEY ACQUI SITI ON 106. 00 107. 00 107. 00 108. 00 10800 LUNG ACQUI SITI ON 108. 00 109. 0	98.00 09850 OTHER REIMBURSABLE COST CENTERS	0. 000000				98. 00
100. 00 10000 18R SERVI CES-NOT APPRVD PRGM 100. 00 101. 00 10100 HOME HEALTH AGENCY 101. 00 102. 00 102.00 010 ID TREATMENT PROGRAM 102. 00 SPECI AL PURPOSE COST CENTERS 105. 00 10500 KI DNEY ACQUI SI TI ON 0. 000000 105. 00 106. 00 10600 HEART ACQUI SI TI ON 0. 000000 107. 00 10700 LI VER ACQUI SI TI ON 0. 000000 107. 00 108. 00 10800 LUNG ACQUI SI TI ON 0. 000000 108. 00 10900 PANCREAS ACQUI SI TI ON 0. 000000 109. 00 10900 PANCREAS ACQUI SI TI ON 0. 000000 109. 00 10000 Interest Acqui SI TI ON 0. 000000 110. 00 11000 INTEREST ACQUI SI TI ON 0. 000000 110. 00 11000 INTEREST EXPENSE 113. 00 113. 00 114. 00 11400 UTI LI ZATI ON REVI EW-SNF	99. 00 09900 CMHC					99.00
100. 00 10000 18R SERVI CES-NOT APPRVD PRGM 100. 00 101. 00 10100 HOME HEALTH AGENCY 101. 00 102. 00 102.00 010 ID TREATMENT PROGRAM 102. 00 SPECI AL PURPOSE COST CENTERS 105. 00 10500 KI DNEY ACQUI SI TI ON 0. 000000 105. 00 106. 00 10600 HEART ACQUI SI TI ON 0. 000000 107. 00 10700 LI VER ACQUI SI TI ON 0. 000000 107. 00 108. 00 10800 LUNG ACQUI SI TI ON 0. 000000 108. 00 10900 PANCREAS ACQUI SI TI ON 0. 000000 109. 00 10900 PANCREAS ACQUI SI TI ON 0. 000000 109. 00 10000 Interest Acqui SI TI ON 0. 000000 110. 00 11000 INTEREST ACQUI SI TI ON 0. 000000 110. 00 11000 INTEREST EXPENSE 113. 00 113. 00 114. 00 11400 UTI LI ZATI ON REVI EW-SNF	99. 10 09910 CORF					99. 10
101. 00 10100 HOME HEALTH AGENCY 102. 00 10200 OPI 0I D TREATMENT PROGRAM 102. 00 SPECI AL PURPOSE COST CENTERS 105. 00 10500 KI DNEY ACQUI SI TI ON 0. 000000 106. 00 10600 HEART ACQUI SI TI ON 0. 000000 106. 00 107. 00 10700 LI VER ACQUI SI TI ON 0. 000000 107. 00 10800 LUNG ACQUI SI TI ON 0. 000000 10900 PANCREAS ACQUI SI TI ON 0. 000000 10900 PANCREAS ACQUI SI TI ON 0. 000000 109. 00 10900 INTESTI NAL ACQUI SI TI ON 0. 000000 110. 00 11100 INTESTI NAL ACQUI SI TI ON 0. 000000 111. 00 11100 ISLET ACQUI SI TI ON 0. 000000 111. 00 113. 00 11300 INTEREST EXPENSE 113. 00 114. 00 11400 UTI LI ZATI ON REVI EW-SNF 114. 00 114. 00 11400 UTI LI ZATI ON REVI EW-SNF						•
102. 00 10200 OPI 0I D TREATMENT PROGRAM 102. 00 SPECI AL PURPOSE COST CENTERS 105. 00 10500 KI DNEY ACQUI SI TI ON 0.000000 106. 00 10600 HEART ACQUI SI TI ON 0.000000 106. 00 107. 00 10700 LI VER ACQUI SI TI ON 0.000000 107. 00 10800 LI VER ACQUI SI TI ON 0.000000 109. 00 10900 PANCREAS ACQUI SI TI ON 0.000000 109. 00 10900 PANCREAS ACQUI SI TI ON 0.000000 109. 00 1000 INTESTI NAL ACQUI SI TI ON 0.000000 110. 00 111. 00 11100 I SLET ACQUI SI TI ON 0.000000 111. 00 113. 00 11300 INTEREST EXPENSE 113. 00 114. 00 11400 UTI LI ZATI ON REVI EW-SNF 114. 00 114. 00 11400 UTI LI ZATI ON REVI EW-SNF 114. 00 114. 00 11400 11500 11						1
SPECIAL PURPOSE COST CENTERS 105.00 10500 KI DNEY ACQUI SI TI ON 0.000000 105.00 106.00 10600 HEART ACQUI SI TI ON 0.000000 106.00 107.00 107.00 108.00 108.00 108.00 108.00 108.00 108.00 108.00 108.00 109.00 1						•
105. 00						102.00
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109. 00 10900 PANCREAS ACQUI SI TI ON 0.000000 110. 00 11000 I NTESTI NAL ACQUI SI TI ON 0.000000 111. 00 1111. 00 11100 I SLET ACQUI SI TI ON 0.000000 111. 00 113. 00 113. 00 114. 00		1				
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111. 00 11100 I SLET ACQUI SI TI ON 0. 000000 111. 00 113. 00 11300 I NTEREST EXPENSE 114. 00 11400 UTI LI ZATI ON REVI EW-SNF 114. 00		0. 000000				
111. 00 11100 I SLET ACQUI SI TI ON 0. 000000 111. 00 113. 00 11300 I NTEREST EXPENSE 114. 00 11400 UTI LI ZATI ON REVI EW-SNF 114. 00	110.00 11000 INTESTINAL ACQUISITION	0. 000000				110. 00
113. 00 11300 I NTEREST EXPENSE 113. 00 11400 UTI LI ZATI ON REVI EW-SNF 114. 00 1140		1				111. 00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF 114. 00		1				
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1116.00	· · · · · · · · · · · · · · · · · · ·	1				1
		1				

Heal th Finar	ncial Systems	FRANCISCAN HEALTH (CRAWFORDSVI LLE	In Lie	u of Form CMS-2	2552-10
COMPUTATI ON	OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0022	Peri od:	Worksheet C	
				From 01/01/2022	Part I	narad.
				To 12/31/2022	Date/Time Pre 5/30/2023 4:1:	
			Title XIX	Hospi tal	Cost	
	Cost Center Description	PPS Inpatient				
		Ratio				
		11. 00				
116.00 11600	HOSPI CE					116. 00
200.00	Subtotal (see instructions)					200. 00
201.00	Less Observation Beds					201. 00
202. 00	Total (see instructions)					202. 00

Health Financial Systems FD/	ANCISCAN HEALTH	I CDAWEODDSVIII	_	ln lie	eu of Form CMS	2552 10
Health Financial Systems FRA APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL		Provi der C		Period: From 01/01/2022 To 12/31/2022	Worksheet D Part I	pared:
		Ti tl e	e XVIII	Hospi tal	PPS	•
Cost Center Description	Capi tal	Swing Bed	Reduced		Per Diem (col.	
·	Related Cost	Adjustment	Capi tal	Days	3 / col . 4)	
	(from Wkst. B,		Related Cost		,	
	Part II, col.		(col . 1 - col			
	26)		2)			
	1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS			•			
30. 00 ADULTS & PEDI ATRI CS	763, 973	0	763, 97	4, 387	174. 14	30.00
31.00 INTENSIVE CARE UNIT	254, 456		254, 45	66 819	310. 69	31.00
32. 00 CORONARY CARE UNIT	0			0 0	0.00	32. 00
33.00 BURN INTENSIVE CARE UNIT	0			0 0	0.00	33. 00
34.00 SURGICAL INTENSIVE CARE UNIT	0			0 0	0.00	34.00
40. 00 SUBPROVI DER - I PF	376, 849	l o	376, 84	1, 700	221. 68	40.00
41. 00 SUBPROVI DER - I RF	0			0 0	0.00	1
43. 00 NURSERY	0	_		0 0	0.00	
44.00 SKILLED NURSING FACILITY	0			0 0	0.00	1
45.00 NURSING FACILITY	0			0 0		45. 00
200.00 Total (lines 30 through 199)	1, 395, 278		1, 395, 27	8 6, 906		200. 00
Cost Center Description	Inpatient	Inpati 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	1, 182	205, 833	В			30.00
31.00 INTENSIVE CARE UNIT	283	87, 925	5			31.00
32. 00 CORONARY CARE UNIT	0	l 0				32. 00
33.00 BURN INTENSIVE CARE UNIT	0	0				33.00
34.00 SURGICAL INTENSIVE CARE UNIT	0					34.00
40. 00 SUBPROVI DER - I PF	1, 022	226, 557	,			40.00
41. 00 SUBPROVI DER - I RF	0					41.00
43. 00 NURSERY	0					43.00
44.00 SKILLED NURSING FACILITY	0					44. 00
45. 00 NURSING FACILITY	0					45. 00
200.00 Total (lines 30 through 199)	2, 487		1			200.00
, , , , , , , , , , , , , , , , , , , ,	,	,	1			

Heal th	Financial Systems FR	ANCISCAN HEALTH	CRAWFORDSVI LL	E	In Li€	eu of Form CMS-2	2552-10
APPORT	TIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der Co	CN: 15-0022	Peri od:	Worksheet D	
					From 01/01/2022	Part II	
					To 12/31/2022		pared:
						5/30/2023 4:1	2 pm
				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)					
		1.00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	889, 432	20, 839, 197			27, 050	50.00
51.00	05100 RECOVERY ROOM	0	0	0.00000	0 0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0.00000	0 0	0	52.00
53.00	05300 ANESTHESI OLOGY	0	0	0.00000	0 0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	543, 229	12, 674, 475	1		28, 677	54.00
54. 01	03630 ULTRA SOUND	27, 260	5, 106, 820	l .	· ·	0	
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0, 100, 000	0.00000		Ō	55. 00
56. 00	05600 RADI OI SOTOPE	69, 946	3, 053, 273			_	
57. 00	05700 CT SCAN	4, 401	19, 736, 280	1	· ·		
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)		3, 444, 706				
		768	3, 444, 700				
59.00	05900 CARDI AC CATHETERI ZATI ON		0 0 0 0 0 0	0.00000		0	
60.00	06000 LABORATORY	242, 007	24, 860, 248				
60. 01	06001 BLOOD LABORATORY	0	0	0.00000	0	0	
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0.00000		0	62. 00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	45	201, 716	0. 00022	78, 444	17	63.00
64.00	06400 I NTRAVENOUS THERAPY	0	0	0.00000	0 0	0	64.00
65.00	06500 RESPIRATORY THERAPY	30, 738	2, 921, 541	0. 01052	683, 608	7, 192	65.00
66. 00	06600 PHYSI CAL THERAPY	153, 822	5, 105, 930	0. 03012	931, 106	28, 050	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	0. 00000		0	67.00
68. 00	06800 SPEECH PATHOLOGY	0	0	1		0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	217, 469	8, 096, 949	1		15, 416	
70. 00	07000 ELECTROENCEPHALOGRAPHY	2.77,107	0,070,717	0.00000		10, 1.0	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	257, 192	12, 084, 657			15, 933	
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	93, 080	1, 944, 532	1	· ·		
73. 00	07300 DRUGS CHARGED TO PATIENTS	98, 081	7, 889, 580	1	· ·		
74. 00		90,001	7,009,300				
	07400 RENAL DIALYSIS	0	0	0.00000		0	
75. 00	07500 ASC (NON-DISTINCT PART)	0	10 170	0.00000		0	
76. 00	03480 ONCOLOGY	4	10, 179	1		0	76. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	201	899, 170			l .	76. 97
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0.00000	00 0	0	77. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0	0				
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.00000		0	89. 00
90.00	09000 CLI NI C	143, 179	1, 019, 757	0. 14040	05	0	90.00
91.00	09100 EMERGENCY	608, 983	56, 036, 150	0. 01086	1, 687, 550	18, 340	91.00
91. 01	04950 WOUND CARE	0	0	0.00000	0 0	0	91. 01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	245, 023	2, 999, 927	0. 08167	6 442, 397	36, 133	92.00
	OTHER REIMBURSABLE COST CENTERS			•	<u> </u>		1
94.00	09400 HOME PROGRAM DI ALYSIS	0	0	0.00000	00 0	0	94.00
95. 00	09500 AMBULANCE SERVI CES		Ĭ				95. 00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	0	<u> </u>	0. 00000	0	0	96.00
97. 00	09700 DURABLE MEDICAL EQUI P-SOLD			0.00000		0	
98. 00	09850 OTHER REIMBURSABLE COST CENTERS			0.00000		0	1
200.00		3, 624, 860	188, 925, 087	1	11, 066, 323	_	
∠00. UC	p protai (Trines 50 tillough 199)	3,024,000	100, 920, 087	I	11,000,323	1 224, 039	₁ 200.00

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

lealth Financial Systems APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER	FRANCISCAN HEALTH R PASS THROUGH COST			Peri od:	u of Form CMS-2 Worksheet D	
				From 01/01/2022 To 12/31/2022	Part III	pared:
		Title	e XVIII	Hospi tal	PPS	<u> </u>
Cost Center Description	Nursi ng Program	Nursi ng Program	Allied Health Post-Stepdowr	Allied Health	All Other Medical	
	Post-Stepdown Adjustments	og. a	Adjustments		Education Cost	
	1A	1. 00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS			1	_1		
30.00 03000 ADULTS & PEDIATRICS 31.00 03100 INTENSIVE CARE UNIT	0	0	1	0 0	0	
B1. 00 03100 INTENSIVE CARE UNIT B2. 00 03200 CORONARY CARE UNIT	0	0	1	0 0	0	31.00
3. 00 03300 BURN INTENSIVE CARE UNIT	0	0	1	0 0	0	
34. 00 03400 SURGI CAL INTENSI VE CARE UNI T		0	ł	-	0	
		0	1	0 0		
IO. 00 04000 SUBPROVI DER - PF I1. 00 04100 SUBPROVI DER - RF		0	1		0	
		0	ł	-	0	
		0		0	U	
14.00 04400 SKILLED NURSING FACILITY	0	0		0		44.00
15.00 04500 NURSING FACILITY 200.00 Total (lines 30 through 199)	0	0		0 0		45. 00
Total (lines 30 through 199) Cost Center Description	Swi ng-Bed	Total Costs	Total Pationt	Per Diem (col.	Inpati ent	200.00
cost center bescription	Adjustment	(sum of cols.	Days	5 ÷ col . 6)	Program Days	
	Amount (see	1 through 3,	Days	3 - (01. 0)	Frogram bays	
		minus col. 4)				
	4. 00	5. 00	6.00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		0.00	0.00	7.00	0.00	
30. 00 03000 ADULTS & PEDIATRICS	0	0	4, 38	7 0.00	1, 182	30.00
31.00 03100 INTENSIVE CARE UNIT		0			283	
32. 00 03200 CORONARY CARE UNIT		0		0.00	0	
3.00 03300 BURN INTENSIVE CARE UNIT		0		0.00	0	33.00
4.00 03400 SURGICAL INTENSIVE CARE UNIT		0		0.00	0	34.00
10. 00 04000 SUBPROVI DER - I PF	o	0	1, 70	0.00	1, 022	40.00
11. 00 04100 SUBPROVI DER - I RF	0	0		0.00	0	41.00
13. 00 04300 NURSERY		0	1	0.00	0	
14.00 04400 SKILLED NURSING FACILITY		0	l .	0.00	Ö	44.00
15. 00 04500 NURSING FACILITY		0		0.00	0	
200.00 Total (lines 30 through 199)		0	l .		_	200.00
Cost Center Description	Inpatient		-7.19	-		
'	Program					
	Pass-Through					
	Cost (col. 7 x					
	col . 8)					
	9. 00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0					30.00
31.00 03100 INTENSIVE CARE UNIT	0					31.00
32.00 03200 CORONARY CARE UNIT	0					32.00
33.00 03300 BURN INTENSIVE CARE UNIT	0					33.00
44.00 03400 SURGICAL INTENSIVE CARE UNIT	0					34.00
	0					40.00
						41.00
	0					
11. 00 04100 SUBPROVI DER - I RF	0					43.00
41. 00 04100 SUBPROVI DER - I RF						
41.00 04100 SUBPROVI DER - I RF 43.00 04300 NURSERY	0					43.00

In Lieu of Form CMS-2552-10

Period:	Worksheet D
From 01/01/2022	Part IV
To 12/31/2022	Date/Time Prepared:
5/30/2023 4:12 pm	THROUGH COSTS

						5/30/2023 4:1	2 pm
			Ti tl	e XVIII	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursi ng	Nursi ng		Allied Health	
		Anestheti st	Program	Program	Post-Stepdow	۱	
		Cost	Post-Stepdown		Adjustments		
			Adjustments				
	T	1.00	2A	2. 00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS			_	_	_1	
50.00	05000 OPERATING 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	52. 00
53.00	05300 ANESTHESI OLOGY	0)	0	0 0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0		2	0	٥	54.00
54. 01	03630 ULTRA SOUND	0		2	0	0 0	54. 01
55. 00 56. 00	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE	0		3	0	0 0	55. 00 56. 00
57.00	05700 CT SCAN	0			0		57.00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0		3	0		58.00
59. 00	05900 CARDIAC CATHETERIZATION	0			0		59.00
60. 00	06000 LABORATORY	0			0		60.00
60. 00	06001 BL00D LABORATORY	0			0		60.00
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		,		٥	9	61. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0			0	0	62.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0			0	ol o	63. 00
64. 00	06400 I NTRAVENOUS THERAPY	0			0		64. 00
65. 00	06500 RESPI RATORY THERAPY	0			0		65. 00
66. 00	06600 PHYSI CAL THERAPY	0			0	ol o	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0			0	ol o	67. 00
68. 00	06800 SPEECH PATHOLOGY	0			0	ol o	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0			0	ol o	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0			0	ol o	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	(0	ol o	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	(0	ol o	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	(o	0	ol o	73. 00
74.00	07400 RENAL DIALYSIS	0	(o	0	o o	74. 00
75.00	07500 ASC (NON-DISTINCT PART)	o			0	ol o	75. 00
76.00	03480 ONCOLOGY	0	(0	0 0	76. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	(o l	0	0 0	76. 97
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	()	0	0 0	77. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0	(0	0	0 0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	(0	0	0 0	89. 00
90. 00	09000 CLI NI C	0	(0	0	0	90. 00
91. 00	09100 EMERGENCY	0	(0	0	0	91. 00
91. 01	04950 WOUND CARE	0	(O	0	0	91. 01
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	92.00
:	OTHER REIMBURSABLE COST CENTERS			-1		al	
94. 00	09400 HOME PROGRAM DI ALYSI S	0	(O	0	0	94. 00
95.00	09500 AMBULANCE SERVICES						95. 00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0			0	0	96.00
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD	0			0	0 0	97.00
98. 00	09850 OTHER REIMBURSABLE COST CENTERS				0	0 0	98. 00
200.00	Total (lines 50 through 199)	l ol	,))	0	0 0	200. 00

In Lieu of Form CMS-2552-10

Period:	Worksheet D
From 01/01/2022	Part IV
To 12/31/2022	Date/Time Prepared:
5/30/2023 4:12 pm	Health Financial Systems FRANCISCAN HEALTH COAPPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provi der CCN: 15-0022 THROUGH COSTS

New York						12/01/2022	5/30/2023 4: 1	2 pm
Medical Country Coun				Ti tl e	XVIII	Hospi tal		
ACCIDENT	Cost Center Des	cription	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
ANDILLARY SERVICE COST CENTERS			Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
MICHELARY SERVICE COST CENTERS			Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
ANCILLARY SERVICE COST CENTERS				4)		8)	7)	
ANCI LLARY SERVICE COST CENTERS					and 4)			
MACILLARY SERVICE COST CENTERS								
50.00			4. 00	5. 00	6.00	7. 00	8. 00	
51 00 05100 RECOVERY ROOM & LABOR ROOM 0 0 0 0 0 0 0 0 0		ST CENTERS	1					
52.00 05200 DELI YERY ROOM & LABOR ROOM 0 0 0 0 0 0 0 0 0			0				l .	
53.00 05300 ANSTHESI OLOGY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0					
54.00 05400 RADIOLOGY-DIAGNOSTIC 0 0 0 12, 674, 475 0.00000 54.01 0.5500 RADIOLOGY-THERAPEUTIC 0 0 0 0 0 0 0 0 0.00000 54.01 0.5500 RADIOLOGY-THERAPEUTIC 0 0 0 0 0 0 0 0 0.00000 54.01 0.500000 54.01 0.500000 54.01 0.500000 54.01 0.500000 54.01 0.500000 54.01 0.500000 54.01 0.500000 54.01 0.500000 54.01 0.500000 54.01 0.500000 54.01 0.500000 54.01 0.500000 54.01 0.500000 54.00 0.00000 55.00 0.000000 55.00 0.00000 55.00000 55.00000 55.000000 55.000000 55.0000000000		LABOR ROOM	0	C	1			
54. 0			0	C				
55 00 0.5500 RADIO LO.GYTHERAPUTIC 0 0 0 3 .053, 273 0.000000 55.00		OSTI C	0	C	1			
56.00 OSGOO RADIO I SOTOPE			0	C)	5, 106, 820		54. 01
57.00 05700 CT SCAN 0 0 0 0 0 19,736,280 0,000000 57.00		PEUTI C	0	C)	0	0.000000	55. 00
SB. 00 OSBOO MAGNETI C RESONANCE I IMAGING (MRI) 0 0 0 3, 444, 706 0, 000000 59, 00 590 00 600 0 0 0 0 0 0 0	56. 00 05600 RADI 0I SOTOPE		0	C)	3, 053, 273	0.000000	56. 00
59.00 05900 CARDIAC CATHETERI ZATION 0 0 0 0 0 0 0 0 0	57.00 05700 CT SCAN		0	C		19, 736, 280	0.000000	57. 00
60.00 06000 LABORATORY 0 0 0 0 24,860,248 0.000000 60.001	58. 00 05800 MAGNETI C RESONA	NCE IMAGING (MRI)	0	C		3, 444, 706	0.000000	58. 00
60.01	59. 00 05900 CARDI AC CATHETE	RI ZATI ON	0	C		0 0	0.000000	59. 00
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	60. 00 06000 LABORATORY		0	C		24, 860, 248	0.000000	60.00
62.00 06200 MPIOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 0 0 0 0 0 0	60. 01 06001 BLOOD LABORATOR	Υ	0	C		0	0.000000	60. 01
63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 0 201,716 0.000000 63.00 64.00 06400 INTRAVENOUS THERAPY 0 0 0 0 0.000000 65.00 65.00 06500 RESPIRATORY THERAPY 0 0 0 0 2,921,541 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 0 0 0 0 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 0 0 0 0 0.000000 65.00 67.00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 0 0 0.000000 68.00 69.00 06900 ELECTROCARDI OLOGY 0 0 0 0 0.000000 69.00 69.00 06900 ELECTROCARDI OLOGY 0 0 0 0 0.000000 69.00 69.00 06900 ELECTROCARDI OLOGY 0 0 0 0 0.000000 69.00 69.00 07000 ELECTROCARDI OLOGY 0 0 0 0 0.000000 69.00 69.00 071.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0.000000 70.00 69.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 12,084,657 0.000000 72.00 69.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0.000000 73.00 69.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0.000000 73.00 69.00 07400 RENAL DIALYSIS 0 0 0 0 0.000000 73.00 69.00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0.000000 75.00 69.00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 0.000000 76.00 69.00 09600 ELECTROCARDI DIALYSIS 0 0 0 0 0.000000 76.00 69.00 09600 ELECTROCARDI DIALYSIS 0 0 0 0 0.000000 76.00 69.00 09600 DURABLE MEDI CAL EQUI P-RINTED 0 0 0 0 0.000000 90.00 69.00 09700 DURABLE MEDI CAL EQUI P-RINTED 0 0 0 0 0.000000 90.00 69.00 09700 DURABLE MEDI CAL EQUI P-RINTED 0 0 0 0.000000 90.00 69.00 09700 DURABLE MEDI CAL EQUI P-RINTED 0 0 0 0.000000 90.00 69.00 09700 DURABLE MEDI CAL EQUI P-RINTED 0 0 0 0.000000 90.00 69.00 09700 DURABLE MEDI CAL EQUI P-RINTED 0 0 0.000000 90.00	61.00 06100 PBP CLINICAL LA	B SERVICES-PRGM ONLY						61. 00
64.00 06400 INTRAVENOUS THERAPY 0 0 0 0 0 0 0 0 0	62.00 06200 WHOLE BLOOD & P	ACKED RED BLOOD CELLS	0	C		0	0.000000	62. 00
65. 00 06500 RESPIRATORY THERAPY 0 0 0 0 2, 921, 541 0.000000 65. 00 66. 00 0.000000 0.000000 0.0000000 0.000000 0.000000 0.0000000 0.000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000	63. 00 06300 BLOOD STORING,	PROCESSING & TRANS.	O	C)	201, 716	0.000000	63. 00
66. 00 06600 PHYSI CAL THERAPY 0 0 0 5,105,930 0.000000 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 0 0.000000 67. 00 68. 00 06800 SPEECH PATHOLOGY 0 0 0 0 0.000000 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 0.000000 69. 00 70. 00 07000 ELECTROCARDI OLOGY 0 0 0 0 0.000000 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 1,944,532 0.000000 71. 00 72. 00 07200 IMPL DEV. CHARGED TO PATIENTS 0 0 0 1,944,532 0.000000 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0,000000 73. 00 74. 00 07400 RENAL DI ALYSIS 0 0 0 0 0.000000 75. 00 75. 00 07500 ASC (NON-DI STINCT PART) 0 0 0 0 0.000000 75. 00 76. 97 07697 CARDI AC REHABILITATI ON 0 0 0 0 0.000000 76. 97 77. 00 07700 ALLOGENEI C STEM CELL ACQUISITI ON 0 0 0 0.000000 77. 00 88. 00 08800 RURAL HEALTH CLINIC 0 0 0 0.000000 97. 00 99. 00 09900 EDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0.000000 97. 00 91. 01 04950 MOUND CARE 0 0 0 0 0.000000 97. 00 92. 00 09200 DESERVATI ON BEDS (NON-DISTINCT PART) 0 0 0 0 0.000000 97. 00 99. 00 09900 CLINIC CENTERS 0 0 0 0 0.000000 97. 00 99. 00 09900 CLINIC CENTERS 0 0 0 0 0.000000 97. 00 99. 00 09900 MBBULANCE SERVI CES 95. 00 99. 00 09900 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 0.000000 97. 00 99. 00 09900 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 0.000000 97. 00 99. 00 09950 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 0.000000 97. 00 99. 00 09950 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 0.000000 97. 00 99. 00 09950 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 0 0.000000 97. 00 99. 00 09950 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 0 0 0 0 0.000000 97. 00 99. 00 09950 OTHER	64.00 06400 I NTRAVENOUS THE	RAPY	o	C		0	0.000000	64. 00
67. 00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 0 0 0 0 0	65. 00 06500 RESPI RATORY THE	RAPY	o	C		2, 921, 541	0.000000	65. 00
68.00 06800 SPEECH PATHOLOGY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	66. 00 06600 PHYSI CAL THERAP	Υ	o	C		5, 105, 930	0.000000	66. 00
68.00 66800 SPEECH PATHOLOGY 0 0 0 0 0 0 0 0.000000 68.00 69.00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0 0.000000 70.00 07000 ELECTROCARDI OLOGY 0 0 0 0 0 0 0.000000 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 12,084,657 0.000000 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 12,984,657 0.000000 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 12,984,532 0.000000 74.00 07400 RENAL DI ALYSIS 0 0 0 0 0 7,889,580 0.000000 75.00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	67. 00 06700 OCCUPATIONAL TH	ERAPY	o	C		0	0.000000	67. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 0 0 0 0			o	C		0	0.000000	68. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 0 0 0 0	69. 00 06900 ELECTROCARDI OLO	GY	o	C		8, 096, 949	0.000000	69. 00
71. 00	70. 00 07000 ELECTROENCEPHAL	OGRAPHY	o	C				70. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 1, 944, 532 0.000000 72.00 73.00 73.00 73.00 73.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 75.00 0.75.00 75.00 0.75.00 75.00 0.75.00 75.00 0.000000 75.00 0.000000 75.00 0.000000 75.00 0.000000 75.00 0.000000 75.00 0.000000 76.00 76.00 0.000000 76.00 76.00 0.000000 76.00 76.00 0.000000 76.00 76			0	C		12, 084, 657		71. 00
73. 00			o	C		1, 944, 532	0.000000	72. 00
74. 00 07400 RENAL DI ALYSI S 0 0 0 0 0 0 0 0 0			0	C	•			
75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 0 0 0 0			0	C				
76. 00		CT PART)	0	C		0		
76. 97 07697 CARDI AC REHABILITATION 0 0 0 899, 170 0.000000 76. 97 77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION 0 0 0 0 0 0 0.000000 77. 00 0000000 00000000 0000000000		,	0	Ċ				
77. 00		I TATI ON	0	Ċ				
SERVICE COST CENTERS			0		l	·		
88. 00			-		1	-		
89. 00			0			0	0.000000	88 00
90. 00			0		1			
91. 00		THE HEALTH SERVER	0		1			
91. 01			0		1			
92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 0 2,999,927 0.000000 92. 00			0		•			
OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DI ALYSI S 0 0 0 0 0 0 0 0 0		(NON_DISTINCT DART)	0	-	1			
94. 00			<u> </u>		′1	2, 777, 721	0.000000	72.00
95. 00					1		0.000000	0/ 00
96. 00			١	C	1		0.00000	
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 0.000000 97. 00 98. 00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 0.000000 98. 00				_			0 000000	
98. 00 09850 OTHER REIMBURSABLE COST CENTERS 0 0 0 0 0 0 0 0 0					ł	-		
200.00 Total (Trues 30 till ough 177) 0 0 0 100, 923, 007 200.00								
	200.00 Total (Thes 50	till odgil 177)	١		ή '	0 100, 723, 007	I	1200.00

