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: 15-0109 Worksheet S Peri od: From 01/01/2023 Parts I-III AND SETTLEMENT SUMMARY 12/31/2023 Date/Time Prepared: 3/28/2024 12:04 pm PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 3/28/2024 Time: 12:04 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 (3) Settled with Audit number of times reopened = 0-9.

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

(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 LAFAYETTE (15-0109) for the cost reporting period beginning 01/01/2023 and ending 12/31/2023 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

	·		Title	XVIII			
		Title V	Part A	Part B	HIT	Title XIX	
		1. 00	2.00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPI TAL	0	233, 098	30, 663	0	-8, 598	1.00
2.00	SUBPROVIDER - IPF	0	0	0		0	2.00
3.00	SUBPROVIDER - IRF	0	-77, 833	0		0	3. 00
5.00	SWING BED - SNF	0	0	0		0	5. 00
6.00	SWING BED - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	-2		0	9. 00
200.00	TOTAL	0	155, 265	30, 661	0	-8, 598	200. 00
The al	nove amounts represent "due to" or "due from"	the applicable	program for th	a alament of t	he above comply	av indicated	

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The number for this information collection is OMB 0938-0050 and the number for the Supplement to Form CMS 2552-10, Worksheet N95, is OMB 0938-1425. The time required to complete and review the information collection is estimated 675 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

151563

29200

FRNACISCAN HEALTH

LAFAYETTE HOSPICE

13.00

14.00

01/01/1984

16. 00 17. 00 18. 00 19. 00			From: 1.00	To: 2.00	15. 00 16. 00 17. 00 18. 00 19. 00
	Cost Reporting Period (mm/dd/yyyy) Type of Control (see instructions)		01/01/2023	12/31/2023	20. 00
		1. 00	2. 00	3.00	-
	Inpatient PPS Information				
22. 00	Does this facility qualify and is it currently receiving payments fo disproportionate share hospital adjustment, in accordance with 42 CF \$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.		N		22. 00
22. 01	Did this hospital receive interim UCPs, including supplemental UCPs, this cost reporting period? Enter in column 1, "Y" for yes or "N" for the portion of the cost reporting period occurring prior to Octo 1. Enter in column 2, "Y" for yes or "N" for no for the portion of t cost reporting period occurring on or after October 1. (see instructions)	r no ber	Y		22. 01
22. 02	Is this a newly merged hospital that requires a final UCP to be determined at cost report settlement? (see instructions) Enter in co 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 for the portion of the cost reporting period on or after October 1.		N		22. 02
22. 03	Did this hospital receive a geographic reclassification from urban trural as a result of the OMB standards for delineating statistical a adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for for the portion of the cost reporting period prior to October 1. Ent 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 (counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" fyes or "N" for no.	reas no er as	N	Y	22. 03
22. 04	Did this hospital receive a geographic reclassification from urban trural as a result of the revised OMB delineations for statistical ar adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for the portion of the cost reporting period prior to October 1. Ent 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 (counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" yes or "N" for no.	eas no er as			22. 04
23. 00	Which method is used to determine Medicaid days on lines 24 and/or 2 below? In column 1, enter 1 if date of admission, 2 if census days, if date of discharge. Is the method of identifying the days in this reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	or 3	3 N		23. 00

13.00

Separately Certified ASC

14.00 Hospi tal -Based Hospi ce

complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4. If line 56 is yes, did this facility elect cost reimbursement for physicians' services as

defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.

Ν

58.00

	program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0. 33	0. 33	01. 20		
					1.00			
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)							
62.00	2.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which 0.00							
	your hospital received HRSA PCRE funding (see instruc	ctions)						
62. 01	Enter the number of FTE residents that rotated from a	a Teaching Health Cent	er (THC) into	your hospital	0. 00	62. 01		
	during in this cost reporting period of HRSA THC proc	gram. (see instruction	ns)					
	Teaching Hospitals that Claim Residents in Nonprovide	er Settings						
63.00	Has your facility trained residents in nonprovider se	ettings during this co	st reporting p	eriod? Enter	N	63.00		
	"Y" for yes or "N" for no in column 1. If yes, comple	ete lines 64 through 6	7. (see instru	ctions)				

Health Financial Systems	FRANCI SC	AN HEALTH LAFAYETTE		In Lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPI	LEX IDENTIFICATION DA	TA Provider CO		riod: com 01/01/2023 12/31/2023	Worksheet S-2 Part I Date/Time Prep 3/28/2024 12:0	pared:
			Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			1. 00	2. 00	3.00	
Section 5504 of the ACA Base Yea			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 ro settings. Enter in column 2 the resident FTEs that trained in yo 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 d non-primary care n column 3 the ratio	0.00	0. 00	0. 000000	64. 00
	Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col. 3/	
			FTEs Nonprovi der Si te	FTEs in Hospital	(col. 3 + col. 4))	
	1. 00	2. 00	3. 00	4. 00	5. 00	
is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00		65. 00
			Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			1. 00	2. 00	3.00	
Section 5504 of the ACA Current		n Nonprovider Setting	sEffective fo	r cost reporti	ng peri ods	
beginning on or after July 1, 20 66.00 Enter in column 1 the number of FTEs attributable to rotations o 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	rovider settings. Ty care resident B the ratio of	0.00	0. 00		66. 00
	Program Name	Program Code	Unwei ghted FTEs		Ratio (col. 3/	
			Nonprovi der Si te	FTEs in Hospital	(col. 3 + col. 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		67. 00

	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCM		eriod: rom 01/01/2 o 12/31/2		Workshe Part I Date/Ti 3/28/20	me Pre	pared:
					1. 0	0	
68. 00	Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-490 For a cost reporting period beginning prior to October 1, 2022, did you obtom MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Final (August 10, 2022)?	tain permissio	n from your				68. 00
				1. 00	2. 00	3.00	
70 00	Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contains	in an IPE subn	rovi der2	N			70. 00
	Enter "Y" for yes or "N" for no. If line 70 is yes: Column 1: Did the facility have an approved GME teaching recent cost report filed on or before November 15, 2004? Enter "Y" for yes 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents i program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes Column 3: If column 2 is Y, indicate which program year began during this c (see instructions)	g program in t s or "N" for n in a new teach s or "N" for n	the most no. (see ni ng no.	IV		0	71. 00
75 00	Inpatient Rehabilitation Facility PPS Is this facility an Inpatient Rehabilitation Facility (IRF), or does it cor	ntain an IRF		Y	T 1		75. 00
	subprovider? Enter "Y" for yes and "N" for no. If line 75 is yes: Column 1: Did the facility have an approved GME teaching recent cost reporting period ending on or before November 15, 2004? Enter "no. Column 2: Did this facility train residents in a new teaching program i CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If or	g program in t "Y" for yes or in accordance column 2 is Y,	"N" for with 42	N	N	0	76. 00
	indicate which program year began during this cost reporting period. (see i	instructions)					
	Long Term Care Hospi tal PPS				1.0	0	
	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no is this a LTCH co-located within another hospital for part or all of the compart of yes and "N" for no. TEFRA Providers		period? Ent	ter	N N		80. 00 81. 00
86. 00	.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no00 Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.						85. 00 86. 00
87. 00	Is this hospital an extended neoplastic disease care hospital classified ur 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	nder section			N		87. 00
			Approved 1 Permanen Adjustmer (Y/N)	nt	Number Appro Permar Adjustn	ved nent ments	
88. 00	Column 1: Is this hospital approved for a permanent adjustment to the TEFR/amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col 89. (see instructions) Column 2: Enter the number of approved permanent adjustments.		1. 00 N		2.0		88. 00
		Wkst. A Line No.		Date	Appro Permar Adjust Amount Discha	nent ment Per arge	
89. 00	Column 1: If line 88, column 1 is Y, enter the Worksheet A line number on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge. Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge.	1.00	2.00		3.0		89. 00
	in target amount per urscharge.		V		XI >		
	Title V and XIX Services		1. 00		2.0	U	
00 00	Does this facility have title V and/or XIX inpatient hospital services? Entyes or "N" for no in the applicable column.	ter "Y" for	N		Υ		90. 00
90. 00	.00 Is this hospital reimbursed for title V and/or XIX through the cost report either in N						91. 00
91. 00	full or in part? Enter "Y" for yes or "N" for no in the applicable column. Are title XIX NF patients occupying title XVIII SNF beds (dual certification	on)? (see			N		92. 00
91. 00 92. 00	full or in part? Enter "Y" for yes or "N" for no in the applicable column. Are title XIX NF patients occupying title XVIII SNF beds (dual certification instructions) Enter "Y" for yes or "N" for no in the applicable column. Does this facility operate an ICF/IID facility for purposes of title V and		N		N N		92. 00 93. 00
91. 00 92. 00 93. 00	full or in part? Enter "Y" for yes or "N" for no in the applicable column. Are title XIX NF patients occupying title XVIII SNF beds (dual certification instructions) Enter "Y" for yes or "N" for no in the applicable column. Does this facility operate an ICF/IID facility for purposes of title V and "Y" for yes or "N" for no in the applicable column. Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no	XIX? Enter	N N				
91. 00 92. 00 93. 00 94. 00 95. 00	full or in part? Enter "Y" for yes or "N" for no in the applicable column. Are title XIX NF patients occupying title XVIII SNF beds (dual certification instructions) Enter "Y" for yes or "N" for no in the applicable column. Does this facility operate an ICF/IID facility for purposes of title V and "Y" for yes or "N" for no in the applicable column.	XIX? Enter			N	0	93. 00

Health Financial Systems FRANCISCAN HEA				u of Form CMS		
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider Co		Period: From 01/01/2023 To 12/31/2023	Worksheet S Part I Date/Time P 3/28/2024 1	repared:	
	<u> </u>	<u> </u>	V	XI X		
98.00 Does title V or XIX follow Medicare (title XVIII) for the i	nterns and res	idents nost	1. 00 Y	2. 00 Y	98. 00	
stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" column 1 for title V, and in column 2 for title XIX.	for yes or "N"	for no in				
98.01 Does title V or XIX follow Medicare (title XVIII) for the r C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for t title XIX.			Y	Y	98. 01	
98.02 Does title V or XIX follow Medicare (title XVIII) for the closed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes for title V, and in column 2 for title XIX.			Y	Y	98. 02	
98.03 Does title V or XIX follow Medicare (title XVIII) for a cri reimbursed 101% of inpatient services cost? Enter "Y" for y for title V, and in column 2 for title XIX.			N I	N	98. 03	
98.04 Does title V or XIX follow Medicare (title XVIII) for a CAH outpatient services cost? Enter "Y" for yes or "N" for no i	.04 Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.					
98.05 Does title V or XIX follow Medicare (title XVIII) and add b Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in	.05 Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.					
98.06 Does title V or XIX follow Medicare (title XVIII) when cost Pts. I through IV? Enter "Y" for yes or "N" for no in colum column 2 for title XIX.	Y	Y	98. 06			
Rural Providers				1		
105.00 Does this hospital qualify as a CAH? 106.00 of this facility qualifies as a CAH, has it elected the all	N		105. 00 106. 00			
for outpatient services? (see instructions) 107.00 Column 1: If line 105 is Y, is this facility eligible for contraining programs? Enter "Y" for yes or "N" for no in column Column 2: If column 1 is Y and line 70 or line 75 is Y, do approved medical education program in the CAH's excluded I	n 1. (see ins you train I&R	tructions) s in an			107. 00	
Enter "Y" for yes or "N" for no in column 2. (see instruct 108.00 is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	i ons)	. ,	N		108. 00	
CIR Section 9412.113(C). Litter 1 101 yes of in 101 ho.	Physi cal	Occupati ona	Speech	Respi rator	у	
100 0016 this best tell suchi files as a CAU as a sect associated as	1.00	2.00	3.00	4.00	100.00	
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109. 00	
				1 00		
110.00 Did this hospital participate in the Rural Community Hospit Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wo applicable.	"Y" for yes or	"N" for no.	f yes,	1. 00 N	110. 00	
Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wo	"Y" for yes or	"N" for no.	f yes, ugh 215, as	N	110. 00	
complete Worksheet E, Part A, lines 200 through 218, and Wo	"Y" for yes or rksheet E-2, I the Frontier Coost reporting olumn 1 is Y, orticipating in	"N" for no. ines 200 through the control of the control of the column 2.	f yes,		110.00	
Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wo applicable. 111.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this c "Y" for yes or "N" for no in column 1. If the response to c integration prong of the FCHIP demo in which this CAH is pa Enter all that apply: "A" for Ambulance services; "B" for a	"Y" for yes or rksheet E-2, I the Frontier Coost reporting olumn 1 is Y, orticipating in	"N" for no. ines 200 through the control of the control of the column 2.	f yes, ugh 215, as	N		
Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wo applicable. 111.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this complete "Y" for yes or "N" for no in column 1. If the response to consintegration prong of the FCHIP demoniate in which this CAH is participate and that apply: "A" for Ambulance services; "B" for a for tele-health services. 112.00 Did this hospital participate in the Pennsylvania Rural Head (PARHM) demonstration for any portion of the current cost in period? Enter "Y" for yes or "N" for no in column 1. If comparison in the demonstration, if applicable.	"Y" for yes or rksheet E-2, I the Frontier Cost reporting olumn 1 is Y, orticipating in dditional beds Ith Model eporting olumn 1 is pating in the	ommunity period? Enter enter the column 2. ; and/or "C"	f yes, ugh 215, as	N 2. 00		
Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wo applicable. 111.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this complete in the period of the FCHIP demonstration for this complete in the period of the FCHIP demonstration for this complete all that apply: "A" for Ambulance services; "B" for a for tele-health services. 112.00 Did this hospital participate in the Pennsylvania Rural Head (PARHM) demonstration for any portion of the current cost in period? Enter "Y" for yes or "N" for no in column 1. If comparing the period of the current cost in the demonstration. In column 3, enter the date the hospital comparticipation in the demonstration, if applicable. Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes on in column 1. If column 1 is yes, enter the method used (A, in column 2. If column 2 is "E", enter in column 3 either "for short term hospital or "98" percent for long term care psychiatric, rehabilitation and long term hospitals provided.	"Y" for yes or rksheet E-2, I the Frontier Cost reporting olumn 1 is Y, orticipating in dditional beds Ith Model eporting olumn 1 is pating in the ased ""N" for no B, or E only) 93" percent (includes	ommunity period? Enter enter the column 2. and/or "C"	f yes, ugh 215, as	N 2. 00	111.00	
Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wo applicable. 111.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this of "Y" for yes or "N" for no in column 1. If the response to dintegration prong of the FCHIP demo in which this CAH is participate in the FCHIP demoin which this CAH is participate and the services; "B" for a for tele-health services. 112.00 Did this hospital participate in the Pennsylvania Rural Health (PARHM) demonstration for any portion of the current cost of the period? Enter "Y" for yes or "N" for no in column 1. If column "Y", enter in column 2, the date the hospital began participation in the demonstration, if applicable. Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes of in column 1. If column 1 is yes, enter the method used (A, in column 2. If column 2 is "E", enter in column 3 either "for short term hospital or "98" percent for long term care	"Y" for yes or rksheet E-2, I the Frontier Cost reporting olumn 1 is Y, or ticipating in dditional beds Ith Model eporting olumn 1 is pating in the ased "N" for no B, or E only) 93" percent (includes rs) based on	ommunity period? Enter enter the column 2. and/or "C"	f yes, ugh 215, as	N 2. 00	111.00	

117. 00 118. 00

117.00 s this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.

118.00 s the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.

Health Financial Systems FRANCISC	AN HEALTH LAFAYETTE			In Lieu	u of Form CM	S-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		CN: 15-0109		i od:	Worksheet S	
			Fro To	m 01/01/2023 12/31/2023	Part I Date/Time P	repared:
		Dramiumo		1,00000	3/28/2024 1	
		Premiums		Losses	Insurance	
		1.00		2.00	2.00	
118.01 List amounts of malpractice premiums and paid losses:		1. 00	0	2. 00 312, 500	3. 00 652. 1	16 118. 01
		'				
118.02 Are mal practice premiums and paid losses reported in	a cost center other t	than the		1. 00 N	2. 00	118. 02
Administrative and General? If yes, submit supporting and amounts contained therein.				IN .		110.02
119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpation	ant Hald Harmless ara	vision in ACA		N	N	119. 00 120. 00
§3121 and applicable amendments? (see instructions) [`	.,	14	120.00
"N" for no. Is this a rural hospital with < 100 beds						
Hold Harmless provision in ACA §3121 and applicable a Enter in column 2, "Y" for yes or "N" for no.	amendments? (see instr	ructi ons)				
121.00 Did this facility incur and report costs for high cos	st implantable devices	s charged to		Υ		121. 00
patients? Enter "Y" for yes or "N" for no.		() (2) -E +L-		V	F 0/	100.00
122.00 Does the cost report contain healthcare related taxes Act?Enter "Y" for yes or "N" for no in column 1. If o				Υ	5. 06	122. 00
the Worksheet A line number where these taxes are in	cl uded.					
123.00 Did the facility and/or its subproviders (if applical services, e.g., legal, accounting, tax preparation, I				N		123. 00
management/consulting services, from an unrelated org	1 3 1 3					
for yes or "N" for no.						
If column 1 is "Y", were the majority of the expenses professional services expenses, for services purchase						
located in a CBSA outside of the main hospital CBSA?			-			
"N" for no.						
Certified Transplant Center Information 125.00 Does this facility operate a Medicare-certified trans	splant center? Enter '	'Y" for ves	$\overline{}$	N		125. 00
and "N" for no. If yes, enter certification date(s)	(mm/dd/yyyy) below.	,				
126.00 f this is a Medicare-certified kidney transplant pro in column 1 and termination date, if applicable, in o		fication dat	е			126. 00
127. 00 If this is a Medicare-certified heart transplant prod		fication date	,			127. 00
in column 1 and termination date, if applicable, in o		G				100.00
128.00 f this is a Medicare-certified liver transplant pro in column 1 and termination date, if applicable, in a		fication date	,			128. 00
129.00 If this is a Medicare-certified lung transplant progr	am, enter the certifi	cation date				129. 00
in column 1 and termination date, if applicable, in c		-+! 6!+!				120.00
130.00 f this is a Medicare-certified pancreas transplant date in column 1 and termination date, if applicable,	9	tilication				130. 00
131.00 If this is a Medicare-certified intestinal transplan	t program, enter the d	certi fi cati on	۱			131. 00
date in column 1 and termination date, if applicable, 132.00 of this is a Medicare-certified islet transplant produced to the control of the		fication date				132. 00
in column 1 and termination date, if applicable, in a		ireation date				132.00
133.00 Removed and reserved	(222)					133. 00
134.00 f this is a hospital-based organ procurement organizing column 1 and termination date, if applicable, in a		ne OPO number	`			134. 00
All Providers	501 dilli1 2.					
140.00 Are there any related organization or home office coschapter 10? Enter "Y" for yes or "N" for no in column are claimed, enter in column 2 the home office chain	n 1. If yes, and home	office costs	,	Y	158014	140. 00
1.00	2. 00			3. 00		
If this facility is part of a chain organization, en		•	name	and address	of the	
home office and enter the home office contractor nam 141.00 Name: FRANCISCAN ALLIANCE, INC. Contractor's I			or's	Number: 0810	1	141. 00
142. 00 Street: 1515 DRAGOON TRAIL PO Box:	1290		0		•	142. 00
143.00 Ci ty: MI SHAWAKA State:	I N	Zip Code	:	4654	6-1290	143. 00
					1.00	
144.00 Are provider based physicians' costs included in Work	ksheet A?				Y	144. 00
				1. 00	2. 00	
145.00 If costs for renal services are claimed on Wkst. A, I	ine 74, are the costs	s for		Y Y	2.00	145. 00
inpatient services only? Enter "Y" for yes or "N" for	no in column 1. If o	column 1 is				
no, does the dialysis facility include Medicare utili period? Enter "Y" for yes or "N" for no in column 2.		reporti ng				
146.00 Has the cost allocation methodology changed from the		t report?		N		146. 00
Enter "Y" for yes or "N" for no in column 1. (See CMS		40, §4020) If	-			
yes, enter the approval date (mm/dd/yyyy) in column 2	۷.		1			I

Health Financial Systems			LAFAYETTE			In Lie	u of Form CMS	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	1	Provi der CC	N: 15-0109	Peri From To	od: n 01/01/2023 12/31/2023		epared:
							1. 00	_
147.00 Was there a change in the statisti	cal basis? Enter "Y"	for yes	s or "N" for	no.			N N	147. 00
148.00 Was there a change in the order of							N	148. 00
149.00 Was there a change to the simplifi	ed cost finding metho	od? Ente	er "Y" for ye	s or "N" f	or no.		N	149. 00
			Part A	Part B		Title V	Title XIX	
			1.00	2.00		3.00	4. 00	
Does this facility contain a provi or charges? Enter "Y" for yes or '								
155. 00 Hospi tal	N TOT HO TOT Each Co	olliporieri	N N	and Part B	s. (See	N 42 CFR 9413	. 13) N	155. 00
156. 00 Subprovi der - IPF			N	N		N	N	156. 00
157. 00 Subprovi der - I RF			N I	N		N	N	157. 00
158. 00 SUBPROVI DER								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
							1. 00	
Mul ti campus								
165.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	ampus hospital that ha	as one o	or more campu	ses in dif	ferent	CBSAs?	N	165. 00
	Name		County		Zip Co		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	Γ) incentive in the Ar	meri can	Recovery and	d Reinvestm	nent Ac	t	1.00	
167.00 Is this provider a meaningful user							Υ	167. 00
168.00 If this provider is a CAH (line 10	05 is "Y") and is a me	eani ngfu	ul user (line	167 is "Y	"), en	ter the		168. 00
reasonable cost incurred for the H								
168.01 If this provider is a CAH and is r						ardshi p		168. 01
exception under §413.70(a)(6)(ii)' 169.00 If this provider is a meaningful u						. enter the	9.0	99169. 00
transition factor. (see instruction	ons)		`					
						Begi nni ng	Endi ng	
						1. 00	2.00	
170.00 Enter in columns 1 and 2 the EHR begins period respectively (mm/dd/yyyy)	peginning date and end	ding dat	te for the re	eporting				170. 00
						1. 00	2. 00	
171.00 If line 167 is "Y", does this prov						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	umn 1. If column 1 is							

Heal th	Financial Systems FRANCISCAN HEAL	_TH_LAFAYETTE		In Lie	eu of Form CMS-	2552-10
	TAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CN: 15-0109	Peri od: From 01/01/2023	Worksheet S-2	
				To 12/31/2023		
				Y/N	Date	04 piii
	PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSE	MENT OHESTIONN	IALDE	1. 00	2. 00	
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS			er all dates in 1	the	
1.00	Provider Organization and Operation Has the provider changed ownership immediately prior to the			N		1. 00
	reporting period? If yes, enter the date of the change in c	column 2. (see	instructions Y/N) Date	V/I	
			1.00	2. 00	3. 00	
2. 00	Has the provider terminated participation in the Medicare P yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.	nn 3, "V" for	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (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 Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" for "R" for Reviewed. Submit complete copy or enter date avacolumn 3. (see instructions) If no, see instructions.	or Compiled,	Y	A	06/30/2024	4. 00
5.00	Are the cost report total expenses and total revenues differences on the filed financial etatements? If we are well to the cost report to the cost		Y			5. 00
	those on the filed financial statements? If yes, submit rec	Onci i i ati on.		Y/N	Legal Oper.	
	Annual Educational Assisting			1. 00	2. 00	
6. 00	Approved Educational Activities Column 1: Are costs claimed for a nursing program? Column the Legal operator of the program?	r Y	Y	6. 00		
7. 00 8. 00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing programs and/or allied health programs approve cost reporting period? If yes, see instructions.		ed during the	e Y		7. 00 8. 00
9. 00	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction	•	al education	N		9. 00
10. 00	Was an approved Intern and Resident GME program initiated of cost reporting period? If yes, see instructions.	or renewed in t	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 1. 00	
	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 p			ost reporting	Y N	12. 00 13. 00
14. 00	instructions.	ince amounts wa	nived? If yes,	see	N	14. 00
15. 00	Bed Complement Did total beds available change from the prior cost reporti				N N	15. 00
		Y/N	t A Date	Y/N	t B Date	
	DCAD Date	1.00	2.00	3. 00	4. 00	
16. 00	PS&R Data 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	Υ	03/12/2024	Y	03/12/2024	16. 00
17. 00	instructions) 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	N		N		17. 00
18. 00	in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	N		N		18. 00
19. 00	cost report? If yes, see instructions. 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

HOSDI T	Financial Systems FRANCISCAN HEAL AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CO	:N: 15_∩1∩0	Peri od:	u of Form CMS Worksheet S-		
HOSFI I	AL AND HOSFITAL HEALTH CARE REIMBORSEMENT QUESTIONNAIRE	Frovider CC			Part II Date/Time Pr 3/28/2024 12	epared:	
		Descri	pti on	Y/N	Y/N		
		Ç)	1. 00	3. 00		
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20. 0	
	Insport data for other. Describe the other day astmortes.	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. 0	
					1. 00		
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	PT CHILDRENS H	OSPI TALS)		1. 00		
	Capital Related Cost						
22. 00	Have assets been relifed for Medicare purposes? If yes, see				N	22. 0	
23. 00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.	ring the cost	N	23. 0			
24. 00	Were new leases and/or amendments to existing leases entered if yes, see instructions	d into during	this cost re	eporting period?	N	24. 0	
25. 00	Have there been new capitalized leases entered into during	the cost repor	ting period?	Plf yes, see	N	25. 0	
26. 00	instructions. Were assets subject to Sec. 2314 of DEFRA acquired during the	e cost reporti	ng period? I	f yes, see	N	26. 0	
27. 00	instructions. Has the provider's capitalization policy changed during the	Type submit	N	27. 0			
27.00	сору.	cost reporting	g perrou: 11	yes, subiii t			
28. 00							
9. 00	period? If yes, see instructions. 10 Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund)						
80. 00	treated as a funded depreciation account? If yes, see instru Has existing debt been replaced prior to its scheduled matur	N	30. C				
	instructions.						
1. 00	Has debt been recalled before scheduled maturity without is: instructions.	N	31. 0				
32. 00	Purchased Services Have changes or new agreements occurred in patient care services.	ontractual	Y	32.0			
33. 00	arrangements with suppliers of services? If yes, see instruction of the services of Sec. 2135.2 applies.		n to competi	tive hidding? If	N	33. 0	
3. 00	no, see instructions.	Trea per tarmin	g to competi	tive brading: 11			
34. 00	Provider-Based Physicians Were services furnished at the provider facility under an a	rrangement wit	h nrovider-h	nased physicians?	Y	34. 0	
	If yes, see instructions.	o .	•	. ,			
35. 00	If line 34 is yes, were there new agreements or amended exi: physicians during the cost reporting period? If yes, see in:		ts with the	provi der-based	N	35.0	
				Y/N	Date		
	Home Office Costs			1.00	2. 00		
	Were home office costs claimed on the cost report?			Y		36.0	
	If line 36 is yes, has a home office cost statement been pro	epared by the	home office?			37. 0	
88. 00	If yes, see instructions. If line 36 is yes , was the fiscal year end of the home offi	ice different	from that of	- N		38.0	
	the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to other	of the home o	ffi ce.			39. C	
	see instructions.	·	,				
10. 00	If line 36 is yes, did the provider render services to the linstructions.	nome office?	r yes, see	N		40.0	
		1. (00	2.	00		
	Cost Report Preparer Contact Information						
1.00		DAVI D		LI		41.0	
	respecti vel y.	FRANCISCAN HEAI	TH			42.0	
12 00						11 12.0	
42. 00 43. 00	preparer.	205-222-0184		DAVI D. LI @FRANCI	COANIAL		

Health Financial Systems FRANCISCAN HEAL			I LAFAYETTE	In Lieu of Form CMS-2552-10				
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE			Provi der CCN: 15-0109		eriod: com 01/01/2023	Worksheet S-2 Part II		
				To		Date/Time Pre	pared:	
				\perp		3/28/2024 12:	04 pm	
			2.00					
			3. 00					
	Cost Report Preparer Contact Information							
41.00	Enter the first name, last name and the title/position	MA	NAGER OF REIMBURSEMENT				41.00	
	held by the cost report preparer in columns 1, 2, and 3,	,						
	respecti vel y.							
42.00	Enter the employer/company name of the cost report						42.00	
	preparer.							
43.00	Enter the telephone number and email address of the cos	t					43.00	
	report preparer in columns 1 and 2, respectively.							

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 HOSPITAL
 AND
 HOSPITAL HEALTH CARE COMPLEX
 STATISTICAL DATA
 | Peri od: | Worksheet S-3 | From 01/01/2023 | Part | To 12/31/2023 | Date/Time Prepared: Provider CCN: 15-0109

				T	o 12/31/2023	Date/Time Prep 3/28/2024 12:0	
						I/P Days / 0/P	04 pili
						Visits / Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH/REH Hours	Title V	
	Component	Li ne No.	No. of beas	Avai I abl e	CAII/ KEII 11001 3	II tie v	
		1.00	2. 00	3. 00	4. 00	5. 00	
	PART I - STATISTICAL DATA	1.00	2.00	3.00	4.00	3.00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00	146	53, 290	0.00	0	1.00
1.00	8 exclude Swing Bed, Observation Bed and	50.00	110	00, 270	0.00	Ĭ	1.00
	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					o	5. 00
6. 00	Hospital Adults & Peds. Swing Bed NF					o o	6. 00
7. 00	Total Adults and Peds. (exclude observation		146	53, 290	0.00		7. 00
7.00	beds) (see instructions)		110	00, 270	0.00	Ĭ	7.00
8. 00	INTENSIVE CARE UNIT	31. 00	17	6, 205	0.00	o	8. 00
9. 00	CORONARY CARE UNIT	01.00	1,7	0, 200	0.00	Ŭ	9. 00
10. 00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12. 00	NEONATAL INTENSIVE CARE UNIT	35. 00	14	5, 110	0.00	0	12.00
13. 00	NURSERY	43. 00	17	3, 110	0.00	Ö	13. 00
14. 00	Total (see instructions)	45.00	177	64, 605	0.00		14. 00
15. 00	CAH visits		177	04, 003	0.00	0	15. 00
15. 10	REH hours and visits				0.00	-	15. 10
16. 00	SUBPROVI DER - I PF				0.00	o l	16. 00
17. 00	SUBPROVI DER - I RF	41. 00	15	5, 475		o	17. 00
18. 00	SUBPROVI DER	41.00	13	3, 473		o l	18. 00
19. 00	SKILLED NURSING FACILITY						19.00
20. 00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY	101. 00				0	22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)	101.00				o l	23. 00
24. 00	HOSPI CE	116. 00	0	0			24. 00
24. 10	HOSPICE (non-distinct part)	30. 00	O				24. 10
25. 00	CMHC - CMHC	30.00					25. 00
26. 00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00				0	26. 25
27. 00	Total (sum of lines 14-26)	07.00	192			o o	27. 00
28. 00	Observation Bed Days		172			0	28. 00
29. 00	Ambul ance Trips					U	29. 00
30. 00	Employee discount days (see instruction)						30.00
31. 00	Employee discount days (see firstruction)						31. 00
32. 00	Labor & delivery days (see instructions)		0	0			32.00
32. 00	Total ancillary labor & delivery room		١	١			32. 00
32.01	outpatient days (see instructions)						32.01
33. 00	LTCH non-covered days						33. 00
33. 00	LTCH site neutral days and discharges						33. 00
34. 00	3	30. 00	0	o		0	
54.00	Tomporary Expansion Covid-17 FIL Acute Cale	30.00	·	ı	T	ı O	34.00

Provider CCN: 15-0109

In Lieu of Form CMS-2552-10

Period: Worksheet S-3

From 01/01/2023 Part I

To 12/31/2023 Date/Time Prepared:
3/28/2024 12:04 pm

						3/28/2024 12:	04 pm
		I/P Days	o/P Visits	/ Trips	Full Time E	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7. 00	8.00	9. 00	10.00	
	PART I - STATISTICAL DATA	'					
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2	8, 379	596	31, 329			1. 00
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)	9, 455	10, 058				2. 00
3.00	HMO IPF Subprovider	0	0				3. 00
4.00	HMO IRF Subprovider	531	194				4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	C			5. 00
6.00	Hospital Adults & Peds. Swing Bed NF		0	(6. 00
7. 00	Total Adults and Peds. (exclude observation	8, 379	596	31, 329)		7. 00
0.00	beds) (see instructions)	0 570	0.4	4 446			0.00
8.00	INTENSIVE CARE UNIT	2, 579	84	4, 449	'		8. 00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT	o	F.2	2, 813	,		11. 00 12. 00
12. 00 13. 00	NEONATAL INTENSIVE CARE UNIT NURSERY	٩	53 53	2, 813			13.00
14. 00	Total (see instructions)	10, 958	786	2, 813 41, 404		1, 222. 32	
15. 00	CAH visits	10, 936	700	41, 402		1, 222. 32	15.00
15. 10	REH hours and visits	0	0	(1		15. 10
16. 00	SUBPROVI DER - I PF	o o	ď		,		16. 00
17. 00	SUBPROVI DER - I RF	1, 506	14	2, 848	0.00	17. 27	
18. 00	SUBPROVI DER	1,300	'	2,040	0.00	17.27	18. 00
19. 00	SKILLED NURSING FACILITY						19.00
20. 00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE						21.00
22. 00	HOME HEALTH AGENCY	9, 497	775	22, 432	0.00	17. 88	
23. 00	AMBULATORY SURGICAL CENTER (D. P.)			,			23. 00
24. 00	HOSPI CE	ol	o	C	0.00	51. 90	1
24. 10	HOSPICE (non-distinct part)			C			24. 10
25. 00	CMHC - CMHC						25. 00
26.00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	o	C	0.00	0.00	26. 25
27. 00	Total (sum of lines 14-26)				0.00	1, 309. 37	27. 00
28.00	Observation Bed Days		О	4, 655	5		28. 00
29. 00	Ambul ance Tri ps	o					29. 00
30.00	Employee discount days (see instruction)			(30.00
31.00	Employee discount days - IRF			C			31.00
32.00	Labor & delivery days (see instructions)	0	310	310			32. 00
32. 01	Total ancillary labor & delivery room			C			32. 01
	outpatient days (see instructions)						
33. 00	LTCH non-covered days	0					33. 00
33. 01	LTCH site neutral days and discharges	0					33. 01
34. 00	Temporary Expansion COVID-19 PHE Acute Care	0	0	C	P		34.00

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 HOSPITAL
 AND
 HOSPITAL HEALTH CARE COMPLEX
 STATISTICAL DATA
 Provider CCN: 15-0109

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

				To	12/31/2023	Date/Time Pre 3/28/2024 12:	
		Full Time Equivalents		Di sch	arges	072072021 12.	O I PIII
	Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11. 00	12.00	13. 00	14. 00	15. 00	
	PART I - STATISTICAL DATA						
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and		0	2, 328	262	8, 480	1. 00
	Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)			1, 617	2, 609		2.00
3.00	HMO IPF Subprovider				0		3. 00
4.00	HMO I RF Subprovi der				1		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						6. 00
7. 00	Total Adults and Peds. (exclude observation						7. 00
0.00	beds) (see instructions)						0.00
8. 00 9. 00	INTENSIVE CARE UNIT						8. 00 9. 00
10.00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11.00
12. 00	NEONATAL INTENSIVE CARE UNIT						12.00
13. 00	NURSERY						13. 00
14. 00	Total (see instructions)	0. 00	0	2, 328	262	8, 480	14. 00
15. 00	CAH visits	0.00	O	2, 320	202	0, 400	15. 00
15. 10	REH hours and visits						15. 10
16. 00	SUBPROVI DER - I PF						16. 00
17. 00	SUBPROVI DER - I RF	0.00	0	128	15	217	17. 00
18. 00	SUBPROVI DER	0.00	O	120	15	217	18. 00
19. 00	SKILLED NURSING FACILITY						19. 00
20. 00	NURSING FACILITY						20. 00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY	0.00					22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24.00	HOSPI CE	0. 00					24. 00
24. 10	HOSPICE (non-distinct part)						24. 10
25.00	CMHC - CMHC						25. 00
26.00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0. 00					26. 25
27.00	Total (sum of lines 14-26)	0. 00					27. 00
28. 00	Observation Bed Days						28. 00
29. 00	Ambul ance Tri ps						29. 00
30.00	Employee discount days (see instruction)						30. 00
31.00	Employee discount days - IRF						31. 00
32.00	Labor & delivery days (see instructions)						32. 00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
33. 00	LTCH non-covered days			0			33. 00
33. 01	LTCH site neutral days and discharges			0			33. 01
34. 00	Temporary Expansion COVID-19 PHE Acute Care						34. 00

Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION

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

					To	12/31/2023	Date/Time Pre 3/28/2024 12:	
		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries		Paid Hours Related to	Average Hourly Wage (col. 4 ÷	
				(from Wkst. A-6)	(col.2 ± col. 3)	Salaries in col. 4	col . 5)	
	DADT II WACE DATA	1. 00	2. 00	3.00	4. 00	5. 00	6. 00	
	PART II - WAGE DATA SALARIES							1
1.00	Total salaries (see	200. 00	118, 335, 609	0	118, 335, 609	2, 723, 497. 00	43. 45	1. 00
2.00	instructions) Non-physician anesthetist Part		C	0	0	0.00	0. 00	2. 00
3. 00	Non-physician anesthetist Part		C	0	0	0.00	0. 00	3. 00
4. 00	Physician-Part A - Administrative		C	0	0	0.00	0.00	4. 00
4. 01 5. 00	Physicians - Part A - Teaching Physician and Non		0 15, 162, 824	0 0	1	0. 00 61, 144. 00		
6. 00	Physician-Part B Non-physician-Part B for hospital-based RHC and FQHC		C	0	О	0.00	0.00	6. 00
7. 00	services Interns & residents (in an approved program)	21. 00	C	0	О	0.00	0. 00	7. 00
7. 01	Contracted interns and residents (in an approved		C	0	О	0.00	0. 00	7. 01
8. 00	programs) Home office and/or related organization personnel		C	0	0	0.00	0. 00	8. 00
9. 00 10. 00	SNF Excluded area salaries (see	44. 00	21, 367, 321	0 1, 110, 984	0 22, 478, 305	0. 00 330, 400. 00	l .	
	instructions) OTHER WAGES & RELATED COSTS							
11. 00	Contract Labor: Direct Patient Care		15, 341, 908	0	15, 341, 908	146, 035. 00	105. 06	11. 00
12. 00	Contract labor: Top level management and other management and administrative services		C	0	0	0. 00	0. 00	12.00
13. 00	Contract Labor: Physician-Part A - Administrative		199, 875	0	199, 875	1, 317. 00	151. 77	13. 00
14. 00	Home office and/or related organization salaries and wage-related costs		C	0	0	0.00	0.00	14. 00
14. 01	Home office salaries		24, 620, 594	0	24, 620, 594	676, 949. 00	36. 37	14. 01
14. 02	Related organization salaries		C	0	0	0.00	l .	14. 02
15. 00	Home office: Physician Part A - Administrative		C)	0	0. 00	0.00	15. 00
16. 00	Home office and Contract Physicians Part A - Teaching		C	0	0	0.00	0.00	16. 00
16. 01	Home office Physicians Part A - Teaching		C	0	0	0.00	0.00	16. 01
16. 02	Home office contract Physicians Part A - Teaching		C	0	0	0.00	0. 00	16. 02
17. 00	WAGE-RELATED COSTS Wage-related costs (core) (see		23, 742, 843	0	23, 742, 843			17. 00
18. 00	instructions) Wage-related costs (other) (see instructions)							18. 00
19. 00 20. 00	Excluded areas Non-physician anesthetist Part		5, 011, 133 0	0 0	5, 011, 133 0			19. 00 20. 00
21. 00	A Non-physician anesthetist Part		C	0	0			21. 00
22. 00	B Physician Part A -		C	0	0			22. 00
22. 01	Administrative Physician Part A - Teaching		2 540 225	0	0			22. 01
23. 00 24. 00 25. 00	Physician Part B Wage-related costs (RHC/FQHC) Interns & residents (in an		2, 568, 225 C	0 0	2, 568, 225 0 0			23. 00 24. 00 25. 00
25. 50	approved program) Home office wage-related		7, 555, 712	0	7, 555, 712			25. 50
25. 51	(core) Related organization wage-related (core)		C	0	0			25. 51
25. 52	Home office: Physician Part A - Administrative - wage-related (core)		C	0	0			25. 52

In Lieu of Form CMS-2552-10
Period: Worksheet S-3
From 01/01/2023 Part II Provider CCN: 15-0109

					Т	o 12/31/2023	Date/Time Pre 3/28/2024 12:	
		Wkst. A Line		Recl assi fi cati		Pai d Hours	Average Hourly	
		Number	Reported	on of Salaries		Related to	Wage (col. 4 ÷	
				(from Wkst.	(col.2 ± col.	Salaries in	col. 5)	
				A-6)	3)	col. 4		
		1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
25. 53	Home office: Physicians Part A		0	0	C			25. 53
	- Teaching - wage-related							
	(core)							
27 00	OVERHEAD COSTS - DIRECT SALARIE		1 227 201	770 270	FF/ 021	/ 071 00	01.05	2/ 00
26. 00	Employee Benefits Department	4. 00	1, 336, 291		· ·			l
27. 00	Administrative & General	5. 00	7, 136, 129	l	7, 136, 129	·		1
28. 00	Administrative & General under		1, 641, 763	0	1, 641, 763	11, 430. 00	143. 64	28. 00
29. 00	contract (see inst.) Maintenance & Repairs	6. 00	0	_	,	0.00	0.00	29. 00
30.00	Operation of Plant	7. 00	2, 921, 233	0	2, 921, 233			1
31.00	Laundry & Linen Service	8. 00	133, 093		133, 093	·		
32. 00	Housekeepi ng	9. 00	2, 001, 826	l e	2, 001, 826	·		1
33. 00	Housekeeping under contract	7.00	2,001,020	0	2,001,620	0.00		1
33.00	(see instructions)		0			0.00	0.00	33.00
34.00	Di etary	10. 00	2, 241, 298	-1, 228, 618	1, 012, 680	47, 094. 00	21. 50	34.00
35. 00	Di etary under contract (see instructions)		0	0	C	0.00	0. 00	35. 00
36. 00	Cafeteria	11. 00	0	1, 228, 618	1, 228, 618	57, 137. 00	21. 50	36. 00
37. 00	Maintenance of Personnel	12. 00	0	0	0	0.00		1
38. 00	Nursing Administration	13. 00	3, 892, 996	-13, 174	3, 879, 822			
39. 00	Central Services and Supply	14. 00	462, 651	0	462, 651	· ·		•
40. 00	Pharmacy	15. 00	3, 086, 074	0	3, 086, 074	·		1
41.00	Medical Records & Medical	16. 00	79, 829	l	79, 829			•
	Records Library		,			1, 1, 1		
42.00	Social Service	17. 00	0	0	C	0.00	0.00	42. 00
43.00	Other General Service	18. 00	0	0	0	0.00	0.00	43. 00

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

					'	0 12/01/2020	3/28/2024 12:	
		Worksheet A	Amount	Reclassi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from	(col.2 ± col.	Salaries in	col. 5)	
				Worksheet A-6)	3)	col. 4		
		1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see		104, 814, 548	0	104, 814, 548	2, 673, 783. 00	39. 20	1. 00
	instructions)							l
2.00	Excluded area salaries (see		21, 367, 321	1, 110, 984	22, 478, 305	330, 400. 00	68. 03	2. 00
	instructions)							l
3.00	Subtotal salaries (line 1		83, 447, 227	-1, 110, 984	82, 336, 243	2, 343, 383. 00	35. 14	3. 00
	minus line 2)							l
4.00	Subtotal other wages & related		40, 162, 377	0	40, 162, 377	824, 301. 00	48. 72	4. 00
	costs (see inst.)							l
5.00	Subtotal wage-related costs		31, 298, 555	0	31, 298, 555	0.00	38. 01	5. 00
	(see inst.)							l
6.00	Total (sum of lines 3 thru 5)		154, 908, 159	-1, 110, 984	153, 797, 175	3, 167, 684. 00	48. 55	6. 00
7.00	Total overhead cost (see		24, 933, 183	-792, 544	24, 140, 639	717, 779. 00	33. 63	7. 00
	instructions)							I

Health Financial Systems	FRANCISCAN HEALTH LAFAYETTE	In Lie	u of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 15-0109	Peri od: From 01/01/2023	Worksheet S-3 Part IV
			Date/Time Prepared:

	To 12/31/2023	Date/Time Prep 3/28/2024 12:0	
		Amount	<u> у , , , , , , , , , , , , , , , , , , </u>
		Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Empl oyer Contributions	3, 626, 674	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)	3, 878, 787	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)	11, 813, 049	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	468, 421	10.00
11. 00	Life Insurance (If employee is owner or beneficiary)	44, 253	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)	496, 026	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15. 00	'Workers' Compensation Insurance	853, 191	15. 00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16.00
	Noncumul ative portion)		
	TAXES		
	FICA-Employers Portion Only	8, 217, 757	17. 00
	Medicare Taxes - Employers Portion Only	0	18. 00
	Unemployment Insurance	2, 783	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)	29, 400, 941	24. 00
	Part B - Other than Core Related Cost		
25. 00	OTHER WAGE RELATED COSTS (SPECIFY)		25. 00

Health Financial Systems	FRANCISCAN HEALTH LAFAYETTE	In Lieu	u of Form CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provi der CCN: 15-0109	From 01/01/2023	Worksheet S-3 Part V Date/Time Prepared:

		0 12/31/2023	3/28/2024 12: 0	
	Cost Center Description	Contract Labor		
		1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	15, 341, 908	29, 400, 941	1.00
2.00	Hospi tal	15, 341, 908	29, 400, 941	2.00
3.00	SUBPROVI DER - I PF			3.00
4.00	SUBPROVI DER - I RF	0	0	4.00
5.00	Subprovi der - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	SKILLED NURSING FACILITY			8.00
9.00	NURSING FACILITY			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			12.00
13.00	Hospi tal -Based Hospi ce	0	0	13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15. 00	Hospital-Based Health Clinic FQHC			15.00
16. 00	Hospi tal -Based-CMHC			16.00
17. 00	RENAL DIALYSIS I	0	0	17.00
18. 00	0ther	0	0	18.00

Heal th	Financial Systems	FRANCISCAN HEALTH	H LAFAYETTE		In Li€	eu of Form CMS-2	2552-10
HOME I	HEALTH AGENCY STATISTICAL DATA		Provider CO	F	eriod: rom 01/01/2023	Worksheet S-4	
			Component	CCN: 15-7124 T	o 12/31/2023	3/28/2024 12:	pared: 04 pm_
					Home Health Agency I	PPS	
	Ta	-			1.	00	
0.00	County	Title V	Title XVIII	Title XIX	Other	Total	0. 00
	HOME HEALTH AGENCY STATISTICAL DATA	1. 00	2. 00	3. 00	4. 00	5. 00	
1.00	Home Health Aide Hours	0	0	-			
2.00	Unduplicated Census Count (see instructions)	0. 00	651. 00		0.00 oyees (Full Ti		2. 00
				·		,	
		Enter the number	of hours in	Staff	Contract	Total	
		your normal v		Starr	Contract	Total	
		0		1. 00	2. 00	3. 00	
3. 00	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES Administrator and Assistant Administrator(s)		40. 00				3. 00
4.00	Director(s) and Assistant Director(s)		40.00	0. 24	0.00	0. 24	4. 00
5. 00 6. 00	Other Administrative Personnel Direct Nursing Service			11. 63 34. 48			5. 00 6. 00
7.00	Nursi ng Supervi sor			0.00	0.00	0.00	7. 00
8. 00 9. 00	Physical Therapy Service Physical Therapy Supervisor			12. 70 0. 00			1
10. 00 11. 00	Occupational Therapy Service Occupational Therapy Supervisor			2. 95 0. 00			•
12. 00	Speech Pathology Service			0. 59			
13. 00 14. 00	Speech Pathology Supervisor Medical Social Service			0. 00 1. 00			•
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15. 00
16. 00 17. 00	Home Health Aide Home Health Aide Supervisor			1. 02 0. 00			1
18. 00				0. 00	0.00	0.00 CBSA Data	18. 00
						1. 00	
	HOME HEALTH AGENCY CBSA CODES Enter in column 1 the number of CBSAs where					6	19. 00
20. 00	List those CBSA code(s) in column 1 serviced first code).	during this cost	reporting p	eriod (line 20	contains the	23844	20. 00
20. 01 20. 02						26900 29200	20. 01 20. 02
20. 03						33140	20. 03
20. 04 20. 05						45460 99915	20. 04 20. 05
		Full Epis Without Wi		LUPA Epi sodes	PEP Only	Total (cols.	
		Outliers 1.00	2. 00	3. 00	Epi sodes 4. 00	1-4) 5. 00	
	PPS ACTIVITY DATA						
21. 00 22. 00	Skilled Nursing Visits Skilled Nursing Visit Charges	3, 832 1, 528, 968	707 282, 093			4, 656 1, 857, 744	1
23. 00 24. 00	Physical Therapy Visits Physical Therapy Visit Charges	2, 378 984, 492	724 299, 736				
25. 00	Occupational Therapy Visits	817	421	19		1, 257	25. 00
26. 00 27. 00	Occupational Therapy Visit Charges Speech Pathology Visits	338, 238 125	174, 294 97			520, 398 227	26. 00 27. 00
28. 00	Speech Pathology Visit Charges	51, 750	40, 158	2, 070	0	93, 978	28. 00
29. 00 30. 00	Medical Social Service Visits Medical Social Service Visit Charges	110 52, 800	49 23, 520		0	160 76, 800	
31. 00	Home Health Aide Visits	28	4 772	C	0	32	31.00
32. 00 33. 00	Home Health Aide Visit Charges Total visits (sum of lines 21, 23, 25, 27,	5, 404 7, 290	2, 002			6, 176 9, 497	32. 00 33. 00
34. 00	29, and 31) Other Charges	o	0	 	0	0	34. 00
35. 00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	2, 961, 652	820, 573	80, 388	2, 793	3, 865, 406	1
36. 00	Total Number of Episodes (standard/non	921		122	2	1, 045	36. 00
37. 00	outlier) Total Number of Outlier Episodes		107		0		
38. 00	Total Non-Routine Medical Supply Charges	0	0	C	0	0	38. 00

Health Financial Systems		EDANCI COAN LIEA	ITU LAFAVETTE		lm liid	u of Form CMC (DEED 10
Health Financial Systems HOSPITAL-BASED HOSPICE IDENTIFICATION		FRANCISCAN HEA	Provider C	^N: 15_0100	Peri od:	eu of Form CMS-2 Worksheet S-9	
11031 TIAL-BASED 11031 TOE TDENTITIOATTO	DATA				From 01/01/2023	PARTS I THROU	GH IV
			Hospi ce CCI	N: 15-1563	To 12/31/2023		
					Hospi ce I	3/28/2024 12:0	04 pm
	Unduplicated				1103pr cc 1		
	Days						
	Title XVIII	Title XIX	Title XVIII	Title XIX	All Other	Total (sum of	
			Skilled	Nursi ng		col s. 1, 2 &	
			Nursi ng	Facility		5)	
	1.00	2.00	Facility 3.00	4. 00	5. 00	6. 00	
PART I - ENROLLMENT DAYS FOR C					5.00	6.00	
1.00 Hospice Continuous Home Care	SST KELOKTING I	EKTODS BEGTINNI	NO BEFORE OCTO	DER 1, 2013			1.00
2.00 Hospice Routine Home Care							2.00
3.00 Hospice Inpatient Respite Care							3. 00
4.00 Hospice General Inpatient Care							4. 00
5.00 Total Hospice Days							5. 00
Part II - CENSUS DATA FOR COST	REPORTING PERI	ODS BEGINNING	BEFORE OCTOBER	1, 2015			
6.00 Number of patients receiving							6. 00
hospice care 7.00 Total number of unduplicated							7. 00
Continuous Care hours billable							7.00
to Medicare							
8.00 Average Length of Stay (line 5							8. 00
/ line 6)							
9.00 Unduplicated census count							9. 00
NOTE: Parts I and II, columns 1 and 2	also include	the days report	ted in columns	3 and 4.			
			Title XVIII	Title XIX	Other	Total (sum of	
						col s. 1	
			1.00			through 3)	
DADT III FNDOLIMENT DAVE FOR	COCT DEDODTING	C DEDLODE BECLA	1.00	2.00	3. 00	4. 00	
PART III - ENROLLMENT DAYS FOR 10.00 Hospice Continuous Home Care	COST REPORTING	PERIODS BEGIN	INTING ON OR AFT	ER OCTOBER T	0 0	1	10. 00
11. 00 Hospi ce Routi ne Home Care			40, 540	1, 0	-		
12.00 Hospice Inpatient Respite Care			75	1	7 2	84	1
13.00 Hospice General Inpatient Care			58		3 0	61	
14.00 Total Hospice Days			40, 674	1, 0	10 870	42, 554	14. 00
PART IV - CONTRACTED STATISTIC	AL DATA FOR COS	ST REPORTING PE	RIODS BEGINNIN	G ON OR AFTE	R OCTOBER 1, 201	5	
15.00 Hospice Inpatient Respite Care							
16.00 Hospice General Inpatient Care			0		0 0		

	Financial Systems FRANCISCAN HEALTH L				eu of Form CMS-2					
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN	: 15-0109	Peri od: From 01/01/2023 To 12/31/2023		pared:				
					1. 00					
	PART I - HOSPITAL AND HOSPITAL COMPLEX DATA				1.00					
	Uncompensated and Indigent Care Cost-to-Charge Ratio					1				
1.00	Cost to charge ratio (see instructions)				0. 178112	1.0				
1.00	Medicaid (see instructions for each line)				0. 170112	1 '				
2. 00	Net revenue from Medicaid				60, 266, 698	2.0				
3. 00	Did you receive DSH or supplemental payments from Medicaid?				N N	3.0				
1. 00	If line 3 is yes, does line 2 include all DSH and/or supplementa	al navments	from Medica	ni d2	14	4.0				
5. 00	If line 4 is no, then enter DSH and/or supplemental payments from		TT OIL MCGT CC		0	5.0				
5. 00										
7. 00	Medicaid cost (line 1 times line 6)		52, 851, 415							
3. 00	Difference between net revenue and costs for Medicaid program (s		02,001,110							
	Children's Health Insurance Program (CHIP) (see instructions for					1				
9. 00										
10.00	Stand-alone CHIP charges		0	10.0						
11. 00	Stand-alone CHIP cost (line 1 times line 10)				0	11.0				
12. 00	Difference between net revenue and costs for stand-alone CHIP (s	see instruct	tions)		0	12.0				
	Other state or local government indigent care program (see instr	ructions for	each line)			1				
13. 00	Net revenue from state or local indigent care program (Not inclu	uded on line	es 2, 5 or 9))	0	13.0				
14. 00	Charges for patients covered under state or local indigent care	program (No	ot included	in lines 6 or	0	14. 0				
	10)									
15. 00	State or local indigent care program cost (line 1 times line 14)				0	15. 0				
16. 00	Difference between net revenue and costs for state or local indi				0	16.0				
	Grants, donations and total unreimbursed cost for Medicaid, CHIF	P and state/	/local indig	jent care progran	ns (see					
17 00	instructions for each line)					17.0				
17.00	Private grants, donations, or endowment income restricted to fur	0	,		0					
18. 00 19. 00	Government grants, appropriations or transfers for support of he			· (oum of lines	0	19.0				
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local 8, 12 and 16)	rnargent ca	are programs	s (Sull of Titles	0	19.0				
			Uni nsured	Insured	Total (col. 1					
			pati ents	pati ents	+ col . 2)					
			1. 00	2. 00	3. 00					
	Uncompensated care cost (see instructions for each line)					1				
20. 00	Charity care charges and uninsured discounts (see instructions)		31, 399, 60							
21. 00	Cost of patients approved for charity care and uninsured discour	nts (see	5, 592, 64	5, 196, 444	10, 789, 090	21.0				
20.00	instructions)	66				00.0				
22. 00	Payments received from patients for amounts previously written or	ULT as		0	0	22. 0				
23. 00	charity care Cost of charity care (see instructions)		5, 592, 64	E 104 444	10, 789, 090	23. 0				
23.00	Cost of charity care (see instructions)		5, 592, 64	5, 196, 444	10, 789, 090	23.0				
					1. 00					
24. 00	Does the amount on line 20 col. 2, include charges for patient of	days heyond	a Length of	stav limit	1.00 N	24. 0				
00	imposed on patients covered by Medicaid or other indigent care p		a rength of	Stay IIIII t	"	27.0				
)E 00	If line 24 is was onter the charges for notions days havened the				_	25 (

If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of

29.00 | Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)

Charges for insured patients' liability (see instructions)

31.00 \mid Total unreimbursed and uncompensated care cost (line 19 plus line 30)

Bad debt amount (see instructions)

27.00 Medicare reimbursable bad debts (see instructions)

28.00 Non-Medicare bad debt amount (see instructions)

Medicare allowable bad debts (see instructions)

30.00 Cost of uncompensated care (line 23, col. 3, plus line 29)

25.00

25 01

26.00

27.00

27.01

28.00

29.00

30.00

7, 936, 822

7, 484, 491

1, 491, 394

12, 280, 484

12, 280, 484 31. 00

294, 015

452, 331

25.00

25. 01

27.01

stay limit

llool +b	Financial Cystems	AFAVETTE		ا ما	u of Form CMC	2552 10		
	FINANCISCAN HEALTH L FAL UNCOMPENSATED AND INDIGENT CARE DATA FRANCISCAN HEALTH L FRANCISCAN HEALTH L FRANCISCAN HEALTH L	Provider CCN:		Period: From 01/01/2023 To 12/31/2023	u of Form CMS-2 Worksheet S-1 Parts I & II Date/Time Pre 3/28/2024 12:	0 pared:		
					1. 00			
	PART II - HOSPITAL DATA				11.00			
	Uncompensated and Indigent Care Cost-to-Charge Ratio							
1.00	Cost to charge ratio (see instructions)				0. 169574	1.00		
	Medicaid (see instructions for each line)					1		
2.00	Net revenue from Medicaid					2.00		
3.00	Did you receive DSH or supplemental payments from Medicaid?			10		3.00		
4.00	If line 3 is yes, does line 2 include all DSH and/or supplement	d?		4.00				
5.00	If line 4 is no, then enter DSH and/or supplemental payments from the line 4 is no.	om Medicaid				5.00		
6. 00 7. 00	Medicaid charges Medicaid cost (line 1 times line 6)					6. 00 7. 00		
8. 00	Difference between net revenue and costs for Medicaid program (saa instructi	one)			8.00		
0.00	Children's Health Insurance Program (CHIP) (see instructions for		0113)			0.00		
9. 00	Net revenue from stand-alone CHIP	04011 11110)				9.00		
10.00	Stand-alone CHIP charges					10.00		
11.00	Stand-alone CHIP cost (line 1 times line 10)					11.00		
12.00	Difference between net revenue and costs for stand-alone CHIP (see instructi	ons)			12.00		
	Other state or local government indigent care program (see inst							
13. 00	Net revenue from state or local indigent care program (Not incl			13.00				
14. 00	Charges for patients covered under state or local indigent care	program (Not	included i	n lines 6 or		14.00		
45.00	10)					45.00		
15.00	State or local indigent care program cost (line 1 times line 14)			i notruoti ono)		15.00		
16. 00	Difference between net revenue and costs for state or local ind Grants, donations and total unreimbursed cost for Medicaid, CHII				15 (500	16. 00		
	instructions for each line)	and State/It	ocai indige	ent care program	15 (566			
17. 00	Private grants, donations, or endowment income restricted to ful	ndi na chari tv	care			17.00		
18. 00	Government grants, appropriations or transfers for support of he					18. 00		
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local			(sum of lines		19.00		
	8, 12 and 16)							
			Jni nsured	Insured	Total (col. 1			
			patients	pati ents	+ col . 2)			
	Uncompensated care cost (see instructions for each line)		1. 00	2. 00	3. 00			
20. 00	Charity care charges and uninsured discounts (see instructions)		31, 347, 19	5, 186, 526	36, 533, 721	20.00		
21. 00	Cost of patients approved for charity care and uninsured discour	nts (see	5, 315, 66		10, 502, 195			
200	instructions)		0,0.0,00	0, 100, 020	.0,002,170			
22. 00	Payments received from patients for amounts previously written	off as	(0	0	22. 00		
	chari ty care							
23. 00	Cost of charity care (see instructions)		5, 315, 66	5, 186, 526	10, 502, 195	23. 00		
0.4.00			1 11 6	11.11	1. 00	0.4.00		
24. 00	Does the amount on line 20 col. 2, include charges for patient imposed on patients covered by Medicaid or other indigent care		rength of	stay limit	N	24. 00		
25. 00			ro program'	s Longth of	0	25. 00		
25.00	5.00 If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit							
25. 01								
26. 00	Bad debt amount (see instructions)				0 7, 837, 616			
27. 00	Medicare reimbursable bad debts (see instructions)				294, 015			
27. 01	Medicare allowable bad debts (see instructions)				452, 331	1		
28.00			7, 385, 285	28.00				

7, 385, 285

1, 410, 668 29. 00 11, 912, 863 30. 00 11, 912, 863 31. 00

28.00

27.00 Medicare reimbursable bad debts (see instructions) 27.01 Medicare allowable bad debts (see instructions)
28.00 Non-Medicare bad debt amount (see instructions)

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

Heal th	Financial Systems	FRANCISCAN HEALTH	LAFAYETTE		In Lie	u of Form CMS-	2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE	OF EXPENSES	Provi der Co		Period: From 01/01/2023 To 12/31/2023	Worksheet A Date/Time Pre 3/28/2024 12:	
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	J 1 2 11 1
		1.00	2. 00	3.00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT		4, 503, 886				
2. 00 4. 00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT	1, 336, 291	0 3, 252, 270		0 7, 391, 303 1 -1, 348, 859		
5. 01	01160 COMMUNI CATI ONS	741, 479	224, 510				
5.02	01140 MGMT INFO SYSTEMS	926, 118	4, 043, 605			4, 654, 316	
5.03	00550 PURCHASI NG	3, 158	534, 176				
5. 04 5. 05	00570 ADMITTING 00580 PATIENT ACCOUNTING	0	1, 310 1, 214, 815			615 1, 214, 815	5. 04 5. 05
5. 06	00560 OTHER ADMINISTRATIVE AND GENERAL	5, 465, 374	119, 277, 509				
7. 00	00700 OPERATION OF PLANT	2, 921, 233	13, 452, 113			9, 296, 606	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	133, 093	777, 936				1
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	2, 001, 826 2, 241, 298	1, 211, 218 2, 399, 565				
11. 00	01100 CAFETERI A	0	0		0 2, 438, 204		1
13. 00	01300 NURSING ADMINISTRATION	3, 892, 996	510, 134				1
14.00	01400 CENTRAL SERVI CES & SUPPLY	462, 651	1, 193, 575				
15. 00 16. 00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	3, 086, 074 79, 829	9, 037, 019 129, 307	12, 123, 09 209, 13			
17. 00	01700 SOCIAL SERVICE	0	0		0 0	0	17. 00
20. 00	02000 NURSI NG PROGRAM	2, 001, 787	1, 102, 356				
23. 00	02301 PHARMACY RESIDENCY	155, 494	13, 409			168, 903	
23. 01	02300 EMS EDUCATION INPATIENT ROUTINE SERVICE COST CENTERS	82, 888	12, 357	95, 24	5 3, 528	98, 773	23. 01
30. 00	03000 ADULTS & PEDIATRICS	22, 830, 472	6, 652, 473	29, 482, 94	5 -7, 383, 374	22, 099, 571	30.00
31. 00	03100 INTENSIVE CARE UNIT	4, 484, 707	905, 179				
35. 00	02060 NEONATAL INTENSIVE CARE UNIT	1, 934, 448	975, 288				
41. 00 43. 00	04100 SUBPROVI DER - I RF 04300 NURSERY	1, 591, 614 0	130, 761 0		5 -108, 859 0 2, 201, 657		
10. 00	ANCILLARY SERVICE COST CENTERS	<u> </u>			2,201,007	2,201,007	10.00
50.00	05000 OPERATING ROOM	10, 987, 843	25, 259, 484			14, 704, 076	
51. 00 52. 00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	584, 378	127, 696 0		4 -26, 850 0 3, 081, 007		
54.00	05400 RADI OLOGY-DI AGNOSTI C	4, 614, 553	8, 420, 674				
55. 00	05500 RADI OLOGY - THERAPEUTI C	475, 824	188, 231		5 -74, 321	589, 734	
56.00	05600 RADI OI SOTOPE	582, 646	71, 773				
56. 01 57. 00	03950 CARDI AC CATH LAB 05700 CT SCAN	1, 425, 290 893, 197	5, 887, 769 727, 952				
58. 00	05800 MRI	326, 667	317, 733				
60.00	06000 LABORATORY	0	11, 459, 136	11, 459, 13	6 -167, 224	11, 291, 912	60.00
65.00	06500 RESPI RATORY THERAPY	1, 983, 426	1, 150, 137				
	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	4, 099, 357 1, 684, 829	1, 329, 952 44, 750				
	06800 SPEECH PATHOLOGY	729, 221	21, 232			744, 982	1
69. 00	06900 ELECTROCARDI OLOGY	1, 669, 802	4, 584, 428	6, 254, 23			
70.00	07000 ELECTROENCEPHALOGRAPHY	642, 343	145, 710	788, 05		705, 431	
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 18, 403, 087 0 14, 781, 580	18, 403, 087 14, 781, 580	
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	Ō		0 25, 239, 274	25, 239, 274	1
73. 01	07301 DI ABETES CENTER	1, 379, 514	26, 470				1
74.00	07400 RENAL DIALYSIS 03480 ONCOLOGY	65, 917	1, 344, 478				
76. 00 76. 01	03952 ANTI COAGULATI ON	3, 124, 037 299, 647	11, 292, 583 52, 776				
76. 02	03951 I NFUSI ON SERVI CES	10, 559	6, 474			8, 602	
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0		0 0	0	
77. 00 78. 00	07700 ALLOGENEIC STEM CELL ACQUISITION 07800 CAR T-CELL IMMUNOTHERAPY	0	0		0	0	77. 00 78. 00
78.00	OUTPATIENT SERVICE COST CENTERS	O O	0		0 0	0	78.00
	09000 CLI NI C	390, 593	510, 402			659, 109	
90. 01	09001 CLINIC - OUTPATIENT INFUSION SERVICE	541, 112	5, 220, 543				
90. 02 91. 00	09002 CLINIC - HOME INF PHARMACOTHERAPY 09100 EMERGENCY	42 5, 715, 774	59 5, 862, 910			96 10, 563, 254	
91. 00	04950 WOUND CARE	974, 741	256, 576				
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
92. 01	09201 OBSERVATION BEDS (DISTINCT PART)	1, 225, 929	1, 112, 839	2, 338, 76	8 -323, 238	2, 015, 530	92. 01
95 NN	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES		0		ol o	0	95. 00
	10100 HOME HEALTH AGENCY	3, 867, 239	420, 903				1
	10200 OPIOID TREATMENT PROGRAM	0	0		0 0		102. 00
112 00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE		-977, 853	-977, 85	3 977, 853	^	113. 00
	11300 INTEREST EXPENSE 11600 HOSPI CE	3, 972, 943	-977, 853 3, 641, 179				
	1 1 11 1	-, -, -, -, -, -, -, -, -, -, -, -, -, -	-, , - , - , - ,	, , , , , , , , , , , , , , , , , , , ,	, , , , , , , , ,	., ., ., , , , ,	1

Health Financial Systems	FRANCISCAN HEAL	TH LAFAYETTE		In Lie	u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der Co		Peri od:	Worksheet A	
				rom 01/01/2023 o 12/31/2023	Date/Time Prep 3/28/2024 12:0	oared: 04 pm
Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati		
			+ col. 2)	ons (See A-6)	Trial Balance	
					(col. 3 +-	
					col . 4)	
	1. 00	2. 00	3. 00	4. 00	5. 00	
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	108, 640, 253	260, 061, 767	368, 702, 020	-1, 086, 551	367, 615, 469	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	56, 585	46, 864	103, 449	-42, 110	61, 339	190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	9, 184, 892	1, 368, 303	10, 553, 195	0	10, 553, 195	192. 00
194. 00 07950 MOB	0	0	(0	0	194.00
194. 01 07951 LI FELI NE	0	0	(0	0	194. 01
194. 02 07952 PATI ENT TRANSPORT	0	0	(0	0	194. 02
194. 03 07954 OTHER NRCC	o	0	(o	0	194. 03
194.04 07953 JV-SAGAMORE ASC	453, 879	137, 100	590, 979	1, 128, 661	1, 719, 640	194. 04
200.00 TOTAL (SUM OF LINES 118 through 199)	118, 335, 609	261, 614, 034	379, 949, 643	s o	379, 949, 643	200. 00

Provi der CCN: 15-0109

| Period: | Worksheet A | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: 3/28/2024 12:04 pm |

				3/28/2024 12:	
	Cost Center Description	Adjustments	Net Expenses		, J
			For Allocation	1	
	GENERAL SERVICE COST CENTERS	6. 00	7. 00		
1.00	00100 CAP REL COSTS-BLDG & FIXT	2, 568, 568	17, 511, 885	5	1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	0	7, 391, 303		2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	1, 184, 807	4, 424, 509		4. 00
5.01	01160 COMMUNI CATI ONS	142, 705	1, 194, 537	,	5. 01
5.02	01140 MGMT INFO SYSTEMS	-616, 823	4, 037, 493		5. 02
5.03	00550 PURCHASI NG	-1, 635	475, 516		5. 03
5. 04	00570 ADMI TTI NG	0	615		5. 04
5.05	00580 PATIENT ACCOUNTING	0	1, 214, 815		5. 05
5.06	00560 OTHER ADMINISTRATIVE AND GENERAL	-31, 477, 713	91, 965, 635		5. 06
7.00	00700 OPERATION OF PLANT	-80, 060	9, 216, 546		7.00
8. 00 9. 00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	0 -210, 161	835, 725 2, 961, 410		8. 00 9. 00
10.00	01000 DI ETARY	-565, 075	1, 414, 974		10.00
11. 00	01100 CAFETERI A	-1, 038, 626	1, 399, 578		11.00
13. 00	01300 NURSING ADMINISTRATION	-490, 975	3, 652, 699		13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	-1, 272, 953	99, 478		14. 00
15. 00	01500 PHARMACY	-846, 905	2, 377, 605		15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	1, 707, 795	1, 916, 743	3	16. 00
17. 00	01700 SOCIAL SERVICE	0	0		17. 00
20.00	02000 NURSI NG PROGRAM	-2, 463, 908	417, 603	3	20. 00
23. 00	02301 PHARMACY RESI DENCY	0	168, 903	l control of the cont	23. 00
23. 01	02300 EMS EDUCATION	-15, 224	83, 549		23. 01
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	050 270	21 240 102	N.	20.00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	-850, 379	21, 249, 192		30.00
35.00	02060 NEONATAL INTENSIVE CARE UNIT	0 -782, 779	4, 625, 188 1, 202, 810		31. 00 35. 00
41. 00	04100 SUBPROVI DER – I RF	-762, 779	1, 202, 610		41.00
43. 00	04300 NURSERY	-210, 418	2, 201, 657		43.00
43.00	ANCILLARY SERVICE COST CENTERS	١	2,201,007	I.	45.00
50.00	05000 OPERATING ROOM	-8, 815, 920	5, 888, 156		50.00
51.00	05100 RECOVERY ROOM	0	685, 224		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	3, 081, 007	,	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	-565, 161	7, 164, 796		54. 00
55. 00	05500 RADI OLOGY - THERAPEUTI C	0	589, 734		55. 00
56. 00	05600 RADI OI SOTOPE	-19, 796	605, 040		56. 00
56. 01	03950 CARDI AC CATH LAB	0	2, 545, 137		56. 01
57. 00	05700 CT SCAN	0	1, 149, 938		57. 00
58. 00	05800 MRI	0	538, 625		58. 00
60.00	06000 LABORATORY	-46, 225	11, 245, 687		60.00
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	-40, 157 -354, 476	2, 214, 550 3, 643, 222		65. 00 66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	-117, 109	1, 588, 975		67.00
68. 00	06800 SPEECH PATHOLOGY	-82	744, 900		68. 00
69. 00	06900 ELECTROCARDI OLOGY	-3, 712, 520	2, 350, 141		69.00
70. 00	07000 ELECTROENCEPHALOGRAPHY	-22, 981	682, 450		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	18, 403, 087	,	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	14, 781, 580		72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	25, 239, 274		73. 00
73. 01	07301 DI ABETES CENTER	-9, 421	1, 381, 581		73. 01
74. 00	07400 RENAL DI ALYSI S	0	1, 366, 816		74. 00
76. 00	03480 ONCOLOGY	0	3, 376, 201		76. 00
76. 01	03952 ANTI COAGULATI ON	-7, 139	294, 557		76. 01
76. 02	03951 NFUSION SERVICES	0	8, 602	1	76. 02
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0		76. 98
77. 00 78. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0 0	0		77. 00 78. 00
70. UU	07800 CAR T-CELL IMMUNOTHERAPY OUTPATIENT SERVICE COST CENTERS	<u> </u>	U	γ <u>'</u>	/0.00
90. 00	09000 CLINIC	-38	659, 071		90.00
90. 01	09001 CLINIC - OUTPATIENT INFUSION SERVICE	-150	550, 986		90. 01
90. 02	09002 CLINIC - HOME INF PHARMACOTHERAPY	0	96		90. 02
91.00	09100 EMERGENCY	-2, 989, 673	7, 573, 581		91.00
91. 01	04950 WOUND CARE	-283, 876	727, 616		91. 01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART				92.00
92. 01	09201 OBSERVATION BEDS (DISTINCT PART)	0	2, 015, 530)	92. 01
	OTHER REIMBURSABLE COST CENTERS				1
	09500 AMBULANCE SERVICES	0	0	l e e e e e e e e e e e e e e e e e e e	95. 00
	10100 HOME HEALTH AGENCY	-7, 138	4, 193, 578		101.00
102.00	10200 OPI OI D TREATMENT PROGRAM	0	0	<u> </u>	102. 00
110 0	SPECIAL PURPOSE COST CENTERS				112 00
	11300 I NTEREST EXPENSE	411 241	4 150 903		113.00
118.00	11600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117)	-411, 241 -52, 728, 862	6, 159, 803 314, 886, 607		116. 00 118. 00
110.00	PI POUDIVIALO (SUM OF LINES I UNIOUGH III)	-52, 120, 002	514,000,007	I	1110.00

Health Financial Systems FRANCISCAN HEALTH LAFAYETTE In Lieu of Form CMS-2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES Provider CCN: 15-0109 Period: From 01/01/2023 To 12/31/2023 Date/Time Prepared: 3/28/2024 12: 04 pm

			3/28/2024 12: 04 p)m
Cost Center Description	Adjustments	Net Expenses		
	(See A-8)	For Allocation		
	6. 00	7.00		
NONREI MBURSABLE COST CENTERS				
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	61, 339	190.	. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	-9, 064, 741	1, 488, 454	192.	. 00
194. 00 07950 MOB	0	0	194.	. 00
194. 01 07951 LI FELI NE	0	0	194.	. 01
194. 02 07952 PATIENT TRANSPORT	0	0	194.	. 02
194. 03 07954 OTHER NRCC	0	0	194.	. 03
194.04 07953 JV-SAGAMORE ASC	0	1, 719, 640	194.	. 04
200.00 TOTAL (SUM OF LINES 118 through 199)	-61, 793, 603	318, 156, 040	200.	. 00

Peri od: From 01/01/2023 To 12/31/2023

Date/Time Prepared: 3/28/2024 12:04 pm

		Increases	_		3/28/2024 12:	04 pm
	Cost Center	Increases Line #	Salary	Other		
	2. 00	3.00	4. 00	5. 00		
	A - LEASE AND RENTS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	2, 951, 144		1. 00
2. 00 3. 00	CAP REL COSTS-MVBLE EQUIP	2. 00 0. 00	0	637, 579 0		2.00
4. 00		0.00	0	0		3. 00 4. 00
5. 00		0.00	Ö	0		5. 00
6.00		0.00	0	0		6. 00
7.00		0.00	0	0		7. 00
8. 00 9. 00		0. 00 0. 00	0	0		8. 00 9. 00
10. 00		0.00	0	0		10.00
11. 00		0.00	o	0		11. 00
12. 00		0.00	0	0		12. 00
13.00		0.00	0	0		13.00
14. 00 15. 00		0. 00 0. 00	0	0		14. 00 15. 00
16. 00		0. 00	Ö	0		16. 00
17. 00		0. 00	0	0		17. 00
18.00		0.00	0	0		18. 00
19. 00 20. 00		0. 00 0. 00	0	0		19. 00 20. 00
21. 00		0.00	0	0		21. 00
22. 00	L	0.00	O	O		22. 00
	TOTALS		0	3, 588, 723		
1. 00	B - DRUGS & MED SUPPLY MEDICAL SUPPLIES CHARGED TO	71. 00	O	18, 403, 087		1.00
1.00	PATIENT	71.00	o o	10, 403, 007		1.00
2.00	IMPL. DEV. CHARGED TO	72. 00	0	14, 781, 580		2. 00
2 00	PATIENTS	72.00		25 220 274		2.00
3. 00 4. 00	DRUGS CHARGED TO PATIENTS	73. 00 0. 00	0	25, 239, 274 0		3. 00 4. 00
5. 00		0.00	Ö	O		5. 00
6.00		0.00	0	0		6. 00
7.00		0.00	0	0		7. 00
8. 00 9. 00		0. 00 0. 00	0	0		8. 00 9. 00
10.00		0.00	Ö	0		10. 00
11. 00		0.00	0	0		11. 00
12.00		0.00	0	0		12.00
13. 00 14. 00	+	0. 00 0. 00	0	0		13. 00 14. 00
15. 00		0.00	Ö	O		15. 00
16.00		0. 00	0	0		16. 00
17. 00		0.00	0	0		17. 00
18. 00 19. 00		0. 00 0. 00	0	0		18. 00 19. 00
20. 00		0.00	0	0		20.00
21.00		0.00	0	0		21. 00
22. 00		0. 00	0	0		22. 00
23. 00 24. 00		0. 00 0. 00	0	0		23. 00 24. 00
25. 00		0.00	0	0		25. 00
26. 00		0.00	Ö	0		26. 00
27. 00		0.00	0	0		27. 00
28. 00		0.00	0	0		28. 00
29. 00 30. 00		0. 00 0. 00	0	0		29. 00 30. 00
31. 00		0.00	Ö	0		31. 00
32.00		0.00	0	0		32. 00
33.00		0.00	0	0		33. 00
34. 00 35. 00		0. 00 0. 00	0	0		34. 00 35. 00
36. 00		0.00	0	0		36. 00
37. 00	L	0.00	o	0		37. 00
	TOTALS		0	58, 423, 941		4
1. 00	C - DEPRECIATION CAP REL COSTS-BLDG & FIXT	1.00	0	11, 570, 525		1.00
2. 00	CAP REL COSTS-BLDG & FIXT	2. 00	0	6, 952, 244		2. 00
3. 00		0. 00	O	0		3. 00
4.00		0.00	0	0		4. 00
5. 00 6. 00		0. 00 0. 00	0	0		5. 00 6. 00
7. 00		0.00	0	0		7. 00
8. 00		0.00	Ö	Ö		8. 00
-		·	·	·		

Provider CCN: 15-0109

Peri od: From 01/01/2023 To 12/31/2023

Date/Time Prepared: 3/28/2024 12:04 pm

		Increases			3/28/2024 12: 04 pm
	Cost Center	Increases Line #	Salary	Other	
	2.00	3. 00	4. 00	5. 00	
9. 00		0.00	0	0	9.00
10.00		0.00	0	0	
11. 00		0. 00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14. 00 15. 00		0. 00 0. 00	0	0	14. 00 15. 00
16. 00		0.00	0	0	
17. 00		0.00	Ö	0	1
18. 00		0.00	0	0	
19. 00		0. 00	0	0	19.00
20.00		0. 00	0 0	0	20.00
21. 00		0.00	0	0	21.00
22. 00 23. 00		0. 00 0. 00	0 0	0	22. 00 23. 00
24. 00		0.00	0	0	
25. 00		0.00	0	0	
26. 00		0.00	O	0	
27.00		0. 00	0	0	27. 00
28. 00		0. 00	0	0	
29. 00		0.00	0	0	
30.00		0.00	0	0	
31.00		0. 00 0. 00	0 0	0	31. 00 32. 00
32. 00 33. 00		0.00	0	0	
34. 00		0.00	0	0	
35. 00		0.00	Ö	0	
36.00		0.00	0	0	
37.00		0. 00	0	0	37.00
38. 00		0. 00	0	0	38.00
39. 00		0.00	0	0	
40.00		0.00	0	0	40.00
41. 00 42. 00		0. 00 0. 00	0	0	41. 00 42. 00
43. 00		0.00	o	0	
44. 00		0.00	O	0	44.00
45.00		0. 00	0	0	45. 00
46.00		0. 00	0	0	46.00
47. 00		0.00	0	0	47.00
48. 00	TOTALS — — — —			<u></u> <u>0</u> 18, 522, 769	48. 00
	D - CAPITALIZED INTEREST		O ₁	10, 322, 709	
1.00	INTEREST EXPENSE	113.00	0	977, 853	1.00
2.00		000	0	0	2.00
	TOTALS		0	977, 853	
	E - EMPLOYEE BENS	= 0.4	اه	0/ 100	1.00
1.00	COMMUNI CATI ONS	5. 01 0. 00	0	86, 439	
2. 00 3. 00		0.00	0	0	2. 00 3. 00
3.00	TOTALS — — — —		0		
	F - CAFETERIA		٩١	00, 107	
1.00	CAFETERI A	1100	<u>1, 228, 6</u> 18	1, 209, 586	
	TOTALS		1, 228, 618	1, 209, 586	
1. 00	G - WORKING WELL JV-SAGAMORE ASC	194. 04	779, 370	349, 291	1.00
1.00	TOTALS	194.04	779, 370	349, 291	1.00
	H - L&D		117, 510	347, 271	
1.00	NEONATAL INTENSIVE CARE UNIT	35.00	419, 847	1, 728	1.00
2.00	NURSERY	43.00	1, 836, 899	364, 758	
3.00	DELIVERY ROOM & LABOR ROOM	<u>52.</u> 00	3, 017, 640	93, 027	
	TOTALS		5, 274, 386	459, 513	
1. 00	I - SCHOOL OF NURSING NURSING PROGRAM	20.00	322, 101	0	1.00
2. 00	NORST NO TROCKAW	0.00	0	0	
3. 00		0.00	Ö	0	
4.00		0. 00	О	0	4.00
5. 00		0.00	0	0	
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
10. 00		0.00	o	0	
11. 00		0. 00	0	0	
12. 00		0. 00	O	0	12.00

Heal th	Financial Systems		FRANCI SCAN HEA	ALTH LAFAYETTE		In Lie	u of Form CMS-	-2552-10
RECLASS	SIFICATIONS			Provi der (CCN: 15-0109	Peri od: From 01/01/2023	Worksheet A-	5
							Date/Time Pro 3/28/2024 12:	
		Increases						
	Cost Center	line #	Salary	Other				