| Peri od: | Worksheet D | From 01/01/2022 | Part IV | To 12/31/2022 | Date/Time Prepared: | To 12/31/2022 | Date/Time Prepared: | To 12/31/2022 | Date/Time Prepared: | To 12/31/2022 | To 12 Health Financial Systems FRANCISCAN HEALTH COAPPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provi der CCN: 15-0022 THROUGH COSTS

					10 12/31/2022	5/30/2023 4:1	
			Title	XVIII	Hospi tal	PPS	
	Cost Center Description	Outpati ent	I npati 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. 8	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			T		Г	
50. 00	05000 OPERATING ROOM	0. 000000	633, 780	1	0 4, 392, 534	0	
51.00	05100 RECOVERY ROOM	0. 000000	0	1	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0	0	52. 00
53. 00	05300 ANESTHESI OLOGY	0. 000000	0	1	0 0	0	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	669, 091	i	0 3, 172, 839	0	54.00
54. 01	03630 ULTRA SOUND	0. 000000	0	1	0	0	54. 01
55. 00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	0	1	0	0	55. 00
56. 00	05600 RADI OI SOTOPE	0. 000000	43, 652	l .	950, 477	0	56. 00
57. 00	05700 CT SCAN	0. 000000	1, 054, 335		0 4, 075, 618	0	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 000000	159, 265	1	0 807, 085	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	0		0	0	59. 00
60. 00	06000 LABORATORY	0. 000000	1, 848, 172	1	0 818, 812	0	60.00
60. 01	06001 BLOOD LABORATORY	0. 000000	0	1	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	78, 444		70, 482	0	63. 00
64. 00	06400 I NTRAVENOUS THERAPY	0. 000000	0	1	0	0	64. 00
65. 00	06500 RESPI RATORY THERAPY	0. 000000	683, 608	1	0 126, 383	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0. 000000	931, 106	1	0 1, 148, 476	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 000000	0	1	0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0. 000000	0		0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 000000	573, 976	1	0 2, 383, 865	0	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0	0	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	748, 627	1	0 1, 587, 986	0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000	281, 282	1	0 374, 359	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	1, 231, 038	1	0 1, 673, 901	0	73. 00
74. 00	07400 RENAL DI ALYSI S	0. 000000	0		0	0	74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0. 000000	0		0	0	75. 00
76. 00	03480 ONCOLOGY	0. 000000	0	l .	0 0	0	76.00
76. 97	07697 CARDI AC REHABI LI TATI ON	0. 000000	0		0 317, 030	0	76. 97
77. 00	07700 ALLOGENEI C STEM CELL ACQUI SI TI ON	0. 000000	0		0 0	0	77. 00
88. 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	0. 000000	0	ı	0 0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000	0		0 0	0	89.00
90.00	09000 CLINIC	0. 000000	0		0 12.026	0	90.00
91.00	09100 EMERGENCY	0. 000000	1, 687, 550		0 6, 672, 364	0	91.00
91.00	04950 WOUND CARE	0. 000000	1,087,550	1	0, 072, 304	0	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	442, 397	1	0 406, 175	0	92.00
92.00	OTHER REIMBURSABLE COST CENTERS	0.000000	442, 377		0 400, 175	0	72.00
94. 00	09400 HOME PROGRAM DI ALYSI S	0. 000000	0		0 0	0	94. 00
95. 00	09500 AMBULANCE SERVICES	0.000000	0				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	1	0 0	0	97. 00
98. 00	09850 OTHER REIMBURSABLE COST CENTERS	0. 000000	0	1	0 0	Ö	•
200.00		3. 000000	11, 066, 323	l .	0 28, 990, 412		200.00
_55.50	1.0ta. (00 00 till ough 177)	1	, 500, 525	I	-, 20, ,,0, 112	. •	1=00.00

APPORT	TONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-0022	Period: From 01/01/2022		narodi
					To 12/31/2022	Date/Time Pre 5/30/2023 4:1	pareu: 2 pm
			Ti tl e	XVIII	Hospi tal	PPS	
				Charges		Costs	
	Cost Center Description	Cost to Charge			Cost	PPS Services	
		Ratio From	Services (see	Rei mbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins			
		1. 00	2.00	(see inst.) 3.00	(see inst.) 4.00	5. 00	
	ANCILLARY SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
50. 00	05000 OPERATI NG ROOM	0. 318257	4, 392, 534		0 0	1, 397, 955	50.00
51.00	05100 RECOVERY ROOM	0. 000000			0 0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	l o		0 0	0	52.00
53.00	05300 ANESTHESI OLOGY	0. 000000	l o		0 0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 310392	3, 172, 839		0 0	984, 824	54.00
54. 01	03630 ULTRA SOUND	0. 034802	0		0 0	0	54. 01
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	0		0 0	0	55. 00
56.00	05600 RADI OI SOTOPE	0. 125481	950, 477	·	0 0	119, 267	56. 00
57.00	05700 CT SCAN	0. 003342	4, 075, 618	8	0 0	13, 621	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 003342	807, 085	5	0 0	2, 697	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	0		0	0	59. 00
60.00	06000 LABORATORY	0. 179567	818, 812	2	0	147, 032	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. 003341	70, 482	2	0	235	
64. 00	06400 I NTRAVENOUS THERAPY	0. 000000)	0	0	64. 00
65. 00	06500 RESPI RATORY THERAPY	0. 441872	126, 383	1	0	55, 845	
66. 00	06600 PHYSI CAL THERAPY	0. 277114	1, 148, 476		0		
67. 00	06700 OCCUPATI ONAL THERAPY	0. 000000	0)	0 0	0	
68. 00	06800 SPEECH PATHOLOGY	0. 000000	0)	0 0		
69. 00	06900 ELECTROCARDI OLOGY	0. 131086	2, 383, 865		0 0		1
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	4 507 00/)	0 0		
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 136160	1, 587, 986	1	0 0		1
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 243386	374, 359	1	0	91, 114	1
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 284589	1, 673, 901		0	476, 374	1
74.00	07400 RENAL DIALYSIS	0.000000			0 0	0	
75. 00 76. 00	07500 ASC (NON-DISTINCT PART) 03480 ONCOLOGY	0.000000			0 0	0	
76. 00 76. 97	07697 CARDI AC REHABI LI TATI ON	0. 016505 0. 003342	317, 030		0 0		
77.00	l l	0. 000000	317,030		0 0	l	1
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION OUTPATIENT SERVICE COST CENTERS	0.000000		1	0 0		77.00
88. 00	08800 RURAL HEALTH CLINIC						88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER						89. 00
90. 00	09000 CLINIC	0. 656493	12, 026		0 0	7, 895	
91. 00	09100 EMERGENCY	0. 097299	1	1	0 0		
91. 01	04950 WOUND CARE	0.000000				1	1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 632438	ł		0 0		
72.00	OTHER REIMBURSABLE COST CENTERS	0. 002 100	100, 170	1	<u> </u>	200,001	72.00
94.00	09400 HOME PROGRAM DIALYSIS	0. 000000			0 0		94. 00
95. 00		0. 000000			0		95.00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000	l o		0 0	0	
	09700 DURABLE MEDICAL EQUIP-SOLD	0. 000000	O		0 0	0	
98.00	1 1	0. 000000			0 0	0	
200.00			28, 990, 412	2	0 0	5, 050, 984	
201.00					0 0	1	201. 00
	Only Charges			1			
202.00	Net Charges (line 200 - line 201)		28, 990, 412	!	0 0	5, 050, 984	202. 00

Heal th Financial Systems FRANCISCAN HEALTH CRAWFORDSVILLE In Lieu of Form CMS-2552-10

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0022 Period: From 01/01/2022 To 12/31/2022 Part V Date/Time Prepared: 5/30/2023 4: 12 pm

Cost Center Description Cost Cost Reimbursed Reimbursed Reimbursed

			Title	XVIII	Hospi tal	PPS	
		Cos	sts		· · · · · · · · · · · · · · · · · · ·		
	Cost Center Description	Cost	Cost	†			
	cost center 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	1			
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	0	0	1			50.00
		1	_				
1	05100 RECOVERY ROOM	0					51.00
	05200 DELIVERY ROOM & LABOR ROOM	0	0				52. 00
	05300 ANESTHESI OLOGY	0	0				53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
54. 01	03630 ULTRA SOUND	0	0				54. 01
	05500 RADI OLOGY-THERAPEUTI C	0	0				55. 00
1	05600 RADI OI SOTOPE	0	Ö				56. 00
	05700 CT SCAN		0				57.00
4		0	_				ł
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0				58. 00
4	05900 CARDI AC CATHETERI ZATI ON	0	0				59. 00
60.00	06000 LABORATORY	0	0				60.00
60. 01	06001 BLOOD LABORATORY	0	0)			60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0					61. 00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0				62. 00
1	06300 BLOOD STORING, PROCESSING & TRANS.		Ö				63. 00
1		0					1
	06400 I NTRAVENOUS THERAPY	0	0				64. 00
	06500 RESPI RATORY THERAPY	0	0				65. 00
66. 00	06600 PHYSI CAL THERAPY	0	0				66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	0				67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0				68. 00
1	06900 ELECTROCARDI OLOGY	0	0				69. 00
	07000 ELECTROENCEPHALOGRAPHY	0	Ö				70. 00
1	·						71.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0					
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72. 00
	07300 DRUGS CHARGED TO PATIENTS	0	0				73. 00
74. 00	07400 RENAL DIALYSIS	0	0)			74. 00
75.00	07500 ASC (NON-DISTINCT PART)	0	0				75. 00
76. 00	03480 ONCOLOGY	0	0)			76. 00
	07697 CARDI AC REHABI LI TATI ON	0	0	,			76. 97
	07700 ALLOGENEIC STEM CELL ACQUISITION	0	Ö				77. 00
+	OUTPATIENT SERVICE COST CENTERS		1 0	1			77.00
							00.00
	08800 RURAL HEALTH CLINIC	1					88. 00
	08900 FEDERALLY QUALIFIED HEALTH CENTER						89. 00
90.00	09000 CLI NI C	0	0)			90.00
91.00	09100 EMERGENCY	0	0)			91.00
91. 01	04950 WOUND CARE	0	0)			91. 01
4	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	,			92.00
	OTHER REIMBURSABLE COST CENTERS			1			72.00
		0	0				94. 00
	09400 HOME PROGRAM DIALYSIS	-	_	Ί			
	09500 AMBULANCE SERVI CES	0					95. 00
	09600 DURABLE MEDICAL EQUIP-RENTED	0	0				96. 00
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0)			97. 00
98. 00	09850 OTHER REIMBURSABLE COST CENTERS	0	0)			98. 00
200.00	Subtotal (see instructions)	0	0)			200. 00
201.00	Less PBP Clinic Lab. Services-Program			1			201. 00
201.00	Only Charges						-01.00
202 00	, , ,			J			202 00
202. 00	Net Charges (line 200 - line 201)	0	0	'I			202. 00

		ANCISCAN HEALTH				u of Form CMS-2	2552-10
APPORT	IONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der C	CN: 15-0022	Peri od: From 01/01/2022	Worksheet D Part II	
			Component	CCN: 15-S022	To 12/31/2022	Date/Time Pre 5/30/2023 4:1	pared:
			Ti tl e	xVIII	Subprovider -	PPS	<u> 2 piii </u>
	Cost Center Description	Capi tal	Total Charges	Ratio of Cos		Capital Costs	
	·	Related Cost	(from Wkst. C,		Program	(column 3 x	
		(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
		Part II, col.	8)	2)			
		26)					
	ANGLEL ADV. CEDVICE, COCT. CENTEDO	1.00	2. 00	3. 00	4. 00	5. 00	_
50. 00	ANCI LLARY SERVI CE COST CENTERS 05000 OPERATI NG ROOM	889, 432	20, 839, 197	0.04268	31 0	0	50.00
51. 00	05100 RECOVERY ROOM	009, 432	20, 639, 197	1		0	1
52. 00	05200 DELIVERY ROOM & LABOR ROOM			1		0	1
53. 00	05300 ANESTHESI OLOGY	0		0.00000		0	1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	543, 229	12, 674, 475	1		1, 315	1
54. 01	03630 ULTRA SOUND	27, 260	5, 106, 820	1		0	1
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0, 100, 020	0. 00000		Ö	1
56. 00	05600 RADI OI SOTOPE	69, 946	3, 053, 273	1		0	1
57. 00	05700 CT SCAN	4, 401	19, 736, 280	1		6	1
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	768	3, 444, 706	1		0	1
59.00	05900 CARDI AC CATHETERI ZATI ON	0	O	i	00	0	59.00
60.00	06000 LABORATORY	242, 007	24, 860, 248	0.00973	142, 674	1, 389	60.00
60. 01	06001 BLOOD LABORATORY	0	0	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	0	0. 00000	00	0	62. 00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	45	201, 716	0. 00022	23 0	0	63.00
64.00	06400 I NTRAVENOUS THERAPY	0	0	0.00000		0	64. 00
65.00	06500 RESPI RATORY THERAPY	30, 738	2, 921, 541	0. 01052	6, 104	64	65. 00
66. 00	06600 PHYSI CAL THERAPY	153, 822	5, 105, 930			1, 257	•
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	0.0000		0	
68. 00	06800 SPEECH PATHOLOGY	0	0	0.00000		0	
69. 00	06900 ELECTROCARDI OLOGY	217, 469	8, 096, 949			591	1
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0.00000		0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	257, 192	12, 084, 657			656	1
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	93, 080	1, 944, 532			0	
73.00	07300 DRUGS CHARGED TO PATIENTS	98, 081	7, 889, 580			954	1
74. 00 75. 00	07400 RENAL DIALYSIS	0	0			0	
76. 00	07500 ASC (NON-DISTINCT PART) 03480 ONCOLOGY	0	10, 179	1 0.0000		0	
76. 00 76. 97	07697 CARDI AC REHABI LI TATI ON	201	899, 170	1		0	1
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0 0 0	1		0	1
77.00	OUTPATIENT SERVICE COST CENTERS			0.00000	0		1 //. 00
88. 00	08800 RURAL HEALTH CLINIC	0	0	0.00000	00 0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	Ö	1		0	
90.00	09000 CLI NI C	143, 179	1, 019, 757	1		0	1
91.00	09100 EMERGENCY	608, 983	56, 036, 150	1		783	1
91. 01	04950 WOUND CARE	0	O	0.00000		0	91. 01
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	2, 999, 927			0	
	OTHER REIMBURSABLE COST CENTERS						
94.00	09400 HOME PROGRAM DIALYSIS	0	0	0.00000	00 0	0	94. 00
95.00	09500 AMBULANCE SERVI CES						95. 00
	09600 DURABLE MEDICAL EQUIP-RENTED	0	O			0	
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0			0	
98. 00 200. 00	O9850 OTHER REIMBURSABLE COST CENTERS Total (lines 50 through 199)	3, 379, 837	0 188, 925, 087	0.0000	0 448, 778	0	98.00

Health Financial Systems	FRANCISCAN HEALTH CF	AWFORDSVI LLE	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0022 Component CCN: 15-S022	Peri od: From 01/01/2022 To 12/31/2022	Worksheet D Part IV Date/Time Prepared: 5/30/2023 4:12 pm

			Ti tl e	e XVIII	Subprovi der -	PPS	<u> </u>
		In state			I PF		
	Cost Center Description	Non Physician		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				1		
50.00	05000 OPERATI NG ROOM	0	C)	0 0	0	50.00
51.00	05100 RECOVERY ROOM	0	0		0 0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	52.00
53.00	05300 ANESTHESI OLOGY	0	0		0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54. 00
54. 01	03630 ULTRA SOUND	0	0		0 0	0	54. 01
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0		0 0	0	55. 00
56.00	05600 RADI OI SOTOPE	0	0		0 0	0	56. 00
57.00	05700 CT SCAN	0	0		0 0	0	57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0	59. 00
60.00	06000 LABORATORY	0	0		0 0	0	60.00
60. 01	06001 BLOOD LABORATORY	0	0		0 0	0	60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61. 00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0 0	0	62. 00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 0	0	63. 00
64.00	06400 I NTRAVENOUS THERAPY	0	0		0 0	0	64.00
65.00	06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0	0		0 0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67.00
68. 00	06800 SPEECH PATHOLOGY	0	0		0 0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	0		0 0	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73. 00
74.00	07400 RENAL DIALYSIS	0	0		0 0	0	74. 00
75.00	07500 ASC (NON-DISTINCT PART)	0	0		0 0	0	75. 00
76.00	03480 ONCOLOGY	0	0		0 0	0	76. 00
76. 97	07697 CARDIAC REHABILITATION	0	0		0 0	0	76. 97
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0		0 0	0	77. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0	0)	0 0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		o o	0	89. 00
90.00	09000 CLI NI C	0	0		0 0	0	90.00
91.00	09100 EMERGENCY	0	0		0 0	0	91.00
	04950 WOUND CARE	0	0		o o	0	91. 01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
94.00	09400 HOME PROGRAM DIALYSIS	0	0		0 0	0	94. 00
	09500 AMBULANCE SERVI CES						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 REIMBURSABLE COST CENTERS	0	0		0	0	98. 00
200.00	Total (lines 50 through 199)	0	0)	0 0	0	200. 00

		ANCISCAN HEALTH				u of Form CMS-2	2552-10
	TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	RVICE OTHER PASS	Provider C	CN: 15-0022	Peri od:	Worksheet D	
THROUG	SH COSTS		Component	CCN: 15-S022	From 01/01/2022 To 12/31/2022	Part IV Date/Time Pre	pared:
			·			5/30/2023 4:1	2 pm
			Title	· XVIII	Subprovi der - I PF	PPS	
	Cost Center Description	All Other	Total Cost	Total	Total Charges		
		Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
		Education Cost		Cost (sum o		$(col. 5 \div col.$	
			4)	col s. 2, 3,	8)	7)	
				and 4)		(see	
		4.00	5. 00	6. 00	7. 00	instructions) 8.00	
	ANCILLARY SERVICE COST CENTERS	4.00	5.00	0.00	7.00	8.00	
50. 00	05000 OPERATI NG ROOM	0	0		0 20, 839, 197	0. 000000	50.00
51. 00	05100 RECOVERY ROOM	0	Ö	•	0 20,007,177	0. 000000	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0. 000000	
53. 00	05300 ANESTHESI OLOGY	0	0		0 0	0. 000000	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 12, 674, 475	0. 000000	
54. 01	03630 ULTRA SOUND	0	Ö		0 5, 106, 820	0. 000000	1
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0		0 0	0.000000	1
56. 00	05600 RADI OI SOTOPE		Ö		0 3, 053, 273	0. 000000	1
57. 00	05700 CT SCAN	0	0		0 19, 736, 280	0. 000000	
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 3, 444, 706	0.000000	1
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0. 000000	
60.00	06000 LABORATORY	0	0		0 24, 860, 248	0. 000000	1
60. 01	06001 BLOOD LABORATORY	0	0		0 0	0. 000000	
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0 0	0. 000000	1
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 201, 716	0. 000000	
64. 00	06400 I NTRAVENOUS THERAPY	0	0		0 0	0.000000	64.00
65.00	06500 RESPI RATORY THERAPY	0	0		0 2, 921, 541	0.000000	65.00
66.00	06600 PHYSI CAL THERAPY	0	0		0 5, 105, 930	0.000000	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0		0 0	0.000000	67.00
68. 00	06800 SPEECH PATHOLOGY	0	0		0 0	0.000000	68.00
69. 00	06900 ELECTROCARDI OLOGY	0	0		0 8, 096, 949	0.000000	69.00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0.000000	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 12, 084, 657	0.000000	71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 1, 944, 532	0. 000000	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 7, 889, 580	0. 000000	73.00
74. 00	07400 RENAL DI ALYSI S	0	0		0	0. 000000	74.00
75. 00	07500 ASC (NON-DISTINCT PART)	0	0		0	0.000000	
76. 00	03480 ONCOLOGY	0	0		0 10, 179	0. 000000	
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	•	0 899, 170	0. 000000	1
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0		0 0	0. 000000	77. 00
	OUTPATIENT SERVICE COST CENTERS			T			
88. 00	08800 RURAL HEALTH CLINIC	0	0	•	0	0.000000	
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0	0.000000	1
90.00	09000 CLINIC	0	0		0 1, 019, 757	0.000000	
91.00	09100 EMERGENCY	0	0		0 56, 036, 150	0.000000	
	04950 WOUND CARE	0	0		0 0	0.000000	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 2, 999, 927	0. 000000	92.00
04.00	OTHER REIMBURSABLE COST CENTERS					0.000000	04.00
	09400 HOME PROGRAM DI ALYSI S	0	0		0 0	0. 000000	
95.00	09500 AMBULANCE SERVICES		_			0 000000	95.00
	09600 DURABLE MEDICAL EQUI P-RENTED	0	0		0 0	0.000000	
	09700 DURABLE MEDICAL EQUIP-SOLD	0	0		0 0	0.000000	
98. 00 200. 00	O9850 OTHER REIMBURSABLE COST CENTERS Total (lines 50 through 199)	0	0		0 100 005 007	0. 000000	98. 00 200. 00
	II LINTAL CLINES BU THYOUGH 1991	i ()	()	II.	0 188, 925, 087		1700 00