					3/20/2024 12.	. U4 PIII
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
	2. 00	3. 00	4.00	5. 00		
13.00		0.00	0	0		13. 00
	TOTALS		322, 101	0		
	J - EMS ALLIED HEALTH					
1.00	EMS EDUCATION	23. 01	9, 513	0		1. 00
	TOTALS		9, 513	0		
500.00	Grand Total: Increases		7, 613, 988	83, 618, 115		500.00

Health Financial Systems RECLASSIFICATIONS In Lieu of Form CMS-2552-10 Peri od: Wo From 01/01/2023 Provider CCN: 15-0109 Worksheet A-6

						To 12/31/2023	Date/Time Prepared 3/28/2024 12:04 pm	
		Decreases					3/20/2024 12: 04 piii	
	Cost Center	Li ne #	Salary	Other 0.00	Wkst. A-7 Ref.			
	6. 00 A - LEASE AND RENTS	7. 00	8.00	9. 00	10. 00			_
1.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	57, 597	10		1. (00
2.00	MGMT INFO SYSTEMS	5. 02	0	80, 906			2. 0	00
3.00	OTHER ADMINISTRATIVE AND	5. 06	0	227, 545	0		3. 0	00
4. 00	GENERAL OPERATION OF PLANT	7. 00	0	464	. 0		4. 0	00
5.00	LAUNDRY & LINEN SERVICE	8. 00	0	73, 758	0		5. 0	
6.00	HOUSEKEEPI NG	9.00	0	9, 460			6. 0	
7. 00 8. 00	DI ETARY NURSI NG ADMI NI STRATI ON	10. 00 13. 00	0	55, 037 188			7. (
9. 00	PHARMACY	15. 00	0	57, 808			9. (
10.00	ADULTS & PEDIATRICS	30.00	0	326, 772			10. 0	
11. 00	INTENSIVE CARE UNIT	31.00	0	3, 658			11. 0	
12. 00 13. 00	OPERATING ROOM RADIOLOGY-DIAGNOSTIC	50. 00 54. 00	0	67, 995 884, 435			12. (
14. 00	RADI OLOGT-DI AGNOSTI C	56. 00	0	10, 500			14. (
15. 00	PHYSI CAL THERAPY	66.00	0	760, 089			15. 0	
16. 00	ELECTROCARDI OLOGY	69. 00	0	425			16. (
17. 00 18. 00	ELECTROENCEPHALOGRAPHY EMERGENCY	70. 00 91. 00	0	645 157, 831			17. (18. (
19. 00	WOUND CARE	91.00	0	22, 714	_		19. (
20. 00	OBSERVATION BEDS (DISTINCT	92. 01	Ö	241, 413			20. 0	
	PART)	444.00		507.070				
21. 00 22. 00	HOSPICE GIFT, FLOWER, COFFEE SHOP &	116. 00 190. 00	0	507, 373 42, 110			21. (
22.00	CANTEEN	190.00	J	42, 110	,		22. (50
	TOTALS			3, 588, 723				
4 00	B - DRUGS & MED SUPPLY	40.00	ام	20. (20	ı	T		00
1. 00 2. 00	DI ETARY NURSI NG ADMI NI STRATI ON	10. 00 13. 00	0	29, 623 8, 213			1. (
3. 00	CENTRAL SERVICES & SUPPLY	14. 00	0	207, 161			3. (
4.00	PHARMACY	15. 00	0	8, 832, 187			4. 0	
5.00	NURSING PROGRAM	20.00	0	14, 373			5. (
6. 00 7. 00	EMS EDUCATION ADULTS & PEDIATRICS	23. 01 30. 00	0	4, 400 1, 802, 602			6. 0	
8. 00	INTENSIVE CARE UNIT	31.00	0	456, 626			8. 0	
9. 00	NEONATAL INTENSIVE CARE UNIT	35. 00	0	116, 159	0		9. (00
10.00	SUBPROVI DER – I RF	41.00	0	38, 608			10. 0	
11. 00 12. 00	OPERATING ROOM RECOVERY ROOM	50. 00 51. 00	0	20, 304, 094 23, 705			11. (
13. 00	RADI OLOGY-DI AGNOSTI C	54.00	0	3, 029, 630			13. (
14. 00	RADIOLOGY - THERAPEUTIC	55. 00	0	12, 077			14. 0	
15.00	RADI OI SOTOPE	56.00	0	12, 381			15. (
16. 00 17. 00	CARDIAC CATH LAB	56. 01 57. 00	0	4, 050, 494 294, 044			16. 0 17. 0	
18. 00	MRI	58. 00	0	104, 242			18. (
19. 00	LABORATORY	60.00	0	114, 411			19. (
20. 00	RESPI RATORY THERAPY	65.00	0	588, 605		l .	20. 0	
21. 00 22. 00	PHYSICAL THERAPY OCCUPATIONAL THERAPY	66. 00 67. 00	0	374, 641 15, 403			21. (
23. 00	SPEECH PATHOLOGY	68. 00	0	768			23. (
24. 00	ELECTROCARDI OLOGY	69.00	0	27, 436			24. 0	
25. 00	ELECTROENCEPHALOGRAPHY	70.00	0	63, 434		l .	25. (
26. 00 27. 00	DI ABETES CENTER RENAL DI ALYSI S	73. 01 74. 00	0	7, 927 32, 251			26. 0 27. 0	
28. 00	ONCOLOGY	74.00 76.00	0	10, 898, 714			28. (
29. 00	ANTI COAGULATI ON	76. 01	0	47, 897			29. 0	
30.00	I NFUSI ON SERVI CES	76. 02	0	7, 580			30. 0	
31. 00 32. 00	CLINIC - OUTPATIENT INFUSION	90. 00 90. 01	0	239, 551 5, 204, 966			31. (
32.00	SERVICE	90.01	J	5, 204, 700			32. 0	50
33.00	EMERGENCY	91. 00	0	632, 116	0		33. 0	00
34.00	WOUND CARE	91. 01	0	174, 996			34. (
35. 00	OBSERVATION BEDS (DISTINCT PART)	92. 01	0	70, 413	0		35. 0	JU
36. 00	HOME HEALTH AGENCY	101.00	0	77, 224	. 0		36.0	00
37.00	HOSPICE	1 <u>16.</u> 00	0	50 <u>4, 9</u> 89			37. 0	00
	TOTALS		0	58, 423, 941				
1. 00	C - DEPRECIATION CAP REL COSTS-BLDG & FIXT	1. 00	0	3, 302, 905	9		1. (00
2. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	79, 289		l .	2. (
3.00	COMMUNI CATI ONS	5. 01	0	596	0		3. 0	00
4. 00 E. 00	MGMT INFO SYSTEMS	5. 02	0	234, 500			4. (
5. 00	PURCHASI NG	5. 03	0	60, 183	0	1	5. 0	JU

	Financial Systems		FRANCISCAN HEA		201 45 0400		u of Form CMS-2552-	<u>-10</u>
RECLAS	SIFI CATIONS			Provider (Period: From 01/01/2023	Worksheet A-6	
						To 12/31/2023	Date/Time Prepared 3/28/2024 12:04 pr	
	Cost Center	Decreases Li ne #	Salary	Other	Wkst. A-7 Ref.	1		
	6. 00	7. 00	8. 00	9. 00	10. 00			
6. 00 7. 00	ADMITTING OTHER ADMINISTRATIVE AND GENERAL	5. 04 5. 06	0	695 1, 068, 864		•	1	00
8.00	OPERATION OF PLANT	7. 00	0	7, 076, 276		1		00
9. 00 10. 00	LAUNDRY & LINEN SERVICE HOUSEKEEPING	8. 00 9. 00	0	1, 546 32, 013		1	10.	00
11. 00	DI ETARY	10. 00	O	137, 950	C	l	11.	
12. 00 13. 00	NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY	13. 00 14. 00	0	237, 881 76, 634			12. 13.	
14. 00	PHARMACY	15. 00	0	8, 588	_		14.	
15.00	MEDICAL RECORDS & LIBRARY	16.00	0	188			15.	
16. 00 17. 00	NURSING PROGRAM EMS EDUCATION	20. 00 23. 01	0	530, 360 1, 585		l .	16. 17.	
18. 00	ADULTS & PEDIATRICS	30. 00	Ö	559, 454		•	18.	
19. 00	INTENSIVE CARE UNIT	31.00	0	276, 449		•	19.	
20. 00 21. 00	NEONATAL INTENSIVE CARE UNIT	35. 00 41. 00	0	53, 927 70, 251	_	l .	20.	
22. 00	OPERATING ROOM	50. 00	0	1, 170, 546	C	1	22.	
23. 00 24. 00	RECOVERY ROOM RADIOLOGY-DIAGNOSTIC	51. 00 54. 00	0	3, 145 1, 388, 586		l .	23. 24.	
25. 00	RADI OLOGY - THERAPEUTI C	55. 00	0	62, 244		•	25.	
26. 00	CARDIAC CATH LAB	56. 01	0	704, 254		•	26.	
27. 00 28. 00	CT SCAN MRI	57. 00 58. 00	0	177, 167 1, 533		l .	27. 28.	
29. 00	LABORATORY	60.00	Ö	52, 813		•	29.	
30.00	RESPIRATORY THERAPY	65.00	0	290, 251		1	30.	
31. 00 32. 00	PHYSI CAL THERAPY OCCUPATI ONAL THERAPY	66. 00 67. 00	0	291, 334 8, 092		•	31.	
33.00	SPEECH PATHOLOGY	68. 00	0	4, 703	C	•	33.	00
34. 00 35. 00	ELECTROCARDI OLOGY ELECTROENCEPHALOGRAPHY	69. 00 70. 00	0	163, 708 18, 543		l .	34. 35.	
36. 00	DI ABETES CENTER	73. 01	0	7, 055		•	36.	
37. 00	RENAL DI ALYSI S	74.00	0	11, 328			37.	
38. 00 39. 00	ONCOLOGY ANTI COAGULATI ON	76. 00 76. 01	0	141, 705 2, 830			38.	
40. 00	INFUSION SERVICES	76. 02	Ö	851		l .	40.	
41.00	CLINIC	90.00	0	948		l .	41.	
42. 00	CLINIC - OUTPATIENT INFUSION SERVICE	90. 01	0	5, 553			42.	00
43. 00	CLINIC - HOME INF PHARMACOTHERAPY	90. 02	0	5	C		43.	00
44. 00	EMERGENCY	91. 00	0	137, 698		1	44.	
45. 00 46. 00	WOUND CARE OBSERVATION BEDS (DISTINCT	91. 01 92. 01	0	15, 413 11, 412		•	45. 46.	
	PART)			·				
47. 00 48. 00	HOME HEALTH AGENCY HOSPICE	101. 00 116. 00	O O	10, 202 30, 716	C	1	47. 48.	
	TOTALS		0	18, 522, 769				
1.00	D - CAPITALIZED INTEREST CAP REL COSTS-BLDG & FIXT	1.00	0	779, 333	11		1.	00
2.00	CAP REL COSTS-MVBLE EQUIP		0	198, 520	11		2.	00
	TOTALS E - EMPLOYEE BENS		0	977, 853				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	83, 312	C		1.	00
2.00	MGMT INFO SYSTEMS	5. 02	0	1	C		1	00
3. 00	OTHER ADMINISTRATIVE AND GENERAL	5. 06	0	3, 126	C		3.	00
	TOTALS			86, 439		1		
1. 00	F - CAFETERI A DI ETARY	10.00	1, 228, 618	1, 209, 586	C	ı	1	00
1.00	TOTALS		1, 228, 618	1, 209, 586				00
1 00	G - WORKING WELL EMPLOYEE BENEFITS DEPARTMENT	4 00	770 270	349, 291			1	00
1. 00	TOTALS	4.00	779, 370 779, 370	34 <u>9, 291</u> 349, 291	<u>c</u>		1.	00
1 00	H - L&D	20.00	4 4/0 101	124.257	1	ı	1	00
1. 00 2. 00	ADULTS & PEDIATRICS NEONATAL INTENSIVE CARE UNIT	30. 00 35. 00	4, 469, 191 805, 195	124, 356 335, 157		•		00
3. 00		000	0	0		1		00
	TOTALS I - SCHOOL OF NURSING		5, 274, 386	459, 513				
1.00	NURSING ADMINISTRATION	13. 00	13, 174	0	C		1.	00
2.00	ADULTS & PEDIATRICS	30. 00	100, 999	0	_	•	2.	00
3. 00 4. 00	INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE UNIT	31. 00 35. 00	27, 965 35, 284	0	_	•		00
	production ve office office	55. 50	35, 254			I .	I =-	

Health Financial Systems RECLASSIFICATIONS FRANCISCAN HEALTH LAFAYETTE In Lieu of Form CMS-2552-10 Provider CCN: 15-0109

Peri od: Worksheet A-o From 01/01/2023 To 12/31/2023 Date/Time Prepared: 3/28/2024 12:04 pm

						3/28/2024 12	. 04 piii
	Decreases						
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10.00		
5.00	OPERATING ROOM	50.00	616	0	(5. 00
6.00	DELIVERY ROOM & LABOR ROOM	52.00	29, 660	0	(0	6. 00
7.00	RADI OLOGY-DI AGNOSTI C	54.00	2, 619	0	(0	7. 00
8.00	RADI OI SOTOPE	56.00	6, 702	0	(0	8. 00
9.00	CARDIAC CATH LAB	56. 01	13, 174	0	(0	9. 00
10.00	PHYSI CAL THERAPY	66. 00	5, 547	0	(0	10. 00
11. 00	CLINIC	90.00	1, 387	0	(0	11. 00
12.00	EMERGENCY	91.00	78, 272	0	(0	12. 00
13.00	WOUND CARE	91. 01	6, 702	0	(0	13. 00
	TOTALS		322, 101				
	J - EMS ALLIED HEALTH						
1.00	EMERGENCY	91. 00	9, 513	0	(1. 00
	TOTALS		9, 513				
500.00	Grand Total: Decreases		7, 613, 988	83, 618, 115			500.00

Provider CCN: 15-0109

				Ť	o 12/31/2023	Date/Time Prepared: 3/28/2024 12:04 pm	
			Acqui si ti ons				
		Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances				Retirements	
		1.00	2. 00	3.00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
1.00	Land	16, 741, 293	2, 484, 626		2, 484, 626		1. 00
2.00	Land Improvements	4, 868, 998	3, 359, 956		3, 359, 956		2. 00
3.00	Buildings and Fixtures	312, 589, 725	70, 642, 815	C	70, 642, 815	0	3. 00
4.00	Building Improvements	1, 247, 401	0	C	0	0	4. 00
5.00	Fi xed Equipment	5, 374, 131	49, 168	C	49, 168	0	5. 00
6.00	Movable Equipment	90, 365, 462	3, 338, 793	C	3, 338, 793	0	6. 00
7.00	HIT designated Assets	0	0	C	0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	431, 187, 010	79, 875, 358	C	79, 875, 358	0	8. 00
9.00	Reconciling Items	15, 400, 697	27, 955, 802	C	27, 955, 802	0	9. 00
10.00	Total (line 8 minus line 9)	415, 786, 313	51, 919, 556	C	51, 919, 556	0	10.00
		Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
		6. 00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
1.00	Land	19, 225, 919	0				1. 00
2.00	Land Improvements	8, 228, 954	0				2. 00
3.00	Buildings and Fixtures	383, 232, 540	0				3. 00
4.00	Building Improvements	1, 247, 401	0				4. 00
5.00	Fixed Equipment	5, 423, 299	0				5. 00
6.00	Movable Equipment	93, 704, 255	0				6. 00
7. 00	HIT designated Assets	0	0				7. 00
8.00	Subtotal (sum of lines 1-7)	511, 062, 368	0				8. 00
9.00	Reconciling Items	43, 356, 499	0				9. 00
10.00	Total (line 8 minus line 9)	467, 705, 869	0				10. 00

Heal th	Financial Systems	FRANCISCAN HEAL	TH LAFAYETTE		In lie	eu of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS			Provider CC	CN: 15-0109	Peri od: From 01/01/2023 To 12/31/2023	Worksheet A-7 Part II	pared:
	SUMMARY OF CAPITAL						
	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 WORK	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	4, 503, 886	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)	4, 503, 886	0		0 0	0	3. 00
		SUMMARY OF 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 WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	4, 503, 886				1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2. 00
	1 - 1 - (4 = 00 00/	I .		,	

0 0 0

4, 503, 886

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	FRANCISCAN HEAI	LTH LAFAYETTE		In Lieu of Form CMS-2552		
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der Co		Peri od: From 01/01/2023 To 12/31/2023		pared:
		2011		51.00		3/28/2024 12:	04 pm
		COMI	PUTATION OF RAT	1105	ALLOCATION OF		
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance	
			Leases	for Ratio	instructions)		
				(col. 1 - col			
				2)			
		1.00	2. 00	3.00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CI						
1.00	CAP REL COSTS-BLDG & FLXT	417, 358, 112				0	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	93, 704, 255	0	93, 704, 25	5 0. 200349	0	2. 00
3.00	Total (sum of lines 1-2)	511, 062, 367			8 1.000000	0	3. 00
		ALLOCA ⁻	TION OF OTHER (CAPI TAL	SUMMARY O	F CAPITAL	
	Cost Center Description	Taxes	Other	Total (sum of	f Depreciation	Lease	
	, , , , , , , , , , , , , , , , , , ,		Capi tal -Relate				
			d Costs	through 7)			
		6. 00	7. 00	8.00	9. 00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CI	ENTERS					
1.00	CAP REL COSTS-BLDG & FLXT	0	0		0 12, 771, 506	2, 951, 144	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		0 6, 952, 244	637, 579	2. 00
3.00	Total (sum of lines 1-2)	0	0		0 19, 723, 750	3, 588, 723	3. 00
			Sl	JMMARY OF CAPI			
	Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
	· ·		instructions)	instructions	Capi tal -Relate	of cols. 9	
			ĺ	1	d Costs (see	through 14)	
					instructions)	y ,	
		11. 00	12.00	13. 00	14. 00	15. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CI	ENTERS		•			
1.00	CAP REL COSTS-BLDG & FLXT	-779, 333	0		0 2, 568, 568	17, 511, 885	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	-198, 520			0 0	7, 391, 303	2. 00
3.00	Total (sum of lines 1-2)	-977, 853			0 2, 568, 568		3. 00
	,		'	'			

To 1/2/31/2/32 3/2/3/2/3 3/2/3/2/3 3/2/3/2/3 3/2/3/3/3	ADJUST	MENTS TO EXPENSES			Provi der CCN: 15-0109	Peri od: From 01/01/2023	Worksheet A-8	
Papersex Classed Frost Into no Ministered A To/From Which be Anount is to the Agriculture A To/From Which be Anount is to the Agriculture A To/From Which be Anount is to the Agriculture A To/From Which be Anount is to the Agriculture A To/From Which be Anount is to the Agriculture A To/From Which be Anount is to the Agriculture A To/From Which be Anount is to the Agriculture A To/From Which be Anount is to the Agriculture A To/From Which be Agriculture A To/From Which								
Cost Center Description Basis/Code (2) Amount Cost Center Line 8 Mast. A-7 Ref.					Expense Classification of	n Worksheet A	3/28/2024 12:	J4 pili
1.00 Investment Income CAR STI				Т	o/From Which the Amount is	s to be Adjusted		
1.00 Investment Income CAR STI								
1.00 Investment Income CAR STI								
Total Investment Income CAP RTI COSTS-LOW FIXT COSTS-LOW COSTS-LOW COSTS-LOW COSTS-LOW COSTS-LOW COSTS-LOW COSTS-LOW C		Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
COSTS BIDS A FIXT (chapter 2) 0 0 0 0 0 0 0 0 0	1.00	040.05	1.00					1.00
0.00	1.00			UC	AP KET CO212-BTDG & FIXI	1.00	0	1.00
Investment Income - other	2. 00			oc	AP REL COSTS-MVBLE EQUIP	2. 00	0	2. 00
1.00 Control	3. 00			0		0.00	0	3.00
5.00 Befunds (chapter 8) 0 0 0 0 0 0 0 0 0	4 00	(chapter 2)		0		0.00		4 00
expenses (chapter 8)	4.00					0.00		4.00
Nental of provider space by suppliers (Chapter 8) 0 0.00	5.00			0		0.00	0	5. 00
Telephone services (pay stations excluded) (chapter 21)	6. 00			0		0.00	0	6.00
Stations excluded) (Chápter 27) 27) 70 27) 70 27) 70 70 70 70 70 70 70	7 00			0		0.00	_	7 00
1	7.00					0.00		7.00
(chapter 21) 10.00 Provider-based physician A-8-2 -22,352,735 a	8 00			0		0.00	_	8 00
10.00 Provider-based physician A-8-2 -22,352,735 0 0 10.00 0 11.00 3 3 3 3 3 3 3 3 3	8.00					0.00		8.00
adjustment			1 4 9 2	-1		0.00	ł	
Chapter 23 2.00 Related organization Transactions (chapter 10) 13.00 Laundry and Linen service 0 0.00 0.13.00 14.00 15.00 Related organization 0.00 0.00 0.13.00 14.00 14.00 0.00 0.00 0.15.00 15.00 Related of quarters to employee and others 0 0.00	10.00		A-0-2	-22, 332, 733				10.00
12.00 Related organization	11. 00			0		0.00	0	11. 00
13.00 Laundry and I linen service 0 0.00 0 13.00 15.00 Rental of quarters to employee and others 0 0.00 0 15.00 15.00 Rental of quarters to employee and others 0 0.00 0 15.00	12. 00	Related organization	A-8-1	1, 664, 715			0	12.00
14.00 Carfetreiral-employees and guests B -1,015,353(CAFETERIA 11.00 0 14.00 0.00 0.15.00 0.00	12 00			0		0.00	0	12 00
and others		1	В	-1, 015, 353 C	AFETERI A		l e	
16.00 Sale of medical and surgical supplies to other than patients 0 0.00 0.	15. 00			0		0.00	0	15. 00
patients	16. 00			0		0.00	0	16. 00
17. 00 Sale of drugs to other than patients 0 0 0 0 0 0 17. 00 0 18. 00 0 18. 00 0 0 18. 00 0 0 0 0 0 0 0 18. 00 0 0 0 0 0 0 0 0 0								
18. 00 Sale of medical records and abstracts 0 0.00 0 18. 00 0 18. 00 0 18. 00 0 18. 00 0 18. 00 0 18. 00 0 19. 00 19. 00	17. 00	1.		O		0.00	0	17. 00
abstracts	10 00	1.		0		0.00		10 00
education (tuition, fees, books, etc.)	16.00			٥		0.00	0	16.00
Dooks, etc.) Nursing and allied health education (tuition, fees, books, etc.) 23.01 0 19.01	19. 00		В	-2, 298, 636 N	URSING PROGRAM	20. 00	0	19. 00
education (tuition, fees, books, etc.)		books, etc.)						
Dooks, etc.) Dooks, etc.) B	19. 01		В	-14, 224 E	MS EDUCATION	23. 01	0	19. 01
21.00 Income from imposition of interest, finance or penal ty charges (chapter 21) 22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments 23.00 Adjustment for respiratory therapy costs in excess of Iimitation (chapter 14) 24.00 Adjustment for physical therapy costs in excess of Iimitation (chapter 14) 25.00 Utilization review - physicians compensation (chapter 21) 0 0 0 0 0 0 0 0 0								
interest, finance or penal ty charges (chapter 21) 22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments and borrowings to repay Medicare overpayments 23.00 Adj ustment for respiratory A-8-3 24.00 Adj ustment for physical in excess of limitation (chapter 14) 25.00 Utilization review - physicians' compensation (chapter 21) 26.00 Depreciation - CAP REL COSTS-BLDG & FIXT			В		AFETERI A		l e	
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments and borrowings to pay Medicare overpayment and borrowings to pay Medicare overpayments and borro	21.00	interest, finance or penalty				0.00	0	21.00
Overpayment's and borrowings to repay Medi care overpayments A-8-3 ORESPIRATORY THERAPY 65.00 23.00	22 00			0		0.00	_	22 00
23. 00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14) 24. 00 Adjustment for physical therapy costs in excess of limitation (chapter 14) 25. 00 Utilization review - physicians' compensation (chapter 21) 26. 00 Depreciation - CAP REL COSTS-BLDG & FIXT 27. 00 Depreciation - CAP REL COSTS-MVBLE EQUIP 28. 00 Non-physician Anesthetist 29. 00 Physicians' assistant 30. 00 Adjustment for respiratory therapy 65. 00 24. 00 24. 00 25. 00 25. 00 26. 00 26. 00 27. 00 28. 00 29. 00 27. 00 28. 00 29. 00 29. 00 30. 00 29. 00 30. 09 4-8-3 30. 09 4-8-3 30. 09 4-8-3 4-8-3 50 6-5. 00 6-5. 00 6-6. 00 6-6. 00 6-6. 00 6-7.	22.00					0.00		22.00
therapy costs in excess of limitation (chapter 14) 24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14) 25.00 Utilization review - physicians' compensation (chapter 21) 26.00 Depreciation - CAP REL COSTS-BLDG & FIXT 27.00 Depreciation - CAP REL COSTS-BLDG & FIXT 28.00 Non-physician Anesthetist 29.00 Physicians' assistant 30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14) 30.99 Hospice (non-distinct) (see instructions)	23 00		Δ_8_3	OR	FSPIRATORY THERAPY	65.00		23 00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14) 25.00 Utilization review - physicians' compensation (chapter 21) 26.00 Depreciation - CAP REL COSTS-BLDG & FIXT 27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP 28.00 Non-physician Anesthetist 28.00 Physicians' assistant 29.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14) 29.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14) 20.00 Physicians' assistant 20.00 Physicians' assistant 21.00 Physicians' assistant 22.00 CAP REL COSTS-MVBLE EQUIP 23.00 Physicians' assistant 24.00 Physicians' compensation 25.00 Physicians' assistant 26.00 CAP REL COSTS-BLDG & FIXT 27.00 CAP REL COSTS-MVBLE EQUIP 28.00 Physicians' assistant 29.00 Physicians	23.00	therapy costs in excess of	7 0 3		EST TRATORT THERAIT	03.00		23.00
therapy costs in excess of limitation (chapter 14) 25. 00 Utilization review - physicians' compensation (chapter 21) 26. 00 Depreciation - CAP REL COSTS-BLDG & FIXT	24 00		A-8-3	O.P.	HYSICAL THERAPY	66.00		24 00
25.00 Utilization review - physicians' compensation (chapter 21) 26.00 Depreciation - CAP REL COSTS-BLDG & FIXT 27.00 Depreciation - CAP REL COSTS-BLDG & FIXT 27.00 Depreciation - CAP REL COSTS-BLDG & FIXT 27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP 28.00 Non-physician Anesthetist 29.00 Non-physician Anesthetist 29.00 Physicians' assistant 30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14) 30.99 Hospice (non-distinct) (see instructions) 0 *** Cost Center Deleted *** 114.00 25.00 0 CAP REL COSTS-BLDG & FIXT 0 CAP REL COSTS-MVBLE EQUIP 2.00 0 27.00 0 27.00 0 28.00 0 0 0 29.00 30.00 0 30.00 0 30.00	21.00	therapy costs in excess of	7, 0, 0		THOUGHE THEIRIT	00.00		21.00
physicians' compensation (chapter 21) 26.00 Depreciation - CAP REL COSTS-BLDG & FIXT	25 00			0 *	** Cost Center Deleted **:	114 00		25 00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT 1.00 0 26.00 27.00 Depreciation - CAP REL COSTS-BLDG & FIXT 1.00 0 26.00 27.00 Depreciation - 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 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	20.00	physicians' compensation			oost conten beneted	111.00		20.00
COSTS-BLDG & FIXT Depreciation - CAP REL COSTS-MVBLE EQUIP 28. 00 Non-physician Anesthetist Physicians' assistant 30. 00 Adjustment for occupational therapy costs in excess of limitation (chapter 14) Hospice (non-distinct) (see instructions) COSTS-MVBLE EQUIP OCAP REL COSTS-	26 00			00	AP REL COSTS-BLDG & FLXT	1 00	0	26 00
COSTS-MVBLE EQUIP 28.00 Non-physician Anesthetist 9.00 Physicians' assistant 30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14) 30.99 Hospice (non-distinct) (see instructions) COSTS-MVBLE EQUIP 0 *** Cost Center Deleted *** 19.00 28.00 29.00 30.00 67.00 30.00 30.99		COSTS-BLDG & FLXT						
28.00 Non-physician Anesthetist 0 *** Cost Center Deleted *** 19.00 29.00 29.00 30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14) Hospice (non-distinct) (see instructions) Another product of the struction of t	27. 00			OC	AP REL COSTS-MVBLE EQUIP	2.00	0	27.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14) 30.99 Hospice (non-distinct) (see instructions) A-8-3 OCCUPATIONAL THERAPY 67.00 30.00 30.00 30.00		Non-physician Anesthetist		0 *	** Cost Center Deleted ***			
therapy costs in excess of limitation (chapter 14) 30.99 Hospice (non-distinct) (see instructions) OADULTS & PEDIATRICS 30.00 30.99			A-8-3	0	CCUPATIONAL THERAPY		i e	
30. 99 Hospi ce (non-distinct) (see instructions) 0 ADULTS & PEDIATRICS 30.00 30.99	23.00	therapy costs in excess of			The state of the s	37.00		25.00
instructions)	30. 99			۵۱۵	DULTS & PEDLATRICS	30.00		30. 99
31. UU TAGLUSTMENT TON SPEECH I A-8-3 OISPEECH PATHOLOGY 68. 00 31. 00		instructions)						
pathology costs in excess of	31.00		A-8-3	0 S	PEECH PATHULUGY	68.00		31.00
limitation (chapter 14)				<u> </u>			<u> </u>	

From 01/01/2023

Separate Classification on Worksheet A 13/28/2024 12:00 to not not not not not not not not not					T	o 12/31/2023		pared:
To/From Which the Amount is to be Adjusted					Expense Classification on	Worksheet A	3/28/2024 12:	04 pm
2.00 CAH HIT Adjustment for Operation and Interest								
2.00 CAH INIT Adjustment For								
2.00 CAH INIT Adjustment For								
2.00 CAH HIT Adjustment for Operation and Interest								
20.00 CAH HIT Adj Insternat Form		Cost Center Description						
Depreciation and Interest B	00.00	TOALL LILT ALL L. C.	1.00					00.00
33.00 MISCELLANEOUS REVENUE B -107,107 EMPLOYEE BENEFITS DEPARTMENT 4,00 0 33.00 1 33.00 MISCELLANEOUS REVENUE B -225,479/MAMT INFO SYSTEMS 5,02 0 33.02 33.02 33.02 33.02 33.02 34.02 34.02 34.03 34.02 34.02 34.03 34.02 34.02 34.03 34.02 34.03 34.02 34.03 34.02 34.03 34.02 34.03 34.02 34.03 34.02 34.03 34.02 34.03 34.03 34.02 34.03	32.00			0		0.00	0	32.00
33.01 MISCELLANEOUS REVENUE B -20/COMMUNICATIONS 5.01 0.33.01	33. 00	1 .	В	-197, 107	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33. 00
MISCELLANEOUS REVENUE B							l	1
MISCELLANEOUS REVENUE B		MI SCELLANEOUS REVENUE				5. 02	0	
CENERAL							l e	
33.05 MI SCELLANEUS REVENUE B -36, 859 DEPERATION OF PLANT 7, 00 0 33.05 33.05 MI SCELLANEUS REVENUE B -565, 075 DI ETARY 10.00 0 33.07 33.05 33.07 MI SCELLANEUS REVENUE B -565, 075 DI ETARY 10.00 0 33.07 33.07 33.07 33.08 MI SCELLANEUS REVENUE B -15, 000 DIVERSING ADMINI STRATION 13.00 0 33.08 33.09 MI SCELLANEUS REVENUE B -4, 432 PIRADIO STRUCK DIVERSING ADMINI STRATION 50.00 0 33.09 33.09 33.01 MI SCELLANEUS REVENUE B -4, 432 PIRADIO STRUCK DIVERSING ADMINI STRATION 50.00 0 33.11 33.11 MI SCELLANEUS REVENUE B -344, 543 PIRADIO STRUCK DIVERSING ADMINI STRATION 50.00 0 33.13 13.31 MI SCELLANEUS REVENUE B -344, 543 PIRADIO STRUCK DIVERSING ADMINI STRATION 50.00 0 33.13 13.31 MI SCELLANEUS REVENUE B -10, 500 DIVERSING ADMINI STRUCK DIVERSING ADMINI STRUCK DIVERSING ADMINI STRUCK DIVERSING ADMINISTRATION 50.00 0 33.13 14 MI SCELLANEUS REVENUE B -10, 500 DIVERSING ADMINISTRATION 50.00 0 33.13 14 MI SCELLANEUS REVENUE B -10, 500 DIVERSING ADMINISTRATION 50.00 0 33.13 14 MI SCELLANEUS REVENUE B -10, 500 DIVERSING ADMINISTRATION 50.00 0 33.10 0 33.05 14 DIVERSING ADMINISTRATION 50.00 0 34.00	33. 04	MI SCELLANEOUS REVENUE	B	-4, 655, 847		5. 06	0	33. 04
33.06 MI SCELLAMEOUS REVENUE B -2010, 161 MOUSEKEPINS 9,00 0,33,07 MI SCELLAMEOUS REVENUE B -565,0750 ETARY 10,00 0,33,07 MI SCELLAMEOUS REVENUE B -565,0750 ETARY 10,00 0,33,07 MI SCELLAMEOUS REVENUE B -715,000 NURSING ADMINISTRATION 13,00 0,33,07 MI SCELLAMEOUS REVENUE B -715,000 NURSING ADMINISTRATION 15,00 0,33,07 MI SCELLAMEOUS REVENUE B -715,000 NURSING ADMINISTRATION 15,00 0,33,07 MI SCELLAMEOUS REVENUE B -715,000 NURSING ADMINISTRATION 15,00 0,33,07 MI SCELLAMEOUS REVENUE B -715,000 NURSING ADMINISTRATION 15,00 0,33,11 MI SCELLAMEOUS REVENUE B -715,000 NURSING ADMINISTRATION 50,00 0,33,12 MI SCELLAMEOUS REVENUE B -715,000 NURSING ADMINISTRATION 50,00 0,33,12 MI SCELLAMEOUS REVENUE B -715,000 NURSING ADMINISTRATION 50,00 0,33,13 MI SCELLAMEOUS REVENUE B -715,000 NURSING ADMINISTRATION 50,00 0,33,13 MI SCELLAMEOUS REVENUE B -715,000 NURSING ADMINISTRATION 50,00 0,33,13 MI SCELLAMEOUS REVENUE B -715,000 NURSING ADMINISTRATION 50,00 0,33,13 MI SCELLAMEOUS REVENUE B -715,000 NURSING ADMINISTRATION 50,00 0,33,13 MI SCELLAMEOUS REVENUE B -715,000 NURSING ADMINISTRATION 50,00 0,33,13 MI SCELLAMEOUS REVENUE B -715,000 NURSING ADMINISTRATION 50,00 0,33,13 MI SCELLAMEOUS REVENUE B -715,000 NURSING ADMINISTRATION 50,00 0,33,13 MI SCELLAMEOUS REVENUE B -715,000 NURSING ADMINISTRATION 50,00 0,33,13 MI SCELLAMEOUS REVENUE B -715,000 NURSING ADMINISTRATION 50,00 0,33,13 MI SCELLAMEOUS REVENUE B -715,000 NURSING ADMINISTRATION 50,00 0,33,13 MI SCELLAMEOUS REVENUE B -715,000 NURSING ADMINISTRATION 50,00 0,33,10 NURSING ADMINISTRATION 50,00 0,33,10 NURSING ADMINISTRATION 50,00 0,33,10 NURSING ADMINISTRATION 50,00 0,34,00 NU	33 05	MUSCELLANEOUS REVENUE	B	-36 859	1	7 00	0	33 05
33.07 MISCELLANEOUS REVENUE B -565,075 DITARY 10.00 0.33.07			I .		}		l e	1
33.09 MISCELLANEOUS REVENUE					1		l	1
33.10 MISCELLANEOUS REVENUE B	33. 08						l	33. 08
MISCELLANEOUS REVENUE	33. 09	MI SCELLANEOUS REVENUE	В	-4, 445	PHARMACY	15. 00	0	33. 09
33.12 MISCELLANEOUS REVENUE B -334, 543 PHYSICAL THERAPY 66, 00 0 33.12					1		l e	1
33. 13 M SCELLANEOUS REVENUE B -116, 900 OCCUPATI ONAL THERAPY 7.73. 01 0 33. 13 33. 14 M SCELLANEOUS REVENUE B -1960 I ABETS CENTER 7.73. 01 0 33. 13 33. 15 M SCELLANEOUS REVENUE B -2, 967 IROME HEALTH AGENCY 101. 00 0 34. 01 34. 01 ADVERTIS ING A -972 IMPLOYEE BENEFITS DEPARTMENT 4. 00 0 34. 01 34. 01 ADVERTIS ING A -1.0, 397 INTHE ADMINISTRATIVE AND 5. 06 0 34. 03 34. 02 ADVERTIS ING A -1.0, 397 INTHE ADMINISTRATIVE AND 5. 06 0 34. 03 34. 03 ADVERTIS ING A -2.1 IS AUSTIS ING A -2.2 IS A AUDIL TS & PEDI ATT IC S -3.0 O -3.4 O							l	1
33.14 MISCELLANEOUS REVENUE B -198DI ABETES CENTER 73.01 0 33.14 34.02 ADVERTIS ING A -972[MIN_OYEE BENEFITS DEPARTMENT 4.00 0 34.01 34.02 ADVERTIS ING A -972[MIN_OYEE BENEFITS DEPARTMENT 4.00 0 34.01 34.02 ADVERTIS ING A -10.89*]COMMINI CATIONS 5.01 0 34.01 34.03 ADVERTIS ING A -11.63*]COMMINI CATIONS 5.00 0 34.02 34.04 ADVERTIS ING A -10.89*]OTHER ADM IN ISTRATI VE AND 5.06 0 34.03 34.05 ADVERTIS ING A -10.89*]OTHER ADM IN ISTRATI VE AND 5.06 0 34.03 34.04 ADVERTIS ING A -2.11*]AURSING ADM IN ISTRATION 13.00 0 34.04 34.05 ADVERTIS ING A -2.11*]AURSING ADM IN ISTRATION 13.00 0 34.05 34.07 ADVERTIS ING A -2.11*]AURSING ADM IN ISTRATION 13.00 0 34.05 34.08 ADVERTIS ING A -165.27*]AURSING PROGRAM 20.00 0 34.07 34.09 ADVERTIS ING A -2.15*]ADULTS A PEDIATRICS 30.00 0 34.09 34.10 ADVERTIS ING A -2.50*[ADULTS IN EXPEDIATRICS 30.00 0 34.09 34.11 ADVERTIS ING A -2.28*[ADULTS IN EXPEDIATRIC S 30.00 0 34.09 34.11 ADVERTIS ING A -2.28*[ADULTS IN EXPEDIATRIC S 30.00 0 34.11 34.12 ADVERTIS ING A -2.28*[ADULTS IN EXPEDIATRIC S 30.00 0 34.11 34.13 ADVERTIS ING A -3.08*[ADULTS IN EXPEDIATRIC ROOM 50.00 0 34.11 34.14 ADVERTIS ING A -3.08*[ADULTS IN EXPEDIATRIC ROOM 50.00 0 34.11 34.15 ADVERTIS ING A -3.08*[ADULTS IN EXPEDIATRIC ROOM 50.00 0 34.11 34.16 ADVERTIS ING A -3.08*[ADULTS IN EXPEDIATRIC ROOM 50.00 0 34.11 34.17 ADVERTIS ING A -3.08*[ADULTS IN EXPEDIATRIC ROOM 50.00 0 34.11 34.18 ADVERTIS ING A -3.08*[ADULTS IN EXPEDIATRIC ROOM 50.00 0 34.11 34.19 ADVERTIS ING A -3.08*[ADULTS IN EXPEDIATE ROOM 50.00 0 34.11 34.11 ADVERTIS ING A -3.08*[ADULTS IN EXPEDIATE ROOM 50.00 0 34.11 34.12 ADVERTIS ING A -3.08*[ADULTS IN EXPEDIATE ROOM 50.00					ł .		· -	1
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34. 00 ADVERTISING A -972EMPLOYEE BENEFITS DEPARTMENT 4. 00 0 34. 01 ADVERTISING A -1. 635PURCHASING 5. 03 0 34. 01 ADVERTISING A -1. 635PURCHASING 5. 03 0 34. 03 ADVERTISING A -1. 635PURCHASING 5. 03 0 34. 03 ADVERTISING A -1. 635PURCHASING 5. 03 0 34. 03 ADVERTISING A -1. 635PURCHASING 5. 06 0 34. 03 ADVERTISING A -1. 635PURCHASING 5. 06 0 34. 03 ADVERTISING A -1. 635PURCHASING A -2. 715PURCHASING A -2. 715PURCHASING A -2. 715PURCHASING A -3. 75PURCHASING					li de la companya de			1
34. 01 ADVERTISING							i e	1
34. 02 ADVERTISING A -1.0,891 OTHER ADMINISTRATIVE AND 5.06 0.34.03 34. 04 ADVERTISING A -2.113 NUESING ADMINISTRATIVE AND 5.06 0.34.03 34. 05 ADVERTISING A -2.113 NUESING ADMINISTRATION 13. 00 0.34.04 34. 05 ADVERTISING A -2.113 NUESING ADMINISTRATION 13. 00 0.34.05 34. 06 ADVERTISING A -2.113 NUESING ADMINISTRATION 13. 00 0.34.06 34. 07 ADVERTISING A -1.05.272 NURSING PROGRAM 20. 00 0.34.07 34. 08 ADVERTISING A -2.113 NUESING ADMINISTRATION 13. 00 0.34.06 34. 07 ADVERTISING A -1.05.272 NURSING PROGRAM 20. 00 0.34.07 34. 08 ADVERTISING A -2.154 ADULTS & PEDIATRICS 30. 00 0.34.07 34. 09 ADVERTISING A -5.0NE ADMINISTRATION 13. 00 0.34.07 34. 09 ADVERTISING A -2.154 ADULTS & PEDIATRICS 30. 00 0.34.08 34. 10 ADVERTISING A -2.2154 ADULTS & PEDIATRICS 30. 00 0.34.08 34. 10 ADVERTISING A -2.2154 ADULTS & PEDIATRICS 30. 00 0.34.08 34. 11 ADVERTISING A -2.2154 ADULTS & PEDIATRICS 30. 00 0.34.08 34. 12 ADVERTISING A -2.2154 ADULTS & PEDIATRICS 30. 00 0.34.08 34. 10 ADVERTISING A -2.2154 ADULTS & PEDIATRICS 30. 00 0.34.08 34. 11 ADVERTISING A -2.2154 ADULTS & PEDIATRICS 30. 00 0.34.08 34. 12 ADVERTISING A -2.2154 ADULTS & PEDIATRICS 30. 00 0.34.13 34. 14 ADVERTISING A -2.2078 ADULTS & PEDIATRICS 30. 00 0.34.13 34. 14 ADVERTISING A -2.2078 ADULTS & PEDIATRICS 30. 00 0.34.13 34. 14 ADVERTISING A -2.208 ADULTS & PEDIATRICS 30. 00 0.34.13 34. 15 ADVERTISING A -2.208 ADULTS & PEDIATRICS 30. 00 0.34.13 34. 16 ADVERTISING A -2.208 ADULTS & PEDIATRICS 30. 00 0.34.13 34. 17 ADVERTISING A -2.208 ADULTS & PEDIATRICS 30. 00 0.34.13 34. 18 ADVERTISING A -2.208 ADULTS & PEDIATRICS 30. 00 0.34.13 34. 19 ADVERTISING A -2.208 ADULTS & PEDIATRICS 30. 00 0.34.13 34. 19 ADVERTISING A -2.208 ADULTS & PEDIATRICS 30. 00 0.34.13 35. 00 DAVERTISING A -2.208 ADULTS & PEDIATRICS 30. 00 0.34.13 36. 00 DAVERTISING A -2.208 ADULTS & PEDIATRICS 30. 00 0.34.13 37. 00 LOBERTISING A -2.208 ADULTS & PEDIATRICS 30. 00 0.34.13 38. 00 DAVERTISING A -2.208 ADULTS & PEDIATRICS 30. 00 0.34.13 38. 00 DAVERTISING A -2.208 ADULTS & P					1		1	1
34, 03 ADVERTISING		•						1
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24, 07 ADVERTI SI NG A -165, 272 MURSI NG PROGRAM 20, 00 0 34, 07			1		1			1
34. 08 ADVERTISING A -2,154 ADULTS & PEDIATRICS 30. 00 0 34. 08							l	1
34. 09 ADVERTISING A -50 MECNATAL INTENSIVE CARE UNIT 35. 00 0 34. 09 34. 10 34. 11 34. 12 ADVERTISING A -875 ADVERTISING 50. 00 0 34. 11 34. 12 ADVERTISING A -287 RADIOLOGY-DIAGNOSTIC 54. 00 0 34. 11 34. 12 ADVERTISING A -4. 097 RADIO ISOTOPE 56. 00 0 34. 12 34. 14 ADVERTISING A -9. 30 RESPIRATORY THERAPY 65. 00 0 34. 13 34. 14 ADVERTISING A -717, 965 PHYSICAL THERAPY 65. 00 0 34. 13 34. 14 ADVERTISING A -717, 965 PHYSICAL THERAPY 67. 00 0 34. 15 34. 15 ADVERTISING A -2029 OCCUPATIONAL THERAPY 67. 00 0 34. 16 34. 16 ADVERTISING A -2. 224 ELECTROCARDIOLOGY 68. 00 0 34. 16 34. 17 ADVERTISING A -2. 224 ELECTROCARDIOLOGY 69. 00 0 34. 17 34. 18 ADVERTISING A -2. 019 DIABETES CENTER 73. 01 0 34. 18 34. 19 ADVERTISING A -2. 019 DIABETES CENTER 73. 01 0 34. 18 34. 19 ADVERTISING A -1. 000 0 34. 19 34. 20 ADVERTISING A -1. 000 0 34. 20					ł .		l .	1
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34. 17 ADVERTISING			1		li de la companya de		i e	1
34. 18 ADVERTISING		•	1				· -	1
34. 19 ADVERTISING A -7 ANTICOAGULATION 76. 01 0 34. 19 34. 20 ADVERTISING A -150 CLINIC - OUTPATIENT INFUSION SERVICE 34. 21 ADVERTISING A -613 EMERGENCY 91. 00 0 34. 21 34. 22 ADVERTISING A -1, 688 WOUND CARE 91. 01 0 34. 22 34. 23 ADVERTISING A -4, 171 HOME HEALTH AGENCY 101. 00 0 34. 23 35. 00 PROVIDER TAX A -22, 221, 244 OTHER ADMINISTRATIVE AND GENERAL 36. 00 FALL OUT ACCOUNTS A -206, 439 COMMUNICATIONS 5. 06 0 35. 00 37. 00 LOBBYING FEES A -10, 446 OTHER ADMINISTRATIVE AND GENERAL 38. 01 DONATIONS A -111, 157 CAP REL COSTS-BLDG & FIXT 1. 00 14 38. 01 39. 00 PHYSICIAN RECRUITMENT A -7, 367 PHYSICIANS PRIVATE OFFICES 192. 00 0 39. 00 40. 01 NRCC PHYSICIANS A -9, 057, 374 PHYSICIANS' PRIVATE OFFICES 192. 00 0 40. 01 41. 00 PONSION TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, 0. 17, 736, 60) 34. 21 ADVERTISING A -150 CLINIC - OUTPATIENT INFUSION 90. 01 34. 22 ADVERTISING 90. 01 34. 21 ADVERTISING 90. 01 34. 22 ADVERTISING 90. 01 34. 24 ADVERTISING 90. 01 34. 22 ADVERTISING 90. 01 34. 24 ADVERTISING		•	1				l e	
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34. 21 ADVERTISING A -613 EMERGENCY 91. 00 0 34. 21 34. 22 ADVERTISING A -1, 688 WOUND CARE 91. 01 0 34. 22 34. 23 ADVERTISING A -4, 171 HOME HEALTH AGENCY 101. 00 0 34. 23 34. 24 ADVERTISING A -11, 296 HOSPICE 116. 00 0 34. 24 35. 00 PROVIDER TAX A -22, 221, 244 OTHER ADMINISTRATIVE AND ENERGY 116. 00 0 34. 24 36. 00 FALL OUT ACCOUNTS A 206, 439 COMMUNICATIONS 5. 01 0 36. 00 37. 00 LOBBYING FEES A -10, 446 OTHER ADMINISTRATIVE AND ENERGY 116. 00 0 37. 00 38. 00 DONATIONS A -17, 143 HOSPICE 116. 00 0 38. 00 38. 01 DONATIONS A -111, 157 CAP REL COSTS-BLDG & FIXT 1. 00 14 38. 01 39. 00 PHYSICIAN RECRUITMENT A -7, 367 PHYSICIANS' PRIVATE OFFICES 192. 00 0 39. 00 40. 01 NRCC PHYSICIANS A -9, 057, 374 PHYSICIANS' PRIVATE OFFICES 192. 00 0 40. 01 41. 00 PENSION A 1, 762, 562 EMPLOYEE BENEFITS DEPARTMENT 4. 00 0 41. 00 50. 00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A,	5 20			750	1	,5.01		5 20
34. 23 ADVERTISING A -4, 171 HOME HEALTH AGENCY 101. 00 0 34. 23 34. 24 ADVERTISING A -11, 296 HOSPICE 116. 00 0 34. 24 35. 00 PROVIDER TAX A -22, 221, 244 OTHER ADMINISTRATIVE AND ENERGY 116. 00 35. 00 GENERAL 5. 00 GENERAL 5. 00 GENERAL 5. 00 35. 00 GENERAL 5. 00 GENERAL 5. 00 37. 00 GENERAL 5. 00 37	34. 21	ADVERTI SI NG	Α	-613		91.00	0	34. 21
34. 24 ADVERTISING A -11, 296 HOSPICE 116. 00 0 34. 24 35. 00 PROVIDER TAX A 206, 439 COMMUNICATIONS 5. 06 37. 00 LOBBYING FEES A 206, 439 COMMUNICATIONS 5. 06 38. 00 DONATIONS A -10, 446 OTHER ADMINISTRATIVE AND GENERAL 5. 06 38. 01 DONATIONS A -111, 157 CAP REL COSTS-BLDG & FIXT 1. 00 14 38. 01 39. 00 PHYSICIAN RECRUITMENT A -7, 367 PHYSICIANS' PRIVATE OFFICES 192. 00 0 39. 00 40. 01 NRCC PHYSICIANS A -9, 057, 374 PHYSICIANS' PRIVATE OFFICES 192. 00 0 40. 00 40. 01 NRCC PHYSICIANS A -9, 057, 374 PHYSICIANS' PRIVATE OFFICES 192. 00 0 40. 00 50. 00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, 50. 00) 34. 24 -11, 296 HOSPICE 116. 00 0 34. 24 -22, 221, 244 OTHER ADMINISTRATIVE AND 5. 06 GENERAL 16. 00 36. 00 36. 00 37. 00 GENERAL 16. 00 0 36. 00 37. 00 GENERAL 17, 143 HOSPICE 116. 00 0 37. 00 38. 01 DONATIONS A -111, 157 CAP REL COSTS-BLDG & FIXT 1. 00 14 38. 01 38. 01 DONATIONS A -7, 367 PHYSICIANS' PRIVATE OFFICES 192. 00 0 39. 00 40. 01 NRCC PHYSICIANS A -9, 057, 374 PHYSICIANS' PRIVATE OFFICES 192. 00 0 40. 00 40. 01 NRCC PHYSICIANS A -9, 057, 374 PHYSICIANS' PRIVATE OFFICES 192. 00 0 40. 00 50. 00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, 50. 00			A				l e	
35. 00 PROVI DER TAX A -22, 221, 244 OTHER ADMINI STRATI VE AND GENERAL 36. 00 FALL OUT ACCOUNTS A 206, 439 (COMMUNI CATI ONS 5. 01 0 36. 00 37. 00 LOBBYI NG FEES A -10, 446 OTHER ADMINI STRATI VE AND GENERAL 38. 00 DONATI ONS A -111, 157 CAP REL COSTS-BLDG & FIXT 1. 00 14 38. 01 39. 00 PHYSI CI AN RECRUI TMENT A -7, 367 PHYSI CI ANS' PRI VATE OFFI CES 192. 00 0 39. 00 40. 01 NRCC PHYSI CI ANS A -9, 057, 374 PHYSI CI ANS' PRI VATE OFFI CES 192. 00 0 40. 01 41. 00 PENSI ON A 1, 762, 562 EMPLOYEE BENEFI TS DEPARTMENT 4. 00 0 41. 00 50. 00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A,			1					
Section Sect			1				ł	1
36. 00 FALL OUT ACCOUNTS A 206, 439 COMMUNI CATIONS 5. 01 0 36. 00 37. 00 LOBBYI NG FEES A -10, 446 OTHER ADMINI STRATI VE AND 5. 06 0 37. 00 GENERAL 116. 00 0 38. 00 DONATI ONS A -17, 143 HOSPI CE 116. 00 0 38. 00 38. 01 DONATI ONS A -111, 157 CAP REL COSTS-BLDG & FI XT 1. 00 14 38. 01 9. 00 PHYSI CI AN RECRUI TMENT A -7, 367 PHYSI CI ANS' PRI VATE OFFI CES 192. 00 0 39. 00 40. 01 NRCC PHYSI CI ANS A -382, 802 HOSPI CE 116. 00 0 40. 00 41. 00 PENSI ON A -9, 057, 374 PHYSI CI ANS' PRI VATE OFFI CES 192. 00 0 40. 01 41. 00 PENSI ON A 1, 762, 562 EMPLOYEE BENEFITS DEPARTMENT 4. 00 50. 00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, 50. 00 TOTAL (sum of lines 1 thru 49)	35.00	PRUVIDER TAX	A	-22, 221, 244		5. 06	0	35.00
37. 00 LOBBYING FEES A -10, 446 OTHER ADMINISTRATIVE AND GENERAL 116. 00 37. 00 GENERAL 116. 00 0 38. 00 38. 01 DONATIONS A -111, 157 CAP REL COSTS-BLDG & FIXT 1. 00 14 38. 01 39. 00 PHYSICIAN RECRUITMENT A -7, 367 PHYSICIANS' PRIVATE OFFICES 192. 00 0 39. 00 40. 00 NRCC PHYSICIANS A -382, 802 HOSPICE 116. 00 0 40. 00 40. 00 PENSION A -9, 057, 374 PHYSICIANS' PRIVATE OFFICES 192. 00 0 40. 01 41. 00 PENSION A 1, 762, 562 EMPLOYEE BENEFITS DEPARTMENT 4. 00 0 41. 00 50. 00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, 50. 00	36. 00	FALL OUT ACCOUNTS	A	206 439		5 01	n	36, 00
38. 00 DONATIONS A -17, 143 HOSPICE 116. 00 0 38. 00 38. 01 DONATIONS A -111, 157 CAP REL COSTS-BLDG & FIXT 1. 00 14 38. 01 39. 00 PHYSICIAN RECRUITMENT A -7, 367 PHYSICIANS' PRIVATE OFFICES 192. 00 0 39. 00 40. 00 NRCC PHYSICIANS A -382, 802 HOSPICE 116. 00 0 40. 00 40. 01 NRCC PHYSICIANS A -9, 057, 374 PHYSICIANS' PRIVATE OFFICES 192. 00 0 40. 01 41. 00 PENSION A 1, 762, 562 EMPLOYEE BENEFITS DEPARTMENT 4. 00 0 41. 00 50. 00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, 50. 00			1		1			
38. 01 DONATIONS A -111, 157 CAP REL COSTS-BLDG & FIXT 1. 00 14 38. 01 39. 00 PHYSICIAN RECRUITMENT A -7, 367 PHYSICIANS' PRIVATE OFFICES 192. 00 0 39. 00 40. 00 NRCC PHYSICIANS A -382, 802 HOSPICE 116. 00 0 40. 00 40. 01 NRCC PHYSICIANS A -9, 057, 374 PHYSICIANS' PRIVATE OFFICES 192. 00 0 40. 01 41. 00 PENSION A 1, 762, 562 EMPLOYEE BENEFITS DEPARTMENT 4. 00 0 41. 00 50. 00 (Transfer to Worksheet A,			[",	.5, 110		2.00		
39.00 PHYSICIAN RECRUITMENT A -7,367 PHYSICIANS' PRIVATE OFFICES 192.00 0 39.00 40.00 NRCC PHYSICIANS A -382,802 HOSPICE 116.00 0 40.00 40.01 NRCC PHYSICIANS A -9,057,374 PHYSICIANS' PRIVATE OFFICES 192.00 0 40.01 41.00 PENSION A 1,762,562 EMPLOYEE BENEFITS DEPARTMENT 4.00 0 41.00 50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A,	38. 00	4	A	-17, 143	HOSPI CE	116. 00	0	38. 00
40.00 NRCC PHYSICIANS A -382,802 HOSPICE 116.00 0 40.00 40.01 NRCC PHYSICIANS A -9,057,374 PHYSICIANS' PRIVATE OFFICES 192.00 0 40.01 41.00 PENSION A 1,762,562 EMPLOYEE BENEFITS DEPARTMENT 4.00 0 41.00 50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A,			1				l e	1
40.01 NRCC PHYSICIANS A -9,057,374 PHYSICIANS' PRIVATE OFFICES 192.00 0 40.01 41.00 PENSION A 1,762,562 EMPLOYEE BENEFITS DEPARTMENT 4.00 0 41.00 50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A,			1		i e			
41.00 PENSION A 1,762,562 EMPLOYEE BENEFITS DEPARTMENT 4.00 0 41.00 50.00 (Transfer to Worksheet A,			1					
50.00 TOTAL (sum of lines 1 thru 49) -61,793,603 50.00 (Transfer to Worksheet A,			1				l e	
(Transfer to Worksheet A,			1		i e	4.00		
	50.00			-01, /73, 003				30.00
	_							

⁽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.

Worksheet A-8-1

From 01/01/2023 OFFICE COSTS 12/31/2023 Date/Time Prepared:

					3/28/2024 12:	04 pm
	Li ne No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost	Included in	
					Wks. A, column	
					5	
	1. 00	2. 00	3. 00	4. 00	5. 00	
		MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OR	GANIZATIONS OR	CLAI MED	
	HOME OFFICE COSTS:		_			l
1.00	l .		NEW CAPITAL	2, 679, 725	0	1. 00
2.00	1	OTHER ADMINISTRATIVE AND GEN	A&G	58, 916, 641	56, 666, 984	
3.00	1	MEDICAL RECORDS & LIBRARY	HI M	1, 707, 786	0	3. 00
3. 01		PHARMACY	COVP / PHARMACY	625, 917	0	3. 01
3.02	l .		SHARED SERVICES	0	169, 661	
4.00	l .	COMMUNI CATI ONS	SHARED SERVICES	0	63, 632	
4.01	1	MGMT INFO SYSTEMS	SHARED SERVICES	0	391, 344	
4.02	5. 06	OTHER ADMINISTRATIVE AND GEN	SHARED SERVICES	0	3, 034, 944	4. 02
4.03	13. 00	NURSING ADMINISTRATION	SHARED SERVICES	0	470, 412	4. 03
4.04	15. 00	PHARMACY	SHARED SERVICES	0	1, 468, 377	4. 04
4.05	0.00			0	0	4. 05
4.06	0.00			0	0	4. 06
4.07	0.00			0	0	4. 07
4.08	0.00			0	0	4. 08
4.09	0.00			0	0	4. 09
4.10	0.00			o	0	4. 10
5.00	TOTALS (sum of lines 1-4).			63, 930, 069	62, 265, 354	5. 00
	Transfer column 6, line 5 to					l
	Worksheet A-8, column 2,					l
	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	FRANCISCAN ALLI	100.00	FRANCISCAN ALLI	100.00	6. 00
7.00	G	FSEH	100.00	FSEH	100.00	7. 00
8.00			0.00		0.00	8. 00
9.00			0.00		0.00	9. 00
10.00			0.00		0.00	10. 00
100.00	G. Other (financial or					100.00
	non-financial) specify:					

- (1) Use the following symbols to indicate interrelationship to related organizations:
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organi zati on.
- E. Individual is director, officer, administrator, or key person of provider and related organization.

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

							10 12/31/2023	3/28/2024 12:	
	Net	Wkst. A-7 Ref.							
	Adjustments								
	(col. 4 minus								
	col. 5)*								
	6. 00	7. 00							
			IENTS REQUIRED AS A RI	SULT OF TRAI	NSACTIONS WITH	RELATED O	RGANIZATIONS OR	CLAI MED	
	HOME OFFICE CO								
1.00	2, 679, 725								1. 00
2.00	2, 249, 657								2. 00
3.00	1, 707, 786								3. 00
3. 01	625, 917								3. 01
3.02	-169, 661								3. 02
4.00	-63, 632								4. 00
4.01	-391, 344								4. 01
4.02	-3, 034, 944	0							4. 02
4.03	-470, 412	0							4. 03
4.04	-1, 468, 377	0							4. 04
4.05	0	0							4. 05
4.06	0	0							4. 06
4.07	0	0							4. 07
4.08	0	0							4. 08
4.09	0	0							4. 09
4.10	0	0							4. 10
5.00	1, 664, 715								5. 00

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

Related Organization(s)		
and/or Home Office		
Type of Business		
6. 00		
 B. INTERRELATIONSHIP TO RELAT	ED ORGANIZATION(S) AND/OR HOME OFFICE:	
	• •	_

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

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

6.00	HOME OFFICE	6. 00
7.00	SISTER FACILITY	7. 00
8.00		8. 00
9.00		9. 00
9. 00 10. 00		10. 00
100.00		100. 00

- (1) Use the following symbols to indicate interrelationship to related organizations:
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

Peri od: From 01/01/2023 To 12/31/2023 Date/Ti me Prepared: 3/28/2024 12:04 pm

							3/20/2024 12.	04 piii
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		ldenti fi er	Remuneration	Component	Component		ider Component	
							Hours	
	1. 00	2. 00	3.00	4.00	5. 00	6. 00	7. 00	
1.00	4. 00	EMPLOYEE BENEFITS DEPARTMENT	210, 015	210, 015	0	211, 500	0	1. 00
2.00	5. 06	OTHER ADMINISTRATIVE AND	3, 793, 998	3, 793, 998	0	211, 500	0	2.00
		GENERAL						
3.00	13.00	NURSING ADMINISTRATION	3, 450	3, 450	0	211, 500	0	3.00
4.00	23. 01	EMS EDUCATION	1, 000	1, 000	0	179, 000	0	4.00
5.00	30.00	ADULTS & PEDIATRICS	848, 225	848, 225	0	211, 500	0	5. 00
6.00	35. 00	NEONATAL INTENSIVE CARE UNIT	782, 729	782, 729	0	211, 500	0	6. 00
7.00	41.00	SUBPROVIDER - IRF	216, 418	216, 418	0	211, 500	0	7. 00
8.00	50.00	OPERATING ROOM	8, 814, 330	8, 814, 330	0	211, 500	0	8. 00
9.00	54. 00	RADI OLOGY-DI AGNOSTI C	560, 552	560, 552	0	211, 500	0	9. 00
10.00	56. 00	RADI OI SOTOPE	15, 699	15, 699	o	211, 500	o	10.00
11.00	60.00	LABORATORY	46, 225	46, 225	o	211, 500	0	11.00
12.00	65. 00	RESPI RATORY THERAPY	39, 227	39, 227	o	211, 500	0	12.00
13.00	66. 00	PHYSI CAL THERAPY	1, 968	1, 968	o	211, 500	0	13.00
14.00	69. 00	ELECTROCARDI OLOGY	3, 710, 296	3, 710, 296	o	211, 500	0	14.00
15.00	70.00	ELECTROENCEPHALOGRAPHY	22, 981	22, 981	o	211, 500	0	15. 00
16.00	73. 01	DI ABETES CENTER	7, 204	7, 204	o	211, 500	0	16.00
17.00	76. 01	ANTI COAGULATI ON	7, 132	7, 132	o	211, 500	o	17.00
18.00	90.00	CLINIC	38	38	o	211, 500	1	18. 00
19.00	91.00	EMERGENCY	2, 989, 060	2, 989, 060	o	211, 500	1	19. 00
20. 00	•	WOUND CARE	282, 188	282, 188	ol	211, 500	1	20.00
200.00	•		22, 352, 735		ol	= ,	o	200. 00
	1	I I	,,,	,,	-1		-1	

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT FRANCISCAN HEALTH LAFAYETTE In Lieu of Form CMS-2552-10 Provider CCN: 15-0109

Peri od: Worksheet A-8-2 From 01/01/2023 To 12/31/2023 Date/Time Prepared:

								3/28/2024 12:	04 pm_
	Wkst. A Line #	Cost Center/Physician	Unadjusted RC	5 Percent	of	Cost of	Provi der	Physician Cost	
		l denti fi er	Limit	Unadj usted	RCE	Memberships &	Component	of Malpractice	
				Limit		Conti nui ng	Share of col.	Insurance	
						Educati on	12		
	1. 00	2. 00	8. 00	9. 00		12. 00	13.00	14. 00	
1.00	4. 00	EMPLOYEE BENEFITS DEPARTMENT)	0	0	0	0	1.00
2.00		OTHER ADMINISTRATIVE AND		o	0	0	0	0	2.00
		GENERAL							
3.00		NURSING ADMINISTRATION)	0	0	0	0	3. 00
4.00	23. 01	EMS EDUCATION		0	0	0	0	0	4. 00
5.00	30.00	ADULTS & PEDIATRICS		o	0	0	0	0	5. 00
6.00	35. 00	NEONATAL INTENSIVE CARE UNIT		o	0	0	0	0	6.00
7.00	41. 00	SUBPROVIDER - IRF		o	0	0	0	0	7.00
8.00	50.00	OPERATING ROOM			0	0	0	0	8.00
9.00	54. 00	RADI OLOGY-DI AGNOSTI C			0	0	0	0	9. 00
10.00	56. 00	RADI OI SOTOPE			0	0	0	0	10.00
11. 00	60.00	LABORATORY		ol	0	0	0	0	11.00
12.00	65. 00	RESPI RATORY THERAPY		ol	0	0	0	0	12.00
13.00	66. 00	PHYSI CAL THERAPY		ol	0	0	0	0	13.00
14.00	69. 00	ELECTROCARDI OLOGY		ol	0	0	0	0	14.00
15.00	70.00	ELECTROENCEPHALOGRAPHY		ol	0	0	0	0	15.00
16.00	73. 01	DI ABETES CENTER		ol	0	0	0	0	16.00
17. 00	76. 01	ANTI COAGULATI ON			0	0	0	o	17.00
18. 00	90.00	CLINIC			0	0	0	o	18. 00
19.00	91. 00	EMERGENCY			0	0	0	o	19. 00
20. 00	91. 01	WOUND CARE		ol	0	0	0	o	20.00
200.00				ol	0	0	0	o	200.00
		ı	•	•		1	1		

						Γο 12/31/2023	Date/Time Pro 3/28/2024 12:	
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		I denti fi er	Component	Li mi t	Di sal I owance			
			Share of col.					
			14					
	1. 00	2. 00	15. 00	16. 00	17. 00	18. 00		
1.00	1	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	210, 015		1. 00
2.00	5. 06	OTHER ADMINISTRATIVE AND	0	0	0	3, 793, 998		2. 00
		GENERAL						
3.00	•	NURSING ADMINISTRATION	0	0	0	3, 450		3. 00
4.00		EMS EDUCATION	0	0	0	1, 000		4. 00
5.00		ADULTS & PEDIATRICS	0	0	0	848, 225		5. 00
6. 00		NEONATAL INTENSIVE CARE UNIT	0	0	0	782, 729		6. 00
7.00		SUBPROVI DER - I RF	0	0	0	216, 418		7. 00
8. 00		OPERATING ROOM	0	0	0	8, 814, 330		8. 00
9. 00	54.00	RADI OLOGY-DI AGNOSTI C	0	0	0	560, 552		9. 00
10.00	56.00	RADI OI SOTOPE	0	0	0	15, 699		10.00
11. 00	60.00	LABORATORY	0	0	0	46, 225		11. 00
12.00	65. 00	RESPI RATORY THERAPY	0	0	0	39, 227		12. 00
13.00	66. 00	PHYSI CAL THERAPY	0	0	0	1, 968		13. 00
14.00	69. 00	ELECTROCARDI OLOGY	0	0	0	3, 710, 296		14. 00
15.00	70.00	ELECTROENCEPHALOGRAPHY	0	0	0	22, 981		15. 00
16.00	73. 01	DI ABETES CENTER	0	0	0	7, 204		16. 00
17.00	76. 01	ANTI COAGULATI ON	0	0	0	7, 132		17. 00
18.00	90.00	CLI NI C	0	0	0	38		18. 00
19.00	91.00	EMERGENCY	0	0	0	2, 989, 060		19. 00
20.00	91. 01	WOUND CARE	0	0	0	282, 188		20.00
200.00			0	0	0	22, 352, 735		200.00

	ALLOCATION - GENERAL SERVICE COSTS	TRANCI SCAN TIEAL	Provi der C	CN: 15-0109	Peri od: From 01/01/2023 Fo 12/31/2023	Worksheet B Part I	
					Го 12/31/2023	Date/Time Pre 3/28/2024 12:	pared: 04 pm
			CAPITAL REI	LATED COSTS			
	Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	COMMUNI CATI ONS	
		for Cost Allocation			BENEFITS DEPARTMENT		
		(from Wkst A col. 7)					
		0	1.00	2. 00	4. 00	5. 01	
1.00	GENERAL SERVICE COST CENTERS O0100 CAP REL COSTS-BLDG & FIXT	17, 511, 885	17, 511, 885				1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	7, 391, 303		7, 391, 303	3		2. 00
4. 00 5. 01	00400 EMPLOYEE BENEFITS DEPARTMENT 01160 COMMUNI CATIONS	4, 424, 509				l	4. 00 5. 01
5. 01	01140 MGMT INFO SYSTEMS	1, 194, 537 4, 037, 493	439, 786 468, 296				
5.03	00550 PURCHASI NG	475, 516	230, 814			l	5. 03
5. 04 5. 05	00570 ADMITTING 00580 PATIENT ACCOUNTING	615 1, 214, 815			0 0		
5.06	00560 OTHER ADMINISTRATIVE AND GENERAL	91, 965, 635	2, 203, 571				1
7. 00 8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	9, 216, 546 835, 725					1
9.00	00900 HOUSEKEEPI NG	2, 961, 410	268, 207	113, 512	78, 193	23, 915	9. 00
10. 00 11. 00		1, 414, 974 1, 399, 578					1
13.00	01300 NURSING ADMINISTRATION	3, 652, 699	79, 357	33, 586	151, 550	23, 915	13. 00
14. 00 15. 00		99, 478 2, 377, 605					
16. 00	01600 MEDICAL RECORDS & LIBRARY	1, 916, 743	104, 451				16. 00
17. 00 20. 00		0 417, 603	960, 154		0 1 90, 773	1	
23. 00		168, 903			6, 074		1
23. 01		83, 549	0		3, 609	0	23. 01
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	21, 249, 192	1, 069, 882	452, 80	713, 309	305, 579	30.00
31.00		4, 625, 188					
35. 00 41. 00		1, 202, 810 1, 397, 098				l	
43. 00	04300 NURSERY	2, 201, 657					1
50. 00	ANCI LLARY SERVI CE COST CENTERS 05000 OPERATI NG ROOM	5, 888, 156	982, 161	415, 67!	429, 172	63, 773	50.00
51.00	05100 RECOVERY ROOM	685, 224	65, 102	27, 553	22, 826	21, 258	51.00
52. 00 54. 00		3, 081, 007 7, 164, 796					
55.00	05500 RADI OLOGY - THERAPEUTI C	589, 734	93, 565	39, 59	18, 586	0	55. 00
56. 00 56. 01		605, 040 2, 545, 137				l e	
57. 00	05700 CT SCAN	1, 149, 938	30, 159	12, 76	34, 889	0	57. 00
58. 00	05800 MRI 06000 LABORATORY	538, 625 11, 245, 687					
		2, 214, 550				90, 345	65.00
66.00		3, 643, 222	21, 135	8, 94!		1	•
67. 00 68. 00		1, 588, 975 744, 900	2, 427	1, 02	0 65, 811 7 28, 484	0	
69. 00		2, 350, 141	217, 784			15, 943	
70. 00 71. 00		682, 450 18, 403, 087	105, 040 0		5 25, 091 0 0	0 0	
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	14, 781, 580	0		0	0	72. 00
73. 00 73. 01		25, 239, 274 1, 381, 581	0 180, 320	76, 310	0 5 53, 885	0 15, 943	
74.00	07400 RENAL DIALYSIS	1, 366, 816	45, 687	19, 336	2, 575	0	74. 00
76. 00 76. 01	03480 ONCOLOGY 03952 ANTI COAGULATI ON	3, 376, 201 294, 557	681, 909 55, 041	288, 60° 23, 29!		0	76. 00 76. 01
76. 02	03951 INFUSION SERVICES	8, 602	0		412	o o	76. 02
76. 98 77. 00		0	0	•	0 0	0	
78. 00		0	0	•			•
90. 00	OUTPATIENT SERVICE COST CENTERS O9000 CLINIC	659, 071	0	1 (15, 203	85, 031	90.00
90. 01	09001 CLINIC - OUTPATIENT INFUSION SERVICE	550, 986	0	•	21, 136	l	1
90. 02		96 7 572 591	566, 950	220.04	2 210 925	0	
91. 00 91. 01	1	7, 573, 581 727, 616	187, 295			i e	1
92.00	1 7	2 015 520	147 007	(2.22	47.004	_	92.00
92. 01	09201 OBSERVATION BEDS (DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	2, 015, 530	147, 286	62, 33!	5 47, 886	0	92. 01
		4 102 570	245 000		0 151 059		95.00
	0 10100 HOME HEALTH AGENCY 0 10200 OPIOID TREATMENT PROGRAM	4, 193, 578 0	245, 988 0		3 151, 058 0 0		101. 00 102. 00
	· · · · · ·	· '			•		

Health Financial System	ns	FRANCISCAN HEAL	TH LAFAYETTE		In Lie	eu of Form CMS-2	2552-10
COST ALLOCATION - GENER	RAL SERVICE COSTS		Provi der CO	F	eriod: rom 01/01/2023		
				T	o 12/31/2023	Date/Time Pre 3/28/2024 12:	pared: 04 pm
			CAPI TAL REL	LATED COSTS			
Cost Cente	r Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	COMMUNI CATI ONS	
		0	1.00	2.00	4. 00	5. 01	
SPECIAL PURPOSE	COST CENTERS						
113.00 11300 INTEREST E	XPENSE						113. 00
116. 00 11600 HOSPI CE		6, 159, 803		C	155, 187		116. 00
	(SUM OF LINES 1 through 117)	314, 886, 607	17, 373, 294	7, 352, 811	4, 191, 443	1, 849, 414	118. 00
NONREI MBURSABLE							
	ER, COFFEE SHOP & CANTEEN	61, 339		•	· ·		190. 00
192. 00 19200 PHYSI CI ANS	' PRIVATE OFFICES	1, 488, 454	27, 520		358, 771		192. 00
194. 00 07950 MOB		0	47, 642	C	0		194. 00
194. 01 07951 LI FELI NE		0	0	C	0		194. 01
194. 02 07952 PATI ENT TR		0	0	C	0		194. 02
194. 03 07954 OTHER NRCC		0	0	C	0		194. 03
194. 04 07953 JV-SAGAMOR		1, 719, 640	0	C	48, 172	0	194. 04
	Adjustments						200. 00
	ost Centers		0	C	0		201. 00
202.00 TOTAL (sum	lines 118 through 201)	318, 156, 040	17, 511, 885	7, 391, 303	4, 600, 596	1, 849, 414	202. 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2023 | Part I | To 12/31/2023 | Date/Time Prepared: | 3/28/2024 | 12: 04 pm

	Cost Center Description	MGMT INFO	PURCHASI NG	ADMITTING	PATIENT	3/28/2024 12: Subtotal	
		SYSTEMS	F 02	F 04	ACCOUNTI NG	FA 05	
	GENERAL SERVICE COST CENTERS	5. 02	5. 03	5. 04	5. 05	5A. 05	
1. 00 2. 00	00100 CAP REL COSTS-BLDG & FLXT 00200 CAP REL COSTS-MVBLE EQUIP						1. 00 2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01 5. 02	O1160 COMMUNI CATIONS O1140 MGMT I NFO SYSTEMS	4, 801, 274					5. 01 5. 02
5. 03	00550 PURCHASI NG	0	841, 340				5. 03
5. 04	00570 ADMI TTI NG	O	0	615			5. 04
5. 05 5. 06	OO580 PATIENT ACCOUNTING OO560 OTHER ADMINISTRATIVE AND GENERAL	0 190, 900	0 273	615	1, 252, 631	95, 700, 444	5. 05 5. 06
7. 00	00700 OPERATION OF PLANT	213, 224	9	0	o	14, 350, 366	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	9, 402	7	0	0	1, 010, 332	8. 00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	194, 103 71, 993	424 743	0	0	3, 639, 764 2, 001, 880	9. 00 10. 00
11. 00	01100 CAFETERI A	87, 344	0	0	0	2, 001, 880	•
13.00	01300 NURSING ADMINISTRATION	141, 194	204	О	0	4, 082, 505	13. 00
14. 00 15. 00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	34, 156 121, 817	5, 185 10, 289	0	0	312, 689 2, 916, 721	14. 00 15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	4, 309	10, 209	0	0	2, 117, 999	16.00
17. 00	01700 SOCIAL SERVICE	O	0	0	0	0	17. 00
20. 00 23. 00	02000 NURSI NG PROGRAM 02301 PHARMACY RESI DENCY	72, 478 5, 620	331 0	0	0	1, 947, 700 180, 597	20. 00 23. 00
23. 00	02300 EMS EDUCATION	4, 170	110	0	0	91, 438	
	INPATIENT ROUTINE SERVICE COST CENTERS				-		
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	437, 484	45, 011	0	71, 172	24, 344, 430	30.00
35.00	02060 NEONATAL INTENSIVE CARE UNIT	253, 716 127, 951	11, 427 2, 908	0	27, 399 7, 848	5, 560, 059 1, 833, 072	31. 00 35. 00
41. 00	04100 SUBPROVI DER - I RF	84, 994	969	0	4, 988	2, 120, 827	41. 00
43. 00	04300 NURSERY	209, 536	0	0	8, 583	3, 173, 511	43. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	189, 656	499, 478	0	195, 649	8, 663, 720	50.00
51.00	05100 RECOVERY ROOM	29, 949	594	O	23, 607	876, 113	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	483, 142	0	0	10, 399	5, 432, 761	52.00
54. 00 55. 00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY - THERAPEUTI C	186, 307 21, 784	56, 327 300	0	78, 686 10, 324	8, 466, 733 773, 892	54. 00 55. 00
56. 00	05600 RADI OI SOTOPE	13, 975	5	Ö	10, 838	661, 041	•
56. 01	03950 CARDI AC CATH LAB	41, 492	101, 594	0	37, 573	3, 157, 476	56. 01
57. 00 58. 00	05700 CT SCAN 05800 MRI	43, 316 12, 668	4, 942 1, 277	0	43, 415 7, 443	1, 319, 423 610, 767	57. 00 58. 00
60. 00	06000 LABORATORY	12,000	17, 479	0	88, 828	11, 692, 114	•
65. 00	06500 RESPI RATORY THERAPY	100, 886	14, 742	0	11, 953	2, 599, 219	65. 00
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	149, 152 53, 893	1, 966 373	0	19, 359 12, 274	4, 019, 630 1, 721, 326	66. 00 67. 00
68. 00	06800 SPEECH PATHOLOGY	23, 930	19	0	5, 375	806, 162	68.00
69. 00	06900 ELECTROCARDI OLOGY	56, 094	688	0	30, 798	2, 828, 844	69. 00
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY	36, 407	1, 592	0	4, 284	899, 319 18, 517, 885	70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 MPL. DEV. CHARGED TO PATIENTS	0	0	0	114, 798 90, 386	14, 871, 966	1
73. 00	07300 DRUGS CHARGED TO PATIENTS	o	0	0	162, 273	25, 401, 547	73. 00
73. 01	07301 DI ABETES CENTER	44, 664	188		0	1, 752, 897	73. 01
74. 00 76. 00	07400 RENAL DI ALYSI S 03480 ONCOLOGY	1, 928 134, 969	528 31, 830	0	4, 269 19, 938	1, 441, 139 4, 655, 476	74. 00 76. 00
76. 01	03952 ANTI COAGULATI ON	7, 609	1, 202	O	657	394, 066	76. 01
76. 02	03951 NFUSION SERVICES	339	155	0	331	9, 839	76. 02
76. 98 77. 00	07698 HYPERBARI C OXYGEN THERAPY 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON	0	0	0	O O	0	76. 98 77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	o	0	Ö	o	0	78.00
66	OUTPATIENT SERVICE COST CENTERS				1	70-	00 5-
90. 00 90. 01	09000 CLINIC 09001 CLINIC - OUTPATIENT INFUSION SERVICE	20, 768 19, 969	821 1, 150	0	1, 453 8, 232	782, 347 601, 473	90. 00 90. 01
90. 01	09002 CLINIC - HOME INF PHARMACOTHERAPY	0	1, 130	0	0, 232	98	90.01
91. 00	09100 EMERGENCY	312, 551	15, 761	0	105, 087	9, 033, 712	91. 00
91. 01	04950 WOUND CARE	27, 005	4, 172	0	4, 389	1, 067, 558	91. 01
92. 00 92. 01	09200 OBSERVATION BEDS (NON-DISTINCT PART 09201 OBSERVATION BEDS (DISTINCT PART)	82, 000	1, 752	0	3, 811	0 2, 360, 600	92. 00 92. 01
	OTHER REIMBURSABLE COST CENTERS	52,500	., .02		5, 511		
	09500 AMBULANCE SERVICES	170.034	1 073	0	0	0	95.00
	10100 HOME HEALTH AGENCY 10200 OPIOID TREATMENT PROGRAM	170, 836 0	1, 873 0	0	6, 532 0	4, 873, 973 0	101.00
.52.00	SPECIAL PURPOSE COST CENTERS	<u> </u>					
	11300 INTEREST EXPENSE					, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	113.00
116. 00 118. 00	11600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117)	158, 701 4, 688, 381	2, 633 841, 331		19, 680 1, 252, 631	6, 496, 004 314, 187, 469	
110.00	TOOD TO TALL (SOM OF LINES I THE OUGH ITT)	7,000,001	041, 331	1 015	1, 202, 001	317, 107, 407	1.10.00

Health Financial Systems	FRANCISCAN HEALTH LAFAYETTE	In Lieu of Form CMS-2552-10	0
COST ALLOCATION - GENERAL SERVICE COSTS	Provi der CCN: 15-0109	Peri od: Worksheet B From 01/01/2023 Part I Date/Time Prepared: 2/28/2024 12:04 pm	