Heal th	Financial Systems FRA	ANCISCAN HEALTH	CRAWFORDSVI LL	E	In Lie	u of Form CMS-	2552-10
	TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER		Provi der Co		Peri od:	Worksheet D	
	SH COSTS			F	rom 01/01/2022	Part IV	
			Component	CCN: 15-S022 T	To 12/31/2022	Date/Time Pre 5/30/2023 4:1	pared:
			Title	xVIII	Subprovi der -	9/30/2023 4: 1 PPS	2 piii
			11 11 0	, AVIII	I PF	113	
	Cost Center Description	Outpati ent	I npati ent	I npati ent	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through	Charges	Pass-Through	
		(col. 6 ÷ col.		Costs (col. 8		Costs (col. 9	
		7)	10.00	x col . 10)	10.00	x col . 12)	
	ANCILLARY SERVICE COST CENTERS	9. 00	10. 00	11. 00	12.00	13. 00	
50. 00	05000 OPERATING ROOM	0. 000000	0		0	0	50.00
51. 00	05100 RECOVERY ROOM	0. 000000	-			0	
	I I	1	0			0	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0			-	52.00
53. 00 54. 00	05300 ANESTHESI OLOGY	0.000000	ū			0	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C 03630 ULTRA SOUND	0. 000000 0. 000000	30, 675 0			0	54. 00 54. 01
55. 00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	0			0	55.00
56. 00	05600 RADI OLOGI - THERAPEUTI C	0. 000000	0			0	56.00
57. 00	05700 CT SCAN	0. 000000	26, 052			0	57.00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 000000	20, 032		1	0	
59. 00	05900 CARDIAC CATHETERIZATION	0. 000000	0			0	59.00
60.00	06000 LABORATORY	0. 000000	142, 674		1	0	60.00
60. 01	06001 BLOOD LABORATORY	0. 000000	142, 074			0	60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0.00000	O			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			0	63.00
64. 00	06400 I NTRAVENOUS THERAPY	0. 000000	0			0	64.00
65. 00	06500 RESPI RATORY THERAPY	0. 000000	6, 104	1		0	65. 00
66.00	06600 PHYSI CAL THERAPY	0. 000000	41, 740		0	0	66, 00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 000000	0		0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0. 000000	0		0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0. 000000	21, 991	(o	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	0	(o	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	30, 807	(o	0	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000	0	(0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	76, 706	(0	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		o	0	75. 00
76.00	03480 ONCOLOGY	0. 000000	0	(0	0	76. 00
76. 97	07697 CARDIAC REHABILITATION	0. 000000	0	C	0	0	76. 97
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000	0	C	0	0	77. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0. 000000	0			0	
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000	0	1	1	0	89. 00
90.00	09000 CLI NI C	0. 000000	0	C		0	90.00
91. 00	09100 EMERGENCY	0. 000000	72, 029	•	-	0	7 00
91. 01	04950 WOUND CARE	0. 000000	0	C		0	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0	(0	0	92.00

0. 000000

0. 000000 0. 000000

0. 000000

448, 778

0

0 0 0

0

294

> 94.00 95.00

96. 00 97. 00

0 98.00 0 200.00

0

OTHER REIMBURSABLE COST CENTERS

96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD

98.00 09850 OTHER REIMBURSABLE COST CENTERS 200.00 Total (lines 50 through 199)

94. 00 | 09400 | HOME PROGRAM DI ALYSI S 95. 00 | 09500 | AMBULANCE SERVI CES

Title XVIII Subprovi der -

			Title	e XVIII	Subprovi der - I PF	PPS	
				Charges	IPF	Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed	,	Cost	PPS Services	
	, , , , , , , , , , , , , , , , , , ,	Ratio From	Services (see	Rei mbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not	` ′	
		Part I, col. 9	ĺ	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			1	_1	_	
	05000 OPERATING ROOM	0. 318257	1		0		
	05100 RECOVERY ROOM	0. 000000	1	l .	0		
	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	1		0	1	
	05300 ANESTHESI OLOGY	0. 000000	l .	1	0	0	
	05400 RADI OLOGY-DI AGNOSTI C	0. 310392	1	1	0	0	54.00
	03630 ULTRA SOUND	0. 034802	0		0	0	
	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE	0. 000000	l .		0	0	55. 00 56. 00
	l	0. 125481	0	1	0	· ·	
	05700 CT SCAN	0. 003342	1	1	0	0	57.00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 003342	1	1		0	
59. 00	05900 CARDI AC CATHETERI ZATI ON	0.000000	1			0	
60.00	06000 LABORATORY	0. 179567	0		9	0	60.00
60. 01 61. 00	06001 BLOOD LABORATORY	0.000000	1		0 0	i	60. 01
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000	1	1			61.00
62. 00 63. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0		0 0	0	62. 00 63. 00
64. 00	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY	0. 003341	1	1		0	1
	06500 RESPI RATORY THERAPY	0. 000000 0. 441872				0	65. 00
	06600 PHYSI CAL THERAPY	0. 441672	1			0	66. 00
67. 00	l		1	1			67. 00
	06700 OCCUPATI ONAL THERAPY	0.000000	1	1		0	1
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0.000000	1			0	
	07000 ELECTROENCEPHALOGRAPHY	0. 131086 0. 000000				0	69. 00 70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 136160	l .	1			1
	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 243386		1			1
	07300 DRUGS CHARGED TO PATIENTS	0. 284589	1	1	140	1	1
	07400 RENAL DIALYSIS	0. 000000	1]	0 0	0	74.00
	07500 ASC (NON-DISTINCT PART)	0. 000000	ł]		0	
	03480 ONCOLOGY	0. 016505	1]		0	76. 00
	07697 CARDI AC REHABI LI TATI ON	0. 003342	ł			0	76. 97
	07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000	1			~	1
77.00	OUTPATIENT SERVICE COST CENTERS	0.00000	1	1	<u> </u>		77.00
88. 00	08800 RURAL HEALTH CLINIC						88. 00
	08900 FEDERALLY QUALIFIED HEALTH CENTER						89. 00
	09000 CLINIC	0. 656493	294	(0	193	
	09100 EMERGENCY	0. 097299			0	0	1
	04950 WOUND CARE	0. 000000	1		0	0	1
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 632438	1		0		
	OTHER REIMBURSABLE COST CENTERS	1 2. 222.22	-		-		1
94.00	09400 HOME PROGRAM DIALYSIS	0. 000000)	(0 0		94. 00
95.00	09500 AMBULANCE SERVICES	0. 000000)		95. 00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000	0)	0	0	96. 00
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD	0. 000000	0)	0	0	97. 00
98. 00	09850 OTHER REIMBURSABLE COST CENTERS	0. 000000	0)	0	0	98. 00
200.00	Subtotal (see instructions)		294		140	193	200. 00
201.00	Less PBP Clinic Lab. Services-Program				0	l	201. 00
	Only Charges						
202.00	Net Charges (line 200 - line 201)		294	.	140	193	202. 00

Health Financial Systems FRAN	ICI SCAN HEALTH CRAWFORDSVILLE	In Lie	eu of Form CMS-2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND V	VACCINE COST Provider CCN: 15-002	Peri od: From 01/01/2022	Worksheet D
	Component CCN: 15-SC		Date/Time Prepared:
			5/30/2023 4:12 pm
	Title XVIII	Subprovi der -	PPS

		litl€	e XVIII	Subprovi der - I PF	PPS	
	Co	sts		I FI		
Cost Center Description	Cost	Cost				
•	Rei mbursed	Rei mbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6. 00	7. 00				
ANCILLARY SERVICE COST CENTERS						_
50. 00 05000 OPERATI NG ROOM	0	0	1			50.00
51. 00 05100 RECOVERY ROOM	0		1			51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0		1			52. 00
53. 00 05300 ANESTHESI OLOGY	0	_	1			53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	_	1			54. 00
54. 01 03630 ULTRA SOUND	0		1			54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	_	1			55. 00
56. 00 05600 RADI 01 SOTOPE	0		1			56. 00
57. 00 05700 CT SCAN	0	l .	1			57. 00
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	_	1			58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	_	1			59. 00
60. 00 06000 LABORATORY	0		1			60.00
60. 01 06001 BLOOD LABORATORY	0	_)			60. 01
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0					61.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	_	1			62.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	_	1			63. 00
64. 00 06400 I NTRAVENOUS THERAPY	0		1			64.00
65. 00 06500 RESPIRATORY THERAPY	0		1			65. 00
66. 00 06600 PHYSI CAL THERAPY	0	_	1			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0		1			67. 00
68. 00 06800 SPEECH PATHOLOGY	0	_	1			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	_	•			69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0		1			70.00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	_	1			71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	_	1			72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0		1			73. 00
74. 00 07400 RENAL DI ALYSI S	0		1			74. 00
75. 00 07500 ASC (NON-DISTINCT PART)	0		1			75. 00
76. 00 03480 ONCOLOGY	0	_	1			76.00
76. 97 O7697 CARDIAC REHABILITATION 77. 00 O7700 ALLOGENEIC STEM CELL ACQUISITION	0		1			76. 97
77. 00 O7700 ALLOGENEIC STEM CELL ACQUISITION OUTPATIENT SERVICE COST CENTERS		0	/			77. 00
88. 00 08800 RURAL HEALTH CLINIC			T			88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER						89. 00
90. 00 09000 CLI NI C	0	0				90.00
91. 00 09100 EMERGENCY			1			91.00
91. 01 04950 WOUND CARE			1			91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		l .	1			92.00
OTHER REIMBURSABLE COST CENTERS			<u>′I</u>			72.00
94. 00 09400 HOME PROGRAM DI ALYSI S	0	0				94. 00
95. 00 09500 AMBULANCE SERVICES						95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED						96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD			1			97. 00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS		-	1			98.00
200.00 Subtotal (see instructions)		_	•			200.00
201.00 Less PBP Clinic Lab. Services-Program						201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)	0	40				202. 00
	•					•

APPURT	TONNENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Pro	ovider C	CN: 15-0022	From 01/01/2022 To 12/31/2022		epared: 2 pm
				Ti tI	e XIX	Hospi tal	Cost	
	·				Charges		Costs	
	Cost Center Description	Cost to Charge	PPS Re	imbursed	Cost	Cost	PPS Services	
	·	Ratio From		es (see		Rei mbursed	(see inst.)	
		Worksheet C,		st.)	Servi ces	Services Not	,	
		Part I, col. 9		ŕ	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. 318257		C	4, 738, 1	35 C	0	50.00
51.00	05100 RECOVERY ROOM	0. 000000		C		0 0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000)	C)	0 0	0	52.00
53.00	05300 ANESTHESI OLOGY	0. 000000)	C)	0 0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 310392	2	C	6, 736, 7	46 C	0	54.00
54. 01	03630 ULTRA SOUND	0. 034802	2	C	936, 2	86 C	0	54. 01
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 000000		C		0 0	0	55. 00
56.00	05600 RADI OI SOTOPE	0. 125481		C	428, 7	21 0	0	56.00
57.00	05700 CT SCAN	0. 003342	2	C	1	0 0	0	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 003342	1	C		0	0	1
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 000000		C		0	0	59. 00
60.00	06000 LABORATORY	0. 179567		C	1	15	Ö	60.00
60. 01	06001 BLOOD LABORATORY	0. 000000		C	0,002,0	0	0	60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000			1		Ĭ	61. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	1	C			О	1
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 003341					0	1
64. 00	06400 I NTRAVENOUS THERAPY		1	C		0 0	0	
		0. 000000	1	0	1	٥	0	1
65. 00	06500 RESPIRATORY THERAPY	0. 441872	1	_	1 0077 .		_	65. 00
66.00	06600 PHYSI CAL THERAPY	0. 277114		C	,		0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 000000		C	1	0 0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0. 000000	1	C	1	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 131086	1	C		/3	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	1	C	1	0	0	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 136160	1	C	-, .		0	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 243386	1	C		0 0	0	
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 284589		C	973, 7	92 C	0	
74. 00	07400 RENAL DI ALYSI S	0. 000000		C)	0 0	0	74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0. 000000	1	C)	0 0	0	75. 00
76. 00	03480 ONCOLOGY	0. 016505		C	1	0 0	0	76. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0. 003342	2	C		0 0	0	76. 97
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000		C)	0 C	0	77. 00
	OUTPATIENT SERVICE COST CENTERS							_
88. 00	08800 RURAL HEALTH CLINIC							88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER							89. 00
90.00	09000 CLI NI C	0. 656493	3	C	203, 2	32 C	0	90.00
91.00	09100 EMERGENCY	0. 097299		C	18, 769, 2	13 C	0	91. 00
91. 01	04950 WOUND CARE	0. 000000)	C		0 0	0	91. 01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 632438	3	C		0 0	0	92.00
	OTHER REIMBURSABLE COST CENTERS		•					
94.00	09400 HOME PROGRAM DIALYSIS	0. 000000				0 0		94. 00
95.00	09500 AMBULANCE SERVI CES	0. 000000		C		0		95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000		C	1	0 0	0	1
97. 00	09700 DURABLE MEDI CAL EQUI P-SOLD	0. 000000		C	•	0 0	ō	1
	09850 OTHER REIMBURSABLE COST CENTERS	0. 000000		C	•	0	Ö	1
200.00		3. 555500		Ċ	I .	76	l .	200. 00
201.00					.5, 555, 2	0 0		201. 00
201.00	Only Charges							00
202.00				C	40, 633, 2	76 C	n	202. 00
00	, 11 1 311 (200 201)	1	1			-1	'	1

 Heal th Financial
 Systems
 FRANCISCAN HEALTH

 APPORTIONMENT OF
 MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST
 Peri od: Worksheet D From 01/01/2022 Part V To 12/31/2022 Date/Time Prepared: 5/30/2023 4:12 pm Provi der CCN: 15-0022

						5/30/2023 4:1	2 pm
			Ti tl	e XIX	Hospi tal	Cost	
		Cos	sts		<u>'</u>		
	Cost Center Description	Cost	Cost				
	cost center bescription	Rei mbursed	Rei mbursed				
		Servi ces	Servi ces Not				
		Subject To	Subject To				
		Ded. & Coins.	Ded. & Coins.				
		(see inst.)	(see inst.)				
		6.00	7. 00				
ANCI	LLARY SERVICE COST CENTERS						
	OO OPERATING ROOM	1, 507, 945	0				50.00
	OO RECOVERY ROOM	0	l o	1			51.00
				•			1
	OO DELIVERY ROOM & LABOR ROOM	0	•	•			52.00
	00 ANESTHESI OLOGY	0	0	1			53. 00
54. 00 0540	00 RADI OLOGY-DI AGNOSTI C	2, 091, 032	0				54.00
54. 01 0363	30 ULTRA SOUND	32, 585	0				54. 01
55. 00 0550	00 RADI OLOGY-THERAPEUTI C	0	0				55. 00
	00 RADI OI SOTOPE	53, 796	0				56. 00
	OO CT SCAN	00,770	0				57. 00
			1	ł			58.00
	OO MAGNETIC RESONANCE IMAGING (MRI)	1	1	1			
	OO CARDI AC CATHETERI ZATI ON	0	0	ł			59. 00
	00 LABORATORY	1, 047, 237	0				60.00
60. 01 0600	01 BLOOD LABORATORY	0	0				60. 01
61.00 0610	OO PBP CLINICAL LAB SERVICES-PRGM ONLY	0					61.00
	00 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0				62.00
	00 BLOOD STORING, PROCESSING & TRANS.	Ö		1			63. 00
				1			1
	00 I NTRAVENOUS THERAPY	0	0	1			64. 00
	00 RESPI RATORY THERAPY	136, 604		1			65. 00
66. 00 0660	00 PHYSI CAL THERAPY	135, 060	0				66. 00
67.00 0670	OO OCCUPATIONAL THERAPY	0	0				67.00
68. 00 0680	00 SPEECH PATHOLOGY	0	0				68. 00
	00 ELECTROCARDI OLOGY	159, 463	0	•			69. 00
	00 ELECTROENCEPHALOGRAPHY	137, 403	0	1			70.00
	· ·	1		•			
	00 MEDICAL SUPPLIES CHARGED TO PATIENTS	291	0	1			71. 00
	00 IMPL. DEV. CHARGED TO PATIENTS	0	0				72. 00
73.00 0730	OO DRUGS CHARGED TO PATLENTS	277, 130	0				73. 00
74.00 0740	OO RENAL DIALYSIS	0	0				74.00
75. 00 0750	OO ASC (NON-DISTINCT PART)	0	0				75. 00
	80 ONCOLOGY	0	0				76. 00
	97 CARDI AC REHABI LI TATI ON	Ö	,				76. 97
	OO ALLOGENEIC STEM CELL ACQUISITION	0	0				77. 00
	PATIENT SERVICE COST CENTERS						
	DO RURAL HEALTH CLINIC						88. 00
89.00 0890	OO FEDERALLY QUALIFIED HEALTH CENTER						89. 00
90.00 0900	DO CLI NI C	133, 420	0				90.00
	OO EMERGENCY	1, 826, 226					91.00
	50 WOUND CARE	0		1			91. 01
				1			
	00 OBSERVATION BEDS (NON-DISTINCT PART)	0	0				92.00
	ER REIMBURSABLE COST CENTERS						
	00 HOME PROGRAM DIALYSIS	0					94. 00
95. 00 0950	OO AMBULANCE SERVICES	0					95. 00
96. 00 0960	OO DURABLE MEDICAL EQUIP-RENTED	0	0				96. 00
	OO DURABLE MEDICAL EQUIP-SOLD	0		ŧ .			97. 00
	50 OTHER REIMBURSABLE COST CENTERS		0	1			98.00
		7 400 700	,	1			200.00
200.00	Subtotal (see instructions)	7, 400, 789		1			1
201. 00	Less PBP Clinic Lab. Services-Program	0					201. 00
1	Only Charges						
202. 00	Net Charges (line 200 - line 201)	7, 400, 789	0	1			202. 00

Title XIX Subprovi der

		Ti tI	e XIX	Subprovi der -	Cost	
			Charges	I PF	Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed		Cost	PPS Services	
cost center bescription	Ratio From	Services (see	Rei mbursed	Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not	(300 111011)	
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins.	Ded. & Coins.		
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0. 318257	0		0	0	50. 00
51.00 05100 RECOVERY ROOM	0. 000000	0	1	_	0	51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0	[C	0	0	52. 00
53. 00 05300 ANESTHESI OLOGY	0. 000000	0		_	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 310392	0	1	_	0	54. 00
54. 01 03630 ULTRA SOUND	0. 034802	0		_	0	54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	0		_	0	55. 00
56. 00 05600 RADI OI SOTOPE	0. 125481	0		_	0	56. 00
57. 00 05700 CT SCAN	0. 003342	0			0	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 003342	0			0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	0			0	59. 00
60. 00 06000 LABORATORY	0. 179567	0			0	60.00
60. 01 06001 BL00D LABORATORY	0. 000000	0			0	60. 01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000		C			61. 00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	0			0	62. 00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 003341	0			0	63. 00
64. 00 06400 I NTRAVENOUS THERAPY	0. 000000	0			0	64. 00
65. 00 06500 RESPIRATORY THERAPY	0. 441872	0			0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 277114	0			0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	0	[C	0	0	67. 00
68.00 06800 SPEECH PATHOLOGY	0. 000000	0		_	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 131086	0		_	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		_	0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 136160	0	1		0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 243386	0		_	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 284589	0	1	_	0	73. 00
74. 00 07400 RENAL DI ALYSI S	0. 000000	0	1	_	0	74. 00
75. 00 07500 ASC (NON-DISTINCT PART)	0. 000000	0	1	_	0	75. 00
76. 00 03480 ONCOLOGY	0. 016505	0	1	_	0	76. 00
76. 97 O7697 CARDI AC REHABI LI TATI ON	0. 003342	0			0	76. 97
77. 00 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON	0. 000000	0	C	0	0	77. 00
OUTPATIENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC	I	T	Γ			00.00
88.00 08800 RURAL HEALTH CLINIC 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER						88. 00 89. 00
	0 (5(402		_		_	1
90. 00 09000 CLI NI C	0. 656493	0	00.000		0	90.00
91. 00 09100 EMERGENCY	0. 097299				0	91.00
91. 01 04950 WOUND CARE 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0			0	91. 01
92. 00 O9200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	0. 632438	0		0	0	92. 00
94. 00 09400 HOME PROGRAM DIALYSIS	0. 000000			0		94. 00
95. 00 09500 AMBULANCE SERVICES	0. 000000					95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000	0			0	1
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0. 000000				0	
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0. 000000			_	0	98. 00
200.00 Subtotal (see instructions)	0.00000			_	0	1
201.00 Less PBP Clinic Lab. Services-Program			90, 909		0	201. 00
Only Charges						201.00
202.00 Net Charges (line 200 - line 201)		0	90, 909	0	n	202. 00
	l .	1	, , , , , ,	1	· ·	,_02.00

Health Financial Systems	FRANCISCAN HEALTH CRA	AWFORDSVI LLE	In Lie	u of Form CMS-2552-10
APPORTI ONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0022	Period: From 01/01/2022	Worksheet D
		Component CCN: 15-S022		
		Title XIX	Subprovi der -	Cost

		Ti tl	e XIX	Subprovider -	Cost	
	Cos	sts		I PF		
Cost Center Description	Cost	Cost	-			
	Rei mbursed	Rei mbursed				
	Servi ces	Servi ces Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
ANCILL ADV. CEDVILCE COCT. CENTEDO	6. 00	7. 00				
ANCILLARY SERVICE COST CENTERS 50. 00 05000 OPERATING ROOM	0	0				50.00
51. 00 05100 RECOVERY ROOM						51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM			1			52.00
53. 00 05300 ANESTHESI OLOGY	0	B .	1			53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	Ö		1			54. 00
54. 01 03630 ULTRA SOUND	0	0				54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0				55. 00
56. 00 05600 RADI 0I SOTOPE	0	0				56. 00
57. 00 05700 CT SCAN	0	0				57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0				58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	1				59. 00
60. 00 06000 LABORATORY	0	-				60. 00
60. 01 06001 BLOOD LABORATORY	0					60. 01
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0					61.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	1				62.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0					63.00
64. 00 06400 I NTRAVENOUS THERAPY 65. 00 06500 RESPI RATORY THERAPY						64. 00 65. 00
66. 00 06600 PHYSI CAL THERAPY			ł			66.00
67. 00 06700 OCCUPATI ONAL THERAPY						67.00
68. 00 06800 SPEECH PATHOLOGY						68. 00
69. 00 06900 ELECTROCARDI OLOGY			•			69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	Ö		•			70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		•			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0				73. 00
74. 00 07400 RENAL DI ALYSI S	0	0				74. 00
75.00 07500 ASC (NON-DISTINCT PART)	0	-				75. 00
76. 00 03480 ONCOLOGY	0		1			76. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	0		•			76. 97
77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0				77. 00
OUTPATIENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC		T	I			00 00
88.00 08800 RURAL HEALTH CLINIC 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER						88. 00 89. 00
90. 00 09000 FEDERALLY QUALIFIED HEALTH CENTER	0	0				90.00
91. 00 09100 EMERGENCY	8, 845		•			91.00
91. 01 04950 WOUND CARE	0,043		1			91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	Ö		•			92. 00
OTHER REIMBURSABLE COST CENTERS		_	I.			
94. 00 09400 HOME PROGRAM DIALYSIS	0	0				94. 00
95. 00 09500 AMBULANCE SERVICES	0					95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0				96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0				97. 00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	1				98. 00
200.00 Subtotal (see instructions)	8, 845	0				200. 00
201.00 Less PBP Clinic Lab. Services-Program	0					201. 00
Only Charges	0.0:-					202 22
202.00 Net Charges (line 200 - line 201)	8, 845	0	Ί			202. 00

Health Financial Systems	FRANCISCAN HEALTH CRAW	WFORDSVI LLE	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	P	Provider CCN: 15-0022	Peri od: From 01/01/2022 To 12/31/2022	Worksheet D-1 Date/Time Pre 5/30/2023 4:1	pared:
		Title XVIII	Hospi tal	PPS	
Cost Center Description	-				
				1. 00	
PART I - ALL PROVIDER COMPONENTS					
INPATIENT DAYS					
4 00 1 11 1 1 1 1 1 1 1	1 1 1 1 1	1 12 1 3		4 007	1 4 00

	Title XVIII Hospital	PPS	
	Cost Center Description	1. 00	
	PART I - ALL PROVIDER COMPONENTS	1.00	
	INPATI ENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	4, 387	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4, 387	2. 00
3. 00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3. 00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	2, 980	4. 00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5. 00
6.00	Total swing-bed SNF type inpatient days (including private room 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 reporting period	0	7. 00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8. 00
9. 00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	1, 182	9. 00
10. 00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10. 00
11. 00	through December 31 of the cost reporting period (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11. 00
12. 00	December 31 of the cost reporting period (if calendar year, enter 0 on this line) Swing-bed NF type inpatient days applicable to titles V or XIX only (including private 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 only (including private room days)	0	13. 00
14. 00	after December 31 of the cost reporting period (if calendar year, enter 0 on this line) Medically necessary private room days applicable to the Program (excluding swing-bed days)	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
17. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0.00	17. 00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0.00	18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	0. 00	19. 00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0. 00	20. 00
21. 00	Total general inpatient routine service cost (see instructions)	5, 915, 642	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5×1 ine 17)	0	22. 00
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	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 (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	5, 915, 642	27. 00
28. 00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)	Ö	29.00
30. 00	Semi -pri vate room charges (excluding swing-bed charges)	0	30.00
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32. 00
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 minus line 33)(see instructions)	0.00	34.00
35. 00	Average per diem private room cost differential (line 34 x line 31)	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 and private room cost differential (line 27 minus line 36)	5, 915, 642	37. 00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38. 00	Adjusted general inpatient routine service cost per diem (see instructions)	1, 348. 45	•
39.00	Program general inpatient routine service cost (line 9 x line 38)	1, 593, 868	39. 00 40. 00
40. 00 41. 00	Medically necessary private room cost applicable to the Program (line 14 x line 35) Total Program general inpatient routine service cost (line 39 + line 40)	0 1, 593, 868	
+ i. UU	protein program general impatrent routine service cost (IINE 37 ± IINE 40)	1, 373, 000	, , , , , , , , , ,