					3/28/2024 12:	O4 pm
Cost Center Description	MGMT INFO	PURCHASI NG	ADMI TTI NG	PATI ENT	Subtotal	
	SYSTEMS			ACCOUNTI NG		
	5. 02	5. 03	5. 04	5. 05	5A. 05	
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	2, 604	0	0	0	156, 427	190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	69, 255	4	0	0	1, 955, 651	192. 00
194. 00 07950 MOB	O	0	0	0	47, 642	194. 00
194. 01 07951 LI FELI NE	o	0	0	0	0	194. 01
194.02 07952 PATIENT TRANSPORT	0	0	0	0	0	194. 02
194. 03 07954 OTHER NRCC	23, 774	0	0	0	23, 774	194. 03
194.04 07953 JV-SAGAMORE ASC	17, 260	5	0	0	1, 785, 077	194. 04
200.00 Cross Foot Adjustments					0	200. 00
201.00 Negative Cost Centers	o	0	0	0	0	201. 00
202.00 TOTAL (sum Lines 118 through 201)	4.801.274	841. 340	615	1, 252, 631	318, 156, 040	202.00

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2023 | Part | | To 12/31/2023 | Date/Time Prepared: | Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0109

				11	0 12/31/2023	Date/lime Pre 3/28/2024 12:	
	Cost Center Description	OTHER ADMI NI STRATI VE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	O4 piii
		5. 06	7. 00	8. 00	9. 00	10.00	
	GENERAL SERVICE COST CENTERS			ı			
1.00	00100 CAP REL COSTS MURLE FOULD						1.00
2. 00 4. 00	OO200 CAP REL COSTS-MVBLE EQUIP OO400 EMPLOYEE BENEFITS DEPARTMENT						2. 00 4. 00
5. 01	01160 COMMUNI CATI ONS						5. 01
5. 02	01140 MGMT INFO SYSTEMS						5. 02
5. 03	00550 PURCHASI NG						5. 03
5.04	00570 ADMITTING						5. 04
5.05	00580 PATIENT ACCOUNTING						5. 05
5.06	00560 OTHER ADMINISTRATIVE AND GENERAL	95, 700, 444	20 522 002				5. 06
7. 00 8. 00	OO7OO OPERATION OF PLANT OO8OO LAUNDRY & LINEN SERVICE	6, 173, 527	20, 523, 893 210, 653				7. 00 8. 00
9. 00	00900 HOUSEKEEPI NG	434, 645 1, 565, 826	511, 052				9. 00
10. 00	01000 DI ETARY	861, 209	528, 696				1
11. 00	01100 CAFETERI A	866, 429	641, 431			0	1
13.00	01300 NURSI NG ADMI NI STRATI ON	1, 756, 294	151, 210		,	0	
14.00	01400 CENTRAL SERVI CES & SUPPLY	134, 519	194, 355		56, 744	0	14. 00
15.00	01500 PHARMACY	1, 254, 773	301, 702		88, 085 58, 107	0 0	
16. 00 17. 00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	911, 163	199, 024 0		58, 107 0		
20. 00	02000 NURSI NG PROGRAM	837, 901	1, 829, 516	_	_	Ö	1
23. 00	02301 PHARMACY RESIDENCY	77, 693	0				1
23. 01	02300 EMS EDUCATION	39, 337	0	0	0	0	23. 01
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	10, 472, 974	2, 038, 597				
31. 00 35. 00	03100 INTENSI VE CARE UNIT 02060 NEONATAL INTENSI VE CARE UNIT	2, 391, 937 788, 588	548, 630 518, 460		-		
41. 00	04100 SUBPROVI DER – I RF	912, 380	678, 560				
43. 00	04300 NURSERY	1, 365, 244	913, 052		266, 574		
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	3, 727, 132	1, 871, 449			0	
51. 00 52. 00	O5100 RECOVERY ROOM O5200 DELIVERY ROOM & LABOR ROOM	376, 904	124, 048			0	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 337, 174 3, 642, 389	2, 239, 060 858, 234		653, 714 250, 569	_	54.00
55. 00	05500 RADI OLOGY - THERAPEUTI C	332, 928	178, 282		52, 051	Ö	
56.00	05600 RADI OI SOTOPE	284, 380	11, 628			0	1
56. 01	03950 CARDI AC CATH LAB	1, 358, 346	504, 093	6, 732	147, 175	0	56. 01
57. 00	05700 CT SCAN	567, 616	57, 467				
58. 00	05800 MRI	262, 752	50, 867			0	
60. 00 65. 00	06000 LABORATORY 06500 RESPI RATORY THERAPY	5, 029, 947 1, 118, 184	298, 828 119, 513		87, 246 34, 893		
66. 00	06600 PHYSI CAL THERAPY	1, 729, 245	40, 272				66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	740, 514	0		0	Ō	1
68. 00	06800 SPEECH PATHOLOGY	346, 811	4, 624	0	1, 350	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	1, 216, 969	414, 975				
70.00	07000 ELECTROENCEPHALOGRAPHY	386, 887	200, 147				
	O7100 MEDICAL SUPPLIES CHARGED TO PATIENT O7200 MPL. DEV. CHARGED TO PATIENTS	7, 966, 394 6, 397, 920	0		0	0	1
73. 00	07300 DRUGS CHARGED TO PATIENTS	10, 927, 791	0	0	0	0	1
73. 01	07301 DI ABETES CENTER	754, 096	343, 590		100, 314	Ō	
74.00	07400 RENAL DIALYSIS	619, 978	87, 054		25, 416	0	
76. 00	03480 ONCOLOGY	2, 002, 786	1, 299, 338		379, 354		
76. 01	03952 ANTI COAGULATI ON	169, 527	104, 877		30, 620		
76. 02 76. 98	03951 INFUSION SERVICES 07698 HYPERBARIC OXYGEN THERAPY	4, 233	0	0	0	0 0	
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION		0	0	_	0	1
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	l o	0		_		
	OUTPATIENT SERVICE COST CENTERS						1
90.00	09000 CLINIC	336, 566	0		0		
90. 01 90. 02	O9001 CLINIC - OUTPATIENT INFUSION SERVICE O9002 CLINIC - HOME INF PHARMACOTHERAPY	258, 754 42	0	0	0	0 0	
91. 00	09100 EMERGENCY	3, 886, 303	1, 080, 290	152, 961	315, 401	Ö	
91. 01	04950 WOUND CARE	459, 263	356, 879				1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
92. 01	09201 OBSERVATION BEDS (DISTINCT PART)	1, 015, 530	280, 646	0	81, 937	0	92. 01
95 00	OTHER REIMBURSABLE COST CENTERS O9500 AMBULANCE SERVICES	I 0	0	0	0	0	95. 00
	10100 HOME HEALTH AGENCY	2, 096, 783	468, 715		_		101. 00
	10200 OPI OI D TREATMENT PROGRAM	0	0				102. 00
	SPECIAL PURPOSE COST CENTERS						
	11300 INTEREST EXPENSE 11600 HOSPICE	2, 794, 581	0	0		_	113. 00 116. 00
118.00	1	93, 993, 164	20, 259, 814		5, 704, 335		
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Health Financial Systems	FRANCISCAN HEALTH LAFAYETTE	In Lieu of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS	Provi der CCN: 15-0109	Peri od: Worksheet B From 01/01/2023 Part I To 12/31/2023 Date/Time Prepared:

			'	0 12/31/2023	3/28/2024 12:	
Cost Center Description	OTHER	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	ADMI NI STRATI VE	PLANT	LINEN SERVICE			
	AND GENERAL					
	5. 06	7.00	8. 00	9. 00	10.00	
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	67, 295	120, 860	0	35, 286	0	190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	841, 321	52, 439	0	15, 310	0	192. 00
194. 00 07950 MOB	20, 496	90, 780	0	0	0	194. 00
194. 01 07951 LI FELI NE	0	0	0	0	0	194. 01
194. 02 07952 PATIENT TRANSPORT	0	0	0	0	0	194. 02
194. 03 07954 OTHER NRCC	10, 228	0	0	0	0	194. 03
194.04 07953 JV-SAGAMORE ASC	767, 940	0	0	0	0	194. 04
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0	0	o	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	95, 700, 444	20, 523, 893	1, 655, 630	5, 754, 931	3, 592, 643	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0109

Peri od: Worksheet B From 01/01/2023 Part I To 12/31/2023 Date/Ti me Prepared:

3/28/2024 12:04 pm Cost Center Description CAFETERI A NURSI NG CENTRAL **PHARMACY** MEDI CAL SERVICES & RECORDS & ADMI NI STRATI ON SUPPLY LI BRARY 11. 00 13.00 15.00 14.00 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 5.01 01160 COMMUNI CATI ONS 5.01 01140 MGMT INFO SYSTEMS 5.02 5.02 5.03 00550 PURCHASI NG 5.03 00570 ADMITTING 5.04 5 04 5.05 00580 PATIENT ACCOUNTING 5.05 5.06 00560 OTHER ADMINISTRATIVE AND GENERAL 5 06 00700 OPERATION OF PLANT 7.00 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 9.00 00900 HOUSEKEEPING 9.00 10.00 01000 DI ETARY 10.00 3, 709, 147 01100 CAFETERIA 11.00 11.00 01300 NURSING ADMINISTRATION 13.00 129, 814 6, 163, 970 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 31, 403 771.671 14.00 15.00 01500 PHARMACY 111, 998 4, 682, 794 0 9.515 15.00 01600 MEDICAL RECORDS & LIBRARY 3, 290, 255 16,00 3,962 C \cap 16.00 17.00 01700 SOCIAL SERVICE C 0 0 0 17.00 02000 NURSING PROGRAM 20.00 66, 636 0 306 0 0 20.00 o 02301 PHARMACY RESIDENCY 23.00 23.00 5. 167 C 0 02300 EMS EDUCATION 23.01 3,834 102 0 0 23.01 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 402, 224 896, 507 41, 623 0 186, 937 30.00 o 31 00 03100 INTENSIVE CARE UNIT 519, 923 71.965 31 00 233 267 10 566 |02060|NEONATAL INTENSIVE CARE UNIT 35.00 117,638 262, 201 2,689 0 20, 613 35.00 41.00 04100 SUBPROVI DER - I RF 78, 144 174, 173 896 0 13, 101 41.00 22, 544 43.00 04300 NURSERY 192,648 429, 389 ol 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 174, 370 388, 649 461, 877 0 514, 018 50.00 05100 RECOVERY ROOM 51.00 27,535 61, 373 549 0 62,005 51.00 52 00 05200 DELIVERY ROOM & LABOR ROOM 444 198 990, 065 27, 312 52 00 0 05400 RADI OLOGY-DI AGNOSTI C 54.00 171, 291 C 52, 087 206, 675 54.00 05500 RADI OLOGY - THERAPEUTI C 20, 029 27, 117 55.00 55.00 277 0 0 0 0 05600 RADI OI SOTOPE 56.00 12,849 28, 638 28, 468 56.00 56.01 03950 CARDI AC CATH LAB 93 945 38 148 85,027 98.687 56 01 57.00 05700 CT SCAN 39,825 4,570 114,032 57.00 05800 MRI 19, 549 58.00 11, 647 1, 181 58.00 60.00 06000 LABORATORY 16, 163 0 233, 314 60.00 06500 RESPIRATORY THERAPY 92.755 206, 739 65.00 13.632 31, 396 65 00 66.00 06600 PHYSI CAL THERAPY 137, 130 305, 647 1,818 50, 847 66.00 67.00 06700 OCCUPATIONAL THERAPY 49,550 110, 440 345 0 32, 239 67.00 06800 SPEECH PATHOLOGY 22,001 68.00 49.038 14. 117 68.00 18 06900 ELECTROCARDI OLOGY 80, 893 69.00 51.573 114, 950 637 69 00 70.00 07000 ELECTROENCEPHALOGRAPHY 33, 472 74, 606 1, 472 0 11, 254 70.00 71 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 301, 525 71.00 237, 406 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 0 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 4, 682, 794 73.00 Λ 0 426, 222 73.00 07301 DI ABETES CENTER 41,064 91, 527 73.01 173 73.01 74.00 07400 RENAL DIALYSIS 1,773 3, 951 488 0 11, 213 74.00 03480 ONCOLOGY 124,091 29, 433 0 76.00 C 52, 369 76.00 76. 01 03952 ANTI COAGULATI ON 6, 996 C 1, 111 0 1,724 76.01 76.02 03951 INFUSION SERVICES 312 0 143 0 871 76.02 0 07698 HYPERBARI C OXYGEN THERAPY 76.98 0 0 0 0 76.98 77.00 07700 ALLOGENEIC STEM CELL ACQUISITION 0 C 0 0 0 77.00 07800 CAR T-CELL IMMUNOTHERAPY 78.00 0 0 78.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 19.094 640, 489 759 0 3.815 90.00 09001 CLINIC - OUTPATIENT INFUSION SERVICE 90.01 18, 360 55, 339 1,064 0 21, 622 90.01 90.02 09002 CLINIC - HOME INF PHARMACOTHERAPY 0 90.02 0 91.00 09100 EMERGENCY 287, 359 14, 574 276, 019 91.00 C 0 04950 WOUND CARE 91 01 24,828 C 3, 858 11, 527 91 01 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 09201 OBSERVATION BEDS (DISTINCT PART) 92.01 75, 391 1,620 0 10, 009 92.01 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 95.00 95.00 0 Ω 101.00 10100 HOME HEALTH AGENCY 157, 067 350, 083 1,732 0 17, 157 101. 00 102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 102.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 116.00 11600 HOSPI CE 145, 910 325, 216 2, 435 51, 692 116. 00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 3, 605, 353 6, 163, 970 771,663 4, 682, 794 3, 290, 255 118. 00 Health Financial Systems FRANCISCAN HEALTH LAFAYETTE In Lieu of Form CMS-2552-10

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0109 | Period: From 01/01/2023 | Part I | Date/Time Prepared: To 12/31/2023 | Date/Time Prepared: To 12/31/2023 | Provider CCN: 15-0109 | Period: From 01/01/2023 | Part I | Date/Time Prepared: To 12/31/2023 | Provider CCN: 15-0109 | Period: From 01/01/2023 | Part I | Date/Time Prepared: To 12/31/2023 | Part I | Date/Time Prepared: To 12/31/2023 | Part I | Date/Time Prepared: To 15/31/2023 | Part I | Date/Time Prepared

				7 12/31/2023	3/28/2024 12:	
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		ADMI NI STRATI ON	SERVICES &		RECORDS &	
			SUPPLY		LI BRARY	
	11. 00	13. 00	14.00	15.00	16. 00	
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	2, 394	0	0	0	0	190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	63, 673	0	3	0	0	192. 00
194. 00 07950 MOB	0	0	0	0	0	194. 00
194. 01 07951 LI FELI NE	0	0	0	0	0	194. 01
194. 02 07952 PATIENT TRANSPORT	0	0	0	0	0	194. 02
194. 03 07954 OTHER NRCC	21, 858	0	0	0	0	194. 03
194.04 07953 JV-SAGAMORE ASC	15, 869	0	5	0	0	194. 04
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	o	0	0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	3, 709, 147	6, 163, 970	771, 671	4, 682, 794	3, 290, 255	202. 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2023 | Part I | To 12/31/2023 | Date/Time Prepared: | 3/28/2024 | 12: 04 pm Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0109

	Cost Center Description	SOCIAL SERVICE	NURSI NG	PHARMACY	EMS EDUCATION	3/28/2024 12: Subtotal	
	cost center bescription		PROGRAM	RESI DENCY			
	GENERAL SERVICE COST CENTERS	17. 00	20. 00	23. 00	23. 01	24. 00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	1					2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01	01160 COMMUNI CATI ONS						5. 01
5. 02	01140 MGMT INFO SYSTEMS						5. 02
5. 03	00550 PURCHASI NG						5. 03
5. 04 5. 05	OO570 ADMITTING OO580 PATIENT ACCOUNTING						5. 04 5. 05
5. 06	00560 OTHER ADMINISTRATIVE AND GENERAL						5. 06
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						10. 00
11. 00	01100 CAFETERI A						11. 00
13.00	01300 NURSI NG ADMI NI STRATI ON						13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY						14. 00
	01500 PHARMACY						15.00
16.00	01600 MEDICAL RECORDS & LIBRARY						16.00
17. 00 20. 00	01700 SOCIAL SERVICE 02000 NURSING PROGRAM	0	5, 216, 203				17. 00 20. 00
23. 00	02301 PHARMACY RESIDENCY	0	5, 210, 203	263, 457			23. 00
23. 01	02300 EMS EDUCATION			203, 437	134, 711		23. 01
20.01	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>			10 1,7 7 1 1		20.0.
30.00	03000 ADULTS & PEDIATRICS	0	1, 705, 347	0	0	43, 810, 898	30.00
31.00	03100 INTENSIVE CARE UNIT	0	472, 190	0	О	10, 418, 821	
35.00	02060 NEONATAL INTENSIVE CARE UNIT	0	595, 766	0	o	4, 555, 813	35. 00
41.00	04100 SUBPROVI DER - I RF	0	0	0	0	4, 439, 978	41. 00
43.00	04300 NURSERY	0	0	0	0	6, 652, 258	43. 00
	ANCILLARY SERVICE COST CENTERS		40.404			44 440 075	
50.00	05000 OPERATING ROOM	0	10, 406 0	0	· ·	16, 648, 375	1
51. 00 52. 00	O5100 RECOVERY ROOM O5200 DELIVERY ROOM & LABOR ROOM	0	500, 808	0		1, 618, 138 12, 690, 303	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	44, 227	0		13, 794, 091	
55. 00	05500 RADI OLOGY - THERAPEUTI C		44, 227	0	0	1, 384, 576	1
56. 00	05600 RADI OI SOTOPE	0	113, 169	0	o	1, 143, 573	1
56. 01	03950 CARDI AC CATH LAB	0	222, 437	0	o	5, 712, 066	1
57. 00	05700 CT SCAN	0	0	0	O	2, 119, 711	
58.00	05800 MRI	0	o	0	o	971, 614	58. 00
60.00	06000 LABORATORY	0	0	0	0	17, 368, 168	60. 00
65. 00	06500 RESPI RATORY THERAPY	0	0	0	0	4, 228, 692	1
66. 00	06600 PHYSI CAL THERAPY	0	93, 658	0	I I	6, 413, 009	
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	0	0	2, 654, 414	67.00
68. 00	06800 SPEECH PATHOLOGY	0	0	0	0	1, 244, 121	1
69. 00 70. 00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY		0	0	0	4, 839, 373 1, 665, 592	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	26, 785, 804	
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	Ö	0	آ	21, 507, 292	
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	ol	263, 457	o	41, 701, 811	
73. 01	07301 DI ABETES CENTER	0	O	0	O	3, 083, 662	
74.00	07400 RENAL DIALYSIS	0	o	0	o	2, 191, 012	74. 00
76.00	03480 ONCOLOGY	0	0	0	0	8, 542, 847	76. 00
76. 01	03952 ANTI COAGULATI ON	0	0	0	0	708, 921	76. 01
	03951 INFUSION SERVICES	0	0	0	0	15, 398	
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0	0	0	0	76. 98
	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78. 00
90. 00	OUTPATIENT SERVICE COST CENTERS O9000 CLINIC	0	23, 414	0	ol	1, 806, 484	90.00
90. 00	09001 CLINIC - OUTPATIENT INFUSION SERVICE		23, 414	0	·	956, 612	
	09002 CLINIC - HOME INF PHARMACOTHERAPY	0	0	0	0	140	1
91. 00	09100 EMERGENCY	0	1, 321, 612	0	134, 711	16, 502, 942	1
	04950 WOUND CARE	0	113, 169	0	0	2, 141, 276	1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		,				92.00
92. 01	09201 OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	3, 825, 733	92. 01
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVI CES	0	0	0	0	0	95. 00
	10100 HOME HEALTH AGENCY	0	0	0	0	8, 102, 356	
102.00	10200 OPI OI D TREATMENT PROGRAM	0	0	0	0	0	102. 00
110 00	SPECIAL PURPOSE COST CENTERS				ı		112 00
	11300 INTEREST EXPENSE 11600 HOSPICE			_		0 015 020	113.00
118.00		0 0	5, 216, 203	263, 457	0 134, 711	9, 815, 838 312, 061, 712	
110.00	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	١	5, 210, 203	203, 437	134,711	312,001,712	1.10.00

Health Financial Systems	FRANCISCAN HEALT	TH_LAFAYETTE		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der CO	CN: 15-0109	Peri od:	Worksheet B	
				From 01/01/2023 To 12/31/2023		narod:
				10 12/31/2023	3/28/2024 12:	
Cost Center Description	SOCI AL SERVI CE	NURSI NG	PHARMACY	EMS EDUCATION	Subtotal	
		PROGRAM	RESI DENCY			
	17. 00	20.00	23. 00	23. 01	24.00	
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	382, 262	190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0		0 0	2, 928, 397	192. 00
194. 00 07950 MOB	0	0		0 0	158, 918	194. 00
194. 01 07951 LI FELI NE	0	0		0 0	0	194. 01
194. 02 07952 PATIENT TRANSPORT	0	0		0 0	0	194. 02
194. 03 07954 OTHER NRCC	0	0		0 0	55, 860	194. 03
194.04 07953 JV-SAGAMORE ASC	0	0		0 0	2, 568, 891	194. 04
200.00 Cross Foot Adjustments		0		0 0	0	200. 00
201.00 Negative Cost Centers	0	0		0 0	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	O	5, 216, 203	263, 4	134, 711	318, 156, 040	202. 00

| Period: | Worksheet B | From 01/01/2023 | Part | To 12/31/2023 | Date/Time Prepared: Provider CCN: 15-0109

Cost Center Description					To 12/31/2023 Date/Time Pre	
A POST SERVICE COST CENTERS 1.00 1.0		Cost Center Description	Intern &	Total	3/28/2024 12:	U4 pili
CENERAL SERVICE COST CENTERS		·				
CENERAL SERVICE COST CENTERS 25.00						
			· ·			
1.00 001000 CAP RET COSTS-RIPE & FIRT				26. 00		
2.00	_					4 00
4.00 00-400 EMPLOYUSE BEKER ITS DEPARTMENT 5.00 1.01 1.01 0.00						
0.11 0.11	1	· ·				1
0.050 NICKLANN NG	1	· ·				1
0.0570 ADMITTING	1	· ·				
5.05 OBSO PATIENT ACCOUNTING 5.06 CONSIGNATION OF PLANT 7.00 CONSIGNATION OF PLA	1					
0.0500 OTHER ADMINISTRATIVE AND DENERAL	- 1					1
2.00	1					1
0,000 00000 DETARY						
10.00 01000 DETARY						1
11.00 11.00 (ARFETRIA 11.00 13.00 (ARS) (MINS) NAS NAMINISTRATION 13.00 13.00 (ARS) (MINS) NAS NAMINISTRATION 14.00 14.00 14.00 (ENITAL) SERVICES & SUPPLY 16.00 15.00 (ARS) (MISS) NAS NAMINISTRATION 15.00 (ARS) (MISS) NAMINISTRATION						•
13.00	1					1
14.00						•
10.00 10.00 MEDICAL RECORDS & LIBRARY	1	01400 CENTRAL SERVICES & SUPPLY				
17. 00 0700 SOCIAL SERVICE	1					1
20.00 02000 NURSING PROGRAM 22.00 23.00 23.00 02300 PARABIMACY RESIDENCY 23.00 23.00 02300 PARABIMACY RESIDENCY 23.00 23.00 23.00 02300 PARABIMACY RESIDENCY 23.00	1					
23. 00 02301 PHARMACY RESIDENCY 22. 01						1
22. 01	1					1
30.00 030000 ADULTS & PEDIATRICS 0 43, 810, 898 30, 00 31.00 03100 INTENSI VE CARE UNIT 0 10, 418, 821 31.00	1	· ·				
13.1 0.0 0.3100 INTERSIVE CARE UNIT 0 10, 418, 821 33.0 0 35.0 0 2056 NEONATAL INTERSIVE CARE UNIT 0 4,555, 813 35.0 0 41.0 0 43.0	-					
35. 00			1			1
11.00 O4100 SUBPROVI DER - I RF 0 4,439,978 41.00	1	· ·	1			
A3. 00 O4300 O4300 O4300 O4300 O4300 O4300	1		1			
SOLIC SOLI	43.00	04300 NURSERY	0	6, 652, 258		43. 00
15.1 00 05100 RECOVERY ROOM & LABOR ROOM 0 1, 618, 138 51, 00 52, 00 05200 DELI VERY ROOM & LABOR ROOM 0 12, 690, 303 52, 00 054, 00 05400 RADIO LOGY -DI AGNOSTI C 0 13, 794, 091 54, 00 56, 00 05600 RADIO LOGY -DI AGNOSTI C 0 13, 384, 576 55, 00 05500 RADIO LOGY - THERAPEUTI C 0 1, 384, 576 55, 00 056, 00 05600 RADIO I SOTOPE 0 1, 143, 572 56, 00 056, 00 03950 CARDI I AC CATH LAB 0 5, 712, 066 56, 01 057, 00 05700 CT SCAM 0 2, 119, 711 57, 00 057, 00 05700 CT SCAM 0 2, 119, 711 57, 00 057, 00 05700 CT SCAM 0 2, 119, 711 58, 00 058, 00 05800 MRI 0 971, 614 58, 00 06, 00 05000 LABORATORY 0 7, 368, 168 66, 00 06, 00 06600 06600 04600 04600 04600 04600 04600 04600 04600 04600 04500	-			44 440 075		
S2-00 05200 DELIVERY ROOM & LABOR ROOM 0 12,690,303 52,00			1			1
SA 00 05400 RADIOLOGY-DI AGNOSTIC 0 13,794,091 54,00	1		1			1
56. 00 05600 RADIO I SOTOPE 0 1,143,573 56. 00	- 1	·	1			1
56. 01 03950 CARDI AC CATH LAB 0 5,712,066 56. 01			0	1, 384, 576		1
57.00 05700 CT SCAN 57.00 05.00 05800 MRI 58.00 06.00			1 -1			1
58. 00 05800 MRI	1		1			1
60.00 06000 LABORATORY 0 17, 368, 168 60, 00 65.00 065000 RESPIRATORY THERAPY 0 4, 228, 692 65. 00 66.00 06600 PHYSI CAL THERAPY 0 6, 413, 009 66. 00 67.00 06700 0CCUPATI ONAL THERAPY 0 2, 654, 414 67. 00 68.00 06600 SPECEH PATHOLOGY 0 1, 244, 121 68. 00 69.00 06900 ELECTROCARDIOLOGY 0 4, 839, 373 69. 00 70.00 07000 ELECTROCARDIOLOGY 0 4, 839, 373 69. 00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 26, 785, 804 71. 00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 21, 507, 292 72. 00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 21, 507, 292 72. 00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 21, 701, 811 73. 00 73.01 07301 DI ABETES CENTER 0 3, 083, 662 73. 01 74.00 07400 RENAL DI ALYSI S 0 2, 191, 012 74. 00 76.00 03480 ONCOLOGY 0 8, 542, 847 76. 00 76.01 03952 ANTI COAGULATI ON 0 768, 921 76. 01 76.02 03951 INFUSI ON SERVI CES 0 15, 398 76. 02 77.00 07700 ALLOGENEIC STEM CELL ACQUI SITI ON 0 0 77.00 0700 CLI INI C 0 0 0 78.00 07000 CLI INI C 0 0 79.00 09000 CLI INI C 0 0 0 79.00 09000 CLI INI C 0 0 79.01 09000 CLI INI C 0 0 79.02 09000 OLI INI C 0 0 79.03 09000 OLI INI C 0 0 79.04 09000 OLI INI C 0 0 79.05 09000 OLI INI C 0 0 79.00 09000 OLI INI C 0 79.00 09000 OLI INI C 0 79.00 09000 OLI INI C			1			
66.00 06600 PHYSICAL THERAPY 0 6.413, 009 66.00 0670 0CCUPATIONAL THERAPY 0 2,654, 414 67.00 68.00 06800 SPEECH PATHOLOGY 0 1,244, 121 68.00 06800 SPEECH PATHOLOGY 0 1,244, 121 68.00 06900 ELECTROCARDIOLOGY 0 4,839,373 69.00 07.00 07.00 0FLECTROCARDIOLOGY 0 1,665,592 70.00 07.00 0FLECTROCARDIOLOGY 0 1,665,592 72.00 07.00 0FLECTROCARDIOLOGY 0 1,70 0,70 07.00 0FLECTROCARDIOLOGY 0 1,70 0,70 07.00 0FLECTROCARDIOLOGY 0 1,70 0,70 0,70 0FLECTROCARDIOLOGY 0 1,70 0,70 0,70 0FLECTROCARDIOLOGY 0 1,70 0,70 0,70 0,70 0FLECTROCARDIOLOGY 0 1,70 0,70 0,70 0FLECTROCARDIOLOGY 0 1,70 0,70 0,70 0,70 0,70 0FLECTROCARDIOLOGY			· · · · · · · · · · · · · · · · · · ·			1
67. 00 06700 OCCUPATI ONAL THERAPY 0 2, 654, 414 67. 00 68. 00 O6800 SPEECH PATHOLOGY 0 1, 244, 121 68. 00 69. 00 O6900 ELECTROCARDI OLOGY 0 1, 244, 121 68. 00 70. 00 O7000 ELECTROENCEPHALOGRAPH 0 1, 665, 592 70. 00 71. 00 O7100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 26, 785, 804 71. 00 72. 00 O7200 IMPL. DEV. CHARGED TO PATI ENTS 0 21, 507, 292 72. 00 73. 00 O7300 DRUGS CHARGED TO PATI ENTS 0 41, 701, 811 73. 00 73. 01 O7300 DRUGS CHARGED TO PATI ENTS 0 41, 701, 811 73. 00 74. 00 O7400 RENAL DI ALYSI S 0 2, 191, 012 74. 00 76. 00 O3480 ONCOLOGY 0 8, 542, 847 76. 00 76. 01 O3952 ANTI COAGULATI ON 0 708, 921 76. 01 76. 02 O3951 INFUSI ON SERVI CES 0 15, 398 76. 02 76. 98 O7698 HYPERBARI C OXYGEN THERAPY 0 0 0 77. 00 O7700 ALLOGENEIC STEM CELL ACQUISITION 0 0 0 78. 00 O7800 CAR T-CELL IMMUNOTHERAPY 0 0 0 79. 00 O7800 CAR T-CELL IMMUNOTHERAPY 0 0 0 79. 01 O9000 CLINIC OUTPATIENT INFUSI ON SERVICE 0 956, 612 99. 01 99. 02 O9000 CLINIC OUTPATIENT INFUSI ON SERVICE 0 2, 141, 276 99. 01 99. 01 O9001 CLINIC OUTPATIENT INFUSI ON SERVICE 0 2, 141, 276 99. 01 99. 01 O9001 CLINIC OUTPATIENT INFUSION SERVICE 0 2, 141, 276 99. 01 99. 01 O9001 DISBERVATION BEDS (INSTINCT PART 0 92. 00 99. 02 O9000 OSESPATION BEDS (INSTINCT PART 0 92. 00 99. 01 O9201 OSESPATION BEDS (INSTINCT PART 0 92. 01 071. 00 O9500 AMBULANCE SERVICES 0 0 0 0 010. 00 O9500 OMBULANCE SERVICES 0 0 0 0 010. 00 O9500 OMBULANCE SERVICES 0 0 0 0 010. 00 O100 OUTPATIENT NETRORGAM 0 0 010. 00 O100 OUTPATIENT NETRORGAM 0 0 0 010. 00 O100 OUTPATIENT NETRORGAM 0 0 0 010. 00 O100 OUTPATIENT NETRORGAM 0 0 0 0 010. 00 O100 OUTPATIENT NETRORGAM 0 0 0 0 0 010. 00 O100 OUTPATIENT NETRORGAM 0	1		0	4, 228, 692		1
68. 00 06800 SPECCH PATHOLOGY 0 1, 244, 121 68. 00 69. 00 06900 ELECTROCARDIOLOGY 0 4, 839, 373 69. 00 70. 00 07000 ELECTROCENCEPHALOGRAPHY 0 1, 665, 592 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0 26, 785, 804 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 21, 507, 292 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 41, 701, 811 73. 00 73. 01 07301 DIABETES CENTER 0 3, 083, 662 73. 01 74. 00 77400 RENAL DI ALYSI S 0 2, 191, 012 74. 00 76. 00 03480 0NCOLOGY 0 8, 542, 847 76. 00 76. 01 03952 ANTI COAGULATI ON 0 708, 921 76. 01 76. 02 03951 INFUSI ON SERVI CES 0 0 0 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 77. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 79. 00 07800 CLINIC - OUTPATIENT INFUSI ON SERVI CE 0 956, 612 90. 01 90. 01 09001 CLINIC - HOME INF PHARMACOTHERAPY 0 16, 502, 942 91. 00 91. 01 04950 WOUND CARE 0 2, 141, 276 91. 01 92. 01 09201 0BSERVATI ON BEDS (NON-DI STI NCT PART 0 0 2, 141, 276 91. 01 92. 01 09201 0BSERVATI ON BEDS (DISTINCT PART 0 0 0 0 92. 01 07900 AUGULATION DEDS (NON-DI STI NCT PART 0 0 0 0 92. 01 07900 OSSERVATI ON BEDS (DISTINCT PART 0 0 0 0 93. 00 0900 OSSERVATI ON BEDS (DISTINCT PART 0 0 0 0 94. 00 0900 OSSERVATI ON BEDS (DISTINCT PART 0 0 0 0 95. 00 0900 OSSERVATI ON BEDS (DISTINCT PART 0 0 0 0 0 96. 00 0900 OSSERVATI ON BEDS (DISTINCT PART 0 0 0 0 0 97. 00 01000 OUTPATIENT PROGRAM 0 0 0 0 98. 00 0900 OSSERVATION BEDS (DISTINCT PART 0 0 0 0 0 0 99. 00 0900 OSSERVATION BEDS (DISTINCT PART 0 0 0 0 0 0 99. 00 0900 OSSERVATION BEDS (DISTINCT PART 0 0 0 0 0 0 0 99. 00 0900 OSSER	1		1			1
69. 00			1			1
70. 00 07000 LECTROENCEPHALOGRAPHY			1			
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 21, 507, 292 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 41, 701, 811 73. 00 7301 DI ABETES CENTER 0 3, 3083, 662 73. 01 74. 00 07400 RENAL DI ALYSI S 0 2, 191, 012 74. 00 07400 RENAL DI ALYSI S 0 2, 191, 012 74. 00 03480 ONCOLOGY 0 8, 542, 847 76. 01 03952 ANTI COAGULATI ON 0 708, 921 76. 01 03951 INFUSI ON SERVI CES 0 15, 398 76. 02 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 0 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 0 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			1			
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 41, 701, 811 73. 00 73. 01 07301 DI ABETES CENTER 0 3,083, 662 73. 01 74. 00 07400 RENAL DI ALYSI S 0 2,191, 012 74. 00 76. 00 03480 ONCOLOGY 0 8,542, 847 76. 00 76. 01 03952 ANTI COAGULATI ON 0 708, 921 76. 01 76. 02 03951 INFUSI ON SERVI CES 0 15,398 76. 02 77. 00 0700 ALLOGENEI C STEM CELL ACQUISITION 0 0 0 708, 921 77. 00 07700 ALLOGENEI C STEM CELL ACQUISITION 0 0 70,800 77. 00 78. 00 07800 CAR T-CELL I IMMUNOTHERAPY 0 0 0 70,800 CAR T-CELL I IMMUNOTHERAPY 0 0 0 70,800 CAR T-CELL I IMMUNOTHERAPY 0 0 0 0 780,000 CAR T-CELL I IMMUNOTHERAPY 0 0 0 0 0 780,000 CAR T-CELL I IMMUNOTHERAPY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1		1			
73. 01 07301 DI ABETES CENTER 0 3,083,662 73. 01 74. 00 07400 RENAL DI ALYSIS 0 2,191,012 74.00 76. 00 03480 ONCOLOGY 0 8,542,847 76. 00 76. 01 03952 ANTI COAGULATI ON 0 708, 921 76. 01 76. 02 03951 INFUSI ON SERVI CES 0 15,398 76. 02 76. 98 07698 PHYPERBARI C OXYGEN THERAPY 0 0 0 77. 00 07700 ALLOGENEIC STEM CELL ACQUI SI TI ON 0 0 0 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 78. 00 09000 CLI NI C 0 0 1,806,484 90. 01 90. 01 09001 CLI NI C 0 0 1,806,484 90. 01 90. 02 09002 CLI NI C - HOME I NF PHARMACOTHERAPY 0 140 90. 02 91. 00 09002 CLI NI C - HOME I NF PHARMACOTHERAPY 0 16,502,942 91. 00 91. 01 04950 WOUND CARE 0 2,141,276 91. 01 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 10. 09201 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 10. 09201 OBSERVATI ON BEDS (DI STI NCT PART) 0 3,825,733 075. 00 0710.00 10100 HOME HEALTH AGENCY 0 8,102,356 101.00 0710.00 10100 HOME HEALTH AGENCY 0 9.00 0710.00 10100 HOME HEALTH AGENCY 0 9.00 0710.0			1 -1			
74. 00			1			1
76. 00 03480 ONCOLOGY 0 8, 542, 847 76. 00 76. 01 76. 01 03952 ANTI COAGULATI ON 0 708, 921 76. 01 76. 01 76. 02 03951 I NFUSI ON SERVI CES 0 15, 398 76. 02 76. 02 76. 08 76. 09 76. 09 76. 09 76. 09 76. 09 76. 00 76.	1		1 1			
76. 02 03951 INFUSION SERVICES	76. 00	03480 ONCOLOGY	0			
76. 98	1	· ·	0			
77. 00 07700 ALLOGENEI C STEM CELL ACQUI SITION 0 0 0 0 0 0 0 78. 00 0 0 0 0 0 0 0 0 0	1	· ·	0	•		
78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0	1	· ·	0	- 1		
90. 00 09000 CLINI C 0 1,806,484 90. 01 90. 01 09001 CLINI C - OUTPATIENT INFUSION SERVICE 0 956,612 90. 01 90. 02 09002 CLINI C - HOME INF PHARMACOTHERAPY 0 140 90. 02 91. 00 09100 EMERGENCY 0 16,502,942 91. 00 91. 01 04950 WOUND CARE 0 2,141,276 91. 01 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART 0 92. 01 09201 OBSERVATI ON BEDS (DISTINCT PART 0 3,825,733 92. 01 07100				-		
90. 01	C	DUTPATIENT SERVICE COST CENTERS				
90. 02 09002 CLINIC - HOME INF PHARMACOTHERAPY 0 140 90. 02 91. 00 9100 EMERGENCY 0 16, 502, 942 91. 00 91. 01 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 92. 00 09201 OBSERVATION BEDS (DISTINCT PART) 0 3, 825, 733 92. 01 0710			1			
91. 00 09100 EMERGENCY 0 16, 502, 942 91. 00 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 09200 OBSERVATI ON BEDS (DI STI NCT PART 0 0700 OTHER REI MBURSABLE COST CENTERS 92. 01 OTHER REI MBURSABLE COST CENTERS 0 09500 AMBULANCE SERVI CES 0 09500 AMBULANCE SERVI CES 0 01.00 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 0 0 0 0 0			1			
91. 01			1			
92. 01 09201 0BSERVATI ON BEDS (DI STINCT PART) 0 3,825,733 92. 01			1			1
OTHER REI MBURSABLE COST CENTERS 95. 00	1	,	1			
95. 00	-	· · · · · · · · · · · · · · · · · · ·	0	3, 825, 733		92. 01
101. 00 10100 HOME HEALTH AGENCY 0 8, 102, 356 102. 00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 0 0 0 0 0 0				0		95 00
102. 00 10200 OPI 0I D TREATMENT PROGRAM O O 102. 00 SPECIAL PURPOSE COST CENTERS	1		1	- 1		
	102.00	10200 OPIOID TREATMENT PROGRAM	1			
113. 00 11300 1N1ERES1 EXPENSE 113. 00			1			440
	113.00 1	I SUU I N E E E X P E S	<u> </u>			J113. 00

Health Financial Systems	FRANCISCAN HEALT	H LAFAYETTE		In Lieu	u of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC	CN: 15-0109	Peri od: From 01/01/2023 To 12/31/2023	Worksheet B Part I Date/Time Prepared: 3/28/2024 12:04 pm
Cost Center Description	Intern & Residents Cost & Post	Total			
	Stepdown				
	Adjustments				
	25. 00	26. 00			
116. 00 11600 HOSPI CE	0	9, 815, 838			116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	312, 061, 712			118. 00
NONRE MBURSABLE COST CENTERS					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	382, 262			190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	2, 928, 397			192. 00
194. 00 07950 M0B	0	158, 918			194. 00
194. 01 07951 LI FELI NE	0	0			194. 01
194. 02 07952 PATIENT TRANSPORT	0	0			194. 02
194. 03 07954 OTHER NRCC	0	55, 860			194. 03
194.04 07953 JV-SAGAMORE ASC	0	2, 568, 891			194. 04
200.00 Cross Foot Adjustments	0	0			200. 00
201.00 Negative Cost Centers	0	0			201. 00
202.00 TOTAL (sum lines 118 through 201)	0	318, 156, 040			202. 00

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2023 Part II
To 12/31/2023 Date/Time Prepared:
3/28/2024 12:04 pm Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0109

					10	12/31/2023	3/28/2024 12:0	
				CAPI TAL REI	_ATED_COSTS			
				DI DO A FLVT	10/01 5 50/// 0		5451 0\/55	
		Cost Center Description	Directly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
			Assigned New Capital				BENEFITS DEPARTMENT	
			Related Costs				DEPARTMENT	
			0	1. 00	2.00	2A	4. 00	
	GENER	AL SERVICE COST CENTERS						
1.00		CAP REL COSTS-BLDG & FIXT						1. 00
2.00		CAP REL COSTS-MVBLE EQUIP		400 704	50.040	47/ 007	47/ 007	2. 00
4. 00 5. 01		EMPLOYEE BENEFITS DEPARTMENT COMMUNICATIONS	0	123, 724		176, 087	176, 087	4. 00 5. 01
5. 01	1	MGMT INFO SYSTEMS		439, 786 468, 296		625, 914 666, 490	1, 109 1, 385	5. 01
5. 02		PURCHASI NG		230, 814		328, 500	1, 303	5. 02
5. 04		ADMI TTI NG	Ö	0		0	0	5. 04
5.05	00580	PATIENT ACCOUNTING	o	0	0	О	0	5. 05
5.06		OTHER ADMINISTRATIVE AND GENERAL	0	2, 203, 571	932, 606	3, 136, 177	8, 171	5. 06
7.00	1	OPERATION OF PLANT	0	3, 274, 489		4, 660, 335	4, 367	7. 00
8.00		LAUNDRY & LINEN SERVICE	0	110, 553		157, 342	199	8. 00
9. 00 10. 00	4	HOUSEKEEPI NG DI ETARY		268, 207 277, 467		381, 719 394, 898	2, 993 1, 514	9. 00 10. 00
11. 00		CAFETERI A		336, 631		479, 102	1, 837	11. 00
13. 00		NURSI NG ADMI NI STRATI ON	o	79, 357		112, 943	5, 800	13. 00
14.00		CENTRAL SERVICES & SUPPLY	o	102, 000	43, 169	145, 169	692	14. 00
15. 00		PHARMACY	0	158, 337		225, 349	4, 614	15. 00
16.00		MEDICAL RECORDS & LIBRARY	0	104, 451		148, 657	119	16. 00
17. 00 20. 00	4	SOCIAL SERVICE NURSING PROGRAM	0	0 960, 154		1 244 515	0 3, 474	17. 00 20. 00
23. 00	4	PHARMACY RESIDENCY		960, 154	1	1, 366, 515 0	232	23. 00
23. 01		EMS EDUCATION		0		0	138	23. 01
	_	IENT ROUTINE SERVICE COST CENTERS	-1	-	-,	-,		
30.00		ADULTS & PEDI ATRI CS	0	1, 069, 882		1, 522, 683	27, 307	30. 00
31. 00		INTENSIVE CARE UNIT	0	287, 928		409, 786	6, 663	
35. 00		NEONATAL INTENSIVE CARE UNIT	0	272, 095		387, 252	2, 263	
41. 00 43. 00		SUBPROVIDER - IRF NURSERY		356, 117 479, 182		506, 835 681, 984	2, 379 2, 746	41. 00 43. 00
10.00		LARY SERVICE COST CENTERS	١	177, 102	202, 002	001, 701	2,710	10.00
50.00		OPERATING ROOM	0	982, 161	415, 675	1, 397, 836	16, 426	50. 00
51.00		RECOVERY ROOM	0	65, 102		92, 655	874	51.00
52. 00 54. 00	4	DELIVERY ROOM & LABOR ROOM RADIOLOGY-DIAGNOSTIC	0	1, 175, 087		1, 672, 413	4, 467	52. 00 54. 00
55. 00	4	RADI OLOGY - DI AGNOSTI C		450, 412 93, 565		641, 038 133, 164	6, 895 711	55. 00
56. 00		RADI OI SOTOPE		6, 103		8, 686	861	56. 00
56. 01	03950	CARDI AC CATH LAB	o	264, 555	111, 966	376, 521	2, 111	56. 01
57. 00		CT SCAN	0	30, 159		42, 923	1, 335	
58. 00	05800		0	26, 696		37, 994	488	58. 00
60. 00 65. 00		LABORATORY RESPI RATORY THERAPY	0	156, 829 62, 722		223, 203 89, 268	0 2, 965	60. 00 65. 00
66. 00		PHYSI CAL THERAPY		21, 135		30, 080	6, 120	66. 00
67. 00		OCCUPATIONAL THERAPY	l o	0		0	2, 519	
68. 00	06800	SPEECH PATHOLOGY	o	2, 427	1, 027	3, 454		68. 00
69. 00		ELECTROCARDI OLOGY	0	217, 784		309, 956	2, 496	
70.00	4	ELECTROENCEPHALOGRAPHY	0	105, 040	44, 455	149, 495	960	
71. 00 72. 00		MEDICAL SUPPLIES CHARGED TO PATIENT IMPL. DEV. CHARGED TO PATIENTS	0	0	0	O O	0	71. 00 72. 00
73. 00		DRUGS CHARGED TO PATTENTS		0		0	0	73.00
73. 01		DI ABETES CENTER	l o	180, 320	76, 316	256, 636	2, 062	
74.00	4	RENAL DIALYSIS	o	45, 687		65, 023	99	74. 00
76. 00		ONCOLOGY	0	681, 909	288, 601	970, 510	4, 670	76. 00
76. 01	1	ANTI COAGULATI ON	0	55, 041	23, 295	78, 336	448	
76. 02 76. 98	1	INFUSION SERVICES	0	0	0	0	16	76. 02
76. 98	1	HYPERBARI C OXYGEN THERAPY ALLOGENEI C STEM CELL ACQUI SITION		0	-	0	0	76. 98 77. 00
78. 00		CAR T-CELL IMMUNOTHERAPY		0	-	Ö	0	78. 00
		TIENT SERVICE COST CENTERS						
90.00		CLI NI C	0	0		0	582	90. 00
90. 01		CLINIC - OUTPATIENT INFUSION SERVICE	0	0	0	0	809	90. 01
90. 02 91. 00	1	CLINIC - HOME INF PHARMACOTHERAPY EMERGENCY	0	0 566, 950	239, 947	0 806, 897	0 8, 414	90. 02 91. 00
91.00		WOUND CARE		187, 295		266, 563	1, 447	91.00
92. 00		OBSERVATION BEDS (NON-DISTINCT PART		107,270	, , , 250	0	1, 147	92. 00
92. 01	09201	OBSERVATION BEDS (DISTINCT PART)	0	147, 286	62, 335	209, 621	1, 833	
05.05		REI MBURSABLE COST CENTERS				_1		05.00
95. 00 101. 00		AMBULANCE SERVICES HOME HEALTH AGENCY	0	0 245, 988		0 350, 096	0 5 782	95. 00 101. 00
		OPIOID TREATMENT PROGRAM		240, 700 N	104, 106	350, 090 N		101.00
			1		1	-1	- 1	

Health Financial Systems	FRANCISCAN HEAL	_TH_LAFAYETTE		In Lie	u of Form CMS-:	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CO		Period: From 01/01/2023 To 12/31/2023	Worksheet B Part II Date/Time Pre 3/28/2024 12:	
Cost Center Description	Di rectl y	CAPITAL REL	ATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE	
	Assigned New Capital Related Costs				BENEFITS DEPARTMENT	
	0	1. 00	2. 00	2A	4. 00	
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE						113. 00
116. 00 11600 HOSPI CE	0	0		0	5, 940	116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	17, 373, 294	7, 352, 81	1 24, 726, 105	160, 427	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	63, 429	26, 84			190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	27, 520	11, 64	7 39, 167	13, 731	192. 00
194. 00 07950 MOB	0	47, 642		0 47, 642	0	194. 00
194. 01 07951 LI FELI NE	0	0		0	0	194. 01
194. 02 07952 PATIENT TRANSPORT	0	0		0	0	194. 02
194. 03 07954 OTHER NRCC	0	0		0	0	194. 03
194.04 07953 JV-SAGAMORE ASC	0	0		0	1, 844	194. 04
200.00 Cross Foot Adjustments				0		200. 00
201.00 Negative Cost Centers		0		0 0	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	0	17, 511, 885	7, 391, 30	3 24, 903, 188	176, 087	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2023 Part II
To 12/31/2023 Date/Time Prepared:
3/28/2024 12:04 pm

					12/31/2023	3/28/2024 12:	
	Cost Center Description	COMMUNI CATI ONS	MGMT I NFO	PURCHASI NG	ADMI TTI NG	PATI ENT	
		5. 01	SYSTEMS 5.02	5. 03	5. 04	ACCOUNTING 5. 05	
	GENERAL SERVICE COST CENTERS	3.01	5. 02	3.03	3.04	3. 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	407.000					4. 00
5. 01 5. 02	01160 COMMUNI CATI ONS 01140 MGMT I NFO SYSTEMS	627, 023	400 E04				5. 01 5. 02
5. 02	00550 PURCHASI NG	20, 721 12, 613	688, 596	341, 118			5. 02
5. 04	00570 ADMI TTI NG	12,013	0	341, 118	0		5. 04
5. 05	00580 PATIENT ACCOUNTING	12, 613	0	0	0	12, 613	5. 05
5. 06	00560 OTHER ADMINISTRATIVE AND GENERAL	65, 765	27, 379	111	0	0	5. 06
7.00	00700 OPERATION OF PLANT	49, 549	30, 581	4	0	0	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	901	1, 348	3	0	0	8. 00
9.00	00900 HOUSEKEEPI NG	8, 108	27, 838	172	0	0	9. 00
10.00	01000 DI ETARY	27, 027	10, 325	301	0	0	10.00
11. 00	01100 CAFETERI A	0	12, 527	0	0	0	11. 00
13.00	01300 NURSI NG ADMI NI STRATI ON	8, 108	20, 250		0	0	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	3, 604	4, 899		0	0	14. 00
15. 00 16. 00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	20, 721 15, 315	17, 471	4, 172 0	0	0 0	15. 00 16. 00
17. 00	01700 SOCIAL SERVICE	15, 315	618 0	0	0		17. 00
20. 00	02000 NURSI NG PROGRAM		10, 395	134	0	ĺ	20.00
23. 00	02301 PHARMACY RESIDENCY	l ol	806		0	1	23. 00
23. 01	02300 EMS EDUCATION	o	598		0	0	23. 01
	INPATIENT ROUTINE SERVICE COST CENTERS			'			
30.00	03000 ADULTS & PEDI ATRI CS	103, 604	62, 744	18, 251	0	697	30. 00
31. 00	03100 I NTENSI VE CARE UNI T	19, 820	36, 388		0		31.00
35. 00	02060 NEONATAL INTENSIVE CARE UNIT	15, 315	18, 351	1, 179	0		35. 00
41. 00	04100 SUBPROVI DER - I RF	21, 621	12, 190		0		41.00
43. 00	04300 NURSERY	0	30, 052	0	0	84	43. 00
E0 00	ANCI LLARY SERVI CE COST CENTERS	21 421	27 200	202 E0E	0	2 242	E0 00
50. 00 51. 00	05000 OPERATING ROOM 05100 RECOVERY ROOM	21, 621 7, 207	27, 200 4, 295	202, 505 241	0	_,	50. 00 51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	23, 423	69, 291	0	0		52.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	54, 054	26, 720		0	l .	54.00
55. 00	05500 RADI OLOGY - THERAPEUTI C	0 0	3, 124		0	101	55. 00
56. 00	05600 RADI OI SOTOPE	o	2, 004		0	1	56. 00
56. 01	03950 CARDI AC CATH LAB	O	5, 951	41, 193	0	368	56. 01
57.00	05700 CT SCAN	o	6, 212	2, 004	0	425	57. 00
58. 00	05800 MRI	0	1, 817	518	0	73	58. 00
60.00	06000 LABORATORY	39, 639	0	7, 087	0	870	60.00
65. 00	06500 RESPI RATORY THERAPY	30, 630	14, 469		0	117	65. 00
66. 00	06600 PHYSI CAL THERAPY	5, 405	21, 391	797	0	190	66.00
67. 00	06700 OCCUPATIONAL THERAPY	0	7, 729		0	120	67.00
68. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0	3, 432		0	53	68.00
69. 00 70. 00	07000 ELECTROCARDI OLOGY	5, 405	8, 045 5, 221	645	0	302 42	69. 00 70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0, 221	i	0	1, 124	
	07200 IMPL. DEV. CHARGED TO PATIENTS		0		0	l	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS		0	Ö	0	1, 589	73. 00
73. 01	07301 DI ABETES CENTER	5, 405	6, 406		0	0	73. 01
74. 00	07400 RENAL DIALYSIS	0	277	214	0	42	74. 00
76.00	03480 ONCOLOGY	o	19, 357	12, 906	0	195	76. 00
76. 01	03952 ANTI COAGULATI ON	0	1, 091	487	0	6	76. 01
76. 02	03951 I NFUSI ON SERVI CES	0	49		0	3	76. 02
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0	0	0	0	76. 98
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY OUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	78. 00
90. 00	09000 CLINIC	28, 829	2, 979	333	0	14	90.00
90.00	09001 CLINIC - OUTPATIENT INFUSION SERVICE	20, 029	2, 979		0	81	90.00
90. 01	09002 CLINIC - HOME INF PHARMACOTHERAPY		2, 004	400	0	0	90.01
91. 00	09100 EMERGENCY		44, 826	l ĭ	0	1, 029	91.00
91. 01	04950 WOUND CARE		3, 873		0	43	91. 01
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART		-,	.,			92.00
92. 01	09201 OBSERVATION BEDS (DISTINCT PART)	O	11, 760	710	0	37	92. 01
	OTHER REIMBURSABLE COST CENTERS						
95. 00	09500 AMBULANCE SERVI CES	0	0	0	0	0	95. 00
	10100 HOME HEALTH AGENCY	0	24, 501	759	0		101. 00
102.00	10200 OPI OI D TREATMENT PROGRAM	0	0	0	0	0	102. 00
440 -	SPECIAL PURPOSE COST CENTERS						440.00
	11300 I NTEREST EXPENSE		22 7/4	1 0/0	^	100	113. 00 116. 00
116.00	11600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117)	627, 023	22, 761 672, 405		0		
110.00	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	1 021,023	072, 403	J-1, 115	U	1 12,013	1, 10, 00

Health Financial Systems	FRANCISCAN HEALTH LAFAYETTE	In Lieu of Form CMS-2552-10)
ALLOCATION OF CAPITAL RELATED COSTS	Provi der CCN: 15-0109	Peri od: Worksheet B From 01/01/2023 Part II To 12/31/2023 Date/Ti me Prepared: 2/38/2024 13:04 pm	-

					3/28/2024 12:	04 pm
Cost Center Description	COMMUNI CATIONS	MGMT INFO	PURCHASI NG	ADMITTING	PATI ENT	
		SYSTEMS			ACCOUNTI NG	
	5. 01	5. 02	5. 03	5. 04	5. 05	
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	373	0	0	0	190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	9, 933	1	0	0	192. 00
194. 00 07950 MOB	0	0	0	0	0	194. 00
194. 01 07951 LI FELI NE	0	0	0	0	0	194. 01
194.02 07952 PATIENT TRANSPORT	0	0	0	0	0	194. 02
194. 03 07954 OTHER NRCC	0	3, 410	0	0	0	194. 03
194.04 07953 JV-SAGAMORE ASC	0	2, 475	2	0	0	194. 04
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	0	0	0	0	201. 00
202.00 TOTAL (sum Lines 118 through 201)	627, 023	688, 596	341, 118	0	12, 613	202.00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0109

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2023 Part II
To 12/31/2023 Date/Time Prepared:
3/28/2024 12:04 pm

				'	0 12/31/2023	3/28/2024 12:	
	Cost Center Description	OTHER	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	·
		ADMI NI STRATI VE AND GENERAL	PLANT	LINEN SERVICE			
		5. 06	7. 00	8.00	9. 00	10.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUI P						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01 5. 02	01160 COMMUNI CATIONS 01140 MGMT INFO SYSTEMS						5. 01 5. 02
5. 02	00550 PURCHASING						5. 02
5. 04	00570 ADMITTING			•			5. 04
5. 05	00580 PATIENT ACCOUNTING						5. 05
5.06	00560 OTHER ADMINISTRATIVE AND GENERAL	3, 237, 603					5. 06
7.00	00700 OPERATION OF PLANT	208, 855	4, 953, 691				7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	14, 704	50, 844				8. 00
9.00	00900 HOUSEKEEPI NG	52, 973	123, 349				9. 00
10.00	01000 DI ETARY	29, 135	127, 607	1		613, 292	
11.00	01100 CAFETERI A	29, 312	154, 817	1	19, 602	0	11.00
13. 00 14. 00	01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY	59, 417 4, 551	36, 496 46, 910	1	4, 621 5, 939	0	13. 00 14. 00
15. 00	01500 PHARMACY	42, 450	72, 819			0	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	30, 825	48, 037	1		0	16. 00
17. 00	01700 SOCI AL SERVI CE	0	10, 007	0	0, 002	0	17. 00
20. 00	02000 NURSI NG PROGRAM	28, 347	441, 576	ō	55, 908	Ō	20.00
23. 00	02301 PHARMACY RESIDENCY	2, 628	0	0	0	0	23. 00
23. 01	02300 EMS EDUCATION	1, 331	0	0	0	0	23. 01
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	354, 309	492, 040			434, 043	1
31. 00	03100 INTENSIVE CARE UNIT	80, 921	132, 419			61, 638	1
35. 00	02060 NEONATAL INTENSIVE CARE UNIT	26, 679	125, 137	1		38, 973	
41.00	04100 SUBPROVI DER – I RF	30, 867	163, 779			39, 665	
43. 00	04300 NURSERY ANCILLARY SERVICE COST CENTERS	46, 187	220, 376	8, 301	27, 902	38, 973	43. 00
50. 00	05000 OPERATING ROOM	126, 092	451, 697	39, 521	57, 190	0	50.00
51. 00	05100 RECOVERY ROOM	12, 751	29, 940			0	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	79, 068	540, 425	1		0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	123, 225	207, 145	1		0	54.00
55.00	05500 RADI OLOGY - THERAPEUTI C	11, 263	43, 031	0	5, 448	0	55. 00
56.00	05600 RADI 0I SOTOPE	9, 621	2, 807	0	355	0	56. 00
56. 01	03950 CARDI AC CATH LAB	45, 954	121, 669	1	15, 405	0	56. 01
57. 00	05700 CT SCAN	19, 203	13, 870	1	.,	0	57. 00
58. 00	05800 MRI	8, 889	12, 277	1	.,	0	58. 00
60.00	06000 LABORATORY	170, 167	72, 126	1		0	60.00
65. 00 66. 00	06500 RESPIRATORY THERAPY	37, 829	28, 846			0	65. 00 66. 00
67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	58, 502 25, 052	9, 720	3, 131 0	1, 231	0	67.00
68. 00	06800 SPEECH PATHOLOGY	11, 733	1, 116	1	141	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	41, 171	100, 159	1		0	69.00
70. 00	07000 ELECTROENCEPHALOGRAPHY	13, 089	48, 308			0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	269, 509	0	1		0	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	216, 447	0	0	0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	369, 678	0	0	0	0	73. 00
73. 01	07301 DI ABETES CENTER	25, 512	82, 930	1	10, 500	0	73. 01
74. 00	07400 RENAL DI ALYSI S	20, 974	21, 011	0	2, 660	0	74. 00
76. 00	03480 ONCOLOGY	67, 756	313, 611	0	39, 707	0	76.00
76. 01	03952 ANTI COAGULATI ON	5, 735	25, 313	0	3, 205	0	76. 01
76. 02 76. 98	03951 I NFUSION SERVI CES 07698 HYPERBARI C OXYGEN THERAPY	143	0	0	0	0	76. 02
76. 98 77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION		0	0	0	0	76. 98 77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY		0	0	0	0	78.00
70.00	OUTPATIENT SERVICE COST CENTERS	<u> </u>		· · · · · · · · ·	ı o	<u> </u>	70.00
90. 00	09000 CLI NI C	11, 386	0	0	0	0	90.00
90. 01	09001 CLINIC - OUTPATIENT INFUSION SERVICE	8, 754	0	o	0	0	
90. 02	09002 CLINIC - HOME INF PHARMACOTHERAPY	1	0	0	0	0	90. 02
91.00	09100 EMERGENCY	131, 477	260, 741	20, 819	33, 013	0	91.00
91. 01	04950 WOUND CARE	15, 537	86, 137	0	10, 906	0	91. 01
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
92. 01	09201 OBSERVATION BEDS (DISTINCT PART)	34, 356	67, 737	0	8, 576	0	92. 01
05.00	OTHER REIMBURSABLE COST CENTERS						05.00
95. 00 101. 00	09500 AMBULANCE SERVI CES 10100 HOME HEALTH AGENCY	70, 936	0 113, 130	0		0	95. 00 101. 00
	10100 HOME HEALTH AGENCY 10200 OPI OI D TREATMENT PROGRAM	70, 936	113, 130	1			101.00
102.00	SPECIAL PURPOSE COST CENTERS	ı U	0		ı U	0	102.00
113. 00	11300 INTEREST EXPENSE						113. 00
116.00	11600 HOSPI CE	94, 543	0	О	ol	0	116. 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	3, 179, 844	4, 889, 952	225, 341	597, 068		
				•			

Health Financial Systems	FRANCISCAN HEALTH LAFAYETTE	In Lie	u of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS	Provi der CCN: 15-0109	Peri od: From 01/01/2023	Worksheet B Part II

			Т	o 12/31/2023	Date/Time Pr 3/28/2024 12	
Cost Center Description	OTHER	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	, or pin
	ADMI NI STRATI VE	PLANT	LINEN SERVICE			
	AND GENERAL					
	5. 06	7. 00	8. 00	9. 00	10.00	
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	2, 277	29, 171	0	3, 693	(190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	28, 463	12, 657	0	1, 602	(192. 00
194. 00 07950 MOB	693	21, 911	0	0	(194. 00
194. 01 07951 LI FELI NE	0	0	0	0		194. 01
194. 02 07952 PATIENT TRANSPORT	0	0	0	0		194. 02
194. 03 07954 OTHER NRCC	346	0	0	0		194. 03
194.04 07953 JV-SAGAMORE ASC	25, 980	0	0	0		194. 04
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	0	0	0		201. 00
202.00 TOTAL (sum lines 118 through 201)	3, 237, 603	4, 953, 691	225, 341	602, 363	613, 29	2 202. 00

| In Lieu of Form CMS-2552-10 | Period: Worksheet B | From 01/01/2023 | Part II | To 12/31/2023 | Date/Time Prepared: 3/28/2024 12: 04 pm

					3/28/2024 12:	04 pm
Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVICES &	PHARMACY	MEDICAL RECORDS &	
			SUPPLY		LIBRARY	
GENERAL SERVI CE COST CENTERS	11.00	13. 00	14. 00	15. 00	16. 00	
1. 00 O0100 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. 01 01160 COMMUNI CATI ONS						5. 01
5. 02 01140 MGMT INFO SYSTEMS						5. 02
5. 03 00550 PURCHASI NG						5. 03
5. 04 00570 ADMI TTI NG						5. 04
5. 05 00580 PATIENT ACCOUNTING						5. 05
5.06 00560 OTHER ADMINISTRATIVE AND GENERAL						5. 06
7. 00 O0700 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						10. 00
11. 00 01100 CAFETERI A	697, 197	,				11. 00
13.00 01300 NURSING ADMINISTRATION	24, 401	1				13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	5, 903		225, 480			14.00
15. 00 01500 PHARMACY	21, 052	o	2, 780	420, 648		15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	745	o o	0	0	250, 398	16. 00
17. 00 01700 SOCIAL SERVICE	C	1	0	0	0	17. 00
20. 00 02000 NURSI NG PROGRAM	12, 525	o o	89	0	0	20.00
23. 00 02301 PHARMACY RESI DENCY	971	0	0	0	0	23. 00
23. 01 02300 EMS EDUCATION	721	0	30	0	0	23. 01
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	75, 605	39, 578	12, 162	0	14, 234	30. 00
31.00 03100 INTENSIVE CARE UNIT	43, 847	22, 953	3, 088	0	5, 480	31.00
35.00 02060 NEONATAL INTENSIVE CARE UNIT	22, 112	11, 575	786	0	1, 570	35. 00
41. 00 04100 SUBPROVI DER - I RF	14, 689	7, 689	262	0	998	41.00
43. 00 04300 NURSERY	36, 212	18, 956	0	0	1, 717	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	32, 776	17, 158	134, 958	0	38, 998	50.00
51.00 05100 RECOVERY ROOM	5, 176	2, 709	160	0	4, 721	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	83, 489	43, 708	0	0	2, 080	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	32, 197	o o	15, 220	0	15, 737	54.00
55. 00 05500 RADI OLOGY - THERAPEUTI C	3, 765	0	81	0	2, 065	55.00
56. 00 05600 RADI 0I SOTOPE	2, 415	1, 264	1	0	2, 168	56.00
56. 01 03950 CARDI AC CATH LAB	7, 171	3, 754	27, 451	0	7, 515	56. 01
57.00 05700 CT SCAN	7, 486	o	1, 335	0	8, 683	57.00
58. 00 05800 MRI	2, 189	o	345	0	1, 489	58. 00
60. 00 06000 LABORATORY	C	0	4, 723	0	17, 766	60.00
65. 00 06500 RESPIRATORY THERAPY	17, 435	9, 127	3, 983	0	2, 391	65.00
66. 00 06600 PHYSI CAL THERAPY	25, 776	13, 493	531	0	3, 872	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	9, 314	4, 876	101	0	2, 455	67.00
68.00 06800 SPEECH PATHOLOGY	4, 136	2, 165	5	0	1, 075	68. 00
69. 00 06900 ELECTROCARDI OLOGY	9, 694	5, 075	186	0	6, 160	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	6, 292	3, 294	430	0	857	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	· C	0	0	0	22, 960	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	C	0	0	0	18, 077	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	C	0	0	420, 648	32, 455	73. 00
73. 01 07301 DI ABETES CENTER	7, 719	4, 041	51	0	0	73. 01
74. 00 07400 RENAL DI ALYSI S	333	174	143	0	854	74.00
76. 00 03480 ONCOLOGY	23, 325	6 O	8, 601	0	3, 988	76. 00
76. 01 03952 ANTI COAGULATI ON	1, 315	6 O	325	0	131	76. 01
76. 02 03951 I NFUSI ON SERVI CES	59	0	42	0	66	76. 02
76. 98 07698 HYPERBARI C OXYGEN THERAPY	C	0	0	0	0	76. 98
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	C	0	0	0	0	77. 00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	C	0	0	0	0	78. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	3, 589	28, 275	222	0	291	90.00
90.01 09001 CLINIC - OUTPATIENT INFUSION SERVICE	E 3, 451	2, 443	311	0	1, 646	90. 01
90. 02 09002 CLINIC - HOME INF PHARMACOTHERAPY	C	1 -1	0	0	0	90. 02
91. 00 09100 EMERGENCY	54, 014	0	4, 259	0	21, 017	91.00
91. 01 04950 WOUND CARE	4, 667	' 이	1, 127	0	878	91. 01
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	-					92.00
92. 01 09201 OBSERVATION BEDS (DISTINCT PART)	14, 171	0	473	0	762	92. 01
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	C	1 -1	0	0	0	95. 00
101.00 10100 HOME HEALTH AGENCY	29, 523	1	506	0	-	101. 00
102.00 10200 OPIOLD TREATMENT PROGRAM	C	0	0	0	0	102. 00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 I NTEREST EXPENSE						113. 00
116. 00 11600 HOSPI CE	27, 426		711	0		116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 1	17) 677, 686	272, 119	225, 478	420, 648	250, 398	118. 00

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

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0109 | Period: From 01/01/2023 | Part II | Date/Time Prepared: To 12/31/2023 | Date/Time Prepared: Provider CCN: 15-0109 | Period: From 01/01/2023 | Part II | Date/Time Prepared: Provider CCN: 15-0109 | Period: From 01/01/2023 | Part II | Date/Time Prepared: Provider CCN: 15-0109 | Period: From 01/01/2023 | Part II | Date/Time Prepared: Provider CCN: 15-0109 | Period: From 01/01/2023 | Part II | Date/Time Prepared: Provider CCN: 15-0109 | Period: From 01/01/2023 | Part II | Date/Time Prepared: Provider CCN: 15-0109 | Period: From 01/01/2023 | Part II | Date/Time Prepared: Provider CCN: 15-0109 | Period: From 01/01/2023 | Part II | Date/Time Prepared: Provider CCN: 15-0109 | Period: From 01/01/2023 | Part II | Date/Time Prepared: Provider CCN: 15-0109 | Period: From 01/01/2023 | Part II | Date/Time Prepared: Provider CCN: 15-0109 | Period: From 01/01/2023 | Part II | Date/Time Prepared: Provider CCN: 15-0109 | Period: From 01/01/2023 | Part II | Date/Time Prepared: Provider CCN: 15-0109 | Period: From 01/01/2023 | Part II | Date/Time Prepared: Provider CCN: 15-0109 | Period: From 01/01/2023 | Part II | Date/Time Prepared: Provider CCN: 15-0109 | Period: From 01/01/2023 | Part II | Date/Time Prepared: Provider CCN: 15-0109 | Period: From 01/01/2023 | Part II | Date/Time Prepared: Provider CCN: 15-0109 | Period: From 01/01/2023 | Part II | Provider CCN: 15-0109 | Period: From 01/01/2023 | Part II | Provider CCN: 15-0109 | Period: From 01/01/2023 | Part II | Provider CCN: 15-0109 | Period: From 01/01/2023 | Part II | Provider CCN: 15-0109 | Period: From 01/01/2023 | Part II | Provider CCN: 15-0109 | Period: From 01/01/2023 | Part II | Provider CCN: 15-0109 | Period: From 01/01/2023 | Part II | Provider CCN: 15-0109 | Period: From 01/01/2023 | Part II | Provider CCN: 15-0109 | Period: From 01/01/2023 | Part II | Provider CCN: 15-0109 | Period: From 01/01/2023 | Part II | Provider CC

				7 12/31/2023	3/28/2024 12:	
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		ADMI NI STRATI ON	SERVICES &		RECORDS &	
			SUPPLY		LI BRARY	
	11.00	13. 00	14.00	15.00	16. 00	
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	450	0	0	0	0	190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	11, 969	0	1	0	0	192. 00
194. 00 07950 MOB	0	0	0	0	0	194. 00
194. 01 07951 LI FELI NE	0	0	0	0	0	194. 01
194. 02 07952 PATI ENT TRANSPORT	0	0	0	0	0	194. 02
194. 03 07954 OTHER NRCC	4, 109	0	0	0	0	194. 03
194. 04 07953 JV-SAGAMORE ASC	2, 983	0	1	0	0	194. 04
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	697, 197	272, 119	225, 480	420, 648	250, 398	202. 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2023 | Part II | To 12/31/2023 | Date/Time Prepared: | 3/28/2024 | 12: 04 pm Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0109

					0 12/31/2023	3/28/2024 12:	
	Cost Center Description	SOCI AL SERVI CE	NURSI NG	PHARMACY	EMS EDUCATION	Subtotal	
		17.00	PROGRAM	RESI DENCY	00.04	04.00	
	GENERAL SERVICE COST CENTERS	17. 00	20. 00	23. 00	23. 01	24. 00	
1.00	00100 CAP REL COSTS-BLDG & FIXT	T T					1.00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01	01160 COMMUNI CATI ONS						5. 01
5. 02	01140 MGMT INFO SYSTEMS						5. 02
5. 03	00550 PURCHASI NG						5. 03
5. 04	00570 ADMITTING						5. 04
5. 05	00580 PATIENT ACCOUNTING						5. 05
5. 06	00560 OTHER ADMINISTRATIVE AND GENERAL						5. 06
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						10.00
11. 00	01100 CAFETERI A						11.00
13. 00	01300 NURSI NG ADMI NI STRATI ON						13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY						14. 00
15. 00	01500 PHARMACY						15. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY						16. 00
17. 00	01700 SOCIAL SERVICE	0					17. 00
20. 00	02000 NURSING PROGRAM		1, 918, 963				20.00
23. 00	l l	1	1, 710, 703		,		1
	02301 PHARMACY RESIDENCY	0		4, 637			23. 00
23. 01	02300 EMS EDUCATION	l ol			2, 863		23. 01
00.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS				1	0.000.405	00.00
30.00	03000 ADULTS & PEDIATRICS	0				3, 299, 105	30.00
31. 00	03100 I NTENSI VE CARE UNI T	0				856, 788	31.00
35. 00	02060 NEONATAL INTENSIVE CARE UNIT	0				672, 164	35. 00
41. 00	04100 SUBPROVI DER - I RF	0				826, 430	41.00
43.00	04300 NURSERY	0				1, 113, 490	43. 00
	ANCILLARY SERVICE COST CENTERS						
50. 00	05000 OPERATI NG ROOM	0				2, 566, 241	
51. 00	05100 RECOVERY ROOM	0				172, 018	51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0				2, 595, 766	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0				1, 185, 934	54.00
55.00	05500 RADI OLOGY - THERAPEUTI C	0				202, 875	55. 00
56.00	05600 RADI OI SOTOPE	0				30, 290	56. 00
56. 01	03950 CARDI AC CATH LAB	O				655, 979	56. 01
57.00	05700 CT SCAN	O				105, 232	57.00
58.00	05800 MRI	o				67, 633	58. 00
60.00	06000 LABORATORY	0				546, 150	60.00
65. 00	06500 RESPIRATORY THERAPY	0				248, 371	65. 00
66. 00	06600 PHYSI CAL THERAPY	0				180, 239	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0				52, 317	67. 00
68. 00	06800 SPEECH PATHOLOGY	0				28, 408	1
69. 00	06900 ELECTROCARDI OLOGY					502, 885	69.00
70. 00	07000 ELECTROENCEPHALOGRAPHY					234, 749	70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT					293, 593	
	07200 IMPL. DEV. CHARGED TO PATIENTS					235, 409	
73. 00	07300 DRUGS CHARGED TO PATIENTS	0				824, 370	
73. 00	07301 DI ABETES CENTER					401, 338	
							73. 01
74.00	07400 RENAL DIALYSIS					111, 804	74.00
76.00	03480 ONCOLOGY					1, 464, 626	
76. 01	03952 ANTI COAGULATI ON					116, 392	76. 01
76. 02	03951 NFUSION SERVICES	0				441	1
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0				0	76. 98
	07700 ALLOGENEIC STEM CELL ACQUISITION	0				0	77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0				0	78. 00
	OUTPATIENT SERVICE COST CENTERS						
90. 00	09000 CLI NI C	0				76, 500	90. 00
90. 01	09001 CLINIC - OUTPATIENT INFUSION SERVICE	0				20, 825	90. 01
90. 02	09002 CLINIC - HOME INF PHARMACOTHERAPY	0				1	90. 02
91.00	09100 EMERGENCY	0				1, 392, 896	91.00
91.01	04950 WOUND CARE	0				392, 870	91. 01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
92. 01	09201 OBSERVATION BEDS (DISTINCT PART)	0				350, 036	92. 01
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVI CES	0				0	95. 00
	10100 HOME HEALTH AGENCY	0				626, 382	
	10200 OPIOID TREATMENT PROGRAM	0					102.00
. 52. 00	SPECIAL PURPOSE COST CENTERS	<u> </u>					1
113 00	11300 INTEREST EXPENSE						113. 00
	11600 HOSPI CE	o				170, 935	1
118.00			0	C	o	22, 621, 482	
110.00	1 1000101ALO (SOM OF LINES I LITTOUGH 117)	١	U		⁷ 1	22, 021, 402	1, 10, 00

Health Financial Systems	FRANCI SCAN HEAL	TH LAFAYETTE		In Lie	eu of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der C	CN: 15-0109	Peri od: From 01/01/2023 To 12/31/2023	Worksheet B Part II Date/Time Pre 3/28/2024 12:	
Cost Center Description	SOCI AL SERVI CE	NURSI NG PROGRAM	PHARMACY RESI DENCY	EMS EDUCATION		
	17. 00	20.00	23. 00	23. 01	24.00	
NONREI MBURSABLE COST CENTERS						
						7

Cost Center Description	SOCIAL SERVICE	NURSI NG PROGRAM	PHARMACY RESI DENCY	EMS EDUCATION	Subtotal	
	17. 00	20.00	23. 00	23. 01	24.00	
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0				126, 323	190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0				117, 524	192. 00
194. 00 07950 MOB	0				70, 246	194. 00
194. 01 07951 LI FELI NE	0				0	194. 01
194. 02 07952 PATIENT TRANSPORT	0				0	194. 02
194. 03 07954 OTHER NRCC	0				7, 865	194. 03
194.04 07953 JV-SAGAMORE ASC	0				33, 285	194. 04
200.00 Cross Foot Adjustments		1, 918, 963	4, 637	2, 863	1, 926, 463	200. 00
201.00 Negative Cost Centers	0	0	C	0	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	0	1, 918, 963	4, 637	2, 863	24, 903, 188	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS FRANCISCAN HEALTH LAFAYETTE

| Period: | Worksheet B | From 01/01/2023 | Part II | To | 12/31/2023 | Date/Time Prepared: Provider CCN: 15-0109

Control Center Description					To 12/31/2023 Date/Time Pre	
### A POST ### A POST		Cost Center Description	Intern &	Total	3/28/2024 12:	U4 pili
STREAM STRINGE COST CENTRIS 76.00		·				
SERIEBAL SERVICE COST CRITERS 25 00 26,000						
DEMERS SERVICE COST SERVICE			· · · · · · · · · · · · · · · · · · ·			
1.00 1.00				26. 00		
2.00	4 00					1 00
0-040 SPECIAL SERVICE SERVERTS DEPARTMENT		1 1	1			1
0.1100 COMMUNICATIONS		1 1				1
0.050 URCHASINO						1
		1 1				1
5.05 OSSO PATENT ACCOUNTING		1 1				1
5.0 6 OSAO OTHER ARMINISTRATIVE AND GENERAL 5.0 6 S.0 0 OSAO OTHER ARMINISTRATIVE 8.0 0 OSAO OTHER ARMINISTRATIVE 8.0 0 OSAO OTHER ARMINISTRATION 11.0 0 OSAO OTHER ARMINISTRATION 12.0 0 OSAO OTHER ARMINISTRA		1 1				1
7.00 00700 OPERATION OF PLANT		1 1				1
9.00 11.00 01000 DI FLARY 011.00 01100 DI FLARY 11.00 11.00 01100 DI FLARY 11.00 11.00 11.00 01100 DI FLARY 11.00 11.00 11.00 11.00 01100 DI FLARY 11.00 11.	7.00	1 1				7. 00
10, 00 10500 DIELARY		1 1				1
11.00 10100 CAFETER		1 1				1
13.00 0.300 MURSI INC ADMINISTRATION 14.00 0.1400 (CHYRTAL STRYLES & SUPPLY 1.5 0.00 1.5 0.0						1
15.00 10.500 PHARMACY 10.00 10.00 10.00 MEDICAL RECORDS & LIBRARY 10.00 10.00 MEDICAL RECORDS & LIBRARY 10.00 10.00 MEDICAL RECORDS & LIBRARY 10.00 10.00 MISSING PROGRAM 20.00 20.00 MISSING PROGRAM 20.00 22.00 22.50 MISSING PROGRAM 22.00 22.50						1
10. 00 10.00 MEDI CAL RECORDS & LI BRARY 10. 00 10. 00 20. 00 20200 NURSI NR FROGRAM 20. 00 20. 00 20200 NURSI NR FROGRAM 20. 00 20. 00 20. 00 20. 00 NURSI NR FROGRAM 20. 00 20. 00 20. 00 20. 00 NURSI NR FROGRAM 20. 00						1
17.00 17.00 SOCIAL SERVICE		i i				1
20.00						1
23. 00 02301 PHARMACY RESIDENCY 23. 01		i i				1
INPATIENT ROUTINE SERVICE COST CENTERS 33.00 33.		1 1				
30.00	23. 01					23. 01
131.00 03100 INTENSIVE CARE UNIT 0 672, 164 33.00	20.00			2 200 105		20.00
35. 00		i i	1			1
A32.00 O4300 DURSERY C COST CENTERS		1 1	1			1
ANCILLARY SERVICE COST CENTERS 50.00		1 1	1 1			1
50.00 050000 050000 050000 050000 050000 050000 050000 050000 050000 050000 050000 050000 050000 050000 0500000000	43. 00		0	1, 113, 490		43.00
STOON OSTOON RECOVERY ROOM ALBOOR ROOM OSTOON O	50. 00		0	2, 566, 241		50.00
54. 00 05400 RADIOLOGY-DIAGNOSTIC 0 1, 185, 934 54. 00 55. 00 05500 RADIOLOGY - THERAPEUTIC 0 202, 875 55. 00 56. 00 05500 RADIOLOGY - THERAPEUTIC 0 30, 290 56. 00 56. 00 03500 RADIOLOGY - THERAPEUTIC 0 30, 290 56. 00 56. 00 03500 CARDIAC CATH LAB 0 0 655, 979 56. 01 57. 00 05700 CT SCAN 0 105, 232 57. 00 56. 00 03500 MR] 0 676, 633 58. 00 60. 00 60000 LABORATORY 0 546, 150 60. 00 60000 LABORATORY 0 546, 150 60. 00 60000 LABORATORY 0 546, 150 60. 00 60000 PHYSICAL THERAPY 0 180, 239 66. 00 66. 00 6600 PHYSICAL THERAPY 0 180, 239 66. 00 66. 00 66000 PHYSICAL THERAPY 0 52, 317 67. 00			1			1
55.00 05500 RADIOLOGY - THERAPEUTIC 0 202, 875 55.00 56.00 56.00 30.500 RADIOLOGY - THERAPEUTIC 0 30.290 56.00 56.01 3950 CARDIAC CATH LAB 0 655, 979 56.01 57.00 05700 CT SCAN 0 105, 232 57.00 57.00 05800 MRI 05800 MRI 0 67, 633 58.00 60.00 06000 LABORATORY 0 546, 150 60.00 06000 LABORATORY 0 248, 371 65.00 66.00 06000 RESPIRATORY 1 180, 239 66.00 06000 RESPIRATORY 0 180, 239 66.00 06000 RESPIRATORY 0 180, 239 66.00 06000 RESPIRATORY 0 52, 317 67.00 06.00 06000 ELECTROCARDIOLOGY 0 28, 408 68.00 06800 SPECH PATHOLOGY 0 28, 408 68.00 06800 SPECH PATHOLOGY 0 522, 885 69.00 070, 00 070, 00 ELECTROCARDIOLOGY 0 522, 885 69.00 070, 00 070, 00 ELECTROCARDIOLOGY 0 234, 749 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 234, 749 71.00 72.00 07200 IMPL DEV. CHARGED TO PATIENTS 0 824, 370 73.00 73.01 07300 DRUGS CHARGED TO PATIENTS 0 824, 370 73.01 73.01 73.01 73.01 74.00 07400 RENAL DIALYSIS 0 401, 338 73.01 74.00 07400 RENAL DIALYSIS 0 411, 804 74.00 74.0		1 1				1
56. 00 05.		1 1				•
56. 01 03950 CARDIAC CATH LAB 0 655, 979 56. 01		1 1				•
58. 00 05800 MR 0 67, 633 58, 00 6000 LABORATORY 0 546, 150 60. 00 60. 00 66500 RESPIRATORY THERAPY 0 248, 371 65. 00 66. 00 66500 RESPIRATORY THERAPY 0 180, 239 66. 00 66. 00 667. 00 66700 00CUPATIONAL THERAPY 0 52, 317 67. 00 67. 00 6700 00CUPATIONAL THERAPY 0 52, 317 67. 00 68. 00 66800 SPEECH PATHOLOGY 0 28, 408 68. 00 6800 SPEECH PATHOLOGY 0 502, 885 69. 00 69. 00 69900 ELECTROCARDI OLOGY 0 502, 885 69. 00 71. 00 7100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0 293, 593 71. 00 71. 00 7100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 234, 749 72. 00 72. 00 73. 00 7300 DIRGS CHARGED TO PATIENTS 0 824, 370 73. 00 73. 00 73.00 07300 DIRGS CHARGED TO PATIENTS 0 824, 370 73. 01 73.00 73. 00 73.00 07300 DIRGS CHARGED TO PATIENTS 0 824, 370 73. 01 73. 01 74. 00 7		1 1	0			1
60. 00 06000 LABORATORY 0 546, 150 60. 00 65. 00 065000 RESPI RATORY THERAPY 0 248, 371 65. 00 66. 00 06600 PHYSI CAL THERAPY 0 180, 239 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 0 52, 317 67. 00 68. 00 066800 SPECTA PATHOLOGY 0 52, 317 67. 00 69. 00 06900 ELECTROCARDI OLOGY 0 502, 885 69. 00 70. 00 07000 ELECTROCARDI OLOGY 0 502, 885 69. 00 71. 00 07100 MCDI CAL SUPPLIES CHARGED TO PATI ENT 0 234, 749 70. 00 71. 00 07100 MCDI CAL SUPPLIES CHARGED TO PATI ENT 0 293, 593 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 235, 409 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 824, 370 73. 00 73. 01 07301 DI ABETES CENTER 0 401, 338 73. 01 74. 00 07400 RENAL DI ALYSIS 0 111, 804 74. 00 76. 00 03480 0NCOLOGY 0 1, 464, 626 76. 00 76. 01 03952 ANTI COAGULATI ON 0 116, 392 76. 01 76. 02 03951 IMPUSION SERVI CES 0 441 76. 02 77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION 0 0 0 77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION 0 0 78. 00 09000 CLI NI C 0 0 0 79. 00 09000 CLI NI C 0 0 0 79. 00 09000 CLI NI C 0 0 0 79. 00 09000 CLI NI C 0 0 0 79. 00 09000 CLI NI C 0 0 0 79. 00 09000 CLI NI C 0 0 0 79. 00 09000 0SERVATION BEDS (DI STINCT PART 0 79. 00 09200 0SERVATION BEDS (DI STINCT PART 0 79. 00 09200 0DSERVATION BEDS (DI STINCT PART 0 79. 00 09200 0DSERVATION BEDS (DI STINCT PART 0 79. 00 09200 0DSERVATION BEDS (DI STINCT PART 0 70. 00 09200 0DSERVATION BEDS (DI STINCT PART 0 70. 00 09200 0DSERVATION BEDS (DI STINCT PART 0 70. 00 09200 0DSERVATION BEDS (DI STINCT PART 0 70. 00 09200 0DSERVATION BEDS (DI STINCT PART 0 70. 00 09200 0DSERVATION BEDS (DI STINCT PART 0 70. 00 09200 0DSERVATION BEDS (DI STINCT PART 0 70. 00 09200 0DSERVATION BEDS (DI STI		1 1				•
65. 00 05500 RESPIRATORY THERAPY 0 180, 239 65. 00 66. 00 06600 PHYSI CAL THERAPY 0 180, 239 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 0 180, 239 66. 00 68. 00 06800 SPEECH PATHOLOGY 0 28, 408 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 50, 285 69. 00 70. 00 07000 ELECTROCARDI OLOGY 0 234, 749 70. 00 71. 00 07000 ELECTROCARDI OLOGY 0 234, 749 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0 293, 593 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 235, 409 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 824, 370 73. 01 73. 01 07301 DI ABETES CENTER 0 401, 338 73. 01 74. 00 07400 RENAL DI ALYSIS 0 401, 338 73. 01 74. 00 07400 RENAL DI ALYSIS 0 111, 804 74. 00 76. 00 03480 ONCOLOGY 0 11, 804 074, 602 76. 01 03952 ANTI COAGULATI ON 0 11, 6392 76. 01 76. 02 03951 INFUSI ON SERVI CES 0 441 76. 00 76. 09 07698 HYPERBARI C DAYGEN THERAPY 0 0 0 441 77. 00 77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION 0 0 0 76. 500 77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION 0 0 0 0 78. 00 00 09000 CLINI C 0 07000 CLINI C 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0						
66.00 06600 PHYSICAL THERAPY 0 180,239 66.00 67.00 670 06700 06700 06700 06700 06700 06800 06800 SPEECH PATHOLOGY 0 52,317 67.00 68.00 06800 SPEECH PATHOLOGY 0 502,885 69.00 69.00 06900 ELECTROCARDI OLOGY 0 502,885 69.00 07.00 07000 ELECTROCARDI OLOGY 70.00				1		1
68. 00		l l				1
69. 00 06900 ELECTROCARDIOLOGY 0 502, 885 70. 00 70. 00 7000 ELECTROCARDIOLOGY 0 234, 749 70. 00 7000 FLECTROENCEPHALOGRAPHY 0 234, 749 70. 00 71. 00 70100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 293, 593 71. 00 7100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 235, 409 72. 00 73. 00 7300 DRUGS CHARGED TO PATIENTS 0 824, 370 73. 00 73. 01 07301 DIABETES CHARGED TO PATIENTS 0 401, 338 73. 01 73. 01 07301 DIABETES CENTER 0 401, 338 73. 01 74. 00 74.00 RENAL DIALYSIS 0 111, 804 74. 00 74.00 RENAL DIALYSIS 0 111, 804 74. 00 75			1 1			1
70. 00 07000 ELECTROENCEPHALGGRAPHY 0 234, 749 70. 00 71. 00 710 0 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0 293, 593 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 235, 409 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 824, 370 73. 01 07301 DI ABETES CENTER 0 401, 338 73. 01 73. 01 07301 DI ABETES CENTER 0 411, 804 74. 00 76. 00 03480 0NCOLOGY 0 11, 464, 626 76. 00 76. 00 03952 ANTI COAGULATI ON 0 116, 392 76. 01 76. 02 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 0 441 76. 02 76. 98 77. 00 07700 ALLOGENEIC STEM CELL ACOUI SITI ON 0 0 0 0 0 0 0 0 0			1 1			
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0 293, 593 71. 00 72. 00 772.00 IMPL. DEV. CHARGED TO PATIENTS 0 235, 409 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 824, 370 73. 00 73. 01 07301 DI ABETES CENTER 0 401, 338 73. 01 74. 00 7400 RENAL DI ALYSIS 0 111, 804 74. 00 7400 RENAL DI ALYSIS 0 111, 804 74. 00 76. 00 03480 ONCOLOGY 0 1, 464, 626 76. 00 76. 00 76. 01 76. 02 76. 02 76. 02 76. 02 76. 02 76. 02 76. 03952 ANTI COAGULATION 0 116, 392 76. 01 76. 02 76. 98 O7508 HYPERBARI C OXYGEN THERAPY 0 0 0 0 76. 98 O7500 ALLOGENEI C STEM CELL ACQUISITION 0 0 0 0 0 0 0 0 0			1			•
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 235, 409 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 824, 370 73. 00 73. 01 07301 DI ABETES CENTER 0 401, 338 73. 00 74. 00 07400 RENAL DI ALYSI S 0 111, 804 74. 00 76. 00 03480 ONCOLOGY 0 1, 464, 626 76. 00 76. 01 03952 INTICOAGULATION 0 116, 392 76. 001 76. 02 03951 INFUSI ON SERVI CES 0 441 76. 00 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 77. 00 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON 0 0 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 00TPATI ENT SERVI CE COST CENTERS 90. 01 09000 CLI NI C 0 0TPATI ENT INFUSI ON SERVI CE 0 20, 825 90. 01 90. 02 09002 CLI NI C - OUTPATI ENT INFUSI ON SERVI CE 0 20, 825 90. 01 90. 02 09002 CLI NI C - HOME INF PHARMACOTHERAPY 0 1, 392, 896 91. 01 90. 02 09200 DEMERGENCY 0 1, 392, 870 99. 02 91. 00 09200 DEMERGENCY 0 350, 036 92. 01 92. 00 09200 DESERVATI ON BEDS (NON-DI STI NCT PART 0 92. 00 92. 01 09201 DESERVATI ON BEDS (DI STI NCT PART 0 92. 00 95. 00 09500 AMBULANCE SERVI CES 0 0 6626, 382 101. 00 101. 00 10100 HOME HEALTH AGENCY 0 626, 382 101. 00 SPECI AL PURPOSE COST CENTERS			1			
73. 01 07301 DI ABETES CENTER 0 401, 338 73. 01 74. 00 07400 RENAL DI ALYSIS 0 111, 804 74. 00 76. 00 03480 ONCOLOGY 0 1, 464, 626 76. 00 76. 01 03952 ANTI COAGULATI ON 0 116, 392 76. 01 76. 02 03951 INFUSI ON SERVI CES 0 441 76. 02 76. 98 07698 PHYPERBARI C OXYGEN THERAPY 0 0 0 77. 00 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON 0 0 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 78. 00 07800 CLI NI C 0 0 0000 CLI NI C 0 0 0 0 0000 CLI NI C 0 0 0 0 0000 CLI NI C 0 0 0 0 0 0000 CLI NI C 0 0 0 0 0 0000 CLI NI C 0 0 0 0 0 0 0000 CLI NI C 0 0 0 0 0 0 0000 CLI NI C 0 0 0 0 0 0 0 0000 CLI NI C 0 0 0 0 0 0 0 0 0000 CLI NI C 0 0 0 0 0 0 0 0 0 0 0000 CLI NI C 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0			72. 00
74. 00			1			
76. 00		1 1	1 -1			
76. 01 03952 ANTI COAGULATI ON 0 116, 392 76. 01 76. 02 03951 INFUSI ON SERVI CES 0 441 76. 02 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 0 76. 02 77. 90 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON 0 0 0 77. 00 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 77. 00 PO. 00 09000 CLI NI C 0 09000 CLI NI C 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			1			
76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 0 77. 00 07700 ALLOGENEI C STEM CELL ACQUISITION 0 0 0 0 77. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		03952 ANTI COAGULATI ON	0			76. 01
77. 00 78. 00 78. 00 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 00TPATI ENT SERVICE COST CENTERS 90. 00 90. 01 90. 00 90. 01 90. 01 90. 01 90. 01 90. 01 90. 01 90. 01 90. 01 90. 01 90. 01 90. 01 90. 01 90. 01 90. 01 90. 01 90. 01 90. 01 90. 01 90. 01 90. 02 91. 00 91. 01 91. 01 92. 00 92. 01 92. 00 92. 01 92. 01 92. 01 92. 01 93. 00 95. 00		i i	0	i i		
78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0			0			
OUTPATIENT SERVICE COST CENTERS 90. 00 09000 CLINIC 90. 00 90. 00 09000 CLINIC 90. 00 90. 01 09001 CLINIC 90. 01 90. 01 90. 01 90. 02 90. 01 90. 02 90. 02 90. 02 90. 02 90. 02 90. 01 90. 02			1 1	- 1		
90. 01	70.00		<u> </u>			70.00
90. 02 09002 CLINIC - HOME INF PHARMACOTHERAPY 0 1 90. 02 91. 00 09100 EMERGENCY 0 1, 392, 896 91. 00 91. 01 04950 WOUND CARE 0 392, 870 91. 01 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART 0 92. 00 09201 OBSERVATION BEDS (DISTINCT PART) 0 350, 036 92. 01 070 07						
91. 00 09100 EMERGENCY 0 1, 392, 896 91. 00 91. 01 04950 WOUND CARE 0 392, 870 91. 01 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0 350, 036 92. 01 07100			-	20, 825		
91. 01 04950 WOUND CARE 0 392, 870 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 92. 00 09201 OBSERVATION BEDS (DISTINCT PART) 0 350, 036 92. 01 07 0 09201 OBSERVATION BEDS (DISTINCT PART) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				1, 392, 896		1
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART 0 92. 01 09201 0BSERVATI ON BEDS (DISTINCT PART) 0 350, 036 92. 01 07500		1 1				1
OTHER REI MBURSABLE COST CENTERS 95. 00	92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0			92. 00
95. 00	92. 01		0	350, 036		92. 01
101. 00	0F 00			O		95.00
102.00 10200 OPLOID TREATMENT PROGRAM 0 0 102.00 SPECIAL PURPOSE COST CENTERS		1 1	1			1
		10200 OPI OI D TREATMENT PROGRAM	1			•
113. UU 113UU NTEREST EXPENSE	140 0-					110.00
	113.00	NITI SUULINIEKESI EXPENSE				1113.00

Heal th Fina	ncial Systems	FRANCISCAN HEALT	H LAFAYETTE		In Lieu	ı of Form CMS-2552-10
ALLOCATI ON	OF CAPITAL RELATED COSTS		Provi der Co	CN: 15-0109	Peri od: From 01/01/2023	Worksheet B Part II
					To 12/31/2023	Date/Time Prepared:
						3/28/2024 12:04 pm
	Cost Center Description	Intern &	Total			
		Residents Cost				
		& Post				
		Stepdown				
		Adjustments				
		25. 00	26. 00			
116. 00 11600	HOSPI CE	0	170, 935			116. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	0	22, 621, 482			118. 00
NONRE	IMBURSABLE COST CENTERS					
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	126, 323			190. 00
192. 00 19200	PHYSICIANS' PRIVATE OFFICES	0	117, 524			192. 00
194. 00 07950	MOB	0	70, 246	,		194. 00
194. 01 0795°	I LI FELI NE	0	0)		194. 01
194. 02 07952	PATIENT TRANSPORT	0	0)		194. 02
194. 03 07954	OTHER NRCC	O	7, 865			194. 03
194. 04 07953	JV-SAGAMORE ASC	o	33, 285			194. 04
200.00	Cross Foot Adjustments	0	1, 926, 463			200. 00
201.00	Negative Cost Centers	0	0)		201. 00
202.00	TOTAL (sum lines 118 through 201)	0	24, 903, 188	1		202. 00
·		•		•		•

					Т	o 12/31/2023	Date/Time Pre 3/28/2024 12:	
			CAPITAL REI	_ATED_COSTS			3/20/2024 12.	54 piii
		Cost Center Description	BLDG & FIXT	MVBLE EQUIP	 EMPLOYEE	COMMUNI CATI ONS	MGMT INFO	
		cost center bescription	(SQUARE FEET)		BENEFITS	COMMON CATTONS	SYSTEMS	
					DEPARTMENT	(PHONE LINE S)	(MANHOURS)	
					(GROSS SALARI ES)			
			1.00	2.00	4.00	5. 01	5. 02	
1 00		AL SERVICE COST CENTERS	742 224					1 00
1. 00 2. 00		CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP	743, 224	741, 202				1. 00 2. 00
4.00		EMPLOYEE BENEFITS DEPARTMENT	5, 251	5, 251				4. 00
5. 01		COMMUNI CATI ONS	18, 665	1			0 005 474	5. 01
5. 02 5. 03		MGMT INFO SYSTEMS PURCHASING	19, 875 9, 796	1			3, 835, 174 0	5. 02 5. 03
5. 04		ADMI TTI NG	0	0	1		0	5. 04
5.05	1	PATIENT ACCOUNTING	00.500	0	· -		0	5. 05
5. 06 7. 00		OTHER ADMINISTRATIVE AND GENERAL OPERATION OF PLANT	93, 522 138, 973	l ·			152, 488 170, 320	5. 06 7. 00
8.00		LAUNDRY & LINEN SERVICE	4, 692	l ·			7, 510	8. 00
9. 00	1	HOUSEKEEPI NG	11, 383	l ·			155, 046	9. 00
10. 00 11. 00		DI ETARY CAFETERI A	11, 776 14, 287	l ·			57, 507 69, 769	10. 00 11. 00
13. 00		NURSING ADMINISTRATION	3, 368	l ·			112, 783	13. 00
14. 00		CENTRAL SERVICES & SUPPLY	4, 329	l ·			27, 283	
15. 00 16. 00		PHARMACY MEDICAL RECORDS & LIBRARY	6, 720 4, 433	1			97, 305 3, 442	15. 00 16. 00
17. 00	1	SOCIAL SERVICE	0	0		0	0	17. 00
20. 00		NURSI NG PROGRAM	40, 750	1			57, 894	20. 00
23. 00 23. 01	1	PHARMACY RESIDENCY EMS EDUCATION	0	0		0	4, 489 3, 331	23. 00 23. 01
23.01		IENT ROUTINE SERVICE COST CENTERS	0	0	72, 401	0	3, 331	23.01
30. 00		ADULTS & PEDIATRICS	45, 407				349, 455	30. 00
31. 00 35. 00		INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE UNIT	12, 220 11, 548				202, 664 102, 205	31. 00 35. 00
41. 00		SUBPROVI DER - I RF	15, 114				67, 892	41. 00
43. 00		NURSERY	20, 337	20, 337	1, 836, 899	0	167, 374	43. 00
50. 00		LARY SERVICE COST CENTERS OPERATING ROOM	41, 684	41, 684	10, 987, 227	24	151, 494	50. 00
51.00	05100	RECOVERY ROOM	2, 763	2, 763	584, 378		23, 923	51. 00
52. 00 54. 00		DELIVERY ROOM & LABOR ROOM RADIOLOGY-DIAGNOSTIC	49, 872 19, 116	1			385, 923 148, 819	
55. 00		RADI OLOGY - THERAPEUTI C	3, 971	3, 971			17, 401	55. 00
56. 00	1	RADI OI SOTOPE	259				11, 163	
56. 01 57. 00		CARDIAC CATH LAB	11, 228 1, 280	l			33, 143 34, 600	
58. 00	05800	MRI	1, 133	l ·			10, 119	58. 00
60.00		LABORATORY	6, 656				0	60.00
65. 00 66. 00		RESPI RATORY THERAPY PHYSI CAL THERAPY	2, 662 897	2, 662 897			80, 586 119, 140	
		OCCUPATI ONAL THERAPY	0	0	1, 684, 829		43, 049	
68. 00	1	SPEECH PATHOLOGY	103				19, 115	
69. 00 70. 00		ELECTROCARDI OLOGY ELECTROENCEPHALOGRAPHY	9, 243 4, 458	1			44, 807 29, 081	69. 00 70. 00
71. 00		MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0.2,0.0	0	0	71. 00
72.00		IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73. 00 73. 01		DRUGS CHARGED TO PATIENTS DIABETES CENTER	7, 653	7, 653	1, 379, 514	6	0 35, 677	73. 00 73. 01
74. 00		RENAL DIALYSIS	1, 939				1, 540	
76. 00	1	ONCOLOGY	28, 941	28, 941			107, 811	
76. 01 76. 02		ANTI COAGULATI ON I NFUSI ON SERVI CES	2, 336	2, 336	299, 647 10, 559		6, 078 271	76. 01 76. 02
76. 98	1	HYPERBARI C OXYGEN THERAPY	Ö	ő	0	0	0	76. 98
77. 00	1	ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	77. 00
78. 00		CAR T-CELL IMMUNOTHERAPY TIENT SERVICE COST CENTERS	0	0		ı Oj	0	78. 00
90.00	09000	CLINIC	0	·			16, 589	90. 00
90. 01 90. 02		CLINIC - OUTPATIENT INFUSION SERVICE CLINIC - HOME INF PHARMACOTHERAPY	0	0	541, 112 42		15, 951 0	90. 01 90. 02
91. 00		EMERGENCY	24, 062	24, 062			249, 660	91. 00
91. 01		WOUND CARE	7, 949	7, 949	968, 039	0	21, 571	91. 01
92. 00 92. 01	1	OBSERVATION BEDS (NON-DISTINCT PART OBSERVATION BEDS (DISTINCT PART)	6, 251	6, 251	1, 225, 929	0	65, 500	92. 00 92. 01
	OTHER	REIMBURSABLE COST CENTERS	I					
		AMBULANCE SERVICES HOME HEALTH AGENCY	0 10, 440	· ·			0 136, 461	
		OPIOID TREATMENT PROGRAM	0	0				102.00

Health Finan	· · · · · · · · · · · · · · · · · · ·	FRANCISCAN HEAL	LTH LAFAYETTE		In Lie	u of Form CMS-	2552-10
COST ALLOCAT	ION - STATISTICAL BASIS		Provi der CO		Peri od:	Worksheet B-1	
					From 01/01/2023 To 12/31/2023	Date/Time Pre 3/28/2024 12:	
		CAPITAL REL	ATED COSTS				
		DI DO A FLYT	10/01 5 50/11 5	5451 0\/55			
	Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS	COMMUNI CATI ONS	MGMT INFO SYSTEMS	
		(SQUARE FEET)	(SQUARE FEET)	DEPARTMENT	(PHONE LINE S)	(MANHOURS)	
				(GROSS	(FIIONE LINE 3)	(WANTOURS)	
				SALARI ES)			
		1.00	2.00	4.00	5. 01	5. 02	
	AL PURPOSE COST CENTERS						
	INTEREST EXPENSE						113. 00
116. 00 11600		0	0			126, 768	
	SUBTOTALS (SUM OF LINES 1 through 117)	737, 342	737, 342	107, 303, 96	2 696	3, 744, 997	118. 00
	MBURSABLE COST CENTERS	2 (22	2 (22			2 222	
	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2, 692		· ·			190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	1, 168 2, 022		9, 184, 89	2		192. 00 194. 00
194. 00 07950		2,022	0				194. 00
	PATIENT TRANSPORT	0	0				194. 01
194. 03 07954		0	0				194. 03
	JV-SAGAMORE ASC	0	Ö	1, 233, 24	9 0		194. 04
200. 00	Cross Foot Adjustments			,,			200.00
201. 00	Negative Cost Centers						201.00
202. 00	Cost to be allocated (per Wkst. B,	17, 511, 885	7, 391, 303	4, 600, 59	6 1, 849, 414	4, 801, 274	202. 00
	Part I)						
203. 00	Unit cost multiplier (Wkst. B, Part I)	23. 562055	9. 972049		,	1. 251905	
204. 00	Cost to be allocated (per Wkst. B,			176, 08	7 627, 023	688, 596	204. 00
205. 00	Part II)			0. 00149	5 900. 895115	0. 179548	205 00
205.00	Unit cost multiplier (Wkst. B, Part			0.00149	900.893113	0. 179548	205.00
206. 00	NAHE adjustment amount to be allocated						206. 00
	(per Wkst. B-2)						
207. 00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)						

| Period: | Worksheet B-1 | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0109

				o 12/31/2023	Date/Time Prep 3/28/2024 12:0	
Cost Center Description	PURCHASI NG	ADMI TTI NG	PATI ENT	Reconciliation	OTHER	94 PIII
	(COSTED REQ ULSI)	(GROSS CHAR GES)	ACCOUNTI NG (GROSS CHAR		ADMINISTRATIVE AND GENERAL	
	0131)	GL3)	GES)		(ACCUM. COST)	
	5. 03	5. 04	5. 05	5A. 06	5. 06	
GENERAL SERVICE COST CENTERS 1.00 O0100 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. 01 01160 COMMUNI CATI ONS						5. 01
5.02 01140 MGMT INFO SYSTEMS 5.03 00550 PURCHASI NG	33, 529, 917					5. 02 5. 03
5. 04 00570 ADMI TTI NG	17	1, 752, 052, 698				5. 04
5. 05 00580 PATIENT ACCOUNTING	0	0	1, 752, 052, 698		000 455 504	5. 05
5.06 OO560 OTHER ADMINISTRATIVE AND GENERAL 7.00 OO700 OPERATION OF PLANT	10, 868 367	0		, ,	222, 455, 596 14, 350, 366	5. 06 7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE	283	0	Ċ		1, 010, 332	8. 00
9. 00 00900 HOUSEKEEPI NG	16, 912	0	C	0	3, 639, 764	9. 00
10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A	29, 623	0		0	2, 001, 880	10. 00 11. 00
13. 00 01130 NURSI NG ADMI NI STRATI ON	8, 133	0		0	2, 014, 015 4, 082, 505	13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY	206, 623	0	C	0	312, 689	14. 00
15. 00 01500 PHARMACY	410, 058	0	C	0	2, 916, 721	15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY 17. 00 01700 SOCI AL SERVI CE	0	0		0	2, 117, 999 0	16. 00 17. 00
20. 00 02000 NURSI NG PROGRAM	13, 195	0		Ö	1, 947, 700	20. 00
23. 00 02301 PHARMACY RESI DENCY	0	0	C		180, 597	23. 00
23.01 02300 EMS EDUCATION INPATIENT ROUTINE SERVICE COST CENTERS	4, 400	0	C	0	91, 438	23. 01
30. 00 03000 ADULTS & PEDIATRICS	1, 793, 843	99, 540, 639	99, 540, 639	0	24, 344, 430	30. 00
31.00 03100 INTENSIVE CARE UNIT	455, 393	38, 319, 832			5, 560, 059	31. 00
35. 00 02060 NEONATAL INTENSIVE CARE UNIT	115, 897	10, 976, 005				35.00
41. 00 04100 SUBPROVI DER - RF 43. 00 04300 NURSERY	38, 608	6, 976, 053 12, 004, 288			2, 120, 827 3, 173, 511	41. 00 43. 00
ANCILLARY SERVICE COST CENTERS	0	12, 004, 200	12, 004, 200	0	3, 173, 311	43.00
50. 00 05000 OPERATING ROOM	19, 905, 563	273, 757, 271			-,,	50.00
51. 00 05100 RECOVERY ROOM 52. 00 05200 DELIVERY ROOM & LABOR ROOM	23, 668	33, 016, 513 14, 543, 395			876, 113 5, 432, 761	51. 00 52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 244, 832	110, 050, 709			8, 466, 733	54. 00
55. 00 05500 RADI OLOGY - THERAPEUTI C	11, 946	14, 439, 163			773, 892	55.00
56. 00 05600 RADI OI SOTOPE	194	15, 158, 487			661, 041	56.00
56. 01 03950 CARDI AC CATH LAB 57. 00 05700 CT SCAN	4, 048, 845 196, 971	52, 549, 167 60, 719, 871	52, 549, 167 60, 719, 871		3, 157, 476 1, 319, 423	56. 01 57. 00
58. 00 05800 MRI	50, 898	10, 409, 651	10, 409, 651		610, 767	58. 00
60. 00 06000 LABORATORY	696, 579	124, 235, 473			11, 692, 114	60.00
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	587, 525 78, 354	16, 717, 884 27, 075, 296			2, 599, 219 4, 019, 630	65. 00 66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	14, 874	17, 166, 723			1, 721, 326	67. 00
68. 00 06800 SPEECH PATHOLOGY	767	7, 517, 268			806, 162	68. 00
69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY	27, 436 63, 434	43, 073, 907 5, 992, 304			_,,	69. 00 70. 00
71. 00 07100 ELECTROENCEPHALOGRAPHY 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	03, 434	160, 556, 594				70.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	126, 414, 414			14, 871, 966	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	226, 955, 190			25, 401, 547	73.00
73. 01 07301 DI ABETES CENTER 74. 00 07400 RENAL DI ALYSI S	7, 473 21, 052	486 5, 970, 694			1, 752, 897 1, 441, 139	73. 01 74. 00
76. 00 03480 ONCOLOGY	1, 268, 519	27, 885, 647			4, 655, 476	76. 00
76. 01 03952 ANTI COAGULATI ON	47, 897	918, 206	·		394, 066	76. 01
76. 02 03951 I NFUSI ON SERVI CES 76. 98 07698 HYPERBARI C OXYGEN THERAPY	6, 182	463, 609	463, 609	0	9, 839 0	76. 02 76. 98
77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION	0	0		0	0	76. 98 77. 00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0	C		0	78. 00
OUTPATIENT SERVICE COST CENTERS	22.714	2 021 402	2 021 402		702 247	00.00
90.00 09000 CLINIC	32, 714 45, 836	2, 031, 482 11, 513, 504			782, 347 601, 473	90. 00 90. 01
90. 02 09002 CLINIC - HOME INF PHARMACOTHERAPY	0	142			98	90. 02
91. 00 09100 EMERGENCY	628, 115	146, 974, 950			9, 033, 712	91.00
91. 01 04950 WOUND CARE 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	166, 271	6, 137, 860	6, 137, 860	0	1, 067, 558	91. 01 92. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	69, 824	5, 329, 625	5, 329, 625	О	2, 360, 600	92. 00 92. 01
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVI CES 101. 00 10100 HOME HEALTH AGENCY	74, 636	0 9, 135, 611	9, 135, 611	_	-	95. 00 101. 00
102.00 10200 OPI OI D TREATMENT PROGRAM	74, 636	9, 135, 611				101.00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 I NTEREST EXPENSE 116. 00 11600 HOSPI CE	104, 931	27, 524, 785	27, 524, 785	_	6, 496, 004	113.00
110. 00 11000 1103F1 0E	104, 931	21, 024, 185	27, 324, 785	0	0, 470, 004	110.00

Health Financial Systems	FRANCISCAN HEALTH LAFAYETTE	In Lie	u of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS	Provi der CCN: 15-0109	Peri od:	Worksheet B-1

0031 A	LEGORITON STRITTSTICAL BASIS		Troviaci co		rom 01/01/2023	WOLKSHEET B 1	
					o 12/31/2023		pared.
				'	0 12/01/2020	3/28/2024 12:	
	Cost Center Description	PURCHASI NG	ADMI TTI NG	PATI ENT	Reconciliation		
	'	(COSTED REQ	(GROSS CHAR	ACCOUNTI NG		ADMI NI STRATI VE	
		UISI)	GES)	(GROSS CHAR		AND GENERAL	
		ŕ	ŕ	GES)		(ACCUM. COST)	
		5. 03	5. 04	5. 05	5A. 06	5. 06	
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	33, 529, 556	1, 752, 052, 698	1, 752, 052, 698	-95, 700, 444	218, 487, 025	118. 00
	NONREI MBURSABLE COST CENTERS						1
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	(0	156, 427	190. 00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	142	0	(0	1, 955, 651	192. 00
194.00	07950 MOB	O	0	(0	47, 642	194. 00
194.01	07951 LI FELI NE	o	0	(0	0	194. 01
194.02	07952 PATIENT TRANSPORT	o	0	(0	0	194. 02
194.03	07954 OTHER NRCC	0	0		0	23, 774	194. 03
194.04	07953 JV-SAGAMORE ASC	219	0		0	1, 785, 077	194. 04
200.00	Cross Foot Adjustments						200.00
201.00							201.00
202.00		841, 340	615	1, 252, 631		95, 700, 444	202. 00
	Part I)			, , , , , ,			
203.00	Unit cost multiplier (Wkst. B, Part I)	0. 025092	0. 000000	0. 000715	5	0. 430200	203. 00
204.00	Cost to be allocated (per Wkst. B,	341, 118	0	12, 613	3	3, 237, 603	204.00
	Part II)			,			
205.00	Unit cost multiplier (Wkst. B, Part	0. 010174	0. 000000	0.000007	7	0. 014554	205. 00
	11)						
206.00	NAHE adjustment amount to be allocated						206. 00
	(per Wkst. B-2)						
207.00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)						

	Financial Systems	FRANCI SCAN HEA		ON 45 0400 5		U OT FORM CMS-	
COST A	LLOCATION - STATISTICAL BASIS		Provi der C		Peri od:	Worksheet B-1	
					rom 01/01/2023 o 12/31/2023	Date/Time Pre	nared:
				'	0 12/31/2023	3/28/2024 12:	
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	T PIII
	oost denter beserretten	PLANT	LINEN SERVICE		(MEALS SERVED)	(MANHOURS)	
		(SQUARE FEET)	(POUNDS OF	(SQS/IKE TEET)	(MERCO SERVED)	(11111111111111111111111111111111111111	
		(SQOTINE TEET)	LAUNDRY)				
		7. 00	8.00	9. 00	10.00	11. 00	
	GENERAL SERVICE COST CENTERS	7.00	0.00	7.00	10.00	11.00	
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. 01
5. 01	01160 COMMUNI CATI ONS		•				5. 02
5. 02	01140 MGMT INFO SYSTEMS						5. 02
5. 03	00550 PURCHASI NG						
5. 04	00570 ADMITTING						5. 04
5. 05	00580 PATIENT ACCOUNTING						5. 05
5.06	00560 OTHER ADMINISTRATIVE AND GENERAL	457.440					5. 06
7.00	00700 OPERATION OF PLANT	457, 142	l .				7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	4, 692					8.00
9.00	00900 HOUSEKEEPI NG	11, 383					9. 00
10.00	01000 DI ETARY	11, 776					10.00
11. 00	01100 CAFETERI A	14, 287	l .	14, 287		3, 222, 534	1
13.00	01300 NURSI NG ADMI NI STRATI ON	3, 368		3, 368		112, 783	1
14. 00	01400 CENTRAL SERVICES & SUPPLY	4, 329				27, 283	1
	01500 PHARMACY	6, 720		6, 720		97, 305	1
16. 00	01600 MEDICAL RECORDS & LIBRARY	4, 433		4, 433		3, 442	1
17.00	01700 SOCIAL SERVICE	0		(0	0	
20.00	02000 NURSI NG PROGRAM	40, 750	0	40, 750	0	57, 894	20.00
23.00	02301 PHARMACY RESIDENCY	0	0	(0	4, 489	23. 00
23. 01	02300 EMS EDUCATION	0	0	C	0	3, 331	23. 01
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	45, 407	417, 849	45, 407	131, 204	349, 455	30.00
31.00	03100 INTENSIVE CARE UNIT	12, 220	63, 654	12, 220	18, 632	202, 664	31.00
35.00	02060 NEONATAL INTENSIVE CARE UNIT	11, 548	26, 532	11, 548	11, 781	102, 205	35.00
41.00	04100 SUBPROVI DER - I RF	15, 114	22, 470	15, 114	11, 990	67, 892	41.00
43.00	04300 NURSERY	20, 337	43, 604			167, 374	43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	41, 684	207, 591	41, 684	0	151, 494	50.00
51.00	05100 RECOVERY ROOM	2, 763	38, 173	2, 763	ol ol	23, 923	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	49, 872	46, 621	49, 872	e o	385, 923	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	19, 116		19, 116	1	148, 819	1
55.00	05500 RADI OLOGY - THERAPEUTI C	3, 971		3, 971		17, 401	1
56.00	05600 RADI OI SOTOPE	259		259		11, 163	1
56. 01	03950 CARDI AC CATH LAB	11, 228				33, 143	
57. 00	05700 CT SCAN	1, 280	· ·	1, 280		34, 600	
58.00	05800 MRI	1, 133	l .	1, 133		10, 119	
60.00	06000 LABORATORY	6, 656	l .			0	1
65. 00	06500 RESPI RATORY THERAPY	2, 662				80, 586	
66. 00	06600 PHYSI CAL THERAPY	897				119, 140	
	06700 OCCUPATI ONAL THERAPY	0	· ·				67. 00
	06800 SPEECH PATHOLOGY	103		103		19, 115	68. 00
	06900 ELECTROCARDI OLOGY	9, 243				44, 807	
	07000 ELECTROENCEPHALOGRAPHY	4, 458		4, 458		29, 081	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0		.,		0	
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	_			0	
73. 00	07300 DRUGS CHARGED TO PATIENTS	0				0	
	07301 DI ABETES CENTER	7, 653	_	7, 653	-	35, 677	1
74. 00	07400 RENAL DI ALYSI S	1, 939		1, 939		1, 540	1
	03480 ONCOLOGY	28, 941		28, 941		107, 811	1
76. 00	03952 ANTI COAGULATI ON	2, 336				6, 078	1
	03951 I NFUSI ON SERVI CES	2, 330		2, 336		271	
	07698 HYPERBARI C OXYGEN THERAPY					0	1
	1 I					0	1
	07700 ALLOGENEIC STEM CELL ACQUISITION						
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0	ıl U		0	0	78. 00
00 00	OUTPATIENT SERVICE COST CENTERS 09000 CLINIC				ol ol	1/ 500	1 00 00
90. 00 90. 01	09000 CLINIC - OUTPATIENT INFUSION SERVICE	0				16, 589	1
	09002 CLINIC - HOME INF PHARMACOTHERAPY					15, 951 0	1
91.00	09100 EMERGENCY	24.042	100 254	24.04			
	l I	24, 062				249, 660	1
	04950 WOUND CARE	7, 949	1	7, 949	0	21, 571	1
	09200 OBSERVATION BEDS (NON-DISTINCT PART	(051		/ 251		/F F00	92.00
92. 01	09201 OBSERVATION BEDS (DISTINCT PART)	6, 251	0	6, 251	0	65, 500	92. 01
0F 00	OTHER REIMBURSABLE COST CENTERS	1	_			^	05 00
	09500 AMBULANCE SERVI CES 10100 HOME HEALTH AGENCY	10 440			1	126 461	
		10, 440				136, 461	
102.00	10200 OPLOLD TREATMENT PROGRAM	0	0	(0	0	102. 00
112 00	SPECIAL PURPOSE COST CENTERS						112 00
	11300 INTEREST_EXPENSE 11600 H0SPICE	0	o		J	126, 768	113.00
110.00	1 1000 NUSPI GE	1 0	1 0	(0	126, 768	1110.00

Health Financial Systems	FRANCI SCAN HEA	LTH LAFAYETTE		In Lie	eu of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der Co		Peri od: From 01/01/2023	Worksheet B-1	
					Date/Time Pre 3/28/2024 12:	
Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
	PLANT (SOUNDE FEET)		(SQUARE FEET)	(MEALS SERVED)	(MANHOURS)	

				Ť	0 12/31/2023	Date/Time Pre 3/28/2024 12:	
	Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY (MEALS SERVED)	CAFETERI A	D4 piii
		(SQUARE FEET)	(POUNDS OF	(SQUARE FEET)	(WEALS SERVED)	(MANHOURS)	
		(SQUARE FEET)	LAUNDRY)				
		7.00	8.00	9, 00	10.00	11. 00	
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	451, 260					118 00
	I MBURSABLE COST CENTERS	1017200	17 1007 00 1	1007.00	1007 000	0, 102, 007	1.10.00
190. 00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2, 692	0	2, 692	0	2, 080	190. 00
	PHYSICIANS' PRIVATE OFFICES	1, 168		1, 168	0		192. 00
194. 00 07950	мов	2, 022	0	0	0	0	194. 00
194. 01 07951	LIFELINE	0	0	0	0	0	194. 01
194. 02 07952	PATIENT TRANSPORT	0	0	0	0	0	194. 02
194. 03 07954	OTHER NRCC	0	0	0	0	18, 990	194. 03
194. 04 07953	JV-SAGAMORE ASC	0	0	0	0	13, 787	194. 04
200.00	Cross Foot Adjustments						200. 00
201. 00	Negative Cost Centers						201. 00
202.00	Cost to be allocated (per Wkst. B,	20, 523, 893	1, 655, 630	5, 754, 931	3, 592, 643	3, 709, 147	202. 00
	Part I)						
203. 00	Unit cost multiplier (Wkst. B, Part I)	44. 896100					
204. 00	Cost to be allocated (per Wkst. B,	4, 953, 691	225, 341	602, 363	613, 292	697, 197	204. 00
	Part II)						
205. 00	Unit cost multiplier (Wkst. B, Part	10. 836219	0. 190377	1. 371985	3. 308154	0. 216351	205. 00
201 00							00/ 00
206. 00	NAHE adjustment amount to be allocated						206. 00
207. 00	(per Wkst. B-2) NAHE unit cost multiplier (Wkst. D,						207. 00
207.00	Parts III and IV)						207.00
l l	parts in and iv)	1		I	1		I

	ALLOCATION - STATISTICAL BASIS	TRANCISCAN HEAL	Provi der CC	CN: 15-0109 P	eri od:	Worksheet B-1	
				F	rom 01/01/2023 o 12/31/2023	3/28/2024 12:	04 pm
	Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVICES &	PHARMACY (COSTED	MEDI CAL RECORDS &	SOCIAL SERVICE	
		ADMINI STRATION	SUPPLY	REQUIS.)	LI BRARY	(TIME SPENT)	
		(DI RECT NRS	(COSTED REQ	ŕ	(GROSS CHAR		
		1 NG) 13. 00	UI SI) 14. 00	15. 00	GES) 16. 00	17. 00	
	GENERAL SERVICE COST CENTERS	13.00	14.00	13.00	10.00	17.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUI P					ı	2.00
4. 00 5. 01	O0400 EMPLOYEE BENEFITS DEPARTMENT O1160 COMMUNI CATIONS					ı	4. 00 5. 01
5. 02	01140 MGMT INFO SYSTEMS					ı	5. 02
5.03	00550 PURCHASI NG					i	5. 03
5. 04 5. 05	OO570 ADMITTING OO580 PATLENT ACCOUNTING					ı	5. 04 5. 05
5.06	00560 OTHER ADMINISTRATIVE AND GENERAL					ı	5. 06
7.00	00700 OPERATION OF PLANT					ı	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE					ı	8. 00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY					ı	9.00
11. 00	01100 CAFETERI A					ı	11. 00
13.00	01300 NURSING ADMINISTRATION	2, 402, 691				1	13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	33, 257, 091	400		ı	14.00
15. 00 16. 00	O1500 PHARMACY O1600 MEDICAL RECORDS & LIBRARY	0	410, 058 0	100 0		ı	15. 00 16. 00
17. 00	01700 SOCIAL SERVICE	o	Ö	Ö		0	1
20. 00	02000 NURSI NG PROGRAM	0	13, 195	0	-	0	
23. 00 23. 01	02301 PHARMACY RESI DENCY 02300 EMS EDUCATI ON	0	0 4, 400	0 0	· ·	0	
23.01	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	ı y	4, 400		<u> </u>	0	23.01
30.00	03000 ADULTS & PEDIATRICS	349, 455	1, 793, 843	0		0	
31.00	03100 NTENSI VE CARE UNI T	202, 664	455, 393	0	,,	0	
35. 00 41. 00	02060 NEONATAL INTENSIVE CARE UNIT 04100 SUBPROVIDER - RF	102, 205 67, 892	115, 897 38, 608	0		0	
43. 00	04300 NURSERY	167, 374	0	0		0	
F0 00	ANCILLARY SERVICE COST CENTERS	154 404	40.005.570		070 757 074		
50. 00 51. 00	O5000 OPERATI NG ROOM O5100 RECOVERY ROOM	151, 494 23, 923	19, 905, 563 23, 668	0		0	1
52. 00	05200 DELIVERY ROOM & LABOR ROOM	385, 923	23, 000	Ö	l ' '	0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	2, 244, 832	0	., ,	0	1
55. 00 56. 00	05500 RADI OLOGY - THERAPEUTI C 05600 RADI OI SOTOPE	0 11, 163	11, 946 194	0	,,	0	
56. 01	03950 CARDI AC CATH LAB	33, 143	4, 048, 845		52, 549, 167	0	
57. 00	05700 CT SCAN	0	196, 971	0	60, 719, 871	0	57. 00
58. 00	05800 MRI	0	50, 898	0	10, 409, 651	0	1
60. 00 65. 00	06500 RESPIRATORY THERAPY	0 80, 586	696, 579 587, 525		124, 235, 473 16, 717, 884	0	1
66. 00	06600 PHYSI CAL THERAPY	119, 140	78, 354				
	06700 OCCUPATI ONAL THERAPY	43, 049	14, 874	0	,	0	1
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	19, 115 44, 807	767 27, 436	0		0	
70. 00	07000 ELECTROENCEPHALOGRAPHY	29, 081	63, 434	Ö	5, 992, 304	0	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	160, 556, 594	0	
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0	0 100	126, 414, 414 226, 955, 190	0	
73. 00	07301 DI ABETES CENTER	35, 677	7, 473		486	0	
74. 00	07400 RENAL DIALYSIS	1, 540	21, 052	0	5, 970, 694	0	
76. 00 76. 01	03480 ONCOLOGY	0	1, 268, 519	0	27, 885, 647 918, 206	0	1
76. 01 76. 02	03952 ANTI COAGULATI ON 03951 NFUSI ON SERVI CES		47, 897 6, 182	0	463, 609	0	
76. 98	07698 HYPERBARI C OXYGEN THERAPY	Ö	0	Ö	0	0	
	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	0	0	0	
78. 00	O7800 CAR T-CELL IMMUNOTHERAPY OUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	78. 00
90. 00	09000 CLINIC	249, 660	32, 714	0	2, 031, 482	0	90.00
90. 01	09001 CLINIC - OUTPATIENT INFUSION SERVICE	21, 571	45, 836	0	11, 513, 504	0	
90. 02	09002 CLINIC - HOME INF PHARMACOTHERAPY	0	(20, 115	0		0	
91. 00 91. 01	O9100 EMERGENCY O4950 WOUND CARE		628, 115 166, 271		146, 974, 950 6, 137, 860	0	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART		100, 27		37 1377 333		92. 00
92. 01	09201 OBSERVATION BEDS (DISTINCT PART)	0	69, 824	0	5, 329, 625	0	92. 01
Q5 00	OTHER REIMBURSABLE COST CENTERS O9500 AMBULANCE SERVI CES		ما	0		0	95. 00
	109000 AMBULANCE SERVICES	136, 461	74, 636	0	9, 135, 611		101.00
	10200 OPIOID TREATMENT PROGRAM	0	0		, , , , , ,		102. 00
112 00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE		П				113. 00

Heal th	Financial Systems	FRANCISCAN HEAL	TH LAFAYETTE		In Lie	u of Form CMS-2552-10
COST AL	LOCATION - STATISTICAL BASIS		Provider CO		Peri od:	Worksheet B-1
					From 01/01/2023	D-+- /T: D
					Γο 12/31/2023	Date/Time Prepared: 3/28/2024 12:04 pm
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE
	oost denter beson peron	ADMI NI STRATI ON	SERVICES &	(COSTED	RECORDS &	SOUTHE SERVICE
		7.5 11. 6.1.6.1.	SUPPLY	REQUIS.)	LI BRARY	(TIME SPENT)
		(DI RECT NRS	(COSTED REQ	,	(GROSS CHAR	(
		I NG)	UISI)		GES)	
		13.00	14.00	15. 00	16.00	17. 00
116.00	11600 HOSPI CE	126, 768	104, 931	(27, 524, 785	0 116. 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	2, 402, 691	33, 256, 730	100	1, 752, 052, 698	0 118. 00
1	NONREI MBURSABLE COST CENTERS				*	
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	(0	0 190. 00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	o	142		0	0 192. 00
194.00	07950 MOB	o	0		0	0 194. 00
194. 01	07951 LI FELI NE	o	0		0	0 194. 01
194. 02	07952 PATIENT TRANSPORT	o	0		0	0 194. 02
194. 03	07954 OTHER NRCC	o	0		0	0 194. 03
194. 04	D7953 JV-SAGAMORE ASC	o	219		0	0 194. 04
200.00	Cross Foot Adjustments					200. 00
201.00	Negative Cost Centers					201. 00
202.00	Cost to be allocated (per Wkst. B,	6, 163, 970	771, 671	4, 682, 794	3, 290, 255	0 202. 00
	Part I)					
203.00	Unit cost multiplier (Wkst. B, Part I)	2. 565444	0. 023203	46, 827. 940000	0. 001878	0. 000000 203. 00
204.00	Cost to be allocated (per Wkst. B,	272, 119	225, 480	420, 648	250, 398	0 204. 00
	Part II)					
205.00	Unit cost multiplier (Wkst. B, Part	0. 113256	0. 006780	4, 206. 480000	0. 000143	0. 000000 205. 00
	[11]					
001 00	INDUCE IN A COLUMN TO A COLUMN					l loo, oo

206. 00

206.00

207.00

NAHE adjustment amount to be allocated (per Wkst. B-2)

NAHE unit cost multiplier (Wkst. D, Parts III and IV)

Provider CCN: 15-0109

				'	o 12/31/2023 Date/lime Pro 3/28/2024 12:	
	Cost Center Description	NURSI NG PROGRAM (ASSI GNED	PHARMACY RESI DENCY (ASSI GNED	EMS EDUCATION (ASSIGNED TIME)		, jo
		TIME)	TIME)	11 11 11 11		
	CENEDAL CEDIU CE COCT CENTEDO	20. 00	23. 00	23. 01		
1. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT			I	I	1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP					2. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT					4. 00
5. 01	01160 COMMUNI CATI ONS					5. 01
5.02	01140 MGMT INFO SYSTEMS					5. 02
5. 03	00550 PURCHASI NG					5. 03
5. 04 5. 05	OO570 ADMITTI NG OO580 PATIENT ACCOUNTI NG					5. 04 5. 05
5. 06	00560 OTHER ADMINISTRATIVE AND GENERAL					5. 06
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					10.00
11. 00 13. 00	01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON					11. 00 13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY					14. 00
15. 00	01500 PHARMACY					15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY					16. 00
17. 00	01700 SOCIAL SERVICE					17. 00
20.00	02000 NURSI NG PROGRAM	8, 020	400			20.00
23. 00 23. 01	02301 PHARMACY RESI DENCY 02300 EMS EDUCATI ON		100	100		23. 00
23.01	I NPATI ENT ROUTI NE SERVI CE COST CENTERS			100	<u>/ </u>	23.01
30. 00	03000 ADULTS & PEDIATRICS	2, 622	0	C		30.00
31.00	03100 INTENSIVE CARE UNIT	726	0	C		31.00
35. 00	02060 NEONATAL INTENSIVE CARE UNIT	916	0	1		35. 00
41.00	04100 SUBPROVI DER - I RF	0	0			41.00
43. 00	04300 NURSERY ANCILLARY SERVICE COST CENTERS	0	0	C	<u> </u>	43.00
50. 00	05000 OPERATING ROOM	16	0	C		50.00
51. 00	05100 RECOVERY ROOM	0	0			51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	770	0	C		52. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	68	0	C		54. 00
55. 00	O5500 RADI OLOGY - THERAPEUTI C	0	0			55. 00
56. 00 56. 01	05600 RADI OI SOTOPE 03950 CARDI AC CATH LAB	174 342	0			56. 00 56. 01
57. 00	05700 CT SCAN	0	0			57. 00
58. 00	05800 MRI	0	0	c		58. 00
60.00	06000 LABORATORY	0	0	C		60.00
65. 00	06500 RESPI RATORY THERAPY	0	0	C		65. 00
66.00	06600 PHYSI CAL THERAPY	144	0	C		66.00
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	0			67. 00 68. 00
69. 00	06900 ELECTROCARDI OLOGY		0			69.00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0	C		70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	C		71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	C		72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	100			73. 00
73. 01 74. 00	07301 DI ABETES CENTER 07400 RENAL DI ALYSI S	0	0			73. 01 74. 00
76. 00	03480 ONCOLOGY	0	0			76.00
76. 01	03952 ANTI COAGULATI ON	O	0	d		76. 01
76. 02	03951 I NFUSI ON SERVI CES	0	0	C		76. 02
76. 98	· ·	0	0	C		76. 98
77. 00		0	0			77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY OUTPATIENT SERVICE COST CENTERS	<u> </u>	0		<u> </u>	78. 00
90. 00	09000 CLINIC	36	0			90.00
90. 01	09001 CLINIC - OUTPATIENT INFUSION SERVICE		Ö	l c)	90. 01
90. 02	09002 CLINIC - HOME INF PHARMACOTHERAPY	0	0	C		90. 02
91.00	l l	2, 032	0	100		91. 00
91. 01	04950 WOUND CARE	174	0	C)	91. 01
92. 00 92. 01	09200 OBSERVATION BEDS (NON-DISTINCT PART 09201 OBSERVATION BEDS (DISTINCT PART)	0	0			92. 00 92. 01
72.01	OTHER REIMBURSABLE COST CENTERS	ı O	0			1 /2.01
95. 00	09500 AMBULANCE SERVICES	0	0	C		95. 00
	10100 HOME HEALTH AGENCY	0	0	C		101. 00
102.00	10200 OPI OI D TREATMENT PROGRAM	0	0	C	<u> </u>	102. 00
112 00	SPECIAL PURPOSE COST CENTERS 11300 NTEREST EXPENSE					113. 00
	11600 HOSPI CE	0	0	C		116. 00
	i la	. 9			I .	

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS FRANCISCAN HEALTH LAFAYETTE In Lieu of Form CMS-2552-10 Provider CCN: 15-0109

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

					3/28/2024 12:	:04 pm_
	Cost Center Description	NURSI NG	PHARMACY	EMS EDUCATION		
		PROGRAM	RESI DENCY	(ASSI GNED		
		(ASSI GNED	(ASSI GNED	TIME)		
		TIME)	TIME)			
		20. 00	23. 00	23. 01		
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	8, 020	100	100		118. 00
	MBURSABLE COST CENTERS					
	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190. 00
192. 00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0		192. 00
194. 00 07950	MOB	0	0	0		194. 00
194. 01 07951	LIFELINE	0	0	0		194. 01
194. 02 07952	PATI ENT TRANSPORT	0	0	0		194. 02
194. 03 07954	OTHER NRCC	0	0	0		194. 03
194. 04 07953	JV-SAGAMORE ASC	0	0	0		194. 04
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	Cost to be allocated (per Wkst. B,	5, 216, 203	263, 457	134, 711		202. 00
	Part I)					
203. 00	Unit cost multiplier (Wkst. B, Part I)	650. 399377	2, 634. 570000	1, 347. 110000		203. 00
204.00	Cost to be allocated (per Wkst. B,	1, 918, 963	4, 637	2, 863		204.00
	Part II)					
205.00	Unit cost multiplier (Wkst. B, Part	239. 272195	46. 370000	28. 630000		205. 00
	11)					
206. 00	NAHE adjustment amount to be allocated	0	0	0		206. 00
	(per Wkst. B-2)					
207. 00	NAHE unit cost multiplier (Wkst. D,	0. 000000	0. 000000	0.000000		207. 00
	Parts III and IV)					

Health Financial Systems	FRANCISCAN HEALTH LAFAYETTE	In Lieu of Form CMS-2552-1			
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0109	Peri od: From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Prepared:		

				Т	o 12/31/2023	Date/Time Pre 3/28/2024 12:	
			Title	e XVIII	Hospi tal	PPS	от р
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	oost conten beschiptren	(from Wkst. B,	Adj.	Total oosts	Di sal I owance	10141 00313	
		Part I, col.	, raj .		Di Sai i Gwarioc		
		26)					
		1.00	2.00	3.00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	0.00	1. 00	0.00	
30. 00	03000 ADULTS & PEDIATRICS	43, 810, 898		43, 810, 898	O	43, 810, 898	30.00
31. 00	03100 INTENSIVE CARE UNIT	10, 418, 821		10, 418, 821		10, 418, 821	
35. 00	02060 NEONATAL INTENSIVE CARE UNIT	4, 555, 813		4, 555, 813		4, 555, 813	
41. 00	04100 SUBPROVI DER – I RF	4, 439, 978		4, 439, 978		4, 439, 978	
	04300 NURSERY	1					
43. 00		6, 652, 258		6, 652, 258	i U	6, 652, 258	43. 00
FO 00	ANCILLARY SERVICE COST CENTERS	1/ /40 275	I	1/ /40 075	ما	1/ /40 275	FO 00
50.00	05000 OPERATI NG ROOM	16, 648, 375		16, 648, 375	1		
51.00	05100 RECOVERY ROOM	1, 618, 138		1, 618, 138		1, 618, 138	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	12, 690, 303		12, 690, 303		12, 690, 303	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	13, 794, 091		13, 794, 091		13, 794, 091	54. 00
55. 00	05500 RADI OLOGY - THERAPEUTI C	1, 384, 576		1, 384, 576		1, 384, 576	
56. 00	05600 RADI 01 S0T0PE	1, 143, 573		1, 143, 573		1, 143, 573	
56. 01	03950 CARDI AC CATH LAB	5, 712, 066		5, 712, 066		5, 712, 066	56. 01
57. 00	05700 CT SCAN	2, 119, 711		2, 119, 711	0	2, 119, 711	57. 00
58.00	05800 MRI	971, 614		971, 614	. 0	971, 614	58. 00
60.00	06000 LABORATORY	17, 368, 168		17, 368, 168	0	17, 368, 168	60.00
65.00	06500 RESPI RATORY THERAPY	4, 228, 692	0	4, 228, 692	. 0	4, 228, 692	65. 00
66.00	06600 PHYSI CAL THERAPY	6, 413, 009	0	6, 413, 009	0	6, 413, 009	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	2, 654, 414	0	2, 654, 414	. 0	2, 654, 414	67. 00
68. 00	06800 SPEECH PATHOLOGY	1, 244, 121	l o	1, 244, 121	0	1, 244, 121	68. 00
69. 00	06900 ELECTROCARDI OLOGY	4, 839, 373		4, 839, 373		4, 839, 373	1
	07000 ELECTROENCEPHALOGRAPHY	1, 665, 592		1, 665, 592		1, 665, 592	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	26, 785, 804		26, 785, 804	1	26, 785, 804	
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	21, 507, 292		21, 507, 292		21, 507, 292	
73. 00	07300 DRUGS CHARGED TO PATIENTS	41, 701, 811		41, 701, 811		41, 701, 811	1
73. 01	07301 DI ABETES CENTER	3, 083, 662		3, 083, 662		3, 083, 662	
74. 00	07400 RENAL DIALYSIS	2, 191, 012		2, 191, 012		2, 191, 012	
76. 00	03480 ONCOLOGY	8, 542, 847		8, 542, 847		8, 542, 847	
	03952 ANTI COAGULATI ON	708, 921		708, 921		708, 921	
76. 01	03951 I NFUSI ON SERVI CES	15, 398		15, 398		15, 398	
	07698 HYPERBARIC OXYGEN THERAPY	15, 390		15, 396		15, 396	1
	l I	_		1			1
	07700 ALLOGENEIC STEM CELL ACQUISITION	0		0	0	0	
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	1 0		C	0	0	78. 00
00.00	OUTPATIENT SERVICE COST CENTERS	1 007 404	Γ	1 00/ 404		1 007 404	00.00
90.00	09000 CLINIC	1, 806, 484		1, 806, 484	1	1, 806, 484	1
	09001 CLINIC - OUTPATIENT INFUSION SERVICE	956, 612		956, 612		956, 612	
90. 02	09002 CLINIC - HOME INF PHARMACOTHERAPY	140		140	1	140	
	09100 EMERGENCY	16, 502, 942		16, 502, 942		16, 502, 942	
91. 01	04950 WOUND CARE	2, 141, 276		2, 141, 276		2, 141, 276	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	5, 667, 509		5, 667, 509		5, 667, 509	1
92. 01	09201 OBSERVATION BEDS (DISTINCT PART)	3, 825, 733		3, 825, 733	0	3, 825, 733	92. 01
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVI CES	0		C	'I U	U	95. 00
101.00	10100 HOME HEALTH AGENCY	8, 102, 356		8, 102, 356	,	8, 102, 356	101. 00
102.00	10200 OPIOID TREATMENT PROGRAM	0		C		0	102. 00
	SPECIAL PURPOSE COST CENTERS						
113.00	11300 NTEREST EXPENSE						113. 00
116.00	11600 H0SPI CE	9, 815, 838		9, 815, 838		9, 815, 838	116. 00
200.00		317, 729, 221	0	1		317, 729, 221	
201.00		5, 667, 509		5, 667, 509		5, 667, 509	
202.00		312, 061, 712					
			•		-1		

					To 12/31/2023	Date/Time Pre 3/28/2024 12:	pared:
			Title	xVIII	Hospi tal	972672024 12. PPS	04 рііі
			Charges	, ,,,,,,	licopi tai	1.10	
	Cost Center Description	Inpati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
	·		·	+ col. 7)	Ratio	I npati ent	
						Ratio	
	LABORT ENT DOUTLAGE CERVICOE COCT CENTERS	6.00	7. 00	8. 00	9. 00	10.00	
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	00 727 200		00 707 00			20.00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	88, 737, 399		88, 737, 39			30.00
35.00	02060 NEONATAL INTENSIVE CARE UNIT	38, 319, 832 10, 976, 005		38, 319, 83 10, 976, 00			31. 00 35. 00
41. 00	04100 SUBPROVI DER – I RF	6, 976, 053		6, 976, 05			41. 00
43. 00	04300 NURSERY	12, 004, 288		12, 004, 28			43. 00
101.00	ANCILLARY SERVICE COST CENTERS	12/001/200		12/001/20	<u> </u>		10.00
50.00	05000 OPERATING ROOM	94, 526, 349	179, 230, 922	273, 757, 27	0.060814	0.000000	50.00
51.00	05100 RECOVERY ROOM	6, 784, 177	26, 232, 336	33, 016, 51	0. 049010	0.000000	51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	14, 440, 512	102, 883	14, 543, 39	0. 872582	0. 000000	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	13, 927, 406	96, 123, 303			0. 000000	
55. 00	05500 RADI OLOGY - THERAPEUTI C	4, 052, 355	10, 386, 808			0. 000000	
56. 00	05600 RADI OI SOTOPE	3, 828, 613	11, 329, 874			0. 000000	
56. 01	03950 CARDI AC CATH LAB	28, 528, 196	24, 020, 971			0.000000	
57. 00	05700 CT SCAN	16, 480, 247	44, 239, 624			0.000000	
58. 00 60. 00	05800 MRI 06000 LABORATORY	2, 971, 272	7, 438, 379			0. 000000 0. 000000	
65. 00	06500 RESPI RATORY THERAPY	54, 369, 020 15, 440, 790	69, 866, 453 1, 277, 094			0.00000	
66. 00	06600 PHYSI CAL THERAPY	8, 789, 428	18, 285, 868			0.00000	
67. 00	06700 OCCUPATI ONAL THERAPY	7, 638, 349	9, 528, 374			0. 000000	
68. 00	06800 SPEECH PATHOLOGY	2, 488, 132	5, 029, 136			0. 000000	
69. 00	06900 ELECTROCARDI OLOGY	14, 794, 835	28, 279, 072			0. 000000	
70.00	07000 ELECTROENCEPHALOGRAPHY	1, 421, 985	4, 570, 319			0.000000	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	69, 047, 527	91, 509, 067			0.000000	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	45, 141, 909	81, 272, 505	126, 414, 41	4 0. 170133	0. 000000	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	48, 186, 755	178, 768, 435	226, 955, 19	0. 183745	0.000000	73. 00
73. 01	07301 DI ABETES CENTER	0	486			0. 000000	
74.00	07400 RENAL DI ALYSI S	3, 868, 716	2, 101, 978			0. 000000	
76. 00	03480 ONCOLOGY	2, 489, 897	25, 395, 750			0. 000000	
76. 01	03952 ANTI COAGULATI ON	1, 670	916, 536			0.000000	
76. 02	03951 NFUSION SERVICES	628	462, 981			0.000000	
76. 98 77. 00	O7698 HYPERBARI C OXYGEN THERAPY O7700 ALLOGENEI C STEM CELL ACQUI SI TI ON	0	0		0. 000000 0. 000000	0. 000000 0. 000000	
78. 00	07800 CAR T-CELL IMMUNOTHERAPY		0	1	0.00000	0. 000000	
70.00	OUTPATIENT SERVICE COST CENTERS	<u> </u>		1	0.00000	0.000000	70.00
90.00	09000 CLINI C	158, 673	1, 872, 809	2, 031, 48	0. 889244	0. 000000	90.00
90. 01	09001 CLINIC - OUTPATIENT INFUSION SERVICE	523, 837	10, 989, 667			0. 000000	
90. 02	09002 CLINIC - HOME INF PHARMACOTHERAPY	0	142			0.000000	90. 02
91.00	09100 EMERGENCY	28, 981, 155	117, 993, 795	146, 974, 95	0. 112284	0. 000000	91.00
91. 01	04950 WOUND CARE	69, 265	6, 068, 595	6, 137, 86	0. 348864	0. 000000	91. 01
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	3, 641, 972	7, 161, 268			0. 000000	
92. 01	09201 OBSERVATION BEDS (DISTINCT PART)	22, 886	5, 306, 739	5, 329, 62	5 0. 717824	0. 000000	92. 01
	OTHER REIMBURSABLE COST CENTERS			1			
		0	0	1	0. 000000	0. 000000	
	10100 HOME HEALTH AGENCY	0	9, 135, 611				101.00
102.00	10200 OPIOID TREATMENT PROGRAM SPECIAL PURPOSE COST CENTERS	0	0	1	0		102. 00
113 00	11300 INTEREST EXPENSE						113. 00
	11600 HOSPI CE		27, 524, 785	27, 524, 78	5		116. 00
200.00		649, 630, 133		1, 752, 052, 69			200.00
201.00	,	3.7,000,100	., .52, .22, 600	', ', 52, 552, 67			201.00
202.00		649, 630, 133	1, 102, 422, 565	1, 752, 052, 69	8		202. 00
				•	•	•	

Health Financial Systems	FRANCISCAN HEALTH LAFAYETTE	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0109	Peri od: From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Prepared: 3/28/2024 12:04 pm

					3/28/2024 12:	04 pm_
			Title XVIII	Hospi tal	PPS	
	Cost Center Description	PPS Inpatient				
		Ratio				
		11. 00				
	INPATIENT ROUTINE SERVICE COST CENTERS					
	03000 ADULTS & PEDIATRICS					30.00
31. 00	03100 INTENSIVE CARE UNIT					31.00
1	02060 NEONATAL INTENSIVE CARE UNIT					35. 00
	04100 SUBPROVI DER - I RF					41.00
	04300 NURSERY					43. 00
	ANCILLARY SERVICE COST CENTERS					1 .0.00
	05000 OPERATING ROOM	0. 060814				50.00
	05100 RECOVERY ROOM	0. 049010				51.00
	05200 DELIVERY ROOM & LABOR ROOM	0. 872582				52. 00
	05400 RADI OLOGY-DI AGNOSTI C	0. 125343				54.00
	05500 RADI OLOGY - THERAPEUTI C	0. 125343				55. 00
4	05600 RADI OLOGT - THERAPEUTI C	0. 075441				1
		1				56. 00 56. 01
	03950 CARDI AC CATH LAB	0. 108699				
4	05700 CT SCAN	0. 034910				57. 00
4	05800 MRI	0. 093338				58. 00
1	06000 LABORATORY	0. 139800				60.00
4	06500 RESPI RATORY THERAPY	0. 252944				65. 00
4	06600 PHYSI CAL THERAPY	0. 236858				66. 00
1	06700 OCCUPATI ONAL THERAPY	0. 154626				67. 00
1	06800 SPEECH PATHOLOGY	0. 165502				68. 00
	06900 ELECTROCARDI OLOGY	0. 112350				69. 00
	07000 ELECTROENCEPHALOGRAPHY	0. 277955				70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 166831				71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 170133				72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 183745				73. 00
73. 01	07301 DI ABETES CENTER	6, 344. 983539				73. 01
74.00	07400 RENAL DIALYSIS	0. 366961				74. 00
76.00	03480 ONCOLOGY	0. 306353				76. 00
76. 01	03952 ANTI COAGULATI ON	0. 772072				76. 01
76. 02	03951 INFUSION SERVICES	0. 033213				76. 02
76. 98	07698 HYPERBARIC OXYGEN THERAPY	0. 000000				76. 98
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000				77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0. 000000				78. 00
	OUTPATIENT SERVICE COST CENTERS					
	09000 CLI NI C	0. 889244				90.00
	09001 CLINIC - OUTPATIENT INFUSION SERVICE	0. 083086				90. 01
	09002 CLINIC - HOME INF PHARMACOTHERAPY	0. 985915				90. 02
	09100 EMERGENCY	0. 112284				91. 00
1	04950 WOUND CARE	0. 348864				91. 01
4	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 524612				92. 00
4	09201 OBSERVATION BEDS (DISTINCT PART)	0. 717824				92. 01
	OTHER REIMBURSABLE COST CENTERS	0.717024				72.01
	09500 AMBULANCE SERVICES	0. 000000				95. 00
	10100 HOME HEALTH AGENCY	0.000000				101. 00
		+				
	10200 OPI OI D TREATMENT PROGRAM					102. 00
	SPECIAL PURPOSE COST CENTERS					112 00
	11300 I NTEREST EXPENSE					113. 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	FRANCISCAN HEALTH LAFAYETTE	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 15-0109	Peri od:

				Т	o 12/31/2023	Date/Time Pre 3/28/2024 12:	
			Ti tI	e XIX	Hospi tal	Cost	
			, i		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	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	43, 810, 898		43, 810, 898	0	43, 810, 898	30.00
31. 00	03100 INTENSIVE CARE UNIT	10, 418, 821		10, 418, 821		10, 418, 821	
35. 00	02060 NEONATAL INTENSIVE CARE UNIT	4, 555, 813		4, 555, 813		4, 555, 813	
41. 00	04100 SUBPROVI DER – I RF	4, 439, 978		4, 439, 978		4, 439, 978	
43. 00	04300 NURSERY	6, 652, 258	ł .	6, 652, 258		6, 652, 258	
10.00	ANCI LLARY SERVI CE COST CENTERS	0,002,200		0,002,200	, ₁	0, 002, 200	
50. 00	05000 OPERATI NG ROOM	16, 648, 375		16, 648, 375	0	16, 648, 375	50.00
51. 00	05100 RECOVERY ROOM	1, 618, 138		1, 618, 138		1, 618, 138	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	12, 690, 303		12, 690, 303		12, 690, 303	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	13, 794, 091		13, 794, 091		13, 794, 091	54. 00
55. 00	05500 RADI OLOGY - THERAPEUTI C	1, 384, 576		1, 384, 576		1, 384, 576	1
56. 00	05600 RADI OI SOTOPE	1, 143, 573		1, 143, 573		1, 143, 573	
56. 01	03950 CARDI AC CATH LAB	5, 712, 066		5, 712, 066		5, 712, 066	
57. 00	05700 CT SCAN					2, 119, 711	
	05800 MRI	2, 119, 711		2, 119, 711		971, 614	
58. 00		971, 614		971, 614			1
60.00	06000 LABORATORY	17, 368, 168		17, 368, 168		17, 368, 168	
65. 00	06500 RESPI RATORY THERAPY	4, 228, 692	0			4, 228, 692	
66. 00	06600 PHYSI CAL THERAPY	6, 413, 009	0	6, 413, 009		6, 413, 009	1
67. 00	06700 OCCUPATI ONAL THERAPY	2, 654, 414	0	2, 654, 414		2, 654, 414	67. 00
68. 00	06800 SPEECH PATHOLOGY	1, 244, 121	0	1, 244, 121		1, 244, 121	1
69. 00	06900 ELECTROCARDI OLOGY	4, 839, 373		4, 839, 373		4, 839, 373	1
	07000 ELECTROENCEPHALOGRAPHY	1, 665, 592		1, 665, 592		1, 665, 592	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	26, 785, 804		26, 785, 804		26, 785, 804	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	21, 507, 292		21, 507, 292		21, 507, 292	
73. 00	07300 DRUGS CHARGED TO PATIENTS	41, 701, 811		41, 701, 811		41, 701, 811	
73. 01	07301 DI ABETES CENTER	3, 083, 662		3, 083, 662		3, 083, 662	
74. 00	07400 RENAL DI ALYSI S	2, 191, 012		2, 191, 012		2, 191, 012	
76. 00	03480 ONCOLOGY	8, 542, 847		8, 542, 847		8, 542, 847	
	03952 ANTI COAGULATI ON	708, 921		708, 921		708, 921	
76. 02	03951 INFUSION SERVICES	15, 398		15, 398	0	15, 398	
	07698 HYPERBARI C OXYGEN THERAPY	0		(-	0	
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0		(0	0	77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0		(0	0	78. 00
	OUTPATIENT SERVICE COST CENTERS						
90. 00	09000 CLI NI C	1, 806, 484		1, 806, 484	0	1, 806, 484	90.00
	09001 CLINIC - OUTPATIENT INFUSION SERVICE	956, 612		956, 612	0	956, 612	90. 01
90. 02	09002 CLINIC - HOME INF PHARMACOTHERAPY	140		140	0	140	90. 02
91.00	09100 EMERGENCY	16, 502, 942		16, 502, 942	0	16, 502, 942	91.00
91. 01	04950 WOUND CARE	2, 141, 276		2, 141, 276	0	2, 141, 276	91. 01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	5, 667, 509		5, 667, 509		5, 667, 509	92. 00
92. 01	09201 OBSERVATION BEDS (DISTINCT PART)	3, 825, 733		3, 825, 733	0	3, 825, 733	92. 01
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVI CES	0		(0	U	95. 00
	10100 HOME HEALTH AGENCY	8, 102, 356		8, 102, 356	, l	8, 102, 356	101.00
102.00	10200 OPI OI D TREATMENT PROGRAM	0)		102. 00
	SPECIAL PURPOSE COST CENTERS						1
113. 00	11300 I NTEREST EXPENSE						113. 00
	11600 HOSPI CE	9, 815, 838		9, 815, 838	3	9, 815, 838	
200.00		317, 729, 221				317, 729, 221	
201.00		5, 667, 509		5, 667, 509		5, 667, 509	
202.00		312, 061, 712				312, 061, 712	
50	1 ()		'		, 9		

					To 12/31/2023	Date/Time Pre 3/28/2024 12:	
			Ti tl	e XIX	Hospi tal	Cost	оч рііі
			Charges	<u> </u>	1100011101	0001	
	Cost Center Description	I npati ent	Outpati ent	Total (col.	Cost or Other	TEFRA	
	·		·	+ col . 7)	Ratio	I npati ent	
						Ratio	
	T	6. 00	7. 00	8. 00	9. 00	10. 00	
00.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	00 707 000		00 707 00	.0		00.00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	88, 737, 399 38, 319, 832		88, 737, 39 38, 319, 83			30. 00 31. 00
35. 00	02060 NEONATAL INTENSIVE CARE UNIT	10, 976, 005		10, 976, 00			35.00
41. 00	04100 SUBPROVI DER – I RF	6, 976, 053		6, 976, 05			41. 00
43. 00	04300 NURSERY	12, 004, 288		12, 004, 28			43. 00
	ANCILLARY SERVICE COST CENTERS	, , , , , , , , ,		, , , , , ,		'	
50.00	05000 OPERATING ROOM	94, 526, 349	179, 230, 922	273, 757, 27	0.060814	0. 000000	50.00
51.00	05100 RECOVERY ROOM	6, 784, 177	26, 232, 336	33, 016, 51	3 0. 049010	0. 000000	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	14, 440, 512	102, 883			0.000000	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	13, 927, 406	96, 123, 303			0. 000000	1
55. 00	05500 RADI OLOGY - THERAPEUTI C	4, 052, 355	10, 386, 808			0.000000	1
56. 00 56. 01	05600 RADI OI SOTOPE	3, 828, 613	11, 329, 874			0.000000	1
56. 01	03950 CARDI AC CATH LAB 05700 CT SCAN	28, 528, 196 16, 480, 247	24, 020, 971 44, 239, 624			0. 000000 0. 000000	
58. 00	05800 MRI	2, 971, 272	7, 438, 379			0.00000	
60.00	06000 LABORATORY	54, 369, 020	69, 866, 453			0.00000	1
65. 00	06500 RESPI RATORY THERAPY	15, 440, 790	1, 277, 094			0. 000000	1
66. 00	06600 PHYSI CAL THERAPY	8, 789, 428	18, 285, 868			0. 000000	1
67. 00	06700 OCCUPATI ONAL THERAPY	7, 638, 349	9, 528, 374			0.000000	
68.00	06800 SPEECH PATHOLOGY	2, 488, 132	5, 029, 136	7, 517, 26	0. 165502	0. 000000	68. 00
69. 00	06900 ELECTROCARDI OLOGY	14, 794, 835	28, 279, 072			0.000000	1
70. 00	07000 ELECTROENCEPHALOGRAPHY	1, 421, 985	4, 570, 319			0. 000000	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	69, 047, 527	91, 509, 067			0. 000000	1
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	45, 141, 909	81, 272, 505			0.000000	
73. 00 73. 01	O7300 DRUGS CHARGED TO PATIENTS O7301 DI ABETES CENTER	48, 186, 755 0	178, 768, 435 486			0. 000000 0. 000000	1
74. 00	07400 RENAL DI ALYSI S	3, 868, 716	2, 101, 978	1		0.00000	1
76. 00	03480 ONCOLOGY	2, 489, 897	25, 395, 750			0.00000	1
76. 01	03952 ANTI COAGULATI ON	1, 670	916, 536			0.00000	1
76. 02	03951 NFUSI ON SERVI CES	628	462, 981			0. 000000	
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0		0. 000000	0.000000	1
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0)	0. 000000	0.000000	77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0		0.000000	0. 000000	78. 00
	OUTPATIENT SERVICE COST CENTERS	1		1			
90.00	09000 CLINIC	158, 673	1, 872, 809			0. 000000	1
90. 01	09001 CLINIC - OUTPATIENT INFUSION SERVICE 09002 CLINIC - HOME INF PHARMACOTHERAPY	523, 837	10, 989, 667			0.000000	1
90. 02 91. 00	09100 EMERGENCY	0 28, 981, 155	142 117, 993, 795	1		0. 000000 0. 000000	1
91.00	04950 WOUND CARE	69, 265	6, 068, 595			0.00000	1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	3, 641, 972	7, 161, 268			0.00000	1
92. 01	09201 OBSERVATION BEDS (DISTINCT PART)	22, 886	5, 306, 739			0. 000000	
	OTHER REIMBURSABLE COST CENTERS						1
95.00	09500 AMBULANCE SERVI CES	0	0		0.000000	0.000000	95. 00
101.00	10100 HOME HEALTH AGENCY	0	9, 135, 611	9, 135, 6	1		101.00
102.00	10200 OPIOID TREATMENT PROGRAM	0	0		0		102. 00
	SPECIAL PURPOSE COST CENTERS						
	11300 INTEREST EXPENSE		07 504 705	27 504 7			113. 00
	11600 HOSPI CE	640 630 133	27, 524, 785				116.00
200. 00 201. 00	,	049, 030, 133	1, 102, 422, 565	1, 752, 052, 69	0		200. 00 201. 00
201.00		649 630 133	1, 102, 422, 565	1 752 052 69	18		201.00
_52.00	1.000. (000 1.100. 0001 0110)	3 , 555, 155	., .52, 122, 500	1 .,	-1	ı	,_02.00

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

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0109 Period: From 01/01/2023 To 12/31/2023 Part I Date/Time Prepared: 3/28/2024 12: 04 pm

				3/28/2024 12:0	04 pm
		Title XIX	Hospi tal	Cost	
Cost Center Description	PPS Inpatient				
	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTER					
30. 00 03000 ADULTS & PEDI ATRI CS					30.00
31. 00 03100 NTENSI VE CARE UNI T	+				31.00
I I					
35. 00 02060 NEONATAL INTENSIVE CARE UNIT					35. 00
41. 00 04100 SUBPROVI DER - I RF					41. 00
43. 00 04300 NURSERY					43. 00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0. 000000				50.00
51.00 05100 RECOVERY ROOM	0. 000000				51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000				52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.00
55. 00 05500 RADI OLOGY - THERAPEUTI C	0. 000000				55.00
56. 00 05600 RADI 01 SOTOPE	0. 000000				56.00
56. 01 03950 CARDI AC CATH LAB	0. 000000				56. 01
57. 00 05700 CT SCAN	0. 000000				57. 00
58. 00 05800 MRI	0. 000000				58. 00
60. 00 06000 LABORATORY	0. 000000				60.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000				65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000				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. 000000				69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000				70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PAT					71.00
· · · · · · · · · · · · · · · · · · ·					
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000				72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000				73. 00
73. 01 07301 DI ABETES CENTER	0. 000000				73. 01
74.00 07400 RENAL DIALYSIS	0. 000000				74.00
76. 00 03480 ONCOLOGY	0. 000000				76. 00
76. 01 03952 ANTI COAGULATI ON	0. 000000				76. 01
76. 02 03951 I NFUSI ON SERVI CES	0. 000000				76. 02
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 000000				76. 98
77. 00 07700 ALLOGENEIC STEM CELL ACQUISITIO					77. 00
78. 00 07800 CAR T-CELL IMMUNOTHERAPY	0. 000000				78.00
OUTPATIENT SERVICE COST CENTERS	0. 000000				70.00
	0.000000				00 00
90. 00 09000 CLINI C	0.000000				90.00
90. 01 09001 CLINIC - OUTPATIENT INFUSION SE					90. 01
90. 02 09002 CLINIC - HOME INF PHARMACOTHERA					90. 02
91. 00 09100 EMERGENCY	0. 000000				91.00
91. 01 04950 WOUND CARE	0. 000000				91. 01
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT	PART 0. 000000				92.00
92. 01 09201 OBSERVATION BEDS (DISTINCT PART	0. 000000				92. 01
OTHER REIMBURSABLE COST CENTERS					
95. 00 09500 AMBULANCE SERVICES	0. 000000				95. 00
101.00 10100 HOME HEALTH AGENCY	0.000000				101.00
102.00 10200 OPI OI D TREATMENT PROGRAM					101.00
					1102.00
SPECIAL PURPOSE COST CENTERS					440 00
113. 00 11300 NTEREST EXPENSE					113. 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	FRANCISCAN HEA	LTH LAFAYETTE		In Li€	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	_ COSTS Provi de			Peri od:	Worksheet D	
				From 01/01/2023 To 12/31/2023		narod:
				10 12/31/2023	3/28/2024 12:	ραιου. O4 nm
		Title	xVIII	Hospi tal PPS		<u>о т р</u>
Cost Center Description	Capi tal	Swi ng Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related 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 & PEDIATRICS	3, 299, 105	0	3, 299, 10	5 35, 984	91. 68	30. 00
31.00 INTENSIVE CARE UNIT	856, 788		856, 78	8 4, 449	192. 58	31.00
35.00 NEONATAL INTENSIVE CARE UNIT	672, 164		672, 16	4 2, 813	238. 95	35. 00
41. 00 SUBPROVI DER - I RF	826, 430	0	826, 43	0 2, 848	290. 18	41.00
43. 00 NURSERY	1, 113, 490		1, 113, 49	0 2, 813	395. 84	43.00
200.00 Total (lines 30 through 199)	6, 767, 977		6, 767, 97	7 48, 907		200. 00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	8, 379	768, 187				30.00
31.00 INTENSIVE CARE UNIT	2, 579	496, 664				31.00
35.00 NEONATAL INTENSIVE CARE UNIT	0	0				35. 00
41. 00 SUBPROVI DER - I RF	1, 506	437, 011				41.00
43. 00 NURSERY	0	0				43. 00
200.00 Total (lines 30 through 199)	12, 464	1, 701, 862				200. 00