Prudict Oil 19 CO22 Period Ministry (Prudict Oil 19 CO22 Period Ministry (Program Days Oil 19 CO22 Per			ANCISCAN HEALTH				u of Form CMS-2	
Dost Center Description	COMPUT	ATION OF INPATIENT OPERATING COST		Provi der Co	CN: 15-0022			pared:
		Cost Center Description		Total	Average Per	Program Days	PPS Program Cost	
Misself (Title V & XIX only)			·		col . 2)		4)	
14.00	42. 00							42. 00
SURN INTERSIVE CARE UNIT		INTENSIVE CARE UNIT						l
17.00								1
Cost Center Description 1.00			0	0	0.0	00 0	0	•
48.00 Program inpatition trancillary service cost (West: 0-3, col. 3, line 200) 48.01 Program inpatition to column 1) 4.00 48.01 Program inpatition to column 1) 4.00 48.01 48.01 Program inpatition to column 1) 4.00 48.01 Program inpatition to column 1) 4.00 48.01 48.01 Program inpatition to column 1) 4.00 48.01 48.01 49.00 48.01 49.00 48.01 49.00 48.01 49.00 48.01 49.00 48.01 49.00 48.01 49.00 48.01 49.00 48.01 49.00 49.00 49.00 48.01 49.00 49.					1		1 00	
10-15 Program inpatient costs (sum of lines 4) through 48 01)(see instructions) 4, 494, 201 49.0							2, 351, 100	1
200. Plass through costs applicable to Program inpatient routine services (from West, D, sum of Parts 1 and 293,788 50.00 110 1968 Plass through costs applicable to Program inpatient ancillary services (from West, D, sum of Parts 1		Total Program inpatient costs (sum of lines	•			corumn 1)		
51.00 Parss through costs applicable to Program inpatient ancil lary services (from Wisst. 0, sum of Parts II 224,839 51.00 and IV) 52.00 Total Program excludable cost (sum of Tines 50 and 51) 518,597 52.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and 4.425,604 53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and 4.425,604 53.00 Total Program discharge 0.00 55.00 54.00 Porgan discharge 0.00 55.00 55.00 Porgan discharge 0.00 55.00 55.00 Porgan anount per discharge (contractor use only) 0.00 55.00 Porgan anount (line 54 x sum of Tines 55, 55.01, and 55.02) 0.01 Total amount per discharge (contractor use only) 0.00 55.02 0.01 Total amount (line 54 x sum of Tines 55, 55.01, and 55.02) 0.01 Total amount (line 54 x sum of Tines 55, 55.01, and 55.02) 0.01 Total amount (line 54 x sum of Tines 55, 55.01, and 55.02) 0.01 Total amount (line 54 x sum of Tines 55, 55.01, and 55.02) 0.01 Total amount (line 55) 0.01	50. 00		atient routine s	services (from	Wkst. D, sum	of Parts I and	293, 758	50.00
and IV)	51. 00		atient ancillary	services (fr	om Wkst. D, s	sum of Parts II	224, 839	51. 00
10.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	52 00	and IV)	,	•				
TARCET MANUAL FINE CAMPUTATION		Total Program inpatient operating cost exclud	ding capital rel	ated, non-phy	sician anesth	etist, and		1
55.00 Target amount per discharge 0.00 55.01 S5.01 Adjustment amount per discharge 0.00 55.01 S5.01 Adjustment amount per discharge (contractor use only) 0.00 55.01 S5.01 S5.01 Adjustment amount per discharge (contractor use only) 0.00 55.01 S5.00 0.00 55.01 S5.00 0.00 55.01 S5.00 0.00 55.00 0.00 55.00 0.00 55.00 0.00 55.00 0.00 55.00 0.00 55.00 0.00 55.00 0.00 55.00 0.00		TARGET AMOUNT AND LIMIT COMPUTATION	02)					
Permanent adjustment amount per discharge 0.00 55.02 50.02 Mistment amount per discharge (contractor use only) 0.00 55.02 55.00 Target amount (line 54 x sum of lines 55, 55.01, and 55.02) 0.00 55.02 55.00								1
56.00 Target amount (line 54 x sum of lines 55, 55.01, and 55.02) 57.00 Difference between adjusted in partient operating cost and target amount (line 56 minus line 53) 57.00 Bonus payment (see instructions) 58.00 Bonus payment (see instructions) 58.00 Expected costs (lesser of line 53 + line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket) 60.00 Expected costs (lesser of line 53 + line 54, or line 55 from prior year cost report, updated by the market basket) 61.00 Continuous improvement bonus payment (if line 53 + line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 55), or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see Instructions) 62.00 Relicef payment (see instructions) 63.00 Allowable Inpatient cost glus incentive payment (see instructions) 64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See Instructions) (lite XVIII only) 65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See Instructions) (lite XVIII only) 66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only): for 67.00 Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only): for 68.00 Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only): for 69.00 Total Medicare swing-bed NF inpatient routine costs (line 64 plus line 65) (title XVIII only): for 69.00 Total Medicare swing-bed NF inpatient routine costs (line 64 plus line 65) (title XVIII only): for 69.00 Total Head (some payment seed to see the fine fine fine fine fine fine fine fin		Permanent adjustment amount per discharge	ise only)					•
8.8.00 Bonus payment (see instructions) 9.00 Trended costs (lesser of line 53 + line 54, or line 55 from the cost reporting period ending 1996. 0.00 Expected costs (lesser of line 53 + line 54, or line 55 from prior year cost report, updated by the market basket) 0.00 Control through improvement bonus payment (if line 53 + line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see Instructions) 0.00 Relice flayment (see instructions) 0.01 Allowable Inpatient cost plus incentive payment (see instructions) 0.01 Allowable Inpatient cost plus incentive payment (see instructions) 0.02 Relice flayment (see instructions) 0.03 Nedicare swing-bed SWF inpatient routine costs after December 31 of the cost reporting period (See Instructions) (lite XVIII only); for 0.05 Nedicare swing-bed SWF inpatient routine costs (line 64 plus line 65) (title XVIII only); for 0.05 Nedicare swing-bed SWF inpatient routine costs (line 64 plus line 65) (title XVIII only); for 0.05 Nedicare swing-bed SWF inpatient routine costs (line 64 plus line 65) (title XVIII only); for 0.05 Nedicare swing-bed SWF inpatient routine costs (line 64 plus line 65) (title XVIII only); for 0.05 Nedicare swing-bed SWF inpatient routine costs (line 64 plus line 65) (title XVIII only); for 0.05 Nedicare swing-bed SWF inpatient routine costs (line 64 plus line 65) (title 20 Nedicare SWF Negicare) (line 13 x line 20) Negicare) (line 14 x line 35) Negicare) (line 14 x line 35) Negicare) (line 14 x line 35) Negicare) (line 15 x line	56.00	Target amount (line 54 x sum of lines 55, 55.	01, and 55.02)				0	56. 00
updated and compounded by the market basket) 60. 00 Expected costs (clesser of IIne 53 + IIne 54, or IIne 55 from prior year cost report, updated by the market basket) 61.00 Continuous improvement bonus payment (if Iine 53 + Iine 54 is less than the lowest of Iines 55 plus 55, 01, or I iine 59, or Iine 60, enter the lesser of 50% of the amount by which operating costs (Iine 53) are less than expected costs (Iines 54 x 60), or 1 % of the amount by which operating costs (Iine 53) are less than expected costs (Iines 54 x 60), or 1 % of the target amount (Iine 56), otherwise enter zero. (see instructions) 62.00 Relide payment (see instructions) 63.00 Allowable Inpatient cost plus incentive payment (see instructions) 64.00 Medicare swing-bed SMF inpatient routine costs through December 31 of the cost reporting period (See Instructions) (III to XVIII only) 65.00 Medicare swing-bed SMF inpatient routine costs (Iine 64 plus Iine 65) (Itile XVIII only): for 0 dec. 00 dec			ng cost and tar	get amount (I	ine 56 minus	Tine 53)		1
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61.00 Continuous improvement bonus payment (if line 53 + line 54 is less than the lowest of lines 55 plus 5.01, or line 59, or line 60. enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions) 0.62.00	60. 00	Expected costs (lesser of line 53 ÷ line 54,	0. 00	60. 00				
Relief payment (see instructions) 0 d2.00	61. 00	Continuous improvement bonus payment (ifline 55.01, orline 59, orline 60, enter the less 53) are less than expected costs (lines 54 x	0	61. 00				
PROGRAM INPATIENT ROUTINE SWING BED COST 64.00 66.00 65.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only) 66.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only) 66.00 CARI, see instructions 67.00 Title V or XIX swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only); for CARI, see instructions 67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (ine 12 x line 19) 68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (ine 13 x line 20) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 70.00 Adjusted general inpatient routine service cost (line 70 + line 2) 71.00 Adjusted general inpatient routine service cost (line 70 + line 2) 72.00 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 73.00 Capital -related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 75.00 Capital -related costs (line 75 + line 2) 76.00 Per diem capital -related costs (line 75 + line 2) 77.00 Aggregate charges to beneficiaries for excess costs (from provider records) 78.00 Inpatient routine service cost (line 7 x line 81) 80.00 Reasonable inpatient routine service costs (see instructions) 80.00 Reasonable inpatient routine service cost (see instructions) 81.00 PART IV - COMPUTATION OF DSSERVATION BED PASS THROUGH COST 71.00 Total Observation bed days (see instructions) 80.00 Total Observation bed days (see instructions)		62.00 Relief payment (see instructions)						
instructions) (title XVIII only) 65. 00 Micdicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only) 70. Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only): for CAH, see instructions 70. CAH, see instructions 70. Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 80. CAH, see instructions 80. Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 10. CAH, see instructions 80. CO Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 10. CAH, see instructions 10. CAH, see inst		PROGRAM INPATIENT ROUTINE SWING BED COST				1 1 (2		
instructions) (title XVIII only) 66.00 66.00 66.00 66.00 67.00 68.00 67.00 67.00 68.00 67.00 68.00 68.00 69.		instructions)(title XVIII only)						
CAH, see instructions 7. 00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 8. 00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 8. 00 Title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 9. 00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 9. 00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 9. 00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 9. 00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 9. 00 Total stitle V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 9. 00 Total stitle V or XIX swing-bed NF inpatient routine costs (line 70 + line 20) 9. 00 Total stitle V or XIX swing-bed NF inpatient routine service cost (line 70 + line 2) 9. 00 Total stitle V or XIX swing-bed NF inpatient routine service costs (line 70 + line 2) 9. 00 Total Program general inpatient routine service costs (line 72 + line 73) 9. 00 Total Program general inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 9. 00 Total Program general inpatient routine service costs (from provider records) 9. 00 Total Program routine service cost (line 75 + line 2) 9. 00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 9. 00 Inpatient routine service cost for excess costs (from provider records) 9. 00 Inpatient routine service cost for excess costs (from provider records) 9. 00 Inpatient routine service cost for comparison to the cost limitation (line 78 minus line 79) 9. 00 Inpatient routine service cost for comparison to the cost limitation (line 78 minus line 79) 9. 00 Inpatient routine service cost for comparison to the cost limitation (line 78 minus line 79) 9. 00 Total Program inpatient ancillary services (see instructions) 9. 00 Total Program inpat	65. 00		ts after Decembe	er 31 of the c	ost reporting	period (See	0	65. 00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 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) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 0 69.00 PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY 70.00 Skilled nursing facility/other nursing facility/lCF/IID routine service cost (line 37) 70.00 Program routine service cost (line 9 x line 71) 71.00 72.00 73.00 74.00 75.00 76.0	66. 00	,	ne costs (line 6	4 plus line 6	5)(title XVII	I only); for	0	66. 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) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY 70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 71.00 Adj usted general inpatient routine service cost per diem (line 70 + line 2) 71.00 Program routine service cost (line 9 x line 71) 72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 + line 2) 77.00 Program capital-related costs (line 9 x line 76) 78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 80.00 Inpatient routine service cost per diem limitation (line 9 x line 81) 82.00 Reasonable inpatient routine service costs (see instructions) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 70.00 Total observation bed days (see instructions) 87.00 Adjusted general inpatient routine cost per diem (line 27 + line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 + line 2) 89.00 Adjusted general inpatient routine cost per diem (line 27 + line 2) 89.00 Adjusted general inpatient routine cost per diem (line 27 + line	67. 00	Title V or XIX swing-bed NF inpatient routing	e costs through	December 31 o	f the cost re	porting period	0	67. 00
69.00 Total title V or XiX swing-bed NF inpatient routine costs (line 67 + line 68) 0 69.00	68. 00	Title V or XIX swing-bed NF inpatient routing	e costs after De	ecember 31 of	the cost repo	orting period	0	68. 00
70.00 71.00 71.00 72.00 72.00 73.00 73.00 74.00 75.00 75.00 76.00 76.00 77.00 76.00 77.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00	69. 00	Total title V or XIX swing-bed NF inpatient i					0	69. 00
72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 73.00 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 9 x line 76) 78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Inpatient routine service cost per diem limitation 80.00 Inpatient routine service cost limitation (line 9 x line 81) 80.00 Reasonable inpatient routine service costs (see instructions) 81.00 Reasonable inpatient ancillary services (see instructions) 82.00 Utilization review - physician compensation (see instructions) 83.00 Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 83.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 1, 348.45 88.00		Skilled nursing facility/other nursing facili	ty/ICF/IID rout	ine service c	ost (line 37)			1
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78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 80.00 Inpatient routine service cost per diem limitation 81.00 Inpatient routine service cost limitation (line 9 x line 81) 82.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) 87.00 RAT IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 17.00 Total Observation bed days (see instructions) 17.00 Total Observation bed days (see instructions) 18.00 Total Observation bed days (see instructions) 19.00 Total Observation bed days (see instructions)		Per diem capital-related costs (line 75 ÷ lin						
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 1, 348.45 88.00								1
81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 81.00 Reasonable inpatient routine service costs (see instructions) 82.00 Reasonable inpatient ancillary services (see instructions) 84.00 Reasonable inpatient ancillary services (see instructions) 85.00 Total Program inpatient operating costs (sum of lines 83 through 85) 86.00 Reasonable inpatient operating costs (sum of lines 83 through 85) 87.00 Reasonable inpatient operating costs (sum of lines 83 through 85) 88.00 Reasonable inpatient operating costs (see instructions) 88.00 Reasonable inpatient routine cost per diem (line 27 ÷ line 2) 89.00 Reasonable inpatient routine cost per diem (line 27 ÷ line 2)		Aggregate charges to beneficiaries for excess	s costs (from pr			us line 79)		1
Reasonable inpatient routine service costs (see instructions) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 87.00 Reasonable inpatient routine service costs (see instructions) 86.00 87.00 Reasonable inpatient routine service costs (see instructions) 87.00 88.00 Reasonable inpatient routine service costs (see instructions) 87.00 88.00 Reasonable inpatient routine service costs (see instructions) 87.00 88.00	81. 00	Inpatient routine service cost per diem limit		81. 00				
85.00 Utilization review - physician compensation (see instructions) 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)		,						1
86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				ns)				1
87.00 Total observation bed days (see instructions) 1,407 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 1,348.45 88.00		Total Program inpatient operating costs (sum	of lines 83 thr					ł
		Total observation bed days (see instructions))	11 0				1
				iine 2)				1

Health Financial Systems F	RANCI SCAN HEALTH	CRAWFORDSVI LLE	E	In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2022 To 12/31/2022		
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	763, 973	5, 915, 642	0. 12914	5 1, 897, 269	245, 023	90.00
91.00 Nursing Program cost	0	5, 915, 642	0.00000	0 1, 897, 269	0	91.00
92.00 Allied health cost	0	5, 915, 642	0.00000	0 1, 897, 269	0	92.00
93 00 All other Medical Education	0	5 915 642	0 00000	1 897 269	0	93 00

Health Financial Systems	FRANCISCAN HEALTH CRAWFORDSVILLE	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0022		Worksheet D-1
	Component CCN: 15-S022	From 01/01/2022 To 12/31/2022	
	Title XVIII	Subprovi der -	PPS

		II the XVIII	I PF	FF3	
	Cost Center Description				
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days			1, 700	
2.00	Inpatient days (including private room days, excluding swing-berivate room days (excluding swing-bed and observation bed day			1, 700	
3.00	do not complete this line.	(S). If you have only pri	vate room days,	0	3. 00
4.00	Semi-private room days (excluding swing-bed and observation be	ed days)		1, 700	4. 00
5.00	Total swing-bed SNF type inpatient days (including private roo	om days) through December	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 3	1 of the cost	0	6. 00
0.00	reporting period (if calendar year, enter 0 on this line)	om days) arter becember e	in or the cost	O	0.00
7. 00	Total swing-bed NF type inpatient days (including private room	n days) through December	31 of the cost	0	7. 00
8. 00	reporting period Total swing-bed NF type inpatient days (including private room	n days) after December 21	of the cost	0	8. 00
8.00	reporting period (if calendar year, enter 0 on this line)	ii days) ai tei beceilibei 31	or the cost	U	0.00
9.00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	1, 022	9. 00
10. 00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII or	alv. (i poludi pa pri voto ro	om days)	0	10. 00
10.00	through December 31 of the cost reporting period (see instruct		ioiii days)	U	10.00
11. 00	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, er Swing-bed NF type inpatient days applicable to titles V or XI)		room days)	0	12. 00
12.00	through December 31 of the cost reporting period	Comy (frictualing private	(1 00 lii days)	U	12.00
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		,	0	14. 00
15. 00	Medically necessary private room days applicable to the Progra Total nursery days (title V or XIX only)	all (excluding swing-bed c	lays)	0	15. 00
16. 00	Nursery days (title V or XIX only)			0	16. 00
47.00	SWING BED ADJUSTMENT		S 11 1	0.00	47.00
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through December 31 of	the cost	0.00	17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of t	he cost	0.00	18. 00
19. 00	reporting period	through December 21 of	the cost	0.00	19. 00
19.00	Medicaid rate for swing-bed NF services applicable to services reporting period	s till ough becember 31 of	the cost	0.00	19.00
20. 00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of th	e cost	0. 00	20. 00
21. 00	reporting period Total general inpatient routine service cost (see instructions	:)		3, 140, 995	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December		ng period (line	0, 110, 770	22. 00
	5 x line 17)				
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reporting	period (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reportir	g period (line	0	24. 00
25 00	7 x line 19)	21 -6		0	25 00
25. 00	Swing-bed cost applicable to NF type services after December 3 x line 20)	or the cost reporting	period (line 8	0	25. 00
26. 00	Total swing-bed cost (see instructions)			0	
27. 00	General inpatient routine service cost net of swing-bed cost (PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)		3, 140, 995	27. 00
28. 00	General inpatient routine service charges (excluding swing-bed	d and observation bed cha	irges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)			0	29. 00
30.00	Semi-private room charges (excluding swing-bed charges)	Line 20)		0. 000000	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)	- ITTIE 26)		0.00000	
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 mir	, ,	i ons)	0.00	
35. 00 36. 00	Average per diem private room cost differential (line 34 x line Private room cost differential adjustment (line 3 x line 35)	ne 31)		0.00	35. 00 36. 00
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost dif	ferential (line	3, 140, 995	
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	ISTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see			1, 847. 64	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line	38)		1, 888, 288	39. 00
40.00	Medically necessary private room cost applicable to the Program	•		1 000 200	40.00
41. 00	Total Program general inpatient routine service cost (line 39	+ ITHE 40)		1, 888, 288	41.00

COMPLIE		ANCISCAN HEALTH C		0000		eu of Form CMS-2	
COMPUT	ATION OF INPATIENT OPERATING COST		Provider CCN: 15- Component CCN: 15		Period: From 01/01/2022 To 12/31/2022	Date/Time Pre	pared:
			Title XVIII		Subprovi der -	5/30/2023 4: 1 PPS	2 pm
	Cost Center Description	Total Inpatient Cost In	patient Days Diem (age Per (col. 1	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	0.0	0 0	0	42.0
43. 00	INTENSIVE CARE UNIT	0	0	0. 0	0 0	0	43.0
44. 00	CORONARY CARE UNIT	0	0	0.0		1	
	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT	0	0	0. 0 0. 0			
47. 00				0.0			47. 0
	Cost Center Description		<u> </u>				
48. 00	Program inpatient ancillary service cost (Wk	st D-3 col 3	line 200)			1. 00 85, 408	48.0
48. 01	Program inpatient cellular therapy acquisiti			ine 10,	column 1)	05, 400	1
49. 00	Total Program inpatient costs (sum of lines					1, 973, 696	49.0
EO 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp	ationt mouting of	und ook (from What	D 0.11m	of Donto L and	22/ 557	
50. 00	Pass through costs appricable to Program The	attent routine se	ervices (from wkst.	D, Suill	or Parts r and	226, 557	50.0
51. 00	Pass through costs applicable to Program inp	atient ancillary	services (from Wks	st. D, s	um of Parts II	7, 015	51.0
E2 00	and IV)	EO and E1)				222 572	E2 0
52. 00 53. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		ited, non-physician	anesth	etist, and	233, 572 1, 740, 124	
	medical education costs (line 49 minus line		,			1,7.10,124] 33. 3
E 4 OO	TARGET AMOUNT AND LIMIT COMPUTATION] [4 0
54. 00 55. 00	Program discharges Target amount per discharge					0.00	
	Permanent adjustment amount per discharge					0.00	1
	Adjustment amount per discharge (contractor					0.00	1
56. 00 57. 00	Target amount (line 54 x sum of lines 55, 55 Difference between adjusted inpatient operat		uet amount (line 54	minus	line 53)	0 0	
58. 00	Bonus payment (see instructions)	ring cost and targ	jet amount (Tine Se	illi rius	11110 33)	0	
59. 00	Trended costs (lesser of line 53 ÷ line 54,		the cost reporting	peri od	endi ng 1996,	0.00	59. 0
60. 00	updated and compounded by the market basket) Expected costs (lesser of line 53 ÷ line 54,		prior year cost re	port u	ndated by the	0.00	60.0
61. 00	market basket) Continuous improvement bonus payment (if lin					0.00	
01.00	55.01, or line 59, or line 60, enter the les (53) are less than expected costs (lines 54 x	ser of 50% of the	amount by which c	perati n	g costs (line	0	01.0
	enter zero. (see instructions)	. 60), 01 1 % 01 1	the target amount ((Title 50), Otherwise		
	Relief payment (see instructions)					0	
63. 00	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instruct	i ons)			0	63.0
64. 00	Medicare swing-bed SNF inpatient routine cos	ts through Decemb	per 31 of the cost	reporti	ng period (See	0	64.0
/F 00	instructions)(title XVIII only)	t6t D	. 21 -6				/ - 0
65. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts after December	31 OF the COST re	eporting	period (See	0	65. 0
66. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line 64	plus line 65)(tit	le XVII	l only); for	0	66. 0
67. 00	CAH, see instructions Title V or XIX swing-bed NF inpatient routin	e costs through D	December 31 of the	cost re	porting period	0	67. 0
	(line 12 x line 19)	-					
68. 00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	e costs after Dec	cember 31 of the co	ost repo	rting period	0	68. 0
69. 00	Total title V or XIX swing-bed NF inpatient					0	69. 0
70. 00	PART III - SKILLED NURSING FACILITY, OTHER N Skilled nursing facility/other nursing facil			ine 37)			70. 0
71. 00	Adjusted general inpatient routine service c	ost per diem (lir		51)			71.0
72.00	Program routine service cost (line 9 x line	,					72. 0
73. 00 74. 00	Medically necessary private room cost applic Total Program general inpatient routine serv)			73. C
75. 00	Capital -related cost allocated to inpatient		•	et B, P	art II, column		75.0
	26, line 45)		·				l
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line						76. 0 77. 0
78. 00	Inpatient routine service cost (line 74 minu						78.0
79. 00	Aggregate charges to beneficiaries for exces	s costs (from pro		76			79. 0
	Total Program routine service costs for comp		st limitation (line	9 78 min	us line 79)		80.0
31. 00 32. 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I						82.0
83. 00	Reasonable inpatient routine service costs (see instructions)					83.0
84.00	Program inpatient ancillary services (see in						84.0
85. 00 86. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum	•	•				85. 0 86. 0
_ 0. 00	PART IV - COMPUTATION OF OBSERVATION BED PAS		g., 00)]
							1 87. C

Health Financial Systems FRA	ANCISCAN HEALTH	CRAWFORDSVI LLI	E	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
		Component (CCN: 15-S022	From 01/01/2022 To 12/31/2022		
		Title	XVIII	Subprovi der -	PPS	
				I PF		
Cost Center Description						
					1.00	
89.00 Observation bed cost (line 87 x line 88) (see	e instructions)				0	89. 00
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	376, 849	3, 140, 995	0. 11997	8 0	0	90.00
91.00 Nursing Program cost	O	3, 140, 995	0. 00000	0 0	0	91.00
92.00 Allied health cost	o	3, 140, 995	0. 00000	0 0	0	92.00
93.00 All other Medical Education	o	3, 140, 995	0. 00000	0 0	0	93. 00

Health Financial Systems	FRANCISCAN HEALTH CRAWFORDSVILLE	In Lie	u of Form CMS-2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der CCN: 15-0022	Peri od:	Worksheet D-3

INPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der Co	CN: 15-0022	Peri od:	Worksheet D-3	
				From 01/01/2022 To 12/31/2022	Date/Time Pre 5/30/2023 4:1	pared:
		Title	xVIII	Hospi tal	PPS	<u> </u>
	Cost Center Description		Ratio of Cos To Charges	t Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS					
	03000 ADULTS & PEDI ATRI CS			2, 359, 814		30. 00
31.00	03100 NTENSI VE CARE UNI T			1, 499, 900		31.00
	03200 CORONARY CARE UNIT			0		32.00
	03300 BURN INTENSIVE CARE UNIT			0		33. 00 34. 00
40. 00	03400 SURGICAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF			0		40.00
41. 00	04100 SUBPROVIDER - I RF					41.00
43. 00	04300 NURSERY					43. 00
.0.00	ANCI LLARY SERVI CE COST CENTERS		1		L	10.00
50.00	05000 OPERATI NG ROOM		0. 31825	633, 780	201, 705	50.00
51.00	05100 RECOVERY ROOM		0.00000	00	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		0.00000	00	0	52. 00
	05300 ANESTHESI OLOGY		0. 00000	0 0	0	53. 00
	05400 RADI OLOGY-DI AGNOSTI C		0. 31039		207, 680	1
	03630 ULTRA SOUND		0. 03480		0	54. 01
	05500 RADI OLOGY-THERAPEUTI C		0.00000		0	55. 00
56.00	05600 RADI 0I SOTOPE		0. 12548		5, 477	1
57. 00	05700 CT SCAN		0.00334			1
58. 00	05800 MAGNETI C RESONANCE I MAGING (MRI) 05900 CARDI AC CATHETERI ZATI ON		0.00334		532	1
59.00	06000 LABORATORY		0.00000		1	59.00
	06001 BLOOD LABORATORY		0. 1795 <i>6</i> 0. 00000		331, 871 0	1
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0.00000		0	61. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 00000		0	62.00
	06300 BLOOD STORING, PROCESSING & TRANS.		0. 00334		1	63.00
64. 00	06400 NTRAVENOUS THERAPY		0. 00000		0	64. 00
65.00	06500 RESPI RATORY THERAPY		0. 44187		302, 067	65.00
66.00	06600 PHYSI CAL THERAPY		0. 2771	4 931, 106	258, 023	66. 00
67.00	06700 OCCUPATI ONAL THERAPY		0.00000	00	0	67. 00
68. 00	06800 SPEECH PATHOLOGY		0.00000	00	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY		0. 13108	573, 976	75, 240	69. 00
	07000 ELECTROENCEPHALOGRAPHY		0.00000		0	70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 13616		101, 933	1
	07200 IMPL. DEV. CHARGED TO PATIENTS		0. 24338		68, 460	1
	07300 DRUGS CHARGED TO PATIENTS		0. 28458			1
	07400 RENAL DIALYSIS		0.00000		0	
	07500 ASC (NON-DISTINCT PART) 03480 ONCOLOGY		0. 00000 0. 01650		0	
	07697 CARDI AC REHABI LI TATI ON		0. 00334		1	1
77. 00	07700 ALLOGENEI C STEM CELL ACQUI SI TI ON		0. 00000			•
77.00	OUTPATIENT SERVICE COST CENTERS		0.0000			77.00
88. 00	08800 RURAL HEALTH CLINIC		0.00000	00	0	88. 00
	08900 FEDERALLY QUALIFIED HEALTH CENTER		0. 00000		0	
90.00	09000 CLI NI C		0. 65649	0	0	90.00
91.00	09100 EMERGENCY		0. 09729	1, 687, 550	164, 197	91. 00
91. 01	04950 WOUND CARE		0.00000		0	91. 01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 63243	442, 397	279, 789	92. 00
	OTHER REIMBURSABLE COST CENTERS		1		1	
	09400 HOME PROGRAM DI ALYSI S		0.00000	00	0	94.00
	09500 AMBULANCE SERVI CES				_	95. 00
	09600 DURABLE MEDICAL EQUIP-RENTED		0.00000		0	
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD		0.00000		0	
	09850 OTHER REIMBURSABLE COST CENTERS		0.00000		0 2, 351, 100	
200. 00 201. 00		(line 61)		11, 066, 323	2, 331, 100	200.00
201.00		(TITIE OI)		11, 066, 323		201.00
202.00	1.100 Sharges (Trillo 200 minus Trillo 201)		I	11,000,020	I	1-02.00

	Financial Systems FRANCISCAN HEALTH CRA ENT ANCILLARY SERVICE COST APPORTIONMENT		CN: 15-0022	Peri od:	u of Form CMS- Worksheet D-3	
		Component	CCN: 15-S022	From 01/01/2022 To 12/31/2022	Date/Time Pre	
		Titl€	e XVIII	Subprovi der -	5/30/2023 4: 1 PPS	2 piii
	Cost Center Description		Ratio of Cos	t Inpatient	Inpati ent	
			To Charges		Program Costs (col. 1 x col.	
				Chai ges	2)	
	INDATIENT POUTING CERVICE COCT CENTERS		1.00	2. 00	3. 00	
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS					30.0
	03100 INTENSIVE CARE UNIT					31.0
32. 00	03200 CORONARY CARE UNIT					32.0
	03300 BURN INTENSIVE CARE UNIT					33.0
34. 00 10. 00	03400 SURGICAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF			2, 648, 048		34. (
	04100 SUBPROVI DER - I RF			2, 040, 040		41. (
13. 00	04300 NURSERY					43. 0
	ANCI LLARY SERVI CE COST CENTERS		2 21==	-	_	ļ
0.00	05000 OPERATING ROOM 05100 RECOVERY ROOM		0. 3182 0. 0000		0	
2. 00	05200 DELIVERY ROOM & LABOR ROOM		0.0000		0	
	05300 ANESTHESI OLOGY		0.0000		0	
4. 00	05400 RADI OLOGY-DI AGNOSTI C		0. 3103	92 30, 675	9, 521	54.
4. 01	03630 ULTRA SOUND		0. 0348		0	1
5.00	05500 RADI OLOGY-THERAPEUTI C		0.0000		0	1
6. 00 7. 00	05600		0. 1254 0. 0033		0 87	
8. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)		0.0033		0	1
9. 00	05900 CARDI AC CATHETERI ZATI ON		0.0000		0	1
0. 00	06000 LABORATORY		0. 1795		25, 620	1
0. 01	06001 BL00D LABORATORY		0.0000		0	1
1. 00 2. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 0000 0. 0000		0	1
3. 00	06300 BLOOD STORING, PROCESSING & TRANS.		0.0000		0	1
4. 00	06400 I NTRAVENOUS THERAPY		0.0000		0	
5. 00	06500 RESPI RATORY THERAPY		0. 4418	72 6, 104	2, 697	65.
6. 00	06600 PHYSI CAL THERAPY		0. 2771		11, 567	1
7. 00	O6700 OCCUPATI ONAL THERAPY		0.0000		0	1
8. 00 9. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY		0. 0000 0. 1310		0 2, 883	
	07000 ELECTROCARDI OLOGI 07000 ELECTROENCEPHALOGRAPHY		0. 0000		2,003	1
1. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 1361		4, 195	1
	07200 IMPL. DEV. CHARGED TO PATIENTS		0. 2433		0	
3.00	07300 DRUGS CHARGED TO PATIENTS		0. 2845		21, 830	1
	07400 RENAL DIALYSIS		0. 0000 0. 0000		0	1
	07500 ASC (NON-DISTINCT PART) 03480 ONCOLOGY		0.0000		0	1
	07697 CARDI AC REHABI LI TATI ON		0.0033		0	
7. 00	07700 ALLOGENEIC STEM CELL ACQUISITION		0.0000	00 0	0	77.
0 00	OUTPATIENT SERVICE COST CENTERS		0.0000	00	0	
	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER		0. 0000 0. 0000		0	
	09000 CLINIC		0. 6564		0	
	09100 EMERGENCY		0. 0972		7, 008	
1. 01	04950 WOUND CARE		0.0000		0	
2. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 6324	38 0	0	92.
4. 00	OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DIALYSIS		0.0000	00 0	0	94.
	09500 AMBULANCE SERVICES		0.0000	0	0	95.
	09600 DURABLE MEDICAL EQUIP-RENTED		0.0000	00 0	0	
7. 00	09700 DURABLE MEDICAL EQUIP-SOLD		0.0000	00 0	0	97.
	09850 OTHER REIMBURSABLE COST CENTERS		0.0000		0	
200. 00 201. 00		(1:50 (1)		448, 778	85, 408	
	Less PBP Clinic Laboratory Services-Program only charges	11ne 61)	1	1 0		201.

Health Financial Systems	FRANCISCAN HEALTH CRAWFORDSVILLE	In Li€	eu of Form CMS-2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der CCN: 15-0022	Peri od:	Worksheet D-3

The NEX TROUBLE The	INPATIENT A	NCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0022	Peri od: From 01/01/2022	Worksheet D-3	
Cost Center Description							
INPATI_ENT_ROUTINE_SERVICE_COST_CENTERS	-		Ti †I	e XIX	Hospi tal		z piii
		Cost Center Description				1'	
INPATIENT BOUTINE SERVICE COST CENTERS		'			•		
IMPATIENT ROUTINE SERVICE COST CENTERS					Charges	(col. 1 x col.	
IMPART ENT ROUTI NE SERVICE COST CENTERS 30.00 31.00 310.00 401.073 & PETATRICS 582,233 30.00 31.00							
30.00		<u> </u>		1.00	2. 00	3. 00	
31.00 03100 IMTERIST VE CARE UNIT					500.000	ı	
32.00	1						•
33.00					436, 448		1
34. 00 0400 SURROLAL INTENSIVE CARE UNIT 0 43. 00 40.					0		1
A0. 00 04000 SUBPROVIDER - I PF					0		
1.0 04100 SUBPROYUDER - IRF 0 41.00 43.00					0		1
43. 00 04300 NURSERY					0		1
MACILLARY SERVICE COST CENTERS					0		1
50.00				1		l .	1 43.00
15.1.00 05.100 RECOVERY ROOM				0. 31825	7 252, 712	80. 427	50.00
S2.00 GS200 GELIVERY ROOM & LABOR ROOM D. 0.000000 O. 0 S3.00	1			1			1
1.53.00 05300 ANESTHESI OLOCY 0.000000 0 0.53.00							ı
54. 00 OS-400 RADIOLOGY-DIA GANOSTIC 0.3103992 361, 938 112, 343 54. 00 55. 01 OS-500 RADIOLOGY-THERAPLUTIC 0.000000 0 0.50. 00 0.000000 0 0.50. 00 0.50.						1	1
1.40						112, 343	1
56. 00 05.	54. 01 03630	ULTRA SOUND		0. 03480	2 40, 340	1, 404	54. 01
1.50	55. 00 05500	RADI OLOGY-THERAPEUTI C		0.00000	0	0	55. 00
SBS 00 OSBOO MAGNETIC RESONANCE I MACING (MRI) 0.003342 0 0.58 00 0.59 00 0.	56.00 05600	RADI OI SOTOPE		0. 12548	1 0	0	56. 00
59.00 05900 CARDIA C CATHETRI ZATION 0.000000 0 0 59.00	57.00 05700	CT SCAN		0.00334	2 0	0	57. 00
60.00 060000 LABORATORY 0.179567 510,143 91,605 00.00 0.		` ,		0.00334	2 0	0	58. 00
60.01 06.001 06	59.00 05900	CARDI AC CATHETERI ZATI ON		0.00000	0 0	0	59. 00
61.00 06100 PBP CLINICAL LAB SERVICES-PREM ONLY 0.000000 0 61.00 062.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.000000 0 062.00 063.00 06300 064.00 064.00 064.00 064.00 064.00 064.00 064.00 064.00 0.000000 0 0.00000 0 0.00000 0				1		91, 605	60.00
62.00 06200 MPIOLE BLOOD & PACKED RED BLOOD CELLS 0,000000 0 062,00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0,0003341 0 0 063,00 64.00 06400 INTRAVENOUS THERAPY 0,000000 0 064,00 65.00 06500 RESPIRATIORY THERAPY 0,441872 276,920 122,363 65.00 06500 RESPIRATIORY THERAPY 0,277114 65,080 18,035 66,00 66.00 06600 PHYSICAL THERAPY 0,277114 65,080 18,035 66,00 67.00 06700 0CCUPATI ONAL THERAPY 0,000000 0 0 67,00 68.00 06600 SPECEL PATHOLOGY 0,000000 0 0 68,00 69.00 06600 SPECEL PATHOLOGY 0,000000 0 0 68,00 69.00 06600 SPECEL PATHOLOGY 0,000000 0 0 70,00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0,136160 4,720 643,71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0,243386 0 0,72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0,243386 0 0,72.00 74.00 07400 RENAL DIALYSIS 0,245389 268,746 76,482 73.00 75.00 07300 ORGOS CHARGED TO PATIENTS 0,245389 0,000000 0 75.00 76.00 03480 ONCOLOGY 0,000000 0 0 75.00 76.00 03480 ONCOLOGY 0,000000 0 0 75.00 76.00 03480 ONCOLOGY 0,000000 0 0 75.00 76.97 07697 CARDIAC REHABILITATION 0,000000 0 0 75.00 76.97 07697 CARDIAC REHABILITATION 0,000000 0 0 75.00 76.97 07697 0,000000 0 0 0 0 0 76.97 0,000000 0 0 0 0 76.97 0,000000 0 0 0 0 76.97 0,000000 0 0 0 0 76.97 0,000000 0 0 0 0 76.97 0,000000 0 0 0 0 76.97 0,000000 0 0 0 0 76.97 0,000000 0 0 0 0 76.97 0,000000 0 0 0 0 76.97 0,000000 0 0 0 0 76.97 0,000000 0 0 0 0 76.97 0,000000 0 0 0 0 76.97 0,000000 0 0 0 0 76.97 0,000000 0 0 0 0 76.97 0,000000 0 0 0 0 76.97 0,000000 0 0 0 0 76.97 0,0000000 0 0 0 0 76.97 0,000000 0 0 0 0 76.97 0,000000 0 0 0 0				1			1
63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0.003341 0 63.00 64.00 06400 INTRAVENDUS THERAPY 0.000000 0.000000 0.000000 65.00 06500 RESPIRATORY THERAPY 0.441872 276,920 122,363 65.00 66.00 06600 PHYSI CAL THERAPY 0.0277114 65,080 18,035 66.00 67.00 06600 OFFICIAL THERAPY 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000				1		1	1
64. 00 06400 INTRAVENOUS THERAPY 0.0000000 0 0.44. 00				1		1	1
65.00 06500 RESPIRATORY THERAPY 0.441872 276, 920 122, 363 65.00 66.00 06600 PHYSI CAL THERAPY 0.277114 65.080 18,035 66.00 67.00 06700 0CCUPATI ONAL THERAPY 0.000000 0 0.67.00 68.00 06800 SPECCH PATHOLOGY 0.000000 0 0.68.00 69.00 06900 ELECTROCARDI OLOGY 0.000000 0 0.00000 70.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 0 0.00000 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0.136160 4,720 643 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.243386 0 0.72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.243386 0 0.72.00 74.00 07400 RENAL DI ALYSIS 0.000000 0 0.74.00 75.00 07500 ASC (NON-DISTINCT PART) 0.000000 0 0.75.00 76.07 07500 ASC (NON-DISTINCT PART) 0.000000 0 0.76.97 77.00 07697 CARDI LA REHABILITATI ON 0.000342 0 0.76.97 77.00 07697 CARDI LA REHABILITATI ON 0.000000 0 0.00000 0 88.00 08800 RURAL HEALTH CLINIC 0.000000 0 0.00000 0 0.00000 99.00 090000 LURGE CHARGEN CELL ACQUISITION 0.000000 0 0.00000 0 91.00 09000 LURGE CHARGEN CELL ACQUISITION 0.000000 0 0.00000 0 91.00 09000 CLINIC COST CENTERS 0.000000 0 0.00000 0 91.00 09000 ELEGRAPY 0.000000 0 0.00000 0 0.00000 0 91.00 09000 LURGE REHABILITATI ON 0.000000 0 0.00000 0 0.00000 0 91.00 09000 LURGE REHABILITIC CENTER 0.000000 0 0.00000 0 0.00000 0				1		0	•
66. 00 06600 PHYSI CAL THERAPY				1		122 242	•
67. 00 06700 0CCUPATI ONAL THERAPY 0. 000000 0 0 67. 00 68. 00 06800 SPEECH PATHOLOGY 0. 131086 96, 276 12, 620 69. 00 69. 00 06900 ELECTROCARDI OLOGY 0. 131086 96, 276 12, 620 69. 00 70. 00 07000 ELECTROENCEPHALLOGRAPHY 0. 000000 0 0 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0. 138160 4, 720 643 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 243386 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 284589 268, 746 76, 482 73. 00 74. 00 07400 RENAL DI ALYSIS 0. 000000 0 0 74. 00 75. 00 07500 ASC (MON-DISTINCT PART) 0. 000000 0 0 76. 07 76. 00 03430 ONCOLOGY 0. 016505 0 0 76. 07 77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION 0. 003342 0 0 76. 97 77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION 0. 000000 0 0 77. 00 79. 00 07900 CELECTROENCEPHALOGRAPHY 0. 003342 0 0 76. 97 79. 00 07900 CELECTROENCEPHALOGRAPHY 0. 000000 0 0 0 76. 97 79. 00 0700 ORDOROENCEPHALOGRAPHY 0. 000000 0 0 0 76. 97 79. 00 0700 ORDOROENCEPHALOGRAPHY 0. 000000 0 0 0 76. 97 79. 00 0700 ORDOROENCEPHALOGRAPHY 0. 000000 0 0 0 76. 97 79. 00 0700 ORDOROENCEPHALOGRAPHY 0. 000000 0 0 0 0 0 79. 00 0700 ORDOROENCEPHALOGRAPHY 0. 000000 0 0 0 0 79. 00 0700 ORDOROENCEPHALOGRAPHY 0. 000000 0 0 0 0 79. 00 0700 ORDOROENCEPHALOGRAPH 0. 000000 0 0 0 0 79. 00 0700 ORDOROENCEPHALOGRAPH 0. 000000 0 0 0 0 79. 00 0700 DURABLE MEDI CALE COUI FERNITED 0. 000000 0 0 96. 00 79. 00 0700 DURABLE MEDI CALE COUI FERNITED 0. 000000 0 0 96. 00 79. 00 0700 DURABLE MEDI CALE COUI FERNITED 0. 000000 0 0 96. 00 79. 00 0700 DURABLE MEDI CALE COUI FERNITED 0. 000000 0 0 96. 00 79. 00 0700 DURABLE MEDI CALE COUI FERNITED 0. 000000 0 0 96. 00 79. 00 0700 DURABLE MEDI C				1			1
68.00				1			1
69. 00 06900 ELECTROCARDIOLOGY 0. 131086 96, 276 12, 620 69. 00 70. 00 7000 ELECTROENCEPHALOGRAPHY 0. 0000000 0 0 70. 00				1		1	1
70. 00 07000 ELECTROENCEPHALOGRAPHY 0.000000 0 0 70.00 71.00 7100 071000 07100 071000 071000 07100 071000 071000 071000 071000 071000 071000 071000				1		-	1
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0. 136160 4,720 643 71. 00 72. 00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 243386 0 0. 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 2484589 268,746 76, 482 73. 00 07400 RENAL DIALYSIS 0. 000000 0 0 74. 00 07500 ASC (NON-DISTINCT PART) 0. 000000 0 0 75. 00 076. 00 03480 NOCOLOGY 0. 016505 0 0. 76. 00 03480 NOCOLOGY 0. 016505 0 0. 76. 97 076. 97 CARDIAC REHABILITATION 0. 003342 0 0 76. 97 07700 ALLOGENEIC STEM CELL ACQUISITION 0. 000000 0 0 0 0 0 0 0				1			1
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.243386 0 0 72. 00 73. 00 7300 DRUGS CHARGED TO PATIENTS 0.284589 268, 746 76, 482 73. 00 74. 00 07400 RENAL DIALYSIS 0.000000 0 0 74. 00 75. 00 75. 00 07500 ASC (NON-DISTINCT PART) 0.000000 0 0 75. 00 76. 00 03480 0NCOLOGY 0.016505 0 0 76. 00 076. 97 07697 CARDIA C REHABILITATION 0.00342 0 0 0 76. 97 07697 CARDIA C REHABILITATION 0.000000 0 0 0 0 0 0 0						643	ı
74. 00 07400 RENAL DIALYSIS 0.000000 0 0 74. 00 75. 00 07500 ASC (NON-DISTINCT PART) 0.000000 0 0 75. 00 76. 00 03480 0NCOLOGY 0.016505 0 0 75. 00 76. 97 07697 CARDIAC REHABILITATION 0.003342 0 0 76. 97 77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION 0.000000 0 0 0 0UTPATIENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC 0.000000 0 0 88. 00 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0.000000 0 0 89. 00 90. 00 09000 CLINIC 0.056493 0 0 90. 00 91. 00 09100 EMERGENCY 0.097299 522, 068 50, 797 91. 01 04950 WOUND CARE 0.000000 0 0 91. 01 92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0.632438 0 0 92. 00 0THER REIMBURSABLE COST CENTERS 0.000000 0 94. 00 95. 00 09500 MBULANCE SERVICES 95. 00 96. 00 09500 DURABLE MEDICAL EQUIP-RENTED 0.000000 0 97. 00 97. 00 09700 DURABLE MEDICAL EQUIP-RENTED 0.000000 0 97. 00 98. 00 09850 OTHER REIMBURSABLE COST CENTERS 0.000000 0 97. 00 99. 00 Total (sum of lines 50 through 94 and 96 through 98) 2,398,943 566,719 200. 00 201. 00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0				1			1
75. 00	73.00 07300	DRUGS CHARGED TO PATIENTS		0. 28458	9 268, 746	76, 482	73. 00
76. 00	74.00 07400	RENAL DIALYSIS		0.00000	0 0	0	74. 00
76. 97 07697 CARDI AC REHABILITATION 0.003342 0 0 76. 97 77. 00 07700 ALLOGENEI C STEM CELL ACQUISITION 0.000000 0 0 0 0 0 0 0	75.00 07500	ASC (NON-DISTINCT PART)		0.00000	0 0	0	75. 00
77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION 0.000000 0 0 0 0 0 0 0	-			1		0	
SERVICE COST CENTERS				1			1
88. 00				0.00000	0 0	0	77. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER						1	
90. 00 09000 CLINIC 0. 656493 0 0 90. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 92. 00 0. 000000 0 0 91. 01 92. 00 0. 000000 0 0 92. 00 0. 000000 0 0 92. 00 0. 000000 0 0 92. 00 0. 000000 0 0 92. 00 0. 000000 0 0 92. 00 0. 000000 0 0 0 92. 00 0. 000000 0 0 0 94. 00 0. 000000 0 0 0 94. 00 0. 000000 0 0 0 95. 00 0. 000000 0 0 0 96. 00 0. 000000 0 0 0 96. 00 0. 000000 0 0 0 97. 00 0. 000000 0 0 0 98. 00 0. 000000 0 0 0 98. 00 0. 000000 0 0 0 98. 00 0. 000000 0 0 0 98. 00 0. 000000 0 0 0 98. 00 0. 000000 0 0 0 98. 00 0. 000000 0 0 0 0. 000000 0							
91. 00 09100 EMERGENCY 0. 097299 522, 068 50, 797 91. 00 91. 01 04950 WOUND CARE 0. 000000 0 0 91. 01 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) 0. 632438 0 0 0 92. 00 000000 0 0 0 0 0 0				1			1
91. 01						_	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0. 632438 0 0 0 92. 00				1			
OTHER REI MBURSABLE COST CENTERS O. 000000 O 94. 00							1
94. 00 09400 HOME PROGRAM DIALYSIS 0.000000 0 94. 00 95. 00 95. 00 96. 00 96. 00 96. 00 96. 00 97. 00 9				0.03243	0	0	72.00
95. 00 99500 AMBULANCE SERVICES 95. 00 99600 DURABLE MEDICAL EQUIP-RENTED 0.0000000 0 96. 00 97. 00 98. 00 9850 OTHER REIMBURSABLE COST CENTERS 0.0000000 0 98. 00 201. 00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 95. 00 95. 00 96. 00 97. 00 0.000000 0 97. 00 98. 00 98. 00 0.000000 0 98. 00 0.000000 0 98. 00 0.000000 0 98. 00 0.000000 0 98. 00 0.000000 0 98. 00 0.000000 0 98. 00 0.000000 0 0.000000 0 0.000000 0				0 00000	0	0	94 00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0.000000 0 96. 00 97. 00 97. 00 98. 00 09850 OTHER REIMBURSABLE COST CENTERS 0.000000 0 98. 00 98. 00 201. 00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 0.000000 0 0 96. 00 97. 00 0.000000 0 0 97. 00 98. 00 0.000000 0 0 98. 00 0.000000 0 0 0.000000 0				0.0000		Ĭ	
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD 0.000000 0 97. 00 98. 00 98. 00 0000000 0 98. 00 98. 00 0000000 0 98. 00 98. 00 0000000 0 98. 00 98. 00 00000000 0 0 0 0 0 0				0.00000	0	0	
98. 00 09850 OTHER REIMBURSABLE COST CENTERS 0.000000 0 98. 00 200. 00 201. 00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0.000000 0 2, 398, 943 566, 719 200. 00 201. 00 20	1					•	1
200.00 Total (sum of lines 50 through 94 and 96 through 98) 2, 398, 943 566, 719 200.00 201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.00	1			1		0	1
201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.00	1	Total (sum of lines 50 through 94 and 96 through 98)				566, 719	1
202.00 Net charges (line 200 minus line 201) 2,398,943 202.00		Less PBP Clinic Laboratory Services-Program only charges	(line 61)		0		
	202. 00	Net charges (line 200 minus line 201)			2, 398, 943		202. 00

Health Financial Systems	FRANCISCAN HEALTH CRAWFORDSVILLE	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0022	From 01/01/2022	Worksheet E Part A Date/Time Prepared: 5/30/2023 4:12 pm