Health Financial Systems	FRANCISCAN HEA	LTH LAFAYETTE		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAP	TAL COSTS	Provi der C		Peri od: From 01/01/2023 To 12/31/2023	Worksheet D Part II Date/Time Pre 3/28/2024 12:	
		Title	: XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 + col	. 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	2, 566, 241	273, 757, 271	0.00937	27, 201, 314	254, 985	50.00
51. 00 05100 RECOVERY ROOM	172, 018	33, 016, 513	0. 00521	0 2, 026, 141	10, 556	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	2, 595, 766	14, 543, 395	0. 17848	5, 256	938	52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 185, 934	110, 050, 709	0. 01077	6 5, 718, 989	61, 628	54.00

202, 875

655, 979

105, 232

67, 633

546, 150

248, 371

180 239

52, 317

28, 408

502 885

234, 749

293, 593

235, 409

824, 370

401, 338

111, 804

116, 392

76,500

20,825

1, 392, 896

392, 870

426, 780

350, 036

15, 482, 968 1, 558, 378, 725

441

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1, 464, 626

30, 290

14, 439, 163

15, 158, 487

52, 549, 167

60.719.871

10, 409, 651

16, 717, 884

27, 075, 296

17, 166, 723

43 073 907

5, 992, 304

160, 556, 594

126, 414, 414

226, 955, 190

5, 970, 694

918, 206

463, 609

2, 031, 482

142

11, 513, 504

146, 974, 950

6, 137, 860

10, 803, 240

5, 329, 625

27, 885, 647

486

7, 517, 268

124, 235, 473

1, 290, 761

1, 475, 396

7, 905, 440

6, 014, 965

16, 511, 526

4, 376, 633

2, 320, 143

1, 992, 471

5, 314, 655

21, 454, 971

17, 839, 843

14, 686, 398

1, 258, 907

2, 389, 897

932

628

14, 373

323, 680

7, 835, 629

1, 596, 645

151, 363, 997

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402, 835

446, 502

959, 067

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2, 948

98, 684

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72, 585

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17, 492

39, 241

33, 218

53, 341

23, 573

125, 525

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1, 118, 196 200. 00

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56.01

57 00

58.00

60.00

65.00

66 00

67.00

68.00

69 00

70.00

71.00

72.00

73 00

74.00

76.00

76.01

76.02

76. 98

77.00

90.00

90.01

91.00

92.00

95.00

05500 RADI OLOGY - THERAPEUTI C

05600 RADI 0I SOTOPE

05700 CT SCAN

06000 LABORATORY

05800 MRI

03950 CARDIAC CATH LAB

06500 RESPIRATORY THERAPY

06700 OCCUPATI ONAL THERAPY

07000 ELECTROENCEPHALOGRAPHY

07300 DRUGS CHARGED TO PATIENTS

07698 HYPERBARIC OXYGEN THERAPY

07800 CAR T-CELL IMMUNOTHERAPY

OUTPATIENT SERVICE COST CENTERS

07700 ALLOGENEIC STEM CELL ACQUISITION

09001 CLINIC - OUTPATIENT INFUSION SERVICE 09002 CLINIC - HOME INF PHARMACOTHERAPY

09200 OBSERVATION BEDS (NON-DISTINCT PART

09201 OBSERVATION BEDS (DISTINCT PART)

Total (lines 50 through 199)

OTHER REIMBURSABLE COST CENTERS

07100 MEDICAL SUPPLIES CHARGED TO PATIENT

07200 IMPL. DEV. CHARGED TO PATIENTS

06600 PHYSICAL THERAPY

06800 SPEECH PATHOLOGY

06900 ELECTROCARDI OLOGY

07301 DI ABETES CENTER

03952 ANTI COAGULATI ON

03951 INFUSION SERVICES

07400 RENAL DIALYSIS

03480 ONCOLOGY

09000 CLI NI C

09100 EMERGENCY

04950 WOUND CARE

95. 00 09500 AMBULANCE SERVICES

55.00

56.00

56.01

57 00

58.00

60.00

65.00

66 00

67.00

68.00

69 00

70.00

71. 00 72. 00

73 00

73.01

74.00

76.00

76.01

76.02

76.98

77.00

78.00

90 00

90.01

90 02

91.00

91. 01

92.00

92.01

200.00

Health Financial Systems	FRANCISCAN HEAL	LTH LAFAYETTE		In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COS			Period: From 01/01/2023 To 12/31/2023	Date/Time Pre 3/28/2024 12:	pared: 04 pm
		Titl∈	XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng Program Post-Stepdown Adj ustments	Nursi ng Program	Allied Health Post-Stepdown Adjustments		All Other Medical Education Cost	
	1A	1. 00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 35. 00 02060 NEONATAL INTENSIVE CARE UNIT	0 0	472, 190 595, 766		0 0 0 0	0	31. 00 35. 00
41.00 04100 SUBPROVI DER - RF 43.00 04300 NURSERY 200.00 Total (Lines 30 through 199)	0 0	0 0 2, 773, 303		0 0 0 0	0 0	
Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
	4.00	5. 00	6.00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 35. 00 02060 NEONATAL INTENSIVE CARE UNIT	0	472, 190 595, 766	4, 44 2, 81	9 106. 13 3 211. 79	2, 579 0	31. 00 35. 00
41.00 04100 SUBPROVI DER - RF 43.00 04300 NURSERY 200.00 Total (Lines 30 through 199)	0	0 0 2, 773, 303	2, 81	0.00	0	1
Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00		-1	·1	1 12, 404	230. 00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	397, 081 273, 709 0	-				30. 00 31. 00 35. 00 41. 00
43. 00 04300 NURSERY 200. 00 Total (lines 30 through 199)	670, 790					43. 00 200. 00

Health Financial Systems		FRANCI SCAN	HEALTH	LAFAYETTE	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY S	SERVI CE OTHER	PASS	Provi der CCN: 15-0109	Peri od: From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Prepared

				Т	o 12/31/2023	Date/Time Pre 3/28/2024 12:	
			Ti tl e	xVIII	Hospi tal	PPS	01 piii
	Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
	·	Anestheti st	Program	Program	Post-Stepdown		
		Cost	Post-Stepdown		Adjustments		
			Adjustments				
		1. 00	2A	2.00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS	_	_	1	1		
50. 00	05000 OPERATI NG ROOM	0		10, 406		0	50.00
51.00	05100 RECOVERY ROOM	0	C	0	_	0	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0		500, 808		0	52. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	C	44, 227		0	54. 00
55. 00	05500 RADI OLOGY - THERAPEUTI C	0		0		0	55. 00
56. 00	05600 RADI OI SOTOPE	0	C	1,,		0	56. 00
56. 01	03950 CARDI AC CATH LAB	0		222, 437	0	0	56. 01
57. 00	05700 CT SCAN	0		9	0	0	57. 00
58. 00	05800 MRI	0		9	0	0	58. 00
60.00	06000 LABORATORY	0	C) C	0	0	60.00
65. 00	06500 RESPI RATORY THERAPY	0	C	C	0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	C	93, 658	0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	C) c	0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	C) c	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	C) c	0	0	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	C	0	0	0	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	C	C	0	0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	C	0	0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	C	1	0	263, 457	73. 00
73. 01	07301 DI ABETES CENTER	0	C	0	0	0	73. 01
74.00	07400 RENAL DIALYSIS	0	C	C	0	0	74. 00
76. 00	03480 ONCOLOGY	0	C	C	0	0	76. 00
76. 01	03952 ANTI COAGULATI ON	0	C	C	0	0	76. 01
76. 02	03951 INFUSION SERVICES	0	C	C	0	0	76. 02
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	C	C	0	0	76. 98
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	C	1	0	0	77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	C	C	0	0	78. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	C	23, 414	0	0	90. 00
90. 01	09001 CLINIC - OUTPATIENT INFUSION SERVICE	0	(C	0	0	0	90. 01
90. 02	09002 CLINIC - HOME INF PHARMACOTHERAPY	0	[C) C	0	0	90. 02
91. 00	09100 EMERGENCY	0	[C	1, 321, 612	. 0	134, 711	91. 00
91. 01	04950 WOUND CARE	0	C	113, 169	0	0	91. 01
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0		220, 608		0	92. 00
92. 01	09201 OBSERVATION BEDS (DISTINCT PART)	0	C	C	0	0	92. 01
	OTHER REIMBURSABLE COST CENTERS						
95. 00	09500 AMBULANCE SERVICES						95. 00
200.00	Total (lines 50 through 199)	0	(2, 663, 508	0	398, 168	200. 00

Health Financial Systems	FRANCISCAN HEALTH	LAFAYETTE	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENTHROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0109	Peri od: From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Prepared: 3/28/2024 12:04 pm

I HROUG	TIRKUUGH CUS13			Τ̈́	o 12/31/2023	Date/Time Prepared: 3/28/2024 12:04 pm	
			Title	XVIII	Hospi tal PPS		<u>о г р</u>
	Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	'	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
		Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
			4)	col s. 2, 3,	8)	7)	
				and 4)		(see	
						instructions)	
		4. 00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	0	10, 406	10, 406		0. 000038	
51.00	05100 RECOVERY ROOM	0	0	C	33, 016, 513	0.000000	51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	500, 808	500, 808	14, 543, 395	0. 034435	52. 00
	05400 RADI OLOGY-DI AGNOSTI C	0	44, 227	44, 227	110, 050, 709	0. 000402	54. 00
	05500 RADI OLOGY - THERAPEUTI C	0	0	C	14, 439, 163	0.000000	55. 00
56.00	05600 RADI 0I SOTOPE	0	113, 169	113, 169	15, 158, 487	0. 007466	56. 00
56. 01	03950 CARDI AC CATH LAB	0	222, 437	222, 437	52, 549, 167	0. 004233	56. 01
57.00	05700 CT SCAN	0	0	C	60, 719, 871	0.000000	57.00
58.00	05800 MRI	0	0	C	10, 409, 651	0.000000	58. 00
60.00	06000 LABORATORY	0	0	C	124, 235, 473	0.000000	60.00
65.00	06500 RESPI RATORY THERAPY	0	0	C	16, 717, 884	0.000000	65.00
66.00	06600 PHYSI CAL THERAPY	0	93, 658	93, 658	27, 075, 296	0. 003459	66. 00
67.00	06700 OCCUPATIONAL THERAPY	0	0	C	17, 166, 723	0.000000	67. 00
68.00	06800 SPEECH PATHOLOGY	O	0	C	7, 517, 268	0.000000	68. 00
69.00	06900 ELECTROCARDI OLOGY	O	0	C	43, 073, 907	0.000000	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	O	0	C	5, 992, 304	0.000000	70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	O	0	C		0.000000	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	o	0	C	126, 414, 414	0.000000	72. 00
	07300 DRUGS CHARGED TO PATIENTS	O	263, 457	263, 457	226, 955, 190	0. 001161	73. 00
73. 01	07301 DI ABETES CENTER	o	0	C	486	0.000000	73. 01
74.00	07400 RENAL DIALYSIS	O	0	C	5, 970, 694	0.000000	74. 00
76.00	03480 ONCOLOGY	O	0	C	27, 885, 647	0.000000	76. 00
76. 01	03952 ANTI COAGULATI ON	O	0	C	918, 206	0.000000	76. 01
76. 02	03951 I NFUSI ON SERVI CES	0	0	C	463, 609	0.000000	76. 02
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0	l c	0	0.000000	76. 98
77.00	07700 ALLOGENEIC STEM CELL ACQUISITION	0	0	C	0	0.000000	77. 00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	C	0	0.000000	78. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	23, 414	23, 414	2, 031, 482	0. 011526	90. 00
90. 01	09001 CLINIC - OUTPATIENT INFUSION SERVICE	0	0	C	11, 513, 504	0.000000	90. 01
90. 02	09002 CLINIC - HOME INF PHARMACOTHERAPY	0	0	l c	142	0.000000	90. 02
	09100 EMERGENCY	0	1, 456, 323	1, 456, 323	146, 974, 950	0. 009909	91. 00
91. 01	04950 WOUND CARE	0	113, 169			0. 018438	91. 01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	220, 608	220, 608	10, 803, 240	0. 020421	92.00
	09201 OBSERVATION BEDS (DISTINCT PART)	O	0	C		0.000000	
	OTHER REIMBURSABLE COST CENTERS						1
95.00	09500 AMBULANCE SERVICES						95. 00
200.00	Total (lines 50 through 199)	o	3, 061, 676	3, 061, 676	1, 558, 378, 725		200. 00

Health Financial Systems	FRANCISCAN HEALTH	I LAFAYETTE		In lie	u of Form CMS-2	552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT . THROUGH COSTS		Provider CCN: 1			Worksheet D	.002 10
			7		Date/Time Prep 3/28/2024 12:0	
		Title XVI	11	Hospi tal	PPS	
Cost Center Description	Outpatient Ratio of Cost	Production of the contract of	npatient Program	Outpatient Program	Outpatient Program	

						3/28/2024 12:	04 pm
			Title	XVIII	Hospi tal	PPS	
	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 before	Charges	
		(col. 6 ÷ col.		Costs (col. 8	Geo	on/after Geo	
		7)		x col. 10)	Recl assi fi cati	Reclassi fi cati	
					on	on	
		9. 00	10.00	11. 00	12.00	12. 01	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0. 000038	27, 201, 314	1, 034	41, 964, 795	0	50.00
51.00	05100 RECOVERY ROOM	0. 000000	2, 026, 141	C	6, 316, 248	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 034435	5, 256	181	0	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000402	5, 718, 989	2, 299	8, 871, 307	0	54.00
55.00	05500 RADI OLOGY - THERAPEUTI C	0. 000000	1, 290, 761		1, 497, 644	0	55. 00
56.00	05600 RADI OI SOTOPE	0. 007466	1, 475, 396	11, 015	3, 154, 719	0	56.00
56. 01	03950 CARDI AC CATH LAB	0. 004233	7, 905, 440			0	56. 01
57. 00	05700 CT SCAN	0. 000000	6, 014, 965		9, 070, 517	0	57. 00
58. 00	05800 MRI	0. 000000	959, 067	Ö	1, 430, 354	0	58.00
60.00	06000 LABORATORY	0. 000000	16, 511, 526	Ö		0	60.00
65. 00	06500 RESPIRATORY THERAPY	0. 000000	4, 376, 633			0	65.00
66. 00	06600 PHYSI CAL THERAPY	0. 003459	2, 320, 143			0	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 000000	1, 992, 471	0,023	42, 787	0	67.00
68. 00	06800 SPEECH PATHOLOGY	0. 000000	402, 835		10, 033	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 000000	5, 314, 655		8, 394, 146	0	69.00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	446, 502	1 0	897, 368	0	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1			23, 598, 583	0	71.00
		0.000000	21, 454, 971		1 1	0	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0.000000	17, 839, 843		28, 049, 463	-	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 001161	14, 686, 398			0	73. 00
73. 01	07301 DI ABETES CENTER	0. 000000	0	0	1	0	73. 01
74. 00	07400 RENAL DI ALYSI S	0. 000000	1, 258, 907	C		0	74. 00
76. 00	03480 ONCOLOGY	0. 000000	2, 389, 897	0	7, 630, 552	0	76. 00
76. 01	03952 ANTI COAGULATI ON	0. 000000	932		170,000	0	76. 01
76. 02	03951 I NFUSI ON SERVI CES	0. 000000	628	0	83, 472	0	76. 02
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0. 000000	0	0	0	0	76. 98
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0. 000000	0	0	0	0	77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0. 000000	0	C	0	0	78. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0. 011526	14, 373	166	210, 924	0	90.00
90. 01	09001 CLINIC - OUTPATIENT INFUSION SERVICE	0. 000000	323, 680	C	3, 181, 685	0	90. 01
90. 02	09002 CLINIC - HOME INF PHARMACOTHERAPY	0. 000000	0	C	0	0	90. 02
91.00	09100 EMERGENCY	0. 009909	7, 835, 629	77, 643	15, 250, 483	0	91.00
91. 01	04950 WOUND CARE	0. 018438	0	C	o	0	91. 01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 020421	1, 596, 645	32, 605	664, 271	0	92.00
92. 01	09201 OBSERVATION BEDS (DISTINCT PART)	0. 000000	0	l c		0	92. 01
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVI CES						95. 00
200.00	Total (lines 50 through 199)		151, 363, 997	183, 483	224, 008, 648	0	200. 00
				•	•		

Health Financial Systems	FRANCISCAN HEALTH	LAFAYETTE	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0109	Peri od: From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Prepared: 3/28/2024 12:04 pm

				10 12/31/2023	3/28/2024 12:	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Outpati ent	Outpati ent				
	Program	Program				
	Pass-Through	Pass-Through				
	Costs (col. 9	Costs (col. 9				
	x col. 12)	x col. 12)				
	before Geo	on/after Geo				
	Recl assi fi cati	Recl assi fi cati				
	on	on				
	13. 00	13. 01				
ANCILLARY SERVICE COST CENTERS		1				
50. 00 05000 OPERATING ROOM	1, 595					50. 00
51. 00 05100 RECOVERY ROOM	0					51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	1			52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	3, 566	0)			54. 00
55. 00 05500 RADI OLOGY - THERAPEUTI C	0	0)			55. 00
56. 00 05600 RADI OI SOTOPE	23, 553)			56. 00
56. 01 03950 CARDI AC CATH LAB	30, 919	0)			56. 01
57. 00 05700 CT SCAN	0	0)			57. 00
58. 00 05800 MRI	0	0)			58. 00
60. 00 06000 LABORATORY	0	0)			60.00
65. 00 06500 RESPI RATORY THERAPY	0	1)			65. 00
66. 00 06600 PHYSI CAL THERAPY	844	l e)			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	1			67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0	1			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0)			69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	1)			70. 00
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0)			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	1)			72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	56, 790	0)			73. 00
73. 01 07301 DI ABETES CENTER	0	0)			73. 01
74. 00 07400 RENAL DI ALYSI S	0	0)			74. 00
76. 00 03480 0NC0L0GY	0	0)			76. 00
76. 01 03952 ANTI COAGULATI ON	0	0)			76. 01
76. 02 03951 I NFUSI ON SERVI CES	0	0)			76. 02
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0		1			76. 98
77.00 07700 ALLOGENEIC STEM CELL ACQUISITION	0		1			77. 00
78. 00 07800 CAR T-CELL IMMUNOTHERAPY	0	0)			78. 00
OUTPATIENT SERVICE COST CENTERS		1	.1			
90. 00 09000 CLI NI C	2, 431	0				90.00
90. 01 09001 CLINIC - OUTPATIENT INFUSION SERVICE	0	1	1			90. 01
90. 02 09002 CLINIC - HOME INF PHARMACOTHERAPY	0	0	2			90. 02
91. 00 09100 EMERGENCY	151, 117	0	2			91.00
91. 01 04950 WOUND CARE	0	1				91. 01
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	13, 565		1			92.00
92. 01 09201 OBSERVATI ON BEDS (DI STI NCT PART)	0	0	7			92. 01
OTHER REIMBURSABLE COST CENTERS						05.00
95. 00 09500 AMBULANCE SERVICES	204 200		J			95. 00
200.00 Total (lines 50 through 199)	284, 380	0	ין			200. 00

From 01/01/2023 Part V Date/Time Prepared: 12/31/2023 3/28/2024 12:04 pm Title XVIII Hospi tal PPS Charges Costs Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Ratio From Services (see Rei mbursed Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Part I, col. 9 Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 1.00 2.00 5. 00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0.060814 41, 964, 795 2, 552, 047 50.00 51.00 05100 RECOVERY ROOM 0.049010 6, 316, 248 0 0 309, 559 51.00 05200 DELIVERY ROOM & LABOR ROOM 0 52 00 0.872582 52 00 0 0 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.125343 8, 871, 307 1, 111, 956 54.00 05500 RADI OLOGY - THERAPEUTI C 0.095890 1, 497, 644 0 143, 609 55.00 237, 995 05600 RADI OI SOTOPE 0.075441 3, 154, 719 0 0 56 00 56 00 03950 CARDIAC CATH LAB 0 56.01 0.108699 7, 304, 224 793, 962 56.01 57.00 05700 CT SCAN 0.034910 9,070,517 316, 652 57.00 0 58.00 05800 MRI 0.093338 1, 430, 354 0 133, 506 58.00 0 06000 LABORATORY 6, 300, 731 60 00 0 139800 880.842 60 00 65.00 06500 RESPIRATORY THERAPY 0. 252944 210, 255 53, 183 65.00 06600 PHYSI CAL THERAPY 0. 236858 244,008 0 0 57, 795 66.00 66.00 0 06700 OCCUPATIONAL THERAPY 42, 787 0 67.00 0.154626 6.616 67.00 0 06800 SPEECH PATHOLOGY 68.00 0.165502 10,033 1,660 68 00 69.00 06900 ELECTROCARDI OLOGY 0.112350 8, 394, 146 0 0 943, 082 69.00 07000 ELECTROENCEPHALOGRAPHY 249, 428 0. 277955 897, 368 0 70.00 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 23, 598, 583 0 0 3, 936, 975 71.00 0.166831 71.00 07200 I MPL. DEV. CHARGED TO PATIENTS 0 0 72 00 0.170133 28, 049, 463 4, 772, 139 72 00 73.00 07300 DRUGS CHARGED TO PATIENTS 0. 183745 48, 914, 606 6, 814 8, 987, 814 73.00 07301 DI ABETES CENTER 0 73.01 6, 344. 983539 0 0 73.01 07400 RENAL DIALYSIS 0 44, 935 74.00 0.366961 122, 452 0 74.00 0 03480 ONCOLOGY 2, 337, 642 76.00 0.306353 7, 630, 552 76.00 03952 ANTI COAGULATI ON 0.772072 175,068 0 0 135, 165 76.01 76.01 0 0 76. 02 03951 INFUSION SERVICES 0.033213 83, 472 2,772 76.02 07698 HYPERBARI C OXYGEN THERAPY 0 76.98 0.000000 C 76.98 0 0 77.00 07700 ALLOGENEIC STEM CELL ACQUISITION 0.000000 C 0 0 77.00 07800 CAR T-CELL IMMUNOTHERAPY 0.000000 78.00 0 0 78.00 OUTPATIENT SERVICE COST CENTERS 90 00 09000 CLINIC 0.889244 0 0 187, 563 90.00 210, 924 0 90.01 09001 CLINIC - OUTPATIENT INFUSION SERVICE 0.083086 3, 181, 685 0 264, 353 90.01 09002 CLINIC - HOME INF PHARMACOTHERAPY 0 0 90. 02 0. 985915 Ω 90.02 09100 EMERGENCY 0 0 0 91.00 0.112284 15, 250, 483 91.00 1, 712, 385 0 91.01 04950 WOUND CARE 0.348864 Λ 91.01 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.524612 664, 271 0 0 348, 485 92.00 09201 OBSERVATION BEDS (DISTINCT PART) 0.717824 417, 953 0 300, 017 92.01 92.01 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0.000000 0 95.00 200.00 Subtotal (see instructions) 224, 008, 648 0 6,814 30, 822, 137 200.00 0 Less PBP Clinic Lab. Services-Program 201.00 201.00 Only Charges

224, 008, 648

0

6.814

30, 822, 137 202. 00

202.00

Net Charges (line 200 - line 201)

Health Financial Systems FRANCISCAN HEALTH LAFAYETTE In Lieu of Form CMS-2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0109 Period: Worksheet D From 01/01/2023 Part V

Date/Time Prepared: 12/31/2023 3/28/2024 12:04 pm Title XVIII Hospi tal PPS Costs 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 OPERATING ROOM 0 50.00 51.00 05100 RECOVERY ROOM 0000000000000000000000000000 0 51.00 52. 00 05200 DELIVERY ROOM & LABOR ROOM 0 52 00 05400 RADI OLOGY-DI AGNOSTI C 54.00 0 54.00 55. 00 05500 RADI OLOGY - THERAPEUTI C 0 55.00 56.00 05600 RADI OI SOTOPE 0 56.00 03950 CARDI AC CATH LAB 0 56.01 56.01 57.00 05700 CT SCAN 0 57.00 05800 MRI 0 58.00 58.00 06000 LABORATORY 0 60 00 60 00 65.00 06500 RESPIRATORY THERAPY 0 65.00 66.00 06600 PHYSI CAL THERAPY 0 66.00 06700 OCCUPATIONAL THERAPY 67.00 0 67.00 0 68.00 06800 SPEECH PATHOLOGY 68.00 69.00 06900 ELECTROCARDI OLOGY 0 69.00 07000 ELECTROENCEPHALOGRAPHY 0 70.00 70.00 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72 00 Ω 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 1, 252 73.00 07301 DI ABETES CENTER 73.01 73.01 0 07400 RENAL DIALYSIS 74.00 0 74.00 03480 ONCOLOGY 76.00 0 76.00 76. 01 03952 ANTI COAGULATI ON 0 76.01 03951 INFUSION SERVICES 76. 02 0 76.02 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 76.98 77.00 07700 ALLOGENEIC STEM CELL ACQUISITION 0 77 00 07800 CAR T-CELL IMMUNOTHERAPY 78.00 78.00 0 OUTPATIENT SERVICE COST CENTERS 0 90.00 09000 CLINIC 90.00 0 09001 CLINIC - OUTPATIENT INFUSION SERVICE 90. 01 0 90.01 09002 CLINIC - HOME INF PHARMACOTHERAPY 0 90. 02 0 0 90.02 09100 EMERGENCY 91.00 0 91.00 04950 WOUND CARE 91.01 0 91.01 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0 92.00 09201 OBSERVATION BEDS (DISTINCT PART) 0 92.01 92.01 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0 95.00 0 200.00 Subtotal (see instructions) 1, 252 200.00 Less PBP Clinic Lab. Services-Program 201.00 201.00 Only Charges 0 202.00 202.00 Net Charges (line 200 - line 201) 1, 252

	Financial Systems TIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider Component		Period: From 01/01/2023 To 12/31/2023	Worksheet D Part II Date/Time Pre 3/28/2024 12:	pared: 04 pm
			Title	: XVIII	Subprovider -	PPS	
	Cost Center Description	Capi tal	Total Charges			Capital Costs	
		Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
		(from Wkst. B,		(col. 1 ÷ col	. Charges	column 4)	
		Part II, col.	8)	2)			
		26)					
	T	1. 00	2.00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50. 00	05000 OPERATING ROOM	2, 566, 241				3, 778	
51. 00	05100 RECOVERY ROOM	172, 018				142	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	2, 595, 766				0	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	1, 185, 934				762	
55. 00	05500 RADI OLOGY - THERAPEUTI C	202, 875				374	
56. 00	05600 RADI 01 SOTOPE	30, 290				49	
56. 01	03950 CARDI AC CATH LAB	655, 979				16	
57. 00	05700 CT SCAN	105, 232				66	
58. 00	05800 MRI	67, 633				63	
60. 00	06000 LABORATORY	546, 150				1, 352	
65. 00	06500 RESPI RATORY THERAPY	248, 371				3, 513	
66. 00	06600 PHYSI CAL THERAPY	180, 239		•		9, 790	
67. 00	06700 OCCUPATI ONAL THERAPY	52, 317				4, 023	
68. 00	06800 SPEECH PATHOLOGY	28, 408				1, 291	68.00
69. 00	06900 ELECTROCARDI OLOGY	502, 885	43, 073, 907	0. 01167	75 41, 552	485	69.00
70. 00	07000 ELECTROENCEPHALOGRAPHY	234, 749				0	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	293, 593	160, 556, 594			613	71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	235, 409	126, 414, 414			585	
73. 00	07300 DRUGS CHARGED TO PATIENTS	824, 370	226, 955, 190	0. 00363	534, 149	1, 940	73.00
73. 01	07301 DI ABETES CENTER	401, 338		825. 79835	0	0	73. 0°
74. 00	07400 RENAL DIALYSIS	111, 804	5, 970, 694	0. 01872	72, 936	1, 366	74.00
76. 00	03480 ONCOLOGY	1, 464, 626				579	1
76. 01	03952 ANTI COAGULATI ON	116, 392				0	
76. 02	03951 I NFUSI ON SERVI CES	441				0	
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0			0	
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION	0				0	
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	0.00000	00	0	78.00
	OUTPATIENT SERVICE COST CENTERS				_		
90. 00	09000 CLI NI C	76, 500				0	1
90. 01	09001 CLINIC - OUTPATIENT INFUSION SERVICE	20, 825	11, 513, 504			3	
90. 02	09002 CLINIC - HOME INF PHARMACOTHERAPY	1	142			0	
91. 00	09100 EMERGENCY	1, 392, 896				339	
91. 01	04950 WOUND CARE	392, 870				0	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	, ,			0	92.00
92. 01	09201 OBSERVATION BEDS (DISTINCT PART)	350, 036	5, 329, 625	0. 06567	7 18, 100	1, 189	92. 01
	OTHER REIMBURSABLE COST CENTERS						
95. 00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50 through 199)		1, 558, 378, 725		5, 642, 121		200.00

Health Financial Sys		FRANCISCAN HEAL				u of Form CMS-	2552-10
	PATIENT/OUTPATIENT ANCILLARY S	ERVICE OTHER PASS	S Provider C	CN: 15-0109	Peri od:	Worksheet D	
THROUGH COSTS			Component	CCN: 15-T109	From 01/01/2023 To 12/31/2023	Part IV Date/Time Pre 3/28/2024 12:	
			Ti tl e	xVIII	Subprovi der - I RF	PPS	
Cost Ce	nter Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
		Anesthetist	Program	Program	Post-Stepdown		
		Cost	Post-Stepdown		Adjustments		
		1.00	Adjustments 2A	2.00	3A	3. 00	
ANCILLARY SEE	VICE COST CENTERS	1.00	ZA.	2.00	JA JA	3.00	
50. 00 05000 OPERATI		0	0	10, 4	06 0	0	50.00
51. 00 05100 RECOVER		0	0	10, 1	0 0	0	
	Y ROOM & LABOR ROOM	0	0	500, 8		0	
	GY-DI AGNOSTI C	0	0	44, 2		Ö	
	GY - THERAPEUTI C	0	0	, =	0 0	0	
56. 00 05600 RADI 0I S		0	0	113, 1	69 0	0	
56. 01 03950 CARDI AC		0	0	222, 4		0	
57. 00 05700 CT SCAN		0	0	, .	0	0	
58. 00 05800 MRI		0	0		0 0	0	
60. 00 06000 LABORAT	ORY	0	0		0 0	0	60.00
65. 00 06500 RESPI RA	TORY THERAPY	0	0		0 0	0	65.00
66. 00 06600 PHYSI CA	L THERAPY	0	0	93, 6	58 0	0	66. 00
67. 00 06700 OCCUPAT	I ONAL THERAPY	0	0		0 0	0	67.00
68. 00 06800 SPEECH	PATHOLOGY	0	0		0 0	0	68.00
69. 00 06900 ELECTRO	CARDI OLOGY	0	0		0 0	0	69.00
70. 00 07000 ELECTRO	ENCEPHALOGRAPHY	0	0		0 0	0	70.00
	SUPPLIES CHARGED TO PATIENT	0	0		0 0	0	71.00
72.00 07200 IMPL. D	EV. CHARGED TO PATIENTS	0	0		0 0	0	72.00
	HARGED TO PATIENTS	0	0		0 0	263, 457	
73. 01 07301 DI ABETE		0	0		0 0	0	
74.00 07400 RENAL D		0	0		0 0	0	
76.00 03480 ONCOLOG		0	0		0 0	0	1
76. 01 03952 ANTI COA		0	0		0 0	0	
76. 02 03951 I NFUSI 0		0	0		0 0	0	
	RIC OXYGEN THERAPY	0	0		0 0	0	1
	EIC STEM CELL ACQUISITION	0	0		0 0	0	
	ELL IMMUNOTHERAPY	0	0		0 0	0	78.00
	RVICE COST CENTERS			1 22 4	14 0	0	90.00
	- OUTPATIENT INFUSION SERVICE	0	0		0 0	0	
	- HOME INF PHARMACOTHERAPY	0	0		0 0	0	
91. 00 09100 EMERGEN		0	0	1, 321, 6	0	134, 711	
91. 00 09100 EMERGEN 91. 01 04950 WOUND (0	0	1, 321, 0		134, 711	
	TION BEDS (NON-DISTINCT PART	0	١	113, 1	0	0	
	TION BEDS (NON-DISTINCT PART)	0	0		0 0	0	
	SABLE COST CENTERS			L	0		72.01
95. 00 09500 AMBULAN							95.00
, 5. 55 0 / 000 / IIII DOL/III	02 02 020	1		I .			, , , , , , ,

Heal th	Financial Systems	FRANCISCAN HEA	LTH LAFAYETTE		In Lie	eu of Form CMS-:	2552-10
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF H COSTS	RVICE OTHER PAS		CN: 15-0109 CCN: 15-T109	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Pre	pared:
			,			3/28/2024 12:	04 pm
			Title	xVIII	Subprovi der - I RF	PPS	
	Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
		Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
		Education Cost		Cost (sum of		(col. 5 ÷ col.	
			4)	col s. 2, 3,	8)	7)	
				and 4)		(see	
			5.00		7.00	instructions)	
	ANOULLARY CERVICE COCT CENTERS	4. 00	5. 00	6. 00	7. 00	8. 00	
F0 00	ANCILLARY SERVICE COST CENTERS		10.407	10.40		0.00000	
50.00	05000 OPERATING ROOM	0				0.000038	
51.00	05100 RECOVERY ROOM	0	1		0 33, 016, 513	l	1
52.00	05200 DELIVERY ROOM & LABOR ROOM	0				l e	
54. 00	05400 RADI OLOGY - DI AGNOSTI C	0	44, 227	1		l	
55. 00	05500 RADI OLOGY - THERAPEUTI C	0	0		0 14, 439, 163	l .	
56.00	05600 RADI OI SOTOPE	0				0.007466	
56. 01	03950 CARDI AC CATH LAB	0	222, 437	1		0.004233	
57. 00	05700 CT SCAN	0	1	1	0 60, 719, 871	0.000000	
58. 00	05800 MRI	0	0	1	0 10, 409, 651	0.000000	
60.00	06000 LABORATORY	0	0		0 124, 235, 473		
65. 00	06500 RESPI RATORY THERAPY	0			0 16, 717, 884		
66.00	06600 PHYSI CAL THERAPY	0		93, 65			
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY		0		0 17, 166, 723	•	
69.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY		0		0 7, 517, 268 0 43, 073, 907	0. 000000 0. 000000	
70.00	07000 ELECTROENCEPHALOGRAPHY		0			0.00000	
70.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT				0 5, 992, 304 0 160, 556, 594		
71.00	07200 IMPL. DEV. CHARGED TO PATIENTS					1	1
73. 00	07300 DRUGS CHARGED TO PATIENTS			l .	,,		
73. 00	07301 DI ABETES CENTER		203, 457		0 486	0.00000	1
74. 00	07400 RENAL DI ALYSI S				0 5, 970, 694	l	•
76. 00	03480 ONCOLOGY		1		0 27, 885, 647	0.00000	
76. 00 76. 01	03952 ANTI COAGULATI ON	0	0		0 918, 206	0.00000	
76. 01	03951 I NFUSION SERVICES				0 463, 609	0.000000	
76. 02	07698 HYPERBARI C OXYGEN THERAPY		ı		0 403, 609	0.000000	
77. 00	07700 ALLOGENEIC STEM CELL ACQUISITION			•	0 0	0.000000	
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	-		0 0	0. 000000	
70.00	OUTPATIENT SERVICE COST CENTERS				0	0.000000	70.00
90.00	09000 CLINIC	0	23, 414	23, 41	4 2, 031, 482	0. 011526	90.00
90. 00	09001 CLINIC - OUTPATIENT INFUSION SERVICE				0 11, 513, 504	l	
90. 02	09002 CLINIC - HOME INF PHARMACOTHERAPY	0	-	1	0 11, 313, 304	0. 000000	
91. 00	09100 EMERGENCY	0				l	
91. 01	04950 WOUND CARE	Ö	.,,			l	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	Ö		1	0 10, 803, 240	l .	1
92. 01	09201 OBSERVATION BEDS (DISTINCT PART)	Ö	-		0 5, 329, 625		
	OTHER REIMBURSABLE COST CENTERS				2,02,,320		1
95.00	09500 AMBULANCE SERVI CES						95. 00
200.00		0	2, 841, 068	2, 841, 06	8 1, 558, 378, 725		200.00
	, , , , , , , , , , , , , , , , , , , ,	•				•	•

Cost (col x col . 10		eri od:	Worksheet D	
Cost Center Description		rom 01/01/2023 o 12/31/2023		
Ratio of Cost To Charges (col. 6 + col. 7) Program Pass-Thron (Costs (col. x col. 16 + col. 7)		Subprovi der - I RF	PPS	
To Charges		Outpati ent	Outpati ent	
Cost (col x col . 10		Program	Program	
ANCILLARY SERVICE COST CENTERS 9.00 10.00 11.00		Charges before		
ANCILLARY SERVICE COST CENTERS			on/after Geo	
ANCILLARY SERVICE COST CENTERS))	Recl assi fi cati		
ANCI LLARY SERVICE COST CENTERS 0.000058		on 12. 00	on 12. 01	
50. 00 05000 OPERATI NG ROOM 0.000038 402, 986 51. 00 05100 RECOVERY ROOM 0.000000 27, 333 52. 00 05200 DELI VERY ROOM & LABOR ROOM 0.000402 70, 692 55. 00 05500 RADI OLOGY - DI AGNOSTI C 0.000000 26, 632 56. 00 05500 RADI OLOGY - THERAPEUTI C 0.000000 26, 632 56. 00 05600 RADI OLOGY - THERAPEUTI C 0.000000 26, 632 56. 00 05600 RADI OLOGY - THERAPEUTI C 0.000000 26, 632 57. 00 075700 CT SCAN 0.000000 37, 930 57. 00 05700 CT SCAN 0.000000 37, 930 58. 00 05800 MRI 0.000000 9, 752 60. 00 06600 LABORATORY 0.000000 307, 527 65. 00 06600 RESPI RATORY THERAPY 0.000000 236, 422 66. 00 06600 PHYSI CAL THERAPY 0.000000 236, 422 66. 00 06600 PHYSI CAL THERAPY 0.000000 1, 319, 980 68. 00 06700 0CCUPATI ONAL THERAPY 0.000000 341, 683 69. 00 06900 ELECTROCARDI OLOGY 0.000000 341, 683 69. 00 06900 ELECTROCARDI OLOGY 0.000000 335, 343 343 343 343 344 683 69. 00 07000 ELECTROCARDI OLOGY 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.0000000 0.0000000 0.00000000		12.00	12.01	
51. 00 05100 RECOVERY ROOM 0.000000 27, 333 0 0 0 0 0 0 0 0 0	15	0	0	50.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM 0.034435 0 54. 00 05400 RADI OLOGY - DI AGNOSTI C 0.000402 70, 692 55. 00 05500 RADI OLOGY - THERAPEUTI C 0.000000 26, 632 56. 00 05600 RADI OI SOTOPE 0.007466 24, 548 56. 01 03950 CARDI AC CATH LAB 0.00233 1, 285 57. 00 05700 CT SCAN 0.000000 37, 930 58. 00 05800 MRI 0.000000 9, 752 60. 00 06600 LABORATORY 0.000000 236, 422 65. 00 06500 RESPI RATORY THERAPY 0.000000 236, 422 66. 00 06600 PHYSI CAL THERAPY 0.003459 1, 470, 603 5, 67. 00 06700 OCCUPATI ONAL THERAPY 0.000000 1, 319, 980 68. 00 06800 SPEECH PATHOLOGY 0.000000 41, 683 69. 00 06900 ELECTROCARDI OLOGY 0.000000 41, 552 70. 00 070	0			
54. 00	0	_	_	
55. 00	28		l .	
56. 00	0		ļ	
56. 01 03950 CARDI AC CATH LAB 0.004233 1, 285 57. 00 05700 CT SCAN 0.000000 37, 930 58. 00 05800 MRI 0.000000 9, 752 60. 00 06000 LABORATORY 0.000000 307, 527 65. 00 06500 RESPI RATORY THERAPY 0.000000 236, 422 66. 00 06600 PHYSI CAL THERAPY 0.003459 1, 470, 603 5, 67. 00 06700 OCCUPATI ONAL THERAPY 0.000000 1, 319, 980 68. 00 06800 SPEECH PATHOLOGY 0.000000 341, 683 69. 00 06900 ELECTROCARDI OLOGY 0.000000 41, 552 70. 00 07000 ELECTROENCEPHALOGRAPHY 0.000000 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.000000 314, 232 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0.00161 534, 149 73. 01 10 JABETES CENTER 0.000000 0 74. 00 07400 RENAL DI ALYSI S 0.000000 1,000000 76. 01 <td< td=""><td>183</td><td></td><td> </td><td></td></td<>	183			
57. 00 05700 CT SCAN 0.000000 37, 930 58.00 05800 MRI 0.000000 9, 752 66.00 06000 LABORATORY 0.000000 307, 527 65.00 06500 RESPI RATORY THERAPY 0.000000 236, 422 66.00 06600 PHYSI CAL THERAPY 0.003459 1, 470, 603 5, 67.00 06700 OCCUPATI ONAL THERAPY 0.000000 1, 319, 980 68.00 06800 SPEECH PATHOLOGY 0.000000 311, 683 69.00 06900 ELECTROCARDI OLOGY 0.000000 41, 552 70.00 07000 ELECTROCARDI OLOGY 0.000000 41, 552 70.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 335, 343 72.00 07200 IMPL. DEV. CHARGED TO PATI ENT 0.000000 314, 232 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 314, 232 73.01 07301 DI ABETES CENTER 0.000000 72, 936 74.00 07400 RENAL DI ALYSI S 0.000000 72, 936 76.00 03480 ONCOLOGY 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000	5		_	
58. 00	0		ļ	
60. 00	0			
65. 00	0			
66. 00	0		_	
67. 00	087	_	_	
68. 00	0			
69. 00	0	0		
70. 00 07000 ELECTROENCEPHALOGRAPHY 0. 000000 0 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0. 000000 335, 343 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0. 000000 314, 232 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 001161 534, 149 73. 01 07301 DI ABETES CENTER 0. 000000 0 74. 00 07400 RENAL DI ALYSI S 0. 000000 72, 936 76. 00 03480 ONCOLOGY 0. 000000 11, 030 76. 01 03952 ANTI COAGULATI ON 0. 000000 0 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0. 000000 0 77. 00 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON 0. 000000 0 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0. 000000 0 90. 01 09001 CLI NI C 0. 011526 0 90. 02 O9002 CLI NI C - 0. 011526 0 90. 01 <t< td=""><td>0</td><td></td><td></td><td></td></t<>	0			
71. 00	0	0	0	70.00
72. 00	0			
73. 00	0	0	0	72.00
73. 01	620	0	0	73.00
74. 00	0	0	0	73. 01
76. 01 03952 ANTI COAGULATI ON 0. 000000 0 76. 02 03951 I NFUSI ON SERVI CES 0. 000000 0 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0. 000000 0 77. 00 07700 ALLOGENEI C STEM CELL ACQUI SI TI ON 0. 000000 0 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0. 000000 0 0UTPATI ENT SERVI CE COST CENTERS 90. 00 09000 CLI NI C 0. 011526 0 90. 01 09001 CLI NI C - 0UTPATI ENT I NFUSI ON SERVI CE 0. 000000 1, 603 90. 02 09002 CLI NI C - HOME INF PHARMACOTHERAPY 0. 000000 0 91. 00 09100 EMERGENCY 0. 000909 35, 803 91. 01 04950 WOUND CARE 0. 018438 0 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0. 000000 0 92. 01 09201 OBSERVATI ON BEDS (DI STI NCT PART) 0. 000000 18, 100	0	0	0	74.00
76. 02 03951	0	0	0	76.00
76. 98 07698 HYPERBARI C OXYGEN THERAPY 0. 000000 0 0 0 0 0 0 0	0	0	0	76. 01
77. 00	0	0	0	76. 02
78. 00	0	0	0	76. 98
OUTPATIENT SERVICE COST CENTERS O. 011526 O	0	0	0	77. 00
90. 00 09000 CLINIC 0. 011526 0 09001 CLINIC - OUTPATIENT INFUSION SERVICE 0. 000000 1, 603 09002 CLINIC - HOME INF PHARMACOTHERAPY 0. 000000 0 091. 0	0	0	0	78. 00
90. 01				
90. 02	0			
91. 00	0		l .	
91. 01 04950 WOUND CARE 0. 018438 0	0	_	_	
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART 0.000000 0 092. 01 09201 0BSERVATI ON BEDS (DISTINCT PART) 0.000000 18, 100	355		1	
92. 01 09201 0BSERVATI ON BEDS (DI STINCT PART)	0		_	
	0			
	0	0	0	92. 01
OTHER REIMBURSABLE COST CENTERS		ı	1	05.66
95. 00 09500 AMBULANCE SERVICES 200. 00 Total (lines 50 through 199) 5,642,121 6,	293	0		95. 00 200. 00

ROUGH COSTS	SERVICE OTHER PASS		CN: 15-0109 CCN: 15-T109	Peri od: From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Prepare
		· ·	XVIII	Subprovi der -	3/28/2024 12: 04 p
				IRF	
Cost Center Description	Costs (col. 9 (x col. 12) before Geo Reclassificati R on	x col. 12) on/after Geo eclassificati on			
ANCI LLARY SERVI CE COST CENTERS	13.00	13. 01			
. 00 05000 OPERATING ROOM	0	0			50
. 00 05100 RECOVERY ROOM . 00 05200 DELIVERY ROOM & LABOR ROOM . 00 05400 RADI OLOGY-DI AGNOSTI C . 00 05500 RADI OLOGY - THERAPEUTI C	0 0	0 0			51. 52. 54.
. 00 05600 RADI OI SOTOPE . 01 03950 CARDI AC CATH LAB . 00 05700 CT SCAN . 00 05800 MRI	0 0 0	0 0 0 0			56 56 57 58
. 00 06000 LABORATORY . 00 06500 RESPI RATORY THERAPY . 00 06600 PHYSI CAL THERAPY . 00 06700 OCCUPATI ONAL THERAPY	0 0 0	0 0 0			60 65 66 67
. 00 06800 SPEECH PATHOLOGY . 00 06900 ELECTROCARDI OLOGY . 00 07000 ELECTROENCEPHALOGRAPHY . 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI EN	0 0	0 0 0			68 69 70 71
. 00	0 0	0 0 0 0			72 73 73 74
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From 01/01/2023 Part V Date/Time Prepared: 12/31/2023 3/28/2024 12:04 pm Title XIX Hospi tal Cost Charges Costs Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Ratio From Services (see Rei mbursed Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Part I, col. 9 Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 1. 00 2.00 5. 00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0.060814 22, 524, 486 0 50.00 51.00 05100 RECOVERY ROOM 0.049010 0 0 0 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 52 00 0.872582 0 18 003 52 00 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.125343 0 12, 333, 570 0 54.00 05500 RADI OLOGY - THERAPEUTI C 0.095890 3, 180, 483 0 55.00 1, 152, 686 56.00 05600 RADI OI SOTOPE 0.075441 56.00 0 03950 CARDIAC CATH LAB 56.01 0.108699 C 0 56.01 57.00 05700 CT SCAN 0.034910 0 57.00 58.00 05800 MRI 0.093338 0 0 58.00 06000 LABORATORY 0 139800 17, 846, 969 60 00 60 00 0 06500 RESPIRATORY THERAPY 65.00 0. 252944 342, 280 0 65.00 06600 PHYSI CAL THERAPY 0. 236858 3, 244, 335 0 66.00 66.00 06700 OCCUPATIONAL THERAPY 0.154626 2, 665, 759 67.00 67.00 0 68.00 06800 SPEECH PATHOLOGY 2, 416, 415 0.165502 0 68 00 69.00 06900 ELECTROCARDI OLOGY 0.112350 0 3, 846, 865 0 69.00 07000 ELECTROENCEPHALOGRAPHY 0. 277955 70.00 70.00 1,062,231 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 10, 733, 862 71.00 0.166831 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72 00 0.170133 6, 525, 523 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0. 183745 21, 916, 035 0 73.00 07301 DI ABETES CENTER 6, 344. 983539 73.01 73.01 C 0 07400 RENAL DIALYSIS 1, 481, 006 74.00 0.366961 0 74.00 03480 ONCOLOGY 76.00 0.306353 0 0 76.00 03952 ANTI COAGULATI ON 0.772072 0 0 0 76.01 76.01 76. 02 03951 INFUSION SERVICES 0.033213 0 0 0 76.02 07698 HYPERBARI C OXYGEN THERAPY 0 0 76.98 0.000000 0 76.98 0 77.00 07700 ALLOGENEIC STEM CELL ACQUISITION 0.000000 0 0 77 00 07800 CAR T-CELL IMMUNOTHERAPY 0.000000 0 0 78.00 78.00 0 OUTPATIENT SERVICE COST CENTERS 0 90 00 09000 CLINIC 0.889244 90.00 430.464 0 90.01 09001 CLINIC - OUTPATIENT INFUSION SERVICE 0.083086 0 1, 880, 617 0 90.01 09002 CLINIC - HOME INF PHARMACOTHERAPY 90. 02 0. 985915 0 C 0 0 0 90.02 09100 EMERGENCY 45, 968, 906 91.00 91.00 0.112284 0 0 91.01 04950 WOUND CARE 0.348864 0 0 91.01 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.524612 0 2, 158, 038 0 0 92.00 09201 OBSERVATION BEDS (DISTINCT PART) 0.717824 0 92.01 92.01 0 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0.000000 0 95.00 200.00 Subtotal (see instructions) 161, 728, 533 0 0 200. 00 Less PBP Clinic Lab. Services-Program o 201.00 201.00 Only Charges

161, 728, 533

0 202.00

0

202.00

Net Charges (line 200 - line 201)

Health Financial Systems	FRANCI SCAN HEALTH	LAFAYETTE	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0109	Peri od: From 01/01/2023	Worksheet D

12/31/2023 Date/Time Prepared: 3/28/2024 12:04 pm Title XIX Hospi tal Cost Costs 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 OPERATING ROOM 1, 369, 804 0 50.00 51.00 05100 RECOVERY ROOM 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 15, 709 0 52 00 52 00 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 1,545,927 54.00 55.00 05500 RADI OLOGY - THERAPEUTI C 304, 977 0 55.00 56.00 05600 RADI OI SOTOPE 86, 960 0 56.00 03950 CARDIAC CATH LAB 0 56.01 0 56.01 57.00 05700 CT SCAN 0 0 57.00 05800 MRI 0 58.00 0 58.00 06000 LABORATORY 2, 495, 006 0 60 00 60 00 65.00 06500 RESPIRATORY THERAPY 86, 578 0 65.00 66.00 06600 PHYSI CAL THERAPY 768, 447 0 66.00 06700 OCCUPATIONAL THERAPY 67.00 412, 196 0 67.00 0 68.00 06800 SPEECH PATHOLOGY 399, 922 68.00 69.00 06900 ELECTROCARDI OLOGY 432, 195 0 69.00 07000 ELECTROENCEPHALOGRAPHY 295, 252 70.00 70.00 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 1, 790, 741 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72 00 1, 110, 207 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 4, 026, 962 0 73.00 07301 DI ABETES CENTER 0 73.01 73.01 07400 RENAL DIALYSIS 543, 471 0 74.00 74.00 0 03480 ONCOLOGY 76.00 0 76.00 76. 01 03952 ANTI COAGULATI ON 0 0 76.01 03951 INFUSION SERVICES 0 0 76. 02 76.02 0 07698 HYPERBARI C OXYGEN THERAPY 0 76.98 76.98 0 77.00 07700 ALLOGENEIC STEM CELL ACQUISITION 0 77 00 07800 CAR T-CELL IMMUNOTHERAPY 0 78.00 78.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLINIC 382, 788 90.00 0 90.01 09001 CLINIC - OUTPATIENT INFUSION SERVICE 156, 253 0 90.01 09002 CLINIC - HOME INF PHARMACOTHERAPY 0 90. 02 90.02 09100 EMERGENCY 91.00 0 91.00 5, 161, 573 91.01 04950 WOUND CARE 0 91.01 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 1, 132, 133 0 92.00 92.01 09201 OBSERVATION BEDS (DISTINCT PART) 0 92.01 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00 200.00 Subtotal (see instructions) 22, 517, 101 0 200.00 Less PBP Clinic Lab. Services-Program 201.00 201.00 Only Charges 202.00 202.00 Net Charges (line 200 - line 201) 22, 517, 101 0

Health Financial Systems	FRANCISCAN HEALTH LAFAYETTE	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0109	Peri od: From 01/01/2023	Worksheet D-1	
		To 12/31/2023	Date/Time Pre 3/28/2024 12:	
	Title XVIII	Hospi tal	PPS	
Cost Center Description				
			1. 00	
PART I - ALL PROVIDER COMPONENTS				

BART All PROFIDE CORPOWNINS			Title XVIII	Hospi tal	PPS	
PART 1 - ALL PROVIDER COMPONENTS		Cost Center Description			1 00	
IMPATEENT DAYS		PART I - ALL PROVIDER COMPONENTS			1.00	
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34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 43, 810, 898 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		, , , , , , , , , , , , , , , , , , , ,				
35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 43, 810, 898 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 0.00 35.00 43,810,898 37.00 1,217.51 38.00 10,201,516 39.00						
36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 43, 810, 898 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 36.00 43,810,898 47.00 47.00 48.00 49.00				tions)		
37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 23, 810, 898 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38. 00 Adjusted general inpatient routine service cost per diem (see instructions) 39. 00 Program general inpatient routine service cost (line 9 x line 38) 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40. 00 40. 00			ne 31)			
27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00		,			-	
PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00	37. 00		and private room cost dit	ferential (line	43, 810, 898	37. 00
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00		PART II - HOSPITAL AND SUBPROVIDERS ONLY				
38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,217.51 38.00 Program general inpatient routine service cost (line 9 x line 38) 10,201,516 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00			JSTMENTS			
39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 10,201,516 39.00 0 40.00	38. 00				1, 217, 51	38, 00
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00		,	*			
41.00 Total Program general inpatient routine service cost (line 39 + line 40) 10,201,516 41.00			•			
	41. 00	Total Program general inpatient routine service cost (line 39	+ line 40)		10, 201, 516	41. 00

	Financial Systems ATION OF INPATIENT OPERATING COST	FRANCISCAN HEALT	H LAFAYETTE Provi der CCN:	15-0109	In Lie Period:	u of Form CMS-2 Worksheet D-1	2552-10
20mi 01					From 01/01/2023 To 12/31/2023	Date/Time Prep 3/28/2024 12:0	
	Cost Center Description	Total Inpatient Costl	Title XV Total A npatient Days Die	Average Per	Hospi tal Program Days	PPS Program Cost (col. 3 x col. 4)	
42.00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4. 00 0 0	5. 00 0	42. 00
	Intensive Care Type Inpatient Hospital Units						
43. 00 44. 00 45. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT	10, 418, 821	4, 449	2, 341. 8	3 2, 579	6, 039, 580	44. 00 45. 00
46. 00 47. 00	SURGICAL INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE UNIT Cost Center Description	4, 555, 813	2, 813	1, 619. 5	6 0		46. 00 47. 00
48. 00	Program inpatient ancillary service cost (Wk	st D-3 col 3	line 200)			1. 00 21, 194, 719	48. 00
48. 01 49. 00	Program inpatient cellular therapy acquisiti Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	on cost (Workshe	et D-6, Part III		column 1)	0 37, 435, 815	48. 01
50. 00	Pass through costs applicable to Program inp	atient routine s	ervices (from Wi	kst. D, sum	of Parts I and	1, 935, 641	50. 00
51. 00	Pass through costs applicable to Program inpland IV)	atient ancillary	services (from	Wkst. D, s	um of Parts II	1, 301, 679	51. 00
52. 00 53. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		ated, non-physic	cian anesth	etist, and	3, 237, 320 34, 198, 495	•
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					
54.00	, 9					0	
55. 00 55. 01	Target amount per discharge Permanent adjustment amount per discharge					0. 00 0. 00	
55. 02	Adjustment amount per discharge (contractor					0. 00	•
56.00	Target amount (line 54 x sum of lines 55, 55		act consumt (line	o E/ minuo	lina E2)	0	
57. 00 58. 00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and tar	get amount (iine	e so illi rius	11 ne 53)	0	57. 00 58. 00
59. 00	Trended costs (lesser of line 53 ÷ line 54,		the cost reporti	ing period	endi ng 1996,	0. 00	
60. 00	updated and compounded by the market basket) Expected costs (lesser of line 53 ÷ line 54,	0.00	60. 00				
61. 00	market basket) 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 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise						61. 00
62. 00 63. 00	enter zero. (see instructions) Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ent (see instruc	tions)			0	1
	PROGRAM INPATIENT ROUTINE SWING BED COST	·	,	++:			
64. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos					0	64. 00 65. 00
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi					0	
67. 00	CAH, see instructions Title V or XIX swing-bed NF inpatient routin	·			3,	0	
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	· ·				0	
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N	•				0	69. 00
70.00	Skilled nursing facility/other nursing facil	ity/ICF/IID rout	ine service cos				70.00
71. 00 72. 00	Adjusted general inpatient routine service c Program routine service cost (line 9 x line		ne /u ÷ line 2)				71. 00 72. 00
73. 00	Medically necessary private room cost applic	able to Program		35)			73. 00
74. 00 75. 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient 26, line 45)			ksheet B, P	art II, column		74. 00 75. 00
76. 00	Per diem capital-related costs (line 75 ÷ li						76. 00
77.00	Program capital -related costs (line 9 x line						77.00
78. 00 79. 00	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces	.*	ovi der records)				78. 00 79. 00
80.00	Total Program routine service costs for comp	arison to the co		line 78 min	us line 79)		80.00
81.00	Inpatient routine service cost per diem limi						81.00
82. 00 83. 00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (82. 00 83. 00
84. 00	Program inpatient ancillary services (see in		7				84. 00
85. 00	Utilization review - physician compensation	(see instruction					85. 00
86. 00	Total Program inpatient operating costs (sum		ough 85)				86. 00
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions					4, 655	87. 00
88. 00	Adjusted general inpatient routine cost per	diem (line 27 ÷	line 2)			1, 217. 51	88. 00
89.00	Observation bed cost (line 87 x line 88) (se	e instructions)				5, 667, 509	89.00

Health Financial Systems	FRANCI SCAN HEAL	_TH_LAFAYETTE		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2023 To 12/31/2023		
		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	3, 299, 105	43, 810, 898	0. 07530	5, 667, 509	426, 780	90.00
91.00 Nursing Program cost	1, 705, 347	43, 810, 898	0. 03892	5, 667, 509	220, 608	91.00
92.00 Allied health cost	0	43, 810, 898	0.00000	5, 667, 509	0	92.00
93.00 All other Medical Education	0	43, 810, 898	0.00000	5, 667, 509	0	93.00

Health Financial Systems	FRANCISCAN HEALTH LAFAYETTE	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0109	Peri od: From 01/01/2023	Worksheet D-1
	Component CCN: 15-T109	To 12/31/2023	Date/Time Prepared: 3/28/2024 12:04 pm
	Title XVIII	Subprovi der -	PPS

Inpartient days (Including private room days, excluding sating-bed and newborn days) 2,848 2,00			II the Aviii	I RF	FF3		
INPACT ALL PROVIDER COMPONENTS		Cost Center Description					
INPATIENT DAYS		DADT I ALL DDOVIDED COMPONENTS			1. 00		
Inpatient days (including private room days, and swing-bed days, excluding newborn) 2,848 2.00							
Derivate room days (excluding swing-bed and observation bed days). If you have only private room days. do not complete this line. do not complete this line. 3.00 Semi-private room days (excluding swing-bed and observation bed days). To complete the swing-bed SW type inpatient days (including private room days) through December 31 of the cost reporting period (if call endary year, enter 0 on this line). 1.01 Total swing-bed SW type inpatient days (including private room days) after December 31 of the cost reporting period (if call endary year, enter 0 on this line). 1.02 Iotal swing-bed W type inpatient days (including private room days) after December 31 of the cost reporting period (if call endary year, enter 0 on this line). 1.03 Iotal swing-bed W type inpatient days (including private room days) after December 31 of the cost reporting period (if call endary year, enter 0 on this line). 1.04 Iotal swing-bed W type inpatient days applicable to the Program (excluding swing-bed and nextorn days) (see instructions) with the cost reporting period (it to will not yeith the cost reporting period (it to will not yeith the cost incomplete and yeith the cost in the cost reporting period (it call endary year, enter 0 on this line). 1.05 Swing-bed SW type inpatient days applicable to title XVII and yi (including private room days) after line will not yeith the cost reporting period (it call endary year, enter 0 on this line). 1.05 Swing-bed SW type inpatient days applicable to title XVII and yeith (including private room days). 1.06 Swing-bed SW type inpatient days applicable to title XVII and yeith (including private room days). 1.07 Swing-bed SW type inpatient days applicable to title XVII and yeith (including private room days). 1.08 Swing-bed SW type inpatient days applicable to title XVII and yeith (including private room days). 1.09 Swing-bed SW type inpatient days applicable to title XVII and yeith (including private room days). 1.00 Swing-bed Not type inpatient days applicable to title XVII and yei	1.00	Inpatient days (including private room days and swing-bed days			2, 848	1. 00	
do not complete finis line. 4. 05 Seim-privater room days (excluding swing-bed and observation bod days) 1. 10 Total swing-bed SW type inpatient days (including private room days) after December 31 of the cost paper ling period (if calendar year, enter 0 on this line) 7. 00 Total swing-bed W type inpatient days (including private room days) after December 31 of the cost paper ling period (if calendar year, enter 0 on this line) 7. 00 Total swing-bed W type inpatient days (including private room days) after December 31 of the cost paper line and the							
Semi-peri vate room days (excluding swing-bed and observation bed days) 5.00 Total swing-bed SNF type inpatient days (including private room days) through December 31 or the cost or reporting period (in claim and the cost of the cost	3.00		ys). If you have only pri	vate room days,	0	3. 00	
Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7.00 7.0	4.00		ed days)		2. 848	4. 00	
1 Total swing-bed SNF type Inpatient days (Including private room days) after becember 31 of the cost reporting period (Ir Calendar year, enter 0 on this line) 1 Total swing-bed NF type inpatient days (Including private room days) after becember 31 of the cost reporting period (Ir Calendar year, enter 0 on this line) 1 Total inpatient days (Including private room days) after becember 31 of the cost reporting period (Ir Calendar year, enter 0 on this line) 1 Total inpatient days including private room days apricable to the Program (excluding swing-bed and newborn days) (see Instructions) 2 No Swing-bed SNF type inpatient days applicable to 11th eXVIII only (Including private room days) after becember 31 of the cost reporting period (See Instructions) 2 No Swing-bed SNF type inpatient days applicable to 11th eXVIII only (Including private room days) after becember 31 of the cost reporting period (Ir Calendar year, enter 0 on this line) 3 No Swing-bed MF type inpatient days applicable to 11th s VIII only (Including private room days) 3 No Swing-bed MF type inpatient days applicable to 11th s VIII only (Including private room days) 3 No Swing-bed MF type inpatient days applicable to 11th s VIII only (Including private room days) 4 No Swing-bed MF type inpatient days applicable to 11th s VIII only (Including private room days) 4 No Swing-bed MF type inpatient days applicable to 11th s VIII only (Including private room days) 5 No Total nursery days (Itile V or XIX only) 6 No Medically necessary private room days applicable to 11th s VIII only (Including private room days) 7 No No Medically necessary private room days applicable to 11th s VIII only (Including private room days) 8 No				31 of the cost		5. 00	
reporting period (if calendar year, enter 0 on this line) 7. 00 Total swing-bed Mi Type Inpatient days (Including private room days) shrough December 31 of the cost reporting period (if calendar year, enter 0 on this line) 8. 00 Total swing-bed Mi Type Inpatient days (Including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 8. 00 Swing-bed SMI type Inpatient days applicable to the Program (excluding swing-bed and newborn days) (see Instructions) 9. 00 Swing-bed SMI type Inpatient days applicable to title XVIII only (Including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 12. 00 Swing-bed SMI type Inpatient days applicable to title XVIII only (Including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 13. 00 Swing-bed MF type inpatient days applicable to titles V or XX only (Including private room days) 14. 00 Modically necessary private room days applicable to titles V or XX only (Including private room days) 15. 00 Total nursery days (title V or XX only) 16. 00 Nursery days (title V or XX only) 17. 00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 18. 00 Medically necessary private room days applicable to services through December 31 of the cost 19. 00 Medical private for swing-bed SMF services applicable to services through December 31 of the cost 19. 00 Medical frate for swing-bed SMF services applicable to services after December 31 of the cost 19. 00 Medical frate for swing-bed SMF services applicable to services through December 31 of the cost 19. 00 Medical frate for swing-bed SMF services applicable to services through December 31 of the cost 20. 00 Medical frate for swing-bed SMF services applicable to services through December 31 of the cost 20. 00 Medical frate for swing-bed SMF services after December 31 of the cost reporting period (line 5 x line 12) 20. 00 Swin	, 00						
Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period 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) No. 20	6.00		om days) after December .	31 of the cost	O	6.00	
Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if cal endar year, enter 0 on this line)	7. 00		n days) through December	31 of the cost	0	7. 00	
reporting period (if calendar year, énter 0 on this line) 9.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions) 10.00 Swing-bed SNR type inpatient days applicable to title XVIII only (including private room days) 11.00 Swing-bed SNR type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 12.00 Swing-bed Wif type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 13.00 Total nursery days (title V or XIX only) 14.00 Medically necessary private room days applicable to the Program (excluding private room days) 15.00 Total nursery days (title V or XIX only) 16.00 Nursery days (title V or XIX only) 17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period 18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 19.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 19.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (line system) 19.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (line system) 19.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line system) 19.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line system) 20.00 Medicare rate for swing-bed NF services after December 31 of the cost reporting period (line system) 20.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line system) 20.00 Swing-bed cost a		' " "	3 , 3				
1.500 0.00 1.500 1.500 0.00 1.500 0.00 1.500 0.00 1.500 0.00 1.500 0.00 1.500 0.00 1.500 0.00 1.500 0.00 1.500 1.500 0.00 1.500	8.00		n days) after December 3°	I of the cost	0	8. 00	
newborn days) (see Instructions) 10. 00 Swing-bed SNF type inpatient days applicable to attic XVIII only (including private room days) through December 31 of the cost reporting period (see instructions) 11. 00 Swing-bed SNF type inpatient days applicable to a title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 12. 00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 13. 00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 14. 00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 15. 00 Total numbery days (Title V or XIX only) 16. 00 Total numbery days (Title V or XIX only) 17. 00 Medicare rate for swing-bed SNF services applicable to be revices after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 18. 00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (in expery days) 19. 00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost on expering period (in experying period (in	9 00		the Program (excluding	swing-bed and	1 506	9 00	
through December 31 of the cost reporting period (see instructions) 1.00 Swing-bed SNT type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 14.00 Medical IV necessary private room days applicable to titles V or XIX only (including private room days) 15.00 I Total nursery days (title V or XIX only) 16.00 I Total nursery days (title V or XIX only) 17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (including private room days) 18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (including private room days) 19.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost opporting period (including private room days) 19.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost opporting period (including private room days) 19.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost opporting period (including private room days) 19.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost opporting period (including private room days applicable to services after December 31 of the cost reporting period (line of the period opporting period opporting period (including private room days applicable to SNF type services after December 31 of the cost reporting period (line of the period opporting period opporting period (including private room days applicable to SNF type services after December 31 of the cost reporting period (line of the period private private private private private private room days applicable	7. 00		o the riogram (exertaining	Swifing bed dild	1,000	7.00	
11.00 Swing-bed SNF type Inpatient days applicable to fittle XVIII only (Including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (Including private room days) 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (Including private room days) 14.00 Medically necessary private room days applicable to titles V or XIX only (Including private room days) 15.00 Norsery days (title V or XIX only) 16.00 Nursery days (title V or XIX only) 17.00 Nursery days (title V or XIX only) 18.00 SWING BED ADJUSTMENT 17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period 18.00 reporting period 19.00 Medical draft for swing-bed SNF services applicable to services after December 31 of the cost reporting period 19.00 Medical draft for swing-bed NF services applicable to services after December 31 of the cost reporting period 20.00 Medical draft for swing-bed NF services applicable to services after December 31 of the cost of reporting period 21.00 Total general inpatient routine service cost (see instructions) 22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 6 x I line 18) 23.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 6 x I line 18) 24.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 6 x I line 18) 25.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 x I line 18) 26.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x I line 18) 27.00 Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x I line 18) 28.00 Swing-bed cost applicable to NF type services after December 3	10.00			oom days)	0	10. 00	
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General inpatient routine service charges (excluding swing-bed and observation bed charges) 9. 00 9. 00 9. 00 30. 00 Semi-private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32. 00 Average private room per diem charge (line 29 ÷ line 3) 33. 00 Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 minus line 33) (see instructions) 34. 00 Average per diem private room cost differential (line 34 x line 31) Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 439, 978) 37. 00 38. 00 Adjusted general inpatient routine service cost per diem (see instructions) Program general inpatient routine service cost (line 9 x line 38) Program general inpatient routine service cost applicable to the Program (line 14 x line 35) 0 28. 00 29. 00 29. 00 30. 00 30. 00 30. 00 30. 00 31. 00 32. 00 32. 00 40. 00 Average per diem private room per diem charge (line 29 ÷ line 3) 0 . 00 32. 00 0 . 00 32. 00 0 . 00 33. 00 34. 00 35. 00 36. 00 37. 00 36. 00 37. 00 37. 00 38. 00 39. 00 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 . 00 40. 00	27. 00		(line 21 minus line 26)		4, 439, 978	27. 00	
29. 00 30. 00 30. 00 Semi-private room charges (excluding swing-bed charges) 30. 00 Semi-private room charges (excluding swing-bed charges) 31. 00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32. 00 Average private room per diem charge (line 29 ÷ line 3) 33. 00 Average semi-private room per diem charge (line 30 ÷ line 4) 34. 00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35. 00 Average per diem private room cost differential (line 34 x line 31) 36. 00 Private room cost differential adjustment (line 3 x line 35) 37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 439, 978) 37. 00 PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38. 00 Adjusted general inpatient routine service cost (line 9 x line 38) Program general inpatient routine service cost (line 9 x line 38) 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 30. 00 0 30. 00 0 0. 00 0 31. 00 0 0. 00 0 32. 00 0 32. 00 0 32. 00 0 33. 00 0 34. 00 0 34. 00 0 35. 00 0 36. 00 0 36. 00 0 37. 00 0 36. 00 0 37. 00 0 37. 00 0 38. 00 0 38. 00 0 39. 00 0 40. 00 0 Medically necessary private room cost applicable to the Program (line 14 x line 35)	28 00		and observation hed cha	arnes)	0	28 00	
30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 29 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 439, 978) 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 (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 30.00 On 0.00 30.00 On 0.00 32.00 On 0.00 32.00 On 0.00 32.00 On 0.00 32.00 On 0.00 On 0.00 32.00 On 0.00 On			a and observation bed en	11 903)			
32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 439, 978) 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0.00 32.00 0.00 32.00 0.00 34.00 0.00 34.00 0.00 35.00 0.00 36.	30.00					30. 00	
Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 439, 978) 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0.00 34.00 34.00 35.00 36.00 37.00 36.00 37.00 37.00 38.00 38.00 40.00		,	- line 28)				
Average per diem private room charge differential (line 32 minus line 33) (see instructions) 34. 00 Average per diem private room cost differential (line 34 x line 31) 35. 00 Average per diem private room cost differential (line 34 x line 31) 36. 00 Private room cost differential adjustment (line 3 x line 35) 37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 439, 978) Adjusted general inpatient routine service cost per diem (see instructions) Adjusted general inpatient routine service cost (line 9 x line 38) Program general inpatient routine service cost (line 9 x line 38) 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0							
35. 00 Average per diem private room cost differential (line 34 x line 31) 36. 00 Private room cost differential adjustment (line 3 x line 35) 37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 439, 978 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38. 00 Adjusted general inpatient routine service cost per diem (see instructions) Program general inpatient routine service cost (line 9 x line 38) 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 0 36. 00 0 36. 00 0 36. 00 0 36. 00 0 37. 00 0 40. 00			ous line 33)(see instruct	tions)			
36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2 x line 35) Adjusted general inpatient routine service cost per diem (see instructions) 38.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 36.00 4, 439, 978 4, 439, 978 4, 439, 978 37.00 37.00 37.00 4, 439, 978 37.00 37.00 4, 439, 978 4, 439, 978 4, 439, 978 38.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)		, , , , , , , , , , , , , , , , , , , ,	, ,	11 0113)			
37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38. 00 Adjusted general inpatient routine service cost per diem (see instructions) Program general inpatient routine service cost (line 9 x line 38) 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 37. 00 4, 439, 978 4, 439, 978 37. 00 4, 439, 978 37. 00 4, 439, 978 37. 00 40. 00			/			36. 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) 1,558.98 38.00 39.00 Program general inpatient routine service cost (line 9 x line 38) 2,347,824 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00		General inpatient routine service cost net of swing-bed cost a	and private room cost dit	ferential (line	4, 439, 978		
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,558.98 38.00 39.00 Program general inpatient routine service cost (line 9 x line 38) 2,347,824 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00							
38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,558.98 38.00 Program general inpatient routine service cost (line 9 x line 38) 2,347,824 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00							
39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 2,347,824 39.00 40.00 40.00	38. 00				1, 558. 98	38. 00	
41.00 lotal Program general inpatient routine service cost (line 39 + line 40) 2,347,824 41.00		, , , , , , , , , , , , , , , , , , , ,	•			40.00	
	41.00	lotal Program general inpatient routine service cost (line 39	+ IIne 40)	I	2, 347, 824	41.00	

	ATION OF INPATIENT OPERATING COST		Provi der Co	N: 15-0109	Peri od:	Worksheet D-1	
0 .				CCN: 15-T109	From 01/01/2023 To 12/31/2023		par
			Title	XVIII	Subprovi der -	PPS	
	Cost Center Description	Total Inpatient Cost	Total npatient Days	Average Per Diem (col. 1		Program Cost (col. 3 x col.	
		1.00	2. 00	col . 2) 3.00	4. 00	4) 5. 00	
. 00	NURSERY (title V & XIX only)	0	0				42
	Intensive Care Type Inpatient Hospital Unit						
00	INTENSIVE CARE UNIT	0	0	0.	00 0	0	
00	CORONARY CARE UNIT						44
. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45
00	NEONATAL INTENSIVE CARE UNIT	0	0	0.	00 0	0	4
	Cost Center Description						
	T					1. 00	
00	Program inpatient ancillary service cost (V			: 10	1 1)	1, 012, 770	
01 00	Program inpatient cellular therapy acquisit Total Program inpatient costs (sum of lines				, corumn r)	3, 360, 594	48
00	PASS THROUGH COST ADJUSTMENTS	3 +1 till ough +0.01) (300 TH311 dc	ti ons)		3, 300, 374	1 7
00	Pass through costs applicable to Program in	npatient routine s	ervices (from	Wkst. D, su	m of Parts I and	437, 011	50
					6.5		<u>۔</u> .
. 00	Pass through costs applicable to Program ir and IV)	npatient ancillary	services (fr	om WKSt. D,	sum of Parts II	38, 611	5
. 00	Total Program excludable cost (sum of lines	s 50 and 51)				475, 622	52
. 00	Total Program inpatient operating cost excl		ated, non-phy	sician anest	hetist, and	2, 884, 972	1
	medical education costs (line 49 minus line					<u> </u>	1
00	TARGET AMOUNT AND LIMIT COMPUTATION						۱.
. 00 . 00	Program discharges Target amount per discharge					0.00	
. 01	Permanent adjustment amount per discharge					0.00	
02	Adjustment amount per discharge (contractor	use only)				0.00	
00	Target amount (line 54 x sum of lines 55, 5	3 /				0	56
00	Difference between adjusted inpatient opera	ating cost and tar	get amount (I	ine 56 minus	line 53)	0	57
00	Bonus payment (see instructions)	55 6				0	
. 00	Trended costs (lesser of line 53 ÷ line 54, updated and compounded by the market basket		tne cost repo	rting period	enaing 1996,	0.00	5
. 00	Expected costs (lesser of line 53 ÷ line 54		prior year o	ost report,	updated by the	0.00	60
. 00	market basket) Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus					0	6
	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)						
. 00	Relief payment (see instructions)					0	62
. 00	Allowable Inpatient cost plus incentive pay	yment (see instruc	tions)			0	63
00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine co	osts through Dosom	har 21 of the	cost roport	ing pariod (Saa	0	
00	instructions)(title XVIII only)	osts through becei	ber 31 of the	cost report	ing period (see	0	64
00	Medicare swing-bed SNF inpatient routine co	osts after Decembe	r 31 of the c	ost reportin	g period (See	0	6!
	<pre>instructions)(title XVIII only)</pre>						
00	Total Medicare swing-bed SNF inpatient rout	tine costs (line 6	4 plus line 6	5)(title XVI	II only); for	0	60
. 00	CAH, see instructions Title V or XIX swing-bed NF inpatient routi	ne costs through	December 31 o	of the cost r	eportina period	0	6
	(line 12 x line 19)	-					
. 00	Title V or XIX swing-bed NF inpatient routi (line 13 x line 20)	ne costs after De	cember 31 of	the cost rep	orting period	0	68
. 00	Total title V or XIX swing-bed NF inpatient	t routine costs (I	ine 67 + line	68)		0	6
	PART III - SKILLED NURSING FACILITY, OTHER						_
. 00 . 00	Skilled nursing facility/other nursing faci Adjusted general inpatient routine service)		70
. 00	Program routine service cost (line 9 x line		no 70 F TITLE	<i>-,</i>			7:
. 00	Medically necessary private room cost appli	,	(line 14 x li	ne 35)			7:
00	Total Program general inpatient routine ser	•					74
00	Capital-related cost allocated to inpatient 26, line 45)	t routine service	costs (from W	orksheet B,	Part II, column		7!
. 00	Per diem capital-related costs (line 75 ÷ l	ine 2)					76
							7
00	Inpatient routine service cost (line 74 mir		ovido	(a)			78
00	Aggregate charges to beneficiaries for excellatal Program routine service costs for com				nus line 701		80
00	Inpatient routine service costs for com	•	Se rimitation	(TITIE /O IIII	1143 1116 /7)		8
. 00	Inpatient routine service cost limitation (82
. 00	Reasonable inpatient routine service costs	,					83
. 00	Program inpatient ancillary services (see i		`				84
. 00	Utilization review - physician compensation						85
. 00	Total Program inpatient operating costs (SUPART IV - COMPUTATION OF OBSERVATION BED PA		ougn 85)				86
	I COMING TATE OF CONSERVATION BED TA						١
. 00	Total observation bed days (see instruction	ns)				0	8.

COMPUTATION OF INPATIENT OPERATING COST Provider CCN: 15-0109 Component CCN: 15-1109 Title XVIII Cost Center Description Period: From 01/01/2023 To 12/31/2023 Date/Time Prepared 3/28/2024 12: 04 pm Figure 1: 12	FRANCISCAN HEALTH LAFAYETTE In Lieu (u of Form CMS-255	52-10
Component CCN: 15-T109 To 12/31/2023 Date/Time Prepared 3/28/2024 12: 04 pm		Worksheet D-1	
IRF	Component CCN: 15-T109 To 12/31/2023 D 3		
Cost Center Description		PPS	
1.00		1. 00	
89.00 Observation bed cost (line 87 x line 88) (see instructions) 0 89.0	e instructions)	0 89	39. 00
Cost Center Description Cost Routine Cost column 1 ÷ Total Observation	Cost Routine Cost column 1 ÷ Total C	Observati on	
(from line 21) column 2 Observation Bed Pass	(from line 21) column 2 Observation	Bed Pass	
Bed Cost (from Through Cost	Bed Cost (from T	Through Cost	
	line 89) (c	(col. 3 x col.	
4) (see		4) (see	
instructions)	ir	instructions)	
1.00 2.00 3.00 4.00 5.00	1.00 2.00 3.00 4.00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST	COST		
90.00 Capi tal -rel ated cost 826, 430 4, 439, 978 0. 186134 0 0 90.0	826, 430 4, 439, 978 0. 186134 0	0 90	90.00
91.00 Nursing Program cost 0 4,439,978 0.000000 0 0 91.0	0 4, 439, 978 0. 000000 0	0 9	91. 00
92.00 Allied health cost 0 4,439,978 0.000000 0 92.0	0 4, 439, 978 0. 000000 0	0 92	92.00
93.00 All other Medical Education 0 4,439,978 0.000000 0 93.0	0 4, 439, 978 0. 000000 0	0 93	93. 00

Health Financial Systems FRANCISCA INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	N HEALTH LAFAYETTE Provider C	CN: 15_0100	Peri od:	eu of Form CMS-2 Worksheet D-3	
THE ATTENT ANGIELANT SERVICE COST ATTORTONWENT	Trovider C		From 01/01/2023		
			To 12/31/2023	Date/Time Pre 3/28/2024 12:	
	Title	e XVIII	Hospi tal	PPS	оч рііі
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		4 00	0.00	2)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2. 00	3. 00	
30. 00 03000 ADULTS & PEDIATRICS			27, 607, 058		30.0
31. 00 03100 NTENSI VE CARE UNI T			12, 567, 654		31.0
35. 00 02060 NEONATAL INTENSIVE CARE UNIT			0		35. 0
H1. 00 04100 SUBPROVI DER - RF			0		41.0
13. 00 04300 NURSERY					43.0
ANCILLARY SERVICE COST CENTERS		'	-		Ī
50. 00 05000 OPERATING ROOM		0. 06081	27, 201, 314	1, 654, 221	50.0
51.00 O5100 RECOVERY ROOM		0. 04901	2, 026, 141	99, 301	51.0
2.00 05200 DELIVERY ROOM & LABOR ROOM		0. 87258			
4. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 12534			
i5. 00 05500 RADI OLOGY - THERAPEUTI C		0. 09589		123, 771	
66. 00 05600 RADI 0I SOTOPE		0. 07544		1	
56. 01 03950 CARDI AC CATH LAB		0. 10869			
57. 00 05700 CT SCAN		0. 03491			
58. 00 05800 MRI		0. 09333		89, 517	1
50. 00 06000 LABORATORY		0. 13980			
55. 00 06500 RESPIRATORY THERAPY		0. 25294			
66. 00 06600 PHYSI CAL THERAPY		0. 23685		549, 544 308, 088	
57.00 06700 0CCUPATIONAL THERAPY 58.00 06800 SPEECH PATHOLOGY		0. 15462 0. 16550			
59. 00 06900 SPEECH PATHOLOGY		0. 10330			
70. 00 07000 ELECTROCARDI OLOGI 70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 11233			
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 16683		3, 579, 354	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 17013			
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 18374			
73. 01 07301 DI ABETES CENTER		6, 344. 98353		0	73.0
74. 00 07400 RENAL DI ALYSI S		0. 36696		461, 970	74.0
76. 00 03480 0NCOLOGY		0. 30635		732, 152	76.0
76. 01 03952 ANTI COAGULATI ON		0. 77207		720	
76. 02 03951 NFUSI ON SERVI CES		0. 03321		21	76.0
76. 98 07698 HYPERBARI C OXYGEN THERAPY		0.00000		0	76. 9
7.00 07700 ALLOGENEIC STEM CELL ACQUISITION		0.00000		0	77.0
78. 00 07800 CAR T-CELL IMMUNOTHERAPY		0.00000	00	0	78.0
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLI NI C		0. 88924		12, 781	
20. 01 09001 CLINIC - OUTPATIENT INFUSION SERVICE		0.08308		1	
PO. 02 09002 CLINIC - HOME INF PHARMACOTHERAPY		0. 98591		070 016	90.0
JI OO HOUTOLEMERICANICA					

0. 112284

0.348864

0.524612

0. 717824

7, 835, 629

1, 596, 645

151, 363, 997

151, 363, 997

91.00

91.01

92.00

92. 01

95.00

201. 00

202. 00

21, 194, 719 200. 00

91.00

91.01

92.00

92. 01

95.00

200.00

201.00

202.00

09100 EMERGENCY

04950 WOUND CARE

09200 OBSERVATION BEDS (NON-DISTINCT PART

Net charges (line 200 minus line 201)

Total (sum of lines 50 through 94 and 96 through 98) Less PBP Clinic Laboratory Services-Program only charges (line 61)

09201 OBSERVATION BEDS (DISTINCT PART)

OTHER REIMBURSABLE COST CENTERS

09500 AMBULANCE SERVICES

Health Fir	nancial Systems FRANCISCAN HEALTH	LAFAVETTE		In Lie	eu of Form CMS-:	2552_10
	ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0109	Peri od:	Worksheet D-3	
TMIATTENT	ANOTEENIN SERVICE COST ATTORTONIMENT		CCN: 15-T109	From 01/01/2023 To 12/31/2023		pared:
		Title	· XVIII	Subprovider -	PPS	<u>0 1 </u>
	Cost Center Description		Ratio of Cos To Charges		Inpatient Program Costs (col. 1 x col.	
			1.00	2. 00	2) 3. 00	
I NP	ATIENT ROUTINE SERVICE COST CENTERS		1.00		0.00	
30.00 030	00 ADULTS & PEDIATRICS					30. 00
	00 INTENSIVE CARE UNIT					31. 00
	060 NEONATAL INTENSIVE CARE UNIT					35. 00
	00 SUBPROVI DER – I RF			3, 671, 214		41. 00
	00 NURSERY					43. 00
	ILLARY SERVICE COST CENTERS		0.0608	1.4	24 507	EO 00
	00 OPERATING ROOM 00 RECOVERY ROOM		0.0608			50. 00 51. 00
	OO DELIVERY ROOM & LABOR ROOM		0. 0490		1	52.00
	00 RADI OLOGY-DI AGNOSTI C		0. 8723		1	54.00
	00 RADI OLOGY - THERAPEUTI C		0. 0958		1	55. 00
	OO RADI OI SOTOPE		0. 0754			
	50 CARDI AC CATH LAB		0. 1086		•	1
	OO CT SCAN		0. 0349			57. 00
58. 00 058	OO MRI		0. 0933	38 9, 752	910	58. 00
	00 LABORATORY		0. 1398	00 307, 527		60.00
65. 00 065	00 RESPI RATORY THERAPY		0. 2529		59, 802	65. 00
	00 PHYSI CAL THERAPY		0. 2368			66. 00
	OO OCCUPATI ONAL THERAPY		0. 1546		1	1
	OO SPEECH PATHOLOGY		0. 1655			1
	OO ELECTROCARDI OLOGY		0. 1123		1	•
	00 ELECTROENCEPHALOGRAPHY 00 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 2779		1	70.00
	00 MPL. DEV. CHARGED TO PATIENTS		0. 1668 0. 1701			71. 00 72. 00
	00 DRUGS CHARGED TO PATTENTS		0. 1701		•	73.00
	01 DI ABETES CENTER		6, 344. 9835		1	73. 00
	OO RENAL DI ALYSI S		0. 3669		1	ł
	80 ONCOLOGY		0. 3063			76. 00
	52 ANTI COAGULATI ON		0. 7720		1	76. 01
76. 02 039	51 INFUSION SERVICES		0. 0332		0	76. 02
	98 HYPERBARI C OXYGEN THERAPY		0.0000	00 0	0	76. 98
	OO ALLOGENEIC STEM CELL ACQUISITION		0.0000	00 0	0	77. 00
	OO CAR T-CELL IMMUNOTHERAPY		0.0000	00 0	0	78. 00
	PATIENT SERVICE COST CENTERS					
90.00 090			0. 8892			90. 00
	01 CLINIC - OUTPATIENT INFUSION SERVICE		0. 0830		1	90. 01
	102 CLINIC - HOME INF PHARMACOTHERAPY		0. 9859			90. 02
	00 EMERGENCY 150 WOUND CARE		0. 1122		1	91. 00 91. 01
	00 OBSERVATION BEDS (NON-DISTINCT PART		0. 3488 0. 5246		1	
	01 OBSERVATION BEDS (NON-DISTINCT PART		0. 5246			
	ER REIMBURSABLE COST CENTERS		0.7170	2.1 13, 100	12,773	, 2. 01
	00 AMBULANCE SERVI CES					95. 00
200.00	Total (sum of lines 50 through 94 and 96 through 98)			5, 642, 121	1, 012, 770	1
201.00	Less PBP Clinic Laboratory Services-Program only charges	(line 61)		C)	201. 00
202.00	Net charges (line 200 minus line 201)			5, 642, 121	1	202. 00

Health Financial Systems	FRANCISCAN HEALTH LAFAYETTE		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der CC	CN: 15-0109	Peri od:	Worksheet D-3	
			From 01/01/2023 To 12/31/2023	Date/Time Pre	
	Ti +I	e XIX	Hospi tal	3/28/2024 12: Cost	04 рііі
Cost Center Description		Ratio of Cost		Inpati ent	
, and the second second		To Charges	Program	Program Costs	
		_	Charges	(col. 1 x col.	
				2)	
LARATI ENT. DOUTLAGE OFFICE OFFICE		1. 00	2. 00	3. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS			4/ 044 54/		
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 NTENSIVE CARE UNIT			16, 044, 516 6, 609, 418		30.00
35.00 02060 NEONATAL INTENSIVE CARE UNIT			0, 009, 418		35.00
41. 00 04100 SUBPROVI DER - I RF			0		41.00
43. 00 04300 NURSERY			6, 622, 774		43.00
ANCILLARY SERVICE COST CENTERS			0,022,771		10.00
50. 00 05000 OPERATI NG ROOM		0. 06081	4 14, 740, 644	896, 438	50.00
51.00 05100 RECOVERY ROOM		0. 04901		0	
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 87258	2 5, 505, 277	4, 803, 806	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 12534	3 1, 979, 073	248, 063	54.00
55. 00 05500 RADI OLOGY - THERAPEUTI C		0. 09589	0 699, 827	67, 106	55. 00
56. 00 05600 RADI 0I SOTOPE		0. 07544	·	36, 838	
56. 01 03950 CARDI AC CATH LAB		0. 10869		0	
57. 00 05700 CT SCAN		0. 03491		0	
58. 00 05800 MRI		0. 09333		0	
60. 00 06000 LABORATORY		0. 13980		1, 483, 733	
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY		0. 25294		897, 237	
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY		0. 23685 0. 15462		257, 720 145, 273	
68.00 06800 SPEECH PATHOLOGY		0. 15462		94, 643	
69. 00 06900 ELECTROCARDI OLOGY		0. 11235	· ·	244, 000	1
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 27795		73, 447	1
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 16683	·	· ·	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 17013		571, 989	1
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 18374	5 8, 458, 882	1, 554, 277	73. 00
73. 01 07301 DI ABETES CENTER		6, 344. 98353	9 0	0	73. 01
74.00 07400 RENAL DIALYSIS		0. 36696	1 364, 680	133, 823	74.00
76. 00 03480 ONCOLOGY		0. 30635		0	
76. 01 03952 ANTI COAGULATI ON		0. 77207		0	
76. 02 03951 I NFUSI ON SERVI CES		0. 03321		0	
76. 98 07698 HYPERBARI C OXYGEN THERAPY		0. 00000		0	
77. 00 07700 ALLOGENEIC STEM CELL ACQUISITION		0.00000		-	
78. 00 07800 CAR T-CELL IMMUNOTHERAPY		0.00000	0 0	0	78. 00
OUTPATIENT SERVICE COST CENTERS					

98, 684

15, 684

558, 777

377, 640

14, 073, 629 200. 00

0.889244

0.083086

0.985915

0. 112284

0.348864

0.524612

0. 717824

110, 975

188, 763

719, 846

4, 976, 464

69, 868, 391

69, 868, 391

90.00

90.01

90.02

91.00

91.01

92.00

92. 01

95.00

201. 00

202. 00

09000 CLI NI C

09100 EMERGENCY

04950 WOUND CARE

09001 CLINIC - OUTPATIENT INFUSION SERVICE 09002 CLINIC - HOME INF PHARMACOTHERAPY

09200 OBSERVATION BEDS (NON-DISTINCT PART

Net charges (line 200 minus line 201)

Total (sum of lines 50 through 94 and 96 through 98) Less PBP Clinic Laboratory Services-Program only charges (line 61)

09201 OBSERVATION BEDS (DISTINCT PART)

OTHER REIMBURSABLE COST CENTERS

09500 AMBULANCE SERVICES

90.00

90. 01

90.02

91.00

91.01

92.00

92. 01

95.00

200.00

201.00

202.00

	ANCILLARY SERVICE COST APPORTIONMENT FRANCISCAN HEALTH LA		CN: 15-0109	Peri od:	u of Form CMS-3 Worksheet D-3	
	С	omponent (CCN: 15-T109	From 01/01/2023 To 12/31/2023	Date/Time Pre 3/28/2024 12:	
		Ti tl	e XIX	Subprovi der - I RF	Cost	
	Cost Center Description		Ratio of Cos To Charges		Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2. 00	3. 00	
	ATIENT ROUTINE SERVICE COST CENTERS					
	DO ADULTS & PEDIATRICS					30.
	DO INTENSIVE CARE UNIT 50 NEONATAL INTENSIVE CARE UNIT					31. 35.
	00 SUBPROVI DER - I RF			582, 682		41.
	OO NURSERY			302, 002		43.
	LLARY SERVICE COST CENTERS					10.
	OO OPERATING ROOM		0. 0608	14 0	0	50.
	DO RECOVERY ROOM		0. 0490	10 0	0	51.
2. 00 0520	DO DELIVERY ROOM & LABOR ROOM		0. 8725	82 0	0	52
. 00 0540	DO RADI OLOGY-DI AGNOSTI C		0. 1253	43 0	0	54
	DO RADIOLOGY - THERAPEUTIC		0. 0958		0	
	DO RADI OI SOTOPE		0. 0754		0	
	50 CARDI AC CATH LAB		0. 1086		0	
	DO CT SCAN		0. 0349		0	
- 1	00 MRI		0.0933		0	
1	DO LABORATORY DO RESPIRATORY THERAPY		0. 1398 0. 2529		300 0	
	00 PHYSI CAL THERAPY		0. 2368		0	
	OO OCCUPATIONAL THERAPY		0. 1546		0	
	OO SPEECH PATHOLOGY		0. 1655		Ö	
	00 ELECTROCARDI OLOGY		0. 1123		0	
. 00 0700	DO ELECTROENCEPHALOGRAPHY		0. 2779	55 0	0	70
. 00 0710	DO MEDICAL SUPPLIES CHARGED TO PATIENT		0. 1668	31 0	0	71
	DO IMPL. DEV. CHARGED TO PATIENTS		0. 1701		0	
	DO DRUGS CHARGED TO PATIENTS		0. 1837		0	
	D1 DI ABETES CENTER		6, 344. 9835		0	
	DO RENAL DIALYSIS		0. 3669		0	
	BO ONCOLOGY 52 ANTI COAGULATI ON		0. 3063 0. 7720		0	
	51 I NFUSI ON SERVI CES		0.7720		0	
	98 HYPERBARI C OXYGEN THERAPY		0.0000		0	
	OO ALLOGENEIC STEM CELL ACQUISITION		0. 0000		0	
	OO CAR T-CELL IMMUNOTHERAPY		0. 0000		0	
	PATIENT SERVICE COST CENTERS					
	DO CLI NI C		0. 8892	44 0	0	90
	D1 CLINIC - OUTPATIENT INFUSION SERVICE		0. 0830		0	90
	D2 CLINIC - HOME INF PHARMACOTHERAPY		0. 9859		0	
	DO EMERGENCY		0. 1122			
	50 WOUND CARE DO OBSERVATION BEDS (NON-DISTINCT PART		0. 3488 0. 5246		0	
	OU OBSERVATION BEDS (NON-DISTINCT PART)		0. 5246			
	ER REIMBURSABLE COST CENTERS		0.7170	<u> </u>	<u> </u>	72
	OO AMBULANCE SERVICES					95
0.00	Total (sum of lines 50 through 94 and 96 through 98)			4, 983	619	
1.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0]	201
2. 00	Net charges (line 200 minus line 201)	,		4, 983		202

		Title XVIII	Hospi tal	3/28/2024 12:	U4 piii
DEC ACCURTS OTHER THAN DUTLIEF PROMOTES 100			Before GEO Reclass	On/After GEO Reclass	
1.00 Bid Amounts other than Dutiller payments for discharges occurring prior to October 1 20.176,100 0.1.01					
1.01 DRG amounts other than outlier payments for discharges occurring prior to October 1 20,176,106 0 1.01	1 00				1 00
1.02 1.02		DRG amounts other than outlier payments for discharges occurring prior to October	_		
1.03 Disk for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (See Instructions) 0 1.03	1. 02	DRG amounts other than outlier payments for discharges occurring on or after Octob	per 1 7, 120, 730	0	1. 02
1.04 1986 For Federal Specific Concreting phyment for Model 4 BPCI for discharges occurring 0 0 1.04	1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurri	ng C	0	1. 03
2.00 Outlier payments for discharges (see instructions)	1. 04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurri	ng C	0	1. 04
2.00 Outlier payment for discharges cocurring pair or to October 1 (see Instructions) 0.4, 302 0.2, 32, 30 Outlier payments for discharges occurring pair or to October 1 (see Instructions) 122, 799 0.2, 43, 30 Outlier payments for discharges occurring are or October 1 (see Instructions) 122, 799 0.2, 43, 30 Outlier payments for discharges occurring are or October 1 (see Instructions) 122, 799 0.2, 43, 40 0.3, 40		Outlier payments for discharges. (see instructions)	C	0	
2.04 Outlier puryments for discharges occurring on or after October 1 (see instructions) 122,799 0 2.04	2.02		C	0	2. 02
Managed Care Simulated Payments 0 0 3 3.00					
Bed days available aiv ded by number or days in the cost reporting period (see 164.25 4.00 Instructions)			122, 799		
Indirect Medical Education Adjustment 5.00 5.			164. 25	_	
FTC count for all opathic and osteopathic programs for the most recent cost reporting period ending on or before 17231/1996, (see instructions) 5.00 5.00 5.00 5.01 FTE cap adjustment for qualifing hospitals under §131 of the CAA 2021 (see 0.00 5.01 Instructions) 6.00 FTE count for all opathic and osteopathic paragrams that meet the criteria for an add-on to the cap for one programs osteopathic paragrams that meet the criteria for an add-on to continue the cap for all opathic and osteopathic paragrams that meet the criteria for an add-on to continue the cap for one programs in the continue that it is a continue to the continue that it is a continue to the continue that it is a continue to the continue that is a continue to the continue that is a continue to the continue to the continue that is a continue to the continue that is a continue to the continue to the continue that is a continue that is a continue to the continue that is a continue to the continue tha					
FIX cap adjustment for qualifing hospitals under \$131 of the CAA 2021 (see instructions) FIX count for all opathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e) 6.00 Rural track program FIX cap limitation adjustment after the cap-building window closed under \$127 of the CAA 2021 (see instructions) 7.00 MAA Section 427 reduction amount to the IME cap as specified under 42 CFR 0.00 7.00 \$10.00	5. 00		ng 0.00		5. 00
Instructions) 1. OFFI Count for all opathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e) 2. OR WAS Section 427 creduction amount to the LME cap as specified under 42 CFR 3. OR WAS Section 427 creduction amount to the LME cap as specified under 42 CFR 3. OR WAS Section 427 creduction amount to the LME cap as specified under 42 CFR 3. OR WAS Section 427 creduction amount to the LME cap as specified under 42 CFR 3. OR WAS Section 427 creduction amount to the LME cap as specified under 42 CFR 3. OR WAS Section 427 creduction amount to the LME cap as specified under 42 CFR 3. OR WAS Section 427 creduction amount to the LME cap as specified under 42 CFR 3. OR WAS Section 427 creduction amount to the LME cap as specified under 42 CFR 3. OR WAS Section 427 creduction amount to the LME cap as specified under 42 CFR 3. OR WAS Section 427 creduction amount to the LME cap as specified under 42 CFR 3. OR WAS SECTION SECT	F 01		0.00		F 01
to the cap for new programs in accordance with 42 CFR 413.79(e) 2.6 26 Nural track programs FIE appl IIII tatton adjustment after the cap-building window closed under \$127 of the CAA 2021 (see instructions) 7.00 MM Section 422 reduction anount to the IME cap as specified under 42 CFR 9.10 S(7)(1)(1)(1)(8)(1) 1.01 ACA \$5.503 reduction amount to the IME cap as specified under 42 CFR 9.10 ACA \$5.503 reduction amount to the IME cap as specified under 42 CFR 9.10 ACA \$5.503 reduction amount to the IME cap as specified under 42 CFR 9.10 ACA \$1.505(7)(1)(1)(8)(2) If the cost report straddles July 1, 2011 then see instructions. 7.02 Adjustment (increase or decrease) to the hospital 's crural track program FIE 1.02 Adjustment (increase or decrease) to the Fite Count for all logathic and osteopathic programs for arfill lated programs in accordance with 413.76(0) and 87 FR 49075 (August 10, 2022) (see instructions) 8.00 Adjustment (increase or decrease) to the FITE count for all logathic and osteopathic programs for affill lated programs in accordance with 42 CFR 413.76(0), 413.77(c)(2)(2)(4) 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 10, 2002). 8.01 The amount of increase if the hospital was awarded FIE cap slots under \$ 5503 of the ACA (ACA If the cost report straddles July 1, 2011, see instructions. 8.02 The amount of increase if the hospital was awarded FIE cap slots under \$ 5503 of the ACA (ACA If the cost report straddles July 1, 2011, see instructions. 8.02 The amount of increase if the hospital was awarded FIE cap slots under \$ 506 of the CAA 20.00 accordance with a subject of the ACA 2021 (see instructions) 8.03 The amount of increase if the hospital was awarded FIE cap slots under \$ 506 of the CAA 20.00 accordance with a subject of the ACA 2021 (see instructions) 8.04 The amount of increase if the hospital was awarded FIE cap slots under \$ 506 of the CAA 20.00 accordance with a subject of the ACA 2021 (see instructions) 9.00 Sun of lines S and S 01, plus line 6, plus lines 8.01 through 8.		instructions)			
under \$127 of the CAA 2021 (see Instructions) 7. 00 MA Section 422 reduction amount to the IME cap as specified under 42 CFR 0.00 §412.105(f)(1)(1)(8)(1) 7. 1 ACA \$5030 reduction amount to the IME cap as specified under 42 CFR 0.00 §412.105(f)(1)(1)(8)(2) If the cost report straddles July 1, 2011 then see Instructions. 7. 01 ACA \$5030 reduction amount to the IME cap as specified under 42 CFR 0.00 §412.105(f)(1)(1)(8)(2) If the cost report straddles July 1, 2011 then see Instructions. 7. 02 Algustnent (Increase or decrease) to the hospital's rural track program FTE 0.00 Initiation(s) for rural track programs with a rural track for Medicare GME affiliated programs in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see 0.00 8. 00 Algustnent (Increase or decrease) to the FTE count for all lopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(1)(4), 417.79(c)(2)(1)(4), 417.79(c)(2)(4), 417.79(c)(2)(4), 417.79(c)(4), 417.79(c)(4), 417.79(c)(4), 417.79(c)(4), 417.79(c)(4), 417.79(c)(4), 417.79(c)(4), 417.79(c)(4), 417.79(c)(4), 417.79(c)(4)		to the cap for new programs in accordance with 42 CFR 413.79(e)			
\$412.105(f)(1)(iv)(B)(1)		under §127 of the CAA 2021 (see instructions)			
\$412.105(f)(1)(IV)(B)(2)(1) The cost report straddles July 1, 2011 then see instructions.	7. 00	· '	0.00		7. 00
limitation(s) for rural track programs with a rural track for Medicare GME affiliated programs in accordance with 413.75(b) and 87 FR 40075 (August 10, 2022) (see instructions)	7. 01	§412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see	0.00		7. 01
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).	7. 02	limitation(s) for rural track programs with a rural track for Medicare GME affilial programs in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see			7. 02
8.01 The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	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),	0.00		8. 00
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) 8.21 The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions) 9.00 Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions) 10.00 FTE count for allopathic and osteopathic programs in the current year from your records 11.00 FTE count for residents in dental and podiatric programs. 12.00 Current year allowable FTE (see instructions) 13.00 Total allowable FTE (see instructions) 14.00 Total allowable FTE count for the penultimate year if that year ended on or after 0.00 september 30, 1997, otherwise enter zero. 15.00 Sum of lines 12 through 14 divided by 3. 16.00 Adjustment for residents in initial years of the program (see instructions) 17.00 Adjustment for residents displaced by program or hospital closure 0.00 18.00 Adjustment for resident displaced by program or hospital closure 0.00 19.00 Current year resident to bed ratio (line 18 divided by line 4). 0.000000 20.00 Prior year resident to bed ratio (see instructions) 0.000000 21.00 Enter the lesser of lines 19 or 20 (see instructions) 0.000000 22.01 IME payment adjustment foe instructions) 0.000000 23.00 IME payment adjustment foe instructions) 0.000000 24.00 IME payment adjustment foe instructions) 0.000000 25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 0.00 24 (see instructions) 0.000000 25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 0.00 24 (see instructions) 0.000000 25.00 IME payments adjustment factor. (see instructions) 0.000000 26.00 IME payments adjustment factor. (see instructions) 0.000000 27.00 IME payments adjustment factor. (see instructions) 0.000000 28.00 IME add-on adjustment factor. (see instructions) 0.0000000 28.00 IME add-on adjustme	8. 01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of t	he 0.00		8. 01
8. 21 The amount of increase if the hospital was awarded FTE cap slots under \$126 of the CAA 0.00 2021 (see instructions) 9. 00 5um of lines 5 and 5. 01, plus line 6, plus lines 6. 26 through 6. 49, minus lines 7 and 7. 01, plus or minus line 7. 02, plus/minus line 8, plus lines 8. 01 through 8. 27 (see instructions) 10. 00 FTE count for allopathic and osteopathic programs in the current year from your 0.00 10. 00 11. 00 FTE count for residents in dental and podiatric programs. 0.00 12. 00 13. 00 10. 01	8. 02	The amount of increase if the hospital was awarded FTE cap slots from a closed	0.00		8. 02
9.00 Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions) 10.00 FTE count for all opathic and osteopathic programs in the current year from your coords 10.00 10.	8. 21	The amount of increase if the hospital was awarded FTE cap slots under §126 of the	e CAA 0.00		8. 21
10.00 FTE count for allopathic and osteopathic programs in the current year from your records 10.00 11.00 11.00 12.00 12.00 11.00 12.00 12.00 12.00 12.00 13.00 10.00 12.00 13.00 10.00 13.00 13.00 10.00 14.00 13.00 10.00 14.00 14.00 15.00 14.00 15.00 14.00 15.00 15.00 16.00 16.00 16.00 16.00 17.00 18.00 18.00 18.00 18.00 19	9. 00	Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7.7.01, plus or minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (se			9. 00
11. 00 FTE count for residents in dental and podiatric programs. 0.00 11. 00 12. 00 Current year allowable FTE (see instructions) 0.00 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, otherwise enter zero. 0.00 14. 00 15. 00 Sum of lines 12 through 14 divided by 3. 0.00 15. 00 16. 00 Adj ustment for residents in initial years of the program (see instructions) 0.00 16. 00 17. 00 Adj ustment for residents displaced by program or hospital closure 0.00 17. 00 18. 00 Adj usted rolling average FTE count 0.00 17. 00 19. 00 Current year resident to bed ratio (line 18 divided by line 4). 0.000000 19. 00 20. 00 Prior year resident to bed ratio (see instructions) 0.000000 20. 00 21. 00 Enter the lesser of lines 19 or 20 (see instructions) 0.000000 21. 00 22. 01 IME payment adjustment (see instructions) 0.000000 21. 00 22. 01 IME payment adjustment — Managed Care (see instructions) 0.00 22	10. 00	FTE count for allopathic and osteopathic programs in the current year from your	0.00		10. 00
12.00 Current year allowable FTE (see instructions) 12.00 13.00 10.00 13.00 10.00 13.00 10.00 13.00 10.00 10.00 13.00 10.00 13.00 10.00 10.00 13.00 14.00 10.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 15.00 15.00 16.00 16.00 16.00 16.00 16.00 17.00 16.00 17.00 16.00 17.00 16.00 17.00 16.00 17.00 16.00 17.00 16.00 17.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00 19.0	11. 00		0.00		11. 00
14.00 Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero. 15.00 Sum of lines 12 through 14 divided by 3. 16.00 Adjustment for residents in initial years of the program (see instructions) 17.00 Adjustment for residents displaced by program or hospital closure 19.00 Current year resident to bed ratio (line 18 divided by line 4). 20.00 Prior year resident to bed ratio (see instructions) 21.00 Enter the lesser of lines 19 or 20 (see instructions) 22.01 IME payment adjustment (see instructions) 23.00 CFR 412.105 (f)(1)(iv)(C). 24.00 IME FTE Resident Count Over Cap (see instructions) 25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 26.00 Resident to bed ratio (divide line 25 by line 4) 27.00 IME payments adjustment factor. (see instructions) 28.00 IME payments adjustment factor. (see instructions) 29.00 IME payments adjustment factor. (see instructions) 20.00 IME payments adjustment for the Add-on for § 422 of the MMA 21.00 IME add-on adjustment factor. (see instructions) 22.01 IME payments adjustment factor. (see instructions) 23.00 CFR 412.105 (f)(1)(iv)(C).		, , , , , , , , , , , , , , , , , , ,		l .	
September 30, 1997, otherwise enter zero. 15.00 Sum of lines 12 through 14 divided by 3. 16.00 Adjustment for residents in initial years of the program (see instructions) 17.00 Adjustment for residents displaced by program or hospital closure 18.00 Adjustment for residents displaced by program or hospital closure 19.00 Adjusted rolling average FTE count 19.00 Current year resident to bed ratio (line 18 divided by line 4). 19.00 Current year resident to bed ratio (see instructions) 19.00 IME payment adjustment (see instructions) 10.00 IME payment adjustment (see instructions) 10.00 IME payment adjustment - Managed Care (see instructions) 10.00 IME payment adjustment for the Add-on for § 422 of the MMA 23.00 IME payment adjustment over Cap (see instructions) 24.00 IME FTE Resident Count Over Cap (see instructions) 25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 26.00 Resident to bed ratio (divide line 25 by line 4) 27.00 IME payments adjustment factor. (see instructions) 28.00 IME payments adjustment factor. (see instructions) 29.00 IME payments adjustment factor. (see instructions) 20.00 IME payments adjustment factor. (see instructions)		, ,		l .	
16.00 Adj ustment for residents in initial years of the program (see instructions) 17.00 Adj ustment for residents displaced by program or hospital closure 18.00 Adj ustment for residents displaced by program or hospital closure 18.00 Adj ustment for residents displaced by program or hospital closure 18.00 Adj ustment for residents displaced by program or hospital closure 18.00 Current year resident to bed ratio (line 18 divided by line 4). 19.00 Current year resident to bed ratio (see instructions) 19.00 Enter the lesser of lines 19 or 20 (see instructions) 20.00 IME payment adj ustment (see instructions) 10.000000 21.00 IME payment adj ustment - Managed Care (see instructions) 10.000000 22.00 Indirect Medical Education Adj ustment for the Add-on for § 422 of the MMA 23.00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 23.00 CFR 412.105 (f)(1)(iv)(C). 24.00 IME FTE Resident Count Over Cap (see instructions) 25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 26.00 Resident to bed ratio (divide line 25 by line 4) 27.00 IME payments adj ustment factor. (see instructions) 28.00 IME add-on adj ustment amount (see instructions) 29.00 IME add-on adj ustment amount (see instructions)	15.00	September 30, 1997, otherwise enter zero.			
17. 00 Adj ustment for residents displaced by program or hospital closure 18. 00 Adj usted rolling average FTE count 19. 00 Current year resident to bed ratio (line 18 divided by line 4). 19. 00 Prior year resident to bed ratio (see instructions) 19. 00 Enter the lesser of lines 19 or 20 (see instructions) 20. 00 IME payment adj ustment (see instructions) 10. 00 IME payment adj ustment (see instructions) 21. 00 IME payment adj ustment - Managed Care (see instructions) 22. 01 Indirect Medical Education Adj ustment for the Add-on for § 422 of the MMA 23. 00 IME FTE Resident Count Over Cap (see instructions) 24. 00 IME FTE Resident Count Over Cap (see instructions) 25. 00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 26. 00 Resident to bed ratio (divide line 25 by line 4) 27. 00 IME payments adj ustment factor. (see instructions) 28. 00 IME payments adj ustment factor. (see instructions) 29. 00 O O O O O O O O O O O O O O O O O O					
18.00 Adjusted rolling average FTE count 0.00 18.00 19.00 Current year resident to bed ratio (line 18 divided by line 4). 0.000000 19.00 20.00 Prior year resident to bed ratio (see instructions) 0.000000 20.00 21.00 Enter the lesser of lines 19 or 20 (see instructions) 0.000000 21.00 22.01 IME payment adjustment (see instructions) 0 0.22.00 22.01 IME payment adjustment - Managed Care (see instructions) 0 0.00 22.01 Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA 0.00 22.01 23.00 CFR 412.105 (f)(1)(iv)(C). 0.00 24.00 25.00 24.00 25.00 24.00 25.00 26.00 26.00 26.00 26.00 26.00 27.00 28.00 1ME add-on adjustment amount (see instructions) 0.000000 27.00 28.00 28.00 28.00 0.000000 0.000000 27.00 28.00					
20. 00 Prior year resident to bed ratio (see instructions) 0.000000 20.00 21. 00 Enter the lesser of lines 19 or 20 (see instructions) 0.000000 21.00 22. 00 IME payment adjustment (see instructions) 0 0 22.00 22. 01 IME payment adjustment - Managed Care (see instructions) 0 0 0 22.01 Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA 0 0 0 0 22.01 Value of Fig. 105 (f)(1)(iv)(C). 0<					
21.00 Enter the lesser of lines 19 or 20 (see instructions) 22.00 IME payment adjustment (see instructions) 22.01 IME payment adjustment - Managed Care (see instructions) 23.00 Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA 23.00 IME payment adjustment - Managed Care (see instructions) 23.00 CFR 412.105 (f)(1)(iv)(C). 24.00 IME FTE Resident Count Over Cap (see instructions) 25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 26.00 Resident to bed ratio (divide line 25 by line 4) 27.00 IME payments adjustment factor. (see instructions) 28.00 IME add-on adjustment amount (see instructions) 21.00 22.00 23.00 23.00 24.00 25.00 26.00 27.00 28.00 IME add-on adjustment amount (see instructions)	19. 00	Current year resident to bed ratio (line 18 divided by line 4).	0. 000000		19. 00
22.00 IME payment adjustment (see instructions) 1 IME payment adjustment - Managed Care (see instructions) 1 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 24.00 IME FTE Resident Count Over Cap (see instructions) 25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 26.00 Resident to bed ratio (divide line 25 by line 4) 27.00 IME payments adjustment factor. (see instructions) 28.00 IME add-on adjustment amount (see instructions) 0 0 22.00 23.00 24.00 25.00 26.00 27.00 28.00 IME add-on adjustment amount (see instructions) 0 0 28.00		· · · · · · · · · · · · · · · · · · ·			
IME payment adj ustment - Managed Care (see instructions) O O O Indirect Medical Education Adj ustment for the Add-on for § 422 of the MMA			0.000000		
23.00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 0.00 CFR 412.105 (f)(1)(iv)(C). 24.00 IME FTE Resident Count Over Cap (see instructions) 0.00 24.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions) 25.00 Resident to bed ratio (divide line 25 by line 4) 0.000000 26.00 Resident to bed ratio (divide line 25 by line 4) 0.000000 27.00 IME payments adjustment factor. (see instructions) 0.000000 27.00 IME add-on adjustment amount (see instructions) 0.000000 0.000000 28.00			C		
24.00 IME FTE Resident Count Over Cap (see instructions) 25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions) 26.00 Resident to bed ratio (divide line 25 by line 4) 27.00 IME payments adjustment factor. (see instructions) 28.00 IME add-on adjustment amount (see instructions) 0.00 26.00 27.00 28.00 IME add-on adjustment amount (see instructions) 0.00 28.00	23. 00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 4	2 0.00		23. 00
24 (see instructions) 26.00 Resident to bed ratio (divide line 25 by line 4) 27.00 IME payments adjustment factor. (see instructions) 28.00 IME add-on adjustment amount (see instructions) 0.000000 27.00 28.00		IME FTE Resident Count Over Cap (see instructions)			
26.00 Resident to bed ratio (divide line 25 by line 4) 0.000000 26.00 27.00 IME payments adjustment factor. (see instructions) 0.000000 27.00 28.00 IME add-on adjustment amount (see instructions) 0 0	25. 00		i ne 0.00		25. 00
28.00 IME add-on adjustment amount (see instructions) 0 0 28.00		Resident to bed ratio (divide line 25 by line 4)		l .	
		, , ,			
		· · · · · · · · · · · · · · · · · · ·			

	Financial Systems FRANCISCAN HEALTH I			u of Form CMS-2	<u> 2552-10</u>
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	F	eriod: rom 01/01/2023		
			o 12/31/2023	Date/Time Prep 3/28/2024 12:0	
		Title XVIII	Hospital Before GEO	PPS On/After GEO	
			Recl ass	Recl ass	
20, 00	Total IME payment (cum of lines 22 and 20)		1. 00	1. 01	29. 00
29. 00 29. 01	Total IME payment (sum of lines 22 and 28) Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0		1
30. 00	Disproportionate Share Adjustment Percentage of SSI recipient patient days to Medicare Part A pat	iant days (see	3.09		30. 00
	instructions)	Tent days (see	3.07		30.00
31. 00 32. 00	Percentage of Medicaid patient days (see instructions) Sum of lines 30 and 31		26. 74 29. 83		31. 00 32. 00
33. 00	Allowable disproportionate share percentage (see instructions)		13. 82		
34. 00	Disproportionate share adjustment (see instructions)		943, 106	0 0n/After 10/1	34. 00
			1.00	2.00	
25.00	Uncompensated Care Payment Adjustment			0	25.00
35. 00 35. 01	Total uncompensated care amount (see instructions) Factor 3 (see instructions)		0. 000000000		35. 00 35. 01
35. 02	Hospital UCP, including supplemental UCP (If line 34 is zero, e	enter zero on this line)	3, 944, 044	3, 147, 711	35. 02
35. 03	(see instructions) Pro rata share of the hospital UCP, including supplemental UCP	(see instructions)	2, 949, 928	791, 228	35. 03
36. 00	Total UCP adjustment (sum of columns 1 and 2 on line 35.03)	,	3, 741, 156		36. 00
40. 00	Additional payment for high percentage of ESRD beneficiary disc Total Medicare discharges (see instructions)	harges (lines 40 through	46)		40.00
70.00	The second secon		Before GEO	On/After GEO	10100
			Reclass 1.00	Recl ass 1. 01	
41. 00	Total ESRD Medicare discharges (see instructions)		0	0	l
41. 01 42. 00	Total ESRD Medicare covered and paid discharges (see instruction Divide line 41 by line 40 (if less than 10%, you do not qualify	•	0.00	-	41. 01 42. 00
43.00	Total Medicare ESRD inpatient days (see instructions)	,	0		43. 00
44. 00	Ratio of average length of stay to one week (line 43 divided by days)	/line 41 divided by 7	0. 000000		44. 00
45. 00	Average weekly cost for dialysis treatments (see instructions)		0.00	0.00	45. 00
46. 00 47. 00	Total additional payment (line 45 times line 44 times line 41.0 Subtotal (see instructions)	01)	0 32, 269, 960	338, 242	46. 00 47. 00
48. 00	Hospital specific payments (to be completed by SCH and MDH, sma	all rural hospitals	0	0	48. 00
	only. (see instructions)			Amount	
				1. 00	
49. 00 50. 00	Total payment for inpatient operating costs (see instructions) Payment for inpatient program capital (from Wkst. L, Pt. I and	Pt II as annlicable)		32, 608, 202 2, 191, 857	
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. I	II, see instructions)		0	51. 00
52. 00 53. 00	Direct graduate medical education payment (from Wkst. E-4, line Nursing and Allied Health Managed Care payment	e 49 see instructions).		0 762, 181	52. 00 53. 00
54. 00	Special add-on payments for new technologies			47, 505	
54. 01 55. 00	Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)			0	
55. 01	Cellular therapy acquisition cost (see instructions)			0	55. 01
56.00	Cost of physicians' services in a teaching hospital (see intruc	•	ough 2E)	0 470, 700	56. 00 57. 00
57. 00 58. 00	Routine service other pass through costs (from Wkst. D, Pt. III Ancillary service other pass through costs from Wkst. D, Pt. IV		ough 35).	670, 790 183, 483	1
59.00	Total (sum of amounts on lines 49 through 58)			36, 464, 018	1
60. 00 61. 00	Primary payer payments Total amount payable for program beneficiaries (line 59 minus I	ine 60)		2, 519 36, 461, 499	1
62.00	Deductibles billed to program beneficiaries	•		2, 696, 572	62. 00
63. 00 64. 00	Coinsurance billed to program beneficiaries Allowable bad debts (see instructions)			37, 600 141, 468	1
65.00	Adjusted reimbursable bad debts (see instructions)			91, 954	65. 00
66. 00 67. 00	Allowable bad debts for dual eligible beneficiaries (see instru Subtotal (line 61 plus line 65 minus lines 62 and 63)	ıctions)		44, 377 33, 819, 281	•
68. 00	Credits received from manufacturers for replaced devices for ap			0	68. 00
69. 00 70. 00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (FOTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	for SCH see instructions)		0	69. 00 70. 00
70. 50	Rural Community Hospital Demonstration Project (§410A Demonstra	ntion) adjustment (see ir	structions)	0	70. 50
70. 75 70. 87	N95 respirator payment adjustment amount (see instructions) Demonstration payment adjustment amount before sequestration			0	70. 75 70. 87
70. 87	SCH or MDH volume decrease adjustment (contractor use only)			0	70. 87
70.89	Proneer ACO demonstration payment adjustment amount (see instru	ıcti ons)			70. 89
70. 90 70. 91	HSP bonus payment HVBP adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions)			0	70. 90 70. 91
70. 92	Bundled Model 1 discount amount (see instructions)			0	70. 92
70. 93 70. 94	HVBP payment adjustment amount (see instructions) HRR adjustment amount (see instructions)			-75, 961 -51, 269	
	Recovery of accelerated depreciation				70. 95

Heal th	Financial Systems FRANCISCAN HEALTH	I AFAVETTE		Inlia	u of Form CMS-:	2552_10
	ATION OF REIMBURSEMENT SETTLEMENT	Provi der Co		Peri od: From 01/01/2023 To 12/31/2023	Worksheet E Part A	pared:
		Title	XVIII	Hospi tal	PPS	
			FFY	(yyyy)	Amount	
				0	1. 00	
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter in the corresponding federal year for the period prior to 10/1)	column 0		0	0	70. 96
70. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter in the corresponding federal year for the period ending on or aft			0	0	70. 97
70. 98	Low Volume Payment-3	,		0	0	70. 98
70. 99	HAC adjustment amount (see instructions)				87, 305	
71. 00	Amount due provider (line 67 minus lines 68 plus/minus lines 6	9 & 70)			33, 604, 746	
71. 01	Sequestration adjustment (see instructions)	,			672, 095	
71. 02	Demonstration payment adjustment amount after sequestration				0,2,0,0	1
71. 03	Seguestration adjustment-PARHM pass-throughs				ŭ	71. 03
72. 00	Interim payments				32, 699, 553	
	Interim payments-PARHM				02,077,000	72. 01
73. 00	Tentative settlement (for contractor use only)				0	
73. 01	Tentative settlement-PARHM (for contractor use only)				Ü	73. 01
74. 00	Balance due provider/program (line 71 minus lines 71.01, 71.02	72 and			233, 098	
7 1. 00	73)	., 72, and			200, 070	7 1. 00
74. 01	Balance due provider/program-PARHM (see instructions)					74. 01
75. 00	Protested amounts (nonallowable cost report items) in accordan	nce with			596, 900	
70.00	CMS Pub. 15-2, chapter 1, §115.2	ioc wi tii			070, 700	70.00
	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	ıcti ons)			0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instruct	i ons)			0	93. 00
94.00	The rate used to calculate the time value of money (see instru	ıcti ons)			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	i ons)			0	96. 00
				Prior to 10/1		
				1. 00	2. 00	
	HSP Bonus Payment Amount			1		
100.00	HSP bonus amount (see instructions)			0	0	100. 00
404.00	HVBP Adjustment for HSP Bonus Payment			0.000000000	0.000000000	101 00
	HVBP adjustment factor (see instructions)			0.0000000000		
102.00	HVBP adjustment amount for HSP bonus payment (see instructions	5)		0	0	102. 00
102.00	HRR Adjustment for HSP Bonus Payment			0.0000	0.0000	100 00
	HRR adjustment factor (see instructions)			0.0000		103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr		uctmont	0	U	104. 00
200 00	Is this the first year of the current 5-year demonstration per					200 00
200.00	Century Cures Act? Enter "Y" for yes or "N" for no.	Tod under t	ne 21St			200. 00
	Cost Reimbursement					1
201 00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line	49)				201. 00
	Medicare discharges (see instructions)	, 1 7]				201.00
	Case-mix adjustment factor (see instructions)					203. 00
203.00	Computation of Demonstration Target Amount Limitation (N/A in	first vear	of the curren	t 5-vear demonst	ration	1200.00
	The second of th	your		. J Jou. demonst		

	73)		200,070	' ''
4. 01	Balance due provider/program-PARHM (see instructions)			74.
5. 00	Protested amounts (nonallowable cost report items) in accordance with		596, 900	
). OO	CMS Pub. 15-2, chapter 1, §115.2		370, 700	/ 5.
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
0. 00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03		0	90.
, 00	plus 2.04 (see instructions)		١	'0.
1. 00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.
2. 00	Operating outlier reconciliation adjustment amount (see instructions)			1 ' ''
3. 00	Capital outlier reconciliation adjustment amount (see instructions)			1
. 00	The rate used to calculate the time value of money (see instructions)		0.00	
5. 00	Time value of money for operating expenses (see instructions)		0.00	1
				96.
. 00	Time value of money for capital related expenses (see instructions)	Dri or to 10/1	On/After 10/1	90.
	UCD Days Primark Assess	1. 00	2. 00	-
	HSP Bonus Payment Amount	1		1.00
0.00	HSP bonus amount (see instructions)	0		100.
	HVBP Adjustment for HSP Bonus Payment			1
	HVBP adjustment factor (see instructions)	0.000000000		
2.00	HVBP adjustment amount for HSP bonus payment (see instructions)	0	[0	102
	HRR Adjustment for HSP Bonus Payment			4
	HRR adjustment factor (see instructions)	0.0000		
4. 00	HRR adjustment amount for HSP bonus payment (see instructions)	0	0	104
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
0.00	Is this the first year of the current 5-year demonstration period under the 21st			200
	Century Cures Act? Enter "Y" for yes or "N" for no.			
	Cost Reimbursement	T		
1.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.
2.00	Medicare discharges (see instructions)			202
3.00	Case-mix adjustment factor (see instructions)			203
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current	5-year demonst	trati on	
	peri od)			1004
	Medicare target amount			204
	Case-mix adjusted target amount (line 203 times line 204)			205
6. 00	Medicare inpatient routine cost cap (line 202 times line 205)			206
	Adjustment to Medicare Part A Inpatient Reimbursement	T		
	Program reimbursement under the §410A Demonstration (see instructions)			207
	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208
	Adjustment to Medicare IPPS payments (see instructions)			209
	Reserved for future use			210
1.00	Total adjustment to Medicare IPPS payments (see instructions)			211.
	Comparision of PPS versus Cost Reimbursement			
	Total adjustment to Medicare Part A IPPS payments (from line 211)			212
2. 00		1	1	213.
	Low-volume adjustment (see instructions)		1	I
13.00	Low-volume adjustment (see instructions) Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement)			218.

Health Financial Systems

LOW VOLUME CALCULATION EXHIBIT 4 Provider CCN: 15-0109

				T' 11	20/11/1		3/28/2024 12:	04 pm
				litle	XVIII	Hospi tal On/After 10/01	PPS	
		W/S E, Part A	Amounts (from	Pre/Post	Period Prior	Urban	Rural	
		line	E, Part A)	Entitlement	to 10/01			
4 00		0	1.00	2.00	3.00	4. 00	4. 01	4 00
1. 00	DRG amounts other than outlier payments	1. 00	0	0	C	0	0	1.00
1. 01	DRG amounts other than outlier payments for discharges	1. 01	20, 176, 109	0	20, 176, 109			1. 01
1. 02	occurring prior to October 1 DRG amounts other than outlier payments for discharges occurring on or after October	1. 02	7, 120, 730	0		7, 120, 730	0	1. 02
1. 03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to	1. 03	0	0	C			1. 03
1. 04	October 1 DRG for Federal specific operating payment for Model 4 BPCI occurring on or after	1. 04	0	0		0	0	1. 04
2. 00	October 1 Outlier payments for discharges (see instructions)	2. 00						2. 00
2. 01	Outlier payments for discharges for Model 4 BPCI	2. 02	0	0	С	0	0	2. 01
2. 02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2. 03	504, 302	0	504, 302			2. 02
2. 03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2. 04	122, 799	0		122, 799	0	2. 03
3.00	Operating outlier reconciliation	2. 01	0	0	С	0	0	3. 00
4. 00	Managed care simulated payments	3. 00	0	0	C	0	0	4. 00
	Indirect Medical Education Adju							
5. 00	Amount from Worksheet E, Part A, line 21 (see instructions)	21. 00	0. 000000	0. 000000	0. 000000	0. 000000	0. 000000	5. 00
6. 00	IME payment adjustment (see instructions)	22. 00	0	0	С	0	0	6. 00
6. 01	IME payment adjustment for managed care (see	22. 01	0	0	С	O	0	6. 01
	instructions) Indirect Medical Education Adju	stment for the	Add-on for Se	ction 422 of t	L he MMΔ			
7. 00	IME payment adjustment factor (see instructions)	27. 00	0. 000000	0. 000000		0.000000	0. 000000	7. 00
8. 00	IME adjustment (see instructions)	28. 00	0	0	С	0	0	8. 00
8. 01	IME payment adjustment add on for managed care (see instructions)	28. 01	0	0	С	O	0	8. 01
9. 00	Total IME payment (sum of lines 6 and 8)	29. 00	0	0	С	0	0	9. 00
9. 01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29. 01	0	0	С	O	0	9. 01
	Disproportionate Share Adjustme							
10. 00	Allowable disproportionate share percentage (see instructions)	33.00	0. 1382	0. 1382	0. 1382	0. 1382	0. 1382	10.00
11. 00	Di sproporti onate share adjustment (see instructions)	34. 00	943, 106	0	697, 085	246, 021	0	11. 00
11. 01	Uncompensated care payments	36.00	3, 741, 156	0	2, 949, 928	791, 228	0	11. 01
12. 00	Additional payment for high per Total ESRD additional payment	centage of ESR 46.00	beneticiary 0	di scharges 0	C	0	0	12. 00
13. 00 14. 00	(see instructions) Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.)	47. 00 48. 00	32, 608, 202 0	0	24, 327, 424 C	8, 280, 778 0	0	
15. 00	(see instructions) Total payment for inpatient operating costs (see	49. 00	32, 608, 202	0	24, 327, 424	8, 280, 778	0	15. 00
16. 00	<pre>instructions) Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)</pre>	50. 00	2, 191, 857	0	1, 614, 897	576, 960	0	16. 00
	1 appricable)	ı	ı l		ı	ı I	l .	ı

Health Financial Systems	FRANCISCAN HEALTH LAFAYETTE	In Lieu of Form CMS-2552-10
LOW VOLUME CALCULATION EXHIBIT 4	Provider CCN: 15-0109	Peri od: Worksheet E From 01/01/2023 Part A Exhi bi t 4

					T	o 12/31/2023	Date/Time Pre 3/28/2024 12:	
				Title	XVIII	Hospi tal	PPS	о . р
				<u> </u>		On/After 10/01		
		W/S E, Part A	Amounts (from	Pre/Post	Period Prior	Urban	Rural	
		line	E, Part A)	Entitlement	to 10/01			
		0	1.00	2.00	3.00	4. 00	4. 01	
17. 00	Special add-on payments for	54.00	47, 505	0	47, 505	0	0	17. 00
	new technologies							
17. 01	Net organ aquisition cost							17. 01
17. 02	Credits received from	68. 00	0	0	C	0	0	17. 02
	manufacturers for replaced							
10 00	devices for applicable MS-DRGs Capital outlier reconciliation	02.00	0	0	,		0	10 00
18. 00	adjustment amount (see	93. 00	0	Ü			0	18. 00
	instructions)							
19 00	SUBTOTAL			0	25, 989, 826	8, 857, 738	0	19. 00
171.00	COBTO TALE	W/S L, line	(Amounts from		20/707/020	Urban	Rural	171.00
		,	L)					
		0	1.00	2. 00	3.00	4. 00	4. 01	
20. 00	Capital DRG other than outlier	1. 00	2, 068, 870	0	1, 520, 271	548, 599	0	20.00
20. 01	Model 4 BPCI Capital DRG other	1. 01	0	0	C	0	0	20. 01
	than outlier							
21. 00	Capital DRG outlier payments	2. 00	122, 987	0	, ., 020	28, 361	0	
21. 01	Model 4 BPCI Capital DRG	2. 01	0	0	C	0	0	21. 01
00.00	outlier payments	F 00	0.0000	0.0000	0.000	0.0000	0.0000	00.00
22. 00	Indirect medical education	5. 00	0. 0000	0. 0000	0. 0000	0. 0000	0. 0000	22. 00
23. 00	percentage (see instructions) Indirect medical education	6. 00	0	0	(0	23. 00
23.00	adjustment (see instructions)	6.00	U	Ü		١	U	23.00
24. 00	Allowable disproportionate	10. 00	0. 0000	0.0000	0.0000	0.0000	0 0000	24. 00
24.00	share percentage (see	10.00	0.0000	0.0000	0.0000	0.0000	0.0000	24.00
	instructions)							
25. 00	Di sproporti onate share	11. 00	0	0	1 0	o	0	25. 00
	adjustment (see instructions)							
26. 00	Total prospective capital	12. 00	2, 191, 857	0	1, 614, 897	576, 960	0	26.00
	payments (see instructions)							
			(Amounts to E,			Urban	Rural	
		l i ne	Part A)					
	1	0	1. 00	2. 00	3. 00	4. 00	4. 01	
27. 00	Low volume adjustment factor	70.0/			0.000000		0. 000000	
28. 00	Low volume adjustment	70. 96			C)	0	28. 00
	(transfer amount to Wkst. E, Pt. A, line)							
29. 00	Low volume adjustment	70. 97				0	0	29. 00
∠7. UU	(transfer amount to Wkst. E,	10.91				١	0	29.00
	Pt. A, line)							
100 00	Transfer low volume		Υ					100.00
. 50. 50	adjustments to Wkst. E, Pt. A.							55. 50
	123 22 3	1	!		ļ	'		

Health Financial Systems	FRANCISCAN HEALTH LAFAYETTE	In Lieu of Form CMS-2552-10
LOW VOLUME CALCULATION EXHIBIT 4	Provi der CCN: 15-0109	Peri od: Worksheet E From 01/01/2023 Part A Exhi bit 4 To 12/31/2023 Date/Ti me Prepared: 3/28/2024 12:04 pm

				Title XVIII	Hospi tal	3/28/2024 12: 0 PPS	04 pm
		Total (Col 2 through 4)					
1.00	DRG amounts other than outlier	5. 00 0					1. (
. 01	payments DRG amounts other than outlier	20, 176, 109					1.
. 02	payments for discharges occurring prior to October 1 DRG amounts other than outlier	7, 120, 730					1.
	payments for discharges occurring on or after October						
. 03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	0					1.
04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	0					1.
. 00	Outlier payments for						2.
. 01	discharges (see instructions) Outlier payments for	0					2.
. 02	discharges for Model 4 BPCI Outlier payments for discharges occurring prior to	504, 302					2.
. 03	October 1 (see instructions) Outlier payments for discharges occurring on or after October 1 (see	122, 799					2.
. 00	instructions) Operating outlier	0					3.
. 00	reconciliation Managed care simulated	0					4
00	payments Indirect Medical Education Adju Amount from Worksheet E, Part	ıstment					5
00	A, line 21 (see instructions) IME payment adjustment (see	0					6
01	instructions) IME payment adjustment for managed care (see	0					6
	instructions)			100 6 11 1994]
00	Indirect Medical Education Adju	istment for the	Add-on for Secti	on 422 of the MMA			1 7
00	(see instructions) IME adjustment (see	0					8
	instructions)	0					
01	IME payment adjustment add on for managed care (see instructions)	U					
00	Total IME payment (sum of lines 6 and 8)	0					9
01	Total IME payment for managed care (sum of lines 6.01 and	0					ç
	8.01) Disproportionate Share Adjustme	en†					1
. 00	Allowable disproportionate share percentage (see						10
. 00	instructions) Disproportionate share	943, 106					1
. 00	adjustment (see instructions) Uncompensated care payments	3, 741, 156					11
	Additional payment for high per			charges			
. 00	Total ESRD additional payment (see instructions)	0					12
00	Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.)	32, 608, 202 0					13
. 00	(see instructions) Total payment for inpatient operating costs (see	32, 608, 202					15
. 00	<pre>instructions) Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)</pre>	2, 191, 857					16

Heal th	Financial Systems	ı	FRANCISCAN HEALTH	ΙΔΕΔΥΕΤΤΕ	Inlie	u of Form CMS-	2552_10
	LUME CALCULATION EXHIBIT 4	·	TANOT SOAN TIERETT	Provi der CCN: 15-0109	Peri od: From 01/01/2023 To 12/31/2023	Worksheet E Part A Exhibi	t 4 epared:
				Title XVIII	Hospi tal	PPS	
		Total (Col 2 through 4) 5.00					-
17. 00	Special add-on payments for new technologies	47, 505					17. 00
	Net organ aquisition cost Credits received from manufacturers for replaced devices for applicable MS-DRGs	0					17. 01 17. 02
18. 00	Capital outlier reconciliation adjustment amount (see instructions)	0					18. 00
19. 00	SUBTOTAL	34, 847, 564					19. 00
		5. 00					
	Capital DRG other than outlier Model 4 BPCI Capital DRG other	2, 068, 870 0					20. 00 20. 01
	than outlier Capital DRG outlier payments Model 4 BPCI Capital DRG outlier payments	122, 987 0					21. 00 21. 01
22. 00	Indirect medical education percentage (see instructions)						22. 00
	Indirect medical education adjustment (see instructions)	0					23. 00
24. 00	Allowable disproportionate share percentage (see instructions)						24. 00
25. 00	Disproportionate share adjustment (see instructions)	0					25. 00
26. 00	Total prospective capital payments (see instructions)	2, 191, 857					26. 00
	•	5. 00			_		-
27. 00 28. 00	Low volume adjustment factor Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	0					27. 00 28. 00
29. 00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	0					29. 00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.						100. 00

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

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 Provider CCN: 15-0109 Period: Worksheet E From 01/01/2023 To 12/31/2023 Date/Time Prepared:

				10	12/31/2023	3/28/2024 12:	
			Title	XVIII	Hospi tal	PPS	
					On/Afte		
		Wkst. E, Pt.	Amt. from	Period to	Urban	Rural	
		A, line	Wkst. E, Pt.	10/01			
		0	A) 1.00	2. 00	3. 00	3. 01	
1. 00	DRG amounts other than outlier payments	1.00	1.00	2.00	3.00	3.01	1. 00
1. 01	DRG amounts other than outlier payments for	1. 01	20, 176, 109	20, 176, 109		0	1. 01
	discharges occurring prior to October 1						
1.02	DRG amounts other than outlier payments for	1. 02	7, 120, 730		7, 120, 730	0	1. 02
	discharges occurring on or after October 1						4 00
1. 03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October	1. 03	0	0		0	1. 03
	11						
1.04	DRG for Federal specific operating payment	1. 04	O		o	0	1. 04
	for Model 4 BPCI occurring on or after						
	October 1						
2.00	Outlier payments for discharges (see	2. 00					2. 00
2. 01	instructions) Outlier payments for discharges for Model 4	2. 02		0	0	0	2. 01
2.01	BPCI	2.02		O	٥	O	2.01
2.02	Outlier payments for discharges occurring	2. 03	504, 302	504, 302			2. 02
	prior to October 1 (see instructions)						
2.03	Outlier payments for discharges occurring on	2. 04	122, 799		122, 799	0	2. 03
2 00	or after October 1 (see instructions)	2 01		0		0	3. 00
3. 00 4. 00	Operating outlier reconciliation Managed care simulated payments	2. 01 3. 00	0	0	0	0	4. 00
4.00	Indirect Medical Education Adjustment	3.00	0	<u> </u>	<u> </u>		4.00
5.00	Amount from Worksheet E, Part A, line 21	21.00	0. 000000	0. 000000	0.000000	0. 000000	5. 00
	(see instructions)						
6.00	IME payment adjustment (see instructions)	22. 00	0	0	0	0	6. 00
6. 01	IME payment adjustment for managed care (see	22. 01	0	0	0	0	6. 01
	instructions) Indirect Medical Education Adjustment for the	Add-on for Se	ection 422 of the	he MMA			
				TO WIND C			
7. 00	IME payment adjustment factor (see	27. 00	0.000000	0.000000	0. 000000	0.000000	7.00
7. 00	IME payment adjustment factor (see instructions)		0. 000000	0. 000000	0. 000000	0. 000000	7. 00
8. 00	instructions) IME adjustment (see instructions)	27. 00 28. 00	0. 000000	0.000000	0. 000000	0	8. 00
	instructions) IME adjustment (see instructions) IME payment adjustment add on for managed	27. 00	0. 000000 0 0	0. 000000 0 0	0. 000000 0 0		
8. 00 8. 01	instructions) IME adjustment (see instructions) IME payment adjustment add on for managed care (see instructions)	27. 00 28. 00 28. 01	0.000000	0. 000000 0 0	0. 000000 0 0	0	8. 00 8. 01
8. 00 8. 01 9. 00	instructions) IME adjustment (see instructions) IME payment adjustment add on for managed care (see instructions) Total IME payment (sum of lines 6 and 8)	27. 00 28. 00 28. 01 29. 00	0. 000000 0 0	0. 000000 0 0	0. 000000 0 0	0 0	8. 00 8. 01 9. 00
8. 00 8. 01	instructions) IME adjustment (see instructions) IME payment adjustment add on for managed care (see instructions) Total IME payment (sum of lines 6 and 8) Total IME payment for managed care (sum of	27. 00 28. 00 28. 01	0.000000 0 0	0. 000000 0 0 0	0. 000000 0 0 0	0	8. 00 8. 01
8. 00 8. 01 9. 00	instructions) IME adjustment (see instructions) IME payment adjustment add on for managed care (see instructions) Total IME payment (sum of lines 6 and 8)	27. 00 28. 00 28. 01 29. 00	0. 000000 0 0	0. 000000 0 0 0	0. 000000 0 0 0	0 0	8. 00 8. 01 9. 00
8. 00 8. 01 9. 00	instructions) IME adjustment (see instructions) IME payment adjustment add on for managed care (see instructions) Total IME payment (sum of lines 6 and 8) Total IME payment for managed care (sum of lines 6.01 and 8.01) Disproportionate Share Adjustment Allowable disproportionate share percentage	27. 00 28. 00 28. 01 29. 00	0. 000000 0 0 0 0	0. 000000 0 0 0 0	0. 000000 0 0 0 0	0 0	8. 00 8. 01 9. 00
8. 00 8. 01 9. 00 9. 01	instructions) IME adjustment (see instructions) IME payment adjustment add on for managed care (see instructions) Total IME payment (sum of lines 6 and 8) Total IME payment for managed care (sum of lines 6.01 and 8.01) Disproportionate Share Adjustment Allowable disproportionate share percentage (see instructions)	27. 00 28. 00 28. 01 29. 00 29. 01	0 0 0 0 0	0 0 0 0 0	0 0 0 0 0. 1382	0 0 0 0	8. 00 8. 01 9. 00 9. 01
8. 00 8. 01 9. 00 9. 01	instructions) IME adjustment (see instructions) IME payment adjustment add on for managed care (see instructions) Total IME payment (sum of lines 6 and 8) Total IME payment for managed care (sum of lines 6.01 and 8.01) Disproportionate Share Adjustment Allowable disproportionate share percentage (see instructions) Disproportionate share adjustment (see	27. 00 28. 00 28. 01 29. 00 29. 01	0 0	0 0 0 0	0 0 0 0	0 0 0	8. 00 8. 01 9. 00 9. 01
8. 00 8. 01 9. 00 9. 01 10. 00 11. 00	instructions) IME adjustment (see instructions) IME payment adjustment add on for managed care (see instructions) Total IME payment (sum of lines 6 and 8) Total IME payment for managed care (sum of lines 6.01 and 8.01) Disproportionate Share Adjustment Allowable disproportionate share percentage (see instructions) Disproportionate share adjustment (see instructions)	27. 00 28. 00 28. 01 29. 00 29. 01 33. 00 34. 00	0. 1382 943, 106	0 0 0 0 1382 697, 085	0 0 0 0. 1382 246, 021	0 0 0 0 0.1382	8. 00 8. 01 9. 00 9. 01 10. 00
8. 00 8. 01 9. 00 9. 01	instructions) IME adjustment (see instructions) IME payment adjustment add on for managed care (see instructions) Total IME payment (sum of lines 6 and 8) Total IME payment for managed care (sum of lines 6.01 and 8.01) Disproportionate Share Adjustment Allowable disproportionate share percentage (see instructions) Disproportionate share adjustment (see	27. 00 28. 00 28. 01 29. 00 29. 01 33. 00 34. 00 36. 00	0. 1382 943, 106 3, 741, 156	0 0 0 0 1382 697, 085	0 0 0 0 0. 1382	0 0 0 0	8. 00 8. 01 9. 00 9. 01
8. 00 8. 01 9. 00 9. 01 10. 00 11. 00	instructions) IME adjustment (see instructions) IME payment adjustment add on for managed care (see instructions) Total IME payment (sum of lines 6 and 8) Total IME payment for managed care (sum of lines 6.01 and 8.01) Disproportionate Share Adjustment Allowable disproportionate share percentage (see instructions) Disproportionate share adjustment (see instructions) Uncompensated care payments	27. 00 28. 00 28. 01 29. 00 29. 01 33. 00 34. 00 36. 00	0. 1382 943, 106 3, 741, 156	0 0 0 0 1382 697, 085	0 0 0 0. 1382 246, 021	0 0 0 0 0.1382	8. 00 8. 01 9. 00 9. 01 10. 00
8. 00 8. 01 9. 00 9. 01 10. 00 11. 00 11. 01 12. 00	instructions) IME adjustment (see instructions) IME payment adjustment add on for managed care (see instructions) Total IME payment (sum of lines 6 and 8) Total IME payment for managed care (sum of lines 6.01 and 8.01) Disproportionate Share Adjustment Allowable disproportionate share percentage (see instructions) Disproportionate share adjustment (see instructions) Uncompensated care payments Additional payment for high percentage of ESF Total ESRD additional payment (see instructions)	27. 00 28. 00 28. 01 29. 00 29. 01 33. 00 34. 00 36. 00 80 beneficiary 46. 00	0. 1382 943, 106 3, 741, 156 di scharges	0 0 0 0 1.1382 697, 085 2, 949, 928	0 0 0 0. 1382 246, 021 791, 228	0 0 0 0 0.1382 0 0	8. 00 8. 01 9. 00 9. 01 10. 00 11. 00 11. 01 12. 00
8. 00 8. 01 9. 00 9. 01 10. 00 11. 00 11. 01 12. 00 13. 00	instructions) IME adjustment (see instructions) IME payment adjustment add on for managed care (see instructions) Total IME payment (sum of lines 6 and 8) Total IME payment for managed care (sum of lines 6.01 and 8.01) Disproportionate Share Adjustment Allowable disproportionate share percentage (see instructions) Disproportionate share adjustment (see instructions) Uncompensated care payments Additional payment for high percentage of ESF Total ESRD additional payment (see instructions) Subtotal (see instructions)	27. 00 28. 00 28. 01 29. 00 29. 01 33. 00 34. 00 36. 00 8D beneficiary 46. 00 47. 00	0. 1382 943, 106 3, 741, 156	0 0 0 0 1.1382 697, 085 2, 949, 928	0 0 0 0. 1382 246, 021	0.1382 0.00 0.00	8. 00 8. 01 9. 00 9. 01 10. 00 11. 00 11. 01 12. 00 13. 00
8. 00 8. 01 9. 00 9. 01 10. 00 11. 00 11. 01 12. 00	instructions) IME adjustment (see instructions) IME payment adjustment add on for managed care (see instructions) Total IME payment (sum of lines 6 and 8) Total IME payment for managed care (sum of lines 6.01 and 8.01) Disproportionate Share Adjustment Allowable disproportionate share percentage (see instructions) Disproportionate share adjustment (see instructions) Uncompensated care payments Additional payment for high percentage of ESE Total ESRD additional payment (see instructions) Subtotal (see instructions) Hospital specific payments (completed by SCH	27. 00 28. 00 28. 01 29. 00 29. 01 33. 00 34. 00 36. 00 80 beneficiary 46. 00	0. 1382 943, 106 3, 741, 156 di scharges	0 0 0 0 1.1382 697, 085 2, 949, 928	0 0 0 0. 1382 246, 021 791, 228	0 0 0 0 0.1382 0 0	8. 00 8. 01 9. 00 9. 01 10. 00 11. 00 11. 01 12. 00
8. 00 8. 01 9. 00 9. 01 10. 00 11. 00 11. 01 12. 00 13. 00	instructions) IME adjustment (see instructions) IME payment adjustment add on for managed care (see instructions) Total IME payment (sum of lines 6 and 8) Total IME payment for managed care (sum of lines 6.01 and 8.01) Disproportionate Share Adjustment Allowable disproportionate share percentage (see instructions) Disproportionate share adjustment (see instructions) Uncompensated care payments Additional payment for high percentage of ESF Total ESRD additional payment (see instructions) Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see	27. 00 28. 00 28. 01 29. 00 29. 01 33. 00 34. 00 36. 00 8D beneficiary 46. 00 47. 00	0. 1382 943, 106 3, 741, 156 di scharges	0 0 0 0 1.1382 697, 085 2, 949, 928	0 0 0 0. 1382 246, 021 791, 228	0.1382 0.00 0.00	8. 00 8. 01 9. 00 9. 01 10. 00 11. 00 11. 01 12. 00 13. 00
8. 00 8. 01 9. 00 9. 01 10. 00 11. 00 11. 01 12. 00 13. 00	instructions) IME adjustment (see instructions) IME payment adjustment add on for managed care (see instructions) Total IME payment (sum of lines 6 and 8) Total IME payment for managed care (sum of lines 6.01 and 8.01) Disproportionate Share Adjustment Allowable disproportionate share percentage (see instructions) Disproportionate share adjustment (see instructions) Uncompensated care payments Additional payment for high percentage of ESF Total ESRD additional payment (see instructions) Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	27. 00 28. 00 28. 01 29. 00 29. 01 33. 00 34. 00 36. 00 8D beneficiary 46. 00 47. 00	0. 1382 943, 106 3, 741, 156 di scharges	0. 1382 697, 085 2, 949, 928 0 24, 327, 424 0	0 0 0 0. 1382 246, 021 791, 228	0.1382 0.00 0.00	8. 00 8. 01 9. 00 9. 01 10. 00 11. 00 11. 01 12. 00 13. 00 14. 00
8. 00 8. 01 9. 00 9. 01 10. 00 11. 00 11. 01 12. 00 13. 00 14. 00	instructions) IME adjustment (see instructions) IME payment adjustment add on for managed care (see instructions) Total IME payment (sum of lines 6 and 8) Total IME payment for managed care (sum of lines 6.01 and 8.01) Disproportionate Share Adjustment Allowable disproportionate share percentage (see instructions) Disproportionate share adjustment (see instructions) Uncompensated care payments Additional payment for high percentage of ESF Total ESRD additional payment (see instructions) Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions) Total payment for inpatient operating costs (see instructions)	27. 00 28. 00 28. 01 29. 00 29. 01 33. 00 34. 00 36. 00 46. 00 47. 00 48. 00 49. 00	0. 1382 943, 106 3, 741, 156 di scharges 0 32, 608, 202 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0. 1382 246, 021 791, 228 0 8, 280, 778 0	0 0 0 0 0.1382 0 0	8. 00 8. 01 9. 00 9. 01 10. 00 11. 00 11. 01 12. 00 13. 00 14. 00
8. 00 8. 01 9. 00 9. 01 10. 00 11. 00 11. 01 12. 00 13. 00 14. 00	instructions) IME adjustment (see instructions) IME payment adjustment add on for managed care (see instructions) Total IME payment (sum of lines 6 and 8) Total IME payment for managed care (sum of lines 6.01 and 8.01) Disproportionate Share Adjustment Allowable disproportionate share percentage (see instructions) Disproportionate share adjustment (see instructions) Uncompensated care payments Additional payment for high percentage of ESF Total ESRD additional payment (see instructions) Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions) Total payment for inpatient operating costs (see instructions)	27. 00 28. 00 28. 01 29. 00 29. 01 33. 00 34. 00 36. 00 20 beneficiary 46. 00 47. 00 48. 00	0. 1382 943, 106 3, 741, 156 di scharges 0 32, 608, 202 0	0. 1382 697, 085 2, 949, 928 0 24, 327, 424 0	0. 1382 246, 021 791, 228 0 8, 280, 778 0	0 0 0 0 0.1382 0 0	8. 00 8. 01 9. 00 9. 01 10. 00 11. 00 11. 01 12. 00 13. 00 14. 00
8. 00 8. 01 9. 00 9. 01 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00	instructions) IME adjustment (see instructions) IME payment adjustment add on for managed care (see instructions) Total IME payment (sum of lines 6 and 8) Total IME payment for managed care (sum of lines 6.01 and 8.01) Disproportionate Share Adjustment Allowable disproportionate share percentage (see instructions) Disproportionate share adjustment (see instructions) Uncompensated care payments Additional payment for high percentage of ESF Total ESRD additional payment (see instructions) Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions) Total payment for inpatient operating costs (see instructions) Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	27. 00 28. 00 28. 01 29. 00 29. 01 33. 00 34. 00 36. 00 80 beneficiary 46. 00 47. 00 48. 00 49. 00 50. 00	0. 1382 943, 106 3, 741, 156 di scharges 0 32, 608, 202 0 32, 608, 202 2, 191, 857	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 1382 246, 021 791, 228 0 8, 280, 778 0	0 0 0 0 0 1382 0 0 0	8. 00 8. 01 9. 00 9. 01 10. 00 11. 00 11. 01 12. 00 13. 00 14. 00 15. 00
8. 00 8. 01 9. 00 9. 01 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00	instructions) IME adjustment (see instructions) IME payment adjustment add on for managed care (see instructions) Total IME payment (sum of lines 6 and 8) Total IME payment for managed care (sum of lines 6.01 and 8.01) Disproportionate Share Adjustment Allowable disproportionate share percentage (see instructions) Disproportionate share adjustment (see instructions) Uncompensated care payments Additional payment for high percentage of ESF Total ESRD additional payment (see instructions) Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions) Total payment for inpatient operating costs (see instructions) Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable) Special add-on payments for new technologies	27. 00 28. 00 28. 01 29. 00 29. 01 33. 00 34. 00 36. 00 46. 00 47. 00 48. 00 49. 00	0. 1382 943, 106 3, 741, 156 di scharges 0 32, 608, 202 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 1382 246, 021 791, 228 0 8, 280, 778 0	0. 1382 0. 1382 0 0	8. 00 8. 01 9. 00 9. 01 10. 00 11. 00 11. 01 12. 00 13. 00 14. 00 15. 00 16. 00
8. 00 8. 01 9. 00 9. 01 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00	instructions) IME adjustment (see instructions) IME payment adjustment add on for managed care (see instructions) Total IME payment (sum of lines 6 and 8) Total IME payment for managed care (sum of lines 6.01 and 8.01) Disproportionate Share Adjustment Allowable disproportionate share percentage (see instructions) Disproportionate share adjustment (see instructions) Uncompensated care payments Additional payment for high percentage of ESF Total ESRD additional payment (see instructions) Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions) Total payment for inpatient operating costs (see instructions) Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable) Special add-on payments for new technologies Net organ acquisition cost	27. 00 28. 00 28. 01 29. 00 29. 01 33. 00 34. 00 36. 00 46. 00 47. 00 48. 00 49. 00 50. 00 54. 00	0. 1382 943, 106 3, 741, 156 di scharges 0 32, 608, 202 0 32, 608, 202 2, 191, 857	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 1382 246, 021 791, 228 0 8, 280, 778 0	0 0 0 0 0 1382 0 0 0	8. 00 8. 01 9. 00 9. 01 10. 00 11. 00 11. 01 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 17. 01
8. 00 8. 01 9. 00 9. 01 10. 00 11. 00 11. 01 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 17. 01	instructions) IME adjustment (see instructions) IME payment adjustment add on for managed care (see instructions) Total IME payment (sum of lines 6 and 8) Total IME payment for managed care (sum of lines 6.01 and 8.01) Disproportionate Share Adjustment Allowable disproportionate share percentage (see instructions) Disproportionate share adjustment (see instructions) Uncompensated care payments Additional payment for high percentage of ESF Total ESRD additional payment (see instructions) Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions) Total payment for inpatient operating costs (see instructions) Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable) Special add-on payments for new technologies	27. 00 28. 00 28. 01 29. 00 29. 01 33. 00 34. 00 36. 00 80 beneficiary 46. 00 47. 00 48. 00 49. 00 50. 00	0. 1382 943, 106 3, 741, 156 di scharges 0 32, 608, 202 0 32, 608, 202 2, 191, 857	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 1382 246, 021 791, 228 0 8, 280, 778 0	0 0 0 0 0.1382 0 0 0	8. 00 8. 01 9. 00 9. 01 10. 00 11. 00 11. 01 12. 00 13. 00 14. 00 15. 00 16. 00
8. 00 8. 01 9. 00 9. 01 10. 00 11. 00 11. 01 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 17. 01	instructions) IME adjustment (see instructions) IME payment adjustment add on for managed care (see instructions) Total IME payment (sum of lines 6 and 8) Total IME payment for managed care (sum of lines 6.01 and 8.01) Disproportionate Share Adjustment Allowable disproportionate share percentage (see instructions) Disproportionate share adjustment (see instructions) Uncompensated care payments Additional payment for high percentage of ESF Total ESRD additional payment (see instructions) Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions) Total payment for inpatient operating costs (see instructions) Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable) Special add-on payments for new technologies Net organ acquisition cost Credits received from manufacturers for replaced devices for applicable MS-DRGs Capital outlier reconciliation adjustment	27. 00 28. 00 28. 01 29. 00 29. 01 33. 00 34. 00 36. 00 46. 00 47. 00 48. 00 49. 00 50. 00 54. 00	0. 1382 943, 106 3, 741, 156 di scharges 0 32, 608, 202 0 32, 608, 202 2, 191, 857	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 1382 246, 021 791, 228 0 8, 280, 778 0	0 0 0 0 0.1382 0 0 0	8. 00 8. 01 9. 00 9. 01 10. 00 11. 00 11. 01 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 17. 01
8. 00 8. 01 9. 00 9. 01 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 17. 00 17. 01 17. 02 18. 00	instructions) IME adjustment (see instructions) IME payment adjustment add on for managed care (see instructions) Total IME payment (sum of lines 6 and 8) Total IME payment for managed care (sum of lines 6.01 and 8.01) Disproportionate Share Adjustment Allowable disproportionate share percentage (see instructions) Disproportionate share adjustment (see instructions) Uncompensated care payments Additional payment for high percentage of ESF Total ESRD additional payment (see instructions) Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions) Total payment for inpatient operating costs (see instructions) Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable) Special add-on payments for new technologies Net organ acquisition cost Credits received from manufacturers for replaced devices for applicable MS-DRGs	27. 00 28. 00 28. 01 29. 00 29. 01 33. 00 34. 00 36. 00 47. 00 48. 00 49. 00 50. 00 54. 00 68. 00	0. 1382 943, 106 3, 741, 156 di scharges 0 32, 608, 202 0 32, 608, 202 2, 191, 857 47, 505	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 1382 246, 021 791, 228 0 8, 280, 778 0	0 0 0 0 0 0 0 0 0 0 0	8. 00 8. 01 9. 00 9. 01 10. 00 11. 01 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 17. 00 17. 02

Health Financial Systems	FRANCISCAN HEALTH	In Lieu of Form CMS-2552-10		
HOSPITAL ACQUIRED CONDITION (HA	C) REDUCTION CALCULATION EXHIBIT 5	Provider CCN: 15-0109	Peri od:	Worksheet E

HOSPI T	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5	Provider CC	CN: 15-0109	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part A Exhibi Date/Time Pre 3/28/2024 12:	pared:
			Title	XVIII	Hospi tal	PPS	
		Wkst. L, line	(Amt. from Wkst. L)		Urban	Rural	
		0	1.00	2. 00	3. 00	3. 01	
20.00	Capital DRG other than outlier	1.00	2, 068, 870	1, 520, 2	71 548, 599	0	20. 00
20. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	0		0 0	0	20. 01
21.00	Capital DRG outlier payments	2.00	122, 987	94, 62	26 28, 361	0	21. 00
21. 01	Model 4 BPCI Capital DRG outlier payments	2. 01	0		0 0	0	21. 01
22. 00	Indirect medical education percentage (see instructions)	5. 00	0. 0000	0.000	0. 0000	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	0. 0000	24. 00
25. 00	Disproportionate share adjustment (see instructions)	11.00	0		0 0	0	25. 00
26. 00	Total prospective capital payments (see instructions)	12.00	2, 191, 857	1, 614, 89	576, 960	0	26. 00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)		Urban	Rural	
		0	1. 00	2. 00	3. 00	3. 01	
27. 00							27. 00
28.00	Low volume adjustment prior to October 1	70. 96	O		0	0	28. 00
29.00	Low volume adjustment on or after October 1	70. 97	0		0	0	29. 00
30.00	HVBP payment adjustment (see instructions)	70. 93	-75, 961		0 -75, 961	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	-51, 269		0 -51, 269	0	31.00
31. 01	HRR adjustment for HSP bonus payment (see instructions)	70. 91	0		0 0	0	31. 01
					Urban	Rural	
		0	1.00	2.00	3. 00	3. 01	
32. 00	HAC Reduction Program adjustment (see instructions)	70. 99			0 87, 305	0	32. 00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100. 00

Health Financial Systems	FRANCI SCAN HEALTH	LAFAYETTE	In Lie	u of Form CMS-2552-10
HOSPITAL ACQUIRED CONDITION	(HAC) REDUCTION CALCULATION EXHIBIT 5	Provider CCN: 15-0109	From 01/01/2023	Worksheet E Part A Exhibit 5 Date/Time Prepared:

3/28/2024 12:04 pm Title XVIII Hospi tal PPS Total (cols. 2 and 3) 4 00 1.00 DRG amounts other than outlier payments 1.00 DRG amounts other than outlier payments for 20, 176, 109 1.01 1.01 discharges occurring prior to October 1 1.02 1.02 DRG amounts other than outlier payments for 7. 120. 730 discharges occurring on or after October 1 1.03 DRG for Federal specific operating payment 0 1.03 for Model 4 BPCI occurring prior to October 1.04 DRG for Federal specific operating payment 1.04 for Model 4 BPCI occurring on or after October 1 2.00 Outlier payments for discharges (see 2.00 instructions) 2.01 Outlier payments for discharges for Model 4 2.01 2.02 Outlier payments for discharges occurring 2.02 504.302 prior to October 1 (see instructions) 2.03 Outlier payments for discharges occurring on 122, 799 2.03 or after October 1 (see instructions) 3.00 Operating outlier reconciliation 3.00 4.00 Managed care simulated payments 4.00 Indirect Medical Education Adjustment 5.00 Amount from Worksheet E, Part A, line 21 5.00 (see instructions) 6.00 IME payment adjustment (see instructions) 0 6.00 0 6 01 IME payment adjustment for managed care (see 6 01 instructions) Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 7.00 IME payment adjustment factor (see 7.00 instructions) 8.00 8.00 IME adjustment (see instructions) 0 8.01 IME payment adjustment add on for managed 0 8.01 care (see instructions) 9.00 Total IME payment (sum of lines 6 and 8) 9.00 Total IME payment for managed care (sum of 9.01 9.01 lines 6.01 and 8.01) Disproportionate Share Adjustment 10.00 Allowable disproportionate share percentage 10.00 (see instructions) 11.00 Disproportionate share adjustment (see 943, 106 11.00 instructions) 3, 741, 156 Uncompensated care payments 11.01 11.01 Additional payment for high percentage of ESRD beneficiary discharges 12.00 Total ESRD additional payment (see 12.00 instructions) 13.00 Subtotal (see instructions) 32, 608, 202 13.00 Hospital specific payments (completed by SCH 14.00 14.00 and MDH, small rural hospitals only.) (see 15.00 Total payment for inpatient operating costs 32, 608, 202 15.00 (see instructions) 16.00 Payment for inpatient program capital (from 2, 191, 857 16.00 Wkst. L, Pt. I, if applicable) 17.00 Special add-on payments for new technologies 47, 505 17.00 17.01 Net organ acquisition cost 17.01 Credits received from manufacturers for 17.02 17.02 0 replaced devices for applicable MS-DRGs 18 00 Capital outlier reconciliation adjustment 18.00 amount (see instructions) 19. 00 SUBTOTAL 34, 847, 564 19.00