	Title XVIII Hospita	al	5/30/2023 4: 1: PPS	z piii
			'	
	DADT A LADATIENT HOODITAL CERVICOSC HADED LODG		1. 00	
1. 00	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS 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		2, 712, 606	•
1. 02	instructions) DRG amounts other than outlier payments for discharges occurring on or after October 1 (see		890, 932	1. 02
1. 03	instructions) DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to Oc	tober	0	1. 03
1. 04	1 (see instructions) DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after		0	1. 04
2.00	October 1 (see instructions) Outlier payments for discharges. (see instructions)		0	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)		11, 266	ı
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)		0	2. 04
3.00	Managed Care Simulated Payments		0	
4. 00	Bed days available divided by number of days in the cost reporting period (see instructions) Indirect Medical Education Adjustment		25. 15	4. 00
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period enditor before 12/31/1996.(see instructions)	ng on	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 cal new programs in accordance with 42 CFR 413.79(e)	o for	0.00	1
6. 26	Rural track program FTE cap limitation adjustment after the cap-building window closed under §12 the CAA 2021 (see instructions)	7 of	0.00	6. 26
7. 00 7. 01	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If		0. 00 0. 00	7. 00 7. 01
7. 02	cost report straddles July 1, 2011 then see instructions. Adjustment (increase or decrease) to the hospital's rural track program FTE limitation(s) for ru		0. 00	7. 02
	track programs with a rural track for Medicare GME affiliated programs in accordance with 413.75 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
8. 01	1998), and 67 FR 50069 (August 1, 2002). The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the	cost	0. 00	8. 01
	report straddles July 1, 2011, see instructions.	COST		
8. 02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)		0.00	8. 02
8. 21	The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)	0.5	0.00	8. 21
9. 00 10. 00	Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus 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	OI	0.00	9. 00
11. 00	FTE count for residents in dental and podiatric programs.		0.00	1
12. 00	Current year allowable FTE (see instructions)			12. 00
13.00	Total allowable FTE count for the prior year.		0.00	13. 00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30,	1997,	0. 00	14. 00
15. 00	otherwise enter zero. Sum of lines 12 through 14 divided by 3.		0.00	15. 00
	Adjustment for residents in initial years of the program (see instructions)			16. 00
17. 00	Adjustment for residents displaced by program or hospital closure			17. 00
18. 00				18. 00
	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	1
	Prior year resident to bed ratio (see instructions) Enter the lesser of lines 19 or 20 (see instructions)		0. 000000 0. 000000	1
	IME payment adjustment (see instructions)		0.000000	1
22. 01	IME payment adjustment - Managed Care (see instructions)		0	22. 01
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA			
23. 00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 $(f)(1)(iv)(C)$.		0.00	
24. 00 25. 00	IME FTE Resident Count Over Cap (see instructions) If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see		0. 00 0. 00	1
26. 00	instructions) Resident to bed ratio (divide line 25 by line 4)		0. 000000	26. 00
	IME payments adjustment factor. (see instructions)		0. 000000	1
	IME add-on adjustment amount (see instructions)		0	•
28. 01 29. 00	IME add-on adjustment amount - Managed Care (see instructions) Total IME payment (sum of lines 22 and 28)		0	1
29. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	1
	Disproportionate Share Adjustment			
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		2. 79	1
31. 00 32. 00	Percentage of Medicaid patient days (see instructions) Sum of lines 30 and 31		9. 32 12. 11	1
33. 00	Allowable disproportionate share percentage (see instructions)		0.00	1
34. 00	Di sproporti onate share adjustment (see instructions)			34. 00

LCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0022	Peri od: From 01/01/2022	Worksheet E Part A	
			To 12/31/2022	Date/Time Prep 5/30/2023 4:1:	pare 2 pm
		Title XVIII	Hospi tal	PPS	
			Prior to 10/1 1.00	0n/After 10/1 2.00	
	Uncompensated Care Payment Adjustment		1.00	2.00	
. 00	Total uncompensated care amount (see instructions)		0	0	
. 01	Factor 3 (see instructions)		0. 000000000	0. 000000000	1
. 02	1 1 1	, enter zero on this line	9) 0	0	35.
. 03	(see instructions) Pro rata share of the hospital UCP, including supplemental U	CP (see instructions)	0	0	35.
. 00		or (see thisti detrons)	0	o .	36
	Additional payment for high percentage of ESRD beneficiary d	ischarges (lines 40 throu	igh 46)		
. 00	Total Medicare discharges (see instructions)		0		40
. 00	Total ESRD Medicare discharges (see instructions)		0		41
. 01	Total ESRD Medicare covered and paid discharges (see instruc		0		41
. 00	Divide line 41 by line 40 (if less than 10%, you do not qual Total Medicare ESRD inpatient days (see instructions)	iry for adjustment)	0.00		42
. 00	Ratio of average length of stay to one week (line 43 divided	by line 41 divided by 7	0. 000000		44
	days)	2,	0.00000		
. 00	Average weekly cost for dialysis treatments (see instruction		0.00		45
. 00		1. 01)	0		46
. 00	, , , , , , , , , , , , , , , , , , , ,		3, 614, 804		47
. 00	Hospital specific payments (to be completed by SCH and MDH, only. (see instructions)	smail rurai nospitais	3, 472, 434		48
	on y. (See That detrons)			Amount	
				1. 00	
. 00	Total payment for inpatient operating costs (see instruction			3, 614, 804	
. 00	Payment for inpatient program capital (from Wkst. L, Pt. I a Exception payment for inpatient program capital (Wkst. L, Pt			271, 946 0	
. 00	Direct graduate medical education payment (from Wkst. E-4, I	The state of the s		0	
. 00	Nursing and Allied Health Managed Care payment	,		0	53
. 00	Special add-on payments for new technologies			74, 225	
. 01	Islet isolation add-on payment	(0)		0	54
. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line	69)		0	55
. 01	Cellular therapy acquisition cost (see instructions) Cost of physicians' services in a teaching hospital (see int	ructions)		0	55 56
. 00	Routine service other pass through costs (from Wkst. D, Pt.	•	hrough 35).	0	
. 00	Ancillary service other pass through costs from Wkst. D, Pt.		,	0	1
. 00	Total (sum of amounts on lines 49 through 58)			3, 960, 975	59
. 00	Primary payer payments			0	60
. 00	Total amount payable for program beneficiaries (line 59 minu	s line 60)		3, 960, 975	
. 00	Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries			484, 968 1, 556	
. 00	Allowable bad debts (see instructions)			58, 197	
. 00	1			37, 828	
. 00	Allowable bad debts for dual eligible beneficiaries (see ins	tructions)		7, 592	
. 00				3, 512, 279	
. 00	Credits received from manufacturers for replaced devices for			0	
. 00	Outlier payments reconciliation (sum of lines 93, 95 and 96) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	. (FUL SUR See LINSTRUCTION	15)	0	
. 50	Rural Community Hospital Demonstration Project (§410A Demons	tration) adjustment (see	instructions)	0	70
. 75	N95 respirator payment adjustment amount (see instructions)	, , , , , , , , , , , , , , , , , , , ,	,	0	70
. 87	Demonstration payment adjustment amount before sequestration			0	70
. 88	SCH or MDH volume decrease adjustment (contractor use only)			0	
. 89	Pioneer ACO demonstration payment adjustment amount (see ins	tructions)			70
. 90	HSP bonus payment HVBP adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions)			0	
. 91 . 92	Bundled Model 1 discount amount (see instructions)			0	70
. 93	HVBP payment adjustment amount (see instructions)			0	70
. 94	HRR adjustment amount (see instructions)			0	
. , .				0	70

Health Financial Systems	FRANCISCAN HEALTH CRAWFORDSVIL	LE .	In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der (CCN: 15-0022	Peri od: From 01/01/2022 To 12/31/2022	Worksheet E Part A Date/Time Pre 5/30/2023 4:13	
	Ti tl	e XVIII	Hospi tal	PPS	
		FFY	(yyyy)	Amount	
			0	1. 00	
70.96 Low volume adjustment for federal fiscal	year (yyyy) (Enter in column 0		2022	654, 810	70. 96

					5/30/2023 4: 12	2 pm
		Title	XVIII	Hospi tal	PPS	
			FFY (уууу)	Amount	
)	1. 00	
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter in	n column 0	20	22	654, 810	70. 96
70.07	the corresponding federal year for the period prior to 10/1)		0.0	.00	00/ //7	70.07
70. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter in		20	22	206, 667	70. 97
70.00	the corresponding federal year for the period ending on or aft Low Volume Payment-3	.er 10/1)				70.00
70. 98 70. 99	,				0	70. 98 70. 99
70. 99	HAC adjustment amount (see instructions) Amount due provider (line 67 minus lines 68 plus/minus lines 6	o 8 70)			4, 373, 756	
71. 00	Sequestration adjustment (see instructions)	19 & 70)			55, 109	
71. 01	Demonstration adjustment (see First detrois) Demonstration payment adjustment amount after sequestration				33, 109	71. 01
71. 02	Sequestration adjustment-PARHM or CHART pass-throughs				U	71. 02
72. 00	Interim payments				4, 405, 528	
72. 01	Interim payments-PARHM or CHART				1, 100, 020	72. 01
73. 00	Tentative settlement (for contractor use only)				0	73. 00
73. 01	Tentative settlement-PARHM or CHART (for contractor use only)					73. 01
74. 00	Balance due provider/program (line 71 minus lines 71.01, 71.02				-86, 881	74. 00
	73)	.,,				
74. 01	Balance due provider/program-PARHM or CHART (see instructions)					74. 01
75.00	Protested amounts (nonallowable cost report items) in accordan	nce with			65, 185	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	of 2.03			0	90.00
	plus 2.04 (see instructions)					
91. 00	Capital outlier from Wkst. L, Pt. I, line 2				0	91. 00
92. 00	Operating outlier reconciliation adjustment amount (see instru				0	92. 00
93. 00	Capital outlier reconciliation adjustment amount (see instruct				0	93. 00
94. 00	The rate used to calculate the time value of money (see instru	ıctions)			0.00	94. 00
95. 00	Time value of money for operating expenses (see instructions)				0	95. 00
96. 00	Time value of money for capital related expenses (see instruct	ions)		5	0	96. 00
				Prior to 10/1		
	HCD Panua Paymant Amount			1. 00	2. 00	
100 00	HSP Bonus Payment Amount HSP bonus amount (see instructions)			0	0	100. 00
100.00	HVBP Adjustment for HSP Bonus Payment			U	U	100.00
404 00	INDE AUJUSTILIENT FOI HOF BONUS FAYINENT					
				1 0000000000	1 000000000	101 00
	HVBP adjustment factor (see instructions)	:)		1. 0000000000	1. 0000000000	
	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions	5)		1.0000000000		101. 00 102. 00
102. 00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions HRR Adjustment for HSP Bonus Payment	3)		0	0	102. 00
102. 00 103. 00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions)	,		1. 0000	1. 0000	102. 00 103. 00
102. 00 103. 00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions)		stment	0	1. 0000	102. 00
102.00 103.00 104.00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr	ation) Adjus		1. 0000	1.0000	102. 00 103. 00 104. 00
102.00 103.00 104.00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per	ation) Adjus		1. 0000	1.0000	102. 00 103. 00
102.00 103.00 104.00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr	ation) Adjus		1. 0000	1.0000	102. 00 103. 00 104. 00
102. 00 103. 00 104. 00 200. 00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no.	ration) Adjus iod under th		1. 0000	1.0000	102. 00 103. 00 104. 00
102. 00 103. 00 104. 00 200. 00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement	ration) Adjus iod under th		1. 0000	1.0000	102. 00 103. 00 104. 00 200. 00
102.00 103.00 104.00 200.00 201.00 202.00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line	ration) Adjus iod under th		1. 0000	1.0000	102. 00 103. 00 104. 00 200. 00
102.00 103.00 104.00 200.00 201.00 202.00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions)	ration) Adjustiod under the	he 21st	1.0000	1.0000	102. 00 103. 00 104. 00 200. 00 201. 00 202. 00
102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period)	ration) Adjustiod under the	he 21st	1.0000	1.0000	102. 00 103. 00 104. 00 200. 00 201. 00 202. 00
102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount	ration) Adjustiod under the	he 21st	1.0000	1.0000 0	102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00
102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204)	ration) Adjustiod under the	he 21st	1.0000	1.0000 0	102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00
102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205)	ration) Adjustiod under the	he 21st	1.0000	1.0000 0	102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00
102.00 103.00 104.00 200.00 201.00 202.00 203.00 204.00 205.00 206.00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement	ration) Adjus riod under tl e 49) first year d	he 21st	1.0000	0 1.0000 0	102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00
102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement	ration) Adjustion under the 49) first year of the cuctions)	he 21st	1.0000	1.0000 0	102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00
102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instr Medicare Part A inpatient service costs (from Wkst. E, Pt. A,	ration) Adjustion under the 49) first year of the cuctions)	he 21st	1.0000	1.0000 0	102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00
102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instr Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions)	ration) Adjustion under the 49) first year of the cuctions)	he 21st	1.0000	1.0000 0	102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00
102. 00 103. 00 104. 00 200. 00 201. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instr Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use	ration) Adjustion under the 49) first year of the cuctions)	he 21st	1.0000	1.0000 0	102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00
102. 00 103. 00 104. 00 200. 00 201. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instr Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions)	ration) Adjustion under the 49) first year of the cuctions)	he 21st	1.0000	1.0000 0	102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00
102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00 211. 00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement	first year of	he 21st	1.0000	0 1.0000 0	102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 205. 00 206. 00 207. 00 208. 00 209. 00 211. 00
102. 00 103. 00 104. 00 200. 00 201. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 210. 00 211. 00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement Total adjustment to Medicare Part A IPPS payments (from line 205)	first year of	he 21st	1.0000	1.0000 0	102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 211. 00 212. 00
102. 00 103. 00 104. 00 200. 00 201. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 210. 00 211. 00 212. 00 213. 00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement Total adjustment to Medicare Part A IPPS payments (from line 2 Low-volume adjustment (see instructions)	ration) Adjustion and adjustic and and adjustic and and adjustic and a	of the current	1.0000	1.0000 0	102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00 211. 00 212. 00 213. 00
102. 00 103. 00 104. 00 200. 00 201. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 210. 00 211. 00 212. 00 213. 00	HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement Total adjustment to Medicare Part A IPPS payments (from line 205)	ration) Adjustion and adjustic and and adjustic and and adjustic and a	of the current	1.0000	1.0000 0	102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 211. 00 212. 00

Health Financial Systems

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 15-0022

| In Lieu of Form CMS-2552-10 | Period: | Worksheet E | From 01/01/2022 | Part A Exhibit 4 | Date/Time Prepared: | 5/30/2023 4:12 pm

				Title	XVIII	Hospi tal	5/30/2023 4: 1. PPS	z piii
			Amounts (from	Pre/Post	Period Prior	Peri od	Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	On/After 10/01	through 4)	
1. 00	DRG amounts other than outlier	0 1, 00	1. 00	2. 00	3.00	4. 00	5. 00 0	1. 00
1.00	payments	1.00		J		0		1.00
1. 01	DRG amounts other than outlier payments for discharges	1. 01	2, 712, 606	0	2, 712, 606		2, 712, 606	1. 01
1. 02	occurring prior to October 1 DRG amounts other than outlier payments for discharges	1. 02	890, 932	0		890, 932	890, 932	1. 02
1. 03	occurring on or after October 1 DRG for Federal specific	1. 03	0	0	0		0	1. 03
	operating payment for Model 4 BPCI occurring prior to October 1							
1. 04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1. 04	0	0		0	0	1. 04
2. 00	Outlier payments for discharges (see instructions)	2. 00						2. 00
2. 01	Outlier payments for	2. 02	0	0	0	0	0	2. 01
2. 02	discharges for Model 4 BPCI Outlier payments for discharges occurring prior to October 1 (see instructions)	2. 03	11, 266	0	11, 266		11, 266	2. 02
2. 03	Outlier payments for discharges occurring on or after October 1 (see	2. 04	0	0		0	0	2. 03
3. 00	instructions) Operating outlier reconciliation	2. 01	0	0	0	0	0	3. 00
4. 00	Managed care simulated payments	3. 00	0	0	0	0	0	4. 00
5. 00	Amount from Worksheet E, Part	21.00	0. 000000	0. 000000	0. 000000	0. 000000		5. 00
3.00	A, line 21 (see instructions)	21.00	0.000000	0.000000	0.00000	0.00000		3.00
6.00	IME payment adjustment (see	22. 00	0	0	0	0	0	6. 00
6. 01	instructions) IME payment adjustment for managed care (see	22. 01	0	0	0	0	0	6. 01
	instructions)	L						
7. 00	Indirect Medical Education Adju IME payment adjustment factor	27.00	0. 000000	0.000000		0. 000000		7. 00
8. 00	(see instructions) IME adjustment (see	28.00	0. 000000	0. 000000	0.00000		0	8. 00
8. 01	instructions) IME payment adjustment add on	28. 01	0	0	0	0	0	8. 01
9. 00	for managed care (see instructions) Total IME payment (sum of	29. 00	0	0	0	0	0	9. 00
9. 01	lines 6 and 8) Total IME payment for managed	29. 01	0	0	0	0	0	9. 01
	care (sum of lines 6.01 and 8.01)							
10. 00	Di sproporti onate Share Adjustmo Allowable di sproporti onate	33. 00	0. 0000	0. 0000	0, 0000	0.0000		10. 00
	share percentage (see instructions)		0.0000	0.0000	0.0000	0.0000		
11.00	Disproportionate share adjustment (see instructions)	34.00	0	0	0	_	0	11. 00
11. 01	Uncompensated care payments Additional payment for high per	36.00	D heneficiary	0 di scharges	0	0	0	11. 01
12. 00	Total ESRD additional payment	46. 00	O	0	0	0	0	12. 00
	(see instructions)							
13. 00 14. 00	Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.)	47. 00 48. 00	3, 614, 804 0	0	2, 723, 872 0	890, 932 0	3, 614, 804 0	13. 00 14. 00
15. 00	(see instructions) Total payment for inpatient operating costs (see	49. 00	3, 614, 804	0	2, 723, 872	890, 932	3, 614, 804	15. 00
16. 00	<pre>instructions) Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)</pre>	50. 00	271, 946	0	205, 970	65, 976	271, 946	16. 00
		•	ı		•	1		

	SEGME GREGOLATION EXITED T			Trovider ex		From 01/01/2022 To 12/31/2022	Date/Time Pre 5/30/2023 4:1	pared:
					XVIII	Hospi tal	PPS	
		W/S E, Part A	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Peri od On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4. 00	5. 00	
17. 00	Special add-on payments for new technologies	54.00	74, 225	0	63, 06			17. 00
17. 01	Net organ aquisition cost							17. 01
17. 02		68.00	0	0		0 0	О	
18. 00	1 '''		О	0		0 0	0	18. 00
19. 00	SUBTOTAL			0	2, 992, 91	1 968, 064	3, 960, 975	19. 00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4. 00	5. 00	
20. 00	Capital DRG other than outlier	1.00	267, 457	0	201, 48	1 65, 976	267, 457	20.00
20. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	0	0		0 0	0	20. 01
21. 00	1	2. 00	4, 489	0	4, 48	9 0	4, 489	21. 00
21. 01	Model 4 BPCI Capital DRG outlier payments	2. 01	0	0		0	0	21. 01
22. 00	1 9	5. 00	0. 0000	0. 0000	0. 000	0. 0000		22. 00
23. 00	Indirect medical education adjustment (see instructions)	6. 00	0	0		0 0	0	23. 00
24. 00	Allowable disproportionate share percentage (see	10.00	0. 0000	0.0000	0. 000	0.0000		24. 00
25. 00	<pre>instructions) Disproportionate share adjustment (see instructions)</pre>	11.00	0	0		0 0	0	25. 00
26. 00		12. 00	271, 946	0	205, 97	0 65, 976	271, 946	26. 00
		W/S E, Part A	(Amounts to E,					
		line	Part A)					
		0	1. 00	2.00	3.00	4. 00	5. 00	
27. 00					0. 21878			27. 00
28. 00		70. 96			654, 81	0	654, 810	28. 00
	(transfer amount to Wkst. E, Pt. A, line)							
29. 00		70. 97				206, 667	206, 667	29. 00
	(transfer amount to Wkst. E, Pt. A, line)							
100 00	Transfor Low Volumo	I	V		I		I	1100 00

100. 00

100.00 Transfer low volume

adjustments to Wkst. E, Pt. A.

Provider CCN: 15-0022

Peri od:

From 01/01/2022

Part A Exhibit 5

Date/Time Prepared: 5/30/2023 4:12 pm 12/31/2022 Hospi tal Title XVIII Period to Total (cols. 2 Wkst. E, Pt. Amt. from Peri od on Wkst. E, Pt. 10/01 A. line after 10/01 and 3) A) 2.00 3. 00 0 4.00 1.00 1.00 DRG amounts other than outlier payments 1. 00 1. 00 DRG amounts other than outlier payments for 1.01 1.01 2, 712, 606 2, 712, 606 2, 712, 606 1.01 discharges occurring prior to October 1 1.02 DRG amounts other than outlier payments for 1.02 890. 932 890, 932 890. 932 1.02 discharges occurring on or after October 1 1.03 DRG for Federal specific operating payment 1.03 С 0 1.03 for Model 4 BPCI occurring prior to October DRG for Federal specific operating payment 1.04 1.04 0 1.04 for Model 4 BPCI occurring on or after October 1 2.00 Outlier payments for discharges (see 2.00 2.00 instructions) 2.01 Outlier payments for discharges for Model 4 2.02 O 2.01 **BPCI** 2 02 Outlier payments for discharges occurring 2 03 11, 266 11, 266 11, 266 2 02 prior to October 1 (see instructions) Outlier payments for discharges occurring on 2.03 2.04 0 2.03 or after October 1 (see instructions) 3.00 Operating outlier reconciliation 2.01 0 3.00 Managed care simulated payments 4.00 3.00 0 4.00 Indirect Medical Education Adjustment 5.00 Amount from Worksheet E, Part A, line 21 21.00 0.000000 0.000000 0.000000 5.00 (see instructions) IME payment adjustment (see instructions) 6.00 22.00 0 0 0 6.00 IME payment adjustment for managed care (see 0 6.01 22.01 0 0 6.01 instructions) Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 7.00 IME payment adjustment factor (see 27. 00 0.000000 0.000000 0.000000 7.00 instructions) 8 00 IME adjustment (see instructions) 28 00 8 00 0 0 0 0 8.01 IME payment adjustment add on for managed 28.01 0 0 8.01 care (see instructions) Total IME payment (sum of lines 6 and 8) 29.00 9.00 0 0 9.00 Total IME payment for managed care (sum of 9.01 29.01 C 0 9.01 lines 6.01 and 8.01) Disproportionate Share Adjustment 10.00 Allowable disproportionate share percentage 33.00 0.0000 0.0000 0.0000 10.00 (see instructions) 11.00 Disproportionate share adjustment (see 34.00 0 0 11.00 0 instructions) 11.01 Uncompensated care payments 36 00 0 0 11.01 Additional payment for high percentage of ESRD beneficiary discharges 12.00 Total ESRD additional payment (see 46. 00 12.00 instructions) 47.00 13 00 2, 723, 872 890, 932 Subtotal (see instructions) 3, 614, 804 3, 614, 804 13 00 14.00 Hospital specific payments (completed by SCH 48.00 14.00 and MDH, small rural hospitals only.) (see instructions) Total payment for inpatient operating costs 49.00 3, 614, 804 2, 723, 872 890, 932 3, 614, 804 15.00 15.00 (see instructions) 16.00 Payment for inpatient program capital (from 50 00 271.946 205 970 65.976 271, 946 16.00 Wkst. L, Pt. I, if applicable) 17.00 Special add-on payments for new technologies 54.00 74, 225 63,069 11, 156 74, 225 17.00 17.01 Net organ acquisition cost 17.01 Credits received from manufacturers for 68.00 17.02 17.02 0 0 0 replaced devices for applicable MS-DRGs 18.00 Capital outlier reconciliation adjustment 93.00 0 18.00 amount (see instructions) 3, 960, 975 19. 00 19.00 SUBTOTAL 2, 992, 911 968, 064

		ANCISCAN HEALTH				eu of Form CMS-	2552-10
HOSPI T	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5	Provider Co		Period: From 01/01/2022 To 12/31/2022	Date/Time Pre 5/30/2023 4:1	pared:
				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	267, 457	201, 48	1 65, 976	267, 457	20.00
20. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	0		0	0	20. 01
21.00	Capital DRG outlier payments	2. 00	4, 489	4, 48	9 0	4, 489	21.00
21. 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
23. 00	Indirect medical education adjustment (see instructions)	6. 00	0		0 0	0	23. 00
24. 00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.000	0.0000		24. 00
25. 00	Di sproporti onate share adjustment (see instructions)	11.00	0		0 0	0	25. 00
26. 00	Total prospective capital payments (see instructions)	12. 00	271, 946	205, 97	0 65, 976	271, 946	26. 00
		Wkst. E, Pt.	(Amt. from				
		A, line	Wkst. E, Pt.				
		0	1.00	2.00	3. 00	4. 00	
27. 00							27. 00
28.00	Low volume adjustment prior to October 1	70. 96	654, 810	654, 81	0	654, 810	28.00
29.00	Low volume adjustment on or after October 1	70. 97	206, 667		206, 667	206, 667	29.00
30.00	HVBP payment adjustment (see instructions)	70. 93	0		0	0	30.00
30. 01	HVBP payment adjustment for HSP bonus payment (see instructions)	70. 90	0		0 0	0	30. 01
31.00	HRR adjustment (see instructions)	70. 94	0		0 0	0	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 0	0	32. 00
	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100. 00

Health Financial Systems	FRANCISCAN HEALTH CRAWFORDSVILLE	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0022	Peri od: From 01/01/2022 To 12/31/2022	Worksheet E Part B Date/Time Prepared: 5/30/2023 4:12 pm