HOSPI T	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5	Provi der CCN: 15-0109	Peri od: From 01/01/2023 To 12/31/2023	Worksheet E Part A Exhib Date/Time Pr 3/28/2024 12	epared:
			Title XVIII	Hospi tal	PPS	
		4. 00				
20.00	Capital DRG other than outlier	2, 068, 870				20. 0
20. 01	Model 4 BPCI Capital DRG other than outlier	0				20.0
21. 00	Capital DRG outlier payments	122, 987				21. 0
	Model 4 BPCI Capital DRG outlier payments	o				21. 0
	Indirect medical education percentage (see					22. 00
	instructions)					
23. 00	Indirect medical education adjustment (see	o				23. 00
	instructions)					
24 00	Allowable disproportionate share percentage					24. 0
	(see instructions)					
25. 00	Disproportionate share adjustment (see	0				25. 0
	instructions)					
26 00	Total prospective capital payments (see	2, 191, 857				26. 0
20.00	instructions)	2, , 00 .				20.0
		4.00				
27. 00						27. 0
	Low volume adjustment prior to October 1	0				28. 0
29. 00	Low volume adjustment on or after October 1	0				29. 0
30. 00	HVBP payment adjustment (see instructions)	-75, 961				30. 0
30. 01	HVBP payment adjustment for HSP bonus	70, 701				30.0
0.01	payment (see instructions)					30.0
R1 00	HRR adjustment (see instructions)	-51, 269				31.0
	HRR adjustment for HSP bonus payment (see	31, 207				31.0
31.01	instructions)					31.0
	This tructions)	(Amt. to Wkst.				
		E, Pt. A)				
		4.00				
32 00	HAC Reduction Program adjustment (see	87, 305				32. 0
.2.00	instructions)	07,303				1 32.0
100 00	Transfer HAC Reduction Program adjustment to					100. 0
. 50. 00	Wkst. E, Pt. A.					1100.0

Health Financial Systems	FRANCISCAN HEALTH LAFAYETTE	In Li€	eu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-010	From 01/01/2023	Worksheet E Part B Date/Time Prepared: 3/28/2024 12:04 pm
	Title XVIII	Hospi tal	PPS

Mark B		Title XVIII	Hospi tal	PPS	04 piii
Next 1				4.00	
1.00 Medical and other services (see instructions) 1.752 1.00		PART R - MEDICAL AND OTHER HEALTH SERVICES		1.00	
20.00 OVES or Rith payment (see Instructions) 26, 171, 060 3.00	1.00			1, 252	1.00
Quiller payment (see Instructions)		· · · · · · · · · · · · · · · · · · ·			•
Dutile reconstitation amount (see instructions)					1
Enter the hospital specific payment to cast ratio (see instructions)					•
Line 2 times line 5 0 0 0 0 0 0 0 0 0		· · · · · · · · · · · · · · · · · · ·			•
Translit floral corridor payment (see Instructions)				0	1
284,380 0.00					•
0 10 10 10 10 10 10 10				_	•
1.00 COMPUTATION OF LESSER OF COST OR CHARGES				204, 300	1
Reasonable Charges				1, 252	•
12.00 Ancil lary service charges 6.814 12.00					
13.00 Organ acquistion charges (from Wistt. D-4, Pt. III, col. 4, line 69) 0.13.00	12.00			/ 014	12.00
1.4 00					•
15.00 Aggregate amount actually collected from patients					•
1.00 Anicunts that would have been realized from patients lable for payment for services on a chargebasis 0 10.00 had souch payment been made in accordance with 14 2 CFR \$413.13(e) 0 10.00					
had such payment been made in accordance with 42 CFR \$413.13(e)*					•
17.00 Ratio of Iline 15 to line 16 (not to exceed 1.000000) 0.0000000 17.00 19.00 19.00 19.00 19.00 Excess of customary charges (see instructions) 0.000000 17.00 19.0	16.00	· · · · · · · · · · · · · · · · · · ·	n a cnargebasis	0	16.00
18.00 Total customary charges (see instructions) 5.52 19.00 19.00 Excess of customary charges over reasonable cost (complete only if fine 18 exceeds line 18) (see 5.562 19.00	17. 00			0. 000000	17. 00
instructions		Total customary charges (see instructions)		6, 814	18. 00
20. 00 Excess of reasonable cost over customary charges (complete only If line 11 exceeds line 18) (see instructions) 1,252 21.00	19. 00		ne 11) (see	5, 562	19. 00
Instructions 1,252 21, 0	20.00	· ·	na 18) (saa	0	20.00
22.00 Interns and residents	20.00		116 10) (366		20.00
23.00 Cost of physicians' services in a teaching hospital (see instructions) 23.00 23.00	21. 00	Lesser of cost or charges (see instructions)		1, 252	21. 00
24. 00 Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) 27, 482, 742 24. 00 COMPUTATION OF REINBURSEMENT STITLEMENT		· · · · · · · · · · · · · · · · · · ·			1
COMPUTATION OF REINBURSEMENT SETTLEMENT Computation					
25.00 Deductibles and coinsurance amounts (for CAH, see instructions) 0 25.00	24.00			21, 402, 142	24.00
27. 00 Subtotal [(I] res 21 and 24 minus the sum of I] res 25 and 26) plus the sum of I] res 22 and 23] (see 23,058,290 27. 00 1	25. 00			0	25. 00
Instructions					1
28. 00 Direct graduate medical education payments (from Wkst. E-4, line 50) 28. 00 28. 00 28. 00 28. 00 28. 00 28. 00 29. 00 28. 00 28. 00 29. 00 28. 00 29. 00 28. 00 29	27. 00		and 23] (see	23, 058, 290	27. 00
28. 50 REH Facility payment amount	28 00	,		0	28 00
Subtotal (sum of lines 27, 28, 28.50 and 29) 30.00 7 cm arry payer payments 31.00 7 cm arry payer payments 32.00 33.00 33.00 33.00 34.00					1
31 .00 Subtotal (line 30 minus line 31)					•
Subtotal (ine 30 minus line 31) 23,051,549 32.00 ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) 33.00 Composite rate ESRD (from Wkst. 1-5, line 11) 3.00 33.00 Allowable bad debts (see instructions) 202,061 35.00 36.00 30 40 40 40 40 40 40					1
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) 3.0 0.					
34.00	02.00			20,001,017	02.00
35.00		Composite rate ESRD (from Wkst. I-5, line 11)			
33. 00		· · · · · · · · · · · · · · · · · · ·			•
37. 00 Subtotal (see instructions) 37. 00 38. 00 MSP-LCC reconciliation amount from PS&R 38. 00 MSP-LCC reconciliation amount from PS&R 8 38. 00 39. 97 39. 98 39. 99 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39. 97 39. 98 39. 99 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39. 98 39. 99 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39. 99 39. 99 39. 90 39.		, , , , , , , , , , , , , , , , , , ,			1
38.00 MSP-LCC reconciliation amount from PS&R 38.00 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0.39.00 0.39.00 0.39.00 0.39.00 0.39.00 0.39.00 0.39.00 0.39.00 0.39.50 0.39.50 0.39.50 0.39.50 0.39.50 0.39.50 0.39.50 0.39.50 0.39.50 0.39.50 0.39.50 0.39.50 0.39.50 0.39.90					•
39.50 Pi oneer ACO demonstrati on payment adjustment (see instructions) 39.50 39.75 39.75 39.75 39.75 39.75 39.97 Demonstration payment adjustment amount (see instructions) 0.39.75 39.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 0.39.98 39.99 RECOVERY OF ACCELERATED DEPRECIATION 0.39.99 40.00 Subtotal (see instructions) 23,253,602 40.00 40.01 Sequestration adjustment (see instructions) 465,072 40.01 40.02 Demonstration payment adjustment amount after sequestration 40.02 40.03 Sequestration adjustment amount after sequestration 40.02 40.03 41.00 Interim payments 41.01 Interim payments 42,757,867 41.00 42.00 Tentative settlement (for contractors use only) 42.00 Tentative settlement (for contractor use only) 42.01 43.00 Bal ance due provider/program (see instructions) 43.01 Bal ance due provider/program-PARHM (see instructions) 43.01 44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,					1
39. 75 N95 respirator payment adjustment amount (see instructions) 0 39. 75 39. 97 Demonstrati on payment adjustment amount before sequestration 0 39. 98 39. 98 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39. 98 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 0 39. 99 40. 00 Subtotal (see instructions) 23, 253, 602 40. 00 40. 01 Demonstration payment adjustment amount after sequestration 465, 072 40. 01 40. 02 Sequestration adjustment amount after sequestration 0 40. 02 40. 03 Sequestration payments adjustment amount after sequestration 22, 757, 867 40. 01 41. 01 Interim payments-PARHM 22, 757, 867 41. 00 41. 01 Interim payments-PARHM 22, 757, 867 41. 00 42. 01 Tentative settlement (for contractors use only) 0 42. 00 43. 00 Balance due provider/program (see instructions) 30, 663 43. 00 43. 01 Balance due provider/program (see instructions) 43. 01 44. 00 Fortested amounts (nonallowable cost report items) in accordance with CMS Pu				0	
39.97 Demonstration payment adjustment amount before sequestration 39.97 39.98 39.98 39.99 39.99 39.99 39.99 39.99 39.90 39.99 39.90 39.99 39.90 39.99 39.90 39.99 39.90 39.90 39.99 39.90					1
39. 98 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39. 98 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 0 39. 99 40. 00 Subtotal (see instructions) 23, 253, 602 40. 00 40. 01 Sequestration adjustment (see instructions) 465, 072 40. 01 40. 02 Sequestration payment adjustment amount after sequestration 0 40. 02 40. 03 Sequestration adjustment-PARHM pass-throughs 40. 03 41. 01 Interim payments 22, 757, 867 41. 00 41. 01 Interim payments-PARHM 41. 01 42. 01 Tentative settlement (for contractors use only) 0 42. 00 42. 01 Tentative settlement-PARHM (for contractor use only) 42. 01 43. 00 Bal ance due provider/program (see instructions) 30, 663 43. 00 44. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44. 00 90. 00 Original outlier amount (see instructions) 0 90. 00 91. 00 Outlier reconciliation adjustment amount (see instructions) 0 90. 00 92. 00					•
40.00 Subtotal (see instructions) 23, 253, 602 40.00 40.01 Sequestration adj ustment (see instructions) 465, 072 40.01 40.02 Demonstration payment adj ustment amount after sequestration 0 40.02 40.03 Sequestration adj ustment-PARHM pass-throughs 22, 757, 867 41.00 41.01 Interim payments-PARHM 22, 757, 867 41.00 41.01 Tentative settlement (for contractors use only) 0 42.00 42.01 Tentative settlement-PARHM (for contractor use only) 42.01 43.00 Bal ance due provider/program (see instructions) 30, 663 43.00 43.01 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 44.00 90.00 Original outlier amount (see instructions) 0 90.00 91.00 Outlier reconciliation adjustment amount (see instructions) 0 91.00 92.00 The rate used to calculate the Time Value of Money 0.00 92.00 93.00 Time Value of Money (see instructions) 0 93.00			tions)		1
40.01 Sequestration adjustment (see instructions) 40.02 Demonstration payment adjustment amount after sequestration 50 do.02 Sequestration adjustment-PARHM pass-throughs 41.00 Interim payments 41.01 Interim payments-PARHM 41.01 Tentative settlement (for contractors use only) 42.00 Tentative settlement-PARHM (for contractor use only) 43.00 Bal ance due provider/program (see instructions) 43.01 Bal ance due provider/program-PARHM (see instructions) 44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 44.00 Si15.2 TO BE COMPLETED BY CONTRACTOR 90.00 Outlier reconciliation adjustment amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 940.01 Time Value of Money (see instructions) 950.02 Time Value of Money (see instructions) 960.00 Time Value of Money (see instructions) 970.00 Time Value of Money (see instructions)				0	39. 99
40. 02 Demonstration payment adjustment amount after sequestration 40. 03 Sequestration adjustment-PARHM pass-throughs 41. 00 Interim payments 41. 01 Interim payments-PARHM 42. 00 Tentative settlement (for contractors use only) 42. 01 Tentative settlement-PARHM (for contractor use only) 43. 00 Balance due provider/program (see instructions) 43. 01 Balance due provider/program-PARHM (see instructions) 44. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 51. 52 TO BE COMPLETED BY CONTRACTOR 90. 00 Original outlier amount (see instructions) 91. 00 Outlier reconciliation adjustment amount (see instructions) 92. 00 The rate used to calculate the Time Value of Money 93. 00 Time Value of Money (see instructions) 94. 00 93. 00 95. 00 Time Value of Money (see instructions) 96. 00 97. 00 97. 00 97. 00 98. 00 Time Value of Money (see instructions) 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00		, , , , , , , , , , , , , , , , , , , ,			1
40.03 Sequestration adjustment-PARHM pass-throughs 41.00 Interim payments 41.01 Interim payments-PARHM 42.00 Tentative settlement (for contractors use only) 42.01 Tentative settlement-PARHM (for contractor use only) 43.00 Balance due provider/program (see instructions) 43.01 Balance due provider/program-PARHM (see instructions) 43.01 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 44.00 Original outlier amount (see instructions) 90.00 Outlier reconciliation adjustment amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Oggan outlier amount (see instructions) 93.00 Time Value of Money (see instructions) 93.00 Oggan outlier amount (see instructions) 93.00 Oggan outlier amount (see instructions) 93.00 Oggan outlier amount (see instructions) 94.00 Oggan outlier amount (see instructions) 95.00 Oggan outlier amount (see instructions) 97.00 Oggan outlier amount (see instructions) 99.00 Oggan outlier amount (see instructions) 99.00 Oggan outlier amount (see instructions) 99.00 Oggan outlier amount (see instructions)					1
41.00 Interim payments 41.01 Interim payments-PARHM 42.00 Tentative settlement (for contractors use only) 42.01 Tentative settlement-PARHM (for contractor use only) 43.00 Balance due provider/program (see instructions) 43.01 Balance due provider/program-PARHM (see instructions) 43.01 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 80.00 Original outlier amount (see instructions) 90.00 Outlier reconciliation adjustment amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 94.00 Outlier reconciliation adjustment amount (see instructions) 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 94.00 Outlier reconciliation adjustment amount (see instructions) 94.00 Outlier reconciliation adjustment amount (see instructions) 95.00 Outlier reconciliation adjustment amount (see instructions) 96.00 Outlier reconciliation adjustment amount (see instructions) 97.00 Outlier reconciliation adjustment amount (see instructions)		, , , , , , , , , , , , , , , , , , , ,			•
42.00 Tentative settlement (for contractors use only) 42.01 Tentative settlement-PARHM (for contractor use only) 43.00 Balance due provider/program (see instructions) 43.01 Balance due provider/program-PARHM (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 94.00 42.00 42.00 42.01				22, 757, 867	1
42.01 Tentative settlement-PARHM (for contractor use only) 43.00 Balance due provider/program (see instructions) 43.01 Balance due provider/program-PARHM (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 94.01 Ag. 01 94.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 1					1
43.00 Balance due provider/program (see instructions) 43.01 Balance due provider/program-PARHM (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 91.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Outlier reconciliation adjustment amount (see instructions) 94.00 Outlier reconciliation adjustment amount (see instructions) 94.00 Outlier reconciliation adjustment amount (see instructions) 94.00 Outlier reconciliation adjustment amount (see instructions) 95.00 Outlier reconciliation adjustment amount (see instructions) 97.00 Outlier reconciliation adjustment amount (see instructions)				0	
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44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 \$115.2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 0 91.00 Outlier reconciliation adjustment amount (see instructions) 0 91.00 The rate used to calculate the Time Value of Money 0.00 92.00 Time Value of Money (see instructions) 0 93.00				30,003	
TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 94.00 Outlier reconciliation adjustment amount (see instructions) 95.00 Outlier reconciliation adjustment amount (see instructions) 97.00 Outlier reconciliation adjustment amount (see instructions) 98.00 Outlier reconciliation adjustment amount (see instructions) 99.00 Outlier reconciliation adjustment amount (see instructions)		Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2,	chapter 1,	0	1
90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Original outlier amount (see instructions) 94.00 Original outlier amount (see instructions) 95.00 Original outlier amount (see instructions) 97.00 Original outlier amount (see instructions)					
91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0 91.00 92.00 93.00	90 00				90 00
92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0.00 92.00 0 93.00					1
					•
94.00 lotal (sum of lines 91 and 93) 0 94.00					
	94. 00	Iotal (sum of lines 91 and 93)		<u> </u>	94.00

Health Financial Systems	FRANCISCAN HEALTH	LAFAYETTE	In Lie	u of Form CMS-	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0109	Peri od: From 01/01/2023	Worksheet E Part B	
				Date/Time Pre 3/28/2024 12:	
-		Title XVIII	Hospi tal	PPS	от рііі
				1. 00	
MEDICARE PART B ANCILLARY COSTS					
200.00 Part B Combined Billed Days				0	200. 00

Health Financial Systems FRANCIAL ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Peri od: | Worksheet E-1 | From 01/01/2023 | Part I | To 12/31/2023 | Date/Time Prepared: Provider CCN: 15-0109

			'	0 12/31/2023	3/28/2024 12: 0	
		Title	XVIII	Hospi tal	PPS	
		I npati en	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2, 00	3. 00	4, 00	
1. 00	Total interim payments paid to provider		32, 457, 253		22, 757, 867	1. 00
2. 00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2. 00
3. 00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3. 00
3. 01	ADJUSTMENTS TO PROVIDER	09/13/2023	242, 300		0	3. 01
3. 02			0		0	3. 02
3. 03			0		0	3. 03
3. 04			Ö		ő	3. 04
3. 05			0		0	3. 05
0.00	Provider to Program				Ü	0.00
3.50	ADJUSTMENTS TO PROGRAM		0		0	3. 50
3. 51			Ö		o	3. 51
3. 52			0		o	3. 52
3. 53			0		o	3. 53
3. 54			0		ol	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		242, 300		o l	3. 99
	3. 50-3. 98)		·		22 757 047	
4. 00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		32, 699, 553		22, 757, 867	4. 00
	TO BE COMPLETED BY CONTRACTOR					
5. 00	List separately each tentative settlement payment after					5. 00
0.00	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					0.00
	Program to Provider		,			
5. 01	TENTATI VE TO PROVI DER		0		0	5. 01
5.02			0		o	5. 02
5.03			0		o	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		o	5. 99
6. 00	5.50-5.98) Determined net settlement amount (balance due) based on					6. 00
	the cost report. (1)				00.440	
6. 01	SETTLEMENT TO PROVIDER		233, 098		30, 663	6. 01
6. 02	SETTLEMENT TO PROGRAM		0		0	6. 02
7. 00	Total Medicare program liability (see instructions)		32, 932, 651		22, 788, 530	7. 00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		()	1. 00	2.00	
8. 00	Name of Contractor					8. 00
					'	'

Component CCN: 15-T109

Title XVIII

		Title	e XVIII	Subprovi der - I RF	PPS	
		Inpatien	it Part A		t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2. 00	3. 00	4. 00	
1.00	Total interim payments paid to provider		3, 362, 724		0	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for		C)	0	2. 00
	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			1	0	3. 01
3. 02	ABSOSTMENTS TO TROVIDER				0	
3. 03			d		0	
3.04			(0	3. 04
3.05			()	0	3. 05
	Provi der to Program		т .	J	_	
3. 50 3. 51	ADJUSTMENTS TO PROGRAM				0	
3. 51					0	
3. 53					0	
3.54			ď		Ō	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		()	0	3. 99
	3. 50-3. 98)					
4. 00	Total interim payments (sum of lines 1, 2, and 3.99)		3, 362, 724		0	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as appropriate)					
	TO BE COMPLETED BY CONTRACTOR					1
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)					
F 01	Program to Provider TENTATIVE TO PROVIDER			\	0	5. 01
5. 01 5. 02	TENTATIVE TO PROVIDER				0	
5. 02					0	
	Provider to Program			1		1
5.50	TENTATI VE TO PROGRAM		C		0	
5. 51			(0	
5. 52					0	
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		C)	0	5. 99
6.00	Determined net settlement amount (balance due) based on					6. 00
3. 00	the cost report. (1)					0.00
6. 01	SETTLEMENT TO PROVI DER		()	0	
6. 02	SETTLEMENT TO PROGRAM		77, 833		0	
7. 00	Total Medicare program liability (see instructions)		3, 284, 891		0	7. 00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		()	1. 00	2. 00	
8. 00	Name of Contractor					8. 00

Health Financial Systems	FRANCISCAN HEALTH	LAFAYETTE	In Lie	u of Form CMS-	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 15-0109	Peri od:	Worksheet E-1	
			From 01/01/2023 To 12/31/2023		pared:
3/28/2024					
		Title XVIII	Hospi tal	PPS	
TO DE COMPLETED BY CONTRACTOR FOR MONOTANDA	DD AACT DEDARTS			1. 00	
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDA! HEALTH INFORMATION TECHNOLOGY DATA COLLECTION					
1.00 Total hospital discharges as defined in AAR		S_3 Dt L col 15 line	1/		1.00
2.00 Medicare days (see instructions)	A 34102 110111 WK31.	3-3, 11. 1 cor. 13 111le	14		2.00
3.00 Medicare HMO days from Wkst. S-3, Pt. I, co	I. 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 Wk	· ·				6. 00
7.00 CAH only - The reasonable cost incurred for	the purchase of ce	ertified HIT technology	Wkst. S-2, Pt. I		7. 00
line 168					0.00
8.00 Calculation of the HIT incentive payment (s	· ·				8.00
9.00 Sequestration adjustment amount (see instru 10.00 Calculation of the HIT incentive payment af		(see instructions)			9. 00 10. 00
I NPATIENT HOSPITAL SERVICES UNDER THE I PPS		(See Tristructions)			10.00
30.00 Initial/interim HIT payment adjustment (see					30.00
31. 00 Other Adjustment (specify)					31. 00
32.00 Balance due provider (line 8 (or line 10) m	inus line 30 and li	ne 31) (see instruction	s)		32. 00

Health Financial Systems	FRANCISCAN HEALTH LAFAYETTE	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0109	Peri od: From 01/01/2023	Worksheet E-3
	Component CCN: 15-T109		Date/Time Prepared: 3/28/2024 12:04 pm
	Title XVIII	Subprovi der -	PPS
		l IRF	

	IRF		
		1. 00	
	PART III - MEDICARE PART A SERVICES - IRF PPS	1.00	
1.00	Net Federal PPS Payment (see instructions)	2, 886, 134	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0. 0120	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	75, 905	3.00
4.00	Outlier Payments	442, 754	4.00
5. 00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)	0. 00	5. 00
5. 01	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. 01
6.00	New Teaching program adjustment. (see instructions)	0.00	6.00
7. 00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)	0. 00	7. 00
8. 00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)	0. 00	8. 00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0. 00	9. 00
10.00	Average Daily Census (see instructions)	7. 802740	
11.00	Teaching Adjustment Factor (see instructions)	0.000000	11.00
12.00	Teaching Adjustment (see instructions)	0	12.00
13.00	Total PPS Payment (see instructions)	3, 404, 793	13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)	0	14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)		15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)	0	16.00
17.00	Subtotal (see instructions)	3, 404, 793	17.00
18. 00	Primary payer payments	0	18. 00
19. 00	Subtotal (line 17 less line 18).	3, 404, 793	
20. 00	Deducti bl es	51, 156	
21. 00	Subtotal (line 19 minus line 20)	3, 353, 637	
22. 00	Coi nsurance	8, 000	
23. 00	Subtotal (line 21 minus line 22)	3, 345, 637	23. 00
24. 00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	0	24. 00
25. 00	Adjusted reimbursable bad debts (see instructions)	0	25. 00
26. 00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	26.00
27. 00	Subtotal (sum of lines 23 and 25)	3, 345, 637	27. 00
28. 00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	28. 00
29. 00	Other pass through costs (see instructions)	6, 293	
30.00	Outlier payments reconciliation	0	30.00
31. 00 31. 50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	31. 00 31. 50
31. 98	Pioneer ACO demonstration payment adjustment (see instructions) Recovery of accelerated depreciation.	0	31. 98
31. 99	Demonstration payment adjustment amount before sequestration	0	31. 99
32. 00	Total amount payable to the provider (see instructions)	3, 351, 930	
32. 01	Sequestration adjustment (see instructions)	67, 039	
32. 02	Demonstration adjustment amount after sequestration	07,037	32. 02
33. 00	Interim payments	3, 362, 724	33. 00
34.00	Tentative settlement (for contractor use only)	0, 002, 721	34. 00
35. 00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)	-77, 833	35. 00
36. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	0	36. 00
	\$115. 2 TO BE COMPLETED BY CONTRACTOR		
50. 00	TO BE COMPLETED BY CONTRACTOR Original outlier amount from Wkst. E-3, Pt. III, line 4	442, 754	50. 00
51.00	Outlier reconciliation adjustment amount (see instructions)	442, 754	51.00
52. 00	The rate used to calculate the Time Value of Money		52. 00
53. 00	Time Value of Money (see instructions)	0.00	53. 00
33. 00	FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING ON OR BEFORE MAY 11, 2023 (THE THE COVID-19 PHE)		33. 00
99. 00	Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.	0. 000000	99.00
	Cal cul ated Teaching Adjustment Factor for the current year. (see instructions)	0. 000000	
		0.00000	, , . 5 1

Health Financial Systems	FRANCISCAN HEALTH LAFAYETTE		In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der C	CCN: 15-0109	From 01/01/2023	Worksheet E-3 Part VII Date/Time Prepared: 3/28/2024 12:04 pm
	Ti +I	I A YI Y	Hospi tal	Cost

			To 12/31/2023	Date/Time Pre 3/28/2024 12:	
		Title XIX	Hospi tal	Cost	<u>о г р</u>
			Inpatient	Outpati ent	
			1, 00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SER	VICES 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			22, 517, 101	2. 00
3.00	Organ acquisition (certified transplant programs only)		0		3. 00
4.00	Subtotal (sum of lines 1, 2 and 3)		0	22, 517, 101	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	22, 517, 101	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e Charges		T		
8.00	Routine service charges		0		8. 00
9.00	Ancillary service charges		69, 868, 391	161, 728, 533	9. 00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0	4/4 700 500	11.00
12. 00	Total reasonable charges (sum of lines 8 through 11)		69, 868, 391	161, 728, 533	12. 00
12 00	CUSTOMARY CHARGES	. comil coo en e cherce	0	0	12.00
13. 00	Amount actually collected from patients liable for payment for basis	services on a charge	0	Ü	13. 00
14. 00	Amounts that would have been realized from patients liable for	navment for services on	0	0	14. 00
14.00	a charge basis had such payment been made in accordance with 4			O	14.00
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)	12 0110 3110. 10(0)	0. 000000	0. 000000	15. 00
16. 00	Total customary charges (see instructions)		69, 868, 391	161, 728, 533	16. 00
17. 00	Excess of customary charges over reasonable cost (complete onl	y if line 16 exceeds	69, 868, 391	139, 211, 432	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)				
19. 00	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 1		0	22, 517, 101	21. 00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be	completed for PPS provide			
22. 00	Other than outlier payments		0	0	22. 00
23. 00	Outlier payments		0	0	23. 00
24. 00	Program capital payments		0		24. 00
25. 00	Capital exception payments (see instructions)		0	0	25. 00
26. 00	Routine and Ancillary service other pass through costs Subtotal (sum of lines 22 through 26)		0	0	26. 00 27. 00
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	22, 517, 101	
29.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT		J O	22, 317, 101	29.00
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	22, 517, 101	31.00
32. 00	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	I 33)	0	22, 517, 101	36. 00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37. 00
38. 00	Subtotal (line 36 ± line 37)		0	22, 517, 101	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)		0	22, 517, 101	
41. 00	Interim payments		0	22, 525, 699	41. 00
42. 00	Balance due provider/program (line 40 minus line 41)		0	-8, 598	42.00
43. 00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub 15-2,	0	0	43. 00
	chapter 1, §115.2		1		I

Health Financial Systems	FRANCISCAN HEALTH LAFAYETTE	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0109	Peri od: From 01/01/2023	Worksheet E-3 Part VII
	Component CCN: 15-T109	To 12/31/2023	Date/Time Prepared: 3/28/2024 12:04 pm
	Title XIX	Subprovider -	Cost

		THE XIX	IRF	0031	
			Inpati ent	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
1.00	Inpatient hospital/SNF/NF services		0		1.00
2.00	Medical and other services			0	2. 00
3.00	Organ acquisition (certified transplant programs only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		0	0	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	0	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e Charges				
8.00	Routine service charges		0		8.00
9.00	Ancillary service charges		4, 983	0	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)		4, 983	0	12.00
	CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for se	rvices on a charge	0	0	13. 00
	basis				
14.00	Amounts that would have been realized from patients liable for page	yment for services on	0	0	14. 00
	a charge basis had such payment been made in accordance with 42 C	FR §413.13(e)			
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0. 000000	1
16. 00	Total customary charges (see instructions)		4, 983	0	
17. 00	Excess of customary charges over reasonable cost (complete only i	f line 16 exceeds	4, 983	0	17. 00
	line 4) (see instructions)				
18. 00	Excess of reasonable cost over customary charges (complete only i	fline 4 exceeds line	0	0	18. 00
40.00	16) (see instructions)				40.00
19. 00	Interns and Residents (see instructions)		0	0	
20.00	Cost of physicians' services in a teaching hospital (see instruct	ions)	0	0	
21. 00	Cost of covered services (enter the lesser of line 4 or line 16)	1 1 1 6 200	0	0	21. 00
22.00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be com	oreted for PPS provide		0	1 22 20
22. 00	Other than outlier payments		0	0	22. 00
23. 00	Outlier payments		0	0	23. 00
24. 00	Program capital payments		0		24. 00
26. 00	Capital exception payments (see instructions)			0	25. 00 26. 00
26.00	Routine and Ancillary service other pass through costs Subtotal (sum of lines 22 through 26)			0	
28. 00				0	
29. 00	Customary charges (title V or XIX PPS covered services only) Titles V or XIX (sum of lines 21 and 27)			0	
29.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT		U U	0	29.00
30. 00	Excess of reasonable cost (from line 18)		l	0	30.00
	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)			0	
32. 00	Deductibles			0	
33. 00	Coinsurance			0	
34. 00	Allowable bad debts (see instructions)			0	34.00
	Utilization review			U	35.00
36. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		0	
37. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	,		0	
38. 00	Subtotal (line 36 ± line 37)			0	38.00
39. 00	Direct graduate medical education payments (from Wkst. E-4)			U	39.00
40. 00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	
41. 00	Interim payments			0	41.00
42. 00	Balance due provider/program (line 40 minus line 41)			0	
43. 00	Protested amounts (nonallowable cost report items) in accordance	with CMS Pub 15-2		0	43.00
10.00	chapter 1, §115.2	386 1 45 10 2,		O	10.00
	- - - - - - -		1		1

Heal th	Financial Systems FRANCISC	CAN HEALTH	LAFAYETTE	In Lie	u of Form CMS-2	552-10
OUTLI E	R RECONCILIATION AT TENTATIVE SETTLEMENT		Provider CCN: 15-0109	Peri od:	Worksheet E-5	
				From 01/01/2023 To 12/31/2023	Date/Time Prep 3/28/2024 12:0	oared: 04 pm_
			Title XVIII		PPS	
					1. 00	
	TO BE COMPLETED BY CONTRACTOR					
1.00	Operating outlier amount from Wkst. E, Pt. A, line 2	d, or sum o	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 instru	uctions)		0	3.00
4.00	Capital outlier reconciliation adjustment amount (se	e instruct	ti ons)		0	4.00
5.00	The rate used to calculate the time value of money (see instru	uctions)		0.00	5.00
6.00	Time value of money for operating expenses (see inst	ructions)			0	6.00
7.00	Time value of money for capital related expenses (se	e instruct	tions)		0	7.00

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

Provider CCN: 15-0109 Peri From

oni y)				10 12/01/2020	3/28/2024 12:	04 pm
		General Fund	Speci fi c	Endowment Fund	Plant Fund	
		1.00	Purpose Fund 2.00	3. 00	4. 00	
	CURRENT ASSETS		1			
1.00	Cash on hand in banks	61, 899, 891		0	0	
2.00	Temporary investments Notes receivable	0	(0	
4. 00	Accounts receivable	76, 847, 550	1	1	0	
5. 00	Other recei vabl e	0		o o	Ö	
6.00	Allowances for uncollectible notes and accounts receivable	-17, 773, 832		0	0	6. 00
7.00	Inventory	6, 581, 269		0	0	
8.00	Prepai d expenses	4, 978, 060		0	0	
9.00	Other current assets	4, 767, 988		1	0	
10. 00 11. 00	Due from other funds Total current assets (sum of lines 1-10)	137, 300, 926			0	
11.00	FIXED ASSETS	137, 300, 920		<u>)</u>	0	11.00
12. 00	Land	19, 225, 919	(0	0	12.00
13.00	Land improvements	-2, 363, 054		0	0	
14.00	Accumulated depreciation	-1, 864, 265	(0		
15. 00	Bui I di ngs	340, 275, 962		-	0	
16.00	Accumulated depreciation	-128, 915, 305		-	0	
17. 00 18. 00	Leasehold improvements	1, 247, 401		-	0 0	
19.00	Accumulated depreciation Fixed equipment	-472, 584 92, 370, 265		-	0	
20. 00	Accumulated depreciation	-34, 994, 952			0	
21. 00	Automobiles and trucks	0 1,771,732		o o	Ö	
22. 00	Accumul ated depreciation	0	(0	0	
23. 00	Major movable equipment	0	(0	0	23.00
24. 00	Accumulated depreciation	0	(0	0	
25. 00	Mi nor equi pment depreci abl e	0	(0	0	
26. 00	Accumulated depreciation	0	(0	0	
27. 00 28. 00	HIT designated Assets Accumulated depreciation	0		0	0	
29. 00	Mi nor equi pment-nondepreci abl e	0		1		
30. 00	Total fixed assets (sum of lines 12-29)	284, 509, 387				
00.00	OTHER ASSETS	201/00//00/		<u>, </u>		00.00
31. 00	Investments	1, 219, 622	(0	0	31.00
32. 00	Deposits on Leases	0	(0	0	
33. 00	Due from owners/officers	0	(1	0	1
34.00	Other assets	89, 600, 182		1	0	
35. 00 36. 00	Total other assets (sum of lines 31-34) Total assets (sum of lines 11, 30, and 35)	90, 819, 804 512, 630, 117		٥ -	0 0	
30.00	CURRENT LIABILITIES	512,030,117		<u> </u>	0	30.00
37. 00	Accounts payable	13, 832, 502		0	0	37.00
38. 00	Salaries, wages, and fees payable	2, 999, 924		0	0	38. 00
39. 00	Payroll taxes payable	10, 496, 239		0	0	
40.00	Notes and Loans payable (short term)	364, 030	(0	0	
41.00	Deferred income	0	(0	0	
42. 00 43. 00	Accel erated payments Due to other funds	-3, 842, 219	,		0	42.00
44. 00	Other current liabilities	6, 848, 886				
45. 00	Total current liabilities (sum of lines 37 thru 44)	30, 699, 362	•	o o		
	LONG TERM LIABILITIES	,		-		
46. 00	Mortgage payable	1, 983, 724	(0	0	
47. 00	Notes payable	8, 634, 907		0		
48. 00	Unsecured Loans	798, 458			-	
49.00	Other long term liabilities	1, 622, 858	•		0	
50. 00 51. 00	Total long term liabilities (sum of lines 46 thru 49) Total liabilities (sum of lines 45 and 50)	13, 039, 947 43, 739, 309		0 0		
31.00	CAPITAL ACCOUNTS	43, 737, 307		<u> </u>		31.00
52. 00	General fund balance	468, 890, 808				52.00
53.00	Specific purpose fund		(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
E7 00	Plant fund balance - invested in plant				0	
57.00	Diant fund balance recorve for plant improvement		I .	1	1 0	58.00
57. 00 58. 00	Plant fund balance - reserve for plant improvement,					
	repl acement, and expansion	468, 890, 808		0	0	59.00
58. 00		468, 890, 808 512, 630, 117		0 0	0	

Provider CCN: 15-0109

					То	12/31/2023	Date/Time Prep 3/28/2024 12:0	
		General	Fund	Speci al	Pur	pose Fund	Endowment Fund	5 1 Dill
				·				
	I 	1.00	2.00	3. 00		4. 00	5. 00	
1.00	Fund balances at beginning of period		456, 931, 556			0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		11, 959, 252			0		2.00
3. 00 4. 00	Total (sum of line 1 and line 2)		468, 890, 808		0	0	0	3. 00 4. 00
4. 00 5. 00	Additions (credit adjustments) (specify)				0		0	4. 00 5. 00
6. 00					0		0	6. 00
7. 00					0		0	7. 00
8.00					0		0	8. 00
9. 00		0			0		0	9. 00
10. 00	Total additions (sum of line 4-9)		0		Ĭ	0	Ĭ	10. 00
11. 00	Subtotal (line 3 plus line 10)		468, 890, 808			0		11. 00
12. 00	Deductions (debit adjustments) (specify)	0	100/070/000		0	J	0	12. 00
13. 00	, (, (, (, /, /, /, /	o			Ō		ol	13. 00
14.00		O			0		o	14.00
15.00		o			0		o	15.00
16.00		O			0		0	16.00
17. 00		0			0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0			0		18.00
19. 00	Fund balance at end of period per balance		468, 890, 808			0		19.00
	sheet (line 11 minus line 18)		51	L				
		Endowment Fund	PI ant	Fund				
		6. 00	7. 00	8. 00				
1.00	Fund balances at beginning of period	0.00	7.00	0.00	0			1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)							2. 00
3.00	Total (sum of line 1 and line 2)	o			0			3. 00
4.00	Additions (credit adjustments) (specify)		0					4.00
5.00			0					5.00
6.00			0					6.00
7.00			0					7.00
8.00			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			11. 00
12. 00	Deductions (debit adjustments) (specify)		0					12. 00
13. 00			0					13.00
14.00			0					14.00
15.00			0					15. 00
16. 00 17. 00			0					16. 00 17. 00
18.00	Total deductions (sum of lines 12-17)		U		0			17.00
19. 00	Fund balance at end of period per balance				0			19. 00
17.00	sheet (line 11 minus line 18)				J			. 7. 00
	12	1	!	!	1		'	

Health Financial Systems FR STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-0109

			То	12/31/2023	Date/Time Pre 3/28/2024 12:	
	Cost Center Description	Inpatient	Н	Outpati ent	Total	U4 pili
	oust deficer beset per on	1, 00		2. 00	3. 00	
	PART I - PATIENT REVENUES				2. 22	
	General Inpatient Routine Services					
1.00	Hospi tal	100, 741, 6	87		100, 741, 687	1.00
2.00	SUBPROVI DER - I PF					2. 00
3.00	SUBPROVI DER - I RF	6, 976, 0	53		6, 976, 053	3. 00
4.00	SUBPROVI DER					4. 00
5.00	Swing bed - SNF		0		0	5. 00
6.00	Swing bed - NF		0		0	6. 00
7.00	SKILLED NURSING FACILITY					7. 00
8.00	NURSING FACILITY					8. 00
9.00	OTHER LONG TERM CARE					9. 00
10. 00	Total general inpatient care services (sum of lines 1-9)	107, 717, 7	40		107, 717, 740	10. 00
	Intensive Care Type Inpatient Hospital Services					
11. 00	INTENSIVE CARE UNIT	38, 319, 8	32		38, 319, 832	1
12.00	CORONARY CARE UNIT					12.00
13.00	BURN INTENSIVE CARE UNIT					13.00
14. 00 15. 00	SURGICAL INTENSIVE CARE UNIT	10.07/.0	OΕ		10 07/ 005	14. 00 15. 00
	NEONATAL INTENSIVE CARE UNIT	10, 976, 0 49, 295, 8			10, 976, 005 49, 295, 837	
16. 00	Total intensive care type inpatient hospital services (sum of lines 11-15)	49, 295, 8	3/		49, 295, 837	16. 00
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	157, 013, 5	77		157, 013, 577	17. 00
18. 00	Ancillary services	459, 220, 3	- 1	916 970 826	1, 376, 191, 161	18.00
19. 00	Outpatient services	33, 396, 2		148, 791, 341	182, 187, 564	19. 00
20. 00	RURAL HEALTH CLINIC	00,070,2	0	0		20.00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	21. 00
22. 00	HOME HEALTH AGENCY		-	9, 135, 611	9, 135, 611	22. 00
23. 00	AMBULANCE SERVICES		0	0	0	23. 00
24.00	CMHC					24.00
25.00	AMBULATORY SURGICAL CENTER (D. P.)					25. 00
26.00	HOSPI CE		0	27, 524, 785	27, 524, 785	26. 00
27. 00	OTHER (SPECIFY)		0	0	0	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst	649, 630, 1	35	1, 102, 422, 563	1, 752, 052, 698	28. 00
	G-3, line 1)					
	PART II - OPERATING EXPENSES		-	070 040 440		
29. 00	Operating expenses (per Wkst. A, column 3, line 200)			379, 949, 643		29. 00
30.00	ADD (SPECIFY)		0			30.00
31. 00 32. 00			0			31. 00 32. 00
33. 00			0			33.00
34. 00			0			34.00
35. 00			0			35.00
36. 00	Total additions (sum of lines 30-35)		0	0		36.00
37. 00	DEDUCT (SPECIFY)		0	Ŭ		37. 00
38. 00			0			38. 00
39. 00			0			39. 00
40.00			0			40. 00
41. 00			0			41. 00
42.00	Total deductions (sum of lines 37-41)			o		42. 00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(trans	fer		379, 949, 643		43. 00
	to Wkst. G-3, line 4)					

	FDANGLOOM UFAL	TI. I 454/5TT5		6.5. 040.6	2550 40
	Financial Systems FRANCISCAN HEAL* ENT OF REVENUES AND EXPENSES	Provider CCN: 15-0109	Period:	u of Form CMS-2 Worksheet G-3	
0.7.1.2			From 01/01/2023 To 12/31/2023		pared:
				1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, li	ne 28)		1, 752, 052, 698	1.00
2.00	Less contractual allowances and discounts on patients' accou	ınts		1, 372, 730, 705	2. 00
3.00	Net patient revenues (line 1 minus line 2)			379, 321, 993	3. 00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	e 43)		379, 949, 643	4. 00
5.00	Net income from service to patients (line 3 minus line 4)			-627, 650	5. 00
	OTHER I NCOME				
6.00	Contributions, donations, bequests, etc			86, 815	
7.00	Income from investments			0	
8.00	Revenues from telephone and other miscellaneous communication	on services		0	8. 00
9.00	Revenue from television and radio service			0	9. 00
10.00	Purchase di scounts			1, 276, 372	10.00
11. 00	Rebates and refunds of expenses			0	11. 00
	Parking Lot receipts			0	
13.00	Revenue from Laundry and Linen service			0	13.00
14.00	Revenue from meals sold to employees and guests			1, 015, 353	14.00
15.00	Revenue from rental of living quarters			0	15. 00
16.00	Revenue from sale of medical and surgical supplies to other	than patients		0	16. 00
17. 00	Revenue from sale of drugs to other than patients			0	17. 00
18.00	Revenue from sale of medical records and abstracts			366	18. 00
19. 00	Tuition (fees, sale of textbooks, uniforms, etc.)			2, 910, 138	19. 00
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	20. 00
21.00	Rental of vending machines			23, 273	21. 00
22. 00	Rental of hospital space			1, 702, 594	22. 00
23.00	Governmental appropriations			0	23. 00
24.00	OTHER OPERATING REVENUE			5, 571, 991	24.00
24. 50	COVI D-19 PHE Fundi ng			0	24. 50
25.00	Total other income (sum of lines 6-24)			12, 586, 902	25. 00
26.00	Total (line 5 plus line 25)			11, 959, 252	26. 00
27. 00	OTHER EXPENSES (SPECIFY)			0	27. 00
28. 00	Total other expenses (sum of line 27 and subscripts)			0	28. 00
29. 00	Net income (or loss) for the period (line 26 minus line 28)			11, 959, 252	29. 00

-87, 426

4, 200, 715

-7.137

4, 193, 578

24.00

24.00 Total (sum of lines 1-23)

Heal th	Financial Systems	ı	FRANCISCAN HEALT	TH LAFAYETTE		In Lie	u of Form CMS-2	2552-10
	ALLOCATION - HHA GENERAL SERVICE			Provi der CO		Period: From 01/01/2023	Worksheet H-1 Part I	
				HHA CCN:		To 12/31/2023	Date/Time Pre 3/28/2024 12:	pared:
						Home Health	PPS	оч рііі
			Capital Rela	nted Costs		Agency I		
		Net Expenses for Cost	Bldgs & Fixtures	Movable Equipment	Plant Operation &	Transportati on	Subtotal (cols. 0-4)	
		Allocation		1. 1.	Mai ntenance		,	
		(from Wkst. H, col. 10)						
	CENEDAL CEDILLOS COCT CENTEDO	0	1. 00	2. 00	3. 00	4. 00	4A. 00	
1. 00	GENERAL SERVICE COST CENTERS Capital Related - Bldg. &	0	0				0	1. 00
2.00	Fixtures	2 120		2 120			0	2.00
2. 00	Capital Related - Movable Equipment	2, 130		2, 130			0	2.00
3. 00 4. 00	Plant Operation & Maintenance	64, 958 93, 656	0	0	64, 958	93, 656	0	3. 00 4. 00
5. 00	Transportation Administrative and General	1, 148, 812	0	2, 130	64, 958		1, 309, 556	
6. 00	HHA REIMBURSABLE SERVICES Skilled Nursing Care	1, 438, 161	o	0	,	ol ol	1, 438, 161	6. 00
7. 00	Physical Therapy	866, 229	0	0			866, 229	•
8. 00 9. 00	Occupational Therapy Speech Pathology	404, 783 82, 727	0	0		0	404, 783 82, 727	•
10. 00	Medical Social Services	58, 378	0	0			58, 378	1
11.00	Home Heal th Ai de	33, 744 0	0	0		0	33, 744	•
12. 00 13. 00	Supplies (see instructions) Drugs	0	0	0	1		0	
14. 00	DME HHA NONREI MBURSABLE SERVI CES	0	0	0	(0	0	14. 00
15. 00	Home Dialysis Aide Services	0	0	0		o	0	15. 00
16.00	Respiratory Therapy Private Duty Nursing	0	0	0			0	
17. 00 18. 00	Clinic	0	0	0			0	
19.00	Health Promotion Activities	0	0	0			0	
20. 00 21. 00	Day Care Program Home Delivered Meals Program	0	0	0			0	
22. 00	Homemaker Service	0	0	0		0	0	
23. 00 23. 50	All Others (specify) Telemedicine	0	0	0			0	
24. 00	Total (sum of lines 1-23)	4, 193, 578 Admi ni strati ve	O Total (cols	2, 130	64, 958	93, 656	4, 193, 578	24. 00
		& General	4A + 5)					
	GENERAL SERVICE COST CENTERS	5. 00	6. 00					
1.00	Capital Related - Bldg. &							1. 00
2. 00	Fixtures Capital Related - Movable							2. 00
	Equi pment							
3. 00 4. 00	Plant Operation & Maintenance Transportation		-					3. 00 4. 00
5. 00	Administrative and General	1, 309, 556						5. 00
6. 00	HHA REIMBURSABLE SERVICES Skilled Nursing Care	653, 030	2, 091, 191					6. 00
7.00	Physi cal Therapy	393, 331	1, 259, 560					7. 00
8. 00 9. 00	Occupational Therapy Speech Pathology	183, 801 37, 564	588, 584 120, 291					8. 00 9. 00
10.00	Medical Social Services	26, 508	84, 886					10. 00
11. 00 12. 00	Home Health Aide Supplies (see instructions)	15, 322 0	49, 066 0					11. 00 12. 00
13.00	Drugs	0	0					13.00
14. 00	DME HHA NONREI MBURSABLE SERVI CES	0	0					14. 00
15.00	Home Dialysis Aide Services	0	0					15.00
16. 00 17. 00	. , , , ,	0	0					16. 00 17. 00
18. 00	Clinic	0	0					18. 00
19. 00 20. 00	Health Promotion Activities Day Care Program	0	0					19. 00 20. 00
21. 00	Home Delivered Meals Program	0	0					21. 00
22. 00 23. 00	Homemaker Service All Others (specify)		0					22. 00 23. 00
23. 50	Tel emedi ci ne	0	О					23. 50
∠4. 00	Total (sum of lines 1-23)	1 1	4, 193, 578					24. 00

	<u>Financial Systems</u> LLOCATION - HHA STATISTICAL BAS		FRANCISCAN HEAL	Provider C		Peri od:	worksheet H-1	
				HHA CCN:		From 01/01/2023 To 12/31/2023		pared: 04 pm
						Home Health	PPS	
		Canital Pol	ated Costs			Agency I		
		Сарттат кет	ateu costs					
		BI dgs &	Movabl e	PI ant	Transportati o	nReconciliation	Admi ni strati ve	
		Fixtures	Equi pment	Operation &	(MI LEAGE)		& General	
		(SQUARE FEET)	(DOLLAR VALUE)	Mai ntenance			(ACCUM. COST)	
		1.00	2. 00	(SQUARE FEET) 3.00	4. 00	5A. 00	5. 00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	4.00	JA. 00	5.00	
1.00	Capital Related - Bldg. &	0				0		1.00
	Fixtures							
2.00	Capital Related - Movable		100			0		2. 00
0.00	Equi pment			400				0.00
3. 00 4. 00	Plant Operation & Maintenance Transportation (see	0	0	100		0		3. 00 4. 00
4.00	instructions)		0		100	9		4.00
5.00	Administrative and General	0	100	100	100	0 -1, 309, 556	2, 884, 022	5. 00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0		0	., .00, .0.	
7.00	Physical Therapy	0	0	0		0	866, 229	
8.00	Occupati onal Therapy	0	0	0		0	404, 783	
9.00	Speech Pathology Medical Social Services	0	0	0		0 0	82, 727	
10. 00 11. 00	Home Health Aide	0	0	0		0	58, 378 33, 744	
12. 00	Supplies (see instructions)	0	0	0			0	1
13. 00	Drugs	Ö	o o	Ö		o o	Ö	•
14.00	DME	0	0	0		0 0	0	14. 00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0			0		
16.00	Respiratory Therapy	0	0	-		0	0	
17. 00 18. 00	Private Duty Nursing	0	0	0		0 0	0	
19. 00	Health Promotion Activities	0	0			0 0	0	
20. 00	Day Care Program	0	0	0		0 0	0	
21. 00	Home Delivered Meals Program	Ö	0	Ö		o o	ő	
22. 00	Homemaker Service	0	0	0		0 0	0	22. 00
23. 00	All Others (specify)	0	0	0		0	0	23. 00
23. 50	Tel emedi ci ne	0	0	0	(0	0	23. 50
24. 00	Total (sum of lines 1-23)	0	100					
25. 00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	2, 130	64, 958	93, 65	6	1, 309, 556	25. 00
	Unit Cost Multiplier	0. 000000	21. 300000	649, 580000	936, 56000		0. 454073	24 00

Worksheet H-2 Part I Date/Time Prepared: 3/28/2024 12:04 pm Provider CCN: 15-0109 Peri od: From 01/01/2023 To 12/31/2023 HHA CCN: 15-7124 Home Health PPS

						Home Health Agency I	PPS	
			CAPITAL REL	ATED COSTS		Agency 1		
	Cost Center Description	HHA Trial Balance (1)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	COMMUNI CATI ONS	MGMT INFO SYSTEMS	
		0	1. 00	2.00	4. 00	5. 01	5. 02	
1. 00 2. 00 3. 00	Administrative and General Skilled Nursing Care Physical Therapy	0 2, 091, 191 1, 259, 560	29, 924 107, 749 64, 890	12, 664 45, 602 27, 463		0	,	1. 00 2. 00 3. 00
4. 00 5. 00 6. 00	Occupational Therapy Speech Pathology Medical Social Services	588, 584 120, 291 84, 886	30, 324 6, 197 4, 383	12, 834 2, 623 1, 855	3, 806	0	21, 060 4, 304 3, 037	4. 00 5. 00 6. 00
7. 00 8. 00 9. 00 10. 00	Home Health Aide Supplies (see instructions) Drugs DME	49, 066 0 0	2, 521 0 0 0	1, 067 0 0	0	0	1, 755 0 0	7. 00 8. 00 9. 00 10. 00
11. 00 12. 00 13. 00 14. 00	Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic	0	0 0	0	0 0	0 0	0	11. 00 12. 00 13. 00 14. 00
15. 00 16. 00 17. 00 18. 00	Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service	0 0	0 0 0 0	0 0 0 0	0 0 0	0	0 0	15. 00 16. 00 17. 00 18. 00
19. 00 19. 50 20. 00 21. 00	All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 24 Line 1 divided by the sum	0 0 4, 193, 578	0 0 245, 988	0 0 104, 108	0 0 151, 058	0 0	0 0 170, 836	19. 00 19. 50 20. 00 21. 00
_	26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places. Cost Center Description	DUDQUAGANO						
	LOST LENTER DESCRIPTION							
		PURCHASI NG	ADMI TTI NG	PATI ENT ACCOUNTI NG	Subtotal	OTHER ADMI NI STRATI VE AND GENERAL	OPERATION OF PLANT	
1.00		5. 03	5. 04	ACCOUNTI NG 5. 05	5A. 05	ADMINISTRATIVE AND GENERAL 5.06	PLANT 7. 00	1.00
1.00	Administrative and General	5. 03	5.04	5. 05 795	5A. 05 82, 784	ADMINISTRATIVE AND GENERAL 5.06 35,614	PLANT 7. 00 57, 018	1.00
2.00	Administrative and General Skilled Nursing Care	5. 03 228 821	5. 04 0 0	5. 05 795 2, 861	5A. 05 82, 784 2, 389, 206	ADMI NI STRATI VE AND GENERAL 5. 06 35, 614 1, 027, 836	7. 00 57, 018 205, 309	2. 00
2. 00 3. 00	Administrative and General Skilled Nursing Care Physical Therapy	5. 03 228 821 494	5. 04 0 0	5. 05 795 2, 861 1, 723	5A. 05 82, 784 2, 389, 206 1, 439, 047	ADMI NI STRATI VE AND GENERAL 5. 06 35, 614 1, 027, 836 619, 078	7. 00 57, 018 205, 309 123, 644	2. 00 3. 00
2. 00 3. 00 4. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy	5. 03 228 821 494 231	5. 04 0 0 0	5. 05 795 2, 861 1, 723 805	5A. 05 82, 784 2, 389, 206 1, 439, 047 672, 460	ADMI NI STRATI VE AND GENERAL 5. 06 35, 614 1, 027, 836 619, 078 289, 292	7. 00 57, 018 205, 309 123, 644 57, 781	2. 00 3. 00 4. 00
2. 00 3. 00 4. 00 5. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology	5. 03 228 821 494 231 47	5. 04 0 0 0 0	5. 05 795 2, 861 1, 723 805 165	5A. 05 82, 784 2, 389, 206 1, 439, 047 672, 460 137, 433	ADMI NI STRATI VE AND GENERAL 5. 06 35, 614 1, 027, 836 619, 078 289, 292 59, 124	7. 00 57, 018 205, 309 123, 644 57, 781 11, 808	2. 00 3. 00 4. 00 5. 00
2. 00 3. 00 4. 00 5. 00 6. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services	5. 03 228 821 494 231 47 33	5. 04 0 0 0 0 0	5. 05 795 2, 861 1, 723 805 165 116	5A. 05 82, 784 2, 389, 206 1, 439, 047 672, 460 137, 433 96, 996	ADMI NI STRATI VE AND GENERAL 5. 06 35, 614 1, 027, 836 619, 078 289, 292 59, 124 41, 728	7. 00 57, 018 205, 309 123, 644 57, 781 11, 808 8, 351	2. 00 3. 00 4. 00 5. 00 6. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide	5. 03 228 821 494 231 47 33	5. 04 0 0 0 0 0	5. 05 795 2, 861 1, 723 805 165	5A. 05 82, 784 2, 389, 206 1, 439, 047 672, 460 137, 433	ADMI NI STRATI VE AND GENERAL 5. 06 35, 614 1, 027, 836 619, 078 289, 292 59, 124	7. 00 57, 018 205, 309 123, 644 57, 781 11, 808 8, 351 4, 804	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions)	5. 03 228 821 494 231 47 33	5. 04 0 0 0 0 0 0 0	5. 05 795 2, 861 1, 723 805 165 116	5A. 05 82, 784 2, 389, 206 1, 439, 047 672, 460 137, 433 96, 996	ADMI NI STRATI VE AND GENERAL 5. 06 35, 614 1, 027, 836 619, 078 289, 292 59, 124 41, 728	7. 00 57, 018 205, 309 123, 644 57, 781 11, 808 8, 351 4, 804	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs	5. 03 228 821 494 231 47 33	5. 04 0 0 0 0 0 0 0 0	5. 05 795 2, 861 1, 723 805 165 116	5A. 05 82, 784 2, 389, 206 1, 439, 047 672, 460 137, 433 96, 996 56, 047	ADMI NI STRATI VE AND GENERAL 5. 06 35, 614 1, 027, 836 619, 078 289, 292 59, 124 41, 728	7. 00 57, 018 205, 309 123, 644 57, 781 11, 808 8, 351 4, 804 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME	5. 03 228 821 494 231 47 33	5. 04 0 0 0 0 0 0 0	5. 05 795 2, 861 1, 723 805 165 116	5A. 05 82, 784 2, 389, 206 1, 439, 047 672, 460 137, 433 96, 996	ADMI NI STRATI VE AND GENERAL 5. 06 35, 614 1, 027, 836 619, 078 289, 292 59, 124 41, 728	7. 00 57, 018 205, 309 123, 644 57, 781 11, 808 8, 351 4, 804 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services	5. 03 228 821 494 231 47 33	5. 04 0 0 0 0 0 0 0 0	5. 05 795 2, 861 1, 723 805 165 116	5A. 05 82, 784 2, 389, 206 1, 439, 047 672, 460 137, 433 96, 996 56, 047	ADMI NI STRATI VE AND GENERAL 5. 06 35, 614 1, 027, 836 619, 078 289, 292 59, 124 41, 728	7. 00 57, 018 205, 309 123, 644 57, 781 11, 808 8, 351 4, 804 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy	5. 03 228 821 494 231 47 33	5. 04 0 0 0 0 0 0 0 0 0	5. 05 795 2, 861 1, 723 805 165 116	5A. 05 82, 784 2, 389, 206 1, 439, 047 672, 460 137, 433 96, 996 56, 047	ADMI NI STRATI VE AND GENERAL 5. 06 35, 614 1, 027, 836 619, 078 289, 292 59, 124 41, 728	7. 00 57, 018 205, 309 123, 644 57, 781 11, 808 8, 351 4, 804 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services	5. 03 228 821 494 231 47 33	5. 04 0 0 0 0 0 0 0 0	5. 05 795 2, 861 1, 723 805 165 116	5A. 05 82, 784 2, 389, 206 1, 439, 047 672, 460 137, 433 96, 996 56, 047	ADMI NI STRATI VE AND GENERAL 5. 06 35, 614 1, 027, 836 619, 078 289, 292 59, 124 41, 728	7. 00 57, 018 205, 309 123, 644 57, 781 11, 808 8, 351 4, 804 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy	5. 03 228 821 494 231 47 33	5. 04 0 0 0 0 0 0 0 0 0	5. 05 795 2, 861 1, 723 805 165 116	5A. 05 82, 784 2, 389, 206 1, 439, 047 672, 460 137, 433 96, 996 56, 047	ADMI NI STRATI VE AND GENERAL 5. 06 35, 614 1, 027, 836 619, 078 289, 292 59, 124 41, 728 24, 111 0 0 0 0 0 0	7. 00 57, 018 205, 309 123, 644 57, 781 11, 808 8, 351 4, 804 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic	5. 03 228 821 494 231 47 33	5. 04 0 0 0 0 0 0 0 0 0	5. 05 795 2, 861 1, 723 805 165 116	5A. 05 82, 784 2, 389, 206 1, 439, 047 672, 460 137, 433 96, 996 56, 047 0 0	ADMI NI STRATI VE AND GENERAL 5. 06 35, 614 1, 027, 836 619, 078 289, 292 59, 124 41, 728 24, 111 0 0 0 0 0 0 0	7. 00 57, 018 205, 309 123, 644 57, 781 11, 808 8, 351 4, 804 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic	5. 03 228 821 494 231 47 33 19 0 0 0 0	5. 04 0 0 0 0 0 0 0 0 0 0	5. 05 795 2, 861 1, 723 805 165 116	5A. 05 82, 784 2, 389, 206 1, 439, 047 672, 460 137, 433 96, 996 56, 047 0 0 0 0 0 0	ADMI NI STRATI VE AND GENERAL 5. 06 35, 614 1, 027, 836 619, 078 289, 292 59, 124 41, 728 24, 111 0 0 0 0 0 0 0	7. 00 57, 018 205, 309 123, 644 57, 781 11, 808 8, 351 4, 804 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities	5. 03 228 821 494 231 47 33 19 0 0 0 0	5. 04 0 0 0 0 0 0 0 0 0 0	5. 05 795 2, 861 1, 723 805 165 116	5A. 05 82, 784 2, 389, 206 1, 439, 047 672, 460 137, 433 96, 996 56, 047 0 0 0 0 0 0	ADMI NI STRATI VE AND GENERAL 5. 06 35, 614 1, 027, 836 619, 078 289, 292 59, 124 41, 728 24, 111 0 0 0 0 0 0 0	7. 00 57, 018 205, 309 123, 644 57, 781 11, 808 8, 351 4, 804 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program	5. 03 228 821 494 231 47 33 19 0 0 0 0	5. 04 0 0 0 0 0 0 0 0 0 0 0	5. 05 795 2, 861 1, 723 805 165 116	5A. 05 82, 784 2, 389, 206 1, 439, 047 672, 460 137, 433 96, 996 56, 047 0 0 0 0 0 0	ADMI NI STRATI VE AND GENERAL 5. 06 35, 614 1, 027, 836 619, 078 289, 292 59, 124 41, 728 24, 111 0 0 0 0 0 0 0	7. 00 57, 018 205, 309 123, 644 57, 781 11, 808 8, 351 4, 804 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 17. 00 18. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service	5. 03 228 821 494 231 47 33 19 0 0 0 0	5. 04 0 0 0 0 0 0 0 0 0 0 0	5. 05 795 2, 861 1, 723 805 165 116	5A. 05 82, 784 2, 389, 206 1, 439, 047 672, 460 137, 433 96, 996 56, 047 0 0 0 0 0 0	ADMI NI STRATI VE AND GENERAL 5. 06 35, 614 1, 027, 836 619, 078 289, 292 59, 124 41, 728 24, 111 0 0 0 0 0 0 0	7. 00 57, 018 205, 309 123, 644 57, 781 11, 808 8, 351 4, 804 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify)	5. 03 228 821 494 231 47 33 19 0 0 0 0	5. 04 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	5. 05 795 2, 861 1, 723 805 165 116	5A. 05 82, 784 2, 389, 206 1, 439, 047 672, 460 137, 433 96, 996 56, 047 0 0 0 0 0 0	ADMI NI STRATI VE AND GENERAL 5. 06 35, 614 1, 027, 836 619, 078 289, 292 59, 124 41, 728 24, 111 0 0 0 0 0 0 0	7. 00 57, 018 205, 309 123, 644 57, 781 11, 808 8, 351 4, 804 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 17. 00 18. 00 19. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 14.00 15.00 16.00 17.00 18.00 19.00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine	5. 03 228 821 494 231 47 33 19 0 0 0 0 0 0	5. 04 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	5. 05 795 2, 861 1, 723 805 165 116 67 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	5A. 05 82, 784 2, 389, 206 1, 439, 047 672, 460 137, 433 96, 996 56, 047 0 0 0 0 0 0 0 0 0 0 0 0 0	ADMI NI STRATI VE AND GENERAL 5. 06 35, 614 1, 027, 836 619, 078 289, 292 59, 124 41, 728 24, 111 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	7. 00 57, 018 205, 309 123, 644 57, 781 11, 808 8, 351 4, 804 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 50
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 50 20. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2)	5. 03 228 821 494 231 47 33 19 0 0 0 0	5. 04 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	5. 05 795 2, 861 1, 723 805 165 116	5A. 05 82, 784 2, 389, 206 1, 439, 047 672, 460 137, 433 96, 996 56, 047 0 0 0 0 0 0 0 4, 873, 973	ADMI NI STRATI VE AND GENERAL 5. 06 35, 614 1, 027, 836 619, 078 289, 292 59, 124 41, 728 24, 111 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	7. 00 57, 018 205, 309 123, 644 57, 781 11, 808 8, 351 4, 804 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 50 20. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column	5. 03 228 821 494 231 47 33 19 0 0 0 0 0 0	5. 04 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	5. 05 795 2, 861 1, 723 805 165 116 67 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	5A. 05 82, 784 2, 389, 206 1, 439, 047 672, 460 137, 433 96, 996 56, 047 0 0 0 0 0 0 0 0 0 0 0 0 0	ADMI NI STRATI VE AND GENERAL 5. 06 35, 614 1, 027, 836 619, 078 289, 292 59, 124 41, 728 24, 111 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	7. 00 57, 018 205, 309 123, 644 57, 781 11, 808 8, 351 4, 804 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 50
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 50 20. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum	5. 03 228 821 494 231 47 33 19 0 0 0 0 0 0	5. 04 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	5. 05 795 2, 861 1, 723 805 165 116 67 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	5A. 05 82, 784 2, 389, 206 1, 439, 047 672, 460 137, 433 96, 996 56, 047 0 0 0 0 0 0 0 4, 873, 973	ADMI NI STRATI VE AND GENERAL 5. 06 35, 614 1, 027, 836 619, 078 289, 292 59, 124 41, 728 24, 111 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	7. 00 57, 018 205, 309 123, 644 57, 781 11, 808 8, 351 4, 804 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 50 20. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 50 20. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus	5. 03 228 821 494 231 47 33 19 0 0 0 0 0 0	5. 04 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	5. 05 795 2, 861 1, 723 805 165 116 67 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	5A. 05 82, 784 2, 389, 206 1, 439, 047 672, 460 137, 433 96, 996 56, 047 0 0 0 0 0 0 0 4, 873, 973	ADMI NI STRATI VE AND GENERAL 5. 06 35, 614 1, 027, 836 619, 078 289, 292 59, 124 41, 728 24, 111 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	7. 00 57, 018 205, 309 123, 644 57, 781 11, 808 8, 351 4, 804 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 50 20. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 50 20. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum	5. 03 228 821 494 231 47 33 19 0 0 0 0 0 0	5. 04 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	5. 05 795 2, 861 1, 723 805 165 116 67 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	5A. 05 82, 784 2, 389, 206 1, 439, 047 672, 460 137, 433 96, 996 56, 047 0 0 0 0 0 0 0 4, 873, 973	ADMI NI STRATI VE AND GENERAL 5. 06 35, 614 1, 027, 836 619, 078 289, 292 59, 124 41, 728 24, 111 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	7. 00 57, 018 205, 309 123, 644 57, 781 11, 808 8, 351 4, 804 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 50 20. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 50 20. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to	5. 03 228 821 494 231 47 33 19 0 0 0 0 0 0	5. 04 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	5. 05 795 2, 861 1, 723 805 165 116 67 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	5A. 05 82, 784 2, 389, 206 1, 439, 047 672, 460 137, 433 96, 996 56, 047 0 0 0 0 0 0 0 4, 873, 973	ADMI NI STRATI VE AND GENERAL 5. 06 35, 614 1, 027, 836 619, 078 289, 292 59, 124 41, 728 24, 111 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	7. 00 57, 018 205, 309 123, 644 57, 781 11, 808 8, 351 4, 804 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 50 20. 00

⁽¹⁾ Column O, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns O through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

Peri od: | Worksheet H-2 | Part | I | Date/Time Prepared: | 3/28/2024 | 12: 04 pm | Home Health | PPS | Part | Prepared: | PPS HHA CCN: 15-7124

						Home Health	PPS	•
	Cost Center Description	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	Agency I NURSI NG	CENTRAL	
	2001 2011101 20001 Pt. 011	LINEN SERVICE	110002112211110	5.2.7	0711 2 1 2 1 1 1 1 1	ADMI NI STRATI ON		
							SUPPLY	
		8. 00	9. 00	10.00	11. 00	13. 00	14. 00	
1. 00	Administrative and General	0	16, 647		19, 11			1. 00
2.00	Skilled Nursing Care	0	59, 942		,			2.00
3.00	Physical Therapy	0	36, 099				457	3.00
4. 00 5. 00	Occupational Therapy Speech Pathology	0	16, 870 3, 447	0	,		214 44	4. 00 5. 00
6. 00	Medical Social Services	0	2, 438	1	2, 79		31	6. 00
7. 00	Home Heal th Ai de	0	1, 403		1		18	7. 00
8. 00	Supplies (see instructions)	0	0		., 0.	0 0	0	8. 00
9.00	Drugs	0	0	0		0	0	9. 00
10.00	DME	0	0	0		0	0	10.00
11. 00	Home Dialysis Aide Services	0	0			0	0	11. 00
12.00	Respiratory Therapy	0	0			0	0	12.00
13. 00 14. 00	Private Duty Nursing Clinic	0	0				0	13. 00 14. 00
15. 00	Health Promotion Activities	0	Ö			0 0	0	15. 00
16. 00	Day Care Program	0	0	0		0	0	16.00
17.00	Home Delivered Meals Program	0	0	0		0	0	17. 00
18. 00	Homemaker Service	0	0	1		0	0	18.00
19. 00	All Others (specify)	0	0	1		0	0	19. 00
19. 50	Telemedicine Total (sum of lines 1-19) (2)	0	134 044	1	157.04	0 250 003	1 722	19. 50
20. 00 21. 00	Unit Cost Multiplier: column	0	136, 846	0	157, 06	7 350, 083	1, 732	20. 00 21. 00
21.00	26, line 1 divided by the sum							21.00
	of column 26, line 20 minus							
	column 26, line 1, rounded to							
	6 decimal places. Cost Center Description	PHARMACY	MEDI CAL	SOCIAL SERVICE	NURSI NG	PHARMACY	EMS EDUCATION	
	cost center bescription	THANWACT	RECORDS &	SOCIAL SERVICE	PROGRAM	RESI DENCY	LWS LDOCATION	
			LI BRARY					
4.00		15. 00	16.00	17. 00	20. 00	23. 00	23. 01	1.00
1. 00 2. 00	Administrative and General Skilled Nursing Care	0	2, 088 7, 515			0 0	0	1. 00 2. 00
3. 00	Physical Therapy	0	4, 526			0 0	0	3. 00
4. 00	Occupational Therapy	0	2, 115		•		ő	4. 00
5.00	Speech Pathology	0	432			0	0	5. 00
6.00	Medical Social Services	0	305			0	0	6. 00
7. 00	Home Heal th Ai de	0	176			0	0	7. 00
8.00	Supplies (see instructions)	0	0			0	0	8. 00
9. 00 10. 00	Drugs DME	0	0			0 0	0	9. 00 10. 00
11. 00	Home Dialysis Aide Services	0	0			0 0	0	11. 00
12. 00	Respiratory Therapy	0	0			0 0	Ō	12. 00
13.00	Private Duty Nursing	0	0	0		0	0	13.00
14.00	Clinic	0	0	-		0	0	14.00
15. 00	Health Promotion Activities	0	0			0	0	15.00
16.00	Day Care Program	0	0	0		0	0	16.00
17. 00 18. 00	Home Delivered Meals Program Homemaker Service	0		0		0 0	0	17. 00 18. 00
19. 00	1	o o	0	l ő			ő	19. 00
	IALL Others (specify)							
19. 50	All Others (specify) Telemedicine	0	Ö	0		0	0	19.50
20. 00	Telemedicine Total (sum of lines 1-19) (2)	0	0 17, 157	0		0 0	0 0	20.00
	Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column	0	0 17, 157	0		0 0	0 0	
20. 00	Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum	0	0 17, 157	0		0 0	0	20.00
20. 00	Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus	0	17, 157	0		0 0	0	20.00
20. 00	Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum	0	17, 157	0		0 0	0	20.00

⁽¹⁾ Column O, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns O through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

Health Financial Systems FRANCALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS Worksheet H-2 Part I Date/Time Prepared: 3/28/2024 12:04 pm Provi der CCN: 15-0109 Peri od: From 01/01/2023 To 12/31/2023 HHA CCN: 15-7124 Home Health PPS

						Agency I	
	Cost Center Description	Subtotal	Intern &	Subtotal	Allocated HHA	Total HHA	
			Residents Cost		A&G (see Part	Costs	
			& Post		11)		
			Stepdown		·		
			Adjustments				
	,	24. 00	25. 00	26. 00	27. 00	28. 00	
1.00	Administrative and General	256, 081	0	256, 081			1. 00
2.00	Skilled Nursing Care	3, 912, 686	0	3, 912, 686	127, 701	4, 040, 387	2. 00
3.00	Physi cal Therapy	2, 356, 639	0	2, 356, 639	76, 914	2, 433, 553	3. 00
4.00	Occupational Therapy	1, 101, 250	0	1, 101, 250	35, 941	1, 137, 191	4. 00
5.00	Speech Pathology	225, 065	0	225, 065	7, 345	232, 410	5. 00
6.00	Medical Social Services	158, 865	0	158, 865	5, 185	164, 050	6. 00
7.00	Home Health Aide	91, 770	0	91, 770	2, 995	94, 765	7. 00
8.00	Supplies (see instructions)	0	0	0	0	0	8. 00
9.00	Drugs	0	0	0	0	0	9. 00
10.00	DME	0	0	0	0	0	10.00
11. 00	Home Dialysis Aide Services	0	0	0	0	0	11. 00
12.00	Respiratory Therapy	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	14. 00
15.00	Health Promotion Activities	0	0	0	0	0	15. 00
16.00	Day Care Program	0	0	0	0	0	16. 00
17.00	Home Delivered Meals Program	0	0	0	0	0	17. 00
18.00	Homemaker Service	0	0	0	0	0	18. 00
19.00	All Others (specify)	0	0	0	0	0	19. 00
19. 50	Tel emedi ci ne	0	0	0	0	0	19. 50
20.00	Total (sum of lines 1-19) (2)	8, 102, 356	0	8, 102, 356	256, 081	8, 102, 356	20. 00
21.00	Unit Cost Multiplier: column				0. 032637		21. 00
	26, line 1 divided by the sum						I
	of column 26, line 20 minus						I
	column 26, line 1, rounded to						l
	6 decimal places.						1

⁽¹⁾ Column O, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns O through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

							3/20/2024 12.0	04 pili
						Home Health Agency I	PPS	
		CAPITAL REL	ATED COSTS					
	Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	COMMUNICATIONS	MGMT INFO	PURCHASI NG	
		(SQUARE FEET)	(SQUARE FEET)	BENEFITS DEPARTMENT	(PHONE LINE S)	SYSTEMS (MANHOURS)	(COSTED REQ UISI)	
				(GROSS	(THONE ETNE 3)	(WANTOOKS)	0131)	
		1.00	2.00	SALARI ES) 4. 00	5. 01	5. 02	5. 03	
1. 00	Administrative and General	1, 270	1, 270		5.01	16, 607	9, 083	1. 00
2. 00	Skilled Nursing Care	4, 573	4, 573	l ·		59, 767	32, 689	2. 00
3.00	Physi cal Therapy	2, 754	2, 754	1, 020, 193	0	35, 999		3. 00
4.00	Occupational Therapy	1, 287	1, 287	476, 729		16, 822		4. 00
5.00	Speech Pathology	263	263		0	3, 438		5. 00
6. 00 7. 00	Medical Social Services Home Health Aide	186 107	186 107		0	2, 426 1, 402		6. 00 7. 00
8. 00	Supplies (see instructions)	107	0		0	1, 402	0	8. 00
9. 00	Drugs	0	0	Ö	O	0	o	9. 00
10.00	DME	0	0		0	0	0	10. 00
11. 00	Home Dialysis Aide Services	0	0		0	0	0	11. 00
12.00	Respiratory Therapy	0	0			0	0	12.00
13. 00 14. 00	Private Duty Nursing		0		1	0	0	13. 00 14. 00
15. 00	Health Promotion Activities		0		Ö	0	Ö	15. 00
16. 00	Day Care Program	0	0	Ö	0	0	o	16. 00
17. 00	Home Delivered Meals Program	0	0	0	0	0	0	17. 00
18. 00	Homemaker Service	0	0	0	0	0	0	18. 00
19. 00 19. 50	All Others (specify)	0	0	_	0	0	0	19.00
20. 00	Telemedicine Total (sum of lines 1-19)	10, 440	10, 440	_	0	136, 461	74, 636	19. 50 20. 00
21. 00	Total cost to be allocated	245, 988	104, 108			170, 836		21. 00
22. 00	Unit cost multiplier	23. 562069	9. 972031	0. 039061	0. 000000	1. 251903	0. 025095	
	Cost Center Description	ADMITTING	PATI ENT	Reconciliation	OTHER	OPERATION OF	LAUNDRY &	
		(GROSS CHAR GES)	ACCOUNTI NG (GROSS CHAR		ADMINISTRATIVE AND GENERAL	PLANT (SQUARE FEET)	LINEN SERVICE (POUNDS OF	
		GES)	GES)		(ACCUM. COST)	(SQUARE FEET)	LAUNDRY)	
		5. 04	5. 05	5A. 06	5.06	7. 00	8. 00	
1.00	Administrative and General	1, 111, 727	1, 111, 727	l .	82, 784	1, 270		1.00
2. 00 3. 00	Skilled Nursing Care Physical Therapy	4, 001, 231 2, 410, 009	4, 001, 231 2, 410, 009	l .	2, 389, 206 1, 439, 047	4, 573 2, 754	0	2. 00 3. 00
4. 00	Occupational Therapy	1, 126, 181	1, 126, 181		672, 460	1, 287	0	4. 00
5. 00	Speech Pathology	230, 162	230, 162	Ö	137, 433	263		5. 00
6.00	Medical Social Services	162, 419	162, 419	0	96, 996	186	0	6. 00
7.00	Home Heal th Aide	93, 882	93, 882		56, 047	107	0	7. 00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8. 00
9. 00 10. 00	Drugs DME	0	0	0	0	0	0	9. 00 10. 00
11. 00	Home Dialysis Aide Services		0		0	0	0	11. 00
12. 00	Respiratory Therapy	0	0		0	0	o	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13. 00
14. 00	Clinic	0	0		1	0	1	
15.00	Health Promotion Activities	0	0		· -	0	0	
16. 00 17. 00	Day Care Program Home Delivered Meals Program	0	0		0	0	0	16. 00 17. 00
18. 00	Homemaker Service		0	Ö	Ö	0	Ö	18. 00
19. 00	All Others (specify)	0	0	Ō	0	0	o	19. 00
19. 50	Tel emedi ci ne	0	0	0	0	0	l o	19. 50
20.00	1				1			
	Total (sum of lines 1-19)	9, 135, 611	9, 135, 611		4, 873, 973			20.00
21. 00 22. 00	Total cost to be allocated	9, 135, 611 0 0. 000000	6, 532		4, 873, 973 2, 096, 783 0. 430200	468, 715	0	21. 00

Worksheet H-2 Part II Date/Time Prepared: 3/28/2024 12:04 pm From 01/01/2023 To 12/31/2023 BASIS HHA CCN: 15-7124

				Home Health Agency I	PPS			
	Cost Center Description	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	
	·	(SQUARE FEET)	(MEALS SERVED)	(MANHOURS)	ADMI NI STRATI ON	SERVICES &	(COSTED	
						SUPPLY	REQUIS.)	
					(DI RECT NRS	(COSTED REQ		
					I NG)	UISI)		
	T	9. 00	10.00	11. 00	13. 00	14. 00	15. 00	
1.00	Administrative and General	1, 270	0	16, 607	16, 607	9, 083	0	
2.00	Skilled Nursing Care	4, 573	0	59, 767		32, 689	0	
3.00	Physical Therapy	2, 754	0	35, 999	l	19, 689	0	3. 00
4.00	Occupational Therapy	1, 287	0	16, 822	l	9, 201	0	
5.00	Speech Pathology	263	0	3, 438	l	1, 880	0	5. 00
6.00	Medical Social Services	186	0	2, 426	1	1, 327	0	
7.00	Home Heal th Ai de	107	0	1, 402		767	0	
8.00	Supplies (see instructions)	0	0	0	· ·	0	0	
9.00	Drugs	0	0	0		0	0	9. 00
10.00	DME	0	0	0		0	0	10.00
11. 00	Home Dialysis Aide Services	0	0	0	0	0	0	11. 00
12. 00 13. 00	Respiratory Therapy	0	0	0	0	0	0	12.00
14. 00	Private Duty Nursing Clinic	0	0	0	0	0 0	0	
15. 00	Health Promotion Activities	0	0	0	0	o o	0	
16. 00	Day Care Program	0	0	0	0	o o	0	16. 00
17. 00	Home Delivered Meals Program	0	0	0	0	0	0	
18. 00	Homemaker Service	0	0	0	0	0	0	18.00
19. 00	All Others (specify)		0	0	0	0	0	19. 00
19. 50	Tel emedi ci ne			0		0	0	19. 50
20. 00	Total (sum of lines 1-19)	10, 440		136, 461	136, 461	74, 636	0	20.00
21. 00	Total cost to be allocated	136, 846		157, 067		1, 732	0	21. 00
22. 00	Unit cost multiplier	13. 107854	0. 000000	1. 151003	l	0. 023206	0. 000000	
	Cost Center Description	MEDI CAL	SOCI AL SERVI CE	NURSI NG	PHARMACY	EMS EDUCATION	2, 22220	
		RECORDS &		PROGRAM	RESI DENCY	(ASSI GNED		
		LI BRARY	(TIME SPENT)	(ASSI GNED	(ASSI GNED	TIME)		
		(GROSS CHAR		TIME)	TIME)			
		GES)	47.00		22.22	00.01		
4 00		16.00	17. 00	20.00	23.00	23. 01		4 00
1.00	Administrative and General	1, 111, 727	0	0		- 1		1.00
2.00	Skilled Nursing Care	4, 001, 231	0	0		0		2.00
3. 00 4. 00	Physical Therapy	2, 410, 009	0	0	0	0		3. 00 4. 00
5.00	Occupational Therapy	1, 126, 181	0 0	0		0		5. 00
6. 00	Speech Pathology Medical Social Services	230, 162 162, 419		0	0	0		6.00
7. 00	Home Heal th Aide	93, 882		0	1	0		7. 00
8.00	Supplies (see instructions)	75,002		0		0		8.00
9. 00	Drugs	0		0		0		9. 00
10.00	DME			0	1	o		10.00
11. 00	Home Dialysis Aide Services		ا	0	1	o		11. 00
12. 00	Respiratory Therapy	0	l o	0	1	o		12. 00
13. 00	Private Duty Nursing	0	o	0		o		13. 00
14. 00	Clinic	0	o	0		o		14. 00
15. 00	Health Promotion Activities	0	o	0	1	O		15. 00
16. 00	Day Care Program	0	o	0	Ó	O		16.00
17. 00	Home Delivered Meals Program	0	O	0	0	0		17. 00
18. 00	Homemaker Service	0	o	0	0	0		18. 00
19. 00	All Others (specify)	0	o	0	0	O		19. 00
19. 50	Tel emedi ci ne	0	o	0	0	О		19. 50
20.00	Total (sum of lines 1-19)	9, 135, 611	o	0	0	O		20. 00
21.00	Total cost to be allocated	17, 157	o	0	0	o		21.00
22. 00	Unit cost multiplier	0. 001878	0. 000000	0.000000	0.000000	0. 000000		22. 00

APPORT	IONMENT OF PATIENT SERVICE COST							2552-10
		S		Provi der (CCN: 15-0109	Peri od:	Worksheet H-3	
				HHA CCN:	15-7124	From 01/01/2023 To 12/31/2023	Part I Date/Time Prep 3/28/2024 12:0	
				Ti tl	e XVIII	Home Health Agency I	PPS	оч рііі
	Cost Center Description	From, Wkst.	Facility Costs	Shared	Total HHA	Total Visits	Average Cost	
		H-2, Part I,	(from Wkst.	Ancillary	Costs (cols.	1	Per Visit	
		col. 28, line	H-2, Part I)	Costs (from Part II)	+ 2)		(col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4. 00	5. 00	
	PART I - COMPUTATION OF LESSER	OF AGGREGATE F						
	BENEFICIARY COST LIMITATION							
1. 00	Cost Per Visit Computation Skilled Nursing Care	2. 00	4, 040, 387		4, 040, 3	87 11, 172	361. 65	1.00
2. 00	Physical Therapy	3.00		(2, 433, 5			
3.00	Occupational Therapy	4. 00			1, 137, 1		365. 66	•
4.00	Speech Pathology	5. 00	1	(0 232, 4		397. 96	
5.00	Medical Social Services	6. 00	1		164, 0		445. 79	1
6.00	Home Heal th Aide	7. 00			94, 7		1, 606. 19	ı
7. 00	Total (sum of lines 1-6)		8, 102, 356		0 8,102,3 Program Visi			7. 00
						Part B		
	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Not Subject			
	·		, ,		Deducti bl es	& Deductibles		
			4 00		Coi nsurance			
	Limitation Cost Computation	0	1.00	2. 00	3. 00	4. 00	5. 00	
8. 00	Skilled Nursing Care		23844	(ol	0		8.00
8. 01	Skilled Nursing Care		26900	(0 5	35		8. 01
8. 02	Skilled Nursing Care		29200		0 2, 2			8. 02
8. 03	Skilled Nursing Care		33140		0	3		8. 03
8. 04 8. 05	Skilled Nursing Care Skilled Nursing Care		45460 99915		0 1, 8 0	0		8. 04 8. 05
9. 00	Physical Therapy		23844			0		9.00
9. 01	Physical Therapy		26900		-	91		9. 01
9.02	Physical Therapy		29200	(1, 6	01		9. 02
9. 03	Physical Therapy		33140		0	0		9. 03
9. 04	Physical Therapy		45460		0 1, 2 0			9. 04
9. 05 10. 00	Physical Therapy Occupational Therapy		99915 23844		0	0		9. 05 10. 00
10. 00	Occupational Therapy		26900		-	41		10.00
10. 02	Occupational Therapy		29200			69		10. 02
10.03	Occupational Therapy		33140	(О	0		10. 03
10.04	Occupational Therapy		45460			47		10. 04
10.05	Occupational Therapy		99915		0	0		10.05
11. 00 11. 01	Speech Pathology Speech Pathology		23844 26900		0	0 11		11. 00 11. 01
11. 02	Speech Pathology		29200		1	26		11. 02
			33140	(0	0		11. 03
11.04	Speech Pathology		45460	(o	90		11. 04
11. 05	Speech Pathology		99915		0	0		11. 05
12.00	Medical Social Services		23844		0	0		12.00
12. 01 12. 02	Medical Social Services Medical Social Services		26900 29200		1	12 86		12. 01 12. 02
12. 02	Medical Social Services		33140		0	0		12. 02
12. 04	Medical Social Services		45460		1	62		12. 04
12.05	Medical Social Services		99915	(О	0		12. 05
13.00	Home Heal th Aide		23844		0	0		13.00
13. 01	Home Health Aide		26900		0	1		13. 01
13. 02 13. 03	Home Health Aide Home Health Aide		29200 33140		0	24		13. 02 13. 03
13. 03	Home Health Aide		45460		0	7		13. 03
	1		99915		Ö	ó		13. 05
13. 05	Thome hear th Arde		1///13	,				

<u>Heal</u> th	Financial Systems		FRANCISCAN HEAL	TH_LAFAYETTE			<u>In L</u> i€	eu of Form CMS-2	<u> 2552-1</u> 0
APPORT	IONMENT OF PATIENT SERVICE COST	rs .		Provi der C	CN: 15-0109	Peri od:		Worksheet H-3	
				HHA CCN:	15-7124		1/01/2023 2/31/2023		pared: 04 pm
				Ti tl e	e XVIII		Heal th	PPS	<u>о, р</u>
	Cost Center Description	From Wkst. H-2	Facility Costs	Shared	Total HHA			Ratio (col. 3	
	· ·	Part I, col.	(from Wkst.	Ancillary	Costs (cols.		om HHA	÷ col. 4)	
		28, line	H-2, Part I)	Costs (from	+ 2)	Red	cords)		
		0	1.00	Part II) 2.00	3.00		4. 00	5. 00	
	Supplies and Drugs Cost Comput		1.00	2.00	0.00		00	0.00	
	Cost of Medical Supplies	8. 00		(0	C	1	
16. 00	Cost of Drugs	9. 00	Program Visits	(Cost of	0	C	0. 000000	16. 00
			Trogram visits		Servi ces				
			Par				art B		
	Cost Center Description	Part A	Not Subject to	Subject to	Part A		ubject to		
			Deductibles & Coinsurance	Deductibles & Coinsurance			tibles & surance	Deductibles & Coinsurance	
		6. 00	7. 00	8. 00	9. 00		0.00	11. 00	
	PART I - COMPUTATION OF LESSER	OF AGGREGATE F	PROGRAM COST, A	GGREGATE OF TH	IE PROGRAM LII	MI TATI ON	COST, O	R	
	BENEFICIARY COST LIMITATION Cost Per Visit Computation								1
1. 00	Skilled Nursing Care	Ιο	4, 656			0 -	1, 683, 842	2	1.00
2.00	Physi cal Therapy	0					1, 078, 885	1	2. 00
3.00	Occupational Therapy	0	1, 257			0	459, 635	1	3. 00
4.00	Speech Pathology	0	227			0	90, 337		4.00
5. 00 6. 00	Medical Social Services Home Health Aide	0	160 32			0	71, 326 51, 398		5. 00 6. 00
7. 00	Total (sum of lines 1-6)		1			-	31, 390 3, 435, 423		7.00
7.00	Cost Center Description		7, 177				07 1007 120		71.00
	T	6. 00	7. 00	8. 00	9. 00	1	0. 00	11. 00	
8. 00	Limitation Cost Computation Skilled Nursing Care	I	1		T			1	8.00
8. 01	Skilled Nursing Care								8. 00
8. 02	Skilled Nursing Care								8. 02
8. 03	Skilled Nursing Care								8. 03
8. 04	Skilled Nursing Care								8. 04
8. 05	Skilled Nursing Care								8. 05
9. 00 9. 01	Physical Therapy Physical Therapy	1							9. 00 9. 01
9. 02	Physical Therapy								9. 02
9. 03	Physical Therapy								9. 03
9. 04	Physical Therapy								9. 04
9.05	Physi cal Therapy								9.05
10. 00 10. 01	Occupational Therapy Occupational Therapy								10. 00 10. 01
10. 01	Occupational Therapy								10.01
10. 03	Occupational Therapy								10. 03
10. 04	Occupational Therapy								10. 04
10. 05	Occupational Therapy								10.05
11.00	Speech Pathology								11.00
11. 01 11. 02	Speech Pathology Speech Pathology								11. 01 11. 02
11. 02	Speech Pathology								11. 03
11. 04	Speech Pathology								11. 04
11. 05	Speech Pathology								11. 05
12. 00	Medical Social Services								12.00
12. 01	Medical Social Services								12. 01
12. 02 12. 03	Medical Social Services Medical Social Services								12. 02 12. 03
12. 03	Medical Social Services								12. 04
12. 05	Medical Social Services								12. 05
13. 00	Home Health Aide								13.00
13. 01	Home Heal th Aide								13. 01
13. 02	Home Health Aide	1							13. 02
13. 03 13. 04	Home Health Aide Home Health Aide								13. 03 13. 04
13. 04	Home Health Aide								13. 04
	Total (sum of lines 8-13)								14. 00

	Financial Systems		FRANCISCAN HEAL		N 45 0100		eu of Form CMS-	
PPORT	IONMENT OF PATIENT SERVICE COST	S		Provi der Co		Peri od: From 01/01/2023		
				HHA CCN:	15-7124	To 12/31/2023	3/28/2024 12:	
				Title	XVIII	Home Health Agency I	PPS	
		Prog	ram Covered Cha	rges	Cost of	Agency		
					Servi ces			
			Part		_	Part B		
	Cost Center Description	Part A	Not Subject to Deductibles &	Subject to Deductibles &	Part A	Not Subject to Deductibles &	Subject to Deductibles &	
			Coi nsurance	Coi nsurance		Coi nsurance	Coi nsurance	
	Supplies and Drugs Cost Computa	6.00	7. 00	8. 00	9. 00	10.00	11. 00	
5. 00	Cost of Medical Supplies	0	1 -1	0		0 0		
5. 00	Cost of Drugs Cost Center Description	Total Program	0	0		0	0	16. (
	cost center bescription	Cost (sum of						
		col s. 9-10) 12.00						-
	PART I - COMPUTATION OF LESSER		L PROGRAM COST, AC	GREGATE OF TH	E PROGRAM LI	MITATION COST, O	₹	
	BENEFICIARY COST LIMITATION							-
00	Cost Per Visit Computation Skilled Nursing Care	1, 683, 842						1.
00	Physical Therapy	1, 078, 885						2.
00	Occupational Therapy	459, 635						3. 4.
00	Speech Pathology Medical Social Services	90, 337 71, 326						5.
00	Home Health Aide	51, 398						6.
00	Total (sum of lines 1-6) Cost Center Description	3, 435, 423						7.
	cost center bescription	12. 00						1
	Limitation Cost Computation							
00 01	Skilled Nursing Care Skilled Nursing Care							8.
02	Skilled Nursing Care							8.
03	Skilled Nursing Care							8. 8.
04 05	Skilled Nursing Care Skilled Nursing Care							8.
00	Physical Therapy							9.
01 02	Physical Therapy Physical Therapy							9. 9.
03	Physical Therapy							9.
	Physical Therapy							9.
05). 00	Physical Therapy Occupational Therapy							9. 10.
. 01	Occupational Therapy							10.
). 02). 03	Occupational Therapy							10.
	Occupational Therapy Occupational Therapy							10.
. 05	Occupational Therapy							10.
. 00	Speech Pathology							11.
. 01 . 02	Speech Pathology Speech Pathology							11.
. 03	Speech Pathology							11.
. 04	Speech Pathology							11.
. 05 . 00	Speech Pathology Medical Social Services							11. 12.
. 01	Medical Social Services							12.
. 02	Medical Social Services							12.
. 03	Medical Social Services Medical Social Services							12. 12.
. 05	Medical Social Services							12.
. 00	Home Heal th Ai de							13.
. 01 . 02	Home Health Aide Home Health Aide							13. 13.
. 02	Home Heal th Aide							13.
	Home Health Aide							13.
3. 04 3. 05	Home Heal th Aide							13.

Heal th	Financial Systems	1	FRANCISCAN HEAL	TH LAFAYETTE		In Lie	u of Form CMS-2	2552-10
APP0R1	TIONMENT OF PATIENT SERVICE COST	S		Provi der C		Peri od:	Worksheet H-3	
		HHA CCN:	15-7124	From 01/01/2023 To 12/31/2023				
					Home Health	PPS		
						Agency I		
	Cost Center Description	From Wkst. C,	Cost to Charge		HHA Shared	Transfer to		
		Part I, col.	Ratio	Charge (from	Ancillary	Part I as		
		9, line		provi der	Costs (col.	1 Indicated		
				records)	x col. 2)			
		0	1. 00	2. 00	3. 00	4. 00		
	PART II - APPORTIONMENT OF COS	T OF HHA SERVIC	ES FURNI SHED B	Y SHARED HOSPI	TAL DEPARTMEN	ITS		
1.00	Physi cal Therapy	66.00	0. 236858	0		0 col. 2, line 2	. 00	1.00
2.00	Occupational Therapy	67.00	0. 154626	0		0 col. 2, line 3	. 00	2. 00
3.00	Speech Pathology	68. 00	0. 165502	0		0 col. 2, line 4	. 00	3. 00
4.00	Cost of Medical Supplies	71. 00	0. 166831	0		0 col. 2, line 1	5. 00	4. 00
5.00	Cost of Drugs	73. 00	0. 183745	0		0 col. 2, line 1	6. 00	5. 00
5.01	Cost of Drugs 1	73. 01	6, 344. 983539	0		0 col. 2, line 1	6. 01	5. 01

	FINANCI SYSTEMS FRANCISCAN HEALTH TION OF HHA REIMBURSEMENT SETTLEMENT	LAFAYETTE Provi der CO	CN: 15-0109	In Lieu of Form CMS- Period: Worksheet H-		
LCOLA	TON OF THE RETINDORSEMENT SETTEMENT	HHA CCN:	15-7124	From 01/01/2023 To 12/31/2023	Part I-II Date/Time Pre	pare
		Title	XVIII	Home Health	3/28/2024 12: 0 PPS	04 p
				Agency I	rt B	
			Part A	Not Subject to	Subject to	
				Deductibles & Coinsurance	Deductibles & Coinsurance	
			1.00	2. 00	3. 00	
-	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTO Reasonable Cost of Part A & Part B Services	MARY CHARGE	<u>S</u>			
	Reasonable cost of services (see instructions)			0 0	0	1.
	Total charges			0 0	0	2.
	customary Charges Amount actually collected from patients liable for payment for	servi ces		O C	0	3.
	on a charge basis (from your records)					
	Amount that would have been realized from patients liable for for services on a charge basis had such payment been made in a with 42 CFR §413.13(b)			0 0	0	4
	Ratio of line 3 to line 4 (not to exceed 1.000000)		0. 0000	0. 000000	0. 000000	5
00	Total customary charges (see instructions)			0 0		6
	Excess of total customary charges over total reasonable cost only if line 6 exceeds line 1)	complete		0 0	0	7
00	Excess of reasonable cost over customary charges (complete onl 1 exceeds line 6)	yifline		0 0	0	8
00	Primary payer amounts			0 2, 863		9
				Part A Services	Part B Servi ces	
-	AND THE COMPUTATION OF THE DELIVERY OF THE PROPERTY.			1. 00	2. 00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT Total reasonable cost (see instructions)				-2, 863	10
00	Total PPS Reimbursement - Full Episodes without Outliers			C	1, 861, 556	11
	Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes			C	241, 073 37, 157	
1	Total PPS Reimbursement - EUPA Episodes				1, 692	
	Total PPS Outlier Reimbursement - Full Episodes with Outliers			C	55, 251	15
	Total PPS Outlier Reimbursement - PEP Episodes			C	0	
	Fotal Other Payments DME Payments				0	17
	Dxygen Payments					19
	Prosthetic and Orthotic Payments			C	0	20
1	Part B deductibles billed to Medicare patients (exclude coins Subtotal (sum of lines 10 thru 20 minus line 21)	urance)		C	0 2, 193, 866	
- 1	Excess reasonable cost (from line 8)					23
- 1	Subtotal (line 22 minus line 23)			C	2, 193, 866	
1	Coinsurance billed to program patients (from your records)				0	25
	Net cost (line 24 minus line 25) Allowable bad debts (from your records)			C	2, 193, 866 0	26
	Adjusted reimbursable bad debts (see instructions)					
.00	Allowable bad debts for dual eligible (see instructions)				0	28
- 1	Total costs - current cost reporting period (see instructions))		C		
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions	5)		C	0	1
	Demonstration payment adjustment amount before sequestration	-,		C		
	Subtotal (see instructions)			C		
	Sequestration adjustment (see instructions)			C	43, 878 0	1
	Demonstration payment adjustment amount after sequestration Sequestration adjustment for non-claims based amounts (see ins	structions)				
	Interim payments (see instructions)			C		
	Tentative settlement (for contractor use only)			C	-	
	Balance due provider/program (line 31 minus lines 31.01, 31.02			C	-	
. 00	Protested amounts (nonallowable cost report items) in accordan	ICG MITH CM2	rub. 15-2,		ı U	35

Health Financial Systems FRANCISCAN HEAL ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAS FOR SERVICES RENDERED In Lieu of Form CMS-2552-10 FRANCISCAN HEALTH LAFAYETTE

Provider CCN: 15-0109 TO PROGRAM BENEFICIARIES HHA CCN: 15-7124

				Home Health Agency I	PPS	
		I npati en	t Part A		t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2.00	3. 00	4. 00	
1. 00 2. 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero			0	2, 149, 990 0	1. 00 2. 00
3. 00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3. 00
3.01				0	0	3. 01
3. 02				0	0	3. 02
3. 03				0	0	3. 03
3.04				0	0	3. 04
3. 05	Provider to Program			0	0	3. 05
3. 50	Frovider to Frogram			ol	0	3. 50
3. 51				o	Ö	3. 51
3. 52				Ö	0	3. 52
3.53				0	0	3. 53
3.54				0	0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	3. 99
4 00	3. 50-3. 98)				0.440.000	4 00
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)			0	2, 149, 990	4. 00
	TO BE COMPLETED BY CONTRACTOR	·				
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)					5. 00
F 01	Program to Provider			ol	0	5. 01
5. 01 5. 02				0		5. 01
5. 03				Ö	l ől	5. 03
	Provider to Program			-1	_	
5.50				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 5.50-5.98)			0	0	5. 99
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER			0	0	6. 01
6. 02	SETTLEMENT TO PROGRAM			0	2	6. 02
7. 00	Total Medicare program liability (see instructions)			Contractor	2, 149, 988	7. 00
				Contractor Number	NPR Date (Mo/Day/Yr)	
	Tu. Talanta	()	1. 00	2. 00	
8. 00	Name of Contractor	I			ı l	8. 00

					Hospi ce I		
		SALARI ES	OTHER	SUBTOTAL (col.	RECLASSIFI -	SUBTOTAL	
		1.00	2. 00	1 plus col. 2) 3.00	CATI ONS 4. 00	5. 00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
1.00	CAP REL COSTS-BLDG & FLXT*		112, 080	112, 080	-112, 080	0	1.00
2. 00	CAP REL COSTS-BUDG & TTXT					0	2.00
		0	426, 009 0	420,009	-426, 009		1
3.00	EMPLOYEE BENEFITS DEPARTMENT*	1 "1	•	2 205 704	0	0	3.00
4.00	ADMI NI STRATI VE & GENERAL*	268, 621	2, 027, 173	2, 295, 794	0	2, 295, 794	4.00
5.00	PLANT OPERATION & MAINTENANCE*		0	0	0	0	5. 00
6.00	LAUNDRY & LINEN SERVICE*		0	0	0	0	6. 00
7.00	HOUSEKEEPI NG*	0	0	0	0	0	7. 00
8.00	DI ETARY*	5 (2) (5)	0	5,00,0	0	0	8. 00
9. 00	NURSING ADMINISTRATION*	562, 865	0	,	0	562, 865	9. 00
10. 00	ROUTINE MEDICAL SUPPLIES*	0	10, 796		0	10, 796	10. 00
11. 00	MEDI CAL RECORDS*	41, 648	0		0	41, 648	11. 00
12. 00	STAFF TRANSPORTATION*	0	0		0	0	12. 00
13.00	VOLUNTEER SERVICE COORDINATION*	77, 292	0	77, 292	0	77, 292	13. 00
14.00	PHARMACY*	0	0	0	0	0	14. 00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	308, 850	308, 850	0	308, 850	15. 00
16.00	OTHER GENERAL SERVICE*	0	0	0	0	0	16. 00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES						17. 00
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	I NPATI ENT CARE-CONTRACTED**		0	0	0	0	25. 00
26.00	PHYSI CI AN SERVI CES**	3, 150	0	3, 150	0	3, 150	26. 00
27.00	NURSE PRACTITIONER**	120, 619	0		0	120, 619	27. 00
28.00	REGI STERED NURSE**	1, 988, 500	0	1, 988, 500	0	1, 988, 500	28. 00
29.00	LPN/LVN**	o	0	0	O	0	29. 00
30.00	PHYSI CAL THERAPY**	0	0	0	O	0	30.00
31.00	OCCUPATI ONAL THERAPY**	0	0	0	O	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0	0	0	0	32. 00
33.00	MEDICAL SOCIAL SERVICES**	299, 681	0	299, 681	o	299, 681	33. 00
34.00	SPIRITUAL COUNSELING**	290, 133	0	290, 133	o	290, 133	34.00
35.00	DI ETARY COUNSELI NG**	0	0	0	ol	0	35. 00
36.00	COUNSELING - OTHER**	0	0	0	o	0	36.00
37. 00	HOSPICE AIDE & HOMEMAKER SERVICES**	320, 439	0	320, 439	o	320, 439	37. 00
38. 00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0	0	o	0	38. 00
39. 00	PATIENT TRANSPORTATION**	0	251, 277	251, 277	0	251, 277	39. 00
40. 00	I MAGI NG SERVI CES**	0	0	0	0	0	40.00
41. 00	LABS & DI AGNOSTI CS**		0	_	o	0	41.00
42. 00	MEDI CAL SUPPLI ES-NON-ROUTI NE**		104, 930		-104, 930	0	42.00
42. 50	DRUGS CHARGED TO PATIENTS**		400, 057	400, 057	-400, 058	-1	42. 50
43. 00	OUTPATIENT SERVICES**		400, 037	400, 037	400, 030	0	43. 00
44. 00	PALLIATIVE RADIATION THERAPY**		0	0	0	0	44. 00
45. 00	PALLIATIVE CHEMOTHERAPY**		0	_	0	0	45. 00
46. 00	OTHER PATIENT CARE SERVICES (SPECIFY)**		0		0	0	46. 00
40.00	NONREI MBURSABLE COST CENTERS	U U		l o	<u> </u>		40.00
60. 00	BEREAVEMENT PROGRAM *	0	0	0	0	0	60.00
		1			0		1
61.00	VOLUNTEER PROGRAM *	0	0			0	61.00
62.00	FUNDRAL SI NG*	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0	0	0	0	65.00
66. 00	RESI DENTI AL CARE*	0	0	0	0	0	66. 00
67. 00	ADVERTI SI NG*	0	0	0	0	0	67. 00
68. 00	TELEHEALTH/TELEMONI TORI NG*	0	0	0	0	0	68. 00
69. 00	THRI FT STORE*	0	0	0	0	0	69. 00
70. 00	NURSING FACILITY ROOM & BOARD*	0	0	0	0	0	70. 00
71. 00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	0	0	0	71. 00
	TOTAL	3, 972, 948	3, 641, 172	7, 614, 120	-1, 043, 077	6, 571, 043	100. 00
+ T	efor the amounts in column 7 to Wket O.E. or						

^{*} Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate.
** See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

					3/28/2024 12: 04	_pm_
		AD ILICTMENTS	TOTAL (I E	Hospi ce I		
		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)			
		6. 00	7.00			
	GENERAL SERVICE COST CENTERS	0.00	7.00			
1.00	CAP REL COSTS-BLDG & FIXT*	0	0			1.00
2.00	CAP REL COSTS-MVBLE EQUIP*	0	0			2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0		;	3.00
4.00	ADMINISTRATIVE & GENERAL*	-411, 240	1, 884, 554			4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	0			5. 00
6.00	LAUNDRY & LINEN SERVICE*	0	0			6.00
7. 00	HOUSEKEEPI NG*	0	0		l	7. 00
8. 00	DI ETARY*	0	0			8. 00
9.00	NURSING ADMINISTRATION*	0	562, 865			9. 00
10.00	ROUTINE MEDICAL SUPPLIES*	0			l l	10. 00
11.00	MEDICAL RECORDS*	0				11.00
12.00	STAFF TRANSPORTATION*	0			l	12.00
13. 00 14. 00	VOLUNTEER SERVICE COORDINATION* PHARMACY*		77, 292			13. 00 14. 00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES*		308, 850			14. 00 15. 00
16. 00	OTHER GENERAL SERVICE*		l I			16. 00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES				l	17. 00
17.00	DIRECT PATIENT CARE SERVICE COST CENTERS				•	17.00
25. 00	I NPATI ENT CARE-CONTRACTED**	0	0		2!	25. 00
26. 00	PHYSI CI AN SERVI CES**	0	1			26. 00
27. 00	NURSE PRACTITIONER**	0	l		I	27. 00
28.00	REGI STERED NURSE**	0	l I			28. 00
29. 00	LPN/LVN**	0	o		2'	29. 00
30.00	PHYSI CAL THERAPY**	0	0		30	30. 00
31. 00	OCCUPATIONAL THERAPY**	0	0		3	31. 00
32. 00	SPEECH/LANGUAGE PATHOLOGY**	0	0		l l	32. 00
33. 00	MEDICAL SOCIAL SERVICES**	0				33. 00
34. 00	SPI RI TUAL COUNSELI NG**	0			l l	34. 00
35. 00	DI ETARY COUNSELI NG**	0	0		l l	35. 00
36.00	COUNSELING - OTHER**	0	220 420			36. 00
37. 00	HOSPICE AIDE & HOMEMAKER SERVICES**	0				37. 00
38. 00 39. 00	DURABLE MEDICAL EQUIPMENT/OXYGEN** PATIENT TRANSPORTATION**	0			l l	38. 00 39. 00
40. 00	IMAGING SERVICES**					40. 00
41. 00	LABS & DI AGNOSTI CS**					41. 00
42. 00	MEDICAL SUPPLIES-NON-ROUTINE**					42. 00
42. 50	DRUGS CHARGED TO PATIENTS**	0				42. 50
43.00	OUTPATIENT SERVICES**	0	o		l	43. 00
44.00	PALLIATIVE RADIATION THERAPY**	0	O		4.	44. 00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0		4!	45. 00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0		4	46. 00
	NONREI MBURSABLE COST CENTERS					
60.00	BEREAVEMENT PROGRAM *	0	1			60. 00
61. 00	VOLUNTEER PROGRAM *	0				61. 00
62. 00	FUNDRAI SI NG*	0	1		I	62. 00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	1			63. 00
64.00	PALLIATIVE CARE PROGRAM*	0	1			64.00
65. 00	OTHER PHYSICIAN SERVICES*	0			•	65. 00
66.00	RESIDENTIAL CARE*	0	0			66. 00 67. 00
67. 00 68. 00	ADVERTI SI NG* TELEHEALTH/TELEMONI TORI NG*				•	57. 00 68. 00
69.00	THRIFT STORE*				•	58. 00 59. 00
70. 00	NURSING FACILITY ROOM & BOARD*				•	70. 00
71. 00	OTHER NONREIMBURSABLE (SPECIFY)*					71. 00
	TOTAL	-411, 240				00.00
	1 · · · · · · · · · · · · · · · · · · ·	1, 2 10	2, 107, 000		110	

^{*} Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate.
** See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

Hospi ce CCN: 15-1563 Peri od: From 01/01/2023 To 12/31/2023

89

Date/Time Prepared: 3/28/2024 12:04 pm

89 100. 00

					3/28/2024 12:	04 piii
				Hospi ce I		
	SALARI ES	OTHER	SUBTOTAL (col.	RECLASSIFI -	SUBTOTAL	
			1 + col . 2)	CATI ONS		
	1. 00	2.00	3. 00	4. 00	5. 00	
DIRECT PATIENT CARE SERVICE COST CENTERS						
25. 00 I NPATI ENT CARE-CONTRACTED						25. 00
26. 00 PHYSI CI AN SERVI CES	0	0	0	0	0	26. 00
27. 00 NURSE PRACTITIONER	3	0	3	0	3	27. 00
28. 00 REGI STERED NURSE	47	0	47	0	47	28. 00
29. 00 LPN/LVN	0	0	0	0	0	29. 00
30. 00 PHYSI CAL THERAPY	0	0	0	0	0	30.00
31. 00 OCCUPATI ONAL THERAPY	0	0	0	0	0	31.00
32. 00 SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32. 00
33.00 MEDICAL SOCIAL SERVICES	7	0	7	0	7	33. 00
34. 00 SPIRITUAL COUNSELING	7	0	7	0	7	34.00
35. 00 DI ETARY COUNSELING	0	0	0	0	0	35. 00
36. 00 COUNSELING - OTHER	0	0	0	0	0	36. 00
37.00 HOSPICE AIDE & HOMEMAKER SERVICES	8	0	8	0	8	37. 00
38.00 DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38. 00
39. 00 PATIENT TRANSPORTATION	0	6	6	0	6	39. 00
40.00 I MAGING SERVICES	0	0	0	0	0	40.00
41.00 LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42. 00 MEDICAL SUPPLIES-NON-ROUTINE	0	2	2	0	2	42.00
42. 50 DRUGS CHARGED TO PATIENTS	0	9	9	0	9	42. 50
43. 00 OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00 PALLIATIVE RADIATION THERAPY	0	0	0	o	0	44. 00
45. 00 PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45. 00
46.00 OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46. 00
100 00 70741 *	1 70	17	0.0	ا	00	100 00

^{*} Transfer the amount in column 7 to Wkst. 0-5, column 1, line 50.

		AD ILICTATIVE	TOTAL (L E	
		ADJUSTMENTS	TOTAL (col. 5	
		6. 00	± col. 6)	
	DIRECT PATIENT CARE SERVICE COST CENTERS	6.00	7.00	
25. 00		T		1 25 00
	I NPATI ENT CARE-CONTRACTED			25. 00
26. 00	PHYSI CI AN SERVI CES	0	0	26. 00
27. 00	NURSE PRACTITIONER	0	3	27. 00
28. 00	REGI STERED NURSE	0	47	28. 00
29. 00	LPN/LVN	0	0	29. 00
30. 00	PHYSI CAL THERAPY	0	0	30.00
31. 00	OCCUPATI ONAL THERAPY	0	0	31. 00
32. 00	SPEECH/LANGUAGE PATHOLOGY	0	0	32. 00
33. 00	MEDICAL SOCIAL SERVICES	0	7	33. 00
34.00	SPI RI TUAL COUNSELI NG	0	7	34. 00
35.00	DI ETARY COUNSELI NG	0	0	35. 00
36.00	COUNSELING - OTHER	0	0	36. 00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	8	37. 00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38. 00
39.00	PATI ENT TRANSPORTATION	0	6	39. 00
40.00	I MAGING SERVICES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	2	42.00
42. 50	DRUGS CHARGED TO PATIENTS	0	9	42. 50
43.00	OUTPATIENT SERVICES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45. 00	PALLIATIVE CHEMOTHERAPY	0	0	45. 00
46. 00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46. 00
	TOTAL *	0	89	100.00

^{*} Transfer the amount in column 7 to Wkst. 0-5, column 1, line 50.

100.00 TOTAL *

ANALYSIS OF HOSPITAL-BASED HOSPICE COSIS FOR HOSPICE ROUTINE HOME CARE

Hospi ce CCN: 15-1563

Peri od: Worksheet 0-2
From 01/01/2023
To 12/31/2023 Date/Ti me Prepared: 3/28/2024 12: 04 pm

					Hospi ce I		
		SALARI ES	OTHER	SUBTOTAL (col.	RECLASSIFI -	SUBTOTAL	
				1 + col. 2)	CATI ONS		
		1.00	2. 00	3. 00	4. 00	5. 00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	I NPATIENT CARE-CONTRACTED						25. 00
26.00	PHYSI CI AN SERVI CES	3, 139	0	3, 139	0	3, 139	26. 00
27.00	NURSE PRACTITIONER	120, 205	0	120, 205	0	120, 205	27. 00
28.00	REGI STERED NURSE	1, 981, 678	0	1, 981, 678	0	1, 981, 678	28. 00
29. 00	LPN/LVN	0	0	C	0	0	29. 00
30.00	PHYSI CAL THERAPY	0	0	C	0	0	30. 00
31.00	OCCUPATI ONAL THERAPY	0	0	C	0	0	31. 00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	C	0	0	32. 00
33.00	MEDICAL SOCIAL SERVICES	298, 652	0	298, 652	. 0	298, 652	33. 00
34.00	SPIRITUAL COUNSELING	289, 137	0	289, 137	0	289, 137	34.00
35.00	DI ETARY COUNSELI NG	0	0	C	0	0	35. 00
36.00	COUNSELING - OTHER	0	0	C	0	0	36. 00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	319, 339	0	319, 339	0	319, 339	37. 00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	C	0	0	38. 00
39.00	PATIENT TRANSPORTATION	0	250, 415	250, 415	0	250, 415	39. 00
40.00	I MAGI NG SERVI CES	0	0	C	0	0	40. 00
41.00	LABS & DIAGNOSTICS	o	0	d	0	0	41. 00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	o	104, 571	104, 571	-104, 655	-84	42. 00
42.50	DRUGS CHARGED TO PATIENTS	o	398, 685	398, 685	-399, 007	-322	42. 50
43.00	OUTPATIENT SERVICES	o	0	C	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	o	0	d	0	0	44. 00
45.00	PALLI ATI VE CHEMOTHERAPY	o	0	d	0	0	45. 00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	l c	0	0	46. 00
100.00	TOTAL *	3, 012, 150	753, 671	3, 765, 821	-503, 662	3, 262, 159	100.00
	sfor the amount in column 7 to Wkst 0-5 col			•	•		

^{*} Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.

		ADJUSTMENTS	TOTAL (col. 5	
		7.D3 03 TMENTO	± col. 6)	
		6. 00	7. 00	
	DIRECT PATIENT CARE SERVICE COST CENTERS			
25.00	I NPATI ENT CARE-CONTRACTED			25.00
26.00	PHYSI CI AN SERVI CES	0	3, 139	26.00
27.00	NURSE PRACTITIONER	0	120, 205	27. 00
28. 00	REGI STERED NURSE	0	1, 981, 678	28. 00
29. 00	LPN/LVN	0	0	29. 00
30.00	PHYSI CAL THERAPY	0	0	30.00
31. 00	OCCUPATI ONAL THERAPY	0	0	31. 00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32. 00
33.00	MEDICAL SOCIAL SERVICES	0	298, 652	33.00
34.00	SPI RI TUAL COUNSELI NG	0	289, 137	34.00
35. 00	DI ETARY COUNSELING	0	0	35. 00
36.00	COUNSELING - OTHER	0	0	36. 00
37. 00	HOSPICE AIDE & HOMEMAKER SERVICES	0	319, 339	37. 00
38. 00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38. 00
39. 00	PATI ENT TRANSPORTATION	0	250, 415	39. 00
40.00	I MAGI NG SERVI CES	0	0	40.00
41. 00	LABS & DIAGNOSTICS	0	0	41. 00
42. 00	MEDI CAL SUPPLI ES-NON-ROUTI NE	0	-84	42. 00
42. 50	DRUGS CHARGED TO PATIENTS	0	-322	42. 50
43.00	OUTPATIENT SERVICES	0	0	43. 00
44. 00	PALLIATIVE RADIATION THERAPY	0	0	44. 00
45. 00	PALLI ATI VE CHEMOTHERAPY	0	0	45. 00
	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46. 00
100.00	TOTAL *	0	3, 262, 159	100. 00

^{*} Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE INPATIENT RESPITE CARE

Hospi ce CCN: 15-1563

Peri od: Worksheet 0-3 From 01/01/2023 To 12/31/2023 Date/Ti me Prepared:

3/28/2024 12:04 pm Hospi ce I SUBTOTAL (col SALARI ES OTHER RECLASSI FI -SUBTOTAL 1 + col. CATI ONS 2) 1.00 2.00 5. 00 3 00 4.00 DIRECT PATIENT CARE SERVICE COST CENTERS 25.00 INPATIENT CARE-CONTRACTED 0 25.00 0 PHYSICIAN SERVICES 26.00 0 6 26, 00 NURSE PRACTITIONER 27.00 238 0 238 238 27.00 o 28.00 REGISTERED NURSE 3,925 0 3, 925 3, 925 28.00 29.00 LPN/LVN 0 29.00 30.00 PHYSI CAL THERAPY 0 0 0 0 0 0 0 0 0 30.00 OCCUPATIONAL THERAPY 0 0 31.00 0 0 31.00 32.00 SPEECH/LANGUAGE PATHOLOGY 0 32.00 33.00 MEDICAL SOCIAL SERVICES 592 592 592 33.00 34.00 573 573 SPIRITUAL COUNSELING 0 34.00 573 35.00 DIETARY COUNSELING 0 0 35.00 36.00 COUNSELING - OTHER 0 0 0 0 0 36.00 HOSPICE AIDE & HOMEMAKER SERVICES 37.00 0 633 37.00 633 633 DURABLE MEDICAL EQUIPMENT/OXYGEN 38.00 38.00 0 C C 0 39.00 PATIENT TRANSPORTATION 0 496 496 0 496 39.00 40.00 I MAGING SERVICES 0 0 40.00 0 0 0 0 0 0 41.00 LABS & DIAGNOSTICS C 0 0 41.00 MEDICAL SUPPLIES-NON-ROUTINE 42.00 207 207 -173 34 42.00 42.50 DRUGS CHARGED TO PATIENTS 790 790 129 42.50 -661 OUTPATIENT SERVICES 43.00 C 0 0 0 43.00 PALLIATIVE RADIATION THERAPY 44.00 C 0 0 0 44.00 45.00 PALLIATIVE CHEMOTHERAPY C 0 0 0 45.00 46.00 OTHER PATIENT CARE SERVICES (SPECIFY) 0 0 46.00 100.00 TOTAL * -834 6, 626 100. 00 5.967 1, 493 7.460

^{*} Transfer the amount in column 7 to Wkst. 0-5, column 1, line 52.

		ADJUSTMENTS	TOTAL (col. 5	
			± col. 6)	
		6. 00	7. 00	
	DIRECT PATIENT CARE SERVICE COST CENTERS			
25. 00	I NPATIENT CARE-CONTRACTED	0	0	25. 00
26. 00	PHYSI CI AN SERVI CES	0	6	26. 00
27.00	NURSE PRACTITIONER	0	238	27. 00
28. 00	REGI STERED NURSE	0	3, 925	28. 00
29. 00	LPN/LVN	0	0	29. 00
30.00	PHYSI CAL THERAPY	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	o	32. 00
33.00	MEDICAL SOCIAL SERVICES	0	592	33.00
34.00	SPIRITUAL COUNSELING	0	573	34.00
35.00	DI ETARY COUNSELI NG	0	o	35. 00
36.00	COUNSELING - OTHER	0	o	36. 00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	633	37. 00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	o	38. 00
39.00	PATIENT TRANSPORTATION	0	496	39. 00
40.00	I MAGING SERVICES	0	o	40.00
41.00	LABS & DIAGNOSTICS	0	o	41.00
42.00	MEDI CAL SUPPLI ES-NON-ROUTI NE	0	34	42.00
42. 50	DRUGS CHARGED TO PATIENTS	0	129	42. 50
43.00	OUTPATIENT SERVICES	0	o	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	o	44. 00
45. 00	PALLI ATI VE CHEMOTHERAPY		o	45. 00
46. 00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	o	46. 00
100.00	TOTAL *	0	6, 626	100. 00

^{*} Transfer the amount in column 7 to Wkst. 0-5, column 1, line 52.

INPATIENT CARE

Hospi ce CCN: 15-1563

From 01/01/2023 To 12/31/2023 Date/Time Prepared: 3/28/2024 12:04 pm

				Hospi ce I		
	SALARI ES	OTHER	SUBTOTAL (col.	RECLASSIFI -	SUBTOTAL	
			1 + col . 2)	CATI ONS		
	1.00	2.00	3.00	4. 00	5. 00	
DIRECT PATIENT CARE SERVICE COST CENTERS						
25. 00 I NPATI ENT CARE-CONTRACTED		0	0	0	0	25. 00
26. 00 PHYSI CI AN SERVI CES	5	0	5	0	5	26. 00
27. 00 NURSE PRACTITIONER	173	0	173	0	173	27. 00
28. 00 REGI STERED NURSE	2, 850	0	2, 850	0	2, 850	28. 00
29. 00 LPN/LVN	0	0	0	0	0	29. 00
30. 00 PHYSI CAL THERAPY	0	0	0	0	0	30. 00
31. 00 OCCUPATI ONAL THERAPY	0	0	0	0	0	31.00
32.00 SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32. 00
33.00 MEDICAL SOCIAL SERVICES	430	0	430	0	430	33. 00
34.00 SPIRITUAL COUNSELING	416	0	416	0	416	34. 00
35. 00 DIETARY COUNSELING	0	0	0	0	0	35. 00
36. 00 COUNSELING - OTHER	0	0	0	0	0	36. 00
37.00 HOSPICE AIDE & HOMEMAKER SERVICES	459	0	459	0	459	37. 00
38.00 DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38. 00
39.00 PATIENT TRANSPORTATION	0	360	360	0	360	39. 00
40.00 I MAGI NG SERVI CES	0	0	0	0	0	40. 00
41.00 LABS & DIAGNOSTICS	0	0	0	0	0	41. 00
42.00 MEDICAL SUPPLIES-NON-ROUTINE	0	150	150	-102	48	42. 00
42.50 DRUGS CHARGED TO PATIENTS	0	573	573	-390	183	42. 50
43. 00 OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00 PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00 PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45. 00
46.00 OTHER PATIENT CARE SERVICES (SPECIFY)	0	o	0	o	0	46. 00
100. 00 TOTAL *	4, 333	1, 083	5, 416	-492	4, 924	100.00
* Transfer the amount in column 7 to Wkst 0-5 co	lumn 1 line 53					

^{*} Transfer the amount in column 7 to Wkst. 0-5, column 1, line 53.

		ADJUSTMENTS	TOTAL (col. 5		
			± col. 6)		
		6. 00	7.00		
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	I NPATI ENT CARE-CONTRACTED	0	0		25.00
26.00	PHYSI CI AN SERVI CES	0	5		26. 00
27.00	NURSE PRACTITIONER	0	173		27. 00
28.00	REGI STERED NURSE	0	2, 850		28. 00
29. 00	LPN/LVN	0	0		29. 00
30.00	PHYSI CAL THERAPY	0	0		30.00
31.00	OCCUPATI ONAL THERAPY	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES	0	430		33.00
34.00	SPIRITUAL COUNSELING	0	416		34.00
35.00	DI ETARY COUNSELING	0	0		35.00
36.00	COUNSELING - OTHER	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	459		37.00
38. 00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		38. 00
39. 00	PATI ENT TRANSPORTATION	0	360		39. 00
40.00	I MAGING SERVICES	0	0		40.00
41.00	LABS & DIAGNOSTICS	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	48		42.00
42. 50	DRUGS CHARGED TO PATIENTS	0	183		42. 50
43.00	OUTPATI ENT SERVI CES	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0		44.00
45.00	PALLI ATI VE CHEMOTHERAPY	0	0		45.00
	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0		46.00
100.00	TOTAL *	0	4, 924	11	00.00

^{*} Transfer the amount in column 7 to Wkst. 0-5, column 1, line 53.

		CAN HEALTH LAFAYETTE			eu of Form CMS-2	
	LLOCATION - DETERMINATION OF HOSPITAL-BASED HOSPICE	NET Provider C		Peri od:	Worksheet 0-5	
EXPENS	ES FOR ALLOCATION	Hospi ce CC		From 01/01/2023 To 12/31/2023		
				Hospi ce I		
	Descriptions		HOSPICE DIREC		TOTAL EXPENSES	
			EXPENSES (see		(sum of cols.	
			instructions)		1 + 2)	
				WKST B PART I		
				(see		
			4.00	instructions)	0.00	
	CENEDAL CEDALCE COCT CENTEDO		1.00	2. 00	3. 00	
1 00	GENERAL SERVICE COST CENTERS CAP REL COSTS-BLDG & FIXT		T		0	1 00
1.00				0	1	
2.00	CAP REL COSTS-MVBLE EQUIP			0 155 107	155 107	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT		1 004 55	0 155, 187		3. 00
4.00	ADMINISTRATIVE & GENERAL		1, 884, 55			4. 00
5.00	PLANT OPERATION & MAINTENANCE			0 0	0	
6.00	LAUNDRY & LINEN SERVICE		1	ٽ -	0	6. 00
7.00	HOUSEKEEPI NG			0	0	
8.00	DI ETARY			0 0	0	8. 00
9.00	NURSI NG ADMI NI STRATI ON		562, 86	· ·		9.00
10.00	ROUTINE MEDICAL SUPPLIES		10, 79			
11.00	MEDICAL RECORDS		41, 64	·		1
12.00	STAFF TRANSPORTATION		1	0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION		77, 29		77, 292	
14.00	PHARMACY			0	1	14. 00
15. 00	PHYSI CI AN ADMI NI STRATI VE SERVI CES OTHER GENERAL SERVI CE		308, 85		308, 850	
16.00				0	0	16. 00 17. 00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES LEVEL OF CARE				0	17.00
50. 00	HOSPICE CONTINUOUS HOME CARE			0	89	50.00
51. 00	HOSPICE CONTINUOUS HOME CARE		3, 262, 15	-	3, 262, 159	
52. 00	HOSPICE INPATIENT RESPITE CARE		6, 62		6, 626	1
53. 00	HOSPICE GENERAL INPATIENT CARE		4, 92		4, 924	
55.00	NONREI MBURSABLE COST CENTERS		4, 72	4	4, 724	33.00
60. 00	BEREAVEMENT PROGRAM		T	ol	0	60.00
61. 00	VOLUNTEER PROGRAM		1	0	0	61.00
62. 00	FUNDRAI SI NG			0	0	62.00
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS		1	0	0	63.00
64. 00	PALLIATIVE CARE PROGRAM			0	0	64.00
65. 00	OTHER PHYSICIAN SERVICES			0	0	65.00
44.00	DECLIDENTIAL CADE					

67.00

69. 00 0

70. 00 0

71.00 0

99. 00

0 66.00

0 68. 00

9, 815, 838 100. 00

3, 656, 035

6, 159, 803

66.00 RESIDENTIAL CARE

68. 00 | TELEHEALTH/TELEMONI TORI NG

99.00 NEGATIVE COST CENTER

69. 00 THRIFT STORE
70. 00 NURSING FACILITY ROOM & BOARD

71.00 OTHER NONREIMBURSABLE (SPECIFY)

67. 00 ADVERTISING

100. 00 TOTAL

Health Financial Systems	FRANCISCAN HEALTH	LAFAYETTE	In Lie	u of Form CMS-2552-10
COST ALLOCATION - HOSPITAL-BASED	HOSPICE GENERAL SERVICE COSTS	Provider CCN: 15-0109	Peri od:	Worksheet 0-6

From 01/01/2023 Part I
To 12/31/2023 Date/Time Prepared: Hospi ce CCN: 15-1563 3/28/2024 12:04 pm Hospi ce I TOTAL EXPENSES CAP REL BLDG & CAP REL MVBLE EMPLOYEE SUBTOTAL Descriptions FIX EQUI P **BENEFITS** DEPARTMENT 1.00 2.00 0 ЗА 3.00 GENERAL SERVICE COST CENTERS CAP REL COSTS-BLDG & FLXT 1.00 1.00 2.00 CAP REL COSTS-MVBLE EQUIP 0 2.00 0 3.00 EMPLOYEE BENEFITS DEPARTMENT 155, 187 155, 187 3.00 4.00 ADMINISTRATIVE & GENERAL 5,006,059 5, 006, 059 4.00 0 0 5.00 PLANT OPERATION & MAINTENANCE 0 5.00 0 0 LAUNDRY & LINEN SERVICE 0 0 6.00 0 0 6.00 7.00 HOUSEKEEPI NG 0 0 0 7.00 8.00 DI ETARY 0 0 0 0 0 0 0 Ω 8.00 NURSING ADMINISTRATION 888, 081 0 888, 081 9.00 9.00 ROUTINE MEDICAL SUPPLIES 10.00 13.231 13, 231 10.00 0 11.00 MEDICAL RECORDS 93, 340 93, 340 11.00 12.00 STAFF TRANSPORTATION 12.00 VOLUNTEER SERVICE COORDINATION 13.00 0 0 13.00 77, 292 77, 292 14.00 PHARMACY 0 Ω 14.00 15.00 PHYSICIAN ADMINISTRATIVE SERVICES 308, 850 0 308, 850 15.00 OTHER GENERAL SERVICE 0 16.00 0 16.00 0 PATIENT/RESIDENTIAL CARE SERVICES 0 17.00 0 17.00 LEVEL OF CARE HOSPICE CONTINUOUS HOME CARE 50.00 89 89 50.00 HOSPICE ROUTINE HOME CARE 51.00 3, 262, 159 0 3, 262, 159 51.00 HOSPICE INPATIENT RESPITE CARE 52.00 6,626 C 0 6, 626 52.00 53.00 HOSPICE GENERAL INPATIENT CARE 4,924 0 0 155, 187 160, 111 53.00 NONREI MBURSABLE COST CENTERS BEREAVEMENT PROGRAM 60.00 n 0 0 n 60.00 0 0 0 VOLUNTEER PROGRAM 00000000000 0 61.00 0 61.00 62.00 FUNDRAI SI NG 0 0 62.00 HOSPICE/PALLIATIVE MEDICINE FELLOWS 0 0 63.00 0 0 63.00 PALLIATIVE CARE PROGRAM 0 0 64.00 0 64.00 65.00 OTHER PHYSICIAN SERVICES 0 0 65.00 RESIDENTIAL CARE 0 0 66.00 0 0 66.00

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9, 815, 838

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155, 187

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0 68.00

0 69.00

0 70.00

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9, 815, 838 100. 00

67.00

71.00

99.00

67 00

68.00

69.00

70.00

71 00

100.00 TOTAL

ADVERTI SI NG

THRIFT STORE

99.00 NEGATIVE COST CENTER

TELEHEALTH/TELEMONI TORI NG

NURSING FACILITY ROOM & BOARD

OTHER NONREIMBURSABLE (SPECIFY)

			·			3/28/2024 12:	04 pm
					Hospi ce I		
	Descriptions	ADMI NI STRATI VE	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		& GENERAL	OPERATION &	LINEN SERVICE			
			MAI NTENANCE				
		4. 00	5. 00	6. 00	7. 00	8. 00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1. 00
2.00	CAP REL COSTS-MVBLE EQUIP						2. 00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3. 00
4.00	ADMINISTRATIVE & GENERAL	5, 006, 059					4. 00
5.00	PLANT OPERATION & MAINTENANCE	0	0				5. 00
6.00	LAUNDRY & LINEN SERVICE	0	0) (6. 00
7.00	HOUSEKEEPING	0	0		0		7. 00
8.00	DI ETARY	0	0		0	C	8.00
9.00	NURSING ADMINISTRATION	924, 323	O		0		9. 00
10.00	ROUTINE MEDICAL SUPPLIES	13, 771	O		0		10.00
11.00	MEDI CAL RECORDS	97, 149	0		0		11. 00
12.00	STAFF TRANSPORTATION	O	0		0		12. 00
13.00	VOLUNTEER SERVICE COORDINATION	80, 446	0		0		13.00
14.00	PHARMACY	0	0		0		14. 00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	321, 454	0		0		15. 00
16.00	OTHER GENERAL SERVICE	0	0		0		16. 00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES	o	0		0		17. 00
	LEVEL OF CARE						
50.00	HOSPI CE CONTI NUOUS HOME CARE	93					50.00
51.00	HOSPICE ROUTINE HOME CARE	3, 395, 282					51.00
52.00	HOSPICE INPATIENT RESPITE CARE	6, 896	O		0	C	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	166, 645	O		0	C	53.00
	NONREI MBURSABLE COST CENTERS			•			1
60.00	BEREAVEMENT PROGRAM	0	C)	0		60.00
61.00	VOLUNTEER PROGRAM	0	0		0		61. 00
62.00	FUNDRAI SI NG	0	0		0		62. 00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0		0		63. 00
64.00	PALLIATIVE CARE PROGRAM	0	0		0		64. 00
65.00	OTHER PHYSICIAN SERVICES	0	0		0		65. 00
66.00	RESI DENTI AL CARE	0	0) (0	C	66. 00
67.00	ADVERTI SI NG	0	0		0		67. 00
68.00	TELEHEALTH/TELEMONI TORI NG	0	0		0		68. 00
69.00	THRI FT STORE	0	0		0		69. 00
70.00	NURSING FACILITY ROOM & BOARD						70. 00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0) (0	C	71. 00
99. 00	NEGATIVE COST CENTER	0	0) (0	C	99. 00
100.00	TOTAL	5, 006, 059	0) (0	C	100. 00
		·					

Heal th Financial	Systems	FRANCISCAN HEALTH LAFAYETTE			In Lieu of Form CMS-2552-10	
COST ALLOCATION	- HOSPITAL-BASED	HOSPICE GENERAL	SERVICE COSTS	Provider CCN: 15-0109	Peri od:	Worksheet 0-6

Hear th	Financiai Systems	FRANCI SCAN HEAL	IH LAFAYETTE		in Lie	U OF FORM CMS-2	2552-10
COST A	LLOCATION - HOSPITAL-BASED HOSPICE GENERAL S	SERVICE COSTS	Provi der Co		Peri od:	Worksheet 0-6	
					From 01/01/2023	Part I	
			Hospi ce CCI	N: 15-1563	To 12/31/2023	Date/Time Pre	pared:
					Hospi ce I	3/28/2024 12:	04 pm
	Descriptions	NURSI NG	ROUTI NE	MEDI CAL	STAFF	VOLUNTEER	
	Descriptions						
		ADMI NI STRATI ON	MEDI CAL	RECORDS	TRANSPORTATI ON	SERVI CE	
		0.00	SUPPLI ES	11 00	12.00	COORDI NATI ON	
	CENEDAL CEDVICE COCT CENTEDS	9. 00	10. 00	11.00	12.00	13. 00	
1 00	GENERAL SERVICE COST CENTERS			1			1 00
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2. 00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3. 00
4.00	ADMINISTRATIVE & GENERAL						4. 00
5. 00	PLANT OPERATION & MAINTENANCE						5. 00
6. 00	LAUNDRY & LINEN SERVICE						6. 00
7.00	HOUSEKEEPI NG						7. 00
8.00	DI ETARY						8. 00
9.00	NURSING ADMINISTRATION	1, 812, 404					9. 00
10.00	ROUTINE MEDICAL SUPPLIES	o	27, 002				10.00
11. 00	MEDI CAL RECORDS	o		190, 48	9		11. 00
12.00	STAFF TRANSPORTATION	0			0		12. 00
13.00	VOLUNTEER SERVICE COORDINATION	o			0	157, 738	13. 00
14. 00	PHARMACY	0			0	0	14. 00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES	0			0	0	15. 00
16. 00	OTHER GENERAL SERVICE	0			0	0	16. 00
17. 00	PATI ENT/RESI DENTI AL CARE SERVI CES					ŭ	17. 00
	LEVEL OF CARE						1 00
50.00	HOSPICE CONTINUOUS HOME CARE	0	1		4 0	4	50.00
51. 00	HOSPICE ROUTINE HOME CARE	0	26, 909	189, 83	-1	157, 197	51.00
52. 00	HOSPICE INPATIENT RESPITE CARE	o o	53			311	52. 00
53. 00	HOSPICE GENERAL INPATIENT CARE	1, 812, 404	39			226	1
33. 00	NONREI MBURSABLE COST CENTERS	1,012,404	37		<u> </u>	220	33.00
60.00	BEREAVEMENT PROGRAM	0			0	0	60.00
61. 00	VOLUNTEER PROGRAM	o o			0	0	61. 00
62. 00	FUNDRAI SI NG				0	0	62. 00
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS				0	0	63. 00
64. 00					0	0	1
	PALLIATIVE CARE PROGRAM				0	0	64.00
65. 00	OTHER PHYSICIAN SERVICES				0	0	65. 00
66.00	RESI DENTI AL CARE				0	0	66.00
67. 00	ADVERTI SI NG	0			0	0	67. 00
68. 00	TELEHEALTH/TELEMONI TORI NG	0		1	0	0	68. 00
69. 00	THRI FT STORE	0			0	0	69. 00
	NURSING FACILITY ROOM & BOARD						70. 00
	` ,	0			0	0	
	NEGATIVE COST CENTER	0	0	1	0	0	1 , , , , , ,
100.00	IOIAL	1, 812, 404	27, 002	190, 48	9 0	157, 738	100. 00

			nospi ce coi	N. 13-1303 1	0 12/31/2023	3/28/2024 12:	
					Hospi ce I		
	Descriptions	PHARMACY	PHYSI CI AN	OTHER GENERAL	PATI ENT/	TOTAL	
			ADMI NI STRATI VE	SERVI CE	RESI DENTI AL		
			SERVI CES		CARE SERVICES		
		14. 00	15. 00	16. 00	17. 00	18. 00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FLXT						1. 00
2.00	CAP REL COSTS-MVBLE EQUIP						2. 00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3. 00
4.00	ADMINISTRATIVE & GENERAL						4. 00
5.00	PLANT OPERATION & MAINTENANCE						5. 00
6.00	LAUNDRY & LINEN SERVICE						6. 00
7.00	HOUSEKEEPING						7. 00
8.00	DI ETARY						8. 00
9.00	NURSING ADMINISTRATION						9. 00
10.00	ROUTINE MEDICAL SUPPLIES						10.00
11.00	MEDI CAL RECORDS						11.00
12.00	STAFF TRANSPORTATION						12.00
13.00	VOLUNTEER SERVICE COORDINATION						13. 00
14.00	PHARMACY	0					14. 00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	630, 304				15. 00
16.00	OTHER GENERAL SERVICE	0					16. 00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES				0		17. 00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	15	C)	206	
51.00	HOSPICE ROUTINE HOME CARE	0	628, 141	(7, 659, 524	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	1, 244		0	15, 506	52. 00
53.00	HOSPICE GENERAL INPATIENT CARE	0	904	. (0	2, 140, 602	53. 00
	NONREI MBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM	0	l			0	60.00
61. 00	VOLUNTEER PROGRAM	0				0	1
62. 00	FUNDRAI SI NG	0				0	62. 00
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0				0	63. 00
64.00	PALLIATIVE CARE PROGRAM	0		(0	64. 00
65. 00	OTHER PHYSICIAN SERVICES	0		(0	65. 00
66. 00	RESI DENTI AL CARE	0	0	(0	0	66. 00
67. 00	ADVERTI SI NG	0		(0	67. 00
68. 00	TELEHEALTH/TELEMONI TORI NG	0		(0	1
69. 00	THRI FT STORE	0		(0	69. 00
70.00	NURSING FACILITY ROOM & BOARD					0	70. 00
71. 00		0	0	(0	0	71. 00
99. 00	NEGATIVE COST CENTER	0	0) c	0	0	99. 00
100.00	TOTAL	0	630, 304	· (0	9, 815, 838	100.00

Health Financial Systems	FRANCI SCAN HEALTH	LAFAYETTE		In Lie	u of Form CMS-2552-10
COST ALLOCATION - HOSPITAL-BASED HO STATISTICAL BASIS	SPICE GENERAL SERVICE COSTS	Provider CCN:	15-0109 15-1563	Peri od: From 01/01/2023 To 12/31/2023	Worksheet 0-6 Part II Date/Time Prepared:

			nospi ce con	1. 13-1303 1	0 12/31/2023	3/28/2024 12:	
					Hospi ce I		
	Cost Center Descriptions	CAP REL BLDG & C	AP REL MVBLE	EMPLOYEE	RECONCI LI ATI ON	ADMI NI STRATI VE	
	'	FLX	EQUI P	BENEFITS		& GENERAL	
		(SQUARE FEET) (DEPARTMENT		(ACCUMULATED	
		(, , , , , , , , , , , , , , , ,	(GROSS		COSTS)	
				SALARI ES)			
		1.00	2. 00	3. 00	4A	4. 00	
	GENERAL SERVICE COST CENTERS	1					
1.00	CAP REL COSTS-BLDG & FLXT	0					1.00
2.00	CAP REL COSTS-MVBLE EQUIP		0				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	o o	100			3. 00
4. 00	ADMINISTRATIVE & GENERAL		0	0		4, 809, 779	4. 00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	-3, 000, 037	4, 607, 777	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
		0	0	0	0	0	
7.00	HOUSEKEEPI NG	0	U	0	0		7. 00
8.00	DI ETARY	0	0	0	0	0	8. 00
9.00	NURSI NG ADMI NI STRATI ON	0	0	0	0	888, 081	9.00
10. 00	ROUTINE MEDICAL SUPPLIES	0	0	0	0	13, 231	1
11. 00	MEDI CAL RECORDS	0	0	0	0	93, 340	1
12. 00	STAFF TRANSPORTATION	0	0	0	0	0	12. 00
13. 00	VOLUNTEER SERVICE COORDINATION	0	0	0	0	77, 292	13. 00
14.00	PHARMACY	0	0	0	0	0	14. 00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	308, 850	15. 00
16.00	OTHER GENERAL SERVICE	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		0	0	17. 00
	LEVEL OF CARE	<u> </u>					1
50.00	HOSPICE CONTINUOUS HOME CARE			0	0	89	50.00
51.00	HOSPICE ROUTINE HOME CARE			0	0	3, 262, 159	51.00
52. 00	HOSPICE INPATIENT RESPITE CARE	o	0	0	0	6, 626	1
53. 00	HOSPICE GENERAL INPATIENT CARE	0	0	100	0	· ·	
00.00	NONREI MBURSABLE COST CENTERS	9	<u> </u>			1007 111	00.00
60.00	BEREAVEMENT PROGRAM	0	O	0	0	0	60.00
61. 00	VOLUNTEER PROGRAM	ő	o o	0		ő	61.00
62. 00	FUNDRAI SI NG		0	0	0	0	62.00
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	63.00
64. 00	PALLIATIVE CARE PROGRAM	0	0	0	0	0	64.00
65. 00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	65.00
	l control of the cont	0	U	0	0		1
66.00	RESI DENTI AL CARE	0	0	0	0	0	66.00
67. 00	ADVERTI SI NG	0	0	0	0	0	67. 00
68. 00	TELEHEALTH/TELEMONI TORI NG	0	0	0	0	0	68. 00
69. 00	THRI FT STORE	0	0	0	0	0	69. 00
70. 00	NURSING FACILITY ROOM & BOARD				0		70.00
71. 00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	
99. 00	NEGATIVE COST CENTER						99. 00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)		0	155, 187		5, 006, 059	
101.00	UNIT COST MULTIPLIER	0. 000000	0. 000000	1, 551. 870000		1. 040809	101.00

Health Financial Systems	FRANCI SCAN HEA	LTH LAFAYETTE		In Lie	eu of Form CMS-2	2552-1
COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL	SERVICE COSTS	Provi der C	CN: 15-0109	Peri od:	Worksheet 0-6	
STATI STI CAL BASI S				From 01/01/2023		
		Hospi ce CC	N: 15-1563	To 12/31/2023		
					3/28/2024 12:	04 pm
				Hospi ce I		
Cost Center Descriptions	PLANT	LAUNDRY &	HOUSEKEEPI NO	G DI ETARY	NURSI NG	
	OPERATION &	LINEN SERVICE	(SQUARE FEET	(IN-FACILITY	ADMI NI STRATI ON	
	MAI NTENANCE	(IN-FACILITY		DAYS)		
	(SQUARE FEET)	DAYS)			(DIRECT NURS.	
					HRS.)	
	E 00	4 00	7 00	9 00	0 00	

	Cost Center Descriptions	PLANT OPERATION & MAINTENANCE (SQUARE FEET)	LAUNDRY & LINEN SERVICE (IN-FACILITY DAYS)	,	DAYS)	NURSI NG ADMI NI STRATI ON (DI RECT NURS. HRS.)	
	I	5. 00	6. 00	7. 00	8. 00	9. 00	
	GENERAL SERVICE COST CENTERS	T		T.			
1.00	CAP REL COSTS-BLDG & FLXT						1. 00
2.00	CAP REL COSTS-MVBLE EQUIP						2. 00
3. 00	EMPLOYEE BENEFITS DEPARTMENT						3. 00
4.00	ADMINISTRATIVE & GENERAL	_					4. 00
5. 00	PLANT OPERATION & MAINTENANCE	0	_				5. 00
6. 00	LAUNDRY & LINEN SERVICE	0	0				6. 00
7. 00	HOUSEKEEPING	0		0	_		7. 00
8.00	DI ETARY	0		0	0)	8. 00
9.00	NURSING ADMINISTRATION	0		0		100	9. 00
10. 00	ROUTINE MEDICAL SUPPLIES	0		0		0	10. 00
11. 00	MEDI CAL RECORDS	0		0		0	11. 00
12. 00	STAFF TRANSPORTATION	0		0		0	12. 00
13. 00	VOLUNTEER SERVICE COORDINATION	0		0		0	13. 00
14. 00	PHARMACY	0		0		0	14. 00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0		0	15. 00
16. 00	OTHER GENERAL SERVICE	0		0		0	16. 00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES	0		0			17. 00
	LEVEL OF CARE	1					
50. 00	HOSPICE CONTINUOUS HOME CARE					0	50.00
51. 00	HOSPICE ROUTINE HOME CARE					0	51. 00
52. 00	HOSPICE INPATIENT RESPITE CARE	0			0	0	52. 00
53. 00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	100	53.00
	NONREI MBURSABLE COST CENTERS	T	Г	T			
60. 00	BEREAVEMENT PROGRAM	0	ŀ	0		0	60.00
61. 00	VOLUNTEER PROGRAM	0		0		0	61.00
62. 00	FUNDRAI SI NG	0		0		0	62. 00
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63. 00
64. 00	PALLIATIVE CARE PROGRAM	0		0		0	64. 00
65. 00	OTHER PHYSI CI AN SERVI CES	0	_	0	_	0	65. 00
66. 00	RESI DENTI AL CARE	0	0	0	Ü	0	66. 00
67. 00	ADVERTI SI NG	0		0		0	67. 00
68. 00	TELEHEALTH/TELEMONI TORI NG	0		0		0	68. 00
69. 00	THRIFT STORE	0		0		0	69. 00
70.00	NURSING FACILITY ROOM & BOARD				_		70.00
71. 00	OTHER NONREIMBURSABLE (SPECIFY)	0		1 0	0	0	71. 00
99. 00	NEGATIVE COST CENTER				_	4 040	99.00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	0 000000	0 000000	0	0 000000	1, 812, 404	
101.00	UNIT COST MULTIPLIER	0. 000000	0. 000000	0.000000	0.000000	18, 124. 040000	101.00

Health Financial Systems	FRANCISCAN HEALTH	LAFAYETTE		In Lie	u of Form CMS-2552-10
COST ALLOCATION - HOSPITAL-BASED HOSPI	E GENERAL SERVICE COSTS	Provider CCN: 15		Peri od:	Worksheet 0-6
STATISTICAL BASIS		U: CON 11		From 01/01/2023	
		Hospi ce CCN: 1	5-1563	To 12/31/2023	Date/Time Prepared: 3/28/2024 12:04 pm

			Hospi ce CCI	N: 15-1563 T	o 12/31/2023	Date/Time Pre 3/28/2024 12:	
					Hospi ce I		<u> </u>
	Cost Center Descriptions	ROUTINE MEDICAL SUPPLIES (PATIENT DAYS)	MEDICAL RECORDS (PATIENT DAYS)	STAFF TRANSPORTATION (MI LEAGE)	VOLUNTEER I SERVI CE COORDI NATI ON (HOURS OF SERVI CE)	PHARMACY (CHARGES)	
		10.00	11. 00	12.00	13.00	14. 00	
	GENERAL SERVICE COST CENTERS	10.00	11.00	12.00	10.00	11100	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL PLANT OPERATION & MAINTENANCE LAUNDRY & LINEN SERVICE HOUSEKEEPING DIETARY NURSING ADMINISTRATION ROUTINE MEDICAL SUPPLIES MEDICAL RECORDS STAFF TRANSPORTATION VOLUNTEER SERVICE COORDINATION PHARMACY PHYSICIAN ADMINISTRATIVE SERVICES OTHER GENERAL SERVICE	42, 554	42, 554	000000000000000000000000000000000000000	42, 554 0 0	000000000000000000000000000000000000000	15. 00 16. 00
17. 00	PATI ENT/RESI DENTI AL CARE SERVI CES LEVEL OF CARE						17. 00
50.00	HOSPICE CONTINUOUS HOME CARE	1	1		1	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	42, 408	42, 408	1		0	
52. 00	HOSPICE INPATIENT RESPITE CARE	84	84	1		0	1
53. 00	HOSPICE GENERAL INPATIENT CARE NONREIMBURSABLE COST CENTERS	61	61	<u> </u>	61	0	53. 00
60. 00	BEREAVEMENT PROGRAM	1			ol ol	0	60.00
61. 00	VOLUNTEER PROGRAM				1	0	
62. 00	FUNDRAI SI NG			1	1	0	
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS			1		0	
64. 00	PALLIATIVE CARE PROGRAM			1		0	
65. 00	OTHER PHYSI CI AN SERVI CES			1	ol	0	
66. 00	RESI DENTI AL CARE			1		0	
67. 00	ADVERTI SI NG			1		0	
68. 00	TELEHEALTH/TELEMONI TORI NG			1		0	
69. 00	THRIFT STORE					0	
70. 00	NURSING FACILITY ROOM & BOARD				1	Č	70.00
71. 00	OTHER NONREIMBURSABLE (SPECIFY)			1		O	
99. 00	NEGATI VE COST CENTER					Č	99. 00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	27, 002	190, 489		157, 738	Ċ	100.00
	UNIT COST MULTIPLIER	0. 634535		l .			

Health Financial Systems	FRANCISCAN HEALTH	LAFAYETTE	In Lie	u of Form CMS-2552-10
COST ALLOCATION - HOSPITAL-BASED HOSPIC STATISTICAL BASIS		Provider CCN: Hospice CCN:	From 01/01/2023	Worksheet 0-6 Part II Date/Time Prepared: 3/28/2024 12:04 pm

						3/28/2024 12:	O4 pm
					Hospi ce I		
	Cost Center Descriptions	PHYSI CI AN	OTHER GENERAL	PATI ENT/			
	'	ADMI NI STRATI VE	SERVI CE	RESI DENTI AL			
		SERVI CES	(SPECI FY	CARE SERVICES			
		(PATIENT DAYS)	BASIS)	(IN-FACILITY			
		,	ĺ	DAYS)			
		15. 00	16.00	17. 00			
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FLXT						1.00
2. 00	CAP REL COSTS-MVBLE EQUIP						2. 00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3. 00
4.00	ADMI NI STRATI VE & GENERAL	4					4. 00
5.00	PLANT OPERATION & MAINTENANCE						5. 00
6.00	LAUNDRY & LINEN SERVICE	•					6. 00
7. 00	HOUSEKEEPI NG						7. 00
8. 00							1
	DI ETARY						8. 00
9.00	NURSI NG ADMINI STRATI ON						9.00
10.00	ROUTINE MEDICAL SUPPLIES						10.00
11. 00	MEDI CAL RECORDS						11. 00
12. 00	STAFF TRANSPORTATION						12. 00
13. 00	VOLUNTEER SERVICE COORDINATION						13. 00
14. 00	PHARMACY						14. 00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES	42, 554					15. 00
16. 00	OTHER GENERAL SERVICE		0)			16. 00
17.00	PATIENT/RESIDENTIAL CARE SERVICES			C)		17. 00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	1	0)			50. 00
51.00	HOSPICE ROUTINE HOME CARE	42, 408	0)			51.00
52.00	HOSPICE INPATIENT RESPITE CARE	84	0) c			52. 00
53.00	HOSPICE GENERAL INPATIENT CARE	61	0) c			53. 00
	NONREI MBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM		0)			60.00
61. 00	VOLUNTEER PROGRAM		0)			61.00
62.00	FUNDRAI SI NG		Ö				62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS		O				63.00
64.00	PALLIATIVE CARE PROGRAM		Ó				64.00
65.00	OTHER PHYSICIAN SERVICES		Ó				65. 00
66. 00	RESI DENTI AL CARE	0	Ó	ol c)		66.00
67. 00	ADVERTI SI NG	1	0				67. 00
68. 00	TELEHEALTH/TELEMONI TORI NG		Ö				68. 00
	THRI FT STORE						69.00
	NURSING FACILITY ROOM & BOARD		٦	1			70.00
	OTHER NONREIMBURSABLE (SPECIFY)	0	o o				71.00
	NEGATIVE COST CENTER			1	<u>'</u>		99.00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	630, 304	_	,			100.00
			0 000000	0 00000			1
101.00	UNIT COST MULTIPLIER	14. 811863	0. 000000	0.000000	4		101. 00

Heal th	Financial Systems	FRANCISCAN HEAL	TH LAFAYETTE		In Lie	eu of Form CMS-2	2552-10
APPORT	IONMENT OF HOSPITAL-BASED HOSPICE SHARED SERV	/ICE COSTS BY	Provi der CC		Peri od:	Worksheet 0-7	
LEVEL	OF CARE		Hospi ce CCN		From 01/01/2023 To 12/31/2023		pared: 04 pm
					Hospi ce I		
				Charges by	LOC (from Provi	der Records)	
	Cost Center Descriptions	From Wkst. C,	Cost to Charge	HCHC	HRHC	HI RC	
		Part I, Col. 9	Rati o				
		line		0.00	2.22		
	I	0	1. 00	2. 00	3. 00	4. 00	
	ANCILLARY SERVICE COST CENTERS				.T	T	
1.00	PHYSI CAL THERAPY	66. 00	0. 236858	(0	0	1. 00
2.00	OCCUPATI ONAL THERAPY	67. 00	0. 154626	(0	0	2. 00
3.00	SPEECH PATHOLOGY	68. 00	0. 165502	(0	0	3. 00
4.00	DRUGS CHARGED TO PATIENTS	73. 00	0. 183745	(0	0	4.00
4.01	DI ABETES CENTER	73. 01	6, 344. 983539	(o	0	4. 01
5.00	DURABLE MEDICAL EQUIP-RENTED	96. 00					5. 00
6.00	LABORATORY	60.00	0. 139800	(0	0	6. 00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0. 166831	(o	0	7. 00
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93. 00					8. 00

Cost Center Descriptions	From Wkst. C, Part I, Col. 9	Cost to Charge Ratio	НСНС	HRHC	HI RC	
	line					
	0	1.00	2.00	3. 00	4. 00	
ANCILLARY SERVICE COST CENTERS						
1.00 PHYSI CAL THERAPY	66. 00		0	0	0	1.00
2.00 OCCUPATIONAL THERAPY	67. 00		0	0	0	2. 00
3. 00 SPEECH PATHOLOGY	68. 00		0	0	0	3. 00
4.00 DRUGS CHARGED TO PATIENTS	73. 00		0	0	0	4. 00
4. 01 DI ABETES CENTER	73. 01		0	0	0	4. 01
5.00 DURABLE MEDICAL EQUIP-RENTED	96. 00					5. 00
6. 00 LABORATORY	60.00	0. 139800	0	0	0	6. 00
7.00 MEDICAL SUPPLIES CHARGED TO PATIENT	71. 00	0. 166831	0	0	0	7. 00
8.00 OTHER OUTPATIENT SERVICE COST CENTER	93. 00					8. 00
9. 00 RADI OLOGY - THERAPEUTI C	55. 00	0. 095890	0	0	0	9. 00
10. 00 ONCOLOGY	76. 00	0. 306353	0	0	0	10.00
10. 01 ANTI COAGULATI ON	76. 01	0. 772072	0	0	0	10. 01
10.02 INFUSION SERVICES	76. 02	0. 033213	0	0	0	10. 02
10. 98 HYPERBARI C OXYGEN THERAPY	76. 98	0. 000000	0	0	0	10. 98
11.00 Totals (sum of lines 1-11)						11. 00
	Charges by LOC (from Provider Records)		Shared Service	J		
Cost Center Descriptions	HGI P	HCHC (col. 1 x col. 2)	COL. 1 x	COL. 1 x	col. 5)	
	5. 00	6.00	7.00	8. 00	9. 00	
ANCILLARY SERVICE COST CENTERS	3.00	0.00	7.00	0.00	7.00	
1. 00 PHYSI CAL THERAPY	0	O	0	0	0	1.00
2. 00 OCCUPATI ONAL THERAPY	0	1	0	0	0	2.00
3. 00 SPEECH PATHOLOGY	0	1	0	0	0	3.00
4. 00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	4.00
4. 01 DI ABETES CENTER	0	1	0	0	0	4. 01
5. 00 DURABLE MEDICAL EQUIP-RENTED			O	O	O	5.00
6. 00 LABORATORY	0	0	0	0	0	6.00
7.00 MEDICAL SUPPLIES CHARGED TO PATIENT		1	0	0	0	7.00
8.00 OTHER OUTPATIENT SERVICE COST CENTER	0	U	U	U	U	8.00
9. 00 RADI OLOGY - THERAPEUTI C	0	0	0	Ō	0	9.00
10. 00 ONCOLOGY	0	0	0	0	0	10.00
10. 01 ANTI COAGULATI ON	0	1	0	0	0	10.00
10. 02 INFUSION SERVICES	0	1	0	0	0	10.01
10. 02 THEOSTON SERVICES 10. 98 HYPERBARI C OXYGEN THERAPY	0	1	0	0	0	10. 02
11.00 Totals (sum of lines 1-11)		0	0	0	0	11. 00
11.00 TOTALS (SUIII OF TITLES 1-11)	ļ	ı	ı V	U	0	1 11.00

Health Financial Systems	FRANCISCAN HEALTH	I LAFAYETTE	In Lie	u of Form CMS-2552-10
CALCULATION OF HOSPITAL-BASED HOSPICE PE	R DIEM COST	Provi der CCN:	Peri od: From 01/01/2023	Worksheet 0-8
		Hospi ce CCN:		Date/Time Prepared:

		nospi ce ccii	. 13-1303 1	0 12/31/2023	3/28/2024 12: (
				Hospi ce I		
			TITLE XVIII	TITLE XIX	TOTAL	
			MEDI CARE	MEDI CAI D		
			1.00	2. 00	3. 00	
	HOSPICE CONTINUOUS HOME CARE					
1.00	Total cost (Wkst. 0-6, Part I, col. 18, line 50 plus Wkst. 0-7	7, col. 6,			206	1.00
	line 11)					
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 10)				1	2. 00
3.00	Total average cost per diem (line 1 divided by line 2)				206. 00	3. 00
4.00	Unduplicated program days (Wkst. S-9 col. as appropriate, line	10)	1	0		4. 00
5.00	Program cost (line 3 times line 4)		206	0		5. 00
	HOSPICE ROUTINE HOME CARE			T T		
6.00	Total cost (Wkst. 0-6, Part I, col. 18, line 51 plus Wkst. 0-7	7, col. 7,			7, 659, 524	6. 00
7 00	line 11)				40.400	7.00
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)				42, 408	7. 00
8.00	Total average cost per diem (line 6 divided by line 7)	4.43		4 000	180. 62	
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, lir	ne 11)	40, 540			9. 00
10. 00	Program cost (line 8 times line 9)		7, 322, 335	180, 620		10. 00
11 00	HOSPICE INPATIENT RESPITE CARE	! 0			15 50/	11 00
11. 00	Total cost (Wkst. 0-6, Part I, col. 18, line 52 plus Wkst. 0-7 line 11)	, coi. 8,			15, 506	11. 00
12. 00	Total unduplicated days (Wkst. S-9, col. 4, line 12)				84	12. 00
13. 00	Total average cost per diem (line 11 divided by line 12)				184. 60	
14. 00	Unduplicated program days (Wkst. S-9, col. as appropriate, lir	no 12)	75	7	104.00	14. 00
15. 00	Program cost (line 13 times line 14)	12)	13, 845			15. 00
13.00	HOSPICE GENERAL INPATIENT CARE		13, 643	1, 272		13.00
16. 00	Total cost (Wkst. 0-6, Part I, col. 18, line 53 plus Wkst. 0-7	7 col 0			2, 140, 602	16. 00
10.00	line 11)	, сог. ,			2, 140, 002	10.00
17. 00	Total unduplicated days (Wkst. S-9, col. 4, line 13)				61	17. 00
18. 00	Total average cost per diem (line 16 divided by line 17)				35, 091. 84	18. 00
19. 00	Unduplicated program days (Wkst. S-9, col. as appropriate, lir	ne 13)	58	3	00,071101	19. 00
	Program cost (line 18 times line 19)	,	2, 035, 327			20. 00
	TOTAL HOSPI CE CARE					
21. 00	Total cost (sum of line 1 + line 6 + line 11 + line 16)				9, 815, 838	21. 00
	Total unduplicated days (Wkst. S-9, col. 4, line 14)				42, 554	
	Average cost per diem (line 21 divided by line 22)				230. 67	
	1 3 1 1 2 (2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	1		'		

ALCUL	FINANCI SCAN HEALTH ATION OF CAPITAL PAYMENT FRANCISCAN HEALTH	Provi der CCN: 15-0109	Peri od:	u of Form CMS-2 Worksheet L	
			From 01/01/2023 To 12/31/2023	Parts I-III Date/Time Pre	pared
		Titl Mall		3/28/2024 12:	04 pm
		Title XVIII	Hospi tal	PPS	1
			<u>Urban</u> 1. 00	Rural 1. 01	
	PART I - FULLY PROSPECTIVE METHOD		1.00	1.01	
	CAPITAL FEDERAL AMOUNT				1
00	Capital DRG other than outlier		2, 068, 870	0	1.0
01	Model 4 BPCI Capital DRG other than outlier		0	0	1.0
00	Capital DRG outlier payments		122, 987		2. 0
01	Model 4 BPCI Capital DRG outlier payments		0		2.0
00	Total inpatient days divided by number of days in the cost re	eporting period (see	106. 58		3.0
00	instructions)		0.00		١.,
00	Number of interns & residents (see instructions)		0. 00 0. 00		4.0
00	Indirect medical education percentage (see instructions) Indirect medical education adjustment (multiply line 5 by the	sum of lines 1 and 1 01			6.0
00	columns 1 and 1.01) (see instructions)	sum of filles I and I.O.	,		0. (
00	Percentage of SSI recipient patient days to Medicare Part A pa	oatient days (Worksheet F	0.00		7.0
	part A line 30) (see instructions)		.,		
00	Percentage of Medicaid patient days to total days (see instru	ıcti ons)	0.00		8. (
00	Sum of lines 7 and 8		0.00		9.
0. 00	Allowable disproportionate share percentage (see instructions)	s)	0.00		10.
. 00	Disproportionate share adjustment (see instructions)		0		11.
. 00	Total prospective capital payments (see instructions)		2, 191, 857		12.
				4 00	
	PART II - PAYMENT UNDER REASONABLE COST			1. 00	
00	Program inpatient routine capital cost (see instructions)			0	1.
00	Program inpatient routine capital cost (see instructions)			0	1
00	Total inpatient program capital cost (line 1 plus line 2)			0	
00	Capital cost payment factor (see instructions)			0	1
00	Total inpatient program capital cost (line 3 x line 4)			0	
				1. 00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS				١.
00	Program inpatient capital costs (see instructions)			0	
00	Program inpatient capital costs for extraordinary circumstance	ces (see instructions)		0	
00 00	Net program inpatient capital costs (line 1 minus line 2)			0 0. 00	1 -
)O	Applicable exception percentage (see instructions)				5.
00	Capital cost for comparison to payments (line 3 x line 4)				6.
00	Percentage adjustment for extraordinary circumstances (see instructions)				7.
00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)				8.
00	Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as applicable)				9.
00	Current year capital payments (from Part 1, fine 12, as applicable) Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)				10.
00	Carryover of accumulated capital minimum payment level over capital payment (from prior year				11.
. 00	Worksheet L, Part III, line 14)	pap. car paymont (110m pri	o. you.	O	' ' '
. 00	Net comparison of capital minimum payment level to capital par	ayments (line 10 plus lir	ne 11)	0	12.
. 00	Current year exception payment (if line 12 is positive, enter			0	1
	Carryover of accumulated capital minimum payment level over ca		,	0	14.
	(if line 12 is negative, enter the amount on this line)		5 1		
	(11 Title 12 13 negative, enter the amount on this fille)				
. 00	Current year allowable operating and capital payment (see ins	structions)		0	15.
i. 00 5. 00	,	structi ons)		0	