-	Title XVI	11	Hospi tal	5/30/2023 4: 1: PPS	2 pm
		11	поѕрі таі	PPS	
				1. 00	
1. 00	PART B - MEDICAL AND OTHER HEALTH SERVICES			0	1. 00
2.00	Medical and other services (see instructions) Medical and other services reimbursed under OPPS (see instructions)			5, 050, 984	2. 00
3.00	OPPS payments			3, 441, 501	3. 00
4.00	Outlier payment (see instructions)			28, 535	4.00
4. 01	Outlier reconciliation amount (see instructions)			0	4. 01
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0. 000	5. 00
6. 00 7. 00	Line 2 times line 5 Sum of lines 3, 4, and 4.01, divided by line 6			0 0. 00	6. 00 7. 00
8. 00	Transitional corridor payment (see instructions)			0.00	8. 00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, lir	ne 200		0	9. 00
10.00	Organ acqui si ti ons			0	10.00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			0	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges				
12. 00	Ancillary service charges			0	12. 00
13. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)			0	13. 00
14.00				0	14.00
	Customary charges			_	
15.00	Aggregate amount actually collected from patients liable for payment for serv			0	15.00
16. 00	Amounts that would have been realized from patients liable for payment for see had such payment been made in accordance with 42 CFR §413.13(e)	ervices o	n 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)			0	18.00
19. 00	Excess of customary charges over reasonable cost (complete only if line 18 ex	ceeds li	ne 11) (see	0	19. 00
00.00	instructions)		40) (00.00
20. 00	Excess of reasonable cost over customary charges (complete only if line 11 exinstructions)	ceeas II	ne 18) (see	0	20. 00
21. 00				0	21. 00
22. 00	g ,			0	22. 00
23. 00	Cost of physicians' services in a teaching hospital (see instructions)			0	23. 00
24. 00				3, 470, 036	24. 00
25. 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT Deductibles and coinsurance amounts (for CAH, see instructions)			0	25. 00
26. 00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, s	see instr	uctions)	674, 007	26. 00
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of			2, 796, 029	27. 00
	instructions)				
28. 00	Direct graduate medical education payments (from Wkst. E-4, line 50)			0	28. 00
29. 00 30. 00				0 2, 796, 029	29. 00 30. 00
31. 00	Subtotal (sum of lines 27 through 29) Primary payer payments			2, 796, 029	31. 00
32. 00	Subtotal (line 30 minus line 31)			2, 796, 029	32. 00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33. 00				0	33.00
34. 00 35. 00	· · · · · · · · · · · · · · · · · · ·			65, 994	34. 00 35. 00
36. 00	· · · · · · · · · · · · · · · · · · ·			42, 896 36, 781	
37. 00				2, 838, 925	
				0	38. 00
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39. 00
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)				39. 50
39. 75 39. 97	N95 respirator payment adjustment amount (see instructions) Demonstration payment adjustment amount before sequestration			0	39. 75 39. 97
39. 98	Partial or full credits received from manufacturers for replaced devices (see	instruc	tions)	0	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION			0	39. 99
40.00	Subtotal (see instructions)			2, 838, 925	40.00
40. 01	Sequestration adjustment (see instructions)			35, 770	40. 01
40. 02	Demonstration payment adjustment amount after sequestration			0	40. 02
40. 03 41. 00	Sequestration adjustment-PARHM or CHART pass-throughs Interim payments			2, 854, 230	40. 03 41. 00
41. 01	Interim payments Interim payments-PARHM or CHART			2, 034, 230	41. 01
42. 00	Tentative settlement (for contractors use only)			0	42. 00
42. 01	Tentative settlement-PARHM or CHART (for contractor use only)				42. 01
43.00	Balance due provider/program (see instructions)			-51, 075	
43. 01	Balance due provider/program-PARHM (see instructions)	. 15 7	chantor 1		43. 01
44. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub §115.2). ID-Z,	спартег Т,	0	44. 00
	TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0	90.00
91. 00	Outlier reconciliation adjustment amount (see instructions)			0	91.00
92.00				0.00	
93. 00 94. 00	Time Value of Money (see instructions) Total (sum of lines 91 and 93)			0	93. 00 94. 00
00	1 (. •	50

Health Financial Systems	FRANCISCAN HEALTH CR	AWFORDSVI LLE	In Lie	u of Form CMS	-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT			Peri od:	Worksheet E	
			From 01/01/2022		
			To 12/31/2022	Date/Time Pr	epared:
				5/30/2023 4:	12 pm
		Title XVIII	Hospi tal	PPS	
				1. 00	
MEDICARE PART B ANCILLARY COSTS					
200.00 Part B Combined Billed Days				-	0 200. 00

Health Financial Systems	FRANCISCAN HEALTH CRAWFORDSVILLE	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0022	Peri od: From 01/01/2022	Worksheet E Part B
	Component CCN: 15-S022	To 12/31/2022	Date/Time Prepared: 5/30/2023 4:12 pm
	Title XVIII	Subprovi der -	PPS

		litle XVIII	Subprovi der -	PPS	
				1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		l	1.00	
00	Medical and other services (see instructions)			40	
00	Medical and other services reimbursed under OPPS (see instructions)	tions)		193	
00	OPPS payments Outlier payment (see instructions)			77 0	3
01	Outlier reconciliation amount (see instructions)			0	
00	Enter the hospital specific payment to cost ratio (see instru-	ctions)		0. 000	5
00	Line 2 times line 5			0	6
00 00	Sum of lines 3, 4, and 4.01, divided by line 6 Transitional corridor payment (see instructions)			0.00	
00	Ancillary service other pass through costs from Wkst. D, Pt.	V. col. 13. line 200		0	9
00	Organ acqui si ti ons	,		0	10
00	Total cost (sum of lines 1 and 10) (see instructions)			40	11
	COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges				1
00	Ancillary service charges			140	12
00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, I	ne 69)		0	13
00	Total reasonable charges (sum of lines 12 and 13)			140	14
. 00	Customary charges Aggregate amount actually collected from patients liable for	payment for services on	a charge basis	0	l 1 15
. 00	Amounts that would have been realized from patients liable for	9	9	0	
	had such payment been made in accordance with 42 CFR §413.13(ŭ		
. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	1
. 00	Total customary charges (see instructions) Excess of customary charges over reasonable cost (complete on	v if line 18 exceeds li	ne 11) (see	140 100	
00	instructions)	y II IIIIC 10 CACCCUS II	110 11) (300	100	'
. 00	Excess of reasonable cost over customary charges (complete on	y if line 11 exceeds li	ne 18) (see	0	20
. 00	instructions) Lesser of cost or charges (see instructions)			40	21
. 00	Interns and residents (see instructions)			0	22
. 00	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	
00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			77	24
00	COMPUTATION OF REIMBURSEMENT SETTLEMENT Deductibles and coinsurance amounts (for CAH, see instructions)	2)		0	25
. 00	Deductibles and Coinsurance amounts relating to amount on line		ructions)	0	
. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26)	•	· · · · · · · · · · · · · · · · · · ·	117	27
00	instructions)	50)		0	20
. 00	Direct graduate medical education payments (from Wkst. E-4, I ESRD direct medical education costs (from Wkst. E-4, line 36)	ne 50)		0	
. 00	Subtotal (sum of lines 27 through 29)			117	
. 00	Primary payer payments			0	
. 00	Subtotal (line 30 minus line 31)	YEC)		117	32
. 00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE Composite rate ESRD (from Wkst. I-5, line 11)	ES)		0	33
	Allowable bad debts (see instructions)			0	34
00	Adjusted reimbursable bad debts (see instructions)			0	35
	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	
	Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R			117	37
. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
50	Pioneer ACO demonstration payment adjustment (see instructions	s)			39
75	N95 respirator payment adjustment amount (see instructions)			0	39
97 98	Demonstration payment adjustment amount before sequestration Partial or full credits received from manufacturers for replace	red devices (see instruc	rtions)	0	39
99	RECOVERY OF ACCELERATED DEPRECIATION	sed devices (see institue	, (1 0113)	0	39
00	Subtotal (see instructions)			117	
. 01	Sequestration adjustment (see instructions)			1	40
02 03	Demonstration payment adjustment amount after sequestration Sequestration adjustment-PARHM or CHART pass-throughs			0	40
00	Interim payments			104	
01	Interim payments-PARHM or CHART				41
00	Tentative settlement (for contractors use only)			0	
01 00	Tentative settlement-PARHM or CHART (for contractor use only) Balance due provider/program (see instructions)			12	42
. 00	Balance due provider/program (see instructions) Balance due provider/program-PARHM (see instructions)			12	43
00	Protested amounts (nonallowable cost report items) in accordar §115.2	nce with CMS Pub. 15-2,	chapter 1,	0	
00	TO BE COMPLETED BY CONTRACTOR				
. 00	Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions)			0	
. 00	The rate used to calculate the Time Value of Money			0. 00	
. 00	Time Value of Money (see instructions)			0.00	
. 00	Total (sum of lines 91 and 93)			0	94

Health Financial Systems	FRANCISCAN HEALTH CR	In Lie	u of Form CMS-	2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0022	Peri od:	Worksheet E	
			From 01/01/2022		
		Component CCN: 15-S022	To 12/31/2022	Date/Time Pre	epared:
		•		5/30/2023 4: 1	2 pm
		Title XVIII	Subprovi der -	PPS	
			I PF		
				1. 00	
MEDICARE PART B ANCILLARY COSTS					
200.00 Part B Combined Billed Days					200. 00

 Heal th
 Financial
 Systems
 FRANCISO

 ANALYSIS
 OF
 PAYMENTS
 TO
 PROVIDERS
 FOR
 SERVICES
 RENDERED
 Provider CCN: 15-0022

					5/30/2023 4: 12	2 pm
			XVIII	Hospi tal	PPS	
		Inpatien	t Part A	Part 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		4, 405, 52	8	2, 854, 230	1. 00
2.00	Interim payments payable on individual bills, either			0	0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER			0	0	3. 01
3.02				0	0	3. 02
3.03				0	0	3. 03
3.04				0	0	3.04
3.05				0	0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM			0	0	3.50
3.51				0	0	3. 51
3.52				0	0	3. 52
3.53				0	0	3. 53
3.54				0	l ol	3. 54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		4, 405, 52	8	2, 854, 230	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5.00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER			0	0	5. 01
5.02				0	0	5. 02
5.03				0	0	5. 03
	Provider to Program					
5. 50	TENTATI VE TO PROGRAM			0	0	5. 50
5. 51				0	0	5. 51
5. 52				0	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5. 99
	5. 50-5. 98)					
6. 00	Determined net settlement amount (balance due) based on					6. 00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER			0	0	6. 01
6. 02	SETTLEMENT TO PROGRAM		86, 88		51, 075	6. 02
7. 00	Total Medicare program liability (see instructions)		4, 318, 64		2, 803, 155	7. 00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
0.00	Nome of Contractor)	1. 00	2. 00	0.00
8. 00	Name of Contractor				1	8. 00

Component CCN: 15-S022

PPS

Title XVIII Subprovi der -

Inpatient Part A			11116	. AVIII	I PF	FF3	
1.00 Total Interim payments paid to provider 1.00 2.00 3.00 4.00 1.00			Inpatien	t Part A		t B	
1.00 Total Interim payments paid to provider 1.00 2.00 3.00 4.00 1.00			mm /dd /\\\\\\\	Amount	mm /dd /\\\\\\	Amount	
Total interim payments paid to provider							
InterIm payments payable on Individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero.	1 00	Total interim payments paid to provider	1.00				1 00
Submitted or to be Submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero 3.00 1 is separately each retroactive lump sum adjustment amount based on subsequent revision of the interin rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) 7 7 7 7 7 7 7 7 7				0			
write "NONE" or enter a zero 1.00 List separately each retroactive lump sum adjustment amount based on subsequent revision of the interin rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 2.01 ADJUSTMENTS TO PROVIDER 2.02 0 0 0 3.02 3.03 0 0 0 3.03 3.04 0 0 0 3.05 Provider to Program 2.51 0 0 0 3.55 2.51 0 0 0 3.55 2.51 0 0 0 3.55 3.53 0 0 0 3.55 3.53 0 0 0 3.55 3.53 0 0 0 3.55 3.54 0 0 0 0 3.55 3.55 0 0 0 0 3.55 3.56 0 0 0 3.55 3.57 0 0 0 0 3.55 3.58 0 0 0 0 3.55 3.59 0 0 0 3.55 3.59 0 0 0 3.55 3.50 0 0 0 0 3.55 3.50 0 0 0 0 3.55 3.50 0 0 0 0 3.55 3.50 0 0 0 0 3.55 3.50 0 0 0 0 3.55 3.50 0 0 0 0 3.55 3.50 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0							
List separately each retroactive lump sum adjustment amount based on subsequent revul sion of the interlin rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider		services rendered in the cost reporting period. If none,					
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)							
For the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)	3.00						3.00
Dayment. If none, write "NONE" or enter a zero. (1) Program to Provider							
Program to Provider							
ADJUSTMENTS TO PROVIDER							
3.02 3.03 3.04 3.05 3.04 3.05 3.04 3.05	3 ∩1			0		0	3 01
3.03 0		ADJUST MIENTS TO TROVIDER					
3.04 0 0 0 3.04 3.05 5.							
3.50 Provider to Program							
3. 50 ADJUSTMENTS TO PROGRAM 0 0 3. 50				0		0	3. 05
3.51 3.52 3.53 3.53 3.54 3.55		Provider to Program					
3.52 3.53 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.59 3.50-3.98) 3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 1,250,114 104 4.00 4.0	3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.53 3.54 3.54 3.54 3.54 3.54 3.54 3.54 3.54 3.54 3.54 3.55 3.573 3.573 3.59 3.50-3.98 3.50-							
3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 1,250,114 104 4.00 (transfer to Wisst. E or Wisst. E-3, line and column as appropriate) To BE COMPLETED BY CONTRACTOR				· -		-	
3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.05-3.98) 0 0 0 3.99							
3.50-3.98 Total Interim payments (sum of lines 1, 2, and 3.99) 1,250,114 104 4.00		Cultural (·			
1, 250, 114	3. 99	· ·		0		O O	3. 99
(transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR	4 00			1 250 114		104	4 00
appropriate TO BE COMPLETED BY CONTRACTOR	4.00			1, 250, 114		104	4.00
5.00 List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider							
desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider		TO BE COMPLETED BY CONTRACTOR					
Write "NONE" or enter a zero. (1) Program to Provider	5.00						5.00
Program to Provider							
TENTATI VE TO PROVIDER							
Solution Solution	F 01					0	F 01
Description		TENTATIVE TO PROVIDER					
Provider to Program						-	
TENTATI VE TO PROGRAM	5.05	Provider to Program		· · · · · ·		J	5. 05
Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.52 0	5. 50			0		0	5. 50
Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Subtotal (sum of lines 5.50-5.98) Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Subtotal (sum of lines 5.50-5.98) Subtotal (subtotal subtotal subto	5. 51			0		0	5. 51
5.50-5.98) Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor Number (Mo/Day/Yr) 0 1.00 2.00	5. 52			0		0	5. 52
6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00	5. 99			0		0	5. 99
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6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor Number (Mo/Day/Yr) 0 1.00 2.00	6.00	,					6. 00
6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) 1,249,295	/ 01			_		4.0	. 01
7.00 Total Medicare program liability (see instructions) 1,249,295 Contractor Number (Mo/Day/Yr) 0 1.00 2.00				010			
Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00							
Number (Mo/Day/Yr) 0 1.00 2.00	7.00	Total modical o program frability (see first detrois)		1, 27, 273			7.00
0 1.00 2.00							
8.00 Name of Contractor 8.00)	1. 00		
	8.00	Name of Contractor					8. 00

Heal th	Financial Systems FRANCISCAN HEALTH C	RAWFORDSVI LLE	In Lie	u of Form CMS-	2552-10
CALCUL	CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 15-0022 Period: W				
			From 01/01/2022 To 12/31/2022		
		Title XVIII	Hospi tal	PPS	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst.	S-3, Pt. I col. 15 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. line 2				3. 00
4.00	Total inpatient days (see instructions)				4. 00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5. 00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 l	ine 20			6. 00
7. 00	CAH only - The reasonable cost incurred for the purchase of cline 168	ertified HIT technology	Wkst. S-2, Pt. I		7. 00
8.00	Calculation of the HIT incentive payment (see instructions)				8. 00
9.00	Sequestration adjustment amount (see instructions)				9. 00
10.00					
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH	,			
30.00	Initial/interim HIT payment adjustment (see instructions)				30. 00
	Other Adjustment (specify)				31.00
22 00	On Delegand due provider (Line 9 (en line 10) minus line 20 and line 21) (ess instructions)				

32.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)

30. 00 31. 00 32. 00

Health Financial Systems	FRANCISCAN HEALTH CRAWFORDSVILLE	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0022	Peri od: From 01/01/2022	Worksheet E-3
	Component CCN: 15-S022		Date/Time Prepared: 5/30/2023 4:12 pm
	Title XVIII	Subprovi der -	PPS
		I PF	

Not IPF PPS cut Payments 2,0 3,0 Not IPF PPS ECT Payments 0,0 0,0 15, 2004. (see Instructions) 0,0 0,0 4,0 15, 2004. (see Instructions) 0,0			. I PF		
Next 11 - MEDICARE PART A SERUICES - IPF PS			-	1 00	
Net Federal IPP PPS Outlier PPS outl		PART II - MEDICARE PART A SERVICES - IPE PPS		1.00	
Net IPF PPS ECT Payments 0 3.00	1.00			1, 099, 397	1.00
1.00 1.00	2.00			257, 183	2. 00
15. 2004. (see Instructions) 4.01 Cap increases for the unset ghted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR 9412.442(d)(1)(1)(1)(f)(1) or (2) (see instructions) 6.00 New Teaching program adjustment. (see Instructions) 7.00 Current year's unwell ghted FTE count of 188 evolution gFTEs in the new program growth period of a "new teaching program" (see instructions) 7.00 Current year's unwell ghted FTE count for residents within the new program growth period of a "new teaching program" (see instructions) 8.00 Intern and resident count for IPP PPS modical education adjustment (see instructions) 9.00 Resembly 10 Certain and resident count for IPP PPS modical education adjustment (see instructions) 9.00 Resembly 10 Certain and resident count for IPP PPS modical education adjustment (see instructions) 9.00 Resembly 10 Certain and resident for the power of .5150 -1). 9.00 Resembly 10 Certain and FTE Count for residents within the new program growth period of a "new teaching program" (see instructions) 9.00 Resembly 10 Certain and resident for the power of .5150 -1). 9.00 Resembly 10 Certain and resident for the power of .5150 -1). 9.00 Resembly 10 Certain and Allied Health Managed Care payment (see instructions) 9.00 Resembly 10 Certain and Allied Health Managed Care payment (see instructions) 9.00 Resembly 10 Certain and Allied Health Managed Care payment (see instructions) 9.00 Resembly 10 Certain and Resembly 10 Certain	3.00	Net IPF PPS ECT Payments		0	3. 00
Cap Increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure. That would not be counted without a temporary cap adjustment under 42 CFR §412. 424(d)(1)(III)(F)(1) or (2) (see Instructions) 0.00 5.00	4.00		ore November	0.00	4. 00
program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR \$41.242(d)(1)(1)(1)(F)(1) or (2) (see instructions) New Teaching program adjustment. (see instructions) OUTCOUNTERING year's unweighted FTE count of 18R excluding FTEs in the new program growth period of a "new teaching program" (see instructions) OUTCOUNTERING year's unweighted FTE count for 18R excluding FTEs in the new program growth period of a "new teaching program" (see instructions) OUTCOUNTERING year's unweighted 18R FTE count for residents within the new program growth period of a "new teaching program" (see instructions) Intern and resident count for 1PPPS medical education adjustment (see instructions) OUTCOUNTERING Adjustment. (ill count for 1PPPS medical education adjustment (see instructions) OUTCOUNTERING Adjustment for 1 mild tip lied by line 9), raised to the power of .5150 -1). OUTCOUNTERING Adjustment for 1 mild tip lied by line 10). OUTCOUNTERING Adjustment for 1 mild tip lied by line 10). OUTCOUNTERING Adjustment for 1 mild tip lied by line 10). OUTCOUNTERING Adjustment for 1 mild tip lied by line 10). OUTCOUNTERING Adjustment for 1 mild tip lied by line 10). OUTCOUNTERING Adjustment for 1 mild tip lied by line 10). OUTCOUNTERING Adjustment for 1 mild tip lied by line 10). OUTCOUNTERING Adjustment for 1 mild tip lied by line 10). OUTCOUNTERING Adjustment for 1 mild tip lied by line 10). OUTCOUNTERING Adjustment for 1 mild tip lied by line 10). OUTCOUNTERING Adjustment for 1 mild tip lied by line 10). OUTCOUNTERING Adjustment for 1 mild tip lied by line 10). OUTCOUNTERING Adjustment for 1 mild tip lied be provided year in the 1 mild tip lied by line 10). OUTCOUNTERING Adjustment for 1 mild tip lied by line 10). OUTCOUNTERING Adjustment for 1 mild tip lied by line 10). OUTCOUNTERING Adjustment for 1 mild tip lied by line 10). OUTCOUNTERING Adjustment for 1 mild tip lied by line 10). OUTCOUNTERING Adjustment for 1 mild tip lied be provided year in the 10 mild tip lied					
CRR \$412, 424(d)(1)(ii)(F)(1) or (2) (see instructions)	4. 01			0. 00	4. 01
New Teaching program adjustment. (see instructions) 0.00 5.00 0.			nt under 42		
Courrent year"s unweighted FTE count of 1&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions) Current year"s unweighted 1&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions) 0.00 7.00	5 00			0.00	5.00
teaching program" (see instructions) 1. 00. Correct year's unweighted laR FTE count for residents within the new program growth period of a "new teaching program" (see instructions) 1. 01. 01. 01. 01. 01. 01. 01. 01. 02. 01. 02. 03. 03. 03. 03. 03. 03. 03. 03. 03. 03			iod of a "new		6.00
teaching program" (see instructions) 0.000 8.00 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000					
Interm and resident count for IPF PPS medical education adjustment (see instructions) 0.00 8, 90 0, 00 Verrage Daily Census (see instructions) 4, 657534 9, 00 0.	7.00		iod of a "new	0. 00	7. 00
Average Dail y Census (see Instructions)		teaching program" (see instuctions)			
Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1). 0.000000 10.00 11.00 11.00 12.00 Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11) 1, 356, 580 12.00 13.00	8.00				8. 00
11.00 Teaching Adjustment (line 1 multiplied by line 10). 2.01 3.00 3					9. 00
12.00 Adjusted A					
Nursing and Allied Health Managed Care payment (see instruction) 13, 00					
14. 00 Organ acquisition (DO NOT USE THIS LINE) 14. 00 15.					
15.00				U	
1. 356, 580 16. 00 17. 0				0	
Primary payer payments					
18.00 Subtotal (fine 16 less line 17). 1,356,580 18.00 52,832 19.00 20.0	17. 00				
20.00 Subtotal (line 18 minus line 19) 1, 303,748 20.00 38.511 21.00 22.00 22.00 23.00 23.00 23.00 24.00 24.00 24.00 25.	18. 00			1, 356, 580	
21.00 Coinsurance 38.511 21.00 22.00 Subtotal (line 20 minus line 21) 1,265,237 22.00 23.00 Aljowable bad debts (exclude bad debts for professional services) (see instructions) 0 23.00 23.00 Aljowable bad debts (see instructions) 0 24.00 25.00 Adjusted reimbursable bad debts (see instructions) 0 25.00 26.00 Subtotal (sum of lines 22 and 24) 1,265,237 26.00 27.00 Direct graduate medical education payments (see instructions) 0 28.00 27.00 Direct graduate medical education payments (see instructions) 0 28.00 00 Other pass through costs (see instructions) 0 28.00 00 Other pass through costs (see instructions) 0 28.00 00 Other pass through costs (see instructions) 0 29.00 00 00 Other pass through costs (see instructions) 0 29.00 00 00 00 00 00 00 00	19.00				
Subtotal (line 20 minus line 21)	20.00	Subtotal (line 18 minus line 19)		1, 303, 748	20.00
Allowable bad debts (exclude bad debts for professional services) (see instructions) 0 23. 00 Adjusted reimbursable bad debts (see instructions) 0 24. 00 Adjusted reimbursable bad debts (see instructions) 0 24. 00 Adjusted reimbursable bad debts (see instructions) 0 24. 00 Adjusted reimbursable bad debts (see instructions) 0 24. 00 Adjusted reimbursable bad debts (see instructions) 0 24. 00 Adjusted reimbursable bad debts (see instructions) 0 24. 00 Adjusted reimbursable bad debts (see instructions) 0 25. 00 Adjusted reimbursable bad debts (see instructions) 0 25. 00 Adjusted reimbursable bad debts (see instructions) 0 25. 00 Direct graduate medical education payments (see instructions) 0 27. 00 Direct graduate medical education payments (see instructions) 0 28. 00 Outlier payments reconciliation 0 29. 00 Outlier payments reconciliation 0 30. 07 Outlier payments (see instructions) 0 30. 07 Outlier payment adjustment amount before sequestration 0 30. 07 Outlier payment adjustment (see instructions) 1, 265, 237 Outlier payment adjustment (see instructions) 1, 265, 237 Outlier payments 1, 250, 114 Outlier reconciliation adjustment amount (see instructions) 0 Outlier payments 1, 250, 114 Outlier payments 1, 250, 114 Outlier payments 2, 257, 183 Outlier payments	21. 00				
24. 00 Adjusted reimbursable bad debts (see instructions) 0 24. 00 Allowable bad debts for dual eligible beneficiaries (see instructions) 0 25. 00 25. 00 27. 00 27. 00 28. 00 29. 00 28. 00 28. 00 28. 00 28. 00 28. 00 00 00 00 00 00 00 00					
Aliowable bad debts for dual eligible beneficiaries (see instructions) 0 25.00					
26. 00 Subtotal (sum of lines 22 and 24) 1, 265, 237 26. 00 27. 00 27. 00 27. 00 27. 00 27. 00 27. 00 27. 00 28. 0		, ,			
27. 00 Direct graduate medical education payments (see instructions) 0 27. 00 28. 00 Other pass through costs (see instructions) 0 28. 00 Other pass through costs (see instructions) 0 29. 00 Outlier payments reconciliation 0 29. 00 Outlier payments reconciliation 0 30. 00					
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29. 00 Outlier payments reconciliation Outlier payments (SEE INSTRUCTIONS) (SPECIFY) Outlier payments (SEE INSTRUCTIONS) (SPECIFY) Outlier payment adjustment amount before sequestration Outlier payment adjustment (see instructions) 1, 265, 237 1, 265, 237 1, 265, 237 1, 265, 237 1, 265, 237 1, 265, 237 1, 265, 237 1, 250, 211 32. 00 Interim payments Outlier payments Outlier payment (for contractor use only) Sequestration adjustment (for contractor use only) Outlier payments Outlier amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, Sequestration adjustment amount (see instructions) Outlier reconciliation adjustment amount (see instructions) Outlier reconciliation adjustment amount (see instructions) Time Value of Money (see instructions) Time Value of Money (see instructions) Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020. Outlier reconciliation adjustment amount period immediately preceding February 29, 2020. Outlier payments Outlier payments Outlier payment adjustment amount (see instructions) Outlier reconciliation adjustment amount (see instructions) Outlier payment sequestration Outlier reconciliation adjustment amoun					
30. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 30. 50 Pioneer ACO demonstration payment adjustment (see instructions) 30. 98 Recovery of accelerated depreciation. Demonstration payment adjustment amount before sequestration 30. 99 Total amount payable to the provider (see instructions) 31. 01 Sequestration adjustment (see instructions) 31. 02 Demonstration payment adjustment amount after sequestration 31. 01 Demonstration payment adjustment (see instructions) 31. 02 Demonstration payment adjustment amount after sequestration 31. 02 Demonstration payment adjustment amount after sequestration 32. 00 Interim payments 33. 00 Tentative settlement (for contractor use only) 34. 00 Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33) 35. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 31. 52 TO BE COMPLETED BY CONTRACTOR Original outlier amount from Worksheet E-3, Part II, line 2 Outlier reconciliation adjustment amount (see instructions) To Be covery of accelerated depreciation. O 30. 90 30. 90 31. 02 32. 00 33. 00 Total amount payable to the provider (see instructions) 1, 265, 237 1, 265, 237 31. 00 31. 00 31. 00 31. 00 31. 00 32. 00 33. 00 Tentative settlement (for contractor use only) 34. 00 35. 00 Salins O 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		, , , , , , , , , , , , , , , , , , , ,			
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52.00 The rate used to calculate the Time Value of Money Time Value of Money (see instructions) FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING BEFORE THE END OF THE COVID-19 PHE 99.00 Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020. 0.000000 99.00					51.00
FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING BEFORE THE END OF THE COVID-19 PHE 99.00 Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020. 0.000000 99.00	52.00			0.00	52.00
99.00 Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020. 0.000000 99.00	53.00				53. 00
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77. Or parediated readining Aujustiment ractor for the current year. (See Histractions)	99. 01	Calculated Teaching Adjustment Factor for the current year. (see instructions)		0. 000000	99. 01

Health Financial Systems	FRANCISCAN HEALTH CRAWFORDSVILL	In Lieu of Form CMS-2552-1		
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CC		From 01/01/2022 To 12/31/2022	Worksheet E-3 Part VII Date/Time Prepared: 5/30/2023 4:12 pm
	Ti +1	o VIV	Hospi tal	Cost

			12/31/2022	5/30/2023 4: 1:	2 pm
		Title XIX	Hospi tal	Cost	
			I npati ent	Outpati ent	
			1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SEF	RVICES FOR TITLES V OR XIX	SERVI CES		
	COMPUTATION OF NET COST OF COVERED SERVICES				
1. 00	Inpatient hospital/SNF/NF services		0		1. 00
2.00	Medical and other services			7, 400, 789	2. 00
3.00	Organ acquisition (certified transplant programs only)		0		3. 00
4.00	Subtotal (sum of lines 1, 2 and 3)		0	7, 400, 789	4. 00
5.00	Inpatient primary payer payments		0		5. 00
6.00	Outpatient primary payer payments		_	0	6. 00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		0	7, 400, 789	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
0.00	Reasonable Charges				0.00
8. 00 9. 00	Routine service charges Ancillary service charges		2, 398, 943	40 (22 27)	8. 00 9. 00
9. 00 10. 00	Organ acquisition charges, net of revenue		2, 398, 943	40, 633, 276	9. 00 10. 00
11. 00	Incentive from target amount computation		0		11. 00
12. 00	Total reasonable charges (sum of lines 8 through 11)		2, 398, 943	40, 633, 276	
12.00	CUSTOMARY CHARGES		2, 370, 743	40, 033, 270	12.00
13. 00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13. 00
13.00	basis	ser vices on a charge		O	13.00
14. 00	Amounts that would have been realized from patients liable for	payment for services on	0	0	14. 00
	a charge basis had such payment been made in accordance with				
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	- ()	0.000000	0.000000	15. 00
16.00	Total customary charges (see instructions)		2, 398, 943	40, 633, 276	16.00
17. 00	Excess of customary charges over reasonable cost (complete onl	y if line 16 exceeds	2, 398, 943	33, 232, 487	17.00
	line 4) (see instructions)				
18. 00	Excess of reasonable cost over customary charges (complete onl	y if line 4 exceeds line	0	0	18. 00
	16) (see instructions)				
	Interns and Residents (see instructions)		0	0	19. 00
20. 00	Cost of physicians' services in a teaching hospital (see instr		0	0	20. 00
21. 00	Cost of covered services (enter the lesser of line 4 or line		0	7, 400, 789	21. 00
22.00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be	completed for PPS provide		0	22.00
	Other than outlier payments		0	0	22. 00 23. 00
	Outlier payments		0	U	
	Program capital payments Capital exception payments (see instructions)		0		24. 00 25. 00
	Routine and Ancillary service other pass through costs		0	0	26. 00
27. 00	Subtotal (sum of lines 22 through 26)		0	0	27. 00
28. 00	Customary charges (title V or XIX PPS covered services only)		0	0	28. 00
29. 00	Titles V or XIX (sum of lines 21 and 27)		0	7, 400, 789	
27.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT		<u> </u>	7, 400, 707	27.00
30. 00	Excess of reasonable cost (from line 18)		0	0	30. 00
31. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6))	0	7, 400, 789	
	Deductibles	•	0	0	32. 00
33. 00	Coinsurance		0	0	33. 00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35. 00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		0	7, 400, 789	36.00
37.00	, , ,		0	0	37.00
38. 00	Subtotal (line 36 ± line 37)		0	7, 400, 789	38. 00
39. 00	Direct graduate medical education payments (from Wkst. E-4)		0		39. 00
40.00	Total amount payable to the provider (sum of lines 38 and 39)			7, 400, 789	
41.00	Interim payments		0	0	41. 00
42.00	Balance due provider/program (line 40 minus line 41)		0	7, 400, 789	
43.00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub 15-2,	0	0	43.00
	chapter 1, §115.2				

Health Financial Systems	FRANCISCAN HEALTH CRAWFORDSVILLE	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0022	Peri od: From 01/01/2022	Worksheet E-3 Part VII
	Component CCN: 15-S022	To 12/31/2022	Date/Time Prepared: 5/30/2023 4:12 pm
	Title XIX	Subprovi der -	Cost

		THE XIX	IPF	0031	
			Inpatient	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICE	S FOR TITLES V OR XIX	SERVI CES		
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		0		1. 00
2.00	Medical and other services			8, 845	2. 00
3.00	Organ acquisition (certified transplant programs only)		o		3. 00
4.00	Subtotal (sum of lines 1, 2 and 3)		0	8, 845	4.00
5.00	Inpatient primary payer payments		0		5. 00
6.00	Outpatient primary payer payments			0	6. 00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		0	8, 845	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable Charges				
8.00	Routine service charges		0		8. 00
9.00	Ancillary service charges		0	90, 909	9. 00
10.00	Organ acquisition charges, net of revenue		0		10. 00
11.00	Incentive from target amount computation		0		11. 00
12.00	Total reasonable charges (sum of lines 8 through 11)		0	90, 909	12. 00
	CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for ser	rvices on a charge	0	0	13.00
	basis				
14. 00	Amounts that would have been realized from patients liable for pay		0	0	14. 00
	a charge basis had such payment been made in accordance with 42 CF	FR §413.13(e)			
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0. 000000	
16. 00	Total customary charges (see instructions)		0	90, 909	16. 00
17. 00	Excess of customary charges over reasonable cost (complete only if	fline 16 exceeds	0	82, 064	17. 00
40.00	line 4) (see instructions)				40.00
18. 00	Excess of reasonable cost over customary charges (complete only if	Fline 4 exceeds line	0	0	18. 00
10.00	16) (see instructions)			0	10.00
19.00	Interns and Residents (see instructions)	ana)	0	0	19.00
20. 00 21. 00	Cost of physicians' services in a teaching hospital (see instructi	OIIS)	0	0 045	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16) PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be comp	aloted for DDS provide	1	8, 845	21.00
22. 00	Other than outlier payments	n'eteu foi PP3 provide	0	0	22. 00
23. 00	Outlier payments		0	0	23. 00
24. 00	Program capital payments		0	U	24. 00
	Capital exception payments (see instructions)		0		25. 00
26. 00	Routine and Ancillary service other pass through costs		0	0	26.00
27. 00	Subtotal (sum of lines 22 through 26)		0	0	27. 00
28. 00	Customary charges (title V or XIX PPS covered services only)		Ö	0	28.00
29. 00	Titles V or XIX (sum of lines 21 and 27)		o	8, 845	
27.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT		<u> </u>	0, 043	27.00
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	8, 845	
32. 00	Deducti bl es		o	0	32.00
33. 00	Coinsurance		o	0	33. 00
34. 00	Allowable bad debts (see instructions)		o	0	34.00
	Utilization review		0		35. 00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33))	o	8, 845	36. 00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		o	0	37. 00
38.00	Subtotal (line 36 ± line 37)		o	8, 845	38. 00
39.00	Direct graduate medical education payments (from Wkst. E-4)		o		39. 00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		o	8, 845	40. 00
41.00	Interim payments		o	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		o	8, 845	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance v	with CMS Pub 15-2,	0	0	43. 00
	chapter 1, §115.2				

Health Financial Systems FRANCISCAN HEALTH CRAWFORDSVILLE In Lieu			u of Form CMS-2	552-10	
OUTLI E	R RECONCILIATION AT TENTATIVE SETTLEMENT	Provider CCN: 15-0022	Peri od:	Worksheet E-5	
			From 01/01/2022 To 12/31/2022	Date/Time Prep 5/30/2023 4:12	
		Title XVIII		PPS	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR				
1.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or	sum of 2.03 plus 2.04 (see i	nstructions)	0	1.00
2.00	Capital outlier from Wkst. L, Pt. I, line 2			0	2.00
3.00	Operating outlier reconciliation adjustment amount (see	instructions)		0	3.00
4.00 Capital outlier reconciliation adjustment amount (see instructions)				0	4.00
5.00 The rate used to calculate the time value of money (see instructions)				0.00	5.00
6.00	Time value of money for operating expenses (see instruct	i ons)		0	6.00
7.00	Time value of money for capital related expenses (see in	nstructions)		0	7.00

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

Provider CCN: 15-0022

| Peri od: From 01/01/2022 | To 12/31/2022 | Worksheet G | Date/Time Prepared: | 5/30/2023 4:12 pm

oni y)				12/01/2022	5/30/2023 4: 1	2 pm
		General Fund	Speci fi c	Endowment Fund		
		1.00	Purpose Fund 2.00	3. 00	4. 00	
	CURRENT ASSETS	1				
1.00	Cash on hand in banks	22, 353, 150	l .	0	0	1
2.00	Temporary investments	0	C	-	0	
3. 00 4. 00	Notes recei vabl e Accounts recei vabl e	22, 210, 962	1	0	0	
5. 00	Other receivable	333, 735	l .	0	0	
6. 00	Allowances for uncollectible notes and accounts receivable	-16, 918, 483	l .	Ö	Ö	
7.00	Inventory	998, 510	c	0	0	7. 00
8.00	Prepaid expenses	277, 613	C	0	0	1
9.00	Other current assets	0	C	1	0	
10.00	Due from other funds	0	C	_	0	1
11. 00	Total current assets (sum of lines 1-10) FIXED ASSETS	29, 255, 487	<u> </u>	0	0	11. 00
12. 00	Land	970, 120		0	0	12. 00
13. 00	Land improvements	3, 753, 111			1	
14.00	Accumulated depreciation	0	c	0	0	14. 00
15. 00	Bui I di ngs	45, 922, 604	c	0	0	
16. 00	Accumulated depreciation	0	C	_	0	1
17. 00	Leasehold improvements	507, 654	C	0	0	
18. 00 19. 00	Accumulated depreciation Fixed equipment	0		0	0	1
20. 00	Accumulated depreciation			0	0	
21. 00	Automobiles and trucks	0		0	l ő	
22. 00	Accumulated depreciation	0	d	0	Ō	
23. 00	Major movable equipment	23, 451, 764	. c	0	0	23. 00
24. 00	Accumul ated depreciation	-41, 822, 414	- c	0	0	
25. 00	Mi nor equi pment depreci abl e	0	C	0	0	
26. 00	Accumulated depreciation	0	C	0	0	
27. 00	HIT designated Assets	0		0	0	
28. 00 29. 00	Accumulated depreciation Minor equipment-nondepreciable	0		ή		1
30. 00	Total fixed assets (sum of lines 12-29)	32, 782, 839	1	_		
00.00	OTHER ASSETS	02,702,007		,		00.00
31.00	Investments	0	C	0	0	31. 00
32.00	Deposits on Leases	0	C	0		
33. 00	Due from owners/officers	0	C	0	0	1
34. 00	Other assets	5, 478, 062	1	1	0	1
35. 00 36. 00	Total other assets (sum of lines 31-34)	5, 478, 062 67, 516, 388		1	0	1
30.00	Total assets (sum of lines 11, 30, and 35) CURRENT LIABILITIES	07, 310, 300	1) 0		30.00
37. 00	Accounts payable	1, 546, 994		0	0	37. 00
38. 00	Salaries, wages, and fees payable	1, 166, 491		0	0	
39.00	Payroll taxes payable	0	c	0	0	39. 00
40.00	Notes and Loans payable (short term)	0	C	0	0	
41. 00	Deferred income	0	C	0	0	
42. 00	Accel erated payments	400 500				42. 00
43. 00 44. 00	Due to other funds Other current liabilities	498, 598 557, 329			0	
45. 00	Total current liabilities (sum of lines 37 thru 44)	3, 769, 412	l .	1		
.0.00	LONG TERM LIABILITIES	0,707,112	·I ~	<u>, </u>		1 .0. 00
46.00	Mortgage payable	0	C	0	0	46. 00
47. 00	Notes payable	0	C	0	0	47. 00
48. 00	Unsecured Loans	0	C	-	1	
49. 00	Other long term liabilities	1, 445, 918	1	-		1
50. 00 51. 00	Total long term liabilities (sum of lines 46 thru 49) Total liabilities (sum of lines 45 and 50)	1, 445, 918 5, 215, 330				
51.00	CAPITAL ACCOUNTS	5, 215, 330	1	<u>, </u>	0	31.00
52. 00	General fund balance	62, 301, 058				52. 00
53.00	Specific purpose fund	, , , , , , , , , , , , , , , , , , , ,	c)		53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55. 00	Donor created - endowment fund balance - unrestricted			0		55. 00
56. 00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	
58. 00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58. 00
59. 00	Total fund balances (sum of lines 52 thru 58)	62, 301, 058		0	0	59. 00
60.00	Total liabilities and fund balances (sum of lines 51 and	67, 516, 388	l .	o o	ő	
	59)					

| Peri od: | Worksheet G-1 | From 01/01/2022 | To 12/31/2022 | Date/Time Prepared: Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES Provider CCN: 15-0022

					To 12/31/2022	Date/Time Pre 5/30/2023 4:1	pared: 2 pm
		General	Fund	Speci al	Purpose Fund	Endowment Fund	
		1.00	2. 00	3. 00	4. 00	5. 00	
1.00	Fund balances at beginning of period		61, 234, 252		0		1.00
2. 00 3. 00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2)		-776, 017 60, 458, 235		0		2. 00 3. 00
4.00	Additions (credit adjustments) (specify)	0	00, 456, 255		0	0	4. 00
5. 00	(5, 55, 5, 5, 5, 5, 5, 5, 5, 5, 5, 5, 5,	O			0	Ō	5. 00
6.00		0			0	0	6. 00
7.00		0			0	0	7. 00
8. 00 9. 00		0			0	0	8. 00 9. 00
10. 00	Total additions (sum of line 4-9)		0		0	· -	10.00
11. 00	Subtotal (line 3 plus line 10)		60, 458, 235		0		11. 00
12. 00	Deductions (debit adjustments) (specify)	0			0	0	12. 00
13.00		0			0	0	13.00
14. 00 15. 00		0			0	0	14. 00 15. 00
16. 00					0	0	16. 00
17. 00		0			0	0	17. 00
18. 00	Total deductions (sum of lines 12-17)		0		0	l .	18. 00
19. 00	Fund balance at end of period per balance sheet (line 11 minus line 18)		60, 458, 235		0		19. 00
	Sheet (Title II iiii lius II lie 10)	Endowment Fund	PI ant	Fund			
1.00	TE 111	6.00	7. 00	8. 00			4.00
1. 00 2. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29)	0			0		1. 00 2. 00
3.00	Total (sum of line 1 and line 2)	0			0		3.00
4.00	Additions (credit adjustments) (specify)		0				4. 00
5.00			0				5. 00
6. 00 7. 00			0				6. 00 7. 00
8. 00			0				8. 00
9.00			0				9. 00
10. 00	Total additions (sum of line 4-9)	0			0		10. 00
11. 00	Subtotal (line 3 plus line 10)	0	0		0		11. 00 12. 00
12. 00 13. 00	Deductions (debit adjustments) (specify)		0				12.00
14. 00			0				14. 00
15. 00			0				15. 00
16.00			0				16. 00
17. 00 18. 00	Total deductions (sum of lines 12-17)		0		0		17. 00 18. 00
19. 00	Fund balance at end of period per balance				0		19. 00
	sheet (line 11 minus line 18)						

Health Financial Systems FRANG STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provi der CCN: 15-0022

			0 12/31/2022	5/30/2023 4:1	
	Cost Center Description	Inpatient	Outpati ent	Total	<u> </u>
	· · · · · · · · · · · · · · · · · · ·	1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES	<u> </u>			
	General Inpatient Routine Services				
1.00	Hospi tal	6, 994, 307	'	6, 994, 307	1.00
2.00	SUBPROVI DER - I PF	4, 085, 188	3	4, 085, 188	2. 00
3.00	SUBPROVI DER - I RF			0	3. 00
4.00	SUBPROVI DER				4. 00
5.00	Swing bed - SNF			0	5. 00
6.00	Swing bed - NF			0	6. 00
7.00	SKILLED NURSING FACILITY			0	7. 00
8.00	NURSING FACILITY			0	8.00
9.00	OTHER LONG TERM CARE			0	9. 00
10.00	Total general inpatient care services (sum of lines 1-9)	11, 079, 495	5	11, 079, 495	10.00
	Intensive Care Type Inpatient Hospital Services	<u> </u>	•		
11.00	INTENSIVE CARE UNIT	4, 280, 744		4, 280, 744	11. 00
12.00	CORONARY CARE UNIT			0	12.00
13.00	BURN INTENSIVE CARE UNIT			0	13.00
14.00	SURGI CAL INTENSIVE CARE UNIT			0	14. 00
15. 00					15. 00
16.00	Total intensive care type inpatient hospital services (sum of lines	4, 280, 744		4, 280, 744	16. 00
	11-15)				
17.00	Total inpatient routine care services (sum of lines 10 and 16)	15, 360, 239		15, 360, 239	17. 00
18.00	Ancillary services	19, 744, 345	109, 115, 584	128, 859, 929	18. 00
19.00	Outpati ent servi ces	4, 866, 729	55, 189, 105	60, 055, 834	19. 00
20.00	RURAL HEALTH CLINIC		0	0	20.00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	21. 00
22. 00	HOME HEALTH AGENCY		0	0	22. 00
23. 00	AMBULANCE SERVICES		0	0	23. 00
24.00	CMHC		0	0	24. 00
24. 10	CORF		0	0	24. 10
25. 00	AMBULATORY SURGICAL CENTER (D. P.)		0	0	25. 00
26. 00	HOSPI CE		0	0	26. 00
27. 00	NON REIMBURSABLE		2, 752, 515	2, 752, 515	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst	. 39, 971, 313	167, 057, 204	207, 028, 517	28. 00
	G-3, line 1)				
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		52, 807, 755		29. 00
30.00	ADD (SPECIFY)				30.00
31.00					31.00
32.00					32.00
33.00					33. 00
34.00					34.00
35.00					35. 00
36.00	Total additions (sum of lines 30-35)		0		36. 00
37.00	DEDUCT (SPECIFY)				37. 00
38. 00					38. 00
39. 00)		39. 00
40.00					40. 00
41.00)		41. 00
42.00	Total deductions (sum of lines 37-41)		0		42. 00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(trans	fer	52, 807, 755		43.00
	to Wkst. G-3, line 4)				

	Health Financial Systems FRANCISCAN HEALTH CRAWFORDSVILLE In Lie STATEMENT OF REVENUES AND EXPENSES Provider CCN: 15-0022 Period:			u of Form CMS-2 Worksheet G-3	
STATE	LETT OF REVENUES AND EXPENUES	11001461 0011. 10 0022	From 01/01/2022		
			To 12/31/2022	Date/Time Prep 5/30/2023 4:1:	
		<u> </u>	'		,
				1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, li			207, 028, 517	1.00
2.00	Less contractual allowances and discounts on patients' accounts	nts		155, 691, 789	
3.00	Net patient revenues (line 1 minus line 2)			51, 336, 728	3. 00
4.00	0 Less total operating expenses (from Wkst. G-2, Part II, line 43)			52, 807, 755	
5.00	00 Net income from service to patients (line 3 minus line 4)			-1, 471, 027	5. 00
	OTHER INCOME				
6.00	Contributions, donations, bequests, etc			29, 351	
7.00				0	7. 00
8.00				0	8. 00
9.00				0	9. 00
10.00	Purchase di scounts			0	10.00
11. 00	Rebates and refunds of expenses			167, 883	
12.00	Parking lot receipts			0	12. 00
13.00	Revenue from Laundry and Linen service			0	
14. 00	Revenue from meals sold to employees and guests			145, 418	
15. 00	Revenue from rental of living quarters			0	15. 00
				0	
	Revenue from sale of drugs to other than patients			0	
18. 00	Revenue from sale of medical records and abstracts				18. 00
				0	
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	
21. 00	Rental of vending machines				21. 00
22. 00	Rental of hospital space				22. 00
23.00	Governmental appropriations			281, 850	
24. 00	PREMI UM REVENUE			55, 042	
24. 50	COVI D-19 PHE Fundi ng			0	24. 50
25. 00	Total other income (sum of lines 6-24)			695, 010	
	Total (line 5 plus line 25)			-776, 017	
27.00	7.00 OTHER EXPENSES			0	27.00

27.00 OTHER EXPENSES
28.00 Total other expenses (sum of line 27 and subscripts)
29.00 Net income (or loss) for the period (line 26 minus line 28)

0 27. 00 0 28. 00 -776, 017 29. 00

	FDANOL COAN LIFALTIL O	ND AWEODDON ALLE		6.5 000.6	2550 40
Heal th Financial Systems FRANCISCAN HEALTH CR CALCULATION OF CAPITAL PAYMENT		Provider CCN: 15-0022	Peri od: From 01/01/2022 To 12/31/2022		
		Title XVIII	Hospi tal	PPS	2 piii
				1. 00	
	PART I - FULLY PROSPECTIVE METHOD				
	CAPITAL FEDERAL AMOUNT				
1. 00	Capital DRG other than outlier			267, 457	1. 00
1. 01	Model 4 BPCI Capital DRG other than outlier			0	1. 01
2.00	Capital DRG outlier payments			4, 489	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 instructions)			10. 41	3. 00
4. 00 5. 00	Number of interns & residents (see instructions)			0. 00 0. 00	4. 00 5. 00
6. 00	Indirect medical education percentage (see instructions)			0.00	6. 00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01) (see instructions)			١	0.00
7. 00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)			0. 00	7. 00
8.00	Percentage of Medical d patient days to total days (see instructions)			0.00	8. 00
9. 00	Sum of lines 7 and 8			0.00	9. 00
10.00	Allowable disproportionate share percentage (see instructions)				10.00
11. 00	Disproportionate share adjustment (see instructions)			0	11. 00
12.00					12.00
				1 00	
	PART II - PAYMENT UNDER REASONABLE COST	1. 00			
1. 00	Program inpatient routine capital cost (see instructions)			0	1. 00
2. 00	Program inpatient ancillary capital cost (see instructions)			ő	2. 00
3. 00				ol	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)				5. 00
	PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)			0	1. 00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2. 00	
3.00	Net program inpatient capital costs (line 1 minus line 2)			0	3. 00
4. 00	Applicable exception percentage (see instructions)			0.00	4. 00
5. 00	Capital cost for comparison to payments (line 3 x line 4)				5. 00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)			0.00	6. 00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)			0	7. 00
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 applicable)			0	9.00
10.00				0	10.00
11 00	Carryover of accumulated conital minimum novement lavel aver a				11. 00
11. 00		capitai payment (Trom pri	oi yeai	ا	
11. 00 12. 00	Carryover of accumulated capital minimum payment level over of Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital pa		,	0	12. 00
	Worksheet L, Part III, line 14)	ayments (line 10 plus lir	ne 11)		
12. 00	Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital pa	ayments (line 10 plus lir the amount on this line	ne 11)	0	12. 00

0 15.00 0 16.00 0 17.00

(if line 12 is negative, enter the amount on this line)

15.00 Current year allowable operating and capital payment (see instructions)

16.00 Current year operating and capital costs (see instructions)

17.00 Current year exception offset amount (see instructions)